QPM Work Group Agenda 5-29-14

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

Thursday, May 29, 2014; 10:00 AM to 12 Noon
4th Floor Conference Room, Pavilion Office Building, Montpelier
Call-In Number: 1-877-273-4202 Passcode: 9883496

Item #	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:00-10:10	Welcome and Introductions; Approval of Minutes	Attachment 1 – FINAL April QPM Minutes	Yes
2	10:10-10:20	Updates • Estimates of Commercial and Medicaid attribution to ACOs • Determining if insurer clinical data samples can be used for ACO measures • Analytics Contractor ***Public Comment***		No
3	10:20-10:40	Continued Discussion on Criteria for Selection of Measures • Review of Adopted Criteria • Additional Information on Population Health Work Group's Proposed Criteria • Vermont Legal Aid Proposal for Payment Measure Criterion #4 ***Public Comment***	Attachment 3A – Adopted Measure Selection Criteria Attachment 3B – Population Health Measure Selection Criteria – Additional Information Attachment 3C – Payment Measure Criteria	Yes
4	10:40-10:50	Proposal for Measure Review Process • Time Frames • Overview of Proposed Measures (see Agenda Item 5) • Development of Options ***Public Comment***		Yes

5	10:50-11:50	Year 2 Proposed Changes to Reporting and Payment Measures – Work Group Input ***Public Comment***	Attachment 5 – Year 2 Proposed Changes to Payment and Reporting Measures	Yes
6	11:50-12:00	Next Steps, Wrap-Up and Future Meeting Schedule		

Attachment 1 - QPM Minutes 4-28-14

VT Health Care Innovation Project
Quality & Performance Measures Work Group Meeting Minutes

Date of meeting: April 28, 2014 at 4th Floor Conference Room, Pavilion Office Building, Montpelier

Attendees: Cathy Fulton, Co-Chair; Georgia Maheras, AOA; Pat Jones, Allan Ramsay, Annie Paumgarten, GMCB; Paul Harrington, VT Medical Society; Heidi Klein, VDH; Lila Richardson, Julia Shaw, VT Legal Aid; Cath Burns, Howard Center; Peter Cobb, VT Assembly of HHA; Fran Keeler, Jen Woodard, DAIL; Diane Leach, NMC; David Martini, DFR; Kim McClellan, NCSS; Jennifer Ertel, Bi-State; Marlys Waller, VT Council of Dev. & Disabilities; Deborah Lisi-Baker, DLTSS Co-Chair; Shawn Skaflestad, Julie Wasserman, AHS; Robin Edelman, VDH; Susan Johnson, NCHC; Norm Ward, OneCare; Joe Smith, Deb Chambers, MVP; Michael Bailit, Bailit Health Purchasing; Robert Wheeler, BCBS; Jenney Samuelson, Blueprint for Health; Alicia Cooper, Aaron French, Cynthia Thomas, DVHA; Sarah Sherbrook, DMH; George Sales, Jessica Mendizabal, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approval of Minutes	Pat Jones called the meeting to order at 10:01 am. Laura Pelosi was not able to attend, and sent her regrets. Cathy Fulton attended by phone and asked for a motion to approve the minutes from March 24th. Diane Leach moved to approve the minutes and Fran Keeler seconded. There was no discussion and the motion passed unanimously.	
2. Updates on Previous Agenda Items	Staff gave updates on the following: • Standard for Measure Review and Modification: Pat reported that the standard was approved with no changes by the GMCB on April 17th. The Core Team asked for flexibility in the timeframe for establishing the year two measure set to allow time to review those measures recommended by Population Health and DLTSS. • Determining if insurer clinical data samples can be used for ACO measures: Alicia Cooper reported that she has been collecting preliminary information from payers and ACOs. ACOs, BCBS, MVP, DVHA, and the GMCB will meet to discuss the potential to collaborate in the first year and subsequent year planning.	

Agenda Item	Discussion	Next Steps

	• Georgia stated the following plans have contracted with ACOs in the following markets:
	  o One Care and CHAC are under contract with DVHA for the Medicaid Shared Savings Program.
	  o BCBS has contracted with each ACO in the commercial market. MVP has executed an agreement with OneCare (and is still waiting on Health First and CHAC).
	  o The number of covered lives for each ACO will be made available in mid-May. Paul Harrington noted it is hard to have an informed discussion about measures without this information.
	• Regarding the SBIRT (Screening, Brief Intervention, Referral to Treatment) measure presentation: Alicia reported that VDH representatives will give a presentation at the next QPM meeting and discuss how their work overlaps with the work of the QPM work group.
	• Pat gave an update on the Analytics Contractor: The GMCB has received responses to the RFP for an analytics contractor to help with shared savings calculations and reporting on quality measures. Negotiations are underway with the successful bidder and the goal is to have a contract in June. The QPM work group will be getting reports from the contractor. Michael Bailit noted we will not have year one quality data until year two.
	• Georgia stated there has been a change in the VHCIP Grant Time Frame: the Core Team announced eight awards and they're in process of contracting now. The second round will be announced after the July Core Team meeting. Georgia may recommend some programmatic changes for the second round at the June meeting to be finalized in July and there will be more time for applicants to respond. The Core Team reallocated a portion of the SIM programmatic budget and will add $1.9 million to the grant budget for a total grant pool of $5.3 million, of which roughly $2.6 is already committed. This doesn't include work group spending (such as HIT investment).
		Pat will share the reporting timeline with the group when it is finalized, to help the work group plan its activities.

3. Criteria for Selection of Measures	Pat reviewed attachment 3a, the Measures Work Group Criteria Selection Survey. Members of the work group received this survey within the past few weeks. The criteria came from three places: 1) already used in year one; 2) research by Bailit about criteria used in other states and by NCQA; 3) recommendations from the Population Health work group. There were 19 responses to the survey.	

Agenda Item	Discussion	Next Steps
	Michael Bailit reviewed results of the survey (attachments 3b and 3c): • Total of 17 criteria to consider; seven comments submitted; all but five of criteria were selected for inclusion by at least 82% of the group. • Most popular criteria are those that were used last year. • It might be difficult to consider a large group of criteria if evaluating each individual measure against each criterion. • This information may not lend itself to a decision matrix but the group could weight each criterion by order of importance. • The group should think about how to use the criteria, and the impact of having more versus less. • Bold faced criteria were those that were used during development of the year one measure set. There was a recommendation to keep all the criteria used last time and add #13 (”Includes a mix of measure types”). • Pat mentioned that some criteria relate to the overall measure set and some relate to evaluating individual measures. #10, #13 and #11 relate to individual measures. • Paul Harrington would like to keep all the criteria, noting that they represent a variety of viewpoints; members would prioritize different criteria for different reasons. • #15 (“Using Mental Health indicators”) would be a high priority, but we could strive to collect data for such measures in a way that is not administratively burdensome. • Paul Harrington referenced the New York Times article he sent to the group that morning: research has indicated that lower income patients might not receive as much recommended care as higher income patients - perhaps indicators of socioeconomic should be considered as a criterion. Poverty may be an important risk adjustment mechanism. • #16 (“Expanded Timeframe”) did not get a lot of support. Heidi noted this request came from the Population Health work group; that group is interested in understanding impacts that extend beyond the grant timeframe. This doesn’t need to be a payment measure criterion but could be important for monitoring and evaluation. There are certain measures that would take longer to track, but they still could be big contributors to quality and health outcomes. • Regarding #9 (“Setting Free”); this is meant to track services across settings of care, and	**Heidi will double check the intent of the recommendation with Population Health Co-Chairs and get back to Pat.**

Agenda Item	Discussion	Next Steps
	ensure accountability for the health system overall. • #15 and #17 should be collected in a clinical setting. The provider could ask questions about health behaviors and whether patients have the resources they need to make healthy choices. • Lila Richardson asked about using analytics for #16, Expanded Timeframe, noting that it's hard to measure how the ACOs are doing in the first two years and to extrapolate that to performance over a longer period. o Heidi added that measuring in an ACO setting only is not going to provide helpful information about those measures or indicators that take multiple years to result in changes. o Jenney Samuelson noted that some ACO measures will have a longer term impact on health, even if they can also be measured in the shorter term. Pat observed that the group was comfortable with everything through #12 on the second page, and #15 and #17 in clinical setting. #14, #9 and #16 are more uncertain. She suggested having a motion to accept all but the last five, and Heidi would bring those back to Population Health to review and provide a more clear recommendation. Cath Burns is sensitive to administrative burden but wants to talk about the measures from a Population Health perspective; she doesn't want to lose focus on the longer term aspects of this work. She noted that including the Population Health recommendations as criteria for reporting measures might promote analysis. Peter Cobb noted that #14 and #15 are broad and may be difficult to apply to single quality measures under consideration. Regarding ACO level measures: the same service is measured is the same way regardless of the setting. Pat noted some measures do cross settings, such as follow up after hospitalization for mental illness. Cathy Fulton moved to adopt the criteria through #12 and consider the last five "under further consideration" to be revisited at the May meeting. Cath Burns seconded the motion. The group has to complete the Year 2 measure review by July 31st so they need to make a final decision on	

Agenda Item	Discussion	Next Steps
	criteria by May or June. No other comments were offered and the motion passed unanimously. Pat referred the group to Payment Measures criteria which were all well supported. Fran Keeler moved to approve the five criteria for the Payment Measure set to be adopted by the work group, Aaron French seconded the motion. Lila Richardson and Julia Shaw expressed concern over the language in criteria #4 including "cost". Shared savings calculations consider cost; the quality measures are intended to ensure that cost reduction efforts do not reduce quality. The group discussed different ways to amend the language so that it is evident the focus is on quality of care. The group agreed that staff and the Health Care Advocate representatives would review criterion #4 offline and draft new language for consideration at the May meeting. Fran withdrew the motion.	**Pat and Alicia will work with the HCA to develop new language for Payment Measure criterion #4.**
4. Year 2 Proposals for New Measures and/or Changes to Pending Measures	Attachments 4a-4c were previously distributed. Michael Bailit reviewed those attachments and Attachment 4d. Nine measures have been proposed to be moved from Pending to Payment or Reporting measures. Aaron French spoke regarding Attachment 4e: CMS has asked that Vermont's Medicaid SSP measures incorporate more outcomes-based measures in the payment measures subset. The proposal is to consider moving the Core-10 and Core-12 measures (both relate to ambulatory care sensitive hospital admissions) from reporting to payment. • Norm Ward noted Core-10/MSSP #9 is a payment measure in Medicare and asked if the group should consider that for Commercial and Medicaid in year two. • Core-10/MSSP #9 is a claims-based outcome measure. • Michael wondered if Core-10 will have an adequate denominator in the commercial population.	**Pat can provide specifications for these measures if they would be helpful to the group.** **Pat will clarify if FQHCs have to report on MSSPs.**

Agenda Item	Discussion	Next Steps
	Deborah Lisi-Baker referenced attachment 4f, noting that DLTSS also wants to look further into subpopulation reporting for the developmental screening measure. • Pat asked for guidance from the DLTSS work group on defining subpopulations. • The DLTSS work group is working with Alicia and Pat to propose which measures should be prioritized for the DLTSS population. • Diane asked to clarify the turnaround timeframe for Core-37. It is stated as 24 hours but there is no clear definition of where that begins and ends. • The DLTSS work group is recommending alternate specifications (NQF #2036) for original measure Core-44 (which lacks specifications). • Regarding Core-44, "address prior to discharge": Collecting this information may not be appropriate prior to discharge. The measure does not allow for flexibility to have the discussion with the PCP at a later time.	**Alicia will provide more detailed specifications for Core-37 and Core-44, and check with NQF to see if exclusions exist.**
5. Next Steps, Wrap up and Future Meeting Schedule	Proposed measures will be reviewed at the next meeting. One member has asked to assess whether the breast cancer screening measure should remain as a reporting measure, given recent research on the effectiveness of mammography in detecting breast cancer. Cathy thanked Paul Harrington for emailing the NY Times article that morning: http://www.nytimes.com/2014/04/28/us/politics/health-laws-pay-policy-is-skewed-panel-finds.html?ref=us&_r=1. **Next meeting:** Thursday, May 29, 2014, 10 am-12 pm, 4th Floor Conf. Room, Pavilion Building, Montpelier.	**Pat will send articles on mammography effectiveness from Betty Rambur.** **If participants have more information regarding changes to measures, please email Alicia and Pat.**

Attachment 3A - Adopted Measure Selection Criteria

Vermont ACO Quality and Performance Measures Work Group
Adopted Criteria – Overall Measure Selection
May 23, 2014

Respondents = 19

Criterion	Description	% of Survey Respondents Recommend "Include"	Adopted at April 2014 QPM WG Meeting?
1. Valid and reliable	**The measure will produce consistent (reliable) and credible (valid) results.**	**100.00%**	**Yes**
10. Representative of the array of services provided and beneficiaries served	**The overall measures set will be representative of the array of services provided, and of the diversity of patients served.**	**100.00%**	**Yes**
3. Uninfluenced by differences in patient case mix	**Providers serving more complex or ill patients will not be disadvantaged by comparative measurement. Measures will be either uninfluenced by differences in patient case mix or will be appropriately adjusted for such differences.**	**94.44%**	**Yes**
8. Not prone to random variation, i.e., sufficient denominator size	**In order to ensure that the measure is not prone to the effects of random variation, the measure type will be considered so as to ensure a sufficient denominator in the context of the program.**	**94.44%**	**Yes**
4. Consistent with state's goals for improved health systems performance	**The measure corresponds to a state objective for improved health systems performance (e.g., presents an opportunity for improved quality and/or cost effectiveness).**	**88.89%**	**Yes**
5. Not administratively burdensome, i.e., feasible to collect	**The measure can be implemented and data can be collected without undue administrative burden.**	**88.89%**	**Yes**
6. Aligned with other measure sets	**The measure aligns with national and state measure sets and federal and state initiatives whenever possible.**	**88.89%**	**Yes**
13. Includes a mix of measure **types**	Includes process, outcome and patient experience (e.g., self-management, perceptions, PCMH CAHPS®) measures, including measures of care transitions and changes in a person's functional status.	**88.89%**	**Yes**
2. Relevant benchmark available	**The measure has been selected from NQF endorsed measures that have relevant benchmarks whenever possible.**	**88.24%**	**Yes**

Criterion	Description	% of Survey Respondents Recommend "Include"	Adopted at April 2014 QPM WG Meeting?
7. Focused on outcomes	**To extent feasible, the measure should focus on outcomes, i.e., improving this measure will translate into significant changes in outcomes relative to costs, with consideration for efficiency.**	**83.33%**	**Yes**
11. Limited in number	**The overall measure set should be limited in number and include only those measures that are necessary to achieve the state's goals.**	**83.33%**	**Yes**
12. Population-based/focused	**The overall measure set should be population-based so that it may be used not only for comparative purposes, but also to identify and prioritize state efforts.** Recognizes population demographics; gives priority to aging population and other ages; considers geographic community and not just patient population; consistent with State Health Improvement Plan.	**82.35%**	**Yes**
14. Considers social determinants	Considers transportation, housing, education, poverty, social health status, community, school and family engagement.	**76.47%**	**No**
15. Considers risk and protective factors	Includes mental health indicators, substance use and misuse, environmental factors (e.g., air, water, walk to school); weaves in prevention of adverse childhood health events.	**75.00%**	**No**
17. Focuses on wellness by patient, physician and system.	Evaluates patient engagement (patient has some responsibility to focus on wellness); health literacy of patient to focus on wellness; physician engagement; cultural competency of physician; care coordination and care management.	**72.22%**	**No**
9. "Setting-free"	Useable across multiple settings and for different populations.	**66.67%**	**No**
16. Expanded timeframe	Do not limit analysis to 3-5 years; need longer analysis (e.g., 20 years) for expected changes and improvements. Develop balanced portfolio of measures – some that are appropriate for short term analysis and others for longer term analysis.	**27.78%**	**No**

Attachment 3B - Population Health Measure Selection Criteria - Additional Information

Population Health Integration in VT Health Care Innovation Project

The overall charge of the Population Health Work Group is to recommend ways in which the Vermont Health Care Innovation Project could better coordinate population health [1]improvement activities and more directly impact population health. The criteria proposed are in line with the population health framework which recognizes the multiple factors that contribute to health outcomes, focuses on primary prevention, and looks at opportunity to impact upstream factors that affect health outcomes.

Use data on health trends and burden of illness to identify priorities

Focus on identified state priorities given burden of illness, known preventable diseases and evidence-based actions that have proven successful in changing health outcomes. The measure is evidence-based, important to making significant gains in population health and improving determinants of health and health outcomes of a population.

Focus on broader population and health outcomes

Consider the health outcomes of a group of individuals, ***including the distribution of such outcomes within the group***, in order to develop priorities and target action. The measure enables evaluation of subpopulations and especially those most vulnerable – due to disability, age, income, etc. The measure can be applied to the entire population – those already presenting with illness and disease as well as those at risk in the future.

Focus on prevention and wellness by patient, physician and system

Focus on prevention, self-care and maintaining wellness. The measure would include actions taken to maintain wellness rather than solely on identifying and treating disease and illness.

Focus upstream to include risk and protective factors

Risk factors are conditions or variables associated with a lower likelihood of positive outcomes and a higher likelihood of negative or socially undesirable outcomes. **Protective factors** have the reverse effect: they enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences from exposure to risk. http://www.who.int/hiv/pub/me/en/me_prev_ch4.pdf. The measure would capture personal health behaviors such as tobacco, diet and exercise, alcohol uses, sexual activity, as well as other health and mental health conditions that are known to contribute to health outcomes.

Link to social determinants and environmental factors

The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics http://www.cdc.gov/socialdeterminants/ .

The measures would include social factors and the physical environment such as: education, employment, income, family support, community, the built environment and environmental quality.

Expanded Timeframe

Many changes to population health will require a longer time frame than the duration of this project. Develop a balanced portfolio of measures with the potential for short term impact (within 3-5 years) and other measures with impact over a longer time frame (5-20 years).

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[1] Population Health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart, 2003). While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors. **Working Definition of Population Health, Institute Of Medicine, Roundtable on Population Health Improvement**
http://**www**.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx

Attachment 3C - Payment Measure Criteria

Vermont ACO Quality and Performance Measures Work Group
Criteria Selection Survey Results – Payment Measure Selection
April 25, 2014

Respondents = 19

Criterion	Description	Percent Recommending "Include"
3. Presents an opportunity for improvement	**The measure offers opportunity for performance improvement to achieve high-quality, efficient health care.**	**94.44%**
5. Representative of the array of services provided and beneficiaries served	**The overall measures set will be representative of the array of services provided, and of the diversity of patients served.**	**94.12%**
1. Relevant benchmark available	**The measure has been selected from NQF-endorsed measures that have relevant benchmarks whenever possible.**	**88.24%**
4. Focused on outcomes	**The measure assesses outcomes~~,~~; i.e., improving this measure will translate into significant changes in quality outcomes ~~relative to quality~~, taking cost into account if applicable ~~and/or cost~~.**	**83.33%**
2. Selected from the commercial or Medicaid Core Measure Set	**The measure can only be selected from the available commercial or Medicaid core measure sets.**	**72.22%**
Comments	None.	

Attachment 5 - Year 2 Proposed Changes to Payment and Reporting Measures

VT Quality and Performance Measures Work Group
Review of Changes in Measures Proposed for Year 2 Reporting and Payment
May 27, 2014

Additional Measures Proposed for 2015 Reporting:

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-8	Developmental Screening in the First Three Years of Life (*currently in Medicaid measure set; proposed for commercial measure set*)	NQF #1448; NCQA (not HEDIS); and CHIPRA	Yes		Medicaid can use claims data, but provider coding for commercial payers is not currently reliable, so the commercial measure could require data from clinical records.	CMS has analyzed data from five states (AL, IL, NC, OR, TN) that reported the measure for FFY12 consistently using prescribed specifications. CMS reports that 12 states reported in FFY13, and 18 intend to do so in FFY14. Best practice is in IL, which reported rates of 77%, 81%, 65% in Years 1-3; the five-state median was 33%, 40%, 28%.	• Vermont Legal Aid • Population Health WG • DLTSS Work Group
Core-30	Cervical Cancer Screening	NQF #0032; NCQA (HEDIS)	Yes	Changes in HEDIS specifications for 2014: • Added steps to allow for two appropriate screening methods of cervical cancer screening: cervical cytology performed every three years in women 21–64 years of age and cervical cytology/HPV co-testing performed every five years in women 30–64 years of age.	For HEDIS purposes in 2014, both commercial and Medicaid plans could use the hybrid method which requires data from clinical records.	HEDIS benchmark available (for HEDIS 2015; no benchmark for 2014). Historical Performance HEDIS 2013 (PPO) • BCBSVT: 72%; CIGNA: 71%; MVP: 71% • National 90th percentile: 78%; **Regional 90th percentile: 82%** • National Average: 74%; Regional Average: 78%	• Population Health WG
Core-34	Prenatal and Postpartum Care	NQF #1517; NCQA (HEDIS)	Yes		HEDIS rates are collected using the hybrid method, using claims data and clinical records.	Timeliness of Prenatal Care Historical Performance HEDIS 2013 (PPO): • BCBSVT: 94%; CIGNA: 74%; MVP: 95% • National 90th percentile: 96%; **Regional 90th percentile: 96%** • National Average: 81%; Regional	• Population Health WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
						Average: 82% Postpartum Care Historical Performance (PPO): • BCBSVT: 83%; CIGNA: N/A; MVP: 84% • National 90th percentile: 86%; **Regional 90th percentile: 90%** • National Average: 70%; Regional Average: 70%	
Core-35/ MSSP-14	Influenza Immunization	NQF #0041; MSSP	Yes		Requires clinical data or patient survey to capture immunizations that were given outside of the PCP's office (e.g., in pharmacies, at public health events)	Medicare MSSP benchmarks available from CMS.	• Population Health WG • DTLSS WG
Core-36/ MSSP-17	Tobacco Use Assessment and Tobacco Cessation Intervention	NQF #0028; MSSP	Yes		Clinical records	CMS set benchmarks for MSSP shared savings distribution. For this measure, the benchmarks equate to the rates for 2014 and 2015 reporting years. For example, the 50th percentile is 50%, and the 90th percentile is 90%. This measure is in use in other states and HRSA and CDC publish benchmarks, so additional benchmarking feasible if there is interest in adoption.	• Population Health WG • DLTSS WG
Core 37	Transition Record Transmittal to Health Care Professional	NQF #0648/#2036 (paired measure – see below)	Yes		Clinical records	None identified	• DTLSS WG
Core-39/ MSSP-28	Hypertension (HTN): Controlling High Blood Pressure	NQF #0018; MSSP	Yes	Guideline change: In December 2013, the eighth Joint National Committee (JNC 8) released updated guidance for treatment of	Clinical records	HEDIS benchmark currently available, but with measure likely to change, there is a possibility that there won't be a benchmark for 2015.	• Population Health WG • DLTSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
				hypertension: • Set the BP treatment goal for patients 60 and older to <150/90 mm Hg. • Keep the BP treatment goal for patients 18–59 at <140/90 mm Hg. <u>Changes in HEDIS Specifications for 2015</u>: Proposed changes to HEDIS specifications in 2015 to align with the JNC 8 guidelines. The measure will be based on one sample for a total rate reflecting age-related BP thresholds. The total rate will be used for reporting and comparison across organizations.		Historical Performance HEDIS 2013 (PPO) • BCBSVT: 61%; CIGNA PPO: 62%; MVP PPO: 67% • National 90th percentile: 65%; **Regional 90th percentile: 78%** • National Average: 57%; Regional Average: 63%	
Core-40/ MSSP-21	Screening for High Blood Pressure and Follow-up Plan Documented	Not NQF-endorsed; MSSP	Yes		Clinical records	CMS set benchmarks for MSSP shared savings distribution. For this measure, the benchmarks equate to the rates for 2014 and 2015 reporting years. For example, the 50th percentile is 50%, and the 90th percentile is 90%. However, this measure is in use by other states so it may be possible to identify benchmarks.	• Population Health WG • DLTSS WG
Core-44	Percentage of Patients with Self-Management Plans	Not NQF-endorsed	No. Need to develop measure specs based on the NCQA standard, or borrow from a state that uses this measure.		Clinical records	This measure is used by some PCMH programs in other states. Benchmarks could be obtained from those states.	• Population Health WG • DLTSS WG (*see Core-44 ALT)*

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-44 (ALT*)	Transition Record with Specified Elements Received by Discharged Patients	NQF #0647/ #2036 (paired measure - see above)	Yes		Clinical records	None identified	• DTLSS WG
Core-45	Screening, Brief Intervention, and Referral to Treatment	Not NQF-endorsed	No, but a form of the measure is in use by Oregon Medicaid		Could potentially use claims or data from clinical records. If claims-based, could involve provider adoption of new codes.	None available, but a form of the measure is in by Oregon Medicaid, so benchmark rates could be available if the same measure was adopted.	• Population Health WG • DLTSS WG • Howard Center
New Measure	LTSS Rebalancing *(proposed for Medicaid measure set)*	Not NQF-endorsed	DAIL has specifications		DAIL collects statewide and county data from claims; potential to collect at ACO level.	None available	• DLTSS WG
New Measures	3 to 5 custom questions for Patient Experience Survey regarding DLTSS services and case management	Not NQF-endorsed	Questions have been developed; would require NCQA approval to add to PCMH CAHPS Survey		Could add to PCMH CAHPS Patient Experience Survey; might increase expense of survey.	None available	• DLTSS WG

Additional Measures Proposed for 2015 Payment:

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-10 MSSP-9	Ambulatory Care-Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	NQF# 0275; AHRQ PQI #05; Year 1 Vermont SSP Reporting	Yes		Claims	National PQI Benchmarks (for Medicare population) available at www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx	• CMS • DVHA

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
		Measure					
Core-12	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	Not NQF-endorsed; AHRQ PQI #92; Year 1 Vermont SSP Reporting Measure	Yes		Claims	National PQI Benchmarks (for Medicare population) available at www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx	• CMS • DVHA • DLTSS WG
Core-15	Pediatric Weight Assessment and Counseling	NQF #0024; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	HEDIS benchmarks available from NCQA. This measure has three components: • BMI Percentile • Counseling for Nutrition • Counseling for Physical Activity BMI Percentile Historical Performance HEDIS 2012 (PPO) • CIGNA PPO:63% • National 90th percentile: 65%; **Regional 90th percentile: 87%** National Average: 25%; Regional Average: 42% Counseling for Nutrition Historical Performance HEDIS 2012 (PPO) • CIGNA PPO: 73% • National 90th percentile: 69%; **Regional 90th percentile: 90%** National Average: 28%; Regional Average: 45% Counseling for Physical Activity Historical Performance HEDIS 2012 (PPO) • CIGNA PPO:72% • National 90th percentile: 65%; **Regional**	• DLTSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
						90th percentile: 86% National Avg.: 26%; Regional Avg.: 42%	
Core-16 MSSP-22-26	Diabetes Composite (D5): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco non-use, Aspirin use	NQF #0729; MSSP; Year 1 Vermont SSP Reporting Measure	Yes. Measure steward (MCM) has changed specs for 2014 and 2015.	Change to national LDL control guideline has impacted this measure.	Clinical records	Available from Minnesota Community Measurement for Minnesota provider performance	• DLTSS WG
Core-17 MSSP-27	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059; MSSP; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	HEDIS benchmarks available from NCQA. Historical Performance HEDIS 2012 (PPO): (Lower rate is better) • BCBSVT: 41% • National 90th percentile: 22%; **Regional 90th percentile: 18%** National Average: 28%; Regional Average: 34%	• DLTSS WG
Core-19 MSSP-18	Depression Screening and Follow-up	NQF #0418; MSSP; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	Measure in use in some other states; we would have to review how it is implemented in the other states to see if benchmarks are available	• DLTSS WG
Core-20 MSSP-16	Adult Weight Screening and Follow-up	NQF #0421; MSSP; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	In use by HRSA so benchmark data may be available.	• DLTSS WG
M&E-14	Avoidable ED Visits (NYU Algorithm)	Not NQF-endorsed; Year 1 Vermont SSP Monitoring and Evaluation Measure	Yes		Claims	Measure used in other states and in research, so it may be possible to identify benchmarks	• DLTSS WG