Care Models and Care Management Work Group Meeting Agenda 10-31-14

VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Agenda

October 31, 2014; 9:00 AM to 11:00 AM
4th Floor Conference Room, Pavilion Building, Montpelier, VT
Call-In Number: 1-877-273-4202; Passcode 2252454

Item #	Time Frame	Topic	Relevant Attachments	Vote To Be Taken
1	9:00 to 9:10	Welcome; Introductions; Approval of Minutes (*Nancy Eldridge to serve as meeting facilitator*)	**Attachment 1a:** August meeting minutes **Attachment 1b:** September meeting minutes	Yes (approval of minutes)
2	9:10 to 9:20	Updates *Integrated Communities Care Management Learning Collaborative:* *-Status of Quality Improvement Facilitator procurement* *-November Kickoff Webinars* *-Potential Learning Session Topics* ***Public Comment***		
3	9:20 to 10:20	Presentation on Blueprint-OneCare Vermont Collaboration *-Craig Jones, MD, Executive Director, Vermont Blueprint for Health* *-Todd Moore, CEO, OneCare Vermont* ***Public Comment***	**Attachment 3a:** Power Point Presentation(s) (Will be distributed when available) **Attachment 3b:** Blueprint for Health Legislative Report: Medical Homes, Teams and Community Health Systems	
4	10:20 to 10:50	Draft Care Management Standards ***Public Comment***	**Attachment 4:** Draft Care Management Standards *(sent to Work Group on September 29)*	Yes (review and eventual approval)

5	10:50 to 11:00	Next Steps, Wrap-Up and Future Meeting Schedule November Meeting Preview: *-Continued Discussion on Care Management Standards* *-Review work plan for Year 2 updates*		

Attachment 1a - CMCM Work Group Meeting
Minutes 8-12-14

Vermont Health Care Innovation Project

VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Minutes

Date of meeting: Tuesday, August 12th, 2014; 9:00 AM to 12:00 PM, Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier, VT.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions, Approval of meeting minutes	Nancy Eldridge called the meeting to order at 9:05 and asked for a motion to approve the July meeting minutes. Laural Ruggles moved approval of the July meeting minutes as is, and Dale Hackett seconded the motion. There was no discussion, and Georgia Maheras took a role call vote. The motion passed unanimously.	
2. Co-Chairs Update	As part of the co-chair update, Nancy indicated that the problem statement was included as Attachment 2 in the meeting handouts. Nancy noted that the group requested that the reference to the Office of Quality and Care Management be removed from the definition of Care Management. Staff will make that change and ensure that all previous feedback is incorporated. An updated version reflecting this edit and any others will be distributed to the work group.	
3. Response to Questions on Integrated Community Learning Collaborative	Nancy reviewed Attachment 3: *Memo re Response to Questions on Integrated Community Learning Collaborative*, and indicated that this memo offers a summary of questions and comments received by work group members and others since the learning collaborative planning group presented its proposal at last month's in-person meeting, as well as responses to the questions offered by the planning group. Nancy opened up the floor to further questions/comments, and the discussion proceeded as follows: • Dale Hackett asked the following series of questions: Can the learning collaborative operate effectively within Medicaid as well as ACOs? How will the learning collaborative incorporate best practices? How will best practices be embraced at the community level? Pat Jones responded by	

Agenda Item	Discussion	Next Steps
	saying that this learning collaborative is an effort to break some new ground by looking at the best ways to integrate care management services at the community level. The planning group has reviewed the literature around best practices in this area, including team based care, shared plans of care, integrated communities, etc. That said we are trying to test models that don't have a great deal of research and application to date. Laural Ruggles also added that she thinks it is good to start with something that is proven, but then you have to adapt it to fit the needs of your community. It is important to have the freedom to innovate based on the needs of the community. • Pat Jones also shared a question that Dale had previously posed to the group, related to what field support (if any) will be offered through the learning collaborative to support people and participants at the community level. Pat noted that although the planning group explored opportunities to participate in national learning collaboratives in this arena, the decision was made to build local capacity internally within Vermont so that these resources can be utilized beyond the time frame of the learning collaborative. Moreover, additional field support will be offered to the pilot communities via the facilitators that will be hired to support the collaborative. Pat also indicated that those who voted on this proposal at the August 6 VHCIP Steering Committee unanimously agreed to recommend the funding.	
4. Summary of Care Management Inventory Survey Responses	Nancy summarized the number of responses to the care management inventory survey and introduced Christine Hughes from Bailit Health Purchasing to review Attachment 4, *Care Management Survey Responses, Summary Presentation*. Christine reviewed the power point presentation, which is focused on the first six questions of the survey, and offers information on who the respondents are, where they are providing services, and what services are being provided. Additional information on the survey results will be presented at the September in-person meeting. Discussion of the presentation ensued, including the following comments/questions: • Joyce Gallimore noted that regarding respondent categorization, Blueprint community health teams often cross over with FQHC activities. She noted that no change is necessary in the categorization, but she agrees that there is a certain degree of overlap amongst the respondent categories. • Regarding slide 10, Dale asked if there would be confusion regarding the categorization of DVHA (VCCI's) response, as DVHA could be categorized as a state agency or a payer. Pat responded that because VCCI operates like a health plan care management program, in this case it should be categorized as a payer. • Regarding slide 17, Pat noted that there is an error in the figure for the number of organizations that responded, and that the correct number should be 3. • Dale Hackett asked what is included in the definition of special services management. Pat referenced	

Agenda Item	Discussion	Next Steps
	the definition provided to survey respondents as indicated on slide 12 and noted that we tried to define the categories so that the same person wouldn't end up in multiple categories. For purposes of the survey, special services is meant to describe services for people who need ongoing special services for an undefined period of time. • Pat reminded the group that this particular presentation is focused on the demographics of the survey and who responded. Next month we will bring more information, and ultimately a detailed analysis of the survey will be incorporated into a report that will be shared with the work group. • Steve Dickens asked if the group would be able to access information regarding, for example, how individual health plans responded to the questions. Michael Bailit noted that it may also be interesting to look at these results from a consumer centric point of view; for example, how do consumers view the services they are receiving? Perhaps a qualitative consumer survey could be utilized to sample consumers who are served by one or more of these programs to get a sense of how many care managers they are interacting with, and for which types of services. Pat noted that the learning collaborative may offer an opportunity to better gauge the consumer perspective. Georgia Maheras also indicated that the state fields multiple consumer surveys that we could use to get a sense of this information. Marge Houy observed that the data shows some interesting opportunities for cross-organization collaboration.	
5. DLTSS Work Group Presentation: Proposed DLTSS Model of Care	Nancy introduced Deborah Lisi-Baker, co-chair of the Disability and Long Term Services and Supports (DLTSS) work group, and Susan Besio of PHPG, consultant to the DLTSS work group, to present Attachment 5, *Proposed DLTSS Model of Care Presentation.* Deborah began the presentation by noting that it includes "core elements" of a care model that can be utilized across diverse settings and populations, and that it incorporates best practices on many levels. It is applicable to all settings and populations, and is not specific to just the DLTSS population. Furthermore, the model includes elements of person centered planning, decision making tools, consumer involvement, and a collaborative team model. The systems and practices should be applicable for people of all backgrounds, institutional and non-institutional settings. The model highlights the importance of working across and collaborating amongst all settings and sectors. Deborah then turned the presentation over to Susan who reviewed the slides in more detail. Discussion of the presentation ensued, and the following comments/questions were raised: • Laural Ruggles commented that she likes how the presentation focuses on core elements that can be broadly applicable, as we don't want to create more silos by grouping people into models. It's good that the elements can be applied across populations. She then asked how many people might be falling through the cracks (e.g., those who could benefit from care management but are not connected to a care manager in any way). Susan responded that when a similar analysis was done in	

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	preparation for the duals demonstration, 1/3 of the 22,000 dual eligible population was not receiving care management (roughly 7,500 individuals). If we extrapolate that figure to the broader Medicaid population receiving DLTSS services, 1/3 could be roughly 12,000 people. This is only a proxy as the analysis has not been done. Furthermore, Susan noted that people enrolled in commercial plans and Medicare aren't necessarily receiving the full spectrum of services that they need, because these services aren't always covered. • Deborah commented that people's health is constantly changing and they can move in and out of needing particular services. Steve Dickens agreed, and further commented that there are many people who have been functioning with disabilities for a long time, but then something happens and their needs change. It is important to capture those evolving needs as soon as possible. The PCP's office is a good place to start, but there may be other potential venues. • Susan noted that the single point of contact is key so that the needs of the individual can be followed over time. She noted that CHTs can be focused on short term interventions, and asked if they could be the single point of contact on an ongoing basis. Laural responded that it depends on who is involved. They don't typically function as case managers, but they are able to find the right person. There are no eligibility criteria for CHT services, and CHTs know how to access resources that are available for people and can direct them to those resources. Laural also noted that the integrated care plan is hard given current HIT infrastructure. Although we may not be there electronically, care plans could be shared on paper in the interim. • Marlys Waller asked about people who want to manage their own services as an individual or family but don't have adequate resources. Deborah noted that the goal is not to give people more coordination than they want. The single point of contact could work behind the scenes to avoid the need for individuals and families to interact with so many people. • Mary Moulton commented that in Washington County the CRT population is slightly over 300 and about 130 (1/3) needed a PCP and/or more coordination. About 15% of those served on an outpatient basis have not seen a PCP in the last year. They decided to shift care coordination to the person that the patient thinks is the best fit. Washington County is trying this model out, and they recognize that there are HIT challenges. Whatever approach it is, it needs to be team based. She also noted that these services could take more time than a care manager has, and asked how it could be funded. Susan responded that the Medicaid health home program could be an option, which offers 90/10 funding for 8 quarters, and offers funding on an ongoing basis for "health home services". Additional research needs to be done to explore the feasibility of this option moving forward. Another funding opportunity was identified via the federal Mental Health Act adopted earlier this year, but this will take some time to unfold. It would potentially be a one year planning grant, but full funding would not be available until 2017. • Jenney Samuelson commented that CHTs have staff embedded in PCPs who are doing long term	

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	management, as well as doing assessments to connect patients with specialized services. Furthermore, she commented that regarding the joint care plan, if the family is acting as their own single point of contact, they need to share their care plan with someone so the providers can be aware and help coordinate on their behalf. • Dale Hackett commented that we don't have a sense of how much money we are spending on care coordination right now, so it is difficult to know how much more we would spend. He also noted that this model may be challenging to people and may cause discomfort, but that doesn't mean it isn't the right thing.	
6. Proposed Process for Developing Care Management Standards	Nancy Eldridge introduced this agenda item by drawing the group's attention to Attachment 6, *Timeline re Proposed Process for Developing Care Management Standards.* She explained that the staff and co-chairs suggest that we bifurcate the development of the aspirational standards with operationalizing and assessing compliance with the standards. At the next meeting, staff, co-chairs and consultants will bring broad care management principles for work group consideration. A smaller working group would be utilized in the future to better understand implementation and compliance needs. Discussion ensued and the following comments/questions were posed: • Madeleine Mongan commented that the NCQA standards are a nationally recognized source, but she wondered about the source of recognition for the other standards. Erin noted that slide 15 of the DLTSS model of care presentation offers sources for those best practice elements contained within. Madeleine asked if those sources could be distributed to the work group, and Susan Besio noted that she will pull those documents together for distribution. • Jenney Samuelson asked how we will reflect updates to the NCQA standards as they are generally updated from time to time. Georgia responded that just as with many other elements of the ACO programmatic standards, we will have on opportunity to reflect on needed updates on a periodic (perhaps annual) basis. • Pat reminded the group that in the case of the NCQA standards, we are looking at the ACO Level standards, although they do build on elements of the PCMH standards. The intent in not to include excessive detail or to require all care management activities to be centralized at the ACO. Rather, the approach so far is to indicate that the ACO should ensure that certain are management standards are met, either by the ACO or by its participating providers.	

Agenda Item	Discussion	Next Steps
7. Next Steps, Wrap-Up and Future Meeting Schedule	**Next Meeting:** *Tuesday September 9th, 10:00 am – 12:00 pm, ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier*	

VHCIP CMCM Work Group Attendance Sheet 8-12-14

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

	First Name	Last Name		Title	Organization	Care Models
1	Peter	Albert			Blue Cross Blue Shield of Vermont	X
2	April	Allen		Director of Policy and Planning	AHS - DCF	MA
3	Ena	Backus			GMCB	X
4	Melissa	Bailey	Melissa Bailey	Dir of operations + Clinical Services	Otter Creek Associates and Matrix Health	X
5	Michael	Bailit	phone		Bailit-Health Purchasing	X
6	Susan	Barrett		Executive Director	GMCB	X
7	Susan	Besio	here	Senior Associate	Pacific Health Policy Group	X
8	Charlie	Biss			AHS - Central Office - IFS	X
9	Beverly	Boget				X
10	Heather	Bollman		VCCI Clinical Manager	AHS - DVHA	X
11	Mary Lou	Bolt			Rutland Regional Medical Center	X
12	Nancy	Breiden		DLP Director	VLA/Disability Law Project	M
13	Stephen	Broer		Director - Behavioral Health Services	Northwest Counseling and Support Servic	X
14	Martha	Buck			Vermont Association of Hospital and Hea	A
15	Dr. Dee	Burroughs-Biron		Health Services Director	Vermont Department of Corrections	M
16	Nick	Carter		VT Public Policy	Planned Parenthood of Northern New En	X
17	Jane	Catton		COO/CNO	Northwestern Medical Center	X
18	Amanda	Ciecior		Health Policy Analyst	AHS - DVHA	S
19	Barbara	Cimaglio		Deputy Commissioner	AHS - VDH	M
20	Ron	Cioffi		CEO	Rutland Area Visiting Nurse Association &	M
21	Amy	Coonradt	here	Health Policy Analyst	AHS - DVHA	X
22	Amy	Cooper		Executive Director	Accountable Care Coalition of the Green	M
23	Maura	Crandall	phone		OneCare Vermont	MA
24	Dana	Demartino		Health Coordinator	Central Vermont Medical Center	M
25	Steve	Dickens	here	Voc-Rehab Employee Assist.	AHS - DAIL	X
26	Nancy	Eldridge	here	Executive Director	Cathedral Square and SASH Program	C/M
27	Cameron	Erickson			MVP Health Care	MA
28	Trudee	Ettlinger			Vermont Department of Corrections	MA
29	Pamela	Farnham			Fletcher Allen Health Care	M

30	Erin	Flynn	here	Health Policy Analyst	AHS - DVHA	S
31	Aaron	French		Deputy Commissioner	AHS - DVHA	X
32	Meagan	Gallagher		VP of Business Operations	Planned Parenthood of Northern New En	X
33	Joyce	Gallimore	phone	Director, Community Health Paymen	Bi-State Primary Care/CHAC	MA/M
34	Lucie	Garand		Senior Government Relations Special	Downs Rachlin Martin PLLC	X
35	Christine	Geiler	C. Geiler	Grant Manager & Stakeholder Coord	GMCB	S
36	Eileen	Girling		Director	AHS - DVHA	M
37	Kelly	Gordon		Project and Operations Director	AHS - DVHA	X
38	Bea	Grause		President	Vermont Association of Hospital and Hea	C/M
39	Dale	Hackett	Deh	Consumer Advocate	None	M
40	Bryan	Hallett				X
41	Selina	Hickman		Policy Director	AHS - DVHA	X
42	Bard	Hill		Director - Policy, Planning & Data Un	AHS - DAIL	X
43	Breena	Holmes			AHS - Central Office - IFS	X
44	Marge	Houy	phone		Bailit-Health Purchasing	X
45	Christine	Hughes	phone		Bailit-Health Purchasing	X
46	Linda	Johnson	Deb from MVP on phone		MVP Health Care	M
47	Pat	Jones	Pat Jones		GMCB	S/M
48	Trinka	Kerr		Chief Health Care Advocate	VLA/Health Care Advocate Project	M
49	Kelly	Lange		Director of Provider Contracting	Blue Cross Blue Shield of Vermont	X
50	Patricia	Launer		Clinical Quality Improvement Facilita	Bi-State Primary Care	M
51	Diane	Leach		VP Quality	Northwestern Medical Center	X
52	Suzanne	Leavitt		Director Quality Choices for Care	AHS - DAIL	X
53	Diane	Lewis			AOA - DFR	A
54	Deborah	Lisi-Baker	here	Disability Policy Expert	Unknown	X
55	Vicki	Loner		Director of Quality and Care Manage	OneCare Vermont	M
56	Georgia	Maheras	here		AOA	S
57	David	Martini			AOA - DFR	M
58	Mike	Maslack				X
59	John	Matulis				X
60	James	Mauro			Blue Cross Blue Shield of Vermont	X
61	Marybeth	McCaffrey		Principal Health Reform Administrato	AHS - DAIL	X
62	Clare	McFadden		Senior Specialized Services Superviso	AHS - DAIL	M
63	Elise	McKenna		Project Manager	AHS - DVHA - Blueprint	X
64	Jill	McKenzie	phone			X
65	Jeanne	McLaughlin			Visiting Nurse Association & Hospice of V	M
66	Kimberly	McNeil		Payment Reform Policy Intern	AHS - DVHA	X
67	Darcy	McPherson		Program Technician	AHS - DVHA	A

68	Madeleine	Mongan	M. u m	Deputy Executive Vice President	Vermont Medical Society	M
69	Judy	Morton	phone		Mountain View Center	M
70	Mary	Moulton	phone	CEO	Washington County Mental Health Servic	M
71	Kirsten	Murphy			AHS - Central Office - DDC	X
72	Reeva	Murphy			AHS - Central Office - IFS	X
73	Sarah	Narkewicz			Rutland Regional Medical Center	X
74	Jessica	Oski			Sirotkin & Necrason	MA
75	Annie	Paumgarten	Anne Paumgarten	Eveluation Director	GMCB	X
76	Luann	Poirer		Administrative Services Manager I	AHS - DVHA	X
77	Betty	Rambur		Board Member	GMCB	X
78	Allan	Ramsay		Board Member	GMCB	X
79	Helen	Reid			Planned Parenthood of Northern New En	X
80	Paul	Reiss		Executive Director,	Accountable Care Coalition of the Green	M
81	Debra	Repice		Manager - Population Health	MVP Health Care	X
82	Julie	Riffon			North Country Hospital	X
83	Laural	Ruggles	here	Marketing/Development Director	Northeastern Vermont Regional Hospital	M
84	Jenney	Samuelson	here	Assistant Director of Blueprint for He	AHS - DVHA - Blueprint	X
85	Jessica	Sattler			Accountable Care Transitions, Inc.	X
86	Rachel	Seelig	here	Attorney	VLA/Senior Citizens Law Project	MA
87	Maureen	Shattuck			Springfield Medical Care Systems	X
88	Julia	Shaw	here	Health Care Policy Analyst	VLA/Health Care Advocate Project	MA
89	Catherine	Simonson		Director of Child, Youth & Family Ser	HowardCenter for Mental Health	M
90	Tom	Simpatico			AHS - DVHA	X
91	Patricia	Singer		Adult Service Utilization Director	AHS - DMH	M
92	Shawn	Skaflestad		Quality Improvement Manager	AHS - Central Office	M
93	Richard	Slusky		Payment Reform Director	GMCB	MA
94	Pam	Smart			Northern Vermont Regional Hospital	X
95	Audrey-Ann	Spence			Blue Cross Blue Shield of Vermont	M
96	Kara	Suter		Reimbursement Director	AHS - DVHA	X
97	Beth	Tanzman		Assistant Director of Blueprint for He	AHS - DVHA - Blueprint	X
98	Emily	Therrien		HCO Administrative Coordinator	Planned Parenthood of Northern New En	A
99	Win	Turner				X
100	Lisa	Viles		Executive Director	Area Agency on Aging for Northeastern V	M
101	Anya	Wallack		Chair	SIM Core Team Chair	X
102	Marlys	Waller	here		Vermont Council of Developmental and M	X
103	Julie	Wasserman	here	VT Dual Eligible Project Director	AHS - Central Office	X
104	Dawn	Weening			AHS - DVHA	MA
105	Robert	Wheeler	phone	Vice President & CMO	Blue Cross Blue Shield of Vermont	MA

106	Bradley	Wilhelm		Senior Policy Advisor	AHS - DVHA	X
107	Jason	Wolstenholme			MoveWell Spine & Sport	M
108	Jennifer	Woodard	here	Long-Term Services and Supports He	AHS - DAIL	X
109	Cecelia	Wu	here	Healthcare Project Director	AHS - DVHA	X
110	Dave	Yacovone		Commissioner	AHS - DCF	M
	KATHY	HENTCY		MH & HC INTEG. DIR	D MH	

CMCM

minutes

① Laural
② Dale

VHCIP CMCM Work Group Roll Call

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate

First Name	Last Name		Title	Organization	Care Models
Amy	Cooper	n/A	Executive Director	Accountable Care Coalition of the Green	M
Paul	Reiss	n/A	Executive Director,	Accountable Care Coalition of the Green	M
Shawn	Skaflestad ✓	✓	Quality Improvement Manager	AHS - Central Office	M
Clare	McFadden	n/A	Senior Specialized Services Superviso	AHS - DAIL	M
April	Allen	n/A	Director of Policy and Planning	AHS - DCF	MA
Dave	Yacovone	n/A	Commissioner	AHS - DCF	M
Patricia	Singer	n/A	Adult Service Utilization Director	AHS - DMH	M
Eileen	Girling	n/A	Director	AHS - DVHA	M
Dawn	Weening	n/A		AHS - DVHA	MA
Barbara	Cimaglio	n/A	Deputy Commissioner	AHS - VDH	M
David	Martini	n/A		AOA - DFR	M
Lisa	Viles	n/A	Executive Director	Area Agency on Aging for Northeastern V	M
Patricia	Launer	n/A	Clinical Quality Improvement Facilita	Bi-State Primary Care	M
Joyce	Gallimore ✓	✓	Director, Community Health Paymen	Bi-State Primary Care/CHAC	MA/M
Audrey-Ann	Spence	n/A		Blue Cross Blue Shield of Vermont	M
Robert	Wheeler ✓	✓	Vice President & CMO	Blue Cross Blue Shield of Vermont	MA
Nancy	Eldridge ✓	✓	Executive Director	Cathedral Square and SASH Program	C/M
Dana	Demartino	n/A	Health Coordinator	Central Vermont Medical Center	M
Pamela	Farnham	n/A		Fletcher Allen Health Care	M
Pat	Jones	✓		GMCB	S/M
~~Richard~~	~~Slusky~~		Payment Reform Director	GMCB	MA
Catherine	Simonson	n/A	Director of Child, Youth & Family Ser	HowardCenter for Mental Health	M
Judy	Morton	✓		Mountain View Center	M
Jason	Wolstenholme	n/A		MoveWell Spine & Sport	M
Cameron	Erickson	n/A		MVP Health Care	MA
Linda	Johnson	n/A		MVP Health Care	M
Dale	Hackett ✓	✓	Consumer Advocate	None	M
Laural	Ruggles ✓	✓	Marketing/Development Director	Northeastern Vermont Regional Hospital	M
Maura	Crandall	~~n/A~~ ✓		OneCare Vermont	MA

~~Vicki~~	~~Lonel~~		Director of Quality and Care Manage	OneCare Vermont	M
Ron	Cioffi	n/A	CEO	Rutland Area Visiting Nurse Association &	M
Jessica	Oski	n/A		Sirotkin & Necrason	MA
Bea	Grause	n/A	President	Vermont Association of Hospital and Hea	C/M
Dr. Dee	Burroughs-Biron	n/A	Health Services Director	Vermont Department of Corrections	M
Trudee	Ettlinger	n/A		Vermont Department of Corrections	MA
Madeleine	Mongan	n/A	Deputy Executive Vice President	Vermont Medical Society	M
Jeanne	McLaughlin	n/A		Visiting Nurse Association & Hospice of V	M
Nancy	Breiden	abstain	DLP Director	VLA/Disability Law Project	M
~~Trinka~~	~~Kerr~~		Chief Health Care Advocate	VLA/Health Care Advocate Project	M
Julia	Shaw ✓	abstain	Health Care Policy Analyst	VLA/Health Care Advocate Project	MA
Rachel	Seelig ✓	abstain	Attorney	VLA/Senior Citizens Law Project	MA
Mary	Moulton	✓	CEO	Washington County Mental Health Servic	M

Attachment 1b - CMCM Work Group Meeting
Minutes 9-12-14

VT Health Care Innovation Project
Care Models and Care Management Work Group Meeting Minutes

Date of meeting: Friday, September 12th, 2014; 10:30 AM to 12:30 PM, 4th Floor Conf Room, Pavilion Building, Montpelier, VT.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions, Approval of meeting minutes	Bea Grause kicked off the meeting at 10:30. A roll call of members both in the room and on the phone revealed not enough members present to vote on the August meeting minutes, and therefore this vote was post-phoned until next month. Bea noted that the meeting minutes approval is the only agenda item scheduled for a vote at this meeting.	
2. Co-Chairs Update	Bea provided a co-chair update and indicated that the co-chairs had recently met with project leadership to beginning planning for year two and the broader long term health care reform vision. In the short term the group will continue to monitor the progress of the integrated communities learning collaborative, finalize development of ACO Care Management Standards, and also look forward to a presentation from the blueprint and OneCare Vermont in October. Nancy Eldridge added that the work group will not be reviewing round two provider grants.	
3. Update on Integrated Community Learning Collaborative	Pat Jones provided an update on the progress of the integrated communities learning collaborative planning efforts. An RFP for two quality improvement facilitators is currently open and can be found at, http://www.vermontbidsystem.com/BidPreview.aspx?BidID=10559 .This RFP amended the existing blueprint RFP for practice facilitators, to include VHCIP facilitators as well. One quality improvement facilitator will develop the learning sessions, assist communities with implementation, outreach and support. The second facilitator will have data analytics expertise and will assist communities with better understanding and using a variety of data sources available in communities to improve care coordination. The communities will focus on at risk populations to start, and will expand to a population wide approach over time. It appears that there is a lot of interest at the community level, and the communities are attempting to utilize existing groups, meetings, and venues as much as possible.	

Agenda Item	Discussion	Next Steps
	The planning group is currently envisioning two tracks for participation. The first is more theory based and the second is more skills based. The planning group has put together a draft list of potential learning topics, located at Attachment 3b. Finally, representatives from the pilot communities shared their impressions on the process to date. Miriam Sheehey indicated that she is going to do a short presentation at the OneCare Vermont clinical advisory board. Marylou Bolt suggested that we remain fluid and throughout the year long process, as we may identify additional needs as we get further along. Jenney Samuelson suggested that we outline what the first few months look like, and then reflect on what logical next steps are. All communities indicated that they are hearing interest from organizations within their communities. Questions were received as follows: • Dale Hackett asked how this work will help create a more efficient system. Bea Grause responded that this will offer tools to build a more systematic approach to care coordination across organizations and communities. Jenney Samuelson added that it's really seeking to get the right care at the right time and not getting over care or under care.	
4. Care Management Survey Responses	Bea Grause introduced Christine Hughes and Margaret Houy of Bailit Health Care to present on the findings of the care management inventory survey. Christine walked the group through the presentation, which can be found at attachment 4, indicating that the first 21 slides were previously presented at the August in person meeting, and that new content begins on slide 22. Questions were received throughout the presentation and are captured as follows: • Dale Hackett noted that blueprint and community service provider service provision is very high, and yet many community service providers don't have secure funding and reimbursement structures. He asked if a block grant might be an effective way to ensuring adequate funding at the community level. Bea Grause responded that at this time, the inventory survey is meant to help us better understand what is in place currently. Questions about new payment models and financial structures are being discussed in the payment models work group. • Dale Hackett asked a question about Slide 33, are social workers working in genetics and epigenetics? Christine responded that we didn't capture this level of information in this question. • Bea Grause posed a question to the presenters, what really jumps out at you as potential actionable items? Christine responded that the top challenges as well as evidence that services are being delivered locally are key takeaways. Marge also commented that there seems to be a lot of	

Agenda Item	Discussion	Next Steps
	duplication as well as opportunities to streamline services, as well as an indication that most of the collaboration is ad-hoc currently. Laural Ruggles commented that it is important that we are careful not to jump to conclusions. The community health team works well because it is fluid and there is no single point of entry, therefore she doesn't think that having ad-hoc relationships is necessarily a bad thing. Christine reminded the group that 80-90% of respondents indicated that they are sharing information with other organizations and making referrals. Bea commented that it seems another finding is that if we had more funding, we could hire more qualified staff, which is not surprising. Also, if we get the HIE flowing, we will be much more efficient. Pat responded that she agrees that that IT resources is a clear need, as well as shared plans of care and care conferences can help meet information sharing needs. Mary Lou Bolt indicated that technical barriers also eat up funding, and inefficiencies eat up time that could be used to work with clients. • Dale Hackett commented that it seems that there is an at risk portion of the population that eats up a high percentage of costs, and for which care management is always a challenge. Pat responded that there is a lot of evidence to support that perception, and that is why we are focusing on this population in the integrated communities learning collaborative. For example, we are trying to get individuals engaged earlier and prevent the movement from at risk to high risk. Bea noted that these individuals are very complex in their needs. • A clarifying question was asked about slide 47 - If you take the average are you excluding the outliers. For example, many DA's have legal relationships with schools, but they come in as average. It may be different in smaller subsets. Christine noted that this may be an area where we can provide more information in the full report. • A question was asked as to when the full report would be distributed. Staff and consultants need some time to work together to outline what information will be contained in the report, but in the meantime Christine offered to share her talking points with the group so they could have some background information to reference when sharing the presentation with others. • Jenney Samuelson suggested that the network analysis might be complementary to this survey analysis and findings as a way to help people understand on a local level what collaboration looks like. Staff indicated that we can connect the VCHIP team with Bailit to share ideas.	
5. Progress on Draft Care Management Standards	Pat Jones offered an update on the development of draft care management standards, including progress since our last meeting, and where in the process that work currently stands. • A smaller group of ACOs and Payers have met twice and made a great deal of progress towards	

Agenda Item	Discussion	Next Steps
	drafting standards with the right level of detail, focusing on broader principles. We are not quite ready to share the draft yet. We anticipate that we will get a draft out in the next two weeks so that work group members have good time to review and reflect before October meeting. The new anticipated schedule will be to have a discussion in October, and a work group vote in November. • Finally, Pat gave a summary of the broad topics that the small group has reached agreement on for inclusion in the standards, including: care management oversight, guidelines and decision aids, population health management, and data collection, integration and use. • Bea recommended that we have a conversation about how the standards address the findings of the survey at our October meeting.	
7. Next Steps, Wrap-Up and Future Meeting Schedule	**Next Meeting:** October 31, 2014; 9:00 – 11:00 AM; EXE – 4th Floor Conf Room, Pavilion Building, Montpelier	

VHCIP CMCM Work Group Attendance 9-12-14

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

✓ via phone/webinar

First Name	Last Name		Title	Organization	Care Models
Peter	Albert	✓		Blue Cross Blue Shield of Vermont	X
April	Allen		Director of Policy and Planning	AHS - DCF	MA
Ena	Backus			GMCB	X
✓ Melissa	Bailey	Melissa Bailey		Otter Creek Associates and Matrix Health	X
Michael	Bailit			Bailit-Health Purchasing	X
Susan	Barrett		Executive Director	GMCB	X
Susan	Besio	✓	Senior Associate	Pacific Health Policy Group	X
Charlie	Biss			AHS - Central Office - IFS	X
Beverly	Boget				X
Heather	Bollman	✓	VCCI Clinical Manager	AHS - DVHA	X
✓ Mary Lou	Bolt	✓		Rutland Regional Medical Center	X
Nancy	Breiden		DLP Director	VLA/Disability Law Project	M
Stephen	Broer		Director - Behavioral Health Services	Northwest Counseling and Support Servic	X
Martha	Buck			Vermont Association of Hospital and Heal	A
Dr. Dee	Burroughs-Biron		Health Services Director	Vermont Department of Corrections	M
Nick	Carter		VT Public Policy	Planned Parenthood of Northern New Eng	X
Jane	Catton		COO/CNO	Northwestern Medical Center	X
Amanda	Ciecior		Health Policy Analyst	AHS - DVHA	S
Barbara	Cimaglio		Deputy Commissioner	AHS - VDH	M
Peter	Cobb		Executive Director	VNAs of Vermont	M
Amy	Coonradt		Health Policy Analyst	AHS - DVHA	X
Amy	Cooper		Executive Director	Accountable Care Coalition of the Green M	M
Maura	Crandall			OneCare Vermont	MA
Claire	Crisman		HCO Administrative Coordinator	Planned Parenthood of Northern New Eng	A
Dana	Demartino		Health Coordinator	Central Vermont Medical Center	M
Steve	Dickens		Voc-Rehab Employee Assist.	AHS - DAIL	X

Nancy	Eldridge	✓	Executive Director	Cathedral Square and SASH Program	C/M
Cameron	Erickson			MVP Health Care	MA
Trudee	Ettlinger			Vermont Department of Corrections	MA
Erin	Flynn	Erin Flynn	Health Policy Analyst	AHS - DVHA	S
Aaron	French		Deputy Commissioner	AHS - DVHA	X
Meagan	Gallagher		VP of Business Operations	Planned Parenthood of Northern New Eng	X
Joyce	Gallimore		Director, Community Health Payment	Bi-State Primary Care/CHAC	MA/M
Lucie	Garand		Senior Government Relations Speciali	Downs Rachlin Martin PLLC	X
Christine	Geiler		Grant Manager & Stakeholder Coordi	GMCB	S
Eileen	Girling		Director	AHS - DVHA	M
Kelly	Gordon		Project and Operations Director	AHS - DVHA	X
Bea	Grause	✓	President	Vermont Association of Hospital and Heal	C/M
✓Dale	Hackett	Deh	Consumer Advocate	None	M
Bryan	Hallett				X
Selina	Hickman		Policy Director	AHS - DVHA	X
Bard	Hill		Director - Policy, Planning & Data Uni	AHS - DAIL	X
Breena	Holmes			AHS - Central Office - IFS	X
Marge	Houy	✓		Bailit-Health Purchasing	X
✓Christine	Hughes			Bailit-Health Purchasing	X
Jay	Hughes			Medicity	X
Linda	Johnson			MVP Health Care	M
Pat	Jones	present		GMCB	S/M
Trinka	Kerr		Chief Health Care Advocate	VLA/Health Care Advocate Project	M
Kelly	Lange		Director of Provider Contracting	Blue Cross Blue Shield of Vermont	X
Patricia	Launer	✓	Clinical Quality Improvement Facilitat	Bi-State Primary Care	M
Diane	Leach		VP Quality	Northwestern Medical Center	X
Suzanne	Leavitt		Director Quality Choices for Care	AHS - DAIL	X
Diane	Lewis			AOA - DFR	A
Deborah	Lisi-Baker		Disability Policy Expert	Unknown	X
Vicki	Loner		Director of Quality and Care Manager	OneCare Vermont	M
Georgia	Maheras	✓		AOA	S
David	Martini			AOA - DFR	M
Mike	Maslack				X
John	Matulis				X
James	Mauro			Blue Cross Blue Shield of Vermont	X

Clare	McFadden		Senior Specialized Services Supervisor	AHS - DAIL	M
Elise	McKenna		Project Manager	AHS - DVHA - Blueprint	X
Jill	McKenzie				X
Jeanne	McLaughlin			Visiting Nurse Association & Hospice of V	M
Kimberly	McNeil		Payment Reform Policy Intern	AHS - DVHA	X
Darcy	McPherson		Program Technician	AHS - DVHA	A
Madeleine	Mongan		Deputy Executive Vice President	Vermont Medical Society	M
Monika	Morse				X
Judy	Morton	✓		Mountain View Center	M
Mary	Moulton		CEO	Washington County Mental Health Servic	M
Kirsten	Murphy			AHS - Central Office - DDC	X
Reeva	Murphy			AHS - Central Office - IFS	X
Sarah	Narkewicz			Rutland Regional Medical Center	X
Jessica	Oski			Sirotkin & Necrason	MA
Annie	Paumgarten	Anne Paumgarten	Eveluation Director	GMCB	X
Luann	Poirer		Administrative Services Manager I	AHS - DVHA	X
Betty	Rambur		Board Member	GMCB	X
Allan	Ramsay		Board Member	GMCB	X
Helen	Reid			Planned Parenthood of Northern New Eng	X
Paul	Reiss		Executive Director,	Accountable Care Coalition of the Green M	M
Debra	Repice	✓	Manager - Population Health	MVP Health Care	X
Julie	Riffon			North Country Hospital	X
Laural	Ruggles	✓	Marketing/Development Director	Northeastern Vermont Regional Hospital	M
✓ Jenney	Samuelson		Assistant Director of Blueprint for Hea	AHS - DVHA - Blueprint	X
Jessica	Sattler			Accountable Care Transitions, Inc.	X
Rachel	Seelig		Attorney	VLA/Senior Citizens Law Project	MA
Maureen	Shattuck			Springfield Medical Care Systems	X
Julia	Shaw	✓	Health Care Policy Analyst	VLA/Health Care Advocate Project	MA
Catherine	Simonson	C Simonson	Director of Child, Youth & Family Serv	HowardCenter for Mental Health	M
Tom	Simpatico			AHS - DVHA	X
Patricia	Singer		Adult Service Utilization Director	AHS - DMH	M
Shawn	Skaflestad	✓	Quality Improvement Manager	AHS - Central Office	M
Richard	Slusky		Payment Reform Director	GMCB	MA
Pam	Smart			Northern Vermont Regional Hospital	X
Audrey-Ann	Spence	✓		Blue Cross Blue Shield of Vermont	M

Kara	Suter	✓	Reimbursement Director	AHS - DVHA	X
Beth	Tanzman		Assistant Director of Blueprint for Hea	AHS - DVHA - Blueprint	X
Win	Turner				X
Lisa	Viles	✓X	Executive Director	Area Agency on Aging for Northeastern Ve	M
Anya	Wallack		Chair	SIM Core Team Chair	X
Marlys	Waller			Vermont Council of Developmental and M	X
Julie	Wasserman	✓	VT Dual Eligible Project Director	AHS - Central Office	X
Dawn	Weening			AHS - DVHA	MA
Kendall	West				X
Robert	Wheeler		Vice President & CMO	Blue Cross Blue Shield of Vermont	MA
Bradley	Wilhelm		Senior Policy Advisor	AHS - DVHA	X
Jason	Wolstenholme			MoveWell Spine & Sport	M
Cecelia	Wu		Healthcare Project Director	AHS - DVHA	X
Mark	Young				X
Lila	Richardson	HR		HCA/VLA	

Attachment 3b - Blueprint for Health Legislative Report: Medical Homes, Teams and Community Health Systems

State of Vermont
Agency of Administration
Health Care Reform
109 State Street
Montpelier, Vermont 05609

REPORT TO THE VERMONT LEGISLATURE

Blueprint for Health Report: Medical Homes, Teams and Community Health Systems

In accordance with Act 144 of 2014, Section 17

Submitted to
The House Committees on Health Care and on Human Services
and the Senate Committees on Health and Welfare and on Finance

Submitted by

Dr. Craig Jones, Executive Director
Blueprint for Health

Robin Lunge, Director of Health Care Reform
Agency of Administration

October 1, 2014

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Executive Summary

Introduction. During the 2014 legislative session, the Vermont General Assembly passed Act No. 144, an Act Relating to Miscellaneous Amendments to Health Care Laws. Section 17, Chronic Care Management; Blueprint Report; requires that on or before October 1, 2014, the Secretary of Administration or designee shall recommend to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance whether and to what extent to increase payments to health care providers and community health teams for their participation in the Blueprint for Health and whether to expand the Blueprint to include additional services or chronic conditions such as obesity, mental conditions, and oral health.

The recommendations in this report reflect input from meetings with clinicians and providers in areas across the state, input from Vermont's major commercial insurers and Medicaid, input from administrative leaders of hospitals, health centers, and Vermont's three Accountable Care Organizations, and input from a large and diverse set of stakeholders as part of the Blueprint's Executive and Planning committee meetings. The Director of the Blueprint Program, in collaboration with the Chair of the Green Mountain Care Board, and healthcare reform leadership within the Administration, have prepared this report to provide the Legislature with the recommendations requested in Act 144, and to submit these recommendations in the context of a more complete plan for the Blueprint program to support the next phases of Vermont's healthcare reforms.

A challenge with the required timing of this report is its relationship with the fiscal year 2016 budget. At the time of writing, given the revenue downgrade that occurred in July 2014, the administration is assuming the FY16 budget will be challenging. The current budget process is just beginning for FY16 and any suggestions for additional funding in the next budget would need to be considered as part of that process. In addition, as the current structure of the Blueprint for Health payments are multi-payer, any contributions by insurers require review as part of the Green Mountain Care Board rate review of insurance products and as part of the hospital budgeting process. Both GMCB processes typically happen over the summer and early fall for the following year.

While this report is premature in time to offer a specific recommendation, it details options for increasing investments as well as highlights other potential budget issues or priorities to be considered in the budget process. In addition, the report makes recommendations for integration and coordination of the Blueprint with other payment and delivery system reforms underway.

Background. The Blueprint program has worked with practices, hospitals, health centers, and other stakeholders to implement a statewide health service model in Vermont. The model includes advanced primary care in the form of patient centered medical homes (PCMHs), multi-disciplinary support services in the form of community health teams (CHTs), a network of self-

management support programs, comparative reporting from statewide data systems, and activities focused on continuous improvement (Learning Health System). The program is intended to assure that all citizens have access to high quality primary care and preventive health services, and to establish a foundation for a high value health system in Vermont.

The transformation brought about by the Blueprint program has been stimulated by two novel alternative payment models, as well as administrative and infrastructure support through Blueprint grants to each service area. The payments tested in the Blueprint program were added on top of routine fee for service revenue, and were intended as a new investment in primary care and team based services. The first payment goes directly to primary care practices based on their qualifying score as a patient centered medical home, providing a direct incentive to improve primary care in accordance with national quality standards (quality payment). The second payment goes to an administrative entity in each area of the state to establish a multi-disciplinary team that serves as a utility to the medical homes in their community, and provides the population with access to essential personnel such as nurse coordinators, social workers, health educators, and dieticians (capacity payment). Both payment streams are capitated as a per person per month (PPPM) payment that is applied to the whole medical home population (capitated population based payments). They are designed to improve health services for the overall medical home population, and are the longest running non fee for service payments that have been tested in Vermont.

As the Blueprint model expanded to each community, Vermont continued to pursue additional healthcare reforms. In 2010, Act 48 set Vermont on a path towards Green Mountain Care, a high value health system with universal coverage for all citizens. Vermont was also the recipient of a State Innovation Model (SIM) grant from the Centers for Medicare and Medicaid Services (CMS). This grant is being used to test new payment models, and to strengthen the health system infrastructure that is necessary for a high value health system. An important focus is being placed on population based payment models, and a health information and data infrastructure that spans all hospitals, practices, and an extended array of providers (medical and non-medical). As part of these efforts, three Accountable Care Organizations (ACOs) have formed bringing independent entities together to deliver more effective health services and to test the impact of multi-payer shared savings programs as a way to improve healthcare quality and outcomes. The substantial collection of reform efforts underway are intended to pave the way towards the ultimate goal of a high quality universal health system for all Vermont residents. For this to be successful, evidence from the United States and other countries emphasizes the importance of maintaining a sharp focus on primary care and prevention, even as broader financial and organizational reforms take hold.

This report discusses integration of the Blueprint for Health with the ACO shared savings programs and recommendations related to the financing and sustainability of the Blueprint for Health as part of a more comprehensive plan to facilitate the transition to Green Mountain Care, emphasizing a continued focus on building a strong foundation of primary care and a community

oriented model with close linkage of medical and social services. In effect, this report serves as a strategic plan for the Blueprint program to work with community providers, ACOs, the GMCB, and other stakeholders to help Vermont achieve a high quality high value health system for all its citizens. Included in this section is a list of key findings and recommendations, which are expanded on in the body of the report.

Summary of Findings

1. At the time of this report, there are 123 medical homes operating in Vermont. Data from Vermont's all payer claims database shows that 347,489 residents were active medical home patients by December of 2013. People receiving care in medical homes have access to multi-disciplinary staff from their local community health team, and an array of self-management programs such as tobacco cessation, Healthier Living Workshops, and the Diabetes Prevention Program.
2. In each area of the state, local program leaders have organized multi stakeholder workgroups to guide medical home expansion, coordinate community health team operations, implement new service models, and plan ways to improve services. These forums are often used to identify health conditions and service models that are a priority in their community, and to plan targeted quality improvement activities.
3. The Blueprint's strategy of combining targeted multi-payer payment reforms, grant support for a transformation infrastructure, and structured learning forums, has led to statewide rollout of priority service models including: advanced primary care consistent with NCQA standards; multi-disciplinary services using community teams as a utility; self-management support through a variety of community based programs, targeted assistance to high risk Medicare beneficiaries through the Support and Services at Home model; and enhanced treatment for people with opiate addiction through the Hub & Spoke program.
4. Outcomes for the medical home population shows advantages in healthcare expenditures, utilization, and quality compared with similar people who received their primary care in non-participating settings. The results strongly suggest that locally organized community health systems can achieve improved outcomes over traditional care.
5. Blueprint payments have stimulated substantial transformation and improved outcomes. Medical and non-medical providers have organized a novel service model in each area of the state, establishing a foundation for a more coordinated health system under Green Mountain Care. These payments have not been adjusted since 2008 and some providers have indicated that the current payment levels should be increased.
6. Each of Vermont's three ACOs have established their own formal governance structure, including separate activities to improve quality and shape more unified operations across the state. The Vermont Health Care Innovation Project workgroups have served as a forum for multi-stakeholder agreement on core quality measures that will be used to judge ACO performance and eligibility for shared savings. Although independent, Vermont's three ACOs share a common interest in improvement on these core quality measures, and a reduction in the rate of growth of healthcare costs.

7. Given the ACO shared savings program concept builds on patient-centered medical homes, there is a substantial overlap of the people and organizations who are participating in Blueprint and ACO activities. The separate activities are all oriented towards improving the quality and effectiveness of health services in their community. The administration recommends and has pursued, jointly with the provider community, to the unification of operations in each community in order to have participants work towards common goals.

Summary of Recommendations

1. *Unified Community Health Systems* – In each Health Service Area, payers, Blueprint and ACO leadership should work together to merge their workgroups, and collaborate with stakeholders to form a single unified health system initiative. The collaborative should include medical and non-medical providers, a shared governance structure with local leadership, focus on improving the results of core ACO quality measures, support the introduction and extension of new service models, and provide guidance for medical home and community health team operations. This approach will establish a data guided community health system collaborative, result in more effective health and human services, and reduce the number of overlapping initiatives that currently exist. Existing Blueprint and VHCIP resources can be purposed to support these collaboratives including local project management, practice facilitators, self-management programs, shared evaluation and comparative reporting, and, shared learning forums.

2. *Unified Performance Reporting & Data Utility* – Payers, Blueprint and ACO leadership should work to co-produce performance dashboards focusing on core ACO measure results as well as other analytics important to support care delivery transformation. These dashboards should present population level results and directly support the work of unified community collaboratives. The dashboards should augment the suite of comparative profiles that are currently produced for practices, HSAs, and organizations, providing a focused set of measure results that are important to all entities participating in ACO activity. Where possible, this approach should be generalized to include sharing data sets, collaborating on analytic activity, and planning for an advanced data infrastructure that can fuel the range of needs for Vermont's health system.

3. *Payment Modifications* – Modifications to current Blueprint payments could help optimize the effectiveness of the community oriented health system (e.g. PCMHs, CHTs, Unified Community Collaboratives). Options include: increasing community health team payments to provide Vermonters with greater access to multi-disciplinary preventive services, and the teams with adequate administrative support; increase medical home payments to maintain practice participation and incent level 3 medical home recognition; and, add an outcomes based payment that directly incents the goals of the unified community collaboratives with payment linked to achievement on core ACO quality measures and changes in avoidable utilization. The administration and the legislature must consider these options within the

larger context of competing budget priorities, such as the loss of the ACA enhanced primary care payments under Medicaid. Given the multi-payer design of the payments, it is also important to consider budgetary and regulatory timelines for commercial payers as well. While budget considerations may limit payment opportunities, Vermont's experience suggests that further investment will strengthen the capacity and effectiveness of unified community health systems, help ACOs meet their goals, and result in a high value learning health system as a foundation for Green Mountain Care.

Program Update

Current Operations. At the time of this report, 123 primary care practices are operating in Vermont as patient centered medical homes (PCMHs) supported by multi-disciplinary community health teams (CHTs). In order for a primary care practice to qualify as a medical home they must achieve a qualifying score in the National Committee for Quality Assurance Patient Centered Medical Home recognition program (NCQA PCMH). In this program, each practice is scored against the NCQAs nationally recognized standards for high quality patient centered care. Community health teams provide medical home patients with more direct and unhindered access to diverse staff such as nurse coordinators, social workers, counselors, dieticians, health educators, and others. The model is intended to stimulate high quality primary care, augmented by essential multi-disciplinary staff, as a coordinating feature in a community oriented health system. Medical homes and community health team staff are intended to strengthen network interactions with a larger array of medical and non-medical providers in their community, and to help people link more seamlessly with the services they need. The implementation and expansion of the model has been supported with a locally organized transformation infrastructure including program managers, CHT leaders, practice facilitators, multi-stakeholder workgroups, and shared learning forums.

Key design principles of the model include: local leadership and organization; consistent statewide quality standards (NCQA PCMH) and measurement of performance against those standards; close coordination between primary care, community health team staff, and community based services; and, an emphasis on prevention, improved control of established health problems, and healthier lifestyles. To enhance the effectiveness of the model, the Blueprint program has worked with a wide range of stakeholders to help organize and extend additional services directed at important needs. One example is the Support and Services at Home Program (SASH). SASH coordinators are based at publically subsidized housing sites. The SASH team includes a coordinator and a Wellness nurse for a panel of 100 people. SASH teams are CHT extenders focused on assisting high risk Medicare beneficiaries to live more satisfying life styles and age more safely in their homes. Another service model is the Hub & Spoke program for patients with opiate addiction and co-occurring mental health problems. This program adds a licensed counselor and nurse coordinator to the CHT (extenders) for Medicaid

beneficiaries who are treated in the practice setting (spokes), and increases capacity at five specialty centers (Hubs) for patients with more complex needs. A third example is the network of self-management programs being offered in all areas of the state including: Healthier Living Workshops for Chronic Disease; Healthier Living Workshops for Diabetes; Healthier Living Workshops for Chronic Pain; and the Diabetes Prevention Program. All components of the program are operating in each Health Service Area in Vermont. A state level summary of key program participants is provided (Table 1).

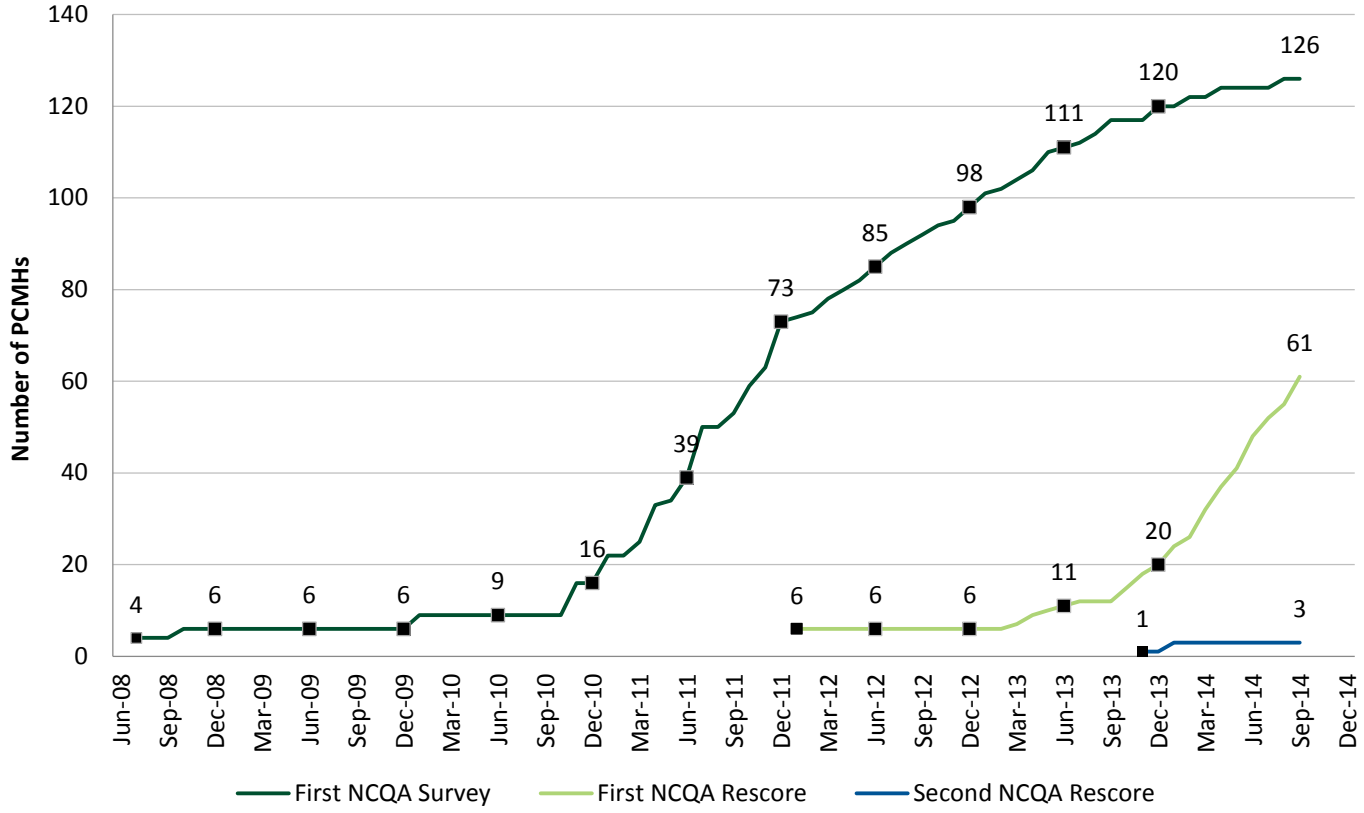
Table 1. Statewide Program Participants.

Key Components	July, 2014
PCMHs (active PCMHs)	123
PCPs (unique providers)	644
Patients (attribution 12/2013*)	347,489
Patients (practice report**)	514,035
CHT Staff (core)	218 staff (133 FTEs)
SASH Staff (extenders)	60 FTEs (48 panels)
Spoke Staff (extenders)	47 staff (30 FTEs)

*This is a count of the unique Vermont residents who received the preponderance of their primary care in a medical home in Vermont during the previous 24 months. The count is derived using an attribution algorithm applied to claims data in Vermont's all payer claims data base. **This is the total patient count reported by all medical home practices. It is not a count of unique individuals, and includes patients who go to more than one medical home practice in Vermont, Vermont residents who went to a Vermont medical home practice but receive the preponderance of their primary care in practices outside of Vermont, and non-Vermont residents who received care in medical home practices in Vermont.

In each area of the state, participating primary care practices and community health teams have organized their operations to meet the NCQA medical home standards. This process is supported by practice facilitators, planning and learning forums, and by the network of self-management programs that help practices meet a particularly challenging section of the standards (Support Self Care Process). A team based at the University of Vermont, in the Vermont Child Health Improvement Program, scores each practice to assure a consistent and independent assessment of healthcare quality. This approach has led to successful recognition of 126 practices, successful re-scoring of 61 practices, and a statewide base of primary care tested against difficult national standards (Figure 1).

Figure 1. Scoring of Patient Centered Medical Homes in Vermont.



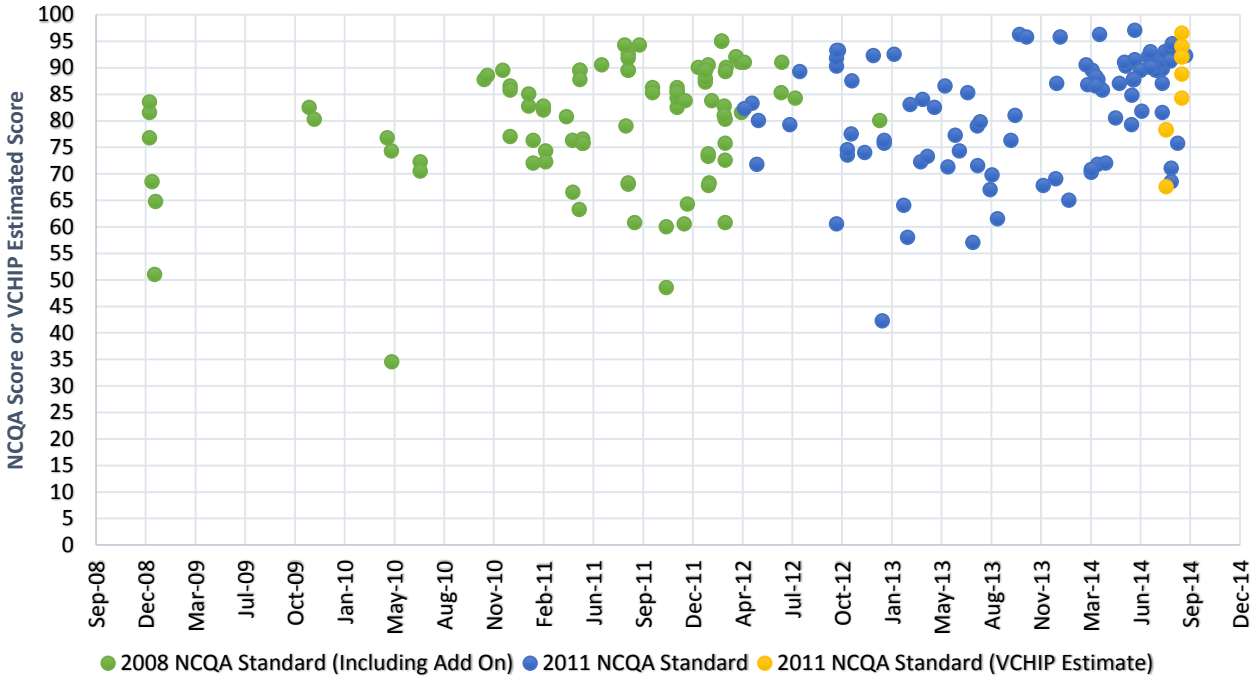
The NCQA medical home standards emphasize practices and policies that are considered important ingredients for high quality patient care, and a high value health system (Table 2). They are based on peer reviewed evidence supplemented by expert opinion, and are updated regularly by the NCQA through a highly structured multi-stakeholder process. With each update the standards are increasingly rigorous, promoting ongoing improvement in the way that primary care practices organize and coordinate care. In one example, the 2011 standards emphasized a structured approach to focusing on goals that are important to the patient, and helping patients achieve those goals through enhanced self-management. In another example, the 2014 update emphasizes a structured approach for integration of services focused on mental and behavioral health. Despite the increasing rigor of the standards, medical home scores in Vermont have been maintained and in many cases improved with re-scoring (Figure 2). This is testimony to the dedication, commitment, and hard work on the part of Vermont's primary care providers, and the effectiveness of the supports and structure offered by the Blueprint program.

Table 2. Patient Centered Medical Home Standards*

Elements	Summary of Criteria
Access During Office Hours	• Same day appointments • Timely clinical advice by phone • Timely clinical advice by electronic message
After Hours Access	• Access to routine & urgent care appointments • Continuity of medical record information for care & advice • Timely clinical advice by telephone
The Practice Team	• Roles for clinical & non-clinical team members • Regular team meetings & communication processes • Standing orders for services • Training & assigning teams to coordinate care
Evidence Based Guidelines	• The practice implements evidence based guidelines through point of care reminders for patients with 3 important conditions, plus high-risk or complex conditions. Third important condition related to unhealthy behaviors, mental health, or substance abuse.
Care Management	• Conducts pre-visit preparations • Collaborates with patient/family to develop an care plan including goals that are reviewed and updated • Gives patient/family a written plan of care • Assesses and addresses barriers when goals are not met • Gives patient/family a clinical summary • Identifies patients/families who might benefit from additional support • Follows up with patients/families who have not kept appointments
Medication Management	• Reviews & reconciles medications with patients/families • Provides information about new prescriptions • Assesses patient response to medications & barriers
Support Self-Care Process	• Documents self-management abilities • Develops & documents self-management plans & goals • Provides educational resources or refers to educational resources • Identify patient specific education resources
Test Tracking & Follow-up	• Tracks lab tests until results are available, flagging & following up overdue • Tracks imaging tests until results are available, flagging & following up overdue results • Flags abnormal lab results, bringing to attention of clinician • Flags abnormal imaging results, bringing to attention of clinician • Notifies patients/families of normal and abnormal lab and imaging results
Referral Tracking & Follow-up	• Giving consultant or specialist clinical reason & pertinent information • Tracking status of referrals, including timing for receiving report • Following up to obtain a specialists report
Continuous Quality Improvement	• Set goals & act to improve =>3 measures of clinical performance • Set goals and act to improve =>1 measure of patient/family experience
Continuity	• Expecting patients/families to select a personal clinician • Documenting patient/family choice of clinician • Monitoring % patient visits with selected clinician or team

*Summarized from 2011 National Committee for Quality Assurance Patient Centered Medical Home Standards

Figure 2. Practice scores over time with evolution of the NCQA medical home standards.

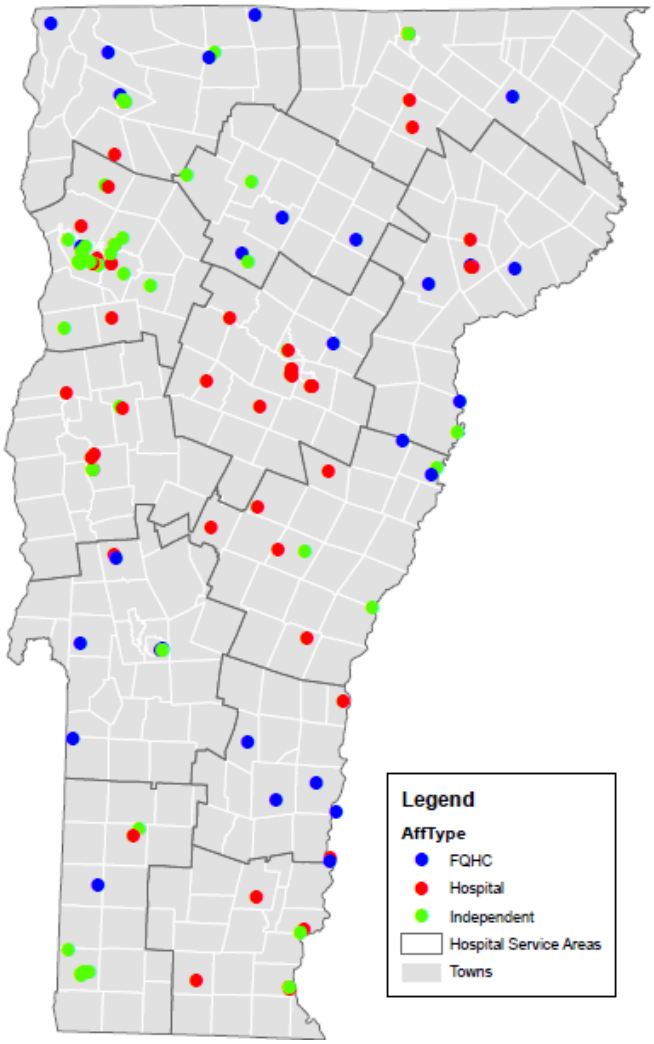


It is important to emphasize that a substantial investment of clinician and staff time is required for a primary care practice to organize workflow, qualify for recognition, and to truly deliver care in accordance with these standards. While the effort may improve quality, it can interfere with the emphasis on high volume productivity that is required in a fee for service world, and may even compromise revenue to the practice. Although payment will be addressed in a separate section, clinicians and practice administrators consistently point out that the current medical home payments do not adequately support the time and work effort that is required to produce the documentation, go through the scoring process, or to provide clinical services in accordance with these demanding yet important standards. Although the medical home payments are capitated and not fee service, they are considered insufficient to offset the time and effort that it takes to truly operate a patient centered medical home, or the pressures of a fee for service payment system that primarily incentivizes doing more units of billable services.

Formation of ACOs. As the Blueprint service model scaled statewide, newer reform initiatives have taken hold including the formation of three Accountable Care Organizations (ACOs). Each ACO is a formal business arrangement of previously independent providers, with the shared purpose of organizing more effective care, improving quality, and achieving shared savings. The three ACOs in Vermont include: Hospitals and hospital affiliated practices (OneCare); Federally Qualified Health Centers (Community Health Accountable Care); and independent practices (Health First). All Blueprint medical homes practices are affiliates in one of these new organizations (Figure 3). Each of the three ACOs has implemented governance structures and work groups for their constituents. The same constituents also participate in

Blueprint governance and workgroups, which are organized by community and inclusive of all ACO practice types.

Figure 3. Medical home practice sites by ACO affiliation



On the surface, it may appear that the purpose and focus of these structures and workgroups are distinct. ACO activities are oriented toward organizational goals including improved health services, achieving benchmarks for quality and healthcare, and qualification for shared savings. Blueprint activities are focused on community level operations including medical home status, integration of the community health team as a shared resource, strengthening of service networks, and quality initiatives that span all practice types. Despite these apparent differences, the work is actually oriented toward similar goals and objectives, and has the potential to be aligned and integrated. In the end, an overarching set of shared interests exists including improving the quality of services that patients and families have access to, improving the health of the population, more effective healthcare utilization and a reduction in unnecessary care, and better control over the growth in healthcare costs. For all involved, high quality primary care

coordinating with other medical and social services is an essential ingredient to accomplishing these shared goals. Included in this report is a proposal for integration of Blueprint and ACO activity in a way that will strengthen the community health system structure that spans all three ACOs, while helping each organization to achieve their respective goals.

Program Outcomes. With program expansion and sufficient time for operations to mature, it is possible to determine whether Blueprint led reforms are leading to improved outcomes. The reforms involved in the program are complex including substantial reorganization at the practice level, administration and function of community health teams, and enhancement of broader service networks in each community. The expectation is that these complex delivery system changes will mature with time, and that their impact will also evolve over time. This section discusses the impact of the program on expenditures and patterns of healthcare as the program expands and operations mature. The outcomes presented reflect the hard work of dedicated providers across the state, the impact that targeted population based payments can have, and they provide an important context for recommendations on payment.

Outcomes are presented for *participant* and *comparison* groups, with results broken out for commercially insured and Medicaid beneficiaries. For each year, the *participant* population includes Vermont residents who received the majority of their primary care in one of the practices that became a medical home by December 2013. Only a small number of these 123 practices were medical homes in 2008, with an increasing number becoming medical homes as the program expanded, particularly from 2011 through 2013 (Table 3). Thus results for the participant population reflect a changing complex environment as more practices join the program, teams expand, and operations mature. The *comparison* population includes Vermont residents, in each year, who received the majority of their primary care in a practice that was not a medical home by December 2013. These practices were not involved in the transformation process or supported by community health teams. The number of people included in the participant and comparison populations is shown for each year (Table 3). It is important to note that the two groups are similar in terms of demographics and clinical characteristics, and that results are adjusted for differences in age, gender, maternity, prevalence of common chronic diseases, and clinical risk group scoring. Data for this evaluation comes from Vermont's all payer claims database with analyses conducted by Onpoint Health Data.

Table 3. Study groups included in the Blueprint evaluation

	Participant Practices Included in Evaluation		Commercial (Ages 18-64 Years)		Medicaid (Ages 18-64 Years)	
	Year of entry into the program		Participant	Comparison	Participant	Comparison
2008	6	For each year of the evaluation, the participant population includes all people who received care in practices that would become medical homes by 2013*	118,132	91,106	23,965	15,344
2009	6		136,445	89,452	30,362	15,851
2010	17		145,207	77,980	36,014	14,792
2011	76		156,695	68,281	40,245	12,980
2012	100		162,211	60,045	45,036	11,771
2013	123		160,350	59,402	44,385	12,247

*Shows how results change for the complete group of practices and their population as a complex transformation takes place. This avoids potential bias of progressively increasing the contribution of more advanced practices.

In 2008, when the initial pilot programs were set up in two communities, total healthcare expenditures per capita were similar for the participant and comparison populations. As the program expanded, year to year growth in healthcare expenditures was lower for participants, particularly from 2011 forward as more of the 123 practices underwent preparation, scoring, and began working with community health teams (Figures 4 and 5). During the same period of time, Medicaid beneficiaries had higher rates of expenditures for Specialized Medicaid Services (SMS) including; Transportation, Home and community-based services, Case management, Dental, Residential treatment, Day treatment, Mental health facilities, and School-based and Department of Education Services (Figure 6). These results suggest that the medical home and community health team setting was associated with lower expenditures for traditional healthcare, and higher use of services targeted at social and economic disparities. The difference in healthcare expenditures was driven by several factors including lower hospitalization rates, and lower expenditures on pharmacy and specialty care. A composite measure of total utilization shows similar divergence between the participant and comparison groups, with the greatest separation from 2011 forward. Emergency department visits are one category of utilization that was not consistently better for participants. Despite lower expenditures, the results for measures of effective and preventive care were either better for participants or similar for both groups (cervical cancer screening, breast cancer screening, imaging studies for low back pain, and recommended assessments for patients with diabetes). Overall, similar patterns were observed in the pediatric population.

Figure 4. Total expenditures per capita - commercially insured ages 18-64

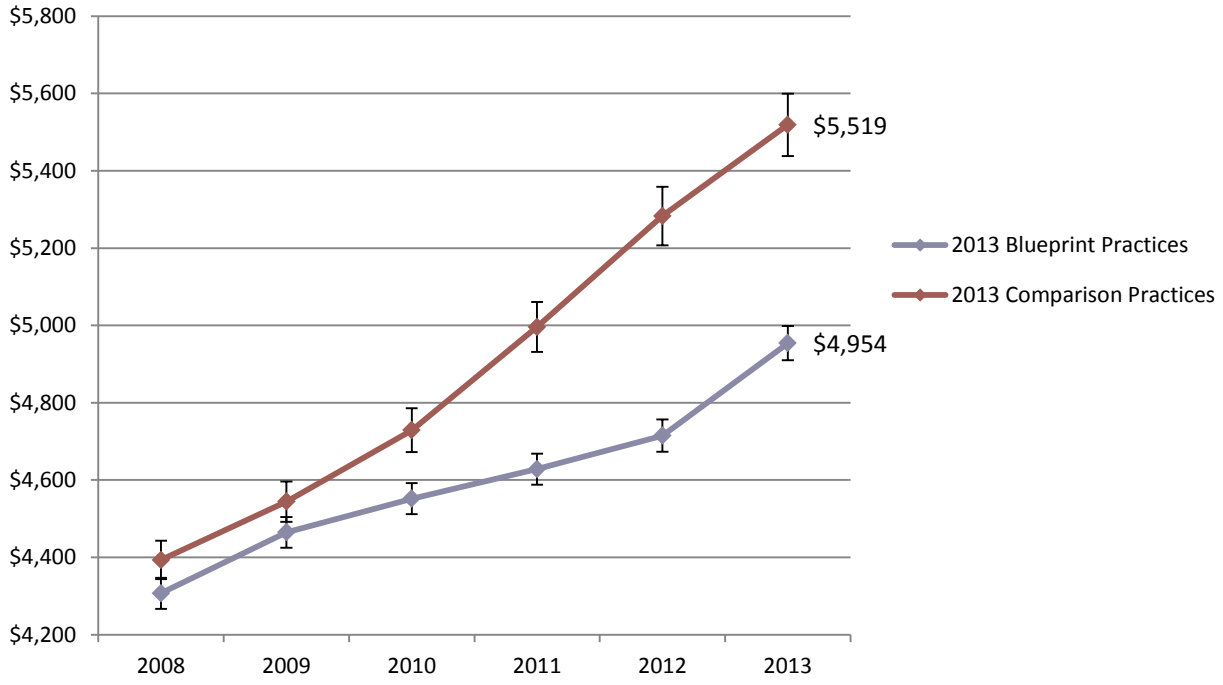


Figure 5. Total expenditures per capita - Medicaid ages 18-64 (excludes SMS*)

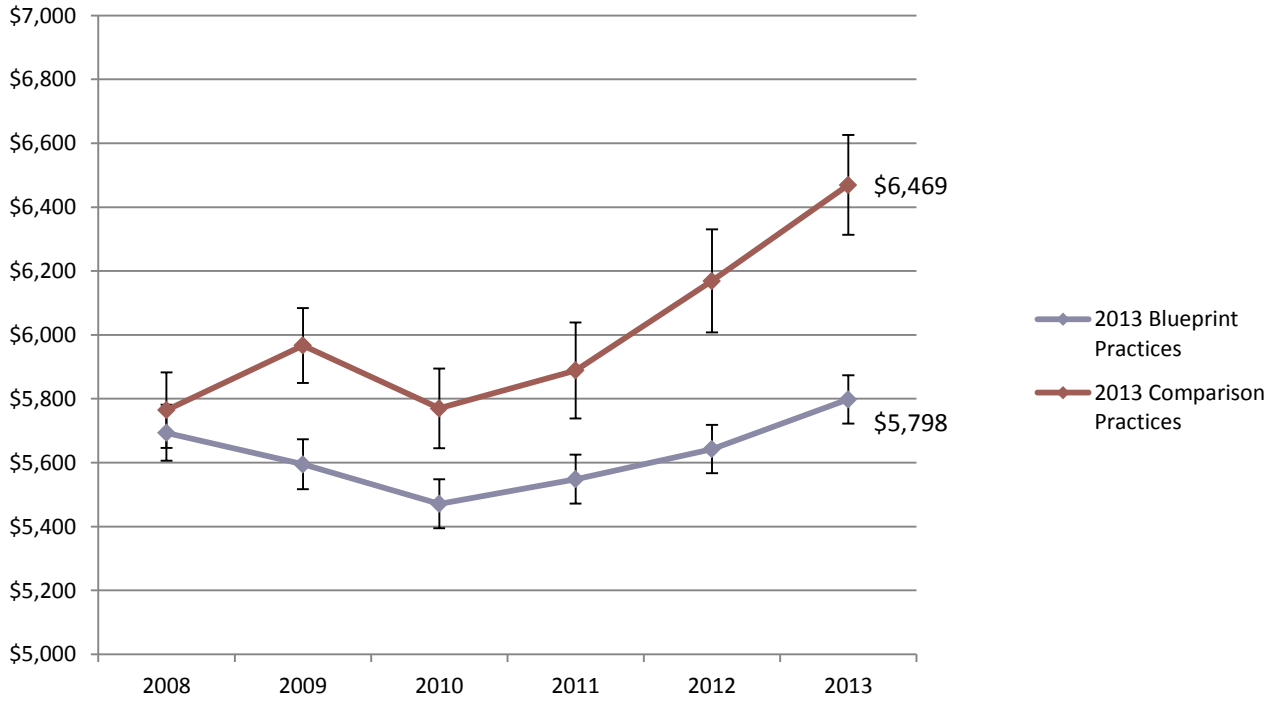
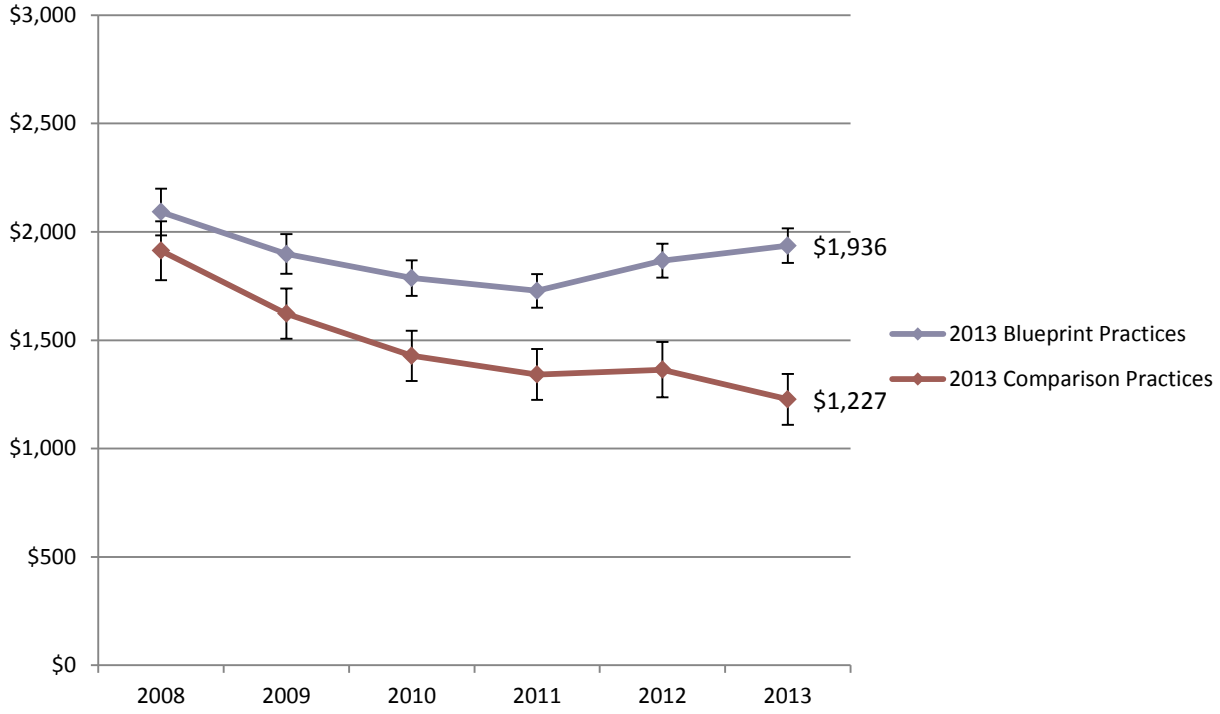


Figure 6. Total expenditures per capita for Special Medicaid Services ages 18-64



In 2013, lower healthcare expenditures for participants offset the payments that insurers made for medical homes and community health teams, a finding that was similar in 2012 (Table 4). It is difficult to fully incorporate the cost of administration at all levels, however, and the figures included in Table 4 are not all inclusive of in kind participation or grants. Overall, these results suggest a positive gain to cost ratio for insurers and their customers, better healthcare for citizens, and they provide an objective rationale for continuing medical home and community health team operations. More importantly, the results highlight that capitated population based payments which are targeted toward specific goals, in conjunction with transformation support through Blueprint grants, can lead to structural and behavioral changes that improve health services and cost outcomes.

Table 4. Returns vs. investments in medical homes and community teams
Note: The costs reflected in this chart is not a state level, but a payer level, analysis and therefore does not include state investments, such as the Blueprint for Health DVHA budget, etc.

Results for Calendar Year 2013	MCAID	Commercial
Number of Participating Beneficiaries	83,939	143,961
Total Medical Home Payments	$2,085,035	$3,576,002
Total CHT Payments	$2,343,603	$5,182,633
Total Investment Annual	$4,428,638	$8,758,635
Total Expenditures per Capita (participants)	$7,776	$4,954
Total Expenditures per Capita (comparison)	$7,877	$5,519
Differential per Capita (participant vs. comparison)	$101	$565
Total Differential (participants vs. comparison)	$8,477,839*	$81,337,965

*Includes expenditures for special Medicaid services

While the results to date are favorable, additional financial and delivery system reforms are necessary in order for Vermonters to have unhindered access to a highly coordinated health system in each area of the state. The remainder of this report is dedicated to a plan to build on the existing foundation, integrate with ACOs, and to establish an infrastructure supportive of the goals of Green Mountain Care.

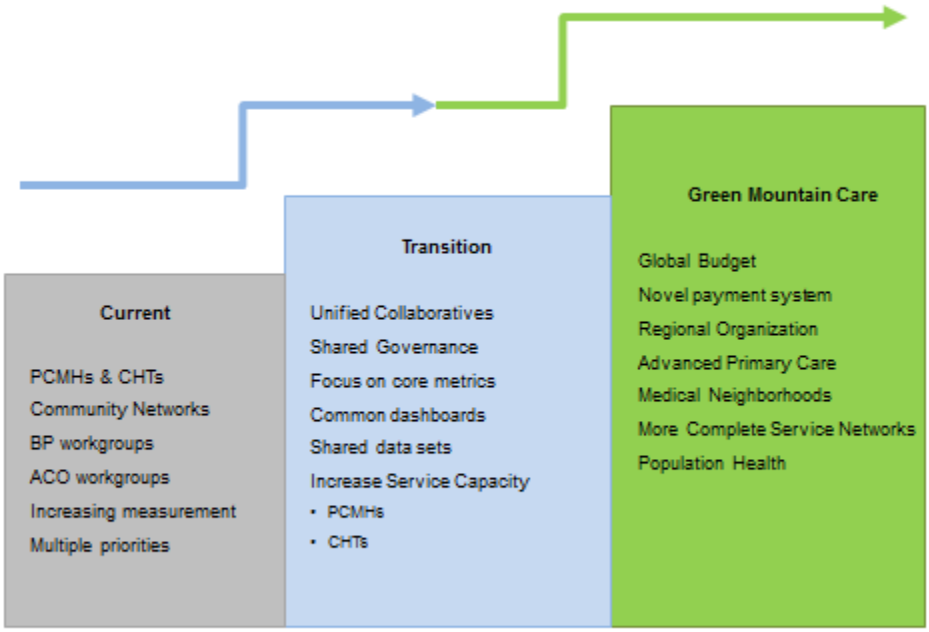
Toward a More Effective Health System

Vermont is moving toward Green Mountain Care; a novel health system with public financing, universal coverage for all citizens, and payment strategies that drive efficiency and value in the delivery system. Planning is underway for a new financing structure and payment strategies are being tested as part of the Vermont Health Care Innovation Project (VHCIP) funded by the Center for Medicare and Medicaid Innovation (CMMI) through a State Innovation Model (SIM) grant. The shared savings model is one example of a payment strategy that is being tested in the VHCIP, with the formation of three ACOs in Vermont including one for hospital affiliated practices, one for health centers, and one for independently owned practices. The VHCIP also

intends to test bundled payments and pay for performance models. This formative work builds on the Blueprint's community oriented reforms including a statewide base of medical homes, and multi-disciplinary teams that provide ancillary health and social services to the medical home population. This collection of activities is at the heart of a dynamic healthcare reform climate in the state, and positions Vermont well to achieve the aims of providing all citizens with access to high quality health services; improving the health of the population; and improving control over healthcare costs.

As Green Mountain Care financing is planned and implemented, it is essential to continue to improve the delivery system in Vermont. The success of a new financing and payment system will ultimately depend on the quality and efficiency of the delivery system, including a strong foundation of primary care that has a central role coordinating services with medical and non-medical providers. This section of the report focuses on a plan to advance Vermont's delivery system during the transition through a series of unifying actions that will: strengthen community oriented health systems; help ACOs achieve their goals; establish a better capability for rolling out new service models; and enhanced use of data to guide service and quality improvement.

Figure 7. Transition to Green Mountain Care



Unified Community Health Systems. A substantial level of Blueprint and ACO activity is taking place in each area of the state, and some level of integration is underway in several communities. By way of comparison, the Blueprint program is based on a community oriented structure designed to provide more effective health services across the population. Each health

service area has organizing meetings that include an extended group of medical and non-medical stakeholders, a project manager, community health team leadership, practice facilitators, self-management workshops, and collaborative learning activities. Each of the three ACOs is by definition organizational in nature with a reflective governance and work meeting structure. Medical home clinicians and Blueprint administrative leadership are participants in the ACO that is associated with their practice type (hospital affiliated, health center, independent). Blueprint activities are primarily focused on organizing medical home and community health team operations, integration of medical and non-medical services, and health services that meet community needs. ACO activities are focused on improving healthcare quality including the results of core ACO measures, and on improved efficiencies that help to control healthcare costs and achieve shared savings. While there are structural differences, Blueprint and ACO activities are ultimately oriented towards common objectives, and they can be aligned through a unified structure that strengthens community health services while achieving each organizations goals.

Recommendation 1.

In each Health Service Area, payers, Blueprint and ACO leadership should work together to merge their workgroups, and collaborate with stakeholders to form a single unified health system initiative. The collaborative should include medical and non-medical providers, a shared governance structure with local leadership, focus on improving the results of core ACO quality measures, support the introduction and extension of new service models, and provide guidance for medical home and community health team operations. This approach will establish a data guided community health system collaborative, result in more effective health and human services, and reduce the number of overlapping initiatives that currently exist. Existing Blueprint and VHCIP resources can be purposed to support these collaboratives including local project management, practice facilitators, self-management programs, shared evaluation and comparative reporting, and, shared learning forums.

Unified health system collaboratives will be well positioned to roll out new service models in their community, whether those models focus on care standards, specific conditions, or complex situations related to health and human circumstances. The ability to introduce and scale models has been demonstrated with medical home standards, community health team operations, condition specific programs (e.g. diabetes), self-management programs, the Hub & Spoke model for addiction and co-occurring mental health disorders, and the Support and Services at Home (SASH) program that helps seniors age safely at home by addressing a complex blend of medical and non-medical needs. Integration of payer, Blueprint and ACO activities will enhance this capability, assuring a common focus across a wider group of stakeholders, and the use of common data for planning and assessment. There are a large number of potential priorities such as: condition oriented programs (e.g. cardiovascular disease, diabetes, depression); or programs oriented towards complex life circumstances that span health and human services (e.g. adverse child events, obesity, addiction, trauma). Priority service models will emerge through activities

with broad stakeholder input including; community needs, ACO priorities, SIM workgroups, and policy. The goal of this plan is to establish unified health collaboratives that can efficiently scale priority service models as they are identified.

In some areas of the state, there has already been a move towards this blended community collaborative. In order to establish a statewide approach, the Blueprint team will work with payers, ACO leadership and constituents around the state in order to; adopt a generalized organizing framework including a representative local leadership structure; and, to plan alignment of local collaborative activity with state level collaborative activity involving ACO and Blueprint leadership teams. Mandated Blueprint leadership meetings, including those for the Executive Committee, and the Planning and Evaluation Committee, will be oriented towards addressing the needs of these collaboratives. Blueprint grants to each area will be designed to support participation in the collaborative structure. The Blueprints comparative evaluation and profiling capabilities will be extended to support ACO measurement needs through collaborative design. The Blueprint's learning collaboratives will be oriented towards the focus for these collaboratives including priority service models and improvement against core quality measures. It is important to note that SIM funds have also been provided to support this type of collaboration in developing the ACOs.

Unified Performance Reporting & Data Utility. In Vermont, and nationally, there is an increasing use of data to guide health services, quality initiatives, and payment. Amongst states, Vermont is comparatively well positioned with a relatively mature all payer claims database and a steadily expanding health information digital infrastructure. In concert, Vermont has seen an increasing demand for meaningful measurement and reporting to support the needs of providers, organizations, insurers, policy leaders, and other stakeholders. A number of measurement and reporting activities have been developed in response to this demand, and they are at the heart of a movement towards a data guided learning health system.

The Blueprint has made extensive use of the all payer claims database for several purposes including: evaluation of the programs impact; and generation of comparative outcomes profiles for practices, service areas, and organizations. The use of all payer claims data allows for measurement across an entire population, which is very important for clinicians who are primarily interested in improving services for everyone they care for. Substantial input from providers has helped to shape the format and output of the profiles, and the last year has seen substantial uptake for evaluation and for planning quality initiatives at a local level. Each profile contains detailed results, comparing a setting to their peers, on measures of utilization, expenditures, and quality. In this way, the profiles provide information on variation to practices, organizations, and service areas. Understanding performance relative to peers, and the extent of variation, provides an evidence basis for identification of opportunities for improvement.

In parallel, ACOs have initiated efforts to produce results for core quality measures, and to study variation for key outcomes across settings. These results are intended to guide quality initiatives and to identify opportunities related to unnecessary utilization and expenditures. In general, each

ACO has had to aggregate and analyze data from various data sources, and often for subsets of the population of interest to an insurer that is sponsoring a shared savings program. This may be in the form of claims data provided by an insurer, or data gathered from administrative and clinical systems in hospitals, health centers, and practices. This can result in time intensive data collection and measurement activity for each ACO. An opportunity exists for the Blueprint and ACOs to collaborate on measurement and reporting activities, and to provide clinicians and community collaboratives with results that pertain to their overall populations.

Recommendation 2.

Payers, Blueprint and ACO leadership should co-produce performance dashboards focusing on core ACO measure results as well as other analytics important to support care delivery transformation. These dashboards should present population level results and directly support the work of unified community collaboratives. The dashboards should also augment the suite of comparative profiles that are currently produced for practices, HSAs, and organizations, providing a focused set of measure results that are important to all entities participating in ACO activity. Where possible, this approach should be generalized to include sharing data sets, collaborating on analytic activity, and planning for an advanced data infrastructure that can fuel the range of needs for Vermont's health system.

Blueprint and ACO leadership have begun discussions to organize collaborative measurement and reporting. The initial step is to co-produce profiles showing comparative results for core ACO measures that are derived from claims data. These can be immediately produced as part of routine Blueprint analytics, and provided in conjunction with the suite of profiles that are currently provided to practices, organizations, and service areas. This collection will directly support the work of unified community collaboratives by providing comparative data for a range of important quality, utilization, and expenditure measures.

Additional opportunities are being examined including the ability to produce results for measures that rely on clinical data, linkage of clinical and claims data, and sharing of analytic data sets with ACOs. With some exceptions, aggregation of clinical data has largely relied on chart review for providers, ACOs, and insurers. Exceptions include the ability for certain organizations to extract clinical data from their own electronic systems, and a well-organized process for common measurement across Federally Qualified Health Centers. However, it is still difficult to consistently measure clinical outcomes for a whole population in a service area, or statewide. Working with VITL, the Blueprint has been aggregating a subset of clinical data in a registry from a growing number of medical home sites across the state. As part of this effort, the Blueprint and VITL have initiated a structured effort to improve clinical data quality that is being transmitted from these source sites. The quality of the registry data is currently being analyzed to determine its utility for measuring key outcomes, and the ability to link this clinical data with claims data. The Blueprint is beginning work with ACO leadership to use this data to produce core measure results for whole populations, and to potentially guide data quality initiatives with

practices and ACO partners across the state. Where appropriate, Blueprint and ACO leaders are considering opportunities to share analytic data sets (claims, clinical) in order to assure efficiencies and reduce the data collection burden on ACOs and providers.

These activities will help to accomplish a number of important goals as Vermont's digital infrastructure continues to develop. First, the culture of using data to guide change is being strengthened across the state at the practice, organization, and community levels. The availability of consistent measurement, across an entire population, is important to fuel this effort. Co-reporting of key measure results that are of common interest across all parties, and the formation of unified community collaboratives to focus on these measures, will advance Vermont's progress towards a learning health system. Second, testing the actual utility and quality of clinical data that is available through the health information infrastructure will help to advance Vermont's health system in several ways. It will allow communities and organizations to use more advanced data to guide their efforts. It will also inform the development of Vermont's digital infrastructure by quantifying data gaps and quality needs. This will help inform VITL as it continues to build data warehousing capabilities, and positions itself as a source for the growing array of analytic needs. It will also inform collaborative data quality initiatives for VITL, Blueprint, ACOs, and others. In the end, analytic systems such as those employed by ACOs, depend on a reliable source of clinical data with consistent quality across settings and organizations.

Payment

Since 2008, two capitated payments have been applied to the medical home population to stimulate expansion of medical homes and community health teams. The first payment stream is a per person per month payment, that goes directly to the practice, based on their score on the NCQA medical home standards. This payment is intended to stimulate high *quality* primary care practice, so the higher a practice scores on the quality standards, the higher the payment. Practices are re-scored every three years providing an incentive to improve practice operations based on the standards. The second payment is a per person per month payment, that goes to an administrative entity in each service area to support community health team operations. This payment is based on the medical home patient population and is intended to build staffing *capacity* so that patients have access to multi-disciplinary support services. The composite of these two payments, driving quality + capacity, was designed to build a foundation of more effective primary care, with better social support services, and better coordination with an extended array of community providers. These payments did not stimulate change in isolation. Additional support was provided for transformation through Blueprint grants, so that activities could be organized at a community level. As discussed in the previous section of the report, local Blueprint and ACO organization can build on this foundation to form a more complete community health system.

The integration work recommended above can be achieved without modifications to the existing Blueprint payment structure, especially given the funding which has been allocated through the SIM grant for this type of work in the provider community. Integration of administrative activity, shared coordination of medical home and community team services, use of measure results, and targeted quality work may occur with existing resources, subject to unforeseen challenges.

The medical home payments and the community health team payments have remained static since 2008. Although many practices say that the process has improved their operations, some practices perceive this as added cost and increased work that adds to an already stressful work environment. During the course of gathering input for this report, the independent practice ACO in Vermont, HealthFirst, notified the Blueprint that their constituent practices do not intend to continue participation without more adequate support for medical home operations. For many clinicians around the state, the community health team has been viewed as a valuable asset that is making a difference in the lives of the patients and families they serve.

Investments in both areas, ideally, would ensure robust participation. However, given the current budget climate, investments in the Blueprint payments must be considered in the context of other potential investments supporting Vermont's health care providers and external federal uncertainties in reimbursement.

Just days before this report was submitted, the federal government did resolve one outstanding uncertainty. On Sept 25, 2014, U.S. Health and Human Services announced that Medicare will continue to support and participate in the "Multi-payer Advanced Primary Care (MAPCP) demonstration. Only those states with programs designed like Vermont were extended. This is a strong positive signal that the demonstration has achieved some of the federal goals.

However, one related uncertainty remains. In recognition of the value of care coordination services, Medicare is offering a fee-for-service alternative to the demonstration program. Some primary care providers have indicated that without further support and adaptation of the existing Blueprint for Health program, they may opt for this alternative instead. This would erode the progress made under the Blueprint. There is a lack of clarity at this time from the federal government on the coordination between approved demonstrations and the new fee-for-service payment. The administration will continue to pursue clarity to determine the impacts on providers and the Blueprint program.

Another federal uncertainty is the discontinuation of the "Medicaid enhanced primary care program (EPCP)", a provision of the Affordable Care Act. Under this program, Medicaid programs reimburse primary care providers at Medicare levels. This has been in place and fully federally funded for two years, 2013-2014. The increase was intended to ensure sufficient provider participation as the Medicaid population expands. As the temporary provision enters its final months without signs of extension and given the current budgetary pressures, the

discontinuation of this federal funding has the potential to destabilize progress made under the Blueprint for Health due to sharp decrease in Medicaid rates for all providers, particularly primary care providers. Ideally, this program would be extended.

Because the Blueprint payments are a multi-payer reform, increases in payments impact not just the state budget, but also private premiums. The administration and the legislature must look at the impact of funding changes on overall health care costs and insurance premium impacts as well as the state budget. Increasing the payments for the Blueprint program is likely to increase private premiums as insurers pass along the reimbursement increase in the first year to their customers. However, it is also important to look at the combined impact of increasing payments and corresponding impacts on utilization and health care expenditures to understand the overall impact these may have on private insurance premiums. Lastly, the administration and legislature must consider how different investments in provider reimbursement impact different types of health care providers and whether and how a particular investment flows to a hospital, to an independent physicians' practice, hospital-owned practices.

Ultimately, the success of any health system is more likely if the underpinnings include the best possible foundation of primary care, close integration of medical and social support services, and community providers operating in more cohesive networks. Given the progress to date, the programmatic recommendations outlined in the previous section of this report will help make cohesive health services a reality in communities across Vermont.

With this background, several payment investment options have been explored to enhance community oriented health services during the transition to Green Mountain Care. Of course, the administration and legislature must also consider, with each option whether to: a) maintain the current payment structure; b) avoid new investments by shifting existing expenditures to support one or more of the options; or, c) add additional monies as a new investment in one or more of the options. Again, this is complicated by the fact that, as a multi-payer initiative, the funding is not just from the state budget, but also impacts private premiums. While the results of the program may justify additional investment, constrained budgets challenge the ability to identify new sources of funding.

Lastly, the timing of the commercial insurance rate review process and Vermont's hospital budget process limits the state's ability to add additional funding in the current fiscal year. Calendar year 2015 insurance premiums have already been set by the Green Mountain Care Board and open enrollment for the individual and small group markets begin in November 2014. Increasing Blueprint payments in FY15 would impact on already approved insurance rates. In addition, the GMCB has already approved the Vermont hospitals' budgets for 2015. Since the Blueprint payments to primary care providers who are employed by a hospital and to some of the community health teams impact on the hospital budget, this would cause disruption to the already approved hospital budgets.

Option 1. Change each insurer's share of the community health team costs. When the program was established, community health team costs were divided among the 5 major insurers (Blue Cross Blue Shield of Vermont; MVP; Cigna; Medicaid; and Medicare) in Vermont, with the intent of treating the teams as a shared resource available to all medical home patients. Costs were evenly divided with some adjustment for the insurer with the lowest market share. As the Blueprint program has expanded, there have been substantial changes in Vermont with regards to insurer market share. One adjustment to insurer cost allocation was made when a particularly large account shifted from one commercial insurer to another. Substantive shifts have continued in both the commercial and Medicaid market share with the implementation of the Affordable Care Act. With the program expanded to the majority of primary care practices, and all service areas, it is important to consider a community health team cost structure that is more reflective of the direction of Vermont's health insurance market. At this time, the direction is towards three dominant insurers, leaving two insurers paying a share of team costs that is not reflective of the market. One option is to implement a community health team cost structure that pins each insurer's share of team costs to their share of the attributed medical home population, which is the population that has most direct access to the community health team. Each insurer's share of costs should be adjusted based on a routine assessment of their attributed medical home market share. To assure a transparent and objective assessment, attributed medical home market share should be determined using consistent methodology applied to data in Vermont's all payer claims database. This proposal suggests a shift in insurer cost allocation, based on December 2013 medical home attribution, as a substantial step toward market alignment (Table 5). Under 18 VSA 706(c), in order for this strategy to be adopted, the Blueprint expansion design and evaluation committee must first recommend a new approach to attribution. If the committee makes this recommendation, the Director may work with private insurers to implement. Any Medicaid participation, however, is subject to appropriation and may not be implemented in the same manner. Medicare's share is held constant in this example since they are outside the reach of Vermont policy, and their current share is in reasonable alignment with their attributed share of the medical home population. If this strategy is implemented, then a proposal will be made to CMS to participate as part of the Multi-Payer Advanced Primary Care Demonstration, which is the program through which Medicare participates in the Blueprint model.

Table 5. Proposed change to align community health team costs with insurer market share

	Current share of CHT Costs	Proposed share of CHT Costs	Current CHT Cost (annual)	Proposed CHT Cost (annual)	Differential (annual)
Medicare	22.22%	22.22%	$2,150,760	$2,150,760	$0
Medicaid	24.22%	33.89%	$2,343,603	$3,279,268	$935,665
BCBS	24.22%	33.89%	$2,343,603	$3,279,268	$935,665
MVP	11.12%	5.00%	$1,076,006	$483,850	$(592,156)
Cigna	18.22%	5.00%	$1,763,024	$483,850	$(1,279,174)
Total	100.00%	100.00%	$9,676,996	$9,676,996	$0

Option 2. Increase community health team payments. Community health team staff provides the medical home population with direct access to multi-disciplinary staff such as nurse coordinators, social workers, dieticians, and health educators. There is no cost-sharing or prior authorization for patients and they can be connected with the teams based on need and clinical judgment. The community health team is considered a distinguishing characteristic of Vermont's medical home model. Increasing the capacity of these teams can directly support new service models for targeted needs such as cardiovascular disease, mental health, addiction, trauma, and adverse childhood experiences. A recent example is the addition of staff to community health teams to enhance treatment capacity for opiate addiction as part of the Hub & Spoke program, demonstrating rapid statewide rollout of a standardized treatment program targeting a high priority need. This option will most immediately increase the effectiveness of the unified community health services model through improved control of chronic conditions, and helping Vermonters live healthier lifestyles that prevent common health conditions. Two examples are provided showing the financial impact of increasing the community health team payments. Depending on how much of the increase goes to administrative vs. staffing costs in each area, an increase from $1.50 to $2.00 per person per month could increase community health team capacity from ~1 FTE to 1.33 FTEs per 2500 attributed medical home patients (Table 6). An increase from $1.50 to $3.00 per person per month could increase capacity from ~1 FTE to 2 FTEs per 2500 attributed medical home patients (Table 7). For both examples, the insurer's annual costs assume that the cost allocation changes presented above (Option 1) have been adopted.

Table 6. Increase community health team payments from $1.50 to $2.00 PPPM
Note: The cost estimates use the proposed share of CHT costs, not the current share by payer.

	Proposed share of CHT Costs	Current CHT Cost (annual)	Proposed CHT Cost (annual)	Differential (annual)
Medicare	22.22%	$2,150,760	$2,150,760	$0
Medicaid	33.89%	$3,279,268	$4,361,426	$1,082,158
BCBS	33.89%	$3,279,268	$4,361,426	$1,082,158
MVP	5.00%	$483,850	$643,520	$159,670
Cigna	5.00%	$483,850	$643,520	$159,670
Total	100.00%	$9,676,996	$12,160,652	$2,483,686

Table 7. Increase community health team payments from $1.50 to $3.00 PPPM
Note: The cost estimates use the proposed share of CHT costs, not the current share.

	Proposed share of CHT Costs	Current CHT Cost (annual)	Proposed CHT Cost (annual)	Differential (annual)
Medicare	22.22%	$2,150,760	$2,150,760	$0
Medicaid	33.89%	$3,279,268	$6,558,536	$3,279,268
BCBS	33.89%	$3,279,268	$6,558,536	$3,279,268
MVP	5.00%	$483,850	$967,700	$483,850
Cigna	5.00%	$483,850	$967,700	$483,850
Total	100.00%	$9,676,996	$17,203,232	$7,526,236

Option 3. Increase medical home payments from an average range of $2.00 - $2.50, to an average range of $4.00 - $5.00 per person per month. As discussed previously, medical home payments, and access to community health team staff, have helped to engage the majority of primary care practices in Vermont in the process of preparation and scoring against the NCQA medical home standards (Figures 1 & 2, Table 2). The national standards have been revised every three years, and are increasingly rigorous in their requirements for primary care practices to demonstrate high quality, patient centered, and well-coordinated preventive care. This option would ensure continued participation, and enhance capacity for primary care practices to apply the increased standards. The investment in medical home payments helps to assure that Vermonters have access to primary care in accordance with NCQA standards, and direct access to community health team staff. Vermont is currently well positioned with a replicable and scalable process for helping practices to prepare for scoring, undergo objective and independent scoring, and to participate in quality initiatives for ongoing quality improvement. Maintaining participation, and continued improvement in concert with increasingly rigorous standards, makes it more likely that Vermont will have a strong primary care base underpinning Green Mountain Care. The proposed increase and the cost impact for each insurer is shown (Table 8).

Table 8. Increase medical home payments to average $4.00 to $5.00 PPPM

	Current PCMH Cost (annual)	Proposed PCMH & CHT Cost (annual)	Differential (annual)
Medicare	$1,549,949	$1,549,949	$0
Medicaid	$2,085,035	$4,170,070	$2,085,035
BCBS	$2,345,330	$4,690,660	$2,345,330
MVP	$404,000	$808,000	$404,000
Cigna	$826,672	$1,653,344	$826,672
Total	$7,210,986	$12,872,023	$5,661,037

Option 4. Increase both community health team and medical home payments. This example demonstrates the cost impact of increasing community health team payments to $3.00 per person per month, and medical home payments to an average of $4.00 - $5.00 per person per month (Table 8). It is the combination of the medical home and community health team that has been

evaluated and demonstrated favorable outcomes in Vermont, and it is not possible to tease out the incremental impact of either of these components in isolation. There is a rationale for further investment in the complete model given the improvements in healthcare utilization, expenditures, and quality; and the appearance of diverging trends between the participant and comparison groups. This option would most likely stimulate the strongest unified health system as Blueprint and ACO activities are integrated in each community, and would add the greatest capacity to extend new priority service models. However, this level of investment also represents the greatest financial challenge in a tight fiscal environment.

Table 9. Increase community health team and medical home payments

	Current PCMH & CHT Cost (annual)	Proposed PCMH & CHT Cost (annual)	Differential (annual)
Medicare	$3,700,709	$3,700,709	$0
Medicaid	$5,364,303	$10,728,606	$5,364,303
BCBS	$5,624,598	$11,249,196	$5,624,598
MVP	$887,850	$1,775,700	$887,850
Cigna	$1,310,522	$2,621,044	$1,310,522
Total	$16,887,982	$30,075,255	$13,187,273

Option 5: Explore the Medicaid Health Home. Under the Affordable Care Act, the federal government authorized a regulatory pathway to support Medicaid Health Homes which includes:

- Enhanced 90/10 federal funding
- For patients who meet complexity criteria, enhanced payment for six core services.

To participate, a state must seek a State Plan Amendment (SPA) approval and agree to quality and financial reporting requirements. Vermont has received SPA approval for a small health home program to fund the Care Alliance for substance abuse treatment. If approved for the program, this funding would only be available for two years. The current Blueprint for Health Community Health Team model (CHT) would need to be adapted to meet requirements of the program thus, there would need to be sufficient time for planning and implementation before this

opportunity could be realized. Additional analysis would need to be done in order to ensure implementation of this option is consistent with Vermont's current model.

Additional Consideration. The medical home payment based on quality, and the community health team payment to build capacity, are both capitated payments applied to the medical home population. Together they represent a blend of capitated payment (quality + capacity) that is designed to stimulate targeted transformation goals. This approach has led to statewide medical homes and community health teams, with evidence of improved outcomes. An additional consideration is to add a new capitated payment based on improvement of specific measure results, and to determine the additive impact of an outcomes based payment (quality + capacity + outcomes vs. quality + capacity alone). The ability for a unified community health collaborative involving all ACOs, to drive improvement based on specific measures, would establish an important step toward a high value health system. One of the proposed activities for Vermont's State Innovation Model (SIM) grant is to test new payment methodologies including pay for performance. The SIM process provides an excellent opportunity to test an outcome based capitated payment as part of their pay for performance portfolio.

Moving Forward

The Blueprint program has stimulated a statewide foundation of medical homes and community health teams which increasingly demonstrate improved outcomes on measures of healthcare utilization and healthcare expenditures. Three independent ACOs have formed for hospital affiliated, health center affiliated, and independent practices. This report represents a plan for integration of Blueprint and ACO activity, advancement toward more unified community health systems, and payment options. It also highlights the challenges to implementing payment changes including budget constraints, identification of funding sources, and prioritization. These circumstances reflect exciting opportunities as well as difficult decision points.

Important progress has been made with regards to the plan outlined in this report. At this time, several communities have already started to integrate Blueprint and ACO activities where common interests were evident. Support for this approach is wide spread amongst Blueprint and ACO participants, and the participants will move forward with detailed planning, including the specifics of the shared governance structure, shared reporting of core ACO measures, whole population profiles, as well as other measures and data sharing.

In addition, state staff is looking at possible administrative simplifications, in particular whether state quality requirements for participation in the Blueprint program may be aligned and streamlined given the NCQA quality requirements. Review and planning for this process is in progress. The Director of the Blueprint and the Chair of the Green Mountain Care Board have worked closely together to plan and prepare this report. This process has helped to clarify the

ways in which the Blueprint team can support the work of the Board and the transition to Green Mountain Care. In particular, the Blueprint team adds capacity in the areas of quality standards, health service models, measurement, and model implementation in collaboration with community provider networks. With regards to payment modifications, commercial insurers and Medicaid have been in detailed discussions with the Blueprint team regarding program results and payment options. These discussions have also been held in the Blueprints public meetings involving a wide range of stakeholders including the Executive Committee, and the Planning Design and Evaluation Committee. While there is broad acknowledgement of the need for payment modification, commercial insurers have expressed the need to accommodate payment modifications through their internal budget planning process and the rate approval processes with the Green Mountain Care Board. Medicaid, and the state budget overall, are impacted by lower than expected revenues and budget constraints. Decision points remain as to whether payment modifications are possible in the current fiscal environment, and if so whether that comes through a shift in existing expenditures vs. identification of funds for new investment.

While these difficult decisions are being considered, they are occurring in a unique environment where Vermont is poised to move forward as the first state with universal coverage and a novel financing system. During the planning and transition, it is important to maintain a focus on continuously improving the delivery system, and in particular effective primary care integrated with social support services, mental health services, and other domains. A strong foundation of primary care and social support services is considered an essential ingredient for a high value health system in countries around the world, despite various forms of coverage, financing, and payment. Vermont's commitment to this difficult and unglamorous work has been extraordinary: as evidenced by the wide range of stakeholders in each area of the state that work together every day; participating in medical home, community health team, and ACO operations; and committed to the shared vision of the best health services for all the citizens in their community.

Attachment 4 - Draft Care Management Standards (sent to Work Group on September 29)

DRAFT
Care Models and Care Management Work Group
Proposed Care Management Standards and Standards Topics
September 26, 2014

Definition of Care Management:
Care Management programs apply systems, science, incentives and information to improve services and outcomes in order to assist individuals and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, evidence based or promising innovative and non-duplicative services.

In order for care management programs to be effective, we recommend that ACOs agree to the following principles:

A. Care Management Oversight

#1: The ACO and/or its participating providers have a process to assess success in meeting the following care management standards, as well as the ACO's care management goals.

#2: The ACO supports participating primary care practices' capacity to meet person-centered medical home requirements related to care management.

B. Guidelines, Decision Aids, and Self-Management

#3: The ACO and/or its participating providers support the consistent adoption of evidence-based clinical guidelines.

#4: The ACO and/or its participating providers have methods for engaging and activating people and their families in support of positive health behaviors.

#5: The ACO and/or its participating providers provide or support the provision of: a) educational resources to assist in self-management, b) self-management tools that enable attributed people/families to record self-care results, and c) connections between attributed people/families and self-management support programs and resources.

C. Population Health Management

#6: The ACO and/or its participating providers have a process for systematically identifying attributed people who need care management services, the types of services they should receive, and the entity or entities that should provide the services.

#7: The ACO and/or its participating providers support the delivery of care management services and collaborate with people needing such services and their families, as well as with other entities providing care management services, including community organizations, long term service and support providers, and payers. Supporting delivery of care management services will include:

- Promoting care coordination and facilitating communication across care settings.
- Developing processes for exchanging health information across care settings and facilitating referrals.

- In collaboration with participating providers and other partner organizations, considering social determinants of health when assessing the need for care management services.

#8: The ACO and/or its participating providers support:

- Promotion of person-centered and directed planning.
- In collaboration with participating providers and other partner organizations, care management services that result in integration between medical care and long term services and supports to address attributed people's needs.

D. Data Collection, Integration and Use

#9: To the best of their ability and with the health information infrastructure available, the ACO and/or its participating providers use an electronic system that a) records structured (searchable) demographic, claims and clinical data required to address care management needs for people attributed to the ACO, and b) supports access to and sharing of attributed persons' demographic, claims and clinical data recorded by other participating providers.

#10: The ACO and/or its participating providers encourage and support participating providers in using data to identify needs of attributed people, support care management services and support performance measurement, including the use of:

- A data-driven method for identifying those patients who would most benefit from care management and for whom care management would improve value through the efficient use of resources and improved health outcomes.
- Methods for measuring and assessing care management activities and effectiveness, to inform program management and improvement activities.