VT Health Care Innovation Project
Core Team Meeting Agenda

January 15, 2016 10:30am-12:00pm
109 State Street, Pavilion Building, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	10:30-10:35	Welcome and Chair's Report	Lawrence Miller	Link to: No-Cost Extension Work to be Performed Link to: December Status Reports Attachment 1: Work Group Workplans
Core Team Processes and Procedures				
2	10:35-10:40	Approval of meeting minutes	Lawrence Miller	Attachment 2: December 9, 2015 *Decision needed.*
Spending Recommendations:				
3	10:40-11:10	Funding requests: a. New: IFS Contract (uses Y2 TBD funds)--$5,000 b. New: DA/SSA Quality Improvement (uses Y2 TBD funds)--$75,000 c. Revision: Terminology Services (uses Y2 TBD funds)--$135,900 d. Revision: CVMC-Sub-Grantee Budget Change Request—no change in total amount	Georgia Maheras	Attachment 3a: Y1 and Y2 Actuals and Funding request Attachment 3b: CVMC Proposal *Decision needed.*

Policy Recommendations				
4	11:10-11:20	Payment Models Work Group: a. Medicaid SSP – Total Cost of Care for Y3 Update b. Commercial SSP-Downside Risk Update	Alicia Cooper and Richard Slusky	Attachment 4a: Medicaid SSP Attachment 4b: Commercial SSP
5	11:20-11:30	*Public Comment*	Lawrence Miller	
6	11:30-11:35	Next Steps, Wrap-Up and Future Meeting Schedule: January 29th, 10:30am-12:00pm, Pavilion Building, 109 State Street, Montpelier	Lawrence Miller	

Attachment 1: Work Group Workplans

Vermont Health Care Innovation Project
2016 DLTSS Work Group Workplan

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Quality and Performance						
1	Provide input on quality and performance related to SIM and other relevant activities.	Continue to develop the DLTSS sub-analysis of Medicaid and Commercial ACO SSP quality and performance measures. Presentation of Year 1 and Year 2 results to the DLTSS Work Group.	April 2016 and November 2016			In progress.	Input on quality and performance measures related to SIM payment models provided, as appropriate.
2		Provide input to Payment Models Work Group on performance measures for Episodes of Care initiative.	Q1 2016			Not yet started.	
3		Research and discuss the emerging body of HCBS/LTSS quality and performance measures to provide input for payment and practice reform efforts.					
4		Disseminate information to Practice Transformation and HDI Work Groups and Steering on sample templates/tools on privacy, confidentiality and HIPAA compliant releases for care management. Provide information to support fully accessibile tools and processes.					
	DLTSS-Specific Core Competencies						
5	Support continued distribution of Disability Awareness Briefs.	Develop and implement a dissemination plan for the Disability Awareness Briefs.	Ongoing			In progress.	Disability Awareness Briefs distributed widely; lessons learned gathered.
6		Collect lessons learned for incorporation into VHCIP Sustainability Plan.	December 2016			Not yet started.	
7	Support development of Core Competency Training specific to DLTSS core competencies.	Execute contract with vendors to develop both general skills based and DLTSS-specific Core Competency Trainings.	January 2016	Core Competency Training initiatives developed and implemented in collaboration with Practice Transformation Work Group.		In progress.	DLTSS-specific Core Competency Training developed and implemented.
8		Assist in the planning, implementation, and monitoring of Core Competency Trainings both within and beyond the Integrated Communities Care Management Learning Collaborative.	Ongoing			Not yet started.	
9		Presentation to Practice Transformation Work Group on DLTSS-specific Core Competency Training.	Spring 2016			Not yet started.	
10		Ensure sample templates/tools on privacy, confidentiality and HIPAA compliant releases for care management are adequately disseminated for use in SIM sponsored activities.	Ongoing			Not yet started.	

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Payment Models						
11	Review current and planned payment methodologies and, as appropriate, recommend payment methodologies to encourage integration between DLTSS, acute care, and population health.	Develop and propose possible new payment models that reimburse for DLTSS-specific population outcomes. Make recommendations regarding implementation, as appropriate.	April 2016			Not yet started.	Payment models reviewed and recommendations developed to encourage integration between DLTSS, acute care, and population health.
12		Receive presentations on current and possible future use of flexible funds within Medicaid to prevent unnecessary hospitalizations, ER visits, and nursing home admissions, and to promote appropriate use of medications, as well as funding other social safety net services.	April 2016			Not yet started.	
13		Recommend payment methodologies that incentivize providers to bridge the service delivery gap between acute/medical care and long-term services and supports.	July 2016			Not yet started.	
14		Collaborate with Population Health Work Group to develop policy, plans, and strategies to create a viable financial model that supports the development of the Accountable Communities for Heath plan.	September 2016			Not yet started.	
15		Provide input to Population Health Work Group as the group develops recommendations on potential links between prevention financing and payment models.	Q2 and Q3 2016			Not yet started.	
16		Identify barriers and develop strategies to address them in Medicare, Medicaid, and commercial coverage and payment policies for people needing DLTSS services (e.g., DME approval process and coverage; curative and hospice benefits; commercial coverage for attendant care; coverage of medical and mental health services in nursing homes to reduce hospital admissions and improve outcomes). Make recommendations for implementation.	Ongoing			Ongoing.	
	Health Data Infrastructure						
17	Provide recommendations on DLTSS technical and IT needs	Monitor the expansion of health information exchange capabilities for DLTSS and other known “non-meaningful use” providers.	Ongoing			Ongoing.	Recommendations provided as appropriate.
18		As requested, work with the HDI Work Group to support the funding recommendation to provide improved VHIE access for Home Health Agencies and Area Agencies on Aging.	Ongoing			Ongoing.	
19		As requested, work with the HDI Work Group on the procurement and implementation of Uniform Transfer Protocol and Shared Care Plan solutions.	Ongoing			Ongoing.	

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Sub-Grant Program						
20	Receive regular updates on Sub-Grant program activities of interest.	Receive regular updates on sub-grantee activities, progress, and lessons learned, as requested by Work Group members.	Ongoing			Ongoing.	
	Ongoing Updates, Education, and Collaboration						
21	Review 2016 DLTSS Work Group Work Plan.	Review and discuss draft workplan.	January 2016			Not yet started.	Work plan finalized.
22	Coordinate and collaborate with other VHCIP Work Groups, the Steering Committee and Core Team on issues of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups. Projects of interest include: • All-Payer Model • Consolidation of ACOs • Next Generation ACO Model • Medicaid Shared Savings analyses • St. Johnsbury Pilot • Prospective Payment initiatives for Home Health and the DAs • Uniform Transfer Protocol • Shared Care Plans • Event Notification System • Frail Elders project • Workforce Demand Model Recommendations • Workforce Strategic Plan • Population Health Plan	Ongoing	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).		Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities across VHCIP.
23		Provide updates to other work groups on DLTSS Work Group activities.	Ongoing			Not yet started.	
24		Obtain regular updates from other work groups.	Quarterly	Obtain regular updates on work groups' progress as appropriate.		Not yet started.	
25	Provide input into VHCIP Population Health Plan and Sustainability Plan.	Review and comment on VHCIP Population Health Plan Draft.	Late 2016			Not yet started.	Work Group input incorporated into VHCIP Population Health and Sustainability Plans.
26		Review and comment on VHCIP Sustainability Plan Draft.	Late 2016			Not yet started.	
27	Contribute to VHCIP Webinar Series.	Contribute topic, speaker, and moderator suggestions for VHCIP's optional monthly educational webinars for staff and participants.	Monthly			Not yet started.	Twelve webinars conducted on staff- and participant-developed topics.

Vermont Health Care Innovation Project
2016 Health Data Infrastructure Work Group Workplan

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Expand Connectivity to HIE						
1	*Gap Remediation* Remediate data gaps that support new payment and care models, as well as quality measurement needed to support those models, as identified in gap analyses (ACO and LTSS Gap Analyses).	If funds approved by Steering Committee and Core Team, support continued data connectivity technical support to ACO member organizations; receive regular reports on progress.	Ongoing		Steering Committee; Core Team	In progress, additional work proposed.	Connections of ACO Member Health Care Organizations increased.
2		If funds approved by Core Team, develop data remediation plan for gaps identified in LTSS technical assessment. Launch Data Gap Remediation for non-MU providers, including LTSS providers (dependent on funding approval by Core Team); receive regular reports on progress and provide input to support incorporation of these activities into VHCIP Sustainability Plan.	January 2016/ Ongoing		Core Team	Proposed.	LTSS organization connections to the VHIE improved.
	Improve Quality of Data Flowing into HIE						
3	Engage in work flow improvement activities at provider practices to improve the quality of the data flowing into the VHIE. These will be identified in gap analyses and analytics, including the LTSS gap analysis.	If funds approved by the Steering Committee and Core Team, support continued workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses; receive regular reports on progress.	January-December 2016			In progress.	ACO Member data quality improved. DLTSS provider data quality improved.
4	Continue data quality initiatives with the DAs/SSAs.	If funds approved by Core Team, support continued workflow improvement activities at Designated Mental Health Agencies (DAs) as identified in gap analyses; receive regular reports on progress.	January-December 2016			In progress.	DA/SSA data quality improved.
	Telehealth						
5	*Telehealth Implementation* Launch a fully accessible telehealth program as defined in Telehealth Strategic Plan.	Support implementation of 12-month telehealth pilots; receive regular reports on progress.	January-December 2016	Release of telehealth RFP, select pilot projects, launch pilots.		Ongoing.	Technical assistance provided.
6		Collect telehealth program lessons learned for incorporation into VHCIP Sustainability Plan.	December 2016				

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Data Warehousing						
7	Research data warehousing needs; develop cohesive strategy for warehousing solutions supporting practices in care transformation; identify solutions for data registry and warehousing needs; implement solutions.	*DA/SSA Data Repository:* Support improved integration of the DA/SSA data through the development and implementation of the VCN Data Repository.	Ongoing			In progress.	DA/SSA Data Repository developed and deployed.
8		Support development of a cohesive strategy for warehousing/data analytics systems, selection of solutions, and implementation of solutions.	January-April 2016			In progress.	Project plan developed and initiation of the project begun.
9		*Clinical Registry:* Support migration of the DocSite to the VITL infrastructure.	January 2016			In progress.	DocSite license migrated and implementation beginning.
	Care Management Tools						
10	Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development.	*Shared Care Plan:* As appropriate, support procurement and implementation of an electronic solution to create and maintain shared care plans across community providers.	January-December 2016			In progress.	Shared Care Plan solution identified and potentially deployed depending on the identified outcomes.
11		*Uniform Transfer Protocol:* As appropriate, support procurement and implementation of an electronic solution to share uniform transfer protocols during care transitions.	January-December 2016			In progress.	Universal Transfer protocol solution identified and deployed.
12		*Event Notification System:* As appropriate, support procurement of a system to improve communication in the transition of care process among providers. Provide information on clinical events such as hospitalizations or discharges to providers.	November 2015-December 2016			In progress.	Communications during care transitions improved through ENS.
	General Health Data						
13	*HIE Planning* Identify HIE connectivity targets; provide input into HIT Plan.	Provide comment on HIT Plan.	January-March 2016			In progress.	Comments provided.
14		Discuss connectivity targets for 2016-2019 and make a recommendation to the Steering Committee and Core Team.	January-June 2016			Proposed.	Connectivity targets identified, documented, and recommended.
15		Discuss a) Informed Consent and general confidentiality issues and b) Federal rules contained in 42 CFR Part 2 Confidentiality Protections.	January-December 2016			Not yet started.	Informed Consent and 42 CFR Part 2 discussed.

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Ongoing Updates, Education, and Collaboration						
16	Reporting on all milestones in the Health Data Infrastructure focus area; review DLTSS and Population Health activities and recommendations.	Review one-page monthly status updates for all Health Data Infrastructure work streams.	Monthly			Ongoing.	Written and verbal monthly updates on all payment models.
17	Review 2016 Health Data Infrastructure Work Group Workplan.	Review and discuss draft workplan, developed with DLTSS and Population Health staff and co-chair input.	January 2016				Workplan finalized.
18	Coordinate and collaborate with other VHCIP Work Groups on other activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups.	Ongoing	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).		Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities across VHCIP.
19		Provide updates to other work groups on Health Data Infrastructure Work Group activities.	Ongoing			Ongoing.	
20		Obtain regular updates from other work groups.	Monthly	Obtain regular updates on work groups' progress as appropriate.		Ongoing.	
21	Provide input into VHCIP Population Health Plan and Sustainability Plan.	Review and comment on VHCIP Population Health Plan Draft.	Late 2016	Plan outline or draft developed by Population Health Work Group.	Population Health Work Group; Steering Committee; Core Team	Not yet started.	Work Group input incorporated into VHCIP Population Health and Sustainability Plans.
22		Review and comment on VHCIP Sustainability Plan Draft.	Late 2016	Plan outline or draft developed by project leadership.	Core Team	Not yet started.	
23	Contribute to VHCIP Webinar Series.	Contribute topic, speaker, and moderator suggestions for VHCIP's optional monthly educational webinars for staff and participants.	Ongoing			Not yet started.	Monthly webinars conducted on staff- and participant-developed topics.

Vermont Health Care Innovation Project
2016 Payment Model Design and Implementation Work Group Workplan

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	ACO Shared Savings Programs (SSPs – Commercial and Medicaid)						
1	Support continued SSP implementation to expand the number of people in the SSPs.	Report on Year 1 Commercial and Medicaid SSP results (including data analyses). If applicable, use sub-analysis to identify driver(s) of savings.	December 2015			In progress.	Stakeholders understand Year 1 results. Stakeholders receive quarterly updates on SSP.
2		Report on Year 2 Commercial and Medicaid SSP results (including data analyses). If applicable, use sub-analysis to identify driver(s) of savings.	October 2016			In progress.	
	Episodes of Care (EOCs)						
3	Support design of 3 EOCs for Medicaid, with implementation of data reports by 3/1/16.	Presentation to work group regarding selected episodes and initial approach.	October 2015			Complete.	Work group votes to approve quality measures; Work Group approves EOC initiative for implementation.
4		Convene clinical sub-group.	February 2016			Not yet started.	
5		Determine proper quality measures for selected episodes.	March 2016		Steering Committee; Core Team	Not yet started.	
6		Develop a strategy for aligning EOC payment model with ACO SSP payment model.	March 2016			Not yet started.	
7		Finalize detailed episode specifications.	April 2016			Not yet started.	
8		Provide progress updates to PMDI Work Group, Steering Committee, and Core Team.	November 2016			Not yet started.	
9	Implement 3 EOCs for Medicaid by 7/1/16.	Create a provider facing reporting template.	June 2016		Steering Committee; Core Team	Not yet started.	Episode reports to providers by end of 2016
10		Receive regular implementation updates.	Ongoing			Not yet started.	
	Accountable Communities for Health (ACH)						
11	Support design and launch ACH peer learning opportunity.	Provide input into design of ACH Peer Learning Opportunity for all interested Health Service Areas.	January 2016	ACH Peer Learning Opportunity activities are in collaboration with the Population Health Work Group.		In progress.	Peer learning system designed and launched; ACHs included in VHCIP Sustainability Plan.
12		Launch ACH peer learning opportunity for all interested Health Service Areas.	February 2016		Steering Committee; Core Team	Not yet started.	
13		Receive regular implementation updates.	Ongoing			Not yet started.	
14		Provide input to support incorporation of ACH activities into VHCIP Sustainability Plan.	December 2016				
15	Research and feasibility study regarding the St. Johnsbury pilot program ongoing	Continue monthly work group meetings. Report on findings and next steps to create an ACH in St Johnsbury	March 2016	St. Johnsbury Pilot Team	Steering Committee; Core Team	Ongoing.	

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Prospective Payment System – Home Health						
16	Support development of Prospective Payment System for Home Health Agencies.	Provide input into design of PPS for HHAs as appropriate.	Ongoing/ Upon Request	DVHA leadership		Ongoing.	PPS design completed for HHAs
	Medicaid Value-Based Purchasing – Mental Health and Substance Abuse						
17	Support development of Medicaid value-based purchasing (VBP) models for mental health and substance abuse services.	Provide input into design Medicaid VBP models for mental health and substance abuse services as appropriate.	Ongoing/ Upon Request		Steering Committee; Core Team		
	All-Payer Model						
18	Receive updates on all payer model feasibility analyses as appropriate.	Monthly updates on all-payer model.	Ongoing/ Upon Request				
	State Activities to Support Model Design and Implementation						
19	Support state activities to support model design and implementation.	Provide input into activities as appropriate, including Integrating Family Services expansion	Ongoing/ Upon Request	IFS leadership team		Ongoing.	New payment model developed for IFS program and expansion.
20		Review and approve proposed IFS quality measures	May 2016		Steering Committee; Core Team		New quality measures in place.
21		Review DLTSS Work Group recommendations on new payment models focused DLTSS populations and providers.		DLTSS Work Group			
22	Receive regular updates as needed and appropriate.	Receive updates on DVHA activities to support model design and implementation, including necessary Medicaid state plan amendments (SPAs), contracting, and program monitoring and compliance plans.	Ongoing/ Upon Request				
23	Receive update on Frail Elders project.	Work group to receive update on Frail Elder project funded by SIM in 2015. Work group to receive two updates in CY 2016	February and June 2016			Ongoing.	Work Group updated.
24	Consider inclusion of population health and prevention activities.	Discuss financing strategies and payment models for inclusion of population health and primary prevention in current and future payment reform activities.	Ongoing			Ongoing.	Robust ongoing discussion; inclusion of population health activities in payment models as appropriate.

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
Ongoing Updates, Education, and Collaboration							
25	Reporting on all SIM milestones in Payment Model Design and Implementation focus area; review DLTSS and Population Health activities and recommendations.	Review one-page monthly status updates for all Payment Model Design and Implementation work streams.	Monthly			Ongoing.	Written and verbal monthly updates on all payment models.
26	Review 2016 Payment Model Design and Implementation Work Group Workplan.	Review and discuss draft workplan, developed with DLTSS and Population Health staff and co-chair input.	January 2016				Workplan finalized.
27	Coordinate and collaborate with other VHCIP Work Groups on other activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups.	Ongoing	Coordinate with other work groups to identify activities of interest and establish regular communication.		Mechanisms established for monthly co-chair meetings and work group reports to Steering.	Well-coordinated and aligned activities across VHCIP.
28		Provide updates to other work groups on Payment Model Design and Implementation Work Group activities.	Ongoing			Ongoing.	
29		Obtain regular updates from other work groups.	Monthly	Obtain regular updates as appropriate.		Ongoing.	
30	Provide input into VHCIP Population Health Plan and Sustainability Plan.	Review and comment on VHCIP Population Health Plan Draft.	Late 2016	Plan outline or draft developed by Population Health Work Group.	Population Health Work Group; Steering Committee; Core Team	Not yet started.	Work Group input incorporated into VHCIP Population Health and Sustainability Plans.
31		Review and comment on VHCIP Sustainability Plan Draft.	Late 2016	Plan outline or draft developed by project leadership.	Core Team	Not yet started.	
32	Contribute to VHCIP Webinar Series.	Contribute topic, speaker, and moderator suggestions for VHCIP's optional monthly educational webinars for staff and participants.	Monthly			Not yet started.	Twelve webinars conducted on staff- and participant-developed topics.

Vermont Health Care Innovation Project
2016 Population Health Work Group Workplan

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Accountable Communities for Health Learning System						
1	Support design and launch ACH peer learning opportunity, and development of ACH Implementation Plan.	Provide information from Prevention Institute research to inform content and direction of leaning opportunity.	November 2015	ACH Peer Learning Opportunity activities and ACH Implementation Plan activities are in collaboration with the Payment Model Design and Implementation Work Group.		Completed.	Peer learning system designed and launched; ACH Implementation Plan developed.
	Population Health Plan						
2	Develop a Population Health Plan (PHP) for CDC and CMMI.	Develop outline for a PHP for CMMI with input from other VHCIP work groups.	Summer 2016	Input from other VHCIP work groups gathered via webinar.	Steering Committee; Core Team	In progress.	Finalized PHP reflects project-wide priorities and SOV goals. Shared understanding of population health and population health goals across all VHCIP work groups.
3		Develop a Population Health Work Group workplan for the PHP to ensure collection of information, exploration of topics, etc.	Spring 2016	Review of key population health definitions and concepts with other work groups. Receive input from Payment Model Design and Implementation Work Group on integrating population health measures into payment models and delivery system reforms.		Not yet started.	
4		Collect and organize materials: population health measures; payment models; care models; financing mechanisms.	Spring 2016			Not yet started.	
5		Execute contract with vendor to draft the PHP.	Spring 2016	DVHA to release RFP, select bidder, and execute contract.		RFP released.	
6		Draft PHP.	Summer 2016			Not yet started.	
7		Share sections with other work groups for comment and revision.	Summer-Fall 2016	Receive feedback from VHCIP work groups.		Not yet started.	
8		Finalize PHP. (Staff Only)	Spring 2017		Steering Committee; Core Team	Not yet started.	

	Ongoing Discussions, Brainstorms, and More						
9	Identify opportunities to build upon reforms and utilize other policy levers for population health improvement	Research opportunities for population health improvement beyond VHCIP – GMCB, VDH, private-sector activities, etc.	Ongoing				
10		Review promising innovations in other states.	Ongoing				
	Ongoing Updates, Education, and Collaboration						
11	Receive regular updates on activities of interest from other VHCIP Work Groups.		Monthly			Ongoing.	Written and verbal monthly updates on all payment models.
12	Review 2016 Population Health Work Group Workplan.	Review and discuss draft workplan.	January 2016				Workplan finalized.
13	Coordinate and collaborate with other VHCIP Work Groups on other activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups.	Ongoing	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).		Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities across VHCIP.
14		Provide updates to other work groups on Practice Transformation Work Group activities.	Ongoing			Ongoing.	
15		Obtain regular updates from other work groups.	Quarterly	Obtain regular updates on work groups' progress as appropriate.		Ongoing.	
16	Provide input into VHCIP Sustainability Plan.	Review and comment on VHCIP Sustainability Plan Draft.	Late 2016			Not yet started.	Work Group input incorporated into VHCIP Sustainability Plan.
17	Contribute to VHCIP Webinar Series.	Contribute topic, speaker, and moderator suggestions for VHCIP's optional monthly educational webinars for staff and participants.	Monthly			Not yet started.	Twelve webinars conducted on staff- and participant-developed topics.

Vermont Health Care Innovation Project
2016 Practice Transformation Work Group Workplan

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
Integrated Communities Care Management Learning Collaborative							
1	Support continued implementation of Integrated Communities Care Management Learning Collaborative, including monitoring and reporting.	Continue implementation of Integrated Communities Care Management Learning Collaborative to all interested communities.	Ongoing			Active implementation in 11 communities state-wide.	Increased uptake of identified process measures, provider and recipient of care satisfaction surveys; and identified program outcome measures.
2		Develop tools, with the assistance of expert faculty and project staff, to support participating communities in implementing the principles of integrated care management. Examples include: shared care plans, eco-maps, root cause analysis, and tools for sharing private client information in a multi-organizational care team.	Ongoing	Receive input from DLTSS Work Group on tools for sharing private client information in a multi-organizational care team.		Comprehensive tool-kit expected by end of first quarter, 2016.	Increased use of key tools across participating communities.
3		Develop measures of program effectiveness to support internal reporting and evaluate impact.	Ongoing			Process measures collected on a bi-monthly basis. Recipient of care satisfaction survey in pilot phase. Provider satisfaction survey and outcome measures in development.	Implementation of all components of evaluation strategy.
4		Compile and share information with participants regarding "conflict-free" case management practices contained in CMS Home and Community-Based Services (HCBS) regulations.	Q1 or Q2 2016	Receive input from DLTSS Work Group and subject matter experts.		Subject matter experts identified, research underway.	Information made available for all participants in the learning collaborative.
5		Provide updates on progress, findings, and lessons learned to Steering Committee, Core Team, and relevant work groups; identify processes and tools to support continued work after SIM (i.e., shared care plan forms, HIPAA-compliant releases to support shared care planning process).	Ongoing			Updates provided on an ad hoc basis.	Updates provided and feedback incorporated into project planning and implementation.
6		Collect Learning Collaborative lessons learned for incorporation into VHCIP Sustainability Plan.	Sept 2016			Lessons learned captured on an ongoing basis as revealed through implementation activities.	Lessons learned incorporated into VHCIP sustainability plan.

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
7	Support the development of Core Competency Trainings for front line care managers and other service providers, focused on general care management skills and DLTSS-specific competencies.	Execute contract with vendor(s) to develop Core Competency Trainings focused on general care management skills and DLTSS-specific competencies.	January 2016	Receive input from and provide updates to DLTSS and Workforce Work Groups, Steering Committee and Core Team.		Vendor selection completed; contracts under development.	Vendor selected and implementation plan and timeline finalized.
8		Support and monitor core competency training development in collaboration with vendor(s).	January -March 2016	Receive input from and provide updates to DLTSS and Workforce Work Groups, Steering Committee and Core Team.		Training development in early stages, pending contract execution.	Development of content for Core Competency Trainings focused on general care management skills and DLTSS-specific competencies.
9		Develop and execute implementation plan for Core Competency Trainings focused on general care management skills and DLTSS-specific competencies on a state-wide basis; including incorporation of a sustainability plan.	April – Dec 2016	Receive input from and provide updates to DLTSS and Workforce Work Groups, Steering Committee and Core Team.		Implementation plan in early states, pending contract execution.	Core competency training provided.
10		Develop and disseminate tool kit for Disability Awareness Briefs developed by DLTSS Work Group.	Ongoing	Provide updates to and receive guidance from DLTSS and Workforce Work Groups.	DLTSS Work Group	Disability awareness briefs developed, tool-kit dissemination plan in early stages.	Disability awareness tool-kit available across the state.
11		Develop measures of program effectiveness to support internal reporting and evaluate impact.	Ongoing			Program monitoring and evaluation plan in early stages pending contract execution.	Monitoring and evaluation plan executed.
	Regional Collaborations						
12	Support continued implementation and expansion of regional collaborations in 14 Health Service Areas.	Continue implementation of regional collaborations in 14 Health Service Areas.	Ongoing	Continued partnership with Blueprint for Health and all Vermont ACOs.		Ongoing.	Regional collaboratives established and implementing quality improvement projects.
13		Provide updates on progress, findings, and lessons learned to Steering Committee, Core Team, and relevant work groups.	Ongoing			Updates occurring on an ad hoc basis.	Updates provided on an ad hoc basis.
	Sub-Grant Program						
14	Continue sub-grant program; convene sub-	Continue to provide quarterly reports on sub-grantee activities and progress to Work Group; provide updates on progress, findings, and	Ongoing			Sub-Grant program underway, updates provided on an ad hoc basis.	Sub-grantees convened at least twice, updates

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	grantees at least twice; use lessons from sub-grantees to inform project decision-making.	lessons learned to Steering Committee, Core Team, and other relevant work groups as requested.					provided to work group and lessons learned carried forward.
15		Sub-grantees present to Work Group.	At least 6 through-out 2016			Sub-grantee presentations planned for upcoming meetings.	
16		Collect sub-grant program lessons learned for incorporation into VHCIP Sustainability Plan.	Sept 2015			Ongoing.	
17	Provide technical assistance to sub-grantees as requested by sub-grantees.	Provide technical assistance to sub-grantees as requested; requests to be reviewed and approved by VHCIP staff according to written process currently in place.	Ongoing			Ongoing.	Technical assistance provided.
	Ongoing Updates, Education, and Collaboration						
18	Reporting on all milestones in the Practice Transformation focus area; review DLTSS and Population Health activities and recommendations.	Review one-page monthly status updates for all Practice Transformation work streams.	Monthly			Ongoing.	Written and verbal monthly updates on all practice transformation activities; lessons learned and scalable interventions identified.
19		Identify lessons learned from Practice Transformation Work Group activities, focusing on scalable interventions, processes, and tools that can be used beyond SIM.	Ongoing			Not yet started.	
20	Review 2016 Practice Transformation Work Group Work Plan.	Review and discuss draft workplan, developed with DLTSS and Population Health staff and co-chair input.	Dec 2015-January 2016			Not yet started.	Work plan finalized.
21	Coordinate and collaborate with other VHCIP Work Groups on other activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups.	Ongoing	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).		Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities across VHCIP.
22		Provide updates to other work groups on Practice Transformation Work Group activities.	Ongoing			Not yet started.	
23		Obtain regular updates from other work groups.	Monthly	Obtain regular updates		Not yet started.	

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
		Projects of interest include: • Shared Care Plan and Universal Transfer Protocol • Accountable Communities for Health Peer Learning Lab • Population Health Plan		on work groups' progress as appropriate.			
24	Provide input into VHCIP Population Health Plan and Sustainability Plan.	Review and comment on VHCIP Population Health Plan Draft.	Late 2016	Plan outline or draft developed by Population Health Work Group.	Population Health Work Group; Steering Committee; Core Team	Not yet started.	Work Group input incorporated into VHCIP Population Health and Sustainability Plans.
25		Review and comment on VHCIP Sustainability Plan Draft.	Late 2016	Plan outline or draft developed by project leadership.	Core Team	Not yet started.	
26	Contribute to VHCIP Webinar Series.	Contribute topic, speaker, and moderator suggestions for VHCIP's optional monthly educational webinars for staff and participants.	Monthly			Not yet started.	Monthly webinars conducted on staff- and participant-developed topics.

Vermont Health Care Innovation Project
2016 Workforce Work Group Workplan

	VHCIP Objectives	Work Group Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Demand Data Collection and Analysis						
1	Perform demand analysis and develop recommendations.	Execute contract for micro-simulation demand model.	December 2015	Develop demand model and develop recommendations from analysis (DOL).		Not yet started,	Consultant contract in place. Functional micro-simulation demand model. Recommendations based on analyses from model; information to be shared between Vermont Department of Health (VDH), Office of Professional Regulation (OPR), and DOL.
2		Provide input into development of micro-simulation demand model.	Q1-Q2 2016			Not yet started,	
3		Assist with reporting related to demand analysis, and guide vendor activities as appropriate.	Q2-Q3 2016			Not yet started.	
4		Subgroup to develop initial recommendations from analysis of demand model information.	Q3-Q4 2016			Not yet started.	
	Supply Data Collection and Analysis						
5	Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan.	Receive regular presentations of supply data (at least 3 times by 9/30/16).	Quarterly	Obtain and analyze workforce supply data (VDH/OPR).		Ongoing.	Supply data incorporated into workforce planning and updates to Workforce Strategic Plan.
6		Publish data reports/analyses on website by 12/31/16.	December 2016			In Progress.	
7		Support distribution of reports/analyses to project stakeholders.	December 2016			Ongoing	
8		Support identification of lessons learned for incorporation into VHCIP Sustainability Plan.	December 2016			Not yet started.	
	Ongoing Work Group Activities						
9	Perform updates to Workforce Strategic Plan.	Perform updates to Workforce Strategic Plan as needed.	Ongoing		AOA and Green Mountain Care Board	Ongoing.	Updated Workforce Strategic Plan.
10		Provide Agency of Administration with Strategic Plan Status Report by end of current administration.	Q4 2016		AOA	Not yet started	Completed Strategic Plan Status Report.
11	Renew and update membership.	Renew and update membership every three years basis according to process outlined in Executive Order #07-13.	Every three years		Secretary of Administration	Not yet started.	Membership updated.

	Ongoing Updates, Education, and Collaboration						
12	Reporting on all milestones related to Workforce, in conjunction with Practice Transformation Work Group.	Review one-page monthly status updates for all Workforce-related work streams.	Monthly			Ongoing.	Written and verbal monthly updates on all payment models.
13	Review 2016 Workforce Work Group Work Plan.	Review and discuss draft workplan, developed with DLTSS and Population Health staff and co-chair input.	December 2015-January 2016				Work plan finalized.
14	Coordinate and collaborate with other VHCIP Work Groups on other activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups. Specific projects of interest include: • Care Management Inventory (Practice Transformation Work Group) • Core Competency Trainings (Practice Transformation Work Group) • Health Information Exchange/Data Interoperability (Health Data Infrastructure Work Group)	Ongoing	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).		Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities across VHCIP.
15		Provide updates to other work groups on Payment Model Design and Implementation Work Group activities.	Ongoing			Not yet started.	
16		Obtain regular updates from other work groups.	Monthly	Obtain regular updates on work groups' progress as appropriate.		Not yet started.	
17	Provide input into VHCIP Population Health Plan and Sustainability Plan.	Review and comment on VHCIP Population Health Plan Draft.	Late 2016	Plan outline or draft developed by Population Health Work Group.	Population Health Work Group; Steering Committee; Core Team	Not yet started.	Work Group input incorporated into VHCIP Population Health and Sustainability Plans.
18		Review and comment on VHCIP Sustainability Plan Draft.	Late 2016	Plan outline or draft developed by project leadership.	Core Team	Not yet started.	
19	Contribute to VHCIP Webinar Series.	Contribute topic, speaker, and moderator suggestions for VHCIP's optional monthly educational webinars for staff and participants.	Monthly			Not yet started.	Twelve webinars conducted on staff- and participant-developed topics.

Attachment 2: December 9, 2015 Minutes

Vermont Health Care Innovation Project
Core Team Meeting Minutes

Pending Core Team Approval

Date of meeting: Monday, December 9, 2015, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's Report	Lawrence Miller called the meeting to order at 1:03. A roll-call was taken and a quorum was present. **Chair's Report:** *Quarterly Report Update:* Quarterly Report was submitted on 11/2. It is now posted on the VHCIP website. *Operational Plan and No-Cost Extension:* Year 2 will be an 18-month performance year as a result of our no-cost extension. Performance Period 3 will start in July, with a small potential overlap to expend carryover from Year 2. We received the request the Friday before Thanksgiving for a full resubmittal of our no-cost extension by the end of November. Georgia and staff put in significant effort to achieve this, and we got a quick response from our Project Officer that she was recommending approval; the process for approval is underway. We have also had helpful conversations with Steve Cha at CMMI. Paul Bengtson noted that there was significant staff effort that went into this submission. Paul Bengtson moved to thank the staff for their work on this submission. Steven Costantino seconded. The motion was approved unanimously.	
2. Approval of Meeting Minutes	Paul Bengtson moved to approve the minutes. Paul Bengtson moved to approve the October 2015 meeting minutes (Attachment 2). Hal Cohen seconded. A roll call vote to approve the minutes was taken. The motion passed with one abstention.	
3. Funding Proposals	Georgia Maheras presented several funding proposals: *Year 2 Actuals to Date:* Georgia noted significant updates based on No-Cost Extension. Extending the Year 2 time period increased Personnel line; all other lines except for Contractual are based on Personnel. • Richard Slusky asked how the No-Cost Extension impacts overall project timeline. Georgia noted that	

Agenda Item	Discussion	Next Steps
	Year 3 will begin in July 2016 and will run through June 2017. This has a minimal impact on our project activities (see timeline submitted with NCE). It will shorten the carryover period at the end of Year 3. • Al Gobeille commented that CMMI's initial letter and our response could be challenging to review since project performance periods don't align with calendar years. • Lawrence Miller commented that we are not yet clear what CMMI will be doing with the SIM program relative to their closure dates and review periods. He added that we are not the only state in this situation, and commented that CMMI may need to extend the program further. • Steven Costantino commented that one of the reasons the SIM grant is so complicated is that the activities for each year are so different. Al Gobeille added that there were significant changes to our activities mid-grant. He requested a budget meeting after the holiday to review the No-Cost Extension. Georgia and Diane will plan a meeting for late January. *Request for Adjustment in Budget for Health*first*:* This was approved in May. *VPQHC Budget Reallocation Request:* This is a budget reallocation request for VPQHC's sub-grant, the NSQIP Surgical Collaborative. The grant was initially intended to reach all hospitals in the state, but some of our small hospitals don't perform enough surgeries to make participation impactful. Reallocated funds will support an additional surgical case reviewer, ACS-NSQIP Conference sponsorship, a surgical home toolkit, collaborative best practices learning session, and hospital enrollment costs for a second year. Discussion: • Al Gobeille commented that it is challenging to assess these new interventions without significant background. He also noted that there was a competitive process for these provider grants, and the Core Team may not have approved these activities if they were part of the initial application. • Paul Bengtson commented that when this was initially reviewed, it seemed like a good thing and had significant hospital support. However, after launch, his hospital determined that the requirements for participation are too onerous. • Catherine Fulton responded that the collaborative has made significant progress in pulling surgical champions together statewide, whether or not hospitals are formally participating. She commented that the ACS-NSQIP standards intend to support standardized data collection and performance reporting, and noted that this is a good tool for comparison and collaboration. • Monica Hutt suggested holding on this and reviewing other funding requests elsewhere. • Steven Costantino asked whether previous reallocation requests have been approved. Georgia noted that no-cost extensions have been approved, but no reallocations approved within the sub-grant program. One request for reallocation was denied. • Al Gobeille commented that he initially thought this was a great idea, but if it's not, we should identify where we made a mistake. He requested additional information from people who thought this was a	

Agenda Item	Discussion	Next Steps
	good idea. Catherine Fulton suggested a presentation from the surgical champions. Al added that he would like to hear from surgical champions at participating and non-participation hospitals. Cathy commented that surgical champions are collaborating whether or not their hospitals are participating. Al asked what the impediment to the original vision has been, and commented that we should apply the same scrutiny to the reallocation that we applied to the original application. He noted that this project impacted the hospital budgeting process as well. Paul Bengtson noted that his staff is participating in some ways, though his hospital is not formally part of the program. • Monica asked whether we could spend these funds elsewhere if they are not reallocated within the sub-grant. Al commented that he doesn't want to take these funds away, or reallocate them yet. • Steven Costantino commented that there are two issues: process, and mission/vision. If VPQHC doesn't do these things, will they still meet the original vision? Al noted that we committed money to a statewide surgical collaborative, and he has not given up on that as a goal. Paul Bengtson noted that Allan Ramsay has been a driver behind this effort. • Robin Lunge commented that she would like a presentation to learn more about this. She noted that if we decide not to fund this and to use money elsewhere, it will require federal approval and the process will not be quick. • Allan Ramsay commented that he is a big supporter of this initiative, both to improve clinical quality and to strengthen the surgical workforce. • Hal Cohen commented that he is also willing to hear from the surgeons, and noted that VPQHC could be asking for more time to be successful, but instead is asking to repurpose funds, which he finds concerning. Catherine Fulton commented that the goal of the surgical home is to continue engaging hospitals, and that all hospitals will continue to be engaged even if they are not fully participating, which will improve outcomes for individual patients. The item was tabled. <u>*Population Health Plan Writer (Year 3 activity)*</u>*:* The Population Health Plan is a required deliverable of our grant. This funding (not to exceed $70,000) would fund a writer. If the Core Team is not comfortable funding this work since it is in Year 3, we will request to suspend the RFP and repost in a few months. Paul Bengtson moved to approve this request and continue moving ahead to allow this work to start quickly in July 2016. Lawrence Miller noted that the contract will not be executed if the Year 3 budget is not approved by CMMI. Al Gobeille seconded. The motion carried unanimously. *Onpoint Health Analytics:* This would supplement a national data file (MarketScan) being used by the federal evaluators (led by RTI International) which does not include BCBS. This request is part of an ongoing price negotiation; we expect to spend significantly less than $50,000 ($110,000 including Truven), but need to finalize	

Agenda Item	Discussion	Next Steps
	contracts quickly. We will finalize negotiations next week and will be able to un-restrict remaining funds quickly. Georgia commented that she wants to get the best possible data file to meet federal needs. Discussion: • Paul Bengtson asked for clarification on what the federal evaluators need. Georgia replied that the federal evaluators need claims data for Vermonters (including those insured by BCBS) participating in the Blueprint and ACO SSPs. Annie Paumgarten noted that it is part of our grant terms to provide this data. This will allow Vermont's results to be compared across the other SIM states. Paul clarified that this is not a request, it's a requirement. • Lawrence noted that this is an unanticipated need. • Richard Slusky noted that BCBS submits all claims data related to the SSP to Lewin, which subscribes to MarketScan. Truven is currently working to get a DUA with BCBS so they can get a direct data feed. They have not yet been successful. Paul Bengtson moved to approve this request. Al Gobeille seconded. The motion was approved unanimously. *Designated Agency Payment Reform Proposal:* This request would impact Year 2 and Year 3 milestones, but the amount requested comes from our Year 2 budget; it was earmarked in a TBD line. This is the result of ongoing work within state government and with the Designated Agencies. Discussion: • Lawrence Miller asked whether this would fund technology infrastructure. Georgia clarified that these funds would support the DAs in preparing for payment reform, including designing the model, provider readiness, and quality reporting and measurement, but not IT. • Steven Costantino commented that he is very supportive of this proposal; behavioral health was a major theme during recent discussions with CMMI. Lawrence Miller noted that in CMMI-speak, behavioral health includes behavioral health, mental health, and substance use disorders. Steven Costantino moved to approve the proposal. Al Gobeille seconded. • Al Gobeille commented that our milestones have shifted based on discussions with CMMI. He also noted that this is a small funding request for this work. Georgia replied that this request is only for six months; she also noted that there is a small additional amount of funding potentially available in Year 2, but it's tied up in federal approval at this time. • Al Gobeille asked how we got to this dollar amount. Georgia replied that we got to this amount through discussions with the DAs during the CCBHC grant application process this summer. This is a best guess estimate for funding that would make a difference, knowing it is insufficient for the long-term view. Al commented that there has been significant discussion across the country and around the world on this issue. He will support this proposal, knowing that it is not enough. He also commented that the scope of	

Agenda Item	Discussion	Next Steps
	work is critical, and asked how AHS and the DAs will weigh in on this to develop a useful final product. Georgia suggested additional information toward the end of January or early February. • Monica Hutt commented that she hopes to vote on this today, rather than waiting until February. She also commented that the DAs all have a developmental disabilities component, which was not part of the CCBHC process but should be included here. • Steve Voigt added that this is aligned with his region's Community Health Needs Assessment. • Hal Cohen voiced his support. • Robin Lunge voiced her support. The motion carried unanimously. *Health*first *Gateway:* Georgia noted that the money for this Gateway will not be available after this month. She also noted that this contract is with VITL since they will build the Gateway. Discussion: • Paul Bengtson asked whether, if we have one ACO in Vermont soon, we will still need this Gateway. Amy Cooper replied that if we are going to form one ACO entity, we will need to get comfortable with the risk profile and performance of all three ACOs might be – this Gateway would get Health*first*'s information organized to support decision-making with the other ACOs. VITL, OneCare, and CHAC have also been involved in the discussion about building this Gateway. • Lawrence Miller asked whether there is another way for VITL to deliver this information without the Gateway design. Mike Gagnon responded that it is not possible now, and that VITL is working on a more efficient way to build these Gateways. • Robin Lunge expressed concern about how late in the process this is coming. • Monica Hutt asked who Health*first* represents. Amy Cooper responded that Health*first* represents independent physicians in the state; the majority are primary care physicians. Monica noted that by the end of SIM/beginning of All-Payer Model, all providers need to be able to contribute data to the VHIE. Lawrence Miller commented that the Gateways pull information out of the VHIE, rather than the other way. John Evans commented that work to connect providers to the VHIE is supported by SIM and a DVHA grant. • Al Gobeille commented that there are a number of possibilities we talk about, including a single ACO and the All-Payer Model. He noted that there is a lot of opportunity for Health*first*, but if it stays independent, it will need this information. He expressed support for this proposal. • Paul Bengtson commented that he is interested in where we'll end up after SIM – what will happen to the structures in place that are no longer needed? Steven Costantino concurred, and noted that whether or not All-Payer Model moves forward, we will need to continue payment transformation. • Al Gobeille suggested an in-depth conversation on sustainability planning.	

Agenda Item	Discussion	Next Steps
	• Julie Wasserman requested an update from the Steering Committee meeting last week. Georgia commented that the Steering Committee reviewed four proposals from the HDI Work Group last week: o Funding for continued gap remediation for the ACOs and an ACO Integrated Informatics Proposal – Both sent back to the HDI Work Group for additional discussion. o Funding for e-health specialists to support data quality improvement at the DAs, and funding for DLTSS provider gap remediation efforts (specific proposals to be defined) – Both proposals received strong Steering Committee support; these proposals will come to the Core Team in late winter/early spring depending on budgeting. Steven Costantino moved to approve this proposal. Al Gobeille seconded. • Georgia noted that the original $284,000 from Year 1 is moved back into Year 1 and is being used for evaluation services. Al Gobeille suggested a future conversation about surrendering money as part of our explanations of these issues. The motion carried unanimously.	
4. Policy Recommendation: St. Johnsbury Pilot Update	Georgia Maheras provided an update on the St. Johnsbury Pilot (Attachment 4). The group discussed the following: • Al asked how this will interact with support for DAs approved earlier today. Georgia clarified that there are two pieces of this – State side and private sector at the DAs – which are complimentary and will support increased alignment. Paul commented that these supportive and synchronous efforts will help local areas get farther. Al noted that this local effort might require the results of the statewide effort. Georgia commented that coordination is happening at a SIM staff level, via contractors (Burns and Associates and Bailit Health Purchasing work on both efforts), and via leadership (Georgia, Alicia Cooper, and Richard Slusky). Al commented that there is significant regional variation in capacity and needs; he does not want this pilot to drive the support we're planning for all DAs. • Steven commented that DVHA would like to give DAs increased flexibility and decrease reporting burden – this could feed into those types of reforms. • Monica commented that a unique piece of the St. Johnsbury work is the Choices for Care analysis. • Al commented that many of us say we want fewer measures, but advocates and others often want more measures. • Doug Bouchard commented that Northeast Kingdom Human Services is a large DA with a budget of $34 million, more than half of which is developmental services. Current measurement, reporting, and billing requirements are extremely cumbersome for his staff and don't benefit patients. He would prefer an overall budget and measurement that focuses on outcomes, including patient satisfaction, and believes that this would allow his agency to serve more people, improve outcomes, increase staff satisfaction, and hopefully reinvest in other community services. • Patrick Flood commented that staff time spent on paperwork represents money spent that could be	

Agenda Item	Discussion	Next Steps
	spent on services. He suggested that setting a limit of time spent on paperwork, and reducing the paperwork and reporting burden in relation to that target. He also noted that the State could save considerable money by increasing the percentage of people served at home through CRT, rather than in nursing homes. • Paul added that his region is not aiming to drive a statewide system, but to improve the health of people in their community. This is an opportunity for the State to gather information from this investment. • Al noted that a big remaining question is how the money will flow. Paul commented that this is in progress, and that the St. Johnsbury team is seeking to spend money more wisely within their community. Patrick commented that there needs to be some policy agreement at the legislative level to support these ideas, in addition to the State staff and contractor support already being put toward this effort. • Steve Voigt commented that he has attended some of the meetings between the St. Johnsbury team and various players at the State, and noted that similar organizations in other states in the region also have lengthy measure lists. • Paul added that the St. Johnsbury community is moving toward using measures of Health Related Quality of Life (see recent paper by Kathleen Hentcy at DMH). • Robin expressed surprise at the difference in tone in presentation to the Legislature and this group. Paul commented that this group's purpose is authentic, and he was surprised that HROC wanted such an in-depth conversation earlier this fall. Robin requested the St. Johnsbury group talk with the Core Team before going to the Legislature. • Lawrence commented that investing in a regional process and ensuring enough specificity before launch is a critical thing because it will allow other regions to follow this path. He also noted that program integrity will be a key issue and requested that sufficient program integrity support be provided up front to support this work. Steven added that Oregon's CCOs have strict program integrity requirements, with significant claw-backs if quality measures are not met. Lawrence noted that risk needs to be limited as organizations are learning. • Al commented that there are regulatory issues involved - partnerships are challenging with significant risk involved. Patrick commented that these organizations are already at financial risk now. Al noted that risk increases as lines between the entities involved are blurred. Doug noted that he is not representing other DAs, and will step out of this process if it will injure his agency; rather the focus is on finding savings and reinvesting them. Patrick concurred. Lawrence concluded discussion by noting that this group would need significant report out on results, and that a pilot is not committing to a model and that St. Johnsbury may need to adapt to a statewide model if one is put in place in the future.	
5. Policy Recommendation:	This item was tabled for the next meeting due to time constraints.	

Agenda Item	Discussion	Next Steps
Payment Models Work Group – Medicaid SSP Total Cost of Care for Y3 Update; Commercial SSP Downside Risk Update		
6. Public Comment	There was no additional public comment.	
7. Executive Session – CMMI Communications		
8. Next Steps, Wrap Up and Future Meeting Schedule	**Next Meeting:** January 11, 1:00pm-3:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP Core Team Member List
Roll Call:

12/9/2015

1° Paul 2° Steve C. | 1° Paul 2° Al | 1° Paul 2° Al | 1° Steven 2° Paul | 1° Steven 2° Al | 1° Al 2° Steven

Member		10/13/15 Minutes	VPQHC Proposal	PH Plan Writer	Onpoint	DA/Pmt Reform	HF Informatics	
First Name	Last Name							Organization
Paul	Bengston	✓			✓	✓	✓	Northeastern Vermont Regional Hospital
Hal	Cohen	✓	—		✓	✓	✓	AHS -CO
Steven	Costantino	✓	✓		✓	✓	✓	AHS - DVHA
Al	Gobeille	✓	✓		✓	✓	✓	GMCB
Monica	Hutt	✓	✓		✓	✓	✓	AHS - DAIL
Robin	Lunge	✓	✓		✓	✓	✓	AOA - Director of Health Care Reform
Lawrence	Miller	✓	✓		✓	✓	✓	AOA - Chief of Health Care Reform
Steve	Voigt	✓	✓		✓	✓	✓	ReThink Health

Erin Taylor

held for a later meeting/ more discussion

Executive Session w/ georga, Diane

VHCIP Core Team Participant List

Attendance: 12/9/2015

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

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

Jaime	Fisher	phone	GMCB	A
Erin	Flynn		AHS - DVHA	S
Joyce	Gallimore		Bi-State Primary Care	X
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Martita	Giard		OneCare Vermont	X
Al	Gobeille	here	GMCB	M
Bea	Grause		Vermont Association of Hospital and Health Systems	X
Sarah	Gregorek		AHS - DVHA	A
Thomas	Hall		Consumer Representative	X
Carrie	Hathaway		AHS - DVHA	X
Selina	Hickman		AHS - Central Office	X
Monica	Hutt	here	AHS - DAIL	M
Kate	Jones	phone	AHS - DVHA	S
Pat	Jones		GMCB	S
Joelle	Judge	here	UMASS	S
Sarah	Kinsler	here	AHS - DVHA	S
Heidi	Klein		AHS - VDH	S
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Robin	Lunge	Phone	AOA	M
Carole	Magoffin	Phone	AHS - DVHA	S
Georgia	Maheras	here	AOA	S
Steven	Maier		AHS - DVHA	S
Mike	Maslack			X
Marisa	Melamed		AOA	S
~~Jessica~~	~~Mendizabal~~		AHS - DVHA	S
Lawrence	Miller	here	AOA - Chief of Health Care Reform	C
Meg	O'Donnell		UVM Medical Center	X
Annie	Paumgarten	here	GMCB	S
Luann	Poirer		AHS - DVHA	S
Frank	Reed		AHS - DMH	X
Lila	Richardson	phone	VLA/Health Care Advocate Project	X
Larry	Sandage		AHS - DVHA	S

Suzanne	Santarcangelo		PHPG	X
Julia	Shaw	here	VLA/Health Care Advocate Project	X
Kate	Simmons		Bi-State Primary Care	X
Richard	Slusky	here	GMCB	S
Carey	Underwood			A
Steve	Voigt	phone	ReThink Health	M
Julie	Wasserman	here	AHS - Central Office	S
Spenser	Weppler	here	GMCB	S
Kendall	West		Bi-State Primary Care	X
James	Westrich		AHS - DVHA	S
Katie	Whitney			A
Bradley	Wilhelm		AHS - DVHA	S
Jason	Williams		UVM Medical Center	X
Sharon	Winn		Bi-State Primary Care	X
Cecelia	Wu	here	AHS - DVHA	S
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Erin Taylor - Bailit Health - phone
Mike Gagnon - VITL - here
John Evans - VITL - here
Giselle Charbonneau - Healthfirst - here
Amy Cooper - Healthfirst - here
Mike Hall - here - VHA
Cathy Fulton - phone - VPQHC
Marianne B - phone - VPQHC
Allan Ramsay - phone - GMCB
Doug Bouchard - here - St. Johnsbury
Patrick Flood - here

Attachment 3a: Y1 and Y2 Actuals and Funding request

Financial Proposals

January 7, 2016

Georgia Maheras, JD

Project Director

AGENDA

- Y1 Actuals to Date
- Y2 Actuals to Date
- New: IFS Contract (uses Y2 TBD funds)
- New: DA/SSA Quality Improvement (uses Y2 TBD funds)
- Revision: Terminology Services (uses Y2 TBD funds)
- Revision: CVMC-Sub-Grantee Budget Change Request

Y1 Actuals to date

Vermont Health Care Innovation Project				
Year 1 Budget				
October 1, 2013 - December 31, 2015				
BUDGET CATEGORY	BUDGET-YEAR 1	ACTUALS and Unpaid Contract Invoices to 12/31/15	CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)	REMAINING UNOBLIGATED BALANCE
Personnel/Benefits	$ 2,657,072.25	$ 2,657,072.25	$ -	$ 0.00
Operating (includes Indirect)	$ 945,675.10	$ 945,675.10	$ -	$ 0.00
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 3,631,455.14	$ 3,191,825.96	$ 439,629.18	
PAYMENT MODELS-TOTAL	$ 3,898,088.35	$ 3,452,618.82	$ 445,469.53	
CARE MODELS-TOTAL	$ 242,754.13	$ 209,329.08	$ 33,425.05	
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ 2,385,707.27	$ 2,143,881.78	$ 241,825.49	
EVALUATION-TOTAL	$ 1,656,538.42	$ 1,613,935.19	$ 42,603.23	
GENERAL-TOTAL	$ 680,068.17	$ 608,700.94	$ 71,367.23	
CMMI Required: Population Health Plan-TOTAL	$ 26,945.68	$ 26,308.18	$ 637.50	
Contractual Total	$ 12,521,557.16	$ 11,246,599.95	$ 1,274,957.21	$ 0.00
TOTAL YEAR 1 BUDGET	$ 16,124,304.51	$ 14,849,347.30	$ 1,274,957.21	$ 0.00

Y2 Actuals (NCE)

Year 2 Budget -Pending CMS/CMMI Approval				
January 1, 2015 - December 31, 2015				
BUDGET CATEGORY	BUDGET-YEAR 2	ACTUALS and Unpaid Contract Invoices to 12/31/15	CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)	REMAINING UNOBLIGATED BALANCE
Personnel/Benefits	$ 2,085,164.00	$ 611,833.55		$ 1,473,330.45
Operating (includes Indirect*except QE 12/31/2015)	$ 1,138,189.00	$ 70,010.88		$ 1,068,178.12
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 6,274,520.00	$ 1,863,584.68	$ 4,410,935.32	
PAYMENT MODELS-TOTAL	$ 4,211,058.75	$ 381,422.49	$ 3,829,636.26	
CARE MODELS-TOTAL	$ 921,531.17	$ 54,195.00	$ 867,336.17	
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ 1,915,230.99	$ -	$ 1,915,230.99	
EVALUATION-TOTAL	$ 664,362.00	$ 108,150.00	$ 556,212.00	
GENERAL-TOTAL	$ 230,000.00	$ -	$ 230,000.00	
CMMI Required: Population Health Plan-TOTAL	$ 7,000.00	$ -	$ 7,000.00	
Contractual Total	$ 14,223,702.91	$ 2,407,352.17	$ 11,816,350.74	$ -
TOTAL YEAR 2 BUDGET	$ 17,447,055.91	$ 3,089,196.60	$ 11,816,350.74	$ 2,541,508.57

Y2 Available Funds (expend by 6/30/16)

- Technical Assistance to Providers Implementing Payment Reform: $400,000.
- HIE Design and Testing: $885,421.50.

- Why?? *Refined estimates*
  - Evaluation Savings (Onpoint/Truven/New RFP)
  - Learning Collaborative Abernathey Savings
  - IHS Global Savings (pushed to Y3)
- Also: SCUP designated TBD: $505,050

NEW request: IFS Consultant

- Background: Integrating Family Services is an AHS Initiative that seeks to bring state government and local communities together to ensure holistic and accountable planning, support and service delivery aimed at meeting the needs of Vermont's children, youth and families. The premise being that giving families early support, education and intervention will produce more favorable health outcomes at a lower cost than the current practice of 'waiting until circumstances are bad enough'.

NEW request: IFS Consultant

- Rationale: IFS is supported by four staff and only one of these positions is dedicated full-time to IFS. There is limited infrastructure to manage this statewide implementation effort which includes grants management, payment reform, quality oversight, guidance documents and coordination. This makes the consultant role key to the continued success of IFS. The consultant has been in her role for over a year and this funding would allow her to complete key tasks already in progress.
- Amount Requested: $5,000
- Timeline: February 2016 through July 2016
- Scope of Work:
  - Assist with development of Service Delivery Framework
  - Refine and reformat IFS compliance manual
  - Coordinate and facilitate stakeholder meeting planned for March 2016
  - Conduct research on best practice and integration efforts nationally
- Budget Line Item: Technical Assistance to Providers Implementing Payment Reform

DA/SSA: Data Quality Improvement

- Request from HDI Work Group and Steering Committee.
- Rationale: Continue work begun in 2015 for data quality improvement for DAs/SSAs.
- Amount requested: $150,000 for use February-December 2016. Contract is with VITL for 2 FTE.
- Scope of Work: E-health specialist/data quality improvement at DA/SSA practice sites to improve data entered into the electronic medical records.

- Background: The Core Team approved funds for this purpose in 2015.
- Budget Line Item: HIE Design and Testing

Terminology Services

- Understanding Data Quality
  - Most, if not all, computerized systems in use today by medical providers utilize non-standard terms and codes for describing lab tests, procedures, medications, problem lists, etc.
  - In order to compare and analyze data across provider organizations these non-standard terms must be translated in order for other systems to understand them.
  - VITL's terminology service will standardize terms so that population health management projects such as the Vermont Blueprint for Health and Accountable Care Organizations can be successful.

Terminology Services: Revision

- Background: Core Team previously approved.
- Scope of Work:
  - Acquisition and implementation of the software and launch standards for Labs and Medications
  - Additional data sets we can normalize in future phases (future budget request):
    - Procedures (CPT, SNOMED, HCPCS)
    - Diagnoses (ICD-9 & 10)
    - Problem Lists
    - Allergies
    - Radiology (RadLex)
    - Vaccines
    - Ethnicity, Race, Gender, Patient Types, Locations (IP, OP, Ambulatory)
- Request: $135,900 for 2/1/16-6/30/16. Funds VITL staff and a sub-contract.
- Budget Line Item: HIE Design and Testing

CVMC – Budget Reallocation Request

1. Background: CVMC is a sub-grantee implementing the SiMH project (Screening, Brief Intervention and Referral to Treatment in the Medical Home)
2. The changes proposed are designed to better support the SBIRT program expansion and to ensure adequate training and development for SiMH staff. The original budget did not account for mileage costs for the clinicians to travel to and between the newly expanded practice locations. All of the requested changes remain within the originally approved grant amount of $500,000 and are the result of underspending in Year 1 of the project.

CVMC – Budget Reallocation Request

- Initial Approval: $500,000
- Request for reallocation within line items:
  - Personnel and Fringe: Add $48,829 for additional clinician to support expansion to pediatric practice
  - Equipment: Add $2,420 to pilot use of tablets for intake process
  - Supplies: Add $4,340 for workstation and NTR to support tobacco cessation program
  - Professional Development/Professional Fees: Add $4,000 for training and professional development
  - Mileage: Add $1,333 for new mileage line item

Attachment 3b: CVMC Proposal

VERMONT

Department of Vermont Health Access
Agency of Human Services
312 Hurricane Lane, Suite 201
[phone] 802-879-5900
Williston, VT 05495
www.dvha.vermont.gov

M E M O R A N D U M

TO:	Ginger Cloud, MS, LCMHC, LADC, SiMH Project Manager
FROM:	Georgia Maheras, VHCIP Project Director
THROUGH:	Leah Korce, Contracts and Grants Manager, Department of Vermont Health Access
DATE:	January 8, 2016
SUBJECT:	Approval of revised budget for CVMC SiMH grant agreement #03410-1458-15

This memo serves to document the approval of a revised budget for the grant agreement to Central Vermont Medical Center under the federally funded Vermont Health Care Innovation Project (VHCIP). The following budget on page 4 of this memo will replace the previously revised budget, approved in January 2015 for the grant agreement #03410- 1458-15.

CVMC is seeking to revise the approved budget for their Vermont Health Care Innovation Project provider grant. The changes proposed are needed to better support the SBIRT program expansion and to ensure adequate training and development for SiMH staff. As well, the original budget did not account for mileage costs for the clinicians to travel to and between the newly expanded practice locations. All of the requested changes remain within the originally approved grant amount of $500,000.

1. **Addition of clinician time**

CVMC is requesting reallocation of funds for additional SBIRT clinician needed to support expansion of SBIRT into pediatric practices and manage influx of referrals for brief treatment at existing practices. The request is for the addition of a .6 FTE SBIRT Clinician for a total amount of $48,829.

2. **Use of Pilot Tablets**

CVMC requests reallocation of funds to pilot the use of tablets for screening at Integrative Family Medicine, Montpelier. The aim is to reduce burden of screens on nursing staff and increase accuracy of SBIRT screens/scoring/logging, including improving the fidelity of the responses because the client will be able to directly respond to the screening questions. This request is for $2,420 to be reallocated for this purpose.

3. **Supplies**

    a. **Office Supplies**

CVMC requests supplies for the new clinician in order to provide a workstation, desk, chair, laptop, phone and general office supplies in the amount of $2,340.

b. Nicotine Replacement Therapy (NRT)

CVMC requests reallocation of $2000 to better support the tobacco cessation program by allocating funds for a pilot program based on vouchers for NRT through a pharmacy to provide the full spectrum of NRT for the recommended length of time. Currently, the time period of free NRT available through the smoking cessation programs does not match the clinically recommended length of time.

4. Professional Development

CVMC is requesting a reallocation of funds to be used for professional development for clinical supervision. At the outset, CVMC did not anticipate any training requirements for clinical staff; however, the expansion of the program has revealed that both clinicians and clinical supervisors require professional development and support in order for the program to be successful.

5. Mileage

CVMC is requesting a reallocation of funds to be used to reimburse clinicians for their mileage as they travel around the state to the various practices. This was not accounted for in the original budget for the project.

Approved by:

Leah Korce, DVHA Business Office

Georgia Maheras, VHCIP Project Director and Deputy Director of Health Care Reform

VERMONT

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Budget Category	Original Budget Year 1 12/1/14 – 11/30/15	Spent to date 12/1/14-9/30/15	Projected Spending 10/1/15-11/30-15	Difference Carried Over	Original Year 2 12/1/15 – 11/30/16	Adjusted Year 2 12//1/15-11/20/16	Total
Personnel	$180,485.00	$102,847.00	$35,200.00	($42,438.00)	$180,485.00	$220,542.00	$358,589.00
Fringe	$49,200.00	$27,796.00	$9,000.00	($12,404.00)	$49,200.00	$58,701.00	$95,497.00
Consultants	$5,000.00	$5,000.00		$0.00	$1,000.00	$1,000.00	$6,000.00
Equipment	$3,960.00	$2,519.00		($1,441.00)	$0.00	$2,420.00	$4,939.00
Supplies	$5,335.00	$4,457.00	$60.00	($818.00)	$5,335.00	$4,340.00	$8,857.00
Professional Development/ Professional Fees*	Originally factored into Supplies*	*	$585.00		*	$4,000.00	$4,000*
Mileage Reimbursement**	Not originally accounted for**	**	$200.00		**	$1,333.00	$1333**
Other Costs	$10,000.00		$10,000.00		$10,000.00	$10,000.00	$20,000.00
Indirect							$0.00
Total	$253,980.00	$142,619.00	$55,045.00	($57,101.00)	$246,020.00	$302,336.00	$500,000.00

Attachment 4a: Medicaid SSP

Vermont Medicaid Shared Savings Program
Total Cost of Care Summary Table

	Year 1 *Core categories formed the baseline Total Cost of Care (TCOC): These categories are aligned with Medicare MSSP*	**Year 2** *ACOs are incentivized to adopt optional categories to increase shared savings rate from 50% to 60%*	**Year 3** *ACOs are required to adopt additional categories selected by DVHA*
Core TCOC	Inpatient hospital, outpatient hospital, professional services, ambulatory surgery center, clinic, federally qualified health center, rural health clinic, chiropractor, independent lab, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, dialysis facility.	Same as first year	Same as first and second years
Additional categories proposed	N/A	Pharmacy and non-emergency transportation	Pharmacy, dental, mental health services administered through DMH, ADAP, personal care services, and non-emergency medical transport
Decision to adopt additional categories	N/A	Neither CHAC nor OCVT elected to adopt the optional TCOC categories	Based on feasibility and readiness research conducted by DVHA SIM staff along with public comments received, DVHA decided not to adopt more categories of service.

December, 2015

Vermont Medicaid Shared Savings Program
Total Cost of Care Summary Table

			Year 3 TCOC will remain at the core category level.

December, 2015

Attachment 4b: Commercial SSP

Vermont Commercial ACO Pilot
Compilation of Pilot Standards
Reflecting Technical and Substantive Changes Approved by the GMCB on September 4, 2014 and Additional Technical Corrections Approved by the GMCB on July 23, 2015.
Proposed Substantive Changes to Remove Downside Risk in Year 3, October 7, 2015; and
Proposed Technical Correction Related to Year 1 Attribution Methodology, and Methodology for Distribution of Savings
October 22, 2015; Approved by the GMCB on November 17, 2015.

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.

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.

[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
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 • 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

CPT-4 Code Description Summary
• 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

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

[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.

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.)

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.

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

[3] The calculation shall exclude the projected value of Allowed claims per claimant in excess of $125,000 per performance year.

ACO attribution by product, shall represent the expected PMPM medical expense spending ("expected spending").

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

- prescription (retail) medications, and

2. dental benefits [4].

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 <u>targeted</u> 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."

<u>Actions Initiated After the Performance Year Ends</u>

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

[4] The exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit.

population using commonly defined insurer data provided to the GMCB or its designee. Medical 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, and
- conversion from allowed to paid claims value.

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.

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.)
- An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not greater than insurer premium approved by the Green Mountain Care Board.

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[5] and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure. 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 reporting of any payment measure with a denominator less than 30.

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

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

#	Measure	Data Source	2012 HEDIS Benchmark (PPO)
Core-1	Plan All-Cause Readmissions NQF #1768, NCQA	Claims	Nat. 90th: .68 Nat. 75th: .73 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: 58.5 Nat. 75th: 46.32 Nat. 50th: 38.66 Nat. 25th: 32.14
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: 67.23 Nat. 75th: 60.00 Nat. 50th: 53.09 Nat. 25th: 45.70
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: 35.28 Nat. 75th: 31.94 Nat. 50th: 27.23 Nat. 25th: 24.09
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, NCQA HEDIS AAB	Claims	Nat. 90th: 28.13 Nat. 75th: 24.30 Nat. 50th: 20.72 Nat. 25th: 17.98
Core-7	Chlamydia Screening in Women NQF #0033, NCQA HEDIS CHL	Claims	Nat. 90th: 54.94 Nat. 75th: 47.30 Nat. 50th: 40.87 Nat. 25th: 36.79

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).

Table 2. Distribution of Shared Savings in Year One 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 f**or **the next pilot year by no later th**an 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.