

# Steering Committee Meeting

Agenda 4-1-15

**Vermont Health Care Innovation Project  
Steering Committee Meeting Agenda**

**April 1, 2015, 1:00pm-3:00 pm**

*Vermont League of Cities and Towns, City Center Building – 1<sup>st</sup> Floor, 89 Main Street, Montpelier, VT*

**Call-In Number: 1-877-273-4202; Passcode: 8155970**

<b>Item #</b>	<b>Time Frame</b>	<b>Topic</b>	<b>Presenter</b>	<b>Relevant Attachments</b>	<b>Action Needed?</b>
1	1:00-1:05pm	Welcome and Introductions	Al Gobeille and Steven Costantino		
2	1:05-1:10pm	Core Team Update: a. Mid-project risk assessment <i>Public comment</i>	Lawrence Miller		
3	1:10-1:15pm	Minutes Approval	Al Gobeille and Steven Costantino	Attachment 1: Draft February Meeting Minutes	Approval of Minutes
4	1:15-1:30pm	Updates: HIE Work Group <ul style="list-style-type: none"> <li>• ACO Gateway and Event Notification System Projects</li> <li>• DA/SSA Data Repository</li> </ul> <i>Public comment</i>	<ul style="list-style-type: none"> <li>• Simone Rueschemeyer</li> <li>• Georgia Maheras</li> </ul>		
5	1:30-2:20pm	Work Group Policy Recommendations <ul style="list-style-type: none"> <li>• Proposed Changes to Year 2 VMSSP Gate &amp; Ladder Methodology</li> </ul> <i>Public comment</i>	Alicia Cooper	Attachment 2a: Year 2 VMSSP Gate & Ladder Presentation Attachment 2b: Memo: Proposed Year 2 VMSSP Gate & Ladder Methodology Attachment 2c: Memo from QPM Work Group: Year 2 ACO Payment Measure Targets & Benchmarks	Approval of Changes to Year 2 VMSSP Gate & Ladder Methodology
6	2:20-2:50pm	Population Health Work Group Update: Population Health Plan <i>Public comment</i>	Tracy Dolan	Attachment 3a: Population Health Integration in VHCIP Attachment 3a: VHCIP Population Health Plan Table of Contents	
7	2:50-3:00pm	Next Steps, Wrap-Up and Future Meeting Schedule	Al Gobeille and Steven Costantino	Next Meeting: April 29, 2015, 1:00pm-3:00pm, Williston	

# Attachment 1

## February Minutes

## **VT Health Care Innovation Project Steering Committee Meeting Minutes**

### **Pending Committee Approval**

**Date of meeting:** Wednesday, February 25, 2015; 1:00-3:00 pm, EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
<b>1. Welcome and Introductions</b>	Al Gobeille called the meeting to order at 1:03 pm.	
<b>2. Core Team Update</b>	Al Gobeille and Lawrence Miller bid farewell to former DVHA Commissioner Mark Larson and welcomed new DVHA Commissioner and Steering Committee Co-Chair Steven Costantino. Attendees introduced themselves.	
<i>Public Comment</i>	No public comments were offered.	
<b>3. Minutes Approval</b>	John Evans moved to approve the minutes from the November Steering meeting. Trinka Kerr seconded. A roll call vote was taken and the motion passed with three abstentions.	
<b>4. 2014 Year in Review: Progress and Major Activities</b>	Georgia Maheras presented and update to the VHCIP (Attachment 2). <ul style="list-style-type: none"> <li>• Slide 10 correction: 197 provider sites connected to the HIE.</li> <li>• State HIT system that is utilized by providers: VITL access launched last year.</li> <li>• EHR adoption rate is around 87%</li> <li>• Update to slide 13: over 92 attendees at the first Learning Collaborative.</li> </ul>	
<i>Public comment</i>	No public comments were offered.	
<b>5. Discussion: Steering Committee Roles and Decision-Making Process</b>	Al Gobeille discussed the role of the Steering Committee (Attachment 3).  The role of the Steering Committee should not be repetitive of work group efforts but guide the Core Team in decision making. The group discussed criteria presented in the memo.	

Agenda Item	Discussion	Next Steps
	<p>The Committee should consider the following:</p> <ul style="list-style-type: none"> <li>• That proposals being received from the work group are going to achieve the goals of the SIM grant.</li> <li>• If the proposal affects any other work group and considered the impact on the goals of other work groups – the Committee should make sure the work groups are all moving in alignment.</li> <li>• Steering Committee can make requests back to work group to revise proposals before they can make recommendations to the Core Team.</li> <li>• Steering Committee should reflect upon the work group’s voting status and whether there was a strong consensus.</li> <li>• Understanding that the work group is where the work should happen. Steering is not the environment where issues should be worked through and proposals should not come to Steering without that understanding. Concerns about feasibility of this with more time sensitive issues.</li> <li>• Reform initiatives are a result of voluntary stakeholders which often results in considerable effort within the work groups.</li> <li>• Work group staff have access to all work group work plans which will support timeliness and work group alignment.</li> <li>• Work groups are looking to the Steering Committee for oversight and guidance in this arena.</li> <li>• The proposal puts Steering in oversight of the process, verses substance, which is better suited for the work groups and Core Team.</li> </ul> <p><i>Public comment</i></p> <p>No further comments were offered.</p>	
<p><b>6. Work Group Policy Recommendation</b></p>	<ol style="list-style-type: none"> <li>1. Erin Flynn presented the Proposed ACO Care Management Standards as approved by the Care Models and Care Management work group (Attachment 4). <ul style="list-style-type: none"> <li>• There were two votes against this proposal in the CMCM work group.</li> <li>• ACOs are looking for the standards to be aspirational guidelines and want to understand how the standards are going to be measured and how are they going to be held accountable. <ul style="list-style-type: none"> <li>▪ Measurement and accountability will be agreed upon officially under the ACO contracts.</li> </ul> </li> <li>• The language in the current proposal is written in the form of a recommendation and is not a mandate.</li> <li>• This work is not applicable to those providers who are not participating in an ACO.</li> <li>• The standards are a collaborative effort between ACO representatives as well as payers.</li> <li>• Referring to the process discussed in agenda item 4, the group agreed that the proposal met the criteria presented in Attachment 2, section 1 b.</li> </ul> </li> </ol> <p>Dale Hackett moved to recommend the standards presented to the Core Team. Tracy Dolan seconded. A roll call vote was taken. The motion passed with two votes against it.</p>	

Agenda Item	Discussion	Next Steps
<p><b>Public comment</b></p>	<p>2. Georgia Maheras presented a letter to the Governor regarding DLTS Funding (Attachment 5).</p> <p>Trinka Kerr moved to recommend the DLTS letter to the Core Team. Nancy Eldridge seconded. The motion passed with six abstentions.</p> <p>No further comments were offered.</p>	
<p><b>7. Work Group Funding Proposals</b></p> <p><b>Public comment</b></p>	<p>1. Georgia Maheras presented the Frail Elders Proposal (Attachment 6a), which addressed concerns raised at the previous meeting. Changes include:</p> <ul style="list-style-type: none"> <li>• Extending project timeline to six months.</li> <li>• Scope expanded which increased the project budget. The budget increase is covered by unallocated money under the SIM grant.</li> <li>• Referring to the process discussed in agenda item 4, the group agreed that the proposal met the criteria presented in Attachment 2, section 1 b.</li> <li>• It was noted that DAIL policy staff support this proposal.</li> </ul> <p>Nancy moved to recommend the proposal to the Core Team and Allan Ramsay seconded. A roll call vote was taken and the motion passed unanimously.</p> <p>2. Jim Hester Contract</p> <ul style="list-style-type: none"> <li>• Tracy Dolan presented Attachment 6b which proposed to amend the current SIM contract with Jim Hester.</li> <li>• Referring to the process discussed in agenda item 4, the group agreed that the proposal met the criteria presented in Attachment 2, section 1 b.</li> </ul> <p>Allan Ramsay moved to recommend the proposal to the Core Team. Dale Hackett seconded. A roll call vote was taken and the motion passed unanimously.</p> <p>No further comments were offered.</p>	
<p><b>8. Next Steps, Wrap Up and Future Meeting Schedule</b></p>	<p><b>Next Meeting:</b> Wednesday, April 1, 2015 1:00 pm – 3:00 pm, Montpelier – location TBA</p>	

Attachment 2a

Year 2 VMSSP Gate & Ladder  
Presentation

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# Proposed Changes to the Year 2 VMSSP Gate & Ladder Methodology

VHCIP Steering Committee  
April 1, 2015

# Overview

- Review
  - Year 1 Payment Measures
  - Year 1 Benchmarks & Targets
  - Year 1 Gate & Ladder Methodology
- Approved Changes to Year 2 Payment Measures
- Work Group Input & Votes
- Proposed Changes to Year 2 Performance Benchmarks & Target
- Proposed Changes to Year 2 VMSSP Gate & Ladder Methodology
- Additional Considerations

# Year 1 Payment Measures

Year 1 Payment Measure		Medicaid SSP	Commercial SSP
<b>Core-1</b>	Plan All-Cause Readmissions	X	X
<b>Core-2</b>	Adolescent Well-Care Visits	X	X
<b>Core-3</b>	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	X	X
<b>Core-4</b>	Follow-Up After Hospitalization for Mental Illness: 7-day	X	X
<b>Core -5</b>	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	X	X
<b>Core-6</b>	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	X	X
<b>Core-7</b>	Chlamydia Screening in Women	X	X
<b>Core-8</b>	Developmental Screening in the First Three Years of Life	X	

# Year 1 Benchmarks

	Medicaid SSP	Commercial SSP
<b>Approach: Use national HEDIS benchmarks for all measures for which they are available; use improvement targets when national benchmarks are unavailable</b>	Core 2-7: National Medicaid HEDIS benchmarks  Core 1 & 8: Improvement targets based on 2012 VT Medicaid performance	Core 1-7: National commercial HEDIS benchmarks

# Year 1 Performance Targets

- *When using National HEDIS Benchmarks:*

Compare each payment measure to the national benchmark and assign 1, 2 or 3 points based on whether the ACO is at the national 25<sup>th</sup>, 50<sup>th</sup> or 75<sup>th</sup> percentile for the measure.

- *When using Improvement Targets:*

Compare each payment measure to VT Medicaid benchmark, and assign 0, 2 or 3 points based on whether the ACO declines, stays the same, or improves relative to the benchmark.

- Statistical significance; targets associated with each point value are set according to ACO-specific attribution estimates

National HEDIS Benchmarks		Improvement Targets: Change Relative to Historic Performance	
25 <sup>th</sup> Percentile	1 Point	Statistically significant decline	0 Points
50 <sup>th</sup> Percentile	2 Points	Statistically same	2 Points
75 <sup>th</sup> Percentile	3 Points	Statistically significant improvement	3 Points

# Year 1 Gates & Ladders

Percentage of available points	Percentage of earned savings: <b>COMMERCIAL</b>	Percentage of available points	Percentage of earned savings: <b>MEDICAID</b>
55%	75%	35%	75%
60%	80%	40%	80%
65%	85%	45%	85%
70%	90%	50%	90%
75%	95%	55%	95%
80%	100%	60%	100%

# Approved Year 2 Payment Measures

Year 2 Payment Measure		Medicaid SSP	Commercial SSP
<b>Core-1</b>	Plan All-Cause Readmissions	X	X
<b>Core-2</b>	Adolescent Well-Care Visits	X	X
<b>Core-3</b>	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	X	X
<b>Core-4</b>	Follow-Up After Hospitalization for Mental Illness: 7-day	X	X
<b>Core -5</b>	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	X	X
<b>Core-6</b>	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	X	X
<b>Core-7</b>	Chlamydia Screening in Women	X	X
<b>Core-8</b>	Developmental Screening in the First Three Years of Life	X	
<b>Core-12</b>	Ambulatory Care Sensitive Condition Admissions: PQI Composite	X	X
<b>Core-17</b>	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	X	X

# QPM Discussion & Recommendation

- The Payment Models Work Group requested input from the Quality and Performance Measures Work Group regarding the selection of benchmarks and the setting of performance targets for the Year 2 ACO Payment Measures used for the Commercial and Medicaid Shared Savings Programs
- After several months of discussion, the Quality and Performance Measures Work Group members voted (during their 12/29/14 meeting) to recommend continued use of the Year 1 approach, with adaptations to accommodate new Payment measures

# Proposed Year 2 Benchmarks & Targets

	Medicaid SSP	Commercial SSP
<b>Approach: Use national HEDIS benchmarks for all measures for which they are available; use improvement targets when national benchmarks are unavailable</b>	<p>Core 2-7, <b>17</b>: National Medicaid HEDIS benchmarks</p> <p>Core 1, 8, <b>12</b>: Improvement targets based on ACO-specific Year 1 Medicaid performance</p>	<p>Core 1-7, <b>17</b>: National commercial HEDIS benchmarks</p> <p>Core <b>12</b>: Improvement targets based on ACO-specific Year 1 commercial performance</p>

National HEDIS Benchmarks		Improvement Targets: Change Relative to Historic Performance	
25 <sup>th</sup> Percentile	1 Point	Statistically significant decline	0 Points
50 <sup>th</sup> Percentile	2 Points	Statistically same	2 Points
75 <sup>th</sup> Percentile	3 Points	Statistically significant improvement	3 Points

# PMWG Discussion & Recommendation

- The Payment Models Work Group solicited public comment regarding modifications to the Gate & Ladder methodology for Year 2 of the Commercial and Medicaid Shared Savings Programs
- After several months of discussion, the Payment Models Work Group members (during their 3/16 meeting) voted—*with the support of the ACOs*—to recommend a number of modifications to the VMSSP Gate & Ladder methodology for Year 2
  - There were no proposals to change the Commercial methodology for Year 2

# Proposed Year 2 Gate & Ladder: Commercial

Percentage of available points	Percentage of earned savings: <b>COMMERCIAL</b>
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

- No change from Year 1

# Proposed Year 2 Gate & Ladder: Medicaid

Points earned (out of 30 possible points)	Percentage of earned savings: <b>MEDICAID</b>
16-17	75%
18	80%
19-20	85%
21	90%
22-23	95%
≥24	100%

- Convert from percentage to absolute points earned
- Increase Gate (to ~55%)
- Allow ACOs to earn additional “Improvement Points”

# For Steering Committee Consideration

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

# For Steering Committee Consideration

- Is the recommendation inconsistent with any other policy or funding priority that has been put in place within the VCHIP project?
  - No; modification to the VMSSP methodology was anticipated beyond Year 1.
- Has the recommendation been reviewed by all appropriate workgroups?
  - There has been formal input from both QPM and PMWG. After three months of discussion, the PMWG voted unanimously to recommend the proposed changes to the Steering Committee with three abstentions.

# Attachment 2b

## Proposed Year 2 VMSSP Gate & Ladder Methodology

## MEMO

DATE: March 16, 2015

TO: VHCIP Steering Committee

FROM: VHCIP Payment Models Work Group

RE: Proposed Year 2 VMSSP Gate & Ladder Methodology

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Based on feedback received during the public comment period and recommendations from the Quality and Performance Measures Work Group regarding payment measure targets and benchmarks (*see Memo dated December 29, 2014*), as well as recent changes to the Medicare Shared Savings Program, the PMWG members have voted to endorse the following changes to the Gate & Ladder methodology for Year 2 of the Vermont Medicaid Shared Savings Program (VMSSP). These changes:

- 1. Increase the minimum quality performance threshold for shared savings eligibility;**
- 2. Include the use of absolute points earned in place of a percentage of points earned to eliminate the need for rounding; and**
- 3. Allow ACOs to earn “bonus” points for significant quality improvement in addition to points earned for attainment of quality relative to national benchmarks.**

The proposed framework assumes that the VMSSP in Year 2 will use the 10 measures approved for Payment by the VHCIP Core Team and the GMCB, and that ACOs will be eligible to earn a maximum of 3 points per measure for a total of 30 possible points. ACOs would have to earn at least 16 out of 30 points to be eligible for any earned shared savings. If an ACO earns 24 or more points, they would be eligible to receive 100% of earned shared savings.

<b>Points Earned (out of 30 possible points)</b>	<b>Percentage of Points Earned</b>	<b>Percentage of Earned Shared Savings</b>
16-17	53.3-56.7	75
18	60.0	80
19-20	63.3-66.7	85
21	70.0	90
22-23	73.3-76.7	95
≥24	≥80.0	100

In addition to earning points for attainment of quality relative to national benchmarks, ACOs would be eligible to earn one additional point for every measure that is compared to a national benchmark for which they improved significantly relative to the prior program year. “Bonus” improvement points will not be available for measures that already use ACO-specific improvement targets instead of national benchmarks (see table below). As such, an ACO could earn up to 7 “bonus” points for improvement; however, no ACO may earn more than the maximum 30 possible points.

This approach will further strengthen the incentives for quality improvement in the VMSSP by providing ACOs with both external quality attainment targets (in the form of national benchmarks) and internal quality improvement targets (by rewarding change over time).

Year 2 Payment Measure		VMSSP Benchmark Method	Eligible for “Bonus” Improvement Point
<b>Core-1</b>	Plan All-Cause Readmissions	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	
<b>Core-2</b>	Adolescent Well-Care Visits	National Medicaid HEDIS benchmarks	X
<b>Core-3</b>	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	National Medicaid HEDIS benchmarks	X
<b>Core-4</b>	Follow-Up After Hospitalization for Mental Illness: 7-day	National Medicaid HEDIS benchmarks	X
<b>Core -5</b>	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	National Medicaid HEDIS benchmarks	X
<b>Core-6</b>	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	National Medicaid HEDIS benchmarks	X
<b>Core-7</b>	Chlamydia Screening in Women	National Medicaid HEDIS benchmarks	X
<b>Core-8</b>	Developmental Screening in the First Three Years of Life	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	
<b>Core-12</b>	Ambulatory Care Sensitive Condition Admissions: PQI Composite	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	
<b>Core-17</b>	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	National Medicaid HEDIS benchmarks	X

Note: Core-1, Core-8, and Core-12 will be ineligible for additional improvement points because these measures are already using ACO-specific change-over-time improvement targets. If national Medicaid benchmarks become available for any of these measures in future, the measures may then become eligible for additional improvement points.

**Example**

Year 2 Payment Measure		Year 1	Y1 Attainment Points	Year 2	Y2 Attainment Points	Y2 Improvement Points
<b>Core-1</b>	Plan All-Cause Readmissions	15.4	2	15.2	2	
<b>Core-2</b>	Adolescent Well-Care Visits	50.9	2	57.7	2	1
<b>Core-3</b>	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	75.9	0	80.4	1	1
<b>Core-4</b>	Follow-Up After Hospitalization for Mental Illness: 7-day	33.6	1	34.8	1	0
<b>Core -5</b>	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	52.4	3	49.5	3	0
<b>Core-6</b>	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	27.3	2	29.7	2	0
<b>Core-7</b>	Chlamydia Screening in Women	47.0	0	47.6	0	0
<b>Core-8</b>	Developmental Screening in the First Three Years of Life	28.2	2	36.3	3	
<b>Core-12</b>	Ambulatory Care Sensitive Condition Admissions: PQI Composite	18.8		17.2	2	
<b>Core-17</b>	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	43.1		38.9	2	1
<b>Sub-Total</b>			<b>12</b>		<b>18</b>	<b>3</b>
<b>Total Points</b>			<b>12/24</b>		<b>21/30</b>	

Statistically significant improvement in Year 2 relative to Year 1 for three eligible measures results in the ACO being awarded 3 “bonus” improvement points. These points are added to the 18 points the ACO receives for quality performance relative to benchmarks, yielding a total of 21 points out of the total possible 30 points.

In the case of Core-3 (LDL-C Screening), the ACO improves from below the national 25<sup>th</sup> percentile to the national 25<sup>th</sup> percentile, and therefore earns a point for attaining a higher target relative to national benchmarks. This improvement also represents significant improvement relative to the ACO’s performance in the prior year, resulting in an additional improvement point for this measure.

In the case of Core-2 (Adolescent Well-Care Visits), the ACO does not improve enough to meet the national 75<sup>th</sup> percentile, but achieves significant improvement relative to the ACO’s performance in the prior year. Thus, the ACO is still awarded for significant improvement, and continues to have an incentive to improve relative to national benchmarks.

### *Methodological Considerations*

This methodology would award an ACO up to 1 additional bonus point for quality performance improvement on each Payment measure that is being compared to a National benchmark. These bonus points would be added to the total points that the ACO achieved for each Payment measure based on the ACO's performance relative to National benchmarks. Under this proposal, the total possible points that could be achieved, including up to 7 bonus points, could not exceed the current maximum 30 total points achievable.

For each qualifying measure, the state or its designee would determine whether there was a significant improvement or decline between the performance year and the prior year by applying statistical significance tests<sup>1</sup>, assessing how unlikely it is that the differences of a magnitude as those observed would be due to chance when the performance is actually the same. Using this methodology, we can be certain at a 95 percent confidence level that statistically significant changes in an ACO's quality measure performance for the performance year relative to the prior program year are not simply due to random variation in measured populations between years.

The awarding of bonus points would be based on an ACO's net improvement on qualifying Payment measures and would be calculated by determining the total number of significantly improved measures and subtracting the total number of significantly declined measures. Bonus points would be neither awarded nor subtracted for measures that were significantly the same. The awarding of bonus points would not impact how ACOs are separately scored on Payment measure performance relative to national benchmarks.

Consistent with the current VMSSP methodology, the total points earned for Payment measures, including any bonus quality improvement points, would be summed to determine the final overall quality performance score and savings sharing rate for each ACO.

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<sup>1</sup> VMSSP would use the same methodology for calculating significance (t-test) as MSSP.

## Attachment 2c

Memo from QPM Work Group:  
Year 2 ACO Payment Measure  
Targets & Benchmarks

## MEMO

DATE: December 29, 2014

TO: VHCIP Payment Models Work Group

FROM: VHCIP Quality & Performance Measures Work Group

RE: Request for Input – Year 2 ACO Payment Measure Targets & Benchmarks

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In response to the Payment Models Work Group's request for input regarding the selection of benchmarks and the setting of performance targets for the Year 2 ACO Payment Measures used for the Commercial and Medicaid Shared Savings Programs, the Quality and Performance Measures Work Group members voted in favor (with 2 votes in opposition) of the following recommendations:

### Year 2 Benchmarks:

- Use national HEDIS benchmarks for all measures for which they are available; use ACO-specific change-over-time improvement targets when national benchmarks are unavailable:

Year 2 Payment Measure		Medicaid SSP	Commercial SSP
Core-1	Plan All-Cause Readmissions	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	National commercial HEDIS benchmarks
Core-2	Adolescent Well-Care Visits	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks
Core -5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks
Core-7	Chlamydia Screening in Women	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks
Core-8	Developmental Screening in the First Three Years of Life	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	NA
Core-12	Ambulatory Care Sensitive Condition Admissions: PQI Composite	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	Improvement targets based on ACO-specific Year 1 commercial SSP performance
Core-17	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks

## Year 2 Performance Targets

- Use the same methodology that was used in Year 1 for assigning points for performance, such that ACOs may earn a maximum of 3 points for each Payment measure:

National HEDIS Benchmarks		Improvement Targets: Change Relative to Historic Performance	
25 <sup>th</sup> Percentile	1 Point	Statistically significant decline	0 Points
50 <sup>th</sup> Percentile	2 Points	Statistically same	2 Points
75 <sup>th</sup> Percentile	3 Points	Statistically significant improvement	3 Points

# Attachment 3a

## Population Health Integration in VHCIP

# Population Health Integration in the Vermont Health Care Innovation Project

The Vermont Health Care Innovation Project (the Project) is testing new payment and service delivery models as part of larger health system transformation to deliver Triple Aims outcomes of better care, lower costs and improved health. The charge of the Population Health Work Group (PHWG) is to recommend ways the Project could better coordinate population health improvement activities and more explicitly improve population health<sup>1</sup>.

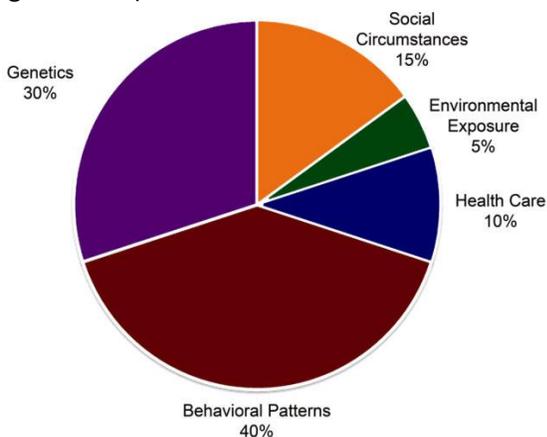
To accomplish the charge of integration of population health and primary prevention within the models being tested in Vermont, the PHWG is committed to several key tasks:

- Develop consensus on a robust set of population health measures to be used in tracking the outcomes of the Project and to be incorporated in the new payment models.
- Offer recommendations on how to pay for population health and prevention through modifications to proposed health reform payment mechanisms.
- Identify promising new financing vehicles that promote financial investment in population health interventions.
- Identify opportunities to enhance current initiatives and health delivery system models (e.g. the Vermont Blueprint for Health and Accountable Care Organizations) to improve population health by better integration of clinical services, public health programs and community based services at the practice and community levels. One potential model is an Accountable Communities for Health.
- Develop the “Plan for Integrating Population Health and Prevention in VT Health Care Innovation.”

## Frameworks to Guide Population Health

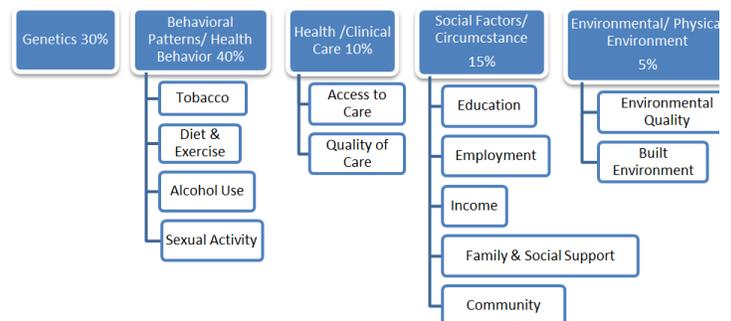
To meet the Triple Aim of moderating cost, improving quality and improving health, increasing access to health care will be insufficient. Access to health care and the quality of medical care account for 10% proportionately to the factors that contribute to premature death (see Figure 1). Therefore, we must seek opportunities to address the multiple factors affecting health outcomes (see Figure 2).

Figure 1: Proportional Contribution to Premature Death



Source: Schroeder, Steven. N Engl J Med 2007;357:1221-8  
Adapted from: McGinnis JM, et.al. *The Case for More Active Policy Attention to Health Promotion*. Health Aff (Millwood) 2002;21(2):78-93.

Figure 2: Factors Affecting Health Outcomes



County Health Rankings adapted to include genetics and McGinnis weighting of factors  
<http://www.countyhealthrankings.org/our-approach>

<sup>1</sup> Population Health is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group” (Kindig and Stoddart, 2003)... While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors. **Institute Of Medicine, Roundtable on Population Health Improvement**  
<http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx>

# Population Health Integration in the Vermont Health Care Innovation Project

## Signs of Successful Integration of Population Health in New Models

### Focus on the Whole Population in an area, not just attributed patients

- Use data on health trends and burden of illness to identify priorities and target evidence-based actions that have proven successful in preventing diseases and changing health outcomes.
- Expand efforts to maintain or improve the health of all people – young, old, healthy, sick, etc. Focus specific attention on the health and wellness of subpopulations most vulnerable in the future due to disability, age, income and other factors.

### Focus on Prevention, Wellness and Well-Being by Patient, Physician and System

- Focus on primary prevention<sup>i</sup> and actions taken to maintain wellness rather than solely on identifying and treating disease and illness.
- Utilize proven evidence-based prevention strategies to address risk and protective factors<sup>ii</sup> and personal health behaviors such as tobacco use, diet and exercise, alcohol use, sexual activity, as well as other health and mental health conditions that are known to contribute to health outcomes.

### Address the Multiple Contributors to Health Outcomes

- Support integrated approaches that recognize the interconnection between physical health, mental health and substance abuse.
- Identify the social determinants of health<sup>iii</sup> and circumstances in which people are born, live, work, and age (e.g. education, employment, income, family support, community, the built and natural environment).

### Create Accountability for Health

- Use measures of quality and performance at multiple levels of change to ensure accountability in system design and implementation for improved population health.
- Build upon existing infrastructure (Blueprint Medical Homes, Community Health Teams, Accountable Care Organizations and public health programs) to connect community resources for health in a geographic area.
- Include partners and resources able to influence the determinants of health and the circumstances in which people live, work and play.

### Create Sustainable Funding Models Which Support and Reward Improvements in Population Health including Primary Prevention and Wellness

- Incentivize payers and health systems to invest in community-wide prevention efforts and to encourage delivery of physical health, mental health and substance use prevention services
- Direct savings, incentives and investments to efforts aimed at primary prevention and wellness including efforts that address the social determinants of health (e.g. housing, transportation, education).
- Develop budgets that explicitly demonstrate spending and/or investments in prevention and wellness.

Identify long and short term multi-sector impacts and capture a portion of those benefits for reinvestment

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<sup>i</sup> Primary prevention aims to prevent disease from developing in the first place. Secondary prevention aims to detect and treat disease that has not yet become symptomatic. Tertiary prevention is directed at those who already have symptomatic disease, to prevent further deterioration, recurrent symptoms and subsequent events. Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier.

<sup>ii</sup> [http://www.who.int/hiv/pub/me/en/me\\_prev\\_ch4.pdf](http://www.who.int/hiv/pub/me/en/me_prev_ch4.pdf)

<sup>iii</sup> (<http://www.cdc.gov/socialdeterminants/>).

**Attachment 3b**

**VHCIP Population Health Plan**

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