VT Health Care Innovation Project
Core Team Meeting Agenda

October 13, 2015 3:00 pm - 4:00 pm
208 Hurricane Lane, AHS Training Room, Williston
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	3:00-3:05	Welcome and Chair's Report: a. Update on contract approvals and document submission to CMMI b. Sub-grantee symposium was October 7th c. Reorg Update d. Operational Plan Update	Lawrence Miller	
Core Team Processes and Procedures				
2	3:05-3:10	Approval of meeting minutes	Lawrence Miller	Attachment 2: August 31, 2015 *Decision needed.*
3	3:10-3:30	Proposed Year 3 Milestones	Georgia Maheras	Attachment 3a: High-Level SIM Goals Attachment 3b: Proposed Year 3 Milestones *Decision needed.*
Spending Recommendations:				

4	3:30-3:45	Funding requests: Proposed Year 3 Budget	Georgia Maheras	Attachment 4a: Year 2 Actuals and Proposed Year 3 Budget (ppt) Attachment 4b: Accountable Communities for Health Proposal (ppt) *Decision needed.*
Policy Recommendations				
5	3:45-3:55	QPM Work Group: Year 3 ACO SSP Proposed Measures	Catherine Fulton and Pat Jones	Attachment 5: Year 3 ACO SSP Proposed Measures (ppt) *Decision needed.*
6	3:55-4:00	*Public Comment*	Lawrence Miller	
7	4:00	Next Steps, Wrap-Up and Future Meeting Schedule: November 2nd, 1-3pm, 4th Floor Conference Room, Pavilion Building, Montpelier	Lawrence Miller	

Attachment 2: Minutes
August 31, 2015

Vermont Health Care Innovation Project
Core Team Meeting Minutes

Pending Core Team Approval

Date of meeting: Monday, August 31, 2015, 1:00pm-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's Report	Lawrence Miller called the meeting to order at 1:00. A roll-call was taken and a quorum was present. **Chair's Report:** *Update on Contract Approvals and Negotiations with CMMI:* We received written approval for our Year 1 Carryover request on Friday after several months of negotiations. We're now able to pay a significant number of our contractors; all were approved retroactively to the date we requested, and we've already started approving invoices and paying contractors. We have not yet received approval for our re-baselined Year 2 budget for contractors, and have now received new instructions for our Year 2 submission which are very different from previous CMMI requests – rather than moving approximately $10 million into our Year 3 budget, CMMI has requested that we move these funds back into Year 2, expand our Year 2 milestones to reflect this change, and plan for a significant carryover period. In response to this, Lawrence has been in touch with Dr. Cha at CMMI, and suggested that in the interest of resolving these issues and moving our work forward, we keep our Year 2 budget the same and give back the funds in question. CMMI has communicated that this is not its desired outcome, and we have a call set up later this week to discuss further. Georgia noted that in our budget request (included in attachments), there is a short list of contracts for which we do not yet have approval; we have not been paying these contractors since June, with the exception of one Green Mountain Care Board contractor being paid out of the State General Fund with permission from Commissioner Reardon. For unapproved contractors, there are varying degrees of risk for these contractors and the State. *Recent Reports Released:* • Prevention Institute Report: Accountable Communities for Health: Opportunities and Recommendations.	

Agenda Item	Discussion	Next Steps
	This is the first report of its kind nationally, and has been getting significant national attention. Tracy Dolan, Karen Hein, and Heidi Klein will be coming back to the project with proposed next steps. Paul Bengtson noted that work is already happening locally to advance this work, sponsored by hospitals and other providers and community organizations. • DLTSS Core Competency Briefs (available here): These will be disseminated both through the Integrated Communities Care Management Learning Collaborative and otherwise. Monica Hutt noted that these briefs begin to embed in education and training best practices for providers working with people with disabilities. Julie Wasserman commented that we are pursuing a multi-pronged distribution strategy to ensure providers and other stakeholders throughout the state receive these briefs. *Sub-Grantee Symposium:* The second sub-grantee symposium will be held October 7th in Montpelier; Core Team members are encouraged to attend this half-day meeting if they are available.	
2. Approval of Meeting Minutes	Robin Lunge moved to approve the July 2015 meeting minutes (Attachment 2). Steven Costantino seconded. A roll call vote to approve the minutes was taken. The motion passed with 2 abstentions. Paul Bengtson noted that the minutes from the July meeting include a comment regarding aligning HIT projects in the future and requested we keep this in mind for future Core Team meetings and discussions.	
3. Mid-Project Risk Assessment: Rebasing and Realignment	Lawrence Miller introduced this item and reiterated the intention to continue to incorporate input from all stakeholders and constituencies, but to reduce the number of meetings we hold monthly. Georgia Maheras presented on the mid-project risk assessment and proposed project governance changes (Attachment 3). The group discussed the following: • Paul Bengtson expressed support for the redesign, and asked that we ensure continued focus on improving care for Vermonters and improving individuals' experience of care. • *Percentage of Vermonters in Alternatives to Fee-for-Service*: o Paul Bengtson asked how we might go from 60% of Vermonters in alternatives to fee-for-service to 80% - is there a ranking of options? Georgia noted that the easiest is to count programs we're not currently counting, such as commercial insurers' value-based payment programs. We'll also examine whether to work to include currently non-participating small group plans and/or ERISA plans. Current beneficiary impact counts are not non-duplicated – Alicia Cooper at DVHA is leading the effort to identify a non-duplicated beneficiary count, which we expect to have by the next quarter. • *Providers Impacted*: o Al Gobeille asked how we're quantifying providers impacted. Georgia noted that this is not a measure requested by CMMI, it's a metric we're using to track our own progress. Al suggested he would do this differently and more expansively, based on providers impacted by improvements – for example, connecting UVMMC and DHMC to the VHIE impacts far more than 400 providers,	

Agenda Item	Discussion	Next Steps
	the current count listed. Georgia and Lawrence commented that we set few goals in this area early in the SIM grant, and are still assessing our impact; there is limited evidence to suggest where future investments could have the largest impact. o Monica Hutt asked whether we can break down providers engaged in the Learning Collaborative by provider type. Georgia noted that our new reporting format focuses more on milestones and could incorporate a breakdown by provider type. o Al Gobeille noted that with GMCB's new role in governing VITL, it's important to have a better sense of how this is impacting VITL. How can we measure progress toward our goal? o Paul Bengtson noted that his community's priority is which providers are connected to the VHIE and reporting meaningful data. He also noted that provider needs should shape connectivity: What is it that DAs need to know about patients' history and experience, for example? o Georgia suggested we provide additional information about impact, especially with regard to health data infrastructure, in future months. Lawrence noted that this work is ongoing. • *Micro-Simulation Demand Model*: Paul Bengtson asked about the micro-simulation demand model. The contract with the vendor is still in process; the model will take about 6 months to build. We hope to receive our first set of data in Spring 2016. This work lives with the Workforce Work Group. • *Population Health Plan*: Al Gobeille asked whether the Population Health Plan will be created in an iterative process with federal partners. Georgia noted that the outline for the plan has been drafted in collaboration with CMMI and CDC, with CDC taking the lead. Georgia suggested that despite previous direction from CMMI, she expects this to be an iterative process. o Paul Bengtson asked what a Population Health Plan recommendation might look like. Georgia suggested that a strategic plan for impacting social determinants of health live with health care leadership across SOV departments, rather than just at VDH. Paul wonders how this could link to Accountable Health Communities and community assessments. Georgia noted that plan development will involve community-based stakeholders. • *Health Data Infrastructure Projects:* o *SCÜP:* Monica Hutt asked whether the Shared Care Plan and Uniform Transfer Protocol were based at the DLTSS Work Group. Georgia clarified that both were based at the HIE/HIT Work Group, though the UTP request initially came from DAIL and the SCP project came from the CMCM Work Group. o *Telehealth:* Monica Hutt asked about the definition of telehealth. Al Gobeille noted that Southwestern Medical Center presented on a telehealth pilot underway with Dartmouth at last week's hospital budget hearings, and commented that there is a great deal of impressive telehealth work in the state and across the country. o *Expanded Connectivity:* Monica Hutt asked whether most HIT investments have focused on traditional medical providers, and that other provider types have less capacity in this area. Georgia agreed, and noted that this is in large part due to federal HIT investments like	

Agenda Item	Discussion	Next Steps
	Meaningful Use that strictly limited provider eligibility for incentive payments. • *Sustainability:* Paul Bengtson asked who will be leading our sustainability efforts. Georgia replied that we don't yet have a lead on this – it will be a huge focus across the project. • Paul Bengtson asked whether this proposal includes changes to the Steering Committee. It does not. Lawrence noted that written comments on the proposed changes were distributed this morning, and requested any additional comments from members. • Paul Bengtson remarked that he was not surprised that most comments came from the DLTSS Work Group. Monica Hutt noted that Hal Cohen submitted some comments not part of this packet that reiterated some specific comments and suggestions around DLTSS inclusion in this process – many of these were also included in Susan Aranoff's comments. Lawrence summarized these, noting that Hal suggested that DLTSS concerns be explicitly included in future workplans and agendas as they relate to our milestones, and that there be a process for raising concerns about inclusiveness. • Julie Wasserman noted that she sent Georgia a crosswalk of DLTSS Year 2 Workplan activities and VHCIP Year 2 milestones this morning, and distributed copies to in-person attendees. Robin requested an electronic copy for members attending by phone. Lawrence solicited additional public comment. • Susan Aranoff noted that these slides have been edited based on Steering Committee comments, though the Steering Committee did not vote on this plan. She noted that the slides don't include subject matter experts yet for each work stream, and suggested this will be important for successful implementation. Lawrence responded that these slides are not final and are illustrative; Georgia will work with staff to make final assignments. Lawrence expressed the desire not to vote today if members aren't ready, noting that Hal Cohen was absent and Monica Hutt is attending via phone. Lawrence deferred to Monica Hutt. • Monica commented that she supports the consolidation and feels ready to vote, and noted that implementation and process are key issues that will ensure success. Lawrence noted that if the proposal is approved today, we would plan for the September work group meetings to happen as scheduled, and the new structure to launch in October. If in September the DLTSS and Population Health Work Groups decide to meet sooner than quarterly to discuss implementation within the transition, we will support it. • Monica suggested that Susan and Julie could also support the new groups in ensuring DLTSS concerns are heard and included. Georgia noted that various staff will act as subject matter experts in different areas for the new work groups, but that there will be one staff person assigned to manage logistics. Monica suggested identifying the DLTSS subject matter expert on these slides to ensure clarity. Georgia supports this change and will work with staff to clarify roles. • Al Gobeille asked how to word a motion. Lawrence suggested moving to support high-level principles.	

Agenda Item	Discussion	Next Steps
	Al Gobeille moved to approve the plan to reduce the number of work groups to the number proposed here and with the structure proposed here, with the Project Director to oversee implementation. Paul Bengtson seconded. The motion carried unanimously.	
4. Policy Recommendation: HIE/HIT Work Group: Telehealth Strategy	Sarah Kinsler presented the principles and core elements of the draft Statewide Telehealth Strategy, drafted by contractor JBS International. The group discussed the following: • Paul Bengtson asked how this strategy takes into account patient portals, mobile devices, wearable devices, and retail clinics. Sarah noted that the strategy addresses some of these issues but not all, and agreed that these are fast developing areas. Karen Bell of JBS International agreed. • Al Gobeille agreed that area is evolving. He noted that there are local companies working in this area. Steven Costantino moved to approve the strategy elements. Al Gobeille seconded. A roll call vote was taken and the motion passed unanimously.	
5. Funding Recommendation: HIE/HIT Work Group: Telehealth Implementation RFP	Sarah Kinsler presented the draft scope of work for the Telehealth Implementation RFP, drafted by contractor JBS International. The group discussed the following: • Al Gobeille noted that some organizations have other ways to fund pilots, for example, Southwestern Medical Center is funding telehealth activities through the hospital budget process. He suggested we amend the RFP to prioritize funding projects that would otherwise not be funded. • Steven Costantino wondered whether telehealth services would replace services Vermonters are already receiving (for example, primary care services) or increase the use of new services. Paul Bengtson suggested that both would happen. In some cases we will have major improvements through telehealth, but those will substitute for other, costly things that we're doing. Hopefully they're less costly. Paul suggested that there are other types of organizations that need to be brought into the telehealth fold to provide the varied services needed. Steven Costantino noted that this could positively impact Medicaid's transportation budget, for example. Lawrence requested a motion for approval for the RFP to be released with a maximum of $1.1 million. Al Gobeille moved. Paul Bengtson seconded. A roll call vote was taken and the motion passed unanimously.	
6. Public Comment	There was no additional public comment.	
7. Next Steps, Wrap Up and Future Meeting Schedule	**Next Meeting:** Monday, October 5, 1:00pm-3:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP Core Team Participant List

Attendance: 8/31/2015

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

First Name	Last Name		Organization	Core Team
Susan	Aranoff	here	AHS - DAIL	S
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
Paul	Bengston	here	Northeastern Vermont Regional Hospital	M
Beverly	Boget		VNAs of Vermont	X
Harry	Chen		AHS - VDH	X
Amanda	Ciecior		AHS - DVHA	S
Hal	Cohen		AHS-CO	M
Amy	Coonradt		AHS - DVHA	S
Alicia	Cooper		AHS - DVHA	S
Steven	Costantino	phone	AHS - DVHA, Commissioner	M
Mark	Craig			X
Diane	Cummings	phone	AHS - Central Office	S
Gabe	Epstein	here	AHS - DAIL	S

Jaime	Fisher		GMCB	A
Erin	Flynn		AHS - DVHA	S
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Martita	Giard		OneCare Vermont	X
Al	Gobeille	here	GMCB	M
Bea	Grause	here	Vermont Association of Hospital and Health Systems	X
Sarah	Gregorek		AHS - DVHA	A
Thomas	Hall		Consumer Representative	X
Carrie	Hathaway		AHS - DVHA	X
Selina	Hickman		AHS - Central Office	X
Monica	Hutt	phone	AHS - DAIL	M
Kate	Jones		AHS - DVHA	S
Pat	Jones		GMCB	S
Joelle	Judge	here	UMASS	S
Sarah	Kinsler	here	AHS - DVHA	S
Heidi	Klein		AHS - VDH	S
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Robin	Lunge	phone	AOA	M
Carole	Magoffin		AHS - DVHA	S
Georgia	Maheras	here	AOA	S
Steven	Maier		AHS - DVHA	S
Mike	Maslack			X
Marisa	Melamed		AOA	S
Lawrence	Miller	here	AOA - Chief of Health Care Reform	C
Meg	O'Donnell		UVM Medical Center	X
Annie	Paumgarten	here	GMCB	S
Luann	Poirer		AHS - DVHA	S
Frank	Reed		AHS - DMH	X
Lila	Richardson	phone	VLA/Health Care Advocate Project	X
Julia	Shaw	here	VLA/Health Care Advocate Project	X
Richard	Slusky		GMCB	S
~~Kara~~	~~Suter~~		AHS - DVHA	S

Carey	Underwood			A
Steve	Voigt		ReThink Health	M
Julie	Wasserman	live	AHS - Central Office	S
Spenser	Weppler		GMCB	S
Kendall	West		Bi-State Primary Care	X
James	Westrich		AHS - DVHA	S
Katie	Whitney			A
Bradley	Wilhelm		AHS - DVHA	S
Jason	Williams		UVM Medical Center	X
Sharon	Winn	phone	Bi-State Primary Care	X
Cecelia	Wu		AHS - DVHA	S
				58

Karen Bell, JBS International - phone

· Diane · Bea · Joelle
· Sue · Sharon · Selena
· Annie · Gabe
· Sarah · Julie

VHCIP Core Team Member List
Roll Call:

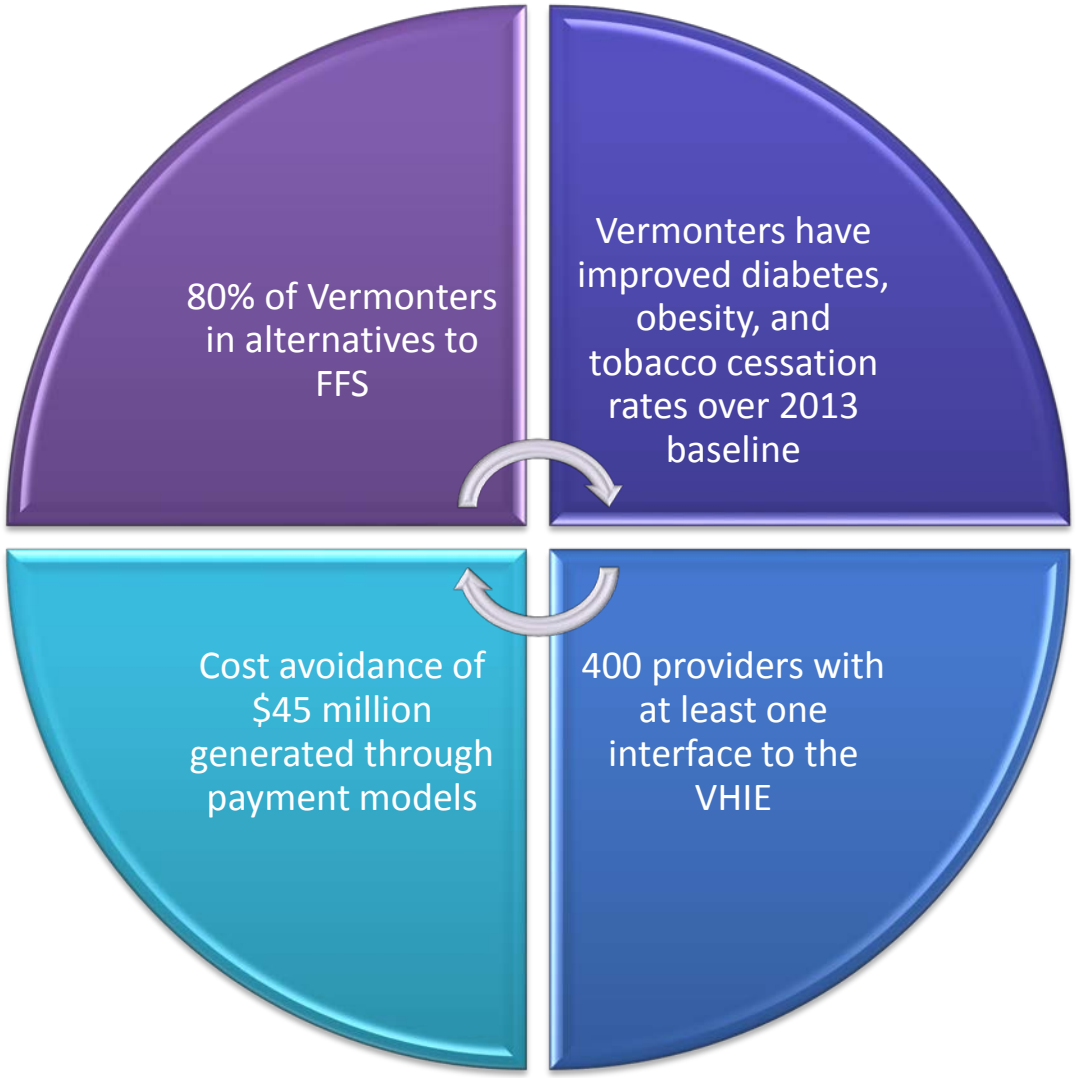
8/31/2015

Member		Minutes	Project Rebasing	Telehealth	Funding Request	
First Name	Last Name					Organization
Paul	Bengston ✓	A	✓	✓	✓	Northeastern Vermont Regional Hospital
Hal	Cohen X	—	—	—	—	AHS -CO
Steven	Costantino ✓	✓	✓	✓	✓	AHS - DVHA
Al	Gobeille ✓	A	✓	✓	✓	GMCB – left @ 2:30 pm
Monica	Hutt ✓	✓	✓	✓	✓	AHS - DAIL
Robin	Lunge ✓	✓	✓	✓	✓	AOA - Director of Health Care Reform
Lawrence	Miller ✓	✓	✓	✓	✓	AOA - Chief of Health Care Reform
Steve	Voigt X	—	—	—	—	ReThink Health

1° Robin 1° Al 1° Steven 1° Al
2° Steven 2° Paul 2° Al 2° Paul

motion passes 4 = abst. | motion passes | motion passes | motion passes

Attachment 3a: High-Level SIM Goals


80% of Vermonters in alternatives to FFS
Vermonters have improved diabetes, obesity, and tobacco cessation rates over 2013 baseline
Cost avoidance of $45 million generated through payment models
400 providers with at least one interface to the VHIE

Attachment 3b: Proposed Year 3 Milestones

Proposed Year 3 Milestones for Core Team 10.13.15

Focus Area	*Final Y2 Milestones*	*How do we measure and when do we report?*	*Proposed Y3 Milestones*
General:			
	Continue to implement project statewide: Implement all Performance Period 2 Milestones	monthly reports to Core Team; quarterly reports to CMMI and legislature	Implement all Performance Period 3 milestones
			Develop Population Health Plan by 12/31/16
			1. Execute contract(s) with vendor(s) to support development of <u>sustainability plan</u> by 1/31/16. Tasks include: a. Design and possible deployment of an integrated data, analytic and Population Health Management toolset infrastructure. b. Design of unified governance model providers within the APM. c. Analysis of all SIM-related activities to determine sustainability path, including governance and financial expenditure recommendations. d. Stakeholder review for sustainability plan. e. Documentation of sustainability plan. 2. Develop Sustainability Plan by 11/1/16.
	Final Y2 Milestones	***How do we measure and when do we report?***	***Proposed Y3 Milestones***
Payment Models			
ACO Shared Savings Programs (SSPs)	Expand the number of people in the Shared Savings Programs in performance period 2 (goal met by 12/31/15): Medicaid/commercial program provider participation target: 950 Medicaid/commercial program beneficiary attribution target: 130,000	Reporting to GMCB and DVHA, measured quarterly.	Expand the number of people in the Shared Savings Programs in performance period 2 (goal met by 12/31/16): Medicaid/commercial program provider participation target: 1000 Medicaid/commercial program beneficiary attribution target: 160,000

Proposed Year 3 Milestones for Core Team 10.13.15

Payment Models	*Final Y2 Milestones*	*How do we measure and when do we report?*	*Proposed Y3 Milestones*
Episodes of Care (EOCs)	3 EOCs designed for Medicaid- implementation of data reports by 1/1/16. Implementation of data reports means: episodes selected, outreach plan to providers designed, first run of historic data provided to providers participating in program.	Monthly status reports	Implement 3 EOCs for Medicaid by 7/1/16. Implementation includes monitoring, reporting of data, evaluation for all three EOCs.
Pay-for-Performance	Roll-out of new P4P investments for CHTs by 7/16 and enhanced direct payments by 1/1/16 according to approved P4P plan (using new funds that were appropriated by the legislature).	Quarterly reports to CMMI and Legislature	Medicaid/commercial/Medicare:Number of providers participating in P4P program target: 698Number of beneficiaries participating in P4P program target: 297,033 P4P incorporated into Sustainability Plan by 10/31/16.
Health Home (Hub & Spoke)	Reporting on program's transition and progress: Quarterly reporting of program progress to CMMI, VHCIP stakeholders.	Quarterly reports to CMMI and Legislature	Medicaid/commercial/Medicare: Number of providers participating in Health Home program target: 65 MDs prescribing to >= 10 patients. Number of beneficiaries participating in Health Home program target: 2,785 Hub + 2,284 Spoke = 5,069 total patients. Health Home incorporated into Sustainability Plan by 10/31/16.
Accountable Communities for Health (ACH)	Feasibility assessment--data analytics: 1. Discussion and planning of investments related to ACH feasibility based on research/report by 11/1/15. 2. Design/creation of ACH learning system for all 14 Vermont Health Service Areas by 12/31/15. 3. Start roll out ACH learning system to at least 3 health service areas by 1/1/16. 4. Research for implementation of a pilot incorporating a payment change (data analysis, financial analysis, stakeholder participation analysis) for at least 1 Vermont region by 1/1/16.	Monthly status reports.	ACH Implementation Plan incorporated into Sustainability Plan by 10/31/16.

Proposed Year 3 Milestones for Core Team 10.13.15

Payment Models	*Final Y2 Milestones*	*How do we measure and when do we report?*	*Proposed Y3 Milestones*
Prospective Payment System – Home Health	1. Creation of a project plan and begin phase 1 activities as required by project plan for PPS-HH by 12/31/15. 2. Design PPS program for home health for launch 7/1/16.	Monthly status reports	1. Implement, monitor and evauate Medicaid PPS program for home health. Implementation by 7/1/16. 2. Monitoring and evaluation occur monthly through 12/31/16.
Prospective Payment System – Designated Agencies	Submit planning grant for Certified Community Behavioral Health Clinics to SAMHSA by 8/5/15. If awarded, begin alignment of new opportunity with SIM activities. (note, no SIM funds used to support this effort).	TBD depending on SAMHSA grant award- will sync up with that schedule.	**Not Y3**
Medicaid Value-Based Purchasing: Mental Health and Substance Use	Not Y1 Carryover	Monthly status reports	1. Based on research and feasibilty analysis, design an alternative to fee-for-service, for Medicaid mental health and substance use services by 12/31/16. 2. Develop implementation timeline based on payment model design and operational readiness by 12/31/16.
All-Payer Model	1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI. 2. Work with CMMI on mutually-agreed upon timeline for 2016 decision-making by 12/31/15.	Monthly status reports	If negotiations are successful, assist with implementation as provided for in APM agreement through the end of the grant term.
State Activities to Support Model Design and Implementation – GMCB	1. Research and planning to identify the components necessary for APM regulatory activities by 11/15/15. 2. Specific regulatory activities and timeline are dependent on discussions with CMMI.	monthly status reports (embedded in the APM monthly status reports)	**Not Y3**

Proposed Year 3 Milestones for Core Team 10.13.15

Payment Models	*Final Y2 Milestones*	*How do we measure and when do we report?*	*Proposed Y3 Milestones*
State Activities to Support Model Design and Implementation – Medicaid	Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 1. Ensure appropriate customer service supports are in place for Medicaid SSP program for 2016 by 11/1/15. 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 12/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 12/31/15. 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout performance period 2 according to the predetermined plan. 5. Develop monitoring and compliance plan for Year 1 EOCs by 12/31/15. 6. Design modifications to existing Integrated Family Services Program so it can expand to at least one additional community on 1/1/16. 7. Research and design related to Frail Elders (timeline dependent upon federal contract approval).	Monthly status report (and embedded in other reports by topic).	1. Obtain SPA for Year 3 of the Medicaid Shared Savings Program by 12/31/16. 2. Execute Year 3 commercial and Medicaid monitoring and compliance plans throughout performance period 3 according to the predetermined plan. 3. Execute Year 1 monitoring and compliance plan for EOCs by 12/31/16. 4. Integrated Family Services (IFS) SPA documents developed for 7/1/16 launch. Expand to 3 more regions by 7/1/16.5. IFS expansion to remainder of State by 12/31/16.

Proposed Year 3 Milestones for Core Team 10.13.15

	Final Y2 Milestones	*How do we measure and when do we report?*	*Proposed Y3 Milestones*
Practice Transformation			
Learning Collaboratives	Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 1. Create expansion plan for remaining Vermont HSAs that want to participate in the Learning Collaborative program by 6/15/15. 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 12/31/15.	monthly status reports.	1. Target 500 Vermont providers have completed the Learning Collaborative by 12/31/16. 2. Report on program effectiveness to Steering Committee and Core Team by 9/30/16. 3. Incorporate Learning Collaborative lessons learned into Sustainability Plan by 10/31/16.
Sub-Grant Program – Sub-Grants	**Not Y2**	**Not Y2**	1. Provide SIM funds to support sub-grantees through 10/31/16.2. Convene sub-grantees at least twice by 12/31/16.3. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.
Sub-Grant Program – Technical Assistance	**Not Y2**	**Not Y2**	Provide technical assistance to sub-grantees as requested by sub-grantees. Provide technical assistance to sub-grantees as requested by sub-grantees: 1. Remind sub-grantees of availability of technical assistance on a monthly basis. 2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees.
Regional Collaborations	Expansion of regional collaborations to all 14 Health Service Areas (HSAs) by 12/31/15. Expansion is complete when all HSAs have a Charter, governing body, and decision-making process.	monthly status reports	**Not Y3**
Workforce – Care Management Inventory	**Not Y2**	**Not Y2**	**Not Y3**

Proposed Year 3 Milestones for Core Team 10.13.15

Practice Transformation	*Final Y2 Milestones*	*How do we measure and when do we report?*	*Proposed Y3 Milestones*
Workforce – Demand Data Collection and Analysis	1. Execute contract for micro-simulation demand modeling by 9/30/15 (dependent on federal approval). 2. Provide preliminary data as defined by the contract to vendor for use in model by 12/31/15.	monthly status reports; report from the vendor.	1. Transfer model to Vermont Dept. of Labor by 12/31/16.
Workforce – Supply Data Collection and Analysis	**Not Y2**	**Not Y2**	Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan: 1. Present data to Workforce Work Group at least 3 times by 9/30/16. 2. Publish data reports/analyses on website by 12/31/16. 3. Distribute reports/analyses to project stakeholders by 12/31/16. 4. Incorporate into sustainability plan by 10/31/16.
	Final Y2 Milestones	***How do we measure and when do we report?***	***Proposed Y3 Milestones***
Health Data Infrastructure			
Expand Connectivity to HIE – Gap Analyses	**Not Y2**	**Not Y2**	**Not Y3**
Expand Connectivity to HIE – Gap Remediation	Remediate data gaps that support payment model quality measures, as identified in gap analyses: 1. Remediate 50% of data gaps for SSP quality measures by 12/31/15. 2. Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15.	monthly status reports	1. Remediate 70% of ACO SSP measures-related gaps as identified in fall 2015. 2. Report on LTSS remediation plan and incorporate into HIT Strategic Plan by 2/28/16. 3. Incorporate into Sustainability Plan by 10/31/16.

Proposed Year 3 Milestones for Core Team 10.13.15

Health Data Infrastructure	***Final Y2 Milestones***	***How do we measure and when do we report?***	***Proposed Y3 Milestones***
Expand Connectivity to HIE – Data Extracts from HIE	**Not Y2**	**Not Y2**	**Not Y3**
Expand Connectivity to HIE	**Not Y2**	**Not Y2**	**Not Y3**
Improve Quality of Data Flowing into HIE	1. Implement terminology services tool to normalize data elements within the VHIE by 10/1/15. 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 12/31/15.	monthly status reports (reports from vendors)	1. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 50% of ACO attributing practives by 6/30/16. Complete workflow improvement by 12/31/16. 2. Engage in workflow improvement activities at designated mental health agencies (DAs) as identified in gap analyses. Start workflow improvement activities in all 16 DAs by 6/30/16 and complete workflow improvement by 12/31/16.
Telehealth – Strategic Plan	Develop telehealth strategic plan by 9/15/15.	completed report by deadline.	**Not Y3**
Telehealth – Implementation	1. Release telehealth program RFP by 9/30/15.2. Award at least one contract to implement the scope of work in the telehealth program RFP by 11/30/15.	RFP released on time; monthly status report (award made and contract written)	Make recommendations for the Sustainability Plan by 10/31/16.

Proposed Year 3 Milestones for Core Team 10.13.15

Health Data Infrastructure	***Final Y2 Milestones***	***How do we measure and when do we report?***	***Proposed Y3 Milestones***
EMR Expansion	1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and Developmental Disability agencies (by 12/31/15). 2. Explore non-EMR solutions for providers without EMRs: develop plan based on LTSS technical gap analysis.	monthly status reports	**Not Y3**
Data Warehousing	1. Implement Phase 1 of DA/SSA data warehousing solution by 12/31/15 (implementation follows implementation project plan). 2. Procure clinical registry software by 12/31/15. 3. Develop a cohesive strategy for developing data systems to support analytics by 12/31/15.	monthly status reports	1. Implement Phase 2 of DA/SSA data warehousing solution by 12/31/16. 2. Begin to implement cohesive strategy for developing data systems to support analytics by 12/31/16.
Care Management Tools	Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development: 1. Event Notification System: procure solution by 11/1/15 implement according to project plan for phased roll out. 2. SCUP (shared care plans and uniform transfer protocol): create project plan for this project that includes business requirements gathering by 9/30; technical requirements by 10/31; and final proposal for review by 11/30/15.		SCUP: launch pilot project based on approved proposal by 5/1/16. Impact 45 (15 in each of three communities) providers by 12/31/16.

General Health Data – Data Inventory	**Not Y2**	**Not Y2**	**Not Y3**
Health Data Infrastructure	***Final Y2 Milestones***	***How do we measure and when do we report?***	***Proposed Y3 Milestones***
General Health Data – HIE Planning	1. VHCIP will provide comment into the HIT Strategic Plan at least 4 times in 2015.2. HDI work group will identify connectivity targets for 2016-2019 by 12/31/15.	monthly status reports	**Not Y3**
General Health Data – Expert Support	Procure appropriate IT-specific support to further health data initiatives- depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.	monthly status reports	Procure appropriate IT-specific support to further health data initiatives- depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.
	Final Y2 Milestones	***How do we measure and when do we report?***	***Proposed Y3 Milestones***
Evaluation:			
Self-Evaluation Plan and Execution	1. Amend vendor self-evaluation contract to reflect new activities within 30 days of CMMI approval of self-evaluation plan. 2. Streamline reporting around other evaluation activities not performed by Impaq within 30 days of CMMI approval of self-evaluation plan.	monthly status reports	Execute self-evaluation plan for 2016 according to timeline for Y3 activities.
Surveys	Conduct annual patient experience survey and other surveys as identified in payment model development: Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings programs-phase 1 to determine impact of performance period 2 activities.	monthly status reports (contractor reports)	1. Conduct patient experience survey to inform Y3 Shared Savings Program by 12/31/16.

Proposed Year 3 Milestones for Core Team 10.13.15

Evaluation	*Final Y2 Milestones*	*How do we measure and when do we report?*	*Proposed Y3 Milestones*
Monitoring and Evaluation Activities Within Payment Programs	1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications: biannual reporting to providers. 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: monthly, quarterly reports depending on type.	monthly status reports (embedded in the SSP reports)	1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications: biannual reporting to providers. 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: monthly, quarterly reports depending on type. 3. Conduct analyses of the EOC program according to program specifications: monthly, quarterly; depending on report type. 4. TBD APM, PPS, Mental Health and Substance Use.

Proposed Year 3 Milestones for Core Team 10.13.15

	Final Y2 Milestones	*How do we measure and when do we report?*	*Proposed Y3 Milestones*
Project Management and Reporting			
Project Management and Reporting – Project Organization	Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2. Monthly staff meetings, co-chair meetings, and Core Team meetings with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Submit quarterly reports to CMMI and the Vermont Legislature.	monthly report to Core Team	Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2. Monthly staff meetings, co-chair meetings, and Core Team meetings with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Submit quarterly reports to CMMI and the Vermont Legislature. 4. Sustainability Plan complete by 11/30/16.
Project Management and Reporting – Communication and Outreach	Engage stakeholders in project focus areas by: 1. Convening 5 Core Team, 5 Steering Committee, and 10 work group public meetings by 12/31/15. 2. Distributing all-participant emails at least once a month. 3. Updating website at least once a week.	Monthly report to Core Team. Quarterly Report to CMMI.	Engage stakeholders in project focus areas by: 1. Convening 10 Core Team, 10 Steering Committee, and 25 work group public meetings by 12/31/16. 2. Distributing all-participant emails at least once a month. 3. Updating website at least once a week.

Attachment 4a: Year 2 Actuals and Proposed Year 3 Budget

2015 Budget to Actuals and 2016 Budget Proposal to Core Team

Georgia Maheras, Project Director

October 13, 2015

2015 Budget to Actuals:

This includes only those contracts that have been approved by CMMI, so it is an incomplete picture.

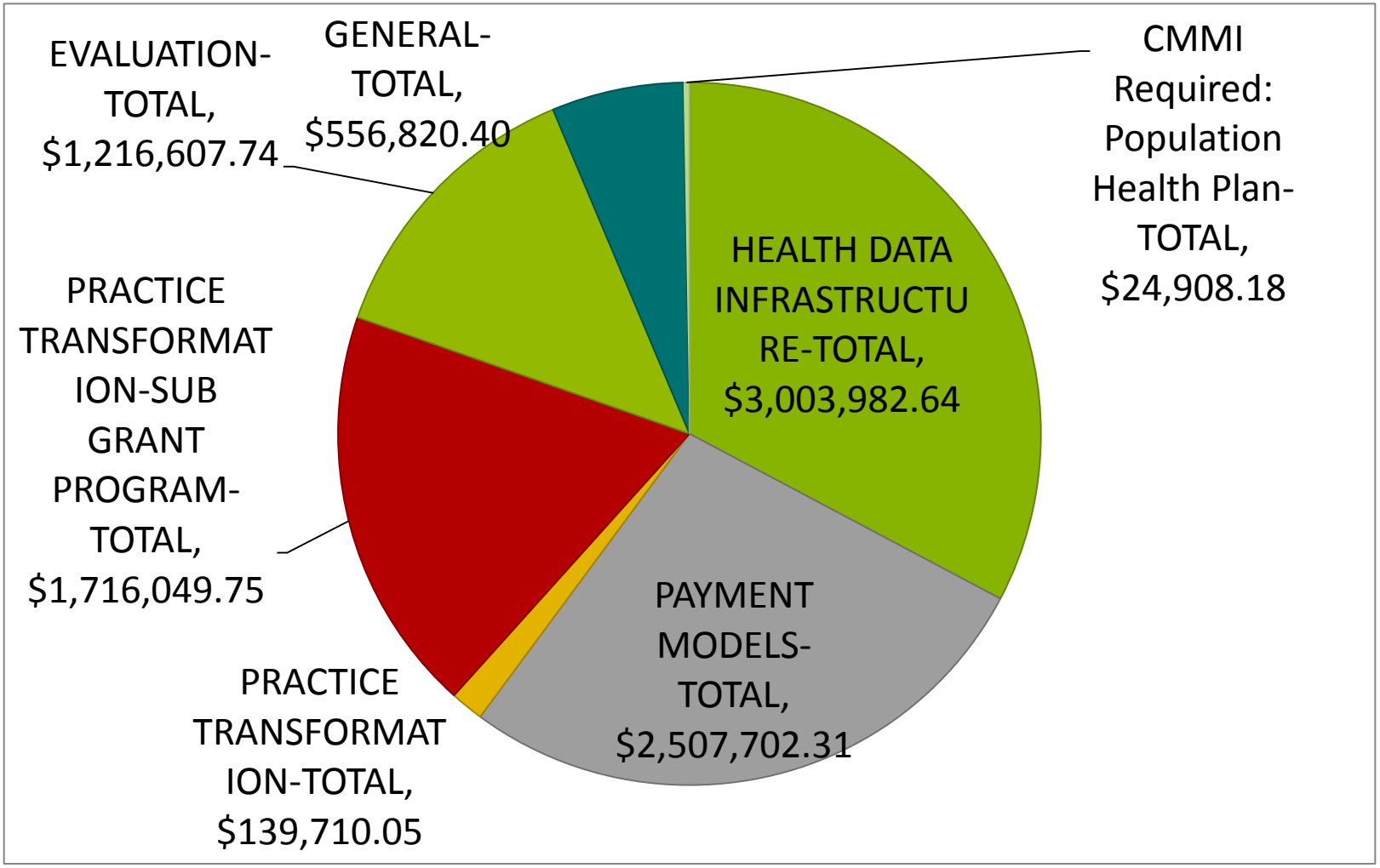
It does not capture the full 3rd quarter for indirect because of the timing.

It is currently broken out in two tables because of the bifurcated approval process.

Table 1:

October 1, 2013 - December 31, 2015				
BUDGET CATEGORY	BUDGET-YEAR 1	ACTUALS and Unpaid Contract Invoices to 09/30/15	CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)	REMAINING UNOBLIGATEDBALANCE
Personnel/Benefits	$ 2,640,859.56	$ 2,674,399.42	$ -	$ (33,539.86)
Operating (includes Indirect*except QE 09/30/2015)	$ 1,039,676.04	$ 878,895.83	$ -	$ 160,780.21
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 3,746,938.64	$ 3,003,982.64	$ 742,956.00	
PAYMENT MODELS-TOTAL	$ 3,859,899.85	$ 2,507,702.31	$ 1,352,197.54	
PRACTICE TRANSFORMATION-TOTAL	$ 232,754.13	$ 139,710.05	$ 93,044.08	
PRACTICE TRANSFORMATION-SUB GRANT PROGRAM-TOTAL	$ 2,285,707.27	$ 1,716,049.75	$ 569,657.52	
EVALUATION-TOTAL	$ 1,521,538.42	$ 1,216,607.74	$ 304,930.68	
GENERAL-TOTAL	$ 769,984.92	$ 556,820.40	$ 213,164.52	
CMMI Required: Population Health Plan-TOTAL	$ 26,945.68	$ 24,908.18	$ 2,037.50	
Contractual Total	$ 12,443,768.91	$ 9,165,781.07	$ 3,277,987.84	$ -
TOTAL YEAR 1 BUDGET	$ 16,124,304.51	$ 12,719,076.32	$ 3,277,987.84	$ 127,240.35

Contractual Spending (Y1):



Vermont Health Care Innovation Project

Table 2:

January 1, 2015 - December 31, 2015				
BUDGET CATEGORY	BUDGET-YEAR 2	ACTUALS and Unpaid Contract Invoices to 09/30/15	CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)	REMAINING UNOBLIGATED BALANCE
Personnel/Benefits	$ 1,023,149.00	$ 132,264.04		$ 890,884.96
Operating (includes Indirect*except QE 09/30/2015)	$ 616,375.00	$ 2,967.30		$ 613,407.70
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 3,574,117.50			
PAYMENT MODELS-TOTAL	$ 11,992,257.74			
CARE MODELS-TOTAL	$ 129,156.67			
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ -			
EVALUATION-TOTAL	$ 105,000.00			
GENERAL-TOTAL	$ -			
CMMI Required: Population Health Plan-TOTAL	$ 7,000.00			
Contractual Total	$ 15,807,531.91	$ -	$ -	$ 15,807,531.91
TOTAL YEAR 2 BUDGET	$ 17,447,055.91	$ 135,231.34	$ -	$ 17,311,824.57

Goal and Assumptions

Goal: Approval of Year 3 budget for submission to CMMI as part of Operational Plan.

Assumptions:

1. This includes personnel and contractual costs for anticipated 2017 no-cost extension.
2. Includes all previously approved contracts and proposes TBDs for certain items still developing.
3. Contract items are formatted by focus area.

Total Budget: $21,223,422.24

- Personnel: $2,011,456.58
- Fringe: $932,310.13
- Travel: $104,314.58
- Equipment: $46,196.46
- Other: $286,804.79
- Supplies: $18,921.67
- CAP: $804,582.63
- Contracts: $17,018,835.40

Project Management: $381,816

- UMass: $381,816

Evaluation: $1,562,499.51

- Self-Evaluation Plan:
  - Impaq International: $1,399,024.51
- Federal Evaluation:
  - Truven Health Analytics: $33,475. (Also, asking for approval for 32,500 in Y2 for same reason.)
    - New contract to provide data files to federal evaluator. Necessary because RTI is using a file without BCBSVT claims files for analysis and this is the only way to get appropriate analysis in federal evaluation. Feds directed us to fund in this way rather than their own contracting vehicle.
- Surveys:
  - Datastat: $130,000
- Monitoring and Evaluation Activities:
  - Lewin, Burns, and Bailit (part of the Payment Models estimates)

Practice Transformation: $6,580,230.21

- Learning Collaboratives:
  - Abernathey: $102,000
  - VPQHC: $102,000
  - TBD: Core Competency: $450,000
  - NEW TBD: $175,000 for Accountable Communities for Health (note that $50,000 is for Y2, while $125,000 is Y3).
- Regional Collaborations:
  - BiState/CHAC: $888,000
  - OneCare: $2,091,140
- Sub-Grantees: $2,595,090.21
- Sub-Grant TA: $50,000
  - Policy Integrity: $50,000
- Workforce Demand Model:$127,000
  - The RFP selection resulted in a vendor $27,000 higher than previously budgeted. This request includes that additional $27,000.

Health Data Infrastructure: $2,917,500

- Telehealth Pilot Program: $1,000,000 (RFP still pending)
- SCÜP/ENS TBD: $1,150,000
- Work Group Support:
  - Stone: $170,000
- Data Warehousing:
  - BHN/VCN: $497,500
  - H.I.S.: $100,000

Payment Model Design and Implementation: $3,043,857.90

- Several contractors provide support across Payment Models:
  - Bailit Health Purchasing, Inc.: $490,000
  - Burns and Associates: $700,000
  - Pacific Health Policy Group: $180,000
  - DLB: $60,000
  - Wakely: $72,000
  - VMSF: $10,329
- ACO SSPs:
  - Lewin: $1,331,528.90
- All-Payer Model:
  - HMA: $200,000

APM Planning: $2,532,931.78

- We have several requests pending that total $5,025,000
- We have $2,532,931.78 available

Attachment 4b: Accountable Communities for Health Proposal

September 21, 2015

ACCOUNTABLE COMMUNITIES FOR HEALTH LEARNING SYSTEM PROPOSAL

Vermont Health Care Innovation Project

AGENDA

1. Population Health Work Group: Accountable Communities for Health Learning System

Population Health Work Group: Accountable Communities for Health Learning System

- Request from the Work Group: Recommend approval of proposed Accountable Communities for Health Learning System.
  - Project timeline: 3-month planning and design phase (October-December 2015); 12-month learning system (January-December 2016)
  - Project estimated cost: $232,000
  - Project Summary: Collaborative peer learning opportunity for Vermont communities interested in becoming Accountable Communities for Health.
  - Budget line item: *Advanced Analytics (Type 1b PHWG)*
- The Population Health Work Group is responsible for recommending ways in which the project could better coordinate health improvement activities and more directly impact population health.

Scope of Work

- This project would create a collaborative peer learning opportunity for Vermont communities interested in becoming Accountable Communities for Health.
  - Building on previous Prevention Institute contract, "Accountable Communities for Health: Opportunities and Recommendations"
  - Provide support and learning opportunity for communities, develop statewide guidance and recommendations

- **Learning System Structure**: Builds on framework of Integrated Communities Care Management Learning Collaborative.
  - Quarterly: Full-day in-person meetings with participating communities and national expert faculty
  - Quarterly: Webinars for participating communities with local or national faculty
  - Ongoing: Meetings within communities, supported by facilitators

Defining Accountable Communities for Health

- **Accountable Community for Health (ACH):** "An aspirational model—accountable for the health and well-being of the entire population in its defined geographic area and not limited to a defined group of patients. Population health outcomes are understood to be the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, economic circumstances and environmental factors. An ACH supports the integration of high-quality medical care, mental and behavioral health services, and social services (governmental and non-governmental) for those in need of care. It also supports community-wide prevention efforts across its defined geographic area to reduce disparities in the distribution of health and wellness."

Background

- VHCIP contracted with the Prevention Institute, a nationally recognized non-profit based in Oakland, to explore the ACH concept, identify communities in Vermont and nationwide that are early leaders in this field, and develop recommendations to support Vermont in moving toward this model.
  - Report, "Accountable Communities for Health: Opportunities and Recommendations" (July 2015)
  - Prevention Institute also presented findings and recommendations to the Population Health Work Group; Tracy Dolan presented them to the Steering Committee in August.

Key Concepts

- Engages a **broad set of partners outside of healthcare** to improve overall population health;
- **Brings together major medical care, mental and behavioral and social services**, across a geographic area, and requires them to operate as partners rather than competitors while also connecting systems set up to integrate/coordinate services for individuals with community-wide prevention efforts;
- Focuses on the **health of all residents in a geographic area** rather than just a patient panel; and
- Identifies multiple strands of resources that can be applied to ACH-defined objectives that **explore the potential for redirecting savings from healthcare costs** in order to sustain collaborative efforts.

Core Elements of the ACH Model

1. Mission
2. Multi-Sectoral Partnership
3. Integrator Organization
4. Governance
5. Data and Indicators
6. Strategy and Implementation
7. Community Member Engagement
8. Communications
9. Sustainable Funding

Accountable Communities for Health Learning System

- **Goal:** Explore this concept with interested communities to support them in building Accountable Health Communities from the ground up.
  - Communities will learn with and from one another and from national innovators;
  - Identify the practical steps and developmental stages in creating an Accountable Community for Health; and
  - Inform the development of necessary state-level policy and guidance to support regional efforts.

Accountable Communities for Health Learning System

- Community interest is high
  - Six community efforts in Vermont were profiled for the Prevention Institute's report:
    - Rise VT (Franklin and Grand Isle Counties)
    - St. Johnsbury Collective Impact (Caledonia and Southern Essex Counties)
    - Environment Community Opportunity Sustainability (Chittenden County)
    - Windsor Health Service Area Accountable Care Community for Health (Windsor County)
    - ReThink Health Upper Connecticut River Valley (Upper Valley)
    - Accountable Community (Windham County)
  - Additional communities have expressed interest in continued engagement and support

Attachment 5: Year 3 ACO SSP Proposed Measures

Proposed Changes for Year 3
ACO Shared Savings Program Measures

VHCIP Core Team

October 13, 2015

Language from GMCB's Suggested Hiatus

- "…If a measure is no longer supported by evidence, the measure should be considered for elimination. If a measure is eliminated, the VHCIP Quality and Performance Measures work group could recommend replacing it with a measure that is supported by evidence…"

Rationale for Proposed Changes

- Quality measures can and do change as the evidence base changes.
- The QPM Work Group's consultant, Bailit Health Purchasing, provided a summary of national changes to measures in Vermont's SSP measure sets.
- There have been recent national changes to one measure in the payment measure set:
  - Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening), a claims-based payment measure (Core-3a)

Rationale for Proposed Changes (cont'd)

- There have been recent national changes to one set of measures in the reporting measure set:
  - Optimal Diabetes Care Composite ("D5"), a set of 5 clinical data-based reporting measures (Core-16)

- There have been recent national changes to two measures in the monitoring & evaluation measure set:
  - Appropriate Medications for People with Asthma (M&E-1)
  - ED Utilization for Ambulatory Care-Sensitive Conditions (M&E-16)

Proposed Year 3 Measure Changes

- During recent meetings, the QPM Work Group voted unanimously to recommend replacements for the LDL Screening, Diabetes Composite, Asthma Medications, and ED Utilization measures.
- Changes to the LDL Screening and Diabetes Composite measures were effective for Year 2 (2015) after being approved by the Steering Committee, Core Team and GMCB. The QPM Work Group is seeking approval to continue these changes into Year 3 (2016).
- Changes to Asthma Medications and ED Utilization measures would be effective for Year 3 (2016).

Recommendation: Replace LDL Screening with Controlling High Blood Pressure

Previous Measure	Recommended Measure
Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening) (Payment Measure)	Hypertension: Controlling High Blood Pressure (Payment Measure)

- LDL screening is no longer considered best practice; as a result, this measure has been dropped by the Medicare Shared Savings Program (MSSP) and NCQA HEDIS.
- Newly proposed HEDIS cholesterol measure (Statin Therapy for Patients with Cardiovascular Disease) has not yet been adopted, and will lack benchmarks when it is.
- QPM Work Group recommendation is to replace LDL Screening with a nationally-endorsed MSSP measure in Year 3, as was done for Year 2:
  - Hypertension: Controlling High Blood Pressure

Recommendation: Replace Optimal Diabetes Care Composite with MSSP Diabetes Composite

Previous Measure	Recommended Measure
Optimal Diabetes Care Composite ("D5," includes LDL Screening, hemoglobin A1c control, blood pressure control, tobacco non-use, and aspirin use) (Reporting Measure)	MSSP Diabetes Composite ("D2," includes hemoglobin A1c poor control and eye exam) (Reporting Measure)

- CMS has retired this measure from the MSSP measure set, most likely because one of the 5 measures that make up the composite is the LDL Screening measure.
- QPM Work Group recommendation for Year 3 is to replace "D5" with the new MSSP Diabetes Composite Measure ("D2"), which consists of 2 measures, as was done for Year 2.
- For the D2 measure, HbA1c Poor Control is already in the Commercial and Medicaid measure sets, Eye Exam is new.

Recommendation: Replace Appropriate Medications for People with Asthma with Medication Management

Current Measure	Recommended Measure
Appropriate Medications for People With Asthma (Monitoring and Evaluation Measure)	**HEDIS® Medication Management for People With Asthma (Monitoring and Evaluation Measure)**

- NCQA is proposing retiring Appropriate Medications for People With Asthma 2016 due to consistently high HEDIS® performance rates and little variation in plan performance for both commercial and Medicaid plans.
- Medication Management for People with Asthma was first introduced in HEDIS® 2012. NCQA views it as a more effective way of assessing asthma medication management. National benchmarks are available, and the measure can be calculated with claims.
- This M&E measure is collected at the Health Plan (statewide) level, rather than at the ACO level.

Recommendation: Replace ED Utilization for ACSCs with Onpoint Avoidable ED Measure

Current Measure	Recommended Measure
ED Utilization for Ambulatory Care Sensitive Conditions (Monitoring and Evaluation Measure)	Onpoint Health Data's Potentially Avoidable ED Utilization (Monitoring and Evaluation Measure)

- AHRQ has retired the ED Utilization for ACSCs measure for unidentified reasons, but is working on other ED-specific measures that have not yet been finalized.
- The Onpoint Health Data Measure looks at ED visits with primary diagnoses for which outpatient ED use was frequent, treatment was commonly provided in another setting (i.e., physician office), and inpatient hospitalizations were extremely rare. The measure is currently used in the Blueprint practice and health service area profiles.
- The measure set also contains M&E-14: Avoidable ED visits-NYU algorithm.

SUMMARY – Year 3 Recommended Measure Changes for Commercial and Medicaid ACO SSPs

Previous/Current Measure	Recommended Replacement Measure	Measure Set
Year 1 Measure: Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening)	MSSP Hypertension: Controlling High Blood Pressure (Payment Measure)	Payment
Year 1 Measure: Optimal Diabetes Care Composite ("D5") D5 includes: • LDL Screening • hemoglobin A1c control • blood pressure control • tobacco non-use • aspirin use	MSSP Diabetes Composite ("D2") D2 includes: • hemoglobin A1c poor control (already in measure set) • eye exam	Reporting

SUMMARY – Year 3 Recommended Measure Changes Commercial and Medicaid Programs (cont'd)

Current Measure	Recommended Replacement Measure	Measure Set
Appropriate Medications for People with Asthma	Medication Management for People with Asthma	Monitoring and Evaluation
ED Utilization for Ambulatory Care Sensitive Conditions	Onpoint Health Data's Potentially Avoidable ED Utilization	Monitoring and Evaluation