Vermont Health Care Innovation Project
Steering Committee Meeting Agenda

October 26, 2016, 1:00pm-3:00pm

4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier

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

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action?
1	1:00-1:10pm	Welcome and Introductions; Minutes Approval	Steven Costantino & Al Gobeille	Attachment 1: Draft September 28, 2016, Meeting Minutes	Approval of Minutes
2	1:10-1:30pm	Core Team Update • All-Payer Model • Brief Sustainability Update *Public comment*	Lawrence Miller & Sarah Kinsler		
3	1:30-2:15	Overview: Year 2 Shared Savings Program Results *Public comment*	Pat Jones & Alicia Cooper	Attachment 3: Summary of Year 2 Shared Savings Program Results	
4	2:15-2:55pm	Population Health Plan *Public comment*	Tracy Dolan & Karen Hein	Attachment 4: Presentation: Draft Population Health Plan Full Draft Population Health Plan available at: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/Vermont%20Population%20Health%20Plan%20%20September%202016.pdf	
5	2:55-3:00pm	Next Steps, Wrap-Up and Future Meeting Schedule *Public comment*	Steven Costantino & Al Gobeille	Next Meeting: Wednesday, November 30, 2016, 1:00-3:00pm, Montpelier	

Attachment 1: Draft September 28, 2016, Meeting Minutes

Vermont Health Care Innovation Project
Steering Committee Meeting Minutes

Pending Committee Approval

Date of meeting: Wednesday, September 28, 2016, 1:00pm-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Minutes Approval	Steven Costantino called the meeting to order at 1:01pm. Steven entertained a motion to approve June 2016 minutes. Susan Aranoff and Cathy Fulton seconded. The minutes were approved with two abstentions (Debbie Ingram and Julia Shaw). A quorum was present.	
2. Core Team Update	Georgia Maheras provided a Core Team update. *Performance Period 2 Annual Report*: The report, which will be posted on the website within the next day and distributed early next week, captures the period between January 2015 and June 2016. The bulk of the content is similar to the content in the Operational Plan. In particular, there have been updates in the evaluation section. Any questions, please contact Georgia. *Upcoming Budget Decisions*: At this time, they are waiting for Federal approvals. Some reallocations for the PP3 budget will be approved at the Core Team's October 10th meeting. Every 3 months, the actual spending is compared to the approved budget to ensure there is sufficient resources; adjustments will be made accordingly. • Mike Hall asked how the decisions will correlate with the discussions of the Steering Committee and also asked whether there are contract and spending decisions that will be presented to the Core Team that haven't been reviewed by the Steering Committee. Georgia responded that based on an initial analysis, recommendations are provided to ensure that budgets are lining up appropriately. In addition, there will be references to previous items that were discussed and reviewed by the Core Team but were delayed. The bulk of the funds are in the sustainability bucket which is in the Core Team's sole purview to determine how to spend. Analysis of the existing contracts is not yet complete. A preliminary proposal for the Core Team Chair will be available to review early next week and then distributed to the rest of the team.	

Agenda Item	Discussion	Next Steps
	Year 2 SSP Results Timeline: The results are not yet available due to additional vetting that must happen to ensure that the data is accurate. The information will be tentatively available on the October 11th webinar. If it's not ready by then, it will be presented at the October 17th PMDI Work Group Meeting in a webinar format. • Sue Aranoff asked about the Medicare Shared Savings Results. Georgia responded that those results will be provided in all of the Year 2 results. There are also updated numbers in the annual progress report as of June 30th 2016.	
3. Brief VHCIP Sustainability Plan Update	Georgia Maheras provided a brief update on VHCIP Sustainability Plan development (see attachments 3a and 3b). • The Sustainability Work Group, chaired by Lawrence Miller and supported by contractor, Myers and Stauffer, is meeting approximately twice a month. The group is working on a draft Sustainability Plan, which is expected to be released in early November, 2016. The plan will be presented at every VHCIP work group and the Steering Committee for review and comment in the month of November. There will also be a lunchtime webinar in November as an additional opportunity for comment. Comments will be compiled, and an edited draft shared with the Core Team for initial review. In spring 2017, additional work with the new administration and Legislature will be done as appropriate. The final plan will be submitted to federal partners by June 30, 2017. • John Evans asked if feedback is being sought from individual organizations or work groups. Georgia responded, both, and in any way that people feel comfortable. Participants should also feel free to contact Georgia Maheras (georgia.maheras@vermont.gov) or Sarah Kinsler (sarah.kinsler@vermont.gov).	
4. VHCIP Evaluation Update	Kate O'Neill, Payment Reform Program Evaluator at GMCB, is overseeing the VHCIP state-led evaluation and presented design for evaluation, progress so far, and next steps (Attachment 4). Craig Stevens of JSI, Vermont's state-led evaluation contractor, participated via phone. • The image on slide 4 (Evaluation Components) is a live link to the final environmental scan. Kate noted that this study is iterative and any feedback is appreciated. • There are about 20 themes that JSI has identified from the progress thus far. Craig pointed out that there is a context and timing to the themes. It's important to revisit what the findings are as new information emerges, and to adjust the work plan accordingly. This is an iterative process and they plan to bring revisions back to the group. Discussion: • Debbie Ingram was interested in the theme of goal alignment. Are the patient goals and reform goals mutually exclusive or is impossible to both achieve quality and save on cost? Craig knows that there are examples where reform and patient goals are aligned, e.g., aging in place. Being able to stay at home is actually a cost saver and a patient goal. Craig stated that they have avoided giving their analysis in this presentation. They are looking to the group to find out what more they should be asking in interviews. o Debbie suggested further exploration around care as people age or quality of life diminishes, and interventions to prolong life could be costly. In particular, how can we have conversations to make those humane decisions and to recognize realities and financial burdens.	

Agenda Item	Discussion	Next Steps
	• Sue Aranoff, in regards to the theme of Roles and Responsibilities, asked: Would you consider adding a focus group with state employees, not just SIM employees, who have been a part of this process to get feedback from them? There's been a tremendous number of state employees from agencies and departments involved and it would be interesting to see what their experiences have been. o Craig responded that that's something to incorporate into their work plan moving forward. The evaluation team did conduct a number of key informant interviews at the beginning of the evaluation with state employees (DVHA, VDH, and others) but it focused more on landscape to give JSI direction. They need to touch back to those organizational folks and ask more granular questions. • Dale Hackett commented that he is struggling with the timeline and with understanding the gaps within data. Georgia responded that in particular around HDI, they've recognized that they need different standards. A benefit of the SIM work to date is that we now we know what's needed. There are different funding streams (i.e., federal HITECH funds) so that we can continue to work on building HDI with other resources. • Steven Costantino asked where data analytics fit in. Craig responded that it would belong in the "view on data" component and it is being addressed in a lot of different ways. Cathy Fulton requested that in addition to data analytics, take the next step and convert it into usable, actionable information to broad stakeholder groups. • Steven struggles with connecting the financial piece to the payment reform. What value is there in the claims data that we can use in the health data side? We have a lot of data. Can we convert it to usable information to guide us to make decisions in the future? There's a huge potential here that we haven't taken advantage of. • Rick Barnett asked, in terms of the evaluation process, how are independent providers being incorporated and evaluated in terms of the value and role that they play in care delivery and payment reform? Craig responded that for example, the Care Management Learning Collaborative work hasn't been around for that long so they're trying to focus on those who have actually been touched and they haven't really gone beyond that to look at broader groups. To that point, care collaboration expansions in the future could include private practitioners.	
5. Public Comment, Next Steps, Wrap Up and Future Meeting Schedule	*Population Health Plan:* The Steering Committee will receive an update after all of the work groups have received the Population Health Plan document. Members are welcome to provide comment prior to the meeting on October 26th. *All Payer Model:* GMCB will be discuss the APM at the next 2-3 meetings. Specifics on public forums will be posted on hcr.Vermont.Gov and GMCB's website. More information will be available after the Governor's press conference with the media. Note that there will be changes to the draft agreement based on analysis. **Next Meeting:** Wednesday, October 26, 2016, 1:00-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP Steering Committee Member List

Sue Aranoff 1°
Cathy Fulton 2°
motion carried
2 abstentions

Member		Member Alternate		Minutes	Wednesday, September 28, 2016
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff ✓				AHS - DAIL
Rick	Barnett ✓				Vermont Psychological Association
Bob	Bick				DA - HowardCenter for Mental Health
~~Peter~~	~~Cobb~~	Beverly	~~Boget~~		VNAs of Vermont
Steven	Costantino ✓				AHS - DVHA, Commissioner
Elizabeth	Cote ✓				Area Health Education Centers Program
Tracy	Dolan ✓	Heidi	Klein		AHS - VDH
David	Martini ✓				DFR
John	Evans ✓	Kristina	Choquette		Vermont Information Technology Leaders
Kim	Fitzgerald ✓				Cathedral Square and SASH Program
Catherine	Fulton ✓				Vermont Program for Quality in Health Care
Kate	Simmons				Bi-State Primary Care/CHAC
Al	Gobeille	Kate	O'Neill ✓		GMCB
Lynn	Guillett				Dartmouth Hitchcock
Dale	Hackett ✓				Consumer Representative
Mike	Hall ✓				Champlain Valley Area Agency on Aging / COVE
Paul	Harrington ✓				Vermont Medical Society

Selina	Hickman	Shawn	Skafelstad		AHS - DVHA
Debbie	Ingram ✓			A	Vermont Interfaith Action
Craig	Jones				AHS - DVHA - Blueprint
Julia	Shaw ✓	(Interim)		A	VLA/Health Care Advocate Project
Deborah	Lisi-Baker				SOV - Consultant
(vacant)					VLA/LTC Ombudsman Project
Todd	Moore	Vicki	Loner		OneCare Vermont
Jeffrey	Tieman				Vermont Association of Hospital and Health Systems
Mary Val	Palumbo ✓				University of Vermont
Ed	Paquin ✓				Disability Rights Vermont
Judy	Peterson				Visiting Nurse Association of Chittenden and Grand Isle Counties
Allan	Ramsay				GMCB
Frank	Reed	Jaskanwar Kathy	Batra Henry ✓		AHS - DMH
Paul	Reiss				HealthFirst/Accountable Care Coalition of the Green Mountains
Simone	Rueschemeyer ✓				Vermont Care Network
Howard	Schapiro				University of Vermont Medical Group Practice
Julie	Tessler	Marlys	Waller		Vermont Council of Developmental and Mental Health Services
Sharon	Winn				Bi-State Primary Care
	34		7		

	Meeting Name:	VHCIP Steering Committee Meeting	
	Date of Meeting:	September 28, 2016	
	First Name	Last Name	
1	Susan	Aranoff	here
2	Ena	Backus	
3	Melissa	Bailey	
4	Heidi	Banks	
5	Rick	Barnett	phone
6	Susan	Barrett	
7	Jaskanwar	Batra	
8	Bob	Bick	
9	Martha	Buck	
10	Kristina	Choquette	
11	Sarah	Clark	
12	~~Peter~~	Cobb	
13	Lori	Collins	
14	Amy	Coonradt	
15	Alicia	Cooper	
16	Steven	Costantino	here
17	Elizabeth	Cote	phone
18	Diane	Cummings	phone
19	Mike	DelTrecco	
20	Tracy	Dolan	phone
21	Richard	Donahey	
22	John	Evans	phone
23	Jamie	Fisher	
24	Kim	Fitzgerald	here

25	Katie	Fitzpatrick	
26	Erin	Flynn	here
27	Aaron	French	
28	Catherine	Fulton	here
29	Lucie	Garand	
30	Christine	Geiler	
31	Al	Gobeille	
32	Lynn	Guillett	
33	Dale	Hackett	here
34	Mike	Hall	here
35	Paul	Harrington	phone
36	Carrie	Hathaway	
37	Karen	Hein	
38	Selina	Hickman	
39	Debbie	Ingram	here
40	Craig	Jones	
41	Kate	Jones	
42	Pat	Jones	
43	Joelle	Judge	here
44	Sarah	Kinsler	
45	Heidi	Klein	
46	Leah	Korce	
47	Andrew	Laing	
48	Kelly	Lange	
49	Deborah	Lisi-Baker	
50	Sam	Liss	
51	Vicki	Loner	

52	Robin	Lunge	
53	Carole	Magoffin	
54	Georgia	Maheras	here
55	David	Martini	here
56	Todd	Moore	here
57	Kate	O'Neill	
58	Brian	Otley	
59	Dawn	O'Toole	
60	Mary Val	Palumbo	here
61	Ed	Paquin	here
62	Judy	Peterson	
63	Anne	Petrow	
64	Luann	Poirer	
65	Allan	Ramsay	
66	Frank	Reed	
67	Paul	Reiss	
68	Simone	Rueschemeyer	
69	Jenney	Samuelson	
70	Larry	Sandage	
71	Suzanne	Santarcangelo	
72	Howard	Schapiro	
73	Julia	Shaw	
74	Shawn	Skafelstad	
75	Holly	Stone	
76	Beth	Tanzman	
77	Julie	Tessler	
78	Beth	Waldman	

79	Marlys	Waller	
80	Julie	Wasserman	here
81	Kendall	West	
82	James	Westrich	
83	Sharon	Winn	
84	David	Yacovone	

Kathy Hentges - DMH - here
Karen Sinor - DVHA - phone
Julie Corwin - DVHA - here

Attachment 3: Summary of Year 2 Shared Savings Program 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 Steering Committee
October 26, 2016

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

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

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

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

Commercial SSP Results 2014-2015

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

Summary of Aggregated Financial Results

- Medicare SSP 2015

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

Medicare SSP Results 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.			

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%

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

Impact on Payment

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

* if shared savings were earned

2015 Medicaid Payment Measures: Strengths and Opportunities

- Strengths:
  - 10 of 14 (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

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

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: Presentation: Draft Population Health Plan

POPULATION HEALTH PLAN

Draft Overview for Discussion and Comment

October 2016

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

"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)

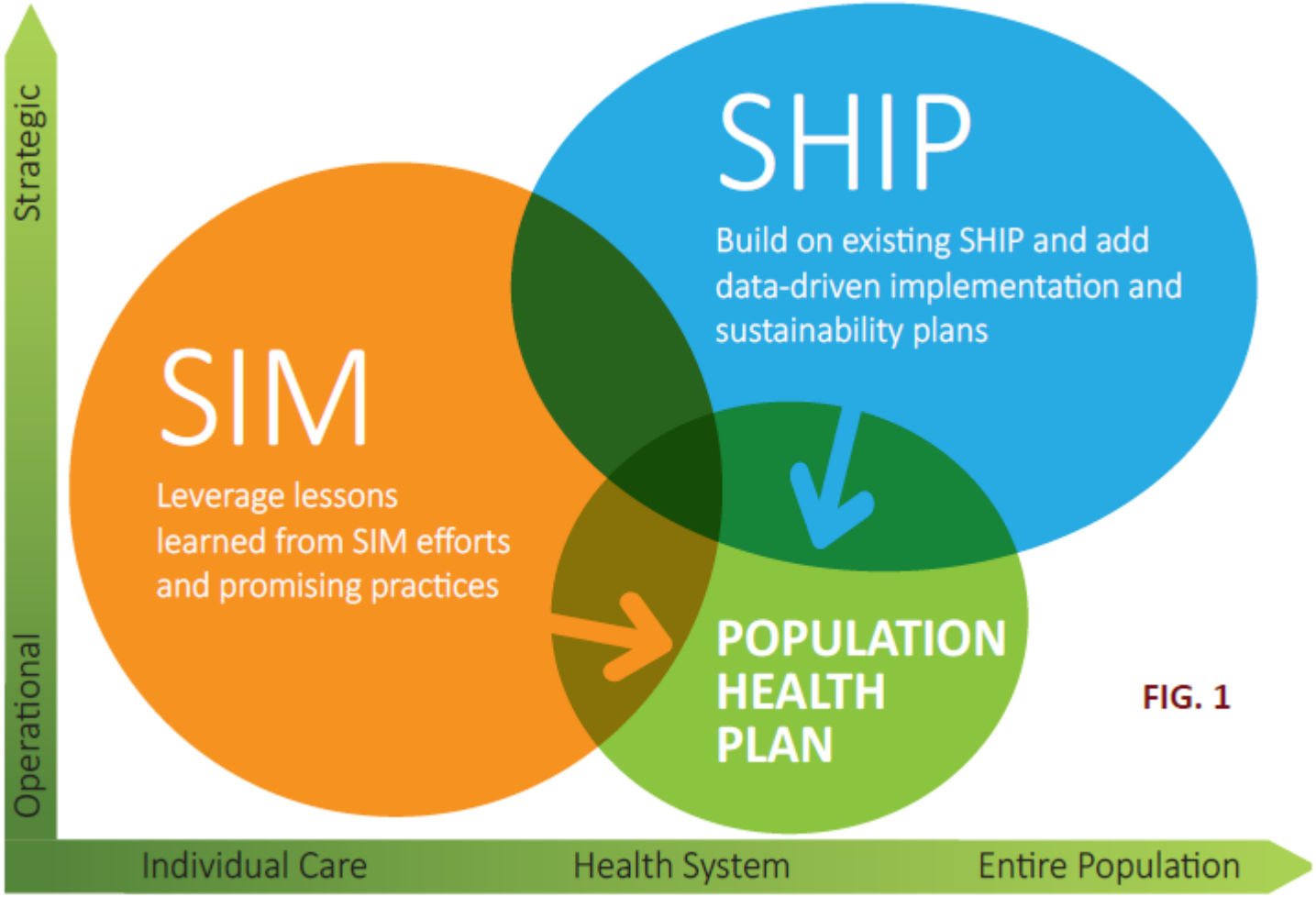
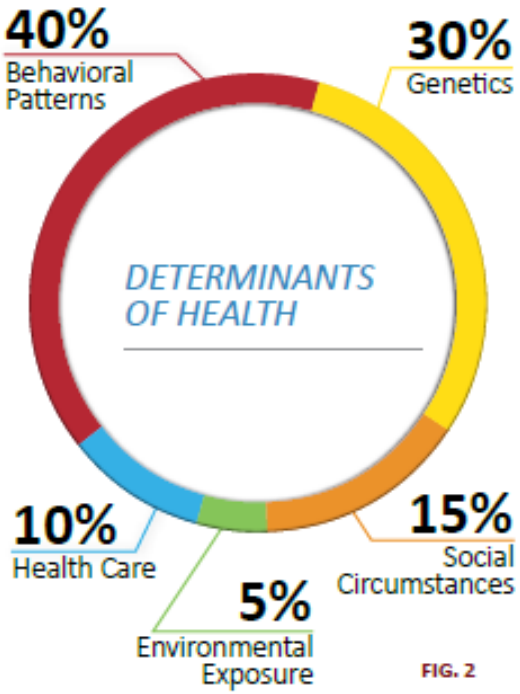


FIG. 1

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

1.0 Acute Care System

Episodic Non-Integrated Care

- Episodic health care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly coordinated chronic care management

2.0 Coordinated Seamless Health Care System

Outcome Accountable Care

- Person-centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk
- HIT integrated
- Focus on care management and preventative care

3.0 Community Integrated Health Care System

Community Integrated Health Care

- Healthy population-centered
- Population health-focused strategies
- Integrated networks linked to community resources capable of addressing psychosocial/economic needs
- Population-based reimbursement
- Learning organization that is capable of rapid deployment of best practices
- Community health integrated
- E-health and telehealth capable

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)

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.

Discussion

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