Vermont Health Care Innovation Project
Payment Model Design and Implementation Work Group Meeting Agenda
Monday, May 16, 2016 1:00 PM – 2:30 PM.
DVHA Large Conference Room, 312 Hurricane Lane, Williston

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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: March Meeting Minutes
2	1:05-1:10	Program Updates • Operational Plan Submission • CMMI Site Visit	Georgia Maheras	N	Operational Plan available online at: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/April%202016%20-%20Vermont%20Year%203%20Operational%20Plan%20with%20attachments.pdf
3	1:10-2:20	Shared Savings Programs – Year 1 Analyses	BCBSVT, GMCB, DVHA, ACOs	N	Attachment 3a: Shared Savings Programs: Year 1 Analyses (Slides) Attachment 3b: Vermont Medicaid Shared Savings Program: Analyses of Utilization and Expenditure in the 2014 Performance Year (Report)
4	2:20-2:25	Public Comment	Cathy Fulton, Andrew Garland	N	
5	2:25-2:30	Next Steps and Action Items	Cathy Fulton, Andrew Garland	N	

Attachment 1: March Meeting Minutes

Vermont Health Care Innovation Project

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

Pending Work Group Approval

Date of meeting: Monday, March 21, 2016, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Cathy Fulton called the meeting to order at 1:04pm. A roll call attendance was taken and a quorum was present. Susan Aranoff moved to approve the February 2016 meeting minutes by exception. Rick Dooley seconded. The minutes were approved with five abstentions (Abe Berman, Mike Del Trecco, Joe Halco, Laural Ruggles, Julia Shaw).	
2. Program Updates	Heidi Klein provided an update on the Accountable Communities for Health Peer Learning Lab initiative. • The State put out a call for Vermont communities interested in participating in a peer learning opportunity to continue to explore the Accountable Communities for Health model. This builds on earlier work by the Prevention Institute to develop this model under the supervision of the Population Health Work Group, as well as the Unified Community Collaboratives and other work ongoing in the state. This initiative is not part of the CMS Accountable Health Communities initiative announced this winter. • 10 communities will participate in the Peer Learning Lab, with varied levels of readiness and existing activity. • A contract to design learning activities and support communities is in process, and hopefully will be executed by next meeting. • Staff are currently working on an analysis of participant applications; when the contractor is hired, they will start with a needs assessments. The group discussed the following: • Heidi clarified UCCs are key players in all, though not at the center of all communities' applications. • Heidi noted that dates for learning events are not yet set. • Cathy Fulton noted that this is just a starting place for continued ongoing work. • Key staff working on this initiative have been working closely with staff for the Integrated Communities Care Management Learning Collaborative to ensure coordination and collaboration. The ICCMLC focuses on integrating care for individuals, whereas this initiative focuses on integrating health care systems with an eye	**Staff will distribute a link to the ACH Peer Learning Lab Information Webinar slides.**

Agenda Item	Discussion	Next Steps
	toward prevention and public health. Laural Ruggles noted that in St. Johnsbury, the same organizations are involved in both initiatives, but with different representatives at each – care managers and others who directly care for patients are attending the ICCMLC, whereas CEOs and other high level leaders are participating in the ACH Peer Learning Lab. • There is not currently a payment model change associated with this initiative. This is exploratory work, and may produce financing recommendations (contrasted with payment model changes). • Does the ACH model include services and providers outside of the medical system? Yes. Vermont is significantly ahead of many other states in terms of coordination and integration of health care services – this adds community-wide prevention. • Participants noted that Community Health Team funding continues to be separate from Unified Community Collaborative funds.	
3. OneCare Vermont Red Cap	Miriam Sheehy and Mike DeSarno presented on OneCare Vermont's REDCap initiative. As part of the SSPs, ACOs are required to collect data on a randomized sample of patients. In 2014, initial attempt at data collection did not go smoothly. In 2015, OneCare used a combination of Excel spreadsheets and a HIPAA-compliant web-based data collection tool, REDCap. Miriam and Mike did a walk through of the REDCap system using example data. • Patients are pre-loaded into REDCap, along with basic demographic data and tax ID numbers. • REDCap is a responsive form that reacts to measure exclusions as clinical data is entered. This supports ease of use, data completeness, and integration of this data with a larger dataset. • There is some capacity for transferring XML data from hospitals into the system to avoid manual data entry. OneCare is working with VITL and is hoping to draw clinical data from the VHIE into an analytics system where it would be married to claims data; not yet clear whether or not it would be able to be moved to this system. • Currently, manual data entry is done both by ACO staff and at practices. • Data can be exported in a variety of files to support development of a consolidated dataset. The group discussed the following: • UVMMC analytics department built the survey logic in-house. • This software is free for members of the REDCap Consortium; OneCare uses UVMMC's license. • OneCare had a good experience using this tool in terms of ease and data completeness. Will likely use it again. • OneCare has a meeting with CHAC and Healthfirst to discuss and demonstrate this tool. • OneCare also did a significant amount of work to analyze its process for data abstraction this year, as well as quality improvement systems checks. Data entry is still an error prone area, but drop-downs support higher data quality. • New technologies are getting better at pulling data out of patient records notes for projects like this to reduce the burden on practices and providers. Miriam noted that this is immature technology. Tests at UVMMC have shown this takes as many, if not more, man hours as manual data abstraction. She also noted that OneCare does most data abstraction for practices to ease this burden, but that there is still a burden for OneCare staff to get trained on the practice's EMR.	

<table>
<tr><th>Agenda Item</th><th>Discussion</th><th>Next Steps</th></tr>
<tr><td></td><td>There are very few exceptions that allow for skipping a patient and pulling them from the randomized sample. If there is nothing entered, that counts as a fail. Rick Dooley noted that this is an advantage of practices doing their own abstraction – they know where information gets hidden within their EMR.
Dale Hackett suggested working with the AHEC, which has some tools and support to offer in this area.</td><td></td></tr>
<tr><td>4. Medicaid Pathway</td><td>Michael Costa and Selina Hickman provided an update on the Medicaid Pathway project (Attachment 4).
Big Goal: Integrated Health System to achieve the Triple Aim. All-Payer Model is only part of this; Medicaid Pathway work is pursuing integrated system for services not subject to financial caps – thinking about what the future looks like for services and providers not included in the first phase of the All-Payer Model (~Medicare A and B services).
All-Payer Model is led by AOA and GMCB.
"This is an evolution, not a revolution" – building on existing all-payer reforms (i.e., SSPs, Blueprint).
Working to agree on a "term sheet" with CMMI now; if agreement is reached, the State will seek to enter into a 5-year agreement later this year. Information on the terms and additional details are available on the GMCB website.
This work on payment models will tie to continued work to support practice transformation.
Medicaid Pathway work is led by AHS Central Office.
Ensuring delivery reform doesn't stop for providers not included under APM cap.
Continuous cycle, similar to Plan-Do-Study-Act. Building on SIM stakeholder engagement process.
DVHA has a key role as a payer. The equivalent of Medicare A&B services accounts for ~35% of Medicaid's payments; the other 65% outside of the APM cap. DMH, DAIL, and VDH ADAP services are a large part of this and will be part of the Medicaid Pathway; in addition, there are some TBD programs and services, including DCF Child Development & Family Service programs and VDH Maternal and Child Health programs. In addition, Integrating Family Services is a model we'll continue to expand.
Mental health and substance abuse services are the starting place for this process – the State is working with providers of these services to answer process questions now. A group of DAs, SSAs, preferred providers are meeting with State staff regularly. There will be an implementation proposal by July 2016, and an operational proposal following that. This will require Legislative action for implementation. The VHCIP DLTSS Work Group has also engaged in this same planning process with support from SIM contractors. Looking to engage with other community providers.
Governance: AHS and DVHA are working closely together on this.
The group discussed the following:
Dale Hackett asked how this will impact the Medicare system. Medicare will continue to be administered by the Federal government. This will change how Medicare pays the ACO. There is no comingling of Medicare and Medicaid funds or population.
Mike Hall asked whether services not initially included in the regulated services cap eventually be brought under the cap. This is a possibility; Selina noted this is part of the Medicaid Pathway idea. Mike Hall suggested</td><td>Slide deck will be distributed.</td></tr>
</table>

Agenda Item	Discussion	Next Steps
	development must happen on a parallel track and eventually merge. Michael Costa added that this is evolving over time and will be ongoing. Discussions with the federal government have always focused on eventual integration; however, the State has been careful to stay away from committing to timelines so that we can ensure readiness before additional services are brought under the cap. • Mike Hall asked how the tension between commercial payers, Medicaid, and Medicare – "Medicaid does heavy lifting and Medicare Trust Fund reaps the benefits" – impacts this work, noting that both service/payment reform paths and funding streams need to converge. Non-included services are generally Medicaid-funded and under-resourced, and will need to pull some funds from the regulated services side if they are to be sufficiently resourced and contribute to decreasing costs. Selina noted that this has been part of discussions and negotiations with federal partners. Regulated services are about 7/8ths of Medicare's spending (all but pharmacy), 2/3 of commercial spending, and 1/3 of Medicaid spending. Aligning across payers is a significant lever, especially for services that overlap. Federal partners are very interested in improving payment parity overall for Medicaid, and in including more services in regulated revenue over time. There is no answer at this point in time. • Mark Burke expressed concerns about APM and Medicaid Pathway because it requires a new method of evaluation. In a non-fee for service system, it's challenging to assign value to services since payment is no longer linked to each individual service. There is currently no accounting method in hospitals to do this, and this is a critical business capacity. High-level thinking is good, but the ground-level is still to be developed. Selina pointed out that there is work going on at this level – AHS is working with DAs and other providers to streamline measurement to reflect what the State needs to know to pay for services. There is still process needed at the provider level to develop this area. Alicia Cooper added that Medicaid is building on SIM stakeholder work in the early phases of the SSPs to align measures across payers and beneficiary populations – this will be a starting point, though there may be opportunities to collect information in new and different ways and build on quality improvement. • Andrew Garland expressed admiration for Slide 17, Medicaid Pathway Process. He suggested this should be the process for APM as well. One of his concerns with APM as a payer is that we haven't answered all of these questions yet, as we move quickly toward payment reform. • Andrew Garland noted that there are some things about today's system that is working, though there are some things that are not. He suggested we take care, move to support transformation, and limit backsliding. • Susan Aranoff commented that whether or not the status quo is working, we don't yet know that the ACO model is working. She renewed her request to see the results from Year 1 of the Medicaid SSP. • Dale Hackett noted that from a consumer perspective, he is concerned that the APM excludes too many categories – how will we ensure things get better for consumers? Selina noted this is a key issue, but emphasized that the payment side of reforms should not impact consumers – benefits are not changing.	
5. Public Comment	There was no additional comment.	
6. Next Steps, and Action Items	**Next Meeting:** Monday, April 18, 2016, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston	

VHCIP Payment Model Design and Inplementation Work Group Member List

Sue 1° Rick 2° mtn approve minutes w/ exception - carried 5 Abstentions

Monday, March 21, 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	Stephanie	Breault		Northwestern Medical Center
		Jane	Catton		Northwestern Medical Center
		Diane	Leach		Northwestern Medical Center
		Don	Shook		Northwestern Medical Center
		Lou	Longo		Northwestern Medical Center
Diane	Cummings	Shawn	Skafelstad		AHS - Central Office
Mike	DelTrecco	Jill	Olson	A	Vermont Association of Hospital and Health Systems
Tracy	Dolan	Heidi	Klein		AHS - VDH
		Cindy	Thomas		AHS - VDH
		Julie	Arel		AHS - VDH
Rick	Dooley	Susan	Ridzon		HealthFirst
		Paul	Reiss		HealthFirst
Kim	Fitzgerald	Stefani	Hartsfield		Cathedral Square and SASH Program
		Molly	Dugan		Cathedral Square and SASH Program
Aaron	French	Erin	Carmichael		AHS - DVHA
		Nancy	Hogue		AHS - DVHA
		Megan	Mitchell		AHS - DVHA
Catherine	Fulton				Vermont Program for Quality in Health Care
Peter	Cobb	Beverly	Boget		VNAs of Vermont

VHCIP Payment Model Design and Inplementation Work Group Member List

Monday, March 21, 2016

Member		Member Alternate			
First Name	**Last Name**	**First Name**	**Last Name**	**Minutes**	**Organization**
		Michael	Counter		VNA & Hospice of VT & NH
Steve	Gordon	Mark	Burke ✓		Brattleboro Memorial Hopsital
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
		Angela	Smith-Dieng		V4A
Paul	Harrington ✓				Vermont Medical Society
Karen	Hein				University of Vermont
Bard	Hill ✓	Patricia	Cummings ✓		AHS - DAIL
		Susan	Aranoff ✓		AHS - DAIL
		Gabe	Epstein ✓		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
		Joe	Halco ✓	A	
David	Martini ✓				AOA - DFR
Lou	McLaren ✓				MVP Health Care
MaryKate	Mohlman	Jenney	Samuelson		AHS - DVHA - Blueprint
Ed	Paquin ✓				Disability Rights Vermont
Abe	Berman ✓	Miriam	Sheehey ✓	A	OneCare Vermont

VHCIP Payment Model Design and Inplementation Work Group Member List

Monday, March 21, 2016

Member		Member Alternate			
First Name	**Last Name**	**First Name**	**Last Name**	**Minutes**	**Organization**
		Vicki	Loner		OneCare Vermont
Laural	Ruggles				Northeastern Vermont Regional Hospital
Julia	Shaw	Rachel	Seelig		VLA/Health Care Advocate Project
Lila	Richardson	Kaili	Kuiper		VLA/Health Care Advocate Project
Kate	Simmons	Kendall	West		Bi-State Primary Care/CHAC
		Patricia	Launer		Bi-State Primary Care
		Melissa	Miles		Bi-State Primary Care
		Heather	Skeels		Bi-State Primary Care
Richard	Slusky	Pat	Jones		GMCB
Julie	Tessler				VCP - Vermont Council of Developmental and Mental Health Services
		Sandy	McGuire		VCP - Howard Center
	31		43		

VHCIP Payment Model Design and Inplementation Work Group

Attendance Sheet 3/21/2016

	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	here	SOV Consultant - Bailit-Health Purchasing	X
10	Susan	Barrett		GMCB	X
11	Jaskanwar	Batra		AHS - DMH	MA
12	Abe	Berman	phone	OneCare Vermont	MA
13	Bob	Bick		DA - HowardCenter for Mental Health	X
14	~~Mary Alice~~	~~Bisbee~~		Consumer Representative	X
15	Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DM	X
16	Beverly	Boget		VNAs of Vermont	MA
17	Mary Lou	Bolt		Rutland Regional Medical Center	X
18	Jill Berry	Bowen		Northwestern Medical Center	M
19	Stephanie	Breault	phone	Northwestern Medical Center	MA
20	Martha	Buck		Vermont Association of Hospital and Health	A
21	Mark	Burke		Brattleboro Memorial Hopsital	MA
22	Donna	Burkett		Planned Parenthood of Northern New Engla	X
23	Catherine	Burns		DA - HowardCenter for Mental Health	X
24	Heather	Bushey		Planned Parenthood of Northern New Engla	MA
25	Gisele	Carbonneau		HealthFirst	A
26	Erin	Carmichael	here	AHS - DVHA	MA
27	Jan	Carney		University of Vermont	X
28	Denise	Carpenter		Specialized Community Care	X

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

65	Suratha	Elango		RWJF - Clinical Scholar	X
66	Gabe	Epstein	phone	AHS - DAIL	S/MA
67	Jamie	Fisher		GMCB	A
68	KIm	Fitzgerald		Cathedral Square and SASH Program	M
69	Katie	Fitzpatrick		Bi-State Primary Care	A
70	Patrick	Flood		CHAC	X
71	Erin	Flynn		AHS - DVHA	S
72	LaRae	Francis		Blue Cross Blue Shield of Vermont	X
73	Judith	Franz		VITL	X
74	Mary	Fredette		The Gathering Place	X
75	Aaron	French		AHS - DVHA	M
76	Catherine	Fulton	here	Vermont Program for Quality in Health Care	C
77	Joyce	Gallimore		Bi-State Primary Care/CHAC	X
78	Lucie	Garand		Downs Rachlin Martin PLLC	X
79	Andrew	Garland	here	MVP Health Care	M
80	Christine	Geiler		GMCB	S
81	Carrie	Germaine		AHS - DVHA	X
82	Al	Gobeille		GMCB	X
83	Steve	Gordon		Brattleboro Memorial Hopsital	M
84	Don	Grabowski		The Health Center	X
85	Maura	Graff	here	Planned Parenthood of Northern New Engla	M
86	Wendy	Grant		Blue Cross Blue Shield of Vermont	A
87	~~Bea~~	~~Grause~~		Vermont Association of Hospital and Health	MA
88	Lynn	Guillett		Dartmouth Hitchcock	X
89	Dale	Hackett	here	Consumer Representative	M
90	Mike	Hall	here	Champlain Valley Area Agency on Aging / C	M
91	Paul	Harrington	phone	Vermont Medical Society	M
92	Stefani	Hartsfield	here	Cathedral Square	MA
93	Carrie	Hathaway		AHS - DVHA	X
94	Carolynn	Hatin		AHS - Central Office - IFS	S
95	Karen	Hein		University of Vermont	M
96	Kathleen	Hentcy		AHS - DMH	MA
97	Jim	Hester		SOV Consultant	S
98	Selina	Hickman	here	AHS - DVHA	X
99	Bard	Hill	phone	AHS - DAIL	M
100	Con	Hogan		GMCB	X

101	Nancy	Hogue		AHS - DVHA	M
102	Jeanne	Hutchins		UVM Center on Aging	M
103	Penrose	Jackson		UVM Medical Center	X
104	Craig	Jones		AHS - DVHA - Blueprint	X
105	Pat	Jones		GMCB	MA
106	Margaret	Joyal		Washington County Mental Health Services	X
107	Joelle	Judge	here	UMASS	S
108	Kevin	Kelley		CHSLV	X
109	Melissa	Kelly		MVP Health Care	X
110	Trinka	Kerr		VLA/Health Care Advocate Project	X
111	Sarah	King		Rutland Area Visiting Nurse Association & H	X
112	Sarah	Kinsler	here	AHS - DVHA	S
113	Heidi	Klein	here	AHS - VDH	MA
114	Tony	Kramer		AHS - DVHA	X
115	Kaili	Kuiper		VLA/Health Care Advocate Project	MA
116	Norma	LaBounty		OneCare Vermont	A
117	Kelly	Lange		Blue Cross Blue Shield of Vermont	M
118	Dion	LaShay		Consumer Representative	X
119	Patricia	Launer		Bi-State Primary Care	MA
120	Diane	Leach		Northwestern Medical Center	MA
121	Mark	Levine		University of Vermont	X
122	Lyne	Limoges		Orleans/Essex VNA and Hospice, Inc.	X
123	Deborah	Lisi-Baker		SOV - Consultant	X
124	Sam	Liss		Statewide Independent Living Council	X
125	Vicki	Loner		OneCare Vermont	MA
126	Lou	Longo		Northwestern Medical Center	MA
127	Nicole	Lukas		AHS - VDH	X
128	Ted	Mable		DA - Northwest Counseling and Support Ser	M
129	Carole	Magoffin	here	AHS - DVHA	S
130	Georgia	Maheras	phone	AOA	S
131	Jackie	Majoros		VLA/LTC Ombudsman Project	X
132	Carol	Maloney		AHS	X
133	Carol	Maroni		Community Health Services of Lamoille Vall	X
134	David	Martini	here	AOA - DFR	M
135	John	Matulis			X
136	James	Mauro		Blue Cross Blue Shield of Vermont	X

137	Lisa	Maynes		Vermont Family Network	X
138	Kim	McClellan		DA - Northwest Counseling and Support Ser	MA
139	Sandy	McGuire		VCP - HowardCenter for Mental Health	M
140	Jill	McKenzie			X
141	Lou	McLaren	here	MVP Health Care	M
142	Darcy	McPherson		AHS - DVHA	X
143	Anneke	Merritt		Northwestern Medical Center	X
144	Melissa	Miles		Bi-State Primary Care	MA
145	Robin	Miller		AHS - VDH	X
146	Megan	Mitchell	here	AHS - DVHA	MA
147	MaryKate	Mohlman		AHS - DVHA - Blueprint	M
148	Madeleine	Mongan		Vermont Medical Society	X
149	Kirsten	Murphy		AHS - Central Office - DDC	X
150	Chuck	Myers		Northeast Family Institute	X
151	Floyd	Nease		AHS - Central Office	X
152	Nick	Nichols		AHS - DMH	X
153	Mike	Nix		Jeffords Institute for Quality, FAHC	X
154	Miki	Olszewski		AHS - DVHA - Blueprint	X
155	Jessica	Oski		Vermont Chiropractic Association	X
156	Ed	Paquin	here	Disability Rights Vermont	M
157	Annie	Paumgarten	here	GMCB	S
158	Laura	Pelosi		Vermont Health Care Association	X
159	Eileen	Peltier		Central Vermont Community Land Trust	X
160	John	Pierce			X
161	Tom	Pitts		Northern Counties Health Care	X
162	Joshua	Plavin		Blue Cross Blue Shield of Vermont	X
163	Luann	Poirer		AHS - DVHA	S
164	Sherry	Pontbriand		NMC	X
165	Alex	Potter		Center for Health and Learning	X
166	~~Amy~~	~~Putnam~~		DA - Northwest Counseling and Support Ser	MA
167	Betty	Rambur		GMCB	X
168	Allan	Ramsay		GMCB	X
169	Frank	Reed		AHS - DMH	MA
170	Paul	Reiss		HealthFirst/Accountable Care Coalition of tl	MA
171	Sarah	Relk			X
172	Virginia	Renfrew		Zatz & Renfrew Consulting	X

173	Lila	Richardson	phone	VLA/Health Care Advocate Project	M
174	Susan	Ridzon		HealthFirst	MA
175	Carley	Riley			X
176	Laurie	Riley-Hayes		OneCare Vermont	A
177	Brita	Roy			X
178	Laural	Ruggles	phone	Northeastern Vermont Regional Hospital	M
179	Jenney	Samuelson		AHS - DVHA - Blueprint	MA
180	Howard	Schapiro		University of Vermont Medical Group Pract	X
181	seashre@msn	seashre@msn.com		House Health Committee	X
182	Rachel	Seelig		VLA/Senior Citizens Law Project	MA
183	Susan	Shane		OneCare Vermont	X
184	Julia	Shaw	phone	VLA/Health Care Advocate Project	M
185	Melanie	Sheehan		Mt. Ascutney Hospital and Health Center	X
186	Miriam	Sheehey	here	OneCare Vermont	MA
187	Don	Shook		Northwestern Medical Center	MA
188	Kate	Simmons	phone	Bi-State Primary Care/CHAC	M
189	Colleen	Sinon		Northeastern Vermont Regional Hospital	X
190	Shawn	Skafelstad	phone	AHS - Central Office	MA
191	Heather	Skeels		Bi-State Primary Care	MA
192	Richard	Slusky	here	GMCB	M
193	Chris	Smith		MVP Health Care	X
194	Angela	Smith-Dieng		V4A	MA
195	Jeremy	Ste. Marie		Vermont Chiropractic Association	X
196	Holly	Stone		UMASS	S
197	Jennifer	Stratton		Lamoille County Mental Health Services	X
198	Beth	Tanzman		AHS - DVHA - Blueprint	X
199	JoEllen	Tarallo-Falk		Center for Health and Learning	X
200	Julie	Tessler		VCP - Vermont Council of Developmental ar	M
201	Cindy	Thomas		AHS - VDH	MA
202	Shannon	Thompson	phone	AHS - DMH	MA
203	Bob	Thorn		DA - Counseling Services of Addison County	X
204	Win	Turner			X
205	Karen	Vastine		AHS-DCF	X
206	Teresa	Voci		Blue Cross Blue Shield of Vermont	MA
207	Nathaniel	Waite		VDH	X
208	Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	X

209	Marlys	Waller		DA - Vermont Council of Developmental an	X
210	Nancy	Warner		COVE	X
211	Julie	Wasserman	here	AHS - Central Office	S
212	Monica	Weeber		AHS - DOC	X
213	Kendall	West		Bi-State Primary Care/CHAC	MA
214	James	Westrich	here	AHS - DVHA	S
215	Robert	Wheeler		Blue Cross Blue Shield of Vermont	X
216	Jason	Williams		UVM Medical Center	X
217	Sharon	Winn		Bi-State Primary Care	X
218	Stephanie	Winters		Vermont Medical Society	X
219	Hillary	Wolfley			X
220	Mary	Woodruff			X
221	Erin	Zink		MVP Health Care	X
222	Marie	Zura		DA - HowardCenter for Mental Health	X
					222

Mike DeSarno - OneCare VT

Michael Costa - AoA

Attachment 3a: Shared Savings Programs: Year 1 Analyses (Slides)

Vermont's Shared Savings Programs – Year 1 (2014) Analyses

VHCIP Payment Model Design and Implementation Work Group

May 16, 2016

Vermont Health Care Innovation Project

Vermont Commercial ACO Shared Savings Programs — Year 1 Update

Kelly Lange, BCBSVT

May 16, 2016

Financial Summary Aggregated Results

- Commercial 2014

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

*If shared savings had been earned

VERMONT
GREEN MOUNTAIN CARE BOARD

Financial Summary PMPM Results

- Commercial 2014

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

*If shared savings had been earned

VERMONT GREEN MOUNTAIN CARE BOARD

2014 Quality Results: Commercial Payment Measures

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

*Maximum points per measure = 3

Impact on Payment
(if there had been Shared Savings)

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

2014 Commercial Payment Measures: Strengths and Opportunities

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

2014 Commercial Reporting Measures

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

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2014 Commercial Reporting Measures: Strengths and Opportunities

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

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GREEN MOUNTAIN CARE BOARD
9

Vermont's Medicaid Shared Savings Program: 2014 Analyses

Payment Model Design and Implementation Work Group

May 16, 2016

Vermont Health Care Innovation Project

Medicaid Shared Savings Program

- 2014 Results

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

VMSSP Analyses

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

Vermont Health Care Innovation Project

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 and 2014

	2012	2014
Attributed to OneCare Vermont	27,662	37,929
Attributed to CHAC	21,080	26,587
Eligible for Attribution (but *not* attributed to an ACO)	32,445	39,472
TOTAL ELIGIBLE FOR ATTRIBUTION	**81,187**	**103,988**

- 2014 Medicaid Expansion increased the number of lives eligible for attribution

Unique Population Segments

	2012		2014	
	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

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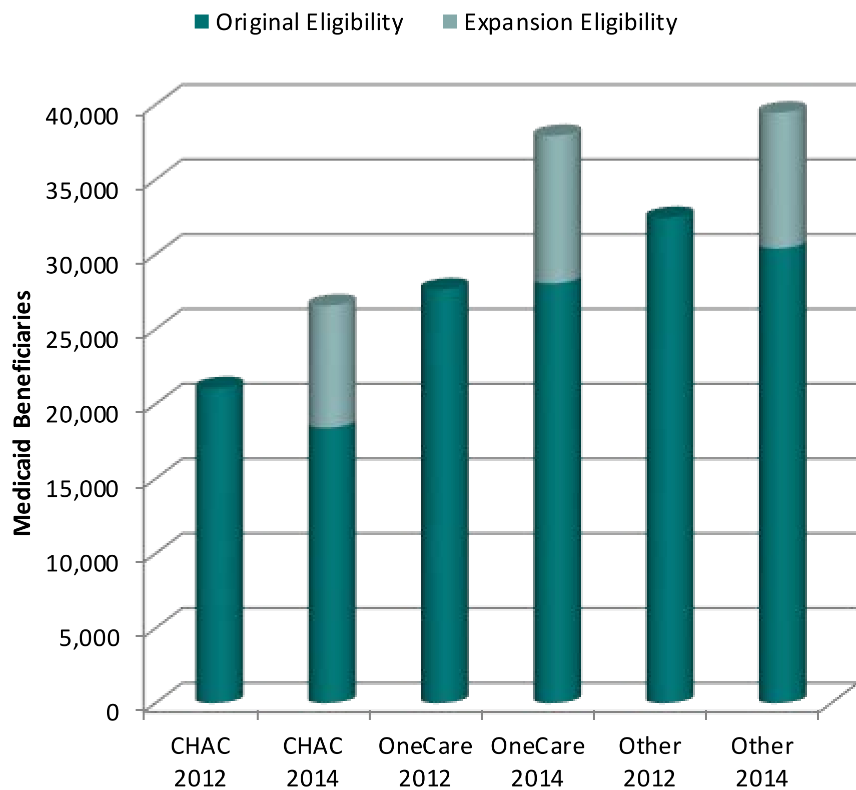
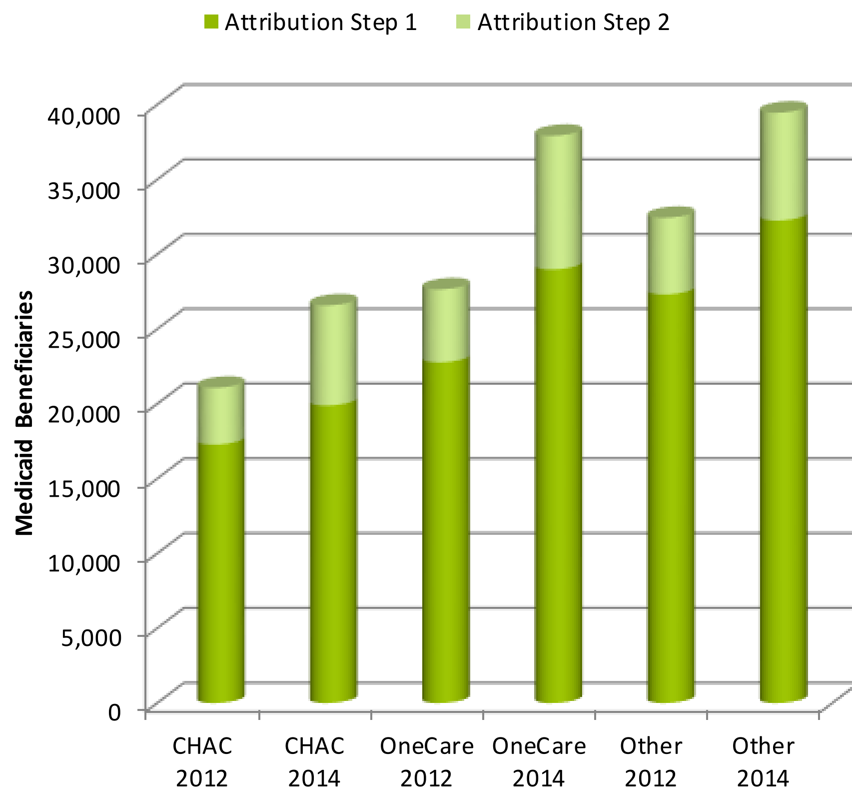
Population Changes from 2012 to 2014

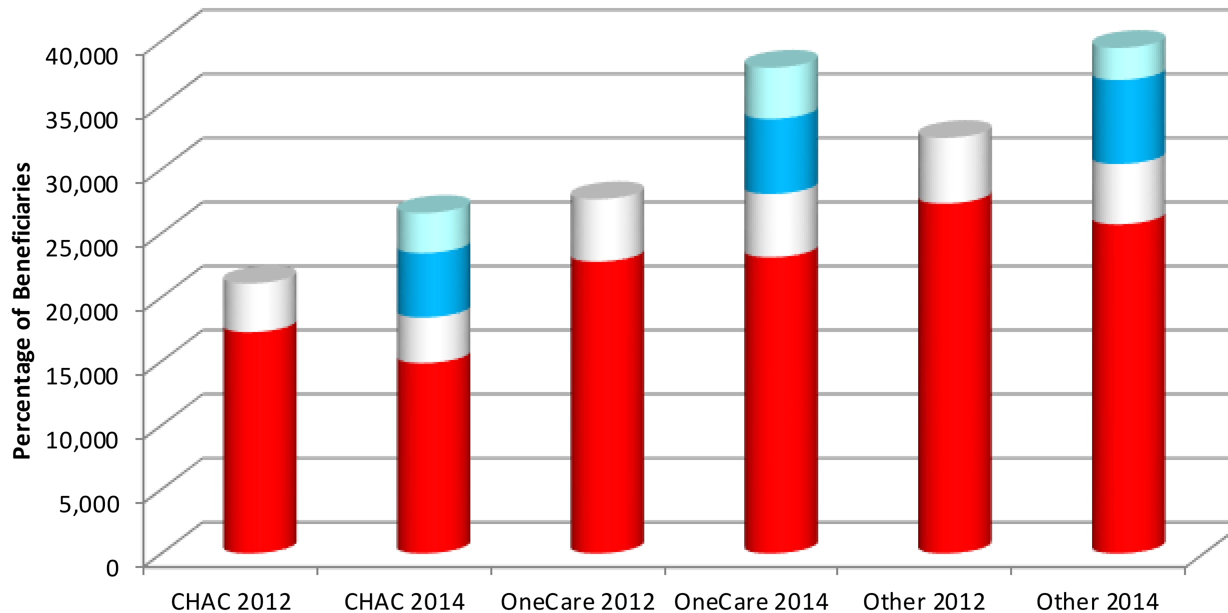




Vermont Health Care Innovation Project

Expenditure Across Population Segments

	2012		2014	
	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

Eligibility: Original vs. Expansion	2012		2014	
	Attribution Steps: Step 1 vs. Step 2		Attribution Steps: Step 1 vs. Step 2	
	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

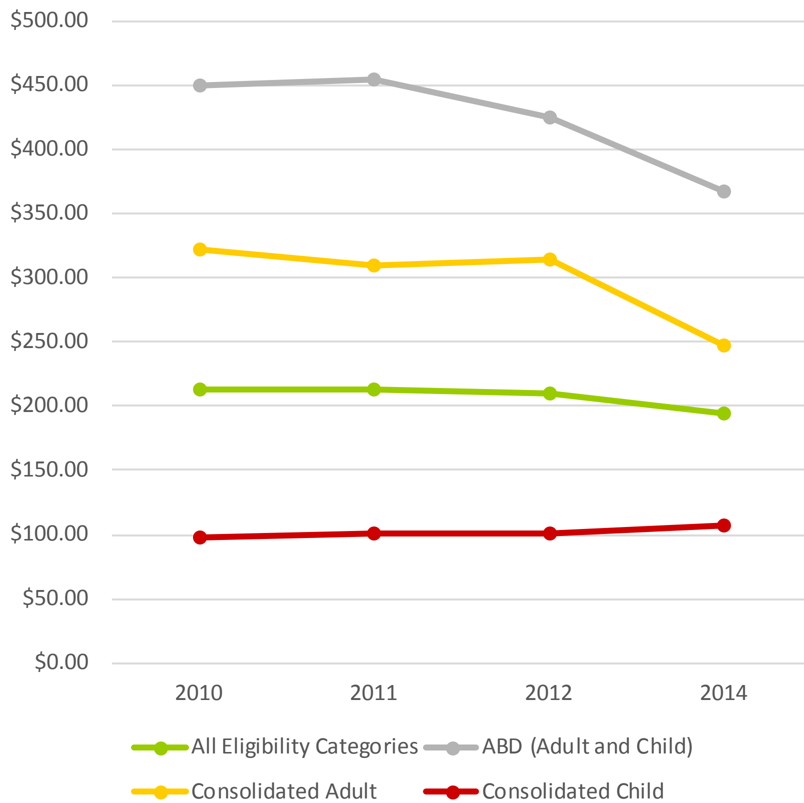
	Cost per Member Year					
	2012		2014			
	Step 1 Attributed; Original Eligibility	Step 2 Attributed; Original Eligibility	Step 1 Attributed; Original Eligibility	Step 1 Attributed; Expansion Eligibility	Step 2 Attributed; Original Eligibility	Step 2 Attributed; Expansion Eligibility
CHAC	$ 3,136	$ 1,021	$ 3,008	$ 3,824	$ 801	$ 505
OneCare	$ 2,679	$ 1,072	$ 2,524	$ 3,663	$ 866	$ 471
Other	$ 2,455	$ 837	$ 2,187	$ 3,263	$ 679	$ 582

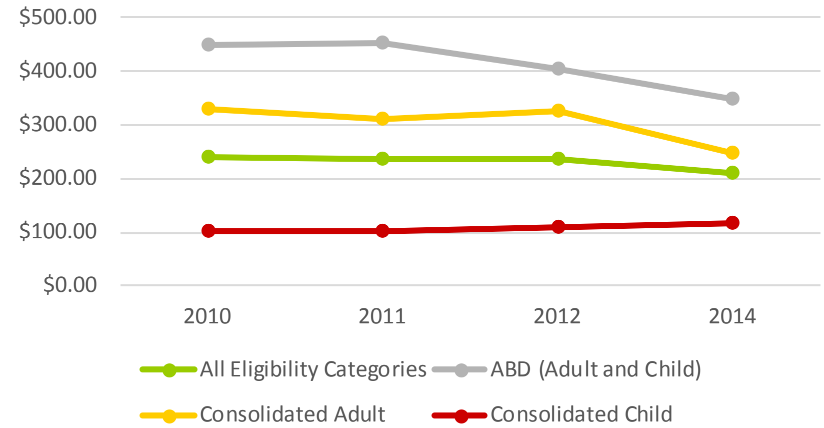
Vermont Health Care Innovation Project

VMSSP Eligibility Categories

- Consolidated Adult
- Consolidated Child
- Aged/Blind/Disabled Adult & Child

Expenditure by Eligibility Category





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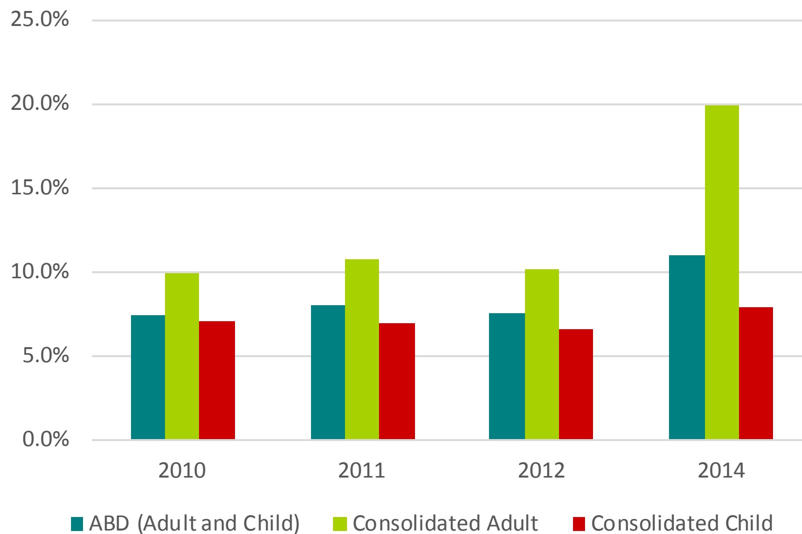
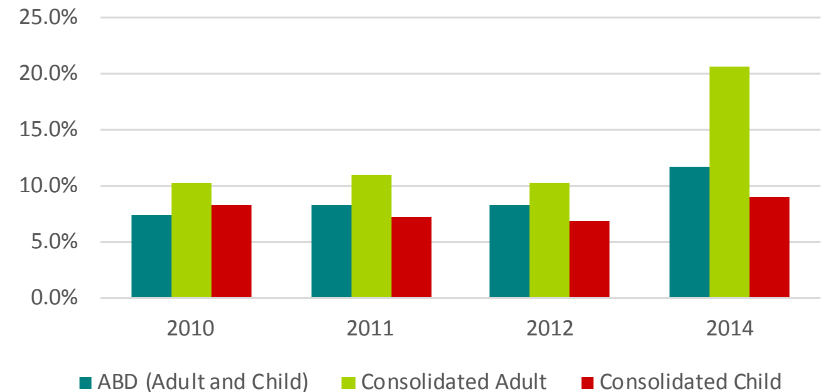
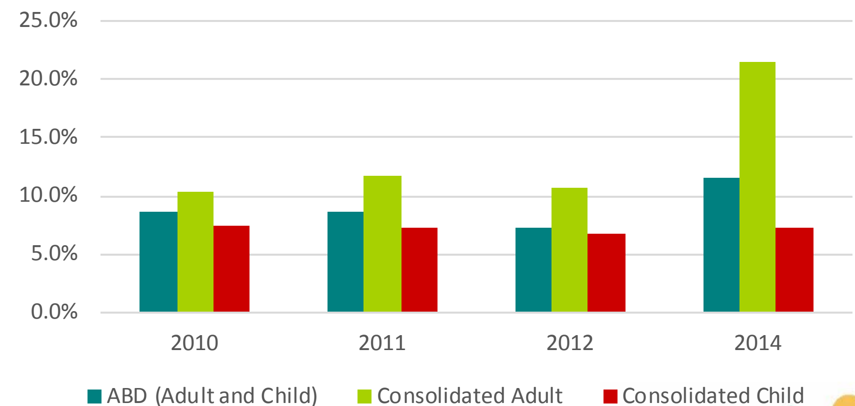
Attributed Lives without TCOC Expenditure







Vermont Health Care Innovation Project

Expenditure by Category of Service

	2012			2014		
	CHAC	OneCare	Statewide	CHAC	OneCare	Statewide
Inpatient	26.8%	26.4%	25.8%	28.9%	27.8%	27.1%
Outpatient	27.8%	29.4%	28.1%	26.3%	27.7%	26.9%
Physician	16.8%	27.9%	24.5%	15.1%	26.2%	22.9%
Federally Qualified Health Center	15.3%	0.6%	6.0%	15.4%	0.2%	6.0%
Psychologist	5.1%	6.2%	5.7%	5.6%	7.6%	6.8%

Expenditure for non-TCOC Services

Non-TCOC (Excluding Pharmacy) Expenditure per Member Year			
	2012	**2014**	**% Change**
CHAC	$2,286	$2,113	-7.6%
OneCare	$2,247	$2,159	-3.9%
Other	$2,169	$1,955	-9.8%

Pharmacy Expenditure per Member Year			
	2012	**2014**	**% Change**
CHAC	$90.44	$86.81	-4.0%
OneCare	$91.41	$92.36	1.0%
Other	$87.94	$80.73	-8.2%

VMSSP Summary

- An influx of beneficiaries newly eligible for Medicaid and a greater proportion of low-utilizing beneficiaries impacted the average cost of care per member in 2014 relative to baseline
- Decreases in utilization across a variety of service categories also contributed to lower per member spending in 2014 relative to baseline
- Such trends will be analyzed following years 2 and 3 of the VMSSP
  - Additional data is needed to understand the impact of this model

Vermont Health Care Innovation Project

2014 Medicaid Payment Measures

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

*Maximum points per measure = 3

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

Vermont Health Care Innovation Project

Impact on Payment

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

2014 Medicaid Payment Measures: Strengths and Opportunities

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

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

2014 Medicaid Reporting Measures

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

2014 Medicaid Reporting Measures: Strengths and Opportunities

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

Examples: ACO Clinical Quality Improvement Efforts in Year 1

Community
Health Accountable Care LLC
Transitioning Our Communities for Better Health

CY14 and CY15: Clinical Quality Initiatives

2014

- Initiate & Empower CHAC Clinical Committee
- Develop 2014 Evidence Based Guidelines
  - COPD, CHF, Diabetes, Falls
- Engage Community Partners
- Utilize Blueprint Practice Profiles to ID best practices

2015

- Link Clinical Committee w/ Operations Staff > PDSAs
- Implement 2014 Guidelines
- Develop 2015 Guidelines:
  - Depression Screening & Tx
- Articulate "10 Points"
- Launch "Data Road Show"
- Launch Remote Monitoring Initiative

Community Health Accountable Care LLC
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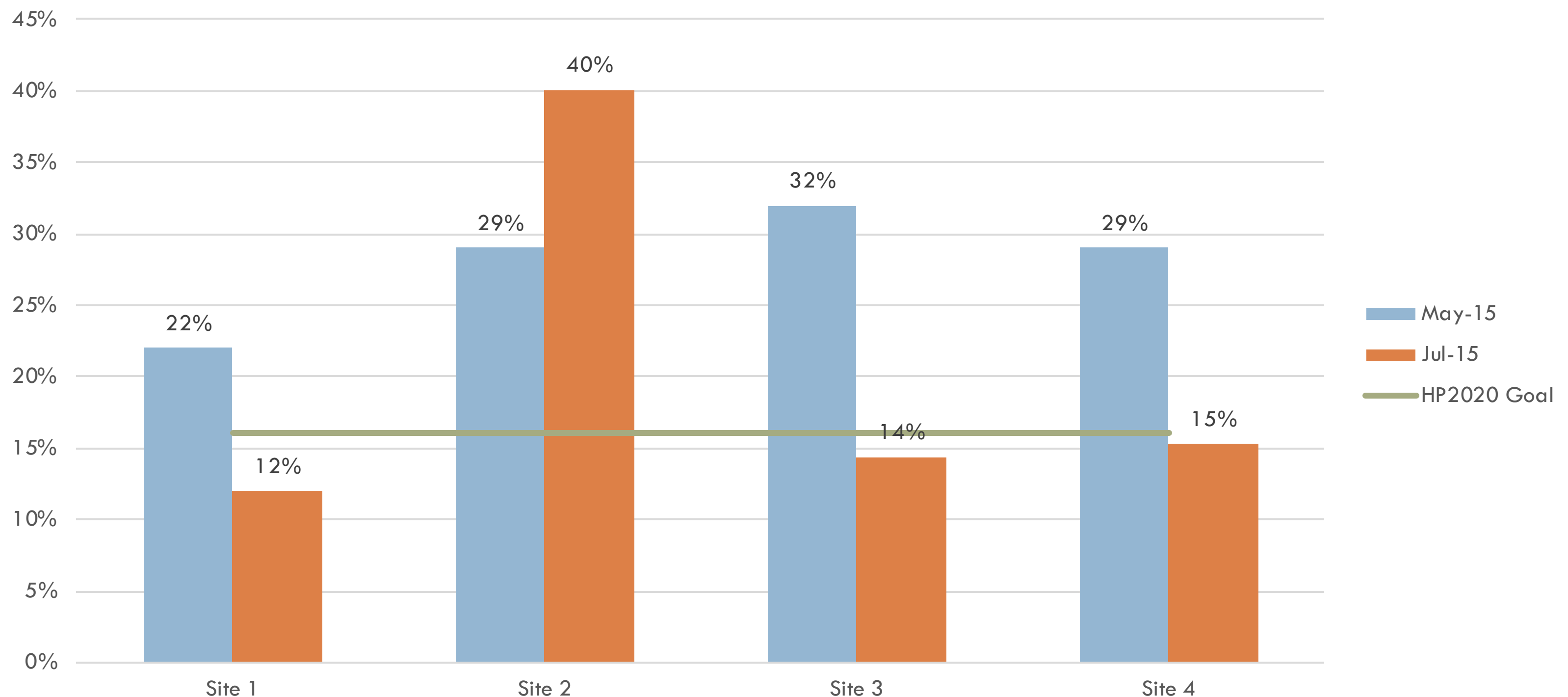
CY14 and CY15: QI at the Practices

- For example, one FQHC completed a PDSA cycle in July 2015 aimed at improving the number of diabetic patients identified as being in poor control (recent A1c>9 or no test within the past year). Significant improvement was made at most practice sites.



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CY14 and CY15: Clinical Quality Improvement

- CHAC QI efforts are resulting in improvements on clinical quality scores.
- Staff are currently analyzing data to determine root of improvements.

CHAC	2014	2015	Improved?
Adult BMI	55.9%	73.7%	Y
Child BMI	42.3%	53.5%	Y
Diabetes Poor Control	20.8%	18.8%	Y
Depression Screening	37.2%	49.8%	Y
Tobacco Screening	69.8%	88.4%	Y
Colorectal Cx Screen	62.8%	65.2%	Y

Table combines Medicare, Medicaid, and Commercial samples, where possible.
Diabetes Poor Control is an inverse measure.

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Ten Critical Points to Transform Vermont's Health System

Bi-State Primary Care Association
30 Years
Serving Vermont & New Hampshire
Improving Access to Primary Health Care for 30 Years
www.bistatepca.org

Vermont's federally qualified health centers (FQHCs) recognize and value the work of the past year on payment reform. However, Vermonters will be healthier and better off only if the system transforms to address social determinants as a priority, commits to comprehensive primary care, invests in strong community-based care systems, and builds capacity to accomplish these goals.

A successfully transformed health system has the following characteristics:

1. Primary care practices are strong and well-supported patient-centered medical homes, with the resources they need to prevent chronic disease, promote wellness, and manage patient care outside the hospital setting.
2. Primary care practitioners have the time they need to address the issues underlying chronic disease and mental health and the resources to maximize primary care practitioner time in direct patient care.
3. Mental health, behavioral health, and primary care work together to provide seamless care to patients.
4. Home health services and primary care practices work together to provide seamless care to patients, and home health is available without regard to Medicare or Medicaid legacy rules around coverage for home health services.
5. Community-based social service agencies are fully-integrated or tightly coordinated with primary care practices, including:
    - Area Agencies on Aging who serve as the eyes and ears of the system, working to keep vulnerable elders housed and out of impoverished living conditions.
    - Mental Health Centers who offer integrated services and supports to Vermonters affected by developmental disabilities, mental health conditions and substance use disorders.
    - The Vermont Food Bank and local food shelves with a pulse on food insecurity in the community, working to feed low-income and underserved Vermonters.
    - Parent Child Centers, shaping solutions to meet the needs of working families.
6. Primary care practices work with community partners to offer a "health coach" option to help patients in making better health decisions and following a healthy lifestyle.
7. Communities integrate wellness-initiatives with schools, employers, community centers, etc.; i.e. meet people where they are.
8. Hospitals are stable and positioned to meet the acute inpatient and outpatient needs of the community, and participate as equals in the delivery system.
9. Systems of care are focused on the local and regional levels, with resources deployed efficiently to meet the needs of the community, and with local strategic and project plans that roll up to a statewide plan.
10. Vermont's Blueprint team retains independence and neutrality to lead the transformation effort, using community collaboration boards (e.g. Blueprint UCCs) with broad community representation to shape and drive the transformation at the local level.

For more information, contact Sharon Winn, Esq., MPH, Director of Vermont Public Policy, Bi-State, (802) 229-0002 or swinn@bistatepca.org.

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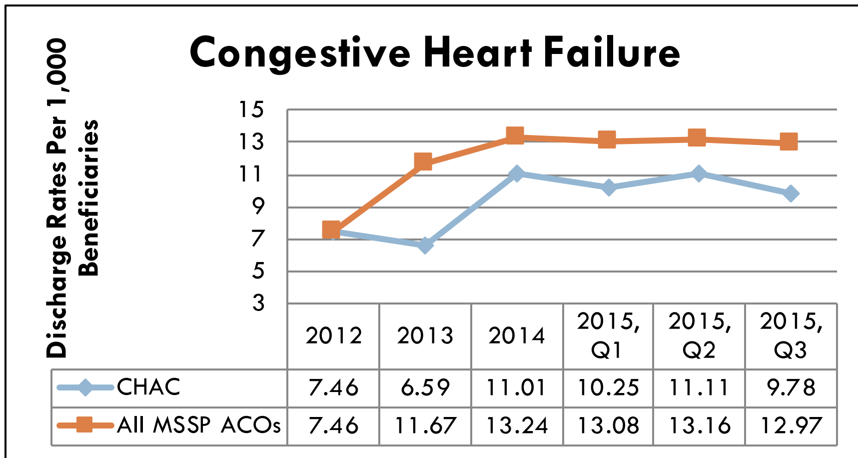
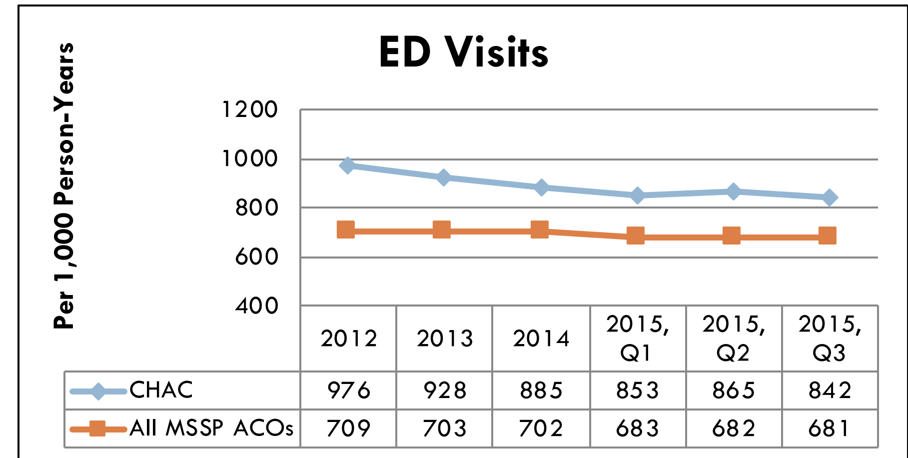
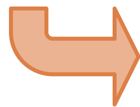
CY15: Utilizing Data to Identify Opportunities



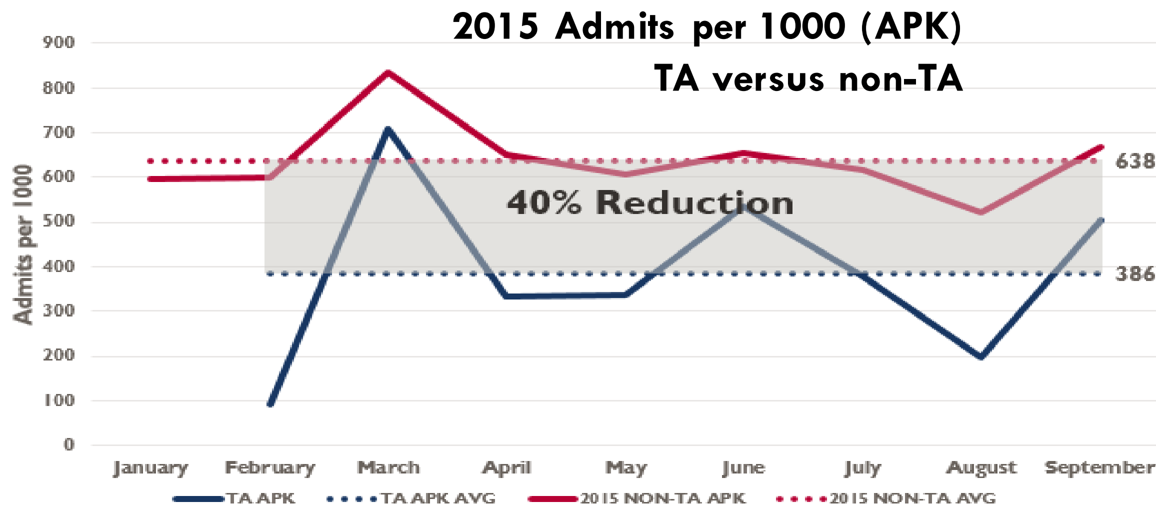
	2012	2013	2014	2015, Q1	2015, Q2	2015, Q3
CHAC	7.46	6.59	11.01	10.25	11.11	9.78
All MSSP ACOs	7.46	11.67	13.24	13.08	13.16	12.97



	2012	2013	2014	2015, Q1	2015, Q2	2015, Q3
CHAC	976	928	885	853	865	842
All MSSP ACOs	709	703	702	683	682	681



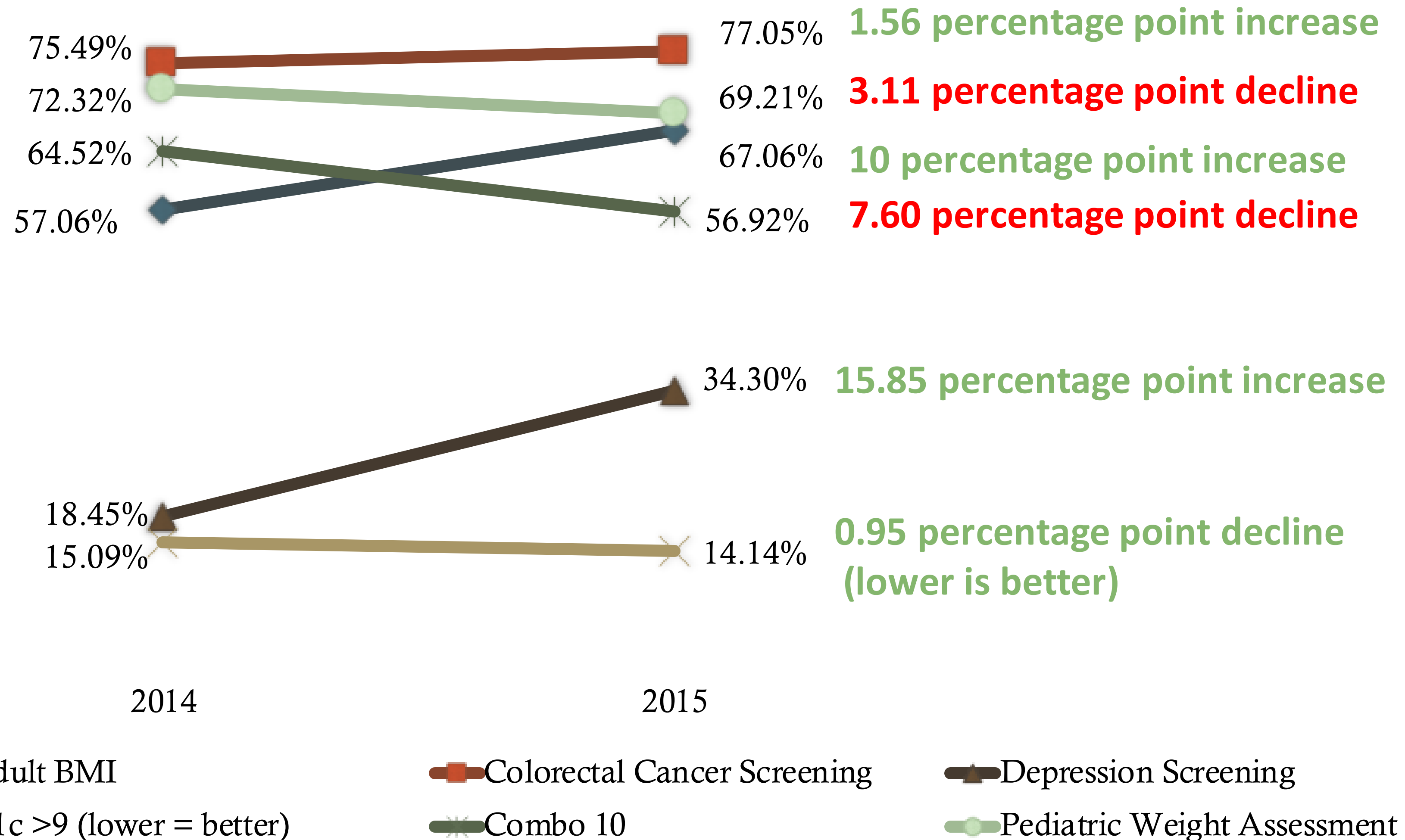
Remote Monitoring Intervention for MSSP patients with COPD, CHF, and Diabetes!



HealthFirst Network ACO Performance

Summary of Performance for Clinical Data Abstraction Measures

Improvement in 4 of 6 Measures from 2014 to 2015



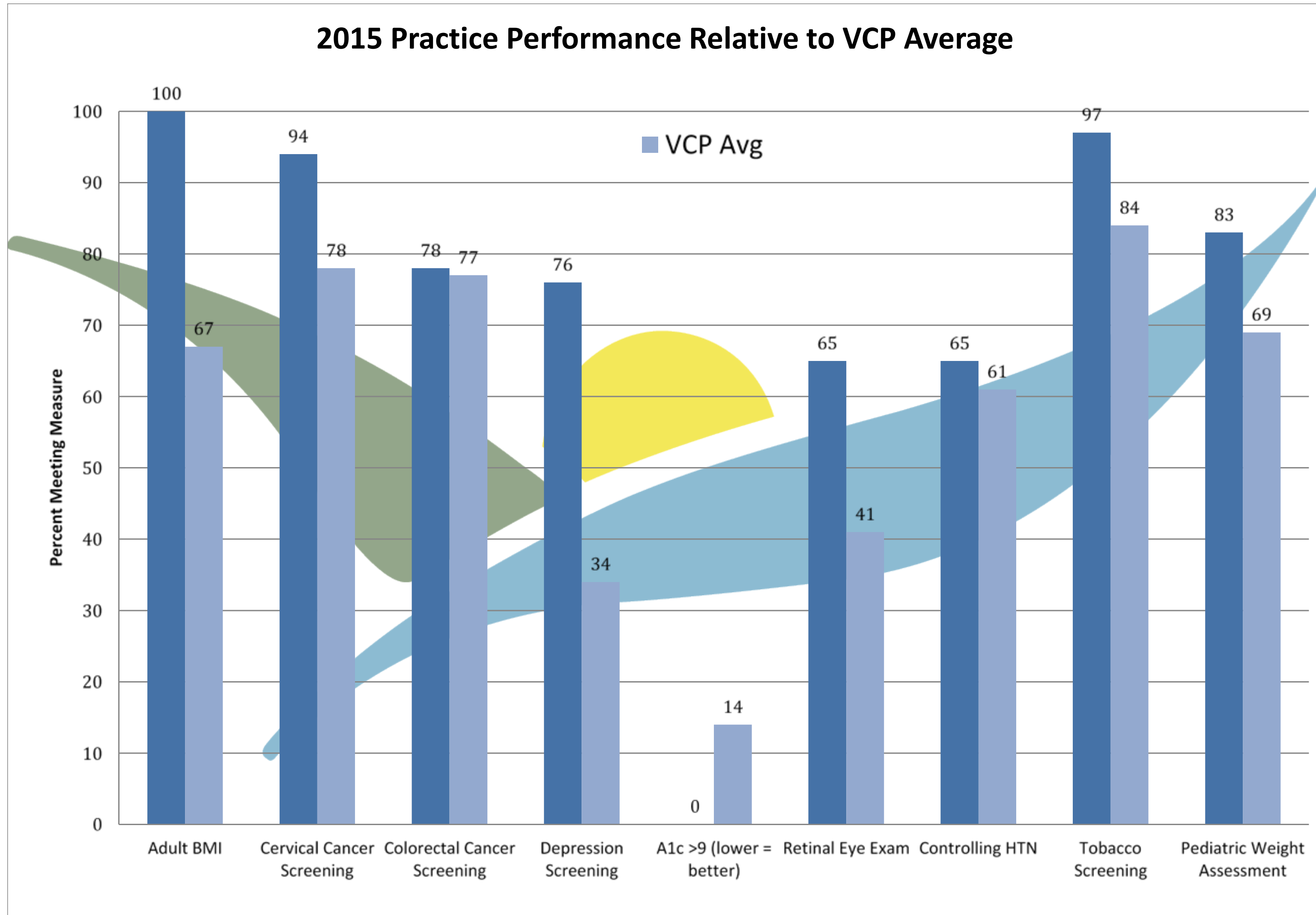
Four of Seven Measures Above 75th National Benchmark

Measure	2014 Percentage	2015 Percentage	2015 HEDIS National Benchmark 25%	50%	75%	90%
Immunizations - Combo 10	**74.19%**	**56.92%**	37.67	45.96	52.61	59.49
Pediatric Weight Assessment	**71.37%**	**69.21%**	6.41	47.41	59.46	69.30
Hemoglobin A1c >9%	**12.26%**	**14.14%**	41.36	35.60	29.93	25.29
Colorectal cancer screening	**76.61%**	**77.05%**	53.59	57.73	61.45	66.84
Depression screening	**19.35%**	**34.30%**	No Benchmark Available			
Adult BMI assessment	**59.68%**	**67.06%**	No Benchmark Available			
Cervical cancer screening		**76.21%**	69.91	73.84	77.84	80.82
Tobacco use/counseling		**83.87%**	No Benchmark Available			
Hypertension screening		**61.29%**	52.61	58.38	62.77	67.25
Diabetes retinal eye exam		**42.34%**	42.06	48.02	53.54	61.37

Sample Practice Report Card

↑ Improvement from 2014 ↓ Worse than 2014 ⊙ No change from 2014 -- Not measured in 2014	Your Practice 2015 (numerator/denominator)		Your Practice 2014	VCP Average 2015	HEDIS National 90th Percentile
Adult BMI	100 (28/28)	↑	78 (18/23)	67	N/A
Cervical Cancer Screening	94 (29/31)	--	--	78	81
Colorectal Cancer Screening	78 (21/27)	↓	96 (26/27)	77	67
Depression Screening & Follow up Counseling	76 (16/21)	↓	94 (17/18)	34	N/A
Diabetes Care: A1c >9 (lower rates better)	0 (0/20)	⊙	0 (0/9)	14	25
Diabetes Care: Retinal Eye Exam	65 (13/20)	--	--	41	61
Controlling HTN (<140/90)	65 (15/23)	--	--	61	N/A
Tobacco Screening & Cessation Counseling	97 (29/30)	--	--	84	N/A
Pediatric Weight Assessment & Nutrition/Exercise Counseling	83 (5/6)	↑	50 (2/4)	69	69

Sample Practice Report Card (page 2)



Strategies for Quality Improvement:

1. Overall network performance for quality measures and utilization is aggregated from Blueprint Practice Profiles, and presented to the HealthFirst Quality Improvement/Care Coordination (QICC) Committee.
2. Quality Manager reviews the individual Practice Report Card with each practice.
3. High-performing practices are identified and workflows shared with lower-performing practices.
4. Clinical Priorities are identified by HealthFirst QICC Committee

Limitations:

1. Claims-based data is not available until late in the year (August), making it difficult to adjust practice patterns and influence change in the current year.
2. Data abstraction from charts is time consuming, labor intensive, and partially subjective depending on documentation habits.

Attachment 3b: Vermont Medicaid Shared Savings Program: Analyses of Utilization and Expenditure in the 2014 Performance Year (Report)

Vermont Medicaid Shared Savings Program:
Analyses of Utilization and Expenditure in the 2014 Performance Year

Overview

The Vermont Medicaid Shared Savings Program (VMSSP) is a three-year (2014-2016) payment model being implemented by the Department of Vermont Health Access (DVHA) in partnership with two participating Accountable Care Organizations (ACOs): OneCare Vermont and Community Health Accountable Care (CHAC). Among the primary objectives of this model is to address the Triple Aim of improving health, improving quality of care, and reducing health care costs for Vermonters. In a shared savings program, an ACO provider network assumes accountability for the total costs and quality of care for a defined group of attributed beneficiaries and for a specific set of covered services. If the ACO is able to reduce expenditure for that population relative to what would have been expected (while meeting pre-defined quality of care targets), the ACO is eligible to share in a portion of the savings accrued during a performance year.

The financial methodology employed by the Vermont Medicaid Shared Savings Program has been certified by an independent actuary, and has been approved by the Centers for Medicare and Medicaid Services (CMS) for incorporation into Vermont's Medicaid State Plan. An independent analytics firm, The Lewin Group, has been contracted to conduct all year-end financial reconciliations on behalf of DVHA and the participating ACOs.

Following the conclusion of the 2014 performance year, The Lewin Group compared actual 2014 per member per month (PMPM) expenditure for ACO-attributed lives and services to the expected 2014 PMPM expenditure (Table 1). This comparison revealed that both ACOs realized lower-than-expected expenditure for their attributed populations of Medicaid members. As a result, both ACOs were eligible to share in a portion of the savings.

Table 1. Vermont Medicaid Shared Savings Program Results, 2014 Performance Year

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

Since the completion of The Lewin Group's final 2014 calculations, further analyses of Medicaid claims data have been conducted to allow for additional understanding of the various factors influencing the Year 1 results. In particular, analyses were focused on:

- understanding differences in unique segments of the ACO-attributed population; and
- exploring utilization and expenditure trends across attribution categories and overall categories of service.

Data for Analyses

Analyses were conducted using comprehensive Vermont Medicaid claims data spanning 4 years and 7 months (from Jan 1, 2011 through August 1, 2015). Claims data used in these analyses were supplemented by provider information (including provider specialty data) available from the Medicaid Management Information System (MMIS).

Using data on Medicaid eligibility and service utilization, the Vermont Medicaid Shared Savings Program attribution methodology was applied to compile datasets of Medicaid members that were eligible for ACO attribution in the 2014 performance year, and members that would have been considered eligible for attribution during comparative baseline years (2011-2013) had the Vermont Medicaid Shared Savings Program been operational at that time.

Each member identified as eligible for attribution in either the 2014 performance year or in the baseline years was assigned to one of three categories to indicate ACO attribution: **CHAC**, **OneCare**, or **Other** ("Other" denotes Medicaid members considered eligible for attribution who were not otherwise attributed to CHAC or OneCare). Data sets also included information about each member's Medicaid eligibility status, Medicaid eligibility category (and whether eligibility was a result of 2014 Medicaid expansion), and whether the member was attributed based on utilization or primary care provider (PCP) of record (Step 1 or Step 2, respectively). Additionally, a claims history for all members who were eligible for attribution in either 2014 or the baseline period was extracted from all DVHA claims with Dates of Service from January 1, 2011 through December 31, 2014.

Analyses excluded any members who were not considered eligible for attribution to an ACO (e.g. members with Medicare or other commercial insurance coverage, members with fewer than 10 months of Medicaid eligibility in a 12-month performance period, and members with limited Medicaid benefits packages).

Analysis I: Vermont Medicaid Shared Savings Program Attribution Methodology, 2014 Medicaid Expansion, and Impact on Per Member Expenditure

The Vermont Medicaid Shared Savings Program employs a two-step methodology to attribute beneficiaries to a participating ACO. **Step 1**, using Medicaid claims data, attributes beneficiaries based on where they received the majority of their primary care services during the performance year. For those beneficiaries who do not have claims for primary care services in the performance year, **Step 2** attributes them based on their self-selected or auto-assigned primary care provider (PCP) as documented in Medicaid eligibility records. Given these two different approaches, there is an inherent possibility during every program year that the utilization and spending

patterns for these subsets of the population will differ. Such differences were observed both in the 2014 performance year and in the baseline years. Beneficiaries attributed in Step 2 tended to be relatively low utilizers of the health care system; therefore, they also demonstrated lower average annual costs of care than beneficiaries attributed in Step 1.

An added nuance in 2014 resulted from the expansion of Medicaid eligibility to more Vermonters. Given that individuals eligible for coverage as a result of Medicaid Expansion were entirely new to Medicaid, there was no historical Medicaid data available on these individuals to inform predictions of their 2014 utilization and spending. The population of Medicaid beneficiaries that was eligible for attribution to an ACO grew (as did the number of Vermont Medicaid beneficiaries overall) from 2012 to 2014 (Table 2). In 2014, members with **Expansion** eligibility comprised 26 percent of the total population eligible for attribution; members with **Original** eligibility constituted the remainder.

Table 2. Vermont Medicaid Population Eligible for Attribution to an ACO, 2012 & 2014

	2012	2014
Attributed to OneCare Vermont	27,662	37,929
Attributed to CHAC	21,080	26,587
Other: Eligible for Attribution (but *not* attributed to an ACO)	32,445	39,472
TOTAL ELIGIBLE FOR ATTRIBUTION	**81,187**	**103,988**

By dividing the analytic population according to attribution "Step 1" or "Step 2", and to "Original" or "Expansion" Medicaid eligibility, it is possible to explore differences in expenditure associated with unique Medicaid population segments (Figure 1).

Figure 1. Dividing the Population Eligible for ACO Attribution by Eligibility and Attribution Step.

	2012		2014	
	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

Figure 2 shows the impact of the 2014 Medicaid Expansion on the overall population eligible for attribution by ACO assignment. Table 3 shows the cost per member year in 2012 and 2014 by Original and Expansion eligibility designation. While overall there is a decrease in per member expenditure from 2012 to 2014, attributed

individuals with Expansion eligibility were, on average, as costly or costlier than attributed individuals with Original eligibility.

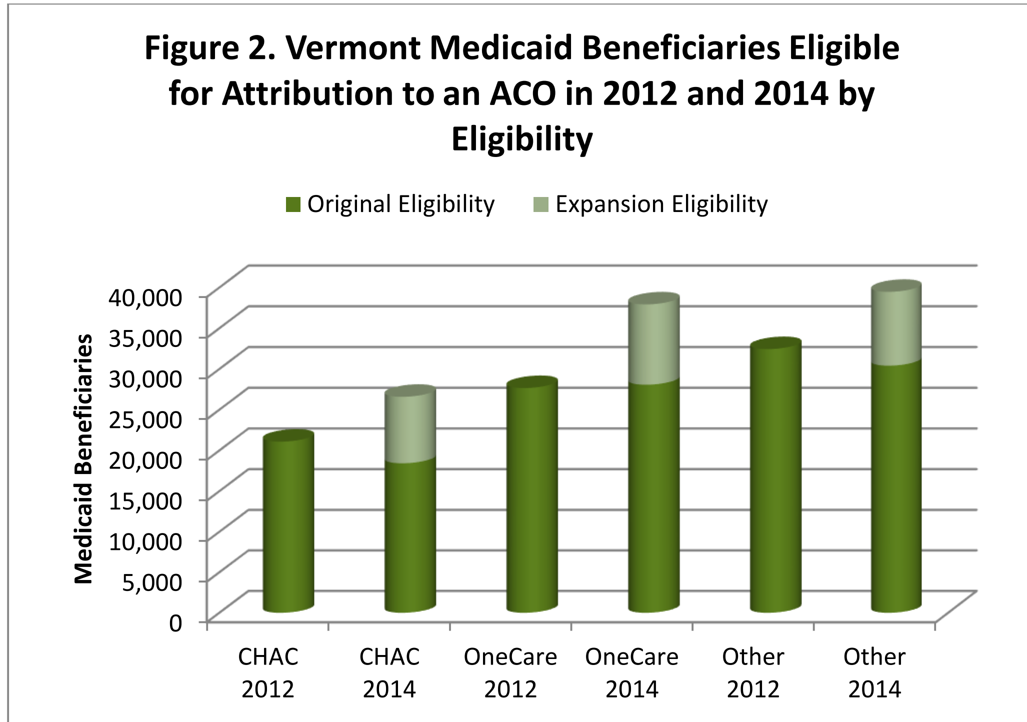


Table 3. Cost per Member Year by Eligibility						
	2012	2014			Overall PMPY Change (2012 to 2014)	Expansion Eligibility Compared to Regular Eligibility (2014)
	Original Eligibility	Original Eligibility	Expansion Eligibility	All Eligibility		
CHAC	$ 2,755	$ 2,582	$ 2,551	$ 2,572	-6.6%	-1.2%
OneCare	$ 2,395	$ 2,232	$ 2,369	$ 2,268	-5.3%	6.1%
Other	$ 2,200	$ 1,954	$ 2,523	$ 2,085	-5.2%	29.1%

Figure 3 shows the relative distribution of Step 1 and Step 2 attribution on the overall population by ACO assignment; in all three ACO groups, the proportion of Step 2 attributed members was higher in the 2014 performance year than it was in the 2012 baseline year. Table 4 shows the cost per member year in 2012 and 2014 by attribution step. While per member expenditure was lower for Step 2 attributed members in both 2012 to 2014, the magnitude of difference was greater in 2014.

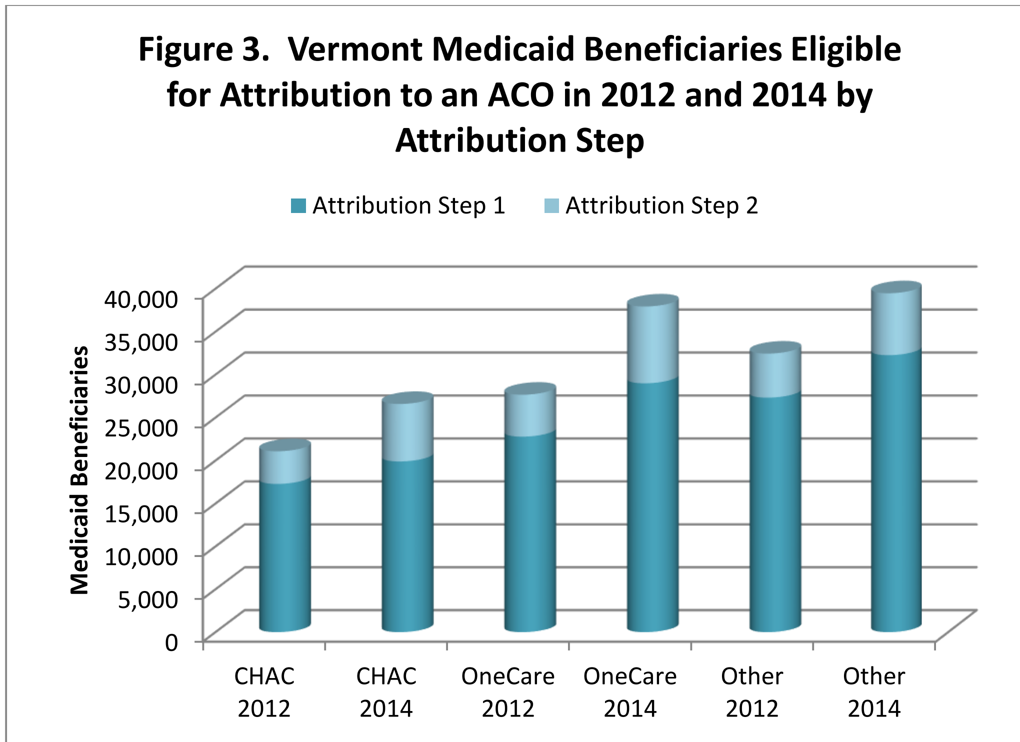


	Table 4. Cost per Member Year by Attribution Step							
	2012			2014			Change from 2012 to 2014	
	Step 1	Step 2	% Difference	Step 1	Step 2	% Difference	Step 1	Step 2
CHAC	$3,136	$1,021	-67.4%	$3,214	$662	-79.4%	2.5%	-35.1%
OneCare	$2,679	$1,072	-60.0%	$2,755	$689	-75.0%	2.8%	-35.7%
Other	$2,455	$837	-65.9%	$2,406	$645	-73.2%	-2.0%	-22.9%

Figure 4 shows the result of segmenting the population eligible for attribution according to both criteria. Table 5 shows the cost per member year in 2012 and 2014 by both eligibility designation and attribution step:

- **Original Eligibility & Step 1:** This population segment experienced a reduction in per member cost from 2012 to 2014 across all ACO attribution groups.
- **Original Eligibility & Step 2:** This population segment experienced a reduction in per member cost from 2012 to 2014 across all ACO attribution groups.
- **Expansion Eligibility & Step 1:** In 2014, this population was costlier than the Original Eligibility groups in both 2012 and 2014. This may be indicative of pent up demand for healthcare among a subset of Medicaid Expansion beneficiaries with new coverage.
- **Expansion Eligibility & Step 2:** In 2014, this population was the least costly of all the population segments; furthermore, Medicaid Expansion beneficiaries with new coverage who were attributed through Step 2

demonstrated even lower expenditure than members with Original eligibility who were attributed through Step 2.

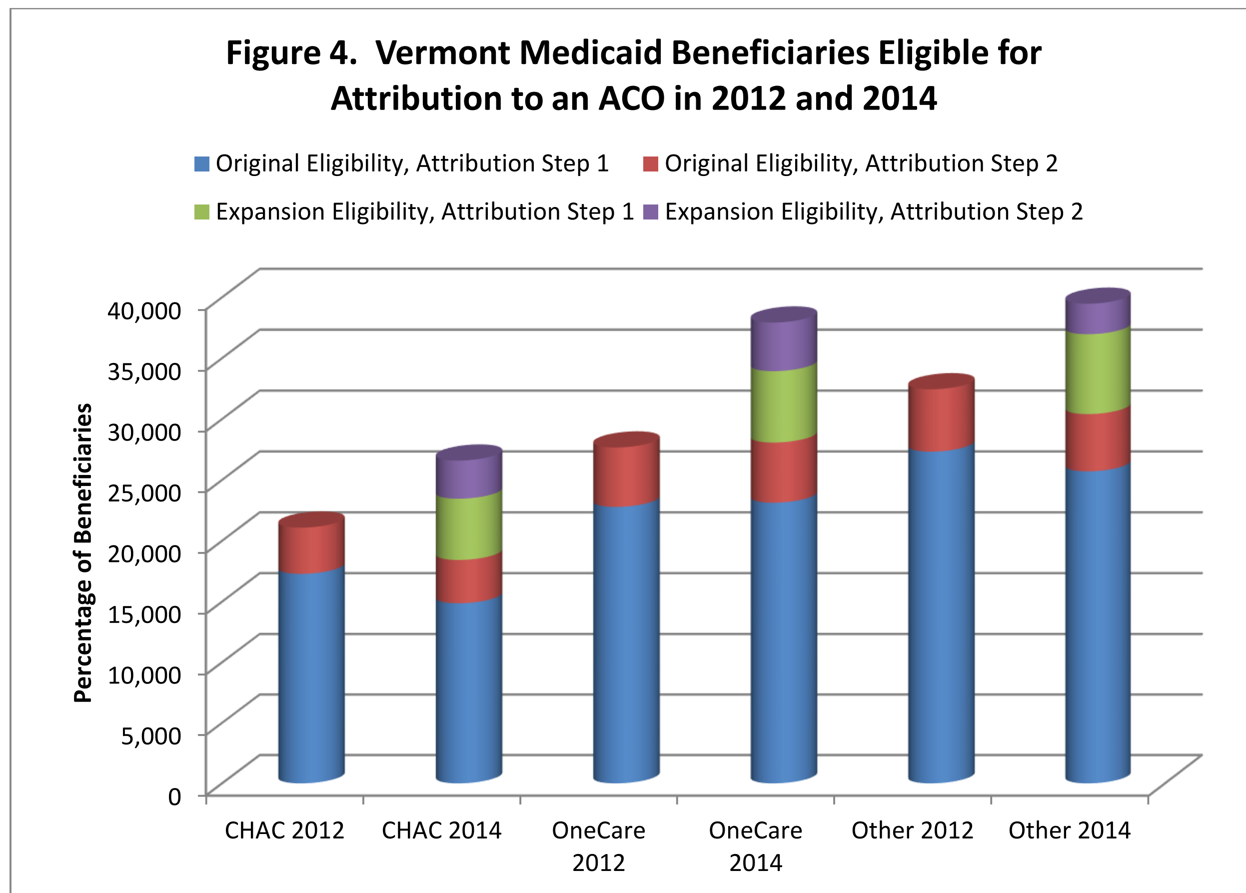


Table 5. Cost per Member Year by Eligibility and Attribution Step

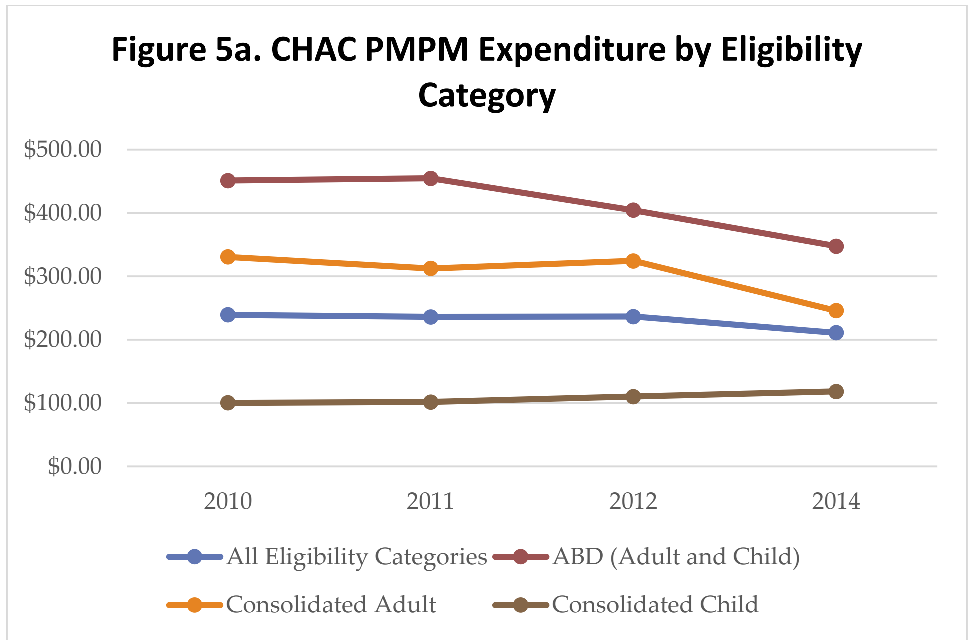
	2012		2014			
	Step 1; Original Eligibility	Step 2; Original Eligibility	Step 1; Original Eligibility	Step 1; Expansion Eligibility	Step 2; Original Eligibility	Step 2; Expansion Eligibility
CHAC	$ 3,136	$ 1,021	$ 3,008	$ 3,824	$ 801	$ 505
OneCare	$ 2,679	$ 1,072	$ 2,524	$ 3,663	$ 866	$ 471
Other	$ 2,455	$ 837	$ 2,187	$ 3,263	$ 679	$ 582

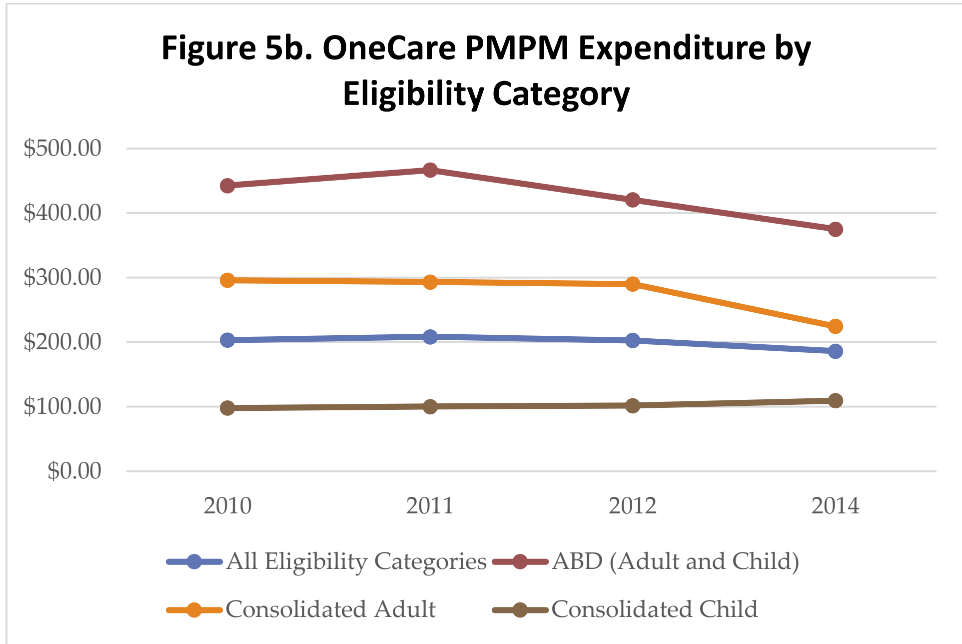
Analysis II: Trends in Expenditure by Eligibility Category and Category of Service

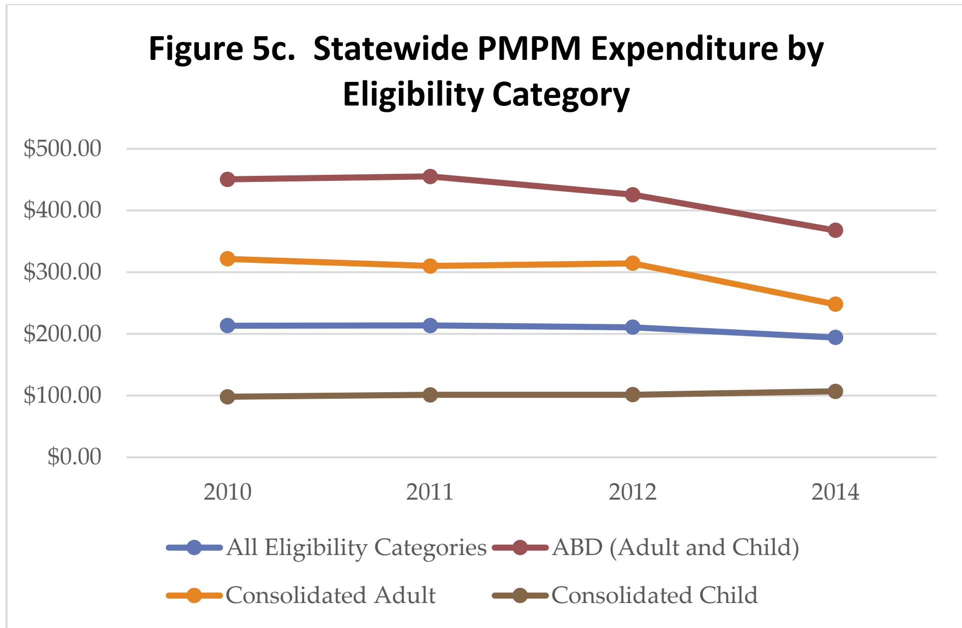
In addition to the above analyses conducted by DVHA staff, additional analyses were conducted by Burns & Associates examining trends in expenditure by Medicaid attribution eligibility category (**Consolidated Adult,**

Consolidated Child, Aged/Blind/Disabled Adult and Child) and by Category of Service. In the following analyses, the **CHAC** and **OneCare** groups are the same as those in the preceding analyses; the **Statewide** comparison group is used below, and is inclusive of all Vermont Medicaid members who were considered eligible for ACO attribution. Thus, the CHAC and OneCare subsets are both included in the Statewide group.

Figures 5a-c show per member per month expenditure by attribution eligibility category across a three-year baseline period (2010-2012) and in the 2014 performance year for CHAC, OneCare, and the Statewide group. Similar patterns are observed in each figure, including an overall decline in PMPM expenditure over time, but fairly stable (and slightly increasing) expenditure for the Consolidated Child eligibility category.







Figures 6a-c present the distribution of attributed Medicaid members with no expenditure in the VMSSP Total Cost of Care Service categories by attribution eligibility category across a three-year baseline period (2010-2012) and in the 2014 performance year. (Individuals represented here may have had expenditure in other Medicaid service categories.) For CHAC, OneCare, and the Statewide group, there are notable increases in the proportions of attributed lives in the 2014 performance year who had no expenditure in the TCOC set of services—in particular for the Consolidated Adult and ABD attribution eligibility categories.

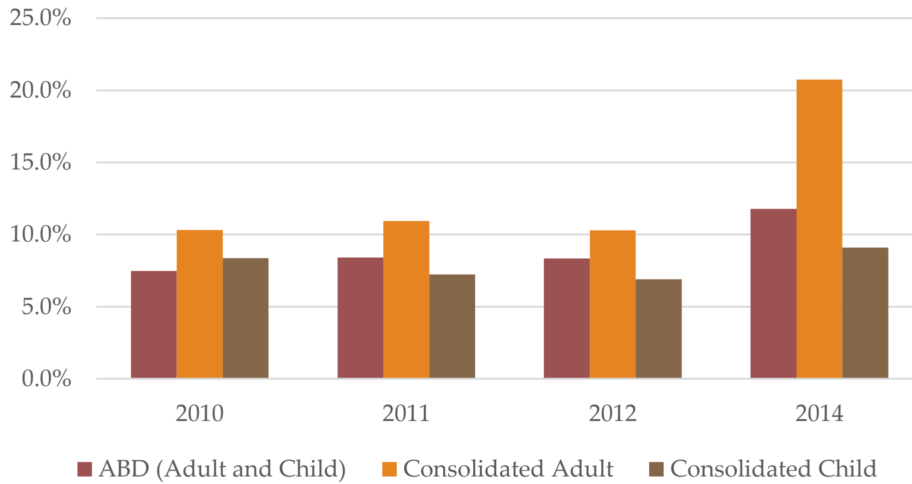


Figure 6a. CHAC Attributed Lives without TCOC Claims by Eligibility Category
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
2010
2011
2012
2014
ABD (Adult and Child)
Consolidated Adult
Consolidated Child

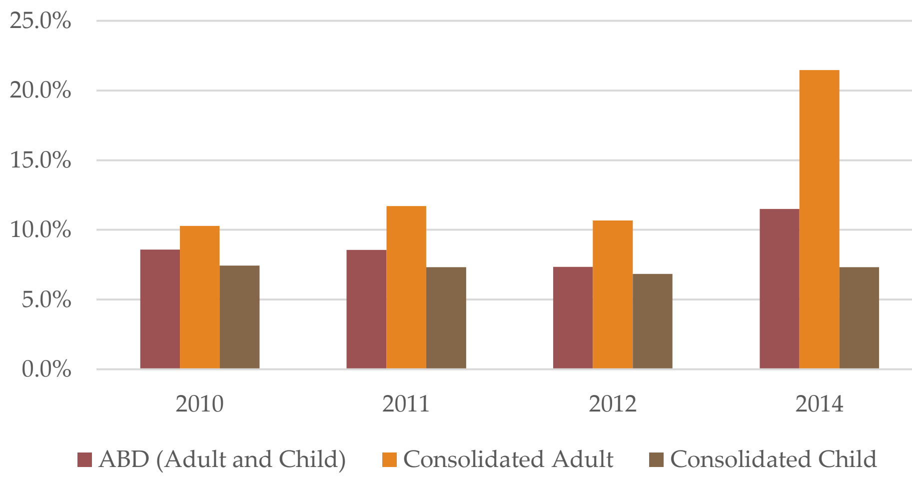


Figure 6b. OneCare Attributed Lives without TCOC Claims by Eligibility Category
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
2010
2011
2012
2014
ABD (Adult and Child)
Consolidated Adult
Consolidated Child

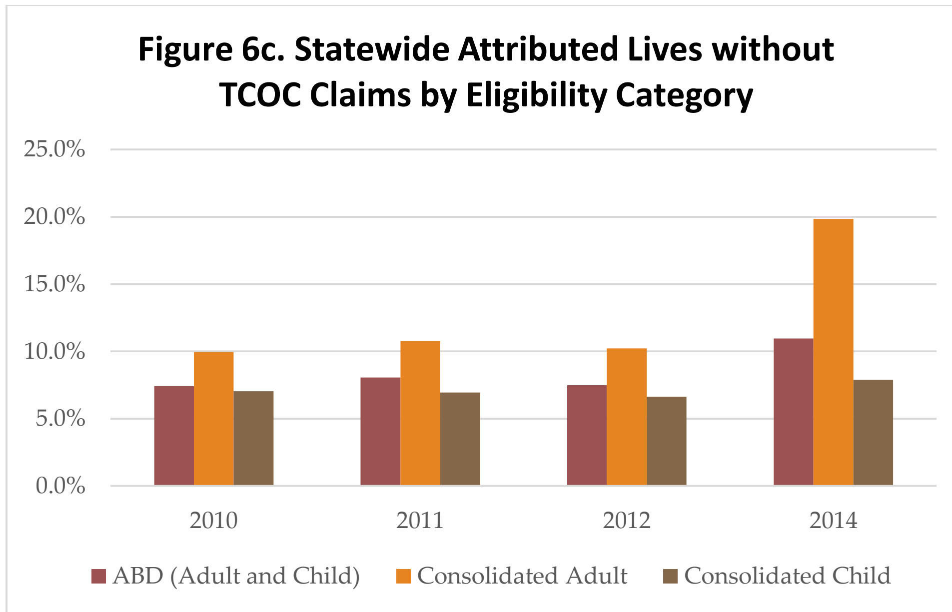
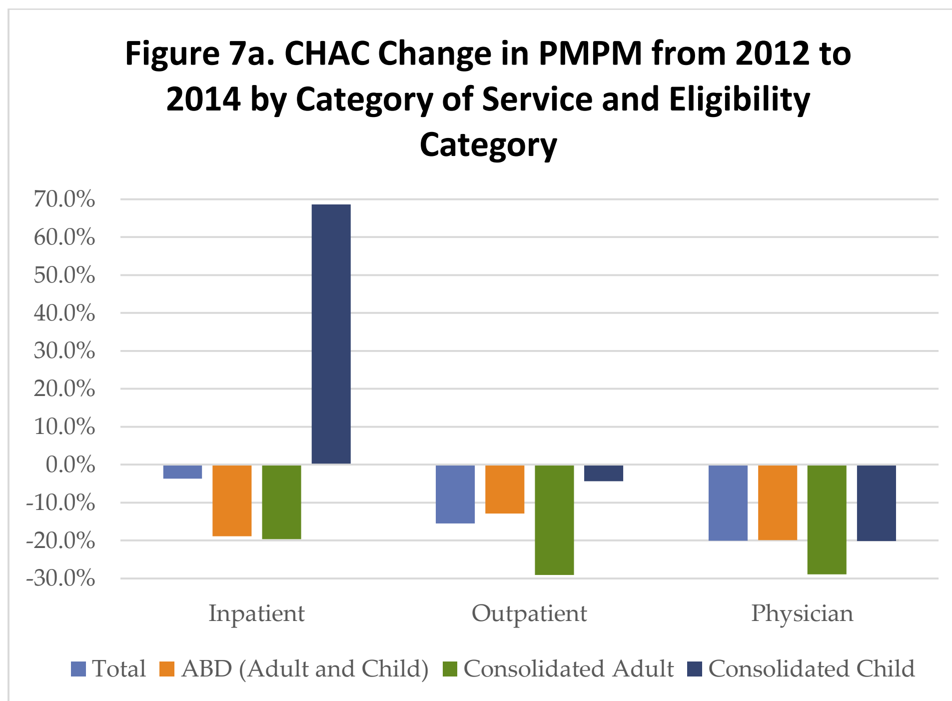


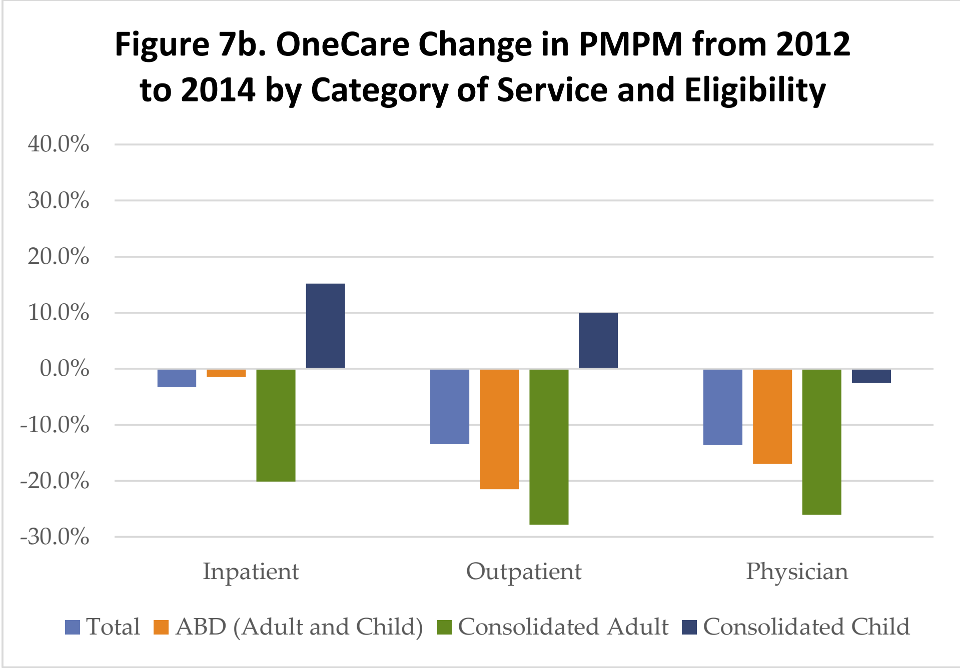
Table 6 shows the distribution of expenditure across Medicaid Categories of Service include in the VMSSP TCOC for each ACO group in 2012 and 2014. The Inpatient, Outpatient, Physician, and Federally Qualified Health Center (FQHC) categories of service account for approximately 85% of TCOC expenditure across ACOs. Figures 7a-c show the change in expenditure from 2012 to 2014 in the Inpatient, Outpatient, and Physician categories of service. While general patterns of decreased expenditure across categories and eligibility groups are present across all three figures, CHAC and OneCare exhibited a greater PMPM reduction in outpatient hospital services than the Statewide group. CHAC also exhibited a greater PMPM reduction in physician and FQHC services than the Statewide potentials.

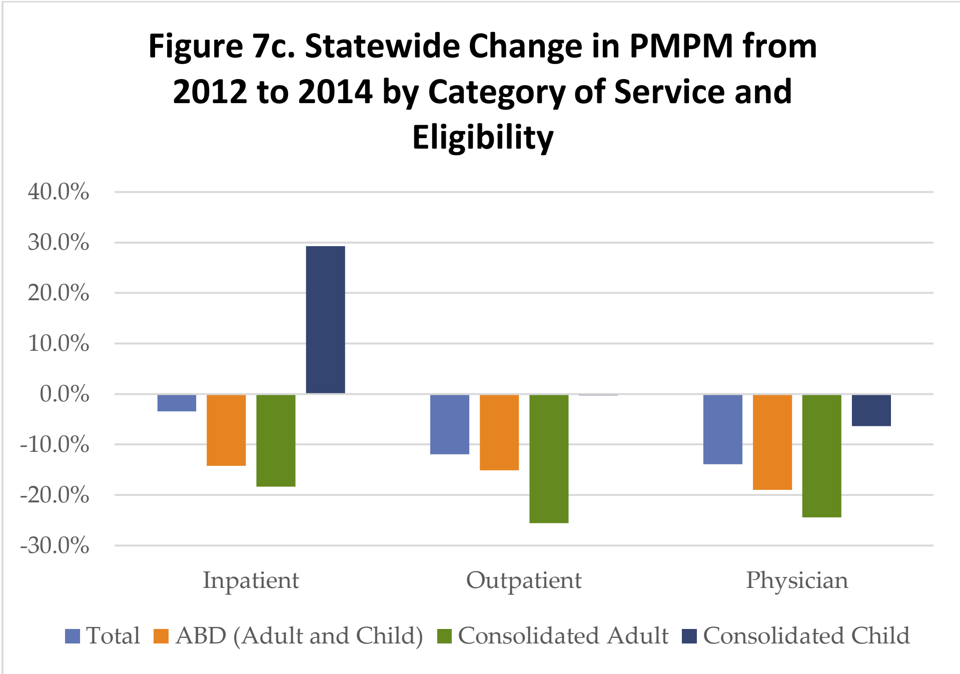
Table 6. ACO Expenditure by Medicaid Category of Service in 2012 and 2014

	Expenditure Breakdown - 2012			Expenditure Breakdown - 2014		
	CHAC	OneCare	Statewide	CHAC	OneCare	Statewide
01: Inpatient	26.8%	26.4%	25.8%	28.9%	27.8%	27.1%
02: Outpatient	27.8%	29.4%	28.1%	26.3%	27.7%	26.9%
03: Physician	16.8%	27.9%	24.5%	15.1%	26.2%	22.9%
05: Nursing Home	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
07: Mental Health Facility	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%
09: Clinic	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
10: Independent Lab	2.1%	1.0%	1.7%	2.4%	1.4%	2.0%
11: Home Health	0.5%	0.4%	0.5%	0.7%	0.7%	0.7%
12: Rural Health Clinic	0.1%	1.8%	1.5%	0.0%	1.9%	1.5%
13: Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
14: Federally Qualified Health Center	15.3%	0.6%	6.0%	15.4%	0.2%	6.0%
15: Chiropractor	0.2%	0.2%	0.2%	0.2%	0.2%	0.3%

16: Nurse Practitioner	0.3%	0.2%	0.3%	0.2%	0.2%	0.2%
17: Nursing	0.4%	0.1%	0.2%	0.3%	0.1%	0.2%
18: Podiatrist	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%
19: Psychologist	5.1%	6.2%	5.7%	5.6%	7.6%	6.8%
20: Optometrist	0.3%	0.5%	0.4%	0.4%	0.5%	0.5%
21: Optician	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
23: Therapies	0.9%	1.1%	1.0%	0.9%	1.1%	1.1%
24: Prosthetic/Orthotic	0.6%	0.9%	0.9%	0.6%	0.8%	0.7%
25: Medical Supplies	0.1%	0.2%	0.2%	0.2%	0.3%	0.3%
26: Durable Medical Equipment	1.2%	1.6%	1.5%	1.4%	1.6%	1.5%
27: Home and Community Based Services	0.2%	0.3%	0.2%	0.1%	0.3%	0.2%
30: Targeted Case Management	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
33: Residential Treatment	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
34: Day Treatment	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
36: Rehab	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%
40: Ambulance	0.8%	0.8%	0.7%	0.8%	0.7%	0.7%
41: Dialysis Facility	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
42: Ambulatory Surgery Center	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%







Analysis III: Utilization of Services outside the Total Cost of Care (TCOC)

While only a subset of Medicaid-covered services are included in the VMSSP Total Cost of Care (TCOC), Medicaid members who are attributed to an ACO continue to receive other Medicaid covered services. DVHA staff conducted a series of analyses to assess whether overall patterns of utilization of non-TCOC services varied from patterns of utilization of TCOC services.

Non-TCOC services include pharmacy, dental, non-emergency transportation, residential services, long-term services and supports, and an array of other services and programs administered by other state departments within the Agency of Human Services (including the Department of Disabilities, Aging and Independent Living; the Department of Mental Health; the Department of Health).

On the whole, expenditure on non-TCOC services (*excluding* pharmacy) is comparable to TCOC expenditure on a per-member per year basis, although the level of utilization of non-TCOC services greatly varies from member to member, and is much higher for people with disabilities or chronic mental health and/or substance abuse health needs. Table 7 shows that the absolute level of spending per member per year was generally less for the non-TCOC services as compared to the TCOC services in both 2012 and 2014.

Table 7. Non-TCOC Expenditure as % difference from TCOC Expenditure

	2012	2014
CHAC	-17%	-18%
OneCare	-6%	-5%
Other	-1%	-6%

Table 8 shows changes in non-TCOC expenditure between 2012 and 2014. While there was an overall pattern of decreased expenditure on non-TCOC services among attributed and non-attributed members, the decrease was greatest among those eligible for attribution but not attributed to an ACO.

Table 8. Non-TCOC Expenditure per Member Year

	2012	2014	% Change
CHAC	$2,286	$2,113	-7.6%
OneCare	$2,247	$2,159	-3.9%
Other	$2,169	$1,955	-9.8%

Table 9 shows changes specifically in pharmacy expenditure between 2012 and 2014. Pharmacy spending generally decreased from 2012 to 2014. Individuals eligible for attribution but not attributed to an ACO experienced a greater average decrease in per member per year expenditure.

Table 9. Pharmacy Expenditure per Member Year

	2012	2014	% Change
CHAC	$90.44	$86.81	-4.0%
OneCare	$91.41	$92.36	1.0%
Other	$87.94	$80.73	-8.2%

Conclusion

The preceding analyses suggest that there were multiple factors influencing the results of the 2014 program year. An influx of beneficiaries newly eligible for Medicaid and a greater proportion of low-utilizing beneficiaries impacted the average cost of care per member in 2014 relative to 2012. However, there were also decreases in utilization across a variety of service categories that further contributed to lower per member spending in 2014 relative to 2012. In some service categories and sub-populations, such decreases were more pronounced among ACO-attributed members than in the population not attributed to ACOs.

As data from the 2015 performance year becomes available, and as we look toward the conclusion of the 2016 performance year, further analyses will be conducted to help better understand the impact of the Vermont Medicaid Shared Savings Program. 2014 was but the first year of VMSSP implementation, and was a unique year for Vermont healthcare reform overall. It will be necessary to analyze additional data from the second and third program years before the state can fully understand the impact of ACOs and the shared savings model on the cost, quality, and experience of care of Vermonters.