Core Team Meeting

Agenda 5-4-15

VT Health Care Innovation Project
Core Team Meeting Agenda

May 4, 2015 1:00 pm-3:00pm
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	1:00-1:05	Welcome and Chair's Report a. VHCIP Project Meeting- June 17th b. Quarterly report submitted on 4/30/15 c. Legislative session update	Lawrence Miller	
Core Team Processes and Procedures				
2	1:05-1:10	Approval of meeting minutes	Lawrence Miller	Attachment 2: March 9, 2015 minutes *Decision needed.*
3	1:10-1:25	Director's Report: a. Staffing Update b. Sub-grantees Update c. ACTT Restructuring d. CMMI Convening April 22nd-23rd *Public comment*	Georgia Maheras	Attachment 3a: Staffing Update Attachment 3b: Sub-grantees report (for background)

Policy Update				
4	1:25-2:10	1. Medicaid Expenditure Analysis *Public Comment*	Susan Besio and Scott Whitman, PHPG	Attachment 4: Medicaid Expenditure Analysis
Financial Update:				
5	2:10-2:50	1. Learning Collaborative Expansion Request: $500,000 (CMCM Work Group) 2. Financial request: a. Policy Integrity- no cost extension b. Truven Health Analytics- no cost extension c. Bailit Health Purchasing- travel adjustment d. Healthfirst Chart Review- no cost extension and budget adjustment e. Clinical Registry-$1,000,000 license fee 3. Funding to support ACOs for Years Two and Three (discussion only) *Public Comment*	5.1 Erin Flynn 5.2 Georgia Maheras 5.3 Lawrence Miller	Attachment 5.1: Learning Collaborative Expansion Request (ppt) Attachment 5.2: April 2015 Financial Request (ppt) Attachment 5.3: Project Budget 4.29.15 (Excel) *Decisions needed for 4.1 and 4.2*
5	2:50-2:55	*Public Comment*	Lawrence Miller	
6	2:55-3:00	Next Steps, Wrap-Up and Future Meeting Schedule: 6/1: 1-3p, Pavilion, Montpelier	Lawrence Miller	

Attachment 2

Minutes

Vermont Health Care Innovation Project
Core Team Meeting Minutes

Pending Core Team Approval

Date of meeting: Monday, April 6, 2015, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's Report	Lawrence Miller called the meeting to order at 1:02. **a) Approval of Meeting Minutes:** Paul Bengtson moved to approve the March 2015 meeting minutes. Al Gobeille seconded. Paul requested an update on the question raised by at the previous meeting about whether VHCIP dollars can be used to lobby State or federal government; Robin Lunge provided an update. Georgia Maheras has checked and VHCIP dollars cannot be used for lobbying. Robin suggested that Georgia contact all Work Group co-chairs to communicate this policy. A roll-call vote was taken and the motion to approve the minutes passed unanimously. **b) Sub-Grant Program Convening – May 27th:** Georgia Maheras gave a brief overview of the planned sub-grant program convenings. The sub-grantees will be convened once in the late spring (scheduled for May 27 at the Capitol Plaza in Montpelier) and again in the fall so that the sub-grantees can learn from one another, discussions can inform work group activities, and sub-grantees can take concrete lessons back to their own projects. The meetings will be a half day each, organized so that half of the sub-grantees present at the spring meeting and the other half present at the fall meeting. The sub-grantees have been organized into four thematic groups: ACOs (will present in May); Transitions of Care (will present in May); Substance Abuse and Stress Management (will present in the fall); and Statewide Best Practices (will present in the fall). The current tentative agenda includes opening remarks, panels and Q&A, and a debrief session. Each sub-grantee will provide in advance a one-page summary of project activities to date and lessons learned. The meeting invitation list will include all Work Group co-chairs, sub-grantee staff, Core Team, VHCIP staff, and our federal partners.	**Georgia will communicate lobbying restrictions on VHCIP funding to Work Group co-chairs.** **Sarah Kinsler will poll Core Team members to schedule a VHCIP Project Meeting in early June 2015.**

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	c) VHCIP Project Meeting: Georgia noted that this meeting, tentatively scheduled for June 3, will be similar to the Project Retreat that took place in November 2014. Multiple members indicated that this date would not work for them. Sarah Kinsler will poll Core Team members to find a better date. **d) Annual Report:** The Year 1 Annual Report was submitted to CMMI on March 30, and is now available online.	

2. Policy Update
 	
a) Year 2 Gate & Ladder Methodology for the Medicaid Shared Savings Program
 	
b) Global Commitment and Choices for Care Waiver Overview
	a) Year 2 Gate & Ladder Methodology for the Medicaid Shared Savings Program: Alicia Cooper presented on proposed changes to the Medicaid Shared Savings Program (VMSSP) Gate & Ladder Methodology.
	• Alicia described Year 1 benchmarks and targets and proposed Year 2 benchmarks and targets.
	  ○ Most measures use national HEDIS benchmarks; for measures without national HEDIS benchmarks, ACOs have improvement targets based on their historic performance.
	  ○ How actively are ACOs using these measures now? Data from Year 1 is just now becoming available. Having benchmarks and targets set prior to Year 1 allowed ACOs to know what they would be measured against; now deciding on changes for Year 2.
	  ○ Al Gobeille noted that there is significant lag time between reporting and results/analyses.
	• Proposed changes to the VMSSP include converting the scale from a percentage of available points to absolute points earned; increasing the gate from 35% to 55%; and allowing ACOs to earn additional "improvement points" for statistically significant improvement on measures with national HEDIS benchmarks. Alicia noted that there are no proposed changes to the Gate & Ladder methodology for the Commercial Shared Savings Program.
	• Alicia described the process by which the proposed changes were discussed at the Payment Models Work Group and addressed the guiding questions reviewed by the Steering Committee.
	
	The group discussed the following:
	• Do improvement points impact the gate and the ladder, or just the ladder? All points that the ACO can earn, whether for attainment relative to national benchmarks or improvement relative to past performance. However, there are a limited number of improvement points ACOs can earn (a total of 8; only for payment measures with national benchmarks, and only for one each). This would require significant quality improvement for the ACO.
	• Why did one Steering Committee member oppose these changes? Al Gobeille noted that we can infer, but we can't be sure of members' thinking.
	• Al does not believe these changes lower the bar. Alicia noted that the 35% gate in Year 1 was chosen because there was limited data to support benchmarks. We now have additional data that allows us to raise the gate.
	
	Public comment:
	• Julie Wasserman requested that Alicia share in general how well ACOs are doing in comparison to the	

Agenda Item	Discussion	Next Steps

	new 55% gate. Alicia reported that the 35% gate in Year 1 was set with limited data; we now have a better sense of what attributed populations look like and have been able to run preliminary analyses, which indicate ACOs are performing around the 55% level. DVHA is not concerned that this change would be punitive; the change is consistent with the program plan. DVHA also believes the introduction of improvement points is a good change, consistent with the Medicare Shared Savings Program changes for the 2015 performance year, and provides an incentive to continue to improve.
	• Do all the ACOs have similar levels of information? All ACOs participating in VMSSP have comparable reports from DVHA. It's the same from Medicare for the MSSP. Blue Cross is having a harder time providing reports from the Commercial SSPs. Also, the ACOs may have different abilities to analyze data.
	
	Paul Bengtson moved to approve the recommendations as approved at the April 1 Steering Committee meeting. Steve Voigt seconded. A roll call vote was taken and the motion passed unanimously with the exception of Robin Lunge, who was absent for this vote.
	
	b) Global Commitment and Choices for Care Waiver Overview: Monica Light, Director of Operations for DAIL, presented on the Global Commitment waiver, now consolidated with the former Choices for Care waiver.
	• Global Commitment 1115 Waiver – demonstration launched in 2005; now includes Choices for Care as of January 30, 2015.
	• Global Commitment includes all Medicaid services except Disproportionate Share Hospital (DSH) payments.
	• Vermont is the only state where a state agency acts as the Managed Care Entity.
	  ○ How is this different from a Managed Care Organization, and is this language also accurate? Because Medicaid Managed Care works differently in Vermont (the Managed Care Entity is a state agency, rather than private), we use the language Managed Care Entity.
	  ○ The legislature is the ultimate oversight for the Agency of Human Services; however, the Agency is required to follow federal law, which supersedes state law. The Agency of Human Services is the Single State Agency (Medicaid agency), which contracts with DVHA through an inter-governmental agreement (which contracts with other AHS departments) to provide Medicaid services. There is significant oversight by CMS; the legislature has limited authority related to their authority over general fund programs and expenditures.
	• The waiver supports flexibility in a variety of areas, especially cost effective alternatives and managed care investments that allow the state to fund services which would otherwise not be allowable. This supports a holistic approach to serving individuals and families and better communication and collaborative planning when individuals or families are eligible for multiple services.
	• All 1115 waivers are required to be budget neutral; the state has a set spending cap for the waiver.
	  ○ How is the State trending with respect to this budget cap? We are well under the cap. Al Gobeille noted that the Medicaid cost shift keeps actual spending lower than it otherwise would	

Agenda Item	Discussion	Next Steps

	be; if Vermont's Medicaid rates were higher, this would put us in a more favorable negotiating position when we renegotiated the waiver. Spending caps exclude CHIP, DSH, and enhanced spending on health information technology.
	• Negotiations for the Global Commitment/Choices for Care consolidation were challenging. CMS has indicated that the next round of waiver negotiations will be more challenging: Vermont's waiver is unique and extremely flexible and sets a precedent that CMS may not want to allow in other states; other states could use similar flexibility in ways that would be harmful to beneficiaries or politically challenging for the federal government.
	• How would this impact/coordinate with a potential All-Payer Waiver? AOA/GMCB are working with CMMI to coordinate All-Payer Waiver approval and Global Commitment renewal simultaneously to ensure alignment, though Al Gobeille stated that it's too early to know how either of these might look.
	  ○ Susan Wehry noted that having both of these waivers might allow us to meet some of the goals of the Duals demonstration, which Vermont did not pursue. Al Gobeille noted that this is possible but raises challenging questions, including how Medicare Part D and LTSS spending could be included. Lawrence noted that this will be an active conversation.
	  ○ Julie Wasserman noted that there will be a Medicaid expenditure analysis presented at the next DLTSS Work Group meeting; this analysis shows that 70% of Medicaid spending is on behalf of the DLTSS population. Al noted that these services could be included in an All-Payer Waiver; however, they may not be included at Total Cost of Care calculations at the outset.
	  ○ Paul Bengtson is interested in the Accountable Communities for Health model, which could allow for flexible spending over a geographic area, rather than focusing on attributable populations. Al believes that this will depend on getting incentives right.	

4. Financial Update **a) 2014 Financial Overview** **b) Financial Request**	**a) 2014 Financial Overview:** Georgia Maheras presented a Year 1 financial report. She noted that the numbers are accurate in the meeting materials, but the graphics are incorrect at this time. An updated version will be posted to the website. • Slide 2 presents a budget with broad categories; actuals and unpaid contract invoices represent money spent in Year 1; remaining unobligated balance represents funds we planned to spend in Year 1 but did not spend. These remaining unobligated funds are not tied to a line item. • Our carryforward includes about $9 million for which we received approval but which we did not spend; we have proposed to keep all of this money in the existing contracts for which they were approved (for example, if additional funds exist within our contract with Bailit Health Purchasing, that money will stay in that contract). We will come back with a reallocation of some of those funds if we find that we will not spend all of it in current contracts and need to change contract scope. Any new contracts will also come to the Core Team for approval. ○ The $9 million unobligated balance can be used for other things but must be spent in 2015; however, we were instructed by the federal government to spend part of this on the sub-grant program (~$2 million). Georgia is also requesting to use some of these dollars for Learning	

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	Collaboratives (see item 4b); the remainder will be allocated at a later date. ○ How does the Core Team supervise the expenditure of these funds? All fiduciary responsibility resides with the agency or department that holds the contract. Each contract has a business office lead and a program lead who ensure monitoring and oversight are being done properly and contract terms are followed. What is the role of the Core Team in ongoing monitoring? Core Team recommends contracts be executed, executing agency is responsible for monitoring. Lawrence Miller noted that Core Team should be looking at results of these contracts when deciding whether or not to recommends expenditure of additional funds. ○ We have now submitted our carryover request to CMMI seven times; Georgia believes this seventh request will be successful. Challenges in getting carryover approved have been administrative, not about program direction or activities. ○ How are contracts that span different budget categories represented? Georgia described this with Bailit Health Purchasing contracts as an example; Georgia does have spreadsheets that represent all elements of each contract with funds spent on each line item and will share these with Core Team members upon request. **b) Financial Requests:** Georgia provided an overview of financial requests, and suggested we review all financial requests and move to approve them as a group unless there are objections. ○ *Request for reallocation:* $500,000 of unobligated funds to support Learning Collaboratives. $1,150,000 would be the new total for the Learning Collaborative program as a whole. Timeline for spending is somewhat flexible since total for the Learning Collaborative program spans Years 2 and 3, though the $500,000 carried over will need to be spent in Year 2. ▪ $150,000 to CMCM Work Group for expansion to additional communities. ▪ $350,000 to DLTSS Work Group for core competency training for providers around care for DLTSS populations. As with the initial Learning Collaborative proposal, the DLTSS Work Group would need to propose a way to use this money specifically; this proposal would go to Steering Committee and Core Team to approve). • *Request to decrease contracts:* Funds would go back into the project budget to be reallocated. ○ Arrowhead Health Analytics: Decrease due to contract termination without prejudice. ○ HIS Professionals: Services provided support the three ACTT projects. As projects have progressed, we have realized that not all services for which HIS was originally contracted are needed given state staff skills (specifically project management was duplicative); $100,000 will be reallocated. The Core Team will receive a comprehensive update on ACTT projects in June. ○ Wakely Actuarial: Scope was added to this contract last fall to support All-Payer Waiver activities. We've since contracted with another vendor to work on the All-Payer Waiver; these funds would go into that contract (see below). • *Request to increase contracts:*	

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	○ All-Payer Model Contract: This would support additional actuarial work and lead programmatic services. This is a time and materials contract, so if work does not occur we will not pay contractors. Al noted that having actuarial services in this contract will make it much easier to get the information AOA/GMCB need to perform analyses needed to negotiate this waiver. ○ Prevention Institute: RFP resulted in bids higher than anticipated; Population Health Work Group will use savings from Work Group Support contract to supplement this contract. ○ JBS International: RFP resulted in bids higher than anticipated; increase comes from additional stakeholder engagement necessary for landscape review and convening of a project steering committee to guide and inform project work. This project includes a landscape review of telehealth activities in Vermont, a review of national telehealth activities, and recommendations to the HIE/HIT Work Group. Paul Bengtson noted that we are far behind much of the rest of the country in terms of telehealth. Al Gobeille noted that there is a bill in Congress that would change telehealth definition and payment; current regulations impact SASH and others. Georgia noted that JBS is working closely with the federal government around telehealth strategies, which will allow us to get a more realistic set of recommendations. Lawrence Miller noted that in sum, these requests total ~$816,000 in increases; ~$257,000 in decreases. Overall, this is approximately $559,000; these requests further allocate about 5% of total carryover funds (~11.1 million). • Susan Wehry noted that initially we felt the need to hire external project management for the ACTT Project, but now are reallocating to project staff. Georgia noted that the ACTT Project is really three different projects; adding them together is starting to feel artificial. Sue Aranoff added that the timing is also quite different. There was no additional public comment. Susan Wehry moved to approve the requests as a group. Harry Chen seconded. A roll call vote was taken A roll call vote was taken and the motion passed unanimously.	
5. Public Comment	No further public comment was offered.	
6. Next Steps, Wrap Up and Future Meeting Schedule	**Next Meeting:** Monday, May 4, 2015, 1:00pm-3:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP Core Team Member List
Roll Call:

4/6/2015

Member		Minutes	Gate and Ladder	Financial: Reallocation	
		1° Paul 2° Al	1° Paul 2° Steve	1° Susan 2° Harry	All financial taken as a group
First Name	**Last Name**				**Organization**
Paul	Bengston ✓	✓	✓	✓	Northeastern Vermont Regional Hospital
Harry	Chen ✓	✓	✓	✓	AHS - VDH/Rep AHS -CO for Hal Cohen
Al	Gobeille ✓	✓	✓	✓	GMCB
Steven	Costantino ✗	not here	→		AHS - DVHA
Robin	Lunge ✓	✓	Not here	✓	AOA
Lawrence	Miller ✓	✓	✓	✓	Chief of Health Care Reform
Steve	Voigt ✓	✓	✓	✓	ReThink Health
Susan	Wehry ✓	✓	✓	✓	AHS - DAIL

VHCIP Core Team Participant List

Attendance: 4/6/2015

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	VHCIP Staff/Consultant
X	Interested Party

First Name	Last Name		Organization	Core Team
Susan	Aranoff	here	AHS - DAIL	S
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
Anna	Bassford		GMCB	A
Paul	Bengston	here	Northeastern Vermont Regional Hospital	M
Beverly	Boget		VNAs of Vermont	X
Harry	Chen	phone	AHS - VDH/Rep AHS -CO for Hal Cohen	M
Amanda	Ciecior	here	AHS - DVHA	S
Hal	Cohen	here	AHS-CO	X
Amy	Coonradt		AHS - DVHA	S
Alicia	Cooper	here	AHS - DVHA	S
Steven	Costantino		AHS - DVHA, Commissioner	M
Mark	Craig			X
Diane	Cummings		AHS - Central Office	S

Paul	Dupre		AHS - DMH	X
Erin	Flynn		AHS - DVHA	S
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Martita	Giard		OneCare Vermont	X
Al	Gobeille	here	GMCB	M
Bea	Grause		Vermont Association of Hospital and Health Systems	X
Sarah	Gregorek		AHS - DVHA	A
Thomas	Hall		Consumer Representative	X
Bryan	Hallett		GMCB	S
Carrie	Hathaway		AHS - DVHA	X
Kate	Jones		AHS - DVHA	S
Pat	Jones	here	GMCB	S
Joelle	Judge	here	UMASS	S
Sarah	Kinsler	here	AHS - DVHA	S
Heidi	Klein		AHS - VDH	S
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
~~Mark~~	~~Larson~~		AHS - DVHA	X
Monica	Light	here	AHS - Central Office	X
Robin	Lunge	phone	AOA	M
Georgia	Maheras	here	AOA	S
Steven	Maier		AHS - DVHA	S
Mike	Maslack			X
Marisa	Melamed		AOA	S
Lawrence	Miller	here	AOA - Chief of Health Care Reform	C
Meg	O'Donnell	here	UVM Medical Center	X
Lisa	Parro		AHS - DAIL	A
Annie	Paumgarten	here	GMCB	S
Luann	Poirer		AHS - DVHA	S
Lila	Richardson		VLA/Health Care Advocate Project	X
Julia	Shaw		VLA/Health Care Advocate Project	X
Richard	Slusky		GMCB	S
Kara	Suter		AHS - DVHA	S

Carey	Underwood			A
Steve	Voigt	Phone	ReThink Health	M
Julie	Wasserman	here	AHS - Central Office	S
Susan	Wehry	here	AHS - DAIL	M
Spenser	Weppler		GMCB	S
Kendall	West		Bi-State Primary Care	X
James	Westrich		AHS - DVHA	S
Katie	Whitney			A
Bradley	Wilhelm		AHS - DVHA	S
Jason	Williams		UVM Medical Center	X
Sharon	Winn		Bi-State Primary Care	X
Cecelia	Wu		AHS - DVHA	S
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Attachment 3a

Staffing Update

VERMONT

Vermont Health Care Innovation Project

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

To: Core Team
Fr: Georgia Maheras
Date: May 4, 2015
Re: Staffing Report

This memo provides an update on VHCIP funded staff recruitment.

Recruitment

VHCIP includes 26 funded positions, of which 21.5 are filled and 4.5 are vacant. Below please find a list of filled and vacant positions:

Agency	Employee Name	Position Title	% dedicated to the project
AHS	Diane Cummings	Fiscal Manager: Financial Manager II	100%
AHS	Julie Wasserman	Program Manager for Duals: Duals Director	100%
AOA	Georgia Maheras	Project Director	100%
DAIL	Susan Aranoff	Health Integration Quality Oversight Analyst	100%
DAIL	Gabe Epstein	Health Policy Analyst	100%
DVHA	Alicia Cooper	Payment Program Director: Health Care Project Director (P4P&EOC)	100%
DVHA	Erin Flynn	Quality Monitoring & Evaluation: Senior Policy Advisor	100%
DVHA	Amy Coonradt	Payment and Policy Specialist: Health Policy Analyst	100%
DVHA	Kara Suter	Payment Reform Director	25%
DVHA	Amanda Ciecior	Service Delivery Analyst: Health Policy Analyst	100%
DVHA	Luann Poirier	Service Delivery Specialist: Administrative Services Manager I	100%
DVHA	Jessica Mendizabal	Fiscal Manager: Contract and Grant	100%

		Administrator	
DVHA	Bradley Wilhelm	Quality Monitoring & Evaluation: Senior Policy Advisor	100%
DVHA	Cecelia Wu	Payment Initiative Director, Shared Savings	80%
DVHA	Sarah Kinsler	Health Care Policy Analyst	100%
DVHA	Jim Westrich	Payment Program Manager: Quality and Oversight Analyst II	100%
DVHA	Brian Borowski	Health Care Statistical Info Administrator	100%
GMCB	Annie Paumgarten	Evaluation Director	100%
GMCB	Christine Geiler	Grant Program Manager: Grant Manager Coordinator	100%
GMCB	Richard Slusky	Payment Reform Director	25%
IFS	Carolynn Hatin	Medicaid Data Analyst: Business Administrator	100%
VDH	Matt Bradstreet	Public Health Analyst III	100%
Vacant Positions			
AOA		Workforce Work Group Manager	50%
DVHA		Payment Program Manager: Health Access Policy & Planning Chief	100%
DVHA	In recruitment	Medicaid Data Analyst: Quality and Oversight Analyst II	100%
DVHA	In recruitment	Sr. Policy Advisor	100%
DVHA	In recruitment	Fiscal Manager: Contract and Grant Administrator	100%

Attachment 3b

Sub-grant Program Update

VHCIP Sub-Grant Program Summary

April 29, 2015

Georgia Maheras, JD

Project Director

Vermont Health Care Innovation Project

Program Summary: Round One Grantees

- Health*first* – ACO Management
- Rutland Area VNA and Associates – Supportive Care for Seriously Ill Patients
- Northeastern Vermont Regional Hospital – Flexible Funding for Community Care Program
- White River Family Practice – Innovative Care Management
- InvestEAP – Resilient Vermont (Stress Reduction)
- VMS Foundation – Pursuing High Value Care (Pre-Operative Testing, Inpatient Lab testing)
- Bi-State – Community Health ACO

Health*first* – ACO Management

- Goal: Increase coordination and communication in medical homes between primary care and other clinical practitioners.

- Opportunity to expand membership via the Clear Choice Urgent Care centers in 4 locations in VT.
- Awaiting a new report on better coordinating mental health care services provided through technical assistance from Bailit Health Purchasing.
- Pan-ACO quality reporting tool successfully used during March for quality data collection.

RRVNA & RRMC – Care Coordination for Seriously Ill Patients

- Goal: Integrate supportive care and improve quality of life for patients with complex conditions.

- Presented program to multiple local organizations (nursing homes, Heart Clinic and Cardiology Group, case managers at RRMC).
- The project is encountering difficulty in convincing stable patients who are referred to the program to utilize services.
- Collaboration with a local company to provide respiratory therapy consultation.

Northeastern Vermont Regional Hospital (NVRH) – Flexible Funding for Integrated Care

- Goal: Reduced overall healthcare costs; more efficient use of Medicaid special services; improved well-being of clients. Population served: Dual Eligibles.

- Piloting use of 'Camden Cards' – introduced via the Integrated Communities Care Management Learning Collaborative.
- Health coach has added more home visit clients (41 total; 10 receiving tobacco cessation counseling).
- Green Mountain United Way/VT211 for emergency care now in use for all Duals seen by health coach.

White River Family Practice (WRFP) – Innovative Management of Chronic Conditions

- Goal: Reduce ER utilization; measure patient self-confidence to target chronic disease interventions; deploy team-based protocols.

- Motivational Interviewing training provided to entire office to support team-based care.
- Care plans and process maps developed for high utilization group.
- Intra-office newsletter developed for VHCIP project updates.

Invest EAP / VTHealthEngage – Early Intervention & Prevention

- Goal: Employ prevention and early intervention services to reduce stress-related antecedents of chronic disease.

- Completed software training and 5-day evidence-based treatment protocol course.
- Health educator provided services to 40 FQHC patients, 6 in crisis with numerous success stories.

VMS Foundation and UVM – Pursuing High Value Care for Vermonters

- Goal: Reduce the rate of unnecessary laboratory testing for stable medical and surgical inpatients and low-risk preoperative candidates.

- Two collaborative regional learning sessions and a webinar have been held to consider the best medical evidence and quality improvement science to be used to support the initiative.
- Regional billing and clinical research database containing all billing and routine lab data for 8 hospitals (~90% inpatient beds) producing monthly performance reports.
- Expansion to all hospitals with easier data extraction and upload process.

Bi-State Primary Care – Community Health Accountable Care (CHAC) Shared Savings

- Goal: Increase provider collaboration across the continuum of care in local communities.

- Actively participating in the Blueprint Unified Community Collaboratives.
- Chart abstraction and quality reporting completed successfully for Medicare; quality reporting for Medicaid and Commercial targeted for completion in April or May 2015.
- Approximately 900 invitations were sent to patients to participate in the 'rising risk' program; a program care coordinator hired and triage protocols for CHF, COPD and Diabetes developed and implemented.

Program Summary: Round Two Grantees

- CVMC – Screening, Brief Intervention and Referral to Treatment (SBIRT) in the Medical Home
- Developmental Disabilities Council – Inclusive Partnership Project
- Vermont Program for Quality in Health Care (VPQHC) – Statewide Surgical Collaborative
- Northwestern Medical Center – RiseVT Project
- Southwestern Vermont Health Care – Transitions of Care
- InvestEAP – King Arthur Flour

CVMC – Screening, Brief Intervention and Referral to Treatment in the Medical Home

- Goal: Implement SBIRT in the medical homes in Central VT with focus on tobacco, alcohol and drug misuse.

- Two medical homes identified to deliver SBIRT services (Montpelier Integrative Health and Barre Internal Medicine).
- The SMS text messaging system Caring Txt VT is now available.
- Initial and secondary screening tools have been implemented at both locations; electronic referrals are made to the SBIRT clinician for quick follow up and risk scores, clinical interventions and progress notes are stored centrally in the medical record.

Developmental Disabilities Council – Inclusive Healthcare Partnership Project

- Goal: Establish a set of innovative best practices for delivery of care to adults with intellectual and developmental disabilities (I/DD).

- Individual with I/DD identified to join project staff as a consumer representative.
- Planning Team assembled to review promising tools and policies from Vermont and around the nation.
- Analysis of claims data to identify health status and utilization patterns; results to be supplemented with focus group and interview data to identify opportunities for improvement.
- Leverage other VHCIP projects and participants – Frail Elders, Blueprint and Integrated Communities Care Management Learning Collaborative.

VPQHC – Statewide Surgical Collaborative

- Goal: Collect and submit surgical clinical data to the American College of Surgeons National Quality Improvement Program (NSQIP) to improve surgical outcomes and performance.

- Established Steering Committee of surgeons to lead statewide collaborative.
- Statewide outreach and NSQIP education to 100% hospitals achieved.
- Multiple EMRs used by hospitals inhibits sharing of surgical clinical records.

Northwestern Medical Center – RiseVT

- Goal: To decrease the percentage of overweight individuals; increase the number of employer-sponsored wellness programs with >50% participation; expand resources for biking and walking.

- Established a robust website, social media (Pintrest, Twitter, Instagram, Facebook) and marketing campaign.
- Piloting wellness scorecard and processes with 10 businesses, 12 families, 3 schools and 1 municipality.
- Official launch in June including a multi-faceted media campaign, event attendance, guerilla marketing strategies and more.

Southwestern Vermont Health Care – Innovations in Transitional Care Management in a Rural Setting

- Goal: To decrease the number of admissions and ED visits for high risk chronic care patients; create shared plans of care and an interdisciplinary team to deliver integrated services.

- Community Team kickoff held with presentations to community agencies, medical homes, nursing homes, home care agencies and expansion to primary care practices.
- HIPAA and privacy training conducted with Community Team to ensure patient confidentiality is maintained among diverse program participants; includes HIPAA agreements, Information Release forms and information sheets for patients.

Invest EAP – Behavioral Screening and Intervention Partnership with King Arthur Flour

- Goal: Demonstrate and evaluate impact of prevention and early intervention services in an employment setting using behavioral health screenings and evidence-based interventions.

- Completed software training and 5-day evidence-based treatment protocol course.
- Outreach materials developed for employees.

VHCIP Provider Sub-grant Symposium

- May 27, 2015 8:30 – 12:30
- Two Panel Discussions
  - ACO Group
  - Transitions of Care Group
    - RAVNA – Care Coordination for Seriously Ill Patients
    - SVHC – TCM in a Rural Setting
    - NVRH – Dual Eligible Care/Flexible Funding
    - WRFP – Innovative Care Management
- Goals:
  - Learn from each other
  - Inform the VHCIP work groups
  - One thing participants will bring back to their project

Attachment 4

Medicaid Expenditure Analysis

State of Vermont Disability & Long Term Services and Supports (DLTSS) Medicaid Expenditures

Calendar Year 2012

April 24, 2014

Revised April, 2015*

Prepared by the Pacific Health Policy Group
for the VHCIP DLTSS Work Group

* Text revised on Slides 2 and 11

Introduction

- Purpose of Discussion
  - Review role of Medicaid related to funding of both "traditional" health services as well as specialized programs and services (Slides 4 through 10)
  - Review Medicaid expenditures on behalf of individuals receiving specialized services versus all other Medicaid program participants (Slides 11 & 12)
  - Review Medicaid expenditures on the basis of eligibility (Slides 13 & 14)

- *Data Notes*
  - *Dates of service between 1/1/12 and 12/31/12*
    - ⇨ *While the claims data used for the analysis are more than two years old, the purpose of this presentation is to review the types of services available within Vermont's specialized programs and the relative amount of resources used to support programs and services. PHPG has conducted annual data analyses of DVHA claims for over twenty years and has observed that relative trends across specialized service categories exhibit very little variation from year-to-year.*
  - *Includes individuals eligible for full Medicaid benefits*
  - *Pharmacy includes rebate factor of 44%*
  - *Claims only; excludes Managed care investments, Medicare Buy-in, and Other Payments made outside the claims system (e.g., PACE capitation payments)*
  - *For Planning Only – Data have not been validated against secondary sources*

Role of the Vermont Medicaid Program

The Vermont Medicaid program essentially has two roles. The Medicaid program's policies related to both service coverage and eligibility reflect these two roles. Medicaid provides coverage for:

"*Traditional Services*"

Like commercial health insurance policies, the Vermont Medicaid program provides coverage for traditional services, such as hospital, physician, pharmacy, and dental services

"*Specialized Programs and Services*"

The Vermont Medicaid program is the primary funding source for several specialized health programs, including long-term care, Developmental Services, and the public mental health and substance abuse treatment systems; these programs receive limited financial support outside of the Vermont Medicaid program. Medicaid also is an important financial resource for supporting public care systems, including Department for Children and Families (DCF) and school-based health services.

Expenditure Summary by Program

In recognition of the Medicaid program's two roles, services were categorized as follows:

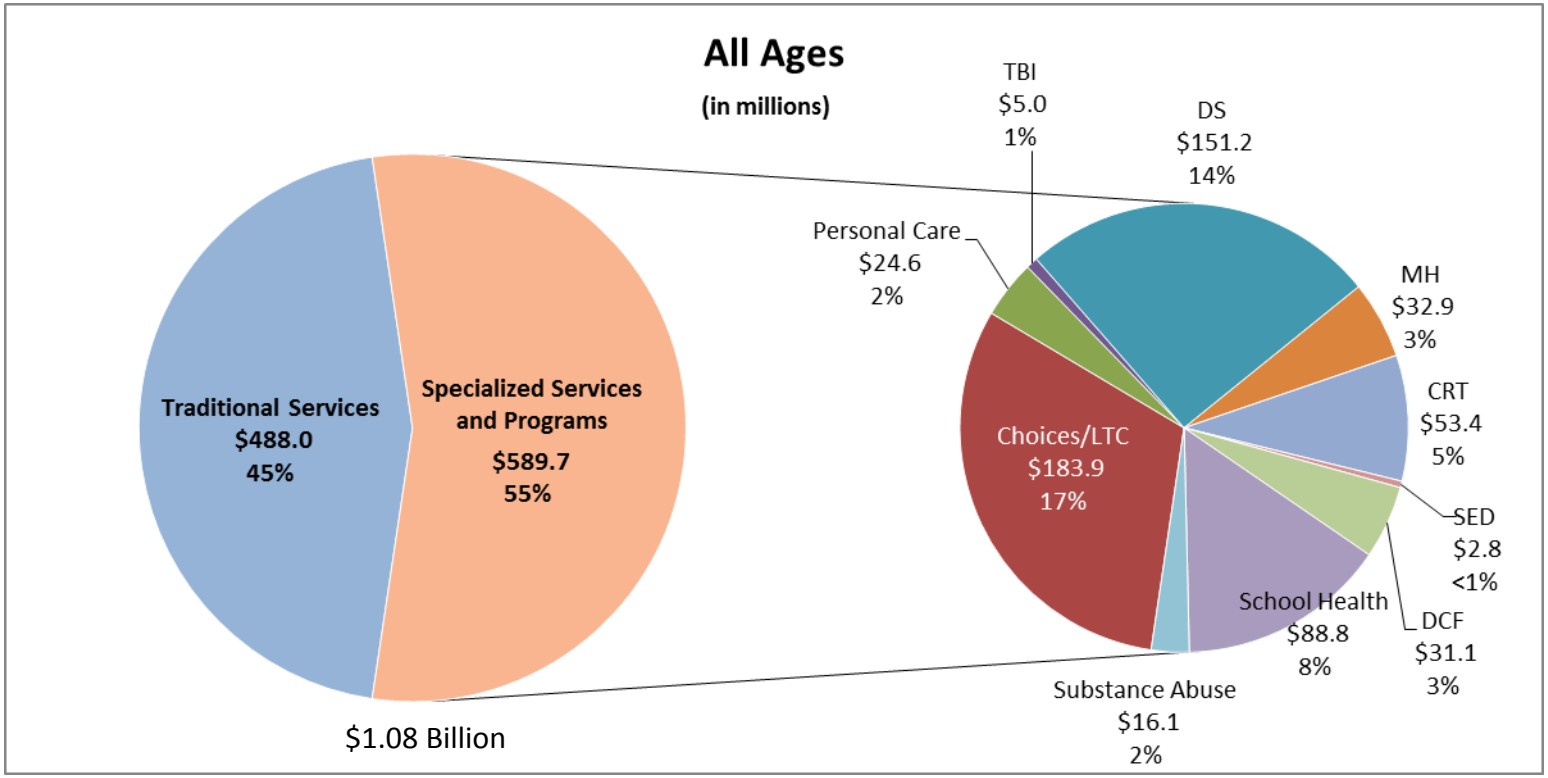
Traditional

- Ambulance
- Dental
- Durable Medical Equipment
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)
- Home Health
- Hospice
- Independent Lab
- Inpatient Hospital
- Medical Supplies
- Other
- Other Practitioner
- Outpatient Hospital
- Pharmacy
- Physician
- Prosthetic/Orthotic
- Therapy Services
- Transportation

Specialized Services and Programs

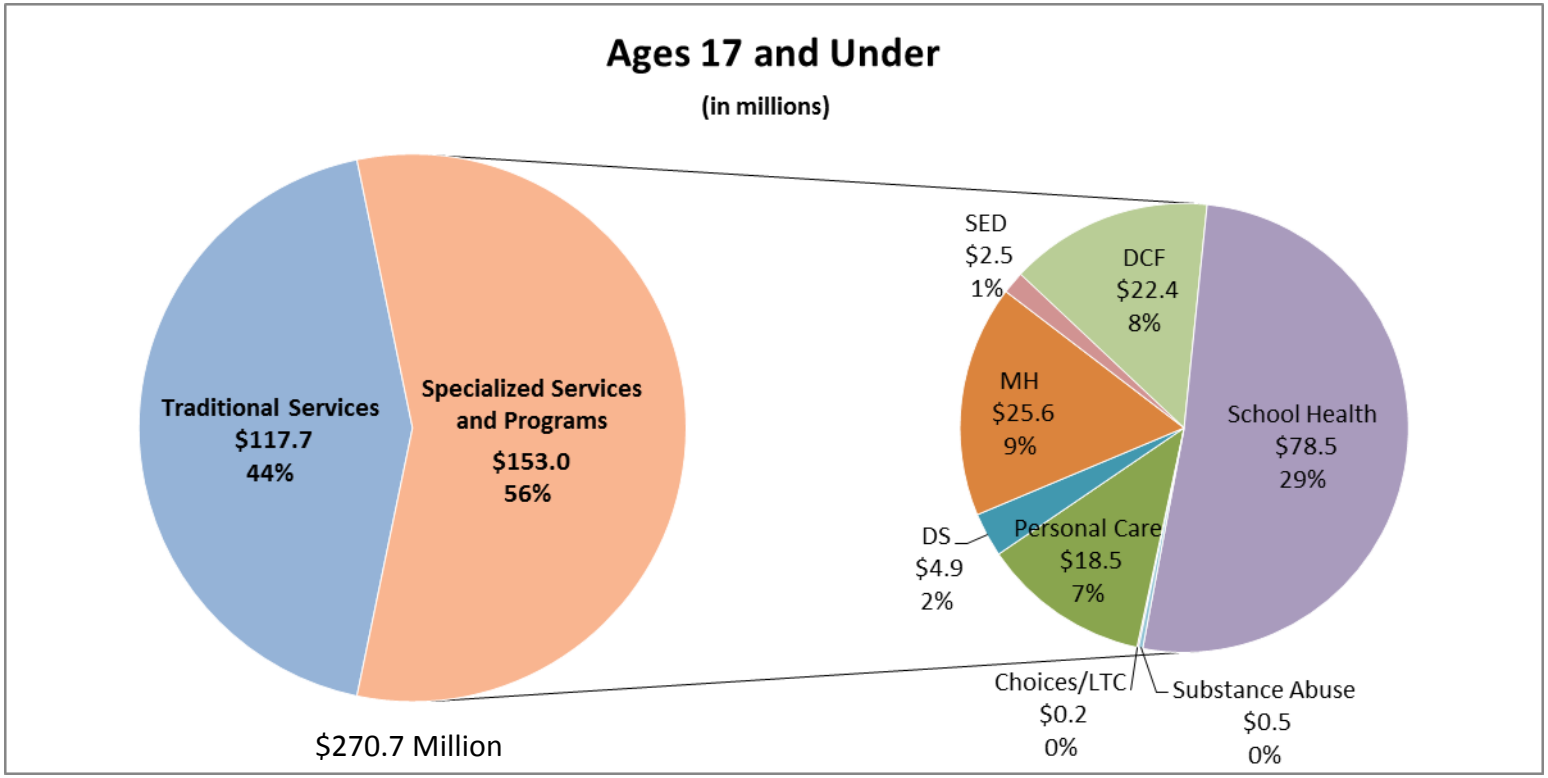
- Choices for Care/Long-Term Care
  - Assistive Community Care, Choices for Care Home and Community Based Services (HCBS), Nursing Home
- Personal Care
- Traumatic Brain Injury (TBI) Program
- Developmental Services
  - Developmental Services, Intermediate Care Facility/Intellectual Disabilities (ICF/ID)
- Mental Health Treatment
  - Community Rehabilitation Treatment, Day Treatment, Day Treatment/Private Non-Medical Institution (PNMI), Children and Adolescents with Serious Emotional Disturbances (SED), Mental Health Facility, Targeted Case Management
- Department for Children and Families - Case Management
- School Health
  - Department of Health, School-Based Health Services (DOE), Success Beyond Six
- Substance Abuse Treatment

Medicaid Expenditure Summary by Program: All Ages



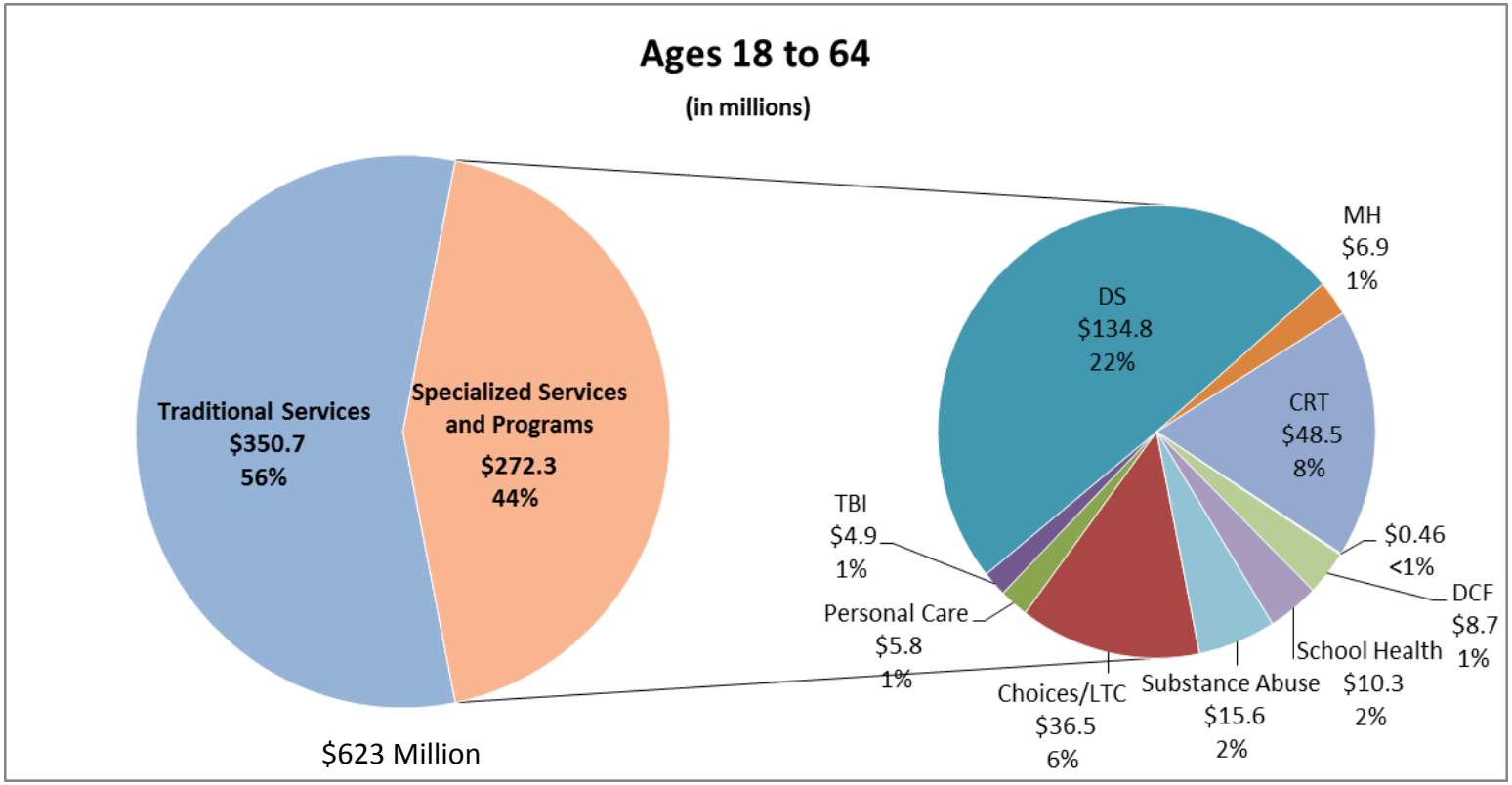
The Vermont Medicaid program spends approximately $488 million **(45%)** for coverage of traditional services and approximately $590 million **(55%)** to support specialized services and programs

Medicaid Expenditure Summary by Program: Ages 17 and Under



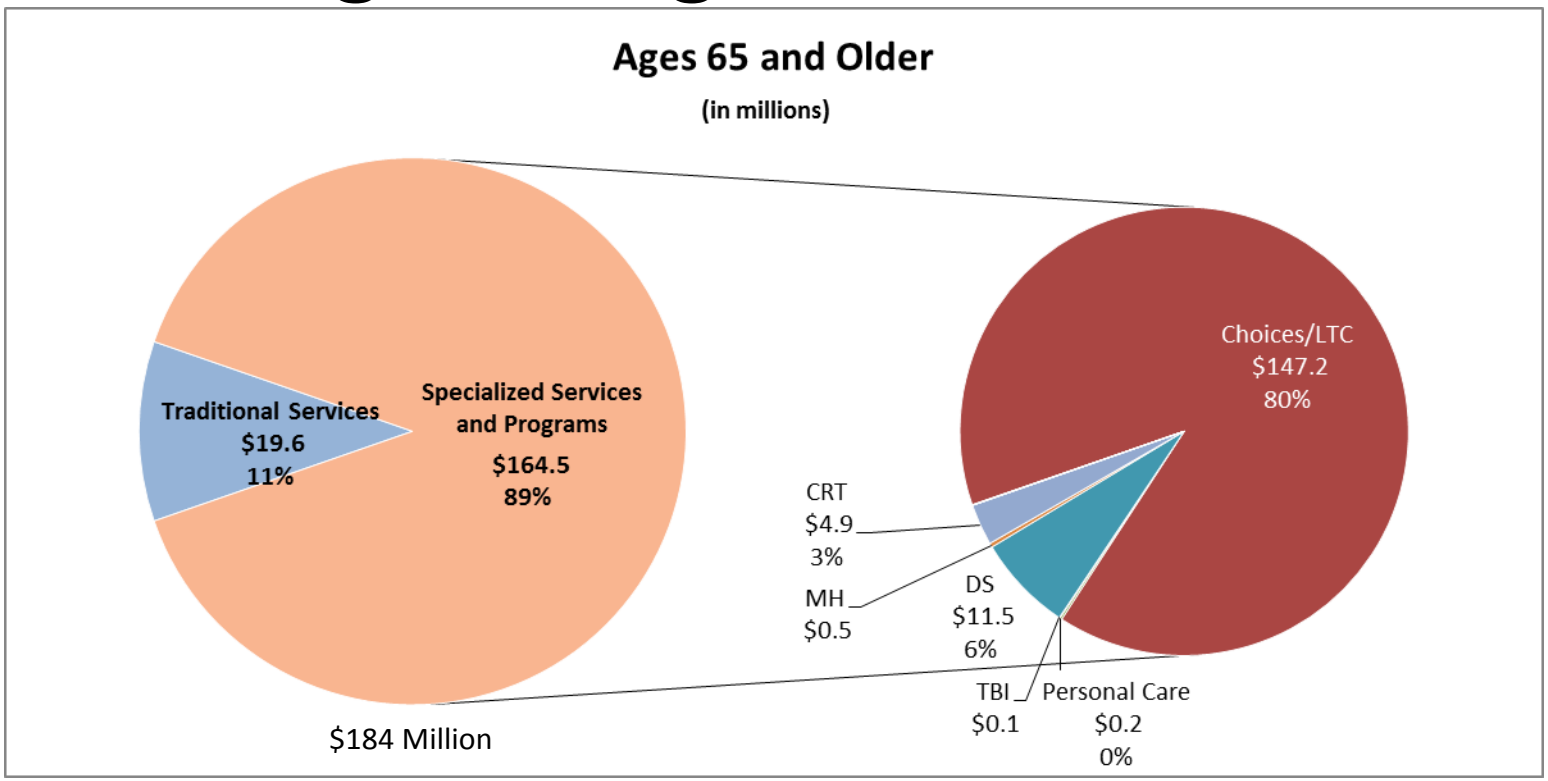
Specialized services for children and adolescents represent more than one-half of total program spending on behalf of children

Medicaid Expenditure Summary by Program: Ages 18 to 64



Developmental Services funding on behalf of adults between the ages of 18 and 64 accounts for approximately one-half of specialized service expenditures for this age group and approximately 90 percent of total Developmental Services spending on behalf of all ages (see Slide 10)

Medicaid Expenditure Summary by Program: Ages 65 and Over



Most Vermonters who are 65 years and older have Medicare coverage for traditional services. For individuals who are dually eligible, Medicaid provides financial assistance to meet Medicare cost sharing obligations and provides coverage for some services not covered by Medicare. Long term care represents eighty percent of total Medicaid expenditures on behalf of individuals ages 65 and older. *(Note: Figures do not include Medicaid payments for Medicare premiums)*

Medicaid Expenditure Detail: Traditional Services

($ millions)

Traditional Services	Age Range			
	Less than 18	18 to 64	65 and Older	Total Paid
Ambulance	$ 0.5	$ 2.7	$ 0.7	$ 3.9
Dental	$ 12.2	$ 7.1	$ 0.4	$ 19.6
Durable Medical Equipment	$ 1.5	$ 5.1	$ 1.2	$ 7.8
FQHC/RHC	$ 7.2	$ 16.0	$ 0.7	$ 23.9
Home Health	$ 1.8	$ 4.2	$ 1.3	$ 7.3
Hospice	$ 0.0	$ 0.3	$ 0.5	$ 0.8
Independent Lab	$ 0.3	$ 5.0	$ 0.0	$ 5.3
Inpatient Hospital	$ 26.8	$ 90.4	$ 3.0	$ 120.2
Medical Supplies	$ 0.2	$ 0.5	$ 0.1	$ 0.8
Other	$ 0.1	$ 1.3	$ 0.3	$ 1.7
Other Practitioner	$ 9.9	$ 16.3	$ 0.5	$ 26.7
Outpatient Hospital	$ 15.8	$ 78.8	$ 5.3	$ 99.9
Pharmacy	$ 16.3	$ 59.1	$ 0.6	$ 76.0
Physician	$ 22.8	$ 56.5	$ 2.8	$ 82.1
Prosthetic/Orthotic	$ 1.3	$ 1.5	$ 0.0	$ 2.9
Therapy Services	$ 0.7	$ 2.2	$ 0.2	$ 3.1
Transportation	$ 0.3	$ 3.9	$ 2.1	$ 6.2
Total	**$ 117.7**	**$ 350.7**	**$ 19.6**	**$ 488.0**

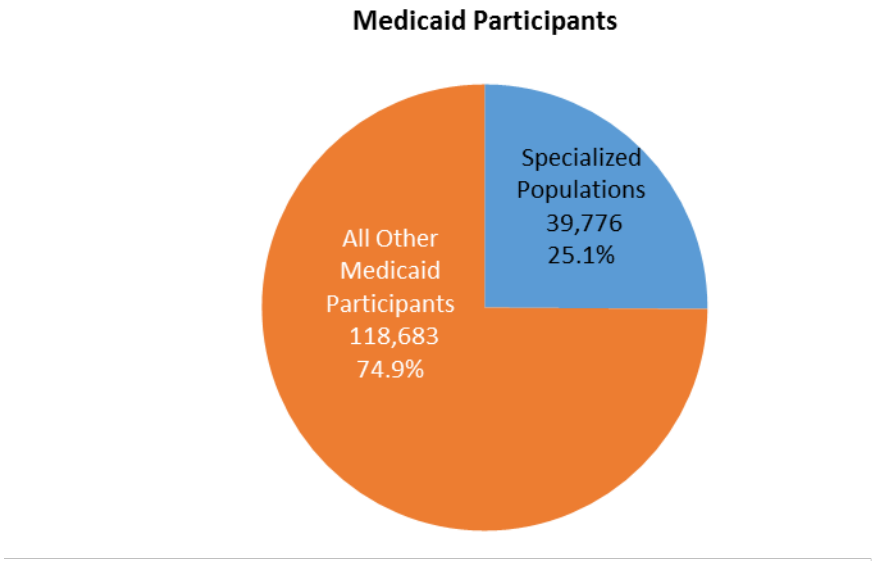
Coverage of traditional services on behalf of non-elderly (ages 18 to 64) adults accounts for approximately 70 percent of Medicaid spending for traditional services. Payments for inpatient and outpatient hospital services total approximately $220 million for all age groups, approximately 45 percent of total spending for traditional services.

Expenditure Detail: Specialized Services and Programs

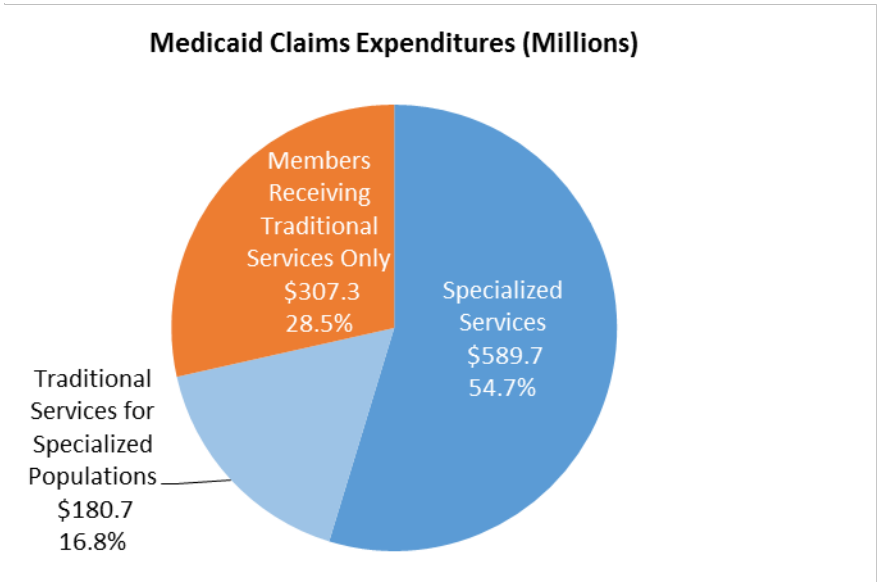
($ millions)

Specialized Services and Programs	Age Range			
	Less than 18	18 to 64	65 and Older	Total Paid
Choices for Care/Long Term Care				
Assistive Community Care	$ -	$ 4.9	$ 10.6	$ 15.4
Choices for Care HCBS	$ -	$ 17.8	$ 33.7	$ 51.5
Nursing Home	$ 0.2	$ 13.7	$ 103.0	$ 116.9
Subtotal	*$ 0.2*	*$ 36.5*	*$ 147.2*	*$ 183.9*
Personal Care Services	$ 18.5	$ 5.8	$ 0.2	$ 24.6
Traumatic Brain Injury (TBI) Program	$ -	$ 4.9	$ 0.1	$ 5.0
Developmental Services				
Developmental Services HCBS	$ 4.9	$ 133.6	$ 11.4	$ 149.9
ICF/ID (DS)	$ -	$ 1.2	$ 0.1	$ 1.3
Subtotal	*$ 4.9*	*$ 134.8*	*$ 11.5*	*$ 151.2*
Mental Health Treatment				
Community Rehabilitation and Treatment (CRT)	$ -	$ 48.5	$ 4.9	$ 53.4
Day Treatment/Private Non-Medical Institution	$ 9.7	$ 1.5	$ 0.2	$ 11.4
HCBS SED Children and Adolescents	$ 2.5	$ 0.3	$ -	$ 2.8
Mental Health Facility	$ 11.8	$ 4.8	$ 0.2	$ 16.8
Targeted Case Management -MH	$ 4.1	$ 0.6	$ 0.0	$ 4.7
Subtotal	*$ 28.0*	*$ 55.7*	*$ 5.4*	*$ 89.1*
Department for Children and Families	$ 22.4	$ 8.7	$ 0.0	$ 31.1
School Health				
Department of Health	$ 1.0	$ 0.1	$ -	$ 1.1
School-Based Health Services (DOE)	$ 35.1	$ 5.1	$ -	$ 40.2
Success Beyond Six	$ 42.4	$ 5.1	$ -	$ 47.5
Subtotal	*$ 78.5*	*$ 10.3*	*$ -*	*$ 88.8*
Substance Abuse Treatment	$ 0.5	$ 15.6	$ 0.0	$ 16.1
Total	**$ 153.0**	**$ 272.3**	**$ 164.5**	**$ 589.7**

Expenditure and Enrollment Summary: Individuals Receiving Specialized Services v. All Other Medicaid Program Participants



158,459 Service Recipients



$1.08 Billion

Individuals receiving specialized services represent approximately 25 percent of total Medicaid participants receiving services, but coverage of services to meet their DLTSS and traditional medical needs comprises 72 percent of Medicaid claims

- Expenditures for these individuals' specialized services accounts for approximately 55% of Vermont Medicaid claims.
- Expenditures for these individuals' traditional medical services accounts for approximately 17% of Vermont Medicaid claims.
- In sum, services to meet these individuals' specialized services and traditional medical needs comprise 72% of Vermont Medicaid claims expenditures.
- The remaining 28% of Vermont Medicaid claims expenditures are for traditional medical services for the enrollees (75%) who are not served by specialized services and programs.

Medicaid Expenditures: Individuals Receiving Specialized Services v. All Other Medicaid Participants

$ millions

Program	Program Participants	Percent of Total	Traditional Services		Specialized Services		All Services	
			Expenditures	Percent of Total	Expenditures	Percent of Total	Expenditures	Percent of Total
Primary Specialized Programs								
Choices for Care/LTC	6,673	4.2%	$ 31.2	6.4%	$ 184.7	31.3%	215.9	20.0%
Personal Care	1,555	1.0%	$ 10.4	2.1%	$ 22.3	3.8%	32.7	3.0%
Traumatic Brain Injury	71	0.0%	$ 0.4	0.1%	$ 5.0	0.8%	5.4	0.5%
Developmental Services	2,952	1.9%	$ 11.8	2.4%	$ 155.8	26.4%	167.6	15.6%
MH Treatment	3,799	2.4%	$ 15.3	3.1%	$ 27.1	4.6%	42.4	3.9%
CRT	2,215	1.4%	$ 17.4	3.6%	$ 55.5	9.4%	72.9	6.8%
SED	95	0.1%	$ 0.7	0.1%	$ 2.8	0.5%	3.5	0.3%
Substance Abuse Treatment	5,186	3.3%	$ 32.7	6.7%	$ 15.9	2.7%	48.6	4.5%
Subtotal	*22,546*	*14.2%*	*$ 120.0*	*24.6%*	*$ 469.1*	*79.5%*	*589.0*	*54.7%*
Other Specialized Programs								
DCF Case Management	6,791	4.3%	$ 32.9	6.7%	$ 29.6	5.0%	62.6	5.8%
Department of Health	164	0.1%	$ 1.3	0.3%	$ 0.5	0.1%	1.8	0.2%
School-Based Health Services	7,141	4.5%	$ 15.6	3.2%	$ 37.6	6.4%	53.1	4.9%
Success Beyond Six	3,134	2.0%	$ 10.9	2.2%	$ 53.0	9.0%	63.9	5.9%
Subtotal	*17,230*	*10.9%*	*$ 60.7*	*12.4%*	*$ 120.7*	*20.5%*	*181.4*	*16.8%*
Subtotal: All Specialized Programs	***39,776***	***25.1%***	***$ 180.7***	***37.0%***	***$ 589.7***	***100.0%***	***770.4***	***71.5%***
All Other Medicaid Participants	***118,683***	***74.9%***	***$ 307.3***	***63.0%***	***$ -***	***0.0%***	***307.3***	***28.5%***
Total	**158,459**	**100.0%**	**$ 488.0**	**100.0%**	**$ 589.7**	**100.0%**	**1,077.8**	**100.0%**

Summary of Expenditures: Basis for Eligibility

- Medicaid eligibility rules reflect the important role of Medicaid in meeting the coverage needs of individuals with specialized needs
- Eligibility rules extend coverage to individuals with specialized needs and extensive health care needs
- Individuals enrolled on the basis of their medical needs represent approximately one-fourth of all Medicaid program participants
- Expenditures on behalf of individuals eligible due to medical needs represent 58 percent of total program expenditures *(Detail provided on next slide)*

Expenditures by Basis of Eligibility and Age *($ millions)*

Service Description	Non-Disability Related Aid Codes				Disability Related Aid Codes				Total: All Participants	Percentage of Expenditures: Disability-Related Aid Codes
Age:	Less than 18	18 to 64	65 and Older	Total	Less than 18	18 to 64	65 and Older	Total		
Program Recipients	58,429	57,500	3,512	**119,441**	4,326	28,056	6,636	**39,018**	**158,459**	
Percentage of Total	*37%*	*36%*	*2%*	***75%***	*3%*	*18%*	*4%*	***25%***		
Traditional Services										
Ambulance	$ 0.4	$ 1.1	$ 0.2	$ 1.8	$ 0.1	$ 1.5	$ 0.5	$ 2.1	$ 3.9	*54%*
Dental	$ 11.2	$ 3.5	$ 0.2	$ 14.9	$ 1.0	$ 3.6	$ 0.2	$ 4.7	$ 19.6	*24%*
Durable Medical Equipment	$ 0.6	$ 1.5	$ 0.4	$ 2.5	$ 0.9	$ 3.6	$ 0.8	$ 5.3	$ 7.8	*68%*
FQHC/RHC	$ 6.7	$ 10.9	$ 0.3	$ 17.9	$ 0.5	$ 5.1	$ 0.4	$ 5.9	$ 23.9	*25%*
Home Health	$ 1.2	$ 1.0	$ 0.3	$ 2.5	$ 0.6	$ 3.2	$ 0.9	$ 4.8	$ 7.3	*66%*
Hospice	$ 0.0	$ 0.1	$ 0.0	$ 0.1	$ -	$ 0.2	$ 0.5	$ 0.7	$ 0.8	*89%*
Independent Lab	$ 0.2	$ 3.9	$ 0.0	$ 4.1	$ 0.0	$ 1.1	$ 0.0	$ 1.1	$ 5.3	*21%*
Inpatient Hospital	$ 22.3	$ 59.7	$ 1.3	$ 83.3	$ 4.5	$ 30.7	$ 1.7	$ 36.9	$ 120.2	*31%*
Medical Supplies	$ 0.1	$ 0.2	$ 0.0	$ 0.3	$ 0.1	$ 0.3	$ 0.0	$ 0.5	$ 0.8	*58%*
Other	$ 0.1	$ 0.4	$ 0.1	$ 0.5	$ 0.0	$ 0.9	$ 0.2	$ 1.2	$ 1.7	*68%*
Other Practitioner	$ 7.1	$ 9.5	$ 0.1	$ 16.7	$ 2.8	$ 6.8	$ 0.4	$ 10.0	$ 26.7	*37%*
Outpatient Hospital	$ 14.1	$ 50.7	$ 2.4	$ 67.2	$ 1.7	$ 28.1	$ 2.9	$ 32.7	$ 99.9	*33%*
Pharmacy	$ 11.4	$ 36.1	$ 0.1	$ 47.6	$ 4.9	$ 23.0	$ 0.5	$ 28.4	$ 76.0	*37%*
Physician	$ 20.5	$ 38.9	$ 1.2	$ 60.6	$ 2.3	$ 17.6	$ 1.6	$ 21.5	$ 82.1	*26%*
Prosthetic/Orthotic	$ 0.4	$ 0.7	$ 0.0	$ 1.2	$ 0.9	$ 0.9	$ 0.0	$ 1.8	$ 2.9	*61%*
Therapy Services	$ 0.5	$ 1.6	$ 0.1	$ 2.2	$ 0.2	$ 0.6	$ 0.1	$ 0.9	$ 3.1	*29%*
Transportation	$ 0.2	$ 0.5	$ 0.5	$ 1.3	$ 0.1	$ 3.3	$ 1.5	$ 4.9	$ 6.2	*79%*
Subtotal: Traditional Services	***$ 97.1***	***$ 220.3***	***$ 7.3***	***$ 324.7***	***$ 20.6***	***$ 130.4***	***$ 12.3***	***$ 163.4***	***$ 488.0***	***33%***
Specialized Services										
Assistive Community Care	$ -	$ 0.4	$ 3.0	$ 3.4	$ -	$ 4.5	$ 7.5	$ 12.1	$ 15.4	*78%*
Choices for Care HCBS	$ -	$ 0.0	$ 4.2	$ 4.3	$ -	$ 17.8	$ 29.5	$ 47.3	$ 51.5	*92%*
Nursing Home	$ -	$ 0.2	$ 3.4	$ 3.6	$ 0.2	$ 13.5	$ 99.6	$ 113.3	$ 116.9	*97%*
Personal Care Services	$ 4.8	$ 0.4	$ 0.1	$ 5.3	$ 13.8	$ 5.4	$ 0.1	$ 19.3	$ 24.6	*79%*
Traumatic Brain Injury (TBI)	$ -	$ -	$ -	$ -	$ -	$ 4.9	$ 0.1	$ 5.0	$ 5.0	*100%*
Developmental Services HCBS	$ 0.8	$ 0.5	$ 1.5	$ 2.8	$ 4.1	$ 133.1	$ 9.9	$ 147.0	$ 149.9	*98%*
ICF/ID (DS)	$ -	$ -	$ -	$ -	$ -	$ 1.2	$ 0.1	$ 1.3	$ 1.3	*100%*
CRT	$ -	$ 3.1	$ 1.4	$ 4.5	$ -	$ 45.4	$ 3.5	$ 48.9	$ 53.4	*92%*
Day Treatment/Private Non-Medical Inst (PNMI)	$ 6.6	$ 1.2	$ 0.1	$ 7.9	$ 3.1	$ 0.3	$ 0.1	$ 3.5	$ 11.4	*31%*
HCBS SED Children and Adolescents	$ 1.7	$ 0.1	$ -	$ 1.8	$ 0.8	$ 0.2	$ -	$ 1.0	$ 2.8	*36%*
Mental Health Facility	$ 7.8	$ 1.6	$ 0.1	$ 9.4	$ 4.0	$ 3.2	$ 0.1	$ 7.4	$ 16.8	*44%*
Targeted Case Management -MH	$ 2.9	$ 0.2	$ 0.0	$ 3.1	$ 1.2	$ 0.3	$ 0.0	$ 1.6	$ 4.7	*34%*
DCF - Case Management	$ 18.9	$ 5.4	$ 0.0	$ 24.2	$ 3.5	$ 3.3	$ 0.0	$ 6.9	$ 31.1	*22%*
Department of Health	$ 0.5	$ 0.0	$ -	$ 0.5	$ 0.5	$ 0.1	$ -	$ 0.5	$ 1.1	*49%*
School-Based Health Services (DOE)	$ 18.3	$ 1.0	$ -	$ 19.4	$ 16.8	$ 4.0	$ -	$ 20.8	$ 40.2	*52%*
Day Trmt - Success Beyond Six	$ 24.9	$ 1.7	$ -	$ 26.6	$ 17.6	$ 3.4	$ -	$ 20.9	$ 47.5	*44%*
Substance Abuse Treatment	$ 0.4	$ 11.5	$ 0.0	$ 11.9	$ 0.1	$ 4.1	$ 0.0	$ 4.2	$ 16.1	*26%*
Subtotal: Specialized Services	***$ 87.5***	***$ 27.4***	***$ 13.9***	***$ 128.7***	***$ 65.5***	***$ 244.9***	***$ 150.6***	***$ 461.0***	***$ 589.7***	***78%***
Total	**$ 184.6**	**$ 247.6**	**$ 21.2**	**$ 453.4**	**$ 86.1**	**$ 375.4**	**$ 162.9**	**$ 624.4**	**$ 1,077.8**	**58%**

Attachment 5.1

Learning Collaborative Expansion

Vermont's Integrated Communities Care Management Learning Collaborative:

Round 1 Progress, and Request for Expansion

Core Team

May 4, 2015

Vermont Health Care Innovation Project

Background

- The VHCIP Care Models and Care Management Work Group identified two key priorities:
  - …to better serve all Vermonters (especially those with complex physical and/or mental health needs), **reduce fragmentation with better coordination of care management activities**…
  - …[to] better **integrate social services and health care services** in order to more effectively understand and address **social determinants of health** (e.g., lack of housing, food insecurity, loss of income, trauma) for at-risk Vermonters…
- The Work Group designated a Planning Group to design a Quality Improvement Learning Collaborative to act on these priorities.
- The Work Group and Steering Committee recommended funding for the Learning Collaborative; the Core Team approved that recommendation in August 2014.

Learning Collaborative Snapshot

- Vermont's delivery system reforms have strengthened coordination of care and services, but people with complex care needs sometimes still experience fragmentation, duplication, and gaps in care and services.
- A number of national models have potential to address these concerns.
- **Health and community service providers from 3 health service areas (Burlington, Rutland, St. Johnsbury) were invited to participate in Round 1 of the year-long Integrated Communities Care Management Learning Collaborative to test interventions from these promising models.**

Learning Collaborative Goals

- To increase knowledge of data sources and use data to identify at-risk people and understand their needs;
- To learn about and implement promising interventions to better integrate care management;
- To improve communication between organizations;
- To systematize referrals, transitions, and co-management;
- To provide tools and training for staff members who engage in care management; and
- To see if interventions improve coordination of care.

Round 1 Participants Include:

- Primary Care Practices participating in ACOs (care coordinators)
- Designated Mental Health Agencies and Developmental Services Providers
- Visiting Nurse Associations and Home Health Agencies
- Hospitals and Skilled Nursing Facilities
- Area Agencies on Aging
- Blueprint Community Health Teams and Practice Facilitators
- Support and Services at Home (SASH coordinators)
- ACOs (OneCare, CHAC)
- Medicaid's Vermont Chronic Care Initiative
- Commercial Insurers (BCBSVT)
- Agency of Human Services Staff

Timeline for Round 1

- **Kick-Off Webinars were held on November 12 and 21:** Approximately 70 people attended
- **1st In-Person Learning Session was held on Jan. 13, 2015:** Approximately 90 people attended
- **Monthly Educational Webinars:** During months without in-person learning sessions
- **First Action/Measurement Period:** Jan.-Feb. 2015
- **2nd In-Person Learning Session was held on March 10, 2015:** Approximately 70 people attended
- **Second Action/Measurement Period:** March-April 2015
- **3rd In-Person Learning Session:** May 19, 2015
- **Third Action/Measurement Period:** May-June 2015
- **Continued Testing and Measurement:** July-Nov. 2015
- **Core Competency Training for Care Managers:** Sept. 2015-Jan. 2016
- **Final Results and Next Steps:** Jan. 2016

Expansion Request

- Round 1 (Burlington, St. Johnsbury and Rutland) is well underway
- Other communities have initiated similar efforts and expressed interest in participation
- There is potential to leverage existing Learning Collaborative for other communities
- Seeking Steering Committee's endorsement of funding request for additional Learning Collaborative rounds to allow expansion to all interested health service areas

Estimated Budget for Rounds 2-4

- Anticipated economies of scale for quality improvement facilitators – $100,000 in estimated costs for one additional facilitator
- Learning Session faculty costs (includes travel) estimated at $110,000 based on Round 1 costs
- Core Competency Training costs estimated at $90,000 (includes Train-the-Trainer costs)
- Facility, logistical support, and supply costs estimated at $200,000
- **Total request: $500,000 (not to exceed amount)**

For Steering Committee Consideration

- Is the recommendation consistent with the goals and objectives of the grant?
  - This recommendation is consistent with the following goals and objectives of the grant (outlined in the Operational Plan):
    - To create commitment to change and synergy between public and private culture, policies and behavior;
    - To increase the level of accountability for cost and quality outcomes among provider organizations; and
    - To ensure accountability for outcomes from both the public and private sectors.
  - The recommendation also supports one of three major goals of VHCIP by supporting efforts to transform care delivery by enabling and rewarding care integration and coordination.

For Steering Committee Consideration

- Is the recommendation inconsistent with any other policy or funding priority that has been put in place within the VCHIP project?
  - No; learning collaboratives were identified in the operational plan as a promising tool for quality improvement and care delivery transformation. Vermont's Integrated Communities Care Management Learning Collaborative is aligned with the CMCM Work Group's charter and workplan (specifically, with the objective of identifying redundancies, gaps, and opportunities for innovation and coordination in order to address unmet needs, minimize duplication, and improve alignment between the models and management of activities).

For Steering Committee Consideration

- Has the recommendation been reviewed by all appropriate Work Groups?
  - The CMCM Work Group reviewed the proposal and voted unanimously (with two abstentions) to approve expansion of the integrated communities care management learning collaborative.
  - In light of the strong correlation between the learning collaborative goals and the elements of the DLTSS Model of Care, co-chairs and staff of both work groups have been and will continue to collaborate closely.
  - Specifically, the DLTSS work group is developing DLTSS-specific core competency training modules that will be made available to Learning Collaborative participants.

Questions/Discussion

Attachment 5.2

Financial Request

Financial Request: May 2015

Georgia Maheras, Project Director

May 4, 2015

Learning Collaborative Expansion

- *Request:* Approve $500,0000 of learning collaborative funds for expansion of the learning collaborative.
- *Details:*
  - Hire one additional quality improvement facilitator, who will work with two existing facilitators to support organizations that provide care management services to work together in a multi-disciplinary team based care approach; implementing best practices, tools, and training resources; and measuring results.
  - At least three in-person learning sessions (including faculty, location, and logistical support) and at least three webinars.

Request for no-cost extension:

- Policy Integrity:
  - Scope: provides technical assistance to sub-grantees
  - Approved amount: $100,000
  - Initial end date: May 2015
  - Request end date: October 31, 2016
  - Rationale: sub-grantees need support throughout their projects, which run through 10/31/16.

Request for no-cost extension:

- Truven Health Analytics:
  - Scope: provides technical assistance to sub-grantees
  - Approved amount: $100,000
  - Initial end date: May 2015
  - Request end date: October 31, 2016
  - Rationale: sub-grantees need support throughout their projects, which run through 10/31/16.

Request to modify payment provisions:

- Bailit Health Purchasing, Inc.:
  - Scope: Support for payment model design, quality measure analysis, care management design.
  - Approved Amount: $1,230,272
  - Travel amount (within the overall amount): $21,000
  - Rationale: This contract inadvertently did not include fully-loaded rates nor explicit travel approval. We need to correct that so that travel is explicitly authorized.

Request for no cost extension:

- Health*first* Chart Review Contract:
  - Scope: This contract supports Health*first*'s measure collection for the commercial and Medicare Shared Savings Programs for 2014.
  - Amount to include in no cost extension: $13,060
  - Rationale: The Core Team approved contracts with each of the State's three ACOs for chart review related activities. Health*first* did not use all of these resources for the 2014 measure collection because fewer commercial records were pulled than initially anticipated. The request is to use the remainder for data collection for the 2015 performance year.

Request for new expenditure:

- Clinical Registry:
  - Scope: Purchase a license for DocSite Clinical Registry
  - Requested Amount: $1,000,000
  - Line Item: *Technology and Infrastructure: Enhancements to centralized clinical registry & reporting systems*
- Rationale: The clinical registry software is no longer available through the current vendor as they are phasing out this product line. This data set is used by the Blueprint for Health and will be used to support the regional Unified Collaboratives for enhanced reporting of clinical data. This allows us to retain the existing data and migrate the system to a new hosted environment.

Attachment 5.3

Project Budget

VHCIP Funding Allocation Plan

	as of 3.7.15	**Contracts Executed (or committed by Core Team)**	**Implementation (March-Oct 2013)**	**Year 1 (10/1/13-12/31/14)**	**Year 2 (1/1/15-12/31/15)**	**Year 3 (1/1/16-12/31/16)**	**Year 4 (1/1/17-9/30/17)**	**Total grant period**	**Category Total**	**Agency**	**Approved Budget Narrative Category**	
Type 1a	Type 1A											
Proposed type 1 without base work group or agency/dept support	*Proposed Type 1 without base work group or agency/dept support (subject to Core Team approval)*											Highlight indicates contract is pending at the Core Team on 3/9/15
	Personnel, fringe, travel, equipment, supplies, other, overhead		**$ 119,615**	**$ 2,835,875**	**$ 3,299,871.00**	**$ 3,368,455.00**	**621,361.00**	**$ 10,245,177**	**$10,245,177.00**	**GMCB, AHS, AOA, DVHA, VDH**	**Personnel; Fringe; etc…**	
	Project management	Total for this category							**$ 630,000.00**			
		Remainder available							0			
		UMASS Commonwealth Med.	**$ -**	**$ 230,000**	**$ 230,000.00**	**$ 170,000.00**	**-**	**$ 630,000**		**AOA**	**Project Management**	
	Evaluation	Total for this category							**$ 2,000,000.00**			
		Remainder available			**$ 67,001.00**	**$ 66,667.00**	**66,667.00**	**$ 200,335**	$ 200,335.00	**GMCB**	**Evaluation**	
		Impaq International	$ -	**$ 194,558**	**$ 583,675.14**	**$ 583,675.00**	**437,756.36**	**$ 1,799,665**		**GMCB**	**Evaluation**	
	Outreach and Engagement	Total for this category							**$ 300,000.00**			
		Remainder available		**$ -**	**$ 500.00**	**$ 150,000.00**	**-**	**$ 300,000**	$ 300,000.00		**Outreach and Engagement**	
		PDI Creative Consulting		**$ 15,000**	**$ 134,500.00**				**$ 149,500.00**	**DVHA**	**Outreach and Engagement**	
	Interagency coordination	Total for this category							**$ 320,000.00**			
		Remainder available			**$ 55,509.43**	**$ 111,019.20**	**111,019.20**	**$ 277,548**	$ 277,547.83	**AOA**	**Interagency Coordination**	
		Arrowhealth Health Analytics		**$ 40,000**	**$ 2,452.17**					**AOA**	**Interagency Coordination**	
	Staff training and Change management	Total for this category							**$ 55,000.00**			
		Remainder available			**$ -**	**$ 20,000.00**		**$ 20,000**		**DVHA**	**Staff Training and Change Management**	
		Coaching Center of Vermont		**$ 15,000**	**$ 20,000.00**			**$ 35,000**		**DVHA**	**Staff Training and Change Management**	
	Technology and Infrastructure	Total for this category							**$ 444,678.00**			
		Remainder available							0			
		VITL		**$ 99,018**				**$ 99,018**		**DVHA**	**Expanded Connectivity to the HIE**	
		VITL		**$ 345,660**				**$ 345,660**		**DVHA**	**Practice Transformation**	
	Grant program	Total for this category							**$ 4,903,145.00**			
		Remainder available					**-**		$ -			

		14 Awardees		$ 560,000	$ 2,000,000.00	$ 2,343,145.00	-	$ 4,903,145		DVHA	TA to providers implementing payment reforms	
	Grant program- Technical Assistance	Total for this category							$ 650,000.00			
		Remainder available							150,000			
		Policy Integrity		$ 20,000	$ 40,000.00	$ 40,000.00	-	$ 100,000		DVHA	TA to providers implementing payment reforms	No Cost Extension Requested 5.4.15 CT meeting
		Wakely		$ 20,000	$ 40,000.00	$ 40,000.00	-	$ 100,000		DVHA	TA to providers implementing payment reforms	
		Truven		$ 20,000	$ 40,000.00	$ 40,000.00	-	$ 100,000		DVHA	TA to providers implementing payment reforms	No Cost Extension Requested 5.4.15 CT meeting
		VPQHC		$ 20,000	$ 40,000.00	$ 40,000.00	-	$ 100,000		DVHA	TA to providers implementing payment reforms	
		Bailit		$ 20,000	$ 40,000.00	$ 40,000.00	-	$ 100,000		DVHA	TA to providers implementing payment reforms	
	Chart Review	Total for this category							$ 395,000.00			
		Remainder available							0			
		Healthfirst		$ 25,000	$ 30,000.00	$ -	-	$ 55,000		DVHA	Model Testing: Quality Measurement	
		CHAC		$ 95,000	$ 100,000.00	$ -	-	$ 195,000		DVHA	Model Testing: Quality Measurement	
		OCV		$ 30,000	$ 120,000.00	$ -	-	$ 150,000		DVHA	Model Testing: Quality Measurement	
	ACO Proposal: Analytics	Total for this category							$ 3,135,000.00			
		Remainder available							0			
		CHAC		$ 177,800	$ 355,600.00	$ -	-	$ 533,400		DVHA	Advanced Analytics: 50%; TA Practice Transformation: 50%	
		OCV		$ 872,733	$ 1,745,467.00	$ -	-	$ 2,618,200		DVHA	Advanced Analytics: 50%; TA Practice Transformation: 50%	
	Advanced Analytics: Financial	Total for this category							$ 600,000.00	DVHA	Advanced Analytics: Financial and Other Modeling	

		Remainder available		$ 20,000	$ -	$ 50,003.00		$ 70,003	$ 70,003.00	DVHA	Advanced Analytics: Financial and Other Modeling	
		Wakely Actuarial		$ 30,000	$ 20,000.00	$ 20,000.00		$ 70,000		DVHA	Advanced Analytics: Financial and Other Modeling	
		Total for this category							$ 700,000.00	DVHA	Advanced Analytics: Financial and Other Modeling AND Policy	
		Health Management Associates			$ 259,997.00	$ -		$ 259,997	$ 259,997.00	GMCB	Advanced Analytics: Financial and Other Modeling	
		Health Management Associates			$ 220,002.00	$ 220,001.00		$ 440,003	$ 440,003.00	GMCB	Advanced Analytics: Policy	
	Subtotal											
Type 1b	Type 1 B											
Proposed type 1 related to base work group support (subject to Core Team approval)	Proposed Type 1 related to base work group support (subject to Core Team approval)											
	Payment Models WG	Total for this category							$ 800,000.00		Advanced Analytics	
		Remainder Available				$ 134,671.00	-	$ 134,671	$ 134,671	DVHA	Advanced Analytics	
		Bailit		$ 80,000	$ 160,000.00	$ 160,000.00	-	$ 400,000		DVHA	Advanced Analytics	Request to reallocate $21,000 for travel within the NTE
		Burns and Associates		$ 125,000	$ -	$ -	-	$ 125,000		DVHA	Advanced Analytics	
		VMSF- Frail Elders Project			$ 140,329.00			$ 140,329		DVHA	Advanced Analytics	
								$ -				
	Quality Perf Measures WG	Total for this category						$ -	$ 400,000.00			
		Remainder Available							0			
		Bailit		$ 80,000	$ 160,000.00	$ 160,000.00	-	$ 400,000		DVHA	Model Testing: Quality Measures	
	HIT/HIE WG	Total for this category							$ 240,000.00	DVHA	Advanced Analytics	
		Remainder Available							0	DVHA	Advanced Analytics	
		Stone Environmental			$ 10,000.00	$ 110,000.00	-	$ 120,000				
		Stone Environmental		$ 20,000	$ 100,000.00			$ 120,000		DVHA	Advanced Analytics	
	Population Health WG	Total for this category							$ 514,039.00	DVHA	Advanced Analytics	
		Remainder Available			$ 43,715.00	$ 316,039.00		$ 359,754	$ 359,754.00	DVHA		

		Hester		$ 21,000	$ 32,000.00	$ -	-	$ 53,000		DVHA	Advanced Analytics	
		Prevention Institute		$ 5,000	$ 101,285.00	$ -	-	$ 106,285		DVHA	Advanced Analytics	
								$ -				
	Workforce	Total for this category							$ 86,000.00	DVHA	Workforce: System-wide capacity	
		Remainder Available		$ -	$ 15,000.00	$ 43,000.00	-	$ 58,000	$ 58,000.00	DVHA	Workforce: System-wide capacity	
		UVM		$ 28,000				$ 28,000		DVHA	Workforce: System-wide capacity	
								$ -				
	Care Models	Total for this category							$ 150,000.00	DVHA	Advanced Analytics	
		Remainder Available			$ 100,000.00	$ 50,000.00	-	$ 150,000	$ 150,000.00	DVHA	Advanced Analytics	
								$ -				
	DLTSS	Total for this category							$ 680,000.00	DVHA	Advanced Analytics	
		Remainder Available				$ 84,800.00		$ 84,800	$ 84,800.00		Advanced Analytics	
		Bailit		$ 79,146	$ 105,527.00	$ 105,527.00	-	$ 290,200		DVHA	Advanced Analytics	
		PHPG		$ 90,000	$ -	$ -	-	$ 90,000		DVHA	Advanced Analytics	
		PHPG		$ 53,750	$ 161,250.00		-	$ 215,000		DVHA	Advanced Analytics	
	Sub Total								$ 2,895,957.00			
Type 1c	Type 1 C		**Impl. Period**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Grant Total**				
Proposed type 1 related to base agency/dept support	Proposed Type 1 related to base agency/dept support											
	GMCB	Total for this category							$ 2,575,000.00	GMCB	Advanced Analytics	
		Remainder Available			$ 250,000.00	$ 125,000.00	-	$ 375,000	$ 375,000.00	GMCB	Advanced Analytics	
		Lewin		$ 289,474	$ 694,737.00	$ 694,736.00	521,053.00	$ 2,200,000		GMCB	Advanced Analytics	
	DVHA	Total for this category							$ 1,425,000.00	DVHA	Advanced Analytics	
		Remainder Available		$ -	$ 612,500.00	$ 612,500.00	-	$ 1,225,000	$ 1,225,000.00	DVHA	Advanced Analytics	
		PHPG-VBP		$ 28,910	$ 71,090.00	$ -	-	$ 100,000		DVHA	Advanced Analytics	
		DLB		35,000	20,000			55,000		DVHA	Advanced Analytics	
		Burns & Associates		$ -	$ 45,000.00	$ -	-	$ 45,000		DVHA	Advanced Analytics	

		RFP pending									Advanced Analytics	
	Sub-Total								**$ 4,000,000.00**			
Type 2	**Type 2**		**Impl. Period**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Grant Total**				
Total proposed type 2 (subject to staff planning, work group/steering committee review and Core Team approval)	Total proposed Type 2 (subject to staff planning, work group/steering committee review and Core Team approval)											
	HIT/HIE	Total for this category							**$ 10,945,155.00**			
		Total Remainder Available						$ 5,259,119.00	$ 5,259,119.00			
		VITL: ACO Gateway Population Health Proposal		**$ 440,321**	**$ -**	$ -	-	**$ 440,321**		**DVHA**	**T&I: Practice Transformation**	
		VITL: ACO Gateway Population Health Proposal		**$ 833,333**	**$ 833,333.00**	$ -	-	**$ 1,666,666**		**DVHA**	**T&I: Expanded Connectivity btw SOV and ACOs/Providers**	
		VITL: ACO Gateway Population Health Proposal		**$ 346,346**	**$ 570,465.00**	**$ -**	-	**$ 916,811**		**DVHA**	**T&I: Expanded Connectivity of HIE Infrastructure**	
		Subtotal: ACO Gateway Population Health Proposal		*$ 1,620,000*	*$ 1,403,798.00*	*$ -*	-	***$ 3,023,798***				
		VITL: ACTT Proposal		**$ 30,308**	**$ 181,846.00**	**$ 141,537.00**	-	**$ 353,691**		**DVHA**	**T&I: Practice Transformation**	
		BHN: ACTT Proposal		**$ 100,141**	**$ 235,538.00**	**$ 135,398.00**	-	**$ 471,077**		**DVHA**	**T&I: Practice Transformation**	
		ARIS: ACTT Proposal		**$ -**	**$ 275,000.00**	**$ -**	-	**$ 275,000**		**DVHA**	**T&I: Expanded Connectivity of HIE Infrastructure**	
		UTP-RFP: ACTT Proposal (Pending)		$ 80,000	**$ 80,000.00**			**$ 160,000**		**DVHA**	**Technology and Infrastructure: Analysis of how to incorporate LTSS, MH/SA**	

		Data Repository: ACTT Proposal (pending)			$ 346,139.00	$ 346,139.00	-	692,278		DVHA	T&I: Enhancements or development of clinical registry and other centralized reporting systems.	
		Bailit: ACTT Proposal		$ 13,357	$ 26,715.00	$ -	-	$ 40,072		DVHA	Technology and Infrastructure: Analysis of how to incorporate LTSS, MH/SA	
		HIS: ACTT Proposal		$ 40,000	$ 60,000.00	$ 20,000.00	-	$ 120,000		DVHA	T&I: Practice Transformation	
		HIS: ACTT Proposal		$ 20,000	$ 100,000.00	$ 80,000.00	-	$ 200,000		DVHA	T&I: Expanded Connectivity of HIE Infrastructure	
		HIS: ACTT Proposal		$ 34,282	$ 102,846.00	$ 68,563.00		$ 205,691		DVHA	T&I: Enhancements or development of clinical registry and other centralized reporting systems.	
		HIS: ACTT Proposal		$ 20,718	$ 62,155.00	$ 41,436.00	-	$ 124,309		DVHA	T&I: Expanded Connectivity btw SOV and ACOs/Providers	
		Subtotal: ACTT Proposal						*$ 2,662,118*				
		Remainder Available: Analysis of how to incorporate LTSS, MH/SA			$ 49,964.00	$ 49,964.00	-	$ 99,928			Technology and Infrastructure: Analysis of how to incorporate LTSS, MH/SA	
		Remainder Available: Practice Transformation			$ 51,219.00	$ 50,532.00	-	$ 101,751			TA: Practice Transformation	
		Total for this category: Telemedicine			$ 625,000.00	$ 625,000.00	-	$ 1,250,000.00			T&I: Telemedicine	
		JBS International			$ 140,442.00			$ 140,442		DVHA	T&I: Telemedicine	
		Remainder Available: Telehealth			505,000.00	625,000.00		1,130,000.00			T&I: Telemedicine	
		Remainder Available: Expanded connectivity of HIE infrastructure				$ 1,007,671.00	-	$ 1,007,671.00			T&I: Expanded Connectivity of HIE Infrastructure	

		VITL: Gap Remediation Request		200,000	$ 450,000.00			$ 650,000.00		DVHA	T&I: Expanded Connectivity of HIE Infrastructure	
		VITL: Gap Remediation Request			$ 118,333.33	$ 165,666.66		$ 284,000.00		DVHA	T&I: Expanded Connectivity of HIE Infrastructure	
		VITL: Gap Remediation Request			$ 306,250.00	$ 61,250.00		$ 367,500.00		DVHA	T&I: Expanded Connectivity of HIE Infrastructure	
		Remainder Available: Integrated platform and reporting system			$ 500,000.00	$ 500,000.00	-	$ 1,000,000.00			T&I: Integrated Platform and Reporting System	
		Remander Available: Expanded connectivity between SOV data sources and ACOs/providers			$ 92,468.00	$ 98,159.00	-	$ 190,627			T&I: Expanded Connectivity btw SOV and ACOs/Providers	reduced by 5,691. 5,691 added to clinical registry below.
		Remainder Available: Enhancements or development of clinical registry and other centralized reporting systems.			$ 1,000,000.00	$ -	-	$ 1,000,000			T&I: Enhancements or development of clinical registry and other centralized reporting systems.	Pending at CT on 5.4.15
								$ -				
	Workforce	Total for this category							$ 644,999.00		Workforce Assessment: System-wide capacity	
		Total Remainder Available				$ 294,999.00		$ 294,999	$ 294,999.00		Workforce Assessment: System-wide capacity	
		Remainder Available: System-wide analysis		$ -		$ 294,999.00	-	$ 294,999		DVHA	Workforce Assessment: System-wide capacity	
		Micro-Sim Workforce Demand Modeling RFP			$ 350,000.00	0		$ 350,000.00		DVHA	Workforce Assessment: System-wide capacity	
	CMCM	Total for this category							$ 2,200,000.00			
		Total Remainder Available			$ 810,000.00	$ 1,040,000.00	-	$ 1,850,000	$ 1,850,000.00			
		Remainder Available: Service delivery for LTSS, MH, SA, Children			$ 700,000.00	$ 700,000.00		$ 1,400,000		DVHA	Model Testing: Service Delivery to support engancement and maintenance of best practice as payment models evolve	

		Learning Collaborative Expansion			$ 335,000.00	$ 165,000.00		$ 500,000		DVHA	TA: Learning Collaboratives	Request pending at 5.4.15 CT meeting for expansion
		Abernathey		$ 6,230	$ 93,770.00			$ 100,000		DVHA	TA: Learning Collaboratives	
		VPQHC			$ 92,500.00	$ 7,500.00		$ 100,000			TA: Learning Collaboratives	
		Faculty and Facilities			$ 100,000.00			$ 100,000		DVHA/AOA	TA: Learning Collaboratives	Clarified for 5.4.15 CT meeting
		Remainder Available: Integration of MH/SA		$ -	$ 75,000.00	$ 75,000.00		$ 150,000		DVHA	Model Testing: integration of MH/SA	
	DLTSS	Total for this category							$ 350,000.00			
		Remainder Available: Learning Collaboratives			$ 250,000.00	$ 100,000.00		$ 350,000		DVHA	TA: Learning Collaboratives	
	QPM	Total for this category							$ 230,918.00	DVHA	Model Testing: Quality Measures	
		Total Remainder Available			$ -	$ -	-	$ -	$ -	DVHA		
		Datastat (Patient Exp Survey)		$ 58,639	$ 113,639.00	$ 58,639.00	-	$ 230,918		DVHA	Model Testing: Quality Measures	
	Sub-Total							$ 13,995,144				
Type 1a	$ 24,118,003											
Type 1b	$ 2,895,957											
Type 1c	$ 4,000,000											
Type 2	$ 13,995,144											
Unallocated	$ -											
Grant Total	$ 45,009,104											