Vermont Health Care Innovation Project
Steering Committee Meeting Agenda

October 28, 2015, 1:00pm-2:30pm
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 Needed?
1	1:00-1:05pm	Welcome and Introductions	Al Gobeille & Steven Costantino		
2	1:05-1:10pm	Minutes Approval	Al Gobeille & Steven Costantino	Attachment 2: Draft September 28, 2015, Meeting Minutes	Approval of Minutes
3	1:10-1:25	Core Team Update: • Year 3 Activities and Budget • Year 3 Operational Plan • Year 2 Approvals • Project-Wide Updates *Public comment*	Lawrence Miller & Georgia Maheras	Attachment 3: Year 2 Actuals and Proposed Year 3 Budget as Presented to VHCIP Core Team on October 13	
4	1:25-2:25	Shared Savings Program Update • Year 1 ACO Shared Savings Program Results • Year 3 ACO Shared Savings Program Downside Risk Decision	Alicia Cooper, Richard Slusky, & Pat Jones	Attachment 4: Year 1 (2014) Results for Vermont's Commercial and Medicaid ACO Shared Savings Programs	
5	2:25-2:30pm	Next Steps, Wrap-Up and Future Meeting Schedule	Al Gobeille & Steven Costantino	Next Meeting: Wednesday, December 2, 2015, 1:00-3:00pm, Williston	

Attachment 2: Draft September 28, 2015, Meeting Minutes

Vermont Health Care Innovation Project
Steering Committee Meeting Minutes

Pending Committee Approval

Date of meeting: Monday, September 28, 2015; 1:00-3:00pm, Vermont State Colleges, Conference Room 101, 575 Stonecutters Way, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Al Gobeille called the meeting to order at 1:00pm. A quorum was present.	
2. Minutes Approval	Bob Bick moved to approve the minutes by exception and Sue Aranoff seconded. The motion passed with five abstentions.	
3. Work Group Policy Recommendation: Year 3 ACO Shared Savings Program (SSP) Measure Changes	Catherine Fulton and Pat Jones presented proposed changes to the Year 3 ACO Shared Savings Program measure set (Attachment 3). • QPM Work Group has recommended changes to four measures where there have been changes to the evidence base and national measure sets. The Work Group approved these changes unanimously. o SSP Payment Measure Set: LDL Screening (change carried over from Year 2). Recommendation: Replace with Controlling High Blood Pressure. o SSP Reporting Measure Set: Optimal Diabetes Care (change carried over from Year 2). Recommendation: 2-part MSSP Diabetes Composite. o SSP Monitoring and Evaluation Measure Set: Appropriate Medications for People with Asthma. Recommendation: HEDIS Medication Management for People with Asthma. o SSP Monitoring and Evaluation Measure Set: Emergency Department (ED) Utilization for Ambulatory Sensitive Conditions. Recommendation: Onpoint Health Data Potentially Avoidable ED Utilization. The group discussed the following. • Allan Ramsay asked about the Medication Management for People with Asthma Measure. Pat responded that this measure looks at whether asthma patients receive visits to manage medications. This is a claims-based measure already collected and reported by health plans, and would not be	

Agenda Item	Discussion	Next Steps
	collected at the ACO level. • Rick Barnett asked about the relationship between the Onpoint ED Utilization measure and the NYU algorithm mentioned in slide 9. Pat Jones replied that the Onpoint measure studied which ED diagnoses almost never result in hospitalization, and identified ~15 diagnoses. The NYU algorithm buckets ED visits into categories (emergent, urgent, non-emergent) which provides a more complex take on avoidable ED visits. The Work Group has identified ED utilization as an opportunity for improvement, and having multiple measures included in the M&E measure set allows for some nuance. Rick noted that the NYU algorithm excludes drugs, alcohol, and mental health; the Onpoint measure may include some of these. Pat can share the measure specs with interested participants. • Paul Harrington noted that VMS objected to the NYU algorithm when it was discussed. VMS feels this is an outdated measure being used inappropriately, and noted that there is evidence behind this. VMS continues to oppose this measure. Pat noted that the NYU algorithm is currently in the Year 1 measure set and no change is proposed. • Dale Hackett commented that we have known since the start of the program that measures would change. He commented that ED visits are sometimes unavoidable when issues are sudden, even if they do not result in a hospitalization. Pat replied that visits that result in hospitalization are not counted. She also noted that we should carefully look at results of these measures because they may indicate access issues or similar. There will be limited benchmarking available for the Onpoint measure, but it does allow us to look at changes over time. Susan Aranoff moved to adopt the changes as presented by exception. Dale Hackett seconded. The motion was approved unanimously.	
4. Core Team Update	Georgia Maheras gave an update on VHCIP governance changes and transition (Attachment 4). • Over the summer, project leadership engaged in a mid-project risk assessment. As a result of this process, project leadership proposed and approved some governance changes to realign the project's work groups with our focus areas and milestones. o Core Team and Steering Committee remain unchanged. ▪ Payment Models (incorporates Payment Models, QPM, Population Health, and some DLTSS) ▪ Practice Transformation (incorporates some DLTSS) ▪ Health Data Infrastructure (incorporates HIE/HIT) ▪ Workforce Work Group (no changes) ▪ DLTSS and Population Health will meet quarterly. o Workplans and participant list for new work groups are being reviewed by staff and co-chairs. The Core Team will receive these at their next meeting, in October. Project leadership is working hard to ensure full integration of the members and workplans of the Population Health and	

Agenda Item	Discussion	Next Steps
	DLTSS Work Groups. The group discussed the following: • Paul Harrington asked when Year 1 ACO SSP results would be presented. Georgia Maheras responded that the Commercial SSP results will be presented to the Green Mountain Care Board in October, and go to Payment Models after that meeting – it will then be presented at Steering. Al Gobeille noted that results have been requested by Rep. Turner; these are being compiled in response to this request and GMCB's response will soon be posted to the web. • Dale Hackett asked how we are ensuring Health Data Infrastructure is linked with Payment Models and Practice Transformation and does not hinder progress in the other two areas. Georgia noted that we are currently updating our HIT Strategic Plan, which provides an opportunity to map a way forward and ensure we are building infrastructure to support activities in the other two areas. Simone Rueschemeyer agreed and commented that we are also working on data quality to ensure the data in the system is useful. Dale asked whether we would have health data systems built and results coming out in time to demonstrate outcomes from SIM. Simone noted that health data systems won't hold this back – we can get data from other systems to measure progress. There will also be work to do after and beyond SIM to support data sharing. Al commented that SIM is testing payment models, but we don't know all of the answers yet. Depending on results, we will set priorities and may choose a different path – we will want to ensure our data systems support whichever path we choose. Georgia Maheras provided an update on Year 2 approval status. • Project leadership has been working with CMMI since June to develop Year 2 milestones – we received very positive feedback from CMMI on Friday, and expect milestones and Year 2 contracts to be approved by October 1. ***Public comment*** There was no additional comment.	
5. Work Group Funding Recommendation: Accountable Communities for Health	Tracy Dolan and Heidi Klein presented a funding request to launch an Accountable Communities for Health Learning System for interested communities in the state (Attachment 5a). • This proposal builds on research by the Prevention Institute on the Accountable Communities for Health model. • Background and key concepts are discussed in Attachment 5a. • There is strong interest in Prevention Institute's research from Vermont communities who feel they are moving toward this model. • The proposed Learning System would provide interested communities with support, peer learning opportunities, and technical assistance to help them take the next step toward becoming Accountable Communities for Health. Project would build on structure of Integrated Communities Care Management	

Agenda Item	Discussion	Next Steps
	Learning Collaborative (mix of peer learning and facilitative support for individual communities). • Proposed budget: $232,000. Builds on Care Management Learning Collaborative experience. The group discussed the following: • Dale Hackett noted that health care systems in other countries have a community focus on mental and behavioral health which has been successful. Heidi Klein responded that there is recognition that physical health and mental health are linked. The ACO and Blueprint practices are doing some work on this, but we believe there needs to be more support in communities to support positive outcomes, connected with the health care system. Dale commented that there needs to be a focus on improving and supporting improvements in the mental health field. • Jay Batra commented that there are some good models being developed in the state around behavioral health integration; however, there is still room for improvement. In St. Johnsbury, the mental health center has embedded a clinician in the FQHC, for example. • Catherine Fulton commented that this is a great opportunity for us to gather and test best practices from Vermont as well as from around the country and the world. Heidi added that there are many positive activities in these communities, and many build on local relationships – one challenge will be learning how to systematize these activities so they don't end when individuals move on. • Kim Fitzgerald asked how these would interact with UCCs. Heidi replied that this will build on good work at the UCC level. The Prevention Institute report recommends building on existing work in communities, but did not identify who would lead this work – it will vary by community. This funding request wouldn't offer funding to communities or regions, but instead offers learning and technical assistance. • Simone Rueschemeyer noted that there are many models of behavioral health-primary care integration. The DAs have been thinking about integration beyond primary care, to housing, transportation, corrections, and more. She hopes that the model will be aligned with UCCs and other activities so we can assess value and lessons learned and build on current work. Tracy Dolan replied that a key component of the Prevention Institute contract was to research existing activity in Vermont to ensure we don't build a new pilot in isolation. Heidi added that this proposal allows for another year of exploration and model development on a local/regional level, rather than moving immediately into piloting a model. • Georgia reminded the group that we have a Population Health Plan and Sustainability Plan due prior to the end of 2016 – this discussion highlights the need to build on existing efforts and retain good ideas. • Dale suggested learning from and building on the Local Motion model. Heidi Klein commented that the ECOS model is one that the Prevention Institute looked at, and Local Motion is very involved. • Susan Aranoff commented that DAIL loves this proposal, and in particular the flexibility around who might lead these efforts in communities.	

Agenda Item	Discussion	Next Steps
	• Jay Batra suggested that payment reform to support this model will be important for it to go statewide. • Dale Hackett commented that there are low cost innovations with positive results, such as bike programs. • Allan Ramsay commented that the community efforts profiled in the Prevention Institute report are great examples of population health interventions. These efforts are concerned about sustainable funding. Will webinars and learning sessions address this issue? Tracy replied that she believes they will address this issue, though communities working toward this model across the country have had varied success in this area. Al Gobeille added that hospital community needs assessment requirements may be relevant to this discussion. • Judy Peterson asked whether we could provide any financial support to participants of these groups – participation in the many pilots currently underway uses staff time and resources. Georgia replied that this creates many challenges – we have 15 additional months for our grant, which would slow down this process significantly. She suggested that the planning and curriculum design period will allow us to be very thoughtful to ensure we're maximizing coordination with other efforts and meetings so that we are using participants' time well. Peter Cobb moved to approve this proposal by exception. Jay Batra seconded. There were no additional questions or comments. The motion was approved unanimously.	
6. Next Steps, Wrap Up and Future Meeting Schedule	There was no additional public comment. **Next Meeting:** Wednesday, October 28, 2015 1:00pm-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier	

VHCIP Steering Committee Member List

Roll Call: 9/28/2015

moved by exception 1° Bob Bick 2° Sue Aranoff

moved by exception 1° Sue 2° Dale

moved by exception 1° Peter Cobb 2° Jay Batra

Member		Member Alternate		Minutes	ACO SSP Measures	Funding Requests	
First Name	Last Name	First Name	Last Name				Organization
	2		1				
Susan	Aranoff						AHS - DAIL
Rick	Barnett						Vermont Psychological Association
Bob	Bick						DA - HowardCenter for Mental Health
Peter	Cobb						VNAs of Vermont
Steven	Costantino						AHS - DVHA, Commissioner
Elizabeth	Cote						Area Health Education Centers Program
Tracy	Dolan	~~Heidi~~	~~Klein~~				AHS - VDH
~~Susan~~	~~Donegan~~	David	Martini				AOA - DFR
John	Evans	~~Kristina~~	~~Choquette~~	A			Vermont Information Technology Leaders
Kim	Fitzgerald	arr. @ 1" (after minutes)					Cathedral Square and SASH Program
Catherine	Fulton						Vermont Program for Quality in Health Care
Joyce	Gallimore						Bi-State Primary Care/CHAC
Don	George						Blue Cross Blue Shield of Vermont
Al	Gobeille			A			GMCB
Bea	Grause						Vermont Association of Hospital and Health Systems
Lynn	Guillett						Dartmouth Hitchcock
Dale	Hackett						None
Mike	Hall	Angela	Smith-Dieng				Champlain Valley Area Agency on Aging / COVE
Paul	Harrington	left before funding request					Vermont Medical Society
Debbie	Ingram			A			Vermont Interfaith Action
Craig	Jones						AHS - DVHA - Blueprint
~~Trinka~~	~~Kerr~~	Julia	Shaw	A			VLA/Health Care Advocate Project
Deborah	Lisi-Baker						SOV - Consultant
Jackie	Majoros						VLA/LTC Ombudsman Project
Todd	Moore	~~Vicki~~	~~Loner~~				OneCare Vermont

none opposed

no abstentions or opposed

Mary Val	Palumbo ✓						University of Vermont
Ed	Paquin x						Disability Rights Vermont
Laura	Pelosi x						Vermont Health Care Association
Allan	Ramsay ✓			A			GMCB
~~Frank~~	~~Reed~~	Jaskanwar	Batra ✓				AHS - DMH
Paul	Reiss	x					Accountable Care Coalition of the Green Mountains
Simone	Rueschemeyer ✓						Vermont Care Network
Howard	Schapiro	x					University of Vermont Medical Group Practice
Shawn	Skafelstad	x					AHS - Central Office
Julie	Tessler	x					DA - Vermont Council of Developmental and MH Services
Sharon	Winn	x					Bi-State Primary Care

VHCIP Steering Committee Participant List

Attendance: 9/28/2015

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

minutes: Bob Bick 1°
Sue Aranoff 2°
mtn to approve by exception

First Name	Last Name		Organization	Steering Committee
Susan	Aranoff	here	AHS - DAIL	S/M
Ena	Backus		GMCB	X
Melissa	Bailey		Vermont Care Network	X
Heidi	Banks		Vermont Information Technology Leaders	X
Rick	Barnett	phone	Vermont Psychological Association	M
Susan	Barrett		GMCB	X
Jaskanwar	Batra	here	AHS - DMH	MA
Bob	Bick	here	DA - HowardCenter for Mental Health	M
Martha	Buck		Vermont Association of Hospital and Health Systems	A
Amanda	Ciecior		AHS - DVHA	S
Sarah	Clark		AHS - CO	X
Peter	Cobb	phone	VNAs of Vermont	M
Lori	Collins		AHS - DVHA	X
Amy	Coonradt		AHS - DVHA	S
Alicia	Cooper		AHS - DVHA	S
Steven	Costantino		AHS - DVHA, Commissioner	C

Elizabeth	Cote		Area Health Education Centers Program	M
Diane	Cummings	here	AHS - Central Office	S
Susan	Devoid		OneCare Vermont	A
Tracy	Dolan	Phere	AHS - VDH	M
Richard	Donahey		AHS - Central Office	X
Susan	Donegan		AOA - DFR	M
Gabe	Epstein	here	AHS - DAIL	S
John	Evans	Phere	Vermont Information Technology Leaders	M
Jaime	Fisher		GMCB	A
Kim	Fitzgerald	here	Cathedral Square / SASH	M
Katie	Fitzpatrick		Bi-State Primary Care	A
Erin	Flynn		AHS - DVHA	S
Aaron	French		AHS - DVHA	X
Catherine	Fulton	here	Vermont Program for Quality in Health Care	M
Joyce	Gallimore		Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Don	George		Blue Cross Blue Shield of Vermont	M
Al	Gobeille	here	GMCB	C
Bea	Grause		Vermont Association of Hospital and Health Systems	M
Sarah	Gregorek		AHS - DVHA	A
Lynn	Guillett		Dartmouth Hitchcock	M
Dale	Hackett	here	None	M
Mike	Hall		Champlain Valley Area Agency on Aging / COVE	M
Janie	Hall		OneCare Vermont	A
Thomas	Hall		Consumer Representative	X
Bryan	Hallett	here	GMCB	S
Paul	Harrington	here	Vermont Medical Society	M
Carrie	Hathaway		AHS - DVHA	X
Diane	Hawkins		AHS - DVHA	X
Karen	Hein			X
Selina	Hickman	here	AHS - Central Office	X
Debbie	Ingram	Phone	Vermont Interfaith Action	M
Craig	Jones		AHS - DVHA - Blueprint	M

Kate	Jones		AHS - DVHA	S
Pat	Jones	here	GMCB	S
Joelle	Judge	here	UMASS	S
Trinka	Kerr		VLA/Health Care Advocate Project	M
Sarah	Kinsler	here	AHS - DVHA	S
Heidi	Klein	here	AHS - VDH	S/MA
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Deborah	Lisi-Baker		SOV - Consultant	M
Sam	Liss		Statewide Independent Living Council	X
Vicki	Loner		OneCare Vermont	MA
Robin	Lunge		AOA	X
Carole	Magoffin		AHS - DVHA	S
Georgia	Maheras	here	AOA	S
Steven	Maier		AHS - DVHA	S
Jackie	Majoros		VLA/LTC Ombudsman Project	M
Carol	Maloney		AHS	X
David	Martini	here	DFR	MA
Mike	Maslack			X
Alexa	McGrath		Blue Cross Blue Shield of Vermont	A
Darcy	McPherson		AHS - DVHA	X
Marisa	Melamed		AOA	S
Jessica	Mendizabal		AHS - DVHA	S
Madeleine	Mongan		Vermont Medical Society	X
Todd	Moore	here	OneCare Vermont	M
Brian	Otley		Green Mountain Power	X
Dawn	O'Toole		AHS - DCF	X
Mary Val	Palumbo	here	University of Vermont	M
Ed	Paquin		Disability Rights Vermont	M
Annie	Paumgarten	here.	GMCB	S
Laura	Pelosi		Vermont Health Care Association	M
Judy	Peterson	here	Visiting Nurse Association of Chittenden and Grand Isle Counties	M
Luann	Poirer		AHS - DVHA	S
Allan	Ramsay	here	GMCB	M
Frank	Reed		AHS - DMH	M
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M

Simone	Rueschemeyer	here	Vermont Care Network	M
Jenney	Samuelson		AHS - DVHA - Blueprint	X
Larry	Sandage		AHS - DVHA	S
Suzanne	Santarcangelo		PHPG	X
Howard	Schapiro		University of Vermont Medical Group Practice	M
Julia	Shaw	here	VLA/Health Care Advocate Project	X
Shawn	Skaflestad	(Interim)	AHS - Central Office	M
Mary	Skovira		AHS - VDH	A
Richard	Slusky		GMCB	S
Angela	Smith-Dieng		Area Agency on Aging	MA
~~Kara~~	~~Suter~~		AHS - DVHA	S
Beth	Tanzman		AHS - DVHA - Blueprint	X
Julie	Tessler		DA - Vermont Council of Developmental and Mental Health Serv	M
Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	S
Julie	Wasserman		AHS - Central Office	S
Spenser	Weppler		GMCB	S
Kendall	West		Bi-State Primary Care Association	X
James	Westrich		AHS - DVHA	S
Bradley	Wilhelm		AHS - DVHA	S
Sharon	Winn		Bi-State Primary Care	M
Cecelia	Wu		AHS - DVHA	S
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Susan Bartlett, AHS - here

Attachment 3: Year 2 Actuals and Proposed Year 3 Budget as Presented to VHCIP Core Team on October 13

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.

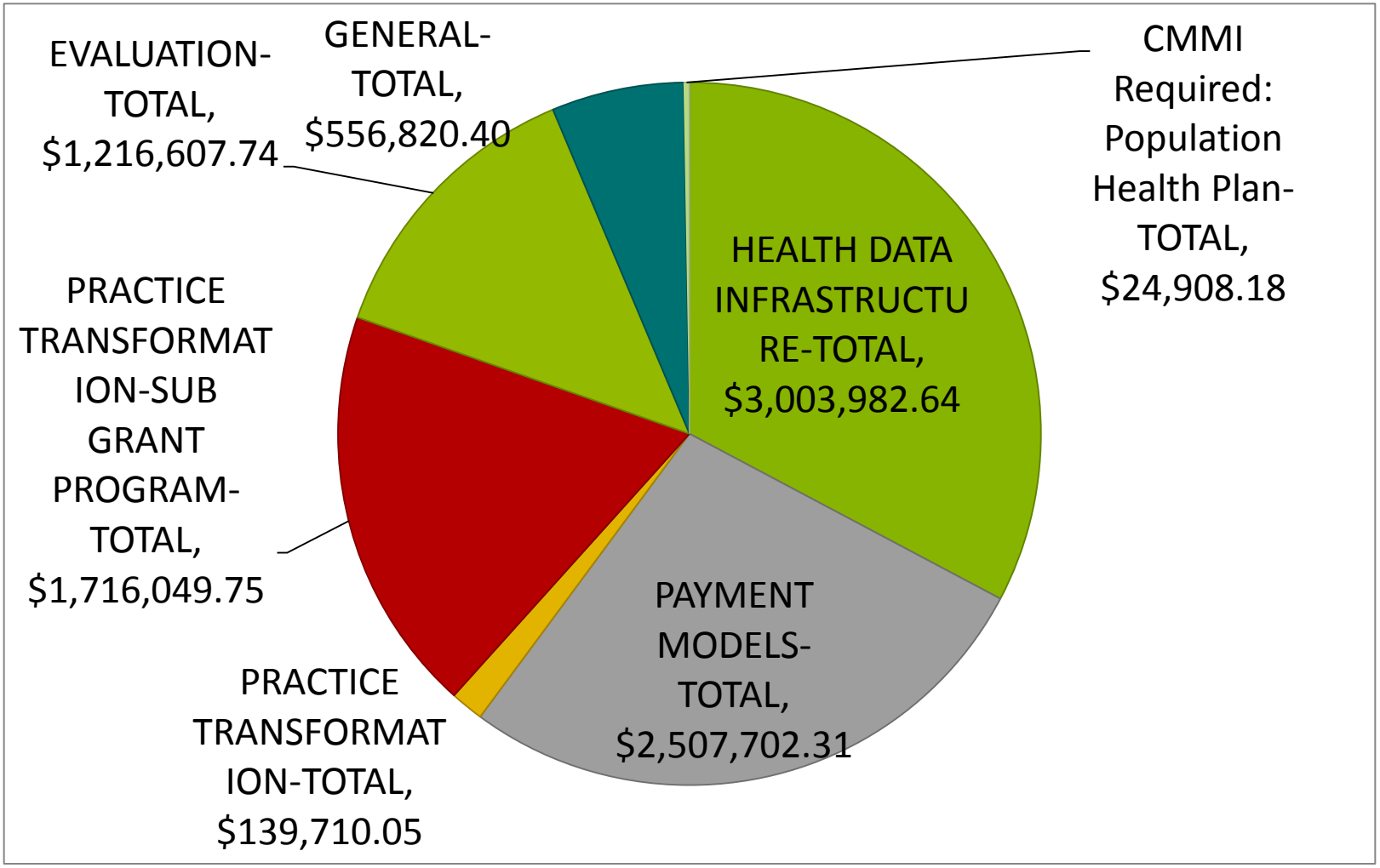
It does not capture the full 3rd quarter for indirect because of the timing.

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 4: Year 1 (2014) Results for Vermont's Commercial and Medicaid ACO Shared Savings Programs

Year 1 (2014) Results for Vermont's Commercial and Medicaid ACO Shared Savings Programs

Richard Slusky, Director of Payment Reform, GMCB
Pat Jones, Health Care Project Director, GMCB
Alicia Cooper, Health Care Project Director, DVHA

Presentation to
VHCIP Steering Committee
October 28th, 2015

VERMONT
GREEN MOUNTAIN CARE BOARD

Presentation Overview

- Financial Results
  - Aggregated
  - Per Member Per Month

- Quality Results
  - Payment Measures
  - Reporting Measures
  - Patient Experience Measures

2

Vermont's ACOs and Shared Savings Programs

ACO Name	2014 Shared Savings Programs
Community Health Accountable Care (CHAC)	Commercial Medicaid Medicare
OneCare Vermont (OCV)	Commercial Medicaid Medicare
Vermont Collaborative Physicians/ Health*first* (VCP)	Commercial Medicare

Financial Summary Aggregated Results

- Medicaid 2014

	Medicaid		
	CHAC	OneCare	VCP
Total Lives	26,587	37,929	N/A
Expected Aggregated Total	$ 67,803,470.45	$ 81,686,552.31	N/A
Target Aggregated Total	N/A	N/A	N/A
Actual Aggregated Total	$ 59,956,030.18	$ 74,931,984.20	N/A
Shared Savings Aggregated Total	$ 7,847,440.27	$ 6,754,568.12	N/A
Total Savings Earned	$ 7,847,440.27	$ 6,754,568.12	N/A
Potential ACO Share of Earned Savings	$ 3,923,720.13	$ 3,377,284.06	N/A
Quality Score	46%	63%	N/A
%of Savings Earned	85%	100%	N/A
Achieved Savings	$ 3,335,162.11	$ 3,377,284.06	N/A

Financial Summary Aggregated Results

➢ Commercial 2014

	Commercial		
	CHAC	OneCare	VCP
Total Lives	9,353	22,260	8,526
Expected Aggregated Total	$31,829,851	$76,413,313	$23,581,249
Target Aggregated Total	$30,817,275	$74,489,076	$22,796,150
Actual Aggregated Total	$34,377,496	$81,899,734	$25,292,905
Shared Savings Aggregated Total	($2,547,645)	($5,486,421)	($1,711,656)
Total Savings Earned	$0	$0	$0
Potential ACO Share of Earned Savings	$0	$0	$0
Quality Score	56%	67%	89%
%of Savings Earned	75%*	85%*	100%*
Achieved Savings	$ -	$ -	$ -

*If shared savings had been earned

Financial Summary Aggregated Results

➢ Medicare 2014

	Medicare		
	CHAC	OneCare	VCP
Total Lives	5,948	55,058	7,639
Expected Aggregated Total	$47,069,176	$466,249,733	$56,724,584
Target Aggregated Total	N/A	N/A	N/A
Actual Aggregated Total	$45,957,103	$470,417,853	$59,486,632
Shared Savings Aggregated Total	$1,112,073^	($4,168,120)	($2,762,048)
Total Savings Earned	$0	$0	$0
Potential ACO Share of Earned Savings	$0	$0	$0
Quality Score	Pay for Reporting	89.15%	92.10%
%of Savings Earned	N/A	N/A	N/A
Achieved Savings	$ -	$ -	$ -

^CHAC did not meet the MSR in the MSSP in order to earn savings

Financial Summary PMPM Results

- Medicaid 2014

	Medicaid		
	CHAC	OneCare	VCP
Actual Member Months	315,833	452,311	N/A
Expected PMPM	$ 214.68	$ 180.60	N/A
Target PMPM	N/A	N/A	N/A
Actual PMPM	$ 189.83	$ 165.66	N/A
Shared Savings PMPM	$ 24.85	$ 14.93	N/A
Total Savings Earned	$ 7,847,440.27	$ 6,754,568.12	N/A
Potential ACO Share of Earned Savings	$ 3,923,720.13	$ 3,377,284.06	N/A
Quality Score	46%	63%	N/A
%of Savings Earned	85%	100%	N/A
Achieved Savings	$ 3,335,162.11	$ 3,377,284.06	N/A

Financial Summary PMPM Results

➢ Commercial 2014

	Commercial		
	CHAC	OneCare	VCP
Actual Member Months	98,213	234,663	88,412
Expected PMPM	$ 324.09	$ 325.63	$ 266.72
Target PMPM	$ 313.78	$ 317.43	$ 257.84
Actual PMPM	$ 350.03	$ 349.01	$ 286.08
Shared Savings PMPM	$ (25.94)	$ (23.38)	$ (19.36)
Total Savings Earned	$ -	$ -	$ -
Potential ACO Share of Earned Savings	$ -	$ -	$ -
Quality Score	56%	67%	89%
%of Savings Earned	75%*	85%*	100%*
Achieved Savings	$ -	$ -	$ -

*If shared savings had been earned

Quality Measurement Overview

- 2014 was baseline year for Vermont's Shared Savings Programs: comprehensive implementation and final Commercial enrollment occurred in Spring of 2014
- Opportunity for improvement was one of the criteria for selection of quality measures
- There is no historical data for Commercial SSP members prior to their enrollment dates, so measures with look-back periods did not have adequate denominators
- Data collection and analysis was challenging, but there was impressive collaboration among ACOs in clinical data collection

Results Should be Interpreted with Caution

- ACOs have different populations

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

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

Simplified Quality Measure Data Flow

Measures From Claims Data

Payers Send Claims Data to Contractor

↓

Contractor Generates Results for Claims Measures

↓

Results Carefully Reviewed, Sent to ACOs and Reported

Measures From Clinical Data

Contractor Generates Sample from Claims Data

↓

ACO Conducts Chart Review

↓

ACO Sends Results to Contractor; Results Reviewed and Reported

Simplified Quality Measure Data Flow (cont'd)

Patient Experience Measures

Primary Care Practices Send Sample Lists to Survey Vendor

↓

Survey Vendor Fields Survey

↓

Responses to Survey Vendor

↓

Vendor Sends Practice-Level Aggregated Results to Practices

↓

ACOs Send Lists to Survey Vendor; ACO Respondents Flagged

↓

Contractor Generates ACO-Level Aggregated Results

↓

ACO-Level Results Reviewed and Reported

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2014 Quality Results: Commercial Payment Measures

Measure	CHAC Rate/ Percentile/ Points*	OCV Rate/ Percentile/ Points*	VCP Rate/ Percentile/ Points*
Adolescent Well-Care Visits	48.40/Above 75th/ 3 Points	54.42/Above 75th/ 3 Points	46.58/Above 75th/ 3 Points
Alcohol and Other Drug Dependence Treatment	22.73/Above 25th/ 1 Point	21.55/Below 25th/ 0 Points	31.25/Above 50th/ 2 Points
Chlamydia Screening	39.57/Above 25th/ 1 Point	43.47/Above 50th/ 2 Points	47.06/Above 75th/ 3 Points
Mental Illness, Follow-Up After Hospitalization	N/A (denominator too small)	69.77/Above 90th/ 3 Points	N/A (denominator too small)

*Maximum points per measure = 3

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Impact on Payment
(if there had been Shared Savings)

Vermont Commercial Shared Savings Program Quality Performance Summary - 2014				
ACO Name	Points Earned	Total Potential Points	% of Total Quality Points	% of Savings Earned*
CHAC	5	9	56%	75%
OneCare	8	12	67%	85%
VCP	8	9	89%	100%
	*If shared savings had been earned			

2014 Commercial Payment Measures: Strengths and Opportunities

- Strengths:
  - 7 of 10 ACO results were above the national 50th percentile
  - 5 of 10 were above the 75th percentile
- Opportunities:
  - 3 of 10 were below the 50th percentile
  - Even when performance compared to benchmarks is good, potential to improve some rates
  - Some variation among ACOs
  - Low Commercial denominators (mostly due to lack of historical data) prevented reporting of some measures; should improve in Year 2

2014 Commercial Reporting Measures

Reporting Measures	CHAC Rate/ Percentile	OneCare Rate/ Percentile	VCP Rate/ Percentile
Testing for Children with Pharyngitis	N/A (denominator too small)	84.38/ Above 50th	88.89/ Above 75th
Immunizations for 2-year-olds	N/A (denominator too small)	50.00/ Above 75th	64.52/ Above 90th
Pediatric Weight Assess./Counseling	55.67/ Above 75th	58.79/ Above 75th	71.37/ Above 90th
Diabetes Care Composite	12.11/ No Benchmark	45.90/ No Benchmark	41.51/ No Benchmark
Diabetes HbA1c Poor Control (lower is better)	13.22/ Above 90th	15.03/ Above 90th	15.09/ Above 90th
Colorectal Cancer Screening	64.97/ Above 75th	70.96/ Above 90th	76.61/ Above 90th
Depression Screen./Follow-Up	23.40/ No Benchmark	22.52/ No Benchmark	19.35/ No Benchmark
Adult BMI Screening and Follow-up	51.30/ No Benchmark	65.04/ No Benchmark	59.68/ No Benchmark

2014 Commercial Reporting Measures: Strengths and Opportunities

- Strengths:
  - Collaboration between ACOs in collecting clinical data
  - For measures with benchmarks, 13 of 13 ACO results were above the national 50th percentile
  - 12 of 13 were above the 75th percentile, and 7 of 13 were above the 90th percentile
- Opportunities:
  - Even when performance compared to benchmarks is good, potential to improve some rates
  - Some variation among ACOs
  - Lack of benchmarks for some Commercial measures hindered further analysis
  - Electronic data capture

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2014 Medicaid Payment Measures

Measure	CHAC Rate/ Percentile/ Points*	OCV Rate/ Percentile/ Points*
ACO All-Cause Readmission	14.93/**/ 2 Points	17.90/**/ 2 Points
Adolescent Well-Care Visits	41.82/Above 25th/ 1 Point	49.00/Above 50th/ 2 Points
Cholesterol Screening for Pts w/Cardiovascular Disease	72.87/Below 25th/ 0 Points	73.09/Below 25th/ 0 Points
Mental Illness, Follow-Up After Hospitalization	54.55/Above 50th/ 2 Points	65.88/Above 75th/ 3 Points
Alcohol and Other Drug Dependence Treatment	25.84/Above 50th/ 2 Points	26.22/Above 50th/ 2 Points
Avoidance of Antibiotics in Adults with Acute Bronchitis	31.78/Above 75th/ 3 Points	29.70/Above 75th/ 3 Points
Chlamydia Screening	51.31/Above 25th/1 Point	49.75/Below 25th/0 Points
Developmental Screening	25.55/**/0 Points	45.50/**/3 Points

*Maximum points per measure = 3

**Core Measures 1 and 8 compared to ACO-specific benchmarks, not national benchmarks

Impact on Payment

Vermont Medicaid Shared Savings Program Quality Performance Summary - 2014				
ACO Name	Points Earned	Total Potential Points	% of Total Quality Points	% of Savings Earned
CHAC	11	24	46%	85%
OneCare	15	24	63%	100%

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2014 Medicaid Payment Measures: Strengths and Opportunities

- Strengths:
  - 10 of 16 ACO results were above the national 50th percentile
  - 4 of 16 were above the 75th percentile
  - Both ACOs met the quality gate and were able to share in savings

- Opportunities:
  - 6 of 16 were below the 50th percentile
  - Some variation among ACOs

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2014 Medicaid Reporting Measures

Reporting Measures	CHAC Rate/ Percentile	OCV Rate/Percentile
COPD or Asthma in Older Adults	28.10/Above 75th	30.88/Above 75th
Breast Cancer Screening	53.09/Above 50th	55.80/Above 50th
Prevention Quality Chronic Composite	28.96/ No Benchmark	42.53/No Benchmark
Pharyngitis, Appropriate Testing for Children	77.12/Above 50th	84.31/Above 75th
Childhood Immunization	47.32/Above 90th	60.84/Above 90th
Weight Assessment and Counseling for Children/Adolescents	32.35/Below 25th	47.63/Above 25th
Optimal Diabetes Care Composite	13.28/No Benchmark	33.05/No Benchmark
Diabetes HbA1c Poor Control	23.59/Above 90th	21.47/Above 90th
Colorectal Cancer Screening	53.45/No Benchmark	58.42/No Benchmark
Screening for Clinical Depression and Follow-Up Plan	40.00/No Benchmark	24.55/No Benchmark
Body Mass Index Screening and Follow-Up	47.58/No Benchmark	65.27/No Benchmark

2014 Medicaid Reporting Measures: Strengths and Opportunities

- Strengths:
  - Impressive collaboration between ACOs in collecting clinical data
  - For measures with benchmarks, 10 of 12 ACO results were above the national 50th percentile
  - 7 of 12 were above the 75th percentile, and 4 of 12 were above the 90th percentile
- Opportunities:
  - Even when performance compared to benchmarks is good, potential to improve some rates
  - Some variation among ACOs
  - Lack of benchmarks for some Medicaid measures hindered further analysis
  - Electronic data capture

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2014 Combined Commercial/Medicaid Patient Experience Results (VCP - Commercial Only)

Adult Patient Exp. Composite	CHAC Rate/ Percentile (Comm+Medicaid)	OneCare Rate/ Percentile* (Comm+Medicaid)	VCP Rate/ Percentile (Comm Only)
Access to Care	50%/Below 25th	62%/Above 25th	63%/Above 25th
Communication	77%/Below 25th	82%/At 25th	84%/Above 25th
Shared Decision-Making	63%/Above 25th	67%/At 50th	N/A
Self-Management Support	51%/Above 25th	53%/At 50th	47%/Above 25th
Comprehensiveness	60%/Above 75th	55%/Above 50th	43%/Above 25th
Office Staff	71%/Below 25th	74%/At 25th	84%/Above 50th
Information	72%/No Benchmark	69%/No Benchmark	69%/No Benchmark
Coordination of Care	74%/No Benchmark	75%/No Benchmark	74%/No Benchmark
Specialist Care	49%/No Benchmark	50%/No Benchmark	44%/No Benchmark

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

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2014 Combined Commercial/Medicaid OneCare Results for UVMMC Practices*

Adult Patient Exp. Composite: Visit-Based Survey	UVM Medical Center/OneCare Top Score Rate/Percentile (Commercial + Medicaid)
Access to Care	90%/Above 90th
Communication	92%/At 50th
Shared Decision-Making	55%/No Benchmark
Self-Management Support	39%/No Benchmark
Comprehensiveness	37%/No Benchmark
Office Staff	95%/Above 50th
Information	56%/No Benchmark
Coordination of Care	79%/No Benchmark
Specialist Care	56%/No Benchmark

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

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2014 Combined Patient Experience Measures: Strengths and Opportunities

- Strengths:
  - Most ACO primary care practices chose to participate
  - State funding (VHCIP and Blueprint) and vendor management reduced burden on practices
  - Use of same survey for Blueprint and ACO evaluation reduced probability of multiple surveys to consumers
- Opportunities:
  - 12 of 17 ACO results with benchmarks are below national 50th percentile
  - Lack of benchmarks hindered further analysis
  - National all-payer benchmarks might not be comparable to VCP Commercial or CHAC/OneCare combined Commercial/Medicaid results

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Summary of 2014 Results

- Implementing Vermont's SSPs in 2014 was complex, and was a learning experience for all participants
- Collaboration among ACOs, providers, payers, state, and contractors was a strength
- Financial results were positive for Medicaid SSP, and were not surprising for Commercial SSP given the use of premiums for setting targets
- Promising quality results for claims/clinical measures
- Opportunities for improvement in Years 2 and 3
- Significant ACO efforts underway to develop data collection, analytic capacity, care management strategies, population health approaches, and ACO/Blueprint collaboration

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Questions/Discussion

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