VT Health Care Innovation Project
Core Team Meeting Agenda

March 14, 2016 1:00pm-3:00pm
109 State Street, Pavilion Building, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	1:00-1:10	Welcome and Chair's Report a. Year 3 Timeline and Operational Plan Submission	Lawrence Miller	Attachment 1: Year 3 Timeline *Update.*
Core Team Processes and Procedures:				
2	1:10-1:15	Approval of meeting minutes	Lawrence Miller	Attachment 2: January 29, 2016 *Decision needed.*
Policy Recommendations:				
3	1:15-1:50	Year 3 Milestones	Georgia Maheras and Sarah Kinsler	Attachment 3: Year 3 Milestones *Decision needed.*
4	1:50-2:00	High Level Goals	Georgia Maheras and Annie Paumgarten	Attachment 4: High-Level Goals Memo to CMMI *Update.*

Spending Recommendations:				
5	2:00-2:05	Year One Closeout	Georgia Maheras	Attachment 5: Year One Final Closeout
6	2:05-2:45	Funding requests: a. Reallocation: Healthfirst (no-cost extension and reallocation) b. Reallocation: RiseVT c. Reallocation: Southwestern d. Reallocation and addition: VMSF (Frail Elders)—additional $10,500 (PP2) e. New Request: MMIS Modification-$750,000 ($100,000 in PP2; $650,000 in PP3) f. New Request: Core Competency Training—DDC $7,856 (PP2) g. Additional Funds Needed: APM Actuarial Support for Medicaid—Wakely Actuarial $30,000 (PP2) Note: previously we had anticipated a preliminary Y3 budget as part of this agenda. This will not be available because of delays in Year 2 contract approvals that are impacting Y3.	Georgia Maheras	Attachment 6a: Year 2 Update and Budget Requests (REVISED 3.11.16) Attachment 6b: Healthfirst request Attachment 6c: RiseVT request Attachment 6d: SWMC request Attachment 6e: VMSF request Attachment 6f: MMIS modification request *Decision needed.*

7	2:45-2:50	VHCIP Sub-Grant Program: Physician Payments	Georgia Maheras and Diane Cummings	Attachment 7: *to be distributed at a later date*
8	2:50-2:55	*Public Comment*	Lawrence Miller	
9	2:55-3:00	Next Steps, Wrap-Up and Future Meeting Schedule: April 11th, 1:00pm-3:00pm, 312 Hurricane Lane, Williston, VT	Lawrence Miller	

Attachment 1: Year 3 Timeline

SIM Timeline

March 14, 2016

Georgia Maheras, JD

Project Director

Key Dates

- Core Team Year 3 Milestone Approval– March 14th
- Core Team Year 3 Budget Approval—April 11th
- Year 3 Operational Plan Due to CMMI—May 1st
- Performance Period 2 ends 6/30/16.
  - Carryover request due 7/30/16 (for unliquidated obligations).
  - Annual Report due to CMMI 9/30/16.
- Year 3 Program Period: July 1, 2016-June 30, 2017.
  - Note: Most of the programmatic work ends 12/31/16.
  - Sustainability Plan and Population Health Plan due 6/30/17.
- Year 3 Carryover: July 1, 2017-October 31, 2017 (evaluation; financial true-ups).

Attachment 2: Minutes
January 29, 2016

Vermont Health Care Innovation Project
Core Team Meeting Minutes

Pending Core Team Approval

Date of meeting: Friday, January 29, 2016, 10:30am-12:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's Report	Lawrence Miller called the meeting to order at 10:35. A roll-call was taken and a quorum was present. Lawrence introduced Holly Stone, a new project manager on the SIM project team through UMass. **Chair's Report:** *Update on HIT Activities:* This item was delayed until later in the meeting. *Update on Resource Allocation:* Georgia provided an update on a request from Deborah Lisi-Baker to find out how much of SIM funding had been expended on DLTSS-related matters. Diane Cummings performed a detailed analysis. Of the total expended so far (~$17 million), about 16% has been expended to support DLTSS items. This includes staff costs, contractor costs, and sub-grantees. Susan Aranoff asked how this corresponded to the total proportion of people with disabilities in our state. Lawrence replied that he will explore this issue further.	
2. Approval of Meeting Minutes	Paul Bengtson moved to approve the 1/15 minutes (Attachment 2). Monica Hutt seconded. A roll call vote to approve the minutes was taken. The motion carried.	
3. Episode of Care Milestone Discussion	Lawrence Miller introduced a proposed modification to our CMMI Milestone on Episodes of Care. • Georgia Maheras noted that we proposed a Medicaid EOC program in our initial SIM application. This was delayed for good reasons: provider fatigue, implementation concurrent with our Shared Savings Programs. We modified our milestones over time to require launch of 3 EOCs in July 2016. Since that time, things have changed – we want to ensure both that DVHA is ready to implement reforms this program and is directionally appropriate given other work at this time. • Alicia Cooper provided an overview of the most recent proposal, which proposed episodes around perinatal services, neonatal services, frequent ED visitors, and work around the IFS program. Burns and Associates performed significant analytics to support this work. Also during this time, we requested	

Agenda Item	Discussion	Next Steps
	modifications to our EOC milestones from our federal partners. Attachment 3a is a memo submitted to our federal partners highlighting some of the challenges we face in seeking to implement EOCs. Challenges include small impacted provider population, small beneficiary timeframe, short implementation period prior to the end of the SIM grant, and interaction between this model and a potential all-payer model in 2017. In response to these challenges, the State proposed focusing EOC work on the Integrating Family Services model, which has shown promise in initial rollout and is ready for expansion to other areas of the state. Our federal partners support this change. The group discussed the following: • Paul Bengtson believes this makes sense, but found the dates a bit confusing. Alicia replied that we're now proposing to build one EOC around the IFS program by 7/1/17 – the concluding point of the SIM grant. • Georgia Maheras noted that conversations with providers involved in IFS have been promising – IFS receives over 30 funding streams currently. There is also concern around proliferation of quality measures. Selina Hickman added that there is a desire within the DA/SSA community to combine some of their efforts with IFS, so we could see some changes to the model prior to launch. • Robin Lunge added that this is consistent with the all-payer model. The regulated services that are part of financial caps do not at this time include IFS services. This would allow for another payment reform that would continue to simplify the payment streams in that system, which could make that system more ready to be incorporated into regulated revenue in the future. Hal Cohen moved to approve the new milestone. Steven Costantino seconded. A roll call vote was taken and the motion as approved unanimously.	
4. Funding Proposals	Georgia Maheras provided a financial update (Attachment 4a – revised presentation): • Year 1 Actuals to Date: Nearly closed out. Year 1 ended on December 31, 2015. We still have some federal approvals pending, but Diane Cummings has worked hard to ensure we will return under $400,000 to the federal government, which is much less than we initially thought. • Year 2 Actuals to Date: We expect to draw down a large amount in March. We will come back to the Core Team with a Year 2 budget reallocation in February and a Year 3 budget in early March. The Core Team received two funding proposals: • DLTSS Gap Remediation • VPQHC Reallocation *DLTSS Gap Remediation ($785,000; $167,000 in Year 2, $618,000 in Year 3):* Georgia Maheras noted that a high-level overview of this proposal received strong support at the HDI Work Group and Steering Committee. This proposal addresses technical solutions to Home Health Agencies (HHAs). HDI and Steering Committee also	

Agenda Item	Discussion	Next Steps
	recommended funding for Area Agencies on Aging, but there are technical reasons we cannot do this. We added $250,000 to this proposal at a late date after receiving confirmation from CMMI that we could use SIM funds to support provider-side VHIE interfaces. Susan Aranoff, Kristina Choquette, and Judith Franz provided additional detail (Attachment 3a): • VHIE connections for HHAs will support implementation of CMS's Next Generation ACO program; they will also allow clinical information sharing to support Vermonters in receiving home- and community-based services and aging in place. • Proposal would expand the scope of VITL's SIM-funded work. • AAAs are not considered health care organizations under HIPAA, so we need to do additional legal and regulatory research around what solution would be most appropriate for them; staff will present a proposal at a later date. • Project would use a phased approach to onboard HHAs and to get HHAs connected to VITLAccess. For interfaces, VITL will work with HHAs and their EHR systems to perform discovery and develop interfaces by organization. VITLAccess allows treating providers to view patient information in the VHIE. Kristina Choquette and Judith Franz described the process of onboarding within HHAs, including the training and workflow support available for providers. Regional training sessions would be available for HHAs as well as other interested organizations, to allow HHAs, primary care clinicians, specialists, and others to come together and share ideas. Webinar trainings will also be available. VITL will also implement a train-the-trainer model, with 1-2 "super-users" in each connected organization. • Phase 1: February –June 2016: Lawrence asked for additional budget detail. Kristina clarified that payment provisions are milestone-based. Georgia Maheras noted that the payment arrangement is coordinated with VITL's other contracts with the State. • Paul Bengtson asked for additional detail on activities within each phase. Judith clarified that each phase impacts a different group of HHAs/users for VITLAccess rollout. Kristina noted that interface development will be informed by discovery process; VITL will work with vendors to ensure interface development is done in a cost effective manner and takes advantage of economies of scale. This is a great deal of work in the first six months; starting in July 2016, interface development will begin. Phase 2 includes $125,000 to pay for agencies' vendor costs to develop connections (a pass-through to agency/vendor); provider-side interface development can cost tens of thousands of dollars. Georgia will support VITL's negotiations with vendors to encourage cost-effective development. Kristina noted that these are not Meaningful Use (MU)-certified providers. Lawrence Miller commented that CMS response to fraud issues nationally has created cash-flow challenges for HHAs, so support for provider-side interface development is critical. • Monica Hutt asked whether this includes Bayada. Judith Franz replied that it does. • Paul Bengtson asked whether federal grant rules allow us to use SIM funds for companies that pay taxes. Lawrence Miller replied that his understanding is that grant income is counted as income and organizations are required to pay taxes on them. • Mike Hall complimented SIM and VITL staff in developing this plan. He commented that he understands	

Agenda Item	Discussion	Next Steps
	the challenges in providing two-way connectivity to the VHIE for organizations not defined as health care organizations under HIPAA, but noted that not having AAA data in the VHIE is a significant gap given their role in providing services under the Choices for Care program. He asked whether there is an opportunity to establish a one-way connection to transmit data into the VHIE, even if AAAs won't be able to view VHIE data. Georgia replied that this is a challenging area of data integration; the federal government has complete jurisdiction about what can be shared, when, why, and how. We have asked the ONC to clarify this issue, and the State and VITL will be meeting with ONC in about a month to discuss this further. John Evans added that pushing patient clinical data from the AAAs to the VHIE is not included in this proposal – it may be possible technologically, but will depend on the system the AAAs use to document. Access to information contained in the VHIE is a HIPAA issue. There are also other organizations impacted by this issue, including SASH, CHTs, and others – some of the providers that need information the most. This is an issue across the nation. Mike noted that being excluded from Meaningful Use was a significant barrier to these providers. He asked what it would take to scope moving AAA information to the VHIE. John replied that VITL is happy to work with the AAAs to develop a proposal. John added that the viewing of VHIE information by non-health care organizations is something VITL could look at – there would have to be a liability component to this to protect the organization, and VITL will start by working with ONC. Lawrence clarified that pursuing this work with the HHAs does not preclude additional work with AAAs. Georgia Maheras will work with VITL and Susan Aranoff to come up with a proposal for discovery for AAAs for the Core Team's consideration at an upcoming meeting. *Revision – VPQHC Sub-Grant Budget Change Request (reduce by $300,000):* Georgia Maheras and Catherine Fulton introduced the VPQHC reallocation request. Dr. Catherine Schneider (Mt. Ascutney) described the project, which supports a surgical quality improvement collaborative (NSQIP) in Vermont, and highlighted current challenges to participating. • Small reductions in surgical infections/complications would pay for the cost of the program; savings would be reaped by the State of Vermont and insurers. • The Collaborative allows hospitals to share best practices across the state based on data analysis of hospital performance. Dr. Schneider noted that changes in the landscape since the program was proposed has led to less-than-expected participation, including participation in ACOs and associated required spending. • Catherine Fulton presented the revised budget, which reduces coordinator time and other staff time but maintains momentum for the organizations that are actively participating. Robust data collection and standardization training makes the data significantly more valuable; this includes real-time qualitative data. Dr. Schneider noted that rollout and launch are the largest challenges – maintenance is less intensive than start-up. She noted that surgical champions around the state are putting a great deal of effort into this work and want to continue to pursue it. Revised budget includes reductions in staff salary and fringe, reduce travel costs, reduced equipment costs, and reduced NSQIP enrollment fees; it includes	

Agenda Item	Discussion	Next Steps
	increases in meeting costs and sponsorship for one national conference. • Hal Cohen asked about the impact of reduced participation. Catherine Fulton noted that training is complete and data collection is starting. She noted that small hospitals have seen great results in other states, include a CAH in Maine that was able to isolate $200,000 in savings as a result of reduced complications. • Georgia Maheras noted that we have an ongoing discussion with CMMI related to clinician stipends, so suggested the Core Team include this caveat in any motion. Lawrence invited a motion to approve these items as proposed. Steve Voigt moved to approve these items. Paul Bengtson seconded. A roll call vote was taken; the motion carried unanimously.	
5. Public Comment	There was no additional public comment. John Evans provided a brief update on two major accomplishments at the end of 2015: • On December 29, the CHAC ACO Gateway went live. This technology allows their beneficiary population's data to move from the VHIE to an analytics environment. • On December 30, VITL went live to move CCDs into the VHIE from UVMMC. VITL has been working with a number of organizations to increase the percentage of total ACO data flowing into the VHIE by the end of 2015; as of December 30, VITL exceeded this goal for a total of 64% (2015 goal was 62%). This is an increase from 42%.	
6. Next Steps, Wrap Up and Future Meeting Schedule	**Next Meeting:** Tuesday, February 8, 2016, 1:00-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP Core Team Participant List

Attendance: 1/29/2016

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

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

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

Julia	Shaw		VLA/Health Care Advocate Project	X
Kate	Simmons		Bi-State Primary Care	X
Richard	Slusky		GMCB	S
Holly	Stone ✓		UMASS	S
Carey	Underwood			A
Steve	Voigt ✓		ReThink Health	M
Julie	Wasserman ✓		AHS - Central Office	S
Spenser	Weppler		GMCB	S
Kendall	West		Bi-State Primary Care	X
James	Westrich		AHS - DVHA	S
Katie	Whitney			A
Bradley	Wilhelm		AHS - DVHA	S
Jason	Williams		UVM Medical Center	X
Sharon	Winn		Bi-State Primary Care	X
Cecelia	Wu		AHS - DVHA	S
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Anne Petrov
Judith Franz
Kristina Choquette
Catherine Fulton
John Evans
Amy Vaughan
Bradley Fuller
Linda Otero
Catherine Schneider

VHCIP Core Team Member List
Roll Call:

1/29/2016

Member		1/15/2016 Minutes	EOC Milestone	Funding Proposals: LTSS Gap Remediation	Funding Proposals: VPQHC Revision	
First Name	Last Name					Organization
Paul	Bengston	✓	✓		✓	Northeastern Vermont Regional Hospital
Hal	Cohen	✓	✓		✓	AHS -CO
Steven	Costantino	joined by ede	✓	left	—	AHS - DVHA
Al	Gobeille x					GMCB
Monica	Hutt	✓	✓		✓	AHS - DAIL
Robin	Lunge	✓	✓		✓	AOA - Director of Health Care Reform
Lawrence	Miller	✓	✓		✓	AOA - Chief of Health Care Reform
Steve	Voigt	✓	✓		✓	ReThink Health

1° Paul 1° Hal 1° Steve V.
2° Monica 2° Steven 2° Paul
Motion carried motion carried motion carried

Attachment 3: Year 3 Milestones

	Focus Area	Performance Period 1 (PP1)[1] Performance Period 1 Milestone	Performance Period 1 (PP1) Current Status and Reporting	Performance Period 1 Carryover (PP1 Carryover) Performance Period 1 Carryover Milestone	Performance Period 1 Carryover (PP1 Carryover) Current Status, Reporting, and Contractors	Performance Period 2 (PP2) Performance Period 2 Milestone	Performance Period 2 (PP2) Current Status, Reporting, and Contractors	Performance Period 3 (PP3) Performance Period 3 Milestone	Metrics	PP1 Carryover and PP2 Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
Project Implementation	CMMI-Required Milestone	**Project Implementation:** Project will be implemented statewide.	Achieved: Project is implemented statewide, implementation is ongoing. *Reporting:* Monthly reports to Core Team, quarterly reports to CMMI and Vermont Legislature.	**Project Implementation:** Continue to implement project statewide. Implement all Performance Period 1 Carryover Milestones.	Ongoing. Will be complete by 12/31/15. *Reporting:* Monthly reports to Core Team, quarterly reports to CMMI and Vermont Legislature. *Contractors:* All contractors	**Project Implementation:** Continue to implement project statewide. Implement all Performance Period 2 Milestones by 6/30/16.	Ongoing. Anticipated completion 6/30/16. *Reporting:* Monthly reports to Core Team, quarterly reports to CMMI and Vermont Legislature. *Contractors:* All contractors.	**Project Implementation:** Continue to implement project statewide. Implement all Performance Period 3 Milestones by 6/30/17.	All metrics	All contractors.	Georgia Maheras	All SIM-funded staff and SIM key personnel
Payment Models	CMMI-Required Milestone	N/A	N/A	**Payment Models:** 50% of Vermonters in alternatives to fee-for-service.	Achieved: 55% of Vermonters in alternatives to fee-for-service as of November 2015, based on unduplicated counts. *Contractors:* Bailit Health Purchasing; Burns and Associates	**Payment Models:** 60% of Vermonters in alternatives to fee-for-service by 6/30/16.	In progress: 55% of Vermonters in alternatives to fee-for-service as of November 2015, based on unduplicated counts. *Contractors:* Bailit Health Purchasing; Burns and Associates; Health Management Associates.	**Payment Models:** 80% of Vermonters in alternatives to fee-for-service by 6/30/17.	CORE_Beneficiaries impacted_[VT]_VTEmployees CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Commercial CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicaid CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicare CORE_Beneficiaries impacted_[VT]_[EOC]_Commercial CORE_Beneficiaries impacted_[VT]_[EOC]_Medicaid CORE_Beneficiaries impacted_[VT]_[EOC]_Medicare	Research, Alignment and Design of Payment Models: Burns and Associates (Medicaid); Bailit Health Purchasing (all payers); Health Management Associates (all-payers).	Georgia Maheras	All SIM-funded staff and SIM key personnel
Population Health Plan[2]	CMMI-Required Milestone	N/A	N/A	N/A	N/A	**Population Health Plan:** Finalize Population Health Plan outline by 6/30/16.	In progress: Draft outline developed; RFP for contractor support released. *Reporting:* Monthly status reports. *Contractors:* TBD.	**Population Health Plan:** Finalize Population Health Plan by 6/30/17.	Not reported on quarterly basis, but required reporting element by end of project.	Population Health Plan Development: James Hester.	Heidi Klein	SIM-funded staff: Sarah Kinsler Key personnel: Tracy Dolan, Heidi Klein
Sustainability Plan	CMMI-Required Milestone	N/A	N/A	N/A	N/A	**Sustainability Plan:** Finalize Sustainability Plan outline and procure contractor to support Plan development by 6/30/16.	In progress: Work to refine sustainability strategy is underway; RFP for contractor support to be released in Q1 2016. *Reporting:* Monthly status reports. *Contractors:* TBD.	**Sustainability Plan:** Finalize Sustainability Plan by 6/30/17.	Not reported on quarterly basis, but required reporting element by end of project.	Sustainability Plan Development: TBD.	Georgia Maheras	All SIM-funded staff All SIM Key Personnel
Focus Area: Payment Model Design and Implementation												
ACO Shared Savings Programs (SSPs)	Payment Model Design and Implementation	**ACO Shared Savings Programs (SSPs):** 1. Implement Medicaid and Commercial ACO SSPs by 1/1/14. 2. Develop ACO model standards: Approved ACO model standards. 3. Produce quarterly and year-end reports for ACO program participants and	1. Achieved: SSPs launched 1/1/2014. 2. Achieved: ACO model standards approved. 3. Achieved: Quarterly and year-end reports produced, and evaluation plan developed. 4. Achieved: 2 Medicaid ACO contracts executed during PP1.	**ACO Shared Savings Programs (SSPs):** 1. Continue implementation activities in support of the initial SSP performance period according to the SSP project plan. 2. Modify program standards by 6/30/15 in preparation for subsequent performance	1. In progress: Implementation is ongoing through 12/31/15. 2. Achieved: Program standards modified and contract amendments finalized. 3. Achieved: Final cost and quality calculations for SSP Year 1 completed by 9/15/15.	**ACO Shared Savings Programs (SSPs):** Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program	In progress. *Reporting:* Reporting to GMCB, and DVHA, measured quarterly. *Contractors:* Bailit Health Purchasing; Burns and Associates; The Lewin Group; Pacific Health Policy Group; Deborah Lisi-Baker; Wakely	**ACO Shared Savings Programs (SSPs):** Expand the number of people in the Shared Savings Programs in Performance Period 3 by 12/31/16: Medicaid/commercial program provider participation target: 960. Medicaid/commercial program	CORE_Beneficiaries impacted_[VT]_VTEmployees CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid	Facilitation: Bailit Health Purchasing; Medicaid: Burns and Associates; Analytics: The Lewin Group; DLTSS/Medicaid: Pacific Health Policy Group; DLTSS: Deborah Lisi-Baker;	TBD – GMCB (Commercial SSP); Amy Coonradt (Medicaid SSP)	SIM-funded staff: Julie Wasserman; Erin Flynn; Amy Coonradt; Susan Aranoff; David Epstein; Amanda Ciecior; James Westrich; Brian Borowski; Carole

[1] Vermont's milestone table organization changed as part of the discussions with CMMI around the Year One Carryover milestones. Milestones were grouped into topic areas matching Vermont's core program areas.
[2] This table includes project areas that were referenced in earlier submissions to CMMI, but which do not have milestones prior to Year Three.

	Focus Area	Performance Period 1 (PP1)[1] Performance Period 1 Milestone	Performance Period 1 (PP1) Current Status and Reporting	Performance Period 1 Carryover (PP1 Carryover) Performance Period 1 Carryover Milestone	Performance Period 1 Carryover (PP1 Carryover) Current Status, Reporting, and Contractors	Performance Period 2 (PP2) Performance Period 2 Milestone	Performance Period 2 (PP2) Current Status, Reporting, and Contractors	Performance Period 3 (PP3) Performance Period 3 Milestone	Metrics	PP1 Carryover and PP2 Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
		payers: Evaluation plan developed. 4. Execute Medicaid ACO contracts: Number ACO contracts executed (goal = 2). 5. Execute commercial ACO contracts: Number of commercial ACO contracts executed (goal = 2).	5. Achieved: 3 commercial ACO contracts executed during PP1. *Reporting:* Reporting to SIM Work Groups, GMCB, and DVHA, measured quarterly.	periods. Finalize contract amendments for subsequent performance periods. 3. Complete final cost and quality calculations for initial SSP performance period by 9/15/15. 4. Maintain 2 contracts with ACOs Year 1 Medicaid ACO-SSP. 5. Maintain 3 contracts with ACOs Year 1 commercial ACO-SSP. 6. Modify initial quality measures, targets, and benchmarks for Y2 program periods by 6/30/15 (based on stakeholder input and national measure guidelines). 7. Medicaid/commercial program provider participation target: 700 Medicaid/commercial program beneficiary attribution target: 110,000	4. In progress: Medicaid SSP Year 2 contracts will be executed by 12/31/15. 5. In progress: Commercial SSP Year 2 contracts are ongoing through 12/31/15. 6. Achieved: measures, targets, and benchmarks modified for SSP Year 2 based on stakeholder input and national guidelines. 7. Achieved: 947 providers participating and 176,100 beneficiaries attributed as of September 2015. *Reporting:* Reporting to SIM Work Groups, GMCB, and DVHA, measured quarterly. *Contractors:* Bailit Health Purchasing; Burns and Associates; The Lewin Group; Wakely Consulting; Pacific Health Policy Group; Deborah LIsi-Baker; UVM Medical Center/ OneCare Vermont; Bi-State Primary Care Association/ Community Health Accountable Care	beneficiary attribution target: 130,000.	Consulting; Bi-State Primary Care Association/ Community Health Accountable Care (CHAC); UVM Medical Center (UVMMC)/OneCare Vermont; Health*first*.	beneficiary attribution target: 140,000.	CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Payer Participation_[VT] CORE_BMI_[VT] CORE_Diabetes Care_[VT] CORE_ED Visits_[VT] CORE_Readmissions_[VT] CORE_Tobacco Screening and Cessation_[VT] CAHPS Clinical & Group Surveys	Actuarial: Wakely Consulting. ACO Implementation: Bi-State Primary Care Association/ CHAC, Health*first,* and UVMMC/OneCare Vermont.		Magoffin; Carolynn Hatin Key personnel: Pat Jones
Episodes of Care	Payment Model Design and Implement ation	**Episodes of Care:** At least 3 episodes launched by 10/2014.	Not achieved: This activity delayed for Performance Period 2/CY2016. *Reporting:* Monthly status reports.	**Episodes of Care:** EOC feasibility analyses: 1. Analyze 20 episodes for potential inclusion in Medicaid EOC program by 7/31/15. 2. Develop implementation plan for EOC program by 7/31/15. 3. Convene stakeholder sub-group at least 6 times by 6/30/15.	1. Achieved: 50 episodes analyzed by 7/31/15. 2. Achieved: EOC implementation plan finalized on 11/16/15. 3. Achieved: Sub-group convened 6 times by 6/15/15. *Reporting:* Monthly status reports. *Contractors:* Burns and Associates.	**Episodes of Care:** Research, design, and draft implementation plan for one EOC based off of the IFS program by 6/30/16.	In progress: This milestone was modified by the Core Team in January 2016. Under this reduced scope, work is to support episode design and preparation for implementation is ongoing. *Reporting:* Monthly status reports. *Contractors:* Burns and Associates; Pacific Health Policy Group.	**Episodes of Care:** Implement EOC Payment Model impacting IFS Program's Service by 7/1/17.	CORE_Beneficiaries impacted_[VT]_[EOC]_Commercial CORE_Beneficiaries impacted_[VT]_[EOC]_Medicaid CORE_Beneficiaries impacted_[VT]_[EOC]_Medicare CORE_Participating Providers_[VT]_[EOC] CORE_Provider Organizations_[VT]_[EOC] CORE_Payer Participation_[VT]	Data Analysis and Program Design: Burns and Associates; Pacific Health Policy Group.	Amanda Ciecior	SIM-funded staff: Julie Wasserman; Susan Aranoff; David Epstein; Amanda Ciecior; James Westrich; Brian Borowski; Carole Magoffin Key personnel: Pat Jones
Pay-for-Performance	Payment Model Design and Implement ation	**Pay-for-Performance:** Develop Medicaid value-based purchasing plan addressing pay-for-performance initiatives: Medicaid value-based purchasing plan developed.	1. Not achieved: In PP1, the Vermont Legislature appropriated additional Medicaid funds to support this milestone. Due to budget constraints, this activity was rescinded. 2. Achieved: Vermont began development of value-based purchasing plan. *Reporting:* Monthly status reports.	**Pay-for-Performance:** 1. Design modifications to the Blueprint for Health P4P program – dependent on additional appropriation in state budget. Modification design completed by 7/1/15 based on Legislative appropriation. 2. Medicaid value-based purchasing case study developed with Integrating Family	1. Achieved: Blueprint for Health P4P modification design completed on 7/1/15. 2. Achieved: Medicaid value-based purchasing case study developed by 6/30/2015. This case study included a rubric for Medicaid value-based purchasing that will be	**Pay-for-Performance:** Roll-out of new P4P investments for Blueprint Community Health Teams (CHTs) by 7/1/15 and enhanced direct payments to Blueprint practices by 1/1/16, according to approved P4P plan (using new funds that were appropriated by the legislature).	Achieved: New P4P investments launched on 7/1/15 and 1/1/16, respectively, according to approved P4P plan. *Reporting:* Quarterly reports to CMMI and Vermont Legislature. *Contractors:* N/A	**Pay-for-Performance:** 1. Expand the number of providers and beneficiaries participating in the Blueprint for Health by 6/30/17: Medicaid/ commercial/ Medicare: Number of providers participating in P4P program target: 715. Number of beneficiaries participating in P4P	CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Commercial CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicaid CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicare CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH] CORE_Payer Participation_[VT]	1. Financial Standards: Non-SIM funded. 2. Care Standards: Non-SIM funded. 3. Quality Measures: Non-SIM funded. 4. Analyses for Design and Implementation: Non-SIM funded. 5. Stakeholder Engagement: Medicaid and	Craig Jones	Key personnel: Craig Jones; Jenney Samuelson

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				Services program completed by 6/30/15.	used for Medicaid-specific reforms moving forward.[3] *Reporting:* Monthly status reports. *Contractors:* N/A			program target: 310,000. 2. P4P incorporated into Sustainability Plan by 6/30/17.		commercial: Non-SIM funded.		
Health Home (Hub & Spoke)	Payment Model Design and Implementation	**Health Home (Hub & Spoke):** Health Homes.	Achieved: Model expanded statewide. *Reporting:* Quarterly reports to CMMI and Vermont Legislature.	**Health Home (Hub & Spoke):** State-wide program implementation: 1. Implement Health Home according to Health Home State Plan Amendment and federal plan for 2015. 2. Report on program participation to CMMI.	1. In progress: Implementation ongoing through 12/31/15. 2. In progress: Reporting ongoing through 12/31/15. *Reporting:* Quarterly reports to CMMI and Vermont Legislature. *Contractors:* N/A	**Health Home (Hub & Spoke):** Reporting on program's transition and progress: Quarterly reporting of program progress to CMMI, VHCIP stakeholders.	Ongoing: Reporting ongoing as required by CMCS and CMMI. *Reporting:* Quarterly reports to CMMI and Vermont Legislature. *Contractors:* N/A	**Health Home (Hub & Spoke):** 1. Expand the number of providers and beneficiaries participating in the Health Home program by 6/30/17: Number of providers participating in Health Home program target: 75 MDs prescribing to >= 10 patients. Number of beneficiaries participating in Health Home program target: 2,900 Hub + 2,300 Spoke = 5,200 total patients. 2. Health Home program incorporated into Sustainability Plan by 6/30/17.	CORE_Provider Organizations_[VT]_[HH] CORE_Participating Providers_[VT]_[HH] CORE_Provider Organizations_[VT]_[HH]	1. Financial Standards: Non-SIM funded. 2. Care Standards: Non-SIM funded. 3. Quality Measures: Non-SIM funded. 4. Analyses for Design and Implementation: Non-SIM funded. 5. Stakeholder Engagement: Non-SIM funded.	Beth Tanzman	Key personnel: Beth Tanzman
Accountable Communities for Health (ACH)	Payment Model Design and Implementation	N/A	N/A	**Accountable Communities for Health:** Feasibility assessment – research ACH design. 1. Convene stakeholders to discuss ACH concepts at least 3 times to inform report. 2. Produce Accountable Community for Health report by 7/31/15.	1. Achieved: Stakeholders convened 3 times to inform report (April 2014, March 2015, June 2015). 2. Achieved: Report finalized in June 2015. *Reporting:* Monthly status reports. *Contractors:* Prevention Institute; James Hester.	**Accountable Communities for Health:** Feasibility assessment – data analytics: 1. Discussion and planning of investments related to ACH feasibility based on research/report by 11/1/15. 2. Design/creation of ACH learning system for all 14 Vermont Health Service Areas by 1/31/16. 3. Start roll out ACH learning system to at least 3 health service areas by 2/1/16. 4. Research for implementation of a pilot incorporating a payment change (data analysis, financial analysis, stakeholder participation analysis) for at least 1 Vermont region by 2/1/16.	1. Achieved: ACH feasibility discussed in September and October 2015. 2. In progress: Basic design for an ACH peer learning opportunity for interested communities complete; work to refine and plan peer learning activities is ongoing; a contractor to support this work was selected in February 2016. 3. Achieved: Applications from interested communities received in February 2016. 4. In progress: Research with St. Johnsbury community ongoing through 2/1/16. *Reporting:* Monthly status reports. *Contractors:* James Hester; Public Health Institute.	**Accountable Communities for Health:** ACH Implementation Plan incorporated into Sustainability Plan by 6/30/17.	CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE Participating Providers_[VT]_[ACO]_Commercial CORE Participating Providers_[VT]_[ACO]_Medicaid CORE Participating Providers_[VT]_[ACO]_Medicare CORE_Payer Participation_[VT]	Implement ACH Learning Systems: James Hester; Public Health Institute.	Heidi Klein	SIM-funded staff: Sarah Kinsler. Key personnel: Tracy Dolan; Heidi Klein
Prospective Payment System – Home Health	Payment Model Design and	N/A	N/A	N/A	N/A	**Prospective Payment System – Home Health:**	1. Achieved: Project plan created.	**Prospective Payment System – Home Health:**	CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider	1. Implementation	Aaron French	SIM-funded staff: Alicia Cooper

[3] The remaining Medicaid value-based purchasing (VBP) activities are in the "State Activities to Support Model Design and Implementation – Medicaid" row below as they apply to all payment models in Vermont's SIM Test, not just pay-for-performance.

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	Implementation					1. Creation of a project plan and begin Phase 1 activities as required by project plan for PPS-HH by 12/31/15. 2. Design PPS program for home health for launch 7/1/16.	2. In progress: PPS design is ongoing through 6/30/16. *Reporting:* Monthly status reports. *Contractors:* N/A	1. Implement, monitor and evaluate Medicaid PPS program for home health. Implementation by 7/1/16. 2. Monitoring and evaluation occur monthly through 6/30/17.	Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE Participating Providers_[VT]_[ACO]_Commercial CORE Participating Providers_[VT]_[ACO]_Medicaid CORE Participating Providers_[VT]_[ACO]_Medicare CORE_Payer Participation_[VT]	analyses – Non-SIM funded.		Key personnel: Aaron French; Tom Boyd
Prospective Payment System – Designated Agencies	Payment Model Design and Implementation	N/A	N/A	N/A	N/A	**Prospective Payment System – Designated Agencies:** Submit planning grant for Certified Community Behavioral Health Clinics to SAMHSA by 8/5/15. If awarded, begin alignment of new opportunity with SIM activities. (Note: No SIM funds used to support this effort.)	Achieved: Planning grant submitted by 8/5/15. Vermont has decided not to pursue this opportunity, and will replace this work with the Medicaid Value-Based Purchasing milestone category (below) in PP3.	N/A	*Activity discontinued; Vermont will replace this activity with the Medicaid Value-Based Purchasing milestone category (below) in PP3.*			
Medicaid Value-Based Purchasing: Mental Health and Substance Abuse (Performance Period 3)	Payment Model Design and Implementation	N/A	N/A	N/A	N/A	N/A	N/A	**Medicaid Value-Based Purchasing: Mental Health and Substance Abuse:** 1. Based on research and feasibility analysis, design an alternative to fee-for-service, for Medicaid mental health and substance use services by 12/31/16. 2. Develop implementation timeline based on payment model design and operational readiness by 12/31/16.	CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicaid	N/A	Amanda Ciecior and Selina Hickman	SIM-funded staff: Amanda Ciecior Key personnel: Selina Hickman; Nick Nichols; Barbara Cimaglio; Aaron French; Susan Bartlett; Melissa Bailey
All-Payer Model	Payment Model Design and Implementation	N/A	N/A	N/A	N/A	**All-Payer Model:** 1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI. 2. Work with CMMI on mutually-agreed upon timeline for 2016 decision-making by 12/31/15.	1. In progress: Research, analytic development, and information gathering are ongoing to support discussions with CMMI. 2. In Progress: An initial timeline is established with CMMI; timeline will change as negotiations are completed to reflect final term sheet. *Reporting:* Monthly status reports. *Contractors:* Burns and Associates, Health Management Associates.	**All-Payer Model:** 1. If negotiations are successful, assist with implementation as provided for in APM agreement through end of SIM grant. 2. Contribute to analytics related to all-payer model implementation design through end of SIM grant. 3. All-Payer Model incorporated into Sustainability Plan by 6/30/17.	CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE Participating Providers_[VT]_[ACO]_Commercial CORE Participating Providers_[VT]_[ACO]_Medicaid CORE Participating Providers_[VT]_[ACO]_Medicare CORE_Payer Participation_[VT]	Analyses: Health Management Associates (actuarial, model design); Burns and Associates (Medicaid financial analyses).	Michael Costa and Ena Backus	SIM-funded staff: Michael Costa Key personnel: Ena Backus; Susan Barrett
State Activities to Support Model Design and Implementation - GMCB	Payment Model Design and Implementation	N/A	N/A	**State Activities to Support Model Design and Implementation – GMCB:** Identify quality measurement alignment opportunities. (in another section previously – the quality section): 1. Review new Blueprint (P4P) measures related to	Achieved. *Reporting:* Monthly status reports (reported with Blueprint activities). *Contractors:* N/A	**State Activities to Support Model Design and Implementation – GMCB:** 1. Research and planning to identify the components necessary for APM regulatory activities by 6/30/16. 2. Specific regulatory activities and timeline are	1. In progress: Research, analytic development, and information gathering are ongoing to support discussions with CMMI. 2. In progress: Negotiations are ongoing. *Reporting:* Monthly status reports (reported with All-Payer Model activities).	N/A (milestones in this category integrated into All-Payer Model milestone for Performance Period 3).	CORE_Beneficiaries impacted_[VT]_VTEmployees CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating	Research and Analyses: Health Management Associates (actuarial, model design).	Michael Costa and Ena Backus	SIM-funded staff: Michael Costa Key personnel: Ena Backus; Susan Barrett

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				new investments by 7/1/15.		dependent on discussions with CMMI.	*Contractors:* Health Management Associates.		Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare			
State Activities to Support Model Design and Implementation - Medicaid	Payment Model Design and Implementation	N/A	N/A	**State Activities to Support Model Design and Implementation – Medicaid:** Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate. 1. Obtain SSP Year 1 State Plan Amendment by 7/31/15. 2. Procure contractor for SSP monitoring and compliance activities by 4/15/15. 3. Procure contractor for data analytics related to value-based purchasing in Medicaid by 9/30/15. 4. Ensure call center services are operational for Medicaid SSP for SSP Year 2.	1. Achieved: SPA approved in June 2015. 2. Achieved: Contractor procured. 3. Achieved: Contractor procured. 4. Achieved: Call center services operational. *Reporting:* Monthly status reports. *Contractors:* Burns and Associates; Wakely Consulting; Pacific Health Policy Group.	**State Activities to Support Model Design and Implementation – Medicaid:** Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 1. Ensure appropriate customer service supports are in place for Medicaid SSP program for 2016 by 11/1/15. 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16. 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan. 5. Develop monitoring and compliance plan for Year 1 EOCs by 6/30/16. 6. Design modifications to existing Integrated Family Services (IFS) Program so it can expand to at least one additional community on 7/1/16. 7. Research and design related to Frail Elders (timeline dependent upon federal contract approval) – final recommendations by 6/30/16.	1. Achieved: Maximus contract in place. 2. Achieved: SPA for Year 2 of the Medicaid SSP was approved in September 2015. 3. Revised: SPA is no longer required for revised EOC milestone. 4. Will be achieved by 12/31/15: SSP Year 1 and Year 2 monitoring and compliance plan implementation. 5. In progress: EOC work has been rolled into the Medicaid Pathway work stream. 6. In progress: The IFS delivery and payment model has since been rolled into the Medicaid Pathway work stream which will target providers across the entire state. Contractors are working with SIM staff and stakeholders to create a system ready for implementation on 1/1/17. 7. In progress: project kicked off in November 2015 after federal contract approval was received. *Reporting:* Monthly status report (and embedded in other reports by topic). *Contractors:* Bailit Health Purchasing; Burns and Associates; Pacific Health Policy Group; Maximus; Wakely Consulting; Vermont Medical Society Foundation; Policy Integrity.	**State Activities to Support Model Design and Implementation – Medicaid:** 1. Obtain SPA for Year 3 of the Medicaid Shared Savings Program by 12/31/16. 2. Execute Year 3 commercial and Medicaid monitoring and compliance plans according to the predetermined plan through 6/30/17. 3. Execute Year 1 monitoring and compliance plan for EOC work stream by 6/30/17.	CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicaid 5b. In progress. Episodes have since been rolled into the Medicaid Pathway work stream 6b. In progress. The IFS delivery and payment model has since been rolled into the Medicaid Pathway work stream which will target providers across the entire state. Contractors are working with SIM staff and stakeholders to create a system ready for implementation on 1/1/17	Facilitation: Data Analyses: Burns and Associates; Waiver Analysis/Medicaid Analysis: Pacific Health Policy Group; Customer Service Support: Maximus; Frail Elders: Vermont Medical Society Foundation; Data Analysis: Policy Integrity; Actuarial Services: Wakely Consulting.	Amanda Ciecior (EOC and IFS); Alicia Cooper (SPAs); Susan Aranoff (Frail Elders and Choices for Care); Amanda Ciecior and Susan Aranoff (St. Johnsbury)	SIM-funded staff: Alicia Cooper; Brad Wilhelm; Amy Coonradt; Amanda Ciecior; Luann Poirier; Susan Aranoff Key personnel: Pat Jones; Bard Hill
All Models	Payment Model Design and Implementation	**All Models:** 1. Consult with Payment Models and Duals Work Groups on financial model design: Develop ACO model standards. 2. Consult with Payment Models and Duals Work	1. Achieved: ACO model standards developed with work group input. 2. Achieved: Analyses defined with work group input.	**All Models:** 1. Consult with stakeholders in all payment models design; implementation. 2. Consult with stakeholders in any	1. Achieved: Stakeholders consulted on payment model design through SIM work group meetings. 2. Achieved: Stakeholders consulted on payment model revision and	N/A (milestones in this category integrated into above categories for PP2).	N/A	N/A (milestones in this category integrated into above categories for PP2).	CORE_Beneficiaries impacted_[VT]_VTEmployees CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare	N/A (milestones in this category integrated into above categories for PP2).	N/A (milestones in this category integrated into above categories	N/A (milestones in this category integrated into above categories for PP2)

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		Groups on definition of analyses. 3. Define analyses: Number of meetings held with payment models and duals Work Groups on the above designs (goal = 2). 4. Procure contractor for internal Medicaid modeling: Contract for Medicaid modeling. 5. Procure contractor for internal Medicaid modeling: Number of analyses performed (goal = 5). 6. Procure contractor for additional data analytics: Contract for data analytics. 7. Define analyses: Number of analyses designed (goal = 5). 8. Procure contractor for additional data analytics: Contract for financial baseline and trend modeling. 9. Perform analyses, procure contractor for financial baseline and trend modeling, and develop model.	3. Achieved: 5 meetings held with work groups on this topic. 4. Achieved: Contractor procured. 5. Achieved: 5 analyses performed. 6. Achieved: Contractor procured. 7. Achieved: 5 analyses defined. 8. Achieved: Contractor procured. 9. Achieved: Analyses performed, contractor procured, model developed. *Reporting:* Monthly status reports.	additional design revision or analyses. 3. Maintain contract for ongoing Medicaid modeling. 4. Maintain contract for additional data analytics. 5. Maintain contract for ongoing financial baseline and trend modeling.	analyses through SIM work group meetings. 3. In progress: Contract for Medicaid modeling ongoing. 4. In progress: Contract for data analytics ongoing. 5. In progress: Contract for ongoing financial baseline and trend modeling ongoing. *Reporting:* Monthly status reports. *Contractors:* Burns and Associates; Bailit Health Purchasing; Wakely Consulting; The Lewin Group; Policy Integrity; Pacific Health Policy Group; Maximus.				CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare		for PP2 and PP3)	
All-Models: Quality Measurement	Payment Model Design and Implementation	**All-Models: Quality Measurement:** 1. Define common sets of performance measures: Convene work group, establish measure criteria, identify potential measures, crosswalk against existing measure sets, evaluate against criteria, identify data sources, determine how each measure will be used, seek input from CMMI and Vermont independent evaluation contractors, finalize measure set, identify benchmarks and performance targets, determine reporting requirements, revisit measure set on regular basis. 2. Ensure provider, consumer and payer buy-in during measure selection: Identification of additional mechanisms for obtaining provider and consumer representation, input and buy-in.	1. Achieved: Performance measures defined. 2. Achieved: Provider, consumer, and payer buy-in maintained during measure selection. 3. Achieved: Payers aligned across measures, measures approved by payers. 4. Achieved: Target setting process established, along with routine assessment process and analytic framework and reports. *Reporting:* Monthly status reports.	**All-Models: Quality Measurement:** 1. Modify initial quality measures, targets, and benchmarks for subsequent program periods (based on stakeholder input and national measure guidelines). 2. Maintain monthly meeting schedule for multi-stakeholder Quality & Performance Measures Work Group. 3. Identify additional opportunities for measure alignment across programs (e.g. ACO SSPs and Blueprint for Health P4P). 4. Complete final quality calculations for initial SSP performance period and report results. Begin interim analytics for subsequent performance period.	1. Achieved: Initial quality measures modified based on stakeholder input and national measure guidelines. 2. Achieved: QPM Work Group met monthly prior to incorporation into new Payment Model Design and Implementation Work Group in October 2015. 3. In progress: Work to identify additional opportunities for measure alignment with Blueprint will be complete by 12/31/15 as part of new payment (see pay-for-performance row above). 4. Achieved: SSP Year 1 quality calculations finalized; interim analytics for SSP Year 2 begun. *Reporting:* Monthly status reports. *Contractors:* Bailit Health Purchasing; Deborah LIsi-Baker; Pacific Health Policy Group.	N/A (milestones in this category integrated into above categories for PP2).	N/A	N/A (milestones in this category integrated into above categories for PP2).	CORE_Beneficiaries impacted_[VT]_VTEmployees CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare	N/A (milestones in this category integrated into above categories for PP2).	N/A (milestones in this category integrated into above categories for PP2 and PP3)	N/A (milestones in this category integrated into above categories for PP2)

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		3. Ensure payer alignment across endorsed measures: • Process for payer approval. 4. Establish plan for target-setting with schedule for routine assessment: • Establish target-setting process, routine assessment process, and analytic framework and reports.										
Focus Area: Practice Transformation												
Learning Collaboratives	Practice Transformation	**Learning Collaboratives:** 1. Provide quality improvement and care transformation support to a variety of stakeholders. 2. Procure learning collaborative and provider technical assistance contractor.	1. Achieved: Quality improvement and care transformation support provided through development of Care Management Learning Collaborative and sub-grant technical assistance. 2. Achieved: Contractor procured. *Reporting:* Monthly status reports.	**Learning Collaboratives:** Launch 1 cohort of Learning Collaboratives to 3-6 communities (communities defined by Vermont's Health Service Areas) by 1/15/15: 1. Convene communities in-person and via webinar alternating format each month for 12 months. 2. Assess impact of Learning Collaborative monthly. 3. Propose expansion of Learning Collaborative as appropriate by 5/31/15.	Achieved: First Learning Collaborative cohort launched to 3 communities. 1. Achieved: Communities convened monthly for in-person or web events monthly for 12 months. 2. Achieved: Impact assessed monthly by community-based learning collaborative leaders and SIM staff. 3. Achieved: Expansion proposed in April 2015. *Reporting:* Monthly status reports. *Contractors:* Nancy Abernathey.	**Learning Collaboratives:** Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 1. Create expansion plan for remaining Vermont HSAs that want to participate in the Learning Collaborative program by 6/15/15. 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.	Achieved: Learning Collaborative cohorts 2 and 3 launched in 8 communities in September 2015. 1. Achieved: Expansion plan proposed in April 2015. 2. Achieved: Expansion launched to 8 new communities began in September 2015. *Reporting:* Monthly status reports. *Contractors:* Deborah Lisi-Baker; Nancy Abernathey; Vermont Partners for Quality in Health Care; Developmental Disabilities Council; Primary Care Development Corporation.	**Learning Collaboratives:** 1. Target: 500 Vermont providers have completed the Learning Collaborative by 12/31/16. 2. Report on program effectiveness to Steering Committee and Core Team by 12/31/16. 3. Incorporate Learning Collaborative lessons learned into Sustainability Plan by 6/30/17.	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] CORE_Provider Organizations_[VT]_[EOC] CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	1. Quality Improvement Facilitation: Nancy Abernathey; Vermont Program for Quality Health Care (VPQHC). 2. Disability Core Competency Research and Implementation: Lisi-Baker; Developmental Disabilities Council. 3. Care Management Core Competency: Primary Care Development Corporation.	Erin Flynn and Pat Jones	SIM-funded staff: Erin Flynn; Jenney Samuelson; Julie Wasserman Key personnel: Pat Jones; Jenney Samuelson
Sub-Grant Program – Sub-Grants	Practice Transformation	**Sub-Grant Program – Sub Grants:** Develop technical assistance program for providers implementing payment reforms.	Achieved: 14 sub-grant awards made to 12 awardees, technical assistance program developed, and technical assistance contractors procured. *Reporting:* Monthly status reports.	**Sub-Grant Program – Sub Grants:** Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/15. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.	Achieved: 1. Achieved: Sub-grantees convened on 5/27/15. 2. Achieved: Sub-grantee quarterly reports reviewed quarterly to gather lessons learned to inform project decision-making. *Reporting:* Monthly status reports. *Contractors:* Sub-Grantees (Vermont Medical Society Foundation; *Healthfirst*; Central Vermont Medical Center Bi-State Primary Care Association/ Community Health Accountable Care; Northwest Medical Center; Northern Vermont Medical Center;	**Sub-Grant Program – Sub Grants:** Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.	Ongoing: 1. Not yet started: Plan to convene sub-grantees at least once in Spring 2016. 2. Ongoing: Analysis and incorporation of lessons learned will continue through 6/30/16. *Reporting:* Monthly status reports. *Contractors:* Sub-Grantees (Vermont Medical Society Foundation; Health*first*; Central Vermont Medical Center; Bi-State Primary Care Association/ CHAC; Northwest Medical Center; Northern Vermont Medical Center; White River Family Practice; Vermont Program for Quality in	**Sub-Grant Program – Sub Grants:** 1. Provide SIM funds to support sub-grantees through 12/31/16. 2. Convene sub-grantees at least twice by 12/31/16. 3. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] CORE_Provider Organizations_[VT]_[EOC] CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	Sub-Grantees (Vermont Medical Society Foundation; Health*first*; Central Vermont Medical Center; Bi-State Primary Care Association/ CHAC; Northwest Medical Center; Northern Vermont Medical Center; White River Family Practice; Vermont Program for Quality in Health Care; InvestEAP; Vermont Developmental Disabilities Council; Rutland	Joelle Judge and Georgia Maheras	SIM-funded staff: Susan Aranoff; Gabe Epstein; Amy Coonradt Key personnel: Heidi Klein

	Focus Area	Performance Period 1 (PP1)[1] Performance Period 1 Milestone	Performance Period 1 (PP1) Current Status and Reporting	Performance Period 1 Carryover (PP1 Carryover) Performance Period 1 Carryover Milestone	Performance Period 1 Carryover (PP1 Carryover) Current Status, Reporting, and Contractors	Performance Period 2 (PP2) Performance Period 2 Milestone	Performance Period 2 (PP2) Current Status, Reporting, and Contractors	Performance Period 3 (PP3) Performance Period 3 Milestone	Metrics	PP1 Carryover and PP2 Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
					White River Family Practice; Vermont Program for Quality in Health Care; InvestEAP; Vermont Developmental Disabilities Council; Rutland VNA; Southwest Medical Center).		Health Care; InvestEAP; Vermont Developmental Disabilities Council; Rutland VNA; Southwest Medical Center).			VNA; Southwest Medical Center).		
Sub-Grant Program – Technical Assistance	Practice Transformation	N/A	N/A	**Sub-Grant Program – Technical Assistance:** Provide technical assistance to sub-grantees as requested by sub-grantees: 1. Remind sub-grantees of availability of technical assistance on a monthly basis. 2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees.	Achieved: 1. Achieved: Sub-grantees reminded of technical assistance availability monthly. 2. Achieved: Technical assistance contracts sufficiently resourced to meet sub-grantee TA requests. *Reporting:* Monthly status reports. *Contractors:* Policy Integrity; Wakely Consulting; Truven.	**Sub-Grant Program – Technical Assistance:** Provide technical assistance to sub-grantees as requested by sub-grantees: 1. Remind sub-grantees of availability of technical assistance on a monthly basis. 2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees.	Ongoing: 1. Ongoing: Sub-grantees will be reminded of technical assistance availability monthly through 6/30/16. 2. Ongoing: Technical assistance contracts sufficiently resourced to meet sub-grantee TA requests through 6/30/16. *Reporting:* Monthly status reports. *Contractors:* Policy Integrity; Wakely Consulting.	**Sub-Grant Program – Technical Assistance:** Provide technical assistance to sub-grantees as requested by sub-grantees through 12/31/16: 1. Remind sub-grantees of availability of technical assistance on a monthly basis. 2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees.	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] CORE_Provider Organizations_[VT]_[EOC] CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	Sub-Grantee Technical Assistance: Policy Integrity; Wakely Consulting.	Susan Aranoff and Joelle Judge	SIM-funded staff: Susan Aranoff; Julie Wasserman; Gabe Epstein; Amy Coonradt Key personnel: Heidi Klein
Regional Collaborations	Practice Transformation	N/A	N/A	**Regional Collaborations:** Establish regional collaborations in health services areas by beginning to develop a Charter, governing body, and decision-making process: 1. Develop Charter, decision-making process, and participants for 6 HSAs by 11/30/15. 2. Require monthly updates from ACOs/Blueprint for Health.	Achieved: 1. Achieved: Charters, decision-making process, and participants for 6 HSAs developed by 11/30/15. 2. Achieved: Monthly updates from ACOs/Blueprint required. *Reporting:* Monthly status reports. *Contractors:* Bi-State Primary Care Association/ Community Health Accountable Care.	**Regional Collaborations:** Expansion of regional collaborations to all 14 Health Service Areas (HSAs) by 6/30/16. Expansion is complete when all HSAs have a Charter, governing body, and decision-making process.	Ongoing: Regional collaborations active in all HSAs; as of February 2016, 14 of 14 communities had a charter in place and had defined one or more focus area. Work continues to support development of governing body and decision-making process. *Reporting:* Monthly status reports. *Contractors:* Bi-State Primary Care Association/ Community Health Accountable Care (CHAC); UVM Medical Center (UVMMC)/ OneCare Vermont.	**Regional Collaborations:** 1. Support regional collaborations in 14 HSAs by providing sub-grants to ACOs and other technical assistance resources. 2. Develop a transition plan by 4/30/17 to shift all HSAs to non-SIM resources. 3. Incorporate into Sustainability Plan by 6/30/17.	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] CORE_Provider Organizations_[VT]_[EOC] CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	ACO Activities: Bi-State Primary Care Association/ CHAC; UVMMC/OneCare Vermont.	Jenney Samuelson	SIM-funded staff: Erin Flynn; Amy Coonradt Key personnel: Pat Jones; Jenney Samuelson
Workforce – Care Management Inventory	Practice Transformation	N/A	N/A	**Care Management Inventory:** Obtain snapshot of current care management activities, staffing, people served, and challenges: 1. Obtain Draft Report by 3/31/15. 2. Present to 2 work groups by 5/31/15. 3. Final Report due by 9/30/15.	Achieved: 1. Achieved: Draft report results presented to CMCM Work Group in February 2015. 2. Achieved: presented to CMCM Work Group and Workforce Work Group. 3. Achieved. *Reporting:* Monthly status reports. *Contractors:* Bailit Health Purchasing.	N/A	N/A	N/A	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] CORE_Provider Organizations_[VT]_[EOC] CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	Care Management Inventory: Bailit Health Purchasing.	Pat Jones and Erin Flynn	SIM-funded staff: Erin Flynn Key personnel: Pat Jones

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Workforce – Demand Data Collection and Analysis	Practice Transformation	N/A	N/A	N/A	N/A	**Workforce – Demand Data Collection and Analysis:** 1. Execute contract for micro-simulation demand modeling by 1/15/16 (dependent on federal approval). 2. Provide preliminary data as defined by the contract to vendor for use in model by 3/15/16.	1. In progress: Contract for demand modeling approved by CMMI in October. Pending execution. Anticipate execution by Q2 2016. 2. Not yet started: DVHA expects to provide data to demand modeling vendor in Q2 2016. *Reporting:* Monthly status reports; reports from vendor. *Contractors:* IHS.	**Workforce – Demand Data Collection and Analysis:** Submit Final Demand Projections Report and present findings to Work Force Work Group by 12/31/16.	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] CORE_Provider Organizations_[VT]_[EOC] CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	Micro-Simulation Demand Model: IHS.	Amy Coonradt	SIM-funded staff: Amy Coonradt Key personnel: Mat Barewicz
Workforce – Supply Data Collection and Analysis	Practice Transformation	N/A	N/A	**Workforce – Supply Data Collection and Analysis:** Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan: 1. Present data to Workforce Work Group at least 3 times by 9/30/15. 2. Publish data reports/analyses on website by 12/31/15. 3. Distribute reports/analyses to project stakeholders by 12/31/15.	1. Achieved. 2. Achieved: Posted on the VDH website. 3. Achieved: Achieved as part of Workforce Work Group presentations. *Reporting:* Monthly status reports. *Contractors:* N/A	**Workforce – Supply Data Collection and Analysis:** Continue to use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan:[4] 1. Present data to Workforce Work Group at least 4 times between 1/1/15 and 6/30/16. 2. Publish data reports/analyses on website by 12/31/15. 3. Distribute reports/analyses to project stakeholders by 12/31/15.	In progress: VDH presented to Health Care Workforce Work Group in February 2016 and proposed forming a sub-group of the Health Care Workforce Work Group and other key subject matter experts. The subgroup will analyze VDH data and provide this analysis to the broader work group, with the goal of informing work group activities. *Contractors:* N/A (staff only).	**Workforce – Supply Data Collection and Analysis:** Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan: 1. Present data to Workforce Work Group at least 3 times by 12/31/16. 2. Publish data reports/analyses on website by 6/30/17. 3. Distribute reports/analyses to project stakeholders by 6/30/17. 4. Incorporate into Sustainability Plan by 6/30/17.	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] CORE_Provider Organizations_[VT]_[EOC] CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	*Staff Only.*	Matt Bradstreet	SIM-funded staff: Matt Bradstreet; Amy Coonradt Key personnel: VDH and OPR licensing staff
	Practice Transformation	Vermont Department of Labor to develop a comprehensive review of all such programs offered by each agency/department of state government - due by the end of 2013.	Achieved. *Reporting:* PP1 Annual Report.	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A
	Practice Transformation	SIM will expand all existing efforts (Blueprint, VITL, providers, VCCI, SASH, Hub and Spoke).	Achieved. *Reporting:* PP1 Annual Report. These activities are now found in the Payment Model Design and Implementation section above for subsequent project periods.	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A
Focus Area: Health Data Infrastructure												
Expand Connectivity to HIE – Gap Analyses	Health Data Infrastructure	**Expand Connectivity to HIE – Gap Analyses:** Perform gap analyses related to quality measures for each payment program, as appropriate; perform baseline gap analyses to understand connectivity	Achieved: Two gap analyses launched in 2014: ACO program and non-MU long-term services and supports providers. *Reporting:* Monthly status reports.	**Expand Connectivity to HIE – Gap Analyses:** Perform gap analyses related to quality measures for each payment program, as appropriate; perform baseline gap analyses to understand connectivity	Achieved: 1. Achieved: DLTSS technical gap *analysis* finalized in October 2015. 2. In progress: bimonthly analyses completed to date; final analysis will be complete by 12/31/15.	N/A	N/A	N/A	CORE_Health Info Exchange_[VT]	Perform Gap Analyses: VITL; H.I.S. Professionals.	Georgia Maheras (ACO); Sarah Kinsler (DLTSS)	SIM-funded staff: Georgia Maheras; Sarah Kinsler; Susan Aranoff; Julie Wasserman; David Epstein

[4] This is a new PP2 milestone. Previously, this work was part of the PP1 Carryover, and there is need to provide workforce supply information as part of the new NCE time period of January-June 2016.

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		of non-Meaningful Use (MU) providers.		of non-Meaningful Use (MU) providers: 1. Complete DLTSS technical gap analysis by 9/30/15. 2. Conduct bimonthly SSP quality measure gap analyses for ACO providers.	*Reporting:* Monthly status reports. *Contractors:* VITL (Vermont Information Technology Leaders); H.I.S. Professionals.							Key personnel: Larry Sandage
Expand Connectivity to HIE – Gap Remediation	Health Data Infrastructure	N/A	N/A	N/A	N/A	**Expand Connectivity to HIE – Gap Remediation:** Remediate data gaps that support payment model quality measures, as identified in gap analyses: 1. Remediate 50% of data gaps for SSP quality measures by 12/31/15. 2. Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15.	Achieved: 1. Achieved: Over 50% of gaps remediated. 2. Achieved: Remediation plan developed. *Reporting:* Monthly status reports. *Contractors:* Vermont Information Technology Leaders (VITL); Vermont Care Partners; H.I.S. Professionals; Pacific Health Policy Group.	**Expand Connectivity to HIE – Gap Remediation:** 1. Remediate 65% of ACO SSP measures-related gaps as identified in Fall 2015/Spring 2016 by 6/30/17. 2. Incorporate Gap Remediation activities into Sustainability Plan by 6/30/17.	CORE_Health Info Exchange_[VT]	Remediation of Data Gaps – VITL; Vermont Care Partners; H.I.S. Professionals; Pacific Health Policy Group.	Georgia Maheras	SIM-funded staff: Georgia Maheras; Susan Aranoff; Julie Wasserman; David Epstein Key personnel: Larry Sandage
Expand Connectivity to HIE – Data Extracts from HIE	Health Data Infrastructure	N/A	N/A	**Expand Connectivity to HIE – Data Extracts from HIE:** Completed development of ACO Gateways with OneCare Vermont (OCV) by 3/31/15 and Community Health Accountable Care (CHAC) by 12/31/15 to support transmission of data extracts from the HIE.	Delayed: OCV Gateway and CHAC Gateway completed as of December 2015; work on Health*first* Gateway is ongoing. *Reporting:* Monthly status reports. *Contractors:* VITL	N/A	N/A	N/A	CORE_Health Info Exchange_[VT]	ACO Gateway: VITL.	Georgia Maheras	SIM-funded staff: Georgia Maheras Key personnel: Larry Sandage
Expand Connectivity to HIE	Health Data Infrastructure	**Expand Connectivity to HIE:** 1. Begin to incorporate long-term care, mental health, home care and specialist providers into the HIE infrastructure. 2. Number of new interfaces built between provider organizations and HIE (goal = 18 additional hospital interfaces and 75 new interfaces to non-hospital health care organizations to include: at least 10 specialist practices; 4 home health agencies; and 4 designated mental health agencies).	1. Achieved (note some PP1 Carryover). 2. Achieved: 16 hospital interfaces built; 75 new interfaces to non-hospital health care organizations built. *Reporting:* Monthly status reports.	**Expand Connectivity to HIE:** Begin to incorporate long-term care, mental health, home care and specialist providers into the HIE infrastructure and expand provider connection to HIE infrastructure: 1. Number of new interfaces built between provider organizations and HIE: Total goal for Y1 = 20 hospital interfaces and 150 interfaces to non-hospital health care organizations by 12/31/15.	1. Achieved: 20 hospital interfaces and 193 non-hospital interfaces built. *Reporting:* Monthly status reports. *Contractors:* VITL.	N/A	N/A	N/A	CORE_Health Info Exchange_[VT]	Interface Development: VITL.	Georgia Maheras	SIM-funded staff: Georgia Maheras Key personnel: Larry Sandage
Improve Quality of Data Flowing into HIE	Health Data Infrastructure	**Improve Quality of Data Flowing into HIE:** Clinical Data: 1. Medication history and provider portal to query the VHIE by end of 2013. 2. State law requires statewide availability of Blueprint program and its IT infrastructure by October 2013.	1. Achieved: 129 queries. 2. Achieved. *Reporting:* Monthly status reports and contractor reports.	**Improve Quality of Data Flowing into HIE:** 1. Data quality initiatives with the DAs/SSAs: Conduct data quality improvement meetings with the DAs/SSAs to focus on the analysis of the current state assessments for each agency: at least 4	1. Achieved. 2. In progress: will be achieved by 12/31/15. *Reporting:* Monthly status reports and contractor reports. *Contractors:* VITL; Behavioral Health Network.	**Improve Quality of Data Flowing into HIE:** 1. Implement terminology services tool to normalize data elements within the VHIE by TBD. 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE	1. In progress. 2. In progress: Workflow improvement activities begun. *Reporting:* Monthly status reports and contractor reports. *Contractors:* VITL; Behavioral Health	**Improve Quality of Data Flowing into HIE:** 1. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 50% of ACO attributing	CORE_Health Info Exchange_[VT]	Terminology Services: VITL. Workflow Improvement: VITL, Behavioral Health Network; UVMMC/OneCare Vermont; TBD.	Georgia Maheras	Key personnel: Larry Sandage

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		Performance Period 1 Milestone	Current Status and Reporting	Performance Period 1 Carryover Milestone	Current Status, Reporting, and Contractors	Performance Period 2 Milestone	Current Status, Reporting, and Contractors	Performance Period 3 Milestone				
				meetings per month with DA/SSA leadership and 6 meetings per month with individual DAs/SSAs to review work flow. 2. Access to medication history to support care: 150 medication queries to the VHIE by Vermont providers by 12/31/15.		as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16.	Network; UVM Medical Center (UVMMC)/ OneCare Vermont; TBD.	practices by 7/1/16. Complete workflow improvement by 12/31/16. 2. Engage in workflow improvement activities at designated mental health agencies (DAs) as identified in gap analyses. Start workflow improvement activities in all 16 DAs by 7/1/16 and complete workflow improvement by 12/31/16.				
Telehealth – Strategic Plan	Health Data Infrastructure	N/A	N/A	N/A	N/A	**Telehealth – Strategic Plan:** Develop telehealth strategic plan by 9/15/15.	Achieved: Telehealth Strategic Plan finalized in September 2015. *Reporting:* Report completed by deadline. *Contractors:* JBS International.	N/A	CORE_Health Info Exchange_[VT]	Telehealth Strategic Plan: JBS International.	Sarah Kinsler	SIM-funded staff: Sarah Kinsler
Telehealth – Implementation	Health Data Infrastructure	N/A	N/A	N/A	N/A	**Telehealth – Implementation:** 1. Release telehealth program RFP by 9/30/15. 2. Award at least one contract to implement the scope of work in the telehealth program RFP by 1/15/16.	1. Achieved: RFP released on 9/18/15. 2. In process. Bidders selected in December 2015; as of February, contract negotiations still underway. *Reporting:* RFP released on time; monthly status reports. *Contractors:* VNA of Chittenden and Grand Isle Counties; Howard Center.	**Telehealth – Implementation:** 1. Continue telehealth pilot implementation through contract end dates. 2. Incorporate Telehealth Program into Sustainability Plan by 6/30/17.	CORE_Health Info Exchange_[VT]	Telehealth Implementation: VNA of Chittenden and Grand Isle Counties; Howard Center.	Jim Westrich	SIM-funded staff: Jim Westrich
EMR Expansion	Health Data Infrastructure	N/A	N/A	N/A	N/A	**EMR Expansion:** 1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and ARIS (Developmental Disability Agencies) (by 6/30/16). 2. Explore non-EMR solutions for providers without EMRs: develop plan based on LTSS technical gap analysis.	1. In progress: Achieved – State Psychiatric Hospital EMR guidance provided in Jan-Mar 2015. On track – ARIS/ Developmental Disability Agencies procurement will be complete by 6/30/16. 2. Achieved: Remediation plan to support VHIE connection for home health agencies developed and approved; this work will be pursued in PP3 under the Care Management Tools work stream. *Reporting:* Monthly status reports. *Contractors:* ARIS; VITL/Department of Mental Health.	N/A	CORE_Health Info Exchange_[VT]	EMR Procurement: ARIS; VITL/Dept of Mental Health. Non-EMR Solutions: ARIS; VITL.	Georgia Maheras	SIM-funded staff: Georgia Maheras Key personnel: Joelle Judge

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		Performance Period 1 Milestone	**Current Status and Reporting**	**Performance Period 1 Carryover Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 2 Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 3 Milestone**				
Data Warehousing	Health Data Infrastructure	N/A	N/A	**Data Warehousing:** Prepare to develop infrastructure to support the transmission, aggregation, and data capability of the DAs and SSAs data into a mental health and substance abuse compliant Data Warehouse: 1. Develop data dictionary by 3/31/15. 2. Release RFP by 4/1/15. 3. Execute contract for Data Warehouse by 10/15/15. 4. Design data warehousing solution so that the solution begins implementation by 12/31/15.	1. Achieved. 2. Achieved. 3. In progress: SOV amended contract with vendor for this work. Contractor will have sub-contract by 11/30/15. 4. Achieved. *Reporting:* Monthly status reports. *Contractors:* Behavioral Health Network.	**Data Warehousing:** 1. Implement Phase 1 of DA/SSA data warehousing solution by 12/31/15 (implementation follows implementation project plan). 2. Procure clinical registry software by 3/31/16. 3. Develop a cohesive strategy for developing data systems to support analytics by 3/31/16.	1. Achieved. 2. Achieved. 3. In progress: Will be completed by 3/31/16. *Reporting:* Monthly status reports. *Contractors:* Behavioral Health Network; Covisint; Stone Environmental.	**Data Warehousing:** 1. Implement Phase 2 of DA/SSA data warehousing solution by 12/31/16. 2. Begin to implement cohesive strategy for developing data systems to support analytics by 12/31/16.	CORE_Health Info Exchange_[VT]	Stakeholder Engagement: Behavioral Health Network. Clinical Registry Procurement: Covisint. Cohesive Strategy Development: Stone Environmental.	Georgia Maheras and Craig Jones	SIM-funded staff: Georgia Maheras Key personnel: Craig Jones; Larry Sandage
Care Management Tools	Health Data Infrastructure	N/A	N/A	**Care Management Tools:** 1. Discovery project to support long- term care, mental health, home care and specialist providers through a Universal Transfer Protocol solution: Report due 4/15/15. 2. Engage in research and discovery to support selection of a vendor for event notification system in Vermont by 10/1/15.	1. Achieved: Report received in February 2015. 2. Achieved: Research and discovery launched in March 2015; vendor selected in September 2015. State, VITL, and vendor currently in contract negotiations. *Reporting:* Monthly status reports. *Contractors:* im21.	**Care Management Tools:** Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development: 1. Event Notification System: Procure solution by 1/15/16 and implement according to project plan for phased roll out. 2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16.	1. In progress: Vendor selected. Federal approval received. State contract pending. 2. In progress: Business and technical requirements gathered; final proposal in development for release in March 2016. *Reporting:* Monthly status reports. *Contractors:* PatientPing; Stone Environmental; TBD.	**Care Management Tools:** 1. Event Notification System: Continue implementation of ENS according to contract with vendor through 12/31/16. 2. Shared Care Plan: Continue implementation of Shared Care Plan solution implemented during Performance Period 2 through 12/31/16. 3. Universal Transfer Protocol: Support workflow improvements at provider practices through existing contracts through 12/31/16. 4. Continue implementation of care management solutions, including VITLAccess, supporting Home Health Agencies and Area Agencies on Aging.	CORE_Health Info Exchange_[VT]	Event Notification System: PatientPing. Shared Care Plans and Universal Transfer Protocol – Research: Stone Environmental; Implementation: TBD.	Georgia Maheras (Event Notification System, Shared Care Plans and Universal Transfer Protocol)	SIM-funded staff: Georgia Maheras; Erin Flynn; Susan Aranoff; Gabe Epstein Key personnel: Larry Sandage; Joelle Judge
General Health Data – Data Inventory	Health Data Infrastructure	**General Health Data – Health Data Inventory:** Conduct data inventory.	Achieved: Data inventory launched in December 2014 following contract execution. *Reporting:* Monthly status report.	**General Health Data – Health Data Inventory:** Complete data inventory: 1. Draft analysis of health care data sources that support payment and delivery system reforms by 4/15/15. 2. Final data inventory due by 10/31/15.	Achieved: 1. Achieved: Draft analysis of data sources completed in Spring 2015. 2. Achieved: Data inventory data collection and final report with recommendations completed in December 2015. *Reporting:* Monthly status reports. *Contractors:* Stone Environmental	N/A	N/A	N/A	CORE_Health Info Exchange_[VT]	Data Inventory: Stone Environmental.	Sarah Kinsler	SIM-funded staff: Sarah Kinsler. Key personnel: Larry Sandage.

	Focus Area	Performance Period 1 (PP1)[1] Performance Period 1 Milestone	Performance Period 1 (PP1) Current Status and Reporting	Performance Period 1 Carryover (PP1 Carryover) Performance Period 1 Carryover Milestone	Performance Period 1 Carryover (PP1 Carryover) Current Status, Reporting, and Contractors	Performance Period 2 (PP2) Performance Period 2 Milestone	Performance Period 2 (PP2) Current Status, Reporting, and Contractors	Performance Period 3 (PP3) Performance Period 3 Milestone	Metrics	PP1 Carryover and PP2 Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
General Health Data – HIE Planning	Health Data Infrastructure	**General Health Data – HIE Planning:** Provide input to update of state HIT Plan.	Achieved: Project staff and stakeholders have provided ongoing input into Vermont HIT Plan update since 2014. *Reporting:* Monthly status report.	N/A	N/A	**General Health Data – HIE Planning:** 1. VHCIP will provide comment into the HIT Strategic Plan at least 4 times in 2015. 2. HDI Work Group will identify connectivity targets for 2016-2019 by 6/30/16.	1. Achieved: VHCIP has provided ongoing input into HIT Strategic Plan in 2015. 2. In progress: This work is occurring throughout January-June 2016. *Reporting:* Monthly status reports. *Contractors:* Stone Environmental.	**General Health Data – HIE Planning:** Finalize connectivity targets for 2016-2019 by 12/31/16.	CORE_Health Info Exchange_[VT]	Support HIE Planning: Stone Environmental.	Larry Sandage	Key personnel: Larry Sandage
General Health Data – Expert Support	Health Data Infrastructure	N/A	N/A	N/A	N/A	**General Health Data – Expert Support:** Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.	Ongoing: Vermont is procuring IT-specific support for health data initiatives as necessary and appropriate. *Reporting:* Monthly status reports. *Contractors:* Stone Environmental; H.I.S. Professionals.	**General Health Data – Expert Support:** Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.	CORE_Health Info Exchange_[VT]	Research and Analyses: Stone Environmental. Project Management and Subject Matter Expertise: H.I.S. Professionals.	TBD	Key personnel: TBD; Larry Sandage
	Health Data Infrastructure	VHCURES: 1. Update rule to include VHC information (Fall 2013). 2. Incorporate Medicare data (Fall 2013). 3. Improve data quality procedures (Fall 2014). 4. Improve data access to support analysis (Fall 2014).	1. Not met: SOV is not using these data in VHCURES due to data limitations. This was previously conveyed to CMMI. 2. Achieved. 3. Achieved. 4. Achieved. *Reporting:* 2014 Annual Report and Milestones Met/Not Met response to CMMI in May 2015.	N/A	N/A	N/A	N/A	N/A	CORE_Health Info Exchange_[VT]	N/A	N/A	N/A
	Health Data Infrastructure	Medicaid Data: A combined advanced planning document for the funding to support the TMSIS is completed and submitted to CMS in July 2013.	Achieved. *Reporting:* 2014 Annual Report and Milestones Met/Not Met response to CMMI in May 2015.	N/A	N/A	N/A	N/A	N/A	CORE_Health Info Exchange_[VT]	N/A	N/A	N/A
Focus Area: Evaluation												
Self-Evaluation Plan and Execution	Evaluation	**Self-Evaluation Plan and Execution:** 1. Procure contractor: Hire through GMCB in Sept 2013. 2. Evaluation (external): • Number of meetings held with Quality and Performance Measurement Work Group on evaluation (goal = 2). • Evaluation plan developed. • Baseline data identified.	1. Achieved: Initial self-evaluation contract (Impaq) executed in September 2014. 2. Achieved: Regular meetings with QPM Work Group and other stakeholders; self-evaluation plan submitted as draft to CMMI in June 2015. *Reporting:* Monthly status reports (contractor weekly reports).	**Self-Evaluation Plan and Execution:** 1. Design Self-Evaluation Plan for submission to CMMI by 6/30/15. a. Elicit stakeholder feedback prior to submission. 2. Once approved by CMMI, engage in Performance Period 1 Carryover activities as identified in the plan.	1. Achieved: Draft self-evaluation plan submitted to CMMI in June 2015, incorporating stakeholder feedback. 2. In progress: Plan resubmitted to CMMI on November 11, 2015. *Reporting:* Monthly status reports (contractor weekly reports). *Contractors:* Impaq International.	**Self-Evaluation Plan and Execution:** 1. Procure new self-evaluation contractor by 2/28/16 to execute contractor-led self-evaluation plan activities.[5] 2. Continue to execute self-evaluation plan using staff and contractor resources.[6] 3. Streamline reporting around other evaluation activities within 30 days of CMMI approval of self-evaluation plan.	1. In progress: RFP released in November 2015; contract is submitted to CMMI and awaiting approval. 2. Ongoing: Self-evaluation plan execution is ongoing using staff and contractor resources. 3. In progress: This is delayed pending final approval of self-evaluation plan. *Reporting:* Monthly status reports.	**Self-Evaluation Plan and Execution:** Execute Self-Evaluation Plan for 2016 and 2017 according to timeline for Year 3 activities.	All metrics	1. Development of Self-Evaluation Plan: Impaq International. 2. Implementation of Self-Evaluation Plan (Monitoring and Evaluation): The Lewin Group; Burns and Associates. 3. Implementation of Self-Evaluation Plan (Provider	Annie Paumgarten	SIM-funded staff: Annie Paumgarten Key personnel: Susan Barrett

[5] Vermont requested modification to this milestone by email, dated 11/23/15.

[6] Vermont's self-evaluation plan relies on numerous staff and contractors, which are described in the Evaluation Remediation Plan submitted on November 25, 2015.

	Focus Area	Performance Period 1 (PP1)[1] Performance Period 1 Milestone	Performance Period 1 (PP1) Current Status and Reporting	Performance Period 1 Carryover (PP1 Carryover) Performance Period 1 Carryover Milestone	Performance Period 1 Carryover (PP1 Carryover) Current Status, Reporting, and Contractors	Performance Period 2 (PP2) Performance Period 2 Milestone	Performance Period 2 (PP2) Current Status, Reporting, and Contractors	Performance Period 3 (PP3) Performance Period 3 Milestone	Metrics	PP1 Carryover and PP2 Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
							Contractors: Burns and Associates; Impaq International; Onpoint; The Lewin Group; Truven.			Surveys and Analyses): TBD.		
Surveys	Evaluation	N/A	N/A	**Surveys:** Conduct annual patient experience survey (Performance Period 1 surveys only): 1. Surveys are completed by 6/30/15 for reporting as part of the first performance period for the Medicaid and commercial Shared Savings Programs.	Achieved: Surveys fielded. *Reporting:* Monthly status reports. *Contractors:* Datastat.	**Surveys:** Conduct annual patient experience survey and other surveys as identified in payment model development: Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings programs – phase 1 to determine impact of Performance Period 2 activities by 6/30/16.	In progress: Surveys distributed. Collection of data and reports are not yet complete. They will be complete by 6/30/16. *Reporting:* Monthly status reports (contractor reports). *Contractors:* Datastat.	**Surveys:** Conduct annual patient experience survey and other surveys as identified in payment model development: Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings Programs by 6/30/17.	CAHPS Clinical & Group Surveys CORE_HCAHPS Patient Rating_[VT]	1. Field Patient Experience Survey: Datastat. 2. Develop Survey Report: Datastat.	Pat Jones and Jenney Samuelson	SIM-funded staff: Annie Paumgarten Key personnel: Pat Jones, Jenney Samuelson
Monitoring and Evaluation Activities Within Payment Programs	Evaluation	N/A	N/A	**Monitoring and Evaluation Activities Within Payment Programs:** Conduct analyses as required by payers related to specific payment models. • Number of meetings held with Quality and Performance Measurement Work Group on evaluation (goal = 2 by 6/30/15). • Payer-specific evaluation plan developed for Medicaid Shared Savings Program as part of State Plan Amendment approval. • Baseline data identified for monitoring and evaluation of Medicaid and commercial Shared Savings Programs by 6/30/15.	Achieved: QPM Work Group met monthly prior to consolidation with Payment Model Design and Implementation Work Group in October 2015; payer-specific evaluation plan included in approved SPA; baseline data identified for monitoring and evaluation of SSPs and included in initial analyses. *Reporting:* Monthly status reports. *Contractors:* Burns and Associates; Bailit Health Purchasing; The Lewin Group.	**Monitoring and Evaluation Activities Within Payment Programs:** 1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications: biannual reporting to providers. 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: monthly, quarterly reports depending on type.	1. Ongoing: Non-SIM funded analyses of PCMH program are conducted twice annually. 2. Ongoing: Monthly and quarterly SSP reports are ongoing. *Reporting:* Monthly status reports (embedded in SSP reports). *Contractors:* Burns and Associates; The Lewin Group.	**Monitoring and Evaluation Activities Within Payment Programs:** 1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications (bi-annual reporting to providers). 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications (monthly, quarterly reports depending on report type). 3. Conduct analyses of the EOC program according to program specifications (monthly, quarterly reports depending on report type). 4. Conduct analyses of the PPS – Home Health program according to program specifications (monthly, quarterly reports depending on report type). 4. TBD: APM, Medicaid VBP – Mental Health and Substance Use.	CORE_BMI_[VT] CORE_Diabetes Care_[VT] CORE_ED Visits_[VT] CORE_HRQL_[VT] CORE_Readmissions_[VT] CORE_Tobacco Screening and Cessation_[VT] CAHPS Clinical & Group Surveys	Financial and Quality Analysis for New Programs: The Lewin Group (SSP); Burns and Associates (Medicaid).	TBD – GMCB, and Erin Flynn	SIM-funded staff: Amy Coonradt; James Westrich; Brian Borowski; Carole Magoffin Key personnel: Pat Jones
Focus Area: Program Management and Reporting												
Project Management and Reporting – Project Organization	Project Management and Reporting	**Project Management and Reporting – Project Organization:** 1. Procure contractor: Contract for interagency coordination. 2. Hire contractor: Contract for staff training and development. 3. Develop curriculum: Training and development curriculum developed. 4. Develop interagency and inter-project	1. Achieved: Contractor procured. 2. Achieved: Contractor hired. 3. Achieved: Training and development curriculum developed. 4. Achieved. Plan developed. 5. Achieved: Survey deployed; results compiled.	**Project Management and Reporting – Project Organization:** 1. Ensure project is organized by procuring sufficient staff and contractor resources on an ongoing basis. 2. Continue interagency coordination across the departments and agencies involved in VHCIP activities.	1. Achieved: Staff and contractor resources procured as needed on an ongoing basis. 2. Ongoing: Interagency coordination is ongoing. 3. Ongoing: Staff training and development activity is ongoing through 12/31/15. 4. Ongoing: Staff training and development activity is ongoing through 12/31/15.	**Project Management and Reporting – Project Organization:** Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2. Monthly staff meetings, co-chair meetings, and Core Team meetings with reporting on budget,	1. Ongoing: Project Management contract scope of work and tasks performed on time. 2. Achieved: Meetings held, reporting presented and discussed. 3. Achieved: Reports submitted. *Reporting:* Monthly report to Core Team.	**Project Management and Reporting – Project Organization:** Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2. Monthly staff meetings, co-chair meetings, and Core Team meetings with reporting on budget,	All metrics	Project Management: University of Massachusetts.	Georgia Maheras	SIM-funded staff: Georgia Maheras; Christine Geiler; Amanda Ciecior

	Focus Area	Performance Period 1 (PP1)[1] Performance Period 1 Milestone	Performance Period 1 (PP1) Current Status and Reporting	Performance Period 1 Carryover (PP1 Carryover) Performance Period 1 Carryover Milestone	Performance Period 1 Carryover (PP1 Carryover) Current Status, Reporting, and Contractors	Performance Period 2 (PP2) Performance Period 2 Milestone	Performance Period 2 (PP2) Current Status, Reporting, and Contractors	Performance Period 3 (PP3) Performance Period 3 Milestone	Metrics	PP1 Carryover and PP2 Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
		communication plan: Interagency and inter-project communications plan developed. 5. Implement plan: Results of survey of project participants re: communications.	*Reporting:* Monthly status reports, monthly staff meetings, monthly Core Team meetings.	3. Continue staff training and development- assess quarterly. 4. Continue to deploy training and development curriculum- assess curriculum quarterly. 5. Implement communications plan by 12/31/15.	5. In progress: Communications plan developed and will be implemented by 12/31/15. *Reporting:* Monthly status reports, monthly staff meetings, monthly Core Team meetings. *Contractors:* The Coaching Center; PDI Creative; University of Massachusetts; Arrowhead Health Analytics; University of Vermont.	milestones, and policy decisions presented and discussed at each meeting. 3. Submit quarterly reports to CMMI and the Vermont Legislature.	*Contractors:* University of Massachusetts.	milestones, and policy decisions presented and discussed at each meeting. 3. Submit quarterly reports to CMMI and the Vermont Legislature. 4. Population Health Plan finalized by 6/30/17. 5. Sustainability Plan finalized by 6/30/17.				
Project Management and Reporting – Communication and Outreach	Project Management and Reporting	**Project Management and Reporting – Communication and Outreach:**Stakeholder engagement: Work groups and more broadly.	Achieved: Robust public and private stakeholder engagement in project activities and decision-making through project work groups, sub-groups, project-specific steering committees, bid review teams, key informant interviews, and more. *Reporting:* Monthly status reports, monthly staff meetings, monthly Core Team meetings.	**Project Management and Reporting – Communication and Outreach:** 1. Engage stakeholders in project focus areas through work groups, Steering Committee, Core Team, Symposia, and other convenings. 2. Target convening 10 Core Team; 5 Steering Committee, and 10 Work Group meetings during this period. 3. Stakeholder engagement plan developed and implemented – revised plan due 8/31/15.	1. Achieved: Robust public and private stakeholder engagement in project focus areas through work groups, Steering Committee, Core Team, Symposia, and other convenings. 2. Achieved. 3. Achieved. *Reporting:* Monthly status reports, monthly staff meetings, monthly Core Team meetings. *Contractors:* PDI Creative; University of Massachusetts.	**Project Management and Reporting – Communication and Outreach:** Engage stakeholders in project focus areas by: 1. Convening 5 Core Team, 5 Steering Committee, and 10 work group public meetings by 6/30/16. 2. Distributing all-participant emails at least once a month. 3. Updating website at least once a week.	1. Achieved: Meetings held in 2015. Additional meetings needed in the NCE period. 2. Achieved: All-participant emails distributed as needed, at least monthly. Additional communications needed in the NCE period. 3. Achieved: Website updated continually, at least weekly. Additional updates needed in the NCE period. *Reporting:* Monthly report to Core Team; quarterly report to CMMI. *Contractors:* University of Massachusetts; PDI Creative.	**Project Management and Reporting – Communication and Outreach:** Engage stakeholders in project focus areas by: 1. Convening 10 Core Team meetings by 6/30/17. 2. Convening 5 Steering Committee public meetings and 20 work group public meetings by 12/31/16. 2. Distributing all-participant emails at least once a month through 12/31/16. 3. Update website at least once a week through 12/31/16, and monthly through 6/30/17.	All metrics	Project Management: University of Massachusetts. Outreach and Engagement: PDI Creative.	Christine Geiler	SIM-funded staff: Christine Geiler; Amanda Ciecior
	Project Management and Reporting	Implement "How's Your Health" Tool by June 2014.	Achieved: Implemented through sub-grant to White River Family Practice Sub-Grant.	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A

Attachment 4: High-Level Goals Memo to CMMI

109 State Street

Montpelier, VT 05609

www.healthcareinnovation.vermont.gov

To: Bridget Harrison, Project Officer, and Jenny Lloyd, Evaluation, CMMI
Fr: Georgia Maheras, Esq., Deputy Director of Health Care Reform for Payment and Delivery System Reform, Agency of Administration, and Director, Vermont Health Care Innovation Project
Cc: Annie Paumgarten, Evaluation Director, GMCB
Date: March 7, 2016
Re: SOV High Level Goals-Supplemental Information

Vermont's high-level SIM goals:

1. 80% of Vermonters in alternatives to fee-for-service (FFS), from 41% in 2013 to 80% in 2017.[1]
2. By 12/31/2016, in adult Vermont residents attributed to an ACO, the % with diabetes HbA1c Poor Control will be 20% or less, 70% or more with an abnormal BMI will have a follow-up plan documented, and 85% or more identified as tobacco users will receive a cessation intervention.
3. The number of providers with at least one interface to the Vermont Health Information Exchange will increase from 130 to at least 400 by 6/30/17.
4. Cost avoidance of $45 million generated through payment models.

Details about each of these is provided below:

1. 80% of Vermonters in alternatives to FFS, from 41% in 2012 to 80% in 2017.

Vermont tracks payer-reported totals of Vermonters for whom providers receive non-FFS payments.

Reporting Measure	**80% of Vermonters in alternatives to FFS**
Description	The total number of eligible Vermonters for whom providers receive an alternative payment within value-based purchasing (VBP) models statewide.
Denominator	Vermonters eligible for attribution to a VBP model. Models included: • Medicare, Medicaid, and Commercial SSP programs; • Blueprint for Health Pay-for-Performance Patient-Centered Medical Home program; • Medicaid VBP (Hub and Spoke Health Home program, Home Health Prospective Payment System, VBP for mental health and substance use); and • Medicaid episode-based payments.
Denominator Exclusions/Exceptions	Medicare Advantage enrollees, Military personnel, uninsured individuals, incarcerated individuals.

Reporting Measure	80% of Vermonters in alternatives to FFS
Numerator	Unduplicated number of eligible beneficiaries directly enrolled in or attributed to one or more testing models.
Level of Reporting	Statewide: Commercial, Medicaid, Medicare
Source for Measure	Payers
Numerator Baseline	Blueprint attributed members from Q4 of calendar year 2012: 238,931
Denominator Baseline	585,000
Baseline	41%
Target	80%

2. ***By 12/31/2016, in adult Vermont residents attributed to an ACO, the % with diabetes HbA1c Poor Control will be 20% or less, 70% or more with an abnormal BMI will have a follow-up plan documented, and 85% or more identified as tobacco users will receive a cessation intervention.***

Measure Name	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent) CMS MSSP-27; NQF #0024
Description	The percentage of attributed individuals 18–75 years of age with diabetes (type 1 and type 2) who had the following: • HbA1c poor control (>9.0%).
Modifications to HEDIS Measure Specifications	1. This measure will be used to assess quality in the ACO population rather than in a health plan population. 2. Since the measure will be applied at the ACO level, we have replaced the term “members” with the term “attributed individuals.”
Level of Analysis	ACO
Source for Measure	ACO medical record review
Baseline	2013 Medicare SSP: OneCare Vermont (OCV): 22.12% Accountable Care Coalition of the Green Mountains (ACCGM): 36.16%
Target	20% or less across all ACOs

Measure Name	Body Mass Index (BMI) Screening and Follow-up CMS MSSP-16; NQF #0421
Description	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit. Normal Parameters: Age 65 years and older BMI ≥ 23 and 30 Age 18 – 64 years BMI ≥ 18.5 and 25

Measure Name	Body Mass Index (BMI) Screening and Follow-up CMS MSSP-16; NQF #0421
Denominator	ACO beneficiaries aged 18 years and older at the beginning of the measurement period.
Denominator Exclusions/ Exceptions	(Exclusion only applied if a calculated BMI was not documented as normal OR was outside parameters with a follow-up not performed during the measurement period.) • Documentation of medical reason(s) for not having a BMI measurement performed during the measurement period (e.g., patient is receiving palliative care, patient is pregnant or patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status). • Documentation of patient reason(s) for not having a BMI measurement performed during the measurement period (e.g., patient refuses BMI measurement or if there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate).
Numerator	ACO beneficiaries with BMI calculated within the past six months or during the current visit and a follow-up plan is documented within the last six months or during the current visit if the BMI is outside of normal parameters.
Level of Analysis	ACO
Source for measure	ACO medical record review
Baseline	2013 Medicare SSP: OCV: 70.94 ACCGM: 41.65
Target	70% or greater across all ACOs

Measure Name	Tobacco Use Assessment and Tobacco Cessation Intervention MSSP-17; NQF #0028
Description	Percentage of ACO beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if identified as a tobacco user.
Denominator	ACO beneficiaries aged 18 years and older who had an encounter during the measurement period.
Denominator Exclusions/ Exceptions	Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy).
Numerator	ACO beneficiaries who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user.
Level of Analysis	ACO

Measure Name	Tobacco Use Assessment and Tobacco Cessation Intervention MSSP-17; NQF #0028
Source for measure	ACO medical record review
Baseline	2013 Medicare SSP: OCV: 91.37 ACCGM: 64.65
Target	85% across ACOs

3. The number of providers with at least one interface to the Vermont Health Information Exchange will increase from 130 to at least 400 by 6/30/17.

Measure Name	VHIE Interfaces
Description	The total number of provider organizations enabled for health information exchange with at least one interface connected to the health information exchange. The interface can be to send or to receive data.
Level of Analysis	Provider organization
Source for Measure	VITL
Baseline	130
Target	400

4. *Cost avoidance of $45 million generated through payment models*

At the conclusion of Vermont's SIM testing period, project-wide cost avoidance will be calculated, taking into account costs avoided as a result of the implementation of a variety of value-based payment models. Aggregate savings will be calculated as the difference between a financial forecast projection (using a trend for what costs would be without SIM investments for attributed populations) and actuals for attributed populations over the 3-year evaluation period, and subtracting $45 million. Savings will be compared to the grant amount of $45 million to calculate an overall return on investment (ROI) for the initiatives. The approaches for measuring cost avoidance due to individual programs may vary by program, depending on the construction of the unique payment models and final implementation status. The following models will be included:

- Shared Savings ACOs
- Expanded Pay-for-Performance in Blueprint
- Episode-based Payment
- All-Payer Model
- Medicaid VBP

Vermont will engage the services of an actuary to assist in calculating and reporting cost avoidance in SIM final reporting in 2017. Cost avoidance methodology will be finalized per CMMI SIM final reporting guidelines and requirements.

Attachment 5

VERMONT

Vermont Health Care Innovation Project

109 State Street

Montpelier, VT 05609

www.healthcareinnovation.vermont.gov

To: VHCIP Core Team
Fr: Georgia Maheras, Project Director and Diane Cummings, Financial Manager
Date: March 11, 2016
Re: Physician Payments in the VHCIP Sub-Grant Program

This memo proposes a new policy for payment of physicians[1], who are in active medical practice, as part of the VHCIP Sub-Grant Program:

> *Vermont's VHCIP Sub-Grant Program, funded through the State Innovation Models Testing Grant, will provide payment to physicians who are actively practicing medicine for the following activity: stakeholder engagement. The rate of payment will be at a rate below fair market value for the amount of time spent. In addition to the rate, VHCIP will compensate for in-state mileage at the approved State of Vermont Bulletin 3.4 rate. VHCIP will not compensate for any out-of-state travel. Sub-grantees will be required to retain documentation, made available to the State upon request, that demonstrates that time spent on VHCIP-approved activities was separate from time spent with patients.*

This policy will be retroactive to the start of the sub-grant program, May 2014, and is applicable to all sub-grantees. Once approved, the policy will be implemented through the VHCIP Finance Team. The Finance Team will ensure that all existing contracts are in conformance with this policy and that all payments made in the best are in compliance. Concurrently, we will submit this policy to CMMI and OAGM.

Recommended Policy: *Vermont's VHCIP Sub-Grant Program, funded through the State Innovation Models Testing Grant, will provide payment to physicians who are actively practicing medicine for the following activity: stakeholder engagement. The rate of payment will be at a rate below fair market value for the time spent. In addition to the rate, VHCIP will compensate for in-state mileage at the approved State of Vermont Bulletin 3.4 rate. VHCIP will not compensate for any out-of-state travel. Sub-grantees will be required to retain documentation, made available to the State upon request, that demonstrates that time spent on VHCIP-approved activities was separate from time spent with patients.*

[1] Please note that there are individuals receiving payment through the sub-grant program who are MDs, but do not actively practice.

Attachment 6a: Year 2 Update and Budget Requests (Revised 3-14-16)

Financial Proposals

March 14, 2016

Georgia Maheras, JD

Project Director

AGENDA

- Y2 Actuals to Date
- Reallocation: Health*first*
- Reallocation: RiseVT
- Reallocation: SWMC
- Reallocation and increase: VMSF
- New request: MMIS Modifications $750,000
- New request: Developmental Disability Council Core Competency Training $7,856
- Additional Funds: Wakely Actuarial $30,000

Y2 Actuals (NCE) to date

Year 2 Budget -Pending CMS/CMMI Approval January 1, 2015 - June 30, 2016				
BUDGET CATEGORY	**BUDGET-YEAR 2**	**ACTUALS and Unpaid Contract Invoices to 02/29/16**	**CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)**	**REMAINING UNOBLIGATED BALANCE**
Personnel/Benefits	$ 2,085,164.00	$ 1,060,379.87		$ 1,024,784.13
Operating (includes Indirect*except QE 03/31/2016)	$ 1,138,189.00	$ 297,249.17		$ 840,939.83
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 6,274,520.00	$ 2,248,833.35	$ 4,025,686.65	
PAYMENT MODELS-TOTAL	$ 4,211,058.75	$ 997,167.08	$ 3,213,891.67	
CARE MODELS-TOTAL	$ 921,531.17	$ 124,549.50	$ 796,981.67	
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ 1,915,230.99	$ 223,102.73	$ 1,692,128.26	
EVALUATION-TOTAL	$ 664,362.00	$ 124,000.00	$ 540,362.00	
GENERAL-TOTAL	$ 230,000.00	$ 4,250.00	$ 225,750.00	
CMMI Required: Population Health Plan-TOTAL	$ 7,000.00	$ 4,962.50	$ 2,037.50	
Contractual Total	$ 14,223,702.91	$ 3,726,865.16	$ 10,496,837.75	$ -
TOTAL YEAR 2 BUDGET	**$ 17,447,055.91**	**$ 5,084,494.20**	**$ 10,496,837.75**	**$ 1,865,723.96**

Reallocation: Health*first*

- Background: Health*first* received a sub-grant in the amount of $600,000.
- Rationale: Under-spending; Clinician hold
- Amount Requested: no increase
- Timeline: extended through 10/31/16
- Scope of Work:
  - Capacity and infrastructure for an ACO
- Budget Line Item: Technical Assistance to Providers Implementing Payment Reform

RiseVT

- Background: NMC is the lead organization within RiseVT, a sub-grantee
- Rationale: Change in reimbursement for travel; budget savings
- Amount Requested: no-change
  - Shift from ¢ravel l·yŘ CNJλyƎŜ . ŜyŜŦλűă to hther category
- Timeline: ends 11/30/16
- Scope of Work:
  - Wellness program throughout Franklin and Grand Isle Counties
- Budget Line Item: Sub-Grant Program

SWMC

- Background: Southwestern Vermont Health Care is a sub-grantee.
- Rationale: underspending; request to reallocate for additional shared learnings.
- Amount Requested: no-change
  - Shift from payroll to: conference expenses
- Timeline: ends 11/30/16
- Scope of Work:
  - Transitional care program.
- Budget Line Item: Sub-Grant Program

VMSF: Frail Elders

- Background: Project funded to identify barriers to best care for frail elders in two rural communities and recommend counter measures utilizing payment innovation. The principal method for problem identification is interviews with patients, families, caregivers and community based health care professionals.
- Rationale: Expand interviews and literature review components of the project.
- Amount requested: $10,500 in additional funds
  - Reallocate: $1,500
- Scope of Work: Literature review, key informant interviews, and billing analytics.
- Budget Line Item: Technical Assistance to Providers Implementing Payment Reform

MMIS Modification to support all-payer model

- Background: Medicaid needs to make modifications to the MMIS system to support the risk-based, capitated payment made to an ACO within the all-payer model.
- Rationale: MMIS Systems must be modified to allow for a prospective capitated payment. The current electronic system cannot make payments in this manner.
- Amount requested: $750,000 (PP2: ; PP3:)
- Budget Line Item: Technical Assistance to Providers Implementing Payment Reform; Sustainability; All-Payer Model

New Request: DDC – Core Competency Training

- Background: Vendor provides DLTSS Core Competency component. Significant interest-request to add a cohort.
- Rationale: Adding a new cohort to support interest in Chittenden County (each cohort is limited to ensure appropriate training).
- Amount requested: $7,856 (PP2)
- Budget Line Item: Technical Assistance to Providers Implementing Payment Reform

Additional Funds: Wakely Actuarial

- Background: Core Team previously approved 9/2014.
- Rationale: Amount Requested: $30,000
- Timeline: April-June 2016 (PP2)
- Scope of Work:
  - Ad Hoc Actuarial Support to VHCIP for the development of payment models and other analyses.
- Budget Line Item: TBD (have to reallocate to actuarial line item as part of Y2 reallocation process with CMMI).

Attachment 6b: Healthfirst request

HEALTH FIRST

MEMO

Date: February 16, 2016

To: Georgia Maheras, VHCIP

From: Amy Cooper, HealthFirst

RE: ***Revised*** Request for Extension and Budget Revision for SIM Grant #03410-1305-15

HealthFirst is seeking to extend our combined SIM grant through October 31, 2016, and to revise the current budget to reflect the additional months and needed reallocations. This memo outlines our modified budget request to exclude all clinician payments from February 2016 onward, per the guidance we received on February 11, 2016. Aside from the exclusion and reallocation of clinician payments, the request is substantially similar to our pending revision request of December 9, 2015. This request is intended to supersede and replace the December 9, 2015, request.

Request for Extension

SIM grant funding has enabled HealthFirst to build both capacity and infrastructure in support of its ACO shared savings programs while supporting the engagement of independent physician members in health reform initiatives at the state level. As we near the end of the funding period, we have identified areas in which, for myriad reasons, our spending was lower than anticipated up to this point in the grant cycle. An extension will allow us to reallocate funding to areas of ongoing need as we continue development of an organizational budget beyond the grant. This transition is critical to HealthFirst's sustainability, and the ability to extend funding across four additional months will further support a smooth transition.

Budget Revisions Overview

The enclosed budget revision reflects what we believe will be the most efficient way to manage our remaining grant funds through the end of the current fiscal year and our requested extension to October 31. If approved, we believe this budget will be able to stand, without further revision, through the remaining life of the grant, saving staff time and paperwork for both HealthFirst and DVHA.

The attached budget is organized into three columns:

- **July 2014 through October 2015 actuals:** A review of actual spending for the first 16 months of the grant enabled us to identify some surplus funding, which we have applied as carry forward for the remainder of the grant, including the requested extension.

- **November 2015 through January 2016 actuals**: This is the period during which HF included in its invoices compensation for our clinical lead and chief medical officer staff positions ($9,725)

1 Mill Street, Chace Mill – Ste. 310, Burlington, VT 05401 P.O. Box 2124, South Burlington, VT 05407-2124
802-878-8811 (voice) 802-878-8816 (fax) contact@vermonthealthfirst.org www.vermonthealthfirst.org

and physician stipends ($4,312.50). This funding ($14,037.50) has been on hold since November. In our revised budget, we count these "held funds" as available to re-allocate to other non-clinician line items in our calculations.

- **February 2016 through October 2016 anticipated spending:** This column includes staff compensation for our executive director, administrative assistant, operations director and quality and care coordination manager (QCCM). All funding for the clinical lead, chief medical officer and physician stipends has been removed and applied to other staff positions. To date, some of our staff positions (quality care and coordination manager and operations director) were paid using a combination of SIM grant funding and other, non-grant HealthFirst income. This revision shifts those positions fully to the grant while shifting expenditures for clinical staff and stipends to HF's other income. Additionally, because our staff is most crucial to maintaining our infrastructure and fulfilling the grant goals, we are applying remaining funding to support the non-clinical staff positions and shifting all non-staff line items to HF's other income. With this configuration, we will be able to fully fund all but less than $1,000 the executive director, administrative assistant, operations director, and QCCM positions through October: the shortfall will be covered using non-grant HF income.

  In order to complete the work started under this grant and transition successfully to the next phase of the organization's development post-grant, our priority is to keep staff in place. Staff costs are fixed, which means we can make reliable expenditure estimates and maximize the value of our grant funding as we continue to work on the goals and priorities set forth in our grant agreement. More variable spending categories, such as supplies, will be covered under HF's other income, which will allow us to invoice for the grant more simply and efficiently. This is another way to save time and money for both HealthFirst and DVHA.

  The clinical positions and stipends that have come under scrutiny were explicit in our grant applications for round 1 and round 2 funding and many of our goals are tied to these positions. By shifting these positions to our non-grant income, we will be able to continue with our work without losing momentum or hindering efficient processing of our invoices. We will continue to report about our progress on activities and initiatives outlined in our grant agreement.

We appreciate DVHA's efforts to keep us updated about the status of our invoices and desk audit. We are hopeful that you will see the same value in our revisions as a pathway to greater efficiency while continuing to the honor the spirit and intention of the grant to support our capacity and infrastructure building.

Please do not hesitate to contact me, Gisele Carbonneau, or Holly Lane if you have any questions or need additional information.

HealthFirst - Combined SIM Grant Budget
Proposed Extension: Grant Term - July 1, 2014 - October 31, 2016 - 28 months
PROPOSED REVISION - February 16, 2016

	Budget Scenario - Excluding Clinician Payments				Current (as submitted May 2015)		
	July 2014- Oct. 2015 Actuals	Nov. 2015 - Jan. 2016 Actuals	Feb. 2016-Oct. 2016 Proposed	TOTAL	July 2014- June 2015	July 2015- June 2016	TOTAL
Personnel: Contract Staff Wages							
Executive Director (contract)	$93,719.66	$19,980.12	$59,097.02	$172,796.80	$70,000.00	$77,000.00	$147,000.00
Administrative Assistant (contract)	$29,416.76	$6,437.52	$19,312.56	$55,166.84	$25,000.00	$25,750.00	$50,750.00
Operations Director (contract)	$38,142.86	$9,321.45	$74,628.35	$125,199.81	$30,000.00	$33,000.00	$63,000.00
Clinical Lead, Other MD (contracts)	$34,050.00	-$9,725.00	$0.00	$24,325.00	$30,000.00	$30,900.00	$60,900.00
Quality and Care Coordination Manager (contract)	$21,666.64	$16,249.98	$56,250.00	$99,583.28	$5,000.00	$60,000.00	$65,000.00
Total Personnel	**$216,995.92**	**$42,264.07**	**$209,287.93**	**$468,547.92**	**$160,000.00**	**$226,650.00**	**$386,650.00**
Fringe (staff only)							
QCCM	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Fringe	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Consultants							
Local Physician Liaison Team	$30,873.75	-$4,312.50	$0.00	$26,561.25	$40,000.00	$12,000.00	$52,000.00
Legal services, HR, IT, other contracts	$49,788.40	$2,250.75	$0.00	$52,039.15	$55,300.00	$45,564.00	$100,864.00
Total Consultants	**$80,662.15**	**-$2,061.75**	**$0.00**	**$78,600.40**	**$95,300.00**	**$57,564.00**	**$152,864.00**
Office							
Rent	$17,900.80	$3,567.72	$0.00	$21,468.52	$13,850.00	$14,550.00	$28,400.00
Utilities	$2,433.19	$497.94	$0.00	$2,931.13	$2,100.00	$2,100.00	$4,200.00
Supplies (incld computers, communication)	$12,203.45	$2,488.26	$0.00	$14,691.71	$9,000.00	$5,000.00	$14,000.00
Outreach (printing/binding, distribution)	$2,437.18	$0.00	$0.00	$2,437.18	$1,200.00	$1,200.00	$2,400.00
Meetings and travel	$7,756.85	$330.05	$0.00	$8,086.90	$4,500.00	$3,750.00	$8,250.00
Bi-annual meeting	$1,736.24	$1,500.00	$0.00	$3,236.24	$1,236.24	$2,000.00	$3,236.24
Total Office	**$44,467.71**	**$8,383.97**	**$0.00**	**$52,851.68**	**$31,886.24**	**$28,600.00**	**$60,486.24**
TOTALS	**$342,125.78**	**$48,586.29**	**$209,287.93**	**$600,000.00**	**$287,186.24**	**$312,814.00**	**$600,000.24**

Undisbursed funds from HF's November & December invoices, counted as available in our calculations.

Attachment 6c: RiseVT request

VERMONT

M E M O R A N D U M

TO:	Georgia Maheras, Esq., Deputy Director of Health Care Reform for Payment and Delivery System Reform and Director, Vermont Health Care Innovation Project
FROM:	Dorey Demers, RiseVT Coordinator
DATE:	March 14, 2016 – UPDATED
SUBJECT:	**REVISED** Request for approval of revised budget for Northwestern Medical Center (RiseVT) Grant agreement #03410-1459-15

This memo serves as a request to revise the budget for the grant agreement to Northwestern Medical Center (NMC), as part of the Provider Sub-grant Program within the Vermont Health Care Innovation Project.

Reallocate Travel line and reinvest in Other Budget Line

Due to recent regulation changes in federal reimbursement for travel, we are requesting that Northwestern Medical Center takes over travel reimbursement for staff. This would allow us to not have to account for a difference in reimbursement from the hospital and reduce the need for multiple forms with different amounts to be accounted for. We are requesting that the $10,000 budgeted for CY 2016 for RiseVT Travel be moved to the "Other" budget line.

Reallocate Benefits and reinvest in Other Budget Line

Benefits for our staff were over projected, resulting in about a $50,000 over-budget for benefits. We are requesting to move these funds to the "Other" Budget line. This would allow us to move even further in our efforts to improve the health and wellness or our residents in Franklin and Grand Isle.

RISE VT will reinvest these funds and provide technical assistance based on evidence-based practices along with mini-grants to targeted communities. Examples may include: promote creation of smoke-free environments; create or enhance access to locations for physical activity and healthy eating; promote increase physical activity and healthy eating options at worksites; encourage increased availability of healthier food and beverage choices at public service venues; support parent and family education programs that promote healthy eating and physical activity; and support municipal ordinances that promote mixed use development including increased walkability or bike-ability.

Existing Budget

Category	*NMC Year 1*	*SIM Year 1*	*NMC Year 2*	*SIM Year 2*
Personnel (Salaries)	$80,000	$ 45,000	$180,000	$ 70,000
Fringe*		$ 63,000		$ 70,000
Travel/Mileage		$ 10,000		$ 10,000
Equipment		$ 16,000		$ 6,000
Supplies		$ 19,500		$ -
Other**	$120,000	$ 46,500	$ 20,000	$ 44,000
Indirect				
Contracts		N/A	N/A	
Total Per Year	$200,000	$200,000	$200,000	$200,000
Total Expenses for 2 Year Grant				$800,000

Proposed Budget

Category	*NMC Year 1*	*SIM Year 1*	*NMC Year 2*	*SIM Year 2*
Personnel (Salaries)	$80,000	$ 45,000	$180,000	$ 70,000
Fringe*		$ 63,000		$ 20,000
Travel/Mileage		$ 10,000		$ -
Equipment		$ 16,000		$ 6,000
Supplies		$ 19,500		$ -
Other**	$120,000	$ 46,500	$ 20,000	$104,000
Indirect				
Contracts		N/A	N/A	
Total Per Year	$200,000	$200,000	$200,000	$200,000
Total Expenses for 2 Year Grant				$800,000

Attachment 6d: SWMC request

Southwestern Vermont HEALTH CARE

100 Hospital Drive | Bennington, VT 05201 | phone 802.442.6361 | fax 802.442.8331 | svhealthcare.org

January 26, 2016

Joelle Judge, JD, PMP

Sr. Project Manager

Vermont Health Care Innovation Project
89 Main Street

Montpelier, VT 05602

Dear Joelle,

Southwestern Vermont Medical Center is requesting the following budget reallocation for the VHCIP grant for 2016. SVMC has been able to complete all required elements of the grant to date without expending all of our payroll expenses. The expenses allocated to the Project Administrator, Data Collection and Administrative Assistant have been managed much more efficiently than anticipated. We are requesting to:

1. Reallocate $ 6,500 from Payroll to Contracts to cover the cost of two additional conferences related to the Transitions in Care Program.
    a. $ 1,500 for Billie Allard to attend the World Health Congress in Washington D.C. where she has been asked to speak on Transitions in Care
    b. $ 5,000 for Transitions in Care staff to attend the Magnet Nursing Conference where SVMC will present on the Transitional Care Nursing and the Community Care Team, which were identified as exemplar programs during our recent SVMC Magnet Survey.

2. Reallocate $ 22,000 from Payroll to Contracts to assist in the cost of the Transitions in Care Regional Conference which SVMC is hosting on September 20, 2016 at the Grand Summit Resort Hotel & Conference Center, Mt. Snow, Vermont. This regional conference will share early results of the project and teach others about the Transitional Care Model. Mary Naylor, PhD, FAAN, RN, the Marian S. Ware Professor in Gerontology and Director of the NewCourtland Center for Transitions and Health, the University of Pennsylvania School of Nursing, has agreed to be the Keynote Speaker. This event was initially approved as part of our initial proposal for the VHCIP Grant, but was removed when we were asked to reduce the budget to $ 400,000 for the final agreement. These expenses would cover the cost of speakers' fees, conference center expenses and additional expenses to host this full day event. Registration fees and sponsors will be sought to cover additional hotel and other conference related expenses.

SVMC is confident with this reallocation of funds that we will continue to remain within our VHCIP budget and continue to meet all the requirements of the grant.

Please contact me if you have any questions or would like any additional detail on this request.
Sincerely,

Billie Lynn Allard MSRN

Billie Lynn Allard, MS, RN
Administrative Director of Care Management, Transitional Care and Ambulatory Services
802.447.5138 (phone)
Billielynn.allard@svhealthcare.org

Southwestern Vermont Medical Center – Justification for budget variance

Thank you for the opportunity to share with you an explanation for our budget variance

Why do we have a variance?

In our approved budget for the grant, we included $44,250 for a project administrator and $37,500 for data collection/analysis/administrative assistant over the 2 year period. We chose to absorb those functions within existing roles (Billie Allard MS, RN, Kathy Arabia RD) as much as possible subsequently spent less money.

Why are we requesting the re-allocation of funds?

In our original budget proposal, we had included sponsoring a regional conference to share our results and creation of a tool kit so programs could be replicated in other locations. Our plan included inviting participation from other grant recipients who also wanted an opportunity to showcase their good work. When we needed to cut the amount of grant funding, we chose to eliminate the conference funding rather than support for FTEs needed for implementation of the project.

Regional conference ($22,000)

We have achieved many of our goals during this project with your support. We would like the opportunity to share the lessons learned, outcome data and demonstrate how we are creating interdisciplinary care delivery in our community by improving the patient experience, improving the health of the population and decreasing the cost. Three years ago, we sponsored a successful, regional conference at Mount Snow in Vermont with 200 participants with positive feedback. Our hope is to invite other grant recipients across the state to share their stories (call for poster abstracts, special interest table discussions) and celebrate the successes made possible through the VHCIP Innovation Grant program.

Magnet conference ($6500)

In November of 2015, we were surveyed by the American Nurses Credentialing Center and successfully achieved our 4th Magnet Nursing Certification. During the announcement from the team, they identified three exemplars of nursing practice, 2 of which were supported by the Innovation Grant funding. (Transitional Care Program, Community Care Team) We have submitted abstracts to the ANCC Magnet 2016 conference in hopes of being selected to do podium presentations at the October 2016 meeting in Orlando, Florida. Thousands of nurses attend this conference and will hear about the meaningful progress being made in Vermont in achieving healthcare reform focused on improving population health while improving the patient experience and decreasing the cost.

Draft Budget Proposal for Conference

Speaker Fees - $10,000 Mary Naylor – University of Pennsylvania –

Conference space - $2000

Audiovisual costs - $1500

Conference planner - $7800

Marketing/ Signage - $1000

Staff and speaker per diem - $1500

Registration Materials - $500

Our goal would be to keep the cost reasonable to allow hospitals and health system to send staff. The proposed format would include 3 speakers, a panel discussion including successful programs across the state and special interest table discussions moderated by experts in their field. Examples include:

Community Care Team (wrap around care plans for patients with addiction and mental illness, decreasing ED visits)

Transitional Care Nurse (partnering with PCPs to identify high risk, chronic care patients with high utilization resulting in decreased admissions and ED visits)

Clinical Pharmacist (meetings with patients in hospital, PCP office and home to assist with medication management, consulting with providers to decrease polypharmacy, drug interactions, decrease cost, improve medication compliance

Reducing Nursing Home Readmissions (implementation of interact in all area nursing homes, empowering LNAs to communicate changes early to improve timely treatment and avoid the need for transfers to ED/hospital)

Community social worker (proactively assisting patients with access to appropriate services and available resources, closing the loop following hospital discharge)

We would be soliciting assistance from across the state to lead table discussions highlighting their work

Attachment 6e: VMSF request

VHCIP Frail Elders Project

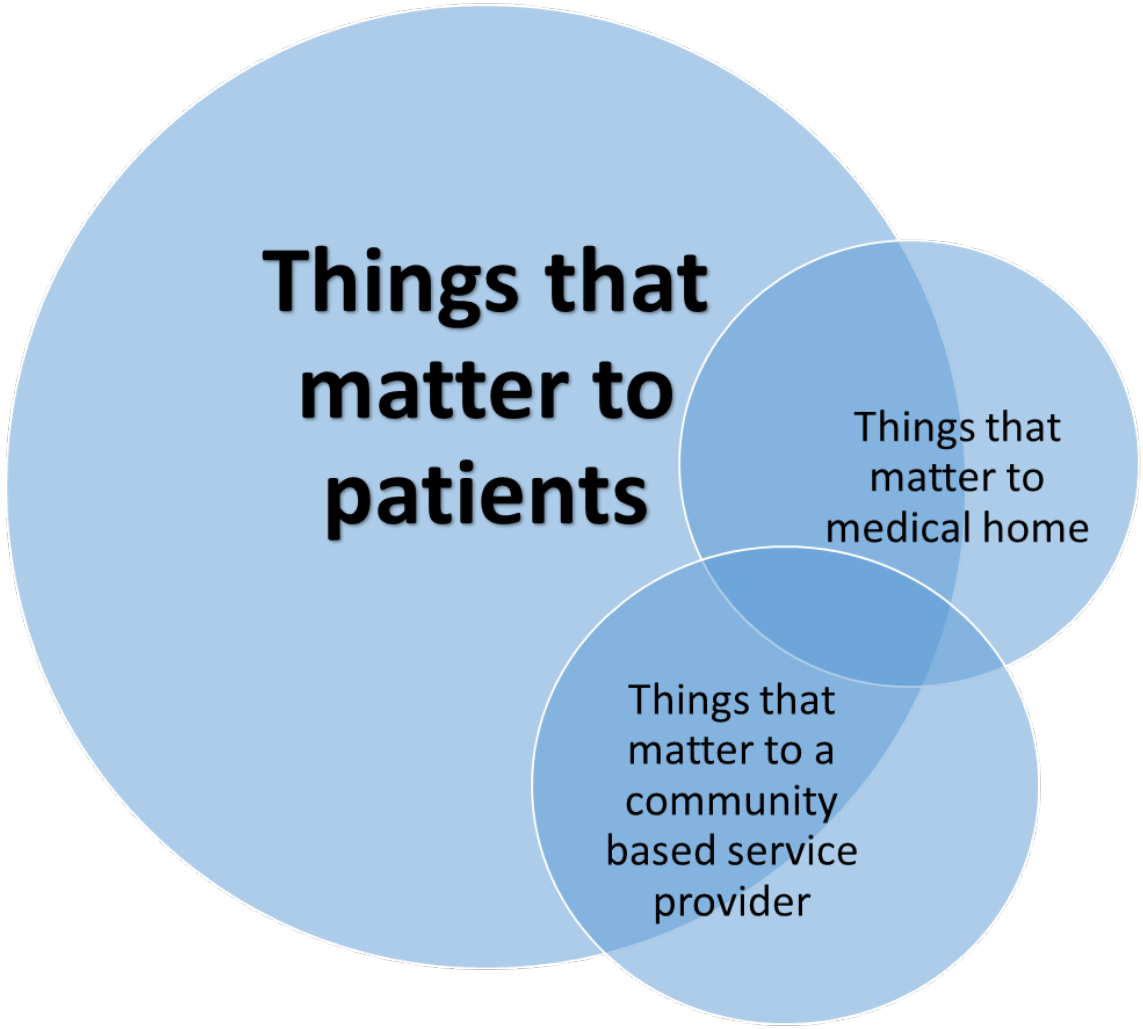
Josh Plavin MD MPH
Brian Costello MD
Nancy Bianchi MSLIS
Fay Homan MD
Milt Fowler MD
Erica Garfin MA
Steve Kappel MPA
Randy Messier MT, MSA, PCMH CCE
Cyrus Jordan MD MPH

SIM Core Team March 14, 2016

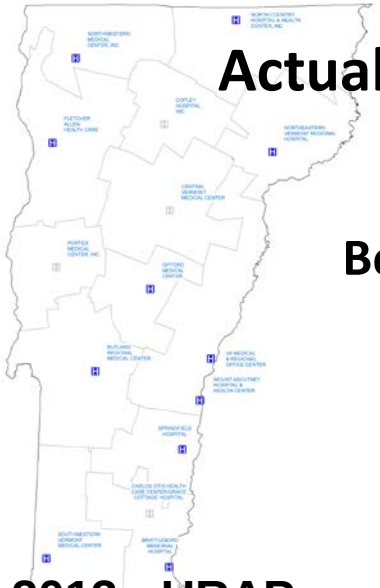
VMS Education & Research Foundation

helping physicians help patients & communities

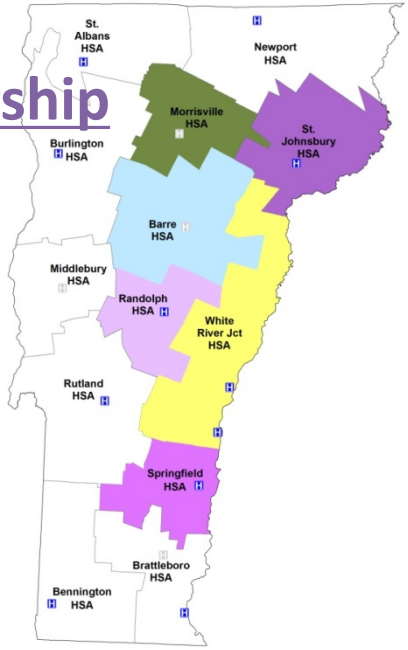
VHCIP Frail Elders Project



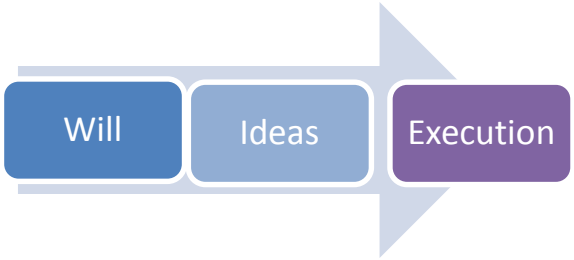
The Green Mountain Care Board
and
VMS Education and Research Foundation



Actualizing reform thru clinician leadership



Better quality, Better health, Lower costs



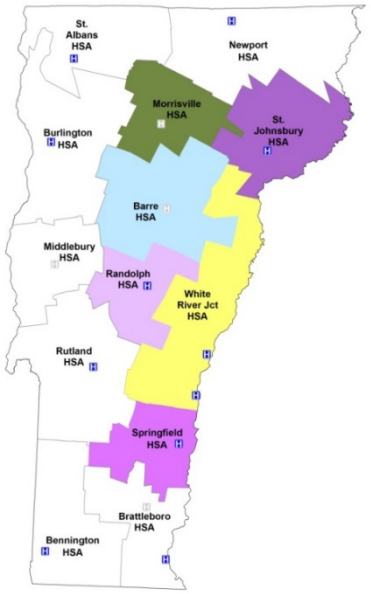
June 2013 - HRAP
Health Resource Allocation Plan

VMS Education & Research Foundation

helping physicians help patients & communities

Thursday December 12th, 2013

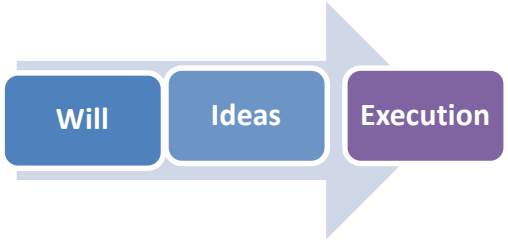
Rural Clinicians Community
GMCB Presentation



Better care, better health, lower costs

How can leaders accelerate innovation?

"You have to have the *will* to improve; You have to have *ideas* about alternatives to the status quo; and then you have to make it real through *execution*. All three have to be arranged by leaders – they are not automatic."



1. Actualize 3 planned levels of care
2. Make VT a magnet for the workforce
3. Become the national benchmark for measurement
4. Reduce the gap between practice and policy

Saturday January 25th, 2014

Vermont Academy of Family Physicians

VERMONT DEPARTMENT OF HEALTH

Actualizing reform thru clinician leadership

Better quality, Better health, Lower costs

1. **Core community based and planned regionalized clinical services**
2. **Integrating social and community services with clinical services**
3. **Measuring things that matter to patients, practices and policymakers**

VMS Education & Research Foundation

helping physicians help patients & communities

VHCIP Frail Elders Project

Target Population

Seniors at risk of a decline in the quality of their lives or a poor health outcome

Frail Elderly Global Aim

We aim to identify barriers to providing the best primary care for high-risk elders in two rural communities; and recommend: 1) Practice changes to primary care, community based care and supportive services which will improve outcomes that matter to patients; 2) Payment innovations to support the redesigns; and 3) Measures to track changes in outcomes that matter to patients.

The project begins with a literature search serving as the cornerstone for our research and recommendations. The principal method for problem identification will be structured interviews with patients, families, caregivers and community based health care professionals. State and regional policy and content experts will be interviewed. Analysis of public claims data bases will complement the qualitative research.

The effort ends with a written report and public presentation of our findings and recommendations to the VHCIP Payment Models Work Group in June 2016.

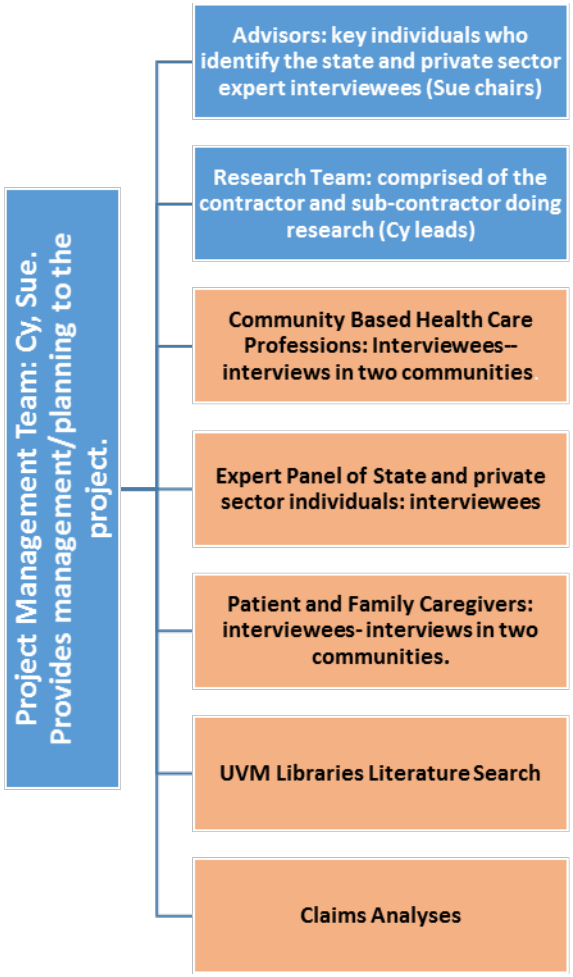
By undertaking this effort we expect to increase the value of the health care system – focusing on outcomes that matter to patients, reducing harm, conserving resources and increasing system efficiencies.

VHCIP Frail Elders Project

Research Focus Areas

1. **What characterizes a frail or high risk senior?**
2. **What are the characteristics of their service utilization?**
3. **What matters to seniors?**
4. **Are there care models known to produce better value (outcomes/cost)?**
5. **What systemic barriers to providing care exist?**
6. **What aspects of the delivery system are and are not working locally?**
7. **How could the local delivery system be improved?**
8. **What are practical and meaningful measures of value? (things that matter to patients/cost of meaningful episodes of care)**
9. **How can seniors be attributed to medical homes?**
10. **What are unnecessary costs and how could they be reduced?**
11. **How can payment reform support the achievement of things that matter to patients?**

VHCIP Frail Elders Project



VHCIP Frail Elders Project

Potential Provider Informant Categories

Category	Gifford	Little Rivers
Medical clinicians – at multiple clinic sites		
• Primary care MDs/DOs	**X**	**X**
• PAs and APRNs	**X**	**X**
• Office nurses	**X**	**X**
• Mental health clinicians	**X**	**X**
• Hospitalists/discharge planners	**X**	**?**
FQHC Care coordinator	**X**	**X**
SASH	**X**	**X**
Adult Day	**X**	**X**
Area Agency on Aging	**X**	**X**
Blueprint project manager	**X**	**X**
Home health	**X**	**X**
Senior center	**X**	**X**
Assisted living/residential care/ Sr. housing provider	**X**	**X**

VHCIP Frail Elders Project

Workplan and Responsibilities

November 13 thru December 2, 2015 — 20 days

Overall intent of project, deliverables and recommendations - Team consensus

Identification of overarching research questions - Team consensus

Interview tools – Erica and Brian; approved by team consensus

Identification of policy informants – Cy and Sue

Identification of provider informants – Milt, Fay,
Identification of patient, family and caregiver informants – Milt, Fay

December 3 thru December 31, 2015 —28 days

Begin utilization data analysis – Steve

Preliminary analysis and report of Literature Review – Brian and Nancy

January 2, 2016 thru February 28, 2016 – 60 days

Schedule interviews — Erica and Brian

Conduct policy expert interviews – Erica

Conduct community provider interviews - Erica

Conduct patient, family/caregiver interviews – Brian/Cy

Conduct utilization data analyses – Steve

March 1 thru March 31 – 30 days

Analysis and written report of policy and community provider interviews – Erica

Analysis and written report of patient, family and caregiver interviews – Brian

Final report of utilization data analyses - Steve

Final analysis and report of Literature Review – Brian and Nancy

April 1 thru May 30 – 60 days

Aggregate analysis prepared – Cy/Josh/Randy

Approved by team consensus process

Final report and presentation prepared – Cy/Josh/Randy

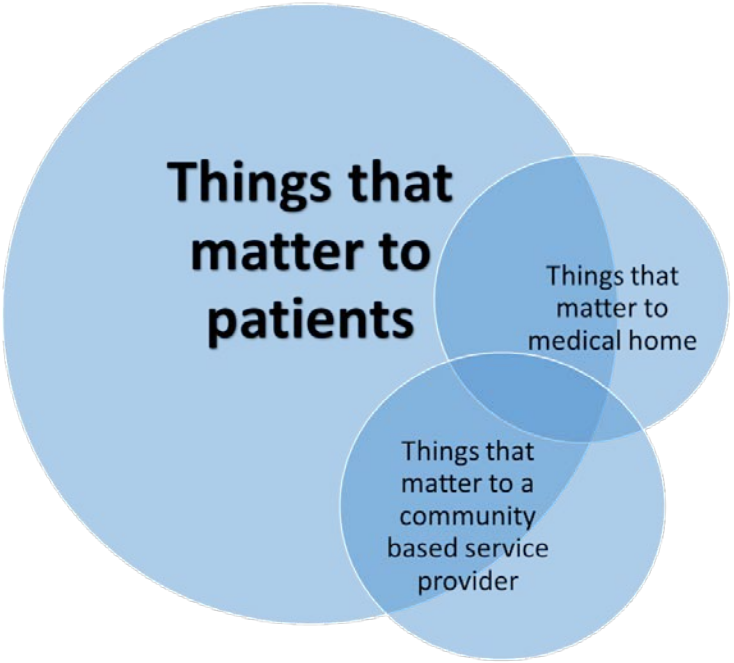
Approved by team consensus process

June 1, 2016

Final written report and PowerPoint presentation complete and ready for distribution

VHCIP Frail Elders Project

Accountability?



The report will include:

- **Literature reviews**
- **Patient, family and care giver interviews**
- **Direct care providers and policy experts interviews**
- **Medicare and Current Beneficiary Survey analyses**
- **Payment innovation to address identified problems and measures of success**

Pursuing High Value Care for Vermonters

Frail Elderly VHCIP Payment Models

Oct 2015-June 2016

Personnel		
Director	$	62,352
Business Manager	$	3,741
Operations Director	$	3,741
Administrative Assistant	$	1,871
Personnel subtotal	$	71,705
Fringe		
	$	-
Travel		
Mileage	$	848
Parking and Tolls	$	25
Equipment		
	$	-
Supplies, meetings		
Conference calls; webinars	$	500
UVM Dana Library	$	1,000
Website	$	500
Supplies subtotal	$	2,000
Indirect		
	$	-
Contracts		
Clinical champion	$	-
Clinical content expert	$	6,126
Clinical content expert	$	6,126
Qualitative Researcher	$	40,500
QI and Measurement content expert	$	3,000
Patient and Family surveyor	$	10,000
Contracts subtotal	$	65,752
Total		
	$	140,329

February 17, 2016

Dear Cy Jordan,

I am writing to request additional funds in the amount of $12,600 for my work as lead on the literature review and lead on the patient and family interviews for the SIM-funded Frail Elderly Project. This additional $12,600 will be for 210 hours of work at $60 per hour.

At the end of this month, I will have billed for the initial 167 hours in my contract. Of the 167 hours, approximately 90 hours will be for the literature review, 40 hours for the patient and family interviews and related work, and the remaining 37 hours for meetings, communication, and collaboration with project team members.

Given the scope of the literature review, the initial budget significantly underestimated the time involved in a comprehensive literature review on the three topics—models of care, patient and family perspectives on care, and mechanisms to identify frail elderly patients. This work is central to the success of the Frail Elderly Project and appropriate analysis of the results of the literature review will require more time. Additionally, more hours will allow for a more detailed analysis of the patient and family interviews and time for synthesis of these findings with the work of other project team members.

The additional 210 hours will be divided between multiple tasks: 120 hours for the analysis of the results of the literature review and write-up, 50 hours for the analysis of the patient and family interviews and write-up, and 40 hours for the synthesis of these findings with the work of the other project team members. Built into these hours is time for meetings, communication, and collaboration with the other project team members.

I thank you for your consideration of this request.

Best,
Brian Costello, MD

Attachment 6f: MMIS modification request

Vermont All Payer Model

MMIS Systems Approach Summary

Last updated 3/6/2016 by Hewlett Packard Enterprise

Table of Contents

Introduction

To provide an initial assessment of systems work required for the Vermont Medicaid Management Information System (MMIS), Hewlett Packard Enterprise technical staff have met with DVHA leaders and Burns and Associates consultants. An initial scope of All Payer Model requirements were identified, and questions were answered to further establish preliminary requirements. The content of this document should be regarded as preliminary for the purpose of work estimates; HPE recognizes that project scope is subject to change.

The information in the Approach Summary Sections on pages 1-5, form the basis for a technical work breakdown and budgetary effort estimates for MMIS Systems Changes, on pages 6-9.

MMIS ACO Program Configuration

1. ACO-Provider Affiliation

   MMIS will receive a master provider roster of Vermont Medicaid enrolled providers affiliated with the ACO(s). Details of the file will include Medicaid Provider Identification number, Tax Identification number, provider NPI and taxonomy for all participating individual and group providers associated with each ACO for the upcoming year. The initial file will be received by November, in advance of the first prospective payment to ACO(s). Retroactive changes to provider

participation will not occur; date of provider affiliation being added must be future to avoid Fee for Service (FFS) claims adjustments. All current provider credentialing/enrollment requirements will still apply to the providers associated with the ACO. We will receive a monthly provider file with updates. HPE's Provider Services Unit will also have the ability to manually update changes to the ACO Provider affiliation data via MMIS screens.

2. Member-ACO Attribution File

   MMIS will receive a file annually, containing the members who have been attributed to each ACO for the upcoming year and the Per Member Per Month (PMPM) rate for each member. The initial file will be received from DVHA or Burns and Associates. Retroactive changes to member participation in the ACO will not occur. Members currently enrolled in Medicare or commercial insurance, based on coverage types to be determined, will not be a part of the ACO. MMIS will utilize the members attributed to each ACO to further determine, based upon eligibility and coverage, what PMPM payments will be made each month.

   The assumption for this estimate, is that no provision for an "opt-out" of MMIS information sharing with the ACO's will exist for phase 1. HPE will share member attribution information with the ACO for those persons attributed to the ACO, as well as sharing member claims information with the ACO. Member ACO enrollment history information will be available within the MMIS.

3. Services Included

   If more than one ACO exists, all ACO's will follow the same service coverage rules. MMIS will use MARs Category of Service combined with a fund source to determine services covered under the All Payer program. Only DVHA fund sources are anticipated to be included at this time. A new reference screen will be created to maintain category of service, funding source, begin and end date for inclusion in ACO covered services. The covered services, along with ACO member attribution and ACO provider affiliation, will be used to determine whether claims are paid as Fee For Service (FFS) or whether providers will be paid by the ACO for those services.

MMIS Claims Processing

4. Claims Adjudication

   Providers will continue to send all Medicaid claims to MMIS and other SoV systems. All claims will be processed and priced using all the same edits, audits, and payment methodologies regardless of whether they are covered by the ACO - with the exception of the payment amount. ACO claims will be priced and receive a "would have paid provider" (WHPP) amount which will represent allowed amount minus copay minus other insurance amount. However the Medicaid payment amount for services covered by the ACO for its members and affiliated providers, will always be zero. The Medicaid claims which are the responsibility of the ACO to pay, are thus referred throughout this document as ACO zero-paid claims.

   A claim will be considered an ACO zero-paid claim only if it meets all of these conditions as of the date of service to the member: a) the member on the claim is attributed to the ACO; b) and the billing provider is affiliated with the ACO, and c) the service being billed is included in the services

covered by the ACO. Otherwise the claim will be processed as Fee for Service and payment will be made directly to the provider (the same as it has been prior to All Payer).

Medicaid co-payment requirements will remain in effect. Patient Share is not impacted at this time, as nursing home services are out of scope. All services currently requiring prior authorization (PA) will continue to require PA. MMIS online claims screens will be modified to include an ACO Claim indicator, which will enable users to easily identify ACO Claims.

Professional claims currently may contain multiple services and services dates per claim. The situation could arise where some details of a professional claim are considered ACO details and some details would be considered Medicaid Fee for Service. A specific Explanation of Benefits (EOB) code will be assigned to the claim details that will identify the reason for ACO zero-paid claims on the providers RA's. The MMIS will store both the paid amount and also the calculated "would have paid provider" (WHPP) for each ACO claim and claim detail. This field will be displayed in the MMIS online screen, and will available in reports and in the Business Objects ad-hoc reporting tool as well.

Any adjustments to ACO zero-paid claims will follow the standard MMIS adjudication process and pay according to the rules of the new version of the claim. This may or may not result in the adjusted claim changing from an ACO zero-paid claim to a Fee for Service claim.

5. Coordination of Benefits

Members with primary Medicare or commercial insurance primary, based on coverage types to be determined, will be excluded from the initial ACO member attribution. Members who have been attributed to an ACO and gain Medicare or primary commercial insurance during the year, will be identified by the MMIS system (via eligibility updates received from ACCESS and from other update processes). MMIS will track the eligibility and coverage changes for attributed members, for purposes of calculating ACO payments. Retroactive knowledge of commercial insurance, when it becomes known and tracked in MMIS, will be used for ACO payment reconciliation.

The casualty collection process and pay and chase liability process will remain a function of DVHA.

The weekly and monthly TPL Retro process that produces claim facsimiles for submission to other carriers will be modified to use the new "would have paid provider" amount, on the facsimiles generated for claims processed by the MMIS as ACO zero-paid claims.

Additional considerations to be solved include: how to handle a recoupment against an ACO claim, and how to handle a claim that presents with a Medicare or commercial insurance payment (where primary carrier is unknown to us).

MMIS Financial Processing

6. Financial Payments

A monthly MMIS financial process will run that generates prospective PMPM payments to the ACOs. This will be based on the number of members attributed to each ACO and each member's rate assignment. Determination of the prospective payment for each member will be based on: confirming member status (alive), member is Medicaid eligible for a portion of the prospective month, and member does not have coverage under Medicare or commercial insurance for the

prospective month, based on coverage types to be determined. If the attributed member does not meet these eligibility conditions, then the prospective PMPM payment for that member will not occur for the month.

Each ACO will receive multiple files in support of payments. A payment remittance file will be generated for the ACO, detailing the number of members for which payments have been made. The ACO will also be provided with supporting Member attribution details (in a separate or the same file), showing the reasons why payment has or has not occurred for each member for that month. HPE will also generate a file containing zero-paid claim data for both paid and denied encounter claims that will be sent to the ACOs in a format that is to be determined. The ACO may use the zero-paid claim detail to help determine ACO payments to providers. The ACO will also receive a file of Fee for Service paid claims for its attributed members, where the claims did not fall within the scope of ACO covered services.

Retroactive changes to member PMPM rate assignments will not occur. MMIS will no longer make the PCPlus PMPM and BluePrint payment for ACO member population.

The MMIS will receive a file from the ACO's containing claim payment information made by the ACO to the attributed providers, in response to ACO zero-paid claims information sent from MMIS to the ACO. This file will be displayed in a new MMIS ACO payment data screen. A mechanism will be created to allow for tracking payment and/or denied reason information for every claim processed by the MMIS as an ACO encounter claim. The ACO will also send a file to MMIS, for any payments made to providers not included in the claims payment information file.

If a refund check is received from a provider for a claim that was paid zero to the ACO, the check will be returned to the provider. A PMPM payment to an ACO will not be voided. If action is necessary, for reasons such as acquisition of commercial insurance or Medicare, it will be addressed in a subsequent reconciliation process rather than via MMIS automation.

MMIS and Data Warehouse Reporting

7. MMIS Reporting

   T-MSIS reporting to CMS will be modified as needed, to distinguish ACO zero-paid claim data from FFS claim data. This may involve updates to the Managed Care T-MSIS file (pending CMS guidance). The Financial Balancing Report (FBR), CMS21, CMS64, and Incurred But Not Reported (IBNR) reports will be modified to include ACO payments, where necessary. The ACO zero-paid claims will be counted in with the Medicaid paid claims for MAPIR. Based on current design, ACO zero-paid claims will be included in all current reports. And should those reports contain payment information, zero provider payments will be calculated (as no direct provider payments occurred). No changes are required to the current Remittance Advice report. A new EOB will be added to identify an ACO encounter zero paid and/or denied claim. The cost reports (State Audit Reports) will be modified to include a column for the "would have paid" amount and the payment amount reported by the ACO. Phase 1 will only include reporting modifications specified in this document.

8. EVAH Data Warehouse Reporting

The MMIS reporting data store (EVAH) and reporting tools (Business Objects) will be reconfigured to enable reporting on ACO zero-paid and ACO denied claims. This will require changes to the data structure as well as updating configuration of Business Objects and reporting universes. All queries that run against the EVAH data store are assumed to be impacted by these configuration changes. Some reports will need to be redesigned, where ACO 'would have paid provider' financial information needs to be included. New analytics reporting may be needed for surveillance and utilization purposes. Data extract, transform, and load (ETL) processes with MMIS, EVAH, and other systems will need to be updated to account for changes in available data.

Other MMIS Impacts

9. Currently, member PCP information is conveyed to providers when they are verifying member Medicaid eligibility via the EDI/Phone methods. Member ACO enrollment will not need to be included in eligibility verification responses.

10. The provider lookup functionality on the web portal does not need to be updated to include provider ACO enrollment status.

11. Program Integrity recoupment. Address how system will enable Void/Recoupment/Denial of claims to be handled, consider situations for recoupment against the ACO.

MMIS Systems Change Summary and Estimates

#	System Area	Change Description	Analysis and Design	Development	Functional Testing
Phase 1, by December 2016 System Change Estimates					
1-4	**ACO Program Configuration in MMIS**		**757 hours**		
	Provider	Create new ACO Provider Type and Specialty combination	2	10	2
	Provider	Load & Update Monthly Provider ACO Affiliations, with ACO affiliation file(s) (externally produced) and generate a summary report and file containing rejected records.	18	120	24
	Provider	Provider-ACO affiliation data maintenance screens, for ongoing enrollments and manual changes	12	80	16
	Member	Load & Update monthly ACO Members, with member attribution file (externally produced) and generate a summary report and file containing rejected records.	18	120	24
	Member	ACO Member information display (screen) with rate	12	80	16
	Reference	Create a new screen to display and maintain services covered under the ACO	12	80	16
	All	Updates to MMIS systems and operations documentation		15	
	All	ACO-MMIS file exchange integration testing			80
5-6	**MMIS Claims Processing Modifications**		**682 hours**		
	Claims	Adjudication logic changes to zero pay ACO claims and capture “would have paid” amount	38	250	50
	Claims	New ACO encounter data screen	9	60	12
	Claims	Modify adjudicated claim header screen to include ACO encounter claim indication with access to the new ACO encounter data screen	6	40	8
	Claims	Modify adjudicated claim detail screen to include ACO encounter claim indication with access to the new ACO encounter data screen	6	40	8
	Claims	Modify the Claims Summary Inquiry screen to include ACO indicator to the	6	20	6

#	System Area	Change Description	Analysis and Design	Development	Functional Testing
		selection criteria			
	Claims Facsimiles	Modify to use the new "would have paid" amount	12	80	16
	All	Updates to MMIS Claims systems and operations documentation		15	
7	**MMIS Financial Payment Processing**		**1146 hours**		
	Financial	ACO PMPM Payment Processing including summary report and file containing ACO attributed members not included in payment	23	150	30
	Financial	Adjudicated claims file to ACO	23	150	30
	Financial	Receive Provider/Claims payment file from ACO and generate a summary report and file containing rejected records.	18	120	24
	Financial	Modify existing Financial Balancing Report (FBR)	15	100	20
	Financial	Modify existing CMS-21 Report	8	50	10
	Financial	Modify existing CMS-64 Report	8	50	10
	Financial	Modify existing Incurred But Not Reported (IBNR)	8	50	10
	Financial	Modify PCPlus PMPM to exclude ACO members	6	40	8
	Financial	Modify BluePrint PMPM to exclude ACO members	6	40	8
	Financial	Addition of a screen to display ACO PMPM payment	9	60	12
	All	Updates to MMIS Financial systems and operations documentation		50	
8	**MMIS Reporting**		**585 hours**		
	Reporting	T-MSIS CMS reporting modifications to populate managed care file and exclude from claims file	45	300	60
	Reporting	Modify MAPIR to count ACO claims (MMIS 2/3)	5	30	5
	Reporting	State Audit updates, TBD other MMIS OnDemand report changes	20	100	20
9	**EVAH Data Warehouse Reporting**		**2010 hours**		
	Business	Redesign, upgrade, and configuration of	80	160	(included

#	System Area	Change Description	Analysis and Design	Development	Functional Testing
	Objects	Business Objects universes for ACO vs FFS reporting			below)
	Business Objects	Redesign, upgrade, and configuration of data warehouse database and ETL processes for ACO data, including modifying MMIS extracts for EVAH, other AHS warehouses, OIG extract	120	80	(included below)
	Business Objects	Modify FBR and other financial report extracts that run directly against EVAH, populate FBR table in EVAH	10	40	20
	Reporting	Modify existing HPE produced, pre-defined Business Objects reports for new configuration and ACO vs. FFS claims (45 reports total, 23 redesign+22 modify)	80	370	110
	Reporting	Assist DVHA and other AHS departments' data analysts, with modifying Business Objects reports for new configuration and for ACO (15 departments/units, approx. 100 users of Bus Object tool across DVHA, DMH, VDH, DCF, DDAIL)	40	190	60
	Analytics	Design of new Program Integrity analytics for ACOs vs FFS surveillance; design for new utilization monitoring of ACO vs FFS populations (does not include any new SUR tools, this could be phase 2?)	60	260	80
	Training	Train data analysts within DVHA and other AHS departments on new Business Objects configuration and reporting, including updates to EVAH training and help documentation	150	100	0
10	**Other MMIS Impacts**		**0 hours**		
		TBD future requirements – mitigate with contingency budget			
	Phase 1 Implementation Project Support		**740 hours**		
		HPE Project Management Support	500		
		Provider documentation and training	100		
		ACO documentation and training (including training on MMIS claims disposition)	40		
		Support for DVHA Operational readiness testing	100		
	Project Risk Management		See recommendations below		

#	System Area	Change Description	Analysis and Design	Development	Functional Testing
	Contingency, for risk of new requirements or changes in Jan 2017 requirements (due to ACO contract negotiation, CMS negotiation, legislative, AHS/DVHA decisions, other)		5% of total		
	Contingency, DVHA management reserve for unidentified risks impacting systems		5% of total		
Phase 1 Total MMIS Systems Effort Estimate			**5920 hours + 10% management contingency budget**		
Phase 2 (after Jan 2017), Pathways to Medicaid, inclusion of additional services in ACO			**TBD hours**		

These areas of systems impact and effort estimates are provided, in advance of detailed requirements and design for purposes of initial project planning. Estimates for each systems change will be further refined by HPE and provided to DVHA as detailed specifications are developed. Estimates could increase if additional complexity is added to requirements by DVHA, and as additional business decisions are made regarding All Payer program scope.

To: Georgia Maheras, Deputy Director for Health Care Reform - Payment and Delivery System Reform

From: Lori Collins, Deputy Commissioner, Medicaid Policy Fiscal & Support Services

Date: March 7, 2016

Subject: Request for SIM funding for required revisions to the MMIS System to accommodate the All Payer Model, ACO Contracting Operational Implementation Project

Purpose:
The purpose of this memo is to request consideration for funding in support of the required MMIS system changes to be completed by Hewlett Packard Enterprises (HPE) in support of the All Payer Model, ACO Contracting Operational Implementation Project. The preliminary cost estimate is approximately $750,000.

Overview of Project
The ACO model is envisioned as a risk-based, capitated payment to an ACO. The three ACOs in the state have a memorandum of understanding to merge into a single ACO. DVHA expects that the ACO would respond to an RFP for this contract. DVHA's current Shared Savings Program is scheduled to end 12/31/2016. This new ACO model would replace the Shared Savings model on 1/1/2017. DVHA is planning to implement an ACO model that is similar to, but not exactly like, the Medicare Next Generation ACO model. The project team will include Medicaid and Vermont-specific design changes where necessary. At the start, Medicare Part A/B-like services will be in the capitation payment. However, there is a commitment to provide a pathway to innovation and integration for DAs, LTSS, Mental Health and other services outside the ACO capitated payment, this component would be considered phase 2. The preparation for this 2nd phase is also starting now but is a separate component of the project being led by AHS and the SIM team.

Critical Steps:
Some of the critical steps that must be implemented in the next 11 months include:

- MMIS Systems must be modified to transition to the new model
- Contract must be executed with an ACO
- Prospective capitation payment rates must be developed
- A process must be developed to monitor the selected ACO
- All impacted stakeholders must be made aware of how this new model impacts them
- Policy must be reviewed and revised to support the new model

Although there are multiple aspects of this project, the purpose of this memo is to request funding related to the MMIS System modifications to be completed by HPE.

Justification for Expenditures:
HPE technical staff have met with DVHA leaders and technical staff in order to determine the preliminary requirements regarding the system work that must be completed in support the new model.

Following these initial discussions HPE has developed a document describing their preliminary understanding of the project and the required resources to complete the work. It must be noted that estimates should be regarding as preliminary as not all requirements are known and the project scope is subject to change. Additionally, since the project is in the early phase, HPE has not yet completed the detailed analysis and design required to support the system modifications. Estimates will be further refined by HPE as detailed specifications are developed.

The accompanying document titled "Vermont All Payer Model MMIS Systems Approach Summary" was developed by HPE and includes their preliminary understanding of the project and preliminary estimates on the number of HPE hours required to complete the proposed work.