Attachment 1 - VHCIP Steering Committee Meeting Agenda 7-09-14

VT Health Care Innovation Project
Steering Committee Meeting Agenda

July 9, 2014 10:00 am- 12:00 pm
4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	10:00-10:05	Welcome and Introductions	Mark Larson and Al Gobeille	Attachment 1: Agenda
2	10:05-10:15	Public Comment	Mark Larson and Al Gobeille	
3	10:15-10:20	Minutes Approval	Mark Larson and Al Gobeille	Attachment 3: May Minutes
4	10:20-10:30	Core Team Update	Anya Rader Wallack	
5	10:30-11:00	Policy: 1. Medicaid and Commercial Shared Savings ACO Program Update 2. Quality and Performance Measures Work Group Year Two Shared Savings ACO Program Measures Update	5.1 Richard Slusky and Kara Suter 5.2 QPM Chairs and Staff	Attachment 5a & 5b: SSP and ACO FAQ and Chart Attachment 5c: Process for Review and Modification Attachment 5d: Payment Measures Criteria Attachment 5e: Adopted Measure Selection Criteria Attachment 5f: Proposed Measure Overview and Benchmarks

6	11:00-11:15	Financial Requests: 1. HIE/HIT Work Group Proposal	Georgia Maheras	
7	11:15-11:50	Six-Month Preview for Steering Committee	Georgia Maheras and Work Group Chairs	Attachment 7: Six-Month Preview for Steering Committee
8	11:50-12:00	Next Steps, Wrap-Up and Future Meeting Schedule	Mark Larson	Next Meeting: August 6th 10am-12pm, Montpelier

Attachment 3 - VHCIP Steering Committee Minutes 5-14-14

VT Health Care Innovation Project
Steering Committee Meeting Minutes

Date of meeting: May 14, 2014 at DVHA Large Conference Rm - 312 Hurricane Lane, Williston 10 am - 12 pm

Members: Melissa Bailey, Stephanie Beck, Bob Bick, Harry Chen, Peter Cobb, Elizabeth Cote, Paul Dupre, John Evans, Catherine Fulton, Dale Hackett, Paul Harrington, Trinka Kerr, Mark Larson (co-chair), Jackie Majoros, David Martini, Todd Moore, Mary Val Palumbo, Ed Paquin, Laura Pelosi, Allen Ramsay, Julie Tessler, and Sharon Winn.

Attendees: Amy Coonradt, Alicia Cooper, Diane Cummings, Tracy Dolan, Erin Flynn, Christine Geiler, Pat Jones, Nelson Lamothe, Georgia Maheras, Marybeth McCaffrey, Annie Paumgarten, Luann Poirer, Richard Slusky, Kara Suter, Julie Wasserman, Spenser Weppler, and Jennifer Woodard.

Agenda Item	Discussion	Next Steps
1. Welcome & Introductions	Mark Larson called the meeting to order at 10:07 am.	
2. Public Comment	Mark Larson asked for public comment and no comments were offered.	
3. Minutes Approval	Trinka Kerr moved to approve the minutes. The motion was seconded by John Evans. The motion passed.	
4. Core Team Update	Georgia Maheras gave a Core Team update: • There will be additional funds available for the Grant Program. • The second round of grants is anticipated to begin in late July. • She will be presenting a six month progress report and a six month preview for VHCIP to the Core Team.	Chrissy will distribute link to docs after they have been presented to Core Team.

Agenda Item	Discussion	Next Steps
	There were no questions from group.	
5. Policy Request	1. No requests at this time.	
6. Financial Requests	1. Population Health Work Group Proposal (attachment 6): Georgia Maheras presented a request from the Population Health Work Group to release an RFP to hire a contractor to assist Vermont in exploring the development and potential application of the Accountable Health Community (AHC) to Vermont's health care system. The deliverable would be a fully developed pilot program. Georgia reviewed the definition an AHC and what some of the major functions could include. The group discussed the presentation and the following points were made: • Tracy Dolan noted that the proposal is consistent with the Population Health Work Group Charter but will also serve to review how Population Health should be included in SIM work. There is a deliverable to provide a report at the end of VHCIP, this will help facilitate the research to support that report. • Both Trinka Kerr and Julie Tessler asked about the type of communities, would there perhaps be a focus on smaller communities and what the scope of the pilot might be? Tracy noted that it could be applied to a variety of service areas. They would see how the model works first before applying it to any sub-population or geographic area. • Paul Harrington asked about previous efforts; Blueprint for example, should be part of the discussion. Tracy responded that Blueprint could be looked at especially core pieces however there are some limitations with regard to resources. • Karen Hein noted that there may be work being performed by the GMCB that could support this effort. • Mark Larson clarified that the group is not proposing to implement any model at this time. • Dale Hackett asked what models were being looked at for potential possibilities. Tracy responded that there are many models across the country. The goal is to create partnerships not typically associated with one another however without research she couldn't speak much more to it. • Karen Hein highlighted that community would be the focus and that the health care industry wouldn't be the drivers.	

Agenda Item	Discussion	Next Steps
	• Peter Cobb asked if a consultant has been picked. Tracy noted that that they haven't released the RFP. • Todd Moore requested that the consultant be made aware of the already existing collaboration efforts. • Jackie Majoros questioned what resources could be allocated and what the source of the AHC definition was? Tracy answered that identifying those resources will be part of the job of the consultant and that the AHC definition is currently pending. • Peter Cobb asked if the group was confident of the project timeline. Tracy expressed that they were and that Jim Hester who currently assists the group could help get the consultant up to speed. Tracy Dolan moved for the Steering Committee to approve the proposal and it was seconded. The motion passed unanimously. 2. <u>Bailit Health Purchasing, Inc. Amendment (attachment 6)</u>: Georgia Maheras presented an amendment to the Bailit Health Purchasing, Inc. contract. The amendment would support work performed in the following VHCIP work groups: Care Models and Care Management, Quality and Performance Measures and Payment Models. Bailit will also perform tasks related to two parts of the ACTT proposal previously approved by the Steering Committee and Core Team. The group discussed the presentation and the following points were made: • Georgia noted that Bailit Health Purchasing, Inc. is also working with Oregon, another SIM testing state. • Pat Jones and Todd Moore both expressed the depth of knowledge and resources that Bailit can provide including detailed crosswalks and analysis. Catherine Fulton noted how helpful Bailit's expertise had been to the QPM work group. • Paul Harrington asked if Bailit has access to the work of other consultants, Truven for example. Georgia responded that yes, that is a feature of all of our contracts and bi-monthly communications will be set-up to foster communication. • Dale Hackett asked where the contract information could be found. Georgia noted that the	

Agenda Item	Discussion	Next Steps
	VHCIP website would house this information. • Jackie Majoros asked if the amendment included consulting services for the Workforce work group. Georgia responded that this is separate. Sharon Winn moved for the Steering Committee to approve the proposal and Trinka Kerr seconded the motion. Allan Ramsay inquired about other sole source contracts we have approved and Georgia noted the DLTSS work group contract with Pacific Health Policy Group and the Population Health work group contract with Jim Hester. The motion passed unanimously. Mark noted that we could do an annual update on sole source contracts. Paul Harrington asked if the Steering Committee get a full balance sheet for the project. Georgia responded that she would be presenting the expenditure analysis to the Core Team and would forward it along to the group. Sharon Winn expressed that the budget conversation should be aligned with the work progress milestones.	
7. Status Reports from Work Group Chairs	The work groups presented their status reports to the committee (attachment 7). **A. <u>Care Models and Care Management</u>** Pat Jones noted that the group has been discussing both the demand (what do we need) and supply (what are we doing). There is a strong need for structured data which then plan to get from Bailit. They are also focusing on the Learning Collaborative and Care Model standards for ACOs. **A. <u>DLTSS</u>** Julie Wasserman explained the work the group has planned around the DLTSS Model of Care. In addition she discussed the additional meeting the group had to discuss the details of the various Medicare, Medicaid, and commercial Shared Savings Programs and related ACOs operating in Vermont. This document will be made available. **B. <u>HIE/HIT</u>** Simone Rueschemeyer noted that the ACTT contract was moving forward. The group has been discussing criteria for prioritizing and recommendation of approval of VHCIP grant proposals. They are also focusing on developing further clarity and criteria development for Telemedicine as well	Chrissy will distribute the DLTSS document after final edits are made.

Agenda Item	Discussion	Next Steps
	as developing referrals for the QPM work group. **C. <u>Payment Models</u>** Kara Suter noted that the group has been working on a revised work plan and are reviewing the timeline. There should be a full ACO update in June for both Commercial and Medicaid and the evaluation/analytic contract is in process. Paul Harrington asked what type of analytics? Richard Slusky answered that it would be validated with all payers. Dale Hackett asked what would happen if we need to change course. Kara explained that this is a different lens on data we have and can't speculate however the work would also be used to inform other work groups. Allen Ramsay inquired about the potential timeframe for presenting models to GMCB. Kara noted that a potential launch might be the 1st or 2nd Qtr. of 2015 but it's speculative. **D. <u>Population Health</u>** Tracy Dolan noted the work group reviewed grants that came through as alternative funding and had a good discussion with Northwestern. They are working on developing criteria for the QPM work group. They have also been reviewing the SIM Operational Plan to make sure that they are aligned with the e deliverables. **E. <u>Quality and Performance Measures</u>** Cathy Fulton noted that 12 of the 17 proposed criteria were accepted, the remaining five need work. Todd Moore asked about the purpose of the criteria. Cathy and Pat expressed that the criteria would serve as baseline guidance and needs to be broad enough so all measures can be evaluated by them. **F. <u>Workforce</u>** Mary Val noted that new licensures will require completing a survey. The LTC Sub-Committee will review all survey work and determine if the information is sufficient enough to create a proposal.	
8. Next Steps, Wrap-Up and Future Meeting Schedule	The next meeting will be Wednesday, June 11th 10 am – 12 pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

Attachment 5a & 5b - SSP and ACO FAQ and Chart

State Innovation Model

109 State Street
Montpelier, VT 05609
http://healthcareinnovation.vermont.gov

Overview of Shared Savings Programs (SSPs) and Accountable Care Organizations (ACOs) in Vermont

July 8, 2014

Please refer to the Table titled "Details of SSPs and ACOs in Vermont" following this narrative for details about the specific SSP-ACO agreements operating in Vermont, including the ACO's provider networks and the estimated percent of attributed lives within each SSP.

1. *What is an Accountable Care Organization (ACO)?*

An ACO is a network of health care providers, such as doctors, hospitals, home health agencies and mental health providers, who have committed to work together to improve health outcomes at lower costs for a defined group of patients. ACOs are intended to organize providers to better control health care cost growth and shift the focus from providing their separate services to coordinating with each other for the benefit of the people they serve. Currently, reimbursement mechanisms for services by ACO providers have not changed, but the ACO and its providers benefit from "shared savings" arrangements with payers.

There are three ACOs in Vermont: Community Health Accountable Care (CHAC), Accountable Care Coalition of the Green Mountains/Vermont Collaborative Physicians (ACCGM/VCP)[1], and OneCare Vermont (OCV). They include, collectively, all of the State's hospitals, plus Dartmouth-Hitchcock, most of the state's physicians, all of the state's federally-qualified health centers and many of the state's home health and mental health providers. All Vermont ACOs have agreed to participate in shared savings programs with Medicare and Vermont commercial payers. Two are participating in a Vermont Medicaid shared savings program.

2. *What is a Shared Savings Program (SSP)?*

In a shared savings program, the ACO provider network agrees to be tracked on total costs and quality of care for the patients it serves, in exchange for the opportunity to share in any savings achieved through better care management. Provider participants in ACOs essentially have agreed that quality can be improved and health care costs can be reduced, and they will work together toward that goal.

This is different from the current predominantly fee-for-service financial model in American health care, which creates incentives for quantity of service but not necessarily quality of service. Rather, Shared Savings is a middle ground between fee-for-service, which can encourage overuse of care, and a

[1] ACCGM is in the Medicare Shared Savings Program and VCP is in the Commercial Shared Savings Program.

per person amount (capitation), which can encourage underuse. Under shared savings, providers still receive fee for service payments – but the total payments are tracked and provider networks can keep some savings if they meet or exceed quality thresholds and the total payments are less than what was projected at the beginning of the year.

3. Do ACOs and SSPs exist in states other than Vermont?

In other states, ACOs exist or are planned. Specifically, Minnesota, Oregon, New Jersey, Maine and Massachusetts all have, or will have, Medicaid Shared Savings Programs where they contract with ACOs. Commercial payers around the country are also creating Shared Savings Programs. In Vermont they are central to the State's reform plans, and are currently considered to be the best available tool for better coordination of effort across providers, better outcomes for patients and reduced costs. We hope Vermont ACOs can be the foundation for long-term cost and quality accountability, and we will evaluate their success over the next three years to see if that is possible.

Vermont has advantages over other states in using ACOs:

- State oversight of the shared savings programs through the Green Mountain Care Board (GMCB)
- A mix of ACO models:
  - One that is statewide and inclusive of most providers
  - One that is FQHC-based
  - Two that are controlled by independent physicians
- All payer participation in shared savings programs. All-payer participation is essential, because otherwise there will not be sufficient incentives for health care providers to re-organize the system and process of care delivery. Having all payers participate in VT, given its size, increases the likelihood of true transformation on the ground.

4. What are the SSP "Standards"?

In the commercial and Medicaid SSPs, "standards" were developed to offer guidance to ACOs participating in either SSP. Examples of standards include the methodology for attribution of lives and parameters related to the calculation of ACO financial performance and shared savings. Rules regarding the operation of the Medicare SSP were developed by the federal government, and are outlined in the Code of Federal Regulations. These rules cannot be altered by Vermont Stakeholders.

The Medicaid and Commercial shared savings programs were developed as part of Vermont's Health Care Innovation Project. The standards were approved by the Vermont Health Care Innovation Project (VHCIP) Steering Committee, the VHCIP Core Team, and the GMCB. We are testing the shared savings model, as well as two other innovative payment models. All three models will be evaluated over a three-year period for their effectiveness at improving quality and controlling cost growth.

5. What are "attributed lives"?

The term "attributed lives" refers to the health plan beneficiaries whose total cost of care is assigned to an ACO by a payer for purposes of calculating shared savings in accordance with the specific Shared Savings Program (SSP) Standards. Details of the mechanisms used for attribution differ across the three SSPs. However, in general, beneficiaries are assigned to ACOs based on where they received a

preponderance of primary care services during the most recent 12 months (24 months for the Commercial SSP). Since not all primary care providers are part of an ACO network, some Vermonters may not be attributed to an ACO, and therefore their cost of care is not included in financial calculations under an SSP.

a. Can a beneficiary who is attributed to an ACO opt-out?

In the Medicare and Medicaid SSPs, ACOs must ensure that the beneficiary has been notified that his/her provider is a participant in the SSP and allow the beneficiary to opt-out of allowing the payer to share his/her medical claims data with the ACO. However, even if beneficiaries opt out of this information-sharing, they will still be attributed to an ACO for purposes of calculating the ACO's Total Cost of Care and potential savings.

b. Are there circumstances where a person attributed to an ACO may receive a different set of services than someone who is not attributed to an ACO?

Attribution to an ACO does not change a beneficiary's access to services. ACOs may provide special clinical interventions to targeted populations who have complex needs or high costs in order to improve their care and control costs. It is likely, however, that these interventions would apply to all individuals served by the providers in an ACO, not just those attributed to the ACO. In addition, ACOs may develop care management models only for individuals attributed to their ACO, in which case these individuals might receive care management differently than someone who is not in an ACO, or someone who is in a different ACO.

c. How does attribution work if an individual has more than one insurance carrier?

Attribution Methodology for Individuals with Multiple Coverage		
Medicare SSP	***Medicaid SSP***	***Commercial SSP***
The purpose of the Medicare SSP is to align incentives between Part A and Part B; as such, the program only attributes a beneficiary to an ACO if the beneficiary has at least 1 month of Part A and Part B enrollment, and the beneficiary cannot have any months of Part A only or Part B only enrollment. • Individuals that have Medicare Part A and have commercial insurance for Part B-like services are excluded from attribution in the Medicare SSP. • Individuals that have both Medicare Part A and Part B, and also has commercial insurance are included in the attribution in the Medicare SSP, as long as they have at least one month of Medicare Part A and Part B enrollment, and do not have any months of Part A only or Part B only enrollment.	The following populations are excluded from attribution to an ACO: • Individuals who are dually eligible for Medicare and Medicaid; • Individuals who have third party liability coverage; • Individuals who have coverage through commercial insurers; • Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.	Individuals are attributed to an ACO only if the commercial insurer is the primary payer, and the product is available on Vermont Health Connect. • Individuals who have Medicare or Medicaid as primary and a commercial plan as secondary are not included in the Commercial SSP. • Individuals that have Medicare Part A and have commercial insurance for Part B-like services are excluded from attribution in the Commercial SSP. • Individuals that have both Medicare Part A and Part B, and also have commercial insurance are excluded from attribution in the Commercial SSP.

6. ***What providers are in the ACOs' networks?***
An ACO's provider network may differ for each SSP in which they are participating. Please see the "Detail of SSPs and ACOs in Vermont" Table for a list of providers in each ACO's network for each SSP. All three SSP programs are very specific about the kinds of providers that are qualified to have attributed lives and these are the "Network Participants". Network Participants are defined by each payer and are mostly primary care clinicians. "Network Affiliates" are providers who don't have lives attributed to them but do have contracts with the ACO to be part of their provider network.

7. ***Is it possible that a given provider would sign multiple contracts with multiple ACOs?***
Currently there are 8 Agreements between SSP payers and ACOs in which providers could have contracts to participate in an ACO network. This number may grow in the future as ACOs expand their participation in all available SSPs. Providers that have attributed lives can only sign contracts with one ACO within each SSP. (If these providers were associated with more than one ACO, it would be unclear which ACO a beneficiary is assigned to, and consequently, which ACO would get any shared savings arising from the ACO provider's efforts.) Providers in practices that do not attribute any lives can sign contract agreements with multiple ACOs:

Current SSP-ACO Agreements in Vermont				
ACOs	**Shared Savings Programs (SSPs)**			
	Medicare	**Medicaid**	**Commercial BCBS-VT**	**Commercial MVP[2]**
Health*first* ACCGM	X			
Health*first* VT Collaborative Physicians			X	
OneCare Vermont	X	X	X	
CHAC	X	X	X	

8. ***Will providers also continue serving people who are not attributed to any ACO?***
Yes, providers also continue to serve people who are not attributed to an ACO.

9. ***What is "Total Cost of Care"?***
ACOs are eligible to share in the savings if the actual "Total Cost of Care" for their attributed lives is less than the predicted Total Cost of Care for a given year. The benefits included in the Total Cost of Care calculation vary by SSP, and in the case of the Medicaid SSP, will expand throughout the three year program.

The Medicaid Shared Savings program does not currently include long-term services and supports (LTSS) in the calculation of Total Cost of Care" – the costs on which an ACO can potentially achieve savings. The State will need to make a decision over the next three years about when and how the total costs of care should be expanded to include LTSS.

[2] There are no attributed lives for the Commercial MVP Shared Savings Program.

Benefits included in Total Cost of Care (TCOC) Calculations		
Medicare SSP	**Medicaid SSP**	**Commercial SSP**
Generally comparable to Medicare Part A and Part B services	All 3 years—Services include inpatient hospital, outpatient hospital, professional services, ambulatory surgery center, clinic, federally qualified health center, rural health center, chiropractor, independent laboratory, home health, hospice, prosthetics, orthotics, medical supplies, durable medical equipment, emergency transportation, and dialysis facility. The State has the option to expand the TCOC beginning in Year 2 (January 1, 2015) of the program to include DLTSS or other specialized services. ACOs will have the option to adopt the expanded TCOC in Year 2 and it will be mandatory beginning in Year 3 (January 1, 2016). Medicaid will seek recommendations from VHCIP Work Groups prior to adopting the expanded TCOC definition.	Most benefits offered through exchange insurance plans, with the following exceptions: • Services that are carved out of the contract by self-insured employer customers • Prescription (retail) medications [potential inclusion in the context of shared (upside and downside) risk in Year 3 following VHCIP Payment Models Work Group discussion] • Dental benefits (the exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit).

10. How does "Shared Savings" work?

If quality and patient experience of care measurement thresholds are met, and there are savings relative to the predicted TCOC for the ACO attributed population, then a portion of those savings is paid to the ACO and the remaining portion goes to the payer. ACOs can increase their share of savings if they perform above the quality and patient experience of care measurement thresholds previously mentioned. Any shared savings payments are in addition to fee-for-service payments already received by health care professionals. The amount of shared savings an ACO will receive depends on: 1) how the savings meet the SSP-defined "Minimum Savings Rate", and 2) how the ACOs perform on SSP-determined quality and performance measures.

Shared Savings Requirements		
Medicare SSP	**Medicaid SSP**	**Commercial SSP**
ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicare savings. Actual amount of savings an ACO can receive is determined by ACO's performance regarding reporting on and meeting quality metrics.	ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicaid savings. The actual amount of savings an ACO can receive is determined by ACO's performance on certain quality metrics.	ACOs do not need to meet a minimum savings rate to qualify for savings. ACOs can receive up to 25% of savings achieved between the expected amount and the minimum savings rate (MSR) (which is calculated based on # of attributed lives in the ACO), and up to 60% of their savings if they exceed the MSR, with a maximum savings of 10% of their expected expenditures. Actual amount of savings an ACO can receive is determined by ACO's performance on certain quality metrics.
Quality Measures for ACOs to Share in Savings**:** • Currently 33 Measures • Year 1: Only must report on measures • Years 2 and 3: Must report on some measures and meet defined performance metrics on others	Quality Measures for ACOs to Share in Savings**:** • Currently 32 Payment and Reporting Measures, 8 of which are Payment Measures that impact shared savings • Years 1 - 3: Must report on some measures and meet defined performance thresholds on others	Quality Measures for ACOs to Share in Savings**:** • Currently 31 Payment and Reporting Measures, 7 of which are Payment Measures that impact shared savings • Years 1 - 3: Must report on some measures and meet defined performance thresholds on others

11. Are there preconditions on how Shared Savings can be spent by ACOs?

The intent of the SSPs is that a portion of the savings is used by the ACO for administration and other costs, and that the remainder is distributed to the professionals who contributed to the implementation of the improvements that led to the savings. The Medicare SSP only allows ACOs to share their Medicare savings with providers that have a Medicare enrolled provider billing number. ACOs participating in the Vermont Medicaid and Commercial SSPs can share their savings with any provider in their network, but are required to share their written plan for distribution of their shared savings with the State each year. Please refer to the "SSPs and ACOs in Vermont" Table for more detail about how each ACO will share its savings with providers under each SSP. The shared savings formulas are still being determined by some ACOs, but will most likely be different depending on the SSP.

12. What is downside risk and how does it work?

Downside risk is designed to address concerns that shared savings is "one-sided" since there are no consequences if the financial calculations actually yield higher costs, or if no care improvement is seen. As such, the Medicare SSP includes the possibility of both upside and downside risk, or both shared savings and penalties. In this two-sided model, ACOs receive shared savings for managing costs and meeting quality and satisfaction benchmarks, but also will be liable for expenses that exceed spending targets (i.e., downside risk). If an ACO agrees to take downside risk, they typically also share in a higher percentage of any savings that are attained.

Risk Parameters		
Medicare SSP	**Medicaid SSP**	**Commercial SSP**
Upside Risk Only for 3 Years, with Up and Downside Risk starting Year 4 if the ACO decides to continue in the Shared Savings Program	ACOs were asked to select from two tracks (one-sided or two-sided model) for contract years one through three of the program. In the case of the one sided model, the maximum sharing rate is 50%; and in the case of the two-sided model, the maximum sharing rate is 60%. To date, all ACOs participating in the Medicaid SSP have chosen one-sided risk model which includes upside Risk Only for 3 Years. All three programs are currently exploring options for inclusion of downside risk after the initial three years of the contract.	Upside Risk Only for 2 Years; Upside and Downside Risk in Year 3; no decisions made regarding Downside Risk after Year 3

13. ***What protections exist for beneficiaries if their provider is negatively impacted by the ACO arrangement for down-side risk (i.e., provider folds because they perform poorly and are required by the ACO to help pay back funds to CMS)?***

The Medicare and Medicaid Shared Savings Programs do not restrict beneficiary access to providers in any way – beneficiaries retain freedom of choice to see the providers they want to see. The commercial Shared Savings Program does not restrict beneficiary access except according to benefit design limitations.

Because the ACO structure is an agreement between the provider and the ACO, the beneficiary will not be directly impacted by their provider's decision to leave an ACO. That said, beneficiaries may notice positive impacts regarding their care delivery because of their provider's participation in an ACO, and therefore a beneficiary may want to seek out another provider who is in the same ACO. A beneficiary's choice of provider is not at all restricted, and they can go to another provider at any time they choose. The state will be monitoring patient experience in several ways to ensure that beneficiaries are getting the necessary care, including a patient experience survey and monitoring appeals and grievances for beneficiary complaints.

14. What is the governance and advisory structure of the ACOs in Vermont?

ACO	Governing Body	Formal Advisory Groups
Health*first* - Accountable Care Coalition of the Green Mountains (ACCGM)	ACCGM Management Committee: Comprised of physician participants, Executive Director and Medicare beneficiary. This committee meets quarterly. The ACCGM Management Committee governs the affairs of ACCGM and has broad authority to act on behalf of and execute the functions of the ACO.	Care Coordination and Quality Improvement Sub-Committee: Comprised of Physician Participants, Executive Director and Clinical Manager of ACCGM. Meets quarterly to review clinical data and make recommendations to the Management Committee for implementation of policies and programs. Compliance and Clinical Implementation Committee: Comprised of participating practice administrators, Executive Director, Clinical Manager and Network Administrator. Meets every other month and reviews compliance and operational aspects of the ACO. Recommendations are made to the Management Committee for adoption/approval.
Health*first* - - Vermont Collaborative Physicians (VCP)	VCP Management Committee: Comprised of physician participants, Executive Director and consumer representative. This committee will meet quarterly and will govern the affairs of VCP.	Clinical Quality and Care Coordination Committee: This Committee will be responsible to the Management Committee for: (1) performance monitoring and improvement; (2) care management and coordination; and (3) protocol adaptation and implementation.
OneCare Vermont (OCV)	The OCV Governing Body includes a beneficiary representative from each of the three Shared Savings Programs, and representatives of the ACO hospitals, physicians and other OCV network providers, including mental health and substance abuse providers and post-acute and long-term care and support services providers.	Clinical Advisory Board (CAB): Comprised of OCV physicians and other providers from across Vermont representing expertise appropriate to the attributed beneficiaries; CAB membership is expanding to include additional providers and specialties to reflect the needs of the broader Medicaid and Commercial populations. Consumer Advisory Group: Will be comprised of representatives from communities served by OCV. Meets at least quarterly, with meeting reports shared at OCV board meetings. Purpose of the Group is to ensure consumers' input and comments are heard, considered, and reported to OCV's board.
Community Health Accountable Care (CHAC)	The CHAC Board includes a beneficiary representative from each of the three Shared Savings Programs, a representative from each FQHC and a representative from Bi-State. Seats are open for representation from a hospital, from behavioral health, and from long-term supports and services. There are two additional at large seats.	The Clinical Committee is responsible for producing clinical guidelines to be used in the care of CHAC patients as well as a network annual quality improvement plan, which prioritizes areas where CHAC overall could improve its performance against its own clinical standards and guidelines as well as against Shared Savings Program goals. The Clinical Committee is also responsible for conducting quarterly performance updates. The Beneficiary Engagement Committee serves to engage beneficiary input into the design of CHAC programs and strategies. The Committee will seek input from a broader set of CHAC beneficiaries than are able to sit on the Governing Board, and will review all feedback from beneficiaries and their representatives to make recommendations to the Governing Board about how to best ensure that patients are represented in CHAC's decision making.

15. Are there other ways ACOs must address beneficiary engagement?

The "Governance" section of the Medicaid SSP contracts between DVHA and ACOs includes the following provisions:

D. 2. Devote an allotted time at the beginning of each in-person governing body meeting to hear comments from members of the public who have signed up prior to the meeting and providing public updates of the ACO's activities.

D. 4. Post summaries of ACO activities provided to ACO's consumer advisory board on the ACO's website.

G. The ACO's governing body must include at least one consumer member who is a Medicaid beneficiary. Regardless of the number of payers with which the Contractor participates, there must be at least two consumer members on the Contractor governing body. Consumer members shall have some prior personal, volunteer, or professional experience in advocating for consumers on health care issues. The Contractor shall not be found to be in non-conformance with this provision if the Contractor has in good faith recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

H. Members of the ACO's management and the governing body must regularly attend consumer advisory board meetings and report back to the ACO's governing body following each meeting of the consumer advisory board. Other consumer input activities shall include but not be limited to hosting public forums and soliciting written comments. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

16. What is the relationship between ACOs and users and providers of human services and long-term services and supports?

The Medicaid Shared Savings Program gives rise to issues that the Medicare and commercial insurer programs don't face. Because Medicaid pays for a broader array of services than other payers, and serves vulnerable populations with very specific needs, we need to carefully consider and make decisions about the scope of the program within Medicaid.

The State is taking a very careful approach to integrating long-term services and supports and specialized disabilities services in shared savings programs. The State, the ACOs and long-term services and supports providers are in the early stages of discussions about whether and how ACOs could bridge health care and human services delivery in a positive way.

17. What will happen to the commercial and Medicaid SSPs after the three year contract is up?

It is understandable that some providers and some consumers may be worried about what the development of the ACOs means for them. The VHCIP Core Team, the Agency of Human Services and the GMCB are committed to continuing a process whereby concerns can be expressed and emerging issues are addressed.

The VHCIP project will be an important avenue of input into the evolution and evaluation of ACOs. Work groups that are part of the project will make recommendations in the coming months about such issues as:

- How to assure that quality measures on which ACOs report reflect the needs of Vermonters, especially those with disabilities;
- Whether and how to expand the scope of total costs to include LTSS;

- How to coordinate care management activities between acute and long-term services providers, and institutional and community-based providers, for the maximum benefit of the people they serve, and assuring that person-directed care is not compromised.

Recommendations from those work groups will be reviewed by the VHCIP Steering Committee, which includes a broad array of health, human services and disability stakeholders, and the VCHIP Core Team. The final recommendations will inform AHS and the GMCB regarding further design of ACO payment programs and long-term ACO oversight.

Details of Shared Savings Programs (SSPs) and Accountable Care Organizations (ACOs) in Vermont

MEDICARE SHARED SAVINGS PROGRAM (MSSP)								
ACO Name	Start Date in Program	Geographic Area	ACO Network Participants[1,2] (Providers with attributed lives)	ACO Network Affiliates[1] (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network[3]	Estimated Medicare Attributed Lives		
						# and % of Total VT Medicare Enrollees (Total N=126,081)[4]	# and % of VT MSSP Eligible Enrollees (Total N=117,015)[5]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Health*first* - Accountable Care Coalition of the Green Mountains (ACCGM)	Jan 1, 2013	Approved Statewide; current network available in Greater Burlington and North Central Vermont	• 30 Physicians – 10 Primary Care	Committee working on Collaborative Care Agreements (CCAs) with practitioners, including: • Specialists • Other specific entities (e.g., Visiting Nurses Association)	• 50% of shared saving distributed to Healthfirst Network Participants and CCA Practitioners o Collaborative Care Agreements (CCAs) will specify responsibilities of CCA Practitioners in order to share in these savings, including patient and network engagement • 50% of shared savings to Collaborative Health Systems[6]	7,446 6%	7,446 6%	583 3%
OneCare Vermont (OCV)	Jan 1, 2013	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All other VT hospitals • Brattleboro Retreat • 4 Federally Qualified Health Centers (FQHCs) • 4 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 28 of 40 Skilled Nursing Facilities • All but one Home Health and Hospice Agency • All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, no DS-only DA, no Children's MH Specialized Service Agency (SSA), and no DS SSAs	• 90% of shared savings distributed to OCV Network Participants; 10% retained by OCV • Separate Incentive Plan Provision for OCV Network Affiliates • Both depend on reporting and performance metrics	52,265[7] 41%	52,265[7] 45%	13,066[8] 61%
Community Health Accountable Care (CHAC)	Jan 1, 2014	8 of 14 Counties (Chittenden, Grand Isle, Franklin, Orleans, Caledonia, Essex, Orange, Washington)	• 5 FQHCs and Bi-State Primary Care Association - 24 FQHC practice sites (includes dental and school based sites) - 97 Primary Care Providers	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 8 of 9 Comprehensive MH/DS DAs, the 1 MH-only DA, no DS-only DA, the 1 Children's MH SSA, and 1 of 4 DS SSAs • 4 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	5,980 4.7%	5,980 5.1%	unknown
TOTALS			~427 Primary Care Providers ~ 67% of 634 Primary Care Providers statewide[9]			65,691 52% of all VT Medicare enrollees	65,691 56% of all VT MSSP Eligible enrollees	At least 13,649 At least 63% of all VT Duals

VERMONT MEDICAID SHARED SAVINGS PROGRAM (VMSSP)								
ACO Name	**Start Date in Program**	**Geographic Area**	**ACO Network Participants[10],[11] (Providers with attributed lives)**	**ACO Network Affiliates[9] (Providers without attributed lives)**	**ACO Shared Savings Distribution with Provider Network[12]**	**Estimated Medicaid Attributed Lives**		
						# and % of Total VT Medicaid Enrollees (Total N= 153,315)[13]	# and % of VT VMSSP Eligible Enrollees (Total N=95,000)[14]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
ACCGM/VCP	NA	NA	NA	NA	NA	NA	NA	NA
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All but 2 other VT hospitals • Brattleboro Retreat • 0 Federally Qualified Health Centers (FQHCs) • 3 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 22 of 40 Skilled Nursing Facilities • All but one Home Health and Hospice Agency • All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, the 1 DS-only DA, the 1 Children's MH Specialized Service Agency (SSA), and all 4 DS SSAs	• 90% of shared savings distributed to OCV **Network Participants and Affiliates**; 10% retained by OCV • Provider amount depends on reporting and performance metrics	29,000 19%	29,000 31%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	13 of 14 Counties (with sites in or significant service to all counties except Bennington)	9 FQHCs and Bi-State Primary Care Association • 49 FQHC practice sites • 233 Primary Care Providers	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 8 of 9 Comprehensive MH/DS DAs, the 1 MH-only DA, the 1 DS-only DA, the 1 Children's MH SSA, and all 4 DS SSAs • 5 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	21,000 14%	21,000 22%	0
TOTALS			~533Primary Care Providers **~84% of 634 Primary Care Providers statewide[15]**			Approximately 50,000 or Approximately 33% of all current VT Medicaid enrollees	Approximately 50,000 or Approximately 53% of all VMSSP Eligible enrollees	0 **0% of all VT Dual Eligibles**

COMMERCIAL SHARED SAVINGS PROGRAM (XSSP) – Blue Cross Blue Shield of Vermont (BCBS-VT) and MVP Health Care (MVP)

ACO Name	Start Date in Program	Geographic Area	ACO Network Participants[16] (Providers with attributed lives)	ACO Network Affiliates[15] (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network[17]	Estimated Commercial Plan Attributed Lives		
						# and % of Total VT Commercial Plan Enrollees (Total N=155,479)[18]	# and % of VT XSSP Eligible Enrollees (Total N=70,000)[19]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Health*first* - - Vermont Collaborative Physicians (VCP)	Jan 1, 2014	Statewide	• 69 Physicians – 24 Primary Care Practices	Committee working on Collaborative Care Agreements (CCAs) with practitioners, including: • Specialists • Other specific entities (e.g., Visiting Nurses Association)	• PCP's to retain the majority of shared savings • VCP to retain a portion for administration and reserves • Collaborative Care Agreements (CCAs) will specify responsibilities of CCA Practitioners in order to share in these savings, including patient and network engagement	7,200 (BCBS only) 5%	7,200 (BCBS only) 10%	0
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All but 3 other VT hospitals • Brattleboro Retreat • 1 FQHC • 2 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 23 of 40 Skilled Nursing Facilities • All but two Home Health and Hospice Agencies • All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, no DS-only DA, the 1 Children's MH Specialized Service Agency (SSA), and 1 of 4 DS SSAs	• 90% of shared savings distributed to OCV Network Participants; 10% retained by OCV • Separate Incentive Plan Provision for OCV Network Affiliates • Both depend on reporting and performance metrics	18,400 (BCBS Only) 12%	18,400 (BCBS Only) 26%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	12 of 14 Counties (with sites in or significant service to all counties except Bennington and Lamoille)	8 Federally Qualified Health Centers (FQHCs) and Bi-State Primary Care Association • 45 FQHC practice sites • 218 Primary Care Providers	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 8 of 9 Comprehensive MH/DS DAs, the 1 MH-only DA, no DS-only DA, the 1 Children's MH SSA, and no DS SSAs • 5 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	8,900 (BCBS Only) 6%	8,900 (BCBS Only) 13%	0
TOTALS			~587 Primary Care Providers ~ 93% of 634 Primary care Providers statewide[20]			34,500 22% of all VT Commercial Plan enrollees	34,500 49%of all VT XSSP Eligible enrollees	0 0% of all VT Dual Eligibles

ACRONYMS

ACCGM:	Accountable Care Coalition of the Green Mountains
ACO:	Accountable Care Organization
BAA:	Budget Adjustment Act
BCBS-VT:	Blue Cross Blue Shield of Vermont
CCA:	Collaborative Care Agreements
CHAC:	Community Health Accountable Care
CHS:	Collaborative Health Systems
DA:	Designated Agency
DHMC:	Dartmouth-Hitchcock Medical Center
DS:	Developmental Services
DVHA:	Department of Vermont Health Access
ESI:	Employer-Sponsored Insurance
ESIA:	Employer-Sponsored Insurance Assistance
FAHC:	Fletcher Allen Health Care
FQHC:	Federally Qualified Health Center
FTEs:	Full-time Equivalents
MH:	Mental Health
MSR:	Minimum Savings Rate
MSSP:	Medicare Shared Savings Program
MVP:	MVP Health Care
NA:	Not Applicable
OCV:	OneCare Vermont
SSA:	Specialized Service Agency
SSP:	Shared Savings Program
TBD:	To Be Determined
VCP:	Vermont Collaborative Physicians
VHAP:	Vermont Health Access Program
VMSSP:	Vermont Medicaid Shared Savings Program
VT:	Vermont
XSSP:	Commercial Shared Savings Program

[1] Current Network Participants and Network Affiliates as of April, 2014; may change over time
[2] ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicare performance and savings; Outcomes for each "life" can only relate to a single ACO.
[3] Under the Medicare SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicare savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics
[4] Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Downloads/2014/Mar/State-County-Penetration-MA-2014-03.zip
[5] MSSP does not include Medicare enrollees in Medicare Advantage Plans. In March 2014, 9,036 Vermonters were enrolled in these Plans. Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Downloads/2014/Mar/State-County-Penetration-MA-2014-03.zip
[6] Healthfirst partnered with Collaborative Health Systems (CHS), a subsidiary of Universal American Corp., to form ACCGM for the Medicare SSP. CHS has partnered with 34 Independent Practice Associations across the country to form Medicare SSP ACOs and provides care coordination, analytics and reporting, technology and other administrative services for the ACOs.
[7] Number of attributed lives is an estimate.
[8] Based on estimated attribution numbers as of June 30, 3014.
[9] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013
[10] Current Network Participants and Network Affiliates as of April, 2014; may change over time
[11] ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicaid performance and savings; outcomes for each "life" can only relate to a single ACO.
[12] Under the Medicaid SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicaid savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics
[13] Based on DVHA SFY'15 Budget Document Insert 2, using SFY '14 BAA enrollment figures; excludes Pharmacy Only Programs and VHAP ESI, Catamount, ESIA, Premium Assistance For Exchange Enrollees < 300%, and Cost Sharing For Exchange Enrollees < 350% (i.e., all programs that financially assist individuals to enroll in commercial products)
[14] Number provided in DVHA's VMSSP RFP; the following populations are excluded from being considered as attributed lives: Individuals who are dually eligible for Medicare and Medicaid; Individuals who have third party liability coverage; Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers; and Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.
[15] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013
[16] Current Network Participants and Network Affiliates as of April, 2014; may change over time
[17] Under the Commercial SSP, ACOs can receive up to 25% of savings achieved between the expected amount and the minimum savings rate (MSR) (which is calculated based on # of attributed lives in the ACO), and up to 60% of their savings if they exceed the MSR, with a maximum savings of 10% of their expected expenditures. Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics
[18] Vermont residents covered in Private Insurance Market, 2012; Source: 2011 Vermont Health Care Expenditure Analysis, Green Mountain Care Board, page 14. Only includes individuals who have a Commercial plan as their primary insurance.
[19] The XSSP eligible population for attribution to an ACO includes individuals who have obtained their commercial insurance coverage through products available on the VT Health Connect Exchange (obtained through the exchange website or directly from the insurer).
[20] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013

Attachment 5c - Process for Review and Modification

VHCIP Quality and Performance Measures Work Group
Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Programs
Work Group Recommendation (Approved February 10, 2014)

Standard:

1. The VHCIP Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set beginning in the second quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines. The goal of the review will be to determine whether each measure should continue to be used as-is for its designated purpose, or whether each measure should be modified (e.g. advanced from Reporting status to Payment status in a subsequent pilot year) or dropped for the next pilot year. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to measures for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes. In the interest of retaining measures selected for Payment and Reporting purposes for the duration of the pilot program, measures should not be removed in subsequent years unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.

2. The VHCIP Quality and Performance Measures Work Group and the VHCIP Payment Models Work Group will review all **targets and benchmarks** for the measures designated for Payment purposes beginning in the second quarter of each pilot year. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national x^{th} percentile) should remain constant or change for the next pilot year. The Work Group should consider setting targets in year two and three that increase incentives for quality improvement. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to benchmarks and targets for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

3. The VHCIP Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set and consider any new measures for addition to the set beginning in the first quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider data availability and quality, patient populations served, and measure specifications, with the goal of developing a plan for measure and/or data systems development and a timeline for implementation of each measure. If the VHCIP Quality and Performance Measures Work Group determines that a measure has the

support of a majority of the voting members of the Work Group and is ready to be advanced from Pending status to Payment or Reporting status or added to the measure set in the next pilot year, the Work Group shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure or be added to the set by July 31st of the year prior to implementation of the changes. New measures should be carefully considered in light of the Work Group's measure selection criteria. If a recommended new measure relates to a Medicare Shared Savings Program (MSSP) measure, the Work Group shall recommend following the MSSP measure specifications as closely as possible. If the Work Group designates the measure for Payment, it shall recommend an appropriate target that includes consideration of any available state-level performance data and national and regional benchmarks. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

4. The VHCIP Quality and Performance Measures Work Group will review **state or insurer performance on th**e **Monitoring and Evaluation measures** beginning in the second quarter of each year, with input from the VHCIP Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless a majority of the voting members of the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the VHCIP Quality and Performance Measures Work Group may recommend that the measure be moved to the Core Measure Set to be assessed at the ACO level and used for either Payment or Reporting. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to the Monitoring and Evaluation measures for the next program year if the changes have the support of a majority of the members of the Work Group. Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

5. The GMCB will release the **final measure specifications f**or **the next pilot year by no later th**an October 31st of the year prior to the implementation of the changes. The specifications document will provide the details of any new measures and any changes from the previous year.

6. If during the course of the year, a national clinical guideline for any measure designated for Payment or Reporting changes or an ACO or payer participating in the pilot raises a serious concern about the implementation of a particular measure, the VHCIP Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the VHCIP Payment Models Work Group. If the VHCIP Quality and Performance Measures Work Group determines that a change to a measure has the support of a majority of the voting members of the Work Group, recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Upon approval of a recommended change to a measure for the current pilot year, the GMCB must notify all pilot participants of the proposed change within 14 days.

Attachment 5d - Payment Measures Criteria

VHCIP Quality and Performance Measures Work Group
ACO Shared Savings Program Year 2 Payment Measure Selection Criteria
As of July 2, 2014

Criterion	Description
Relevant benchmark available	The measure has been selected from NQF-endorsed measures that have relevant benchmarks whenever possible.
Selected from the commercial or Medicaid Core Measure Set	The measure can only be selected from the available commercial or Medicaid core measure sets.
Presents an opportunity for improvement	The measure offers opportunity for performance improvement to achieve high-quality, efficient health care.
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.
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.
Focus on prevention and wellness by patient, physician and system*	Focus on prevention, self-care and maintaining wellness. The measure would include actions taken to maintain wellness rather than solely on identifying and treating disease and illness.
Focus upstream to include risk and protective factors*	The measure would capture personal health behaviors such as tobacco, diet and exercise, alcohol use, sexual activity, as well as other health and mental health conditions that are known to contribute to health outcomes.

*** These final two criteria from the Population Health Work Group were adopted by the QPM Work Group at its June 2014 meeting.**

Attachment 5e - Adopted Measure Selection Criteria

VHCIP Quality and Performance Measures Work Group
Adopted Criteria for ACO Shared Savings Programs – Year 2 Overall Measure Selection
As of July 2, 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.

The following criteria from the Population Health Work Group were adopted by the QPM Work Group at its June 2014 meeting:

Focus on prevention and wellness by patient,	Focus on prevention, self-care and maintaining wellness. The measure would include actions taken to maintain wellness rather than solely on

physician and system	identifying and treating disease and illness.
Focus upstream to include risk and protective factors	The measure would capture personal health behaviors such as tobacco, diet and exercise, alcohol use, sexual activity, as well as other health and mental health conditions that are known to contribute to health outcomes.

Attachment 5f - Proposed Measure Overview and Benchmarks

VT Quality and Performance Measures Work Group
Review of Changes in Measures Proposed for Year 2 Reporting and Payment
June 20, 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	Cervical Cancer Screening	NQF #0032; NCQA (HEDIS)	Yes	Changes in HEDIS specifications for 2014: • 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)			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 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%	• Population Health WG
Core-35/ MSSP-14	Influenza Immunization	NQF #0041; MSSP	Yes		Requires clinical data or patient survey to capture immunizations that were given outside of the PCP's office (e.g., in pharmacies, at	Medicare MSSP benchmarks available from CMS.	• Population Health WG • DTLSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
					public health events)		
Core-36/ MSSP-17	Tobacco Use Assessment and Tobacco Cessation Intervention	NQF #0028; 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%. 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	Hypertension (HTN): Controlling High Blood Pressure	NQF #0018; MSSP	Yes	Guideline change: In December 2013, the eighth Joint National Committee (JNC 8) released updated guidance for treatment of 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. Changes in HEDIS Specifications for 2015: 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.	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. 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%	• Population Health WG • DLTSS WG
Core-40/ MSSP-21	Screening for High Blood Pressure and Follow-up Plan Documented	Not NQF-endorsed; MSSP			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-	Not NQF-endorsed	No. Need to develop measure		Clinical records	This measure is used by some PCMH programs in other states. Benchmarks could be obtained from	• Population Health WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
	Management Plans		specs based on the NCQA standard, or borrow from a state that uses this measure.			those states.	• DLTSS WG (*see Core-44 ALT)*
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 proposed 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; may 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 Measure	Yes		Claims	National PQI Benchmarks (for Medicare population) available at www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx	• CMS • DVHA
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	Pediatric Weight Assessment and Counseling	NQF #0024; Year 1	Yes		Clinical	HEDIS benchmarks available from NCQA.	• DLTSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
		Vermont SSP Reporting Measure			records	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 90th percentile: 86%** National Avg.: 26%; Regional Avg.: 42%	
Core-16 MSSP-22-26	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	Yes. Measure steward (MCM) changed specs for 2014 and 2015.	Change to national LDL control guideline impacted this measure.	Clinical records	Available from Minnesota Community Measurement for Minnesota provider performance	• DLTSS WG
Core-17 MSSP-27	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059; MSSP; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	HEDIS benchmarks available from NCQA. Historical Performance HEDIS 2012 (PPO): (Lower rate is better) • BCBSVT: 41%	• DLTSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
						• National 90th percentile: 22%; **Regional 90th percentile: 18%** National Average: 28%; Regional Average: 34%	
Core-19 MSSP-18	Depression Screening and Follow-up	NQF #0418; MSSP; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	Measure in use in some other states; we would have to review how implemented to see if benchmarks are available	• DLTSS WG
Core-20 MSSP-16	Adult Weight Screening and Follow-up	NQF #0421; MSSP; Year 1 Vermont SSP Reporting Measure	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 Evaluation Measure	Yes		Claims	Measure used in other states and in research, so it may be possible to identify benchmarks	• DLTSS WG

Attachment 7 - Steering Committee Six-Month Outlook

Steering Committee Six-Month Outlook

July 9, 2014

Georgia Maheras, JD

Project Director

SIX-MONTH PREVIEW

August 2014

- Quarterly Progress Report
- Contract Update
- Work Group Action:
  - Quality and Performance Measures: Year 2 Shared Savings ACO Program Measures Recommendation

September 2014

- RFP Release:
  - For contracts anticipated to begin in January-March 2015
- Work Group Action:
  - HIE/HIT: Telemedicine/Telemonitoring Recommendations
  - Care Models/Care Management: Shared Savings Program Recommendations

October 2014

- Work Group Action:
  - Workforce: Strategic Plan Update
  - HIE/HIT: Strategic Plan Update
  - Payment Models: Year Two Shared Savings Program Recommendations

November 2014

- Year One Progress Report
- Grant Program Update
- Work Group Action:
  - DLTSS: recommendations around barriers in current payment and coverage structures

December 2014

- Work Group Action:
  - Payment Models: EOC and P4P Program Recommendations
  - QPM: EOC and P4P Quality Measure Recommendations

January 2015

- Contract Update
- Work Group Action:
  - Care Models and Care Management: Learning Collaborative Recommendation