VT Health Care Innovation Project - Payment Model Design and Implementation Work Group Meeting Agenda
Monday, October 17, 2016 1:00 PM – 3:00 PM.
4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier
Call in option: 1-877-273-4202 Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	1:00-1:05	Welcome and Introductions; Approve meeting minutes	Cathy Fulton, Andrew Garland	Y – Approve minutes	Attachment 1: September Meeting Minutes
2	1:05-1:30	Program Updates • Sustainability Update • APM Update	Sarah Kinsler, Lawrence Miller	N	
3	1:30-1:50	Year 2 Shared Savings Program Results Overview	Pat Jones, Alicia Cooper	N	Attachment 3: Summary of Year 2 SSP Results
4	1:50-2:50	Population Health Plan: Review and Discussion	Sarah Kinsler	N	Attachment 4: Population Health Plan Overview Link to: Vermont Population Health Plan - September 2016 (for public comment by November 2nd)
5	2:50-2:55	Public Comment	Cathy Fulton, Andrew Garland	N	
6	2:55-3:00	Next Steps and Action Items	Cathy Fulton, Andrew Garland	N	

Attachment 1: September Meeting Minutes

Vermont Health Care Innovation Project
Payment Model Design and Implementation Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Monday, September 19, 2016, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Catherine Fulton called the meeting to order at 1:01pm. A roll call attendance was taken and a quorum was present. Dale Hackett moved to approve the July 2016 minutes by exception, and Ed Paquin seconded. The minutes were approved with two abstentions (Heather Skeels and Pat Jones). Cathy noted changes to the order of items on the meeting agenda.	
2. Program Updates	Heidi Klein provided an update on the ACH Peer Learning Lab. • There are 10 different communities participating in the ACH Peer Learning Lab. • The Learning Lab curriculum is being developed and facilitated by a contractor, the Public Health Institute (PHI). PHI has also built a website for participating communities with resources around the 9 core elements that are foundational to creating ACHs; a link will be distributed. • They are receiving interesting feedback from the participating communities who are connecting the work of the ACH to the work of the Community Collaboratives. The ACH is about building upon existing work to advance integrated care and services for individuals, along with community-wide prevention strategies. Results will be available soon. • Participating communities are at varied stages of readiness and have varied levels of population health and public health integration into local governance. • Next gathering of the Peer Learning Lab is at the end of September. Each community will present their status both with the 9 core elements and the project that they've chosen to focus on. • ACHs are also being featured at a conference on 9/20 sponsored by Southwestern Medical Center. Heidi might have more to report after that. Georgia Maheras provided a timeline update for results from Year 2 of the Medicaid and Commercial Programs.	ACH Link

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	• At the last PMDI Work Group meeting, it was discussed that results would be available in September. Results need to be vetted thoroughly, and vetting is not yet complete. The expectation is to have the results ready in October. Pat Jones thanked those who are working overtime on vetting the results. Pat anticipates that the GMCB will see the results within the next 3 weeks. • Getting results to VHCIP participants as soon as they are vetted is a priority: the monthly webinar for October, scheduled for Tuesday, October 11, from 12-1, will be dedicated to this topic if the results are available by that date. If not, the October 17 PMDI Work Group meeting will be broadcasted as a webinar to ensure a broad group of stakeholders is able to participate. Georgia Maheras provided an update on the development of the Sustainability Plan. • The State engaged a contractor, Myers and Stauffer, to support sustainability planning starting in July. • The Sustainability Sub-Group is a group of private-sector stakeholders that will make sustainability recommendations for review by the VHCIP work groups. The group has met twice since the beginning of September and will meet twice in October and are looking at work by work stream (PMDI, Practice Transformation, HDI, as well as evaluation, project management, governance). • As a result of those meetings, key informant interviews and other conversations with a parallel group of State leaders, Myers and Stauffer will draft a sustainability plan which will be available to all VHCIP participants for review in early November. • The plan will be presented to every VHCIP work group and the Steering Committee in November for discussion and feedback. Feedback will be collected, looped back, and presented to the Core Team in December as a draft document. Comments and feedback will be tracked, as will how comments are addressed. Sarah Kinsler added that they will be providing updates on this process through the end of the year. Contact Sarah Kinsler (sarah.kinsler@vermont.gov) and Georgia Maheras (georgia.maheras@vermont.gov) if you want to give feedback and thoughts outside of that process. Feel free to contact Myers and Stauffer directly. Sarah and Georgia will set up a call with them if that is your preference.	
3. Medicaid Pathway: Payment Model Update	Georgia Maheras and Kara Sutter provided an update on the development of a payment model for the Medicaid Pathway work (Attachment 4). • The Medicaid Pathway process began in late 2015. Led by AHS, the focus is on services primarily funded by Medicaid. The big goal is to have an integrated health care system to achieve the Triple Aim. • Slide 4 shows that it's a continuous reform cycle. Right now, the Medicaid Pathway process is in the bottom box. Sue Aranoff provided feedback on Slide 4: suggesting to add "and delivery" in addition to payment. • Slide 7 shows a framework the federal government uses for payment reform and in this framework, APM stands for Alternative Payment Models. Kara added that the amount of risk and link to performance grows as you move from left to right. Medicare systems are now teetering between Category 2 and Category 3. Category 3 and 4 is where the ACOs are moving: a population-based approach where payments are based on the needs of the population. There is some amount of accountability in risk and link to quality and performance. Category 3 keeps	

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	an underlying payment structure, similar to what the SSP did. Category 4 moves to a global payment approach and changes the way payments are made. • Slide 8 shows an older chart from the Commonwealth Fund. The hyperlink has valuable reading to see more topics like risk (use the link on the very bottom of the slide). Dale Hackett noted that Category 4 looks very different than the way it was talked about in Population Health. Kara responded that in Category 4, the payments made under the model are truly population-based. One payment per person over the course of a year is calculated at the person level, which shifts risk from payers to providers. • Laural Ruggles clarified that population-based is about an attributed group of people vs. the term "population health" in public health. Georgia noted that the Population Health Work Group is a difference concept than the population-based payment structure. Georgia will provide feedback to federal partners that "population-based" needs to be clearer because it creates confusion from the primary and secondary prevention front. • Sue Aranoff asked about the current state of attribution and Georgia will have an answer after the meeting. • Dale asked if it also does not change the significance with a practice being associated with a hospital because of risk. Georgia responded that it does have a potential to change that practice, hopefully fostering more integration as you move along the categories. • This past Friday, an Information Gathering Process (IGP) form was released. The graphic with timeline and trajectory for reforms is one possibility. It has not been decided if DS will be in Phase 1. Feedback in this area would be particularly helpful. The goal is get people to react and to give feedback. Every SIM participant should have received the IGP document via email. Let Georgia or Julie Corwin know if you didn't get a copy. • On developmental disability services, Kara mentioned that they tend to be grouped all in one but they're not all the same. Feedback is needed to determine which will be in or out. There is discussion around categorizing into a more population-based cohort that can be created and aggregated as an evolution of this. Kara noted that the current strawman is an episode and is not an attributed population concept. Payment would be triggered based on a beneficiary arriving at the door and receiving a certain amount of treatment. The rates would be DA-specific but this is not final. Georgia added that there's a link in the IGP that shows pros and cons and why they didn't go down the attribution path. There's a few things in the data that lend itself more to a service-based episode model and invite feedback on that. • Dale: The GMCB meeting was looking at budget. Days of cash on hand was the metric and it was not at a healthy number. Georgia noted a parallel activity: the legislature passed a requirement last session asking AHS, in partnership with VT Care Partners and the AOA, to develop a report on the financial stats, staffing vacancies, waitlists, and other access measures. This is an ongoing, companion activity about what types of protections to put in place and where to target accountability based on an entity's ability to handle or not handle risk given where they are financially. The report is due January 15. • Maura asked: for clarification on the focus of the Medicaid Pathway, to see a slide that shows a bigger picture of the other services, if IFS would be included, and if women's specialty health will be included. o Georgia replied that it's focused on every Medicaid service, but the first roll out is mental health and substance use services, and then LTSS, and then a systematic review of all services. IFS is embedded in the	Current state of attribution Complete the IGP request; return feedback to Julie.corwin @vermont.g ov

Agenda Item	Discussion	Next Steps
	blue boxes and they are revising the scope table to determine what's in and what's out. Women Specialty Health is excluded from Phase 1 from a feasibility perspective but will need to confirm that. • Dale asked: if there is any way that federal funds are not going to be maximized and if the All Payer model will match. Georgia noted that Selina also manages the 1115 Global Commitment Waiver and her job is to ensure that we're maximizing funds. There is specific language in the Waiver that allows us to do this. Going forward, they're making sure that federal Medicaid gives flexibility. The All Payer Waiver focuses on Medicare. Any references to Medicaid refer to the 1115 Waiver; there's complete alignment because it's referred to directly. In depth conversations with DMH, DAIL or ADAP might be helpful to inform participants' comments regarding the IGP. Kara noted that there is more background in the IGP. • Georgia thanked everyone for their time. Any questions, reach out to Georgia or Selina Hickman. Julie Corwin is collecting formal comments on the IGP (Julie.Corwin@vermont.gov).	MP scope document
4. Simplifying Clinical Quality Measure Collection	Leah Fullem from OneCare Vermont and Heather Skeels from Bi-State Primary Care Association and CHAC disucssed some of the quality measure collection processes that have been developed across ACOs in support of the Shared Savings Programs. Heather Skeels provided an overview about what the current chart abstraction process entails for clinical quality measurement. • There are 18 measures needed to collect from Medicare, 18 from Medicaid, and 8 more from the commercial payers. There is an overlap in those as much as possible. There are 21 measures altogether. • Every January, they get a list of patients from each payer. Within that list, about 2,000 patients qualify for one or more of the measures. They split those 3 lists amongst the member organizations. They have to report back to all of the payers in the order that they received the patient. There has to be a minimum of 248 patients in order. They can skip a patient who doesn't have a qualifying measure but a reason has to be given. • For Medicare, they get a list of 616 patients per measure. They pull a minimum of 350 patients (an oversample). For some of the measures (for example, depression screening) if a patient is diagnosed with depression, they can't get counted in the denominator and is skipped. At least a third fall out of the measure. Heather showed an example of the depression screening spreadsheet (about 2.5 feet long, double-sided for each patient). • There are some other tools that OneCare uses to simplify the collection. EHRs are fantastic tools, however, one of the problems is that information cannot be extracted from a scanned document. Leah discussed ongoing work toward the goal of minimizing the manual abstractions required to do quality measurement under the SSP and other programs • In 2014, SIM funds were allocated to create an ACO Gateway within VITL. This mechanism filters information to specific analytics platforms. In July 2015, OneCare began implementation of a new platform, Health Catalyst. It's an integrated enterprise data warehouse which incorporates claims from payers, clinical messages from HIE, and direct connections to UVM Medical Center and Dartmouth Hitchcock EPIC platforms. • The purpose of this data warehouse was to do automated quality measurement. They went live with their first set of applications in May 2016, one of which was a scorecard that monitored the Medicare SSP quality measures	

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<tr><th>Agenda Item</th><th>Discussion</th><th>Next Steps</th></tr>
<tr><td></td><td>(both claims and clinical measures). Most of the work was actually mapping the clinical data from the VHIE. The data was still very messy because every message from every EMR system was different.
• A report From VITL on June 30th: 67 organizations are sending information to VITL which is not where they need to be. They're getting labs from the hospitals. They get CCDs (continuity of care documents, like a patient summary) from only 1/3 of primary care practices. There's a lot of work just to get practices hooked up. The data they are getting doesn't contain 100% of the elements needed. Another problem is that only 56% of patients are actually matching within the VHIE. 5 data elements to match: Name, DOB, gender, address. (For example, John A. Smith and John Anthony Smith are not matching). They are working with VITL on how to improve matching. There are eight measures that require information that are not in any structure data fields within EMR. (For example: a requirement for a follow-up counseling for heart failure). The medical center has some natural language processing tools. They are going through pilots but these are hugely expensive technical solutions.
• Dale asked about investment and timeline to improve this process.
    o Heather said it would take a long time and wouldn't know how to quantify cost because there are so many levels. Leah added another area of development is dealing with different EHR vendors and their issues. The Office of the National Coordinator is trying to get everyone to do the same thing. There's some progress, but it won't be fast and there's a lot of moving pieces.
• Leah added that they've learned a lot from the quality measurement. It's been helpful for practices to understand the care that they're giving and to get some outside feedback. Chart abstraction is not a waste of time or resources. This baseline setting is needed to talk to the feds about an all payer waiver. It's really important to understand what the actual cost is and to set realistic expectations for what resources are needed. Rick Dooley commented that it was really beneficial for practices to start thinking about quality and they had never thought about it before. The burden of intense time and resources has to be absorbed somewhere.
• Georgia referred to the HDI Work Group. There is a significant amount of federal funding but maintenance and operations is not covered from federal funds. The HDI work group has several conversations upcoming to set up a clear trajectory and how to do that thoughtfully. Leah commented that money doesn't necessarily help the problem. Yes, more money is needed but where to target is what to figure out as a State. Heather noted that getting to the root cause of the issue is tricky. For example, proving 'no test' is really hard because it's not an actionable piece of data.
• Cathy asked about the status of the master patient index.
    o Georgia responded that several years ago, DII said it would develop master person index but it didn't work out as hoped. There's a new focus within AHS and programs that it impacts (Reach Up, Medicaid, DCF, etc.) Additionally, there is no master person index within the HIE. It's a challenging project and the tech exists. There is more to come.</td><td></td></tr>
<tr><td>5. Public Comment</td><td>There was no additional comment.</td><td></td></tr>
<tr><td>6. Next Steps and Action Items</td><td>Next Meeting: Monday, October 17, 2016, 1:00-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.</td><td></td></tr>
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VHCIP Payment Model Design and Inplementation Work Group Member List

Monday, September 19, 2016

Dalett 1° Ed. P 2° Motion carried 2 Abstentions

Member		Member Alternate			
First Name	Last Name	First Name	Last Name	Minutes	Organization
Melissa	Bailey	Shannon	Thompson		AHS - DMH
		Jaskanwar	Batra		AHS - DMH
		Kathleen	Hentcy		AHS - DMH
		Frank	Reed		AHS - DMH
Jill Berry	Bowen	Devin	Batchelder		Northwestern Medical Center
		Jane	Catton		Northwestern Medical Center
		Diane	Leach		Northwestern Medical Center
		Don	Shook		Northwestern Medical Center
		Lou	Longo		Northwestern Medical Center
Diane	Cummings ✓	Shawn	Skafelstad ✓		AHS - Central Office
Mike	DelTrecco				Vermont Association of Hospital and Health Systems
Tracy	Dolan	Heidi	Klein ✓		AHS - VDH
		Cindy	Thomas		AHS - VDH
		Julie	Arel		AHS - VDH
Rick	Dooley ✓	Susan	Ridzon		HealthFirst
		Paul	Reiss		HealthFirst
Kim	Fitzgerald	Stefani	Hartsfield		Cathedral Square and SASH Program
		Molly	Dugan		Cathedral Square and SASH Program
Aaron	French	Erin	Carmichael ✓		AHS - DVHA
		Nancy	Hogue		AHS - DVHA
		Megan	Mitchell		AHS - DVHA
Catherine	Fulton ✓				Vermont Program for Quality in Health Care
Beverly	Boget	Michael	Counter		VNAs of Vermont

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Monday, September 19, 2016

Member		Member Alternate			
First Name	Last Name	First Name	Last Name	Minutes	Organization
Steve	Gordon	Mark	Burke		Brattleboro Memorial Hopsital
		Bonnie	McKellow ✓		
Maura	Graff ✓	Heather	Bushey		Planned Parenthood of Northern New England
Dale	Hackett ✓				Consumer Representative
Mike	Hall ✓	Sandy	Conrad		Champlain Valley Area Agency on Aging / COVE
Paul	Harrington ✓				Vermont Medical Society
Karen	Hein				University of Vermont
Bard	Hill	Patricia	Cummings		AHS - DAIL
		Susan	Aranoff ✓		AHS - DAIL
Jeanne	Hutchins				UVM Center on Aging
Kelly	Lange	Teresa	Voci		Blue Cross Blue Shield of Vermont
Ted	Mable	Kim	McClellan		DA - Northwest Counseling and Support Services
		Tim	Gallagan		DA - Northwest Counseling and Support Services
David	Martini ✓				AOA - DFR
Chris	Smith ✓				MVP Health Care
MaryKate	Mohlman	Jenney	Samuelson		AHS - DVHA - Blueprint
Ed	Paquin ✓				Disability Rights Vermont
Abe	Berman ✓	Miriam	Sheehey		OneCare Vermont
Noah	Fellem ✓	Vicki	Loner		OneCare Vermont

Sara Barry
Susan Shane

VHCIP Payment Model Design and Inplementation Work Group Member List

Monday, September 19, 2016

Member		Member Alternate			
First Name	Last Name	First Name	Last Name	Minutes	Organization
Laural	Ruggles				Northeastern Vermont Regional Hospital
Julia	Shaw				VLA/Health Care Advocate Project
Lila	Richardson	Kaili	Kuiper		VLA/Health Care Advocate Project
Kate	Simmons	Kendall	West		Bi-State Primary Care/CHAC
		Patricia	Launer		Bi-State Primary Care
		Melissa	Miles		Bi-State Primary Care
		Heather	Skeels		Bi-State Primary Care
Pat	Jones				GMCB
Julie	Tessler				VCP - Vermont Council of Developmental and Mental Health Services
		Sandy	McGuire		VCP - Howard Center
	31		38		

VHCIP Payment Model Design and Inplementation Work Group

Attendance Sheet 9/19/2016

	First Name	Last Name		Organization	Payment Model Design and Implementation
1	Peter	Albert		Blue Cross Blue Shield of Vermont	X
2	Susan	Aranoff	here	AHS - DAIL	MA
3	Julie	Arel		AHS - VDH	MA
4	Bill	Ashe		Upper Valley Services	X
5	Lori	Augustyniak		Center for Health and Learning	X
6	Debbie	Austin		AHS - DVHA	X
7	Ena	Backus		GMCB	X
8	Melissa	Bailey		Vermont Care Partners	M
9	Michael	Bailit		SOV Consultant - Bailit-Health Purchasing	X
10	Susan	Barrett		GMCB	X
11	Devin	Batchelder		Northwestern Medical Center	MA
12	Jaskanwar	Batra		AHS - DMH	MA
13	Abe	Berman	phone	OneCare Vermont	MA
14	Bob	Bick		DA - HowardCenter for Mental Health	X
15	Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DM	X
16	Beverly	Boget		VNAs of Vermont	MA
17	Mary Lou	Bolt		Rutland Regional Medical Center	X
18	Jill Berry	Bowen		Northwestern Medical Center	M
19	Stephanie	Breault		Northwestern Medical Center	MA
20	Martha	Buck		Vermont Association of Hospital and Health	A
21	Mark	Burke		Brattleboro Memorial Hopsital	MA
22	Donna	Burkett		Planned Parenthood of Northern New Engla	X
23	Catherine	Burns		DA - HowardCenter for Mental Health	X
24	Heather	Bushey		Planned Parenthood of Northern New Engla	MA
25	Gisele	Carbonneau		HealthFirst	A
26	Erin	Carmichael	here	AHS - DVHA	MA
27	Jan	Carney		University of Vermont	X
28	Denise	Carpenter		Specialized Community Care	X

29	Jane	Catton		Northwestern Medical Center	MA
30	Alysia	Chapman		DA - HowardCenter for Mental Health	X
31	Joshua	Cheney		VITL	A
32	Joy	Chilton		Home Health and Hospice	X
33	Barbara	Cimaglio		AHS - VDH	X
34	Daljit	Clark		AHS - DVHA	X
35	Sarah	Clark		AHS - CO	X
36	Judy	Cohen		University of Vermont	X
37	Lori	Collins		AHS - DVHA	X
38	Connie	Colman		Central Vermont Home Health and Hospice	X
39	Sandy	Conrad		V4A	MA
40	Amy	Coonradt	here	AHS - DVHA	S
41	Alicia	Cooper	here	AHS - DVHA	S
42	Janet	Corrigan		Dartmouth-Hitchcock	X
43	Brian	Costello			X
44	Michael	Counter		VNA & Hospice of VT & NH	M
45	Mark	Craig			X
46	Diane	Cummings	here	AHS - Central Office	M
47	Patricia	Cummings		AHS - DAIL	MA
48	Michael	Curtis		Washington County Mental Health Services	X
49	Jude	Daye		Blue Cross Blue Shield of Vermont	A
50	Jesse	de la Rosa		Consumer Representative	X
51	Danielle	Delong		AHS - DVHA	X
52	Mike	DelTrecco		Vermont Association of Hospital and Health	M
53	Yvonne	DePalma		Planned Parenthood of Northern New Engla	X
54	Trey	Dobson		Dartmouth-Hitchcock	X
55	Tracy	Dolan		AHS - VDH	M
56	Rick	Dooley	here	HealthFirst	M
57	Molly	Dugan		Cathedral Square and SASH Program	MA
58	Lisa	Dulsky Watkins			X
59	Robin	Edelman		AHS - VDH	X
60	Jennifer	Egelhof		AHS - DVHA	MA
61	Suratha	Elango		RWJF - Clinical Scholar	X
62	Jamie	Fisher		GMCB	A
63	Kim	Fitzgerald		Cathedral Square and SASH Program	M
64	Katie	Fitzpatrick		Bi-State Primary Care	A

65	Erin	Flynn	here	AHS - DVHA	S
66	LaRae	Francis		Blue Cross Blue Shield of Vermont	X
67	Judith	Franz		VITL	X
68	Mary	Fredette		The Gathering Place	X
69	Aaron	French		AHS - DVHA	M
70	Catherine	Fulton	here	Vermont Program for Quality in Health Care	CC
71	Lucie	Garand		Downs Rachlin Martin PLLC	X
72	Andrew	Garland	here	BCBSVT	CC
73	Christine	Geiler		GMCB	S
74	Carrie	Germaine		AHS - DVHA	X
75	Al	Gobeille		GMCB	X
76	Steve	Gordon		Brattleboro Memorial Hopsital	M
77	Don	Grabowski		The Health Center	X
78	Maura	Graff	here	Planned Parenthood of Northern New Engla	M
79	Wendy	Grant		Blue Cross Blue Shield of Vermont	A
80	Lynn	Guillett		Dartmouth Hitchcock	X
81	Dale	Hackett	here	Consumer Representative	M
82	Mike	Hall	phone	Champlain Valley Area Agency on Aging / C	M
83	Catherine	Hamilton		Blue Cross Blue Shield of Vermont	X
84	Paul	Harrington	phone	Vermont Medical Society	M
85	Stefani	Hartsfield		Cathedral Square	MA
86	Carrie	Hathaway		AHS - DVHA	X
87	Karen	Hein	phone	University of Vermont	M
88	Kathleen	Hentcy		AHS - DMH	MA
89	Jim	Hester		SOV Consultant	S
90	Selina	Hickman		AHS - DVHA	X
91	Bard	Hill	phone	AHS - DAIL	M
92	Con	Hogan		GMCB	X
93	Nancy	Hogue		AHS - DVHA	M
94	Jeanne	Hutchins		UVM Center on Aging	M
95	Penrose	Jackson		UVM Medical Center	X
96	Craig	Jones		AHS - DVHA - Blueprint	X
97	Pat	Jones	here	GMCB	MA
98	Margaret	Joyal		Washington County Mental Health Services	X
99	Joelle	Judge	here	UMASS	S
100	Kevin	Kelley		CHSLV	X

101	Melissa	Kelly		MVP Health Care	X
102	Trinka	Kerr		VLA/Health Care Advocate Project	X
103	Sara	King		Rutland Area Visiting Nurse Association & H	X
104	Sarah	Kinsler	here	AHS - DVHA	S
105	Heidi	Klein	phone	AHS - VDH	MA
106	Tony	Kramer		AHS - DVHA	X
107	Kaili	Kuiper		VLA/Health Care Advocate Project	MA
108	Norma	LaBounty		OneCare Vermont	A
109	Kelly	Lange		Blue Cross Blue Shield of Vermont	M
110	Dion	LaShay		Consumer Representative	X
111	Patricia	Launer		Bi-State Primary Care	MA
112	Diane	Leach		Northwestern Medical Center	MA
113	Mark	Levine		University of Vermont	X
114	Lyne	Limoges		Orleans/Essex VNA and Hospice, Inc.	X
115	Deborah	Lisi-Baker		SOV - Consultant	X
116	Sam	Liss		Statewide Independent Living Council	X
117	Vicki	Loner		OneCare Vermont	MA
118	Lou	Longo		Northwestern Medical Center	MA
119	Nicole	Lukas	here	AHS - VDH	X
120	Ted	Mable		DA - Northwest Counseling and Support Ser	M
121	Carole	Magoffin	here	AHS - DVHA	S
122	Georgia	Maheras	here	AOA	S
123	David	Martini	here	AOA - DFR	M
124	James	Mauro		Blue Cross Blue Shield of Vermont	X
125	Lisa	Maynes		Vermont Family Network	X
126	Kim	McClellan		DA - Northwest Counseling and Support Ser	MA
127	Sandy	McGuire		VCP - HowardCenter for Mental Health	M
128	Jill	McKenzie			X
129	Darcy	McPherson		AHS - DVHA	X
130	Anneke	Merritt		Northwestern Medical Center	X
131	Robin	Miller		AHS - VDH	X
132	Megan	Mitchell		AHS - DVHA	MA
133	MaryKate	Mohlman		AHS - DVHA - Blueprint	M
134	Kirsten	Murphy		AHS - Central Office - DDC	X
135	Chuck	Myers		Northeast Family Institute	X
136	Floyd	Nease		AHS - Central Office	X

137	Nick	Nichols		AHS - DMH	X
138	Mike	Nix		Jeffords Institute for Quality, FAHC	X
139	Miki	Olszewski		AHS - DVHA - Blueprint	X
140	Jessica	Oski		Vermont Chiropractic Association	X
141	Ed	Paquin	here	Disability Rights Vermont	M
142	Eileen	Peltier		Central Vermont Community Land Trust	X
143	John	Pierce			X
144	Tom	Pitts		Northern Counties Health Care	X
145	Joshua	Plavin		Blue Cross Blue Shield of Vermont	X
146	Luann	Poirer		AHS - DVHA	S
147	Sherry	Pontbriand		NMC	X
148	Alex	Potter		Center for Health and Learning	X
149	Betty	Rambur		GMCB	X
150	Allan	Ramsay		GMCB	X
151	Frank	Reed		AHS - DMH	MA
152	Paul	Reiss		HealthFirst/Accountable Care Coalition of t	MA
153	Sarah	Relk			X
154	Virginia	Renfrew		Zatz & Renfrew Consulting	X
155	Lila	Richardson	phone	VLA/Health Care Advocate Project	M
156	Susan	Ridzon		HealthFirst	MA
157	Carley	Riley			X
158	Laurie	Riley-Hayes		OneCare Vermont	A
159	Brita	Roy			X
160	Laural	Ruggles	here	Northeastern Vermont Regional Hospital	M
161	Jenney	Samuelson		AHS - DVHA - Blueprint	MA
162	Howard	Schapiro		University of Vermont Medical Group Pract	X
163	seashre@msn	seashre@msn.com		House Health Committee	X
164	Rachel	Seelig		VLA/Senior Citizens Law Project	MA
165	Susan	Shane	phone	OneCare Vermont	X
166	Julia	Shaw	here	VLA/Health Care Advocate Project	M
167	Melanie	Sheehan		Mt. Ascutney Hospital and Health Center	X
168	Miriam	Sheehey		OneCare Vermont	MA
169	Don	Shook		Northwestern Medical Center	MA
170	Kate	Simmons		Bi-State Primary Care/CHAC	M
171	Colleen	Sinon		Northeastern Vermont Regional Hospital	X
172	Shawn	Skafelstad	here	AHS - Central Office	MA

173	Heather	Skeels	new	Bi-State Primary Care		MA
174	Chris	Smith	phone	MVP Health Care		X
175	Angela	Smith-Dieng		AHS - DAIL		X
176	Jeremy	Ste. Marie		Vermont Chiropractic Association		X
177	Jennifer	Stratton		Lamoille County Mental Health Services		X
178	Beth	Tanzman		AHS - DVHA - Blueprint		X
179	JoEllen	Tarallo-Falk	phone	Center for Health and Learning		X
180	Julie	Tessler		VCP - Vermont Council of Developmental a		M
181	Cindy	Thomas		AHS - VDH		MA
182	Shannon	Thompson		AHS - DMH		MA
183	Bob	Thorn		DA - Counseling Services of Addison County		X
184	Win	Turner				X
185	Karen	Vastine		AHS-DCF	X	
186	Teresa	Voci		Blue Cross Blue Shield of Vermont		MA
187	Nathaniel	Waite		VDH		X
188	Beth	Waldman		SOV Consultant - Bailit-Health Purchasing		X
189	Marlys	Waller		DA - Vermont Council of Developmental an		X
190	Nancy	Warner		COVE		X
191	Julie	Wasserman	here	AHS - Central Office		S
192	Kendall	West		Bi-State Primary Care/CHAC		MA
193	James	Westrich	here	AHS - DVHA		S
194	Robert	Wheeler		Blue Cross Blue Shield of Vermont		X
195	Jason	Williams		UVM Medical Center		X
196	Sharon	Winn		Bi-State Primary Care		X
197	Stephanie	Winters		Vermont Medical Society		X
198	Hillary	Wolfley				X
199	Mary	Woodruff				X
200	Erin	Zink		MVP Health Care		X
201	Marie	Zura		DA - HowardCenter for Mental Health		X
						201

Kate O'Neill - GMCB Evaluation
Julie Corwin - DVHA
Karen Sutor - Burns & Assoc.

Attachment 3: Summary of Year 2 SSP Results

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 Payment Model Design and Implementation Work Group

October 17, 2016

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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.

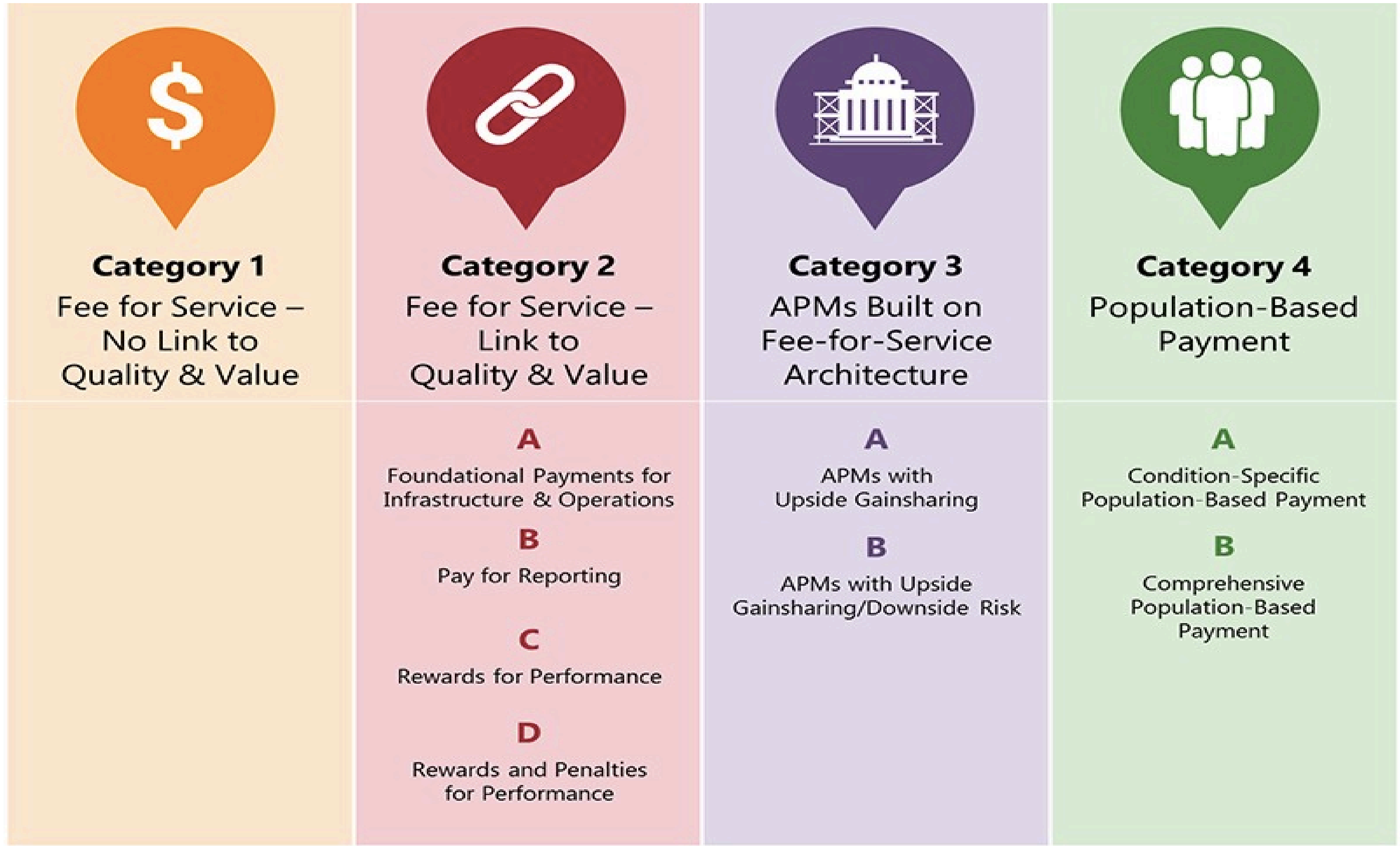
- **Principle 7 from the Health Care Payment Learning Action Network (LAN):**

"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 Draft Agreement currently under review 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

Results Should be Interpreted with Caution

- ACOs have different populations

- ACOs had different start dates:
  - VCP - July 2012
  - OneCare – January 2013
  - CHAC – January 2014

- Commercial targets in 2015 continued to be based on Vermont Health Connect premiums, rather than actual claims experience

Summary of 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

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Summary of 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

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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 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

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Summary of 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

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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%

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Summary of 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

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Medicare SSP Results 2014-2015

Medicare			
	2014+2015 Aggregate Difference from Target	2014 Quality Score	2015 Quality Score
CHAC	$ (3,004,094.00)	Reporting Only	97%
OneCare	$ (31,127,911.00)	89%	96%
VCP*	$ (2,762,048.00)	92%	
*VCP participated in Medicare SSP in 2014 only.			

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Takeaways from 2015 SSP 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 reporting year for CHAC; both had quality scores greater than 90%

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Payment Measure Overview

- Medicaid and Commercial payment measure set was mostly stable between 2014 and 2015; outcome measures added 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

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

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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**

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2015 Medicaid Payment Measures: Strengths and Opportunities

- Strengths:
  - 10 of 14 (71%) of ACO results were above the national 50th percentile *(compared to 10 of 16 in 2014)*
  - 6 of 14 (43%) were above the 75th percentile *(compared to 4 of 16 in 2014)*
  - Both ACOs met the quality gate and CHAC was able to share in savings
- Opportunities:
  - 4 of 14 (29%) were below the 50th percentile *(compared to 6 of 16 in 2014)*
  - Opportunity to improve Chlamydia Screening across both ACOs
  - Some variation among ACOs

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2015 Quality Results: 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

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2015 Commercial Payment Measures: Strengths and Opportunities

- Strengths:
  - 16 of 22 (73%) of ACO results were above the national 50th percentile *(compared to 7 of 10 in 2014)*
  - 15 of 22 (68%) were above the 75th percentile *(compared to 5 of 10 in 2014)*
- Opportunities:
  - 6 of 22 (27%) were below the 50th percentile *(compared to 3 of 10 in 2014)*
  - 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

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 movement toward commercial targets, decrease in CHAC's Medicaid PMPM (lower is better), and no change in OneCare's Commercial PMPM are encouraging
- 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

Questions/Discussion

Attachment 4: Population Health Plan Overview

POPULATION HEALTH PLAN

Draft Overview for Discussion and Comment

October 2016

Vermont Health Care Innovation Project

Discussion

- From your work group's point of view, how does this plan advance your work?
- How well do the goals and recommendations of the plan align with yours for moving ahead?
- What else would you want to see in order to get behind this plan?

INTRODUCTION AND BACKGROUND

Vermont Health Care Innovation Project

"We need to shift from focusing on health care to focusing on health."

Karen Hein, MD

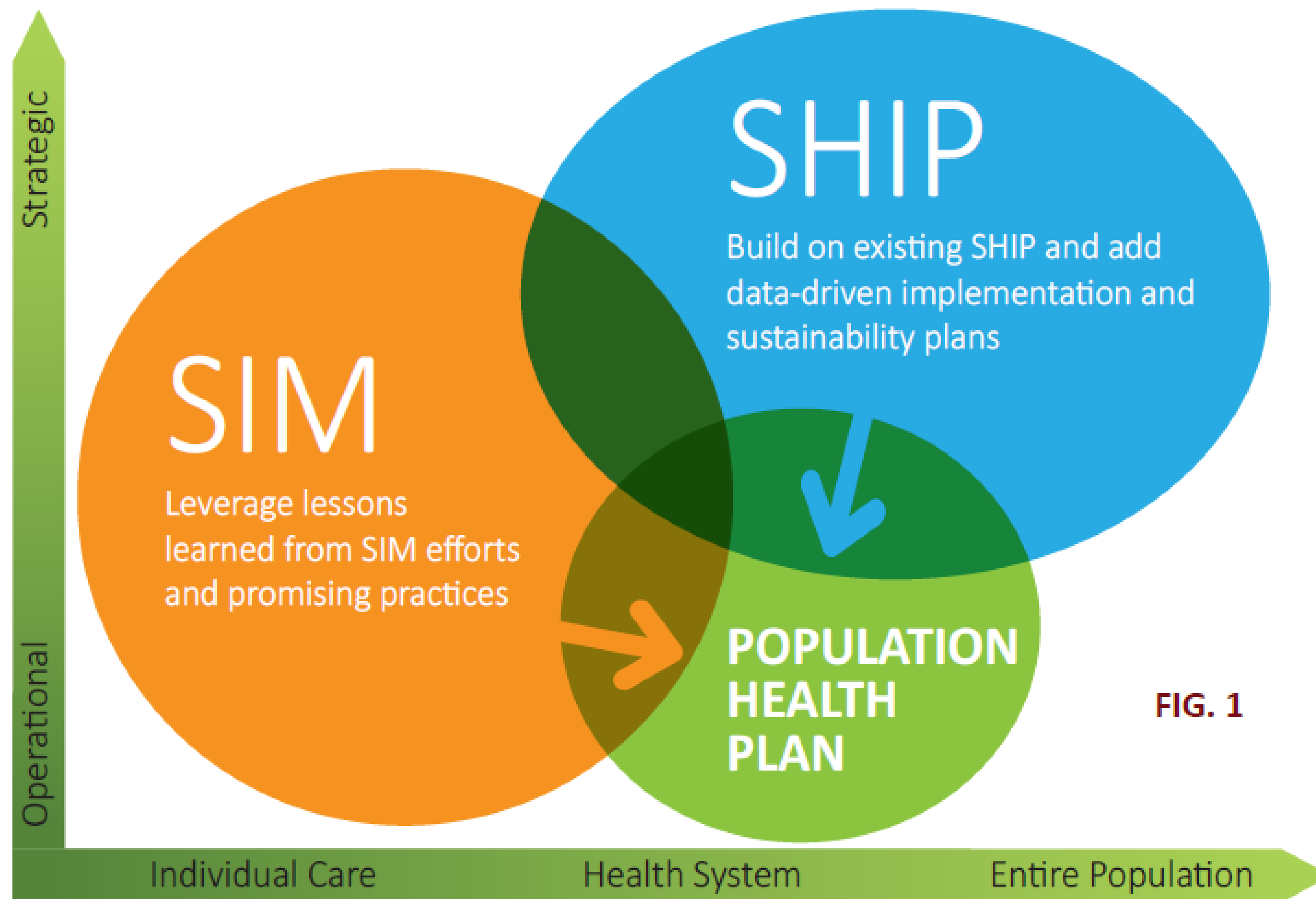
The Population Health Plan…

- Leverages and builds upon existing priorities, strategies, and interventions included in Vermont's State Health Improvement Plan (SHIP) and other state initiatives

- Addresses the integration of public health and health care delivery

- Leverages payment and delivery models as part of the existing health care transformation efforts

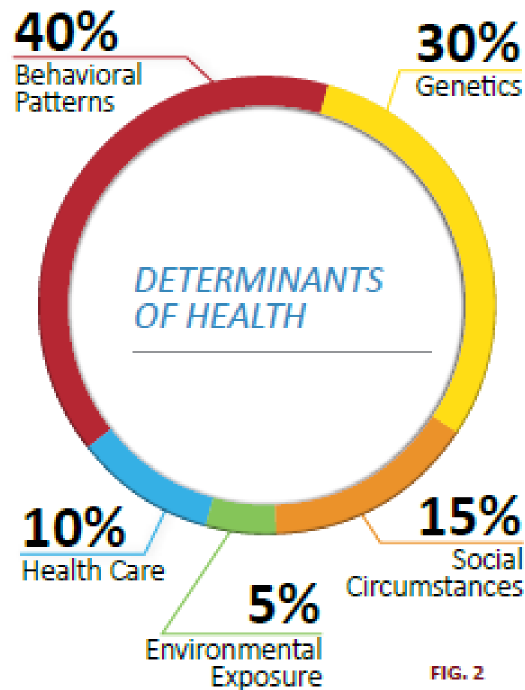
Building on State Innovation Models (SIM/VHCIP) and the State Health Improvement Plan (SHIP)



Vermont Health Care Innovation Project

Key Definitions

- **Health**: Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.
- **Population Health**: The health outcomes (morbidity mortality, quality of life) of a group of individuals, including the distribution of such outcomes within the group.



- **Social Determinants of Health**: The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

FIVE PRINCIPLES FOR IMPROVING POPULATION HEALTH

Principles for Improving Population Health

1. Use Population-Level Data on Health Trends and Burden of Illness to Identify Priorities and Target Action.
2. Focus on Prevention, Wellness, and Well-Being at All Levels – Individual, Health Care System, and Community.
3. Address the Multiple Contributors to Health Outcomes
4. Community Partners are Engaged in Integrating Clinical Care and Service Delivery with Community-Wide Population Prevention Activities.
5. Create Sustainable Funding Models Which Support and Reward Improvements in Population Health, including Primary Prevention and Wellness.

RECOMMENDATIONS

Policy Levers:

Governance Requirements: include entities that have the authority, data/information, and strategies

Care Delivery Requirements and Incentives to move from acute care to more coordinated care

Metrics and Data of population health outcomes

Payment and Financing Methodologies towards value-based payment and alternative sustainable financing for population health and prevention

State: Governance Requirements

- Embed governance requirements in Medicaid contracts with ACOs and other providers.
- Require ACOs, through Act 113 of 2016, to include public health and prevention leaders in their governing entities.
- Create a statewide public/private stakeholder group, similar to the Population Health Work Group, that recommends activities to State health policy leadership.
- Expand partnerships to other sectors that impact health. Build upon the Governor's Health in All Policies Task Force.

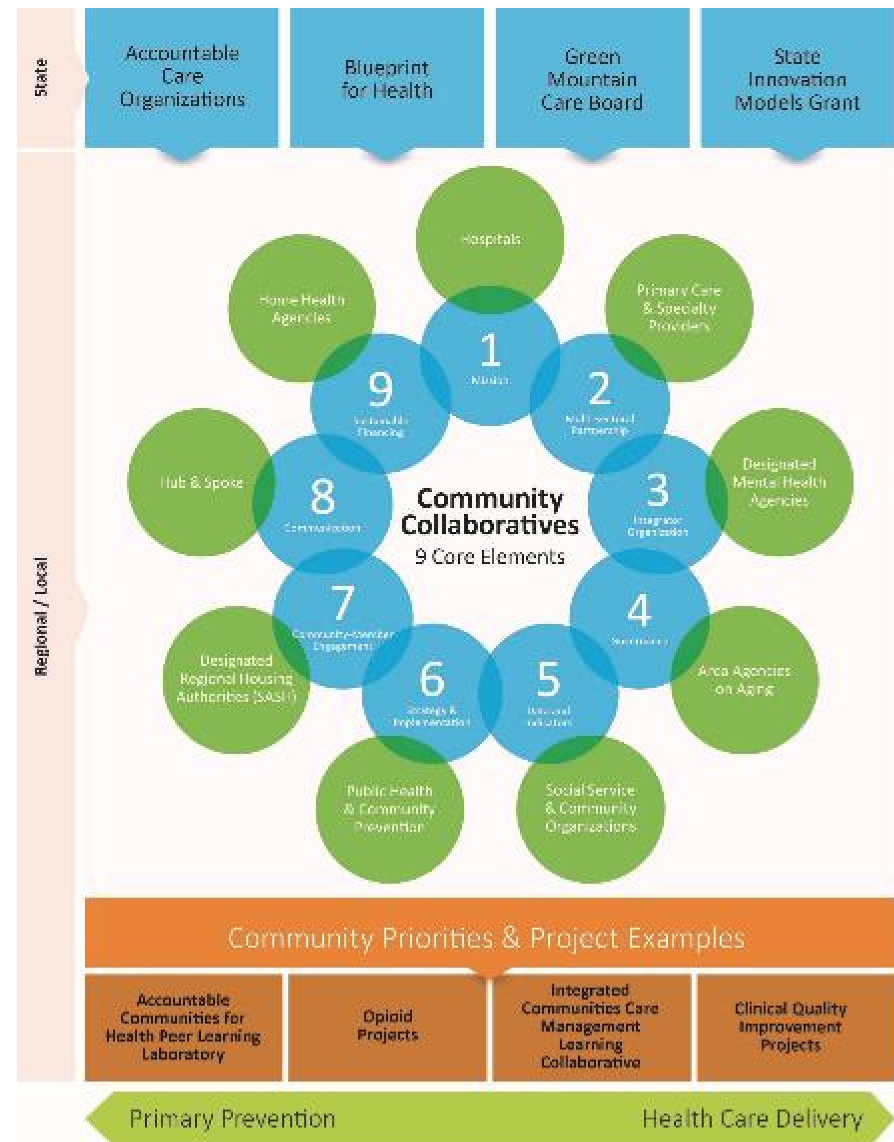
Regional: Governance Requirements

- Continue to expand partnerships to other sectors that impact health at the community or regional levels including housing, business, city and town planners, among others.

- Expand existing Community Collaboratives to meet all of the components of Accountable Communities for Health.

SPOTLIGHT: Accountable Communities for Health

An ACH is accountable for the health and well-being of the entire population in its defined geographic area. It supports the integration of high-quality medical care, mental health services, substance use treatment, and long-term services and supports, and incorporates social services. It also supports community-wide primary and secondary prevention efforts.



Lever: Care Delivery Requirements and Incentives

- Current: Vermont is utilizing state policy levers to create the foundation for payment reforms and care delivery reforms to move our health care system from acute care to more coordinated care.

- Future: Expand upon the regional integration started with the Community Collaboratives.

Lever: Care Delivery Requirements and Incentives

State: Care Delivery Requirements and Incentives

- Direct the overall flow and distribution of health resources within the State.
  - Certificate of Need program, Health Resource Allocation Plan, Insurance Rate Review, Hospital Budget Review, Professional Licensure, and contracting can help the State
- Set expectations to demonstrate success
  - Healthy Vermonters 2020, the All-Payer Model population health measures, and the Vermont Model of Care.

Regional Care Delivery Requirements and Incentives

- Incentivize Community Collaboratives to develop into Accountable Communities for Health

- Utilize *Prevention Change Packets* – developed by VDH in collaboration with OneCare – to incorporate prevention strategies to improve population health at all levels of the health system

Lever: Metrics and Data

- Require the collection of specific population health metrics
  - Track population health measures through the All-Payer Model Framework
- Set guidelines to move away from only using clinical, claims, and encounter-based metrics.
- Continue use of population health measures to drive statewide priority setting for improvement initiatives
  - for example, inclusion of screening measures for obesity, tobacco use, cancer into the payment and reporting quality measures for payment reforms.

Regional : Metrics and Data

- Use data gathered by hospitals through the Federally required Community Health Needs Assessments (CHNAs) to determine the highest priority health needs of the community and develop an implementation strategy to meet those needs.

- Provide regional-specific data, like that through the Blueprint Profiles to each hospital service area.

Lever: Payment and Financing Methodologies

- Payment methodologies – how health care providers and other organizations are paid for their work

- Financing methodologies – how funds move through the health system

- Two strategies to fund population health goals or social determinants of health:
  - Value-based payment models for providers
  - Alternative financing models for population health and prevention (not grant-based)

Vermont Health Care Innovation Project

Lever: Payment and Financing Methodologies

A conceptual model for sustainable financing includes…

- Diverse financing vehicles
- Balanced portfolio of interventions
- Integrator or backbone organization
- Reinvestment of savings

State: Payment and Financing Methodologies

- The Green Mountain Care Board: support hospital investment in population health initiatives through its Community Health Needs Assessment Policy.

- The Department of Health and Department of Vermont Health Access: increase referral to population health management activities by allowing utilization of certain codes by clinicians for payment.

- The Agency of Human Services: incorporate mechanisms that encourage or require public health accountability in value-based contracts.

- Track population health measures through the All-Payer Model.

Regional: Payment and Financing Methodologies

- Pool resources within a region to support a target a specific initiative like food security or ending homelessness.

- Reinvest savings in community-wide infrastructure to enable healthy lifestyles and opportunity

MEASURING SUCCESSFUL PLAN IMPLEMENTATION

Signs we are on the path to success

- Health system actions are primarily driven by data about population health outcomes; goals and targets should be tied to these statewide data and priorities identified in the State Health Improvement Plan.

- The health system creates health and wellness opportunity across the care and age continuum and utilizes approaches that recognize the interconnection between physical health, mental health and substance use, and the underlying societal factors.

Signs we are on the path to success

- Payment and financing mechanisms are in place for prevention strategies in the clinical setting, through clinical/community partnerships, and for community wide infrastructure and action.

- An expanded number of entities are accountable for the health of the community including health care providers, public health, community providers and others who affect health through their work on housing, economic development, transportation, and more, resulting in true influences on the social determinants of health.

Vermont Health Care Innovation Project

Discussion

- From your work group's point of view, how does this plan advance your work?
- How well do the goals and recommendations of the plan align with yours for moving ahead?
- What else would you want to see in order to get behind this plan?

Vermont Health Care Innovation Project