State of Vermont
Green Mountain Care Board
89 Main Street
Montpelier VT 05620

Report to the Legislature

REPORT ON THE GREEN MOUNTAIN CARE BOARD'S PLAN TO ALIGN PERFORMANCE MEASURES ACROSS PROGRAMS THAT IMPACT PRIMARY CARE

In accordance with Act 112 of 2016

Submitted to the
Senate Committee on Health and Welfare and the House Committee on Health Care

Submitted by the
Green Mountain Care Board

January 13, 2017

Funding for this report was provided by the State of Vermont,
Vermont Health Care Innovation Project, under Vermont's State Innovation Model (SIM) grant,
awarded by the Center for Medicare and Medicaid Services Innovation Center (CMMI)
CDFA Number 93.624
Federal Grant Number 1G1CMS 3311811 -03-01

TABLE OF CONTENTS

Executive Summary 1

Introduction 2

Research Methodology 3

Catalogue of Performance Measure Requirements 4

Summary of Measure Set Research 11

Stakeholder Perspectives on Measure Alignment in Vermont 12

Recommended Elements of Proposed Alignment Plan 16

Proposed Alignment Plan 17

Appendices

Appendix 1: Interviews Conducted for Act 112 Study 19

Appendix 2: Measures Found in Each Measure Set 20

Executive Summary

This report presents the results of Green Mountain Care Board (GMCB) efforts to catalogue primary care performance measures and develop a plan to align such measures in response to Act 112 of April 2016. Act 112 states that the GMCB "…shall survey and catalogue all existing performance measures required of primary care providers in Vermont…" and "…develop a plan to align performance measures across programs that impact primary care…"

The GMCB[1] catalogued the performance measures for which primary care practices currently are accountable or will likely be held accountable in 2017. Through research and interviews, the GMCB identified eight measure sets with accountability implications for Vermont primary care practices, catalogued the performance measures within each set, and identified the degree of alignment and misalignment across the measure sets. Interviews with 31 representatives of primary care practices, payers and other organizations involved in provider performance measurement activity contributed to this research.

Key findings from the measure set research include the following:

- 113 distinct primary care measures are projected to be in use in Vermont in 2017. Because many of these measures are not applicable to all Vermont primary care practices, practices experience accountability expectations for fewer measures.
- Almost half of these measures are at least partially aligned across measure sets, meaning that they are in use or "shared" by two or more measure sets, while the remaining measures appear in only one measure set.
- The degree of alignment across measure sets in Vermont is higher than observed in a 2013 study of measure set alignment in 25 states, but there is still room for improved alignment.

Interviews with primary care providers across the state and with the Vermont Medical Society revealed that many feel some progress towards alignment has occurred in recent years. These interviews also determined that the measure burden felt by primary care providers stems at least as much—if not more—from electronic health record documentation demands and national patient-centered medical home recognition documentation requirements as from lack of measure alignment. Nevertheless, the GMCB's research found opportunity for improved alignment, a sentiment shared uniformly across the interviewees. Further, these conversations indicated agreement on principles for an alignment plan, including the establishment of statewide priorities for measure adoption, a clear opportunity for primary care provider input, and a lead role for the State in facilitating alignment. The GMCB's recommendations are based on these principles, and include the formation of a Measure Alignment Council.

[1] The GMCB was assisted in this work by contractor Bailit Health Purchasing, LLC.

Additional complementary recommendations are contained in the main body of the report.

Introduction

A great proliferation of quality measures has occurred over the past two decades in response to concern that there was no valid and comparable basis for assessing health care quality. As a result, quality measure alignment, or the lack thereof, has been of growing national interest. In 2013, a study of measure sets in 25 states and three regional collaboratives found 1,367 measures (mostly related to primary care) in use across 48 measure sets, of which 509 were distinct, non-duplicated measures.[2,3] Furthermore, only 20 percent of all 509 measures were used in more than one program, indicating that non-alignment was a significant issue. There are now multiple national efforts that focus on measure alignment, including the Core Quality Measures Collaborative formed by the Centers for Medicare & Medicaid Services (CMS) and America's Health Insurance Plans (AHIP).[4]

The issue of quality measure non-alignment is under scrutiny at the individual state level as well. For example, in Massachusetts alone, there are over 500 quality measures (not all of which are related to primary care) that are in use across the state.[5] Several Massachusetts agencies, including the Statewide Quality Advisory Committee,[6] managed by the Center for Health Information Analysis, as well as the Health Policy Commission, have initiated statewide conversations to develop a coordinated strategy for measure alignment.[7] Several other states, including Rhode Island and Washington, have previously acted to align health care provider performance measure sets. In fact, Round 2 of the CMS State Innovation Model test grants requires states to develop aligned measure sets across payers.[8]

---

[2] Bazinsky K and Bailit M. "*The Significant Lack of Alignment Across State and Regional Health Measure Sets*." Buying Value, Washington, DC, September 15, 2013. Available at: www.buyingvalue.org/wp-content/uploads/2014/02/buying-value-common-measures-Bailit-State-Measure-Set-Brief-9-10-13-FINAL-FINAL.docx

[3] "If a measure showed up in multiple measure sets, it was counted once (e.g., breast cancer screening was counted 30 times in the total measures chart since it appeared in 30 different measure sets, but was counted once as a "distinct" measure). If a program used a measure multiple times ("variations on a theme"), it was only counted once (*e.g.,* the Massachusetts PCMH Initiative used three different versions of the tobacco screening measure; it is counted only once as a distinct measure)." For more information, refer to the Buying Value study in Footnote 2.

[4] Center for Medicare & Medicaid Services. Press Release "CMS and major commercial health plans, in concert with physician groups and other stakeholders, announce alignment and simplification of quality measures." February 16, 2016. Available at: www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-02-16.html.

[5] Center for Health Information Analysis. "Standard Quality Measure Set (SQMS): 2016 Quality Measure Catalog." 2016. Available at: www.chiamass.gov/assets/docs/g/sqac/2016/2016-Quality-Measure-Catalog.xlsx. Accessed November 17, 2016.

[6] For more information, visit the Statewide Quality Advisory Committee's website available at: www.chiamass.gov/sqac/. Accessed November 17, 2016.

[7] Health Policy Commission. "*2015 Cost Trends Report*." 2015. Available at: www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-cost-trends-report.pdf.

[8] For more information, visit: http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-a-look-at-round-2-grantees/. Accessed November 17, 2016.

In April 2016, the Vermont Legislature passed Act 112, stating that the GMCB "in consultation with the Agency of Human Services and the Vermont Medical Society, shall survey and catalogue all existing performance measures required of primary care providers in Vermont, including the Centers for Medicare & Medicaid Services' quality measures." In addition, GMCB was instructed to "develop a plan to align performance measures across programs that impact primary care."

For purposes of this study, the GMCB broadly interpreted the legislation's reference to performance measures "required of" primary care providers in Vermont. Specifically, two categories of measures for which primary care providers are held accountable for their performance were identified and catalogued:

1. Measures reported by practices or another party, for which practices are explicitly expected to excel or improve performance and/or report performance ("Reporting Measures"), and
2. Measures for which practice performance generates financial consequences in the form of incentives and/or penalties ("Payment Measures").

This report first describes the research methodology. It then presents the results of the cataloguing of performance measures required of primary care providers in Vermont, including the degree of alignment across measure sets. The report then examines stakeholder input received over the course of 31 interviews, and presents a proposed alignment plan.

Research Methodology

The first step in the cataloguing process was to identify current and planned 2017 performance measures for which primary care practices are or will likely be held accountable, either directly or indirectly (*e.g.,* via a practice's contract with an Accountable Care Organization (ACO)). The GMCB identified qualifying measure sets generated by the following entities:

1. Blue Cross Blue Shield of Vermont (BCBSVT);
2. Centers for Medicare and Medicaid Services (CMS), for Medicare;
3. Department of Vermont Health Access (DVHA), including the Blueprint for Health and Medicaid;
4. Health Resources and Services Administration (HRSA), for Federally Qualified Health Centers (FQHCs);
5. MVP Health Care, and
6. Vermont's All-Payer Model.

Included among these measures sets are ACO measure sets employed by BCBSVT during 2016 and specified in an ACO RFP by DVHA for 2017.

This research was verified and supplemented by conducting interviews with payers and other organizations, including the GMCB, Agency for Human Services, DVHA, the Blueprint for

Health, the Vermont Department of Health, BCBSVT, MVP Health Care, and the New England Quality Improvement Network-Quality Improvement Organization (QIN-QIO).

The research was further verified by speaking with a range of providers and provider organizations, including providers in FQHC, independent, and hospital-owned primary care practice settings, and ACO representatives. In several cases, interviews were conducted with staff members responsible for organizing and documenting the practice's response to required performance measures. These interviews helped confirm the research on measure set identification, and provide an understanding of provider views on alignment across these measure sets. A full listing of interviews conducted for this report is found in Appendix 1.

Catalogue of Performance Measure Requirements

Research and interviews identified eight measure sets for which primary care practices in Vermont are held accountable in some manner. These measure sets are in use today and/or planned for use in 2017.

- Four measure sets include measures to which financial incentives and/or penalties are applied.
- One measure set includes measures upon which practices are explicitly expected to excel or improve.
- The remaining three measure sets include measures upon which practices are explicitly expected to excel or improve *and* which also include a smaller subset of measures to which financial incentives and/or penalties are applied.

Measures from the Vermont All-Payer ACO Model Agreement between CMS and the State that are applicable to primary care practices are included in the analysis since these measures are candidates for arrangements with primary care providers participating in Vermont ACO(s), although whether that will occur in 2017 is uncertain at the time of this report.[9] All of the 63 CMS Merit-based Incentive Payment System (MIPS) measures specific to primary care are also included in the analysis. It is important to note that practices are required to report on a small subset of MIPS measures, and that practices participating in a Medicare Next Generation ACO or another Advanced Alternative Payment Model (AAPM) are not required to participate in the MIPS program at all. Vermont's All-Payer ACO Model is considered an AAPM.

Only measures that are related to primary care are included in the analysis. Measures that are included in a federal or state measure set, but are not related to primary care, are excluded. An overview of the measure sets included in the analysis and their primary care-related measures

[9] Two sub-measures from a Vermont All-Payer ACO Model composite measure ("Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)" and "Controlling High Blood Pressure") are counted as two individual measures for the purpose of this analysis.

can be found in Figure 1. A complete list of measures included in each measure set is found in Appendix 2.

Initially, 204 primary care-focused measures were identified across the eight measure sets. Table 1 lists the measure sets included in the report by type of accountability. Of these 204 measures, 113 are distinct, non-duplicated measures.

Because many of the measures are not applicable to all Vermont primary care practices (*e.g.,* the total set of Medicare MIPS measures cited above, the HRSA measures for FQHCs only), or have limited practice impact (*e.g.,* MVP measures due to low state enrollment), practices experience accountability expectations for fewer than 113 measures. Furthermore, it is important to note that a majority of measures utilize claims or survey data and are therefore generated by an entity other than the practice (usually a health plan or an ACO). Less than half of all measures require practices to submit data.

Figure 1: Primary Care Measure Sets in Use in Vermont[10]

Federal/National

CMS Medicare Shared Savings Program (MSSP)
- 29 measures
- Shared savings percentage influenced by ACO performance on measures

CMS Merit-based Incentive Payment System (MIPS)
- 63 measures across three measure sets
- Reporting to CMS is only required if a practice is not a part of an Advanced Alternative Payment Model

HRSA Unified Data System (UDS)
- 15 measures
- Reporting to HRSA on all measures

State

BCBSVT ACO Shared Savings Program
- 29 measures
- Shared savings percentage influenced by performance on 9 measures
- Reporting to or by BCBSVT is required for the remaining 21 measures
- One measure is found in both categories

Proposed DVHA ACO Shared Savings Program
- 7 measures identified from the RFP
- Shared savings percentage influenced by performance on measures

MVP Quality Reporting System (QRS) & Profile Reports
- 38 distinct measures
- Payment is tied to performance on 7 measures through the QRS
- Reporting to or by MVP for all measures; performance is recorded in a profile and/or gaps-in-care report

Vermont All-Payer ACO Model
- 9 measures
- Future ACO-practice financial terms are likely to incorporate these measures

Vermont Blueprint Incentive & Profile Reports
- 14 distinct measures
- Payment is tied to performance on 4 measures
- Reporting by Blueprint for 11 measures; performance is recorded in a practice profile report
- One measure is found in both categories

[10] Non-primary care-related measures are excluded from the counts in this figure. Because the MIPS measure set includes the entirety of two CAHPS surveys, and not composite measures, these measures are completely excluded from our analysis, unlike the individual CAHPS survey composite measures included as part of the BCBSVT ACO Shared Savings Program measure set. The three measure sets that are included in our analysis are: General Practice/Family Medicine, Internal Medicine, and Pediatrics.

Table 1: List of Measure Sets in Use in Vermont

Measure Set	Type of Accountability[11]
BCBSVT ACO Shared Savings Program	Payment: includes reporting by GMCB analytics contractor and/or by ACO
	Reporting: includes reporting by GMCB analytics contractor, by ACO and/or by practices
CMS Medicare Shared Savings Program (MSSP)	Payment: includes reporting by CMS and by ACO
CMS Merit-based Incentive Payment System (MIPS)	Payment: includes reporting by practices
Proposed DVHA ACO Shared Savings Program	Payment:[12] includes reporting by ACO and potentially by analytics staff or contractor
HRSA Unified Data System (UDS)	Reporting: includes reporting by practices (FQHCs only)
MVP Health Care	Payment: includes reporting to practices
	Reporting: includes reporting by plans and practices
Vermont All-Payer ACO Model	Payment: State Reporting[13] to CMS
Vermont Blueprint for Health	Payment: includes reporting to practices
	Reporting: includes "profile report" reporting to practices

Voluntary Measure Sets with Limited Impact

The research identified three additional programs that include accountability expectations for practices, but for which participation is a) voluntary and b) limited in terms of the numbers of participating practices. Two programs are managed by Qualidigm, the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Vermont,[14] and one is led by the Vermont Child Health Improvement Program (VCHIP).[15] These programs include:

1. QIN-QIO's Cardiovascular Health and Million Hearts Initiative;
2. QIN-QIO's Everyone with Diabetes Counts Program, and
3. VCHIP's Child Health Advances Measured in Practice (CHAMP).

Participating primary care providers may elect to submit data for select measures in the case of the QIN-QIO programs, or participate in annual data collection activities in the case of the

[11] "Reporting to practices" indicates that practices have no additional reporting responsibilities.
[12] Includes measures cited in DVHA's 2016 ACO request for proposals. Negotiations of the final terms of the contract were not complete as of the date of this report.
[13] The GMCB anticipates that DVHA may include some or all of the All-Payer ACO Model measures in its ACO contracts.
[14] There are two Vermont practices that participate in QIN-QIO's Cardiovascular Health and Million Hearts initiative and 15 Vermont practices participating in QIN-QIO's Everyone with Diabetes Counts program. Communication with Jill McKenzie, QIN-QIO, September 8, 2016.
[15] There are 44 pediatric and family medicine practices currently participating in VCHIP's CHAMP program. For more information, visit: www.med.uvm.edu/vchip/champ. Accessed November 17, 2016.

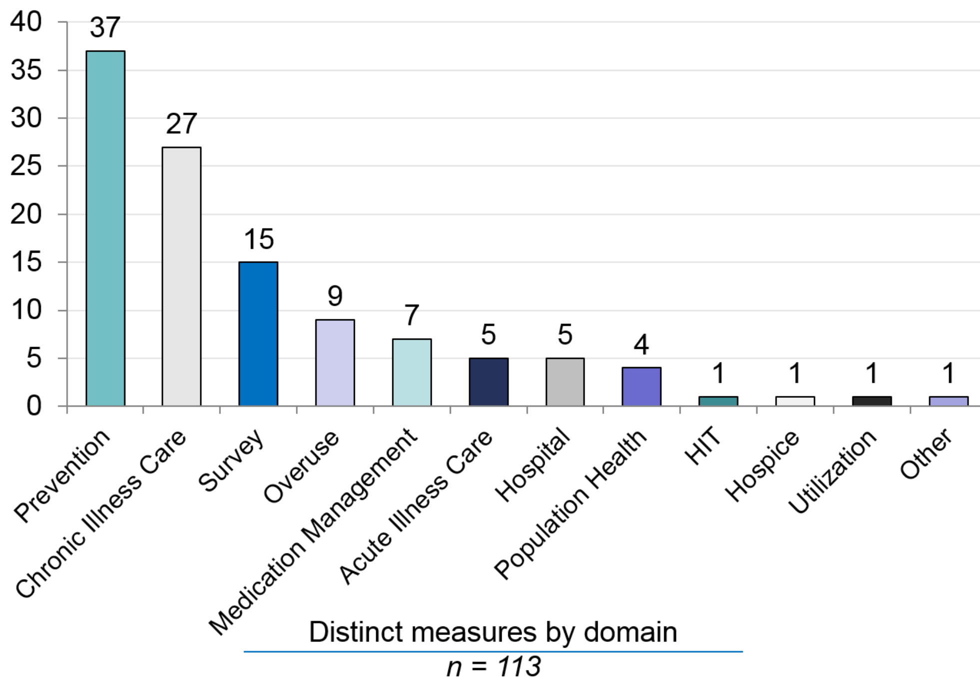
CHAMP program. Most of the measures for these programs are included in one or more of the eight measure sets in Table 1.

The Vermont Blueprint for Health is also a voluntary program, but the broad scope of practice participation in the Blueprint (133 primary care practices as of September 2016[16]) led to the inclusion of these measures in the list of measure sets in Figure 1, Table 1, and Appendix 2.

Stratification of Measures by Domain and Condition

The 113 distinct measures from the eight measure sets were stratified using the following twelve domains: Acute Illness Care, Chronic Illness Care, HIT, Hospice, Hospital, Medication Management, Other, Overuse, Population Health, Prevention, Survey, and Utilization. The domains were selected from the Buying Value Measure Selection tool,[17] a tool supported by the Robert Wood Johnson Foundation for state development of aligned measure sets. Figure 2 displays the distribution of the 113 distinct measures by domain.

Figure 2: Distinct Measures by Domain

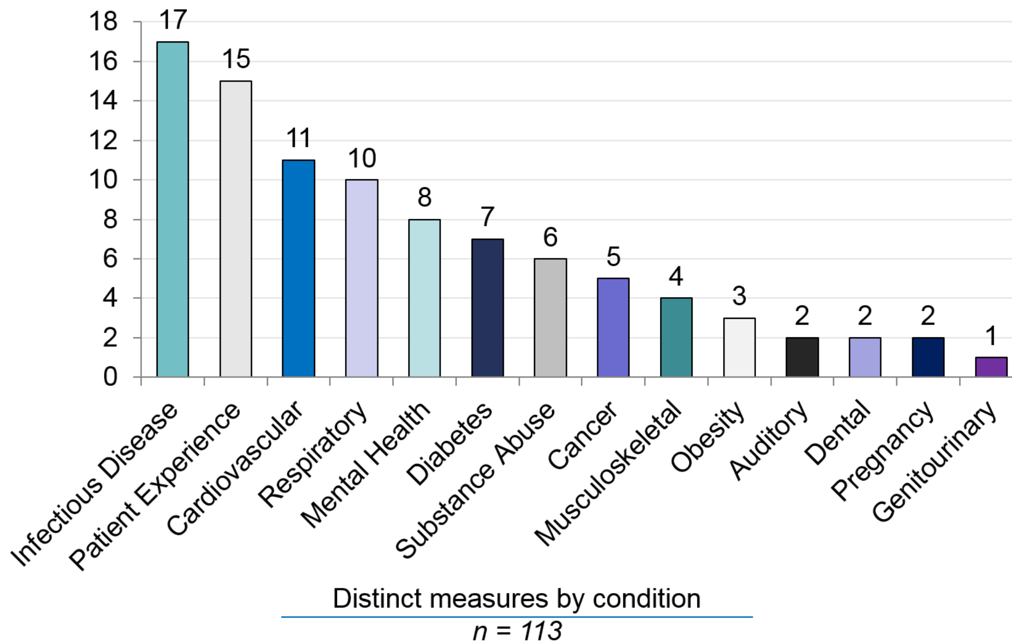


[16] This number includes practices that have achieved Patient-Centered Medical Home (PCMH) status and those that were working with the Blueprint to become a PCMH as of September 28, 2016. Communication with Candace Elmquist, Blueprint for Health, September 28, 2016.

[17] The GMCB deviated from the domains utilized in the Buying Value Tool in one respect. For the purpose of this analysis, patient experience measures were placed in a "survey" domain. The Buying Value Measure Selection Tool is available at: www.buyingvalue.org/. Accessed November 17, 2016.

Of the 113 distinct measures, 93 were also stratified using the following 14 condition categories: Auditory, Cancer, Cardiovascular, Dental, Diabetes, Genitourinary, Infectious Disease, Mental Health, Musculoskeletal, Obesity, Patient Experience, Pregnancy, Respiratory, and Substance Abuse. The remaining 20 measures were not related to specific conditions, and instead were placed in two categories: Patient Safety and Other. Figure 3 shows the 93 distinct measures by condition category.

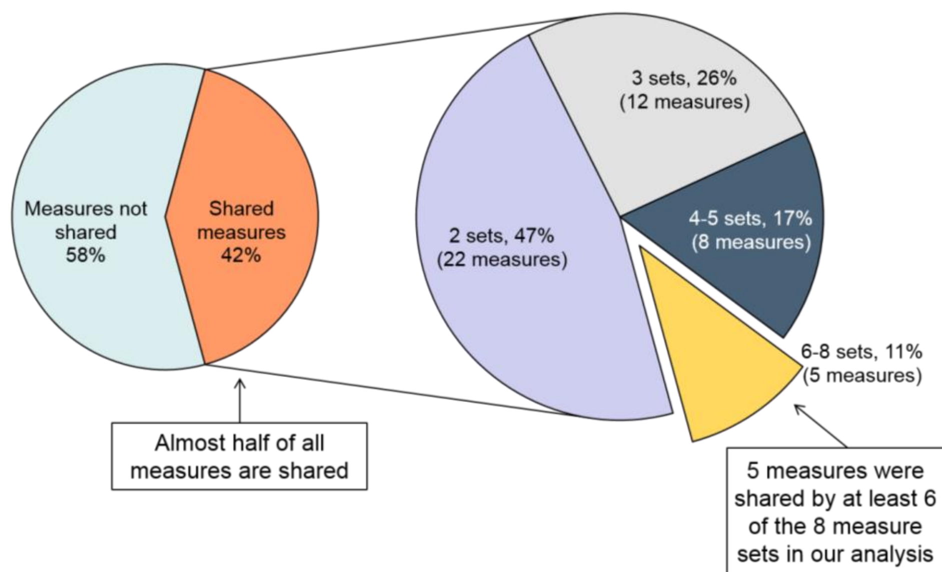
Figure 3: Distinct Measures by Condition Category



Analysis of Measure Alignment

Of the 113 distinct measures, 47 (42 percent) are in use in two or more measure sets. This degree of alignment is notably higher than what was seen nationally in the 2013 Buying Value study, where only 20 percent of measures were found in two or more measure sets. Looking at just the 47 shared distinct measures identified by the research, 47 percent are being used in two measure sets, 26 percent are being used in three measure sets, 17 percent are being used in four or five measure sets, and 11 percent are being used in six to eight measure sets. Figure 4 displays the distribution of the shared measures across measure sets.

Figure 4: Distribution of Alignment of Shared Measures across Measure Sets



It is helpful to look at the most aligned measures, *i.e.,* those included in four or more measure sets. Thirteen measures are included in this category, which corresponds to 12 percent of the 113 distinct measures included in this analysis. Table 3 lists these 13 measures by domain.

Table 3: Most Aligned Measures

Domain	Measure Name	Number of Measure Sets
Chronic Illness Care	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	8
	Comprehensive Diabetes Care: Eye Exam	6
	Controlling High Blood Pressure	6
Overuse	Appropriate Testing for Children with Pharyngitis	4
Prevention	Adolescent Well-Care Visits	6
	Cervical Cancer Screening	6
	Colorectal Cancer Screening	5
	Screening for Clinical Depression and Follow-Up Plan	5
	Tobacco Use Assessment: Screening and Cessation Intervention	5
	Breast Cancer Screening[18]	4
	Childhood Immunization Status	4
	Chlamydia Screening	4
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	4

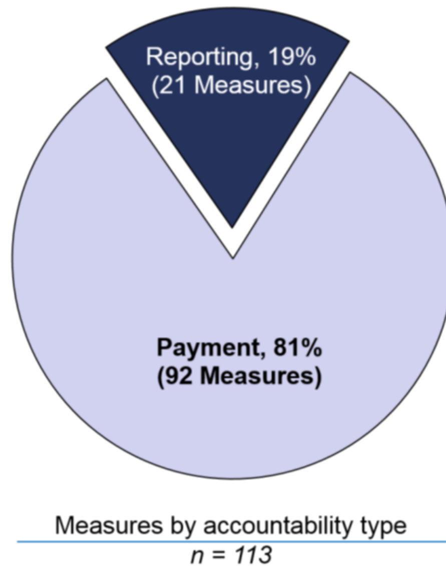
Measures were classified into two categories reflecting how they are employed to hold primary care practices accountable for performance:

1. Measures reported by practices or another party, for which practices are explicitly expected to excel or improve performance and/or report performance ("*Reporting Measures*") and
2. Measures for which practice performance has financial consequences in the form of incentives and/or penalties ("*Payment Measures*"). Payment measures are often also Reporting Measures. In such cases, they are categorized as Payment Measures. These measures are in many cases Payment Measures for ACOs; the analysis makes an important assumption that ACO payment measures are (or will be) used by ACOs as Payment Measures for primary care practices.

[18] One version of the "Breast Cancer Screening" measure (NQF #0031) is found in four measure sets. However, another version of the measure (NQF #2372) is found in one additional measure set.

Figure 5 shows the stratification of distinct measures by the two accountability categories. Four-fifths of distinct measures are linked to payment in at least one measure set.

Figure 5: Distinct Measures by Type of Accountability



Half of all measures linked to payment (46 measures) are found in two or more measure sets. Every one of the "most aligned" measures listed in Table 3 is linked to payment in at least one measure set.

Summary of Measure Set Research

There are eight primary care accountability measure sets and 113 associated distinct primary care measures projected to be in use in Vermont in 2017. However, for most primary care practices, many of these measures are unlikely to have any accountability consequences.

For those measures where performance has financial consequences, the consequences are most often directly experienced by ACOs, and the measures impact primary care practices only if the ACO incorporates the measures into its compensation arrangements with associated practices.

While the degree of alignment in Vermont is higher than what has been reported nationally, opportunity remains for additional alignment.

Stakeholder Perspectives on Measure Alignment in Vermont

A number of Vermont stakeholders interviewed for this report share the view that progress is being made on alignment of measure sets for which primary care providers are being held accountable, and that alignment is an ongoing focus in Vermont. Many Vermont programs are considering measures that are in use in other state and national measure sets when developing and reviewing their own program requirements. Practitioners expressed frustration with the growing complexity of reporting, however, particularly at the national level. Both the breadth of CMS and National Committee for Quality Assurance (NCQA)[19] measure requirements, and in the case of CMS, the number of non-aligned measure sets, is a source of concern. The perceived burden of measure reporting and the lack of measure set alignment are not as pronounced at the state level.

The interviews indicated that there is opportunity for improved measure alignment across both state and national measure sets; this conclusion is supported by the results of the measure analysis above. This section of the report summarizes stakeholder perspectives and describes a plan for improving alignment across the measure sets for which primary care practices in Vermont are being held accountable.

Insights Gained from Provider Interviews

Research included interviews with 11 primary care provider organization representatives, plus the Vermont Medical Society. The practice interviews included representatives from two FQHCs, two hospital-based practices, an academic medical center faculty practice, and three independent practices with fewer than ten providers. Providers expressed a range of views on the extent of current alignment across measure sets in Vermont, but many feel that there is at least some progress towards increased alignment in recent years. Interviews revealed that providers believe there remains an opportunity to improve primary care measure set alignment in Vermont. Questions about measure set alignment revealed that lack of alignment is not the primary provider concern with quality measurement, however. Some providers are not aware of the number of measure sets for which they are accountable, or the contents of those measure sets.

Rather, the primary care providers' concerns with performance measurement stem from several sources, with interviewed providers expressing significant concern with the following burdens.

- **Documentation requirements necessary for NCQA Patient-Centered Medical Home (PCMH) recognition**. Primary care practices that achieve NCQA PCMH recognition receive enhanced Medicare, Medicaid and Commercial insurer payments through the Blueprint for Health program. Documentation requirements associated with NCQA PCMH recognition were explicitly identified as a priority concern by half of the interviewed

[19] NCQA is the primary national recognition organization for Patient-Centered Medical Homes.

primary care practice representatives. NCQA requires quality measurement and improvement evidence for PCMH recognition.[20]

The requirements that appear to be of greatest concern to interviewed practices have to do with documentation of clinical care in the patient record—often in an electronic health record (EHR). In this respect, providers are more concerned with NCQA requirements to document clinical care in order to generate multiple clinical quality measures than with being subject to non-aligned measures. One interviewee added the insight that for primary care clinicians, documentation is not difficult for individual measures, but is tedious in aggregate. Several interviewees noted that documentation ("clicking the boxes") of screening and assessment questions and of provision of health behavior counseling is a particular burden (*e.g.,* BMI screening, tobacco screening, clinical depression screening and related follow-up plans). Primary care providers would like fewer such measures. While provider concerns about these requirements fall outside the scope of this report, the NCQA PCMH documentation requirements are important for their contribution to providers' overall sense of administrative burden.

- **Blueprint Incentive Measure and Meaningful Use documentation requirements**. These were cited less in provider interviews than the topics above, but both received mention. The Blueprint currently has four clinical quality incentive measures that impact payments to practices. All are claims-based or derived passively from the statewide clinical registry, so data collection is of minimal burden to practices. Meaningful Use incentives do call for documentation, although not specific to quality measures. One provider explained: "Although the Meaningful Use core objectives might not technically be 'quality measures' they do reflect the administrative burden to demonstrate EMR functionality as an up-to-date competent practice (and to trigger Meaningful Use payments)."

- **EHR functionality**. Interviews showed that primary care providers are experiencing improved efficiencies but also increased burden from their EHR systems. EHRs have the potential for more efficient collection of clinical data, but several providers observed that EHRs are also contributing to the 'pile on' of documentation requirements at the front lines of patient care. Interviews revealed that some practices are managing EHR documentation requirements by establishing, for example, processes that rely on nurses to complete these requirements before the provider steps into the room. Smaller practices may lack the workforce to support some of these workflow modifications.

  Relatedly, one pediatrician spoke to the mismatch between EHR requirements and the nature of her practice; she commented on her EHR's requirement that she collect an 'end-of-

[20] NCQA is changing its standards in 2017 PCMH to respond to practice feedback on administrative burden, but it is likely to continue to impose these general requirements on primary care practices seeking such recognition.

life' plan from her young patients. While the concerns associated with EHRs are outside the scope of this study, they are noted because their cumulative effect appears to be contributing to a sense of burnout among some primary care providers in Vermont.[21]

- **The value of measures for which clinical record documentation is required**. Not only do providers dislike "clicking" boxes, but it troubles them when they have to do so for measures that they consider to be unsupported by clinical evidence. A few interviewees made general references to lack of supporting evidence for measures which providers are required to report, or when measure specifications do not reflect the most recent evidence-based practices (*e.g*., an interviewee suggested that CMS' blood pressure control measure does not match the current American College of Cardiology guideline). Another interviewee noted that changes to measures add to the general sense of burden, and prevent practices from working to improve performance and outcomes on a consistent set of measures over the long term.

- **Variations in specifications for similar measures across measure sets**. Several providers noted that small differences in measure specifications across measure sets result in administrative burden on practices; when these variations occur, one process for collecting data for that measure is insufficient. The measure set analysis identified two instances of similar measures with diverging specifications; there are two measures related to breast cancer screening and two measures related to adult BMI assessment. BMI measurement requires clinical data collection so it is more burdensome to practices, while breast cancer screening measurement relies on claims data.

In sum, these interviews illustrate that primary care practices view NCQA PCMH recognition requirements, payer performance measures, Meaningful Use requirements, and EHR functionality as one large undifferentiated set of dispiriting documentation demands.

Primary care practices offered a range of suggestions for achieving improved measure alignment, including triaging or prioritizing a limited set of measures, delegating measure selection to a single organization, ensuring clinician input, working toward standardization of how EHRs collect data, and placing a one- or two-year moratorium on adding new measures to existing sets.

Insights Gained from Payer, State and Other Stakeholder Interviews

Research included nine interviews with payers, State staff, and other stakeholders, including representatives from the GMCB, the Agency for Human Services, the Department of Health, DVHA (Medicaid, Payment Reform and the Blueprint for Health, separately), Blue Cross Blue

[21] The topic of burnout among primary care physicians and the contributions of EHRs to burnout is not unique to Vermont; a recent *NEJM Catalyst* story noted that 54 percent of U.S. physicians are experiencing burnout, and that EHRs are a factor. Click here to access the article.

Shield of Vermont, MVP Health Care, and the New England QIN-QIO. These discussions confirmed provider feedback regarding the burdensome impact of measure requirements when combined with other requirements from the ACOs, the Blueprint for Health, CMS, and NCQA. Interviewees acknowledged ongoing efforts to create alignment across measure sets—particularly state measure sets—while noting the constraints (or burdens) of working within federal regulations. These interviewees also shared their observations of the variable EHR/IT capabilities across primary care practices in the state, noting that practices with fewer resources to devote to IT implementation may experience a higher degree of documentation burden.

Several interviewees reflected on the multi-stakeholder process that was used in 2013 to establish the aligned measure requirements under the GMCB-facilitated ACO Shared Savings Program, noting that while such a collaborative process can be productive, it can also have the unintended consequence of creating larger measure sets than originally envisioned. Others commented that the prior collaborative process became unwieldy, with multiple layers of approval for measures recommended by a work group. One interviewee expressed the desire to avoid a multilayer review and approval process in the future.

Interviews with payers and other stakeholders yielded several suggestions on how to achieve greater alignment, including:

- State facilitation of a collaborative process for vetting measures;
- More discerning prioritization of measures;
- Leveraging the State's All-Payer ACO Model to achieve greater alignment;
- Creation of a State 'menu' of measures from which payers can tailor a set to meet their needs, and
- Use of the Medicare Merit-based Incentive Payment System (MIPS) and Medicare Next Generation ACO measures as the "yardstick" or "magnet" to bring about improved alignment, with additional measures required of primary care practices only when there is a compelling need (*e.g.*, pediatric and maternity measures).

Payer and other stakeholder interviewees added that an alignment effort must both "define who is in charge" and also respect efforts already underway such as the ACO Shared Savings Program. One payer echoed the sentiment of providers in describing the need for an inclusive statewide "standing process for development and maintenance of a measure set."

Feedback from Primary Care Advisory Group

The Green Mountain Care Board has established a Primary Care Advisory Group in response to Section 10 of Act 113 of 2016. The Group consists of 22 primary care providers (four of whom were individually interviewed for this report). The Group was provided with a summary of draft findings and recommendations at its December 14, 2016 meeting, and Group members provided the following additional feedback regarding quality measurement and other administrative burdens:

- Providers experience specific burden around "clicking boxes" for clinical quality measures. Entering required information that is sometimes not germane into electronic health records takes time away from direct patient care.
- Compiling the documentation required to meet NCQA PCMH recognition standards in order to obtain Blueprint payments is very burdensome; the Group recommended eliminating the NCQA recognition requirement.
- Extensive coding for Medicare payment is extremely time-consuming, and the Group wondered if the alternative payment structure envisioned in the All-Payer Model Agreement presents an opportunity to work with the federal government to reduce those requirements.
- The Group also noted that more extensive coding for risk adjustment purposes, in order to accurately calculate quality measure results and financial targets, adds to the primary care workload.

This feedback is consistent with themes from the provider interviews conducted for this report. In addition, members offered support for the Primary Care Advisory Group serving as the provider component of the Measure Advisory Council.

Based on information gleaned from the performance measures catalogue and interviews, the GMCB has identified alignment plan elements recommended by stakeholders and developed the proposed alignment plan, as outlined in the following sections.

Recommended Elements of Proposed Alignment Plan

While this research revealed that lack of measure set alignment is not the principle source of primary care provider dissatisfaction, it also revealed opportunity for improved alignment—and stakeholders almost uniformly shared that view. Interviewees frequently described the current process by which measures are selected as "siloed" with little communication between measure sponsors. This observation most frequently pertained to interviewees' perceptions of federal measure sets, but implementation of state-level measure sets was not exempt from this criticism.

Most stakeholders believe that the State should play a role in facilitating alignment, although a number noted that the biggest contributor to non-alignment was the federal government. Some advocated for the GMCB to negotiate with CMS a delegation of measure set definition authority to the State so that Vermont could have one truly aligned measure set.

To respond to the legislative directive for the GMCB to develop a plan to align performance measures for primary care, GMCB staff identified the following principles during the course of discussions with primary care practices and other stakeholders across the state:

- There should be statewide priorities and guidelines for measure adoption, including consideration of broad population health goals.
- The measure review process should consider the administrative burden placed on practices when considering measure adoption.

- There should be a clear role for primary care clinicians in the measure review process.
- Practices should have access to a learning network or technical assistance resources specific to performance measurement; such technical resources could include Blueprint's quality improvement facilitators or the Vermont Care Organization's clinical consultants.

Proposed Alignment Plan

The GMCB recommends the following primary care measure alignment plan.

1. A Measure Alignment Council should be created and charged with coordinating and prioritizing performance measure sets specific to primary care in Vermont. This Measure Alignment Council should be broadly inclusive of primary care practice representatives from across Vermont, with additional participation from representatives of DVHA, private insurers, ACOs and consumers, but in limited number to ensure an efficient and effective body. The GMCB recommends four charges for the Measure Alignment Council:

    - Use the broad population goals established in the All-Payer ACO Model as a means of informing and prioritizing primary care measures across existing programs. While not all of the All-Payer ACO Model measures are applicable to individual primary care practices, some of them are, and primary care measures should be aligned with the All-Payer ACO Model measure set.
    - Provide input on the design of a clear and efficient process for consideration of potential measure introduction, retirement and replacement.
    - Identify technical assistance needs of primary care practices related to implementation of performance measures, and identify potential technical assistance resources.
    - Conduct a periodic assessment of alignment across measure sets for which primary care practices in the State of Vermont are held accountable.

    The All-Payer ACO Model identifies broad population and health goals as one of the primary benefits of pursuing the model. One of the tasks of the Measure Alignment Council could be to build upon the linkage between process milestones, health care delivery system quality measures, and population health measures reflected in the All-Payer ACO Model, a linkage that supports focus in quality improvement efforts. Another task could be to determine to what extent state measure sets should conform with additional federal measure sets, specifically the Medicare MIPS and Next Generation ACO measures.

    Given the mission and priorities of the GMCB, the Board could oversee implementation of the alignment plan. This view was supported by a number of interviewees, including both payers and providers. As one interviewee noted, "having GMCB lead is the only

answer … because GMCB is the only one looking at all … sources of measures." The Measure Alignment Council could periodically present measure set recommendations to the GMCB for review and approval.

2. As noted above, the lack of alignment of federal measure sets with one another was a source of significant concern. To the extent afforded by state law and Vermont's All-Payer ACO Model agreement with CMS, the GMCB should work with CMS under the All-Payer ACO Model to seek alignment between federal measure sets and state-specific measure sets affecting Vermont's primary care practices. The GMCB should work to ensure that ACO-payer and ACO-provider measures under the All-Payer ACO Model align with existing state measure sets, and that they comply with the processes developed with input from the Measure Alignment Council.

The goal of this recommended plan is to create a vehicle for prioritizing and aligning measures on a statewide basis. By housing this responsibility with the GMCB and obtaining input from the Measure Alignment Council, Vermont should be able to improve alignment of primary care measures that are within the State's control.

Appendix 1: Interviews Conducted for Act 112 Study

Stakeholder Type	Organization	Interviewee(s)	Date of Interview
Payers, State Agencies, and Medicare Quality Organization	Department of Vermont Health Access (DVHA): Medicaid Quality Unit	Erin Carmichael, Megan Mitchell	August 15, 2016
	DVHA: Blueprint for Health	Jenney Samuelson, Mary Kate Mohlman	August 22, 2016
	Green Mountain Care Board	Susan Barrett	August 23, 2016
	MVP Health Care	Susan Gretkowski, Cliff Waldman, MD, Mike Farina, Craig Jasenski, Jessica Muratore	August 23, 2016
	BCBSVT	Kelly Lange, Teresa Voci	August 24, 2016
	DVHA: Payment Reform	Alicia Cooper	September 1, 2016
	New England QIN-QIO	Jill McKenzie	September 8, 2016
	Vermont Department of Health	Heidi Klein	September 21, 2016
	Vermont Agency of Human Services	Shawn Skaflestad	October 14, 2016
Providers	Northern Counties Health Care	Sharon Fine, MD	August 31, 2016
	Northwestern Medical Center	Sarah DeSilvey, APRN	September 1, 2016
	Little Rivers Health Care	Fay Homan, MD	September 2, 2016
	Little Rivers Health Care	Donna Ransmeier	September 14, 2016
	Northern Counties Health Care	Tim Tanner, MD	September 6, 2016
	Hagan, Rinehart & Connolly Pediatricians, PLLC	Jill Rinehart, MD	September 16, 2016
	Middlebury Family Health	Jean Andersson-Swayze, MD and Stacy Ladd	September 20, 2016
	Appletree Bay Primary Care (UVM CNHS faculty practice)	Deborah Wachtel, NP	September 20, 2016
	OneCare Vermont	Norman Ward, MD, Sara Barry, and Leah Fullem	September 21, 2016
	Thomas Chittenden Health Center	Rick Dooley, PA	September 28, 2016
	Vermont Medical Society	Paul Harrington	October 24, 2016
	Family Practice of Newport	John Lippman, MD	October 27, 2016

Appendix 2: Measures Found in Each Measure Set

NQF Number	Measure Name	BCBSVT ACO Shared Savings Program		CMS MSSP	CMS MIPS	Proposed DVHA ACO Shared Savings Program	HRSA UDS	MVP		Vermont All-Payer ACO Model	Vermont Blueprint	
		Payment	Profile/ Reporting					Payment	Profile/ Reporting		Payment	Profile/ Reporting
0002	Appropriate Testing for Children with Pharyngitis		X		X				X			X
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	X								X		
0005	CAHPS: Getting Timely Care, Appointments, and Information			X								
0005	CAHPS: How Well Your Providers Communicate			X								
0005	CAHPS: Patient Rating of Provider			X								
0006	CAHPS: Health Status/Functional Status			X								
0018	Controlling High Blood Pressure	X		X	X		X		X	X[c]		
0022	Use of High-Risk Medications in the Elderly								X[m]			
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/ Adolescents		X		X		X		X			
0028	Tobacco Use: Screening and Cessation Intervention		X	X	X		X			X		
0031	Breast Cancer Screening			X				X	X			X
0032	Cervical Cancer Screening		X		X		X	X	X			X

NQF Number	Measure Name	BCBSVT ACO Shared Savings Program		CMS MSSP	CMS MIPS	Proposed DVHA ACO Shared Savings Program	HRSA UDS	MVP		Vermont All-Payer ACO Model	Vermont Blueprint	
		Payment	Profile/ Reporting					Payment	Profile/ Reporting		Payment	Profile/ Reporting
0033	Chlamydia Screening	X			X			X	X			
0034	Colorectal Cancer Screening		X	X	X		X		X			
0038	Childhood Immunization Status		X		X		X[m]		X[m]			
0041	Influenza Immunization			X	X							
0043	Pneumonia Vaccination Status for Older Adults			X								
0052	Use of Imaging Studies for Low Back Pain				X				X			X
0053	Osteoporosis Management in Women who had a Fracture (OMW)				X				X			
0054	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis								X			
0055	Comprehensive Diabetes Care: Eye Exam		X[c]	X	X	X[c]			X			X
0056	Diabetes: Foot Exam				X							
0057	Comprehensive Diabetes Care: Hemoglobin A1c Testing								X			X
0058	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	X			X				X			
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	X	X[c]	X	X	X[c]	X			X[c]	X	
0061	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)								X			
0062	Comprehensive Diabetes Care: Medical Attention for Nephropathy				X				X			X

NQF Number	Measure Name	BCBSVT ACO Shared Savings Program		CMS MSSP	CMS MIPS	Proposed DVHA ACO Shared Savings Program	HRSA UDS	MVP		Vermont All-Payer ACO Model	Vermont Blueprint	
		Payment	Profile/ Reporting					Payment	Profile/ Reporting		Payment	Profile/ Reporting
0066	Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy--Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)			X								
0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic			X	X		X					
0069	Appropriate Treatment for Children with Upper Respiratory Infection				X				X			X
0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)				X							
0071	Persistence of Beta-Blocker Treatment After a Heart Attack				X				X			
0081	Heart Failure (HF): Angiotensin- Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)				X							
0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)			X	X							
0101	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls			X	X[m]							

NQF Number	Measure Name	BCBSVT ACO Shared Savings Program		CMS MSSP	CMS MIPS	Proposed DVHA ACO Shared Savings Program	HRSA UDS	MVP		Vermont All-Payer ACO Model	Vermont Blueprint	
		Payment	Profile/ Reporting					Payment	Profile/ Reporting		Payment	Profile/ Reporting
0105	Anti-depressant Medication Management				X				X			
0108	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication				X				X[m]			
0209	Pain Brought Under Control Within 48 Hours				X							
0275	Chronic Obstructive Pulmonary Disease (PQI-05)		X	X								
0277	Congestive Heart Failure Admission Rate (PQI-08)			X								
0326	Advance Care Plan				X							
0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis				X							
0409	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis				X							
0418	Screening for Clinical Depression and Follow-Up Plan		X	X	X		X			X		
0419	Documentation of Current Medications in the Medical Record			X	X							
0421	Adult Body Mass Index (BMI) Assessment		X	X	X							
0549	Pharmacotherapy Management of COPD Exacerbation								X[m]			
0575	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) (CDC)								X			

NQF Number	Measure Name	BCBSVT ACO Shared Savings Program		CMS MSSP	CMS MIPS	Proposed DVHA ACO Shared Savings Program	HRSA UDS	MVP		Vermont All-Payer ACO Model	Vermont Blueprint	
		Payment	Profile/ Reporting					Payment	Profile/ Reporting		Payment	Profile/ Reporting
0576	Follow-Up After Hospitalization for Mental Illness	X			X				X			
0577	Use of Spirometry Testing in the Assessment and Diagnosis of COPD								X			
0653	Acute Otitis Externa (AOE): Topical Therapy				X							
0654	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use				X							
0710	Depression Remission at Twelve Months			X	X							
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment				X							
1382	Live Births Weighing Less Than 2,500 Grams						X					
1392	Well-Child Visits in the First 15 Months of Life							X	X			
1407	Immunizations for Adolescents				X			X[m]	X[m]			
1448	Developmental Screening In the First Three Years of Life		X			X					X	
1516	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life							X	X			X
1517	Prenatal & Postpartum Care					X	X[m]					
1525	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy				X							
1768	Plan All-Cause Readmission	X							X			

NQF Number	Measure Name	BCBSVT ACO Shared Savings Program		CMS MSSP	CMS MIPS	Proposed DVHA ACO Shared Savings Program	HRSA UDS	MVP		Vermont All-Payer ACO Model	Vermont Blueprint	
		Payment	Profile/ Reporting					Payment	Profile/ Reporting		Payment	Profile/ Reporting
1799	Medication Management for People with Asthma				X				X[m]	X		
1800	Asthma Medication Ratio								X			
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)								X			
1959	Human Papillomavirus (HPV) Vaccine for Female Adolescents								X			
2082	HIV Viral Load Suppression				X							
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling				X							
2371	Annual Monitoring for Patients on Persistent Medications								X[m]			
2372	Breast Cancer Screening				X							
2508	Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk						X					
NA	Adolescent Well-Care	X						X	X	X	X	X
NA	Adult BMI Assessment								X			
NA	Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Overuse)				X							
NA	Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use)				X							

NQF Number	Measure Name	BCBSVT ACO Shared Savings Program		CMS MSSP	CMS MIPS	Proposed DVHA ACO Shared Savings Program	HRSA UDS	MVP		Vermont All-Payer ACO Model	Vermont Blueprint	
		Payment	Profile/ Reporting					Payment	Profile/ Reporting		Payment	Profile/ Reporting
NA	Adult Sinusitis: Computerized Tomography for Acute Sinusitis (Overuse)				X							
NA	Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)				X							
NA	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users				X							
NA	CAHPS ACO Survey: Access to Specialist		X	X								
NA	CAHPS PCMH Survey: Access to Care Composite		X									X
NA	CAHPS PCMH Survey: Communications Composite		X									
NA	CAHPS PCMH Survey: Comprehensiveness Composite		X									
NA	CAHPS PCMH Survey: Coordination of Care Composite		X									
NA	CAHPS PCMH Survey: Information Composite		X									
NA	CAHPS PCMH Survey: Office Staff Composite		X									
NA	CAHPS PCMH Survey: Self-Management Support Composite		X									
NA	CAHPS PCMH Survey: Shared Decision Making		X	X								
NA	CAHPS: Health Promotion and Education			X								

NQF Number	Measure Name	BCBSVT ACO Shared Savings Program		CMS MSSP	CMS MIPS	Proposed DVHA ACO Shared Savings Program	HRSA UDS	MVP		Vermont All-Payer ACO Model	Vermont Blueprint	
		Payment	Profile/ Reporting					Payment	Profile/ Reporting		Payment	Profile/ Reporting
NA	CAHPS: Stewardship of Patient Resources			X								
NA	Cholesterol Treatment (Lipid Therapy for Coronary Artery Disease Patients)						X[m]					
NA	Documentation of Signed Opioid Treatment Agreement				X							
NA	Elder Maltreatment Screen and Follow-Up Plan				X							
NA	Evaluation or Interview for Risk of Opioid Misuse				X							
NA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence									X		
NA	Follow-Up After Emergency Department Visit for Mental Illness					X				X		
NA	Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk				X							
NA	Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in patients with Hepatitis C Cirrhosis				X							
NA	HIV Linkage to Care						X					
NA	Lead Screening in Children								X			
NA	Non-Recommended Cervical Cancer Screening in Adolescent Females				X							
NA	Opioid Therapy Follow-up Evaluation				X							
NA	Optimal Asthma Control				X							

NQF Number	Measure Name	BCBSVT ACO Shared Savings Program		CMS MSSP	CMS MIPS	Proposed DVHA ACO Shared Savings Program	HRSA UDS	MVP		Vermont All-Payer ACO Model	Vermont Blueprint	
		Payment	Profile/ Reporting					Payment	Profile/ Reporting		Payment	Profile/ Reporting
NA	Osteoarthritis (OA): Function and Pain Assessment				X							
NA	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment			X								
NA	Prevention Quality Indicators #92: Chronic Conditions Composite	X				X					X	
NA	Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented			X	X							
NA	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists				X							
NA	Rate of Ambulatory ED Visits per 1,000 MM					X						
NA	Rx Generic Rate								X			
NA	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease			X	X							
NA	Tobacco Use and Help with Quitting Among Adolescents				X							
NA	Tuberculosis Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier				X							

NQF Number	Measure Name	BCBSVT ACO Shared Savings Program		CMS MSSP	CMS MIPS	Proposed DVHA ACO Shared Savings Program	HRSA UDS	MVP		Vermont All-Payer ACO Model	Vermont Blueprint	
		Payment	Profile/ Reporting					Payment	Profile/ Reporting		Payment	Profile/ Reporting
NA	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older				X							

X^c: Indicates that the measure is included as a composite measure in the measure set. However, each measure component is counted separately for the purpose of this analysis.
X^m: Indicates that the measure sets include a modified version, or only a specific component, of the specified measure.