

VHCIP Steering Committee Update

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
General:				
		Project will be implemented statewide	Complete	
Payment Models:				
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.
Outreach:				
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	
Health Data Infrastructure:				
VHCURES:		<ul style="list-style-type: none"> Update rule to include VHC information (Fall 2013) Incorporate Medicare data (Fall 2013) Improve data quality procedures (Fall 2014) Improve data access to support analysis (Fall 2014) 	<ol style="list-style-type: none"> 1. Not met 2. Implemented 3. Implemented 4. Implemented 	Remove #1- no plan to update the VHCURES rule at this time.
Clinical Data: <ul style="list-style-type: none"> Medication history and provider portal to query the VHIE by end of 2013 State law requires statewide availability of Blueprint program and its IT infrastructure by October 2013 		<ul style="list-style-type: none"> Medication history and provider portal to query the VHIE by end of 2013 State law requires statewide availability of Blueprint program and its IT infrastructure by October 2013 	Complete	
Medicaid Data: <ul style="list-style-type: none"> A combined advanced planning document for the funding to support the TMSIS is completed and submitted to CMS in July 2013 			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"> Update all payer claims data base rule incorporating VHC information Enhance current database with new VHC information As needed collect data directly from VHC payers. 			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"> Process for payer approval 			Complete	
Ensure provider, consumer and payer buy-in during measure selection: <ul style="list-style-type: none"> Identification of additional mechanisms for obtaining provider and consumer representation, input and buy-in 			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"> Establish target-setting process, routine assessment process, and analytic framework and reports 			Complete	
Learning Collaboratives/Care Delivery Transformation				
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	
Evaluation:				
Procure contractor	Contract for internal evaluation	Hire through GCMCB in Sept 2013	Complete	

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
Payment Model Implementation Activities:				
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.
Provider Targets:				
Number of Blueprint practice providers participating in one or more testing models	goal = 500		628-Complete	
Initiative Support:				
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
Workforce (Note: in new framework, these activities are in Care Delivery and Practice Transformation)				
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	

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
Payment Models:				
	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	
Health Data Infrastructure:				
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.
Quality Measurement:				
EOC/Bundle-specific measurement activities		Establish measure criteria (November 2013). Identify potential measures (December 2013 through February 2014).	Not Met	
Evaluation:				
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

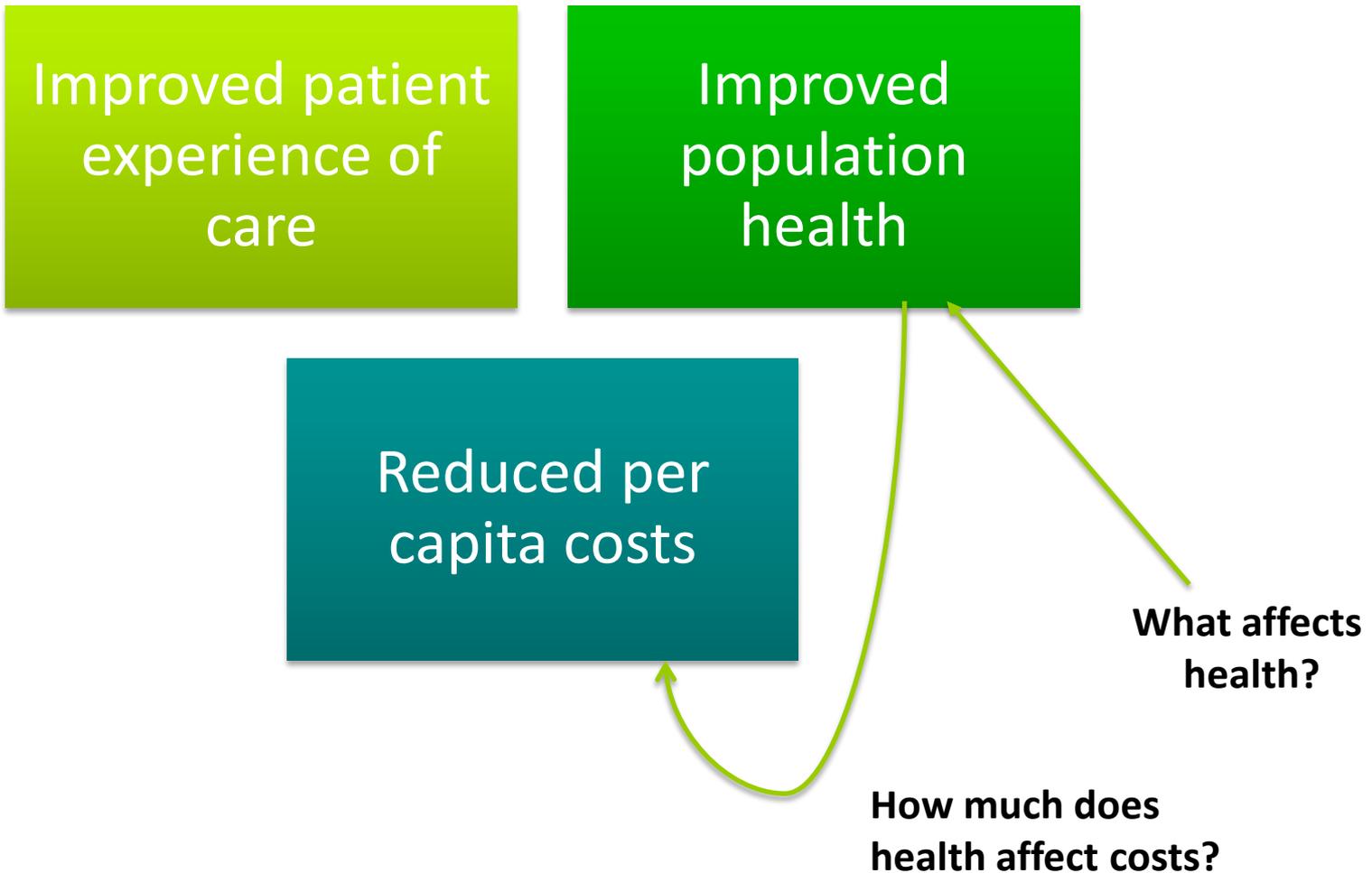
Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Progress through 3/31/15
Consult with performance measures work group	Number of meetings held with performance measures WG on evaluation (goal = 2)		Not Met	
Input baseline data	Baseline data identified		Not Met	
Provider Targets:		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

Alignment Presentation

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

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?

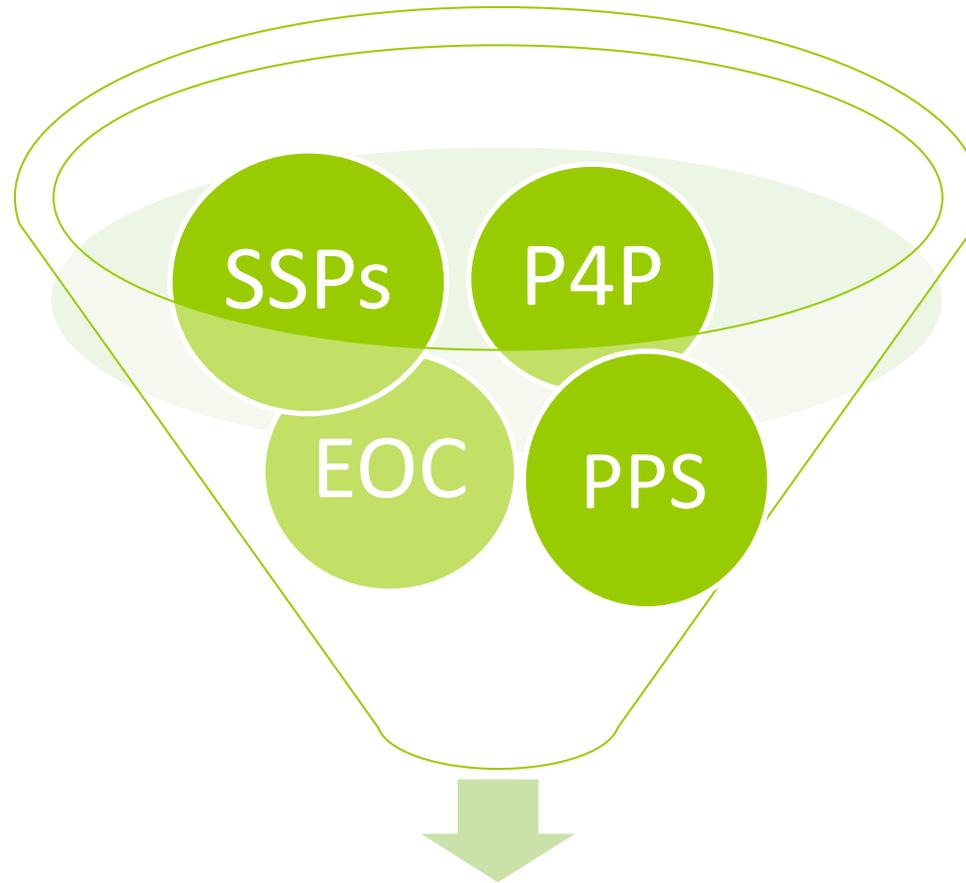
- The all-payer model/system will encourage providers to strengthen their relationships with patients and better coordinate care for Vermonters.
- The system will have incentives to promote health and support Vermonters in choosing healthier behaviors.
- The system will allow Vermonters to better understand 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.