VT Health Care Innovation Project - Payment Model Design and Implementation Work Group Meeting Agenda
Monday, November 21, 2016 1:00 PM – 3:00 PM.
DVHA Large Conference Room, 312 Hurricane Lane, Williston
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: October Meeting Minutes
2	1:05-1:15	Program Updates	Sarah Kinsler	N	
3	1:15-2:15	Sustainability Plan Review and Discussion	Sarah Kinsler	N	Attachment 3: Presentation – Draft Sustainability Plan Full Draft Sustainability Plan available at: http://healthcareinnovation.vermont.gov/content/vermont-sim-sustainability-plan-draft-november-2016
4	2:15-2:50	Year 2 Shared Savings Program Results: Continued Discussion	Alicia Cooper, Pat Jones	N	Attachment 4: 2015 SSP Results
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: October Meeting Minutes

Vermont Health Care Innovation Project
Population Health Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Monday, October 17, 2016, 1:00-3:00pm, 4th Floor Conference Room, Pavilion Building, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Andrew Garland called the meeting to order at 1:01pm. A roll call attendance was taken and a quorum was present. Sue Aranoff moved to approve the September 2016 minutes by exception, and Dale Hackett seconded. The minutes were approved with one abstention (Kate Simmons).	
2. Program Update: • Brief Sustainability Plan Update • Update on APM	Sustainability Plan Update: Sarah Kinsler delivered an update on the process to create the SIM Sustainability Plan and thanked those who are participating in that stakeholder process. There have been three meetings thus far that have centered on the three focus areas of the SIM project overall (Practice Transformation, Health Data Infrastructure and Payment Model Design and Implementation) and the activities that are occurring within each focus area. A draft plan will be released around November 2, and will be presented at every work group and the Steering Committee in November. A webinar in November will give participants an additional opportunity to offer feedback. The Core Team will receive a recommended plan in December that will be provided to the incoming administration. APM Update: Lawrence Miller provided an update on the status of the All-Payer Model (APM). The draft agreement from CMMI has been published and was put out for public comment. The public comment period ended last Thursday, 10/13; the vast majority of comments relate to implementation, and follow up questions have been sent to CMS as a result of that process. The next step will be to receive a draft back from CMS and then the Green Mountain Care Board (GMCB) will need to take a vote. We are moving toward a final draft so that the Board can make a recommendation to the governor. The Global Commitment 1115 Waiver (expires 12/31/2016) is also being renegotiated simultaneously. Lawrence clarified that while the public comment period has ended, GMCB will continue to take comments related to their decision whether to recommend approval or disapproval. • Lila Richardson asked if a summary of comments made on the draft agreement will be made public. Ultimately, yes, but it will not be released until a draft has been released by CMS. The Administration has not yet issued any responses to comments.	

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	• Sue Aranoff asked if the Administration and GMCB will provide written responses to comments they have received. Lawrence replied that the Administration has not yet decided whether it will respond to all comments individually or in writing, noting that many comments were verbal. He could not comment on the GMCB process for this. • Dale Hackett noted that he has compared the documents for the APM and the Medicaid Pathway side by side to try to understand how they relate. He commented that the Medicaid Pathway must be adequately funded if it will keep pace with the APM and support parity. Lawrence replied that the APM and Global Commitment 1115 waiver work together. For the Medicaid Pathway, the 1115 waiver sets up a framework, and the Medicaid needs funding that matches that framework. Dale commented that the documents indicate that extra waiver funds may be sought. Lawrence clarified that in the 1115 waiver there is financial capacity for these activities (and other AHS activities); the APM includes some one-time funding that will then transition to Medicare-based funding. Year 3 of the APM shows a fully integrated plan that provides the foundation for the negotiations for the next 1115 waiver. He also noted that Vermont needs an 1115 waiver that stands on its own if APM does not proceed or if it fails.	
3. Year 2 Shared Savings Program Results Overview	Andrew Garland introduced the agenda item and offered thanks Alicia Cooper and Pat Jones, noting their hard work to prepare these materials. He noted that this discussion will be augmented by a webinar on October 28, and that the November PMDI meeting will also reserve time for further discussion on this topic. Pat Jones and Alicia Cooper presented high-level results from Year 2 of Vermont's Medicaid and Commercial Shared Savings Programs (SSPs) as well as the Medicare Shared Savings Program. • The Shared Savings Programs (SSPs) are part of a broader context in Vermont and nationally: in 2015, the federal government passed the Medicare Access and Children Health Insurance Program Reauthorization Act (MACRA). MACRA creates 2 tracks for payment reform under Medicare: 1) Merit-Based Incentive Payment System (MIPS) – reimburses providers based on results of quality measures (upside or downside); 2) Advanced Alternative Payment Models – provides financial incentives for providers who chose to participate and disincentives for those who do not. Vermont's current SSPs do not qualify as Advanced Alternative Payment Models; however, the All-Payer Model would qualify. • Cautions in interpreting results: The three ACOs have different populations and different SSP start dates/levels of maturity. In addition, Commercial targets continue to be based on Vermont Health Connect premiums, rather than actual claims experience. • Takeaways from the 2015 SSP results: Medicaid SSP: CHAC earned modest savings; PMPM declined from 2014 to 2015. Overall quality scores improved. 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	

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	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%. • A few notes regarding Medicaid and Commercial payment measures: o Medicaid and Commercial payment measure set was mostly stable between 2014 and 2015; outcome measures added in 2015 o Multiple years of data for Commercial SSP members resulted in adequate denominators for measures with look-back periods o Medicaid "Quality Gate" more rigorous in 2015 (35% to 55%) o Data collection and analysis is challenging, but there continues to be impressive collaboration among ACOs in clinical data collection • Medicaid SSP Quality Results: Payment Measures – (Slide 36). Strengths: o 10 of 14 measures of ACO results were above the 50th percentile nationally; 6 of 14 were above the 75th percentile Both ACOs met the quality gate and CHAC will receive shared savings Opportunities: o 4 of 14 measures were below the 50th percentile o Opportunity to improve Chlamydia Screening measure across both participating ACOs o Some variation among ACOs • Commercial SSP Quality Results: Payment Measures Strengths: o 16 of 22 measures were above the 50th percentile nationally; 15 of 22 were above the 75th percentile Opportunities: o 6 of 22 measures were below the 50th percentile o Opportunity to improve Alcohol and Other Drug Dependence Treatment measure across all ACOs o Even when performance compared to benchmarks is good, potential to improve some rates o Some variation among ACOs The group discussed the following: • Dale Hackett asked, do we look at who is doing the best and see what they're doing that makes them the leader? Pat stated that this is the goal. Additionally, Vermont Department of Health has developed Change Packets for each payment measure and has been working with OneCare Vermont to co-brand these and roll them out to practices. Each of our ACOs are working on these issues with their practices and with each other. Kate Simmons agreed.	

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	• Susan Shane asked about the impact of 42 CFR Part 2 on alcohol and drug treatment measures. Pat responded that certainly not having access to good data makes it hard to do this kind of analysis, but working across the network there is still the ability to make sure that the initial engagement and follow up treatment occurs. Susan added that the ACOs are not getting any data on this measure, and Pat agreed that yes, it adds to the challenge, but one approach working with providers to make sure that there is initial intervention and follow-up once the diagnosis occurs. Paul Harrington noted that the Substance Abuse and Mental Health Services Administration (SAMHSA) has a draft rule to make the access to this type of information easier. • Paul asked Pat and Alicia for their opinion: have Vermont's Shared Savings Programs been a success? He noted savings are built into the All-Payer Model agreement, so lack of savings from the SSPs is of concern. Pat responded there have been some savings within the Medicaid program, noting that the movement toward target in the Commercial SSP is encouraging. She also noted that when states try these kinds of reform programs, it can take years for the impact to fully play out. • Sue Aranoff suggested adding percentages (actual vs. goal) to the presentation of the financial results to highlight the percent changes over time.	
4. Population Health Plan: Review and Discussion	Sarah Kinsler presented the draft Population Health Plan, noting that the draft Plan (summarized in Attachment 4; full draft plan available here: Population Health Plan) is a draft; we hope and expect to have comments and feedback from a broad stakeholder group. • This is the culmination of two years of work from the Population Health Work Group. We would like folks to consider the following three questions as they review this document and provide feedback: 1. From your work group's point of view, how does this plan advance your work? 2. How well do the goals and recommendations of the plan align with yours for moving ahead? 3. What else would you want to see to get behind this plan? The group discussed the following: • Dale Hackett asked if we are thinking about how to keep ourselves healthy, particularly during stressful times. Sarah spoke about the impact of social policy and politics in shaping the environment in which individuals and communities live, work, and play. Karen Hein added that the CDC Social Impact Pyramid also illustrates how other interventions can help with this (such as 'making health choices the easy choice'). Lawrence Miller also added that there are critical points that address these kinds of concerns with community and large-scale disasters or events that are built into response plans – e.g. the response to Hurricane Irene. • Ed Paquin raised a point of caution, noting that the health system is not necessarily best situated to address all factors that impact health (e.g., clean water). The acute care delivery system is good at what it's good at, but other parts of our system (e.g., schools) are great contributors to the overall health of our communities. Ed noted that acute care services are critical for many people, including the elderly and people with disabilities, and he is concerned about any plan that would shift resources away from those	

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	key areas where they are needed and where the actual expertise exists. Karen Hein reminded the group that this is guideline and not meant to be specific – it's a framework. • Jim Hester raised a point that any effort in this area needs a variety of financial vehicles and can't just rely on financial resources from the acute care setting, for example. • Dale Hackett asked about population health metrics under the APM. The APM contains some Vermont-wide population health targets and this plan proposes that Vermont utilize population health metrics like these in the future. Karen Hein noted that there is a Robert Wood Johnson grant that is currently looking at the statewide budget for health (including health care services expenditures and the components that are being spent on health) and intends to look broader, wider, deeper than just the health care sector. Jim Hester also added that the draft APM agreement proposes three tiers for measures – State-level, attributed lives, and care process measures. • Karen Hein pointed out that there is brand new money available to finance population health activities through Community Development Financial Institutions (CDFIs). • Dale Hackett asked if there is a plan to coordinate across the Population Health Plan, Sustainability Plan, and All-Payer Model planning. Sarah replied that the Population Health Plan is not intended as a detailed workplan, but rather as a roadmap, along with the APM. Karen Hein added that the Accountable Communities for Health work is a key resource that could support detailed workplan development within communities. The Population Health Plan can be a guide for evaluating the models and whether we are aligning ourselves with the various initiatives across the state. • Dale Hackett suggested that this plan document and others should highlight what happens if we do not make recommended investments. Questions and comments regarding the Population Health Plan may be submitted to Georgia Maheras (Georgia.maheras@vermont.gov), Heidi Klein (Heidi.klein@vermont.gov), and/or Sarah Kinsler (sarah.kinsler@vermont.gov) until 10/31. Participants should feel free to provide written or verbal comments – please feel free to call or email and use whatever form you wish to provide comments. A second draft will be created in November and further drafts in Spring for the ultimate due date to CMMI in June 2017.	
5. Public Comment	There was no public comment.	
6. Next Meeting and Next Steps	**Next Meeting:** Monday, November 21, 2016, 1:00pm-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston	

VHCIP Payment Model Design and Inplementation Work Group Member List

Sue A 1° Dale H 2° Motion Carried 1 abstention

Monday, October 17, 2016					
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
		Chris	Hickey ✓		
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
		Nicole	Lucas ✓		
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, October 17, 2016

Member		Member Alternate			
First Name	**Last Name**	**First Name**	**Last Name**	**Minutes**	**Organization**
Bonnie	McKellar	Mark	Burke		Brattleboro Memorial Hopspital
		Steve	Gordon		Brattleboro Memorial Hopspital
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
		Vicki	Loner		OneCare Vermont

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Monday, October 17, 2016

Member		Member Alternate			
First Name	**Last Name**	**First Name**	**Last Name**	**Minutes**	**Organization**
		Leah	Fullem		OneCare Vermont
		Sara	Barry ✓		
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 ✓	A (Kate)	Bi-State Primary Care/CHAC
		Patricia	Launer ✓		Bi-State Primary Care
		Heather	Skeels		Bi-State Primary Care
Pat	Jones ✓	Kate	O'Neill		GMCB
Julie	Tessler				VCP - Vermont Council of Developmental and Mental Health Services
		Sandy	McGuire ✓		VCP - Howard Center
	31		40		

Q ✓

VHCIP Payment Model Design and Inplementation Work Group

Attendance Sheet 10/17/2016

	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	Sara	Barry	phone	OneCare Vermont	X
12	Devin	Batchelder		Northwestern Medical Center	MA
13	Jaskanwar	Batra		AHS - DMH	MA
14	Abe	Berman		OneCare Vermont	MA
15	Bob	Bick		DA - HowardCenter for Mental Health	X
16	Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DM	X
17	Beverly	Boget	phone	VNAs of Vermont	MA
18	Mary Lou	Bolt		Rutland Regional Medical Center	X
19	Jill Berry	Bowen		Northwestern Medical Center	M
20	Stephanie	Breault		Northwestern Medical Center	MA
21	Martha	Buck		Vermont Association of Hospital and Health	A
22	Mark	Burke		Brattleboro Memorial Hopsital	MA
23	Donna	Burkett		Planned Parenthood of Northern New Engla	X
24	Heather	Bushey		Planned Parenthood of Northern New Engla	MA
25	Gisele	Carbonneau		HealthFirst	A
26	Erin	Carmichael	phone	AHS - DVHA	MA
27	Denise	Carpenter		Specialized Community Care	X
28	Jane	Catton		Northwestern Medical Center	MA

29	Alysia	Chapman		DA - HowardCenter for Mental Health	X
30	Joshua	Cheney		VITL	A
31	Joy	Chilton		Home Health and Hospice	X
32	Barbara	Cimaglio		AHS - VDH	X
33	Daljit	Clark		AHS - DVHA	X
34	Sarah	Clark		AHS - CO	X
35	Judy	Cohen		University of Vermont	X
36	Lori	Collins		AHS - DVHA	X
37	Connie	Colman		Central Vermont Home Health and Hospice	X
38	Sandy	Conrad		V4A	MA
39	Amy	Coonradt		AHS - DVHA	S
40	Alicia	Cooper	here	AHS - DVHA	S
41	Janet	Corrigan		Dartmouth-Hitchcock	X
42	Julie	Corwin		AHS - DVHA	S
43	Brian	Costello		Consultant	X
44	Michael	Counter		VNA & Hospice of VT & NH	M
45	Mark	Craig			X
46	Diane	Cummings		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	phone	HealthFirst	M
57	Molly	Dugan		Cathedral Square and SASH Program	MA
58	Lisa	Dulsky Watkins		Consultant	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	Judith	Franz		VITL	X
67	Mary	Fredette		The Gathering Place	X
68	Aaron	French		AHS - DVHA	M
69	Catherine	Fulton	here	Vermont Program for Quality in Health Care	CC
70	Lucie	Garand		Downs Rachlin Martin PLLC	X
71	Andrew	Garland	here	BCBSVT	CC
72	Christine	Geiler	here	GMCB	S
73	Carrie	Germaine		AHS - DVHA	X
74	Al	Gobeille		GMCB	X
75	Steve	Gordon		Brattleboro Memorial Hopsital	M
76	Don	Grabowski		The Health Center	X
77	Maura	Graff		Planned Parenthood of Northern New Engla	M
78	Wendy	Grant		Blue Cross Blue Shield of Vermont	A
79	Lynn	Guillett		Dartmouth Hitchcock	X
80	Dale	Hackett	here	Consumer Representative	M
81	Mike	Hall		Champlain Valley Area Agency on Aging / C	M
82	Catherine	Hamilton		Blue Cross Blue Shield of Vermont	X
83	Paul	Harrington	here	Vermont Medical Society	M
84	Stefani	Hartsfield	phone	Cathedral Square	MA
85	Carrie	Hathaway		AHS - DVHA	X
86	Karen	Hein	phone	University of Vermont	M
87	Kathleen	Hentcy		AHS - DMH	MA
88	Jim	Hester	phone	SOV Consultant	S
89	Selina	Hickman		AHS - DVHA	X
90	Bard	Hill		AHS - DAIL	M
91	Con	Hogan		GMCB	X
92	Nancy	Hogue		AHS - DVHA	M
93	Jeanne	Hutchins	phone	UVM Center on Aging	M
94	Penrose	Jackson		UVM Medical Center	X
95	Craig	Jones		AHS - DVHA - Blueprint	X
96	Pat	Jones	here	GMCB	MA
97	Margaret	Joyal		Washington County Mental Health Services	X
98	Joelle	Judge	here	UMASS	S
99	Kevin	Kelley		CHSLV	X
100	Melissa	Kelly		MVP Health Care	X

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

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

173	Jennifer	Stratton		Lamoille County Mental Health Services	X
174	Kara	Suter		Burns and Associates	X
175	Beth	Tanzman		AHS - DVHA - Blueprint	X
176	JoEllen	Tarallo-Falk		Center for Health and Learning	X
177	Julie	Tessler		VCP - Vermont Council of Developmental ar	M
178	Cindy	Thomas		AHS - VDH	MA
179	Shannon	Thompson		AHS - DMH	MA
180	Bob	Thorn		DA - Counseling Services of Addison County	X
181	Win	Turner			X
182	Karen	Vastine		AHS-DCF	X
183	Teresa	Voci		Blue Cross Blue Shield of Vermont	MA
184	Nathaniel	Waite		VDH	X
185	Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	X
186	Marlys	Waller		DA - Vermont Council of Developmental an	X
187	Nancy	Warner		COVE	X
188	Julie	Wasserman	here	AHS - Central Office	S
189	Kendall	West	here	Bi-State Primary Care/CHAC	MA
190	James	Westrich	here	AHS - DVHA	S
191	Jason	Williams		UVM Medical Center	X
192	Sharon	Winn		Bi-State Primary Care	X
193	Stephanie	Winters		Vermont Medical Society	X
194	Hillary	Wolfley		Vermont Program for Quality in Health Care	X
195	Erin	Zink		MVP Health Care	X
196	Marie	Zura		DA - HowardCenter for Mental Health	X
					196

Attachment 3: Sustainability Plan Presentation

Vermont State Innovation Model (SIM) Draft Sustainability Plan

Georgia Maheras, Project Director,
Vermont Health Care Innovation Project
(SIM)

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1

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2

Vermont SIM Sustainability Plan Overview

Purpose of the Plan

- Identify and document the process for sustainability.
- Consider the lessons learned from the various SIM investments, and how they might contribute to program sustainability.
- Determine activities and investments to sustain.
- Determine lead entities and key partners.

Sustainability Defined

Sustainability is defined as an organization's ability to maintain a project over a defined period of time. Elements of sustainability include:

- Leadership support;
- Financial support;
- Legislative/regulatory/polic y support;
- Provider-partner support;
- Stakeholder (community and advocacy) support;
- Data support;
- Health information technology (HIT) and health information exchange (HIE) system support;
- Project growth and change support;
- Administrative support; and
- Project management support.

(Program Susainability Assessment Tool, https://sustaintool.org/understand, 2016)

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5

Plan Research and Development: Vermont SIM Research

Myers and Stauffer, a contractor with the State, used the following methods to assist in the development of the Sustainability Plan:

- Conducted research on Vermont's Medicaid program, legislature, government structure, geography, relevant legislation, policy, and political environment.
- Met with JSI, the SIM State-Led Evaluation contractor, and reviewed available evaluation materials.
- Deployment of an electronic stakeholder survey. Survey was sent to over 300 SIM participants to seek input on the sustainability priorities within each focus area; 47 responses received. A copy of this survey, including results, can be found in Appendix B of the Plan.

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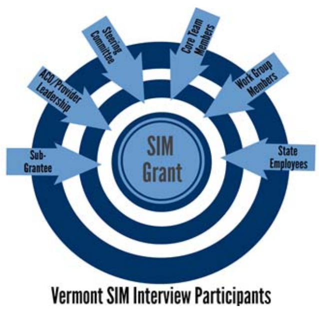
6

Plan Research and Development: Vermont SIM Research (cont.)

Myers and Stauffer also conducted key informant interviews:

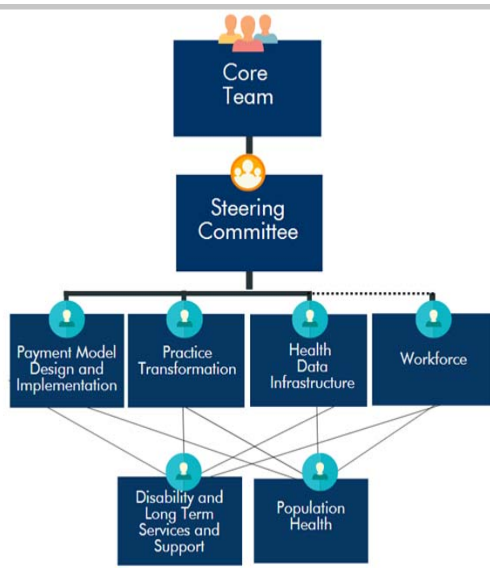


- 12 individuals from the private and public sector were interviewed.
- Interviews were performed to identify areas of successful SIM investment that should be sustained and barriers to sustainability.
- A comprehensive summary of the key informant interviews can be found in Appendix C of the Plan.

Plan Research and Development: Sustainability Sub-Group

- Lawrence Miller, Sub-Group Chair and Core Team Chair
- Paul Bengtson, Northeastern Vermont Regional Hospital (NVRH), Core Team Member
- Steve Voigt, ReThink Health, Core Team Member
- Cathy Fulton, VPQHC, Payment Model Design & Implementation Work Group Co-Chair
- Laural Ruggles, NVRH, Practice Transformation Work Group Co-Chair
- Simone Rueschemeyer, Vermont Care Network, Health Data Infrastructure Work Group Co-Chair
- Deborah Lisi-Baker, UVM, DLTSS Work Group Co-Chair
- Karen Hein, Population Health Work Group Co-Chair
- Mary Val Palumbo, Health Care Workforce Work Group Co-Chair
- Andrew Garland, BCBSVT, Payment Model Design and Implementation Work Group Co-Chair
- Lila Richardson, Office of the Health Care Advocate
- Vicki Loner, OneCare
- Kate Simmons, CHAC
- Holly Lane, Healthfirst
- Paul Harrington, Vermont Medical Society
- Dale Hackett, consumer, member of PMDI, PT, HDI, DLTSS, and PH Work Groups
- Stefani Hartsfield, Cathedral Square, HDI Work Group member
- Kim Fitzgerald, Cathedral Square, Steering Committee and PMDI Work Group member

SIM Governance



- Stakeholders have reported that the governance structure, particularly the Work Groups, are the cornerstone of Vermont's SIM experience and have served to bring about unprecedented collaboration, shared learning, and cross-program innovation.
- **The plan recommends that the functions of SIM governance be sustained, even if the SIM-specific governance structure is not continued.**

Sustainability Recommendations

Three Categories of Investment

The State views SIM investments in three categories with respect to sustainability:

- **One-time investments** to develop infrastructure or capacity, with limited ongoing costs;
- **New or ongoing activities** which will be supported by the State after the end of the Model Testing period; and
- **New or ongoing activities** which will be supported by private sector partners after the end of the Model Testing period.

Some projects remain ongoing at the time of the delivery of the initial draft report. In these cases, we have indicated sustainability status is pending the project's completion.

Lead Entities

Lead Entities – The organization recommended to assume ownership of a project once the SIM funding opportunity has ended.

A Lead Entity may be a public or private sector organization from the Vermont health care community. These entities may not have complete governance over a project, but they do have a significant leadership role and responsibility. This includes the responsibility to convene the Key Partners.

Lead Entities are likely to include, but are not limited to State Agencies, Departments, programs, and regulatory bodies, including:

VERMONT Agency of Administration

VERMONT AGENCY OF HUMAN SERVICES

VERMONT Blueprint for Health Smart choices. Powerful tools.

VERMONT GREEN MOUNTAIN CARE BOARD

It will also include the Vermont Care Organization (VCO).

Key Partners

Key Partners – A more comprehensive network of State partners, payers, providers, consumers, and other private-sector entities who will be critical partners in sustaining previously SIM-funded efforts.

Key Partners may be public or private sector entities within or outside of the Vermont health care community. These entities represent the broader community and overlapping concerns inherent in a project's mission and objectives.

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13

Key Partners (cont'd)

Depending on the project, Key Partners may include those listed above as Lead Entities. Key Partners also are likely to include:

- Additional State Agencies and Departments, including the Vermont Department of Health (VDH), the Department of Labor (DOL), and the Department of Information and Innovation (DII);
- Payers, including commercial and public (Medicare and Medicaid)
- Providers and provider organizations;
- The Community Collaboratives active in each region of Vermont;
- Key statewide organizations and programs like the Vermont Program for Quality in Health Care, Inc. (VPQHC), Support and Services at Homes (SASH), and Vermont Information Technology Leaders (VITL); and
- Federal partners: CMS, the Center for Medicare & Medicaid Innovation (CMMI), and the Office of the National Coordinator for Health Information Technology (ONC).

Vermont Health Care Innovation Project

14

Recommendations: Payment Model Design and Implementation

Investment Category			
SIM Focus Areas and Work Streams	One-Time Investment	Ongoing Investments *State-Supported*	Ongoing Investment *Private Sector*
Payment Model Design and Implementation			
ACO Shared Savings Programs (SSPs)		●	●
Pay-for-Performance (Blueprint for Health)		●	●
Health Home (Hub & Spoke)		●	●
Accountable Communities for Health		●	●
Prospective Payment System – Home Health		●	●
Medicaid Pathway		●	●
All-Payer Model		●	●

Recommendations: Payment Model Design and Implementation (cont'd)

On-Going Sustainability: Task Owner			
SIM Focus Areas and Work Streams	Lead Entity *(Primary Owner)*	Key Partners	Special Notes
ACO Shared Savings Programs (SSPs)	GMCB	Payers (DVHA, BCBSVT, CMS), ACOs, VCO	Activity continued through transitional period.
Pay-for-Performance (Blueprint for Health)	VCO	AHS (DVHA-Blueprint) and GMCB	Note that both VCO and AHS will be engaged in subsequent P4P activities.
Health Home (Hub & Spoke)	AHS	DVHA-Blueprint	Anticipating additional Health Home initiatives for different services. Leverage Blueprint experience.
Accountable Communities for Health	Blueprint/VCO	VDH, AOA	Aligned with Regional Collaborations/CCs. (See Practice Transformation.) Additional information can be found in Vermont's Population Health Plan.
Prospective Payment System – Home Health	AHS/DAIL	VNAs of Vermont and New Hampshire, HHAs	Anticipate additional PPS for different services.
Medicaid Pathway	AHS	Provider Partners	A comprehensive list of key partners can be found here.
All-Payer Model	GMCB	AOA, AHS, ACOs, CMMI, Payers (DVHA, BCBSVT, CMS), providers	

Payment Model Design and Implementation: ACO Shared Savings Programs (SSPs)

- Designed to align with the Medicare Shared Savings Program (SSP) Track 1, but will end after a transitional period.
- The State will implement a Medicare Next Generation ACO concept through the All-Payer Model framework.
- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** GMCB
  - **Recommended Key Partners:** DVHA, BCBSVT, CMS, ACOs, VCO

Payment Model Design and Implementation: Blueprint for Health (Pay-for-Performance)

- Provides performance payments to advanced primary care practices recognized as patient-centered medical homes (PCMHs).
- Provides multi-disciplinary support services in the form of community health teams (CHTs); a network of self-management support programs; comparative reporting from statewide data systems; and activities focused on continuous improvement.
- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** VCO
  - **Recommended Key Partners:** AHS, DVHA-Blueprint, and GMCB

Payment Model Design and Implementation: Health Home / Hub and Spoke

- Health Home initiative created under Section 2703 of the Affordable Care Act for Vermont Medicaid beneficiaries with opioid addiction.
- Integrates addictions care into general medical settings (Spokes) and links these settings to specialty addictions treatment programs (Hubs) in a unifying clinical framework.
- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AHS
  - **Recommended Key Partners:** DVHA-Blueprint

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Payment Model Design and Implementation: Accountable Communities for Health

- Provides peer learning activities to support integration of community-wide prevention and public health efforts with integrated care efforts through a Peer Learning Laboratory.
- Peer learning activities and local facilitation to support communities in developing ACH competencies began in June 2016 and will continue through the conclusion of the Peer Learning Laboratory in January 2017.
- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** Blueprint/VCO
  - **Recommended Key Partners:** VDH, AOA

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Payment Model Design and Implementation: Medicaid Pathway

- Process designed to advance payment and delivery system reform for services not included in the initial implementation of Vermont's All-Payer Model.
- The goal is to support a more integrated system for all Vermonters; including integrated physical health, long-term services and supports, mental health, substance abuse treatment, developmental disabilities services, and children's service providers.

- **Sustainability Recommendation:** New activities and investments.
  - **Recommended Lead Entity:** AHS
  - **Recommended Key Partners:** Provider Partners

Payment Model Design and Implementation: All–Payer Model

- The All-Payer Model will build on Vermont's existing all-payer payment alternatives to better support and promote a more integrated system of care and a sustainable rate of overall health care cost growth.
- Through the legal authority of the Green Mountain Care Board (GMCB) and facilitated by an All-Payer Accountable Care Organization Model Agreement with CMMI, the state can enable the alignment of commercial payers, Medicaid, and Medicare in an Advanced Alternative Payment Model. Specifically, the State will apply the Next Generation ACO payment model, with modifications, and subsequently, a Vermont Medicare ACO Initiative model across all payers. The GMCB will set participating ACO rates on an all-payer basis to enable the model.

- **Sustainability Recommendation:** New activities and investments.
  - **Recommended Lead Entity:** GMCB
  - **Recommended Key Partners:** AOA, AHS, ACOs, CMMI, payers (DVHA, BCBSVT, CMS), and providers

Recommendations: Practice Transformation

SIM Focus Areas and Work Streams	Investment Category: One-Time Investment	Investment Category: Ongoing Investments *State-Supported*	Investment Category: Ongoing Investment *Private Sector*
Practice Transformation			
Learning Collaboratives		●	●
Sub-Grant Program		●	●
Regional Collaborations		●	●
Workforce – Care Management Inventory	●		
Workforce – Demand Data Collection and Analysis		*Project Delayed*	
Workforce – Supply Data Collection and Analysis		●	

SIM Focus Areas and Work Streams	On-Going Sustainability: Task Owner: Lead Entity *(Primary Owner)*	Key Partners	Special Notes
Learning Collaboratives	Blueprint/VCO	Community Collaboratives, VPQHC, SASH	This work stream also includes the Core Competency Training. Aligned with Regional Collaborations/CCs. Note there are contract obligations related to this in the DVHA-ACO program for 2017.
Sub-Grant Program	AHS	AOA	
Regional Collaborations	Blueprint/VCO	AHS, VDH	Aligned with Learning Collaboratives, Accountable Communities for Health.
Workforce – Care Management Inventory	One-time Investment		
Workforce – Demand Data Collection and Analysis	AOA	DOL, VDH, GMCB, provider education, private sector.	AOA to coordinate across DOL, VDH, provider education, private sector.
Workforce – Supply Data Collection and Analysis	AOA		

Practice Transformation: Learning Collaboratives and Core Competency Training

- The Integrated Communities Care Management Learning Collaborative is a hospital service area-level rapid cycle quality improvement initiative.
- It is based on the Plan-Do-Study-Act (PDSA) quality improvement model, and features in-person learning sessions, webinars, implementation support, and testing of key interventions.
- The Core Competency Training series provides a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities statewide.
- Core curriculum covers competencies related to care coordination and disability awareness.

- **Sustainability Recommendation:** On-going activities and investments.
  - **Recommended Lead Entity:** Blueprint/VCO
  - **Recommended Key Partners:** Community Collaboratives, VPQHC, and SASH

Practice Transformation: Sub-Grant Program

- The VHCIP Provider Sub-Grant Program launched in 2014, has provided 14 awards to 12 provider and community-based organizations who are engaged in payment and delivery system transformation.
- Awards range from small grants to support employer-based wellness programs, to larger grants that support statewide clinical data collection and improvement programs. The overall investment in this program is nearly $5 million. The Core Competency Training series provides a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities statewide.
- Sub-grantees performed a self-evaluation and some have engaged in sustainability planning.
- **Sustainability Recommendation:** Status is pending project's completion. Ongoing evaluations of individual sub-grant projects continue.
  - **Recommended Lead Entity:** AHS
  - **Recommended Key Partner:** AOA

Vermont Health Care Innovation Project

25

Practice Transformation: Sub-Grant Technical Assistance

- The Sub-Grant Technical Assistance program was designed to support the awardees of provider sub-grants in achieving their project goals.
- Direct technical assistance to sub-grant awardees has been valuable to the SIM experience, but will prove costly if sustained over a considerable period of time. Additionally, it will become less necessary as awardees get farther along in their programs. Sub-grantees performed a self-evaluation and some have engaged in sustainability planning.
- The State of Vermont will develop a contractor skills matrix as a resource for future awardees. Awardees would be responsible for selecting and securing contractor resources for technical assistance.
- **Sustainability Recommendation:** One-time Investment.

Vermont Health Care Innovation Project

26

Practice Transformation: Regional Collaborations

- Within each of Vermont's 14 hospital service areas (HSAs), Blueprint for Health and ACO leadership have merged their regional clinical work groups and chosen to collaborate with stakeholders using a single unified health system initiative.
- These groups focus on reviewing and improving the results of core ACO Shared Savings Program quality measures; supporting the introduction and extension of new service models; and providing guidance for medical home and Community Health Team operations.

- **Sustainability Recommendation:** On-going activities and investments.
  - **Recommended Lead Entity:** Blueprint/VCO
  - **Recommended Key Partners:** AHS and VDH

Practice Transformation: Care Management Inventory

- Survey administered to provide insight into the current landscape of care management activities in Vermont.
- The survey aimed to better understand State-specific staffing levels and types of personnel engaged in care management, in addition to the populations being served.
- The project was completed as of February 2016.

- **Sustainability Recommendation:** One-time investment.

Practice Transformation: Demand Data Collection and Analysis

- A "micro-simulation" demand model uses Vermont-specific data to identify future workforce needs for the State by inputting various assumptions about care delivery in a high-performing health care system.
- The selected vendor for this work will create a demand model that identifies ideal workforce needs for Vermont in the future, under various scenarios and parameters.
- This project is delayed.
- **Sustainability Recommendation:** Status is pending project completion.

Practice Transformation: Supply Data Collection and Analysis

- The Vermont Office of Professional Regulation (OPR) and Vermont Department of Health (VDH) work in tandem to assess current and future supply of providers in the State's health care workforce for health care work force planning purposes, through collection of licensure and re-licensure data and the administration of surveys to providers during the licensure/re-licensure process.
- Surveys include key demographic information for providers, and are used for workforce supply assessment and predicting supply trends.
- Infrastructure to support the continued use of this data exists, and it will continue to be supported by the State of Vermont, OPR and VDH.
- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA
  - **Recommended Key Partners:** DOL, VDH, GMCB, provider education, and private sector

Recommendations:
Health Data Infrastructure

SIM Focus Areas and Work Streams	One-Time Investment	Ongoing Investments *State-Supported*	Ongoing Investment *Private Sector*
	Investment Category		
Health Data Infrastructure			
Expand Connectivity to HIT – Gap Analysis	●		
Expand Connectivity to HIT – Gap Remediation		●	●
Expand Connectivity to HIT – Data Extracts from HIE	●		
Improve Quality of Data Flowing into HIE		●	●
Telehealth – Strategic Plan	●		
Telehealth - Implementation		●	●
Electronic Medical Record Expansion		●	●
Data Warehousing		●	●
Care Management Tools –Event Notification System			●
Care Management Tools – Shared Care Plan		●	●
Care Management Tools –Universal Transfer Protocol	●		
General Health Data – Data Inventory		●	
General Health Data – HIE Planning	●		
General Health Data – Expert Support	●		

Vermont Health Care Innovation Project

31

Recommendations:
Health Data Infrastructure (cont'd)

On-Going Sustainability: Task Owner			
SIM Focus Areas and Work Streams	Lead Entity *(Primary Owner)*	Key Partners	Special Notes
Expand Connectivity to HIT – Gap Analysis	One-Time Investment		
Expand Connectivity to HIT – Gap Remediation	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Expand Connectivity to HIT – Data Extracts from HIE	One-Time Investment		
Improve Quality of Data Flowing into HIE	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Telehealth – Strategic Plan	One-Time Investment		
Telehealth - Implementation	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Electronic Medical Record Expansion	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Data Warehousing	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Care Management Tools –Event Notification System	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Care Management Tools – Shared Care Plan	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Care Management Tools –Universal Transfer Protocol	One-Time Investment		
General Health Data – Data Inventory	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
General Health Data – HIE Planning	One-Time Investment		
General Health Data – Expert Support	One-Time Investment		

* AOA is the recommended lead entity, pending establishment of a coordinating entity as recommended in the HIT Plan.

Vermont Health Care Innovation Project

32

Health Data Infrastructure: Expand Connectivity to HIE – Gap Analysis

- The Gap Analysis is an evaluation of the EHR system capability of health care organizations, interface ability of the EHR system, and the data transmitted within those interfaces.
- Created a baseline determination of the ability of health care organizations to produce Year 1 Medicare, Medicaid, and commercial Shared Savings ACO Program quality measure data. Evaluated data quality among the 16 designated and specialized service agencies.
- Reviewed the technical capability of DLTSS providers statewide.

- **Sustainability Recommendation**: One-time investment.

Health Data Infrastructure: Expand Connectivity to HIE – Gap Remediation

- The Gap Remediation project addresses gaps in connectivity and clinical data quality of health care organizations to the Health Information Exchange.
- The ACO Gap Remediation component improves the connectivity for all Vermont Shared Savings Program measures among ACO member organizations. The Vermont Care Partners (VCP) Gap Remediation improves the data quality for the 16 Designated Mental Health and Specialized Service agencies (DAs and SSAs). In addition, a DLTSS Gap Remediation effort to increase connectivity for Home Health Agencies was approved in January 2016 based on the results of the DLTSS Information Technology Assessment. Infrastructure to support the continued use of this data exists, and it will continue to be supported by the State of Vermont, OPR and VDH.
- Gap Remediation efforts for ACO member organizations and Vermont Care Partners dovetail with data quality improvement efforts.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Expand Connectivity to HIE – Data Extracts from HIE

- This project provides a secure data connection from the VHIE to the ACOs' analytics vendors for their attributed beneficiaries.
- Allows ACOs direct access to timely data feeds for population health analytics.
- **Sustainability Recommendation:** One-time investment.

Health Data Infrastructure: Improve Quality of Data Flowing into the HIE

- The Data Quality Improvement Project is an analysis performed of ACO members' EHRs on each of 16 data elements. Allows ACOs direct access to timely data feeds for population health analytics.
- VITL engages providers and makes workflow recommendations to change data entry to ensure the data elements are captured. In addition, VITL performs comprehensive analyses to ensure that each data element from each health care organization (HCO) is formatted identically.
- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Telehealth

- *Strategic Plan* - The strategy includes four core elements and a road map based on the prioritization of telehealth projects and their alignment with new clinical processes adopted as payment reform evolves.
  - **Sustainability Recommendation:** One-time investment.
- *Implementation* - Vermont is funding two pilot projects that can address a variety of geographical areas, telehealth approaches and settings, and patient populations. The primary purpose is to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout Vermont. Projects were selected in part based on demonstration of alignment with the health reform efforts currently being implemented as part of the SIM Grant process.
  - **Sustainability Recommendation:** Ongoing activities and investments in the area of telehealth; not necessarily these two pilots.
    - **Recommended Lead Entity:** AOA*
    - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Electronic Medical Record Expansion

- Electronic medical record (EMR) expansion focuses on assisting in the procurement of EMR systems for non-Meaningful Use (MU) providers.
- Includes technical assistance to identify appropriate solutions and exploration of alternative solutions.
- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Data Warehousing

- The Vermont Care Network (VCN) Data Repository will allow the Designated Mental Health Agencies and Specialized Service Agencies to send specific data to a centralized data repository.
- Long-term goals of the data repository include accommodating connectivity to the Vermont Health Information Exchange (VHIE), as well as Vermont State agencies, other stakeholders, and interested parties.
- It is expected that this project will provide VCN members with advanced data analytic capabilities to improve the efficiency and effectiveness of their services.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Care Management Tools

- *Shared Care Plan Project* - A planning activity that ensures that the components of a shared care plan are captured in a technical solution that allows providers across the care continuum to electronically exchange critical data and information as they work together in a team based, coordinated model of care.
  - **Sustainability Recommendation:** Ongoing activities and investments.
    - **Recommended Lead Entity:** AOA*
    - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, HHS (CMS, ONC).
- *Universal Transfer Protocol* - Sought to provide a Universal Transfer Protocol to Vermont's provider organizations. Pursued through provider workflow activities.
  - **Sustainability Recommendation:** One-time investment

Health Data Infrastructure: Care Management Tools (cont.)

- *Event Notification System* – A system to proactively alert participating providers regarding their patient's medical service encounters.
  - **Sustainability Recommendation:** Ongoing activities and investments.
    - **Recommended Lead Entity:** AOA*
    - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Vermont Health Care Innovation Project

41

Health Data Infrastructure: General Health Data Inventory

- A health data inventory that will support future health data infrastructure planning.
- This project built a comprehensive list of health data sources in Vermont, gathered key information about each, and catalogued them in a web-accessible format.
- The resulting data inventory is a web-based tool that allows users (both within the State and external stakeholders) to find and review comprehensive information relating to the inventoried datasets.
- Periodic updates will be needed.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Vermont Health Care Innovation Project

42

Health Data Infrastructure: HIE Planning

- The HIE planning project resulted from a perceived gap in high-level planning and research in local and nationwide best practices for providing a robust, interoperable ability to transmit accurate and current health information throughout the Vermont health care landscape.
- This project will conduct further research in best practices around improving clinical health data quality and connectivity resulting in recommendations to the HIE/HIT work group.
- Additionally, the HDI work group has participated on multiple occasions in the 2015 revision of Vermont HIT Plan.
- Plan is to finalize connectivity targets for 2016-2019 by December 31, 2016.
- **Sustainability Recommendation:** One-time investment.

Vermont Health Care Innovation Project

43

Recommendations: Evaluation

SIM Focus Areas and Work Streams	Investment Category: One-Time Investment	Ongoing Investments *State-Supported*	Ongoing Investment *Private Sector*
Evaluation			
Self-Evaluation Plan and Execution	One-Time Investment		
Surveys		•	•
Monitoring and Evaluation Activities within Payment Programs		•	•

On-Going Sustainability: Task Owner

SIM Focus Areas and Work Streams	Lead Entity *(Primary Owner)*	Key Partners	Special Notes
Self-Evaluation Plan and Execution	One-Time Investment		
Surveys	VCO	Providers, AHS, Consumers, Office of the Health Care Advocate, GMCB	Patient experience surveys. Note that there are numerous patient experience surveys that are deployed annually in addition to the one used as part of the SSP.
Monitoring and Evaluation Activities within Payment Programs	AHS/GMCB	Payers, VCO, Office of the Health Care Advocate, AOA	Payers, State regulators, and VCO/providers will monitor and evaluate payment models. There are specific evaluation requirements for the GMCB and AHS as a result of the 1115 waiver and APM. Patient experience surveys are a tool for monitoring and evaluation.

Vermont Health Care Innovation Project

44

Evaluation

- *Self-Evaluation Plan and Execution* - The State works with an independent contractor to perform a State-Led Evaluation of Vermont's SIM effort.
  - **Sustainability Recommendation:** One-time investment.
- *Surveys* - As part of broader payment model design and implementation and evaluation efforts, the State conducts annual patient experience surveys and other surveys as identified in payment model development. There are numerous patient experience surveys that are deployed annually, in addition to the one used as part of the SSP.
  - **Sustainability Recommendation:** Ongoing activities and investments.
    - **Recommended Lead Entity:** VCO
    - **Recommended Key Partners:** Providers, AHS, Consumers, OHCA, GMCB.

Vermont Health Care Innovation Project

Evaluation

- *Monitoring and Evaluation Activities within Payment Programs* - The state conducts analyses as necessary to monitor and evaluate specific payment models. Monitoring occurs by payer and by program to support program modifications. Ongoing monitoring and evaluation by State of Vermont staff and contractors occurs as needed.
  - **Sustainability Recommendation:** Ongoing activities and investments.
    - **Recommended Lead Entity:** AHS/GMCB
    - **Recommended Key Partners:** Payers, VCO, OHCA, and AOA

Vermont Health Care Innovation Project

Project Management

- Vermont SIM is managed through a combination of State personnel and outside vendors with project management expertise.
- The project management function under SIM considers both the program and administration functions of government such as soliciting public comment, ensuring appropriations, and managing resources; as well as managing the various projects, groups, and relationships that SIM initiated.
- As SIM projects transition from the demonstration phase to the program phase, project management functions will transition to program staff in Medicaid, or other partners.

- **Sustainability Recommendation:** Ongoing activities and investments.

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47

Plan Timeline

- November and December 2016 – First draft complete and under review by SIM Work Groups and Steering Committee. Core Team will review a revised draft in late December.
- Spring 2017 – Second draft of the SIM Sustainability Plan will be developed based on feedback from SIM Work Groups, Steering Committee, Core Team, and Sustainability Sub-Group.
- June 2017 – Following Core Team approval, final SIM Sustainability Plan will be submitted to CMMI. The Sustainability Plan is due June 30, 2017.

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48

The plan is currently in draft.
Please provide comments and questions to:
Georgia Maheras
(georgia.maheras@vermont.gov, 802-505-5137)
or **Sarah Kinsler**
(sarah.kinsler@vermont.gov, 802-798-2244)

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Attachment 4: 2015 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

November 21, 2016

Vermont Health Care Innovation Project

Presentation Overview

- Shared Savings Programs in Broader Health Care Reform Context

- Financial Results and Overall Quality Scores
  - Medicaid Aggregated, PMPM and Year-to-Year
  - Commercial Aggregated, PMPM and Year-to-Year
  - Medicare Aggregated and Year-to-Year

- Detailed Quality Results
  - Medicaid and Commercial Payment Measures
  - Medicaid and Commercial Reporting Measures
  - Combined Medicaid and Commercial Patient Experience Measures

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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 Agreement has a clear goal of connecting an ACO delivery model with population-based payments envisioned in Category 4 of the APM Framework *(see following slide)*. Models in Category 4 would qualify as AAPMs under QPP.

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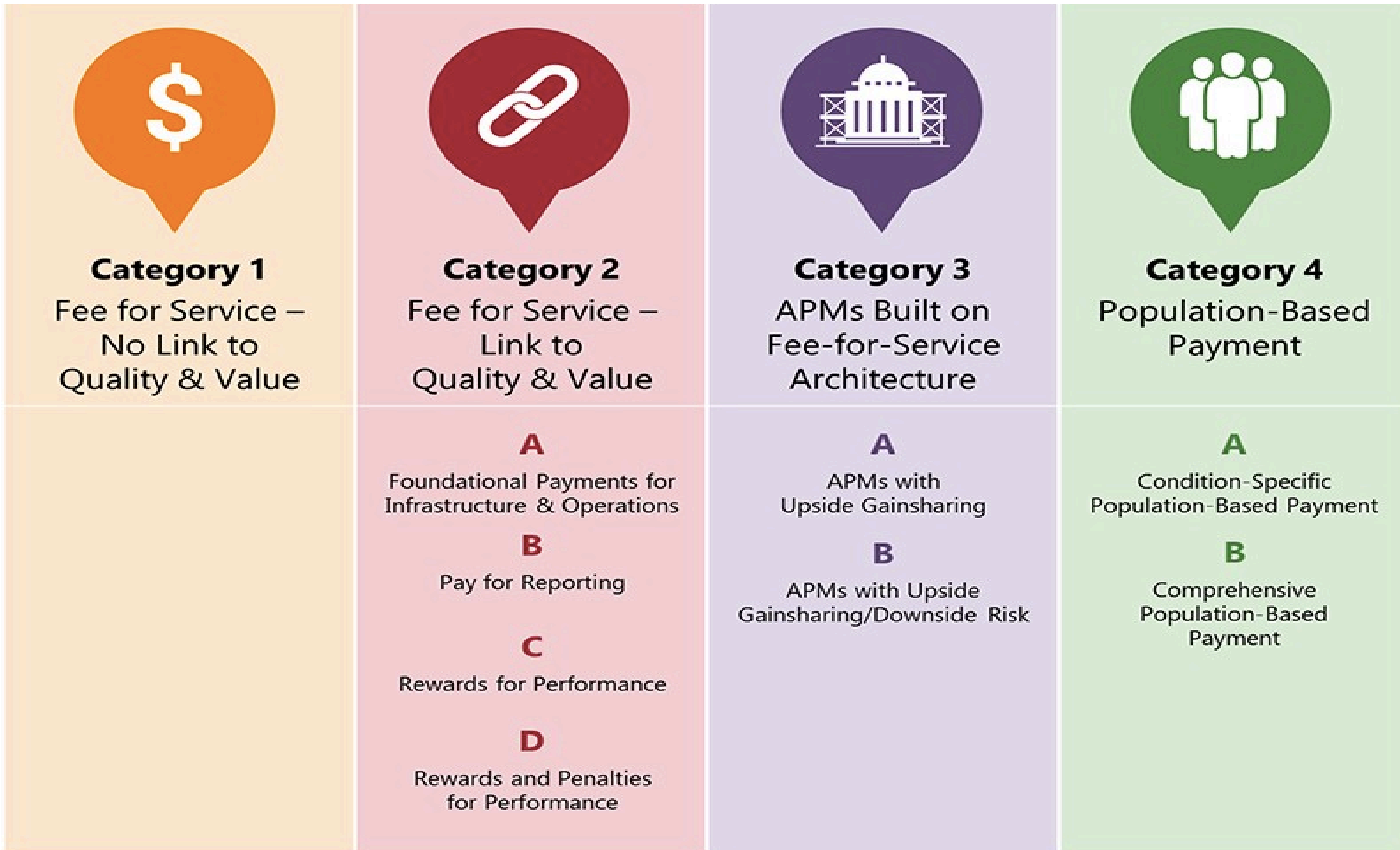
Alternative Payment Model Framework



Naussbaum, McLellan, Smith, and Patrick H. Conway

Vermont's ACOs and Shared Savings Programs (SSPs)

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

Financial Results and Overall Quality Scores

Results Should be Interpreted with Caution

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

Summary of 2015 Aggregated Financial Results

- Medicaid SSP 2015

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

*If shared savings had been earned

Summary of 2015 Financial PMPM Results

- Medicaid SSP 2015

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

*If shared savings had been earned

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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 2015 Aggregated Financial Results

- Commercial SSP 2015

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

*If shared savings had been earned

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Summary of 2015 Financial PMPM Results

- Commercial SSP 2015

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

*If shared savings had been earned

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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 2015 Aggregated Financial Results

➢ Medicare SSP 2015

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

Medicare SSP Results 2013-2015

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

*CHAC participated in Medicare SSP in 2014 and 2015 only.

**VCP participated in Medicare SSP in 2013 and 2014 only.

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Takeaways from 2015 Financial & Overall Quality Results

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

Detailed Quality Results

Quality Measure Overview

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

Results Should be Interpreted with Caution

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

2015 Medicaid Payment Measures

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

*Maximum points per measure = 3

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

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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**

Vermont Health Care Innovation Project

2015 Medicaid Payment Measures: Strengths and Opportunities

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

2015 Commercial Payment Measures

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

*Maximum points per measure = 3, except as noted below
** No national benchmark; awarded maximum of 2 points based on change over time

Impact on Payment

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

*If shared savings had been earned

Vermont Health Care Innovation Project

2015 Commercial Payment Measures: Strengths and Opportunities

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

2015 Medicaid Reporting Measures

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

2015 Medicaid Reporting Measures: Strengths and Opportunities

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

2015 Commercial Reporting Measures

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

2015 Commercial Reporting Measures: Strengths and Opportunities

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

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

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

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

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2015 Combined Commercial/Medicaid OneCare Results for UVMMC Practices*

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

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

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2015 Combined Patient Experience Measures: Strengths and Opportunities

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

Summary of 2015 Results

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

Vermont Medicaid Shared Savings Program: 2015 Supplemental Analyses

VMSSP Analyses

I. Understanding differences in unique population segments
II. Understanding changes in utilization and expenditure across categories of service

VMSSP Attribution Methodology

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

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VMSSP Attribution Snapshot: 2012 - 2015

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

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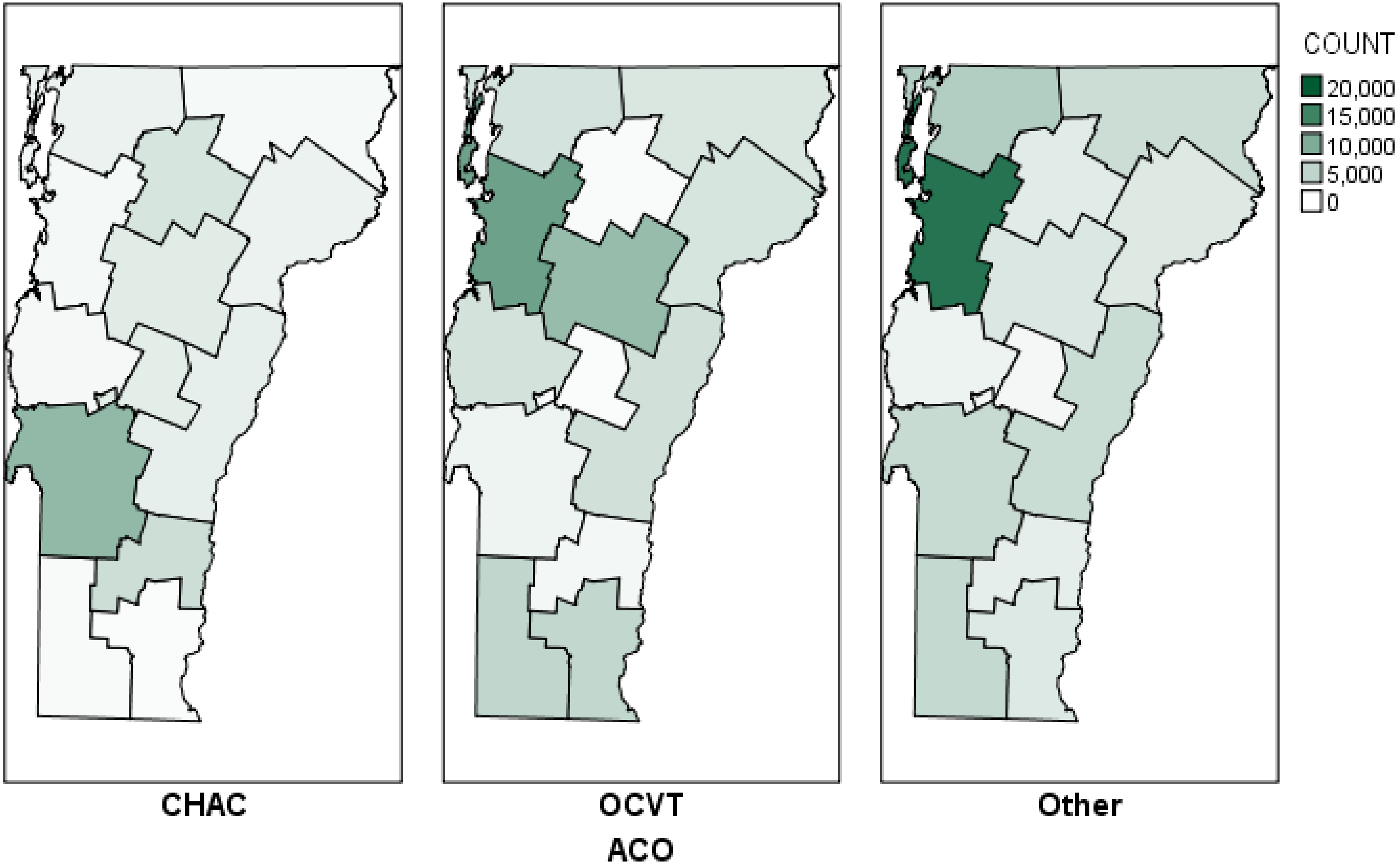
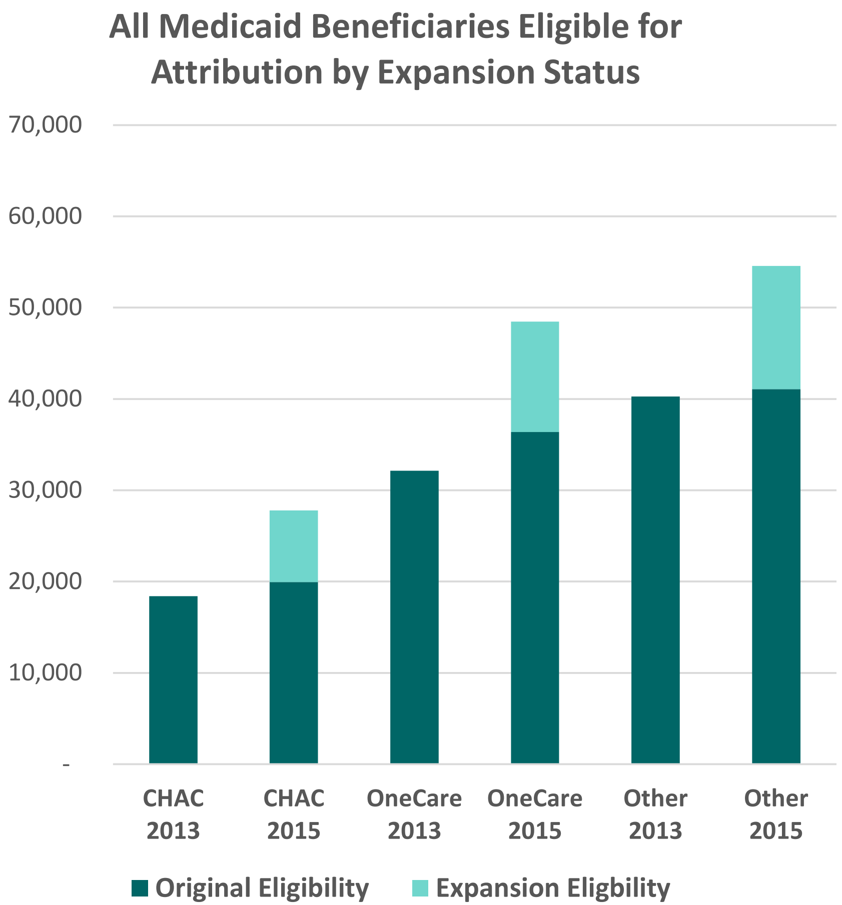
2015 VMSSP Attribution by HSA

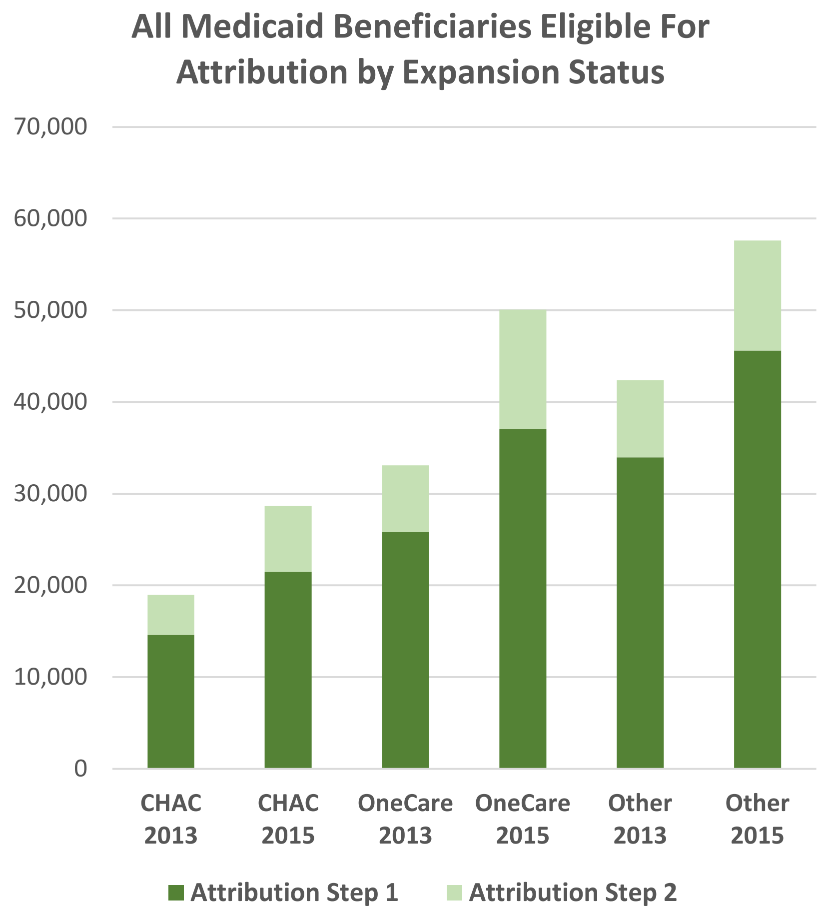


Unique Population Segments

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

Population Changes from 2013 to 2015





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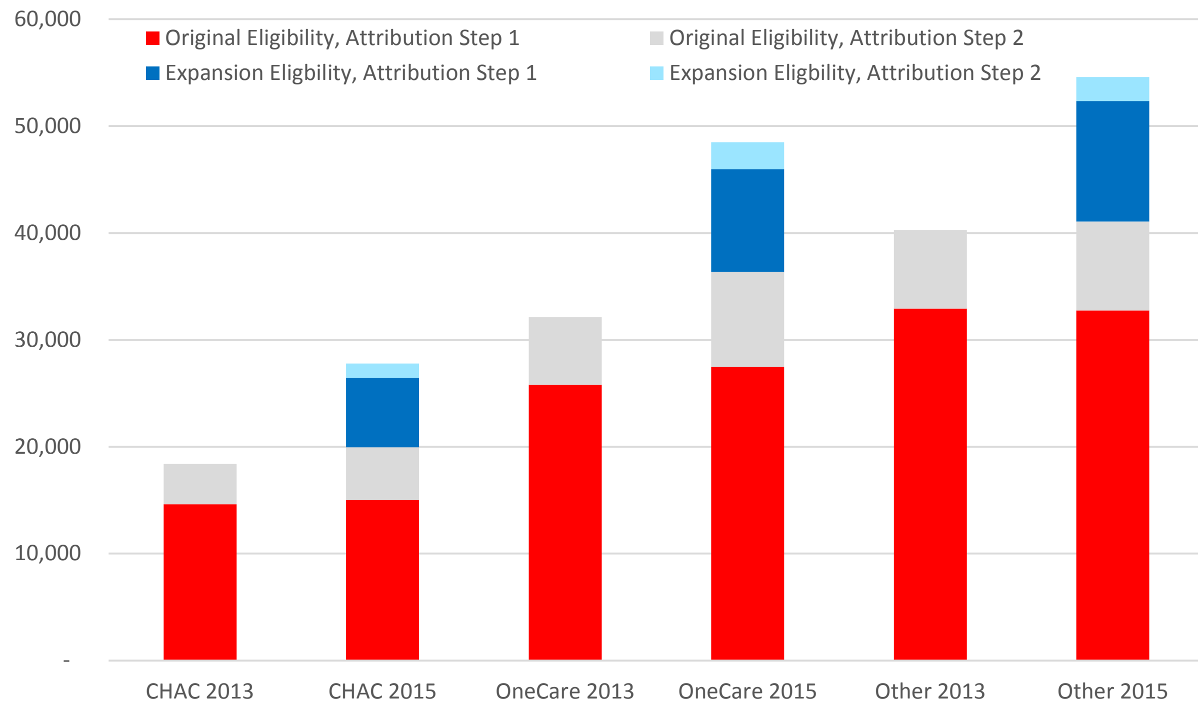
Attribution Across Population Segments

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

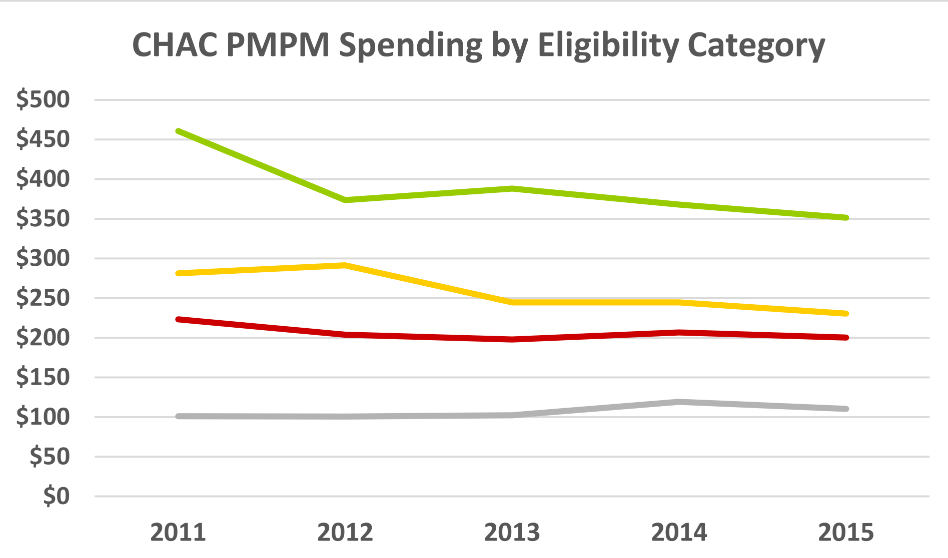


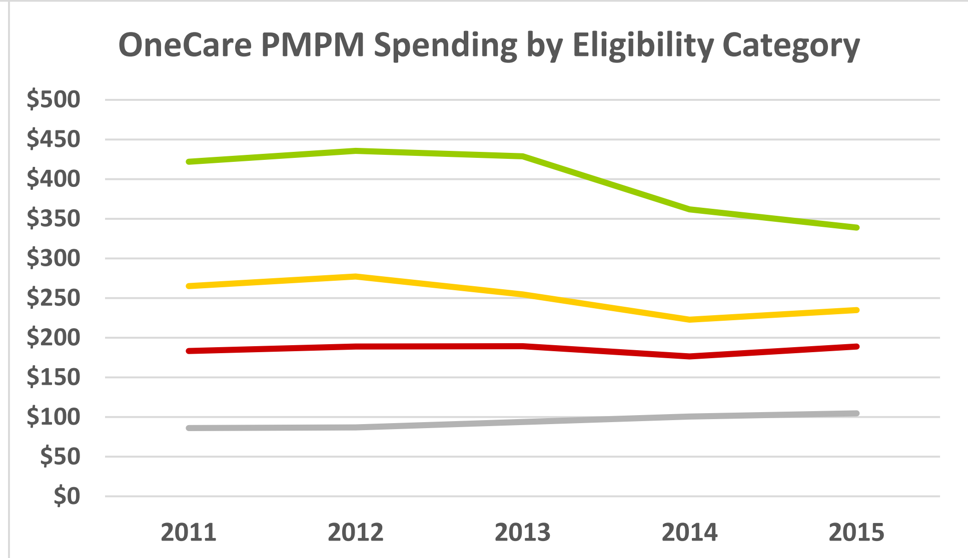
Expenditure Across Population Segments

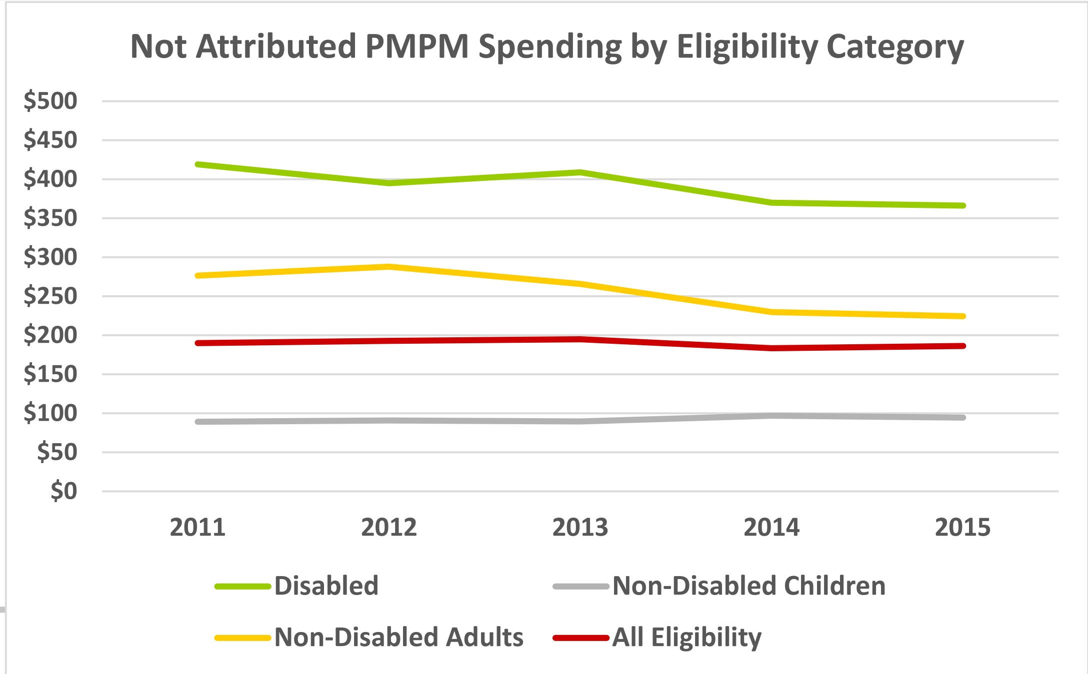
	Baseline Period		Implementation Period	
	Attribution Steps: Step 1 vs. Step 2		Attribution Steps: Step 1 vs. Step 2	
Eligibility: Original vs. Expansion	Original Eligibility & Step 1	Original Eligibility & Step 2	Original Eligibility & Step 1	Original Eligibility & Step 2
	Expansion Eligibility & Step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

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

Expenditure by Eligibility Category

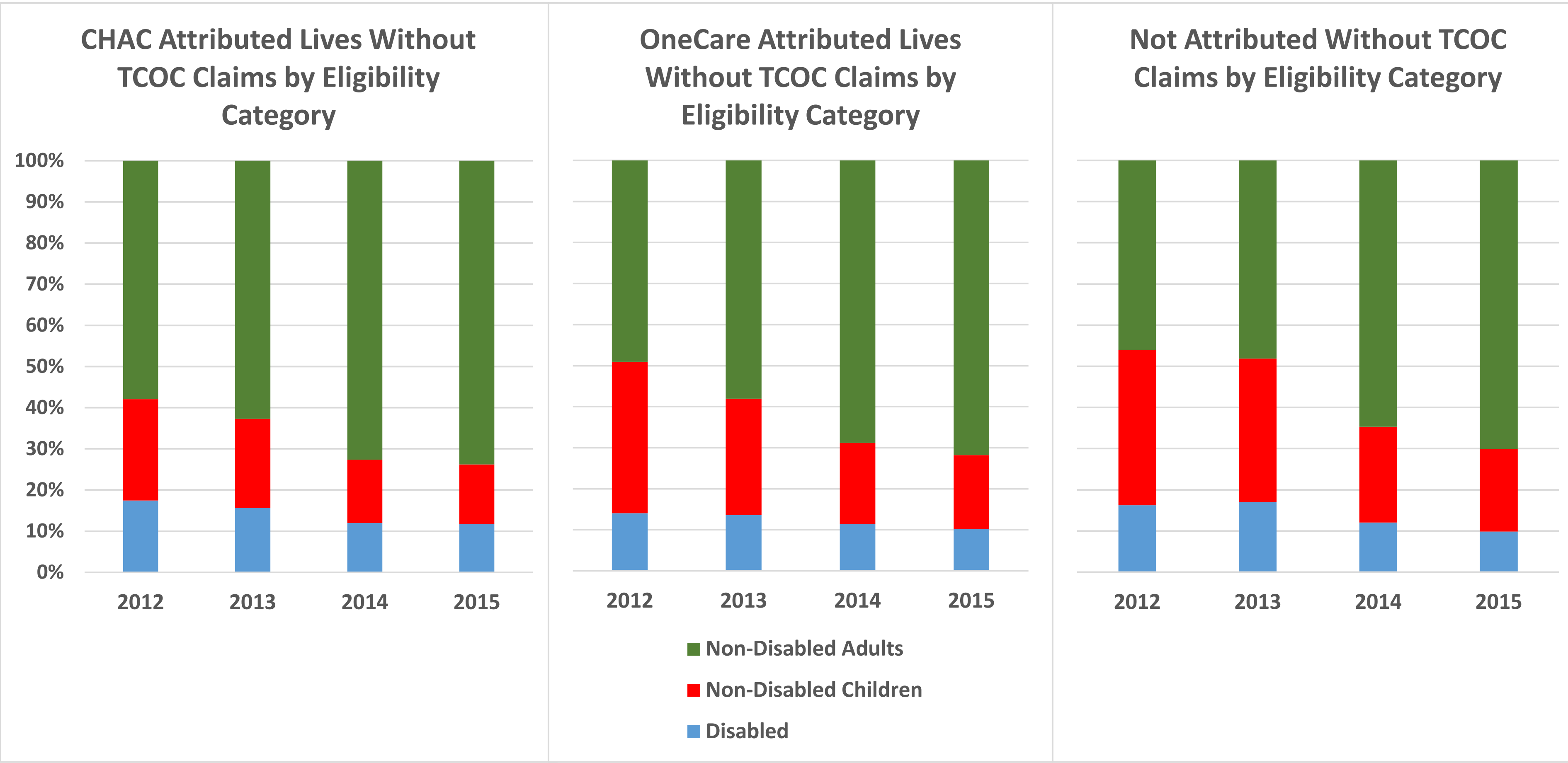






Vermont Health Care Innovation Project

Attributed Lives without TCOC Expenditure



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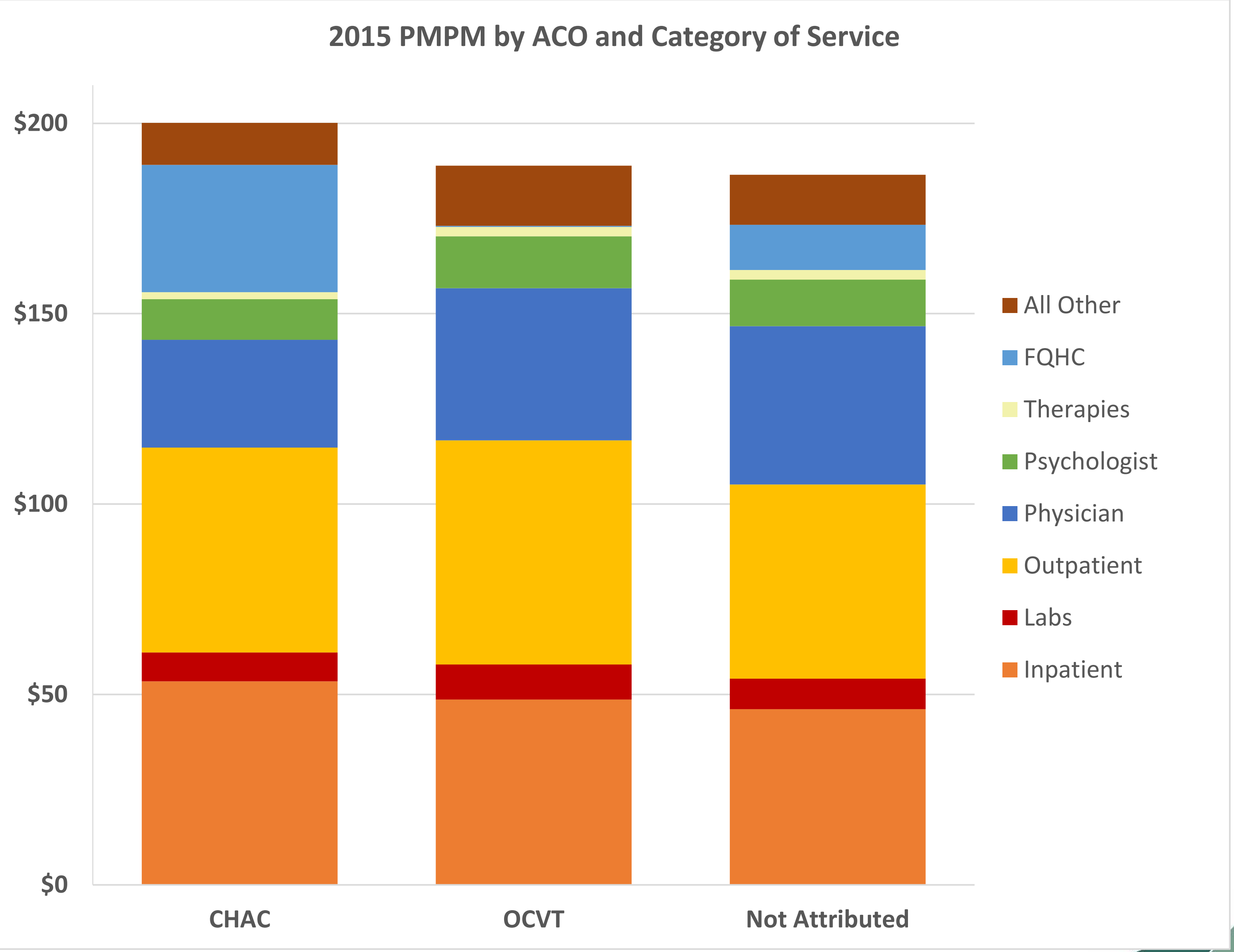
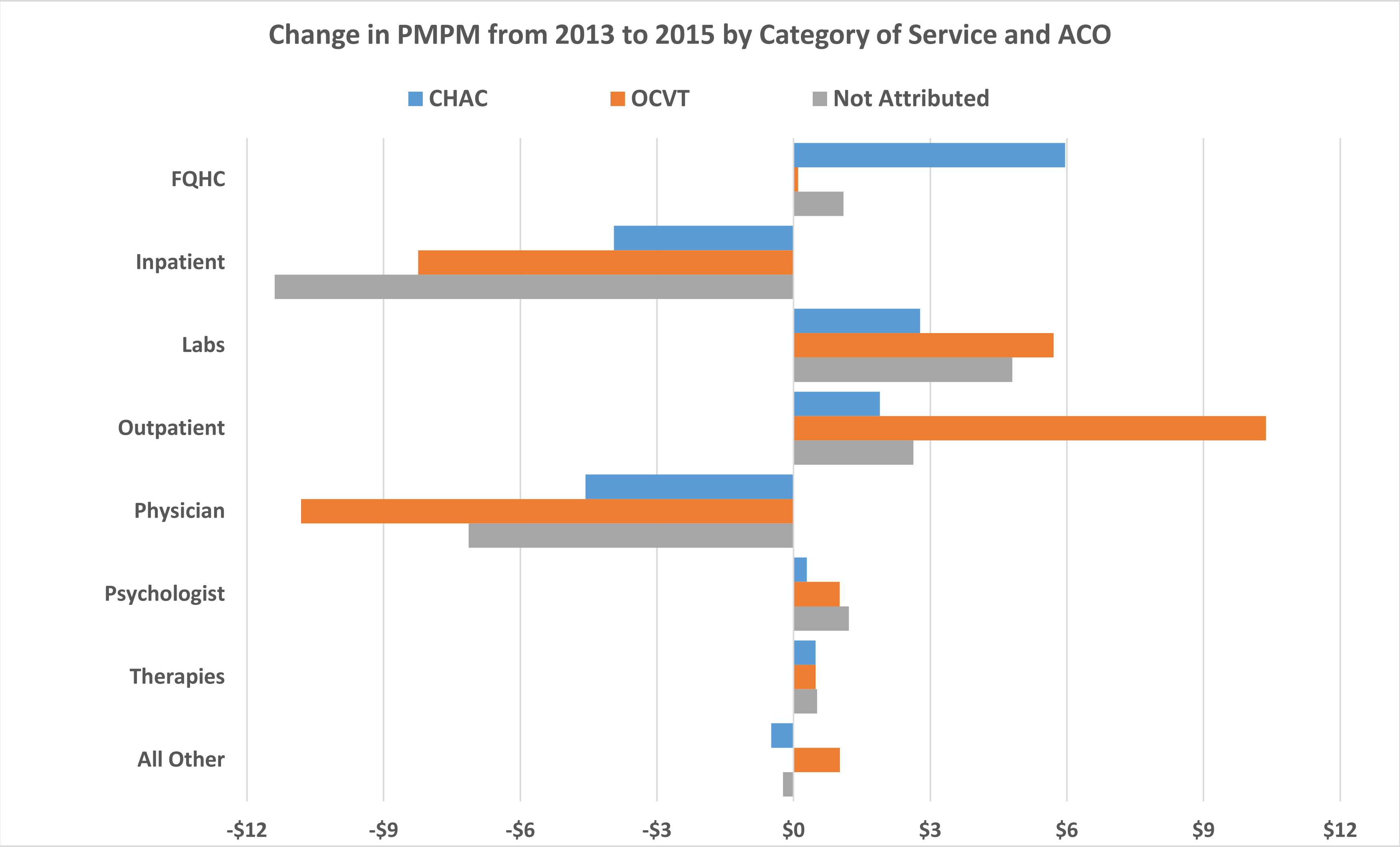
Expenditure by Category of Service



Expenditure Change by Category of Service



Vermont Health Care Innovation Project

OneCare Vermont 2015 SSP Results Highlights

- OneCare ranks among the top 20% of 392 Medicare ACOs in the country in "value", as calculated by ranking total cost per beneficiary with overall quality measure results by ACO.

- OneCare providers provide care to Medicare beneficiaries at 3% less cost than the national average.

- We have seen significant improvement in our quality measure results over 3 years.

- We have seen significant decrease in variation in both total cost per beneficiary and quality measure results at among our Health Service Areas, with quality improving in all communities.

OneCareVermont

Interventions to improve value

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

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

OneCareVermont

48

Community
Health Accountable Care LLC
Transitioning Our Communities for Better Health

CHAC Initiatives 2014-2016

2014

Develop Recommendations:
- COPD
- CHF
- Diabetes
- Falls Risk Assessment

Launch CHAC Clinical Committee

2015

Implement tele-monitoring intervention (*Pharos*)

Launch "Data Roadshows"

Encourage adoption (through trainings and TA) of Recommendations:
- COPD
- CHF
- Diabetes
- Falls Risk Assessment

Develop Recommendations:
- Depression Screen & Treatment

Launch joint meetings of CHAC Clinical and Operations Committees to review data findings & set goals

Sustain bimonthly meetings of Clinical Committee as working committee

2016

Local investments of VMSSP 2014 earnings

Implement event notification system (*PatientPing*)

Increase enrollment in tele-monitoring intervention

Roll out data visualization software (*Qlik*)

Engage in "Data Roadshows" for PY2015

Require documentation of implement-ation of 1+ Recommendation:
- COPD
- CHF
- Diabetes
- Falls Risk Assessment
- Depression Screen & Treatment

Encourage adoption (through trainings and TA) of Recommendations:
- Depression Screen & Treatment

Joint Clinical and Operations Committees work on PDSA cycles to improve data findings

Sustain bimonthly meetings of Clinical Committee as working committee

HealthFirst Highlights

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

HEALTH FIRST

Questions?

Vermont Health Care Innovation Project