VT Health Care Innovation Project
Core Team Meeting Agenda

March 1, 2017, 10:30am-12:00pm
Ash Conference Room, Waterbury State Office Complex, Waterbury
Call-In Number: 1-877-273-4202; Passcode: 439-746-685

Item #	Time	Topic	Presenter	Relevant Attachments
1	10:30-10:35	Welcome and Chair's Report • Conflict of Interest Policy • Evaluation Site Visit 3/13-3/16	Mary Kate Mohlman	*Update.* Attachment 1a: Changes to Standards for Core Team Attachment 1b: ACO Standards for Core Team Attachment 1c: Myers & Stauffer Core Team Update *To be distributed at a later date.*
Core Team Processes and Procedures:				
2	10:35-10:40	Approval of meeting minutes	Mary Kate Mohlman	Attachment 2: December 20, 2016 Meeting Minutes *Decision needed.*
Core Team Updates:				
3	10:40-10:45	Project Updates	Georgia Maheras	Attachment 3: Background Powerpoint *Update.*
4	10:45-11:00	Evaluation Overview	Kathryn O'Neill	Attachment 4: Evaluation Update Powerpoint *Update.*
Core Team Financial:				
5	11:00-11:35	Budget Update and Proposed PP2 and PP3 Reallocations	Georgia Maheras and Diane Cummings	Attachment 5: Budget Powerpoint *Decision needed.*
7	11:35-11:45	*Public Comment*	Mary Kate Mohlman	
8	11:45-12:00	Next Steps, Wrap-Up, and Future Meeting Schedule: TBD	Mary Kate Mohlman	

TO: VHCIP Core Team
FROM: Pat Jones, Health Care Project Director, Green Mountain Care Board
DATE: February 26, 2017
RE: Changes to the Commercial ACO Shared Savings Program Pilot Standards

GMCB and DVHA staff, working with ACO Shared Savings Program (SSP) Operations Group members, identified consensus updates to the Commercial ACO Shared Savings Program Pilot Standards for Year 3. The Green Mountain Care Board (GMCB) approved these changes in December 2016. The changes are summarized below and contained in track changes in the attached document.

1. **Year 3 Payment Methodology**
   These are the most substantive changes, and are found in Section VI, "Calculation of ACO Financial Performance and Distribution of Shared Risk Payments." During 2016, the Operations Group considered and ultimately endorsed a revised payment methodology for Year 3. The modified methodology, proposed by BCBSVT and OneCare and supported by all the ACOs, starts with each ACO's Year 1 experience and trends it forward to Year 3, resulting in a medical expense expected spending target that is informed by each ACO's own historical experience rather than by GMCB-approved Exchange premiums. The proposed Year 3 methodology makes two additional adjustments to the target:
   - The first adjustment is for demographics (age and gender of each ACO's population in Year 1 compared to age and gender of each ACO's population in Year 3).
   - The second adjustment is to reflect the benefit plans selected by individuals enrolled in each ACO, and changes to these selection patterns from Year 1 to Year 3.

   This approach differs from Years 1 and 2 in two ways. First, ACO expected spending targets in Years 1 and 2 were developed using GMCB-approved Exchange premiums and then risk adjusted based on the individual ACO's attributed population. Second, the Year 3 methodology uses demographic rather than clinical risk factors for adjusting ACO expected spending. BCBSVT and the ACOs felt that this alternative approach would provide the ACOs with more timely calculated values of expected spending targets.

2. **Year 3 Truncation of Claims for High-Cost Patient Outliers**
   In Spring 2016, the Operations Group unanimously endorsed modification of the high-cost outlier truncation point definition for Year 3 of the ACO pilot. An analysis of historical medical expense data by OneCare Vermont showed that the 99.9th percentile equated to $239,000, which is a truncation point above the 99.0th percentile method used by Medicare (and by DVHA). The Operations Group concluded that removing too many high cost members reduces the ACOs' incentive to manage costs that are amenable to management, and supported raising the truncation point for high-cost members from $125,000 to $250,000.

3. **Distribution of Shared Savings When There is an Insurer Loss on Exchange Business**
   During the November 28, 2016 Operations Group meeting, BCBSVT proposed and the ACOs subsequently supported a clarification that BCBSVT would not be required to distribute shared savings earned by the ACOs if BCBSVT realizes a loss on its Exchange business resulting in overall Qualified Health Plan (QHP) business allowable costs above the target amount set by the ACA Risk Corridor program.

4. **Methodology for Distribution of Shared Savings – Treatment of Measure Core-12 (Rate of Hospitalization for Ambulatory Care-Sensitive Conditions)**
   When reviewing data on measure Core-12 (Rate of Hospitalization for Ambulatory Care-Sensitive Conditions) during 2016, the Operations Group determined that the measure's numerators were so low that it would be virtually impossible to demonstrate the statistically significant improvement needed to earn three points for this measure. The Operations Group unanimously supported a proposal by the Office of the Health Care Advocate to have a maximum of two points for this measure (the ACO would receive 2 points if performance stayed statistically the same over time, and 0 points if performance statistically significantly declined).

5. **Quality Measure and Benchmark Updates**
   "Table 1. Core Measures for Payment in Year Three of the Commercial Pilot" was updated to incorporate 2016 HEDIS® benchmarks, in accordance with guidance provided in the Standards that "calculations will be performed annually using the most currently available HEDIS benchmark data at the time final shared savings calculations are performed."

   In addition, Table 1 has been updated to reflect that Core-39 (Controlling High Blood Pressure) has replaced the former Core-3 (Cholesterol Management for Patients with Cardiovascular Conditions). A footnote has been added to indicate that a HEDIS® 2014 National Commercial Benchmark has served as the benchmark for Core-39 during Years 2 and 3 of the ACO Commercial Shared Savings Pilot.

6. **Additional Clarifications**
   GMCB staff, in consultation with the Operations Group, made the following additional clarifications to the Standards:
   - ACO-responsible services used to define expected spending exclude vision benefits (in addition to excluding retail prescription medications and dental benefits).
   - The GMCB will not publicly report the results of payment measures with a denominator less than 30.
   - The 'ladder' for distribution of any shared savings will remain the same for all three years of the Commercial Pilot.

I would be glad to provide additional information about any of these changes.

Vermont Commercial ACO Pilot
Compilation of Pilot Standards
Reflecting Technical and Substantive Changes Approved by the GMCB as of December 22, 2017

This document contains ACO commercial pilot standards originally reviewed and approved by the Green Mountain Care Board and the Vermont Health Care Improvement Project Steering Committee and Core Team during meetings that took place in October and November 2013. These standards have ~~and~~ subsequently been clarified and modified.

ACO pilot standards are organized in the following four categories:

- Standards related to the ACO's structure:
  - Financial Stability
  - ~~Risk Mitigation~~
  - Patient Freedom of Choice
  - ACO Governance

- Standards related to the ACO's payment methodology:
  - Patient Attribution Methodology
  - Calculation of ACO Financial Performance and Distribution of Shared Risk Payments

- Standards related to management of the ACO:
  - Care Management
  - Payment Alignment
  - Data Use Standards

- Process for review and modification of measures.

The objectives and details of each ~~draft~~ standard follow.

I. Financial Stability

Objective: Protect ACOs from the assumption of "insurance risk" (the risk of whether a patient will develop an expensive health condition) when contracting with private and public payers so that the ACO can focus on management of "performance risk" (the risk of higher costs from delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment of a particular condition).

A. Standards related to the effects of provider coding patterns on medical spending and risk scores

1. The GMCB's Analytics Contractor will assess whether changes in provider coding patterns have had a substantive impact on medical spending, and if so, bring such funding and documentation to the GMCB for consideration with participating pilot ACOs.
2. The Payers and ACOs shall participate in a GMCB-facilitated process to review and consider the financial impact of any identified changes in ACO provider coding patterns.

B. Standards related to downside risk.

1. The Board has established that for the purposes of the pilot program, the ACOs will not assume downside risk in Years 1 through 3 of the pilot program.

C. Standards related to financial oversight.

The payer will furnish financial reports regarding each ACO's risk performance for each six-month performance period to the GMCB, and the VHCIP Payment Models Work Group or its successor in accordance with report formats and timelines defined by the GMCB, through a collaborative process with ACOs and payers.

D. Minimum number of attributed lives for a contract with a payer for a given line of business.

1. For Year 1 of the ACO pilot, an ACO participating with one commercial payer must have at least five thousand (5,000) commercial attributed lives as of June 30, 2014. For Year 1 of the ACO pilot, an ACO participating with two commercial payers must have three thousand (3,000) commercial attributed lives for each of the two payers, for an aggregate minimum of six thousand (6,000) commercial attributed lives, as of June 30, 2014.

   In order to establish the number of an ACO's commercial attributed lives, the payer will, on July 1, 2014, or as soon thereafter as possible, provide the ACO with an account of ACO's commercial attributed lives as of June 30, 2014. Based upon the number of an ACO's commercial attributed lives as of June 30, 2014, the ACO and payer may proceed as follows: if the commercial attributed lives are below the minimum number required for participation, the payer or the ACO may:
      a. terminate their agreement for cause as of June 30, 2014; or

b. agree to maintain their agreement in full force and effect.

2. In Performance Years 2 and 3, a participating insurer may elect to not participate with an ACO, if: (1) that ACO is participating with one commercial insurer and that ACO's projected or actual attributed member months with that insurer fall below 60,000 annually; or (2) that ACO is participating with two commercial insurers and that ACO's projected or annual attributed member months with that insurer fall below 36,000 annually.

If an ACO falls below the attribution threshold required for participation in the pilot in Years 2 and 3, it may request that the relevant payers participate in a GMCB-facilitated process to determine whether one or more of the payers would find it acceptable to waive the enrollment threshold and either a) establish a contract with the ACO in the absence of meeting this requirement, or b) permit an already-contracted ACO eligibility to share in any generated savings. While the GMCB will facilitate this process, the decision regarding whether to waive the enrollment threshold and contract with the ACO, or to permit a contracted ACO to share in any savings, remains with the payer.

E. **The ACO will notify the Board if the ACO is transferring risk to any participating provider organization within its network.**

III. Patient Freedom of Choice

1. ACO patients will have freedom of choice with regard to their providers consistent with their health plan benefit.

IV. ACO Governance

1. The ACO must maintain an identifiable governing body that has responsibility for oversight and strategic direction of the ACO, and holding ACO management accountable for the ACO's activities.

2. The organization must identify its board members, define their roles and describe the responsibilities of the board.

3. The governing body must have a transparent governing process which includes the following:
    a. publishing the names and contact information for the governing body members;
    b. devoting an allotted time at the beginning of each in-person governing body meeting to hear comments from members of the public who have signed up prior to the meeting and providing public updates of ACO activities;
    c. making meeting minutes available to the ACO's provider network upon request, and
    d. posting summaries of ACO activities provided to the ACO's consumer advisory board on the ACO's website.

4. The governing body members must have a fiduciary duty to the ACO and act consistently with that duty.

5. At least 75 percent control of the ACO's governing body must be held by or represent ACO participants or provide for meaningful involvement of ACO participants on the governing body. For the purpose of determining if this requirement is met, a "participant" shall mean an organization that:

    a. has, through a formal, written document, agreed to collaborate on one or more ACO programs designed to improve quality, patient experience, and manage costs, and

    b. is eligible to receive shared savings distributions based on the distribution rules of the ACO or participate in alternative financial incentive programs as agreed to by the ACO and its participants.

A "participant" does not need to have lives attributed to the ACO to be considered a participant. An organization may have lives attributed to one ACO but still participate in another ACO as per meeting conditions 5a and 5b above. So long as conditions 5a and 5b above are met, that organization will be considered a "participant" if seated on a governing body.

6. The ACO's governing body must at a minimum also include at least one consumer member who is a Medicare beneficiary (if the ACO participates with Medicare), at least one consumer member who is a Medicaid beneficiary (if the ACO participates with Medicaid), and at least one consumer member who is a member of a commercial insurance plan (if the ACO participates with one or more commercial insurers). Regardless of the number of payers with which the ACO participates, there must be at least two consumer members on the ACO governing body. These consumer members should have some personal, volunteer, or professional experience in advocating for consumers on health care issues. They should also be representative of the diversity of consumers served by the organization, taking into account demographic and non-demographic factors including, but not limited to, gender, race, ethnicity, socioeconomic status, geographic region, medical diagnoses, and services used. The ACO's governing board shall consult with advocacy groups and organizational staff in the recruitment process.

   The ACO shall not be found to be in non-conformance if the GMCB determines that the ACO has with full intent and goodwill recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

7. The ACO must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including the establishment of a consumer advisory board, with membership drawn from the community served by the ACO, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of ACO management and the governing body must regularly attend consumer advisory board meetings and report back to the ACO governing body following each meeting of the consumer advisory board. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

V. Patient Attribution Methodology

Patients will be attributed to an ACO as follows:

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all members who meet the following criteria as of the last day in the look back period:
    - Employer situated in Vermont or member/beneficiary residing in Vermont for commercial insurers (payers can select one of these options);
    - The insurer is the primary payer.

3. For products that require members to select a primary care provider, and for which the member has selected a primary care provider, attribute those members to that provider.

4. For other members, select all claims identified in step 2 with the following qualifying CPT Codes[1] in the look back period (most recent 24 months) for primary care providers where the provider specialty is internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, naturopathic medicine; or is a nurse practitioner, or physician assistant; or where the provider is an FQHC or Rural Health Clinic.

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established Patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services

[1] Should the Blueprint for Health change the qualifying CPT codes to be other than those listed in this table, the VHCIP Payment Models Work Group shall consider the adoption of such changes.

CPT-4 Code Description Summary
• New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463 • Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

5. Assign a member to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the NPIs of the individual providers associated with it.

6. If a member has an equal number of qualifying visits to more than one practice, assign the member/beneficiary to the one with the most recent visit.

7. Insurers can choose to apply elements in addition to 5 and 6 above when conducting their attribution. However, at a minimum use the greatest number of claims (5 above), followed by the most recent claim if there is a tie (6 above).

8. Insurers will run their attributions at least monthly.

9. In order to be considered a primary care practice eligible for attribution of patients under these standards, a practice shall demonstrate the capability of providing the following services at a minimum:

Preventive care	o comprehensive "wellness" visits o immunizations: counseling and administration o injections and medications administered in the office o lipid, diabetes, depression, substance abuse, obesity, and blood pressure screening, and management and initial treatment of abnormal screenings o ordering and managing the results of USPSTF-recommended screening tests for ages /risk groups appropriate to specialty. For example: - Pediatrics/ Family Medicine: newborn screening, developmental screening, lead screening - Internal Medicine/Family Medicine: colon, breast, cervical cancer screenings
Acute care	Acute care of appropriate common problems for age groups of specialty (e.g., sore throat, headache, febrile illness, abdominal pain, chest pain, urinary symptoms, rashes, GI disorders, bleeding) o telephone triage and same-day visit capability o 24/7 telephone availability for triage and care coordination o ordering and managing appropriate testing, prescribing medications, and coordinating referrals and consultations for specialty care
Chronic care	Chronic care of common medical problems, including at least: allergies, asthma, COPD, diabetes (type 2), hypertension, lipid disorders, GERD, depression and anxiety o arranging and managing regular testing, screenings, consultations appropriate to the conditions
Coordination of care	o providing a "Medical Home" for a panel of patients o maintaining a comprehensive, current medical record, including receipt, sign-off and storage of external records, consults, hospitalizations and testing o assisting in transition of care into facilities, and in return to outpatient care
Other	o selected outpatient laboratory tests (lipids, HbA1c and PT/INR[2]) o health education and counseling services performed in the office o routine vision and hearing screening o prescribing common primary care acute and chronic medications using an unrestricted DEA license

[2] Prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are used to determine the clotting tendency of blood.

10. A qualified primary care practitioner to whom lives have been attributed by a payer may only participate as a primary care practitioner in one ACO. If a qualified primary care practitioner works under multiple tax ID numbers, the practitioner may not use a specific tax ID number with more than one ACO.

11. If a member has not selected a primary care provider at time of enrollment, that member will be attributed in accordance with the claims-based patient attribution methodology specified above back to the later of his or her effective date of enrollment or the first date of the performance year.

12. In instances when a provider supplier* terminates his or her participation in an ACO during a performance year, the provider will remain an attributing provider with the ACO for the remainder of the performance year and the claims data for the provider's attributed lives will continue to be shared with the original ACO. Likewise, if a provider supplier joins an already-enrolled ACO participant during a performance year, then the provider will become an attributing provider with that ACO for the remainder of the performance year. The only exception to this latter provision occurs in those instances when a provider is switching from one participating ACO to another; under such circumstances, the provider will remain an attributing provider for the remainder of the performance year with the ACO of origin.

    For purposes of Year One, this policy pertains to: a) ACO Medicaid provider suppliers who are on the Medicaid provider roster as of March 31, 2014; and b) ACO commercial provider suppliers who are on the insurer provider roster as of July 1, 2014. For purposes of Years Two and Three, this policy pertains to Medicaid and commercial provider suppliers who are on the respective provider rosters as of January 1 of that performance year.

    *For purposes of this policy, a "provider supplier" refers to an individual practitioner.

13. For Year 1, if a member has not selected a primary care provider at time of enrollment, that member will be attributed in accordance with the claims-based patient attribution methodology specified above, supplemented by paid pharmacy claim PCP prescriber information for those members not otherwise attributed using the above methodology. In addition, for Year 1, insurers will consider Year 1 claims data for covered primary care services incurred through April 30, 2015 for those members not otherwise attributed using Year 1 date-of-service claims.

VI. Calculation of ACO Financial Performance and Distribution of Shared Risk Payments

(See attached ~~spreadsheet~~9-14-16 memo from Martine B. Lemieux to Abe Berman for additional detail regarding the calculation of expected and targeted PMPM medical expense.)

I. Actions Initiated Before the Performance Year Begins

Step 1: Determine the expected PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO.

For Years 1 and 2, ~~T~~the medical expense portion of the GMCB-approved Exchange ("Exchange" shall be defined as Vermont Qualified Health Plans approved by the GMCB) premium for each Exchange-offered product, adjusted from allowed to paid amounts, adjusted for excluded services (see below), high-cost outliers[3], and risk-adjusted for the ACO-attributed population, and then calculated as a weighted average PMPM amount across all commercial products with weighting based on ACO attribution by product, shall represent the expected PMPM medical expense spending ("expected spending").

For Year 3, the expected PMPM medical expense spending shall be calculated by:

1. Using the medical allowed claims incurred for each Exchange-offered product;
    a. Medical allowed claims do not include retail pharmacy claims or claims allowed under separate non-medical dental or vision benefits.
2. Splitting medical allowed claims based on actual ACO experience (using attribution information for Year 1);
3. Calculating a unit cost trend for each ACO, using actual hospital budget increases approved by the GMCB;
4. Excluding high-cost outliers (claim amounts exceeding $250,000);
5. As in Years 1 and 2, adjusting (consistently across all ACOs) claims for other rating factors (including demographics, health status of the newly insured, pool morbidity, Blueprint payments, etc.); and
6. Adjusting to account for
    a. Changes in demographic scores from the base period to the performance year, using factors in the Society of Actuaries (SOA) Health Care Costs – From Birth to Death report[4]

[3] The calculation shall exclude the projected value of a~~A~~llowed claims per claimant in excess of $125,000 per performance year ~~for Yyears 1 and 2 and in excess of $250,000 for Yyear 3~~.

[4] "Health Care Costs – From Birth to Death Report," Society of Actuaries, June 2013. Click here to access.

b. Changes in benefit mix from the base period to the performance year, using the HHS induced utilization factors.

~~The ACO responsible services used to define expected spending shall include all covered services except for:~~

- ~~prescription (retail) medications; and~~
- ~~dental benefits, and~~
- ~~vision benefits.~~

~~The GMCB will also calculate the expected spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending."~~

At the request of a pilot ACO or insurer and informed by the advice of the GMCB's actuary and participating ACOs and insurers, the GMCB will reconsider and adjust expected spending if unanticipated events, or macro-economic or environmental events, occur that would reasonably be expected to significantly impact medical expenses or payer assumptions during the Exchange premium development process that were incorrect and resulted in significantly different spending than expected.

Step 2: Determine the targeted PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO.

Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population. The GMCB will approve the target rate.

The GMCB will also calculate the targeted spending for the ACO population on an insurer-by-insurer basis in the same fashion, as described within the attached worksheet. The resulting amount for each insurer is called the "insurer-specific targeted spending."

Actions Initiated After the Performance Year Ends

Step 3: Determine actual spending and whether the ACO has generated savings.

No later than eight months (i.e., two months following the six-month claim lag period) following the end of each pilot year, the GMCB or its designee shall calculate the actual medical expense spending ("actual spending") by Exchange metal category for each ACO's attributed population using commonly defined insurer data provided to the GMCB or its designee.

For Yyears 1 and 2, mMedical expense spending shall be defined to include all paid claims for ACO-responsible services as defined above.

PMPM medical expense spending shall then be adjusted as follows:

- clinical case mix using the risk adjustment model utilized by Center for Consumer Information and Insurance Oversight (CCIIO) for the federal exchange. The GMCB may consider alternatives for future years;
- truncation of claims for high-cost patient outliers whose annual claims value exceed $125,000 for Year 1 and 2, and $250,000 for Year 3, and
- conversion from allowed to paid claims value.

For Yyear 3, PMPM medical expense spending shall be defined to include all allowed medical claim charges for ACO-responsible services as defined above.

PMPM medical expense spending shall then be adjusted as follows:

- changes in demographic scores from the base period to the performance year, using factors in the "Health Care Costs – From Birth to Death".[5];
- changes in benefit mix from the base period to the performance year, using the HHS induced utilization factors, and
- truncation of claims for high-cost patient outliers whose annual claims value exceed $250,000.

Insurers will assume all financial responsibility for the value of claims that exceed the high-cost outlier threshold.

The GMCB or its designee shall aggregate the adjusted spending data across insurers to get the ACO's "actual spending." The actual spending for each ACO shall be compared to its expected spending.

- If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer.
- If the ACO's actual aggregate spending is less than the expected spending, then it will be said to have "generated savings" and the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers.
- If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer.

[5] "Health Care Costs – From Birth to Death Report," Society of Actuaries, June 2013. Click here to access. https://www.soa.org/Research/Research-Projects/Health/research-health-care-birth-death.aspx

Once the GMCB determines that the ACO has generated aggregate savings across insurers, the GMCB will also calculate the actual spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific actual spending." The GMCB shall use this insurer-specific actual spending amount to assess savings at the individual insurer level.

Once the insurer-specific savings have been calculated, an ACO's share of savings will be determined in two phases. This step defines the ACO's eligible share of savings based on the degree to which actual PMPM spending falls below expected PMPM spending. The share of savings earned by the ACO based on the methodology above will be subject to qualification and modification by the application of quality performance scores as defined in Step 4.

- If the insurer-specific actual spending for the ACO population is between the insurer-specific expected spending and the insurer-specific targeted spending, the ACO will share 25% of the insurer-specific savings.
- If the insurer-specific actual spending is below the insurer-specific targeted spending, the ACO will share 60% of the insurer-specific savings. (The cumulative insurer-specific savings would therefore be calculated as 60% of the difference between actual spending and targeted spending plus 25% of the difference between expected spending and targeted spending.)
- For Year 3, since expected and actual claims are based on allowed charges, the insurer-specific savings shall be multiplied by the actual paid--to--allowed ratio for each ACO.
- An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not be greater than insurer premium approved by the Green Mountain Care Board. An insurer will not be obligated to distribute shared savings if the insurer realizes a loss on its Exchange business where overall Qualified Health Plan business allowable costs are above the target amount set by the ACA Risk Corridor program.

If the sum of ACO savings at the insurer-specific level is greater than that generated in aggregate, the insurer-specific ACO savings will be reduced to the aggregate savings amount. If reductions need to occur for more than one insurer, the reductions shall be proportionately reduced from each insurer's shared savings with the ACO for the performance period. Any reductions shall be based on the percentage of savings that an insurer would have to pay before the aggregate savings cap.

Step 4: Assess ACO quality performance to inform savings distribution.

The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the

ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.

Methodology for distribution of shared savings: Compare the ACO's performance on the payment measures (see Table 1 below for an example) to the HEDIS PPO national percentile benchmark[6] and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.

- An exception to this methodology will be the treatment of measure Core-12 (Rate of Hospitalization for Ambulatory Care--Sensitive Conditions) due to its lack of a HEDIS benchmark. For Core-12, a 2-point scoring approach shall apply to the Year 2 distribution of shared savings calculation. If the ACO's performance for Core-12 stays statistically significantly the same from ~~Year 1 to Year 2~~one performance year to the next, the ACO will receive 2 points, and if the ACO's performance declines in a statistically significant manner from ~~Year 1 to Year 2~~one performance year to the next, the ACO will receive 0 points.

These calculations will be performed annually using the most currently available HEDIS benchmark data at the time final shared savings calculations are performed.

For purposes of calculations pertaining to the distribution of any shared savings payment, an ACO's performance on a payment measure will be excluded from the calculation in those instances in which the ACO's denominator for that payment measure is less than 30. ~~For purposes of public reporting of the ACO's performance, an explanation of the ACO's small denominator and its significance will accompany~~ The GMCB will not report~~ing of~~ any payment measure with a denominator less than 30.

Table 1. Core Measures for Payment in Year ~~Two~~~~One~~ Three of the Commercial Pilot

#	Measure	Data Source	2015~~2~~ HEDIS Benchmark (PPO)[7]	2016 HEDIS Benchmark (PPO)[8]
Core-1	~~Plan~~ ACO All-Cause Readmissions NQF #1768, NCQA	Claims	Nat. 90th: 0.596360 Nat. 75th: 0.6766 Nat. 50th: 0.7216 Nat. 25th: 0.7735 ~~Nat. 90th: .68~~ ~~Nat. 75th: .73~~	Nat. 90th: 0.67 Nat. 75th: 0.75 Nat. 50th: 0.80 Nat. 25th: 0.87

[6] NCQA has traditionally offered several HEDIS commercial product benchmarks, e.g., HMO, POS, HMO/POS, HMO/PPO combined, etc.

[7] 2015 HEDIS National Commercial Benchmarks for Performance Year 2014.

[8] 2016 HEDIS National Commercial Benchmarks for Performance Year 2015.

			~~Nat. 50th: .78~~ ~~Nat. 25th: .83~~ *Please note, in interpreting this measure, a lower rate is better.*	
Core-2	Adolescent Well-Care Visits HEDIS AWC	Claims	Nat. 90th: 61.71 Nat. 75th: 47.83 Nat. 50th: 39.39 Nat. 25th: 33.07 ~~Nat. 90th: 58.5~~ ~~Nat. 75th: 46.32~~ ~~Nat. 50th: 38.66~~ ~~Nat. 25th: 32.14~~	Nat. 90th: 61.18 Nat. 75th: 48.86 Nat. 50th: 41.52 Nat. 25th: 33.87
~~Core-3~~	~~Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only for Year 1)~~	~~Claims~~	~~Nat. 90th: 89.74~~ ~~Nat. 75th: 87.94~~ ~~Nat. 50th: 84.67~~ ~~Nat. 25th: 81.27~~	
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day NQF #0576, NCQA HEDIS FUH	Claims	Nat. 90th: 63.59 Nat. 75th: 57.1 Nat. 50th: 50.37 Nat. 25th: 42.11 ~~Nat. 90th: 67.23~~ ~~Nat. 75th: 60.00~~ ~~Nat. 50th: 53.09~~ ~~Nat. 25th: 45.70~~	Nat. 90th: 62.74 Nat. 75th: 56.53 Nat. 50th: 49.14 Nat. 25th: 41.42
Core-5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite) NQF #0004, NCQA HEDIS IET ~~CMMI~~	Claims	Nat. 90th: 31.14 Nat. 75th: 28.27 Nat. 50th: 24.63 Nat. 25th: 21.94 ~~Nat. 90th: 35.28~~ ~~Nat. 75th: 31.94~~ ~~Nat. 50th: 27.23~~ ~~Nat. 25th: 24.09~~	Nat. 90th: 29.78 Nat. 75th: 26.63 Nat. 50th: 23.60 Nat. 25th: 21.05
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, NCQA HEDIS AAB	Claims	Nat. 90th: 33.52 Nat. 75th: 28.18 Nat. 50th: 24.80 Nat. 25th: 21.43 ~~Nat. 90th: 28.13~~ ~~Nat. 75th: 24.30~~ ~~Nat. 50th: 20.72~~ ~~Nat. 25th: 17.98~~	Nat. 90th: 34.63 Nat. 75th: 28.49 Nat. 50th: 24.33 Nat. 25th: 20.91

Core-7	Chlamydia Screening in Women ~~– Total~~ NQF #0033, NCQA HEDIS CHL	Claims	Nat. 90th: 56.36 Nat. 75th: 46.72 Nat. 50th: 41.62 Nat. 25th: 37.29~~Nat. 90th: 54.94~~ ~~Nat. 75th: 47.30~~ ~~Nat. 50th: 40.87~~ ~~Nat. 25th: 36.79~~	Nat. 90th: 56.75 Nat. 75th: 47.79 Nat. 50th: 42.18 Nat. 25th: 37.21
Core-12	Prevention Quality Chronic Composite (Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite) AHRQ PQI #92	Claims	No benchmark available.	No benchmark available.
Core-17	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent) NQF #0059, NCQA HEDIS	Clinical	Nat. 90th: 25.29 Nat. 75th: 29.93 Nat. 50th: 35.60 Nat. 25th: 41.36 *Please note, in interpreting this measure, a lower rate is better.*	Nat. 90th: 27.41 Nat. 75th: 32.12 Nat. 50th: 38.20 Nat. 25th: 50.00 *Please note, in interpreting this measure, a lower rate is better.*
Core-39	Controlling High Blood Pressure CMS MSSP ACO 28[9]	Clinical	Nat. 90th: 67.25[10] Nat. 75th: 62.77 Nat. 50th: 58.38 Nat. 25th: 52.61	Nat. 90th: 68.06 Nat. 75th: 58.79 Nat. 50th: 52.32 Nat. 25th: 46.78

The Gate: In order to retain savings for which the ACO is eligible in accordance with Steps 1-3 above, the ACO must earn meet a minimum threshold for performance on a defined set of common measures to be used by all pilot-participating commercial insurers and ACOs. For the commercial pilot, the ACO must earn 55% of the eligible points in order to receive savings. If the ACO is not able to meet the overall quality gate, then it will not be eligible for any shared savings. If the ACO meets the overall quality gate, it may retain at least 75% of the savings for which it is eligible (see Table 2).

The Ladder: In order to retain a greater portion of the savings for which the ACO is eligible, the ACO must achieve higher performance levels for the measures. There shall be six steps on the ladder, which reflect increased levels of performance (see Table 2).

[9] Replaces Core-3 Cholesterol Management for Patients with Cardiovascular Conditions.
[10] Benchmark for Core-39 is a HEDIS 2014 National Commercial Benchmark (Performance Year 2013).

Table 2. Distribution of Shared Savings in Years One, Two and ~~Two~~ Three of Commercial Pilot

% of eligible points	% of earned savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Eligibility for shared savings based on performance improvement.

Should the ACO, in Years 2 or 3, fail to meet the minimum quality score, it may still be eligible to receive shared savings if the GMCB determines, after providing notice to and accepting written input from the insurer and ACO (and input from ACO participants, if offered), that the ACO has made meaningful improvement in its quality performance as measured against prior pilot years. The GMCB will make this determination after conducting a public process that offers stakeholders and other interested persons sufficient time to offer verbal and/or written comments related to the issues before the GMCB.

Step 5: Distribute shared savings payments

The GMCB or its designee will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad within four months of the end of the performance year and inform the insurers and ACOs of the results, providing supporting documentation when doing so. If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then within two weeks of the notification, the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.

The GMCB or its designee will complete the analysis of savings within two months of the conclusion of the six-month claim lag period and inform the insurers and ACOs of the results, providing supporting documentation when doing so. The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.

VII. Care Management Standards

Objective: Effective care management programs close to, if not at, the site of care for those patients at highest risk of future intensive resource utilization is considered by many to be the linchpin of sustained viability for providers entering population-based payment arrangements. The following care management standards were developed in early 2015 by the VHCIP Care Models and Care Management Work Group and subsequently approved by the VHCIP Steering Committee, the VHCIP Core Team and the GMCB.

Definition of Care Management:

Care Management programs apply systems, science, incentives and information to improve services and outcomes in order to assist individuals and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, evidence based or promising innovative and non-duplicative services. It is understood that in order to support individuals and to strengthen community support systems, care management services need to be culturally competent, accessible and personalized to meet the needs of each individual served.

In order for care management programs to be effective, we recommend that ACOs agree to the following standards:

A. Care Management Oversight (based partially on NCQA ACO Standards PO1, Element B, and PC2, Element A)

#1: The ACO has a process and/or supports its participating providers in having a process to assess their success in meeting the following care management standards, as well as the ACO's care management goals.

#2: The ACO supports participating primary care practices' capacity to meet person-centered medical home requirements related to care management.

#3: The ACO consults with its consumer advisory board regarding care management goals and activities.

B. Guidelines, Decision Aids, and Self-Management (based partially on NCQA ACO Standards PO2, Elements A and B, and CM4, Elements C)

#4: The ACO supports its participating providers in the consistent adoption of evidence-based guidelines, and supports the exploration of emerging best practices.

#5: The ACO has and/or supports its participating providers in having methods for engaging and activating people and their families in support of each individual's specific needs, positive health behaviors, self-advocacy, and self-management of health and disability.

#6: The ACO provides or facilitates the provision of and/or supports its participating providers in providing or facilitating the provision of: a) educational resources to assist in self-management of health and disability, b) self-management tools that enable attributed people/families to record self-care results, and c) connections between attributed people/families and self-management support programs and resources.

C. Population Health Management (based partially on NCQA ACO Standards CM3, Elements A and B, and CT1, Elements A, B, D, and E)

#7: The ACO has and/or supports its participating providers in having a process for systematically identifying attributed people who need care management services, the types of services they should receive, and the entity or entities that should provide the services. The process includes but is not limited to prioritizing people who may benefit from care management, by considering social determinants of health, mental health and substance abuse conditions, high cost/high utilization, poorly controlled or complex conditions, or referrals by outside organizations.

#8: The ACO facilitates and/or supports its participating providers in facilitating the delivery of care management services. Facilitating delivery of care management services includes:

- Collaborating and facilitating communication with people needing such services and their families, as well as with other entities providing care management services, including community organizations, long term service and support providers, and payers.
- Developing processes for effective care coordination, exchanging health information across care settings, and facilitating referrals.
- Recognizing disability and long terms services and supports providers as partners in serving people with high or complex needs.

#9: The ACO facilitates and/or supports its participating providers in facilitating:

- Promotion of coordinated person-centered and directed planning across settings that recognizes the person as the expert on their goals and needs.
- In collaboration with participating providers and other partner organizations, care management services that result in integration between medical care, substance use care, mental health care, and disability and long term services and supports to address attributed people's needs.

D. Data Collection, Integration and Use (partially based on NCQA ACO Standard CM1, Elements A, B, C, E, F and G)

#10: To the best of their ability and with the health information infrastructure available, and with the explicit consent of beneficiaries unless otherwise permitted or exempted by law, the ACO uses and/or supports its participating providers in using an electronic system that: a) records structured (searchable) demographic, claims, and clinical data required to address care management needs for people attributed to the ACO, b) supports access to and sharing of attributed persons' demographic, claims and clinical data recorded by other participating providers, and c) provides people access to their own health care information as required by law.

#11: The ACO encourages and supports participating providers in using data to identify needs of attributed people, support care management services and support performance measurement, including the use of:

- A data-driven method for identifying people who would most benefit from care management and for whom care management would improve value through the efficient use of resources and improved health outcomes.
- Methods for measuring and assessing care management activities and effectiveness, to inform program management and improvement activities.

VIII. Payment Alignment

Objective: Improve the likelihood that ACOs attain their cost and quality improvement goals by aligning payment incentives at the payer-ACO level to the individual clinician and facility level.

1. The performance incentives that are incorporated into the payment arrangements between a commercial insurer and an ACO should be appropriately reflected in those that the ACO utilizes with its contracted providers. ACOs will share with the GMCB their written plans for:
    a. aligning provider payment (from insurers or Medicaid) and compensation (from ACO participant organization) with ACO performance incentives for cost and quality, and
    b. distributing any earned shared savings.

2. ACOs utilizing a network model should be encouraged to create regional groupings (or "pods") of providers under a shared savings model that would incent provider performance resulting from the delivery of services that are more directly under their control. The regional groupings or "pods" would have to be of sufficient size to reasonably calculate "earned" savings or losses. ACO provider groupings should be incentivized individually and collectively to support accountability for quality of care and cost management.

3. Insurers shall support ACOs by collaborating with ACOs to align performance incentives by considering the use of alternative payment methodology including bundled payments and other episode-based payment methodologies.

IX. Vermont ACO Data Use Standards

ACOs and payers must submit the required data reports detailed in the "Data Use Report Standards for ACO Pilot" in the format defined.

X. Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Program

1. The VHCIP Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set beginning in the second quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines. The goal of the review will be to determine whether each measure should continue to be used as-is for its designated purpose, or whether each measure should be modified (e.g. advanced from Reporting status to Payment status in a subsequent pilot year) or dropped for the next pilot year. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to measures for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will include annual updates to the Payment and Reporting measures included in the Core Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes. In the interest of retaining measures selected for Payment and Reporting purposes for the duration of the pilot program, measures should not be removed in subsequent years unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.

2. The VHCIP Quality and Performance Measures Work Group and the VHCIP Payment Models Work Group will review all **targets and benchmarks** for the measures designated for Payment purposes beginning in the second quarter of each pilot year. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national xth percentile) should remain constant or change for

the next pilot year. The Work Group should consider setting targets in year two and three that increase incentives for quality improvement. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to benchmarks and targets for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will include annual updates to the targets and benchmarks for measures designated for Payment purposes as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

3. The VHCIP Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set and consider any new measures for addition to the set beginning in the first quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider data availability and quality, patient populations served, and measure specifications, with the goal of developing a plan for measure and/or data systems development and a timeline for implementation of each measure. If the VHCIP Quality and Performance Measures Work Group determines that a measure has the support of a majority of the voting members of the Work Group and is ready to be advanced from Pending status to Payment or Reporting status or added to the measure set in the next pilot year, the Work Group shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure or be added to the set by July 31st of the year prior to implementation of the changes. Such recommendations will include annual updates to measures designated as Pending in the Core Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). New measures should be carefully considered in light of the Work Group's measure selection criteria. If a recommended new measure relates to a Medicare Shared Savings Program (MSSP) measure, the Work Group shall recommend following the MSSP measure specifications as closely as possible. If the Work Group designates the measure for Payment, it shall recommend an appropriate target that includes consideration of any available state-level performance data and national and regional benchmarks. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

4. The VHCIP Quality and Performance Measures Work Group will review **state or insurer performance on the Monitoring and Evaluation measures** beginning in the second quarter of each year, with input from the VHCIP Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless a majority of the voting members of the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the VHCIP Quality and Performance Measures Work Group may recommend that the measure be moved to the Core Measure Set to be assessed at the ACO level and used for either Payment or Reporting. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to the Monitoring and Evaluation measures for the next program year if the changes have the support of a majority of the members of the Work Group. Such recommendations will include annual updates to the Monitoring and Evaluation measures included in the Monitoring and Evaluation Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

5. The GMCB will release the **final measure specifications for the next pilot year by no later than** October 31st of the year prior to the implementation of the changes. The specifications document will provide the details of any new measures and any changes from the previous year.

6. If during the course of the year, a national clinical guideline for any measure designated for Payment or Reporting changes or an ACO or payer participating in the pilot raises a serious concern about the implementation of a particular measure, the VHCIP Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the VHCIP Payment Models Work Group. If the VHCIP Quality and Performance Measures Work Group determines that a change to a measure has the support of a majority of the voting members of the Work Group, recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Upon approval of a recommended change to a measure for the current pilot year, the GMCB must notify all pilot participants of the proposed change within 14 days.

Vermont Health Care Innovation Project
Core Team Meeting Minutes

Pending Core Team Approval

Date of meeting: Monday, December 20, 2016, 1:00-3:00pm, Ash Conference Room, Waterbury State Office Complex.
Core Team Attendees: Lawrence Miller, Steven Costantino, Paul Bengtson, Robin Lunge, Hal Cohen (phone), Steve Voigt (phone)

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's Report	Lawrence Miller called the meeting to order at 1:03pm. A roll-call attendance was taken and a quorum was present. *Chair's Report*: • Sustainability Plan Update: The final 2016 meeting of the Sustainability Sub-Group was earlier today.	
2. Approval of Meeting Minutes	Paul Bengtson moved to approve the minutes from the previous meeting. Steven Costantino seconded. A roll call vote was taken and the minutes were approved.	
3. Sustainability Plan	Venesa Day from Myers & Stauffer provided a summary of the draft Sustainability Plan and summarized feedback from the VHCIP work groups and Steering Committee provided at November and December meetings. The Sustainability Plan draft is available here, and summarized in Attachment 3a. • This is a draft developed based on recommendations of the Sustainability Sub-Group, a private-sector stakeholder group which was chaired by Lawrence and included at least one co-chair from all Work Groups, as well as ACO representatives, a consumer, consumer advocate representatives, and more. • For activities that are proposed to continue, the proposed Lead Entity would provide stewardship and ownership. The Lead Entity is not meant to be the sole decision-making organization, but would work with Key Partners to ensure work is sustained. • VHCIP work groups provided comments at their November or December meetings. A new draft reflecting feedback received from work groups, stakeholders, and the Core Team will be developed in early Spring 2017 for additional review by the Core Team and eventual approval and submission. • The Sustainability Plan is due to CMMI on June 30, 2017. It is a required deliverable of the SIM grant. • For more information: Review the full plan, or watch a recorded webinar on this topic.	

Agenda Item	Discussion	Next Steps
	Discussion: • Paul Bengtson expressed strong interest in workforce supply issues. Lawrence noted that the newly appointed incoming Secretary of Labor, Mike Schirling, is a former Burlington Police Chief with a great deal of experience in community development and dealing with Burlington's opiate crisis. • Paul commented that Vermont's total population is likely to remain relatively flat, but a larger proportion will shift into the "non-productive" category as the population ages. This could create significant workforce issues. In addition, demand for primary care physicians is likely to increase. Paul noted that some indicators are obvious and intuitive. How can we fast-track supply of new clinicians? Some areas of the state are harder hit than others. • When will Blueprint payments start flowing through VCO? 2018 (still through AHS in 2017). Paul commented that he hopes the State and VCO have a vision and understanding of how the system could best work. Lawrence agreed, and suggested that it would be important to have practice transformation support outside of the ACO so that non-ACO participating organizations can continue to engage in continuous improvement. • Consumer engagement – Is this about how consumers were engaged in the Sustainability Plan process to date, or how to engage consumers going forward? This section of the plan seeks to highlight the role of consumers in the SIM process generally, and expressing the importance of consumer engagement in future reforms. • Accountable Communities for Health – How aware are leaders around the state about this concept? SIM has supported research to define a Vermont-specific model (Prevention Inst report, summer 2015), and has further explored through the Peer Learning Lab, which will result in recommendations and policy options for the State to further support ACHs. These initiatives are iterative, and continue to further our learning about the ACH concept and to create connections within and across communities. • The next version of the Sustainability Plan will further incorporate the Vermont Model of Care and some other key deliverables which stakeholders indicated were critical to include and codify in the Plan. The Core Team will receive a revised Sustainability Plan draft in early Spring for additional review. The meeting materials also include Attachment 3b, a monthly report to the Core Team from Myers & Stauffer.	
4. Connectivity Criteria	Georgia introduced this item, noting that the State worked closely with VITL to develop a methodology for identifying VHIE connectivity targets and to develop the targets themselves, which relate to the number of providers we will connect to the VHIE in the future. VITL was unable to attend this Core Team meeting, and sends regrets. Georgia also noted that the Steering Committee did not have a quorum at their December (final) meeting, so did not vote on this item; these targets were recommended by the HDI Work Group. • Paul asked about an HIT RFP within the DAs. Georgia clarified that the DAs are considering whether to acquire a single EMR. Lawrence added that this is an RFI intended to gather business requirements to think about how or whether to seek a unified EMR. Lawrence noted that this intersects with consent management and 42 CRF Part 2 issues.	

Agenda Item	Discussion	Next Steps
	Larry Sandage presented connectivity targets for the VHIE (Attachment 4). • Slide 4: Georgia noted that some providers within the long-term care category (a Federal designation) are not considered health care organizations under the federal definition, which leads to confidentiality and consent issues. This has prevented us from developing targets for some provider types. • Slide 5: Ongoing maintenance and upgrades are a significant portion of VITL's work. Discussion: • These recommendations assume level funding. Georgia noted that enhanced 90/10 match for expenditures in this category ends after 2021. • What kind of backup and security/privacy planning is involved in this? VITL stores all information with an offsite contractor which meets stringent security standards. • Who are the 176 LTSS providers currently connected? Nursing homes, AAAs, and other HCBS providers (not HHAs, which are listed separately). Robin Lunge noted that nursing homes are in the APM in Year 4. Georgia noted that there are still some entities without EMRs who are using paper, Excel, Word, or other methods of documenting information. Robin asked if there are other ways to do this that are more efficient; Georgia noted that this is a possibility. Lawrence suggested a cloud-based, openly available EMR system for these types of users may make the most sense; he has had a few conversations with the AHS Health Services Enterprise leadership on this topic. • Where do summary connection numbers come from? The HDI Work Group received a much more granular view; enforceability is a high priority. • Steven added that the Steering Committee conversation included discussion of what impact this would have on provider practices and their workflows. • Paul commented that his region's connectivity and ability to use analytics is less than he would like. • How is this sustainable? Lawrence noted that over time increasing proportions of work go to updates and maintenance, but that this continues to be an important investment in workflow and workforce (especially passive data collection). Lawrence requested a motion to approve the connectivity criteria (methodology) and targets. Paul moved to approve the target proposal. Steven Costantino seconded. A roll call vote was performed and the motion passed with one abstention.	
5. Budget Update and Proposed PP2 and PP3 Reallocations	Georgia Maheras presented two budget reallocations (Attachment 5). • Slide 3: Year 2 Budget includes changes based on carryover request approved by CMMI yesterday. We will be able to draw down the overwhelming majority of Year 2 funds. • Slide 4: Year 3 YTD. This includes obligated but unspent funds as well as unobligated funds.	

Agenda Item	Discussion	Next Steps
	• Slide 7: The Year 3 budget total has not changed, though there have been some modifications within the Contracts budget; in the future, there may also be reductions in 2017 to the equipment and CAP lines because of low spending. o Project Management – UMass: Ending contract as of 12/31 (rather than 6/30) because key personnel left the project. o Evaluation – JSI: JSI reduced due to lower than anticipated data visualization costs. o Health Data Infrastructure – HIS Professionals: Reduced due to match actuals. o Health Data Infrastructure – Opiate Alliance: Adding funds due to a shift between PP2 and PP3. o PMDI – Burns: Codifies an earlier funding increase. o PMDI – Deborah Lisi-Baker: Adding funds due to increased stakeholder engagement activity in 2016. Julie Wasserman noted that she had initially requested a no-cost extension for this contract, which is not contained in the current proposal. Lawrence replied that the no-cost extension is disallowable within the contract, due to the time period restrictions within our funding buckets and within the contract, so this will require a new contracting vehicle. Georgia noted that there is a difference between State contract authority and federal authorization for a time period – we have State contracting authority for this contract, but don't have federal authorization for continued spending in Performance Period 3. Federal authorizations were based on Q4 2015 and Q1 2016 spending within each contract. Susan Aranoff commented that the Vermont Developmental Disabilities Council believes continued consumer engagement is critical, especially given that SIM continues formally through June. Lawrence noted that continued consumer engagement at all levels was a significant discussion at this morning's Sustainability Sub-Group meeting. This is a relatively new contract matter and can't be addressed until the new year. He noted that the incoming AHS Secretary has been an active SIM participant and is familiar with this work. o Smaller amounts captured from other contracts contribute to larger amount available for sustainability: $1.7 million (previously $1.2 million). • Proposed expenditures: o Qlik Licenses: $300,000. A web-based data visualization tool; if approved, licenses could be acquired by the State at a discount. Ongoing costs to be paid by VCO. Licenses are momentary, not site licenses, so more individuals can utilize this tool. Paul noted that hospital EMRs provide some of these functions. Georgia clarified that Qlik would include information from a variety of sources, including from the VHIE, from VCO's UVM data, from Care Navigator, and more – and can provide real-time reports. In addition, the interface is very intuitive. o VCO: $1.2 million. Support VCO's ability to collect, analyze, and use data to support QI. Continued support for Community Collaboratives, as well as quality improvement initiatives. Includes specific outreach to FQHCs/CHAC members.	

Agenda Item	Discussion	Next Steps
	▪ Separate from SIM funds, there is a specific Medicare funding opportunity to support ACO activities to impact Medicare lives. The amount is not quite sufficient for our needs, nor is the Medicaid amount. This use of SIM funds, which are flexible, can fill the gap; this is an approach supported by CMMI and the incoming Administration. ▪ Paul noted that at some point, VCO members are going to have to fund VCO in an ongoing fashion. Lawrence noted that scale will support this to some extent by spreading fixed overhead. ▪ Julie Wasserman noted that at a past Core Team meeting, the Core Team voted to approve $1.2 million in sustainability funds which would not all go to VCO – what changed? Lawrence noted that the total amount increased, so not all funds are going to VCO. In addition, we received additional clarity on the financial ask and the deliverables, and additional clarity on what we can spend other funds on. These tasks have no alternative funding sources to meet federal expectations for the APM. There would be $200,000+ left reallocated. ▪ Susan Aranoff commented that the motion approved at the previous meeting would include readiness for non-VCO providers, and a process for non-VCO providers to apply for those funds. Lawrence noted that this includes CHAC and OneCare, as well as possibly Healthfirst. It also includes funding for Community Collaboratives which are not VCO-specific and does include non-ACO providers. Sue suggested that there should be more process to include more non-ACO providers and stronger contract requirements and enforcement. Lawrence noted that there will be later approval of a contract if this request is approved. Robin commented that the Green Mountain Care Board has begun drafting a rule to support the ACO regulatory process. Lawrence requested a motion to approve the budget update as presented in Attachment 5. Paul Bengtson moved approval and requested a full budget for this project at a future date. Steven Costantino seconded. A roll call vote was taken and the motion was approved.	
6. Public Comment	There was no public comment.	
7. Next Steps, Wrap Up and Future Meeting Schedule	This is the final Core Team meeting of 2016. A number of Core Team members are appointees and will likely change in 2017. The incoming administration may also wish to restructure the organization of the Core Team. This is Lawrence's final meeting as Chair. Core Team members thanked each other for their participation, and Lawrence for his leadership.	

VHCIP Core Team Member List

Roll Call: 12/20/2016

1° Paul 2° Steven | 1° Paul 2° Steven | 1° Paul 2° Steven | ul more contract detail to the Core Team as follow-up.

Member		11/14/2016 Minutes	Connect. Criteria	Budget Reallocation	
First Name	Last Name				Organization
Paul	Bengston ✓	✓	✓	✓	Northeastern Vermont Regional Hospital
Hal	Cohen ✓	✓	✓	✓	AHS -CO
Steven	Costantino ✓	✓	✓	✓	AHS - DVHA
Al	Gobeille	—	—	—	GMCB
Monica	Hutt X	—	—	—	AHS - DAIL
Robin	Lunge ✓	✓	~~Abstain~~	✓	AOA - Director of Health Care Reform
Lawrence	Miller ✓	✓	✓	✓	AOA - Chief of Health Care Reform
Steve	Voigt ✓	✓	—	—	ReThink Health
		passes	passes	passes	

Attendees:
Kate O'Neill
Dale Hackett
Larry Sandage
Sue Aranoff
Chrissy Geiler
Julie Wasserman

Venesa Day
Diane Cummings
Karen Sinor
Sarah Kinsler
Georja Maheras

VHCIP Update: Core Team

Georgia Maheras, Project Director

Vermont Health Care Innovation Project (SIM)

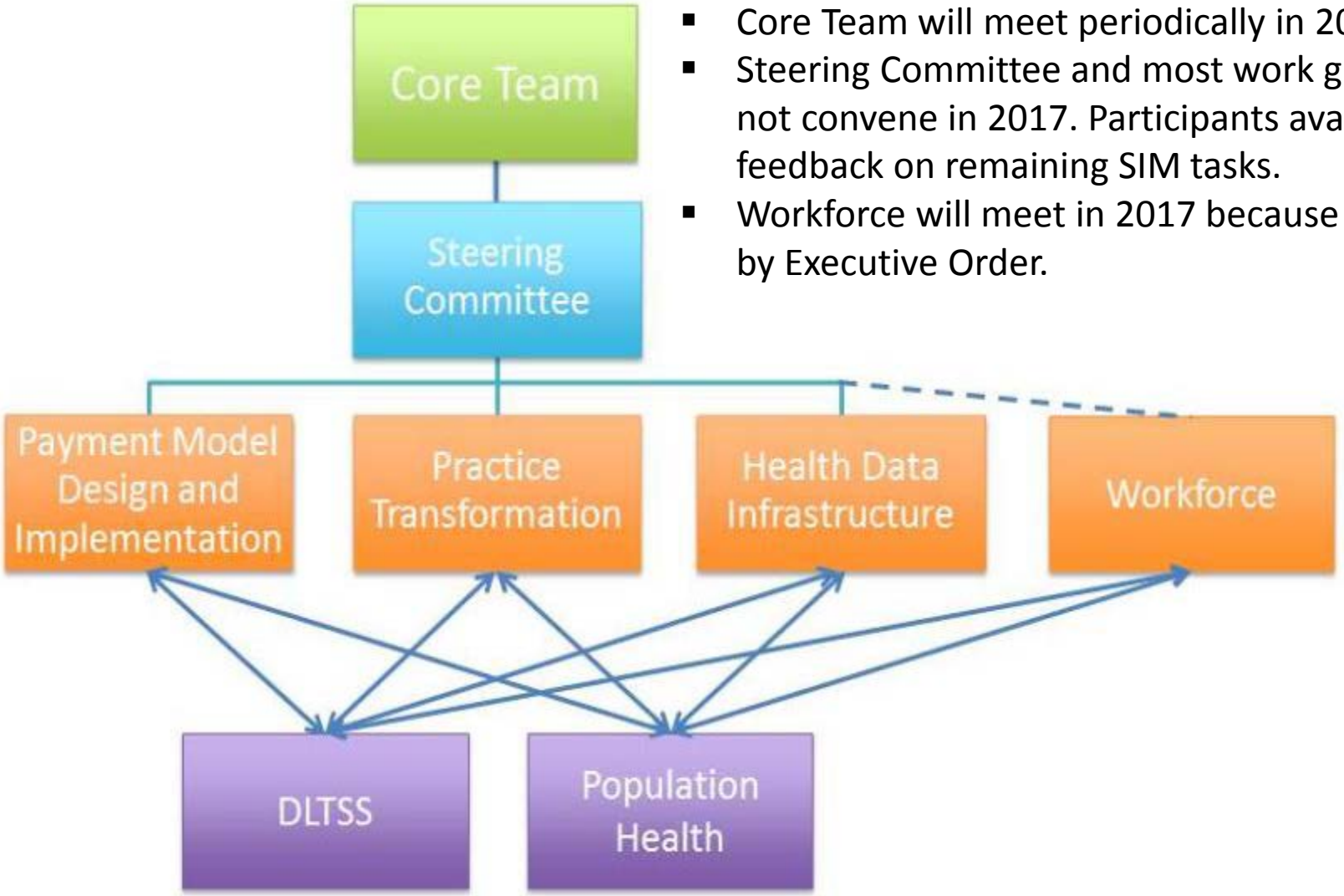
February 2017

State Innovation Model (SIM) Testing Grant:

- Awarded to only 6 states in round one.
- Vermont received $45 million from the Center for Medicare and Medicaid Innovation.
- Funds spread across 4.5 years.
  - In final performance period (ends 6/30/17) with a no-cost extension, final funds will be expended by 11/30/17.
- CMMI is testing: Innovative payment and service delivery models that have the potential to lower costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while maintaining or improving quality of care for program beneficiaries.
  - i.e., Can states use their unique tools to influence payment and delivery system reform?

GOVERNANCE

SIM Governance: Public-Private Partnership



- Core Team will meet periodically in 2017.
- Steering Committee and most work groups will not convene in 2017. Participants available for feedback on remaining SIM tasks.
- Workforce will meet in 2017 because created by Executive Order.

Core Team Responsibilities

- This group meets monthly to provide overall direction to Vermont's SIM project, synthesizes and acts on guidance from the Steering Committee, makes funding decisions, sets project priorities, and helps resolve any conflicts within the project initiatives.
- Approve Sustainability Plan and Population Health Plan.
- Review Evaluation results.

Steering Committee Responsibilities

- The Steering Committee met monthly through December 2016 to inform, educate, and guide the Core Team in all of the work planned and conducted under the SIM grant. In particular, the group guided the Core Team's decisions about investment of project funds, necessary changes in state policy, and how best to influence desired innovation in the private sector.
- The membership of the Steering Committee brought a broad array of perspectives from multiple agencies within state government, and multiple groups and organizations from outside state government. The Steering Committee included at least one of the co-chairs of each work group.

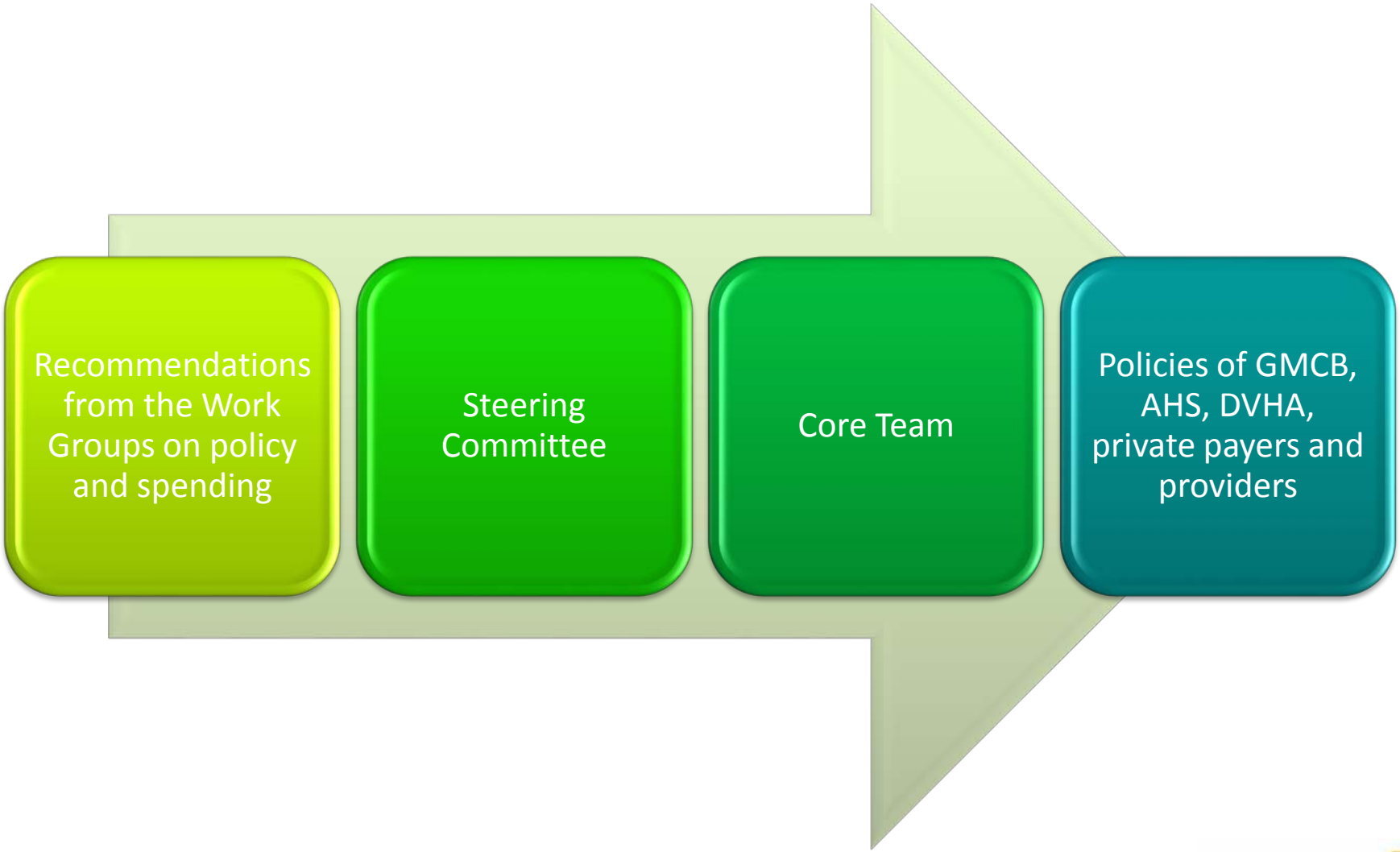
Work Group Responsibilities

- Vermont's SIM project has been supported and guided by six work groups.
  - Payment Model Design and Implementation
  - Practice Transformation
  - Health Data Infrastructure Work Groups
  - Workforce Work Group
  - Disability and Long-Term Services and Supports (DLTSS) Work Group
  - Population Health Work Group
- These work groups reported up to the Steering Committee and Core Team, and made policy recommendations and funding recommendations to those groups. Member lists and workplans for these work groups are available on the project website: http://healthcareinnovation.vermont.gov.

Core Team

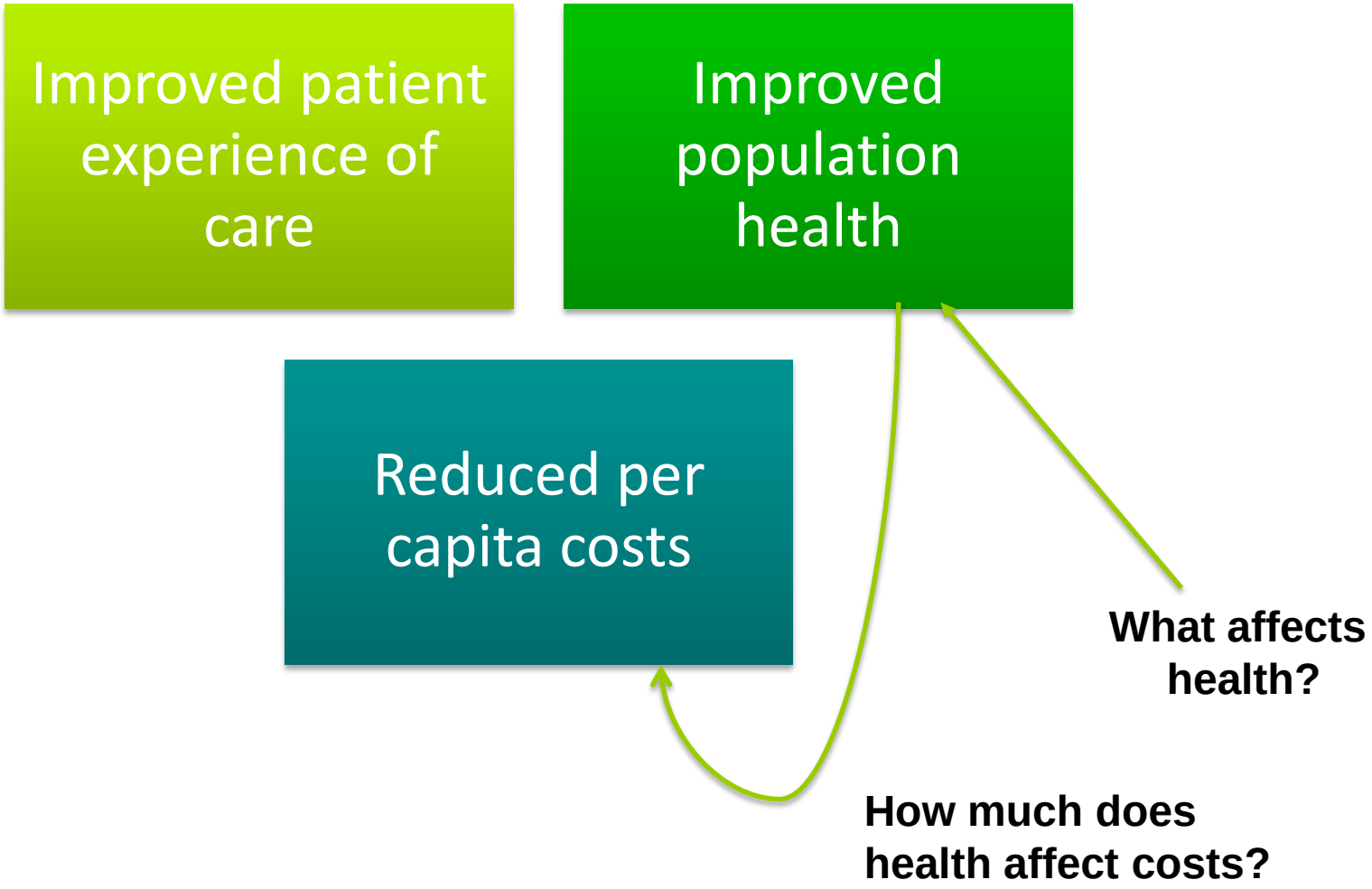
- Mary Kate Mohlman, Director of Health Care Reform, Chair
- Al Gobeille, Secretary of Human Services
- Robin Lunge, Member of the Green Mountain Care Board
- Cory Gustafson, Commissioner of the Department of Vermont Health Access
- Monica Hutt, Commissioner of the Department of Disabilities, Aging and Independent Living
- Harry Chen/Mark Levine, Commissioner of the Department of Health
- Melissa Bailey, Commissioner of the Department of Mental Health
- Steve Voigt, Rethink Health
- Paul Bengtson, CEO of Northeastern Vermont Regional Hospital

How does the project work?



WHAT IS VERMONT DOING?

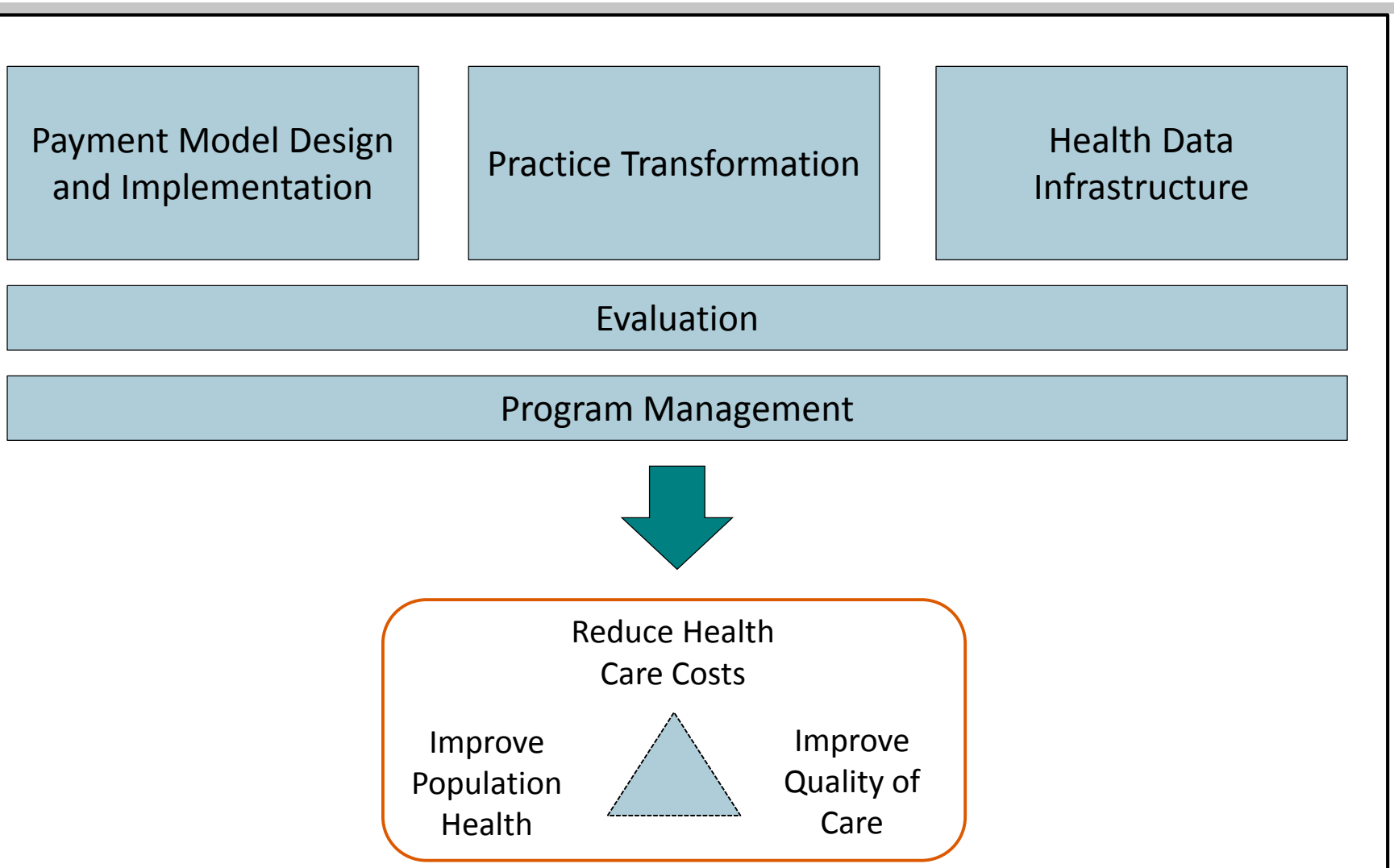
VHCIP's goal: the "triple aim"



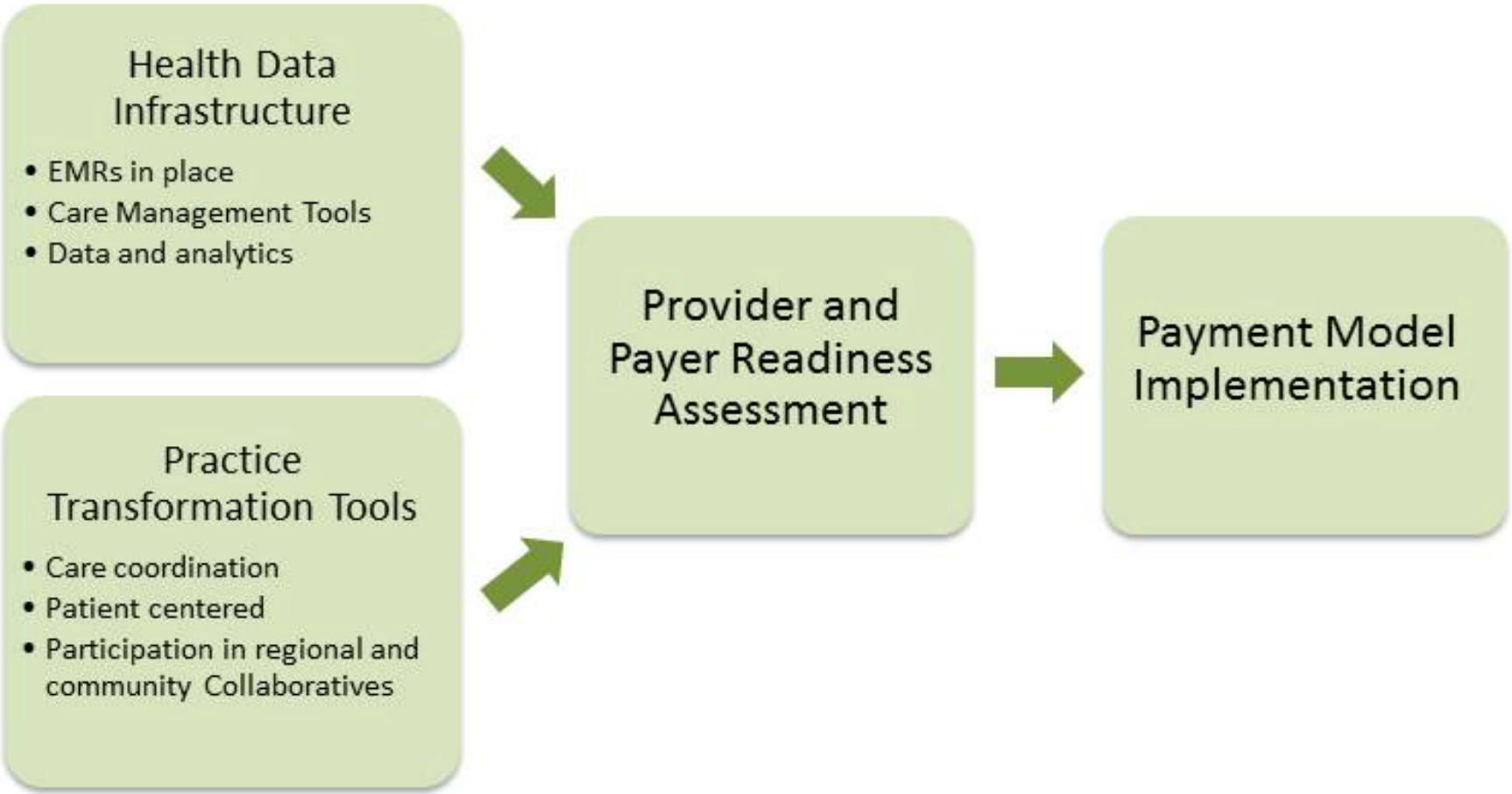
Four specific programmatic goals:

- 80% of Vermonters in alternatives to fee-for-service (FFS), from 41% in 2013 to 80% in 2017.
- By 12/31/2016, in adult Vermont residents attributed to an ACO, the % with diabetes HbA1c Poor Control will be 20% or less, 70% or more with an abnormal BMI will have a follow-up plan documented, and 85% or more identified as tobacco users will receive a cessation intervention.
- The number of providers with at least one interface to the Vermont Health Information Exchange will increase from 130 to at least 400 by 6/30/17.
- Cost avoidance of $45 million generated through payment models.

How do we do it?



Building Blocks to a Successful Payment Model



PAYMENT MODELS

A new payment system should promote value for money

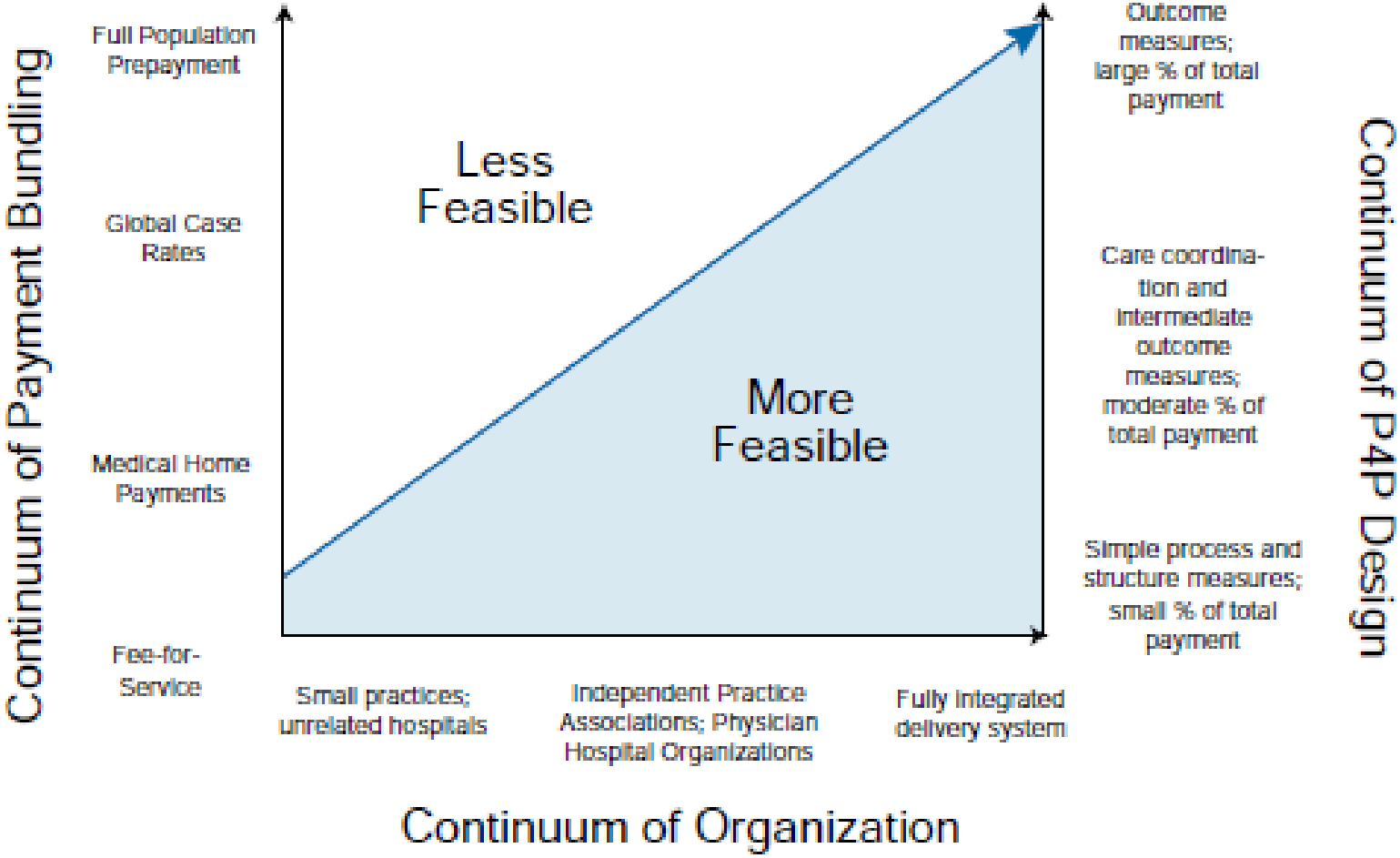
"The ultimate objective of any payment reform is to motivate behavioral change that leads to lower costs, better care coordination, and better quality.

Providers will be better able to achieve these objectives if the payment methodology:

- is clinically meaningful
- communicates actionable information in a form and at a level of detail sufficient to achieve sustainable behavior changes."

Cutler, David M., Ph.D., and Ghosh, Kaushik , Ph.D. (March 22, 2012) The Potential for Cost Savings through Bundled Episode Payments, *N Engl J Med 2012*; 366:1075-1077. DOI: 10.1056/NEJMp1113361

Framework for High Performance System



Source: The Commonwealth Fund, 2008

Programs

- **Medicaid and commercial Shared Savings ACO Programs: Launched 2014.[1]**
  - **Medicaid 2014-2016**
  - **Commercial 2014-2017**
- **Blueprint for Health (P4P): Launched 2007. Changes over time.**
- **All-Payer Model (Population-based payment design):**
  - **Medicaid Next Gen 2017**
  - **Year 0 for Medicare and commercial**
- **Research and preliminary design for Medicaid services not included in the initial year of the APM(bundled payments, P4P).**

[1] Bold text indicates ongoing work.

PRACTICE TRANSFORMATION

Programs

- Care Management landscape analysis
- Learning Collaboratives: 2014-2016
  - In 11 of Vermont's HSAs
  - Core Competency Trainings in care management and disability awareness.
- Sub-Grant Program: 2014-2016
  - 14 awards totaling $4.9m
- **Community Collaboratives (Blueprint/ACO alignment)[1]**
- **Accountable Communities for Health**
- Workforce supply and **demand modeling.**

[1] Bold text indicates ongoing work.

HEALTH DATA INFRASTRUCTURE

Programs

- Gap Analyses for ACO and DLTSS providers.
- Gap Remediation for ACO member organizations and Designated Mental Health and Specialized Service Agencies.
- ACO Gateways for OneCare, CHAC, and Health*first*.
- Data Quality improvement for ACO providers and Designated Agencies.
- Telehealth Strategic Plan finalized; **Telehealth Pilots selected**[1].
- EMRs acquired for five Specialized Services Agencies (SSAs) and for the Dept. of Mental Health/State Psychiatric Hospital.
- **DA/SSA Data Repository developed**.
- Business and technical requirements developed for Universal Transfer Protocol and Shared Care Plan solutions.
- **Event Notification System launched**.
- Health Data Inventory completed.
- **Interfaces and VITLAccess connections for Home Health Agencies**.

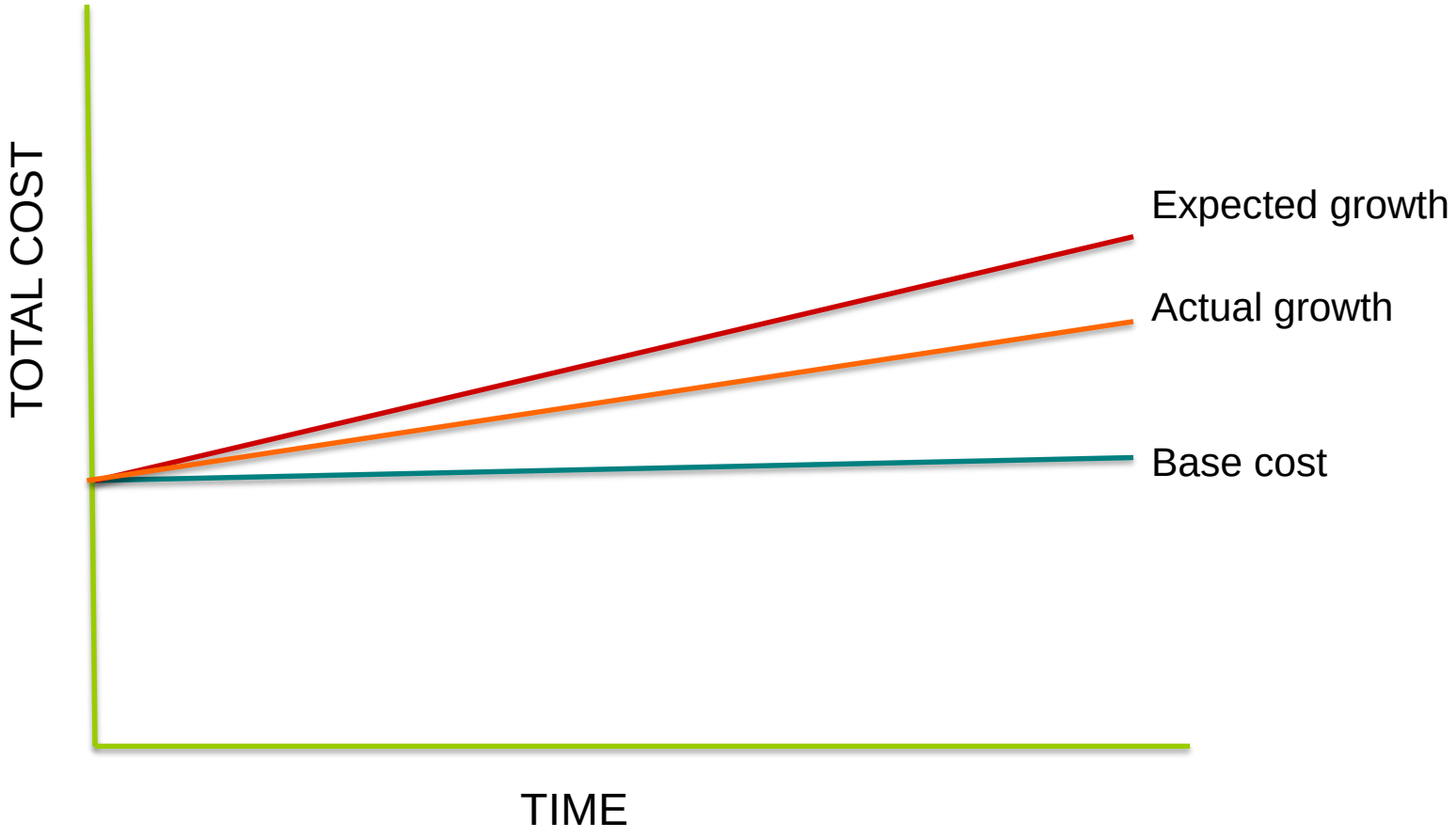
[1] Bold text indicates ongoing work.

HOW ARE WE DOING?

What is success?

- Supporting creation and implementation of value-based payments for providers in Vermont across all payers.
- Supporting the inclusion of 80% of Vermonters in alternatives to fee-for-service.
- Creation of a system of care management that is agreed to by all payers and providers that:
  - Utilizes advanced primary care infrastructure to the greatest extent possible;
  - fills gaps;
  - eliminates duplication of effort;
  - creates clear protocols for providers;
  - reduces confusion and improves the care experience for patients; and
  - follows best practices.
- Creation of a health data infrastructure to support a high-performing health system.
- Includes activities that *support provider and payer readiness* to participate in alternative payment models.

Savings are dollars not spent



Snapshot of SIM Payment Model Impacts

		Q4 2016
Beneficiaries Impacted	Commercial SSP*	44,472
	Medicaid SSP*	67,515
	Medicare SSP*	55,487
	Commercial Blueprint (APMH/P4P)	119,069
	Medicaid Blueprint (APMH/P4P)	96,958
	Medicare Blueprint (APMH/P4P)	74,366
	Medicaid Health Home	3,241
Participating Providers	Medicare, Medicaid, Commercial SSPs	1,105
	Blueprint (APMH/P4P)	795
	Medicaid Health Home	180
Provider Organizations	Medicare, Medicaid, Commercial SSPs	60
	Blueprint (APMH/P4P)	128
	Medicaid Health Home	5

Snapshot of SIM Care Delivery & Health Data Infrastructure Impacts

	Impact
Health Data Infrastructure	1000+ Providers
Care Delivery & Practice Transformation: Learning Collaboratives	~440 Providers
Care Delivery & Practice Transformation: Sub-Grant Program	14,078 Providers 339,648 Vermonters

What's left?

- **Payment Models:**
  - **Y3 SSP calculations and reporting continue through no-cost extension period.**
  - **Medicaid and APM-specific design and implementation activities (6/30/17).**
- **Practice Transformation:**
  - **Community Collaboratives (OCV) (6/30/17).**
  - **Accountable Communities for Health (4/1/17).**
  - **Workforce Demand Modeling (4/1/17).**
- **Health Data Infrastructure:**
  - **Finish Telehealth; HHA; ENS; Data repository (6/30/17).**
- **Evaluation: Gathering lessons learned from across the project. Evaluation activities continue through no-cost extension period.**
- **Population Health Plan (due to CMMI 6/30/17).**
- **Sustainability Planning (due to CMMI 6/30/17).**
- **Final financial decisions (9/30/17).**
- **Final reporting through no-cost extension period.**

Want to know more? Check out our monthly status reports:
http://healthcareinnovation.vermont.gov/tags/status-reports

Population Health Plan

- VDH is lead on plan development; assisted by contractor.
  - Draft completed and presented to stakeholders in Fall 2016.
  - Stakeholders requested additional input opportunities prior to final submission.
- CMMI required element (must include actionable steps).
  - CMMI guidance indicates that the Population Health Plan should complement the State Health Improvement Plan and include actionable steps for advancing integration of population health and primary prevention activities with health system transformation efforts. The Population Health Plan draft submitted in Fall 2016 received positive feedback from CMMI, federal partners, and SIM Technical Assistance partners.
- Approval needed by 6/30/17.

Sustainability Plan

- Project Director is lead on development; supported by contractor.
  - Draft completed and presented to stakeholders in Fall 2016.
  - Stakeholders requested additional input opportunities prior to final submission.
- CMMI required element (must include actionable steps).
  - CMMI guidance indicates that the Sustainability Plan should provide "an evidence-based financial model for sustaining new payment and service delivery model(s) after the testing phase is complete based on leveraging a comprehensive set of funding sources." It must include a vision statement, a governance section, a description of how SIM-supported payment and delivery system reforms are expected to evolve and which activities will be continued, and how they will be supported in the future.
  - The Sustainability Plan draft submitted in Fall 2016, which omitted financial information in deference to the Governor's budget, received positive feedback from CMMI, federal partners, and SIM Technical Assistance partners.
- Approval needed by 6/30/17.

Final Reporting

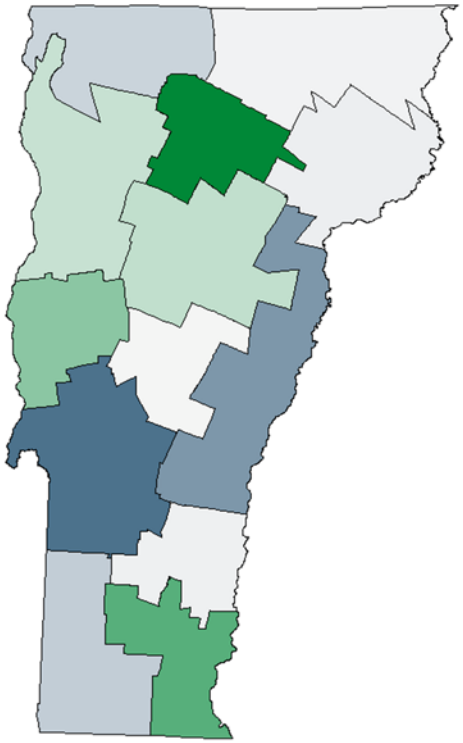
- Quarterly Reports due to CMMI (and Legislature).
- Biweekly phone calls with CMMI.
- Monthly Status Reports.
- Final Programmatic Report due within 30 days of end of final expenditures (12/31/17).
- Final Financial Report due 90 days after end of final expenditures (2/28/17).

Final Financial Decisions

- Core Team is given Actuals to Budget updates at each meeting for PP2 and PP3.
- Decisions regarding budget reallocations at each meeting.
- No-Cost Extension due 4/30/17 so Core Team decision must be prior to this.

Financial Snapshot (illustrative- as of 12/2016)

Year 3 Budget - CMS/CMMI Approved July 1, 2016 - June 30, 2017				
BUDGET CATEGORY	**BUDGET-YEAR 3**	**ACTUALS and Unpaid Contract Invoices to 11/30/16**	**CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)**	**REMAINING UNOBLIGATED BALANCE**
Personnel/Benefits	$ 1,552,759.00	$ 634,926.24		$ 917,832.76
Operating (includes Indirect*except 9/30/16)	$ 659,604.57	$ 113,571.62		$ 546,032.95
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 2,117,124.00	$ 423,989.88	$ 1,693,134.12	
PAYMENT MODELS-TOTAL	$ 2,980,439.05	$ 1,129,612.67	$ 1,850,826.38	
CARE MODELS-TOTAL	$ 593,503.60	$ 309,583.76	$ 283,919.84	
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ 47,238.00	$ 21,351.77	$ 25,886.23	
EVALUATION-TOTAL	$ 1,450,543.71	$ 107,562.18	$ 1,342,981.53	
GENERAL-TOTAL	$ 281,851.00	$ 53,233.52	$ 228,617.48	
SUSTAINABILITY-TOTAL	$ 1,715,056.65	$ 99,666.68	$ 1,615,389.97	
CMMI Required: Population Health Plan-TOTAL	$ 40,000.00	$ 25,625.00	$ 14,375.00	
Contractual Total	$ 9,225,756.01	$ 2,170,625.46	$ 7,055,130.55	$ -
TOTAL YEAR 3 BUDGET	**$ 11,438,119.58**	**$ 2,919,123.32**	**$ 7,055,130.55**	**$ 1,463,865.71**



VHCIP State-Led Evaluation Overview

VERMONT
GREEN MOUNTAIN CARE BOARD

Overview

Areas of Work

- Conduct a State-led Qualitative Evaluation Study
- Provide Evaluation Findings
- Create and Assist in Implementing a Learning Dissemination Plan

Three Research Areas

- Care Integration
- Use of Clinical and Cost Data to Promote Value-Based Care
- Payment and Delivery System Reform

Major Components

- Site Visits (clinical, care coordination, sub-grantees)
- Focus Groups (IFS, Dual-Eligible, complex health needs, SASH)
- Provider Surveys (Advanced Practice Professionals and Care Coordination Staff)
- Learning Dissemination and Data Visualization (variety of audiences, communication channels, dissemination method, plus exploratory on-line dashboard and visual report decks)

Themes in Early Findings

Health Reform/SIM Generally

- Vision, Goal Alignment
- Structure
- Reform Roles and Responsibilities
- Integration
- High Value Activities
- Expansion
- State Standardization and Local Customization
- Community Scale
- Provider Involvement

Data and Data Infrastructure

- Building Capacity
- Standardization
- Compatibility
- Burden

Payment Reform

- Transparency
- Approaches/Strategies
- Investments in Delivery System Redesign
- Policy and Payment Barriers
- Measurement Alignment

Care Coordination

- Building on Existing Infrastructure
- Quality Improvement and Performance Measurement
- Care Integration
- Commitments and Incentives
- Resources

Looking Ahead

Spring 2017:

- Complete Data Gathering
- Establish findings and recommendations
- Disseminate and communicate findings

Fall 2017:

- Final Evaluation Report due

Budget to Actuals and Budget Reallocation for PP3

March 1, 2017

Georgia Maheras, JD

Project Director

Year 1 Budget-Complete

Vermont Health Care Innovation Project Year 1 Budget October 1, 2013 - December 31, 2015				
BUDGET CATEGORY	**BUDGET-YEAR 1**	**FINAL EXPENSES**	**CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)**	**REMAINING UNOBLIGATED BALANCE**
Personnel/Benefits	$ 2,657,072.25	$ 2,657,072.25	$ -	$ -
Operating (includes Indirect)	$ 945,675.10	$ 945,675.10	$ -	$ 0.00
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 3,631,455.14	$ 3,553,086.46	$ 78,368.68	
PAYMENT MODELS-TOTAL	$ 3,898,088.35	$ 3,725,234.22	$ 172,854.13	
CARE MODELS-TOTAL	$ 242,754.13	$ 219,429.08	$ 23,325.05	
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ 2,385,707.27	$ 2,376,417.48	$ 9,289.79	
EVALUATION-TOTAL	$ 1,656,538.42	$ 1,645,151.77	$ 11,386.65	
GENERAL-TOTAL	$ 680,068.17	$ 671,457.20	$ 8,610.97	
CMMI Required: Population Health Plan-TOTAL	$ 26,945.68	$ 26,945.68	$ -	
Contractual Total	$ 12,521,557.16	$ 12,217,721.89	$ 303,835.27	$ 0.00
TOTAL YEAR 1 BUDGET	**$ 16,124,304.51**	**$ 15,820,469.24**	**$ 303,835.27**	**$ 0.00**

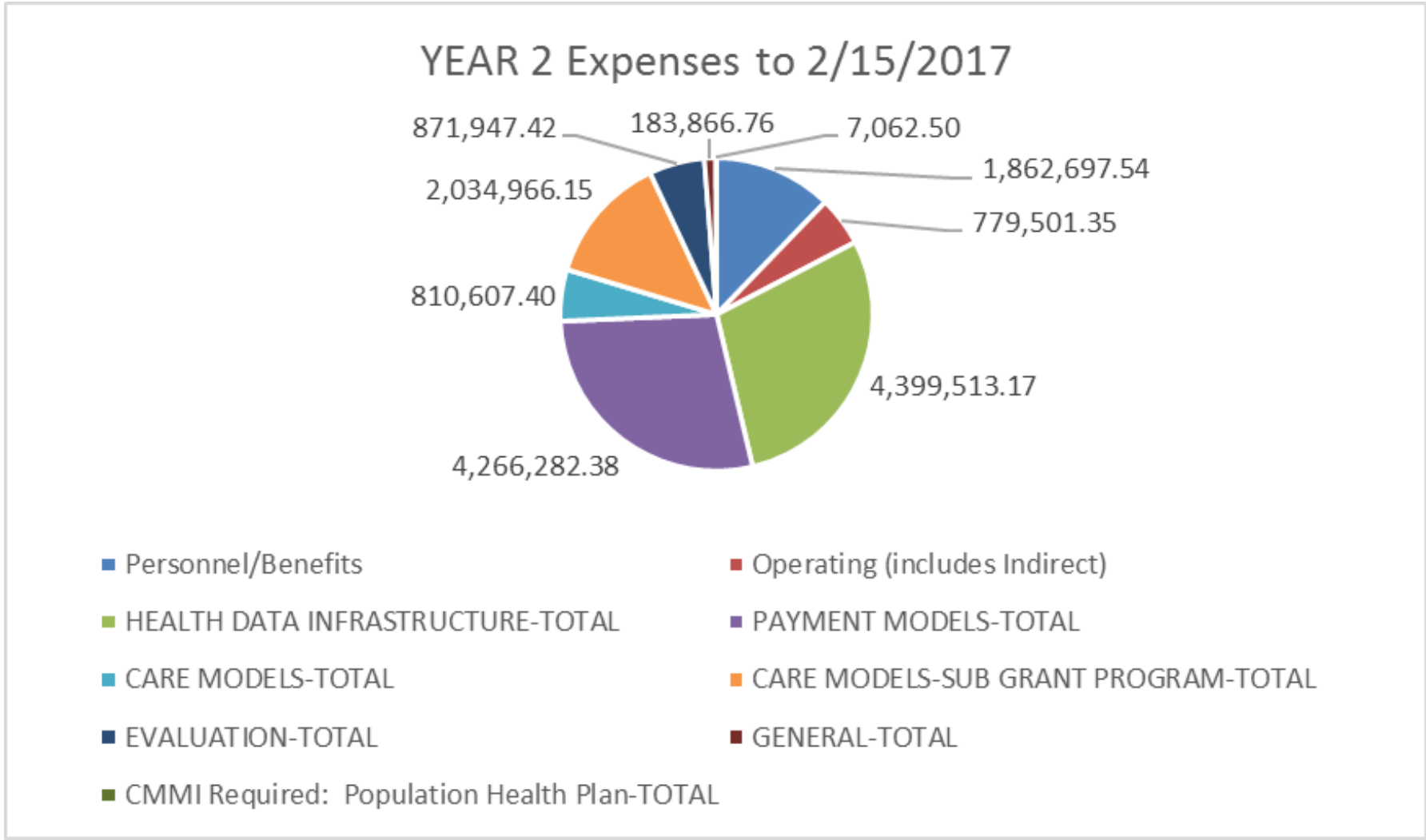
Year 2 Budget

Year 2 Budget -CMS/CMMI Approved January 1, 2015 - June 30, 2017				
BUDGET CATEGORY	**BUDGET-YEAR 2**	**ACTUALS and Unpaid Contract Invoices to 02/15/17**	**CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)**	**REMAINING UNOBLIGATED BALANCE**
Personnel/Benefits	$ 1,862,697.54	$ 1,862,697.54		$ (0.00)
Operating (includes Indirect)	$ 798,501.35	$ 779,501.35		$ 19,000.00
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 5,083,817.92	$ 4,399,513.17	$ 684,304.75	
PAYMENT MODELS-TOTAL	$ 5,117,318.73	$ 4,266,282.38	$ 851,036.35	
CARE MODELS-TOTAL	$ 1,228,366.77	$ 810,607.40	$ 417,759.37	
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ 2,288,500.24	$ 2,034,966.15	$ 253,534.08	
EVALUATION-TOTAL	$ 876,924.11	$ 871,947.42	$ 4,976.69	
GENERAL-TOTAL	$ 183,866.76	$ 183,866.76	$ -	
CMMI Required: Population Health Plan-TOTAL	$ 7,062.50	$ 7,062.50	$ -	
Contractual Total	$ 14,785,857.02	$ 12,574,245.78	$ 2,211,611.24	$ -
TOTAL YEAR 2 BUDGET	**$ 17,447,055.91**	**$ 15,216,444.67**	**$ 2,211,611.24**	**$ 19,000.00**

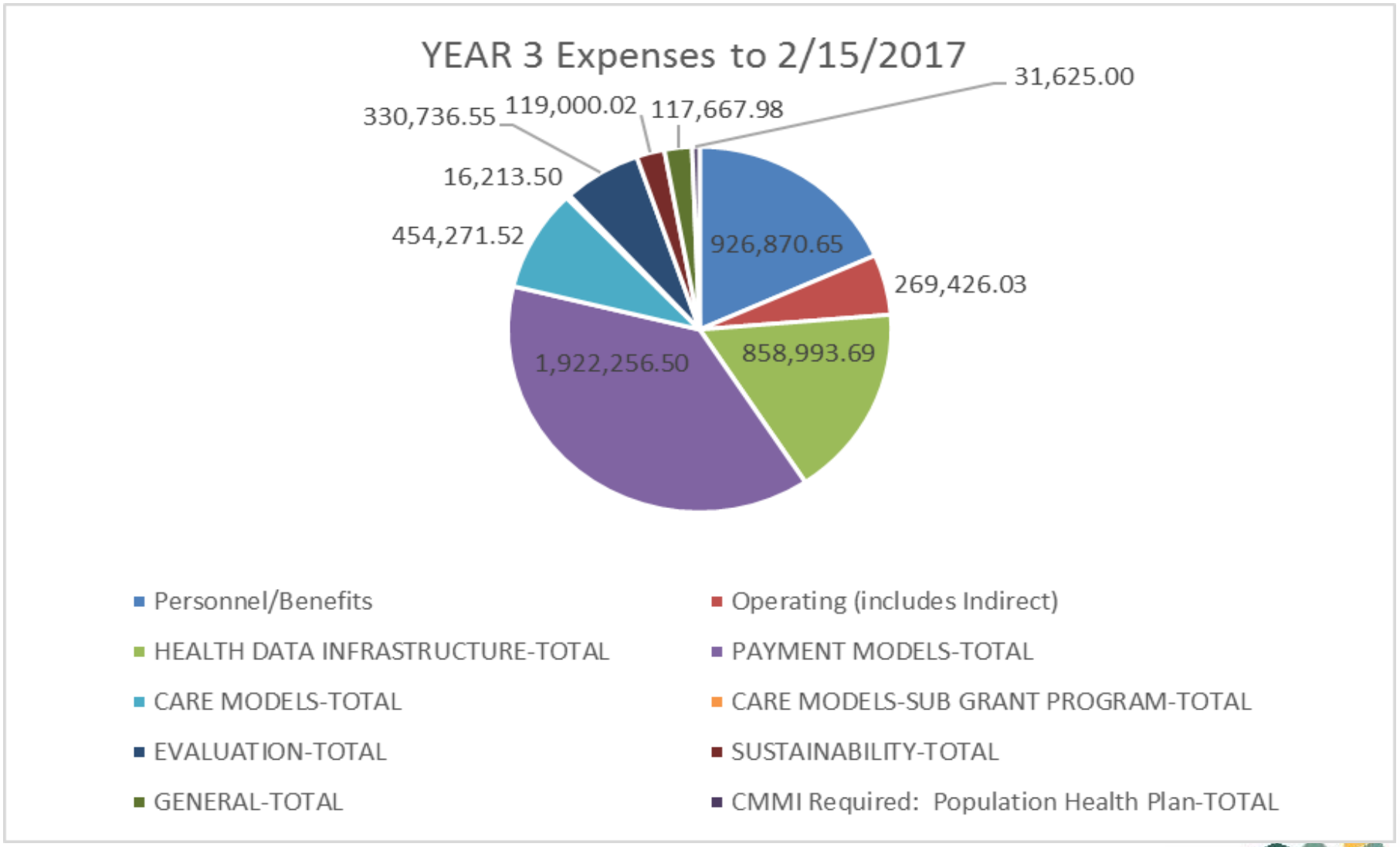
Year 3 Budget-YTD

Year 3 Budget - CMS/CMMI Approved July 1, 2016 - June 30, 2017				
BUDGET CATEGORY	**BUDGET-YEAR 3**	**ACTUALS and Unpaid Contract Invoices to 02/15/17**	**CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)**	**REMAINING UNOBLIGATED BALANCE**
Personnel/Benefits	$ 1,552,759.00	$ 926,870.65	$ 625,888.35	$ -
Operating (includes Indirect Actuals*except 03/31/17)	$ 659,604.57	$ 269,426.03	$ 163,605.13	$ 226,573.41
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 2,117,124.00	$ 858,993.69	$ 1,258,130.31	
PAYMENT MODELS-TOTAL	$ 2,980,439.05	$ 1,922,256.50	$ 1,058,182.56	
CARE MODELS-TOTAL	$ 593,503.60	$ 454,271.52	$ 139,232.08	
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ 47,238.00	$ 16,213.50	$ 31,024.50	
EVALUATION-TOTAL	$ 1,450,543.71	$ 330,736.55	$ 1,119,807.16	
GENERAL-TOTAL	$ 281,851.00	$ 117,667.98	$ 164,183.02	
SUSTAINABILITY-TOTAL	$ 1,715,056.65	$ 119,000.02	$ 1,596,056.63	
CMMI Required: Population Health Plan-TOTAL	$ 40,000.00	$ 31,625.00	$ 8,375.00	
Contractual Total	$ 9,225,756.01	$ 3,850,764.76	$ 5,374,991.25	$ -
TOTAL YEAR 3 BUDGET	**$ 11,438,119.58**	**$ 5,047,061.44**	**$ 6,164,484.73**	**$ 226,573.41**

Pie chart


YEAR 2 Expenses to 2/15/2017
871,947.42
183,866.76
7,062.50
1,862,697.54
2,034,966.15
779,501.35
810,607.40
4,399,513.17
4,266,282.38
Personnel/Benefits
Operating (includes Indirect)
HEALTH DATA INFRASTRUCTURE-TOTAL
PAYMENT MODELS-TOTAL
CARE MODELS-TOTAL
CARE MODELS-SUB GRANT PROGRAM-TOTAL
EVALUATION-TOTAL
GENERAL-TOTAL
CMMI Required: Population Health Plan-TOTAL

Pie chart


YEAR 3 Expenses to 2/15/2017
31,625.00
330,736.55
119,000.02
117,667.98
16,213.50
454,271.52
926,870.65
269,426.03
858,993.69
1,922,256.50
Personnel/Benefits
Operating (includes Indirect)
HEALTH DATA INFRASTRUCTURE-TOTAL
PAYMENT MODELS-TOTAL
CARE MODELS-TOTAL
CARE MODELS-SUB GRANT PROGRAM-TOTAL
EVALUATION-TOTAL
SUSTAINABILITY-TOTAL
GENERAL-TOTAL
CMMI Required: Population Health Plan-TOTAL

PP2 Reallocation Request

1. Increase funds for Burns and Associates (sub-grant program savings) by $257,602.01.

PP3 Total Budget: $11,438,119.58

- Personnel: $1,060,990
- Fringe: $491,769
- Travel: $32,987.50
- Equipment: $14,608.76
- Other: $177,572.50
- Supplies: $10,040
- CAP: $424,395.81
- Contracts: $9,225,756.01

Project Management: $120,000
Evaluation: $676,823.04

No Changes:

- Project Management:
  - UMass: $120,000
- Evaluation:
  - Self-Evaluation Plan:
    - JSI: $562,773.50 learning dissemination/data visualization was lower cost than previous estimate.
  - Surveys:
    - Datastat: $114,049.54
    - Monitoring and Evaluation Activities:
      - Lewin, Burns, and Bailit (part of the Payment Models estimates)

Practice Transformation: $3,085,396.15

- Learning Collaboratives:
  - Abernathey: $19,000
  - VPQHC: $62,198.60
  - Core Competency:
    - DDC: $144,412.50
    - PCDC: $191,850.98 (reduction of $11,139.02)
  - Accountable Communities for Health: $130,983 (reduction of $29,017)
- Regional Collaborations:
  - BiState/CHAC: $861,225.05
  - OneCare: $2,245,570
- Practice Transformation:
  - DA/SSA (Medicaid Pathway): $400,000 (No-Cost Extension to 6/30/17)
- Sub-Grant TA:
  - Policy Integrity: $25,000
- Workforce Demand Model:
  - IHSGlobal: $277,000 (Increase of $82,000 due to allocation from PP2 to PP3)

Health Data Infrastructure: $1,781,911.80

- Home Health Agency Project:
  - VITL: $618,000 (Budget Reallocation- see below)
- Designated Agency Data Quality:
  - VITL: $75,000
- ACO Gateway Support:
  - VITL: $269,370
- Work Group Support:
  - Stone: $93,000
- Data Warehousing:
  - BHN/VCN: $626,754 (Budget Reallocation- see below)
  - H.I.S.: $7,965
- Opiate Alliance: $91,822.82

Payment Model Design and Implementation: $1,509,786.45

- Several contractors provide support across Payment Models:
  - Bailit Health Purchasing, Inc.: $244,920 (No-Cost Extension request)
  - Burns and Associates: $350,000
  - Pacific Health Policy Group: $180,000
  - DLB: $21,000
  - Maximus: $200
  - Friedman: $10,000
- ACO SSPs:
  - Lewin: $778,666.45

Sustainability and Population Health Plan:

No Changes.

- Sustainability Plan:
  - Myers & Stauffer: $200,000
- Population Health Plan:
  - VT Public Health Assn: 30,000
  - Hester: $5,000

Amount remaining in sustainability: $143,309.59

For Discussion-proposed budget reallocations:

- BHN/VCN Data Repository:
  - Initial scope and budget required ADT and CCD/CCDA information to be shared by DAs into the repository. This is not technically feasible and would cost $30,000 per agency to implement and put timelines at risk. The data will be in the repository, but through different means than in the initial scope of work.

  - Request: Leverage several existing tools to achieve a very similar result for a much smaller investment, and within our project timeline. Engage Designated Agency Data Analysts to design extracts from their EMR systems. These extracts use industry standard tools to populate a file specification that we have developed based on modified HL7 ADT CCD format. Leveraging our current investment in import and Extract, Transform, Load (ETL) capabilities currently in place to process MSR files. This mechanism will be copied and adapted to process a more robust data set, on a much higher frequency, and will be automated to the greatest extent possible.
  - The warehousing vendor will also provide additional support services for the DAs.
  - All changes are within the original contract amount.