Population Health

Work Group Meeting

Agenda 5-12-15

VT Health Care Innovation Project
Population Health Work Group Meeting Agenda

Date: Tuesday May 12, 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** • Accountable Communities for Health – PI at June Mtg. • Collaboration with CMCM Work Group • Technical Assistance Request		**Attachment 3:** Technical Assistance Request	
4	3:00	**Financing and Payment for Population Health Prevention** • overview of the components of a sustainable financial model and a brief recap of financing vehicles for funding population health • Discuss the criteria for an effective payment model and the issues which have been encountered in meeting those criteria • Review the current status of the development of payment models nationally and in Vermont, including examples	Jim Hester	**Attachment 4**: 4a: Relevant Articles	
5	3:50	**Next Steps** *What information do work group members need in order to continue our work together?*	Karen Hein		

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

Attachment 2

April Minutes

Vermont Health Care Innovation Project

Vermont Health Care Innovation Project
Population Health Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: April 14, 2015; 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome, Roll Call, & Agenda Review	Karen Hein called the meeting to order at 2:33pm. A roll call attendance was taken and a quorum was present. Karen Hein reviewed the meeting agenda.	
2. Approval of Minutes	Penrose Jackson moved to approve the March 10, 2015, minutes by exception. Laural Ruggles seconded. The minutes were approved with two abstentions.	
3. Project Updates: • **Accountable Communities for Health** • **Population Health Work Group Work Plan**	Heidi Klein provided updates on our work with the Prevention Institute to investigate Accountable Communities for Health and on the Population Health Work Group Work Plan. • *Accountable Communities for Health:* Tracy and others have presented to other VHCIP Work Groups on this project. Heidi clarified that there is no funding for pilot communities associated with this project; it is a research project. Prevention Institute has shared initial findings from their national review of ACH exemplars, and has also spoken with Vermont communities who might be moving along the path to Accountable Communities for Health. The Prevention Institute will be back in Vermont in June to present their final report. • *Population Health Work Group Work Plan (See Attachment 3):* Heidi described the process that went into creating this workplan. Work Group leadership identified three major areas of exploration, based on which Heidi drafted a Work Plan for the Population Health Work Group. The Work Group also includes objectives and tasks which overlap with other VHCIP Work Groups and identifies specific endorsements and dependencies to encourage connections. o Heidi pointed out a few of the objectives this group achieved during the first quarter of 2015 and noted things to come later this spring.	

Agenda Item	Discussion	Next Steps
	The group discussed the following: • Jesse de la Rosa requested additional information on the Integrated Communities Care Management Learning Collaborative. Heidi and Laural Ruggles briefly described the Learning Collaborative, active in three communities; it uses a rapid-cycle quality improvement model to support integrated care management for high-risk patients. Laural also noted that the CMCM Work Group voted to expand the learning collaborative to a new group of three communities. That recommendation will go to the Steering Committee later this month. Heidi suggested that this might be an agenda item for a future meeting of this Work Group.	
4. Paying for Population Health Prevention: Paper Outline	Heidi Klein presented the outline for a paper (Attachment 4) that members of the Work Group leadership team (Heidi Klein and Jim Hester), with support from other project staff (Sarah Kinsler and Mandy Ciecior), are working on. • This will be the first in a series of papers; all will feed into the Population Health Plan. • This paper will describe the payment models Vermont is testing through VHCIP and identify strategic policy levers for embedding population health and prevention in these models. • Alicia's presentation (Item #5 on today's agenda) will mirror this content.	

5.Paying for Population Health Prevention 101	Alicia Cooper, Payment Reform Director on the SIM team at DVHA, presented (Attachment 5) on the payment reform landscape in Vermont and SIM's role in changing payment for population health. (Note: Alicia also staffs the VHCIP Quality and Performance Measurement Work Group.)
	
	• Alicia noted that today's presentation is the tip of the iceberg – there are nuances and exceptions to every piece of this discussion, but today's presentation is a high level overview.
	• Vermont has a relatively simple payer landscape: Medicare, Medicaid (and CHIP), and commercial (BCBS, MVP, and Cigna; Blue Cross dominates the market).
	  o Alicia briefly described each insurer type, including which populations they cover and a general description of covered benefits.
	  o Many large employers are self-insured, and contract with commercial insurers for claims administration.
	• Providers can be paid based on a variety of methods, including fee-for-service and other systems like case rate (ex/ DRG), and per-diem; Alicia briefly described each. Alicia provided a high-level diagram of how money flows through the system under each major payer category (Medicare, Medicaid, commercial).
	  o Different providers are paid using different methods by each payer and sometimes by the same payer; for example, Medicare pays critical access hospitals different from other hospitals.
	• Vermont's payment reform activities have been underway for nearly a decade; existing and new payment reform activities are supported by VHCIP. In the future, we're looking ahead to a potential all-payer model currently being discussed with CMS.
	  o One example is the Blueprint for Health, a program that supports primary care practices based on the medical home model (VHCIP Testing Model: Pay for Performance).	

Agenda Item	Discussion	Next Steps
	• Value-Based Payment Definition: 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. o Value-based purchasing includes a range of payment models (slide 18); the goal is to shift further along this range toward increased incentives for provider integration and increased provider accountability for quality and costs. • Alicia described the payment models being tested through VHCIP. The group discussed the following: • *Vermont's ACO programs were planning on moving toward shared risk. Is this still happening?* In the Medicaid Shared Savings Program, ACOs have decided not to opt for shared risk. In the Commercial Shared Savings Program, this is a possibility. Medicare recently introduced a new ACO model, the Next Generation ACO Model, which includes increasing shared risk. • *What's the difference between capitation and global budgets?* Karen Hein responded that a global budget is given to a group to care for a defined population (usually geographic); capitation could be one way to arrive at a global budget, but there are others, for example, using historical budgets. • *Are schools or school-based providers integrated into the system anywhere in Vermont? This could be a good opportunity for increased integration and care coordination.* Integrated Family Services (IFS) is an approach that identifies families instead of individual children as the target; this might be a good topic to present to this group. The Secretary of Human Services is also having conversations about how IFS can support integration, but Carol Maloney noted that these conversations are somewhat siloed and could be better connected to the Blueprint and regional conversations. • *What does provider integration mean, and what provider types are included?* Laural Ruggles commented that she's thinking bigger than just medical providers, including human services and social services. Karen Hein noted that there are carrots (incentives) and sticks (penalties) to encourage integration and well managed care. A wide range of partners, including medical and social/human services, will be critical in meeting the quality and cost containment goals. The Blueprint's community health teams (CHTs) might provide some of the building blocks for this. • Loyola University has developed a clinically integrated network (CIN) which includes Loyola's nursing school, and has significant interaction with a local high school that includes embedded primary care and emphasizes mental health and prevention. Vermont's pharmacy school is doing something similar, putting pharmacists in primary care offices. • Shared language is incredibly important for allowing schools, human services, and other allied parts of the system to participate. JoEllen Tarallo-Falk encouraged VHCIP to offer funding to Vermont communities to test bundling of services and provider integration. Heidi asked for feedback on what Work Group members would like to learn next to continue this exploration.	

Agenda Item	Discussion	Next Steps
	• Sue Aranoff suggested more information on how these models are being tested in Vermont; for example, the Nursing Home Bundled Payment Initiative. • Mary Kate Mohlman from the Blueprint suggested a presentation on the payment modifications the Blueprint is considering, which move further up the ladder of value-based payment. • Steve Gordon suggested a presentation on the Blueprint and ACO coordination efforts (Unified Community Collaboratives). (Tracy noted that this Work Group did have a presentation on this a few months ago; Steve suggested we continue to stay up-to-date on this work.) • Shawn Skaflestad suggested a presentation on IFS and how this is being implemented on the ground. • Pennrose Jackson reminded the group that this is the Population Health Work Group; we need to think outside the clinical delivery system. Hospitals are preparing to implement community health needs assessments; these result in funding to improve community health outside the clinical delivery system. • Julie Arel suggested oral health/dental health, which has significant impacts on overall health. Karen Hein noted that pediatric dental coverage is considered an essential health benefit for Qualified Health Plans on the Health Insurance Exchange (Vermont Health Connect).	
6. Next Steps	**Next Meeting:** Tuesday, May 12, 2015, 2:30 PM – 4:00 PM; Calvin Coolidge Conference Room, National Life Building, Montpelier	

Penrose Jackson 1°
Laural Ruggles 2°

Motion to approve the minutes by exception
Motion Carried - 2 abstentions

VHCIP Population Health Work Group Member List

Roll Call: 4/14/2015

Member		Member Alternate		Minutes		
First Name	**Last Name**	**First Name**	**Last Name**			**Organization**
Susan	Aranoff ✓					AHS - DAIL
Jill Berry	Bowen					Northwestern Medical Center
Mark	Burke					Brattleboro Memorial Hopsital
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
Carol	Maloney ✓					AHS - Central Office
Melissa	Miles ✓					Bi-State Primary Care
Laural	Ruggles ✓			A		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
Karen	Vastine ✓			A		AHS - DCF
Teresa	Voci ✓	LaRae	Francis			Blue Cross Blue Shield of Vermont
Stephanie	Winters ✓					Vermont Medical Society
	30		6			

VHCIP Population Health Work Group Participant List

Attendance: 4/14/2015

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	Phone	AHS - DAIL	S/M
Julie	Arel	Phone	VDH	X
Lori	Augustyniak		Center for Health and Learning	MA
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
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		Brattleboro Memorial Hopsital	M
Donna	Burkett	Phone	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	phone	VNAs of Vermont	M
Judy	Cohen		University of Vermont	M
Amy	Coonradt		AHS - DVHA	S
Alicia	Cooper	here	AHS - DVHA	S
Janet	Corrigan		Dartmouth-Hitchcock	X
Brian	Costello			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			X
Trudee	Ettlinger		AHS - DOC	MA
Erin	Flynn		AHS - DVHA	S
LaRae	Francis	here	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	phone	Brattleboro Memorial Hopsital	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		AHS - Central Office - IFS	S
Karen	Hein	here		C/M
Kathleen	Hentcy		AHS - DMH	M
Jim	Hester		SOV Consultant	S
Penrose	Jackson	here	UVM Medical Center	M
Pat	Jones		GMCB	S/M
Joelle	Judge	here	UMASS	S
Sarah	Kinsler	here	AHS - DVHA	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		University of Vermont	X
Lyne	Limoges		Orleans/Essex VNA and Hospice, Inc.	M
Nicole	Lukas		AHS - VDH	X
Ted	Mable	phone	DA - Northwest Counseling and Support Services	M
Georgia	Maheras		AOA	S
Carol	Maloney	here	AHS	X
Mike	Maslack			X
~~Jill~~	~~McKenzie~~			X
Melissa	Miles	here	Bi-State Primary Care	M
Chuck	Myers		Northeast Family Institute	X
Annie	Paumgarten		GMCB	S
Luann	Poirer		AHS - DVHA	S
Carley	Riley			X
Brita	Roy			X
Laural	Ruggles	here	Northeastern Vermont Regional Hospital	M
Jenney	Samuelson		AHS - DVHA - Blueprint	M
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		OneCare Vermont	M
Shawn	Skaflestad	phone	AHS - Central Office	M
Chris	Smith		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
Karen	Vastine	here	AHS-DCF	
Teresa	Voci	here	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		Bi-State	X
James	Westrich		AHS - DVHA	S

Stephanie	Winters		Vermont Medical Society	M
Mary	Woodruff			X
Cecelia	Wu		AHS - DVHA	S
McKenna	Lee		OneCare Vermont	
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Suratha Elango
MaryKate Mohlman

RWJF-
Blueprint

Attachment 3

Technical Assistance Request

May 4, 2015

Paying for Prevention Technical Assistance Request

The VHCIP Population Health Workgroup requests assistance in identifying policy levers that have been utilized by other States or communities, that enable them to incorporate population health specific goals into payment reform activities.

To date, Vermont has worked to integrate population health goals into payment reform activity largely through the inclusion of population health measures in required measure sets for our Shared Savings Programs; we are currently brainstorming additional potential policy levers to support population health goals through our payment reform activities (shared savings ACOs; P4P through enhanced payments to PCMH recognized primary care practices; analytics around episodes of care – no payment component for now). Equally important to identifying the overall levers is helping workgroup staff to understand how other states are measuring success and whether or not leveraging the policies has helped to achieve their population health goals.

This information will be used in the creation of a Population Health Plan currently being written by workgroup staff. Future additions will begin to incorporate suggestions regarding ways to go forward and finance various population health initiatives. In order to improve the health of all Vermonters through primary and preventive care, policy levers to do so must be identified and TA assistance is requested.

Attachment 4

Paying for Prevention Articles

May 4, 2015

Overview of Articles

CHCS Population Health Issue Brief: this paper reviews the different approaches that states have used in trying to incorporate population health into ACO shared savings models. See in particular the discussion of challenges on page 6 and the summary of state strategies in table 1 on page 7.

http://www.chcs.org/resource/population-health-in-medicaid-delivery-system-reforms/

RWJF AH Emerging Challenges: This brief discusses three challenges in designing sustainable payment reform, with particular focus on the problem of aligning physician compensation. See the discussion of three different approaches to this problem starting on page 1

http://www.academyhealth.org/files/FileDownloads/RWJF_AH%20Emerging%20Challenges%20FINAL.pdf

PCMH Attribution and Enrollment: This is one of the central issues in building a payment model and the brief provides a good summary of the state of the art, particularly of the attribution models currently in use. It provides a good summary of the challenges of these models (page 9) and some of the key considerations in their design (page 10).

http://www.nashp.org/wp-content/uploads/sites/default/files/PCMH_Attribution_and_Enrollment.pdf

Asthma Case Study: This paper summarizes four different approaches to paying for optimal pediatric asthma care. See the discussion of public health and payment reform (page 15), and the review of lessons learned starting on page 17.

http://www.brookings.edu/~/media/research/files/papers/2015/04/27-asthma-case-study/asthma-case-study.pdf

Financial Model For A Sustainable Community Health System

Population Health Workgroup
May 12, 2015

Jim Hester
jhester@alum.mit.edu

PHWG Charter

Three tasks, including

"How to pay for population health through modifications to proposed health reform payment mechanisms, and identification of promising new financing vehicles that promote financial investment in population health interventions."

Questions

- How to support a community health system and reward improvements in population health and well being?
  - Financing for infrastructure
  - Funding for interventions
- How to align payments for services to support improvements in population health?
- How to capture part of savings for reinvestment?

Outline

- Recap: Community Health System
- Components of financial model
- Overview of financial vehicles: sources
- Review of payment models
  - Elements and criteria
  - Issues
  - Examples
- Options for VT agenda for paying for health
- Disclaimer: my thoughts and interpretation, not a PHWG or VHCIP proposal

US Health Care Delivery System Evolution

Health Delivery System Transformation Critical Path

Acute Care System 1.0

Episodic Non-Integrated Care

- Episodic health care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly coordinated chronic care management

Coordinated Seamless Healthcare System 2.0

Outcome Accountable Care

- Patient/person centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk
- HIT integrated
- Focus on care management and preventive care

Community Integrated Health System 3.0

Community Integrated Healthcare

- Healthy population centered
- Population health focused strategies
- Integrated networks linked to community resources capable of addressing psycho social/economic needs
- Population-based reimbursement
- Learning organization: capable of rapid deployment of best practices
- Community health integrated
- E-health and telehealth capable

Halfon N. et al, Health Affairs November 2014

Structure of a Community Health System

The CHS is made up of

- Backbone/integrator organization for governance structure and key functions
- Intervention partners to implement specific short, intermediate, and long term health-related interventions
- Financing partners who engage in specific transactions

Financial sustainability is dependent upon CHS adding value to partners and stakeholders: development fee

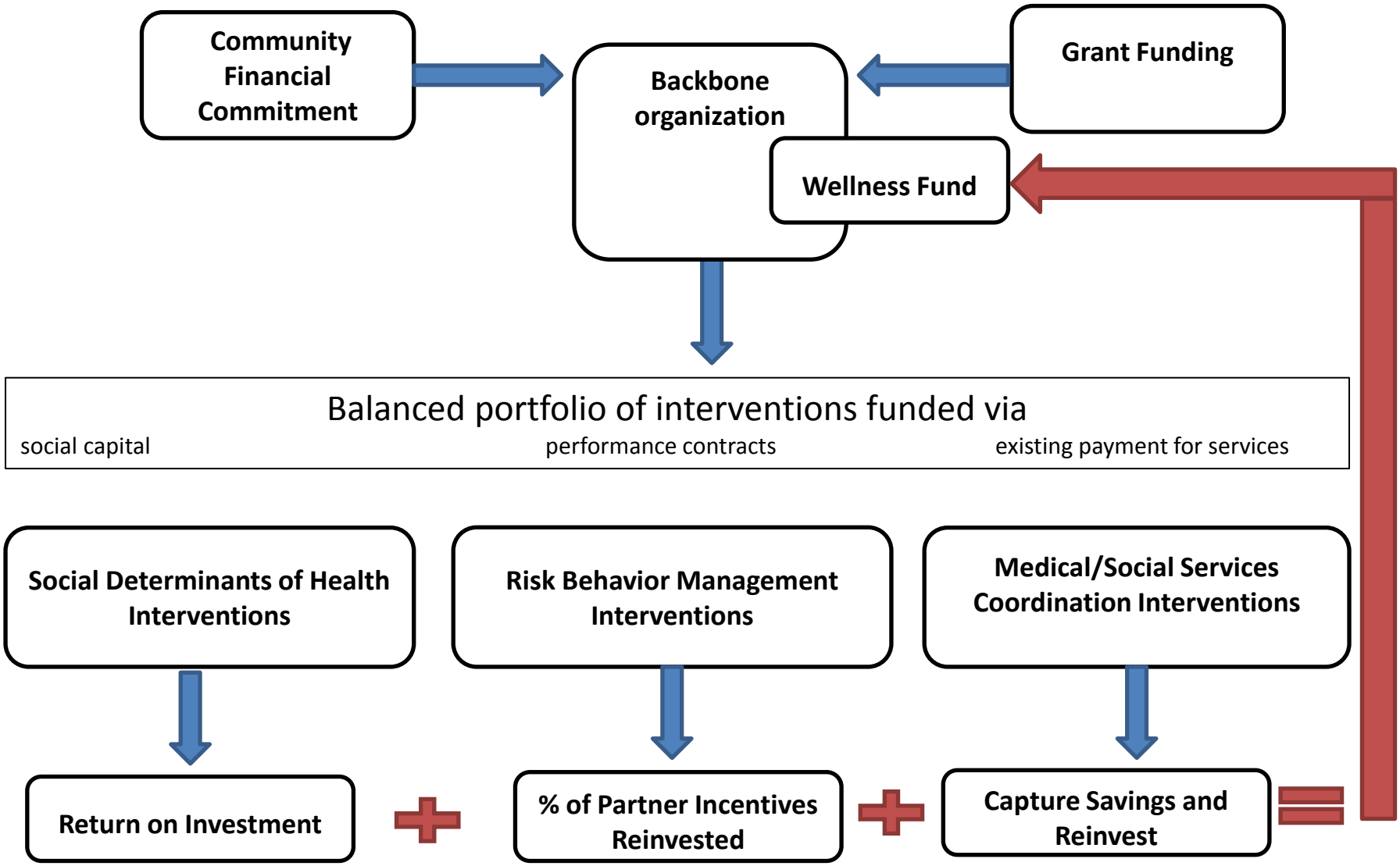
Note: ACH is one example of CHS

Building a Balanced Portfolio

No silver bullet – need to

- Balance portfolio in terms of
  - Spectrum of time horizons for impacts
  - Level of evidence/investment risk
  - Scale
- Match financing vehicle to intervention and close transaction

Backbone Organization's Aggregation and Alignment of Investments and Reinvestments



Inventory of Financing Vehicles

- Payment for clinical services- (2.0 based)
  - Global Budget
    - Shared savings
    - Capitation
    - Total Accountable Care Organization (TACO)
  - PMPM care coordination fee modified by performance
- Public financing:
- Innovative funding sources

Growing Inventory of Financing Vehicles

Innovative funding sources

- Hospital
  - community benefit
  - Investments: Dignity, Trinity, Dartmouth-Hitchcock
- Community development, e.g., CDFI (AHEAD)
- Social capital, e.g., social impact bonds
- Foundations: Program Related Investments (PRI)
- Employers e.g. subscription, employee benefits
- Prevention/wellness trusts

Issue: fragmentation, lack of coordination

IOM Roundtable on Pop Health 2/2014

Components of Financial Model

- Support for Community Health System
  - Infrastructure
  - Balanced portfolio of interventions
- System wide population based global budget for
  - Defined population
  - Broad scope of services/core interventions
- Aligned payments allocating funds to service providers
  - Inside system
  - Outside system
- Reinvestment of part of savings

Paying for infrastructure

Potential models for supporting infrastructure

- Allocation of global cap: OR CCO
- Subscription fee: Upper Valley RTH
- Development fee on transactions
- Reinvestment of savings

Payment Taxonomy Framework

	Category 1: *Fee for Service—No Link to Quality*	Category 2: *Fee for Service—Link to Quality*	Category 3: *Alternative Payment Models Built on Fee-for-Service Architecture*	Category 4: *Population-Based Paymen*
Description	*Payments are based on volume of services and not linked to quality or efficiency*	*At least a portion of payments vary based on the quality or efficiency of health care delivery*	*Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk*	*Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long perioc (e.g. ≥1 yr)*
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3 5

Stage 3: Shared Saving/Risk

- Retains FFS payment for cash flow
- Uses attributed population and risk adjusted budgets
- Annual settlement against target total cost
- Modifies financial results using quality and population health scores
  - Threshold gate
- VT issue: regional/HSA performance

Stage 4 Global Capitation/Budget

- Capitation: population based
  - What population?
  - What risk adjustment?
  - What scope of service?
- Global budget: historical spend trended with adjustments
- Quality and health measures: Support 3.0
  - Monitoring
  - Modify payments

Criteria for Payment Model for Health

- Defined population: identifies targeted population
  - Scale: results statistically significant
  - Accurate for system
- Impact: incentives for desired outcomes
  - Scale: impact on total revenue
  - Measures: balanced, robust measures of health
- Monitors and protects against gaming and accounts for changes in population
- Minimizes variation due to ‘insurance risk’
  - Risk adjustment for global budget/capitation
  - Stop loss insurance
    - individuals
    - Aggregate population
- Operationally feasible
  - Data accuracy/availability
  - Partnerships

Generic issues

- Defining population
  - Attributed based on historical use of providers
    - No patient buy in
    - Misses low utilizers
    - Retrospective: don’t know population during year
  - Enrolled
    - Perceived limitation of choice
    - Patient resistance: assignment?
  - Geographic area
    - Patient migration into and out of area
    - Provider buy in

Generic Issues

- Limited impact
  - Scale: small impact
    - P4P
    - Medicare Advantage 5 star rating
    - Medicare Shared savings program
  - Limited sets of measures: clinical services
- Operational feasibility
  - Data availability, timeliness, accuracy
  - Silos
  - Partnerships: missing, immature

Examples: paying for health

Individual interventions

- Clinical/preventive care:
  - FFS with P4P
  - Patient centered medical home
  - Pediatric asthma care: bundles (Brookings)
  - CMMI cardiac risk reduction
- Public health: taxes, grants
- Community resources
  - Referral: community health team VT Blueprint

CMMI Blood Pressure Control

- Use ASCVD cardiac risk predictor of heart attack in 10 years
- Measure each patient but aggregate scores for physician panel and practice
- Pay for aggregate reduction in 10 year risk for panel
- Moves away from surrogate process measures

Examples: paying for health

Models for multiple interventions

- Pay for performance
  - Self insured employer: Marathon Health
- Global budget/capitation with pop health thresholds
  - ACO shared saving: Milbank
  - Oregon CCO: pop health allocation of pmpm

Lexington KY: Marathon Health

- Town initiative for its 6700 employees and family members
- Self insured employer partnering with Marathon Health, a for-profit company
- Interventions: portfolio
  - Benefit redesign
  - Dedicated health clinic and pharmacy: MedicalHome@Work™
  - Population segmentation and targeted interventions
- Marathon guarantees Triple Aims outcomes

Marathon Health: Population Health Performance Guarantee

% of Participants with the Condition that Achieve the Results

	Eligible Participants with the Following Conditions	Will Achieve the Following Results	Minimum target for Year 1	Minimum target for Year 2	Minimum Target for Year 3
1	Systolic BP > 140	Reduce by 12 mmHg or normal	30.0%	35.0%	40.0%
2	Diastolic BP > 90	Reduce by 5 mmHg or normal	30.0%	35.0%	40.0%
3	Glucose > 100	Reduce 15% or normal	10.0%	12.5%	15.0%
4	Tot. Cholesterol > 200	Reduce 10% or normal	10.0%	12.5%	15.0%
5	LDL Cholesterol > 160	Reduce 10% or normal	10.0%	12.5%	15.0%
6	HDL Cholesterol < 40	Increase 10% or normal	10.0%	12.5%	15.0%
7	Triglycerides > 200	Reduce 20% or normal range	10.0%	12.5%	15.0%
8	Overweight / Obesity	Reduce weight 5% or BMI normal	3.0%	4.0%	5.0%
9	Smokers	Quit for at least 90 days	3.0%	4.0%	5.0%

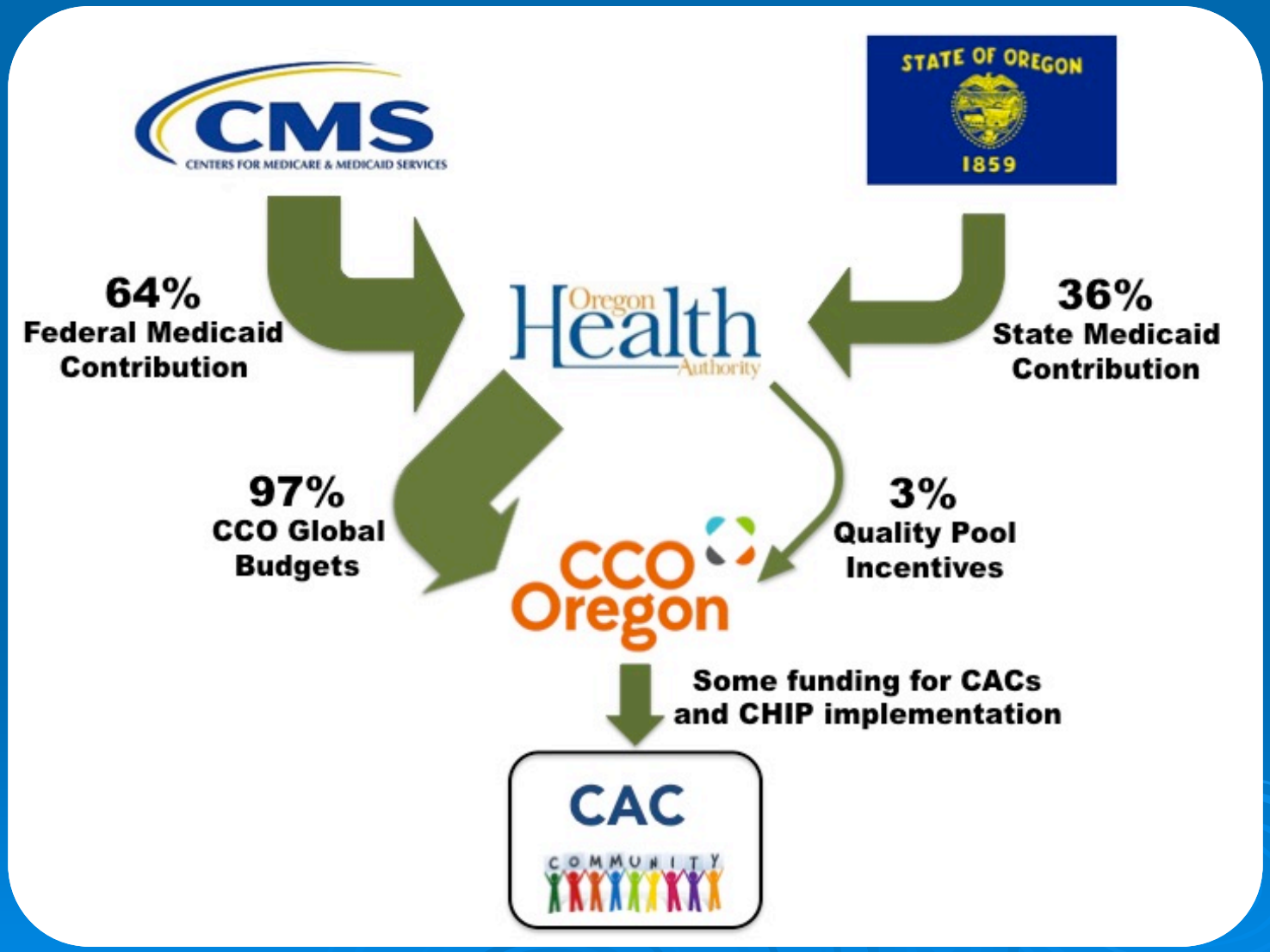
Two Year Results

- Total cost of care: 8% decline
- Population health outcomes: 39% of all employees with biometric values above normal (N=643/1,659) made measureable progress
  - 8% with weight loss,
  - 37% with lower blood pressure,
  - 35% with lower blood sugar
  - 16% stopped smoking

Oregon CCOs

- Provide care to Oregon's Medicaid population.
- Networks of payers, health care providers, mental health and addiction service providers, and sometimes dental care providers.
- 16 CCOs serving 16 distinct regions and 990,000 Medicaid beneficiaries in Oregon.
- Explicit goals to meet the Triple Aim: "Better health, better care, and lower costs."

Oregon CCOs


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
STATE OF OREGON
1859
64%
Federal Medicaid Contribution
Oregon Health Authority
36%
State Medicaid Contribution
97%
CCO Global Budgets
3%
Quality Pool Incentives
CCO Oregon
Some funding for CACs and CHIP implementation
CAC
COMMUNITY

Oregon CCOs Outcomes

- ↓ Emergency department visits
- ↓ Hospital admissions for chronic obstructive pulmonary disease and short-term complications from diabetes
- ↑ Enrollment in Patient-centered Primary Care Homes
- Community prevention efforts coordinated by 3 dedicated employees of county health dept.

Aligning MD Compensation

- Cornerstone: 240 MD multispecialty group
- Thedacare: integrated health system
- CA Medical Groups and IPA

RWJ “Three emerging challenges for sustainable payment reform”

CA IPA's & Medical Groups

Service Type	Recommended Payment Model
Prevention services	Fee-for-service (For capitated physicians, a P4P bonus)
Chronic care	Capitation
Acute care outpatient	Fee-for-service
Acute inpatient	Capitation to group-contracted hospitalists and/or episode-based payment
Palliative and end-of-life	Episode-based payment

Possible Vermont Agenda

- One of tasks identified in PHWG charter
- Build on other proposals
  - in Blueprint/ACO proposal
  - in PHWG charter: metrics, ACH
- Examples of possible projects, (not a formal proposal)

Vermont Delivery System Transformation

- Create aligned payment model for all payers
  - Primary care: Blueprint for Health
  - Statewide ACO network: savings sharing, payment metrics, monitoring metrics
  - Evolve to population based budget: Medicare/Medicaid waiver
- Integration of Blueprint and ACO's
  - Regional unified community health system
  - Unified reporting system
- Community health system model
  - Evolution: ACO to AHC
  - integrated clinical, public health and community services

Proposed Payment Modifications

Payment Component	Eligibility	Intended Result
Base Payment	Participation in UCC Recognized on NCQA 2011	Organize practice and CHT activity to support UCC initiatives
NCQA Rescore Payment	Rescore on current NCQA standards (discretionary)	Maintain medical home quality & operations
Quality Composite Payment	HSA measure results • Top 50th percentile • Beat benchmarks • Incremental improvement	Coordinate with others to improve quality and coordination as reflected by core measures
Total Utilization Index	HSA measure results • Top 50th percentile • Incremental improvement	Coordinate with others to reduce unnecessary utilization and variation

Issues With VT Payment Models

- Blueprint payment model
  - Metrics
  - attributed patients
- ACO transition to Next Gen
  - Defining covered population
  - Allocating savings/losses to HSA regions
- Global budget/capitation: all payer waiver
  - Who pay to?
  - Allocation to MD's, hospitals, other providers
- Evolution of regional structure: UCC to AHC

Examples for Payment Agenda

- Align PCP payment: enhanced population health metrics in HSA component of Blueprint model
- Population based global budget for ACH
  - Payment for infrastructure and reinvestment
  - Build on UCC structure
  - One element of AHC pilot

Examples for Payment Agenda

- Test enrollment model
  - Commercial: self insured, VT connect
  - Medicaid
  - Medicare: Next Gen ACO, Medicare Advantage
- Align specialty care compensation
  - Physicians
  - Bundled payments