

Attachment 1 - VHCIP Steering Committee Meeting Agenda 9-03-14

**VT Health Care Innovation Project
Steering Committee Meeting Agenda**

September 3, 2014 9:30 am- 12:30 pm

DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action Needed?
1	9:30-9:35	Welcome and Introductions	Al Gobeille	Attachment 1: Agenda	
2	9:35-9:45	<i>Public Comment</i>	Al Gobeille		
3	9:45-9:50	Minutes Approval	Al Gobeille	Attachment 3: August Meeting Minutes	Approval of Minutes
4	9:50-10:00	Core Team Update <i>Public comment</i>	Anya Rader Wallack		N/A
5	10:00-11:00	Financial Requests: 1. Workforce WG RFP: Demand Modeling: \$250,000-\$350,000. 2. DLTSS WG RFP: Work Group Support: \$215,000. 3. HIE/HIT WG RFP: Telehealth Planning: TBD.	Georgia Maheras	Attachment 5: Financial Proposal PowerPoint	Decisions regarding each of the four proposals.

		<p>4. HIE/HIT WG Contract: Stone Environmental: \$120,000.</p> <p><i>Public Comment</i></p>			
6	11:00-12:20	<p>Policy:</p> <p>1. Quality and Performance Measures Work Group Year Two Shared Savings ACO Program Measures Discussion</p> <p><i>Public comment</i></p>	Al Gobeille	<p>Attachment 6a: SSP Measures Presentation for Steering Committee FINAL 8.6.14 (<i>previously distributed</i>)</p> <p>Attachment 6b: Year 2 Proposed Measures Overview with Benchmarks (<i>previously distributed</i>)</p> <p>Attachment 6c: Comments provided to Steering Committee (.pdf)</p> <p>Attachment 6d: Summary of Comments and Votes</p> <p>Attachment 6e: Summary of Comments</p>	Decision regarding measure set.
7	12:20-12:30	Next Steps, Wrap-Up and Future Meeting Schedule	Al Gobeille	<p>Next Meeting: October 1, 2014</p> <p>10am-12pm, Montpelier</p>	

Attachment 3 - VHCIP Steering
Committee Minutes 8-06-14

**VT Health Care Innovation Project
Steering Committee Meeting Minutes**

Date of meeting: August 6, 2014 at DVHA Large Conference Rm – Pavilion Building, Montpelier 10 am - 12 pm

Agenda Item	Discussion	Next Steps
Welcome and Introductions	Mark Larson called the meeting to order at 10:02am.	
<i>Public Comment</i>	None provided at this time	
Minutes Approval	Ed Paquin moved to approve the minutes. Bob Bick seconded the motion. A roll call was taken and the minutes were approved.	The roll call should be amended to reflect that Harry Chen abstained.
Core Team Update <i>Public comment</i>	Georgia Maheras provided an update on Core Team activities. The Core Team released the second round of the sub-grant program solicitation for applications on July 24 th . The Core Team will be discussing the scoring for these applications at their meeting on August 13 th . The Core Team will also review a budget realignment at that meeting.	
Policy: 1. Quality and Performance Measures Work Group Year Two Shared Savings ACO Program Measures Update <i>Public comment</i>	<p>Please review to the two attachments provided to the Steering Committee for additional background on this agenda item:</p> <ul style="list-style-type: none"> • Attachment 5a: SSP Measures Presentation for Steering Committee FINAL 8.6.14. • Attachment 5b: Year 2 Proposed Measures Overview with Benchmarks. <p>The Steering Committee engaged in a robust discussion about the proposed measure set after the Quality and Performance Measures Work Group (QPM) Staff and Co-Chairs introduced the proposed</p>	<p>There will be a public comment period until close of business on 8/20/14. Please submit comments on the proposed Year Two Shared Savings ACO Program Measure Set Changes to: Alicia.cooper@state.vt.us and Pat.jones@state.vt.us.</p> <p>These comments, as well as a summary, will be provided to the</p>

	<p>changes to the measure set for Year Two:</p> <ul style="list-style-type: none"> • Harry Chen requested that the QPM Work Group also review the comments submitted to the Steering Committee and provide any additional information to the Steering Committee on 9/3. • Monica Light asked whether the Steering Committee would vote on the measure set in its entirety or by individual measure. Georgia responded that last year the Steering Committee voted on the set in its entirety and that is ideal, but it can be done measure by measure. • Trinka Kerr asked about how this relates to ongoing activities to align the Shared Savings Program Measure Set with the Blueprint measures. The response is that there are plans to unify the reporting of measures for both programs in provider profiles and that quality improvement collaborations can be unified across regions. • Allan Ramsay comments that integration between these two programs is valuable. • Todd Moore expressed a concern that the process seemed tilted a bit away from providers delivering the care. • Allan asked if year one performance measure information was used to inform the year two decision. Cathy Fulton and Pat Jones indicated that the QPM Work Group members were aware of what data was available and that Bailit, the consultant working with the QPM Work Group, used as much historical data as possible. Kara Suter added that the work group had not yet set the targets and scoring for the Year Two measures and that the performance and data from year one would be used as part of that discussion. • Don George asked whether/if the QPM Work Group had 	<p>Steering Committee in advance of their meeting on September 3rd.</p>
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	<p>reviewed the patient experience measures and what about the approved payment criteria would prohibit a patient experience measure from becoming a payment measure. He asked whether the QPM Work Group would consider changing this measure to payment. Cathy and Pat responded that no one recommended that this measure be elevated from Reporting to Payment and that it was not reviewed by the work group, but could be.</p> <ul style="list-style-type: none"> • Dale expressed concern that it is hard to develop year two measures without year one data. Cathy responded that data is starting to flow about year one and Bob Bick commented that data is not necessarily a pre-requisite for some quality measures. • Jackie Majoros asked whether the measure criteria would be modified in the future. The response is that yes, they can be modified next year, but will use the Year Two criteria as a starting point. • Mike Gagnon asked whether the work group considered the electronic availability of the clinical measures. Pat responded that the work group reviewed whether the measures had specifications, but that the HIE/HIT Work Group was responsible for reviewing the electronic capability. 	
<p>Financial Requests:</p> <ol style="list-style-type: none"> 1. CMCM Work Group: Learning Collaborative Proposal \$300,000 <p><i>Public Comment</i></p>	<p>Attachment 6a: Financial Proposal PowerPoint</p> <p>Georgia and Pat introduced this proposal and several members of the Care Models and Care Management Work Group (CMCM) participated in the proposal’s explanation.</p> <p>The Steering Committee expressed interest in the selection of the</p>	<p>Any Steering Committee members who are interested in participating in the regional learning collaboratives or who know of organizations that should be involved should provide contact information</p>

	<p>learning collaborative pilot sites as well as the community participants. The CMCM Work Group explained that the three communities were selected because they volunteered to be early sites for this work. Additionally, these sites have populations that need more coordinated care. Each community will be given the latitude to pick their priority areas for improvement based on their data and populations. Each site will include, at a minimum, the entities listed on the powerpoint, but welcome and request additional regional collaborators. The goal is to engage all organizations within the community and be as inclusive and broad as possible. Several Steering Committee members encouraged the learning collaborative sites to be inclusive. The CMCM Work Group requested that they help with outreach to entities to participate.</p> <p>Bob Bick asked why the budget was a little unclear: specifically, there is \$50,000 not clearly accounted for. Pat Jones responded that CMCM had information about the cost of facilitators (95,000 each) that was supported by current contracts, but the cost of the Learning Sessions was not as clear and that this is an estimate and a not-to-exceed amount. Allan Ramsay asked why this was not considered a provider grant. Georgia responded that there was a separate line-item in the SIM budget for learning collaboratives and that the responsibility for developing these was given to the CMCM Work Group. Monica Light recommended adding in the AHS Field Directors for each region.</p> <p>Monica asked how the findings and information from this learning collaborative will be used to flow through the rest of the VHCIP. Pat responded that this is a tool that will be used to inform the CMCM Work Group about best practices in care coordination.</p> <p>Jackie also asked how the learning collaborative communities would</p>	<p>to Pat Jones and Erin Flynn at: Pat.Jones@state.vt.us and Erin.flynn@state.vt.us .</p>
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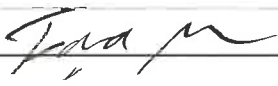





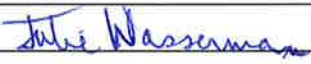
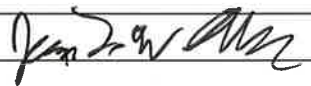
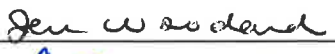

	<p>integrate person-directed care. The CMCM Work Group responded that they would operationalize that at the community level and that they had previously discussed this in the planning for this work.</p> <p>The intent is that this would expand across the state.</p> <p>Motion to approve made by Dale and seconded by Harry. Motion passed on a roll call vote with one abstention.</p>	
<p>Next Steps, Wrap-Up and Future Meeting Schedule</p>	<p>Next Meeting: September 3rd, Williston</p>	<p>This meeting will be extended 30 minutes to allow for sufficient discussion and voting on the Proposed Year Two Shared Savings Program ACO Measure Set.</p>

VHCIP Steering Committee Attendance List 8-06-14

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

First Name	Last Name		Title	Organization	Steering Committee
Ena	Backus			GMCB	X
Melissa	Bailey	Melissa Bailey		Otter Creek Associates and Matrix Heal	X
Heidi	Banks			Vermont Information Technology Lead	X
John	Barbour		Executive Director	Champlain Valley Area Agency on Aging	M
Rick	Barnett	RT Barnett	President	Vermont Psychological Association	X
Susan	Barrett		Executive Director	GMCB	X
Anna	Bassford			GMCB	A
Jaskanwar	Batra	Jaskanwar	MENSAE DIRECTOR	DMH	X
Susan	Besio		Senior Associate	Pacific Health Policy Group	X
Bob	Bick	Bob Bick	Director of Mental Health and Subs	HowardCenter for Mental Health	M
Martha	Buck			Vermont Association of Hospital and H	A
Harry	Chen	Harry Chen	Commissioner	AHS - VDH	M
Amanda	Ciecior		Health Policy Analyst	AHS - DVHA	X
Peter	Cobb		Executive Director	VNAs of Vermont	M
Lori	Collins			AHS - DVHA	X
Amy	Coonradt	Amy Coonradt	Health Policy Analyst	AHS - DVHA	X
Alicia	Cooper	Alicia Cooper	Quality Oversight Analyst	AHS - DVHA	X
Elizabeth	Cote			Area Health Education Centers Program	M
Diane	Cummings	Diane Cummings	Financial Manager II	AHS - Central Office	X
Susan	Devoid			OneCare Vermont	A
Tracy	Dolan		Deputy Commissioner	AHS - VDH	X
Richard	Donahey		Financial Director III	AHS - Central Office	X
Susan	Donegan		Commissioner	AOA - DFR	M
Paul	Dupre	Paul Dupre	Commissioner	AHS - DMH	M
Nancy	Eldridge	Nancy Eldridge	Executive Director	Cathedral Square and SASH Program	M
John	Evans	John Evans for JKE	President and CEO	Vermont Information Technology Lead	M
Audrey	Fargo		Administrative Assistant	Vermont Program for Quality in Health	A
Cyndy	Fischer			OneCare Vermont	A
Katie	Fitzpatrick		VT Administrative Asst.	Bi-State Primary Care	A
Erin	Flynn	Erin Flynn	Health Policy Analyst	AHS - DVHA	X

Aaron	French		Deputy Commissioner	AHS - DVHA	X
Catherine	Fulton	<i>C Fulton</i>	Executive Director	Vermont Program for Quality in Health	M
Lucie	Garand		Senior Government Relations Spec	Downs Rachlin Martin PLLC	X
Christine	Geiler		Grant Manager & Stakeholder Coord	GMCB	S
Don	George	<i>Don George</i>	President and CEO	Blue Cross Blue Shield of Vermont	M
Jim	Giffin		CFO	AHS - Central Office	X
Al	Gobeille		Chair	GMCB	C
Bea	Grause		President	Vermont Association of Hospital and He	M
Sarah	Gregorek			AHS - DVHA	A
Dale	Hackett	<i>D Hackett</i>	Consumer Advocate	None	M
Janie	Hall		Corporate Assistant	OneCare Vermont	A
Thomas	Hall			Consumer Representative	X
Bryan	Hallett				X
Paul	Harrington		President	Vermont Medical Society	M
Carrie	Hathaway		Financial Director III	AHS - DVHA	X
Diane	Hawkins			AHS - DVHA	X
Karen	Hein	<i>Karen Hein</i>	Board Member	GMCB	X
Brendan	Hogan		Consultant	Bailit-Health Purchasing	X
Debbie	Ingram			Vermont Interfaith Action	M
Craig	Jones		Director	AHS - DVHA - Blueprint	M
Kate	Jones			AHS - DVHA	S
Pat	Jones	<i>Pat Jones</i>		GMCB	X
Trinka	Kerr	<i>Trinka Kerr</i>	Chief Health Care Advocate	VLA/Health Care Advocate Project	M
Heidi	Klein			AHS - VDH	X
Nelson	Lamothe			UMASS	S
Kelly	Lange		Director of Provider Contracting	Blue Cross Blue Shield of Vermont	X
Mark	Larson		Commissioner	AHS - DVHA	C
Diane	Lewis			AOA - DFR	A
Monica	Light	<i>Monica Light</i>	Director of Health Care Operations,	AHS - Central Office	M
Deborah	Lisi-Baker		Disability Policy Expert	Unknown	M
Sam	Liss		Chairperson	Statewide Independent Living Council	X
Bill	Little		Vice President	MVP Health Care	M
Robin	Lunge		Director of Health Care Reform	AOA	S
Georgia	Maheras			AOA	S
Steven	Maier		HCR-HIT Integration Manager	AHS - DVHA	X
Jackie	Majoros	<i>J Majoros</i>	State Ombudsman	VLA/LTC Ombudsman Project	M
David	Martini			AOA - DFR	MA
Marybeth	McCaffrey		Principal Health Reform Administrator	AHS - DAIL	X
Alexa	McGrath			Blue Cross Blue Shield of Vermont	A

Kimberly	McNeil		Payment Reform Policy Intern	AHS - DVHA	X
Darcy	McPherson		Program Technician	AHS - DVHA	X
Marisa	Melamed			AOA	A
Madeleine	Mongan		Deputy Executive Vice President	Vermont Medical Society	X
Todd	Moore		CEO	OneCare Vermont	M
Brian	Otley		COO	Green Mountain Power	X
Dawn	O'Toole		Director of Operations	AHS - DCF	X
Mary Val	Palumbo		Associate Professor	University of Vermont	M
Ed	Paquin	✓ 	Ed Paquin	Disability Rights Vermont	M
Annie	Paumgarten		Eveluation Director	GMCB	X
Laura	Pelosi		Executive Director	Vermont Health Care Association	M
Judy	Peterson		President and CEO	Visiting Nurse Association of Chittende	M
Luann	Poirer		Administrative Services Manager I	AHS - DVHA	X
Allan	Ramsay		Board Member	GMCB	M
Stephen	Rauh			GMC Advisory Board	X
Lori	Real		Chief Operating Officer	Bi-State Primary Care/CHAC	M
Paul	Reiss		Executive Director,	Accountable Care Coalition of the Green	M
Simone	Rueschemeyer		Director	Behavioral Health Network of Vermont	M
Jenney	Samuelson		Assistant Director of Blueprint for I	AHS - DVHA - Blueprint	X
Larry	Sandage			AHS - DVHA	X
Howard	Schapiro		Interim President	University of Vermont Medical Group P	M
Julia	Shaw		Health Care Policy Analyst	VLA/Health Care Advocate Project	X
Shawn	Skaflestad		Quality Improvement Manager	AHS - Central Office	X
Mary	Skovira		Executive Staff Assistant	AHS - VDH	A
Richard	Slusky		Payment Reform Director	GMCB	X
Kara	Suter		Reimbursement Director	AHS - DVHA	X
Beth	Tanzman		Assistant Director of Blueprint for I	AHS - DVHA - Blueprint	X
Julie	Tessler		Executive Director	Vermont Council of Developmental and	M
Anya	Wallack		Chair	SIM Core Team Chair	X
Barbara	Walters		Chief Medical Director	OneCare Vermont	M
Julie	Wasserman		VT Dual Eligible Project Director	AHS - Central Office	X
Spenser	Weppler			GMCB	X
James	Westrich				X
Bradley	Wilhelm		Senior Policy Advisor	AHS - DVHA	X
Sharon	Winn		Director, Vermont Public Policy	Bi-State Primary Care	M
Jennifer	Woodard		Long-Term Services and Supports I	AHS - DAIL	X
Cecelia	Wu		Healthcare Project Director	AHS - DVHA	X
Dave	Yacovone		Commissioner	AHS - DCF	M
Mike	Maslack				X

		Miriam Stecher	Clin. Quality	OCD	
		Patricia A. Launer	Q Manager	Bi-State/CHAC	

minutes

10 EA

20 Bob

VHCIP Steering Committee Member Roster 8-06-14

C	Chair
M	Member
MA	Member Alternate

First Name	Last Name		Title	Organization	Steering Committee
John	Barbour		Executive Director	Champlain Valley Area Agency on Aging	M
Bob	Bick	✓	Director of Mental Health and Subs	Howard Center for Mental Health	M
Harry	Chen	✓	Commissioner	AHS - VDH	M
Peter	Cobb		Executive Director	VNAs of Vermont	M
Elizabeth	Cote			Area Health Education Centers Program	M
Susan	Donegan		Commissioner	AOA - DFR	M
Paul	Dupre	✓	Commissioner	AHS - DMH	M
Nancy	Eldridge	✓	Executive Director	Cathedral Square and SASH Program	M
John	Evans	✓	President and CEO	Vermont Information Technology Leaders	M
Catherine	Fulton	✓	Executive Director	Vermont Program for Quality in Health Care	M
Don	George	abstain	President and CEO	Blue Cross Blue Shield of Vermont	M
Al	Gobeille		Chair	GMCB	C
Bea	Grause		President	Vermont Association of Hospital and Health Systems	M
Dale	Hackett	✓	Consumer Advocate	None	M
Paul	Harrington		President	Vermont Medical Society	M
Debbie	Ingram			Vermont Interfaith Action	M
Craig	Jones		Director	AHS - DVHA - Blueprint	M
Trinka	Kerr	✓	Chief Health Care Advocate	VLA/Health Care Advocate Project	M
Mark	Larson	abstain	Commissioner	AHS - DVHA	C
Monica	Light	✓	Director of Health Care Operations	AHS - Central Office	M
Deborah	Lisi Baker		Disability Policy Expert	Unknown	M
Bill	Little		Vice President	MVP Health Care	M
Jackie	Majoros	abstain	State Ombudsman	VLA/LTC Ombudsman Project	M
David	Martin			AOA - DFR	MA
Todd	Moore	✓	CEO	OneCare Vermont	M
Mary Val	Palumbo		Associate Professor	University of Vermont	M
Ed	Paquin	✓	Ed Paquin	Disability Rights Vermont	M

Laura	Petosi		Executive Director	Vermont Health Care Association	M
Judy	Peterson		President and CEO	Visiting Nurse Association of Chittenden and Grand Is	M
Allan	Ramsay	✓	Board Member	GMCB	M
Lori	Rea		Chief Operating Officer	Bi-State Primary Care/CHAC	M
Paul	Reiss		Executive Director,	Accountable Care Coalition of the Green Mountains	M
Simone	Rueschemeyer	✓	Director	Behavioral Health Network of Vermont	M
Howard	Schapiro		Interim President	University of Vermont Medical Group Practice	M
Julie	Tessler	✓	Executive Director	Vermont Council of Developmental and Mental Health	M
Barbara	Walters	<i>abstain</i>	Chief Medical Director	OneCare Vermont	M
Sharon	Winn		Director, Vermont Public Policy	Bi-State Primary Care	M
Dave	Yacovone		Commissioner	AHS - DCF	M

Roll Call for Learning Collab.

VHCIP Steering Committee Member Roster 8-06-14

C	Chair
M	Member
MA	Member Alternate

- Craig joined @ 10:30
- Al arrived @ 11:00

2^o Harry

Rick Barnett ✓

First Name	Last Name		Title	Organization	Steering Committee
John	Barbour		Executive Director	Champlain Valley Area Agency on Aging	M
Bob	Bick	abst	Director of Mental Health and Subs	HowardCenter for Mental Health	M
Harry	Chen	✓	Commissioner	AHS - VDH	M
Peter	Cobb		Executive Director	VNAs of Vermont	M
Elizabeth	Cote			Area Health Education Centers Program	M
Susan	Donegan		Commissioner	AOA - DFR	M
Paul	Dupre	✓	Commissioner	AHS - DMH	M
Nancy	Eldridge	✓	Executive Director	Cathedral Square and SASH Program	M
John	Evans	Gaymon ✓	President and CEO	Vermont Information Technology Leaders	M
Catherine	Fulton	reused	Executive Director	Vermont Program for Quality in Health Care	M
Don	George	✓	President and CEO	Blue Cross Blue Shield of Vermont	M
Al	Gobeille	abst.	Chair	GMCB	C
Bra	Grause		President	Vermont Association of Hospital and Health Systems	M
Dale	Hackett	✓	Consumer Advocate	None	M
Paul	Harrington		President	Vermont Medical Society	M
Debbie	Ingram			Vermont Interfaith Action	M
Craig	Jones	Jones ✓	Director	AHS - DVHA - Blueprint	M
Trinka	Kerr	✓	Chief Health Care Advocate	VLA/Health Care Advocate Project	M
Mark	Larson	✓	Commissioner	AHS - DVHA	C
Monica	Light	✓	Director of Health Care Operations	AHS - Central Office	M
Deborah	Lisi-Baker		Disability Policy Expert	Unknown	M
Bill	Little		Vice President	MVP Health Care	M
Jackie	Majoros	✓	State Ombudsman	VLA/LTC Ombudsman Project	M
David	Martini			AOA - DFR	MA
Todd	Moore	✓	CEO	OneCare Vermont	M
MV	Palumbo	Palumbo ✓	Associate Professor	University of Vermont	M
Ed	Paquin	✓	Ed Paquin	Disability Rights Vermont	M

Laura	Peios		Executive Director	Vermont Health Care Association	M
Judy	Peterson		President and CEO	Visiting Nurse Association of Chittenden and Grand Is	M
Allan	Ramsay	✓	Board Member	GMCB	M
Eori	Real		Chief Operating Officer	Bi-State Primary Care/CHAC	M
Paul	Reiss		Executive Director,	Accountable Care Coalition of the Green Mountains	M
Simone	Rueschemeyer	✓	Director	Behavioral Health Network of Vermont	M
Howard	Schapiro		Interim President	University of Vermont Medical Group Practice	M
Julie	Tessler	✓	Executive Director	Vermont Council of Developmental and Mental Health	M
Barbara	Walters	✓	Chief Medical Director	OneCare Vermont	M
Sharon	Wirth		Director, Vermont Public Policy	Bi-State Primary Care	M
Dave	Yacovone		Commissioner	AHS - DCF	M

Attachment 5 - Financial Proposal PowerPoint

Financial Proposals

September 3, 2014

Georgia Maheras, JD

Project Director

AGENDA

1. Workforce WG RFP: Workforce Demand Modeling
2. DLTSS WG RFP: Work Group Support
3. HIE/HIT Work Group RFP: Telemedicine Planning
4. HIE/HIT Work Group Contract: Stone Environmental, Inc. Contract

Workforce Work Group RFP: Demand Modeling

- Request from the Workforce Work Group :
 - Project timeline: December 1, 2014-June 30, 2015
 - Project estimated cost: \$250,000-\$350,000
 - Project Summary: To contract for services for workforce demand modeling
 - Budget line item: Workforce: System-wide Analysis
- The Workforce Work Group is responsible for providing spending and policy recommendations about the recruitment and retention of the health care workforce.

Intent of Contract/Relationship to VHCIP Goals

- *VHCIP's Operational Plan outlines the following tasks:*

“ The [Workforce Strategic] Plan also outlines current workforce capacity issues and calls for ongoing workforce assessments through surveys of all health professions as part of licensure and through the development of Vermont-appropriate metrics for determining supply and demand...Development and analysis of supply, demand, and performance measures utilizing a team of data analysts, workforce experts, facilitators, and researchers that reach out to all health professionals across the state.”

Scope of Work

- Construction of a micro-simulation health needs model for the state of Vermont. The model should be able to assess and forecast the medical requirements of Vermont residents on an individual scale to aid the state in the understanding of workforce requirements under an ideal, universal, healthcare delivery system.
- The model should be able to account for multiple aspects of a professionally staffed health workforce.

Scope of Work cont.

- Providing the ability to adjust the model to a demand-based micro-simulation in order to capture the actual utilization of healthcare providers by Vermonters. It should include the effects of economic, social, and other barriers to access in order to provide an accurate depiction of the usage of health services.
- In the process of assessing and identifying a future ideal level of healthcare utilization by provider type, a baseline or current level of healthcare utilization will be identified based on existing factors currently influencing the Vermont population.
- An assessment of complex demand determinates, such as developments in science and technology, and projected changes in disease and chronic illness rates that accompany shifting demographics.

DLTSS RFP: Work Group Support

- Request from the DLTSS Work Group :
 - Project timeline: November 1, 2014- October 31, 2015
 - Project estimated cost: \$215,000
 - Project Summary: To contract for services to support the DLTSS Work Group in executing their work plan
 - Budget line item: Workforce: System-wide Analysis
- The DLTSS Work Group is responsible for providing recommendations regarding payment and delivery system reforms as they relate to those Vermonters with disabilities or in need of long term services and supports.

Intent of Contract/Relationship to VHCIP Goals

This work group is responsible for incorporating into Vermont's payment and delivery system reform efforts specific strategies to achieve improved quality of care, improved beneficiary experience and reduced costs for people with disabilities, related chronic conditions and those needing long term services and supports, including:

- Developing recommendations regarding the improvement of existing care models and the design of new care models to better address the needs of people with disabilities, related chronic conditions and those needing long term services and supports, in concert with VHCIP efforts;
- Developing recommendations regarding the design of new payment models initiated through the VHCIP project to improve outcomes and reduce costs for people with disabilities, related chronic conditions and those needing long term services and supports;
- Developing recommendations to integrate the service delivery systems for acute/medical care and long term services and supports;
- Developing recommendations for IT infrastructure to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports;
- Continuing to address coordination and enhancement of services for the dually-eligible population and other Vermonters who have chronic health needs and/or disabilities through such mechanisms as the Medicaid ACO program, further design of Green Mountain Care, and other approaches.

Scope of Work

- Recommend care model elements and strategies that improve beneficiary service and outcomes for people with disabilities, related chronic conditions and those needing long term services and supports.
- Identify provider payment models that encourage quality and efficiency among the array of primary care, acute and long-term services and support providers who serve people with disabilities, related chronic conditions and those needing long term services and supports.
- Identify mechanisms to incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports to achieve a more integrated and seamless delivery system.
- Incorporate person-centered, disability-related, person-directed, and cultural competency issues into all VHCIP activities.
- Identify Medicare/Medicaid/commercial insurance coverage and payment policy barriers that can be addressed through Vermont's health care reform efforts to improve integration of care for people with disabilities, related chronic conditions and those needing long term services and supports.

Scope of Work

- Identify mechanisms to minimize the incentives for cost-shifting between Medicare, Medicaid and commercial payers.
- Incorporate representation from Commercial Insurers into the VHCIP Disability and Long Term Services and Supports Work Group.
- Recommend incentives for ACOs to re-invest savings to address the needs of people with disabilities, related chronic conditions and those needing long term services and supports to prevent unnecessary hospitalizations, ER visits, and nursing home admissions.
- Identify DLTSS quality and performance measures to evaluate the outcomes of people with disabilities, related chronic conditions and those needing long term services and supports. These quality and performance measures shall be consistent with the core principles articulated in State law and regulation: the Developmental Disabilities Act of 1996, Choices for Care regulations pursuant to Act 56 (2005), and the Mental Health Care Reform Act 79 (2012).
- Identify technical and IT needs to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports.
- Other activities as identified by the Work Group to assist in successful implementation of payment and care models to best support people with disabilities, chronic conditions and those needing long term services and supports.

HIE/HIT Work Group RFP: Telemedicine/Telehealth Planning

- Request from the HIE/HIT Work Group :
 - Project timeline: January 1, 2015- July 31, 2016 (up to 18 months)
 - Project estimated cost: TBD
 - Project Summary: Contract with one person/entity to take the lead in creating a coordinated strategy and future direction for telehealth in Vermont and to assist in the selection and oversight of projects designed to test the hypothesis.
 - Budget line item: Technology and Infrastructure: Telemedicine
- The HIE/HIT Work Group is responsible for developing criteria and an RFP for distribution of SIM funds related to telehealth.

Intent of Contract/Relationship to VHCIP Goals

- *VHCIP's Budget Narrative outlines the following:*

“Startup and 1 year pilot (with potential expansion support for year 2) of a program and technology for home telemonitoring and web-based patient/family engagement. Program to be self-sustained by the ACO/Network in subsequent years...The State envisions using emerging but available technology to pilot a home telemonitoring project for patients with complex chronic disease, and/or high readmission-risk acute episodes. We would intend to evaluate the impact of more aggressive and dedicated home monitoring on patient outcomes and cost.”

Scope of Work

- Conduct a statewide inventory of equipment and services (Dartmouth, Bi-State, Home Health, MH/SA, public & private providers, payers, and education/research). The scope will include: medical (traditional, mental health and substance abuse, and more), human services, monitoring, distance learning. The goal will be to define the current landscape including the identification of barriers. The inventory needs to include what is happening currently around the state and innovation around the country and should be in a form that can be easily updated in future years.
- Investigate telehealth data systems , analyze options for a common statewide solution, and if deemed appropriate, recommend steps (or perhaps phases) to implement such a solution over time.

Scope of Work

- Develop a statewide telehealth/telemedicine strategy by 7/1/15 for Vermont that identifies goals and objectives, addresses barriers and issues (such as interstate licensing, payment, allowable originating sites, remote patient monitoring, culture and practice patterns, security/privacy, and broadband), and makes recommendations for future projects and initiatives. Convene a telehealth/telemedicine steering committee to guide the development of statewide telehealth/telemedicine strategies and projects .
- Develop an RFP for telehealth pilot projects that would test or further one or both of the following goals:
 - Broad and coordinated telehealth programs or initiatives should lead to better access to care and services, better care experiences for patients, better health outcomes for populations, and lower costs, especially in rural areas.
 - Common statewide telehealth solutions should lead to more efficient data sharing and more successful programs.

HIE/HIT Work Group Proposal: Stone

- Request from the HIE/HIT Work Group :
 - Project timeline: October 1, 2014-September 30, 2015
 - Project estimated cost: \$120,000
 - Project Summary: To contract for services supporting the analysis of existing health data systems and development of a recommendation for a health information data structure to facilitate create access to Vermont's health information.
 - Budget line item: Work Group Consulting
- The HIE/HIT Work Group is responsible for providing funding and policy recommendations regarding the health information system and infrastructure necessary to support a high performing health care system.
- Provides dedicated subject matter expertise in the area of health information.

Intent of Contract/Relationship to VHCIP Goals

- This contract is intended to provide information and background to support the work group's charge:
- Guide investments in the expansion and integration of health information technology, as described in the SIM proposal, including:
 - support for enhancements to EHRs and other source data systems
 - expansion of technology that supports integration of services and enhanced communication, including connectivity and data transmission from source systems such as mental health providers and long-term care providers
 - implementation of and/or enhancements to data repositories
 - implementation of and/or enhancements to data integration platform(s)
 - development of advanced analytics and reporting systems

Scope of Work

- The contractor will work with the HIE/HIT Work Group, Vermont State Agencies and Contractors on an initial data source discovery phase. This phase will result in a compilation of possible data sources, responsible agencies, organizations or individuals, and type of data. As the project progresses, this list may expand as additional data sources are identified.
- Based on the prioritized data sources identified in Phase 1, the contractor will develop a detailed inventory of each of the health information data sources. Prior to conducting the inventory, the contractor will work with the work group to specify key items to include in the inventory.

Deliverables

- Compile/Inventory Data Sources
- Develop a web-based inventory system that enables all users to search all the data source information collected.

Sole source justification

- Stone is a Vermont company that has been working in the spatial analysis field for over 25 years. In the field of spatial analysis, they are national experts.
- They have performed contracts for several Vermont agencies around health data spatial analyses including the GMCB, DVHA-Blueprint for Health and the Department of Health.
- In particular, Stone uses its significant expertise in spatial analysis to identify ways in which Vermont can improve its health information data sets.
- The team at Stone is comprised of data aggregators and analysts. Because of their experience across data sectors, Stone is able to use the best practices for all data and apply them to Vermont's health information.

Sole source justification

- Key personnel for this work include David Healy, who has decades of experience with both Vermont and national data sets.
- One key attribute of Stone is that they are not currently serving as a vendor of any of Vermont's key health data sets and do not intend to pursue this work in the future and they can remain objective, which is critical to this project.

Attachment 6a - SSP Measures
Presentation for Steering
Committee FINAL 8.6.14
(previously distributed)

Vermont ACO Shared Savings Program Quality Measures: Recommendations for Year 2 Measures from the VHCIP Quality and Performance Measures Work Group

Presentation to VHCIP Steering Committee
August 6, 2014

Measure Use Terminology: Core

Payment

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

Reporting

- ACOs will be required to report on these measures. Performance on these measures will be not be considered when calculating shared savings.

Pending

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

Measure Use Terminology: Monitoring & Evaluation

Monitoring

- These are measures that would provide benefit from tracking and reporting. They will have no bearing on shared savings; nonetheless, they are important to collect to inform programmatic evaluation and other activities. These measures will be reported at the plan or state-level. Data for these measures will be obtained from sources other than the ACO (e.g., health plans, state).

Utilization & Cost

- These measures reflect utilization and cost metrics to be monitored on a regular basis for each ACO. Data for these measures may be obtained from sources other than the ACO.

Year 1 Payment Measures – Claims Data

Commercial &
Medicaid

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

Medicaid-Only

- Developmental Screening in the First Three Years of Life

**Medicare Shared Savings Program measure*

Year 1 Reporting Measures – Claims Data

Commercial
& Medicaid

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

**Medicare Shared Savings Program measure*

Year 1 Reporting Measures – Clinical Data

Commercial
& Medicaid

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

**Medicare Shared Savings Program measure*

Year 1 Reporting Measures – Survey Data

Commercial
& Medicaid

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

Year 1 Monitoring & Evaluation Measures

PLAN-LEVEL MONITORING

- Appropriate Medications for People with Asthma
- Comprehensive Diabetes Care: Eye Exams for Diabetics
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Follow-up Care for Children Prescribed ADHD Medication
- Antidepressant Medication Management

STATE-LEVEL MONITORING

- Family Evaluation of Hospice Care Survey
- School Completion Rate
- Unemployment Rate

UTILIZATION & COST

- Total Cost of Care
- Resource Utilization Index
- Ambulatory surgery/1000
- Average # of prescriptions PMPM
- Avoidable ED visits- NYU algorithm
- Ambulatory Care (ED rate only)
- ED Utilization for Ambulatory Care-Sensitive Conditions
- Generic dispensing rate
- High-end imaging/1000
- Inpatient Utilization - General Hospital/Acute Care
- Primary care visits/1000
- SNF Days/1000
- Specialty visits/1000

- Annual Dental Visit

Year 1 Pending Measures

- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)*
- Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic*
- Influenza Immunization*
- Tobacco Use Assessment and Tobacco Cessation Intervention*
- Coronary Artery Disease (CAD) Composite*
- Hypertension (HTN): Controlling High Blood Pressure*
- Screening for High Blood Pressure and Follow-up Plan*
- Cervical Cancer Screening
- Proportion not admitted to hospice (cancer patients)
- Elective delivery before 39 weeks
- Prenatal and Postpartum Care
- Care Transition-Transition Record Transmittal to Health Care Professional
- How's Your Health?
- Patient Activation Measure

- Frequency of Ongoing Prenatal Care
- Percentage of Patients with Self-Management Plans
- Screening, Brief Intervention, and Referral to Treatment
- Trauma Screen Measure
- Falls: Screening for Future Fall Risk*
- Pneumococcal Vaccination for Patients 65 Years and Older*
- Use of High Risk Medications in the Elderly
- Persistent Indicators of Dementia without a Diagnosis

**Medicare Shared Savings Program measure*

QPM WG Year 2 Measure Review Process

- **Goals were to adhere to transparent process and obtain ongoing input from WG members and other interested parties**
- **March-June**
 - Interested parties and other VHCIP Work Groups presented Year 2 measure changes for consideration
 - WG reviewed and finalized criteria to be used in evaluating overall measure set and payment measures
 - WG reviewed and discussed proposed measure changes
- **June-July**
 - Co-Chairs/Staff/Consultant scored each recommended measure against approved criteria on 0-1-2 point scale and developed proposals for Year 2 measure changes for the WG's consideration
 - WG reviewed and discussed proposals
- **July**
 - WG voted on measures during July 29th meeting

QPM Criteria for Evaluating All Measures

- ✓ Valid and reliable
- ✓ Representative of array of services provided and beneficiaries served by ACOs
- ✓ Uninfluenced by differences in patient case mix or appropriately adjusted for such differences
- ✓ Not prone to effects of random variation (measure type and denominator size)
- ✓ Consistent with state's objectives and goals for improved health systems performance
- ✓ Not administratively burdensome
- ✓ Aligned with national and state measure sets and federal and state initiatives whenever possible
- ✓ Includes a mix of measure types
- ✓ Has a relevant benchmark whenever possible
- ✓ Focused on outcomes
- ✓ Focused on prevention, wellness and/or risk and protective factors
- ✓ Limited in number and including measures necessary to achieve state's goals (e.g., opportunity for improvement)
- ✓ Population-based

QPM Criteria for Evaluating Payment Measures

- ✓ Presents an opportunity for improvement
- ✓ Representative of the array of services provided and beneficiaries served
- ✓ Relevant benchmark available
- ✓ Focused on outcomes
- ✓ Focused on prevention and wellness
- ✓ Focused on risk and protective factors
- ✓ Selected from the Commercial or Medicaid Core Measure Set

Summary of Year 2 Recommended Changes

- QPM Work Group voted to:
 - Re-classify **9 existing** measures
 - 3 to Payment
 - 5 to Reporting
 - 1 to M&E
 - Add **2 new** measures
 - 1 to Reporting (Patient Experience Survey)
 - 1 to M&E

Recommended Year 2 Payment Measures

– Claims Data

Commercial &
Medicaid

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)*
- **Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite** (*10-5 vote of QPM WG; move from Reporting*)

Medicaid-Only

- Developmental Screening in the First Three Years of Life

**Medicare Shared Savings Program measure*

Recommended Year 2 Payment Measures

– Clinical Data

Commercial
& Medicaid

- **Diabetes Care: HbA1c Poor Control (>9.0%)*** *(10-5 vote of QPM WG; move from Reporting)*
- **Pediatric Weight Assessment and Counseling** *(10-5 vote of QPM WG; move from Reporting)*

**Medicare Shared Savings Program measure*

Recommended Year 2 Reporting Measures – Claims Data

Commercial
& Medicaid

- Ambulatory Care-Sensitive Conditions Admissions: COPD*
- ~~Breast Cancer Screening*~~
- ~~Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: Composite~~
- Appropriate Testing for Children with Pharyngitis
- **Avoidable ED Visits** *(9-6 vote of QPM WG; move from M&E)*

Commercial-
Only

- **Developmental Screening in the First Three Years of Life** *(10-4 vote of QPM WG; already in Y1 Payment Measure Set for Medicaid SSP)*

**Medicare Shared Savings Program measure*

Recommended Year 2 Reporting Measures – Clinical Data

Commercial &
Medicaid

- Adult BMI Screening and Follow-Up*
- Screening for Clinical Depression and Follow-Up Plan*
- Colorectal Cancer Screening*
- Diabetes Composite
 - *HbA1c control**
 - *LDL control**
 - *High blood pressure control**
 - *Tobacco non-use**
 - *Daily aspirin or anti-platelet medication**
- ~~Diabetes HbA1c Poor Control*~~
- Childhood Immunization Status
- ~~Pediatric Weight Assessment and Counseling~~
- **Cervical Cancer Screening** (*Unanimous vote of QPM WG, move from Pending*)
- **Tobacco Use: Screening & Cessation Intervention*** (*Unanimous vote of QPM WG, move from Pending*)

**Medicare Shared Savings Program measure*

Recommended Year 2 Reporting Measures

– Patient Experience Survey Data

Commercial
& Medicaid

- Access to Care
- Communication
- Shared Decision-Making
- Self-Management Support
- Comprehensiveness
- Office Staff
- Information
- Coordination of Care
- Specialist Care
- **Provider Knowledge of DLTS Services and Help from Case Manager/Service Coordinator**
(11-3 vote of QPM WG; NEW)

Recommended Year 2 Monitoring & Evaluation Measures

PLAN-LEVEL MONITORING

- Appropriate Medications for People with Asthma
- Comprehensive Diabetes Care: Eye Exams for Diabetics
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Follow-up Care for Children Prescribed ADHD Medication
- Antidepressant Medication Management
- **Breast Cancer Screening** (*Unanimous vote of QPM WG; moved from Reporting*)

STATE-LEVEL MONITORING

- Family Evaluation of Hospice Care Survey
- School Completion Rate
- Unemployment Rate
- **LTSS Rebalancing** (*Medicaid-only; state and county level; unanimous vote of QPM WG; NEW*)
- **SBIRT** (*for pilot sites; unanimous vote of QPM WG; move from Pending*)

UTILIZATION & COST

- Total Cost of Care
 - Resource Utilization Index
 - Ambulatory surgery/1000
 - Average # of prescriptions PMPM
 - Avoidable ED visits- NYU algorithm
 - Ambulatory Care (ED rate only)
 - ED Utilization for Ambulatory Care-Sensitive Conditions
 - Generic dispensing rate
 - High-end imaging/1000
 - Inpatient Utilization - General Hospital/Acute Care
 - Primary care visits/1000
 - SNF Days/1000
 - Specialty visits/1000
- Annual Dental Visit

Recommended Year 2 Pending Measures

- Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)*
 - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic*
 - Influenza Immunization*
 - ~~Tobacco Use Assessment and Tobacco Cessation Intervention*~~
 - Coronary Artery Disease (CAD) Composite*
 - Hypertension (HTN): Controlling High Blood Pressure*
 - Screening for High Blood Pressure and Follow-up Plan*
 - ~~Cervical Cancer Screening~~
 - Care Transition-Transition Record Transmittal to Health Care Professional
 - Percentage of Patients with Self-Management Plans
- How's Your Health?
 - Patient Activation Measure
 - Elective delivery before 39 weeks
 - Prenatal and Postpartum Care
 - Frequency of Ongoing Prenatal Care
 - ~~Screening, Brief Intervention, and Referral to Treatment~~
 - Trauma Screen Measure
 - Falls: Screening for Future Fall Risk*
 - Pneumococcal Vaccination for Patients 65 Years and Older*
 - Use of High Risk Medications in the Elderly
 - Persistent Indicators of Dementia without a Diagnosis
 - Proportion not admitted to hospice (cancer patients)

**Medicare Shared Savings Program measure*

Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant recommended considering these measures for promotion
- QPM work group members voted to retain Year 1 status

Year 1 Measure Category	Year 2 Suggested Measure Category	Measure	QPM Vote
Pending	Reporting	Prenatal and Postpartum Care (Clinical Data)	5 in favor of promotion 9 opposed to promotion
Pending	Reporting	Influenza Immunization (Clinical Data)	7 in favor of promotion 7 opposed to promotion

Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant DID NOT recommend considering this measure for promotion
- Work group members requested additional consideration for use as Reporting in Year 2
- QPM work group members voted to retain Year 1 status

Year 1 Measure Category	Year 2 Suggested Measure Category	Measure	QPM Vote
Pending	Pending	Screening for High Blood Pressure and Follow-Up Plan Documented (Clinical Data)	2 in favor of promotion to Reporting 11 opposed to promotion

Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant DID NOT recommend considering these measures for promotion
- QPM work group members chose not to vote on these measures

Year 1 Measure Category	Year 2 Suggested Measure Category	Measure
Reporting	Reporting	Optimal Diabetes Care (D5 – Composite)
Reporting	Reporting	Rate of Hospitalization for ACSCs (COPD/Asthma in Older Adults)
Reporting	Reporting	Screening for Clinical Depression & Follow-Up
Reporting	Reporting	Adult BMI Assessment
Pending	Pending	Controlling High Blood Pressure
Pending	Pending	Care Transition Record Transmitted to Health Care Professional
Pending	Pending	Transition Record with Specified Elements Received by Discharged Patients
Pending	Pending	Percentage of Patients with Self-Management Plans

Attachment 6b - Year 2 Proposed Measures
Overview with Benchmarks (previously
distributed)

VT Quality and Performance Measures Work Group
Review of Changes in Measures Proposed for Year 2 Reporting and Payment
June 20, 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 (<i>currently in Medicaid measure set; proposed for commercial measure set</i>)	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%.	<ul style="list-style-type: none"> Vermont Legal Aid Population Health WG DLTSS Work Group
Core-30	Cervical Cancer Screening	NQF #0032; NCQA (HEDIS)	Yes	<u>Changes in HEDIS specifications for 2014:</u> <ul style="list-style-type: none"> 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) <ul style="list-style-type: none"> BCBSVT: 72%; CIGNA: 71%; MVP: 71% National 90th percentile: 78%; Regional 90th percentile: 82% National Average: 74%; Regional Average: 78% 	<ul style="list-style-type: none"> Population Health WG
Core-34	Prenatal and Postpartum Care	NQF #1517; NCQA (HEDIS)			HEDIS rates are collected using the hybrid method, using claims data and clinical records.	Timeliness of Prenatal Care Historical Performance HEDIS 2013 (PPO): <ul style="list-style-type: none"> BCBSVT: 94%; CIGNA: 74%; MVP: 95% National 90th percentile: 96%; Regional 90th percentile: 96% National Average: 81%; Regional 	<ul style="list-style-type: none"> Population Health WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
						<p>Average: 82%</p> <p>Postpartum Care Historical Performance (PPO):</p> <ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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 50 th percentile is 50%, and the 90 th 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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • DTLSS WG
Core-39/ MSSP-28	Hypertension (HTN): Controlling High Blood Pressure	NQF #0018; MSSP	Yes	<u>Guideline change:</u> 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.	<ul style="list-style-type: none"> • 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
				<p>hypertension:</p> <ul style="list-style-type: none"> 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. <p><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.</p>		<p>Historical Performance HEDIS 2013 (PPO)</p> <ul style="list-style-type: none"> 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			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 50 th percentile is 50%, and the 90 th percentile is 90%. However, this measure is in use by other states so it may be possible to identify benchmarks.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> Population Health WG DLTSS WG Howard Center
New Measure	LTSS Rebalancing (<i>proposed for Medicaid measure set</i>)	Not NQF-endorsed	DAIL has proposed specifications		DAIL collects statewide and county data from claims; potential to collect at ACO level.	None available	<ul style="list-style-type: none"> DLTSS WG
New Measures	3 to 5 custom questions for Patient Experience Survey regarding DLTS services and case management	Not NQF-endorsed	Questions have been developed; may require NCQA approval to add to PCMH CAHPS Survey		Could add to PCMH CAHPS Patient Experience Survey; might increase expense of survey.	None available	<ul style="list-style-type: none"> 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 Measure	Yes		Claims	National PQI Benchmarks (for Medicare population) available at www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx	<ul style="list-style-type: none"> • CMS • DVHA
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	<ul style="list-style-type: none"> • CMS • DVHA • DLSS WG
Core-15	Pediatric Weight Assessment and Counseling	NQF #0024; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	<p>HEDIS benchmarks available from NCQA. This measure has three components:</p> <ul style="list-style-type: none"> • BMI Percentile • Counseling for Nutrition • Counseling for Physical Activity <p>BMI Percentile Historical Performance HEDIS 2012 (PPO)</p> <ul style="list-style-type: none"> • CIGNA PPO: 63% • National 90th percentile: 65%; Regional 90th percentile: 87% <p>National Average: 25%; Regional Average: 42%</p> <p>Counseling for Nutrition Historical Performance HEDIS 2012 (PPO)</p> <ul style="list-style-type: none"> • CIGNA PPO: 73% • National 90th percentile: 69%; Regional 90th percentile: 90% <p>National Average: 28%; Regional Average: 45%</p>	<ul style="list-style-type: none"> • DLSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
						Counseling for Physical Activity Historical Performance HEDIS 2012 (PPO) <ul style="list-style-type: none"> CIGNA PPO:72% National 90th percentile: 65%; Regional 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 <u>Reporting Measure</u>	Yes. Measure steward (MCM) changed specs for 2014 and 2015.	Change to national LDL control guideline impacted this measure.	Clinical records	Available from Minnesota Community Measurement for Minnesota provider performance	<ul style="list-style-type: none"> DLTSS WG
Core-17 MSSP-27	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059; MSSP; Year 1 Vermont SSP <u>Reporting Measure</u>	Yes		Clinical records	HEDIS benchmarks available from NCQA. Historical Performance HEDIS 2012 (PPO): (Lower rate is better) <ul style="list-style-type: none"> BCBSVT: 41% National 90th percentile: 22%; Regional 90th percentile: 18% National Average: 28%; Regional Average: 34%	<ul style="list-style-type: none"> DLTSS WG
Core-19 MSSP-18	Depression Screening and Follow-up	NQF #0418; MSSP; Year 1 Vermont SSP <u>Reporting Measure</u>	Yes		Clinical records	Measure in use in some other states; we would have to review how implemented to see if benchmarks are available	<ul style="list-style-type: none"> DLTSS WG
Core-20 MSSP-16	Adult Weight Screening and Follow-up	NQF #0421; MSSP; Year 1 Vermont SSP <u>Reporting Measure</u>	Yes		Clinical records	In use by HRSA so benchmark data may be available	<ul style="list-style-type: none"> DLTSS WG
M&E-14	Avoidable ED Visits (NYU Algorithm)	Not NQF-endorsed; Year 1 Vermont SSP <u>Monitoring and Evaluation Measure</u>	Yes		Claims	Measure used in other states and in research, so it may be possible to identify benchmarks	<ul style="list-style-type: none"> DLTSS WG

Attachment 6c - Comments
provided to Steering
Committee (.pdf)

Anonymous e-mail (Miriam):

-----Original Message-----

From: vt-cms-support@egov.com [<mailto:vt-cms-support@egov.com>] On Behalf Of Green Mountain Care Board

Sent: Friday, August 15, 2014 1:42 PM

To: Bassford, Anna

Subject: Form submission from: Public Comment

Submitted on Friday, August 15, 2014 - 13:42 Submitted by anonymous user: [192.240.41.254]

Submitted values are:

Name: Miriam

Affiliation, if applicable:

Address:

Telephone Number:

Email Address:

Topic: Other

Comment: The measure set that is being proposed for Medicaid measures appears to be unreasonable. Some of the measures are not able to be captured or to have a well known goal to aim for. I am not sure that they will be meaningful or satisfactory.

The results of this submission may be viewed at:

<http://gmcboard.vermont.gov/node/243/submission/1226>



BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

August 20, 2014

The Honorable Al Gobielle and the Honorable Mark Larson
Co-chairs, Steering Committee - Vermont Healthcare Innovation Project (VHCIP)

Re: Proposed Year 2 Measures for Vermont Accountable Care Organizations (ACOs)

Dear Chairman Gobielle and Commissioner Larson:

Please accept the comments below in response to the Proposed Year 2 Measure changes for Vermont Accountable Care Organizations (ACOs).

Blue Cross and Blue Shield of Vermont (BCSBVT) has enjoyed being a key stakeholder in the development and the implementation of the ACO Shared Savings Pilot working alongside providers, ACO representatives, state stakeholders and public representatives for the past two years. BCBSVT, as the only commercial payer in the Commercial ACO XSSP pilot, has approximately 35,000 members attributed between the three ACOs. We continue to actively work with our ACO partners developing and implementing the Year 1 components of this program with the goals of improving care coordination and improving quality, which will lead to better health outcomes for our members, and lowering the cost of care which will lead directly to providing relief for our premium payers.

The collaborative efforts of the stakeholders over a two year period allowed for a complex ACO program to be deployed despite knowing the rules and standards would need to be amended as the program matured. BCBSVT agrees with the need for flexibility and continually looking to advance and improve this large initiative, while ensuring any modifications focus on an improved delivery system without increased administrative burdens on BCSBVT or the ACOs.

BCBSVT has been an active participant in all subgroups looking to improve upon the ACO XSSP standards, including the Quality and Performance Workgroup. Over the past six months BCBSVT has collaborated with stakeholders re-assessing the quality metrics used to evaluate the ACOs. BCBSVT's experience with our own quality program includes assessing the appropriateness of quality metrics. Through this experience, we have learned that it is important for the following factors to be evaluated when adding or removing quality metrics— data availability, administrative requirements, availability of benchmark data, and relevance of the metric in evaluating quality of care and patient satisfaction.

The Honorable Al Gobielle and the Honorable Mark Larson

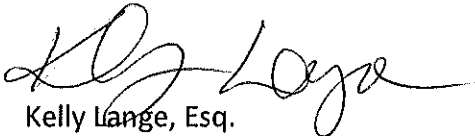
August 20, 2014

Page Two

Throughout the development of the ACO XSSP Commercial Pilot Standards and evaluation of metrics, BCBSVT has been an advocate on behalf of our members to ensure that the focus is not only on reducing the cost of care but also on improved quality of care, patient satisfaction and access to care. It is with this focus that BCBSVT recommends the only modification to the current metrics be to move the 8 patient satisfaction metrics (Core Measures 21-29) from evaluation to payment.

Our members are the ultimate recipients of impacts of this program and therefore it is imperative we ensure their evaluations are included in the determination of an ACO's performance metrics. These metrics are already being collected and appropriate benchmarks have been identified thus no additional burden is placed upon the pilot participants. Moreover, as the work of the Care Models workgroup progresses, the ACOs will likely play a larger role in care coordination and member touch-points in Year 2. Moving these measures to make them payment factors corresponds with the increase in member impact the ACOs propose to take. Ensuring member satisfaction is a key component of evaluating the success of this pilot therefore should be directly linked to the payment metrics. This is a necessary step to demonstrate to our members that this pilot is committed not simply to financial savings but also quality of care and member experiences.

BCBSVT is committed to continuing evaluation of new metrics as this program matures and initial results are reviewed. We appreciate the open and collaborative process with the stakeholders and the VHCIP Steering Committee and look forward to continued work on this program.



Kelly Lange, Esq.

Director Provider Contracting

Community Health Accountable Care (CHAC) comments on proposed measures for 2015 (e-mail from Joyce Gallimore on 7-28-14):

1. CHAC has supported and the QPM approved two measures to be moved from Pending to Reporting: Cervical Cancer Screening and Tobacco Use Assessment and Cessation Intervention. In general, we do not support moving measures en masse that are Reporting in Year 1 to Payment in Year 2, but CHAC is approaching the discussion with an understanding that as a group we are trying to collaborate, listen to the debate and review the measures that are discussed in the context of the CRITERIA that the committee has adopted. For example, we will support moving the HbA1c<9 measure, the pediatric weight assessment, the rate of hospitalization for COPD, and the developmental screening (XSSP) measure from reporting to payment. However, when new measures are introduced that do not have a baseline, are not claims based and/or have collection or definition issues, we do not support adding those to Year 2.
2. CHAC recognizes the need to give special consideration to special populations. For example there are DLTSS measures that have been discussed. We will support adding some questions to the satisfaction survey to obtain more information from the population through self reported data. If the measure is already being collected by the State in another way (e.g., the DLTSS rebalancing measure), we do not support adding it to the ACO Measure Set.
3. CHAC is concerned about the burden on the clinical and administrative staff at the health centers and on the CHAC administrative staff of the quantity of chart pulls and diversity of measurement. CHAC consequently would strongly advocate reducing the number of required chart pulls for each measure from 411 to something lower (e.g., in the past HRSA has required that the FQHCs do 70 chart pulls per measure for Uniform Data Systems reporting). CHAC agrees that it is important that the number of chart pulls yield statistically significant results.

Best Wishes, Joyce

Joyce Gallimore, MPH, CPHQ
Director, Community Health Accountable Care, LLC Bi-State Primary Care Association
61 Elm Street - Montpelier VT 05602
802-229-0002 ext. 222 (phone)
802-223-2336 (fax)
jgallimore@bistatepca.org<mailto:jgallimore@bistatepca.org>

August 8, 2014 e-mail from DCF:

Hi Pat,

I hope this email finds you well. I'm writing on behalf of DCF Commissioner Dave Yacovone to offer comments on the Year 2 ACO measures (see below).

Apologies for the delay in offering these comments, but I hope that they are helpful. Please feel free to contact us with any follow up questions or clarifications.

All best,

April

Dear Ms. Jones,

I am writing to offer my comments on the Year 2 Measures, on behalf of the Department for Children and Families. I applaud the work group for considering measures that are directly relevant to child health and family well-being.

- I support the inclusion of "pediatric weight assessment and counseling" as a Payment measure.
- I strongly support the promotion of "developmental screening in the first three years of life" to a Reporting measure. I do not believe that promoting this item to a Payment measure is indicated at this point, due to the potential issues with claims data.
- I support the promotion of "prenatal and post-partum care" to a Reporting measure, though believe that this measure should only include prenatal care due to the differing timelines for post-partum care.

Thank you for your consideration.

Commissioner Dave Yacovone
Department for Children and Families

April Allen

Director of Policy and Planning
Department for Children and Families
5 North, 103 S. Main St., Waterbury, VT 05671-5920
Cell: 802-760-7851

E-mail version of DVHA comments:

August 20, 2014

The Honorable Mark Larson and the Honorable Al Gobeille
Co-Chairs, Steering Committee
Vermont Health Care Innovation Project

Re: Proposed Year 2 Measure Changes for Medicaid and Commercial ACO Shared Savings Programs

Dear Commissioner Larson and Chairman Gobeille,

DVHA would like to thank the members of the Quality and Performance Measures work group for their thoughtful discussion of all proposed measure changes. DVHA has been an active participant in the work group, and feels that the recommendations presented to the Steering Committee characterize a balance between enhancing the rigor of the Medicaid and Commercial Shared Savings Programs in the second pilot year and addressing concerns about administrative and financial burden on providers and ACOs. DVHA believes that the foundation of a healthy population is centered on a strong relationship between a patient and his or her primary care provider. Updating the Shared Savings Programs' measure sets in Year 2 represents an opportunity to further prioritize measures that can be improved by the care provision and coordination that such a patient-provider relationship affords. Furthermore, shared accountability between providers and payers is central to the promise of the ACO model. As the Vermont Medicaid Shared Savings Program is upside-risk only in its first three years, the development and evolution of a robust quality measurement framework is essential for ensuring shared accountability.

Consequently, DVHA enthusiastically supports the promotion of the three recommended measures from Reporting to Payment in Year 2, as all three may be positively impacted with strengthening of the patient-provider relationship. Moreover, in response to Vermont's State Plan Amendment for the Vermont Medicaid Shared Savings Program, CMS has strongly suggested that more outcomes-focused measures be added for determining shared savings eligibility in program Years 2 and 3. As such, DVHA is particularly pleased with the "Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite" and "Diabetes Care: HbA1c Poor Control" recommendations. We are also supportive of using "Pediatric Weight Assessment and Counseling" as a Payment measure in Year 2 as it is closely aligned with Vermont's overall goals for health improvement, and as the majority of Year 1 Payment measures focus on care quality for the adult population.

With appreciation for the challenges associated with clinical measure collection, DVHA also supports moving “Cervical Cancer Screening” and “Tobacco Use: Screening and Cessation Intervention” from the Pending list to the Reporting list. Additionally, DVHA is in favor of using the claims-based “Avoidable ED Visits” for Reporting. All three of these measures stand to improve as a result of an established relationship with a primary care provider.

Although the Medicaid Shared Savings Program is already including “Developmental Screening in the First Three Years of Life” among its Payment measures, DVHA supports the Commercial Shared Savings Program using this measure for Reporting in Year 2. We also support the inclusion of an additional patient experience survey question for Reporting. This presents an opportunity to learn valuable information about the population with disability and long term service and support needs, particularly with respect to the relationships they have with both their primary care and specialist providers.

DVHA also recognizes the value of the Monitoring and Evaluation measure set as a repository of ACO-, health plan-, and state-level information to track overall program progress. Accordingly, we support the inclusion of additional state-level “LTSS Rebalancing” and “Screening, Brief Intervention, and Referral to Treatment (SBIRT)” measures in Year 2. However, DVHA is actively engaged in a Performance Improvement Project focusing on mammography among Medicaid beneficiaries and would be in favor of retaining “Breast Cancer Screening” as a Reporting measure.

Finally, although the Quality and Performance Measures work group did not recommend the promotion of “Rate of Hospitalization for Ambulatory Care Sensitive Conditions: COPD and Asthma in Older Adults” from Reporting to Payment, DVHA is in favor of using this measure for Payment in Year 2. This is another claims-based measure that can be impacted by the establishment of patient-provider connections, and would be consistent with CMS’ request to use more outcomes-focused measures for determining shared savings eligibility in the Medicaid Shared Savings Program. In accordance with Don George’s recommendation at the August 6th Steering Committee Meeting, DVHA would also support the use of any Year 1 patient experience survey questions for Payment in Year 2.

The majority of the Quality and Performance Measures work group’s proposed changes represent re-classification of existing measures—only two new measures were proposed for inclusion in the second year. If the Year 2 recommendations were to be approved, the ACOs would not be directly responsible for the collection of either new measure, and would be responsible for only one additional measure requiring manual abstraction. Other measures would continue to be collected in the same manner as Year 1. Furthermore, there would still be considerable overlap between the measures being used for the Medicare Shared Savings Program (MSSP) and the Medicaid and Commercial Shared Savings Programs (albeit with considerably fewer measures being used for Year 2 Payment in the Commercial and Medicaid programs than in the Medicare program). While DVHA continues to be a supporter of measure alignment

across programs, we firmly believe that it is important to ensure that measures are included to appropriately capture the quality of care for populations unique to the Medicaid and Commercial programs.

In summary, DVHA supports the recommended changes to the Year 2 measures, and believes such changes reinforce the development of relationships between patients and their primary care providers to improve the delivery and quality of care as Vermont makes strides toward health care system transformation. DVHA is grateful for the opportunity to provide input, and for the careful consideration of these recommendations by the Steering Committee. This process speaks to the collaborative nature of the Vermont Health Care Innovation Project and its commitment to engagement of stakeholders representing a diverse array of perspectives.

Sincerely,

Aaron French, MSN, RN, BC
Deputy Commissioner, Health Services & Managed Care
Department of Vermont Health Access



August 18, 2014

The Honorable Al Gobielle and the Honorable Mark Larson
Co-chairs, Steering Committee - Vermont Healthcare Innovation Project (VHCIP)

Re: Proposed Year 2 Measures for Vermont Accountable Care Organizations (ACOs)

Dear Chairman Gobielle and Commissioner Larson,

The ACO Governance board of Healthfirst, on behalf of the two ACO programs that we are currently participating in through the Accountable Care Coalition of the Green Mountains (ACCGM) and Vermont Collaborative Physicians (VCP), fully supports the positions regarding ACO Year 2 measures stated in the Vermont Medical Society's Comment Letter dated Aug 12, 2014.

We are heavily engaged in the Green Mountain Care Board's ACO Pilot Program efforts and truly want the effort to succeed, however we strongly believe that adding additional measures in Year 2 will increase cost and administrative burden and decrease our physicians' ability to focus - diluting improvement efforts and overall quality performance results.

We also believe it is very important to bear in mind the practical reality that implementation of the Commercial XSSP Program was delayed by seven months (we did not receive confirmation that attribution thresholds had been met qualifying us to participate until July), meaning that execution against Year 1 measures (physician education/training, updating data capture templates in EMRs, re-designing work flow to capture new measures) cannot even begin until the year is almost over.

Finally, as you are aware, ACO pilot programs have no up-front payment for care or administration, so each measure selected will have a financial burden applied to the ACO that they may not recover. Any additional measure requirements will take resources away from actually providing clinical care and care management services to the attributed population.

In summary, we fully appreciate the well-meaning efforts of many interested parties to have ACOs work to improve care, however with the number of measures already applied and the delay in implementation of year 1 ACO pilots we respectfully urge a postponement of consideration of new payment measures until year 3.

Sincerely,



Dr. Paul Reiss, MD
Chairman of the Board of Directors, Healthfirst



Amy E Cooper, MBA
Executive Director, Healthfirst

cc: Pat Jones, GMCB
Georgia Maheras, VHCIP



August 19, 2014

Northwestern Medical Center
133 Fairfield Street
St. Albans, VT 05478

RE: Year 2 Proposed Medicaid & Commercial Quality Measures for Reporting & Payment

Dear Chairman Gobeille and Commissioner Larson,

Please find Northwestern Medical Center's recommendations for the Year 2 proposed Medicaid and Commercial measure changes for Vermont Accountable Care Organizations, noted as Attachment A. We are urging you to consider the input of the hospital and providers who are instrumental in providing the quality care to which these measures apply.

Specifically, we are requesting the following:

1. Take into account only measures that meet the strictest criteria as voted upon at the Quality & Performance Measures workgroup, which include

- validity and reliability to provide consistent and credible results,
- representative of the array of services provided and beneficiaries served,
- uninfluenced by patient case mix index,
- not prone to random variation,
- consistent with state goals for improved health systems performance,
- not administratively burdensome,
- aligned with other measure sets,
- includes a mix of measure sets,
- relevant benchmarks available,
- focused on outcomes,
- limited in number, and
- population based focus.

While all submitted measures have merit on some level, few consistently met these top rated criteria. Of these criteria, valid reliable results with relevant benchmarks (which might be more up to date than the Medicare chosen targets), focus upon outcomes that truly represent reflections of quality care delivery without random variation, alignment with other existing measure sets, and limited in number are critical ones to consider. Alignment with already existing Medicare measures, when appropriate, is highly recommended.

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2. Request that no measures be added to reporting not already vetted through monitoring and evaluation, or any to Medicaid payment in that no data from year 1 has been received by our organization, limiting any opportunity to address any unknown process or delivery of care issues

An analysis of this data is needed to determine whether data variation exists due to data collection methodology failures, un-identified variation, or if indeed, performance improvement needs to occur to improve delivery of care. Fully vetting measures in monitoring and evaluation is prudent prior to selection for reporting and subsequent advancement to payment.

3. Minimize any non-claim based measures, taking into consideration if a reliable claim based methodology does not exist from which to extract data

In a physician engagement survey conducted this past year, our providers volunteered clear feedback on the substantial impact healthcare reform is having upon their practices. Primary care providers, who are experiencing the greatest impact, speak to the growing documentation needs that detract from the time they wish to spend with their patients. Administrative burden was one of the greatest professional dissatisfiers and one that continues to increase incrementally, which the magnitude of these proposed measures would intensify. While providers repeatedly echo the desire to give quality care, and be measured upon their efforts, creating additional workload has negative consequences to the system attempting to be improved. Our primary care providers are instrumental to our reform efforts, and considering their input and suggestions is one we take very seriously.

4. Consider that additional measures, in fact almost doubling the number of measures, will dilute performance improvement efforts

In the world of quality improvement, the selection of a few strong indicators or performance measures is the hallmark of strong project management. We caution teams to select 1-3 critical measures, looking at outcomes, process, financial, and satisfaction to choose the most relevant ones possible. The approach being taken with Medicaid measures does not take into consideration the existing 33 measures to a great extent, nor the attempt to limit measures for data collection.

Thank you for your anticipated consideration of these recommendations provided by our St. Albans Health Service Area Clinical Advisory Board and multi-disciplinary provider participants. As a single entity representing this community, I respectfully put forth these comments. Please feel free to contact me with any questions.

Respectfully,

Diane M. Leach

Diane M. Leach, RN, MSN
CQO, Vice President, Quality & Medical Staff Services
Northwestern Medical Center
133 Fairfield Street, St. Albans, VT 05478
Email: dleach@nmcinc.org
Phone: (802) 524-1205

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Additional Measures Proposed for 2015 Reporting:

#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
Core-8	Developmental Screening in the First Three Years of Life <i>(currently in Medicaid measure set; proposed for commercial measure set)</i>	NQF #1448; NCQA (not HEDIS); and CHIPRA	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.	Children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented: <ul style="list-style-type: none"> • by 12 months of age • by 24 months of age • by 36 months of age 	Medicaid claims data available, but provider coding for commercial payers for this specific measure is not, so this measure could (and most likely will) require data from clinical record review. <ul style="list-style-type: none"> - This measure is problematic not from a quality of care delivery, but in data capture. Pediatricians report that this is being done, however it is assessed and documented in the general well-child visit and billed as one code for Commercial. Whereas a separate code exists for developmental screening, it is not routinely used as a separate billing code for Medicaid, and no code exists separately for coding in Commercial. Not sure if this would result in an additional cost being billed out for the same visit, but this would need to be determined. If it does, it adds cost to a visit.
Core-30 PQRS MU	Cervical Cancer Screening	NQF #0032; NCQA (HEDIS); PQRS (add'tl core); MU (CMS)	The percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> • Women age 21-64 who had cervical cytology performed every 3 years. 	<ul style="list-style-type: none"> • The number of women who were screened for cervical cancer, as identified in steps 1 and 2 below. • Step 1: Identify women 24-64 years of age as of December 31 of the measurement year who had 	Adopted 6/23/14 by QPM WG - support this as a Reporting measure - recognized issue of young women who are older than 21 years of age but have not been and are not currently sexually

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
		124v1)	<ul style="list-style-type: none"> Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. <p><u>Note:</u> Due to significant specification changes, NCQA will not publicly report this measure for HEDIS 2014.</p>	<p>cervical cytology (Cervical Cytology Value Set) during the measurement year or the two years prior to the measurement year.</p> <ul style="list-style-type: none"> Step 2: From the women who did not meet step 1 criteria, identify women 35–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Value Set) and a human papillomavirus (HPV) test (HPV Tests Value Set) with service dates four or less days apart during the measurement year or the four years prior to the measurement year. Sum the events from steps 1 and 2 to obtain the rate. 	<p>active. Pelvic exams and cervical cancer screening might be deferred, but this would subject these women to this screening to be compliant. Need additional exclusion criteria.</p>
Core-34	Prenatal and Postpartum Care	NQF #1517; NCQA (HEDIS)	<p>Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.</p> <p>Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</p>	<p>Timeliness of Prenatal Care: A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.</p> <p>Postpartum Care: A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after</p>	<p>Do not support this measure as proposed</p> <ul style="list-style-type: none"> - A patient who fails to present within the first trimester for care would not meet this measure. Quality care delivery cannot begin before a patient presents for care - some patients do not know they are pregnant until after 3 months. - If a patient began prenatal care in a critical access hospital and became high

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
				<p>delivery, as documented through either administrative data or medical record review.</p>	<p>risk, and then delivered at a tertiary care hospital (would not have received care in the first trimester by that organization), would this be deemed non-compliance as well (not clear)?</p> <p>Obstetricians noted a postpartum visit generally occurring well before 21 days if needed. Suggestion: % of deliveries that had a postpartum visit prior to 56 days, allowing for stated maximum time frame? Language change not considered</p>
<p>Core-35/ MSSP-14 PQRS MU</p>	<p>Influenza Immunization</p>	<p>NQF #0041; MSSP; PQRS (alt core); MU (CMS 147v1)</p>	<p>Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization</p>	<p>Patients who received an influenza immunization OR who reported previous receipt* of an influenza immunization</p> <p>*Previous receipt can include: previous receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).</p>	<p>Epidemiologists state that research does not support the efficacy of this intervention.</p> <p>Requires patient survey to determine immunizations that were given outside the physician office ie. pharmacies, public health offerings, etc.</p> <p>Allow documentation of medical reason, patient reason, or system reason exclusions as evidence of compliance.</p> <p>No national benchmarks available.</p>

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
Core 11	Breast Cancer Screening				Support move to Monitoring & Evaluation - Controversy regarding frequency and effectiveness of breast cancer screening exists from recent studies. Recommend moving measure to M&E for health plan evaluation.
Core-36/ MSSP-17 PQRS	Tobacco Use Assessment and Tobacco Cessation Intervention	NQF #0028; MSSP; PQRS (core)	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user	Patients who were screened for tobacco use* at least once during the two-year measurement period AND who received tobacco cessation counseling intervention** if identified as a tobacco user *Includes use of any type of tobacco **Includes brief counseling (3 minutes or less), and/or pharmacotherapy	Adopted 6/23/14 by QPM WG - support this as a Reporting measure Screening for tobacco and tobacco products reasonable. Change language to " <u>offered</u> cessation counseling interventions" as many users refuse interventions if not interested in attempting to stop.
Core-37	Transition Record Transmittal to Health Care Professional	NQF #0648/ #2036 (paired measure - see below)	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Unable to achieve this timeframe with weekend/holiday - even if sent within 24 hours, receipt will be up to 72 hours which is minimum recommended. "Follow-up care within 24 hours of discharge" is not always possible - would recommend this be more specific ie. % of patients seen by mental health professional within 24 hours of discharge for follow-up? which could then be a claims based audit measure. Otherwise, make this "% of patients

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
					discharged with recommended follow-up plan"?
					No national benchmarks.
Core-39/ MSSP-28 PQRS MU	Hypertension (HTN): Controlling High Blood Pressure	NQF #0018; MSSP; PQRS (add'tl core); MU (CMS 165v1)	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. <u>Note:</u> This information is for HEDIS 2014, it will be revised for 2015 to change the age ranges and change the blood pressure limit to align with revised guidelines.	The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.	As per above, controversy between this measurement specifications and current research exists - recommend 150/90 as recommended target. Holding providers accountable for the control of a patient's BP, with a treatment plan, when diet, exercise, or medication regime adherence might not be occurring is not reasonable. Recommend: "% of patients with treatment plans for hypertension 150/100 AND continuing monitoring and evaluation of efficacy of recommended treatment plan". This is a very controversial MSSP ACO measure currently.
Core-40/ MSSP-21	Screening for High Blood Pressure and Follow-up Plan Documented	Not NQF-endorsed; MSSP	Percentage of patients aged 18 years and older seen during the measurement period who were screened for high blood pressure (BP) AND a recommended follow-up plan is documented based on the current blood pressure reading as indicated	Patients who were screened for high blood pressure and a recommended follow-up plan is documented as indicated if the blood pressure is pre-hypertensive or hypertensive	Lack of consistency between professional organizations exists as to what is considered hypertension. Most physicians have adopted the less aggressive goal of 150/100 as the new benchmark per evidence based practice as fewer unintended health impacts ie. falls, vertigo, fainting.

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
					Eliminate "pre-hypertensive" as this is not generally a treated condition. "Pre-hypertensive" is not currently part of the Medicare measure - adopt the same language so that it can be uniformly audited and reported.
Core-44	Percentage of Patients with Self-Management Plans	MA PCMH Initiative measure. Not NQF-endorsed	Percentage of patients with specified conditions who had at least one self-management goal during the measurement period	# of patients in every disease/condition patient population with one documented self-management goal during the measurement period.	<p>Unable to audit this measure without considerable effort - too global ("every disease/condition"); too variable (patient chosen, provider prescribed, condition warranted?); too vague a measure.</p> <p>Recommend at-risk population specific self-management plans - ie. # of patients with prescribed home weight measurement self-management plan.</p> <p>No benchmarks available. Not endorsed. Not able to easy measure this without chart audits. No central location in EHR to audit compliance.</p>
Core-44 (ALT*)	Transition Record with Specified Elements Received by Discharged Patients	NQF #0647/ #2036 (paired measure - see above)	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was	Patients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the following elements:	<p>Due to the detail of this measure, this becomes a manual audit. How will this be audited at all these various sites if it cannot be done by coding?</p> <p>Reasonable expectations include principal diagnosis at discharge which</p>

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
			documented) at the time of discharge including, at a minimum, all of the specified elements	<p>Inpatient Care</p> <ul style="list-style-type: none"> Reason for inpatient admission, AND Major procedures and tests performed during inpatient stay and summary of results, AND Principal diagnosis at discharge <p>Post-Discharge/ Patient Self-Management</p> <ul style="list-style-type: none"> Current medication list, AND Studies pending at discharge (e.g., laboratory, radiological), AND Patient instructions <p>Advance Care Plan</p> <ul style="list-style-type: none"> Advance directives or surrogate decision maker documented OR Documented reason for not providing advance care plan <p>Contact Information/Plan for Follow-up Care</p> <ul style="list-style-type: none"> 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND Contact information for obtaining results of studies pending at discharge, AND Plan for follow-up care, AND 	<p>may be very different than the reason for admission (and potentially irrelevant), current medication list, and patient instructions/follow-up plan.</p> <p>Advanced Directive hospital requirement is to ask about the existence of an AD, ask that it be provided if one exists, and if a patient does not have one to ask if they would like help to fill one out.</p> <p>Due to the confusion patients have over this process - ie. healthcare decision maker proxy vs all matters proxy, and variations in AD components, providers must have a copy in order to know the intricacies of the intended document.</p> <p>It is often inadvisable due to the patient's condition or new diagnosis to have this conversation in the hospital.</p> <p>Plan for follow-up care is reasonable, except for those patients who have no primary care physician or site for f/u</p>

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
				<ul style="list-style-type: none"> Primary physician, other health care professional, or site designated for follow-up care 	<p>care. This measure component cannot be reliably met.</p>
Core-45	<p>Screening, Brief Intervention, and Referral to Treatment</p> <p>(Note: The predecessor ACO Measures Work Group did not define specifications for this measure. Those provided are those in use by Oregon Medicaid.)</p>	<p>Oregon CCO incentive pool measure. Not NQF-endorsed. See www.oregon.gov/oha/CCO/Data/SBIRT%20Guidance%20Document%20--%20Revised%20September%202013.pdf</p>	<p>Patients ages 18 years and older who have had a qualifying outpatient visit or home visit during the measurement year, and who completed a full, standardized screening tool (e.g., AUDIT, DAST) because they indicated risky or problematic substance use during the brief, annual screen.</p>	<p>Patients who completed a full, standardized screening tool as indicated by one of the following CPT or HCPCS codes:</p> <p>99420, with diagnoses code v79.1 or v82.9 – used for patients who received a full screen based on responses to the annual brief screening. There are no time limitations or requirements for this code. This is also used when a brief intervention lasting less than 15 minutes is performed.</p> <ul style="list-style-type: none"> 99408 – used for patients who were screened and received a brief intervention (15-30 mins) 99409 – used for patients who were screened and received a brief intervention (> 30 mins) G0396 – used for patients who received alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention (15-30 minutes) G0397 – used for patients who 	<p>IF patients do not complete standardized screening tool, compliance is lacking. While this might be requested, patients can refuse.</p> <p>Reasonable to expect clinical screening tool for assessment of risk, followed by intervention plan based upon results of screening.</p> <p>No national benchmarks.</p>

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
				received alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention (>30 minutes)	
New Measure	LTSS Rebalancing (<i>proposed for Medicaid measure set</i>)	Not NQF-endorsed	<p>Proportion of eligible beneficiaries receiving care in a home or community-based setting (instead of an institutional setting).</p> <p>DAIL collects statewide and county data from claims on a monthly point-in-time basis; potential to collect specific information at ACO level. Currently information is collected for clients in DAIL's Choices for Care (CFC) program.</p> <p><u>NOTE:</u> The majority of CFC clients are dually eligible, and therefore attributed to the Medicare Shared Savings Program.</p>	Choices for Care clients receiving Home and Community-Based Services (HCBS)	<p>Do not support this measure - already being collected at state level on a small subset of beneficiaries, so do not recommend a secondary data collection methodology</p> <p>Have not had an opportunity to see or consider this data for improvement.</p> <p>No benchmarks available</p>
New Measures	3 to 5 custom questions for Patient Experience Survey regarding DLTSS services and case management	Not NQF-endorsed	<p>To Core-28, add:</p> <ul style="list-style-type: none"> In the last 12 months, how often did the provider seem informed and up-to-date about any care you got from other service and support providers (if applicable), such as home health agencies, area agencies on aging, developmental or mental health service agencies, substance abuse 	TBD	<p>Do not support this measure</p> <p>At the foundation, this patient satisfaction question has merit - however, providers DO NOT get all the information needed to be informed, and in the case of mental health and substance abuse, are prohibited from having this information shared with</p>

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
			<p>providers, vocational rehabilitation, etc.?</p> <ul style="list-style-type: none"> If you ask for something, does your case manager/ service coordinator help you get what you need? <i>Any necessary branching questions</i> <p>To Core-29, add:</p> <ul style="list-style-type: none"> In the last 12 months, how often did the specialist you saw seem informed and up-to-date about any care you got from other service and support providers (if applicable), such as home health agencies, area agencies on aging, developmental or mental health service agencies, substance abuse providers, vocational rehabilitation, etc.? <i>Any necessary branching questions</i> 		<p>them. VITL has stated that this is a major block from an HIE perspective.</p> <p>This question asks "how often" - what if only one referral was needed? Does a lower number mean less compliance than a higher number?</p> <p>Patients are often dissatisfied if they are NOT eligible for services - which could be reflected as the physician was responsible in this question. Recommend: "If you were referred for care by community agencies, how well do you feel you got the services you needed? OR "Did you get the services you needed in a timely manner?"</p> <p>For the second question: What if a patient does not have a case manager or service coordinator? Will the answer automatically be "no"? Need to assess what services a patient gets before you can ask if they are satisfied - which then gives information on what services are areas for targeted improvement.</p> <p>For the third question: Specialists will uniformly NOT have all this information</p>

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
					<p>as primary care offices are the recipient. This is not a realistic expectation for specialists (ie. podiatrist seen for diabetic care would not have full community care service records).</p> <p>Recommend: "In the past 12 months, how often did the specialist you saw have the information needed to treat you?" (there needs to be an option that "no specialist care was required").</p>

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Additional Measures Proposed for 2015 Payment:

#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
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 <u>Reporting Measure</u>	Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions.	Discharges, for patients ages 40 years and older with either: <ul style="list-style-type: none"> • A principal ICD-9-CM diagnosis code for COPD (excluding acute bronchitis) • A principal ICD-9-CM diagnosis code for asthma; or • A principal ICD-9-CM diagnosis code for acute bronchitis and any secondary ICD-9-CM diagnosis codes for COPD (excluding acute bronchitis) 	Assume CLAIMS based audit measure. Need Year 1 data before move out of Reporting.
Core-12	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	Not NQF-endorsed; AHRQ PQI #92; Year 1 Vermont SSP <u>Reporting Measure</u>	Prevention Quality Indicator (PQI) composite of chronic conditions per 100,000 population ages 18 and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower- extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.	Discharges, for patients 18 years and older that meet the inclusion and exclusion rules for the numerator in any of the following PQIs: <ul style="list-style-type: none"> • PQI #1 Diabetes with short-term complications admission rate • PQI #3 Diabetes with long-term complications admission rate • PQI# 5 Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate • PQI #7 Hypertension admission rate • PQI #8 Heart failure admission rate • PQI #13 Angina without a cardiac procedure admission rate • PQI #14 Uncontrolled diabetes admission rate • PQI #15 Asthma in younger adults admission rate • PQI #16 Lower- extremity amputation among patients with diabetes Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.	Keep as Reporting. Do not recommend having same conditions measured in more than one measure - remove Asthma, COPD as already gathering this data in Core-10 above. No data from Year 1 to ascertain: Can this be obtained by coding to this level of specificity? If not, this will be a lengthy, time consuming manual audit due to

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
					inclusion/exclusion criteria that will need to be applied.
Core-15 PQRS MU	Pediatric Weight Assessment and Counseling	NQF #0024; Year 1 Vermont SSP <u>Reporting Measure</u> ; PQRS (alt core); MU (CMS 115v1)	The percentage of attributed individuals 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. <ul style="list-style-type: none"> • BMI percentile documentation. • Counseling for nutrition. • Counseling for physical activity. 	The number of attributed individuals 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. <ul style="list-style-type: none"> • BMI percentile documentation. • Counseling for nutrition. • Counseling for physical activity. 	Keep as Reporting. This will be a manual audit. No data from year 1 to analyze. Recommend: Change to "Referral for nutrition and/or physical activity counseling if appropriate" for a more intensive intervention that might be indicated.
Core-16 MSSP- 22-26 PQRS MU	Diabetes Composite (D5): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco non-use, Aspirin use (note LDL removed for 2014)	NQF #0729; MSSP; Year 1 Vermont SSP <u>Reporting Measure</u> ; PQRS (BP & LDL control only); MU (CMS 163v1 (LDL only))	Please note that this measure is in a transition phase due to changes in national guidelines for cholesterol management. For the 2014 reporting year, dates of service between 1/1/2013 – 12/31/2013 the measure is: the percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco	Patients ages 18 to 75 with diabetes who meet all of the following targets from the most recent visit during the measurement year: A1c less than 8.0, LDL less than 100, Blood Pressure less than 140/90, Tobacco non-user and Daily aspirin for patients with diagnosis of ischemic vascular disease use unless contraindicated.	This is a highly controversial MSSP measure. Holding a provider accountable to a clinical target that is highly impacted upon patient behavior is problematic. And, the targets are not founded in consistent research. Recommend:

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
			<p>non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes.</p> <p>Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated.</p> <p>For the 2015 reporting year, dates of service 1/1/2014 - 12/31/2014 the cholesterol component (LCL<100) is temporarily removed from the numerator.</p> <p>For the 2016 reporting year, dates of service 1/1/2015 - 12/31/2015 plan for a new cholesterol component to be</p>		<p>"Treatment plans exist with goal of A1C < 9.0 and BP <150/100, smoking cessation options offered, and ASA". This is less aggressive, reflects the most recent research, and holds providers accountable to interventions.</p>

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
			added.		
Core-17 MSSP-27 PQRS MU	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059; MSSP; Year 1 Vermont SSP Reporting Measure; PQRS (add'tl core); MU (CMS 122v1)	The percentage of attributed individuals 18-75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0%).	Number of attributed individuals 18-75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0%).	Keep as Reporting - no data from Year 1 to analyze. Use same language as Medicare measure.
Core-19 MSSP-18 MU	Depression Screening and Follow-up	NQF #0418; MSSP; Year 1 Vermont SSP Reporting Measure; MU (CMS 2v2)	Percentage of patients aged 12 years and older screened for clinical depression during the measurement period using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Patients screened for clinical depression during the measurement period using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Use same language as Medicare measure.
Core-20 MSSP-16 PQRS MU	Adult Weight Screening and Follow-up	NQF #0421; MSSP; Year 1 Vermont SSP Reporting Measure; PQRS (core); MU (CMS 69v1)	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit.	Patients with BMI calculated within the past six months or during the current visit, and a follow-up plan is documented within the last six months or during the current visit if the BMI is outside of normal parameters. Patients with BMI calculated within the past 12 months or during the current visit, and a follow-up or recommended plan is documented if BMI >40.	Change to within 12 months or at annual visit for BMI calculation. Normal parameters needs to be defined ie. BMI >40. Follow up plan might not require re-visit, so this could add system costs. Recommend: "follow-up plan is

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
					documented"
M&E-14	Avoidable ED Visits (NYU Algorithm)	Not NQF-endorsed; Year 1 Vermont SSP <u>Monitoring and Evaluation</u> Measure	Percentage of ED visits that were potentially avoidable.	<p>ED Visits are classified into the categories below:</p> <ul style="list-style-type: none"> • Non-emergent - The patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours; • Emergent/Primary Care Treatable - Based on information in the record, treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting. The complaint did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting (e.g., CT scan or certain lab tests) • Emergent - ED Care Needed - Preventable/ Avoidable - Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.); and • Emergent - ED Care Needed - Not Preventable/ Avoidable - Emergency department care was required and ambulatory care treatment could not have prevented the condition (e.g., trauma, appendicitis, myocardial infarction, etc.). • Injury • Mental health diagnosis • Alcohol-related health principal diagnosis • Drug-related health principal diagnosis (excluding alcohol). • Not classified - not in one of the above categories 	<p>Do not support this measure.</p> <p>This measure is open to interpretation with the definitions as it is based on opinion as to what is emergent vs non-emergent.</p> <p>It is a totally manual audit to obtain valid results, and will require a full chart review to determine the appropriate level of urgency. This is an extremely time intensive manual audit measure with significant inter-audit reliability issues</p> <p>There are myriad reasons why a patient comes to the ED, even with a minor issue.</p> <p>Medicare measure on ED Utilization is recommended</p>

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#	Measure Name	Use by Other Programs	Description	Numerator	FEEDBACK
					<p>instead. Or, use coding of ED visits as a proxy for this measure.</p> <p>With ICD-10 in 2015, this methodology may not be available to use until/if updated.</p>

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August 11, 2014

The Honorable Al Gobeille and The Honorable Mark Larson
Co-Chairs, Steering Committee
Vermont Health Care Innovation Project (VHCIP)

Re: *Year 2 Measure Changes for Vermont Accountable Care Organizations*

Dear Chairman Gobeille and Commissioner Larson:

We are writing to urge you to give serious consideration to the recommendations of the practicing clinical providers – the ones that are and will be held accountable for the Medicaid and Commercial Shared Savings Program (SSP) measures (please see attachment A for the letter to the VHCIP Quality Measurement and performance workgroup co-chairs that lays out the providers' recommendations). Specifically we are asking you to: 1) avoid moving any additional measures to payment in year two due to the significant delay in getting attribution or claims data to the ACOs in year one; and 2) minimize the amount of new measures that require manual abstraction in year two– taking into consideration those that have been deemed by the providers as meaningful, reliable, and actionable.

Over the last month, we have actively sought input from the provider communities on the proposed measure changes in year two (2015) for the Medicaid and Commercial SSP programs. We have held meetings with practicing physicians and providers across Vermont in every health service. We have also met with clinical leaders at the Vermont Child Health Improvement Program (VCHIP) and the American Academy of Pediatrics Vermont Chapter (AAP-VT). Lastly, we have brought forward the collective input from these providers to OneCare Vermont's Clinical Advisory Board (CAB), which unanimously endorsed the recommendations as provided to the VCHIP co-chairs and committee members.

The feedback and recommendations by the provider community, with the exception of the CAB endorsement, were collated and provided in writing to the co-chairs, staff, and consultants of the VHCIP Quality Measurement and Performance workgroup. The related vote on behalf of the provider community was cast at the July 29, 2014, VCHIP Quality Measurement and Performance workgroup meeting. Unfortunately, the collective voice of all these practicing clinicians was minimized to one vote under the workgroup voting practices, and thus the majority of their recommendations were not carried on the workgroup's votes.



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The CAB, representing 50 practicing physicians and 5 home health, mental health, and skilled nursing providers (see attachment B for a comprehensive listing), combined with the input received from VCHIP, AAP-VT, and Fletcher Allen Health Care provided for a strong and united voice from the provider community on the proposed measure set. Although most cannot attend a three-hour monthly meeting due to their busy practices, they took the time to provide thoughtful feedback and advice to OneCare Vermont as their representative on this workgroup. We again urge you to seriously consider their recommendations.

Lastly, in addition to the input from OneCare Vermont providers, we understand through discussions with the Vermont Medical Society and Healthfirst that they will also be submitting their recommendations on the year two measures to the Steering committee and that each of our organizations' recommendations are fully aligned for the year two measures.

We thank the committee in advance for their willingness to seriously consider the recommendations of Vermont's practicing clinicians on the year two Medicaid and Commercial SSP programs measures.

Respectfully,

Norman Ward, MD
Executive Medical Director
OneCare Vermont

Barbara Walters, DO
Chief Medical Officer
OneCare Vermont

Victoria Loner MHCDS, RNC
Clinical Operations Director
OneCare Vermont

Enclosures

cc: Clinical Advisory Board Voting Members
Todd Moore, OneCare Vermont
Anna Noonan RN, Fletcher Allen Health Care
Dr. Judith Shaw, Vermont Child Health Improvement Program
Dr. Jill Rinehart, American Academy of Pediatrics Vermont Chapter
Pat Jones, Green Mountain Care Board
Georgia Maheras, Vermont Health Care Innovation Project
Paul Harrington, Vermont Medical Society
Dr. Paul Reis, Healthfirst
Diane Leach RNC, Northwestern Medical Center
Joyce Gallimore, Community Health Accountable Care
Jason Williams, Fletcher Allen Health Care
Dr. Howard Schapiro, Fletcher Allen Health Care



Attachment A: OneCare Vermont's Recommendations on the Year 2 Measures to the VHCIP Quality Measurement and performance workgroup co-chairs:

July 23, 2014

Dear Ms. Fulton and Ms. Pelosi:

OneCare Vermont's participating providers, founding organizations, members of the Clinical Advisory Board and clinical leaders at the Vermont Child Health Improvement Program (VCHIP) and the American Academy of Pediatrics Vermont Chapter (AAP-VT) have reviewed the recommendations from VHCIP's co-chairs, staff, and consultants regarding changes to Medicaid and Commercial SSP measures that would become effective in 2015. Unfortunately, because of the tight timeline provided by the committee to provide feedback, we were unable to vet our response to these recommendations as outlined below with our entire Clinical Advisory Board as would be our protocol. Therefore, at the next Clinical Advisory Board Meeting on 7/29/2014, the following recommendations will be presented to the committee based on the collective feedback from front-line subject matter experts noted above and the expertise within OneCare Vermont.

Proposed Payment Measures

1) Comprehensive Diabetes Care HbA1c Poor Control (>9 percent)

- a. Recommendation: Agree clinically relevant as a reporting and payment measure; however, given that we have no data yet would be advisable to postpone moving to payment*
- b. Rationale:
 - National Benchmarks exist
 - The measure aligns with both the ACOs clinical priorities as well as the Blueprint for Health. Specifically, the OneCare Vermont Clinical Advisory Board, based on the CMS quality measures results for CY 2014, decided to make diabetes care a clinical priority and diabetes care has been a core focus in the Blueprint for Health for many years.

2) Pediatric Weight Assessment and Counseling

- a. Recommendation: Keep as Reporting *
- b. Rationale:
 - The ACOs have not received any claims data for year 1 to assess eligible members and their baseline. Asking the ACOs to move it to performance in 2015 when we do not have 2014 baseline eligibility or data is not feasible.



- 3) This measure reflects a current joint priority of VCHIP and the Maternal and Child Health (MCH) Division of the Vermont Department of Health (VDH), and is the subject of a pilot project of VCHIP's "CHAMP" network for FY '15. Data from this project may be available to inform a recommendation regarding this measure next year.
- 4) Rate of Ambulatory Care Sensitive Conditions (composite)
 - a. Recommendation: Keep as Reporting*
 - b. Rationale:
 - The ACO's have not received any claims data for year 1 to assess eligible members and their baseline. Asking the ACO's to move it to performance in 2015 when we do not have 2014 baseline eligibility or data is not feasible.
- 5) Developmental Screening in First 3 years of life
 - a. Recommendation: Keep as Reporting *
 - b. Rationale:
 - Data from VCHIP's project, "Developmental Screening in Primary Care," indicated that providers are not consistently using the CPT billing code 96110, nor do they consistently use the standardized tools that meet the criterion listed in the NQF standard. Recommend further study on this measure once ACO's receive data on their eligible population.
 - This measure also reflects a current joint priority of VCHIP and the MCH Division at VDH, and is the subject of ongoing efforts to address the findings from the prior study.

Proposed Reporting Measures

- 1) Cervical Cancer Screening
 - a. Recommendation: Resolved and approved at 6/23/14 QPM meeting*
- 2) Tobacco Use (Screening and Cessation Intervention)
 - a. Recommendation: Resolved and approved at 6/23/14 QPM meeting. However, CMS is proposing to retire some measures and is looking to the ACOs for feedback. If the measure is retired, we would request that the State follow suit.*
- 3) Developmental Screening (Commercial)
 - a. Recommendation: Agree to add as reporting for commercial*
 - a. Rationale:
 - Supported by the Pediatric Community (VCHIP, AAP-VT and MCH at VDH)
 - NQF and CHIPRA measure
 - Claims based so lower administrative burden with collection
 - Already an approved measure for the Medicaid SSP



- 4) Avoidable ED Visits (NYU algorithm):
 - a. Recommendation: Keep as monitoring and evaluation*
 - b. Rationale:
 - This algorithm does NOT decide if a visit is avoidable or not. The results are percentages of visits that may have been avoidable based on claims sets of statistically relevant sizes. Thus it would be dangerous to use this at a patient level detail.
 - This algorithm is older and may not have been maintained. Furthermore, when ICD-10 happens it may be rendered useless if not updated.

- 5) Custom DLSS Survey Questions:
 - a. Recommendation :Not recommended as additional survey questions at this time*
 - b. Rationale:
 - The focus of the questions are directed at different service provider (non-primary care)
 - Potentially a small N- not actionable at this time

- 6) Prenatal and Postpartum Care:
 - a. Recommendation: Not recommended as an additional measure*
 - b. Rationale:
 - Administratively burdensome, bundled payment will require some degree of manual abstraction, in order not to show falsely low compliance rates
 - Composite of pre and post-partum. Postpartum concern is that if patients are seen outside the 56 day window then no credit is given.
 - More of a process than an outcome measure
 - Open to looking at monitoring and evaluation if we were to establish “Maternity Care Homes”

- 7) Influenza Immunization:
 - a. Recommendation: Not recommended as an additional measure*ⁱ
 - b. Rationale:
 - Administratively burdensome, not logistically feasible due to several structural reasons: measure dependent on the person self-reporting to providers when care is received outside of the primary care setting; current immunization registry does not receive data from some commercial pharmacies, work-place administration, and other community immunization initiatives; and many of the exclusion reasons require chart review (allergy, declined, vaccine not available).



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Proposed Monitoring and Evaluation Measures

- 1) SBIRT
 - a. Recommendation: Agree to monitoring and evaluation (M+E) as long as that is performed by the Pilot sites and not at the ACO level. Note, until this is wide spread and accepted should continue to stay in M+E*

- 2) LTSS Rebalancing
 - a. Recommendation: Agree to monitoring and evaluation as long as it continues to be monitored by DAIL and is not aggregated to the ACO level. Of note, the majority of the population will more than likely not be attributed to Medicaid or Commercial SSP Plans.*

If our Clinical Advisory Board changes or amends the recommendations we will contact you in writing. Thank you for the opportunity to provide input. If you have any questions please feel free to contact me directly at the number below.


Respectfully,

VICTORIA LONER MHCDS, RN -VHCIP Quality and Performance Measure Voting Member
Director, Accountable Care Clinical Operations
OneCare Vermont
(802) 847-6255

cc: Clinical Advisory Board Voting Members/packet 7/29
Dr. Barbara Walters, OneCare Vermont
Dr. Norman Ward, OneCare Vermont
Anna Noonan, Fletcher Allen
Dr. Judith Shaw, Vermont Child Health Improvement Program
Dr. Jill Rinehart, American Academy of Pediatrics Vermont Chapter
Pat Jones, Green Mountain Care Board
Deborah Lisi-Baker and Judy Peterson, DLTSS Co-Chairs

* As noted above, our Clinical Advisory Board has not been able to vote on these recommendations. Therefore, all recommendations are contingent on their final approval.

Attachment B: Clinical Advisory Board Members

Clinical Advisory Board by Group							
Physician	PCP	Specialty	Hospital Service Area	Hospital/Practice	Geographic	Continuum of Care	Ad Hoc (non-voting)
Belden, Clifford MD		Radiology	Lebanon/Hanover	Dartmouth Hitchcock	X		
Burke, Mark MD		Cardiology	Brattleboro	Brattleboro Cardiology	X		
Ciccarelli, Ovieto MD		Surgery	Randolph	Gifford Surgical Associates	X		
Coddaire, David MD	X	Family Medicine	Morrisville	Morrisville Family Health	X		
Depman, Mark MD		Internal Medicine	Berlin	Central Vermont Emergency Services	X		
Fama, Teresa, MD	X	Family Medicine	Berlin	Central Vermont Medical Center	X		
Galasso, Andrea DO	X	Internal Medicine	Brattleboro	Brattleboro Internal Medicine	X		
Halsey, David MD		Orthopedics	Burlington	Fletcher Allen Orthopaedics & Rehab	X		
Harris, Katrina DO	X	Internal Medicine	Springfield	Springfield Hospital	X		
Kemble, Sarah MD	X	Internal Medicine	Springfield	Chester Family Medicine	X		
Kenny, Karen MD		OBGYN	St. Johnsbury	Northeastern Vermont Regional Hospital	X		
King, John MD	X	Family Medicine	Burlington	Milton Family Practice	X		
Kniffin, Fred MD		Emergency Medicine	Porter	Porter Hospital	X		
Leonard, Debra MD		Pathology	Burlington	Fletcher Allen Pathology	X		
Lippmann, John MD	X	Family Medicine	Newport	Family Practice of Newport	X		
Meyer, Richard, MD	X	Family Medicine	Townshend	Grace Cottage Family Health	X		
Perlin, Steven MD		Radiology	Newport	North Country Hospital	X		
Plavin, Joshua MD	X	Internal Medicine	Randolph	Gifford Medical Center	X		
Poole, James MD		Hospital Medicine	Bennington	Southwestern Vermont Medical Center	X		
Rousse, Michael MD	X	Internal Medicine	St. Johnsbury	Northeastern Vermont Regional Hospital	X		
Saferstein, Susan MD	X	Internal Medicine	St. Albans	Northwestern Medical Center	X		
Samuelson, Joshua DO	X	Family Medicine	Bennington	Southwestern Vermont Medical Center	X		
Schneider, Catherine MD		Surgery	Windsor	Mt. Ascutney Hospital	X		
Scott, Deborah MD	X	Internal Medicine	Windsor	Mt. Ascutney Hospital	X		
Shapiro, Stan MD		Cardiology	Rutland	Rutland Regional Medical Center	X		
Johns, Martin MD		Emergency Medicine	Randolph	Gifford Medical Center		X	
Menzies, Isaura MD	X	Geriatric Medicine	Burlington	Fletcher Allen Health Care		X	
Sturtevant, Norman MD		Radiology	Burlington	Fletcher Allen Health Care		X	
Ades, Steve MD		Medical Oncology	Burlington	Fletcher Allen Health Care			X
Allen, Gilman MD		Pulmonary	Burlington	Fletcher Allen Health Care			X
Bertges, Daniel MD		Vascular	Burlington	Fletcher Allen Health Care			X
Clauss, David MD		Emergency Medicine	Burlington	Fletcher Allen Health Care			X
Clough, Jaina MD		Palliative Care	Burlington	Fletcher Allen Health Care			X
Cowder, Andrew MD		Urology	Bennington	Southwestern Vermont Medical Center			X
Daly, Margaret MD		Endocrinology	Rutland	Rutland Regional Medical Center			X
Fitts, James MD, PhD, FACC		Cardiology	Rutland	Rutland Regional Medical Center			X
Frankle, Gordon MD		Psychiatry	Rutland	Rutland Regional Medical Center			X
Grant, Steven MD		Hospital Medicine	Burlington	Fletcher Allen Health Care			X
Gregory, Todd MD		Emergency Medicine	Rutland	Rutland Regional Medical Center			X
Hall, Jennifer DO		Psychiatry	Burlington	Fletcher Allen Health Care			X
Hyman, Neil MD		Surgery	Burlington	Fletcher Allen Health Care			X
Jones, Dan MD		Pathology	Lebanon/Hanover	Alice Peck Day Memorial Hospital			X
Kenosh, Mike MD		Neurology	Rutland	Rutland Regional Medical Center			X
Krause, William MD		Pulmonary	Rutland	Rutland Regional Medical Center			X
Masuck, Tony MD		Pathology	Rutland	Rutland Regional Medical Center			X
Reich, Harvey MD		Critical Care	Rutland	Rutland Regional Medical Center			X
Schnure, Joel MD		Endocrinology	Burlington	Fletcher Allen Health Care			X
Winget, Joe MD		Cardiology	Burlington	Fletcher Allen Health Care			X
Wulfman, Carrie MD		Family Medicine	Middlebury	Porter Hospital			X
Zamvil, Linda MD		Psychiatry	Morrisville	Stowe Family Practice			X
Joyal, Margaret		Mental Health	Washington County	Washington County Mental Health Services			X
Mairs, Greg		Mental Health	Addison County	Counseling Service of Addison County			X
Shakespeare, William		Mental Health	Windham & Windsor Counties	Health Care and Rehabilitation Services			X
Hunt, Elizabeth, MD							

E-mail from Peter Reed

From: Peter Reed [<mailto:peterntreed@gmail.com>]

Sent: Wednesday, August 13, 2014 12:31 PM

To: ADM - Innovation Project Info

Subject: attn: Pat Jones - ACO metrics as discussed 8/12/14 in population health work group

Dear Ms. Jones,

This is public comment on the ACO metrics discussed yesterday at the population health work group. I am a pediatric resident at UVM and have a strong interest in mitigating the social determinants of health, particularly in children.

I was very impressed with the list of metrics as a group. I think it is ambitious but that we should be ambitious. In that vein, I would like to suggest the addition of metrics that would assess an ACO's contribution to mitigating social determinants within their communities. (I'm assuming that, legally, we can measure whatever we want even if it falls outside of health care delivery.)

Some possible measures:

- dollars (or % of total budget) spent on providing transportation to patients
- % of foods sourced locally, organically, fair trade
- donations (in kind or \$) made to local organizations that assist with housing security, food security, addiction, criminal rehabilitation, etc
- direct services offered to assist with housing security, food security, addiction, criminal rehabilitation, etc

This list could be much longer and there will be some things that make more appropriate measures than others according to your criteria. My sentiment is that ACOs are a good idea but will ultimately fail to contain costs if they are not also in the game of improving the conditions upstream that lead to poor health downstream. So I think we should be measuring what they are doing to address the social determinants of health and encourage them to broaden their scope.

Thank you,

Peter Reed

MEMORANDUM

TO: Catherine Fuller and Laura Pelosi, Co-Chairs Quality and Performance Measures Work Group
FR: Julie Tessler, Executive Director, Vermont Council of Developmental and Mental Health Services
RE: Measures for Substance Abuse and Mental Health Conditions
DA: July 28, 2014

As communicated previously the Vermont Council for Developmental and Mental Health Services would like to see additions to the Quality and Performance Measures Work Group proposed measure changes. Specifically, we strongly encourage screening for substance abuse and mental health conditions.

Although, we appreciate the effort to minimize the workload of the providers, the omission of the substance abuse and depression measures for reporting represents a missed opportunity for improving the health outcomes. The link between substance abuse and depression and the increased incidence of deleterious health outcomes and subsequent health care utilization is well established. Further, we know that alcohol, drug abuse are significant drivers of health care expenditures. Similar findings exist with regard to the effects of mental illness in general. Given this, including measures for substance use and depression for reporting represents an important facet of responsible clinical practice. Collecting this information can improve treatment by addressing key social determinants of health and lead to better health outcomes.

We strongly recommend including these measures in year 3 reporting. Possibly including a simple series of questions about substance use and depression indicators for reporting is enough, but providers should get credit for this effort.

Per the discussion with Catherine at the DLTSS work group last week, we do have nationally recognized screening tools for substance abuse to recommend.

Our colleagues at ADAP recommend the AUDIT and DAST, NIDA Adult and the PHQ-2 depression screen. These tools are used for adults (18+) in SBIRT.

Another option for substance abuse screening is the CAGE and the CAGE-Aid that are endorsed by Johns. Also, the PHQ-9 (there is a modified version for adolescents) is a widely used screen for depression in adults and was designed for use in primary care settings. Here are some links for these tools:

http://www.hopkinsmedicine.org/johns_hopkins_healthcare/downloads/CAGE%20Substance%20Screening%20Tool.pdf

<http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf>

Thank you for considering our perspective. We would be happy to support this work moving forward.

To: Quality and Performance Measures Working Group, VHCIP

From: Tracy Dolan, Acting Commissioner and Barbara Cimaglio, Deputy Commissioner, Alcohol and Drug Abuse Programs, Vermont Department of Health

Date: August 20, 2014

Re: Proposed ACO Measures for Year 2

The Vermont Department of Health appreciates your effort to seek input from many stakeholders. We offer our comments in line with Healthy Vermonter's 2020 data, which reflect the health status of Vermonters and the key priorities of the State Health Improvement Plan that was developed in collaboration with multiple governmental and private sector public health partners. The plan's strategic priorities focus on conditions that are preventable and actions that will have a positive impact on multiple health outcomes in the future.

We are strongly **supportive** of the following decisions that were made by the Quality and Performance Measures Workgroup and would like to respectfully request that these decisions be maintained by the Steering Committee and Green Mountain Care Board:

- Screening, Brief Intervention, and Referral to Treatment (SBIRT, Core-45) moving from Pending to State-level Monitoring
- Developmental Screening in First Three Years of Life (Core 8) moving from Pending to Reporting
- Cervical Cancer Screening (Core 30) moving from Pending to Reporting
- Tobacco Use Screening and Cessation Intervention (Core 36) moving from Pending to Reporting
- Avoidable ED visits (M&E 14) moving to Reporting
- Pediatric Weight Assessment and Counseling (Core 15) moving from Reporting to Payment
- Comprehensive Diabetes Care (Core 17) moving from Reporting to Payment

We are **concerned** about the following decisions that were made by the Quality and Performance Measures Workgroup against the recommendations of the co-chairs, staff and consultants who used a thorough and balanced approach to evaluate each measure:

- Prenatal & Postpartum Care (Core-34)
- Influenza Immunization (Core-35)
- Screening for High Blood Pressure with Follow up Plan Documented (Core 40)

We are also **concerned** that no discussion or voting took place despite the co-chair recommendations for the following measures:

- Controlling Blood Pressure (Core 39)
- Optimal Diabetes Care (Core 16)
- Adult Weight Screening and Follow Up (Core 20)
- Screening for Clinical Depression and Follow-Up (Core 19)
- Care Transition Record Transmitted to Health Care Professional (Core-37)

Concerns about Decisions Made: Supporting Rationale and Data

We would like to explain the basis of our concern about decisions that were made by the Quality and Performance Measures Workgroup against the recommendations of the co-chairs as we understand there is the potential that these decisions will be reconsidered by the Steering Committee and Green Mountain Care Board.

Prenatal & Postpartum Care (Core-34) Early and adequate prenatal care improves outcomes for mothers and babies, including prematurity reduction and improved birth weight. Postpartum care ensures that relevant conditions and concerns are discussed including medical conditions, contraception, breastfeeding, postpartum depression. We recognize that this data may not be easy to collect however there is currently no other measure for tracking or improving pregnancy care in the ACO measure set.

Influenza Immunization (Core-35) CDC recommends a yearly flu vaccine as the first and most important step in protecting against flu. However our data indicate that few heed this advice:

- During the 2012-2013 flu season, only 41.5% of adults in the U.S. were vaccinated against seasonal flu.¹
- Between 2002-2012, 41% of Vermont adults were vaccinated against seasonal flu²
- The Healthy People 2020 target is 70.0%³

The proposed measure would track whether clinicians would need to ask patients about their vaccination status. This may prompt those who have not yet been vaccinated to take positive preventive action.

Screening for and control of high blood pressure (Core 40) We feel strongly that screening for and control of high blood pressure (Core 40) is a priority that should not be delayed while we await national guidelines. The percentage of Vermonters with hypertension has been increasing steadily since 2005 and is now at 27% of the adult population. Blood pressure screening and follow up would enable practices to better identify patients in poor control for which simple and manageable solutions exist. The U.S. Preventive Services Task Force (USPSTF) lists screening for hypertension as a Grade A

¹ (<http://www.cdc.gov/flu/fluview/coverage-1213estimates.htm>)

² (http://healthvermont.gov/research/brfss/documents/summary_brfss_2012.pdf).

³ (<http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=23>).

recommendation which means there is high certainty that the net benefit is substantial.⁴ The USPSTF found good evidence that blood pressure measurement can identify adults at increased risk for cardiovascular disease due to high blood pressure and that treatment of high blood pressure in adults substantially decreases the incidence of cardiovascular events. As this is an endorsed measure (NQF 421), we recommend using the most liberal guidelines to start in order to move towards encouraging practices to be accountable for improving blood pressure control. As national guidelines are reached, those guidelines can be incorporated in the measure.

Concerns about Votes not Taken: Supporting Rationale and Data

Controlling High Blood Pressure (Core-39) We are disappointed this measure is remaining pending as no vote was taken, but do not have any substantial concern. We strongly urge that it is revisited next year.

Optimal Diabetes Care Composite (Core-16) We would like to see this measure be considered for payment level in Year 3.

Adult BMI Assessment (Core 20) We are extremely concerned that Adult BMI Assessment (Core 20) was not discussed or voted upon for transition from reporting to payment. BRFSS data indicates that Vermont continues to move in the wrong direction for overweight and/or obese status. In 2012, 23% of Vermont adults (20 and older) reported being obese, and an additional 37% were overweight. Furthermore, supporting national data findings, 2014 Vermont focus group data tell us that many Vermonters do not recognize that they are overweight or obese or understand there is a need to make a change. Research has shown that as weight increases to reach overweight and obesity levels, the risks for the following conditions, *many of which we are measuring in payment or reporting categories*, also increases: coronary heart disease, Type 2 diabetes, Cancers (endometrial, breast, and colon), Hypertension (high blood pressure), Dyslipidemia (for example, high total cholesterol or high levels of triglycerides), and Stroke. We feel that moving Core 20 to payment status is critical in supporting our efforts to reduce chronic disease and curb escalating health care costs. We strongly encourage the Steering Committee and Green Mountain Care Board to consider Adult BMI Assessment as a payment measure.

Screening for Clinical Depression and Follow Up (Core 19) There is a significant association between substance abuse and mental health treatment. People with co-occurring disorders are more difficult to treat, more likely to have treatment adherence problems, and more likely to have poorer outcomes than those with only a mental health or substance use disorder.^{5,6} Substance abuse and co-occurring

⁴ U.S. Preventive Services Task Force. Screening for High Blood Pressure: U.S. Preventive Services Task Force Reaffirmation Recommendation Statement. AHRQ Publication No. 08-05105-EF-2, December 2007. First published in *Ann Intern Med* 2007;147-783-786. <http://www.uspreventiveservicestaskforce.org/uspstf07/hbp/hbprs.htm>

⁵ Kelly, T. M., Daley, D. C., & Douaihy, A. B. (2012). Treatment of substance abusing patients with comorbid psychiatric disorders.

Addictive Behavior, 37(1), 11–24. doi:10.1016/j.addbeh.2011.09.010

⁶ Herbeck, D. M., Fitek, D. J., Svikis, D. S., Montoya, I. D., Marcus, S. C., & West, J. C. (2005). Treatment compliance in patients with comorbid psychiatric and substance use disorders. *The American Journal on Addictions*, 14(3), 195–207. doi:10.1080/10550490590949488

mental health and substance use disorders are common in Vermont and significantly impact the health care system. It is estimated that:

- Approximately 10% of the Vermont population age 12 and older can be diagnosed with alcohol or drug dependence or abuse.⁷
- Approximately 20% of adult Vermonters had any mental illness in the last year.⁸
- Among those with a past year substance use disorder, 42.8 percent had a co-occurring mental illness.⁹
- Of mental health patients treated in Vermont's Designated Agencies, 19% also have a substance use diagnosis¹⁰

Given the prevalence of both substance abuse and mental health issues, screening for both should be standard practice in medical settings.

Care Transition Record Transmitted to Health Care Professional (Core-37) A key challenge in treating those with substance abuse and mental health issues is the coordination of care with physical healthcare providers. More people access the health care system through primary care than any other access point. The Care Transition Record Transmitted to Health Care Professional (Core-37) therefore is critical. We strongly support measures representing coordination of care across all providers.

⁷ National Survey on Drug Use and Health, 2010 and 2011

⁸ <http://www.samhsa.gov/data/2k12/NSDUH110/sr110-adult-mental-illness.htm>

⁹ <http://oas.samhsa.gov/NSDUH/2k9NSDUH/MH/2K9MHRResults.pdf>

¹⁰ http://mentalhealth.vermont.gov/sites/dmh/files/pip/DMH-PIP_April_13_2012.pdf

Background Information on Proposed Quality and Performance Measure Changes for Year 2 of Vermont’s ACO Shared Savings Programs

1. Measure Changes Recommended by QPM Work Group

Proposed Measure Name	VT Measure ID	Measure Description	Source of Data	Medicare SSP? (Y2 Use)	VT Year 1 Use	QPM Work Group Year 2 Recommend.	QPM Work Group Vote VDH COMMENTS
Breast Cancer Screening	Core-11	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	Claims	Yes (R)	Reporting	M & E	Move to M&E: unanimous vote
SBIRT Substance Abuse Screening	Core-40	Patients ages 18 years and older who have had a qualifying outpatient visit or home visit during the measurement year, and who completed a standardized screening tool.	Medical Records	No	Pending	M & E	Move to M&E: unanimous vote
LTSS Rebalancing	New Measure	Proportion of eligible beneficiaries in DAIL’s Choices for Care program receiving care in a home or community-based setting (instead of an institutional setting).	Claims	No	Not in Year 1 Measure Set	M & E	Move to M&E: unanimous vote
Developmental Screening in First Three Years of Life (Commercial SSP)	Core-8	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.	Claims	No	Payment (Medicaid only) Not used for Commercial	Reporting (Commercial)	Voted 10-4 to move to Reporting (Commercial): In the future, VDH would recommend moving this to Payment
Cervical Cancer Screening	Core-30	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> • Women age 21–64 who had cervical cytology performed every 3 years. • Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. 	Medical Records	No	Pending	Reporting	Move to Reporting: unanimous vote VDH is highly supportive of this recommendation
Tobacco Use: Screening & Cessation Intervention	Core-36	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.	Medical Records	Yes (P)	Pending	Reporting	Move to Reporting: unanimous vote VDH is highly supportive of this recommendation
Custom DLTSS Survey Questions (Composite)	New Measure	<ul style="list-style-type: none"> • In the last 12 months, how often did the provider seem informed and up-to-date about any care you got from other service and support providers (if applicable), such as home health agencies, area agencies on aging, developmental or mental health service agencies, substance abuse providers, vocational rehabilitation, etc.? 	Existing Survey	No	Not in Year 1 Measure Set	Reporting	Voted 11-3 to add to survey as Reporting: Y: DAIL, DVHA, VDH, BiState, CHAC, BCBS, Home Health, GMCB, VPQ, Legal Aid, HCA

Proposed Measure Name	VT Measure ID	Measure Description	Source of Data	Medicare SSP? (Y2 Use)	VT Year 1 Use	QPM Work Group Year 2 Recommend.	QPM Work Group Vote VDH COMMENTS
		<ul style="list-style-type: none"> If you ask for something, does your case manager/service coordinator help you get what you need? In the last 12 months, how often did the specialist you saw seem informed and up-to-date about any care you got from other service and support providers (if applicable), such as home health agencies, area agencies on aging, developmental or mental health service agencies, substance abuse providers, vocational rehabilitation, etc.? 					N: OCV, NMC, VMS A: HF
Avoidable ED Visits	M&E-14	Percentage of ED visits that were potentially avoidable. ED Visits are classified as non-emergent; emergent/primary care treatable; emergent – ED care needed – preventable/avoidable; emergent - ED care needed - not preventable/avoidable; injury; mental health diagnosis; alcohol-related health principle diagnosis; drug-related health principle diagnosis (excluding alcohol); not classified – not in one of the above categories.	Claims	No	M & E	Reporting	Voted 9-6 to move to Reporting: VDH is highly supportive of this recommendation
Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite	Core-12	Prevention Quality Indicator (PQI) composite of chronic conditions per 100,000 population ages 18 and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.	Claims	No	Reporting	Payment	Voted 10-5 to move to Payment: Y: DAIL, DVHA, VDH, BiState, CHAC, Home Health, GMCB, VPQ, Legal Aid, HCA N: HF, BCBS, NMC, OCV, VMS
Pediatric Weight Assessment and Counseling	Core-15	The percentage of attributed individuals 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> BMI percentile documentation. Counseling for nutrition. Counseling for physical activity. 	Medical Records	No	Reporting	Payment	Voted 10-5 to move to payment: VDH is highly supportive of this recommendation
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	Core-17	The percentage of attributed individuals 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0%).	Medical Records	Yes (P)	Reporting	Payment	Voted 10-5 to move to payment: VDH is highly supportive of this recommendation

Measures Proposed But Not Recommended for Change by QPM Work Group

Proposed Measure Name	VT Measure ID	Measure Description	Source of Data	Medicare SSP? (Y2 Use)	VT Year 1 Use	QPM Work Group Year 2 Recommend.	QPM Work Group Vote
Prenatal & Postpartum Care	Core-34	Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	Medical Records	No	Pending	Pending (proposed for Reporting)	Voted 9-5 to remain as Pending. VDH requests reconsideration;
Influenza Immunization	Core-35	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Medical Records	Yes (P)	Pending	Pending (proposed for Reporting)	Voted 7-7 to move from Pending to Reporting (tie vote means motion failed; CHAC later clarified vote). VDH requests reconsideration
Screening for High Blood Pressure and Follow-up Plan Documented	Core-40	Percentage of patients aged 18 years and older seen during the measurement period who were screened for high blood pressure (BP) AND a recommended follow-up plan is documented based on the current blood pressure reading as indicated.	Medical Records	Yes (R)	Pending	Pending (proposed for Reporting)	Voted 2-11 to move from Pending to Reporting (motion failed). VDH requests reconsideration
Controlling High Blood Pressure	Core-39	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	Medical Records	Yes (P)	Pending	Pending (proposed for Reporting)	Did not vote at 7-29-14 QPM meeting VDH is highly supportive of this recommendation and requests reconsideration
Optimal Diabetes Care Composite	Core-16	Percentage of patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated.	Medical Records	Yes (P)	Reporting	Reporting (proposed for Payment)	Did not vote at 7-29-14 QPM meeting VDH is highly supportive of this recommendation and requests reconsideration
Adult Weight Screening and Follow Up	Core-20	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit.	Medical Records	Yes (P)	Reporting	Reporting (proposed for Payment)	Did not vote at 7-29-14 QPM meeting VDH is highly supportive of this recommendation and requests

Proposed Measure Name	VT Measure ID	Measure Description	Source of Data	Medicare SSP? (Y2 Use)	VT Year 1 Use	QPM Work Group Year 2 Recommend.	QPM Work Group Vote
							consideration
Rate of Hospitalization for Ambulatory Care Sensitive Conditions: COPD and Asthma for Older Adults	Core-10	Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions.	Claims	Yes (P)	Reporting	Reporting (proposed for Payment)	Did not vote at 7-29-14 QPM meeting
Screening for Clinical Depression and Follow-Up	Core-19	Percentage of patients aged 12 years and older screened for clinical depression during the measurement period using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Medical Records	Yes (P)	Reporting	Reporting (proposed for Payment)	Did not vote at 7-29-14 QPM meeting VDH is highly supportive of this recommendation and requests consideration
Care Transition Record Transmitted to Health Care Professional	Core-37	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	Medical Records	No	Pending	Pending (proposed for Reporting)	Did not vote at 7-29-14 QPM meeting VDH is highly supportive of this recommendation and requests consideration
Transition Record with Specified Elements Received by Discharged Patients	Core-44 (alt.)	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements.	Medical Records	No	Pending	Pending (proposed for Reporting)	Did not vote at 7-29-14 QPM meeting
Percentage of Patients with Self-Management Plans	Core-44	Percentage of patients with specified conditions who had at least one self-management goal during the measurement period.	Medical Records	No	Pending	Pending (proposed for Reporting)	Did not vote at 7-29-14 QPM meeting

Abbreviations in “Medicare SSP?” Column: (R)=Used as Reporting Measure in Year 2 of the MSSP Program; (P)=Used as Payment Measure in Year 2 of the MSSP Program

Abbreviations in “QPM Work Group Vote” Column: HF=Healthfirst; BCBS=Blue Cross Blue Shield of Vermont; CHAC=Community Health Accountable Care; DAIL=Vermont Department of Disabilities, Aging and Independent Living; GMCB=Green Mountain Care Board; HCA=Office of Health Care Advocate; NMC=Northwestern Medical Center; OCV=OneCare Vermont; VDH=Vermont Department of Health; VMS=Vermont Medical Society; VPQ=Vermont Program for Quality in Health Care

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August 20, 2014

Al Gobeille and Mark Larson
Co-Chairs, Steering Committee
Vermont Health Care Innovation Project

Re: Vermont ACO Shared Savings Program Quality Measures: Recommendations for Year Two Measures from the VHCIP Quality and Performance Measures Work Group

Dear Mr. Gobeille, Mr. Larson, and members of the VHCIP Steering Committee,

Thank you for the opportunity to comment on the Recommendations for ACO Shared Savings Program (SSP) Year Two Quality Measures from the VHCIP Quality and Performance Measures (QPM) Work Group. Representatives from The Office of the Health Care Advocate (HCA) and other projects at Vermont Legal Aid (VLA) have been actively involved in the Vermont Health Care Innovation Project (VHCIP), including the QPM work group. We respect the QPM work group's intensive process and strongly recommend that the Steering Committee accept its recommended changes to the ACO measure sets.

The QPM work group includes a large number of provider members. Many different provider organizations are represented in the group, including ACOs, FQHCs, hospitals, the Vermont Medical Society, and numerous others. The work group includes only two consumer advocates, both from Vermont Legal Aid. No consumers are active members of the QPM work group. The measures recommended for promotion to the Payment and Reporting Measure sets received support from providers, payers, and a variety of other stakeholders, as well as from our consumer advocates. All measures that were considered for promotion were thoroughly vetted by the work group co-chairs, staff, and consultant. Those recommended for promotion were found to be valid and reliable, feasible to implement, aligned with statewide goals, and important to the health and care of Vermonters.

Our comments focus on the three areas: I) Support for the recommended additions to the Payment and Reporting Measure sets II) Concern about the limited scope of the measure sets, and III) Additional recommendations for promotion to the Payment and Reporting Measure sets.

I. Support for the recommended changes to the Payment and Reporting Measure sets

We support the QPM work group's recommendation to promote three measures to the Payment Measure set and four measures to the Reporting Measure set for year two of the ACO SSPs.

We also support the QPM work group's recommendation to add two new measures, one to the Reporting Measure set and one to the Monitoring and Evaluation set.

Measures recommended by the QPM work group for promotion to the Payment Measure set:

a. Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (Core-17/MSSP-27)

The Comprehensive Diabetes Care measure is an essential addition to the Payment Measure set. It covers a large number of Vermonters, evaluates a critical health outcome, identifies an addressable area of improvement, and is linked to myriad health outcomes, some of which are life-threatening. This measure evaluates a chronic condition, one of the state's health care priorities. It has clearly defined benchmarks and is a payment measure in the Medicare SSP, further supporting promotion to the year two Payment Measure set. Promotion of this measure was supported in the QPM work group vote by representatives from provider organizations, payers, and state agencies, as well as by our consumer advocates.

b. Pediatric Weight Assessment & Counseling (Core-15)

The addition of this pediatric measure will begin to improve the balance of the Payment Measure set across populations. In year one, the Commercial SSP had only one pediatric measure in its Payment Measure set and the Medicaid SSP had only two. This is an unacceptably low level of accountability for one of Vermont's largest and most vulnerable populations. Addressing obesity in Vermont's pediatric population has the potential to reduce rates of chronic illness and improve the health and well-being of Vermonters well into the future. Promotion of this measure was supported in the QPM work group vote by representatives from provider organizations, payers, and state agencies, as well as by our consumer advocates.

c. Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite (Core-12)

This measure is an important addition to the Payment Measure set. It measures an essential aspect of quality of care that should see significant improvements with the care coordination and integration efforts of the ACOs. It is claims-based and is a payment measure in the Medicare SSP, so promotion to Payment Measure set should not add significant administrative burden for the ACOs. Promotion of this measure was supported in the QPM work group vote by representatives from provider organizations, payers, and state agencies, as well as by our consumer advocates.

Measures recommended by the QPM work group for promotion to the Reporting Measure set:

- a. Cervical Cancer Screening (Core-30), and
- b. Tobacco Use Screening & Cessation Intervention (Core-36/MSSP-17)

We commend the QPM work group on its unanimous decision to recommend promotion of these two measures to the Reporting Measure set. We strongly support these additions and appreciate the group's recognition of the importance of these clinical practices. Promotion of these measures to the Reporting Measure set for year two is essential so that they can be considered for promotion to the Payment Measure set in year three. In the year one Payment and Reporting measure sets, there were only two women's health measures (Chlamydia screening and breast cancer screening). The breast cancer screening measure has been recommended for demotion for year two. There were no measures related to tobacco use in the year one Payment and Reporting measure sets.

- c. Avoidable Emergency Department Visits (M&E-14)

This measure captures an extremely important issue that affects patients and the health system at many levels. In theory, scores for this measure should improve greatly with the Patient Centered Medical Home and ACO models. This is a great outcome measure for care coordination efforts. We strongly support the QPM work group's recommendation to promote this measure to the Reporting set for year two. A reporting year is essential so that this measure can be considered for the Payment Measure set for year three. Promotion of this measure was supported in the QPM work group vote by representatives from provider organizations, payers, and state agencies, as well as by our consumer advocates.

- d. Developmental Screening in First Three Years of Life (Core-8)

Although we advocated for this measure to be promoted to the Commercial SSP Payment Measure set (it was included in the Medicaid SSP Payment Measure set in year one, and will be included again in year two), we support the QPM work group's recommendation for its promotion to the Reporting Measure set. This measure captures an important aspect of pediatric care and one for which early intervention can have lasting impacts. Promotion of this measure was supported by everyone in attendance at the QPM work group meeting. The four dissenting votes, including ours, were from those advocating for the measure to be further promoted to the Payment Measure set.

Measure recommended by the QPM work group for addition to the Reporting Measure set:

- a. Custom DLTSS Survey Questions (New)

The custom Disability and Long Term Services and Supports (DLTSS) survey questions are one of the only ways in which care for the DLTSS population will be measured in the context of the ACOs. Inclusion of these questions will add no administrative burden on the part of providers or the ACOs because the survey is being fielded by the State of Vermont and the Blueprint for Health. These questions will collect meaningful information from the DLTSS

population and will give the ACOs invaluable information about the level of success achieved by their care and coordination models. Care coordination for the DLTSS population is a major opportunity for improvement for the ACOs. Addition of these questions was supported in the QPM work group vote by representatives from provider organizations, payers, and state agencies, as well as by our consumer advocates.

II. Concern about the limited scope of the measure sets

a. The measure sets are too limited to adequately assess quality of care

We remain concerned that the Payment and Reporting Measure sets are too limited to adequately assess quality of care. The Centers for Medicare and Medicaid Services (CMS) has expressed concern that the Payment Measure set includes too few outcomes-based measures. Quality measurement is an essential part of the ACO SSP model, and broad measure sets are necessary to gain a comprehensive picture of the quality of patient care. While we understand that it is easier to see improvement when ACOs focus on a limited number of measures, we think it is more important to measure a broad range of areas to ensure that ACOs are maintaining and improving *overall* quality of care and care coordination, rather than simply targeting a few measured areas (“teaching to the test”).

A comprehensive measure set would cover diverse populations including adult, maternity, and pediatric; healthy and chronically ill; and physically disabled, developmentally disabled, and in need of long term services and supports (DLTSS). A comprehensive measure set would include a range of process, outcome, and experience measures to ensure that patients are not adversely affected by the ACO model. The year one and recommended year two measure sets fall far short of this breadth. Coverage is particularly poor for pediatric, maternity, and DLTSS populations. For example, there are no payment or reporting measures that evaluate pregnancy, childbirth, or the postnatal period. Poor coverage of these vulnerable populations in the measure sets is particularly concerning because they are at high risk for health disparities (<http://www.cdc.gov/minorityhealth/populations/atrisk.html>).

We find it problematic that so many measures are recommended to remain in the Pending Measure set for year two. For a measure to be considered for payment in the future, it is important for the measure to have a reporting year. Since this is a three-year demonstration, measures left pending for year two will not mature to payment before the end of the demonstration. Many important measures have been recommended to remain pending for year two. We would like to see as many measures as possible promoted from pending to reporting for year two of the ACO SSPs.

b. The methodology used to evaluate and select measures for promotion was insufficient

We have concerns about the incomplete and inflexible way in which the matrix and criteria were applied to recommend changes to the measure sets. The criteria should have been applied to *all* the pending, monitoring and evaluation, and reporting measures rather than only to those

specifically recommended for promotion by work groups, individuals, or organizations. Notably, those making recommendations did not have access to the matrix.

It is our opinion that some criteria (e.g., consistency with state goals) should have been weighted more heavily than others. Additionally, some criteria had incomplete information for some measures. For example, missing information for ‘potential for improvement’ resulted in scores of zero for some measures. Since raw scores were used regardless of the completeness of the available information, this led to artificially low scores for some measures. Furthermore, the matrix failed to take into account alternative approaches to benchmarking such as year over year improvement for measures with no national benchmarks. This resulted in artificial deflation of scores for DLTSS measures.

III. Additional recommendations for promotion to the Payment and Reporting Measure sets

While we would like to see many more measures promoted for year two of the ACO SSPs, there are a few that we think are particularly important.

Additional recommendation for promotion to the Payment Measure set

Adult Weight (BMI) Screening and Follow-up (Core-20/MSSP-16)

We advocate for promotion of this measure to the Payment Measure set. This is a Medicare SSP payment measure and evaluates an essential aspect of care that is important for the health of many Vermonters (in 2013, approximately one fourth of Vermont adults were obese (BRFSS)). Obesity is a major predictor of chronic illness, one of the state’s health care priorities. This is an issue that Vermont’s health care system should be working harder to address. This measure was recommended for promotion by the DLTSS work group.

Additional recommendations for promotion to the Reporting Measure set

Influenza Immunization (Core-35/MSSP-14)

We advocate for the promotion of this measure to the Reporting Measure set. Influenza immunization is extremely important to the health of Vermonters, particularly for our most vulnerable populations. Immunization coverage is a known issue in Vermont that warrants additional attention. The goal of this measure, which is already a Medicare SSP payment measure, is to document immunization only for those patients who have an office visit prior to or during flu season. It allows for immunization at the practice OR report of prior immunization at another location. This is a basic and important clinical practice and should not be overly challenging for Vermont’s providers. This measure was recommended for promotion by the QPM work group co-chairs, staff, and consultant, as well as by the Population Health and DLTSS work groups. Promotion of this measure was supported in the QPM work group’s tie vote (7-7) by representatives from provider organizations, payers, and state agencies, as well as by our consumer advocates.

Prenatal & Postpartum Care (Core-34)

We advocate for the promotion of this measure to the Reporting Measure set. There are currently no maternity measures included in the Payment or Reporting measure sets. Women are at high risk during pregnancy, delivery, and the first few months post-partum. Additionally, pregnancy can be a unique opportunity to reach patients who do not normally interact with the health care system. The health of a mother during and after pregnancy can have long lasting effects not only on herself, but on her child(ren) as well. This measure was recommended for promotion by the QPM work group co-chairs, staff, and consultant, as well as by the Population Health work group.

Care Transition Record Transmitted to Health Care Professional (Core-37) and Transition Record with Specified Elements Received by Discharged Patients (Core-44 [ALT])

We advocate for the promotion of the two care transitions measures to the Reporting Measure set. Particularly for those with LTSS needs, coordination of care is a significant issue. It is essential that the infrastructure for collecting this information be put in place now, so that these measures can be further promoted in the future. This is especially important given the State's decision not to pursue the duals demonstration, without which the natural home for care coordination efforts is the ACOs. These measures were recommended for promotion by the DLTSS work group.

In conclusion

The year one measure sets were developed with considerable concern for provider burden and with the understanding that additional measures would be added throughout the demonstration. Many important measures were not recommended for promotion by the QPM work group due to concern about administrative burden. Given the extremely limited nature of the year one measure sets, we believe our recommendations are reasonable and essential to ensure that quality of care is appropriately evaluated. Quality measures that are tied to payment are one of the only ways to ensure that providers do not limit care as a means of achieving savings. Without more robust measure sets, the accountability of ACOs will continue to be in name only.

Again, we thank you for your thoughtful consideration of our comments on this matter.

Sincerely,

s/ Lila Richardson, Member, QPM Work Group

s/ Rachel Seelig, Member, QPM Work Group

s/ Julia Shaw, Alternate Member, QPM Work Group

s/ Nancy Breiden, Director, Disability Law Project

s/ Trinka Kerr, Chief Health Care Advocate

s/ Jackie Majoros, State Long Term Care Ombudsman

VERMONT MEDICAL SOCIETY

August 19, 2014

The Honorable Al Gobeille and the Honorable Mark Larson
Co-Chairs, Steering Committee
Vermont Health Care Innovation Project (VHCIP)

Re: Proposed Year 2 Measure Changes for Vermont Accountable Care Organizations (ACO)

Dear Chairman Gobeille and Commissioner Larson,

Last month, the Milbank Memorial Fund released an issue brief entitled "Advances in Multi-Payer Alignment: State Approaches to Aligning Performance Metrics across Public and Private Payers." The brief examines how common standards of provider quality and value could be developed so system improvement can accelerate and it looks to Maine, Vermont, and Wisconsin to help provide the answers.

For the Vermont Medical Society (VMS), perhaps the most useful statement in the issue brief deals with adopting the appropriate number of measures. It states that "it is important to consider the administrative work associated with data collection and data analytics for each measure. Furthermore, it can be difficult for providers to focus on too many quality improvement initiatives at one time, which may dilute improvement efforts and overall results."¹

OneCareVermont and the Accountable Care Coalition of the Green Mountains participation agreements in implementing their Medicare MSSP ACOs require the use of 33 quality measures that physicians and other health professional will be held accountable for. There are 26 clinical measures and 7 patient satisfaction measures. Of the 26 clinical measures, 19 will be used to help determine the level of any shared savings.

For year 1 of the Commercial and Medicaid ACO measure set, the Green Mountain Care Board (GMCB) endorsed 32 measures: 23 clinical measures and 9 patient satisfaction measures. Of these 23 clinical measures, 8 would be used to help determine the level of any shared savings.

The VMS opposed the GMCB's endorsement of the 32 new measures and instead recommended the addition of a limited set of relevant and easily reported pediatric and maternity measures to the existing 33 Medicare measures, in order to create common standards of provider quality and value in the Commercial and Medicaid ACO measures set.

The VMS recommendation was based on the understanding that physicians are not going to differentiate between the sources of payment (Medicare, BCBSVT or Medicaid) with respect to the clinical care they provide to their patients. The 32 Commercial and Medicaid measures, on

¹ "Advances in Multi-Payer Alignment: State Approaches to Aligning Performance Metrics across Public and Private Payers." Milbank Memorial Fund. July 2014. Page 8

top of the 33 Medicare measures, create a total of 53 ACO accountability measures. Physicians will feel they are accountable for all of the relevant 53 measures on behalf of their patients.

The Compilation of Pilot Standards October 9, 2013 Draft in Section VI (II) (Step 6) (1) on pages 14 states: “[I]n the interest of maintaining the stability of the measure set, the Year 1 Payment and Reporting measures will not be modified for Year 2 unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.”

The VHCIP Quality Measurement and Performance workgroup’s Year 2 Medicaid and Commercial ACO recommendations to the VHCIP Steering Committee add three new payment measures, four new reporting measures and one new survey question for a total of 56 measures for year two (assuming no change in Medicare). As a participant in the workgroup, I feel the above pilot standard was never referred to or followed in the development of the Year 2 recommendations.

Each year, the VMS conducts a survey of its membership in order to help inform its annual priority setting retreat. This year’s survey contained the three following questions that are relevant to the subject of quality measurement:

Q1. Documentation and administrative issues interfere with my ability to serve patients well. Response: 80% strongly agreed or agreed.

Q4. Reporting quality measures are an increasing administrative burden. Response: 75% strongly agreed or agreed.

Q14. There should be a consistent set of quality measures used by all payers. Response: 83% strongly agreed or agreed.

The VMS believes that a number of the VHCIP Quality Measurement and Performance workgroup’s Year 2 Medicaid and Commercial ACO recommendations would significantly add the already high administrative burden facing Vermont providers and that such a large number of measures would make targeted quality improvement activities extremely difficult.

During the workgroup’s deliberations, the VMS joined with OneCareVermont, Healthfirst, Northwestern Medical Center and BCBSVT in consistently voting together on the proposed 2015 ACO reporting or payment measures.

For the reasons stated in the July 23, 2014 letter from OneCareVermont to workgroup co-chairs Catherine Fulton and Laura Pelosi, the VMS makes the following Year 2 quality measurement recommendations, in order that system improvement can accelerate while also considering the administrative work associated with data collection and data analytics for each measure.

VMS opposes adding the following three new Proposed Payment Measures. Since the ACOs have not received any claims data for year 1 to assess eligible members and their baseline, asking ACOs to move it to performance in 2015 when they do not have 2014 baseline eligibility or data is not feasible:

1. Comprehensive Diabetes Care HbA1c Poor Control (>9 percent)
2. Pediatric Weight Assessment and Counseling
3. Rate of Ambulatory Care Sensitive Conditions (composite)

VMS supports adding the following three new Proposed Reporting Measures

1. Cervical Cancer Screening
2. Tobacco Use (Screening and Cessation Intervention)
3. Developmental Screening (Commercial)

VMS opposes adding the following new Proposed Reporting Measure

Avoidable ED Visits (NYU algorithm). Since this algorithm does not decide if a visit is avoidable or not, the results are percentages of visits that may have been avoidable based on claims sets of statistically relevant sizes. It would therefore be dangerous to use this at a patient level detail.

VMS opposes adding the following new Survey Question

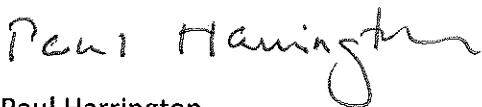
Custom DLTSS Survey Questions. Since the focus of the questions are directed at different service provider (non-primary care) and the potentially a small sample size, the question is inappropriate for the current ACO services.

VMS supports moving the following existing Reporting Measure to Monitoring and Evaluation

Breast cancer Screening. Recent studies have raised questions about the effectiveness of breast cancer screening.

Thank you for giving the VMS the opportunity to provide input and please let me know if you have any questions or if I can be of further assistance.

Sincerely,



Paul Harrington
Executive Vice President, Vermont Medical Society

Attachment

cc: VMS Council
Pat Jones, GMCB
Georgia Maheras, VHCIP

**Comparison of 2014 and Proposed 2015 ACO Reporting or Payment Measures for
VMSSP (Medicare ACO), Vermont Commercial ACO, and Vermont Medicaid ACO**

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

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

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

(V) 2015 changes supported by OneCareVermont, Healthfirst, Northwestern Medical Center, Vermont Medical Society, BCBSVT
(X) 2015 changes opposed by OneCareVermont, Healthfirst, Northwestern Medical Center, Vermont Medical Society, BCBSVT

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

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

(V) 2015 changes supported by OneCareVermont, Healthfirst, Northwestern Medical Center, Vermont Medical Society, BCBSVT
(X) 2015 changes opposed by OneCareVermont, Healthfirst, Northwestern Medical Center, Vermont Medical Society, BCBSVT

MSSP	Measure Description	Data: Claims, Medical Record, or Survey?	Medicare ACO Use Year 2 2014	Commercial ACO Use 2014	Medicaid ACO Use 2014
N	PCMH Patient Experience: Coordination of Care	S		R	R
N	PCMH Patient Experience: Specialist Care	S		R	R
N	DLTSS Custom Survey Question	S		(R)	(R)
	Total Measures for Payment or Reporting 2014	53	33	31	32
	Total Proposed Measures for Payment or Reporting 2015	(56?)	(33?)	35	35

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

(V) 2015 changes supported by OneCareVermont, Healthfirst, Northwestern Medical Center, Vermont Medical Society, BCBSVT

(X) 2015 changes opposed by OneCareVermont, Healthfirst, Northwestern Medical Center, Vermont Medical Society, BCBSVT

Attachment 6d - Summary of Comments and Votes

Proposed Quality and Performance Measure Changes for Year 2 of Vermont’s ACO Shared Savings Programs
QPM Work Group Vote and Summary of Comments to Steering Committee

1. Measure Changes Recommended by QPM Work Group

Proposed Measure Name	VT Measure ID	Measure Description	Source of Data	Medicare SSP? (Y2 Use)	VT Year 1 Use	QPM Work Group Year 2 Recommend.	QPM Work Group Vote	Summary of Comments to Steering Committee
Breast Cancer Screening	Core-11	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	Claims	Yes (R)	Reporting	M & E	Move to M&E: unanimous vote	VMS, HF and NMC expressed support for move to M&E; DVHA expressed opposition for move to M&E (would like to retain as Reporting).
SBIRT Substance Abuse Screening	Core-40	Patients ages 18 years and older who have had a qualifying outpatient visit or home visit during the measurement year, and who completed a standardized screening tool.	Medical Records	No	Pending	M & E	Move to M&E: unanimous vote	VDH, DVHA, OCV expressed support for move to M&E; VT Council expressed support for move to Reporting.
LTSS Rebalancing	New Measure	Proportion of eligible beneficiaries in DAIL’s Choices for Care program receiving care in a home or community-based setting (instead of an institutional setting).	Claims	No	Not in Year 1 Measure Set	M & E	Move to M&E: unanimous vote	DVHA expressed support to add to M&E; OCV expressed support for move to M&E as long as it continues to be monitored by DAIL and is not aggregated to the ACO level; NMC and CHAC expressed opposition for collection other than what already occurs at the state level.
Developmental Screening in First Three Years of Life (Commercial SSP)	Core-8	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.	Claims	No	Payment (Medicaid only) Not used for Commercial	Reporting (Commercial)	Voted 10-4 to move to Reporting (Commercial): Y: HF, CHAC, BiState, BCBS, Home Health, GMCB, NMC, OCV, VMS, VPQHC N: VDH, DAIL, Legal Aid, HCA (all indicated they wanted measure promoted to Payment)	Legal Aid, HCA, HF, VDH, VMS, DVHA, CHAC, OCV, DCF, VDH expressed support for move to Reporting. Legal Aid, HCA, CHAC and VDH also expressed support for current or eventual move to Payment.

Proposed Measure Name	VT Measure ID	Measure Description	Source of Data	Medicare SSP? (Y2 Use)	VT Year 1 Use	QPM Work Group Year 2 Recommend.	QPM Work Group Vote	Summary of Comments to Steering Committee
Cervical Cancer Screening	Core-30	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> • Women age 21–64 who had cervical cytology performed every 3 years. • Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. 	Medical Records	No	Pending	Reporting	Move to Reporting: unanimous vote	Legal Aid, HCA, HF, VDH, VMS, DVHA, CHAC, OCV, NMC expressed support for move to Reporting.
Tobacco Use: Screening & Cessation Intervention	Core-36	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.	Medical Records	Yes (P)	Pending	Reporting	Move to Reporting: unanimous vote	Legal Aid, HCA, HF, VDH, VMS, DVHA, CHAC, OCV, NMC expressed support for move to Reporting.
Custom DLTSS Survey Questions (Composite)	New Measure	<ul style="list-style-type: none"> • In the last 12 months, how often did the provider seem informed and up-to-date about any care you got from other service and support providers (if applicable), such as home health agencies, area agencies on aging, developmental or mental health service agencies, substance abuse providers, vocational rehabilitation, etc.? • If you ask for something, does your case manager/service coordinator help you get what you need? • In the last 12 months, how often did the specialist you saw seem informed and up-to-date about any care you got from other service and support providers (if applicable), such as home health agencies, area agencies on aging, developmental or mental health service agencies, substance abuse providers, vocational rehabilitation, etc.? 	Existing Survey	No	Not in Year 1 Measure Set	Reporting	Voted 11-3 to add to survey as Reporting: Y: DAIL, DVHA, VDH, BiState, CHAC, BCBS, Home Health, GMCB, VPQ, Legal Aid, HCA N: OCV, NMC, VMS A: HF	Legal Aid, HCA, CHAC, DVHA expressed support to add to Reporting; HF, VMS, OCV, NMC expressed opposition to add to Reporting.
Avoidable ED Visits	M&E-14	Percentage of ED visits that were potentially avoidable. ED Visits are classified as non-emergent; emergent/primary care treatable; emergent – ED care needed – preventable/avoidable; emergent - ED care needed	Claims	No	M & E	Reporting	Voted 9-6 to move to Reporting: Y: HF, DAIL, DVHA, VDH, Home Health, GMCB, VPQ, Legal Aid, HCA	Legal Aid, HCA, VDH, DVHA expressed support for move to Reporting; VMS, OCV, NMC expressed opposition for move to Reporting.

Proposed Measure Name	VT Measure ID	Measure Description	Source of Data	Medicare SSP? (Y2 Use)	VT Year 1 Use	QPM Work Group Year 2 Recommend.	QPM Work Group Vote	Summary of Comments to Steering Committee
		- not preventable/avoidable; injury; mental health diagnosis; alcohol-related health principle diagnosis; drug-related health principle diagnosis (excluding alcohol); not classified – not in one of the above categories.					N: BiState, CHAC, BCBS, NMC, OCV, VMS	
Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite	Core-12	Prevention Quality Indicator (PQI) composite of chronic conditions per 100,000 population ages 18 and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.	Claims	No	Reporting	Payment	Voted 10-5 to move to Payment: Y: DAIL, DVHA, VDH, BiState, CHAC, Home Health, GMCB, VPQ, Legal Aid, HCA N: HF, BCBS, NMC, OCV, VMS	Legal Aid, HCA, DVHA expressed support for move to Payment; HF, VMS, OCV, NMC expressed opposition for move to Payment (support keeping as Reporting).
Pediatric Weight Assessment and Counseling	Core-15	The percentage of attributed individuals 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> • BMI percentile documentation. • Counseling for nutrition. • Counseling for physical activity. 	Medical Records	No	Reporting	Payment	Voted 10-5 to move to payment: Y: DAIL, DVHA, VDH, BiState, CHAC, Home Health, GMCB, VPQ, Legal Aid, HCA N: HF, BCBS, NMC, VMS, OCV	Legal Aid, HCA, DVHA, CHAC, DCF, VDH expressed support for move to Payment; HF, VMS, OCV, NMC expressed opposition for move to Payment (support keeping as Reporting).
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	Core-17	The percentage of attributed individuals 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0%).	Medical Records	Yes (P)	Reporting	Payment	Voted 10-5 to move to payment: Y: DAIL, DVHA, VDH, BiState, CHAC, Home Health, GMCB, VPQ, Legal Aid, HCA N: HF, BCBS, NMC, VMS, OCV	Legal Aid, HCA, DVHA, CHAC, DCF, VDH expressed support for move to Payment; HF, VMS, OCV, NMC expressed opposition for move to Payment (support keeping as Reporting).

2. Measures Proposed But Not Recommended for Change by QPM Work Group

Proposed Measure Name	VT Measure ID	Measure Description	Source of Data	Medicare SSP? (Y2 Use)	VT Year 1 Use	QPM Work Group Year 2 Recommend.	QPM Work Group Vote	Summary of Comments to Steering Committee
Prenatal & Postpartum Care	Core-34	<p>Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.</p> <p>Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</p>	Medical Records	No	Pending	Pending (proposed for Reporting)	<p>Voted 9-5 to remain as Pending.</p> <p>Y: HF, DAIL, BiState, BCBS, Home Health, NMC, OCV, VMS, VPQ</p> <p>N: VDH, BiState, GMCB, Legal Aid, HCA</p>	Legal Aid, HCA, and VDH expressed support for move to Reporting; DCF expressed support for moving Prenatal Care component to Reporting; OCV and NMC expressed opposition for move to Reporting.
Influenza Immunization	Core-35	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Medical Records	Yes (P)	Pending	Pending (proposed for Reporting)	<p>Voted 7-7 to move from Pending to Reporting (tie vote means motion failed; CHAC later clarified vote).</p> <p>Y: DAIL, VDH, CHAC (reversed post-vote), GMCB, VPQ, Legal Aid, HCA</p> <p>N: HF, BiState, BCBS, Home Health, NMC, OCV, VMS</p>	Legal Aid, HCA, and VDH expressed support for move to Reporting; OCV and NMC expressed opposition for move to Reporting.
Screening for High Blood Pressure and Follow-up Plan Documented	Core-40	Percentage of patients aged 18 years and older seen during the measurement period who were screened for high blood pressure (BP) AND a recommended follow-up plan is documented based on the current blood pressure reading as indicated.	Medical Records	Yes (R)	Pending	Pending (proposed for Reporting)	<p>Voted 2-11 to move from Pending to Reporting (motion failed).</p> <p>Y: VDH; Legal Aid</p> <p>N: DAIL, CHAC, BiState, BCBS, GMCB, Hospice, NMC, OCV, VMS, VPQ, HCA</p>	VDH expressed support for move to Reporting; NMC expressed opposition for move to Reporting.
Controlling High Blood Pressure	Core-39	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement	Medical Records	Yes (P)	Pending	Pending (proposed for Reporting)	Did not vote at 7-29-14 QPM meeting	VDH expressed support for considering move to Reporting in Year 3; NMC expressed opposition for move to

Proposed Measure Name	VT Measure ID	Measure Description	Source of Data	Medicare SSP? (Y2 Use)	VT Year 1 Use	QPM Work Group Year 2 Recommend.	QPM Work Group Vote	Summary of Comments to Steering Committee
		year.						Reporting (suggested alternative process measure).
Optimal Diabetes Care Composite	Core-16	Percentage of patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated.	Medical Records	Yes (P)	Reporting	Reporting (proposed for Payment)	Did not vote at 7-29-14 QPM meeting	VDH expressed support for move to Payment in Year 3.
Adult Weight Screening and Follow Up	Core-20	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit.	Medical Records	Yes (P)	Reporting	Reporting (proposed for Payment)	Did not vote at 7-29-14 QPM meeting	Legal Aid, HCA, VDH expressed support for move to Payment; NMC recommended measure changes.
Rate of Hospitalization for Ambulatory Care Sensitive Conditions: COPD and Asthma for Older Adults	Core-10	Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions.	Claims	Yes (P)	Reporting	Reporting (proposed for Payment)	Did not vote at 7-29-14 QPM meeting	DVHA, CHAC expressed support for move to Payment; NMC expressed opposition for move to Payment.
Screening for Clinical Depression and Follow-Up	Core-19	Percentage of patients aged 12 years and older screened for clinical depression during the measurement period using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Medical Records	Yes (P)	Reporting	Reporting (proposed for Payment)	Did not vote at 7-29-14 QPM meeting	VDH expressed support for move to Payment; VT Council expressed support for inclusion in Reporting.
Care Transition Record Transmitted to Health Care Professional	Core-37	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was	Medical Records	No	Pending	Pending (proposed for Reporting)	Did not vote at 7-29-14 QPM meeting	Legal Aid, HCA, VDH expressed support for move to Reporting; NMC expressed opposition for move to Reporting.

Proposed Measure Name	VT Measure ID	Measure Description	Source of Data	Medicare SSP? (Y2 Use)	VT Year 1 Use	QPM Work Group Year 2 Recommend.	QPM Work Group Vote	Summary of Comments to Steering Committee
		transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.						
Transition Record with Specified Elements Received by Discharged Patients	Core-44 (alt.)	Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements.	Medical Records	No	Pending	Pending (proposed for Reporting)	Did not vote at 7-29-14 QPM meeting	Legal Aid, HCA expressed support for move to Reporting; NMC expressed opposition for move to Reporting.
Percentage of Patients with Self-Management Plans	Core-44	Percentage of patients with specified conditions who had at least one self-management goal during the measurement period.	Medical Records	No	Pending	Pending (proposed for Reporting)	Did not vote at 7-29-14 QPM meeting	NMC expressed opposition for move to Reporting.
Patient Experience Composites	Core-21 through Core-29	Composite measures on Access to Care, Communication, Shared Decision-Making, Self-Management Support, Comprehensiveness, Office Staff, Information, Coordination of Care, Specialist Care	Existing Survey	No	Reporting	Did not consider change	Did not vote at 7-29-14 QPM meeting (proposed to Steering Committee).	BCBSVT and DVHA expressed support for move to Payment.
ACO's Contribution to Mitigating Social Determinants Within Their Communities	Not in current measure sets	Several potential measures: \$ or % of total budget spent on providing transportation to patients; % of foods sourced locally, organically, fair trade; donations (in-kind or \$) made to local organizations that assist with housing security, food security, addiction, criminal rehabilitation, etc.; direct services offered to assist with housing security, food security, addiction, criminal rehabilitation, etc.	Not specified	No	Not in current measure sets	Did not consider change	Did not vote at 7-29-14 QPM meeting (proposed during Steering Committee comment period).	Dr. Peter Reed (pediatric resident) expressed support for adding to ACO Shared Savings Program measure sets.

Abbreviations in "Medicare SSP?" Column: (R)=Used as Reporting Measure in Year 2 of the MSSP Program; (P)=Used as Payment Measure in Year 2 of the MSSP Program

Abbreviations in “QPM Work Group Vote” and “Summary of Comments to Steering Committee” Columns: HF=Health*first*; BCBS=Blue Cross Blue Shield of Vermont; CHAC=Community Health Accountable Care; DAIL=Vermont Department of Disabilities, Aging and Independent Living; DCF=Department for Children and Families; DVHA=Department of Vermont Health Access; GMCB=Green Mountain Care Board; HCA=Office of Health Care Advocate; NMC=Northwestern Medical Center; OCV=OneCare Vermont; VDH=Vermont Department of Health; VMS=Vermont Medical Society; VPQ=Vermont Program for Quality in Health Care; VT Council=Vermont Council for Developmental and Mental Health Services

Attachment 6e - Summary of Comments

Summary of Written Feedback on Proposed Year 2 Measures by Commenter

Commenter	Comment Summary
Blue Cross Blue Shield of Vermont	Expresses appreciation for the QPM work group’s process. Supports only the promotion of all Year 1 <i>Patient Experience Survey</i> composite measures to Payment in Year 2, to ensure that beneficiary evaluations are included in the assessment of the success of the pilot program.
Community Health Accountable Care	Generally supports the Year 2 measure changes as recommended by the QPM work group. Also advocates for a reduction in the number of charts required for sampling in clinical measure collection, given the administrative burden on clinical and administrative practice staff.
Department of Children and Families	Supports the QPM work group’s recommendations of measures that are directly relevant to child health and family well-being. Specifically: <ul style="list-style-type: none"> - <i>Pediatric Weight Assessment and Counseling</i> as a Payment measure - <i>Developmental Screening in the First Three Years of Life</i> as a Reporting measure (commercial) - <i>Prenatal and Post-partum Care</i> as a Reporting measure, though only including the prenatal care component due to the differing timelines for post-partum care.
Department of Vermont Health Access	Supports the Year 2 measure changes as recommended by the QPM work group, and believes such changes reinforce the development of relationships between patients and their primary care providers needed to improve the delivery and quality of care during the implementation of the pilot program. Proposes two changes to proposed measure recommendations: <ul style="list-style-type: none"> - Prefers that <i>Breast Cancer Screening</i> remains a Reporting measure - Recommends promotion of <i>Rate of Hospitalization for Ambulatory Care Sensitive Conditions: COPD and Asthma in Older Adults</i> from Reporting to Payment
Healthfirst	Supports the position of the Vermont Medical Society. Expresses concerns about the addition of measures in Year 2 for the following reasons: <ul style="list-style-type: none"> - Increased cost and administrative burden on providers and ACOs, potentially detracting from clinical care provision - Delayed Year 1 implementation resulted in delayed development of initiatives focusing on Year 1 measures Requests postponement of consideration of new measures until Year 3.

Summary of Written Feedback on Proposed Year 2 Measures by Commenter

Anonymous	Expresses concerns about the feasibility of collecting certain Medicaid measures, and limited availability of well-known goals.
Northwestern Medical Center	<p>Expresses support for some measures as proposed by the QPM work group, and opposition to others, citing the following concerns:</p> <ul style="list-style-type: none"> - Very few of the proposed measures exhibit all of the merits prioritized in the QPM work group’s measure selection criteria - New measures should not be added for Year 2 without an understanding of Year 1 performance - Use of non-claims-based measures results in significant financial and administrative burden - The addition of new measures in Year 2 will dilute more targeted performance improvement efforts
OneCare Vermont	<p>Expresses support for some measures as proposed by the QPM work group, and opposition to others, with the following specific requests:</p> <ul style="list-style-type: none"> - Avoid moving any measures to Payment in Year 2, given the delay in Year 1 program implementation - Minimize the number of measures requiring manual abstraction <p>Additionally, notes that feedback from the broad OneCare provider network was minimized to a single vote in the QPM work group setting, and expresses concern that the perspective of practicing clinicians may not have been adequately represented in the recommendation-making process.</p>
Dr. Peter Reed	<p>Supports the measures as proposed by the QPM work group, and requests additional consideration of measures that would assess an ACO’s contributions to addressing social determinants of health in communities they serve. Specifically:</p> <ul style="list-style-type: none"> - dollars or % of total budget spent on providing transportation to patients - % of foods sourced locally, organically, fair trade - donations made to local organizations that assist with housing security, food security, addiction, criminal rehabilitation, etc. - direct services offered to assist with housing security, food security, addiction, criminal rehabilitation, etc.
Vermont Council of Developmental and Mental Health Services	<p>Suggests additions to the proposed measures to include substance abuse and mental health screening measures, thereby increasing opportunities for ACOs to improve health outcomes and coordinate care for a potentially high-utilizing population. Recommends consideration of the following substance abuse screening tools:</p> <ul style="list-style-type: none"> - AUDIT and DAST

Summary of Written Feedback on Proposed Year 2 Measures by Commenter

	<ul style="list-style-type: none"> - NIDA Adult - PHQ-2 - PHQ-9 - CAGE and CAGE-Aid
<p>Vermont Department of Health</p>	<p>Expresses appreciation for the QPM work group’s measure review process, supports the proposed Year 2 measures, and encourages additional consideration of the following measures given their importance for population health and their alignment with the priorities of the State Health Improvement Plan:</p> <ul style="list-style-type: none"> - <i>Prenatal & Postpartum Care</i> - <i>Influenza Immunization</i> - <i>Screening for High Blood Pressure with Follow up Plan Documented</i> - <i>Controlling Blood Pressure</i> - <i>Optimal Diabetes Care</i> - <i>Adult Weight Screening and Follow-Up</i> - <i>Screening for Clinical Depression and Follow-Up</i> - <i>Care Transition Record Transmitted to Health Care Professional</i>
<p>Vermont Legal Aid/Office of the Health Care Advocate</p>	<p>Supports the Year 2 measure changes as recommended by the QPM work group, and notes that the use of Payment measures is a primary way to ensure that the quality of care is maintained or improved while ACOs work toward achieving savings. Additionally, expresses concern about the following:</p> <ul style="list-style-type: none"> - Limited scope of the measure set, in that populations included in the Medicaid and commercial shared savings programs do not have adequate quality measure coverage (e.g. pediatric, maternity, and DLTSS populations) - Limited promotion of Pending measures, impacting the ability of such measures to be considered for Payment before the end of the pilot program - Restricting the scoring of measures against selection criteria to those that were recommended for Year 2 reconsideration, rather than evaluating all program measures - Giving all criteria equal weight in the scoring methodology <p>Requests additional consideration of the following measures:</p> <ul style="list-style-type: none"> - <i>Prenatal & Postpartum Care</i> - <i>Influenza Immunization</i> - <i>Adult Weight Screening and Follow-Up</i> - <i>Care Transition Record Transmitted to Health Care Professional</i>

Summary of Written Feedback on Proposed Year 2 Measures by Commenter

	<ul style="list-style-type: none">- <i>Transition Record with Specified Elements Received by Discharged Patients</i>
Vermont Medical Society	<p>Expresses support for some measures as proposed by the QPM work group, and opposition to others, citing the following concerns:</p> <ul style="list-style-type: none">- Insufficient alignment between the Commercial/Medicaid SSPs and the Medicare SSP (for both Year 1 and proposed Year 2) measure sets- Increasing the number of measures used would increase financial and administrative burden on providers- No measures should be newly used for Payment in Year 2 without baseline Year 1 data available