# Inventory of Quality Activities in Vermont

August 24, 2012

Prepared by:
Rossana Valencia
Jen Vaccaro
Gabriel Malseptic
Ann Lawthers
Paul Kirby

# Table of Contents


1. Introduction ..... 2
    1.1 Overview of ACA requirements ..... 2
    1.2. Methods for developing the inventory ..... 4
    1.3 Organization of this report ..... 5
2. Accreditation/Certification Activities ..... 6
    2.1. Inventory of Accreditation/Certification Activities ..... 6
    2.2. Accreditation and Certification Key Findings and Themes ..... 7
3. Quality Measurement ..... 8
    3.1 Inventory of Quality Measurement Activities ..... 9
    3.2 Quality Measurement Findings/Key Themes ..... 15
4. Quality Improvement ..... 20
    4.1. Inventory of Quality Improvement Activities ..... 20
    4.2. Quality Improvement Findings/Key Themes ..... 31
5. Public Reporting and Provider Ratings ..... 34
    5.1. Inventory of Vermont Public Reporting and Provider Rating Activities ..... 34
    5.2. Public Reporting Findings/Key Themes ..... 37
    5.3. Ratings Findings/Key Themes ..... 38
6. Gap Analysis and Discussion ..... 39
    6.1. Quality requirements related to certification of qualified health plans ..... 40
    6.2. Quality Information for Plan Selection ..... 42
    6.3. Ongoing Monitoring of QHP Performance ..... 45
    6.4. Opportunities for Leveraging Existing Quality Activities in Vermont ..... 46
Appendix 1: Initial Outreach Email to Vermont Stakeholders ..... 47
Appendix 2: Sample Interview Guide ..... 48
Appendix 3: Vermont Data Sources ..... 57
Appendix 4: State Requirements for MCOs and Designated Agencies ..... 62
Appendix 5: MCO QI Goals & Initiatives for 2012 (Rule H9-03) ..... 65

**Vermont Acronym Guide**

| | |
|---|---|
| ACA | Affordable Care Act |
| ACOs | Accountable Care Organizations |
| ADAP | Alcohol and Drug Abuse Program |
| APCP | Advanced Primary Care Practice |
| BCBS | Blue Cross Blue Shield |
| BPH | Blueprint for Health |
| CAHPS® | Consumer Assessment of Healthcare Providers and Systems |
| CHIP | Children's Health Insurance Program |
| CHT | Community Health Team |
| DCF | Department of Children and Families |
| DFR | Department of Financial Regulation (formally BISHCA) |
| DMH | Department of Mental Health |
| DVHA | Department of Vermont Health Access |
| EHB | Essential Health Benefits |
| EHR | Electronic Health Record |
| EMR | Electronic Medical Records |
| FQHC | Federally Qualified Health Centers |
| HEDIS® | Healthcare Effectiveness Data and Information Set |
| HHA | Home Health Agency |
| HHS | Health and Human Services |
| HRSA | Health Resources and Services Administration |
| HSA | Health Service Areas |
| IROs | Independent Review Organizations |
| IOM | Institute of Medicine |
| MOU | Memorandum of Understanding |
| NCQA | National Committee for Quality Assurance |
| NESCIES | New England States Collaborative Insurance Exchange Systems |
| NHCQF | Northeast Health Care Quality Foundation |
| NAIC | National Association of Insurance Commissioners |
| OASIS | Outcome and Assessment Information Set |
| PCMH | Patient Centered Medical Home |
| PPC | Physician Practice Connections |
| PPS | Prospective Payment System |
| QHP | Qualified Health Plan |
| QIO | Quality Improvement Organization |
| SDM | Shared Decision Making |
| UVM | University of Vermont |
| VCHIP | Vermont Child Health Improvement Program |
| VITL | Vermont Information Technology Leaders |
| VDH | Vermont Department of Health |

# 1. Introduction

This report provides Vermont with an inventory of existing quality programs and initiatives in the state of Vermont. As stated in the Contract between the University of Massachusetts Medical School (UMass) and the state of Vermont:

> "The Contractor shall produce a comprehensive inventory of existing quality programs that have been implemented by Vermont's public-sector and private-sector health insurers, the State and employers."

The inventory addresses two questions:

- What is the current scope of quality activities conducted by Vermont state agencies, insurers, health plans and providers?
- To what extent do those activities meet or exceed the quality activities required by the Affordable Care Act pertaining to Health Insurance Exchanges?

In addition, during the course of the data collection interviews, we asked a third question:

- What is your vision for quality and the new Health Insurance Exchange?

This report summarizes the ACA and Vermont requirements for quality activities, describes our methodology for collecting inventory data, and includes our findings in the following areas: accreditation and certification; quality measurement; quality improvement; public reporting and rating of plans. The findings are presented as separate inventories for each activity.

## 1.1 Overview of ACA requirements

Both the federal Affordable Care Act (ACA) and Vermont regulations and statutes (such as Act 48 and the Department of Financial Regulation's Rule H-2009-03 ["Rule 9-03"]) stress the importance of health care quality. However, the Vermont framework is more ambitious and more detailed with respect to promoting quality than is the ACA. This section will briefly outline key quality-related provisions in the ACA and Vermont frameworks, with particular emphasis on Vermont's stronger provisions. For a more detailed discussion of these provisions, please refer to the previous UMass report, "Preliminary Analysis of Affordable Care Act Laws and Regulations Relating to Quality Measurement."

The ACA and Vermont frameworks establish three major mechanisms for promoting quality care:

1. certification requirements for plans participating in the Exchange
2. assignment of plan quality ratings to assist consumers in plan selection, and
3. ongoing monitoring of health plan performance by the Exchange.

First, the ACA makes each state responsible for certification of qualified health plans (QHPs). Only certified QHPs may be marketed through the Exchange. Initial federal guidance on certification has been minimal, but in general the ACA framework sets only minimum requirements; states are free to go further in making health plan quality a factor in certification decisions. States may require health plans to have

accreditation by bodies such as the NCQA or URAC prior to certification as a QHP, even though the ACA does not mandate this.[1] The ACA also requires that QHPs provide information on plan quality to consumers, but does not yet specify the content. But again, states may impose reporting requirements on their own, and Vermont in fact already has robust requirements in place through Rule 9-03.[2] Finally, both Vermont and the ACA require plan issuers to engage in quality improvement (QI) activities in order to receive QHP certification, with implementation of QI requirements to occur once regulations have been drafted. Vermont's Act 48 and Rule 9-03 go beyond the ACA's QI language by requiring QHPs to participate in "joint quality improvement activities" with other plans, and by stipulating that QHPs must actively participate in the Blueprint for Health, Vermont's state-led delivery system transformation program.[3] [4]

A system of health plan ratings designed to help consumers choose a plan is the second method for promoting health plan quality. The ACA directs Exchanges to develop a rating system, but leaves details for future rulemaking.[5] Act 48 again goes beyond the ACA language on health plan ratings, adding provisions that Vermont's rating system encompass both quality and wellness, and by expanding the ACA-mandated enrollee satisfaction survey to also include a survey of providers contracted by health plans.[6] As in all areas of health reform, the ACA's flexible framework allows Vermont to add these significant new dimensions to the minimal federal requirements.

The third mechanism for promoting quality care is the Exchange's role in ongoing monitoring of QHP performance, after the initial certification. The ACA describes three core responsibilities for Exchanges related to plan monitoring: oversight of the satisfaction survey for enrollees[7]; monitoring of operational indicators such as member complaints, appeals, disenrollments, and denied claims;[8] and ongoing evaluation of QHP quality improvement initiatives, with plan-level (payer) incentives tied to the results of QI activities.[9] Vermont statutes and regulations again add details to the ACA language. For example, Act 48 links payer-side incentives to the additional goals of increasing consumer satisfaction and controlling cost growth, two areas not mentioned in the ACA section on incentives.[10] Rule 9-03 adds integration of treatment for mental health and medical conditions, and improved management of chronic conditions to the list of incentive goals.[11] Rule 9-03 also requires health plans to annually submit data on enrollee satisfaction, member grievances and utilization review denials.

---

[1] ACA, Section 1311(c)(1)(D). http://housedocs.house.gov/energycommerce/ppacacon.pdf

[2] Vermont Rule H-2009-03, parts 6.6 and 6.7. http://www.dfr.vermont.gov/sites/default/files/REG-H-09-03.pdf

[3] Act 48, § 1806(c)(2) and (3). http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf;

[4] Vermont Rule H-2009-03, parts 6.3(D) and 6.4(C)

[5] ACA, Section 1311(c)(3) and (4); 45 CFR Part 155.205(b).

[6] Act 48, § 1805(5) and (13).

[7] ACA, Sections 1311(c)(4)

[8] ACA, Sections 1311(c)(1)(D) and 1311(e)(3)(A).

[9] ACA Sections 1311(g).

[10] Act 48, amending 18 V.S.A. §9377; ACA, Section 1311(g).

[11] Vermont Rule H-2009-03, part 6.4 (C), and part 6.5 (K).

To summarize, the ACA's emphasis on state flexibility means that Vermont can implement its vision for making health plan quality central to the Exchange's functions. Additional impetus for a strong quality role is the ACA requirement that Exchanges only certify plans are "in the interests of qualified individuals and qualified employers."[12] Quality is always in the interests of individuals and employers. As the state moves towards a unified health system under Green Mountain Care, the mechanisms for promoting plan quality under the Exchange can serve as a strong starting point.

## 1.2. Methods for developing the inventory

### *1.2.1 Consulting with stakeholders and experts*

During the month of May of 2012, the UMass Quality Team conducted individual and group interviews with key stakeholders across Vermont's health care system to collect information on current quality improvement, measurement, and reporting activities in the state as well as their thoughts on the future Exchange. Potential key informants were identified by the Department of Vermont Health Access (DVHA). DVHA sent an initial email to Vermont stakeholders requesting their participation in the interviews (see Appendix 1: Initial Outreach Email to Vermont Stakeholders) UMass followed up with stakeholders who responded to the initial email, by emailing a summary of the interview objectives and scheduling telephone interviews with willing respondents. Effort was made to include key stakeholders from multiple levels of the health care delivery system. Below is a table that provides information on the types of stakeholders interviewed for this report.

**Table 1**: Quality Stakeholder Outreach Results

| Entity / Metric, by #[13] of stakeholder groups | State Agency | Advocacy | Quality Oversight Org. | Insurer/ Health Plan | Academia | Trade Association | Provider | Total |
|---|---|---|---|---|---|---|---|---|
| Received Initial Outreach[14] | 10 | 3 | 2 | 3 | 1 | 1 | 5 | **25** |
| Responded to Initial Outreach | 6 | 3 | 1 | 2 | 1 | 1 | 1 | **15** |
| Did not respond to Initial Outreach | 4 | 0 | 1 | 1 | 0 | 0 | 4 | **10** |
| Targeted for follow-up | 0 | 1 | 1 | 2 | 0 | 1 | 1 | **6** |
| Responded to follow-up | N/A | 1 | 1 | 2 | N/A | 1 | 1 | **6** |
| Interviews conducted | 7 | 3 | 2 | 3[15] | 1 | 1 | 1 | **18** |
| # of people interviewed | 13 | 5 | 4 | 7 | 2 | 2 | 1[16] | **34** |

[12] ACA, Section 1311(e)(1)(B).

[13] Number of groups, not individuals.

[14] Most initial outreach was via a letter sent by Deputy Commissioner Lindsey Tucker. Other initial outreach was conducted by UMass as a result of referral.

[15] Received one written response.

[16] Executive Vice President of the VT Medical Society.

### 1.2.2 Data collection

Each interview was conducted by a minimum of two UMass Quality Team members using a semi-structured interview guide (see Appendix 2: Sample Interview Guide): 1) a primary interviewer to conduct the interview and 2) a secondary interviewer to take detailed notes and record responses. Interviews typically lasted between 40 to 60 minutes. To aid in the note taking and analysis, interviewers requested permission to audio-record responses for subsequent review and transcription. The UMass Quality Team used their detailed notes taken during the interviews and the audio recordings to draft the final interview notes.

The final set of notes were imported into Atlas.ti.ver.6.2 ©, a qualitative data analysis software program. To guide the qualitative analysis, the UMass Quality Team developed a codebook and coding scheme based on the interview guide questions and themes that emerged from the data. To ensure reliability, the UMass Quality Team employed a consensus-based approach to coding; each interview was coded by a primary coder and then a secondary coder. Through the coding, analysts discussed the codes, coding process and any coding discrepancies, to ensure that codes were consistently and reliably applied. Once the coding and quality assurance processes were completed, the UMass Quality Team reviewed the coded text for emergent themes that shaped and populated this report.

### 1.2.3 Reviewing the web for Vermont activities

In addition to conducting interviews with key stakeholder groups, the UMass Quality Team performed web-based research on current Vermont quality activities relating to the following areas: certification requirements, rating qualified health plans, rewarding plans, public reporting to consumers, and other ACA information. The focus of this research was guided by the ACA requirements for the Exchange. UMass Quality Team members developed a grid to house all of the information gathered. The grid consisted of three areas: legislative requirements, public plans, and commercial insurers.

### 1.2.4 Limitations

The opinions of the interviewees may not reflect the formal views of the organizations or agencies they represented.

## 1.3 Organization of this report

This report is organized into sections; one section for each inventory:

- Accreditation and certification
- Quality measurement
- Quality Improvement
- Public reporting and rating of plans

Findings have been summarized into tables with additional detail in appendices as appropriate. Each section concludes with a summary of key findings and themes from the inventory.

# 2. Accreditation/Certification Activities

This section provides information on the status of Vermont providers with respect to accreditation and certification. As noted above (see page 2), the ACA requires each Exchange to certify qualified health plans.

## 2.1. Inventory of Accreditation/Certification Activities

All three of Vermont's major health plans have NCQA health plan accreditation. In addition, the FQHCs and providers participating in the Blueprint for Health have or are seeking NCQA patient centered medical home certification. Some providers in Vermont have also sought other types of NCQA recognition. The hospitals and home health agencies are either accredited by the Joint Commission or have received Medicaid or Medicare certification. DMH certifies all of the Designated Agencies that provide mental health services to Vermont residents. Table 2 below summarizes the breadth of certification and accreditation that occurs in Vermont.

**Table 2: Summary of Accreditation and Certification Activities in Vermont, 2012**

| Entity | Accreditation | | | Certification/Recognition | | |
|---|---|---|---|---|---|---|
| | NCQA | URAC | TJC | NCQA/ PCMH Recog. | Phys. Board Cert. | Other |
| **Health Plans** | | | | | | |
| **Cigna:**<br>• PPO members are in accredited products | √ | | | √ | √ | |
| **MVP:**<br>• HMO/ POS members are in accredited products<br>• PPO members are not in accredited products | √ | | | √ | √ | |
| **BCBSVT:**<br>• PPO and POS members are in accredited products<br>• Case management is URAC accredited<br>• 75-80% of their physicians are board certified.<br>• 60% of their primary care physicians are NCQA recognized | √ | √ | | √ | √ | √ |
| **Providers** | | | | | | |
| **Mental Health and Substance Abuse:**<br>• Designated Agencies are certified by DMH<br>• Methadone providers are accredited by the Commission on the Accreditation of Rehabilitation Facilities<br>• Preferred substance abuse providers are required to obtain a letter of approval from the Vermont Dept of health in order to receive state funds (including Medicaid) for substance abuse treatment. | | | | | | √ |
| **Federally Qualified Health Centers:**<br>• FQHCs apply for NCQA PCMH recognition every 3 years. Seven of 8 FQHCs are recognized medical homes.<br>• Participate in Meaningful Use certification | | | | √ | √ | √ |

| Entity | Accreditation | | | Certification/Recognition | | |
|---|---|---|---|---|---|---|
| | NCQA | URAC | TJC | NCQA/ PCMH Recog. | Phys. Board Cert. | Other |
| **Home Health Agencies:**<br>• All HHAs are Medicare certified | | | | | | √ |
| **Hospitals:**<br>• Acute hospitals are accredited by TJC<br>• None of the critical access hospitals are accredited<br>• All of the critical access hospitals are certified by Medicare/Medicaid | | | √ | | √ | √ |
| **Primary Care Practices:**<br>• Around 95 practices in VT have NCQA PCMH recognition as part of their Blueprint participation. | | | | √ | √ | |

## 2.2. Accreditation and Certification Key Findings and Themes

Vermont stakeholders interviewed for this report indicated that most health plans and several providers in Vermont have already acquired some form of accreditation or special certification from a nationally recognized accreditation agency (NCQA, URAC or TJC).

### *2.2.1. Accreditation*

All health plans in Vermont are accredited by the National Committee for Quality Assurance (NCQA). NCQA accreditation evaluates how well a health plan manages its entire delivery system, including physicians, hospitals and other facilities, and administrative services. URAC accreditation focuses on quality within a single functional area in an organization. For example, one plan noted that they had received URAC accreditation for their case management.

The Department of Financial Regulation (DFR) allows for NCQA and URAC accreditation deeming. In an effort to avoid unnecessary duplication of efforts by Vermont MCOs, DFR has compared Rule 9-03 requirements with current accreditation requirements for NCQA and URAC to identify areas of overlap. If an MCO has undergone NCQA and/or URAC review, DFR will allow deeming of certain Rule 9-03 requirements.

### *2.2.2. Certification/Recognition*

At the provider level, primary care practices participating in the Blueprint for Health must obtain NCQA Patient Centered Medical Home (PCMH) recognition. In order for a practice to be qualified as a Blueprint participant, a University of Vermont (UVM) VCHIP team will visit and score the site against NCQA standards for formal recognition. NCQA subsequently reviews the VCHIP results and issues an official score. There are six PCMH standards, including must-pass elements, which can result in one of three levels of recognition. Practices seeking PCMH recognition from NCQA complete a Web-based data collection tool and provide documentation that validates responses. In addition to PCMH recognition, providers can obtain other types of NCQA recognition.

The six Prospective Payment System (PPS) hospitals in Vermont are accredited under The Joint Commission (TJC) and the eight critical access hospitals are certified for Medicare and Medicaid. They receive regular surveys by CMS to ensure that they are meeting the federal conditions of participation.[17]

FQHCs apply for NCQA medical home recognition every 3 years, like other practices that seek to maintain their recognition. There are eight FQHCs in Vermont, seven of which participate in the Blueprint and thus are recognized as patient centered medical homes under NCQA. The eighth FQHC is preparing for recognition. It was also noted that of the seven accredited sites, all but one are at Level 3 certification. To maintain FQHC status each center has to re-apply to HRSA Bureau of Primary Care Health Care (BPHC) annually. Every 3 to 5 years BPHC conducts a more intensive recertification process that requires all FQHCs to participate.

### *2.2.3. Special Certifications*

The Vermont Department of Mental Health (DMH) designates their community mental health agencies. The Commissioner of the Department of Mental Health designates one agency in each geographic area of the state to assure that people in local communities receive services and supports consistent with available funding, the state System of Care Plans, the local System of Care Plans, outcome requirements, and regulations promulgated by DMH. DMH also participates in certifying, recertifying, and decertifying agencies in its preferred provider network. Designated Agencies (DAs) are evaluated for re-designation every four years.

In addition, DMH has moved to a deeming process for agencies that hold a national accreditation status. For agencies that hold that status, fewer elements will be reviewed. The implementation of this change will limit duplication of effort and allow DMH to focus on Vermont-specific requirements of agencies as given in *Administrative Rules for Agency Designation*.

At the provider level, physicians receive board certification, which demonstrates exceptional expertise in a particular specialty and/or subspecialty of medical practice.

The federal government, through its promotion of adoption and use of EMRs, is certifying different practices for different stages of meaningful use. By putting into action and meaningfully using an EHR system, providers may experience a reduction in errors, availability of records and data, reminders and alerts, clinical decision support, and e-prescribing/refill automation.

# 3. Quality Measurement

This section summarizes the breadth and depth of ongoing quality measurement activities in Vermont. The ACA and Vermont law require Exchanges to collect and report quality information to consumers, providers, and employers.

[17] The Vermont State Psychiatric hospital closed on August 30, 2011 due to damage sustained from Tropical Storm Irene. The hospital has been closed for the indefinite future but there is planning for a replacement facility and collaboration with other hospitals with psychiatric units.

## 3.1 Inventory of Quality Measurement Activities

Vermont is engaged in both national and state-led initiatives that include measurement and reporting of quality of care within and across health care systems. Table 3 and Table 4 provide detailed information on current national quality measurement activities in the state of Vermont. The first table describes the initiatives, while the second table shows key areas of focus which include prevention and screening, chronic condition management, mental health, patient experience of care, and improving health outcomes. Where known, specific measure sets are referenced (far right hand columns). Table 5 and

Table 6 show similar detail for state specific initiatives. Please note that a single measure may fall into multiple domains. For example, the HEDIS® measure, controlling high blood pressure, represents both a health outcome and a chronic care measure. Where such overlap occurs, we have checked both columns.

**Table 3: Vermont's Participation in National Quality Measurement Activities, 2012**

| (National Agency/Organization) Initiative | Description |
|---|---|
| **(Bureau of Primary Health Care, HRSA) Uniform Data System** | Primary care grantees funded by the Health Resources and Services Administration (HRSA) (includes community health centers, migrant health centers, health care for the homeless, public housing primary care, and other grantees under Section 330 of the Public Health Service Act) are required to submit data to the Bureau of Primary Health Care on selected quality of care indicators which include screening and prevention measures (e.g., prenatal care) and chronic care measures (e.g., asthma). |
| **(CMS) Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant**. | Vermont, in partnership with the State of Maine, was awarded a five-year CHIPRA demonstration grant to enhance the quality of care delivered to children in these states. As part of the demonstration, Vermont will expand the Vermont Blueprint for Health central registry (DocSite) to include data elements and performance measures for four areas of pediatric care (preventive services, asthma, ADHD, obesity), and to include *Bright Futures* performance measures (oral health, mental health). |
| **(CMS) Home Health Quality Initiative** | CMS requires Medicare-certified home health agencies to collect data for all adult patients using the Outcome and Assessment Information Set (OASIS). CMS reports results on select quality metrics on the Home Health Compare website. The measure set includes prevention and screening measures (e.g., influenza immunization), chronic care measures (e.g., diabetes), and patient experience of care. |
| **(CMS) Hospital Quality Initiative** | Eligible hospitals (acute care hospitals, children's hospitals, and critical access hospitals) may volunteer to submit their data to CMS for public reporting in order to receive increased payment. Critical access hospitals are not eligible for the financial incentive but may elect to submit data for any or all of the measures in the measure set, which include acute care measures (e.g. heart attack, pneumonia), patient safety measures (e.g., serious complications and deaths), and patient experience of care. |
| **(CMS) Nursing Home Quality Initiative** | CMS requires Medicare-certified nursing home providers to submit resident assessment data using the Minimum Data Set (MDS). MDS assessment data are used to generate quality measure/indicator reports that present data on a set of measures of quality of care at the state and national level. The measure set includes chronic care measures and post-acute care measures for short stay and long stay residents. |
| **(NCQA) HEDIS Quality Measurement** | Each of the three major health plans (CIGNA, MVP, and BCBS) in Vermont participates in HEDIS (Health Plan Employer Data and Information Set) and the CAHPS® (Consumer Assessment of Health Providers and Systems) survey through NCQA on an annual basis. |

**Table 4: National Measurement Activities – Domains and Measures**

## Inventory of Vermont Quality Activities

| | Domain | | | | | | | | | | | Measures | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **National Measurement Activities in Vermont** | Access/Availability of Care | Prevention and Screening | Care Coordination | Chronic Condition Management | Health Outcomes | Mental Health | Pediatric Care | Use of Services | Cost of Care | Patient Experience | Provider Experience | HEDIS | CHIPRA or Bright Futures | NQF Endorsed | Meaningful Use | Locally-Derived | CAHPS | OASIS | MDS |
| (Bureau of Primary Health Care, HRSA) Uniform Data System | | ✓ | | ✓ | ✓ | | ✓ | | | | | | | | ✓ | | | | |
| (CMS) CHIPRA | | ✓ | | ✓ | ✓ | ✓ | ✓ | | | | | ✓ | ✓ | ✓ | | | | | |
| (CMS) Home Health Quality Initiative | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | | ✓ | | | ✓ | ✓ | |
| (CMS) Hospital Quality Initiative | | ✓ | | ✓ | ✓ | | ✓ | | | ✓ | | | | ✓ | | | ✓ | | |
| (CMS) Nursing Home Quality Initiative | | ✓ | | | ✓ | ✓ | | | | | | | | ✓ | | | | | ✓ |
| (NCQA) HEDIS and Quality Measurement | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | | ✓ | | |
| Number of Initiatives | **2** | **6** | **1** | **5** | **6** | **4** | **4** | **2** | **1** | **3** | **0** | **2** | **1** | **5** | **1** | **0** | **3** | **1** | **1** |

**Table 5: Description of Vermont State-Led Measurement Initiatives, 2012**

| **(Responsible Agency) Initiative** | **Description** |
|---|---|
| **(Disabilities, Aging and Independent Living – DAIL) Vermont Home Care Licensure** | In order to become a designated home health agency for Vermont, a home health agency must collect and report data to the Vermont Department of Disabilities, Aging, and Independent Living on selected quality indicators. |

| | |
|---|---|
| **(DFR) Common Profiling Workgroup** | Pilot initiative to pool or aggregate data from each of the three major Vermont health plans to produce physician-level reports and to evaluate the process. The initial pilot focuses on pediatric HEDIS quality measures for asthma, upper respiratory infections, and pharyngitis. Initiated by DFR under Rule 9-03, Section 6.3(B)7 and (B)8, includes requirements to improve health care delivered to members by adopting and publishing quality standards for specialists (including mental health care providers) and hospitals and use those measures to annually measure the performance of high-volume providers; this project is now facilitated by VPQHC in combination with MCOs. |
| **(DFR) Health Care Insurance Reimbursement Survey** | Vermont law (Act 71) requires commercial insurers in Vermont to provide information comparing reimbursement paid for selected primary care health services in order to assess the impact of reimbursement on access to health care, cost -shifting, and workforce shortages and recruitment and retention of health care professionals (18 V.S.A. 9409.a) |
| **(DFR) Health Care Price and Transparency** | Vermont law (Rule H-2007-05) requires health insurers in Vermont to provide hospital and provider level information to their members including information on nationally recognized quality measures approved by the Commissioner of the Department and the cost of care. |
| **(DFR) Health Plan Report Card & Annual MCO Data Filing Evaluation Report** | Vermont law (Rule H-2009-03) requires MCOs to submit data on key performance indicators to DFR on an annual basis, including all required HEDIS and CAHPS quality measures from which certain measures are selected for public reporting (available on the DFR website). MCOs are also required to conduct an annual satisfaction survey of their provider network. MCOs must submit annual year-end quality improvement goals reports showing progress on both individual goals/projects, at least one joint goal with each of their mental health delegates, and joint goals with at least one other MCO. |
| **(DFR) Hospital Report Card** | Vermont law (Act 53) requires hospitals to submit information about hospital quality of care, patient satisfaction, and pricing and financial information to DFR for public reporting. Comparative information for Vermont hospitals is published on the DFR website. Vermont hospitals are also required to provide "qualitative" requirements on each of their websites to complete the "Hospital Report Card." These additional requirements include at least three current quality improvement or patient safety projects, strategic initiatives and process for public participation, hospital governance, and the hospital complaint process. |
| **(DFR) Vermont Healthcare Claims Uniform Reporting & Evaluation System** | Vermont law (Rule H-2008-01) requires commercial insurers in Vermont to submit eligibility and claims data for Vermont residents to DFR through VHCURES on an annual basis. Onpoint Health Data, a nonprofit independent organization, measures and reports health care system performance for DFR in an annual report (available on the DFR website). |
| **(DMH) Child, Adolescent, Adult & Family Mental Health** | DMH conducts a biennial survey to evaluate patient experience with adult and adolescent public mental health programs in Vermont. |
| **(DMH) Vermont Mental Health Consumer (Satisfaction) Survey** | DMH conducts an annual survey to assess consumer satisfaction with Community Rehabilitation and Treatment programs in Vermont for the adult and child patient populations. Under Act 129, MCOs are required to field the Experience of Care Survey which is submitted to the Department annually on July 15th. |

| | |
|---|---|
| **(DMH) Vermont Mental Health Performance Indicator Project** | DMH produces weekly reports on key performance indicators within and across statewide public sector systems of mental health care. Data is submitted to DMH by designated community agencies. |
| **(DVHA) Vermont Blueprint for Health** | A state-led initiative to transform the health care system in Vermont. The Blueprint has worked to build a health information infrastructure that supports quality measurement for clinical decision support and tracking, population management, and performance reporting on a range of health care quality and outcome measures for primary care practices. |
| **(VDH) Vermont Physician Survey** | The Vermont Department of Health conducts a biannual survey to assess access to health care in Vermont. Surveys are mailed to all active providers (physicians, dentists, and physician assistants) at the time of their relicensing in order to collect information on the supply of health care providers, including geographic distribution and specialty, in the state. |
| **(VDH) National Outcome Measures (NOMs) for ADAP Prevention Grantees** | Preferred Substance Abuse Providers are required to submit a data set on each patient admitted and discharged to services (outpatient, residential). This results in a profile of each provider; these National Outcome Measures (NOMs) are required by SAMHSA (Substance Abuse & Mental Health Services Administration) as a condition of their Federal Substance Abuse Prevention & Treatment Block Grant. The measures include: primary substances for which patient enters treatment, employment status, arrest history, use of recovery support. VDH/ADAP also looks at time to access treatment, and engagement in treatment as quality measures. This data is used for quality improvement related to substance abuse treatment services. |
| **(VDH) Substance Abuse Treatment** | The Vermont Department of Health administers a survey to evaluate patient experience with substance abuse treatment. |

**Table 6: State-Led Quality Measurement Activities – Domains and Measures**

| State-Led Measurement Activities in Vermont | Domain | | | | | | | | | | | Measure | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Access/Availability of Care | Screening Prevention and | Care Coordination | Chronic Condition Management | Health Outcomes | Mental Health | Pediatric Care | Use of Services | Cost of Care | Patient Experience | Provider Experience | HEDIS | CHIPRA or Bright Futures | NQF Endorsed | SAMHSA | Locally-Derived | CAHPS |
| (DAIL) Vermont Home Care Licensure | ✓ | | | | | | | ✓ | | | | | | | | | |
| (DFR) Common Profiling Workgroup | | | | ✓ | | | ✓ | | | | | ✓ | | | | | |
| (DFR) Health Care Insurance Reimbursement Survey | | | | | | | | | ✓ | | | | | | | | |
| (DFR) Health Care Price and Quality Transparency (MCOs) (H-2007-05) | | | | | ✓ | | | | ✓ | | | | | ✓ | | | |
| (DFR) Health Plan Report Card and MCO Data Filing Evaluation Report | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | | ✓ | | ✓ | ✓ |
| (DFR) Hospital Report Card | ✓ | ✓ | | | ✓ | | | ✓ | ✓ | ✓ | | | | ✓ | | ✓ | ✓ |
| (DFR) Vermont Healthcare Claims Uniform Reporting & Evaluation System | | ✓ | | ✓ | | ✓ | | ✓ | ✓ | | | ✓ | | | | | |
| (DMH) Child, Adolescent & Family Mental Health | | | | | | ✓ | ✓ | | | ✓ | | | | | | | |
| (DMH) Vermont Mental Health Consumer (Satisfaction) Survey | ✓ | | | | ✓ | ✓ | | | | ✓ | | | | | | | |
| (DMH) Vermont Mental Health Performance Indicator Project | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | |
| (DVHA) Vermont Blueprint for Health | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| (VDH) Vermont Physician Survey | ✓ | | | | | | | | | | | | | | | | |
| (VDH) National Outcome Measures (NOMs) for ADAP Prevention Grantees | ✓ | ✓ | | | | ✓ | | | ✓ | | | | | | ✓ | | |
| (VDH) Substance Abuse Treatment | | | | | | ✓ | | | | ✓ | | | | | | | |
| **Number of Initiatives** | **8** | **5** | **2** | **5** | **4** | **8** | **5** | **6** | **7** | **7** | **2** | **4** | **1** | **4** | **1** | **3** | **3** |

## 3.2 Quality Measurement Findings/Key Themes

Quality measurement is widely practiced in Vermont and touches all sectors of the health care delivery system: hospitals, health plans, home health agencies, nursing facilities, physicians, mental health care providers, other non-physician providers, and consumers. In addition to the initiatives listed above, other measurement activities that are currently underway or in development in Vermont include:

- *Accountable Care Organization (ACO) Pilot:* Vermont law requires the Health Care Reform Commission (HCRC) to investigate how the ACO model can be incorporated into the state's comprehensive health reform program. As part of the pilot, ACOs will report patient experience data in addition to clinical process and outcome measures.[18]

- *Green Mountain Care Board:* The Green Mountain Care Board was created to oversee the design of Green Mountain Care, Vermont's single-payer system. Vermont law requires the board "to develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures." (Act 48, Section 9375(b)(8)).

- *Integrated Family Services Initiative:* The Agency of Human Services is exploring the possibility of creating an integrated and consistent continuum of services to families in Vermont by combining all services for children, youth, and families into a single department. Current, children's services exist in each of the individual departments with overall oversight from the Secretary's Office at AHS. As part of this effort, the workgroups are charged with developing a system of measurement to evaluate the quality of care for children, youth, and families.

### *3.2.1. Measures and Domains*

The domains of quality typically captured by Vermont measurement activities provide a well-rounded view of the quality of care delivered by Vermont providers and received by Vermont consumers. Mental health and long-term services are well-represented in Vermont's measurement landscape. Only care coordination and provider experience seem to be under-represented among measurement activities (two initiatives each).

#### Measures

Currently collected measures include measures from national measure sets as well as locally derived measures. Data on health services utilization and expenditures are also collected by the Blueprint, by state agencies such as the Vermont Department of Financial Regulation (DFR), and by health plans for NCQA HEDIS. These data help to assess healthcare system resource utilization and cost efficiency.

In the domain of access, Vermont law also requires Managed Care Organizations (MCOs) and other service providers to collect information on the access and availability of medical and mental health services by analyzing health information data to identify gaps and omissions in care. That data is submitted annually to DFR. Examples of access measures include timeliness of care (HEDIS) and health plan network availability.

---

[18] Hester J, Lewis J, McKethan A. *The Vermont Accountable Care Organization Pilot: A community health system to control total medical costs and improve population health*. The Commonwealth Fund; 2010. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/May/1403_Hester_Vermont_accountable_care_org_pilot.pdf. Accessed June 22, 2012.

The NCQA HEDIS measure set includes measures of prevention and screening, e.g. adolescent and child well care visits, childhood immunizations, as well as measures reflecting the treatment and management of chronic conditions, e.g. comprehensive diabetes care.

Some of the measures specific to hospitals and nursing homes include infection rates, mortality, and readmission rates. Note, however, that the current HEDIS hospital readmission measure is non-specific, limiting its usefulness for quality improvement.

Patient Experience of Care measures evaluate consumer satisfaction with their health care provider and health care services. Patient experience of care measures in Vermont are collected at the health plan and provider level through the Blueprint (CAHPS-PCMH) and DFR (CAHPS for the Health Plan Report Card and HCAHPS for the Hospital Report Card). The Department of Mental Health also administers the Mental Health Consumer Satisfaction Survey on an annual basis to assess patient satisfaction with Community, Rehabilitation, and Treatment programs in Vermont. The collection of patient experience information by health plans and provider groups is mandated both at the federal (e.g. HHCAHPS survey for home care agencies) and state level (e.g., CAHPS survey for MCOs).

### National vs. Local Measures

Vermont stakeholders interviewed for this report indicated a preference for using nationally recognized measures such as NCQA/HEDIS or measures endorsed by the National Quality Forum (NQF), especially for public reporting. HEDIS measures are widely known and accepted for measuring and comparing quality of care between health plans and providers. Vermont Rule-H-2009-03 requires standardized reporting by MCOs on selected quality of care measures using the HEDIS measure set and CAHPS survey to assess health plan member satisfaction. The use of nationally-recognized measures such as HEDIS is recommended for the following reasons:

- Measures are standardized and incorporate evidence-based medicine
- Measures are well tested
- HEDIS measures are audited each year by external NCQA-certified auditors
- Measures are widely collected and reported, allowing for comparison between health plans and providers

“Home-grown” or locally-derived measures are useful for identifying opportunities for improvement within an organization or to measure health processes and outcomes that have not been well studied. However, Vermont stakeholders interviewed for this report do not consider these types of measures credible for public reporting or assessing performance between plans or provider groups for determining payment. The home-grown measures that have been used in Vermont are generally derived from existing or national metrics and are used by plans and providers for quality improvement purposes. Locally-derived measures are also collected by DFR, and include member grievances, provider satisfaction, and utilization review denials. Below is one stakeholder’s perspective on the appropriate use of nationally recognized and home-grown measures.

> *If reporting publicly and comparing [providers] to one another, it is essential that they are using measures that have been well [tested] in the field and if they are outcome measures, [that] there is a good risk adjustment strategy… [Their] feeling is that you can actually have a more imperfect measure if all you are trying to do is get a handle on where you are and whether you are moving in the right direction or not. That is very different from looking at how [provider] A is doing as compared to [provider] B. Once you get to public reporting or payment, it should be clearly defined and well tested so you know that you are making the comparison you think you’re making or paying someone*

*for their true performance. [They] see the precision of measurement along a continuum and how you are using the measure has a big impact on how precise it needs to be.*[19]

### 3.2.2. Data Collection Processes

Through collaborative efforts between federal and state agencies, insurers, service providers, and other organizations in Vermont, the state has built an extensive health information infrastructure that supports quality measurement across health care systems.

#### Data Sources

Data typically used for quality measurement come from many different sources. Each source has limitations peculiar to its original purpose. For example, claims data, while widely used for quality measurement, lack clinical detail as they were developed to pay claims rather than to assess the quality of medical care.

Table 7 below provides information on the types of data sources in Vermont. Appendix 3: Vermont Data Sources gives additional detail about each of these sources. The data sources have been grouped into the three most common categories of data: administrative (e.g. claims, encounter), medical record and other clinical data, and survey (both patient and provider).

**Table 7: Vermont Data Sources**

| (Steward) Data Source | Description |
|---|---|
| ***Administrative Data Sources*** | |
| (VDH) Vermont Uniform Hospital Discharge Data Set | VDH collects hospital discharge data from Vermont's 14 general acute care hospitals for Vermont residents and non-residents. Under interstate agreement with agencies outside of Vermont, the state also collects hospital discharge data for Vermont residents using hospitals in bordering states. |
| (VFR) Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) | Vermont's multi-payer claims database. Vermont law (Rule H-2008-01) requires insurers in Vermont to submit eligibility and claims data to DFR through VHCURES on an annual basis. |
| (DFR) Hospital and Plan Data | Under H 9-03, Vermont Hospitals and MCOs report a wide variety of data to DFR on an annual basis. |
| ***Medical Record and other Clinical Data*** | |
| (CDC) National Healthcare Safety Network Database | Internet-based surveillance system managed by the Division of Healthcare Quality Promotion at CDC. Used to monitor adverse events and incidents in health care facilities including acute care hospitals, psychiatric hospitals, and long term care facilities. |
| (CMS) Minimum Data Set | Standardized uniform comprehensive assessment of all residents in Medicare or Medicaid certified facilities. Certified nursing facilities are required by federal law to complete and electronically submit data to the state. |
| (CMS) Outcome Assessment and Information Set | Standardized comprehensive assessment of all patients in Medicare or Medicaid certified home health agencies. Home Health Agencies are required by federal law to complete and electronically submit data to the state. |

[19] Note: This is an **excerpt** from the **interviewer's notes.**

| (Steward) Data Source | Description |
|---|---|
| (Covisint DocSite) Blueprint Central Registry | Web-based clinical registry, hosted by Covisint Docsite. Hospitals and practices in Vermont are able to transmit data from electronic medical records (EMRs) and other data sources to the central registry. The state of Vermont is currently working to expand the use of the central registry across the state. |
| (DFR) Medical Record Review | Medical record chart reviews are conducted by health plans and other organizations for quality improvement purposes, quality assurance, and conducting performance measurement (e.g. HEDIS). HEDIS data are a required submission by MCOs under Rule 9-03 to DFR annually, along with CAHPS. |
| (VITL) Vermont Health Information Exchange (VHIE) | Data from EMR systems, hospital data systems, practice management systems, and direct data entry from an array of health care providers will be transmitted electronically through the VHIE. Patient data from health care organizations and providers will be transmitted through VHIE to the Blueprint Central Registry (DocSite). VHIE will also be used to compile and transmit immunization data from health care providers to the Vermont Department of Health Immunization Registry. |
| ***Survey Data*** | |
| (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS) | CAHPS surveys are administered by mail and telephone to consumers and patients to evaluate their experiences with a range of health care services and service providers. CAHPS is an annually required submission by MCOs under Rule 9-03, along with HEDIS. |
| (CDC) Behavioral Risk Factor Surveillance System | A standard national telephone survey of adults designed by the CDC and administered through the Vermont Department of Health. |
| (CDC) Youth Risk Behavior Survey | The Department of Health's Division of Alcohol and Drug Abuse Programs and the Department of Education Student Health and Learning Team conduct a biennial survey with middle and high school students in Vermont to measure the prevalence of behaviors that contribute to the leading cause of death, disease, and injury among youth. |
| (DFR) Effectiveness of Care Survey | DFR receives mental health satisfaction surveys from MCOs as a requirement of Act 129. |
| (DFR) Provider Satisfaction Survey | DFR receives provider satisfaction surveys annually from MCOs as a requirement under Rule 9-03. These surveys require the MCO to include ten standard state-approved questions for comparison purposes. |
| (DMH) Child, Adolescent & Family Mental Health Satisfaction Survey | DMH conducts a biennial survey to evaluate patient experience with adult and adolescent public mental health programs in Vermont. Surveys are sent to all young people aged 14-18 who received six or more Medicaid-reimbursed services from one of Vermont's ten regional community mental health centers. |
| (DMH) Vermont Mental Health Consumer (Satisfaction) Survey | DMH conducts an annual survey to assess consumer satisfaction with Community Rehabilitation and Treatment programs in Vermont for the adult and child patient populations. |
| (VDH) Vermont Adult Tobacco Survey | A telephone survey administered through the Department of Health used to evaluate the effectiveness of Vermont Tobacco Control Program efforts to reduce smoking and increase awareness and knowledge of smoking-related health issues. |
| (VDH) Vermont Physician Survey | The Vermont Department of Health conducts a biennial survey to assess access to health care in Vermont. Surveys are mailed to all active providers (physicians, dentists, and physician assistants) at the time of their relicensing. |

In addition to the data sources listed above, health plans in Vermont use administrative claims and medical record chart reviews (collected in-house or by an external vendor) to calculate and measure their clinical quality and performance. Data collection for NCQA/HEDIS measurement is conducted on an

annual basis. Health plans in Vermont also engage in ad-hoc measurement and reporting to identify and address quality improvement opportunities.

The Blueprint is currently working with the University of Vermont Center for Clinical and Translational Sciences (UVM CCTS) to develop a platform that integrates data from Vermont's multi-payer claims database, clinical data from the Blueprint Central Registry (DocSite), and data from other sources (e.g., hospital data systems, public health surveillance). This platform will include a web based interface or dashboard that can be used for comparative outcomes and performance reporting.[20] Health insurers in Vermont are participating in a pilot to aggregate data across the three major health plans to provide more meaningful measurement to specialist practices, as a requirement under Rule H-2009-03. These efforts further Vermont's ability to provide consistent and coordinated measurement and reporting to consumers for evaluating quality of care.

### Centralized data collection and reporting

Two Vermont data sources bear special mention because they act not only as data warehouses but as data reporting mechanisms as well.

The Blueprint's web based centralized registry (Covisint DocSite) is capable of flexible reporting. Providers can independently create reports for various 'population level' activities such as identifying patients who have not had recommended assessments for their health conditions, or who have had assessments with results that need follow up. These reports can be generated and used by practice staff and Community Health Team members to proactively reach out to patients and coordinate services. Providers can also create comparative performance reports that show the rates at which their patients are receiving recommended care and are achieving health related goals. Comparative reports can be shown at several levels, including providers: within a practice, across independent practices and organizations, and across HSAs within the state and at the statewide level.

The Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES), the state's all-payer database coordinated by DFR, serves as a resource for measuring and producing reports for quality and monitoring purposes.[21]

A third source, the Department of Financial Regulation collects a wide range of information under the provisions of Rule H-2009-03.

### Data Quality

The Northeast Health Care Quality Foundation (NEHCQF), Medicare's QIO for the New England states, and the Vermont Program for Quality in Health Care (VPQHC) help DFR collect hospital data for public reporting (Hospital Report Card). Prior to publication, VPQHC staff reviews specific data to ensure that the data are clean and accurate. This is done through historical review and comparison and cross-checking. NEHCQF obtains hospital measures using AHRQ's HCUP Database; their bio-statistician reviews the data and creates composite scores which are reported with the individual hospital condition

---

[20] Department of Vermont Health Access. Vermont Blueprint for Health 2011 Annual Report. Available at: http://hcr.vermont.gov/sites/hcr/files/Blueprint%20Annual%20Report%20Final%2001%2026%2012%20_Final_.pdf. Accessed on June 22, 2012.

[21] http://www.dfr.vermont.gov/health-care/health-insurers/vermont-healthcare-claims-uniform-reporting-and-evaluation-system-vhcure

measures, which are then uploaded and hosted to a contracted database and reported via the DFR website.

As part of their participation in HEDIS, health plans in Vermont are also required to validate data through an external auditor. The auditor must be NCQA-certified. This allows for more reliable comparisons between health plans and providers. In addition, health plans have established internal processes for validating data (e.g. identify outliers compared to overall results and national benchmarks). Health plans also review results with practices before results are publicly reported. One health plan noted that they provide outreach and education to providers on coding and submission of data.

The state has also established standards for the quality of the data submitted to Vermont's multi-payer database (VHCURES). Each data element is assigned a minimum percent completeness threshold and a maximum tolerance for data issues threshold for evaluating the content of the data submitted. Failure to meet the threshold levels for one or more data elements results in an automatic failure of the submission.[22] VHCURES has been used to analyze patient attribution to Blueprint-participating medical homes; the results of that analysis are compared to the insurers' Blueprint patient attributions to ensure that patients are appropriately attributed to medical homes. VITL works with the Covisint DocSite team to ensure that data transmitted through the VHIE to the central registry is accurate.

# 4. Quality Improvement

This section catalogs the wide-ranging and numerous quality improvement initiatives in Vermont. ACA requirements for quality improvement focus on the Exchange's responsibility to monitor quality improvement activities and to reward plans that perform well.

## 4.1. Inventory of Quality Improvement Activities

Vermont is engaged in quality improvement (QI) initiatives across all health care domains and delivery systems.

[22] Maine Health Data Processing Center. National Claims Data Management System (NCDMS) Carrier Data Requirements Reference Manual. Available at: http://www.dfr.vermont.gov/sites/default/files/data_requirements_refmanual_rev10-08.pdf. Accessed on June 22, 2012.

## Inventory of Vermont Quality Activities

Table 8 below provides a summary of current quality improvement activities in the state of Vermont, which were identified through the key informant interviews. Additional information was derived via web-based research of publicly available data and reports.[23]

[23] Note: We have included several components of the Blueprint for Health in Table 5 as the initiative requires enrolled practices to participate in ongoing quality improvement initiatives.

**Table 8: Quality Improvement programs and projects in Vermont, 2012**

| Initiative | Description |
|---|---|
| **Blueprint – *Community Health Teams:*** | The Community Health Teams (CHTs) are multi-disciplinary locally-based teams established to provide patients with direct access to an enhanced range of services, and with closer and more individualized follow up.<br><br>CHTs focus on:<br><br>a) Providing panel management and referral tracking tools to improving practices' ability to follow patients;<br>b) Providing additional practice-based health care and mental health professionals to assist primary care practices;<br>c) Improving communication and collaboration among primary practices, hospitals, and community organizations; and<br>d) Facilitating care coordination and care transitions; and supporting the shift from episode-based to proactive whole-person care. |
| **Blueprint – *Advanced Primary Care Practices (APCPs):*** | APCPs are primary care practices that deliver care consistent with the NCQA[24] standards for a Patient Centered Medical Home.[25] The Blueprint helps practices meet the NCQA PPC-PCMH standards by providing the infrastructure – i.e. CHTs, the DocSite centralized registry, and population management tools. APCPs are also supported by an enhanced payment proportional to their NCQA PCMH score.[26]<br><br>Per NCQA PCMH standards, APCPs focus on:<br><br>a) Enhancing access and continuity of care;<br>b) Identifying and managing specific patient populations;<br>c) Helping patients plan and manage care;<br>d) Supporting the self-care process;<br>e) Tracking referrals and follow-up care; and<br>f) Measuring and improving performance. |
| **Blueprint – *Expansion and Quality Improvement Program (EQuIP):*** | EQuIP Practice Facilitators assist primary care internal medicine, family practice, and pediatric primary care practices with their transformation into APCPs and continuous quality improvement efforts. Facilitators are trained to develop relationships and work with the providers they support on data guided cycles of QI on a wide range of processes.<br><br>Practice Facilitators focus on:<br><br>a) Facilitating ownership and support for Continuous Quality Improvement (CQI) by tailoring established QI approaches to "real life" practice settings and issues;<br>b) Teaching the Model for Improvement and the Clinical Microsystems curriculum, and incorporating these tools into daily practice to improve care and measure change;<br>c) Assisting practices in evaluating their performance against the NCQA PCMH standards and developing action plans as outlined in the Scoring Timeline by the Blueprint for Health;<br>d) Supporting practice teams in the implementation of rapid change cycles into clinical practice. These cycles may focus on such topics as: shared decision making, self |

[24] National Committee for Quality Assurance

[25] PCMH standards

[26] The enhanced payment is one component of "Phase 1" payment reform). All major public and commercial insurers in VT are participating in "Phase 1", as mandated by VT statute.

| Initiative | Description |
|---|---|
| | management support, or mental health and substance abuse treatment in clinical practice;<br>e) Supporting the incorporation of the CHT resources into practice workflow by working with the practice and CHT to establish the workflow and referral process to the CHT; and<br>f) Facilitating meetings and trainings among practices Blueprint staff, CHT staff, Covisint DocSite Clinical Quality Advisers, Vermont IT Leaders, support staff and other practice facilitators. |
| **Blueprint Community Health Teams Extender – *Vermont Chronic Care Initiative (VCCI):*** | The VCCI provides Medicaid Care Coordinators who act as case managers for high-risk patients with particular chronic conditions. Once a patient no longer requires care coordination services, s/he will continue to be monitored by an APCP and supported by CHTs as necessary, moving back into VCCI if indicated.<br><br><u>VCCI care coordinators focus on:</u><br><br>a) Working intensively with high-risk patients until specific treatment goals are met; and<br>b) Maintaining frequent communication with joint care conferences. |
| **Blueprint Community Health Teams Extender – *Support and Services at Home Program (SASH):*** | The SASH program provides support and services to Medicare beneficiaries, so that individuals can live and age safely in their own homes.<br><br><u>SASH Teams focus on:</u><br><br>a) Supporting transitions after a hospital or rehabilitation facility stay;<br>b) Providing self management education and coaching particularly relating to chronic health conditions; and<br>c) Providing care coordination services. |
| **Blueprint – *Self-Management Workshops:*** | The Blueprint supports health service areas in offering several types of self-management workshops. These workshops are standardized group interventions for adults living with or at risk of chronic illness. Workshops include:<br><br>a) Healthier Living Workshops – Chronic Disease;<br>b) Healthier Living Workshops – Diabetes;<br>c) Healthier Living Workshops – Chronic Pain;<br>d) Freshstart Tobacco Cessation Workshops;<br>e) Diabetes Prevention Program. |
| **Blueprint – *Shared Decision Making (SDM):*** | The Blueprint has an agreement with Health Dialog to train practice facilitators, CHT members, and interested primary care practice staff in the theory and methods of the SDM model. The goal of SDM is to empower patients to clarify questions and concerns, identify their personal preferences, resolve areas of conflict, and have more informed and productive discussions with providers. |
| **Blueprint – *Wellness Recovery Action Plan (WRAP):*** | WRAP is a standardized group intervention for adults with mental illness using a set curriculum and implementation model to promote the principles of recovery.<br><br><u>WRAP's interventions focus on:</u><br><br>a) Facilitating group discussions often led by peers or co-facilitators who have experienced mental illness; |

| Initiative | Description |
|---|---|
| | b) Disseminating education materials and personal wellness tool which participants can use to help maintain well being in the face of symptoms; and<br>c) Encouraging participants to develop an advance directive that guides the involvement of family members, supporters, and health professionals in the event that the individual is not able to act on his or her own behalf. |
| **Cigna – *National Colorectal Cancer Screening*** | Cigna participates with a national program to outreach to eligible members to improve their understanding and use of cancer screening services. |
| **Cigna – *Well-Informed Program*** | This program uses integrated data to identify gaps or omissions in care and then communicates with members and their physicians if a gap is identified. Cigna uses this program for all practices, not just Blueprint participating practices. |
| **Gifford Medical Center – *Improving Transitions of Care Between Hospital and Primary Care*** | This quality improvement effort conducted patient flow and patient safety analyses to decrease the time between hospital discharge and the first follow-up appointment with primary care for patients ages 70+ and over who are discharged home.<br><br>Results: From the baseline period, the average days to follow-up appointment with primary care after an acute visit reduced by approximately 60% from 15 to 6 days.[27] |
| **MVP – *Hospital Readmissions*** | This project focuses on reducing hospital readmissions. The project is supported, in part, by building CMS Hospital Compare metrics into provider (hospital) contracts. |
| **MVP – *Registry Data Quality Project*** | This is a 5-year project in which MVP is collaborating with care providers to assess which data points and the quality of those data that providers enter into the practice registry. MVP also monitors, on a quarterly basis, which provider groups submit data to the statewide immunization registry. |
| **Northeast Health Care Quality Foundation (NHCQF) – *Cancer Screening and Adult Vaccination*** | As the Medicare QIO for Vermont, NHCQF conducts data collection and QIPs on adult vaccination and cancer screening in the outpatient setting. |
| **Northeast Health Care Quality Foundation (NHCQF) – *Cardiac Population Health Project*** | NHCQF contributes to the Million Hearts campaign by engaging patients with cardiac disease and conducting secondary prevention around blood pressure control, aspirin use, smoking cessation, and lipid management. |
| **Northeast Health Care Quality Foundation (NHCQF) – *Patient Safety and Clinical Pharmacy Services Collaborative (PSPC)*** | NHCQF is extending the Health Resources and Services Administration's (HRSA) pharmacy collaborative to Vermont practices. The PSPC assists practices in submitting data to HRSA to help address adverse drug events in five major areas:<br><br>a) Complications related to warfarin use;<br>b) Care of diabetes;<br>c) Use/Overuse of psychotherapeutic drugs;<br>d) Polypharmacy and how to reduce prescriptions; and |

[27] Vermont Program for Quality in Health Care, Inc. Vermont Health Care Quality Report, 2011.

| Initiative | Description |
|---|---|
| | e) Patients with multiple chronic conditions. |
| **Southwestern Vermont Health Care (SVMC)[28] – *Reducing Avoidable Hospitalizations*** | The goal of this project is to reduce the 30-day readmission rate. The project coordinates and complements several other initiatives at SVMC to reduce utilization including the Blueprint for Health and Project BOOST.[29] The SVMC Improving Transitions of Care Team (multi-disciplinary care team) is establishing and implementing best practices across the care setting by building on the strength of existing integrated services across SVMC, Centers for Living and Rehabilitation, Putnam Medical Group, and the Visiting Nurses Association and Hospice.<br><br><u>SVMC is using the following models/principles to inform this effort:</u><br><br>a) Six Sigma quality improvement methodology;<br>b) Wagner Chronic Care Model; and<br>c) Patient and Family Centered Practice Principles.<br><br>Results: From April 2009 to April 2011, SVMC's 30-day all-payer hospital readmission rate was reduced by approximately 46%, from 11% to 5.9%.[30] |
| **University of Vermont Office of Primary Care and AHEC[31] –*Best Prescribing Practices Education and*** | In order to improve patient safety, primary care providers receive training in best prescribing practices of narcotics. Additionally, UVM is testing the integration of pharmacy providers into statewide patient-centered medical home practices using various models. |

[28] For other QI projects at SVMC, please refer to their website: http://svhealthcare.org/act-53/Quality/

[29] Better Outcomes for Older Adults for Safe Transitions

[30] Vermont Program for Quality in Health Care, Inc. Vermont Health Care Quality Report, 2011.

[31] Area Health Education Centers

| Initiative | Description |
|---|---|
| ***Integration*** | |
| **Vermont Assembly of Home Health Agencies (VAHHA)**[32] | VAHHA collects and benchmarks data on potentially avoidable events and supports individual agencies' QI goals based on these data. VAHHA has led and sponsored a variety of QI initiatives to reduce the rate of hospitalization and improve community tenure of their members, including:<br><br>a) ***Chronic Disease Management Program***[33] is a train-the-trainer project that conducts best practice training with agency staff related to care of Congestive Heart Failure, Diabetes, COPD, and Depression;<br>b) ***Start the Conversation Program*** encourages advance directive planning, and hospice utilization in the home care and nursing home setting;<br>c) ***Telehealth monitoring program*** – specifics not provided;<br>d) ***Better Breathing Program*** trained physical therapists receive advanced training in breathing techniques and working with patients to help reduce anxiety and improve their breathing;<br>e) ***Stop and Call falls reduction program*** directs any care provider who hears about a fall to collect and share information about the patient with the agency supervisor and case manager to ensure good follow-up and a multidisciplinary approach to falls; and<br>f) ***Low Vision falls reduction program*** helps patients with vision problems function within the home.<br><br>Results: By targeting CHF and COPD patients-COPD and pneumonia across several initiatives, they reduced the hospitalization rate by approximately 39%, from 31% to 19%. |
| **Vermont Child Health Improvement Program – *Youth Health Improvement Initiative (YHII)*** | The YHII is a statewide quality improvement project to improve the health care delivered to VT youth, ages 8-18, in collaboration with DFR, Blue Cross Blue Shield of Vermont, CIGNA, The Vermont Health Plan, MVP, CIGNA Behavioral health, Magellan Behavioral Health, Department of Health, AHEC, Department of Mental Health, and Medicaid so that pediatric and family practices can work on one coordinated approach to improving health care for this age group.<br><br>2012 Goal: Identify barriers and facilitators that contribute to annual well care visit rates for adolescents. This will be accomplished through focus groups of family and pediatric practices, youth, and parents. |
| **Vermont Department of Health – *Immunization Program*** | This statewide program provides outreach to ensure children and adults receive needed immunizations.<br><br>Outreach is conducted by:<br><br>a) Providing up-to-date vaccine, materials, training, and support to public and private vaccine providers;<br>b) Working in partnership with immunization providers, and local and statewide professional organizations;<br>c) Raising public awareness about immunizations and vaccines; and |

[32] VAHHA serves as Vermont's Local Area Network for Excellence (LANE). LANEs are stakeholder organizations that serve as the central hubs of activity in the Home Health Quality Improvement National Campaign and are charged with raising awareness, providing participant encouragement, facilitating recruitment of and communication among agencies.

[33] Co-sponsored by Pentahealth LLC, Little Rock, AR.

| Initiative | Description |
|---|---|
| | d) Contacting providers to collect immunization data of pediatric panel.<br><br>Additionally, there is a joint MCO quality improvement project, under Rule 9-03, aimed at improving data on DVH's Immunization Exchange. |
| **Vermont Program for Quality in Health Care (VPQHC)[34] – *Transitions in Care Project*** | VPQHC partners with the Northeast Health Care Quality Foundation to provide hospitals with technical assistance in data collection and QI methods to reduce hospital readmissions and improve patient safety.<br><br>In this project VPQHC focuses on:<br>a) Reviewing serious reportable events at hospitals to assess patient safety system;<br>b) Provider education and training in medication reconciliation, discharge planning, and care coordination; and<br>c) Patient engagement and health literacy. |
| ***Vermonters Taking Action Against Cancer (VTAAC)*** | A multi-stakeholder coalition[35] that aims to promote collaboration and effective resource use while implementing the Vermont Cancer Plan (VCP) into action.<br><br>The VCP is divided into five areas: prevention, screening, treatment, survivorship, and palliation/end-of-life care. |

The ACA has signaled specific areas of interest for quality improvement. These areas include readmissions, patient safety and medication errors, health outcomes, wellness, and health disparities. Table 9 shows which quality improvement domains are addressed by the Vermont initiatives.

**Table 9: Summary of Current Quality Improvement Programs in Vermont**

| Vermont Quality Improvement Activities | Quality Improvement Domain | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Access/ Availability | Prevention and Screening | Care Coordination | Chronic Condition Management | Health Outcomes | Mental Health | Pediatric Care | Patient Experience | Patient Safety |
| Blueprint – *Community Health Teams*. | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Blueprint – *Advanced Primary Care Practices (APCPs)* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

[34] VPQHC is engaged in several QIPs. For more detail, please refer to VPQHC's annual report which can be found at: http://www.vpqhc.org/interior.php/pid/109/sid/603/tid/1141

[35] Other co-collaborators also mentioned in this report: Bi-State Primary Care Associate, BCBSVT, DVHA, CIGNA Health Plan, Fletcher Allen Medical Center, Gifford Medical Center, MVP Health Plan, University of Vermont, Vermont Assembly of Home Health Agencies, Vermont Department of Health, Vermont Medical Society, Vermont Program for Quality in Health Care.

## Inventory of Vermont Quality Activities

| Vermont Quality Improvement Activities | Quality Improvement Domain | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Access/ Availability | Prevention and Screening | Care Coordination | Chronic Condition Management | Health Outcomes | Mental Health | Pediatric Care | Patient Experience | Patient Safety |
| Blueprint – *Expansion and Quality Improvement Program (EQuIP)* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Blueprint Community Health Teams Extender – *Vermont Chronic Care Initiative (VCCI)* | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | |
| Blueprint Community Health Teams Extender – *Support and Services at Home Program (SASH)* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Blueprint – *Self Management Programs* | | ✓ | | ✓ | ✓ | ✓ | | | |
| Blueprint – *Shared Decision Making (SDM)* | | | | | | | | ✓ | |
| Blueprint – *Wellness Recovery Action Plan (WRAP)* | | ✓ | ✓ | | | ✓ | | | |
| Cigna – *National Colorectal Cancer Screening* | | ✓ | | | | | | ✓ | |
| Cigna – *Well-Informed Program* | | | ✓ | | | | | | |
| Gifford Medical Center – *Improving Transitions of Care Between Hospital and Primary Care* | ✓ | | ✓ | | | | | | ✓ |
| MVP – *Hospital Readmissions* | | | | | ✓ | | | | |
| MVP – *Registry Data Quality Project* | | ✓ | | | | | ✓ | | |
| Northeast Health Care Quality Foundation (NHCQF) – *Cancer Screening and Adult Vaccination* | | ✓ | | | | | | | |
| Northeast Health Care Quality Foundation (NHCQF) – *Cardiac Population Health Project* | | ✓ | | ✓ | | | | | |
| Northeast Health Care Quality Foundation (NHCQF) – *Patient Safety and Clinical Pharmacy Services Collaborative (PSPC)* | | | | ✓ | ✓ | | | | ✓ |
| Southwestern Vermont Health Care (SVMC) – *Reducing Avoidable Hospitalizations* | | | | ✓ | ✓ | | | ✓ | ✓ |
| University of Vermont Office of Primary Care and Area Health Education Centers – *Best Prescribing Practices Education and Integration* | | | | | | | | | ✓ |
| Vermont Assembly of Home Health Agencies (VAHHA) | | ✓ | | ✓ | | ✓ | | ✓ | ✓ |
| Vermont Child Health Improvement Program – *Youth Health Improvement Initiative (YHII)* | ✓ | ✓ | | | | | ✓ | | |

| Vermont Quality Improvement Activities | Quality Improvement Domain | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Access/ Availability | Prevention and Screening | Care Coordination | Chronic Condition Management | Health Outcomes | Mental Health | Pediatric Care | Patient Experience | Patient Safety |
| Vermont Department of Health – *Immunization Program* | ✓ | ✓ | | | | | | | |
| Vermont Program for Quality in Health Care (VPQHC)[36] – *Transitions in Care project* | | | ✓ | | | | | ✓ | ✓ |
| *Vermonters Taking Action Against Cancer* | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | |

In addition to the initiatives described above, the Department of Mental Health has secured a number of federal grants to improve the delivery of mental health services in Vermont for both children and adults. Table 10 outlines some of the current or recently completed QI initiatives and models which have been supported through grants.

DMH has also convened three separate workgroups to address specific concerns raised by advocates regarding possible inappropriate use of psychiatric medications with children and adolescents.

**Table 10: DMH Grant Funded Quality Improvement Projects, 2012**

| QI Focus | Interventions/Accomplishments | Population | Grant Detail |
|---|---|---|---|
| ▪ Trauma-informed care | ▪ Through the creation of a *Vermont Child Trauma Collaborative* comprised of 12 community mental health treatment centers serving Vermont's 14 counties, this initiative will fully implement and sustain the Attachment, Self-Regulation and Competency (ARC) Framework for treatment of children with complex trauma and their families.<br>▪ Agency of Human Services adopted a policy supporting the use of this model.[37] | ▪ Children with complex mental health needs | ▪ Grantor: SAMHSA National Child Traumatic Stress Initiative Community Treatment and Services Centers Grant<br>▪ October 2009 – September 2012 (3 years) |
| ▪ Youth in Transition | ▪ This initiative will develop a system of care for Vermont's transition-aged youth with severe emotional disturbance (SED) to have adequate preparation and the | ▪ Adolescents ages 16-21, inclusive, with | ▪ Grantor: SAMHSA Cooperative Agreements for Comprehensive Community Mental Health Services for Children and Their Families |

[36] VPQHC is engaged in several QIPs. For more detail, please refer to VPQHC's annual report which can be found at: http://www.vpqhc.org/interior.php/pid/109/sid/603/tid/1141

[37] Source: http://mentalhealth.vermont.gov/initiatives

| QI Focus | Interventions/Accomplishments | Population | Grant Detail |
|---|---|---|---|
| | necessary supports to be productively engaged in the community and free from incarceration.[38] | their families | Program<br>▪ October 2008 – September 2014 (6 years) |
| ▪ Youth Suicide Prevention | ▪ Developed two websites: http://www.umatterucanhelp.com/ (for gatekeepers) and http://www.umatterucangethelp.com/ (for youth ages 11 through 23);<br>▪ Conducted successful public information campaign (Facebook, radio and internet advertisements) as evidenced by Umatter advertisements on Facebook with over 4,000 hits since December 2010;<br>▪ Trained 170 school professionals from 32 Supervisory Unions in Gatekeeper, Protocol Development and Lifelines curriculum;<br>▪ Trained 80 professionals (mental health, law enforcement and first responders, social services & youth serving professionals) using the Connect model.[39] | ▪ At-risk youth | ▪ Grantor: SAMHSA (Garrett Lee Smith Memorial Youth Suicide Prevention Grant)<br>▪ 2009 – 2012 (3 years)<br>▪ Initiative led by the Center for Health and Learning, with support from the VDH and DMH. |
| ▪ Jail Diversion--Trauma Recovery: MHISSION-VT[40] | ▪ This statewide intergovernmental initiative will address the needs of Vermont veterans and other adults with trauma spectrum-illnesses who are involved or at risk of involvement with the criminal justice system through identification, screening/assessment, and diversion from the criminal justice system to evidence-based treatment and supports. | ▪ Adults, specifically veterans and adults at risk of criminal justice system involvement | ▪ Grantor: SAMHSA Jail Diversion and Trauma Recovery Grant<br>▪ October 2008 – September 2013 (5 years) |
| ▪ Mental Health Transformation Grant | ▪ This grant will develop peer-based prevention and early intervention services and supports for young adults with or at risk of serious mental illness (SMI). | ▪ Young adults ages 18 – 34, with or at risk of SMI | ▪ Grantor: SAMHSA Mental Health Transformation Grant<br>▪ October 2010 to September 2015 (5 years) |
| ▪ Vermont | ▪ This initiative will establish an independent | ▪ Mental health | ▪ Grantor: SAMHSA Transformation |

[38] Source: http://mentalhealth.vermont.gov/initiatives

[39] Source: http://mentalhealth.vermont.gov/sites/dmh/files/publications/Youth_Suicide_Prevention_Platform_2012.pdf

[40] MHISSION: Mental Health Intergovernmental Service System Interactive Online Network for Vermont

| QI Focus | Interventions/Accomplishments | Population | Grant Detail |
|---|---|---|---|
| Evidence-Based Practices Cooperative | *Evidence-Based Practices Cooperative* focused on:<br>o The identification, review, and adoption of evidence-based and promising practices in Vermont; and<br>o The improvement and sustainability of evidence-based and promising practices currently being provided in Vermont. | agencies and providers | Transfer Initiative<br>▪ December 2010 to March 2012 (1.25 years) |

The state of Vermont requires that managed care organizations (MCOs) and designated mental health agencies (DAs) satisfy quality improvement requirements on an annual basis in accordance with Rule H 9-03. Under Rule 9-03, MCOs are required to present year-end results of quality improvement projects (QIPs). Certain requirements can be met by utilizing accreditation review to provide information otherwise obtained from the mandatory external quality review activities; this process is known as deeming. State requirements for MCOs and DMH Designated Agencies are shown in Appendix 4: State Requirements for MCOs and Designated Agencies. MCO QI goals and initiatives for 2012 under Rule 9-03 are shown in Appendix 5.

## 4.2. Quality Improvement Findings/Key Themes

### *4.2.1. Collaborating for Quality Improvement*

Almost all stakeholders interviewed were familiar with quality improvement initiatives in the state and most were able to speak about specific projects or programs in which their organization had participated. Most notable was the frequency with which informants spoke of collaborative efforts to foster quality improvement, pushed forward by certain organizations playing leadership roles in bringing stakeholders together. The following organizations were noted for their facilitating and coordinating roles in quality improvement programs.

- *Vermont Program for Quality in Health Care* was mentioned frequently as a strong partner in providing guidance on data collection and quality improvement, particularly for healthcare utilization and care transitions from acute to primary care.

- *Vermont Assembly of Home Health Agencies*, which serves as Vermont's Local Area Network for Excellence, has helped Vermont become the first state in which all Medicare-certified home care agencies have enrolled in the federal Home Health Quality Improvement campaign, a program focused on eliminating unnecessary hospitalizations.[41]

- *The University of Vermont (UVM)* has played a strong role in supporting primary care for adults and children, both through its Office of Primary Care and through VCHIP. One health plan

[41] http://www.vnavt.com/VAHHA%20News%20Winter%202010.pdf

representative captured VCHIP's extensive involvement in promoting and advising on range of QI activities:

> *[The plan is] engaged with UVM on the child health improvement program on a project in its 12th year called the youth health improvement initiative. The plan has an MOU with VCHIP aimed at making improvements in wellness for child and adolescent health. Last year [the plan] focused on depression screening in adolescents. This year [the plan) is focusing on facilitating well visits. [The plan] also looked at Chlamydia screening in that population last year. That is an ongoing project with VCHIP that BISHCA[42] has encouraged all the plans to participate in…VCHIP has been working to bring the pediatric practices up on Blueprint and making sure quality has been incorporated in what those practices need to do to achieve certification.*

Vermont has made concerted attempts to improve health care delivery by leveraging payer and provider relationships through policy initiatives and memoranda of understanding (MOU). Currently, Vermont's Act 48 and Rule 9-03 exceed the QI requirements for QHPs found in the ACA.[43] Vermont's QI mandate has resulted in QI projects ranging from short-term projects (e.g. projects designed improve depression screening in adults) to long-term programs that improve the delivery and coordination of primary care (e.g. statewide immunization registry). Additionally, health insurers have worked collaboratively with state agencies and quality improvement organizations in Vermont on projects such as the Youth Health Improvement Initiative and DFR's Common Profiling Workgroup.

Below are some highlights of how Vermont agencies support QI initiatives:

- *Joint QI Requirements:* As described earlier in this report, both Act 48 and Rule 9-03 require plans to engage in "joint quality improvement activities" with other plans.[44] The emphasis on joint quality improvement by plans is a significant innovation that fits with the longer-term goal of an integrated health delivery system.

- *Blueprint for Health:* The Blueprint is Vermont's flagship health care reform initiative to provide technical assistance and incentives (both financial and personnel) to primary care practices in order to promote patient-centered primary care accreditation and the use of well-coordinated community-based health, social and economic services. The Blueprint's mandate that participating practices achieve NCQA recognition ensures a minimum standard of QI activity, but affords practices the freedom to customize their projects. One informant captured this point well:

  > *Quality improvement is scored against NCQA standards—that is an extensive set of QI standards. Each practice (has) to demonstrate cycles of planned quality improvement. The topic will vary but there has to be structured methods and they have to demonstrate those structured methods within each practice. Within each community, they choose an area of focus (e.g. diabetes, mental health) and they work on QIPs with the community health teams and practices at that level. So the topics will vary by practice and by community, but what is consistent is that it is being done, that it is being supported by*

[42] Now the Department of Financial Regulation.

[43] ACA Section 1311(g)(1).

[44] Act 48, Section 1806(c)(2).; Vermont Rule H-2009-03, part 6.3 (D), pp. 65-66.

*facilitators, and that it needs to be done in order to be qualified as an NCQA medical home.*

- *DMH:* In addition to DMH's active pursuit of federal grants[45] to support innovation in service delivery for individuals with mental health conditions, the agency has made concerted efforts to promote agency-wide adoption and use of trauma-informed care, and peer-based and peer-run organizations.

- *Green Mountain Care Board (GMCB):* Formed with the passage of Act 48 in 2011, the GMCB is focused on containing health costs. As part of its duties, the GMCB evaluates how insurance carriers and hospital define QI activities. In some instances, GMCB may permit a hospital to exceed its budget cap to implement QI activities that align with state priorities, e.g. investing in primary care.

- *Vermont Department of Health (VDH):* VDH works in collaboration with VPQHC, with small- and mid-size hospitals, and with long-term care and home health agencies on QI initiatives. Key areas in focus are utilization of health care, patient satisfaction and cost.

### *4.2.2. Identifying Opportunities for Quality Improvement*

ACA guidance recommends that QI projects focus on specific areas: health outcomes, preventing hospital readmissions, improving patient safety and reducing medication errors, implementing wellness and health promotion activities, and reducing disparities. Vermont is already engaged in several activities that address the ACA preferred domains. However, one informant shed light on Vermont's unique position with regard to addressing health disparities,[46] specifically in the Medicare population:

*(We work on) reducing health disparities-technically yes…The problem in Vermont is that there aren't many [disparate groups] in the Medicare population and it's true across the three New England states. So when [health disparities] are looked at (they were collecting data every quarter until about a year ago), there is no disparity. The numbers are small and not statistically different.*

Two respondents spoke about the nature of QI projects and the dynamic between health plans and care providers. From the health care provider standpoint, the manner in which QI projects are identified and designed[47] becomes most relevant when plans and insurers tie ratings and/or or financial incentives to QI performance. The following two quotes illustrate the tension in this dynamic.

*Look at how Vermont compares nationally with regard to quality metrics. Generally we are in the top decile. [It's] not by accident, but by decades long focus on quality improvement. [Quality improvement] has been a part of physician climate for a long time… [Insurance companies] should support QI activities with information they have in claims files…but shouldn't be ranking physicians, in part because it's been demonstrated that if you have 3 different insurance*

[45] (See preceding table)

[46] In June 2010 VDH published a report on health disparities in Vermont with recommendations. For more information, we recommend this report which can be accessed at: http://healthvermont.gov/research/healthdisparities.aspx

[47] The selection of Quality Measures was a major point raised by many respondents. Exchange planners should refer to the detail on measure selection, data sources, collection methods, and reporting, when considering the adoption of future QI projects.

*companies, as they do in Vermont, it's not uncommon to have the 3 different insurance companies rank the same physician differently. It's an example of the flaw of each insurance company having its own rankings based on its own metrics and patient population attributed to that insurance company.*

One health plan representative spoke about its approach to identifying QI goals in collaboration with providers and other stakeholders to foster mutual ownership and commitment to them:

*We (the carrier) work with providers as partners to achieve QI goals they set (rather than to independently pursue). We have various inputs (HEDIS and CAHPS are the 2 major ones). (We) use member complaints, inputs (we) either get or discover in their UM (Utilization Management) program. The sales team brings quality opportunities. (We) work outside to collaborate with stakeholder groups and work groups including: Department of Health; Vermonters Taking Action Against Cancer; Pediatric Advisory Council; and Community Health Teams with Blueprint.*

# 5. Public Reporting and Provider Ratings

This section presents findings related to the penetration of public reporting and the practice of rating health plans and providers. The ACA requires the Exchange to report quality information to consumers and to implement a system of health plan ratings designed to help consumers choose a plan (see p. 2-3 of this report).

## 5.1. Inventory of Vermont Public Reporting and Provider Rating Activities

Vermont participates in a wide range of public reporting of quality data across the healthcare landscape, and some of its health plans engage in provider rating. The table below provides an overview of these activities and demonstrates the extent to which health plans and different service providers in the state participate in quality rating and public reporting to consumers.

**Table 11: Summary of Ratings and Public Reporting in Vermont, 2012**

| Entity | Health Plan or Provider Ranking/ Rating | Consumer Reporting | Tied to Incentives (Financial and non-financial) |
|---|---|---|---|
| **Health Plans** | | | |
| **(MVP)** Physician quality reporting program compares providers to their overall means and goals.<br>• Sets goals at the 90th percentile (NCQA national benchmarks).<br>• Provides different star ratings depending on how providers fare against those benchmarks.<br>• Star ratings are on the MVP website under the physician quality metrics section (reported at the practice level)<br>• Star ratings are not risk adjusted. | √ | √ | √ |

## Inventory of Vermont Quality Activities

| Entity | Health Plan or Provider Ranking/ Rating | Consumer Reporting | Tied to Incentives (Financial and non-financial) |
|---|---|---|---|
| **(MVP)** Provides providers with top performer awards.<br>• Reviews providers that provide outstanding quality in certain areas (e.g. diabetes, adolescent care, etc.)<br>• Presents groups with a plaque<br>• Authors a news article for Healthy Practice<br>• Sends a press release to local papers | √ | √ | |
| **(BCBSVT)** Provider directory (available for their members) and quality results on certain standard measures (at the practice level) are available on their website. | | √ | √ |
| **(Cigna)** Provider directory which serves to steer customers to quality providers and potentially increase their panel of patients | | √ | √ |
| **(Cigna)** Released a full set of PPO benchmark and plan-level detail results by NCQA (for the past 4 years). | | √ | |
| **(DFR)** Annual Evaluation of the Rule H-2009-03<br>Managed Care Organization Data Filings. Report highlights:<br>• MCO performance levels and trends on HEDIS and CAHPS measures<br>• MCO HEDIS and CAHPS superscore calculations<br>• Suggests areas that may be appropriate subjects for MCO quality improvement initiatives | √ | √ | |
| **(DFR) Health Plan Report Card:**<br>• Publishes this health plan report card so consumers can compare the performance of health plans in Vermont, both annually and over time.<br>• Review health plan performance during the most recent reporting period for measures of Experience of Care and Service, Preventive Care, Acute Illness Care and Chronic Illness Care.<br>• Each health plan's score is compared to the national average and the New England average, which is often higher than the national average. | √ | √ | |
| **Community Health Centers** | | | |
| **(HRSA BPHC) Federally Quality Health Centers:**<br>• FQHCs have federal site visits every 3-5 years to survey QIPs. As a result of the survey, best practices are shared with entire BiState Primary Care membership. The survey covers clinical, financial, and administrative processes**.** | | √ | |
| **Home Health Agencies** | | | |
| **(CMS) Home Health Compare (Generated by OASIS data set):**<br>• Home Health Compare has information about the quality of care provided by "Medicare-certified" home health agencies throughout the nation. | √ | √ | |
| **Hospitals** | | | |
| **(CMS) Hospital Compare:**<br>• Hospital Compare displays rates for Process of Care measures that show whether or not hospitals provide some of the care that is | √ | √ | |

| Entity | Health Plan or Provider Ranking/ Rating | Consumer Reporting | Tied to Incentives (Financial and non-financial) |
|---|---|---|---|
| recommended for patients being treated for a heart attack, heart failure, pneumonia, asthma (children only) or patients having surgery.<br>• Hospitals voluntarily submit data from medical records about the treatments their patients receive for these conditions. The data include patients with Medicare, those enrolled in Medicare health plans, and those who don't have Medicare. | | | |
| **(CMS) HCAHPS Hospital Survey:**<br>• Provides a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. | | √ | |
| **(DFR) Hospital Report Card:**<br>• Vermont law requires DFR to report on its website, annually, comparable hospital data about quality of care, hospital infection rates, patient safety, patient experience, nurse staffing levels, financial health, costs for services, patient satisfaction and other hospital information.<br>• Hospitals are also required to provide, on their websites, quality improvement and safety project information, information about hospital governance and public participation, as well as information about strategic initiatives and the hospital complaint process.<br>• Information about cost of care, cost shifting, comparing state averages, and hospital financial health is produced separately from the quality and patient experience data. | | √ | |
| **VPQHC Annual Report:**<br>• Aims to highlight, inform and disseminate the quality improvement work accomplished in 2011 through their collaboration with hospital based multidisciplinary project teams and community partners.<br>• Focuses on the overarching goal of improving transitions of care and reducing avoidable readmissions. | | √ | |
| **Individual or Group Providers** | | | |
| **(Covisint) DocSite:**<br>• A statewide clinical data repository, which the Blueprint adopted 3-4 years ago, as a tool that Blueprint practices use for panel management and reporting activities. | √ | | |
| **(Blueprint) NCQA PCMH Certification:**<br>• Increasing achievement results in higher per member per month payments. | √ | | √ |
| **(CMS) Meaningful Use – Federal EHR Incentives:**<br>• The federal EHR incentives are paid out to eligible health care providers after they have invested in EHR systems and demonstrated they've achieved a specific level of EHR use, which the government calls "meaningful use".<br>• Meaningful use occurs when eligible practitioners use a certified EHR in a meaningful manner, and also use that technology for the | | √ | √ |

| Entity | Health Plan or Provider Ranking/ Rating | Consumer Reporting | Tied to Incentives (Financial and non-financial) |
|---|---|---|---|
| electronic exchange of health information and to submit clinical quality and other measures to improve health care quality. | | | |
| **Nursing Facilities** | | | |
| **(CMS) Nursing Home Compare:**<br>• Nursing home characteristics such as number of beds, type of ownership, and whether or not the nursing home participates in Medicare, Medicaid or both.<br>• Resident characteristics including percent of residents with pressure sore, percent of residents with urinary incontinence and more.<br>• Summary information about nursing homes during their last State inspection.<br>• Information on the number of registered nurses, licensed practical or vocational nurses, and nursing assistants in each nursing home. | √ | √ | |
| **(Division of Licensing and Protection) Standard Survey Results for Nursing Homes:**<br>• The Division of Licensing and Protection conducts a standard survey of each licensed nursing home on a periodic basis. A Statement of Findings or Statement of Deficient Practice is issued subsequent to that inspection, and these facility reports are public records. | | √ | |
| **State Agency** | | | |
| **(Department of Disability, Aging and Independent Living) Quality Awards Program:**<br>• State Survey Agency participates in the quality awards program run by the Department of Disability, Aging and Independent Living. The Division of Rate Setting calculates the payments. This program gives monetary awards to nursing homes that meet certain criteria (e.g., threshold of deficiencies, no complaints and resident satisfaction score that are higher than the state average). They must also participate with Local Area Networks for Excellence (LANEs). No more than five providers receive awards, and they use the money for capital projects. | √ | | √ |
| **(VDH) Health Disparities Report:**<br>• Report presents information, maps, data and trends that highlight health disparities as they exist today in the state, as well as recommended actions that can be taken to reduce these disparities. | | √ | |
| **(DMH) Vermont Mental Health Performance Indicator Project (DMH):**<br>• DMH produces weekly reports on key performance indicators within and across statewide public sector systems of mental health care. Data is submitted to DMH by designated community agencies. | | √ | |

## 5.2. Public Reporting Findings/Key Themes

Public reporting already occurs throughout Vermont. For example, nursing homes, hospitals and home health agencies all submit data to CMS that is then reported to consumers through the Hospital Compare, Nursing Home Compare and Home Health Compare websites. These tools allow consumers to search for

a specific entity and then provide detailed information which could include an overall quality rating or rates for specific measures.

Within the state, the Department of Financial Regulation (DFR) requires MCOs, hospitals, and home health agencies to regularly submit data to them. Vermont state law requires DFR to publish hospital reports. For example, DFR posts a Hospital and Health plan report card on their website through which consumers can view how each plan or hospital performed in several areas. The health plan report card provides information on how each Vermont health plan performed during the most recent reporting period in areas such as preventive care, acute illness care, and chronic illness care measures. Each health plan's score is compared to the national average and to the New England average. The hospital reports contain information about quality of care, hospital infection rates, patient safety, nurse staffing levels, financial health, costs for services, and other hospital characteristics. The results are published on DFR's website in a comparative format.

DFR requires standardized reporting by MCOs of key performance indicators, such as HEDIS, that can be used to evaluate MCO performance and identify opportunities for improvement. DFR also requires that all MCOs (with the exception of managed mental health care organizations) annually administer and report their CAHPS survey results. Rule 9-03 also requires MCOs to file certain Vermont-specific measures. Once the data have been submitted by the MCOs, DFR analyzes the data and produces a report that compares MCOs to their own prior performance, to each other and to external benchmarks, as available. External benchmark data are generally obtained from the NCQA Quality Compass. The analysis also identifies opportunities for improvement specific to each MCO.

The Vermont Department of Mental Health collects data from DAs and provides several reports on their website. DMH specifically gathers data on adult mental health, child, adolescent and family mental health. Reports within these topic areas include: satisfaction surveys, performance indicator project reports, and state system of care plans.

One stakeholder noted difficulties in reporting reliable data at the provider level. For example, hospitals must have sufficient numbers of surgeries performed to calculate reliable infection rates for public reporting. However, of Vermont's 14 acute care hospitals only a few are able to report data at the provider-site level.

> *Challenge for reporting on some Vermont providers, (e.g. hospitals) is that they have small numbers*.

## 5.3. Ratings Findings/Key Themes

The ACA will require the future Exchange to assign ratings to each QHP. Quality ratings can be used to provide quality information to consumers and/or to incentivize health care providers to provide improved levels of care.

### *5.3.1. Financial Incentives*

#### VT Blueprint for Health

NCQA's PCMH scoring of Advanced Primary Care Practices (APCPs) includes elements related to patient centered self management goals. Enhanced payments based on these scores function as direct incentives to focus on setting and tracking patient centered/patient generated goals.

Phase I payment reform includes a Per Patient Per Month payment (PPPM) based upon the primary care practice's NCQA PCMH score. This is a quality based payment that is in addition to traditional Fee for Service (volume based payment) and is the beginning of a move towards quality incentives. The PPPM promotes access, communication, guideline based care, well coordinated preventive health services, use of electronic tracking systems, and population management. Practices are scored against the NCQA standards by a University of Vermont based team, establishing an independent, objective, and consistent method to guide quality based payment. The UVM VCHIP evaluation is reviewed and finalized by NCQA. Each practice receives a score, and the higher the score, the higher the PPPM payment received from the insurers.

#### Health Plans

***Pay for Quality Program.*** One plan highlighted their pay for quality program, which was established before the Blueprint but had a similar framework to Blueprint. The program allowed for providers to receive payments if they achieve the mean or goal. This was for high volume physician groups (primary care doctors who have 250 or more members). Although this program is being phased out due to the Blueprint Initiative, the plan still has some groups that get this reimbursement.

***Chronic Conditions.*** DFR, under Rule 9-03, identifies quality and care management requirements for MCOs and indicates that they should assist, support and provide incentives to all contracted primary care practices to better manage chronic conditions by: offering access to provider and practice-specific patient-level data and reports that will aid them in their efforts to provide good chronic care to patients admitted to or discharged from inpatient care, or patients who have and have not received recommended outpatient care.

#### Hospitals

***CMS Value Based Purchasing.*** Hospitals in Vermont, including the eight critical access hospitals, are required by the state to submit hospital level data on all the inpatient measures. The hospitals have to submit data and each of the measures are evaluated based on the current performance, baseline period and the benchmark and they are also evaluated on improvement compared to the baseline period. Then there is an award of points and the fraction of points are translated to a fraction of payment. The hospitals submit data to the CMS data warehouse. The required data is posted on the state's site-Northeast Health Care Quality Foundation (NHCQF). The benchmark for the CMS value based purchasing is the national average (scoring is based on this benchmark).

### *5.3.2. Non-Financial Incentives*

#### Health plans

Few plans received non-financial incentives; however, one plan indicated that recognizing physician quality in their provider directory serves to steer customers to quality providers and may also potentially increase the provider's panel of patients.

# 6. Gap Analysis and Discussion

In this section we compare Vermont quality activities to federal and state quality requirements and also present stakeholder comments related to the Exchange as gathered through the interview process. We have organized the comparison by the three major mechanisms for promoting quality that are available to

an Exchange: certification, quality rating and ongoing monitoring of health plan performance (see above, "Overview of ACA requirements," page 2). Overall, Vermont is well positioned to implement a Health Insurance Exchange in terms of the ACA and state requirements for quality and quality reporting.

We conclude the report by discussing opportunities for an Exchange to leverage and potentially strengthen existing quality activities.

## 6.1. Quality requirements related to certification of qualified health plans

Entities wishing to offer products through the Exchange must be certified by the Exchange. The next three sections discuss the readiness of the three major Vermont health plans, Cigna, MVP and BCBS, to obtain certification.

### *6.1.1. Accreditation*

The first quality-related certification requirement is that the Health Insurance Exchange ensure that qualified health plans are "accredited with respect to local performance on clinical quality measures, within timeframe established by Exchange."[48] The federal legislation specifically names the HEDIS measures, the CAHPS surveys as well as other types of information. Vermont Act 48 does not impose any additional accreditation requirements.

As shown in Section II, all health plans currently operating in Vermont have accreditation for their HMO products. It should be noted, however, that MVP's PPO product line is not NCQA accredited.

Section II also shows that many Vermont providers participate in recognition and certification programs beyond the basic NCQA and Joint Commission offerings. For example, a sizeable number of Vermont providers have achieved NCQA recognition as medical homes.

At least one stakeholder noted that since all of the three major health plans in VT are already NCQA accredited, and that the process of accreditation is lengthy and time consuming, it would be challenging to impose any additional credentialing or accreditation requirements on providers. The interviewee suggested that the Exchange leverage existing accreditation requirements instead of adding requirements.

> *Most plans are NCQA accredited. There has been angst about there being so many additional regulatory requirements. The reviewers should look at this layer and see what the plans are already doing.*[49]

**Finding:**

- Many Vermont providers exceed minimum ACA requirements by securing additional certification and recognition.

### *6.1.2. Reporting quality information*

The ACA requires health plans seeking "qualified" status to report quality measure information and enrollee satisfaction information to their own enrollees, prospective enrollees and the Health Insurance

[48] ACA, Section Sec. 1311(c)(1)(D)).

[49] Quote from interview.

Exchange. Included in the quality measure information is the pediatric core set. While Act 48 has no additional provisions relating to quality measure reporting, Rule 9-03 does have extensive annual reporting requirements.

As shown in Section III of this report, each of the three major health plans in Vermont (Cigna, MVP and BCBS) participate in HEDIS and CAHPS measurement through NCQA on an annual basis. These data are reported not only to NCQA and AHRQ, but also to the Department of Financial Regulation pursuant to Rule H-2009-03. DFR produces a Health Plan report card annually for consumers and an annual comparative MCO data filing evaluation report, both of which are available on the DFR website. In addition, all three plans report quality information to their members.

Vermont stakeholders interviewed for this report indicated that they would like the Exchange to drive administrative simplification in quality measurement. Vermont is currently engaged in efforts to coordinate and standardize measurement across the three major health plans and across service providers through the Blueprint.

> *Instead of creating a secondary infrastructure for measuring things like HEDIS, measure it through the already existing Blueprint infrastructure which will be measuring HEDIS.*

In addition to using measures that are valid, consistent, and aligned, stakeholders suggested that processes be established to validate the data collected and submitted. Vermont does have systems in place to validate data submitted by Vermont health plans and Blueprint practices for comparative analysis and performance reporting. The Exchange may be able to build on these efforts to develop a system for data validation that could be expanded to other service providers with limited capacity.

> *Important considerations are the granularity of the reporting, i.e. level of reporting, and the validity of reports. Expects that some system of validation will be needed. In the NF world, the survey process helps validate the MDS. Recommends a random validation process for any data collected by the Exchange.*

**Finding**

- ***No gap.*** The three major health plans already report quality data to NCQA, enrollees and the state (DFR).

### *6.1.3. Reporting on quality improvement activities*

To become certified, prospective issuers must implement and report on their quality improvement strategies, strategies that provide increased reimbursement or other incentives for improved quality. Vermont additionally requires potential issuers to engage in joint quality improvement activities with other plans.

Section IV describes the quality improvement activities undertaken by Cigna, MVP and BCBSVT and Section V details how the both the state and the plans are using QI to incent higher performance.

In addition, Vermont's Act 48 requires certified health plans to conduct and report on joint quality improvement projects. As discussed in the Introduction, this requirement is a significant addition to the more minimal quality improvement requirements mentioned in the ACA.

#### Finding

- ***No gap.*** All three major health plans are currently engaging in, and reporting on, QI projects undertaken separately, and in cooperation with each other and with the state.

## 6.2. Quality Information for Plan Selection

The Health Insurance Exchange is required to provide consumers and employers with two types of quality information: quality relative to other plans (quality ratings) and enrollee satisfaction survey results. The goal of presenting this information is to allow consumers to easily compare the QHPs available through the Exchange.

### *6.2.1. Quality ratings*

Vermont's three major health plans already engage in quality rating to varying degrees. For example, Cigna and MVP identify their "top" performers in their provider directories. Although the federal government has yet to issue guidance on a possible rating strategy, it is likely to be similar to the "star" rating system employed by CMS for hospitals and nursing facilities.

Stakeholders interviewed for this report expressed skepticism and doubt that a rating system would work well in Vermont. First, the Vermont market is small - only 3 health plans.

> *VT has such a small market which has geographically isolated vendors that these activities don't quite align with the environment. Measurement and ranking of carriers is a challenge because of small market*.

The experience of interviewees to date is that different carriers use different schemes to rate and rank providers. This can lead to a provider being a "top" performer according to one plan and in a different tier in a second plan.

A second concern focused on adverse selection. Some stakeholders believe that the benefit designs of plans offered by the Exchange will inadvertently promote adverse selection with some plans attracting healthier patients than others. The need for risk-adjustment of measures or ranking based on an entire population rather than a plan's population came up in several conversations.

The specific decision points for Vermont vis a vis a rating system include:

1. Where will the Exchange get data to produce quality ratings?
2. Which providers' quality data will be included in the rating?
3. Which metrics will be included in the rating?
4. How will a performance benchmark be determined? Will benchmarks be derived from Vermont performance or will benchmarks be based on national data?

#### 1. Data Sources

As catalogued in Appendix 3: Vermont Data Sources, the Exchange has many possible sources of data from which to construct the ratings. The all-payer claims database and the Blueprint Registry represent two promising sources of information for the Exchange. However, the most logical source of data for quality ratings is the information DFR collects from plans under Rule 9-03.

### 2. Provider Types

Hospitals and nursing homes are already rated by CMS using their “star” system. For purposes of the Exchange, CMS has not released guidance about which providers to include in ratings of plans for consumer choice. It is likely however, that while plan-level reporting is required, measurement will include a mix of provider types, such as is the case for CMS’ rating of Medicare Advantage plans. Thus the plan will report on all primary care providers in their network and all hospitals in their network.

### 3. Metrics

Table 4 and

Table 6 present the wide range of quality metrics currently captured by Vermont organizations and agencies. The Exchange will not lack for options when choosing which measures to include in a rating. One strategy for deciding which metrics to include involves first deciding on the domains of quality to capture and then using explicit selection criteria to choose measures within each domain. The Measure Applications Partnership of the National Quality Forum, offers several tools for selecting measures.[50] Alignment of metrics across purchasers will also be important to prevent mixed messages about quality being sent to providers of care.

Vermont's DFR already puts together a robust report card for both plans and hospitals, although the hospital report card will be moved to the Vermont Department of Health in 2013. The metrics in the report cards cover multiple domains.

#### 4. Benchmarks

Stakeholders expressed concern about how Vermont will determine the benchmarks for a quality rating system.

##### Finding

- ***Gap*:** While Vermont health plans have some experience with rating systems, Vermont needs to proceed carefully and cautiously in making decisions about summary quality ratings. A number of issues need to be resolved. Vermont will need to work through the many issues surrounding measure selection, benchmarking and ultimately, ratings.

- ***Exceeds expected requirements:*** Vermont's measurement landscape provides ample opportunity for expanding the required measure set for rankings, when that guidance is released.

### *6.2.2. Public Reporting of Satisfaction Information*

Per the ACA and Vermont law, the Exchange must provide consumers and health care professionals with the results of satisfaction surveys. Vermont health plans already collect and report CAHPS information. In addition, Vermont hospitals, home health agencies and nursing facilities report applicable CAHPS data to CMS for the various Compare websites. Other surveys are routinely conducted by the Vermont Department of Health (tobacco, BRFSS, physician) and the Vermont Department of Mental Health (consumer satisfaction).

It is likely that the minimum federal requirements for consumer experience reporting will focus on Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

##### Finding

- ***No gap.*** The three health plans already collect CAHPS survey data on a routine basis.

- ***Exceeds expected requirements:*** Vermont's Act 48 expands the satisfaction survey requirement to include providers (i.e., provider satisfaction with the health plan as a business partner) in addition to the consumer satisfaction domains. DFR already collects provider satisfaction data from the plans.

[50] See www.qualityforum.org http://www.qualityforum.org/.../MAP_Selection_Criteria_Guide.aspx

## 6.3. Ongoing Monitoring of QHP Performance

Monitoring of QHPs after their initial certification will be a core responsibility of the Exchange, but as with other aspects of the ACA, the details await future rulemaking. In addition, there is considerable substantive overlap between initial QHP certification and ongoing monitoring.

The ACA describes three core responsibilities for Exchanges related to plan monitoring:[51]

- Oversight of the enrollee satisfaction survey for each health plan that has more than 500 enrollees,
- Monitoring of complaints and appeals, and review of health plan data, including disenrollment and the number of denied claims, and
- Evaluation of QHP quality improvement strategies and providing incentives based on the results of these strategies.

### *6.3.1. Enrollee/Provider Satisfaction Surveys*

As discussed above, the Vermont health plans already collect CAHPS member satisfaction survey data, as well as provider satisfaction data mandated by Act 48. Vermont Rule 9-03 requires plans to report survey data annually.

#### Finding

- ***No Gap:*** Plans already report satisfaction data annually, so the existing data stream can satisfy both ACA and Vermont requirements.
- ***Exceeds expected requirements:*** The addition of provider satisfaction data represents a significant innovation.

### *6.3.2. Monitoring of Health Plan Data*

Vermont Rule 9-03 currently requires health plans to provide annual data on all of the quality domains mentioned in the ACA. In addition to satisfaction survey data, plans report on care quality (HEDIS), and on administrative measures that may affect both satisfaction and quality. These administrative measures include service access indicators, utilization management activities, member disenrollments, and member grievances.

#### Finding

- ***No Gap:*** Vermont rules already require extensive annual reporting on all dimensions of plan quality.

### *6.3.3. Plan Incentives for Quality Improvement*

While the ACA lays out a broad vision of using “market-based incentives” to encourage health plan QI activities,[52] the details await future HHS rulemaking. The key point of clarity to date is that incentives will function at the plan level, through reimbursement policies. Act 48 links any incentive aimed at reducing

[51] ACA Section 1311 (c) and (e).

[52] ACA Section 1311(g).

costs to "maintaining or improving health outcomes and patient consumer satisfaction." No matter the incentive structure selected, care must be taken to avoid unintended consequences such as providers avoiding sicker patients.

#### Finding

- ***No Gap:*** Act 48's provisions on quality improvement already encompass the substantive areas discussed in the ACA.

- ***Exceeds expected requirements:*** Act 48 includes ambitious additional goals that reflect Vermont's commitment to a high-quality, affordable health system, as expressed in the Blueprint for Health.

## 6.4. Opportunities for Leveraging Existing Quality Activities in Vermont

The Vermont Health Insurance Exchange has a unique opportunity to embrace a vision that goes beyond meeting federal and state requirements for an Insurance Exchange. The preceding paragraphs describe how Vermont is positioned to meet legislated requirements. But these requirements only set a floor of what an Exchange *must* do to ensure that qualified health plans meet basic quality standards. The ACA emphasizes flexibility in allowing states to go beyond the minimum requirements in promoting quality. Act 48, as Vermont's legislative enactment of the Exchange, takes advantage of this flexibility by laying out an ambitious quality agenda. So the Exchange, through its policy decisions and web presence as well as its purchasing power can serve as an agent to promote the alignment of quality and quality improvement across Vermont.

First, designers may choose to use existing capacity and systems in Vermont rather than creating new structures to meet federal reporting requirements. For example, the Exchange is positioned to create linkages to both the Blueprint Registry and VHCURES all-payer database as sources of data for quality rating and reporting. When selecting metrics to include on its web page or in its plan ratings, the Exchange has several national and state measurement initiatives to select from. At a minimum, aligning certification requirements and quality improvement reporting requirements with current activities under H 9-03 represents another opportunity to use what is already in place.

Second, the Exchange, through its web reporting mechanism has the chance to promote better consumer decision-making and to encourage value-based choices. By making relevant information available and educating consumers how to use the information for decision-making, the Exchange can steer consumers to cost and quality efficient plans and providers. This in turn incentivizes providers to align the way care is delivered.

Finally, the Exchange can work with other large purchasers in Vermont such as the Vermont Medicaid program and the three commercial carriers to align initiatives around desired quality goals. The range of quality improvement activities already operating in Vermont is impressive. From the design of benefit packages to web content to other policies, the Exchange has the opportunity to further high quality care in Vermont.

# Appendix 1: Initial Outreach Email to Vermont Stakeholders

Dear X:

I would like to request your participation in the State of Vermont's planning of its Health Benefit Exchange, opening in 2014. As you may be aware, the passage of the Affordable Care Act (ACA) and Vermont's Act 48 require each state to develop and implement an Exchange to allow consumers and small businesses to access affordable, high quality health insurance. To create a successful Exchange, we are contacting key stakeholders to assist in our understanding of the full range of Vermont activities in the many areas related to health plan quality.

The Department of Vermont Health Access has contracted with the University of Massachusetts Medical School (UMass) to develop a robust quality program for Vermont's Health Benefit Exchange. The quality program will need to meet ACA requirements for Qualified Health Plans (QHPs) available in the Exchange as well as the quality measurement and reporting goals identified in Act 48, Vermont's new universal health care law. This includes cost containment, quality of health care, and the promotion of health through prevention and healthy lifestyles. An important first step in this process is to better understand existing quality programs in Vermont's public and private health care sectors. UMass will conduct interviews with key stakeholders as part of the information-gathering process. Would you be willing to participate in an interview? Your knowledge and experience will strengthen the Exchange planning and development process.

The main focus of the stakeholder interviews is to gather information on current quality programs and initiatives in Vermont. The information will be used to develop a comprehensive quality inventory to assess existing quality data collection, measurement, and improvement programs and provide recommendations on implementing and coordinating the Exchange with these activities. The interviews will take approximately one hour and will be confidential as all the reported information will not be attributed to any individual. Questions will be provided in advance and will focus on quality measurement and improvement activities that are in your purview or that you are interested in discussing. If applicable to your work, we will also ask about methods for ratings health plans on quality, provider incentives strategies, and public reporting to consumers.

In the next two weeks, a representative from UMass (cc'd) will contact you to schedule a convenient time for a phone interview. Please contact me with any questions.

We appreciate your time and thank you in advance for your cooperation.

# Appendix 2: Sample Interview Guide

**VERMONT QUALITY INVENTORY**
**Interview Guide**

Date of Interview: _____
Person(s) Interviewed: _____
Title/Organization: _____
Interview Completed by: _____

Follow-up Interview Required?
(Note: if yes, contact XX to set up the follow-up interview.)

**Introduction**

I. Greetings and Introductions – confirm interviewees title and role

II. Brief Description of Project
   a. University of Massachusetts contracted by the Department of Vermont Health Access to help design the quality component of Vermont's health exchange and to ensure that this component meets or exceeds the standards required by the Affordable Care Act.
   b. Work Products
      i. Create an inventory of existing Vermont quality measurement, quality improvement and other quality activities as related to a future Insurance Exchange
      ii. Identity areas where Vermont programs fall short of ACA requirements as well as exceed ACA requirements; and
      iii. Develop a set of recommendations for integrating existing Vermont quality activities into the Exchange

III. Explain roles of team
   a. Facilitator
   b. Time keeper/Note taker
   c. Get permission/consent to record phone call

IV. Interview Purpose/Objectives
   a. Identify your organization's activities that are related to key exchange functions:

b. Identify opportunities to leverage the ACA requirements such that they strengthen and reinforce existing Vermont quality related initiatives.

V. "Before we begin, could you provide us with a brief description of your agency's scope and regulatory authority?"

VI. Ask if any questions before starting.

# Accreditation

**ACA Requirements:**

- Establish process for certification, recertification, and decertification of QHPs, based on accreditation and other criteria.
- The ACA requires each qualified health plan to be accredited "with respect to local performance on clinical quality measures."

**Question Goal (For UMMS Team Use):** We are looking for whether Vermont providers are accredited or certified and by whom

| Questions | Responses |
|---|---|
| 1. Are you familiar with the types of accreditation and certification that are required of Vermont providers?<br>▪ Prompts:<br>1. What is the accrediting organization?<br>2. What percent are accredited?<br>3. What is the incentive for accreditation? | |
| 2. Are there any kinds of special certification programs that the state requires providers to undergo?<br>▪ Prompts:<br>1. What is the certifying organization?<br>2. What is the type of certification (e.g. medical certification for physicians)?<br>3. What is the incentive for certification? | |

# Quality Measurement

**ACA Requirements:**

- The ACA requires issuers seeking certification to provide information to enrollees and the Exchange on required federal quality measures.
- QHPs must report pediatric quality measures (CHIPRA core set) at least annually (Sec 1311(c)(1)(I).. The Exchange will also need to collect data from QHPs on administrative measures that affect member access to care, such as disenrollment and denial of claims; and enrollee satisfaction survey data (TBD by HHS in future) (Sec 1311(c)(4)).

**Question Goal (For UMMS Team Use):** We are looking for types of *routine* measurement used by Vermont state agencies. We are looking for:

- **External reporting**
- **Domains** of quality covered
- Names of **measure sets**
- How data are **collected and reported** (internal reporting only or external reporting as well)

Since the Exchange requires public reporting, probably of standard measures, how much extra work will state agencies have to do?

| Questions | Responses |
|---|---|
| 3. Does your agency **require routine quality measurement and reporting** from Vermont health plans/health insurers/health care providers?<br>Prompts:<br>▪ Measures used (ask for documents if not already submitted)?<br>• HEDIS, CAHPS, OASIS standard measure sets<br>• Vermont-specific (locally derived) measures<br>• Any preference for Vermont-specific vs. nationally recognized measures?<br>• Extra domains: care coordination, access<br>▪ How are data typically collected (ask for documents?<br>• Type of data used – administrative claims, medical record or survey<br>• Who collects the data – Agency or health plan/health insurer or provider?<br>• Who calculates results – Agency or health plan/health insurer or provider?<br>• How is the accuracy of submitted data ensured? Any audit requirement?<br>▪ To whom do you report the results of measurement?<br>• Do you report results publicly to **consumers** or other groups? | |

| | |
|---|---|
| • What measures?<br>• How are results reported?—print, web, raw data?<br>  ▪ Do you have any feedback or lessons learned based on your involvement in measurement activities that Exchange planners should consider? | |

# Quality Improvement

**ACA Requirements:**

- QHPs must implement and report on quality improvement strategy (defined in Sec. 1311(g)), subject to future guidance from HHS.
- Beginning in 2015, health plans seeking certification through an Exchange must contract only with hospitals (more than 50 beds) that have a demonstrated patient safety evaluation system and also have a comprehensive hospital discharge program
- Exchange web sites must provide consumers and employers with two types of quality information: quality relative to other plans (quality ratings) and enrollee satisfaction survey results.[53] The goal of presenting this information is to allow consumers to easily compare the QHPs available through the Exchange. Neither the ACA nor the Final Rule gives details on the actual content of the quality rating system and satisfaction survey. These will be the subject of future rulemaking.

**Question Goal (For UMMS Team Use):** We are looking for projects in specific topic areas:

- health **outcomes**
- preventing hospital **readmissions**
- improving **patient safety** and reducing medication errors
- implementing **wellness and health promotion** activities
- reducing **disparities**
  - **access**
  - **care coordination**

We are also looking for whether they use standard and specific methodology for doing the projects.

| Questions | Responses |
|---|---|
| 1. Do you currently collect information about quality improvement projects?<br>Prompts:<br>• Which types of health plans/insurers or providers<br>• What types of information are you collecting?<br>  • Routine/ad hoc<br>  • Specific topics<br>  • Specific or standard reporting tools or methods used to collect information about quality improvement projects.<br><br>2. Are the results of QIP's made available to external audiences, e.g. consumers? | |

[53] ACA Section 1311(d)(4)(C), later 45 CFR Part 155.205(b).

# Ratings, Incentives and Rewards

**ACA Requirements:**

- Exchange must assign ratings to each QHP (Sec 1311(d)(4)(D)), using system developed by HHS in future rulemaking (Sec 1311(c)(3)).

**Question Goal (For UMMS Team Use):** Are Vermont state agencies involved in any of the extra Exchange activities?

- **Tiering**/scoring/rating used in Vermont?
- **Pay-for Performance**

| Questions | **Responses** |
|---|---|
| 1. Have you been involved in or are you aware of any initiatives related to the following?<br>• Rating or tiering providers, insurers, or health plans?<br>• Pay-for-performance?<br>• Other types of incentive programs, financial or non-financial, to improve the quality of care?<br>2. Please tell me about the initiative(s).<br>Prompts:<br>• Organization spearheading the initiative<br>• How tiers determined, what is the difference between tiers?<br>• Incentive for what behavior?<br>• Financial/non-financial?<br>• Withhold, bonus, risk?<br><br>3. Do you have any feedback or lessons learned from your experience of these activities that might be helpful for the Exchange planners to consider? | |

# Vision

**Question Goal (For UMMS Team Use):** Chance for interviewee to offer opinions about interface between Exchange and their world.

| Questions | **Responses** |
|---|---|
| 1. What is your vision for quality and the new Health Insurance Exchange?<br>2. How do you envision the new Health Insurance Exchange quality requirements impacting Vermont providers, insurers, state agencies, and residents?<br>a. Do you foresee any benefits?<br>b. Do you foresee any challenges? | |

| | |
|---|---|
| **Everything that you have shared with me today has been very helpful. Is there anything else you would like to tell us?**<br><br>**Thank you for your time.** | |

# Appendix 3: Vermont Data Sources

| (Steward) Data Source | Description | Domains/Topic Areas |
|---|---|---|
| ***Administrative Data Sources*** | | |
| (DFR) Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) | • Vermont's multi-payer claims database.<br>• Vermont law (Rule H-2008-01) requires insurers in Vermont to submit eligibility and claims data to DFR through VHCURES on an annual basis.<br>• Data is used to measure and report health care system performance on selected key measures.<br>• The Blueprint has worked with DFR (formerly BISHCA) to identify Blueprint patients in the multi-payer database. This allows for analysis of trends and outcomes in Blueprint patients as compared to a matched control group. | |
| (VDH) Vermont Uniform Hospital Discharge Data Set | • VDH collects hospital discharge data from Vermont's 14 general acute care hospitals for Vermont residents and non-residents. Under interstate agreement with agencies outside of Vermont, the state also collects hospital discharge data for Vermont residents using hospitals in bordering states.<br>• VDH uses the data to produce the Vermont Hospital Utilization Reports | • Inpatient Hospital Utilization<br>• Outpatient Hospital Utilization<br>• Emergency Department Hospital Utilization |
| ***Medical Record and Other Clinical Data*** | | |
| (Covisint-DocSite) Blueprint Central Registry | • Web-based patient registry, hosted by Covisint Docsite.<br>• Hospitals and practices in Vermont transmit data from electronic medical records (EMRs) and other data sources to the central registry.<br>• In addition to patient care and population management, the registry is used to track performance and quality improvement activities. Blueprint practices are able to see how their providers compare internally and how they compare to other practices, health service areas (HSAs), | • Asthma<br>• Coronary Artery Disease (CAD)<br>• Diabetes<br>• Attention Deficit Hyperactivity Disorder (ADHD)<br>• Obesity<br>• Health Maintenance (Adult<br>• Patient Health Questionnaire (PHQ-9)<br>• Community Health Team Care Coordination<br>• Medicaid Care Coordination |

| (Steward) Data Source | Description | Domains/Topic Areas |
|---|---|---|
| | and results for VT overall. | and Child)<br>• High Blood Pressure (HTN)<br>• Perinatal |
| Medical Record Review | Medical record chart reviews are conducted by health plans and other organizations for quality improvement purposes, quality assurance, and conducting performance measurement (e.g. HEDIS). Examples of chart reviews conducted in Vermont include:<br>• BCBS-VT is required to perform a medical record chart review on high-volume providers once every 3 years to evaluate documentation methods.<br>• The University of Vermont Child Health Improvement Program conducts a systematic review of 4500 patient charts per year to identify trends in healthcare quality and outcomes. | |
| (CMS) Minimum Data Set (MDS) | • Standardized uniform comprehensive assessment of all residents in Medicare or Medicaid certified facilities.<br>• Certified nursing facilities are required by federal law to complete and electronically submit data to the state.<br>• MDS data is used for:<br>o Care planning and management<br>o Medicare Reimbursement<br>o Survey Process<br>o Reporting on Quality Measures (e.g., Nursing Home Compare) | • Self-Reported Moderate/Severe Pain<br>• High-Risk Residents with Pressure Ulcers<br>• New/Worsened Pressure Ulcers<br>• Physical Restraints<br>• Falls<br>• Psychoactive Medication Use in Absence of Psychotic or Related Condition<br>• Antianxiety/Hypnotic Medication Use<br>• Behavior Symptoms Affecting Others<br>• Depressive Symptoms<br>• Urinary Tract Infection<br>• Catheter Inserted and Left in Bladder<br>• Low-Risk Residents Who Lose Bowel/Bladder Control<br>• Excessive Weight Loss<br>• Need for Health with ADLs Has Increased |
| (CDC) National Healthcare Safety Network Database (NHSN) | • Internet-based surveillance system managed by the Division of Healthcare Quality Promotion at CDC used to monitor adverse events and incidents in health care facilities including acute care hospitals, psychiatric hospitals, and long term care facilities.<br>• NHSN data is used in VT by DFR to monitor and report on healthcare-associated infections (e.g., Hospital Report Card) | |

## Inventory of Vermont Quality Activities

| (Steward) Data Source | Description | Domains/Topic Areas |
|---|---|---|
| (CMS) Outcome Assessment and Information Set (OASIS) | • Standardized comprehensive assessment of all patients in Medicare or Medicaid certified home health agencies.<br>• Home Health Agencies are required by federal law to complete and electronically submit data to the state.<br>• OASIS data is used by home health agencies to identify areas for improvement and for public reporting of quality measures (e.g., Home Health Compare) | • Managing Daily Activities<br>• Managing Pain and Treatment Symptoms<br>• Treating Wounds and Preventing Pressure Sores<br>• Preventing Harm<br>• Preventing Unplanned Hospital Care |
| (VITL) Vermont Health Information Exchange | • Data from EMR systems, hospital data systems, practice management systems, and direct data entry from an array of health care providers are transmitted electronically through the VITL, allowing providers to compile and share clinical and demographic data of patients.<br>• Patient data from health care organizations and providers are transmitted through VITL to the Blueprint Central Registry (DocSite). This allows the Blueprint community health teams to assist with population management.<br>• VITL is also used to compile and transmit immunization data from health care providers to the Vermont Department of Health Immunization Registry. | • |
| ***Survey Data Sources*** | | |
| (CDC) Behavioral Risk Factor Surveillance System | • A telephone survey of adults administered through the Department of Health.<br>• Results from the survey are used to plan, support, and evaluate health promotion and disease prevention programs.<br>• Results are also used to track Department of Health goals (e.g. Healthy Vermonters 2010) and other BRFSS data reports. | • Alcohol Consumption<br>• Asthma<br>• Cancer<br>• Cardiovascular Disease Prevalence<br>• Cognitive Impairment<br>• Colorectal Cancer Screening<br>• COPD<br>• Depression<br>• Diabetes<br>• Exercise/Physical Activity<br>• Falls<br>• Family Planning<br>• HIV/AIDS and other STD/STI<br>• Immunizations<br>• Oral Health<br>• Prescription Drugs<br>• Prostate Cancer Screening<br>• Sexual Behavior<br>• Tobacco Use<br>• Women's Health |

## Inventory of Vermont Quality Activities

| (Steward) Data Source | Description | Domains/Topic Areas |
|---|---|---|
| (DMH) Child, Adolescent & Family Mental Health Satisfaction Survey | • DMH conducts a biennial survey to evaluate patient experience with adult and adolescent public mental health programs in Vermont.<br>Surveys are sent to all young people aged 14-18 who received six or more Medicaid-reimbursed services from one of Vermont's ten regional community mental health centers. | The survey evaluates patient's experience with regard to the program:<br>• Staff<br>• Quality<br>• Services<br>Outcomes |
| (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS) | CAHPS surveys are administered by mail and telephone to consumers and patients to evaluate their experiences with a range of health care services and service providers including:<br>o Health Plans<br>o Hospitals<br>o Home Health Care<br>o Nursing Homes<br>o Individual providers and groups | Topic areas that are covered differ across CAHPS surveys and include:<br>• Access<br>• Communication<br>• Courteous and Helpful Office Staff<br>• Customer Service<br>• Global Ratings<br>• Patient Care<br>• Pain Management<br>• Care Coordination |
| (VDH) Vermont Adult Tobacco Survey | • A telephone survey administered through the Department of Health used to evaluate the effectiveness of Vermont Tobacco Control Program efforts to reduce smoking and increase awareness and knowledge of smoking-related health issues. | • Prevalence<br>• Smoking Cessation<br>• Program Awareness & Utilization<br>• Secondhand Smoke<br>• Health Care Providers & Interventions<br>• Attitudes toward Smoking<br>• Media Campaign Awareness |
| (DMH) Vermont Mental Health Consumer (Satisfaction) Survey | • DMH conducts an annual survey to assess consumer satisfaction with Community Rehabilitation and Treatment programs in Vermont for the adult and child patient populations. | • Access<br>• Services<br>• Respect<br>• Autonomy<br>• Outcomes |
| (VDH) Vermont Physician Survey | • The Vermont Department of Health conducts a biennial survey to assess access to health care in Vermont.<br>• Surveys are mailed to all active providers (physicians, dentists, and physician assistants) at the time of their relicensing.<br>• Data is used as the basis for shortage area designations and recruitment and retention activities. | • Specialty<br>• Practice Setting<br>• Town(s) of practice<br>• Patient Care Hours Per Week<br>• Demographics<br>• Years Worked in Vermont<br>• Accepting New Patients (Primary Care and Specialty) |

## Inventory of Vermont Quality Activities

| (Steward) Data Source | Description | Domains/Topic Areas | |
|---|---|---|---|
| (CDC) Youth Risk Behavior Survey | • The Department of Health's Division of Alcohol and Drug Abuse Programs and the Department of Education Student Health and Learning Team conduct a biennial survey with middle and high school students in Vermont to measure the prevalence of behaviors that contribute to the leading cause of death, disease, and injury among youth. | • Demographics<br>• Personal Safety and Violence<br>• Alcohol, tobacco, and other drugs<br>• Attitudes and perceptions about alcohol, cigarette, and marijuana use<br>• Sexual behavior and orientation | • Body Image<br>• Nutrition<br>• Physical Activity<br>• Youth assets |

# Appendix 4: State Requirements for MCOs and Designated Agencies

The following subsections summarize the state requirements for MCOs and DAs as required by the Division of Financial Regulation[54] (DFR) and Department of Mental Health (DMH), respectively.

### State Requirements for Managed Care Organizations (MCOs) (Rule H-2009-03)

- **Quality Improvement Goals:** MCOs are required to present year-end results of quality improvement projects (QIPs), including, at least:
    - One joint mental health project between the MCO and its mental health delegate[55];
    - Two joint goals (one joint goal for managed mental health care organizations) with other MCOs[56].
    - MCO must actively participate in quality improvement initiatives aimed at improving public health that are sponsored by the Department of Health, Agency of Human Services, Agency of Administration and/or other state agencies.
- **Access, Care Coordination, Continuity of Care:** Each MCO shall ensure timely access to effective, medically necessary care and shall monitor and take action, as necessary, to improve coordination and continuity of care for its members across service providers.
    - *Deeming Opportunity:* MCO fully meets NCQA HP QI 10, Element A. Note that deeming opportunities are only applicable during DFR compliance evaluations for Baseline Reviews and Triennial Reviews. As part of those reviews, MCOs *may* be deemed to have fulfilled the requirements of Rule 9-03 that are determined by the Commissioner to be able to be met through accreditation by an independent accreditation organization approved by the Department (DFR).
    - Additional quality improvement requirements include:
        - Improving care across contracted provider networks, at a minimum for high-volume providers, by working directly with providers to continually improve performance over time thru constructive engagement, motivation and support and processes to promote accountability that annually include: provider accessibility, clinical quality, efficiency of clinical practice or patient experience of care.

[54] Formerly the Banking, Insurance, Securities & Health Care Administration (BISHCA)

[55] As required by Section 6.4(C) of Rule 9-03

[56] As required by Section 6.3(D) of Rule 9-03

- Measuring performance annually for primary care providers, specialist physicians, mental health and substance abuse providers, acute care hospitals, and hospitals providing mental health and substance abuse services.

- Motivating and supporting high-volume provider efforts to generate quality improvement through the use of provider incentives (financial and non-financial) and the provision of resources to assist providers in improving performance.

- Assisting providers who do not meet MCO standards by taking appropriate action to correct deficiencies, including establishing correction action plans with providers, monitoring providers to determine where they have implemented corrective actions and take appropriate and significant action when a provider has not implemented corrective action.

- Maximizing the number of members receiving care consistent with treatment protocols and practices that are informed by generally accepted medical and scientific evidence and practice parameters consistent with prevailing standards of medical practice. MCOs shall review the practices and protocols of at least once every two years, and adopt and publish quality standards for primary care providers, specialists (including mental health and substance abuse providers, and hospitals.

- Promoting the use of preventive health services and inform members at least one a year about preventive care services available to them.

- Conducting an annual quality management program evaluation that includes an evaluation of the effectiveness of the strategies it employed.

- **Chronic Condition Management:** Each MCO shall develop and maintain a program under the direction of its medical director that is designed to assist its members and their providers in managing chronic conditions in a way that will improve the health status of members who have chronic conditions.

    - *Deeming Opportunity:* If a managed care organization participates in the Blueprint for Health chronic care initiative, it may be deemed to meet the requirements of this section for those geographic areas in which the blueprint for health is active.

    - *Deeming Opportunity:* There are a number of deeming opportunities, through URAC or NCQA, regarding chronic care management. MCOs *may* be deemed to have fulfilled the requirements of Rule 9-03 that are determined by the Commissioner to be able to be met through accreditation by an independent accreditation organization approved by the Department (DFR).

## State Requirements for Mental Health Designated Agencies (DAs)[57]

- **Quality Improvement and Outcomes:** Each DA agency must actively engage in quality improvement (QI) and demonstrate its ability to use outcomes from all levels of agency operations (consumer care, program effectiveness and overall agency administration) to inform decision making and improve service delivery.

- **Quality Assurance System:** Each DA must demonstrate a QI and assurance system, by maintaining, at a minimum:

    - A written description of the QI program that clearly defines the QI structure and procedures and assigns responsibility to appropriate individuals for maintaining service quality;

    - An annual update of the QI plan that reflects the use of agency data and outcomes and includes changes in the objectives, timelines, scope and planned projects or activities for the year, monitors the previous year's issues, and evaluates the QI program.

**Performance Evaluation:** DMH evaluates the performance of mental health programs offered by DAs every four years. The reviews offer opportunities to focus on the system of care's ability to achieve desired outcomes, to recognize program accomplishments and challenges, and to identify areas for quality improvement. Programs are evaluated across four domains: access, practice patterns, outcomes/results of treatment, and structure/administration. Results are populated in terms of: strengths, challenges, recommendations for improvement, and required improvements or deficiencies.

[57] As required by Section 4.8.of Administrative Rules on Agency Designation, Department of Development and Mental Health Services.

# Appendix 5: MCO QI Goals & Initiatives for 2012 (Rule H9-03)

| BCBSVT & TVHP (file joint QI goals) | |
|---|---|
| • **Appropriate Testing for Children with Pharyngitis** | • Common measurement collaborative with BISHCA, VPQ, other payers |
| • **Childhood Immunizations - Combination 2** | • Collaborative approach working with other payers, pediatric advisory council, and department of health |
| • **Women's Health - Breast Cancer Screening** | • Collaborate with Vermonters Taking Action Against Cancer (VTAAC) and large employer groups to promote screenings |
| • **Women's Health - Cervical Cancer Screening** | • Collaborate with VTAAC to promote screenings |
| • **Youth Health - Well Child Visits** | • Joint payer initiative to improve rates |
| • **Cardiac Rehabilitation** | • Care management program outreach to members and providers with the aim to improve cardiac rehabilitation participation rates for eligible members |
| • **Follow-up Care for Children Prescribed ADHD Medication - present to BISHCA** | • Joint project with Magellan. Member and provider outreach around behavioral health issue, specifically ADHD follow up care |
| • **Antidepressant Medication Management** | • Joint project with Magellan. Member and provider outreach around behavioral health issue, specifically antidepressant medication management |
| • **Catamount Service Improvement Project** | • Service improvement for the Catamount product in the areas of understanding of Chronic Care Management, Smooth Transitions and Member Eligibility and Billing Process |
| • **Women's Health - Chlamydia Screening ages 16-24** | • Member outreach on the importance of regular screenings for Chlamydia - combine with cervical cancer (pap smears and HPV tests) reminders. |
| • **Prenatal and Postpartum Care** | • Member and provider outreach to stress the importance of ongoing prenatal care and a postpartum visit on or between 21 and 56 days after delivery |

| CIGNA | |
|---|---|
| • **Improve member satisfaction with access to healthcare needs.** | • Improving ratings for the following CAHPS questions:<br>o How often could you find Plan Information on Cost when you needed it?<br>o How satisfied are you with the accuracy and value of pharmacy benefit information on the CIGNA member website?<br>o How easy is it to find information on the CIGNA member website about the cost and quality of health care provided by my doctors and hospitals?<br>o How strongly do you agree or disagree with the following statement? The information about cost and quality of health care on the CIGNA member website was helpful when making health care |

| CIGNA | |
|---|---|
| | decisions. |
| • **Improve provider satisfaction** | • Increase number of electronic fund transactions.<br>• Notify providers of local Provider Relations Representative.<br>• Implement internal web based tool to allow for increased on line drug authorizations and more efficient turn- around times.<br>• Implement redesigned provide portal to include pharmacy information |
| • **Improve Colorectal Cancer Screening Rates** | |
| • **Improve Post-Partum Follow-up Visit Rates** | |
| • **Improve collaboration between medical and mental health providers when member is prescribed new antidepressant medication.** | • Joint project with mental health delegate |
| • **Youth Health Improvement Initiative** | • Continue participation with other payers and VCHIP to improve preventive care services to adolescents in Vermont. |

| MVP Health Plan | |
|---|---|
| • **Vermont Youth Health Improvement Initiative** | • Implement VT all-payer QI collaborative with VCHIP to improve adolescent access to preventive services<br>• Year 11 project focus on adolescent preventive health improvements |
| • **Implement Year 2 of BISHCA-required joint all-payer QI collaborative on improving childhood immunizations** | • Improve accuracy and completeness of immunization claims submission to the Vermont Immunization registry |
| • **Common physician measurement all-payer quality management collaborative** | • Continue to expand pilot project for pediatric measures |
| • **Implement Year 2 of Vermont BISHCA-required QI collaborative with PrimariLink, MVP's MBHO** | • Communication & Coordination of Complex Case Management for high utilizing members with mental health diagnoses |

## BEHAVIORAL HEATH

| Magellan Behavioral Health |
|---|
| • **Improving caller experience with first contact issue resolution** |
| • **Improve BCBSVT's HEDIS results for the initiation and engagement in treatment for alcohol and other drug dependence.** |
| • **Improve outcomes of members enrolled in Magellan's Intensive Care Management (ICM) Program and create an integrated approach to intervening with members who have co-existing behavioral health and medical issues.** |
| • **Improve coordination between medical and mental health providers by identification and treatment of children and adolescents diagnosed with ADHD** |

## Inventory of Vermont Quality Activities

| Cigna Behavioral Health |
| --- |
| • **Improve 7-Day ambulatory follow-up rates for HEDIS measure for Follow-up After Hospitalization for Mental Illness** |
| • **Alcohol and Other Drug (AOD): Increase the percentage of adults, 13 years and older, with an AOD diagnosis who initiate treatment and engage in treatment** |
| • **Cigna HealthCare and Cigna Behavioral Health Vermont Collaborative Quality Initiative: Improving Coordination of Care for Customers Receiving a New Prescription for Antidepressant Medication** |
| • **Improve Participant Satisfaction as indicated by the Vermont Experience of Care Survey (EOC) for identified questions**<br>o Improve member satisfaction with customer service by 7.2 percentage points over 2011 results as indicated by the Vermont Experience of Care (EOC) Participant Satisfaction survey, question # 12: In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called customer service?<br>o Improve wait times regarding access to urgent care services by 9.9 percentage points over 2011 results as indicated by the Vermont Experience of Care (EOC) Participant Satisfaction survey, question # 3: In the last 12 months when you needed counseling or treatment right away, how often did you see someone within 24 hours of your request for an appointment? |
| • **Vermont Youth Health Improvement Initiative (YHII) - Improve patients getting screening and linking to Mental Health care** |