VHCIP Core Team Meeting

Agenda 6-1-15

VT Health Care Innovation Project
Core Team Meeting Agenda

June 1, 2015 1:00 pm-3:00pm
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
1	1:00-1:05	Welcome and Chair's Report: a. Update on negotiations with CMMI	Lawrence Miller	Attachment 1a: Year One Milestones Met and Removed Attachment 1b: Year One Milestones Not Met Attachment 1c: Alignment Powerpoint
Core Team Processes and Procedures				
2	1:05-1:10	Approval of meeting minutes	Lawrence Miller	Attachment 2: May 20, 2015 minutes *Decision needed.*
Policy Recommendations				
3	1:10-1:20	Request for approval of modifications to quality measures from QPM Work Group	Pat Jones and Alicia Cooper	Attachment 3a - Year 2 ACO SSP Measures Changes Attachment 3b: Priority Changes and Options for ACO Measures *Decision needed.*

Evaluation				
4	1:20-2:05	Presentation of Self-Evaluation Plan	Annie Paumgarten; Impaq International	Attachment 4: *to be distributed at a later date* *Decision Needed*
Spending Recommendations				
5	2:05-2:20	Funding requests: 1. *No-Cost Extension:* a. *Stone Environmental (through 12/31/15)* b. *Coaching Center (through 12/31/15)* c. *Deborah Lisi-Baker (through 12/31/15)* 2. *Shared Care Plans and Universal Transfer Protocol (SCÜP) Project (from HIE/HIT WG):* a. *June-July 2015; $36,500*	Georgia Maheras; Simone Rueschemeyer	Attachment 5: Financial Requests (ppt)
6	2:20-2:50	ACO Proposals: 1. Community Health Accountable Care 2. OneCare Vermont	Georgia Maheras; representatives from each of the ACOs	Attachment 6a: CHAC Packet Attachment 6b: OneCare Packet
7	2:50-2:55	*Public Comment*	Lawrence Miller	
8	2:55-3:00	Next Steps, Wrap-Up and Future Meeting Schedule: Next Meeting (previously July 6th, moved to **July 23rd – EXE 4th Floor Conference Room, Pavilion, 1-3pm**)	Lawrence Miller	

Attachment 1a

Year One Milestones

Met and Removed

Y1 Milestone Table: completed and removed

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
General:				
		Project will be implemented statewide	Complete	
Payment Models:				
SSPs		Implement Medicaid and commercial ACO-SSPs by 1/1/14	Complete	
Consult with payment models and duals WGs on financial model design		Develop ACO model standards	Complete	
Develop ACO model standards		Approved ACO model standards	Complete	
Health Homes		Included in timeline table	Complete	
P4Ps (new)	Create quality incentive pool for Medicaid-- Participation in the Medicaid program would be required for enrolled providers but include intentional levels of adoption and a phase-in period so all providers could participate appropriate to their level of readiness.	Create in Y1	Not Met	Remove because we did not have new Medicaid dollars in the FY15 budget to support this initiative.
Develop Medicaid value-based purchasing plan addressing pay-for-performance initiatives. *This is the same as the item above with a different name.*	Medicaid value-based purchasing plan developed		Not Met	Remove because we did not have new Medicaid dollars in the FY15 budget to support this initiative.
Duals Demo	Implemented per demo specifications		Not met	Remove because the State did not pursue this demonstration.
Outreach:				
Implement "How's Your Health Tool"	Implemented by 6/2014	Implemented by 6/2014	Complete	Implemented through White

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
				River Family Practice Sub-Grant
Stakeholder engagement-work groups and more broadly	Unspecified	Unspecified	Complete	
Health Data Infrastructure:				
VHCURES:		• Update rule to include VHC information (Fall 2013) • Incorporate Medicare data (Fall 2013) • Improve data quality procedures (Fall 2014) • Improve data access to support analysis (Fall 2014)	1. Not met 2. Implemented 3. Implemented 4. Implemented	Remove #1- no plan to update the VHCURES rule at this time.
Clinical Data: • Medication history and provider portal to query the VHIE by end of 2013 • State law requires statewide availability of Blueprint program and its IT infrastructure by October 2013		• Medication history and provider portal to query the VHIE by end of 2013 • State law requires statewide availability of Blueprint program and its IT infrastructure by October 2013	Complete	
Medicaid Data: • A combined advanced planning document for the funding to support the TMSIS is completed and submitted to CMS in July 2013			Complete	
Provide input to update of state HIT plan	Updated state HIT plan		Complete	
Begin to incorporate long term care, mental health, home care and specialist providers into the HIE infrastructure	Provide regional extension center (REC) like services to non-EHR providers to include long term care, mental health, home health and specialists and begin development of interfaces to the VHIE for these provider groups that		Complete	

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
	currently have EHRs with the goal over three years of achieving 50 new interfaces.			
Expand the scope of VHCURES to support the integration of both claims and clinical data and provide this capability to ACOs/providers and potentially payers	Number of providers approved for use of VHCURES data		Not met	Remove- VHCURES procurement put on hold in Spring 2015.
Vermont Health Connect: • Update all payer claims data base rule incorporating VHC information • Enhance current database with new VHC information • As needed collect data directly from VHC **payers.**			Not met	Remove- we do not use this data set for any analyses; relying on VHCURES or direct feeds from carriers
Quality Measures: (Note in new framework, these fall within the Payment Models section)				
Define common sets of performance measures: convene work group, establish measure criteria, identify potential measures, crosswalk against existing measure sets, evaluate against criteria, identify data sources, determine how each measure will be used, seek input from CMMI and Vermont independent evaluation contractors, finalize measure set, identify benchmarks and performance targets, determine reporting requirements, revisit measure set on regular basis			Complete	
Ensure payer alignment across endorsed measures • Process for payer approval			Complete	
Ensure provider, consumer and payer buy-in during measure selection: • Identification of additional mechanisms for obtaining provider and consumer representation, input and buy-in			Complete	

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
Establish plan for target-setting with schedule for routine assessment: • Establish target-setting process, routine assessment process, and analytic framework and reports			Complete	
Learning Collaboratives/Care Delivery Transformation				
SIM will expand all existing efforts (Blueprint, VITL, providers, VCCI, SASH, Hub and Spoke)	Unspecified		Complete	
Provide quality improvement and care transformation support to a variety of stakeholders	All 14 IHS Work Groups are offered CQI training and accept and implement such training		Complete	We explored the IHS model and chose a different path to meet this milestone developing our learning collaboratives.
	All practices that want facilitation have access to such resources		Complete	
	All providers that want such training have access to it; providers have working knowledge of Vermont's transformation initiatives		Complete	
Procure learning collaborative and provider technical assistance contractor	Contract for learning collaborative and provider technical assistance		Complete	
Develop technical assistance program for providers implementing payment reforms	Number of providers served by technical assistance program (goal = 20)		Complete	
Evaluation:				
Procure contractor	Contract for internal evaluation	Hire through GMCB in Sept 2013	Complete	

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
Payment Model Implementation Activities:				
Procure contractor for internal Medicaid modeling		Contract for Medicaid modeling	Complete	
Procure contractor for additional data analytics		Contract for data analytics	Complete	
Define analyses		Number of analyses designed (goal = 5)	Complete	
Procure contractor for internal Medicaid modeling		Number of analyses performed (goal = 5)	Complete	
Define analyses		Number of meetings held with payment models and duals WGs on the above designs (goal = 2)	Complete	
Consult with payment models and duals WGs on definition of analyses			Complete	
Perform analyses; Procure contractor for financial baseline and trend modeling; and Develop model.			Complete for SSPs	
Produce quarterly and year-end reports for ACO program participants and payers		Evaluation plan developed	Complete	
Execute Medicaid ACO contracts		Number of Medicaid ACO contracts executed (goal = 2)	Complete	
Execute commercial ACO contracts		Number of commercial ACO contracts executed (goal = 2)	Complete	
Procure contractor for additional data analytics		Contract for financial baseline and trend modeling	Not Met	Remove- redundant to other milestones.
Provider Targets:				
Number of Blueprint practice providers participating in one or more testing models	goal = 500		628- Complete	
Initiative Support:				
Procure contractor		Contract for interagency coordination	Complete	
Hire contractor		Contract for staff training and development	Complete	
Develop curriculum		Training and development curriculum developed	Complete	
Develop interagency and inter-project communications plan		Interagency and inter-project communications plan developed	Complete	
Implement plan		Results of survey of project participants re: communications	Complete	

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Notes
Workforce (Note: in new framework, these activities are in Care Delivery and Practice Transformation				
Professional training and education	Build on the variety of health professional training and education programs offered throughout the state	Vermont Department of Labor to develop a comprehensive review of all such programs offered by each agency/department of state government - due by the end of 2013	Complete	

Attachment 1b

Year One Milestones

Not Met

Y1 Milestone Table: Milestones not met

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Progress through 3/31/15
Payment Models:				
	90% of beneficiaries in alternatives to FFS: 90% of Vermonters; 80% of primary care providers; 100% hospitals; 100% home health agencies; 100% DAs across all models being tested; 100% public payers (Medicare and Medicaid); 100% Commercial payers with 5% or more of commercial market share if Blueprint is included; 33% of Commercial Payers with 5% or more of commercial market share if Blueprint is not included.		Beneficiary target not met- 50-60% of beneficiaries. Complete for primary care providers, hospitals, DAs, public payers, commercial payers. On track for primary care providers; home health agencies.	Complete for primary care providers, hospitals, DAs, public payers, commercial payers. On track for primary care providers; home health agencies.
EOCs	The first year of the program would be voluntary participation; subsequent years would transition to bundled payments. Since providers would be paid at a bundled rate instead of FFS, they would have to participate in order to receive payment.	At least 3 launched by 10/2014	Preliminary analyses; stakeholder engagements	Financial component is delayed significantly due to provider reform fatigue; progress is being made on analytic component through public-private subgroup
Develop standards for bundled and episode-based payments		Approved standards for bundled and episode-based payments	Not Met	
Execute contracts for bundled and episode-based payments		Contracts executed	Not met	
Health Data Infrastructure:				
Expand provider connection to HIE infrastructure		Number of new interfaces built between provider organizations and HIE (goal = 18 additional hospital interfaces and 75 new interfaces to non-hospital healthcare organizations to include: at least 10 specialist practices; 4 home health	Not met.	

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Progress through 3/31/15
		agencies; and 4 designated mental health agencies)		
Identify necessary enhancements to centralized clinical registry & reporting systems		Completed needs assessment for enhancements to centralized clinical registry and reporting systems. *This milestone and the next two are all part of one project.*	Begun; more complicated than anticipated so more work needed.	Significant progress on discovery portion.
Procure contractor to develop initial use cases for the integrated platform and reporting system		Contractor hired	Research conducted.	
Design the technical use cases and determine the components of the integrated platform that are required to implement these use cases		Contract for the development of 6 primary use cases for the integrated platform and reporting system	Begun.	
Develop criteria for telemedicine sub-grants	Number of telemedicine initiatives funded (goal = 1)		RFP released for tele-health strategy; vendor selected.	Contractor started Feb 2015.
Quality Measurement:				
EOC/Bundle-specific measurement activities		Establish measure criteria (November 2013). Identify potential measures (December 2013 through February 2014).	Not Met	
Evaluation:				
Evaluation (external)	Number of meetings held with performance measures WG on evaluation (goal = 2)	2 meetings with QPM WG	Not Met	
Develop evaluation plan	Evaluation plan developed		Not Met	Significant progress

Category	By end of project	Milestone (Y1)	Progress through 12/31/14	Progress through 3/31/15
Consult with performance measures work group	Number of meetings held with performance measures WG on evaluation (goal = 2)		Not Met	
Input baseline data	Baseline data identified		Not Met	
Provider Targets:				
Number of providers participating in one or more testing models		goal = 2000	Not Met- 926	

Attachment 1c

Alignment Presentation

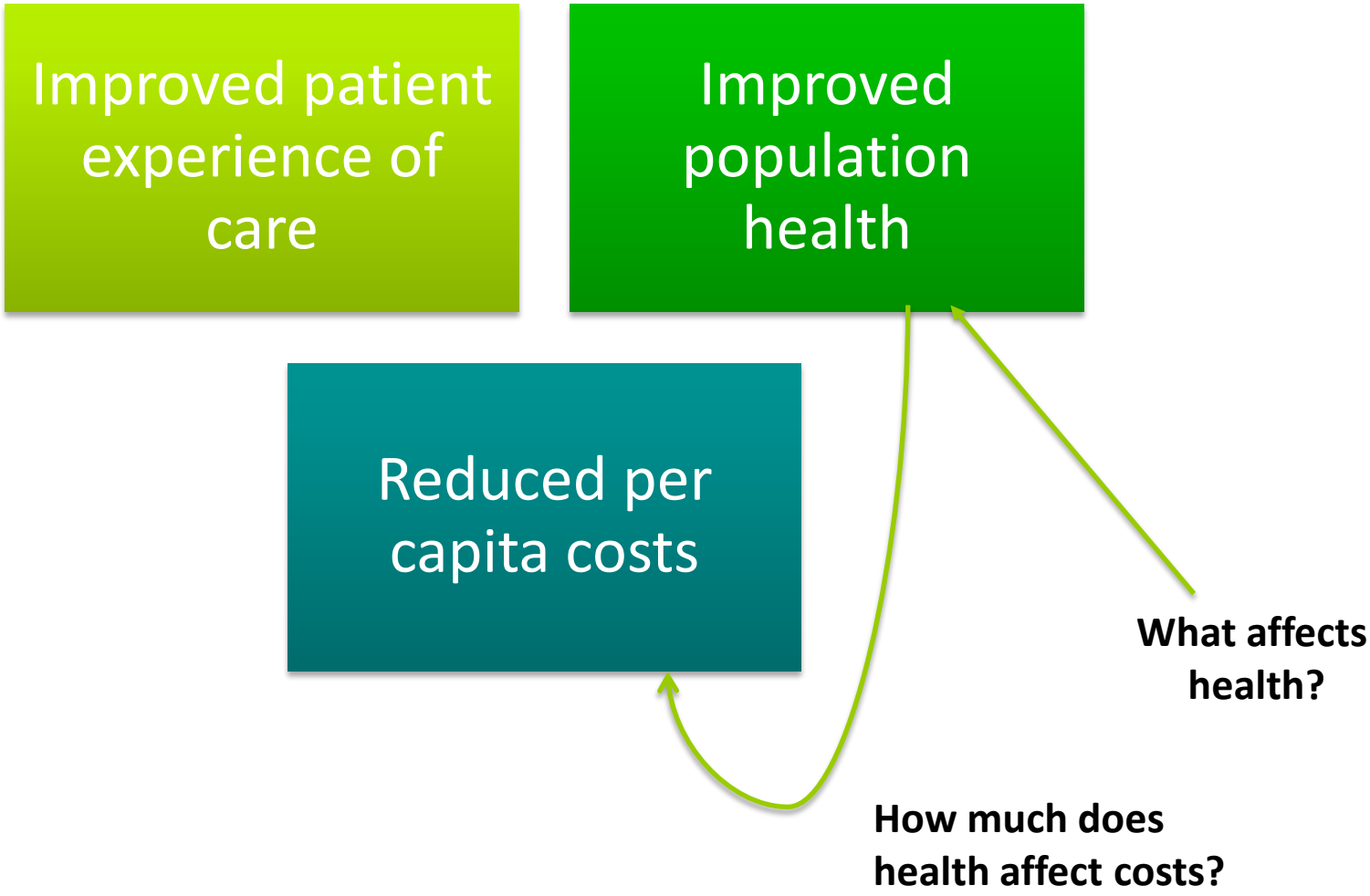
Achieving the Triple Aim in Vermont

Aligning Vermont's Health Care Innovation Project (SIM) with the All Payer Model

Submitted to CMMI on May 22, 2015

Vermont Health Care Innovation Project

Goal: Achieve the Triple Aim



Vermont's Delivery Reform Goals

Vermont Health Care Innovation Project (SIM)

- **Align** financial incentives with the Triple Aim (Multi-Payer Payment Models)
- **Enable** and reward care integration and coordination and support provider transformation (Care Delivery)
- **Develop** a health information system that supports improved care and measurement of value (Health Data Infrastructure)

All Payer Model (APM)

- **Align** financial incentives with the Triple Aim (Multi-Payer Payment Models)
- **Enable** and reward care integration and better coordinate care for Vermonters (Care Delivery)
- **Sustain** a health information system that supports the triple aim (Health Data Infrastructure)
- **Create** a sustainable growth trend for Vermonters while ensuring high quality care

Achieving Multi-Payer Payment and Delivery System Reforms: *5 Components for Success*

- **Payment Models**
  - Financial and quality measurement (payer side)
- **Care Delivery**
  - Practice transformation (provider side)
- **Health Data Infrastructure**
  - Information to make it all work (provider, payer, and state)
- **Evaluation**
  - Determine what is working (state side)
- **Federal Waivers & Funding**
  - Regulatory flexibility through the Global Commitment Medicaid waiver and All Payer Model Agreement
  - All Payer Model Implementation funding through the State Innovation Model Testing Grant (SIM)

Payment Models: *Programs*

- **Blueprint for Health**, Advanced Practice Medical Homes and Community Health Teams
  - Multi-Payer Advanced Primary Care Practice (MAPCP) & Medicaid Health Home (opiate addiction).
  - Implemented capitated payments to housing authorities for Support and Services at Home (SASH) as part of MAPCP.
  - Adding a pay for performance payment that ties a portion of medical home payment to service area outcomes (community interdependencies).
  - Payment and Quality measurement aligned across payers & creates a framework for All Payer Model primary care components.
- **Shared Savings Programs with ACOs**
  - Implemented for Medicare and commercial payers.
  - Medicaid program implemented with state plan amendment pending.
  - Quality Measurement largely aligned across payers.
  - "Training Wheels" for providers to get ready for capitation under APM.
- **Episodes of Care/Bundled Payments**
  - in design phase through VHCIP.
  - Low risk method to identify inefficiencies in the health care system, in particular around specialty care.

Care Delivery: *Programs*

- **Blueprint for Health**
  - Practice Transformation
    - State staff and contract assistance for practice transformation funded through Global Commitment and other state funding.
    - Provides practice facilitation to assist primary care practices with NCQA certification and enables medical homes to change operations on the ground to improve quality and reduce costs.
  - Community Health Teams
    - Provide care coordination and wrap-around support for advance practices funded through Global Commitment and other state funding.
    - Includes Medicaid care coordination staff on team.
  - Regional Planning Teams
    - integrated and used as the ACO regional teams.
    - Directs resources at the community level.

Care Delivery: *Programs*

- **Accountable Care Organizations**
  - Key, provider led organizational component for care delivery.
  - Integrate care beyond primary care, establish regional priorities.
  - Infrastructure funding through VHCIP.
  - Likely to become key organizations in APM.
- **Learning Collaboratives**
  - Provides a forum for sharing information among health care providers in order to ensure readiness for payment reform and to promote change at the service delivery level.
  - Organized and funded through VHCIP.
  - Assists with provider readiness for capitation through the APM.

Care Delivery: *Programs*

- **Provider Transformation Sub-Grants**
  - Funding through VHCIP to promote innovative delivery or payment reforms at the health care provider level
  - Encourages transformation in care delivery and determines models which may be scaled or shared with other providers
  - Assists with provider readiness prior to capitation through the APM

Health Data Infrastructure Investments

- **Clinical data –** *providers need information in a usable format in order to create efficiencies and reduce utilization.*
  - **Blueprint for Health Clinical Data Registry** – funded through Global Commitment and other state funding.
  - **Health Information Exchange (VITL)**--funding from multiple sources, including SIM, to create interoperability between electronic medical records and to provide access to high quality clinical information between providers through *VITLAccess.*
  - **Shared Care Plans/Transfer protocols**—design funded through SIM.
  - **Event notification system** -- design and implementation funded through SIM.
- **Claims data –** *the state, providers, and payers need utilization and expenditure for health system planning and regulation.*
  - **VHCURES** –funded through Global Commitment and other state funding.
- **Survey data –** *providers and others need to understand what patients are experiencing in order to ensure quality and access are not compromised.*
  - **Numerous including Patient Experience Surveys**– funded through SIM, Global Commitment, and other state and federal funding.

Evaluation

- **Vermont Health Care Innovation Project**
  - Ongoing quality measurement & evaluation of specific components of the project.
  - Facilitate: a regular, robust reporting to CMMI; inform the need to adjust implementation activities as needed to maximize project impact; provide a rigorous, empirical basis for recommendations to scale-up and broadly diffuse VHCIP initiatives.
- **Blueprint for Health**
  - On-going quality measurement & evaluation of the program interventions on cost impacts.
  - Recent Medicare evaluation shows model is one of most successful in MAPCP program.
  - For more information see the Blueprint for Health Annual Report
    - http://blueprintforhealth.vermont.gov/sites/blueprint/files/BlueprintPDF/AnnualReports/VTBlueprintforHealthAnnualReport2014_Final.2015.01.26.pdf

Federal Waivers and Funding

- Global Commitment to Health Waiver
  - An 1115 Medicaid waiver that:
    - Creates a public managed care entity with flexibility and funding to support the health of Vermont's Medicaid beneficiaries.
      - Must comply with Medicaid Managed Care regulations
    - Creates flexible eligibility for long-term services and supports to allow access to home and community based services on the same basis as nursing home care.
- State Innovation Model Grant
  - Testing grant to provide funding for payment and delivery reform innovations.
- All Payer Model Agreement
  - See next slides!

Why an All Payer Model as the next evolution?

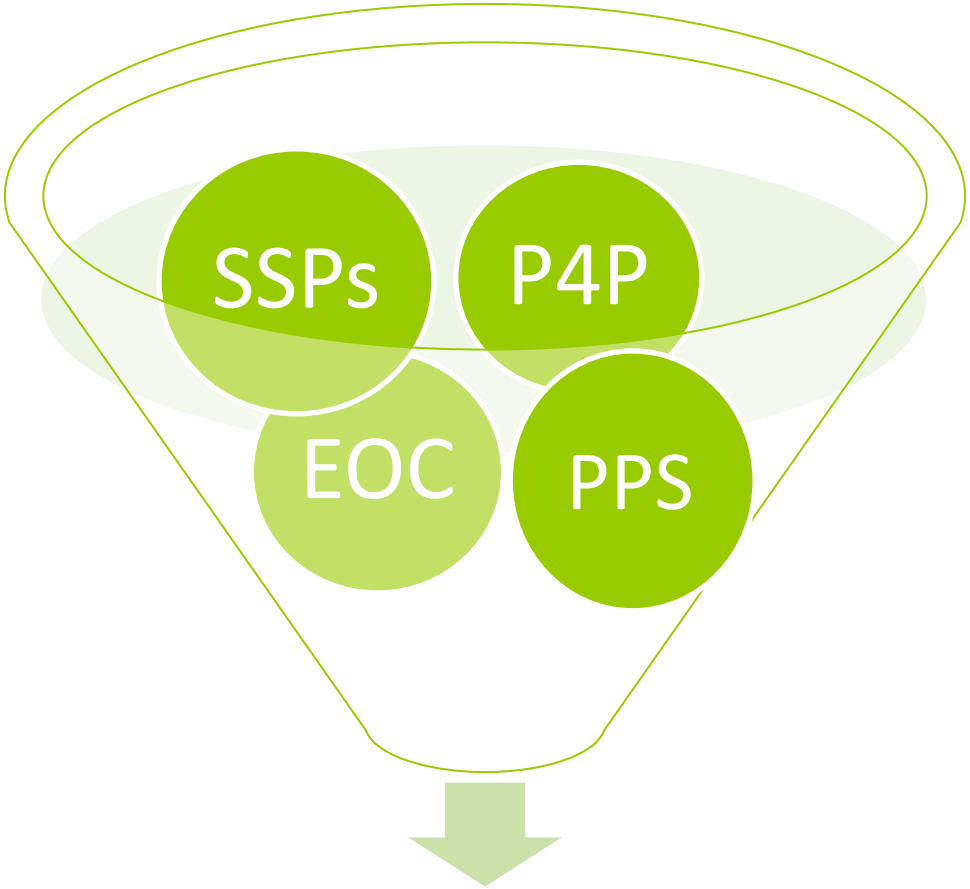
- The all-payer model/system will encourage providers to strengthen their relationships with patients and better coordinate care for Vermonters.
- The system will have incentives to promote health and support Vermonters in choosing healthier behaviors.
- The system will allow Vermonters to better understand the total and out-of-pocket costs they face and the quality of the services they receive.
- The system will ensure treatment is done is the least costly setting and that patients are engaged in their health care and health outcomes.

Implementing an All Payer Model

- Create a rate-setting agency at GMCB, which allows for regulation across all payers and which provides cost control while improving quality.
  - APM agreement and Global Commitment create the flexibility through waivers necessary to do this.
  - APM agreement and GC create the base, trend, and savings targets.
- Evolve payment methodologies from payment models implemented by payers and supported by Blueprint & SIM grant.
  - APM agreement and Global Commitment create the flexibility through waivers necessary to do this.
- Evolve quality measures from payment models implemented by payers and supported by Blueprint & SIM grant.
  - APM agreement and Global Commitment create the flexibility through waivers necessary to do this.

All-Payer Model: Payment Models

- **Builds on reforms:**



All Payer Model: Care Delivery

- **Builds on reforms by:**
  - Ensuring more providers, including DLTSS providers, are ready to take accountability for cost and quality over time.
  - Creating provider readiness for capitation prior to implementation to ensure that patient access and quality of care is not compromised.
  - Enabling providers to change operations on the ground, so savings do not compromise quality of care, patient experience, or access to care.

All Payer Model: Health Data Infrastructure

- **Use current investments and continue to build infrastructure over time by:**
  - Continuing to build an interoperable health data infrastructure for clinical decision-making to ensure provider community is ready to take accountability for cost and quality prior to implementation of rate-setting and capitation.
  - Building infrastructure across more provider types, such as DLTSS, over time.
  - Using and continuing to refine the data infrastructure necessary for quality reporting after capitation.
  - Reducing duplication in reporting and simplifying, where possible.
  - Demonstrating reliable information in order to build trust by providers in the data provided and to ensure it is used by providers to create efficiencies.

Attachment 2

May Minutes

Vermont Health Care Innovation Project
Core Team Meeting Minutes

Pending Core Team Approval

Date of meeting: Wednesday, May 20, 2015, 2:00pm-4:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's Report	Lawrence Miller called the meeting to order at 2:00. A quorum was present.	
2. Approval of Meeting Minutes	Steve Voigt moved to approve the May 4, 2015, meeting minutes (Attachment 2). Steven Costantino seconded. A roll call vote was taken and the motion to approve the minutes passed with one abstention.	
3. Executive Session: Mid-Project Risk Assessment *Public Comment*	Lawrence Miller introduced the Executive Session. Robin moved to enter Executive Session to discuss matters related to the State of Vermont's contractual relationship with CMMI for the State Innovation Model Testing Grant Cooperative Agreement, and requested that the following staff be invited to participate in the Executive Session: Georgia Maheras, Sarah Kinsler, Kara Suter, Diane Cummings, Ena Backus, Michael Costa, and Craig Jones. Susan Wehry seconded. A roll call vote was taken and the motion passed unanimously. Following discussion in Executive Session, Steven Costantino moved to end Executive Session. Harry Chen seconded. A roll call vote was taken and the motion to end Executive Session passed unanimously. No public comment was offered.	
6. Public Comment	No further public comment was offered.	
7. Next Steps, Wrap Up and Future Meeting Schedule	**Next Steps:** The Executive Session included a discussion of issues related to CMMI and certain documents to be submitted to CMMI – no policy decisions were made. The results of this discussion will be brought back to public session at the next meeting, on June 1, and at the June 17 VHCIP Project-Wide Convening. **Next Meeting:** Monday, June 1, 2015, 1:00pm-3:00pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP Core Team Member List
Roll Call:

5/20/2015 1° Steve V. 2° Steve C. 1° Robin 2° Susan 1° Steve C. 2° Hal

Member		5/4/2015 Minutes	Into Exec Session	Out of Exec Session		
First Name	Last Name					Organization
Paul	Bengston	✓	✓	✓	✓	Northeastern Vermont Regional Hospital
Hal	Cohen	/ Hemphill → Abstain	✓	✓	✓✓	AHS -CO
Steven	Costantino	✓	✓	✓	✓	AHS - DVHA
Al	Gobeille	✓	✓	✓	not here	GMCB
Robin	Lunge	✓	✓	✓	✓	AOA - Director of Health Care Reform
Lawrence	Miller	✓	✓	✓	✓	AOA - Chief of Health Care Reform
Steve	Voigt	✓	✓	✓	✓	ReThink Health
Susan	Wehry	✓	✓	✓	✓	AHS - DAIL

phone: Susan Wehry, Al Gobeille, Craig Jones

Attendance: Kara Suter, Michael Costa, Dave Cummings, Sarah Kinsler, Gerya Maheras, Ena Backus,

Attachment 3a

Year 2 ACO Measures Changes

Proposed Changes to Year 2 ACO Shared Savings Program Measures

VHCIP Core Team

June 1, 2015

Background

- Quality measures can and do change as the evidence base changes.
- The QPM Work Group's consultant, Bailit Health Purchasing, provided a summary of national changes to measures in Vermont's Year 2 SSP measure sets.
- There have been recent national changes to two measures in the payment/reporting measure sets:
  - Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening), a claims-based payment measure
  - Optimal Diabetes Care Composite ("D5"), a clinical data-based reporting measure

Proposed Year 2 Measure Changes

- At its May 18 meeting, the QPM Work Group voted unanimously to recommend replacement measures for these two measures.
- This recommendation would be effective for Year 2 (2015) of the Medicaid and Commercial Shared Savings Programs.
- The Work Group will consider this recommendation when completing its review of measures for Year 3 (2016) of the Medicaid and Commercial Shared Savings Programs during the next couple of months.

Recommendation: Replace LDL Screening with Controlling High Blood Pressure

Current Measure	Recommended Measure
Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening) (Payment Measure)	Hypertension: Controlling High Blood Pressure (Payment Measure)

- LDL screening is no longer considered best practice; as a result, this measure has been dropped by the Medicare Shared Savings Program (MSSP) and NCQA HEDIS.
- Newly proposed HEDIS cholesterol measure (Statin Therapy for Patients with Cardiovascular Disease) has not yet been adopted, and will lack benchmarks when it is.
- QPM Work Group recommendation is to replace LDL Screening with a nationally-endorsed MSSP measure:
  - Hypertension: Controlling High Blood Pressure

Recommendation: Replace Optimal Diabetes Care Composite with MSSP Diabetes Composite

Current Measure	Recommended Measure
Optimal Diabetes Care Composite ("D5," includes LDL Screening, hemoglobin A1c control, blood pressure control, tobacco non-use, and aspirin use) (Reporting Measure)	MSSP Diabetes Composite ("D2," includes hemoglobin A1c poor control and eye exam) (Reporting Measure)

- CMS has retired this measure from the MSSP measure set, most likely because one of the 5 sub-measures is the LDL Screening measure.
- QPM Work Group recommendation is to replace "D5" with the new MSSP Diabetes Composite Measure ("D2").
- Two of the remaining three sub-measure topics in "D5" would be addressed for the broader population by the current "Tobacco Use: Screening and Cessation" reporting measure, and the proposed "Hypertension: Controlling High Blood Pressure" payment measure.

SUMMARY – Year 2 Recommended Measure Changes Commercial and Medicaid Programs

Current Measure	Recommended Replacement Measure	Year 2 2015 – Measure Set
Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening)	**Hypertension: Controlling High Blood Pressure (Payment Measure)**	Payment
Optimal Diabetes Care Composite **"D5" includes:** • **LDL Screening** • **hemoglobin A1c control** • **blood pressure control** • **tobacco non-use** • **aspirin use**	**MSSP Diabetes Composite** **"D2," includes:** • **hemoglobin A1c poor control** • **eye exam**	Reporting

For Steering Committee Consideration

- Is the recommendation consistent with the goals and objectives of the grant?
  - This recommendation is consistent with the following goals and objectives of the grant (outlined in the Operational Plan):
    - To increase the level of accountability for cost and quality outcomes among provider organizations;
    - To establish payment methodologies across all payers that encourage the best cost and quality outcomes;
    - To ensure accountability for outcomes from both the public and private sectors; and
    - To create commitment to change and synergy between public and private culture, policies and behavior.

For Steering Committee Consideration

- Is the recommendation inconsistent with any other policy or funding priority that has been put in place within the VCHIP project?
  - No; modification of ACO SSP measure sets in response to national measure changes was anticipated beyond Year 1.
- Has the recommendation been reviewed by all appropriate workgroups?
  - These recommendations were approved unanimously by the QPM Work Group after discussion at 3 meetings. The Work Group also considered input on the Hypertension measure from the VT Commissioner of Health, Harry Chen, MD; other Department of Health staff; and Virginia Hood, MD, a nephrologist from the UVM Medical Center.

Attachment 3b

Priority Changes and Options for ACO Measures

bailit health PURCHASING

56 Pickering Street Needham, MA 02492 T: (781)453-1166 F: (781)453-1167 www.bailit-health.com

TO: Pat Jones and Alicia Cooper
FROM: Michael Bailit and Michael Joseph
DATE: April 7, 2015
RE: Changes to ACO Measures

In our memo dated 3-10-15 we identified changes in national measure sets that are relevant to the Vermont ACO measure set. Last week you asked that we provide you with options for measures that could replace measures that have been retired, or have been proposed for retirement, from national measure sets. This memo responds to that request.

I. Payment Measures

Measure	Reason	Options for Replacement
Core-3a: Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening Only)	Removed from HEDIS 2015 due to a change in the national guideline	1. Statin Therapy for Patients with Cardiovascular Disease *This is a newly proposed HEDIS 2016 measure, effectively replacing LDL screening. CMS is likely to adopt the measure, but has not yet done so. NCQA will not publish benchmarks for 2016, but is likely to do so for 2017. Final specifications will be released with in July.* 2. (Core-39/ MSSP-28) Hypertension (HTN): Controlling High Blood Pressure, or (Core-40/ MSSP-21) Screening for High Blood Pressure and follow-up plan documented *These currently pending measures assess high blood pressure, a significant population health risk. They align with the MSSP and benchmarks exist, but they require clinical data.*

II. Reporting Measures

Measure	Reason for Retirement	Options for Replacement
Core-16 (MN Community Measurement's Optimal Diabetes Care)	CMS has retired this measure (MSSP-22-25) from the MSSP measure set. This may be because MSSP-23 (Core-16b) is an LDL control measure.	1. The revised MN Community Measurement Optimal Diabetes Care for 2015 *MN Community Measurement has replaced the LDL measure with a statin use measure. Maine has adopted this measure.* 2. The three remaining individual measure components of Core-16 not already in the measure set, i.e., Core-16c: Blood Pressure <140/90, Core-16d: Tobacco Non-Use, and Core-16e: Aspirin Use *All of these are evidence-based measures of effective diabetes management. Benchmarks are available for the blood pressure control measure.* 3. Blood pressure control *This is an important outcome measure for management of diabetes. Benchmarks are available for the diabetes blood pressure control measure.*

III. Monitoring and Evaluation Measures

Measure	Reason for Retirement	Options for Replacement
M&E-1: Appropriate Medications for People with Asthma	NCQA is proposing retiring this measure for 2016 due to consistently high HEDIS performance rates and little variation in plan performance for both commercial and Medicaid plans.	1. Medication Management for People with Asthma *This measure was first introduced in HEDIS 2012. NCQA views it as a more effective way of assessing asthma medication management. National benchmarks are available, and the measure can be calculated with claims.*
M&E-16: ED Utilization for Ambulatory Care-Sensitive Conditions	AHRQ has retired this measure for unidentified reasons.	AHRQ is working on ED-specific PQI measures, and conducted a beta test for the draft ED-PQI SAS software from March – May 2014. The beta test was conducted to test how well the software calculates the measures using data from different users and to see how reliable the program is. The measure has not yet been finalized. In the meantime, the measure set still contains M&E-14: Avoidable ED visits-NYU algorithm. This measure is available only at the end of the year, but captures related content to the retired measure.

IV. Pending Measures

Measure	Reason for Retirement	Options for Replacement
Core-3b: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)	Removed from HEDIS 2015 due to a change in the national guideline	See option 1 for Core-3a on page 1.
Core-38: Coronary Artery Disease (CAD) Composite <100 mg/dL)	CMS has retired this measure (MSSP-32) from the MSSP measure set, in all likelihood because it is an LDL control measure.	See option 1 for Core-3a on page 1.

Attachment 4

Self-Evaluation Plan

Evaluation of Vermont's State Innovation Model Grant

Self-Evaluation Plan

June 1, 2015

OVERVIEW

Overview

1. Background
2. Evaluation Questions
3. Proposed Approach
4. Questions & Discussion

1. BACKGROUND

Evaluation Environment

- CMMI evaluation conducted by Research Triangle Institute (RTI) focuses on the impact of SIM funds on:
  - health care expenditures, utilization, care coordination, quality of care, provider response
- National perspective essential but limits tailoring of the evaluation to address states' priorities
- Vermont needs specific, actionable information from the self-evaluation to inform further transformation in its areas of strength and growth

History

- Rapid pace of change led to a mismatch between self-evaluation design and Vermont's needs
- Literature review -> April 16 discussion with Vermont SIM leaders identified value in a thematic approach to the self-evaluation
  - Based on the discussion, the IMPAQ Team provided 6 short, theme-driven proposals for discussion

Use of Data/Performance Measurement (combined)	**Care Coordination/ Integration**	**Practice Transformation Resources**
Payment Reform Effects	**Event Notification/HIE**	**Evaluation Synthesis/Dissemination**

History

- From these, Vermont identified 3 high priority topics

Use of Data/Performance Measurement (combined)	**Care Coordination/ Integration**	
Payment Reform Effects		

- The IMPAQ Team re-designed the self-evaluation to address these three themes through a single set of visits to carefully-selected sites
- A mixed-methods (qualitative + survey) approach.

Selected Themes Cover 3 VHCIP Logic Model Focus Areas

	Logic Model Focus Areas		
Self-Evaluation Themes	Promote Value-Based Care	Facilitate Care Coordination/ Integration	Invest in HIT and HIE
Care Coordination/Integration		X	X
Use of Clinical and Economic Data to Promote Value-Based Care	X	X	
Payment Reform/Incentives	X		

2. EVALUATION QUESTIONS BY THEME

Care Coordination/Integration Questions

1. What are key examples of care coordination/integration approaches being tested/implemented across the state?
2. What are the key characteristics of each approach in the sites that are studied, and how do they vary in evidence base, design, setting, focus, resource utilization, and cost, and in comparison to national care models?
3. What evidence is available to demonstrate effectiveness of each approach? How solid is the evidence? What are the key lessons learned from each?
4. What environmental and organizational features enhance care coordination/integration approaches? What features result in barriers?
5. Based on resources, cost, and perceived success, which appear to be most suitable for scaling up?
6. What information do health care providers (physicians, nurses, care coordinators, social workers, others) need from other providers/care settings in order to provide high quality, coordinated and integrated care? How available, timely and high of quality is this information? [HIE focus]

Use of Clinical/Economic Data Questions

1. What data are being communicated, by whom, how are they being communicated (and through what intermediary structures) and for what purposes are they being communicated?
2. What assistance or support is provided to those intended to use data?
3. How are data being received, understood and applied?
   - Are the right data being communicated?
   - What do providers perceive as most and least useful about the processes and data shared? What elements are most and least useful to improve patient care and practice efficiency? Do the data contain information that providers want and think they can make use of?
   - How could the content or communication mode of the data be modified to make it coincide more closely with provider needs and allow effective provider responses?
   - What data-related burdens or redundancies do providers/practices cite?

Payment Reform/Incentives Questions

1. Under what financial incentive structure(s) do providers practice in Vermont?
   - How do providers view the current incentive structure(s) under which they practice? Why?
   - What changes, if any, have taken place in the way providers practice as a result of these incentive structures?
   - How do attitudes toward incentives and changes providers have made in practice (if any) differ across provider types (primary care, specialty care), practice sizes (solo, small and large group), and ownership (hospital-owned vs independent).
2. What further adaptations at the practice and provider level do providers anticipate in the transition to next generation payment models, such as shared savings with downside risk, episode-of-care based payment, and global budgeting? What additional support or technical assistance do providers anticipate needing in making this transition?

3. PROPOSED APPROACH

Overview

<u>Site Visits</u> (20 total)

Strategically selected (diversity + payoff across multiple themes)

Key informant interviews + focus groups to ensure we get the Vermonter's perspective

<u>Provider Surveys</u> (2 samples)

Physicians +
Care Coordination/Integration Professionals

Task 1: Develop Site Visit Plan

Environmental Scan

Preliminary Site List

Final Site List

Site Selection Criteria

- Relevance to multiple themes
- Generalizability
- Operational maturity
- Scope and scale
- Successful implementation
- Diversity

Trans-provider organizations (UCC, LIT, CHT, VCCI, CIT. ACO)

Institutional Providers

Individual Providers

Geography/ Demographics

Task 1: Develop Site Visit Plan

- Deliverables
  - Draft Site Visit Plan detailing the final list of proposed sites by October 9, 2015 *(informed by discussion with Vermont on suitability of sites in weeks preceding)*
  - Final Site Visit Plan 7 days after comments on draft received

Task 2: Conduct Site Visits

- Pre-work:
  - Schedule efficiently
  - Develop semi-structured discussion & focus group guides and customize to sites
  - Train research team
- Travel to conduct interviews, focus groups
- Record, transcribe, subject transcripts/documents to formal qualitative analysis (NVivo)
  - Inductive process generates findings
- Theme-specific qualitative reports after site visits

Task 3: Provider Surveys

- Mail/web hybrid protocol, two distinct samples
  - Physicians and care coordination/integration professionals
  - Limited question overlap possible across samples
- Minimize time burden (< 20 minutes)
- Goal is to test generalizability of qualitative findings
  - Qualitative findings drive survey question development

Task 3: Provider Surveys

- Samples
  - All physicians (N ≅ 1900), expected response rate 35%
  - All care coordination/integration professionals (N ≅ 500), expected response rate 45%
- Protocol
  - Launch pre-notification campaign through existing channels prior to sending out pre-notification letter
  - Pre-notification letter (including “key” to web survey)
  - Mail and follow-up in 3 rounds + reminder phone calls

Task 3: Provider Surveys

- Deliverables
  - Draft survey instruments by January 27, 2017
  - Final survey instruments by February 28, 2017
  - Field reports weekly while surveys are being fielded (TBD)

Task 4: Reporting

Just-in-time Reports

- 6 monthly short reports
- Emergent findings from site visits
- VT feedback useful in refining interpretation of data
- **January-June 2016**

Interim Reports

- 3 reports
- Theme-focused
- Summative within qualitative data
- **October 2016**

Final Report

- One report
- Integrates qualitative & quantitative findings by theme
- **July 2017**

Issue Briefs

- Up to 3 briefs
- Topics of Vermont's choosing
- 2-3 page non-technical summaries for wide dissemination
- **July 2017**

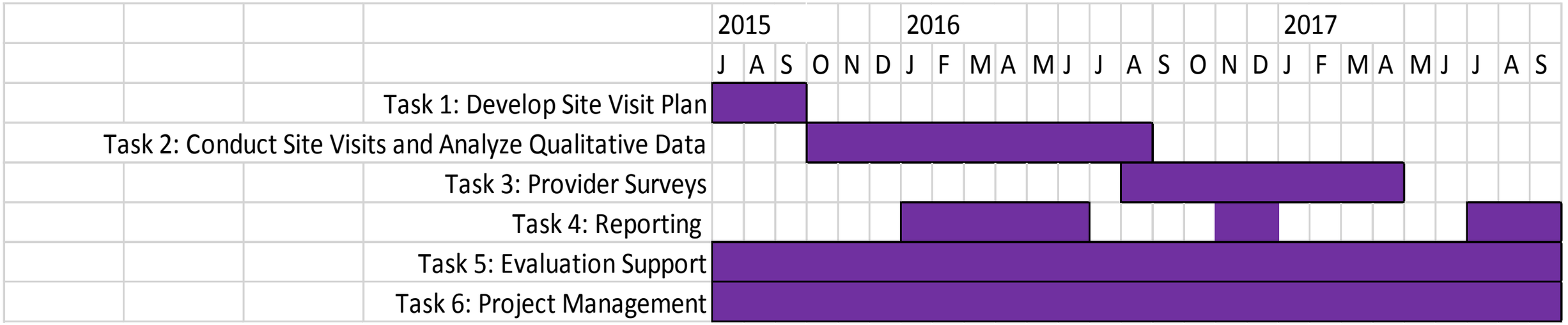
Task 5: Evaluation Support

- Extend and enhance Vermont's self-evaluation capacity
  - Attend and provide analysis of meeting proceedings (ACO, sub-grantee)
  - Review of sub-grantee evaluation synthesis & dissemination plan + products
  - Other duties as assigned

Task 6: Project Management

- As detailed in the already-approved Management Plan
- We remain flexible to meet changing needs
- Deliverables
  - Revised management plan by July 22, 2015
  - Monthly progress reports

Proposed Task Structure & Timeline



4. QUESTIONS & DISCUSSION

1 BACKGROUND

1.1 State Innovation Model Initiative

Created by the Patient Protection and Affordable Care Act (ACA), the Center for Medicare & Medicaid Innovation (CMMI) supports the development and testing of innovative health care payment and service delivery models. On April 1, 2013, CMMI awarded cooperative agreements to six states, including the State of Vermont, to design and implement a statewide health care innovation plan intended to accelerate over a four-year period health care transformation with the goal of achieving higher quality health care, improved health, and lower health care costs.

The overarching goal of the program, referred to as the State Innovation Model (SIM) Initiative, is to test whether new payment and service delivery models will produce superior results when implemented in the context of a state-sponsored Health Care Innovation Plan.[1] SIM Initiatives are comprised of two complementary components:

- **State Innovation Models**. Comprehensive approaches to transforming the health system of a state that include new payment and delivery models as well as a broad array of other strategies to improve population health.
- **Payment and delivery models**. Specific models, such as accountable care organizations (ACOs), patient-centered medical homes (PCMHs), or other integrated care models, that when combined with new payment methodologies can reward the provision of better care and health improvements at lower cost.

The SIM initiative is based on the premise that Governor-sponsored, multi-payer payment and delivery models that have broad stakeholder input and engagement, and set in the context of broader state innovation, will achieve sustainable delivery system transformation that significantly improves health system performance. The SIM Initiative tests whether State Governors and their executive agencies, working in collaboration with key public and private stakeholders and CMS can accelerate community-based health system improvements, with greater sustainability and effect, to produce better results for Medicare, Medicaid, and CHIP beneficiaries.

1.2 Vermont Health Care Innovation Program

Vermont's SIM grant project, referred to as the Vermont Health Care Innovation Program (VHCIP), is expending $45 million in SIM grant funds to promote the "Triple Aim" objectives

[1] State Innovation Models Initiative: Round Two Funding Opportunity Announcement (FOA) http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf

through the transformation of the State's volume-driven delivery system to one that is value-driven.

1.2.1 VHCIP Overview

As shown in the evaluation's logic model in Exhibit 1, VHCIP strives to increase provider-level accountability for cost and quality, monitoring and assessment of cost and quality, sharing of health information across settings, and management of population health. To achieve these outcomes, VHCIP is supporting the design, implementation, and evaluation of a variety of activities and implementation resources that build upon the State' health insurance reforms and experiences gained as an early adopter of innovative delivery and payment models. These activities are organized around three focus areas:

Using financial incentives to promote value-based care – VHCIP is supporting the development and implementation of new payment models that promote the creation of a delivery system that strives to reward the efficient provision of high quality health care. As a part of this work, organizations are involved in strengthening performance-based payments to Blueprint PCMHs, testing three ACO models, and providing analytic support for the future development of episode-based bundled payments.

Facilitating care coordination & integration – VCHIP is supporting the creation of a delivery system that provides more integrated and coordinated care. By providing care that involves both the clinicians, patients and other support services in the coordination and management of care, Vermont hopes to capitalize on opportunities to improve care and reduce costs in areas such as decreases in readmissions and reducing overuse of testing and procedures.

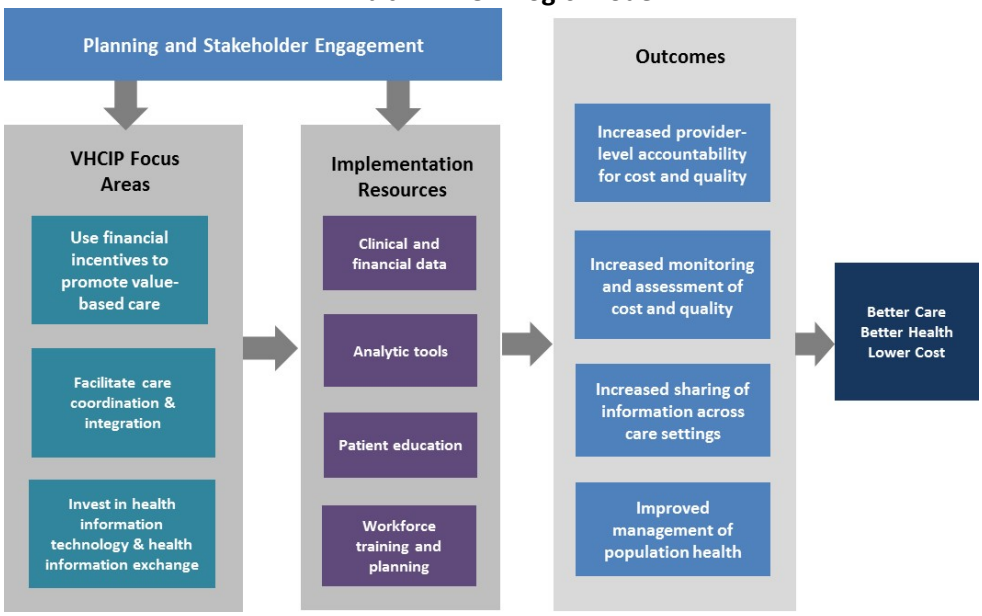
Investing in health information technology & health information exchange – VHCIP is supporting the construction of an interoperable system through which providers input, extract, and exchange electronic health information to support optimal care delivery and population health management. Investing in this technology and data infrastructure has potential effects on health care processes such as more timely delivery of appropriate care and avoidance of unnecessary duplication of imaging and testing.

To support transformation, VHCIP is also supporting a variety of activities intended to provide the information and tools needed to deliver and manage care in a system that holds provider organizations accountable for cost and quality.

- *Clinical and financial data* – Activities that support the improved collection, transmission, and reporting of clinical and financial data;
- *Analytic tools* – Activities that identify, evaluate or use tools to collect, analyze and/or report clinical and financial data and to define and manage episodes of care;

- *Patient education* - Activities undertaken to teach the patient how to improve their health status; and
- *Workforce training and planning* – Activities geared towards workforce/employee planning and training that seek to improve care, coordination, quality and cost.

Exhibit 1: VHCIP Logic Model[2]



In designing and targeting VHCIP-sponsored initiatives and implementation support resources, health reform leaders have prioritized poor and medically vulnerable Vermonters, many of whom are elderly and have disabilities and/or chronic illnesses. Closing gaps in care for these state- and federally-vulnerable individuals will result in improved health and quality of life as well as cost savings that benefit all Vermonters.

During the first year, VHCIP supported capacity-building activities by implementing project governance procedures, initiating operations and developing structures and processes for promoting stakeholder engagement. In its second year, VHCIP is focusing on preparing for the transition from a shared savings to a capitated, population-based payment model. In addition to activities focused on laying the groundwork for analyzing and reporting provider performance data and building a unified, regional system of care management, VHCIP is engaged in a focused program of sub-grants to support HIE capacity, innovative demonstrations and other activities aligned to its three focus areas.

[2] Exhibit 1 updates the logic model presented in the 2014 VHCIP Operational Plan submitted to GMCB October 2014.

1.2.2 The Vermont Context

These activities are being implemented within a state that has a strong foundation and leadership for health reform. Vermont is a mainly rural state, with fourteen acute care hospitals and a wide range of independent physicians. The state, facilitated through Act 48 in 2011, embarked on a move away from volume-based payment by testing innovative payment and healthcare service delivery models that will lead to better health and behavioral health care for individuals, better health for populations, and better control of growth in health spending. As detailed in Act 48, these payment reforms are expected to align with, and build on, the Blueprint for Health and the statewide health information technology plan and clinical registry, and emphasize coordinated patient care. The Green Mountain Care Board (GMCB), the entity charged with broad authority to implement health reform, implemented several pilot innovations upon which SIM activities are built. Another key feature of Vermont's foundation for health system reform is Blueprint for Health, which has transformed the delivery of primary care through payment reform and the establishment of Community Health Teams.

1.2.3 VHCIP Self-Evaluation

Terms of the federal SIM grant require two evaluations: one conducted by the federal government and another conducted by the state. IMPAQ International, LLC (IMPAQ) has been selected by the state of Vermont to conduct the state evaluation. IMPAQ and its partner Brandeis University (the IMPAQ Team) will design and implement Vermont's self-evaluation plan. Additionally, IMPAQ will collaborate with Vermont staff, stakeholders, the federal evaluation contractor (Research Triangle Institute) and CMMI to minimize duplication of evaluation efforts, reduce burden on project participants and support the development of actionable evaluation results for Vermont. The self-evaluation has two primary goals:

1. Provide timely feedback to inform mid-course corrections in the implementation and operation of VHCIP sponsored-initiatives, and
2. Generate actionable recommendations to guide Vermont state-leadership's decisions to scale-up and diffuse VHCIP-supported initiatives.

To achieve these objectives, the evaluation team will utilize a mixed-methods approach, analyzing a complementary combination of qualitative and quantitative data. Qualitative data will be obtained from document reviews and key informant interviews conducted with strategically-selected VHCIP leaders, system- or sub-system level leaders (e.g. ACOs, unified community collaboratives), practice managers and administrators, and frontline care providers. The quantitative portion of the work will use two surveys of frontline care providers to assess how generalizable qualitative findings.

1.2.4 Research Questions

Based on discussions with VHCIP leaders on their priorities, the IMPAQ Team's knowledge of VHCIP-focused activities and a thorough feasibility assessment, we propose that the following research questions guide the VHCIP self-evaluation. The questions are organized into three themes that were identified as high priority by VHCIP and GMCB leaders: Care Coordination, Use of Clinical and Economic Data to Promote Value-Based Care, and Payment Reform. The proposed research questions cover all three of the VHCIP logic model focus areas as summarized in Exhibit 1 (on page 3).

Care Integration and Coordination. Care integration and coordination are key features of many SIM activities, and a major activity contributing to the goals of improving patient experience, improving population health, and reducing the per capita cost of health care. The majority of health spending is driven by patients with multiple conditions, multiple providers, and complex care needs. Nationally, there is a growing literature that defines frameworks for care integration and coordination, and recommends measures for assessing its effectiveness.[3] Across Vermont, care integration and coordination supported by the SIM grant takes a variety of forms, including, for example, identifying, reaching out to, and offering enhanced services to vulnerable populations at risk of admission to a nursing home; coordinating care for patients with particular diseases across a spectrum of social service and medical providers; improving care transitions to avoid hospital readmissions; and in some cases building on activities of existing community care teams. These models vary, but understanding the features of each that are most effective is critical to guide scaling up of care integration and coordination. The following research questions will inform Vermont in directing SIM activities in this area:

1. What are key examples of care coordination/integration approaches being tested/implemented across the state?
2. What are the key characteristics of each approach in the sites that are studied, and how do they vary in evidence base, design, setting, focus, resource utilization, and cost, and in comparison to national care models?
3. What evidence is available to demonstrate effectiveness of each approach? How solid is the evidence? What are the key lessons learned from each?
4. What environmental and organizational features enhance care coordination/integration approaches? What features result in barriers?
5. Based on resources, cost, and perceived success, which appear to be most suitable for scaling up?
6. What information do health care providers (physicians, nurses, care coordinators, social workers, others) need from other providers/care settings in order to provide high

[3] Agency for Health Care Research and Quality, *Care Coordination, Overview and Literature Review*. (http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html; http://integrationacademy.ahrq.gov/literaturecollection). Collins C, Hewson DL, Munger R, Wade T. *Evolving Models of Behavioral Health Integration in Primary Care.* New York, NY: Milbank Memorial Fund;2010.

quality, coordinated and integrated care? How available, timely and high of quality is this information?

Use of Clinical and Economic Data to Promote Value-Based Care. Data play a pivotal role in Vermont's efforts to transform its health system through VHCIP. Various project activities use clinical and cost data in different ways: to inform providers, for internal and external monitoring, for quality improvement, for payment, and to identify opportunities for efficiency. Clinical and cost data are shared with various audiences and come from a variety of sources including VHCURES, automated extracts from EMRs, and manual abstraction of medical records. The high data flow occurs in an environment that places numerous competing demands on providers, including tracking an ever-changing regulatory environment, running a business, providing compassionate, coordinated care and complying with a long list of reporting requirements. Examples of such data include: regular reports sent to providers with information to identify high cost conditions and target outreach and education; cost information regarding hospitalizations and hospital readmissions; services where utilization and spending vary across regions or providers, thus identifying opportunities for gaining efficiency; and quality metrics that inform clinical care.

However, data is not always perceived by providers as interpretable or actionable. The way in which providers interpret, trust, and use data is important to know in order to provide necessary content in a user-friendly format. For this theme, we will visit practices to examine the process of producing, communicating and sharing data in support of transformation, as well as how these data are received, understood and applied by providers. The research questions outlined below will guide the evaluation for this theme:

1. What data are being communicated, by whom, how are they being communicated (and through what intermediary structures) and for what purposes are they being communicated?
2. What assistance or support is provided to those intended to use data?
3. How are data being received, understood and applied?
    a. Are the right data being communicated?
    b. What do providers perceive as most and least useful about the processes and data shared? What elements are most and least useful to improve patient care and practice efficiency? Do the data contain information that providers want and think they can make use of?
    c. How could the content or communication mode of the data be modified to make it coincide more closely with provider needs and allow effective provider responses?
    d. What data-related burdens or redundancies do providers/practices cite?

Payment Reform and Financial Incentive Structures. In the early phases of VHCIP implementation, physicians are operating in a system which simultaneously employs multiple—and likely intersecting—payment models and financial incentive structures. These models may

include capitated, fee-for service and/or shared savings payments. As VHCIP accelerates Vermont's health system transformation, the variety of payment models and incentives confronting providers is likely to become yet more complex, adding additional models and incentives even while fee-for-service payment remains in place for some care. For this theme, the following research questions will guide the project:

1. Under what financial incentive structure(s) do providers practice in Vermont?
    a. How do providers view the current incentive structure(s) under which they practice? Why?
    b. What changes, if any, have taken place in the way providers practice as a result of these incentive structures?
    c. How do attitudes toward incentives and changes providers have made in practice (if any) differ across provider types (primary care, specialty care), practice sizes (solo, small and large group), and ownership (hospital-owned vs independent).
2. What further adaptations at the practice and provider level do providers anticipate in the transition to next generation payment models, such as shared savings with downside risk, episode-of-care based payment, and global budgeting? What additional support or technical assistance do providers anticipate needing in making this transition?

Research Questions and Logic Model Focus Areas. Exhibit 2 summarizes the relationship between research themes and VHCIP logic model focus areas. Both the payment reform and use of clinical and economic data themes directly address efforts to promote value-based care in Vermont. The care coordination/integration theme has an obvious linkage to the logic model's focus on facilitating care coordination/integration but also addresses health information exchange (HIE) due to the importance of having the information necessary to provide optimal care accessible to the right people at the right time. The HIE emphasis is reflected in the research questions proposed for the Care Coordination/Integration theme.

Exhibit 2: Mapping of Proposed Research Questions to Logic Model Focus Areas

	Logic Model Focus Areas		
Research Question Themes	**Promote Value-Based Care**	**Facilitate Care Coordination/ Integration**	**Invest in HIT and HIE**
Care Coordination/Integration		X	X
Use of Clinical and Economic Data to Promote Value-Based Care	X	X	
Payment Reform	X		

1.3 Task Structure

We propose to address the research questions summarized in Section 1.2 through a project structured around six tasks, summarized in Exhibit 3. Section 2 of the document details the IMPAQ Team's proposed approach to each task.

Exhibit 3: Proposed Task Structure

Task	Deliverable(s)	Deliverable Timeline
Task 1: Develop Site Visit Plan Conduct environmental scan and background research to definitively identify sites that will be visited or interviewed by phone as part of Task 2.	Draft Site Visit Plan Final Site Visit Plan	October 9, 2015 7 days after receiving written comments on draft plan
Task 2: Conduct Site Visits and Analyze Qualitative Data Execute the approved site visit plan by visiting or conducting phone calls with sites, performing analysis of qualitative data.		
Task 3: Provider Surveys Identify key ideas from the findings developed as part of Task 2 and assess whether the findings are typical in statewide surveys focused on 1) uses of data for transformation among physicians/providers and 2) strengths and challenges related to care integration/coordination	Draft survey instruments Final survey instruments Field reports	November 28, 2016 December 19, 2016 Weekly while surveys are being fielded (TBD)
Task 4: Reporting Provide a comprehensive written report summarizing and integrating findings from Tasks 2 and 3	JIT Reports Draft Interim Reports Final Interim Reports Draft final report Final report	Monthly from January-June 2016 October 17, 2016 November 14, 2016 July 24, 2017 August 14, 2017
Task 5: Evaluation Support Support the Vermont SIM Self-Evaluation as directed by the Evaluation Director, including reviewing plans for synthesizing and disseminating findings, documents summarizing self-evaluation findings generated by Vermont, attending and conducting analysis of meetings (ACO, sub-grantee meetings)	As requested	As requested
Task 6: Project Management Ensuring the self-evaluation is completed on time, within budget and within scope	Revised Management Plan Monthly Progress Reports	July 22, 2017 Monthly on the 18th

2 APPROACH

2.1 Task 1: Develop Site Visit Plan

The IMPAQ Team proposes to complete 20 in-person site visits through a total of six one-week trips to Vermont to be made between November 2015 and June 2016. Each trip will involve from 3-5 visits to different sites (e.g., a physician practice, Community Health Team office, ACO administrative office, Unified Community Collaborative meeting) identified as relevant to the self-evaluation. Site visits will be supplemented by 10 additional hour-long phone conferences with moderate priority sites or sites we are not able to schedule for in-person visits.

The specific sites to be visited or scheduled for phone conferences will be identified through the following three-step process:.

1. *Environmental Scan.* We will collect and review Vermont-specific information related to each of the three research themes. For the care coordination/integration theme, for example, we would want to identify, collect and review materials from the published and grey literature that are related in any way to care coordination or care integration in Vermont. We will also review the list of VHCIP activities that served as the basis for the literature review/best practices issue brief. Conversations with VHCIP leaders or other individuals with expertise related to any of the three research themes will be combined with review of relevant documents.
2. *Develop a preliminary list of sites.* Based on interviews with VHCIP leaders and the environmental scan, the IMPAQ Team will develop a preliminary list of sites to consider. Where there is doubt as to appropriateness of a site we will err on the side of inclusion and formally assess its suitability later, as summarized below. The preliminary site visit list will be shared with VHCIP leaders in order to assess if any essential sites have been omitted or whether any sites known to be unsuitable have been included.
3. *Identify a final set of sites to be visited.* The IMPAQ Team will review the preliminary list of sites and select a final set of candidate sites based on the following criteria:
    - Relevance to multiple research themes: We will favor sites where we can conduct discussions that are relevant to more than one research theme. For example, we would favor a primary care practice that has an innovative care management model and also participates in OneCare Vermont's clinical and economic data communication over a practice that has a key feature that addresses one theme alone. Selecting sites in this way will make the most efficient use of travel time and resources by enabling us to ask questions across multiple research themes to multiple informants at the same site.

- Generalizability: Does the site have the potential to yield findings that are broadly applicable or is the site unique in many ways that would limit generalizability?
- Operational maturity: Has the site been in place long enough to yield experiences that informants can reflect upon?
- Scope and scale: Is the site involved in programs or activities that are intended to reach a large portion of Vermont residents?
- Successful implementation: Has the site had at least some success in the programs or activities with which it is involved?
- Diversity: We will work to ensure that sites selected for visits represent the diversity of activities that are taking place in Vermont both in and out of the SIM initiative. At a minimum we will consider sites across the following categories:
    - **Trans-provider organizations.**
        - Unified Community Collaboratives, Local Interagency Teams or other interdisciplinary teams that drive care and service coordination at the policy level.
        - Community Health Teams, Vermont Chronic Care Initiative, Children's Integrated Services teams and other interdisciplinary teams that drive care and service coordination at the individual case level
    - **Institutional Providers**
        - Hospitals
        - Long term care facilities
    - **Individual Provider Practices**
        - Primary care practices and specialist practices
        - Small independent practices and larger hospital-owned practices
        - PCMH and Non-PCMH
        - ACO participant and non-participant
        - Heavy VHCIP and/or Blueprint involved and no involvement
        - High performing practices and underperforming practices
        - PCMHs with unique approaches to coordination/integration of behavioral health, substance abuse, alternative health and/or other multi-disciplinary care coordination
    - **Geography/demographics**
        - Across HSAs
        - Rural/urban
        - Serving low socio-economic status (SES) and non-low SES Vermonters

DELIVERABLES

- The IMPAQ Team will provide a Draft Site Visit Plan detailing the final list of proposed sites to be visited by October 9, 2015.
- Within 7 days of receiving written feedback from Vermont on the Draft Site Visit Plan, the IMPAQ Team will provide a Final Site Visit Plan.

2.2 Task 2: Conduct Site Visits and Analyze Qualitative Data

2.2.1 Schedule Site Visits

Site visits will be scheduled with the goal of minimizing travel time and expense. After Vermont approves the final site visit plan we will first identify a rough sequence of trips that will permit us to consolidate visits to sites that are reasonably close to each other. For example, if there were four sites between Burlington and Montpelier included in the final Site Visit Plan, we would identify a tentative window of 2-3 weeks during the field period where a trip to that region might occur. After a window has been identified, we will reach out via telephone to contacts at each site to ascertain availability for the personnel with whom we need to meet. Where availability of the majority of interviewees does not match with the tentative site visit window, we will adjust the window as necessary.

2.2.2 Conduct Site Visits

Once the schedule has been finalized, we will prepare to conduct the site visits. In addition to arranging for logistical details such as travel and a community-based (library, community center) location for any focus groups, we will prepare site- and interviewee-specific interview guides based on the research themes appropriate to the site. For example, at a large primary care practice that participates in an ACO and participates in a VHCIP-funded care model project, we would likely draw from the care coordination, data use and payment model themes. Interview guides will be further customized by interviewee type. A practice manager interviewee, for example, would be unlikely to get detailed questions on the adequacy of clinical data exchange for care coordination/integration while a social worker involved in coordinating community services on hospital discharge would be unlikely to get detailed questions on the impact of financial incentives on clinical practice.

Develop Interview Guides. Following initial meetings with State staff, the IMPAQ Team will develop draft interview guide(s) for each site visit. Semi-structured interview protocols will employ the Lofland and Lofland model.[4] In this model a series of relatively broad questions are asked of each respondent and they are encouraged to provide what information on the subject that they see as most important. In this way it is possible to solicit information that might be missed by a more narrowly constructed instrument. It also allows us to determine what the respondents believe are more important of the factors we wish to explore, rather than imposing the interviewers' priorities on them. Finally this allows unanticipated issues to be revealed which may be added to the protocol in subsequent interviews.

We will prepare our broad questions with a number of "probe questions" that reflect key theories underlying the analysis. This will allow us to address issues of specific interest identified by Vermont. We will not ask probe questions if the respondent spontaneously

[4] Lofland, J. and Lofland L. "Analyzing Social Settings", University of California, Davis 1995

provides the information sought. However, if that information is not provided, we will ask the questions. This allows the research to benefit from both a semi-structured interview model, which allows maximum input from knowledgeable respondents, and the consistency and completeness of information characteristic of a more structured interview questionnaire.

All IMPAQ Team members who will participate in one or more site visits will receive training on how to use the interview guides, proper procedures for gaining consent to record interviews, and on expectations for note taking.

Conduct Interviews. The majority of interviews will be conducted by one senior and one junior team member. The senior member will lead the interviews and the junior member will serve as note taker. In isolated circumstances, scheduling constraints may require a team to split up to conduct two interviews simultaneously. Where no note taker is present, we will ensure that any interview conducted by junior staff is recorded and reviewed the same day by the senior staff on the site visit. Where discussion exceeds the time available for the interview and the interviewee is interested in sharing more observations, a follow-up phone call will be scheduled at a mutually convenient time. Where last-minute scheduling conflicts prevent an interview from occurring, a follow-up phone call will be scheduled to collect data as soon as possible after the team returns home.

Develop discussion guides for focus groups. In addition to the key informant interviews we plan to conduct on the site visits, we have budgeted for two care-coordination focus groups to be conducted with Vermonters whose lives have been affected by care coordination, broadly defined. We will develop discussion guides for these groups based on the IMPAQ Team's knowledge of the relevant literature and of the care coordination/integration landscape in Vermont.

Recruit for focus groups. Participants will be recruited by the IMPAQ team using a list of names and contact information obtained from staff of one or more car coordination/integration sites which we visit. We will send a pre-notification letter on IMPAQ, state or program/practice letterhead as is most appropriate inviting the individual to attend the group and confidentially share their experiences. Members of the IMPAQ Team will call each potential participant to explain the purpose of the group, to answer any questions and to secure participation in the group. Individuals who agree to participate will receive a confirmation letter with details on time, date and location within 7 days of expressing a willingness to participate and a phone call from an IMPAQ Team member the night before the focus group.

Conduct focus groups. We will conduct focus groups in the late afternoon or early evening in a library or community center conference room that is within 30 minutes driving time for each prospective participant. We will provide light refreshments for each group and limit the group to between 90 minutes and 2 hours total duration. Each group will be led by an experienced moderator and a note-taker. With participants' permission, the proceedings will be recorded and transcribed for qualitative analysis.

2.2.3 Qualitative Data Analysis

Data Sources and Coding. For coding and sorting of data, IMPAQ will use N-Vivo version 10.1. We will load transcripts of interviews and focus groups conducted during site visits into NVivo for coding. If our site visits yield planning documents or internal memoranda that are relevant to the discussions conducted with key informants, these will also be loaded into NVivo for analysis.

Coding of textual materials will take place in several steps. All interview or focus group transcripts will first undergo a structural coding, intended to identify text associated with a particular question in the interview guide[5]. Subsequent to structural coding, all transcripts and other documents will be subject to advanced systematic coding and analysis.[6] This approach is compatible with the systematic structural coding that will have already been applied to the transcripts and also with a grounded theory approach. Grounded theory utilizes an iterative, inductive and deductive process and places great value on simple systematic procedures to allow emergence of findings or themes from qualitative data.[7]

During the initial coding phase, the IMPAQ Team will review transcripts to develop codes and categories, and to identify emergent themes. We will then apply open coding to larger segments of text. During axial coding, we will note possible relationships between codes and code groups and develop descriptive subcodes and categories. Through constant comparative analysis, analysts may refine, restructure and reapply codes until saturation is reached. Saturation will be assessed in real time and is defined as the point in the coding process where new codes/themes no longer emerge from transcripts. As themes are identified and codes established they will be shared with the PD and IMPAQ Team members who participated in site visits for review and agreement.

Analysis. Coded and sorted analysis files from NVivo will be shared with the entire IMPAQ Team and will serve as the basis for creating written reports. Report authors, drawn from the Team's senior staff, will review the codes most commonly assigned to transcripts to develop an idea of key themes or findings which emerged from the interviews and focus groups. Where possible, themes will be compared across different types of sites (small vs. large practices, primary vs specialty care, Community Health Teams staff vs provider office-based care coordinators). Quotes from interviews that effectively illustrate key themes will be extracted from transcripts to enhance the written report.

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[5] Guest, G. and MacQueen, K.M. (2008) Handbook for Team-Based Qualitative Research. Rowman & Littlefield Pub Incorporated, Washington DC.

[6] Boeije, H. (2002) A purposeful approach to the constant comparative method in the analysis of qualitative interviews. Quality & Quantity, 36, 391-409. doi:10.1023/A:1020909529486

[7] Strauss, A., J. Corbin (1998) Basics of qualitative research: techniques and procedures for developing grounded theory.[Sec.ed.] London: Sage

2.3 Task 3: Provider Surveys

The evaluation team will design and field two mail-to-web surveys to document the experiences and perceptions of frontline care providers. One survey will focus on primary care and specialty physicians and another will focus on providers involved in care coordination/integration activities (possibly including CHT staff, social workers, case managers and others to be determined). The survey effort will generate generalizable and consistently measured perspectives related to each of the research themes included in the self-evaluation. Each survey instrument will draw from and complement the qualitative findings generated as part of Task 2 that provide in-depth information from a relatively small number of individuals acting in a diverse array of roles and settings.

While a provider survey is planned as part of the RTI national evaluation of the SIM program, it is not well-positioned to meet Vermont's needs for the self-evaluation. In addition to an expected response rate of 5%, there are indications from CMMI that state-level survey responses will not be shared. The surveys proposed as part of the self-evaluation are designed to achieve a higher response rate and directly address the topics of primary concern to VHCIP leaders.

2.3.1 Survey Development

Two separate survey instruments will be developed, one for physicians and one for providers engaged in care coordination/integration. While the surveys will be targeted at distinct audiences and consist of different questions, there may be some overlap between the two instruments related to the care coordination research theme which is relevant to both target audiences.

In order to minimize respondent burden, the instruments developed by the IMPAQ Team will be designed to be completed in no more than 15 minutes. Each survey will begin with a short introduction describing the purpose of the survey, the role of the IMPAQ Team, and a statement regarding the confidentiality of responses. Each survey will contain roughly 20-30 questions depending on the length and complexity of the items. Questions will be developed by the IMPAQ Team based on findings that emerge from Task 2. Related to care coordination/integration, for example, we might find that lack of access to high speed internet is a challenge to effective coordination of care cited by informants across a number of sites. This finding could be developed into a closed-ended survey item that asks respondents to agree or disagree with the statement "Lack of high speed internet makes it hard to provide the best possible care for the patients I serve." Questions in both surveys will be designed to be broadly applicable to the population of respondents rather than targeting topics likely to be of concern only to a minority of respondents. Where possible, we will adapt items from established survey instruments whose reliability and validity is known.

Each survey instrument will be carefully pre-tested before being fielded. We will conduct initial pretests with IMPAQ staff members who are not part of the team. Each survey instrument will

be further tested by 3-5 individuals identified by VHCIP staff who meet the sample criteria (physician or care coordination/integration professional) and are willing to serve as volunteer testers. Phone or e-mail debriefs will be conducted with all respondents participating in testing in order to confirm that the questions are being interpreted as intended and that the wording of instructions and survey items is clear. The survey will be revised to take into account feedback gained from pilot participants before it is finalized and fielded.

2.3.2 Sample Design

For the physician provider survey, we intend to survey the universe of primary care and specialty physicians in Vermont, a total of approximately 1900 providers.[8] With the assistance of VHCIP leaders, we will request physician contact information from the Vermont Department of Health licensing database.

The care coordination/integration survey design will also focus on the universe of care coordination/integration providers, based on the operational definition of care coordination/ integration established as part of the site visit plan. For budget purposes, we have estimated that a total of 500 care coordination/integration providers will be surveyed.

2.3.3 Survey Protocol

Both the physician and care coordination/integration provider surveys will be administered following the same protocol. The distribution of the survey will be preceded by communication through existing channels (existing email distribution lists, provider professional association newsletters) to announce that a survey is forthcoming and to emphasize the importance of responding so that everyone's opinions can be recorded.

The survey will be distributed through a hybrid mail/web strategy designed to enhance response rates among busy professionals. Respondents will first receive a USPS Priority Mail envelope containing a letter on State of Vermont letterhead signed by a State official. The letter will explain the purpose of the survey, request the respondent's participation, and provide a link to the web-based survey along with a unique token code to associate the respondent's answers with their identity in the sample file. Non-responders will receive additional follow-up with a second letter and paper questionnaire provided approximately three weeks after the initial mailing, a postcard reminder five weeks after the initial mailing and another letter/questionnaire approximately seven weeks after the initial mailing. The follow-up protocol also includes up to two reminder phone calls placed to each non-respondent.

[8] http://healthvermont.gov/research/HlthCarePrvSrvys/documents/phys10bk.PDF

2.3.4 Survey Analysis

Survey analysis will focus on descriptive and comparative techniques subject to the limitations of response rates. For example, we expect to be able to compare attitudes and experiences of primary care providers who participate in Blueprint with those who do not participate in Blueprint, and to be able to compare responses from care coordination/integration providers who practice in rural communities to responses from those who practice in urban areas.

DELIVERABLES

- Draft survey instruments by January 27, 2017
- Final survey instruments by February 28, 2017
- Field reports weekly while surveys are being fielded (TBD)

2.4 Task 4: Reporting

The goal of reporting of results of the evaluation will be to provide Vermont feedback in a variety of ways to meet short-term and longer-term information needs. While the site visits are in progress, we will share emergent findings though a series of monthly "Just-in-Time" reports. After the site visits have concluded, we will summarize qualitative findings in a series of theme-based interim reports. Near the end of the project, we will summarize overall evaluation findings and provide recommendations to VHCIP leaders through a final report.

2.4.1 Just-in-Time Findings Reporting

The evaluation team will communicate preliminary findings through "Just-in-Time" (JIT) reports. JIT reports are provisional in nature and provide a vehicle for disseminating actionable, high-interest findings from qualitative investigations and trend analyses. The aim of JIT reporting will be to provide timely information that may be helpful for program modification, expansion and/or replication. It is important to recognize that the reporting of qualitative findings are constrained by the need to protect the confidentiality of key informants. This will place some limits on report format, but it is a practical necessity to ensure candid responses to what may sometimes be sensitive questions.

JIT reports will be presented as written memos and presented verbally at Monthly Vermont SIM leadership meetings. The JIT format will be the primary vehicle through which the IMPAQ Team will provide timely feedback to site visit participants and the opportunity for site staff to ask clarifying questions. Our goal is to communicate in a JIT format at least monthly while site visits are ongoing to generate findings of broad interest to VHCIP leaders and stakeholders. The format will also provide opportunity for the evaluation team to use feedback shared by the audience to refine their interpretation of their findings and, in the early phases of the evaluation, to inform refinements in site visit interview guides and survey questionnaire design.

2.4.2 Interim Reports

After the completion of site visits and qualitative analysis that pertains to a particular theme, the evaluation team will generate Interim Reports (IRs) that address findings for each theme. IRs will extend and refine information communicated through JITs by summarizing and synthesizing a wider range of findings and incorporating accumulated feedback to inform implications for on-the-ground practice.

IRs will be submitted to the GMCB Evaluation Director in draft form and will be finalized based on comments and suggestions provided by VHCIP leaders and relevant stakeholders. IRs will be formatted in a manner suitable for dissemination to CMMI and other State-level stakeholders. It is our intention to finalize each IR within 30 days of receiving written feedback on the initial draft. IR content will be presented (in either final or draft form) in a Power Point format in Monthly Progress updates or in-person to broader stakeholder audiences or through IMPAQ-hosted webinars, as requested and scheduled by the GMCB Evaluation Director.

2.4.3 Final Report and Issue Briefs

Following the final phase of the self-evaluation, the IMPAQ Team will provide a high-level summary of the evaluation methodology, a summary and synthesis of key findings, and a set of findings-based recommendations in a final report (FR). The FR will be submitted to the GMCB Evaluation Director in draft form and be finalized based on comments and suggestions provided by VHCIP staff and relevant stakeholders. The FR will be formatted in a manner suitable for dissemination to CMMI and other State-level stakeholders. To maximize accessibility to a broad audience of stakeholders, the findings and recommendations presented in the FR will be organized around the three research themes proposed for the self-evaluation. Findings and recommendations contained in the FR will be presented in an in-person briefing to stakeholder audiences and/or through an IMPAQ-hosted webinar, as requested and scheduled by the GMCB Evaluation Director. In addition, the team will prepare up to three issue briefs based on report content for wider dissemination.

DELIVERABLES

- Just-in-time reports monthly from January 2016 through June 2016
- Draft interim qualitative reports October 17, 2016
- Final interim qualitative reports November 14, 2016
- Draft final report July 24, 2017
- Finalized final report August 14, 2017

2.5 Task 5: Evaluation Support

In this Task, the IMPAQ Team will make team members available to the GMCB Evaluation Director on an as-needed basis to extend and enhance the State of Vermont's capacity to

evaluate various VHCIP activities. To date, members of the IMPAQ team have attended ACO meetings and meetings of VHCIP to serve an additional set of eyes and ears to provide an independent, expert assessment of meeting proceedings and to help contextualize them within VHCIP activities.

Moving forward, the IMPAQ team is available to review and comment on documents related to evaluations conducted of sub-grantee and other VHCIP-related activities. This might include reviewing the State's plan to synthesize and disseminate findings from the evaluations and later to review and comment on documents designed to disseminate findings from the evaluations. Other activities will be performed only at the direction of the GMCB evaluation director.

2.6 Task 6: Project Management

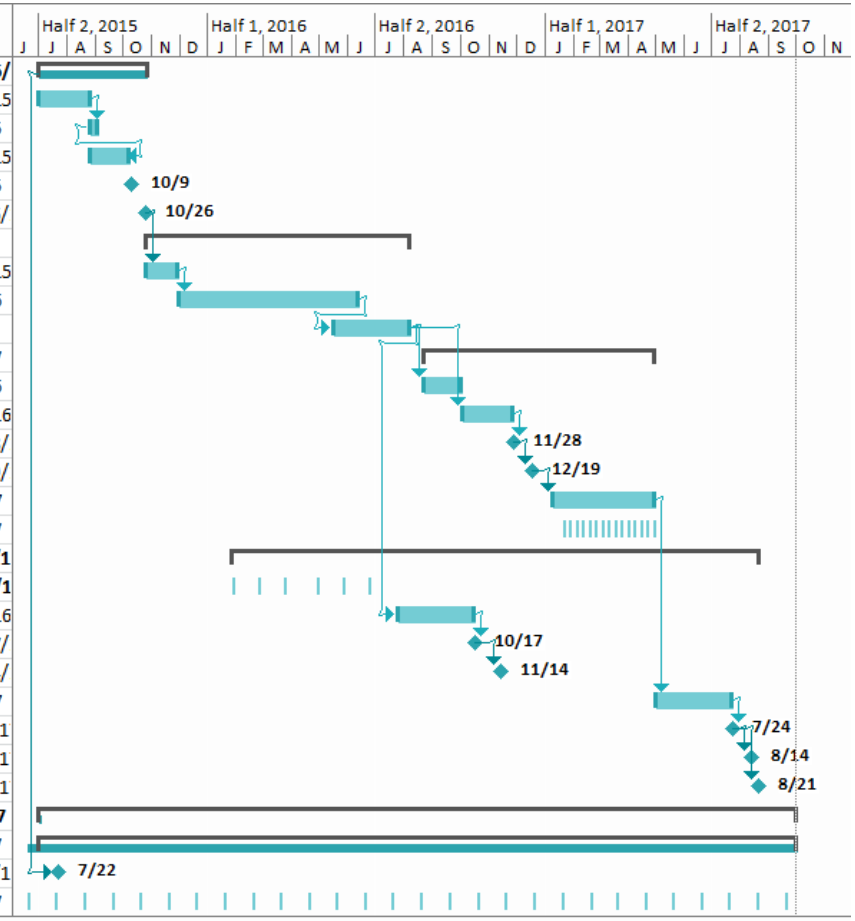
The IMPAQ Team will manage the project as detailed in the Management Plan approved by Vermont in March 2015. A revised Management Plan reflecting the new task structure will be provided to Vermont within 30 days of approval of the self-evaluation design. While the procedures outlined in the Management Plan are meant to ensure a high level of performance, the IMPAQ Team remains flexible and will adjust the management approach should project needs evolve. A proposed high-level work breakdown structure is provided in Exhibit 4.

DELIVERABLES

- Revised management plan by July 22, 2015
- Monthly progress reports by the 18th of each month

Exhibit 4: Proposed Work Breakdown Structure

ID	Task Mode	Task Name	Duration	Start	Finish
1		**Task 1: Develop Site Visit Plan**	**84 days**	**Wed 7/1/15**	**Mon 10/26/**
2		Conduct environmental scan	40 days	Wed 7/1/15	Tue 8/25/15
3		Generate preliminary site list	5 days	Wed 8/26/1	Tue 9/1/15
4		Generate final site list	30 days	Wed 8/26/1	Tue 10/6/15
5		Draft Site Visit Plan	0 days	Fri 10/9/15	Fri 10/9/15
6		Final Site Visit Plan	0 days	Mon 10/26/	Mon 10/26/
7		**Task 2: Conduct Site Visits and Analyze Qualitati**	**205 days**	**Mon 10/26/**	**Fri 8/5/16**
8		Schedule site visits	25 days	Mon 10/26/	Fri 11/27/15
9		Conduct site visits	140 days	Mon 11/30/	Fri 6/10/16
10		Perform qualitative analysis	60 days	Mon 5/16/1	Fri 8/5/16
11		**Task 3: Provider Surveys**	**180 days**	**Mon 8/22/1**	**Fri 4/28/17**
12		Develop survey samples	30 days	Mon 8/22/1	Fri 9/30/16
13		Develop survey instruments	40 days	Mon 10/3/1	Fri 11/25/16
14		Draft survey instruments	0 days	Mon 11/28/	Mon 11/28/
15		Final survey instruments	0 days	Mon 12/19/	Mon 12/19/
16		Field survey	80 days	Mon 1/9/17	Fri 4/28/17
17		**Survey field status reports**	**71 days**	**Fri 1/20/17**	**Fri 4/28/17**
33		**Task 4: Reporting**	**408 days**	**Wed 1/27/1**	**Mon 8/21/1**
34		**Just-in-time reports**	**106 days**	**Wed 1/27/1**	**Wed 6/22/1**
41		Write interim qualitative reports	60 days	Mon 7/25/1	Fri 10/14/16
42		Draft interim qualitative reports	0 days	Mon 10/17/	Mon 10/17/
43		Final interim qualitative reports	0 days	Mon 11/14/	Mon 11/14/
44		Write draft final report	60 days	Mon 5/1/17	Fri 7/21/17
45		Deliver draft final report	0 days	Mon 7/24/1	Mon 7/24/1
46		Deliver final report	0 days	Mon 8/14/1	Mon 8/14/1
47		Deliver issue briefs	0 days	Mon 8/21/1	Mon 8/21/1
48		**Task 5: Evaluation Support**	**589 days**	**Wed 7/1/15**	**Sat 9/30/17**
50		**Task 6: Project Management**	**588 days**	**Wed 7/1/15**	**Fri 9/29/17**
51		Revised management plan	0 days	Wed 7/22/1	Wed 7/22/1
52		**Monthly Progress Reports**	**588 days**	**Wed 7/1/15**	**Fri 9/29/17**



Attachment 5

Financial Requests

Financial Proposals

June 1, 2015

Georgia Maheras, JD

Project Director

AGENDA

1. No Cost Extension Requests:
   - Stone Environmental #28079 to 12/31/15
   - The Coaching Center #27383 to 12/31/15
   - Deborah Lisi-Baker #26033 to 12/31/15

2. HIE/HIT Work Group: Shared Care Plans and Universal Transfer Protocol (SCÜP) Project

No-Cost Extension Requests

- Stone Environmental: Data Inventory (total contract is $120,000)
- Coaching Center: Staff Training (total contract is $15,000)
- Deborah Lisi-Baker: DLTSS Work Group Support (total contract is $55,000)

- All three are funded with federally-approved carryforward dollars, but have contract termination dates in May and June.

HIE/HIT Work Group: Shared Care Plans and Universal Transfer Protocol (SCÜP) Project

- Request from the Work Group :
  - Project to be proposed and approved in two-month waves.
  - Project timeline: June 1, 2015-October 31, 2015
    - This phase: June 1, 2015-July 21, 2015
  - Project estimated cost: $ 177,700
    - This phase: $ 36,500
  - Project summary: This project will provide a technological solution that supports Vermont's providers and caregivers in successfully navigating transitions between care settings.
  - Budget line item: Type 2, HIE/HIT.
- The HIE/HIT Work Group is responsible for exploring and recommending technology solutions to achieve SIM's desired outcomes.

Intent of Contract/Relationship to VHCIP Goals

- *VHCIP's Operational Plan outlines the following tasks:*

HIE/HIT Work Group

This group will build on the work of the work group to date and:

- Identify the desired characteristics and functions of a high-performing statewide information technology system;
- Explore and recommend technology solutions to achieve VHCIP's desired outcomes;
- Develop criteria for a telehealth pilot program and launch that program;
- Guide investments in the expansion and integration of health information technology, as described in the SIM proposal, including:
  - Support for enhancements to EHRs and other source data systems;
  - Expansion of technology that supports integration of services and enhanced communication, including connectivity and data transmission from source systems such as mental health providers and long-term care providers;
  - Implementation of and/or enhancements to data repositories; and
  - Development of advanced analytics and reporting systems.

Scope of Work

- Hire one Business Analyst and contract with one Subject Matter Expert to support requirements gathering and development of the technology proposal.

Attachment 6a

CHAC Proposal

General Information:

Lead Organization Applying: Bi-State Primary Care Association

Collaborating Organizations: in support of Community Health Accountable Care, LLC

Key Contact for Applicant: Kate Simmons, MBA, MPH, Director VT Operations

Relationship to Applicant: employed

Key Contact Email: ksimmons@bistatepca.org

Key Contact Phone Number: 802-229-0002, ext. 217

Key Contact Mailing Address: 61 Elm Street, Montpelier, VT 05602

Fiscal Officer (must be different from Key Contact): Abby Mercer, CFO

Relationship to Applicant: employed

Fiscal Officer Email: amercer@bistatepca.org

Fiscal Officer Phone Number: 603-228-2830 ext 118

Fiscal Officer Mailing Address (if different from Key Contact): 525 Clinton Street; Bow NH 03304

Project Title and Brief Summary:

Project Title (limit to 40 characters):

Furthering Community Health Accountable Care in FY16 and FY17

CHAC is an FQHC-led ACO with a vision to achieve better care for individuals, better health for populations, and lower growth in expenditures in connection with both public and private payment systems. Extension of CHAC's capacity is necessary to maintain adequate staffing, an operating budget, and continue a patient centered telemonitoring program which has already made an impact in the lives of many attributed at-risk patients. A robust analytics solution, including the selection of a vendor and the purchase of visualization software, will enable CHAC to identify opportunities for further clinical and operational innovations at the population and individual provider levels. The outcome will be improved quality and reduced cost of care, particularly for high risk patients.

Budget Request Summary

Budget Category	FY16 7/1/15-6/30/16	FY17 7/1/16-12/31/16	Total
Personnel		$117,059.73	$117,059.73
Fringe		$26,923.74	$26,923.74
Travel		$10,000.00	$10,000.00
Equipment			
Supplies		$4,806.80	$4,806.80
Modified Total Direct Cost	$8,500.00	$23,361.80	$31,861.80
Contracts	$246,500.00	$250,500.00	$497,000.00
Other*	$40,000	$37,830.92	$77,830.92
Total	$295,000	$470,482.99	$764,982.99

*Please see separate budget justification.

Activities for which the applicant is requesting funding

Bi-State, on behalf of Community Health Accountable Care, LLC (CHAC) including the Federally Qualified Health Centers (FQHC) providers, and other community stakeholders are pleased to have the opportunity to request VHCIP funding for the following activities (also found in the workplan):

- Extension of CHAC's capacity until the end of calendar year 2016,
- Extension of CHAC's care management model which includes a tele-monitoring outreach program, and
- Establishment of a claims based analytics system.

Capacity:

To create efficiencies and enable flexibility, CHAC has executed a management services agreement with Bi-State for Bi-State to provide administrative, clinical, financial, and leadership support. Funding from VHCIP will provide partial funding for key Bi-State staff positions in support of the ACO activities, including the ACO Director (Bi-State's Director of Community

Health Payment Systems), Director of Healthcare Informatics, Clinical QI lead (Community Health Quality Manager), Project Manager, Project Coordinator for Payment Reform Implementation, and other partial staff positions to manage this project and support functions of the ACO (FTEs and additional information is provided in the budget). Bi-State was fortunate to receive original funding from VHCIP which became effective July 14th, 2014 and is set to end on June 30th, 2016. With this funding CHAC was able to fulfill the scope of work promised which included:

- Hiring and maintaining appropriate staffing including a Community Health Accountable Care LLC (CHAC) Director and Project Coordinator,
- Executing and monitoring activities, including a quality compliance program, to ensure compliance with CHAC's Medicaid and Commercial Shared Savings Program and regulatory Agreements and requirements.
- Recruiting providers who will participate and collaborate with CHAC.
- Providing leadership for CHAC's activities regarding budget, quality improvement, data repository and reporting services in collaboration with CHAC's senior management staff.
- Reporting for CHAC's Medicaid and Commercial Shared Savings Program Agreements according to schedule.
- Supporting CHAC's Board of Directors Meetings.
- Supporting CHAC's Clinical, Financial, Beneficiary Engagement, and Operations Committees in collaboration with the respective Chairs.
- Maintaining CHAC's website to meet compliance requirements, and provide general information for beneficiaries and the public.
- Representing CHAC at State meetings.

- Presenting programmatic reports to the VHCIP work groups, Steering Committee, and Core Team, as requested.

CHAC's three Shared Savings Program contracts extend through December 31, 2016. Bi-State would like to request an additional six months of funding for existing staff at approximately current levels to support their continued work in this otherwise unfunded period of time.

With further funding Bi-State will be able to continue supporting other programmatic expenses such as meeting costs, legal and professional services, insurances, travel, supplies, postage, facility expenses, etc. through the end of calendar year 2016. In particular, the use of legal and professional services has become an ongoing necessity within the ever changing environment of payment reform to ensure that CHAC remains compliant with all requirements of the Medicaid and Commercial Shared Savings Program.

For performance year 2014, Bi-State contracted with Westaff to engage 3 temporary staff members and increased the partial staff positions of some FTEs to conduct the ACO quality reporting. This team of individuals proved to be essential for the success of this endeavor. Extension of CHAC's capacity will allow for Bi-State to ensure that adequate staffing is allocated for the required performance year 2015 ACO quality reporting.

Extension of Medicare Telemonitoring Intervention:

CHAC has developed a care management model that includes a telemonitoring program. In 2014, CHAC contracted with a telemonitoring provider, Pharos Innovations, LLC, to run a daily monitoring system for Medicare beneficiaries with COPD, CHF, and Diabetes. Enrollment began in February 2015, and CHAC currently has approximately 190 beneficiaries enrolled. There is

national evidence that telemonitoring and active engagement with patients who have these conditions will reduce readmissions. CHAC's target population for this intervention is 300-375 individuals, targeting the patients at the health centers who are participating in the Medicare contract. Patients are engaged daily through a telephone call, and are followed up on if they have an 'alert'. CHAC has contracted through VNA of VT to engage Central Vermont Home Health and Hospice (CVHHH) to hire 1.5 FTE for centralized care coordination, follow up on the alerts, provision of patient education, and facilitation of referrals if necessary. The CHAC Clinical Committee developed three triage protocols on COPD, CHF, and Diabetes for home health to use when the Care Coordinator is determining whether to refer the patient. The CVHHH Centralized Care Coordinator has already shared a number of stories of the impact the program is making in the lives of CHAC's patients. This is just one that speaks to the population health focus CHAC is working toward: There was an FQHC patient who was legally blind with the diagnosis of Congestive Heart Failure. She alerted in the system, and the Care Coordinator followed up with a phone call to her. The patient had transportation issues that the Centralized Care Coordinator helped her to work out, and upon her visit at the FQHC it was found that she had pneumonia and was sent home with antibiotics. Upon further investigation, the Centralized Care Coordinator discovered through the patient's alerts that is she is not able to weigh herself daily due to her blindness. So, the Centralized Care Coordinator made a referral to Home Health, which will include telemonitoring, and a referral to Occupational Therapy and to the MSW to help fit her with a scale that will work for her. CHAC expects to see an impact on admissions and readmissions from the use of this telemonitoring program by the summer of 2015.

Currently the contract with Pharos Innovations, LLC lasts through June 30, 2016 and the contract with the Central Vermont Home Health and Hospice is only funded through December 31, 2015. Bi-State is requesting funding to extend both contracts through December 31, 2016 to align with the end of the contract for the Medicare Shared Savings Program.

Contract with Analytics Vendor:

Bi-State and the CHAC members remain eager to invest in an analytics solution to consume claims data and produce actionable reports. While CHAC has implemented an intervention program for the Medicare population, it has been a challenge to create viable interventions for the Medicaid and Commercial populations. In this proposal and related project plan, Bi-State is requesting VHCIP provider funding to adopt and implement an analytics solution that would enable Bi-State and the CHAC members to address this challenge by identifying key areas for quality improvement that would lead to innovative interventions in an effort to reduce admissions and readmissions for the Medicaid and Commercial populations. Funding for this type of investment would allow Bi-State to contract with a vendor that could use Medicaid and Commercial claims data to report and display information with a user friendly interface at the ACO, participant, and individual provider levels. The analytics platform will allow us to identify high-cost or high-utilizing patients across the spectrum, track interventions, identify transitions in care, ED utilization, and comparison against ACO quality benchmarks. The FQHCs and their community partners identified this type of system as a critical need, as it will allow the FQHCs to proactively manage patients that they serve.

Ultimate selection of an analytics vendor will be made by the CHAC Board upon receipt of funding. Bi-State staff have continued to vet vendors and explore the terms of a procurement.

The vendor that has over the past few months seemed most promising (and the best leverage of past State investment) is The Lewin Group for their Optum Healthview Tableau software. Lewin is a current VHCIP evaluator, very familiar with CHAC's claims data already, and Lewin has already begun populating the Tableau software with CHAC's claims data feeds. The goal is to successfully analyze the Medicaid and Commercial claims data with a future aspiration to expand the system to include feeds from the VITL HIE and feeds directly from the EHRs at the FQHCs.

Number of Providers and Patients Impacted

CHAC was founded by seven Federally Qualified Health Centers (FQHCs). Since inception CHAC's network has grown to include ten FQHCs, five hospitals, fourteen designated agencies, and nine certified home health agencies. In total our network consists of almost 300 attributing providers and participant agreements with community partners and support service providers. As an ACO we serve about 35,000 patients in total with about 20,000 on Medicaid, about 6,000 on Medicare, and about 8,000 in the commercial exchange population. All providers and patients in CHAC's network would be impacted by the receipt of further funding as we are requesting funds to further support CHAC's infrastructure, continuity of already existing programs, and funding for an investment in an analytics platform that would enable CHAC to analyze data from and generate supplementary interventions for our patient populations.

Project Relationship to VHCIP Goals

Bi-State received original funding to use CHAC as a testing model for payment reform under the State Innovation Models and Testing Grant. This proposal is requesting funding to further this project and to invest in analytics that will allow more opportunities for innovation to be realized.

CHAC's goals as a Shared Savings Program Accountable Care Organization are perfectly aligned with VHCIP's: to improve care; improve population health; and reduce health care costs.

Dissemination of Lessons Learned

Bi-State staff and CHAC members participate in and attend all of the VHCIP workgroups as well as the statewide learning collaboratives and the Blueprint Unified Community Collaboratives. CHAC values collaboration with the other ACOs and our community partners and strives to be inclusive in every aspect. For example, CHAC's clinical committee members, including partners from the behavioral health network and the home health agencies, had significant input on the statewide Care Management Standards. The best practice recommendations on COPD, CHF, falls risk assessment, and Diabetes have been adopted and are being implemented within CHAC's statewide network, and CHAC is currently sharing these recommendations outside of our network with the other ACOs and the Blueprint UCCs. With further funding it is CHAC's goal to continue pursuing quality improvement and care management interventions based on the ACO quality measures. We intend to continue participating in all relevant work groups and learning collaboratives.

Data Infrastructure Alignment

As stated previously, CHAC's proposed claims based analytics solution, particularly if Lewin is selected, will leverage the past investment made by the State. This solution is also compatible with VITL's work on the HIE, and could be a repository at the other end of CHAC's "ACO Gateway." More generally, it is important to note that CHAC's Director of Health Care Informatics, Kate Simmons, has been an integral stakeholder in the ACO Gateway and HIE remediation projects, and Project Manager Heather Skeels is a regular and active participant in the VHCIP HIE Work Group.

Alternative Funding Sources Sought and Rationale for Requesting SIM Funds

As we submitted in our original proposal, Bi-State's work supporting CHAC had been self-funded, with cash contributions from the original members – which are themselves non-profits with carefully constructed budgets (7 FQHCs and Bi-State) – to fund legal and consultant costs and the beginning of CHAC's staff. Bi-State was able to leverage previously existing federal grants for some activities and partial funding of some staff positions. The original funding from the VHCIP Provider grant was necessary to sustain and augment Bi-State's efforts on behalf of CHAC and other providers to maintain CHAC's basic infrastructure, launch the work of the CHAC Board and four standing committees including support of the work on the best practice recommendations, and to launch a care management model that incorporates a telemonitoring program for our at-risk Medicare population. Since then, CHAC has received cash contributions from two new FQHC members, and Bi-State on behalf of CHAC submitted a proposal in response to an RFP from RCHN's Community Health Foundation with the goal of using funding to support further development and implementation of the clinical best practice recommendations throughout our network. A new VHCIP Provider grant is necessary to sustain CHAC's infrastructure, staffing, and telemonitoring program through the end of the Shared Savings Program time frame; and to supply CHAC with an analytics system to enhance the capacity for analysis and development of measures based clinical interventions and recommendations.

Technical Assistance Needs

As in our original proposal Bi-State is very interested in technical assistance around data analysis. As stated in this proposal, funding for analysis of claims data through the contracted use of vendor software would fulfill the technical assistance services previously sought. Additionally, we remain interested in approaching other national foundations to help support our work and ask whether VHCIP could support this effort as requested with letters of support, etc.

Potential Return on Investment

The overall goal of the telemonitoring program is to avert admissions and help patients manage their care through daily monitoring and enhanced referral patterns. Within the first two months of use, there had already been over 2000 interactions with patients that made a positive impact on their health. With increased patient awareness of their health and reduced health care spending through averted admission, this program could have a huge impact to create savings for program years two (CY2015) and three (CY2016).

The quality measures of the Medicare, Medicaid and Commercial ACOs have influenced CHAC's processes for targeted decision making and projects for performance improvement. The analytics software will help identify additional conditions that require system-wide care management, will identify populations and patients with the highest health care utilization and associated costs, and will support specified care coordination to improve the health of these patients. Our current partnerships with the community mental health centers, home health agencies, and other community service providers will continue to allow for great success in developing best practice care models and transitions across the continuum of care. Further integration will help reduce duplication, enhance patient experience, and improve health outcomes.

CHAC will continue to focus on quality improvement and cost reduction efforts for all patients, regardless of insurance status. The data produced by the analytics tool would be shared with all VT FQHCs, the CHAC Board, and appropriate committees. This means that potentially 133,600 patients, who receive approximately 500,000 medical visits annually, will be impacted by the quality improvement activities the analytics tool will support as quality improvements are not be limited to only attributed patients. Approximately one quarter of the Medicaid population in the

state receives care at an FQHC, so these quality improvement initiatives and associated cost savings will continue to have an immense direct impact on the state's economy.

Avoiding Duplication and Complementing Existing Effort

The Furthering Community Health Accountable Care in FY16 and FY17 project will enable the extension of CHAC's current initiatives and build on existing collaborative efforts throughout the state. First, CHAC is an FQHC-led ACO, which created a unique opportunity for VT and for collaborations with the other two ACOs. As stated previously, the FQHCs in VT have a long history of cooperation amongst themselves and with their community partners. CHAC originally utilized these existing relationships to create an integrated network that has thus far been very efficient in producing tangible outcomes as evidenced by the clinical recommendations on COPD, CHF, falls risk, and Diabetes that have been adopted throughout our network. The quick implementation of our telemonitoring program, which has already helped many patients, is another example of this efficiency and enthusiasm for providing the best care to our patient population. The analytics system will leverage the State's past investment and use current data feeds. Through current and future collaborations and participation with the other ACOs, VHCIP Work Groups, Blueprint, and learning collaboratives, and by building on an existing data sharing structure CHAC will avoid duplication and complement activities that are currently underway in VT.

Summary of Evidence Base for Proposed Activities

Telemonitoring of individuals with chronic diseases continues to be proven as a best practice. In a study from a 2011 Health Affairs, chronically ill Medicare patients enrolled in a telehealth program had reduced health care expenditures of 7.7-13% per quarter compared to similar patients who did not have the benefit of daily contact. Numerous articles show reductions in

hospital admissions and re-admissions and better adherence to medication. Patient satisfaction is consistently high and patient's have a higher understanding of their own diseases.

Earlier findings on ACOs indicated the greatest cost savings occurred in patients with multiple co-morbidities (McWilliams, Landon and Chernew, 2013); the use of an analytics solution will enable CHAC providers to identify and manage care for these complex and high-cost patients.

References Cited:

McWilliams, J.M., Landon, B.E., and Chernew, M.E. (2013). Changes in health care spending and quality for Medicare beneficiaries associated with a commercial ACO contract. *JAMA, 310*(8), 829-836, doi:10.1001/jama.2013.276302

Budget Justification

Furthering Community Health Accountable Care in FY16 and FY17

Salaries and Wages

Bi-State requests VHCIP support for the following positions for the time period of July 1, 2016 through December 31, 2016. This represents Bi-State's current VHCIP funded positions at approximately current FTE levels.

Furthering Community Health Accountable Care in FY16 and FY17				
Personnel				
Salaries		FTE	6 mo adj.	Request
CHAC Director (Joyce Gallimore)				$ 42,000.00
Project Coordinator (Kendall West)				$ 22,491.00
Director, Healthcare Informatics (Kate Simmons)				$ 9,177.32
Administrative Assistant (TBH)				$ 3,570.00
Data Coordinator (Katie Fitzpatrick)				$ 5,355.00
Community Health Quality Manager (Patty Launer)				$ 8,201.03
Project Manager (Heather Skeels)				$ 6,965.39
Finance / IT / Compliance / Communication				$ 19,300.00
Salaries	$ 117,059.73			$ 117,059.73
Benefits	$ 26,923.74			$ 26,923.74
Total Personnel	*$ 143,983.46*	*$ -*		*$ 143,983.46*

Fringe Benefits

Bi-State's fringe benefits are calculated as a percentage of employee salaries/wages each year. Bi-State's FY16 fringe rate is 23%. Fringe benefits include 12% for health, dental, long-term disability and life insurance, and 403(b) retirement plan; 11% for FICA & Medicare taxes, workers compensation and unemployment insurance.

Fringe calculations are presented on the staffing table, above.

Travel

Bi-State is requesting $5,000 for in-state travel (mileage) and an additional $5,000 for out-of-state travel (conferences). This line item supports CHAC's participation in regional and national conferences as well as in-state travel to participant sites, meetings, etc.

Consultant / Contractual Costs

Bi-State anticipates four major contracts utilizing VHCIP funding.

(1) Contract with Pharos Innovations, LLC, to extend telemonitoring intervention for six months through December 31, 2016 (current 18-month contract ends June 30, 2016). This intervention, implemented in February 2015, enrolls 200-375 Medicare beneficiaries for daily telemonitoring. Beneficiaries flagged by Pharos' proprietary "Tel-Assurance" software are contacted by a triage care coordinator for appropriate triage and follow-up. Bi-State's current contract with Pharos was negotiated to the rate of $16,000/month (or $42.67 PPPM, when fully enrolled with 375 patients) –

Bi-State's current request for an additional $96,000 was estimated by multiplying the current monthly rate by 6 months..

(2) Contract with VNA of VT to extend triage care coordination services through December 31, 2016 (current 12-month contract ends December 31, 2015). This work is being provided by Central VT Home Health and Hospice, under a subgrant from VNA of VT. This contract complements the Pharos contract and provides local and high quality care coordination expertise utilizing the Tel-Assurance software for CHAC's enrolled Medicare beneficiaries. Bi-State's current one-year contract with VNA of VT is for $150,138 – Bi-State's current request for an additional $165,000 was estimated by increasing the current rate by 10% to reflect a full year at full care coordination capacity (the Y1 rate included lower initial FTEs for initial months).

A note on (1) and (2): When Bi-State originally negotiated a contract with VNA of VT, Bi-State only had funding to support 12 months of VNA of VT, forcing the VNA of VT contract to be out of alignment with the Pharos contract. Bi-State appreciates the opportunity for additional VHCIP funds to align both complementary contracts onto the same schedule and to continue the intervention for a complete ACO program year (instead of ending the intervention arbitrarily mid-year).

(3) Contract with Analytics vendor - ***NEW***. Bi-State and the CHAC members remain eager to invest in an analytics solution to consume claims data and produce actionable reports. Although ultimate selection will be made by the CHAC Board upon receipt of funding, Bi-State staff have continued to vet vendors and explore the terms of a procurement. The vendor that has consistently seemed most promising (and the best leverage of past State investment) is The Lewin Group for their Optum Healthview Tableau software. Lewin is a current VHCIP evaluator and already uses the Tableau software and CHAC claims data feeds in its evaluation work for the State. Bi-State staff have engaged in demonstrations with Lewin and are preparing the CHAC Board to demo the product. Bi-State staff have additionally requested a preliminary quote from Lewin. Lewin estimates the cost to Bi-State to be $144,000/year (assumes data feeds for Medicaid and Commercial claims data). It is possible that this amount could be reduced to approximately $130,000/year if Lewin is permitted (via DUAs, etc.) to utilize their existing CHAC data feeds to populate Bi-State's instance of the analytics software. Bi-State's current request for $216,000 was estimated as 1.5 times the $144,000 quote (and assumes an 18-month contract).

(4) Contract with Westaff for temporary contract staffing. To accomplish the PY2014 ACO quality reporting, Bi-State contracted with Westaff and another temporary contract staffing firm to engage short-term staff for chart abstraction. Bi-State was highly satisfied with the caliber of staff that Westaff offered, and anticipates utilizing them as the sole vendor for temporary contract staff for PY2015 reporting. (PY2015 reporting will also necessitate the time of Bi-State employees). PY2014 reporting required ~1,200 hours of employee and contract staff time. Bi-State's current request for $20,000 assumes 600 hours times at an estimated hourly rate of $33.33.

Supplies

Bi-State budgets $1,576 per FTE for office general office supplies.

Other

Bi-State anticipates other costs to include meeting expenses, legal costs, beneficiary engagement, insurance, and facility costs.

Meeting expenses for Board, Committee, and Other meetings are budgeted at $200/month and include facility rental, A/V rental, etc. (Meals/food is not included in this estimate.). Bi-State has budgeted for 6 months of meeting expenses for a total request of $1,200.

Legal expenses are estimated at 100 hours in FY16 and 25 hours in FY17 at $350/hour for a total of $43,750. 100 hours are estimated in FY16 as CHAC anticipates there will be work needed for contract review and development (e.g., new contract with analytics vendor, contract amendments to VNA of VT and Pharos contracts), revisions to CHAC's participant agreement and operating agreement, and CHAC will need assistance with review of a compliance plan. $350/hour is the rate charged by Feldesman Tucker Leifer Fiddell, one of Bi-State's counsels expert in FQHCs, federal programs, and network development. This rate represents a 50% discount from their commercial rates (because of Bi-State's non-profit status and work with FQHCs).

Bi-State requests $10,000 for beneficiary engagement. These funds are needed for beneficiary opt-out mailings and to provide reimbursement to beneficiaries for travel associated with their participation in CHAC Board and Committee meetings.

Bi-State requests $4,845 to purchase business insurances for our CHAC work through December 2016. Insurances include: general liability, Directors & Officers, Errors and Omissions, professional liability, and cyberliability.

Facility costs are Bi-State's expenses related to office facilities. These are currently calculated at $14.98/square foot/year for the estimated 2408 square feet required from project staff (for a 6 month period), for a request of $18,035.93.

Total Direct Costs **$733,621.18**

Modified Total Direct Costs **$31,861.80**

Modified Total Direct Cost (MTDC) includes all direct salaries and wages, applicable fringe benefits, materials and supplies, services, travel, and up to the first $25,000 of each subaward (regardless of the period of performance of the subawards under the award). MTDC excludes equipment, capital expenditures, charges for patient care, rental costs, tuition remission, scholarships and fellowships, participant support costs and the portion of each subaward in excess of $25,000.

Furthering Community Health Accountable Care in FY16 and FY17			
		FY16	*FY17*
Personnel	*Total*	*7/1/15-6/30/16*	*7/1/16-12/31/16*
Salaries	$ 117,059.73		$ 117,059.73
Benefits	$ 26,923.74		$ 26,923.74
Total Personnel	*$ 143,983.46*		*$ 143,983.46*
Contractual			
Analytics (e.g., Lewin for Optum HealthView Tableau)	$ 216,000.00	$ 144,000.00	$ 72,000.00
Temporary Staffing Agency (Chart Abstraction for PY2015)	$ 20,000.00	$ 20,000.00	
Triage Care Coordination: VNA of VT	$ 165,000.00	$ 82,500.00	$ 82,500.00
Telemonitoring Intervention: Pharos Innovations, LLC	$ 96,000.00		$ 96,000.00
Total Contractual	*$ 497,000.00*	*$ 246,500.00*	*$ 250,500.00*
Travel			
Mileage	$ 5,000.00		$ 5,000.00
Conferences	$ 5,000.00		$ 5,000.00
Total Travel	*$ 10,000.00*	*$ -*	*$ 10,000.00*
Other			
Legal Services (Compliance, Contract Expertise)	$ 43,750.00	$ 35,000.00	$ 8,750.00
Beneficiary Engagement (e.g., reimbursement for travel, mailings, etc.)	$ 10,000.00	$ 5,000.00	$ 5,000.00
Insurances	$ 4,845.00		$ 4,845.00
Meetings	$ 1,200.00		$ 1,200.00
Facility	$ 18,035.93		$ 18,035.93
Supplies	$ 4,806.80		$ 4,806.80
Total Other	*$ 82,637.73*	*$ 40,000.00*	*$ 42,637.73*
Modified Total Direct Cost			
Modified Total Direct Cost	$ 31,861.80	$ 8,500.00	$ 23,361.80
Total MTDC	*$ 31,861.80*	*$ 8,500.00*	*$ 23,361.80*
Total Request	**$ 765,482.99**	**$ 295,000.00**	**$ 470,482.99**

Furthering Community Health Accountable Care in FY16 and FY17
Deliverables and Implementation Timeline for VCHIP Provider Grant Proposed Activities

Q1: January – March; Q2: April-June. Q3: July-September. Q4: October-December.

Need 1: Original funding for CHAC's basic infrastructure is currently set to end on June 30, 2016.

Goal 1: Extend CHAC's capacity through December 31, 2016.

Objective 1.1: Maintain the adequate and appropriate staffing for CHAC through Bi-State's management services agreement and an operating budget for CHAC expenses and infrastructure.

Activities	Anticipated Outcomes	Milestone	Implementation Timeline	Person Responsible	Comment
Revise CHAC's operating budget	Staff will understand funding is secure through CY16	Approval of revised budget by CHAC Board	Q4 2015	CHAC Director	
	CHAC will have an operating budget that will extend through CY 2016	Approval of revised budget by CHAC Board	Q4 2015	CHAC Director, CHAC CFO, CHAC Informatics Director	
Obtain legal and professional services when needed	Bi-State and CHAC members will be able to seek legal and professional guidance on important issues, including vendor contracting, compliance, etc.	Contracted legal review of current policies and procedures	Q3 2015; ongoing	CHAC Director	

Need 2: Vendor contracts pertinent to the telemonitoring program currently end on December 31, 2015 and June 30, 2016.					
Goal 1: Extend CHAC's care management model which includes a telemonitoring outreach program through duration of Medicare Shared Savings Program.					
Objective 1.1: To extend the existing contracts with the Pharos Innovations, LLC and the VNA of Vermont for the telemonitoring program and the care coordination aspect, respectively, through the end of calendar year 2016 to align with the end of the MSSP time frame.					
Activities	**Anticipated Outcomes**	**Milestone**	**Implementation Timeline**	**Person Responsible**	**Comment**
Extend vendor contracts	Vendor contracts will be extended through CY 2016 and at least 1.0 FTE from the VNA will be maintained for the remainder of the project.	Timely execution of VNAVT contract amendment. Timely execution of Pharos contract amendment.	Q4 2015 Q2 2016	CHAC Informatics Director CHAC Informatics Director	
Maintain patient enrollment in telemonitoring program	Patient enrollment in the telemonitoring program will be maintained through CY 2016	At least 200 patients will continuously be enrolled in the telemonitoring program	Ongoing through Q4 2016	CHAC Informatics Director	

Need 3: Bi-State and the CHAC Members have recognized the lack of current capacity to effectively analyze claims data in a meaningful way.					
Goal 3: Invest in an analytics solution to consume claims data and produce actionable information					
Objective 3.1: Contract with a vendor for analytic services and for visualization software that will leverage past investments by the State and use current claims feeds to create drilled down data reports for use within CHAC's network.					
Activities	**Anticipated Outcomes**	**Milestone**	**Implementation Timeline**	**Person Responsible**	**Comment**
Select vendor	Vendor will be selected adhering to Bi-State's procurement policy. Selected vendor will be endorsed by CHAC Board.	CHAC Board approval of vendor selection	Q3 2015	CHAC Informatics Director	Subset of CHAC Board is participating in demonstration of Lewin product on 5/27/2015.
Contract with analytics vendor	Bi-State will execute contract with a selected vendor for analytics services and to purchase visualization software	Timely execution of contract	Q3 2015	CHAC Informatics Director	

Objective 3.2: Use the vendors services and the visualization software to report out health center level and individual provider level data to the FQHCs and our community partners to increase awareness of improvement areas and aid the selection of new population based interventions					
Activities	**Anticipated Outcomes**	**Milestone**	**Implementation Timeline**	**Person Responsible**	**Comment**
Develop evaluation plan once vendor is selected	Bi-State will be able to test the effectiveness of the data and provide health centers with individualized reports.	Evaluation plan will include education, implementation, data testing, and use metrics (e.g. risk stratification, QI, and care coordination)	Q4 2015	CHAC Informatics Director	
Select focus areas for quality improvement initiatives	CHAC committee members will be able to select new areas of focus based on analysis of the claims data.	Three to four improvement areas will be chosen and approved by CHAC's Clinical Committee and/or Board.	Q4 2015	CHAC Informatics Director	
Develop clinical and operational best practice recommendations or intervention programs	Best practice recommendations or intervention programs for new focus areas will be adopted by CHAC's network	Implementation of best practice recommendations or intervention programs	Q1 2016	CHAC Informatics Director	
Evaluate impact of improvement initiatives	Bi-State and CHAC members will be able to analyze the impact of initiatives using the claims based analytics on a quarterly or more frequent basis	Reporting dashboard will be created and shared for past and new focus areas of improvement.	Q4 2015& ongoing quarterly	CHAC Informatics Director	

Attachment 6b

OneCare Proposal

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Dear Ms. Maheras,

Thank you for the opportunity to respond to the Core Team's request for application for SIM funding for years two and three of the investment cycle. In the interest of improving health of population of Vermonters across the state, and seeking to reduce cost of health care delivery, OneCare Vermont would like to request funding for the following items listed below:

1. Capacity planning for support health reform development, quality improvement, analytics, and clinical facilitation, in the amount of $2,000,000, used to offset network participant fees.

    a. In a short two years time, OneCare Vermont has amassed and retained the state's largest value-based care network of hospitals and physicians. As the state moves towards a comprehensive payment reform structure, we at OneCare feel it vitally important to provide the network with the most value as possible in the formative years, and offsetting the fees of network participants will help to improve their capabilities to deliver care while participating in this essential entity of health care reform.

2. Technical assistance funds to assist VITL in the construction of links to critical provider's EHRs across the state, in the amount of $750,000.

    a. The persistent derivation of data from providers, and the storage of it in a secure, well-curated manner, is the life blood of any successful population health management strategy and system. OneCare Vermont, as well as other value-based entities and initiatives across the state cannot improve health in a meaningful way, nor reduce costs over time, without complete and valid data sets from points of care. It is our intention to enhance efforts in creating the pipes to provider's electronic data in a secure manner, bringing the totality of data closer to 100% in terms of

available and mineable electronic clinical data for purposes of population health management.

b. We request these funds for the specific scope of deploying a team of consultants to work in collaboration with the VITL provider outreach staff, to directly implement data connections to providers' EHR systems (where none presently exist) and to assess and correct deficiencies in quality of data from extant data connections.

3. Implemention fees offset for a statewide Care Management tool, in the amount of $250,000.

    a. Set up costs associated with the institution of a healthcare technology platform that enables real-time, team-based care coordination and communication. The Care Management system will extend collaboration of care across the continuum as well as to as patients, members and family caregivers. By targeting centralized administration and use of this tool at the statewide ACO level, cost reductions for the top 5% of the most expensive patients will be realized by assuring enhanced communication of data and care needs for these patients, such that inefficiences and waste are driven out through appropriate and systematic processes at the regional level.

4. Implementation of a statewide Post-Acute Care Network patient identification and tracking system, to be integrated with the statewide HIE, in the amount of $500,000.

    a. PatientPing.com is the nation's fastest growing and top-rated patient tracking system across the continuum of care. To reduce costs associated with avoidable readmissions and over-utilization due to broken communication links, PatientPing enables real-time admissions and discharge notifications anywhere patients receive care through a fully secure hub and spoke web based interface. There are significant economies of scale associated with a statewide approach to this level of post-acute care tracking and sustainability of this, once implemented, will be born by OneCare Vermont as part of normal cost of business to sustain the cost savings achieved.

Kind regards,

Greg Robinson
Vice President, Finance
OneCare Vermont