Health Care Innovation Project
Core Team Meeting
Monday, October 14, 2013

1:30-3:30 PM

Agenda

1. Chair's report

    - CMS "Reverse Site Visit"
    - Meeting of SIM testing states in Chicago
    - Operational Plan follow-up and approval for testing phase (see attached CMS questions and Vermont answers)
    - Project staff hiring
    - Project contractor hiring
    - Medicaid ACO update
    - Commercial ACO update
    - Project kickoff and steering committee meeting agendas

2. Discussion of SIM Funding Allocation Proposal (see attached background memo and two other documents from Anya Rader Wallack)

3. Action items

    - Approval of funding allocation proposal type 1 and type 2 designations and processes
    - Approval of selected type 1 expenditures (see explanation in background memo)

ANSWERS TO CMS QUESTIONS ON VERMONT'S SIM OPERATIONAL PLAN

ACCOUNTABILITY TARGETS

1. Please define aims for the primary drivers established in the Driver Diagram: Clinical quality measures; Patient experience measures; Population health measures; Cost growth measures.

See attached draft of proposed Driver Diagram metrics. This draft will be reviewed by the SIM Performance Measures Work Group on September 30 and October 7. The Work Group will make a recommendation to the SIM Steering Committee by October 14 and the Steering Committee will discuss the proposed metrics at its October 16 meeting. Our goal is to have a set of metrics recommended to and approved by the SIM Core Team by mid-November at the latest.

2. The SIM milestone timeline indicates the earliest a new model will launch is Q1 2014 (SSP). Please describe what will be tested starting Oct 1.

We intend to launch the shared savings ACO programs for both commercial insurers and Medicaid on January 1, 2014. Detailed design of the other testing models will follow. While January 1 will mark the launch in terms of having in place ACO/payer contracts, much work has gone into development of the programs to date through our payment models and performance measures work groups. These groups have been meeting for more than nine months to develop standards for the programs. We anticipate approval of the standards developed through this process by the SIM Core Team prior to October 1 (see draft commercial standards and draft Medicaid RFP, attached). We will therefore have the bulk of program design (see below for discussion of data submission standards, still in development) in place by October 1, and will execute contracts as shortly thereafter as possible. January 1 will be the start date of the program for purposes of calculating total costs of care, calculating savings and reporting performance measures.

3. Please provide a list of specific milestones/metrics for each work-stream of the SIM investment for Test Year 1 ($14,442,587.96), including quarterly targets for each milestone/metric.

Below is a list of planned year one activities for Vermont's project, followed by a list of proposed metrics and milestones associated with those activities.

Table 1: planned year one activities (see attached timeline)
Advanced analytics
Procure contractor for internal Medicaid modeling
Procure contractor for additional data analytics
Define analyses
Consult with payment models and duals WGs on definition of analyses
Perform analyses
Procure contractor for financial baseline and trend modeling
Develop model
Consult with payment models and duals WGs on financial model design
Produce quarterly and year-end reports for ACO program participants and payers
Evaluation (external)
Procure contractor
Develop evaluation plan
Consult with performance measures WG
Input baseline data
Evaluation (internal)
Hire staff
Procure contractor
Develop evaluation plan
Consult with performance measures WG
Input baseline data
Initiative Support
Procure contractor
Develop interagency and inter-project communications plan
Implement plan
State staff training and development
Hire contractor
Develop curriculum
Model Testing
Develop ACO model standards
Execute Medicaid ACO contracts
Execute commercial ACO contracts
Develop standards for bundled and episode-based payments
Execute contracts for bundled and episode-based payments
Develop Medicaid value-based purchasing plan addressing pay-for-performance initiatives
Procure learning collaborative and provider technical assistance contractor
Establish learning collaboratives for providers engaged in each of the

testing models
Develop technical assistance program for providers implementing payment reforms
Technology and Infrastructure
Provide input to update of state HIT plan
Expand provider connection to HIE infrastructure
Identify necessary enhancements to centralized clinical registry & reporting systems
Procure contractor to develop initial use cases for the integrated platform and reporting system
Design the technical use cases and determine the components of the integrated platform that are required to implement these use cases
Develop criteria for telemedicine sub-grants
Expand the scope of VHCURES to support the integration of both claims and clinical data and provide this capability to ACOs/providers and potentially payers
Begin to incorporate long term care, mental health, home care and specialist providers into the HIE infrastructure

Table 2: year one metrics of progress and milestones
Advanced analytics
Contract for Medicaid modeling
Contract for data analytics
Number of analyses designed (goal = 5)
Number of analyses performed (goal = 5)
Contract for financial baseline and trend modeling
Financial baseline and trend model developed
Number of meetings held with payment models and duals WGs on the above designs (goal = 2)
Evaluation (external)
Contract for external evaluation
Evaluation plan developed
Number of meetings held with performance measures WG on evaluation (goal = 2)
Baseline data identified
Evaluation (internal)
Staff hired
Contract for internal evaluation
Evaluation plan developed
Baseline data identified

Initiative Support
Contract for interagency coordination
Interagency and inter-project communications plan developed
Results of survey of project participants re: communications
State staff training and development
Contract for staff training and development
Training and development curriculum developed
Model Testing
Approved ACO model standards
Number of Medicaid ACO contracts executed (goal = 2)
Number of commercial ACO contracts executed (goal = 2)
Approved standards for bundled and episode-based payments
Medicaid value-based purchasing plan developed
Number of providers participating in one or more testing models (goal = 2000)
Number of Blueprint practice providers participating in one or more testing models (goal = 500)
Contract for learning collaborative and provider technical assistance
Number of learning collaboratives for providers conducted (goal = 3 day long meetings)
Number of providers served by technical assistance program (goal = 20)
Technology and Infrastructure
Updated state HIT plan
Number of new interfaces built between provider organizations and HIE (goal = 18 additional hospital interfaces and 75 new interfaces to non-hospital healthcare organizations to include: at least 10 specialist practices; 4 home health agencies; and 4 designated mental health agencies)
Completed needs assessment for enhancements to centralized clinical registry and reporting systems
Contract for the development of 6 primary use cases for the integrated platform and reporting system
Number of telemedicine initiatives funded (goal = 1)
Number of providers approved for use of VHCURES data
Provide regional extension center (REC) like services to non-EHR providers to include long term care, mental health, home health and specialists and begin development of interfaces to the VHIE for these provider groups that currently have EHRs with the goal over three years of achieving 50 new interfaces.

ANSWERS TO OTHER QUESTIONS

B7. For Track 1, Ready-to-Go States, has the State fully integrated or aligned its planned transformation with existing State Plan Amendment and waiver authorities?

Internal and independent assessment of waiver authority found the SIM programs consistent with AHS/DHVA authorities under the existing Global Commitment Waiver. Currently the Choices for Care and CHIP populations fall outside the Global Commitment waiver. Efforts are underway to bring all the populations and services under a single Global Commitment waiver.

Until that time, Vermont will continue to submit State Plan Amendments (SPA) for reimbursement activities. The SIM team and the waiver renewal teams are actively coordinating to ensure continued authority under the Global Commitment waiver terms and conditions and inclusion should the waiver be expanded to include Choices for Care and CHIP population and services.

The 90-day window is approximate; a SPA must be submitted in the quarter during which the change is implemented and there are multiple formal and informal opportunities to reach agreement on the SPA. We have estimated there is little risk if the SPA is not approved in the window on the timeline.

Medicaid ACO Shared Savings Program
Vermont Medicaid plans to submit a State Plan Amendment consistent with guidance released on August 30, 2013 http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf).

In addition to the submission of the SPA, Vermont Medicaid also plans to:

- Provide a concept paper to CMS team that
    - will address the questions raised in the August 30th guidance;
    - october submission; and
    - will include a completed measures matrix (CHCS Medicaid Learning Collaborative Tool).
- Participate in question and answer teleconferences as requested

Vermont Medicaid is optimistic that the SPA will be approved within a reasonable timeframe because:

- The standards and measures were developed over the last ten months and reflect the efforts of an intensive, multi-stakeholder work group.

- They are highly consistent with either Medicare or Vermont commercial payer programs.
- The approach (i.e., concept paper, measures matrix) was recommended based on consultation with CMS partners through RWJ/CHCS Medicaid ACO Learning Collaborative.
- Vermont's program shares much in common with the approved SPA in Minnesota; through the LC, Vermont was able to leverage its experience and lessons and have incorporated them into their programmatic design.
- Answers to questions posed in the recent guidance on shared savings programs would be addressed prior to submission.
- Medicaid is participating in robust external and internal monitoring and evaluation (M&E) efforts associated with participation in the CMMI/State Innovation Model.

Episodes of Care (EOC) Program

Transitioning episodes into bundled payments is scheduled to occur in year two of the program.

At that time, Medicaid will have submitted SPAs as needed across its FFS payment systems included in the bundled payments. Some combination of inpatient, outpatient, professional services and long term care services and supports may be involved depending on the final episode selection, slated for later this year. The State will have sufficient time, due to phasing in of bundled payments in year two, to do a thorough review of SPA requirements as part of the implementation plan. Medicaid would consider developing a concept paper in year one if requested. Medicaid would also be prepared to submit a SPA prior to implementation of bundled payments to avoid delay in SPA approval and bundled payment adoption in year two of the program.

Pay-for-Performance (EOC) Program(s)

Vermont Medicaid plans to submit SPAs for P4P programs as appropriate. Most have an anticipated launch date of July 1, 2014. In the early years of the programs, P4P incentives will be funded by legislatively mandated increases in funding and there will be no penalties which would create access concerns. A Medicaid Value-based Purchasing Plan is currently under development and could be shared if requested. Much of the focus of the P4P programs will be to align with other payer efforts around value-based approaches in Vermont hospitals, outpatient hospital departments, primary care and specialist providers, and FQHCs/RHCs.

D11. Has the state developed process(es)/mechanisms for data collection on a regularly defined basis to support its delivery system and payment reform efforts?

Vermont has in place a formal process for collection of claims data for our all-payer claims dataset (APCD), known as VHCURES. Data are fed to this repository on a monthly basis from Medicaid and major commercial insurers with 2,000 or more covered lives doing business in the state. (There is an exemption for insurers with less than 200 covered lives; commercial insurers with enrollment of 201 -1,999 covered lives submit data less frequently). Medicare data are released to the state on an annual basis. Medicaid and Commercial payers submit data to VHCURES using standard files. Medicare data iare submitted as final action Standard Analytic Files (SAF) and these data are also incorporated into the VHCURES database. All data are reviewed for meeting data quality standards and then combined into cumulative extracts released on a quarterly schedule.Each quarterly extract includes claims current through the end of the prior quarter. These extracts are sent automatically to the state each quarter on a rolling and continuous basis.

VHCURES data will be one source supporting Vermont's SIM efforts. These data will be the primary source utilized by the state for analysis and modeling of the impact of payment changes, baseline expenditures and trends, and population-based rates of service use and expenditures.

The data also will be available to providers and others seeking to perform their own analyses. The state has a data use policy and procedure, which allows providers, researchers and other entities to receive VHCURES data. An applicant must submit a request to the GMCB, which is reviewed to determine whether the release of the data complies with Vermont law. Under a "broad use" data use agreement, CMS has authorized GMCB to re-release Medicare data to other Vermont state agencies and contractors performing work directed and funded by the state.

We have contracted with Truven to support general analysis of VHCURES data, some of which will be relevant to the SIM project. See attached Truven analysis plan. We also have contracted with Burns and Associates to use VHCURES and additional Medicaid data to support analysis of the impact of testing models in Medicaid. Likewise, we contracted with Wakely Consulting (an actuarial firm) to develop a rudimentary forecasting model for expenditure trends. We anticipate releasing RFPs and/or renewing these contracts to continue this work and ensure it supports the SIM project.

The Green Mountain Care Board has statutory authority for VHCURES and has begun a process of updating the regulations that govern required payer submissions to the dataset. See attached Proposed Changes to the VHCURES APCD Regulations. GMCB is also developing an updated specification for the data collection and aggregation system and a contract to accommodate changes in the regulations and the state's future data

and analytical needs. The major proposed enhancements to the system include improved technology to generate: stable and consistent unique person identifiers for improved internal linkage and linkage with other health data sources; automated and efficient processing to improve data quality; more accurate, timely, and robust master provider index; and improved access to the data for approved researchers and analysts.

In addition, the State will collect data directly from providers participating in the ACO models. The standards for those data submissions are under development by the SIM Performance Measures Work Group, with recommendations expected in October. One source for those data will be the Vermont Health Information Exchange Network (VHIE), operated by Vermont Information Technology Leaders (VITL). The VHIE currently receives over 2 million transactions of clinical data per month from 113 independent practices, 7 of Vermont's 8 Federally Qualified Health Centers (FQHC) and 17 hospitals in Vermont and upstate New York and New Hampshire. The VHIE in turn provides clinical data to statewide registries and analytics entities including the DocSite registry maintained by the State of Vermont. In early 2014, VITL will introduce a provider portal designed to allow query-based access of the VHIE's clinical data for use in point of care decision-making.

D11. Has the state developed process(es)/mechanisms for data collection on a regularly defined basis to support its delivery system and payment reform efforts?

Shared Savings ACO Programs

The "data use standards" which includes defining the process and mechanism for data collection in support of the model will be finalized in October's work group meetings.

The standards will define the role and responsibilities of the ACOs, payers and third party data and analytics contractor with respect to data collection and reporting. To the extent possible, the approach will leverage and encourage efficiencies in the use of:

- Vermont's Multi-Payer Claims Database
- Vermont's Clinical Registry
- Blueprint for Health Practice Profiles

An RFP for the third party data and analytics contractor will be released once the data use standards are finalized, anticipated to be in October. It should be noted that the State plans to release a new RFP for the State's Clinical Registry vendor (currently Covisant/Docsite) in early 2014; requirements based on these standards would be considered in the request.

Episodes of Care Programs and P4P Programs

The same "Data use standards" will be adopted for the EOC program. Where there is a need for a targeted approach different from the one used to implement the Shared Savings ACO Program, it would be developed through the work group meetings. Based on the work plan, we would expect these to be finalized in Summer 2014.

D12. Has the state designed a formal measurement reporting mechanism across payers and providers?

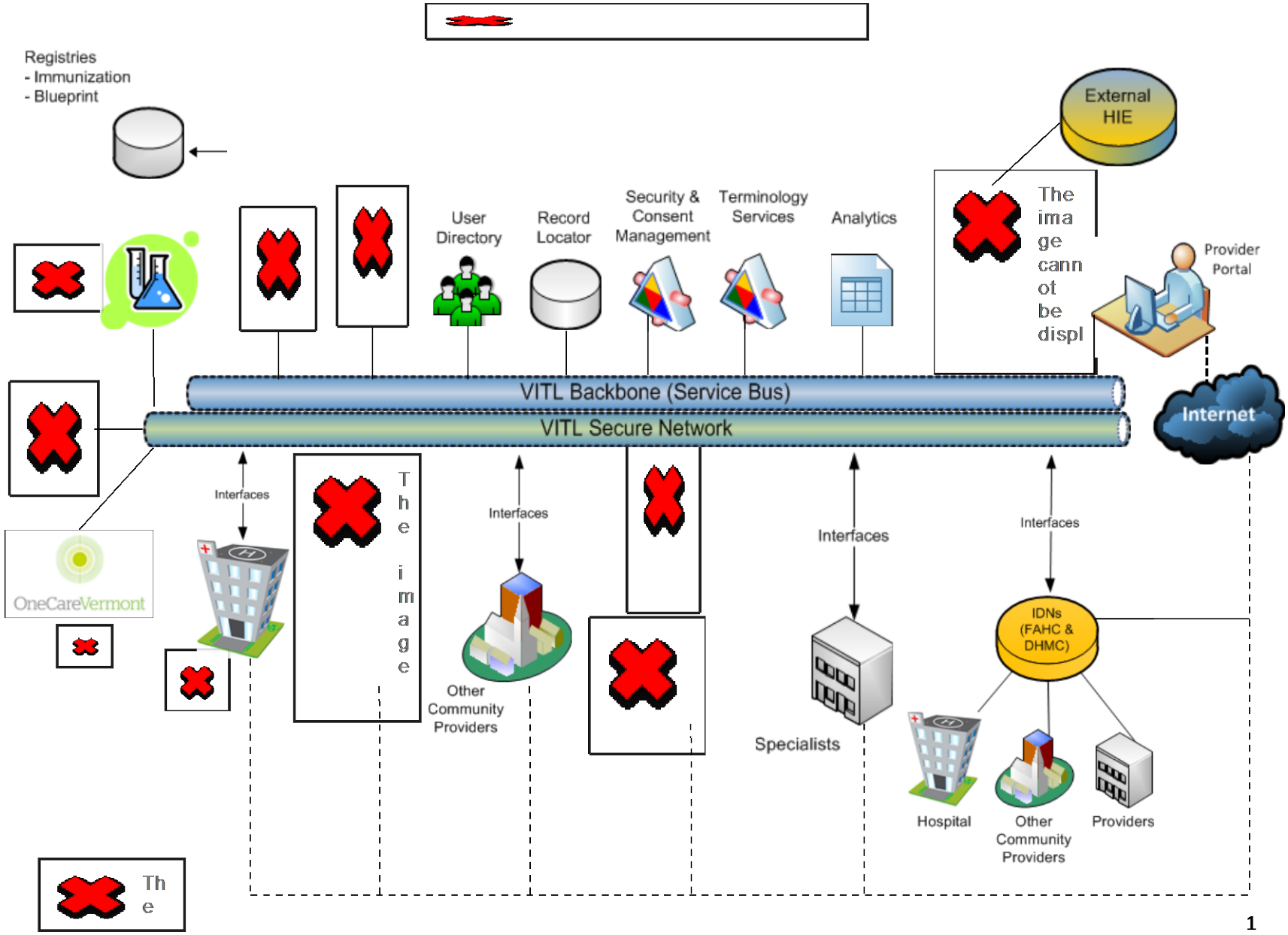
Formal measurement reporting is being developed as part of each of our payment testing models. See response to D11 above. We would also envision that the analytics contractor would serve as the primary reporting vehicle to both the federal and state evaluation contractors.

In addition, the work groups have defined a core measure set for the shared savings ACO programs and will do the same for the other program models (see attached for ACO measures).

E13. Has the State proposed health information technology (HIT) that is aligned with and leverages prior federal investments in health information exchange (HIE), meaningful use of electronic health record technologies by various provider categories, and potential strategies and approaches to improve use and deployment of HIT?

See accountability targets in tables 1 and 2. The activities proposed build on the significant progress to date in establishing meaningful use in provider practices and completing build-out of interfaces between practices and the state's HIE. The schematic below depicts how this system works. See also attached slides from VITL detailing progress to date.

VERMONT HEALTH INFORMATION EXCHANGE ARCHITECTURE



H23. Are participating providers required to implement key features of the proposed model under contract or are they otherwise committed to participating for the duration of the model testing period?

See accountability targets in tables 1 and 2. We expect to have contracts signed for the ACO models prior to January 1, 2014.

Under the commercial and Medicaid programs, participating ACOs will be required to sign a three-year agreement. All parties anticipate that the underlying agreements between the providers and the ACO would likely be negotiable on an annual basis. Should the ACO fall below the participation threshold, the agreement would terminate.

Episodes of Care (EOC)
The first year of the program would be voluntary participation; subsequent years would transition to bundled payments. Since providers would be paid at a bundled rate instead of FFS, the would have to participate in order to receive payment.

Pay-for-Performance (P4P) Programs
Participation in the Medicaid program would be required for enrolled providers but include intentional levels of adoption and a phase-in period so all providers could participate appropriate to their level of readiness.

I24. Has the state defined a common set of performance measures, consistent with endorsed measures (e.g. NQF, Meaningful Use, CDC recommended population health measures, CMMI Core measure set), including quality, patient satisfaction, financial and health outcomes, aligned with existing quality initiatives and relevant to the specific innovation model proposed?

The State has defined draft sets of measures for two purposes:

1. Tracking provider performance under the ACO model;
2. Tracking overall project outcomes and progress toward the project aims.

The first set of measures was developed by the Performance Measures Work Group. The Work Group will do additional work on their proposal at its October meetings. The initial draft (see attached) was reviewed in the SIM Steering Committee meeting on September 18. The Steering Committee provided some feedback on the draft at that time, and was asked to submit additional feedback as soon as possible. The Steering Committee's October 16 agenda will include review of final recommendations from the Work Group. The Work Group also is assessing existing provider capacity to report

clinical measures, as was requested by the Steering Committee. Our goal is to reach agreement on a final set of measures in October for incorporation in the contracts between commercial insurers and ACOs and Medicaid and ACOs beginning January 1.

The second set of measures has been drafted by staff (see attached) and will be reviewed by the Performance Measures Work Group at their next meeting. The Work Group is expected to make recommendations to the Steering Committee prior to the October 14 meeting and the Steering Committee will discuss on October 14 with the goal of making a recommendation to the SIM Core Team as soon as possible. We will also seek input from the federal evaluation team in development of this measure set.

K30. Has the state recruited new/additional staff and/or contractors (as budgeted in SIM application) to adequately support SIM activities?

The state is in active recruitment for SIM staff. As indicated in the table below, the state has filled more than one-third of the SIM positions. The state anticipates hiring of the remainder by the end of November. The state has released two RFPs: one for project management services and one for independent evaluation. The state has selected a vendor for project management services and is in the contracting phase for that scope of work. The state expects to award the independent evaluation contract by the middle of November.

Position Number	Position Name	Dept	Position Title	% to Project
737009	Kara Suter	DVHA	Reimbursement Director	25%
277008	Richard Slusky	GMCB	Payment Reform Director	25%
720175	Diane Cummings	AHS	Financial Manager II	100%
730242	Micah Demers	DVHA	Health Care Project Director	100%
	Recruiting/Interviewing	DVHA	Health Care Project Director	100%
	Recruiting/Interviewing	DVHA	Contract & Grant Administrator	100%
	Recruiting/Interviewing	DVHA	Health Access Policy & Planning Chief	100%
730245	Alicia Cooper	DVHA	Quality Oversight Analyst	100%
	Recruiting/Interviewing	DVHA	Quality Oversight Analyst	100%
730256	LuAnn Poirier	DVHA	Health Care Statistical Information Administrator	100%
	Recruiting/Interviewing	DVHA	Health Care Statistical Information Administrator	100%
	Recruiting/Interviewing	DVHA	Health Care Statistical Information Administrator	100%

	RFR in preparation	IFS	Health Care Statistical Information Administrator	100%
730252	Ann Reeves	DVHA	Senior Policy Advisor	100%
	Recruiting/Interviewing	DVHA	Senior Policy Advisor	100%
	Recruiting/Interviewing	DVHA	Senior Policy Advisor	100%
	Recruiting/Interviewing	DVHA	Health Policy Analyst	100%
	Recruiting/Interviewing	DVHA	Health Policy Analyst	100%
730255	Erin Flynn	DVHA	Administrative Services Manager I	100%
	Position to be posted, recruitment/interviews by 9/30/13	DAIL	Health Care Policy Analyst	100%
	Position to be posted, recruitment/interviews by 9/30/13	DAIL	Quality Oversight Analyst	100%
	Recruiting/Interviewing	AOA	Deputy Cost Containment	100%
270016	Christine Geiler	GMCB	Grant Manager Coordinator	100%
	Recruiting/Interviewing	GMCB	Payment Reform Program Evaluator	100%

M34. Has the state initiated training of practice transformation and care process redesign supports that leverage existing statewide learning and action networks (eg., PCMH, Health Home, regional extension centers) and other communication vehicles to engage providers?

The state will be releasing an RFP for the design of these processes in October. While we intend to utilize the existing learning collaborative structure embedded in the Blueprint for Health as part of our overall effort, we also intend to broaden the scope of collaboratives to include providers who are not part of a Blueprint practice and to address issues specific to payment model and care model transformation arising from the SIM project. Our contractor will work with us to develop that curriculum and an expended list of potential participants.

P39. Are project activities specified / planned in a way that they can complete and produce measurable results during the project's period of performance? Explanation of how the sequence of model implementation and model support activities on the timeline will directly (or indirectly) impact projected results; outline any risks of delay and evidence of past performance in order to justify the timelines that the State has proposed.

The program start dates are staggered so as to sequence SIM work group, steering committee and Core Team review, but there will be a minimum of two performance years on which to base the evaluation, even if implementation were to be delayed. Statewide efforts under the Green Mountain Care Board and internal M&E efforts will

continue past the SIM testing period and would be informed by the federal independent evaluation.

Program	Implementation Date	Performance Years Under SIM
Shared Savings ACO Program	January 1, 2014	2.75
Episodes of Care Program	October 1, 2014	2

R43. Has the state arranged for internal resources or contracted with an entity for managing data collection and reporting processes (self-evaluation, reporting to CMMI, and financial data for multi-payer systems)?

The state is managing data collection and reporting processing through the Evaluation Director position and an evaluation contract. The state is in active recruitment for the Evaluation Director position and will have that position filled by the middle of November. Additionally, as discussed above, the state released an RFP for independent evaluation and that bid should be awarded in mid-November.

TO: SIM Core Team

FROM: Anya Rader Wallack, Chair

SUBJECT: SIM Funding Allocation Proposal

DATE: October 10, 2013

Background and the case for a funding allocation plan

Vermont received a State Innovation Model (SIM) grant in February 2013. Vermont's approved grant budget is $45 million. Grant funds will be expended over the next three years. Grant funds will be used to support Vermont's Health Innovation Project. The goals of this project are to:

- Improve Vermonters' experience of care;
- Improve population health and quality of care; and
- Reduce health care costs.

The SIM grant will help the project accomplish these goals by supporting three major dimensions of project work:

- Expand health information technology;
- Facilitate the development, execution, and testing of three payment models across all payers; and
- Implement and align new care management and care coordination models.

The grant also includes support to improve workforce development, measure patient engagement and fund other related efforts.

The grant application and the approved grant budget identified general categories of project spending. These are summarized below in Table 1.

Table 1

ESTIMATED COST TO BUDGET					
	Implementation	Year 1	Year 2	Year 3	Total
Personnel	$ 568,700.21	$ 1,621,093.63	$ 1,703,161.50	$ 1,789,382.57	$ 5,915,149.14
Fringe Benefits	$ 263,592.32	$ 751,376.90	$ 789,415.35	$ 829,378.82	$ 2,741,671.63
Travel	$ 39,375.00	$ 78,750.00	$ 78,750.00	$ 78,750.00	$ 275,625.00
Equipment	$ 68,287.50	$ 34,875.00	$ 34,875.00	$ 34,875.00	$ 172,912.50
Supplies	$ 281.25	$ 2,250.00	$ 2,250.00	$ 2,250.00	$ 7,875.00
Other	$ 19,828.13	$ 158,625.00	$ 158,625.00	$ 158,625.00	$ 555,187.50
Overhead	$ 277,479.88	$ 648,437.45	$ 681,264.60	$ 715,753.03	$ 2,366,059.66
Contractor	$	$ 12,001,667.00	$ 11,063,330.00	$ 9,910,003.00	$ 32,975,000.00
Total:	**$ 1,681,311.05**	**$ 15,297,074.99**	**$ 14,511,671.45**	**$ 13,519,017.43**	**$ 45,009,074.92**

During the first six months of the grant, work has been done to refine the estimates of necessary project funding in various categories. In addition, some urgent spending decisions have been made by the SIM Core Team[1]. There are many more decisions to be made about the specific expenditure of funds within the broad categories identified in the grant.

In the past six months we also have developed a robust structure for gathering input on the project from "stakeholders" through a slate of work groups, a project Steering Committee and the Core Team. Stakeholders who are part of this structure have asked for clarification about their role in project funding decisions. To answer this question, and to distribute SIM resources most effectively, coordinate with other public and private investments and comply with state and federal requirements for the expenditure of grant funds, the State needs a workable and efficient process to get input from stakeholders and get necessary approval for expenditure of SIM funds. This document includes an initial proposal for such a process.

On September 30, Vermont was notified that we had been approved to move to the "testing" period of the SIM grant. This means we can move forward with project activities and with project expenditures, subject to certain ongoing necessary federal approvals (for example, CMS must approve all contracts supported with grant funds). This creates more urgency for defining the rules and processes for how funding allocation decisions are made and, in particular, to recommend how and when we include SIM stakeholders meaningfully in project spending decisions.

[1] Specifically, the Core team approved on August 18 the expenditure of funds for hiring a project management vendor, for hiring of a project evaluation vendor and to partially fund a contract with VITL for project-related activities.

Specific proposal for SIM funding allocation

This proposal attempts to balance three potentially competing needs:

1. The need for meaningful input on project investments from project participants, particularly private sector partners who are engaged in activities that also advance the goals of the project[2];
2. The need for appropriate controls on spending to assure fiduciary accountability, compliance with state and federal requirements and coordination with related investments[3];
3. The need to move expeditiously to invest grant funds, to maximize the impact of the project within the grant period.

I am proposing that grant and contract funds be segregated into two categories for purposes of decision-making. These are described in the graphic in the attached document. The proposal includes the following components:

- SIM expenditures are sorted into two categories – type 1 and type 2
- Type 1 expenditures include:
    - Personnel, fringe, travel, equipment, supplies, other, overhead, interagency coordination (as identified in original grant budget), provider grant program (with work group and steering committee input on grant criteria)
    - Expenditures approved by the Core Team prior to 10/1/13 (Project Management contract $, Evaluation contract $, VITL contract $)
    - Ongoing project management resources, with Core Team approval
    - Base support for each work group (extension of existing contractor technical assistance or new contract), both with approval of Core Team
    - Base support for each lead agency, including support for "change management," with Core Team approval
- Type 2 expenditures include all other grant funds
- Type 1 expenditures will be reviewed on a "fast track" with only approval of the Core Team necessary under the SIM project (additional reviews may be necessary as described below)
- Type 2 expenditures will be reviewed by SIM work groups. Staff will develop recommendations for the expenditure of those funds and those recommendations will be reviewed by the appropriate work group, then the Steering Committee and ultimately the Core Team.
- Any expenditures that relate to or potentially have an impact on any of the following will also be subject to review and approval by the state's Health Services Enterprise

[2] Note that all project expenditures must comply with state procurement requirements, which are described at the end of this document and with state conflicts-of-interest policies.

Executive Committee and possibly other approval processes within the Agency of Human Services:
    - the state's Implementation Advanced Planning Document (IAPD), which governs our use of certain federal funds for information technology;
    - the state's Global Commitment waiver; or
    - other Medicaid funding agreements.
- All contracts are subject to the state's procurement rules
- All recommendations arising from SIM work groups, the SIM Steering Committee and the SIM Core Team will be subject to conflict-of-interest policies to be developed
- All contracts are subject to approval from CMS

Attached are two documents that reflect this proposal: a flow chart that shows how type 1 and type 2 expenditures would gain approval; and a spreadsheet that shows a proposed allocation of grant funds based on the distinction between type 1 and type 2 expenditures. Georgia Maheras, Richard Slusky and Kara Suter assisted me in developing this spreadsheet. The tables in the spreadsheet also describe additional sub-categories within those two categories. For type 2 funds, this includes an allocation of funds across work groups according to our assessment of the work group jurisdiction.

Decision points for October 14

Please review the attachments and come to the October 14 meeting prepared to address two questions:

- Do you approve of the general allocation of funds and the processes proposed for approval of the two types of expenditures?
- Do you approve of the specific subset of type 1 expenditures identified as "type 1a" in the attached spreadsheet?

Justification for additional type 1 expenditures and a request for your approval of those expenditures will be provided at the November Core team meeting. In addition, I hope to present recommendations to you in November regarding conflict-of-interest rules that could apply to all project participants.

NOTE: STATE PROCUREMENT RULES AND CMS APPROVALS

All contracts must follow the state's procurement policy, which includes the following steps:

a. Release of a request for proposals, simplified bid or determination to execute a sole source contract. An example of an RFP is found here: http://gmcboard.vermont.gov/sites/gmcboard/files/SIM_PMO_RFP061413.pdf.
b. Identification of a bid review team. Review by that team of the bids. Note that bids must include significant documentation to be considered worthy of review.

c. Recommendation by the bid review team of a specific vendor to the decision-maker.
d. Negotiate scope of work and contract terms with the vendor.
e. Prepare the contract in standard form. This is where all contract terms and conditions are put together into one document.
f. Obtain AG approval.
g. Obtain DII approval (if necessary).
h. Obtain AOA approval (if necessary).
i. Execute contract.

CMMI must also approve all contracts and grants. This federal approval is in addition to the current overall grant approval. CMMI has approved expenditure of funds for the general purposes of the SIM grant, but they require specific contract approval as well to make sure the contract scopes of work are in line with their requirements and the terms and conditions of the SIM award.

Type 1 expenditures:

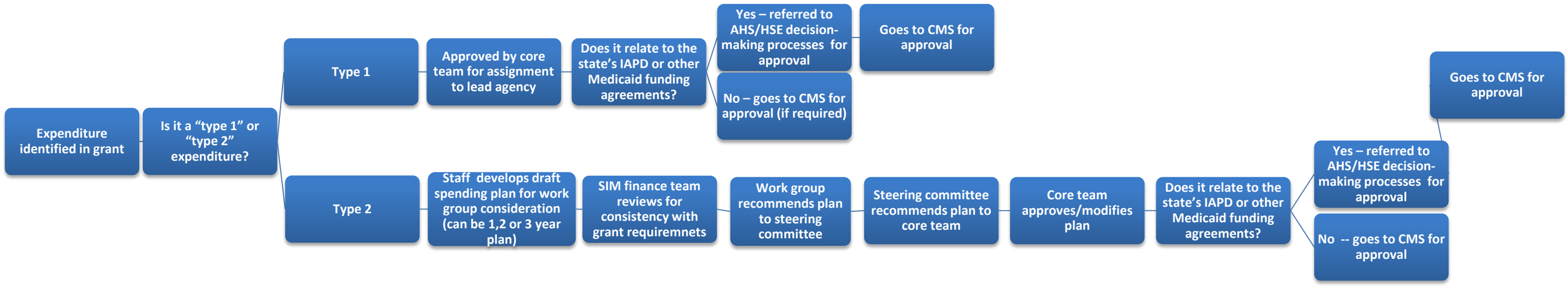
- Personnel, fringe, travel, equipment, supplies, other, overhead, interagency coordination, staff training and change management (as identified in approved grant budget)
- Provider grant program (with input from work group and steering committee on criteria)
- Expenditures approved by the Core Team prior to 10/1/13 (Project Management contract $, Evaluation contract $, VITL contract $)
- Ongoing project management resources, with Core Team approval
- Base support for each work group (extension of existing contractor technical assistance or new contract), with Core Team approval
- Base support for each lead agency, with Core Team approval

Type 2 expenditures:

- All other

NOTE: all contract expenditures are subject to state procurement rules and all recommendations/decisions of work groups, Steering Committee and Core team are subject to conflict-of-interest rules

Proposed decision-making process for SIM grant expenditures
Draft for discussion only, 10/10/13



		Implementation (March-Oct 2013)	Year 1	Year 2	Year 3	Total grant period	
Type 1a							
Proposed type 1 without base work group or agency/dept support (subject to Core Team approval)	*Total Type 1a*						
	Personnel, fringe, travel, equipment, supplies, other, overhead	1,475,000	3,355,103	3,355,103	3,355,102	11,540,308	
	Project management	225,000	700,000	700,000	700,000	2,325,000	
	Evaluation		1,000,000	1,000,000	1,000,000	3,000,000	
	Interagency coordination		110,000	110,000	110,000	330,000	
	Staff training and Change management		100,000	100,000	100,000	300,000	Support Conferences and Educational Opportunities
	VITL Contract		1,177,846			1,177,846	
	Grant program		933,333	933,333	933,334	2,800,000	Allow workgroups to recommend or suggest criteria they think is important for allocation of money.
	Subtotal	1,700,000	7,376,282	6,198,436	6,198,436	21,473,154	

Type 1b			**Year 1**	**Year 2**	**Year 3**	**Grant Total**	
Proposed type 1 related to base work group support (subject to Core Team approval)							
	Payment Models						
	Bailit/Murray		0	200,000	200,000	400,000	To develop EOC program and P4P programs
	Burns and Associates or other vendor		200,000	200,000	0	400,000	To develop EOC program and P4P programs
	Measures						

	Bailit/Murray		0	200,000	200,000	400,000	
	HIT/HIE		150,000	150,000	150,000	450,000	No contractor identified
	Population Health		100,000	100,000	100,000	300,000	No contractor identified
	Workforce		100,000	100,000	100,000	300,000	No contractor identified
	Care Models		250,000	250,000	250,000	750,000	No contractor identified
	Duals						
	Hogan/Besio/Wakely		250,000	250,000	250,000	750,000	
			1050000	1,450,000	1,250,000	3,750,000	

Type 1c			**Year 1**	**Year 2**	**Year 3**	**Grant Total**	
Proposed type 1 related to base agency/dept support (subject to Core Team approval)							
	GMCB/DVHA						
	ACO Analytics Contractors		400,000	400,000	200,000	1,000,000	This contractor would support the development of spending targets, whether an ACO met those targets and how potential savings are distributed
	GMCB						
	Model testing support		125,000	125,000	125,000	375,000	Support GMCB analytics related to payment model development
	DVHA						

	Modifications to MMIS, etc…		350,000	150,000	0	500,000	Resources to support updates to adjudication or analytic systems and processes like MMIS.
	Broad dissemination of programmatic information to providers and consumers		100,000	100,000	100,000	300,000	Communications to providers and consumers regarding program/billing changes.
	Analytics support to implement models		250,000	50,000	50,000	400,000	
	Technical support of web-based participation and attestation under the P4P program		125,000	100,000	25,000	250,000	Aimed to reduce administrative burden to implement and improve participation in P4P programs
	Analytic support		100,000	100,000	100,000	100,000	Support Medicaid analytics related to payment model development
			1,450,000	1,025,000	600,000	2,925,000	
Type 2			**Year 1**	**Year 2**	**Year 3**	**Grant Total**	
Total proposed type 2 (subject to staff planning, work group/steering committee review and Core Team approval)							
	HIT/HIE						
	Practice Transformation Teams		856,666	856,666	856,667	2,570,000	
	Clinical Registry		466,666	466,666	466,667	1,400,000	
	Integrated Platform		666,666	666,666	666,667	2,000,000	
	Expanded Connectivity between SOV and providers		833,333	833,333	833,334	2,500,000	
	Telemedicine		416,666	416,666	416,667	1,250,000	
	Expanded Connectivity HIE			661,077	661,077	1,322,154	
	Workforce						
	Surveys		80,000	80,000	0	160,000	

	Data analysis		0	150,000	150,000	300,000	
	System-wide analysis		546,666	546,666	546,667	1,640,000	
	Care Models						
	Service delivery for LTSS, MH, SA, Children		533,333	533,333	533,334	1,600,000	
	Learning Collaboratives		500,000	325,000	325,000	1,150,000	This item could support outreach and mailings associated with notification and education on new care delivery and payment reform models.
	Analysis of how to incorporate LTSS, MH/SA		100,000	100,000	100,000	300,000	This includes technology support to Medicaid Home Health Initiatives including Hub and Spoke.
	Practice Facilitators		170,000	170,000	170,000	510,000	
	Integration of MH/SA		50,000	50,000	50,000	150,000	
			5,219,996	5,856,073	5,776,080	16,852,154	

Type 1a	21,473,000
Type 1b	3,750,000
Type 1c	2,925,000
Type 2	16,852,154
Grant Total	45,000,154