Attachment 1 - Disability and LTSS Work Group Meeting Agenda 2.20.2014

VT Health Care Innovation Project
"Disability and Long Term Services and Supports" Work Group Meeting Agenda
Thursday, February 20th, 2014; 10:00 AM to 12:30 PM
AHS Training Room, 208 Hurricane Lane, Williston, VT
Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item #	Time Frame	Topic	Relevant Attachments	Action #
1	10:00 – 10:10	**Welcome and Introductions** Deborah Lisi-Baker and Judy Peterson	• Attachment 1: Meeting Agenda	
2	10:10 – 10:50	**Integrated Long Term Supports "Pilot" in Caledonia County** Patrick Flood, CEO Northern Counties Health Care	• Attachment 2: Caledonia "Duals" Proposal	
3	10:50 – 10:55	**Contractor Support** Georgia Maheras	• Attachment 3: Contractor Support Memo	
4	10:55 – 11:20	**New Name, Mandate and Charter for Work Group** Deborah Lisi-Baker and Judy Peterson	• Attachment 4: New draft Charter	
5	11:20 – 11:25	**Questions, Comments and Ideas on new mandate (received to date)** Julie Wasserman	• Attachment 5: Questions, Comments and Ideas document	
6	11:25 – 12:10	**AHS LTSS Performance Measures** Alicia Cooper, SIM Quality Oversight Analyst	• Attachment 6: DLTSS Quality Measures Powerpoint • Attachment 7: DLTSS Measures Narrative • Attachment 8: DLTSS Measures Proposal • Attachment 9: 2014 ACO Measures (Core and M&E)	
7	12:10 – 12:25	**Public Comment/Updates** Deborah Lisi-Baker and Judy Peterson		
8	12:25 – 12:30	**Wrap up/Next Steps**		

Attachment 2 - Caledonia Duals Proposal 2.20.2014

Caledonia "Duals" Proposal

Several agencies in Caledonia County are proposing a Duals "look alike" project.

The key elements are person-centered services, flexible funding and integration.

The partners include:

Northeastern Vermont Regional Hospital

Northern Counties Health Care (including Caledonia Home Health)

Rural Edge (housing)

Northeastern Vermont Area Agency on Aging

Northeast Kingdom Human Services

Community Health Team

The parties have started meeting regularly.

The project will work with existing structures, and focus on communication and creativity among the partners. The project will identify individuals at risk (high need, high utilization) and wrap flexible services as needed around them. Partner organizations will staff a team that will identify persons at risk and manage their services through a lead case manager.

Desired outcomes include:

Improved customer satisfaction

Reduction of unnecessary nursing home placements

Reduction of unnecessary hospital and ER use

Reduction in homelessness

Improved health outcomes

The project is requesting funding for one project coordinator and flexible funds.

The project will rely on receiving Medicare and Medicaid expenditure data from DVHA.

Attachment 3 - DLTSS WG Support Proposal 2.20.2014

109 State Street
Montpelier, VT 05609
www.gmcboard.vermont.gov/sim_grant

TO: DLTSS Work Group
FROM: Georgia Maheras
Date: 2/12/14
RE: Contractor support for the disability and long term services and supports work group

I am requesting a DLTSS Work Group recommendation for the following:

> Recommendation of contractor support for the disability and long term services and supports work group: Pacific Health Policy Group for $90,000 for March 1, 2014-February 28, 2015 and Bailit Health Purchasing for $90,000 for March 1, 2014-February 28, 2015.

Support for the DLTSS Work Group

Vermont's Duals Demonstration Design Grant funded several contracts from 2011-2013. In 2013, the Duals Demonstration was formally merged with Vermont's SIM activities. A new SIM Work Group was created to perform much of this work. Soon after the merger of these two projects, the Duals Demonstration Grant ran out of funds to support these activities. The expectation was that at some point, SIM funds would take over paying for these contracts and then Duals Demonstration Implementation funds would take over once those funds were provided to the State. Because the state is not pursuing the Duals Demo, the Duals Implementation funds will not be available. However, the work group (now renamed the disability and long term services and support work group) will continue to be part of the SIM project and will need technical support.

Two contractors have been providing technical support to this work over the past two years: Pacific Health Policy Group (PHPG) and Bailit Health Purchasing (Bailit). Two individuals have been leading this effort on behalf of these vendors: Susan Besio (PHPG) and Brendan Hogan (Bailit) and they work as a team complementing each other's skill sets. The scopes of work for these two contracts, as well as the charge of the new work group, are described below.

1. **PHPG*: $*90*,000 to support* *__Type 1b__* __Disability and Long Term Services and Supports__ *__Work Group__***

The Contractor shall provide support for DLTSS Work Group tasks, activities and decision-making, including, but not limited to, the following areas:

- Care models to support integrated care for people with disabilities, chronic conditions and those needing long term services and supports
- Payment models to support integrated care for people with disabilities, chronic conditions and those needing long term services and supports
- LTSS quality and performance measures to evaluate the outcomes of people with disabilities, chronic conditions and those needing long term services and supports
- IT infrastructures to support new payment and care models for integrated care for people with disabilities, chronic conditions and those needing long term services and supports
- Strategies to incorporate person-centered, disability-related, person-directed, and cultural competency issues into all VHCIP activities
- Identification of barriers in current Medicare, Medicaid and commercial coverage and payment policies, and strategies to address them
- Other activities as identified by the Work Group to assist successful implementation of payment and care models to best support people with disabilities, chronic conditions and those needing long term services and supports.

The Contractor also shall support the DLTSS Work Group and leadership (i.e., VCHIP and DLTSS Project Staff, Work Group Chairs and other Consultants) by performing the following activities:

- Work closely with VHCIP and DLTSS Work Group leadership to strategize and develop agendas for Work Group meetings, preparing handouts and preparing discussion materials
- Actively participate in DLTSS Work Group meeting discussions
- Conduct research on specific topics and developing summary documents and / or presentations
- Provide ad hoc support for project leadership and achievement of VHCIP goals via telephone calls and electronic mail communications (e.g., exchange of information about project developments and updates, sharing of information regarding relevant topics, new publications and/or national news; discussion of recent events and implications for project direction; contributing to discussion about policy or operational decisions; etc.)
- Attend VHCIP Steering Committee meetings and other VHCIP Work Group meetings as necessary to support the goals of the DLTSS Work Group

Deliverables:

1. Develop and / or contribute to agendas, white papers, presentations and other materials for the DLTSS Work Group, and for other VHCIP Work Groups as requested.
2. Participate in monthly DLTSS Work Group meetings, and sub work-group meetings as needed.
3. Participate in monthly DLTSS Work Group planning meetings.
4. Attend VHCIP Steering Committee meetings and other VHCIP Work group meetings as needed.
5. Provide research and summary documents to support DLTSS work plan and decision-making.
6. Work with VHCIP Project Staff regarding IT infrastructure needs by providing research, papers and documents that support Work Group recommendations and decision-making.
7. Work with VHCIP Project Staff to develop care models that support integrated care.
8. Work with VHCIP Project Staff to develop payment models that support integrated care.
9. Provide ad hoc research, analyses and communications to support DLTSS Work Group tasks and activities.

2. **Bailit*: $90,000 to support <u>Type 1b</u> <u>Disability and Long Term Services and Supports</u> <u>Work Group</u>***

The Contractor shall provide support for DLTSS Work Group tasks, activities and decision-making, including, but not limited to, the following areas:

- Care models to support integrated care for people with disabilities, chronic conditions and those needing long term services and supports
- Payment models to support integrated care for people with disabilities, chronic conditions and those needing long term services and supports
- LTSS quality and performance measures to evaluate the outcomes of people with disabilities, chronic conditions and those needing long term services and supports
- IT infrastructures to support new payment and care models for integrated care for people with disabilities, chronic conditions and those needing long term services and supports
- Strategies to incorporate person-centered, disability-related, person-directed, and cultural competency issues into all VHCIP activities

- Identification of barriers in current Medicare, Medicaid and commercial coverage and payment policies, and strategies to address them
- Other activities as identified by the Work Group to assist successful implementation of payment and care models to best support people with disabilities, chronic conditions and those needing long term services and supports.

The Contractor also shall support the DLTSS Work Group and leadership (i.e., VCHIP and DLTSS Project Staff, Work Group Chairs and other Consultants) by performing the following activities:

- Work closely with VHCIP and DLTSS Work Group leadership to strategize and develop agendas for Work Group meetings, preparing handouts and preparing discussion materials
- Actively participate in DLTSS Work Group meeting discussions
- Conduct research on specific topics and developing summary documents and / or presentations
- Provide ad hoc support for project leadership and achievement of VHCIP goals via telephone calls and electronic mail communications (e.g., exchange of information about project developments and updates, sharing of information regarding relevant topics, new publications and/or national news; discussion of recent events and implications for project direction; contributing to discussion about policy or operational decisions; etc.)
- Participate in HIT/HIE Work Group Meetings
- Attend VHCIP Steering Committee meetings and other VHCIP Work Group meetings as necessary to support the goals of the DLTSS Work Group

Deliverables:

1. Develop and / or contribute to agendas, white papers, presentations and other materials for the DLTSS Work Group, and for other VHCIP Work Groups as requested.
2. Participate in monthly DLTSS Work Group meetings, and sub work-group meetings as needed.
3. Participate in monthly DLTSS Work Group planning meetings.
4. Attend VHCIP Steering Committee meetings and other VHCIP Work group meetings as needed.
5. Provide research and summary documents to support DLTSS work plan and decision-making.
6. Work with VHCIP Project Staff regarding IT infrastructure needs by providing research, papers and documents that support Work Group recommendations and decision-making.
7. Work with VHCIP Project Staff to develop care models that support integrated care.

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8. Work with VHCIP Project Staff to develop payment models that support integrated care.
9. Provide ad hoc research, analyses and communications to support DLTSS Work Group tasks and activities.

Disability and Long Term Services and Supports Work Group Charge:
The Disability and Long Term Services and Supports Work Group will build on the extensive work of the Dual Eligible Demonstration Steering, Stakeholder, and Work Group Committees over the past two years. The goal of the Disability and Long Term Services and Supports Work Group (D-LTSS) is to incorporate into Vermont's health care reform efforts specific strategies to achieve improved quality of care, improved beneficiary experience and reduced costs for people with disabilities, chronic conditions and those needing long term services and supports. The VHCIP Disability and LTSS Work Group will:

- develop recommendations regarding the improvement of existing care models and the design of new care models to better address the needs of people with disabilities, chronic conditions and those needing long term services and supports, in concert with VHCIP efforts;
- develop recommendations regarding the design of new payment models initiated through the VHCIP project to improve outcomes and reduce costs for people with disabilities, chronic conditions and those needing long term services and supports;
- develop recommendations to integrate the service delivery systems for acute/medical care and long term services and supports;
- develop recommendations for IT infrastructure to support new payment and care models for integrated care among people with disabilities, chronic conditions and those needing long term services and supports;
- continue to address coordination and enhancement of services for the dually-eligible population and other Vermonters who have chronic health needs and/or disabilities through such mechanisms as the Medicaid ACO program, further design of Green Mountain Care, and other approaches.

Attachment 4 - Disability and LTSS Work Group Charter draft 2.20.2014

VT Health Care Innovation Project
"Disability and Long Term Services & Supports" Work Group
Charter

February 20, 2014

DRAFT

EXECUTIVE SUMMARY

The Disability and Long Term Services and Supports Work Group will build on the extensive work of the Dual Eligible Demonstration Steering, Stakeholder, and Work Group Committees over the past two years. The goal of the Disability and Long Term Services and Supports Work Group (D-LTSS) is to incorporate into Vermont's health care reform efforts specific strategies to achieve improved quality of care, improved beneficiary experience and reduced costs for people with disabilities, chronic conditions and those needing long term services and supports. The VHCIP Disability and LTSS Work Group will:

- develop recommendations regarding the improvement of existing care models and the design of new care models to better address the needs of people with disabilities, chronic conditions and those needing long term services and supports, in concert with VHCIP efforts;
- develop recommendations regarding the design of new payment models initiated through the VHCIP project to improve outcomes and reduce costs for people with disabilities, chronic conditions and those needing long term services and supports;
- develop recommendations to integrate the service delivery systems for acute/medical care and long term services and supports;
- develop recommendations for IT infrastructure to support new payment and care models for integrated care among people with disabilities, chronic conditions and those needing long term services and supports;
- continue to address coordination and enhancement of services for the dually-eligible population and other Vermonters who have chronic health needs and/or disabilities through such mechanisms as the Medicaid ACO program, further design of Green Mountain Care, and other approaches.

SCOPE OF WORK

1. Recommend care model elements and strategies that improve beneficiary service and outcomes for people with disabilities, chronic conditions and those needing long term services and supports.
2. Identify provider payment models that encourage quality and efficiency among the array of primary care, acute and long-term services and support providers who serve people with disabilities, chronic conditions and those needing long term services and supports.

3. Identify mechanisms to incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports to achieve a more integrated and seamless delivery system.
4. Incorporate person-centered, disability-related, person-directed, and cultural competency issues into all VHCIP activities.
5. Identify Medicare/Medicaid/commercial insurance coverage and payment policy barriers that can be addressed through Vermont's health care reform efforts to improve integration of care for people with disabilities, chronic conditions and those needing long term services and supports.
6. Identify mechanisms to minimize the incentives for cost-shifting between Medicare, Medicaid and commercial payers.
7. Incorporate representation from Commercial Insurers into the VHCIP Disability and Long Term Services and Supports Work Group.
8. Recommend incentives for ACOs to re-invest savings to address the needs of people with disabilities, chronic conditions and those needing long term services and supports to prevent unnecessary hospitalizations, ER visits, and nursing home admissions.
9. Identify LTSS quality and performance measures to evaluate the outcomes of people with disabilities, chronic conditions and those needing long term services and supports.
10. Identify technical and IT needs to support new payment and care models for integrated care among people with disabilities, chronic conditions and those needing long term services and supports.

DELIVERABLES

1. Inclusion of new members on the D-LTSS Work Group, including representation from commercial payers.
2. Recommendations for model of care elements and strategies that can be integrated and aligned with other VHCIP models of care.
3. Recommendations for payment methodologies that: a) incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports; b) incentivize ACOs to re-invest savings to address the needs of people with disabilities, chronic conditions and those needing long term services and supports to prevent unnecessary hospitalizations, ER visits, and nursing home admissions; and c) reduce the incentive to cost shift between Medicare, Medicaid and commercial payers.
4. Action plan for inclusion of identified person-centered, disability-related, person-directed, and cultural competency items in all VHCIP Work Group efforts.
5. Action plan to implement strategies addressing barriers in current Medicare, Medicaid, and commercial coverage and payment policies.

6. Action plan for inclusion of LTSS quality and performance metrics to evaluate the outcomes of people with disabilities, chronic conditions and those needing long term services and supports.
7. Recommendations regarding the technical and IT needs to support new payment and care models for integrated care among people with disabilities, chronic conditions and those needing long term services and supports.
8. Other activities as identified to assist successful implementation of payment and care models to best support people with disabilities, chronic conditions and those needing long term services and supports.

MILESTONES (Timeline subject to change)

January – April 2014

- Recommendations for model of care elements and strategies.
- Complete action plan for inclusion of identified person-centered, disability-related, person-directed, and cultural competency items in all VHCIP Work Group activities.

May – August 2014

- Complete action plan for inclusion of LTSS quality and performance metrics to evaluate the outcomes of people with disabilities, chronic conditions and those needing long term services and supports.

September – December 2014

- Recommendations for payment methodologies that incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports; incentivize ACOs to reinvest savings to address the needs of people with disabilities, chronic conditions and those needing long term services and supports; and reduce the incentive to cost shift between Medicare, Medicaid and commercial payers.
- Recommendations regarding the technical and IT needs to support new payment and care models for integrated care among people with disabilities, chronic conditions and those needing long term services and supports.

January – April 2015

- Complete action plan to implement strategies addressing barriers in current Medicare, Medicaid, and commercial coverage and payment policies.

- Other activities as identified to support successful preparation and implementation of payment and care models to best support people with disabilities, chronic conditions and those needing long term services and supports.

MEMBERSHIP REQUIREMENTS

The Disability and Long Term Services and Supports Work Group will meet monthly, with possible additional sub-committee meetings. Members are expected to participate regularly in meetings and may be required to review materials in advance. Members are expected to communicate with their colleagues and constituents about the activities and progress of the Work Group and to represent their organizations and constituencies during work group meetings and activities.

RESOURCES AVAILABLE FOR STAFFING AND CONSULTATION

Work Group Chairs:

- Deborah Lisi-Baker, Disability Policy Analyst
  dlisibaker@gmail.com

- Judy Peterson, VNA of Chittenden & Grand Isle Counties
  Peterson@vnacares.org

Work Group Staff:

- Erin Flynn, Department of Vermont Health Access
  Erin.Flynn@state.vt.us

- Julie Wasserman, AHS Vermont Dual Eligible Project
  Julie.Wasserman@state.vt.us

Consultants:

- Susan Besio, Pacific Health Policy Group
  sbesio@PHPG.com

- Brendan Hogan, Bailit Health Purchasing
  bhogan@bailit-health.com

Additional resources may be available to support consultation and technical assistance to the Work Group.

WORK GROUP PROCESSES

1. The Work Group will meet monthly.

2. The Work Group Co-Chairs plan and distribute the meeting agenda through project staff.
3. Related materials are to be sent to Work Group members, staff, and interested parties prior to the meeting date/time.
4. Work Group members, staff, and interested parties are encouraged to call in advance of the meeting if they have any questions related to the meeting materials that were received.
5. Minutes will be recorded at each meeting.
6. The Work Group Co-Chairs will preside at the meetings.
7. Progress on the Work Group's work will be reported as the Monthly Status Report.
8. The Work Group's Status Reports and Recommendations are directed to the Steering Committee.

AUTHORIZATION

____ Date: _________________

Project Sponsor/Title

Attachment 5 - Questions Comments Ideas for DLTSS Work Group 2.20.2014

VHCIP “Disability and Long Term Services & Supports” Work Group
(former Dual Eligible Work Group)

Questions, Comments and Ideas
February 20, 2014

The goal of the “Disability and Long Term Services and Supports” Work Group is to incorporate into Vermont’s health care reform efforts specific strategies to achieve improved quality of care, improved beneficiary experience and reduced costs for people with disabilities, chronic conditions and those needing long term services and supports.

1. I’d like for the new group to look at ways new technologies can be used to improve quality of life, safety and wellness for seniors at home. Items to include automated med dispensers, motion detectors, tele-health, etc.

2. This comment has three parts:

   a. Although everyone wants flexibility regarding the benefits that will be provided, there will still need to be some parameters governing what is covered. Medical necessity will still need to be defined and expected for any benefit provided. Having parameters would help to assure that both providers and beneficiaries have similar expectations. They would also provide the framework that will be needed for the appeals process.

   b. The model of care described in the document that was distributed at the meeting of Jan 16 describes the beneficiary being able to choose their Enhanced Care Coordinator from any of the organizations included in the ICP. I am concerned with how efficient and realistic it would be to expect all of the organizations within an ICP to become fully ready to provide Enhanced Care Coordination. Some of the organizations are quite small, and might have difficulty absorbing the additional work and maintaining availability as the single point of contact while upholding their individual missions. I suggest that there be flexibility for the ICPs regarding how many of their member organizations have staff who are fully prepared to be Enhanced Care Coordinators.

   c. At the meeting, all seemed to agree that there has been a divide between medical services and long term care supports that needs to be bridged. Because of the varied backgrounds of the ICP member organizations, the amount of training and preparation needed to bridge the divide would vary a lot by organization and it would be particularly challenging to achieve consistency across all of the organizations.

Attachment 6 - DLTSS QM Slides 2.20.2014

Quality Measurement of Disability and Long Term Services & Supports (DLTSS) in the Vermont Medicaid Shared Savings Program

VHCIP Disability & Long Term Care Work Group Meeting

February 20, 2014

Disability and Long Term Services & Supports (DLTSS)

A diverse range of medical, mental health, substance abuse, developmental disability, personal, and social services that assist people with a physical, cognitive, or mental disability to live more independently.

DLTSS in Vermont

- Medicaid is primary payer for DLTSS
- In State FY 2013:
  - 21% of Medicaid enrollees received DLTSS
  - 55% of Medicaid budget was spent on services for this group

DLTSS in Vermont

- Specialized Medicaid DLTSS programs include:
  - Choices for Care
  - Developmental Disabilities Services
  - Community Rehabilitation & Treatment
  - Attendant Services Program
  - Traumatic Brain Injury Program
- Enrollees in these programs also receive community Medicaid (state plan) services

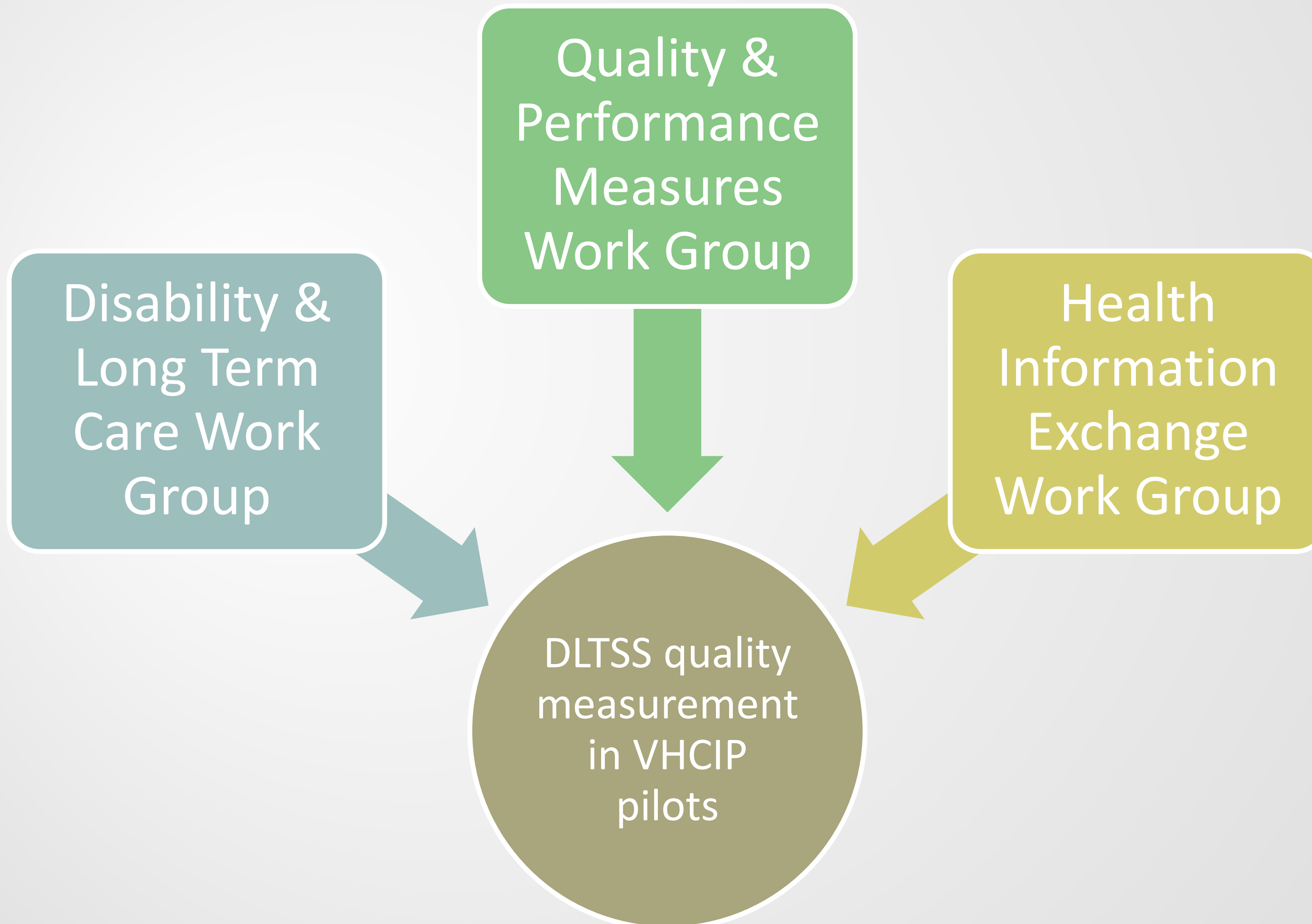
DLTSS Quality Measurement

- Ensure improvement in comprehensive and integrated service delivery and care coordination
- Ensure person-centered service planning process meets needs of consumers and caregivers
- Monitor progress toward system rebalancing
- Optimize choice and control in receipt of services and engagement in community life

Challenges with DLTSS Quality Measurement

- Relatively few nationally endorsed DLTSS measures exist
- Majority of current measures are medical/clinical or survey-based
  - Similar to measures used in other populations
- Lack of standardized outcome measures
- Limitations in collecting and transmitting DLTSS quality data electronically

Opportunity for VHCIP



Opportunity for ACOs

- Medicaid SSP Year 2: ACOs will have the *option* of expanding the definition of Total Cost of Care to include the full spectrum of Medicaid services, including DLTSS.
- Medicaid SSP Year 3: ACOs will be *required* to adopt the expanded definition of Total Cost of Care.
- Tracking utilization and quality of care to achieve shared savings
  - Full attributed population
  - DLTSS population

Objective

- To develop a proposal for a **short-term** (~3 year) strategy for DLTSS quality measurement for the Vermont Medicaid SSP pilot

- Identify measures that can be used to assess quality of care in the ACOs' DLTSS populations while minimizing administrative and financial burden on ACOs, payers, and providers
  - Claims-based measures
  - Leveraging current ACO, Medicaid, and AHS measurement activities
- Complement longer-term initiatives to connect DLTSS providers to the HIE
  - Improve the ability to capture and report quality and outcome data

Possible Framework for DLTSS Quality Measurement in Medicaid SSP

Stage	ACO SSP Pilot Years	Proposal
1	1-3	As part of annual reports from the Analytics Contractor to the ACOs, reports on Core Measures could be further broken down to reflect quality of care in VT Medicaid DLTSS population
2	2-3	Include additional claims-based DLTSS measures that are already being collected by AHS in annual ACO Monitoring & Evaluation measure reports
3	2-3	Promote Pending measures to Reporting status within the ACO Core Measure Set
4	3	ACOs choose **X** DLTSS measures from a menu of **Y** for which they will be assessed *-or-* ACOs will be assessed on **X** additional DLTSS measures

Continuation of Duals Measure Selection Process

- Stage 1: 3 of the current ACO Payment measures were included in the Duals measure set
- Stage 3: 3 ACO Pending measures recommended for promotion were included in the Duals measure set
- Stage 4: Duals measure set may serve as starting point for discussions of new DLTSS measures to be considered for Year 3 of the Medicaid SSP
- In addition:
  - Several current ACO Reporting and M&E measures were included in the Duals measure set
  - Current AHS consumer experience surveys capture information related to survey metrics included in the Duals measure set

Timeline

- VHCIP Quality & Performance Measures work group needs to begin discussion of any new or pending measures in the first quarter of the program year (Jan-Mar 2014)
  - Meeting March 17th
- Work group recommendations regarding changes to the ACO measure sets need to be finalized by July 2014
  - Allowing time for Steering Committee, Core Team, and GMCB approval of proposed changes

Attachment 7 - DLTSS Measures Narrative 2.20.2014

Proposal for Quality Measurement of Disability and Long Term Services & Supports (DLTSS) in the Vermont Medicaid Shared Savings Program

Disability and Long Term Services & Supports (DLTSS): A diverse range of medical, mental health, substance abuse, developmental disability, personal, and social services that assist people with a physical, cognitive, or mental disability to live more independently.

Agency of Human Services DLTSS Measures Discussion Group: A group of representatives from AHS Central Office, the Department of Disabilities, Aging and Independent Living, the Department of Mental Health, and the Department of Vermont Health Access who met monthly between November 2013-February 2014 to discuss ongoing DLTSS quality measurement activities within AHS, and potential opportunities for DLTSS quality measurement in the Vermont Medicaid Shared Savings Program (SSP).

Objective: To develop a proposal for a **short-term** (~3 year) strategy for DLTSS quality measurement for the Vermont Medicaid SSP pilot. The focus of this effort has been to identify measures that can be used to assess quality of care and outcomes in the ACOs' DLTSS populations while minimizing administrative and financial burden on ACOs, payers, and providers. Emphasis is on using claims-based measures to the extent possible, and leveraging current ACO, Medicaid, and AHS measurement activities to avoid the duplication of efforts. This strategy is meant to *complement longer-term initiatives* to connect DLTSS providers to the HIE, and to improve the ability to capture, send, receive, and report clinical quality and outcome data.

DLTSS in Vermont: Vermont's Medicaid program is the primary payer for DLTSS. In State Fiscal Year 2013, approximately 55% of the Vermont Medicaid budget was spent on the ~21% of Medicaid enrollees receiving DLTSS (including Choices for Care, Developmental Services/Home & Community-Based Services, Community Rehabilitation & Treatment, Traumatic Brain Injury, Attendant Services Program, and other services for people who are aged, blind and disabled).

Program	Department	Description/Summary of Services	Population Served (End of SFY 2013)	Current Measurement Activities
Choices for Care (CFC)	Department of Disabilities, Aging and Independent Living	Choices for Care (CFC) is a Medicaid-funded long-term services and supports program that pays for care and support for older Vermonters and adults with physical disabilities. The overall goal of CFC is to give people choice and control over where and how their needs are met. For people who need "nursing home level of care", services are provided in their own homes, in	4,954	MDS Measures OASIS Measures Rebalancing Measures

		Residential Care/Assisted Living Homes, or in nursing facilities. HCBS services include case management, personal care, respite care, companion care, adult day services, homemaker, assistive devices and home modifications, personal emergency response systems, and 'flexible choices'.		Consumer Experience Survey
Developmental Disabilities Services (DDS)	Department of Disabilities, Aging and Independent Living	Developmental Disabilities Services (DDS) help people and their families to increase independence and be part of their local communities. These services provide funding to prevent institutionalization and address personal health and safety as well as public safety. Services support people with developmental disabilities to live dignified lives and find opportunities for community participation though home supports, employment services, community supports, family supports, service coordination, crisis services, clinical interventions, and respite.	2,767	Consumer Experience Survey Tracking of utilization, consumer employment
Community Rehabilitation & Treatment (CRT)	Department of Mental Health	Designated Agencies deliver a range of therapeutic services to adults with chronic and persistent mental illness who are determined to be eligible due to significant impairment in functioning. Emphasis of care is on assistance with symptom management with a focus on achieving sustained recovery. Services provided include clinical assessment, emergency care, individual, group, and family therapy; medication services, service planning and coordination, and community supports.	2,752	Consumer Experience Survey Tracking of utilization, consumer employment
Attendant Services Program (ASP)	Department of Disabilities, Aging and Independent Living	The Attendant Services Program (ASP) supports personal care services for adults with a "severe and permanent disability" who need physical assistance with activities of daily living (such as bathing, getting dressed and eating) to remain in their homes.	182	Consumer Experience Survey

Traumatic Brain Injury (TBI) Program	Department of Disabilities, Aging and Independent Living	The Traumatic Brain Injury (TBI) Program serves Vermonters with moderate to severe traumatic brain injuries, diverting or returning them from hospitals and facilities to community-based settings. Services include case management, rehabilitation services, community supports, environmental and assistive technology, crisis support, respite, employment support, and special needs (ongoing long-term) services.	70	Consumer Experience Survey Tracking of consumer employment *Other metrics in development*

Challenges with DLTSS Quality Measurement: Despite several decades of efforts to develop DLTSS quality metrics, very few DLTSS measures have yet been nationally endorsed or standardized. Of the measures currently in use, the majority are medical or clinical in scope because they more closely mirror nationally validated metrics used to assess quality in other patient populations. Another avenue for DLTSS quality measurement is to survey individuals about their experiences and engagement with DLTSS care. Despite current challenges, measuring quality of care for this population remains a high priority for Vermont and other states, helping to ensure that service delivery and care coordination continue to improve, and that the care being provided meets the needs of consumers and caregivers.

Opportunity for ACOs: In the second year of the Vermont Medicaid Shared Savings Program, ACOs will have the option of expanding the definition of Total Cost of Care to include the full spectrum of Medicaid services, including DLTSS. In the third program year, ACOs will be required to adopt this expanded definition of Total Cost of Care. In order to achieve savings in later program years, it will be important for ACOs to track utilization and quality of care not only for the attributed population as a whole, but also for the subset of the population receiving DLTSS.

Attachment 8 - DLTSS Measures Proposal 2.20.2014

Stage	ACO SSP Pilot Years	Proposal	Potential Challenges	Potential Opportunities
1	Years 1-3	As part of annual reports from the Analytics Contractor to the ACOs, reports on Core Measures will be further broken down to reflect quality of care in VT Medicaid DLTSS population*; performance on these metrics for DLTSS population will not impact payment. ***Core-1, Core-3-7 if ≥30 eligible individuals per measure*	1. Concerns about validity of estimates when sample sizes are small. In keeping with NCQA public reporting requirements, measures will not be calculated when there are fewer than 30 eligible DLTSS individuals per measure in an ACO.	1. Will inform ACOs and payers about the quality of care among DLTSS beneficiaries before ACOs are required to include relevant services in the Total Cost of Care definition. 2. Can be implemented with no impact on Year 1 ACO measure set or data collection procedures.
2	Years 2-3	Include additional claims-based DLTSS measures that are already being collected by AHS in annual ACO Monitoring & Evaluation measure reports. *Specific utilization and employment metrics to be supplied by DMH & DAIL*	1. May not be possible for departments to split populations by ACO; however, several other M&E measures are also being reported at the plan- or state-level.	1. Will inform ACOs and payers about the utilization and cost of care among DLTSS beneficiaries. 2. Will leverage ongoing AHS data collection and measure reporting, adding no burden to ACOs, payers, or providers.
3	Years 2-3	Promote Pending measures to Reporting status within the ACO Core Measure Set. ***Suggested measures for DLTSS population: Core-35, Core-37, Core-47, Core-48*	1. Additional data collection will be required for measures that aren't already being used by Medicare Shared Savings Program (MSSP). 2. Overall challenges with collection and accuracy of clinical quality data. 3. Concerns about validity of estimates when sample sizes are small. In keeping with NCQA public reporting requirements, measures will not be calculated when there are fewer than 30 eligible individuals per measure in an ACO.	1. Will inform ACOs and payers about the quality of care among DLTSS beneficiaries when ACOs have the option and/or requirement to include relevant services in the Total Cost of Care definition. 2. Measures focus on areas of importance to DLTSS in absence of concurrent Duals Demonstration, and can be applied to the full Medicaid SSP population.

4	Year 3	ACOs choose **X** DLTSS measures from a menu of **Y** for which they will be assessed. -or- ACOs will be assessed on **X** additional DLTSS measures.	1. New measures will need to be vetted by the VHCIP Q&PM Work Group before they can be considered for inclusion in the ACO Core measure set. 2. Additional data collection will be required for new measures, with associated burden depending on the number and types of measures (claims vs. clinical). 3. Concerns about validity of estimates when sample sizes are small. In keeping with NCQA public reporting requirements, measures will not be calculated when there are fewer than 30 eligible DLTSS individuals per measure in an ACO.	1. Will inform ACOs and payers about the quality of care among DLTSS beneficiaries when ACOs are required to include relevant services in the Total Cost of Care definition. 2. Allows ACOs to focus on specific needs of their LTSS population based on what they have learned from above activities in Years 1-2. 3. Allows VHCIP Q&PM Work Group a full year to evaluate and approve additional measures.

In addition, DAIL and DMH will share with the ACOs the results of their annual consumer experience surveys.

*DLTSS Population includes clients in the following Medicaid programs: Choices for Care, Disability Services/Home & Community-Based Services, Community Rehabilitative Treatment, Traumatic Brain Injury, and Attendant Services Program.

**See “2014 ACO Measures (Core and M&E).pdf” document for corresponding list of measures.

Attachment 9 - 2014 ACO Measures (Core and M&E)

VT ACO Pilot Year 1 Performance Measures

Approved by GMCB and VHCIP Core Team and Steering Committee, November 2013
Clarified January 16, 2014

The predecessor work group to the VHCIP Quality and Performance Measures Work Group (the ACO Measures Work Group) developed an ACO Performance Measure Set. Within that measure set there is a Core Measure Set and a Monitoring and Evaluation Measure Set.

The Core Measure Set consists of those measures for which each ACO participating in the Vermont ACO pilot program has accountability for reporting and payment purposes. Payment measures are those for which ACO **performance** potentially impacts the amount of shared savings that the ACO may retain. Reporting measures are those for which ACO **reporting** is a performance requirement. The measures designated for Monitoring and Evaluation are not considered to be Core Measures. Both measure sets were subsequently approved by the former ACO Standards Work Group and reviewed by the VHCIP Steering Committee. Final approval of the Core Measure Set was granted by the VHCIP Core Team in November 2013 and the Green Mountain Care Board in December 2013.

I. VERMONT ACO CORE MEASURE SET

The Core Measure set consists of those measures for which the ACO has accountability for either reporting or payment purposes. The measures designated for monitoring and evaluation are not considered Core Measures. **(32 measures for Year 1 payment and reporting; 23 Year 1 pending measures)**

1. **Commercial and Medicaid Quality Measures for Payment (8 measures):** *ACO performance on measures designated for "payment" will be considered when calculating shared savings. The payers will be responsible for submitting all of the relevant claims files for these measures to the state Analytics Contractor. The Analytics Contractor will be responsible for calculating performance on the measures for the Medicaid population, for the individual commercial payer populations, and for the combined commercial populations for each ACO. All payment measures are subject to an annual review of data availability, quality and performance. The use of the measures may shift in Year Two and/or Three as a result of these annual reviews.*

   a. **Claims-based Measures for Payment in Year One (8 measures):**
      1. (Core-1) All-Cause Readmission
      2. (Core-2) Adolescent Well-Care Visit
      3. (Core-3a) Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening Only)[1]

[1] Core-3a is the claims-based HEDIS measure "Cholesterol Management for Patients with Cardiovascular Conditions" (LDL-screening only) and will be used for payment until Core 3b, the clinical data-based

4. (Core-4) Follow-up After Hospitalization for Mental Illness, 7 day
5. (Core-5) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement
6. (Core-6) Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis
7. (Core-7) Chlamydia Screening in Women
8. (Core-8) *Developmental Screening in the First Three Years of Life (Medicaid only)*

~~9.~~ *[(Core-9) Depression Screening by 18 years of age was removed from the measure set prior to finalization and was not presented to or approved by the GMCB.]*

2. <u>Commercial and Medicaid Quality Measures for Reporting (24 measures):</u> *ACOs will be required to provide information to the state Analytics Contractor on the clinical data-based Reporting measures either through electronic means or as a result of chart reviews. If payers are collecting data on the clinical data-based measures in a way that allows them to determine ACO-level performance, the payers may provide information to the Analytics Contractor on behalf of the ACO. Performance on these measures will not be considered when calculating shared savings. All reporting measures are subject to an annual review of data availability, quality and performance. The use of the measures may shift in Year Two and/or Three as a result of these annual reviews.*

a. **Claims-based Measures for Reporting in Year One (4 measures):**
   1. (Core-10/ MSSP-9) Ambulatory Care-Sensitive Conditions Admissions: COPD[2]
   2. (Core-11/ MSSP-20) Mammography /Breast Cancer Screening
   3. (Core-12) Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite
   4. (Core-13) Appropriate Testing for Children with Pharyngitis

b. **Clinical Data-based Measures for Reporting in Year One (11 measures):**
   1. (Core-14) Childhood Immunization Status (Combo 10)
   2. (Core-15) Pediatric Weight Assessment and Counseling
   3. (Core-16a/ MSSP 22) Diabetes Composite (D5) (All or Nothing Scoring): Hemoglobin A1c Control (<8 percent)
   4. (Core-16b/ MSSP 23) Diabetes Composite (D5) (All or Nothing Scoring): Low Density Lipoprotein (<100)
   5. (Core-16c/ MSSP 24) Diabetes Composite (D5) (All or Nothing Scoring): Blood Pressure <140/90
   6. (Core-16d/ MSSP 25) Diabetes Composite (D5) (All or Nothing Scoring): Tobacco Non-Use

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"IVD: Complete Lipid Panel and LDL Control" measure which is currently pending, is ready to be used for payment, at which point it will replace Core 3a.

[2] Any ACO participating in the MSSP is required to submit MSSP measure results for the Medicare population (with the exclusion of the patient experience measures) to the GMCB for review.

7. (Core-16e/ MSSP 26) Diabetes Composite (D5) (All or Nothing Scoring): Aspirin Use
8. (Core-17/ MSSP-27) Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent)
9. (Core-18/ MSSP-19) Colorectal Cancer Screening
10. (Core-19/ MSSP-18) Depression Screening and Follow-up
11. (Core-20/ MSSP-16) Adult Weight (BMI) Screening and Follow-up

c. **Patient Experience Measures for Reporting in Year One (9 measures):**

1. (Core-21) Access to Care Composite
2. (Core-22) Communication Composite
3. (Core-23) Shared Decision-Making Composite
4. (Core-24) Self-Management Support Composite
5. (Core-25) Comprehensiveness Composite
6. (Core-26) Office Staff Composite
7. (Core-27) Information Composite
8. (Core-28) Coordination of Care Composite
9. (Core-29) Specialist Composite

3. Commercial and Medicaid Quality Measures Pending in Year One (23 measures):

Measures designated as "pending" are included in the core measure set, but are not required for reporting in Year One. Pending measures are considered to be of importance to the ACO pilot, but are not required for initial reporting for one of the following reasons: the target population is not presently included in the pilot, lack of availability of clinical or other required data, lack of sufficient baseline data, lack of clear or widely-accepted specifications, or the measure is presently overly burdensome to collect. All pending measures are subject to an annual review of data availability, quality and performance. The use of the measures may shift in Year Two and/or Three as a result of these annual reviews.

a. Pending claims-based measures (1 measure):

1. (Core-49) *Use of High Risk Medications in the Elderly (Medicaid only, duals-specific measure)*

b. Pending clinical data-based measures (20 measures):

1. (Core- 3b/ MSSP-29) Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)[3]

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[3] Core-3a is the claims-based HEDIS measure "Cholesterol Management for Patients with Cardiovascular Conditions" (LDL-screening only) and will be used for payment until Core 3b, the clinical data-based "IVD: Complete Lipid Panel and LDL Control" measure which is currently pending, is ready to be used for payment, at which point it will replace Core 3a.

2. (Core-30) Cervical Cancer Screening
3. (Core-31/ MSSP-30) Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
4. (Core-32) Proportion not admitted to hospice (cancer patients)
5. (Core-33) Elective delivery before 39 weeks
6. (Core-34) Prenatal and Postpartum Care
7. (Core-35/ MSSP-14) Influenza Immunization
8. (Core-36/ MSSP-17) Tobacco Use Assessment and Tobacco Cessation Intervention
9. (Core-37) Care Transition-Transition Record Transmittal to Health Care Professional
10. (Core-38a/ MSSP-32) Coronary Artery Disease (CAD) Composite: Lipid Control
11. (Core-38b/ MSSP-33) Coronary Artery Disease (CAD) Composite: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy- Diabetes of Left Ventricular Systolic Dysfunction (LVEF <40%)
12. (Core-39/ MSSP-28) Hypertension (HTN): Controlling High Blood Pressure
13. (Core-40/ MSSP-21) Screening for High Blood Pressure and follow-up plan documented
14. (Core-43) *Frequency of Ongoing Prenatal Care (Medicaid only)*
15. (Core-44) *Percentage of Patients with Self-Management Plans (Medicaid only)*
16. (Core-45) *Screening, Brief Intervention, and Referral to Treatment (Medicaid only)*
17. (Core-46) *Trauma Screen Measure (Medicaid only)*
18. (Core-47/ MSSP-13) *Falls: Screening for Future Fall Risk (Medicaid only, duals-specific measure)*
19. (Core-48/ MSSP-15) *Pneumococcal Vaccination for Patients 65 Years and Older (Medicaid only, duals-specific measure)*
20. (Core-50) *Persistent Indicators of Dementia without a Diagnosis (Medicaid only, duals-specific measure)*

c. Pending survey-based measures (2 measures):

1. (Core-41) How's Your Health?
2. (Core-42) Patient Activation Measure

II. VERMONT ACO MONITORING & EVALUATION MEASURE SET

The Monitoring and Evaluation Measure Set consists of measures with one of three characteristics. First, it includes Monitoring measures that were not prioritized for Core Measure Set inclusion because baseline insurer-level performance suggests that there is not currently a sufficiently high opportunity for improvement to warrant such inclusion. Second, it includes Monitoring measures for which ACO level measurement is not presently feasible. Third, it includes a comprehensive set of service utilization and cost Evaluation measures.

Monitoring and Evaluation measures are distinctive from Core Measure Set Reporting and Payment measures in that they will have no bearing on shared savings and will not be collected at the ACO level; nonetheless, they are important to collect to inform programmatic evaluation and selection of measures for future inclusion in the Core Measure Set. These measures will be reported at the insurer, the state level, or both to the state Analytics Contractor. Data for these measures will be obtained from sources other than the ACO (e.g., health insurers, VHCURES, Department of Education). Performance on the Monitoring measures will be reviewed at the insurer or state level on an annual basis. The measures will remain Monitoring measures unless the Quality and Performance Measures Work Group, determines that there is an opportunity for improvement. The Work Group, with input from the Payment Models Work Group, may recommend at the measure should be moved to the Core Measure Set and performance assessed at the ACO level and used for either payment or reporting. **(23 measures in total)**

1. **Commercial and Medicaid Measures for Monitoring (9 measures):** *These are measures that all pilot participants would benefit from tracking and reporting. They are distinctive from Reporting and Payment in that they will have no bearing on shared savings; nonetheless, they are important to collect to inform programmatic evaluation and other activities. These measures will be reported at the insurer level, the state level, or both, and will come from sources other than the ACO. All measures are subject to an annual review of data availability, quality and performance. The use of the measures may shift in Years Two and/or Three as a result of these annual reviews.*

   a. **Claims-based Monitoring measures (6 measures):** *These measures will be reported by each payer and will be reported at the payer level rather than at the ACO level.*

      1. (M&E-1) Appropriate Medications for People with Asthma
      2. (M&E-2) Comprehensive Diabetes Care: Eye Exams for Diabetics
      3. (M&E-3) Comprehensive Diabetes Care: Medical Attention for Nephropathy
      4. (M&E-4) Use of Spirometry Testing in the Assessment and Diagnosis of COPD
      5. (M&E-5) Follow-up Care for Children Prescribed ADHD Medication
      6. (M&E-6) Antidepressant Medication Management

   b. **Survey-based Monitoring measures (1 measure):**

      7. (M&E-7) Family Evaluation of Hospice Care Survey

   c. **Monitoring measures derived from other non-ACO sources (2 measures):**

      8. (M&E-8) School Completion Rate

9. (M&E-9) Unemployment

2. **<u>Commercial and Medicaid Measures for Evaluation (14 measures):</u>**

These measures reflect utilization and cost metrics to be monitored on a quarterly basis for each ACO, and will be reported by each payer. Commercial information will be reported by individual commercial payer and for the combined commercial populations for each ACO. All measures are subject to an annual review of data availability, quality and performance. The use of the measures may shift in Years Two and/or Three as a result of these annual reviews.

a. Claims-based Evaluation measures (14 measures):

1. (M&E-10) Health Partners TCOC: Total Cost Index (TCI)
2. (M&E-11) Health Partners TCOC: Resource Use Index (RUI)
3. (M&E-12) Ambulatory surgery/1000
4. (M&E-13) Average # of prescriptions PMPM
5. (M&E-14) Avoidable ED visits-NYU algorithm
6. (M&E-15) Ambulatory Care (ED rate only)
7. (M&E-16) ED Utilization for Ambulatory Care-Sensitive Conditions
8. (M&E-17) Generic dispensing rate
9. (M&E-18) High-end imaging/1000
10. (M&E-19) Inpatient Utilization - General Hospital/Acute Care
11. (M&E-20) Primary care visits/1000
12. (M&E-21) SNF Days/1000
13. (M&E-22) Specialty visits/1000
14. (M&E-23) *Annual Dental Visit (Medicaid only)*

b. Clinical data-based Evaluation measures (no measures)

- none

III. CMS MSSP-ONLY MEASURES

Medicare Shared Savings Program (MSSP)-only measures are required of ACOs participating in the MSSP program. Any ACO participating in MSSP is also required to submit the MSSP results for the claims and clinical data-based measures annually to the state Analytics Contactor for monitoring and evaluation purposes. **(12 measures in total)**

1. **Medicare-only Claims and Clinical Data-based Measures (5 measures):**
   1. (MSSP-8) Risk-Standardized All-Condition Readmission
   2. (MSSP-10) Ambulatory Care-Sensitive Conditions Admissions: Heart Failure
   3. (MSSP-11) Percent of Primary Care Physicians who Successfully Qualify for an EHR Incentive Program
   4. (MSSP-12) Medication Reconciliation
   5. (MSSP-31) Heart Failure: Beta Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

2. **Medicare-only Patient Experience Measures (using the Medicare-specific National Implementation Survey) (7 measures):**
   1. (MSSP-1) Getting Timely Care, Appointments and Information
   2. (MSSP-2) How Well Your Providers Communicate
   3. (MSSP-3) Patient Rating of Provider
   4. (MSSP-4) Access to Specialist
   5. (MSSP-5) Health Promotion and Education
   6. (MSSP-6) Shared Decision Making
   7. (MSSP-7) Health Status/ Functional Status