Vermont Health Care Innovation Project

Steering Committee Meeting Agenda

May 25, 2016, 1:00pm-2:30pm

4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier

Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action?
1	1:00-1:10pm	Welcome and Introductions; Minutes Approval	Steven Costantino & Al Gobeille	Attachment 1: Draft March 30, 2015, Meeting Minutes	Approval of Minutes
2	1:10-1:15pm	Core Team Update • Performance Period 3 Operational Plan Submission • CMMI Site Visit *Public comment*	Lawrence Miller & Georgia Maheras		
3	1:15-1:25pm	Performance Period 2 Budget Update *Public comment*	Georgia Maheras	Attachment 3: Performance Period 2 Budget Update	
4	1:25-1:45pm	Performance Period 3 Activities and Budget *Public comment*	Georgia Maheras	Attachment 4a: Performance Period 3 Budget Attachment 4b: Performance Period 3 Milestone Summary	
5	1:45-2:25pm	Medicaid Pathway Discussion, Continued *Public comment*	Michael Costa and Selina Hickman	Attachment 5: Medicaid Pathway Presentation (March 30, 2016)	
6	2:25-2:30pm	Next Steps, Wrap-Up and Future Meeting Schedule	Steven Costantino & Al Gobeille	Next Meeting: Wednesday, June 29, 2016, 1:00-3:00pm, Montpelier	

Attachment 1: March 30, 2015, Meeting Minutes

Vermont Health Care Innovation Project
Steering Committee Meeting Minutes

Pending Committee Approval

Date of meeting: Wednesday, March 30, 2016, 1:00pm-3:30pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Minutes Approval	Al Gobeille called the meeting to order at 1:03pm. A quorum not present. A quorum was present after the fourth agenda item. *Minutes Approval:* Bob Bick moved to approve the January 27, 2016, meeting minutes by exception. Kim Fitzgerald seconded. The minutes were approved with 5 abstentions (Abe Berman, Bob Bick, Trinka Kerr, Allan Ramsey, Simone Rueschemeyer).	
2. Core Team Update	Georgia Maheras provided a Core Team update. • *Performance Period 3 Milestones and Year 3 Operational Plan:* The Core Team approved proposed Year 3 milestones at their 3/14 meeting. o Attachment 2a: Purple column is PP3 milestones. These are very similar to what was approved by the Core Team last October; some due dates and milestones have changed. Project leadership will now negotiate with CMMI on the details of these milestones. Initial conversations with CMMI have been positive, though they would like additional information on baseline. Reach out to Georgia (georgia.maheras@vermont.gov) or Sarah Kinsler (sarah.kinsler@vermont.gov) with questions about milestones. This attachment will be updated in time for May meeting. o Year 3 Operational Plan due to CMMI on May 2. • *Recent Approvals:* The Core Team approved a few funding items at their 3/14 meeting: o Reallocations for Healthfirst, RiseVT, Southwestern Medical Center; reallocation and additional funds for Vermont Medical Society Foundation; and new requests for MMIS modifications, core competency training (Vermont Developmental Disability Council), and APM actuarial support for Medicaid (Wakely)	

Agenda Item	Discussion	Next Steps
Public Comment	o Year 3 budget was not ready in time for 3/14 meeting; it will be presented at 4/11 Core Team meeting. As of 3/14, we were still waiting for some Year 2 approvals from CMMI – we have since received these. Update on Year 2 actuals to date is included in 3/14 Core Team materials. • *Performance Period 2 Budget Update:* We have received a number of federal approvals in the last few weeks – thanks to the finance team! There was no additional comment.	
3. Shared Care Plan and Universal Transfer Protocol Update	Georgia Maheras provided an update on the Shared Care Plan (SCP) project (Attachment 3). • This builds on significant work over the past year. Project team identified business and technical requirements through significant research and interviews with three communities around the state. There are at least six solutions in some phase of deployment in the state, with major barriers to implementation (sign-on fatigue, consent policy and architecture issues), and sustainability as a significant issue. • Possible solutions include a policy solution to address consent architecture and policy; or technical solutions. Field of technical solutions is crowded, with solutions from the State (MMISCare), ACOs (OneCare's Care Navigator solution), VCHIP at UVM, and individual communities (Windsor, Newport, and Bennington). • In November, the HDI Work Group approved continued research in this area but specified that we should not invest in a new technology solution not yet in development or implementation in the state. • Staff recommendation in March 2016: Do not pursue technology solution at this time; instead focus on consent and remaining HDI initiatives. The group discussed the following: • SAMHSA proposed rule: State comments are being submitted by AHS General Counsel. SIM participant organizations should free to share comments and thoughts with AHS. • Simone Rueschemeyer added that there has been a significant amount of discussion at the HDI Work Group about this. The choice not to make a recommendation related to a technology solution was a challenging one. • Consent: Georgia Maheras provided an example from the Area Agencies on Aging. AAAs are a part of multi-organizational care teams, but are not considered Health Care Organizations under federal frameworks – they require individual consent to receive/share information as part of a care team. Simone Rueschemeyer added that consent management is also a significant challenge – written consent is not consent forever, and we need a robust consent management system to deal with this on an ongoing basis. Dale Hackett commented that consent must be active for long enough to support ongoing treatment.	

Agenda Item	Discussion	Next Steps
	• Al Gobeille noted that Health Information Exchanges around the country and internationally have a variety of policies to allow consumers to opt in or opt out of sharing information. John Evans added that the VHIE gets consent information (what information can be used for, and by whom) by providers. Some individuals are involved in patient care but who aren't licensed providers. In Vermont, we can aggregate information, which is a benefit. Vermont has an opt-in consent policy which requires consumers to actively provide consent to be included in the VHIE. Most US states have opt-out policies – patients are assumed to consent unless patients actively refuse. • Dale Hackett suggested we receive more information on opt-in vs. opt-out. Ed Paquin noted that care team members should not have a hard time asking individuals to provide consent. Al Gobeille agreed but noted that there are good arguments on both sides.	
4. Core Competency Training Update	Pat Jones provided an update on the Core Competency Training initiative, which grew out of the Integrated Communities Care Management Learning Collaborative (Attachment 4). • Pat thanked all of the organizations that have sent participants to attend trainings, as well as project staff and work group leadership from the Practice Transformation Work Group and DLTSS Work Group. • Agendas and materials are available on the VHCIP website at http://healthcareinnovation.vermont.gov/node/884 The group discussed the following: • Jay Batra asked who is doing these trainings. Pat replied that Primary Care Development Corporation (PCDC) is the contractor for the care management core competency trainings, and that they have tailored training materials and curriculum for the Vermont context. Vermont Development Disabilities Council (DDC, lead is Kirsten Murphy) is leading the disability awareness training. Both contractors had very well developed curriculums and content expertise. • Georgia Maheras added that the DDC contract is posted on the VHCIP website, and the PCDC contract will be soon – more details about curriculum are included in contract scope. • Cathy Fulton asked whether train-the-trainer programs would provide continual certification and recertification going forward. Pat replied that this is the idea – there may be people newly entering this field or who could not attend these trainings and wanted to have ways to continue to provide this going forward.	
5. Medicaid Pathway	Michael Costa and Selina Hickman provided an update on the Medicaid Pathway project (Attachment 4). • Big Goal: Integrated Health System to achieve the Triple Aim. All-Payer Model (APM) is only part of this; Medicaid Pathway work is pursuing integrated system for services not subject to APM's financial caps – thinking about what the future looks like for services and providers not included in the first phase of the All-Payer Model (~Medicare A and B services). • All-Payer Model is led by AOA and GMCB.	

Agenda Item	Discussion	Next Steps
	o "Evolution, not revolution" – APM is building on existing all-payer reforms (i.e., SSPs, Blueprint) and working to align payers across the system. Model is based on the federal Next Generation ACO program. Continued work to align payment with quality/value while reducing cost. GMCB would be the regulating authority for the APM. o Working to agree on a "term sheet" with CMMI now; if agreement is reached, the State will seek to enter into a 5-year agreement later this year. Information on the terms and additional details are available on the GMCB website. o This work on payment models will tie to continued work to support practice transformation. • Medicaid Pathway work is led by AHS Central Office. o Ensuring delivery reform and work to increase payment reform readiness doesn't stop for providers not included under APM cap. o Continuous cycle, similar to Plan-Do-Study-Act. Building on SIM stakeholder engagement process. o DVHA has a key role as a payer and lead implementer for APM, which impacts ACO providers. Services covered by APM (equivalent of Medicare A&B services) accounts for ~35% of Medicaid's payments; the other 65% is outside of the APM cap. DMH, DAIL, and VDH ADAP services are a large part of this and will be part of the Medicaid Pathway; in addition, there are some TBD programs and services, including DCF Child Development & Family Service programs and VDH Maternal and Child Health programs. In addition, Integrating Family Services is an existing model we'll continue to expand – AHS isn't trying to recreate the wheel, but instead build off of success here. We have opportunities to thoughtfully work through how to work with each of these sectors as we go through the Medicaid Pathway process. o "All-inclusive population-based payment" = CMMI's preferred term for capitated payment. Under APM, this would apply to a subset of services – services provided by ACO providers that are provided to attributed ACO members that also fall within regulated services. The group discussed the following: • Dale Hackett asked whether the Next Generation model encourages community provider participation. Michael replied that this will hopefully incentivize provider investments in community services by giving providers predictable payments and cash flow. Al Gobeille added that taking on accountability will necessitate investing in primary care, substance abuse, and community services to reduce overall costs. • Jay Batra asked what "integrated health system" means in this context. Michael replied that to him, it means getting people the right care at the right time at the right place and creating financial incentives that support this, rather than financial incentives that support additional service volume. Jay agreed. • Allan Ramsay noted that fee-for-service, for all its faults, promotes delivery of care at high volumes. There are some areas where we need to promote volume, like primary care and substance abuse and	

Agenda Item	Discussion	Next Steps
	mental health services. In addition, non-FFS payment models are hard to explain to patients. He also noted that cost-sharing is becoming a bigger issue for patients under the current FFS issue. He suggested these are issues we need to address and respect during this process. Michael replied that he thinks of the APM as a series of relationships between payers, ACOs, and providers. Allan added that the system needs to promote delivery of some services and reduce delivery of other services. Al Gobeille noted that some pieces of the system are already capitated – insurance premiums, some provider salaries are two examples. He noted Kaiser as an example of an organization that has separated revenues from workforce motivation/provider payment. Julie Wasserman added that Kaiser pays all providers constant salaries divorced from volume, and shares savings to the system with physicians at year end. Kaiser also reduces salary inequity between primary care and specialists. • Dale Hackett noted that under the Global Commitment waiver, we pay in the 5th year if we overspend compared to targets, which is a big challenge. • Susan Aranoff commented that Medicaid Pathway discussions have been helpful for raising understanding about parts of the system that are underfunded. • Dale Hackett asked about how this impacts very high level outcome measures like unintended pregnancy and graduation rates. Selina replied that quality measurement and performance expectations are a key piece, and these will look different in the future than they have under FFS. Al Gobeille added those are very high-level indicators that look much more broadly than APM. Cathy Fulton added that these are community and population health measures, which might be impacted by a better functioning health system but aren't how we'll measure the success of the APM. Al noted that there have been efforts in Vermont to look at high-level measures like these and link them to our work. • Julie Tessler asked how DVHA will be involved in the Medicaid Pathway. Michael replied that DVHA will also participate in Medicaid Pathway activities. Ed Paquin commented that there is another category of activities that are particularly sensitive to legislative appropriations; some categories (e.g., privately funded nursing home services) are not included here or in other health care reforms. Michael confirmed that there are some things that would not change within the APM, including legislative appropriations and the Medicaid budget process. Selina added that the Medicaid services covered through an ACO are well aligned with the Medicare and commercial services covered by an ACO – we expect that change will be profound for those providers for that set of services due to all-payer alignment. For services primarily funded by Medicaid, alignment doesn't offer the same benefits. • Mike Hall commended the administration for describing a Medicaid Pathway. He voiced concern that we are building a Medicaid Pathway that will be siloed from the main set of reforms. He suggested that the long-term objective should be to figure out how the Medicaid Pathway and APM merge, not creating a permanent parallel track. Where is there an "on-ramp" for Medicaid Pathway providers and services to join the main model? Selina agreed that these are challenges, but there are still too many unknowns to identify a date when some or all providers will join the main model. Al Gobeille added that the APM is	

Agenda Item	Discussion	Next Steps
	still developing and infrastructure isn't in place yet, but that Medicaid Pathway has infrastructure in place. Michael agreed with Mike and Al and noted that this conversation is still developing. • Georgia Maheras suggested the team come back for a longer presentation at a future meeting.	
6. Public Comment, Next Steps, Wrap Up and Future Meeting Schedule	There was no additional public comment. **Next Meeting:** Likely to be cancelled.	

Bob Bick 1° Kim Fitzgerald 2° Minutes approved by exception 5 Abstentions

VHCIP Steering Committee Member List

Member		Member Alternate		Minutes	
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff ✓				AHS - DAIL
Rick	Barnett				Vermont Psychological Association
Bob	Bick ✓			✓	DA - HowardCenter for Mental Health
Peter	Cobb ✓				VNAs of Vermont
Steven	Costantino				AHS - DVHA, Commissioner
Elizabeth	Cote				Area Health Education Centers Program
Tracy	Dolan ✓	Heidi	Klein		AHS - VDH
Susan	Donegan	David	Martini ✓		AOA - DFR
John	Evans ✓	Kristina	Choquette		Vermont Information Technology Leaders
Kim	Fitzgerald ✓				Cathedral Square and SASH Program
Catherine	Fulton ✓				Vermont Program for Quality in Health Care
Joyce	Gallimore				Bi-State Primary Care/CHAC
Al	Gobeille ✓				GMCB
Lynn	Guillett				Dartmouth Hitchcock
Dale	Hackett ✓				Consumer Representative
Mike	Hall ✓	Angela	Smith-Dieng		Champlain Valley Area Agency on Aging / COVE
Paul	Harrington				Vermont Medical Society

Selina	Hickman ✓	Shawn	Skafelstad		AHS - DVHA
Debbie	Ingram				Vermont Interfaith Action
Craig	Jones				AHS - DVHA - Blueprint
Trinka	Kerr ✓			A	VLA/Health Care Advocate Project
Deborah	Lisi-Baker				SOV - Consultant
Jackie	Majoros ✓				VLA/LTC Ombudsman Project
Todd	Moore	Vicki	Loner		OneCare Vermont
		ARR	Berman ✓	A	
Jill	Olson	Mike	DelTrecco		Vermont Association of Hospital and Health Systems
Mary Val	Palumbo ✓				University of Vermont
Ed	Paquin ✓				Disability Rights Vermont
Laura	Pelosi				Vermont Health Care Association
Judy	Peterson ✓				Visiting Nurse Association of Chittenden and Grand Isle Counties
Allan	Ramsay ✓			A	GMCB
Frank	Reed	Jaskanwar	Batra ✓		AHS - DMH
Paul	Reiss				HealthFirst/Accountable Care Coalition of the Green Mountains
Simone	Rueschemeyer ✓			A	Vermont Care Network
Howard	Schapiro				University of Vermont Medical Group Practice
Julie	Tessler ✓	Marlys	Waller		Vermont Council of Developmental and Mental Health Services
Sharon	Winn				Bi-State Primary Care
	36		9		

H 1st Q ✓

	Meeting Name:	VHCIP Steering Committee Meeting	
	Date of Meeting:	March 30, 2016	
	Last Name (a-z)	First Name	
1	Aranoff	Susan	Phone
2	Backus	Ena	
3	Bailey	Melissa	
4	Banks	Heidi	
5	Barnett	Rick	
6	Barrett	Susan	
7	Batra	Jaskanwar	here
8	Bick	Bob	here
9	Buck	Martha	
10	Choquette	Kristina	
11	Clark	Sarah	
12	Cobb	Peter	Phone
13	Collins	Lori	
14	Coonradt	Amy	
15	Cooper	Alicia	
16	Costantino	Steven	
17	Cote	Elizabeth	
18	Cummings	Diane	here
19	DelTrecco	Mike	
20	Dolan	Tracy	Phone
21	Donahey	Richard	
22	Donegan	Susan	
23	Epstein	Gabe	
24	Evans	John	Phone
25	Fisher	Jamie	
26	Fitzgerald	Kim	here
27	Fitzpatrick	Katie	
28	Flynn	Erin	
29	French	Aaron	
30	Fulton	Catherine	here
31	Gallimore	Joyce	
32	Garand	Lucie	
33	Geiler	Christine	
34	Gobeille	Al	here

35	Guillett	Lynn	
36	Hackett	Dale	here
37	Hall	Mike	here
38	Hall	Thomas	
39	Hall	Janie	
40	Harrington	Paul	
41	Hathaway	Carrie	
42	Hatin	Carolynn	
43	Hein	Karen	phone
44	Hickman	Selina	here
45	Ingram	Debbie	
46	Jones	Craig	
47	Jones	Kate	
48	Jones	Pat	here
49	Judge	Joelle	here
50	Kerr	Trinka	here
51	Kinsler	Sarah	here
52	Klein	Heidi	
53	Korce	Leah	
54	Laing	Andrew	
55	Lange	Kelly	
56	Lisi-Baker	Deborah	
57	Liss	Sam	
58	Loner	Vicki	
59	Lunge	Robin	
60	Magoffin	Carole	
61	Maheras	Georgia	here
62	Majoros	Jackie	here
63	Maloney	Carol	
64	Martini	David	here
65	McPherson	Darcy	
66	Mongan	Madeleine	
67	Moore	Todd	
68	Olson	Jill	
69	Otley	Brian	
70	O'Toole	Dawn	
71	Palumbo	Mary Val	phone

72	Paquin	Ed	here
73	Paumgarten	Annie	here
74	Pelosi	Laura	
75	Peterson	Judy	
76	Petrow	Anne	
77	Philibert	Dawn	
78	Poirer	Luann	
79	Ramsay	Allan	here
80	Reed	Frank	
81	Reiss	Paul	
82	Rueschemeyer	Simone	here
83	Samuelson	Jenney	
84	Sandage	Larry	
85	Santarcangelo	Suzanne	
86	Schapiro	Howard	
87	Shaw	Julia	
88	Skafelstad	Shawn	
89	Slusky	Richard	
90	Smith-Dieng	Angela	
91	Stone	Holly	
92	Tanzman	Beth	
93	Tessler	Julie	here
94	Waldman	Beth	
95	Waller	Marlys	
96	Wasserman	Julie	here
97	West	Kendall	
98	Westrich	James	
99	Wilhelm	Bradley	
100	Wilson	Nicole	
101	Winn	Sharon	
102	Yacovone	David	

Michael Costa - AOA

Attachment 3: Performance Period 2 Budget Update

VHCIP Performance Period 2 Budget

Georgia Maheras

May 25, 2016

Year 1 Actuals to Budget:

Vermont Health Care Innovation Project Year 1 Budget October 1, 2013 - December 31, 2015				
BUDGET CATEGORY	**BUDGET-YEAR 1**	**ACTUALS and Unpaid Contract Invoices to 04/30/16**	**CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)**	**REMAINING UNOBLIGATED BALANCE**
Personnel/Benefits	$ 2,657,072.25	$ 2,657,072.25	$ -	$ -
Operating (includes Indirect)	$ 945,675.10	$ 945,675.10	$ -	$ 0.00
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 3,631,455.14	$ 3,553,086.46	$ 78,368.68	
PAYMENT MODELS-TOTAL	$ 3,898,088.35	$ 3,725,225.83	$ 172,862.51	
CARE MODELS-TOTAL	$ 242,754.13	$ 219,429.08	$ 23,325.05	
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ 2,385,707.27	$ 2,376,415.79	$ 9,291.49	
EVALUATION-TOTAL	$ 1,656,538.42	$ 1,645,149.97	$ 11,388.45	
GENERAL-TOTAL	$ 680,068.17	$ 671,457.20	$ 8,610.97	
CMMI Required: Population Health Plan-TOTAL	$ 26,945.68	$ 26,945.68	$ -	
Contractual Total	$ 12,521,557.16	$ 12,217,710.01	$ 303,847.15	$ 0.00
TOTAL YEAR 1 BUDGET	**$ 16,124,304.51**	**$ 15,820,457.36**	**$ 303,847.15**	**$ 0.00**

Year 2 Actuals to Budget (4/30):

Year 2 Budget -CMS/CMMI Approved January 1, 2015 - June 30, 2016				
BUDGET CATEGORY	**BUDGET-YEAR 2**	**ACTUALS and Unpaid Contract Invoices to 04/30/16**	**CONTRACTUAL OBLIGATIONS (less paid & unpaid invoices)**	**REMAINING UNOBLIGATED BALANCE**
Personnel/Benefits	$ 2,085,164.00	$ 1,493,579.06		$ 591,584.94
Operating (includes Indirect*except QE 03/31/2016)	$ 1,138,189.00	$ 522,882.79		$ 615,306.21
Contractual:				
HEALTH DATA INFRASTRUCTURE-TOTAL	$ 6,274,520.00	$ 2,530,148.40	$ 3,744,371.60	
PAYMENT MODELS-TOTAL	$ 4,211,058.75	$ 2,167,316.98	$ 2,043,741.77	
CARE MODELS-TOTAL	$ 921,531.17	$ 163,743.52	$ 757,787.65	
CARE MODELS-SUB GRANT PROGRAM-TOTAL	$ 1,915,230.99	$ 771,018.25	$ 1,144,212.74	
EVALUATION-TOTAL	$ 664,362.00	$ 367,814.26	$ 296,547.74	
GENERAL-TOTAL	$ 230,000.00	$ 62,045.35	$ 167,954.65	
CMMI Required: Population Health Plan-TOTAL	$ 7,000.00	$ 6,012.50	$ 987.50	
Contractual Total	$ 14,223,702.91	$ 6,068,099.25	$ 8,155,603.66	$ -
TOTAL YEAR 2 BUDGET	**$ 17,447,055.91**	**$ 8,084,561.10**	**$ 8,155,603.66**	**$ 1,206,891.15**

Attachment 4a: Performance Period 3 Budget

Performance Period 3 Activities and Budget

May 25, 2016

Georgia Maheras, JD

Project Director

YEAR 3 BUDGET

Assumptions

Assumptions:

1. This includes personnel and contractual costs for anticipated 2017 no-cost extension.
2. Includes all previously approved contracts and proposes TBDs for certain items still developing.
3. Contract items are formatted by focus area.
4. Assumes our most recent PP2 reallocation and subsequent carryover are approved.

Total Budget: $11,437,714.50

Category	Amount
Personnel	$ 1,060,990.00
Fringe Benefits	$ 491,769.00
Travel	$ 32,987.50
Equipment	$ 14,608.75
Supplies	$ 10,040.00
Other	$ 177,572.50
CAP	$ 424,395.81
Contractor	$ 9,225,350.93
Total:	$ 11,437,714.50

Project Management: $281,851
Evaluation: $561,639.26

- Project Management:
  - UMass: $281,851
- Evaluation:
  - Self-Evaluation Plan:
    - JSI: $444,522*
  - Surveys:
    - Datastat: $117,117.26*
  - Monitoring and Evaluation Activities:
    - Lewin, Burns, and Bailit (part of the Payment Models estimates)

*Lower than Core Team approvals because actuals are lower.

Practice Transformation: $3,165,299.10

- Learning Collaboratives:
  - Abernathey: $19,000*
  - VPQHC: $62,198.60**
  - Core Competency:
    - DDC: $94,315.50
    - PCDC: $202,990**
  - Accountable Communities for Health: $160,000
- Regional Collaborations:
  - BiState/CHAC: $961,225.05**
  - OneCare: $1,045,570**
- Practice Transformation:
  - DA/SSA (Medicaid Pathway): $400,000
- Sub-Grant TA:
  - Policy Integrity: $25,000
- Workforce Demand Model:
  - IHSGlobal: $195,000

*Lower than Core Team approval because actuals are lower.

**Higher than Core Team PP3 approval (funds shift from PP2 approvals)

Health Data Infrastructure: $1,787,124

- Home Health Agency Project:
  - VITL: $618,000
- Designated Agency Data Quality:
  - VITL: $75,000
- ACO Gateway Support:
  - VITL: $269,370
- Work Group Support:
  - Stone: $120,000
- Data Warehousing:
  - BHN/VCN: $626,754*
  - H.I.S.: $8,000
- Opiate Alliance: $70,000

*Higher than Core Team PP3 approval (funds shift from PP2 approvals)

Payment Model Design and Implementation: $1,644,786.45

- Several contractors provide support across Payment Models:
  - Bailit Health Purchasing, Inc.: $244,920
  - Burns and Associates: $350,000*
  - Pacific Health Policy Group: $180,000
  - DLB: $16,000
  - Wakely: $70,000
  - Maximus: $200
  - Friedman: $5,000
- ACO SSPs:
  - Lewin: $778,666.45**

*Lower than Core Team approval because actuals are lower.

**Higher than Core Team PP3 approval (funds shift from PP2 approvals)

Sustainability and Population Health Plan: $1,854,651.57

- Sustainability Plan:
  - RFP: $100,000
- Population Health Plan:
  - RFP: $30,000*
  - Hester: $10,000
- Sustainability Misc. (should be 20%): $1,714,651.57

*Lower than Core Team approval because actuals are lower.

Attachment 4b: Performance Period 3 Milestone Summary

Vermont Health Care Innovation Project
Performance Period 3 Milestone Summary

CMMI-Required Milestones		
Performance Period 3 Milestone	*Lead(s) and Contractors Supporting*	*Progress Toward Milestones*
Project Implementation Continue to implement project statewide. Implement all Performance Period 3 Milestones by 6/30/17.	*Lead(s):* Georgia Maheras *Contractors:* All contractors.	• Statewide project implementation continues, with focus on achieving our SIM Milestones.
Payment Models 80% of Vermonters in alternatives to fee-for-service by 6/30/17.	*Lead(s):* Georgia Maheras *Contractors:* Bailit Health Purchasing; Burns and Associates.	• Currently ~60% of Vermonters are in alternatives to fee-for-service.
Population Health Plan Finalize Population Health Plan by 6/30/17.	*Lead(s):* Georgia Maheras, Heidi Klein *Contractors:* James Hester; Vermont Public Health Association.	• The Population Health Plan will build upon the existing State Health Improvement Plan and offer a strategic pathway forward to systematically connect integrated care management efforts with community-wide prevention strategies to improve population health outcomes. • During 2014 and 2015, the Population Health Work Group and staff developed a definition of population health, came to consensus on core concepts, and developed documents to communicate concepts to project stakeholders. • In the first half of 2015, project staff developed a rough outline for the Population Health Plan with technical assistance support from CDC and CHCS. This outline is being refined and finalized in the first half of 2016 with input from the Population Health Work Group and other VHCIP work groups. • In late 2015, DVHA released an RFP seeking support for writing the Population Health Plan. The RFP was rereleased and an apparently successful awardee was named in April 2016.
Sustainability Plan Finalize Sustainability Plan by 6/30/17.	*Lead(s):* Georgia Maheras *Contractors:* TBD.	• The Sustainability Plan is a required deliverable of Vermont's SIM grant, and will build on ongoing conversations between State leadership, project stakeholders, and CMMI. • During 2015, Project leadership developed a high-level sustainability strategy and began project-level sustainability planning. • Vermont released an RFP seeking contractor support for sustainability planning and development of the Sustainability Plan document. A bidder has been selected and a contract will commence in early July 2016. • Vermont's comprehensive sustainability plan depends in part on our negotiations with CMMI regarding the implementation of a Next Generation ACO style All-Payer Model in Vermont.

Payment Model Design and Implementation		
Performance Period 3 Milestone	*Lead(s) and Contractors Supporting*	*Progress Toward Milestones*
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. (Baseline as of December 2015: 940) Medicaid/commercial program beneficiary attribution target: 140,000. (Baseline as of December 2015: 179,076).	*Lead(s):* Richard Slusky – GMCB (Commercial SSP); Amy Coonradt (Medicaid SSP) *Contractors:* Bailit Health Purchasing; Burns and Associates; The Lewin Group; Pacific Health Policy Group; Policy Integrity; Deborah Lisi-Baker; Wakely Consulting; Bi-State Primary Care Association/ Community Health Accountable Care (CHAC); UVM Medical Center (UVMMC)/OneCare Vermont.	• Modeled closely after the Medicare Shared Savings Program, this alternative payment model for commercial and Medicaid beneficiaries in Vermont was launched in 2014 as a three-year program. Beneficiaries are attributed to one of three accountable care organizations (ACOs) in the State. ACOs must meet quality targets to be eligible to share in any savings. • Medicaid SSP Year 2 contract negotiations between DVHA and Medicaid SSP ACOs are complete. • Expansion of Total Cost of Care for Year 3 of the Medicaid SSP was considered in 2015. DVHA reviewed all potential services to include in Year 3 before determining not to include them. DVHA notified the ACOs that it would not include additional services on September 1, 2015. • The Green Mountain Care Board published the Year 1 (CY2014) quality, cost, and utilization performance results for each of the ACOs in the commercial SSP in Fall 2015. • In Performance Period 2, the project focus has been on continued program implementation and evolution of program standards based on cost and quality results from the first performance period of both the Medicaid and commercial SSPs. • During Performance Period 3, the SSPs will target additional beneficiaries and focus on expanding the number of Vermonters served in this alternative payment model. • The commercial SSP will not offer downside risk as originally proposed in Year 3. **Total Providers Impacted:** 1015; **Total Vermonters Impacted:** 191,784 (March 2016)
Episodes of Care (EOCs): *Activity discontinued; decision made in collaboration with CMMI in April 2016.*		

Pay-for-Performance (Blueprint) 1. Expand the number of providers and beneficiaries participating in the Blueprint for Health by 6/30/17: Medicaid/ commercial/ Medicare providers participating in P4P program target: 715. (Baseline as of December 2015: 706) Medicaid/ commercial/ Medicare beneficiaries participating in P4P program target: 310,000. (Baseline as of December *2015:* 309,713) 2. P4P incorporated into Sustainability Plan by 6/30/17.	*Lead(s):* Craig Jones *Contractors:* Non-SIM funded.	• The Blueprint for Health provides performance payments to advanced primary care practices recognized as patient centered medical homes (PCMHs), as well as providing multi-disciplinary support services in the form of community health teams (CHTs), a network of self-management support programs, comparative reporting from state-wide data systems, and activities focused on continuous improvement. • The Blueprint for Health engaged with its Executive Committee, DVHA and AHS leadership, and VHCIP stakeholders to discuss potential modifications to both the Community Health Team (CHT) and Patient-Centered Medical Home (PCMH) payments. Such modifications include shifting payers' CHT payments to reflect current market share (7/1/2015), increasing the base payments to PCMH practices (5/1/2015 for Medicaid, 1/1/2016 for commercial insurers), and adding an incentive payment for regional performance on a composite of select quality measures (1/1/2016). The legislature appropriated $2.4 million for Medicaid Blueprint payments (both CHT and PCMH) in State Fiscal Year 2016. • A number of quality measures have been selected as the basis for the performance incentive payment that will be incorporated in 2016; these measures are aligned with those being used for the Medicaid and commercial SSPs. • The Blueprint has approached a saturation point where the program has recruited most of the primary care practices in the state, and the rate of onboarding of new practices has slowed. It is anticipated that 6 new practices will join by the end of 2016, and that the currently enrolled practices will maintain participation. • Since 2015, the Blueprint has been working on a model for integrating efforts with the ACOs. • In early 2016 further decisions will be made regarding the program's trajectory within finance models that are proposed for 2017. **Total Providers Impacted:** 712; **Total Vermonters Impacted:** 307,900 (March 2016)
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 each prescribing to >= 10 patients. (Baseline as of December 2015: 72) Number of beneficiaries participating in Health Home program target: 2,900 Hub + 2,300 Spoke = 5,200 total patients. (Baseline as of December 2015: 5,179) 2. Health Home program incorporated into Sustainability Plan by 6/30/17.	*Lead(s):* Beth Tanzman *Contractors:* Non-SIM funded.	• The Hub and Spoke initiative is a Health Home initiative created under Section 2703 of the Affordable Care Act for Vermont Medicaid beneficiaries with the chronic condition of opioid addiction. The Health Home integrates addictions care into general medical settings and links these settings to specialty addictions treatment programs in a unifying clinical framework. Two payments are used: bundled monthly rate for Hubs and a capacity-based payment for Spokes. • Access to treatment has steadily expanded, from 2,867 Medicaid beneficiaries receiving treatment in January 2013 to 5,179 in December 2015. • Program implementation and reporting are ongoing. **Total Participating Providers:** 72; **Total Vermonters Impacted:** 5,179 (December 2015)

Accountable Communities for Health 1. Continue implementation of ACH learning system (ACH Peer Learning Laboratory) to 10 participating communities. 2. Develop ACH Implementation Plan based on lessons learned from ACH Peer Learning Laboratory by 6/30/17. 3. ACH Implementation Plan incorporated into Sustainability Plan by 6/30/17.	*Lead(s):* Heidi Klein *Contractors:* James Hester, Public Health Institute.	• This effort will seek to align programs and strategies related to integrated care and services for individuals and community-wide prevention efforts to improve health outcomes within a geographic community. The first phase of this work focused on research to further define the Accountable Communities for Health (ACH) model and identify core elements. The second phase of Vermont's Accountable Communities for Health work will bring together multi-disciplinary teams from communities across the state to further explore how this model might be implemented and develop community capacity; this effort will be known as the ACH Peer Learning Lab. • Planning for an ACH Peer Learning Lab for interested communities is ongoing. The Peer Learning Lab launched in January 2016 with the release of recruitment materials and an informational webinar. Ten communities were selected to participate in February. Through an RFP process, the State has identified an apparently successful awardee to provide curriculum design and facilitation services to support participating communities and document lessons learned for the State; contract negotiations are ongoing as of April 2016. • Work to identify opportunities to enhance new health delivery system models, such as the Blueprint for Health and Accountable Care Organizations (ACOs), to improve population health by better integration of clinical services, public health programs and community based services at both the practice and the community levels is ongoing.
Prospective Payment System – Home Health: *Activity discontinued; decision made in collaboration with CMMI in April 2016.*		
Medicaid Value-Based Purchasing (Medicaid Pathway) 1. Mental Health and Substance Abuse: 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. Develop implementation timeline based on payment model design and operational readiness by 12/31/16. 2. Other Medicaid VBP Activities: Engage in research and feasibility analysis to support additional Medicaid Value-Based Purchasing activities.	*Lead(s):* Georgia Maheras; Selina Hickman *Contractors:* Burns and Associates, Deborah Lisi-Baker; Pacific Health Policy Group.	• The Medicaid Pathway work stream, newly renamed in Performance Period 3, includes and builds on Vermont's SIM-supported Medicaid Value-Based Purchasing efforts. This work stream complements the All-Payer Model, described below. • Project leadership is currently developing a work plan for contractors and gathering stakeholder input through ongoing meetings with leadership from the Agency of Human Services and members of the provider community. There are two main focus areas: mental health/substance abuse/developmental disabilities and long-term services and supports/choices for care waiver population. Work group members and consultants have started to narrow in on the scope of services in this work stream for each focus area. • Contractors continue to work with State to develop finalized project plan to implement new payment and delivery system by 1/1/17.

All-Payer Model 1. If negotiations are successful, assist with implementation as provided for in ALL-PAYER MODEL 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.	*Lead(s):* Michael Costa; Ena Backus *Contractors:* Bailit Health Purchasing, Burns and Associates, TBD.	• Vermont continues to explore an All-Payer Model. An All-Payer Model will build on existing all-payer payment alternatives to better support and promote a more integrated system of care and a sustainable rate of overall health care cost growth. Value-based payments that shift risk on to health care providers and that are aligned across all payers encourages collaboration across the care continuum and can result in better health outcomes for Vermonters. • Negotiations between CMMI and SOV continue. SOV proposed a term sheet to CMMI on January 25, 2016. The term sheet sets out the basic outline for a potential all-payer model agreement, including the legal authority of the state to enter into such an agreement, the performance period for the agreement, waivers necessary to facilitate payment change and additional covered services, data sharing, and an evaluation of the demonstration. • The stakeholder outreach and public process to vet the term sheet and potential model design began almost immediately, as the GMCB held two days of public meetings to discuss the proposed term sheet on January 28 and 29, 2016. The hearings were well attended by stakeholders. Concurrently, SOV staff has been testifying before relevant legislative committees to explain the term sheet and prospective model to Vermont's policy makers. • Vermont's three major ACOs voted to form a single corporate entity in anticipation of an All-Payer Model. • The State of Vermont would participate in the All-Payer Model as a payer via Medicaid.
State Activities to Support Model Design and Implementation – Medicaid Pursue state plan amendments and other federal approvals as appropriate for each payment model; ensure monitoring and compliance activities are performed: 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.	*Lead(s):* Alicia Cooper *Contractors:* Burns and Associates; Pacific Health Policy Group; Maximus; Wakely Consulting; Policy Integrity; Vermont Care Network (VCN/BHN); Opiate Alliance; Kim Friedman; Deborah Lisi-Baker.	• For all Medicaid payment models that are designed and implemented as part of Vermont's State Innovation Model grant activity, there are a number of Medicaid-specific state activities that must occur. These activities ensure that Vermont Medicaid is in compliance with its Medicaid State Plan and its Global Commitment for Health (1115) waiver, and that newly established programs will be monitored for their impact on Medicaid beneficiaries. • Both Year 1 and 2 SSP State Plan Amendments were approved in 2015. • ACO data sharing is ongoing. • Year 3 SSP State Plan Amendment was submitted to CMS in Q1 2016. • Coordinating stakeholders to begin planning for expansion of Integrating Family Services program.

Care Delivery and Practice Transformation		
Performance Period 3 Milestone	*Lead(s) and Contractors Supporting*	*Progress Toward Milestones*
Learning Collaboratives 1. Target: 400 Vermont providers have participated in Learning Collaborative activities (including Integrated Communities Care Management Learning Collaborative or Core Competency Trainings) by 12/31/16. (*Baseline as of December 2015:* 200) 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.	*Lead(s):* Erin Flynn; Pat Jones *Contractors:* Deborah Lisi-Baker; Nancy Abernathey; Vermont Partners for Quality in Health Care; Developmental Disabilities Council; Primary Care Development Corporation.	• Vermont's Learning Collaboratives share and diffuse best practices for care coordination and to help multi-organizational teams deliver care most effectively. This work has grown to encompass two initiatives: The Integrated Communities Care Management Learning Collaborative and a Core Competency Training Series for front-line care management staff. • The Integrated Communities Care Management Learning Collaborative works to engage as many patient-facing care providers within each community as possible, including nurses, care coordinators, social workers, mental health clinicians, physicians, and others, from a broad spectrum of health, community and social service organizations that includes primary care practices, community health teams, home health agencies, mental health agencies, Area Agencies on Aging, housing organizations, social service organizations, and others. Participants are convened for at least four in-person learning sessions and multiple webinars, as well as regular local meetings to support work. The fourth in-person learning session for the first cohort took place on September 29, 2015, where discussion of additional needs and sustainability within communities occurred. Two additional cohorts (8 additional communities) have joined the Learning Collaborative, with the first in-person learning sessions occurring in November 2015and additional sessions will take place throughout July-December 2016. • The Core Competency Training initiative will offer a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities state-wide. Core curriculum will cover competencies related to care coordination and disability awareness. Trainings launched in March 2016; in total, 34 separate training opportunities will be made available to up to 240 participants state-wide.

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. 4. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.	*Lead(s):* Joelle Judge; Georgia Maheras *Contractors: Sub-Grantees (Vermont Medical Society Foundation; Healthfirst; UVM Health Network at Central Vermont Medical Center; Bi-State Primary Care Association/CHAC; Northwestern Medical Center; Northeastern Vermont Regional Hospital; White River Family Practice; Vermont Program for Quality in Health Care; InvestEAP; Vermont Developmental Disabilities Council; Rutland Area VNA and Hospice; Southwestern Vermont Health Care); University of Massachusetts.*	• The VHCIP Provider Sub-Grant Program was launched in 2014 and has provided 14 awards to 12 provider and community-based organizations who are engaged in payment and delivery system transformation. Awards range from small grants to support employer-based wellness programs, to larger grants that support state-wide clinical data collection and improvement programs. The overall investment in this program is nearly $5 million. • Sub-grantees continue to report on activities and progress, highlighting lessons learned. • All sub-grantees convened on October 7, 2015, for the second in a series of symposiums designed to share lessons learned and inform the SIM project overall. They will convene again June 15, 2016 with a final event planned for Fall 2016.
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. 3. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.	*Lead(s):* Joelle Judge; Georgia Maheras *Contractors:* Policy Integrity.	• The Sub-Grant Technical Assistance program was designed to support the awardees of provider sub-grants in achieving their project goals. Sub-grantee technical assistance contracts are executed; contractors are available for technical assistance as requested by sub-grantees and approved by project leadership according to a detailed SIM process.

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.	*Lead(s):* Jenney Samuelson *Contractors:* Bi-State Primary Care Association/ Community Health Accountable Care (CHAC); UVM Medical Center (UVMMC)/ OneCare Vermont.	• Within each of Vermont's 14 Health Service Areas, Blueprint for Health and ACO leadership have merged their work groups and chosen to collaborate with stakeholders using a single unified health system initiative (known as a "Regional Collaborations"). Regional Collaborations include medical and non-medical providers (e.g., long-term services and supports providers and community providers), and a shared governance structure with local leadership. These groups focus on reviewing and improving the results of core ACO Shared Savings Program quality measures, supporting the introduction and extension of new service models, and providing guidance for medical home and community health team operations. • Regional Collaborations have launched in each of the State's 14 Health Service Areas. There are weekly stakeholder meetings to discuss further development and direction of these Regional Collaborations. Regular presentations to SIM work groups on progress in each region highlight case studies from communities seeing positive outcomes on the ground.
Workforce – Demand Data Collection and Analysis Submit Final Demand Projections Report and present findings to Workforce Work Group by 12/31/16.	*Lead(s):* Amy Coonradt *Contractors:* IHSGlobal.	• A "micro-simulation" demand model will use Vermont-specific data to identify future workforce needs for the State by inputting various assumptions about care delivery in a high-performing health care system. The selected vendor for this work will create a demand model that identifies ideal workforce needs for Vermont in the future, under various scenarios and parameters • Vermont's Agency of Administration expects to execute a contract with IHS for micro-simulation demand-modeling in Q2 2016, with work expected to begin in Q2 2016.
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.	*Lead(s):* Amy Coonradt *Contractors:* N/A.	• The Office of Professional Regulation and Vermont Department of Health (VDH) work in tandem to assess current and future supply of providers in the state's health care workforce for health care work force planning purposes, through collection of licensure and relicensure data and the administration of surveys to providers during the licensure/relicensure process. • The Vermont Department of Health hired additional staff to develop and administer surveys to accompany provider re-licensure applications, and perform analysis on licensure data and develop provider reports on various health care professions. • VDH staff reports analysis findings to the SIM work group on an ongoing basis.

Health Data Infrastructure		
Performance Period 3 Milestone	*Lead(s) and Contractors Supporting*	*Progress Toward Milestones*
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. (*Baseline as of December 2015:* 62%) 2. Remediate data gaps for LTSS providers according to remediation plan developed in Performance Period 2 by 6/30/17. 3. Incorporate Gap Remediation activities into Sustainability Plan by 6/30/17.	*Lead(s):* Georgia Maheras; Larry Sandage *Contractors:* Vermont Information Technology Leaders (VITL); Vermont Care Network (BHN/VCN); H.I.S. Professionals; UVM Medical Center /OneCare Vermont.	• The Gap Remediation project addresses gaps in connectivity and clinical data quality of health care organizations to the Health Information Exchange. The ACO Gap Remediation component improves the connectivity and data quality for all Vermont Shared Savings Program measures among ACO member organizations. The Vermont Care Partners (VCP) Gap Remediation component will improve the data quality for the 16 Designated Mental Health and Specialized Service agencies (DAs and SSAs). • ACO Gap Remediation work has been in progress since March 2015, with significant progress to date. In December 2015, VITL increased the percentage of total ACO data being transmitted to the VHIE to 62%-64%. • As a result of findings of the DLTSS Information Technology Assessment, the HDI Work Group recommended further investment into connections for the Area Agencies on Aging and Home Health Agencies in the November Work Group meeting. A contract with VITL to provide connectivity interface discovery and implementation to Home Health Agencies is in development. This contract will also provide onboarding services to Home Health Agencies for access to VITL's provider portal, VITLAccess.
Improve Quality of Data Flowing into HIE 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. Report on improvement over baseline by 6/30/17.	*Lead(s):* Georgia Maheras; Larry Sandage *Contractors:* VITL; Vermont Care Network (BHN/VCN).	• The Data Quality Improvement Project is an analysis performed of ACO members' Electronic Health Record on each of sixteen data elements. Additional data quality work with Designated Agencies (DAs) to improve the quality of data and usability of data for this part of Vermont's health care system. • There was a contract with VITL to work with providers and the ACOs to improve the quality of clinical data in the HIE for use in population health metrics within the Shared Savings Program. Data quantity and quality improvements resulted in the resolution of 64% of data gaps for SSP quality measures. • Ongoing work with Vermont Care Network and VITL to improve data quality and work flows at Designated Mental Health Agencies (DAs). VITL will work with DAs to implement the workflow improvements in each agency through the development of a toolkit that will provide the necessary documentation, workflows, and answers to specific questions needed.
Telehealth – Implementation 1. Continue telehealth pilot implementation through contract end dates. 2. Incorporate Telehealth Program into Sustainability Plan by 6/30/17.	*Lead(s):* Jim Westrich *Contractors:* VNA of Chittenden and Grand Isle Counties; Howard Center.	• Telehealth pilots will allow Vermont to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout the State of Vermont. • A draft RFP scope was developed by the State and JBS International, drawing on the telehealth definition, guiding principles, and key Telehealth Strategy elements. Two bidders were selected in late 2015, based on demonstration of alignment with the health reform efforts currently being implemented as part of the SIM Grant process. • Contract negotiations are underway; contract execution is expected in Spring 2016.
Data Warehousing 1. Implement Phase 2 of DA/SSA data warehousing 2. Obtain approval of cohesive strategy for developing data systems to support analytics by 10/31/16. Operationalize the approved cohesive strategy for developing data systems to support analytics by 12/31/16.	*Lead(s):* Georgia Maheras; Craig Jones *Contractors:* Vermont Care Network (VCN/BHN); Stone Environmental.	• Vermont Care Network (VCN/BHN) is working on behalf of Designated Mental Health Agencies (DAs) and Specialized Service Agencies (SSAs) to develop a behavioral health-specific data repository, which will to aggregate, analyze, and improve the quality of the data stored within the repository and to share extracts with appropriate entities. • Data quality work, data dictionary development, training on analytic software, and other supporting tasks are all in progress to support the project once the team is ready for implementation. Implementation began in late 2015 and will continue through the end of 2016. •

Care Management Tools 1. Event Notification System: Continue implementation of ENS according to contract with vendor through 12/31/16. 2. Shared Care Plan: Recommend revisions to the VHIE consent policy and architecture to better support shared care planning by 6/30/17. 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.	*Lead(s):* Georgia Maheras; TBD *Contractors:* Stone Environmental; TBD.	*Event Notification System* • During Performance Period 2, Vermont negotiated and executed contracts with VITL and an event notification system (ENS) vendor, to provide admissions, discharge, and transfer notifications to Vermont providers. To date, the project has connected the ENS vendor with the VHIE and launched the initial kickoff of the ENS service in April, with continued rollout throughout the first half of Performance Period 3. *Shared Care Plan/ Universal Transfer Protocol* • Throughout Performance Period 2, the SIM team performed discovery work on the feasibility and business requirements to support investment in a technology solution for the Shared Care Plans and Universal Transfer Protocol projects. This work culminated in the decision in March 2016 not to pursue technology solutions. • The Shared Care Plan project work will focus on revisions to the VHIE consent policy and architecture in Performance Period 3, and Universal Transfer Protocol project goals will be pursued through workflow redesign support within practices leveraging our successful Learning Collaborative program.
General Health Data – HIE Planning Finalize connectivity targets for 2016-2019 by 12/31/16. Incorporate targets into Sustainability Plan by 6/30/17.	*Lead(s):* Larry Sandage; TBD *Contractors:* Stone Environmental.	• Contractor selected and kickoff meeting with outlined roles and responsibilities conducted; initial efforts to identify connectivity targets have begun.
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.	*Lead(s):* Georgia Maheras; TBD *Contractors:* Stone Environmental.	• IT-specific support to be engaged as needed. • Enterprise Architect, Business Analyst and Subject Matter Experts engaged to support identified research and development initiatives as appropriate.

Evaluation		
Performance Period 3 Milestone	*Lead(s) and Contractors Supporting*	*Progress Toward Milestones*
Self-Evaluation Plan and Execution Execute Self-Evaluation Plan for 2016 and 2017 according to timeline for Performance Period 3 activities.	*Lead(s):* Annie Paumgarten *Contractors:* Burns and Associates; JSI; The Lewin Group.	• Draft Self-Evaluation Plan submitted to CMMI for review in June 2015; a revised plan was finalized in November 2015. • Vermont re-released the RFP for the State-led Study portion of the State-led Evaluation Plan in November 2015 due to significant differences between planned implementation activities and original contract scope. Vermont selected a bidder in December 2015; a contract with the new State-led Evaluation contractor was executed and work launched in March 2016.
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.	*Lead(s):* Pat Jones, Jenney Samuelson *Contractors:* Datastat.	• Patient experience surveys for the patient-centered medical home and shared savings program are fielded annually.
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. TBD: APM, Medicaid VBP – Mental Health and Substance Use.	*Lead(s):* Alicia Cooper; Richard Slusky (GMCB) *Contractors:* Burns and Associates; The Lewin Group.	• Ongoing activities including conducting surveys as identified in payment model development; analyses of the commercial and Medicaid Shared Savings Programs according to program specifications, and ongoing monitoring and evaluation by SOV staff and contractors occurring as needed according to project plan for each payment model.

General Program Management		
Performance Period 3 Milestone	*Lead(s) and Contractors Supporting*	*Progress Toward Milestones*
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, 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.	*Lead(s):* Georgia Maheras *Contractors:* University of Massachusetts.	• Project management contract in place to support project organization and reporting.
Project Management and Reporting – Communication and Outreach Engage stakeholders in project focus areas by: 1. Convening 10 Core Team meetings between 7/1/16 and 6/30/17. 2. Convening 5 Steering Committee public meetings and 20 work group public meetings between 7/1/16 and 12/31/16. 3. Distributing all-participant emails at least once a month through 12/31/16. 4. Update website at least once a week through 12/31/16, and monthly through 6/30/17.	*Lead(s):* Christine Geiler *Contractors:* University of Massachusetts.	• Communication and outreach plan drafted and implemented. • SIM Work Groups and other stakeholder engagement activities ongoing. • Website undergoing updates; new site expected to launch by June 2016 and then update on an ongoing basis.

Attachment 5: Medicaid Pathway Presentation 5-25-16

MEDICAID PATHWAY

INTEGRATED HEALTH SYSTEM UPDATE 5/25/16

KEY QUESTIONS FOR TODAY

1. What is the Medicaid Pathway?
2. Delivery system transformation:
    1. Goals
    2. Scope
    3. Organization
3. Next Steps

WHY IS THERE A MEDICAID PATHWAY?

- The All Payer Model is focused on an ACO delivery model for services that look like Medicare part A & B.
- The majority of Medicaid paid services (about 65%) are not equivalent to Medicare part A & B and/or will not be included in the initial ACO delivery model.
- To get to a truly integrated health system, AHS has to commit to delivery and payment reform for the 65% of cost that is not addressed yet through the all-payer model.

THE PROJECT IN PERSPECTIVE

Big Goal:

Integrated health system able to achieve the triple aim

- ✓ Improve patient experience of care
- ✓ Improving the health of populations
- ✓ Reduce per capita cost

Implement Next Generation-type ACO:

- Way to pursue goal of integrated system for certain services and providers.
- Enables Medicare, Medicaid and Commercial Payers to align value based payments for health care.
- Subject to additional regulation and caps on total spending.

Medicaid Pathway:

- Way to pursue goal of integrated system for services and providers outside of the financial caps of all-payer model.
- Enables Medicaid to align value based payment models with All Payer and ACO design.
- Subject to legislative caps on spending.

CRITICAL TAKE-AWAY:

The regulated revenue and financial cap deal with the feds and DVHA's implementation are part of the all-payer model and reforms, not the whole ballgame for payment and delivery system reform.

WHAT IS THE MEDICAID PATHWAY?

- The Medicaid Pathway is a Process.
- The process is facilitated by the State of Vermont and includes Medicaid service providers who provide services that are not wholly included in the initial APM implementation, such as LTSS, mental health, substance abuse services and others.
- The Medicaid Pathway advances payment and delivery system reform for services not subject to the additional caps and regulation required by the APM. The goal is alignment and integration of payment and delivery principles that support a more integrated system of care.

STEPS IN THE MEDICAID PATHWAY PROCESS

1. **Delivery System Transformation (Model of Care)**
   - What will providers be doing differently?
   - What is the scope of the transformation?
   - How will transformation support integration?
2. **Payment Model Reform (Reimbursement Method, Rate Setting)**
   - What is the best reimbursement method to support the Model of Care (e.g. fee for service, case rate, episode of care, capitated, global payment)?
   - Rate setting to support the model of care, control State cost and support beneficiary access to care
   - Incentives to support the practice transformation
3. **Quality Framework (including Data Collection, Storage and Reporting)**
   - What quality measures will mitigate any risk inherent in preferred reimbursement model (e.g. support accountability and program integrity); allow the State to assess provider transformation (e.g. structure and process); and assure beneficiaries needs are met?
4. **Outcomes**
   - Is anyone better off?

SOV provides support with readiness assessment, resources and technical assistance

DELIVERY SYSTEM TRANSFORMATION

COMPARISON OF NATIONAL EVIDENCED-BASED MODELS				
Core Elements Vermont Model *	Commission on Long-Term Care, September 2013 Report to Congress	CCBHC Model	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	✓	(peer)		✓
Actively Involved Primary Care Physician		(coordinated)	✓	
Provider Network with Specialized Program Expertise	✓	✓	✓	✓
Integration between Medical & Specialized Program Care	✓	✓	✓	✓
Single Point of Contact for person with Specialized 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	✓	✓	✓	✓
*** Elements Fully Align with CMS & National Committee for Quality Assurance (NCQA) DLTSS Model of Care**				

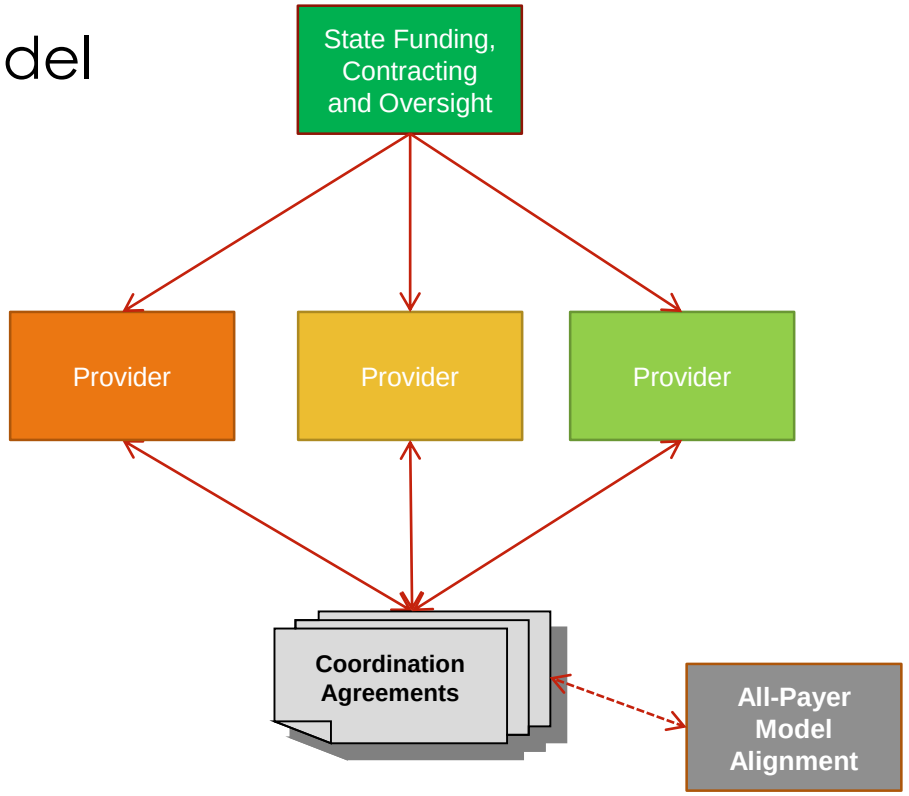
SCOPE OF THE MODEL- GROUP 1

Scope may change over time based on model discussions and findings. Current scope for work group planning includes:

- DMH Funded:
  - Adult and Children's MH services (Excluding Success Beyond Six, PNMI)
  - Emergency MH services
  - CRT
- ADAP & DMH Funded Substance Abuse Treatment & Recovery Services
- DAIL Funded Developmental Disability Services
- IFS Involved Services (CIS tbd)

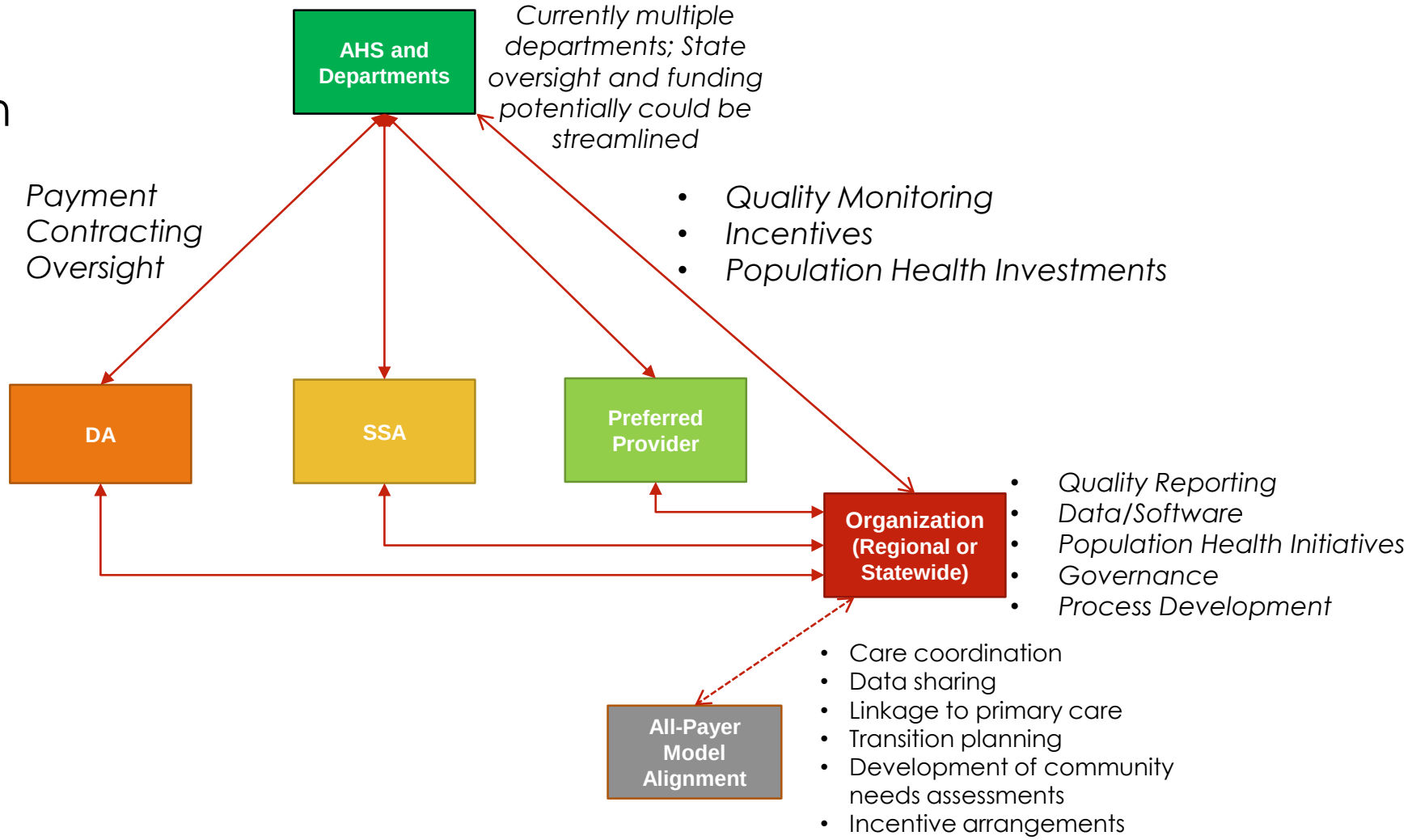
ORGANIZED DELIVERY SYSTEM OPTIONS

- Service Coordination Model



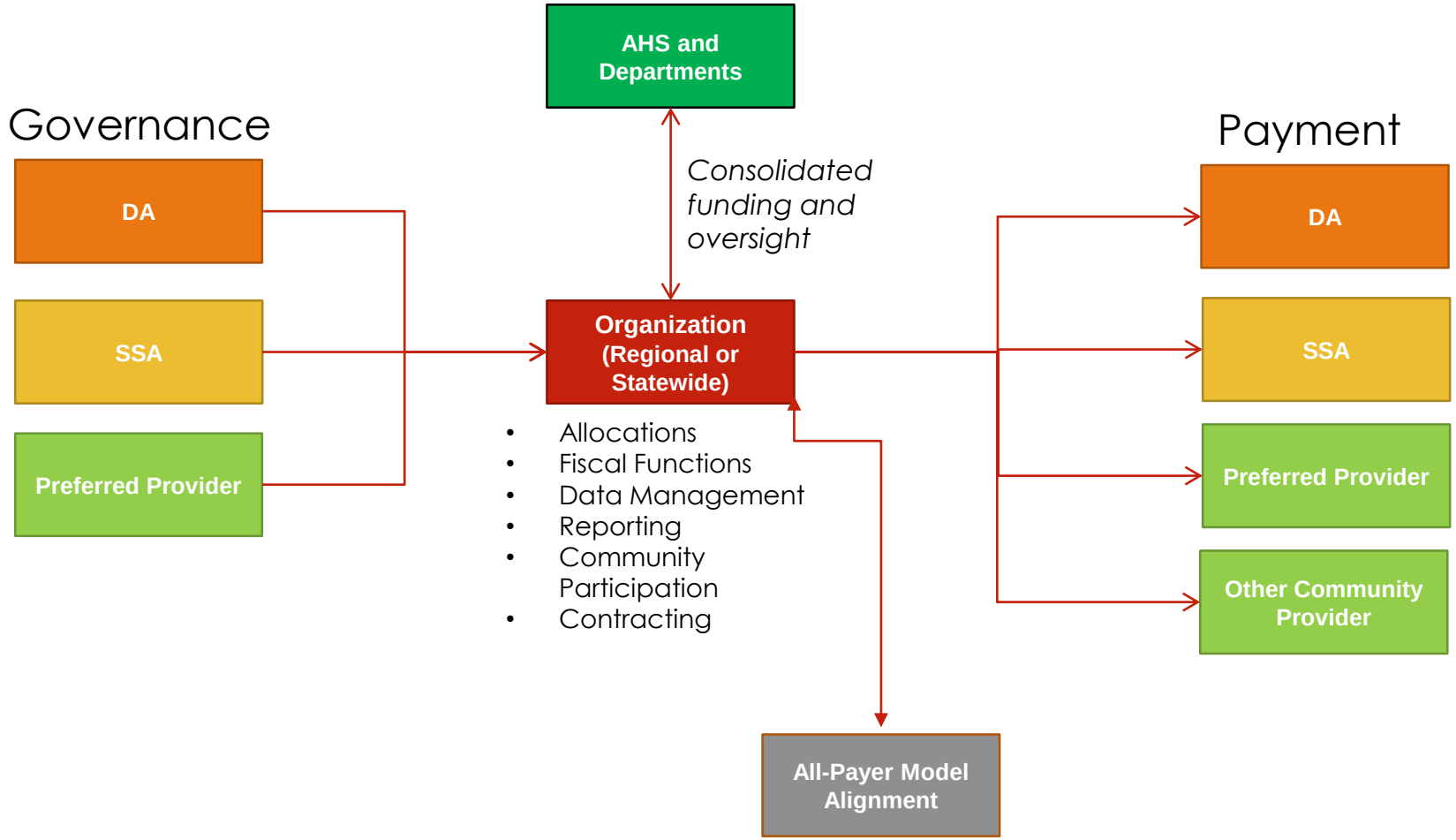
ORGANIZED DELIVERY SYSTEM OPTIONS

- Partial Integration



ORGANIZED DELIVERY SYSTEM OPTIONS

- Integration Model



Similar to the VCRHYP, IFS and CIS Delivery Models

NEXT STEPS

- Finalize Payment Reform Elements – June ‘16
- Develop Quality Framework – June/July‘16
- Evaluate infrastructure and funding requirements- June/July‘16
- Stakeholder feedback loop- ongoing
- Finalize Delivery System Design- July‘16
- Implementation planning- July-December‘16

- Implementation- July 2017