VHCIP Core Team Agenda 9.29.14

VT Health Care Innovation Project
Core Team Meeting Agenda

September 29, 2014 10:00-12:00 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: September 10, 2014 meeting minutes. Decision needed.
Policy Update				
3	10:15-10:40	Quality and Performance Measures *Public Comment*	QPM Staff and Co-Chairs	*To be distributed later.* This will be a discussion only. No decisions needed.
Core Team Processes and Procedures				
4	10:40-11:50	Executive Session: Sub-Grant Program *Public Comment*	Georgia Maheras	

5	11:50-11:55	*Public Comment*	Anya Rader Wallack	
6	11:55-12:00	Next Steps, Wrap-Up and Future Meeting Schedule: 9/29: 10:00-12:00 Montpelier	Anya Rader Wallack	

Attachment 2 - Core Team Minutes 9.10.14

VT Health Care Innovation Project
Core Team Meeting Minutes

Date of meeting: September 10, 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, GMCB; Mark Larson, DVHA; Harry Chen, AHS; Steve Voigt.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's report	Anya Wallack called the meeting to order at 10:02 am and reminded Core Team members that the Grant Program applications were due on 9/12. She also invited the Core Team members to a VHCIP event on November 4th to review year one and kick-off year two of the project.	
2. Approval of Minutes	Paul moved to approve the August 13th minutes. This was seconded by Steve. All approved with one abstention (Harry Chen). Mark Larson was not present.	
3. Policy Update	Pat Jones and Alicia Cooper reviewed the recommended year two Shared Savings Program measure set (attachments a-d). Pat and Alicia confirmed that this is for calendar year 2015 and that we will have reports about calendar year 2014 in the summer/fall of 2015. Pat noted that the work group process was respectful and that this was an area where it was not possible for the work group to get consensus on all of the measures. The Core Team clarified that the Avoidable ED Visit measure is based on an algorithm that has not been updated in over 10 years. The Core Team also confirmed that CMS has recommended to Medicaid that they use more outcome measures for the Medicaid program for future years. Pat reminded the Core Team that in addition to this measure set being used for reporting and payment of shared savings, the providers will use the data for quality improvement initiatives. Alicia summarized the comments received by the Steering Committee about the proposed measure set. Anya indicated that the Core Team will be soliciting additional public comment on this measure set and that people should provide comments to Pat Jones and Alicia Cooper	

Agenda Item	Discussion	Next Steps
	(pat.jones@state.vt.us and Alicia.cooper@state.vt.us) by September 23rd. If an organization or individual has already provided comment, they do not need to resubmit their comments to the Core Team. Several individuals provided public comment: *Paul Harrington:* Provided comment on the avoidable ED visit measure. The algorithm is based on ICD-9 and ICD-10 will go into effect partway 2015 and it does not appear as if the creators of that algorithm will update it to accommodate this change. *Dale Hackett:* asked about coding errors. Paul replied that there is variation in coding practice so not actually errors. Kara added that this is related to the payment system where the data is entered and that the measure algorithms account for the level of accuracy within data entry systems. *Allan Ramsay:* Noted that the avoidable ED visit measure was never intended to be a triage tool or measure appropriateness of ED use. The Core Team engaged in some discussion about the accountability for both payment and reporting measures.	
4. Core Team Processes and Procedures	Sub-Grant Program Update: Georgia provided the Core Team with draft guidance for use in their scoring of sub-grant proposals (attachment 4). Georgia also offered to speak with any Core Team member about potential conflict of interest related to these applications.	
5. Spending Recommendations and Decisions	Georgia reviewed the financial request memo (attachment 5b) and the updated funding allocation chart (attachment 5a). The Core Team reviewed each of the proposals individually. a. Wakely Actuarial: $200,000 Steve moved to approve and Paul seconded the motion, all approved. b. Stone Environmental: $120,000	

Agenda Item	Discussion	Next Steps
	The Core Team raised several questions about this proposal and asked for additional information regarding the primary purpose of the information collected and the sustainability of the website. This item is tabled pending receipt of additional information. c. UVM: Workforce Symposium: $10,000 Paul moved to approve and Steve seconded the motion, all approved. d. DLTSS RFP: Work Group Support: $215,000 Susan moved to approve and Al seconded the motion, all approved. e. HIE/HIT Work Group: Telehealth Planning: $120,000 Paul moved to approve and Robin seconded the motion, all approved. f. Workforce Work Group: Micro-Simulation Demand Modeling: $250,000-$350,000 Al moved to approve and Susan seconded the motion, all approved.	
5. Public Comment	N/A	
6. Next Steps, Wrap up	**Next meeting:** September 29, 2014, 10:00-12:00pm, DFR 3rd Floor Conference Room, 89 Main St, Montpelier.	

VHCIP Core Team Attendance 9-10-14

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

✓ on phone

First Name	Last Name		Title	Organization	Core Team
Ena	Backus			GMCB	X
Susan	Barrett		Executive Director	GMCB	X
Anna	Bassford			GMCB	A
Paul	Bengston		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		Financial Manager II	AHS - Central Office	X
Paul	Dupre		Commissioner	AHS - DMH	X
Erin	Flynn		Health Policy Analyst	AHS - DVHA	X
Lucie	Garand		Senior Government Relations Special	Downs Rachlin Martin PLLC	X
Christine	Geiler		Grant Manager & Stakeholder Coordi	GMCB	S
Al	Gobeille		Chair	GMCB	M
Sarah	Gregorek			AHS - DVHA	A
Thomas	Hall			Consumer Representative	X
Bryan	Hallett				X
Carrie	Hathaway		Financial Director III	AHS - DVHA	X
Kate	Jones			AHS - DVHA	S
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	✓	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
Mike	Maslack				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	KS	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			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 Hea	AHS - DAIL	X
Cecelia	Wu		Healthcare Project Director	AHS - DVHA	X
PAUL	HARRINGTON	PLH	EVP	VMS	
ALLAN	RAMSAY			GMCB	
Sharon	Winn		Dir Public Policy	Bi - State	
Lila	Richardson	~~HCA Legal Intern~~		HCA / VT legal Aid	
Gisele	Carbonneau	H F			

Amy Cooper Healthfirst

	D-ch		advocate		

VHCIP Core Team Roll Calls 9-10-14

C	Chair
M	Member

Postponed action

First Name	Last Name	minutes	weekly	Stone	uum	DLTSS	HIE: telemed	Title	workforce RFP	Organization	Core Team
Paul	Bengston ✓	✓	✓		✓	✓	✓	CEO	✓	Northeastern Vermont Regional Hospital	M
Harry	Chen phone	A	✓		✓	✓	✓	Commissioner	✓	AHS - VDH	M
Al	Gobeille ✓	✓	✓		✓	✓	✓	Chair	✓	GMCB	M
Mark	Larson arr. at 10^{18}	=	✓		✓	✓	✓	Commissioner	✓	AHS - DVHA	M
Robin	Lunge ✓	✓	✓		✓	✓	✓	Director of Health Care Reform	✓	AOA	M
Steve	Voigt ✓	✓	✓		✓	✓	✓		✓		M
Anya	Wallack ✓	✓	✓		✓	✓	✓	Chair	✓	SIM Core Team Chair	C
Susan	Wehry ✓	✓	✓		✓	✓	✓	Commissioner	✓	AHS - DAIL	M

Minutes: 1° Paul
2° Steve

Stone: 1° VN
2°

DLTSS: 1° Susan
2° Al

Wkforce: 1° Al
2° Susan

Weekly: 1° Steve
2° Paul

UUM: 1° Paul
2° Steve

Telemed: 1° Paul
2° Robin

Attachment 3a - 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 VHCIP Steering Committee and Core Team, as of 9-26-14

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

Proposed Measure Name	VT Measure ID	Measure Description	Source of Data	Medicare SSP? (Y2 Use)	VT Year 1 Use	QPM Work Group Year 2 Recommend.	QPM Work Group Vote	Summary of Comments to Steering Committee and Core Team
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: • Women age 21–64 who had cervical cytology performed every 3 years. • Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	Medical Records	No	Pending	Reporting	Move to Reporting: unanimous vote	Legal Aid, HCA, HF, VDH, VMS, DVHA, CHAC, OCV, NMC expressed support for move to Reporting.
Tobacco Use: Screening & Cessation Intervention	Core-36	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.	Medical Records	Yes (P)	Pending	Reporting	Move to Reporting: unanimous vote	Legal Aid, HCA, HF, VDH, VMS, DVHA, CHAC, OCV, NMC expressed support for move to Reporting.
Custom DLTSS Survey Questions (Composite)	New Measure	• In the last 12 months, how often did the provider seem informed and up-to-date about any care you got from other service and support providers (if applicable), such as home health agencies, area agencies on aging, developmental or mental health service agencies, substance abuse providers, vocational rehabilitation, etc.? • If you ask for something, does your case manager/service coordinator help you get what you need? • In the last 12 months, how often did the specialist you saw seem informed and up-to-date about any care you got from other service and support providers (if applicable), such as home health agencies, area agencies on aging, developmental or mental health service agencies, substance abuse providers, vocational rehabilitation, etc.?	Existing Survey	No	Not in Year 1 Measure Set	Reporting	Voted 11-3 to add to survey as Reporting: Y: DAIL, DVHA, VDH, BiState, CHAC, BCBS, Home Health, GMCB, VPQ, Legal Aid, HCA N: OCV, NMC, VMS A: HF	Legal Aid, HCA, CHAC, DVHA expressed support to add to Reporting; HF, VMS, OCV, NMC, VAHHS, 8 Hospital Chief Medical Officers expressed opposition to add to Reporting.
Avoidable ED Visits	M&E-14	Percentage of ED visits that were potentially avoidable. ED Visits are classified as non-emergent; emergent/primary care treatable; emergent – ED care needed – preventable/avoidable; emergent - ED care needed	Claims	No	M & E	Reporting	Voted 9-6 to move to Reporting: Y: HF, DAIL, DVHA, VDH, Home Health, GMCB, VPQ, Legal Aid, HCA	Legal Aid, HCA, VDH, DVHA expressed support for move to Reporting; VMS, OCV, NMC, VAHHS, 8 Hospital Chief Medical Officers expressed

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 and Core Team
		- 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	opposition for move to Reporting.
Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite	Core-12	Prevention Quality Indicator (PQI) composite of chronic conditions per 100,000 population ages 18 and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.	Claims	No	Reporting	Payment	Voted 10-5 to move to Payment: Y: DAIL, DVHA, VDH, BiState, CHAC, Home Health, GMCB, VPQ, Legal Aid, HCA N: HF, BCBS, NMC, OCV, VMS	Legal Aid, HCA, DVHA expressed support for move to Payment; HF, VMS, OCV, NMC, VAHHS, 8 Hospital Chief Medical Officers 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: • BMI percentile documentation. • Counseling for nutrition. • Counseling for physical activity.	Medical Records	No	Reporting	Payment	Voted 10-5 to move to payment: Y: DAIL, DVHA, VDH, BiState, CHAC, Home Health, GMCB, VPQ, Legal Aid, HCA N: HF, BCBS, NMC, VMS, OCV	Legal Aid, HCA, DVHA, CHAC, DCF, VDH expressed support for move to Payment; HF, VMS, OCV, NMC, VAHHS, 8 Hospital Chief Medical Officers expressed opposition for move to Payment (support keeping as Reporting).
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	Core-17	The percentage of attributed individuals 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control (>9.0%).	Medical Records	Yes (P)	Reporting	Payment	Voted 10-5 to move to payment: Y: DAIL, DVHA, VDH, BiState, CHAC, Home Health, GMCB, VPQ, Legal Aid, HCA N: HF, BCBS, NMC, VMS, OCV	Legal Aid, HCA, DVHA, CHAC, DCF, VDH expressed support for move to Payment; HF, VMS, OCV, NMC, VAHHS, 8 Hospital Chief Medical Officers 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. **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. Y: HF, DAIL, BiState, BCBS, Home Health, NMC, OCV, VMS, VPQ 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). Y: DAIL, VDH, CHAC (reversed post-vote), GMCB, VPQ, Legal Aid, HCA 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). Y: VDH; Legal Aid 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; VAHHS=Vermont Association of Hospitals and Health Systems; 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 3b - Year Two Measures Comment 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: - *Pediatric Weight Assessment and Counseling* as a Payment measure - *Developmental Screening in the First Three Years of Life* as a Reporting measure (commercial) - *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: - Prefers that *Breast Cancer Screening* remains a Reporting measure - 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: - Increased cost and administrative burden on providers and ACOs, potentially detracting from clinical care provision - Delayed Year 1 implementation resulted in delayed development of initiatives focusing on Year 1 measures Requests postponement of consideration of new measures until Year 3.

Summary of Written Feedback on Proposed Year 2 Measures by Commenter

Anonymous	Expresses concerns about the feasibility of collecting certain Medicaid measures, and limited availability of well-known goals.
Northwestern Medical Center	Expresses support for some measures as proposed by the QPM work group, and opposition to others, citing the following concerns: - Very few of the proposed measures exhibit all of the merits prioritized in the QPM work group's measure selection criteria - New measures should not be added for Year 2 without an understanding of Year 1 performance - Use of non-claims-based measures results in significant financial and administrative burden - The addition of new measures in Year 2 will dilute more targeted performance improvement efforts
OneCare Vermont	Expresses support for some measures as proposed by the QPM work group, and opposition to others, with the following specific requests: - Avoid moving any measures to Payment in Year 2, given the delay in Year 1 program implementation - Minimize the number of measures requiring manual abstraction 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: - dollars or % of total budget spent on providing transportation to patients - % of foods sourced locally, organically, fair trade - donations made to local organizations that assist with housing security, food security, addiction, criminal rehabilitation, etc. - direct services offered to assist with housing security, food security, addiction, criminal rehabilitation, etc.
Vermont Council of Developmental and Mental Health Services	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:

Summary of Written Feedback on Proposed Year 2 Measures by Commenter

	- AUDIT and DAST - NIDA Adult - PHQ-2 - PHQ-9 - 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: - *Prenatal & Postpartum Care* - *Influenza Immunization* - *Screening for High Blood Pressure with Follow up Plan Documented* - *Controlling Blood Pressure* - *Optimal Diabetes Care* - *Adult Weight Screening and Follow-Up* - *Screening for Clinical Depression and Follow-Up* - *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: - Limited scope of the measure set, in that populations included in the Medicaid and commercial shared savings programs do not have adequate quality measure coverage (e.g. pediatric, maternity, and DLTSS populations) - Limited promotion of Pending measures, impacting the ability of such measures to be considered for Payment before the end of the pilot program - Restricting the scoring of measures against selection criteria to those that were recommended for Year 2 reconsideration, rather than evaluating all program measures - Giving all criteria equal weight in the scoring methodology Requests additional consideration of the following measures: - *Prenatal & Postpartum Care* - *Influenza Immunization* - *Adult Weight Screening and Follow-Up*

Summary of Written Feedback on Proposed Year 2 Measures by Commenter

	- *Care Transition Record Transmitted to Health Care Professional* - *Transition Record with Specified Elements Received by Discharged Patients* Further notes that: A) Consumers are underrepresented in all levels of the Vermont Health Care Innovation Project (VHCIP), whereas providers are strongly represented; B) Quality measures are important not only for informing quality improvement initiatives, but also for monitoring overall quality of care; and C) ACO quality measures are intended to assess quality of care throughout the health care system, not just at the hospital level.
Vermont Medical Society	Expresses support for some measures as proposed by the QPM work group, and opposition to others, citing the following concerns: - Insufficient alignment between the Commercial/Medicaid SSPs and the Medicare SSP (for both Year 1 and proposed Year 2) measure sets - Increasing the number of measures used would increase financial and administrative burden on providers - No measures should be newly used for Payment in Year 2 without baseline Year 1 data available Adds additional information in opposition of the use of 'Avoidable ED Visits' as a Reporting measure, and reiterates importance of clinicians' input in the design of payment reform initiatives.
Jennifer Fels, Southwestern Vermont Health Care	Recommends that measures be standardized across CMS measures and the Vermont Blueprint for Health and incorporate NCQA Medical Home certification requirements, and that measure capture should be automated from electronic medical records to the extent possible.
Chief Medical Officers of 8 Vermont Hospitals	Express support for the recommendations made by the Vermont Medical Society and OneCare Vermont, citing concerns about additional administrative burden early on during pilot implementation.
Vermont Association of Hospitals and Health Systems	Express support for the recommendations made by the Vermont Medical Society and OneCare Vermont.

Summary of Written Feedback on Proposed Year 2 Measures by Commenter

Bi-State Primary Care Association	Measurement can be a burden, but consumers have a right to know whether care meets standards and achieves the best outcomes possible. Measures should provide information that's meaningful to consumers, policy makers, or providers. Bi-State's members aren't concerned that a broad scope of measures will cause providers to be spread too thin as they engage in improving results that don't meet targets. The delivery system should prioritize the improvement initiatives that are most needed, likely to be most effective, and based on solid data. Some measures' data sources are still incomplete and unreliable. Full transparency is the shortest path to identifying and sharing best practices, targeting administrative resources to the areas of greatest need or efficiency, keeping a spotlight on trouble spots, and revealing areas for data collection improvement. We need to streamline data capture (e.g., by maximizing data captured via claims) and eliminate wasteful duplication in chart extraction (e.g., payers, ACOs, others).

Attachment 3c - Year Two Measures Comments

VERMONT MEDICAL SOCIETY

VHCIP Core Team
Pat Jones, Green Mountain Care Board
Alicia Cooper, Department of Vermont Health Access

September 23, 2014

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

Dear Ms. Jones and Ms. Cooper,

On behalf of the physician members of the Vermont Medical Society, please provide the VHCIP Core Team with these comments regarding the VHCIP Quality Measurement and Performance workgroup's Year 2 Medicaid and Commercial ACO recommendations.

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, 7 are being used by the BCBSVT and 8 are being used by Medicaid to 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 top of the 33 Medicare measures, create a total of 53 ACO accountability measures. Physicians are accountable for all of the relevant 53 measures on behalf of their patients.

The VHCIP Quality Measurement and Performance workgroup's Year 2 Medicaid and Commercial ACO recommendations 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).

The VMS believes that a number of the VHCIP Quality Measurement and Performance workgroup's Year 2 Medicaid and Commercial ACO recommendations would add significantly to 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 voting together on the recommended 2015 ACO reporting and payment measures - as outlined below and as shown in the attached table.

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In order that system improvement can accelerate while also considering the administrative work associated with data collection and data analytics, the VMS makes the following Year 2 quality measurement recommendations:

VMS opposes adding the three new Proposed Payment Measures. ACOs will not receive their final 2014 quality measures report used to distribute savings until August 31, 2015. However, the workgroup's recommendation would mandate that ACOs operate under three new additional payments measures beginning on January 1, 2015 - eight months before they receive their 2014 data.

The lack of the final 2014 quality measures report before implementing the three additional payment measures, will make it impossible to analyze 2014 performance and begin focusing on areas of benchmarked quality improvement. VMS opposes adding the following three new Proposed Payment Measures:

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). The results generated by this algorithm merely represent the percentages of visits that *may* have been avoidable based on claims sets of statistically relevant sizes. Since this algorithm does not decide if an individual Emergency Department 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.

The designers of the algorithm make it clear that it was never intended to determine whether ED use in a specific case is appropriate: "It is important to recognize that the algorithm is not intended as a triage tool or a mechanism to determine whether ED use in a specific case is "appropriate" (e.g., for reimbursement purposes)."[1]

In addition, since the algorithm was designed to use ICD 9, it will be out-of-date on October 1, 2015, when the use of ICD 10 will be mandated by CMS. ICD-10 includes about 68,000 diagnosis codes compared to ICD-9's 13,000.

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[1] http://wagner.nyu.edu/faculty/billings/nyued-background

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.

In its August 11, 2014 letter to the VHCIP Steering Committee, OneCareVermont indicated that it had actively sought input from provider communities on the proposed measure changes in year two (2015) for the Medicaid and Commercial SSP programs.

They met with clinical leaders at the Vermont Child Health Improvement Program (VCHIP) and the American Academy of Pediatrics Vermont Chapter (AAP-VT). They then brought forward the collective input from these providers to OneCare Vermont's 54-member Clinical Advisory Board (CAB), which unanimously endorsed the recommendations as provided to the VCHIP co-chairs and committee members.

In its August 18, 2014 letter to the VHCIP Steering Committee, the ACO Governance board of Health*first*, on behalf of the two ACO programs that they 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.

Over the past several years of Vermont's health care reform efforts, state officials at all levels have frequently cited the importance of clinicians' input in the design of payment reform initiatives and that the future success of payment reform is dependent on the support of those providing direct patient care to Vermonters.

On behalf of the VMS, I respectfully ask the VHCIP Core Team to support the shared recommendations of the VMS, OneCareVermont, Health*First* and Northwestern Medical Center on the Year 2 Measure Changes for Vermont Accountable Care Organizations.

Please let me know if you have any questions or if I can be of further assistance.

Sincerely,

Paul Harrington
Executive Vice President, Vermont Medical Society

cc: VMS Council

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

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September 23, 2014

Anya Rader Wallack
Chair, Core Team
Vermont Health Care Innovation Project

Re: Year 2 Quality Measure Recommendations for Vermont's ACO Shared Savings Programs

Dear Anya,

Thank you for the opportunity to comment on the Quality and Performance Measures (QPM) Work Group's Year 2 Quality Measure Recommendations for Vermont's Accountable Care Organization (ACO) Shared Savings Programs. Vermont Legal Aid and the Office of the Health Care Advocate are actively involved in the QPM work group. We respect the work group's intensive process and strongly recommend that the Core Team accept its recommended changes to the ACO measure sets. We appreciate the Core Team's willingness to consider comments previously submitted to the Steering Committee. Our comments to the Steering Committee, dated August 20, 2014, are attached.

In addition to our previous comments, we would like to emphasize three points: A) Consumers are underrepresented in all levels of the Vermont Health Care Innovation Project (VHCIP), whereas providers are strongly represented; B) Quality measures are important not only for informing quality improvement initiatives, but also for monitoring overall quality of care; and C) ACO quality measures are intended to assess quality of care throughout the health care system, not just at the hospital level.

A) Providers are strongly represented at all levels of the VHCIP, whereas consumers are underrepresented.

Providers are represented at all levels of the VHCIP. The Core Team, which was originally described as including only state agency representatives, was expanded to include a provider and a member of the business community but no consumers or consumer advocates. The QPM work group includes only two consumer advocates and no consumer members. Multiple provider organizations were represented in the votes on measure recommendations, including ACOs, Federally Qualified Health Centers, hospitals, and the Vermont Medical Society. The measures recommended for the Payment and Reporting Measure sets were supported by providers, payers, and other stakeholders, as well as by consumer advocates. While we understand it is difficult for some providers to attend VHCIP meetings, many providers do actively participate. There are many barriers to consumer participation including employment, need for child, elder, or dependent care, lack of transportation, and the complex nature of many of the materials.

B) Quality measures are important for monitoring overall quality of care as well as for informing quality improvement initiatives.

We understand that quality improvement initiatives are often difficult to implement, and that providers prefer to focus their improvement efforts on a small number of initiatives. However, a comprehensive set of ACO quality measures is essential in order to monitor the overall quality of care provided by ACOs. Even if ACOs score poorly on more measures than they can immediately address with improvement efforts, this is important information for patients, providers, organizations, and advocates to have.

C) ACO quality measures are intended to assess quality of care throughout the health care system, not just at the hospital level.

On a few occasions, it has been mentioned that hospitals do not have complete control over some of the areas that have been proposed to be measured, such as avoidable emergency departments (ED) use. We would like emphasize that the quality measures are intended to assess quality of care and care coordination throughout the health care system, not just at the hospital level. We believe that measures such as avoidable ED use are essential and should motivate hospitals and other health care providers to improve communication and work together to improve care and ensure that patients receive care at the appropriate location whenever possible.

In conclusion

Quality measures that are tied to payment are one of the only ways to ensure that providers do not limit care or decrease quality 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

September 23, 2014

The Honorable Anya Rader Wallack, Ph.D.
Chair, VHCIP Core Team
Vermont Health Care Innovation Project
109 State Street
Montpelier, VT 05620

Re: Year 2 ACO Shared Savings Program measures recommendations

Dear Dr. Wallack:

We are writing to convey our comments on the proposed changes to the ACO Shared Savings Programs (SSPs) that the VHCIP Core Team will be considering at its next meeting on September 29. Those recommendations were made by the Quality & Performance Measures Work Group and were forwarded to you, without comment, by the VHCIP Steering Committee for review and action.

OneCare Vermont, representing a broad coalition of physicians, hospitals, designated agencies and other providers from around the state, and the Vermont Medical Society have already submitted comprehensive comments on the recommendations before you. While those organizations support a number of the proposed changes, they strongly oppose several of them:

- Moving three current "reporting" measures to "payment" measures (Comprehensive Diabetes Care, Pediatric Weight Assessment and Counseling, and Rate of Ambulatory Care Sensitive Conditions);
- Adding a new "reporting" measure (Avoidable ED Visits); and
- Adding a new survey question (the custom DLTSS survey questions).

We, the undersigned Chief Medical Officers of Vermont's hospitals – all of which are network participants in the ACOs that are participating in the Medicaid and the commercial SSPs – are writing to express our strong support for the recommendations made by the VMS and OneCare Vermont for the reasons they have already articulated so clearly.

From our positions on the front line of health care delivery, we can affirm our organizations' commitment to improving care while helping to reform our payment system so that it aligns with and supports the kind of high-level, population-based care that all Vermonters will benefit from. Our participation in the ACO SSPs is a bold first step in that journey, and one that has required a considerable commitment of time and effort from not only our organizations but the individual providers and support staff who, in the end, bear the burden of documenting the clinical interactions by which our efforts are being measured.

As voluntary participants in these SSPs, we are already collecting and reporting on roughly three dozen measures. But because both the Medicaid and commercial programs are new this year, we have yet to receive any claims data for Year One that would give us even a baseline from which to work. Adding new payment measures without such a baseline is not reasonable. We also echo the concerns that have been raised about adding measures that may not give us actionable data, such as the avoidable ED use algorithm or the DLTSS survey, whose questions are directed at non-primary care providers.

We recognize the hard work that has gone into the development of the recommendations before you, and respect the inclusive process by which so many voices have been heard. We also appreciate the motivations of those who support the continued expansion of the ACO performance and quality measures, since they reflect the same motivation we have as we treat our patients on a daily basis. Linking quality measures to payments is key to ensuring that any system gains we make financially are not being achieved at the expense of Vermonters' health.

Having said that, we would ask that you honor the commitment we as providers have made to helping to craft a better payment and delivery system by not imposing additional administrative burdens so early in these pilots.

Thank you for your consideration of our request.

Phil Brown, Vice President of Medical Staff Affairs, Central Vermont Medical Center

Trey Dobson, Chief Medical Officer, Southwestern Vermont Health Care

Fred Kniffin, Chief Medical Officer, Porter Medical Center

Baxter Holland, Vice President, Director of Medical Affairs, Rutland Regional Medical Center

Stephen Leffler, Chief Medical Officer, Fletcher Allen

Catherine Schneider, Chief Medical Officer, Mount Ascutney Hospital

Joel Silverstein, President of Medical Staff, Copley Hospital

Lowrey Sullivan, Chief Medical Officer, Northwestern Medical Center

From: Fels, Jennifer [mailto:Jennifer.Fels@svhealthcare.org]
Sent: Friday, September 12, 2014 3:07 PM
To: Jones, Pat
Cc: Dobson, Carl (Trey)
Subject: RE: Additional Opportunity for Public Comment Related to Measures

Pat,

Thank for the opportunity to comment on the ACO measures.

I highly recommend that measures be standardized across CMS measures and the Vermont Blueprint for Health and incorporate NCQA Medical Home certification requirements. The alignment of measures will reduce the administrative burden and support greater buy in across providers and partners. The vehicle for measure capture should be automated from electronic medical records, as much as possible.

I appreciate your consideration.

Jennifer

Jennifer Fels
802-440-4047
Jennifer.fels@svhealthcare.org

From: Bea Grause <Bea@vahhs.org>
Date: September 22, 2014 at 4:29:40 PM EDT
To: "Anya Wallack (anya@arrowheadha.com) (anya@arrowheadha.com)" <anya@arrowheadha.com>, Anya Rader Wallack <Anya.Wallack@state.vt.us>
Cc: "Georgia Maheras, Esq." <georgia.maheras@state.vt.us>
Subject: CMO letter re ACO measure changes 9-23-14

Hi Anya,

I wanted to pass along this letter supporting OneCare's positions on the proposed ACO measure changes. VAHHS has not officially weighed in on this issue, but we also are supportive of the OneCare and Medical Society positions. I am happy to put our general position on letterhead if desired.

This attached letter however, reflects the specific support of many hospital CMOs. Happy to discuss. Bea

Attachment 3d - Additional Year Two Measures Comments

From: Sharon Winn <swinn@bistatepca.org>
Date: September 26, 2014 at 5:06:08 PM EDT
To: "Maheras, Georgia" <Georgia.Maheras@state.vt.us>
Subject: Bi-State late measures comments

Hi Georgia,

I know we're late so you may not be able to accept officially our comments on the measures. We offer them anyway so you'll know our position. We approach this more from a principles perspective than reaction to specific measures, so maybe there are thoughts that will be helpful to you and the team.

As a matter of principle, Bi-State believes measurement and transparency are a good thing. We understand and agree with the oft-voiced sentiment that measuring is a burden to the delivery system, but we also believe consumers of our health care services have a right to know whether their provider's practice systems and philosophy are delivering care that meets standards and achieves the best outcome possible. But the measures we invest in should provide information that's actually meaningful to consumers, policy makers, or providers.

Bi-State's members are not concerned that a broad scope of measure will cause providers to be spread too thin as they engage in improving every result that does not meet a target. Instead, we believe the delivery system should be held accountable to prioritizing the use of its limited resource to target improvement initiatives where they are most needed and will be most effective; and only where we have great confidence the opportunity to improve is based on solid data.

This means, of course, both the system and consumers will have to tolerate known imperfections unless or until we are able to deploy more resource for improvement. Importantly, the imperfections will be, for now and possibly for many years to come, as much in data integrity as they are in actual delivery of care. In other words, we can produce a lot of measures, but there are many measures whose data sources are still incomplete and unreliable. We should not launch improvement initiatives based on bad data.

Full transparency is the shortest path to identifying and sharing best practices, targeting administrative resources to the areas of greatest need or most efficient areas/practices, and keeping a spotlight on the trouble spots. Full transparency also will reveal areas of data collection opportunity.

All of this said, however, we agree some measures are too expensive to produce. Bi-State's resource to do chart extraction is limited. The burden at the clinician and practice level to operationalize a measure is still overlooked or at best underestimated. The process of capturing data is inefficient. As a group we need to recognize we are in the early years of data gathering.

We encourage active discussion and action to streamline administrative capture (e.g. maximizing the amount of data that can be captured via claims sources) and eliminate wasteful duplication in chart extraction (payers for HEDIS, ACOs for reporting, and various other entities for quality improvement initiatives).

Thank you for the opportunity to weigh in on this important decision.

Sharon
Sharon M. Winn, Esq., MPH
Director, Vermont Public Policy
Bi-State Primary Care Association
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