Proposal for Delivery System Reforms:

Integrating Vermont ACO and Blueprint Activities

Phase II Payment Reforms

Developed in Collaboration

Vermont Blueprint for Health

One Care

CHAC

Health First

Introduction

This proposal presents a plan for a next phase of delivery system reforms in Vermont to increase the capacity of primary care, provide citizens with better access to team based services, and strengthen the basis for a community oriented health system structure across Vermont. The suggested programmatic and payment changes are designed to establish a more systematic approach to coordinating local services and quality initiatives across the state. This will be achieved thru integration of Accountable Care Organization (ACO) and Blueprint program activities in a unified collaborative to guide quality and coordination initiatives in each service area; and, an aligned medical home payment model that promotes coordination and better service area results on core measures of quality and performance. The proposed changes represent a natural next phase for the evolution of health services in Vermont by building on delivery system advancements in each community, and on the organizational capabilities of the three ACO provider networks (OneCare, CHAC, and Healthfirst). The structural, programmatic and payment changes proposed in this plan are designed to achieve the aim of providing citizens with more accessible services; more equitable services; more patient centered services; more recommended and preventive services; and more affordable services.

Background

Blueprint. During the last six years, stakeholders across the state have worked with the Blueprint program to implement a novel healthcare model designed to provide citizens with better access to preventive health services, and to improve control over growth in healthcare costs. The statewide model includes:

- high quality primary care based on national standards for a patient centered medical home
- community health teams providing the medical home population with access to multi-disciplinary staff such as nurse care coordinators, social workers, and dieticians
- integrated health services workgroups to strengthen networks in each community and improve coordination between medical and social services and
- a statewide learning health system thru data guided quality initiatives at the practice, community, and statewide levels.

Implementation of the model has been supported by Multi-insurer payment reforms, as well as Blueprint grants to each area of the state that support project managers, practice facilitators, self-management programs, and assistance with health information technology and data quality. Results of a six year trend analysis demonstrate improvements in healthcare utilization, healthcare expenditures, better linkage of Medicaid beneficiaries to social support services, and improvements in healthcare quality (HEDIS).

Provider Networks. At the same time, Vermont's healthcare reform initiatives have continued to push forward on several fronts including implementation of an insurance exchange in alignment with the Affordable Care Act (Vermont Health Connect), and the introduction of shared savings programs designed to improve quality and control over health care costs. As part of this process, healthcare providers have established three statewide ACO networks based on common business interests. The three networks include OneCare, CHAC, and HealthFirst. Each of the three provider networks has established an administrative structure to guide participation in Vermont's healthcare reform processes including participation in shared savings programs. These new provider networks, and in particular their ability to organize initiatives and represent the interests of their constituents, adds important organizational capacity to Vermont's healthcare landscape.

Integration. The three ACO provider networks can help to organize healthcare improvement priorities with their members (vertical organization). The Blueprint program with Community Health Teams and Integrated Workgroups has helped to organize coordination at a community level, across settings and provider types (horizontal). This plan blends these strengths and adds meaningful participation of additional provider types, in a formal collaborative structure that will improve services for citizens in each service area in Vermont. Modifications to current medical home payments are proposed which are integral to support coordination in each community, and to align medical home incentives with the quality and performance goals of the new collaboratives.

Programmatic Changes

Unified Community Collaboratives - Principles & Objectives. Presently, an array of meetings focused on quality and coordination are taking place in communities across Vermont. Most areas have Blueprint integrated health services workgroups as well as workgroups for participants in the provider network shared savings programs (ACOs). The Blueprint meetings are oriented towards coordination of community health team operations and services across providers in the community (community, horizontal) while the ACO meetings are oriented towards meeting the goals of the participating provider network (organizational, vertical). The same providers may be participating in multiple meetings, with overlapping but distinct work on coordination of services and quality.

This proposal calls for development of a Unified Community Collaborative (UCC) in each Hospital Service Area (HSA) in order to coalesce quality and coordination activities, strengthen Vermont's community health system infrastructure, and to help the three provider networks meet their organization goals. In many areas of the state the proposed collaboratives represent a significant advancement in terms of the assortment of provider types who would participate in, and help lead, a unified forum. They build on a strong community oriented culture in the state with the underlying premise that the UCC structure, with administrative support and an aligned medical home payment model, will result in more effective health services as measured by:

- Improved results for priority measures of quality
- Improved results for priority measures of health status
- Improved patterns of utilization (preventive services, unnecessary care)
- Improved access and patient experience

Unified Community Collaboratives – Activities. As proposed, the UCCs will provide a forum for organizing the way in which medical, social, and long term service providers' work together to achieve the stated goals including:

- Use of comparative data to identify priorities and opportunities for improvement
- Use of stakeholder input to identify priorities and opportunities for improvement
- Develop and adopt plans for improving
    - quality of health services
    - coordination across service sectors
    - access to health services
- Develop and adopt plans for implementation of new service models
- Develop and adopt plans for improving patterns of utilization
    - Increase recommended and preventive services
    - Reduce unnecessary utilization and preventable acute care (variation)
- Work with collaborative participants to implement adopted plans and strategies including providing guidance for medical home and community health team operations

Unified Community Collaboratives – Structure & Governance. To date, Blueprint project managers have organized their work based on a collaborative approach to guiding community health team operations and priorities. In most cases, this has stimulated or enhanced local innovation and collaborative work. The three new medical provider networks have each established a more formal organizational structure for improving quality and outcomes among their constituents. The provider networks are looking to establish improved collaboration and coordination with a range of service providers in each community. The proposed collaboratives build from these complimentary goals and capabilities, enhance community coordination, and improve the ability for each provider network to achieve their goals. This is accomplished using a formal structure with a novel leadership team that balances the influence of the three medical provider networks, and the influence of medical, social, and long term providers.

We are proposing that the UCC in each HSA have a leadership team with up to 11 people based on the following structure:

- 1 local clinical lead from each of the three provider networks in the area
    - OneCare

  - CHAC
  - HealthFirst (not present in all HSAs)
- 1 local representative from each of the following provider types that serves the HSA
  - VNA/Home Health
  - Designated Agency
  - Designated Regional Housing Authority
  - Area Agency on Aging
  - Pediatric Provider
- Additional representatives selected by local leadership team (up to total of 11)

The proposal is for the leadership team to guide the work of the UCC in their service area with responsibilities including:

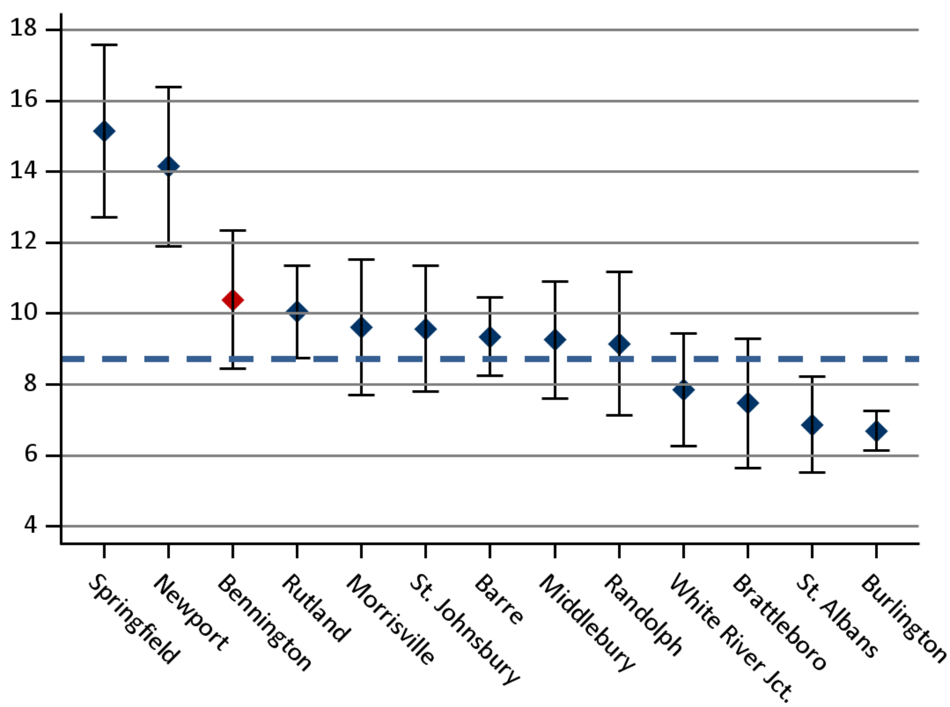
- Developing a plan for their local UCC
- Inviting the larger group of UCC participants in the local service area (including consumers)
- Setting agendas and convening regular UCC meetings (e.g. monthly)
- Soliciting structured input from the larger group of UCC participants
- Making final decisions related to UCC activities (consensus, vote as necessary)
- Establishing UCC workgroups to drive planning & implementation as needed

The UCC leadership team will be supported in their work with the following resources:

- Leadership team participation from each ACO provider network in the area
- Organizational support from the ACO provider networks
- Goals and objectives established by ACO provider networks
- Convening and organizing support from the Blueprint project manager
- Support on quality work from Blueprint practice facilitators
- Blueprint HSA grants structured to support the work of the UCC
- Collaboration between the Blueprint and UCC leaders on analytics & evaluation
- ACO Provider network performance reporting on the ACO population
- Blueprint profiles with comparative performance reporting on the whole population, including the results of core ACO measures (practice, HSA levels)
- Ongoing programmatic collaboration (Blueprint, Provider Networks, UCC leaders, others)
- Modification to medical home payments to support provider networks and UCC goals

Unified Community Collaboratives – Basis for Regional Health Systems. As UCCs mature, they have the potential to emerge as governing and fiscal agents in regionally organized health systems. This could include decision making and management of community health team funds, Blueprint community grants, and ultimately budgets for sectors of health services (e.g. pre-set capitated primary care funds). In order to be effective an agent for cohesive regional systems, it is essential for UCCs to establish leadership teams, demonstrate the capability to engage a range of providers in sustained collaborative activity (medical, social, and long term support providers), demonstrate the capability to lead quality and coordination initiatives, and demonstrate the ability to organize initiatives that tie to overall healthcare reform goals (e.g. core measures). Ideally, UCCs will demonstrate effective regional leadership to coincide with opportunities offered by new payment models and/or a federal waiver in 2017.

Unified Community Collaboratives – Opportunity to Guide Improvement. Current measurement of regional and practice level outcomes across Vermont highlights opportunities for UCCs to organize more cohesive services and lead improvement. When adjusted for differences in the population, there is significant variation in measures of expenditures, utilization, and quality. The variation across settings offers an opportunity for UCC leadership teams and participants to examine differences, and to plan initiatives that can reduce unnecessary variation and improve rates of recommended services. One example is the Prevention Quality Indicator (PQI) measuring the rate of hospitalizations per 1,000 people, ages 18 and older, for a composite of chronic conditions including: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputations, COPD, asthma, hypertension, heart failure, and angina without a cardiac procedure. The 2013 service area results for this indicator, which is included in Vermont's core measure set for shared savings programs, highlights the variation that is seen with most core quality and performance measures.



Overall improvement in this measure, and reduction in variation across settings, is most likely with well-planned coordination across provider types including primary care, specialty care, and community services that improve self-management capabilities for vulnerable populations such as seniors without adequate support. Hospitalization rates for these types of conditions are driven by complex life circumstances, often related to social, economic, and behavioral factors that influence the ability to engage in daily preventive care. While the measure is one of traditional healthcare utilization, outcomes will be better with cohesive integration of health and human services addressing non-medical as well as medical needs. The UCC, and the proposed leadership team, is designed to establish a structured forum to guide this level of integration. A coordinated effort to identify those at risk in the community, to assess the factors that limit effective management, and to organize a community team approach to prevention will have the greatest opportunity to improve outcomes.

Payment Model

Current payment structure. To date, two payments have been adopted by all major insurers to support the roll out and maturation the Blueprint program. The first payment is made to primary care practices based on their score on NCQA medical home standards. In effect, this represents a payment for the <u>quality</u> of services provided by the practice as assessed by the NCQA standards. The second is a payment to support community health team staff as a shared cost with other insurers. This represents an up-front investment in <u>capacity</u> by providing citizens with greater access to multi-disciplinary medical and social services in the primary care setting. Both are capitated payments (PPPM) applied to the medical home population. Although these two payments are relatively low compared to the overall revenue that primary care practices generate; when combined with the dedication of primary care practice teams and the Blueprint program supports, they have led to statewide expansion of medical homes and community health teams. There is growing evidence that medical homes and community health teams favorably impact healthcare expenditures, utilization, and quality. However, the medical home payments have not been increased in the last six years and are widely perceived as inadequate to support the effort required to comply with increasingly demanding NCQA standards. Some practices, particularly independent practices that don’t have the administrative support that hospital affiliated practices and health centers have, may choose not to continue participating at the current payment levels due to the time and costs associated with medical home recognition and operations. Similarly, community health team payments have not kept up with the administrative costs that are required to operate the expanded program, or the salary and compensation costs to employ the workforce. In some cases, this has led to a reduction in the staffing that is available to patients as adjustments are made to accommodate administrative and staff salary pressures. Lastly, while these payments have stimulated successful program expansion, it is important to consider whether a modified medical home payment model can be used to support collaborative activity and the effectiveness of a community health system infrastructure.

Proposed medical home payment structure. The proposed medical home payment model is designed to more adequately fund medical home costs, and to directly align medical home incentives with the goals of the collaboratives and the ACO provider networks. The proposed payment changes anticipate multi-payer participation, a doubling of medical home payments, and a new performance component to the payment model. In this proposal, the total capitated payment to medical homes is based on a composite of medical home recognition, collaborative participation, and performance. The outcome measures driving the performance component include a Quality Index comprised of core ACO quality measures, and a Total Utilization Index. Improvement on these metrics, such as higher scores on the quality index and less variation on the utilization index, is directly aligned with the goals of Vermont's health reforms. The new medical home payment model includes the following elements:

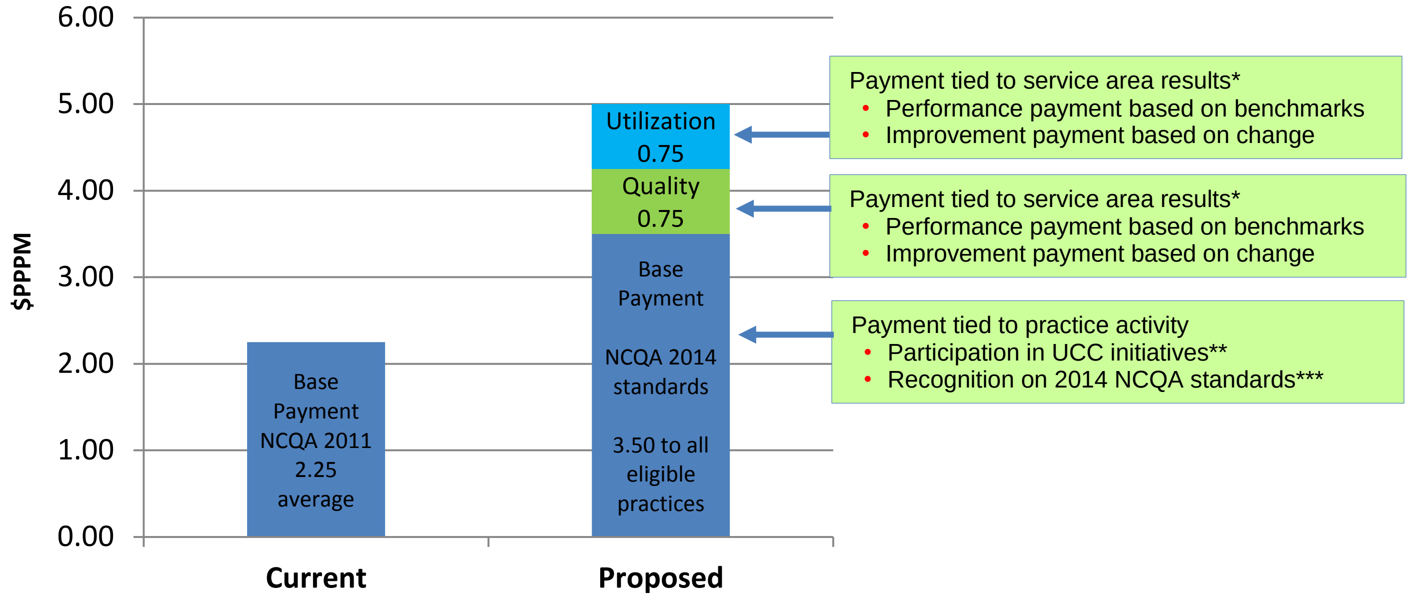
- Base Component: Based on NCQA recognition & UCC Participation.
  - Requires successful recognition on 2014 NCQA standards (any qualifying score)
  - Requires active participation in the local UCC including; orienting practice and CHT staff activities to achieve the goals that are prioritized by the local UCCs. Minimum requirement is active participation with at least one UCC priority initiative each calendar year.
  - All qualifying practices receive $3.50 PPPM

- Quality Performance Component: Based on HSA results for Quality Index.
  - Up to $ 0.75 PPPM for results that exceed benchmark, or
  - Up to $ 0.50 PPPM for significant improvement if result is below benchmark

- Utilization Performance Component: Based on HSA results for Utilization Index.
  - Up to $ 0.75 PPPM for results that exceed benchmark, or
  - Up to $ 0.50 PPPM for significant improvement if result is below benchmark

- Total Payment = Base + HSA Quality Performance + HSA TUI Performance
- Total Payment ranges from $3.50 to $5.00 PPPM

Comparison of current and proposed medical home payments



*Incentive to work with UCC partners to improve service area results.
**Organize practice and CHT activity as part of at least one UCC quality initiative per year.
***Payment tied to recognition on NCQA 2014 standards with any qualifying score. This emphasizes NCQAs priority 'must pass' elements while de-emphasizing the documentation required for highest score.

The new payment model is designed to promote collaboration and interdependent work by linking a portion of each practices potential earnings to measure results for the whole service area (HSA). It is also intended to more directly focus efforts on improved health outcomes and reduced growth in health expenditures. In theory, the combination of the UCC structure and decision making process, with the interdependent nature of the payment model, will lead to better organization and coordination across provider groups. In contrast, a medical home payment linked solely to practice quality is less likely to stimulate better coordination across a service area. Although fee for service is still the predominate payment, this suggested payment model is an important *step* towards a more complete capitated payment structure with a performance component that is anticipated for 2017. It will help to stimulate the culture and activity that is essential for a high value, community oriented health system. The implementation of this payment model is only possible with an increase in payment amounts to more adequately support the work that is required to operate a medical home and the multi-faceted payment structure. The incentive structure that is woven into the payment model includes:

- Requires active and meaningful participation in UCCs including: attention to variable and unequal outcomes on core measures; and, coordination with collaborative partners to improve services.

- Requires that practices maintain NCQA recognition, however shifts the emphasis to the most important Must Pass elements in the medical home standards and de-emphasizes the intensive documentation that is required to achieve the highest score.
- Introduces a balance between payment for the quality of the process (NCQA standards) and payment for outcomes (quality and utilization)
- Rewards coordination with UCC partners to achieve better results on service area outcomes for a composite of core quality measures (directly links incentives for medical homes to statewide healthcare reform priorities)
- Rewards coordination with UCC partners to achieve better service area results for the total utilization index (case mix adjusted), which has a predictable impact on healthcare expenditures (directly links incentives for medical homes to statewide healthcare reform priorities)

Opportunity to improve care and reduce variation. It is important to note that across Vermont there is significant variation in the results of quality and utilization measures, after adjustment for important differences in the populations served. Unequal quality and utilization, for comparable populations with comparable health needs, provides an opportunity to examine differences in regional health services, and to plan strategies that improve the overall quality of healthcare that citizens receive. The Blueprint currently publishes Profiles displaying comparative measure results for each participating practice and for each service area. The profiles include the results of core quality measures which have been selected thru a statewide consensus process. The objective display of the variation that exists across service areas, and across practices within each service area, can support the work of the UCCs including identification of opportunities where quality and utilization should be more equal, and implementation of targeted strategies to reduce undesirable variation.

Proposed changes for community health team payments. Currently, community health team payments average $1.50 PPPM. This proposal calls for an increase to $3.00 PPPM to increase ancillary support services available to medical home patients, and to more adequately support salary and administrative costs for a community team infrastructure. In addition to the increase, the proposal is to adjust each insurer's share of community health team costs to reflect their proportion of attributed medical home patients in the Vermont market. This will be calculated by applying each insurer's percentage of the attributed medical home population to the total community health team costs. Total community health team costs will be based on the total number of unique patients reported by medical home practices using a 24 month look back. Insurers proportion of the medical home population will be updated with a new attribution count twice yearly. Due to the terms in the current Multi-Payer Demonstration Program with CMS, Medicare's share will remain constant with a 22.22% share of community health team costs which is in close alignment with their market share. An example of the change to each insurer's share of costs, based on their current proportion of attributed medical home patients, is shown below.

Market share basis for community health team costs.

	Current share of CHT Costs	Proposed share of CHT Costs*
Medicare	22.22%	22.22%
Medicaid	24.22%	35.66%
BCBS	24.22%	36.92%
MVP	11.12%	4.71%
Cigna	18.22%	0.49%
Total	100.00%	100.00%

*Each insurer's percentage of community health team cost is based on their attributed proportion of the total medical home population.

Quality and Performance Framework

Design Principles. This plan calls for use of Vermont's core performance and quality measures, in conjunction with comparative performance reporting, to help guide UCC activities and medical home payments. This approach ties the work of medical homes and UCCs directly to priorities for state led health reforms as reflected by the core measure set, which was selected using a statewide consensus process as part of the Vermont Healthcare Improvement Program (SIM). The three medical provider networks share a common interest in the results of the core measures which are used to determine whether network clinicians are eligible for payment as part of shared savings programs (SSP).

The proposal calls for use of a subset of these measures, which can be consistently reported using centralized data sources, to provide targeted guidance for the work of the UCCs. The intent is that UCCs will work to improve the results on some or all of the subset, depending on local priorities and the decisions made by each UCC. The subset of measures will be also be used to generate an overall composite result for the service area (quality composite). The composite result will be used to determine whether medical homes are eligible for a portion of their augmented payment (see payment model).

In addition to the subset of core quality and performance measures, this plan incorporates use of the Total Resource Utilization Index (TRUI), a standardized and case mix adjusted composite measure designed for consistent and comparable evaluation of utilization and cost across settings. Comparative results of the TRUI, adjusted for differences in service area populations, can be used in combination with more granular utilization measures to identify unequal healthcare patterns and opportunities for UCC participants to reduce unnecessary utilization that increases expenditures but doesn't contribute to better quality. Similar to the core quality and performance composite, the service area result for the TRUI will be used to determine whether medical homes are eligible for an additional portion of their augmented payment (see payment model).

Used together, the two composite measures promote a balance of better quality (core quality and performance) with more appropriate utilization (TRUI). Linking payment to measure results for the whole service area establishes interdependencies and incentives for medical home providers to work closely with other collaborative participants to optimize outcomes. Routine measurement and comparative reporting provides UCCs with the information they need to guide ongoing improvement. In this way, the proposed measurement framework serves as the underpinning for a community oriented learning health system and helps UCCs to:

- Establish clear measurable goals for the work of the collaborative
- Guide planning and monitoring of quality and service model initiatives
- Align collaborative activities with measurable goals of state led reforms
- Align collaborative activities with measurable goals of shared saving programs

Measure Set. Implementation of this plan depends on selection of a subset of quality and performance measures from the full core measure set that was established thru VHCIP. The intent is for a *meaningful* limited set that can be measured consistently across all service areas, using centralized data sources that are populated as part of daily routine work (e.g. all payer claims database, clinical data warehouse). Ideally, measures will be selected that maximize measurement capability with existing data sources, prevent the need for additional chart review, and avoid new measurement burden for providers. At the same time, work should continue to build Vermont's data infrastructure so that more complete data sets and measure options are available. Vermont's full set of core measures are shown in Appendix A, with the subset that can currently be generated using centralized data sources shown below:

- Plan All-Cause Readmissions
- Adolescent Well-Care Visit
- Ischemic Vascular Disease (IVD): Complete Lipid Panel (Screening Only)
- Follow-up after Hospitalization for Mental Illness, 7 Day
- Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (a) Initiation, (b) Engagement
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Developmental Screening in the First Three Years of Life

- Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults
- Mammography / Breast Cancer Screening
- Rate of Hospitalization for Ambulatory Care Sensitive Conditions: PQI Chronic Composite
- Appropriate Testing for Children with Pharyngitis
- Cervical Cancer Screening
- Influenza Vaccination
- Percent of Beneficiaries With Hypertension Whose BP<140/90 mmHg
- Pneumonia Vaccination (Ever Received)
- Ambulatory Sensitive Condition Admissions: Congestive Heart Failure
- Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use - Adult
- Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%) – Adult
- Comprehensive Diabetes Care: Eye Exams for Diabetics
- Comprehensive Diabetes Care: Medical Attention for Nephropathy

Process to select measures. Given the importance of these measures, a stepwise process is recommended to select a subset that will be used to help guide the work of UCCs, and as the basis for a performance portion of medical home payments.

- Leadership from the three provider networks recommends a consensus subset. It is essential for medical home clinicians to help prioritize the subset since their payment is partly tied to service area results. This first step allows the primary care community to coalesce around a subset of measures, which are selected from an overall set that represents state level reform priorities (statewide consensus process).
- The consensus subset, recommended by the three provider networks, should be vetted thru key committees to assure that a balanced subset is selected (meaningful, practical, and usable). Committees to be considered include: VHCIP - Quality & Performance Measurement Workgroup, Payment Models Workgroup, Core Committee; BP - Executive Committee, Planning & Evaluation Committee.

Attributes that should be considered when selecting the subset include:

- Will improvement in these measures contribute in a meaningful way to the goals of Vermont's health reforms (e.g. quality, health, affordability)
- Is there a real opportunity for service areas to improve the results of these measures with better quality and coordination (UCC work, medical homes)?
- Is sufficient data currently available so that these measures can be measured in all service areas?

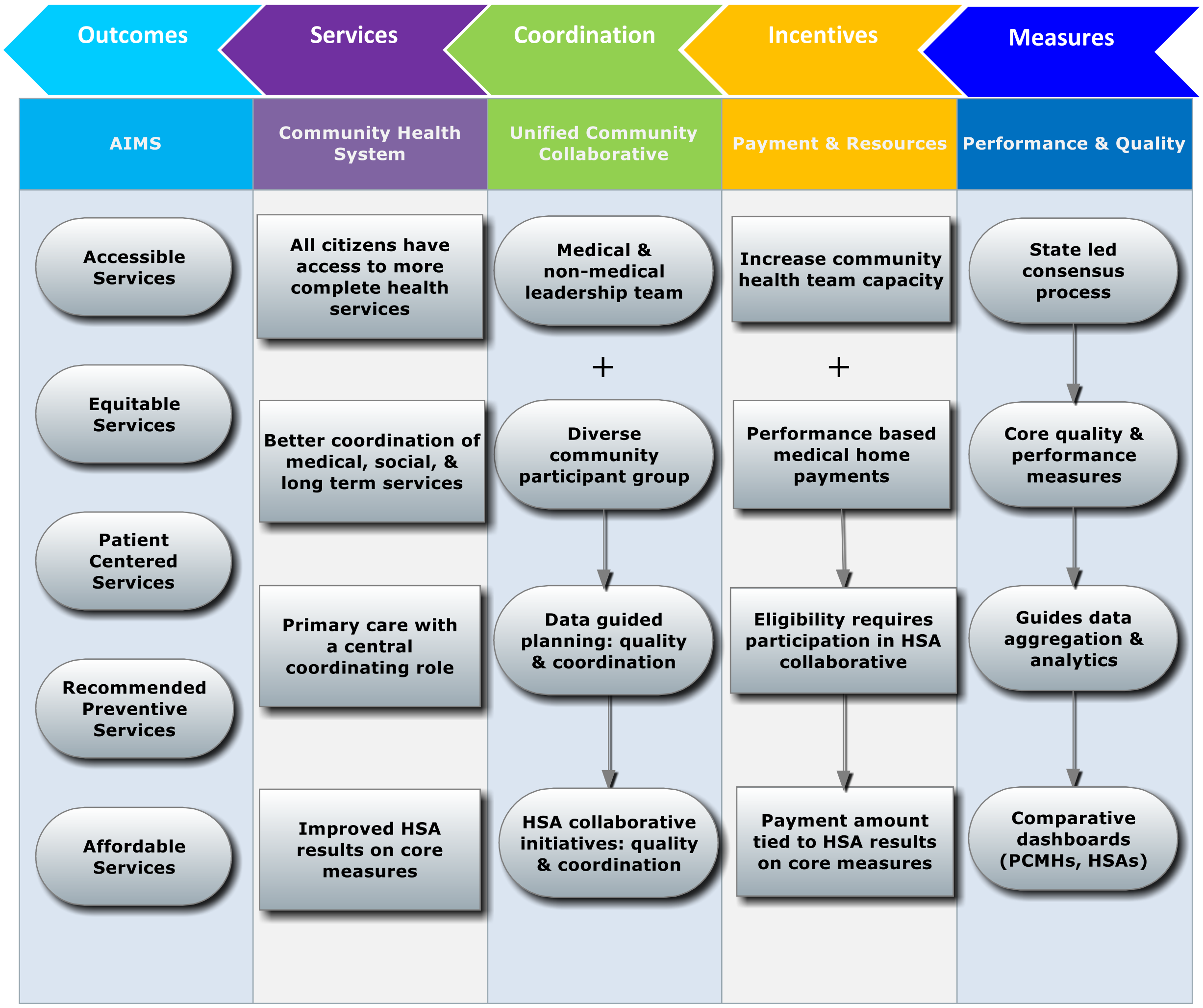
- Can measure results be generated and routinely reported, in a usable format, for use by UCC participants?
- Are regional and national benchmarks available for these measures?

Linking Healthcare & Population Health. The most substantial improvement in results for these core performance and quality measures is likely to be achieved by addressing the medical, social, economic, and behavioral components that converge to drive poor health outcomes. Although the core measures are oriented to the healthcare sector, the program and payment strategies outlined in this plan stimulate interdependency and coordination of a broader nature. The makeup of the collaborative leadership team, decision making process, and link between medical home payment and service area outcomes are all designed to assure that citizens have access to more cohesive and complete services. Collectively, the plan is a first step in using comparative measurement as a driver for a broader community health system. However, an important next step would be to incorporate measures that reflect non-medical determinants as part of the framework to guide community health system activities. As part of this plan, it is recommended that the VHCIP Population Health workgroup work with provider network leadership and other stakeholders to identify a subset of core population health measures that can be reliably measured and used in concert with the current core quality and performance measures.

Strategic Framework for Community Health Systems

This plan is intended to provide Vermont's citizens with more accessible services; more equitable services; more patient centered services; more recommended and preventive services; and more affordable services. Strategically, the plan starts with Vermont's consensus based core performance and quality measures, and positions these measures as drivers for local community level learning health systems. Medical home financial incentives are in part tied to service area results for these core measures and to their participation in local collaborative initiatives. The collaboratives are designed to lead initiatives which will improve quality and performance, including the results of core measures, thru better coordination. Ultimately, data guided community initiatives, involving medical and non-medical providers, will provide citizens with direct access to more complete and effective services. The use of core measures as proposed, with detailed information on local variation and outcomes, is a substantial step towards a performance oriented community health system. Results to date in Vermont suggest that medical homes working with community health teams, and other local providers, will lead to a measurable increase in recommended preventive services and a reduction in unnecessary and avoidable services. The strategic framework to achieve the desired aims is outlined below.

Strategic Framework.



Decision Points.

Successful implementation of this plan depends on several key actions and decision points. First, the plan depends on an increase in medical home and community health team payment levels. As part of his budget proposal to the Vermont state legislature, Governor Shumlin announced his intention to increase Medicaid's portion of these payments starting January 1, 2016. His proposal calls for a doubling of current amounts which will support the new performance based payment model, an essential ingredient to maintain primary care participation and to stimulate community health system activity across Vermont. To be effective, these increases need to be multi-payer, involving all major insurers in Vermont.

Second is the selection of a subset of Vermont's consensus measures that will be used to comprise the quality index portion of the payment model. These measures are important since they will help set priorities for community improvement and medical home payment. They must be consistently measurable across all service areas with sufficient historical data so that benchmarks for payment and improvement can be set. Pragmatically, the data should be available in Vermont's central data sources so that additional local data collection is not necessary.

Third is the structure of the payment model. This includes the number of components that are included in the composite payment structure, the weight of each component, and the use of service are results to drive a portion of the payments. This proposal calls for three components with the following weights; Base ($3.50 PPPM for all eligible practices), Quality (up to $0.75 PPPM based on performance), and Utilization (up to $0.75 PPPM based on performance). It also calls for the use of service area results to determine whether practices receive the performance portions of the payment. This represents an increase in the base payment for all participating medical home practices while introducing performance based components with an incentive to coordinate closely with other local providers.

This structure is based on extensive discussion and input with the three ACO provider networks, Blueprint committees and local program participants, Vermont's insurers, and with VHCIP committees. While there is not unanimous agreement, this structure provides a strong consensus based plan with incentives that are designed to elevate community health system coordination and learning health system activity to a new level.

Appendix A. VHCIP Core Quality & Performance Measures

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-1		Plan All-Cause Readmissions	NQF #1768, HEDIS measure	Adult	For members 18 years and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.
Core-2		Adolescent Well-Care Visit	HEDIS measure	Pediatric	The percentage of members 12-21 years who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.
Core-3	MSSP-29	Ischemic Vascular Disease (IVD): Complete Lipid Panel (Screening Only)	NQF #0075, NCQA	Adult	The percentage of members 18-75 years who were discharged alive for acute myocardial infarction, coronary artery bypass grafting, or percutaneous coronary intervention in the year prior to the measurement year or who had a diagnosis of Ischemic Vascular Disease during the measurement year and one year prior, who had LDL-C screening.
Core-4		Follow-up after Hospitalization for Mental Illness, 7 Day	NQF #0576, HEDIS measure	Adult	The percentage of discharges for members 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.
Core-5		Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (a) Initiation, (b) Engagement	NQF #0004, HEDIS measure	Adult	(a) The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received initiation of AOD treatment within 14 days. (b) The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and had two additional services with a diagnosis of AOD within 30 days of the initiation visit.
Core-6		Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	NQF #0058, HEDIS measure	Adult	The percentage of adults 18-64 years with a diagnosis of acute bronchitis who were not dispensed an antibiotic.
Core-7		Chlamydia Screening in Women	NQF #0033, HEDIS measure	Adult and Pediatric	The percentage of women 16-24 years who were identified as sexually active and who had at least one test for chlamydia during the measurement period.

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-8		Developmental Screening in the First Three Years of Life	NQF #1448	Pediatric	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.
Core-10	MSSP-9	Ambulatory Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	NQF, AHRQ (Prevention Quality Indicator (PQI) #5)	Adult	All discharges with an ICD-9-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or asthma. This is an observed rate of discharges per 1,000 members.
Core-11	MSSP-20	Mammography / Breast Cancer Screening	NQF #0031, HEDIS measure	Adult	The percentage of women 50-74 years who had a mammogram to screen for breast cancer in the last two years.
Core-12		Rate of Hospitalization for Ambulatory Care Sensitive Conditions: PQI Chronic Composite	NQF, AHRQ (Prevention Quality Indicator (PQI) Chronic Composite)	Adult	Prevention Quality Indicators' (PQI) overall composite per 100,000 population, ages 18 years 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, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection.
Core-13		Appropriate Testing for Children with Pharyngitis	NQF #0002	Pediatric	Percentage of children 2-18 years who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A strep test for the episode.
Core-14		Childhood Immunization Status (Combo 10)	NQF #0038, HEDIS measure	No	The percentage of children 2 years of age who had each of nine key vaccinations (e.g., MMR, HiB, HepB, etc.).

VT Measure ID	Medicare Shared Savings Program Measure ID	Measure Name	Nationally Recognized/ Endorsed	Included in HSA Profile?	Measure Description
Core-15		Pediatric Weight Assessment and Counseling	NQF #0024	No	The percentage of members 3-17 years who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity.
Core-16	MSSP-22,-23,-24,-25,-26	Diabetes Composite (D5) (All-or-Nothing Scoring): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco Non-Use, Aspirin Use	NQF #0729 (composite)	Adult	(a) MSSP-22: Percentage of patients 18-75 years with diabetes who had HbA1c <8% at most recent visit; (b) MSSP-23: Percentage of patients 18-75 years with diabetes who had LDL <100 mg/dL at most recent visit; (c) MSSP-24: Percentage of patients 18-75 years with diabetes who had blood pressure <140/90 at most recent visit; (d) MSSP-25: Percentage of patients 18-75 years with diabetes who were identified as a non-user of tobacco in measurement year; (e) MSSP-26: Percentage of patients 18-75 years with diabetes and IVF who used aspirin daily -- Aspirin use was not included as part of the profile composite.
Core-17	MSSP-27	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059, NCQA	Adult	Percentage of patients 18-75 years with diabetes whose HbA1c was in poor control >9%.
Core-18	MSSP-19	Colorectal Cancer Screening	NQF #0034, NCQA HEDIS measure	No	The percentage of members 50-75 years who had appropriate screening for colorectal cancer.
Core-19	MSSP-18	Depression Screening and Follow-Up	NQF #0418, CMS	No	Patients 12 years and older who had negative screening or positive screening for depression completed in the measurement year with an age-appropriate standardized tool. Follow-up for positive screening must be documented same day as screening.

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Core-20	MSSP-16	Adult Weight Screening and Follow-Up	NQF #0421, CMS	No	Patients 18 years and older who had BMI calculated during the last visit in the measurement year or within the prior 6 months. In cases where the BMI is abnormal, a follow-up plan must be documented during the visit the BMI was calculated or within the prior 6 months.
Core-21		Access to Care Composite	NCQA	No	NCQA Survey - percentage of patients who could get appointments or answers to questions from providers when needed.
Core-22		Communication Composite	NCQA	No	NCQA Survey - percentage of patients who felt they received good communication from providers.
Core-23		Shared Decision-Making Composite	NCQA	No	NCQA Survey - percentage of patients whose provider helped them make decisions about prescription medications.
Core-24		Self-Management Support Composite	NCQA	No	NCQA Survey - percentage of patients whose provider talked to them about specific health goals and barriers.
Core-25		Comprehensivenes s Composite	NCQA	No	NCQA Survey - percentage of patients whose provider talked to them about depression, stress, and other mental health issues.
Core-26		Office Staff Composite	NCQA	No	NCQA Survey - percentage of patients who found the clerks and receptionists at their provider's office to be helpful and courteous.
Core-27		Information Composite	NCQA	No	NCQA Survey - percentage of patients who received information from their provider about what to do if care was needed in the off hours and reminders between visits.
Core-28		Coordination of Care Composite	NCQA	No	NCQA Survey - percentage of patients whose providers followed-up about test results, seemed informed about specialty care, and talked at each visit about prescription medication.
Core-29		Specialist Composite	NCQA	No	NCQA Survey - percentage of patients who found it easy to get appointments with specialists and who found that their specialist seemed to know important information about their medical history.
VT Measure ID	**Medicare Shared Savings Program Measure ID**	**Measure Name**	**Nationally Recognized/ Endorsed**	**Included in HSA Profile?**	**Measure Description**
Core-30		Cervical Cancer Screening	NQF #0032, HEDIS measure	Adult	The percentage of females 21-64 years who received one or more PAP tests to screen for cervical cancer in the measurement year or two years prior to the measurement year.

Core-31	MSSP-30	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	NQF #0068, NCQA	No	Percentage of patients 18 years and older with IVD who had documentation of using aspirin or another antithrombotic during the measurement year.
Core-35	MSSP-14	Influenza Vaccination	NQF #0041, AMA-PCPI	Adult	Patients 6 months and older with an outpatient visit between October and March who received an influenza vaccine.
Core-36	MSSP-17	Tobacco Use Assessment and Cessation Intervention	NQF #0028, AMA-PCPI	No	Percentage of patients 18 years and older who had a negative tobacco screen or positive tobacco screen with cessation intervention in the two years prior to the measurement year.
Core-38	MSSP-32	Drug Therapy for Lowering LDL Cholesterol	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	No	Percentage of patients 18 years and older with a diagnosis of CAD and an outpatient visit in the measurement year whose LDL-C <100 mg/dL or LDL-C >=100 mg/dL and who received a prescription of a statin in the measurement year.
Core-38	MSSP-33	ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	NQF #0074 CMS (composite) / AMA-PCPI (individual component)	No	Percentage of patients 18 years and older with a diagnosis of CAD and a LVEF < 40% or diagnosis of CAD and diabetes who received a prescription of ACE/ARB medication in the measurement year.
Core-39	MSSP-28	Percent of Beneficiaries With Hypertension Whose BP<140/90 mmHg	NQF #0018, NCQA HEDIS measure	Adult	Percentage of patients 18-85 years with hypertension whose BP was in control <140/90 mmHg.
Core-40	MSSP-21	Screening for High Blood Pressure and Follow-Up Plan Documented	Not NQF-endorsed; MSSP	No	Percentage of patients 18 years and older seen during the measurement period who were screened for high blood pressure and a recommended follow-up plan is documented based on the current blood pressure reading as indicated.
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Core-47	MSSP-13	Falls: Screening for Fall Risk	NQF #0101	No	Percentage of patients 65 years and older who had any type of falls screening in the measurement year.
Core-48	MSSP-15	Pneumonia Vaccination (Ever Received)	NQF #0043	Adult	Patients 65 years and older who had documentation of ever receiving a pneumonia vaccine.
	MSSP-1	CG CAHPS: Getting Timely Care,	NQF #0005, AHRQ	No	CMS Survey - Getting Timely Care, Appointments, and Information

		Appointments, and Information			
	MSSP-2	CG CAHPS: How Well Your Doctors Communicate	NQF #0005, AHRQ	No	CMS Survey - How Well Your Doctors Communicate
	MSSP-3	CG CAHPS: Patients' Rating of Doctor	NQF #0005, AHRQ	No	CMS Survey - Patients' Rating of Doctor
	MSSP-4	CG CAHPS: Access to Specialists	NQF #0005, AHRQ	No	CMS Survey - Access to Specialists
	MSSP-5	CG CAHPS: Health Promotion and Education	NQF #0005, AHRQ	No	CMS Survey - Health Promotion and Education
	MSSP-6	CG CAHPS: Shared Decision Making	NQF #0005, AHRQ	No	CMS Survey - Shared Decision Making
	MSSP-7	CG CAHPS: Health Status / Functional Status	NQF #0006 , AHRQ	No	CMS Survey - Health Status/Functional Status
	MSSP-8	Risk-Standardized, All Condition Readmission	CMS, not submitted to NQF (adapted from NQF #1789)	No	All discharges with an ICD-9-CM principal diagnosis code for COPD or asthma in adults ages 40 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with COPD or asthma. This is an observed rate of discharges per 1,000 members.

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	MSSP-10	Ambulatory Sensitive Condition Admissions: Congestive Heart Failure	NQF #0277, AHRQ (Prevention Quality Indicator (PQI) #8)	Adult	All discharges with an ICD-9-CM principal diagnosis code for CHF in adults ages 18 years and older, for ACO assigned or aligned Medicare fee-for-service (FFS) beneficiaries with CHF. This is an observed rate of discharges per 1,000 members.
	MSSP-11	Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment	CMS EHR Incentive Program Reporting	No	Percentage of Accountable Care Organization (ACO) primary care physicians (PCPs) who successfully qualify for either a Medicare or Medicaid Electronic Health Record (EHR) Program incentive payment.
	MSSP-12	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	NQF #0554	No	Percentage of patients 65 years and older who were discharged from any inpatient facility in the measurement year and had an outpatient visit within 30 days of the discharge who had documentation in the outpatient medical record of reconciliation of discharge medications with current outpatient medications during a visit within 30 days of discharge.
	MSSP-31	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	NQF #0083	No	Percentage of patients 18 years and older with a diagnosis of heart failure who also had LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.
M&E-2		Comprehensive Diabetes Care: Eye Exams for Diabetics	NQF #0055, HEDIS measure	Adult	Percentage of patients with diabetes 18-75 years who received an eye exam for diabetic retinal disease during the measurement year.
M&E-3		Comprehensive Diabetes Care: Medical Attention for Nephropathy	NQF #0062, HEDIS measure	Adult	Percentage of patients with diabetes 18-75 years who received a nephropathy screening test during the measurement year.