

# VHCIP Core Team Meeting

Agenda 6-1-15

## **VT Health Care Innovation Project Core Team Meeting Agenda**

June 1, 2015 1:00 pm-3:00pm  
4<sup>th</sup> Floor Conference Room, Pavilion Building, 109 State Street, Montpelier  
*Call-In Number: 1-877-273-4202; Passcode: 8155970*

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	1:00-1:05	Welcome and Chair's Report: a. Update on negotiations with CMMI	Lawrence Miller	Attachment 1a: Year One Milestones Met and Removed  Attachment 1b: Year One Milestones Not Met  Attachment 1c: Alignment Powerpoint
<b>Core Team Processes and Procedures</b>				
2	1:05-1:10	Approval of meeting minutes	Lawrence Miller	Attachment 2: May 20, 2015 minutes  <i>Decision needed.</i>
<b>Policy Recommendations</b>				
3	1:10-1:20	Request for approval of modifications to quality measures from QPM Work Group	Pat Jones and Alicia Cooper	Attachment 3a - Year 2 ACO SSP Measures Changes  Attachment 3b: Priority Changes and Options for ACO Measures  <i>Decision needed.</i>

Evaluation				
4	1:20-2:05	Presentation of Self-Evaluation Plan	Annie Paumgarten ; Impaq International	Attachment 4: <i>to be distributed at a later date</i>  <i>Decision Needed</i>
Spending Recommendations				
5	2:05-2:20	Funding requests:  <ol style="list-style-type: none"> <li>1. <i>No-Cost Extension:</i> <ol style="list-style-type: none"> <li>a. <i>Stone Environmental (through 12/31/15)</i></li> <li>b. <i>Coaching Center (through 12/31/15)</i></li> <li>c. <i>Deborah Lisi-Baker (through 12/31/15)</i></li> </ol> </li> <li>2. <i>Shared Care Plans and Universal Transfer Protocol (SCÜP) Project (from HIE/HIT WG):</i> <ol style="list-style-type: none"> <li>a. <i>June-July 2015; \$36,500</i></li> </ol> </li> </ol>	Georgia Maheras; Simone Ruescheyer	Attachment 5: Financial Requests (ppt)
6	2:20-2:50	ACO Proposals:  <ol style="list-style-type: none"> <li>1. Community Health Accountable Care</li> <li>2. OneCare Vermont</li> </ol>	Georgia Maheras; representatives from each of the ACOs	Attachment 6a: CHAC Packet Attachment 6b: OneCare Packet
7	2:50-2:55	<i>Public Comment</i>	Lawrence Miller	
8	2:55-3:00	Next Steps, Wrap-Up and Future Meeting Schedule: TBD-Next Meeting (previously scheduled for July 6 <sup>th</sup> , moving due to vacations)	Lawrence Miller	

Attachment 1a  
Year One Milestones  
Met and Removed

**Y1 Milestone Table: completed and removed**

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
<b>General:</b>				
		Project will be implemented statewide	Complete	
<b>Payment Models:</b>				
SSPs		Implement Medicaid and commercial ACO-SSPs by 1/1/14	Complete	
Consult with payment models and duals WGs on financial model design		Develop ACO model standards	Complete	
Develop ACO model standards		Approved ACO model standards	Complete	
Health Homes		Included in timeline table	Complete	
P4Ps (new)	Create quality incentive pool for Medicaid-- Participation in the Medicaid program would be required for enrolled providers but include intentional levels of adoption and a phase-in period so all providers could participate appropriate to their level of readiness.	Create in Y1	Not Met	Remove because we did not have new Medicaid dollars in the FY15 budget to support this initiative.
Develop Medicaid value-based purchasing plan addressing pay-for-performance initiatives. <i>This is the same as the item above with a different name.</i>	Medicaid value-based purchasing plan developed		Not Met	Remove because we did not have new Medicaid dollars in the FY15 budget to support this initiative.
Duals Demo	Implemented per demo specifications		Not met	Remove because the State did not pursue this demonstration.
<b>Outreach:</b>				
Implement "How's Your Health Tool"	Implemented by 6/2014	Implemented by 6/2014	Complete	Implemented through White

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
				River Family Practice Sub-Grant
Stakeholder engagement-work groups and more broadly	Unspecified	Unspecified	Complete	
<b>Health Data Infrastructure:</b>				
VHCURES:		<ul style="list-style-type: none"> <li>Update rule to include VHC information (Fall 2013)</li> <li>Incorporate Medicare data (Fall 2013)</li> <li>Improve data quality procedures (Fall 2014)</li> <li>Improve data access to support analysis (Fall 2014)</li> </ul>	<ol style="list-style-type: none"> <li>Not met</li> <li>Implemented</li> <li>Implemented</li> <li>Implemented</li> </ol>	Remove #1- no plan to update the VHCURES rule at this time.
Clinical Data: <ul style="list-style-type: none"> <li>Medication history and provider portal to query the VHIE by end of 2013</li> <li>State law requires statewide availability of Blueprint program and its IT infrastructure by October 2013</li> </ul>		<ul style="list-style-type: none"> <li>Medication history and provider portal to query the VHIE by end of 2013</li> <li>State law requires statewide availability of Blueprint program and its IT infrastructure by October 2013</li> </ul>	Complete	
<b>Medicaid Data:</b> <ul style="list-style-type: none"> <li>A combined advanced planning document for the funding to support the TMSIS is completed and submitted to CMS in July 2013</li> </ul>			Complete	
Provide input to update of state HIT plan	Updated state HIT plan		Complete	
Begin to incorporate long term care, mental health, home care and specialist providers into the HIE infrastructure	Provide regional extension center (REC) like services to non-EHR providers to include long term care, mental health, home health and specialists and begin development of interfaces to the VHIE for these provider groups that		Complete	

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
	currently have EHRs with the goal over three years of achieving 50 new interfaces.			
Expand the scope of VHCURES to support the integration of both claims and clinical data and provide this capability to ACOs/providers and potentially payers	Number of providers approved for use of VHCURES data		Not met	Remove- VHCURES procurement put on hold in Spring 2015.
Vermont Health Connect: <ul style="list-style-type: none"> <li>Update all payer claims data base rule incorporating VHC information</li> <li>Enhance current database with new VHC information</li> <li>As needed collect data directly from VHC payers.</li> </ul>			Not met	Remove- we do not use this data set for any analyses; relying on VHCURES or direct feeds from carriers
Quality Measures: (Note in new framework, these fall within the Payment Models section)				
Define common sets of performance measures: convene work group, establish measure criteria, identify potential measures, crosswalk against existing measure sets, evaluate against criteria, identify data sources, determine how each measure will be used, seek input from CMMI and Vermont independent evaluation contractors, finalize measure set, identify benchmarks and performance targets, determine reporting requirements, revisit measure set on regular basis			Complete	
Ensure payer alignment across endorsed measures <ul style="list-style-type: none"> <li>Process for payer approval</li> </ul>			Complete	
Ensure provider, consumer and payer buy-in during measure selection: <ul style="list-style-type: none"> <li>Identification of additional mechanisms for obtaining provider and consumer representation, input and buy-in</li> </ul>			Complete	

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
Establish plan for target-setting with schedule for routine assessment: <ul style="list-style-type: none"> <li>Establish target-setting process, routine assessment process, and analytic framework and reports</li> </ul>			Complete	
<b>Learning Collaboratives/Care Delivery Transformation</b>				
SIM will expand all existing efforts (Blueprint, VITL, providers, VCCI, SASH, Hub and Spoke)	Unspecified		Complete	
Provide quality improvement and care transformation support to a variety of stakeholders	All 14 IHS Work Groups are offered CQI training and accept and implement such training		Complete	We explored the IHS model and chose a different path to meet this milestone developing our learning collaboratives.
	All practices that want facilitation have access to such resources		Complete	
	All providers that want such training have access to it; providers have working knowledge of Vermont's transformation initiatives		Complete	
Procure learning collaborative and provider technical assistance contractor	Contract for learning collaborative and provider technical assistance		Complete	
Develop technical assistance program for providers implementing payment reforms	Number of providers served by technical assistance program (goal = 20)		Complete	
<b>Evaluation:</b>				
Procure contractor	Contract for internal evaluation	Hire through GMCB in Sept 2013	Complete	

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
<b>Payment Model Implementation Activities:</b>				
Procure contractor for internal Medicaid modeling		Contract for Medicaid modeling	Complete	
Procure contractor for additional data analytics		Contract for data analytics	Complete	
Define analyses		Number of analyses designed (goal = 5)	Complete	
Procure contractor for internal Medicaid modeling		Number of analyses performed (goal = 5)	Complete	
Define analyses		Number of meetings held with payment models and duals WGs on the above designs (goal = 2)	Complete	
Consult with payment models and duals WGs on definition of analyses			Complete	
Perform analyses; Procure contractor for financial baseline and trend modeling; and Develop model.			Complete for SSPs	
Produce quarterly and year-end reports for ACO program participants and payers		Evaluation plan developed	Complete	
Execute Medicaid ACO contracts		Number of Medicaid ACO contracts executed (goal = 2)	Complete	
Execute commercial ACO contracts		Number of commercial ACO contracts executed (goal = 2)	Complete	
Procure contractor for additional data analytics		Contract for financial baseline and trend modeling	Not Met	Remove-redundant to other milestones.
<b>Provider Targets:</b>				
Number of Blueprint practice providers participating in one or more testing models	goal = 500		628-Complete	
<b>Initiative Support:</b>				
Procure contractor		Contract for interagency coordination	Complete	
Hire contractor		Contract for staff training and development	Complete	
Develop curriculum		Training and development curriculum developed	Complete	
Develop interagency and inter-project communications plan		Interagency and inter-project communications plan developed	Complete	
Implement plan		Results of survey of project participants re: communications	Complete	

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
<b>Workforce (Note: in new framework, these activities are in Care Delivery and Practice Transformation)</b>				
Professional training and education	Build on the variety of health professional training and education programs offered throughout the state	Vermont Department of Labor to develop a comprehensive review of all such programs offered by each agency/department of state government - due by the end of 2013	Complete	

Attachment 1b  
Year One Milestones  
Not Met

**Y1 Milestone Table: Milestones not met**

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Progress through 3/31/15
<b>Payment Models:</b>				
	90% of beneficiaries in alternatives to FFS: 90% of Vermonters; 80% of primary care providers; 100% hospitals; 100% home health agencies; 100% DAs across all models being tested; 100% public payers (Medicare and Medicaid); 100% Commercial payers with 5% or more of commercial market share if Blueprint is included; 33% of Commercial Payers with 5% or more of commercial market share if Blueprint is not included.		Beneficiary target not met- 50-60% of beneficiaries. Complete for primary care providers, hospitals, DAs, public payers, commercial payers. On track for primary care providers; home health agencies.	Complete for primary care providers, hospitals, DAs, public payers, commercial payers. On track for primary care providers; home health agencies.
EOCs	The first year of the program would be voluntary participation; subsequent years would transition to bundled payments. Since providers would be paid at a bundled rate instead of FFS, they would have to participate in order to receive payment.	At least 3 launched by 10/2014	Preliminary analyses; stakeholder engagements	Financial component is delayed significantly due to provider reform fatigue; progress is being made on analytic component through public-private subgroup
Develop standards for bundled and episode-based payments		Approved standards for bundled and episode-based payments	Not Met	
Execute contracts for bundled and episode-based payments		Contracts executed	Not met	
<b>Health Data Infrastructure:</b>				
Expand provider connection to HIE infrastructure		Number of new interfaces built between provider organizations and HIE (goal = 18 additional hospital interfaces and 75 new interfaces to non-hospital healthcare organizations to include: at least 10 specialist practices; 4 home health	Not met.	

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Progress through 3/31/15
		agencies; and 4 designated mental health agencies)		
Identify necessary enhancements to centralized clinical registry & reporting systems		Completed needs assessment for enhancements to centralized clinical registry and reporting systems. <i>This milestone and the next two are all part of one project.</i>	Begun; more complicated than anticipated so more work needed.	Significant progress on discovery portion.
Procure contractor to develop initial use cases for the integrated platform and reporting system		Contractor hired	Research conducted.	
Design the technical use cases and determine the components of the integrated platform that are required to implement these use cases		Contract for the development of 6 primary use cases for the integrated platform and reporting system	Begun.	
Develop criteria for telemedicine sub-grants	Number of telemedicine initiatives funded (goal = 1)		RFP released for tele-health strategy; vendor selected.	Contractor started Feb 2015.
<b>Quality Measurement:</b>				
EOC/Bundle-specific measurement activities		Establish measure criteria (November 2013). Identify potential measures (December 2013 through February 2014).	Not Met	
<b>Evaluation:</b>				
Evaluation (external)	Number of meetings held with performance measures WG on evaluation (goal = 2)	2 meetings with QPM WG	Not Met	
Develop evaluation plan	Evaluation plan developed		Not Met	Significant progress

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Progress through 3/31/15
Consult with performance measures work group	Number of meetings held with performance measures WG on evaluation (goal = 2)		Not Met	
Input baseline data	Baseline data identified		Not Met	
<b>Provider Targets:</b>				
Number of providers participating in one or more testing models		goal = 2000	Not Met- 926	

# Attachment 1c

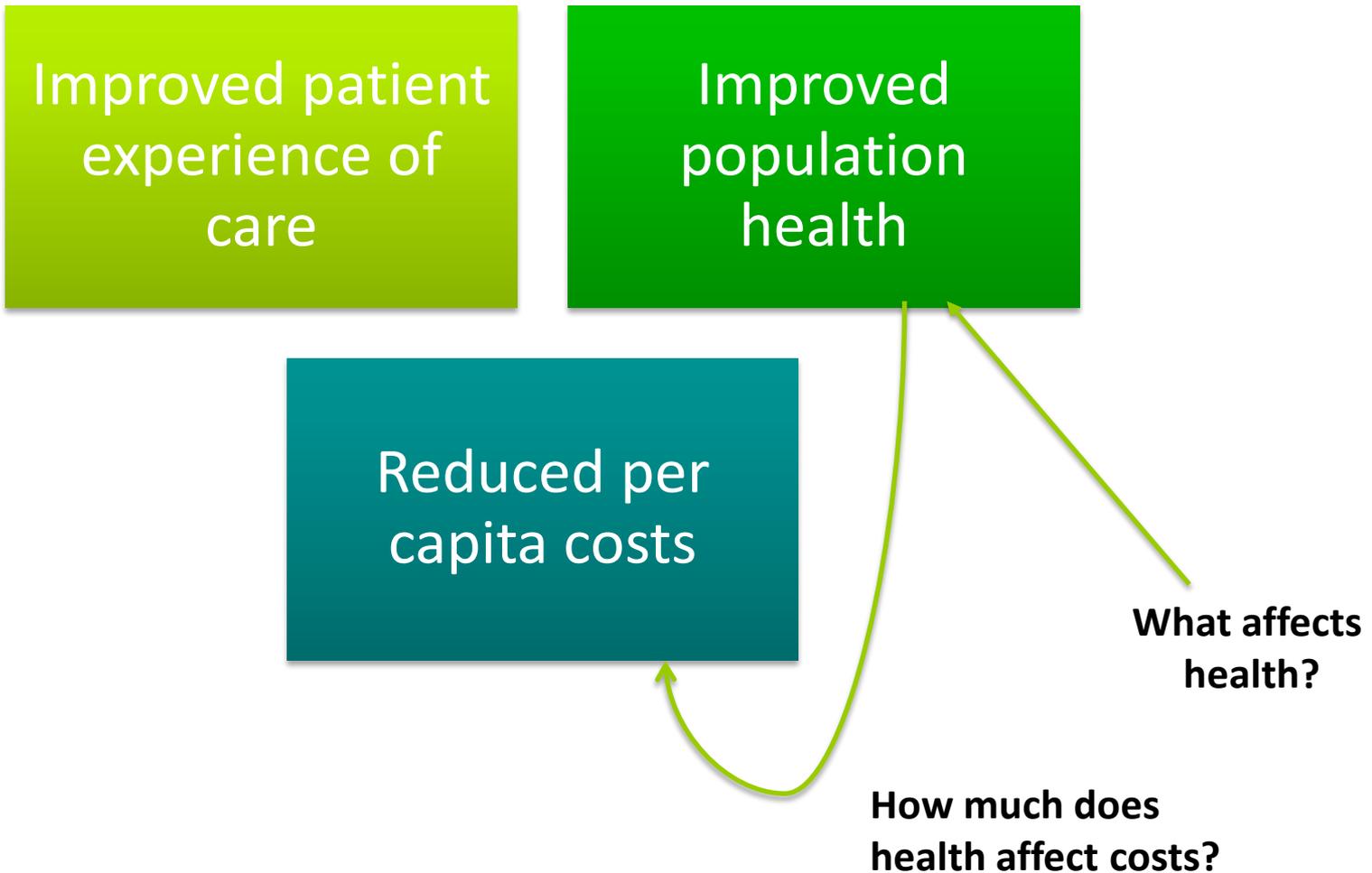
## Alignment Presentation

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# Achieving the Triple Aim in Vermont

Aligning Vermont's Health Care Innovation  
Project (SIM) with the All Payer Model  
Submitted to CMMI on May 22, 2015

# Goal: Achieve the Triple Aim



# Vermont's Delivery Reform Goals

## Vermont Health Care

### Innovation Project (SIM)

- **Align** financial incentives with the Triple Aim (Multi-Payer Payment Models)
- **Enable** and reward care integration and coordination and support provider transformation (Care Delivery)
- **Develop** a health information system that supports improved care and measurement of value (Health Data Infrastructure)

### All Payer Model (APM)

- **Align** financial incentives with the Triple Aim (Multi-Payer Payment Models)
- **Enable** and reward care integration and better coordinate care for Vermonters (Care Delivery)
- **Sustain** a health information system that supports the triple aim (Health Data Infrastructure)
- **Create** a sustainable growth trend for Vermonters while ensuring high quality care

# Achieving Multi-Payer Payment and Delivery System Reforms: *5 Components for Success*

- **Payment Models**
  - Financial and quality measurement (payer side)
- **Care Delivery**
  - Practice transformation (provider side)
- **Health Data Infrastructure**
  - Information to make it all work (provider, payer, and state)
- **Evaluation**
  - Determine what is working (state side)
- **Federal Waivers & Funding**
  - Regulatory flexibility through the Global Commitment Medicaid waiver and All Payer Model Agreement
  - All Payer Model Implementation funding through the State Innovation Model Testing Grant (SIM)

# Payment Models: *Programs*

- **Blueprint for Health, Advanced Practice Medical Homes and Community Health Teams**
  - Multi-Payer Advanced Primary Care Practice (MAPCP) & Medicaid Health Home (opiate addiction).
  - Implemented capitated payments to housing authorities for Support and Services at Home (SASH) as part of MAPCP.
  - Adding a pay for performance payment that ties a portion of medical home payment to service area outcomes (community interdependencies).
  - Payment and Quality measurement aligned across payers & creates a framework for All Payer Model primary care components.
- **Shared Savings Programs with ACOs**
  - Implemented for Medicare and commercial payers.
  - Medicaid program implemented with state plan amendment pending.
  - Quality Measurement largely aligned across payers.
  - “Training Wheels” for providers to get ready for capitation under APM.
- **Episodes of Care/Bundled Payments**
  - in design phase through VHCIP.
  - Low risk method to identify inefficiencies in the health care system, in particular around specialty care.

# Care Delivery: *Programs*

## ■ **Blueprint for Health**

### — Practice Transformation

- State staff and contract assistance for practice transformation funded through Global Commitment and other state funding.
- Provides practice facilitation to assist primary care practices with NCQA certification and enables medical homes to change operations on the ground to improve quality and reduce costs.

### — Community Health Teams

- Provide care coordination and wrap-around support for advance practices funded through Global Commitment and other state funding.
- Includes Medicaid care coordination staff on team.

### — Regional Planning Teams

- integrated and used as the ACO regional teams.
- Directs resources at the community level.

# Care Delivery: *Programs*

## ■ **Accountable Care Organizations**

- Key, provider led organizational component for care delivery.
- Integrate care beyond primary care, establish regional priorities.
- Infrastructure funding through VHCIP.
- Likely to become key organizations in APM.

## ■ **Learning Collaboratives**

- Provides a forum for sharing information among health care providers in order to ensure readiness for payment reform and to promote change at the service delivery level.
- Organized and funded through VHCIP.
- Assists with provider readiness for capitation through the APM.

# Care Delivery: *Programs*

## ■ **Provider Transformation Sub-Grants**

- Funding through VHCIP to promote innovative delivery or payment reforms at the health care provider level
- Encourages transformation in care delivery and determines models which may be scaled or shared with other providers
- Assists with provider readiness prior to capitation through the APM

# Health Data Infrastructure Investments

- **Clinical data** – *providers need information in a usable format in order to create efficiencies and reduce utilization.*
  - **Blueprint for Health Clinical Data Registry** – funded through Global Commitment and other state funding.
  - **Health Information Exchange (VITL)**--funding from multiple sources, including SIM, to create interoperability between electronic medical records and to provide access to high quality clinical information between providers through *VITLAccess*.
  - **Shared Care Plans/Transfer protocols**—design funded through SIM.
  - **Event notification system** -- design and implementation funded through SIM.
- **Claims data** – *the state, providers, and payers need utilization and expenditure for health system planning and regulation.*
  - **VHCURES** –funded through Global Commitment and other state funding.
- **Survey data** – *providers and others need to understand what patients are experiencing in order to ensure quality and access are not compromised.*
  - **Numerous including Patient Experience Surveys**— funded through SIM, Global Commitment, and other state and federal funding.

# Evaluation

## ■ Vermont Health Care Innovation Project

- Ongoing quality measurement & evaluation of specific components of the project.
- Facilitate: a regular, robust reporting to CMMI; inform the need to adjust implementation activities as needed to maximize project impact; provide a rigorous, empirical basis for recommendations to scale-up and broadly diffuse VHCIP initiatives.

## ■ Blueprint for Health

- On-going quality measurement & evaluation of the program interventions on cost impacts.
- Recent Medicare evaluation shows model is one of most successful in MAPCP program.
- For more information see the Blueprint for Health Annual Report
  - [http://blueprintforhealth.vermont.gov/sites/blueprint/files/BlueprintPDF/AnnualReports/VTBlueprintforHealthAnnualReport2014\\_Final.2015.01.26.pdf](http://blueprintforhealth.vermont.gov/sites/blueprint/files/BlueprintPDF/AnnualReports/VTBlueprintforHealthAnnualReport2014_Final.2015.01.26.pdf)

# Federal Waivers and Funding

- Global Commitment to Health Waiver
  - An 1115 Medicaid waiver that:
    - Creates a public managed care entity with flexibility and funding to support the health of Vermont's Medicaid beneficiaries.
      - Must comply with Medicaid Managed Care regulations
    - Creates flexible eligibility for long-term services and supports to allow access to home and community based services on the same basis as nursing home care.
- State Innovation Model Grant
  - Testing grant to provide funding for payment and delivery reform innovations.
- All Payer Model Agreement
  - See next slides!

# Why an All Payer Model as the next evolution?

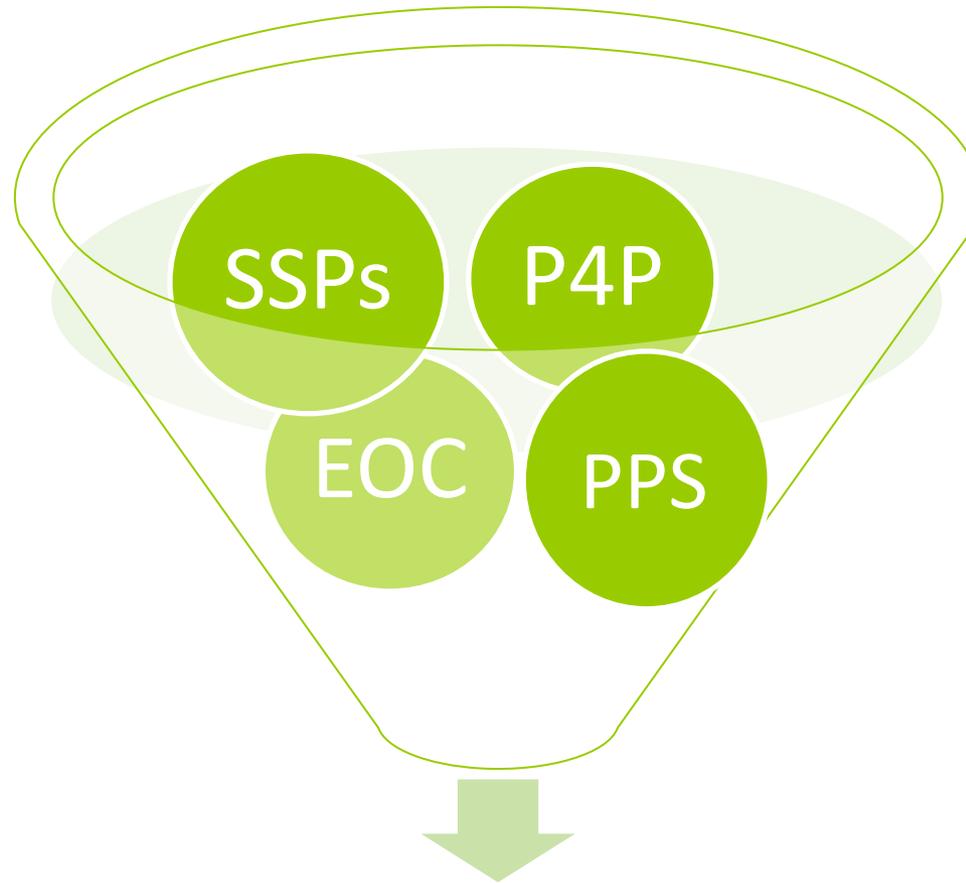
- The all-payer model/system will encourage providers to strengthen their relationships with patients and better coordinate care for Vermonters.
- The system will have incentives to promote health and support Vermonters in choosing healthier behaviors.
- The system will allow Vermonters to better understand the total and out-of-pocket costs they face and the quality of the services they receive.
- The system will ensure treatment is done in the least costly setting and that patients are engaged in their health care and health outcomes.

# Implementing an All Payer Model

- Create a rate-setting agency at GMCB, which allows for regulation across all payers and which provides cost control while improving quality.
  - APM agreement and Global Commitment create the flexibility through waivers necessary to do this.
  - APM agreement and GC create the base, trend, and savings targets.
- Evolve payment methodologies from payment models implemented by payers and supported by Blueprint & SIM grant.
  - APM agreement and Global Commitment create the flexibility through waivers necessary to do this.
- Evolve quality measures from payment models implemented by payers and supported by Blueprint & SIM grant.
  - APM agreement and Global Commitment create the flexibility through waivers necessary to do this.

# All-Payer Model: Payment Models

- Builds on reforms:



All-Payer Model

# All Payer Model: Care Delivery

- **Builds on reforms by:**
  - Ensuring more providers, including DLTSS providers, are ready to take accountability for cost and quality over time.
  - Creating provider readiness for capitation prior to implementation to ensure that patient access and quality of care is not compromised.
  - Enabling providers to change operations on the ground, so savings do not compromise quality of care, patient experience, or access to care.

# All Payer Model: Health Data Infrastructure

- **Use current investments and continue to build infrastructure over time by:**
  - Continuing to build an interoperable health data infrastructure for clinical decision-making to ensure provider community is ready to take accountability for cost and quality prior to implementation of rate-setting and capitation.
  - Building infrastructure across more provider types, such as DLTSS, over time.
  - Using and continuing to refine the data infrastructure necessary for quality reporting after capitation.
  - Reducing duplication in reporting and simplifying, where possible.
  - Demonstrating reliable information in order to build trust by providers in the data provided and to ensure it is used by providers to create efficiencies.

# Attachment 2

## May Minutes

## Vermont Health Care Innovation Project Core Team Meeting Minutes

### Pending Core Team Approval

**Date of meeting:** Wednesday, May 20, 2015, 2:00pm-4:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
<b>1. Welcome and Chair's Report</b>	Lawrence Miller called the meeting to order at 2:00. A quorum was present.	
<b>2. Approval of Meeting Minutes</b>	Steve Voigt moved to approve the May 4, 2015, meeting minutes (Attachment 2). Steven Costantino seconded. A roll call vote was taken and the motion to approve the minutes passed with one abstention.	
<b>3. Executive Session: Mid-Project Risk Assessment</b>	<p>Lawrence Miller introduced the Executive Session. Robin moved to enter Executive Session to discuss matters related to the State of Vermont's contractual relationship with CMMI for the State Innovation Model Testing Grant Cooperative Agreement, and requested that the following staff be invited to participate in the Executive Session: Georgia Maheras, Sarah Kinsler, Kara Suter, Diane Cummings, Ena Backus, Michael Costa, and Craig Jones. Susan Wehry seconded. A roll call vote was taken and the motion passed unanimously.</p> <p>Following discussion in Executive Session, Steven Costantino moved to end Executive Session. Harry Chen seconded. A roll call vote was taken and the motion to end Executive Session passed unanimously.</p>	
<i>Public Comment</i>	No public comment was offered.	
<b>6. Public Comment</b>	No further public comment was offered.	
<b>7. Next Steps, Wrap Up and Future Meeting Schedule</b>	<p><b>Next Steps:</b> The Executive Session included a discussion of issues related to CMMI and certain documents to be submitted to CMMI – no policy decisions were made. The results of this discussion will be brought back to public session at the next meeting, on June 1, and at the June 17 VHCIP Project-Wide Convening.</p> <p><b>Next Meeting:</b> Monday, June 1, 2015, 1:00pm-3:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.</p>	

# VHCIP Core Team Member List

## Roll Call:

5/20/2015  
 1<sup>o</sup> Steve V.  
 2<sup>o</sup> Steve C.  
 1<sup>o</sup> Robin  
 2<sup>o</sup> Susan  
 1<sup>o</sup> Steve C.  
 2<sup>o</sup> Hanky

Member		5/4/2015 Minutes	1 <sup>mo</sup> Exec Session	out of the 4th	Organization
First Name	Last Name				
Paul	Bengston ✓	✓	✓	✓	Northeastern Vermont Regional Hospital
Hal	Cohen / Hemmick → Abstain ✓		✓	✓✓	AHS - CO
Steven	Costantino ✓	✓	✓	✓	AHS - DVHA
Al	Gobeille ✓	✓	✓	not here	GMCB
Robin	Lunge ✓	✓	✓	✓	AOA - Director of Health Care Reform
Lawrence	Miller ✓	✓	✓	✓	AOA - Chief of Health Care Reform
Steve	Voigt ✓	✓	✓	✓	ReThink Health
Susan	Wehry ✓	✓	✓	✓	AHS - DAIL

phone: Susan wehry, Al Gobeille, Craig Jones

Attendance: Kara Suter, Michael Costa, Dave Cumming, Sarah Kinler,  
 Gergo Maheras, Ena Balkus,

# Attachment 3a

## Year 2 ACO Measures Changes

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# **Proposed Changes to Year 2 ACO Shared Savings Program Measures**

VHCIP Core Team  
June 1, 2015

# Background

- Quality measures can and do change as the evidence base changes.
- The QPM Work Group's consultant, Bailit Health Purchasing, provided a summary of national changes to measures in Vermont's Year 2 SSP measure sets.
- There have been recent national changes to two measures in the payment/reporting measure sets:
  - Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening), a claims-based payment measure
  - Optimal Diabetes Care Composite ("D5"), a clinical data-based reporting measure

# Proposed Year 2 Measure Changes

- At its May 18 meeting, the QPM Work Group voted unanimously to recommend replacement measures for these two measures.
- This recommendation would be effective for Year 2 (2015) of the Medicaid and Commercial Shared Savings Programs.
- The Work Group will consider this recommendation when completing its review of measures for Year 3 (2016) of the Medicaid and Commercial Shared Savings Programs during the next couple of months.

# Recommendation: Replace LDL Screening with Controlling High Blood Pressure

Current Measure	Recommended Measure
<b>Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening) (Payment Measure)</b>	<b>Hypertension: Controlling High Blood Pressure (Payment Measure)</b>

- LDL screening is no longer considered best practice; as a result, this measure has been dropped by the Medicare Shared Savings Program (MSSP) and NCQA HEDIS.
- Newly proposed HEDIS cholesterol measure (Statin Therapy for Patients with Cardiovascular Disease) has not yet been adopted, and will lack benchmarks when it is.
- QPM Work Group recommendation is to replace LDL Screening with a nationally-endorsed MSSP measure:
  - Hypertension: Controlling High Blood Pressure

# Recommendation: Replace Optimal Diabetes Care Composite with MSSP Diabetes Composite

Current Measure	Recommended Measure
Optimal Diabetes Care Composite (“D5,” includes LDL Screening, hemoglobin A1c control, blood pressure control, tobacco non-use, and aspirin use) (Reporting Measure)	MSSP Diabetes Composite (“D2,” includes hemoglobin A1c poor control and eye exam) (Reporting Measure)

- CMS has retired this measure from the MSSP measure set, most likely because one of the 5 sub-measures is the LDL Screening measure.
- QPM Work Group recommendation is to replace “D5” with the new MSSP Diabetes Composite Measure (“D2”).
- Two of the remaining three sub-measure topics in “D5” would be addressed for the broader population by the current “Tobacco Use: Screening and Cessation” reporting measure, and the proposed “Hypertension: Controlling High Blood Pressure” payment measure.

# SUMMARY – Year 2 Recommended Measure Changes Commercial and Medicaid Programs

Current Measure	Recommended Replacement Measure	Year 2 2015 – Measure Set
<b>Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening)</b>	<b>Hypertension: Controlling High Blood Pressure (Payment Measure)</b>	Payment
<b>Optimal Diabetes Care Composite</b>  “D5” includes: <ul style="list-style-type: none"> <li>• LDL Screening</li> <li>• hemoglobin A1c control</li> <li>• blood pressure control</li> <li>• tobacco non-use</li> <li>• aspirin use</li> </ul>	<b>MSSP Diabetes Composite</b>  “D2,” includes: <ul style="list-style-type: none"> <li>• hemoglobin A1c poor control</li> <li>• eye exam</li> </ul>	Reporting

# For Steering Committee Consideration

- Is the recommendation consistent with the goals and objectives of the grant?
  - This recommendation is consistent with the following goals and objectives of the grant (outlined in the Operational Plan):
    - To increase the level of accountability for cost and quality outcomes among provider organizations;
    - To establish payment methodologies across all payers that encourage the best cost and quality outcomes;
    - To ensure accountability for outcomes from both the public and private sectors; and
    - To create commitment to change and synergy between public and private culture, policies and behavior.

# For Steering Committee Consideration

- Is the recommendation inconsistent with any other policy or funding priority that has been put in place within the VCHIP project?
  - No; modification of ACO SSP measure sets in response to national measure changes was anticipated beyond Year 1.
- Has the recommendation been reviewed by all appropriate workgroups?
  - These recommendations were approved unanimously by the QPM Work Group after discussion at 3 meetings. The Work Group also considered input on the Hypertension measure from the VT Commissioner of Health, Harry Chen, MD; other Department of Health staff; and Virginia Hood, MD, a nephrologist from the UVM Medical Center.

Attachment 3b

Priority Changes and  
Options for ACO Measures

TO: Pat Jones and Alicia Cooper  
FROM: Michael Bailit and Michael Joseph  
DATE: April 7, 2015  
RE: Changes to ACO Measures

In our memo dated 3-10-15 we identified changes in national measure sets that are relevant to the Vermont ACO measure set. Last week you asked that we provide you with options for measures that could replace measures that have been retired, or have been proposed for retirement, from national measure sets. This memo responds to that request.

### I. Payment Measures

Measure	Reason	Options for Replacement
Core-3a: Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening Only)	Removed from HEDIS 2015 due to a change in the national guideline	<p>1. Statin Therapy for Patients with Cardiovascular Disease <i>This is a newly proposed HEDIS 2016 measure, effectively replacing LDL screening. CMS is likely to adopt the measure, but has not yet done so. NCQA will not publish benchmarks for 2016, but is likely to do so for 2017. Final specifications will be released with in July.</i></p> <p>2. (Core-39/ MSSP-28) Hypertension (HTN): Controlling High Blood Pressure, or (Core-40/ MSSP-21) Screening for High Blood Pressure and follow-up plan documented <i>These currently pending measures assess high blood pressure, a significant population health risk. They align with the MSSP and benchmarks exist, but they require clinical data.</i></p>

### II. Reporting Measures

Measure	Reason for Retirement	Options for Replacement
Core-16 (MN Community Measurement's Optimal Diabetes Care)	<p>CMS has retired this measure (MSSP-22-25) from the MSSP measure set.</p> <p>This may be because MSSP-23 (Core-16b) is an LDL control measure.</p>	<p>1. The revised MN Community Measurement Optimal Diabetes Care for 2015 <i>MN Community Measurement has replaced the LDL measure with a statin use measure. Maine has adopted this measure.</i></p> <p>2. The three remaining individual measure components of Core-16 not already in the measure set, i.e., Core-16c: Blood Pressure &lt;140/90, Core-16d: Tobacco Non-Use, and Core-16e: Aspirin Use <i>All of these are evidence-based measures of effective diabetes management. Benchmarks are available for the blood pressure control measure.</i></p> <p>3. Blood pressure control <i>This is an important outcome measure for management of diabetes. Benchmarks are available for the diabetes blood pressure control measure.</i></p>

### III. Monitoring and Evaluation Measures

Measure	Reason for Retirement	Options for Replacement
M&E-1: Appropriate Medications for People with Asthma	NCQA is proposing retiring this measure for 2016 due to consistently high HEDIS performance rates and little variation in plan performance for both commercial and Medicaid plans.	1. Medication Management for People with Asthma <i>This measure was first introduced in HEDIS 2012. NCQA views it as a more effective way of assessing asthma medication management. National benchmarks are available, and the measure can be calculated with claims.</i>
M&E-16: ED Utilization for Ambulatory Care-Sensitive Conditions	AHRQ has retired this measure for unidentified reasons.	AHRQ is working on ED-specific PQI measures, and conducted a beta test for the draft ED-PQI SAS software from March – May 2014. The beta test was conducted to test how well the software calculates the measures using data from different users and to see how reliable the program is. The measure has not yet been finalized.  In the meantime, the measure set still contains M&E-14: Avoidable ED visits-NYU algorithm. This measure is available only at the end of the year, but captures related content to the retired measure.

### IV. Pending Measures

Measure	Reason for Retirement	Options for Replacement
Core-3b: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)	Removed from HEDIS 2015 due to a change in the national guideline	See option 1 for Core-3a on page 1.
Core-38: Coronary Artery Disease (CAD) Composite <100 mg/dL)	CMS has retired this measure (MSSP-32) from the MSSP measure set, in all likelihood because it is an LDL control measure.	See option 1 for Core-3a on page 1.

# Attachment 4

## Self-Evaluation Plan

# Attachment 5

## Financial Requests

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# Financial Proposals

June 1, 2015

Georgia Maheras, JD

Project Director

# AGENDA

## 1. No Cost Extension Requests:

- Stone Environmental #28079 to 12/31/15
- The Coaching Center #27383 to 12/31/15
- Deborah Lisi-Baker #26033 to 12/31/15

## 2. HIE/HIT Work Group: Shared Care Plans and Universal Transfer Protocol (SCÜP) Project

# No-Cost Extension Requests

- Stone Environmental: Data Inventory (total contract is \$120,000)
- Coaching Center: Staff Training (total contract is \$15,000)
- Deborah Lisi-Baker: DLTSS Work Group Support (total contract is \$55,000)
  
- All three are funded with federally-approved carryforward dollars, but have contract termination dates in May and June.

# HIE/HIT Work Group: Shared Care Plans and Universal Transfer Protocol (SCÜP) Project

- Request from the Work Group :
  - Project to be proposed and approved in two-month waves.
  - Project timeline: June 1, 2015-October 31, 2015
    - This phase: June 1, 2015-July 21, 2015
  - Project estimated cost: \$ 177,700
    - This phase: \$ 36,500
  - Project summary: This project will provide a technological solution that supports Vermont's providers and caregivers in successfully navigating transitions between care settings.
  - Budget line item: Type 2, HIE/HIT.
- The HIE/HIT Work Group is responsible for exploring and recommending technology solutions to achieve SIM's desired outcomes.

# Intent of Contract/Relationship to VHCIP Goals

- *VHCIP's Operational Plan outlines the following tasks:*

## **HIE/HIT Work Group**

This group will build on the work of the work group to date and:

- Identify the desired characteristics and functions of a high-performing statewide information technology system;
- Explore and recommend technology solutions to achieve VHCIP's desired outcomes;
- Develop criteria for a telehealth pilot program and launch that program;
- Guide investments in the expansion and integration of health information technology, as described in the SIM proposal, including:
  - Support for enhancements to EHRs and other source data systems;
  - Expansion of technology that supports integration of services and enhanced communication, including connectivity and data transmission from source systems such as mental health providers and long-term care providers;
  - Implementation of and/or enhancements to data repositories; and
  - Development of advanced analytics and reporting systems.

# Scope of Work

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- Hire one Business Analyst and contract with one Subject Matter Expert to support requirements gathering and development of the technology proposal.

# Attachment 6a

## CHAC Proposal

*General Information:*

Lead Organization Applying: Bi-State Primary Care Association

Collaborating Organizations: in support of Community Health Accountable Care, LLC

Key Contact for Applicant: Kate Simmons, MBA, MPH, Director VT Operations

Relationship to Applicant: employed

Key Contact Email: [ksimmons@bistatepca.org](mailto:ksimmons@bistatepca.org)

Key Contact Phone Number: 802-229-0002, ext. 217

Key Contact Mailing Address: 61 Elm Street, Montpelier, VT 05602

Fiscal Officer (must be different from Key Contact): Abby Mercer, CFO

Relationship to Applicant: employed

Fiscal Officer Email: [amercer@bistatepca.org](mailto:amercer@bistatepca.org)

Fiscal Officer Phone Number: 603-228-2830 ext 118

Fiscal Officer Mailing Address (if different from Key Contact): 525 Clinton Street; Bow NH 03304

*Project Title and Brief Summary:*

Project Title (limit to 40 characters):

Furthering Community Health Accountable Care in FY16 and FY17

CHAC is an FQHC-led ACO with a vision to achieve better care for individuals, better health for populations, and lower growth in expenditures in connection with both public and private payment systems. Extension of CHAC's capacity is necessary to maintain adequate staffing, an operating budget, and continue a patient centered telemonitoring program which has already made an impact in the lives of many attributed at-risk patients. A robust analytics solution, including the selection of a vendor and the purchase of visualization software, will enable CHAC to identify opportunities for further clinical and operational innovations at the population and individual provider levels. The outcome will be improved quality and reduced cost of care, particularly for high risk patients.

**Budget Request Summary**

<b>Budget Category</b>	<b>FY16 7/1/15-6/30/16</b>	<b>FY17 7/1/16-12/31/16</b>	<b>Total</b>
Personnel		\$117,059.73	\$117,059.73
Fringe		\$26,923.74	\$26,923.74
Travel		\$10,000.00	\$10,000.00
Equipment			
Supplies		\$4,806.80	\$4,806.80
Modified Total Direct Cost	\$8,500.00	\$23,361.80	\$31,861.80
Contracts	\$246,500.00	\$250,500.00	\$497,000.00
Other*	\$40,000	\$37,830.92	\$77,830.92
<b>Total</b>	<b>\$295,000</b>	<b>\$470,482.99</b>	<b>\$764,982.99</b>

\*Please see separate budget justification.

**Activities for which the applicant is requesting funding**

Bi-State, on behalf of Community Health Accountable Care, LLC (CHAC) including the Federally Qualified Health Centers (FQHC) providers, and other community stakeholders are pleased to have the opportunity to request VHCIP funding for the following activities (also found in the workplan):

- Extension of CHAC’s capacity until the end of calendar year 2016,
- Extension of CHAC’s care management model which includes a tele-monitoring outreach program, and
- Establishment of a claims based analytics system.

**Capacity:**

To create efficiencies and enable flexibility, CHAC has executed a management services agreement with Bi-State for Bi-State to provide administrative, clinical, financial, and leadership support. Funding from VHCIP will provide partial funding for key Bi-State staff positions in support of the ACO activities, including the ACO Director (Bi-State’s Director of Community

Health Payment Systems), Director of Healthcare Informatics, Clinical QI lead (Community Health Quality Manager), Project Manager, Project Coordinator for Payment Reform Implementation, and other partial staff positions to manage this project and support functions of the ACO (FTEs and additional information is provided in the budget). Bi-State was fortunate to receive original funding from VHCIP which became effective July 14th, 2014 and is set to end on June 30th, 2016. With this funding CHAC was able to fulfill the scope of work promised which included:

- Hiring and maintaining appropriate staffing including a Community Health Accountable Care LLC (CHAC) Director and Project Coordinator,
- Executing and monitoring activities, including a quality compliance program, to ensure compliance with CHAC's Medicaid and Commercial Shared Savings Program and regulatory Agreements and requirements.
- Recruiting providers who will participate and collaborate with CHAC.
- Providing leadership for CHAC's activities regarding budget, quality improvement, data repository and reporting services in collaboration with CHAC's senior management staff.
- Reporting for CHAC's Medicaid and Commercial Shared Savings Program Agreements according to schedule.
- Supporting CHAC's Board of Directors Meetings.
- Supporting CHAC's Clinical, Financial, Beneficiary Engagement, and Operations Committees in collaboration with the respective Chairs.
- Maintaining CHAC's website to meet compliance requirements, and provide general information for beneficiaries and the public.
- Representing CHAC at State meetings.

- Presenting programmatic reports to the VHCIP work groups, Steering Committee, and Core Team, as requested.

CHAC's three Shared Savings Program contracts extend through December 31, 2016. Bi-State would like to request an additional six months of funding for existing staff at approximately current levels to support their continued work in this otherwise unfunded period of time.

With further funding Bi-State will be able to continue supporting other programmatic expenses such as meeting costs, legal and professional services, insurances, travel, supplies, postage, facility expenses, etc. through the end of calendar year 2016. In particular, the use of legal and professional services has become an ongoing necessity within the ever changing environment of payment reform to ensure that CHAC remains compliant with all requirements of the Medicaid and Commercial Shared Savings Program.

For performance year 2014, Bi-State contracted with Weststaff to engage 3 temporary staff members and increased the partial staff positions of some FTEs to conduct the ACO quality reporting. This team of individuals proved to be essential for the success of this endeavor. Extension of CHAC's capacity will allow for Bi-State to ensure that adequate staffing is allocated for the required performance year 2015 ACO quality reporting.

**Extension of Medicare Telemonitoring Intervention:**

CHAC has developed a care management model that includes a telemonitoring program. In 2014, CHAC contracted with a telemonitoring provider, Pharos Innovations, LLC, to run a daily monitoring system for Medicare beneficiaries with COPD, CHF, and Diabetes. Enrollment began in February 2015, and CHAC currently has approximately 190 beneficiaries enrolled. There is

national evidence that telemonitoring and active engagement with patients who have these conditions will reduce readmissions. CHAC's target population for this intervention is 300-375 individuals, targeting the patients at the health centers who are participating in the Medicare contract. Patients are engaged daily through a telephone call, and are followed up on if they have an 'alert'. CHAC has contracted through VNA of VT to engage Central Vermont Home Health and Hospice (CVHHH) to hire 1.5 FTE for centralized care coordination, follow up on the alerts, provision of patient education, and facilitation of referrals if necessary. The CHAC Clinical Committee developed three triage protocols on COPD, CHF, and Diabetes for home health to use when the Care Coordinator is determining whether to refer the patient. The CVHHH Centralized Care Coordinator has already shared a number of stories of the impact the program is making in the lives of CHAC's patients. This is just one that speaks to the population health focus CHAC is working toward: There was an FQHC patient who was legally blind with the diagnosis of Congestive Heart Failure. She alerted in the system, and the Care Coordinator followed up with a phone call to her. The patient had transportation issues that the Centralized Care Coordinator helped her to work out, and upon her visit at the FQHC it was found that she had pneumonia and was sent home with antibiotics. Upon further investigation, the Centralized Care Coordinator discovered through the patient's alerts that is she is not able to weigh herself daily due to her blindness. So, the Centralized Care Coordinator made a referral to Home Health, which will include telemonitoring, and a referral to Occupational Therapy and to the MSW to help fit her with a scale that will work for her. CHAC expects to see an impact on admissions and readmissions from the use of this telemonitoring program by the summer of 2015.

Currently the contract with Pharos Innovations, LLC lasts through June 30, 2016 and the contract with the Central Vermont Home Health and Hospice is only funded through December 31, 2015. Bi-State is requesting funding to extend both contracts through December 31, 2016 to align with the end of the contract for the Medicare Shared Savings Program.

**Contract with Analytics Vendor:**

Bi-State and the CHAC members remain eager to invest in an analytics solution to consume claims data and produce actionable reports. While CHAC has implemented an intervention program for the Medicare population, it has been a challenge to create viable interventions for the Medicaid and Commercial populations. In this proposal and related project plan, Bi-State is requesting VHCIP provider funding to adopt and implement an analytics solution that would enable Bi-State and the CHAC members to address this challenge by identifying key areas for quality improvement that would lead to innovative interventions in an effort to reduce admissions and readmissions for the Medicaid and Commercial populations. Funding for this type of investment would allow Bi-State to contract with a vendor that could use Medicaid and Commercial claims data to report and display information with a user friendly interface at the ACO, participant, and individual provider levels. The analytics platform will allow us to identify high-cost or high-utilizing patients across the spectrum, track interventions, identify transitions in care, ED utilization, and comparison against ACO quality benchmarks. The FQHCs and their community partners identified this type of system as a critical need, as it will allow the FQHCs to proactively manage patients that they serve.

Ultimate selection of an analytics vendor will be made by the CHAC Board upon receipt of funding. Bi-State staff have continued to vet vendors and explore the terms of a procurement.

The vendor that has over the past few months seemed most promising (and the best leverage of past State investment) is The Lewin Group for their Optum Healthview Tableau software.

Lewin is a current VHCIP evaluator, very familiar with CHAC's claims data already, and Lewin has already begun populating the Tableau software with CHAC's claims data feeds. The goal is to successfully analyze the Medicaid and Commercial claims data with a future aspiration to expand the system to include feeds from the VITL HIE and feeds directly from the EHRs at the FQHCs.

### **Number of Providers and Patients Impacted**

CHAC was founded by seven Federally Qualified Health Centers (FQHCs). Since inception CHAC's network has grown to include ten FQHCs, five hospitals, fourteen designated agencies, and nine certified home health agencies. In total our network consists of almost 300 attributing providers and participant agreements with community partners and support service providers. As an ACO we serve about 35,000 patients in total with about 20,000 on Medicaid, about 6,000 on Medicare, and about 8,000 in the commercial exchange population. All providers and patients in CHAC's network would be impacted by the receipt of further funding as we are requesting funds to further support CHAC's infrastructure, continuity of already existing programs, and funding for an investment in an analytics platform that would enable CHAC to analyze data from and generate supplementary interventions for our patient populations.

### **Project Relationship to VHCIP Goals**

Bi-State received original funding to use CHAC as a testing model for payment reform under the State Innovation Models and Testing Grant. This proposal is requesting funding to further this project and to invest in analytics that will allow more opportunities for innovation to be realized.

CHAC's goals as a Shared Savings Program Accountable Care Organization are perfectly aligned with VHCIP's: to improve care; improve population health; and reduce health care costs.

### **Dissemination of Lessons Learned**

Bi-State staff and CHAC members participate in and attend all of the VHCIP workgroups as well as the statewide learning collaboratives and the Blueprint Unified Community Collaboratives. CHAC values collaboration with the other ACOs and our community partners and strives to be inclusive in every aspect. For example, CHAC's clinical committee members, including partners from the behavioral health network and the home health agencies, had significant input on the statewide Care Management Standards. The best practice recommendations on COPD, CHF, falls risk assessment, and Diabetes have been adopted and are being implemented within CHAC's statewide network, and CHAC is currently sharing these recommendations outside of our network with the other ACOs and the Blueprint UCCs. With further funding it is CHAC's goal to continue pursuing quality improvement and care management interventions based on the ACO quality measures. We intend to continue participating in all relevant work groups and learning collaboratives.

### **Data Infrastructure Alignment**

As stated previously, CHAC's proposed claims based analytics solution, particularly if Lewin is selected, will leverage the past investment made by the State. This solution is also compatible with VITL's work on the HIE, and could be a repository at the other end of CHAC's "ACO Gateway." More generally, it is important to note that CHAC's Director of Health Care Informatics, Kate Simmons, has been an integral stakeholder in the ACO Gateway and HIE remediation projects, and Project Manager Heather Skeels is a regular and active participant in the VHCIP HIE Work Group.

### **Alternative Funding Sources Sought and Rationale for Requesting SIM Funds**

As we submitted in our original proposal, Bi-State's work supporting CHAC had been self-funded, with cash contributions from the original members – which are themselves non-profits with carefully constructed budgets (7 FQHCs and Bi-State) – to fund legal and consultant costs and the beginning of CHAC's staff. Bi-State was able to leverage previously existing federal grants for some activities and partial funding of some staff positions. The original funding from the VHCIP Provider grant was necessary to sustain and augment Bi-State's efforts on behalf of CHAC and other providers to maintain CHAC's basic infrastructure, launch the work of the CHAC Board and four standing committees including support of the work on the best practice recommendations, and to launch a care management model that incorporates a telemonitoring program for our at-risk Medicare population. Since then, CHAC has received cash contributions from two new FQHC members, and Bi-State on behalf of CHAC submitted a proposal in response to an RFP from RCHN's Community Health Foundation with the goal of using funding to support further development and implementation of the clinical best practice recommendations throughout our network. A new VHCIP Provider grant is necessary to sustain CHAC's infrastructure, staffing, and telemonitoring program through the end of the Shared Savings Program time frame; and to supply CHAC with an analytics system to enhance the capacity for analysis and development of measures based clinical interventions and recommendations.

### **Technical Assistance Needs**

As in our original proposal Bi-State is very interested in technical assistance around data analysis. As stated in this proposal, funding for analysis of claims data through the contracted use of vendor software would fulfill the technical assistance services previously sought. Additionally, we remain interested in approaching other national foundations to help support our work and ask whether VHCIP could support this effort as requested with letters of support, etc.

### **Potential Return on Investment**

The overall goal of the telemonitoring program is to avert admissions and help patients manage their care through daily monitoring and enhanced referral patterns. Within the first two months of use, there had already been over 2000 interactions with patients that made a positive impact on their health. With increased patient awareness of their health and reduced health care spending through averted admission, this program could have a huge impact to create savings for program years two (CY2015) and three (CY2016).

The quality measures of the Medicare, Medicaid and Commercial ACOs have influenced CHAC's processes for targeted decision making and projects for performance improvement. The analytics software will help identify additional conditions that require system-wide care management, will identify populations and patients with the highest health care utilization and associated costs, and will support specified care coordination to improve the health of these patients. Our current partnerships with the community mental health centers, home health agencies, and other community service providers will continue to allow for great success in developing best practice care models and transitions across the continuum of care. Further integration will help reduce duplication, enhance patient experience, and improve health outcomes.

CHAC will continue to focus on quality improvement and cost reduction efforts for all patients, regardless of insurance status. The data produced by the analytics tool would be shared with all VT FQHCs, the CHAC Board, and appropriate committees. This means that potentially 133,600 patients, who receive approximately 500,000 medical visits annually, will be impacted by the quality improvement activities the analytics tool will support as quality improvements are not be limited to only attributed patients. Approximately one quarter of the Medicaid population in the

state receives care at an FQHC, so these quality improvement initiatives and associated cost savings will continue to have an immense direct impact on the state's economy.

### **Avoiding Duplication and Complementing Existing Effort**

The Furthering Community Health Accountable Care in FY16 and FY17 project will enable the extension of CHAC's current initiatives and build on existing collaborative efforts throughout the state. First, CHAC is an FQHC-led ACO, which created a unique opportunity for VT and for collaborations with the other two ACOs. As stated previously, the FQHCs in VT have a long history of cooperation amongst themselves and with their community partners. CHAC originally utilized these existing relationships to create an integrated network that has thus far been very efficient in producing tangible outcomes as evidenced by the clinical recommendations on COPD, CHF, falls risk, and Diabetes that have been adopted throughout our network. The quick implementation of our telemonitoring program, which has already helped many patients, is another example of this efficiency and enthusiasm for providing the best care to our patient population. The analytics system will leverage the State's past investment and use current data feeds. Through current and future collaborations and participation with the other ACOs, VHCIP Work Groups, Blueprint, and learning collaboratives, and by building on an existing data sharing structure CHAC will avoid duplication and complement activities that are currently underway in VT.

### **Summary of Evidence Base for Proposed Activities**

Telemonitoring of individuals with chronic diseases continues to be proven as a best practice. In a study from a 2011 Health Affairs, chronically ill Medicare patients enrolled in a telehealth program had reduced health care expenditures of 7.7-13% per quarter compared to similar patients who did not have the benefit of daily contact. Numerous articles show reductions in

hospital admissions and re-admissions and better adherence to medication. Patient satisfaction is consistently high and patient's have a higher understanding of their own diseases.

Earlier findings on ACOs indicated the greatest cost savings occurred in patients with multiple co-morbidities (McWilliams, Landon and Chernew, 2013); the use of an analytics solution will enable CHAC providers to identify and manage care for these complex and high-cost patients.

References Cited:

McWilliams, J.M., Landon, B.E., and Chernew, M.E. (2013). Changes in health care spending and quality for Medicare beneficiaries associated with a commercial ACO contract. *JAMA*, 310(8), 829-836, doi:10.1001/jama.2013.276302

**Budget Justification**

**Furthering Community Health Accountable Care in FY16 and FY17**

**Salaries and Wages**

Bi-State requests VHCIP support for the following positions for the time period of July 1, 2016 through December 31, 2016. This represents Bi-State’s current VHCIP funded positions at approximately current FTE levels.

<b>Furthering Community Health Accountable Care in FY16 and FY17</b>				
Personnel				
Salaries		FTE	6 mo adj.	Request
CHAC Director (Joyce Gallimore)				\$ 42,000.00
Project Coordinator (Kendall West)				\$ 22,491.00
Director, Healthcare Informatics (Kate Simmons)				\$ 9,177.32
Administrative Assistant (TBH)				\$ 3,570.00
Data Coordinator (Katie Fitzpatrick)				\$ 5,355.00
Community Health Quality Manager (Patty Launer)				\$ 8,201.03
Project Manager (Heather Skeels)				\$ 6,965.39
Finance / IT / Compliance / Communication				\$ 19,300.00
	Salaries	\$ 117,059.73		\$ 117,059.73
	Benefits	\$ 26,923.74		\$ 26,923.74
	<i>Total Personnel</i>	<i>\$ 143,983.46</i>	<i>\$ -</i>	<i>\$ 143,983.46</i>

**Fringe Benefits**

Bi-State’s fringe benefits are calculated as a percentage of employee salaries/wages each year. Bi-State’s FY16 fringe rate is 23%. Fringe benefits include 12% for health, dental, long-term disability and life insurance, and 403(b) retirement plan; 11% for FICA & Medicare taxes, workers compensation and unemployment insurance.

Fringe calculations are presented on the staffing table, above.

**Travel**

Bi-State is requesting \$5,000 for in-state travel (mileage) and an additional \$5,000 for out-of-state travel (conferences). This line item supports CHAC’s participation in regional and national conferences as well as in-state travel to participant sites, meetings, etc.

**Consultant / Contractual Costs**

Bi-State anticipates four major contracts utilizing VHCIP funding.

- (1) Contract with Pharos Innovations, LLC, to extend telemonitoring intervention for six months through December 31, 2016 (current 18-month contract ends June 30, 2016). This intervention, implemented in February 2015, enrolls 200-375 Medicare beneficiaries for daily telemonitoring. Beneficiaries flagged by Pharos’ proprietary “Tel-Assurance” software are contacted by a triage care coordinator for appropriate triage and follow-up. Bi-State’s current contract with Pharos was negotiated to the rate of \$16,000/month (or \$42.67 PPPM, when fully enrolled with 375 patients) –

Bi-State's current request for an additional \$96,000 was estimated by multiplying the current monthly rate by 6 months..

- (2) Contract with VNA of VT to extend triage care coordination services through December 31, 2016 (current 12-month contract ends December 31, 2015). This work is being provided by Central VT Home Health and Hospice, under a subgrant from VNA of VT. This contract complements the Pharos contract and provides local and high quality care coordination expertise utilizing the Tel-Assurance software for CHAC's enrolled Medicare beneficiaries. Bi-State's current one-year contract with VNA of VT is for \$150,138 – Bi-State's current request for an additional \$165,000 was estimated by increasing the current rate by 10% to reflect a full year at full care coordination capacity (the Y1 rate included lower initial FTEs for initial months).

A note on (1) and (2): When Bi-State originally negotiated a contract with VNA of VT, Bi-State only had funding to support 12 months of VNA of VT, forcing the VNA of VT contract to be out of alignment with the Pharos contract. Bi-State appreciates the opportunity for additional VHCIP funds to align both complementary contracts onto the same schedule and to continue the intervention for a complete ACO program year (instead of ending the intervention arbitrarily mid-year).

- (3) Contract with Analytics vendor - **NEW**. Bi-State and the CHAC members remain eager to invest in an analytics solution to consume claims data and produce actionable reports. Although ultimate selection will be made by the CHAC Board upon receipt of funding, Bi-State staff have continued to vet vendors and explore the terms of a procurement. The vendor that has consistently seemed most promising (and the best leverage of past State investment) is The Lewin Group for their Optum Healthview Tableau software. Lewin is a current VHCIP evaluator and already uses the Tableau software and CHAC claims data feeds in its evaluation work for the State. Bi-State staff have engaged in demonstrations with Lewin and are preparing the CHAC Board to demo the product. Bi-State staff have additionally requested a preliminary quote from Lewin. Lewin estimates the cost to Bi-State to be \$144,000/year (assumes data feeds for Medicaid and Commercial claims data). It is possible that this amount could be reduced to approximately \$130,000/year if Lewin is permitted (via DUAs, etc.) to utilize their existing CHAC data feeds to populate Bi-State's instance of the analytics software. Bi-State's current request for \$216,000 was estimated as 1.5 times the \$144,000 quote (and assumes an 18-month contract).
- (4) Contract with Westaff for temporary contract staffing. To accomplish the PY2014 ACO quality reporting, Bi-State contracted with Westaff and another temporary contract staffing firm to engage short-term staff for chart abstraction. Bi-State was highly satisfied with the caliber of staff that Westaff offered, and anticipates utilizing them as the sole vendor for temporary contract staff for PY2015 reporting. (PY2015 reporting will also necessitate the time of Bi-State employees). PY2014 reporting required ~1,200 hours of employee and contract staff time. Bi-State's current request for \$20,000 assumes 600 hours times at an estimated hourly rate of \$33.33.

## Supplies

Bi-State budgets \$1,576 per FTE for office general office supplies.

## Other

Bi-State anticipates other costs to include meeting expenses, legal costs, beneficiary engagement, insurance, and facility costs.

Meeting expenses for Board, Committee, and Other meetings are budgeted at \$200/month and include facility rental, A/V rental, etc. (Meals/food is not included in this estimate.). Bi-State has budgeted for 6 months of meeting expenses for a total request of \$1,200.

Legal expenses are estimated at 100 hours in FY16 and 25 hours in FY17 at \$350/hour for a total of \$43,750. 100 hours are estimated in FY16 as CHAC anticipates there will be work needed for contract review and development (e.g., new contract with analytics vendor, contract amendments to VNA of VT and Pharos contracts), revisions to CHAC's participant agreement and operating agreement, and CHAC will need assistance with review of a compliance plan. \$350/hour is the rate charged by Feldesman Tucker Leifer Fiddell, one of Bi-State's counsels expert in FQHCs, federal programs, and network development. This rate represents a 50% discount from their commercial rates (because of Bi-State's non-profit status and work with FQHCs).

Bi-State requests \$10,000 for beneficiary engagement. These funds are needed for beneficiary opt-out mailings and to provide reimbursement to beneficiaries for travel associated with their participation in CHAC Board and Committee meetings.

Bi-State requests \$4,845 to purchase business insurances for our CHAC work through December 2016. Insurances include: general liability, Directors & Officers, Errors and Omissions, professional liability, and cyberliability.

Facility costs are Bi-State's expenses related to office facilities. These are currently calculated at \$14.98/square foot/year for the estimated 2408 square feet required from project staff (for a 6 month period), for a request of \$18,035.93.

**Total Direct Costs** **\$733,621.18**

**Modified Total Direct Costs** **\$31,861.80**

Modified Total Direct Cost (MTDC) includes all direct salaries and wages, applicable fringe benefits, materials and supplies, services, travel, and up to the first \$25,000 of each subaward (regardless of the period of performance of the subawards under the award). MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs and the portion of each subaward in excess of \$25,000.

<b>Furthering Community Health Accountable Care in FY16 and FY17</b>			
		FY16	FY17
Personnel	<i>Total</i>	<i>7/1/15-6/30/16</i>	<i>7/1/16-12/31/16</i>
Salaries	\$ 117,059.73		\$ 117,059.73
Benefits	\$ 26,923.74		\$ 26,923.74
	<i>Total Personnel</i>	<i>\$ 143,983.46</i>	<i>\$ 143,983.46</i>
Contractual			
Analytics (e.g., Lewin for Optum HealthView Tableau)	\$ 216,000.00	\$ 144,000.00	\$ 72,000.00
Temporary Staffing Agency (Chart Abstraction for PY2015)	\$ 20,000.00	\$ 20,000.00	
Triage Care Coordination: VNA of VT	\$ 165,000.00	\$ 82,500.00	\$ 82,500.00
Telemonitoring Intervention: Pharos Innovations, LLC	\$ 96,000.00		\$ 96,000.00
	<i>Total Contractual</i>	<i>\$ 497,000.00</i>	<i>\$ 250,500.00</i>
Travel			
Mileage	\$ 5,000.00		\$ 5,000.00
Conferences	\$ 5,000.00		\$ 5,000.00
	<i>Total Travel</i>	<i>\$ 10,000.00</i>	<i>\$ 10,000.00</i>
Other			
Legal Services (Compliance, Contract Expertise)	\$ 43,750.00	\$ 35,000.00	\$ 8,750.00
Beneficiary Engagement (e.g., reimbursement for travel, mailings, etc.)	\$ 10,000.00	\$ 5,000.00	\$ 5,000.00
Insurances	\$ 4,845.00		\$ 4,845.00
Meetings	\$ 1,200.00		\$ 1,200.00
Facility	\$ 18,035.93		\$ 18,035.93
Supplies	\$ 4,806.80		\$ 4,806.80
	<i>Total Other</i>	<i>\$ 82,637.73</i>	<i>\$ 42,637.73</i>
Modified Total Direct Cost			
Modified Total Direct Cost	\$ 31,861.80	\$ 8,500.00	\$ 23,361.80
	<i>Total MTDC</i>	<i>\$ 31,861.80</i>	<i>\$ 23,361.80</i>
	<b>Total Request</b>	<b>\$ 765,482.99</b>	<b>\$ 470,482.99</b>

<b>Furthering Community Health Accountable Care in FY16 and FY17</b> <b>Deliverables and Implementation Timeline for VCHIP Provider Grant Proposed Activities</b> Q1: January – March; Q2: April-June. Q3: July-September. Q4: October-December.					
<b>Need 1: Original funding for CHAC’s basic infrastructure is currently set to end on June 30, 2016.</b>					
Goal 1: Extend CHAC’s capacity through December 31, 2016.					
Objective 1.1: Maintain the adequate and appropriate staffing for CHAC through Bi-State’s management services agreement and an operating budget for CHAC expenses and infrastructure.					
Activities	Anticipated Outcomes	Milestone	Implementation Timeline	Person Responsible	Comment
<i>Revise CHAC’s operating budget</i>	Staff will understand funding is secure through CY16	Approval of revised budget by CHAC Board	Q4 2015	CHAC Director	
	CHAC will have an operating budget that will extend through CY 2016	Approval of revised budget by CHAC Board	Q4 2015	CHAC Director, CHAC CFO, CHAC Informatics Director	
<i>Obtain legal and professional services when needed</i>	Bi-State and CHAC members will be able to seek legal and professional guidance on important issues, including vendor contracting, compliance, etc.	Contracted legal review of current policies and procedures	Q3 2015; ongoing	CHAC Director	

<b>Need 2: Vendor contracts pertinent to the telemonitoring program currently end on December 31, 2015 and June 30, 2016.</b>					
Goal 1: Extend CHAC's care management model which includes a telemonitoring outreach program through duration of Medicare Shared Savings Program.					
Objective 1.1: To extend the existing contracts with the Pharos Innovations, LLC and the VNA of Vermont for the telemonitoring program and the care coordination aspect, respectively, through the end of calendar year 2016 to align with the end of the MSSP time frame.					
<b>Activities</b>	<b>Anticipated Outcomes</b>	<b>Milestone</b>	<b>Implementation Timeline</b>	<b>Person Responsible</b>	<b>Comment</b>
<i>Extend vendor contracts</i>	Vendor contracts will be extended through CY 2016 and at least 1.0 FTE from the VNA will be maintained for the remainder of the project.	Timely execution of VNAVt contract amendment.	Q4 2015	CHAC Informatics Director	
		Timely execution of Pharos contract amendment.	Q2 2016	CHAC Informatics Director	
<i>Maintain patient enrollment in telemonitoring program</i>	Patient enrollment in the telemonitoring program will be maintained through CY 2016	At least 200 patients will continuously be enrolled in the telemonitoring program	Ongoing through Q4 2016	CHAC Informatics Director	

<b>Need 3: Bi-State and the CHAC Members have recognized the lack of current capacity to effectively analyze claims data in a meaningful way.</b>					
Goal 3: Invest in an analytics solution to consume claims data and produce actionable information					
Objective 3.1: Contract with a vendor for analytic services and for visualization software that will leverage past investments by the State and use current claims feeds to create drilled down data reports for use within CHAC's network.					
<b>Activities</b>	<b>Anticipated Outcomes</b>	<b>Milestone</b>	<b>Implementation Timeline</b>	<b>Person Responsible</b>	<b>Comment</b>
<i>Select vendor</i>	Vendor will be selected adhering to Bi-State's procurement policy. Selected vendor will be endorsed by CHAC Board.	CHAC Board approval of vendor selection	Q3 2015	CHAC Informatics Director	Subset of CHAC Board is participating in demonstration of Lewin product on 5/27/2015.
<i>Contract with analytics vendor</i>	Bi-State will execute contract with a selected vendor for analytics services and to purchase visualization software	Timely execution of contract	Q3 2015	CHAC Informatics Director	

Objective 3.2: Use the vendors services and the visualization software to report out health center level and individual provider level data to the FQHCs and our community partners to increase awareness of improvement areas and aid the selection of new population based interventions					
Activities	Anticipated Outcomes	Milestone	Implementation Timeline	Person Responsible	Comment
<i>Develop evaluation plan once vendor is selected</i>	Bi-State will be able to test the effectiveness of the data and provide health centers with individualized reports.	Evaluation plan will include education, implementation, data testing, and use metrics (e.g. risk stratification, QI, and care coordination)	Q4 2015	CHAC Informatics Director	
<i>Select focus areas for quality improvement initiatives</i>	CHAC committee members will be able to select new areas of focus based on analysis of the claims data.	Three to four improvement areas will be chosen and approved by CHAC's Clinical Committee and/or Board.	Q4 2015	CHAC Informatics Director	
<i>Develop clinical and operational best practice recommendations or intervention programs</i>	Best practice recommendations or intervention programs for new focus areas will be adopted by CHAC's network	Implementation of best practice recommendations or intervention programs	Q1 2016	CHAC Informatics Director	
<i>Evaluate impact of improvement initiatives</i>	Bi-State and CHAC members will be able to analyze the impact of initiatives using the claims based analytics on a quarterly or more frequent basis	Reporting dashboard will be created and shared for past and new focus areas of improvement.	Q4 2015& ongoing quarterly	CHAC Informatics Director	

# Attachment 6b

## OneCare Proposal



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Agency of Administration  
State of Vermont  
109 State Street  
Montpelier, VT 05620

Dear Ms. Maheras,

Thank you for the opportunity to respond to the Core Team's request for application for SIM funding for years two and three of the investment cycle. In the interest of improving health of population of Vermonters across the state, and seeking to reduce cost of health care delivery, OneCare Vermont would like to request funding for the following items listed below:

1. Capacity planning for support health reform development, quality improvement, analytics, and clinical facilitation, in the amount of \$2,000,000, used to offset network participant fees.
  - a. In a short two years time, OneCare Vermont has amassed and retained the state's largest value-based care network of hospitals and physicians. As the state moves towards a comprehensive payment reform structure, we at OneCare feel it vitally important to provide the network with the most value as possible in the formative years, and offsetting the fees of network participants will help to improve their capabilities to deliver care while participating in this essential entity of health care reform.
2. Technical assistance funds to assist VITL in the construction of links to critical provider's EHRs across the state, in the amount of \$750,000.
  - a. The persistent derivation of data from providers, and the storage of it in a secure, well-curated manner, is the life blood of any successful population health management strategy and system. OneCare Vermont, as well as other value-based entities and initiatives across the state cannot improve health in a meaningful way, nor reduce costs over time, without complete and valid data sets from points of care. It is our intention to enhance efforts in creating the pipes to provider's electronic data in a secure manner, bringing the totality of data closer to 100% in terms of

available and mineable electronic clinical data for purposes of population health management.

- b. We request these funds for the specific scope of deploying a team of consultants to work in collaboration with the VITL provider outreach staff, to directly implement data connections to providers' EHR systems (where none presently exist) and to assess and correct deficiencies in quality of data from extant data connections.
3. Implementation fees offset for a statewide Care Management tool, in the amount of \$250,000.
    - a. Set up costs associated with the institution of a healthcare technology platform that enables real-time, team-based care coordination and communication. The Care Management system will extend collaboration of care across the continuum as well as to patients, members and family caregivers. By targeting centralized administration and use of this tool at the statewide ACO level, cost reductions for the top 5% of the most expensive patients will be realized by assuring enhanced communication of data and care needs for these patients, such that inefficiencies and waste are driven out through appropriate and systematic processes at the regional level.
  4. Implementation of a statewide Post-Acute Care Network patient identification and tracking system, to be integrated with the statewide HIE, in the amount of \$500,000.
    - a. PatientPing.com is the nation's fastest growing and top-rated patient tracking system across the continuum of care. To reduce costs associated with avoidable readmissions and over-utilization due to broken communication links, PatientPing enables real-time admissions and discharge notifications anywhere patients receive care through a fully secure hub and spoke web based interface. There are significant economies of scale associated with a statewide approach to this level of post-acute care tracking and sustainability of this, once implemented, will be born by OneCare Vermont as part of normal cost of business to sustain the cost savings achieved.

Kind regards,

Greg Robinson  
Vice President, Finance  
OneCare Vermont