# VHCIP Core Team Agenda 9.10.14

# *VT Health Care Innovation Project*
# *Core Team Meeting Agenda*

**September 10, 2014 10:00-12:30 pm**
**DFR - 3rd Floor Large Conference Room, 89 Main Street, Montpelier**
***Call-In Number: 1-877-273-4202; Passcode: 8155970***

| Item # | Time Frame | Topic | Presenter | Relevant Attachments |
|---|---|---|---|---|
| 1 | 10:00-10:10 | Welcome and Chair's Report | Anya Rader Wallack | |
| **Core Team Processes and Procedures** | | | | |
| 2 | 10:10-10:15 | Approval of meeting minutes | Anya Rader Wallack | Attachment 2: August 13, 2014 meeting minutes. |
| **Policy Update** | | | | |
| 3 | 10:15-11:15 | Quality and Performance Measures<br><br>*Public Comment* | QPM Staff and Co-Chairs | Attachment 3a: SSP Proposed Year Two Changes<br>Attachment 3b: Summary of Comments by Measure<br>Attachment 3c: Year Two Measures Comments Summary<br>Attachment 3d: Year Two Measures Comments |

| | | | | |
|---|---|---|---|---|
| **Core Team Processes and Procedures** | | | | |
| 4 | 11:15-11:20 | Grant Program Update<br><br>*Public Comment* | Georgia Maheras | |
| **Spending recommendations and decisions** | | | | |
| 5 | 11:20-12:15 | Financial Update:<br>a. Wakely--Actuarial: $200,000<br>b. Stone Environmental: $120,000<br>c. UVM: Workforce Symposium: $10,000<br>d. DLTSS RFP: Work Group Support: $215,000<br>e. HIE/HIT Work Group: Telehealth Planning: $120,000<br>f. Workforce Work Group: Micro-Simulation Demand Modeling: $250,000-$350,000<br><br>*Public Comment* | Georgia Maheras | Attachment 4a: VHCIP Revised Project Budget 9.5.14<br>Attachment 4b: Financial memo |
| 6 | 12:15-12:25 | *Public Comment* | Anya Rader Wallack | |
| 7 | 12:25-12:30 | Next Steps, Wrap-Up and Future Meeting Schedule:<br>9/29: 10:00-12:00 Montpelier | Anya Rader Wallack | |

# Attachment 2 - Core Team Minutes 8.13.14

***VT Health Care Innovation Project***
***Core Team Meeting Minutes***

**Date of meeting:** August 13, 2014 **Location:** DFR 3rd Floor Conference Room, 89 Main Street, Montpelier VT

**Members:** Anya Rader Wallack, Chair; Robin Lunge, AOA; Susan Wehry, DAIL; Paul Bengtson, NVRH; Al Gobeille[1], GMCB; Mark Larson, DVHA; Steve Voigt.

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| **1. Welcome and Chair's report** | Anya Wallack called the meeting to order at 1:08 pm and gave a preview of the upcoming Core Team review of the Year 2 Shared Savings ACO Program Measures. The Core Team will be briefed on the measures as recommended by the Steering Committee on September 10th. The expectation is that the Core Team will not vote on the measure set until their September 29th meeting. | |
| **2. Approval of Minutes** | Steve moved to approve the July 17th minutes. This was seconded by Robin. All approved with one abstention (Susan Wehry). | |
| **3. Core Team Processes and Procedures** | Sub-Grant Program Update: The Core Team reviewed the proposed timeline and process as well as the scoring sheet (attachments 3a and 3b). The Core Team approved the timeline and scoring sheet for use in Round Two of the Sub-Grant Program. | |
| **4. Spending Recommendations and Decisions** | Georgia provided an updated VHCIP 4- year project budget. The revised budget includes a crosswalk to the approved budget narrative categories and amount remaining in any categories. The Core Team requested some additional formatting changes for clarity and these will be incorporated in subsequent versions of the document. The Core Team approved the revised budget unanimously on a motion made by Paul and seconded by Steve. The next step is to submit | |

[1] Al Gobeille joined the meeting at 1:56pm during the Learning Collaborative discussion.

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| | this revised budget to CMMI for federal approval. | |
| **4. Spending Recommendations and Decisions cont.** | Georgia presented two financial proposals to the Core Team for approval:<br>1. CMCM Proposal for a Learning Collaborative: $300,000<br>2. Arrowhead Health Analytics Proposal: $110,000<br><br>1. Learning Collaborative: Pat Jones and Erin Flynn presented this proposal referring to Attachment 4b. Miriam Sheehy also provided information on this proposal. The Core Team engaged in discussion about this item. This included conversation around who participates in the collaborative, how is at-risk defined and how responsive this proposal was to those who are working to improve care management. The Core Team approved this proposal on a motion made by Susan and seconded by Paul. Mark Larson was not in the room for this vote.<br>2. Arrowhead Health Analytics: Anya recused herself from this discussion and requested that Robin Lunge Chair the remainder of the meeting. Robin introduced this contract and Georgia provided background. Michael Clasen, Deputy Secretary of the Agency of Administration, provided additional information. There was brief discussion regarding which agency held the contract and contract management. The Core Team approved this proposal on a motion made by Paul and seconded by Steve. Mark Larson was not in the room for this vote. | |
| **5. Public Comment** | N/A | |
| **6. Next Steps, Wrap up** | **Next meeting:** September 10, 2014, 1-3:30 pm, DFR 3rd Floor Conference Room, 89 Main St, Montpelier. | |

# VHCIP Core Team Attendance Sheet 8-13-14

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

| First Name | Last Name | | Title | Organization | Core Team |
|---|---|---|---|---|---|
| Ena | Backus | | | GMCB | X |
| Susan | Barrett | | Executive Director | GMCB | X |
| Anna | Bassford | | | GMCB | A |
| Paul | Bengston | PeRB | CEO | Northeastern Vermont Regional Hospital | M |
| Beverly | Boget | | | | X |
| Harry | Chen | | Commissioner | AHS - VDH | M |
| Amanda | Ciecior | | Health Policy Analyst | AHS - DVHA | X |
| Amy | Coonradt | | Health Policy Analyst | AHS - DVHA | X |
| Alicia | Cooper | | Quality Oversight Analyst | AHS - DVHA | X |
| Mark | Craig | | | | X |
| Diane | Cummings | DCummings | Financial Manager II | AHS - Central Office | X |
| Paul | Dupre | | Commissioner | AHS - DMH | X |
| Erin | Flynn | Erin Flynn | Health Policy Analyst | AHS - DVHA | X |
| Lucie | Garand | | Senior Government Relations Specia | Downs Rachlin Martin PLLC | X |
| Christine | Geiler | | Grant Manager & Stakeholder Coord | GMCB | S |
| Al | Gobeille | | Chair | GMCB | M |
| Sarah | Gregorek | | | AHS - DVHA | A |
| Thomas | Hall | | | Consumer Representative | X |
| Bryan | Hallett | | | | X |
| Carrie | Hathaway | phone | Financial Director III | AHS - DVHA | X |
| Kate | Jones | | | AHS - DVHA | S |
| Pat | Jones | Pat Jones | | GMCB | X |
| Heidi | Klein | | | AHS - VDH | X |
| Kelly | Lange | | Director of Provider Contracting | Blue Cross Blue Shield of Vermont | X |
| Mark | Larson | | Commissioner | AHS - DVHA | M |
| Diane | Lewis | | | AOA - DFR | A |
| Monica | Light | phone | Director of Health Care Operations, C | AHS - Central Office | X |

| | | | | | |
|---|---|---|---|---|---|
| Robin | Lunge | | Director of Health Care Reform | AOA | M |
| Georgia | Maheras | | | AOA | S |
| Steven | Maier | | HCR-HIT Integration Manager | AHS - DVHA | X |
| David | Martini | | | AOA - DFR | X |
| Marybeth | McCaffrey | | Principal Health Reform Administrato | AHS - DAIL | X |
| Kimberly | McNeil | | Payment Reform Policy Intern | AHS - DVHA | X |
| Marisa | Melamed | | | AOA | A |
| Lawrence | Miller | | | | X |
| Meg | O'Donnell | | | Fletcher Allen Health Care | X |
| Lisa | Parro | | | AHS - DAIL | A |
| Annie | Paumgarten | | Eveluation Director | GMCB | X |
| Kristy | Pirie | | | AHS - Central Office | A |
| Luann | Poirer | | Administrative Services Manager I | AHS - DVHA | X |
| Lila | Richardson | | Attorney | VLA/Health Care Advocate Project | X |
| Julia | Shaw | | Health Care Policy Analyst | VLA/Health Care Advocate Project | X |
| Richard | Slusky | RS | Payment Reform Director | GMCB | X |
| Kara | Suter | | Reimbursement Director | AHS - DVHA | X |
| Carey | Underwood | | | King Arthur Flour | A |
| Steve | Voigt | | | | M |
| Anya | Wallack | | Chair | SIM Core Team Chair | C |
| Julie | Wasserman | JW | VT Dual Eligible Project Director | AHS - Central Office | X |
| Susan | Wehry | | Commissioner | AHS - DAIL | M |
| Spenser | Weppler | | S | GMCB | X |
| Katie | Whitney | | | | A |
| Bradley | Wilhelm | | Senior Policy Advisor | AHS - DVHA | X |
| Jason | Williams | | Government Relations Strategist | Fletcher Allen Health Care | X |
| Jennifer | Woodard | | Long-Term Services and Supports He | AHS - DAIL | X |
| Cecelia | Wu | | Healthcare Project Director | AHS - DVHA | X |
| Mike | Maslack | | | | X |
| Miriam | Sheehey | | Green Mt. Care VT. | | |
| Ena | Backus | | GMCB Deputy Director | | |
| Joyce | Gallimore | phone | | | |
| | | | | | |
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# VHCIP Core Team Roll Call

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

minutes

| First Name | Last Name | | Title | Organization | Core Team | |
|---|---|---|---|---|---|---|
| Paul | Bengston ✓ | ✓ | CEO | Northeastern Vermont Regional Hospital | M | |
| Harry | Chen n/a | | Commissioner | AHS - VDH | M | |
| Al | Gobeille ~~n/a~~ | n/a | Chair | GMCB | M | |
| Mark | Larson ✓ | ✓ | Commissioner | AHS - DVHA | M | |
| Robin | Lunge ✓ | 2 ✓ | Director of Health Care Reform | AOA | M | |
| Steve | Voigt ✓ | 1 ✓ | | | M | |
| Anya | Wallack ✓ | ✓ | Chair | SIM Core Team Chair | C | |
| Susan | Wehry ✓ | Abst. | Commissioner | AHS - DAIL | M | |

Revised budget ① Paul
& presentation ② Steve
app'd unanimously

Al joined at 1:56
during LC discussion

learning collab. ① Susan
⇒ mark out of room ② Paul
for this vote
app'd unanimously

Arrowhead ① Paul
→ Mark out of room for this vote ② Steve

Anya recused herself

# Attachment 3a - SSP Proposed Year Two Changes

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

August 18, 2014

# ACO SSP Measure Categories

**PAYMENT**

Payment measures are collected at the ACO level. ACO responsible for collecting clinical data-based measures. How ACO performs influences amount of shared savings.

**REPORTING**

Reporting measures are collected at the ACO level. ACO responsible for collecting clinical data-based measures. How the ACO performs does NOT influence the amount of shared savings.

**MONITORING & EVAL**

Monitoring measures are collected at the State or Health Plan levels; cost/ utilization measures at the ACO level. ACO not responsible for collecting these measures. How the ACO performs does NOT influence the amount of shared savings.

**PENDING**

Pending measures are considered to be of interest, but are not currently collected.

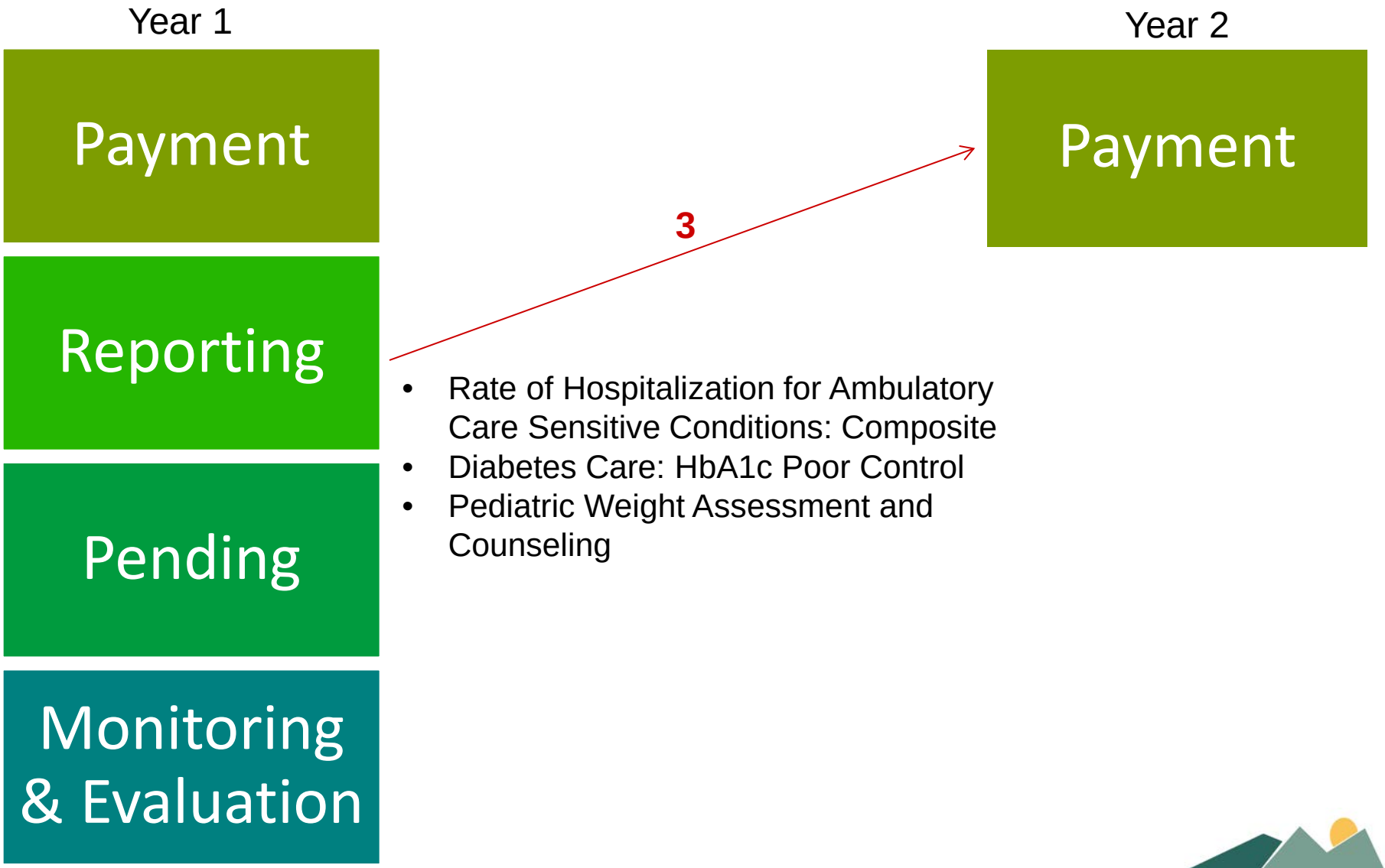
# QPM WG Year 2 Measure Review Process

- **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

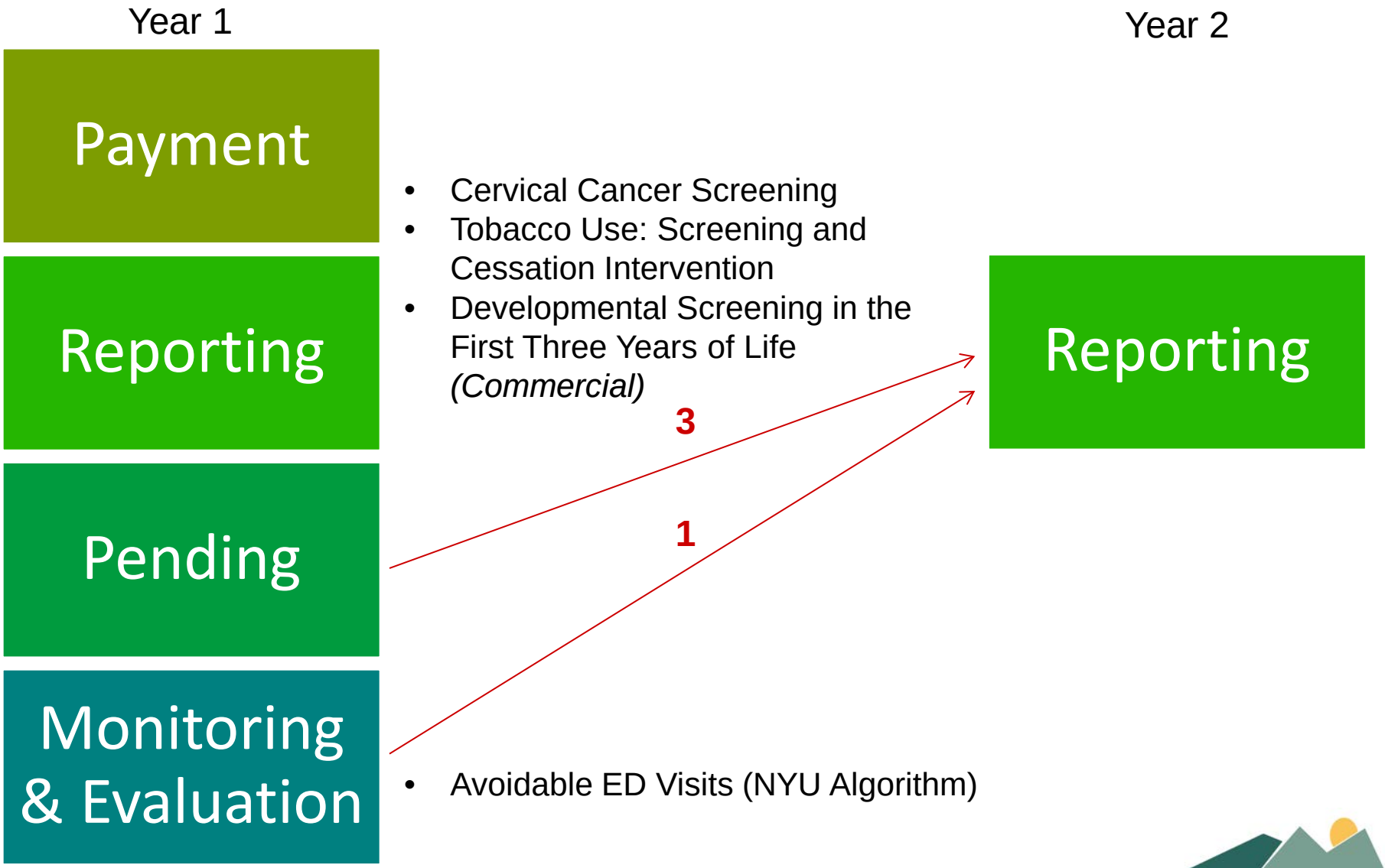
# Summary of Year 2 Recommended Changes

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

# Re-classify Three Year 1 Reporting Measures to Payment



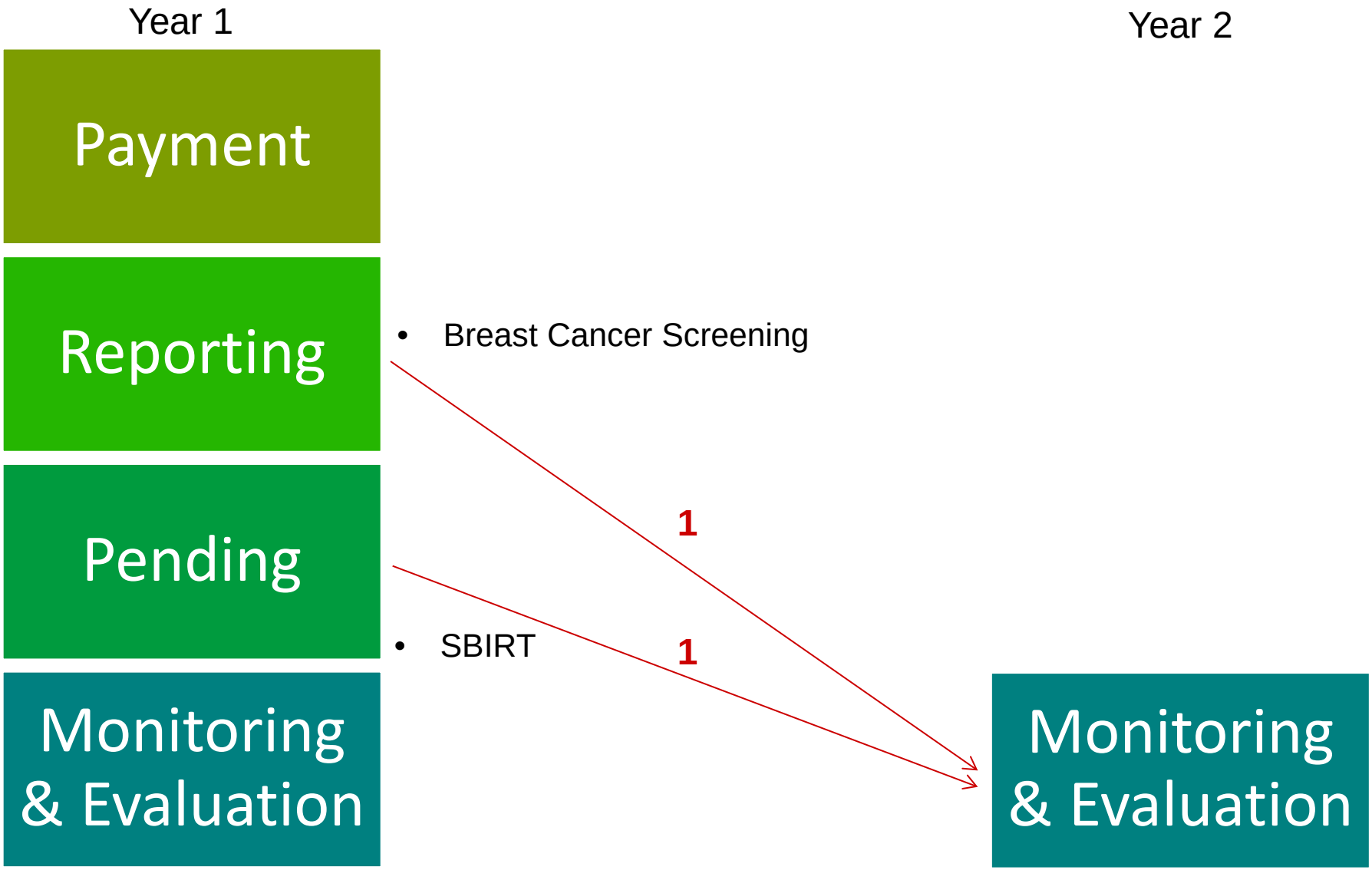
# Re-classify Three Year 1 Pending Measures and One Year 1 M&E Measure to Reporting






Vermont Health Care Innovation Project

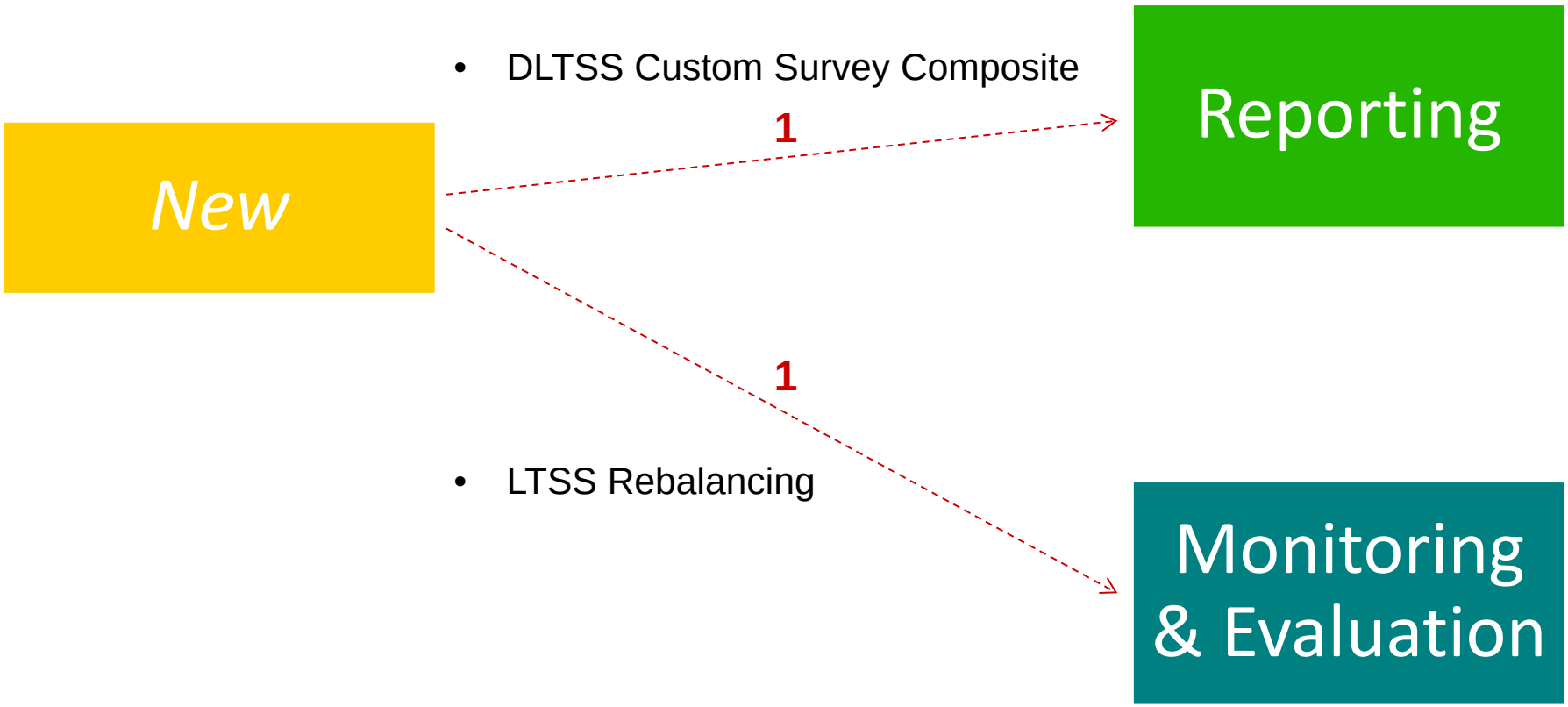
# Re-classify One Year 1 Reporting Measure and One Year 1 Pending Measure to M&E



# Add Two New Measures (One to Reporting and One to M&E)

Year 1

Year 2



# Number of Measures by Category: Year 1 and Proposed Year 2 Measures

| Current Year 1 | Proposed Year 2 |
| --- | --- |
| Payment (7 Commercial/ 8 Medicaid) | Payment (10 Commercial/ 11 Medicaid) |
| Reporting (24)* | Reporting (25 Commercial/ 24 Medicaid)* |
| Monitoring & Evaluation (22 Commercial/ 23 Medicaid) | Monitoring & Evaluation (24 Commercial/ 25 Medicaid) |

***Reporting category counts Diabetes Composite as 5 measures because each sub-measure is counted as 1 measure. If this measure was only counted as 1 measure, the Reporting numbers would decrease by 4 in Y1 and Y2.**

# 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<br><br>(Clinical Data) | **5** in favor of promotion<br><br>**9** opposed to promotion |
| Pending | Reporting | Influenza Immunization<br><br>(Clinical Data) | **7** in favor of promotion<br><br>**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<br><br>(Clinical Data) | **2** in favor of promotion to Reporting<br><br>**11** opposed to promotion |

# Other Proposed Measures

- QPM Co-Chairs/Staff/Consultant DID NOT recommend considering these measures for promotion
- QPM work group members did not vote on these measures at the July 29, 2014 work group meeting

| 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 |

# APPENDIX:

## YEAR ONE MEASURE SET WITH RECOMMENDED YEAR 2 CHANGES

# 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 DLTSS 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
- Frequency of Ongoing Prenatal Care
- Elective delivery before 39 weeks
- Prenatal and Postpartum 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)
- ~~Developmental Screening in the First Three Years of Life (commercial)~~

**Medicare Shared Savings Program measure*

# Attachment 3b - Summary of Comments by Measure

# 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)<br><br>Not used for Commercial | Reporting (Commercial) | Voted 10-4 to move to Reporting (Commercial):<br><br>Y: HF, CHAC, BiState, BCBS, Home Health, GMCB, NMC, OCV, VMS, VPQHC<br><br>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:<br>• Women age 21–64 who had cervical cytology performed every 3 years.<br>• 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 | • 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.?<br>• If you ask for something, does your case manager/service coordinator help you get what you need?<br>• 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:<br><br>Y: DAIL, DVHA, VDH, BiState, CHAC, BCBS, Home Health, GMCB, VPQ, Legal Aid, HCA<br><br>N: OCV, NMC, VMS<br><br>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:<br><br>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:<br><br>Y: DAIL, DVHA, VDH, BiState, CHAC, Home Health, GMCB, VPQ, Legal Aid, HCA<br><br>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:<br>• BMI percentile documentation.<br>• Counseling for nutrition.<br>• Counseling for physical activity. | Medical Records | No | Reporting | Payment | Voted 10-5 to move to payment:<br><br>Y: DAIL, DVHA, VDH, BiState, CHAC, Home Health, GMCB, VPQ, Legal Aid, HCA<br><br>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:<br><br>Y: DAIL, DVHA, VDH, BiState, CHAC, Home Health, GMCB, VPQ, Legal Aid, HCA<br><br>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 | **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.<br><br>**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.<br><br>Y: HF, DAIL, BiState, BCBS, Home Health, NMC, OCV, VMS, VPQ<br><br>N: VDH, BiState, GMCB, Legal Aid, HCA | 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) | Voted 7-7 to move from Pending to Reporting (tie vote means motion failed; CHAC later clarified vote).<br><br>Y: DAIL, VDH, CHAC (reversed post-vote), GMCB, VPQ, Legal Aid, HCA<br><br>N: HF, BiState, BCBS, Home Health, NMC, OCV, VMS | 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) | Voted 2-11 to move from Pending to Reporting (motion failed).<br><br>Y: VDH; Legal Aid<br><br>N: DAIL, CHAC, BiState, BCBS, GMCB, Hospice, NMC, OCV, VMS, VPQ, HCA | 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-Manage-ment 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 3c -Year Two Measures Comments Summary

## 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 *Patient Experience Survey* 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:<br>- *Pediatric Weight Assessment and Counseling* as a Payment measure<br>- *Developmental Screening in the First Three Years of Life* as a Reporting measure (commercial)<br>- *Prenatal and Post-partum Care* 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:<br>- Prefers that *Breast Cancer Screening* remains a Reporting measure<br>- Recommends promotion of *Rate of Hospitalization for Ambulatory Care Sensitive Conditions: COPD and Asthma in Older Adults* from Reporting to Payment |
| **Health*first*** | Supports the position of the Vermont Medical Society. Expresses concerns about the addition of measures in Year 2 for the following reasons:<br>- Increased cost and administrative burden on providers and ACOs, potentially detracting from clinical care provision<br>- Delayed Year 1 implementation resulted in delayed development of initiatives focusing on Year 1 measures<br>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** | Expresses support for some measures as proposed by the QPM work group, and opposition to others, citing the following concerns:<br>- Very few of the proposed measures exhibit all of the merits prioritized in the QPM work group's measure selection criteria<br>- New measures should not be added for Year 2 without an understanding of Year 1 performance<br>- Use of non-claims-based measures results in significant financial and administrative burden<br>- The addition of new measures in Year 2 will dilute more targeted performance improvement efforts |
| **OneCare Vermont** | Expresses support for some measures as proposed by the QPM work group, and opposition to others, with the following specific requests:<br>- Avoid moving any measures to Payment in Year 2, given the delay in Year 1 program implementation<br>- Minimize the number of measures requiring manual abstraction<br>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. |
| **Dr. Peter Reed** | 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:<br>- dollars or % of total budget spent on providing transportation to patients<br>- % of foods sourced locally, organically, fair trade<br>- donations made to local organizations that assist with housing security, food security, addiction, criminal rehabilitation, etc.<br>- direct services offered to assist with housing security, food security, addiction, criminal rehabilitation, etc. |
| **Vermont Council of Developmental and Mental Health Services** | 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:<br>- AUDIT and DAST |

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| | - NIDA Adult<br>- PHQ-2<br>- PHQ-9<br>- CAGE and CAGE-Aid |
| **Vermont Department of Health** | 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:<br>- *Prenatal & Postpartum Care*<br>- *Influenza Immunization*<br>- *Screening for High Blood Pressure with Follow up Plan Documented*<br>- *Controlling Blood Pressure*<br>- *Optimal Diabetes Care*<br>- *Adult Weight Screening and Follow-Up*<br>- *Screening for Clinical Depression and Follow-Up*<br>- *Care Transition Record Transmitted to Health Care Professional* |
| **Vermont Legal Aid/Office of the Health Care Advocate** | 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:<br>- 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)<br>- Limited promotion of Pending measures, impacting the ability of such measures to be considered for Payment before the end of the pilot program<br>- Restricting the scoring of measures against selection criteria to those that were recommended for Year 2 reconsideration, rather than evaluating all program measures<br>- Giving all criteria equal weight in the scoring methodology<br>Requests additional consideration of the following measures:<br>- *Prenatal & Postpartum Care*<br>- *Influenza Immunization*<br>- *Adult Weight Screening and Follow-Up*<br>- *Care Transition Record Transmitted to Health Care Professional* |

| | |
|---|---|
| | - *Transition Record with Specified Elements Received by Discharged Patients* |
| **Vermont Medical Society** | Expresses support for some measures as proposed by the QPM work group, and opposition to others, citing the following concerns:<br>- Insufficient alignment between the Commercial/Medicaid SSPs and the Medicare SSP (for both Year 1 and proposed Year 2) measure sets<br>- Increasing the number of measures used would increase financial and administrative burden on providers<br>- No measures should be newly used for Payment in Year 2 without baseline Year 1 data available |

# Attachment 3d - Year Two Measures Comments

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.

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 BCSBVT 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 <u>two</u> 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 <u>one</u> 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

Health*first*, Inc.
*...the future starts now*

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 Health*first*, 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,

Health*first*, Inc.
*...the future starts now*

Dr. Paul Reiss, MD
Chairman of the Board of Directors, Health*first*

Amy E Cooper, MBA
Executive Director, Health*first*

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*
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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 (*currently in Medicaid measure set; proposed for commercial measure set*)** | 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:<br>• by 12 months of age<br>• by 24 months of age<br>• 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.<br>- 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:<br>• Women age 21–64 who had cervical cytology performed every 3 years. | • The number of women who were screened for cervical cancer, as identified in steps 1 and 2 below.<br>• 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**<br>- recognized issue of young women who are older than 21 years of age but have not been and are not currently sexually |

| # | Measure Name | Use by Other Programs | Description | Numerator | FEEDBACK |
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| | | 124v1) | • Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.<br><br>Note: Due to significant specification changes, NCQA will not publicly report this measure for HEDIS 2014. | cervical cytology (Cervical Cytology Value Set) during the measurement year or the two years prior to the measurement year.<br>• 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.<br>• Sum the events from steps 1 and 2 to obtain the rate. | active. Pelvic exams and cervical cancer screening might be deferred, but this would subject these women to this screening to be compliant.<br>Need additional exclusion criteria. |
| **Core-34** | **Prenatal and Postpartum Care** | NQF #1517; NCQA (HEDIS) | **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.<br><br>**Postpartum Care**: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. | 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.<br><br>Postpartum Care: A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after | **Do not support this measure as proposed**<br>- 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.<br>- If a patient began prenatal care in a critical access hospital and became high |

| # | Measure Name | Use by Other Programs | Description | Numerator | FEEDBACK |
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| | | | | delivery, as documented through either administrative data or medical record review. | 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)?<br><br>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 |
| **Core-35/ MSSP-14 PQRS MU** | **Influenza Immunization** | NQF #0041; MSSP; PQRS (alt core); MU (CMS 147v1) | 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 | Patients who received an influenza immunization OR who reported previous receipt* of an influenza immunization<br><br>*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 measures is applied (typically, prior vaccination would include influenza vaccine given since August 1st). | Epidemiologists state that research does not support the efficacy of this intervention.<br><br>Requires patient survey to determine immunizations that were given outside the physician office ie. pharmacies, public health offerings, etc.<br><br>Allow documentation of medical reason, patient reason, or system reason exclusions as evidence of compliance.<br><br>No national benchmarks available. |



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| # | Measure Name | Use by Other Programs | Description | Numerator | FEEDBACK |
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| **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<br><br>*Includes use of any type of tobacco<br>**Includes brief counseling (3 minutes or less), and/or pharmacotherapy | **Adopted 6/23/14 by QPM WG - support this as a Reporting measure**<br><br>Screening for tobacco and tobacco products reasonable. Change language to "offered 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.<br><br>"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 |

| # | Measure Name | Use by Other Programs | Description | Numerator | FEEDBACK |
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| | | | | | discharged with recommended follow-up plan"?<br><br>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.<br><br>Note: 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.<br>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<br>screened for high blood pressure (BP) AND a recommended follow-up plan is documented based<br>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. |

| # | Measure Name | Use by Other Programs | Description | Numerator | FEEDBACK |
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| | | | | | 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. | 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.<br><br>Recommend at-risk population specific self-management plans - ie. # of patients with prescribed home weight measurement self-management plan.<br><br>No benchmarks available. Not endorsed. Not able to easy measure this without chart audits. No central location in EHR to audit compliance. |
| **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: | 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?<br><br>Reasonable expectations include principal diagnosis at discharge which |

| # | Measure Name | Use by Other Programs | Description | Numerator | FEEDBACK |
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| | | | documented) at the time of discharge including, at a minimum, all of the specified elements | Inpatient Care<br>• Reason for inpatient admission, AND<br>• Major procedures and tests performed during inpatient stay and summary of results, AND<br>• Principal diagnosis at discharge<br><br>Post-Discharge/ Patient Self-Management<br>• Current medication list, AND<br>• Studies pending at discharge (e.g., laboratory, radiological), AND<br>• Patient instructions<br><br>Advance Care Plan<br>• Advance directives or surrogate decision maker documented OR Documented reason for not providing advance care plan<br>Contact Information/Plan for Follow-up Care<br>• 24-hour/7-day contact information including physician for emergencies related to inpatient stay, AND<br>• Contact information for obtaining results of studies pending at discharge, AND<br>• Plan for follow-up care, AND | may be very different than the reason for admission (and potentially irrelevant), current medication list, and patient instructions/follow-up plan.<br><br>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.<br><br>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.<br><br>It is often inadvisable due to the patient's condition or new diagnosis to have this conversation in the hospital.<br><br>Plan for follow-up care is reasonable, except for those patients who have no primary care physician or site for f/u |



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| | | | | • Primary physician, other health care professional, or site designated for follow-up care | care. This measure component cannot be reliably met. |
| **Core-45** | **Screening, Brief Intervention, and Referral to Treatment**<br><br>(Note: The predecessor ACO Measures Work Group did not define specifications for this measure. Those provided are those in use by Oregon Medicaid.) | Oregon CCO incentive pool measure. Not NQF-endorsed. See www.oregon.gov/oha/CCOData/SBIRT%20Guidance%20Document%20--%20Revised%20September%202013.pdf | 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. | Patients who completed a full, standardized screening tool as indicated by one of the following CPT or HCPCS codes:<br>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.<br>• 99408 – used for patients who were screened and received a brief intervention (15-30 mins)<br>• 99409 – used for patients who were screened and received a brief intervention (> 30 mins)<br>• G0396 – used for patients who received alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention (15-30 minutes)<br>• G0397 – used for patients who | IF patients do not complete standardized screening tool, compliance is lacking. While this might be requested, patients can refuse.<br><br>Reasonable to expect clinical screening tool for assessment of risk, followed by intervention plan based upon results of screening.<br><br>No national benchmarks. |

| # | Measure Name | Use by Other Programs | Description | Numerator | FEEDBACK |
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| | | | | received alcohol and/or substance abuse (other than tobacco) structured assessment and brief intervention (>30 minutes) | |
| **New Measure** | **LTSS Rebalancing** ***(proposed for Medicaid measure set)*** | Not NQF-endorsed | Proportion of eligible beneficiaries receiving care in a home or community-based setting (instead of an institutional setting).<br><br>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.<br><br>NOTE: The majority of CFC clients are dually eligible, and therefore attributed to the Medicare Shared Savings Program. | Choices for Care clients receiving Home and Community-Based Services (HCBS) | **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**<br><br>Have not had an opportunity to see or consider this data for improvement.<br><br>No benchmarks available |
| **New Measures** | **3 to 5 custom questions for Patient Experience Survey regarding DLTSS services and case management** | Not NQF-endorsed | To Core-28, add:<br>• 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 | **Do not support this measure**<br><br>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 |



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| | | | providers, vocational rehabilitation, etc.?<br>• If you ask for something, does your case manager/service coordinator help you get what you need?<br>• *Any necessary branching questions*<br><br>To Core-29, add:<br>• 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.?<br>• *Any necessary branching questions* | | them. VITL has stated that this is a major block from an HIE perspective.<br><br>This question asks "how often" - what if only one referral was needed? Does a lower number mean less compliance than a higher number?<br><br>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?"<br><br>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.<br><br>For the third question: Specialists will uniformly NOT have all this information |



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| | | | | | 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).<br><br>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"). |

## *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 Reporting Measure | 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:<br>• A principal ICD-9-CM diagnosis code for COPD (excluding acute bronchitis)<br>• A principal ICD-9-CM diagnosis code for asthma; or<br>• 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.<br><br>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 Reporting Measure | 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:<br>• PQI #1 Diabetes with short-term complications admission rate<br>• PQI #3 Diabetes with long-term complications admission rate<br>• PQI# 5 Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate<br>• PQI #7 Hypertension admission rate<br>• PQI #8 Heart failure admission rate<br>• PQI #13 Angina without a cardiac procedure admission rate<br>• PQI #14 Uncontrolled diabetes admission rate<br>• PQI #15 Asthma in younger adults admission rate<br>• PQI #16 Lower- extremity amputation among patients with diabetes<br>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.<br><br>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 |

| # | Measure Name | Use by Other Programs | Description | Numerator | FEEDBACK |
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| | | | | | inclusion/exclusion criteria that will need to be applied. |
| **Core-15 PQRS MU** | **Pediatric Weight Assessment and Counseling** | NQF #0024; Year 1 Vermont SSP Reporting Measure; 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.<br>• BMI percentile documentation.<br>• Counseling for nutrition.<br>• 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.<br>• BMI percentile documentation.<br>• Counseling for nutrition.<br>• Counseling for physical activity. | **Keep as Reporting. This will be a manual audit. No data from year 1 to analyze.**<br><br>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 Reporting Measure; 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.<br><br>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.<br>Recommend: |

| # | Measure Name | Use by Other Programs | Description | Numerator | FEEDBACK |
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| | | | 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.<br><br>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.<br><br>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.<br>For the 2016 reporting year, dates of service 1/1/2015 – 12/31/2015 plan for a new cholesterol component to be | | "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. |



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| | | | 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.<br><br>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.<br><br>Normal parameters needs to be defined ie. BMI >40.<br><br>Follow up plan might not require re-visit, so this could add system costs. Recommend: "follow-up plan is |

| # | 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 Monitoring and Evaluation Measure | Percentage of ED visits that were potentially avoidable. | ED Visits are classified into the categories below:<br>• 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;<br>• 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)<br>• 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<br>• 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.).<br>• Injury<br>• Mental health diagnosis<br>• Alcohol-related health principal diagnosis<br>• Drug-related health principal diagnosis (excluding alcohol).<br>• Not classified - not in one of the above categories | **Do not support this measure.**<br>This measure is open to interpretation with the definitions as it is based on opinion as to what is emergent vs non-emergent.<br><br>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<br>There are myriad reasons why a patient comes to the ED, even with a minor issue.<br><br>Medicare measure on ED Utilization is recommended |

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



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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 | Barbara Walters, DO | Victoria Loner MHCDS, RNC |
| Executive Medical Director | Chief Medical Officer | Clinical Operations Director |
| OneCare Vermont | OneCare Vermont | 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

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**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.

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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

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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 DLTSS 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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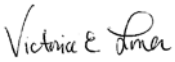
**Proposed Monitoring and Evaluation Measures**

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

OneCareVermont

| 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, Ovleto 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 Hospita | 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 Hospita | 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 Servi | | | | X |
| Mairs, Greg | | Mental Health | Addison County | Counseling Service of Addision 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 secuirty, food security, addiction, criminal rehabilitation, etc

This list could be much longer and there will 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.

VERMONT

**Department of Health**

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 flu[2]
- 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/fluvaxview/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

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[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 diagnosis[10]

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 though 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/2K9MHResults.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<br><br>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)<br><br>Not used for Commercial | Reporting (Commercial) | Voted 10-4 to move to Reporting (Commercial):<br><br>**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:<br>• Women age 21–64 who had cervical cytology performed every 3 years.<br>• 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<br><br>**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<br><br>**VDH is highly supportive of this recommendation** |
| Custom DLTSS Survey Questions (Composite) | New Measure | • 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:<br><br>Y: DAIL, DVHA, VDH, BiState, CHAC, BCBS, Home Health, GMCB, VPQ, Legal Aid, HCA |



**Green = Supportive** **Yellow = Concerned**

| 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<br><br>VDH COMMENTS |
|---|---|---|---|---|---|---|---|
| | | • If you ask for something, does your case manager/service coordinator help you get what you need?<br>• 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<br><br>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:<br><br>**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:<br><br>Y: DAIL, DVHA, VDH, BiState, CHAC, Home Health, GMCB, VPQ, Legal Aid, HCA<br><br>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:<br>• BMI percentile documentation.<br>• Counseling for nutrition.<br>• Counseling for physical activity. | Medical Records | No | Reporting | Payment | Voted 10-5 to move to payment:<br><br>**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:<br><br>**VDH is highly supportive of this recommendation** |



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## 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.<br><br>**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.<br><br>**VDH requests reconsideration;** |
| Influenza Immunization | Core-35 | Percentage of pati ents 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).<br><br>**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).<br><br>**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<br><br>**VDH is highly supportive of this recommendation and requests consideration** |
| 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<br><br>**VDH is highly supportive of this recommendation and requests consideration** |
| 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<br><br>**VDH is highly supportive of this recommendation and requests** |



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| 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<br>**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<br>**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-Manage-ment 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 |



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**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=Health*first*; 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 of 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

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

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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, Health*first*, 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

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 √MSSP (Medicare ACO), Vermont Commercial ACO, and Vermont Medicaid ACO

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

| MSSP | Measure Description | Data: Claims, Medical Record, or Survey? | Medicare ACO Use Year 2 2014 | Commercial ACO Use 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 | *(√R)* | *(√R)* |
| 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 *(√M&E)* | R *(√M&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.

***(√)*** 2015 changes **supported** by OneCareVermont, Health*first,* Northwestern Medical Center, Vermont Medical Society, BCBSVT

***(X)*** 2015 changes **opposed** by OneCareVermont, Health*first,* 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, Health*first,* Northwestern Medical Center, Vermont Medical Society, BCBSVT

***(X)*** 2015 changes **opposed** by OneCareVermont, Health*first,* 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, Health*first,* Northwestern Medical Center, Vermont Medical Society, BCBSVT

***(X)*** 2015 changes **opposed** by OneCareVermont, Health*first,* Northwestern Medical Center, Vermont Medical Society, BCBSVT

# Attachment 4a - VHCIP Revised Project Budget 9.5.14

# VHCIP Funding Allocation Plan

| | as of 8.7.14 | Contracts Executed (or committed by Core Team) | Implementation (March-Oct 2013) | Year 1 (10/1/13-12/31/14) | Year 2 (1/1/15-12/31/15) | Year 3 (1/1/16-12/31/16) | Year 4 (1/1/17-9/30/17) | Total grant period | Category Total | Agency | Approved Budget Narrative Category | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Type 1a** | Type 1A | | | | | | | | | | | |
| *Proposed type 1 without base work group or agency/dept support* | *Proposed Type 1 without base work group or agency/dept support (subject to Core Team approval)* | | | | | | | | | | | **Green indicates the money has been committed through hiring or contracts. Blue indicates the money has been approved for spending, but the contract is pending. Highlight indicates contract is pending at the Core Team.** |
| | Personnel, fringe, travel, equipment, supplies, other, overhead | | $ 119,615 | $ 2,835,875 | $ 3,299,871.00 | $ 3,368,455.00 | 621,361.00 | $ 10,245,177 | $10,245,177.00 | GMCB, AHS, AOA, DVHA, VDH | Personnel; Fringe; etc… | |
| | Project management | Total for this category | | | | | | | $ 630,000.00 | | | |
| | | Remainder available | | | | | | | 0 | | | |
| | | UMASS Commonwealth Med. | $ - | $ 230,000 | $ 200,000.00 | $ 200,000.00 | - | $ 630,000 | | AOA | Project Management | |
| | Evaluation | Total for this category | | | | | | | $ 2,000,000.00 | | | |
| | | Remainder available | | | $ 67,001.00 | $ 66,667.00 | 66,667.00 | $ 200,335 | $ 200,335.00 | GMCB | Evaluation | |
| | | RFP-Vendor selected pending CMMI approval | $ - | $ 194,558 | $ 583,675.14 | $ 583,675.00 | 437,756.36 | $ 1,799,665 | | GMCB | Evaluation | |
| | Outreach and Engagement | Total for this category | | | | | | | $ 300,000.00 | | | |
| | | Remainder available | | $ 15,000 | $ 135,000.00 | $ 150,000.00 | - | $ 300,000 | $ 300,000.00 | | Outreach and Engagement | |
| | | RFP pending | | | | | | | | DVHA | Outreach and Engagement | |
| | Interagency coordination | Total for this category | | | | | | | $ 320,000.00 | | | |
| | | Remainder available | | | $ 30,988.00 | $ 97,000.00 | 82,012.00 | $ 210,000 | $ 210,000.00 | AOA | Interagency Coordination | |
| | | Arrowhealth Health Analytics | | $ 40,000 | $ 70,000.00 | | | | | AOA | Interagency Coordination | |
| | Staff training and Change management | Total for this category | | | | | | | $ 55,000.00 | | | |
| | | Remainder available | | | $ 20,000.00 | $ 20,000.00 | | $ 40,000 | | DVHA | Staff Training and Change Management | |
| | | Coaching Center of Vermont | | $ 15,000 | | | | $ 15,000 | | DVHA | Staff Training and Change Management | |
| | Technology and Infrastructure | Total for this category | | | | | | | $ 1,177,846.00 | | | |
| | | Remainder available | | | | | | | 0 | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | VITL | | $ 431,500 | $ 400,000.00 | | | $ 831,500 | | DVHA | Expanded Connectivity to the HIE | there will be carryover here. Not sure of exact amount. 400k is estimate by GJM |
| | | VITL | | $ 346,346 | | | | $ 346,346 | | DVHA | Practice Transformation | there will be carryover here. Not sure of exact amount. 400k is estimate by GJM |
| | Grant program | Total for this category | | | | | | | $ 5,295,102.00 | | | |
| | | Remainder available | | $ 126,878 | $ 1,459,112.00 | $ 1,459,112.00 | - | $ 3,045,102 | $ 3,045,102.00 | | | |
| | | 7 Awardees | | $ 560,000 | $ 1,130,000.00 | $ 560,000.00 | - | $ 2,250,000 | | DVHA | TA to providers implementing payment reforms | |
| | Grant program- Technical Assistance | Total for this category | | | | | | | $ 500,000.00 | | | |
| | | Remainder available | | | | | | | 0 | | | |
| | | Policy Integrity | | $ 20,000 | $ 40,000.00 | $ 40,000.00 | - | $ 100,000 | | DVHA | TA to providers implementing payment reforms | |
| | | Wakely | | $ 20,000 | $ 40,000.00 | $ 40,000.00 | - | $ 100,000 | | DVHA | TA to providers implementing payment reforms | |
| | | Truven | | $ 20,000 | $ 40,000.00 | $ 40,000.00 | - | $ 100,000 | | DVHA | TA to providers implementing payment reforms | |
| | | VPQHC | | $ 20,000 | $ 40,000.00 | $ 40,000.00 | - | $ 100,000 | | DVHA | TA to providers implementing payment reforms | |
| | | Bailit | | $ 20,000 | $ 40,000.00 | $ 40,000.00 | - | $ 100,000 | | DVHA | TA to providers implementing payment reforms | |
| | Chart Review | Total for this category | | | | | | | $ 395,000.00 | | | |
| | | Remainder available | | | | | | | 0 | | | |
| | | Healthfirst | | $ 25,000 | $ 30,000.00 | $ - | - | $ 55,000 | | DVHA | Model Testing: Quality Measurement | |
| | | CHAC | | $ 95,000 | $ 100,000.00 | $ - | - | $ 195,000 | | DVHA | Model Testing: Quality Measurement | |
| | | OCV | | $ 30,000 | $ 120,000.00 | $ - | - | $ 150,000 | | DVHA | Model Testing: Quality Measurement | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ACO Proposal: Analytics | Total for this category | | | | | | | $ 3,135,000.00 | | | |
| | | Remainder available | | | | | | | 0 | | | |
| | | CHAC | | $ 177,800 | $ 355,600.00 | $ - | - | $ 533,400 | | DVHA | Advanced Analytics: 50%; TA Practice Transformation: 50% | |
| | | OCV | | $ 872,733 | $ 1,745,467.00 | $ - | - | $ 2,618,200 | | DVHA | Advanced Analytics: 50%; TA Practice Transformation: 50% | |
| | Advanced Analytics: Financial | Total for this category | | | | | | | $ 600,000.00 | DVHA | Advanced Analytics: Financial and Other Modeling | |
| | | Remainder available | | $ 20,000 | $ 100,000.00 | $ 280,000.00 | | $ 400,000 | $ 400,000.00 | DVHA | Advanced Analytics: Financial and Other Modeling | |
| | | Wakely Actuarial | | $ 30,000 | $ 150,000.00 | $ 20,000.00 | | $ 200,000 | | DVHA | Advanced Analytics: Financial and Other Modeling | Pending at Core Team 9.10.14 |
| | Advanced Analytics: Policy and modeling | Total for this category | | | | | | | $ 440,003.00 | DVHA | Advanced Analytics: Financial and Other Modeling | |
| | | Remainder available | | | $ 220,002.00 | $ 220,001.00 | | $ 440,003 | $ 440,003.00 | DVHA | Advanced Analytics | |
| | Subtotal | | | | | | | | $25,093,128.00 | | | |
| | | | | | | | | | | | | |
| **Type 1b** | Type 1 B | | | | | | | | | | | |
| *Proposed type 1 related to base work group support (subject to Core Team approval)* | Proposed Type 1 related to base work group support (subject to Core Team approval) | | | | | | | | | | | |
| | **Payment Models WG** | Total for this category | | | | | | | $ 800,000.00 | | Advanced Analytics | |
| | | Remainder Available | | | $ 137,500.00 | $ 137,500.00 | - | $ 275,000 | $ 275,000 | DVHA | Advanced Analytics | |
| | | Bailit | | $ 80,000 | $ 160,000.00 | $ 160,000.00 | - | $ 400,000 | | DVHA | Advanced Analytics | |
| | | Burns and Associates | | $ 125,000 | $ - | $ - | - | $ 125,000 | | DVHA | Advanced Analytics | |
| | | | | | | | | $ - | | | | |
| | **Quality Perf Measures WG** | Total for this category | | | | | | $ - | $ 400,000.00 | | | |
| | | Remainder Available | | | | | | | 0 | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Bailit | | $ 80,000 | $ 160,000.00 | $ 160,000.00 | - | $ 400,000 | | DVHA | Model Testing: Quality Measures | |
| | | | | | | | | | | | | |
| | HIT/HIE WG | Total for this category | | | | | | | $ 240,000.00 | DVHA | Advanced Analytics | |
| | | Remainder Available | | | $ 10,000.00 | $ 110,000.00 | - | $ 120,000 | $ 120,000.00 | DVHA | Advanced Analytics | |
| | | Stone Environmental | | $ 20,000 | $ 100,000.00 | | | $ 120,000 | | DVHA | Advanced Analytics | Pending at Core Team on 9.10.14 |
| | Population Health WG | Total for this category | | | | | | | $ 298,000.00 | DVHA | Advanced Analytics | |
| | | Remainder Available | | | $ 100,000.00 | $ 100,000.00 | | $ 200,000 | $ 200,000.00 | DVHA | | |
| | | Hester | | $ 21,000 | $ 7,000.00 | $ - | - | $ 28,000 | | DVHA | Advanced Analytics | |
| | | AHC RFP | | $ 5,000 | $ 65,000.00 | $ - | - | $ 70,000 | | DVHA | Advanced Analytics | |
| | | | | | | | | $ - | | | | |
| | Workforce | Total for this category | | | | | | | $ 86,000.00 | DVHA | Workforce: System-wide capacity | |
| | | Remainder Available | | $ - | $ 33,000.00 | $ 43,000.00 | - | $ 76,000 | $ 76,000.00 | DVHA | Workforce: System-wide capacity | |
| | | UVM | | $ 10,000 | | | | $ 10,000 | | DVHA | Workforce: System-wide capacity | Pending at Core Team on 9.10.14 |
| | | | | | | | | $ - | | | | |
| | Care Models | Total for this category | | | | | | | $ 150,000.00 | DVHA | Advanced Analytics | |
| | | Remainder Available | | | $ 100,000.00 | $ 50,000.00 | - | $ 150,000 | $ 150,000.00 | DVHA | Advanced Analytics | |
| | | | | | | | | $ - | | | | |
| | DLTSS | Total for this category | | | | | | | $ 680,000.00 | DVHA | Advanced Analytics | |
| | | Remainder Available | | | | $ 84,800.00 | | $ 84,800 | $ 84,800.00 | | Advanced Analytics | |
| | | Bailit | | $ 79,146 | $ 105,527.00 | $ 105,527.00 | - | $ 290,200 | | DVHA | Advanced Analytics | |
| | | PHPG | | $ 90,000 | $ - | $ - | - | $ 90,000 | | DVHA | Advanced Analytics | |
| | | WG Support RFP | | $ 53,750 | $ 161,250.00 | | - | $ 215,000 | | DVHA | Advanced Analytics | Pending at Core Team on 9.10.14 |
| | Sub Total | | | | | | | | $ 2,654,000.00 | | | |

# VHCIP Funding Allocation Plan

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Type 1c** | Type 1 C | | **Impl. Period** | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Grant Total** | | | | |
| *Proposed type 1 related to base agency/dept support* | Proposed Type 1 related to base agency/dept support | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | **GMCB** | Total for this category | | | | | | | **$ 2,575,000.00** | **GMCB** | **Advanced Analytics** | |
| | | Remainder Available | | | **$ 250,000.00** | **$ 125,000.00** | - | **$ 375,000** | $ 375,000.00 | **GMCB** | **Advanced Analytics** | |
| | | Lewin | | **$ 289,474** | **$ 694,737.00** | **$ 694,736.00** | **521,053.00** | **$ 2,200,000** | | **GMCB** | **Advanced Analytics** | |
| | **DVHA** | Total for this category | | | | | | | **$ 1,425,000.00** | **DVHA** | **Advanced Analytics** | MMIS modfications, dissemination of info to providers, analytics, tech support |
| | | Remainder Available | | $ - | **$ 676,090.00** | **$ 676,090.00** | - | **$ 1,352,180** | $ 1,352,180.00 | **DVHA** | **Advanced Analytics** | |
| | | PHPG-VBP | | **$ 28,910** | **$ 28,910.00** | **$ -** | **-** | **$ 57,820** | | **DVHA** | **Advanced Analytics** | |
| | | DLB | | **$ 15,000** | **$ -** | **$ -** | **-** | **$ 15,000** | | **DVHA** | **Advanced Analytics** | |
| | **Sub-Total** | | | | | | | | **$ 4,000,000.00** | | | |

| Type 2 | Type 2 | | Impl. Period | Year 1 | Year 2 | Year 3 | Year 4 | Grant Total | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total proposed type 2 (subject to staff planning, work group/steering committee review and Core Team approval) | Total proposed Type 2 (subject to staff planning, work group/steering committee review and Core Team approval) | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | **HIT/HIE** | Total for this category | | | | | | | **$ 10,211,947.00** | | | |
| | | Total Remainder Available | | | | | | **$ 4,526,031** | $ 4,526,031.00 | | | |
| | | VITL: ACO Gateway Population Health Proposal | | **$ 440,321** | **$ -** | $ - | - | **$ 440,321** | | **DVHA** | **T&I: Practice Transformation** | |
| | | VITL: ACO Gateway Population Health Proposal | | **$ 833,333** | **$ 833,333.00** | $ - | - | **$ 1,666,666** | | **DVHA** | **T&I: Expanded Connectivity btw SOV and ACOs/Providers** | |
| | | VITL: ACO Gateway Population Health Proposal | | **$ 346,346** | **$ 570,465.00** | **$ -** | - | **$ 916,811** | | **DVHA** | **T&I: Expanded Connectivity of HIE Infrastructure** | |
| | | *Subtotal: ACO Gateway Population Health Proposal* | | *$ 1,620,000* | *$ 1,403,798.00* | $ - | - | ***$ 3,023,798*** | | | | |
| | | VITL: ACTT Proposal | | **$ 30,308** | **$ 181,846.00** | **$ 141,537.00** | - | **$ 353,691** | | **DVHA** | **T&I: Practice Transformation** | |
| | | BHN: ACTT Proposal | | **$ 100,141** | **$ 235,538.00** | **$ 135,398.00** | - | **$ 471,077** | | **DVHA** | **T&I: Practice Transformation** | |
| | | ARIS: ACTT Proposal | | **$ 150,000** | **$ 125,000.00** | **$ -** | - | **$ 275,000** | | **DVHA** | **T&I: Expanded Connectivity of HIE Infrastructure** | |
| | | UTP-RFP: ACTT Proposal (Pending) | | $ 80,000 | **$ 80,000.00** | | | **$ 160,000** | | **DVHA** | **Technology and Infrastructure: Analysis of how to incorporate LTSS, MH/SA** | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Data Repository: ACTT Proposal (pending) | | | $ 346,139.00 | $ 346,139.00 | - | 692,278 | | DVHA | T&I: Enhancements or development of clinical registry and other centralized reporting systems. | |
| | | Stipends: ACTT Proposal (pending) | | $ 10,000 | $ 20,000.00 | | | $ 30,000 | | DVHA | Pending CMMI review. | |
| | | Bailit: ACTT Proposal | | $ 13,357 | $ 26,715.00 | $ - | - | $ 40,072 | | DVHA | Technology and Infrastructure: Analysis of how to incorporate LTSS, MH/SA | |
| | | HIS: ACTT Proposal | | $ 40,000 | $ 60,000.00 | $ 20,000.00 | - | $ 120,000 | | DVHA | T&I: Practice Transformation | |
| | | HIS: ACTT Proposal | | $ 20,000 | $ 100,000.00 | $ 80,000.00 | - | $ 200,000 | | DVHA | T&I: Expanded Connectivity of HIE Infrastructure | |
| | | HIS: ACTT Proposal | | $ 34,282 | $ 102,846.00 | $ 68,563.00 | | $ 205,691 | | DVHA | T&I: Enhancements or development of clinical registry and other centralized reporting systems. | |
| | | HIS: ACTT Proposal | | $ 20,718 | $ 62,155.00 | $ 41,436.00 | - | $ 124,309 | | DVHA | T&I: Expanded Connectivity btw SOV and ACOs/Providers | |
| | | *Subtotal: ACTT Proposal* | | | | | | *$ 2,662,118* | | | | |
| | | Remainder Available: Analysis of how to incorporate LTSS, MH/SA | | | $ 49,964.00 | $ 49,964.00 | - | $ 99,928 | | | Technology and Infrastructure: Analysis of how to incorporate LTSS, MH/SA | |
| | | | | | | | | | | | | |
| | | Remainder Available: Practice Transformation | | | $ 50,533.00 | $ 50,532.00 | - | $ 101,065 | | | T&I: Practice Transformation | |
| | | | | | | | | | | | | |
| | | Total for this category: Telemedicine | | | $ 625,000.00 | $ 625,000.00 | - | $ 1,250,000.00 | | | T&I: Telemedicine | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Telehealth Planning RFP | | | $ 120,000.00 | | | $ 120,000 | | | T&I: Telemedicine | Pending at Core Team 9.10.14 |
| | | Remainder Available: Telehealth | | | 505,000.00 | 625,000.00 | | 1,130,000.00 | | | T&I: Telemedicine | |
| | | | | | | | | | | | | |
| | | Remainder Available: Expanded connectivity of HIE infrastructure | | | $ 788,345.00 | $ 788,344.00 | - | $ 1,576,689.00 | | | T&I: Expanded Connectivity of HIE Infrastructure | |
| | | | | | | | | | | | | |
| | | Remainder Available: Integrated platform and reporting system | | | $ 500,000.00 | $ 500,000.00 | - | $ 1,000,000.00 | | | T&I: Integrated Platform and Reporting System | |
| | | | | | | | | | | | | |
| | | Remander Available: Expanded connectivity between SOV data sources and ACOs/providers | | | $ 98,159.00 | $ 98,159.00 | - | $ 196,318 | | | T&I: Expanded Connectivity btw SOV and ACOs/Providers | |
| | | | | | | | | | | | | |
| | | Remainder Available: Enhancements or development of clinical registry and other centralized reporting systems. | | | $ 151,016.00 | $ 151,016.00 | - | $ 302,031 | | | T&I: Enhancements or development of clinical registry and other centralized reporting systems. | |
| | | | | | | | | $ - | | | | |
| | **Workforce** | Total for this category | | | | | | | $ 644,999.00 | | Workforce Assessment: System-wide capacity | |
| | | Total Remainder Available | | | | $ 294,999.00 | | $ 294,999 | $ 294,999.00 | | Workforce Assessment: System-wide capacity | |
| | | Remainder Available: System-wide analysis | | $ - | | $ 294,999.00 | - | $ 294,999 | | DVHA | Workforce Assessment: System-wide capacity | |
| | | System-wide analysis | | | $ 350,000.00 | 0 | | $ 350,000.00 | | DVHA | Workforce Assessment: System-wide capacity | |
| | | | | | | | | | | | | |
| | **CMCM** | Total for this category | | | | | | | $ 2,200,000.00 | | | |
| | | Total Remainder Available | | | $ 810,000.00 | $ 1,040,000.00 | - | $ 1,850,000 | $ 1,850,000.00 | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Remainder Available: Service delivery for LTSS, MH, SA, Children | | | $ 700,000.00 | $ 700,000.00 | | **$ 1,400,000** | | **DVHA** | **Model Testing: Service Delivery to support engancement and maintenance of best practice as payment models evolve** | **Coordinate with DLTSS** |
| | | Remainder Available: Learning Collaboratives | | | $ 35,000.00 | $ 265,000.00 | | **$ 300,000** | | **DVHA** | **TA: Learning Collaboratives** | |
| | | Learning Collaboratives RFP | | $ 60,000 | $ 290,000.00 | | | **$ 350,000** | | **DVHA** | **TA: Learning Collaboratives** | |
| | | Remainder Available: Integration of MH/SA | | $ - | $ 75,000.00 | $ 75,000.00 | | **$ 150,000** | | **DVHA** | **Model Testing: integration of MH/SA** | **Coordinate with DLTSS** |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | **QPM** | Total for this category | | | | | | | $ 205,000.00 | **DVHA** | **Model Testing: Quality Measures** | |
| | | Total Remainder Available | | | $ 14,541.00 | $ 14,541.00 | | **$ 29,082** | $ 29,082.00 | **DVHA** | | |
| | | Datastat (Patient Exp Survey) | | **$ 58,639** | **$ 58,639.00** | **$ 58,639.00** | **-** | **$ 175,918** | | **DVHA** | **Model Testing: Quality Measures** | |
| | **Sub-Total** | | | | | | | **$ 13,261,946** | | | | |
| | | | | | | | | | | | | |

**VHCIP Funding Allocation Plan**

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| **Type 1a** | $ 25,093,128 | | | | | | | | | | | |
| **Type 1b** | $ 2,654,000 | | | | | | | | | | | |
| **Type 1c** | $ 4,000,000 | | | | | | | | | | | |
| **Type 2** | $ 13,261,946 | | | | | | | | | | | |
| **Unallocated** | $ - | | | | | | | | | | | |
| **Grant Total** | $ 45,009,074 | | | | | | | | | | | |
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# Attachment 4b - Financial Memo

109 State Street
Montpelier, VT 05609

To: Core Team
Fr: Georgia Maheras
Date: 9/5/14
Re: Request for Approval of SIM Funding Actions

I am requesting Core Team approval for six SIM funding actions:

1. Proposal to execute a contract with Wakely Actuarial Consulting to provide actuarial services related to the SIM Grant. Cost: $200,000. Duration: November 1, 2014-December 31, 2016.
2. Proposal to execute a contract with Stone Environmental to provide a health data information inventory. Cost: $120,000. Duration: November 1, 2014-June 30, 2015.
3. Proposal to execute a contract with UVM to provide conference support services. Cost: $10,000. Duration: October 1, 2014-November 30, 2014.
4. Proposal to release an RFP for DLTSS Work Group Support. Cost: $215,000. Duration: October 15, 2014-October 14, 2015.
5. Proposal to release an RFP for the HIE/HIT Work Group related to Telehealth Planning. Cost: $120,000. Duration: January 1, 2015-June 30, 2016.
6. Proposal to release an RFP for the Workforce Work Group related to Micro-Simulation Demand Modeling: $250,000-$350,000.

***REQUEST #1- Type 1 a Proposal to fund actuarial services for an amount not to exceed 200,000:***

I propose that we use Financial Analytic funds to support a contract with Wakely Consulting. These funds would be used for the remainder of the project and the estimated cost is $200,000.

**Proposal Summary:**

1. Actuarial Support to VHCIP for development of forms required by CMMI as part of the reporting process for the State Innovation Models Testing Grant.

The State of Vermont is required to provide CMMI with actuarially supported documents as part of its State Innovation Models Testing (SIM) Grant. These forms include templates provided by CMMI and certified by actuaries that indicate the potential savings of Vermont's SIM Grant. The Contractor will complete these forms on behalf of the State of Vermont and provide actuarial memos describing the methodology used to complete them. The Contractor will only perform this activity if requested by the State of Vermont and will provide the documents by the federal deadline.

2. Ad Hoc Actuarial Support to VHCIP for the development of payment models and other analyses.

**Relationship to VHCIP goals:**
This work aligns with the VHCIP goals by allowing us to report appropriately to CMMI as required. It also provides VHCIP with the ability to do ad hoc financial modeling as necessary for the design of our payment models.

***Recommendation:*** Authorize executing a contract with Wakely Consulting for actuarial support. The total project cost is an amount not to exceed $200,000. The term is November 1, 2014-December 31, 2015.

***REQUEST #2- Type 1c Proposal to execute a contract with Stone Environmental to provide a health data information inventory. Cost: $120,000. Duration: November 1, 2014-June 30, 2015.***

This is a request to execute a new sole source contract with Stone Environmental. The contract would be for $120,000 for a term of eight months. This would be funded by the HIE/HIT Work Group Support line item within the VHCIP budget.

**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.

**Relationship to VHCIP/HIE/HIT Work Group 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

**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.
- 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.

***Recommendation:*** Execute a sole source contract with Stone Environmental to perform a health data information inventory and website. The total project cost is: $120,000. The term is November 1, 2014-June 30, 2015.

***Request #3: Type 1c Proposal to execute a contract with UVM to provide conference support services. Cost: $10,000. Duration: October 1, 2014-November 30, 2014.***

This is a request to execute a new sole source contract with UVM to provide conference support services. The contract would be for $10,000 for a term of eight weeks. This would be funded by the Workforce Work Group Support line item within the VHCIP budget.

**Scope of Work:**

The contractor will provide conference support services for the Workforce Symposium scheduled for November 10, 2014. The contractor will provide the following activities:

1. Preparation and distribution of publicity. Design and distribution of marketing pieces; publicity in Journals, Meeting lists, Internet marketing, as applicable.
2. Registration of participants, including handling of all inquiries, website on-line registrations, confirmation, and all correspondence regarding directions and instructions.
3. Preparation of materials for participants including: syllabus, folders, name-tags, evaluations, certificates, and other enclosures as needed.
4. Financial management, including deposit of registration fees, payment of billing for conference food, and profit/loss statement following conclusion of program.
5. On site meeting management for the duration of the conference.
6. Complete conference wrap-up, including tabulating evaluations, speaker and supporter thank you letters, financial payments and statements as above.

**Relationship to VHCIP/Workforce Work Group Goals:**
This contract is intended to provide support for the work group's fall symposium. The conference will charge a registration fee to, in part, pay for the conference food as that cannot be reimbursed by SIM. UVM will collect that registration fee for the State. Additionally, UVM will develop marketing materials and disseminate invitations for the symposium and provide name tags and other day-of conference materials.

**Sole Source Justification:**
The University of Vermont currently performs this work for the Blueprint for Health and numerous entities across the state. They are experienced in conference management and have the ability to quickly develop online registration tools and process the symposium registrations.

***Recommendation:*** Execute a sole source contract with UVM to provide conference support services for an amount not to exceed $10,000. The term is October 1, 2014-November 30, 2014.

***Request #4: Proposal to release an RFP for DLTSS Work Group Support. Cost: $215,000. Duration: October 15, 2014-October 14, 2015.***

This is a request to release an RFP for DLTSS Work Group Support. The contract would be for an amount not to exceed $215,000 for a term of 12 months. This would be funded by the DLTSS Work Group Support line item within the VHCIP budget.

**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.
- 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.

**Relationship to VHCIP/DLTSS Work Group Goals:**

This contract will support the DLTSS Work Group in supporting its 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.

***Recommendation:*** Release an RFP for DLTSS Work Group Support for an amount not to exceed $215,000. The term is October 15, 2014-October 14, 2015.

***Request #5: Proposal to release an RFP for the HIE/HIT Work Group related to Telehealth Planning. Cost: $120,000. Duration: January 1, 2015-June 30, 2016.***

This is a request to release an RFP for Telehealth Planning. The contract would be for an amount not to exceed $120,000 for a term of up to 18 months. This would be funded by the Technology and Infrastructure: Telemedicine line item within the VHCIP budget.

**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.
- 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.

**Relationship to VHCIP/HIE/HIT Work Group Goals:**
This contract will support the HIE/HIT Work Group developing a telehealth pilot program as required by approved SIM Grant. 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.

***Recommendation:*** Release an RFP for telehealth planning for an amount not to exceed $120,000. The term is January 1, 2015-June 30, 2016.

***Request #6: Proposal to release an RFP for the Workforce Work Group related to Micro-Simulation Demand Modeling: $250,000-$350,000.***

This is a request to release an RFP for Micro-Simulation Demand Modeling. The contract would be for an amount not to exceed $350,000 for a term of up to 12 months. This would be funded by the Workforce: System-wide Analysis line item within the VHCIP budget.

**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.

- 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.

**Relationship to VHCIP/Workforce Work Group Goals:**
This contract will support the Workforce Work Group in developing recommendations around workforce strategic planning. 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.

***Recommendation:*** Release an RFP for micro-simulation workforce demand modeling for an amount not to exceed $350,000 for a 12-month term.