

VHCIP Workforce
Work Group
Agenda 6-24-15

***VT Health Care Innovation Project
Health Care Workforce Work Group Meeting Agenda***

**Wednesday, June 24, 2015; 3:00-5:00pm
Vermont State College, Conference Room 101**

575 Stonecutters Way, Montpelier

Call-in Number: 1-877-273-4202; Conference ID: 420-323-867

Item #	Time Frame	Topic	Presenter	Decision Needed? (Y/N)	Relevant Attachments (describe document type: powerpoint, word, excel, etc...)
1	3:00-3:05	Welcome and Introductions	Mary Val Palumbo Robin Lunge	N	<ul style="list-style-type: none"> • <u>Attachment 1: 6-24-15 Meeting Agenda</u>
2	3:05-3:10	Approval of Meeting Minutes	Mary Val Palumbo Robin Lunge	Y	<ul style="list-style-type: none"> • <u>Attachment 2: 4-22-15 Meeting Minutes</u>
3	3:10-3:20	Updates: <ul style="list-style-type: none"> - Demand Modeling update - status of workforce-related initiatives/grants around the state - Issues to watch 	Mary Val Palumbo Robin Lunge Group Discussion	N	
4	3:20 – 4:05	Payment Models updates and discussion: <ul style="list-style-type: none"> - ACO Shared Savings Program - Episodes of Care - Blueprint - Pay for Performance 	Alicia Cooper Jenney Samuelson	N	<ul style="list-style-type: none"> • <u>Attachment 4a – PMWG Update (SSP and EOC)</u> • <u>Attachment 4b – VT ACO SSP Table</u> • <u>Attachment 4c – BP P4P Update (forthcoming)</u>
5	4:05-4:50	Discussion and Review: Strategic Plan	Charlie MacLean – Group Discussion	N	<ul style="list-style-type: none"> • <u>Attachment 5– Strategic Plan Priorities Matrix</u>
6	4:50-5:00	Public Comment/Wrap Up/Next Steps	Mary Val Palumbo Robin Lunge	N	

Attachment 2

April 22, 2015

Minutes

Vermont Health Care Innovation Project Workforce Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, April 22, 3:00-5:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Mary Val Palumbo called the meeting to order at 3:03pm. A roll call attendance was taken and a quorum was not present.	
2. Approval of February Meeting Minutes	Approval of the February minutes was delayed due to lack of a quorum; the Work Group will vote on the February meeting minutes at the June Workforce Work Group meeting, assuming a quorum is present.	
3. Updates: Demand Modeling; Strategic Plan; Workforce-Related Initiatives/Grants around the State	<p><i>Demand Modeling Update:</i> Amy Coonradt provided an update. The Department of Vermont Health Access (DVHA) has received five bids for the Demand Modeling work; Amy, Charlie MacLean, Mat Barewicz, Jess Mendizabal, and Georgia Maheras are on the bid review team and will receive demonstrations from bidders in the next few weeks. Janet Kahn raised a concern: Demand modeling may not include professions that have not historically been part of the health care workforce (for example, acupuncturists). Dawn Philibert noted that Mat Barewicz would be better able to speak to this. Amy noted that the scope of work for the Demand Modeling RFP includes alternative medicine professions, and many bidders responded to this item.</p> <p><i>Strategic Plan Update:</i> Mary Val provided an update on work to update the Workforce Strategic Plan. A sub-committee to discuss updates to the Strategic Plan has now met three times. It will soon be ready for input from the rest of the Work Group; Amy will distribute the revised plan to Work Group members by the end of May. Mary Val requested member input on the plan before the June meeting. (The sub-committee will also request specific feedback from members with expertise in particular areas.) Amy will compile comments for discussion and a vote at the June Work Group meeting; after which the approved plan will be presented back to the Green Mountain Care Board (GMCB).</p> <p><i>Workforce-Related Initiatives/Grants around the State:</i> Mary Val pushed this topic to Item #7.</p>	Members will receive an updated version of the Workforce Strategic Plan by the end of May, and will be asked to provide input on the Workforce Strategic Plan for discussion at the June Workforce Work Group meeting.

Agenda Item	Discussion	Next Steps
<p>4. Discussion/ Inventory of Workforce-Related Surveys around VT</p>	<p>Mary Val Palumbo introduced this agenda item, which rose out of Strategic Plan revisions. Mary Val requested attendees share information on work at their organizations or agencies to collect information on workforce demand.</p> <ul style="list-style-type: none"> • Bi-State Primary Care Association is collecting self-reported vacancy information for primary care providers and some specialists in non-primary care specialties. This is typically information collected via phone, but it is not a global survey – only practices that have requested to participate. • The Area Health Education Center (AHEC) has a workforce specialist that tracks vacancies around the state with the purpose of placing residents who are graduating and seeking jobs, or to place others who “owe” time to the state based on participation in programs like Educational Loan Repayment. It was noted that this is a supply survey and does not contain vacancies, but benchmarks. • The Vermont Psychological Association, in partnership with the Social Work Association and Counselors Association, is developing an online survey of membership to assess whether membership are practicing full- or part-time providing mental health services in private practice. (Mary Val points out that this is supply data.) • Peter Cobb will seek information on current demand information collection at VNAs of Vermont. Local VNAs post job information on the VNAs of Vermont website, but no analysis has ever been performed. Peter will request an analysis from human resources. • Mary Val noted that the nursing survey, a phone interview of 11 of 14 hospital HR departments, was conducted last year. This is published on the AHEC website. That survey will be repeated this year. • Dawn Philibert noted that the Department of Health (VDH) is also collecting supply-side data through licensure. • Stephanie Pagliuca volunteered to reach out to Vermont Association of Hospital and Health Systems (VAHHS) to inquire about their survey activities. • What about alcohol and drug treatment providers? Madeleine Mongan suggested that someone reach out to the Designated Agencies (DAs). Dawn Philibert noted that there’s current legislation about a registry of substance abuse providers that is of concern for VDH because it would represent a significant reporting and maintenance burden. • Lori Lee Schoenbeck noted that there are areas where there is demand for naturopathic providers where there are no providers or providers are overwhelmed with demand – how is this need assessed? How do we survey a community of prospective patients about demand? Madeleine Mongan suggested surveying practices about vacancies. • Ellen Grimes suggested that demand data for dentistry may be off – there is unmet need, but graduating students are not finding openings. It was noted that both VDH’s dental division and the dental society both track supply and demand of dentists to some extent. • Charlie MacLean suggested that benchmarking could be helpful, and noted that maldistribution is the biggest issue for many specialties – there are geographic areas with oversupply and areas with 	

Agenda Item	Discussion	Next Steps
	<p>undersupply. To look at newer professions, it may be helpful to consider selecting benchmarks to assess penetration. Charlie also looks at providers per population compared to other states; Vermont far exceeds many states in terms of primary care providers per population, for example. Demand analyses could help us decide whether we need more or fewer providers than what we have in various specialties. Mary Val asked whether there are national benchmarks for naturopaths per population, in response to Lori Lee’s earlier question.</p> <ul style="list-style-type: none"> • Peter Cobb asked whether we would like to collect demand data about non-licensed professions like direct care workers, personal care assistants, etc. He suggested that those positions have high turnover, so can be hard to capture consistent demand, but he will put out a survey in late spring or early summer. 	
<p>5. Review 2015 Workforce Work Group Workplan</p>	<p>Sarah Kinsler introduced the Workforce Work Group Workplan and described the process by which the Workplan was created.</p> <p>The group discussed the following:</p> <ul style="list-style-type: none"> • On Row 4, Dawn Philibert suggested that the target date be ongoing. • Madeleine Mongan suggested that on the Strategic Plan item (Row 3), the note about the RFP be removed since we have since decided not to pursue • Mary Val Palumbo asked about funding associated with this Work Group. Is funding specifically tied to supply and demand research, as Georgia had suggested at a previous meeting, or is it broader? Could we specifically fund a proposal like Lori Lee’s or Peter’s, for demand modeling for specific provider types like naturopaths or visiting nurses associations (VNAs)? This group previously had funding proposals that were outside the SIM funding scope. Mary Val suggested that it would be good to get an accounting from Georgia: How much will Demand Modeling work cost, and how much total is available? How much is allocated to support Work Group staff? • Peter Cobb asked whether Demand Modeling RFP responses have taken into account private duty nursing. Charlie MacLean noted that the contractor the review team selects can include this information if we give ask them to; Mary Val noted that there will be assumptions that we will verify. Madeleine Mongan noted that some hospitals and other care settings that employ traveling nurses or other providers that might not show up in these models, though supply side data might fill this gap. Madeleine and Charlie suggested we seek more information on the minimum dataset for licensing data. • Charlie requested an update on efforts to hear from the Payment Models and Care Models and Care Management (CMCM) Work Groups. This group heard from the CMCM Work Group on their Integrated Communities Care Management Learning Collaborative in February; their other activities have focused on developing ACO Care Management Standards and a provider survey. Dawn Philibert noted that this highlights the intersectional nature of the Workforce Work Group’s work. Madeleine Mongan suggested that that the group look at the ACO Care Management standards and see whether they are relevant. Beth Tanzman suggested the group wait until the three Learning Collaborative communities have had more 	<p>Sarah Kinsler will follow up with Georgia on funding questions.</p>

Agenda Item	Discussion	Next Steps
	<p>time to assess outcomes.</p> <ul style="list-style-type: none"> Mary Val noted that this group has not presented to other work groups; Lori Lee Schoenbeck and Dawn Philibert suggested that this could be a good step. Mary Val suggested that presenting the Workforce Strategic Plan following approval by GMCB could be a good topic for presentations. Madeleine Mongan agreed. Mary Val noted that all VHCIP Work Group Co-Chairs do meet semi-regularly and that she would connect with other co-chairs at the next meeting. 	
<p>6. Presentation/ Discussion: VDH/Office of Professional Regulation (OPR) Survey Reports</p>	<p>Dawn Philibert introduced Rich McCoy, Chief of Public Health Statistics at VDH. Peggy Brozicevic was unable to participate in today’s meeting, so Rich will be providing an overview with Dawn leading discussion. A sample of VDH’s reporting format was also distributed.</p> <ul style="list-style-type: none"> Rich provided an overview of the survey process. Rich noted the challenges of gathering a full census report for the 2012 survey due to a change in procedure: specifically, that the relicensing process has moved to an online portal, and requires a great deal of follow up and administrative work. Previously 5 provider types had been surveyed, beginning in the 1990s; now surveying 25+ specialties. This work is supported by coordination with Licensing, but still requires a great deal of manual data entry and follow up. VDH is focused on data quality. One key data element is full-time equivalent (FTE) information – an important piece for policy-making. However, this often requires a significant amount of follow-up. <ul style="list-style-type: none"> Lori Lee Schoenbeck asked whether the FTE includes patient time only, or paperwork as well. Rich responded that this isn’t made clear in the survey, though the survey generally defines work hours to include paperwork, reporting, etc. (though not on-call hours). Data is reported in two ways: a statistical report, and a report with a summary that highlights changes and other key data points. VDH has been behind on their reporting cycle and had hoped to get back on track this summer. Rich will connect with Peggy to get a timeline to this group. <p>The group discussed the following:</p> <ul style="list-style-type: none"> Staff and contractors are struggling to extract data; VDH expects this to be easier going forward. Mary Val Palumbo asked whether VDH had considered dropping their desired response rate to 90% or lower given the work associated with collecting this information. Charlie MacLean suggests that it would be easy to test this by throwing out the last 10% collected and comparing results. Rich responded that for some specialties, it is easy to collect the last 10%; for others it’s a challenge. Rich and Mary Val noted that VDH needs to balance how many resources to put to this task, as well as how long to delay reports in order to collect data that is as complete as possible (“census-level”). Rich noted that the physician survey is the top priority. Lori Lee Schoenbeck suggested the survey include provider capacity and patients currently served as a source for demand data. Charlie MacLean thought this was unlikely to come from a survey; the closest is 	

Agenda Item	Discussion	Next Steps
	<p>whether or not providers are accepting more patients. Charlie suggested Vermont’s all-payer claims database could provide much of this information but that this would require a great deal of analysis.</p> <ul style="list-style-type: none"> • Mary Val asked whether this group could have a one-pager that summarizes all professions. Madeleine Mongan suggested that this is included in the report’s executive summary. Charlie MacLean suggested that interpreting this information could be a good task for this group – VDH’s task is descriptive but does not draw out the key lessons. Mary Val suggested this could be a good task for a contractor, in conjunction with review of the literature. This group could inform conclusions or discussion. • Burt Wilcke noted that the number of specialty physician assistants has grown remarkably over the past decade; the group discussed possible reasons for this. • Dawn Philibert asked whether there was some benefit to creating summaries of each provider type. Madeleine Mongan noted that much of this information is already in reports. Mary Val suggested that VDH’s job is to get this data as soon as possible, and again asked whether 100% response rates are necessary. Dawn asked Rich whether there is a statistically acceptable way to assess this. Rich suggested that a few rounds of follow-up are important; additional response can be critical in situations where there is low response rate in a particular county, for example. Mary Val suggested a preliminary report when 80% of responses are in to support quicker reporting and reduce VDH workload. Rich responded that this could work in some situations but will depend on the data. Charlie MacLean suggested that if this is a mandate, providers would complete it; Mary Val suggests licensing boards would need to be involved. <p>Mary Val Palumbo and Dawn Philibert suggested we table this issue for now.</p>	
<p>7. Other topics: Discussion, Non-SIM Funding Proposals</p>	<p><i>Status of Workforce-Related Initiatives and Grants around the State:</i> (Moved from Item #3) Mary Val Palumbo suggested that this group continue to regularly discuss workforce-related grants this group has received, submitted or is considering submitting.</p> <ul style="list-style-type: none"> • Grants funded: <ul style="list-style-type: none"> ○ Madeleine Mongan offered to report on this on behalf of Vermont Medical Society Foundation at the next meeting. ○ Lori Lee Schoenbeck noted that the Blueprint has funded grants to support participating practices who are transferring from one EHR to a new EHR for participating practices; funds can support hiring additional staff to perform data entry/transfer records. • Grants submitted: <ul style="list-style-type: none"> ○ Charlie MacLean and Mary Val Palumbo submitted a large grant application to the Health Resources and Services Administration (HRSA) on workforce development within training programs/continuing education activities related to elderly patients. Expect to hear this summer. ○ Peter Cobb announced that Home Health agencies as a group and VNAs of Vermont have submitted an application for a grant around palliative care for hospice-eligible patients who have 	

Agenda Item	Discussion	Next Steps
	<p>not elected hospice. Expect to hear within a few weeks.</p> <ul style="list-style-type: none"> • Possible future grant opportunities: <ul style="list-style-type: none"> ○ Mary Val Palumbo noted that the second round of the Future of Nursing State Implementation Grant is due in June. Two focus areas – academic progression (marketing to encourage nurses to go back to school for a bachelor’s degree) and a nurse practitioner residency program within three independent nurse practitioner-led practices in the state. Requires a match of \$75,000; Mary Val requests suggestions about possible sources of match funding. 	
8. Public Comment, Wrap-Up, Next Steps, Future Agenda Topics	<p>No further comments were offered.</p> <p>Next Meeting: June 24, 2015, 3:00-5:00pm, Conference Room 101, Vermont State Colleges, 575 Stone Cutters Way, Montpelier.</p>	

VHCIP Workforce Work Group Member List

Roll Call: 4/22/2015

Member		Member Alternate		February Minutes		Organization
First Name	Last Name	First Name	Last Name			
David	Adams					UVM Medical Center
Tom	Alderman					Department of Education
Molly	Backup					Consumer Representative
Mat	Barewicz					Department of Labor
Rick	Barnett					Vermont Psychological Association
Ethan	Berke					Dartmouth Institute for Health Policy & Clinical Practice
David	Blanck					Consumer Representative
Peggy	Brozicevic					AHS - VDH
Denise	Clark					Consumer Representative
Peter	Cobb					VNAs of Vermont
Tim	Donovan					Vermont State Colleges
Ellen	Grimes					Vermont Technical College
Lorraine	Jenne					DA - HowardCenter for Mental Health
Janet	Kahn					UVM College of Medicine
Nicole	LaPointe					Northeastern Vermont Area Health Education Center
Robin	Lunge					AOA
Charlie	MacLean					University of Vermont
Madeleine	Mongan					Vermont Medical Society
Stephanie	Pagliuca					Bi-State Primary Care
Mary Val	Palumbo					University of Vermont
Dawn	Philibert					AHS - VDH
Lori Lee	Schoenbeck					Consumer Representative
Stuart	Schurr	Susan	Aranoff			AHS - DAIL
Beth	Tanzman					AHS - DVHA - Blueprint
Deborah	Wachtel					Consumer Representative
Burton	Wilcke					University of Vermont
	26		0			

~~12~~ - 13 No Quorum

VHCIP Workforce Work Group Participant List

Attendance:

4/22/2015

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

First Name	Last Name		Organization	Workforce
David	Adams		UVM Medical Center	M
Tom	Alderman		Department of Education	M
Susan	Aranoff	<i>None</i>	AHS - DAIL	S
Molly	Backup		Consumer Representative	M
Ena	Backus		GMCB	X
Mat	Barewicz		Department of Labor	M
Rick	Barnett	<i>None</i>	Vermont Psychological Association	M
Susan	Barrett		GMCB	X
Paul	Bengston		Northeastern Vermont Regional Hospital	X
Ethan	Berke		Dartmouth Institute for Health Policy & Clinical Practice	M
Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DMH	X
David	Blanck		Consumer Representative	M
Peggy	Brozicevic		AHS - VDH	M
Amanda	Ciecior	<i>None</i>	AHS - DVHA	S
Denise	Clark		Consumer Representative	M
Peter	Cobb	<i>None</i>	VNAs of Vermont	M

Amy	Coonradt	here	AHS - DVHA	S
Elizabeth	Cote		Area Health Education Centers Program	X
Karen	Crowley		AHS - Central Office - IFS	X
Kathy	Demars		Lamoille Home Health and Hospice	X
Tim	Donovan		Vermont State Colleges	M
Terri	Edgerton		AHS - Central Office - IFS	X
Erin	Flynn		AHS - DVHA	S
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Ellen	Grimes	phone	Vermont Technical College	M
Bryan	Hallett		GMCB	S
Karen	Hein			X
Deanna	Howard		Dartmouth	X
Lorraine	Jenne		DA - Howard Center for Mental Health	M
Joelle	Judge	here	UMASS	S
Janet	Kahn	phone		M
Sarah	Kinsler	here		S
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Nicole	LaPointe		Northeastern Vermont Area Health Education Center	M
Robin	Lunge		AOA	IC
Charlie	MacLean	here	University of Vermont	M
Georgia	Maheras		AOA	S
Jackie	Majoros		VLA/LTC Ombudsman Project	X
Mike	Maslack			X
John	Matulis	here	DHMC	X
Angel	Means		Visiting Nurse Association of Chittenden and Grand Isle Counties	X
Marisa	Melamed		AOA	S
Sarah	Merrill		DNH	X
Madeleine	Mongan	here	Vermont Medical Society	M
Meg	O'Donnell		UVM Medical Center	A
Stephanie	Pagliuca	phone	Bi-State Primary Care	M
Mary Val	Palumbo	here	University of Vermont	C
Annie	Paumgarten		GMCB	S
Dawn	Philibert	here	AHS - VDH	S/M
Luann	Poirer		AHS - DVHA	S

Ken	Schatz		AHS - DCF	X
Lori Lee	Schoenbeck	None	Consumer Representative	M
Stuart	Schurr		AHS - DAIL	M
Julia	Shaw		VLA/Health Care Advocate Project	X
Nancy	Solis		Dartmouth Institute for Health Policy & Clinical Practice	A
Kara	Suter		AHS - DVHA	S
Joy	Sylvester		Northwestern Medical Center	X
Beth	Tanzman	None	AHS - DVHA - Blueprint	M
Tony	Treanor		DA - Northwest Counseling and Support Services	X
Deborah	Wachtel		Consumer Representative	M
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Kendall	West			X
James	Westrich		AHS - DVHA	S
Burton	Wilcke	None	University of Vermont	M
Cecelia	Wu		AHS - DVHA	S
				66

Rich McCoy ~~here~~/phone VDH - Public Health Statistics Chief

Attachment 4a
Payment Models Work Group
Update (SSP and EOC)

Payment Models Work Group Update

- ACO Shared Savings Program

- Episodes of Care

Health Care Work Force Work Group
Meeting

June 24, 2015

Presentation Agenda:

- 1.) Background on ACO Shared Savings Programs
- 2.) Vermont ACO SSP to date
- 3.) Episodes of Care (EOC) work to date

Background: ACO Shared Savings Program

WHAT IS AN ACO SHARED SAVINGS PROGRAM (SSP)?

What is an ACO Shared Savings Program (SSP)?

A performance-based contract between a payer and provider organization that sets forth a value-based program to govern the determination of sharing of savings between the parties.



ACO model graphic property of the Premier health care alliance.
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VERMONT STATE INNOVATION MODEL



http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2012/Aug/1618_Forster_accountable_care_strategies_premier.pdf

Vermont Health Care Innovation Project

How are Patients Attributed to an ACO?

People see their Primary Care Provider (PCP) as they usually do

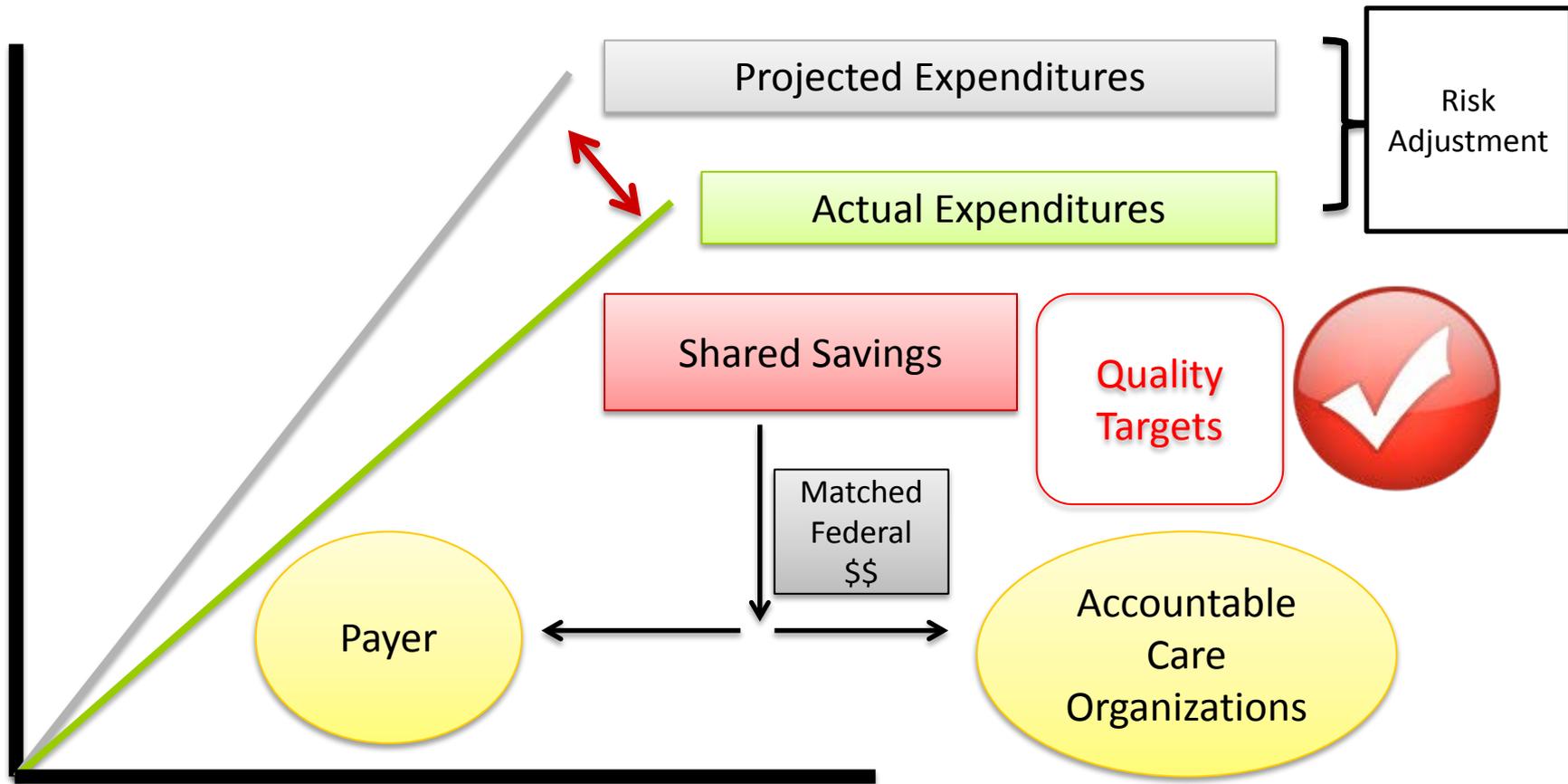


If their PCP belongs to an ACO, the ACO can share savings based on the cost and quality of services provided to that person



Providers bill as they usually do

Calculating Shared Savings



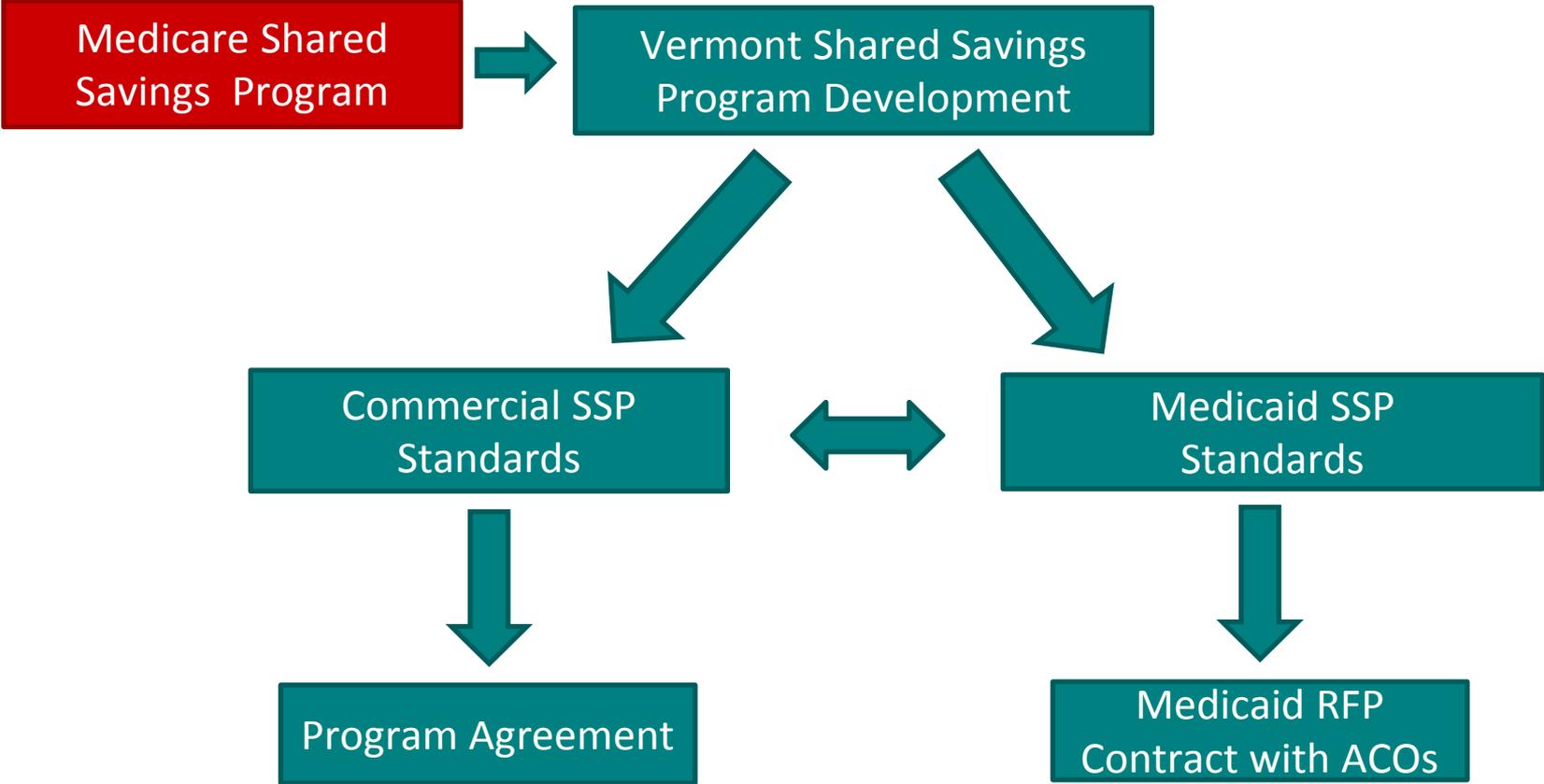
ACO Shared Savings Program

ACO SHARED SAVINGS PROGRAMS IN VERMONT

Shared Savings Programs In Vermont

- Shared Savings Program standards in Vermont were developed as a result of collaboration among payers, providers, and stakeholders, facilitated by the State
- Develop ACO/SSP standards to that include:
 - Attribution of Patients
 - Establishment of Expenditure Targets
 - Distribution of Savings
 - Impact of Performance Measures on Savings Distribution
 - Governance

Development of VT Shared Savings Program



ACO Shared Savings Program

Quality Measures

PAYMENT

Payment measures are collected at the ACO level. ACO responsible for collecting clinical data-based measures. How ACO performs influences amount of shared savings.

REPORTING

Reporting measures are collected at the ACO level. ACO responsible for collecting clinical data-based measures. How the ACO performs does NOT influence the amount of shared savings.

MONITORING & EVAL

Monitoring measures are collected at the State or Health Plan levels; cost/ utilization measures at the ACO level. ACO not responsible for collecting these measures. How the ACO performs does NOT influence the amount of shared savings.

PENDING

Pending measures are considered to be of interest, but are not currently collected.

Year 1 & 2 Payment Measures

Commercial &
Medicaid

- All-Cause Readmission
- Adolescent Well-Care Visits
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)*
- Rate of Hospitalization for Ambulatory Care Sensitive Conditions: Composite+
- Diabetes Care: HbA1c Poor Control (>9.0%)*+

Medicaid Only

- Developmental Screening in the First Three Years of Life

* Medicare Shared Savings Program measure

+ Year 2 only

Impact of Payment Measures

“Gate and Ladder” Approach:

- For most payment measures, compare each measure to the national benchmark and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.
- For payment measures without national benchmarks, compare each measure to Vermont benchmark or baseline performance, and assign 0, 2 or 3 points based on whether the ACO declines, stays the same, or improves relative to the benchmark.
- If the ACO does not achieve the required percentage of the maximum available points across all payment measures, it is not eligible for any shared savings (“quality gate”).

“Gates and Ladders” for Vermont Payers

Commercial SSP

% of available points	% of earned savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Medicaid SSP*

% of available points	% of earned savings
35%	75%
40%	80%
45%	85%
50%	90%
55%	95%
60%	100%

* The Medicaid SSP was modified for Year 2, with changes including the opportunity to earn bonus points for quality improvement, increasing the “gate” from 35% to 55%, and using absolute points earned in place of percentage points, to eliminate the need for any rounding.

Changes to Medicaid Gate and Ladder Methodology – Year 2

- PMWG members voted to **approve** modifications to the VMSSP G&L Methodology for Year 2
- Presentations and public commentary occurred November 2014 through March 2015
- Changes included:
 - Increasing the minimum quality performance threshold for shared savings eligibility (ie, increased the “gate” from 35% to 55% for Medicaid);
 - Including the use of absolute points earned in place of a percentage of points earned to eliminate the need for rounding; and
 - Allowing ACOs to earn “bonus” points for significant quality improvement in addition to points earned for attainment of quality relative to national benchmarks.

ACO Landscape in Vermont

- See handout: “VT ACO SSP Table”

Episodes of Care

VHCIP EPISODES OF CARE WORK TO DATE

VHCIP & Episodes of Care

- **2012:** SIM Application
 - Propose bundled payment models based on EOC
- **2013:** Year 1 Operational Plan
 - Pursuing bundled payment models based on EOC
 - Propose developing EOC analytics tools to drive delivery system transformation
- **2014:** Year 2 Operational Plan
 - Bundled payment models not a high priority for stakeholders
 - Propose focus on EOC analytics to drive delivery system transformation and complement other VHCIP initiatives
- **2015:** PMWG develops EOC Sub-Group

EOC Sub-Group Charge

The Episodes of Care sub-group (a sub-group of the *Payment Models Work Group*) will play a key role in developing and defining the future of Episodes data use in Vermont. The sub-group will recommend a number of episodes for further exploration using already established selection criteria. The sub-group will also aid in the development of a Request for Proposals (RFP) to elicit bids from potential vendors to produce user-friendly data reports related to selected episodes in the State. Sub-group members will be asked to provide recommendations regarding:

- selection and definition of episodes
- methodological considerations
- identification of appropriate quality measures
- report development and dissemination for delivery system transformation including identification of the need for additional provider supports to enhance the use of data and analytics
- bid review and vendor selection

Sub-Group Representation

- Blue Cross Blue Shield of Vermont
- Blueprint for Health
- DAIL
- DVHA
- GMCB
- MVP Health Care
- OneCare Vermont
- Vermont Association of Hospitals and Health Systems
- Vermont Medical Society
- Vermont Program for Quality in Health Care

Episodes of Care

- Conceptually, an episode of care consists of all related services for one patient for a specific diagnostic condition from the onset of symptoms until treatment is complete
 - Operationally, episode definitions may vary
- Episodes constitute clinically and economically meaningful units of service
- Episode-based payment models are being tested in three other SIM States:
 - Round 1: Arkansas
 - Round 2: Ohio and Tennessee

Using Episodes of Care

- To identify opportunities in support of delivery system transformation:
 - Do utilization patterns for specific conditions suggest excessively high or variable rates of particular services?
 - How do cost and utilization patterns differ across providers who serve patients for clinically-similar conditions?
 - How much duplication of service occurs for patients seen by different providers in different settings over time?
 - How do different care categories (e.g. inpatient facility, pharmacy, outpatient lab, etc.) impact overall episode costs?

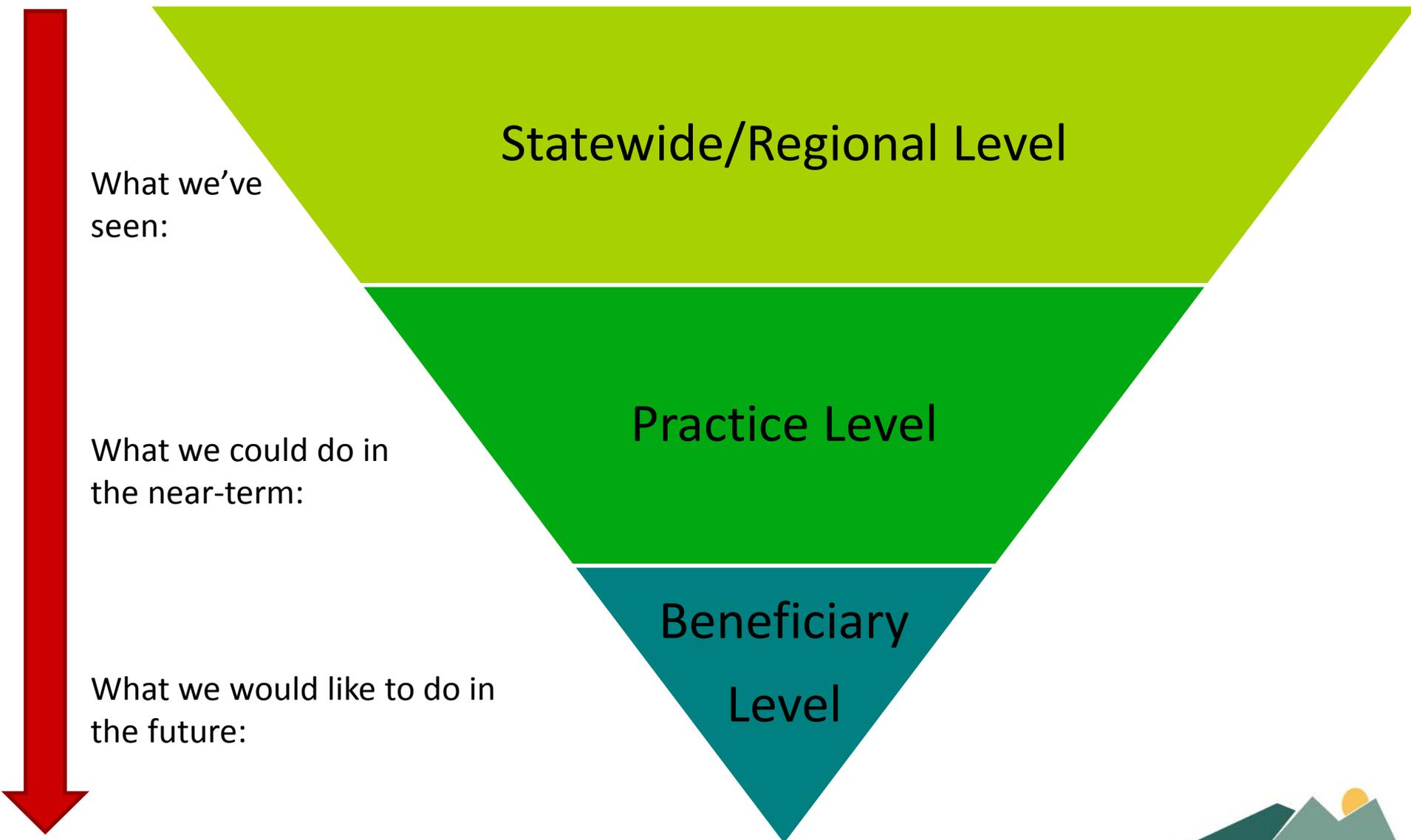
Types of Improvements Expected

- Making efficient substitutions among treatment options
- Avoiding complications
- Managing acute conditions
- Managing chronic conditions
- Reducing costs without sacrificing quality of care

Sub-Group Activity to Date (Jan-Apr)

- Reviewed preliminary PMWG EOC analyses (HCi3)
- Discussed related initiatives of interest
 - Arkansas' (SIM) EOC analytics and reporting
 - MVP's EOC analytics and reporting
 - Blueprint for Health analytics and practice & HSA profiles
- Discussed potential for use of episode analytics in Vermont
 - Potential provider types to receive episodes reports
 - Potential strategies for disseminating reports
 - Potential data sources for episodes analytics
 - Potential vendor capabilities

Phases of Episode-Based Analysis



Questions?

Attachment 4b

VT ACO SSP Table

Vermont Shared Savings Program ACO Table - Updated 6-16-15

MEDICARE SHARED SAVINGS PROGRAM (MSSP)								
ACO Name	Start Date in Program	Geographic Area	ACO Network Participants ^{i, ii} (Providers with attributed lives)	ACO Network Affiliates ¹ (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network ⁱⁱⁱ	Estimated Medicare Attributed Lives		
						# and % of Total VT Medicare Enrollees (Total N= 110,916) ^{iv}	# and % of VT MSSP Eligible Enrollees (Total N=101,410) ^v	# and % of Dual Eligibles within Attributed Lives (Total N=20,018)
OneCare Vermont (OCV)	Jan 1, 2013	Statewide	<ul style="list-style-type: none"> 2 Academic Medical Centers (FAHC and UVMCC) All other VT hospitals Brattleboro Retreat 3 Federally Qualified Health Centers (FOHCs) 4 Rural Health Centers 400+ Primary Care Physician FTEs (VT & NH) <ul style="list-style-type: none"> - 2000+ Specialty Care Physicians (VT & NH) 	<ul style="list-style-type: none"> 29 of 40 Skilled Nursing Facilities 11 VNA/ Home Health All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, no DS-only DA, no Children's MH Specialized Service Agency (SSA), and no DS SSAs 	<ul style="list-style-type: none"> 90% of shared savings distributed to OCV Network Participants; 10% retained by OCV Separate Incentive Plan Provision for OCV Network Affiliates Both depend on reporting and performance metrics 	55,114 50%	55,114 54%	13,222 = 7,619 QMB only and QMB/Medicaid coverage + 5,603 Other Dual Eligible Status 66%
Community Health Accountable Care (CHAC)	Jan 1, 2014	12 of 14 Counties (Addison, Chittenden, Grand Isle, Franklin, Orleans, Caledonia, Essex, Orange, Rutland, Washington, Windham, Windsor)	<ul style="list-style-type: none"> 113 Primary Care Physicians Family: 70; NP/PA: 36; IM: 6; Peds: 1 	<ul style="list-style-type: none"> 5 of 9 FOHC sites 19 unique practice locations 	<ul style="list-style-type: none"> Distribution methodology to be determined. 	4,956 4%	4,956 5%	unknown
TOTALS			~513 Primary Care Providers			60,070 54% of all VT Medicare enrollees	60,070 59% of all VT MSSP Eligible enrollees	13,222+ At least 66% of all VT Duals

Vermont Shared Savings Program ACO Table - Updated 6-16-15

VERMONT MEDICAID SHARED SAVINGS PROGRAM (VMSSP)								
ACO Name	StartDate in Program	Geographic Area	ACO Network Participants ^{vi, vii} (Providers with attributed lives)	ACO Network Affiliates ⁹ (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network ^{viii}	Estimated Medicaid Attributed Lives		
						# and % of Total VT Medicaid Enrollees (Total N= 132,829) ^{ix}	# and % of VT VMSSP Eligible Enrollees (Total N=95,000) ^{xv}	# and % of Dual Eligibles within Attributed Lives (Total N=20,018)
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	<ul style="list-style-type: none"> 2 Academic Medical Centers (FAHC and DHMC) 10 additional VT hospitals 12 Pediatric Clinics 4 Naturopathic Centers 80 unique practice sites 650+ Attributing Physician FTEs RN/PA:111; Family: 239; Peds: 109; Geriatric: 3; Internal: 194; Naturopathic: 12 	<ul style="list-style-type: none"> All 11 Mental Health Designated Agencies 13 Hospitals 241 unique practice sites 2,770 Participating Providers Specialty: 1157; PA/NP: 103; Women: 166; Mental/Counseling: 364; EMER: 292; Family: 33; General/ IM: 236; Hospice/HH: 13; Peds: 96; Social Work: 165; Other: 135 	<ul style="list-style-type: none"> 90% of shared savings distributed to OCV Network Participants and Affiliates; 10% retained by OCV Provider amount depends on reporting and performance metrics 	30,236	30,236	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	Statewide	<ul style="list-style-type: none"> 7 FOHCs and Bi-State Primary Care Association 37 unique practice sites 229 Attributing Physician FTEs EMER: 2; Family: 124; NP/PA: 38; Internal: 34; Ger: 1; PEDS: 19 	<ul style="list-style-type: none"> 97 unique practice sites 8 State Designated Agencies 6 hospitals, 26 health centers, 21 behavioral/mental health centers 1,357 Participating Providers EMER: 61; Family: 12; NP/PA: 72; Internal: 37; Mental/Counseling: 939; General: 27; Specialty: 128; Behavioral: 20; Dental: 33; Other: 26 	<ul style="list-style-type: none"> Distribution methodology to be determined. 	17,884	17,884	0
TOTALS			~879 Primary Care Providers			48,120 36.2% of all current VT Medicaid enrollees	48,120 50.7% of all VMSSP Eligible enrollees	0 0% of all VT Dual Eligibles

Vermont Shared Savings Program ACO Table - Updated 6-16-15

COMMERCIAL SHARED SAVINGS PROGRAM (XSSP) – Blue Cross Blue Shield of Vermont (BCBS-VT)								
ACO Name	Start Date in Program	Geographic Area	ACO Network Participants ^{xi} (Providers with attributed lives)	ACO Network Affiliates ¹⁵ (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network ^{xii}	Estimated Commercial Plan Attributed Lives		
						# and % of Total VT Commercial Plan Enrollees (Total N=341,077) ^{iv}	# and % of VT XSSP Eligible Enrollees (Total N=70,000) ^{xiii}	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Healthfirst - - Vermont Collaborative Physicians (VCP)	Jan 1, 2014	Statewide	<ul style="list-style-type: none"> 111 Physicians - 26 Primary Care Practices 	Committee working on Collaborative Care Agreements (CCAs) with practitioners, including: <ul style="list-style-type: none"> Specialists Other specific entities (e.g., Visiting Nurses Association) 	<ul style="list-style-type: none"> PCP's to retain the majority of shared savings VCP to retain a portion for administration and reserves Collaborative Care Agreements (CCAs) will specify responsibilities of CCA Practitioners in order to share in these savings, including patient and network engagement 	8,130 (BCBS only) 2%	8,130 (BCBS only) 12%	0
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	<ul style="list-style-type: none"> 2 Academic Medical Centers (UVMHC and DHMC) 10 Vermont Hospitals and 1 NH Hospital (Cheshire) Brattleboro Retreat 1 Federally Qualified Health Center (FQHC) 3 Rural Health Clinics 300+ Primary Care Physician FTEs (VT & NH Physicians) 1,900+ Specialty Care Physicians (VT & NH Physicians) 	<ul style="list-style-type: none"> 19 Skilled Nursing Facilities 10 VNA/Home Health 11 Designated Agencies (DA)s 	<ul style="list-style-type: none"> 90% of shared savings distributed to OCV Network Participants; 10% retained by OCV Separate Incentive Plan Provision for OCV Network Affiliates Both depend on reporting and performance metrics 	22,908 (BCBS Only) 7%	22,908 (BCBS Only) 33%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	13 of 14 Counties (with sites in or significant service to all counties except Lamoille)	<ul style="list-style-type: none"> 338 Physicians Gen: 8; Specialist: 31; Counselor/Mental: 28; Dental: 19; Emer: 14; Family: 110; NP/PA: 47; IM: 32; Women: 21; Peds: 20; Social Worker: 7 	<ul style="list-style-type: none"> 33 FQHC Practice Sites 4 dental locations 3 other practice sites 	Distribution methodology to be determined.	8,048 (BCBS Only) 2%	8,048 (BCBS Only) 11%	0
TOTALS			~749 Providers			37,252 11% of all VT Commercial Plan enrollees	37,252 53% of all VT XSSP Eligible enrollees	0 0% of all VT Dual Eligibles

Vermont Shared Savings Program ACO Table - Updated 6-16-15

ⁱ Current Network Participants and Network Affiliates as of April, 2014; may change over time

ⁱⁱ ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicare performance and savings; Outcomes for each "life" can only relate to a single ACO.

ⁱⁱⁱ Under the Medicare SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicare savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics

^{iv} Source: <http://hcr.vermont.gov/sites/hcr/files/2015/2014%20VHHIS%20Comprehensive%20Report%20.pdf>

^v MSSP does not include Medicare enrollees in Medicare Advantage Plans. In March 2014, 9,036 Vermonters were enrolled in these Plans. Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/Downloads/2014/Mar/State-County-Penetration-MA-2015-06.zip

^{vi} Current Network Participants and Network Affiliates as of April, 2014; may change over time

^{vii} ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicaid performance and savings; outcomes for each "life" can only relate to a single ACO.

^{viii} Under the Medicaid SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicaid savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics

^{ix} Source: <http://hcr.vermont.gov/sites/hcr/files/2015/2014%20VHHIS%20Comprehensive%20Report%20.pdf>

^x Number provided in DVHA's VMSSP RFP; the following populations are excluded from being considered as attributed lives: Individuals who are dually eligible for Medicare and Medicaid; Individuals who have third party liability coverage; Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers; and Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.

^{xi} Current Network Participants and Network Affiliates as of April, 2014; may change over time

^{xii} Under the Commercial SSP, ACOs can receive up to 25% of savings achieved between the expected amount and the minimum savings rate (MSR) (which is calculated based on # of attributed lives in the ACO), and up to 60% of their savings if they exceed the MSR, with a maximum savings of 10% of their expected expenditures. Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics

^{xiii} The XSSP eligible population for attribution to an ACO includes individuals who have obtained their commercial insurance coverage through products available on the VT Health Connect Exchange (obtained through the exchange website or directly from the insurer).

^{xv} Based on DVHA SFY'15 Budget Document Insert 2, using SFY '14 BAA enrollment figures; excludes Pharmacy Only Programs and VHAP ESI, Catamount, ESIA, Premium Assistance For Exchange Enrollees < 300%, and Cost Sharing For Exchange Enrollees < 350% (i.e., all programs that financially assist individuals to enroll in commercial products)

Attachment 4c

Blueprint Pay for Performance

Update

Attachment 5

Strategic Plan Priorities Matrix