VHCIP Core Team Agenda 4-21-14

VT Health Care Innovation Project
Core Team Meeting Agenda

April 21, 2014 1:00-3:30 pm
DFR - 3rd Floor Large Conference Room, 89 Main Street, 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	Anya Rader Wallack	
Core Team Processes and Procedures				
2	1:10-1:15	Approval of meeting minutes	Anya Rader Wallack	Attachment 2a: March 10, 2014 Meeting minutes Attachment 2b: March 14, 2014 Meeting minutes
3	1:15-1:50	Project Director Report: a. Grant Program Update b. Staffing Report c. Medicaid Shared Savings Program Update- including discussion of email sent from Deborah Lisi-Baker *Public Comment*	Georgia Maheras	Attachment 3: Staffing Report dated April 14, 2014
Policy recommendations and decisions				

		No policy recommendations or decisions this month		
Spending recommendations and decisions				
4	1:50-3:15	Financial Update: a. HIE/HIT Work Group Proposals: (pending at Steering Committee on 4/16) i. Project 1: Data gathering, data quality & remediation for Designated Agencies and Specialized Service Agencies. This project has two phases – a planning and an implementation phase. Cost: $1,949,046 ii. Project 2: Planning for Long Term Services and Supports Data Reporting and Provider IT Gap Analyses. Cost: $178,000 iii. Project 3: Universal Transfer Form Protocol Planning. Cost: $215,072 b. Evaluation contract update c. Federal timeline and no-cost extension. *Public Comment*	Georgia Maheras	Attachment 4a: ACTT Partners PowerPoint dated April 16, 2014. Attachment 4b: VHCIP Spending Tracking as of April 16, 2014 Attachment 4c: Memo from G. Maheras Re: VHCIP Financial Update and Request for Approval of SIM Funding Actions Attachment 4d: Memo from G. Maheras Re: VHCIP Grant Timeline
5	3:15-3:20	Public Comment	Anya Rader Wallack	
7	3:20-3:30	Next Steps, Wrap-Up and Future Meeting Schedule:	Anya Rader Wallack	

		5/19: 1:00-3:30 pm at DFR in Montpelier		

Attachment 2a - Core Team Minutes 03-10-14

VT Health Care Innovation Project
Core Team Meeting Minutes

Date of meeting: March 10, 2014 at 109 State Street, Montpelier - EXE Conference Room 4rd Floor
Call in: 877-273-4202 Passcode: 8155970
Members: Anya Rader Wallack, Robin Lunge, Susan Wehry, Doug Racine, Steve Voigt, Al Gobeille and Mark Larson.
Attendees: Georgia Maheras, Annie Paumgarten, Diane Cummings, Meg O'Donnell, Julia Shaw, Kara Suter.

Agenda Item	Discussion	Next Steps
1 Welcome and Chair's report	Anya called the meeting to order at 1:00pm.	
4 Continued discussion of Grant Program; Executive session	Al Gobeille made a motion to go into Executive Session with select employees present to discuss the Grant Program because a public conversation would disadvantage the State or the program applicants if information about the decisions is prematurely released. This was seconded by Steve Voigt and the motion passed unanimously. Al Gobeille made the motion to leave Executive Session; this was seconded by Steve Voigt. The motion passed unanimously.	
5 Public Comment	None offered.	
6 Next Steps, Wrap up	Next meeting : March 14, 10am – 12pm DVHA Large Conference Room, 312 Hurricane Lane, Williston	

Attachment 2b - Core Team Minutes 3-14-14

VT Health Care Innovation Project
Core Team Meeting Minutes

Date of meeting: March 14, 2014 Location: DVHA Large Conference Room, 312 Hurricane Lane, Williston

Call in: 877-273-4202 Passcode: 8155970

Members: Anya Rader Wallack, Chair; Robin Lunge, AOA; Susan Wehry, DAIL; Steve Voigt, King Arthur Flour; Paul Bengtson, NVRH; Al Gobeille, GMCB; Mark Larson, DVHA; Doug Racine, AHS.

Attendees: Georgia Maheras, AOA; Annie Paumgarten, Pat Jones, GMCB; Kara Suter, Robert Pierce, DVHA; Jim Leary; Diane Cummings and Julie Wasserman, AHS.

Agenda Item	Discussion	Next Steps
1 Welcome and Chair's report	Anya Radar Wallack called the meeting to order at 10:06 am.	
2 Approval of Minutes	Robin Lunge moved to approved the minutes and Al Gobeille seconded the motion. All were in favor and the minutes were approved (Mark Larson was not present for this motion).	
3 Continued Discussion of Grant Program (Executive Session)	Al Gobeille moved to enter into executive session and invited staff to attend to discuss the grant applications. Robin Lunge seconds this motion. The motion passed unanimously. Anya explained the review process to the group and they discussed potential funding for the projects. Susan Wehry was present for the Executive Session, but did not participate in the Grant Program selection due to potential Conflicts of Interest.	**Anya will communicate to the group the plan to release the awards the week of March 17th.**

Agenda Item	Discussion	Next Steps
	Al moved to exit Executive Session. Steve Voigt seconded the motion and it passed unanimously. Paul Bengston did not participate in the Executive Session, nor did he participate in the Grant Program Selection due to a Conflict of Interest. He participated in the rest of the meeting.	
4 Finance Update	1. <u>Grant Program Selection:</u> Robin Lunge moved to approve the following applications and amounts: #4, $250,000 #7 $350,000 #8 $176,400 #12 $112,063.43 #13 $363,070 #16 $400,000 Combine #23 and #33 for a total of $538,829 #31 $400,000 All of these are approved on the condition that the Core Team will request revised budgets from all applicants. Al seconded the motion with an amendment that applicant #7 must match the award with 80% of non-SIM funding. Paul Bengtson abstained and the motion passed. The official award announcement date is March 25. 2. <u>Contracting Request Memo: Population Health Work Group Proposal (attachment 4):</u> The Population Health Work group proposed to extend the contract with Jim Hester, who will assist with payment models, resources creating ACOs and measures, and will liaise with federal partners. The contract is for 12 months, not to exceed $28,000. Al Gobeille moved to approve the proposal and Paul Bengtson seconded the motion. The motion passed unanimously.	
5 Policy Request	1. <u>QPM work group: Proposed Standard Relating to Shared Saving Program/ACO measure review and modification (attachment 5):</u>	

Agenda Item	Discussion	Next Steps
	Pat Jones discussed the proposed standard changes to the commercial Medicaid shared savings program in years two and three. Measures would go through the VHCIP approval process and be finalized by September 30, 2014 to be released by Oct. 31, 2014 to allow time for ACOs to prepare for following year. The QPM work group will begin reviewing payment measures and target benchmarks in the first quarter of this year, by the end of March, and begin reviewing all other measures in the second quarter. The measures would need to be approved by the Steering Committee, Core Team and the Green Mountain Care Board. The group discussed the following key points: • The QPM work group has a pending measures set list. If members from other work groups wish to submit a measure they can submit it to the work group staff and co-chairs for review. • There are four primary reasons a measure may be on the pending list: o There may not be any specifications for the measure o There is disagreement over a specification o The population that measure focuses on is not yet part of the program (such as with the dual eligible population) o The measure is considered too great • A number of pending measures are under the Medicare shared savings program, which are being monitored, but not necessarily in the purview of the QPM work group. • The DLTSS and Population Health work groups are going to recommend measures. • Georgia Maheras and Anya Radar Wallack are working on an interactive timeline and will share with group when complete. Robin Lunge moved to approve the standard, stating that the Core Team wants to make sure the other work groups have sufficient time to weigh in on this process especially in year one and that the QPM should allow some flexibility in the time frame for this year. This was seconded by Al Gobeille. There was no further discussion and the motion passed unanimously.	
6 Public Comment	No additional public comments were offered.	

Agenda Item	Discussion	Next Steps
7 Next Steps, Wrap up	Next meeting: April 21, 2014, 1-3:30 pm, DFR 3rd Floor Conference Room, 89 Main St, Montpelier.	

Attachment 3 - Staffing Report

109 State Street
Montpelier, VT 05609
www.gmcboard.vermont.gov/sim_grant

To: Core Team
Fr: Georgia Maheras
Date: April 14, 2014
Re: Staffing Report

This memo provides an update on VHCIP funded staff recruitment. It should be noted that there is a significant number of state staff working on this project who are not funded by the grant, but are nonetheless integral to the success of the work.

Recruitment

VHCIP includes 24 funded positions, of which 14.5 are filled and 9.5 are vacant. Of those, 2.25 of the positions are at the Green Mountain Care Board, 2 are at the Department of Aging and Independent Living, 3 are at the Agency of Human Services Central Office, 16.25 are at the Department of Vermont Health Access, and 1.5 is at the Agency of Administration. Below please find a list of filled and vacant positions:

Position Title	Agency	Employee Name	% dedicated to the project
Fiscal Manager: Financial Manager II	AHS	Diane Cummings	100%
Program Manager for Duals: Duals Director	AHS	Julie Wasserman	100%
Project Director	AOA	Georgia Maheras	100%
Payment Program Manager	DAIL	Jennifer Woodard	100%
Fiscal Manager: Contract and Grant Administrator	DVHA	Robert Pierce	100%
Payment Program Manager: Quality Oversight Analyst	DVHA	Alicia Cooper	100%
Quality Monitoring & Evaluation: Senior Policy Advisor	DVHA	Erin Flynn	100%
Payment and Policy Specialist: Health Policy Analyst	DVHA	Amy Coonradt	100%
Payment Reform Director	DVHA	Kara Suter	25%

Quality Monitoring & Evaluation: Senior Policy Advisor	DVHA	Bradley Wilhelm	100%
Service Delivery Specialist: Administrative Services Manager I	DVHA	Luann Poirier	100%
Service Delivery Specialist: Health Policy Analyst	DVHA	Amanda Ciecior	100%
Evaluation Director	GMCB	Annie Paumgarten	100%
Grant Program Manager: Grant Manager Coordinator	GMCB	Christine Geiler	100%
Payment Reform Director	GMCB	Richard Slusky	25%
Quality Monitoring & Evaluation: Business Administrator	IFS/AHS	Carolynn Hatin	100%
Workforce Work Group Manager	AOA	Recruiting at AOA	50%
Payment Program Manager	DAIL	Recruiting at DAIL	100%
Payment Initiative Director, Shared Savings	DVHA	Recruiting at DVHA	100%
Payment Initiative Director, Payment Pilots	DVHA	Recruiting at DVHA	100%
Payment Program Manager: Policy and Planning Chief	DVHA	Recruiting at DVHA	100%
Medicaid Data Analyst: Quality Oversight Analyst	DVHA	Recruiting at DVHA	100%
Medicaid Data Analyst: Health Care Statistical Information Administrator	DVHA	Recruiting at DVHA	100%
Medicaid Data Analyst: Health Care Statistical Information	DVHA	Recruiting at DVHA	100%

109 State Street
Montpelier, VT 05609
www.gmcboard.vermont.gov/sim_grant

Administrator			
Medicaid Data Analyst: Health Care Statistical Information Administrator	DVHA	Recruiting at DVHA	100%
Quality Monitoring & Evaluation: Senior Policy Advisor	DVHA	Recruiting at DVHA	100%

We have recently revised all of the job descriptions for the DVHA positions to enable us to complete recruitment for these positions. We are also launching a new series of advertising for these positions. The advertising will include: LinkedIn postings, posting on the DVHA and State HR recruitment sites, posting at Academy Health's upcoming meeting in early February, posting to university recruitment sites and encouraging all VHCIP staff to distribute the positions to their professional networks. This recruitment is bearing fruit as we have hired several individuals.

Attachment 4a - Advancing Care Through Technology Presentation

ACTT PARTNERS

ADVANCING CARE THROUGH TECHNOLOGY

UPDATE FOR THE VHCIP STEERING COMMITTEE

APRIL 16, 2014

Recommendation from the HIE/HIT Work Group

- The HIE/HIT Work Group recommended approval of three projects:
  - Project 1: Data gathering, data quality & remediation for Designated Agencies and Specialized Service Agencies. This project has two phases – a planning and an implementation phase. Cost: $1,949,046
  - Project 2: Planning for Long Term Services and Supports Data Reporting and Provider IT Gap Analyses. Cost: $178,000
  - Project 3: Universal Transfer Form Protocol Planning. Cost: $215,072

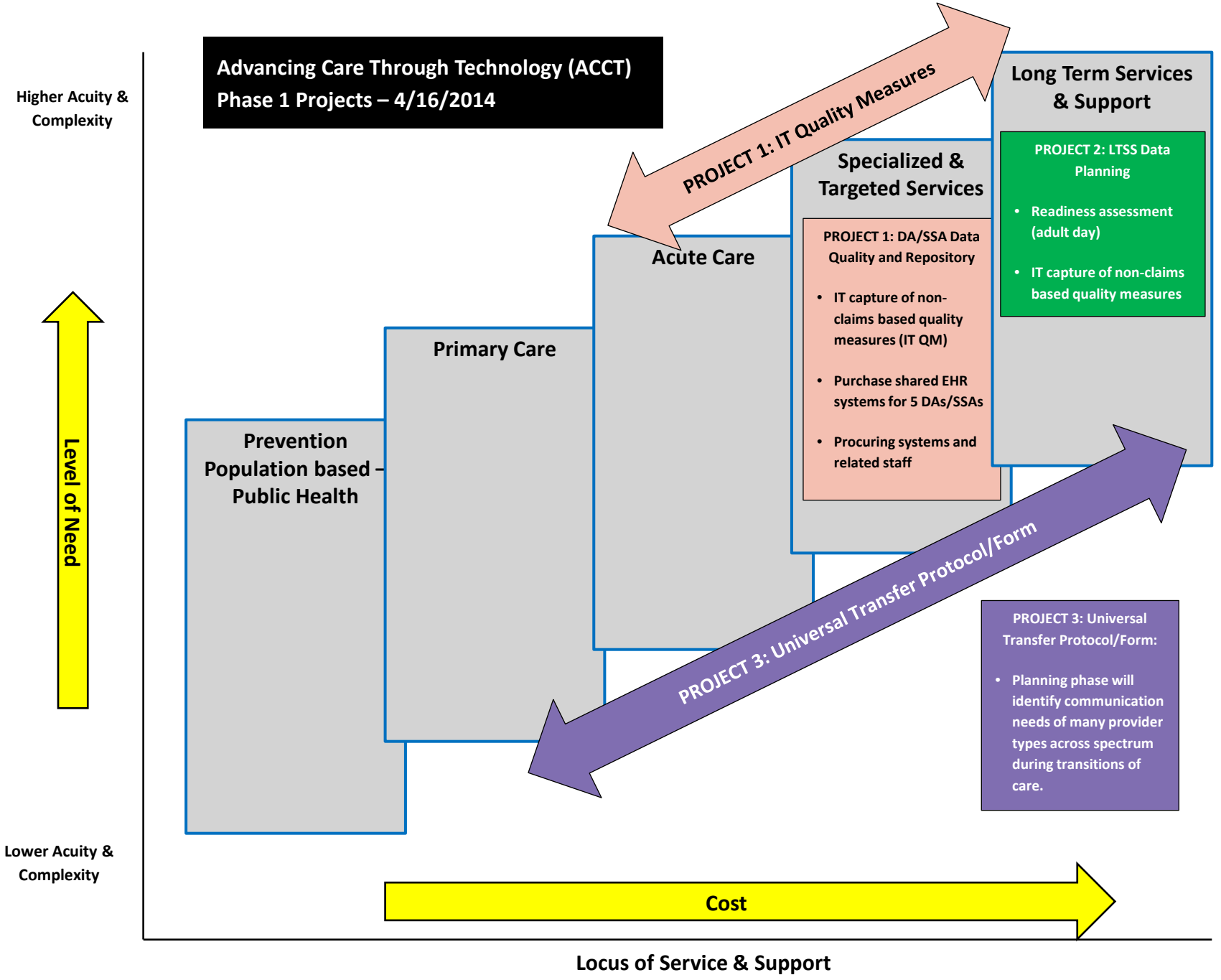
Additional request for Steering Committee consideration:

- Overall Project Management for these three projects: $120,000

Total requested: $2,462,118

ACTT Goals
Improve DLTSS information exchange

- **Source Systems**: improve utilization, functionality and interoperability of the DLTSS source systems providing data for the exchange of information
- **Data Quality:** improve DLTSS data quality and accuracy for the exchange of information
- **Communication**: improve ability to exchange information
- **EHR Integration**: align and integrate Vermont's DLTSS electronic health information systems


Advancing Care Through Technology (ACCT)
Phase 1 Projects – 4/16/2014
Higher Acuity & Complexity
Level of Need
Lower Acuity & Complexity
Locus of Service & Support
Cost
PROJECT 1: IT Quality Measures
Prevention Population based – Public Health
Primary Care
Acute Care
Specialized & Targeted Services
Long Term Services & Support
PROJECT 1: DA/SSA Data Quality and Repository
IT capture of non-claims based quality measures (IT QM)
Purchase shared EHR systems for 5 DAs/SSAs
Procuring systems and related staff
PROJECT 2: LTSS Data Planning
Readiness assessment (adult day)
IT capture of non-claims based quality measures
PROJECT 3: Universal Transfer Protocol/Form
PROJECT 3: Universal Transfer Protocol/Form:
Planning phase will identify communication needs of many provider types across spectrum during transitions of care.

Project 1
DA/SSA Data Quality and Repository

- Phase 1:
  - Identify data and reporting needs and create data dictionary for DA/SSA system
  - Enable pilot discover process for measurement and HIE and develop toolkit for statewide use
  - Utilize tools statewide and conduct current state EHR capability analysis for DAs/SSAs
  - Procure unified EHR for five developmental disability agencies in consultation with VITL
  - Conduct architectural design process with VITL and necessary stakeholders to identify characteristics of, and infrastructure for, desired solution for data repository (potential ability to leverage VITL statewide infrastructure)
- Phase 2:
  - Begin quality remediation of identified data elements that relate to VHCIP models being tested
  - Begin DA/SSA connectivity to HIE through VITL
  - Execute repository project based on phase one decision

Project 2
Planning for DLTSS Data Reporting

- Update and/or Conduct DLTSS Provider Information Technology Gap Analyses and Develop a Remediation budget
  - Review existing reports related to information technology gap remediation work
  - Work with VITL
- Convene meetings with DLTSS providers and provider associations to assess current IT systems
- Create a report of analyses that need to be conducted
- Create a complete plan for conducting IT gap remediation analyses based on work under this project maximizing low-tech and high-tech solutions as appropriate
- Planning work related to non-claims based measures for DLTSS programs

Project 3
Planning for Universal Transfer Protocol/Form

- Technical support for a planning process to develop a uniform transfer form/protocol.
  - Look at low-tech and high-tech solutions
- This will enable providers, and other interested parties, to identify the current challenges, future vision, and communication bridges to more seamless delivery of services and supports during care transitions.
- Develop the functional requirements around the realistic and useable exchange of information during transitions of care between different types of providers

BUDGET

PROJECT	COSTS
Project1: *Phase 1* Data gathering for Designated Agencies and Specialized Service Agencies. *	$799,184
Project 1: *Phase 2* Remediation and Repository *	$1,149,862
Project 2: LTSS Data Planning/Provider IT Gap Analyses *	$178,000
Project 3: Universal Transfer Form *	$215,072
Program management	$120,000
TOTALS	**$2,462,118**

*All projects include funds for VITL

Attachment 4b - VHCIP spending tracking as of 4.16.14

VHCIP Funding Allocation Plan

		Implementation (March-Oct 2013)	Year 1	Year 2	Year 3	Total grant period	
Type 1a	Type 1A						
Proposed type 1 without base work group or agency/dept support	*Proposed Type 1 without base work group or agency/dept support (subject to Core Team approval)*						**Green indicates the money has been committed through hiring or contracts. Blue indicates the money has been approved for spending, but the contract is pending. Red indicates pending Core Team Approval.**
	Personnel, fringe, travel, equipment, supplies, other, overhead	**$ 107,898**	**$ 2,912,103**	$ 3,412,103	$ 3,412,103	$ 9,844,207	Includes new .5FTE in AOA for work force. **Transfer $500,000 unspent personnel to grant program-technical assistance.**
	Duals personnel and fringe		**$ 110,000**			**$ 110,000**	Year 1 paid out of Carryover
	Project management	**$ 30,000**	**$ 470,000**	$ 700,000	$ 670,000	$ 1,870,000	**Year 1 paid out of Carryover. Run rate is lower than expected in year one. Recommend moving $305,000 to ACO Analytics.**
	Evaluation		**$ 200,000**	**$ 900,000**	**$ 900,000**	**$ 2,000,000**	**Contracting delays. Estimated new cost of $1.5million on different timeline. Recommend moving 1,000,000 from Evaluation to Grant Program.**
	Outreach and Engagement		**$ -**			**$ -**	**Year 1 paid out of Carryover Recommend moving these funds to ACO Analytics- $100,000**

	Interagency coordination		$ -	$ 110,000	$ 110,000	$ 220,000	**Recommend moving these funds to ACO Analytics- 110,000**
	Staff training and Change management		**$ 20,000**	$ 100,000	$ 100,000	$ 220,000	**Support Conferences and Educational Opportunities. Recommend reducing this to $20,000 for Year 1 and using remainder for ACO Analytics- $80,000**
	VITL Contract		**$ 1,177,846**			**$ 1,177,846**	
	Grant program		**$ 3,428,435**	**$ 933,333**	**$ 933,334**	**$ 5,295,102**	**Increase of $1,918,000 from other categories.**
	Grant program- Technical Assistance		**$ 500,000**			**$ 20,737,155**	**500,000 from personnel due to unspent funds in that category.**
	Subtotal	**$ 137,898**	**$ 8,818,384**	**$ 6,155,436**	**$ 6,125,437**	**$ 20,737,155**	

VHCIP Funding Allocation Plan

Type 1b	Type 1 B		**Year 1**	**Year 2**	**Year 3**	**Grant Total**	
Proposed type 1 related to base work group support (subject to Core Team approval)	Proposed Type 1 related to base work group support (subject to Core Team approval)						
	Payment Models						
	Bailit		$ -	$ 200,000	$ 200,000	$ 400,000	To support ACO work, Care Models Work
	Burns and Associates or other vendor		**$ 200,000**	$ 200,000	$ -	$ 400,000	**To develop EOC program and P4P programs. Note that only 125,000 has been approved by CT. Anticipate needing the remainder in year two.**
						$ -	
	Measures					$ -	
	Bailit/Murray		$ -	$ 200,000	$ 200,000	$ 400,000	
	Patient Experience Survey		**$ 300,000**			**$ 300,000**	
						$ -	
	HIT/HIE		**$ 50,000**	$ 150,000	$ 150,000	$ 350,000	**No contractor identified. Recommend moving $100,000 to Grant Program**
						$ -	
	Population Health		**$ 100,000**	$ 100,000	$ 100,000	$ 300,000	**28,000 expended on Hester contract in year one.**
						$ -	
	Workforce		$ -	$ 43,000	$ 43,000	$ 86,000	**No contractor identified. Recommend moving 43,000 to Grant Program.**
						$ -	
	Care Models		**$ 50,000**	$ 250,000	$ 250,000	$ 550,000	**No contractor identified. Recommend moving $200,000 to ACO Analytics.**
						$ -	
	Duals					$ -	
	Hogan/Besio/Wakely		**$ 180,000**	$ 250,000	$ 250,000	$ 680,000	**$180,000 identified in year one for PHPG and Hogan. Recommend moving $70,000 to ACO Analytics.**

	Sub Total		**$ 880,000**	**$ 1,393,000**	**$ 1,193,000**	**$ 3,466,000**	

VHCIP Funding Allocation Plan

Type 1c	Type 1 C		**Year 1**	**Year 2**	**Year 3**	**Grant Total**	
Proposed type 1 related to base agency/dept support	Proposed Type 1 related to base agency/dept support						
	GMCB/DVHA						
	ACO Analytics Contractors		**$ 733,333**	**$ 748,333**	**$ 733,334**	**$ 2,215,000**	**This contractor would support the development of spending targets, whether an ACO met those targets and how potential savings are distributed. RFP released. This contract is higher than anticipated. Recommend moving funds to provide additional $1.215 million**
						$ -	
	GMCB					$ -	
	Model testing support		$ 125,000	$ 125,000	$ 125,000	$ 375,000	Support GMCB analytics related to payment model development
						$ -	
	DVHA					$ -	
	Modifications to MMIS, etc…		**$ 275,000**	$ 150,000	$ -	$ 425,000	Resources to support updates to adjudication or analytic systems and processes like MMIS. **Recommend moving 75,000 to Grant Program.**
	Broad dissemination of programmatic information to providers and consumers		$ -	$ 100,000	$ 100,000	$ 200,000	Communications to providers and consumers regarding program/billing changes. **Recommend moving 100,000 to ACO Analytics Contract.**
	Analytics support to implement models		$ -	$ 50,000	$ 50,000	$ 100,000	**recommend moving 250,000 to ACO Analytics Contract.**

	Technical support of web-based participation and attestation under the P4P program		$ 125,000	$ 100,000	$ 25,000	$ 250,000	Aimed to reduce administrative burden to implement and improve participation in P4P programs
	Analytic support		$ 100,000	$ 100,000	$ 100,000	$ 300,000	Support Medicaid analytics related to payment model development
	Sub-Total		**$ 1,358,333**	**$ 1,373,333**	**$ 1,133,334**	**$ 3,865,000**	

VHCIP Funding Allocation Plan

Type 2	Type 2		Year 1	Year 2	Year 3	Grant Total	
Total proposed type 2 (subject to staff planning, work group/steering committee review and Core Team approval)	Total proposed Type 2 (subject to staff planning, work group/steering committee review and Core Team approval)						
	HIT/HIE						
	Practice Transformation Teams		$ 530,933	$ 856,666	$ 856,667	$ 2,244,266	$90,612 in year one is unallocated. Use 90,612 of year one and 856,666 of year two for ACTT Proposal.
	Clinical Registry		$ 466,666	$ 466,666	$ 466,667	$ 1,399,999	Use 466,666 of year one for ACTT Proposal.
	Integrated Platform		$ 666,666	$ 666,666	$ 666,667	$ 1,999,999	
	Expanded Connectivity between SOV and providers		$ 833,333	$ 833,333	$ 446,237	$ 2,112,903	Use 387,097 of year three for ACTT Proposal. Reallocate between years. Balance of $446,237 remains.
	Telemedicine		$ 416,666	$ 416,666	$ 416,667	$ 1,249,999	
	Expanded Connectivity HIE		$ 346,346	$ 661,077	$ 661,077	$ 1,668,500	Use 661,077 of year three for ACTT Proposal. Reallocate between years.
						$ -	
	Workforce					$ -	
	Surveys		$ -	$ 80,000	$ -	$ 80,000	Recommend moving 80,000 to Grant Program
	Data analysis		$ -	$ 150,000	$ 150,000	$ 300,000	
	System-wide analysis		$ 96,666	$ 546,666	$ 546,667	$ 1,189,999	$150,000 request for year one data analysis- RFP is pending. Remainder unallocated. Recommend moving 300,000 to Grant Program. Remainder is 96,666 in Year One.
						$ -	
						$ -	
	Care Models					$ -	

	Service delivery for LTSS, MH, SA, Children		$ 533,333	$ 533,333	$ 533,334	$ 1,600,000	
	Learning Collaboratives		**$ 350,000**	$ 325,000	$ 325,000	$ 1,000,000	This item could support outreach and mailings associated with notification and education on new care delivery and payment reform models. **Recommend moving 150,000 to Grant Program**
	Analysis of how to incorporate LTSS, MH/SA		$ 100,000	$ 100,000	$ 100,000	$ 300,000	This includes technology support to Medicaid Home Health Initiatives including Hub and Spoke.
	Practice Facilitators		$ -	$ 170,000	$ 170,000	$ 340,000	**recommend moving 170,000 to Grant Program.**
	Integration of MH/SA		$ 50,000	$ 50,000	$ 50,000	$ 150,000	
						$ -	
	Sub-Total		**$ 4,390,609**	**$ 5,856,073**	**$ 5,388,983**	**$ 15,635,665**	

VHCIP Funding Allocation Plan

Type 1a	$ 20,737,155	Type 1 A					
Type 1b	$ 3,466,000	Type 1 B					
Type 1c	$ 3,865,000	Type 1 C					
Type 2	$ 15,635,665	Type 2					
Unallocated (Year 1)	$ 1,305,350	Balance Avail.					
Grant Total	$ 45,009,170	Grant Total					

Attachment 4c - VHCIP Finance Memo

109 State Street
Montpelier, VT 05609

To: Core Team
Fr: Georgia Maheras
Date: 4/21/14
Re: VHCIP Financial Update and Request for Approval of SIM Funding Actions

I am requesting Core Team approval for seven SIM funding actions:

1. Proposal to contract for services supporting: data gathering, data quality & remediation for Designated Agencies and Specialized Service Agencies. This project has two phases – a planning and an implementation phase. Cost: $1,949,046.*
2. Proposal to contract for services supporting data quality & remediation: e-Health Specialists. Cost: $200,000.
3. Proposal to contract for services supporting: Planning for Long Term Services and Supports Data Reporting and Provider IT Gap Analyses. Cost: $178,000.*
4. Proposal to contract for services supporting: Universal Transfer Form Protocol Planning. Cost: $215,072.*
5. Proposal to contract for services supporting project management for items #1-4. Cost: $120,000.
6. Proposal to increase the amount approved for statewide analytics activities related to the implementation, monitoring, reporting, and evaluation of the Commercial and Medicaid Shared Savings Accountable Care Programs. The increase would be from a budgeted amount of $1,000,000 to an amount not to exceed $2,200,000.
7. Proposal to adjust the SIM budget to reflect an increase in the Grant Program line item of $1,918,000.

REQUEST #1- Type 2 Proposal to contract for services supporting: data gathering, data quality & remediation for Designated Agencies and Specialized Service Agencies for an amount not to exceed $1,949,046:

The HIE/HIT Work Group recommended approval of a proposal to contract for services to support data gathering, data quality & remediation for Designated Agencies and Specialized Service Agencies. This recommendation was moved forward by the Steering Committee on April 16, 2014. *Funding for this proposal bridges three project years and is in the SIM-approved budget under HIE/HIT: Clinical Registry, Practice Transformation Teams, Expanded Connectivity-HIE, Expanded Connectivity Between SOV and Providers.*

The HIE/HIT Work Group reviewed this proposal at its February and March meetings. This work group requested clarifications of VITL and the ACTT Partners, who made the proposal. These clarifications are appended to the proposal. The work group passed a motion on February 26, 2014. This motion was sent to the Steering Committee for review at their March 5th meeting.

*Note that each of these proposals includes funding for VITL as the state's designated HIE.

The Steering Committee reviewed the proposal on March 5th and set aside the requested funding pending receipt of additional information at its April 16th meeting. The Steering Committee recommended funding of this proposal on April 16th.

The presentation, proposal and motion are appended to this memo.

Project Summary
This project will take place over a two year period and has two distinct phases. Phase One will include: Work with all of the Designated and Specialized Service Agencies (DA/SSA) toward the development of a data dictionary; DA/SSA agency assessment against the data set; planning and architectural design for the data warehouse; and procurement of a unified Electronic Health Record for five developmental disability agencies. The selection process for choosing an EHR/Vendor for the DA/SSAs will be done in consultation with VITL. The DA/SSA data warehouse planning and architectural design will be done in consultation with VITL, DVHA and other necessary stakeholders. The planning and design work will lead to Phase Two which will include the DA/SSA data warehouse implementation and testing. Phase Two will also include data quality work and remediation with DA/SSAs in conjunction with VITL and other necessary stakeholders including DVHA, DMH, ACOs and others. Expenditures include: IT Project Management, legal, VITL consultation and staff; Behavioral Health Network (BHN) staff, EHR infrastructure, and warehouse infrastructure.

The Behavioral Health Network of Vermont (BHN) is proposed to be the recipient of the funds for Project 1 and will be responsible for completing the scope of work. BHN will hire necessary staff, consultants, and subcontractors to complete the work and will provide regular progress reports to VHCIP leadership, staff, and appropriate work groups.

Recommendation: Execute a sole source contract with BHN for the work performed under this project. BHN will sub-contract for some components of this project and will follow state procurement and approval practices. The State will contract directly with VITL for the portion of this project that is in their purview. The total project cost is: $1,949,046. The term is June 2014-July 2016.

REQUEST #2- Type 2 Proposal to contract for services supporting: supporting data quality & remediation: e-Health Specialists. Cost: $200,000:

I recommend that the Core Team add additional funds to the proposal described in Request #1. The project in Request #1 includes installation of electronic health records and ensuring data quality at the DAs and SSAs. The state and VITL have identified ways to ensure these installations and data quality are done in the most efficient and successful manner possible. One of the ways to ensure success is to deploy e-Health Specialists. The e-Health Specialists have historically been funded by the federal government through the state to VITL. This federal funding has ended. The state, with VITL, needs to identify the best way to support these

services moving forward in the absence of the federal funds and those conversations are ongoing at DVHA. Due to the timing of contracts, I recommend providing $200,000 to support the data quality work at the DAs and SSAs because it is not clear there will be other state funds or federal funds to support this work and we have determined that in the absence of services like this, the data in the VHIE is of extremely poor quality. These funds may not be spent, if we identify other funds, but I want to ensure we have the necessary resources. *Funding for this proposal bridges three project years and is in the SIM-approved budget under HIE/HIT: Clinical Registry, Practice Transformation Teams, Expanded Connectivity-HIE, Expanded Connectivity Between SOV and Providers.*

Recommendation: Execute a sole source contract, if necessary, with VITL for the work performed under this project. The total project cost is: $200,000. The term is June 2014-June 2016.

REQUEST #3- Type 2 Proposal to contract for services supporting: Planning for Long Term Services and Supports Data Reporting and Provider IT Gap Analyses. Cost: $178,000:

The HIE/HIT Work Group recommended approval of a proposal to contract for services supporting Planning for Long Term Services and Supports Data Reporting and Provider IT Gap Analyses. This recommendation was moved forward by the Steering Committee on April 16, 2014. The proposal provides data gap analyses to support the LTSS providers participating in the Shared Savings ACO Programs. *Funding for this proposal bridges two project years and is in the SIM-approved budget under HIE/HIT: Clinical Registry, Practice Transformation Teams, Expanded Connectivity-HIE, Expanded Connectivity Between SOV and Providers.*

The HIE/HIT Work Group reviewed this proposal at its February and March meetings. This work group requested clarifications of VITL and the ACTT Partners, who made the proposal. These clarifications are appended to the proposal. The work group passed a motion on February 26, 2014. This motion was sent to the Steering Committee for review at their March 5th meeting.

The Steering Committee reviewed the proposal on March 5th and set aside the requested funding pending receipt of additional information at its April 16th meeting. The Steering Committee recommended funding of this proposal on April 16th.

The presentation, proposal and motion are appended to this memo.

Proposal Summary

This project has two separate components. This funding request is for the first component only. The first component is anticipated to involve working with VITL, other contractors and DLTSS providers, AHS Quality Workgroup staff, AHS IT staff and DLTSS providers and stakeholders to review existing DLTSS measures. The review of the DLTSS measures is in advance of the

measures that are being proposed for use in the Medicaid Shared Savings Program in 2015 and 2016. The AHS Quality Workgroup staff have proposed DLTSS claims based measures currently and this project will determine if any non-claims based measures need IT support for use in 2016. Additionally, if after the planning phase it is determined that the IT support exceeds the phase 1 budget a comprehensive plan and budget for a Phase 2 request to the HIT/HIE workgroup will be developed.

The second part of this work involves continuing IT gap remediation work for DLTSS providers. This work is anticipated to involve VITL, other contractors and DLTSS providers will meet to review existing analyses that have been conducted by a previous state contractor. The discussions with providers will be part of this planning phase to build a comprehensive budget request for Phase Two that allows for IT gap remediation work to occur. The discussions will be specific to each separate DLTSS provider group/association/project including: Aging and Disability Resource Connections (ADRC); Area Agencies on Aging (AAA); Vermont Association of Adult Services (VAADS); Vermont Council for Developmental and Mental Health Services/Behavioral Health Network (VT Council/BHN); Vermont Assembly of Home Health and Hospice Agencies (VAHHA); and Vermont Health Care Association (VHCA). The work will build upon previous analysis and existing IT options to maximize both low-tech and high-tech solutions as appropriate.

The varying contractors listed in this project are proposed to be the recipients of the funds. If provider stipends are approved by CMMI they will be either disbursed directly by DVHA or through a subcontract with a contractor.

Recommendation: Execute several contracts, with the stipends subject to CMMI approval, according to the table below:

COST SUMMARY	**Phase One Total**
Project Leadership Assistance- sole source	$30,000
Other contractors & LTSS provider *Association* stipends-contract structure depends on CMMI response	$40,000
IT Consultation-sole source	$60,000
VITL Subject Matter Expertise/ IT Consultation-sole source	$48,000
Total	**$178,000**

The total project cost is: $178,000. The term is June 2014-December 2014.

REQUEST #4- Type 2 Proposal to contract for services supporting: Universal Transfer Form Protocol Planning. Cost: $215,072:

The HIE/HIT Work Group recommended approval of a proposal to contract for services to plan for a Uniform Transfer Form Protocol. This recommendation was moved forward by the

Steering Committee on April 16, 2014. *Funding for this proposal bridges two project years and is in the SIM-approved budget under HIE/HIT: Clinical Registry, Practice Transformation Teams, Expanded Connectivity-HIE, Expanded Connectivity Between SOV and Providers.*

The HIE/HIT Work Group reviewed this proposal at its February and March meetings. This work group requested clarifications of VITL and the ACTT Partners, who made the proposal. These clarifications are appended to the proposal. The work group passed a motion on February 26, 2014. This motion was sent to the Steering Committee for review at their March 5th meeting.

The Steering Committee reviewed the proposal on March 5th and set aside the requested funding pending receipt of additional information at its April 16th meeting. The Steering Committee recommended funding of this proposal on April 16th.

The presentation, proposal and motion are appended to this memo.

Proposal Summary

This project aims to improve integration of communication among acute and post-acute health care providers and community based supportive service providers to enable Vermont to reach the next level of performance and service integration, with lower total medical expenditure (TME) and higher patient satisfaction. Today, modes of communication among different provider types vary from electronic to manual modes such as fax, telephone, and paper. Significant constraints on improved care integration and coordination include the lack of common information exchange processes, agreed upon content, and access to a shared health information exchange.

In Phase 1 of this project, we will consider the data sets each provider needs, which must convey both medical and social information. We will also consider the impact to existing workflow processes and behaviors that will arise as the result of the introduction of new workflow processes for communication during transfers. The work described here will focus on several provider types, some of which have EMR systems, and at least one will not. Mandating a form or protocol does not guarantee that people will use it well, or even that they will use it at all. Phase 1 will be a discovery process and business requirements gathering effort. Phase 1 will result in the creation of a detailed project charter for the technical design of the actual Universal Transfer Protocol (Phase 2). Contingent on available funding, technical design and implementation will follow in Phases 2 and 3. The outcome upon completion of all three phases will be a common communication methodology, platform, and UTP.

It is anticipated that contractors will be hired to assist with the following tasks: Project Leadership Assistance; IT project leadership and VITL will provide subject matter expertise and

IT consultation. If approved by CMMI the provider stipends will be either directly disbursed by DVHA or through a subcontract with a contractor.

Recommendation: Execute several contracts, with the stipends subject to CMMI approval, according to the table below:

COST SUMMARY	**Phase One Total**
Project leadership Assistance – sole source	$10,272
LTSS provider *Association* stipends- contract structure depends on CMMI response	$ 20,000
Contractor IT Project Leadership-sole source	$ 180,000
VITL Subject Matter Expertise/ IT Consultation-sole source	$ 4,800
Total	**$ 215,072**

The total project cost is: $215,072. The term is June 2014-October 2014.

REQUEST #5- Type 2 Proposal to contract for services supporting project management for items #1-3. Cost: $120,000:

The HIE/HIT Work Group recommended approval of three proposals listed above. At the Steering Committee meeting on March 5th, the Steering Committee added in an IT Project Management component. *Funding for this proposal bridges three project years and is in the SIM-approved budget under HIE/HIT: Clinical Registry, Practice Transformation Teams, Expanded Connectivity-HIE, Expanded Connectivity Between SOV and Providers.*

Proposal Summary

The IT Project Management serves as oversight and accountability for all of the projects listed in #1-4. This contractor would serve a 'clerk of the works' for all of these projects. The funding for this contract would be *in addition* to the proposed budget to ensure that the core of the project is not impacted by this additional financial pressure.

Recommendation: Follow state procurement rules to acquire an IT Project Manager. The total project cost is: $120,000. The term is June 2014-June 2016.

REQUEST #6- Type 1c Proposal to increase the amount approved for statewide analytics activities related to the implementation, monitoring, reporting, and evaluation of the Commercial and Medicaid Shared Savings Accountable Care Programs. The increase would be from a budgeted amount of $1,000,000 to an amount not to exceed $2,200,000:

At its November 18th meeting, the Core Team approved a Type 1c line item for ACO Analytics. This line item was estimated at $1,000,000 for three years of analytics and directed the GMCB

to release an RFP for this work. The GMCB released an RFP for these services on January 17, 2014 and received seven bids on February 18, 2014. The bid review team consisted of representatives from the GMCB, DVHA, two of the ACOs and one of the commercial payers. The team met on March 10th and scored the bids. The bid review team identified the three top proposals; those 3 vendors were sent follow up questions and requests for clarification of their budgets and costs on March 14th. The vendors submitted their responses the following week. The bid review team met again on March 26th to discuss and select a vendor based on the responses submitted. Unfortunately all of the bids came in significantly higher than the estimated amount in the budget approved by the Core Team. Because of this the GMCB approved vendor #1 with a not to exceed amount of $2.2 million and to allow GMCB staff to negotiate with the selected vendor around scope and price to try and reduce the bid.

The funds for this would move year one funds from: Project Management, Outreach and Engagement, Interagency Coordination, Staff Training and Change Management, DLTSS Consulting Support, Broad dissemination of programmatic information to providers and consumers, Analytics support to implement models

Recommendation: Approve a modification to the VHCIP Budget line items to accommodate an ACO Analytics contract increase of $1.2 million for a total of $2.2 million 3-year contract. Vendor 1 is recommended for the following reasons:

ACO Analytics Scope of Work:

Mandatory Tasks

A. Calculation of ACO Financial Performance and Calculation of the Distribution of Earned Savings Payments

– The Contractor shall be responsible for the calculation of interim and final determination of savings for the three ACO SSP pilot years (i.e., calendar years 2014, 2015 and 2016, respectively), and of the distribution formula of any savings for distribution to the ACOs. Savings calculations shall be performed using claim data submitted by the Participating Payers to the Contractor using the file format that payers use to submit data to the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES).

B. Calculation of ACO Performance Measures

-- The Contractor shall calculate the quality measures comprising the Core Measure Set (Attachment I). The Core Measure Set consists of measures of ACO performance using three distinct data sources:

- Clinical data-based quality measures: These measures will be generated by the ACOs and reported as numerators and denominators to the Contractor.
- Claims-based quality measures: These measures will by generated by the Contractor using claim data provided by the Participating Payers.

        - Survey-based quality measures: These measures will be generated by a third-party survey contractor and reported as numerators and denominators to the Contractor.
    - The Contractor shall also calculate or aggregate quality, cost and utilization measures comprising the Monitoring and Evaluation Measure Set. The Monitoring and Evaluation Measure Set consists of measures using four types of data sources:
        - Claims-based utilization measures: These measures will be generated by the Participating Payers and reported as numerators and denominators to the Contractor.
        - Claims-based cost measures: These measures will by generated by the Contractor using claim data provided by the Participating Payers.
        - Claims-based quality measures: These measures will by generated *at the payer level* by the Participating Payers using claim data and reported as numerators and denominators to the Contractor.
        - Other measures: These measures will be generated by other parties identified by the GMCB and reported as numerators and denominators to the Contractor.

C. Calculation of the Impact of ACO Quality Performance on the Distribution of Shared Savings

- Should one or more ACOs be found to have generated savings after the conclusion of a pilot year, the Contractor shall annually utilize ACO-specific quality measures to determine what percentage of the savings should be distributed by one or more Participating Payers to one or more Participating ACOs. The Contractor shall utilize the methodologies contained within Appendices N and O for the purposes of performing the specified calculations, and shall report the results in writing to the GMCB upon task completion.
- Mandatory Tasks

D. Report Design and Generation

- The Contractor shall propose to the GMCB report designs to present findings of all calculated and aggregated measures by ACO and by covered population (i.e., commercially–insured and Medicaid). Intended audiences include the GMCB, DVHA, Participating Payers and ACOs, policymakers, other interested stakeholders and consumers. The GMCB expects that the Contractor will propose varied report formats and content as appropriate to satisfy the needs of diverse audiences.

E. Other Activities

- The Contractor shall conduct an assessment of the timeliness and completeness of the VHCURES database for informing the calculation of ACO financial performance as defined in Section 3.2.A, and for generating claims-based cost, quality and utilization measures as defined in Section 3.2.B. The Contractor shall submit the methodology for GMCB review and approval by December 1, 2014, and shall complete the assessment by October 1, 2015.

- The Contractor shall conduct an annual assessment of the financial effect of changes in medical coding practices on ACO expenditures.

- The Contractor shall design and generate ad-hoc reports during the contract period as requested by the GMCB and DVHA.
- The Contractor shall participate as requested in VHCIP work group, subgroup and other related meetings that pertain to the scope of work.
- The Contractor shall review the results of its calculations performed as part of Section 3.2.A-C tasks with interested Participating ACOs and Payers, and shall work with such ACOs and Payers to reconcile any inconsistencies (such as conflicting Contractor and Participating Payer patient attribution counts) or other possible methodological or data quality concerns that Participating ACOs and Payers might identify, and shall do so as directed by the GMCB.

- As requested by the GMCB, the Contractor shall provide feedback and advice to the GMCB and DVHA and to VHCIP-related work groups and committees concerning experience with the conduct of tasks defined within Sections 3.2.A-D and with respect to the implications of contemplated changes to existing measure sets.
- The Contractor shall be prohibited from utilizing the data provided to it except as directed within this RFP and as directed by the GMCB and DVHA to address the stated objectives of the Vermont Health Care Innovation Project. Any unauthorized use of data obtained through the contract expected to result from this RFP shall be grounds for contract termination.

- Defined Reports
  - The Contractor shall produce reports that provide the results of tasks undertaken.
- Ad Hoc Reports
  - The Contractor shall prepare and submit to the GMCB ad hoc reports utilizing data reported to the Contractor to meet requirements Sections 3.2.A-D and as may be separately provided to the Contractor by DVHA. Attachment P contains examples of possible ad hoc report content and formats to be requested by the GMCB.

REQUEST #7- Type 1a Proposal to adjust the SIM budget to reflect an increase in the Grant Program line item of $1,918,000:

The Core Team has requested that we identify additional funds to support the provider Grant Program by adjusting other items in the VHCIP Budget. The accompanying excel spreadsheet provides adjustments to numerous line items to provide $1,918,000 in additional funds for the Grant Program.

Attachment 4d - VHCIP Grant Timeline Memo

VERMONT

Vermont Health Care Innovation Project

109 State Street
Montpelier, VT 05609

To: Core Team
Fr: Georgia Maheras
Date: 4/21/14
Re: VHCIP Grant timeline

In this memo, I recommend that we extend the VHCIP/SIM Grant Project by three months and that you allow me to work with the finance team and key project staff to revise the project budget to reflect this new timeframe.

CMMI approached the State of Vermont, along with all of the other first round SIM Test States, with an offer to do a three month no-cost extension of our VHCIP project. CMMI's rationale is that many states did not launch their models until January 2014 and this would allow states to have three full years of model testing rather than two years and 9 months.

I recommend that we extend the VHCIP/SIM Grant Project for the following reasons:

1. One of the biggest challenges this project faces is the compressed timeline. The additional three months affords a little bit of flexibility in an otherwise very tight timeline of activities.
2. Our first model did not begin until January, 2014 and this program runs on a calendar year basis. The three additional months all us to provide full staffing and project management support to this program.
3. The Episode of Care/Bundled Payment Model development was slowed down intentionally due to staff and stakeholder fatigue. Three months will give Vermont more time to implement and evaluate this program.
4. The Core Team is anticipating releasing a second round of grant funding later in 2014. These awards will result in funds flowing several months later than the first round awardees. These additional months allow our providers more time to innovate within the scope of this project.
5. CMMI has indicated that each SIM Test state needs to develop a population health plan by 2017. This was not a deliverable when Vermont was first awarded the grant and we do not yet have official guidance from CMMI about the form and structure of this plan. The additional time will allow us to complete this unexpected deliverable while not sacrificing stakeholder process.
6. The VHCIP work groups are involved in making recommendations for both the workforce and HIT strategic plans. These plans are due in January of each year. The three month extension will allow these work groups to develop recommendations

*Note that each of these proposals includes funding for VITL as the state's designated HIE.

throughout 2016, rather than just partway, which could result in an incomplete set of recommendations or weaker process.

7. We can support these additional three months utilizing personnel vacancy savings, and reallocating items within the overall project budget.

VHCIP Core Team 4-21-14 Meeting Additional Materials

To: Members of the VHCIP Core Team

From: Deborah Lisi-Baker, Co-Chair, Disability and Long Term Services and Supports (DLTSS) Work Group (formerly the Dual Eligible Work Group)

Date: April 11, 2014

I recently had the pleasure of participating in a joint meeting of the Co-Chairs of both the Care Models and Care Management (CM/CM) Work Group and the DLTSS Workgroup, along with a few other key staff and consultants. Our goal was to develop a shared plan for integrating the DLTSS Work Group recommendations on care models and standards that will be used by the VHCIP partners, including Vermont ACOs. I am writing this letter at the suggestion of the Joint Chairs: Bea Grause, Nancy Eldridge, Judy Peterson; but it is my own letter, rather than a document written for the group.

In preparation for our Joint Co-Chairs meeting, I reviewed our work groups' charters and workplans, Federal and State documents related to the purpose of the ACO shared savings programs in Vermont, and the concerns and issues raised by advocates and providers in both the earlier Duals Stakeholder Group and the current DLTSS Work Group.

One of the documents the Joint Co-Chairs discussed that I reviewed was the language in the State's existing contract with Medicaid ACO's, specifically Section VI, Care Management Standards, Item C. The language of this section raised questions that have a direct impact on the role of our work groups, the role of AHS, and the emerging role of the ACOs, particularly with regard to Medicaid services and the role of Designated Agencies operating under contract with AHS. We discussed this language and the Joint Co-Chairs asked me to follow up with the Core Team, to gain greater clarity on the expected role of the Work Groups and the VHCIP Core Team, the role of the Agency of Human Services and the role of ACOs in establishing and overseeing the implementation of any care models and standards that emerge from our VHCIP work.

The language in question is from the OneCare Medicaid ACO Contract which states in Section VI Care Management Standards, item C. on page 22 (see attached for Section VI in full):

> "… Any AHS employee and/or contractor who provides care coordination services to Medicaid eligible persons shall, to the best of his/her ability, and so long as it is consistent with AHS programs or procedures and with Medicaid's legal obligations, cooperate with the Clinical Model or Care Model developed by the ACO."

Following the meeting, I was asked to contact Kara Suter who wanted to make sure I understood the intent of this language and did not take it out of context. I met with her and wrote up a summary for her review and edits, in order to make sure that I accurately understood and represented her explanation. Kara made

important points: that the contract is only intended to address implementation of the shared savings model, that the shared savings model does not even include most DLTSS services yet, and that it does not replace or supplant existing statutory roles and policies established by the State. She also noted that the State had started with more directive language, referring to the goal of having the ACOs adopt any care model and standards emerging from the VHCIP work groups and the Core Team, but had been advised by lawyers that this kind of aspirational language did not belong in contracts. I greatly appreciate the time Kara took to provide this background, which is very helpful; but I am left with many of my broader concerns unresolved.

Kara made it clear that the intention behind the language in question was that the State move quickly to develop the care management standards and models and that then these standards would become part of new language within the State's contracts with Medicaid ACOs. However, contracts are negotiated by both parties; there is nothing in place, that I know of, establishing the shared understanding that the VHCIP care model and/or standards will be adopted by the ACOs and the State.

Without the aspirational language, or some other policy document clarifying the State's intent and role in implementing care management standards or models, there is no formal requirement that the ACO and partnering providers abide by the model developed by the CM/CM team with input from other groups, including the DLTSS workgroup. The CM/CM Work Group and the DLTSS Work Group are moving forward in good faith, but even the language of the CM/CM Charter and Workplan is pretty vague and does not provide much clarity on how the State and ACOs will use the products of their work.

I believe the Care Management Standards in the State's Medicaid ACO Contract has had perhaps an unintended negative impact on the negotiations and language of ACO contracts with providers. Though I have not been able to review the actual contracts, I have heard providers express concern about the inappropriate role and authority of OneCare in care management decisions.

The lack of clarity on ACOs' role in implementing current statutory requirements leads to continual concern about the impact of the ACO model on existing systems and safeguards established for persons with disabilities receiving Medicaid-funded DLTSS services through AHS Departments and provider networks, as established in law, regulation and contract. There is uncertainty in terms of the role of AHS, and the commitment of the State to preserve programs and protections that have been built over the last 20 years.

The Joint CM/CM and DLTSS Co-Chairs have agreed that we need to disseminate overarching care model standards/criteria to guide all VHCIP Work Groups. The attached "Proposed DLTSS Model of Care Criteria" is a table of standards that can be used as a starting point.

I thank you for your consideration of these issues and ask that you reply with a written response.

With sincere thanks,

Deborah Lisi-Baker

Co-Chair, DLTSS Work Group

VI. Care Management Standards

A. The Contractor will maintain regular contact with Vermont Chronic Care Initiative (VCCI) to ensure that efforts around care management are well coordinated through regular and ad-hoc in-person and telephonic meetings; at minimum, the Contractor agrees to a meeting monthly but as frequently as both parties agree is needed.

B. The Contractor will maintain as needed contact with other Vermont Agency of Human Services (AHS) departments engaged in care management or care coordination activities particularly as it relates to federal mandates (e.g., Early Periodic Screening, Diagnosis, and Treatment) and vulnerable populations (e.g., Disabilities, Traumatic Brain Injury, Integrated Family Services). Examples of this contact will include but not be limited to: meetings (in-person and telephonic), educational outreach, partnering, launching or rolling out new or existing initiatives, and direct care coordination.

C. If requested, the Contractor will, no more frequently than annually and no sooner than 60 days from the request, participate with the State to create a written plan describing detailed approach to care management activities described above. Any AHS employee and/or contractor who provides care coordination services to Medicaid eligible persons shall, to the best of his/her ability, and so long as it is consistent with AHS programs or procedures and with Medicaid's legal obligations, cooperate with the Clinical Model or Care Model developed by the ACO. Should there be a conflict between the ACO's Clinical Model or Care Model and AHS programs or procedures, AHS employees and contractors shall cooperate with and implement the Clinical Model or Care Model of the ACO for a mutually agreeable time frame. DVHA and AHS acknowledge that this cooperation is critical to ACO in order to meet the quality, patient experience and financial performance thresholds under this Agreement. In the event of a dispute regarding the Clinical Model or Care Model, the parties may invoke the Dispute Resolution process set forth in Section 5 of Attachment A.

Basis for Design of Proposed DLTSS Model of Care

NATIONAL EVIDENCED-BASED DLTSS MODEL OF CARE ELEMENTS				
Core Elements	Commission on Long-Term Care, September 2013 Report to Congress	CMS & National Committee for Quality Assurance (NCQA) DLTSS Model of Care	Medicaid Health Homes (CMS)	Consumer-Focused Medicaid Managed Long Term Services and Supports (Community Catalyst)
Person Centered **and Directed** Process for Planning and Service Delivery	✓	✓	✓	✓
Access to Independent Options Counseling & Peer Support	✓	✓		✓
Actively Involved Primary Care Physician		✓	✓	
Provider Network with Specialized DLTSS Expertise	✓	✓	✓	✓
Integration between Medical & DLTSS Care	✓	✓	✓	✓
Single Point of Contact for person with DLTSS Needs across All Services	✓	✓	✓	
Standardized Assessment Tool	✓	✓		✓
Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services		✓	✓	✓
Care Coordination and Care Management	✓	✓	✓	✓
Interdisciplinary Care Team		✓	✓	✓
Coordinated Support during Care Transitions	✓	✓	✓	✓
Use of Technology for Sharing Information	✓	✓	✓	✓