Quality and Performance Measures

Work Group Meeting

Agenda 4-13-15

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

April 13, 2015; 9:00 AM to 11:00 AM
4th Floor Conference Room, Pavilion Building, Montpelier, VT
Call-In Number: 1-877-273-4202 Passcode: 420323867

Item #	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	9:00-9:05	Welcome and Introductions; Approval of Minutes	Attachment 1: March QPM Minutes	YES – Approval
2	9:05-9:15	Updates • Gate and Ladder for Year 2 ACO Payment Measures ***Public Comment***		
3	9:15-10:00	Use of Performance Measures in Blueprint-ACO Unified Community Collaboratives – Part 2 (Jenney Samuelson) • How UCCs/RCPCs will use ACO quality results • Inclusion of ACO measures in Blueprint profiles • Using quality and utilization measures in enhanced PCMH payments ***Public Comment***	Attachment 3: (will be sent when available)	
4	10:00-10:15	Green Mountain Care Board Vote on Hiatus for Year 3 Measures ***Public Comment***	Attachment 4: GMCB Measures Hiatus Description	
5	10:15-10:55	Year 3 ACO Shared Savings Program Measures ***Public Comment***	Attachment 5: Priority Changes and Options for Year 3 Measures	
6	10:55-11:00	Wrap-Up and Next Steps ***Next Meeting: May 18, 2015; 9:00-11:00; DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT***		

Attachment 1

March Minutes

VT Health Care Innovation Project
Quality and Performance Measures Work Group Meeting Minutes
Pending Work Group Approval

Date of meeting: March 16, 2015

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Roll call was taken and a quorum was present.	
2. Updates	**Data Collection Update:** CHAC and Healthfirst confirmed that they have completed clinical data collection for Medicare. Medicaid clinical data collection is well underway. Commercial clinical data collection is delayed, primarily due to delays in receiving data from BCBSVT to create samples for chart reviews. The only measure for which there are not commercial samples at this point is childhood immunization. The ACOs have demonstrated patience and flexibility during this first year of data collection; BCBSVT and the analytics vendor (Lewin) are working hard to complete the work. Some measures that rely on claims data require a 12-month look back period. Because many people didn't sign up for insurance on Vermont Health Connect until spring of 2014, there are low commercial numbers for some of these measures. For the patient experience survey, Jenney Samuelson and Pat Jones have been working with the survey vendor (DataStat) to field the CAHPS PCMH survey to approximately 90 primary care practices that have agreed to use the survey. The survey can be used for NCQA recognition for practices participating in the Blueprint, as well as for ACO measurement.	
3. Minutes Approval	Catherine Fulton called for a motion to approve the February 23rd minutes; Rick Dooley moved to approve the minutes and Paul Harrington seconded the motion. A roll call vote was taken and the minutes were approved.	
4. GMCB Discussion	Pat Jones provided an update on the GMCB's discussion of a potential hiatus in new/promoted measures for Year 3. The GMCB is planning to vote on the hiatus at its meeting on Thursday.	

Agenda Item	Discussion	Next Steps
	Cathy Fulton reviewed the proposal that the GMCB is considering: "1. To allow ACOs to focus on enhancing data collection capability and improving quality of care and health outcomes, there will be a hiatus on changes to the measure set for Year 3, unless there are changes in measure specifications or in the evidence that serves as the basis for a particular measure. 2. If a measure specification changes, the change would be incorporated into the measure set specifications, in accordance with "Vermont Commercial ACO Pilot Compilation of Pilot Standards: Section X. Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Program." 3. If a measure is no longer supported by evidence, the measure should be considered for elimination. If a measure is eliminated, the VHCIP Quality and Performance Measures work group could recommend replacing it with a measure that is supported by evidence, in accordance with "Vermont Commercial ACO Pilot Compilation of Pilot Standards: Section X. Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Program." Representatives from Healthfirst, VMS and OneCare all indicated that they support the hiatus. ACO representatives agreed that while the collection and reporting process for the quality measures is onerous, they consider them important and are committed to reporting them as required. HCA noted that the measures have a function other than to identify areas for quality improvement; they also serve as a check to ensure that medically necessary treatment is still being provided when there is a focus on cost containment and a move away from fee for service payment. It was noted that the work group has worked hard to select measures that cover a wide variety of domains (e.g., chronic care, preventive care, acute care, various age groups).	
5. Work Plan	The group reviewed the high level points in the work plan, included in the materials as Attachment 3. The work plan development process included creating a standardized format for all work groups so that it was easy to look at the plans across groups. The content was also revised so that all work plans include the same level of detail and bridge activities between work groups that might be shared, or of interest to other work groups. A high-level timeline for the entire project is also going to be provided in a chronological format. The QPM work plan has specific overlap with the DLTSS and Population Health work plans; DLTSS is considering a sub-analysis of the measure results to show how certain sub-populations are performing on some of the measures.	
6.Changes in measures	Michael Bailit reviewed national changes in measures that are in Vermont's ACO shared savings program (SSP) measure set, as outlined in Attachment 4: HEDIS changes of note: NCQA has retired the cholesterol (LDL) screening measure that is currently a payment measure for the Vermont SSPs (Core 3a). The guideline has changed, and clinicians have changed treatment as a result. Replacement measures related to statin use for certain patients are being considered but have not yet been adopted. If they are adopted, it will take an additional couple of years to develop benchmarks.	Discuss measure changes and potential alternatives in more depth at next meeting (in particular,

Agenda Item	Discussion	Next Steps
	NCQA is also proposing retirement of the appropriate medication for people with asthma measure and replacing it with the medication management for people with asthma measure (the latter was adopted in 2012). Appropriate medication for asthma is currently a monitoring and evaluation measure in the ACO SSP measure sets, and is collected at the health plan level rather than the ACO level. The medication management measure could be considered as a replacement measure. NCQA is considering several new measures for 2016; one of them is related to mental health. If these were adopted, benchmark data would not be available for quite some time. Other measure changes of note: CMS is dropping the optimal diabetes care measure from the Medicare Shared Savings Program (MSSP) measure set. This is a reporting measure for the Vermont programs. Michael Bailit indicated that the cholesterol screening component that has experienced guideline changes (as noted above) is most likely the reason for this change. The measure steward (Minnesota Community Health) has already replaced the cholesterol screening component with a statin component, and is still using the measure. He said it is considered a good measure, and would not be surprised if CMS reinstates it if statin measures receive national endorsement. The most important changes for Vermont's ACO SSPs are the cholesterol screening and optimal diabetes care measure changes. The work group discussed the possibility of alternative measures, and expressed interest in digging deeper on these changes at the next meeting agenda. Hypertension measures in particular were discussed as an alternative to cholesterol screening. The group also expressed interest in a deeper dive on the optimal diabetes care measure and the ED utilization for ambulatory care sensitive conditions measure (AHRQ is apparently retiring the ED measure, which is a Moitoring and Evaluation measure for Vermont's ACO SSPs).	cholesterol screening, optimal diabetes care, hypertension, and ED use for ambulatory care sensitive conditions).
7. Review of reporting templates for Year 1 measures	Draft templates for reporting Year 1 claims-based measure results were included as Attachments 5a and 5b. The first template would be used to show payment and reporting claims-based measure results. It shows how each ACO performs on the measure and also shows the national benchmarks at 25th, 50th and 75th percentiles, along with the 2012 (and potentially 2013) Vermont statewide results when available. Numerical results and color coding to reflect performance against benchmark will be shown in each cell, and a second tab will show the numerators and denominators underlying the calculations. Measures with denominators less than 30 will not be reported. Rick Dooley asked if denominators and numerators could be shown on the first tab (perhaps in parentheses). A work group member asked if we would be able to link these measures with overall health outcomes for Vermonters, to see if health is actually improving. Heidi Klein reported that the population health group has asked for technical assistance along those lines, to help link the measures in the ACO SSP measure set to	Revise templates to show numerators and denominators on summary tab. Work group members can provide any additional feedback on the templates to Pat Jones or Alicia Cooper

Agenda Item	Discussion	Next Steps
	population health indicators. Shawn Skaflestad asked why the 2012 VT Medicaid performance is a benchmark used in the template. Alicia responded that these benchmarks are needed for the Core 1 and Core 8 measures, where there is not a national Medicaid benchmark. Historical VT Medicaid performance will be used as the benchmark instead. The draft template for claims-based ACO-level monitoring and evaluation measures was reviewed. Mike Nix asked about who is included in the ED measures. He noted that the UVM Medical Center is finding value in looking carefully at the population using ED services as well as the population as a whole, in order to analyze what factors result in people visiting the ED. Pat Jones observed out that the three pilot sites participating in the Integrated Communities Care Management Learning Collaborative (Burlington, Rutland and St. Johnsbury) are analyzing ED data to identify people who might benefit from well-coordinated care management. The Blueprint-ACO Unified Community Collaboratives are also reviewing this type of data as well, and working on determining factors that influence ED use and other measures.	
8. Next Steps, Wrap Up and Future Meeting Schedule	**Next Meeting: NOTE DATE CHANGE** **April 13, 2015 - 9:00 to 11:00**	

VHCIP QPM Work Group Member List

Roll Call: 3/16/2015

Rick Dooley 1°
Paul Harrington 2°

Member		Member Alternate		Minutes		
First Name	Last Name	First Name	Last Name			Organization
Susan	Aranoff ✓	Patricia	Cummings	Y		AHS - DAIL
Jaskanwar	Batra ✓	Kathleen	Hentcy	A		AHS - DMH
Catherine	Burns	Kim	McClellan ✓	Y		DA - HowardCenter for Mental Health
Connie	Colman	Peter	Cobb			Central Vermont Home Health and Hospice
Yvonne	DePalma					Planned Parenthood of Northern New England
Rick	Dooley ✓			Y		HealthFirst
Judith	Franz					VITL
Aaron	French	Cynthia	Thomas ✓	Y		AHS - DVHA
Catherine	Fulton ✓			Y		Vermont Program for Quality in Health Care
Joyce	Gallimore ✓	Kate	Simmons	Y		CHAC
Paul	Harrington ✓			Y		Vermont Medical Society
Pat	Jones ✓	Richard	Slusky	Y		GMCB
Heidi	Klein ✓	Robin	Edelman	A		AHS - VDH
Diane	Leach					Northwestern Medical Center
Vicki	Loner	Miriam	Sheehey			OneCare Vermont
Mike	Nix ✓			Y		Jeffords Institute for Quality, FAHC
Laura	Pelosi					Vermont Health Care Association
Paul	Reiss	Amy	Cooper			Accountable Care Coalition of the Green Mountains
Lila	Richardson ✓	Julia	Shaw	Y		VLA/Health Care Advocate Project
Rachel	Seelig					VLA/Senior Citizens Law Project
Lily	Sojourner	Shawn	Skaflestad ✓	Y		AHS - Central Office
Heather	Skeels	Patricia Kate	Launer Simmons ✓	A		Bi-State Primary Care
Jennifer	Stratton					Lamoille County Mental Health Services
Monica	Weeber					AHS - DOC
Robert	Wheeler	Teresa	Voci ✓	Y		Blue Cross Blue Shield of Vermont
	25		14			

Minutes approved

VHCIP QPM Work Group Participant List

Attendance: 3/16/2015

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	VHCIP Staff/Consultant
X	Interested Party

First Name	Last Name		Organization	QPM
Peter	Albert		Blue Cross Blue Shield of Vermont	X
Susan	Aranoff	here	AHS - DAIL	S/M
Bill	Ashe		Upper Valley Services	X
Ena	Backus		GMCB	X
Melissa	Bailey	here		X
Michael	Bailit	phone	SOV Consultant - Bailit-Health Purchasing	S
Susan	Barrett		GMCB	X
Jaskanwar	Batra	here	AHS - DMH	M
Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH	X
Catherine	Burns	here	DA - HowardCenter for Mental Health	M
Joshua	Cheney		VITL	A
Amanda	Ciecior	here	AHS - DVHA	S
Peter	Cobb		VNAs of Vermont	MA
Connie	Colman		Central Vermont Home Health and Hospice	M
Amy	Coonradt	here	AHS - DVHA	S
Amy	Cooper	here	Accountable Care Coalition of the Green Mountains	MA

Alicia	Cooper	here	AHS - DVHA	S
Janet	Corrigan		Dartmouth-Hitchcock	X
Patricia	Cummings		AHS - DAIL	MA
Jude	Daye		Blue Cross Blue Shield of Vermont	A
Yvonne	DePalma		Planned Parenthood of Northern New England	M
Rick	Dooley	here	HealthFirst	M
Robin	Edelman		AHS - VDH	MA
Erin	Flynn		AHS - DVHA	S
Judith	Franz		VITL	M
Aaron	French		AHS - DVHA	M
Catherine	Fulton	phone	Vermont Program for Quality in Health Care	C/M
Joyce	Gallimore	phone/here	Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Bryan	Hallett		GMCB	S
Paul	Harrington	phone	Vermont Medical Society	M
Kathleen	Hentcy		AHS - DMH	MA
Bard	Hill		AHS - DAIL	MA
Craig	Jones		AHS - DVHA - Blueprint	X
Pat	Jones	here	GMCB	S/M
Joelle	Judge	here	UMASS	S
Sarah	Kinsler	here		S
Heidi	Klein	here	AHS - VDH	S/M
Peter	Kriff		PDI - Creative Consulting	X
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Patricia	Launer		Bi-State Primary Care	MA
Diane	Leach		Northwestern Medical Center	M
Deborah	Lisi-Baker		SOV - Consultant	X
Vicki	Loner		OneCare Vermont	M
Nicole	Lukas		AHS - VDH	X
Georgia	Maheras	phone	AOA	S
Mike	Maslack			X
Kim	McClellan		DA - Northwest Counseling and Support Services	MA
Darcy	McPherson		AHS - DVHA	X

Jessica	Mendizabal		AHS - DVHA	S
Robin	Miller	Here	AHS - VDH	X
Mike	Nix	Here	Jeffords Institute for Quality, FAHC	M
Annie	Paumgarten	Here	GMCB	S
Laura	Pelosi		Vermont Health Care Association	C/M
Luann	Poirer		AHS - DVHA	S
Sherry	Pontbriand		NMC	X
Betty	Rambur		GMCB	X
Allan	Ramsay		GMCB	X
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Lila	Richardson	Phone	VLA/Health Care Advocate Project	M
Jenney	Samuelson	Here	AHS - DVHA - Blueprint	X
Ken	Schatz		AHS - DCF	X
Rachel	Seelig	Here	VLA/Senior Citizens Law Project	M
Julia	Shaw		VLA/Health Care Advocate Project	MA
Miriam	Sheehey		OneCare Vermont	MA
Kate	Simmons	Phone	Bi-State Primary Care/CHAC	MA
Colleen	Sinon		Northeastern Vermont Regional Hospital	X
Shawn	Skaflestad	Here	AHS - Central Office	M
Heather	Skeels		Bi-State Primary Care	M
Richard	Slusky		GMCB	S/MA
Jennifer	Stratton		Lamoille County Mental Health Services	M
Kara	Suter		AHS - DVHA	S
Julie	Tessler		DA - Vermont Council of Developmental and Mental Health Serv	X
Cynthia	Thomas	Here	AHS - DVHA	MA
Win	Turner			X
Teresa	Voci	Phone	Blue Cross Blue Shield of Vermont	MA
Nathaniel	Waite		VDH	X
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Julie	Wasserman	here	AHS - Central Office	S
Monica	Weeber		AHS - DOC	M
Kendall	West			X
James	Westrich	here	AHS - DVHA	S
Robert	Wheeler		Blue Cross Blue Shield of Vermont	M
Bradley	Wilhelm		AHS - DVHA	S

Cecelia	Wu	here	AHS - DVHA	S
				86

MaryKate Mahlmann here Blueprint

Attachment 3

Performance Measures in the Blueprint

VERMONT

Department of Vermont Health Access

VERMONT Blueprint for Health

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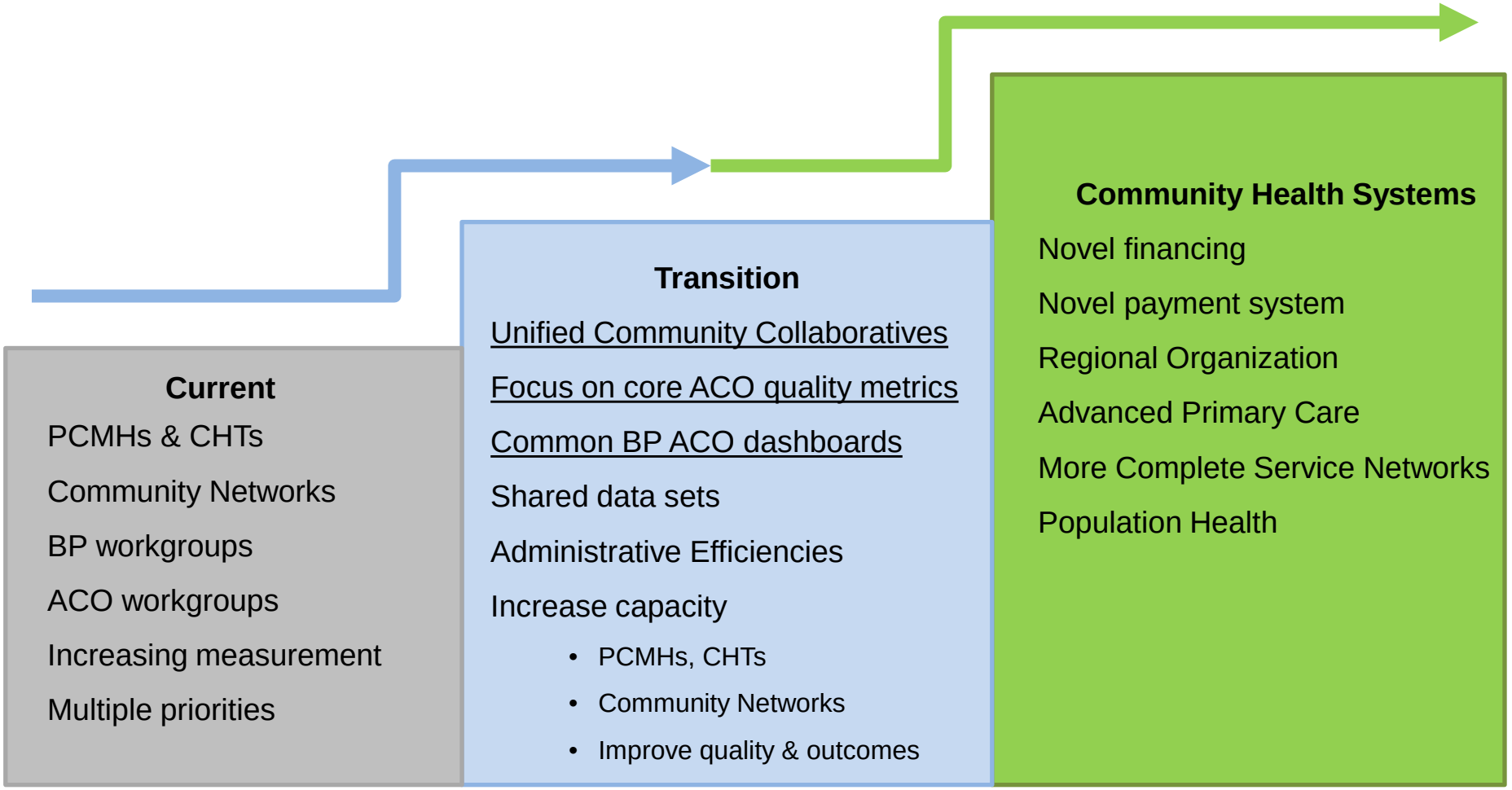
Community Oriented Health Systems: *Incorporating ACO Measures Into Quality Profiles to Support Quality Improvement*

VHCIP Quality and Performance Measures Work Group

April 13, 2015

Transition to Community Health Systems



Strategy for Building Community Health Systems

Action Steps

- Unified Community Collaboratives (quality, coordination)
- Unified Performance Reporting & Data Utility
- Increase support for medical homes and community health teams
- Novel medical home payment model

Unified Community Collaboratives

- Unified local quality collaboratives (blend BP & ACO groups)
- Focus on core ACO measures (add ACO measure dashboard)
- Leadership team includes clinical leadership from ACOs, Mental Health Agency, Area Agency on Aging, Home Health Agency, Pediatrics, Housing Organization, to form a leadership team of up to 11 members
- Convene community stakeholders
- Regular leadership and workgroup meetings
- Local groups adopt charter and select leadership
- Guide quality & coordination initiatives

Unified Performance Reporting

- Co-produce comparative profiles
- Service area and practice level profiles
- Comparative results for expenditures, utilization, and quality
- Include dashboard with results for core ACO measures
- Possible through a linkage of claims and clinical data
- Objective basis for planning & extension of best practices

Data Utility

- Integration of diverse data sets for advanced measurement
- HSA profiles incorporate claims, clinical, BRFSS data
- Claims and clinical data are linked for hybrid measures
- Produce analytic data sets to meet ACO measurement needs
- Share analytic data sets with ACOs
- Collaborative work (VITL, others) to build data infrastructure

Practice Profiles Evaluate Care Delivery

Commercial, Medicaid, & Medicare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Practice Profile: ABC P

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Typ

Welcome to the *2014 Blueprint Practice Profile* from the Blueprint for Health, a state-led initiative transforming the way that health care and overall health services are delivered in Vermont. The Blueprint is leading a transition to an environment where all Vermonters have access to a continuum of seamless, effective, and preventive health services.

Blueprint practice profiles are based on data from Vermont's all-payer claims database, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES). Data include all covered commercial, Full Medicaid, and Medicare members, attributed to Blueprint practices starting by December 31, 2013.

Practice Profiles for the adult population cover members ages 18 years and older; pediatric profiles cover members between the ages of 1 and 17 years.

Utilization and expenditure rates presented in these profiles have been risk adjusted for demographic and health status differences among the reported populations.

This reporting includes only members with a visit to a primary care physician, as identified in VHCURES claims data, during the current reporting year or the prior year.

Demographics & Health Status

	Practice	H.S.A.	St
Average Members	4,081	84,070	1
Average Age	50.6	50.1	
% Female	55.6	55.5	
% Medicaid	14.5	13.0	
% Medicare	23.7	22.2	
% Maternity	2.1	2.1	
% with Selected Chronic Conditions	50.1	38.8	
Health Status (CRG)			
% Healthy	39.0	43.9	
% Acute or Minor Chronic	18.8	20.5	
% Moderate Chronic	27.9	24.5	
% Significant Chronic	15.4	12.3	
% Cancer or Catastrophic	1.4	1.3	

Table 1: This table provides comparative information on the demographics ... status of your practice, all Blueprint practices in your Hospital Service Area ... state as a whole. Included measures reflect the types of information used to ... adjusted rates: age, gender, maternity status, and health status.

Average Members serves as this table's denominator and adjusts for partial ... enrollment during the year. In addition, special attention has been given to ... Medicaid and Medicare: This includes adjustment for each member's enrollment ... Medicaid or Medicare, the member's practices' percentage of membership ... or Medicare, Medicare disability or end-stage renal disease status, and the ... the member required special Medicaid services that are not found in comm... populations (e.g. day treatment, residential treatment, case management, ... services, and transportation).

The Selected Chronic Conditions measure indicates the proportion of memb... through the claims data as having one or more of seven selected chronic co... asthma, chronic obstructive pulmonary disease, congestive heart failure, co... disease, hypertension, diabetes, and depression.

The Health Status measure aggregates 3M™ Clinical Risk Grouper (CRG) cla... the year for the purpose of generating adjusted rates. Aggregated risk class... include: Healthy, Acute (e.g., ear, nose, throat infection) or Minor Chronic ... chronic joint pain), Moderate Chronic (e.g., diabetes), Significant Chronic (... CHF), and Cancer (e.g., breast cancer, colorectal cancer) or Catastrophic (... dystrophy, cystic fibrosis).

Demographics & Health Status | Cost of Care | Utilization | Effective & Preventive Care | Da...


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Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Total Expenditures per Capita

Figure 1: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Expenditures by Major Category

Figure 2: Presents annual risk-adjusted rates for the major components of cost (as shown in Figure 1) with expenditures capped statewide for outlier patients. Some services provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services.

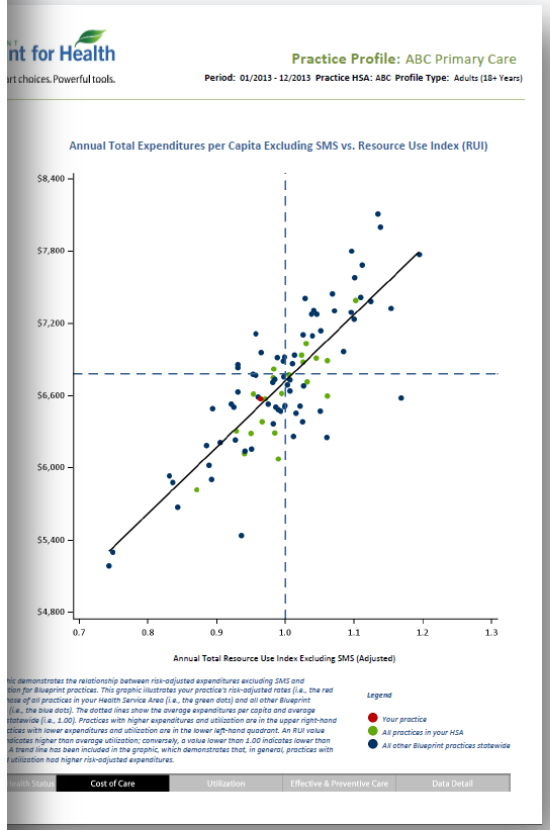
Total Expenditures Excluding SMS

Figure 3: Presents annual risk-adjusted rates and 95% confidence intervals with expenditures excluding Special Medicaid Services capped statewide for outlier patients. Expenditures include both plan and member out-of-pocket payments (i.e., copay, coinsurance, and deductible).

Total Resource Use Index (RUI) Excluding SMS

Figure 4: Presents annual risk-adjusted rates and 95% confidence intervals. Since price per service varies across Vermont, a measure of expenditures based on resource use — Total Resource Use Index (RUI) — is included. RUI reflects an aggregated cost based on utilization and intensity of services across major components of care (e.g., inpatient) and excludes Special Medicaid Services. The practice and HSA are indexed to the statewide average (1.00).

Demographics & Health Status | Cost of Care | Utilization | Effective & Preventive Care | Data Detail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Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 Practice HSA: ABC Profile Type: Adults (18+ Years)

Annual Total Expenditures per Capita Excluding SMS vs. Resource Use Index (RUI)

...ic demonstrates the relationship between risk-adjusted expenditures excluding SMS and ... for Blueprint practices. This graphic illustrates your practice's risk-adjusted rates (i.e., the red ... of all practices in your Health Service Area (i.e., the green dots) and all other Blueprint ... (i.e., the blue dots). The dotted lines show the average expenditures per capita and average ... statewide (i.e., 1.00). Practices with higher expenditures and utilization are in the upper right-hand ... with lower expenditures and utilization are in the lower left-hand quadrant. An RUI value ... indicates higher than average utilization; conversely, a value lower than 1.00 indicates lower than ... A trend line has been included in the graphic, which demonstrates that, in general, practices with ... utilization had higher risk-adjusted expenditures.

Health Status | Cost of Care | Utilization | Effective & Preventive Care | Data Detail

ONPOINT Health Data

Claims Data – PQI Composite (Chronic): Rate of Hospitalization for ACS Conditions (Core-12)

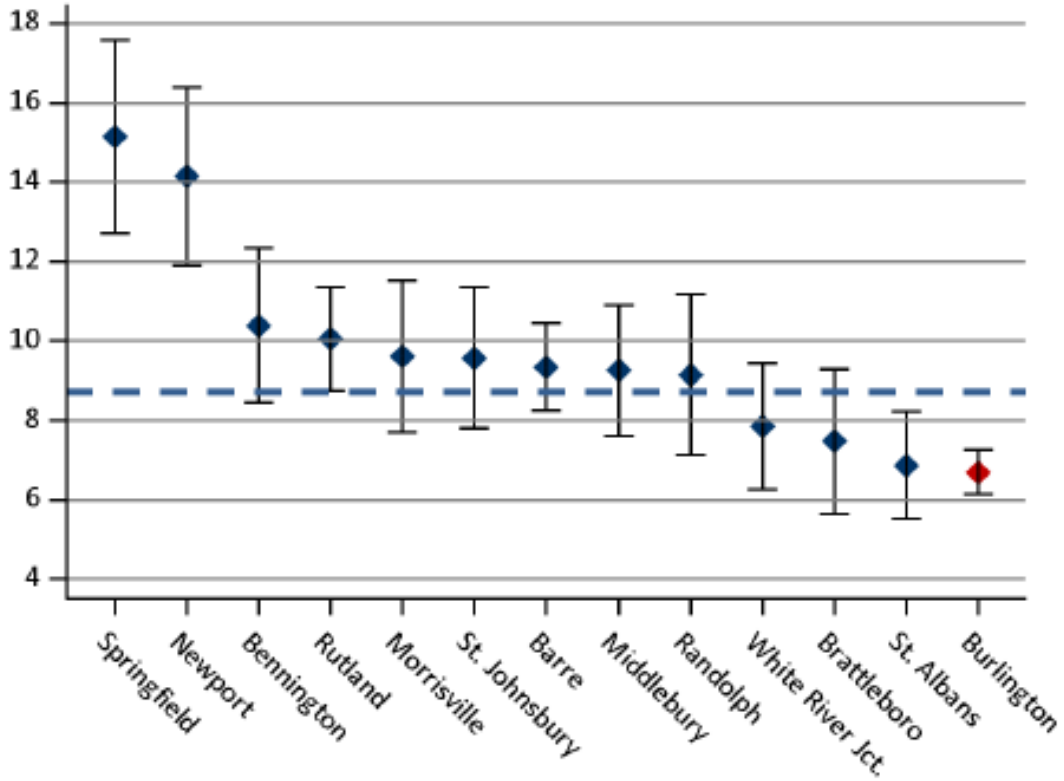


Figure 27: This Prevention Quality Indicator (PQI) presents a composite of chronic conditions per 1,000 members, ages 18 years and older. This measure includes admissions for at least one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputations, COPD, asthma, hypertension, heart failure, and angina without a cardiac procedure. The blue dashed line indicates the statewide average.

Claims & Clinical Data – Hypertension: Blood Pressure in Control (Core-39, MSSP-28)

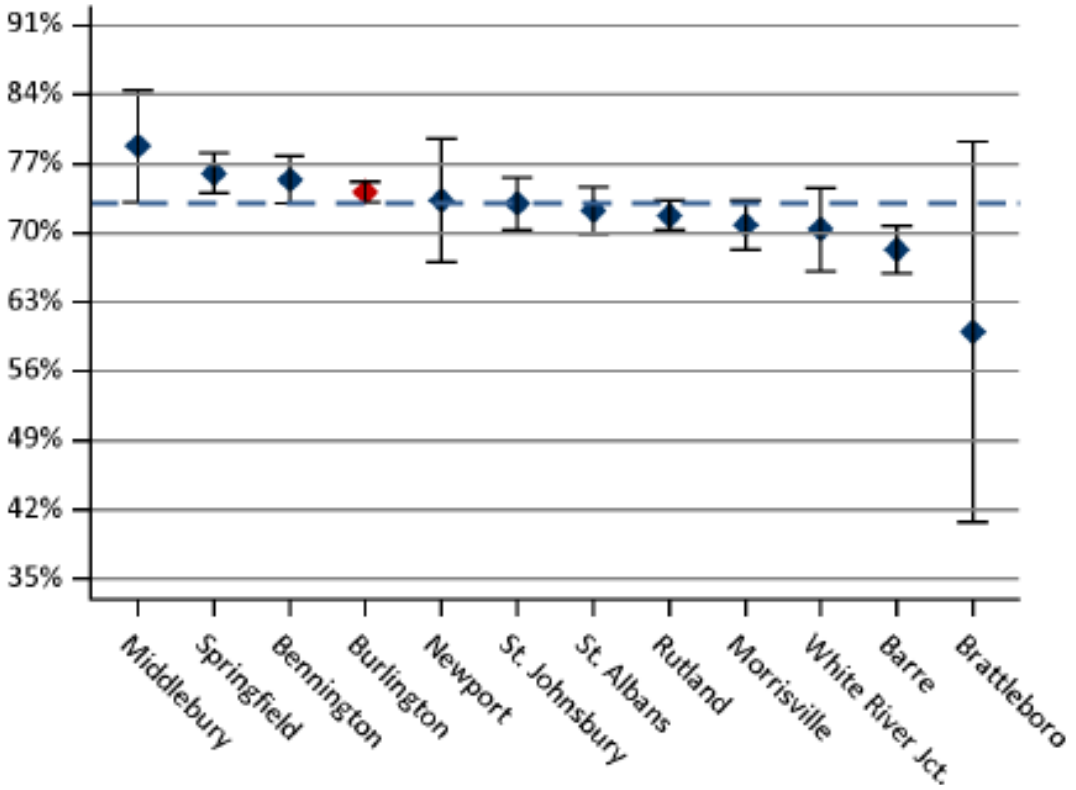


Figure 34: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with hypertension, ages 18–85 years, whose last recorded blood pressure measurement in the DocSite clinical database was in control (<140/90 mmHg). Members with hypertension were identified using claims data. The denominator was then restricted to those with DocSite results for a blood pressure reading during the measurement year. The blue dashed line indicates the statewide average.

Claims & Clinical Data – Diabetes: Poor Control (Core-17, MSSP-27)

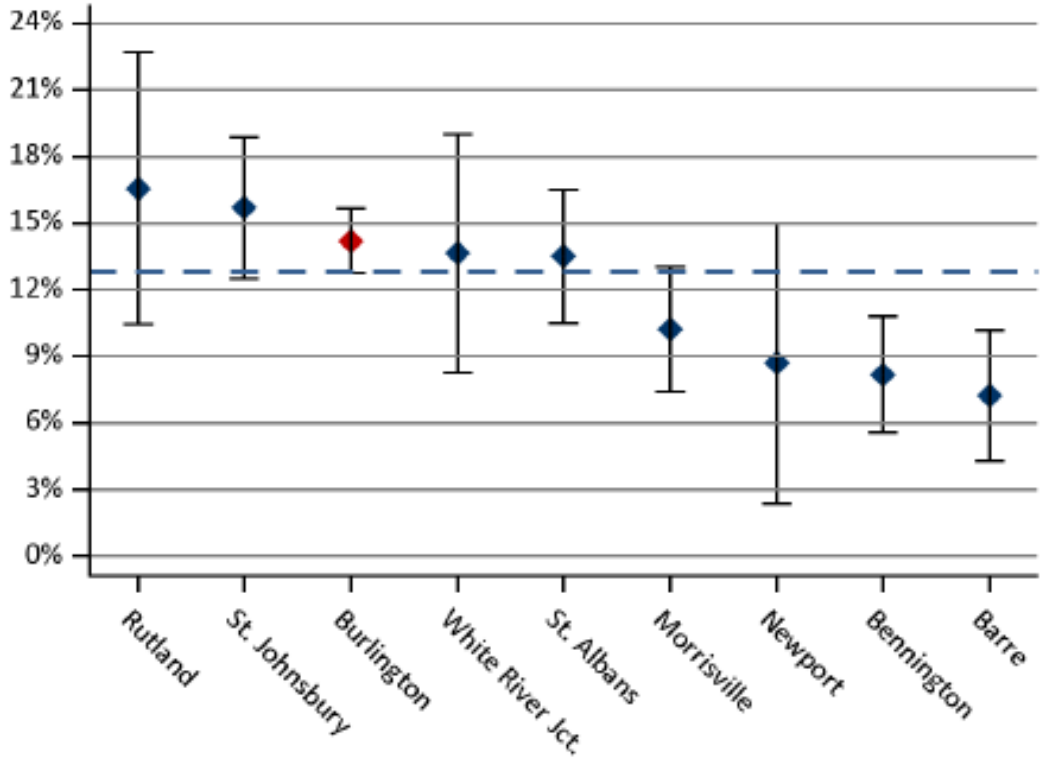
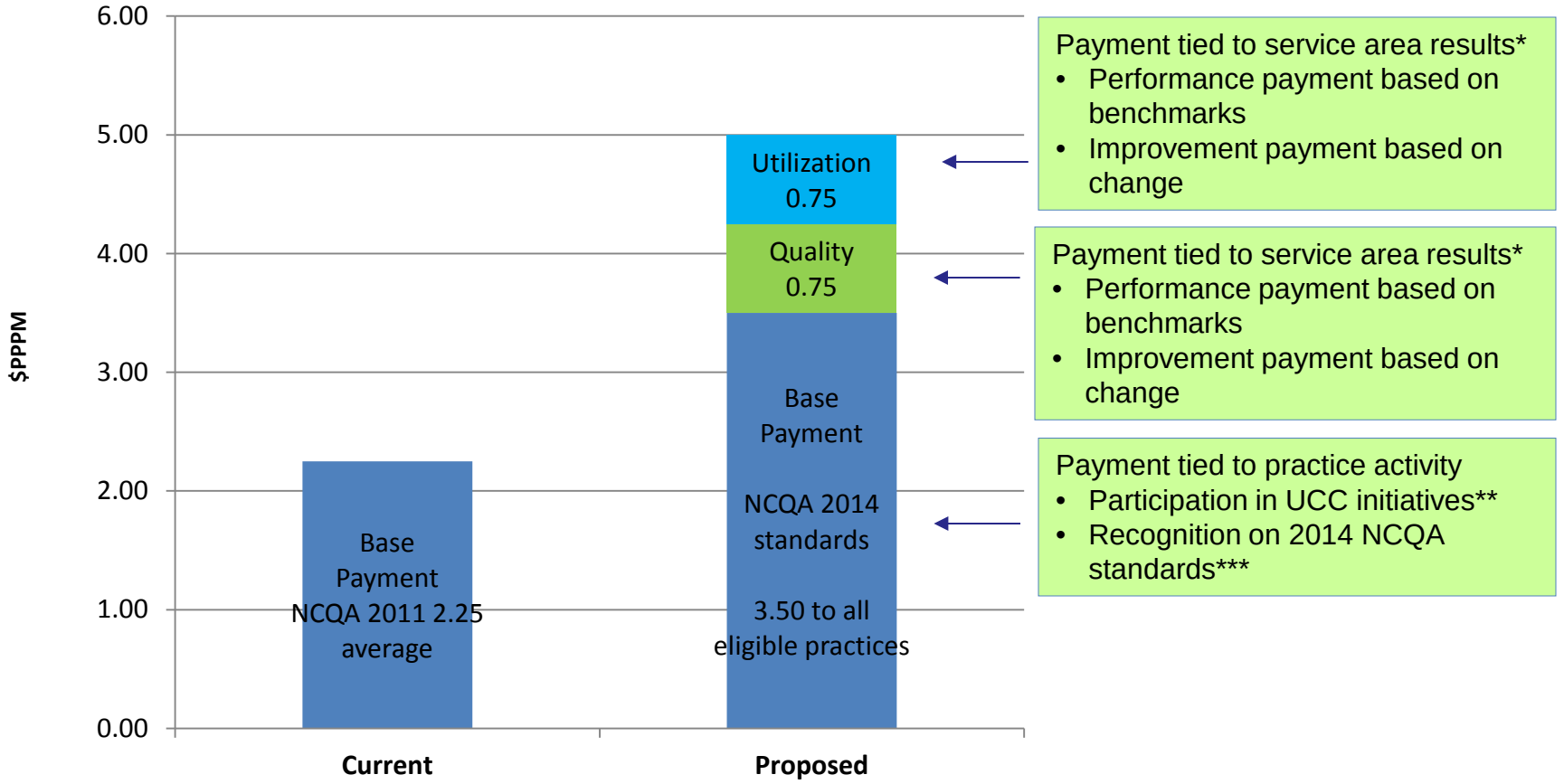


Figure 33: Presents the proportion, including 95% confidence intervals, of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded hemoglobin A1c test in the DocSite clinical database was in poor control (>9%). Members with diabetes were identified using claims data. The denominator was then restricted to those with DocSite results for at least one hemoglobin A1c test during the measurement year. The blue dashed line indicates the statewide average.

Health Service Area Profiles

http://blueprintforhealth.vermont.gov/node/680

Comparison of current and proposed medical home payments



*Incentive to work with UCC partners to improve service area results.
**Organize practice and CHT activity as part of at least one UCC quality initiative per year.
***Payment tied to recognition on NCQA 2014 standards with any qualifying score. This emphasizes NCQAs priority 'must pass' elements while de-emphasizing the documentation required for highest score.

Proposed Medical Home Payments

- Base Component: Based on NCQA recognition & UCC Participation.
  - Requires successful recognition on 2014 NCQA standards (any qualifying score)
  - Requires active participation in the local UCC including; orienting practice and CHT staff activities to achieve the goals that are prioritized by the local UCCs. Minimum requirement is active participation with at least one UCC priority initiative each calendar year.
  - All qualifying practices receive $3.50 PPPM

- Quality Performance Component: Based on HSA results for Quality Index.
  - Up to $ 0.75 PPPM for results that exceed benchmark, or
  - Up to $ 0.50 PPPM for significant improvement if result is below benchmark

- Utilization Performance Component: Based on HSA results for Utilization Index.
  - Up to $ 0.75 PPPM for results that exceed benchmark, or
  - Up to $ 0.50 PPPM for significant improvement if result is below benchmark

Total Payment = Base + HSA Quality Performance + HSA TUI Performance

Total Payment ranges from $3.50 to $5.00 PPPM

Community Oriented Health Systems

- Core measures & NCQA standards provide a statewide framework
- PCMH payment model incents quality & coordination
- Community collaboratives guide quality & coordination initiatives
- More effective health services & community networks
- Health System (Accessible, Equitable, Patient Centered, Preventive, Affordable)

Attachment 4

GMCB Measures Hiatus Description

OCTOBER 2014

CHANGES TO THE QUALITY AND PERFORMANCE MEASURES FOR VERMONT'S ACO SHARED SAVINGS PROGRAMS

The Green Mountain Care Board is seeking public comment on the proposed moratorium on changes to the quality and performance measures for year 3 of Vermont's ACO shared savings programs. The comment period runs from Thursday, October 23 through Monday, December 1 at 4:30pm."

GMCB Statement Regarding Year 3 ACO Commercial Shared Savings Quality and Performance Measures:

The Green Mountain Care Board is considering a hiatus on adding or promoting quality and performance measures for Year 3 (Calendar Year 2016) of the ACO Commercial Shared Savings Program. The Board requests that the VHCIP Quality and Performance Measures Work Group, Steering Committee, and Core Team also consider this proposal, which is based on a desire to provide stability and predictability to the program. It will also allow the GMCB a chance to review and evaluate year 1 and 2 results of the ACO Commercial Shared Savings Program.

Specifically, the Board proposes the following:

1. To allow ACOs to focus on enhancing data collection capability and improving quality of care and health outcomes, there will be a hiatus on changes to the measure set for Year 3, unless there are changes in measure specifications or in the evidence that serves as the basis for a particular measure.
2. If a measure specification changes, the change would be incorporated into the measure set specifications, in accordance with "Vermont Commercial ACO Pilot Compilation of Pilot Standards: Section X. Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Program."
3. If a measure is no longer supported by evidence, the measure should be considered for elimination. If a measure is eliminated, the VHCIP Quality and Performance Measures work group could recommend replacing it with a measure that is supported by evidence, in accordance with "Vermont Commercial ACO Pilot Compilation of Pilot Standards: Section X. Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Program."

There are two underlying reasons for the Board's proposal. The first is that significant time, energy and resources have been devoted to developing the Year 1 and Year 2 measure sets, without attaining consensus. Understandably, participants in the measure development process bring a variety of valid perspectives to this work. In general, providers are concerned that adding measures would increase administrative burden, dilute quality improvement efforts, and detract from patient care. Advocates for additional measures want to ensure that the measure set is representative of various domains and populations, and that quality is monitored as cost-saving efforts are implemented. Despite participants' best efforts, consensus was not achieved for the Year 1 and Year 2 measure sets. While the process was respectful, it was also divisive, time-consuming, and resource-intensive.

Second, there is a lag in obtaining ACO performance measure results, and the Board would like to consider Year 1 and 2 results before making further changes to the measure set. Results will not be available until the third quarter of 2015 for Year 1 of the program (2014), the third quarter of 2016 for Year 2 (2015), and the third quarter of 2017 for Year 3 (2016). In fact, Year 1 and Year 2 results may not be available during the Year 3 measurement review process, and the ACO Commercial Shared Savings pilot will end before Year 3 results are available.

The Board believes that it is not a good investment of time and resources to consider measure additions and/or promotions for Year 3 of the ACO Shared Savings Program, especially given Vermont's dynamic health care reform landscape. Therefore, we hope that everyone involved will see the value of the measures we have in place as well as the value of allowing some time to assess their impact.

Attachment 5

Priority Changes and Options for Year 3 Measures

bailit health PURCHASING

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TO: Pat Jones and Alicia Cooper
FROM: Michael Bailit and Michael Joseph
DATE: April 7, 2015
RE: Changes to ACO Measures

In our memo dated 3-10-15 we identified changes in national measure sets that are relevant to the Vermont ACO measure set. Last week you asked that we provide you with options for measures that could replace measures that have been retired, or have been proposed for retirement, from national measure sets. This memo responds to that request.

I. Payment Measures

Measure	Reason	Options for Replacement
Core-3a: Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening Only)	Removed from HEDIS 2015 due to a change in the national guideline	1. Statin Therapy for Patients with Cardiovascular Disease *This is a newly proposed HEDIS 2016 measure, effectively replacing LDL screening. CMS is likely to adopt the measure, but has not yet done so. NCQA will not publish benchmarks for 2016, but is likely to do so for 2017. Final specifications will be released with in July.* 2. (Core-39/ MSSP-28) Hypertension (HTN): Controlling High Blood Pressure, or (Core-40/ MSSP-21) Screening for High Blood Pressure and follow-up plan documented *These currently pending measures assess high blood pressure, a significant population health risk. They align with the MSSP and benchmarks exist for Core-39, but these measures require clinical data.*

II. Reporting Measures

Measure	Reason for Retirement	Options for Replacement
Core-16 (MN Community Measurement's Optimal Diabetes Care)	CMS has retired this measure (MSSP-22-25) from the MSSP measure set. This may be because MSSP-23 (Core-16b) is an LDL control measure.	1. The revised MN Community Measurement Optimal Diabetes Care for 2015 *MN Community Measurement has replaced the LDL measure with a statin use measure. Maine has adopted this measure.* 2. The three remaining individual measure components of Core-16 not already in the measure set, i.e., Core-16c: Blood Pressure <140/90, Core-16d: Tobacco Non-Use, and Core-16e: Aspirin Use *All of these are evidence-based measures of effective diabetes management. Benchmarks are available for the blood pressure control measure.* 3. Blood pressure control for diabetes *This is an important outcome measure for management of diabetes. Benchmarks are available.*

III. Monitoring and Evaluation Measures

Measure	Reason for Retirement	Options for Replacement
M&E-1: Appropriate Medications for People with Asthma	NCQA is proposing retiring this measure for 2016 due to consistently high HEDIS performance rates and little variation in plan performance for both commercial and Medicaid plans.	1. Medication Management for People with Asthma *This measure was first introduced in HEDIS 2012. NCQA views it as a more effective way of assessing asthma medication management. National benchmarks are available, and the measure can be calculated with claims.*
M&E-16: ED Utilization for Ambulatory Care-Sensitive Conditions	AHRQ has retired this measure for unidentified reasons.	AHRQ is working on ED-specific PQI measures, and conducted a beta test for the draft ED-PQI SAS software from March – May 2014. The beta test was conducted to test how well the software calculates the measures using data from different users and to see how reliable the program is. The measure has not yet been finalized. In the meantime, the measure set still contains M&E-14: Avoidable ED visits-NYU algorithm. This measure is available only at the end of the year, but captures related content to the retired measure.

IV. Pending Measures

Measure	Reason for Retirement	Options for Replacement
Core-3b: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)	Removed from HEDIS 2015 due to a change in the national guideline	See option 1 for Core-3a on page 1.
Core-38: Coronary Artery Disease (CAD) Composite <100 mg/dL)	CMS has retired this measure (MSSP-32) from the MSSP measure set, in all likelihood because it is an LDL control measure.	See option 1 for Core-3a on page 1.