QPM Work Group Meeting

Agenda 8-24-15

VT Health Care Innovation Project (VCHIP)
Quality and Performance Measures (QPM) Work Group Meeting AGENDA

August 24 2015; 9:00 AM to 11:00 AM
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call-In Number: 1-877-273-4202 Passcode: 420323867

Item	Timeframe	Presenter/Topic	Relevant Attachments	Decision Needed?
1	9:00AM - 9:05AM	**Convene Meeting** • Welcome and Introductions • Roll Call • Approval of Minutes	**Attachment 1:** June 22 QPM Minutes	YES – Approval of minutes
2	9:05AM – 9:15AM	**Updates** • CMMI Site Visit • Status of Year 2 Measure Changes ***Public Comment***		
3	9:15AM - 10:45AM	**Year Three: Proposed Measure Changes** • Schedule of QPM, Payment Models, Steering, Core, GMCB Measure Review and Approval • QPM previously-recommended changes for Year 3 (asthma, blood pressure, diabetes) • Replacing M&E #16 (ED Utilization for Ambulatory Care Sensitive Conditions) • Potential changes to national Patient Experience Survey ***Public Comment***	**Attachment 3a:** Summary of QPM-recommended Year 3 Measure Changes **Attachment 3b:** Options for ACSC ED Utilization Measure (previously distributed for June meeting) **Attachment 3c:** Onpoint Avoidable ED Measure Q&A	YES – Decision on M&E #16; finalize Year 3 recommendations for Payment Models, Steering Committee, Core Team, DVHA and GMCB YES – Affirm that questions that comprise Patient Experience Survey measures can change as national survey changes
4	10:45AM – 11:00AM	**Wrap-Up and Next Steps** Next meeting scheduled for September 21, 2015; 9-11 AM; 4th Floor Pavilion Conference Room, Montpelier, VT		

Attachment 1

June Minutes

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

Date of meeting: June 22, 2015, 9:00am to 11:00 am, 4th Floor Conf Room, Pavilion Building, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approval of Minutes	Roll call was taken and a quorum was present. Sue Aranoff moved to approve the minutes via exception; Laura Pelosi seconded the motion. The motion was approved with two abstentions.	
2. Updates	**Project-wide convening - June 17, 2015:** Georgia Maheras provided a summary of the convening that was held last week to review the Year 2 milestones, based upon CMMI's request that the state revise its milestones. The goal was to improve understanding of the milestones and ensure they are attainable. Participants at the convening addressed questions including: How will we get there? How can we all work together to achieve these goals? Project management staff members are currently summarizing strategies and activities to achieve these milestones; that summary will be submitted to the Core Team in July. Project leadership was impressed by the participants' engagement and candor, and expressed their thanks to participants. Cathy Fulton commented on how exciting it was to see the connections being formed between separate but related work groups and project deliverables. **Immunization measures in IOM report:** Pat Jones reported that it appears the IOM report ("Vital Signs") is using an immunization measure for 3-year-olds that does not include all of the immunizations in the measure for 2-year-olds that is being used for Vermont's Medicaid and Commercial ACO Shared Savings Programs. The measure in the IOM report is the same measure that FQHCs collect for UDS and is also a measure that VDH monitors, which may provide an opportunity for future alignment. It appears that there are benchmarks for the measure. **Status of Work Group's recommended changes to Year 2 ACO Shared Savings Program measures:** Pat updated the status of changes to the Year 2 Measure Set recommended by the Work Group at its last meeting. Consistent with the Work Group's recommendation, the VHCIP Steering Committee and Core Team unanimously approved:	

Agenda Item	Discussion	Next Steps
	• Changing the Diabetes Composite reporting measure in the Commercial and Medicaid SSPs from a 5-part measure to the 2-part measure that CMMI began using on 2015 for the Medicare Shared Savings Program (MSSP). • Eliminating the LDL Screening payment measure in the Commercial and Medicaid SSPs, and substituting it with the Controlling High Blood Pressure MSSP measure for the LDL measure. On Thursday (6/25/15), the GMCB will discuss these changes for the Commercial SSP (GMCB unanimously approved the changes on 6/25/15).	
3. All Payer Model Update	Lawrence Miller provided a very informative presentation on the proposed All Payer Model (see attached Power Point). The Work Group had a number of questions that were discussed as follows: • Sue asked for an update on the Blueprint funding proposal. Mary Kate Mohlman reported that a majority of the Blueprint's Executive Committee members voted in favor of changes in practice per member per month (PMPM) rates, with 2 no votes and 2 abstentions. The Committee approved a Baseline PMPM payment of $3.00, with an additional $0.25 PMPM each for quality and utilization incentive payments. On Thursday (6/18/15) the GMCB approved the plan at its rate review meeting. On Friday (6/19/15) letters went to insurers describing the change. • Lawrence noted that a goal is for data and reporting to be non-duplicative. Three years is not a lot of time to develop sustainable capacity in data and reporting, and in other areas. At the end of the grant, the state will have to be prepared to let some things go and retain the most valuable interventions. How do we make sure measurements and evaluation provide rapid feedback to inform the Legislature as it is making decisions about funding on-going interventions? • Vermont will leverage the 1115 waiver; the state is working to renew the agreement at the end of 2016 in a way that is aligned with the All Payer Model. • Robin Edelman asked if the 1115 waiver would continue to cover the costs for Vermonters to participate in self-management programs. Lawrence said the decision of what to continue to fund is an on-going process both at the Agency and at the Legislature. • Sue asked whether the payments would be for all treatment provided by hospital-affiliated physicians. Lawrence responded that this is where the flexibility comes into play – these are the kinds of decisions that we need to work through. It has to be sustainable and possible – we could decide to include all hospital costs, including pharmacy. We just need to keep an eye on the trends and on designing a balanced system. A key decision is what services are to be funded through the All Payer Model. For example, if we decided to exclude costs for substance abuse treatment, we'd be excluding important costs that are driving Vermont's health care spending right now. • The ultimate goal is to align the system with the genuine desire of providers to care for their patients. A key element in containing total cost of care is to provide transparency so that patients can choose their providers and treatment plans with knowledge about the cost and the quality of care they're seeking. • Heidi Klein asked about quality measures – would a broader set of measures be part of the All Payer	

Agenda Item	Discussion	Next Steps
	Model? Lawrence said the ACO SSP measures are the most critical measures. If we can develop a quality measurement system that is able to harvest the metrics electronically, providers will be more likely to participate. • It is important to ensure that we have an adequate number of skilled providers willing to fully participate in the process and the model, who are willing to turn their attention to the patient in front of them and to give the patient the experience they deserve – especially in a system that constrains their clinical time in all directions. • Lila Richardson asked about the role for public input in the All Payer Model. Lawrence responded that this is a negotiation process with CMS. There are some very clear guardrails that CMS has outlined in the process. The public process will occur once the determination is made that the model will actually be a 'good deal' for Vermont. • There is opportunity for public input is in the performance monitoring and quality measure process. Heidi added that there are far more measures than what are included in the ACO SSP measure sets that impact cost, quality and health outcomes. • The goal is to work through the framework agreement with CMS over the next few months to get to the point at which we can design the framework for the model in more detail. The timeline is to use 2015 to build the framework, with implementation planning in 2016 and a launch of the program in 2017. • Sue referred to the process of negotiating Medicaid contracts with ACOs – e.g. Oregon is allowing ACOs to spend money on housing. To what extent will we have that type of flexibility under an All Payer Model? Lawrence responded that the goal is to build that flexibility into the system, by extending the flexibility of Medicaid spending to Medicare and commercial payers. Cathy thanked Lawrence for his presentation.	
4. Year 3 ACO Shared Savings Program Measures	**Year 3 ACO Shared Savings Program Measures:** Robin Edelman asked about the timeline for making changes to Year 2 measures. Pat responded that the Medicaid contract amendment process is underway now and will fully incorporate the measures into the Year 2 measures set in the next month or so. Pat reviewed the decisions made to cardiac and diabetes measures for Year 2 – the question is whether the group wants to recommend these same changes for Year 3. Heather Skeels asked about flexibility if the measures are determined later to not be aligned with current practice. The Work Group does have ongoing flexibility to address changes of that nature. The motion from last meeting that resulted in recommendations to change the Year 2 measure set: was read: "*For Year 2 (2015) of the Medicaid and Commercial Shared Savings Programs to eliminate the LDL Screening payment measure and replace it with the Medicare Shared Savings Program Blood Pressure Control measure as a payment measure; and to eliminate the Diabetes Care Composite ("D5") reporting*	

Agenda Item	Discussion	Next Steps
	measure and replace it with the Medicare Shared Savings Program ("D2") measure as a reporting measure." Diane Leach noted there are 2 blood pressure measures for MSSP. The recommended measure is Controlling High Blood Pressure. The blood pressure control measure is much more feasible to collect and measure than the other measure (screening and follow-up plan). Diane reflected concern from providers that maintaining the lower blood pressure is causing them to over-treat patients. Pat added that ACOs will be compared to national benchmarks and not to a 100% compliance rate. Mike Nix asked for clarity about the measure. If you get the patient to the target rate one time, is that enough? What is the point in time that is being measured? Miriam Sheehey will provide additional information; providers need additional education in order to understand the measure in their working environment. Heidi Klein made a motion to recommend continuation of` both of the Year 2 measure changes into Year 3, by exception, as follows: "For Year 3 (2016) of the Medicaid and Commercial Shared Savings Programs to eliminate the LDL Screening payment measure and replace it with the Medicare Shared Savings Program Blood Pressure Control measure as a payment measure; and to eliminate the Diabetes Care Composite ("D5") reporting measure and replace it with the Medicare Shared Savings Program ("D2") measure as a reporting measure." Heather Skeels seconded the motion. Vicki Loner asked whether the motion ensures alignment with MSSP; Pat replied that it does. Patty Launer asked about the description of the Controlling High Blood Pressure measure in Attachment 4b. Pat noted that there is a mistake in the attachment – the MSSP measure is blood pressure at or below 140/90 for all ages. The motion passed unanimously. **M&E-16: ED Utilization for Ambulatory Care-Sensitive Conditions:** The measure steward, AHRQ, is no longer supporting this measure. There are at least 3 options for Year 3: 1) Continue to use even though it will not be supported and updated 2) Replace with Avoidable ED measure from Onpoint Health Data 3) Do not use and do not replace Bailit Health Purchasing recommends using the Onpoint measure, which is also being used at the Blueprint. The measure looks at diagnoses -- such as sore throat, viral infections, ear infections, joint pain, fatigue, and headache -- that rarely result in hospitalization. Julie Wasserman asked about urinary tract infection, common in the nursing home setting. It is not included in the list of diagnoses. Diane Leach asked whether a higher diagnosis would supersede a lower diagnosis, or if a visit that resulted in an admission would be	

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	counted. For example, would admission after a diagnosis of headache be included? The measure would be collected at the ACO level. It could not initially be trended over time because the Year 1 measure would be different. Vicki Loner asked if it could be monitored in Year 2 and then included in Year 3. Pat said she thought the state could ask the contractor to perform the calculations for Year 2. Heidi Klein pointed out the differences between the AHRQ and Onpoint measures. Heather Skeels said that in a way, they are inverse measures. Whereas the AHRQ measure was derived from a measure of ambulatory care-sensitive inpatient use, Onpoint's measure is geared to outpatient ED visits that rarely result in hospitalization. Except for asthma, none of the diagnostic categories across these two measure specifications have any overlap. The focus on preventable ED use supports the Triple Aim. Patty noted that the measures could provide important information about access, e.g., after-hours access to primary care. There were questions about whether the Onpoint measure has been tested or validated. Mike Nix proposed holding off until the August meeting to obtain more information. Diane Leach added that ICD-10 has huge implications for all these measures. Mary Kate Mohlman will ask Onpoint about the switchover of this measure to ICD-10 and for detailed specifications. **Year 1 Measure Results:** Results should be ready for the September meeting. Maura Graff asked if there is one place to find all the measures. Staff will update the Medicare/Medicaid/Commercial SSP crosswalk table and will also update the website.	
8. Next Steps, Wrap Up and Future Meeting Schedule	**NOTE: The July Meeting is CANCELED.** **Next Meeting:** Monday, August 24, 2015; 9:00 am – 11:00 am; DVHA Large Conference Room, 312 Hurricane Lane, Williston; Call-In Number: 1-877-273-4202, Conference ID: 420-323-867	

VHCIP QPM Work Group Member List

Roll Call: 6/22/2015

Sue Aranoff 1°
Laura Pelosi 2°

taken together
Heidi Klein 1°
Heather Skeels 2°

- vote postponed to August meeting

Member		Member Alternate		Minutes	Yr 3 Measures			
					Cardiac Disease	Diabetes	ED Util.	
First Name	Last Name	First Name	Last Name					Organization
Susan	Aranoff ✓	Patricia	Cummings ✓					AHS - DAIL
Jaskanwar	Batra	Kathleen	Hentcy					AHS - DMH
Catherine	Burns ✓	Kim	McClellan	no vote				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							HealthFirst
Judith	Franz							VITL
Aaron	French	Erin	Carmichael ✓					AHS - DVHA
Catherine	Fulton ✓							Vermont Program for Quality in Health Care
Maura	Graff ✓							Planned Parenthood of Northern New England
Paul	Harrington							Vermont Medical Society
Pat	Jones ✓	Richard	Slusky					GMCB
Heidi	Klein ✓	Robin	Edelman	A				AHS - VDH
Patricia	Launer ✓	Kate	Simmons					CHAC
Diane	Leach ✓							Northwestern Medical Center
Vicki	Loner ✓	Miriam	Sheehey	A				OneCare Vermont
David	Martini							DFR
Mike	Nix ✓							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					VLA/Health Care Advocate Project
Rachel	Seelig ✓							VLA/Senior Citizens Law Project
Shawn	Skaflestad ✓	Lily	Sojourner					AHS - Central Office
Heather	Skeels ✓	Patricia	Launer					Bi-State Primary Care
Jennifer	Stratton							Lamoille County Mental Health Services
Monica	Weeber							AHS - DOC
Robert	Wheeler	Teresa	Voci ✓					Blue Cross Blue Shield of Vermont
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VHCIP QPM Work Group Participant List

Attendance: 6/22/2015

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		Vermont Care Partners	X
Michael	Bailit		SOV Consultant - Bailit-Health Purchasing	S
Susan	Barrett		GMCB	X
Jaskanwar	Batra		AHS - DMH	M
Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH	X
Catherine	Burns	phone - joined late	DA - HowardCenter for Mental Health	M
Erin	Carmichael	phone	AHS - DVHA	MA
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		Accountable Care Coalition of the Green Mountains	MA
Alicia	Cooper	here	AHS - DVHA	S
Janet	Corrigan		Dartmouth-Hitchcock	X
Patricia	Cummings	phone	AHS - DAIL	MA
Jude	Daye		Blue Cross Blue Shield of Vermont	A
Yvonne	DePalma		Planned Parenthood of Northern New England	M
Rick	Dooley		HealthFirst	M
Robin	Edelman	here	AHS - VDH	MA
Gabe	Epstein	here	AHS - DAIL	S
Erin	Flynn		AHS - DVHA	S
Judith	Franz		VITL	M
Aaron	French		AHS - DVHA	M
Catherine	Fulton	here	Vermont Program for Quality in Health Care	C/M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Maura	Graff	here	Planned Parenthood of Northern New England	M
~~Bryan~~	~~Hallett~~		GMCB	S
Paul	Harrington		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	AHS - DVHA	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	here	CHAC	M
Diane	Leach	here	Northwestern Medical Center	M
Deborah	Lisi-Baker		SOV - Consultant	X
Vicki	Loner	Phone	OneCare Vermont	M
Nicole	Lukas	here	AHS - VDH	X
Georgia	Maheras	here	AOA	S
David	Martini		DFR	M

Mike	Maslack			X
Kim	McClellan		DA - Northwest Counseling and Support Services	MA
Darcy	McPherson		AHS - DVHA	X
Jessica	Mendizabal		AHS - DVHA	S
Anneke	Merritt		Northwestern Medical Center	X
Robin	Miller		AHS - VDH	X
MaryKate	Mohlman	here	AHS - DVHA - Blueprint	X
Mike	Nix	phone	Jeffords Institute for Quality, FAHC	M
Annie	Paumgarten	here	GMCB	S
Laura	Pelosi	here	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	here	VLA/Health Care Advocate Project	M
Jenney	Samuelson		AHS - DVHA - Blueprint	X
Rachel	Seelig	here	VLA/Senior Citizens Law Project	M
Julia	Shaw	here	VLA/Health Care Advocate Project	MA
Miriam	Sheehey	phone	OneCare Vermont	MA
Kate	Simmons		Bi-State Primary Care/CHAC	MA
Colleen	Sinon		Northeastern Vermont Regional Hospital	X
Shawn	Skaflestad	phone	AHS - Central Office	M
Heather	Skeels	here	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
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		Bi-State	X

James	Westrich	here	AHS - DVHA	S
Robert	Wheeler		Blue Cross Blue Shield of Vermont	M
Bradley	Wilhelm		AHS - DVHA	S
Cecelia	Wu		AHS - DVHA	S
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Lawrena Miller - AOA . here

Carole Magoffin - DUHA - here

Attachments 3a – 3c

Proposed Measure Changes

Proposed Changes for Year 3 ACO Shared Savings Program Measures

VHCIP Quality and Performance Measures Work Group

August 24, 2015

Language from GMCB's Suggested Hiatus

- "…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…"

Rationale for Proposed Changes

- Quality measures can and do change as the evidence base changes.
- The QPM Work Group's consultant, Bailit Health Purchasing, provided a summary of national changes to measures in Vermont's SSP measure sets.
- There have been recent national changes to one measure in the payment measure set:
  - Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening), a claims-based payment measure (Core-3a)

Rationale for Proposed Changes (cont'd)

- There have been recent national changes to one set of measures in the reporting measure set:
  - Optimal Diabetes Care Composite ("D5"), a set of 5 clinical data-based reporting measures (Core-16)

- There have been recent national changes to two measures in the monitoring & evaluation measure set:
  - Appropriate Medications for People with Asthma (M&E-1)
  - ED Utilization for Ambulatory Care-Sensitive Conditions (M&E-16)

Proposed Year 3 Measure Changes

- During recent meetings, the QPM Work Group voted unanimously to recommend replacements for the LDL Screening, Diabetes Composite, and Asthma Medications measures.
- Changes to the LDL Screening and Diabetes Composite measures were effective for Year 2 (2015) after being approved by the Steering Committee, Core Team and GMCB. The QPM Work Group is seeking approval to continue these changes into Year 3 (2016).
- Changes to Asthma Medications and ED Utilization measures would be effective for Year 3 (2016).

Recommendation: Replace LDL Screening with Controlling High Blood Pressure

Previous Measure	Recommended Measure
Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening) (Payment Measure)	Hypertension: Controlling High Blood Pressure (Payment Measure)

- LDL screening is no longer considered best practice; as a result, this measure has been dropped by the Medicare Shared Savings Program (MSSP) and NCQA HEDIS.
- Newly proposed HEDIS cholesterol measure (Statin Therapy for Patients with Cardiovascular Disease) has not yet been adopted, and will lack benchmarks when it is.
- QPM Work Group recommendation is to replace LDL Screening with a nationally-endorsed MSSP measure in Year 3, as was done for Year 2:
  - Hypertension: Controlling High Blood Pressure

Recommendation: Replace Optimal Diabetes Care Composite with MSSP Diabetes Composite

Previous Measure	Recommended Measure
Optimal Diabetes Care Composite ("D5," includes LDL Screening, hemoglobin A1c control, blood pressure control, tobacco non-use, and aspirin use) (Reporting Measure)	MSSP Diabetes Composite ("D2," includes hemoglobin A1c poor control and eye exam) (Reporting Measure)

- CMS has retired this measure from the MSSP measure set, most likely because one of the 5 measures that make up the composite is the LDL Screening measure.
- QPM Work Group recommendation for Year 3 is to replace "D5" with the new MSSP Diabetes Composite Measure ("D2"), which consists of 2 measures, as was done for Year 2.
- For the D2 measure, HbA1c Poor Control is already in the Commercial and Medicaid measure sets, Eye Exam is new.

Recommendation: Replace Appropriate Medications for People with Asthma with Medication Management

Current Measure	Recommended Measure
Appropriate Medications for People With Asthma (Monitoring and Evaluation Measure)	**HEDIS® Medication Management for People with Asthma (Monitoring and Evaluation Measure)**

- NCQA is proposing retiring Appropriate Medications for People with Asthma 2016 due to consistently high HEDIS® performance rates and little variation in plan performance for both commercial and Medicaid plans.
- Medication Management for People with Asthma 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. QPM recommendation for Year 3 is to replace Appropriate Medications for People with Asthma with this measure.
- This M&E measure is collected at the Health Plan (statewide) level, rather than at the ACO level.

Recommendation: Replace [or Retire or Retain] ED Utilization for ACSCs with [TBD]

Current Measure	Recommended Measure
ED Utilization for Ambulatory Care Sensitive Conditions (Monitoring and Evaluation Measure)	[TBD]

- AHRQ has retired this measure for unidentified reasons, but is working on other ED-specific measures that have not yet been finalized.
- The measure set still contains M&E-14: Avoidable ED visits-NYU algorithm.

SUMMARY – Year 3 Recommended Measure Changes for Commercial and Medicaid ACO SSPs

Previous/Current Measure	Recommended Replacement Measure	Measure Set
Year 1 Measure: Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening)	MSSP Hypertension: Controlling High Blood Pressure (Payment Measure)	Payment
Year 1 Measure: Optimal Diabetes Care Composite ("D5") D5 includes: • LDL Screening • hemoglobin A1c control • blood pressure control • tobacco non-use • aspirin use	MSSP Diabetes Composite ("D2") D2 includes: • hemoglobin A1c poor control (already in measure set) • eye exam	Reporting

SUMMARY – Year 3 Recommended Measure Changes Commercial and Medicaid Programs (cont'd)

Current Measure	Recommended Replacement Measure	Measure Set
Appropriate Medications for People with Asthma	Medication Management for People with Asthma	Monitoring and Evaluation
ED Utilization for Ambulatory Care Sensitive Conditions	[TBD]	Monitoring and Evaluation

bailit health PURCHASING

56 Pickering Street Needham, MA 02492 T: (781)453-1166 F: (781)453-1167 www.bailit-health.com

TO: Pat Jones
FROM: Michael Bailit, Michael Joseph and Margaret Trinity
DATE: June 18, 2015
RE: ACO ACSC ED Utilization Measure Options

You recently asked us to research options for the Ambulatory Care-Sensitive Conditions (ACSC) Emergency Department (ED) measure (M&E-16), including: 1) continuing to use the current measure, which is based on PQI specifications that are no longer endorsed by AHRQ; 2) replacing the measure with an ACSC measure developed by Onpoint Health Data; and 3) dropping the measure without replacement. This memo explains the substantive differences between the specifications for the AHRQ PQI and the Onpoint ACSC measure specifications, discusses the pros and cons of the three alternative approaches, and offers a recommendation for further discussion.

AHRQ's ACSC ED Measure

The ACSC ED measure used by Vermont in Year 1 of the ACO SSP is based on an AHRQ PQI specification that focuses on ambulatory care-sensitive conditions such as asthma, diabetes and dehydration -- conditions where timely and effective ambulatory care can decrease hospitalizations by preventing the onset of an illness, or by managing a chronic disease or condition. Our understanding is that AHRQ no longer endorses the specifications upon which Vermont based this measure for Year 1.

Onpoint Health Data's ACSC ED Measure

Onpoint Health Data originally developed the methodology for an ACSC ED measure for the New Hampshire Comprehensive Health Care Information System and the New Hampshire Department of Health and Human Services. For this measure, Onpoint developed a set of diagnostic categories that are most likely to represent conditions that are non-urgent and/or treatable in primary care settings. These categories include diagnoses where outpatient ED use or office visits were common, but for which inpatient hospitalization was rare.[1]

Onpoint uses this same measure for Vermont Blueprint reporting. In addition, the measure is the same as that reported in Onpoint's 2010 publication *Tri-State Variation in Health Services Utilization & Expenditures in Northern New England*, prepared in response to a request from the former Vermont Department of Banking, Insurance, Securities & Health Care Administration.

[1] Information on the diagnostic categories included in Onpoint's ACSC ED measure may be found on page 42 of the *Tri-State* report at: http://gmcboard.vermont.gov/sites/gmcboard/files/Tri-State-Commercial-Variation.pdf

Pros and Cons of the Three Options

As you are aware, there is no one methodology for measuring ACSC ED visit utilization that has been universally adopted. The AHRQ measure and the Onpoint measure offer two divergent approaches. Whereas the AHRQ measure was derived from a measure of ambulatory care-sensitive inpatient use, Onpoint's measure is geared to outpatient ED visits that do not result in hospitalization. In fact, except for asthma, none of the diagnostic categories across these two measure specifications have any overlap.

In weighing the three options, it should also be noted that AHRQ is developing a new set of measures for Emergency Department Patient Quality Indicators (ED PQIs). Preliminary testing of SAS software to support these new indicators was done in the spring of 2014. AHRQ has not released the specifications for public review or a timetable indicating when they may be available. As these specifications are not available for immediate implementation, Bailit Health is not considering them as an option for the short term. However, once the ED PQI specifications are released, we recommend that the Quality and Performance Measures Work Group consider them.

The aforementioned three options each present distinct advantages and disadvantages.

- Continue to Use AHRQ's ACSC ED Measure. This measure has the advantage of identifying high rates of ambulatory care-sensitive ED visits in a community, meaning visits that should have been treated successfully in outpatient settings but that present in an emergency department. The results of this measure can serve as an important warning of lack of adequate prevention efforts, a shortage of primary care resources, ineffective deployment of those resources, or other barriers to care. Another advantage is that because this measure was used in Year 1 of the pilot, Vermont will be able to compare results from Year 1 to Year 2 and beyond. A disadvantage of this measure is that because AHRQ no longer endorses it, AHRQ will no longer be providing updates or support for this measure. Furthermore, the fact that AHRQ no longer supports this measure reduces its credibility.

- Adopt Onpoint's ACSC ED Measure. One advantage of the measure developed by Onpoint is its goal of measuring the proper functioning of the outpatient health care delivery system. The specification codes used for this measure suggest that it is a measure of: 1) whether patients are appropriately using the health care system; 2) how well patients are able to access primary care, after-hours care, nurse help lines or urgent care walk-in centers; and 3) how well primary care physicians are managing their patients with routine care needs. As such, the Onpoint Health Data measure appears to offer a viable basis for an ACSC ED measure specification for Vermont's consideration. A disadvantage of this measure is that, if adopted for Year 2, Vermont will not be able to compare results for this measure to results from its Year 1 AHRQ PQI-based ACSC ED utilization measure. In addition, we do not yet know if the Onpoint measure has been tested for validity and reliability. We are seeking this information, however.

- Drop AHRQ Measure without Replacement. The clear disadvantage of this approach is that the ACO SSP measure set would then lack a measure of emergency department utilization of ambulatory care-sensitive conditions—and the warning signals such a measure might offer in terms of optimizing primary care resources by the ACOs.

  As you are aware, the ACO SSP measure set does include M&E-14: Avoidable ED Visits (NYU algorithm), which seeks to classify ED visits into categories (non–emergent, emergent/primary care treatable, etc.), using claims data. The algorithm used by this measure assumes a specific distribution of certain ICD-9 codes falls into its categories. For example, in the case of urinary tract infections (ICD-9-CM code 599.0), each case is assigned 66 percent "non-emergent," 17 percent "emergent/primary care treatable," and 17 percent "emergent - ED care needed - preventable/avoidable." This measure provides a view of potentially preventable ED visits, but is less specific than the Onpoint measure. It also does not lend itself to quarterly reporting as well as the alternatives due to the nature of the algorithm.

Bailit Health Recommendation

We recommend adoption of the Onpoint ACSC ED measure for two reasons: 1) it is a measure already familiar to the provider community and others in Vermont; and 2) the specifications are readily available and Onpoint can provide support for any needed updates or questions. Dropping the AHRQ measure without replacement is not a desirable alternative because it would leave the state without a means of measuring the ability of its primary care system to treat non-urgent conditions in outpatient care settings. Continuing with the AHRQ measure into Year 2 and beyond will present challenges in terms of maintaining the measure, and is therefore not a recommended option.

TO: Quality and Performance Measures (QPM) Work Group
FROM: QPM Staff and Co-Chairs
RE: Responses to Questions about Onpoint Potentially Avoidable ED Measure
DATE: August 14, 2015

Background

During discussion on options for replacing the Ambulatory Care-Sensitive Conditions Emergency Department measure (M&E-16) at the June 22, 2015 VHCIP Quality and Performance Measures Work Group Meeting, there were several questions about the Onpoint Health Data Potentially Avoidable ED measure that was recommended by Bailit Health. Work Group and Blueprint for Health staff followed up on those questions. The questions and the responses from Onpoint can be found below.

Question: Members of the VHCIP work group wanted more information on the development of Onpoint's Potentially Avoidable ED visits measure (such as why some diagnoses were included and others, such as UTI, excluded), and whether it had undergone any validation or reliability testing.

Answer: The ICD-9 diagnoses included in the measure were developed empirically from a statewide commercial and Medicaid APCD claims database. The goal was to identify a set of ICD-9 diagnoses with the following criteria: outpatient ED use was frequent, treatment was commonly provided in another setting (i.e., physician office), and inpatient hospitalizations were extremely rare.

In terms of reliability and validity:

- The method is reliable because it was claims-based, computer-driven, would produce the same result every time, has been replicated in multiple states, multiple payer types, and has been applied to both claims data and also to a hospital outpatient discharge dataset.
- Validity was determined empirically by identifying ICD-9 diagnoses from inpatient ED, outpatient ED, and office setting claims and ensuring that inpatient hospitalization was rare and office visit rates were high. We also removed diagnoses that were clearly good reasons for going to the emergency department (e.g., injuries and poisonings). The method was clinically validated by a physician Medicaid director and has since been reviewed with stakeholder groups, including physicians in two other states. The fact that these visits consistently account for about 25-30% of all outpatient ED visits is in general agreement with the estimates of proportion of service that represent over-use of medical care. Statistical validity requires an independent "gold-standard" data source, where an attending physician had independently determined that the patient did not require the emergency department for treatment. This would allow for statistical measures of validity: sensitivity, specificity, and Kappa. That statistical validity has not been done.

Question #2: Members of the VHCIP Workgroup wanted to know whether a secondary and more serious diagnoses supplanted the original "avoidable" diagnosis in the reporting of the measure. For example if someone was initially admitted with an infection that turned out to be sepsis, would that initial diagnosis be included in the measure count?

Answer: First, this measure applies to outpatient emergency department visits only. So an ED visit resulting in admission is not included in the measure. Only the primary diagnosis code for the ED visit is used in the measure. No secondary diagnoses are searched or used in the measure.

Question #3. We want to confirm Onpoint analytics is prepared to incorporate the change from ICD 9 to ICD 10 by October.

Answer: Yes, Onpoint is prepared to make the conversion from ICD-9 to ICD-10.