VT Health Care Innovation Project
Quality and Performance Measures Work Group Meeting Agenda

Monday, October 21, 2013; 10:00 AM to 12 Noon
DFR Third Floor Large Conference Room, City Center, 89 Main Street, Montpelier, VT
Call-In Number: 1-866-951-1151; Passcode 7865626

Item #	Time Frame	Topic	Relevant Attachments	Action #
1	10:00-10:10	Welcome and Introductions		
2	10:10-10:25	Relationship of Work Group to Broader VHCIP (SIM) Governance Structure and Other Work Groups (including HIE Performance Measures Subcommittee)	VHCIP Overview for Q and PM Work Group	
3	10:25-10:40	Work Group Goals and Activities	Q and PM Work Group Description from SIM Op Plan	
4	10:40-10:55	Commercial and Medicaid ACO Shared Savings Measures: Process, Criteria for Measure Selection, Recommended Measures, Use of Measures	ACO Measures Summary…; 2014 Comparison…	
5	10:55-11:15	Reporting Measures: Criteria for Attaining Full Payment	Reporting Measures Scoring Options	
6	11:15-11:35	Draft Measure Modification Standard	ACO Standards draft – process for review and modification of measures	
7	11:35-11:50	Measures for SIM Driver Diagram	Driver Diagram; SIM Driver Diagram Measurement Categories and Goals	
8	11:50-12:00	Next Steps, Wrap-Up and Future Meeting Schedule		

Vermont Health Care Innovation Project

Overview for Quality and Performance Measures Work Group

October 21, 2013

What are we trying to do through this project?

- Create/accelerate three things, on a statewide, all-payer basis:
  - An integrated system of value-based provider payment
  - An integrated system of care coordination and care management
  - An integrated system of electronic medical records

How will we do it?

- Input through 7 work groups on policy and spending
- Recommendations:
  - work groups → steering committee → core team
- On what?
  - Coordinated policy:
    - Payment
    - Care management
    - Health information exchange
  - Targeted funding:
    - Modeling and testing payment reforms
    - Expanding health information exchange
    - Supporting providers to change their business models

SIM grant requirements

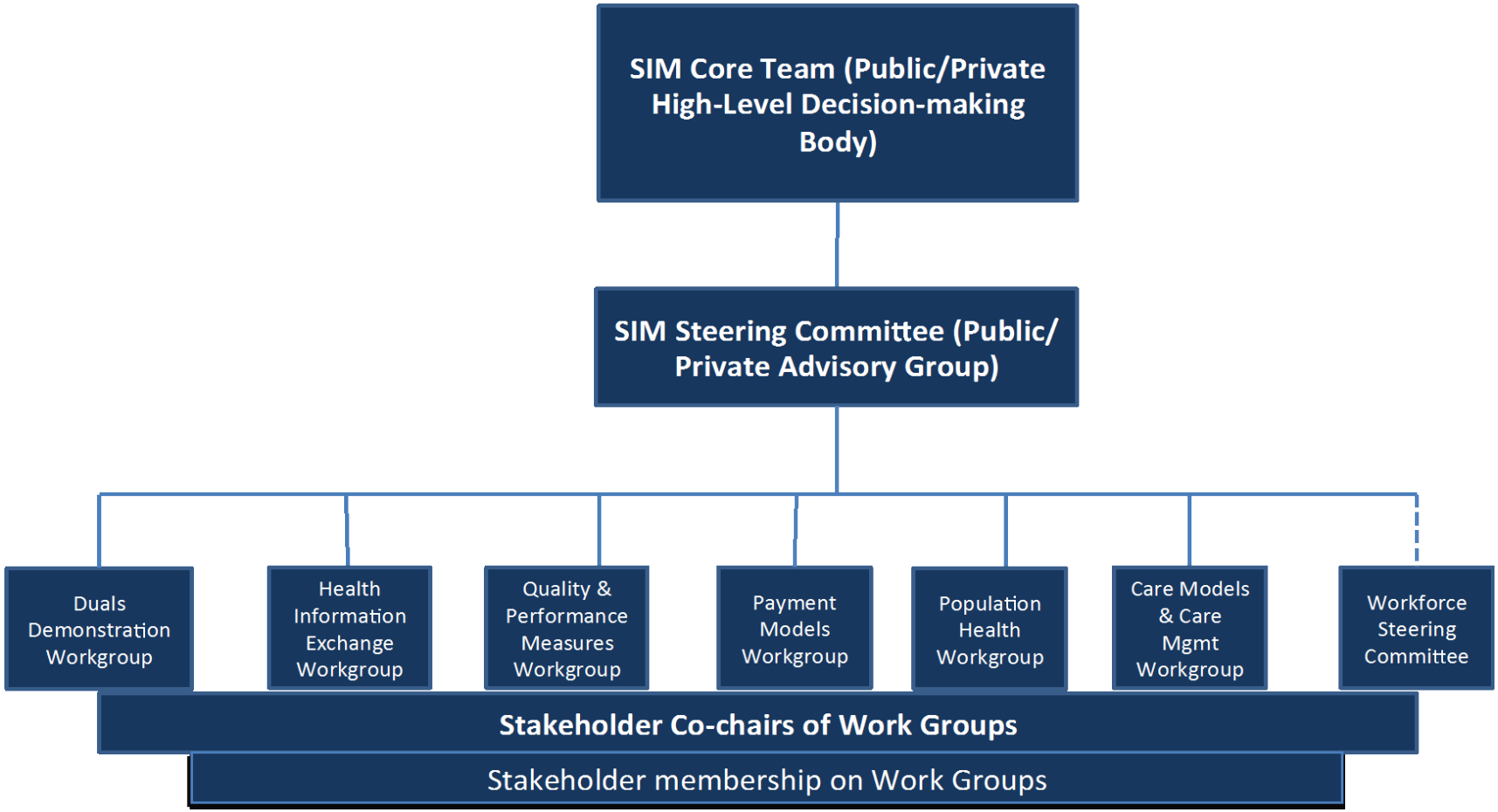
- Address the triple aim (cost, quality, patient experience)
- Include multiple payers
- Test models of value-based payment (if you are requesting a testing grant)
- Include a broad array of stakeholders
- Show strong support for the project from the Governor
- Align with other federal demonstrations and waivers
- Prove “readiness” to test by October 1
- Rigorous evaluation

Vermont Health Care Innovation Project

SIM grant history

- Application submitted in September 2012
- Grant awarded in March 2013
- JFC approved receipt of funds in May
- Steering committee launched in June
- Operational plan submitted July 31
- Approved for testing phase on September 30
- Reconstituting and launching work groups now

Vermont health care innovation project governance structure*



*In addition to the standing work groups, we have agreed to create a time-limited group to address the interface between designated mental health agencies and SIM activities/recommendations

Input on SIM Decisions

Core Team

- Anya Rader Wallack, Chair
- Robin Lunge, Director of Health Care Reform
- Doug Racine, Secretary of Human Services
- Al Gobeille, Chair of the Green Mountain Care Board
- Mark Larson, Commissioner of the Department of Vermont Health Access
- Susan Wehry, Commissioner of the Department of Disabilities, Aging and Independent Living
- Lisa Ventriss, President of the Vermont Business Roundtable (to be replaced by Steve Voigt in mid-October)
- Paul Bengtson, CEO of Northeastern Vermont Regional Hospital

Work Group Chairs

Payment Models

Don George, President and CEO, BCBSVT

Stephen Rauh, Health Policy Consultant and Member of GMCB Advisory Board

Care Models and Care Management

Bea Grause, President, Vermont Association of Hospitals and Health Systems

Susan Barrett, Director of Vermont Public Policy, Bi-State Primary Care

Health Information Exchange

Simone Rueschemeyer, Behavioral Health Network

Brian Otley, Chief Operating Officer, Green Mountain Power

Dual Eligibles

Deborah Lisi-Baker, Disability Policy Expert

Judy Peterson, Visiting Nurse Association of Chittenden and Grand Isle Counties

Quality and Performance Measures

Catherine Fulton, Executive Director, Vermont Program for Quality in Health Care

Laura Pelosi, Vermont Health Care Association

Population Health Management

Tracy Dolan, Deputy Commissioner, Department of Health

Karen Hein, M.D., Member of the Green Mountain Care Board

Workforce Steering Committee (a slightly different animal)

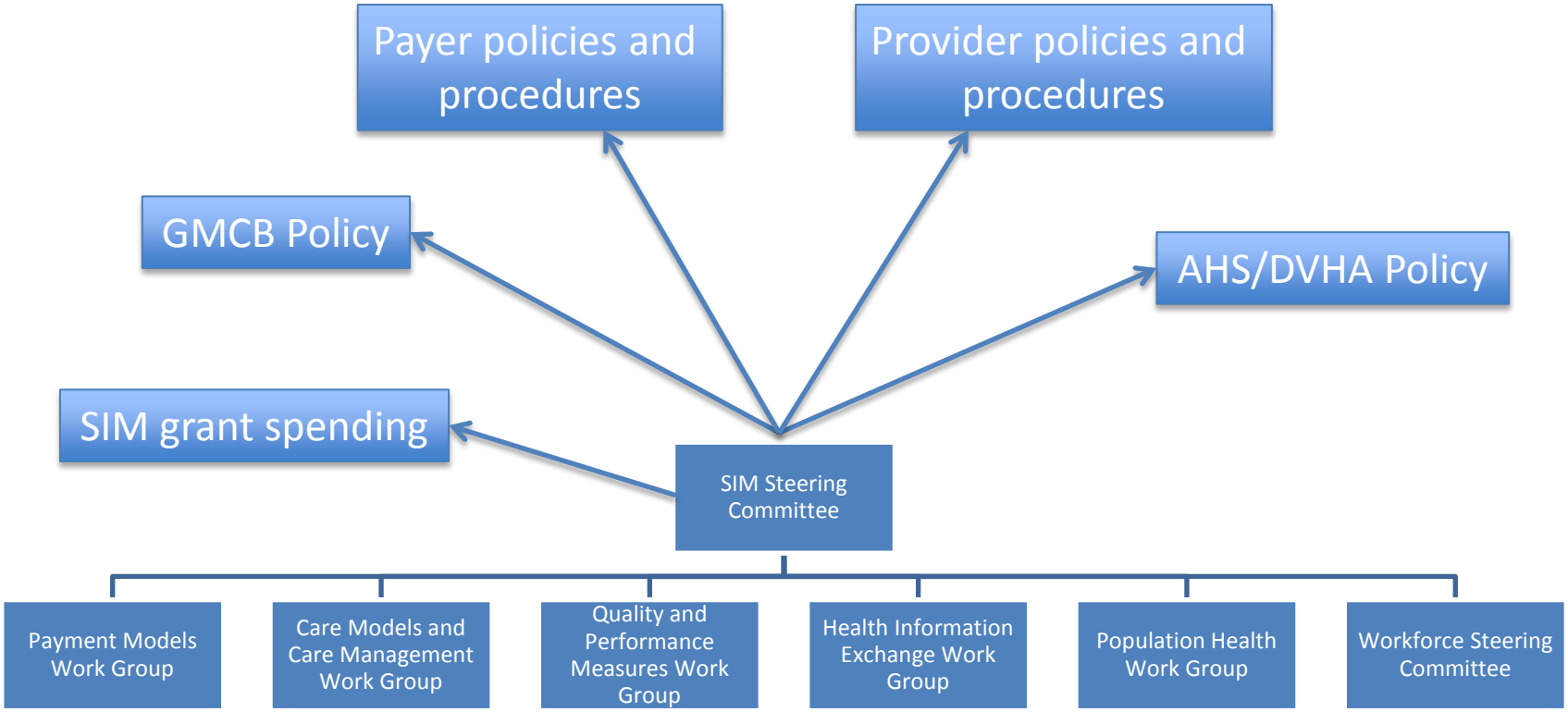
Mary Val Palumbo, R.N.

David Reynolds

Expectations for work groups

- Develop a formal charter
- Develop a work plan
- Meet at least monthly
- Report monthly to Steering Committee and Core Team
- Recommend contractor support for your work
- Recommend spending of certain SIM funds

Expected influence of the health care innovation project



Vermont Health Care Innovation Project

Description of Quality and Performance Measures Work Group from Vermont's "State Innovation Model Operational Plan for Health System Innovation" dated July 31, 2013:

This group will build on the work of the ACO Quality and Performance Measures Work Group, and will recommend standardized measures that will be used to:

- Evaluate the performance of Vermont's payment reform models relative to state objectives;
- Qualify and modify shared savings, episodes of care, pay for performance, and health home payments; and
- Communicate performance to consumers through public reporting.

The overarching goal of quality and performance measurement is to focus health care reform and quality improvement efforts to control growth in health care costs, improve health care, and improve the health of Vermont's population.

The work group's deliverables will include recommendations on consolidated and standardized sets of all-payer quality and performance measures to be used to indicate improvements in performance, monitor adherence to quality standards, and qualify and modify payments to providers or provider organizations. When possible, the focus will be on nationally accepted measures that can be benchmarked. As needed, the work group will make recommendations regarding data resources for proposed measures, troubleshooting measurement barriers, and supporting measurement issue resolution. Performance measures will be reviewed on at least an annual basis, and will be revised, retired or replaced as appropriate.

Commercial and Medicaid Shared Savings Program: Recommended Year 1 Performance Measures

Vermont Health Care Innovation Project

Quality and Performance Measures Work Group

October 21, 2013

Presentation Overview

- ACO Measures Work Group
  - Members
  - Objectives
  - Process
- Recommended Measures
  - Payment
  - Reporting
- Impact of Measures on Reporting

ACO Measures Work Group

ACO Measures Work Group Members

Representatives from wide variety of organizations, including:

- Accountable Care Coalition of the Green Mountains
- Agency of Administration
- Agency of Human Services
- Bi-State Primary Care Association
- Blue Cross and Blue Shield of Vermont
- Blueprint for Health
- Department of Financial Regulation
- Department of Mental Health
- Department of Vermont Health Access
- Fletcher Allen Health Care
- Green Mountain Care Board
- MVP Health Care
- OneCare
- Vermont Assembly of Home Health Agencies
- Vermont Association of Hospitals and Health Systems
- Vermont Information Technology Leaders
- Vermont Legal Aid
- Vermont Medical Society
- Vermont Program for Quality in Health Care

ACO Measures Work Group Objectives

To identify standardized measures that will be used to:

- Evaluate the performance of Vermont's Accountable Care Organizations (ACOs) relative to state objectives for ACOs,
- Qualify and modify shared savings payments, and
- Guide improvements in health care delivery.

Criteria for Selecting Measures

- Representative of array of services provided and beneficiaries served by ACOs;
- Valid and reliable;
- NQF-endorsed measures with relevant benchmarks whenever possible;
- Aligned with national and state measure sets and federal and state initiatives whenever possible;
- Focused on outcomes to the extent possible;
- Uninfluenced by differences in patient case mix or appropriately adjusted for such differences;
- Not prone to effects of random variation (measure type and denominator size);
- Not administratively burdensome;
- Limited in number and including only measures necessary to achieve state's goals (e.g., opportunity for improvement);
- Population-based; and
- Consistent with state's objectives and goals for improved health systems performance.

Work Group Process

- Over the course of nine months (January 2013-October 2013), the ACO Measures Work Group met about every two weeks.

- Two sub-groups also held several meetings:
  - Patient Experience of Care Survey Sub-group
  - End-of-Life Care Measures Sub-group

1/29/2014

7

Work Group Process (continued)

- **Created "crosswalk" of over 200 measures from numerous measure sets, including:**
  - BCBSMA Alternative Quality Contract
  - Blueprint for Health
  - Buying Value
  - CHIPRA
  - CMS Medicare Shared Savings Program
  - Initial Core Set of Adult Health Care Quality Measures for Medicaid Eligible Adults
  - Maine ACO
  - Meaningful Use
  - NCQA
  - OneCare
  - PQRS
  - Uniform Data System (required for FQHCs)
  - Vermont reporting requirements for providers and health plans

Work Group Process (continued)

Work Group Participants:

- Identified their priority measures for consideration
- Eliminated measures through application of criteria and extensive discussion
- Expressed support for and concerns about measures
- Focused on measures in various domains, with national specifications, with benchmarks, and with opportunities for improvement
- Compromised
- Expressed widespread support, but not quite unanimity

Recommended Measures

Two Measure Sets

Core Measure Set

- The Core Measure Set consists of measures for which the ACO has current or pending responsibility for collection, for either reporting or payment purposes.

Monitoring and Evaluation (M&E) Measure Set

- The Monitoring & Evaluation Measure Set consists of measures that will be used for programmatic monitoring, evaluation, and planning. Collection of these measures will not influence the distribution of shared savings.

Measure Use Terminology: Core Measure Set

Payment

- Performance on these measures will be considered when calculating shared savings.

Reporting

- ACOs will be required to report on these measures. Performance on these measures will be not be considered when calculating shared savings; ACO submission of the clinical data-based reporting measures will be considered when calculating shared savings.

Pending

- Measures that are included in the core measure set but are not presently required to be reported. Pending measures are considered of importance to the ACO model, but are not required for initial reporting for one of the following reasons: target population not presently included, lack of availability of clinical or other required data, lack of sufficient baseline data, lack of clear or widely accepted specifications, or overly burdensome to collect.

Recommended Year 1 Payment Measures
(Claims data)

Commercial and Medicaid Shared Savings Programs:

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)*

Medicaid Shared Savings Program:

- Developmental Screening in First 3 Years of Life
- Depression Screening by 18 Years of Age

*Related to Medicare Shared Savings Program Measure

Recommended Year 1 Reporting Measures
(Claims data)

Commercial and Medicaid Shared Savings Programs:

- Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults*
- Breast Cancer Screening*
- Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite
- Appropriate Testing for Children with Pharyngitis

*Medicare Shared Savings Program Measure

Recommended Year 1 Reporting Measures
(Clinical Data)

Commercial and Medicaid Shared Savings Programs:

- Adult BMI Screening and Follow-Up*
- Screening for Clinical Depression and Follow-Up Plan*
- Colorectal Cancer Screening*
- Diabetes Composite
  - HbA1c control*
  - LDL control*
  - High blood pressure control*
  - Tobacco non-use*
  - Daily aspirin or anti-platelet medication*
- Diabetes HbA1c Poor Control*
- Childhood Immunization Status
- Pediatric Weight Assessment and Counseling

*Medicare Shared Savings Program Measure

Recommended Year 1 Reporting Measures
(Survey Data)

Patient Experience Survey Composite Measures:

- Access to Care
- Communication
- Shared Decision-Making
- Self-Management Support
- Comprehensiveness
- Office Staff
- Information
- Coordination of Care
- Specialist Care

Impact of Measures on Payment

Impact of Payment Measures: Commercial

Commercial "Gate and Ladder" Approach:

- Compare each payment measure to the national benchmark and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.

- If the ACO does not achieve at least 55% of the maximum available points across all payment measures, it is not eligible for any shared savings ("quality gate").

- In proposed commercial SSP "quality ladder," ACO earns:
  - 75% of potential savings for achieving 55% of available points,
  - 85% of potential savings for achieving 65% of available points,
  - 95% of potential savings for achieving 75% of available points.

Commercial Shared Savings Program Ladder (proposed)

Percentage of available points	Percentage of earned savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Impact of Payment Measures: Medicaid

Medicaid "Gate and Ladder" Approach:

- *(Core-2 – Core-7)* Compare each payment measure to the national benchmark and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.
- *(Core-1 & Core-8)* Compare each payment measure to VT Medicaid benchmark, and assign 0, 2 or 3 points based on whether the ACO declines, stays the same, or improves relative to the benchmark.
  - Statistical significance; targets associated with each point value to be calculated when initial ACO attribution estimates are available
- If the ACO does not achieve at least 35% of the maximum available points across all payment measures, it is not eligible for any shared savings ("quality gate").
- In proposed commercial SSP "quality ladder," ACO earns:
  - 75% of potential savings for achieving 35% of available points,
  - 85% of potential savings for achieving 45% of available points,
  - 95% of potential savings for achieving 55% of available points.

Medicaid Shared Savings Program Ladder
(proposed)

Percentage of available points	Percentage of earned savings
35%	75%
40%	80%
45%	85%
50%	90%
55%	95%
60%	100%

Use of Reporting Measures in Shared Savings Distribution Determination Options Analysis
October 17, 2013

Option	Strengths	Weaknesses
#1: The ACO must submit *all* reporting measures[1], completely and in a timely manner, to retain any savings. Failure to do so will result in a forfeiture of 20% of net savings after consideration of payment measure performance in Year 1, and 50% in Year 2.	• Strong incentive to report, consistent with Work Group intent that reporting be a requirement.	• ACO could forfeit some savings for failure to adequately report on one of seven measures.
#2: The ACO must submit *most* reporting measures (e.g., 5 of 7), completely and in a timely manner, to retain any savings. Failure to do so will result in a forfeiture of 20% of net savings after consideration of payment measure performance in Year 1, and 50% in Year 2.	• Affords ACO a margin for failure.	• Could result in an ACO choosing not to pursue two measures altogether.
#3: The ACO will receive 1 point for each measure it submits completely and in a timely manner.	• The implications for non-reporting are less threatening to the ACO with Option #1, and possibly Option #2.	• The idea of including the reporting measures in the algorithm was previously rejected by the ACO Standards Work Group.

"Completely": ACOs shall have two options for reporting each of the measures:
1) using a random sample[2] of 411 commercially insured patients and 411 Medicaid patients, or
2) using EHR-generated data for the entire Medicaid measure-eligible patient population for providers representing at least 50%[3] of Medicaid ACO membership and for the entire commercial measure-eligible patient population for providers representing at least 50% of commercial ACO membership

"Timely": by the submission due date

[1] Includes clinical data-based measures only and not payer-generated or patient experience measures.
[2] Three options for sample generation: ACOs, payers individually, and payers collectively via GMCB's analytics contractor.
[3] Percentage proposed to increase in subsequent years.

Joint ACO Measures and Standards Work Group
Process for Review and Modification of Measures Standard
October ~~9~~18, 2013 Revised Draft

Standard:

1. The SIM Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set at the beginning of the third quarter of each pilot year, with input from the SIM Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines. The goal of the review will be to determine whether each measure should continue to be used as-is for its designated purpose, or whether each measure should be modified (e.g. advanced from Reporting status to Payment status in a subsequent pilot year) or dropped for the next pilot year. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Final approval for any changes must be received no later than September 30th of the year prior to implementation of the changes. In the interest of ~~maintaining the stability~~retaining measures selected for Payment and Reporting purposes for the duration of the pilot program, ~~of the measure set, the Year 1 Payment and Reporting~~ measures ~~will~~ should not be ~~modified~~ removed ~~for Year 2~~in subsequent years unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.

2. The SIM Quality and Performance Measures Work Group and the SIM Payment Models Work Group will review all **targets and benchmarks** for the measures designated for Payment purposes at the beginning of the third quarter of each pilot year when NCQA publishes its Quality Compass product. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national xth percentile) should remain constant or change for the next pilot year. The Work Group should consider setting targets in year two and three that increase incentives for quality improvement. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Final approval for any changes must be received no later than September 30th of the year prior to implementation of the changes.

3. The SIM Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set beginning in the first quarter of each pilot year, with input from the SIM Payment Models Work Group. For each measure, these reviews will consider data availability and quality, patient populations served, and measure specifications, with the goal of developing a plan for measure and/or data systems development and a timeline for implementation of each measure. If ~~during the review,~~ the SIM Quality and Performance Measures Work Group determines that a measure has the support of the Work Group and is ready to be ~~implemented~~advanced from Pending status to Payment or Reporting status in the next pilot year, it shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure. If the

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Work Group designates the measure for Payment, it shall recommend an appropriate target that includes consideration of any available state-level performance data and national benchmarks. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Final approval for any changes must be received no later than September 30th of the year prior to implementation of the changes.

4. The SIM Quality and Performance Measures Work Group will review **state or insurer performance on the Monitoring and Evaluation measures** during the third quarter of each year after NCQA publishes its Quality Compass product, with input from the SIM Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the SIM Quality and Performance Measures Work Group may recommend that the measure be moved to the Core Measure Set to be assessed at the ACO level and used for either Payment or Reporting. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Final approval for any changes must be received no later than November 30th of the year prior to implementation of the changes.

5. The GMCB will release the **final measure specifications for the next pilot year by no later than** November 30~~th~~th. The specifications document will provide the details of any new measures and any changes from the previous year.

6. If during the course of the year, a national clinical guideline for any measure designated for Payment or Reporting changes or an ACO or payer participating in the pilot raises a serious concern about the implementation of a particular measure, the SIM Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the SIM Payment Models Work Group. Recommendations will go to the SIM Steering Committee, GMCB, and the SIM Core Team for review. Upon approval of a recommended change to a measure for the current pilot year, the GMCB must notify all pilot participants of the proposed change within 14 days.

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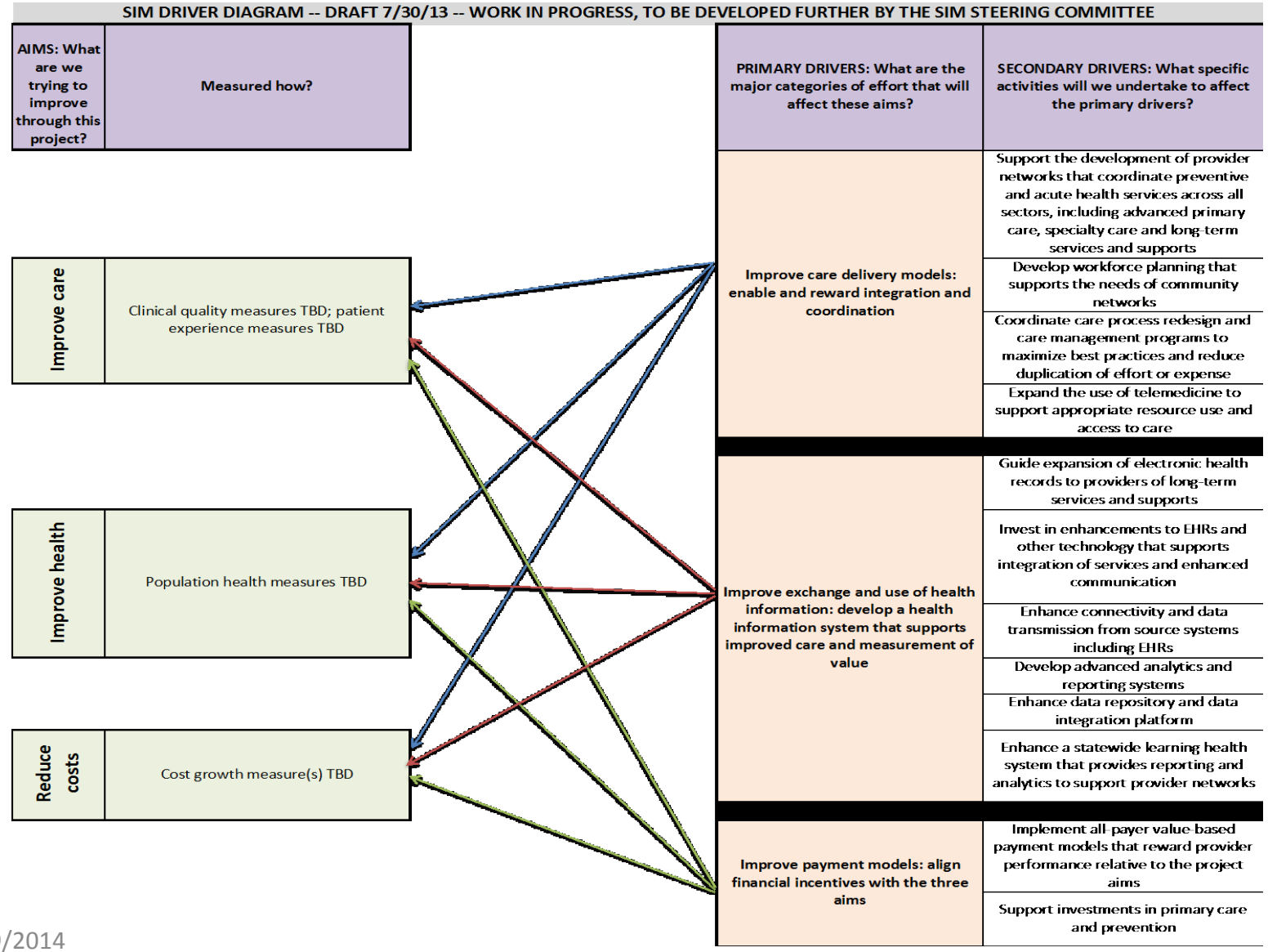
DRAFT-Vermont driver diagram



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Proposed Measurement Strategy for Vermont SIM Driver Diagram
(Based on Recommended Year 1 Commercial/Medicaid Payment and Reporting Measures)

Vermont SIM Aim #1 -- Improved Care:

Patient Experience (9 Composite Measures) – Access to Care, Communication, Shared Decision-Making, Self-Management Support, Comprehensiveness, Office Staff, Information, Coordination of Care, Specialist Care

- ***By 2017, Vermont will achieve statistically significant improvement in at least 3 patient experience composites for attributed ACO shared savings members, attributed PCMH members, or both.***

Mental Health and Substance Abuse Treatment Process of Care (4 Measures) – Follow-up After Hospitalization for Mental Illness, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Adult Depression Screening and Follow-Up, Depression Screening by 18 Years of Age

- ***By 2017, Vermont will achieve statistically significant improvement in at least 2 mental health and substance abuse process of care measures at the ACO, PCMH, health plan and/or state level.***

Adult Process of Care (5 Measures) – Adult Weight (BMI) Screening and Follow-Up, Colorectal Cancer Screening, Mammography/Breast Cancer Screening, Chlamydia Screening in Women, Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis

- ***By 2017, Vermont will achieve statistically significant improvement in at least 2 adult process of care measures at the ACO, PCMH, health plan and/or state level.***

Pediatric Process of Care (5 Measures) – Pediatric Weight Assessment and Counseling, Childhood Immunization Status, Adolescent Well-Care Visits, Developmental Screening in the First Three Years of Life, Appropriate Testing for Children with Pharyngitis

- ***By 2017, Vermont will achieve statistically significant improvement in at least 2 pediatric process of care measures at the ACO, PCMH, health plan and/or state level.***

Vermont SIM Aim #2 -- Improved Health:

Chronic Disease Outcome Measures (3 Measures) – Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening Only); Diabetes: Hemoglobin A1c Poor Control; Diabetes Composite (Hemoglobin A1c Control, LDL Control, Blood Pressure Control, Tobacco Non-Use, Aspirin Use)

- ***By 2017, Vermont will achieve statistically significant improvement in at least 1 chronic disease outcome measure at the ACO, PCMH, health plan, and/or state level.***

- ***See also Process of Care Measures under Aim #1 (Improved Care).***

Vermont SIM Aim #3 -- Reduced Costs:

Hospital Admission or Readmission Measures (3 Measures) – All-Cause Readmission, Ambulatory Care-Sensitive Conditions Admissions (COPD), Rate of Hospitalization for Ambulatory Care-Sensitive Conditions (PQI Composite)

- ***By 2017, Vermont will achieve statistically significant improvement in at least 1 hospital admission or readmission measure at the ACO, PCMH, health plan and/or state level.***

Total Cost of Care Measures (2 Measures) – Total Cost of Care (Total Cost Index), Total Cost of Care (Resource Use Index)

- ***By 2017, Vermont will achieve statistically significant improvement in at least 1 total cost of care measure at the ACO, PCMH, health plan and/or state level.***

Comparison of Proposed 2014 ACO Reporting or Payment Measures for MSSP (Medicare ACO), Vermont Commercial ACO, and Vermont Medicaid ACO

Key: Y=Yes; N=No; C=Claims; MR=Medical Record; S=Survey; R=Reporting; P=Payment

MSSP	Measure Description	Data: Claims, Medical Record, or Survey?	Medicare ACO Use Year 2 2014	Commercial ACO Use Proposed 2014	Medicaid ACO Use Proposed 2014
Y	Risk-Standardized All Condition Readmission	**C**	**R**		
Y	Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults	**C**	**P**	**R**	**R**
Y	Ambulatory Sensitive Conditions Admissions: Heart Failure	**C**	**P**		
Y	% of PCPs who Successfully Qualify for an EHR Program Incentive Payment	**Other**	**P**		
Y	Medication Reconciliation	**MR**	**P**		
Y	Falls: Screening for Future Fall Risk	**MR**	**P**		
Y	Influenza Immunization	**MR**	**P**		
Y	Pneumococcal Vaccination for Patients 65 and Older	**MR**	**P**		
Y	Adult BMI Screening and Follow-Up	**MR**	**P**	**R**	**R**
Y	Tobacco Use: Screening and Cessation Intervention	**MR**	**P**		
Y	Screening for Clinical Depression and Follow-Up Plan	**MR**	**P**	**R**	**R**
Y	Colorectal Cancer Screening	**MR**	**R**	**R**	**R**
Y	Breast Cancer Screening	**C**	**R**	**R**	**R**
Y	Screening for High Blood Pressure and Follow-Up Documented	**MR**	**R**		
Y	Diabetes Composite (HbA1c control)	**MR**	**P**	**R**	**R**
Y	Diabetes Composite (LDL Control)	**MR**	**P**	**R**	**R**
Y	Diabetes Composite (High Blood Pressure Control)	**MR**	**P**	**R**	**R**
Y	Diabetes Composite (Tobacco Non Use)	**MR**	**P**	**R**	**R**
Y	Diabetes Composite (Daily Aspirin or Antiplatelet Medication)	**MR**	**P**	**R**	**R**
Y	Diabetes HbA1c poor control	**MR**	**P**	**R**	**R**
Y	Hypertension: Controlling High Blood Pressure	**MR**	**P**		
Y	IVD: Complete Lipid Panel and LDL Control	**MR/C***	**P**	**P***	**P***
Y	IVD: Use of Aspirin or Another Antithrombotic	**MR**	**P**		
Y	Heart Failure: Beta Blocker Therapy for LVSD	**MR**	**R**		
Y	Coronary Artery Disease Composite (Lipid control)	**MR**	**R**		
Y	Coronary Artery Disease Composite (ACE or ARB for LVSD)	**MR**	**R**		

*Recommendation for Vermont Commercial/Medicaid ACO is to substitute the claims based Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening only) for the medical record based IVD: Complete Lipid Panel and LDL Control measure, due to data collection challenges.

MSSP	Measure Description	Data: Claims, Medical Record, or Survey?	Medicare ACO Use Year 2 2014	Commercial ACO Use Proposed 2014	Medicaid ACO Use Proposed 2014
N	All-Cause Readmission	**C**		**P**	**P**
N	Adolescent Well-Care Visit	**C**		**P**	**P**
N	Follow-Up After Hospitalization for Mental Illness (7 day)	**C**		**P**	**P**
N	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	**C**		**P**	**P**
N	Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	**C**		**P**	**P**
N	Chlamydia Screening in Women	**C**		**P**	**P**
N	Developmental Screening in First 3 Years of Life	**C**			**P**
N	Depression Screening by 18 Years of Age	**C**			**P**
N	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	**C**		**R**	**R**
N	Appropriate Testing for Children With Pharyngitis	**C**		**R**	**R**
N	Childhood Immunization Status	**MR**		**R**	**R**
N	Pediatric Weight Assessment and Counseling	**MR**		**R**	**R**
	Patient Experience Surveys				
Y	NIS Patient Experience: Getting Timely Care, Appointments, Information	**S**	**P**		
Y	NIS Patient Experience: How Well Providers Communicate	**S**	**P**		
Y	NIS Patient Experience: Patients' Rating of Provider	**S**	**P**		
Y	NIS Patient Experience: Access to Specialists	**S**	**P**		
Y	NIS Patient Experience: Health Promotion and Education	**S**	**P**		
Y	NIS Patient Experience: Shared Decision Making	**S**	**P**		
Y	NIS Patient Experience: Health Status/Functional Status	**S**	**R**		
N	PCMH Patient Experience: Access to Care	**S**		**R**	**R**
N	PCMH Patient Experience: Communication	**S**		**R**	**R**
N	PCMH Patient Experience: Shared Decision-Making	**S**		**R**	**R**
N	PCMH Patient Experience: Self-Management Support	**S**		**R**	**R**
N	PCMH Patient Experience: Comprehensiveness	**S**		**R**	**R**
N	PCMH Patient Experience: Office Staff	**S**		**R**	**R**
N	PCMH Patient Experience: Information	**S**		**R**	**R**
N	PCMH Patient Experience: Coordination of Care	**S**		**R**	**R**
N	PCMH Patient Experience: Specialist Care	**S**		**R**	**R**
	Total Measures for Payment or Reporting 2014		**33**	**31**	**33**

*Recommendation for Vermont Commercial/Medicaid ACO is to substitute the claims based Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening only) for the medical record based IVD: Complete Lipid Panel and LDL Control measure, due to data collection challenges.