H. 761:
Cataloguing and Developing an Alignment Plan for Quality Measures

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Why Have Quality Measures?

In an environment of health care reform, quality measures are important to:

- Ensure that quality and access are maintained while we are working to achieve cost containment
- Create incentives that reward high quality care
- Guide improvements in health care delivery
- Evaluate health system performance relative to our goals

Four Areas for Alignment and Administrative Simplification

- Selecting measures that are required by other programs and/or that are claims-based
- Ensuring that specifications are aligned whenever possible
- Collaborating to reduce data collection burden
- Coordinating reporting and dissemination of results to reduce burden and increase impact

Measure Selection Criteria

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

Measure Selection Process

- Created crosswalk of over 200 measures from numerous measure sets, including:
  - Blue Cross Blue Shield of Massachusetts Alternative Quality Contract
  - Blueprint for Health
  - Buying Value
  - CHIPRA (Children's Health Insurance Reauthorization Act)
  - CMS Medicare Shared Savings Program
  - Initial Core Set of Adult Health Care Quality Measures for Medicaid Eligible Adults
  - Maine Measure Sets
  - Meaningful Use
  - National Committee for Quality Assurance HEDIS® Measure Set
  - Physician Quality Reporting System
  - Uniform Data System (required for FQHCs)
  - Vermont reporting requirements for hospitals and health plans

Measure Selection Process (cont'd)

Work Group Participants:

- Identified their priority measures for consideration
- Eliminated measures through application of criteria and extensive discussion
- Expressed support for and concerns about measures
- Focused on measures in various domains, for representative populations, with national specifications, with benchmarks, and with opportunities for improvement
- Expressed widespread support, but not complete unanimity

Measure Selection: Final Approval

VHCIP

- Presented to VHCIP Work Groups (e.g., Payment Models, Steering Committee, Core Team) for review, public comment, revision and approval

DVHA

- After Core Team approval, incorporated into DVHA contracts with ACOs for Medicaid Shared Savings Program

GMCB

- After Core Team approval, presented to GMCB for review, public comment, revision and approval. Subsequently incorporated into BCBSVT contracts with ACOs for Commercial Shared Savings Program

GMCB's Suggested Hiatus for 2016

"…the Board proposes the following:

1. To allow ACOs to focus on enhancing data collection capability and improving quality of care and health outcomes, there will be a hiatus on changes to the measure set for Year 3, unless there are changes in measure specifications or in the evidence that serves as the basis for a particular measure.

2. If a measure specification changes, the change would be incorporated into the measure set specifications…

3. If a measure is no longer supported by evidence, the measure should be considered for elimination. If a measure is eliminated, the VHCIP Quality and Performance Measures work group could recommend replacing it with a measure that is supported by evidence…"

Measure Selection: Examples of Changing Evidence Leading to Measure Changes

- Breast Cancer Screening was a reporting measure in Year 1; recent studies have resulted in questions about efficacy; now reviewing health plan-level results instead of collecting ACO-level results.
- Evidence no longer supports cholesterol screening for people with cardiovascular conditions; eliminated measure in Year 2 and replaced with blood pressure control for people with hypertension.
- When Medicare SSP diabetes care composite was changed from 5 measures to 2 measures, the measures were changed accordingly for the Vermont SSPs.

Aligning and Improving Specifications

- Strong reliance on existing measure specifications (generally from national sources)
- When national specifications change, Vermont specifications change
- Medicare Shared Savings Program (MSSP) specifications are first choice; ACOs required to use those specifications if they participate in MSSP
- Example: Adjusted timing for newborn immunizations for childhood immunization measure

Simplifying Data Collection

Of the 30 measures in Vermont's Commercial and Medicaid ACO Shared Savings Program measure sets:

- 10 are claims-based, calculated by the GMCB's analytics contractor from insurer claims feeds
- 10 are from a patient experience survey that is fielded by a certified vendor; that contract is managed and financed by the state
- 10 are collected from medical records; the 3 ACOs have engaged in impressive collaboration to reduce burden and improve data quality

Coordinating Reporting and Dissemination of Results

- GMCB Analytics Contractor (funded through VHCIP/SIM) calculates claims-based measures; GMCB and DVHA work together to format and report results to ACOs and the public.
- State's Patient Experience Survey vendor (funded through VHCIP and DVHA/Blueprint) fields survey and provides results for nearly 100 practices. GMCB and DVHA work together to format and report results. >12,000 Vermonters responded to the survey in Year 1.
- ACO measures have been added to Blueprint health service area and practice profiles, so that regions and practices get a unified report. Regional community collaboratives use results to prioritize quality improvement initiatives.

Practice & Health Service Area Profiles

VERMONT Blueprint for Health

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HSA Profile: Randolph

Period: July 2013 - June 2014 **Profile Type:** Adults (18+ Years)

Welcome to the *2014 Blueprint Hospital Service Area (HSA) Profile* from the Blueprint for Health, a state-led initiative transforming the way that health care and comprehensive health services are delivered in Vermont. The Blueprint is leading a transition to an environment where all Vermonters have access to a continuum of seamless, effective, and preventive health services.

Blueprint HSA Profiles are based primarily on data from Vermont's all-payer claims database, the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). Data include all covered commercial, Full Medicaid, and Medicare members attributed to Blueprint practices that began participating on or before June 30, 2014.

Blueprint HSA Profiles for the adult population cover members ages 18 years and older; pediatric profiles cover members between the ages of 1 and 17 years. Practices have been rolled up to the HSA level.

Utilization and expenditure rates presented in these profiles have been risk adjusted for demographic and health status differences among the reported populations.

These profiles use three key sources of data: VHCURES, the DocSite clinical database, and the Behavioral Risk Factor Surveillance Study (BRFSS), a telephone survey conducted annually by the Vermont Department of Health.

This reporting includes only members with a visit to a primary care physician, as identified in VHCURES claims data, during the current reporting year or the year prior. Rates for HSAs reporting fewer than 30 members for a measure are not presented in alignment with NCQA HEDIS guidelines.

Demographics & Health Status

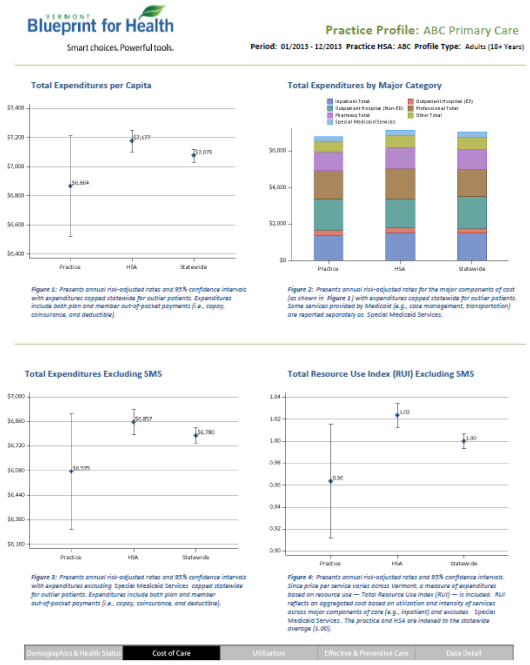
	HSA	Statewide
Average Members	7,198	225,930
Average Age	50.7	49.6
% Female	55.2	55.2
% Medicaid	22.1	19.5
% Medicare	21.9	20.6
% Maternity	1.9	2.0
% with Selected Chronic Conditions	39.7	41.0
Health Status (CRG)		
% Healthy	49.3	42.9
% Acute or Minor Chronic	19.0	19.6
% Moderate Chronic	20.8	23.9
% Significant Chronic	10.1	12.5
% Cancer or Catastrophic	0.8	1.1

Table 1: *This table provides comparative information on the demographics and health status of the specified HSA and of the state as a whole. Included measures reflect the types of information used to generate adjusted rates: age, gender, maternity status, and health status.*

Average Members serves as this table's denominator and adjusts for partial lengths of enrollment during the year. In addition, special attention has been given to adjusting for Medicaid and Medicare. This includes adjustment for each member's enrollment in Medicaid or Medicare, the member's HSA's percentage of membership that was Medicaid or Medicare, Medicare disability or end-stage renal disease status, and the degree to which the member required special Medicaid services that are not found in commercial populations (e.g., day treatment, residential treatment, case management, school-based services, and transportation).

The % with Selected Chronic Conditions *measure indicates the proportion of members identified through the claims data as having one or more of seven selected chronic conditions: asthma, chronic obstructive pulmonary disease, congestive heart failure (CHF), coronary heart disease, hypertension, diabetes, and depression.*

The Health Status (CRG) *measure aggregates 3M™ Clinical Risk Grouper (CRG) classifications for the year for the purpose of generating adjusted rates. Aggregated risk classification groups include:* Healthy, Acute *(e.g., ear, nose, throat infection)* or Minor Chronic *(e.g., minor chronic joint pain),* Moderate Chronic *(e.g., diabetes),* Significant Chronic *(e.g., diabetes and CHF), and* Cancer *(e.g., breast cancer, colorectal cancer)* or Catastrophic *(e.g., HIV, muscular dystrophy, cystic fibrosis).*



VERMONT Blueprint for Health

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Practice Profile: ABC Primary Care

Period: 01/2013 - 12/2013 **Practice HSA:** ABC **Profile Type:** Adults (18+ Years)

Total Expenditures per Capita

Total Expenditures by Major Category

Total Expenditures Excluding SMS

Total Resource Use Index (RUI) Excluding SMS

Demographics & Health Status | Cost of Care | Utilization | Effective & Preventive Care | Data Detail

Publicly available Vermont Blueprint HSA Profiles

blueprintforhealth.vermont.gov/node/680

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- Many other data collection requirements imposed on primary care providers – EMRs, federal programs, etc.
- GMCB will continue to encourage and support efforts that reduce burden on providers, and seek balance and alignment.
- Through VHCIP (SIM), investments support reliable electronic data capture to reduce reliance on providers to collect the most burdensome measures – those that use clinical data from medical records.
- GMCB supports the bill's requirements to survey and catalogue performance measures, and develop a plan to align measures.

Questions?