VHCIP Core Team Additional Materials 10.08.14

TO: SIM Core Team

FROM: Anya Rader Wallack

DATE: October 3, 2014

SUBJECT: Year Two Shared Savings Program Measures

At our meeting on October 8, I will ask the Core Team to vote on the proposed changes to ACO performance measures for year two of the Medicaid and commercial shared savings programs. Pat Jones and Alicia Cooper have briefed us on the recommendations from the Quality and Performance Measures Work Group a couple times.

The work group was divided on some of the recommendations. The Steering Committee reviewed the work group's recommendations and did not take a position in favor of or against them. We have provided ample opportunity for public input prior to both the Steering Committee consideration and our consideration. I am again sending you the summary of comments we received (attached).

The primary division in the work group, and the source of most opposition to the recommendations, relates to moving certain measures from the reporting category to the payment category, thereby using them as a partial basis for calculation of any year two sharing of savings between payers (Medicaid and BCBSVT) and Accountable Care Organizations. Of particular note is the opposition of the Vermont Medical Society, two of the three ACOs and the chief medical officers of all Vermont hospitals to the inclusion of three new measures in the payment set. In addition, several groups opposed using the proposed avoidable ED measure for reporting, due to weaknesses in that measure and impending implementation of ICD-10 coding, which could further undermine the measure's validity.

In preparation for our vote on this issue, I asked Georgia to explore whether there is any room for a compromise, beyond that discussed by the work group, which would satisfy all parties. Unfortunately, the answer seems to be no. I nonetheless think it is worth considering a compromise that would balance our desire to add meaningful new measures to our measure set (in particular, measures related to long term services and supports) against what I believe is legitimate provider concern about:

- The overall burden of reporting, especially where measures can not be calculated from claims data;
- The lack of any reporting experience on which to base out decisions about which measures should be used for payment; and

- Potential "overload" of measures, which could dilute efforts to improve both the reliability of reporting and performance improvement efforts guided by the measures.

In this spirit I offer the following proposal for compromise:

	Original proposal	**ARW proposal**

Reclassify	9 measures:
	• 3 to payment
	  o ASC admissions
	  o Diabetes care
	  o Pediatric weight assessment and counseling
	• 4 to reporting
	  o Cervical cancer screening
	  o Tobacco use
	  o Dev. Screening in first 3 years
	  o Avoidable ED use
	• 2 to M&E:
	  o Breast cancer screening
	  o SBIRT
		6 measures:
		• 1 to payment
		  o ASC admissions
		• 3 to reporting
		  o Cervical cancer screening
		  o Tobacco use
		  o Dev. Screening in first 3 years
		• 2 to M&E:
		  o Breast cancer screening
		  o SBIRT

Add	2 measures:
	• 1 to reporting
	  o DLTSS survey
	• 1 to M&E
	  o DLTSS rebalancing
		2 measures:
		• 1 to reporting
		  o DLTSS survey
		• 1 to M&E
		  o DLTSS rebalancing

I look forward to our discussion on October 8. Feel free to contact me before then if you have any questions.

Summary of Written Feedback on Proposed Year 2 Measures by Commenter

Commenter	Comment Summary
Blue Cross Blue Shield of Vermont	Expresses appreciation for the QPM work group's process. Supports only the promotion of all Year 1 *Patient Experience Survey* composite measures to Payment in Year 2, to ensure that beneficiary evaluations are included in the assessment of the success of the pilot program.
Community Health Accountable Care	Generally supports the Year 2 measure changes as recommended by the QPM work group. Also advocates for a reduction in the number of charts required for sampling in clinical measure collection, given the administrative burden on clinical and administrative practice staff.
Department of Children and Families	Supports the QPM work group's recommendations of measures that are directly relevant to child health and family well-being. Specifically: - *Pediatric Weight Assessment and Counseling* as a Payment measure - *Developmental Screening in the First Three Years of Life* as a Reporting measure (commercial) - *Prenatal and Post-partum Care* as a Reporting measure, though only including the prenatal care component due to the differing timelines for post-partum care.
Department of Vermont Health Access	Supports the Year 2 measure changes as recommended by the QPM work group, and believes such changes reinforce the development of relationships between patients and their primary care providers needed to improve the delivery and quality of care during the implementation of the pilot program. Proposes two changes to proposed measure recommendations: - Prefers that *Breast Cancer Screening* remains a Reporting measure - Recommends promotion of *Rate of Hospitalization for Ambulatory Care Sensitive Conditions: COPD and Asthma in Older Adults* from Reporting to Payment
Health*first*	Supports the position of the Vermont Medical Society. Expresses concerns about the addition of measures in Year 2 for the following reasons: - Increased cost and administrative burden on providers and ACOs, potentially detracting from clinical care provision - Delayed Year 1 implementation resulted in delayed development of initiatives focusing on Year 1 measures Requests postponement of consideration of new measures until Year 3.

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Anonymous	Expresses concerns about the feasibility of collecting certain Medicaid measures, and limited availability of well-known goals.
Northwestern Medical Center	Expresses support for some measures as proposed by the QPM work group, and opposition to others, citing the following concerns: - Very few of the proposed measures exhibit all of the merits prioritized in the QPM work group's measure selection criteria - New measures should not be added for Year 2 without an understanding of Year 1 performance - Use of non-claims-based measures results in significant financial and administrative burden - The addition of new measures in Year 2 will dilute more targeted performance improvement efforts
OneCare Vermont	Expresses support for some measures as proposed by the QPM work group, and opposition to others, with the following specific requests: - Avoid moving any measures to Payment in Year 2, given the delay in Year 1 program implementation - Minimize the number of measures requiring manual abstraction Additionally, notes that feedback from the broad OneCare provider network was minimized to a single vote in the QPM work group setting, and expresses concern that the perspective of practicing clinicians may not have been adequately represented in the recommendation-making process.
Dr. Peter Reed	Supports the measures as proposed by the QPM work group, and requests additional consideration of measures that would assess an ACO's contributions to addressing social determinants of health in communities they serve. Specifically: - dollars or % of total budget spent on providing transportation to patients - % of foods sourced locally, organically, fair trade - donations made to local organizations that assist with housing security, food security, addiction, criminal rehabilitation, etc. - direct services offered to assist with housing security, food security, addiction, criminal rehabilitation, etc.
Vermont Council of Developmental and Mental Health Services	Suggests additions to the proposed measures to include substance abuse and mental health screening measures, thereby increasing opportunities for ACOs to improve health outcomes and coordinate care for a potentially high-utilizing population. Recommends consideration of the following substance abuse screening tools:

	- AUDIT and DAST - NIDA Adult - PHQ-2 - PHQ-9 - CAGE and CAGE-Aid
Vermont Department of Health	Expresses appreciation for the QPM work group's measure review process, supports the proposed Year 2 measures, and encourages additional consideration of the following measures given their importance for population health and their alignment with the priorities of the State Health Improvement Plan: - *Prenatal & Postpartum Care* - *Influenza Immunization* - *Screening for High Blood Pressure with Follow up Plan Documented* - *Controlling Blood Pressure* - *Optimal Diabetes Care* - *Adult Weight Screening and Follow-Up* - *Screening for Clinical Depression and Follow-Up* - *Care Transition Record Transmitted to Health Care Professional*
Vermont Legal Aid/Office of the Health Care Advocate	Supports the Year 2 measure changes as recommended by the QPM work group, and notes that the use of Payment measures is a primary way to ensure that the quality of care is maintained or improved while ACOs work toward achieving savings. Additionally, expresses concern about the following: - Limited scope of the measure set, in that populations included in the Medicaid and commercial shared savings programs do not have adequate quality measure coverage (e.g. pediatric, maternity, and DLTSS populations) - Limited promotion of Pending measures, impacting the ability of such measures to be considered for Payment before the end of the pilot program - Restricting the scoring of measures against selection criteria to those that were recommended for Year 2 reconsideration, rather than evaluating all program measures - Giving all criteria equal weight in the scoring methodology Requests additional consideration of the following measures: - *Prenatal & Postpartum Care* - *Influenza Immunization* - *Adult Weight Screening and Follow-Up*

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	- *Care Transition Record Transmitted to Health Care Professional* - *Transition Record with Specified Elements Received by Discharged Patients* Further notes that: A) Consumers are underrepresented in all levels of the Vermont Health Care Innovation Project (VHCIP), whereas providers are strongly represented; B) Quality measures are important not only for informing quality improvement initiatives, but also for monitoring overall quality of care; and C) ACO quality measures are intended to assess quality of care throughout the health care system, not just at the hospital level.
Vermont Medical Society	Expresses support for some measures as proposed by the QPM work group, and opposition to others, citing the following concerns: - Insufficient alignment between the Commercial/Medicaid SSPs and the Medicare SSP (for both Year 1 and proposed Year 2) measure sets - Increasing the number of measures used would increase financial and administrative burden on providers - No measures should be newly used for Payment in Year 2 without baseline Year 1 data available Adds additional information in opposition of the use of 'Avoidable ED Visits' as a Reporting measure, and reiterates importance of clinicians' input in the design of payment reform initiatives.
Jennifer Fels, Southwestern Vermont Health Care	Recommends that measures be standardized across CMS measures and the Vermont Blueprint for Health and incorporate NCQA Medical Home certification requirements, and that measure capture should be automated from electronic medical records to the extent possible.
Chief Medical Officers of 8 Vermont Hospitals	Express support for the recommendations made by the Vermont Medical Society and OneCare Vermont, citing concerns about additional administrative burden early on during pilot implementation.
Vermont Association of Hospitals and Health Systems	Express support for the recommendations made by the Vermont Medical Society and OneCare Vermont.

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Bi-State Primary Care Association	Measurement can be a burden, but consumers have a right to know whether care meets standards and achieves the best outcomes possible. Measures should provide information that's meaningful to consumers, policy makers, or providers. Bi-State's members aren't concerned that a broad scope of measures will cause providers to be spread too thin as they engage in improving results that don't meet targets. The delivery system should prioritize the improvement initiatives that are most needed, likely to be most effective, and based on solid data. Some measures' data sources are still incomplete and unreliable. Full transparency is the shortest path to identifying and sharing best practices, targeting administrative resources to the areas of greatest need or efficiency, keeping a spotlight on trouble spots, and revealing areas for data collection improvement. We need to streamline data capture (e.g., by maximizing data captured via claims) and eliminate wasteful duplication in chart extraction (e.g., payers, ACOs, others).