

Model Testing Application Project Narrative

A. Description of the State Health Care Innovation Plan Testing Strategy

This proposal represents an opportunity for the State of Vermont to strengthen its infrastructure and capacity to implement and evaluate health care payment and delivery system reforms. Vermont's State Health Care Innovation Plan includes a range of reforms that are diverse in both scope and breadth and are based on evidence-based approaches to achieving the three principle aims of the Affordable Care Act and Vermont's Act 48: better care for individuals, better health for populations, and better control of growth in health spending.

Vermont proposes testing how to balance incentives and drive delivery system change using a range of population-based, collaborative, and individual-based reforms. Under the SIM grant, Vermont's payers (Medicaid and Commercial) will test three existing Medicare models: the Shared Savings Accountable Care Organization, Bundled Payments and Pay-for-Performance. By coordinating the testing and roll-out of these models across all payers and providers, including both health and long term care providers, Vermont will be able to address many limitations of previous reform pilots.

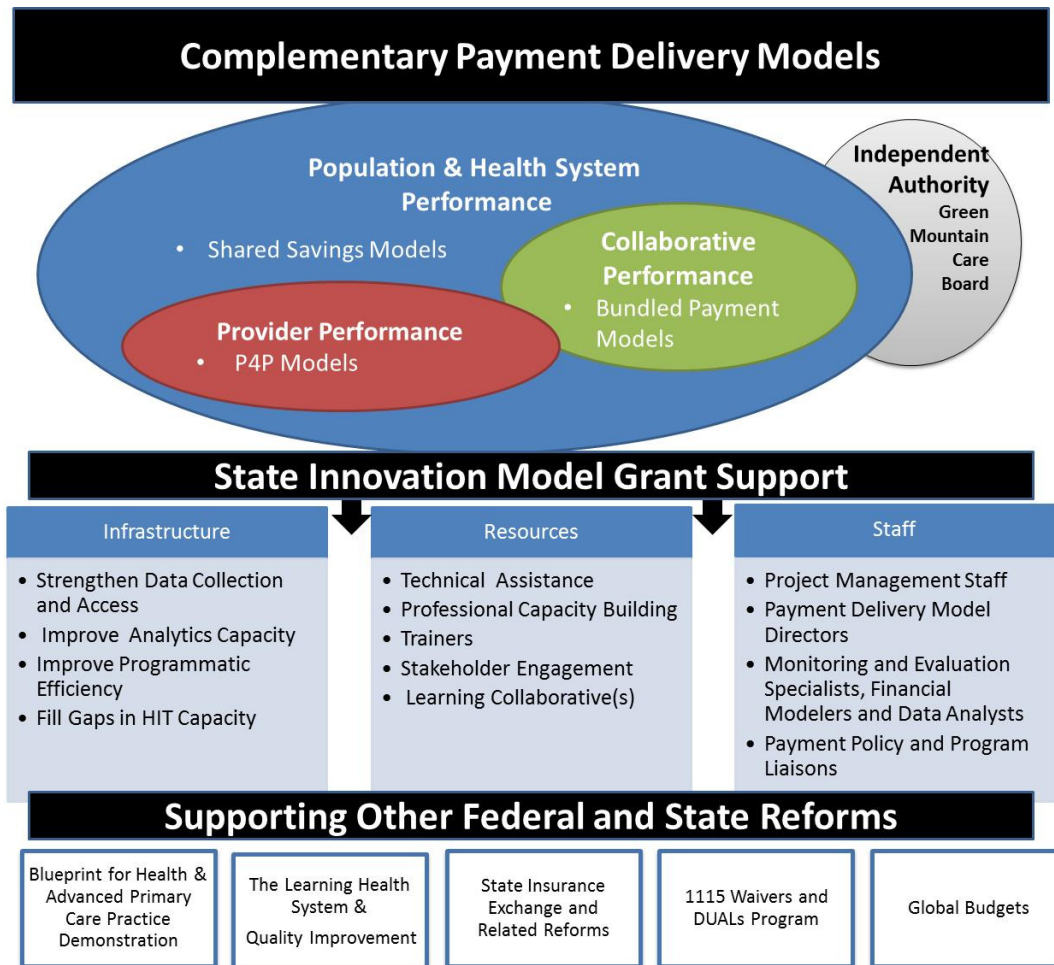
Vermont will leverage SIM funding to accelerate expansion and rigorous evaluation of these models, particularly within the Medicaid and CHIP program. The models will maintain beneficiary due process protections within Medicare, Medicaid and CHIP, and strive to improve both access and quality. Findings will help not only Vermont's long term strategy for reform

but also add to the body of evidence on effective and scalable health reform across broader payers and populations nationally.

Section B contains a detailed description of the three models being tested under the grant.

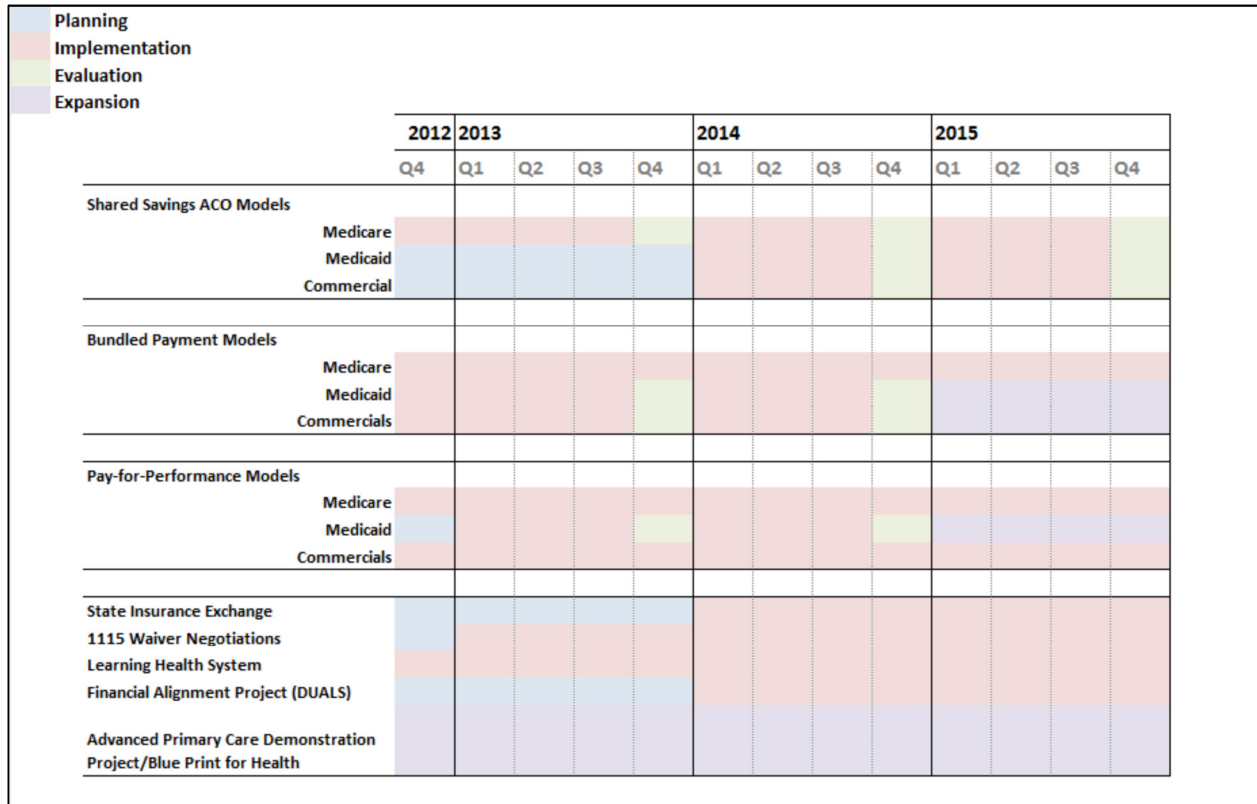
Figure 1 illustrates the model framework and how SIM grant funding will support their implementation and evaluation as well as coordination with ongoing federal and state programs and initiatives.

Figure 1. Vermont State Innovation Model Framework



We anticipate the following timeline for implementation of these models:

Figure 2. Timeline for Vermont Testing Model and Related Activities



Governor Shumlin has delegated submission of this grant application to the Agency of Human Services (AHS) and its Department of Vermont Health Access (DVHA). AHS is the Single State Agency for Medicaid and it designates DVHA as the unit responsible for the operation of the Vermont Medicaid Program. Medicaid programs for Vermont’s most vulnerable citizens (former 1915(c)) and other optional state plan services are managed across the member departments of AHS. In 2005, under an 1115 demonstration waiver and in state statute, DVHA was authorized to operate the bulk of the state’s Medicaid program as if it were a managed care entity. DVHA maintains Medicaid partnerships across state government through interdepartmental agreements to operate the Medicaid program using the Medicaid managed

care regulatory framework found in 42 CFR 438 et. seq. DVHA also houses the state's Division of Health Care Reform (including Health Information Technology planning) and the nationally recognized Blueprint for Health Multi-Payer Advanced Primary Care model (MAPCP). In addition, DVHA's state appropriation includes the spending authority for the state's second 1115 waiver, Choices for Care, operated by the Department of Aging and Independent Living. Choices for Care provides consumers in need of long term services and support with full choice between a home and community-based package of care or traditional nursing facility care. Both these 1115 waivers are nationally recognized for the breadth and scope of innovations aimed at improving access and quality of care while containing costs.

The Governor has directed DVHA to collaborate with the Green Mountain Care Board (GMCB) in overseeing and implementing grant-supported activities. The GMCB is the state's free-standing health care regulatory agency, with responsibility for approval of hospital budgets, small group and individual health insurance rates and certificates of need. The GMCB also has a statutory responsibility to develop and implement multi-payer payment reform policy, moving the state away from predominance of fee-for-service payments. It has the authority to implement all-payer and all-provider rate-setting, has final authority on the state's health information technology plan, its health care workforce plan and the benefits to be offered in the Health Benefit Exchange, and is charged with developing a "unified health care budget" for the state. AHS, DVHA and the GMCB will carry out the activities proposed in this application according to a mutually agreed-upon memorandum of understanding approved by the Governor's Office.

1. Model Purpose

Vermont's Act 48, passed in 2011, established an explicit state policy "to contain costs and to provide, as a public good, comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents in a seamless manner regardless of income, assets, health status, or availability of other health coverage." Vermont's proposed testing models will advance this goal. The three models we propose have four aims:

- I. **Increase both organizational coordination and financial alignment between Blueprint advanced primary care practices and specialty care**, including mental health and substance abuse services, long term services and supports, and care for Vermonters living with chronic conditions;
- II. **Implement and evaluate the impact of value-based payment methodologies** that encourage delivery system changes, improvements in care coordination and quality, and better management of costs;
- III. **Coordinate a financing and delivery model for enhanced care management and new service options for Vermonters dually-eligible for Medicare and Medicaid** with additional Medicare shared savings models, a Medicaid shared savings model and other models of population-based payment being tested in Vermont; and,
- IV. **Accelerate development of a Learning Health System infrastructure**, including: a reliable repository for clinical and claims data populated by a statewide digital infrastructure; statewide assessments of patient experience and team based services; ready access to comparative reporting and modeling; teams of skilled facilitators to support transformation; and an array of activities to support ongoing improvement. This

infrastructure will be designed to meet the needs of providers engaged in delivery system reform and the state’s needs for ongoing evaluation of the impact of reforms on health care quality, costs, patient experience and population health.

The table below summarizes the unique purpose of each model.

Table 1. Testing Models

Population-based Performance	Coordination-based Performance	Provider-based Performance
VT Shared Savings ACO Models	Bundled Payment Models	P4P Models
To support an integrated delivery and financing system for Vermonters through an organized network of participating providers who have agreed to align their clinical and financial goals and incentives to improve patient experience and quality of care and reduce cost.	To remove FFS incentives and replace with those which reward collaboration and evidence-based practices across specialties and primary care providers for targeted episodes or types of care which represent opportunities for high return on investment	To enable all payers, particularly Medicaid, to use P4P approaches to improve performance and quality of its health systems

2. Scope of the Models

The scope of the models, in terms of both service breadth and geographic coverage, varies. Our intent is to scale up all successful models, in a coordinated fashion, to serve Medicare, Medicaid and CHIP beneficiaries and commercially-insured Vermonters across the spectrum of physical health, behavioral health (including mental health and substance abuse services) and long-term services after the testing period. A variety of providers have expressed a willingness to participate in the models, including regional physician-hospital collaboratives, statewide networks and a statewide coalition of community health centers and federally-qualified health clinics. The following table describes the expected scope of each of models to be tested:

Table 2. Scope of Models

Population-based Performance	Coordination-based Performance	Provider-based Performance
VT Shared Savings ACO Models	Bundled Payment Models	P4P Models
<p>1. Medicare –Covers A & B costs for Medicare beneficiaries attributed to ACOs participating in Medicare’s Shared Savings Program.</p> <p>2. Medicaid—Covers all Medicaid costs for Medicaid beneficiaries attributed to ACOs participating in Medicaid’s Shared Savings Program including children covered under the CHIP program who are often served in the Blueprint’s expanded pediatric medical homes. This population also could include the Medicare related costs of dual eligible population if integrated with the Financial Alignment initiative for dual eligible beneficiaries.</p> <p>3. Commercial—Covers all costs for commercial beneficiaries attributed to ACOs participating in commercial payer Shared Savings Programs.</p>	<p>Vermont has several bundled payment pilots under development, two of which include Medicaid and Commercial payers:</p> <p>1. Approximately 300 oncology patients in St. Johnsbury health service area (HSA). The scope of services to be included in the pilot are primary care, specialty care and hospital care for all patients who meet pilot criteria and agree to participate in the program.</p> <p>2. Approximately 100 patients in the southeastern areas of the state receiving detoxification and additional services and treatment in inpatient setting.</p>	<p>1. Medicare—Under its value-based purchasing program, Medicare is phasing in P4P programs to cover all providers (e.g. the Hospital Value-based Purchasing Program and PQRS)</p> <p>2. Medicaid—Building on Medicare and commercial payer efforts to expand P4P to all providers serving all Medicaid beneficiaries.</p> <p>3. Commercial—Commercial P4P programs vary in scope and reach.</p>

3. Description of the Models that Will be Tested

The three models to be tested are outlined in the table below. All closely mirror those being tested by Medicare and are actively addressing limitations in previous pilots. In each case, the models will help build provider capacity to report and act on performance data and better manage population health and, in the case of shared savings and bundled payments, the models will help prepare providers for more advanced forms of payment models that involve performance accountability and financial risk.

Table 3. Description of Models

Population-based Performance	Coordination-based Performance	Provider-based Performance
<p>VT Shared Savings ACO Models</p> <p>Under this model, payers contract with provider-led organizations who agree to take responsibility for the quality and costs of care for a defined population. The model is meant to increase accountability through sharing risk with providers and provide positive financial incentives, in the form of shared savings, for improving the organization and delivery of care.</p> <p>There currently are two provider-led Medicare shared savings accountable care organizations under development in Vermont.</p> <ul style="list-style-type: none"> • A Hospital-centric ACO: Fletcher Allen and Dartmouth-Hitchcock, 12 of Vermont's Community Hospitals, 3 FQHCs and a number of independent physicians have collaborated to apply to become an ACO under the CMS SSP. If approved, this would be operational 1/1/2013. • An IPA-centric ACO consisting of @ 100 physicians statewide received designation as a CMS SSP-ACO beginning July 1, 2012. <p>In addition, six of the State's eight Federally Qualified Health Centers (FQHCs) are organizing a Medicaid and Commercial SSP-ACO.</p> <p>These organizations will be invited to participate in state ACO programs for Medicaid and commercial payers that will be developed under the SIM grant.</p>	<p>Bundled Payment Models</p> <p>Under this model, volume-based incentives are replaced with episodic-based payments which encourage collaboration and efficiency across providers and systems. The model also better controls growth in spending by targeting the top drivers of spending.</p>	<p>P4P Models</p> <p>Under this model, volume-based incentives are replaced with incentives for improving quality and efficiency of care.</p>

4. Value Proposition and Performance and Improvement Objectives to be Achieved

We believe these models have the potential to improve health and health care while reducing costs by: supporting person-centered services and shared decision-making, allowing flexible use of resources to truly manage and coordinate the care of patients and incentivizing performance through value-based payment strategies that specifically tie payment to performance and give providers the potential to share in savings based on the care they provide. The table below summarizes the unique value proposition and performance objectives

of each model. The performance objectives and standards for each of the models will be defined further by the state in collaboration with providers, payers and other stakeholders as part of this project. Our State Innovation Plan provides more detail on our efforts to date to develop standards for payment reform models.

Table 4. Value Proposition of the Models

Population-based Performance	Coordination-based Performance	Provider-based Performance
VT Shared Savings ACO Models	Bundled Payment Models	P4P Models
<p>The SSP models provide a framework for providers to transition to two sided risk models by 2016. SSPs also offer a way to bridge the gap between medical service providers, behavioral health and substance abuse providers and providers of long term services and supports by incenting cooperation and accountability through the potential for shared savings resulting from improved care coordination, delivery of high quality and cost effective care, and an increased focus on prevention and wellness.</p> <p>Specific objectives include:</p> <ul style="list-style-type: none"> • Improve care coordination; • Reduce utilization of preventable and unnecessary services • Improve adherence to clinical standards • Integrate EHRs analytics • Reduce the growth of total cost of care • Improve consumer experience 	<p>The bundled payment models complement the other models by rewarding essential specialty care providers coordinating with the PCMHs.</p> <p>These models have the potential to have targeted impacts between providers whose coordination with primary care improves quality and reduce costs for targeted, high return on investment episodes of care.</p> <p>Specific objectives include:</p> <ul style="list-style-type: none"> • Improve system organization • Reduce duplication and maximize system resources • Improve care coordination among specialists and primary care providers • Improve quality and reduce long-term costs • Improve consumer experience 	<p>These programs will complement shared savings programs by allowing individual providers to be rewarded for their contribution to increased quality and outcomes for the people they serve.</p> <p>By ensuring population and individual rewards for quality, the alignment of financial incentives for each provider is better balanced.</p> <p>Specific objectives include:</p> <ul style="list-style-type: none"> • Payment increasingly based on value • Quality reporting, measurement and evaluation of outcomes improvements • Improve care delivery and coordination • Improve consumer experience

5. Evidence Basis for Testing the Models

There is growing evidence of the success of patient-centered medical homes and the value of care coordination and disease management both nationally and in Vermont [1-16]. Over the past year, findings from the first wave of CMS and CMMI-sponsored demonstration programs

have provided both evidence of their potential and limitations that must be overcome [3, 5, 10, 17-19]. Vermont will proactively address shortcomings identified in previous pilots and build on the body of evidence about the potential for these models to transform care and improve system performance. Evidence in support of these models is summarized below.

Table 5. Evidence Base

Population-based Performance	Coordination-based Performance	Provider-based Performance
VT Shared Savings ACO Models	Bundled Payment Models	P4P Models
<p>Evidence on Accountable Care Organization (ACO) shared-savings models suggests significant potential for improving quality and lowering costs. In Medicare’s Physician Group Practice Pilot (PGPP) Demonstration substantial quality gains and savings were achieved for some participants; most savings were found among dually eligible beneficiaries [2, 5].</p> <p>Blue Cross Blue Shield of Massachusetts’ (BCBSMA) Alternative Quality Contract (AQC) employs a global payment as a strategy for improving quality and reducing the annual rate of growth in health care spending. Payments are tied to quality, performance, and outcome benchmarks over a five-year period. The AQC reports lowered costs and improved quality after year one. [2, 3, 5, 10]</p> <p>A global budget facilitates clinical and technological integration and allows for evidence-based care to be coordinated across settings [17, 20-22].</p>	<p>Bundled payments show substantial promise for delivering savings and improved quality both as a stand-alone tool and as a component of a global budget [23, 24].</p> <p>A study by the Agency for Healthcare Research and Quality (AHRQ) of 20 bundled payment interventions found that the introduction of bundled payments was associated with reductions in health care spending and utilization[25].</p> <p>Bundled payments also have been proven effective in strengthening care coordination and quality measurement[26]. The strength of bundled payments as a cost containment and quality improvement device may be improved if employed across providers and care settings to be consistent with Vermont’s proposed integrated healthcare system.</p>	<p>Used in conjunction with shared savings and bundled payment models, P4P adds a strong incentive for interdisciplinary provider teams to coordinate care [27, 28].</p> <p>A literature review suggests some positive effects of financial incentives at the physician, provider group, and health care payment system levels. Pay-for-performance programs must be accompanied by ongoing monitoring and evaluation to ensure that financial incentives do not have an adverse effect on health care quality and access[29]. Vermont has key evaluation infrastructure for monitoring P4P already in place, and will improve upon this infrastructure.</p> <p>Geisinger Health System ties total physician compensation to performance incentives that are defined annually for each type of clinician. Claims data from a regional health plan demonstrate that physicians directly employed by Geisinger have improved quality and efficiency faster than other physicians in the same health plan’s network[30].</p>

6. Theory of Action

Our theory of action combines public policy levers, public and private leadership and financial incentives to create cultural and organizational change that measurably affect the three goals of reduced cost growth, improved population health and improved consumer experience.

Combined these three models will better achieve our desired outcomes than any of them in isolation or deployed in an uncoordinated manner. Below is a summary of the theory of action underlying each model.

Table 6. Theory of Action

Population-based Performance	Coordination-based Performance	Provider-based Performance
VT Shared Savings ACO Models	Bundled Payment Models	P4P Models
<p>This program will incent the formation of accountable, integrated provider-led networks of care which will include qualified providers who collectively work towards improving quality and managing rising costs.</p> <p>The program also prepares these providers to move over time towards more predictable and controlled payment models where both payer and providers share the risk of escalating costs. This program also complements other financial models because it focuses on broad population health improvement across the full continuum of medical, mental health, substance abuse, and long term services and supports.</p> <p>In the long term, having multi-payer shared savings pools equitably distributed based on the achievement of both expenditure targets and quality performance measures will provide sufficient incentives that will lead to a more fully integrated person-centered delivery system. As these networks work to meet both expenditure targets and quality performance measures, the result will meet the needs of Vermonters in a comprehensive, cost effective, and coordinated way.</p>	<p>Bundled payment models incent coordination among primary and specialty care providers on targeted high-cost episodes of care.</p> <p>The payment models remove volume-based FFS incentives and replace them with rewards for efficiency and quality of care.</p> <p>In the long terms, moving a large proportion of high cost episodes under a bundled payment will help provide payers a mechanism to better control costs.</p>	<p>These programs increase the individual providers' accountability for the quality and cost of care.</p> <p>It also ensures that dollars are maximized to reward those systems and providers that provide the best care and outcomes for the population served.</p> <p>Having P4P models also ensure that even if an individual provider does not share greatly in savings, that their contribution to better outcomes is rewards and continually incented.</p>

These models will be coordinated with the following related state-level payment reform efforts, as well as federal initiatives (described under #7 below):

- The state's 1115 waiver renewals;
- A proposed initiative to improve care to individuals dually eligible for Medicare and Medicaid beginning January 2014; and
- GMCB's effort to implement global budgets for up to two of the state's 14 hospitals beginning in October 2013.

These initiatives are described in greater detail in the State Health Care Innovation Plan.

7. Other Federal Initiatives in the State and Plans for Coordination

Vermont is one of eight states participating in the Centers for Medicare and Medicaid Innovation's **Multi-payer Advanced Primary Care Practice (MAPCP) demonstration project**. Through the MAPCP demonstration, called the Blueprint for Health in Vermont, Medicare participates along with Medicaid and commercial payers and provides Vermont's participating primary care practices recognized as patient-centered medical homes (PCMHs) with an enhanced per patient per month (PPPM) payment based on an independently derived NCQA quality score. In addition, MAPCP shares in the costs of the Blueprint's Community Health Teams (CHTs) and provides significant funding for Vermont's Support and Services at Home (SASH) program, which provides additional support for high-risk Medicare beneficiaries. The Blueprint is the foundation for high quality primary care and as such is the underpinning of proposed health care payment reforms and delivery system innovations in Vermont.

Vermont submitted a proposal to the federal government in May 2012 for a **demonstration waiver related to “dually eligible” individuals**. Vermont currently manages all Medicaid dollars associated with the nearly 22,000 dually eligible Vermonters as if it were a managed care organization under its two 1115 waivers. Under the proposal, the State of Vermont would also assume responsibility for Medicare dollars. As described in further detail in the Innovation Plan, the foundation of this duals demonstration relies on the establishment of an integrated *person-directed* delivery system based on payment reforms and full integration of care and is in alignment with the goals of this SIM proposal.

As envisioned, payment reform in the duals project will be achieved through Vermont’s existing managed Medicaid structure under the Global Commitment to Health Waiver. The state will receive a prospective blended capitated rate for the full continuum of Medicare and Medicaid benefits. The goal of the Dual Eligible project is to improve outcomes, enhance quality, and control costs by providing integrated and person-centered care through integrated care providers (ICPs). Vermont hopes to enter into a Memorandum of Understanding (MOU) with CMS during CY 2012, followed by a contract in 2013 and implementation in January 2014. An important element of the proposal outlined here is development of plans for integrating the duals project’s payment and service delivery models with the Medicare Shared Savings ACO, to which some Vermont Medicare beneficiaries already have been attributed and more will be attributed beginning January 1, 2013. Key questions for Vermont include: will payment models for ACOs and duals ICPs be integrated or separate?; if separate, how will the state maximize

continuity of care from the beneficiary perspective?; how will savings be achieved and, if achieved, shared across the models?

8. Plan for Sustainability of the Models after the Testing Phase

We expect that work under this grant will lead to:

- valid testing of the proposed payment and delivery models;
- capacity-building for providers who operate under a shared savings model to assume greater financial and performance risk in the future; and
- capacity-building to scale the other payment models (other than shared savings) to a broader array of services, providers and areas within the state.

Through collaboration with stakeholders and policymakers, models that are successful and scalable will be incorporated into Vermont health care delivery and financing through changes in statewide policy through the authority of the GMCB and Medicaid payment policy. The next stage of health reform implementation also will take into account any mid-course corrections, additional policy actions necessary (such as provider rate-setting and risk adjustment across providers) and early experience from the reformed insurance market under the Health Benefit Exchange.

9. Potential to Replicate the Service Delivery Models in Other States

Vermont's models are both useful and valuable as a demonstration because the approach is replicable, scalable, and based on emerging best practices in person-centered care.

Vermont's proposed model for testing focuses on three specific initiatives that are currently being tested on smaller scales across the country – the advanced primary care medical home

model, the shared savings ACO model, and bundled payments that encourage provider integration for specific patient populations and services. Additionally, development of oversight for integrated provider networks in the form of ACOs, along with support and measurement of other value-based purchasing strategies on a statewide basis will provide other states with an important understanding of the potential of these models.

10. Communities that Will Be the Focus of Model Testing, and Plans for Roll-out

See scope of models described above. All models are intended ultimately to be statewide, but some of the bundled payment initiatives are more regionally-focused at the outset.

11. Likelihood of Success and Potential Risk Factors

Vermont is confident in the ability of this testing model to proceed. We have to our advantage: a strong history of collaborative health reform with CMS and within the state; strong state authority to manage health care costs, quality and resource allocation; considerable provider community enthusiasm and leadership for payment and delivery reform; multi-payer participation in reform efforts; experience through CMS waivers with bundled payments for smaller sub-specialties; and, continued multi-stakeholder involvement in shaping Vermont's health reforms.

While we are confident in our ability to succeed, we also are keenly aware of a number of risks that we have attempted to address through our funding request. Specific risk factors and the strategy for addressing them are included in Table 7 below.

Table 7: Potential Risks and Strategies to Address Within the SIM Grant

Potential Risks	Strategy to Address/Mitigate
Defining and reporting measurable results	Vermont will build off its current measures and work to improve its reporting infrastructure to improve the capacity and sophistication of the reporting to allow for more robust measurement of the model’s success.
Engagement of high-risk enrollees in care	To support its testing model, Vermont proposes to utilize SIM funds to implement a statewide public health campaign focused on the importance of engagement of individuals in their care; in addition Blueprint CHTs and extenders will continue to focus efforts on engaging high risk enrollees in their care.
Attribution and churning	In determining how to attribute savings across models, including the SIM testing model and the State’s Dual Eligibles project, the state will develop a specified attribution methodology that works in the aggregate to address appropriate attribution and churn.
Incentive imbalances within the payment system and across payers	In developing criteria for ACOs, Vermont will include criteria aimed at requiring balanced incentives with the payment system and across payers to appropriately compensate providers across the continuum of care for their role in the management and care of an individual.
Lack of robust evidence for definitive practices	Vermont will continually review the results of its own work as well as conduct ongoing literature reviews and interviews with key experts to keep as up to date as possible on evidence that support best practices.
Need to tailor strategies to specific populations and program requirements	While there are advantages to building off existing, proven program structures and requirements, the special needs of the Medicaid population, especially those of people requiring long term services and supports may call for adjustments beyond those already in use by commercial payers and/or Medicare.
Pressure on AHS/DVHA as state Medicaid agency given competing priorities and potential need for short-term budget savings	The SIM funding will provide much needed staff and consultant support to AHS/DVHA to accelerate the implementation of the strategies included within the testing model.
Historical silos across state agencies that serve single population	Vermont’s 1115 Waivers have provided departments and state agencies with the opportunity to work collaboratively with regards to budget and finance plans. Through this grant AHS/DVHA and GMCB will co-chair an internal group that will serve as a forum to allow for integrated policy discussions and unified solutions that promote our statewide goal.
The complexity of implementation and multi-payer coordination as well as incorporating planned state insurance exchange plans into consideration.	The GMCB will continue to work closely and collaboratively with AHS/DVHA and with the state’s major health insurers to address implementation and coordination issues. In addition, because DVHA is responsible for both the SIM grant and the implementation of the Exchange and GMCB is responsible for payment reform across the state, they will ensure the alignment and coordination of the plans to be offered in the Exchange with the SIM testing model.
A concern that providers with a high Medicaid population who have less experience integrating all aspects of healthcare in their coordination efforts and sharing risk may delay uptake of reform.	Through the SIM grant, Vermont will provide infrastructure support and technical assistance to all Medicaid enrolled providers to support robust care coordination and potentially risk sharing.
Most Medicaid reimbursement	The SIM grant will support the move of Medicaid from fee-for-service to

continues to be based in FFS methodologies; there is not yet a comprehensive system which includes quality as a dimension of payment.	value-based purchasing strategies by leveraging strategies used and being developed for Medicare and the commercial market. Additionally, improved HIT infrastructure will allow greater opportunity for measurement of quality and outcomes, ultimately tying both to payment.
Strong relationships between hospitals, acute care, mental health, substance abuse, and long term services and supports providers are not universal.	Vermont will be identifying gaps and possible collaborations among stakeholders in an ongoing manner and will work with providers in fostering relationships that can lead to better care and health outcomes due to collaboration among stakeholders.
Ensuring ongoing stakeholder support and education for reform.	Vermont will utilize its existing stakeholder groups and advisory boards, particularly the GMCB and the Medicaid and Exchange Advisory Board to keep stakeholders informed of the progress in implementing the model and outreach and education opportunities.

12. Current Clinical Quality and Beneficiary Experience Outcomes and Specific

Improvement Targets

Vermonters receiving coverage through Medicaid and CHIP give the program high marks in terms of access to care, discussion with personal doctor, and coordination. In the 2011 CAHPS survey of Vermonters covered by Medicaid:

- 84% reported obtaining urgent care right away; and 88% reported obtaining non-urgent care within time needed;
- 98% reported receiving information on choice of treatment and 64% reported discussing prevention of illness with their personal doctor;
- 93% reported that their doctor provided easily understandable explanations, and that their doctor listened to them; and,
- 82% reported that their personal doctor was up to date on other care received; and 89% of those receiving care coordination services reported that the care coordinator provided the help that they needed.

Vermont also tracks its Medicaid and CHIP performance against HEDIS measures. The state performs near or at the national Medicaid average for well-child visits, and substantially above

for treatment of asthma and upper respiratory ailments in children, and follow up for children on ADHD medications. However, Vermont has lower than average performance in terms of cancer screening rates, diabetes treatment and timeliness of prenatal treatment.

In addition to the specific improvement targets included in Healthy Vermont 2020, the state will aim to achieve the following improvement targets under this Testing Model:

- Improved access to care in terms of obtaining both urgent and non-urgent care when needed;
- Improved patient experience with care coordination;
- Improvements in specific clinical process and outcome measures tracked by the Blueprint for Health including (not limited to):
 - Proportion of patients at goal for treatment of chronic conditions for a number of chronic conditions (e.g. Blood Pressure, Cholesterol, LDL, Hgb A1c, Lung Function)
 - Proportion of patients with chronic conditions who have a recorded self-management goal along with tracking of progress against the goal over time
 - Proportion of children with age and gender appropriate assessments as recommended in Bright Futures
 - Proportion of adults with age and gender appropriate assessments and treatments as recommended in national guidelines
 - Adolescent Well-Care Visits, by Age Group
 - Well-Child Visits, by Age
 - Adults' Access to Preventive/Ambulatory Health Services, by Age Group
 - Several measures of cancer screening (breast, cervical, colorectal)

- Chlamydia Screening in Women, by Age Group
- Diabetes Care – several measures
- Cholesterol Management for Cardiovascular Condition
- Use of Appropriate Medications for People With Asthma, by Age Group

13. Current Population Health Status

Both the Commonwealth Fund and the United Health Foundation most recently ranked Vermont as the healthiest state.¹ Vermont's strength includes high rates of high school graduation, high rates of pre-natal care, low rates of violent crime, and low incidence of infectious disease. Challenges include high rates of binge drinking and moderate rates of immunization. Despite these generally positive scores, too many individuals residing in Vermont continue to suffer from conditions that are largely preventable. Vermont's State Health Assessment (Healthy Vermonters 2020) describes priority indicators that have been chosen by public health, health care and human services professionals as important areas of focus for improving the health of Vermonters over the next decade. Examples of objectives are:

- Increase the % of adults who meet physical activity guidelines from 59 to 65%.
- Reduce coronary heart disease deaths from 112 to 99 per 100,000 people.
- Increase the % of adults who receive recommended colorectal cancer screening from 71 to 80%
- Reduce hospitalization for asthma in children under 5 years of age from 18.8 to 14 per 100,000 people.

¹ See Commonwealth Fund 2009 Report Card on State by State Status; accessible at <http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/State-Scorecard.aspx>. See also United Health Foundation's America's Health Rankings 2011, accessible at <http://www.americashealthrankings.org/SiteFiles/Statesummary/VT.pdf>.

- Increase the % of children age 19-35 months who receive recommended vaccines from 41% to 80%.
- Reduce the % of 12-17 year olds who binge drink from 11 to 10%.

Based on analysis of the Healthy Vermonters 2020 indicators, three overarching priority areas for health improvement were identified by public health and external stakeholders and will be part of Vermont’s 2012-2015 State Health Improvement Plan:

- Reduction of the prevalence of chronic disease through improving physical activity, nutrition and decreasing the rates of tobacco use;
- Reduction in the prevalence of Vermonters with or at risk of substance abuse and/or mental illness; and,
- Improvement of childhood immunization rates.

Too many Vermonters, especially younger, less educated, minority and lower income citizens, experience real differences in years of healthy life when compared to the general population.

These disparities are summarized in table 8.

Table 8. Health Disparities by Income, Vermont, 2010

Disease	% adults with income more than 2.5 times poverty level	% adults with income less than 2.5 times poverty level
Diabetes	4%	8%
Heart Disease & Stroke	5%	11%
Asthma	8%	13%
Obesity	21%	28%
Depression	16%	34%

14. Waiver Authorities that Exist, and any New Waivers or State Plan Amendments

Necessary

The State is preparing for renewal and extension of its Global Commitment to Health Waiver and intends to extend its current Medicaid managed care regulatory structures. Under this structure the state has considerable flexibility to ensure access to care and network adequacy as well as to utilize various reimbursement strategies not limited to those found in the state plan. Under this waiver, assuming all covered service obligations are met, the state may use what would be considered “excess capitated revenue” in a private MCO to invest public funds in activities that improve the health outcomes of Vermonters. To date, these investments have included a wide range of approaches to improvement of care including incentive payments to providers who achieve targeted outcomes and programs that adopt a public health approach. The state will need to maintain and enhance those authorities to ensure successful CMMI outcomes envisioned in this proposal. In addition the state will need to work with CMMI to ensure authorization and access to necessary Medicare data as part of this project.

15. Extent to Which Models Can be Implemented If Waivers or Approvals are Not

Provided

We believe most, if not all, of the innovations we propose can be implemented under Medicaid and Medicare waiver or demonstration authority previously granted to the state. Broader Medicare data use authority will be critical to our success in implementing the data integration platform and analytics described below.

16. Additional Targeted Improvements Not Described Above

In addition to support for implementation of the models described above, we are seeking grant support for key investments in “health system infrastructure” within Vermont that cuts across all the models. We propose six types of targeted improvements in Vermont’s health system infrastructure (all directed at AIM #4). These are:

- Improved clinical and claims data transmission, integration, analytics and predictive modeling;
- Expanded measurement of patient experience;
- Improved capacity to measure and address health care workforce needs;
- Targeted efforts to enhance Vermonters’ understanding and active management of their own health;
- Learning health system activities; and
- Investments in enhanced telemedicine and home-monitoring capabilities.

Each of these initiatives is described in more detail below.

Improved clinical and claims data transmission, integration, analytics and predictive modeling

Vermont has in place four central elements of an integrated health data system:

1. A multi-payer claims dataset (VHCURES) that contains claims from public and private payers and has been mapped to key measures of utilization, expenditures and quality tracked by the Blueprint for Health;
2. A statewide health information exchange (VHIE) with capacity to produce care summaries and continuity of care documents (CCD), lab and other diagnostic reports,

demographics related to admissions, discharges, and transfers and to query or pull clinical data from participating providers' Electronic Health Record (EHR) systems;

3. A "central registry" that captures a defined set of clinical data from Vermont health care practices;
4. Trainers who work with individual provider sites to develop the data input capacity and quality controls necessary to produce reliable data sets for analysis and feedback.

These data resources provide a strong foundation to support the data needs of integrated provider networks as they expand throughout the state. The state is actively working with payers and providers to expand HIT adoption and HIE connectivity statewide, building on a seven year base of planning, consensus building, governance refinement, and early implementation of a standards-based technical architecture. The SIM grant provides the opportunity to further enhance and integrate these technologies for greater connectivity among providers, patients, and support services in the community. Specific enhancements under this project will include:

A. Expanded capacity for transmission of high quality clinical data from EHRs and other sources to the Vermont Health Information Exchange (VHIE) and the central clinical registry.

Vermont recognizes the critical importance of immediately available and actionable clinical and claims data that allows providers the opportunity to evaluate their performance and identify opportunities for improvement using clinical and claims data that is structured, reliable, and sufficiently complete to support their efforts. Current data capture and quality work is guided by the Blueprint's core data dictionary and measure set. Facilitators work with lead clinicians at

each site to optimize capture of guideline-based elements in EHR (and other) systems as part of routine care. The SIM grant will be used to enhance and speed up this end-to-end data capture and quality improvement process; to support mapping of tracking system templates against the core data dictionary, enhance clinical flow to optimize use of tracking systems; and to provide increased capacity within the VHIE and central registry. A high-priority focus for this effort will be assuring efficient and reliable data capture related to quality measures that are embedded in the testing models proposed in this application.

B. Accelerated development of an integrated data platform to support more advanced

analytics, modeling, and simulations. Vermont's foundation includes a maturing set of data sources across an array of domains. These include VHCURES claims data and clinical data from the VHIE and the centralized registry. There are other data sources that are important to fully understand health. Vermont is dedicated to bringing data from an array of disparate sources into an integrated platform to support the most advanced assessments of health, wellness, quality of services, and costs. Data sources we intend to add include: the hospital discharge data set, nursing home Minimum Data Set, home health Outcome and Assessment Information Set, the Social Assistance Management System for long term support and services, the Developmental Disabilities and Mental Health Monthly Service Report, the Alcohol and Drug Abuse Programs reporting systems, and Public Health registries and reporting systems, as well as the expanded scope of clinical data that will be available through expansion of the registry's data dictionary and other clinical tracking systems.

Our plans include implementation of one or more integrated informatics platforms and establishment of routine methods for complex data management to populate these platforms. The SIM grant will support: health analytics and informatics platform software and interfaces necessary to merge clinical, administrative, and claims data; data mapping and normalization across those source systems for its use in the integrated data platform; secure transmission networks; and data management and quality assurance within the platform(s). Currently, the Blueprint, GMCB, and other state users have limited capacity to evaluate outcomes with data from each discrete source. Vermont would like to enhance data integration, analytic capacity, and modeling sophistication.

C. Development of predictive models and simulations to guide a learning health system. The SIM grant also offers the opportunity to contract with top experts in the country to support advanced analytics and predictive modeling, including health services researchers, health economists, and actuaries. Given the scope of Vermont's data sources, and the plan for integrated data platforms (described above), the goal would be to employ a broad range of expertise to go beyond traditional boundaries including experts from the social sciences and other domains that are important to human health and wellness. The results of this work will include algorithms and models that can be programmed into the reporting platforms that overlay Vermont's data sources. It also will include clear methods for generating comparative groups and adjusted outcomes, methods that will evolve as Vermont gains access to claims data from outside of the state.

Expansion of patient experience survey capacity including intensified sampling of targeted populations and additional content for specific health services interventions.

Currently, the University of Vermont (UVM) evaluation team is an official surveyor for the NCQA PCMH CAHPS based Patient Experience Survey. They are conducting statewide sampling to evaluate patient experience in the Blueprint. The SIM grant will be used to intensify targeted sampling to determine the impact of specific payment and delivery reforms on a person's experience. This may include expanded use of mail and internet sampling, and the addition of phone based sampling. In addition, we intend to add to our data-gathering tools a cutting-edge patient engagement measurement instrument developed by John Wasson at The Dartmouth Institute.

Improved capacity to measure and address health care workforce needs.

Vermont has been engaged in health care workforce development since the mid 90s when the first physician licensing survey was implemented. The first health care workforce development plan was completed in 2004 and took a broad look at over 35 health professions. Common themes in workforce planning have been assuring a safe, adequate, well distributed health care workforce, but lack of data – on both supply and demand – is a constant barrier to this work.

We seek to address this critical need through this grant.

A major focus of the activities defined within this proposal concentrate on development of health care professional surveys for all health professions, as well as collection of demand-side data related to Vermonters' access to care. We will employ three specific strategies:

Strategy #1: Improve workforce planning and monitoring through the collection, analysis and benchmarking of health care workforce data. Vermont will work with each of the targeted health professional licensing boards (up to 40) to adapt the national minimum data set requirements of each specific profession to meet Vermont's health reform goals. We will program the minimum data set survey into licensing and registration processes. Each year of the grant, we will target a new cohort of professions. Also, we will engage consultants to extract data from the online licensing data set so that it is accurate and meaningful and to improve metrics and benchmarks of workforce need. The development of these metrics in conjunction with the analysis of health care workforce licensing data will provide the supply and demand data necessary to target specific professions and the geographic areas of high need with strategic recruitment and retention activities.

Strategy #2: Improving workforce depth and strength through job retention services and training of direct care staff workers. We propose to implement the Personal and Home Care Aide Training (PHCAST) Program, in collaboration with Department for Children and Families. The training of personal and home care aides is an essential element in the provision of quality care to families coping with children and other family members who have mental illness, disabilities and/or life limiting conditions as well as people choosing to live as independently as possible who are older or may have a severe mental illness and/or other disabilities. The PHCAST program would ensure competent personal and home care aides with acquired skills that would be transportable to any job market in the nation, thus strengthening the direct care worker workforce.

Strategy #3: Add to Existing Consumer-Based Data Collection Measures of Access to Care, Barriers to Care and Gaps in Provider Supply. Vermont conducts a household health insurance survey by phone on an annual basis. The survey gathers information about household demographics, health insurance coverage and health care costs. We propose adding to that survey a rigorous assessment of barriers to care, highlighting any gaps in provider supply from the demand side. We will design survey questions to allow for comparison with available benchmarks, such as the Massachusetts Health Insurance Survey, and will assure both an adequate sample size and appropriate questions to assess barriers to accessing specific types of professionals, including primary care practitioners, specialists and mental health and substance abuse practitioners.

Taken together, these initiatives will provide Vermont with a rich source of information to assess health care workforce needs, improve the supply of LTSS workers and track the impact of reforms on workforce strength.

Targeted efforts to enhance Vermonters' understanding and active management of their own health.

Vermont's State Health Improvement Plan describes key priorities for reducing the prevalence of chronic disease among Vermonters including increased physical activity and improved nutrition, smoking cessation, improved mental health and decreased use of alcohol and drugs.

Through the SIM funding, Vermont proposes two engagement initiatives:

1. Vermont's Health Portal: Vermont proposes to design and implement a web portal (with links to the Health Benefit Exchange) that will guide consumers to resources that meet their unique health needs, using a Health Risk Assessment (HRA) as an entry tool. With the explosion of Internet accessibility, online delivery offers potential for significantly greater reach of evidence-based health promotion and chronic risk factor management programs for adults. There is evidence that community wide campaigns that include a combination of HRA, health education and social supports are effective in increasing physical activity, improving nutrition and reducing smoking prevalence (CDC Community Guide). Using the results of the HRA to steer any individual immediately to educational materials and online or community level resources and social supports (such as Blueprint primary care practices and Community Health Teams) will promote healthy behaviors that respond to the unique risk factors identified in the HRA. Local resources would be highlighted including Healthier Living Workshops currently offered through the Blueprint Community Health Teams, and recreational programs supported by Department of Health district offices and local health and wellness coalitions.

2. Public engagement in appropriate use of health services: Increasing use of preventive services and other cost saving and effective clinical interventions depends both on the health care system's ability to deliver appropriate services as well as people's understanding of the benefits of preventive and other services and their motivation and ability to access services and make good healthcare decisions. Vermont proposes utilizing SIM funding to develop and implement a social marketing media campaign that encourages healthcare consumers to engage in their own health by being more proactive about making appropriate health decisions.

By promoting preventive services, better information about other medical services and testing, and shared decision making between patients and their healthcare providers, we will support the state's goal of increasing the appropriate use of health care resources among Vermonters. Resources will include the *Choosing Wisely* campaign and Shared Decision Making tools that help physicians, patients and other healthcare stakeholders think and talk about the best use of health care resources. Vermont will launch two campaigns (television, radio, print and social media) a year which will include the following: promotion of specific preventive services with a focus on those services most aligned toward decreasing the most expensive health conditions; promotion of tools for the public and patients on *Choosing Wisely*, and promotion of health care decision tools and other resources for patients and providers.

These efforts will be guided by a work group that involves representatives of provider groups, payers and consumers, as well as state leaders responsible for development of the Health Benefit Exchange. The charge of the workgroup will be to coordinate direct-to-consumer outreach, messaging and diffusion of self-management tools with clinical and insurance market interventions for consistency and maximum impact.

Learning Health System Activities

Expanded team of skilled facilitators to support transformation and ongoing cycles of continuous improvement. The Blueprint has established a team of Practice Facilitators to support primary care practices as they prepare to be scored against the NCQA PCMH standards. These facilitators also support practices and CHTs with ongoing data-guided improvement. The

SIM grant will scale this asset as new payment strategies are tested. This will include an increase in the number of facilitators, as well as the resources and training necessary to assure a high functioning team. Vermont will work closely with CMMI to assure that the facilitators' work, training, and methods reinforce the goals of the payment reforms and health services models that are being tested. Vermont will also continue to work with leaders in the US and Canada to assure that best practices are adapted as they are identified in AHRQs practice facilitation demonstration, and from the growing number of facilitator programs in both countries.

Enhanced shared learning forums at the local, regional, and state level. The Blueprint directly supports an array of shared learning forums in Vermont. Examples include: Integrated Health Services Workgroups in each Health Service Area (HSA); regular meetings of Blueprint Project Managers and Practice Facilitator Teams from each HSA for problem solving and identification of best practices; and the Blueprint Annual Conference which brings together local and national leaders. As new payment reforms and service models are tested, it will be necessary to expand the number and type of shared learning forums at the local, regional, and state level. For example, a near term plan to add in a structured network for Substance Use and Mental Health, with supportive payment reforms, will require new learning forums along with comparative performance reporting to guide ongoing improvement. The SIM grant will provide the opportunity to establish, test, and refine these forums along with other communication strategies.

Investments in enhanced telemedicine and home-monitoring capabilities.

Patient transfers among acute care hospitals can be among the most important transitions for delivering cost effective care. Transfers that occur and could have been safely avoided are costly in many ways. Conversely, a patient with complications or potential for deterioration that is not appropriately transferred for advanced care often end up among the most costly outlier cases. As part of Vermont's efforts to develop a more integrated health care delivery system, we will provide support for piloting telemedicine technology, and propose to implement a telemedicine transfer consult program to determine medical necessity of inter-facility transfers among Vermont's hospitals. In addition, we will pilot implementation of emerging technology for home telemonitoring for patients with complex chronic disease, and/or high risk of hospital readmission. We intend to evaluate the impact of more aggressive and dedicated home monitoring on patient outcomes and cost.

17. Project Processes and Operational Planning

a. Data collection and reporting

In order to evaluate the impact of our proposed reforms, the state anticipates needing the following data, in addition to that which is available through VHCURES:

1. *Medicare enrollment and claims data for Parts A and B* including Quarterly 100% VT beneficiary enrollment files (2007-current); monthly unadjudicated TAP files for MAPCP attributed beneficiaries (2009- current); annual final action files for 100% of VT beneficiaries (2007-current). This data includes full eligibility demographic and geographic data for all VT Medicare beneficiaries.

2. *Substance Abuse and Mental Health Data* for 100% of VT Medicare beneficiaries (2007-current). Data should capture utilization, charges, and paid claims (final action files) for Substance Abuse and Mental Health Services.
3. *Claims data on populations outside of Vermont to generate comparison groups and benchmarks.* The SIM grant will be used to establish sustainable access to external sources of claims data and to set up the processes for routine transmission, formatting, creation of person level records across insurers, and integration of this data into Vermont's All-Payer Claims Database.
4. *Additional Patient Experience Surveys.* Expansion of patient experience survey capacity including intensified sampling of targeted populations and additional content for specific health services to determine the impact of specific interventions on patient experience, as well as patient experience in settings outside the ACP setting (e.g. mental health, substance use, specialty care, social services, long term services and supports, home health, public health and community prevention programs).
5. *Person-entered data, for real-time clinical use and immediate feedback.* Using a decentralized, internet-based patient-experience measurement tool, we will collect information directly from patients, in order to assess health status, satisfaction, and to create action plans designed to improve self-management. Linking this data to clinical registry will allow for measurements of an individual's experience of care to be linked to specific clinical and non-clinical interventions.

b. Provider payment systems

Development of provider payment systems to implement all three of the models proposed in this application will be a major focus of efforts under this grant. We will work with Medicaid and DVHA's Management Information System vendor to design and implement new payment methodologies in conjunction with project leaders. In addition, we will work with private payers to address the technical and operational needs associated with implementing the payment models. In both cases, model development, systems testing and implementation will be supported by both staff and contractors hired under the grant.

c. Model enrollment and assignment processes

Model enrollment and assignment processes will be developed as part of the grant activities. Enrollment (if any) will vary by model. For example, bundled payment initiatives will focus on specific clinically-defined patient populations while the shared savings ACO will rely on an attribution methodology. The Blueprint currently utilizes a claims-derived methodology for attributing patients to primary care practices. The same methodology is utilized for the Medicare Shared Savings ACO. Likely we will replicate this methodology for the Medicaid and commercial SSP-ACOs. The definition of attributed patients for pay-for-performance initiatives also will vary, driven largely by a specific scope of services and target population. In no case will beneficiary choice of provider be curtailed.

d. Contracting and administrative processes

Contracting under the project will be overseen by the agencies and departments with lead responsibility for grant tasks – please see budget and budget narrative. Overall administration of grant funds and necessary grant reporting will be the responsibility of DVHA.

e. Continuous improvement analysis and performance optimization process

Continuous improvement analysis will be a major focus of our data analytics, described both under infrastructure development above and in section VII of the grant application, relating to performance reporting and continuous improvement. We are seeking funding for data collection, data analysis, learning collaboratives and facilitators, all of which will be part of an infrastructure designed to support continuous improvement.

f. Other processes needed to complete delivery system reform

The other processes necessary to complete the reforms described in this application relate primarily to development of internal management infrastructure and capabilities within participating provider organizations. The organizations with whom we will be working to implement this plan all are new or within a developmental stage. They will require support to develop the capabilities necessary to implement these reforms, some of which we propose providing under the grant. In addition, it will be necessary for payers to implement new payment methodologies within their operations.

g. Project management and governance

This project will be managed jointly by the AHS/Department of Vermont Health Access (DVHA) and the Green Mountain care Board (GMCB) under a Memorandum of Understanding that spells out specific roles, responsibilities and accountabilities. Co-leaders of the project will be the Commissioner of DVHA and the Chair of the GMCB. All aspects of project management will involve a partnership between the state and major stakeholders in the private sector. Our overarching goal will be to assure that this project is not “state dictated” but rather project activities and resources serve all constituencies who should be engaged in developing a high

performance health system in Vermont. As such, we will establish a State Innovation Model Steering Committee that will advise us on all elements of the project. This Steering Committee will include representatives of all major payers, providers involved in the testing models, consumers and other key stakeholders.

In addition, we will establish a Steering Committee to assist with development of the data integration, informatics and analytic platform described in this application, as well as the efforts to facilitate data transmission and data feedback for a learning health system. Again, this must be a resource for all involved, and necessitates deep involvement from data “sources” and data “users.” Additional workgroups will be established to assist with implementation of other specific project elements and to offer technical input and on-the-ground feedback.

h. Model staffing and roles

Model staffing is described fully in our budget and budget narrative. We are requesting 28 staff positions, 4.25 at the GMCB and 23.25 at the Agency of Human Services. GMCB staff will be focused on Medicare and Commercial payer payment reforms, stakeholder coordination and evaluation, while AHS staff will support an array of Medicaid and CHIP payment reform and integration activities across six departments. The Chair of the GMCB and the Commissioner of DVHA will co-lead the project and provide overall direction.

B. Expected Transformation of Major Provider Entities Within the State, Rationale for their Transformation, and Evidence of their Commitment to Making Specified Changes

By integrating a robust model for primary care with specialty care and long-term services and supports through payment models, data reporting and analytics, the state will promote a system in which provider organizations are rewarded for better management of service delivery, better outcomes and better patient experience. If successful, these models have the potential to be expanded, scaled up and strengthened to complete a dramatic transformation of health care organizations in Vermont and the relationships between them. Our plan provides specific financial incentives for providing this high quality care through enhanced pay-for-performance, bundled payments and shared savings models. As evidenced in their letters of support, payers and providers in Vermont are committed to aligning their payment strategies in a manner that ensures consistent expectations for quality performance, and already are forming new strategic alliances to improve care and reduce cost trends. Both the Blueprint expansion and the development of ACOs are far more than payment reform strategies. These efforts can encourage delivery system transformation that is keenly focused on the integration and coordination of person-centered care. The Blueprint will reach an impressive 80 percent of Vermonters by October 2013, and will continue to have a tremendous transformative impact on primary care delivery in Vermont. Likewise, the development of financial incentives that support individual, group and network-wide collaboration and performance improvement is likely to have a transformative effect on specialty care (including mental health), hospital care and long-term services and supports, resulting in a higher-performing, better organized system of care for all Vermonters.

C. Roles of Other Payers and Stakeholders Participating in the Model

The State's Medicaid Agency, AHS/DVHA, will participate directly in the model testing in numerous ways: DVHA will directly co-manage the overall project and will provide administrative management for grant funds; DVHA in partnership with other AHS departments will use grant funds to develop some Medicaid-specific payment models; and DVHA will participate in all-payers models that are appropriate for and adaptable to their covered populations. Private payers will participate in the development of both statewide payment reform models such as the shared savings programs, and targeted models such as bundled payments. Their participation, as it is with our current payment reform pilots, will be aimed at gathering both technical input and ultimately participation in payment changes.

Providers will be involved in the project principally as direct participants in the testing models – those who choose to participate will be involved in implementation planning, testing and evaluation. Providers individually and through their professional organizations will be included in development of the statewide “infrastructure development” described in the grant. Vermont is fortunate to have engaged stakeholders that share the state's vision to improve the health of Vermonters, improve health care outcomes and reduce the cost growth of health care in the state. All stakeholders have been working diligently for many years on a continued path of improvement to the state's health care delivery and payment system. Act 48 mandates “public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system.”

The state has created internal structures which will be leveraged in the management of the SIM grant to ensure coordination in health care reform activities among executive branch agencies, including a health care reform leadership team which is led by the Governor's Director of Health Reform and includes the key agency secretaries, departmental commissioners and deputies, and a health care cabinet that meets quarterly for broader coordination. In addition, there are additional project-based structures for inter-agency development of policy and operations related to specific initiatives. In addition, the health reform leadership works closely with and reports to the general assembly's Health Care Oversight Committee, a legislative interim committee charged with overseeing health care reform, and with the Mental Health Oversight Committee, a legislative interim committee focusing on mental health systems issues, in particular the replacement of the Vermont State Hospital. The Administration also collaborates with the Senate Health and Welfare Committee and the House Health Care and Human Services Committees.

Each state entity working in and responsible for health reform has developed advisory bodies to ensure its work appropriately engages stakeholders. The GMCB has a General Advisory Committee, a Payment Reform Advisory Group and two technical advisory groups: the health care professional technical advisory group and the mental health advisory group. DVHA has six advisory bodies: the Medicaid and Exchange Advisory Board; the Duals Stakeholder Advisory Group; and the Blueprint's Executive Committee, Expansion Design and Evaluation Work Group, Payment Implementation Work Group, and Provider Practice Work Group. In addition to the

formal working groups, the State engages Vermonters in their communities on various health reform topics through public hearings and other forums.

D. Linkage of the Models to the State’s Health Care Innovation Plan

Vermont’s Health Care Innovation Plan sets as its central goal development of a high performance health system in the state. That goal is consistent with the State’s Strategic Plan for Health Reform and with the Triple Aim. This proposal would add financial, technical and organizational support to a foundational building block for achieving the goal: development of payment and care delivery models that move away from rewarding volume of service, toward rewarding better health, better outcomes of care processes and improved quality of life for Vermonters. We have described in this application and in the Innovation Plan how this effort relates to other state-level and federal health reform efforts underway in Vermont. We also have described how the models proposed here will create linkages across physical and mental health and long-term services and supports. We believe our established state health reform agenda, along with the statewide and comprehensive nature of our proposed reforms, offer a unique opportunity to establish the high performing health system we have described.

E. Multi-Stakeholder Commitment

Vermont is fortunate to have engaged stakeholders that share the state’s vision to improve the health of Vermonters, improve health care outcomes and reduce the cost growth of health care in the state. All stakeholders have been working diligently for many years on a continued path of improvement to the state’s health care delivery and payment system. Act 48 mandates “public participation in the design, implementation, evaluation, and accountability mechanisms

of the health care system.” As detailed above and in the State Health Care Innovation Plan, there are a number of state entities responsible for overseeing, regulating and monitoring the health care system in Vermont. Each is committed to the successful implementation of these testing models and to measurably improving the health status of Vermonters while containing costs, as evidenced by letters of support included from the Agency for Human Services, the Department of Vermont Health Access, the Green Mountain Care Board, and the Department of Financial Regulation. Each state entity working in and responsible for health reform has developed advisory bodies to ensure its work appropriately engages stakeholders. These advisory boards will play a key role in the state’s efforts to keep stakeholders informed of the Grant’s progress and to obtain input on implementation and outcomes.

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