Near Term Priorities for Healthcare Reform

Vermont is well positioned to be a national leader in the move away from fee for service (volume) to alternative payment models and a value based health system. The All-Payer Waiver (APW) that is currently being negotiated with CMMI provides a pathway to the most complete restructuring of healthcare payment in Vermont, and provides the flexibility that an accountable health system (AHS) needs for innovation and effective delivery system reform. At the same time, the vast majority of Vermont's healthcare providers are negotiating a novel reorganization to operate as part of a statewide accountable health system. Together, an All-Payer Waiver and a unified Accountable Health System will enter Vermont into a new transformational phase that involves complex social change and a major shift in the business practices of numerous stakeholders. Previous experience with delivery system reform in Vermont highlights the importance of state leadership to prioritize the mission, set a course, and help to align providers around a common purpose. Important roles for state leadership include knowledgeable guidance, neutral convening, and programmatic facilitation, along with diligent oversight, measurement, and monitoring on behalf of the states citizens.

The following is a list of general recommendations to state leadership that will help meet near term goals (2016-2017) and successful transition towards a value based health system. These recommendations reflect the opinion and experience of the outgoing Blueprint program director.

1. **Achieve successful negotiation of an All-Payer Waiver with CMMI** – At this stage, successful procurement of the waiver should be considered a 'must do'. The waiver establishes a novel opportunity for a whole population approach to payment reform, delivery system reforms, and cost control. As it currently stands, the waiver uses 2017 as a bridge year to continue strengthening Vermont's foundation of advanced primary care, community health system structure, with services increasingly focused on prevention and population health. Successful negotiation would position Vermont to have one of the most advanced health systems in the country, and leverage previous accomplishments to the fullest extent. This is a unique opportunity for Vermont's citizens, at a unique time in the nation's healthcare history. It should not be missed. In return for maximum flexibility, Vermont probably should be willing to accept the challenge of actually improving quality and controlling cost growth compared to national trends. The federal government projects that national healthcare spending will grow at an average rate of 5.7% from 2017 to 2019, and 5.8% from 2017 to 2015, a rate that is 1.3% ahead of the GDP (National Health Expenditure Projections 2015-2026. Health Affairs published online July 13, 2016). For its own economic health, Vermont needs to be able to beat this trend, which it can do with the flexibility offered by the waiver, and the coordinated efforts of a statewide data driven accountable health system. Its aspirational, it's tough, but the status quo is not sustainable for Vermont's tax payers, businesses, and citizens.

   Important Milestone – if Vermont does not have an all-payer waiver with CMMI, then Medicare payments for medical homes, community health teams, and SASH will stop on December 31, 2016. This will likely have a significant detrimental impact on Vermont's delivery system foundation. Vermont will move backwards instead of grasping the opportunity to lead the nation.

2. **Actively engage and maintain the commitment of Medicaid, commercial insurers, and self-insured businesses to participate in an aligned all payer model** – move as close as possible to an all-payer approach. Alignment of financing and payment models across payers establishes common incentives for an accountable health system, including the ability to focus on whole population health and well-being. The transition to an accountable health system implies that a provider led system will accept a substantial degree of responsibility for coordination, quality and costs, which means that the business model should change for commercial insurers and Medicaid.

   Important Consideration – An all-payer model, and an accountable health system, means that the business practices of insurers in Vermont should change substantially. During 2016-2017, Medicaid and commercial insurers need to examine their business practices and cost structures to see if there are opportunities for reducing overhead and administrative costs. The transfer of financial risk to the accountable provider network, and the responsibility of the provider network for quality and coordination, should change the work and costs that insurers have traditionally been responsible for including quality, risk management, utilization management, case management, etc. Insurers need excellent capability for oversight and monitoring in the interests of the customers and citizens they serve. But they shouldn't need to do the same level of direct services and management. Changes in insurer's business practices and administrative cost structures should be examined to determine if they can help contribute to controlling costs for tax payers and the individuals, families, and businesses that pay for healthcare coverage. Ideally, the state and/or GMCB will monitor whether commercial insurers and Medicaid adjust their business and cost structure in response to the changing landscape, and whether gains are realized by citizens and businesses. It is important to pay similar attention to cost efficiencies on the insurer side of the equation as well as provider efficiency and quality.

   Important Consideration – Given the states commitment to controlling healthcare costs, there should be a substantive assessment of whether the cost of coverage passed onto citizens and businesses is responsive to changes in healthcare expenditures. This analysis would support the responsibilities of the GMCB as well as policy decisions by the Administration and Legislature. The All-Payer Claims Database allows for close measurement of actual healthcare expenditures. There is no comparable statewide measurement of actual changes in insurance costs for businesses, families, and individuals, limiting the ability to quantify any relationship between changes in insurance costs vs. changes in healthcare expenditures.

   Important Consideration – Commercial insurers need to continue to contribute claims to Vermont's All-Payer Claims Database, and should work actively to solicit contribution from their self-insured customers. In an environment with an accountable health system, working under an all-payer model, there is a shared interest across providers, insurers, and citizens for accountability, measurement, and monitoring. The ability to evaluate comparative performance and variation across all settings, and across all segments of the population, is essential in order to oversee and guide Vermont's reforms. An All-Payer Claims Database is a key ingredient for consistent measurement, monitoring, and modeling across all settings. The GMCB and other evaluators will

not be able to adequately measure health system performance without this asset.

3. **Support alliance of ACOs and the development of a more integrated Accountable Health System (VCO)** – Given Vermont's size, provider landscape, and culture, a statewide provider alliance sharing responsibility for key outcomes provides the best opportunity to leverage the CMMI waiver, promote regional innovation, and to build a value based health system. With formation of VCO, participating providers will have a collective interest to control growth in costs, meet quality goals, improve health, and shift business emphasis from sick care to preventive care. This will be a complex transformation that will take time to mature, with many challenges and hiccups along the way.

   Important Consideration – Success in this venture will be more likely if state leadership expresses a well-articulated vision, helping to catalyze alliance formation and public confidence. At the same time, the state must emphasize the commitment to measurement, monitoring of comparative performance, and public transparency to assure that the interests of Vermont's citizens are protected. The state needs to have adequate resources in place for all aspects of this including expert oversight, regulation, data aggregation, measurement, monitoring, and programmatic assistance to the provider community for innovation and transformation. The Blueprint team can assist in a substantial way to help meet these needs and can also serve as a programmatic interface between the state and developing VCO.

4. **Support Blueprint work with VCO and the extended network of providers –** Blueprint and the three ACOs have been working closely together to strengthen the capabilities of our statewide, data guided, learning system. Regional collaborative structures are woven into the fabric in each of the 14 service areas and are included in VCO planning as local nodes for coordination and quality. Collectively, they form a statewide network for scale, spread, and shared learning driven by variation and comparative performance. This somewhat unique statewide transformation network is a substantial asset to help meet the goals of a value based accountable health system.

   Important Consideration – In order for the transition to be most effective, state leadership should continue to recognize and support the Blueprint program as a transformation engine and an asset to Vermont's evolving health system. At the same time, the Blueprint program needs to maintain its steadfast commitment to accountability by measuring the programs impact, the health system performance, and routinely reporting results to the legislature and in peer review publication. To date, the Blueprint program has demonstrated the ability to successfully support complex delivery system reforms, and has worked closely with providers and other stakeholders to build a foundation that positions Vermont as uniquely ready for statewide accountable health and alternative payment models. It will take time for the newly organizing accountable health system to be ready to fully absorb the Blueprints operations and capabilities. As state leadership continues to change, it is important to maintain a commitment to the Blueprint program so it can serve as a valuable and proven asset to help shape Vermont's health system.

5. **Support Blueprint work to implement new service models that involve AHS Departments and external providers –** The Blueprint team has been effective at research, design, and statewide implementation of new service models (e.g. PCMH, CHT, Hub & Spoke, Complex Care Management Collaboratives, Transformation and Learning System Network, Women's Health Initiative). AHS will have ongoing needs to scale and spread evidence based services for complex populations. It is unlikely that ACO(s) or VCO will be ready or willing to manage many of these services for some time.

   Important Consideration – To some degree, the Blueprint programs innovation, research, and program implementation capabilities have been underutilized in the Agency of Human Services. A substantial opportunity exists for working across Departments for integration, coordination, and the scale and spread of service models for the complex populations served by the state. The Blueprint team is particularly configured to help meet this need, and there are important untapped opportunities. Successful implementation is contingent on prioritization by state leadership, and in particular the active support of the Administration, Secretary, and Commissioners.

6. **Support for advancement of Vermont's data utility and data use –** Increasingly, Vermont's data systems are being used to measure health, quality, system effectiveness, and the drivers responsible for variation across provider settings and regions. Results are being used to promote an objective approach to shared learning, ongoing improvement, and medical home performance payments. The Blueprint program has worked intensively on data management, data aggregation, data linkage, data quality, and data use in support of delivery system reforms. This has included linking data from multiple sources including; all-payer claims data, EHR derived clinical data, provider practice data, patient experience data, behavioral risk factor data, and corrections data. Additional data extracts are planned for linkage and use. Products and use cases include comparative performance profiles (practice, service area), variation analyses, outcomes evaluation, predictive modeling, and peer review publication. These activities have helped to advance the data use culture in practice settings and service areas across the state. This work, with assistance from VITL, GMCB, DVHA, VDH, and DOC, demonstrates that data from Vermont's statewide data systems can be routinely linked and used to produce novel information. Despite the accomplishments, it should be noted that the Blueprints use of data is a result of intensive programmatic attention and effort. This method is not cost efficient and doesn't come close to achieving the potential that is available with an innovative systems based approach.

   It is essential for Vermont to pave an accelerated path to an advanced data infrastructure, and to prioritize a near term mission to optimize use of the state's multi-dimensional data for population health. This requires a change in the culture and approach that the state has taken, including structural changes that can rapidly and effectively address issues like architecture, data governance, aggregation, linkage, and advanced use, *across* departments and agencies. Vermont is well positioned to take the next steps. However, the work is complex and it will require visionary and experienced leadership, prioritization, and optimal use of federal funding targeted for this purpose. State leadership needs to carefully consider its approach including program leadership and accountability.

Important Consideration – The next phase of data infrastructure development would benefit from a dedicated executive program leader, reporting and accountable to the Secretary of Administration and Legislature, with the ability to convene and lead across agencies, departments, and external stakeholders such as VITL and provider organizations. Clear leadership and a clear path forward as a Governors priority could launch Vermont to be a national leader in the aggregation and use of data, in parallel with the development of a novel health system (APW, VCO). The state is in a unique position to achieve the promise of a novel data infrastructure, a promise that should not be held back by the current challenges of distributed leadership, separation of authority and accountability for success, and a level of bureaucracy related to IT development that is unexplainable given the size and nature of Vermont state government. The executive program leader should have deep understanding of health services, using data to guide a learning system, and a general understanding of the technical architecture that can meet these needs. This should not be considered an IT job, or an informatics job.

Summary of Blueprint Activities Planned for 2016-2017

Outlined below are Blueprint program activities as currently planned for 2016-2017. They are intended to assist Vermont's successful transition to the next phase of health reform. They are particularly architected to accelerate the transition to a health system that is responsible for the health, well-being, cost, and quality of services for a whole population. These plans are informed through routine interaction with the large group of stakeholders and providers that participate as part of the Blueprint program, the Blueprints advisory committees, and detailed planning meetings with Vermont's ACO(s).

1. **Collaboration With ACOs** – continue to converge statewide ACO and BP activities and support readiness for providers to operate as part of a learning health system by 2018 including;
   - Assist health and human services providers in each service area with readiness to operate as part of a well-coordinated data driven network in an All Payer Accountable Health System (APW, VCO).
   - Assist community collaboratives in each service area with readiness to use comparative data, conduct formal decision making, and guide local coordination & quality initiatives in alignment with system priorities.
   - Enhance a culture of clinician leadership. Educate and engage clinician participation in community collaborative activities and health system priorities (crosses all topics).

   Priorities for Collaboration with ACOs

   a. Community Collaborative Capacity & Operations
      i. Strategies to enhance capabilities for local leadership, planning, and implementation
      ii. Incorporate Community Needs Assessments into community collaborative planning
      iii. Help with identification of opportunities and responsive service models (based on VT data)
      iv. Planning and guiding best use of CHT staffing
      v. Use of monthly statewide meeting to strengthen community collaborative capacity

b. Support deployment of novel service models
   i. Disease management and complex care protocols and other linked initiatives
   ii. Broad implementation of VCO playbooks in communities and practices
   iii. Integrated Community Care Management Learning Collaborative
c. Promote the wellness, prevention, self-management agenda
   i. Review the profile: capacity, strengths, opportunities, needs of current programs
   ii. Review the self-management network: how programs are coordinated and operated
   iii. Optimize operations, understanding, and utilization of programs in communities
   iv. Examine opportunities including prevention needs and strategies for scale and spread
   v. Integrate community based primary prevention models and explore environmental, policy and systems change to realize the promise of health in all policies
d. Understanding & interpreting data, and how to use it to guide transformation including planning, implementation, and ongoing improvement of services
   i. Community collaborative interpretation and use of data
   ii. Practice level interpretation and use of data
   iii. Individual clinician interpretation and use of data
   iv. Objective use of variation to identify drivers and responsive strategies
e. Optimize use of data infrastructure for population health and a learning system
   i. Examining the opportunities with the complete data infrastructure (OCV, State)
   ii. Health Catalyst & Care Navigator as catalyst for community activities and coordination of services
   iii. Blueprint clinical registry as source for Health Catalyst & Care Navigator
   iv. Linked data for evaluation & modeling (APCD, Clinical, BRFSS, CAHPS, Corrections, other)
f. Coordinate committee structures for Blueprint and VCO
   i. Option – Cancel BP Executive Committee meetings. Rationale is that BP team is working as part of VCO committee structure. Requires Administration agreement and probably requires change in guiding statue.
   ii. Option – Maintain BP Executive Committees meeting as regularly scheduled events separate from VCO committee meetings. Advisory in nature. Plan agenda and format in collaboration with VCO leadership. Show BP Committees meeting as advisory forum to VCO (dashed line).
   iii. Other Options?
g. Developing workforce for population health, alternative payment models, and accountable care (workforce for the future). Collaborate with appropriate organizations to develop capabilities through direct experience and field training, and collaboration on programs and research.
   i. Medical students & residents
   ii. Community Health Workers
   iii. Social workers
   iv. Students in social sciences
   v. Students in economics and business
   vi. Students in other disciplines (communications, engineering)

h. Align payment models and incentives.
   i. Align measures in Blueprint performance payments with VCO priorities
   ii. Explore value based incentives more broadly
   iii. Primary care incentives and value-based add-ons
   iv. Full continuum and community based incentive models
   v. Determine the mix of provider and community performance payments

2. **Implementation and Expansion of Health & Human Service Models for Complex Populations** – Research, planning, and statewide implementation of health & human service models for high risk populations and complex needs. May involve populations and services that are not yet priorities or a focus of the ACO(s).
   a. Women's Health Initiative – research, design, & planning underway
   b. Hub & Spoke – expanding capacity, profiles & predictive modeling to guide program
   c. Work with state leadership to examine other priorities – (e.g. mental health, ACEs, home visits, family & children services)

3. **Publication of Manuscripts & Reports** – Embedding science as part of planning, implementation, and guidance of a statewide learning system. Peer review verification
   a. Practice Profiles (comparative outcomes, linked data) – production every 6 months
   b. Service Area Profiles (comparative outcomes, linked data) – production every 6 months
   c. Comparative Profiles for Opiate Addiction Treatment sites (Hub & Spoke) – preparation
   d. Vermont's Community Oriented PCMH Model Outcomes – published PHM
   e. Impact of MAT in Vermont – published JSAT
   f. State Data Infrastructure for Preventive Care: Diabetes model – submitted
   g. Adjustment Model for Whole Population Analyses – submitted
   h. State Data Infrastructure to Support Population Health: Hypertension – Analysis
   i. Relationship Between Practice Intensity of HIT Work & Population Outcomes – Analysis

4. **Continue to Advance Vermont's Data Infrastructure & Data Utility –** Using the state's unique statewide data sources to support a whole population learning system.
   a. Data Aggregation – current linkage (claims, clinical, provider, CAHPs, BRFSS, corrections)
   b. Data Aggregation – enhance linked analytic data set with new sources (labor, DAIL, others)
   c. Data Use – additional predictive models for outreach, quality, prevention, cost control
   d. Data Use – web access to linked analytic data set for advanced users
   e. Clinical Registry – increase scale (number of sources contributing EHR data)
   f. Clinical Registry – increase scope (array of standardized data elements aggregated)
   g. Clinical Registry – optimize quality (data guided field work with source sites)
   h. Clinical Registry – optimize use (extracts for key user groups e.g. ACOs)
   i. Clinical Registry – optimize use (enhance reporting platform for key users)
   j. Provider Registry – expand scope of provider information (e.g. OB, others)
   k. State Data Infrastructure – promote cause of a systematic and consistent approach to identity management across state systems and VITL HIE.

Recommendations to Optimize Blueprint Effectiveness

In order for the program to be most effective, consideration should be given to the following recommendations offered as the opinion of the outgoing program director.

Recommendation. The Blueprint program should continue on as a program even as ACO(s) assume increasing responsibility for the quality and effectiveness of the healthcare their network delivers.

a. This recommendation considers the current state of readiness of ACO(s) to make the investments that the Blueprint makes, or to manage and operate Blueprint functions. Examples include:
    i. Current capabilities for research, design, implementation, scale, and spread of more comprehensive health and human service models. At this stage the ACOs may need to focus on targeted initiatives to meet near term accountable care goals
    ii. Convening, managing, and financial support for a statewide learning system transformation network including ACO and non-ACO participants. At this stage, this network is best managed collaboratively by the Blueprint team and ACO leaders
    iii. Implementation and operation of the statewide network of self-management programs that address upstream behaviors, risk factors, and prevention. The ACO(s) are not ready to invest in or manage this network even though their leadership has expressed interest in expanding and strengthening the programs.
    iv. Demonstrated capabilities to access, link, and use the state's unique data sources for evaluation, and to drive coordination and quality initiatives on a whole population basis. ACO(s) are investing in a data infrastructure to support their business and care management needs for their attributed populations. Both levels of data infrastructure are needed, with use of the state's sources providing the best opportunity for impartial evaluation and oversight of system performance in the interest of all citizens.
b. With time ACO(s) may be ready to absorb some of these Blueprint functions. At this time the ACO(s) will likely be consumed with gearing up their new business and governance structure, planning and implementing operations and new payment models, and prioritization of services and measures that help them meet near term goals (e.g. Part A, Part B spectrum).
c. Given these considerations, the state's investments to date will be most effectively leveraged if the Blueprint program continues to function and works closely with ACO(s) to help build a statewide accountable health system (work plan outlined above).

Recommendation. The Blueprint should continue as a program based within state government. The programs position within state government supports unique and important advantages.

a. The ability and priority to guide transformation designed to meet the health needs and interests of all citizens, while ACO(s) will primarily be focused on the population for whom they are financially responsible
b. The position to impartially convene, negotiate, and plan across all stakeholder and provider groups, including those that don't formally participate as part of the ACO

c. The ability to access and advance the use of state held data systems, in the interests of Vermont's citizens, for evaluation, comparative performance monitoring, development of novel prediction models, learning system functions, and quality improvement
d. The ability to leverage the states investments by supporting the innovation, data aggregation, evaluation, modeling, and other needs of the GMCB.

Recommendation. To be effective, the Blueprint Program should at a minimum maintain current funding levels, with restoration of recent funding cuts if possible.

a. The Blueprints budget was cut by ~20% in the last 12 months, despite extensive work demonstrating program impact and ROI. These cuts limit the ability of the program to meet needs including local program leadership, the transformation network, the self-management network, data aggregation & management, information generation, and learning system activities. Early on, the Blueprint program made a strategic decision to invest in these supportive 'transformation' assets. In retrospect, the investments made by the Blueprint program reflect a more complete and systematic approach to health reform compared to other states in the MAPCP demonstration, and may account for the relative effectiveness for Vermont as compared to other demonstration states.
b. The cuts in the Blueprint budget, with resulting cuts to community grants and programs, is weakening what has emerged as a highly effective and somewhat unique infrastructure. This may dampen the ability of the program to support and accelerate progress towards a more fully integrated accountable health system.
c. At some point, ACO(s) may be ready to invest in and maintain these assets. That is not likely to happen at this early stage of VCO formation. It is in the states interest to leverage its investments, and to support the emerging accountable health system with the complete package of Blueprint transformation assets that have proven to be effective.

Recommendation. To be effective, the Blueprint Program should have strong leadership, and in particular an Executive Director that is experienced with leading transformation across medical, social, and behavioral services providers.

a. Early on, in addition to emphasizing primary care and medical home operations, the Blueprint program was designed to strengthen the integration of medical, social, behavioral, and other community base services. This approach has emerged as a defining attribute of the program, and there is now a national emphasis on formal community level integration of these services. With the move towards a unified accountable health system, Vermont is uniquely positioned to leverage this foundation which includes (but is not limited to) primary care medical homes, community health teams, support and services at home, hub & spoke for opiate addiction, and the newest program for women's health.
b. One of the Blueprints strengths is the ability to work across communities, provider organizations, and state agencies to guide implementation of these types of complex and more holistic service

trimodels. The scope of the Blueprint program will be best served by a visionary and innovative leader who possesses a wide range of professional and personal skills.