VT Health Care Innovation Project
Core Team Meeting Agenda

December 9, 2015 1:00 pm - 3:00 pm
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	1:00-1:05	Welcome and Chair's Report: a. Quarterly Report Update b. Operational Plan and No-Cost Extension Update	Lawrence Miller	Attachment 1: Quarterly Report: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Reports/Vermont_Q3_2015_Quarterly_Report_to_CMMI.pdf
Core Team Processes and Procedures				
2	1:05-1:10	Approval of meeting minutes	Lawrence Miller	Attachment 2: October 13, 2015 *Decision needed.*
Spending Recommendations:				
3	1:10-2:00	Funding requests: a. Request for adjustment in budget for VPQHC (Y2 and Y3). Change is current scope for 2016 sub-grant activities. b. Population Health Plan-Writer (Y3): $70,000 c. Onpoint-Evaluation (Y2 and Y3): $50,000	Georgia Maheras	Attachment 3a: Y2 Actuals and Funding request Attachment 3b: VPQHC proposal Attachment 3c: DA Payment Reform Project Plan

		d. DA/Payment Reform Proposal (Y2): $400,000 e. Health*first* Gateway and Informatics (Y2 and Y3): $284,000		Attachment 3d: Health*first* Proposal *Decision needed.*
Policy Recommendations				
4	2:00-2:30	St. Johnsbury Pilot Update	Georgia Maheras/Erin Taylor	Attachment 4: St. J Project Update
5	2:30-2:40	Payment Models Work Group: a. Medicaid SSP – Total Cost of Care for Y3 Update b. Commercial SSP-Downside Risk Update	Alicia Cooper/Cecilia Wu and Richard Slusky	Attachment 5a: Medicaid SSP Attachment 5b: Commercial SSP
6	2:40-2:50	*Public Comment*	Lawrence Miller	
7	2:50-3:00	Executive Session: CMMI Communications	Lawrence Miller	
8	3:00	Next Steps, Wrap-Up and Future Meeting Schedule: January 11th, 1-3pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier	Lawrence Miller	

Attachment 2: October 13, 2015 Minutes

Vermont Health Care Innovation Project
Core Team Meeting Minutes

Pending Core Team Approval

Date of meeting: Monday, October 13, 2015, 3:00-4:00pm, AHS Training Room, 208 Hurricane Lane, Williston.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's Report	Lawrence Miller called the meeting to order at 3:04. A roll-call was taken and a quorum was present. **Chair's Report:** *Update on Contract Approvals and Document Submission to CMMI:* We received final approvals for Year 2 last Friday, including all pending contracts. Those agreements are being executed, and money is flowing. *Sub-Grantee Symposium:* The second sub-grantee symposium was held October 7th in Montpelier; there were 46 attendees for three panels. All materials and notes from the Q&A will be posted to the VHCIP website later this week; we will send the link out to participants and the Core Team. *Reorg Update:* The VHCIP reorganization is going well so far. Comments to workplans and participant lists have been incorporated, and new workplans for the remainder of 2015 are posted to the VHCIP website. *Operational Plan Update:* Our Year 3 Operational Plan is due on November 2 – we will be reviewing proposed Year 3 milestones and budget today that will help us build this plan.	
2. Approval of Meeting Minutes	Monica Hutt asked whether Hal Cohen's letter would be included in the minutes; Georgia Maheras responded that it would be, along with all other comments. Monica also asked about the status of comments related to DLTSS Work Group integration into the new governance structure. Georgia responded that the Secretary's suggestions and other related comments have been integrated into the new structure and workplans, and Lawrence requested the minutes for the August 31 and October 13 meetings reflect this. Paul Bengtson moved to approve the July 2015 meeting minutes (Attachment 2). Hal Cohen seconded. A roll call vote to approve the minutes was taken. The motion passed with one abstention.	

Agenda Item	Discussion	Next Steps
3. Proposed Year 3 Milestones	Georgia Maheras presented on High-Level SIM Goals (Attachment 3a) and Proposed Year 3 Milestones (Attachment 3b). Note that for CMMI's purposes and our budgetary purposes, some Year 2 activities are extending into CY 2016 (Year 2 Carryover activities), and some Year 3 activities will extend into CY 2017 (Year 3 Carryover activities). • A new high-level goal added: 400 providers with at least one interface to the VHIE. o Al Gobeille asked where we are now. Georgia responded that we have over 300 providers (or provider organizations) with at least one interface to the VHIE. Georgia noted that staff are confident we will be able to meet this goal with planned Year 3 activities. o An interface is one connection between a provider organization location and the HIE, with data flowing in at least one direction (HIE to provider or provider to HIE). o Monica Hutt asked whether we expect connections to continue to increase following the project. Georgia responded that we do. Monica asked how this might impact provider types that are not yet connected to the VHIE. o Lawrence Miller noted that the project also has sub-goals related to quantity and quality of data flowing to and from the VHIE. • Draft milestones have been reviewed by CMMI. CMMI has indicated that they are directionally correct. Core Team approval will allow project leadership and staff to continue developing the Operational Plan. These milestones, with one exception, continue work that has been ongoing in Year 2; it also places a more explicit focus on sustainability planning. The new milestone is on Medicaid Value-Based Purchasing – Mental Health and Substance Abuse. This milestone was previously related to a SAMHSA planning grant the state had applied for; this is a less specific goal, and is also responsive to feedback we received from CMMI related to the All-Payer Model. These milestones represent our agreement with CMMI; they are high level, with more granular activities represented in work group workplans and other internal documents. o *Episodes of Care:* Al Gobeille noted that we've struggled with bandwidth related to implementing Episodes of Care. Paul Bengtson asked whether Episodes are synonymous with bundled payments; they are not. Alicia Cooper reported that DVHA has a short list of episodes currently under review by DVHA leadership; this list will likely be proposed to the Payment Models Work Group in November. Paul Bengtson noted that this will further complicate an already complicated relationship between payers and providers. Georgia noted that the bundled payment structure could be beneficial within Medicaid payment, as it could impact patients and services currently not covered by the SSPs. Robin noted that if we do not pursue Episodes, we will need another strategy to reach our goal of 80% of Vermonters in alternative payment methodologies by the end of 2016. o *Prospective Payment Methodology – Home Health:* This is related only to acute care. Georgia noted that this is legislatively mandated. o *State Activities to Support Model Design and Implementation – Medicaid:* It is likely that the state	

Agenda Item	Discussion	Next Steps
	will pursue a State Plan Amendment for Integrated Family Services – this is more secure long-term than using Vermont's Global Commitment Waiver Authority. o *Care Management Tools:* The SCÜP Project includes providers beyond traditional medical providers. o *Medicaid Value-Based Purchasing – Mental Health and Substance Abuse:* This was initially related to the SAMHSA CCBHC planning grant, which we have decided not to pursue. Monica Hutt noted that this grant only ever applied to two-thirds of the DA's services (mental health and substance abuse, but not developmental services) – she suggested we add someone with developmental services expertise to this working group. The group discussed the following: • Paul Bengtson commented that there is a lot of good work ahead of us. Paul Bengtson moved to approve the Year 3 milestones as presented, along with the new high-level SIM goal discussed earlier. Hal Cohen seconded. Public comment: • Susan Aranoff noted that the Year 3 milestone in the Expand HIE Connectivity – Gap Remediation work stream indicates further planning in Year 3 for gaps identified for LTSS providers, rather than actual remediation work. Lawrence noted this isn't precluded as an option, but it does not commit the state to doing this work. Georgia added that there are a number of pending proposals that will come before this group at the November meeting, but that there is not enough money in our budget to fund all of these proposals – however, we are hoping to find additional funds due to underspending in Year 2. This milestone does not preclude expenditures in this area, but it does not obligate expenditures in this area either given funding shortfalls. Georgia noted that there is currently money in an existing contract to perform remediation related to the ACOs for this year. o Monica Hutt commented that DLTSS is a large chunk of the state's Medicaid budget, and it's a disconnect that we wouldn't invest in remediation for these providers. Georgia noted that our initial budget when we applied for the SIM grant included $60 million just for health data investments, and had to undergo significant cuts – also, many DLTSS providers don't have the infrastructure to support $25,000 in EMR maintenance annually, for example. o Susan Aranoff noted that we've always had increased connectivity for non-Meaningful Use providers in our plans. The motion carried unanimously.	
4. Funding Recommendation:	Georgia Maheras presented a high-level proposed Year 3 budget. • Year 2 Actuals and Proposed Year 3 Budget (Attachment 4a)	

Agenda Item	Discussion	Next Steps

Proposed Year 3 Budget	• Some Year 2 activities will continue into Year 3.
	• We expect to be able to present a more accurate picture of Year 3 spending at the November Core Team meeting.
	• For Year 3, less money is TBD than in the past due to ongoing Core Team decisions on Year 3 spending.
	• Total Budget for Year 3 (January 2016-September 2017): $21,223,422.24
	  o Other Category: Higher than in the past (includes Learning Collaborative facilities and faculty)
	  o Contract Category: See detail on Slides 8-13.
	
	The group discussed the following:
	• Paul Bengtson is excited about our Year 3 plans.
	
	Paul Bengtson moved to approve the budget as presented. Hal Cohen seconded. A roll call vote was taken and the motion passed unanimously.	

5. Policy Recommendation: QPM Work Group – Year 3 ACO SSP Proposed Measures	Georgia introduced proposed changes to the Year 3 ACO Shared Savings Program measure set (Attachment 3). Pat Jones noted that proposed changes are summarized on slides 10 and 11.
	• The QPM Work Group has recommended changes to four measures where there have been changes to the evidence base and national measure sets. The Work Group approved these changes unanimously.
	  o SSP Payment Measure Set: LDL Screening (change carried over from Year 2). Recommendation: Replace with Controlling High Blood Pressure.
	  o SSP Reporting Measure Set: Optimal Diabetes Care (change carried over from Year 2). Recommendation: 2-part MSSP Diabetes Composite.
	  o SSP Monitoring and Evaluation Measure Set: Appropriate Medications for People with Asthma. Recommendation: HEDIS Medication Management for People with Asthma.
	  o SSP Monitoring and Evaluation Measure Set: Emergency Department (ED) Utilization for Ambulatory Sensitive Conditions. Recommendation: Onpoint Health Data Potentially Avoidable ED Utilization.
	• These changes were unanimously approved by the Steering Committee on 9/28.
	
	Al Gobeille moved to approve the changes. Hal Cohen seconded. A roll call vote was taken and the motion passed unanimously.	

6. Public Comment	There was no additional public comment.	
7. Next Steps, Wrap Up and Future Meeting Schedule	**Next Meeting:** Monday, November 2, 1:00pm-3:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP Core Team Participant List

Attendance: 10/13/2015

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

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

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

Suzanne	Santarcangelo		PHPG	X
Julia	Shaw		VLA/Health Care Advocate Project	X
Kate	Simmons		Bi-State Primary Care	X
Richard	Slusky		GMCB	S
Carey	Underwood			A
Steve	Voigt ✓		ReThink Health	M
Julie	Wasserman ✓		AHS - Central Office	S
Spenser	Weppler		GMCB	S
Kendall	West		Bi-State Primary Care	X
James	Westrich		AHS - DVHA	S
Katie	Whitney			A
Bradley	Wilhelm		AHS - DVHA	S
Jason	Williams		UVM Medical Center	X
Sharon	Winn		Bi-State Primary Care	X
Cecelia	Wu		AHS - DVHA	S
				62

VHCIP Core Team Member List
Roll Call:

10/13/2015 1° Paul 2° Hal 1° Paul 2° Hal 1° Paul 2° Hal 1° Al 2° Hal

Member		8/31/15 Minutes	Yr 3 Milestones	Yr 3 Budget	ACH Proposal	Yr 3 ACO Measures	
First Name	Last Name						Organization
Paul	Bengston ✓	✓	✓	✓		left	Northeastern Vermont Regional Hospital
Hal	Cohen ✓	✓	✓	✓		✓	AHS -CO
~~Steven~~	~~Costantino~~ X	—	—	—		—	AHS - DVHA not here
Al	Gobeille ✓	✓	✓	✓		✓	GMCB
Monica	Hutt ✓	✓	✓	✓		✓	AHS - DAIL
Robin	Lunge ✓	✓	✓	✓		✓	AOA - Director of Health Care Reform
Lawrence	Miller ✓	✓	✓	✓		✓	AOA - Chief of Health Care Reform
Steve	Voigt ✓	A	✓	✓		✓	ReThink Health

Al

Attachment 3a: Y2 Actuals and Funding request

Financial Proposals

December 9, 2015

Georgia Maheras, JD

Project Director

AGENDA

- Y2 Actuals to Date
- Request for adjustment in budget for Health*first*(chart review)-No-Cost Extension
- Request for adjustment in budget for VPQHC(sub-grant). Change in current scope.
- Population Health Plan-Writer: $100,000
- Onpoint-Evaluation: $50,000
- DA/Payment Reform Proposal: $400,000
- Health*first* Gateway and Informatics: $284,000

Y2 Actuals (NCE)

	Total Budget	Liquidated as of 11/30/2015	Balance	12/02/2015 Realigned Budget
Personnel	$699,111.00	$312,006.51	$387,104.49	$1,424,779.00
Fringe	$324,038.00	$139,783.12	$184,254.88	$660,385.00
Equipment	$18,290.00	$4,324.67	$13,965.33	$36,037.00
Supplies	$9,520.00	$679.03	$8,840.97	$14,300.00
Travel	$41,300.00	$5,281.13	$36,018.87	$81,375.00
Construction	$ -	$ -	$ -	$ -
Other	$267,620.00	$9,375.56	$258,244.44	$436,565.00
Contractual	$15,807,531.91	$1,012,774.82	$14,794,757.09	$14,223,702.91

Health*first*: No-Cost Extension

- Request from Health*first*: use funds appropriated for 2015 chart review for the chart review activities in 2016.
- Rationale: Health*first* overestimated the cost of the chart review for 2015 (identified efficiencies in the process).
- Amount requested: $13,060 for use in 2016.

- Background: The Core Team approved chart review funds for all three ACOs to use in 2015 based on estimates provided by the ACOs.

VPQHC: Budget Reallocation Request

- Background: VPQHC is a sub-grantee implementing the NSQIP – Statewide Surgical Collaborative. The initial proposal targeted all of Vermont's hospitals.
- Request: 5 out of the 12 eligible hospitals have enrolled and an additional hospital has committed to the ACS-NSQIP enrollment process to collect data utilizing the database to identify opportunities for improvement. Ask to repurpose the funds previously identified for those other hospitals.

VPQHC: Budget Reallocation Request

- Initial Approval: $900,000
- Request to reallocate funds that were previously supporting the additional 6-7 hospitals for:
  - Additional Surgical Case Reviewer;
  - ACS-NSQIP Conference Sponsorship;
  - Surgical Home Toolkit;
  - Collaborative Best Practices Learning Session;
  - Hospital Enrollment Costs (Y2).

NEW request: Population Health Plan Writer

- Background: A population health plan is a required deliverable.
- Amount requested: $70,000
- Time period for contract: July 1, 2016-June 30, 2017
- Scope of Work:
  - Research promising community level innovations in payment and service delivery in others parts of the country to coordinate health improvement activities and more directly impact population health;
  - Identify key features to consider in developing recommendations for VT;
  - Determine which features are present in the innovations currently underway through VHCIP and other health system reforms and what expansion in the scope of delivery models would be recommended; and
  - Identify initiatives in Vermont that have some of the features necessary to improve population health by better integration of clinical services, public health programs and community based services at both the practice and the community levels.

NEW request: Onpoint Health Analytics

- Background: We need to submit a new data file to CMMI in Marketscan format.
- Amount requested: $50,000 ($25,000 for two time periods)
- Time period for contract: December 1, 2015-June 30, 2016
- Scope of Work: Develop VHCURES extract for use by Truven for federal evaluation.

NEW request: Provider Support for DAs

- Background: Y2 APM Milestones and Y3: "1. Based on research and feasibility analysis, design an alternative to fee-for-service, for Medicaid mental health and substance use services by 12/31/16; 2. Develop implementation timeline based on payment model design and operational readiness by 12/31/16. "
- Amount requested: $400,000
- Time period for contract: January 1, 2016-June 30, 2016
- Scope of Work:
  - Ensure continued provider readiness for the new payment system.

Provider Support for DAs

- This project falls within Vermont's payment and delivery system reform activities. The State will utilize the resources available within the State Innovation Models Testing Grant and update the VHCIP Core Team on this project's launch and development.
- *Goals:*
  - Design a sub-capitated payment arrangement, or other alternative to fee-for-service, for the mental health and substance use system, especially the Designated Mental Health Agencies, that builds on the IFS work in progress and explicitly considers sustainability and integration over time. Please note that the specific services within the new payment arrangement, as well as the specific payment methodology will be identified as part of the discovery and design process.
  - The new payment arrangement should align with the all-payer model payment arrangement and structure.
  - The new payment arrangement, which will include quality measures and a streamlined designation process in accordance with the all payer model regulatory structure, will be developed collaboratively between providers, including DAs and the State.
  - The project aims to reduce silos, streamline payment and reporting, and improve payment flexibility to achieve the triple aim.
  - The project will produce an implementation plan that incorporates necessary operational changes for the State and a timeline, for presentation to and approval by AHS leadership before 12/31/2016.

NEW request: Health*first* Gateway and Informatics

- Background: Core Team approved 3 ACO gateways in 2014. CHAC and OCV gateways built or under construction. Health*first* gateway not built due to HF choice to delay and pursue other alternatives. Gateways provide ACO-specific attributed life clinical data from the VHIE to the ACOs for population health analytics. A data feed like this is necessary for successful use of HIE clinical data.
  - $284,000 approved. Federal funds for this purpose expire om 12/31/15 due to Y1 Carryover restrictions.

NEW request: Health*first* Gateway and Informatics

- Rationale: HF has determined that the alternate solution they were seeking was not viable. Requesting to use Y2 and Y3 funds for this activity.
- Budget: $284,000 for initial gateway design and implementation.
- Timeline: January 1, 2016-June 30, 2017.
- *Note: Contract is with VITL, not HF.*

Attachment 3b: VPQHC proposal

Vermont Program for Quality in Health Care, Inc.

Vermont Health Care Innovation Project
Grant # 03410-1461-15
Proposal to VHCIP

Statewide Surgical Services Collaborative
Alternative Funding Proposal

Since the VHCIP Provider Grant Program funding to support the Statewide Surgical Services Collaborative was announced, VPQHC has worked diligently to engage and enroll hospital Surgical Champions. The target enrollment for this project was 100% of Vermont's eligible hospitals. At this point, five out of the twelve eligible hospitals have enrolled or committed to the ACS-NSQIP enrollment process to collect data utilizing the database to identify opportunities for improvement. As a result of limited enrollment and increased knowledge of the requirements of ACS NSQIP, the Statewide Surgical Services Collaborative seeks to re-purpose these funds to alternative activities to support the improvement efforts intended through this project.

Background

Five out of twelve hospitals (2 CAH and 3 PPS) have enrolled in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). These hospitals are:

- Mt. Ascutney Hospital
- Brattleboro Memorial Hospital
- Southwestern Vermont Medical Center
- Porter Hospital
- Rutland Regional Medical Center

North Country Hospital indicated their intention to participate in the Statewide Surgical Services Collaborative but due to exceedingly small eligible case volumes have decided against participation in the Collaborative at this time. This revised budget reserves funding for North Country to join should the organization prioritize this work in the near future.

Per guidance provided by the VHCIP Project Director, VPQHC recognizes the need to continue hospital cost-sharing related to the activities of the Statewide Surgical Service Collaborative. Hospital participation costs include activities to support the Surgical Champion, SCR, Quality Director, Information Technology, and Infection control staff in establishing and maintaining the ACS-NSQIP program. This cost-sharing responsibility is intended to reinforce sustainable commitment for the hospital participants in these activities going forward.

We have included the hospital costs of participation as listed below, followed by a revised budget and budget narrative for alternative activities to re-purpose excess grant funds in alignment with the scope and purpose of the grant.

Hospital Costs

Each hospital is responsible for ACS NSQIP program integration which includes significant human resource time from multiple hospital departments. Initially we only recognized the time of the Surgical Clinical Reviewers in performing the actual work. We have come to realize after talking with enrolled and participating hospitals, there is a significant amount of time IT needs to devote to setting up the data integration interfaces and continually monitor improvements in data collection since the SCR is working off several electronic medical records (EMRS).
Quality Directors hire and orient the new SCRS to their role and meet regularly to discuss data trends and programmatic improvement. Surgeon champions devote time for weekly meetings with the SCR and monthly collaborative meetings. Infection control and quality personnel knowledge and expertise are also required for analysis of complications and participation in quality improvement initiatives addressing Surgical Site Infections (SSI) as identified through the NSQIP data collection and analysis process. These additional professional resources complete the interdisciplinary improvement team skill set to effectively address areas for improvement. In our previous budget, we did not account for these additional personnel costs hospitals will incur in response to ACS NSQIP participation.

The costs of these resources are delineated in the attached budget and represent a total cost for the hospital participant of approximately 53% of the total program participation costs.

Revised Budget Narrative

Five areas of activity are requested in the process of re-purposing the funding that was earmarked for the six hospitals who have not indicated their ability to participate currently. The four activities are:

1. Salary Support for SCR's for Year 1 and Year 2 at 100% of required FTE level
2. Hospital enrollment fees for Year 1 and Year 2
3. A Statewide Surgical Services Collaborative meeting
4. Sponsored attendance for the Surgical Champions and Surgical Care Reviewers at the National ACS-NSQIP conference
5. Perioperative Surgical Home Toolkit

Surgical Case Reviewer (SCR) Continued Salary Support

Full salary support for Year 1 and continued salary support for the Surgical Case Reviewers through Year 2 of the data collection and submission process. Continued

hospital participation beyond Year 2 of the VHCIP grant period is entirely borne by each participating hospital's budget commitment.

Hospital Enrollment Fees

The budget was revised to cover the first and second year of hospital enrollment fees. Because our surgical case volumes are so low, it will take several years of participation in ACS NSQIP for stakeholders to reap the benefits of participating in a rigorous program like ACS NSQIP. If we can pay hospital enrollment fees for two years, this will help establish ACS NSQIP in participating hospitals beyond the grant period.

Statewide Collaborative Meeting

The collaborative meeting budget was increased to provide additional funds to host statewide collaborative meetings for hospitals to review comparative data, share outcomes and identify best practices. A face to face meeting of leaders and stakeholders encourages communication, conviction, and collaboration to maintain and sustain hospital engagement in NSQIP. It is through these discussions that best practice becomes evident and is then able to be broadly disseminated to improve current practice. The monthly collaborative meetings help build momentum to create positive change in surgical care, building toward the larger collaborative meeting discussions and learning health system.

National Conference Sponsorship

ACS NSQIP encourages each hospital to attend the National Conference to engage in national conversation regarding best practice. In 2016, our collaborative intends to present the Vermont experience at the national conference. This opportunity will feature the sustaining support provided by the VHCIP Provider Grant Program and Vermont's state innovation project. The National Conference will be held in San Diego July 16-19th. The revised budget reflects administrative fees, hotel and travel for an SCR and Surgical Champion from each participating hospital, the statewide project coordinator, Chair of the Collaborative, and Executive Director of VPQHC to attend the conference.

Perioperative Surgical Home Toolkit

The available funds present an opportunity to develop a perioperative surgical home toolkit that will benefit all hospitals performing surgery in Vermont. The toolkit will contain patient centric information that will educate the patient throughout the surgical experience and engage the patient with the health care team through all phases of the perioperative period to enhance recovery, improve satisfaction and reduce costs.

ACTIVITY	DESCRIPTION	BUDGET REQUEST
Year 2 Surgical Case Reviewer	Full salary support for each Surgical Case Reviewer @ original salary request level	$160,417
ACS-NSQIP Conference Sponsorship	Sponsored attendance to the ACS-NSQIP National Conference for Surgical Champions (SC), Surgical	$42,000

ACTIVITY	DESCRIPTION	BUDGET REQUEST
	Case Reviewers (SCR), Lead Surgical Champion (Dr. James Hebert) Statewide Collaborative Coordinator and VPQHC Executive Director	
Surgical Home Toolkit	Creation of toolkit (webpage and/or patient surgical pamphlet and/or safety checklist) to be developed and distributed to all hospitals.	$71,000
Collaborative Best Practices Learning Session	Sponsored meetings to share performance data, internal improvement efforts and identification of best practices based on comparative performance results.	$10,223
Hospital Enrollment Costs	Year 2 ACS- NSQIP enrollment fees for participating hospitals	$73,500

VPQHC Grant Revision Request for NSQIP Project - December 2015

Total cost of project for 2 years	**Revised with hospital costs:**								
VHCIP Funding	$1,909,411								
% funded by VHCIP	$ 900,000								
	47.13%								
	Original VHCIP Grant Total	**Revised VHCIP Grant Total**	**VHCIP Grant Total Difference Revised Over (Under) Original**	**Original Hospital Cost Share Total**	**Revised Hospital Cost Share Total**	**Hospital Costs Total Difference Revised Over (Under) Original**	**Original Total VHCIP Grant and Hospital Cost Share Total**	**Revised Total VHCIP Grant and Hospital Cost Share Total**	**Total VHCIP Grant and Hospital Cost Share Difference Revised Over(Under) Original**
Personnel:									
Project Coordinator	$ 136,267	$ 136,267	$ -	$ -			$ 136,267	$ 136,267	$ -
Surgical Care Reviewers- 10 FTE original for one year for six months/1.083 FTE revised year one; 0 FTE original year one/2.92 FTE year two	$ 275,000	$ 220,000	$ (55,000)	$ 687,500	$ -	$ (687,500)	$ 962,500	$ 220,000	$ (742,500)
Sr. Analyst/Epidemiologist	$ 22,661	$ 22,661	$ -				$ 22,661	$ 22,661	$ -
Executive Director	$ 9,914	$ 9,914	$ -				$ 9,914	$ 9,914	$ -
Administrative Assistant	$ 10,622	$ 10,622	$ -				$ 10,622	$ 10,622	$ -
Business Office	$ 11,278	$ 11,278	$ -				$ 11,278	$ 11,278	$ -
IT Manager	$ 4,993	$ 4,993	$ -				$ 4,993	$ 4,993	$ -
Quality Improvement and Infection Control Staff 0 original/6 revised	$ -		$ -	$ -	$ 123,250	$ 123,250	$ -	$ 123,250	$ 123,250
IT Support in Hospital in 12 original/6 revised	$ -	$ -	$ -	$ 78,750	$ 54,375	$ (24,375)	$ 78,750	$ 54,375	$ (24,375)
12 Original/6 Revised Surgical Champions	$ -	$ -	$ -	$ 150,000	$ 585,000	$ 435,000	$ 150,000	$ 585,000	$ 435,000
Total Salaries	$ 470,736	$ 415,735	$ (55,000)	$ 916,250	$ 762,625	$ (153,625)	$ 1,386,986	$ 1,178,360	$ (208,626)
Fringe @ 30%	$ 143,351	$ 130,059	$ (13,292)	$ 296,499	$ 246,785	$ (49,713)	$ 439,849	$ 376,844	$ (63,005)
Salaries and Fringe	$ 614,086	$ 545,794	$ (68,292)	$ 1,212,749	$ 1,009,410	$ (203,338)	$ 1,826,834	$ 1,555,204	$ (271,630)
									$ -
Program Costs:									$ -
Training fee for Coordinator	$ 2,500	$ 2,500	$ -	$ -			$ 2,500	$ 2,500	$ -
Travel to hospitals and meetings by VPQHC Statewide SS Collabortative Coordinator staff; Avg. 5 trips per month Avg 200 miles RT @.$56 per mile-12 Original/6 Revised Plus Revised for Later Start Date	$ 11,559	$ 7,728	$ (3,831)	$ -			$ 11,559	$ 7,728	$ (3,831)
Computer Equipment -12 Original/6 Revised computers for SCRs	$ 12,000	$ 6,000	$ (6,000)	$ -			$ 12,000	$ 6,000	$ (6,000)

Meetings including one Statewide All Day Collaborative - Revised to reflect actual in year one	$ 2,600	$ 10,723	$ 8,123				$ 2,600	$ 10,723	$ 8,123
Conference sponsorship for collaborative leaders (6 Surgical Champions+6SCR's+2 VPQHC) to present at National NSQIP Conference San Diego-New Revised	$ -	$ 42,000	$ 42,000				$ -	$ 42,000	$ 42,000
		$ -	$ -				$ -	$ -	$ -
Surgical Home toolkit - New in Revised	$ -	$ 71,000	$ 71,000				$ -	$ 71,000	$ 71,000
Enrollment fees -annual - 12 Original for one year/5 Revised 1st year and to pay 2 years' enrollment fee for 6 hospitals in 2nd year	$ 180,000	$ 137,000	$ (43,000)	$ 180,000			$ 360,000	$ 137,000	$ (223,000)
Total Program Costs	$ 208,659	$ 276,951	$ 68,292	$ 180,000			$ 388,659	$ 276,951	$ (111,708)
							$ -	$ -	$ -
9.39% Indirect Costs	$ 77,256	$ 77,256	$ (0)	$ -			$ 77,256	$ 77,256	$ (0)
							$ -	$ -	$ -
Total Costs	**$ 900,000**	**$ 900,000**	**$ (0)**	**$ 1,392,749**	**$ 1,009,410**	**$ (203,338)**	**$ 2,292,748**	**$ 1,909,411**	**$ (383,337)**

Attachment 3c: DA Payment Reform Project Plan

DRAFT FOR DISCUSSION PURPOSES ONLY

Medicaid Mental Health/APM/SIM Alignment

The State of Vermont has committed to move forward with development of Designated Agency and substance use provider payment and delivery system reforms during the 3rd year of the SIM demonstration and in preparation for participation in the All-Payer Model waiver. This draft plan proposes critical elements and activities to move forward.

SIM Payment and Delivery System Reforms

Vermont's experience in payment and delivery system reform has enabled us to identify critical steps for success in our efforts. In addition to these lessons learned, we commissioned a report that focuses specifically on Medicaid payment and delivery system transformation. This report proposes a series of questions that help to assess readiness and identify work required on the road to successful reform:

1. Care Delivery: are providers ready?
2. Health Data Infrastructure: are providers ready?
3. What are the services we want to include? Who is covered by those services?
    a. What is the current financial methodology?
    b. What are the current program requirements?
4. Level of accountability: (ie. what VBP model do we employ?)
    a. What level of risk can the providers take on?
5. What quality measures should we use?
    a. Make sure they are aligned with the existing measures in use.
    b. Electronic collection/provider burden
6. Should it be mandatory or voluntary?
7. Are there enough lives/money/services for this to work? Small numbers problem.

Proposed Project Plan:

This project falls within Vermont's payment and delivery system reform activities. The State will utilize the resources available within the State Innovation Models Testing Grant and update the VHCIP Core Team on this project's launch and development.

Goals:

1. Design a sub-capitated payment arrangement, or other alternative to fee-for-service, for the mental health and substance use system, especially the Designated Mental Health Agencies, that builds on the IFS work in progress and explicitly considers sustainability and integration over time. Please note that the specific services within the new payment arrangement, as well as the specific payment methodology will be identified as part of the discovery and design process.
2. The new payment arrangement should align with the all-payer model payment arrangement and structure.

3. The new payment arrangement, which will include quality measures and a streamlined designation process in accordance with the all payer model regulatory structure, will be developed collaboratively between providers, including DAs and the State.
4. The project aims to reduce silos, streamline payment and reporting, and improve payment flexibility to achieve the triple aim.
5. The project will produce an implementation plan that incorporates necessary operational changes for the State and a timeline, for presentation to and approval by AHS leadership before 12/31/2016.

The project will have a steering committee comprised of public and private sector individuals that will guide the work.

Design Phase (October 20, 2015-December 31, 2016):

Identification of Steering Committee and Project Team

Resources:

Utilize contractors/SOV staff to perform the following tasks:

a. Meeting planning and facilitation
b. Medicaid medical and non-medical financial analysis
c. Medicaid payment model design and data analytics
d. Quality measurement selection
e. Legal analysis to analyze state and federal laws and ensure waiver alignment
f. Ensure continued provider readiness for the new payment system.

Activities:

The project team, as described above, will meet at least every two weeks to develop the design for this project. As the design is developed, the project will provide updates and concepts to the VHCIP/SIM Payment Model Design and Implementation Work Group, Steering Committee, and Core Team.The project team will engage in the following activities, noting they must be aligned with the all-payer model:

1. Explanation of how this project fits explicitly within the state's other payment and delivery system reform efforts, including, but not limited to: the Blueprint for Health, Shared Savings Programs, All-Payer Model, Episodes of Care, and Prospective Payment Systems.
    a. This project assumes that questions 1 and 2 above have been answered and that the providers have attained some level of readiness for these reforms.
        i. There are a variety of providers who provide mental health and substance use services. The initial review of provider readiness has determined that many of these providers are ready, however, depending on the specific services identified and the specific payment methodology, there may be some provider types who are more or less ready to accept the new payment methodology.

The payment methodology design will incorporate the need to accommodate this potential variation in readiness.

2. Analyze the current financial methodology and program requirements.
    a. Include in the analysis information regarding the emergency services requirement of the Designated Agencies.
3. Identification of targeted beneficiaries and accompanying attribution methodology.
    a. This will include a method to extract appropriate data related to these beneficiaries.
    b. This includes an analysis of the level of risk that providers are able to bear in a new payment model.
4. Identification of targeted services.
    a. This will include a list of services, a plan for how to measure utilization and expenditure related to these services and proposed expansions beyond the initial set of services.
    b. This will also include any requests for waiver of certain activities.
    c. This includes an analysis to determine the ideal payment model to design for this part of the health care system (see item 7, below).
5. Identification of quality measures.
    a. This will include measures for reporting, monitoring, and payment. This will also include measure specification and a process for reporting and analyzing the measures.
    b. These will be identified building on "System of Excellence" work by Vermont Care Partners.
6. Determination of new payment model.
    a. This will include analysis of actual cost in relation to item 2, sustainability and goals around access to care.
    b. This will include considerations of funding streams for inclusion in relation to item 5.
    c. This will include considerations of different services, funding streams, and provider readiness.
7. Develop next steps related to an application to CMS for a State Plan Amendment related to implementation of this plan. This should include identification of necessary actuarial and financial analyses, programmatic analyses, quality measure analyses, and compliance.
8. Development of subsequent phases of the project that would expand to additional services and providers and project plans for those phases.

For all of the activities above, the project team may also identify processes to identify program design elements (for example, the project team may indicate that they will adopt CCBHC program and Quality requirements or the Medicaid Shared Savings Program measures, but use different targets) if that is more appropriate for that particular activity.

Attachment 3d: Healthfirst Proposal

ACO Gateway and Data Reporting Proposal

Submitted by:

Amy Cooper, Executive Director, HealthFirst

Michael Gagnon, VITL Chief Technology Officer

October 21, 2015

Table of Contents

Overview

Vermont Information Technology Leaders (VITL) and Health*first* Vermont collaborative Physicians (VCP) jointly submit this proposal to build the ACO message processing gateway within the VHIE, previously approved for funding, and secure approval and funding to build an ACO clinical reporting capability to support robust data management and quality measure reporting.

VCP member practices need to be able to collect, store and transmit structured, reliable, complete and actionable clinical data. High quality data are a prerequisite for a healthcare system to accurately measure and assess performance against a broader patient population. This proposal requests funds to implement tools to:

1) appropriately match and filter VCP member practice data and commercial beneficiary data within the VHIE
2) provide accurate and timely reporting of ACO measures to ACO management

For reference, the table below shows VCP participating practices, their attributed lives

Vermont Collaborative Physicians Practices	Attributed Lives 9-15
Thomas Chittenden Health Center	1281
Good Health PC	836
Evergreen Family	709
Pediatric Medicine	698
White River Family Practice	677
Richmond Family Medicine	561
Essex Pediatrics	523
Middlebury Family Health	390
Ann Goering PC dba Winooski Family	369
Charlotte Family Health	353
Hagan, Rinehart & Connolly	343
Mousetrap Pediatrics	342
Alder Brook Family	280
Richmond Pediatric & Adol Med	197
Mark Logan MD PC	153
Christopher Hebert, MD	151
Max Bayard MD PC	137
Paul Rogers MD	131
Gene Moore MD PLLC	112
Joseph Nasca MD	89
Roger Giroux MD (Brookside)	66
Seth Coombs MD	63
Green Mountain Pediatrics	50
Bruce Bullock, MD	47
VCP TOTAL	8558

Building these Gateway and reporting capabilities for VCP in 2016 will bring all patients into play for the purpose of the potential all-payer model, collaborative planning for the waiver in 2016, and/or other population-based payment programs.

Core Requirements

- The VCP ACO Gateway must be funded to provide data filtering for the lives attributed to VCP primary care practices
- VCP Member practices must be able to send ADT, VXU, CCD messages
- VCP resources and member practices must be engaged and responsive to assist in:
    - Improving data quality
    - Identifying quality measures for reporting
    - Testing
    - Securing and providing beneficiary data to the VHIE
    - VCP commitment to funding maintenance for at least 1 year with a PMPM payment

VITL may hire consultants to assist with the design and build process in order to effectively and efficiently deliver ACO quality measure reporting. A set of detailed requirements will be developed as the discovery phase completes.

Proposal

This proposal includes all the necessary work for VCP to have full gateway, at cost of $185,000, and quality measure reporting and support for a full year after deployment, at cost of $286,000. Timeline will be 26 weeks. The options for each type of work will be described in each section of the proposal and will be defined during the Analysis Phase of the project.

The work encompasses five required phases which are:

1. Planning
2. Analysis
3. Build Phase 1 – VCP Gateway
4. Build Phase 2 – VCP Quality Measure Reporting
5. Support

There are two key assumptions for this proposal which are:

1. The VITL core data warehouse is already funded and must be in place for this project to be successful.
2. Basic ACO reporting can be accomplished with the core warehouse and the Tableau tool, but an additional option would be to provide more advanced ACO analytics by outsourcing this to an ACO analytics vendor.

What follows is a description, including work requirements and options for each phase. In each section we will discuss the Core and Secondary Requirements from above that can be met with the proposed solution.

Planning

In the planning phase, VITL will partner with VCP to identify their quality measure reporting needs. The key steps in this part of the project are communicating with stakeholders on the project concepts and deliverables and gaining their support. In addition, there will be early work on the project plan, data flow concepts, further defining the system requirements and developing a Roadmap for developing the system. We will collectively define the Critical Success Factors and establish how we plan to measure success. We will also discuss each requirement and determine where each of them should be in the Roadmap and Phase of the project.

VITL has a wealth of project management knowledge and experience. We utilize the Project Management Body of Knowledge (PMBOK) process promoted by the Project Management Institute (PMI). Some of our staff are Project Management Professionals certified by the PMI. For this project we will develop the following project artifacts:

- A project charter
- A complete project plan
- A risk analysis
- A project budget
- Communications plan
- Weekly status reports
- Weekly update meetings
- Implementation plan
- Test plan
- Project acceptance document

The Project Charter will be developed first and will set the scope of the project and set expectations. The project plan, risk assessment, budget and communications plan will be developed at the beginning of the project. Status reports and meetings will happen each week starting at project inception. The Implementation Plan and Test Plan will be developed during the early part of the Build Phase. The Project Acceptance Document will be developed during the latter part of the Analysis Phase and will be used for VCP acceptance.

Deliverables: Critical Success Factors, Roadmap, Project Plan, Project Governance Plan

Analysis

The analysis part of the project is often the most critical part. This is where system requirements are defined, design work is completed, and the final scope of services is determined. It is also where the

project governance is established, which will be required to make decisions on scope. At this point in the project, making changes to the scope can be accounted for in the project plan and will not require much rework. This phase of the project will also include an inventory of system assets, staff and data and review and analysis of what each organization and their vendor can support.

The goal of this phase is to finalize what is in scope, what is out of scope, and to develop a series of design and specification documents which can be used to build the system. This is also where the final project charter, project plan and budget can be determined

Analysis Phase Tasks

1. Managing the Analysis Phase of the Project

   This will include all the project management, developing the analysis phase project plan, coordinating technical staff meetings, progress monitoring and reporting, financial reporting and management reporting to the overall project manager as required. The deliverable is the project plan.

2. Executive Management

   Executive management will be provided by VITL for this phase of the project to ensure that requirements are determined and the project stays on track. There are several significant technical and business decisions that must be made during this phase and VITL's executive management will be involved in helping to make those decisions. The deliverables are the executive business decisions for the project.

3. VCP Warehouse Design

   While VITL has experience with data management and building data warehouses, we have limited direct experience with ACO data modeling. To ensure we build the warehouse correctly, one option would be to work with the VCP to hire a consultant to assist with this design process. VITL will issue an RFP and work with the VCP team to choose an appropriate contractor. VITL will then work with this contractor to model the database and structures based on previously completed data analysis work. The deliverable will be a detailed database design specification to include a data dictionary, table structures, data elements and relationships.

   While VCP can get much of its data from standard ADT and CCD formats, we believe that your warehouse will require additional data from your EHR and other systems to enrich the data warehouse. During the Analysis Phase we would work with the VCP to develop the specifications for collecting any reports, developing the data model, designing the load procedures and designing reports that could be produced from these data. The deliverable will be a design specification for the collection of data and the reports from the warehouse.

4. Infrastructure Design

   This will involve designing a hosted private server infrastructure for running the VCP warehouse. This includes network and server planning, as well as determining any special software that we

might need for data collection. It also includes determining requirements for the secure network, data handling, user privileges, user roles and interfaces. The deliverable will be a plan for a hosted warehouse environment plus a data security plan.

5. Interface specs for ADT & Labs

   This involves developing the specifications for each of the vendor systems that will be participating in the VCN. While VITL has a standard for this, we must work with the EHR system vendors to determine what they can produce and then review numerous actual sample messages to develop a final specification. This is discovery work done with the site and the vendor and will result in a deliverable of a negotiated final specification.

6. Interface specs for CCDs

   This involves developing the CCD specifications for each of the vendor systems that will be participating in the VCP. This work is similar to developing the ADT specification but with much more variability and more consequences for missing or incomplete data. While a standard CCD specification exists, VITL must again work with the EHR system vendors to determine what they can produce and then review numerous actual sample messages to develop a final specification. This is discovery work done with the site and the vendor which will result in a deliverable of a negotiated final specification.

Build

Build Phase 1 – VCP Gateway Tasks

1. Managing the Build Phase of the project

   This will include all of the project management, developing a project plan for the build phase, coordinating technical staff meetings, progress monitoring and reporting, financial reporting and management reporting as required. We broke this into two parts in the budget to reflect the relative effort, but this will be an ongoing task. The VITL ACO PM will be directly involved with the project and will work closely with VCP to guide the design process and assist with decision making. Deliverables include a Medicity ICOF for the Build Phase and a project plan.

2. Building the VCP ACO interfaces required for the VHIE to populate the warehouse

   This is the work that VITL does to develop ACO interfaces to send beneficiary and member practice matched data to a downstream analytics vendor, in this case VITL's Data Warehouse. The deliverable will be the completed interfaces to the warehouse.

Build Phase 2 – VCP Quality Measure Reporting Tasks

1. Managing the Build Phase of the project

   This will include all of the project management, developing a project plan for the build phase, coordinating technical staff meetings, progress monitoring and reporting, financial reporting and

management reporting as required. We broke this into two parts in the budget to reflect the relative effort, but this will be an ongoing task. In addition to the project management staff, VITL Technical Leadership will be directly involved with the project and will work closely with the VCP to guide the design process and assist with decision making. Deliverables include a project plan for the Build Phase and associated documents.

2. Developing the initial reports required by VCP

   VITL will commit to developing up to 4 reports for use by VCP and identified users during this phase. These reports can be for State reporting, internal use, or any other function as required by VCP. Deliverables are the report specification and initial reports.

3. Developing a feedback loop to VCP for continuous data quality improvement

   One of the most important parts of any warehouse or analytics project is to develop a feedback loop to the source organizations to allow for continuous quality improvement. VCP will get access to a Data Quality "scorecard" to see the results of their data feeds. This feedback loop should be valuable in getting submitters to understand the quality of the data they are submitting and making incremental improvements. Deliverables include a data quality scorecard and feedback loop for data submitters.

3. Upgrading the infrastructure for hosting the full warehouse

   This will involve setting up all the servers and the network for hosting the data warehouse and any analytics tools for VCP. VITL currently uses Rackspace as its secure hosting vendor and will dedicate a server to the VCP for purposes of security and privacy protections. Deliverables will be a robust infrastructure for warehouse, reporting and analytics.

4. The final design and build of the data warehouse VCP structure

   Based on the design done by VITL and the consultant, we will build the final data warehouse in Microsoft SQL Server Enterprise on the server described above. This involves setting up the data tables, fields and relationships and determining the expected queries that will be performed to set up star or snowflake schemas. A star schema is likely to focus on a patient's events fact table across various dimensions. Deliverables will be the final warehouse schema.

5. Developing the reports required by VCP

   VITL will commit to developing up to two additional reports for use by the VCP and their members. These reports can be for State reporting, internal use, or any other function as required by the VCP. These reports are in addition to the Data Quality Scorecards described above. Deliverables will be the final 3 - 5 reports as determined by VCP.

6. Installing the visual analytics toolkit and training users

   As part of this project VITL envisioned that the VCP would eventually want to perform ad-hoc analyses. To that end, VITL included X licenses for Tableau which is a powerful and visually oriented analytics tool. If VCP decides to pursue this option then VITL will deploy this tool. VITL also included training costs for 3 staff in the project. The VCP could use all these licenses or perhaps assign one to VITL for performing ad-hoc analyses for VCP members. Deliverables will be the installation and training on the chosen analytics tool

Timeline

VCP Warehouse Timeline

Id	Task	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
	Planning Phase												
P.1	Planning and Project Approval												
	Analysis Phase												
A.1	Project Management												
A.2	Executive Leadership												
A.3	VCP Warehouse Design												
A.4	Infrastructure Design												
A.5	Interface specs for ADT												
A.6	Interface specs for CCDs												
	Build Phase												
B.1	Project Management												
B.2	Executive Management												
	Develop Gateway												
B.3	Infrastructure Setup												
B.4	Interface Build and Test												
B.5	Warehouse Build												
B.6	Warehouse Deployment												
B.7	Implementation												

Costs

VITL - VCP Statement of Work

Task #	Task	Owner	Timeline	Requirements	Units	Unit Type	Rate	Labor Total	Other Costs	Total Costs	Notes
	Planning										
P.1	VCP Planning	VITL		Leadership	60	Hours	$200.00	$12,000.00		$12,000.00	
P.2	VCP Concept	VITL		VITL Staff	100	Hours	$125.00	$12,500.00		$12,500.00	
	Planning Phase Totals				**60**			**$24,500.00**	**$0.00**	**$24,500.00**	
	Analysis & Design		**Duration (weeks)**								
A.1	Project Management	VITL	Ongoing	VITL PM	60		$125.00	$7,500.00		$7,500.00	
A.2	Executive Management	VITL	Ongoing	VITL Leadership	40		$200.00	$8,000.00		$8,000.00	
A.3	VCP Warehouse Design	VITL	12	VITL Staff	200		$125.00	$25,000.00		$25,000.00	
A.4	Infrastructure Design	VITL	2	VITL Staff	40		$125.00	$5,000.00		$5,000.00	
A.5	Interface specs for ADT & Labs	VITL	1	VITL Staff	20		$125.00	$2,500.00		$2,500.00	
A.6	Interface specs for CCDs	VITL	2	VITL Staff	40		$125.00	$5,000.00		$5,000.00	
	Analysis Phase Total		12		**400**			**$53,000.00**		**$53,000.00**	
	Build & Implementation										
B.1	Project Management		Ongoing		120	Hours	$125.00	$15,000.00		$15,000.00	
B.2	Executive Management		Ongoing		40	Hours	$200.00	$8,000.00		$8,000.00	
B.3	Infrastructure Setup	VITL	2	VITL Staff	40		$125.00	$5,000.00		$5,000.00	
B.4	Interface Build and Test	VITL	8	VITL Staff	120		$125.00	$15,000.00		$15,000.00	
B.5	Warehouse Build	VITL	8	VITL Staff	512		$125.00	$64,000.00	$50,000.00	$114,000.00	Other are consulting fees
B.6	Warehouse Deployment	VITL	4	VITL Staff	80		$125.00	$10,000.00		$10,000.00	
B.7	Implementation	VITL	1	VITL Staff	120		$125.00	$15,000.00		$15,000.00	
	Build Phases Total		16		**1032**			**$132,000.00**		**$182,000.00**	
	Infrastructure and Software										
I.1	Rackspace Server/Network Allocation	VITL		Rackspace	12	Months	$1,000.00	$12,000.00		$12,000.00	
I.2	Develop Gateway	VITL	12	Medicity	1	Gateway	$185,000.00	$185,000.00		$185,000.00	
I.3	Infrastructure Setup	VITL	4	VITL Staff	80	Hours	$125.00	$10,000.00		$10,000.00	
I.4	Tableau Licenses	VITL		Tableau	3	Licenses	$1,500.00	$4,500.00		$4,500.00	
	Infrastructure & Software Total		4					**$211,500.00**		**$211,500.00**	
	Total all Phases									**$471,000.00**	

Conclusion

VITL is excited to be working with the Health*first* VCP to develop VCP ACP Gateway and quality measure reporting solution. We feel that VITL is best positioned to provide VCP with data management and integration services that are matched to this smaller scale ACO. VITL is also the only organization that can integrate VCP data into the VHIE and match patient data to the state Master Patient Index concurrently with beneficiary identification.

VITL staff also has significant experience with clinical data warehousing and reporting. Most of this experience was gained through work with different organizations. VITL is now making strategic investments in data management and warehousing capabilities that will benefit the VCP project. Those investments include a Rhapsody integration engine, SQL Server Enterprise DBMS, and Tableau. Additional investments in a terminology services engine are underway through the data remediation project as part of the VHCIP Population Health ACO project. Additionally, VITL has the server, firewall and disaster recovery infrastructure through our hosting vendor Rackspace. All of these investments in both personnel and systems are designed to provide exactly the type of services the VCP is requesting as part of this project.

Attachment 4: St. J Project Update

St. Johnsbury Project Update

Georgia Maheras
Erin Taylor, Bailit Health Purchasing
December 9, 2015

St. J Pilot Work Group Participants

- Collaboration of three leading providers in St. J and state agency representatives
  - Northeast Vermont Regional Hospital
  - Northern Counties Health Care, Inc. (FQHC)
  - Northeast Kingdom Human Services (DA)
  - State: Agency of Administration, DAIL, DVHA, DMH, DOH, GMCB

Background

1. St. J providers interest in a global budget for Medicaid services to be managed through an Accountable Community for Health (ACH).
2. Population Health Work Group (PHWG) and Prevention Institute recommendations for ACH in Vermont.
3. GMCB discussions with providers, DVHA and insurers on an all-payer model with a unified ACO.

The SIM Core Team requested work to bring these three streams of activity together.

Process

- St. J group timeline
  - June 2015: Design and research on St. J ACH began
  - Five meetings since June 2015
  - Additional “sub-group” meetings
  - 6-month design and discovery process
  - Early 2016: Present final recommendations to SIM Core Team
- During this time
  - Launch of a formal planning process for Vermont ACH
  - All-payer model planning continued to advance

Charge of the Group

- At first meeting, St. J group decided to focus on payment reform for LTSS:
  - Recognition of concurrent ACO and ACH activities;
  - Avoid duplication and conflict
- St. J group is looking at services not contemplated in the initial scope of the all-payer model:
  1. Choices for Care, specifically HCBS;
  2. Designated Agency services; and
  3. Integrating Family Services (IFS).
- Anticipate that pilot will a) lead to future alignment with ACO and ACH; b) have potential use statewide.

Choices for Care

- Subgroup of provider and state representatives brainstorming new payment approaches:
  - Increase flexibility to improve care; and
  - Improve coordination of care.
- Conceptual proposal:
  - Team-based case management;
  - Bundled payment for personal care services for Home Health Agency; and
  - Shared savings – primarily for reduced nursing facility services.
- Developing oversight and accountability structure.
- Update to DLTSS Work Group in December.

Designated Agency Services

- DA provider concerned with time spent managing to reporting requirements.
- Reducing and aligning measures would free up resources for the provision of care.
- Leverage current AHS process to standardize and streamline quality measures for all DAs.
- DA subgroup and AHS to discuss regional recommendations (12/10/15).
- Discussions have also expanded to a new payment model for DA services.

Integrating Family Services (IFS)

- Ongoing IFS meetings with stakeholders in St. J.
- St. J Pilot work group partners involved in stakeholder discussions.
- Upon stakeholder approval to proceed, IFS will work with St. J partners on a work plan.
- St. J work group providers hope for a 7-1-16 IFS implementation date, with 7-1-17 as a fall back date.

Next Steps

- More work to define details of payment model and test shared savings viability.
- Parties still working toward goal of developing an ACH:
  - VDH will engage St. J work group in ACH planning process; and
  - VDH developing regional learning opportunities to exchange information.
- Next work group meeting: 12/28
  - Choices for Care payment model.
  - DA review of AHS draft streamlined measure set.
  - IFS implementation plan if buy-in from broader St. J stakeholders.

Attachment 5a: Medicaid SSP

Vermont Medicaid Shared Savings Program
Total Cost of Care Summary Table

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

December, 2015

Attachment 5b: Commercial SSP

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

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

ACO pilot standards are organized in the following four categories:

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

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

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

- Process for review and modification of measures.

The objectives and details of each draft standard follow.

I. Financial Stability

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

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

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

B. Standards related to downside risk.

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

C. Standards related to financial oversight.

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

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

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

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

a. terminate their agreement for cause as of June 30, 2014; or
b. agree to maintain their agreement in full force and effect.

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

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

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

III. Patient Freedom of Choice

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

IV. ACO Governance

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

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

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

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

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

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

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

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

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

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

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

V. Patient Attribution Methodology

Patients will be attributed to an ACO as follows:

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

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

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

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

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

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463

CPT-4 Code Description Summary
• Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

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

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

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

8. Insurers will run their attributions at least monthly.

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

Preventive care	o comprehensive "wellness" visits o immunizations: counseling and administration o injections and medications administered in the office o lipid, diabetes, depression, substance abuse, obesity, and blood pressure screening, and management and initial treatment of abnormal screenings o ordering and managing the results of USPSTF-recommended screening tests for ages /risk groups appropriate to specialty. For example: - Pediatrics/ Family Medicine: newborn screening, developmental screening, lead screening - Internal Medicine/Family Medicine: colon, breast, cervical cancer screenings
Acute care	Acute care of appropriate common problems for age groups of specialty (e.g., sore throat, headache, febrile illness, abdominal

	pain, chest pain, urinary symptoms, rashes, GI disorders, bleeding) o telephone triage and same-day visit capability o 24/7 telephone availability for triage and care coordination o ordering and managing appropriate testing, prescribing medications, and coordinating referrals and consultations for specialty care
Chronic care	Chronic care of common medical problems, including at least: allergies, asthma, COPD, diabetes (type 2), hypertension, lipid disorders, GERD, depression and anxiety o arranging and managing regular testing, screenings, consultations appropriate to the conditions
Coordination of care	o providing a "Medical Home" for a panel of patients o maintaining a comprehensive, current medical record, including receipt, sign-off and storage of external records, consults, hospitalizations and testing o assisting in transition of care into facilities, and in return to outpatient care
Other	o selected outpatient laboratory tests (lipids, HbA1c and PT/INR[2]) o health education and counseling services performed in the office o routine vision and hearing screening o prescribing common primary care acute and chronic medications using an unrestricted DEA license

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

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

12. In instances when a provider supplier* terminates his or her participation in an ACO during a performance year, the provider will remain an attributing provider with the ACO for the remainder of the performance year and the claims data for the provider's attributed lives will continue to be shared with the original ACO. Likewise, if a provider supplier joins an already-enrolled ACO participant during a performance year, then the provider will become

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

an attributing provider with that ACO for the remainder of the performance year. The only exception to this latter provision occurs in those instances when a provider is switching from one participating ACO to another; under such circumstances, the provider will remain an attributing provider for the remainder of the performance year with the ACO of origin.

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

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

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

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

(See attached spreadsheet.)

I. Actions Initiated Before the Performance Year Begins

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

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

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

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

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

- prescription (retail) medications, and

2. dental benefits [4].

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

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

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

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

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

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

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

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

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

population using commonly defined insurer data provided to the GMCB or its designee. Medical spending shall be defined to include all paid claims for ACO-responsible services as defined above.

PMPM medical expense spending shall then be adjusted as follows:

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

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

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

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

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

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

- If the insurer-specific actual spending for the ACO population is between the insurer-specific expected spending and the insurer-specific targeted spending, the ACO will share 25% of the insurer-specific savings.

- If the insurer-specific actual spending is below the insurer-specific targeted spending, the ACO will share 60% of the insurer-specific savings. (The cumulative insurer-specific savings would therefore be calculated as 60% of the difference between actual spending and targeted spending plus 25% of the difference between expected spending and targeted spending.)
- An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not greater than insurer premium approved by the Green Mountain Care Board.

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

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

The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.

Methodology for distribution of shared savings: Compare the ACO's performance on the payment measures (see Table 1 below for an example) to the HEDIS PPO national percentile benchmark[5] and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure. These calculations will be performed annually using the most currently available HEDIS benchmark data at the time final shared savings calculations are performed.

For purposes of calculations pertaining to the distribution of any shared savings payment, an ACO's performance on a payment measure will be excluded from the calculation in those instances in which the ACO's denominator for that payment measure is less than 30. For purposes of public reporting of the ACO's performance, an explanation of the ACO's small denominator and its significance will accompany reporting of any payment measure with a denominator less than 30.

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

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

#	Measure	Data Source	2012 HEDIS Benchmark (PPO)
Core-1	Plan All-Cause Readmissions NQF #1768, NCQA	Claims	Nat. 90th: .68 Nat. 75th: .73 Nat. 50th: .78 Nat. 25th: .83 *Please note, in interpreting this measure, a lower rate is better.
Core-2	Adolescent Well-Care Visits HEDIS AWC	Claims	Nat. 90th: 58.5 Nat. 75th: 46.32 Nat. 50th: 38.66 Nat. 25th: 32.14
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only for Year 1)	Claims	Nat. 90th: 89.74 Nat. 75th: 87.94 Nat. 50th: 84.67 Nat. 25th: 81.27
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day NQF #0576, NCQA HEDIS FUH	Claims	Nat. 90th: 67.23 Nat. 75th: 60.00 Nat. 50th: 53.09 Nat. 25th: 45.70
Core-5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite) NQF #0004, NCQA HEDIS IET CMMI	Claims	Nat. 90th: 35.28 Nat. 75th: 31.94 Nat. 50th: 27.23 Nat. 25th: 24.09
Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, NCQA HEDIS AAB	Claims	Nat. 90th: 28.13 Nat. 75th: 24.30 Nat. 50th: 20.72 Nat. 25th: 17.98
Core-7	Chlamydia Screening in Women NQF #0033, NCQA HEDIS CHL	Claims	Nat. 90th: 54.94 Nat. 75th: 47.30 Nat. 50th: 40.87 Nat. 25th: 36.79

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

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

Table 2. Distribution of Shared Savings in Year One of Commercial Pilot

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

Eligibility for shared savings based on performance improvement.

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

Step 5: Distribute shared savings payments

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

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

VII. Care Management Standards

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

Definition of Care Management:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VIII. Payment Alignment

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

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

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

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

IX. Vermont ACO Data Use Standards

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

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

1. The VHCIP Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set beginning in the second quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines. The goal of the review will be to determine whether each measure should continue to be used as-is for its designated purpose, or whether each

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

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

3. The VHCIP Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set and consider any new measures for addition to the set beginning in the first quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider

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

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

Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

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

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