

Population Health
Work Group Meeting
Agenda 4-14-15

VT Health Care Innovation Project Population Health Work Group Meeting Agenda

Date: Tuesday April 14, 2015 Time: 2:30-4:00 pm
 Location ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier
 Call-In Number: 1-877-273-4202; Passcode: 420-323-867

All Participants: Please ensure that you sign in on the attendance sheet the will be circularized at the beginning of the meeting, Thank you.

AGENDA					
Item #	Time	Topic	Presenter	Relevant Attachments	Action #
1	2:30	Welcome, roll call and agenda review	Karen Hein	Attachment 1: Agenda	
2	2:35	Approval of Minutes	Tracy Dolan	Attachment 2: Minutes	
3	2:40	Project Updates <ul style="list-style-type: none"> • Accountable Communities for Health • Work Plan 		Attachment 3: Work Plan	
4	2:45	Paying for Population Health Prevention: Outline of paper underdevelopment	Heidi	Attachment 4: Outline	
5	3:00	Paying for Population Health Prevention 101 What we pay for now – medical, alcohol and drug use, etc. Shift to paying for value and outcomes Brief overview of models being tested	Alicia Cooper	Attachment 5: Coming soon	
6	3:50	Next Steps <i>What information do work group members need in order to continue our work together?</i>	Karen Hein		

OPEN ACTION ITEM LOG					
Date Added	Action Number	Assigned to:	Action /Status	Due Date	Date Closed
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			•		
			•		

Attachment 2

March Minutes

VT Health Care Innovation Project Population Health Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Tuesday, March 10, 2015; 2:30 – 4:00 pm, ACCD – Calvin Coolidge Conference Room, 1 National Life Drive

Agenda Item	Discussion	Next Steps
1. Welcome, roll call agenda review	The work group welcomed members of Prevention Institute (PI) to Vermont! Leslie Mikkelsen, Will Haar, Victoria Nichols, Kalahn Taylor-Clark and Lisa Dulsky-Watkins attended the meeting to give an overview of the work that will be done under the contract to support the Population Health Work Group (PHWG)'s exploration of Accountable Communities for Health. The PI has been asked to conduct national research to learn about efforts to create community-wide accountability for the improvement of health outcomes. Additionally, PI will be researching efforts here in VT that appear to be aimed in this direction.	
2. Approval of minutes	A motion to accept the February minutes was made by Susan Aranoff and seconded by Peter Cobb. A roll call vote approved the minutes with two abstentions.	
3. Project Updates	<ul style="list-style-type: none"> • Orientation for new members <p>An orientation packet has been created for the PHWG – for use in both orienting new members to this group, as well as to provide to other work groups to help share purpose and goals across the project. The packet includes definitions and the overall population health framework, among other things. It will also help other SIM states as they are reaching out to us. VT appears to be at the forefront of some of the thinking behind population health and other SIM states are asking for help as they begin their planning work.</p> <ul style="list-style-type: none"> • Actions in other work groups <p>As the Year 2 workplans are finalized, we will review other work group plans and reach out to them, as the PHWG is meant to provide the 'population health lens' through which to view the work across the project. We may ask for presentations from other groups and may present to them.</p>	
4. Accountable Communities for	We are lucky and thrilled to have such a powerful and innovative group working with us. Prevention Institute staff members presented from the slides that are included in the published meeting materials – also linked here .	

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<p>Health</p>	<p>Please note there are some references to particular slides in the notes below.</p> <p>Leslie Mikkelson, Will Haar and Kalahn Taylor-Clark presented an overview of the work done thus far – including summaries of the initial round of interviews at the sites across the country who have already begun to work with the Accountable Community for Health (ACH) model</p> <p>Following are notes that accompany the slides in the materials linked above.</p> <p>Research process used by Prevention Institute:</p> <p><u>Phase I</u></p> <p>Review the field to identify national exemplars of the ACH theme Conduct interviews with multiple stakeholders Present preliminary findings Produce case studies</p> <p><u>Phase II</u></p> <p>Survey the field to identify VT examples of the same (ACH work) Identify several VT sites to conduct site visits Conduct visits Produce case studies</p> <p><u>Deliverables</u></p> <p>Produce preliminary reports Produce final report</p> <ul style="list-style-type: none"> • Results of national investigation • Results from the VT survey • Update on VT site visits <p>VT Research</p> <p>PI also received information from a number of communities about their efforts. In order to take a deeper dive on a few different approaches, PI Identified three sites with which to begin in the Vermont exploration:</p> <ul style="list-style-type: none"> • Franklin and Grand Isle Counties • St. Johnsbury • Burlington 	

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	<p>ACH – Accountable Community for Health How do we, systemically integrate medical care with community wide prevention and wellness efforts? How do we create sustainable payment models and financing mechanisms to support this integrated approach?</p> <p>National Exemplars: (see slides for details)</p> <p>Oregon – Coordinated Care Organizations (CCO) Medicaid population (90% is receiving services via the CCO!) It’s comprised of multiple payers, dental care, mental health providers and many others. 16 regions within the state; each have their own CCO. See slide 13 within the PI presentation.</p> <p>The idea is more to use the ‘carrot’ of rewards, versus the ‘stick’ for penalties related to participation in the CCO. The funding source is used to fund activities like smoking cessation programs (For example, one CCO carves out \$1.33PMPM to fund these activities) as well as several positions to help coordinate population based health programs. Outcomes are measured on a statewide basis, i.e. hospitalizations, ED visits, enrollment in patient-centered primary care homes. The CCO has the requirement to create a community health improvement plan. The advisory committees are comprised of consumer representatives (at least a majority) and other community stakeholders. At this time, the CCOs are funded via Medicaid dollars; the potential expansion to the broader population will be explored in subsequent interviews and research.</p> <p>OH – Live Health Summit County OH (~550,000 people) Initially begun when 7 healthcare partners collaborated to create a white paper. Perhaps the first “Accountable Care Community” example. The initiative was initially supported by a bio-technology company committed to the health of its employees and interested in economic development. Austen Biomedical served as original integrator/backbone/quarterback for 80+ collaborative partners with the intent to create connections, obtain savings and ultimately reinvest savings</p> <p>The company has since pulled out of the initiative and the county health department is the ‘quarterback’ as it has responsibility for the health of the population. 8 core staff people support the initiative. Executive committee (hospital, university, Federally Qualified Health Center) he initiative has a ‘Health in all Policies’ approach to incorporate into the local governmental structure. The funding source is approximately 80% grant and 20% general fund contributions.</p> <p>Bernalillo County – NM – Pathways to Healthy Bernalillo County Hub Pathways Model – this model starts with a dedicated staff person/entity/navigator to coordinate and act as fiscal agent to support coordination and referral to a range of services needed to support high risk individuals (e.g. transportation. Focus is on at-risk people in the community, identified not only within clinical settings but also via social service and community based organizations. They are then referred to the hub, where a community health worker follows the client through the process. This is county funded, currently</p>	

Agenda Item	Discussion	Next Steps
	<p>\$800,000/year, over a 7 year period; 10% to hub/integrator 2.5 FTE. with 90% of funds to the community services; There is an incentive structure set up – how many pathways might a consumer follow – this decision is made jointly with the individual and the community health worker. There are currently 21 pathways available to consumers/clients within a service based model.</p> <p>CO – Pueblo Triple Aim Coalition (PTAC) Began as a tobacco-free initiative. Started as a 501c3 organization – goal is to make Pueblo County the healthiest county in CO. They are a Re-Think Health program with the Triple Aim, Collective Impact and ReThink Health as their three goals. They encompass high level community support, with high-level participation from hospital executive organizations. Currently, this is entirely grant funded. They have the strongest tobacco-free policy in CO and have documented Medicaid savings through reductions in teen pregnancy.</p> <p>CA – LiveWell San Diego This was initiated 5 years ago and is county based. The overall vision is the health and well-being of their population using the pyramid approach documented on slide 27 in the presentation. They focus on 4 strategic approaches:</p> <ul style="list-style-type: none"> • Building a better service delivery system • Supporting positive choices • Pursuing policy and environmental changes • Improving the culture within <p>The backbone of the program is the San Diego County Health and Human Services Agency with 5 regional leadership teams (approximately 600,000 people per region). This initiative produces a great deal of information and literature; the language is consistent across the program/county; very well coordinated system of communication. They have leveraged existing positions and funding streams to create and support this program. This program has a very thorough measurement program. See slide 30 in the presentation for the measures highlighted. The indicators exemplify the cross-responsibility of the health outcomes between the government and the community partners</p>	
<p>5. Next steps</p>	<p>The next meeting is: Tuesday, April 14, 2015 2:30 pm – 4:00 pm</p> <p>ACCD - Calvin Coolidge Conference Room</p>	

Agenda Item	Discussion	Next Steps
	1 National Life Drive, Montpelier Call-In Number: 1-877-273-4202 Conference ID: 420-323-867	

VHCIP Population Health Work Group Member List

Roll Call: 3/10/2015

*Susan Aranoff 10
Peter Cobb 20*

Main checks approval

Member		Member Alternate			
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff ✓			✓	AHS - DAIL
Jill Berry	Bowen				Northwestern Medical Center
Mark	Burke ✓			✓	Brattleboro Memorial Hospital
Donna	Burkett ✓			✓	Planned Parenthood of Northern New England
Dr. Dee	Burroughs-Biron	Trudee	Ettlinger		AHS - DOC
Daljit	Clark	Jenney	Samuelson		AHS - DVHA
Peter	Cobb ✓			✓	VNAs of Vermont
Judy	Cohen ✓			✓	University of Vermont
Jesse	de la Rosa ✓			✓	Consumer Representative
Tracy	Dolan ✓	Heidi	Klein	✓	AHS - VDH
Joyce	Gallimore				CHAC
Karen	Hein ✓			✓	
Kathleen	Hentcy	Charlie	Biss		AHS - DMH
Penrose	Jackson ✓			✓	UVM Medical Center
Pat	Jones				GMCB
Patricia	Launer				Bi-State Primary Care
Lyne	Limoges				Orleans/Essex VNA and Hospice, Inc.
Ted	Mable ✓			✓	DA - Northwest Counseling and Support Services
Melissa	Miles ✓			✓	Bi-State Primary Care
Laural	Ruggles				Northeastern Vermont Regional Hospital
Julia	Shaw				VLA/Health Care Advocate Project
Melanie	Sheehan				Mt. Ascutney Hospital and Health Center
Miriam	Sheehey ✓			✓	OneCare Vermont
Shawn	Skaflestad ✓			✓	AHS - Central Office
Chris	Smith ✓			✓	MVP Health Care
JoEllen	Tarallo-Falk	Lori	Augustyniak		Center for Health and Learning
Teresa	Voci	LaRae	Francis		Blue Cross Blue Shield of Vermont
Stephanie	Winters				Vermont Medical Society
	28		6		

VHCIP Population Health Work Group Participant List

Attendance:

3/10/2015

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

First Name	Last Name		Organization	Population Health
Susan	Aranoff	None	AHS - DAIL	S/M
Julie	Arel	None	VDH	X
Lori	Augustyniak		Center for Health and Learning	MA
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
Abe	Berman		OneCare Vermont	MA
Bob	Bick		DA - HowardCenter for Mental Health	X
Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH	X/MA
Mary Lou	Bolt		Rutland Regional Medical Center	X
Jill Berry	Bowen		Northwestern Medical Center	M
Mark	Burke	None	Brattleboro Memorial Hospital	M
Donna	Burkett	None	Planned Parenthood of Northern New England	M
Dr. Dee	Burroughs-Biron		AHS - DOC	M
Jan	Carney		University of Vermont	X
Amanda	Ciecior		AHS - DVHA	S

Barbara	Cimaglio		AHS - VDH	X
Daljit	Clark		AHS - DVHA	MA
Peter	Cobb	here	VNAs of Vermont	M
Judy	Cohen	phone	University of Vermont	M
Amy	Coonradt		AHS - DVHA	S
Alicia	Cooper		AHS - DVHA	S
Janet	Corrigan		Dartmouth-Hitchcock	X
Brian	Costello	here		X
Mark	Craig			X
Wendy	Davis		University of Vermont	X
Jesse	de la Rosa	here	Consumer Representative	M
Trey	Dobson		Dartmouth-Hitchcock	X
Tracy	Dolan	here	AHS - VDH	C/M
Kevin	Donovan		Mt. Ascutney Hospital and Health Center	X
Lisa	Dulsky Watkins	here		X
Trudee	Ettlinger		AHS - DOC	MA
Erin	Flynn		AHS - DVHA	S
LaRae	Francis		Blue Cross Blue Shield of Vermont	MA
Joyce	Gallimore		Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Steve	Gordon		Brattleboro Memorial Hospital	X
Don	Grabowski		The Health Center	X
Wendy	Grant		Blue Cross Blue Shield of Vermont	A
Thomas	Hall		Consumer Representative	X
Bryan	Hallett		GMCB	S
Catherine	Hamilton		Blue Cross Blue Shield of Vermont	X
Carolynn	Hatin	here	AHS - Central Office - IFS	S
Karen	Hein	here		C/M
Kathleen	Hentcy		AHS - DMH	M
Jim	Hester	here	SOV Consultant	S
Penrose	Jackson	phone	UVM Medical Center	M
Pat	Jones		GMCB	S/M
Joelle	Judge	here	UMASS	S

Sarah	Kinsler	here		S
Heidi	Klein	here	AHS - VDH	S/MA
Norma	LaBounty		OneCare Vermont	A
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Patricia	Launer		Bi-State Primary Care	MA
Mark	Levine	phone	University of Vermont	X
Lyne	Limoges		Orleans/Essex VNA and Hospice, Inc.	M
Nicole	Lukas		AHS - VDH	X
Ted	Mable	here	DA - Northwest Counseling and Support Services	M
Georgia	Maheras	here	AOA	S
Mike	Maslack			X
Jill	McKenzie			X
Melissa	Miles	here	Bi-State Primary Care	M
Chuck	Myers	here	Northeast Family Institute	X
Annie	Paumgarten		GMCB	S
Luann	Poirer		AHS - DVHA	S
Carley	Riley			X
Brita	Roy	phone		X
Laural	Ruggles		Northeastern Vermont Regional Hospital	M
Jenney	Samuelson		AHS - DVHA - Blueprint	M
Ken	Schatz		AHS - DCF	X
seashre@msn.com	seashre@msn.com		House Health Committee	X
Julia	Shaw		VLA/Health Care Advocate Project	M
Melanie	Sheehan		Mt. Ascutney Hospital and Health Center	M
Miriam	Sheehey	phone	OneCare Vermont	M
Shawn	Skaflestad	phone	AHS - Central Office	M
Mary	Skovira		AHS - VDH	A
Chris	Smith	phone	MVP Health Care	M
Kaylan	Sobel		The Council of State Governments	X
Kara	Suter		AHS - DVHA	S
JoEllen	Tarallo-Falk		Center for Health and Learning	M
Teresa	Voci		Blue Cross Blue Shield of Vermont	M
Nathaniel	Waite		VDH	X
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Kendall	West	here		X

James	Westrich		AHS - DVHA	S
Stephanie	Winters		Vermont Medical Society	M
Mary	Woodruff	None		X
Cecelia	Wu		AHS - DVHA	S
McKenna	Lee		OneCare Vermont	
				88

Kim Maclellan - here
 Micah Demers BCBSVT phone
~~Julia R~~
 Carol Maboney - here

Attachment 3

Work Plan

**Vermont Health Care Innovation Project
Year 2 Population Health Work Group Workplan
3/9/2015**



	Objectives	Supporting Activities	Target Date	Responsible Parties	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
Population Health Plan, Population Health Definition, and Population Health Financing Options								
1	Develop a Population Health Plan (PHP) for CDC and CMMI.	Develop outline for a PHP for CMMI.	Year 1 Q3-Q4	Staff; co-chairs; consultant.	Present draft outline to other VHCIP and State of Vermont stakeholders for consideration (other VHCIP Work Groups; AHS agencies).	Steering Committee	<ul style="list-style-type: none"> Initial outline reviewed by Population Health Work Group at August 2014 meeting. 	<ul style="list-style-type: none"> Initial outline reviewed by Population Health Work Group. PHP workplan developed; materials gathered. PHP drafted and sent to Steering Committee.
2		Develop a Population Health Work Group workplan for the PHP to ensure collection of information, exploration of topics, etc.	Year 2 Q1	Staff.				
3		Collect and organize materials.	Year 2 Q1	Staff.				
4		Draft of PHP including elements to be tested in Year 3.	Year 2 Q4	Staff.				
5	Develop a shared understanding of factors contributing to population health outcomes.	Define "population health."	Year 1	Staff; co-chairs; consultant; work group members.	<ul style="list-style-type: none"> Adopt population health definition (Population Health Work Group). Present definition and Population Health 101 materials to other VHCIP stakeholders (other VHCIP Work Groups and Steering Committee). 	Steering Committee	<ul style="list-style-type: none"> Definition adopted by Population Health Work Group. Socio-ecological framework adopted by Population Health Work Group. Population Health 101 materials shared with QPM Work Group. 	<ul style="list-style-type: none"> Definition adopted by Population Health Work Group and reviewed by broader VHCIP stakeholders. Framework for identifying contributors to population health adopted. Population Health 101 materials shared with other VHCIP work groups.
6		Share frameworks for identifying the major contributors to population health.	Year 2 Q1	Staff.				
7		Create materials that show connection between social determinants, population health, and clinical measures.	Year 2 Q1	Staff; co-chairs; consultant; work group members; DLTSS, Care Models, and Payment Models Work Groups leadership.				
8		Seek common population health definition throughout the project and by all work groups. Share core concepts and outline with all work groups and Steering Committee.	Year 2 Q1	Staff; co-chairs; consultant; work group members; VHCIP Work Group leadership and Steering Committee.				
9	Identify financing options to pay for prevention.	Identify promising financing vehicles that promote financial investment in population health interventions.	Year 2 Q2	Consultant.	<ul style="list-style-type: none"> Coordinate to identify and assess prevention and population health financing mechanisms (Vermont Department of Health). Work with other VHCIP Work Groups to identify potential links between prevention financing and payment models being tested (Payment Models and DLTSS Work Groups). 			<ul style="list-style-type: none"> Prevention financing vehicles identified based on statewide and national scan. Recommendations provided to Payment Models Work Group.
10		Produce analytics on the options being explored in other communities and nationally; conduct a Strengths, Weaknesses, Opportunities, and Threats assessment in Vermont.		Consultant.				
11		Provide recommendations to Payment Models Work Group (with input from DLTSS Work Group) to consider link with payment models being tested.	Year 2 Q2 or Q3	Staff; consultant; Payment Models and DLTSS Work Group Staff.				
Population Health Measures								
12	Develop consensus on	Collect existing sets of population health	Year 1-	Staff; work group	<ul style="list-style-type: none"> Coordinate to ensure 	QPM Work	<ul style="list-style-type: none"> Initial identification of set 	<ul style="list-style-type: none"> Existing population health

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	population health measures.	measures currently used in Vermont, and by CDC and/or CMMI.	Year 2 Q1	members; QPM Work Group leadership.	tracking of CMMI core measures (Vermont Department of Health). • Receive input on integrating population health measures into other payment models and delivery system reforms (Payment Models Work Group).	Group	completed. • Collection of Year 1 data is ongoing.	measures collected. • Performance related to obesity, tobacco, and diabetes tracked. • Population health measures recommended to QPM Work Group for inclusion in Shared Savings Program. • Population health measures included in other payment and delivery system models as appropriate. • Population health measures integrated into project evaluation.
13		Create plan to ensure tracking on performance related to core measures from CMMI (obesity, tobacco, and diabetes).	Year 2 Q1	Staff; QPM Work Group leadership.				
14		Recommend appropriate set of measures for payment models, including SSP, Episode of Care, and Pay-for-Performance, as requested by QPM Work Group; coordinate and collaborate with QPM Work Group on measures related to population health.	Year 1 Year 2	Staff; QPM Work Group leadership.				
15		Identify and support integration of population health measures for other payment models being tested and other delivery system reforms as appropriate; make recommendations to QPM Work Group with input from Payment Models.		Staff; QPM and Payment Models Work Group leadership.				
16		Work with evaluation team to integrate population health measures in project evaluation.	Year 2 Q1	Staff; co-chairs; evaluation director.				
Accountable Communities for Health								
17	Examine models for Accountable Communities for Health (AHC).	Examine models that connect payment models and systems of care for population health improvement and review theoretical models of community health systems to improve population health.	Year 1	Staff; co-chairs; consultant; work group members.		Population Health Work Group	• Presentation on Total Accountable Care Organizations by CHCS, October 2014. • Presentation by Washington State Innovation Project, November 2014.	• Models that connect payment and systems of care for population health identified. • Promising practices for community integration of clinical care, mental and behavioral health, and primary prevention identified from within Vermont, nationally, and internationally.
18		Look at examples from outside Vermont for promising practices for integration of clinical care, mental and behavioral health, and primary prevention.	Year 1 Q4- Year 2 Q2	Prevention Institute.				
19		Identify Vermont exemplars of community integration of clinical care, mental and behavioral health, and primary prevention.	Year 1 Q4- Year 2 Q2					
20		Share models of integration to improve population health outcomes with potential pilot communities.	Year 2 Q3					
21		Share work with VHCIP Work Groups to consider link with payment/care models being tested.	Year 2 Q3	Staff; co-chairs; consultant.				
22	Decide whether or not to field an AHC pilot; develop proposal materials/pilot process.	Decide whether to launch an AHC pilot.	Year 2 Q3	Staff; co-chairs; consultant.		Steering Committee		• Decision made regarding pursuit of an AHC pilot; if pursuing pilot, proposal materials/pilot processes developed.
23		Develop proposal materials and process for Vermont AHC Pilot.	Year 2 Q3					
Support and Inform Implementation of Payment Models								
24	Review current payment models,	Review current payment models.	Year 2 Q1	Staff; co-chairs; consultant; Payment	Coordinate to review payment models (Payment Models			Payment models reviewed and prioritized.

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25	prioritize payment models for analysis by Population Health Work Group, and collaborate with other work groups on payment models.	Prioritize payment models for analysis by Population Health Work Group.		Models Work Group leadership.	Work Group leadership).				
26		Collaborate with other work groups, including Payment Models and DLTSS, to develop policy, plans, and strategies to create a viable financial model to support population health goals.	Ongoing 2015	Work group members; staff; consultant; Payment Models and DLTSS Work Group members.	Collaborate to develop policy, plans, and strategies to create viable financial model to support population health goals (DLTSS and Payment Models Work Groups).				
27	Review Shared Savings/ACO model.	Review Shared Savings/ACO model being tested.		Staff; co-chairs; consultant; Payment Models Work Group leadership; ACOs.	Coordinate to review Shared Savings/ACO model and analyze strengths and limitations (Payment Models Work Group leadership, ACOs).		<ul style="list-style-type: none"> Overview presentation by Georgia Maheras at October 2013 meeting. 	<ul style="list-style-type: none"> Shared Savings/ACO model reviewed; strengths, limitations, and features that address principles for population health/primary prevention identified. Overview of ACO, TACO, and ACH created. 	
28		Recommend criteria and measures.							
29		Identify how savings can be shared with population health prevention partners.							
30		Analyze strengths and limitations in integration of population health.		Staff; co-chairs; consultant.					
31		Create overview of ACO, TACO, and ACH models.					<ul style="list-style-type: none"> Draft overview of ACO, TACO, and ACH models created in late 2014. 		
32	Identify features that address principles for integrating population health and primary prevention.		Staff; co-chairs; consultant; work group members.						
33	Review Episodes of Care model.	When model is ready to be tested, review Episodes of Care model: compare with population-based data and risk/protective factors; prioritize health outcomes. Coordinate with Payment Models Work Group on timing.	Year 2 Q2 (or later)	Staff; co-chairs; consultant; Payment Models Work Group leadership.	Coordinate to review Episodes of Care model and analyze strengths and limitations (Payment Models Work Group leadership).			Episodes of Care model reviewed; strengths, limitations, and opportunities to include payment for population health identified.	
34		Analyze strengths and limitations in integration of population health.	Year 2 Q2 (or later)	Staff; co-chairs; consultant; work group members.					
35		Identify best lever and strategy to include payment for and/or activity related to population health.	Year 2 Q2 (or later)						
36	Review Pay-for-Performance model.	When model is ready to be tested, review Pay-for-Performance model. Coordinate with Payment Models Work Group and Blueprint for Health on timing.		Staff; co-chairs; consultant; Payment Models Work Group, Prevention Institute, Blueprint for Health.	Coordinate to review Pay-for-Performance model and analyze strengths and limitations (Payment Models Work Group leadership, Blueprint for Health).		<ul style="list-style-type: none"> Not expanding beyond Blueprint this year. 	Pay-for-Performance model reviewed; strengths, limitations, and opportunities to include payment for population health identified.	
37		Analyze strengths and limitations in integration of population health.		Staff; co-chairs; consultant; work group members.					
38		Identify best lever and strategy to include payment for and/or activity related to population health.							
39	Review population-based global budget/payment model.	Review population-based global budget/payment models being tested.		Staff; co-chairs; consultant; Payment Models Work Group leadership.	Coordinate to review population-based global budget/payment model and analyze strengths and limitations (Payment Models			Population-based global budget/payment model reviewed; strengths, limitations, and opportunities to include payment for	
40		Analyze strengths and limitations in integration of		Staff; co-chairs;					

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41		population health. Identify best lever and strategy to include payment for and/or activity related to population health.		consultant; work group members.	Work Group leadership).			population health identified.
Support and Inform Implementation of Care Models								
42	Identify opportunities to include population health and broad range of community prevention partners in existing care models.	Develop matrix of existing care models and features for improving population health.		Staff; co-chairs; consultant; Blueprint for Health.	Identify existing care models and features for improving population health (CMCM Work Group, Blueprint for Health, providers).	CMCM Work Group	<ul style="list-style-type: none"> Initial presentation from Blueprint staff and NVRH/Mt. Ascutney at July 2014 meeting. 	Current care models reviewed, and opportunities to include population health and community prevention partners identified.
43		Explore options to build upon Blueprint delivery system.	Year 1 Q4	Work group members; Blueprint for Health; ACOs.	Receive information on Blueprint delivery system model (Blueprint).		<ul style="list-style-type: none"> Presentation on regional care management from Craig Jones at December 2014 meeting; possibly coordinate with Payment Models Work Group for joint presentation from Craig Jones in March or April 2015. 	
44		Review ACO system of care.		Staff; co-chairs; consultant; ACOs.	Receive information on ACO system of care (ACOs).			
45		Explore opportunities to collaborate with Care Models Integrated Community Learning Collaborative: identify Population Health Work Group members in learning collaborative communities and link with Health Department District Office in those communities. Set regular check-ins with work group members in learning collaborative communities.	Year 1 Q4- Year 2 Q1	Staff; co-chairs; consultant; CMCM Work Group leadership.	Coordinate to increase connection with Learning Collaborative leadership and Learning Collaborative communities (CMCM Work Group).			
46		Review provider grants for lessons learned related to population health..	Year 2 Q1	Staff; co-chairs; consultant; CMCM Work Group leadership.	Gather additional information about provider grants (sub-grantees, CMCM Work Group leadership).			
47		Review other innovations for systems of care for population health from other SIM states, IOM Population Health, etc.		Staff; co-chairs; consultant.				
48		Recommend care management best practices to CMCM Work Group.	Ongoing	Work group members; staff; consultant; CMCM Work Group members.	N/A			
Ongoing Updates, Education, and Collaboration								
49	Review and approve Population Health Work Group Workplan.	Draft Workplan.	Q1 2015	Staff.	N/A	N/A		Updated workplan adopted.
50	Coordinate and collaborate with other VHCIP Work Groups on other activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups.	Ongoing	Staff; co-chairs; work group members; other work groups.	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).	N/A	<ul style="list-style-type: none"> Mechanisms established for monthly co-chair meetings and work group reports to steering committee. 	Well-coordinated and aligned activities among work groups
51		Coordinate with CMCM Work Group on Accountable Health Communities Initiative.	Ongoing	Staff; co-chairs; work group members; CMCM	Coordinate with Accountable Health Communities initiative			

	Objectives	Supporting Activities	Target Date	Responsible Parties	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
52		Obtain regular updates on relevant sub-grantee projects.	Ongoing	Work Group. Staff; co-chairs; work group members; sub-grantees.	(CMCM Work Group). Obtain regular updates on relevant sub-grantee projects (Sub-Grantees).			
53	Coordinate with, update, and receive education from VHCIP Core Team, Steering Committee, other VHCIP leadership and stakeholders, and AHS agencies as appropriate.	Overall VHCIP project status updates.	Ongoing	Staff; co-chairs; work group members; VHCIP leadership.	N/A	N/A		Well-coordinated and aligned activities across VHCIP.
54		Update Steering Committee, Core Team, and other VHCIP groups and stakeholders as appropriate.	Ongoing	Staff; co-chairs; work group members; VHCIP leadership	N/A	N/A		

Attachment 4

Outline

Identify financing options to pay for prevention.

Paying for Population Health Prevention #1

Purpose of the paper:

The ultimate goal is to identify options for paying for population health and prevention as part of our exploration of various models within the Vermont Health Care Innovation Project. This paper has two sections. The first section provides a basic explanation of the current payment structures and the new models being tested through the Vermont Health Care Innovation Project. The second section provides an analysis and recommendations on the opportunities for including payment of population health and community-wide prevention strategies. The next paper will focus on promising financing vehicles that promote and/or enable financial investment in population health interventions.

Introduction/Background

Transition to value based payment¹

CMS 4 stages

CMS goals

SIM goals/strategy

VT Current System: What do we currently pay and how?

Population Served

attribution

enrollment

geography

Scope of Services

Medical +

Social services

Community-wide prevention

¹ CMS factsheet “Better Care, Smarter Spending, Healthier People: Paying Providers for Value not Volume

Identify financing options to pay for prevention.

Payment model vs financing model

Section1: VHCIP Payment Models Being Tested

Brief review of model being tested²

Key factors to consider

Accountable entity

Payer

Services included

Models

Episodes of Care

Pay for Performance (P4P) e.g. Blueprint

Shared Savings: transitional model

Commercial ACOs

Medicaid ACOs

Global budget

Population based vs. experience driven

Insurance risk vs performance driven

Section 2: Strategies to Include Payment for Activity Related to Population Health Prevention

Models

Episodes of Care

Pay for Performance (P4P) e.g. Blueprint

ACO Shared Savings: transitional model

Global budget

² Provided by VHCIP staff or Ballit

Attachment 5

Paying for Population Health

Paying for Health Care in Vermont

Population Health Work Group Meeting
April 14, 2015

Outline

- How Vermont currently pays for health care:
 - Who are the payers?
 - What beneficiaries and services do payers cover?
 - How are providers paid?
- Payment Reform in Vermont:
 - What is Value Based Purchasing?
 - What models are being tested in Vermont?



Who are the payers in Vermont?

- Medicare
- Medicaid
 - Children's Health Insurance Program (CHIP)
- Commercial Payers (Private Insurance)
 - Blue Cross Blue Shield of Vermont
 - MVP
 - Others (very small market share)

How are Vermonters covered?

Table 1
Primary Type of Insurance Coverage

	Rate					
	2000	2005	2008	2009	2012	2014
Private Insurance	60.1%	59.4%	59.9%	57.2%	56.8%	54.4%
Medicaid	16.1%	14.7%	16.0%	17.6%	17.9%	21.2%
Medicare	14.4%	14.5%	14.3%	15.3%	16.0%	17.7%
Military	0.9%	1.6%	2.4%	2.2%	2.5%	3.0%
Uninsured	8.4%	9.8%	7.6%	7.6%	6.8%	3.7%

Data Source: 2014 Vermont Household Health Insurance Survey

Who is covered by Medicare?

- **FEDERAL** health insurance program
- Population Covered
 - Individuals ≥ 65
 - Individuals < 65 with permanent disabilities
 - Individuals with ESRD and ALS

What services does Medicare cover?

Medicare Benefit	Services Covered
Part A	Inpatient hospital stays, skilled nursing facility stays, some home health visits, and hospice care. Part A benefits are subject to a deductible and coinsurance.
Part B	Physician visits, outpatient services, preventive services, and some home health visits. Part B benefits are subject to a deductible and cost sharing.
Part C*	Medicare Advantage program through which beneficiaries can enroll in a private managed care health plan and receive all Medicare-covered Part A and Part B benefits (and typically Part D benefits).
Part D	Outpatient prescription drugs through private plans that contract with Medicare; enrollment is voluntary. Part D benefits require monthly premiums and cost sharing.

*Negligible number of Medicare beneficiaries in VT enrolled in MA plans

Who is covered by Medicaid/CHIP?

- **FEDERAL & STATE** health insurance program
 - Jointly financed by Federal & State governments
 - Programs designed by States (aligned with Federal requirements)
 - Benefits vary by State
- **Population Covered**
 - Non-elderly low-income adults
 - Pregnant women
 - Children
 - Elderly & Disabled

What services does Medicaid cover?

Medicaid Benefits: Mandatory and Selected Optional Services

Mandatory services

- Inpatient and outpatient hospital services;
- Physician, midwife, and nurse practitioner services;
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children up to age 21;
- Laboratory and x-ray services;
- Family planning services and supplies;
- Federally qualified health center (FQHC) and rural health clinic (RHC) services;
- Freestanding birth center services (added by ACA);
- Nursing facility (NF) services for individuals age 21+;
- Home health services for individuals entitled to NF care;
- Tobacco cessation counseling and pharmacotherapy for pregnant women (added by ACA); and
- Non-emergency transportation to medical care

Selected optional services

- Prescription drugs
- Dental care
- Durable medical equipment
- Personal care services
- Home and community-based services (HCBS)

NOTE: The mandatory and optional services shown here apply for Medicaid beneficiaries who qualify under pre-ACA eligibility rules. Newly eligible adults under the ACA Medicaid expansion receive Alternative Benefit Plans (ABPs), which must include the ten categories of “essential health benefits” specified in the ACA as well as family planning services and supplies, FQHC and RHC services, and non-emergency medical transportation, and provide parity between physical and mental health/substance use disorder benefits.

Who is covered by Commercial Payers?

- **PRIVATE** Health Insurance Programs
- Population Covered
 - Individuals covered by employer-sponsored insurance (and their dependents)
 - Individuals independently purchasing insurance (non-group)
 - Ex. Coverage purchased through Vermont Health Connect
 - Individuals with public insurance seeking additional coverage

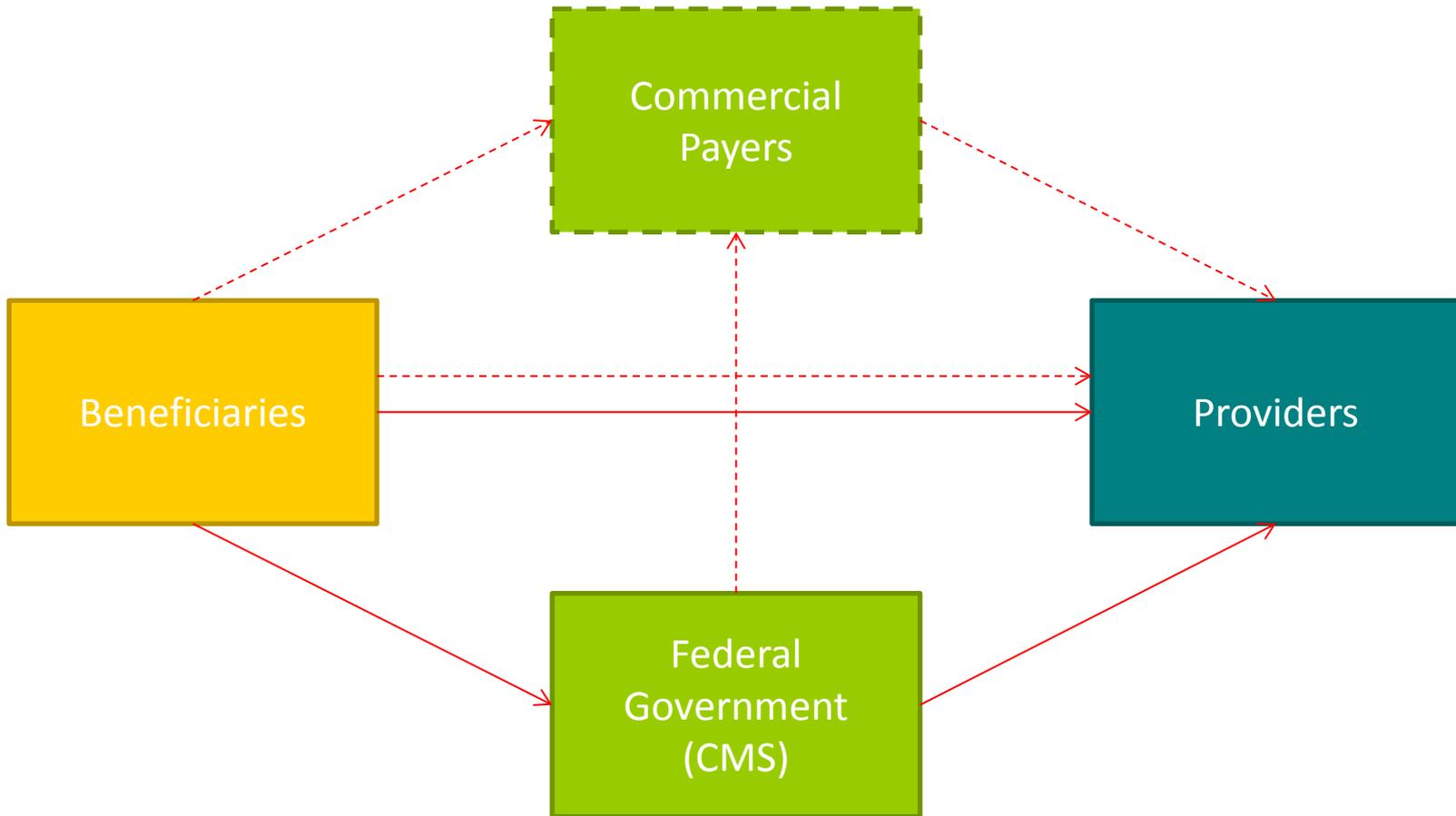
What services do Commercial Payers cover?

- Services covered, deductibles, and cost sharing arrangements can vary by plan
- Qualified Health Plans must cover “essential health benefits”:
 - Ambulatory patient services
 - Emergency services
 - Hospitalization
 - Pregnancy, maternity, and newborn care
 - Mental health and substance use disorder services, including behavioral health treatment
 - Prescription drugs
 - Rehabilitative and habilitative services and devices
 - Laboratory services
 - Preventive and wellness services and chronic disease management
 - Pediatric services, including oral and vision care

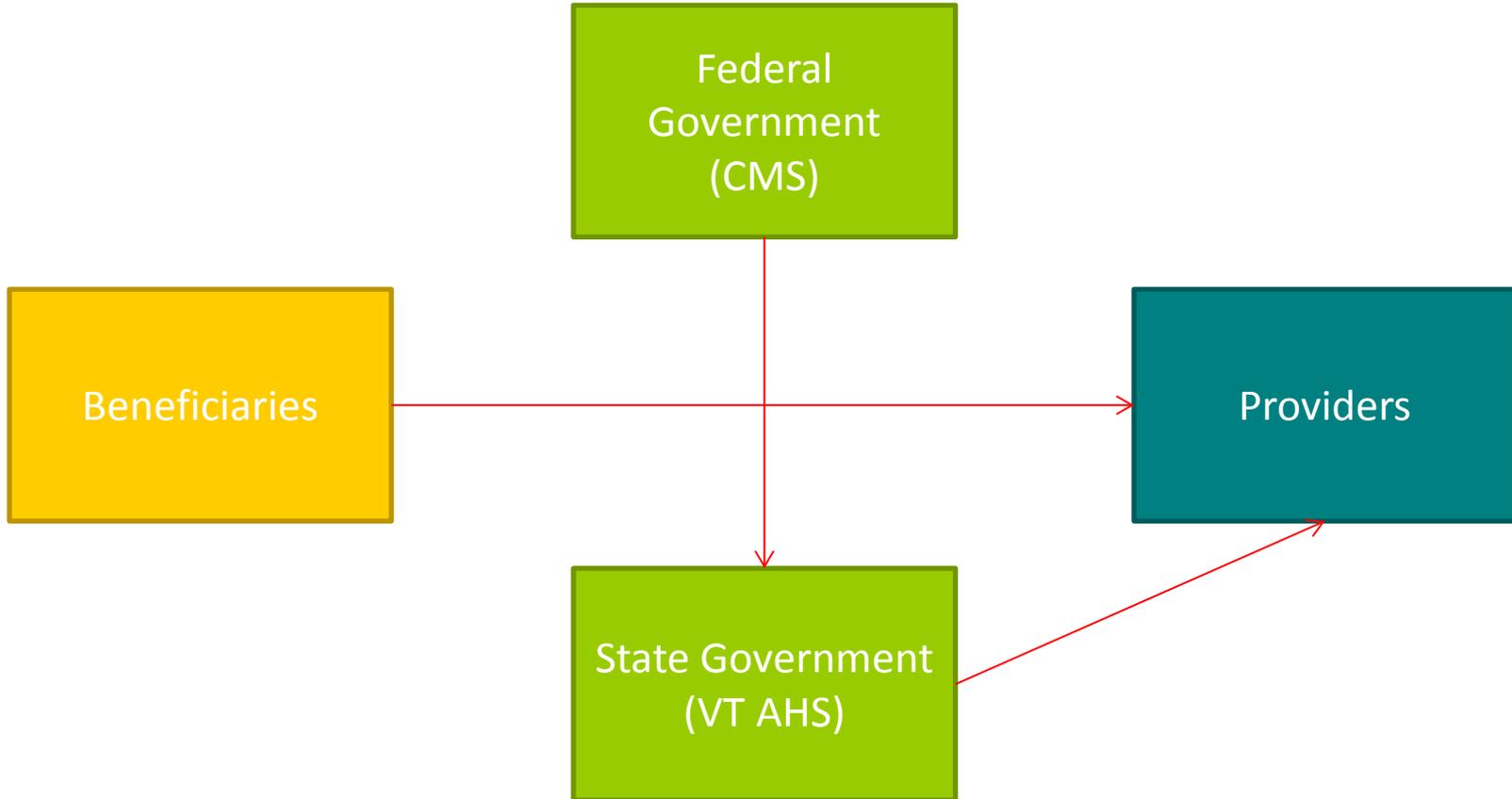
How are providers paid?

- Providers bill payers (and patients) in a Fee-for-Service (FFS) system
 - **Fee-for-Service:** A billing system in which a provider charges a set amount for each service provided
 - **Fee-schedule:** A listing of accepted fees or established allowances for specified medical procedures
- Alternatively, payers can establish allowable amounts for each service using a variety of techniques:
 - **Case Rate (ex. DRGs):** The amount a provider can receive for a selected set of services during a specified period of time
 - **Per-Diem:** A set fee for each day a patient spends in a facility

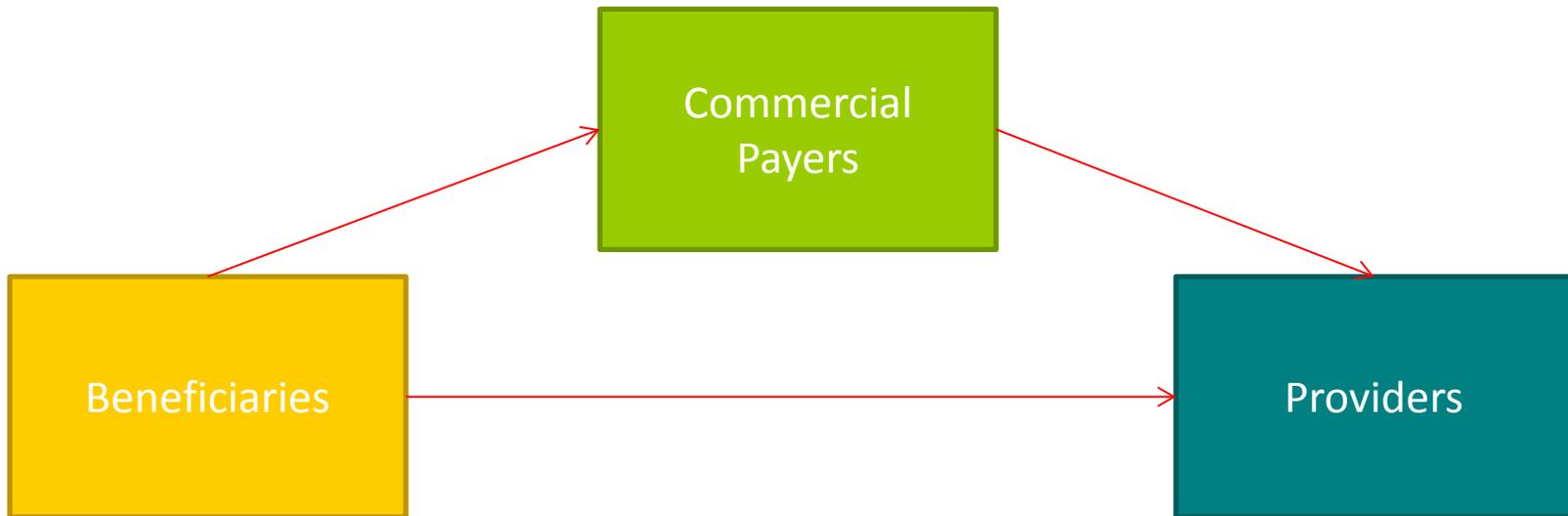
How are providers paid under Medicare?



How are providers paid under Medicaid?



How are providers paid by Commercial payers?



Payment Reform in Vermont

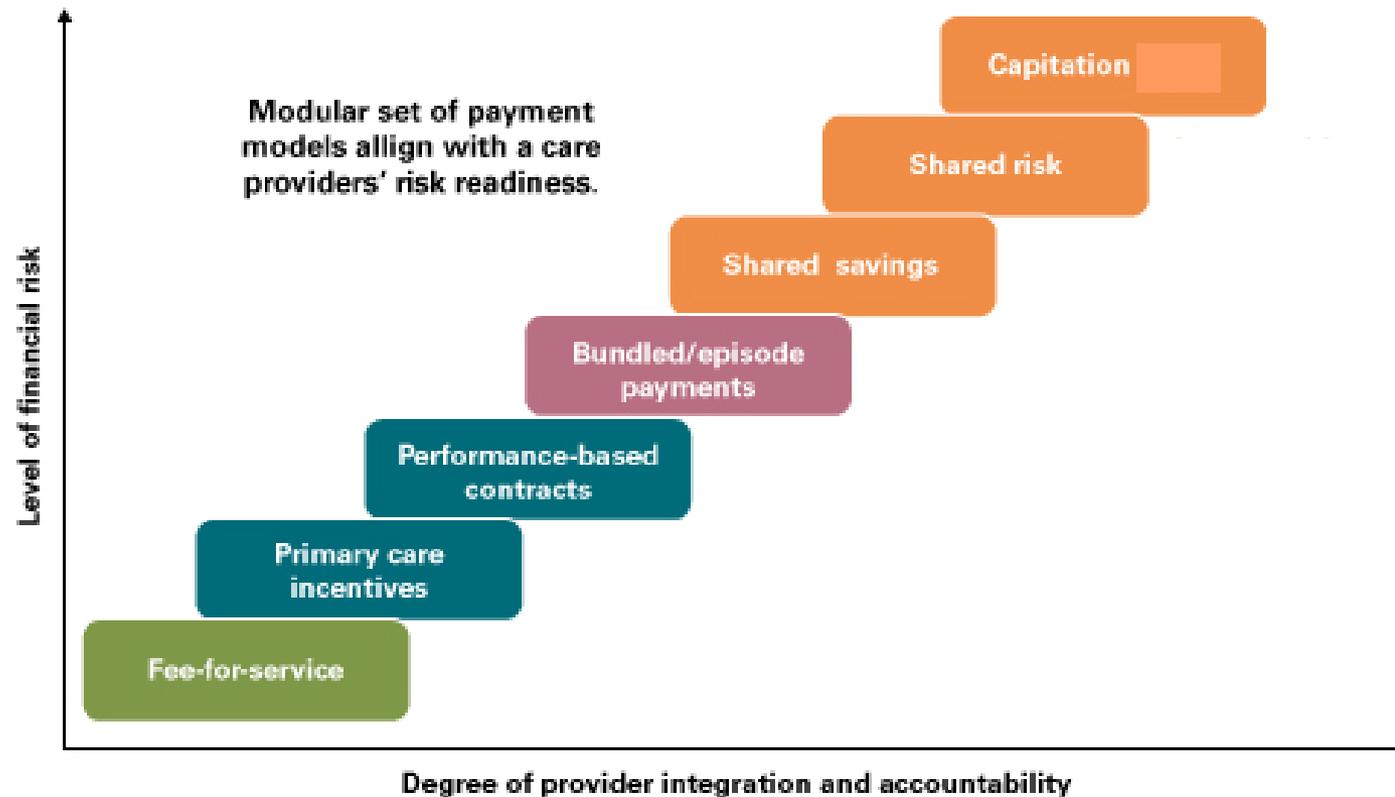
- Designing and testing new, alternative models of paying for health care
- *SIM: support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for all residents*
- Current: VHCIP, Blueprint for Health, etc.
 - Multi-stakeholder collaboration to design & implement alternative payment models across payers
- Future: All-Payer Model

Value-Based Payment

- Any system of paying for health care that emphasizes quality care and cost management
- Represents a shift from paying for the **volume** of services delivered to the **value** of services delivered
- Movement away from the Fee-for-Service model

Value-Based Payment

Value-based payment continuum



Source: United Health Group, 2012.

Initiatives to be Tested in Vermont

- Accountable Care Organization Shared Savings Programs
 - Medicare
 - Medicaid
 - Commercial
- Pay-for-Performance
- Episodes of Care*

*Focus on analytics rather than developing payment model

Key Facts: VHCIP Payment Testing Models

Pay-for-Performance:

Pay-for-performance (P4P) is a method of reimbursing health care providers that rewards high performance on pre-determined quality measures. Often, P4P models build on fee-for-service payments, offering additional performance payments or incentive payments to providers who are high performers and/or providers that demonstrate improvement. P4P programs can incentivize high quality care and promote quality improvement efforts. There is a growing interest in these programs due to variation in quality across providers, difficulty within the current payment system to reward high-quality, cost-effective care, and the lack of incentive within the current system to encourage providing services with long-term health or cost savings payoff.¹ Quality measures can be outcome-based (improvements in patient health status) or process-based (improvements in care processes), and measured in comparison to benchmarks (relative to a national or statewide goal) or in comparison to past performance.

P4P in Vermont. The Vermont Health Care Innovation Project is currently implementing P4P through the Blueprint for Health, an advanced primary care practice program administered by the Department of Vermont Health Access (DVHA) in which Medicare, Medicaid, and commercial insurers participate. Under the Blueprint, active since 2008, primary care practices can receive performance based on their recognition as a patient-centered medical home by the National Committee on Quality Assurance (NCQA), a national accrediting body.² In Vermont, as across the country; there are also various Medicare and private insurer-led P4P activities that are outside the activities sponsored by the VHCIP.

Key Facts: Pay-for-Performance in Vermont

Payment Model Summary: Fee-for-service plus incentive payment for medical home recognition.

Accountable Entity: Participating Primary Care Providers.

Payer(s): Medicare, Medicaid, and commercial payers.

Services Included: Basic medical services (such as those covered by Medicare Parts A and B), plus some social services through community health teams (CHTs).

Episodes of Care:

An episode of care is created by taking health insurance claims and grouping them into clinically similar “episodes”: a series of separate, but clinically related services delivered over a defined time period. These episodes usually include costs of care for an individual beneficiary across multiple healthcare settings. The Centers for Medicare & Medicaid Services (CMS) identify a number of advantages for using episodes of care as a unit of analysis:

- Because they are defined by clinically similar procedures or conditions, episodes are likely to compare similar patients;
- Episodes capture the multiple ways in which health care services can be combined and substituted to produce the best patient outcome at a lower cost; and
- Episodes encourage improved coordination by measuring quality and cost across providers and settings.³

Episodes are difficult to define because of differing opinions regarding which services should be grouped together. Further, because they are often defined by a particular condition, episodes may not capture the important interactions between conditions.

Episodes of Care in Vermont. Under VHCIP, the State of Vermont is pursuing expanded use of episode of care analytics – analyses that measure cost and quality for selected episodes of care and assess variation on cost and quality for each episode – to support care delivery transformation. The State is not currently

pursuing incentive payment programs or bundled payment arrangements that pay providers per episode or based on performance on episodes. VHCIP leveraged an existing contract to perform statewide analysis of priority episodes in 2014, and chartered a sub-group of the Payment Models Work Group in early 2015 to further study the potential of EOC analytics to improve care delivery and drive down costs. Efforts in 2015 will focus on testing whether the use of episode of care analytics can drive care delivery transformation and pave the way for renewed interest in bundled payment programs or payment incentives.

Key Facts: Episodes of Care in Vermont

Payment Model Summary: No payments at this time; the State is currently pursuing use of episode of care analytics to assess and compare provider performance on cost and quality.

Accountable entity: TBD; currently in development in VHCIP Episodes of Care sub-group.

Payer(s): N/A

Services Included: TBD; currently in development in VHCIP Episodes of Care sub-group.

Accountable Care Organizations (ACOs):

An ACO is a network of health care providers, such as doctors, hospitals, home health agencies and mental health providers, who have committed to work together to improve health outcomes at lower costs for a defined group of patients. ACOs are intended to incentivize providers to improve care and better control health care cost growth by increasing coordination and investment in high value services like preventive care and primary care. ACOs and their providers enter into contracts with payers that give them financial accountability for health care costs for their patients. Under “shared savings” arrangements (also known as “upside risk”), ACOs receive a portion of savings if they save money and meet quality targets. Under some ACO programs, ACOs can also enter into “shared risk” arrangements (also known as “downside risk”) which require them to share in losses if they exceed spending targets. Currently, ACO providers receive predominantly fee-for-service reimbursement; shared savings and shared risk arrangements compare projected spending to actual fee-for-service spending.

ACOs in Vermont. There are three ACOs in Vermont: Community Health Accountable Care (CHAC), Accountable Care Coalition of the Green Mountains/Vermont Collaborative Physicians (ACCGM/VCP), and OneCare Vermont (OCV). They include, collectively, all of the State’s hospitals, plus Dartmouth-Hitchcock, most of the state’s physicians and federally-qualified health centers, and many of the state’s home health and mental health providers. All Vermont ACOs have agreed to participate in shared savings programs with Medicare and Blue Cross Blue Shield, the only payer participating in Vermont’s commercial ACO program. Two are participating in Vermont’s Medicaid shared savings program.⁴

Key Facts: Accountable Care Organizations in Vermont

Payment Model Summary: Fee-for-service with shared savings component contingent on clinical quality and demonstrated cost savings.

Accountable Entity: Participating Accountable Care Organizations.

Payer(s): Medicare, Medicaid, and commercial payers.

Services Included: Basic medical services (such as those covered by Medicare Parts A and B), with potential to expand scope of services in Year 3.

1. http://www.oregon.gov/oha/ohpr/hfb/delivery/payment_reform_provider_reimbursement_paper.pdf
2. healthcareinnovation.vermont.gov/.../VHCIP_Year_2_Operational_Plan_11-2014-9.pdf
3. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/downloads/Defining_An_Episode_Logic_Backgrounder.pdf.
4. [http://healthcareinnovation.vermont.gov/resources/Overview_of_Shared_Savings_Programs_\(SSPs\)_and_Accountable_Care_Organizations_\(ACOs\)_in_Vermont](http://healthcareinnovation.vermont.gov/resources/Overview_of_Shared_Savings_Programs_(SSPs)_and_Accountable_Care_Organizations_(ACOs)_in_Vermont)