VHCIP Core Team Agenda 6-17-14

VT Health Care Innovation Project
Core Team Meeting Agenda

June 17, 2014 9:00-10:00 am
DFR - 3rd Floor Large Conference Room, 89 Main Street, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	9:00-9:10	Welcome and Chair's Report • Site Visit Update	Anya Rader Wallack	Attachment 1: Site Visit Agenda
Core Team Processes and Procedures				
2	9:10-9:15	Approval of meeting minutes	Anya Rader Wallack	Attachment 2a: April 21, 2014 meeting minutes. Attachment 2b: May 19, 2014 meeting minutes.
Policy recommendations and decisions				
3	9:15-9:35	Quality and Performance Measures Work Group Update	QPM Chairs and Staff	Attachment 3a: Payment Measure Criteria 5.29.14 Attachment 3b: Adopted Measure Selection Criteria 5.29.14 Attachment 3c: Year Two Proposed Measures 6.12.14

Core Team Processes and Procedures				
4	9:35-9:50	Project Director Report: a. Timeline Changes due to project extension b. Staffing Update *Public Comment*	Georgia Maheras	Attachment 4a: Revised CMMI reporting timelines 6.12.14 Attachment 4b: Staffing Report 6.17.14
Spending recommendations and decisions				
		No update this month		
5	9:50-9:55	Public Comment	Anya Rader Wallack	
6	9:55-10:00	Next Steps, Wrap-Up and Future Meeting Schedule: 7/16: 1:00-3:00 pm at DFR in Montpelier	Anya Rader Wallack	

Attachment 1 - Site Visit Agenda

CMMI Site Visit to the State of Vermont
Great Room, Main Street Landing[1]
One Main Street, Burlington, VT
June 18, 2014
9:00 am-5:00 pm

Call-in Number: 1-877-273-4202
Password: 2252454

Agenda Items			
Topics	***Proposed Time***	***Owner***	***Attendees***
Introductions	**9:00-9:20**	**State**	**CMMI Team: Clare Wrobel, Karen Murphy, Ankit Patel, Mary Andrawis** **SOV Team: Anya Rader Wallack, Georgia Maheras, Kara Suter, Richard Slusky, Annie Paumgarten, Pat Jones**
SIM Program Updates • Operational Plan Update Guidance • Goals/Objectives and Milestone Calendar • Evaluation • Technical Assistance • Learning system • Round 2	**9:20-10:20**	**CMMI**	**CMMI Team** **SOV Team**
Status of SIM Model **Recap of project goals (Anya Rader Wallack)** • Three central desired outcomes: **(15 minutes)** o Preponderance of alternative payment models o Functioning system of health information exchange o Coordinated care management	**10:20-12:30**	**State**	**CMMI Team** **SOV Team** **SOV Core Team Members: Mark Larson, Robin Lunge, Susan Wehry, Paul Bengtson** **OCVT Representatives: Todd Moore, Churchill Hindes, Dr. Barbara Walters, Dr. Norm**

[1] For more information about the meeting location, please look here: http://www.mainstreetlanding.com.

Status of the project: where are we at on each front? **Part 1: payment models (70 minutes)** • ACO program standards (Kara Suter and Richard Slusky) • ACO development (ACO representatives) • Episode-of-care analysis (Kara Suter and Richard Slusky) **Part 2: health information exchange and investments (45 minutes)** • HIE/HIT build-out (John Evans) • Support for ACO needs (John Evans and Todd Moore) • Support for behavioral health and LTSS providers (Simone Rueschemeyer and John Evans)			**Ward** **ACCGM/VCP Representatives: Dr. Paul Reiss, Amy Cooper** **VITL Representative: John Evans** **BHN Representative: Simone Rueschemeyer**
Half hour break: walk on Burlington shore or inside the gallery at the performing arts center depending on the weather	**12:30-1:00 *lunch available at this time**		**All**

Continuation of Status Update:
Part 3: coordinated care management (30 minutes)
• Inventory of care models and care management (Pat Jones)
• Model of care for ACO programs (Pat Jones and Kara Suter)
• Learning Collaboratives (Kara Suter and Pat Jones)
 	
Part 4: (80 minutes)
• Shared Savings ACO Programs – Joyce Gallimore (20 minutes)
• Sub-Grantee highlight: Dr. Cy Jordan (30 minutes)
• Other activities: (Georgia Maheras) (30)
  • Workforce, DLTSS
  • Population Health (Heidi Klein)
	(lunch can carry over into this section)
	
	1:00-2:50
		State	**CMMI Team**
			
			SOV Team
			SOV Core Team Member: Al Gobeille
			
			CHAC Representative: Joyce Gallimore
			
			Sub-grantee: Dr. Cy Jordan
			SOV: Heidi Klein

Accountability Targets, Risk Mitigation Strategy & Project Budget	**2:50-3:50**	**State Project Director** **State AOR**	**CMMI Team** **SOV Team**
Wrap-up & Next Steps • Requests for CMMI • Recommendations for SIM program	**3:50-4:50**	**CMMI**	**CMMI Team** **SOV Team**

Attachment 2a - Core Team Minutes 4-21-14

VT Health Care Innovation Project
Core Team Meeting Minutes

Date of meeting: April 21, 2014 Location: DVHA Large Conference Room, 312 Hurricane Lane, Williston

Members: Anya Rader Wallack, Chair; Robin Lunge, AOA; Susan Wehry, DAIL; Steve Voigt, King Arthur Flour; Paul Bengtson, NVRH; Al Gobeille, GMCB; Doug Racine, AHS; Mark Larson, DVHA.

Attendees: Georgia Maheras, AOA; David Martini, DFR; Richard Slusky, Spenser Weppler, GMCB; Diane Cummings, AHS; Kara Suter, Steve Maier, Carrie Hathaway, DVHA; Bea Grause, VT Association of Hospital and Health Systems; Lila Richardson, VT Legal Aid, Brendan Hogan, Bailit Health Purchasing, Simone Rueschemeyer, Behavioral Health Network; Jessica Mendizabal and Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's report	Anya Rader Wallack called the meeting to order at 1:07 pm. She stated that the Governor held two press conferences last month and that the grant program was covered in *Modern Healthcare*. Paul Bengtson stated he appreciated the work group status reports. Anya noted that the Project Management staff was working on getting those out to the groups in an easy to understand format and they should be sent out more in advance in the future. Questions can be directed to Georgia. Anya referenced a memo she sent to Jeb Spaulding about her contractual work with Dartmouth and Jim Weinstein. If the group has any questions they should direct those to Anya and Georgia. Anya will avoid conflicts of interest by recusing herself from voting. The work she is doing with Dartmouth will not affect the work she performs under the SIM grant. Dartmouth put a grant application into CMMI for their long term vision for payment reform which would have implications for OneCare and next generation ACOs in Northern New England. The project is in the beginning phases and Anya's job is to help operationalize these efforts.	

Agenda Item	Discussion	Next Steps
2. Approval of Minutes	Anya asked the group to review the minutes from the March meetings, noting her name was misspelled in the March 14th minutes. The minutes were approved unanimously (Mark Larson was not present for this motion).	**The minutes will be updated and reposted to the website.**
3. Project Director Report	A. Grant Program Update The grant contracts are currently being written and expect to be completed by the middle or end of May. B. Staffing Report (attachment 3) Overall recruitment efforts are going well. Data Analyst positions have been challenging to fill. Kara Suter and Georgia Maheras are working on more innovative recruitment efforts in this area. C. Medicaid Shared Savings Program Update (including a discussion of the email sent from Deb Lisi-Baker, Co-Chair of the DLTSS work group, found under additional meeting materials). Susan Wehry presented the memo and the group discussed some overall concerns. Deb's letter questions which team or organization is accountable if the programs are not successful. Anya noted the Core Team is advisory and in charge of overall SIM funding but ultimately not responsible for contracts, which are the responsibility of the lead agency. Susan referenced page two of the contract noting the contract belongs with AHS. The group discussed the following points: • Care Management Standards, excerpted from the current contract, are included in the additional materials. • The general concern is that there might not be sufficient protection against an ACO changing a proposed model of care. More discussion on this topic needs to take place in the CMCM work group.	• **Susan will work with Doug on contract language.** • **Anya will draft a written response to Deb Lisi-Baker's letter and share with group for comment before sending to Deb.** • **Al will share the letter that details what the GMCB role as an independent evaluator (previously distributed to group) and Anya will work on edits/updates to that letter.**
4. Finance Update	Paul Bengtson referred to the overall health care reform budget and asked if there was a way to see how projects are connecting or overlapping in a diagram format. Robin responded that the information exists in different forms and will work on putting it together one document after the legislative session. Paul asked how the money is being accounted for and how the results measure	**Al and Robin will diagram the overall system health care budget and how the**

Agenda Item	Discussion	Next Steps
	against the promises that are being made. Al Gobeille offered to have the GMCB put something together to diagram that. The idea of the SIM grant is meant to test health care reform theories and see what works. Paul referred to Dr. Hsaio's report noting the expected savings by 2015. Robin stated the plan did not pass the legislature, but the GMCB and the Administration is doing work around looking at costs without change and what are savings related to costs. They are working on improving the expenditure analysis over the next several months. They are seeing savings associated with different efforts. For the purposes of the SIM application the State used Wakely to look at current expenditures and make an assumption about what reform efforts are going to affect: making sure that the cost in grant dollars is still less than what the savings will be. Current data sources used to track total health care expenditures don't often capture the investments. **A. <u>HIE/HIT Work Group Proposals (attachment 4a):</u>** The Advancing Care Through Technology (ACTT) proposal has gone to the Steering Committee twice and this is an updated version. Recommendations have resulted from discussions with AHS and VITL, making it a more solid proposal. Simone Rueschemeyer reviewed the following: 1. *Project 1:* Data gathering, data quality & remediation for Designated Agencies (DAs) and Specialized Service Agencies (SSAs). This project applies to all the services provided even if it's not a mandated service by that agency (and needs to include children not just adults). This project has two phases – a planning and an implementation phase. Cost: $1,949,046 (which includes funding for VITL and the state's Health Information Exchange (HIE)). 2. *Project 2:* Planning for Long Term Services and Supports Data Reporting and Provider IT Gap Analyses. Cost: $178,000 3. *Project 3:* Universal Transfer Form Protocol Planning. Cost: $215,072 The Finance Memo submitted by Georgia Maheras was discussed (attachment 4c): • Georgia asked for an increase in funds for data quality as a place holder in case it's needed in the future. • Data remediation refers to making sure data is entered consistently with no spelling errors, etc. • Steve Maier and Georgia will make sure there is no duplication of payments for this project.	**different projects overlap or connect.** **Georgia will provide a list of contracts that may be extended.**

Agenda Item	Discussion	Next Steps
	• The proposal addresses what AHS asks for, reporting to the numerous government entities and ACOs, and trying to mitigate administrative burdens for the DAs. • This project involves a lot of coordinated effort where there is some overlap in existing contracts to maximize services. DA participants need to indicate when it's becoming unmanageable. • Project management will occur at Behavioral Health Network. • Simone is confident the funding requested will get the job done. • SIM funding is the most likely federal funds for these entities. Steve Voigt moved to approve items 1-5 of the Finance Memo dated April 21, 2014 and Susan Wehry seconded. Steve asked if it reflects negatively not to seek funding elsewhere. Georgia responded that the funding request mobilizes resources as quickly as possible and we've learned how to do in a way that takes advantage of excitement from federal partners, noting there is always up to a 30 day delay for federal approval. Anya noted the resource planning at VITL has been an issue and it is better to make more decisions up front. Simone would come back to the group before Phase 2 Implementation with a new proposal and request for more funding. HIE Work Group co-chairs and staff are meeting to discuss the HSE and how it connects to the Data Warehouse proposed by VITL. Carrie Hathaway stated that DVHA is contracting with Pacific Health Policy Group and identifying necessary reporting requirements for designated agencies. The motion passed unanimously. Anya noted that throughout this process Simone has not voted on this proposal at either the HIE Work Group or at the Steering Committee meetings (since Behavioral Health Network is a beneficiary). **B. <u>Evaluation contract update and Revisions to Overall Grant Budget</u>** Georgia gave the following update: contract negotiations with the selected evaluation contractor broke down. GMCB has gone with the second highest scoring vendor in the RFP bid process, and is starting negotiations with that vendor (though they can't disclose at this time). The contract total is still within the "not to exceed" amount previously approved by the Core Team. Georgia reviewed the requested changes to the VHCIP Funding Allocation Plan (attachment 4b) and her Finance Memo (attachment 4c):	

Agenda Item	Discussion	Next Steps
	Regarding the RFP for a new analytics contract at the GMCB, the original bids all came in higher than previously approved $1.2 million. GMCB recently approved to increase the total allowable maximum to $2.2 million to be spent over three years. Richard Slusky confirmed they are trying to actively negotiate to bring the costs down under that amount. The cost increased because there is a lot of work to do around financial analysis and quality management in the State and the team estimated their best guess when releasing the RFP. Georgia noted this is an effort toward finding an alternative to all parties doing their own analytics and they had payers and ACOs on the bid review team. There may be some duplication but the GMCB has worked to minimize it and the State won't pay for any duplication. Payers may want to check our data against theirs but the information will not be duplicated. Robin Lunge moved to approve item 6 of attachment 4c, a $1.2 million increase in funding for statewide analytics activities. Steve Voigt seconded the motion. Susan asked why funding was being moved out of year one for *Outreach* and *Broad dissemination of programmatic information to providers and consumers*. Georgia responded that for the latter, it was timed incorrectly and scheduled to happen in year two. The incremental costs will not increase in year two. They've received bids for Outreach efforts but they were not acceptable. They need to revise the language in the RFP and re-release it, making sure they depict the exact needs of the grant. Most original responses were marketing related. The motion passed unanimously. Regarding item 7 in attachment 4c: additional funds for the grant program are reallocated from year one funds that will not be spent, including funding for the learning collaborative, surveys to MMIS and work group support. $1 million is also taken out of the Evaluation line item. This was over budgeted initially and Georgia is confident about reallocating at this time. Susan Wehry moved to approve reallocating $1,918,000 into the grant program and Steve Voigt seconded. The motion passed unanimously.	

Agenda Item	Discussion	Next Steps
	C. <u>Federal timeline and no-cost extension (attachment 4d).</u> Georgia reviewed a separate memo requesting approval to extend the SIM grant by three months to allow for model testing. The extension does not increase the award. The offer was extended to all states by CMMI to allow for three full years of testing. Five out of the six states will most likely extend their grants. The extension will give leeway in the timeline and grant program goals, allowing grant awardees complete work and will align better with 2017 goals. The new grant end date will be December 31, 2016 and CMMI has indicated that it will be possible to extend the evaluation contract beyond that time. Susan Wehry moved to approve the request to increase the grant timeline and Steve Voigt seconded. The motion passed unanimously.	
5. Public Comment	Lila Richardson asked when grant program details would be available. Georgia stated that we are waiting for some information back from the grantees and will have more information soon on the VHCIP website. She also echoed the DLTSS work group's concerns on how the DLTSS population will be treated because they don't fit into the medical model. These are lifelong, not episodic conditions. She wanted the Core Team to keep in mind that the care is very different. Anya stated that DVHA, AHS and DAIL are working on this effort.	
6. Next Steps, Wrap up	Next meeting: May 19, 2014, 1-3:30 pm, DFR 3rd Floor Conference Room, 89 Main St, Montpelier.	

Attachment 2b - Core Team Minutes 5-19-14

VT Health Care Innovation Project
Core Team Meeting Minutes

Date of meeting: May 19, 2014 Location: DFR 3rd Floor Conference Room, 89 Main Street, Montpelier VT

Members: Anya Rader Wallack, Chair; Robin Lunge, AOA; Susan Wehry, DAIL; Steve Voigt, King Arthur Flour; Paul Bengtson, NVRH; Al Gobeille, GMCB; Doug Racine, AHS; Mark Larson, DVHA.

Attendees: Georgia Maheras, AOA; Diane Cummings, AHS; Kate Jones, Kara Suter, DVHA; Bea Grause, VT Association of Hospital and Health Systems; Lila Richardson, VT Legal Aid; Susan Barrett, GMCB; Jessica Mendizabal and Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's report	Anya Rader Wallack called the meeting to order at 1:05 pm. She noted that the response letter was sent to Deb Lisi-Baker and shared with group; it is also posted to the VHCIP website. Al Gobeille created a memo that was distributed in the materials packet (attachment 1). The memo explains the roles of different organizations in health care reform. Mark and Al will refine and bring back to the Core Team at a later date. The site visit from CMMI is scheduled for June 18th. More details will follow but members may be asked to participate at some point during the day. The site visit will take place in Burlington.	**Chrissy will send an email to members to hold the date on their calendars for the site visit.** **Participants should let Georgia know time preferences.**
2. Approval of Minutes	The minutes from the April 21st meeting will be reviewed at the June meeting.	
3. Project Director Report	**A. <u>Progress report and six month preview:</u>** • Anya distributed a slide to describe the summarization of the three points that would constitute success of this project.	**Anya will share the slide electronically**

Agenda Item	Discussion	Next Steps

	• Robin will compile the health care reform diagram referred to at the last meeting soon.
	• Georgia presented the information in the PowerPoint presentation (attachment 3).
	• Anya noted slide six relates directly to the slide she distributed.
	• The cross collaboration of work groups is going well. Paul expressed appreciation for the work thus far.
	• The Workforce development work group has a strategic plan that is separate from the SIM project and they have turned more focus toward it.
	  o The Department of Health and Office of Professional Responsibility are working together on survey data collection and analysis.
	  o Demand side models are being developed nationally and they have not decided if they will tie themselves to that, or develop their own.
	  o This group is behind with some of the data collection. They are trying to manage this and moved to monthly meetings to manage their charge more effectively.
	• Recommendations for Shared Savings ACO Program quality measures have been given to the QPM work group by DLTSS and Population Health. The QPM work group will be reviewing at their June and July meetings, then the recommendations would go to the Steering Committee and presented to the Core Team in August.
	• For some groups there has been less production of work and more education on the substantive policy areas. Payment Models slowed down their work around Episodes of Care at the request of the group.
	• Regarding health care system costs- Robin can include an update with Partners for Health Care Reform at a future Core Team meeting.
	• Members of the Core Team may attend the hospital association meeting in September. Bea will send invitations to members.
	• The September 2nd meeting may be rescheduled and a second meeting will be scheduled to review grant applications.
	• The Year One Milestones chart was emailed to group (attachment 3b). All tasks are on track for completion. The chart is missing grant program information but it will be included in year two milestones.
	
	B. <u>CMMI Update:</u>
	• Site Visit is scheduled for June 18.
		with the group.

Agenda Item	Discussion	Next Steps

	• The Risk Mitigation Plan is required by CMMI to identify and prioritize risks and develop mitigations for those risks. This is a more detailed plan that what was submitted with the previous Operational Plan.
	• Co-chairs are currently providing input on risks and the Core Team will review at June meeting.
	• Examples of risks include departure of Key Personnel and what the impact would be and what are ways to mitigate this from happening.
	
	C. <u>Grant Program Discussion:</u>
	• Round One final contracts are near completion. There are two waves of contracts, scheduled start dates will likely be June 15th and July 1st.
	• Georgia proposed adding a cap on funding requests and a fixed time period (due to the remaining time in the overall VHCIP grant cycle).
	  • The Core Team approved the fixed time period, but not the cap.
	• The grant management team could feasibly handle up to eight more awards.
	• Applicants will be encouraged to apply in Round Two because the time period for a third round may not leave enough time for project completion.
	• Georgia reviewed attachment 3d- the Proposed Grant Application noting that page one should not be modified because its language that came from the feds.
	• The group discussed potential changes to the review process in particular the Q&A portion:
	  o Narrow down the applications and then have more direct contact with the applicants.
	  o The group could divide them up and have one person go into depth on several of them.
	  o Set aside time at the meeting to call the applicants as a team and then leave an hour at the end of the meeting to discuss.
	  o There are three extra weeks for review in round two.
	• Georgia will provide written recommendations from work groups at the June and July meetings.
		Members should email Georgia with other suggestions for the Grant Program.

Agenda Item	Discussion	Next Steps
		The June meeting may be rescheduled since the Governor's Opiate Summit takes place on the same day.
4. Finance Update	A. The overview of VHCIP contract spending to date was distributed as attachment 4c in the meeting materials packet. Attachment 4a makes the following finance requests: B. Population Health Work Group Proposal: RFP to support development of Accountable HealthCare pilots. • The group has already performed research on other models. There are three different types of models happening around the country, one is already happening in VT and is meant to be the most promising. Contractor Jim Hester is assisting with this. The third model is a social impact bond and the State has already done a lot of work around this. Paul moved to approve the request stating he felt confident in Karen Hein's expertise. Al seconded the motion. Susan Wehry stated she was unsure of the relevance of this request. There was no further discussion. Susan abstained and the motion passed. C. Amendment to Bailit Health Purchasing, Inc. contract: • $1,000,000 to support three VHCIP work groups. • Several State agencies currently contract with Bailit. Bailit also contracts with other states and at the national level which has helped inform VT decisions. • The contract supports the work of QPM, Payment Models and the DLTSS work	

Agenda Item	Discussion	Next Steps
	groups. • The state may eventually create one master agreement. Al moved to approve the request and Steve seconded the motion. Al asked how will this affect the staff that have been supporting the work groups. Georgia responded that without this investment state staff will be spending more time. This contract will help us meet critical deadlines. It will reduce the time spent managing the Bailit contracts currently in force. The amount requested is a well-informed estimate based on the average spend per month considering the work they have done over the past few years. The motion passed unanimously. D. Sole Source Contract with the Coaching Center: $15,000 to support team building and change management. The Coaching Center would provide team building activities for our project for staff at a minimum and it is not yet a requirement to incorporate members or chairs. Paul moved to approve the request, Al seconded. The motion passed unanimously.	
5. Public Comment	Bea Grause commented that the CMCM work group is in the process of developing care management standards. They recently became aware of NCQA standards and Bailit is doing the initial review, which has been helpful and relieves Pat Jones of some work.	
6. Next Steps, Wrap up	Next meeting: June 16, 2014, 1-3:00 pm, DFR 3rd Floor Conference Room, 89 Main St, Montpelier.	

Attachment 3a- Payment Measure Criteria 5.29.14

Vermont Quality and Performance Measures Work Group

ACO Shared Savings Program Year 2 Payment Measure Selection Criteria
Approved on May 29, 2014

Criterion	Description
1. Relevant benchmark available	**The measure has been selected from NQF-endorsed measures that have relevant benchmarks whenever possible.**
2. Selected from the commercial or Medicaid Core Measure Set	**The measure can only be selected from the available commercial or Medicaid core measure sets.**
3. Presents an opportunity for improvement	**The measure offers opportunity for performance improvement to achieve high-quality, efficient health care.**
4. Focused on outcomes	**The measure assesses outcomes; i.e., improving this measure will translate into improvements in quality outcomes, and take cost into account if applicable.**
5. Representative of the array of services provided and beneficiaries served	**The overall measures set will be representative of the array of services provided, and of the diversity of patients served.**

Attachment 3b - Adopted Measure Selection Criteria 5.29.14

Vermont ACO Quality and Performance Measures Work Group
Adopted Criteria – Year 2 Overall Measure Selection
As of May 29, 2014

Criterion	Description
Valid and reliable	The measure will produce consistent (reliable) and credible (valid) results.
Representative of the array of services provided and beneficiaries served	The overall measures set will be representative of the array of services provided, and of the diversity of patients served.
Uninfluenced by differences in patient case mix	Providers serving more complex or ill patients will not be disadvantaged by comparative measurement. Measures will be either uninfluenced by differences in patient case mix or will be appropriately adjusted for such differences.
Not prone to random variation, i.e., sufficient denominator size	In order to ensure that the measure is not prone to the effects of random variation, the measure type will be considered so as to ensure a sufficient denominator in the context of the program.
Consistent with state's goals for improved health systems performance	The measure corresponds to a state objective for improved health systems performance (e.g., presents an opportunity for improved quality and/or cost effectiveness).
Not administratively burdensome, i.e., feasible to collect	The measure can be implemented and data can be collected without undue administrative burden.
Aligned with other measure sets	The measure aligns with national and state measure sets and federal and state initiatives whenever possible.
Includes a mix of measure types	Includes process, outcome and patient experience (e.g., self-management, perceptions, PCMH CAHPS®) measures, including measures of care transitions and changes in a person's functional status.
Relevant benchmark available	The measure has been selected from NQF endorsed measures that have relevant benchmarks whenever possible.
Focused on outcomes	To extent feasible, the measure should focus on outcomes, i.e., improving this measure will translate into significant changes in outcomes relative to costs, with consideration for efficiency.
Limited in number	The overall measure set should be limited in number and include only those measures that are necessary to achieve the state's goals.
Population-based/focused	The overall measure set should be population-based so that it may be used not only for comparative purposes, but also to identify and prioritize state efforts. Recognizes population demographics; gives priority to aging population and other ages; considers geographic community and not just patient population; consistent with State Health Improvement Plan.

Note: The Work Group is considering additional criteria put forth by the Population Health Work Group.

Attachment 3c - Year Two Proposed Measures 6.12.14

VT Quality and Performance Measures Work Group
Review of Changes in Measures Proposed for Year 2 Reporting and Payment
June 12, 2014

Additional Measures Proposed for 2015 Reporting:

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-8	Developmental Screening in the First Three Years of Life (*currently in Medicaid measure set; proposed for commercial measure set*)	NQF #1448; NCQA (not HEDIS); and CHIPRA	Yes		Medicaid can use claims data, but provider coding for commercial payers is not currently reliable, so the commercial measure could require data from clinical records.	CMS has analyzed data from five states (AL, IL, NC, OR, TN) that reported the measure for FFY12 consistently using prescribed specifications. CMS reports that 12 states reported in FFY13, and 18 intend to do so in FFY14. Best practice is in IL, which reported rates of 77%, 81%, 65% in Years 1-3; the five-state median was 33%, 40%, 28%.	• Vermont Legal Aid • Population Health WG • DLTSS Work Group
Core-30 PQRS MU	Cervical Cancer Screening	NQF #0032; NCQA (HEDIS) PQRS (add'l core); MU (CMS 124v1)	Yes	<u>Changes in HEDIS specifications for 2014:</u> • Added steps to allow for two appropriate screening methods of cervical cancer screening: cervical cytology performed every three years in women 21–64 years of age and cervical cytology/HPV co-testing performed every five years in women 30–64 years of age.	For HEDIS purposes in 2014, both commercial and Medicaid plans could use the hybrid method which requires data from clinical records.	HEDIS benchmark available (for HEDIS 2015; no benchmark for 2014). Historical Performance HEDIS 2013 (PPO) • BCBSVT: 72%; CIGNA: 71%; MVP: 71% • National 90th percentile: 78%; **Regional 90th percentile: 82%** • National Average: 74%; Regional Average: 78%	• Population Health WG
Core-34	Prenatal and Postpartum Care	NQF #1517; NCQA (HEDIS)	Yes		HEDIS rates are collected using the hybrid method, using claims data and clinical records.	Timeliness of Prenatal Care Historical Performance HEDIS 2013 (PPO): • BCBSVT: 94%; CIGNA: 74%; MVP: 95% • National 90th percentile: 96%; **Regional 90th percentile: 96%** • National Average: 81%; Regional	• Population Health WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
						Average: 82% Postpartum Care Historical Performance (PPO): • BCBSVT: 83%; CIGNA: N/A; MVP: 84% • National 90th percentile: 86%; **Regional 90th percentile: 90%** • National Average: 70%; Regional Average: 70%	
Core-35/ MSSP-14 PQRS MU	Influenza Immunization	NQF #0041; MSSP; PQRS (alt core); MU (CMS 147v1)	Yes		Requires clinical data or patient survey to capture immunizations that were given outside of the PCP's office (e.g., in pharmacies, at public health events)	Medicare MSSP benchmarks available from CMS.	• Population Health WG • DTLSS WG
Core-36/ MSSP-17 PQRS	Tobacco Use Assessment and Tobacco Cessation Intervention	NQF #0028; MSSP; PQRS (core)	Yes		Clinical records	CMS set benchmarks for MSSP shared savings distribution. For this measure, the benchmarks equate to the rates for 2014 and 2015 reporting years. For example, the 50th percentile is 50%, and the 90th percentile is 90%. This measure is in use in other states and HRSA and CDC publish benchmarks, so additional benchmarking feasible if there is interest in adoption.	• Population Health WG • DLTSS WG
Core 37	Transition Record Transmittal to Health Care Professional	NQF #0648/#2036 (paired measure – see below)	Yes		Clinical records	None identified	• DTLSS WG
Core-39/ MSSP-28 PQRS MU	Hypertension (HTN): Controlling High Blood Pressure	NQF #0018; MSSP; PQRS (add'l core); MU	Yes	<u>Guideline change</u>: In December 2013, the eighth Joint National Committee (JNC 8) released updated guidance for treatment of	Clinical records	HEDIS benchmark currently available, but with measure likely to change, there is a possibility that there won't be a benchmark for 2015.	• Population Health WG • DLTSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
		(CMS 165v1)		hypertension: • Set the BP treatment goal for patients 60 and older to <150/90 mm Hg. • Keep the BP treatment goal for patients 18–59 at <140/90 mm Hg. <u>Changes in HEDIS Specifications for 2015</u>: Proposed changes to HEDIS specifications in 2015 to align with the JNC 8 guidelines. The measure will be based on one sample for a total rate reflecting age-related BP thresholds. The total rate will be used for reporting and comparison across organizations.		Historical Performance HEDIS 2013 (PPO) • BCBSVT: 61%; CIGNA PPO: 62%; MVP PPO: 67% • National 90th percentile: 65%; **Regional 90th percentile: 78%** • National Average: 57%; Regional Average: 63%	
Core-40/ MSSP-21	Screening for High Blood Pressure and Follow-up Plan Documented	Not NQF-endorsed; MSSP	Yes		Clinical records	CMS set benchmarks for MSSP shared savings distribution. For this measure, the benchmarks equate to the rates for 2014 and 2015 reporting years. For example, the 50th percentile is 50%, and the 90th percentile is 90%. However, this measure is in use by other states so it may be possible to identify benchmarks.	• Population Health WG • DLTSS WG
Core-44	Percentage of Patients with Self-Management Plans	Not NQF-endorsed	No. Need to develop measure specs based on the NCQA standard, or borrow from a state that uses this measure.		Clinical records	This measure is used by some PCMH programs in other states. Benchmarks could be obtained from those states.	• Population Health WG • DLTSS WG (*see Core-44 ALT)*

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-44 (ALT*)	Transition Record with Specified Elements Received by Discharged Patients	NQF #0647/ #2036 (paired measure - see above)	Yes		Clinical records	None identified	• DTLSS WG
Core-45	Screening, Brief Intervention, and Referral to Treatment	Not NQF-endorsed	No, but a form of the measure is in use by Oregon Medicaid		Could potentially use claims or data from clinical records. If claims-based, could involve provider adoption of new codes.	None available, but a form of the measure is in by Oregon Medicaid, so benchmark rates could be available if the same measure was adopted.	• Population Health WG • DLTSS WG • Howard Center
New Measure	LTSS Rebalancing *(proposed for Medicaid measure set)*	Not NQF-endorsed	DAIL has specifications		DAIL collects statewide and county data from claims; potential to collect at ACO level.	None available	• DLTSS WG
New Measures	3 to 5 custom questions for Patient Experience Survey regarding DLTSS services and case management	Not NQF-endorsed	Questions have been developed; would require NCQA approval to add to PCMH CAHPS Survey		Could add to PCMH CAHPS Patient Experience Survey; might increase expense of survey.	None available	• DLTSS WG

Additional Measures Proposed for 2015 Payment:

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-10 MSSP-9	Ambulatory Care-Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	NQF# 0275; AHRQ PQI #05; Year 1 Vermont SSP Reporting	Yes		Claims	National PQI Benchmarks (for Medicare population) available at www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx	• CMS • DVHA

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
		Measure					
Core-12	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	Not NQF-endorsed; AHRQ PQI #92; Year 1 Vermont SSP Reporting Measure	Yes		Claims	National PQI Benchmarks (for Medicare population) available at www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx	• CMS • DVHA • DLTSS WG
Core-15 PQRS MU	Pediatric Weight Assessment and Counseling	NQF #0024; Year 1 Vermont SSP Reporting Measure; PQRS (alt core); MU (CMS 115v1)	Yes		Clinical records	HEDIS benchmarks available from NCQA. This measure has three components: • BMI Percentile • Counseling for Nutrition • Counseling for Physical Activity BMI Percentile Historical Performance HEDIS 2012 (PPO) • CIGNA PPO:63% • National 90th percentile: 65%; **Regional 90th percentile: 87%** National Average: 25%; Regional Average: 42% Counseling for Nutrition Historical Performance HEDIS 2012 (PPO) • CIGNA PPO: 73% • National 90th percentile: 69%; **Regional 90th percentile: 90%** National Average: 28%; Regional Average: 45% Counseling for Physical Activity Historical Performance HEDIS 2012 (PPO) • CIGNA PPO:72% • National 90th percentile: 65%; **Regional**	• DLTSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
						90th percentile: 86% National Avg.: 26%; Regional Avg.: 42%	
Core-16 MSSP-22-26 PQRS MU	Diabetes Composite (D5): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco non-use, Aspirin use	NQF #0729; MSSP; Year 1 Vermont SSP Reporting Measure; PQRS (BP & LDL control only); MU (CMS 163v1 [LDL only])	Yes. Measure steward (MCM) has changed specs for 2014 and 2015.	Change to national LDL control guideline has impacted this measure.	Clinical records	Available from Minnesota Community Measurement for Minnesota provider performance	• DLTSS WG
Core-17 MSSP-27 PQRS MU	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059; MSSP; Year 1 Vermont SSP Reporting Measure; PQRS (add'l core); MU (CMS 122v1)	Yes		Clinical records	HEDIS benchmarks available from NCQA. Historical Performance HEDIS 2012 (PPO): (Lower rate is better) • BCBSVT: 41% • National 90th percentile: 22%; **Regional 90th percentile: 18%** National Average: 28%; Regional Average: 34%	• DLTSS WG
Core-19 MSSP-18 MU	Depression Screening and Follow-up	NQF #0418; MSSP; Year 1 Vermont SSP Reporting Measure; MU (CMC 2v2)	Yes		Clinical records	Measure in use in some other states; we would have to review how it is implemented in the other states to see if benchmarks are available	• DLTSS WG
Core-20 MSSP-16 PQRS MU	Adult Weight Screening and Follow-up	NQF #0421; MSSP; Year 1 Vermont SSP Reporting Measure; PQRS (core); MU (CMS 69v1)	Yes		Clinical records	In use by HRSA so benchmark data may be available.	• DLTSS WG
M&E-14	Avoidable ED Visits (NYU Algorithm)	Not NQF-endorsed; Year 1 Vermont SSP Monitoring and	Yes		Claims	Measure used in other states and in research, so it may be possible to identify benchmarks	• DLTSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
		Evaluation Measure					

Attachment 4a - Revised CMMI reporting timelines 6.12.14

Revised Reporting Timeline

- Budget:
  - Year One reallocation and carryover: **July 30th**
  - Revised overall project budget and year two budget: **October 31st**
- Quarterly Reports: (stay the same)
  - Q3 Report: **July 30th**
  - Q4 Report: **October 30th**
- Operational Plan Update: **October 31st**
  - Includes: self-evaluation plan, risk mitigation plan, any other project updates.

Attachment 4b - Staffing Report 6.17.14

109 State Street
Montpelier, VT 05609
www.healthcareinnovation.vermont.gov

To: Core Team
Fr: Georgia Maheras
Date: June 17, 2014
Re: Staffing Report

This memo provides an update on VHCIP funded staff recruitment and requests approval of three changes related to the staff.

Recruitment

VHCIP includes 24 funded positions, of which 15.5 are filled and 8.5 are vacant. Of those, 2.25 of the positions are at the Green Mountain Care Board, 2 are at the Department of Aging and Independent Living, 3 are at the Agency of Human Services Central Office, 16.25 are at the Department of Vermont Health Access, and 1.5 is at the Agency of Administration. Below please find a list of filled and vacant positions:

Agency	Employee Name	Position Title	% dedicated to the project
AHS	Diane Cummings	Fiscal Manager: Financial Manager II	100%
AHS	Julie Wasserman	Program Manager for Duals: Duals Director	100%
AOA	Georgia Maheras	Project Director	100%
DAIL	Jennifer Woodard	Payment Program Manager: Health Policy Analyst	100%
DVHA	Alicia Cooper	Payment Program Manager: Quality Oversight Analyst	100%
DVHA	Erin Flynn	Quality Monitoring & Evaluation: Senior Policy Advisor	100%
DVHA	Amy Coonradt	Payment and Policy Specialist: Health Policy Analyst	100%
DVHA	Kara Suter	Payment Reform Director	25%
DVHA	Amanda Ciecior	Service Delivery Analyst: Health Policy Analyst	100%

DVHA	Luann Poirier	Service Delivery Specialist: Administrative Services Manager I	100%
DVHA	Jessica Mendizabal (eff. 6/23)	Fiscal Manager: Contract and Grant Administrator	100%
DVHA	Bradley Wilhelm	Quality Monitoring & Evaluation: Senior Policy Advisor	100%
DVHA	Cecelia Wu	Payment Initiative Director, Shared Savings	80%
GMCB	Annie Paumgarten	Evaluation Director	100%
GMCB	Christine Geiler	Grant Program Manager: Grant Manager Coordinator	100%
GMCB	Richard Slusky	Payment Reform Director	25%
IFS	Carolynn Hatin	Medicaid Data Analyst: Business Administrator	100%
AOA	Recruiting at AOA	Workforce Work Group Manager	50%
DAIL	Recruiting at DAIL (new posting end of June)	Payment Program Manager	100%
DVHA	Recruiting at DVHA	Payment Initiative Director, Payment Pilots	100%
DVHA	Recruiting at DVHA	Payment Program Manager: Policy and Planning Chief	100%
DVHA	Recruiting at DVHA	Medical Data Analyst: Quality Oversight Analyst	100%
DVHA	Recruiting at DVHA	Medicaid Data Analyst: Health Care Statistical Information Administrator	100%
DVHA	Recruiting at DVHA	Medicaid Data Analyst: Health Care	100%

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		Statistical Information Administrator	
DVHA	Recruiting at DVHA	Medicaid Data Analyst: Health Care Statistical Information Administrator	100%
DVHA	Recruiting at DVHA (pending)	Quality Monitoring & Evaluation: Senior Policy Advisor	100%

As you can see in the table above, Jessica Mendizabal will be leaving UMass (and the Project Management Team) and working directly for DVHA in a contracts administrative function.

Recommended Change to Staffing Structure:

As discussed previously, the VHCIP has experienced recruitment challenges with the Data Analyst positions (highlighted in yellow above). DVHA has been successful in obtaining contractor support for similar work. Additionally, VHCIP has been unable to execute a contract for workforce analysis at the Department of Health due to lack of qualified bids. The Department of Health has, however, successfully recruited for analysts and believes there is a strong pool of applicants for this position. Additionally, the changes in the Project Management Team structure (George Sales' departure and Jessica Mendizabal's transition to DVHA) have provided me with the opportunity to review the structure of this team and what skills are necessary to centrally support VHCIP. To solve these three issues, I recommend the following:

1. Transition one of the Data Analyst positions to the Department of Health. This position would be converted into a workforce analyst.
2. Transition the previously allocated $150,000 for workforce analysis from VDH to DVHA for contract data analysis.
3. Convert one Data Analyst position to a Policy Analyst working to support VHCIP with me directing this person's work.