Vermont Health Care Innovation Project
Health Data Infrastructure Meeting Agenda

October 28, 2016, 3:00-5:00pm

Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex

Call-In Number: 1-877-273-4202; Passcode: 2252454

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action Needed?
1	9:00-9:05am	Welcome and Introductions; Minutes Approval	Simone Rueschemeyer & Brian Otley	Attachment 1: Draft September 21, 2016, Meeting Minutes	Approval of Minutes
2	9:05-9:10am	Project Updates: • Brief Sustainability Update	Georgia Maheras & Sarah Kinsler		
3	9:10-9:35am	Population Health Plan Review and Discussion	Tracy Dolan and Heidi Klein	Attachment 3: Presentation: Draft Population Health Plan Full Draft Population Health Plan available at: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/Vermont%20Population%20Health%20Plan%20%20September%202016.pdf	
4	9:35-10:15am	Connectivity Targets	Larry Sandage	Attachment 4: HIE Connectivity Criteria Proposal Attachment 4 was shared with participants on 10/18 for review and comment prior to the 10/28 Work Group meeting.	Vote to Approve
5	10:15-10:55am	Consent Discussion	Larry Sandage	Attachment 5: HIE Consent Management Solution Scope of Work – Proposed Attachment 5 was shared with participants on 10/18 for review and comment prior to the 10/28 Work Group meeting.	Vote to Approve
6	10:55-11:00am	Public Comment Next Steps, Wrap-Up and Future Meeting Schedule	Simone Rueschemeyer & Brian Otley	**Next Meeting – RESCHEDULED**: **Friday, November 18, 2016, 3:00-5:00pm, Montpelier**	

Additional Attachments:

- Attachment 7: HIT and Interoperability Policy Lever Compendium

Attachment 1: Draft September 21, 2016, Meeting Minutes

Vermont Health Care Innovation Project
HDI Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, September 21, 2016, 9:00am-11:00am, Ash Conference Room, Waterbury State Office Complex, 280 State Drive, Waterbury.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Minutes Approval	Georgia Maheras called the meeting to order at 9:05am. A roll call attendance was taken and a quorum was not initially present. A quorum was *July Meeting Minutes:* Heather Skeels moved to approve the July meeting minutes by exception; Nancy Marinelli seconded. The minutes were approved with no abstentions.	
2. Project Updates	Georgia Maheras provided project updates: • Brief Sustainability Update: Hired a contractor, Myers & Stauffer, to support this effort. Multiple components: a survey for stakeholders, a private sector stakeholder group, and a parallel State leadership group. A draft will be released in early November for stakeholder review and comment, and will be presented to every work group in November for review and discussion. We will also host a webinar as an additional opportunity for comment. All feedback will be documented; the stakeholder group will reconvene to consider responses to comment and make a recommendation to the Core Team for approval. The final plan will be approved in Spring 2017 to ensure the new Governor's administration has an opportunity to review. Feel free to contact Georgia or Sarah Kinsler to provide input. • ONC Clinical Quality Measurement Conference: ONC recently held a conference with states to support peer learning around clinical quality measurement. They hope to develop some toolkits as well as influence ONC policy. This was a very interesting meeting; Georgia is synthesizing notes from Vermont's team. We are also inviting a few key contacts to come to Vermont so we can learn from them: Dr. David Kendrick, who specializes in using electronic clinical quality measures for practice transformation, and Lucia Savage, ONC's Chief Privacy Officer, who specializes in explaining HIPAA and other privacy rules.	
3. Event Notification System Update	Brian Manning from PatientPing provided an update on rollout of our Event Notification System (Attachment 3). • PatientPing's Event Notification System uses data from the VHIE to provide notifications (pings) to providers on a patient's care team when the patient transitions between care settings.	

Agenda Item	Discussion	Next Steps
	• Status Update: PatientPing is providing pings on over 56,000 CHAC members, and 4,200 high-risk OneCare members. Pings to date: 44,771 total. • New providers continue to sign on to receive pings. The group discussed the following: • Arsi Namdar asked whether HHAs are being notified, and whether there has been progress in working with EMRs, especially big players like McKesson. Brian noted that PatientPing gets admission, discharge, and transfer information through the VHIE. HHAs have a dynamic census; they send their census to PatientPing in real time; for 90 days following service through an HHA, the HHA will get a ping of the patient has an admission, discharge, or transfer. PatientPing does integrate with many EMRs and receives information directly from EMRs. Pings can't currently be consumed through EMRs (only through a web interface), but PatientPing is working on an API for this. • Susan Aranoff asked whether numbers on slide 3 under the VITL bullet are unduplicated – CHAC and OneCare numbers are subsets of 44,771, the total number. Brian responded that this is correct. • Dale Hackett asked how many of the CHAC patients are high-utilizers so he can compare to the OneCare number. Brian did not have that data but could pull it. He noted that PatientPing is tracking CHAC's entire population, but only a sub-set of OneCare's population. He commented that PatientPing is building new features that will allow the identification of high-risk patients in real-time based on utilization, rather than waiting for claims data. • Chris Dussault noted that AAAs and SASH don't have access to the VHIE because they are not included in the definition of a health care provider in statute. Brian clarified that organizations don't need to be able to access the VHIE to receive updates on the patients they are tracking. SASH is receiving pings. Stefani Hartsfield noted that SASH can only see ADT information by contracting PatientPing – a slice of the full information in the VHIE. • Susan Aranoff asked whether PatientPing is working with AAAs in other states. Brian responded that this is not currently occurring; it hasn't come up as much in other states. • Nancy Marinelli asked whether PatientPing is working with residential care homes, assisted living residences, adult day providers, traumatic brain injury providers, or other types of long-term care providers. Brian responded that this hasn't happened yet. Nancy suggested that these providers, many of whom are Choices of Care providers, should be added to the list for future discussions.	
4. Data Utility Update	David Healy and Rachel Block, both part of the contracted HDI Work Group support team from Stone Environmental, provided an update on the Data Utility project (Attachment 4). • State HIEs vary significantly, but there's still much to learn from other states! • Key topics are governance, functions, and HIE/HIT program sustainability. • Key state roles (themes Rachel has identified and categorized across states): States have taken varied approaches to each of these roles.	

Agenda Item	Discussion	Next Steps
	• Georgia Maheras noted that results of this work will be part of transition documents for the next Administration; we are likely to have final results by the end of the year. • Georgia invited members to email her with comments or feedback. The group discussed the following: • Susan Aranoff asked whether any states are dealing with cost and expense through regulation, and what states' roles are. Rachel replied that states are relying on this opportunity to maximize Medicaid match funding. New York has an HIT fund similar to Vermont's, and is considering whether or how they want to continue this in the future, but New York and Vermont are the exception to the rule. Some payers are creating incentive payments to particular providers for HIE participation, but this is market-based. Susan asked whether any states are regulating provider HIE access costs, noting that this is becoming a necessity for providers, and that the VHIE has a monopoly. Rachel replied that one other state has granted a monopoly to regional HIEs, and there's a component of statewide coordination for statewide patient lookup. The state has not regulated participation costs, but the basic service package regional HIEs are providing is regulated. Arsi Namdar noted that most HIE services have been free for providers so far; introducing costs for HIE services will be very hard for providers. Georgia noted that this is not the path Vermont is planning to take; this service is a utility and should be funded appropriately in a way that allows us to maximize federal funding opportunities.	
5. Telehealth Pilot Update	Georgia noted that it's been quite a while since we've had an update on this topic. Delays in contracting have delayed this project, which will wrap up in 2017. Jim Westrich provided an update on the telehealth pilots. • DVHA received several RFP responses and selected two to pursue as pilots. The two selected pilots were with the Howard Center and VNAs of Chittenden and Grand Isle Counties. • Howard Center pilot is to do remote dosing for clients with opiate addiction who are receiving particular therapies. Secure dispensers of medication, plus video technology to monitor dosing, allows patients to receive medication at home. Howard Center has selected a vendor for video technology, and has scheduled a staff training for later this month. Clinical staff will do video review and are creating clinical workflows for this; Howard Center is also selecting appropriate clients for this pilot. • VNAs of Chittenden and Grand Isle Counties leads the second pilot, partnering with Franklin County Home Health and Central Vermont Home Health and Hospice. This pilot will share telemonitoring information, as well as other information, through the VHIE. Arsi Namdar added: This pilot is working with McKesson and Honeywell to install VHIE interfaces; they are currently in testing. Data will go from the system, to field nurses' laptops, to the VHIE system.	
6. Home Health Agency VITLAccess Rollout and Interface Build Update	Larry Sandage and Susan Aranoff provided an update on the Home Health Agency VITLAccess rollout and interface build (Attachment 6). • The goal is to connect HHAs to the VHIE through interfaces and allow them to access to clients' broader health records stored in the VHIE through VITLAccess.	

Agenda Item	Discussion	Next Steps
	• This project initially included AAAs in its scope, but legal issues have prevented us from pursuing this path; this work is on hold. • Slide 4: Should be titled "VITL Interface Implementation" • Larry noted that Arsi Namdar has been a huge asset to this team. Susan Aranoff seconded that Arsi has been a wonderful partner, as has Holly Stone, who is the project manager. Arsi noted that this has been a very satisfying project to work on.	
7. Universal Transfer Protocol/ Integrated Communities Care Management Learning Collaborative Update	Erin Flynn provided an update on work toward a Universal Transfer Protocol (UTP) through the Integrated Communities Care Management Learning Collaborative (Attachment 7). • When the decision was made not to pursue a technical solution for UTP in Spring 2016, it was decided that UTP goals would be pursued through workflow redesign, leveraging the Integrated Communities Care Management Learning Collaborative, a provider learning collaborative which has grown out of the Practice Transformation Work Group. • Erin reviewed content at the September 6-7 learning sessions, which focused in part on this topic, and walked through the steps participating providers took to identify key care transitions and the information they need to support care continuity through those transitions. The group discussed the following: • Dale Hackett and Nancy Marinelli asked for more information on the chart used at the learning sessions. The full curriculum from this learning session will be posted to the VHCIP website soon. • Erin described the process of identifying standard data elements for key information. • Susan Aranoff asked whether or how the key data elements have changed since the first UTP report that was put together by im21 in 2014. Erin noted that this work within the Learning Collaborative builds on the efforts to develop shared care plan templates. There was also a great deal of discussion about OneCare's Care Navigator tool, which is currently being rolled out. She believes we are further along, though this work isn't done. There is a feasible shared care plan solution being tested now in Care Navigator, which is a significant advance. Georgia Maheras added that we've done a lot of education within IT and in the provider sphere and implemented certain standards; providers are starting to understand the benefit of standardized data sets. Ken Gingras added that this is a reminder – it underscores the necessity of having a common language and broad standards that make are understandable across the state and the country. • Stefani Hartsfield commented that the decision not to endorse one shared care plan solution in 2015 and 2016 led us to this point. Terry O'Malley was able to describe this to people intimately involved in care management, which was very beneficial, but this group also needs to see and understand those slides. She requested that we send those slides to this group. Care team meetings that support better and more coordinated patient care are also a key success. • Erin noted that the Learning Collaborative will continue to hold shared learning events with Blueprint and ACO support – she expects this conversation will continue.	**Send Terry O'Malley slides from ICCMLC to group.**

Agenda Item	Discussion	Next Steps
8. VCN Data Repository Update	Ken Gingras provided an update on the VCN Data Repository Project (Attachment 8). • Vermont Care Partners members are participating. • The data repository will include two years of historical MSR data. Based on this information, built a first dashboard. VCN has been working to develop a full list of metrics and compare to the MSR data. The first dashboard shows that VCN can answer many key questions about their system of care. Cross-referencing and standardization has meant the loss of some granularity and specificity. • VCN also did training to teach agencies how to securely upload data on a monthly basis after they send to DMH. Training is now complete; VCN is still working with agencies to make this a monthly habit. VCN is also doing training on using their monthly portal to set up and manage users and security levels. At least one person has been trained at all agencies, and this is currently rolling out so people can access initial dashboards and provide feedback. • Phase 2: Vendors are working to develop transmitting agents at each agency that allow secure transmission to the repository. VCN will also be developing additional dashboards; it also plans to train agency staff to develop and distribute their own dashboards. • Ken walked through a redacted screenshot of a dashboard. The group discussed the following: • Heather Skeels asked whether VCN is tracking who logs on so they can follow-up. Ken replied that the vendor should be able to provide that, but hasn't accessed it yet. Heather noted this has been very helpful for CHAC; Nancy Marinelli commented that this would also be helpful for agencies. • Dale Hackett asked how reliable the information in the dashboards is, and how this is communicated to users. Ken replied that data quality is a huge topic and something VCN is also working on. The data repository will allow VCN to work with administrators and agency IT folks to work backward to identify data quality issues. • Nancy Marinelli asked whether this will replace the MSR. Georgia noted that AHS is working on this through the Medicaid Pathway – rather than replacing the MSR, the way it's submitted may change to make information easier to submit, receive, and analyze. The audience for the DMH-submitted MSR report and the repository/dashboards are different at this point. This tool allows the agencies to get more feedback on the data they're submitting. In Phase 2, there will be new information daily to allow for more granularity and faster response.	
9. Public Comment, Next Steps, Wrap-Up, and Future Meeting Schedules	Dale Hackett asked whether other states have found sustainable funding solutions for ongoing maintenance and operations of systems. Georgia replied that this is an issue in every state due to restrictions in federal HIT funds. **Next Meeting – DATE CHANGED:** Friday, October 28, 2016, 3:00-5:00pm, Ash Conference Room (2nd floor above main entrance), Waterbury State Office Complex, 280 State Drive, Waterbury. • Topics include connectivity targets and consent management; materials will be distributed early in October for written comment as well as for discussion at the work group meeting.	

Attachment 3: Presentation: Draft Population Health Plan

POPULATION HEALTH PLAN

Draft Overview for Discussion and Comment

October 2016

Discussion

- From your work group's point of view, how does this plan advance your work?
- How well do the goals and recommendations of the plan align with yours for moving ahead?
- What else would you want to see in order to get behind this plan?

INTRODUCTION AND BACKGROUND

"We need to shift from focusing on health care to focusing on health."

Karen Hein, MD

The Population Health Plan…

- Leverages and builds upon existing priorities, strategies, and interventions included in Vermont's State Health Improvement Plan (SHIP) and other state initiatives

- Addresses the integration of public health and health care delivery

- Leverages payment and delivery models as part of the existing health care transformation efforts

Building on State Innovation Models (SIM/VHCIP) and the State Health Improvement Plan (SHIP)

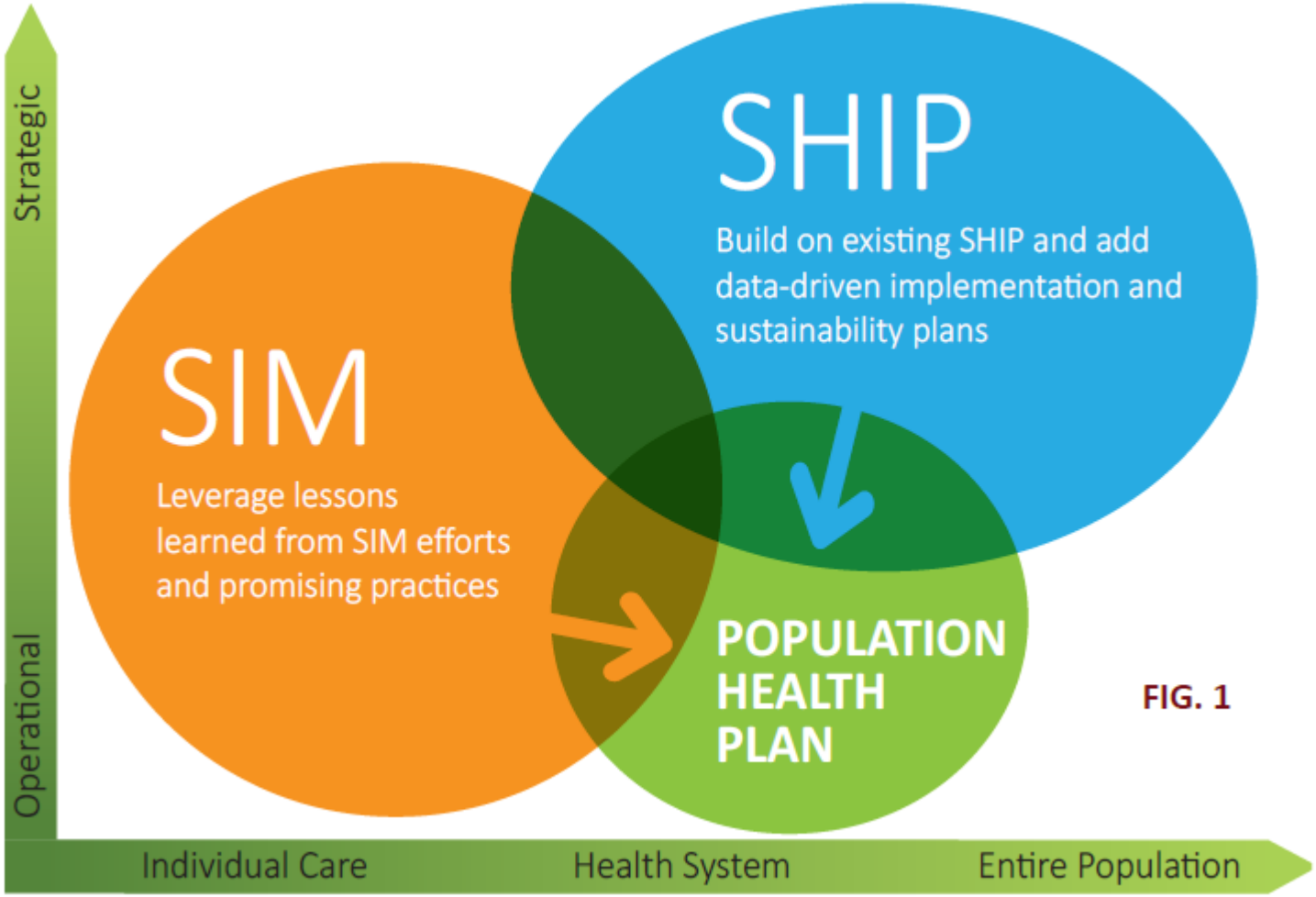
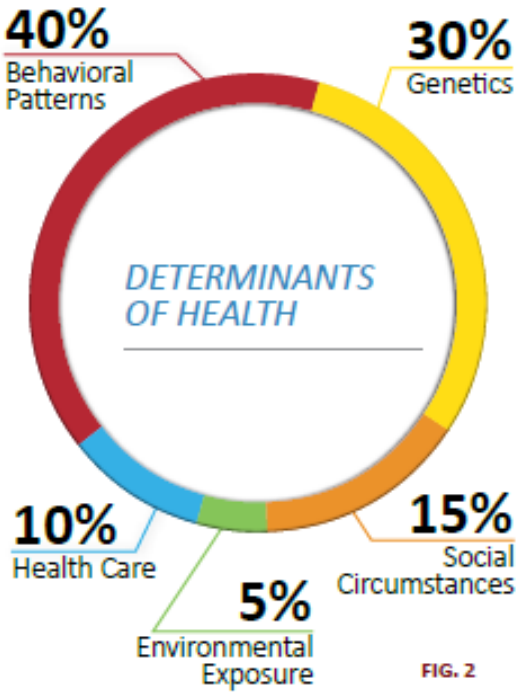


FIG. 1

Key Definitions

- **Health**: Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.
- **Population Health**: The health outcomes (morbidity mortality, quality of life) of a group of individuals, including the distribution of such outcomes within the group.



- **Social Determinants of Health**: The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

FIVE PRINCIPLES FOR IMPROVING POPULATION HEALTH

Principles for Improving Population Health

1. Use Population-Level Data on Health Trends and Burden of Illness to Identify Priorities and Target Action.
2. Focus on Prevention, Wellness, and Well-Being at All Levels – Individual, Health Care System, and Community.
3. Address the Multiple Contributors to Health Outcomes
4. Community Partners are Engaged in Integrating Clinical Care and Service Delivery with Community-Wide Population Prevention Activities.
5. Create Sustainable Funding Models Which Support and Reward Improvements in Population Health, including Primary Prevention and Wellness.

RECOMMENDATIONS

Policy Levers:

Governance Requirements: include entities that have the authority, data/information, and strategies

Care Delivery Requirements and Incentives to move from acute care to more coordinated care

Metrics and Data of population health outcomes

Payment and Financing Methodologies towards value-based payment and alternative sustainable financing for population health and prevention

State: Governance Requirements

- Embed governance requirements in Medicaid contracts with ACOs and other providers.
- Require ACOs, through Act 113 of 2016, to include public health and prevention leaders in their governing entities.
- Create a statewide public/private stakeholder group, similar to the Population Health Work Group, that recommends activities to State health policy leadership.
- Expand partnerships to other sectors that impact health. Build upon the Governor's Health in All Policies Task Force.

Regional: Governance Requirements

- Continue to expand partnerships to other sectors that impact health at the community or regional levels including housing, business, city and town planners, among others.

- Expand existing Community Collaboratives to meet all of the components of Accountable Communities for Health.

SPOTLIGHT: Accountable Communities for Health

An ACH is accountable for the health and well-being of the entire population in its defined geographic area. It supports the integration of high-quality medical care, mental health services, substance use treatment, and long-term services and supports, and incorporates social services. It also supports community-wide primary and secondary prevention efforts.

Lever: Care Delivery Requirements and Incentives

- Current: Vermont is utilizing state policy levers to create the foundation for payment reforms and care delivery reforms to move our health care system from acute care to more coordinated care.

- Future: Expand upon the regional integration started with the Community Collaboratives.

Lever: Care Delivery Requirements and Incentives

1.0 Acute Care System

Episodic Non-Integrated Care

- Episodic health care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly coordinated chronic care management

2.0 Coordinated Seamless Health Care System

Outcome Accountable Care

- Person-centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk
- HIT integrated
- Focus on care management and preventative care

3.0 Community Integrated Health Care System

Community Integrated Health Care

- Healthy population-centered
- Population health-focused strategies
- Integrated networks linked to community resources capable of addressing psychosocial/economic needs
- Population-based reimbursement
- Learning organization that is capable of rapid deployment of best practices
- Community health integrated
- E-health and telehealth capable

State: Care Delivery Requirements and Incentives

- Direct the overall flow and distribution of health resources within the State.
  - Certificate of Need program, Health Resource Allocation Plan, Insurance Rate Review, Hospital Budget Review, Professional Licensure, and contracting can help the State
- Set expectations to demonstrate success
  - Healthy Vermonters 2020, the All-Payer Model population health measures, and the Vermont Model of Care.

Regional Care Delivery Requirements and Incentives

- Incentivize Community Collaboratives to develop into Accountable Communities for Health

- Utilize *Prevention Change Packets* – developed by VDH in collaboration with OneCare – to incorporate prevention strategies to improve population health at all levels of the health system

Lever: Metrics and Data

- Require the collection of specific population health metrics
  - Track population health measures through the All-Payer Model Framework
- Set guidelines to move away from only using clinical, claims, and encounter-based metrics.

- Continue use of population health measures to drive statewide priority setting for improvement initiatives
  - for example, inclusion of screening measures for obesity, tobacco use, cancer into the payment and reporting quality measures for payment reforms.

Regional : Metrics and Data

- Use data gathered by hospitals through the Federally required Community Health Needs Assessments (CHNAs) to determine the highest priority health needs of the community and develop an implementation strategy to meet those needs.

- Provide regional-specific data, like that through the Blueprint Profiles to each hospital service area.

Lever: Payment and Financing Methodologies

- Payment methodologies – how health care providers and other organizations are paid for their work
- Financing methodologies – how funds move through the health system
- Two strategies to fund population health goals or social determinants of health:
  - Value-based payment models for providers
  - Alternative financing models for population health and prevention (not grant-based)

Lever: Payment and Financing Methodologies

A conceptual model for sustainable financing includes…

- Diverse financing vehicles
- Balanced portfolio of interventions
- Integrator or backbone organization
- Reinvestment of savings

State: Payment and Financing Methodologies

- The Green Mountain Care Board: support hospital investment in population health initiatives through its Community Health Needs Assessment Policy.
- The Department of Health and Department of Vermont Health Access: increase referral to population health management activities by allowing utilization of certain codes by clinicians for payment.
- The Agency of Human Services: incorporate mechanisms that encourage or require public health accountability in value-based contracts.
- Track population health measures through the All-Payer Model.

Regional: Payment and Financing Methodologies

- Pool resources within a region to support a target a specific initiative like food security or ending homelessness.

- Reinvest savings in community-wide infrastructure to enable healthy lifestyles and opportunity

MEASURING SUCCESSFUL PLAN IMPLEMENTATION

Signs we are on the path to success

- Health system actions are primarily driven by data about population health outcomes; goals and targets should be tied to these statewide data and priorities identified in the State Health Improvement Plan.

- The health system creates health and wellness opportunity across the care and age continuum and utilizes approaches that recognize the interconnection between physical health, mental health and substance use, and the underlying societal factors.

Signs we are on the path to success

- Payment and financing mechanisms are in place for prevention strategies in the clinical setting, through clinical/community partnerships, and for community wide infrastructure and action.

- An expanded number of entities are accountable for the health of the community including health care providers, public health, community providers and others who affect health through their work on housing, economic development, transportation, and more, resulting in true influences on the social determinants of health.

Discussion

- From your work group's point of view, how does this plan advance your work?
- How well do the goals and recommendations of the plan align with yours for moving ahead?
- What else would you want to see in order to get behind this plan?

HEALTH INFORMATION EXCHANGE CONNECTIVITY TARGET PROPOSAL

Larry Sandage

October 28, 2016

Project Background

- Intent: *From 2016 HDI Workplan* – Discuss connectivity targets for 2016-2019 and make a recommendation to the Steering Committee and Core Team.

- During review, expanded projections to a 10 year outlook.

- The proposed criteria are targets and are not intended as milestones or requirements.

Statements & Assumptions

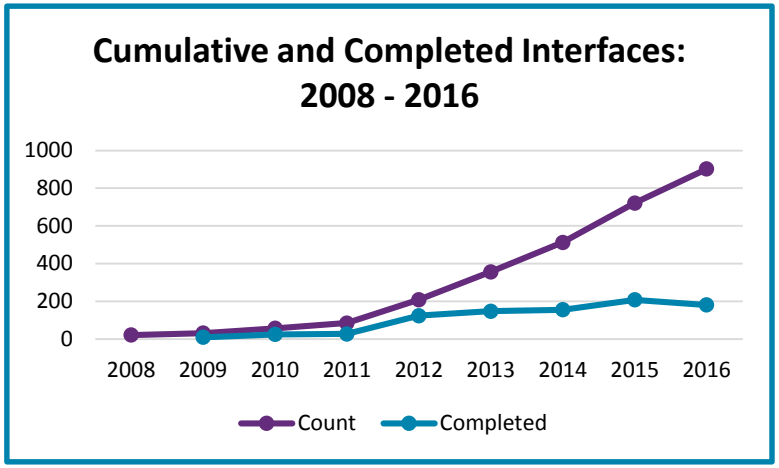
- All information for this proposal is based off of the "Health Care Organization Connectivity Report", submitted to the State by Vermont Information Technology Leaders (VITL) on July 13, 2016 and revised in September 2016.
  - This report provided a comprehensive overview of VITL's progress to data in connecting providers to the VHIE.
- It should be generally acknowledged that these criteria alone should not be the only measurement of success for connectivity of HCOs. Over time, these criteria should likely shift to better reflect their impact on health care delivery.

Statements & Assumptions (Cont'd.)

- Proposed criteria is based on the following premises:
  - Certain provider sites will only require certain types of interfaces
  - For estimating purposes, each provider site requiring a type of interface will have only a maximum of one interface per type calculated.
  - The report provided by VITL provided a denominator for most Health Care Organization (HCO) types. Once a target reaches the denominator, the criteria goal will be assumed to have been met.
- All estimates are contingent on willing HCO participation, resource, vendor capability, and funding.
- Replacement interfaces for HCOs that either change or upgrade their EHR system account for a significant amount of effort and are difficult to estimate. To account for this, the estimates for *new interfaces* are deliberately set at a lower rate to allow for the fluctuation of replacement interface rates. Replacement interfaces are not included as part of this proposal.

Methodology

- Analysis begins by understanding what has been accomplished to date through the VITL Connectivity Report:



Date	Count	Completed
2008	22	
2009	32	10
2010	57	25
2011	85	28
2012	209	124
2013	357	148
2014	513	156
2015	721	208
2016*	902	181

- Based on this progress, it is reasonable to assume that progress will continue at approximately the same rate until a saturation point is reached.
- The “Count” value above is the cumulative number of connections. This number frequently includes more than one connection per HCO.
- * The 2016 count is not complete as this data was provided halfway through 2016 and the previous years are based on calendar year.

Methodology (Cont'd)

- The Connectivity Report provides in-depth information on the number and types of connections per provider types as well as a helpful estimate of the total number of interfaces for a given Health Care Organization (HCO) type. This proposal will forecast potential connectivity target criteria by Health Care Organization type. Below is the current state (as of June 2016) of connections per Health Care Organization type:

Live Interfaces per Health Care Organization

(Source: VITL 2016 Provider Connectivity Report)

HCO Type	BP-ADT	BP-Clin	CCD	ADT	IMMUN	MDM	ORD-LAB	RES-LAB	RES-RAD	RES-TRANS	TOTAL
Commercial Lab								3			3
Designated Agency								40	37	37	114
FQHC			18	45	42	1		57	32	27	222
Home Health Agency			1	5							6
Hospital			3	15	15	0	2	34	15	15	99
Long Term Care Services								3	2	2	7
Primary Care	9	9	35	66	64	2	10	55	21	18	289
Specialty Care	1	1	10	21	38	2	8	45	18	18	162
Grand Total	**10**	**10**	**67**	**152**	**159**	**5**	**20**	**237**	**125**	**117**	**902**

Methodology (Cont'd)

- As the criteria are developed, certain considerations must be made:
  - Type of Health Care Organization
  - Technical and financial resource
  - Need
  - Some types of providers may never have a need to connect (For instance, a retiring practice)
  - Vendor capability
  - Privacy & Security Regulations (42 CFR Part 2, FERPA)

- Basic methodology for a given HCO type:
  1. Average the progress with that Health Care Organization type for a given interface type over the past five years
  2. Using those averages, project the connectivity targets for the next ten years.
  3. In many cases, new interfaces will not be possible or needed for a Health Care Organization type. In these cases, focus increased effort on other Health Care Organization types.

- Very Basic Example:
  - Health Care Organization Type X has had 40 ADT interfaces established over the past five years. In five years, an expected additional 40 would be established. However, there are only 60 HCO Type X sites, so within 3 years, resource for this HCO type would be re-allocated to other HCO types.

Feedback on Methodology

- This proposal is intended to be flexible and provide expectations for the next ten years.
- Work group requested an emphasis on:
  - CCD interfaces in general
  - ADT interfaces for LTSS providers
  - CCD interfaces for Specialty Care and Nursing Homes
- While developing the methodology proposal and noting saturation points for different types of HCOs, reallocation of interface work from one HCO type to another was tracked in the "Change" column to note increased emphasis on that type of HCO.

Proposed Targets – Designated Agencies

Designated Agencies - Current Estimates							
Maximum Sites:					61		
Date	CCD	ADT	IZ	ORD-LAB	RES-LAB	RES-RAD	RES-TRANS
2012-2016	0	0	0	0	40	37	37
5 Year Avg.	0	0	0	0	8	7	7
2017	0	0	0	0	48	44	44
2018	0	0	0	0	56	51	51
2019	0	0	0	0	61	58	58
2020	0	0	0	0	61	61	61
2021	0	0	0	0	61	61	61
2022	0	0	0	0	61	61	61
2023	0	0	0	0	61	61	61
2024	0	0	0	0	61	61	61
2025	0	0	0	0	61	61	61
2026	0	0	0	0	61	61	61

No Change – goals to be met by 2020

Designated Agencies - Revised Estimates								
Maximum Sites:					61			
Date	CCD	ADT	IZ	ORD-LAB	RES-LAB	RES-RAD	RES-TRANS	Change
2012-2016	0	0	0	0	40	37	37	
5 Year Avg.	0	0	0	0	8	7	7	
2017	0	0	0	0	48	44	44	
2018	0	0	0	0	56	51	51	
2019	0	0	0	0	61	58	58	
2020	0	0	0	0	61	61	61	
2021	0	0	0	0	61	61	61	
2022	0	0	0	0	61	61	61	
2023	0	0	0	0	61	61	61	
2024	0	0	0	0	61	61	61	
2025	0	0	0	0	61	61	61	
2026	0	0	0	0	61	61	61	

Designated Agencies Interface Notes:

- Progress with ADT & CCD interfaces will be on hold until a solution for 42 CFR Part 2 data sharing is available.
- Results – Lab Interfaces will likely reach their maximum implementation within the 10 year time-frame.
- Results – Radiology and Results – Transcriptions will likely reach maximum implementation as well.

KEY
Additional Interfaces
Met Goal

Proposed Targets – Home Health

Home Health - Current Estimates							
Maximum Sites:				19			
Date	CCD	ADT	IZ	ORD-LAB	RES-LAB	RES-RAD	RES-TRANS
2012-2016	1	5	0	0	0	0	0
5 Year Avg.	0	1	0	0	0	0	0
2017	10	13	0	0	0	0	0
2018	10	14	0	0	0	0	0
2019	10	15	0	0	0	0	0
2020	10	16	0	0	0	0	0
2021	10	17	0	0	0	0	0
2022	10	18	0	0	0	0	0
2023	10	19	0	0	0	0	0
2024	10	19	0	0	0	0	0
2025	10	19	0	0	0	0	0
2026	10	19	0	0	0	0	0

Home Health - Revised Estimates								
Maximum Sites:				19				
Date	CCD	ADT	IZ	ORD-LAB	RES-LAB	RES-RAD	RES-TRANS	Change
2012-2016	1	5	0	0	0	0	0	
5 Year Avg.	0	1	0	0	0	0	0	
2017	10	13	0	0	0	0	0	
2018	12	14	0	0	0	0	0	+2
2019	14	15	0	0	0	0	0	+2
2020	16	16	0	0	0	0	0	+2
2021	19	19	0	0	0	0	0	+5
2022	19	19	0	0	0	0	0	
2023	19	19	0	0	0	0	0	
2024	19	19	0	0	0	0	0	
2025	19	19	0	0	0	0	0	
2026	19	19	0	0	0	0	0	

Home Health Interface Notes:

- Shown in 2017 (but not highlighted) is the accelerated ADT and CCD efforts under the Home Health Connectivity Project
- Emphasis on CCD interfaces
- All interface goals met within a 5 year horizon

KEY
Additional Interfaces
Met Goal

Proposed Targets – Hospitals

Hospitals - Current Estimates							
Maximum Sites:				19			
Date	CCD	ADT	IZ	ORD-LAB	RES-LAB	RES-RAD	RES-TRANS
2012-2016	3	15	15	2	34	15	15
5 Year Avg.	1	3	3	0	7	3	3
2017	4	18	18	2	41	18	18
2018	5	19	19	2	48	19	19
2019	6	19	19	2	55	19	19
2020	7	19	19	2	62	19	19
2021	8	19	19	2	69	19	19
2022	9	19	19	2	76	19	19
2023	10	19	19	2	83	19	19
2024	11	19	19	2	90	19	19
2025	12	19	19	2	97	19	19
2026	13	19	19	2	104	19	19

Hospitals - Revised Estimates								
Maximum Sites:				19				
Date	CCD	ADT	IZ	ORD-LAB	RES-LAB	RES-RAD	RES-TRANS	Change
2012-2016	3	15	15	2	34	15	15	
5 Year Avg.	1	3	3	0	1	3	3	
2017	4	18	18	2	35	18	18	
2018	7	19	19	2	36	19	19	+2
2019	10	19	19	2	37	19	19	+2
2020	13	19	19	2	38	19	19	+2
2021	16	19	19	2	39	19	19	+2
2022	19	19	19	2	40	19	19	+2
2023	19	19	19	2	41	19	19	
2024	19	19	19	2	42	19	19	
2025	19	19	19	2	43	19	19	
2026	19	19	19	2	44	19	19	

Hospital Interface Notes:

- Emphasis on CCD interfaces
- Not enough information to provide Lab Result estimates – estimates accommodate for minimal growth
- All interface goals met within a 6 year horizon

KEY
Additional Interfaces
Met Goal

Proposed Targets – Long Term Care

Long Term Care - Current Estimates							
Maximum Sites:				83			
Date	CCD	ADT	IZ	ORD-LAB	RES-LAB	RES-RAD	RES-TRANS
2012-2016	0	0	0	0	3	2	2
5 Year Avg.	0	0	0	0	1	0	0
2017	0	0	0	0	4	2	2
2018	0	0	0	0	5	2	2
2019	0	0	0	0	6	2	2
2020	0	0	0	0	7	2	2
2021	0	0	0	0	8	2	2
2022	0	0	0	0	9	2	2
2023	0	0	0	0	10	2	2
2024	0	0	0	0	11	2	2
2025	0	0	0	0	12	2	2
2026	0	0	0	0	13	2	2

Long Term Care - Revised Estimates								
Maximum Sites:				83				
Date	CCD	ADT	IZ	ORD-LAB	RES-LAB	RES-RAD	RES-TRANS	Change
2012-2016	0	0	0	0	3	2	2	
5 Year Avg.	0	0	0	0	1	0	0	
2017	2	2	0	0	4	2	2	+4
2018	4	4	0	0	5	2	2	+4
2019	7	8	0	0	6	2	2	+7
2020	14	16	0	0	7	2	2	+15
2021	21	24	0	0	8	2	2	+15
2022	29	36	0	0	9	2	2	+20
2023	36	49	0	0	10	2	2	+20
2024	43	62	0	0	11	2	2	+20
2025	57	83	0	0	12	2	2	+35
2026	77	83	0	0	13	2	2	+20

Long Term Care Interface Notes:

- Per feedback from the HDI Work Group, emphasis on CCD and ADT interfaces
- Perhaps put more emphasis on Lab Result interfaces.

KEY
Additional Interfaces
Met Goal

Proposed Targets – Specialty Care

Specialty Care - Current Estimates							
Maximum Sites:				**897**			
Date	**CCD**	**ADT**	**IZ**	**ORD-LAB**	**RES-LAB**	**RES-RAD**	**RES-TRANS**
2012-2016	10	21	38	8	45	18	18
5 Year Avg.	2	4	8	2	9	4	4
2017	12	25	46	10	54	22	22
2018	14	29	54	12	63	26	26
2019	16	33	62	14	72	30	30
2020	18	37	70	16	81	34	34
2021	20	41	78	18	90	38	38
2022	22	45	86	20	99	42	42
2023	24	49	94	22	108	46	46
2024	26	53	102	24	117	50	50
2025	28	57	110	26	126	54	54
2026	30	61	118	28	135	58	58

Specialty Care - Revised Estimates								
Maximum Sites:				**897**				
Date	**CCD**	**ADT**	**IZ**	**ORD-LAB**	**RES-LAB**	**RES-RAD**	**RES-TRANS**	**Change**
2012-2016	10	21	38	8	45	18	18	
5 Year Avg.	2	4	8	2	9	4	4	
2017	12	27	46	10	54	22	22	+2
2018	14	33	54	12	63	26	26	+2
2019	18	42	62	14	72	30	30	+7
2020	24	54	70	16	81	34	34	+12
2021	32	69	78	18	90	38	38	+17
2022	40	91	86	20	99	42	42	+24
2023	50	113	94	22	108	46	46	+26
2024	62	143	102	24	117	50	50	+36
2025	74	174	110	26	126	54	54	+37
2026	86	200	118	43	143	73	73	+85

Specialty Care Interface Notes:

- Per feedback from the HDI Work Group, emphasis on CCD and ADT interfaces
- Provider Types:

Anesthesiology	Neurology
Private Beh. Health/Psych.	Orthopedics/Sports Med.
Cardiology	Osteopath
Chiropractor	Pain Mgmt/Physiatry
Dentist/Oral Surgery	Podiatry
Dermatology	PT/OT
Endocrinology/Diabetes	Pulmonology
ENT/Allergy	Radiology
Eye Care	Specialty
Gastro/Digestive Services	Specialty - Other
Hem/Oncology	Surgery - general, plastic, etc
Homeopathy	Urgent Care
Internal Medicine	Urology

KEY
Additional Interfaces
Met Goal

Proposed Targets – Primary Care

Primary Care - Current Estimates							
Maximum Sites:				159			
Date	CCD	ADT	IZ	ORD-LAB	RES-LAB	RES-RAD	RES-TRANS
2012-2016	35	66	64	10	55	21	18
5 Year Avg.	7	13	13	2	11	4	4
2017	42	79	77	12	66	25	22
2018	49	92	90	14	77	29	26
2019	56	105	103	16	88	33	30
2020	63	118	116	18	99	37	34
2021	70	131	129	20	110	41	38
2022	77	144	142	22	121	45	42
2023	84	157	155	24	132	49	46
2024	91	159	159	26	143	53	50
2025	98	159	159	28	154	57	54
2026	105	159	159	30	159	61	58

Primary Care - Revised Estimates								
Maximum Sites:				159				
Date	CCD	ADT	IZ	ORD-LAB	RES-LAB	RES-RAD	RES-TRANS	Change
2012-2016	35	66	64	10	55	21	18	
5 Year Avg.	7	13	13	2	11	4	4	
2017	46	79	77	12	66	25	22	+4
2018	57	92	90	14	77	29	26	+4
2019	69	105	103	16	88	33	30	+5
2020	81	123	116	18	99	37	34	+10
2021	94	142	129	20	110	41	38	+12
2022	112	159	142	22	121	45	42	+15
2023	129	159	155	24	140	55	51	+30
2024	143	159	159	26	159	69	65	+35
2025	159	159	159	28	159	88	85	+40
2026	159	159	159	30	159	102	99	+20

Primary Care Interface Notes:

- Emphasis on CCD and ADT interfaces

KEY
Additional Interfaces
Met Goal

Proposed Targets – FQHCs

FQHCs - Current Estimates							
Maximum Sites:					**82**		
Date	**CCD**	**ADT**	**IZ**	**ORD-LAB**	**RES-LAB**	**RES-RAD**	**RES-TRANS**
2012-2016	18	45	42	0	57	32	27
5 Year Avg.	4	9	8	0	11	6	5
2017	22	54	50	0	68	38	32
2018	26	63	58	0	79	44	37
2019	30	72	66	0	82	50	42
2020	34	81	74	0	82	56	47
2021	38	82	82	0	82	62	52
2022	42	82	82	0	82	68	57
2023	46	82	82	0	82	74	62
2024	50	82	82	0	82	80	67
2025	54	82	82	0	82	82	72
2026	58	82	82	0	82	82	77

FQHCs - Revised Estimates								
Maximum Sites:					**82**			
Date	**CCD**	**ADT**	**IZ**	**ORD-LAB**	**RES-LAB**	**RES-RAD**	**RES-TRANS**	**Change**
2012-2016	18	45	42	0	57	32	27	
5 Year Avg.	4	9	8	0	11	6	5	
2017	22	54	50	0	68	38	32	
2018	26	63	58	0	79	44	37	
2019	33	72	66	0	82	50	45	+6
2020	39	81	74	0	82	56	52	+4
2021	47	82	82	0	82	62	61	+8
2022	55	82	82	0	82	68	70	+8
2023	63	82	82	0	82	74	79	+8
2024	70	82	82	0	82	80	82	+6
2025	78	82	82	0	82	82	82	+4
2026	82	82	82	0	82	82	82	

FQHC Interface Notes:

- Progress with ADT & CCD interfaces may be impeded in some cases until a solution for 42 CFR Part 2 data sharing is available.
- Emphasis on CCD and Transcription Result interfaces
- All interface goals met within a 10 year horizon

KEY
Additional Interfaces
Met Goal

Results & Next Steps

Results:

- This exercise was to provide projections of the HIE's ability to meet Vermont's connectivity needs given current capacity and accomplishments to date.
- By 2026, over 90% of known or anticipated interface needs will be met.

Next Steps:

- Provide feedback & alternate emphasis on certain HCOs.

Questions?

Attachment 4: HIE Connectivity Criteria Proposal

Attachment 5: HIE Consent Management Solution Scope of Work – Proposed

Consent Management Solution

Statement of Work

For the Vermont Health Information Exchange (VHIE)

October 1, 2016

Overview

The State of Vermont, in collaboration with the Vermont Information Technology Leaders (VITL), wishes to implement a Clinical Consent Management solution for the Vermont Health Information Exchange (VHIE). This solution shall provide services to allow health care providers to obtain, store, and update the status of clinical consent through VITLAccess, the provider portal for the VHIE.

The State of Vermont is an "opt-in" state for consent to access, view, or redisclose. This means that the patient's information is only accessible if the patient grants consent for the provider to access the information. Any patient who has granted consent to access is currently not able to restrict what segments of their health record is accessed. Vermont consent to view is consent for all data in the VHIE to all authorized users.

The VITLAccess patient portal service currently has a consent process workflow with limited technology in place to support the workflow. VITLAccess has the current ability to monitor the time, date, patient, user, and information viewed. However, it currently lacks the ability to query, update, and provide proof (ie. provide a scan of a signed consent form) of a patient's consent status through the provider portal itself. A consent indicator is available to be updated within VITLAccess, but that is not currently being utilized for consent management.

Objectives

1. Provide a simple, easy-to-use solution to support health care providers in establishing and validating their client's health information privacy preferences in compliance with State and Federal privacy regulations.
2. Facilitate the collection and storage of consent and consent documents for clinical health information access.
3. Provide a technical solution to support the gathering, management, and any re-disclosure workflows in compliance with 42 CFR Part 2 (Confidentiality of Drug and Alcohol Abuse treatment) and HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations.
4. Ensure that the consent management structure includes functionality to allow for proper access to the information contained within the VHIE.
5. Provide ability for role-based querying of the consents being managed. Ensure that the system is able to query other consent management systems that are the source of truth for certain data.
6. Provide ability for the Consent Management solution to query more authoritative Consent Management solution or be queried by less authoritative solutions.

Scope Statement

This Statement of Work (SOW) is for VITL to procure technical services to develop and/or provide a Consent Management solution for the VHIE. This procurement shall follow applicable State procurement practices and will be performed in collaboration with the Department of Vermont Health Access (DVHA). The solution shall, if feasible, utilize open source technology.

The solution will allow for the following three categories of Vermont consent:

- Opt in –Authorized user has access to the patient's data
- Default (opt out) – User is not authorized to access patient data. An authorized user who requires access must break glass to access the patient data.
- Patient directed Opt out – User is not authorized to access patient data and is not made aware that patient information is available. An authorized user who requires access must break glass to patient information is available and then use break glass to access the patient data.

Criteria for Success

This procurement for the Vermont HIE is intended to facilitate health care organization consent workflow and further ensure compliance of Federal and State privacy regulations. Upon completion of the implementation of this solution, health care organizations should view management of patient consent as a useful tool to provide assurance of compliance and not as an additional process burden.

Project Management

Project Organization

This procurement shall be consistent with the Project Management Institute Project Management Methodologies stated in the Project Management Body of Knowledge (PMBOK). The Project Management Plan shall address the initiating, planning, controlling, executing, and closing processes. The project will be led by a team consisting of at least two provider-sector representatives, a State of Vermont representative, along with the appropriate members of the VITL team.

Project Duration

Milestone Description	Estimated Duration	Deliverable
Phase I. Discovery	+30 Days	• Requirements gathered • Project plan developed
Phase II. Procurement	+90 Days	• Develop and release RFP • Review & evaluate RFP responses • Identify preferred vendor • Develop and execute contract
Phase III. Development & Implementation of IT Solution	+90 Days	• Provisioning of necessary hardware/software • Configuration of systems per specified requirements for base configuration • Configuration of extensible service availability • Development of required rules
Phase IV. Testing & Validation	+30 Days	• Testing & validation

Milestone Description	Estimated Duration	Deliverable
Phase V. Deployment	+30 Days	• "Go Live" • Applicable initial training/outreach
Phase VI. Conclusion & Closeout	+30 Days	• Review lessons learned
TOTALS	+300 Days	

Attachment 7: HIT and Interoperability Policy Lever Compendium

Policy Lever*	Policy Lever Description	Policy Lever Uses For HIT & Interoperability	Example Activities for Your State	Actual/Proposed/Expired	Source	
Accountable Care Arrangements	Providers operating under accountable care arrangements are responsible, under a contract with a payer entity (Medicare, Medicaid, commercial health plans, employer group health plans, etc.), for providing healthcare for a defined population group and measuring specific health outcomes and other quality metrics, such as patient satisfaction. In general, if spending by the accountable providers exceeds the level set by the contract (e.g. expected spending based on historical trend), or does not achieve the specified health outcomes/quality metrics, the providers are at risk for these costs. On the other hand, if the accountable providers are able to meet the health outcomes/quality metrics at a lower cost than specified in the contract, they may share in those cost savings with the payer. Examples include the Medicare Shared Savings Program, multi-payer ACOs, and Medicaid ACOs. (Source: http://bit.ly/1Lj51sy)	The contracting entity can require of Accountable Care Arrangements any number of interoperability activities. For example, ACOs may be required to use ONC certified health IT. Accountable Care Arrangements can also impose process requirements, such as care coordination through the use of health IT. This payment reform model can also stand alone since the providers covered under ithave a financial incentive to coordinate care through the use of interoperable health IT.	There are three ACO's in Vermont: OneCare Vermont Community Health Accountable Care HealthFirst	Actual	ACO websites in Vermont: http://www.vthealth1st.org/index.php https://www.onecarevt.org/ http://www.communityhealthaccountablecare.com/	
Advanced Directives Registry	Advanced Directives Registries are central repositories for legal documents (e.g., living will, power of attorney for health care, etc.) indicating one's desires for care and nominating a personal representative to make health care decisions in one's behalf in an event of emergency or incapacitation. Many states have established registries for proxy or health care provider access. Other states have contracted with private, national registries.	States can mandate or encourage the creation of Advanced Directives Registries if they do not already exist within their states. For existing registries, states could require that they are interoperable with HIT or HIE in the state or region to ensure that patients advanced directives are easily accessible by health care providers in different care settings and locations.	Vermont Ethics network provides an advanced directive registry that is supported by the State Health Department.	Actual	Vermont ethics network and health department websites: http://www.vtethicsnetwork.org/ http://healthvermont.gov/vadr/index.aspx	
Advanced Primary Care Arrangements	Advanced Primary Care Arrangements can include either or both components of Delivery System Reform: changing the way care is delivered and changing the way care is paid for. The former can be broadly defined as additional responsibilities that are required of providers, generally primary care physicians, while achieving certain quality metrics in exchange for a payment, either an additional fee per encounter or a PMPM amount. Advanced Primary Care can also include changes to the way care is paid for, incorporating such elements as risk-bearing arrangements. Advanced Primary Care has different names and is supported by different programs: Medicaid Health Home, Patient-Centered Medical Home, Comprehensive Primary Care Initiative, Advanced Primary Care Initiative, and others. These forms of Advanced Primary Care can be a part of Medicare, Medicaid, private payer programs, or some form of multi-payer arrangement.	Advanced Primary Care Arrangements can drive interoperability by specifying the Health IT interoperability requirements of providers participating in the related programs. For example, a Medicaid program can require practices achieve NCQA recognition as Level 2 or 3 Patient Centered Medical Homes to receive enhanced reimbursement. Such a program would require that practices support care coordination functions that necessitate interoperable health IT usage.	Under the multi-payer reform initiatives demonstration program, funded by CMS, states are participating in initiative to make advanced primary care practices more broadly available. CMS participated in Vermont's Blueprint for Health program described below.	Actual	CMS Multi-Payer Advanced Primary Care Practice: http://innovation.cms.gov/initiatives/Multi-Payer-Advanced-Primary-Care-Practice/	
Advanced Primary Care Arrangements	Advanced Primary Care Arrangements can include either or both components of Delivery System Reform: changing the way care is delivered and changing the way care is paid for. The former can be broadly defined as additional responsibilities that are required of providers, generally primary care physicians, while achieving certain quality metrics in exchange for a payment, either an additional fee per encounter or a PMPM amount. Advanced Primary Care can also include changes to the way care is paid for, incorporating such elements as risk-bearing arrangements. Advanced Primary Care has different names and is supported by different programs: Medicaid Health Home, Patient-Centered Medical Home, Comprehensive Primary Care Initiative, Advanced Primary Care Initiative, and others. These forms of Advanced Primary Care can be a part of Medicare, Medicaid, private payer programs, or some form of multi-payer arrangement.	Advanced Primary Care Arrangements can drive interoperability by specifying the Health IT interoperability requirements of providers participating in the related programs. For example, a Medicaid program can require practices achieve NCQA recognition as Level 2 or 3 Patient Centered Medical Homes to receive enhanced reimbursement. Such a program would require that practices support care coordination functions that necessitate interoperable health IT usage.	Vermont's Blueprint for Health is an early implementation of a patient centered medical home concept, and is supported by founding legislation and subsequently supported by legislation for expansion. It is the goal of the Blueprint for Health program to have every Vermont person participating in a Blueprint practice. Payment reform has also been implemented as part of the Blueprint for Health program, adding elements of an accountable care organization. The Blueprint is also staffed to provide facilitation and project management assistance to practices as they implement their EHR systems and begin to move data through the exchange and into a clinical data repository. Hundreds of thousands of such transactions occur each month and there is much expansion to go. Essentially the Blueprint represents an early implementation of REC-like services.	Actual	Blueprint for Health Website: http://blueprintforhealth.vermont.gov/Blueprint_101	
Advanced Primary Care Arrangements	Advanced Primary Care Arrangements can include either or both components of Delivery System Reform: changing the way care is delivered and changing the way care is paid for. The former can be broadly defined as additional responsibilities that are required of providers, generally primary care physicians, while achieving certain quality metrics in exchange for a payment, either an additional fee per encounter or a PMPM amount. Advanced Primary Care can also include changes to the way care is paid for, incorporating such elements as risk-bearing arrangements. Advanced Primary Care has different names and is supported by different programs: Medicaid Health Home, Patient-Centered Medical Home, Comprehensive Primary Care Initiative, Advanced Primary Care Initiative, and others. These forms of Advanced Primary Care can be a part of Medicare, Medicaid, private payer programs, or some form of multi-payer arrangement.	Advanced Primary Care Arrangements can drive interoperability by specifying the Health IT interoperability requirements of providers participating in the related programs. For example, a Medicaid program can require practices achieve NCQA recognition as Level 2 or 3 Patient Centered Medical Homes to receive enhanced reimbursement. Such a program would require that practices support care coordination functions that necessitate interoperable health IT usage.	In 2010, in Act 128, the Vermont legislature codified the developmental work conducted through the Blueprint's pilots, defining the components of medical homes, community health teams, and payment reform in statute. Act 128 also sets an ambitious expansion schedule for the Blueprint: by July 1, 2011, there shall be at least two medical homes in each of the state's 13 hospital service areas (HSA) and by October 1, 2013, the Blueprint shall expand statewide to primary care practices – including pediatric practices – to serve every Vermonter.	Actual	Act 128: http://www.google.com/url?sa=t&rct=j&q=&esrc=s&fmn=1&source=web&cd=1&cad=rja&uact=8&ved=0CB8QFjAA&url=http%3A%2F%2Fwww.leg.state.vt.us%2Fdocs%2F2010%2FActs%2FACT128.pdf&ei=9aH0VMPfGti2yATh4GoAQ&usg=AFQjCNGXQYr06Vk1MfShw2_cMmX5e9nP6w&sig2=tbEWC5e Medicaid Approved Health Home State Plan Amendments: http://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-	
Advanced Primary Care Arrangements	Advanced Primary Care Arrangements can include either or both components of Delivery System Reform: changing the way care is delivered and changing the way care is paid for. The former can be broadly defined as additional responsibilities that are required of providers, generally primary care physicians, while achieving certain quality metrics in exchange for a payment, either an additional fee per encounter or a PMPM amount. Advanced Primary Care can also include changes to the way care is paid for, incorporating such elements as risk-bearing arrangements. Advanced Primary Care has different names and is supported by different programs: Medicaid Health Home, Patient-Centered Medical Home, Comprehensive Primary Care Initiative, Advanced Primary Care Initiative, and others. These forms of Advanced Primary Care can be a part of Medicare, Medicaid, private payer programs, or some form of multi-payer arrangement.	Advanced Primary Care Arrangements can drive interoperability by specifying the Health IT interoperability requirements of providers participating in the related programs. For example, a Medicaid program can require practices achieve NCQA recognition as Level 2 or 3 Patient Centered Medical Homes to receive enhanced reimbursement. Such a program would require that practices support care coordination functions that necessitate interoperable health IT usage.	Vermont's Medicaid Health Home SPA targets beneficiaries receiving Medication Assisted Therapy (MAT) for the chronic condition of Opioid Therapy. The Hub & Spoke system will build on the Blueprint's Health Information architecture, which includes a central clinical registry (Covisint DocSite) and use of the Vermont Health Information Exchange providers. This health information architecture supports guideline-based preventive healthcare, coordinated health services, an integrated health record across services and organizations, and flexible reporting. The Hub & Spoke initiative will be the first expansion of this capacity to specialty addictions treatment providers. An opioid treatment measures set is being developed for DocSite for visit planning and documentation. Hub and Spoke Health Home staff will document directly in the practice EMR. The goal is to have information on day-to-day provisions of care documented in practice EMRs, hospital data systems, and practice management systems and then transmitted via interfaces to the Health Information Exchange (VHIE) and then into the Covisint DocSite Clinical Registry. DocSite is web-based and receives data feeds of guideline-based data elements from practices and hospitals. Data sources include EMRs, hospital data systems, practice management systems, and direct data entry. To facilitate concurrent review of hospital stays for better transitional care planning, the State is developing automated procedures with hospital ERs and inpatient discharge planners, as well as CHTs, to receive daily feeds on Medicaid patients. Residential substance abuse service providers also will be included in the procedures developed. Treatment information will be documented in the EMR and communicated through the central clinical registry Covisint DocSite, which contains clinical information as well as documentation and tracking of self management goals and action plans. Information will be shared through the central clinical registry Covisint DocSite as well as through existing information sharing technologies and Electronic Medical Records (EMRs). DocSite is a web-based registry that receives feeds of guideline-based data elements from practices and hospitals. Data sources include EMRs, hospital data systems, practice management systems, and direct data entry. Data from these sources is sent to the registry through Vermont's Health Information Exchange infrastructure run by Vermont Information Technology Leaders (VITL). In addition to patient care and population management, the registry supports flexible performance reporting with measures derived from national guidelines on health care quality and outcomes. Concurrent review of hospital stays requires that Vermont Medicaid be notified when admissions occur. The State is developing automated procedures with hospital emergency departments and inpatient discharge planners, as well as CHTs, to receive daily feeds on Medicaid patients. Residential substance abuse providers also will be included in the procedures developed. Covisint DocSite can make specific information related to a patient's care available for reference in Individual and Family Support Services.	Actual	Medicaid Approved Health Home State Plan Amendments: http://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html (Filter by State; Search term= Health Home) VT 14-007 Approval Date 4/10/14	
All Payer Claims Database (APCD) Policies	APCDs are large-scale databases that systematically collect medical claims, pharmacy claims, dental claims, and/or eligibility and provider files from private and public payers. A multitude of states have passed legislation enabling the collection of health care claims in a centralized APCD. Some states require reporting to an APCD.	How APCDs are created and modified has direct impacts on how they can be used and by whom. APCDs can be used primarily for research studies and outcomes measures to improve quality of care. However, these systems can also be designed to support expanded use cases. For example, such data could potentially be used for decision making by providers in alternative payment models who require enhanced understanding of patients' total cost of care.	Vermont has a Multi-Payer Claims Database which includes data from all payers who cover more than 200 lives in Vermont. In addition to collecting this data from these payers, a fee is collected which is the primary source of funds for the State HIT Fund, also administered by DVHA.	Actual	All-Payer Claims Database Website: http://gmcboard.vermont.gov/hit/vhcures	

Certificate of Need (CON) Regulations	According to NCSL, state certificate of need (CON) programs are aimed at restraining health care facility costs and allowing coordinated planning of new services and construction. Historically, a CON is granted by a state's health planning agency to an applicant organization (corporation, not-for-profit, partnership or public entity) to authorize capital projects such as building expansions or ordering new high-tech devices. CON regulations are just one mechanism states have to regulate cost or duplication of services with their states. According to NCSL research, about 36 states retain some type of CON program, law or agency as of 2014. (Source: http://bit.ly/1Jmpuvw)	State CON regulations can require that newly built, merged, or bought hospitals or other facilities require providers to have access to an HIE, clinical alerts, obtain Direct accounts, or impose other requirements to advance a state's health IT goals.	New health care projects in Vermont must obtain a Certificate of Need (CON) from the Green Mountain Care Board prior to implementation. The CON process is intended to prevent unnecessary duplication of health care facilities and services, guide their establishment in order to best serve public needs, promote cost containment, and ensure the provision and equitable allocation of high quality health care services and resources to all Vermonters.	Actual	Website: http://gmcboard.vermont.gov/con	
Credentialing Policies	Credentialing is a process used to evaluate the qualifications and practice history of a health professional. This process includes a review of certain requirements including completed education, training, residency and licenses. It also includes any certifications issued by a board in an area of specialty.	States can require that all providers submit credentialing information to a centralized source. This would be done to ease the administrative burden of providers having to submit the same information to multiple entities. However, this information can then be made available electronically to support other functions beyond credentialing. For example, this information could be leveraged for provider directories, either to create one or to improve the quality of data within one.	Vermont's payers, including Medicaid, all have credentialing policies. Currently credentialing is not aligned. Act 152 requires Vermont to work across agencies to align accountable care organizations with Medicaid, including the alignment of credentialing. This act requires every managed care organization to be accredited by a national independent accreditation organization approved by the Department of Financial Regulation. This may include private and/or non-profit organizations. By the end of 2017, Vermont must determine ways to better align Medicaid and private health insurance issuers, including the area of accreditation. *Sec. 7 of Act 152 of 2016, 18 V.S.A. 9414(b)(4)—term used is managed care organization. All of the health insurance issuers in the state are considered managed care organizations.	Actual	Payer Websites: http://www.mvphealthcare.com/provider/credentialing.html http://bcbsvt.com/provider/contracting/credentialing.html http://www.vtmedicaid.com/#/	
eCQM Reporting	Clinical quality measures (CQMs) are tools that help measure and track the quality of health care services provided by health professionals or facilities within the health care system. Through various programs, states and/or the federal government can create electronic CQM submission requirements.	The EHR Incentive Program ("Meaningful Use") allows states to require that Medicaid providers report eCQMs to the state. However, states can have their own programs that may have eCQM requirements as well. Furthermore, programs can require or encourage that eCQMs be reported via an HIE or network of HIEs.	The Vermont EHR Incentive program does not require eCQM submission, but there are many programs in Vermont that collect and analyze clinical quality measures. Two value-based programs are: The Medicaid and commercial shared savings program in Vermont and the Vermont Blueprint for Health require CQM sets that are collected and analyzed in separate and unique ways.	Actual	Websites: http://www.vtlawhelp.org/sites/default/files/VT%20ACO%20Shared%20Savings%20Program%20Quality%20Measures_0.pdf	
Episode of Care Risk-Sharing	Episode of care risk-sharing is a payment methodology that reimburses a provider or providers for a bundle of services related to a particular condition, over a certain period of time, under a pre-established rate. It is a payment methodology that incentivizes providers to deliver appropriate care in order to achieve desired outcomes and cost savings. One example is the Medicare Bundled Payments for Care Improvement initiative.	Episode of care risk sharing can include requirements for interoperability, such as HIT/HIE use. However, this payment model can also stand alone since the providers covered under the bundle of care have a financial incentive to coordinate care through the use of interoperable health IT.	From 2014 through early 2016, Vermont worked to develop an episode-based payment model for the Medicaid population which would be implemented to best complement other payment models that are presently in operation in the state. In April 2016, following internal discussion and discussion with CMMI, Vermont's SIM leadership team elected to discontinue this activity.	Actual	Website: http://legislature.vermont.gov/assets/Legislative-Reports/VHCIP-Report-to-Legislature-Q2-2016.pdf	
E-Prescribing (eRx) Mandate or Encouragement	E-prescribing entails a prescriber's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point-of-care. States have passed legislation or regulations supporting or encouraging the use of e-prescribing.	E-prescribing mandates or encouragement are direct levers encouraging the use of health IT and the interoperable exchange of data to improve outcomes for patients.	Vermont does not a specific legislative mandate requiring e-prescribing, but as of April, 2014, the ONC reports that 81 - 100 % of physicians in Vermont use e-prescribing.	Actual	Website: http://www.beckershospitalreview.com/healthcare-information-technology/25-things-to-know-about-e-prescribing.html	
Federal or State Grants	State governments receive and award numerous grants to support a broad range of health care activities. State governments also receive federal grants and either implement them or regrant the funds to sub-state entities. [Note: As federal-level policies are out of scope for the Compendium, this policy lever is limited to considering state actions in connection to federal grants.]	State governments can tie specific health IT or interoperability requirements to sub-state grants. For example, grants that are being used to purchase health IT should require technology that is certified or standards compliant.	The Health Data program in Vermont awards a grant to Bi-State Primary Care to support clinical data quality and analytics for the FQHC's in the state. The money for this grant comes from the state HIT fund which is generated from a fee of (2ths of 1%) paid on all health insurance claims which generates annual revenues for the state to then provide grants in support of HIT and HIE. The Vermont Health Care Innovation Project coordinates policy and resources for health care reform statewide. With a $45 million dollar federal State Innovation Model (SIM) grant VHCIP funds proposals to improve health care delivery, to build health information technology and databases, and to test new models for paying providers.	Actual	Website: http://dvha.vermont.gov/administration/contracts http://healthcareinnovation.vermont.gov/	
HHS Dual Eligibles Policy	The Affordable Care Act established the Medicare-Medicaid Coordination Office. The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) serves people who are enrolled in both Medicare and Medicaid, Medicare-Medicaid enrollees, also known as dual eligibles. The Medicare-Medicaid Coordination Office works with the Medicaid and Medicare programs, across Federal agencies, States and stakeholders to align and coordinate benefits between the two programs effectively and efficiently.	The Duals demonstrations projects can include the spectrum of health IT interoperability requirements such as care coordination.	Vermont proposed a demonstration project back in 2012, but it was never implemented.	Actual	http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/November%202014%20-%20VHCIP%20Year%202%20Operational%20Plan%20.pdf	
HIE Advisory Council / Oversight Board	States can create some form of oversight entity to either govern or encourage HIE at the state-level. Typically, these states have enabling legislation or policy pointing to the mix of stakeholder representation to the council or board, and often specifying appointments by the governor and legislature or other state authority. Advisory councils or oversight boards provide formal, structured, stakeholder feedback and a process for engagement with representatives of those who contribute to and utilize healthcare data and have a critical interest in its exchange.	These entities can further interoperability via their consideration of policy, governance, and technical alignment among stakeholders within their jurisdiction and beyond. These bodies can oversee the operations of an HIE in the state, and thus can have a direct role in furthering interoperability and exchange. If not overseeing exchange operations, the councils and boards play an important function ensuring that broad perspectives are kept informed about and help to advise the formation of state policy on interoperability and exchange.	The Vermont HIE is operated Vermont Information Technology Leaders (VITL) and is governed by a board of directors which is composed of representatives from a broad group of stakeholders including: Health plans, Hospitals, Physicians, Other health care providers, State government, Employers and consumers	Actual	Website: https://www.vitl.net/about/corporate-structure/board-directors http://legislature.vermont.gov/statutes/section/18/219/09352	
HIE Connection or Interoperability Mandate	States can pass laws or create policies that mandate interoperability, require the use of health IT standards, or require connection to an HIE.	Minnesota has a law mandating that all providers in the state adopt "interoperable" HIT by 2015 and that they all connect to a state certified HIE. Texas has a law calling on its Health and Human Services Commission to ensure that appropriate information technology systems used by its HHS agencies are interoperable with each other and with outside systems.	Act 48, Sec. 10 requires a review of the scope of HIT to ensure that the full range of information technology related to health care reform is included. The Green Mountain Care Board (GMCB) publishes mandatory connection criteria for creating or maintaining connectivity to the Vermont Health Infomaion Exchange.	Actual	Act 48: http://www.google.com/url?sa=t&rct=j&q=&esrc=s&fmn=1&source=web&cd=1&ved=0CB0QFjAA&url=http%3A%2F%2Fwww.leg.state.vt.us%2Fdocs%2F2012%2FActs%2FACT048.pdf&ei=5qD0VOC5NIr6yASH6YLwCA&usg=AFQjCNFqznnm_JJ1-4CdHhdqYAiC17DMIA&sig2=JGr7mOMNupnBVz_2ZHkZXw http://gmcboard.vermont.gov/documents/publications/decisions/connectivity	
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Medicare and Medicaid EHR Incentive Program ("Meaningful Use")	The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs), and Medicare Advantage Organizations to promote the adoption and meaningful use of interoperable health information technology (HIT) and qualified electronic health records (EHRs).	The requirements of the program seek to support near-term goals for delivery system reform and lay a foundation for broader efforts to pursue interoperability and quality initiatives focused on improving patient outcomes. Each state or territory offers the Medicaid EHR Incentive Program voluntarily, with all states having launched programs to date (http://go.cms.gov/1mFwAE7). The purpose of the program is to improve outcomes, facilitate access, simplify care and reduce costs by providing major financial support to providers and states, learning opportunities created and leveraged through technical assistance from CMS and others, and to establish sustainable data-driven infrastructure that will create a framework for improving healthcare quality and outcomes.**	The Vermont EHR Incentive program has awarded over $45 million dollars in incentive payments since the program started in 2011.	Actual	Website: http://healthdata.vermont.gov/ehrip	
Medicaid State Plan Amendments (SPA)	A Medicaid and CHIP state plan is an agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state. (http://bit.ly/1k21ZSS)	The Affordable Care Act (Sec. 2703) gives states an opportunity to submit a Medicaid state plan amendement to CMS to create a health home program. The goal of the Medicaid health home state plan option is to promote access to and coordination of care. States have flexibility to define the core health home services, but they must provide all six core services, linked as appropriate and feasible by health information technology: • Comprehensive care management; • Care coordination; • Health promotion; • Comprehensive transitional care and follow-up; • Individual and family support; and • Referral to community and social support services. [Note: To search examples of Medicaid Health Home SPAs in the "Example Activities Catalogue" tab, filter the "Policy Lever" column by "Medicaid State Plan Amendments (SPA); Advanced Primary Care Arrangements".]	Vermont has 114 SPA's going back to 2009. They can be found at the website listed under the source column	Actual	https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html	
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Medicaid Waivers	The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. Each authority has a distinct purpose, and distinct requirements. There are four primary types of waivers and demonstration projects: Section 1115 Research and Demonstration; Section 1915(b) Managed Care; Section 1915(c) Home and Community-based Services; and Concurrent Section 1915(b) and (c). (Source: http://bit.ly/1PdfI2R)	Medicaid waivers can have direct and indirect implications. Direct implications include standard terms and conditions as part of the wavier that require health IT infrastructure development. Indirect interoperability implications can be through programs or requirements that rely on or are facilitated by health IT. Special terms and conditions (STCs) can hold a state and its managed care entities accountable for HIT adoption or interoperability (e.g., connection to an exchange entity).	Vermont had two Medicaid waivers that were consolidated under the Global Committment waiver on 30 January 2015: Global Commitment to Health (1115a) includes all state plan Medicaid services, developmental Disabilities services, etc. Choices for Care (1115a) Long term care Medicaid for physical disabilities and older Vermonters. Vermont is also pursuing an All Payer Model that can be found here: http://gmcboard.vermont.gov/sites/gmcb/files/documents/APM-Companion-Paper-Formatted%20FINAL2.pdf	Actual	Website: http://medicaidwaiver.org/state/vermont.html https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf http://gmcboard.vermont.gov/sites/gmcb/files/documents/APM-Companion-Paper-	
Prescription Drug Monitoring Programs (PDMP)	According to the National Alliance for Model State Drug Laws (NAMSDL), a PDMP is a statewide electronic database which collects designated data on substances dispensed in the state. The PDMP is housed by a specified statewide regulatory, administrative or law enforcement agency. The housing agency distributes data from the database to individuals who are authorized under state law to receive the information for purposes of their profession. (Source: http://1.usa.gov/1MwEVXu)	States can take steps to ensure that PDMP data is accessible by providers across the care continuum.	Vermont has a Prescription Monitoring System codified by statute (18 VSA sec. 4281 et seq)	Actual	Websites: http://legislature.vermont.gov/statutes/fullchapter/18/084A http://healthvermont.gov/adap/VPMS.aspx	
State Privacy and Security Policies	States can enact privacy, security, and confidentiality policies concerning health records. This can include additional protections/restrictions on use/exchange of certain information (e.g., minors, HIV/AIDS, mental health). Some of these policies are notable because they are above the HIPAA floor.	States can work to clarify or align state laws to allow for more computable privacy while ensuring appropriate data is protected and shared.	Vermont law protects an individual's right to privacy and confidentiality of medical information.1 Medical information obtained by state agencies for health-related research is confidential.2 Health care providers must obtain written authorization from patients prior to disclosing medical information to third parties Vermont law permits the disclosure of medical information for specific reasons. For example, health care providers are required to report medical information to the Department of Health or to other state authorities to protect public health and enable medical research.	Actual	Website: http://www.healthinfolaw.org/state-topics/46,63/f_topics	
Private Grants/Contracts	Private grants can include monetary awards to support health IT adoption or interoperability activities.	Although not a federal or state lever, there are private sector entities that are willing to provide grants to support HIE and interoperability.	Vermont Care Partners has a HRSA grant that is funding about 20% of a data repository that will enable Network-wide analytics, process improvement, and efficiencies. The balance of funds come from the Vermont Healthcare Innovation Project that manages our SIM grant.	Actual		
Private Sector Accreditation Programs	Accreditation programs can be run by private and/or non-profit entities as a means of assuring certain standards for specific health services or programs are adhered to.	These accrediting bodies could augment their existing accreditation programs by adding requirements related to the use health IT or interoperability.	Currently credentialing is not aligned. Act 152 requires Vermont to work across agencies to align accountable care organizations with Medicaid, including the alignment of credentialing. Vermont law requires every managed care organization to be accredited by a national independent accreditation organization approved by the Department of Financial Regulation. This may include private and/or non-profit organizations. By the end of 2017, Vermont must determine ways to better align Medicaid and private health insurance issuers, including the area of accreditation.		Vermont Law Sec. 7 of Act 152 of 2016	
Provider Licensure	To practice medicine, physicians and other providers need to be licensed in the respective state(s) in which they practice medicine. States have their own licensure boards which establishe the rules and regulations for granting health care provider licenses.	States can require certain providers are using an exchange entity (such as an HIE) as a condition of licensure.	The Vermont Board of Medical Practice licenses allopathic physicians, physician assistants and podiatrists, and certifies anesthesiologist assistants and radiologist assistants. Nurses, osteopaths and other health professionals are regulated by the Vermont Secretary of State's Office of Professional Regulation.	Actual	Website: http://healthvermont.gov/hc/med_board/bmp.aspx https://secure.vtprofessionals.org/Default.aspx	
Public Health Surveillance	Local, state, and federal public health agencies rely on immunization, syndromic surveillance, and reportable lab results data to carry out their surveillance activities under state and federal laws.	States can require that public health surveillance data submissions be sent via a designated HIE, or a certified/registered/deemed HIE. States or public health entities can require that public health surveillance data submissions be sent electronically to improve interoperability. This includes the use of standard submission formats, transport mechanism, or common information. Medicaid HITECH funding is available for public health IT infrastructure.**	The Vermont Department of Health's Division of Health Surveillance Investigates and monitors reportable diseases, Identifies disease causing agents, and offers counseling, testing, and follow-up services to prevent the spread of disease. An immunization registry is part of this division and supports MU by allowing submissions to the registry via the Vermont HIE. Other proposed activites that are being discussed include: - Leveraging HIE to support laboratory reporting into the National ELectronic Disease Surveillance System - Secure connection of Laboratory Information Management System (STARLIMS) to HIE - Exchange of vital records (birth and death) with other states via HIE	Actual	Website: http://healthvermont.gov/admin/hs.aspx	

Qualified Health Plan Certification Requirements	The Affordable Care Act (ACA) requires insurance companies seeking to sell products on either a federal or state insurance exchange to be certified as a Qualified Health Plan (QHP). QHPs must be licensed (typically by the state department of insurance) in the state in which they operate. The federal QHP certification requirements may be exceeded by state requirements.	States have the ability to influence QHP Health IT policies in two ways: (1) All QHPs whether certified by the FFP or a state-based exchange need to meet a state's licensing requirement and (2) Exchanges operated by states could include Health IT certification requirements that exceed federal certification requirements. Through one or the other avenues, states could potentially require expanded provider directories, submission of encounter data, and inclusion of an HIT measure (such as percent of providers meeting MU) in the quality rating system.	Vermont has certification requirements recently adopted 3/15/2016	Actual	File: http://dvha.vermont.gov/budget-legislative/ahs-bulletin-15-01p-proposed-rule.pdf	
Rate Setting and Rate Review	Rate-setting is the setting of limits on the rates or budgets of the hospitals. States may use a formula-based approach, some review rates or budgets of hospitals individually, and some use a mix of these two approaches.	Maryland has a unique all-payer rate-setting system for hospital services. It is because of this lever that the state is able to require all hospitals connect to a state-wide HIE to provide ADT data. This system is made possible by a 1971 law that established unique statutory exemption for the Health Services Cost Review Commission (HSCRC) with power to oversee the rate setting. The HSCRC believed that hospitals should operate under consistent payment incentives. Thus, in 1977 it negotiated a waiver to require Medicare and Medicaid to pay Maryland hospitals on the basis of rates it approved. The Medicare waiver is important for making the overall rate setting program work in MD.	The State of Vermont regulates health insurance rates to ensure that Vermonters pay a fair price for quality coverage. The process also examines whether insurance companies have sufficient assets to run their business and to pay for the medical claims of their policyholders. In addition to having the primary responsibility for reviewing rate requests for comprehensive major medical health insurance plans, the Green Mountain Care Board (GMCB) regulates hospital budgets and major capital expenditures, taking a broad view of the many factors that influence the affordability, accessibility, and quality of Vermonters' health care. The Vermont Agency of Human Services established a rate setting division in 1978 as an independent division of the Agency of Human Services. The Division provides the Agency and its departments with special financial, accounting, auditing, and related legal expertise, particularly relating to payments to Medicaid providers. The Department of Disabilities, Aging, and Independent Living and the Division of Rate Setting in the Agency of Human Services shall review current reimbursement rates for providers of enhanced residential care, assistive community care, and other long term home and community based care services and shall consider ways to: (1) ensure that rates are reviewed regularly and are sustainable, reasonable, and adequately reflect economic conditions, new home and community based services rules, and health system reforms; (2) encourage providers to accept residents without regard to their source of payment. (b) On or before January 15, 2016, the Department and the Agency shall provide their findings and recommendations to the House Committee on Human Services and the Senate Committees on Health and Welfare and on Finance.	Actual	Website: http://ratereview.vermont.gov/how_reviewed http://humanservices.vermont.gov/departments/office-of-the-secretary/ahs-drs http://dail.vermont.gov/dail-statutes/legislative-testimony-2016/medicaid-rate-setting-report-2016	
State Appropriated Funds	Each state passes an annual budget that appropriates money for all state run and supported activities and needs for the fiscal year.	States can devote annual funds to supporting health IT activities through the appropriations process. The amount committed can be used for direct operations of an HIE or for creating grant programs for sub-state HIEs. States can also provide grants or loans to providers to assist with adopting HIT.	Over the past seven years, Vermont has utilized HIT Fund dollars and matching federal funds to support HIT/HIE infrastructure. In the past two years, the infrastructure has benefited from additional federal funds through the State Innovation Models Testing Grant. This combination of funds has enabled Vermont to make significant headway in building and operating an electronic health information exchange infrastructure. The State of Vermont launched the Health Information Technology (HIT) fund in 2008. This fund is dedicated to supporting programs that provide electronic health information systems and practice management systems for health care and human service practitioners in Vermont. As provided for in 32 V.S.A. Chapter 243, the HIT fund accumulates receipts raised by a 0.199% charge on private health benefit claims.73 The claims tax is administered by the Vermont Department of Taxes. Currently, management of the fund and its expenditures has been delegated by the Agency of Administration (AOA) to the Department of Vermont Health Access (DVHA) under 18 V.S.A. Chapter 219, Subchapter 1. Under current law, the HIT fund will sunset on June 30, 2017.	Actual	Website: http://healthdata.vermont.gov/sites/healthdata/files/VHITP%204.8.16_web.pdf	
State Assessment, Fee, Tax, or "Tax-like" Fund	States have legislative power to employ taxes or assessments that are earmarked for HIE.	New revenue can ensure that state-operated HIE activities have resources to be self sustainable beyond any support it may be receiving from other sources. Vermont is the only state explicitly doing this, with it's 0.02% assessment on insurance claims to fund the HIE.	Realizing the state's ambitious goals could not be achieved without more formal, systemic investment in HIT, Vermont instituted its Health IT Fund in 2008. A fee (2ths of 1%) paid on all health insurance claims generates annual revenues for the state Fund which then provides grants to support HIT and HIE. The Fund is currently scheduled to sunset July 1, 2017, though proposals have been made to the State legislature to extend the Fund further.	Actual	Vermont Statute Chapter 241 - Health IT Fund: http://legislature.vermont.gov/statutes/section/32/241/10301	
State Designation of Exchange Entity	States can confer certain legal status or authorities upon a non-state exchange entity. This can result in the creation of a quasi-governmental entity, public-private partnership, or some other entity. Such designation may be necessary for transfer of funds from the state and/or federal government.	Such entities can be charged with a specific mission that can include fostering HIT adoption/use, advancing exchange of health data via national standards, playing a role in stakeholder convening, etc.	Vermont has a single HIE, established by law, and mandated to provide specific services to the Vermont health care environment. The requirement is on the hospitals to be connected to VITL.	Actual	ONC Health Information Technology: Vermont Health Information Technology Strategic and Operational Plan Profile: http://healthit.gov/sites/default/files/vt-plan-summary_updated-2012-01-04_508.pdf	
State HIE / HISP Accreditation, Certification, Registration, or Qualification	States can deem particular exchange entities as meeting certain exchange or interoperability requirements. This can be called certification, qualification, accreditation, or registration. It can be voluntary or required for some specific role, such as to have the authority to operate within the state or to connect to the state. This can occur through legislative authority or via operational policies (i.e., contractually working with only one HIE or only certain RHIOs).	With appropriate incentives, HIE/HISP Accreditation, Certification, Registration, or Qualification could be used to developed harmonized policies and procedures around health information exchange and interoperability at the state-level.	In a health information exchange, the core infrastructure includes the systems and personnel to operate the components at the center of the network. The core infrastructure shall be certified for compliance by at least one independent certifier of industry standard information security practices, such as the Electronic Healthcare Network Accreditation Commission (EHNAC). EHNAC is an independent, non-profit accrediting agency that evaluates an organization's ability to meet standards and best practices.	Actual	Vermont Health Information Technology Plan October 2009: http://hcr.vermont.gov/sites/hcr/files/IT_Strategic__Implementation_Plan__10-11-09__0.pdf	
State Insurance Commission (Commissioner) Policies	State Insurance Commissioner is an executive office in many states, some in the state cabinet. The office differs state by state. State insurance commissioners can manage provider networks and expectations for quality.	State Insurance Commissions can be used to pursue different policy and regulatory goals targeting health plans. Quality expectations managed by the commission can include health IT and interoperability requirements. Policies can include requirements specific to value-based purchasing models that plans licensed by the state must follow.	The mission of the Insurance Division of the Vermont Department of Financial Regulation is to maintain affordability and availability of insurance for Vermonters, ensure that insurers are able to meet their contractual obligations, to ensure reasonable and orderly competition among insurers, and to protect Vermont consumers against unfair and unlawful business practices. The Green Mountain Care Board also assists by regulating health insurance rates. Toward this goal, the Vermont Department of Financial Regulation is part of the U.S. insurance regulatory framework which is a highly coordinated state-based national system designed to protect policyholders and to serve the greater public interest through the effective regulation of the U.S. insurance marketplace. Through the National Association of Insurance Commissioners (NAIC), insurance regulators establish national standards and best practices, conduct peer reviews and coordinate their regulatory oversight to better protect the interests of consumers while ensuring a strong, viable insurance marketplace. U.S. insurance regulators also participate in the International Association of Insurance Supervisors (IAIS) along with the NAIC by participating in all its major standard-setting initiatives, including working with fellow regulators from around the world to better supervise cross-border insurers, identifying systemic risk in the insurance sector, and creating international best practices. The Insurance Division regulates the insurance industry in Vermont and protects the public in these general areas: • Solvency laws require insurance companies to operate in a fiscally responsible manner so that, after taking their customers' money (premiums), they can be counted on to pay claims down the road. • Consumer protection laws require companies to sell legal insurance products through licensed producers, treat consumers fairly, and pay claims in a timely manner. • Health insurance laws require that consumers are afforded full disclosure of information, a full and fair review of a grievance and that health plans meet quality and access standards for care. • Health insurance plans are audited annually and periodically by the Insurance Division for compliance with Vermont regulations. • All insurance policies sold in Vermont are reviewed and approved by the Insurance Division to ensure that they provide the protections required by Vermont law.	Actual	Website: http://www.dfr.vermont.gov/insurance/insurance-division http://ratereview.vermont.gov/	
State Lab Requirements	Labs are regulated by the Clinical Laboratory Improvement Acts (CLIA) to adhere to certain standards of quality and process, including how they send results to providers. These regulations are enforced by CMS and must be met in order for CMS to pay for services provided by labs. States can impose additional requirements for labs operating within their jurisdiction.	States can impose additional requirements on labs above CLIA related to HIE or interoperability.	The statute (Act 128) also requires hospitals, which operate most of the clinical laboratory services in the state, to maintain interoperable connectivity to the HIE network as a condition in their annual budget approval process.	Actual	Act 128: http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&uact=8&ved=0CB8QFjAA&url=http%3A%2F%2Fwww.leg.state.vt.us%2Fdocs%2F2010%2FActs%2FACT128.pdf&ei=9aH0VMPtGti2yAThv4GoAQ&usg=AFQjCNGXQYrO6Vk1MfS	

State Purchasing/Contracting of Health Care Services	States purchase health care services through competitive grants and contracts. These pucchasing/contracting activities generally fall into the following categories: Medicaid or CHIP Managed Care Contracts: Managed care organizations are systems of care that are contractually paid to be accountable for the care delivered to a specified population for a specified period of time. These entities are almost exclusively paid on a per member per month basis, possibly with additional payments. They are risk-based contracts, meaning that the MCO is at risk for the total cost of care for the services they are responsible for within the population they serve. State Employee Benefits Contracts: All 50 states provide health insurance coverage for eligible state employees. This can be done in two ways. In a self-insured model, the state pays the actual cost of providing health care to its employees. In a non-self-insured model, the state would pay premiums to an HMO or managed care organization which the state hires as an outside administrator to run the program. State Facilities/Agencies Contracts for Health Care Provision: Many states function as health services provider for certain populations (e.g., prisons, mental health clinics). States can contract with health care professionals to provide such medical services. (States can also directly employ such providers and purchase relevant health IT systems, which is covered separately below.) Other Contracts: States engage in many other direct contracting for health related services, such as for the medical component of workmen's compensation.	While negotiating new contracts or renewing existing contracts, states can ensure that certain health IT requirements are embedded within the contract language. For example, states can require that MCOs require their network of providers to connect to a designated HIE, encourage health IT adoption, require use of best available standards, or conduct patient engagement via health IT tools and technologies (e.g., patient portals).	Although Vermont has inserted language encouraging the use of health infromation technology and participation in health infromation exchange in many of it's RFP's or procurement agreements, and has identified them as key components for success in many programs, there are no current mandates requiring those activites.	Actual		
State Purchasing/Contracting of Health IT	States directly purchase inforamtion systems systems as part of their operations outside of Medicaid or their direct provision of care. This can include EHRs for their prisons, public health reporting systems, non-MMIS claims processing systems, etc.	These purchasing activities can advance interoperability by leveraging health IT standards and certification.	Vermont has purchased an electronic health record system for the state psychiatric hospital. In the RFP for the procurement, it was specified that the chosen EHR must include features and functions that help facilitate the attainment of Meaningful Use Attestation stages 1-3 and must interoperate with the Vermont Health Information Exchange.	Actual	Website: http://bgs.vermont.gov/purchasing/bids/InformationTechnologyRFPVtPsychiatricCareHospital	
State-level Legal Protections	States can enact laws that offer legal protections to entities for certain exchange activities.	Providing legal protection or reduced liability for certain activities can encourage HIEs to participate in exchange where the law might be ambiguous. For example, a state may have certain safe harbors that limit liability for those participating in certain exchange activities.	Although perhaps not intended to provide a "safe harbor", Vermont does have a statute expressly exempting our HIE and it's associated staff, directors, and officers from classification as a health care provider. (j) Scope of activities. VITL and any person who serves as a member, director, officer, or employee of VITL with or without compensation shall not be considered a health care provider as defined in subdivision 9432(8) of this title for purposes of any action taken in good faith pursuant to or in reliance upon provisions of this section relating to VITL's: (1) governance; (2) electronic exchange of health information and operation of the statewide Health Information Exchange Network as long as nothing in such exchange or operation constitutes the practice of medicine pursuant to 26 V.S.A. chapter 23 or 33; (3) implementation of privacy provisions; (4) funding authority; (5) application for waivers of federal law; (6) establishment and operation of a financing program providing electronic health records systems to providers; or (7) certification of health care providers' meaningful use of health information technology.	Actual	Vermont statute : 18 V.S.A. § 9352	
Telehealth	TBD	TBD	Vermont contracted with JBS International to develop a Statewide Telehealth Strategy to guide future investments in this area. The Strategy, developed in collaboration with the State of Vermont and private sector stakeholders, includes four core elements: a coordinating body to support telehealth activities; alignment of state policies relevant to telehealth; telehealth technology investments that are secure, accessible, interoperable, cloud-based, and aligned with Vermont's HIT infrastructure; and clinician engagement. The Strategy also includes a Roadmap based on Vermont's transition from volume-based to value-based reimbursement methodologies to guide prioritization of telehealth projects and their alignment with new clinical processes adopted as payment reform evolves. This project is complete. Vermont is funding pilot projects that can address a variety of geographical areas, telehealth approaches and settings, and patient populations over a 12-month time period. The primary purpose is to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout the State of Vermont. Projects were selected in part based on demonstration of alignment with the health reform efforts currently being implemented as part of the SIM Grant process.	Actual	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/HIE/Telehealth_Strategy_Report_Final_9-16-15.pdf	
Behavioral Health Integration	TBD	TBD	Vermont Collaborative Care is a partnership between BCBSVT and Brattleboro retreat. The project began in April 2015. BCBSVT analyses demonstrated that utilization and cost for mental health (MH) and substance abuse (SA) were focused within key population segments and diagnosis categories. BCBSVT identified key barriers to integration and worked proactively to train staff and otherwise address issues. Integrated Clinical Advisory group has resulted in significant engagement; integrated training model includes practicing clinicians from a variety of disciplines.•BCBSVT is seeing significant results following increased integration, reduction of barriers to MH/SA care(including both inpatient days and regular outpatient care), investment in proactive treatment (rather than emergency treatment), increased focus on care transitions and after-care at discharge.•Engaging community providers to pay for clinicians on call to prevent unnecessary hospital admissions whenpatients present in ED. Supporting community consultation groups that give providers CEUs In 2014, Vermont began exploring the possibility of an All Payer Model based on Medicare's Next Generation Accountable Care Organization (ACO) model with federal partners at the Centers for Medicare & Medicaid Innovation. As ACO-focused delivery reforms mature under the All Payer Model they must begin to integrate with providers that support Community-Based Services in Vermont and address thesocial determinants of health in order to realize a fully organized and accountable system of care. Vermont's physical health care, disability and long-term services and supports (DLTSS), mental health, and substance abuse treatment systems cannot work in isolation. Reform objectives must include the development of an organized delivery system for serving individuals and promoting integration across services for: •Mental Health; •Substance Abuse Treatment; •Physical Health; and •Long-Term Services and Supports for, o Individuals with physical disabilities, o Older Vermonters, and o Individuals with developmental disabilities.	Actual	June PMDI workgroup minutes: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/6-20-16%20PMDI%20Meeting%20Minutes.pdf Medicaid Pathways activieis: http://healthcareinnovation.vermont.gov/content/vt-medicaid-pathway-information-gathering-september-2016	
Correctional Health	TBD	TBD				
Tribal Health	TBD	TBD				
Managed Care Organization	TBD	TBD				

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