VT Health Care Innovation Project
Steering Committee Meeting Agenda

February 12, 2014 1:30 pm- 3:30 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	1:30-1:35	Welcome and Introductions	Al Gobeille and Mark Larson	Attachment 1: Agenda
2	1:35-1:45	Public Comment	Al Gobeille and Mark Larson	
3	1:45-1:48	Minutes Approval	Al Gobeille and Mark Larson	Attachment 3: January Minutes
4	1:48-1:50	Reminder: Conflict of Interest Policy	Georgia Maheras	
5	1:50-1:55	Shared Savings ACO Program Update: a. Commercial Program (Mark Larson) b. Medicaid Program (Richard Slusky)	Mark Larson and Richard Slusky	
6	1:55-2:05	Core Team Update	Anya Rader Wallack	
7	2:05-2:10	Grant Program Update	Georgia Maheras	
8	2:10-2:45	Status Reports from Work Group Chairs:	Work Group	Attachment 8: Status Report (distributed at a later

		a. Care Models: *Bea Grause and Renee Kilroy* b. Duals: *Deborah Lisi-Baker and Judy Peterson* c. HIE/HIT: *Brian Otley and Simone Rueschemeyer* d. Payment Models: *Don George and Stephen Rauh* e. Population Health: *Karen Hein and Tracy Dolan* f. Quality and Performance Measures: *Cathy Fulton and Laura Pelosi* g. Workforce: *Robin Lunge and Mary Val Palumbo*	Chairs	time)
9	2:45-3:25	Financial Requests: 1. Workforce WG Spending Proposal 2. DLTSS WG Spending Proposal 3. *Potential:* HIE/HIT WG Spending Proposal	Georgia Maheras	Attachment 9a: Workforce Work Group Spending Proposal Memo Attachment 9b: DLTSS Work Group Spending Proposal Memo Attachment 9c: Population-Based Collaborative Health Information Exchange (HIE) with all Q and A
10	3:25-3:30	Next Steps, Wrap-Up and Future Meeting Schedule	Al Gobeille and Mark Larson	Next Meeting: March 5th 1:00 pm-3:00 pm in Williston

VT Health Care Innovation Project
Steering Committee Meeting Minutes

Date of meeting: Jan 15, 2014 in the 4th Floor Conf. Room, Pavilion Building, Montpelier: Call In 877-273-4202 Passcode: 8155970

Attendees: Anya Rader Wallack, Al Gobeille, Georgia Maheras, Simone Rueschemeyer, Mary Val Palumbo, Tracy Dolan, Cathy Fulton, Nancy Eldridge, Abe Berman, Marybeth McCaffrey, Harry Chen, Trinka Kerr, Peter Cobb, Jenny Samuelson, John Evans, Julie Tessler, Elizabeth Cote, Todd Moore, Dale Hackett, Allan Ramsay, Richard Slusky, Pat Jones, Annie Paumgarten, Julie Wasserman, Diane Cummings, Nelson LaMothe, George Sales.

Agenda Item	Discussion	Next Steps
1 Welcome and Introductions	Al Gobeille brought the meeting to order at 10:01am, and requested that Steering Committee members submit a signed acknowledgement of the Conflict of Interest Policy as soon as possible to George.sales@partner.state.vt.us.	
2 Minutes Approval	A motion was made to accept the December Meeting minutes. It was duly seconded and passed unanimously.	
3 Core Team Update	Anya Rader Wallack presented an update on recent Core Team activity: The Core Team is hoping to release the Grant Program Application on January 23rd. There will be an applicant conference call on January 27th and the Frequently Asked Questions (FAQ) will be distributed after that call. Nancy Eldridge has been appointed as the new Co-Chair of Care Models Care Management Work Group. Anya announced that the Governor made a decision not to pursue the Duals Demo at this time. The Duals Work Group will continue its work developing payment and care models in collaboration with other work groups.	
4 Discussion of Grant Program	Georgia Maheras provided additional information about the Grant Program. CMMI has not yet approved the program, but that is expected by January 21st. Georgia requested that everyone send questions to her for inclusion in the FAQ. VHCIP will announce the Grant Program through	

Agenda Item	Discussion	Next Steps
	a press release, posting on the state websites and distribution to al VHCIP participants. The Grant Program will have more than one round of applications. Tracy Dolan asked about the role of Steering Committee members in the Grant Program. Steering Committee members are invited to develop questions about the program and submit them to Georgia. Anya Rader Wallack said that Core Team will score all grant proposals, alleviating any conflicts by the Work Groups or Steering Committee. The Core Team is also developing a scoring methodology for the Grant Program. The Core Team will likely weight the “ability to deliver” with more points than the “concept/idea”. Karen Hein commented about the 1st round’s quick application deadline, and asked if round 2 dates would be more flexible for provider organizations with different abilities to apply, who may also want to partner with other community service organizations. Anya confirmed multiple rounds will occur, some dollars will be held, and due dates will be more flexible. Mary Val asked about the range of dollars to be awarded. The Core Team specifically decided not to designate a range.	
5 Status Reports:	Work Group (WG) Co-Chairs Updates to Steering Committee :	
5a Care Models	Care Models – Nancy Eldridge: The Work Group met yesterday with a focus on effective team building. The WG is intent on building upon the Blueprint for Health concept, and not reinventing the wheel. The WG voted to continue its contract with Bailit Health Purchasing providing technical assistance. The WG also reviewed PowerPoint presentation by the Commonwealth Fund comparing different developed nations’ effectiveness in delivering health care.	
5b Duals	Duals - Judy Peterson: Judy said that there was not much to add to the earlier information about the Duals Demonstration. The WG’s goal is to move forward on care delivery and payment reform, and to integrate their work with the other WG’s. Deborah Lisi-Baker commented that a formal written report on the decision not to move forward with the Duals	

Agenda Item	Discussion	Next Steps
	Demonstration project would be forthcoming.	
5c HIE/HIT	HIE/HIT - Simone Rueschemeyer: The WG met last Friday and reviewed the draft Work Plan. Vermont's three ACOs presented a proposal to the WG; no vote was taken, and the plan is to meet with ACO's and VITL next week to go over WG questions on the proposal. The WG hopes to bring a recommendation to Steering Committee next month. Trinka Kerr asked for more explanation about the proposal and how the ACOs are working together. Richard Slusky responded that the ACOs approached him about how they could meet and collaborate to the benefit of the state and the ACOs. To avoid potential anti-trust violations, the ACOs meet with the GMCB. The focus of these meetings centered on a collaborative approach to HIE solutions. Topics include: a real time encounter notification, VITL acting as sole source for information, and whether there can be a shared pipeline to ACOs Analytics contractors. The ACO proposal is to provide funding to VITL to collaborate with ACOs to improve care and analytics. Tracy Dolan suggested that the Care Models be looped into the ACO HIE proposal conversation. Anya elaborated on VITL's biggest challenge: Vermont has 14 hospitals and 11 diff systems; and directed that any work affecting models of care must be processed through the Care Models WG. Dale Hackett raised a concern about data security, and whether information shared info with patients is part of the plan.	
5d Payment Models	Payment Models - Richard Slusky: Richard provided an update on the Shared Savings ACO Programs. The payers are still in negotiations with the ACOs. At its recent meeting, the WG accepted their Charter. The WG discussed Episodes of Care (EOC), which is planned as the next payment model and care delivery system change.	
5e Population Health	Population Health- Tracy Dolan: Next month, the WG's agenda is to analyze how measures implemented in other states drive healthcare behaviors and incentivize quality and payment. Dale Hackett asked whether the WG will track measures and project healthcare implications. And whether tracking genetic markers on the horizon? Tracy responded that the statistics are	

Agenda Item	Discussion	Next Steps
	not linked with patient – but eventually, recommendations are to move in this direction; and no plans to engage in genetic analysis are being discussed. The State of Vermont participated in a conference call with the CDC and CMMI to discuss linking measures in a clinical environment for diabetes, tobacco, body mass index (BMI) and their link with morbidity and mortality.	
5f Quality & Performance Measures	Quality & Performance Measures- Cathy Fulton: The WG approved their Charter and a proxy voting policy. The WG is identifying ways to avoid manual chart extractions for reporting measures and working with other work groups on this effort.	
Workforce Committee	Workforce- Mary Val Palumbo: The WG requested that its members submit ideas for contractual services in support of Workforce data analysis, and projections for review at its January meeting. The WG will also focus on the supply-side of the health care workforce.	
6 Financial Requests	Georgia Maheras requested the Steering Committee approve a financial request from the Quality & Performance Measures (QPM) Work Group to support a contractor to assist them in their work. This request is for an amendment to the Bailit Health Purchasing Contract in the amount of $200,000. Bailit's role is technical in nature, to identify measures and conduct an analysis. Nancy Eldridge made a motion to accept QPM's proposal. Cathy Fulton seconded the motion and it passed unanimously.	
7 Public Comment	Simone Reuschemeyer asked if there are any new methods or processes developed by a WG that they be shared with other Co-Chairs. Nelson LaMothe will act as clearing house for sharing methods and processes.	
8 Next Steps, Wrap Up and Future Meetings	VHCIP is moving the Steering Committee meetings to meet a week in advance of the monthly Core Team meeting.	

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To: Steering Committee
Fr: Workforce Work Group
Date: 2.6.14
Re: Proposal to contract for services supporting the collection of data on the Vermont Health Care Workforce

Recommendation: Release an RFP to execute a contract for up to $150,000 for workforce data analysis. The term is one year with an option to renew.

Proposal:

Description of Need: The Vermont Department of Health has been collecting, analyzing and publishing health care provider workforce data since 1994. The data have historically been collected in conjunction with the relicensing process, and included physicians, dentists and physician assistants. Among other uses, the information has been essential to designating geographic regions within the state as medically underserved; for this purpose a complete census of licensed providers, rather than a partial survey is required. Despite there being interest in performing analyses of other health professions beyond those listed above, the VDH has not had adequate staff to take on this work.

In 2013, Act 79, Sec.44 mandated the collection of these data for all health professions in order to assist with health care planning. At the same time, at the national level the National Center for Health Workforce Analysis has been collaborating with national professional organizations and state licensure boards to develop Minimum Data Sets (MDS) to answer questions on the supply and distribution of the U.S. healthcare workforce. In general the MDS consists of health professional demographic information, educational pathway, specialization, location of practice, and percent effort. The MDS will provide comparable data across states.

The data to be collected in Vermont will need to meet these related, but distinct needs: provide information needed for workforce development planning; determine medically underserved areas; and collect information consistent with the national Minimum Data Set. For those professions that have been surveyed in the past, it will also be important to collect information that is consistent with prior years to allow for comparisons across time. For newly surveyed professions, in addition to the standard questions included in the MDS, there will be other questions that may be unique to that profession.

In order to respond to this increase in the number of health care professions surveyed additional support will be needed to design the forms, analyze the data, produce reports and respond to requests for special analyses.

Scope of Work: The Contractor will provide the following activities and deliverables:

- For each of the health professions: Familiarize themselves with the information needed for planning purposes, for purposes of determining medical underservice, the MDS for that profession, if one exists, and any previous surveys conducted for that profession, and the relicensing schedule.

- Design a set of questions to meet the various requirements and review with interested parties.

- Collaborate with the appropriate Licensing Organization to incorporate the form into the relicensing process. This might include working with the Licensing Organization who will incorporate the questions directly into the relicensing forms, or developing a separate survey that is linked to the relicensing form.

- If needed, prepare paper forms using the software determined by the Department of Health, for individuals who do not relicense on-line.

- Analysis of the survey data, including identifying any limitations of the data.

- Produce one or more reports for each health care profession that can be used for planning purposes and to provide summarized data for the public.

- Provide special analyses as needed for interested parties such as the *Workforce Development Committee,* or the *State Office of Primary Care and Rural Health.*

Benefits Derived: As a result of this contract detailed information about the current health care workforce will be available and can be used for workforce development planning. In addition the information will be used to determine if there are areas of the state that are medically underserviced, and if so will be used to obtain a designation of medical underservice which can be used to develop assistance such as Federally Qualified Health Centers and Rural Health Centers. The information will be collected in a manner that is consistent with national standards, and therefore can be compared to other states and the nation.

Process Background:

c. A competitive RFP will be required to contract for services.

Review Criteria:

Training in survey design and analysis

Experience with survey design

Experience with analysis of survey data

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Ability to produce reports that are accurate, clear and are appropriate for various audiences.

Ability to complete work within specified timeframes.

Ability to communicate and work with interested parties.

Performance Measures:

For each health care profession

- Complete the design of the questions within the time needed to incorporate into the relicensing process
- Analyze the data and identify limitations
- Produce reports within specified timeframes

Note – the timeline for the analysis and reporting is out of the control of the contractor. It will depend on (1) receiving the dataset and (2) whether forms need to be designed for other professions with the relicensing deadline taking precedence. In addition – we already have multiple surveys in the field, so they can't all be analyzed and reports produced at the same time.

VERMONT

State Innovation Model

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TO: Steering Committee
FROM: Georgia Maheras
Date: 2/6/14
RE: Contractor support for the disability and long term services and supports work group

I am requesting a Steering Committee recommendation for the following:

> Conditional recommendation, pending work group action on February 20th, of contractor support for the disability and long term services and supports work group: Pacific Health Policy Group for $90,000 for March 1, 2014-February 28, 2015 and Bailit Health Purchasing for $90,000 for March 1, 2014-February 28, 2015.

Support for the DLTSS Work Group

Vermont's Duals Demonstration Design Grant funded several contracts from 2011-2013. In 2013, the Duals Demonstration was formally merged with Vermont's SIM activities. A new SIM Work Group was created to perform much of this work. Soon after the merger of these two projects, the Duals Demonstration Grant ran out of funds to support these activities. The expectation was that at some point, SIM funds would take over paying for these contracts and then Duals Demonstration Implementation funds would take over once those funds were provided to the State. Because the state is not pursuing the Duals Demo, the Duals Implementation funds will not be available. However, the work group (now renamed the disability and long term services and support work group) will continue to be part of the SIM project and will need technical support.

Two contractors have been providing technical support to this work over the past two years: Pacific Health Policy Group (PHPG) and Bailit Health Purchasing (Bailit). Two individuals have been leading this effort on behalf of these vendors: Susan Besio (PHPG) and Brendan Hogan (Bailit) and they work as a team complementing each other's skill sets. The scopes of work for these two contracts, as well as the charge of the new work group, are described below.

1. **PHPG*: $90,000 to support <u>Type 1b</u>* <u>Disability and Long Term Services and Supports</u> *<u>Work Group</u>***

The Contractor shall provide support for DLTSS Work Group tasks, activities and decision-making, including, but not limited to, the following areas:

- Care models to support integrated care for people with disabilities, chronic conditions and those needing long term services and supports
- Payment models to support integrated care for people with disabilities, chronic conditions and those needing long term services and supports
- LTSS quality and performance measures to evaluate the outcomes of people with disabilities, chronic conditions and those needing long term services and supports
- IT infrastructures to support new payment and care models for integrated care for people with disabilities, chronic conditions and those needing long term services and supports
- Strategies to incorporate person-centered, disability-related, person-directed, and cultural competency issues into all VHCIP activities
- Identification of barriers in current Medicare, Medicaid and commercial coverage and payment policies, and strategies to address them
- Other activities as identified by the Work Group to assist successful implementation of payment and care models to best support people with disabilities, chronic conditions and those needing long term services and supports.

The Contractor also shall support the DLTSS Work Group and leadership (i.e., VCHIP and DLTSS Project Staff, Work Group Chairs and other Consultants) by performing the following activities:

- Work closely with VHCIP and DLTSS Work Group leadership to strategize and develop agendas for Work Group meetings, preparing handouts and preparing discussion materials
- Actively participate in DLTSS Work Group meeting discussions
- Conduct research on specific topics and developing summary documents and / or presentations
- Provide ad hoc support for project leadership and achievement of VHCIP goals via telephone calls and electronic mail communications (e.g., exchange of information about project developments and updates, sharing of information regarding relevant topics, new publications and/or national news; discussion of recent events and implications for project direction; contributing to discussion about policy or operational decisions; etc.)
- Attend VHCIP Steering Committee meetings and other VHCIP Work Group meetings as necessary to support the goals of the DLTSS Work Group

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Deliverables:

1. Develop and / or contribute to agendas, white papers, presentations and other materials for the DLTSS Work Group, and for other VHCIP Work Groups as requested.
2. Participate in monthly DLTSS Work Group meetings, and sub work-group meetings as needed.
3. Participate in monthly DLTSS Work Group planning meetings.
4. Attend VHCIP Steering Committee meetings and other VHCIP Work group meetings as needed.
5. Provide research and summary documents to support DLTSS work plan and decision-making.
6. Work with VHCIP Project Staff regarding IT infrastructure needs by providing research, papers and documents that support Work Group recommendations and decision-making.
7. Work with VHCIP Project Staff to develop care models that support integrated care.
8. Work with VHCIP Project Staff to develop payment models that support integrated care.
9. Provide ad hoc research, analyses and communications to support DLTSS Work Group tasks and activities.

2. Bailit*: $90,000 to support Type 1b* Disability and Long Term Services and Supports *Work Group*

The Contractor shall provide support for DLTSS Work Group tasks, activities and decision-making, including, but not limited to, the following areas:

- Care models to support integrated care for people with disabilities, chronic conditions and those needing long term services and supports
- Payment models to support integrated care for people with disabilities, chronic conditions and those needing long term services and supports
- LTSS quality and performance measures to evaluate the outcomes of people with disabilities, chronic conditions and those needing long term services and supports
- IT infrastructures to support new payment and care models for integrated care for people with disabilities, chronic conditions and those needing long term services and supports
- Strategies to incorporate person-centered, disability-related, person-directed, and cultural competency issues into all VHCIP activities

- Identification of barriers in current Medicare, Medicaid and commercial coverage and payment policies, and strategies to address them
- Other activities as identified by the Work Group to assist successful implementation of payment and care models to best support people with disabilities, chronic conditions and those needing long term services and supports.

The Contractor also shall support the DLTSS Work Group and leadership (i.e., VCHIP and DLTSS Project Staff, Work Group Chairs and other Consultants) by performing the following activities:

- Work closely with VHCIP and DLTSS Work Group leadership to strategize and develop agendas for Work Group meetings, preparing handouts and preparing discussion materials
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- Provide ad hoc support for project leadership and achievement of VHCIP goals via telephone calls and electronic mail communications (e.g., exchange of information about project developments and updates, sharing of information regarding relevant topics, new publications and/or national news; discussion of recent events and implications for project direction; contributing to discussion about policy or operational decisions; etc.)
- Participate in HIT/HIE Work Group Meetings
- Attend VHCIP Steering Committee meetings and other VHCIP Work Group meetings as necessary to support the goals of the DLTSS Work Group

Deliverables:

1. Develop and / or contribute to agendas, white papers, presentations and other materials for the DLTSS Work Group, and for other VHCIP Work Groups as requested.
2. Participate in monthly DLTSS Work Group meetings, and sub work-group meetings as needed.
3. Participate in monthly DLTSS Work Group planning meetings.
4. Attend VHCIP Steering Committee meetings and other VHCIP Work group meetings as needed.
5. Provide research and summary documents to support DLTSS work plan and decision-making.
6. Work with VHCIP Project Staff regarding IT infrastructure needs by providing research, papers and documents that support Work Group recommendations and decision-making.
7. Work with VHCIP Project Staff to develop care models that support integrated care.

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8. Work with VHCIP Project Staff to develop payment models that support integrated care.
9. Provide ad hoc research, analyses and communications to support DLTSS Work Group tasks and activities.

Disability and Long Term Services and Supports Work Group Charge:
The Disability and Long Term Services and Supports Work Group will build on the extensive work of the Dual Eligible Demonstration Steering, Stakeholder, and Work Group Committees over the past two years. The goal of the Disability and Long Term Services and Supports Work Group (D-LTSS) is to incorporate into Vermont's health care reform efforts specific strategies to achieve improved quality of care, improved beneficiary experience and reduced costs for people with disabilities, chronic conditions and those needing long term services and supports. The VHCIP Disability and LTSS Work Group will:

- develop recommendations regarding the improvement of existing care models and the design of new care models to better address the needs of people with disabilities, chronic conditions and those needing long term services and supports, in concert with VHCIP efforts;
- develop recommendations regarding the design of new payment models initiated through the VHCIP project to improve outcomes and reduce costs for people with disabilities, chronic conditions and those needing long term services and supports;
- develop recommendations to integrate the service delivery systems for acute/medical care and long term services and supports;
- develop recommendations for IT infrastructure to support new payment and care models for integrated care among people with disabilities, chronic conditions and those needing long term services and supports;
- continue to address coordination and enhancement of services for the dually-eligible population and other Vermonters who have chronic health needs and/or disabilities through such mechanisms as the Medicaid ACO program, further design of Green Mountain Care, and other approaches.

Vermont Health Care Innovation Project (VHCIP)

DRAFT Project Proposal

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Population-Based Collaborative Health Information Exchange (HIE) Project

Version 1.0 - Presented to VHCIP HIE Work Group

February 5, 2013

Prepared by:

Accountable Care Coalition of the Green Mountains

Community Health Accountable Care

OneCare Vermont Accountable Care Organization

Vermont Information Technology Leaders

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VIII. Appendix C: Q and A from HIE Work Group Leaders/Members

IX. Appendix D: PowerPoint Presentation of Concept to HIE Work Group January 10, 2014

X. Appendix E: February 2, 2014 Q and A from HIE Work Group Leaders/Members

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I. Project Purpose, Background and Summary

Purpose Statement

The purpose of the project is to develop and implement a population-based infrastructure within Vermont HIE capabilities, to fully align with national health care reform through CMS and to fully align with Vermont healthcare reform which emphasizes that collaborative clinically integrated providers are held accountable for the cost and quality of health care delivered to the populations they serve.

Background

The work plan for the VHCIP/HIE Work Group states:

> "Vermont's strategy for health system innovation emphasizes several key operational components of high-performing health systems: integration within and between provider organizations, movement away from fee-for-service payment methods toward population-based models, and payment based on quality performance."

Four Vermont organizations have partnered to develop a collaborative, statewide approach designed to support this strategy. These organizations include:

- The Accountable Care Coalition of the Green Mountains (ACCGM)
- Community Health Accountable Care (CHAC)
- OneCare Vermont (OCV)
- Vermont Information Technology Leaders (VITL)

The proposal developed by the above organizations is intended to be in direct alignment with the goals of the VHCIP grant.

Over the last nine years VITL has worked closely with Vermont's healthcare providers, many of whom are members of the three ACOs, to assist them with the shift from a paper to an electronic environment (see Appendix A, ACO Participants). The result is that Vermont enjoys one of the highest electronic health record (EHR) adoption rates in the United States. At the same time, VITL has worked with these providers to build the infrastructure to connect EHRs as the source systems for clinical documentation to the Vermont Health Information Exchange (VHIE).

This progress can now be leveraged broadly to better inform clinical decision making at the point of care and to utilize clinical data for analytics and population health data management.

The advent of specific ACOs measures requires that the four organizations perform a Data Gap Analysis that aligns with the HIE Workgroup's goal 'to improve the utilization, functionality and interoperability of the source systems providing data for the exchange of health information'. A second purpose of the analysis also aligns directly with the HIE Workgroup objective to identify gaps related to EHR usage as well as the ability of source systems to provide information such as

lab results, admission/discharge/transfer (ADT) and other data needed to achieve the ACO measures.

VITL's work with healthcare provider members of the three ACOs has closed many technology gaps. However, a thorough analysis based on the ACO measures will identify gaps in technology that still exist and will result in future recommendations also aligned with the HIE Workgroup's objective to 'invest in technologies that improve the integration of health care services'. These recommendations will be submitted as part of a second proposal for 'remediation' through investments in EHRs and the development of interfaces between the EHR and the VHIE, thereby supporting the HIE Workgroup objective to 'facilitate connectivity to the HIE for ACOs and their participating providers and affiliates'.

This proposal also includes the expansion of VITL's infrastructure to support the exchange of clinical data for analytics. VITL will build 'gateways' which allow the clinical data of specific beneficiary populations to be sent to analytics sources (as directed by provider groups) for population health management. A diagram for the ACO application of these 'gateways' is included in Appendix B, ACO Gateway Architecture. It is important to stress that this technology is useful for any future population based management program. Analytics will include a combination of clinical and payer specific claims data designed to assist ACO provider members report and perform against the ACO measures.

An additional aspect of this proposal is the development of an Event Notification System (ENS) designed to inform both ACO member organizations and any authorized healthcare provider statewide choosing to participate, that a patient involved in their care has been admitted, discharged or transferred by an acute care hospital in Vermont or by Dartmouth Hitchcock Medical Center in New Hampshire. This service achieves the HIE Workgroup's related objective that technology investments result in 'enhanced communication among providers'.

The last aspect of this proposal is designed to recognize the need to provide on-going customer and system support once the technical infrastructure and technology service investments have been made. A per member per month methodology based on the total number of ACO beneficiaries has been development to sustain these support costs.

The three ACOs and VITL believe that collaborating to effectively build a single common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients directly supports the goals of the VHCIP.

The following table demonstrates the strong alignment of this project with the VHCIP HIE Workgroup objectives.

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HIE Goals	VHCIP/HIE Work Group Objectives	Alignment with Population-Based Collaborative HIE Project
To improve the utilization, functionality & interoperability of the source systems providing data for the exchange of health information	• Explore and, as appropriate, invest in technologies that improve the integration of health care services and enhanced communication among providers • Identify core requirements for source systems to meet SOV HIE standards	→ Event Notification System → Data Gap Analysis
To improve data quality and accuracy for the exchange of health information	• Increase resources to facilitate improved EHR utilization at the provider practice level • Identify and resolve gaps in EHR usage, lab result, ADT, and immunization reporting, and transmission of useable CCDs. • Improve consistency in data gathering and entry • Support the Development of advanced analytics and reporting systems as needed	→ Data Gap Analysis → Data Gap Remediation → ACO Gateways
To improve the ability of all health and human services professionals to exchange health information	• Facilitate connectivity to the HIE for ACOs and their participating providers and affiliates • Standardize technical connectivity requirements to participating provider entities • Facilitate EHR adoption to current non-adopters • Facilitate connectivity to providers who are not yet connected to the HIE regardless of ACO participation	→ Data Gap Remediation → Data Gap Remediation → Date Gap Remediation → Data Gap Remediation

The benefits we intend to achieve as a result of funding this proposal include:

- Making rapid progress against the state HIE plan
- Providing a path for 2014 patient care benefits of healthcare information exchange across providers and through ACO population approaches
- Exploits the efficiencies of a collaborative project effort involving all three Vermont ACOs, their providers, VITL and the VHCIP work group
- Provides a mechanism for the VHCIP work group to measure and demonstrate tangible progress

We are excited with the opportunity to advance healthcare reform efforts in Vermont and believe this proposal assures that a health care system is affordable and sustainable through coordinated efforts to lower overall costs and improve health and health care for Vermonters.

II. Scope of Work

Project Activity Scope

There are three major threads to the project we are proposing:

1) **Connect Providers (Information from Providers to VITL)**
    a. Hospitals – Various Systems Interfaced to VITL
    b. Physician/Ambulatory EHRs Interfaced to VITL
    c. Community Providers Information Interfaced to VITL
    d. Home Health, Skilled Nursing Facilities, Designated Agencies for Mental Health, Substance Abuse, and Developmental Disabilities, and other Designated and Specialized Service Agencies.
    e. Potential – Other Information Sources Interfaced to VITL
2) **Make Information Available (Information from VITL to providers, ACOs, others)**
    a. Complete development and implementation of electronic population ‘gateway’ to GMCB/State Analytic Vendors/ACOs/Payers
        i. Supports analytic systems and payment reform efforts
        ii. Enables full-functionality NNEACC tool for OneCare Vermont ACO and its providers
        iii. Enables full functionality tool for CHAC and ACCGM analytics vendors
3) **Install and activate an Event Notification System (ENS)**
    a. Select a vendor and install an ENS
        i. Provides notification to health care providers of medical events that might trigger interventional care, e.g., an ED admission or a hospital discharge.
        ii. The ENS can be used by any health care provider in Vermont

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Project Data Scope

CHAC, OneCare, and ACCGM have collectively identified several Health Information Exchange needs. It will prove imperative for the ACOs to receive at the ACO level real-time admission, discharge, and transfer information re: ACO beneficiaries, wherever they are in the health system. The ACOs would also find value in receiving real-time lab results, discharge summaries, radiology reports, and immunization results. The tasks to be completed, specific deliverables, and timelines are listed in the table below.

		Task	Deliverable	Target Date
Gap Analysis			**The analysis is for all year 1 measures, inclusive of Medicare, Medicaid and Commercial**	
		Who has an EHR	VITL will identify for each participant for whom we have EHR data the EHR used by that participant.	Q1 2014
		Those who are unknowns	Based on the outcome of Task #1, VITL will contact each participant for whom VITL has no EHR information. VITL will update its customer base to reduce the number of OCV participants with unknown EHRs.	Q1 2014
		Hospitals sending lab results	VITL has knowledge of which hospitals are sending lab results to the VHIE. There is not a dependency on practices.	Q1 2014
		Health care organizations sending ADT	VITL has knowledge of which health care organizations are sending ADT to the VHIE. This includes hospitals and practices. VITL will also indicate which organizations could technically send an ADT but are not in the process of building an ADT interface.	Q1 2014

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		Task	Deliverable	Target Date
		Health care organizations sending immunization	VITL has knowledge of which health care organizations are sending VXU (immunizations) to the VHIE. This includes hospitals and practices. VITL will also indicate which organizations could technically send a VXU but are not in the process of building a VXU interface.	Q1 2014
		Health care organizations sending CCDs	VITL knows which organizations are sending clinical data through the VHIE. VITL will be able to identify which organizations are sending CCDs that could be parsed and forwarded to NNEACC in a flat file for NNEACC analytics. VITL will also indicate which organizations could technically send a CCD but are not in the process of building a CCD interface.	Q1 2014
		For those organizations ending CCDs, what quality measures are included	VITL will review data in Docsite to identify which of the quality measure data elements are included in a CCD for those organizations sending CCDs.	Q1 2014
Gateway				
	OCV Medicare			
		Build Medicity functionality - Beneficiary file	A OCV master person index is created for Medicare beneficiaries	Q1 2014

		Task	Deliverable	Target Date
		OCV Labs	OCV Medicare filtering on labs is complete, and sent to NNEACC	Q1 2014
		OCV ADT, CCD, VXU	OCV Medicare filtering on ADT, CCD and VXU is complete, and sent to NNEACC	Q2 2014
		Build NNEACC CCD Interfaces	Convert inbound CCDs to a flat file for NNEACC	Q3 2014
	OCV Medicaid			
		Build Medicity functionality - Beneficiary file	A OCV master person index is created for Medicaid beneficiaries	Q3 2014
		OCV Labs, ADT, CCD, VXU	OCV Medicaid filtering on lab, ADT, CCD and VXU is complete, and sent to NNEACC	Q3 2014
	OCV Commercial			
		Build Medicity functionality - Beneficiary file	A OCV master person index is created for commercial beneficiaries	Q3 2014
		OCV Labs, ADT, CCD, VXU	OCV commercial filtering on lab, ADT, CCD and VXU is complete, and sent to NNEACC	Q3 2014
	CHAC			

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		Task	Deliverable	Target Date
		Build Medicity functionality - Beneficiary file	A CHAC master person index is created for CHAC beneficiaries	Q4 2014
		OCV Labs, ADT, CCD, VXU	CHAC beneficiary Medicare filtering on lab, ADT, CCD and VXU is complete, and sent to NNEACC	Q4 2014
	ACCGM			
		Build Medicity functionality - Beneficiary file	An ACCGM master person index is created for ACCGM Medicare and commercial beneficiaries	Q4 2014
		OCV Labs, ADT, CCD, VXU	ACCGM beneficiary Medicare and commercial filtering on lab, ADT, CCD and VXU is complete, and sent to NNEACC	Q4 2014
	ENS		An Event Notification System (ENS) delivers real-time ADT information about a patient's medical services encounter, for instance at the time of hospitalization, to a permitted recipient with an existing relationship to the patient, such as a primary care provider. The functionality is not limited to ACOs, but is open to any health care provider.	
		One time software license purchase	Software license fee	Q4 2014

		Task	Deliverable	Target Date
		One time ENS Implementation	Implementation fee	Q4 2014
		One time hosting environment setup	Build the hosting infrastructure	Q4 2014
		Onboarding per provider organization	Onboarding the organization that will receive event notifications	Q4 2014
First Year Support				
		OCV Medicare		Feb 2014
		OCV Medicaid		June 2014
		Commercial		July 2014
		CHAC		November 2014
		ACCGM		[not live 2014]

III. Health Care Delivery System Impact

There is broad agreement on the power and importance of health information exchange (HIE) in providing well-coordinated, high quality healthcare which avoids waste. Both Vermont and national reform have focused on new programs and incentives for networks of health care providers to take accountability for populations of patients they serve. In Vermont, the formation of these networks and participation in available programs has been very strong, and this is now a part of the unique Vermont story growing nationally. The types of providers across the continuum of care and services represented at the table are also expanding. Appendix A shows the three ACO organizations in Vermont and the very broad network of participation they have today.

Given the strong ACO participation, we are envisioning many cross-collaborative relationships which further supports this multi-ACO approach to HIE. Although some providers have not decided to participate with any of the ACOs to date, we expect this project and approach to connect and support providers who may end up taking an independent path under reform. We believe that incentives to be a part of an ACO network should exist, but would expect some pathway will be available to those who choose independence but wish to collaborate on patient care.

ACO-based programs use a model of "attribution" of patients based on physician relationships with patients and are strongly focused on primary care relationships. As the table indicates, there are nearly 450 primary care physicians representing a strong majority of all the primary care physicians in the state of Vermont participating across the three ACO organizations. With the payer programs in place or expected to be in place for Medicare, Medicaid, and across the Vermont Health Connect plans from Blue Cross Blue Shield of Vermont and MVP Healthcare, we expect over 100,000 Vermonters to be attributed in 2014 and grow over time.

To proactively coordinate care and measure quality, Vermont's ACOs envision the availability of the key information tools described earlier from VITL to support our efforts. We plan to make great use of the population-based pipeline of information to (a) feed our ACO analytic and care management systems, and (b) support collaborative processes across the continuum of care, especially as patients transition from one setting of care to another. Specific examples of tools and processes that will be enabled by the project requested in this document, with its additive HIE infrastructure developed by VITL, are anticipated to include:

- Combined cost, utilization, quality, and clinical reporting to fully capture the current performance and opportunities for improving care to a population of patients
- Generation of such population-based analysis at any level desired: compare among ACOs, ACO wide, regional, local community, or individual practice or provider

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- More refined and accurate reports identifying specific "capturable" opportunities for improvement; an example would be greatly expanding analysis on metrics based on national physician associations guidelines on avoiding waste and unnecessary care based on evidenced based research (example: "Choosing Wisely" campaign)
- Real time quality metric performance monitoring for the designated population measures in ACO programs; an ACOs population "score" can be known through the year giving us an opportunity to improve
- Automated annual submissions of quality information to CMS, DVHA, Commercial Payers, and the GMCB for the selected patient samples rather than relying on retrospective (and costly) chart or EHR audits
- Movement beyond simple and incomplete registries of patients with chronic illness into a much richer and effective chronic disease management program based on complete clinical information and risk analysis
- Drive evidenced-based care "gap analysis" by patient to ensure no patient falls through the cracks who would benefit from specific approaches based on clinical outcomes research
- Drives systems to better assign patients needing care coordination to "work lists" for those most able to engage with that patients and coordinate their care, whether they be staff in the PCMH, hospital, community based provider, home health agency, designated agency, other support services programs, or at the ACO itself.
- Provides those assigned a "care manager" the tools and combined visit history and clinical snapshot of the patient to jump start and monitor that patient's care
- Provide a single real time source alerting those involved in a patient's care about a major clinical event (such as a hospital admission or Emergency Room visit); this will allow more proactive coordination and planning for that patient's needs given the acute nature of the major events

Please note that these are all systems and processes in development, and to be deployed using the underlying capabilities from this project. Some including the Event Notification System are included in the project scope, but others are being developed by the ACOs and their providers. Not all the tools and processes above will be defined and in place by the end of the project and may vary in scope and design by each ACO. Additional VHCIP assistance for an ACO or among the ACOs in developing and deploying the systems and processes described above may be included in other projects proposals for VHCIP work groups.

Overall, the three ACOs and non-ACO estimates are given in Appendix A.

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IV. Project Budget

Project Budget

A table summarizing the project budget by components is as follows:

		Item	Units	Rate	Labor	Purchased Service	Total	Justification
Salaries and Wages								
		Project Managers	3,470.40	$ 125	$ 433,800		$ 433,800	These are fuly loaded rate, incldunig salary, benefits, overhead, and contingency. There are 2-3 project managers almost full time. No costs have been inlcuded for ENS implementation and eHealth Secialists for gap analysis.
Subtotal Salaries							**$ 433,800**	
Systems								
	OCV Medicare							
		Build Medicity functionality - Beneficiary file	1			$ 12,650	$ 12,650	
		OCV Labs	1			$ 132,250	$ 132,250	
		OCV ADT, CCD, VXU	1			$ 250,700	$ 250,700	
		Build NNEACC CCD	1			$ 34,500	$ 34,500	
	OCV Medicaid							
		Build Medicity functionality - Beneficiary file	1			$ 12,650	$ 12,650	
		OCV Labs, ADT, CCD, VXU	1			$ 172,500	$ 172,500	
	OCV Commercial							
		Build Medicity functionality - Beneficiary file	1			$ 12,650	$ 12,650	
		OCV Labs, ADT, CCD, VXU	1			$ 172,500	$ 172,500	
	CHAC							
		Build Medicity functionality - Beneficiary file	1			$ 12,650	$ 12,650	
		OCV Labs, ADT, CCD, VXU	1			$ 172,500	$ 172,500	
	ACCGM							
		Build Medicity functionality - Beneficiary file	1			$ 12,650	$ 12,650	
		OCV Labs, ADT, CCD, VXU	1			$ 172,500	$ 172,500	

		Item	Units	Rate	Labor	Purchased Service	Total	Justification
Systems								
	ENS							
		One time software license purchase	1			$ 125,000	$ 125,000	
		One time ENS Implementation	1			$ 156,250	$ 156,250	
		One time hosting environment setup	1			$ 31,250	$ 31,250	
		Onboarding per provider organization	100			$ 312,500	$ 312,500	
Subtotal Systems							**$ 1,795,700**	
First Year Support								
		OCV Medicare	1				$ 465,740	Prorated at # of beneficiaries * number of months expected to be live * $.73 PMPM
		OCV Medicaid	1				$ 127,020	
		Commercial	1				$ 118,552	
		CHAC	1				$ 82,986	
		ACCGM	1				$ -	
Subtotal First Year Suport							**$ 794,298**	
Total First Year							**$ 3,023,798**	

The hours for project managers are spread across all projects.

V. **Sustainability Plan**

This proposal identifies specific investments in four key aspects of developing and sustaining health information exchange capabilities and services needed by Vermont's ACOs to achieve their goals as part of Vermont's healthcare reform efforts.

The four organizations have managed to move the collaboration along through a common goal for a unified system, with open and positive discussion, and facilitation by state representatives and VITL staff. Governance discussions have continued, topics including a potential steering committee consisting of the collaboratives' representatives, and appropriate state membership (tbd).

The gap analysis will identify the gaps that exist among state-wide ACO data requirements and data capacity. The prioritization and costs associated with the remediation of those gaps will be part of a second proposal. The building of ACO 'gateways' leverages the existing infrastructure of the VHIE by deploying the technical architecture to support movement of data from source systems to analytics destinations. Installing a system that improves quality and timeliness of transitions of care through real-time notification of important clinical encounters leverages and expands the VHIE's capabilities to provide a service for all Vermont healthcare providers.

Once investments are made in technology and services, the on-going costs associated with providing customer and system support need to be sustained financially.

These costs include customer support to ACO participants and encompass: patient identity management; interface maintenance, upgrades and replacement; continuously measuring and improving data quality; and the provision of a 24x7 support center.

Sustaining costs for system infrastructure support include: interface monitoring; monitoring message routing; maintaining beneficiary matching rules; maintaining message transformers to include consent flags; resolving errors and performing testing on new interfaces; and maintaining provider profiles and other aspects of an Event Notification System.

The investments recommended in this proposal are minimal in comparison to the investments made to develop and maintain the VHIE, yet are designed to leverage current technological capabilities to directly support ACO needs as part of healthcare reform efforts. It is anticipated that accountable care approaches to the Medicare beneficiary population will be expanded over the next few years to include Medicaid and commercially insured beneficiary populations. The VHIE and the investments recommended in this proposal will continue to be leveraged to support the data exchange and measures based analytic services required to support these additional ACO and other beneficiary populations.

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In 2014 the proposed technology investments will shift from implementation to the need to provide ongoing customer and system support. As a result, these costs will occur incrementally and can be linked to the specific capabilities and functions the investments generate.

VITL is undertaking these technologies based on both the existing infrastructure of the VHIE and its internal capabilities, expertise and experience with the exchange of health information. Some of the requested services are at the forefront of HIE technology so precise costs associated with deployment and sustainability are not completely known. As a result, a range for the costs of sustaining the technology have been developed within the total not to exceed investment request.

The methodology used to develop a framework for estimating the costs of sustaining customer and system support was based on expectations of growth in the ACO beneficiary population. VITL's costs for sustaining the VHIE, as a subset of its total expenses, was used to determine customer and system support costs. The development of a per member per month rate was developed by dividing the total potential number of ACO beneficiary population members by the costs associated with sustaining the VHIE.

This proposal's request for support cost funding encompasses a range from $570,000 to $800,000 based on the computed per member per month rate, estimates of timelines for technology shifting from implementation to support and estimates of increases in ACO beneficiary populations over the first year of the VHCIP.

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Appendix A – ACO Participants

Accountable Care Organization (ACO) Networks in Vermont

ACO/Network	Hospitals	Federally Qualified Health Centers (FQHC)	Primary Care Physicians (PCP)	Specialty Care Physicians (SCP)	Skilled Nursing Facility (SNF)	Home Health Agencies (HH)	Designated Agencies (DA) for Mental Health & Substance Abuse (MH & SA)	Other Designated Agencies (DA) and/or Long Term Supports & Services (LTSS)
OneCare Vermont (OCV)	2 AMCs 5 Community PPS 8 CAH 1 MH Specialty Hospital	3 FQHCs	All Hospital employed (60 Practices) Participating FQHC Practice Sites (8 Practices) 12 Independent Practices **TOTAL: 300+ PCP FTEs**	All Hospital Employed (1800 Physicians) 30 Independent Specialty Practices (60 Physicians)	All Hospital Owned SNF included Additional Affiliate Agreements with 29 Independent SNF	Affiliate Agreements with 10 Local Home Health Agencies	Affiliate Agreements with 10 Mental Health and Substance Abuse Agencies	Network Affiliate Agreements Expected
Community Health Accountable Care (CHAC)	Expected Local Collaboration	7 FQHCs	Participating FQHC Practice Sites (35 Practice Sites) **TOTAL: 100+ PCP FTEs**	Any FQHC Employed	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected
Accountable Care Coalition of the Green Mountains (ACCGM) for Medicare SSP **Vermont Collaborative Physicians (VCP) for Commercial Exchange SSP** NOTE: Both in collaboration with HealthFirst Independent Physician Network	Expected Local Collaboration	None	15 Independent Practices **TOTAL: 45+ PCP FTEs**	Independent Specialty Practices Collaboration through HealthFirst	Expected Local Collaborations	Expected Local Collaborations	Expected Local Collaborations	Expected Local Collaborations
Vermont Sub-Total in ACOs	100%	91%	70% (Approx.)	85% (Approx.)	80% (Approx.)	80% (Approx.)	100%	TBD

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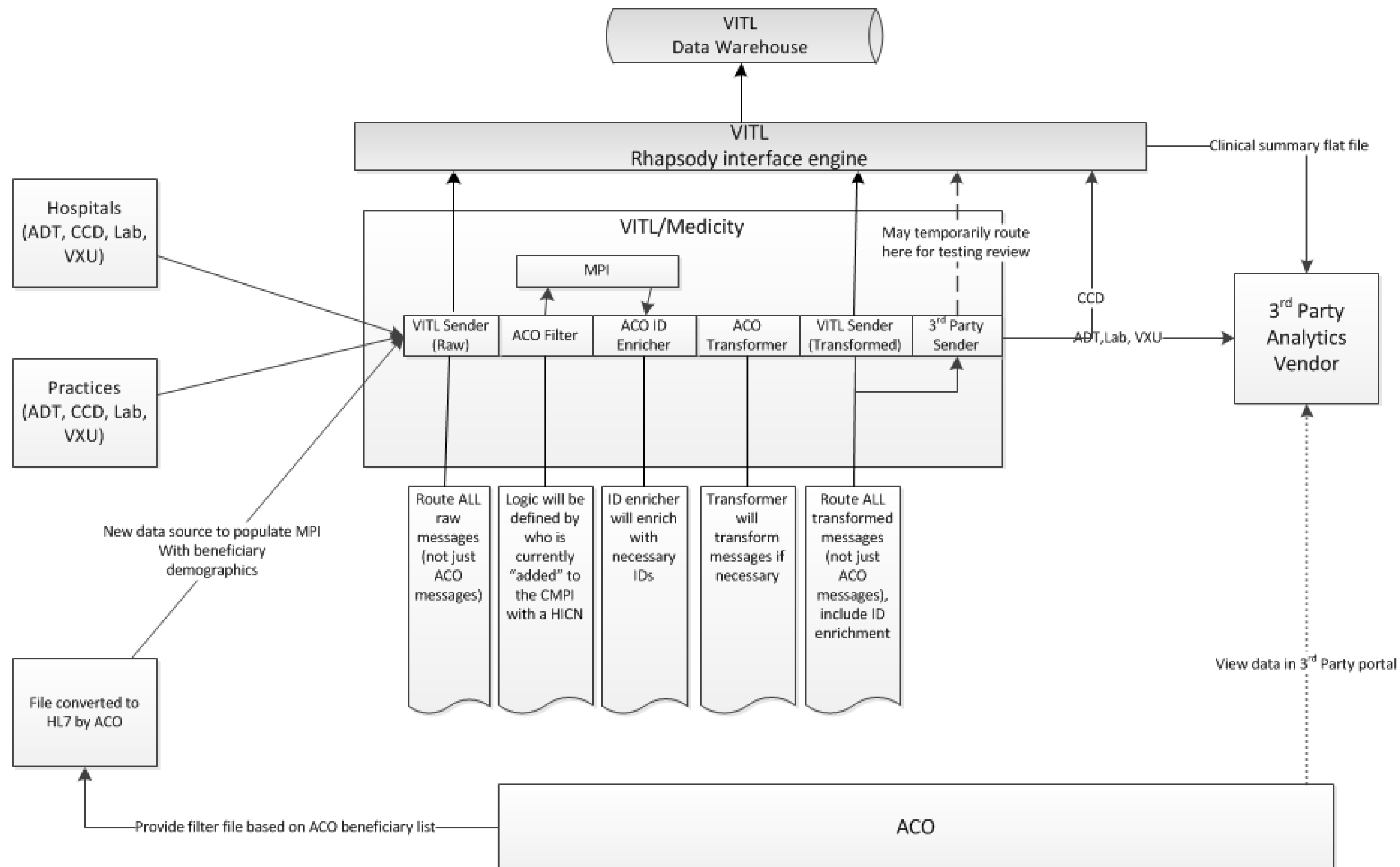
Appendix B – ACO Gateway Architecture



Appendix C - HIE Work Group Q & A

Questions for the Population-Based Collaborative Health Information Exchange (HIE) Project Presenters - January 17, 2014

Introduction

Several of the questions relate to the statewide impact to non-ACO providers. Briefly, this is how non-ACO providers would envision their participation in health care reform.

VITL sends and receives data from health care organizations throughout Vermont, including all hospitals, most FQHCs, a majority of primary care providers, and other specialists and long term care. The data is not specific to ACOs and beneficiary populations. The patient care goals of ACOs are to collect quality clinical data electronically. Their facilitation for their members to achieve these goals in turn expands quality clinical data in the Vermont Health Information Exchange (VHIE). The VHIE is not restrictive to ACO providers, but is accessible to any health care provider who has signed the appropriate legal agreements with VITL. Providers may access the VHIE through a provider portal. In addition, any health care provider may participate in the Event Notification System, again, not restrictive to ACO providers. In summary then, the emphasis on quality clinical electronic data by the ACO and an Event Notification System accrues to both ACO and non-ACO providers.

The questions below were submitted by the VHCIP/HIE Work Group.

Questions related to budget:

1. *[This question was submitted by the Work Group leadership team]* Your budget has a range of $2,110,000 to $3,045,000. In order for the HIE Work Group to consider a recommendation, you will either need to provide a specific budget number or a "not to exceed" number that can be incorporated into an Agreement/Contract and a statement of work to support the estimated budget. Please provide a more detailed statement of work and the specific amount or "not to exceed number" you would like the work group to consider.
   The ACOs and VITL are in an early planning phase. Although we believe the range provided is sound based on significant experience by VITL leadership, we are working on more firm specifications from which a more detailed model of timing and use of funds by VITL, including obtaining firm quotes by third party technology partners, can be developed. The desire is to be as specific and cost

conscious as possible once the quotes have been obtained, but some patience and understanding of the pioneering nature of this work is requested. Our formal request for the system build currently outlined at this point can be considered as a not to exceed $3M budget.

2. *[This question was submitted by the Work Group leadership team]* Is it the intention of the PAN ACO group to seek additional SIM/VHCIP funding for Gap Remediation and support costs in 2015 and 2016? In this regard, the work group is also interested in the sustainability plan for supporting the costs of this infrastructure beyond 2016. As part of the sustainability plan, please indicate which parts of the project will be on-going operational expenses as opposed to developmental expenses.

   Would you please provide the group with an estimate of additional costs that you will be asking the work group to support, if any, and what other sources of funding you intend to pursue to insure the sustainability of this infrastructure beyond 2016.

   - **We envision this system becoming the back bone data system for much of the health reform effort during the next number of years. Once built, many participants, the state and commercial insurers included, in addition to the ACOs, are likely to derive benefits through more information and better coordination of care and cost management. Consequently, the ACOs envision full funding of system maintenance support through VHCIP until at least 2016 or at least until shared savings begin to occur. This would come from either (or a combination of) additional SIM/VHCIP funds in 2015/2016 or through a separate sustainable ACO operational funding model (with VITL support fees included) as developed through other mechanisms and implemented for 2015 or 2016. VITL is looking for confirmation that support costs will continue after development and implementation of the infrastructure.**
   - **Funding of maintenance and system enhancements beyond 2016 will, in all likelihood, need to be funded by all of the participants and beneficiaries of an improved care coordination model. We envision this sustainable model of ACO funding (again, with VITL support fees included) must be fully developed (negotiated) and implemented before the end of 2016 to ensure sustainability of the system. These discussions should begin in the second half of 2014.**
     - **To specify the funds needed in the 2015/2016, and beyond, the ACOs will need to provide attributed lives for 3 years to VITL**
   - **We will also provide targeted funds needed for Gap Remediation (currently TBD) by June 2014**

3. As with the FQHCs, the IT resources at DA/SSAs and other full spectrum provider agencies are limited. The Pan ACO proposal will require quite a bit of agency IT staff time. Will the Pan ACO proposal provide incentive payments/stipends/subsidies for these agencies?
   No incentive payments/stipends/subsidies were included in the initial proposal for either the current or prospective ACO members. We envisioned that these sorts of

additional resources, if needed, would be identified in the Gap Remediation plan. Separate funding can then be requested either as part of an expanded ACO request or by the organizations themselves.

4. Does the $0 figure for gap analysis in the "Support Costs" section assume that all gaps/challenges will be identified initially and that no others will be discovered in subsequent project years? What happens when there are changes in ACO-provider affiliations after the gap analysis is complete?
Gap analysis will be used to determine plans for gap remediation. Gaps will continue to be generated, e.g., EHR replacement in the future. This funding request is for ACO gaps that currently exist. A reasonable level of change in ACO programs and subsequent HIE needs are part of the ongoing support payments model, but any major changes in approach, number of measures, or other ACO requirements may require additional one-time projects and new gap analysis and remediation.

5. It seems there are still questions about the feasibility of funding Gap Remediation activities. In the event that VHCIP funding is not available (or not sufficient to cover all remediation activity), how will remediation be funded? If only *limited* funding is available for remediation, how will providers/practices be prioritized for EHR upgrades & related activities? This is particularly relevant for provider types known to have large gaps at present. In the absence of a plan for addressing the costs of subsequent phases, the initial investment of $2-3M is concerning. [The major investment is in the gateway build, but the utility of a gateway seems limited if there are still problems with capturing and transmitting data accurately.]
Most likely, the ACO proposal will as we've indicated create the backbone for a system which will be expanded to other users over some number of years, and through a variety of funding sources in addition to those we have now. We envision handling this problem as it arises and with the clarity of the results of the gap analysis. In general, if needs are beyond resources and such limits are placed, priority will be set based on attributed lives and the providers holding the source data elements for the required quality measures of ACO programs. Subsequent funding sources will likely need to be found and employed for further rounds of gap remediation.

Questions related to vendor selection:

6. *[This question was submitted by the Work Group leadership team]* We assume that you are recommending that this contract, if approved, would be with VITL as the provider of the services you have described. Please confirm, and please also confirm that VITL agrees with this arrangement.
We agree and third party contracts required would be sub-contractors to VITL.

Questions related to scope of work and/or existing contracts:

7. *[This question was submitted by the Work Group leadership team]* We are aware that VITL has an existing contract with DVHA to fund specific work that is related to what the PAN ACO Group is proposing. Please describe the specific work that is being funded under the current DVHA contract, what the status of that work is, and specifically how the PAN ACO proposal would supplement, not duplicate the work that is already under contract. The Work Group wants to be very clear that it does not intend to recommend funding for work that is already under contract.
   The grant agreement between DVHA and VITL covers, in general:

   - **New interfaces to hospitals, designated agencies, home health, and specialists**
   - **Provide "REC-like" services to organizations other than primary care**
   - **Expand the VITL in-house infrastructure**
   - **Conduct several exploratory projects that would facilitate faster interface implementation**

   None of these services would be funded through SIM. The Pan ACO work is focused on filtering data based on a beneficiary population against membership of an entity (ACO), which had not been envisioned when the DVHA-VITL agreement was developed in the spring of 2013. This new work will primarily include both a general clinical data feed (ACO Gateway) for a beneficiary population and an event notification system (ENS). The budget for the Event Notification System is for license and implementation which does not overlap labor estimates in the DVHA grant, which is focused on proof of concept and will include RFP development, and vendor evaluation and selection. Additional focus is also being added for the ACO program-specific data elements for the new Vermont Shared Savings programs which were approved by the VHCIP and not known previously. To emphasize, the SIM funding will not fund any work defined previously in the DVHA grant.

8. *[This question was submitted by the Work Group leadership team]* The State requires specific statements of deliverables and timelines in all contracts that it executes. In order to develop a contract with you, we will need you to provide a written estimate of the deliverables related to your Scope of Work, and the timelines associated with each of those deliverables.
   Yes, we understand and agree.

9. Broadly, it would be helpful to see significantly more detail about how the project will proceed, and how the work group /VHCIP governance will be kept apprised of progress and challenges on a regular basis.
   The Pan ACOs and VITL recommend summary updates at each HIE workgroup and more detailed and substantial updates quarterly. We anticipate HIE work group chairs will provide SIM Steering Committee updates on the project and sponsor (if desired) our quarterly updates onto the Steering Committee agenda. In addition, a more detailed project plan and budget are being prepared to help all committees involved in the recommendation and approval process to be clearer on proposed deliverables, timelines, and cost estimates.

10. How will provider types be prioritized for assessment during the gap analysis? Has a schedule been developed for this component, and what activities will the gap analysis include?
No prioritization is necessary and all ACO provider participants including affiliate participants are included. A schedule exists and the analysis is underway. Scope:

Task	**Description**
1. Who has an EHR	VITL maintains customer information on all ACO participants. VITL will identify for each participant for whom we have EHR data the EHR used by that participant.
2. Those who are unknowns	Based on the outcome of Task #1, VITL will contact each participant for whom VITL has no EHR information. VITL will update its customer base to reduce the number of ACO participants with unknown EHRs.
3. Hospitals sending lab results	VITL has knowledge of which hospitals are sending lab results to the VHIE. There is not a dependency on practices.
4. Health care organizations sending ADT	VITL has knowledge of which health care organizations are sending ADT to the VHIE. This includes hospitals and practices. VITL will also indicate which organizations could technically send an ADT but are not in the process of building an ADT interface.
5. Health care organizations sending VXU	VITL has knowledge of which health care organizations are sending VXU (immunizations) to the VHIE. This includes hospitals and practices. VITL will also indicate which organizations could technically send a VXU but are not in the process of building a VXU interface.
6. Organizations sending CCDs (clinical summaries) through the VHIE (does not specify what they are sending)	VITL knows which organizations are sending clinical data through the VHIE. VITL will be able to identify which organizations are sending CCDs that could be parsed and forwarded to NNEACC in a flat file for NNEACC analytics. VITL will also indicate which organizations could technically send a CCD but are not in the process of building a CCD interface.

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Task	Description
7. The GMCB approved quality measure data elements include measures that may be included in a Blueprint CCD. For those organizations sending CCDs VITL will identify which of the ACO-Blueprint measures are actually being sent.	VITL will review data in Docsite to identify which of the quality measure data elements are included in a CCD for those organizations sending CCDs.

11. I'm somewhat concerned about the scope of the gap analysis with respect to measures. Though the list of measures to be considered is substantial, it is by no means comprehensive. This investment may well improve providers' abilities to capture quality information for a finite set of (largely primary care) measures, but achieving near-perfect electronic collection of these measures—as currently specified—after several years won't necessarily be sufficient in an ever-evolving measure environment, nor will it aid other provider types in collection of measures relevant to their services.
    We are working on the existing scope of work for the gap analysis based on the VHCIP Data Subgroup measures. We believe that building the documentation methods and HIE connections focused on this important and varied set of measures will pave the way for additional measures (i.e. let's prove we can do it for these measures and not get bogged down with too many competing information elements).

12. Could you provide a description of the longer-term impacts of the proposed work in a post-ACO context? Given that the ACO model is designed to be a transitional model, and considering the size of the investment and the projected duration of this effort, it would be helpful to know how the products and benefits will translate to subsequent models or systems.
    Although "Shared Savings Programs" with quality and satisfaction measures are generally considered to be transitional models, we anticipate that clinically integrated networks of providers (whether called ACOs or not) taking accountability for the total cost and quality of populations will be a long term model of healthcare delivery. Data sharing will remain a key and will continue post SIM funding. As indicated previously, we believe we are building the foundation data engine for the State of Vermont, and this model will be useful for any population of attributed lives. We think subsequent rounds of funding will very readily provide expansion for other stakeholders.

13. On slide 7, "Well designed tools and interfaces to access that information subject to data use agreements and patient consent model." What I see as potentially missing is a view to the aggregate state data. I think the outlined efforts assist in getting a more complete data set by increasing the network effect, but I don't see in the proposal a plan to create and analyze the data at a state aggregate level. It serves a mutual purpose to all ACOs to build the platform so they can take their own data out for use by their analytic tools for their patient population, but from a payment and quality perspective there may be a need for a tool to look at it from a more global perspective. Is that one of things considered in the "3rd Party Analytics Vendors?" Medicity isn't positioned to provide analytics at a population level. That said, the project underway as mentioned before, may be a catalyst that is beneficial to the State if it is done well. There is a benefit to the ACOs to ensure quality (they don't want garbage out).
The scope of the request does not include designing or providing, or allocating funds for ACOs to obtain and deploy analytics systems. The scope provides a foundation for improvements of data quality, to feed into the analytics vendors. We do believe a separate dialogue on this is a worthwhile discussion however, and in all probability, this project will provide the pathway for statewide analytics.

14. Event notification is missing in the current HIE system, and needed. An overlay with the Care Models group should be a discussion of what should happen for patients who have a triggering event, but aren't engaged in the current care system. That won't be a question the ACOs are primarily focused on. For them, it's a person, but not one of their members for whom they are responsible. It may come down to the State who is looking out to the common good to pursue that question.
The Event Notification System is important to the success of the ACOs and better patient management, so it is being requested by the ACOs as part of the scope of the project. However, ENS is global, not specific to ACOs. We expect this to be used by providers regardless of their participation in an ACO.

15. On Slide 9, in order to understand how care transitions will be impacted by event notification, please provide descriptions (e.g. use case examples) describing how "Event notification" will benefit people receiving services from providers working in the following settings:
    - private homes –case manager or family member managing person's services
    - residential care home manager
    - adult day center director
    - designated agency case managers
    - nursing facility discharge planners

    Providers in each of the aforementioned settings will have access to the Event Notification System once they have signed a data sue agreement with VITL. This type of design and use of case process will be a part of the ACO work with its network and with the VHCIP Care Models and Care Management subgroup where common

approaches across ACOs is warranted. We expect the ENS system once created to expand as needed within the entire health care delivery system.

16. Can you provide specific clinical examples of how this grant will improve the delivery of care in Vermont? And for care delivered by practices not in the ACO?
    - **This will provide data to analytics vendors to enable ACOs to do central analysis and identification of population-level improvement opportunities, as well as deploy patient-level systems to providers identifying specific gaps in care and evidence-based suggestions for clinical interventions to reduce more costly services and improve quality.**
    - **This will allow more progress more rapidly than other approaches for providers to see aggregated data on their patients across the Vermont network in support of patient management and site of service care delivery**
    - **The emphasis on data quality for ACOs to achieve their cost savings benefits patients regardless of their insurance coverage. Practices not in an ACO may have access to that data.**
    - **Practices not in an ACO will be able to fully utilize the Event Notification System.**

17. Will this proposal provide resources to individual practices to develop interfaces with the HIE or the ACO or others?
    Additional resources may be identified in gap remediation. This is specific to the defined scope of the Pan ACOs, including Participating Providers and Affiliates. Some work on HIE interfaces is already within the scope of VITLs contracts with DVHA, other work required outside the scope of this project will most likely require other VHCIP or other funding

18. How does this proposal implement efficient, cost-effective bi-directional solutions for sharing key information across provider types, since many LTSS providers lack EHR.
    a. On Slide 8, is bi-directional communication between all types of providers participating in an ACO implied in the phrase "electronic data to be routed to ACOs"? Please explain and give examples.
    We will include assessment of data elements needed from these providers and they will be able to participate in an ENS and can access data in VITL Access. We expect the gap analysis to identify where gaps exist and the extent of remediation work and funding required.

19. Could this work be expanded to include processes to share information across provider types through web portals that support common tools (e.g. uniform transition of care form)?
    Yes, it could be expanded through VITL Access or ACO-based analytic and care management systems. We fully expect this work to lead directly to increased ability to share information. It is not however in the current scope of this proposal.

20. On Slide 3 what is meant by "relevant clinical information"

At a minimum the data elements required to support CMS-defined and VHCIP-developed and GMCB approved quality measures and events.

21. On Slide 6, Please describe the benefits of "the Gateway Build" for people receiving services from providers working in community based settings (e.g. private homes, Area Agencies on Aging, residential care homes, adult day centers).
    a. On Slide 9, how will the "Gateway Build" be used to connect long-term services and support providers with primary care and hospital providers? Please provide descriptions (e.g. use case examples) describing which "source systems" will be connected (e.g. OASIS? MDS? DA/EHR? etc.)
    b. On Slide 10, can a more detailed explanation of the ACO Gateway Architecture be shared?

    VITL is glad to provide more detail on what functionality is provided by a gateway, as a data disseminator. Again, this proposed system and project form the foundation upon which we think much of the statewide data sharing will ultimately occur. Gap remediation is intended to identify where further work will be needed and to frame some discussions as to priorities and resources needed. Ultimately, the success of the system and the benefits which accrue to patients will be dependent on the universality of coverage, so the long term goal is to connect all providers.

Questions related to data, including potential data collection restrictions:

22. *[This question was submitted by the Work Group leadership team]* Specific concerns have been raised by members of the work group regarding the ability of the Designated Mental Health Agencies to share information with VITL and other providers given the privacy restrictions related to the exchange of sensitive health information, including especially from federally regulated substance abuse treatment programs (42 CFR Part 2). How do you intend to address those restrictions in your proposal?
    The scope of work for the ACOs does not include addressing 42 CFR Part 2. VITL is pursuing some options with DVHA that are parallel and independent of the Pan ACO work. A formal plan for addressing the issue is being developed jointly among VITL, DVHA, FQHCs, and the Designated Agencies.

23. What about Specialized Service Agencies? How does their client data fit in? (NFI, small Developmental Disability stand-alone agencies)
    The proposed scope is ACO membership and affiliates at this time but we hope to involve all who touch ACO-attributed patients in the discussion

24. What kind of access will affiliate providers have to the data analytics for their clients? There are a number of platforms so that may differ from one ACO to the other.
    This is the outcome of ACO specific decisions. ACOs intend to deploy analytics to providers across the continuum of care community.

25. What will be the impact on existing infrastructure? I see the work with the VHIE allowing for a more robust clinical data set that can enhance the current claims data set. I'm not sure alone whether either, VHIE or claims, paints a full picture, so the statement "build a single common infrastructure to electronically report on quality measures" stands out to me.
    It will expand and improve the existing infrastructure by matching claims and clinical data to enable the exchange of clinical data for analytics and event notification system. This approach mitigates the need for multiple identical infrastructures, by building a single cost effective infrastructure.

Questions related to the ACO structure and/or VITL relationships:

26. How many of the DA/SSA clients will be attributed to the ACOs?
    Patients are attributed to the ACOs by the patient attribution methodology. The ACOs at this time do not know the number of attributed patients for the new programs
27. How many full spectrum clients will be attributed?
    Same as previous answer.
28. How are SASH teams working with VITL and the ACOs?
    The providers are working with SASH directly, through Blueprint initiatives, and through the VHCIP Care Model and Care Management workgroup. This is an area that is likely to get more attention either in the gap analysis or in the next generation of the project.
29. How will the individual practices that are not part of the ACO be represented in this process?
    The scope of work includes ACO providers and affiliates for the ACO gateway routing of data. It also includes an event notification system encompassing all providers in Vermont. It will also form the foundation for future expansion. We support a similar effort by VITL for all providers to have the richest data set available for ACO-attributed patients, and in a next generation system, for all providers to have access.
30. How will project be administered among the ACOs given they are very different in their size, scale, governance, and makeup?
    This is in process among the ACOs and VITL. So far, we have managed to move the collaboration along through a common goal for a unified system, discussion, and facilitation by state representatives and VITL staff. If we find the need to create a more formal decision making process, then we'll have to draft one. Discussions and work sharing has been extremely collegial to this point.
31. Is (or would) the PAN ACO group be willing to include staff familiar with the technology systems supporting the following LTSS providers:

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- Home Health
- Area Agencies on Aging
- Nursing Facilities
- Developmental Disabilities services

VITL has and will continue to work with any and all providers in Vermont. The ACOs and VITL want to be open and collaborative with these LTSS providers as this project works with them. The ACOs are actively working on participation agreements with a number of providers and agencies and that activity in combination with the gap analysis will quite naturally bring LTSS providers to the table either on this round or the next.

32. On Slide 6, are the ACO participants in the Designated Agencies limited to Mental Health ($199M) and Substance Abuse ($20M)?
The ACOs are interested in discussions related to any organizations involved with attributed members. The Medicaid Shared Savings Program (and Medicare and Commercial as well) as developed and approved by the VHCIP Payment Models work group contains information on which patient populations are attributed and which specific spending items are included in the cost targets and when.

33. On Slide 6, are developmental disabilities services ($160M) and Traumatic Brain Injury providers included within the ACO participant network?
Same as previous answer.

34. On Slide 8, which "care managers" are within the scope of those being notified of important clinical events?
A primary goal of this project is sharing clinical data in support of care management.
This type of design and use case process will be a part of ACO work with its network and with the VHCIP Care Models and Care Management subgroup where common approaches across ACOs is warranted. While this effort is starting among the three ACOs, the goal is that each ACO "network" will encompass a very broad scope of care managers. Any health care provider in Vermont who has a data use agreement with VITL may participate in the Event Notification System.

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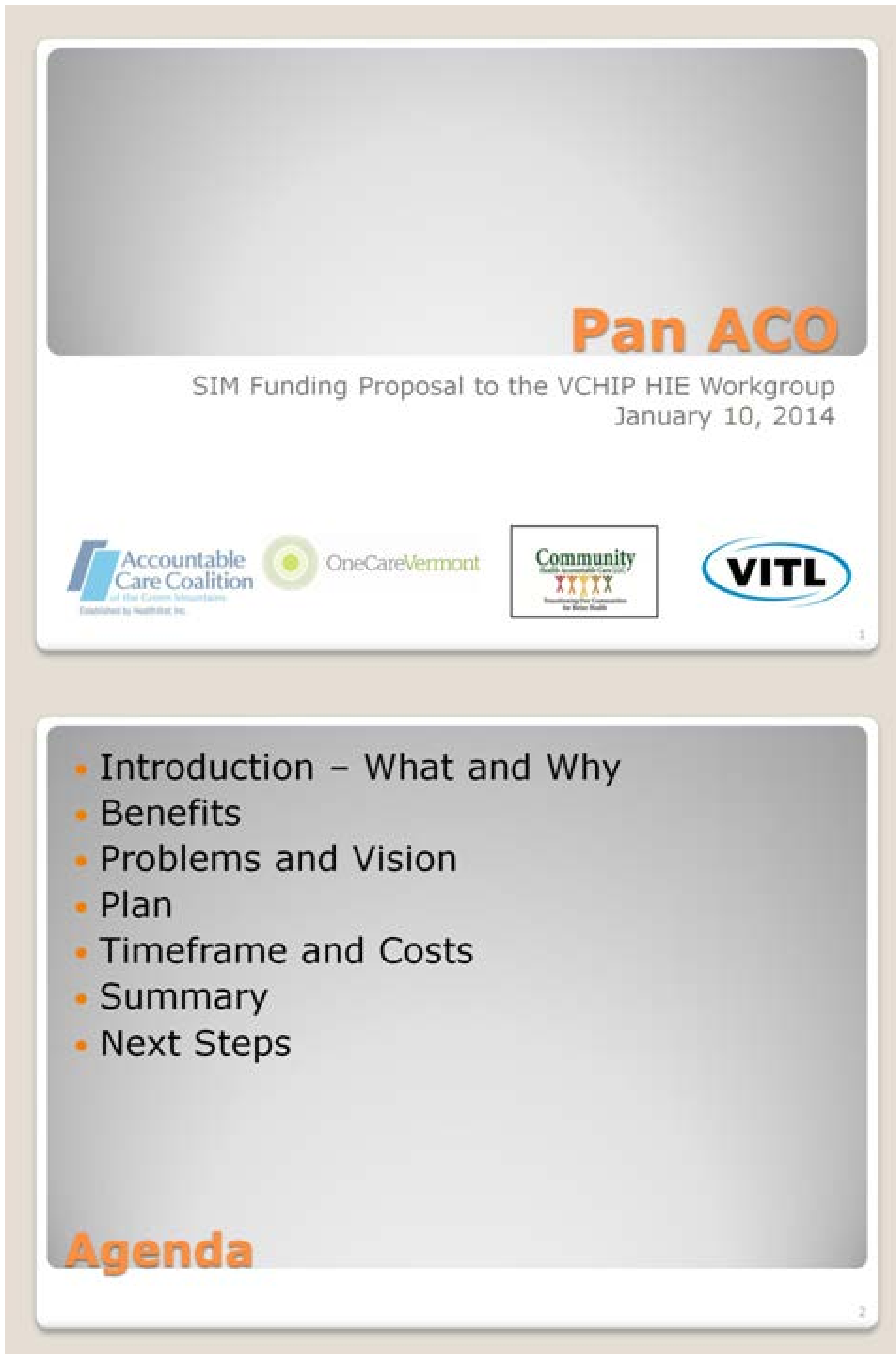
V. Appendix D – PowerPoint to HIE Work Group



- There are **three Accountable Care Organizations** in Vermont, whose members comprise a large and growing majority of the healthcare delivery system in the state:
  - OneCare Vermont (OCV)
  - Community Health Accountable Care (CHAC)
  - Accountable Care Coalition of the Green Mountains (ACCGM)
- **Collaborating** to effectively build a single common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients.
  - **Key Message: Heavily aligns with the state HIE Plan and Priorities**

What Are We Doing?

3

- The Pan ACO collaboration is to support health care payment and delivery system reforms aimed at improving care, improving the health of the population, and reducing per capita health care costs, by 2017.
- The **3 ACOs are collaborating** on aligned processes and infrastructure where it makes sense including **with VITL to build technology infrastructure** that is consistent with a state-wide **high performing healthcare system**.

Why Are We Collaborating?

4

Benefits

- Make **rapid progress against state HIE plan**
  - Faster than other approaches
- Provide **path for 2014 patient care benefits** of healthcare information exchange across providers and through ACO population approaches
  - Clinically more impactful, earlier than other approaches
- **Exploit the efficiencies of a collaborative project effort** involving all three Vermont ACOs, their providers, VITL, and the VHCIP work group
  - Less expensive than other approaches
- Provide a mechanism for the VHCIP work group to **measure and demonstrate tangible progress**
  - More concrete to show progress to CMS/CMMI, VHCIP Steering Committee, Core Team, GMCB

5

ACO Participants

	Hospitals	FQHC	PCPs - Blueprint PCMH	PCP - Non-Blueprint Practices	Specialty Physician	SNF	HH	MH & SA
OCV	2 AMCs 5 Community PPS 8 CAH 1 MH Specialty Hospital	3 FQHCs	All Hospital employed (60 Practices) Participating FQHC Practice Sites (8 Practices) 12 Independent Practices	2 Independent Practices	All Hospital Employed (1000 Physicians) 30 Independent Specialty Practices (60 Physicians)	All Hospital Owned Affiliate Agreements with 29 Independent SNF	Affiliate Agreements with 10 Local Home Health Agencies	Affiliate Agreements with 10 Mental Health and Substance Abuse Providers
CHAC	Expected Local Collaborations	7 FQHCs	Participating FQHC Practice Sites(35 Practice sites) 100+ PCP FTEs	None	Any FQHC Employed	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected
ACCGM	Expected Local Collaborations	None	10 Independent Practices	2 Independent Practices	6 Independent Practices	Expected Local Collaborations	Expected Local Collaborations	Expected Local Collaborations
Sub-Total in ACOs	**100%**	**91%**	**70%**	**40%**	**85%**	**80%**	**80%**	**100%**
Remaining Providers	None	None	30%	60%	15%	20%	20%	None

6

- All providers **seamlessly contributing a full range of accurate clinical information** electronically to VITL
- **Well designed tools and interfaces** to access that information subject to data use agreements and patient consent models
- **Designed to serve a range of customers** including providers, ACOs, GMCB, other regulators, DVHA/payers, others where appropriate

Vision of the Future

- We **don't know the current baseline status** of provider ability to capture and electronically transmit the clinical information needed for ACO/VCHIP Quality Measure data elements
- We need a way for **electronic data to be routed to ACOs** for Care Management and Analytic processes to support patient care
- We don't have the ability to **notify our Providers and Care Managers real time** when our patients have an important clinical event
- We still need to **fill some basic gaps** in HIE interfaces and data element exchange from hospitals and other providers

Problems to be Addressed

- **Gap Analysis**
  - Identify the gap among state-wide ACO data requirements and data capacity
- **Pan ACO Gateway Build**
  - Build the technical architecture to support movement of data from source systems to analytics destinations *(next slide)*
- **Event Notification**
  - Install a system that improves quality and timeliness of transitions of care through real-time notification of important clinical encounters
- **Gap Remediation**
  - Expand data capacity of the State for improved population management

Scope of Work

9

ACO Gateway Architecture

VITL Data Warehouse

VITL Rhapsody interface engine

Clinical summary flat file

Hospitals (ADT, CCD, Lab, VXU)

Practices (ADT, CCD, Lab, VXU)

VITL/Medicity

MPI

VITL Sender (Raw) | ACO Filter | ACO ID Enricher | ACO Transformer | VITL Sender (Transformed) | 3rd Party Sender

May temporarily route here for testing review

CCD

ADT, Lab, VXU

3rd Party Analytics Vendor

New data source to populate MPI With beneficiary demographics

File converted to HL7 by ACO

View data in 3rd Party portal

Provide filter file based on ACO beneficiary list

ACO

10

Revised: 1/2/2014

File name: ACO Architecture - SM-1-2-14 with CCD.vsd

Initiative	Timeframe[1]
Gap Analysis	• Estimated Start – Q1 2014 • Estimated complete Q3 2014
Pan ACO Gateway Build	• Estimated Start - Q1 2014 • Estimated complete –Q2 2015
Event Notification	• Estimated Start – Q1 2014 • Estimated complete – Q4 2014
Gap Remediation	• Estimated Start – Q1 2015 • Estimated complete – Q3 2016

[1] Start dates dependent on release of SIM funds

Timeframe

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Initiative	Low Estimate[1]	High Estimate
Gap Analysis	$50,000	$75,000
Pan ACO Gateway Build	$1,115,000	$1,545,000
Event Notification	$375,000	$625,000
Gap Remediation (full)	TBD	TBD
Support	$570,000	$800,000
Total	**$2,110,000**	**$3,045,000**

[1] Based on preliminary pricing

Implementation Costs & 1st Year Support

12

Initiative		Annual Support[1] (2015 and ongoing)
Gap Analysis		$0
Pan ACO Gateway (annual)	50,000 Beneficiaries: 100,000 Beneficiaries: 200,000 Beneficiaries:	$438,000 $876,000 $1,752,000
Event Notification		Range of $82,100 - $136,800
Gap Remediation (full)		TBD

[1] Based on preliminary pricing

Support Costs (multiple sources of funding)

13

- **Collaboration** of 3 ACOs
- Providing **care to majority of Vermont residents**
- Collaborating with VITL to build single common patient data infrastructure to:
  - Better **manage patient care** (Improve Care)
  - Report on **quality of care** (Improve Care)
  - Notify and **manage care transitions** (Improve Care)
  - **Exchange relevant clinical information** among caregivers (Improve Care)
  - **Reduce healthcare costs**

Summary

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Next Steps

- **Support from the VCHIP HIE Workgroup** for the vision and collaborative effort
- **Approve for release of SIM funds** for committed initiatives
  - **Implementation: $2,110,000 - $3,045,000**
  - **Support: Ongoing funding of support requires additional discussion of funding sources**
- **Support for refinement of costs** and well-defined funding requirements
  - Pan ACO to refine Implementation and Support Costs: **June 2014**
- **Timing is critical**

15

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Appendix E: February 2, 2014 Q and A from HIE Work Group Leaders/Members

Questions for the Population-Based Collaborative Regarding their Proposal

2/2/2014

Responses from the Population-Based Collaborative

2/4/14

GAP ANALYSIS

Can you provide more detail on the gap analysis? Does it include data quality work at individual provider sites? Will the gap analysis include an overview of which sites are sending what data? And the quality of that data?

The gap analysis will include the following:

1. **Which EHR an organization has if they have one. Some of this is new work, as we have not done an assessment of all healthcare organizations in Vermont.**
2. **For each organization that has an EHR, we will determine if they do have any of an ADT, VXU or CCD interface. For those who do not have one of those interfaces, we will determine if the organization is capable of developing that interface. This is new work.**
3. **For those organizations sending a compliant CCD, we will determine what data being sent matches the quality measures. This is new work.**

The gap analysis does not include a data quality analysis as the term is used by Blueprint. For example, an HgA1C is useful data to the ACOs – we wouldn't necessarily do a data quality assessment on the HgA1C results.

How does this gap analysis differ from the gap analyses that have already taken place? What is the gap between what has already been done in previous analyses by VITL and others versus the end goal for this analysis?

VITL has not historically performed gap analyses. Generally VITL is approached by healthcare organization to install interfaces, or VITL is directed to work with practices to install interfaces (e.g., Blueprint). VITL has not done a statewide survey of healthcare organizations' capacities. We are doing it in a limited capacity under DVHA for home health and designated agencies, but not as a statewide

comprehensive survey. However based on the amount of work completed we have a good database of what does exist which is a useful base for a gap analysis. The gap analysis is to identify what doesn't exist, and what it would take to eliminate the gap.

What is the deliverable? It would be good to document that we will have quarterly reports (if not more) regarding the work the PAN ACO group is doing to the workgroup and to have a written document of the gap analysis.

The deliverable is a matrix of gaps. The data being evaluated covers identification of EHR vendor or lack thereof; what interfaces are - in production/pending/or unavailable – by organization; and what clinical data is being sent or lacking compared to the quality measures. The gap analysis template is provided in a separate document.

REMEDIATION

What do you anticipate the data remediation to consist of? What are the deliverables? Is data quality work a part of the anticipated remediation process? Does it, in your mind, include "human interaction"? In other words do you anticipate the involvement of Sprint Teams, E-health specialists and others?

The gap analysis will identify:

- **Healthcare organizations that don't have EHRs**
- **For organizations that do have EHRs, what is their capacity to send any of ADT, CCD, or VXU?**
- **For organizations that can send CCDs, what effort is necessary for them to send quality measure data?**

Each of these gaps will have a cost to remediate. It is the purview of the ACOs in conjunction with SIM to determine which and how many gaps to address. We anticipate the sprint teams and eHealth specialist to be involved in the data remediation.

Based on the assumption that a significant amount of the gap analysis should already be completed, can you estimate the amount needed for remediation? It would be helpful to have more of an estimate on future build-out.

There is still more work to be completed for the gap analysis. There have been additional organizations for CHAC and ACCGM, and additional measures. A significant amount of work has been completed. Most data has been collected – it is presently being consolidated. The collaboration will complete the gap analysis, and project a budget for remediation. The gaps exist whether or not there is a plan to remediate them, so we don't believe a remediation budget would be necessary for

approval of the builds and gap analysis. The SIM HIE Workgroup can determine how much, if any, remediation should be funded.

TIMELINE

Please redefine the timeline based on an April 1 2014 timeframe (QTR 1, etc.). Specifically, does your proposed timeline start as soon as the funds are released or are you still anticipating having the Q1 work done in Q1 2014?

This is new information to the collaborative. Our understanding was that this work could be charged against the SIM grant as of last November 2013. Further discussions are required as to who funds the work that is completed or underway.

BUDGET

Support: Please detail this line item out – what is the VHCIP "buying" here? How is it different from what the state pays for in the DVHA grant to support VITL and the operation of the VHIE?

There are three components to the proposal: gap analysis; build of the gateways, and event notification.

Gap Analysis

The scope of this has been answered in previous questions, i.e., VITL does not conduct gap analyses, so this work is specific to this project and not covered under the DVHA grant.

Gateway

Building the gateways- there are three tasks to this work which are specific to this project and not covered under the current DVHA grant:

1. **The logic that matches inbound interface data to a beneficiary file and to a participant file, perform some data transformation on the interface messages, and send matched and processed interface messages to the correct analytics destination.**
2. **Medicity adds the logic to approximately 65 physical interfaces. Each interface is a complex software program.**
3. **VITL tests each interface to make sure the matching logic is correct. As each interface can support more than one healthcare organization, the testing exceeds the number of physical interfaces.**

Event notification

This is a new project and not funded by DVHA.

Please breakdown personnel expenses, a bit more detail on what program managers would be doing and if these positions are current employees or contractors, names for those positions. If the positions are yet to be filled or contracted, please so indicate.

Project managers make sure that a project has a plan, the timeframes are met, and the appropriate resources are available when necessary. As project work increases to meet the proposed scope of work, the identified project managers will become dedicated to the associated work. VITL also has subject matter experts who do data analysis and test interfaces. This work is done predominantly by three existing VITL staff. There may be other tasks that get assigned to eHealth Specialists, but presently this is seen to be consistent with their current responsibilities in the DVHA grant and is not included in the estimate.

The personnel expenses include their hourly rate, plus benefits, plus overhead, plus an administrative expense. Note that an administrative expense has not been applied to any of the other costs in the proposal.

The rate in the proposal is the low end of the rate VITL pays for consulting services. As a private enterprise the service rate is consistent with consulting rates and VITL personnel expenses.

There needs to be a transition from DVHA funding supporting healthcare reform, and SIM funding supporting healthcare reform (see answer to SUSTAINABILTY). As the work requirements preceded the SIM funding the only option without incurring additional expense was to use VTL staff.

ACO GATEWAY:

?

ENS

Who are the 100 provider organizations referenced – breakdown by provider group? What technology does a provider need in order to participate in an ENS?

VITL and the ACOs have not selected a vendor or product, so the required technology is an unknown. The intent is that a provider organization would have minimal technology requirements in order for the service to have as wide an audience as possible.

The 100 provider organization is a placeholder to build a budget. Given the number of hospitals, FQHCs, designated agencies, home health agencies, long term care and existing practices, 100 organizations seemed like a reasonable placeholder to

represent the initial number of benefitting entities. The service is planned to be offered to all eligible healthcare providers in Vermont.

SUSTAINABILITY

We understand that there is no formal sustainability plan in place for the years beyond 2016, but we would like to understand your thoughts about how such a plan might be structured, and which organizations or state departments would be expected to contribute to the sustainability plan, and how costs might be allocated

Over the next five years VITL will seek to transition from predominantly state and federal grant revenue to non-governmental revenue. This transition is based on the assumption that government funding is in effect an investment used to assess, build and deploy technology (Gap Analysis, Remediation and the Gateways) and that once it is implemented, the costs for both the services offered as a result of the technology (Event Notification System) as well as the on-going support and customer costs associated with the technology (PMPM Support Costs) should be borne by those organizations/individuals that receive the benefit of the services and the technology over the long term.

This transition will not occur immediately. Government funding needs to continue at its current level for a period of time to ensure that the technology needs of both the beneficiaries and the State's health care reform initiatives are met. Funding under the VHCIP is a component of this technology investment, albeit of a time limited nature and for specific aspects of health care reform goals.

Over the next five years the expected non-government revenue sources are expected to be based on the following: use of VITLAccess, the provider portal; ACO customer service and support; use of the Event Notification System; and potentially other services/capabilities currently in the planning stages to include an image sharing network, connectivity to the Health Information Exchange of NY (HIXNY) and clinical analytics services.

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SUPPORT

You should clarify what this "support "actually covers, and how you calculated the number of lives for each ACO. We need to understand this in more detail.

Each ACO provided VITL with the number of covered lives in the first year. Based on when VITL thinks the gateway will be complete for the ACO, the annual support fees were prorated to number of months of usage by the ACO.

Support covers the following:

Customer Support

- **Customer support (patient identity management)**
- **Interface maintenance (upgrade, replacements)**
- **Data quality (missing, inaccurate)**
- **Support center (I forgot my password)**

System Support

- **Interface monitoring (messages not processing)**
- **Monitor message routing**
- **Maintain beneficiary matching rules**
- **Maintain message transformer (consent flags, EVN fields)**
- **Error resolution and testing (new interface)**
- ***Event notifications (TBD)***

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