VT Health Care Innovation Project
"Disability and Long Term Services and Supports" Work Group Meeting Agenda
Tuesday, November 1, 2016; 10:00 PM to 12:30 PM
Ash Conference Room
Waterbury State Office Complex
Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:00 – 10:05	**Welcome; Approval of Minutes** Deborah Lisi-Baker	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from October 6, 2016	Yes
2	10:05 – 10:10	**DLTSS Data Gap Remediation Project – Update** Sue Aranoff, DAIL and Larry Sandage, DVHA	• Attachment 2: HIT-Home Health Update 11-1-16	
3	10:10 – 11:00	**All Payer Model including Medicaid Next Gen and Medicare SSP ACO Programs** Michael Costa	• http://hcr.vermont.gov/engagement for additional reference materials	
4	11:00 – 12:00	**Year 2 Medicaid and Commercial ACO Shared Savings Results** Pat Jones, GMCB and Alicia Cooper, DVHA **2015 Medicare ACO Shared Savings Results** Martita Giard, OneCare / Kate Simmons, CHAC	• Attachment 4a: Year 2 (2015) Results for VT's Commercial and Medicaid ACO Shared Savings Programs • Attachment 4b: CHAC/ OneCare Presentation	
5	12:00 – 12:20	**Global Commitment Renewal - Update** Selina Hickman, AHS		

6	12:20 – 12:30	**Public Comment** Deborah Lisi-Baker	**Final Meeting:** • **Thursday, December 1, 2016,** 10:30 am – 12:00 Waterbury State Office Complex, Ash Conference Rm	

Attachment 1b: Minutes from October 6, 2016

Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, October 6, 2016, 10:00am-12:30pm, Elm Conference Room, Waterbury State Office Complex.

Agenda Item	Discussion	Next Steps
1. Welcome	Deborah Lisi-Baker called the meeting to order at 10:05am. A roll call attendance was taken and a quorum was present. Susan Aranoff moved to approve the October 2016 meeting minutes by exception. Sam Liss seconded. The minutes were approved with 2 abstentions (Alicia Cooper, Joy Chilton).	
2. Home and Community-Based Rules/ Independent Options Counseling	Megan Tierney-Ward and Roy Gerstenberger from DAIL presented on Home- and Community-Based Services (HCBS) rules and Independent Options Counseling. Deborah Lisi-Baker reminded the group that this is a brief overview; the State may convene a longer discussion at a later date. • Federal rules governing HCBS Medicaid funds were recently revisited. New rules address three areas: settings, person-centered planning, and conflict-free case management. Vermont's HCBS program sits within the Global Commitment for Health waiver. • Megan described the process to assess alignment within Choices for Care (CFC). In CFC alignment report, describes how State is structured and why this is through the comprehensive quality strategy, and how it relates to Vermont. Megan walked through various federal requirements and provided examples (e.g., "home-like" setting). DAIL assesses how each provision of the rule applies to three settings (Adult Family Care, Adult Day, and Home-Based Case Management). Person-Centered Planning Requirements: Describes process for person-centered care plan development. Still awaiting federal guidance on "conflict-free" provisions. DAIL will look at other programs once assessment of CFC is done – CFC is the first step in the process. This rule applies now and will apply into the future, so will continue to guide DAIL and providers. o Barb Prine asked how DAIL will solve the conflict-free case management issue. Megan replied that the State is working to get clarification from the federal government on various provisions of the rule. Vermont is a small state without many providers that emphasizes provider choice for beneficiaries.	

Agenda Item	Discussion	Next Steps
	• Roy briefly discussed the process for aligning developmental disabilities services with the new HCBS rules. DAIL is also responding to Act 140, which required some rule changes. A transition advisory committee engages individuals who receive services, advocates, and providers, to discuss how to take action. Working to be sensitive to provider needs and burden. Additionally, Vermont has long been a leader in providing HCBS and avoiding institutional settings for people with developmental disabilities. Some settings receive heightened scrutiny (farmsteads – only one in Vermont). This group is ahead of the process. o Barb Prine requested a public forum as DAIL comes to decisions, especially conflict-free case management, to ensure public input. Megan agreed and noted that DAIL knows this is a critical issue that must be addressed in partnership with stakeholders.	
3. DLTSS Sub-Analysis of ACO Performance Measures	Alicia Cooper presented a DLTSS sub-analysis of ACO performance measures in Year 1 of Vermont's Medicaid Shared Savings Programs (MSSP). Sub-analysis was a request from this group at the start of the MSSP. • Bard Hill noted that 97% of Choices for Care participants are dually eligible for Medicare and Medicaid and are attributed to Medicare ACOs rather than through Medicaid, so this sub-analysis does not include many CFC recipients. • Bard clarified that Assistive Community Care services fall under Vermont's Medicaid State Plan, not Choices for Care (slide 5). • The designation of "eligible but unattributed" are individuals who were eligible for ACO attribution but did not meet utilization-based attribution criteria (control population for this analysis). • Individuals in the DLTSS sub-population are also included in total calculations (Attachment 3a, slide 8). Attachment 3b includes data from which charts in slide deck were developed. • Julie Wasserman highlighted data from Attachment 3b showing that for 2 important avoidable hospitalization measures (COPD & Asthma, and Ambulatory Care Sensitive Conditions), DLTSS individuals in an ACO had a much higher likelihood of being unnecessarily hospitalized than people who were not affiliated with an ACO. In other words, DLTSS individuals in an ACO had worse outcomes on these measures than DLTSS individuals not associated with an ACO. Julie recommended we work with the ACOs to help them reduce "avoidable" hospitalizations for their DLTSS population. • Data from future performance years will allow the State to start assessing trends over time. • Alicia concluded by noting that for many measures, sub-population quality measures were similar to or better than full ACO population. Alicia also noted that individuals in the ACO DLTSS sub-population experienced proportionally more hospital admissions than the full ACO populations; and that individuals in the ACO DLTSS sub-population experienced more (avoidable) hospital admissions than DLTSS individuals not attributed to an ACO. Kirsten Murphy suggested a recent white paper by Green Mountain Self Advocates includes information on how attitudes might impact care received by this sub-population in Vermont.	
4. Medicaid Pathway Updates	*Mental Health, Substance Abuse, and Developmental Services:* Selina Hickman and Melissa Miles were unavailable today. Roy Gerstenberger provided an update on the Developmental Services piece of this initiative, noting that services paid for by the Department of Mental Health have been an initial focus of this effort; DS will be included later.	

Agenda Item	Discussion	Next Steps
	• A sub-group has been working to identify appropriate measures of success. Outcome measures for DLTSS sub-populations and people with developmental disabilities are somewhat different. • DS system has unique readiness for integrated approach. Funding has been bundled from the State, with individualized budgets based on individual needs. • No history of national or standardized system of measures for DS. Questions are standard, but information collection is not standardized. • Inclusion of people with disabilities living in the community is a key principle. Measuring this is a challenge. Bard Hill added that socioeconomic factors are also a driver of health status and health utilization, and measures are starting to develop in this area. There is also momentum now about person-centered outcomes and results around issues like social isolation, housing, and employment. • Dale Hackett suggested we need measures that help us assess both outcomes and current performance of programs like Medicaid Pathway. Bard described some measures that are used to assess person-centered outcomes. *Long-Term Services and Supports/Choices for Care*: Bard provided an update on the CFC leg of the Medicaid Pathway effort, including key goals and opportunities identified through a group process. • Barb Prine noted that CFC payment rates are low, and that she sees this as the biggest problem in the system. She asked why this isn't a goal. Bard replied that he can't solve that problem on the current program budget, and noted that this is a problem across programs and settings. He added that this is both a wage problem and a workforce problem, and that this is true across programs as well. CFC and related programs include over 10,000 workers – this is a system-wide problem. CFC is trying to give people more flexibility in how to use their money so that individual needs can be met and good outcomes achieved. Suzanne Santarcangelo commented that more information about staffing is included in detailed notes. Bard added that many CFC enrollees pay for services from friends or family members, who are not otherwise part of the health care workforce.	
4. All-Payer Model	Robin Lunge provided an update on the All-Payer Model. • All-Payer Model: A draft agreement with the federal government was released last week. This is currently under legal review at both state and federal levels. Documents and information on how to provide comments are available at: http://gmcboard.vermont.gov/payment-reform/APM. • Global Commitment 1115 Medicaid Waiver: The State filed a waiver renewal earlier this year following a public process last winter; a verbal agreement has been reached and legal review is underway. CMS does not allow the State to release draft terms before they are approved. • Susan Aranoff asked how comments and questions about the All Payer Model are being gathered and responded to. Information on forums and GMCB meetings are on the GMCB website. Individuals are asking questions verbally and receiving verbal responses at forums; GMCB written comment period is open. Each AHS Commissioner has a process for internal staff to provide feedback through Commissioners and the AHS Secretary. State employees can speak as private citizens at public events outside of work time.	

Agenda Item	Discussion	Next Steps
	o Deadline for initial comments is 10/13 at noon; GMCB meets on 10/13. o The State received a great deal of comments on the APM Term Sheet in January, which includes most of the terms of the agreement; there were some changes in response to that feedback. Major changes since January: Floor on financial model, quality measures. These would be the best areas to focus comments. • Slide 8 describes the roles of the APM agreement and Global Commitment 1115 Waiver renewal, which are aligned but serve different purposes. • APM includes a financial target roughly equivalent to Medicare A&B services – equals approximately 35% of total Medicaid spending. Spending on services outside this are not included in the overall financial goal. This limits growth in hospital and medical services but allows for growth in other service sectors. o Sam Liss asked where pharmacy services fit in. Robin noted that these are excluded for the moment due to data system issues at Medicare, as well as challenges for controlling pharmacy spending. • Financial targets compare sending on total cost of care (Medicare A&B-like services) attributed to an ACO in years 1-2 to 3.5%. In Year 3 there is an analysis of scale, which determines whether total cost of care across Medicare, Medicaid and commercial will be compared to 3.5%. There is also a Medicare-specific growth target compared to national trend (calculations defined in waiver terms). Medicare savings target is a very modest savings goal of .1-.2% depending on national Medicare trend (this is different from Medicare SSP/Next Generation ACO minimum savings requirements for ACOs). • There are three levels of measures in the model: population health measures assessed statewide, ACO measures by which ACOs are assessed, and process measures assessed at the ACO level. These are defined in an agreement appendix in great detail, and summarized in GMCB slides at the website linked above. o Population health goals: Improve access to primary care; reduce deaths due to suicide and drug overdose; and reduce prevalence and morbidity of chronic disease. Other measure levels build up to these goals. ▪ Dale Hackett commented that these measures are significantly impacted by long-term factors and life experiences of individuals. Robin agreed and suggested that aligned measures at all three levels will help the system as a whole work toward these goals over the long-term. • The APM agreement does not include any Medicare waivers at this time, but does include Medicare beneficiary protections like choice of provider, accessing out-of-state providers, maintaining the same cost sharing, and more. The areas that CMMI are allowed to waive under federal law are related to not paying fee-for-service, and can include benefit enhancements. o Barb Prine asked how this relates to low Medicare rates that discourage some providers from participating. How will APM solve that problem? Robin explained that fee-for-service Medicare will stay the same, and the State will not be involved in Medicare FFS rate setting now or in the future unless the agreement is amended. In the Vermont Medicare ACO program (NextGen), GMCB can set a Vermont-specific payment trend/benchmark for Medicare NextGen ACO program. They also have the ability to set Vermont-specific quality measures for that program. This is a narrow State authority that	

Agenda Item	Discussion	Next Steps
	allows us to customize the NextGen ACO program for Vermont. This could help address that challenge if the ACO could find a way to add value to those services (e.g., if DME expenditures would reduce the overall health care costs for an ACO, the ACO could be incentivized to invest in DMEs). • New federal law passed in 2015 (MACRA) imposes quality targets and potentially FFS rate reductions for providers that stay in FFS Medicare (Merit-Based Incentive Payment System, or MIPS). Providers can also pursue Medicare payment reforms or join an Advanced Alternative Payment Model (AAMP) to avoid these penalties (APM would qualify under this provision). An important point for providers – the current status quo is changing no matter what. • Susan Aranoff commented that she understood that CHAC and OneCare did not perform well under the Medicare SSP this year. What are the implications of low ACO performance? Robin replied that NextGen (which moves toward capitation with robust quality measurement and risk adjustment) are different programs – shared savings is training wheels to help providers get started on changing care but doesn't include strong enough financial incentives for robust change. Both ACOs will continue to participate in the Medicare Shared Savings Program for 2017. The Vermont Care Organization (VCO) would enter NextGen in 2018. In the APM, Vermont has negotiated a 2017 baseline for the ACO program (instead of the currently offered 2014). This ensures a more realistic base. • Dale Hackett asked about workforce changes required to participate in AAMPs. Robin replied is that MIPS is designed to be budget neutral for Medicare and to push providers into value-based programs, which will redistribute some payments but it's hard to predict how it will shape out.	
5. Population Health Plan and Accountable Communities for Health	Heidi Klein (VDH, staff of Population Health Work Group) presented the draft Population Health Plan and provided an update on the Accountable Communities for Health work stream. • This is a draft plan; we hope to receive substantive feedback from every work group. The report not only represents the work done in the Population Health Work Group, but the collective work done on recommendations to ensure that population health is adequately addressed moving forward. The final report will be submitted to CMMI and will be used in the State. • Vermont's State Health Improvement Plan (SHIP – a requirement for every state with an accredited Public Health Department) addresses specific health improvement goals for the State (e.g., addressing tobacco use or heart disease). The Population Health Plan (PHP – a requirement of the SIM grant) takes a systems approach and identifies structural opportunities within health system reform to integrate prevention, public health and community-wide strategies. • Key Principles: Developed by Population Health Work Group to guide efforts. (Slide 8) • Policy Levers: Builds on a framework from the Center for Health Care Strategies (CHCS). Four levers to identify opportunities to move toward improved population health. The PHP makes recommendations for each of these levers at the State and regional levels. Heidi walked through examples of recommendations. Discussion:	

Agenda Item	Discussion	Next Steps
	• Sam Liss asked how capitation serves as a limiting parameter for improving population health and individual health in that it eventually might limit services across the board. Bard Hill responded with the idea of a balanced portfolio: money is limited and we will have to make choices about that investment portfolio because there are so many competing interests; he sees a value in investing in prevention. Heidi encouraged people to look at Elizabeth Bradley's research on why we spend so much money in health care services but with such poor results, compared with other countries. The conversation on spending more on social services has started robustly in Vermont. • Barb Prine asked where would elimination of poverty fit in the principles. Heidi responded that it would be in principle number 3 ("Address the multiple contributors to health outcomes"). Barb noted that poverty should be front and center, as per her own experience with clients. Heidi mentioned that many of the groups in the ACH Peer Learning Lab have identified that and discussed how it will be addressed. It's part of the conversation but not yet fully developed. Email comments on the Population Health Plan draft to Heidi Klein (Heidi.klein@vermont.gov), Sarah Kinsler (Sarah.kinsler@vermont.gov), or Georgia Maheras (Georgia.maheras@vermont.gov). Comments are due by October 31, 2016.	
6. Public Comment/Next Steps	**Next Meeting:** Tuesday, November 1, 2016, 10:00am-12:30pm, Ash Conference Room, Waterbury State Office Complex	

VHCIP DLTSS Work Group Member List

Sue 1° Sam 2° - Motion Carried - 2 abstentions

Member		Member Alternate		July Minutes	6-Oct-16
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff ✓				AHS - DAIL
Molly	Dugan ✓				Cathedral Square and SASH Program
Mary	Fredette				The Gathering Place
Kate	Simmons	Kendall	West		Bi-State Primary Care
Martita	Giard	Susan	Shane ✓		OneCare Vermont
Joy	Chilton ✓			A	Home Health and Hospice
Dale	Hackett ✓				Consumer Representative
Mike	Hall				Champlain Valley Area Agency on Aging
Jeanne	Hutchins				UVM Center on Aging
Pat	Jones ✓				GMCB
Dion	LaShay ✓				Consumer Representative
Deborah	Lisi-Baker ✓				SOV - Consultant
Sam	Liss ✓				Statewide Independent Living Council
Barbara	Prine ✓				VLA/Disability Law Project
Jessa	Barnard				Vermont Medical Society
Kirsten	Murphy ✓				Developmental Disabilities Council
Nick	Nichols				AHS - DMH

Ed	Paquin				Disability Rights Vermont
Eileen	Peltier				Central Vermont Community Land Trust
Paul	Reiss	Amy	Cooper		Accountable Care Coalition of the Green Mountains
Jenney	Samuelson	Craig	Jones		AHS - DVHA
Rachel	Seelig				VLA/Senior Citizens Law Project
Julie	Tessler	Marlys	Waller		DA - Vermont Care Partners
Julie	Wasserman				AHS - Central Office
Jason	Williams				UVM Medical Center
	25		5		

	Meeting Name:	VHCIP DLTSS Work Group Meeting	
	Date of Meeting:	October 6, 2016	
	First Name	Last Name	
1	Susan	Aranoff	here
2	Debbie	Austin	
3	Ena	Backus	
4	Jessa	Barnard	
5	Susan	Barrett	
6	Bob	Bick	
7	Denise	Carpenter	
8	Alysia	Chapman	
9	Joy	Chilton	Phone
10	Amy	Coonradt	here
11	Amy	Cooper	~~Alex~~
12	Alicia	Cooper	here
13	Julie	Corwin	
14	Michael	Costa	
15	Molly	Dugan	phone
16	Erin	Flynn	
17	Mary	Fredette	
18	Lucie	Garand	
19	Christine	Geiler	
20	Martita	Giard	
21	Dale	Hackett	here
22	Mike	Hall	
23	Selina	Hickman	
24	Bard	Hill	here

25	Jeanne	Hutchins	
26	Craig	Jones	Phone
27	Pat	Jones	Phone
28	Margaret	Joyal	
29	Joelle	Judge	here
30	Sarah	Kinsler	here
31	Tony	Kramer	
32	Andrew	Laing	
33	Dion	LaShay	Phone
34	Deborah	Lisi-Baker	here
35	Sam	Liss	here
36	Carole	Magoffin	here
37	Georgia	Maheras	here
38	Lisa	Maynes	
39	Mary	Moulton	
40	Kirsten	Murphy	here
41	Nick	Nichols	
42	Miki	Olszewski	
43	Kate	O'Neill	here
44	Ed	Paquin	
45	Eileen	Peltier	
46	John	Pierce	
47	Luann	Poirer	
48	Barbara	Prine	here
49	Paul	Reiss	
50	Virginia	Renfrew	
51	Jenney	Samuelson	

52	Suzanne	Santarcangelo	here
53	Rachel	Seelig	
54	Susan	Shane	phone
55	Julia	Shaw	
56	Angela	Smith-Dieng	
57	Beth	Tanzman	
58	Julie	Tessler	
59	Bob	Thorn	
60	Beth	Waldman	
61	Marlys	Waller	
62	Julie	Wasserman	here
63	Kendall	West	
64	James	Westrich	
65	Jason	Williams	
66	Scott	Whittman	
67	David	Yacovone	
68	Marie	Zura	

Sarah Freeman - RTI (federal evaluation team)
Megan Tierney-Ward - DAIL
Roy Gerstenberger - DAIL
Heidi Klein - VDH
Robin Lunge - HCR

Attachment 2: HIT-Home Health Update

DISABILITY AND LONG TERM SERVICES AND SUPPORT DATA GAP REMEDIATION PROJECT:

November 1, 2016

Susan Aranoff

Larry Sandage

Holly Stone

Project Overviews

1. Implement VITLAccess for Home Health Agencies
   - VITLAccess is a provider portal that allows access to health care providers to patient care information from other entities.

2. Develop Interfaces from Home Health Agencies' EHRs to the VHIE
   - An interface is the "connector" that allows information to flow from a provider's electronic health record system to the Vermont Health Information Exchange (VHIE).

In Summary:

- **Allow the information to flow and be shared**
- **Provide access to the client's health record**

1- VITL*Access* Implementation Update & Risks

Phase 1 February 15 - June 30, 2016 COMPLETED (305 Users)

Addison County Home Health & Hospice	**Lamoille Home Health & Hospice**	**VNA of Chittenden & Grand Isle counties (Including the VT Respite House)**	**Bayada Home Health Care**

Phase 2 July 1 - December 31, 2016 In Progress (195 Users)

CVHHH Enrollment completed Training scheduled - November 3rd and November 10th	**VNA and Hospice of The SW Region** Introductory meeting held. Core Team meeting **to discuss next steps on October 24th**	**VNA of VT & NH** Introductory meeting held Enrollment/Training Dates **TBD**

Phase 3 July 1 - December 31, 2016 In Progress (100 Users)

VNA Orleans/ Essex Introductory mtg. & Enrollment Completed	**Franklin County Home Health** Introductory meeting scheduled November 7th	**Manchester Health Services** **Not yet scheduled**	**Caledonia Home Health & Hospice** Introductory meeting scheduled October 31st

2-VHIE Interface Project

- *Goal: To increase the interoperability of Home Health Agency client information and provide access to client health records for Home Health Agency providers.*

- *Objective: HHA's establish connections to VHIE to implement the NextGen Medicare Shared Savings Program and comply with the IMPACT Act.*

- *Budget: The Vermont Health Care Innovation Project (VHCIP) has allocated significant funding in support of HHA information interoperability by the end of 2016. A 2017 project funding extension is proposed.*

VHIE Interface Target Implementation & Risks

Phase 1- VITL Assessment: February 15 - June 30, 2016 (COMPLETED)

Franklin County Home Health ADT & CCD interface **COMPLETE**

Phase 2- October 2016 – March 31, 2017 (Scheduling)

Caledonia Home Health & Hospice- SOW signed

VNA Orleans/ Essex- SOW signed

Lamoille Home Health & Hospice-New vendor

Bayada Home Health Care- awaiting SOW signature

Manchester Health awaiting SOW Signature

Phase 3 January 1 – June 30, 2017 (Pending)

CVHHH- Pending State & Fed extension approval

VNA of Chittenden & Grand Isle counties- Pending State & Fed extension approval

VNA and Hospice of The SW Region Awaiting SOW Signature

VNA of VT & NH- Awaiting SOW Signature

Addison County Home Health & Hospice- Changing Vendors (NA)

Questions?

Thank you!

Attachment 4a: Year 2 (2015) Results for VT's Commercial and Medicaid ACO Shared Savings Programs

Year 2 (2015) Results for Vermont's Commercial and Medicaid ACO Shared Savings Programs

Pat Jones, Health Care Project Director, GMCB
Alicia Cooper, Health Care Project Director, DVHA

Presentation to VHCIP DLTSS Work Group
October 31, 2016

Vermont Health Care Innovation Project

Presentation Overview

- Shared Savings Programs in Broader Health Care Reform Context
- Financial Results and Overall Quality Scores
  - Medicaid Aggregated, PMPM and Year-to-Year
  - Commercial Aggregated, PMPM and Year-to-Year
  - Medicare Aggregated and Year-to-Year
- Detailed Quality Results
  - Medicaid and Commercial Payment Measures
  - Medicaid and Commercial Reporting Measures
  - Combined Medicaid and Commercial Patient Experience Measures

SSPs in Broader Health Care Reform Context

- **Medicare Access and Children Health Insurance Program Reauthorization Act (MACRA):**

This 2015 federal law creates two payment reform programs for Medicare: the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (AAPMs). MIPS and AAPMs provide financial incentives for health care providers who participate in payment reform or quality programs, and financial disincentives for health care providers who do not participate.

- **Principle 7 from the Health Care Payment Learning Action Network (LAN):**

"Centers of excellence, patient centered medical homes, and accountable care organizations are delivery models, not payment models. In many instances, these delivery models have an infrastructure to support care coordination and have succeeded in advancing quality. They enable APMs and need the support of APMs, but none of them are synonymous with a specific APM. Accordingly, they appear in multiple categories of the APM Framework, depending on the underlying payment model that supports them."

- **Vermont's current SSPs do not qualify as Advanced Alternative Payment Models:**

SSPs built on fee-for-service payment with upside gainsharing, such as Vermont's, do not qualify as an AAPM under the new MACRA Rule (known as the "Quality Payment Program" or QPP). By contrast, the Vermont All-Payer Accountable Care Organization Agreement has a clear goal of connecting an ACO delivery model with population-based payments envisioned in Category 4 of the APM Framework *(see following slide)*. Models in Category 4 would qualify as AAPMs under QPP.

Alternative Payment Model Framework

Naussbaum, McLellan, Smith, and Patrick H. Conway

Vermont's ACOs and Shared Savings Programs (SSPs)

ACO Name	2015 Shared Savings Programs
Community Health Accountable Care (CHAC)	Commercial Medicaid Medicare
OneCare Vermont (OneCare)	Commercial Medicaid Medicare
Vermont Collaborative Physicians/ Health*first* (VCP)	Commercial

Financial Results and Overall Quality Scores

Results Should be Interpreted with Caution

- ACOs have different populations
- ACOs had different start dates
- Commercial financial targets in 2015 continued to be based on Vermont Health Connect premiums, rather than actual claims experience
- Medicare's methodology for calculating shared savings is reportedly more challenging for lower-cost ACOs

Summary of 2015 Aggregated Financial Results

- Medicaid SSP 2015

	Medicaid		
	CHAC	OneCare	VCP
Total Lives	28,648	50,091	N/A
Expected Aggregated Total	$ 64,814,757.48	$ 101,495,988.72	N/A
Target Aggregated Total	N/A	N/A	N/A
Actual Aggregated Total	$ 62,405,070.32	$ 102,802,366.80	N/A
Shared Savings Aggregated Total	$ 2,409,687.16	$ (1,306,378.08)	N/A
Total Savings Earned	$ 2,409,687.16	$ -	N/A
Potential ACO Share of Earned Savings	$ 603,278.72	$ -	N/A
Quality Score	57%	73%	N/A
%of Savings Earned	75%	95%*	N/A
Achieved Savings	$ 452,459.00	$ -	N/A

*If shared savings had been earned

Summary of 2015 Financial PMPM Results

- Medicaid SSP 2015

	Medicaid		
	CHAC	OneCare	VCP
Actual Member Months	342,772	599,256	N/A
Expected PMPM	$ 189.09	$ 169.37	N/A
Target PMPM	N/A	N/A	N/A
Actual PMPM	$ 182.06	$ 171.55	N/A
Shared Savings PMPM	$ 7.03	$ (2.18)	N/A
Total Savings Earned	$ 2,409,687.16	$ -	N/A
Potential ACO Share of Earned Savings	$ 603,278.72	$ -	N/A
Quality Score	57%	73%	N/A
%of Savings Earned	75%	95%*	N/A
Achieved Savings	$ 452,459.00	$ -	N/A

*If shared savings had been earned

Medicaid SSP Results 2014-2015

Medicaid								
	2014 PMPM	2015 PMPM	2014 PMPM Difference from Target	2015 PMPM Difference from Target	2014+2015 PMPM Difference from Target	2014+2015 Aggregate Difference from Target	2014 Quality Score	2015 Quality Score
CHAC	$189.83	$182.06	$ 24.85	$ 7.03	$ 31.88	$ 10,258,137.21	46%	57%
OneCare	$165.66	$171.55	$ 14.93	$ (2.18)	$ 12.75	$ 5,446,625.15	63%	73%

Summary of 2015 Aggregated Financial Results

- Commercial SSP 2015

	Commercial		
	CHAC	OneCare	VCP
Total Lives	10,084	27,137	10,061
Expected Aggregated Total	$ 36,930,311.76	$93,486,032.12	$ 28,163,838.10
Target Aggregated Total	$ 35,826,535.08	$91,213,298.67	$ 27,318,912.50
Actual Aggregated Total	$ 38,386,092.48	$97,270,203.03	$ 31,784,051.50
Shared Savings Aggregated Total	$ (1,455,780.72)	$ (3,784,170.91)	$ (3,620,213.40)
Total Savings Earned	$ -	$ -	$ -
Potential ACO Share of Earned Savings	$ -	$ -	$ -
Quality Score	61%	69%	87%
%of Savings Earned	80%*	85%*	100%*
Achieved Savings	$ -	$ -	$ -

*If shared savings had been earned

Summary of 2015 Financial PMPM Results

- Commercial SSP 2015

	Commercial		
	CHAC	OneCare	VCP
Actual Member Months	103,836	278,863	104,570
Expected PMPM	$ 355.66	$ 335.24	$ 269.33
Target PMPM	$ 345.03	$ 327.09	$ 261.25
Actual PMPM	$ 369.68	$ 348.81	$ 303.95
Shared Savings PMPM	$ (14.02)	$ (13.57)	$ (34.62)
Total Savings Earned	$ -	$ -	$ -
Potential ACO Share of Earned Savings	$ -	$ -	$ -
Quality Score	61%	69%	87%
%of Savings Earned	80%*	85%*	100%*
Achieved Savings	$ -	$ -	$ -

*If shared savings had been earned

Commercial SSP Results 2014-2015

Commercial								
	2014 PMPM	2015 PMPM	2014 PMPM Difference from Target	2015 PMPM Difference from Target	2014+2015 PMPM Difference from Target	2014+2015 PMPM Aggregate from Target	2014 Quality Score	2015 Quality Score
CHAC	$350.03	$369.68	$ (25.94)	$ (14.02)	$ (39.96)	$ (4,003,425.94)	56%	61%
OneCare	$349.01	$348.81	$ (23.38)	$ (13.57)	$ (36.95)	$ (9,270,591.85)	67%	69%
VCP	$286.08	$303.95	$ (19.36)	$ (34.62)	$ (53.98)	$ (5,331,869.72)	89%	87%

Summary of 2015 Aggregated Financial Results

- Medicare SSP 2015

	Medicare		
	CHAC	OneCare	VCP
Total Lives	6,600	55,841	N/A
Expected Aggregated Total	$52,542,031	$484,875,870	N/A
Target Aggregated Total	N/A	N/A	N/A
Actual Aggregated Total	$56,658,198	$511,835,661	N/A
Shared Savings Aggregated Total	$ (4,116,167)	($26,959,791)	N/A
Total Savings Earned	$0	$0	N/A
Potential ACO Share of Earned Savings	$0	$0	N/A
Quality Score	97.19%	96.09%	N/A
%of Savings Earned	N/A	N/A	N/A
Achieved Savings	$ -	$ -	N/A

Medicare SSP Results 2013-2015

Medicare SSP Results 2013-2015						
	2013+2014+2015 Aggregate Difference from Target	2013 Difference from Target, as % of Total Target Expenditures	2014 Difference from Target, as % of Total Target Expenditures	2015 Difference from Target, as % of Total Target Expenditures	2014 Quality Score	2015 Quality Score
CHAC*	$ (3,004,094.00)	N/A	2.36%	-7.83%	Reporting Only	97%
OneCare	$ (30,794,491.00)	0.09%	-0.89%	-5.56%	89%	96%
VCP**	$ (5,182,660.00)	-3.36%	-4.87%	N/A	92%	N/A
*CHAC participated in Medicare SSP in 2014 and 2015 only.						
**VCP participated in Medicare SSP in 2013 and 2014 only.						

Takeaways from 2015 Financial & Overall Quality Results

- **Medicaid SSP:**
  - CHAC earned modest savings; PMPM declined from 2014 to 2015
  - OneCare PMPM financial results farther away from targets
  - Overall quality scores improved by 11 percentage points for CHAC and 10 percentage points for OneCare
- **Commercial SSP:**
  - CHAC and OneCare PMPM financial results closer to targets; no change in OneCare's PMPM from 2014 to 2015; VCP's farther away from target
  - Targets still based on premiums in 2015, rather than claims experience
  - Overall quality scores improved by 5 percentage points for CHAC and 2 percentage points for OneCare; VCP overall quality score declined by 2 percentage points (still would have qualified VCP for 100% of savings)
- **Medicare SSP:**
  - CHAC and OneCare aggregate financial results farther away from targets; Medicare doesn't report PMPM results
  - Quality improved by 7 percentage points for OneCare; 2015 was first year that quality score was reported for CHAC; both had quality scores greater than 90%

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Detailed Quality Results

Quality Measure Overview

- Medicaid and Commercial measure set was mostly stable between 2014 and 2015; outcome measures added to payment set in 2015
- Multiple years of data for Commercial SSP members resulted in adequate denominators for measures with look-back periods
- Medicaid “Quality Gate” more rigorous in 2015
- Data collection and analysis is challenging, but there continues to be impressive collaboration among ACOs in clinical data collection

Results Should be Interpreted with Caution

- ACOs have different populations
- ACOs had different start dates
- There are no payer-specific benchmarks for Patient Experience Survey; had to combine Commercial and Medicaid results and compare to national all-payer results that include Medicare beneficiaries

2015 Medicaid Payment Measures

Measure	CHAC Rate/ Percentile/ Points*	OCV Rate/ Percentile/ Points*
All-Cause Readmission	18.31/**/2 Points	18.21/**/2 Points
Adolescent Well-Care Visits	40.16/Below 25th/0 Points	48.09/Above 50th/2 Points
Mental Illness, Follow-Up After Hospitalization	50.26/Above 50th/2 Points	57.91/Above 75th/3 Points
Alcohol and Other Drug Dependence Treatment	28.82/Above 50th/2 Points	26.86/Above 50th/2 Points
Avoidance of Antibiotics in Adults with Acute Bronchitis	20.28/Above 25th/1 Point	30.50/Above 75th/3 Points
Chlamydia Screening	48.03/Below 25th/0 Points	50.09/Below 25th/0 Points
Developmental Screening	12.51/**/2 Points	44.80/**/2 Points
Rate of Hospitalization for People with Chronic Conditions (per 100,000)	424.52/**/2 Points	624.84/**/2 Points
Blood Pressure in Control	67.64/Above 75th/3 Points	67.92/Above 75th/3 Points
Diabetes Hemoglobin A1c Poor Control (lower rate is better)	22.77/Above 90th/3 Points	21.83/Above 90th/3 Points

*Maximum points per measure = 3

**No national benchmark; awarded points based on change over time

Impact on Payment

Vermont Medicaid Shared Savings Program Quality Performance Summary - 2015				
ACO Name	**Points Earned**	**Total Potential Points**	**% of Total Quality Points**	**% of Savings Earned***
CHAC	17	30	57%	75%
OneCare	22	30	73%	95%

* **if shared savings were earned**

2015 Medicaid Payment Measures: Strengths and Opportunities

- Strengths:
  - 10 of 14 ACO results for measures with benchmarks were above the national 50th percentile
  - 6 of 14 ACO results for measures with benchmarks were above the 75th percentile
  - Both ACOs met the quality gate and CHAC was able to share in savings
- Opportunities:
  - 4 of 14 ACO results for measures with benchmarks were below the 50th percentile
  - Opportunity to improve Chlamydia Screening across both ACOs
  - Some variation among ACOs

2015 Commercial Payment Measures

Measure	CHAC Rate/ Percentile/Points*	OCV Rate/ Percentile/Points*	VCP Rate/ Percentile/Points*
ACO All-Cause Readmission (lower is better)	0.83/Below 25th/ 0 Points	1.05/Below 25th/ 0 Points	0.58/Above 90th/ 3 Points
Adolescent Well-Care Visits	47.89/Above 75th/ 3 points	57.23/Above 75th/ 3 Points	54.81/Above 75th/ 3 Points
Mental Illness, Follow-Up After Hospitalization	N/A (denominator too small)	62.75/Above 75th/ 3 Points	N/A (denominator too small)
Alcohol and Other Drug Dependence Treatment	21.48/Below 25th/ 0 Points	19.55/Below 25th/ 0 Points	22.17/Above 25th/ 1 Point
Avoidance of Antibiotics in Adults with Acute Bronchitis	15.18/Below 25th/ 0 Points	31.60/Above 75th/ 3 Points	46.27/Above 90th/ 3 Points
Chlamydia Screening	48.96/Above 75th/ 3 Points	50.49/Above 75th/ 3 Points	52.22/Above 75th/ 3 Points
Rate of Hospitalization for People with Chronic Conditions (per 100,000)	197.11/**/ 2 Points	99.23/**/ 0 Points	12.76/**/ 2 Points
Blood Pressure in Control	65.81/Above 75th/ 3 Points	70.70/Above 90th/ 3 Points	61.29/Above 50th/ 2 Points
Diabetes Hemoglobin A1c Poor Control (lower rate is better)	20.57/Above 90th/ 3 Points	15.13/Above 90th/ 3 Points	12.50/Above 90th/ 3 Points

*Maximum points per measure = 3, except as noted below

** No national benchmark; awarded maximum of 2 points based on change over time

Impact on Payment

Vermont Commercial Shared Savings Program Quality Performance Summary - 2015				
ACO Name	Points Earned	Total Potential Points	% of Total Quality Points	% of Savings Earned*
CHAC	14	23	61%	80%
OneCare	18	26	69%	85%
VCP	20	23	87%	100%

*If shared savings had been earned

2015 Commercial Payment Measures: Strengths and Opportunities

- Strengths:
  - 16 of 22 ACO results for measures with benchmarks were above the national 50th percentile
  - 15 of 22 ACO results for measures with benchmarks were above the 75th percentile
- Opportunities:
  - 6 of 22 ACO results for measures with benchmarks were below the 50th percentile
  - Opportunity to improve Alcohol and Other Drug Dependence Treatment across all ACOs
  - Even when performance compared to benchmarks is good, potential to improve some rates
  - Some variation among ACOs

2015 Medicaid Reporting Measures

Reporting Measures	CHAC Rate/ Percentile	OCV Rate/Percentile
COPD or Asthma in Older Adults	347.70/No Benchmark	412.57/No Benchmark
Cervical Cancer Screening	57.67/No Benchmark	62.35/No Benchmark
Tobacco Use Assessment & Cessation	86.74/ No Benchmark	95.65/No Benchmark
Pharyngitis, Appropriate Testing for Children	76.23/Above 50th	80.91/Above 75th
Childhood Immunization	26.91/Above 25th	56.49/Above 90th
Weight Assessment and Counseling for Children/Adolescents	49.85/Above 25th	57.50/Above 50th
Optimal Diabetes Care Composite	36.31/No Benchmark	41.00/No Benchmark
Colorectal Cancer Screening	59.77/No Benchmark	66.39/No Benchmark
Screening for Clinical Depression & Follow-Up Plan	29.68/No Benchmark	36.94/No Benchmark
Body Mass Index Screening & Follow-Up	78.65/No Benchmark	71.39/No Benchmark

2015 Medicaid Reporting Measures: Strengths and Opportunities

- Strengths:
  - For measures with benchmarks, 4 of 6 ACO results were above the national 50th percentile
  - 2 of 6 ACO results for measures with benchmarks were above the 75th percentile, and 1 of 6 was above the 90th percentile
- Opportunities:
  - 2 of 6 ACO results for measures with benchmarks were below the national 50th percentile
  - Even when performance compared to benchmarks is good, potential to improve some rates
  - Some variation among ACOs
  - Lack of benchmarks for some Medicaid measures hindered further analysis

2015 Commercial Reporting Measures

Reporting Measures	CHAC Rate/ Percentile	OneCare Rate/Percentile	VCP Rate/ Percentile
Developmental Screening	12.73/No Benchmark	56.25/No Benchmark	70.66/No Benchmark
Hospitalizations for COPD or Asthma in Older Adults (lower is better)	75.53/No Benchmark	83.01/No Benchmark	19.78/No Benchmark
Pharyngitis, Appropriate Testing for Children	N/A (denominator too small)	88.75/Above 75th	90.70/Above 90th
Immunizations for 2-year-olds	N/A (denominator too small)	74.24/Above 90th	56.92/Above 75th
Weight Assessment and Counseling for Children/Adolescents	57.28/Above 50th	67.97/Above 75th	70.16/Above 90th
Colorectal Cancer Screening	70.25/Above 90th	70.92/Above 90th	77.42/Above 90th
Depression Screening and Follow-Up	42.25/No Benchmark	41.38/No Benchmark	34.27/No Benchmark
Adult BMI Screening and Follow-up	77.27/No Benchmark	74.24/No Benchmark	68.95/No Benchmark
Cervical Cancer Screening	52.92/Below 25th	71.78/Above 25th	76.61/Above 50th
Tobacco Use Assessment and Cessation	92.68/No Benchmark	96.77/No Benchmark	72.18/No Benchmark
Diabetes Composite	40.82/No Benchmark	47.48/No Benchmark	42.34/No Benchmark

2015 Commercial Reporting Measures: Strengths and Opportunities

- Strengths:
  - For measures with benchmarks, 11 of 13 ACO results were above the national 50th percentile
  - 9 of 13 ACO results for measures with benchmarks were above the 75th percentile, and 6 of 13 were above the 90th percentile
- Opportunities:
  - For measures with benchmarks, 2 of 13 ACO results were below the national 50th percentile
  - Improvement opportunity for cervical cancer screening
  - Even when performance compared to benchmarks is good, potential to improve some rates
  - Some variation among ACOs
  - Lack of benchmarks for some Commercial measures hindered further analysis

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2015 Combined Commercial/Medicaid Patient Experience Results: CHAC and OneCare

Adult Patient Exp. Composite	CHAC Rate/ Percentile (Commercial + Medicaid)	OneCare Rate/ Percentile* (Commercial + Medicaid)
Access to Care	50%/Below 25th	59%/Above 25th
Communication	83%/Above 25th	80%/Below 25th
Shared Decision-Making	65%/At 50th	64%/Above 25th
Self-Management Support	53%/Above 50th	44%/Above 25th
Comprehensiveness	56%/Above 50th	53%/Above 50th
Office Staff	76%/At 25th	73%/Below 25th
Information	65%/No Benchmark	66%/No Benchmark
Coordination of Care	76%/No Benchmark	69%/No Benchmark
Specialist Care	49%/No Benchmark	48%/No Benchmark
LTSS Care Coordination	53%/No Benchmark	55%/No Benchmark

*OneCare rate does not include UVMMC practice results; they used a similar survey that can't be combined with these results

2015 Combined Commercial/Medicaid OneCare Results for UVMMC Practices*

Adult Patient Exp. Composite: Visit-Based Survey	UVM Medical Center/OneCare Top Score Rate/Percentile (Commercial + Medicaid)
Access to Care	82%/Above 90th
Communication	94%/Above 75th
Shared Decision-Making	62%/No Benchmark
Self-Management Support	47%/No Benchmark
Comprehensiveness	44%/No Benchmark
Office Staff	87%/Below 25th
Information	57%/No Benchmark
Coordination of Care	76%/No Benchmark
Specialist Care	46%/No Benchmark

*UVMMC-owned practices voluntarily fielded a visit-based survey that was similar to the annual survey used for ACOs; survey differences prevent direct comparison.

2015 Combined Patient Experience Measures: Strengths and Opportunities

- Strengths:
  - Most ACO primary care practices chose to participate
  - State funding (VHCIP and Blueprint) and vendor management reduced burden on practices
  - Use of same survey for Blueprint and ACO evaluation reduced probability of multiple surveys to consumers
  - 4 of 12 ACO results for measures with benchmarks were at or above the national 50th percentile
- Opportunities:
  - 8 of 12 ACO results for measures with benchmarks were below the national 50th percentile; 3 of 12 were below the national 25th percentile
  - Lack of benchmarks hindered further analysis
  - VCP did not have adequate denominators for reporting
  - National all-payer benchmarks might not be comparable to CHAC/OneCare combined Commercial/Medicaid results

Summary of 2015 Results

- Financial results positive for CHAC in Medicaid SSP
- No savings in Commercial and Medicare SSPs; Commercial targets still based on premiums
- CHAC and OneCare showed movement toward commercial targets
- There was a decrease in CHAC's Medicaid PMPM (lower is better), and no change in OneCare's Commercial PMPM
- Improvements in overall quality scores for CHAC and OneCare; continued high performance for VCP
- ACOs working to develop data collection, analytic capacity, care management strategies, and population health approaches
- Collaboration among ACOs, Blueprint, providers, payers

Vermont Medicaid Shared Savings Program: 2015 Supplemental Analyses

VMSSP Analyses

I. Understanding differences in unique population segments

II. Understanding changes in utilization and expenditure across categories of service

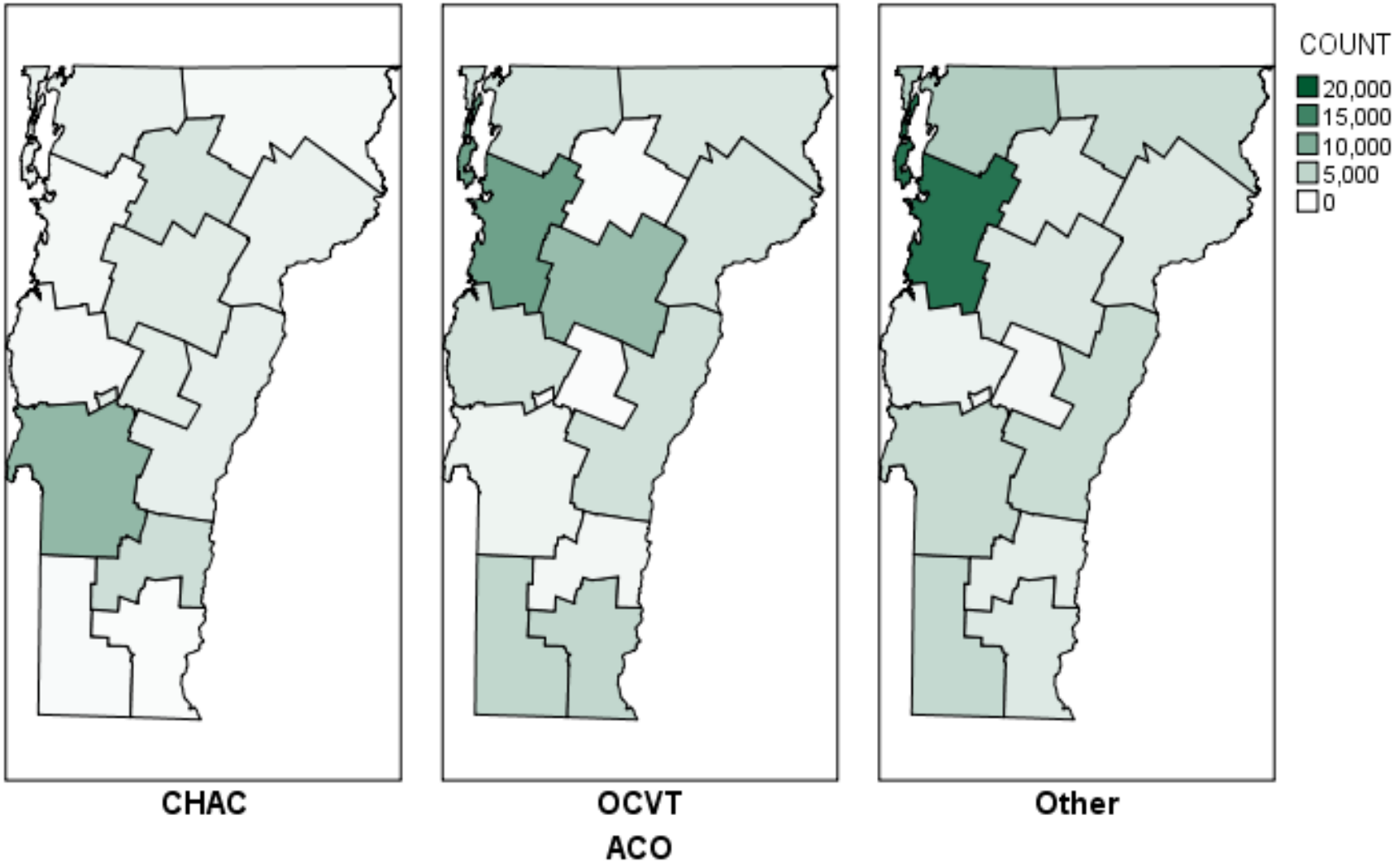
VMSSP Attribution Methodology

- **Includes** adults and children with at least 10 months of Medicaid eligibility in the program year
- **Excludes** beneficiaries dually eligible for Medicare and Medicaid, beneficiaries with other sources of insurance coverage, and beneficiaries without comprehensive benefits packages
- Attribution based on beneficiary relationship with Primary Care Provider
  1. Based on primary care claims in program year, OR
  2. Based on PCP of record (self-selected or auto-assigned)

VMSSP Attribution Snapshot: 2012 - 2015

	2012	2013	2014	2015
Attributed to OneCare Vermont	26,580	33,092	37,959	50,091
Attributed to CHAC	15,980	18,927	22,014	28,648
Eligible for Attribution (but *not* attributed to an ACO)	38,628	42,363	43,667	57,609
TOTAL ELIGIBLE FOR ATTRIBUTION	**81,187**	**94,427**	**103,640**	**136,348**

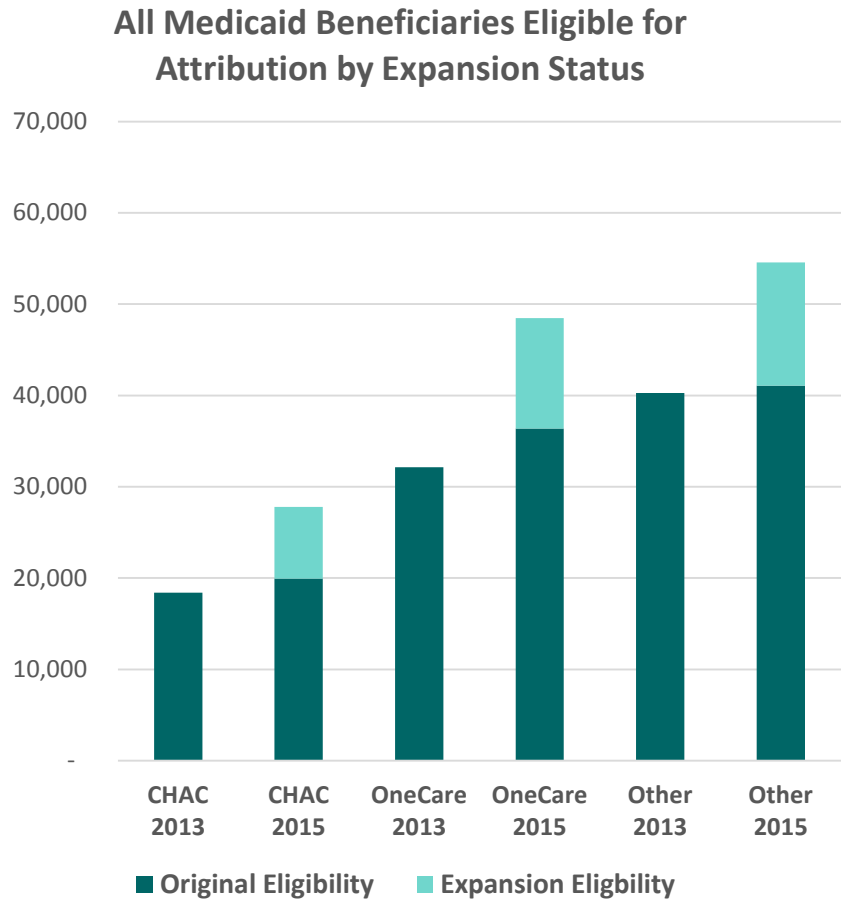
2015 VMSSP Attribution by HSA

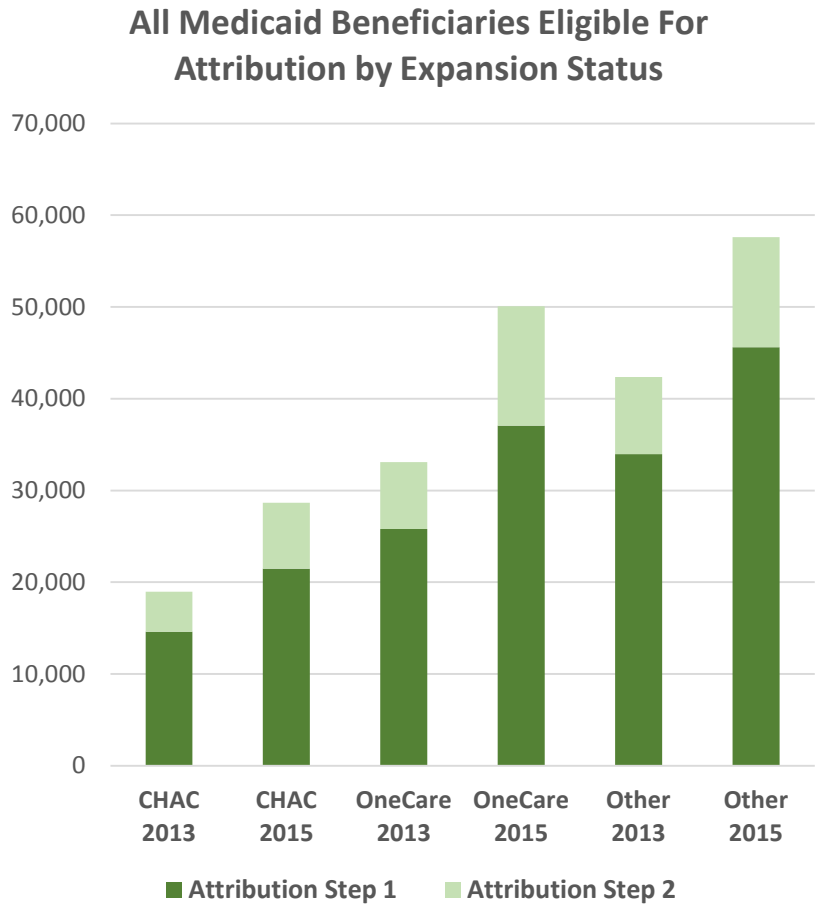


Unique Population Segments

	Baseline Period		Implementation Period	
	Attribution Steps: Step 1 vs. Step 2		Attribution Steps: Step 1 vs. Step 2	
Eligibility: Original vs. Expansion	Original Eligibility & Step 1	Original Eligibility & Step 2	Original Eligibility & Step 1	Original Eligibility & Step 2
	Expansion Eligibility & Step 1	Expansion Eligibility & Step 2	Expansion Eligibility & Step 1	Expansion Eligibility & Step 2

Population Changes from 2013 to 2015





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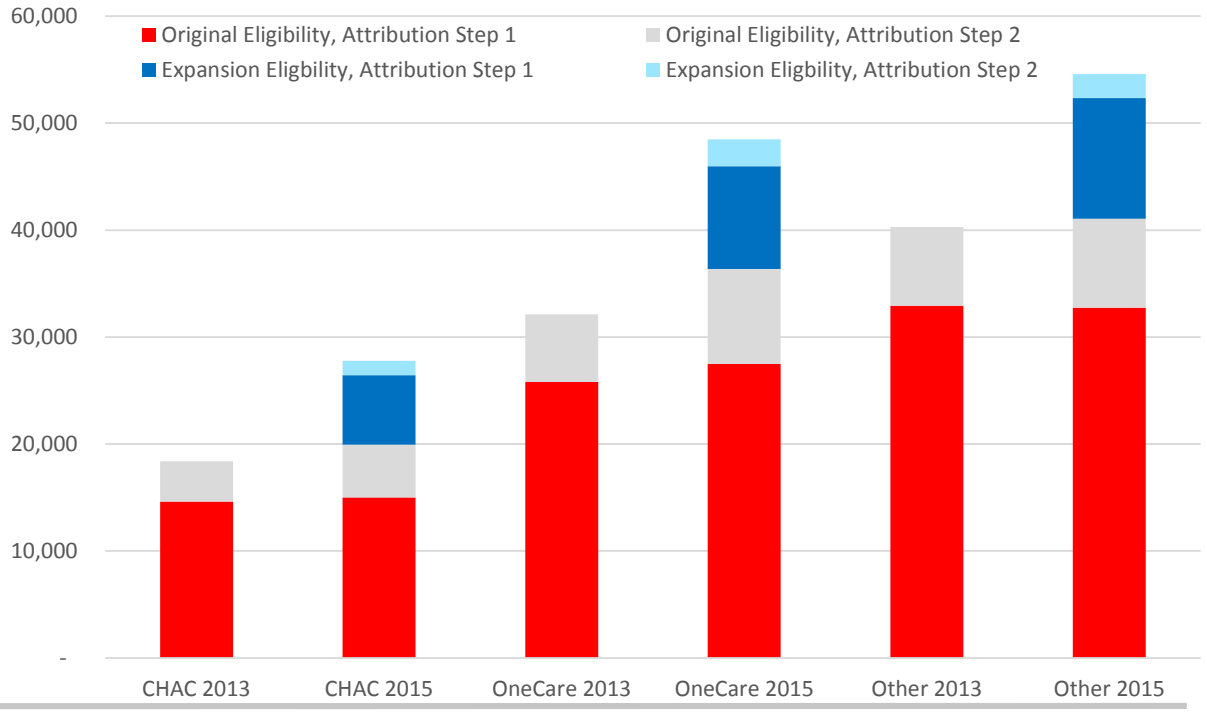
Attribution Across Population Segments

	Baseline Period		Implementation Period	
	Attribution Steps: Step 1 vs. Step 2		Attribution Steps: Step 1 vs. Step 2	
Eligibility: Original vs. Expansion	Original Eligibility & Step 1	Original Eligibility & Step 2	Original Eligibility & Step 1	Original Eligibility & Step 2
	Expansion Eligibility & Step 1	Expansion Eligibility & Step 2	Expansion Eligibility & Step 1	Expansion Eligibility & Step 2



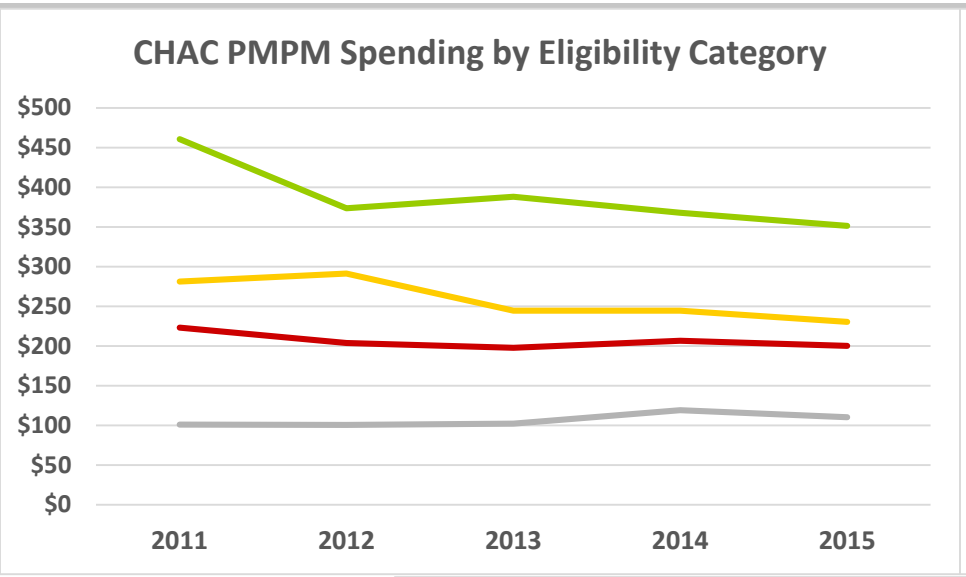
Vermont Health Care Innovation Project

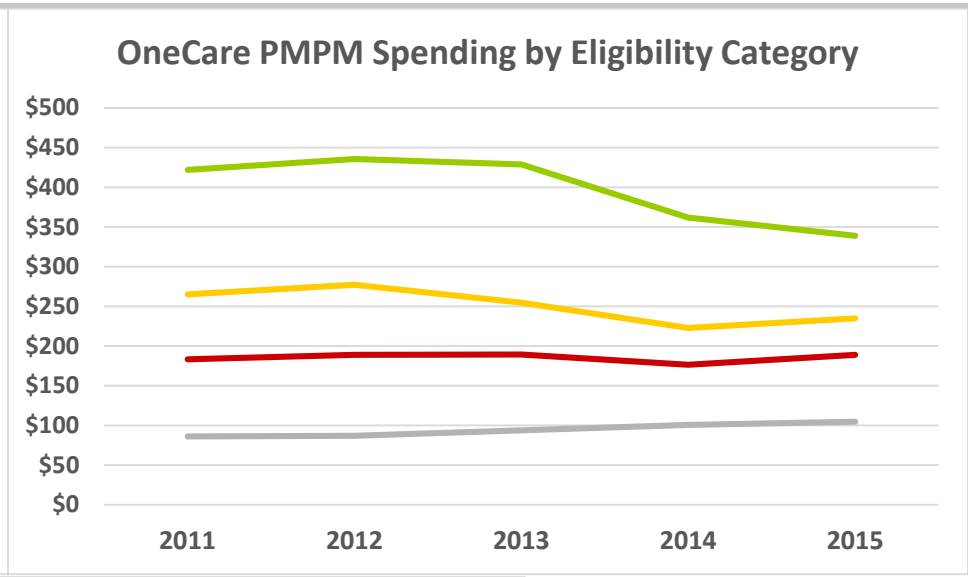
Expenditure Across Population Segments

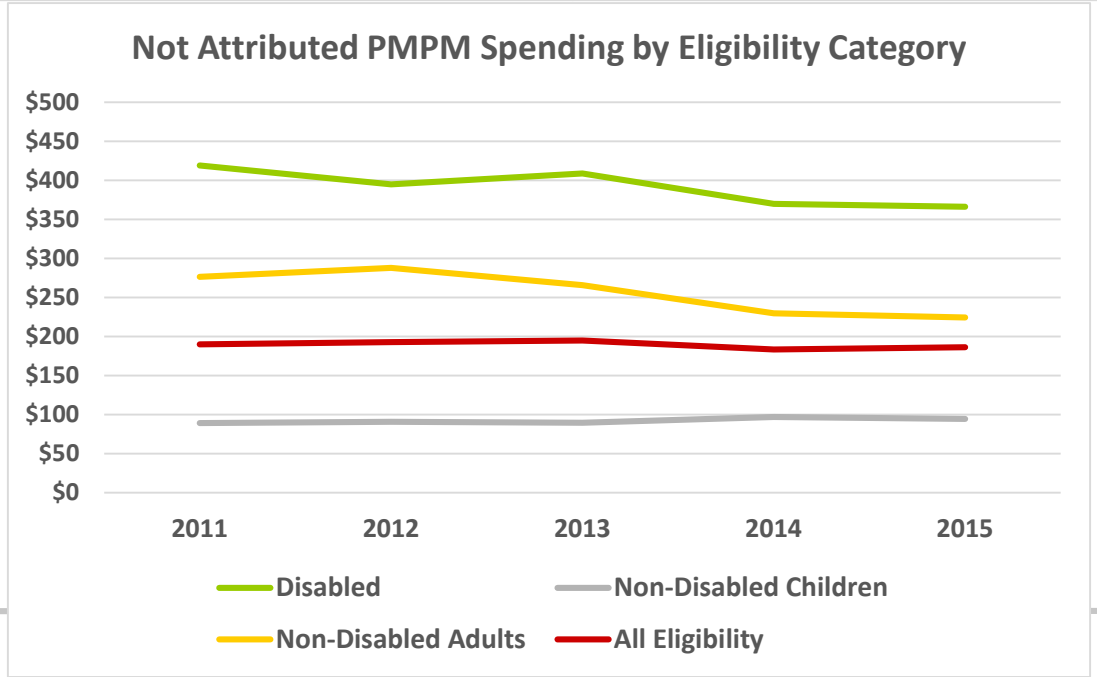
	Baseline Period		Implementation Period	
	Attribution Steps: Step 1 vs. Step 2		Attribution Steps: Step 1 vs. Step 2	
Eligibility: Original vs. Expansion	Original Eligibility & Step 1	Original Eligibility & Step 2	Original Eligibility & Step 1	Original Eligibility & Step 2
	Expansion Eligibility & Step 1	Expansion Eligibility & Step 2	Expansion Eligibility & Step 1	Expansion Eligibility & Step 2

	Cost per Member Month					
	2013		2015			
	Step 1 Attributed; Original Eligibility	Step 2 Attributed; Original Eligibility	Step 1 Attributed; Original Eligibility	Step 1 Attributed; Expansion Eligibility	Step 2 Attributed; Original Eligibility	Step 2 Attributed; Expansion Eligibility
CHAC	$ 241	$ 52	$ 218	$ 326	$ 39	$ 118
OneCare	$ 227	$ 56	$ 200	$ 330	$ 48	$ 146
Other	$ 228	$ 61	$ 191	$ 341	$ 46	$ 122

Expenditure by Eligibility Category

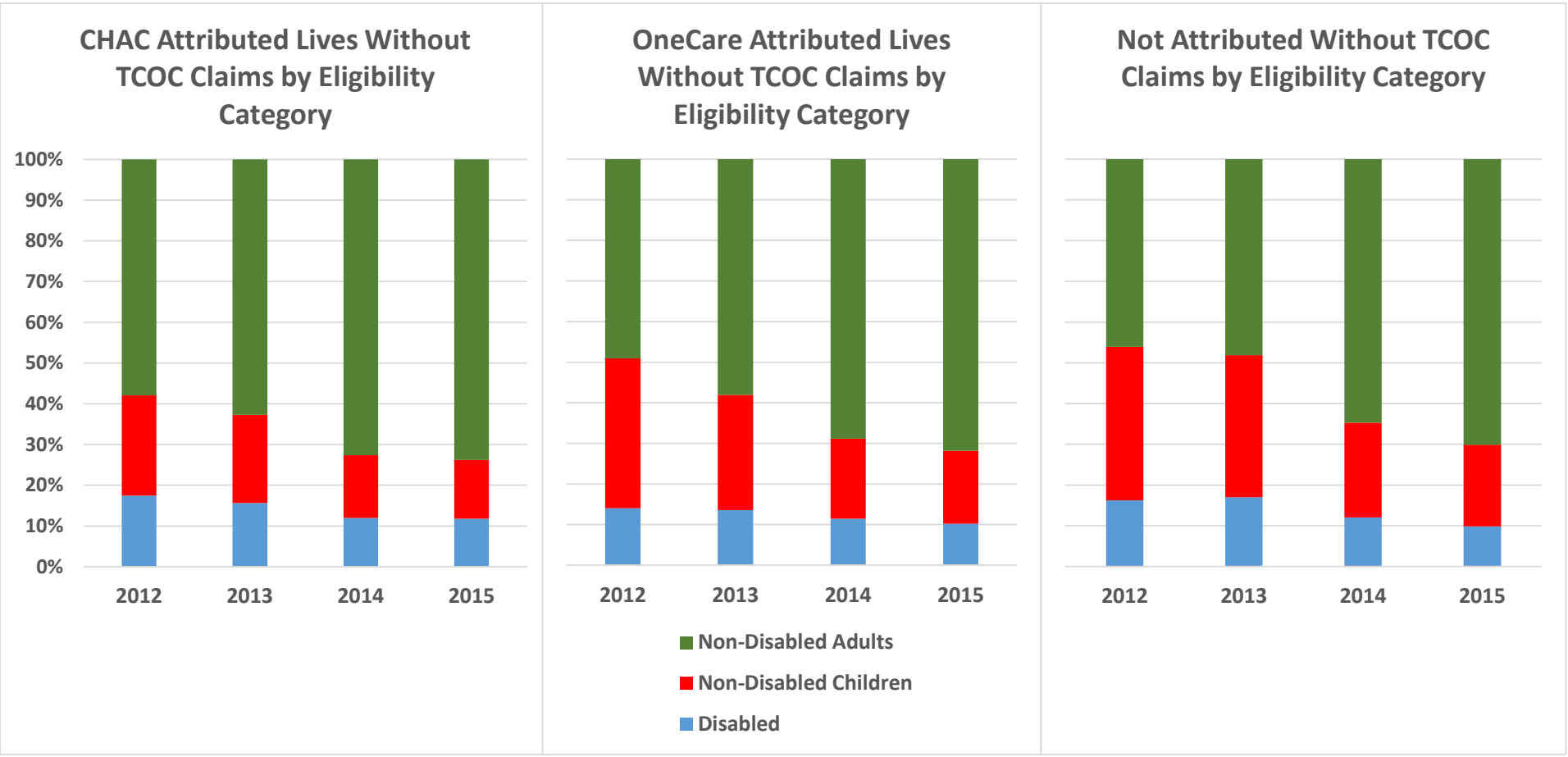




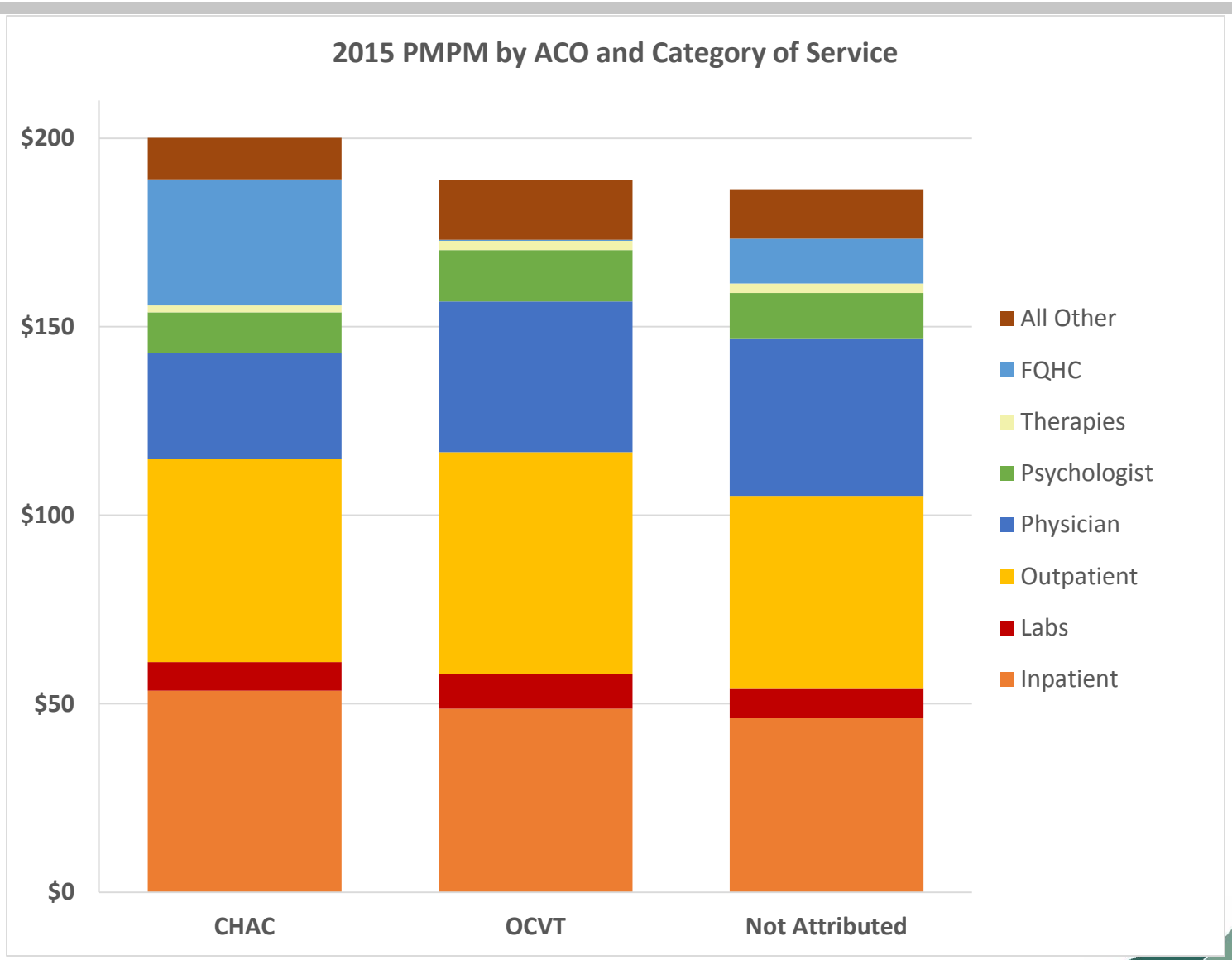


Vermont Health Care Innovation Project

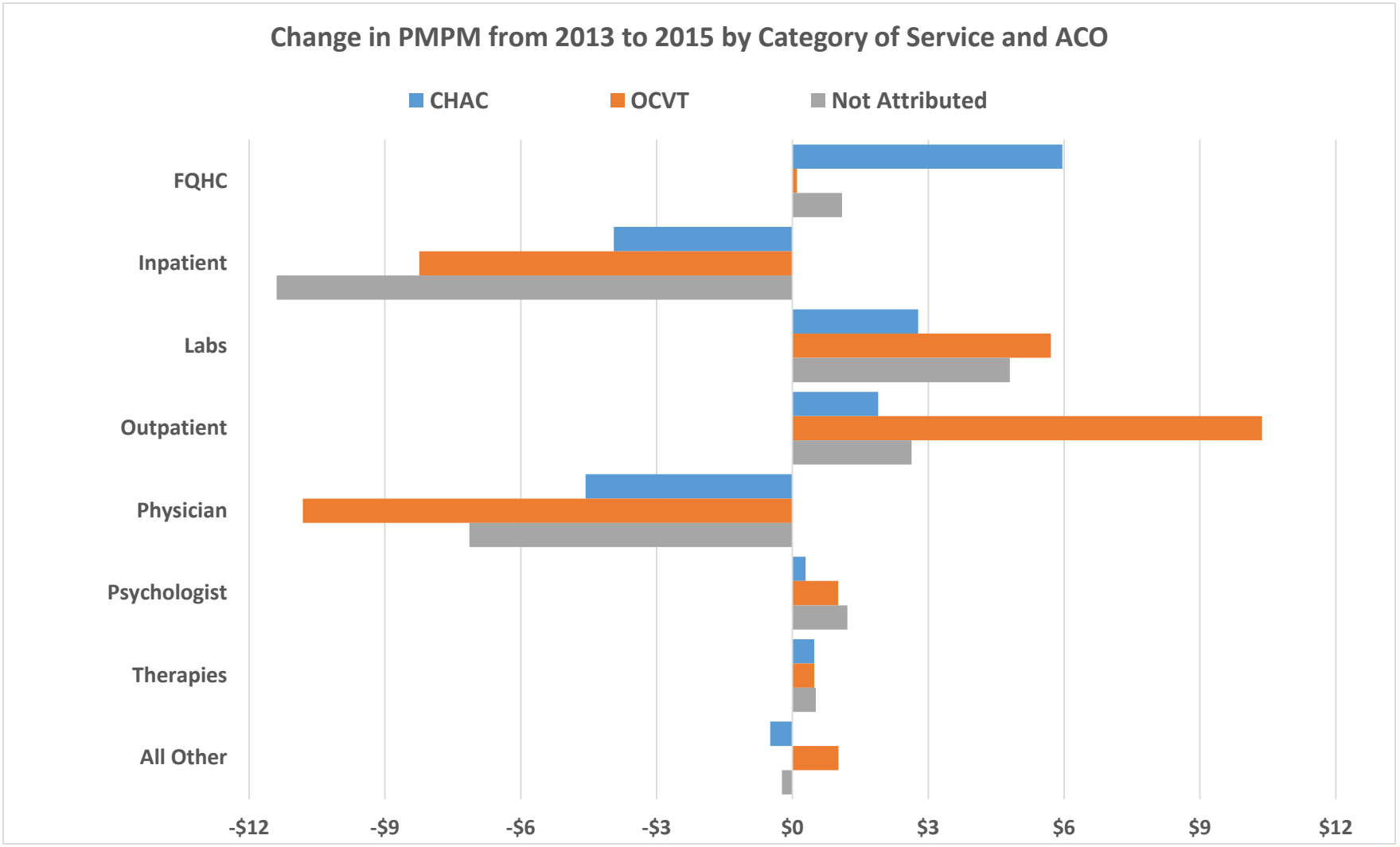
Attributed Lives without TCOC Expenditure



Expenditure by Category of Service



Expenditure Change by Category of Service



Vermont Health Care Innovation Project

OneCare Vermont 2015 SSP Results Highlights

- OneCare ranks among the top 20% of 392 Medicare ACOs in the country in "value", as calculated by ranking total cost per beneficiary with overall quality measure results by ACO.
- OneCare providers provide care to Medicare beneficiaries at 3% less cost than the national average.
- We have seen significant improvement in our quality measure results over 3 years.
- We have seen significant decrease in variation in both total cost per beneficiary and quality measure results at among our Health Service Areas, with quality improving in all communities.

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Interventions to improve value

OneCare has successfully executed on several opportunities since 2015 to improve care coordination, facilitate quality improvement, and provide important information and analysis to Vermont care providers, including:

- Engaging the Top 5% of high utilizers in care coordination activities
- Facilitating communication & comprehensive integrated care coordination (i.e. Care Navigator, RWJF Grant)
- Strengthening Community Collaboratives by providing resources, data analytics, and QI support
- Actively monitoring and communicating trends and variation in cost, quality and utilization performance
- Examples:
  - Implementation of care coordination software in four pilot communities
  - Statewide Learning Collaboratives (e.g. SBIRT, pediatric ACO quality measures)
  - Total Joint Symposium 11/14/2016

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Transitioning Our Communities for Better Health

CHAC Initiatives 2014-2016

2014	2015	2016
		Local investments of VMSSP 2014 earnings
		Implement event notification system (*PatientPing*)
		Increase enrollment in tele-monitoring intervention
		Roll out data visualization software (*Qlik*)
	Implement tele-monitoring intervention (*Pharos*)	Engage in "Data Roadshows" for PY2015
	Launch "Data Roadshows"	
	Encourage adoption (through trainings and TA) of Recommendations: • COPD • CHF • Diabetes • Falls Risk Assessment	Require documentation of implement-ation of 1+ Recommendation: • COPD • CHF • Diabetes • Falls Risk Assessment • Depression Screen & Treatment
	Develop Recommendations: • Depression Screen & Treatment	Encourage adoption (through trainings and TA) of Recommendations: • Depression Screen & Treatment
Develop Recommendations: • COPD • CHF • Diabetes • Falls Risk Assessment	Launch joint meetings of CHAC Clinical and Operations Committees to review data findings & set goals	Joint Clinical and Operations Committees work on PDSA cycles to improve data findings
Launch CHAC Clinical Committee	Sustain bimonthly meetings of Clinical Committee as working committee	Sustain bimonthly meetings of Clinical Committee as working committee

HealthFirst Highlights

- Data from commercial SSP demonstrated the value of independent providers, providing high quality care at lower cost.
- Targeted practice interventions, including sharing of "best practices", focused on ACO clinical priorities for chronic diseases and health maintenance
- Aggregation of HealthFirst network Blueprint practice & regional data encouraged independent practices to start thinking outside their walls
- Formation of Clinical Implementation Committee – a group of practice managers who meet bi-monthly to discuss logistical changes & workflow improvements – improved communication and collaboration between practices
- ACO collaboration between all three ACOs for quality measure collection enhanced a unified approach to quality measurement going forward

HEALTH FIRST

Questions?

Attachment 4b: CHAC/ OneCare Presentation

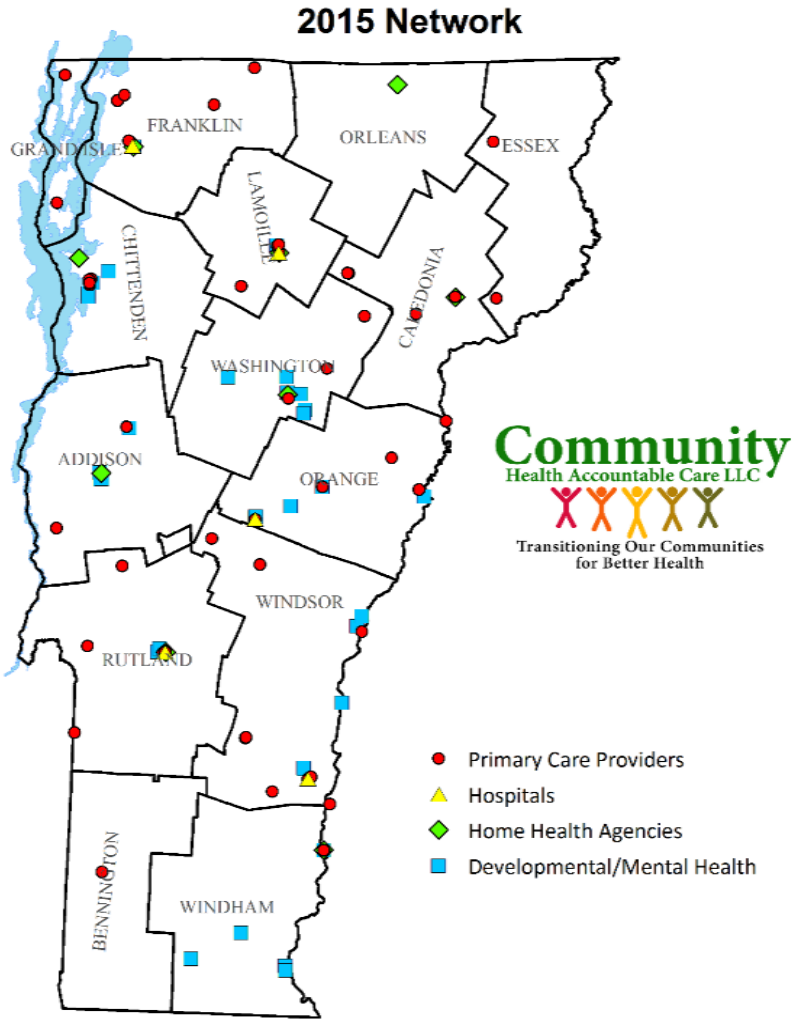
CHAC & OneCare VT
2015 Medicare Shared Savings Program Results

DLTSS Work Group – November 1, 2016

Kate Simmons, CHAC Director

Martita Giard, OCV Director, ACO Program Strategy & Development

2015 Network Composition - CHAC



CHAC's MSSP Participant Network, 2015

- 6 Federally Qualified Health Centers
- 7 Hospitals
- 14 Designated Agencies
- 9 Certified Home Health Agencies

CHAC Covered Lives

- ~6,400 Medicare Lives
- ~35,300 Total Lives

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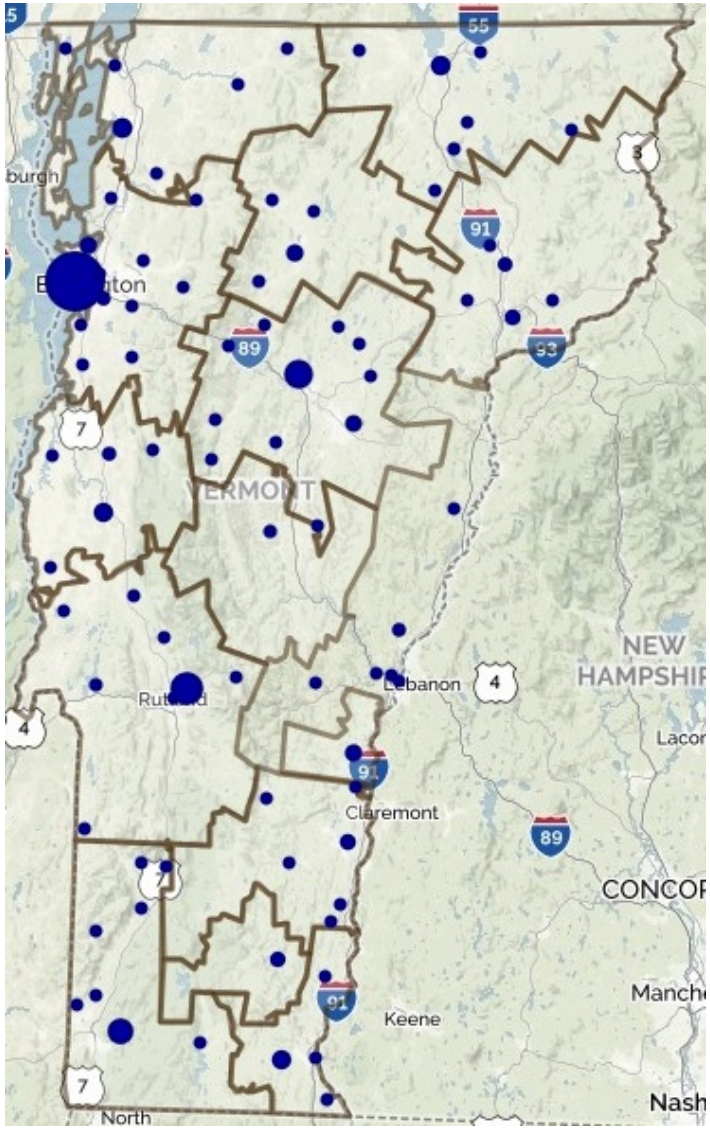
2015 Network Composition - OCV



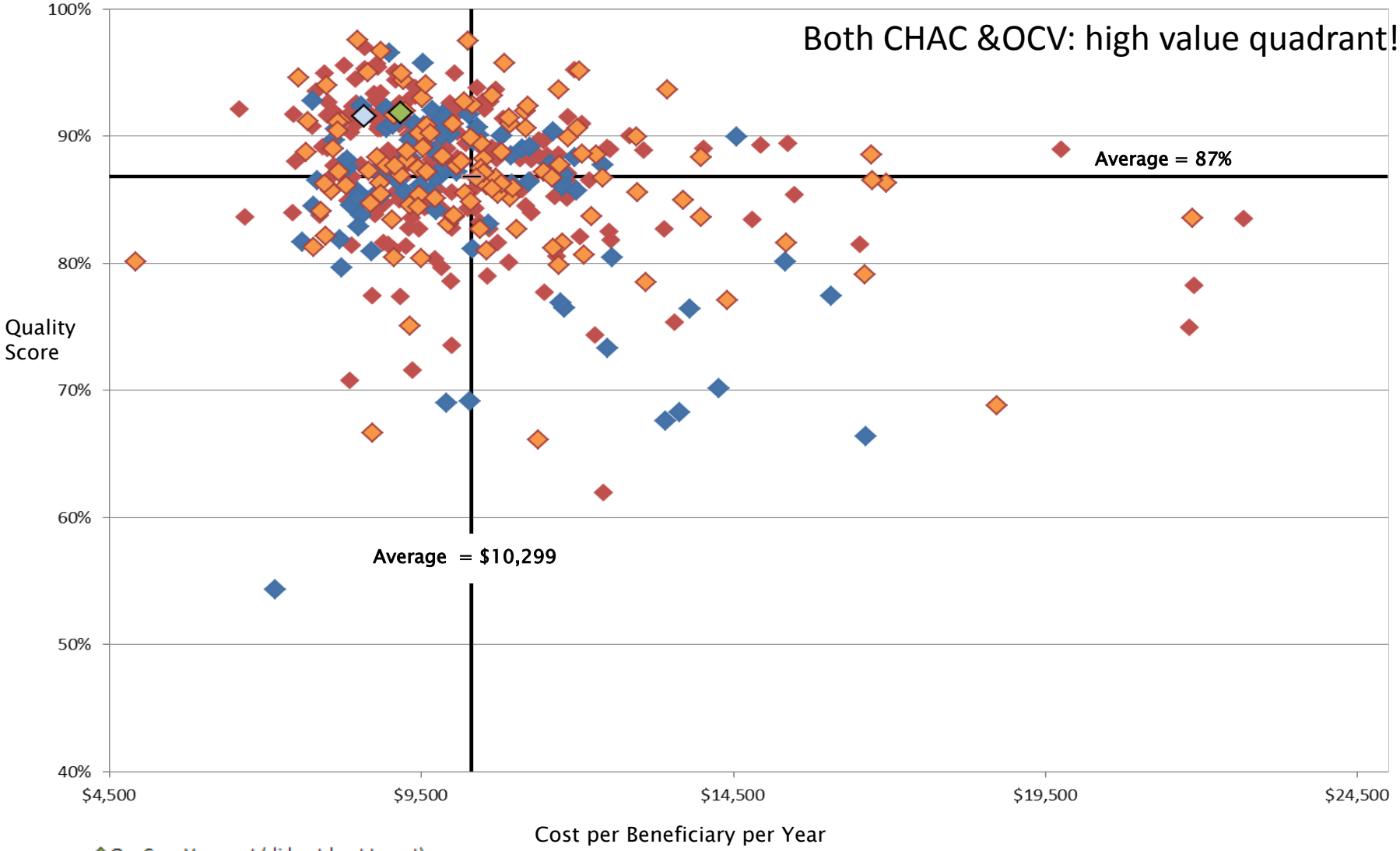
OCV's MSSP Participant Network, 2015

- 3 Federally Qualified Health Centers
- 14 Hospitals
- 1 Psychiatric Facility
- 9 Designated Agencies
- 11 Certified Home Health Agencies
- 28 SNFs
- 53 Independent Practices

OCV Covered Lives

- ~55,300 Medicare lives
- ~133,600 Total lives

MSSP ACO Cost vs. Quality 2015 Results
(Quality Score Fully Calculated[1])



[1]This figure is calculated internally as if all measures were performance scored rather than any pay-for-reporting; this calculation will more closely match the CMS-Calculated figure over time as CMS decreases the pay-for-reporting component (score does not include quality improvement points).

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Transitioning Our Communities for Better Health

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Impacting TCOC is Hard When the VT Benchmark Starts so Low

	2013	2014		2015	
2015 MSSP Results	**OCV**	**OCV**	**CHAC**	**OCV**	**CHAC**
(A) Target Spend PMPM	$713.94	$728.08	$675.00	$746.95	$681.16
(B) Actual Spend PMPM	$713.28	$734.59	$659.05	$788.48	$734.52
(C) Aggregate Savings (Loss) PMPM [(A) – (B)]	$0.66	($6.51)	$15.95	($41.53)	($53.36)
(D) Member Months	500,424	640,381	69,732	649,144	77,136
(E) Total Savings (Loss) [(D) x (C)]	$333,420	($4,168,120)	$1,112,073	($26,959,791)	($4,116,167)
Percent Under/Over Target	-0.09%	0.89%	-2.36%	5.56%	7.83%
Quality Score Factor (if savings achieved, percent of ACO's share to be paid)	100%	89%	100%	96%	97%
Prior Year Actual Spend PMPM	N/A	$713.28	N/A	$734.59	$659.05
Unadjusted Annual Growth % *(Unadjusted for Population Changes including Risk/Demographic Profile and Coverage/Plan Factors)*	N/A	2.99%	N/A	7.34%	11.45%

Why did TCOC for CHAC and OCV increase from 2014 to 2015?

CHAC:

- # of hospitalizations increased (more pts w/ multiple stays)
- Cost of hospitalizations increased

- OCV:
  - Inpatient PMPM spend grew 9% & utilization grew 5%
  - ED PMPM utilization grew 4%
  - Outpatient PMPM spend grew 4%
  - Part B (physician/supplier) PMPM spend grew 5%
    - led by a 4% growth in E&M visits spend and
    - 18% growth in Part B drugs spend

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CHAC – Striking Quality Improvement

MSSP Measure	2014	2015	Change	Primary Reason for Improvement
ACO 13: Screening for Future Falls Risk	8.72%	25%	16.28	Improved Clinical Pathways (Falls Risk Recommendations); Documentation; Enhanced Workflow
ACO 17: Screening for Tobacco Use and Cessation Counseling	76.84%	90%	13.16	Improved Clinical Pathways (education regarding measure parameters); Documentation; Enhanced Workflow
ACO 18: Screening for Clinical Depression and Follow-Up Plan	51.49%	63.38%	11.89	Improved Clinical Pathways (Depression Recommendations); Documentation; Enhanced Workflow; Community Collaboration

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OCV Striking Quality Improvement

MSSP Measure	2014	2015	Change	Primary Reason for Improvement
ACO 13: Screening for Future Falls Risk	47.31%	65.56%	18.25	Improved Clinical Pathways; Documentation; Enhanced Workflow; Community Collaboration
ACO 15: Pneumonia Vaccination Status for Older Adults	77.80%	84.70%	6.90	Documentation; Enhanced Workflow
ACO 18: Screening for Clinical Depression and Follow-Up Plan	28.07%	35.02%	6.95	Improved Clinical Pathways; Documentation; Enhanced Workflow; Community Collaboration

OCV & CHAC Excel on Quality

- OCV
  - Received 6.68 Quality Improvement Points in 2015 for significantly improving on 10 quality measures
  - 2015 final quality score is 96.1%; a 6.9% increase over 2014.
  - OCV increases overall quality performance from 2013-2015
    - 2013: 100%
    - 2014: 89.2%
    - 2015: 96.1%
- CHAC
  - Striking improvement from 2014 score of ~70% to 2015 score of 97%
  - Received 2.28 Quality Improvement Points in 2015 for significantly improving on 4 quality measures

CHAC – A Deeper Dive: Falls Risk

Evidence based best practice is identified by clinical leadership and condensed into actionable guidelines, education and training are completed, and a structured location for documenting care is incorporated into the medical record.

- Evidence-based clinical recommendations for assessing patients for Falls Risk, and patient education materials, were developed and presented to provider teams in a variety of forums (Community Collaboratives, one-on-one meetings with provider staff, provider trainings). Examples of medical record templates were presented to staff at primary care offices.

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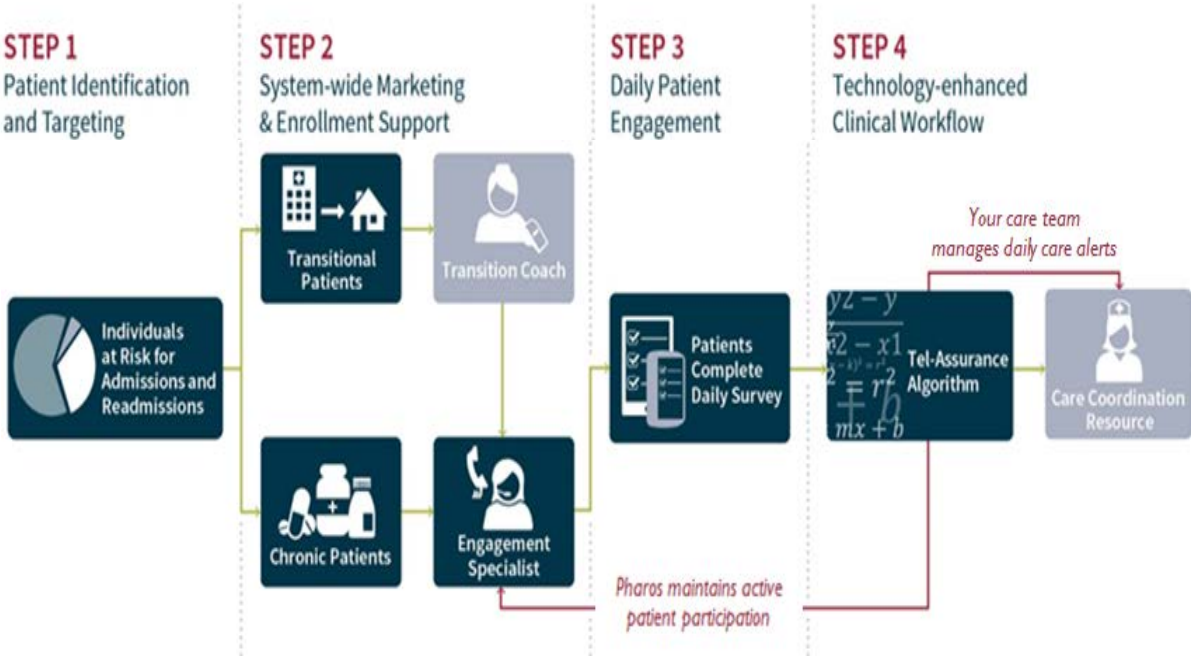
CHAC Initiative: Remote Monitoring



- ~220 CHAC Medicare beneficiaries enrolled in 2015
- 19%-36% reduction in admissions/1000 (~$1.9M)
- 26% reduction in ED visits (~$174K)

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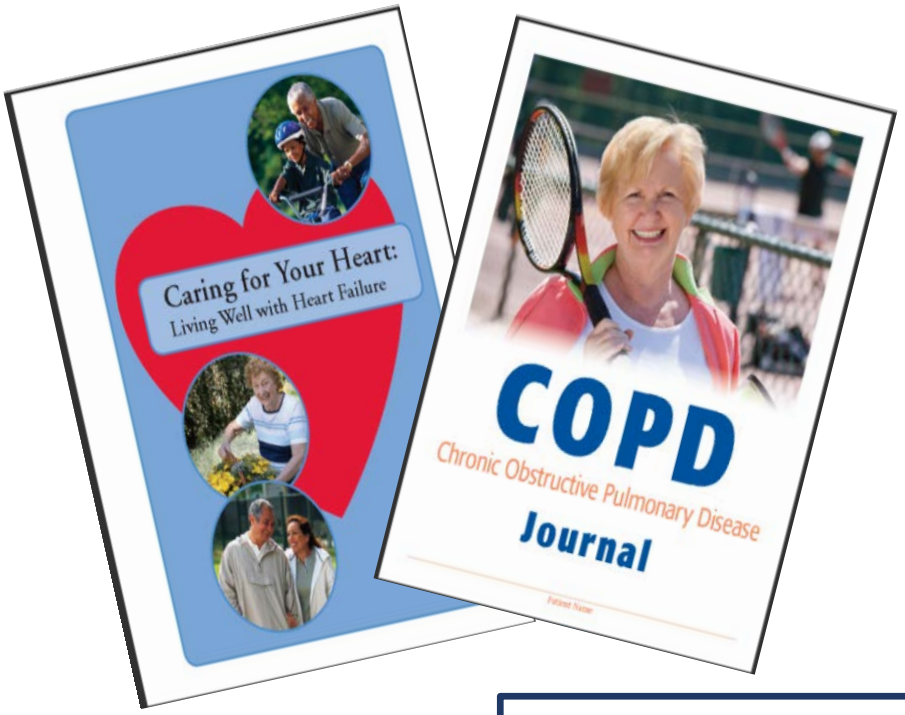
CHAC Initiatives 2014-2016



2014	2015	2016
Develop Recommendations: • COPD • CHF • Diabetes • Falls Risk Assessment	Implement tele-monitoring intervention (*Pharos*)	Implement event notification system (*PatientPing*)
Launch CHAC Clinical Committee	Launch "Data Roadshows"	Increase enrollment in tele-monitoring intervention
	Encourage adoption (through trainings and TA) of Recommendations: • COPD • CHF • Diabetes • Falls Risk Assessment	Roll out data visualization software (*Qlik*)
	Develop Recommendations: • Depression Screen & Treatment	Engage in "Data Roadshows" for PY2015
	Launch joint meetings of CHAC Clinical and Operations Committees to review data findings & set goals	Require documentation of implement-ation of 1+ Recommendation: • COPD • CHF • Diabetes • Falls Risk Assessment • Depression Screen & Treatment
	Sustain bimonthly meetings of Clinical Committee as working committee	Encourage adoption (through trainings and TA) of Recommendations: • Depression Screen & Treatment
		Joint Clinical and Operations Committees work on PDSA cycles to improve data findings
		Sustain bimonthly meetings of Clinical Committee as working committee

OCV Major Milestone Accomplishments

- Care Coordination
  - Expanded Scope and Depth of Top 5% Initiative
  - Facilitated Statewide Learning Collaboratives
  - Awarded Robert Wood Johnson Grant for Transforming Complex Care
  - Developed and Deployed Best Practice Tools

- Quality Improvement
  - Achieved Significant Improvements in Quality Measures
  - Evolved Community Collaboratives and Quality Improvement Activities

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Integrated Care Management

Data Sources

Claims Data

Clinical Data (HIE and direct EMR feeds)

OneCare Data Warehouse
WorkbenchOne

CARE NAVIGATOR
Care Management Data Storage

Data Access

Accessible using pc and mobile devices

Accessible by Care coordinators in the continuum of care and patients

Outputs

Care Coordinator and Patient work on assessment and build shared care plan

Assessment

Care Plan

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2016 Care Navigator Timeline

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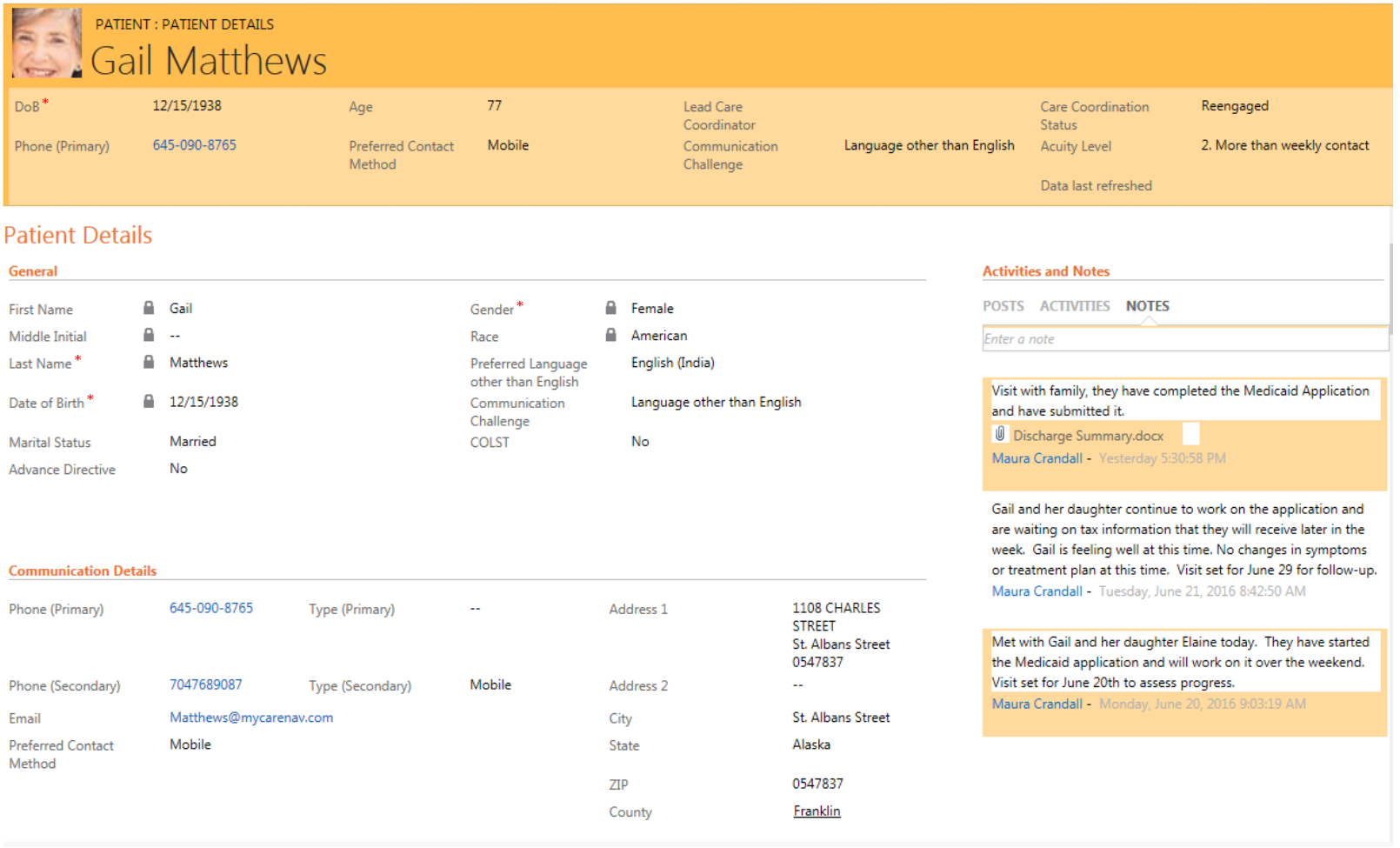
CN Patient Dashboard Patient Details and Notes

Goal: Improve Communication among care team members



PATIENT : PATIENT DETAILS

Gail Matthews

DoB *	12/15/1938	Age	77	Lead Care Coordinator		Care Coordination Status	Reengaged
Phone (Primary)	645-090-8765	Preferred Contact Method	Mobile	Communication Challenge	Language other than English	Acuity Level	2. More than weekly contact
						Data last refreshed	

Patient Details

General

First Name	Gail	Gender *	Female
Middle Initial	--	Race	American
Last Name *	Matthews	Preferred Language other than English	English (India)
Date of Birth *	12/15/1938	Communication Challenge	Language other than English
Marital Status	Married	COLST	No
Advance Directive	No		

Communication Details

Phone (Primary)	645-090-8765	Type (Primary)	--	Address 1	1108 CHARLES STREET St. Albans Street 0547837
Phone (Secondary)	7047689087	Type (Secondary)	Mobile	Address 2	--
Email	Matthews@mycarenav.com			City	St. Albans Street
Preferred Contact Method	Mobile			State	Alaska
				ZIP	0547837
				County	Franklin

Activities and Notes

POSTS ACTIVITIES NOTES

Enter a note

Visit with family, they have completed the Medicaid Application and have submitted it.
Discharge Summary.docx
Maura Crandall - Yesterday 5:30:58 PM

Gail and her daughter continue to work on the application and are waiting on tax information that they will receive later in the week. Gail is feeling well at this time. No changes in symptoms or treatment plan at this time. Visit set for June 29 for follow-up.
Maura Crandall - Tuesday, June 21, 2016 8:42:50 AM

Met with Gail and her daughter Elaine today. They have started the Medicaid application and will work on it over the weekend. Visit set for June 20th to assess progress.
Maura Crandall - Monday, June 20, 2016 9:03:19 AM

OCV Major Milestone Accomplishments

- Population Health Technology Advancements
  - Developed a Statewide Population Health Platform to Provide Actionable Data to Participants- WorkbenchOne
  - Rolled out an Integrated Care Coordination Platform- Care Navigator
  - Instituted and Deployed a new Quality Collection Tool- RedCap
  - Piloted the State Event Notification System- PatientPing

- Finance
  - Designed a Provider Payment Structure that is Consistent with Value Based Principles
  - Developed a Financial Model with Provisions for Community Investments and Quality Incentive Pool

Population Health Management Platform

Attributed Beneficiary/ Claims Feeds

VHCURES/Blueprint All-payer Datasets

HIE Clinical Data Feeds Direct EMR Feeds

HIE ADT Feeds

Internal Warehouse & Tools

SAS · Microsoft SQL Server · Qlik

HealthCatalyst ignite change

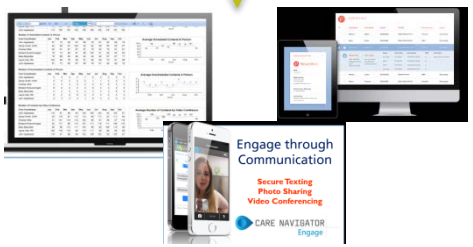
2-way data flow

BLUEPRINT HEALTHCARE IT

PATIENTPING

Maintained by Data Architect team

WorkbenchOne



Produced by PHM Analytics team

Deep Dive Analytics
Financial Modeling
Predictive Modeling
Outcomes Analysis
QI Project Support

Population-level Dashboards
Self-Service Analytics
Quality Measure Scorecards

Care Coordination Population Dashboards
Risk Stratification for Focused Population Reviews
Integrated Patient Records
Shared Care Plans
Transition of Care Support
Real-time Event Notification

Regulatory Reporting

CMS · VERMONT · DVHA · GMCB · BlueCross BlueShield

Board of Directors
Population Health Committee
Clinical & Community Transform. Council
Pediatric and Mental Health Councils
QI Council

Facilitated by Clinical and Network Ops teams

Community Collaboratives

Providers

Care Coordinators

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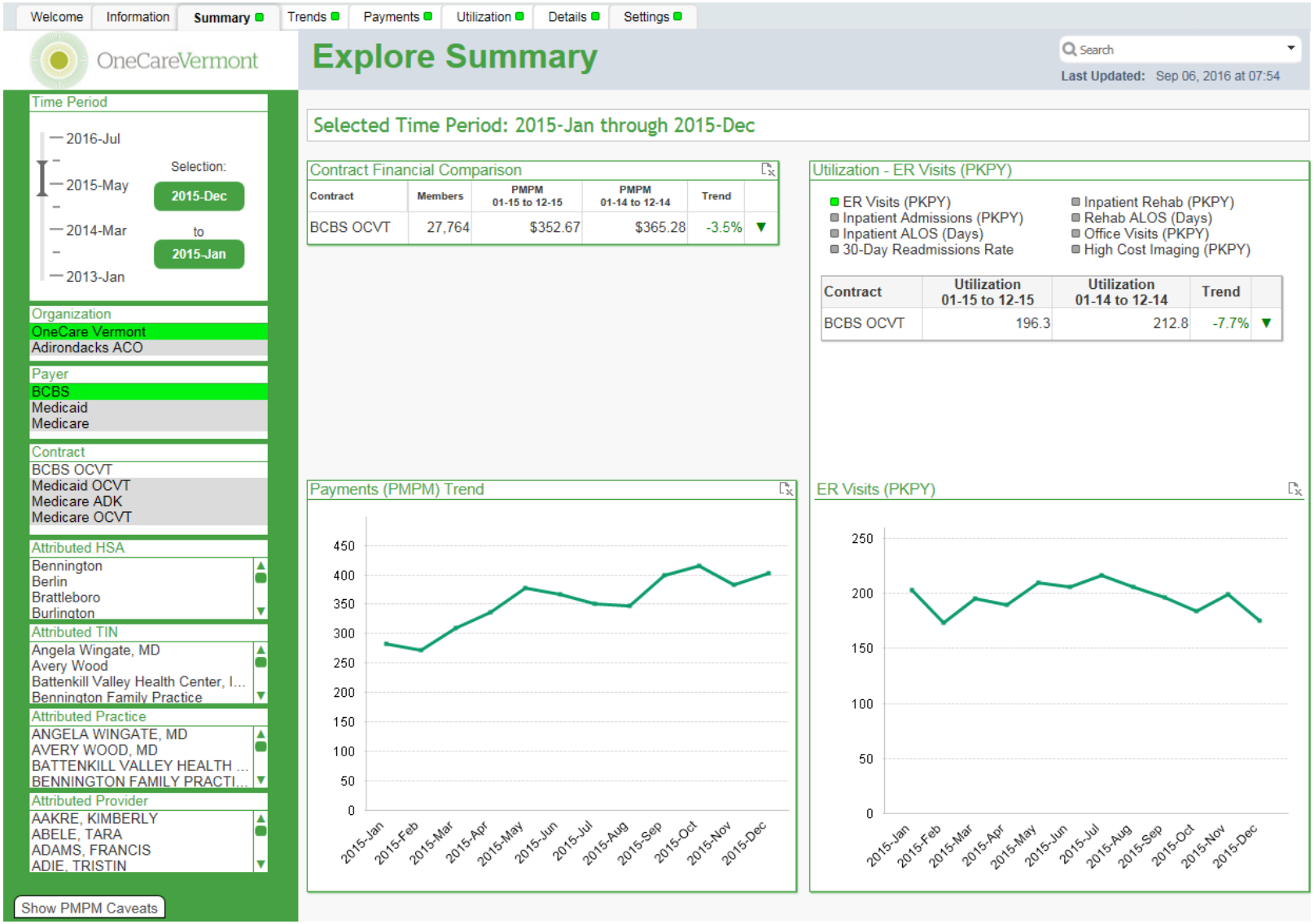
PMPM Analyzer



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Moving forward with VCO in the Future

- CHAC & OCV continued alignment through VCO to support providers, hospitals and community partners
- Both CHAC & OCV continue with MSSP Non-Risk in 2017
- Risk & Non-Risk in 2018 and possibly 2019
- Work strengthened and enhanced by the continued and aligned work of the Community Collaboratives with support from OCV & CHAC