

# *VT Health Care Innovation Project Population Health Work Group Meeting Agenda*

Date: Tuesday, January 14, 2014 Time: 2:30-4:00 pm

Location ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier

Call-In Number: 1-877-273-4202; Passcode: 9883496

**All Participants: Please ensure that you sign in on the attendance sheet the will be circularized at the beginning of the meeting, Thank you.**

<b>AGENDA</b>					
Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action #
1	2:30	Welcome and introductions	Tracy Dolan Karen Hein		
2	2:35	Business: <ul style="list-style-type: none"> <li>• approval of minutes</li> <li>• work group members vs. interested parties</li> <li>• conflict of interest policy</li> </ul>	Tracy Dolan Karen Hein	Attachment 2a – Minutes Attachment 2b – COI Policy	
3	2:40	Agenda Review and Meeting Goals <ul style="list-style-type: none"> <li>• Create a shared understanding of current measures environment (ACOs) and how they will drive or won't drive health behavior</li> <li>• Share federal requirements</li> <li>• Discuss opportunity to identify additional measures for years 2 and 3 for ACO</li> <li>• Discuss options for additional measures that would complement and not be required by ACOs but could be collected and inform</li> </ul>	Tracy Dolan Karen Hein	Attachment 1 - Agenda Attachment 3 - PowerPoint	
4	2:45	CMS/CDC Population Health Measures + on going VDH measures	Tracy Dolan Heidi Klein	Attachment 4 - Federal measures	
5	2:50	ACO Measures Presentation <ul style="list-style-type: none"> <li>• Share the measure</li> <li>• Explain intended Uses</li> <li>• Review prior development process</li> <li>• Identify process for introducing new measures</li> </ul>	Pat Jones 20 min presentation 10 min Q&A	Attachment 5 - ACO Measures	

6	3:20	<p>Discussion – Options for Using Population Health /Multiple-Determinants Data</p> <p><i>What strikes you about this list of measures given our conversation last time about non-clinical contributors to population health outcomes?</i></p> <p><i>What are some of the ways that population health measures could be used in the context of the 3 aims of this VHCIP project? Measures for what purpose(s)?</i></p> <p><i>Which other work groups would be important connections? How can we bring this discussion to the other work groups?</i></p>	Heidi Klein (this includes the time for public comment)	Flip chart notes from last meeting (contributors to health)	
7	3:50	<p>Next Steps</p> <p>Wrap Up: <i>What information do work group members need in order to continue our discussion of population health measures?</i></p> <p>Next Steps:</p> <p>Special note: Check out funding opportunities for Provider Grant</p>	Tracy Dolan Karen Hein	Attachment 7 – VHCIP Grant Program Application	

**OPEN ACTION ITEM LOG**

<b>Date Added</b>	<b>Action Number</b>	<b>Assigned to:</b>	<b>Action /Status</b>	<b>Due Date</b>	<b>Date Closed</b>
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## ***VT Health Care Innovation Project Population Health WG Meeting Minutes***

**December 10, 2013 2:30-4:00 p.m.**

**DFR, 3<sup>rd</sup> Floor Conference Room, 89 Main St., Montpelier, VT**

**Attendees:** Ena Backus, Bob Bick, Jill Berry, Mark Burke, Judy Cohen, Janet Corrigan, Trey Dobson, Tracy Dolan, Karen Hein, Jim Hester, Frances Keeler, Heidi Klein, Nicole Lukas, Mark Levine, Kim McClellan, Melissa Miles, Chuck Myers, Nick Nichols, Betty Rambur, Loral Ruggles, Jenney Samuelson, Deborah Shannon, Stephanie Winters, Mary Woodruff, Georgia Maheras, George Sales

<b>Agenda Item</b>	<b>Topic</b>	<b>Presenter</b>
<b>1 – Welcome, Introductions, Approval of Minutes</b>	<p>The meeting started at 2:45 with welcome remarks from the chair, and a brief introduction of those who were new to the group.</p> <p>The first action was to approve the minutes from the previous meeting held in November 13, 2013. Motion to approve was called for by Mark Burke, and was seconded by Stephanie Winters. All of the members approved it, with no dissensions or abstentions.</p>	<b>Karen Hein</b>
<b>2 – Agenda Review 3 – Population Health Measures – Health through Lens of Contributors to Health</b>	<p>Karen Hein reviewed the agenda, and reminded of the group of the triple aim of the Federal requirements: Improve care, Improve overall health of the population, and seek ways to reduce health care costs. The focus of this meeting was to begin addressing the first work area for the population health work group: developing recommendations for measures to incentivize and track improved population health outcomes. The intention is to build upon the current, largely clinical, measures for ACOs for year 1 of the project. In order to begin, Tracy Dolan provided information about current population health measures collected in VT. She distributed the Vermont State Health Improvement Plan which is based on ‘Leading Health Indicators’ and the ‘Healthy Vermonters 2020 Indicator’ data.</p>	<b>Karen Hein Tracy Dolan</b>
<b>4 – Contributors Analysis 5 – Discussion Linking Clinical and</b>	<p>Heidi Klein reviewed the Institute of Medicine’s ‘Health Outcome Logic Model’, which outlines how ‘Resources and Capacity’ impacts ‘Interventions’, which results in ‘Healthy Conditions’, and eventually ‘Healthy Outcomes’. This model recognizes that factors outside the clinical setting are important contributors to health outcomes. Measures in these other domains therefore may be</p>	<b>Heidi Klein Karen Hein</b>

<p><b>Population Health – What would it mean to the project?</b></p>	<p>useful to the VHCIP. Using this model, she engaged the working group in a brief activity to consider the contributors to the clinical measures being tracked by the ACOs. The group identified a range of personal (knowledge, attitudes, beliefs), behavioral (e.g. diet, exercise, medication compliance), social and economic (poverty) and environmental (access to healthy foods) factors that would contribute to and/or impact ones control for diabetes. Some of the exchanges and reflections from the group exercise:</p> <ul style="list-style-type: none"> <li>• Question if we will be addressing all ACO measures? There are 7-8 that currently speak to population health; expect to start there but not all may be a good fit.</li> <li>• Jim Hester states that the charge of GMCB is to improve health of population, and that it may reward through payment model that lead to improved health. Question was raised for this payment model: what are the measures?</li> <li>• Janet Corrigan -- measurement could be active part of change process → patient tracking a way of engagement and facilitating behavior change; consider on-line tools for young people to measure and track their own status. Karen added that the group should consider obstacles and unintended consequences of measures</li> <li>• Other comments on the exercise were very positive. Stephanie Winters stated that the determinants exercise helped. She posited how physicians would be scared, as many of the factors are social determinants</li> <li>• Issue was raised by Heidi Klein that we will need to recommend who measures it and who is accountable, and Jenney Samuelson also asked what the top 7-9 measures are.</li> <li>• Laural Ruggles stated how this exercise proved how little is affected/controlled by physicians, but Tracy Dolan added these are not measures for physicians necessarily, and that no final determination has been set as this information will be used and by whom. Jenney Samuelson cautioned not to be too broad so that physicians cannot impact – consider instead ACO to ACC to drive new partnership</li> <li>• Mark Burke commented on the shifting population in Medicaid presents a problem for ACO attribution and geographic population-based approaches which occur at the individual level; partnerships essential and happening at community levels, but need to be highlighted and supported. Jim Hester questions to measure, and what the denominator is, and adds that the system level could be accountable beyond the patient panel to consider entire community. Georgia Maheras adds that Community Health Needs Assessments (CHNA) provide some baseline to address some of the questions above, and Karen Hein suggested that in the next meeting, the group will share information on CHNA, and tie to budget. Laural adds that this effort is already</li> </ul>	
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	<p>being done at her hospital.</p> <p>Tracy – Dr. Chen’s screening and referring cessation for tobacco great for individuals already smoking vs. looking at all smokers → changes scale and opportunities for intervention</p> <p>NFI – physical safety and complex trauma important to address → can we focus here? ACE indicators?</p>	
<b>6 – Public Comments</b>	There were no public comments or question, and Karen Hein invited the group to interact and network with each other for the remainder of the meeting.	<b>Public/Open</b>
<b>7 – Next Meeting</b>	<ul style="list-style-type: none"> <li>• Pat Jones to come for a deeper dive on ACO measures and opportunities for adding population health</li> <li>• Interest in academic articles? Yes</li> <li>• January 14<sup>th</sup> 2:30-4:00 National Life, Calvin Coolidge Room; parking</li> <li>• Continue to send materials in one single PDF</li> </ul>	

## CONFLICT OF INTEREST POLICY

For

### VERMONT HEALTH CARE INNOVATION PROJECT (VHCIP) CORE TEAM, STEERING COMMITTEE AND WORK GROUPS

#### I. PURPOSE

The purpose of this Conflict of Interest Policy is to ensure the independence and impartiality of the VHCIP Governance Structure, including the Core Team, Steering Committee and Work Groups (“the Committee”) when it is contemplating entering into a transaction or arrangement that might benefit the private interest of any Core Team, Steering Committee or work group member. Nothing in this policy shall relieve any person from compliance with additional conflict of interest policies such as the Executive Code of Ethics, state personnel policies, and Agency of Administration bulletins, including but not limited to Bulletin 3.5, Contracting Procedures.

#### II. DEFINITIONS

1. Interested person: Any member or subcommittee member or other individual in a position to exercise influence over the affairs of the Committee who has a direct or indirect interest, as defined below, is an “interested person.”
2. Interest: A person has an “interest” if the person has, directly or indirectly, through business, investment, or family:
  - a. An ownership or investment interest in any entity with which the Committee has a transaction or arrangement or is negotiating a transaction or arrangement, or
  - b. A compensation or other pecuniary arrangement with the Committee or with any entity or individual with which the Committee has a transaction or arrangement or is negotiating a transaction or arrangement, or
  - c. A potential ownership or investment interest in, or compensation or pecuniary arrangement with any entity or individual with which the Committee is negotiating a transaction or arrangement, or
  - d. Any other relationship that the person determines may compromise his or her ability to render impartial service or advice to the Committee.

Compensation includes direct and indirect remuneration as well as gifts or favors that are substantial in nature.

An interest is not necessarily a conflict of interest and a conflict of interest does not arise where an individual’s interest is no greater than that of other persons generally affected by the outcome of the matter.

### III. PROCEDURES

1. Duty to Disclose: Any interested person must disclose the existence of his or her interest to the Committee and shall be given the opportunity to disclose all material facts to the Committee.
2. Duty to Voice Concerns: In the event any member becomes concerned that an interested person has an undisclosed interest or is exerting inappropriate influence related to an interest, this concern shall be raised with the Chair of the Core Team and the VHCIP Project Director.
3. Determining Whether a Conflict of Interest Exists: After disclosure of the interest and all material facts, and after any necessary discussion with the interested person, the Core Team shall determine whether the person has a conflict of interest that requires the interested person to remove him or herself from the matter under consideration. In no event shall an interested person participate in the deliberation and/or determination of any matter in which he or she will receive any compensation from the Committee for employment, professional contract, or otherwise.
4. Restriction on Participation: It shall be the responsibility of the Project Director to instruct an interested person on any restriction on his or her participation in any consideration of the subject matter of the conflict of interest, and it shall be the responsibility of the Project Director and all non-interested members of the Committee to enforce such restrictions.
5. Procedures for Addressing the Conflict of Interest:
  - a. An interested person shall leave any Committee meeting during discussion of, and the vote on, any transaction or arrangement that involves a conflict of interest and shall otherwise not participate in the matter in any way.
  - b. If necessary, the Chair of the Core Team shall appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.
  - c. After exercising due diligence, including consideration of independent comparability data, valuations, estimates, or appraisals, the Committee shall determine whether the Committee can obtain a more advantageous transaction or arrangement with reasonable effort from a person or entity that would not give rise to a conflict of interest.
  - d. If a more advantageous transaction or arrangement is not reasonably attainable under circumstances that would not give rise to a conflict of interest, the Core Team shall determine by majority vote (or quorum) of all of the disinterested members (regardless of the number present at the meeting): (1) whether the transaction or arrangement is in the public's best interest, (2) whether the transaction or arrangement is fair and reasonable to the Committee, and (3) whether to enter into the transaction or arrangement consistent with such determinations.

6. Records of Proceedings: The minutes of the Committee or affected sub-committee shall contain:
  - a. The names of the persons who disclosed or otherwise were found to have an interest in connection with an actual or possible conflict of interest.
  - b. The names of the persons who were present for the discussion and votes relating to the transaction or arrangement, the content of the discussion, including a summary of any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection with the discussion.
7. Violations of the Conflict of Interest Policy:
  - a. If the Committee has reasonable cause to believe that an interested person has failed to disclose actual or possible conflicts of interest, it, through the Co-Chairs, shall inform the Core Team and the Core Team shall afford him or her an opportunity to explain the alleged failure to disclose.
  - b. If, after hearing the response of the person and making such further investigation as may be warranted under the circumstances, the Core Team determines that he or she has in fact failed to disclose an actual or possible conflict of interest, it shall take appropriate action.

#### **IV. ANNUAL STATEMENTS**

- a. Each Committee member shall annually sign a statement which affirms that he or she has received a copy of this Conflict of Interest Policy, has read and understands the Policy, and has agreed to comply with the Policy (Attachment A).

#### **V. COMPLIANCE AND PERIODIC REVIEWS:**

The Core Team shall make periodic reviews of compliance with this policy.

Adopted by the VHCIP Core Team

Date: 12.9.13

**Attachment A:**  
**CONFLICT OF INTEREST POLICY ACKNOWLEDGEMENT**

I, \_\_\_\_\_, a participant in the Vermont Health Care Innovation Project (VHCIP) Grant governance process, acknowledge having received, read, and understood the VHCIP Grant Conflict of Interest Policy dated \_\_\_\_\_, and agree to adhere to it.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Name: (print) \_\_\_\_\_

# Vermont Health Care Innovation Project

## Population Health Working Group

Tracy Dolan and Karen Hein, Co-chairs

January 14, 2014

# Population Health Measures

- ▶ Population Health Work Group Charge:
  - Develop recommendations for population health measures.
- ▶ Key Questions for this work group:
  - What is being collected?
  - What is needed for SIM?
  - How will these connect to payment models? ACOs one example

# Agenda

1. Welcome and introductions
2. Business: approve minutes; work group members and interested parties; conflict of interest
3. Agenda Review
4. CMS/CDC Population Health Measures
5. ACO Measures Presentation
6. Discussion – Options for Using Population Health /Multiple–Determinants Data
7. Next Steps

# CMS/CDC Population Health Measures

## ▶ Definition of population health:

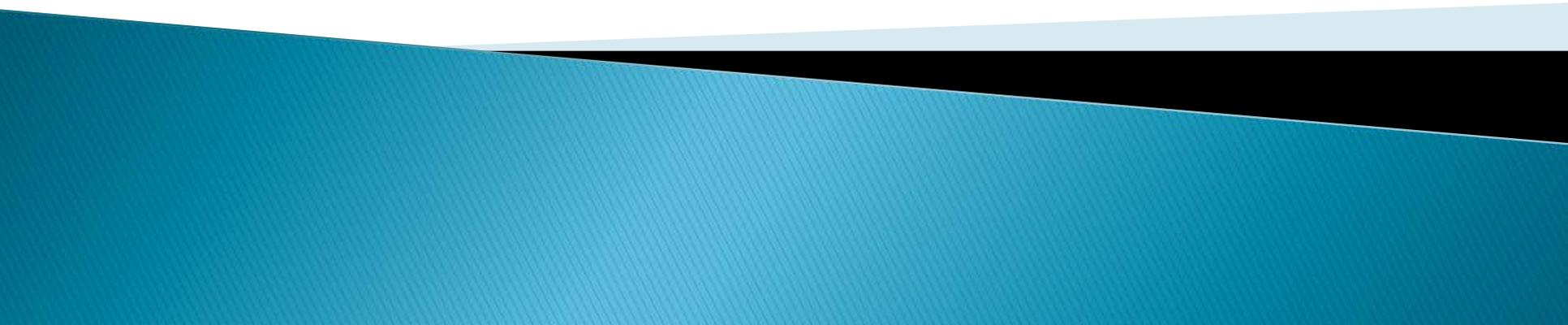
The factors that influence the health outcomes of groups of individuals, including the distribution and equity of such outcomes across various segments of society

(adopted from Kindig et al *Am J Public Health*. 2003;93:380–383).

## ▶ Selected based on the following three criteria:

- High population burden, societal costs
- Amenable to interventions with potential improvement in health, quality of care and decreased costs within the next three to five years
- Data for the measure are available for major segments of the population at the state and/or substate level.

**Vermont's Accountable Care Organizations  
and  
Shared Savings Programs:  
Year 1 Performance Measures**



# Presentation Overview

- ▶ ACOs and Shared Savings Programs
  - Definitions
  - Vermont Landscape
- ▶ Measures Work Group
  - Members
  - Objectives
  - Process
- ▶ Year 1 Measures
  - Payment
  - Reporting
  - Monitoring and Evaluation
- ▶ Impact of Measures on Payment

# Accountable Care Organizations

- Accountable Care Organizations (ACOs) are composed of and led by health care providers who have agreed to be accountable for the cost and quality of care for a defined population
- These providers work together to coordinate care for their patients and establish mechanisms for shared governance
- Provider participation in an ACO is voluntary; ACO participation in a Shared Savings Program is also voluntary

# Shared Savings Programs

Shared Savings Programs are payment reform initiatives developed by health care payers. Shared Savings Programs are offered to health care providers who agree to participate with the payers to:

- Promote accountability for the care of a defined population
- Coordinate care
- Encourage investment in infrastructure and care processes
- Share a percentage of savings realized as a result of their efforts

# Medicare Shared Savings Program Participation

Currently, two Vermont ACOs participate in a Medicare Shared Savings Program:

- Accountable Care Coalition of the Green Mountains (ACCGM), July 1, 2012
- OneCare Vermont, January 1, 2013

A third ACO has just received Medicare approval:

- Community Health Accountable Care (CHAC), 2014

# Vermont SSP Participation

- Potential pool is all Vermont Health Connect enrollees and Medicaid beneficiaries
- Participating payers include BCBSVT, MVP Health Care and Medicaid
- Potential ACOs include OneCare, ACCGM and CHAC
- Operations beginning in 2014

# Measure Selection Process

# ACO Measures Work Group Members

- Accountable Care Coalition of the Green Mountains
- Agency of Administration
- Agency of Human Services
- Bi-State Primary Care Association
- Blue Cross and Blue Shield of Vermont
- Blueprint for Health
- Department of Financial Regulation
- Department of Mental Health
- Department of Vermont Health Access
- Fletcher Allen Health Care
- Green Mountain Care Board
- MVP Health Care
- OneCare
- Vermont Assembly of Home Health Agencies
- Vermont Association of Hospitals and Health Systems
- Vermont Information Technology Leaders
- Vermont Legal Aid
- Vermont Medical Society
- Vermont Program for Quality in Health Care

# Work Group Objectives

To identify standardized measures that will be used to:

- Evaluate the performance of Vermont's Accountable Care Organizations (ACOs) relative to state objectives for ACOs,
- Qualify and modify shared savings payments, and
- Guide improvements in health care delivery.

# Criteria for Selecting Measures

- Representative of array of services provided and beneficiaries served by ACOs;
- Valid and reliable;
- NQF-endorsed measures with relevant benchmarks whenever possible;
- Aligned with national and state measure sets and federal and state initiatives whenever possible;
- Focused on outcomes to the extent possible;
- Uninfluenced by differences in patient case mix or appropriately adjusted for such differences;
- Not prone to effects of random variation (measure type and denominator size);
- Not administratively burdensome;
- Limited in number and including only measures necessary to achieve state's goals (e.g., opportunity for improvement);
- Population-based; and
- Consistent with state's objectives and goals for improved health systems performance.

# Work Group Process

- Over the course of nine months (January 2013-October 2013), the ACO Measures Work Group met about every two weeks.
- Two sub-groups also held several meetings:
  - Patient Experience of Care Survey Sub-group
  - End-of-Life Care Measures Sub-group
- Measures approved in December 2013

# Year 1 ACO Shared Savings Measures

# Two Measure Sets

## Core Measure Set

- The Core Measure Set consists of measures for which the ACO has current or pending responsibility for collection, for either reporting or payment purposes.

## Monitoring and Evaluation (M&E) Measure Set

- The Monitoring & Evaluation Measure Set consists of measures that will be used for programmatic monitoring, evaluation, and planning. Collection of these measures will not influence the distribution of shared savings.

# Measure Use Terminology: Core Measure Set

## Payment

- Performance on these measures will be considered when calculating shared savings.

## Reporting

- ACOs will be required to report on these measures. Performance on these measures will not be considered when calculating shared savings; ACO submission of the clinical data-based reporting measures will be considered when calculating shared savings.

## Pending

- Measures that are included in the core measure set but are not presently required to be reported. Pending measures are considered of importance to the ACO model, but are not required for initial reporting for one of the following reasons: target population not presently included, lack of availability of clinical or other required data, lack of sufficient baseline data, lack of clear or widely accepted specifications, or overly burdensome to collect.

# Year 1 Payment Measures (Claims data)

## Commercial and Medicaid Shared Savings Programs:

- ▶ All-Cause Readmission
- ▶ Adolescent Well-Care Visits
- ▶ Follow-Up After Hospitalization for Mental Illness (7-day)
- ▶ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- ▶ Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- ▶ Chlamydia Screening in Women
- ▶ Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)\*

## Medicaid Shared Savings Program:

- ▶ Developmental Screening in First 3 Years of Life

\*Related to Medicare Shared Savings Program Measure

# Year 1 Reporting Measures (Claims data)

## Commercial and Medicaid Shared Savings Programs:

- ▶ Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults\*
- ▶ Breast Cancer Screening\*
- ▶ Rate of Hospitalization for Ambulatory Care–Sensitive Conditions: PQI Composite
- ▶ Appropriate Testing for Children with Pharyngitis

\*Medicare Shared Savings Program Measure

Blue font signifies CMS Population Health Measure

# Year 1 Reporting Measures (Clinical Data)

## Commercial and Medicaid Shared Savings Programs:

- ▶ Adult BMI Screening and Follow-Up\*
- ▶ Screening for Clinical Depression and Follow-Up Plan\*
- ▶ Colorectal Cancer Screening\*
- ▶ Diabetes Composite
  - HbA1c control\*
  - LDL control\*
  - High blood pressure control\*
  - Tobacco non-use\*
  - Daily aspirin or anti-platelet medication\*
- ▶ Diabetes HbA1c Poor Control\*
- ▶ Childhood Immunization Status
- ▶ Pediatric Weight Assessment and Counseling

\*Medicare Shared Savings Program Measure

Blue font signifies CMS population health measures

# Year 1 Reporting Measures (Survey Data)

## Patient Experience Survey Composite Measures:

- ▶ Access to Care
- ▶ Communication
- ▶ Shared Decision-Making
- ▶ Self-Management Support
- ▶ Comprehensiveness
- ▶ Office Staff
- ▶ Information
- ▶ Coordination of Care
- ▶ Specialist Care

# Year 1 Monitoring and Evaluation Measures

- ▶ Appropriate Medications for People with Asthma
- ▶ Comprehensive Diabetes Care Measure: Eye Exams
- ▶ Comprehensive Diabetes Care: Medical Attention for Nephropathy
- ▶ Use of Spirometry Testing in Assessment & Diagnosis of COPD
- ▶ Follow-Up Care for Children Prescribed ADHD Medication
- ▶ Antidepressant Medication Management
- ▶ Family Evaluation of Hospice Care Survey
- ▶ School Completion Rate
- ▶ Unemployment Rate
- ▶ Total Cost of Care Population-Based PMPM Index
- ▶ Health Partners Total Cost of Care

# Year 1 Monitoring and Evaluation Measures (continued)

- ▶ Annual Dental Visit
- ▶ Avoidable ED Visits (NYU algorithm)
- ▶ Ambulatory Care (ED rate only)
- ▶ ED Utilization for Ambulatory Care–Sensitive Conditions
- ▶ Primary Care Visits/1000
- ▶ Specialty Visits/1000
- ▶ Ambulatory Surgery/1000
- ▶ Inpatient Utilization – General Hospital/Acute Care
- ▶ SNF Days/1000
- ▶ High–End Imaging/1000
- ▶ Average # of Prescriptions PMPM
- ▶ Generic Dispensing Rate

# Impact of Measures on Payment

# Impact of Payment Measures: Commercial Commercial “Gate and Ladder” Approach:

- ▶ 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.
- ▶ If the ACO does not achieve at least 55% of the maximum available points across all payment measures, it is not eligible for any shared savings (“quality gate”).
- ▶ In commercial SSP “quality ladder,” ACO earns:
  - 75% of potential savings for achieving 55% of available points,
  - 85% of potential savings for achieving 65% of available points,
  - 95% of potential savings for achieving 75% of available points.

# Impact of Payment Measures: Medicaid

## Medicaid “Gate and Ladder” Approach:

- ▶ For most payment measures, compare each 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.
- ▶ For two payment measures without national Medicaid benchmarks (All-cause Readmission and Developmental Screening), compare each 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.
- ▶ If the ACO does not achieve at least 35% of the maximum available points across all payment measures, it is not eligible for any shared savings (“quality gate”).
- ▶ In commercial SSP “quality ladder,” ACO earns:
  - 75% of potential savings for achieving 35% of available points,
  - 85% of potential savings for achieving 45% of available points,
  - 95% of potential savings for achieving 55% of available points.

# Consideration of Additional Measures

- ▶ Some stakeholders expressed concern about number of measures (administrative burden and QI resources)
- ▶ Sources of measures: pending measures, MSSP measures, federal population health measures
- ▶ Proposal for adding new measures is to go through work group process, with review by VHCIP Steering Committee, and review and approval by VHCIP Core Team and Green Mountain Care Board

# Discussion

# Discussion

- ▶ What strikes you about this list of measures given our conversation last time about non-clinical contributors to population health outcomes?

# Discussion

- ▶ What are some of the ways that population health measures could be used in the context of the 3 aims of this VHCIP project?

# Discussion

- ▶ Which other work groups would be important connections? How can we bring this discussion to the other work groups?

## Population Health Measures

The measures were selected based on the following three criteria:

- High population burden, societal costs
- Amenable to interventions with potential improvement in health, quality of care and decreased costs within the next three to five years
- Data for the measure are available for major segments of the population at the state and/or substate level.

Topic	Population Health Measure	Population Data Source/ Link	Related NQF # / Measure
<b>Core Measures</b>			
Tobacco - Adult	Four Level Smoking Status	BRFSS – 2011  <a href="http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=TU&amp;yr=2011&amp;key=8171&amp;state=US">http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=TU&amp;yr=2011&amp;key=8171&amp;state=US</a>	NQF 0028  <b>Measure Pair: A) Tobacco Use Assessment, B) Tobacco Cessation Intervention</b> A) Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period, B)Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period
Tobacco	Percent of adult smokers who have made a quit attempt in the past year	BRFSS 2011  To Be Provided	NQF 0028  <b>Measure Pair: A) Tobacco Use Assessment, B) Tobacco Cessation Intervention</b> A) Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period, B)Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period
Obesity - Adult	Weight Classification by BMI	BRFSS – 2011  <a href="http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=OB&amp;yr=2011&amp;key=8261&amp;state=All">http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=OB&amp;yr=2011&amp;key=8261&amp;state=All</a>	NQF 0024 NQF 0421  <b>Adult Weight Screening and Follow-Up</b> Percentage of patients aged 18 years and older with a calculated BMI documented in the medical record AND if the most recent BMI is outside the parameters, a follow up plan is documented
Obesity - Youth	Obese: Students who were >=95 <sup>th</sup> Percentile for BMI (based on 2000 CDC Growth Charts)	YRBS – 2011	No relevant NQF measure identified  <b>Body Mass Index (BMI) 2 through 18 Years of Age</b> Percentage children, 2 through 18 years of age, whose weight is classified based on BMI percentile for age and gender
Physical Activity	Participated in enough Aerobic and Muscle Strengthening exercises to meet guidelines	BRFSS - 2011  <a href="http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=PA&amp;yr=2011&amp;key=8291&amp;state=All">http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=PA&amp;yr=2011&amp;key=8291&amp;state=All</a>	No relevant NQF measure identified

## Population Health Measures

Fruit and Vegetable Consumption	Median intake of fruits and vegetables (times per day)	Behavioral Risk Factor Surveillance System.  See report: <a href="http://www.cdc.gov/nutrition/downloads/State-Indicator-Report-Fruits-Vegetables-2013.pdf">http://www.cdc.gov/nutrition/downloads/State-Indicator-Report-Fruits-Vegetables-2013.pdf</a>	No relevant NQF measure identified
Food Desert/ Food Availability	Percentage of the population living in census tracts designated as food deserts	USDA: <a href="http://www.ers.usda.gov/data-products/food-access-research-atlas">http://www.ers.usda.gov/data-products/food-access-research-atlas</a>  <a href="http://assessment.communitycommons.org/DataReport/SelectArea.aspx?reporttype=FOOD">http://assessment.communitycommons.org/DataReport/SelectArea.aspx?reporttype=FOOD</a>	No relevant NQF measure identified
Diabetes	Percentage of Adults(aged 18 years or older) with Diabetes Having Two or More A1c Tests in the Last Year	BRFSS 2012  2012 Data Forthcoming	NQF 0729  <b>Optimal Diabetes Care</b> The percentage of patients 18-75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure<140/90 mm Hg, tobacco non-use and daily aspirin usage for patients with diagnosis of IVD) with the intent of preventing or reducing future complications associated with poorly managed diabetes.
Diabetes	Percentage of Adults (aged 18 years or older) with Diabetes Receiving a Foot Exam in the Last Year	BRFSS 2012  2012 Data Forthcoming	NQF 0056  <b>Foot Exam</b> Percentage of adult patients with diabetes aged 18-75 years who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam)
Diabetes	Percentage of Adults (aged 18 years or older) with Diabetes Receiving a Dilated Eye Exam in the Last Year	BRFSS 2012  2012 Data Forthcoming	NQF 0055  <b>Eye Exam</b> Percentage of adult patients with diabetes aged 18-75 years who received an eye screening for diabetic retinal disease during the measurement year
<b>Additional Measures for Consideration</b>			
<b>Community Characteristics</b>			
Health Care Access	Do you have any type of health care coverage?	BRFSS 2011  <a href="http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=HC&amp;yr=2011&amp;key=8021&amp;state=All">http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=HC&amp;yr=2011&amp;key=8021&amp;state=All</a>	No relevant NQF measure identified
Tobacco	Legislation – Smokefree Indoor Air	CDC OSH State Tobacco Activities Tracking and Evaluation (STATE) System – 2013  <a href="http://apps.nccd.cdc.gov/statesystem/DetailedReport/DetailReports.aspx">http://apps.nccd.cdc.gov/statesystem/DetailedReport/DetailReports.aspx</a>	No relevant NQF measure identified

## Population Health Measures

Tobacco - Youth	Smoked cigarettes on at least one day in the last 30 days	YRBS – 2011  <a href="http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?TT=&amp;OUT=&amp;SID=HS&amp;QID=H31&amp;LID=&amp;YID=&amp;LID2=&amp;YID2=&amp;COL=&amp;ROW1=&amp;ROW2=&amp;HT=&amp;LCT=&amp;FS=&amp;FR=&amp;FG=&amp;FSL=&amp;FRL=&amp;FGL=&amp;PV=&amp;TST=&amp;C1=&amp;C2=&amp;QP=G&amp;DP=&amp;VA=CI&amp;CS=Y&amp;SYID=&amp;EYID=&amp;SC=&amp;SO=">http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?TT=&amp;OUT=&amp;SID=HS&amp;QID=H31&amp;LID=&amp;YID=&amp;LID2=&amp;YID2=&amp;COL=&amp;ROW1=&amp;ROW2=&amp;HT=&amp;LCT=&amp;FS=&amp;FR=&amp;FG=&amp;FSL=&amp;FRL=&amp;FGL=&amp;PV=&amp;TST=&amp;C1=&amp;C2=&amp;QP=G&amp;DP=&amp;VA=CI&amp;CS=Y&amp;SYID=&amp;EYID=&amp;SC=&amp;SO=</a>	HP2020 LHI Objective  NQF 0028  <b>Measure Pair: A) Tobacco Use Assessment, B) Tobacco Cessation Intervention</b>  A) Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period, B) Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period
<b>Key Health Behaviors</b>			
Motor vehicle injury prevention	Driving after drinking in the past 30 days	BRFSS 2012 (not asked annually) During the past 30 days, how many times have you driven when you've had perhaps too much to drink? <a href="http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=IN&amp;yr=2010&amp;qkey=7315&amp;state=All">http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=IN&amp;yr=2010&amp;qkey=7315&amp;state=All</a>	No relevant NQF measure identified
<b>Health Care Quality and Outcomes</b>			
Colorectal Cancer	Percentage of respondents aged 50-75 years who reported colorectal test use, by test type: <ul style="list-style-type: none"> <li>Up-to-date with CRC screening</li> <li>FOBT within 1 year</li> <li>Sigmoidoscopy within 5 years with FOBT within 3 years</li> <li>Colonoscopy within 10 years</li> </ul>	BRFSS 2012  2012 Data Forthcoming	NQF – 0034  <b>Colorectal Cancer Screening</b> Percentage of members 50-75 years of age who had appropriate screening for colorectal cancer
Healthcare associated infections	Patient Safety- Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure	To Be Provided	NQF 1717  Facility-wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure - Standardized infection ratio (SIR) of hospital-onset CDI Laboratory-identified in nurseries and neonatal intensive care units (NICUs)
Immunization Rate – Adult	Adults aged 65+ who have had a flu shot within the past year	BRFSS - 2011  <a href="http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=IM&amp;yr=2011&amp;qkey=8341&amp;state=US">http://apps.nccd.cdc.gov/BRFSS/list.asp?cat=IM&amp;yr=2011&amp;qkey=8341&amp;state=US</a>	NQF 0041      Influenza Vaccination  Percentage of patients aged 6 months and older seen for a visit between October 1 and the end of February who received an influenza immunization OR patient reported previous receipt of an influenza immunization

## Population Health Measures

Immunization Rate – Child	Estimated Vaccination Coverage* with Individual Vaccines and Selected Vaccination Series	US National Immunization Survey, 2011 <a href="http://www2a.cdc.gov/nip/coverage/nis/CountNIS.asp?fmt=v&amp;rpt=tab03_antigen_state_2011.xlsx&amp;qtr=Q1/2011-Q4/2011">http://www2a.cdc.gov/nip/coverage/nis/CountNIS.asp?fmt=v&amp;rpt=tab03_antigen_state_2011.xlsx&amp;qtr=Q1/2011-Q4/2011</a>	NQF 0038  <b>Childhood Immunization Status</b> Measure calculates a rate for each recommended vaccines and nine separate combination rates.
Blood Pressure / Hypertension	Taking medicine for high blood pressure control among adults aged >= 18 years	BRFSS – 2011  To Be Provided	NQF 0018  <b>HTN: Controlling High Blood Pressure</b> Percentage of patients > 18 years of age with a diagnosis of hypertension in the first six months of the measurement year or any time prior with last BP < 140/90 mm Hg
Cholesterol		NQF 0074  To Be Provided	<b>Lipid Control</b> Percentage of patients aged 18 years and older with a diagnosis of CAD seen within a 12 month period who have a LDL-C result <100 mg/dL OR patients who have a LDL-C result >=100 mg/dL and have a documented plan of care to achieve LDL-C <100mg/dL, including at a minimum the prescription of a statin
HIV	<b>Stage 3 (AIDS) at the time of diagnosis of HIV infection, among persons aged 13 years and older</b>	<a href="http://www.cdc.gov/hiv/pdf/statistics_2010_HIV_Surveillance_Report_vol_17_no_3.pdf#page=15">http://www.cdc.gov/hiv/pdf/statistics_2010_HIV_Surveillance_Report_vol_17_no_3.pdf#page=15</a>	NQF 1999  Percentage of persons 13 years and older diagnosed with Stage 3 HIV infection (AIDS) within 3 months of a diagnosed HIV infection.
	<b>HIV viral suppression at most recent viral load test, among persons aged 13 years and older with HIV infection</b>	<a href="http://www.cdc.gov/hiv/pdf/statistics_2010_HIV_Surveillance_Report_vol_18_no_2.pdf#page=20">http://www.cdc.gov/hiv/pdf/statistics_2010_HIV_Surveillance_Report_vol_18_no_2.pdf#page=20</a> (limited state set)	NQF 2082  Percentage of patient, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year.
<b>Measures of Health</b>			
Health Related Quality of Life	Health Related Quality of Life— physically and mentally unhealthy days In the past month.	BRFSS 2011 Unique data run. DPH may need provide as it is not regularly reported by BRFSS  Also here on CDI site from 2010 <a href="http://apps.nccd.cdc.gov/cdi/SearchResults.aspx?IndicatorIds=36,50,44,136,135,55,16,122,123,124&amp;StateIds=46&amp;StateNames=United%20States&amp;FromPage=HomePage">http://apps.nccd.cdc.gov/cdi/SearchResults.aspx?IndicatorIds=36,50,44,136,135,55,16,122,123,124&amp;StateIds=46&amp;StateNames=United%20States&amp;FromPage=HomePage</a>	No relevant NQF measure identified
Low Birth Weight	Percent of live births <2500 g.	<a href="http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=5425">http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=5425</a>  and can be computed at: <a href="http://wonder.cdc.gov/">http://wonder.cdc.gov/</a>	No relevant NQF measure identified

**Comparison of Proposed 2014 ACO Reporting or Payment Measures for  
MSSP (Medicare ACO), Vermont Commercial ACO, and Vermont Medicaid ACO**

**Key: Y=Yes; N=No; C=Claims; MR=Medical Record; S=Survey; R=Reporting; P=Payment**

<b>MSSP</b>	<b>Measure Description</b>	<b>Data: Claims, Medical Record, or Survey?</b>	<b>Medicare ACO Use Year 2 2014</b>	<b>Commercial ACO Use Proposed 2014</b>	<b>Medicaid ACO Use Proposed 2014</b>
Y	Risk-Standardized All Condition Readmission	C	R		
Y	Ambulatory Sensitive Conditions Admissions: COPD or Asthma in Older Adults	C	P	R	R
Y	Ambulatory Sensitive Conditions Admissions: Heart Failure	C	P		
Y	% of PCPs who Successfully Qualify for an EHR Program Incentive Payment	Other	P		
Y	Medication Reconciliation	MR	P		
Y	Falls: Screening for Future Fall Risk	MR	P		
Y	Influenza Immunization	MR	P		
Y	Pneumococcal Vaccination for Patients 65 and Older	MR	P		
Y	Adult BMI Screening and Follow-Up	MR	P	R	R
Y	Tobacco Use: Screening and Cessation Intervention	MR	P		
Y	Screening for Clinical Depression and Follow-Up Plan	MR	P	R	R
Y	Colorectal Cancer Screening	MR	R	R	R
Y	Breast Cancer Screening	C	R	R	R
Y	Screening for High Blood Pressure and Follow-Up Documented	MR	R		
Y	Diabetes Composite (HbA1c control)	MR	P	R	R
Y	Diabetes Composite (LDL Control)	MR	P	R	R
Y	Diabetes Composite (High Blood Pressure Control)	MR	P	R	R
Y	Diabetes Composite (Tobacco Non Use)	MR	P	R	R
Y	Diabetes Composite (Daily Aspirin or Antiplatelet Medication)	MR	P	R	R
Y	Diabetes HbA1c poor control	MR	P	R	R
Y	Hypertension: Controlling High Blood Pressure	MR	P		
Y	IVD: Complete Lipid Panel and LDL Control	MR/C*	P	P*	P*
Y	IVD: Use of Aspirin or Another Antithrombotic	MR	P		
Y	Heart Failure: Beta Blocker Therapy for LVSD	MR	R		
Y	Coronary Artery Disease Composite (Lipid control)	MR	R		
Y	Coronary Artery Disease Composite (ACE or ARB for LVSD)	MR	R		

\*Recommendation for Vermont Commercial/Medicaid ACO is to substitute the claims based Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening only) for the medical record based IVD: Complete Lipid Panel and LDL Control measure, due to data collection challenges.

Yellow highlight signifies CMS population health measure

MSSP	Measure Description	Data: Claims, Medical Record, or Survey?	Medicare ACO Use Year 2 2014	Commercial ACO Use Proposed 2014	Medicaid ACO Use Proposed 2014
N	All-Cause Readmission	C		P	P
N	Adolescent Well-Care Visit	C		P	P
N	Follow-Up After Hospitalization for Mental Illness (7 day)	C		P	P
N	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	C		P	P
N	Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	C		P	P
N	Chlamydia Screening in Women	C		P	P
N	Developmental Screening in First 3 Years of Life	C			P
N	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	C		R	R
N	Appropriate Testing for Children With Pharyngitis	C		R	R
N	Childhood Immunization Status	MR		R	R
N	Pediatric Weight Assessment and Counseling	MR		R	R
	<b>Patient Experience Surveys</b>				
Y	NIS Patient Experience: Getting Timely Care, Appointments, Information	S	P		
Y	NIS Patient Experience: How Well Providers Communicate	S	P		
Y	NIS Patient Experience: Patients' Rating of Provider	S	P		
Y	NIS Patient Experience: Access to Specialists	S	P		
Y	NIS Patient Experience: Health Promotion and Education	S	P		
Y	NIS Patient Experience: Shared Decision Making	S	P		
Y	NIS Patient Experience: Health Status/Functional Status	S	R		
N	PCMH Patient Experience: Access to Care	S		R	R
N	PCMH Patient Experience: Communication	S		R	R
N	PCMH Patient Experience: Shared Decision-Making	S		R	R
N	PCMH Patient Experience: Self-Management Support	S		R	R
N	PCMH Patient Experience: Comprehensiveness	S		R	R
N	PCMH Patient Experience: Office Staff	S		R	R
N	PCMH Patient Experience: Information	S		R	R
N	PCMH Patient Experience: Coordination of Care	S		R	R
N	PCMH Patient Experience: Specialist Care	S		R	R
	<b>Total Measures for Payment or Reporting 2014</b>		<b>33</b>	<b>31</b>	<b>32</b>

\*Recommendation for Vermont Commercial/Medicaid ACO is to substitute the claims based Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening only) for the medical record based IVD: Complete Lipid Panel and LDL Control measure, due to data collection challenges.

Yellow highlight signifies CMS population health measure

## Vermont Health Care Innovation Project Grant Program Application

Draft dated 12.23.2013

### I. Background

The federal Centers for Medicare and Medicaid Innovation (CMMI) awarded the State Innovation Model (SIM) grant to Vermont. The grant provides funding and other resources to support health care payment and delivery system reforms aimed at improving care, improving the health of the population, and reducing per capita health care costs, by 2017. To maximize the impact of non-governmental entity involvement in this health care reform effort, Vermont identified funding within its SIM grant to directly support providers engaged in payment and delivery system transformation. The State has determined that a competitive grant process will foster innovation and promote success among those providers eager to engage in reforms. These grants will be reviewed by the VHCIP/SIM Core Team using the criteria found in the Grant Program (GP) Criteria.

Applicants can seek technical assistance support as well as direct funding. The total amount available for direct funding is \$3,377,102.

GP grants will support provider-level activities that are consistent with overall intent of the SIM project, in two broad categories:

1. Activities that directly enhance provider capacity to test one or more of the three alternative payment models approved in Vermont's SIM grant application:
  - a. Shared Savings Accountable Care Organization (ACO) models;
  - b. Episode-Based or Bundled payment models; and
  - c. Pay-for-Performance models.
2. Infrastructure development that is consistent with development of a statewide high-performing health care system, including:
  - a. Development and implementation of innovative technology that supports advances in sharing clinical or other critical service information across different types of provider organizations;
  - b. Development and implementation of innovative systems for sharing clinical or other core services across different types of provider organizations;
  - c. Development of management systems to track costs and/or quality across different types of providers in innovative ways.

Preference will be given to applications that demonstrate:

- Support from and equitable involvement of multiple provider organization types that can demonstrate the grant will enhance integration across the organizations;
- A scope of impact that spans multiple sectors of the continuum of health care service delivery (for example, prevention, primary care, specialty care, mental health and long term services and supports);

- Innovation, as shown by evidence that the intervention proposed represents best practices in the field;
- An intent to leverage and/or adapt technology, tools, or models tested in other States to meet the needs of Vermont's health system;
- Consistency with the Green Mountain Care Board's specifications for Payment and Delivery System Reform pilots. The Green Mountain Care Board's specifications can be found here: <http://gmcboard.vermont.gov/PaymentReform>.

## **II. What these grants will fund**

Grants will fund the following types of activities. Appendix B includes a detailed list of federal guidelines around this funding.:

- Data analysis
- Facilitation
- Quality improvement
- Evaluation
- Project development

## **III. Grant submission requirements**

Applicants will be expected to provide the following in support of their application:

- GP Application Cover Form. This form is found in Appendix A.
- Grant Narrative. The Grant Narrative should be a maximum of 12 pages double-spaced, 12 point font, with 1-inch margins, paginated in a single sequence. The Grant Narrative should contain the following information:
  - a. A clear description of the activities for which the applicant is requesting funding or technical assistance;
  - b. A clear description of alternative funding sources sought and rationale for requesting SIM funds;
  - c. A description of technical assistance services sought. Appendix D provides more detail about the technical assistance services available under this grant .
  - d. A description of the project's potential return-on-investment in terms of cost savings and quality improvement, and plans for measuring both;
  - e. A description of how the project will avoid duplication where similar innovations in Vermont are currently underway;
  - f. A summary of the evidence base for the proposed activities or technical assistance;
- A project plan, staffing structure, deliverables description, and timeline for completion of the proposed activities. This includes a project management plan with implementation timelines and milestones.

- Executed Memorandum of Understanding or other demonstration of support from partner providers, if applicable.
- Budget Narrative. Budget Narrative guidance is found in Appendices B and C. The Budget Narrative should contain the following:
  - a. A budget for the proposed project, consistent with specified budget formats;
  - b. A description of any available matching support, whether financial or in-kind;
  - c. Information regarding on-going support that may be needed for work begun under this grant.

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#### **IV. State resources available to grantees**

Grant recipients may receive the following support, to the extent that a need has been clearly established in the grant application. More detail about the technical assistance can be found in Appendix D:

- Supervision to ensure compliance with federal antitrust provisions;
- Assistance in aligning with other testing models in the state;
- Assistance with appropriately attributing outcomes and savings to testing models;
- Overall monitoring of health care quality and access;
- Funding for specific activities;
- Technical Assistance:
  - Meeting facilitation
  - Stakeholder engagement
  - Data analysis
  - Financial modeling
  - Professional learning opportunities

#### **V. Compliance and Reporting Requirements**

As a responsible steward of federal funding, the state, through the Agency of Human Services, Department of Vermont Health Access (DVHA), monitors its sub-recipients utilizing the following monitoring tools:

- 1) Ensure that sub-recipient is not disbarred/suspended or excluded for any reason
- 2) Sub-award agreement
- 3) Sub-recipient meeting and regular contact with sub-recipients
- 4) Required pre-approval for changes to budget or scope of grant
- 5) Quarterly financial reports
- 6) Bi-annual programmatic reports
- 7) Audit
- 8) Desk Reviews
- 9) Site audits

In its use of these monitoring tools, the State emphasizes clear communication to ensure a feedback loop that supports sub-recipients in maintaining compliance with federal requirements. The State may at any time elect to conduct additional sub-recipient monitoring. Sub-recipients therefore should maintain grant records accurately in the event that the State exercises this right. The State may also waive its right to perform certain sub-recipient monitoring activities. If, at any

time, the State waives its right to certain sub-recipient monitoring activities, it will note which activities were not completed and the reasons why that activity was not necessary. Each of the monitoring tools and policies regarding their use are described in detail below.

### **1) Sub-recipient status**

When signing the sub-award agreement, Sub-recipient's certify that neither the Sub-recipient nor Sub-recipient principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs or programs supported in whole or in part by federal funds.

Additionally DVHA will utilize the Excluded Parties List System ([www.epls.gov](http://www.epls.gov)) to confirm that neither the Sub-recipient nor its principals are presently disbarred at least once during DVHA's fiscal year. DVHA will print a screen shot of its EPLS search, and place it in the Sub-recipient's files.

### **2) Sub-award agreement**

A sub-award agreement is provided to each sub-recipient at the beginning of each grant. This sub-award agreement will detail the Catalog of Federal Domestic Assistance (CFDA) program name and number, the award name and number as assigned by the funder, the award period, and the name of the federal awarding agency. This sub-award agreement will also include: definitions, the scope of work to be performed, payment provisions, funder grant provisions, blank financial and programmatic reports, and a copy of this policy. Other information may be included if necessary.

Unless any changes are required, only one sub-award document will be generated for the term of a grant, even if that term spans several years. All sub-recipients must sign the sub-award agreement and any additional documents sent with the sub-award, or funding will be terminated.

### **3) Sub-recipient meeting/ sub-recipient contact**

The State may decide, at the beginning of a grant or at any time during a grant, to host a meeting of grant partners in order to review grant goals and/or obligations. A sub-recipient meeting may be held with one individual sub-recipient, or with multiple sub-recipients.

The State will also maintain contact with sub-recipients. Sub-recipients are expected to notify the State if they are having any difficulty carrying out their grant responsibilities or if they need clarification of their grant responsibilities.

Sub-recipients meeting and sub-recipient contact will be noted on the sub-recipient checklist, with appropriate supporting documentation included in the sub-recipient's folder.

#### **4) Required pre-approval for changes to budget or scope of grant**

As stated above, all sub-recipients must seek prior approval from the grants manager at the State to utilize grant funding for any activities not explicitly described in the goals section of the narrative. Sub-recipients must also seek prior approval before making any changes to their section of the budget.

Notes regarding any prior approval requested by a sub-recipient, or a sub-recipient's failure to comply with this grant term, will be maintained on the sub-recipient checklist.

#### **5) Quarterly financial reports**

The Sub-recipient will submit accurate financial reports to the State no later than the tenth of the month following the quarter being reported (January 10th, April 10th, July 10th, October 10th). A blank copy of the required financial report will be provided with the sub-award agreement. All questions regarding financial reports should be directed to Robert Pierce at robert.pierce@state.vt.us.

Financial reports will be reviewed by the State for accuracy and to ensure that all charges are eligible to be reimbursed by the grant. Sub-recipients are expected to respond promptly to all questions concerning financial reports.

Sub-recipient's submission of quarterly financial reports will be recorded and monitored on the sub-recipient checklist.

#### **6) Bi-annual programmatic reports**

The sub-recipient will submit accurate programmatic reports to the State no later than the tenth of the month following the 6-month period being reported (January 10<sup>th</sup> and July 10<sup>th</sup>). A blank copy of the required programmatic reports will be provided with the sub-award agreement. All questions regarding programmatic reports should be directed to Georgia Maheras at georgia.maheras@state.vt.us.

Programmatic reports will be reviewed by the State for accuracy and to ensure that all charges are eligible to be reimbursed by the grant. Sub-recipients are expected to respond promptly to all questions concerning programmatic reports

### **7) Audit**

Sub-recipients who spent at least \$500,000 in federal funds from all federal sources during their fiscal year must have an audit performed in accordance with OMB Circular A-133. The A-133 compliant audit must be completed within 9 months of the end of the sub-recipient's fiscal year. The sub-recipient shall provide the State with a copy of their completed A-133 compliant audit including:

- The auditor's opinion on the sub-recipient's financial statements,
- the auditor's report on the sub-recipient's internal controls,
- the auditor's report and opinion on compliance with laws and regulations that could have an effect on major programs,
- the schedule of findings and questioned costs,
- and the sub-recipients corrective action plan (if any).

The State will issue a management decision on audit findings within 6 months after receipt of the sub-recipient's A-133 compliant audit report.

If a sub-recipient's schedule of findings and questioned costs did not disclose audit findings relating to the Federal awards provided by the State and the summary schedule of prior audit findings did not report the status of audit findings relating to Federal awards provided by the State, the sub-recipient may opt not to provide the A-133 compliant audit report to the State. In this case, the State will verify that there were no audit findings utilizing the Federal Audit Clearinghouse database.

Any sub-recipient that, because it does not meet the \$500,000 threshold or because it is a for-profit entity, does not receive an audit performed in accordance with OMB Circular A-133 may at its option and expense have an independent audit performed. The independent audit should be performed to obtain reasonable assurance about whether the sub-recipient's financial statements are free of material misstatement. The independent audit should also take into consideration the sub-recipient's internal control, but does not necessarily have to contain the auditor's opinion on the agency's internal control. If the sub-recipient elects to have an audit report that covers more than the sub-recipient's financial statements, the State requests that the entirety of the auditor's report be provided to the State.

If the sub-recipient chooses not have an independent audit and the sub-recipient will receive at least \$10,000 during the current fiscal year, they will be subject to on-site monitoring during the award period.

Sub-recipients who are individual contractors will not be subject to on-site monitoring based solely on the lack of an independent audit.

## **8) Desk Reviews**

All sub-recipients who are estimated to receive \$10,000 or more during the fiscal year will undergo a desk review at least once during the grant period. If a sub-recipient receives less than \$10,000, the State may at its discretion opt to conduct a desk review. During a desk review, sub-recipients might be expected to provide:

- Adequate source documentation to support financial requests including but not limited to an income statement, payroll ledgers, cancelled checks, receipts ledgers, bank deposit tickets and bank statements, and timesheets.
- If salary is funded under the award and if the staff whose salary is funded under the award is charged to other funding sources, time distribution records to support the amounts charged to federal funding provided by the State.
- A statement verifying that the organization has a system in place for maintaining its records relative to federal funding provided by the State for the amount of time as specified in the sub-award document.
- Adequate documentation to support required match, if any.

#### **9) Site visits**

All sub-recipients who receive \$50,000 or more in federal funding passed through the State for three consecutive fiscal years (July 1 – June 30), will undergo a site visit at least once during the three year period. Sub-recipient will be subject to desk monitoring during the intervening years. The State will arrange a suitable date and time for on-site monitoring with the sub-recipient. Recipients receiving a site visit will be expected to provide all of the back-up documentations as specified above, as well as:

- A written policy manual specifying approval authority for financial transactions.
- A chart of accounts and an accounting manual which includes written procedures for the authorization and recording of transactions.
- Documentation of adequate separation of duties for all financial transactions (that is, all financial transactions require the involvement of at least two individuals).
- If grant funds are utilized to purchase equipment, demonstration that the organization maintains a system for tracking property and other assets bought or leased with grant funds.
- A copy of the agency's Equal Opportunity Policy and Practices in Hiring.

**Appendix A: Application Cover Form**

*General Information:*

Organization Applying: \_\_\_\_\_

Key Contact for Applicant: \_\_\_\_\_

Key Contact Email and Phone Number: \_\_\_\_\_

*Project Title and Brief Summary:*

Project Title: \_\_\_\_\_

Brief Summary of the Project (max. 150 words):

*Budget Request Summary:*

<b>Budget Category</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>
Personnel			
Fringe			
Travel			
Equipment			
Supplies			
Indirect			
Contracts			
<b>Total</b>			

## Appendix B: CMMI Funding Restrictions

All funds expended through this grant program must comply with the federal guidelines found in the State Innovation Models FOA found

here: [http://innovation.cms.gov/Files/x/StateInnovation\\_FOA.pdf](http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf)

The cost principles address four tests in determining the allowability of costs. The tests are as follows:

- **Reasonableness (including necessity)**. A cost is reasonable if, in its nature or amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The cost principles elaborate on this concept and address considerations such as whether the cost is of a type generally necessary for the organization's operations or the grant's performance, whether the recipient complied with its established organizational policies in incurring the cost or charge, and whether the individuals responsible for the expenditure acted with due prudence in carrying out their responsibilities to the Federal government and the public at large as well as to the organization.
- **Allocability**. A cost is allocable to a specific grant, function, department, or other component, known as a cost objective, if the goods or services involved are chargeable or assignable to that cost objective in accordance with the relative benefits received or other equitable relationship. A cost is allocable to a grant if it is incurred solely in order to advance work under the grant; it benefits both the grant and other work of the organization, including other grant-supported projects or programs; or it is necessary to the overall operation of the organization and is deemed to be assignable, at least in part, to the grant.
- **Consistency**. Recipients must be consistent in assigning costs to cost objectives. They must be treated consistently for all work of the organization under similar circumstances, regardless of the source of funding, so as to avoid duplicate charges.
- **Conformance**. This test of allowability—conformance with limitations and exclusions contained in the terms and conditions of award, including those in the cost principles—may vary by the type of activity, the type of recipient, and other characteristics of individual awards. "Allowable Costs and Activities" below provides information common to most HHS grants and, where appropriate, specifies some of the distinctions if there is a different treatment based on the type of grant or recipient.

These four tests apply regardless of whether the particular category of costs is one specified in the cost principles or one governed by other terms and conditions of an award. These tests also apply regardless of treatment as a direct cost or an indirect cost. The fact that a proposed cost is awarded as requested by an applicant does not indicate a determination of allowability.

### Direct Costs and Indirect Costs

This is for illustrative purposes. We strongly recommend applicants review all of the federal guidance provided in the FOA found here: [http://innovation.cms.gov/Files/x/StateInnovation\\_FOA.pdf](http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf).

Direct costs are costs that can be identified specifically with a particular award, project or program, service, or other organizational activity or that can be directly assigned to such an activity with a high degree of accuracy. Direct costs include, but are not limited to, salaries, travel, equipment, and supplies directly benefiting the grant-supported project or program. Indirect costs (also known as “facilities and administrative costs”) are costs incurred for common or joint objectives that cannot be identified specifically with a particular project, program, or organizational activity. Facilities operation and maintenance costs, depreciation, and administrative expenses are examples of costs that usually are treated as indirect costs. There is a 10% cap on indirect costs. The organization is responsible for presenting costs consistently and must not include costs associated with its indirect rate as direct costs.

Examples of Unallowable Direct Costs:

- Alcohol
- Alteration and Renovation Costs
- Animals
- Bad Debts
- Bid and Proposal Costs
- Construction or Modernization
- Dues/Membership-Unallowable for Individuals (unless fringe benefit or employee development costs if applied as established organization policy across all funding sources).
- Entertainment
- Fines and Penalties
- Fundraising
- Honoraria- if this cost is for speaker fee that it is allowable as a direct cost.
- Invention, Patent or Licensing Costs-unless specifically authorized in the NOA.
- Land or Building Acquisition
- Lobbying
- Meals (Food)
- Travel

### Appendix C: Budget Narrative Guidance

#### INTRODUCTION

This guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by ensuring that the required or needed information is provided. In the budget request, awardees should distinguish between activities that will be funded under this agreement and activities funded with other sources.

#### A. Salaries and Wages

For each requested position, provide the following information: name of staff member occupying the position, if available; annual salary; percentage of time budgeted for this program; total months of salary budgeted; and total salary requested. Also, provide a justification and describe the scope of responsibility for each position, relating it to the accomplishment of program objectives.

<i>Position Title and Name</i>	<i>Annual</i>	<i>Time</i>	<i>Months</i>	<i>Amount Requested</i>
<i>Project Coordinator Susan Taylor</i>	<i>\$45,000</i>	<i>100%</i>	<i>12 months</i>	<i>\$45,000</i>
<i>Finance Administrator John Johnson</i>	<i>\$28,500</i>	<i>50%</i>	<i>12 months</i>	<i>\$14,250</i>
<i>Outreach Supervisor (Vacant*)</i>	<i>\$27,000</i>	<i>100%</i>	<i>12 months</i>	<i>\$27,000</i>

#### **Sample Justification**

*The format may vary, but the description of responsibilities should be directly related to specific program objectives.*

#### Job Description: Project Coordinator - (Name)

*This position directs the overall operation of the project; responsible for overseeing the implementation of project activities; coordination with other agencies; development of materials, provisions of in service and training; conducting meetings; designs and directs the gathering, tabulating and interpreting of required data; responsible for overall program evaluation and for staff performance evaluation; and is the responsible authority for ensuring necessary reports/documentation are submitted to HHS. This position relates to all program objectives.*

#### B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed. This can be done for all FTE in one table instead of itemizing per employee.

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**Sample**

*Example: Project Coordinator — Salary \$45,000*

<i>Retirement 5% of \$45,000</i>	=	<i>\$2,250</i>
<i>FICA 7.65% of \$45,000</i>	=	<i>3,443</i>
<i>Insurance</i>	=	<i>2,000</i>
<i>Workers' Compensation</i>	=	<i>_____</i>
		<i>Total:</i>

**C. Consultant Costs**

This category is appropriate when hiring an individual to give professional advice or services (e.g., training, expert consultant, etc.) for a fee but not as an employee of the awardee organization. Hiring a consultant requires submission of the following information:

1. Name of Consultant;
2. Organizational Affiliation (if applicable);
3. Nature of Services to be Rendered;
4. Relevance of Service to the Project;
5. The Number of Days of Consultation (basis for fee); and
6. The Expected Rate of Compensation (travel, per diem, other related expenses)—list a subtotal for each consultant in this category.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the body of the budget request, a summary should be provided of the proposed consultants and amounts for each.

**D. Equipment**

Provide justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the “Other” category. All IT equipment should be uniquely identified. As an example, we should not see a single line item for “software.” Show the unit cost of each item, number needed, and total amount.

<u>Item Requested</u>	<u>How Many</u>	<u>Unit Cost</u>	<u>Amount</u>
<i>Computer Workstation</i>	<i>2 ea.</i>	<i>\$2,500</i>	<i>\$5,000</i>
<i>Fax Machine</i>	<i>1 ea.</i>	<i>600</i>	<i><u>600</u></i>

**Sample Justification**

*Provide complete justification for all requested equipment, including a description of how it will be used in the program. For equipment and tools which are shared among programs, please cost allocate as appropriate. States should provide a list of hardware, software and IT equipment which will be required to complete this effort. Additionally, they should provide a list of non-IT equipment which will be required to complete this effort.*

**E. Supplies**

Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.

**Sample Budget**

*Supplies*

*General office supplies (pens, pencils, paper, etc.)*

<i>12 months x \$240/year x 10 staff</i>	<i>=</i>	<i>\$2,400</i>
<i>Educational Pamphlets (3,000 copies @) \$1 each)</i>	<i>=</i>	<i>\$3,000</i>
<i>Educational Videos (10 copies @ \$150 each)</i>	<i>=</i>	<i>\$1,500</i>
<i>Word Processing Software (@ \$400—specify type)</i>	<i>=</i>	<i>\$ 400</i>

**Sample Justification**

*General office supplies will be used by staff members to carry out daily activities of the program. The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Word Processing Software will be used to document program activities, process progress reports, etc.*

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**F. Other**

This category contains items not included in the previous budget categories. Individually list each item requested and provide appropriate justification related to the program objectives.

**Sample Justification**

*Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If the items are not self-explanatory and/or the cost is excessive, include additional justification. For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).*

**G. Total Direct Costs**                    \$ \_\_\_\_\_

Show total direct costs by listing totals of each category.

**H. Indirect Costs**    \$ \_\_\_\_\_

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement established with the Cognizant Federal agency. A copy of the most recent indirect cost rate agreement must be provided with the application.

**Sample Budget**

The rate is \_\_\_\_\_% and is computed on the following direct cost base of \$ \_\_\_\_\_.

<i>Personnel</i>	\$	
<i>Fringe</i>	\$	
<i>Travel</i>	\$	
<i>Supplies</i>	\$	
<i>Other</i>	\$ _____	
<i>Total</i>	\$	x _____% = Total Indirect Costs

## **Appendix D: Technical Assistance**

### **State resources available to grantees**

Projects supported by the Provider Grants Program may be provided the following supports, to the extent that a need has been clearly established in the grant application:

- Supervision to ensure compliance with federal antitrust provisions;
- Assistance in aligning with other testing models in the state;
- Assistance with appropriately attributing outcomes and savings to testing models;
- Overall monitoring of health care quality and access;
- Funding for specific activities;
- Technical Assistance:
  - Meeting facilitation
  - Stakeholder engagement
  - Data analysis
  - Financial modeling
  - Professional learning opportunities