

## **VT Health Care Innovation Project Core Team Meeting Agenda**

April 6, 2015 1:00 pm-3:00pm  
DVHA Large Conference Room, 312 Hurricane Lane, Williston  
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 <ul style="list-style-type: none"> <li>a. Sub-Grant Program Convening- May 27<sup>th</sup></li> <li>b. VHCIP Project Meeting- June xxx</li> <li>c. Annual Report submitted on March 30<sup>th</sup>: <a href="http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Reports/SOV%20Year%201%20Annual%20Progress%20Report%20Final%203.30.15.pdf">http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Reports/SOV%20Year%201%20Annual%20Progress%20Report%20Final%203.30.15.pdf</a></li> </ul>	Lawrence Miller	
<b>Core Team Processes and Procedures</b>				
2	1:05-1:10	Approval of meeting minutes	Lawrence Miller	Attachment 2: March 9, 2015 minutes <i>Decision needed.</i>
<b>Policy Update</b>				
3	1:10-1:55	1. Y2 Gate and Ladder methodology for the Medicaid Shared Savings ACO Program  <i>Public Comment</i>	3.1 Alicia Cooper  3.2 Monica Light	Attachment 3.1a: Year Two Gate and Ladder Presentation for CT (ppt)  Attachment 3.1b: Memo from SC to PMWG

		2. Global Commitment and Choices for Care Waiver Overview		Attachment 3.1c: Memo from QPM to PMWG <i>Decision needed.</i>  Attachment 3.2: Global Commitment April 2015 (ppt)
<b>Financial Update:</b>				
4	1:55-2:45	1. 2014 Financial Overview 2. Financial request  <i>Public Comment</i>	Georgia Maheras	Attachment 4.1: Year One Financial Overview (ppt) Attachment 4.2: March 2015 Financial Request (ppt) Attachment 4.3: Project Budget 4.6.15 (Excel)
5	2:45-2:55	<i>Public Comment</i>	Lawrence Miller	
6	2:55-3:00	Next Steps, Wrap-Up and Future Meeting Schedule: 5/4: 1-3p, Pavilion, Montpelier	Lawrence Miller	



**Vermont Health Care Innovation Project  
Core Team Meeting Minutes**

**Pending Core Team Approval**

**Date of meeting:** Monday, March 9, 2015, 12:30-2:00pm, EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
<b>1. Welcome and Chair's Report</b>	<p>Lawrence Miller called the meeting to order at 12:36. A roll call attendance was taken and a quorum was present.</p> <p>Lawrence Miller provided the Chair's report: Lawrence and Georgia will be doing a mid-point progress review and risk assessment. Lawrence invited members to offer suggestions of risks or concerns and encouraged them to contact him offline.</p>	
<b>2. Meeting Minutes</b>	<p>Lawrence Miller invited comment from members on the minutes from the previous meeting. There were no amendments. Susan Wehry moved to approve the February 2015 meeting minutes. Robin Lunge seconded. A roll-call vote was taken and the motion carried.</p>	
<b>3. Core Team Role</b>	<p>Lawrence Miller launched a discussion on the role of the Core Team, following up on earlier discussions on the role of the Steering Committee and Core Team. Georgia Maheras presented a decision-making process and slides on the Steering Committee and Core Team roles (Attachments 3a and 3b). Georgia emphasized that the Core Team does not have statutory authority to execute contracts or change policy; the Core Team makes recommendations for funding and policy change to GMCB, AHS, DVHA, private payers, and providers.</p> <p>The Core Team discussed the following:</p> <ul style="list-style-type: none"> <li>• How quickly have we been able to get contract approvals from CMMI? Georgia responded that this depends on CMMI workload; some are approved very quickly and others take time when CMMI has many other approvals on their plate. Georgia noted that CMMI has been willing to approve contracts retroactively to make up for this. Lawrence noted that it's important for the Core Team to recognize that work done while waiting for CMMI approval puts General Fund dollars at risk.</li> <li>• Do we expect an audit from CMMI this year? Unknown.</li> </ul>	

Agenda Item	Discussion	Next Steps
<p><b>4. Policy Update</b></p>	<p>Lawrence Miller introduced two policy update items:</p> <ul style="list-style-type: none"> <li>• DLTSS Work Group Letter to the Governor</li> <li>• ACO Care Management Standards</li> </ul> <p><i>DLTSS Work Group Letter to the Governor (Attachments 4.1a and 4.1b):</i> This was discussed at the November and December 2014 meeting, as well as the January 2015 Steering Committee and Core Team meetings. At the January Core Team meeting, this group decided it was appropriate for this to go forward with caveats noting that state employees declined to participate in this process. Private sector members of the DLTSS Work Group also sent a letter under separate cover in December.</p> <ul style="list-style-type: none"> <li>• Is this different from other concerns about budget cuts? Lawrence commented that if a group wants to communicate something to the Governor and votes to do that, it's appropriate. He noted that this put state employees in an awkward position, but the current language notes this clearly and the aims are consistent with the project. He believes this is an appropriate level of advocacy. The Workforce Work Group is sending a similar letter in their role as an advisory group appointed by the Governor.</li> <li>• What would the Core Team's cover letter say? Susan Wehry expressed hesitation. While she supports the Work Group members speaking their mind, it may be outside the scope of SIM and the Core Team. The letter makes advocacy-style statements without data, and sending it on to the Governor may be read as an endorsement of these statements.</li> <li>• Did this go through the appropriate process? The letter was approved by the DLTSS Work Group with many abstentions from state employees, and passed through the Steering Committee.</li> <li>• Harry Chen suggested that the cover letter include a statement that the Core Team does not endorse the message in the letter rather than taking a position.</li> <li>• Could there be a potential issue with use federal funds that support the Work Groups for non-SIM activities and/or lobbying activities? Robin Lunge noted that she believes this meets the definition of advocacy under Vermont law; she is not worried about this letter, but about future activities.</li> <li>• Steve Costantino recommends informing the DLTSS Work Group of Robin's concern, perhaps following additional research into Robin's concern.</li> </ul> <p>Steven Costantino moved to pass the letter along with a cover memo describing the process, and to perform an analysis to address Robin's legal concerns. Robin Lunge seconded. The motion carried.</p> <p><i>ACO Care Management Standards:</i> Erin Flynn presented the ACO Care Management Standards as approved by the CMCM Work Group and Steering Committee (Attachment 4.2). The CMCM Work Group, with leadership from a sub-group, worked for 11 months to develop consensus standards. The CMCM Work Group voted to approve the standards at their February meeting with a small language change; it was approved by the Steering Committee at its February meeting.</p>	<p><b>Perform an analysis to address legal concerns raised by Robin Lunge; report back to the Core Team at 4/6/2015 meeting.</b></p>

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> <li>• What does culturally competent mean? Erin Flynn suggested that there could be many definitions, but that language was added at the suggestion of the DLTSS Work Group. Paul Bengtson suggested that for providers, this means understanding the needs of various populations, including people with disabilities, children, frail elders, people from other cultures, or others.</li> <li>• Who performs these functions in communities, and how can we prevent this care management structure from being duplicative? Pat Jones noted that many of the standards include language that state that “ACOs have a process for and/or support participating providers in” care management activities.</li> <li>• Paul Bengtson noted that ACOs are not necessarily the last stop on the train. Lawrence Miller noted that these standards will need to be worked into contracts, another hurdle.</li> <li>• When did the introductory language change from “agree to be guided by” to “agree to”? At the February 10<sup>th</sup> meeting. There was one dissenting vote on the language change, from one of the ACOs, but that ACO has since expressed that they have considered this further and have no objections. Julie Wasserman noted that the original language proposed did include “agree to” – it was then changed to “agree to be guided by” and back to “agree to.”</li> <li>• Does CMS have to approve these standards? No. The contracts with ACOs will need to meet CMS standards; for the Commercial Shared Savings Program, contracts will go to GMCB. Contracts between DVHA and ACOs will need to be amended, but Vermont’s Medicaid State Plan does not include this level of detail and will not need to be amended.</li> </ul> <p>Steve Voigt moved to approve the standards. Paul Bengtson seconded. The motion carried.</p>	
<p><b>5. Financial Update</b></p>	<p>Georgia Maheras presented a general financial update and two financial requests:</p> <ul style="list-style-type: none"> <li>• Frail Elders Proposal</li> <li>• Jim Hester Contract Amendment</li> </ul> <p><i>General Financial Update (Attachment 4a):</i> Georgia noted that we do not yet have 2014 actuals due to state financial processes. She also noted that she plans to request a reallocation in June or July, similar to Year 1. In addition, CMS has indicated that it will not fund HIT provider stipends; this line has been removed.</p> <ul style="list-style-type: none"> <li>• How much flexibility is there to move remaining funds to areas where it will be effectively applied? Quite a bit. Within a funding category (ex/Evaluation), it is easy to reallocate funds. If funds need to move between categories, federal approval is required. We will attempt to bring only one reallocation request to CMMI, as they have requested.</li> <li>• Can we look to other groups to identify potential areas for funding? There are some areas that we could pull into our work using these funds; however, Georgia and Lawrence prefer to complete their risk assessment first.</li> <li>• Can unexpended funds all be carried forward, or only some? We can carry forward all funds; however,</li> </ul>	

Agenda Item	Discussion	Next Steps
	<p>we must identify specifically what the carryover funds will be used for. Our 2014 carryover request is still with CMMI pending approval. Funds must be spent in the next testing year (2015), however, we can also carry forward funds from 2015 to 2016. We expect to put funds in the 2016 budget that are intended to carry over to 2017 to complete our evaluation and retroactive SSP analyses.</p> <p><i>Frail Elders Proposal</i> (Attachment 5b): The conversation around this proposal began last spring, prompted by two rural FQHC providers who wanted to provide better care for frail elders. This was initially developed at the Payment Models Work Group, went to Steering Committee, was sent back for further work, and was revised by a sub-group. It was approved by the Steering Committee in February. The contractor would be the Vermont Medical Society Education Foundation. The scope has expanded since this was originally proposed: an Expert Panel was added, as well as additional interviews.</p> <ul style="list-style-type: none"> <li>• Does VMSF feel confident that they can perform all of the work included in this proposal, following the expanded scope? Yes, and members can find further details in the budget detail.</li> <li>• How would this link to Area Agencies on Aging, DAs, and others? Page 1 of the proposal describes these connections: the project would form an Expert Panel to inform this work and would include representatives from each of these provider groups and others.</li> <li>• How does this project deal with data and information sharing difficulties between different provider types? The project does not seek to solve this problem. There is separate work going on in the state to support these data connections; DAIL believes this project will help move this forward, even if it doesn't solve the problem.</li> <li>• How has DAIL been involved in this proposal? DAIL has been very involved, and feels confident that its provider network is well incorporated.</li> <li>• Susan Wehry noted that under the "Definition of areas of study" section, we identify a librarian doing billing claims. Georgia Maheras indicated that this was in error; this work will be done by a different contractor.</li> </ul> <p>Paul Bengtson moved to approve this proposal with the change suggested above by Susan Wehry. Susan Wehry seconded. The motion carried.</p> <p><i>Jim Hester Contract Amendment</i>: Georgia Maheras presented an amendment to Jim Hester's contract to work with the Population Health Work Group. These funds were specifically allocated to the Population Health Work Group; the Work Group had a remainder in their 2015 funds (they still have \$43,000 remaining).</p> <ul style="list-style-type: none"> <li>• What has Jim done so far in his work with the Population Health Work Group? Created several PowerPoints for presentation to the Work Group. He also participates in planning and strategy sessions for the Work Group, and provides support to the Work Group as requested on various research and analysis tasks, and lends his national expertise to our conversations. Under this amended contract, one</li> </ul>	

Agenda Item	Discussion	Next Steps
	<p>of his tasks will be to investigate and report on models for funding population health activities.</p> <p>Steve Voigt moved to approve the contract amendment. Harry Chen seconded. There was no public comment. The motion carried.</p>	
<b>6. Public Comment</b>	No further public comment was offered.	
<b>7. Next Steps, Wrap Up and Future Meeting Schedule</b>	<p><i>Next Steps:</i></p> <ul style="list-style-type: none"> <li>• Progress summary and risk assessment is underway; it will be presented to this group after the legislative session.</li> </ul> <p>Paul Bengtson suggested a presentation on HIE/HIT would be helpful. He commented that money could be saved if data collection, analytics, and exchange efforts were aligned or combined across entities. Lawrence Miller noted that the State HIT Plan is currently being revised; this process has just started, so timing is good. He suggested that passive claims and clinical data collection will be critical for success.</p> <p><b>Next Meeting:</b> Monday, April 6, 2015, 1:00pm-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston</p>	

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# Proposed Changes to the Year 2 VMSSP Gate & Ladder Methodology

VHCIP Core Team  
April 6, 2015

# Overview

- Review
  - Year 1 Payment Measures
  - Year 1 Benchmarks & Targets
  - Year 1 Gate & Ladder Methodology
- Approved Changes to Year 2 Payment Measures
- Work Group Input & Votes
- Proposed Changes to Year 2 Performance Benchmarks & Target
- Proposed Changes to Year 2 VMSSP Gate & Ladder Methodology
- Additional Considerations

# Year 1 Payment Measures

Year 1 Payment Measure		Medicaid SSP	Commercial SSP
<b>Core-1</b>	Plan All-Cause Readmissions	X	X
<b>Core-2</b>	Adolescent Well-Care Visits	X	X
<b>Core-3</b>	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	X	X
<b>Core-4</b>	Follow-Up After Hospitalization for Mental Illness: 7-day	X	X
<b>Core -5</b>	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	X	X
<b>Core-6</b>	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	X	X
<b>Core-7</b>	Chlamydia Screening in Women	X	X
<b>Core-8</b>	Developmental Screening in the First Three Years of Life	X	

# Year 1 Benchmarks

	Medicaid SSP	Commercial SSP
<b>Approach: Use national HEDIS benchmarks for all measures for which they are available; use improvement targets when national benchmarks are unavailable</b>	Core 2-7: National Medicaid HEDIS benchmarks  Core 1 & 8: Improvement targets based on 2012 VT Medicaid performance	Core 1-7: National commercial HEDIS benchmarks

# Year 1 Performance Targets

- *When using National HEDIS Benchmarks:*

Compare each payment measure to the national benchmark and assign 1, 2 or 3 points based on whether the ACO is at the national 25<sup>th</sup>, 50<sup>th</sup> or 75<sup>th</sup> percentile for the measure.

- *When using Improvement Targets:*

Compare each payment measure to VT Medicaid benchmark, and assign 0, 2 or 3 points based on whether the ACO declines, stays the same, or improves relative to the benchmark.

- Statistical significance; targets associated with each point value are set according to ACO-specific attribution estimates

National HEDIS Benchmarks		Improvement Targets: Change Relative to Historic Performance	
25 <sup>th</sup> Percentile	1 Point	Statistically significant decline	0 Points
50 <sup>th</sup> Percentile	2 Points	Statistically same	2 Points
75 <sup>th</sup> Percentile	3 Points	Statistically significant improvement	3 Points

# Year 1 Gates & Ladders

Percentage of available points	Percentage of earned savings: <b>COMMERCIAL</b>	Percentage of available points	Percentage of earned savings: <b>MEDICAID</b>
55%	75%	35%	75%
60%	80%	40%	80%
65%	85%	45%	85%
70%	90%	50%	90%
75%	95%	55%	95%
80%	100%	60%	100%

# Approved Year 2 Payment Measures

Year 2 Payment Measure		Medicaid SSP	Commercial SSP
<b>Core-1</b>	Plan All-Cause Readmissions	X	X
<b>Core-2</b>	Adolescent Well-Care Visits	X	X
<b>Core-3</b>	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	X	X
<b>Core-4</b>	Follow-Up After Hospitalization for Mental Illness: 7-day	X	X
<b>Core -5</b>	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	X	X
<b>Core-6</b>	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	X	X
<b>Core-7</b>	Chlamydia Screening in Women	X	X
<b>Core-8</b>	Developmental Screening in the First Three Years of Life	X	
<b>Core-12</b>	Ambulatory Care Sensitive Condition Admissions: PQI Composite	X	X
<b>Core-17</b>	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	X	X

# QPM Discussion & Recommendation

- The Payment Models Work Group requested input from the Quality and Performance Measures Work Group regarding the selection of benchmarks and the setting of performance targets for the Year 2 ACO Payment Measures used for the Commercial and Medicaid Shared Savings Programs
- After several months of discussion, the Quality and Performance Measures Work Group members voted (during their 12/29/14 meeting) to recommend continued use of the Year 1 approach, with adaptations to accommodate new Payment measures

# Proposed Year 2 Benchmarks & Targets

	Medicaid SSP	Commercial SSP
<b>Approach: Use national HEDIS benchmarks for all measures for which they are available; use improvement targets when national benchmarks are unavailable</b>	<p>Core 2-7, <b>17</b>: National Medicaid HEDIS benchmarks</p> <p>Core 1, 8, <b>12</b>: Improvement targets based on ACO-specific Year 1 Medicaid performance</p>	<p>Core 1-7, <b>17</b>: National commercial HEDIS benchmarks</p> <p>Core <b>12</b>: Improvement targets based on ACO-specific Year 1 commercial performance</p>

National HEDIS Benchmarks		Improvement Targets: Change Relative to Historic Performance	
25 <sup>th</sup> Percentile	1 Point	Statistically significant decline	0 Points
50 <sup>th</sup> Percentile	2 Points	Statistically same	2 Points
75 <sup>th</sup> Percentile	3 Points	Statistically significant improvement	3 Points

# PMWG Discussion & Recommendation

- The Payment Models Work Group solicited public comment regarding modifications to the Gate & Ladder methodology for Year 2 of the Commercial and Medicaid Shared Savings Programs
- After several months of discussion, the Payment Models Work Group members (during their 3/16 meeting) voted—*with the support of the ACOs*—to recommend a number of modifications to the VMSSP Gate & Ladder methodology for Year 2
  - There were no proposals to change the Commercial methodology for Year 2

# Proposed Year 2 Gate & Ladder: Commercial

Percentage of available points	Percentage of earned savings: <b>COMMERCIAL</b>
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

- No change from Year 1

# Proposed Year 2 Gate & Ladder: Medicaid

Points earned (out of 30 possible points)	Percentage of earned savings: <b>MEDICAID</b>
16-17	75%
18	80%
19-20	85%
21	90%
22-23	95%
≥24	100%

- Convert from percentage to absolute points earned
- Increase Gate (to ~55%)
- Allow ACOs to earn additional “Improvement Points”

# For Core Team 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 increase the level of accountability for cost and quality outcomes among provider organizations;
    - To establish payment methodologies across all payers that encourage the best cost and quality outcomes;
    - To ensure accountability for outcomes from both the public and private sectors; and
    - To create commitment to change and synergy between public and private culture, policies and behavior.

# For Core Team Consideration

- Is the recommendation inconsistent with any other policy or funding priority that has been put in place within the VCHIP project?
  - No; modification to the VMSSP methodology was anticipated beyond Year 1.
- Has the recommendation been reviewed by all appropriate work groups?
  - There has been formal input from both QPM and PMWG. After three months of discussion, the PMWG voted unanimously to recommend the proposed changes to the Steering Committee with three abstentions.
  - The Steering Committee voted to recommend the proposed changes to the Core Team with one vote in opposition.

## MEMO

DATE: March 16, 2015

TO: VHCIP Steering Committee

FROM: VHCIP Payment Models Work Group

RE: Proposed Year 2 VMSSP Gate & Ladder Methodology

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Based on feedback received during the public comment period and recommendations from the Quality and Performance Measures Work Group regarding payment measure targets and benchmarks (*see Memo dated December 29, 2014*), as well as recent changes to the Medicare Shared Savings Program, the PMWG members have voted to endorse the following changes to the Gate & Ladder methodology for Year 2 of the Vermont Medicaid Shared Savings Program (VMSSP). These changes:

- 1. Increase the minimum quality performance threshold for shared savings eligibility;**
- 2. Include the use of absolute points earned in place of a percentage of points earned to eliminate the need for rounding; and**
- 3. Allow ACOs to earn “bonus” points for significant quality improvement in addition to points earned for attainment of quality relative to national benchmarks.**

The proposed framework assumes that the VMSSP in Year 2 will use the 10 measures approved for Payment by the VHCIP Core Team and the GMCB, and that ACOs will be eligible to earn a maximum of 3 points per measure for a total of 30 possible points. ACOs would have to earn at least 16 out of 30 points to be eligible for any earned shared savings. If an ACO earns 24 or more points, they would be eligible to receive 100% of earned shared savings.

<b>Points Earned (out of 30 possible points)</b>	<b>Percentage of Points Earned</b>	<b>Percentage of Earned Shared Savings</b>
16-17	53.3-56.7	75
18	60.0	80
19-20	63.3-66.7	85
21	70.0	90
22-23	73.3-76.7	95
≥24	≥80.0	100

In addition to earning points for attainment of quality relative to national benchmarks, ACOs would be eligible to earn one additional point for every measure that is compared to a national benchmark for which they improved significantly relative to the prior program year. “Bonus” improvement points will not be available for measures that already use ACO-specific improvement targets instead of national benchmarks (see table below). As such, an ACO could earn up to 7 “bonus” points for improvement; however, no ACO may earn more than the maximum 30 possible points.

This approach will further strengthen the incentives for quality improvement in the VMSSP by providing ACOs with both external quality attainment targets (in the form of national benchmarks) and internal quality improvement targets (by rewarding change over time).

Year 2 Payment Measure		VMSSP Benchmark Method	Eligible for “Bonus” Improvement Point
<b>Core-1</b>	Plan All-Cause Readmissions	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	
<b>Core-2</b>	Adolescent Well-Care Visits	National Medicaid HEDIS benchmarks	X
<b>Core-3</b>	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	National Medicaid HEDIS benchmarks	X
<b>Core-4</b>	Follow-Up After Hospitalization for Mental Illness: 7-day	National Medicaid HEDIS benchmarks	X
<b>Core -5</b>	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	National Medicaid HEDIS benchmarks	X
<b>Core-6</b>	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	National Medicaid HEDIS benchmarks	X
<b>Core-7</b>	Chlamydia Screening in Women	National Medicaid HEDIS benchmarks	X
<b>Core-8</b>	Developmental Screening in the First Three Years of Life	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	
<b>Core-12</b>	Ambulatory Care Sensitive Condition Admissions: PQI Composite	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	
<b>Core-17</b>	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	National Medicaid HEDIS benchmarks	X

Note: Core-1, Core-8, and Core-12 will be ineligible for additional improvement points because these measures are already using ACO-specific change-over-time improvement targets. If national Medicaid benchmarks become available for any of these measures in future, the measures may then become eligible for additional improvement points.

**Example**

Year 2 Payment Measure		Year 1	Y1 Attainment Points	Year 2	Y2 Attainment Points	Y2 Improvement Points
<b>Core-1</b>	Plan All-Cause Readmissions	15.4	2	15.2	2	
<b>Core-2</b>	Adolescent Well-Care Visits	50.9	2	57.7	2	1
<b>Core-3</b>	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	75.9	0	80.4	1	1
<b>Core-4</b>	Follow-Up After Hospitalization for Mental Illness: 7-day	33.6	1	34.8	1	0
<b>Core -5</b>	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	52.4	3	49.5	3	0
<b>Core-6</b>	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	27.3	2	29.7	2	0
<b>Core-7</b>	Chlamydia Screening in Women	47.0	0	47.6	0	0
<b>Core-8</b>	Developmental Screening in the First Three Years of Life	28.2	2	36.3	3	
<b>Core-12</b>	Ambulatory Care Sensitive Condition Admissions: PQI Composite	18.8		17.2	2	
<b>Core-17</b>	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	43.1		38.9	2	1
<b>Sub-Total</b>			<b>12</b>		<b>18</b>	<b>3</b>
<b>Total Points</b>			<b>12/24</b>		<b>21/30</b>	

Statistically significant improvement in Year 2 relative to Year 1 for three eligible measures results in the ACO being awarded 3 “bonus” improvement points. These points are added to the 18 points the ACO receives for quality performance relative to benchmarks, yielding a total of 21 points out of the total possible 30 points.

In the case of Core-3 (LDL-C Screening), the ACO improves from below the national 25<sup>th</sup> percentile to the national 25<sup>th</sup> percentile, and therefore earns a point for attaining a higher target relative to national benchmarks. This improvement also represents significant improvement relative to the ACO’s performance in the prior year, resulting in an additional improvement point for this measure.

In the case of Core-2 (Adolescent Well-Care Visits), the ACO does not improve enough to meet the national 75<sup>th</sup> percentile, but achieves significant improvement relative to the ACO’s performance in the prior year. Thus, the ACO is still awarded for significant improvement, and continues to have an incentive to improve relative to national benchmarks.

### ***Methodological Considerations***

This methodology would award an ACO up to 1 additional bonus point for quality performance improvement on each Payment measure that is being compared to a National benchmark. These bonus points would be added to the total points that the ACO achieved for each Payment measure based on the ACO's performance relative to National benchmarks. Under this proposal, the total possible points that could be achieved, including up to 7 bonus points, could not exceed the current maximum 30 total points achievable.

For each qualifying measure, the state or its designee would determine whether there was a significant improvement or decline between the performance year and the prior year by applying statistical significance tests<sup>1</sup>, assessing how unlikely it is that the differences of a magnitude as those observed would be due to chance when the performance is actually the same. Using this methodology, we can be certain at a 95 percent confidence level that statistically significant changes in an ACO's quality measure performance for the performance year relative to the prior program year are not simply due to random variation in measured populations between years.

The awarding of bonus points would be based on an ACO's net improvement on qualifying Payment measures and would be calculated by determining the total number of significantly improved measures and subtracting the total number of significantly declined measures. Bonus points would be neither awarded nor subtracted for measures that were significantly the same. The awarding of bonus points would not impact how ACOs are separately scored on Payment measure performance relative to national benchmarks.

Consistent with the current VMSSP methodology, the total points earned for Payment measures, including any bonus quality improvement points, would be summed to determine the final overall quality performance score and savings sharing rate for each ACO.

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<sup>1</sup> VMSSP would use the same methodology for calculating significance (t-test) as MSSP.

## MEMO

DATE: December 29, 2014

TO: VHCIP Payment Models Work Group

FROM: VHCIP Quality & Performance Measures Work Group

RE: Request for Input – Year 2 ACO Payment Measure Targets & Benchmarks

In response to the Payment Models Work Group’s request for input regarding the selection of benchmarks and the setting of performance targets for the Year 2 ACO Payment Measures used for the Commercial and Medicaid Shared Savings Programs, the Quality and Performance Measures Work Group members voted in favor (with 2 votes in opposition) of the following recommendations:

### Year 2 Benchmarks:

- Use national HEDIS benchmarks for all measures for which they are available; use ACO-specific change-over-time improvement targets when national benchmarks are unavailable:

Year 2 Payment Measure		Medicaid SSP	Commercial SSP
Core-1	Plan All-Cause Readmissions	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	National commercial HEDIS benchmarks
Core-2	Adolescent Well-Care Visits	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks
Core -5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite)	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks
Core-7	Chlamydia Screening in Women	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks
Core-8	Developmental Screening in the First Three Years of Life	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	NA
Core-12	Ambulatory Care Sensitive Condition Admissions: PQI Composite	Improvement targets based on ACO-specific Year 1 Medicaid SSP performance	Improvement targets based on ACO-specific Year 1 commercial SSP performance
Core-17	Diabetes Mellitus: HbA1c Poor Control (>9.0%)	National Medicaid HEDIS benchmarks	National commercial HEDIS benchmarks

## Year 2 Performance Targets

- Use the same methodology that was used in Year 1 for assigning points for performance, such that ACOs may earn a maximum of 3 points for each Payment measure:

National HEDIS Benchmarks		Improvement Targets: Change Relative to Historic Performance	
25 <sup>th</sup> Percentile	1 Point	Statistically significant decline	0 Points
50 <sup>th</sup> Percentile	2 Points	Statistically same	2 Points
75 <sup>th</sup> Percentile	3 Points	Statistically significant improvement	3 Points

# GLOBAL COMMITMENT & MEDICAID MANAGED CARE

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General Overview

April 2015

# Global Commitment 1115 Waiver

- The Global Commitment Demonstration provides Vermont with the flexibility to apply managed care concepts in order to increase access to care, improve quality of care and control program costs
- Vermont's Global Commitment to Health Demonstration began October 1, 2005; the initial term ended December 31, 2010, it has been extended through December 31, 2016
- Our Choices for Care long-term care waiver (previously its own 1115 demo) is now part of our Global Commitment Demonstration (eff. 1/30/15)

# Section 1115 Demonstration Waivers

- Federal government can “waive” many, but not all, of the laws governing Medicaid, including eligible people and services
- Section 1115 waiver authority is intended to encourage state innovation in the Medicaid program
- Often, states identify ways to save Medicaid funds and are permitted to use the savings to expand coverage
- The Federal government approves Section 1115 Demonstrations for five-year terms, and existing Demonstrations can be extended (typically three-year renewals)

# Waiver Flexibilities, examples and limits

- Examples of requirements that can be “waived”:
  - Statewideness/Uniformity
  - Amount, Duration, Scope of Services
    - as long as the amount, duration and scope of covered services meets the minimum requirements under Title XIX of the Act
  - Payment to Providers
    - establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved state plan.
  - Freedom of Choice of Provider (restrict to “network”)
- Requirements that are not waived (require Medicaid State Plan approval):
  - New/changed provider types and qualifications
  - New benefits or services
  - Reimbursement for non-GC populations.

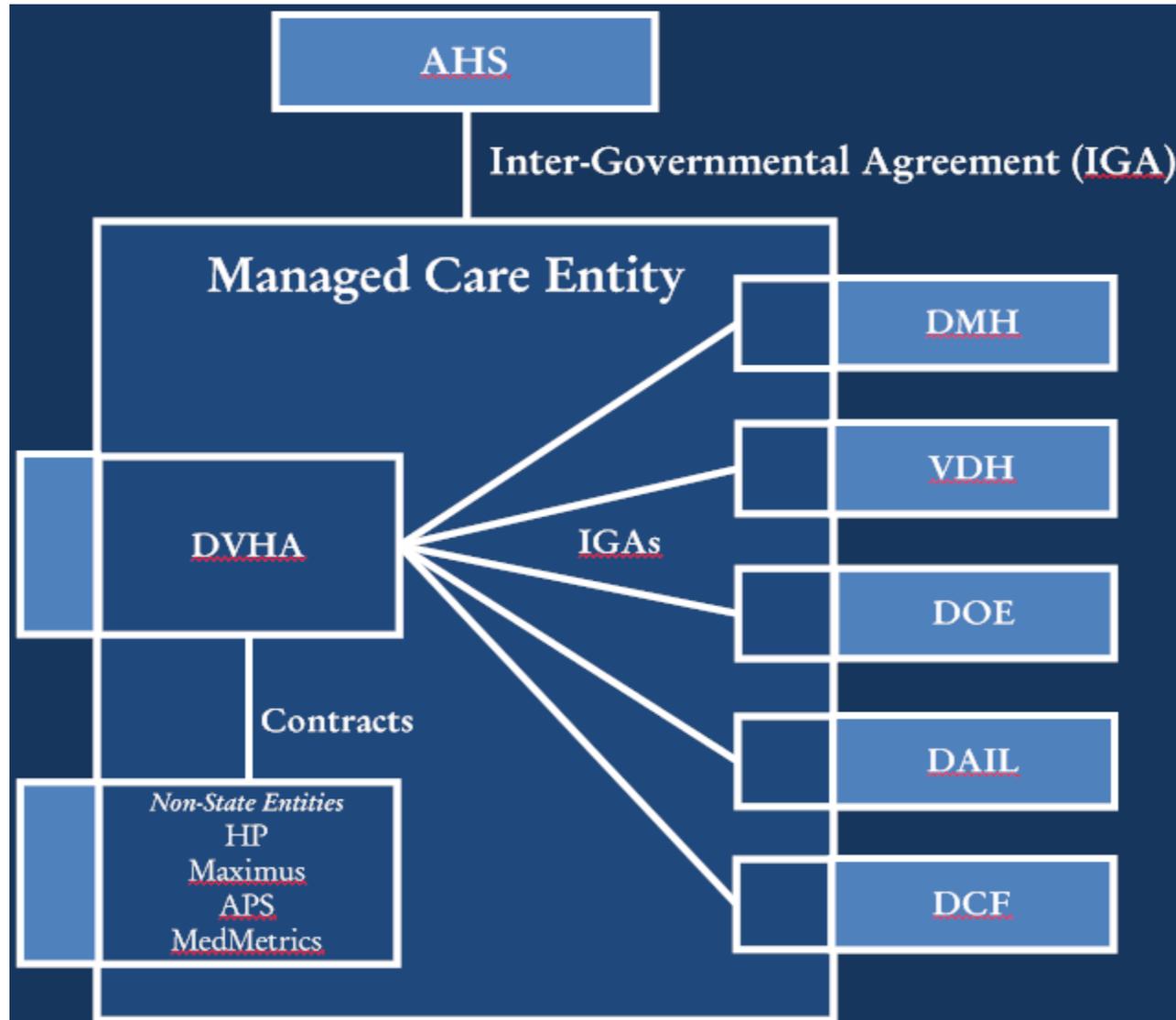
# Global Commitment 1115 Waiver

- The Global Commitment Demonstration covers all Medicaid services in Vermont, including:
  - Acute Care Services
  - Long Term Care Services & Supports
  - Traumatic Brain Injury (TBI)
  - Children's Mental Health
  - Community Rehabilitation and Treatment (CRT)
  - Developmental Disability Services (DS)

# Medicaid Managed Care Regulations

- The State must adhere to Medicaid managed care regulations for all GC funded programs and activities (42 CFR 438 et. seq.)
  - Enrollee Rights & Protections
  - Quality Assessment & Improvement
    - *Comprehensive State Quality Strategy*
  - Program Integrity
- Public Input Process

# Medicaid Managed Care Structure



# Flexibilities of Managed Care Delivery Model

- Greater flexibility in what can be reimbursed (cost effective alternatives & managed care investments).
- A holistic approach to serving individuals and families
- Better communication and collaborative planning when more than one service is being provided to a single consumer or family (Chronic Care, Community Health Teams, Integrated Family Services, etc.)

# Impact of Global Commitment Model: Increased Integration

- Operational aspects of GC promote a more unified approach to managing program development or expansion across AHS Departments
- Accounting and budgeting for GC is done as a whole agency
- Elimination of duplicative business processes, program monitoring and reporting requirements
- More efficient and flexible reimbursement mechanisms (e.g., bundled rates, capitation payments, pay-for-performance and/or outcome based contracts)
- More effective data collection systems to support ongoing assessment of service quality and improvement
- Collective AHS-wide compliance with federal Medicaid managed care rules and other waiver requirements.

# Global Commitment Financing

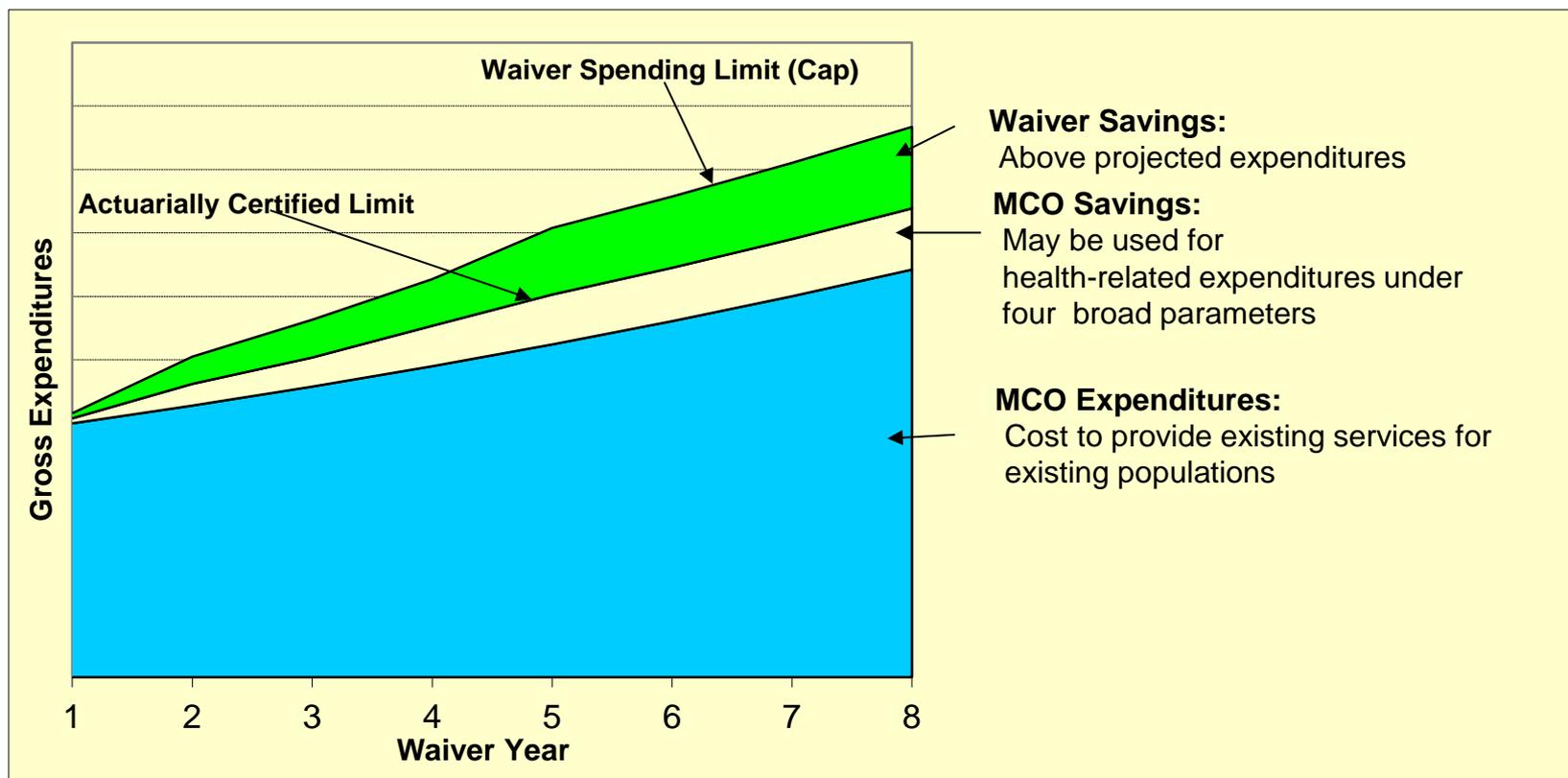
- Section 1115 Demonstrations must be budget neutral (Demonstration expenditures cannot exceed estimated program expenditures under traditional Medicaid rules)
  - Special Terms and Conditions establish aggregate spending limit (\$13.7 Billion over 11.25 years)
- Managed care model design incorporates second spending limit
  - Program spending limited to Per Member, Per Month (PMPM) limits, established in accordance with federal managed care rate setting requirements

# Managed Care Rate Setting

## Calculation of the Per Member, Per Month (PMPM) Limit

- An independent actuary establishes rate ranges across several rate categories, based on a CMS-approved methodology
- AHS establishes a rate within the actuarially-certified rate ranges
- The PMPM limit cannot change once established. The opportunity to adjust for significant fluctuation is October of the following Federal Fiscal Year

# Global Commitment



The Waiver Spending Limit excludes:

- CHIP (uninsured children with incomes between 225 and 300 percent of the Federal Poverty Level)
- Disproportionate Share Hospital (DSH) Payments
- Enhanced FFP for IT Infrastructure, Affordable Care Act initiatives

# Managed Care Rate Setting

Program financing and the role of the PMPM limits were modified per GAO concerns:

	Original Waiver (Oct. 1, 2005 – Dec. 31, 2010)	Renewal (Jan. 1, 2011 – Dec. 31, 2016)
<b>Role of PMPM</b>	Payment Rate	Payment Limit
<b>Federal Medicaid Funding</b>	PMPM rate represented matching event; capitation payment paid into Global Commitment Fund	Actual program expenditures represent matching event (medical, administrative, managed care investments)

- Establishing a prospective per member per month payment under our old terms put the State at risk for caseload and utilization fluctuations. The new terms and conditions significantly reduce the state's risk for caseload increase and utilization spikes

# Managed Care Investments

Expenditures within the per member per month limit (calculated over the life of the Demonstration) can include expenditures for the following purposes:

- Reduce the rate of uninsured and or underinsured in Vermont;
- Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
- Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system

# 1/30/2015 Waiver Consolidation

- Added Choices for Care; all Medicaid enrollees will be covered under GC terms
- Restores Medicaid member months lost with ACA – former VHAP/Catamount enrollees transitioned to VHC
- Retains stringent member protections for long-term care recipients
- Difficult negotiations with CMS; tenor of the conversation was markedly different than in prior years
  - Expect a challenging process for 1/1/2017

# Questions/Discussion

- Waiver governing documents located here:  
<http://dvha.vermont.gov/administration/global-commitment-to-health-1115-waiver-2015-documents>

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# Year One Financial Report

Georgia Maheras, Project Director

April 6, 2015

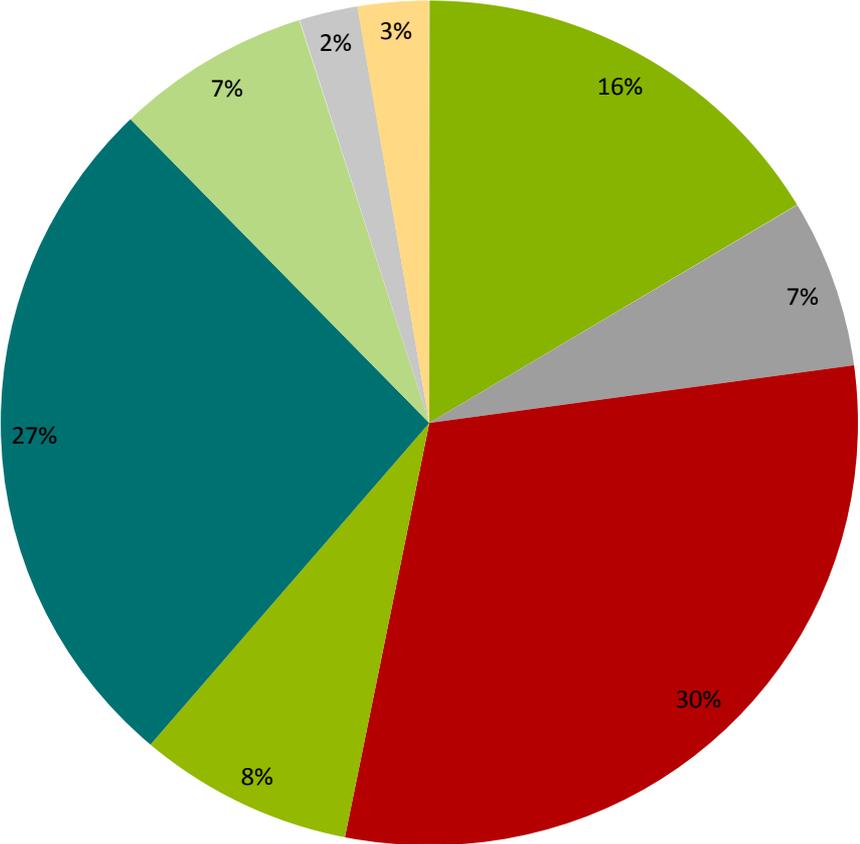
# Year One Budget to Actuals

October 1, 2013 - December 31, 2014

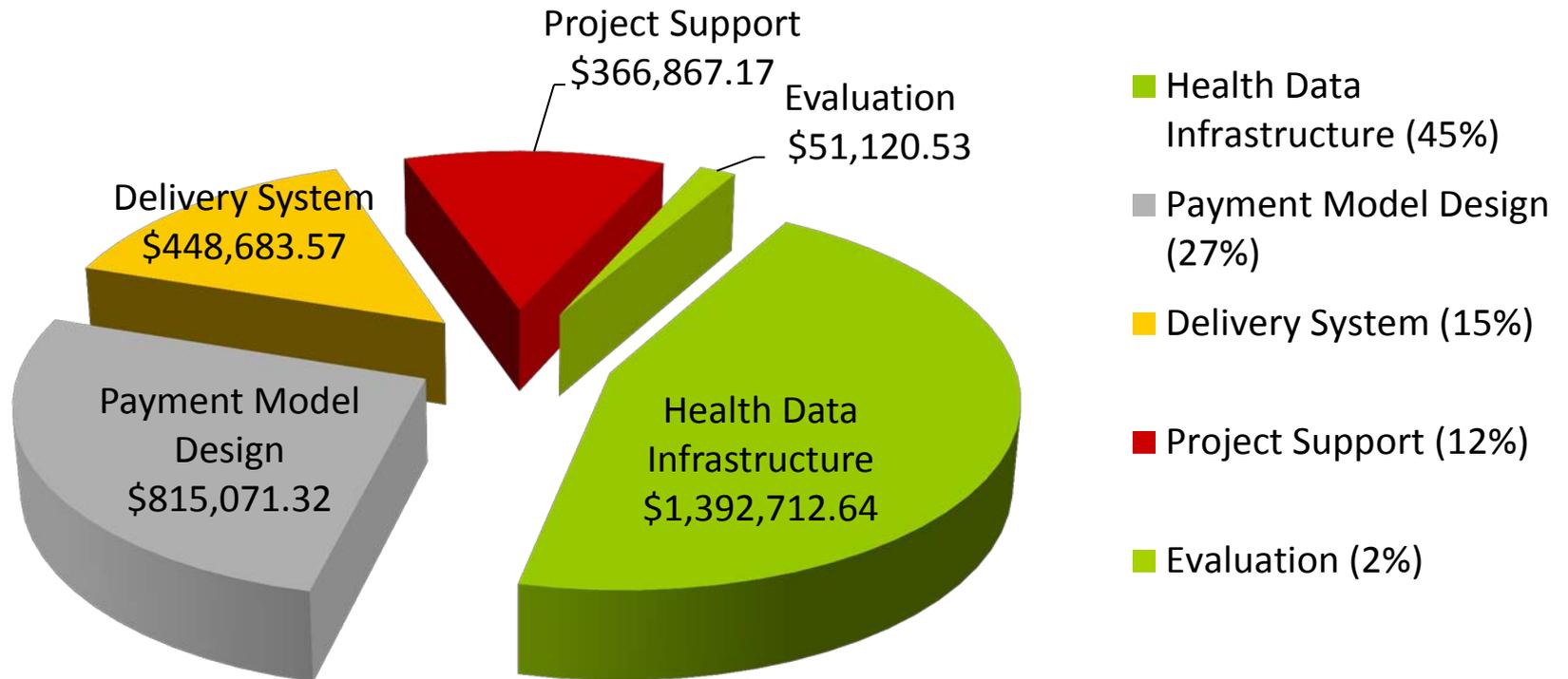
BUDGET CATEGORY	BUDGET	ACTUALS and Unpaid Contract Invoices to 12/31/14	CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)	REMAINING UNOBLIGATED BALANCE
Personnel/Benefits	\$ 2,640,859.56	\$ 1,433,831.56	\$ -	\$ 1,207,028.00
Operating (includes Indirect)	\$ 1,039,676.04	\$ 508,309.05	\$ -	\$ 531,366.99
Contractual:				
Health Data Infrastructure	\$ 4,891,427.00	\$ 1,392,712.64	\$ 2,765,546.28	
Payment Model Design	\$ 1,303,490.94	\$ 815,071.32	\$ 488,383.37	
Delivery System	\$ 4,272,376.39	\$ 448,683.57	\$ 3,823,692.82	
Project Support	\$ 1,186,993.66	\$ 366,867.17	\$ 820,126.49	
Evaluation	\$ 354,967.20	\$ 51,120.53	\$ 303,846.67	
TBA	\$ 434,513.72			
Contractual Total	\$ 12,443,768.91	\$ 3,074,455.23	\$ 8,201,595.63	\$ 1,167,718.05
<b>TOTAL YEAR 1 BUDGET</b>	<b>\$ 16,124,304.51</b>	<b>\$ 5,016,595.84</b>	<b>\$ 8,201,595.63</b>	<b>\$ 2,906,113.04</b>

# Year One Actuals

- Personnel/Benefits
- Health Data Infrastructure
- Project Support
- Operating (includes Indirect)
- Payment Model Design
- Evaluation
- Contractual:
- Delivery System
- TBA



# Year One Contract Detail



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# Financial Request: March 2015

Georgia Maheras, Project Director

April 6, 2015

# Request for reallocation

- Carryforward has \$11,107,708.67 in unobligated funds. Majority are used to fund existing contracts whose work began in 2014, but continues in 2015.

*Request:* Use \$500,000 of unobligated funds to increase investment in the Learning Collaboratives. This will allow for an expansion of existing program and provide funds to support core competency training related to Vermonters with disabilities. New total for this program is: \$1,050,000. Add \$150,000 to CMCM Work Group and \$350,000 to DLTSS Work Group.

# Request to decrease contracts:

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- Arrowhead Health Analytics:
  - Approved amount: \$70,000
  - New amount: \$42,452.17
  - Rationale: Contract terminated.

# Request to decrease contracts:

- H.I.S. Professionals:
  - Approved Amount: \$650,000
  - New Amount: \$550,370
  - Rationale: This contract provides for three types of activity to support the ACTT projects: Program Management, Project Management, and Subject Matter Expertise. As the ACTT suite of projects has progressed, it is evident that the Program Management component is not needed. This amendment removes funds that can be better deployed to support VHCIP goals.

# Request to decrease contracts:

- Wakely Actuarial Consulting:
  - Approved Amount: \$200,000
  - New Amount: \$70,000
  - Rationale: The Core Team approved additional scope for actuarial support of the all-payer waiver last fall. This scope will be performed by a different contractor and keeping the scope and funds in this agreement is redundant.

# Request to increase contracts:

- All-Payer Model Contract:
  - Approved Amount: \$440,003 (\$600,000)
  - New Amount: \$700,000
  - Rationale: This contract went out to bid requesting the contractor perform some services, but included optional actuarial services. The selection process resulted in a change in selection of actuarial support from a previously approved vendor. Additionally, the contract negotiation resulted in the need for some additional funds to support potential ad hoc activities.

# Request to increase contracts:

- Prevention Institute:
  - Approved Amount: \$70,000
  - New Amount: \$106,285
  - Rationale: This RFP resulted in bids higher than anticipated. The Population Health Work Group leadership had contractual savings from another agreement in 2014 and will use those funds to support this agreement.

# Request to increase contracts:

- JBS International:
  - Approved Amount: \$120,000
  - New Amount: \$140,002
  - Rationale: This RFP resulted in bids higher than anticipated. This contract requests them to do significant stakeholder work, which is more time-consuming than our estimates. Additionally, we added scope that relates to in-depth analysis of other state's activities to support recommendations in designing telehealth strategies for Vermont.

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	
<b>Type 1a</b>	Type 1A											
<i>Proposed type 1 without base work group or agency/dept support</i>	<i>Proposed Type 1 without base work group or agency/dept support (subject to Core Team approval)</i>											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	Request pending at 4.6.15 CT meeting
	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					-		\$ -			

VHCIP Funding Allocation Plan

		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	
		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	
		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	



VHCIP Funding Allocation Plan

		Bailit		\$ 80,000	\$ 160,000.00	\$ 160,000.00	-	\$ 400,000		DVHA	Model Testing: Quality Measures	
	<b>HIT/HIE WG</b>	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	
	<b>Population Health WG</b>	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	Request pending at 4.6.15 CT meeting
								\$ -				
	<b>Workforce</b>	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	
								\$ -				
	<b>Care Models</b>	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	
								\$ -				
	<b>DLTSS</b>	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	
	<b>Sub Total</b>								\$ 2,895,957.00			

VHCIP Funding Allocation Plan

Type 1c	Type 1 C		Impl. Period	Year 1	Year 2	Year 3	Year 4	Grant Total				
<i>Proposed type 1 related to base agency/dept support</i>	Proposed Type 1 related to base agency/dept support											
	<b>GMCB</b>	Total for this category							<b>\$ 2,575,000.00</b>	<b>GMCB</b>	<b>Advanced Analytics</b>	
		Remainder Available			\$ 250,000.00	\$ 125,000.00	-	\$ 375,000	\$ 375,000.00	<b>GMCB</b>	<b>Advanced Analytics</b>	
		Lewin		\$ 289,474	\$ 694,737.00	\$ 694,736.00	521,053.00	\$ 2,200,000		<b>GMCB</b>	<b>Advanced Analytics</b>	
	<b>DVHA</b>	Total for this category							<b>\$ 1,425,000.00</b>	<b>DVHA</b>	<b>Advanced Analytics</b>	
		Remainder Available		\$ -	\$ 612,500.00	\$ 612,500.00	-	\$ 1,225,000	\$ 1,225,000.00	<b>DVHA</b>	<b>Advanced Analytics</b>	
		PHPG-VBP		\$ 28,910	\$ 71,090.00	\$ -	-	\$ 100,000		<b>DVHA</b>	<b>Advanced Analytics</b>	<b>FYI: Contract amendment</b>
		DLB		35,000	20,000			55,000		<b>DVHA</b>	<b>Advanced Analytics</b>	
		Burns & Associates		\$ -	\$ 45,000.00	\$ -	-	\$ 45,000		<b>DVHA</b>	<b>Advanced Analytics</b>	
		RFP pending									<b>Advanced Analytics</b>	
	<b>Sub-Total</b>								<b>\$ 4,000,000.00</b>			

VHCIP Funding Allocation Plan

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)										
	<b>HIT/HIE</b>	Total for this category									
		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	
		<i>Subtotal: ACO Gateway Population Health Proposal</i>	\$ 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.	

VHCIP Funding Allocation Plan

		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	
		<i>Subtotal: ACTT Proposal</i>						\$ 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	Request pending at 4.6.15 CT meeting
		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	

VHCIP Funding Allocation Plan

		Remainder Available: Integrated platform and reporting system			\$ 500,000.00	\$ 500,000.00	-	\$ 1,000,000.00			T&I: Integrated Platform and Reporting System	
		Remainder Available: Expanded connectivity between SOV data sources and ACOs/providers			\$ 98,159.00	\$ 98,159.00	-	\$ 196,318			T&I: Expanded Connectivity btw SOV and ACOs/Providers	
		Remainder Available: Enhancements or development of clinical registry and other centralized reporting systems.			\$ 151,016.00	\$ 151,016.00	-	\$ 302,031			T&I: Enhancements or development of clinical registry and other centralized reporting systems.	
								\$ -				
	<b>Workforce</b>	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	
	<b>CMCM</b>	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	
		Remainder Available: Learning Collaboratives			\$ 335,000.00	\$ 165,000.00		\$ 500,000		DVHA	TA: Learning Collaboratives	Request pending at 4.6.15 CT meeting
		Abernathey		\$ 6,230	\$ 93,770.00			\$ 100,000		DVHA	TA: Learning Collaboratives	
		VPQHC			\$ 92,500.00	\$ 7,500.00		\$ 100,000			TA: Learning Collaboratives	
		Remainder Available: Integration of MH/SA		\$ -	\$ 75,000.00	\$ 75,000.00		\$ 150,000		DVHA	Model Testing: integration of MH/SA	

VHCIP Funding Allocation Plan

	<b>DLTSS</b>	Total for this category							<b>\$ 350,000.00</b>			
		Remainder Available: Learning Collaboratives			\$ 250,000.00	\$ 100,000.00		\$ 350,000		DVHA	TA: Learning Collaboratives	Request pending at 4.6.15 CT meeting
	<b>QPM</b>	Total for this category							<b>\$ 230,918.00</b>	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	
	<b>Sub-Total</b>							<b>\$ 13,995,144</b>				

VHCIP Funding Allocation Plan

<b>Type 1a</b>	\$	24,118,003										
<b>Type 1b</b>	\$	2,895,957										
<b>Type 1c</b>	\$	4,000,000										
<b>Type 2</b>	\$	13,995,144										
<b>Unallocated</b>	\$	-										
<b>Grant Total</b>	\$	45,009,104										