VHCIP Core Team Agenda 7.16.14

VT Health Care Innovation Project
Core Team Meeting Agenda

July 16, 2014   1:00-3:30 pm
DFR - 3rd Floor Large Conference Room, 89 Main Street, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	1:00-1:10	Welcome and Chair's Report	Anya Rader Wallack	
Core Team Processes and Procedures				
2	1:10-1:15	Approval of meeting minutes	Anya Rader Wallack	Attachment 2: June 17, 2014 meeting minutes.
Policy Update				
3	1:15-1:30	Commercial SSP Standards Update	Richard Slusky	Attachment 3a: Commercial SSP Standards Approved by GMCB w/revisions Attachment 3b: Commercial SSP Substantive Changes to Standards Attachment 3c: Commercial SSP Technical Changes to Standards
Core Team Processes and Procedures				

4	1:30- 2:15	Grant Program Application *Public Comment*	Georgia Maheras	Attachment 4a: Draft Application Attachment 4b: Recommendations from work groups
Spending recommendations and decisions				
5	2:15- 3:20	Financial Update: a. Evaluation Contract: $1,800,000 (*request to increase previously approved amount due to contract negotiations)* b. Chart Review Proposal: $395,000 c. ACO Proposal: $3,135,000	Georgia Maheras	Attachment 5a: Finance memo from G. Maheras dated July 10, 2014. Attachment 5b: VHCIP spending tracking as of July 10, 2014 (Excel).
6	3:15- 3:25	Public Comment	Anya Rader Wallack	
7	3:25- 3:30	Next Steps, Wrap-Up and Future Meeting Schedule: 8/13: 1:00-3:30 pm at DFR in Montpelier	Anya Rader Wallack	

Attachment 2 - Core Team Minutes
6.17.14

VT Health Care Innovation Project
Core Team Meeting Minutes

Date of meeting: June 17, 2014 **Location:** DFR 3rd Floor Conference Room, 89 Main Street, Montpelier VT

Members: Anya Rader Wallack, Chair; Robin Lunge, AOA; Susan Wehry, DAIL; Paul Bengtson, NVRH; Al Gobeille, GMCB; Mark Larson, DVHA.

Attendees: Georgia Maheras, AOA; Diane Cummings, AHS; Pat Jones, Annie Paumgarten, Richard Slusky, Spenser Weppler, Susan Barrett, GMCB; Julia Shaw, VT Legal Aid; Alicia Cooper, Kara Suter, DVHA; Cathy Fulton, Laura Pelosi, QPM Work Group Co-Chairs; Heidi Klein, VDH; Jessica Mendizabal and Nelson LaMothe, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome and Chair's report	Anya Wallack called the meeting to order at 9:02 am and gave an update on the CMMI Site visit taking place tomorrow, June 18th. The agenda (attachment 1) includes the status of Payment and Care Model pilots and Health Information Exchange efforts. There is interest in the all payer waiver from the CMMI team so they may discuss that as well. There are three types of waivers: Medicaid; section 1332 from ACA (alternatives to ACA which can't be implemented until 2017); and all-payer waiver from CMMI.	
2. Approval of Minutes	Paul moved to approve the April 21 minutes. Al seconded. Susan asked to amend the language regarding her task for the AHS contracts (page 2) to the following: "Susan will work with Doug to review the contract language for subsequent iterations." The motion passed unanimously pending the changes. Robin Lunge moved to approve the May 19th minutes and Susan Wehry seconded. The motion passed unanimously.	**The April minutes will be revised and posted to the VHCIP website.**

Agenda Item	Discussion	Next Steps

3. Quality and Performance Measures Work Group Update	QPM Work Group Co-Chairs Catherine Fulton and Laura Pelosi gave the following update (attachments 3a-c):
	• QPM work group will attend the Payment Models July meeting to discuss the recommended measures.
	• Currently have approved criteria for overall measure selection.
	• Plan to develop year 2 measure specifications by October 31st.
	• Population Health and DLTSS work groups have proposed measures that QPM work group is currently reviewing. Howard Center, Legal Aid, and Betty Rambur have all made additional measure recommendations (most are from Pending Measures and Medicaid/Medicare SSP measures).
	• During measure review the QPM Work Group considers: administrative burden for providers; data quality and standardization; and mitigating duplication of efforts. Providers participate in the work group discussions.
	• All three ACOs are developing capacity to collect Medicare, Medicaid and Commercial SSP measures. It is extra work to collect them for Medicaid and Commercial, but they are already working together on it.
	• Medicaid data will not be available until after one full performance year. There will be interim data available starting in August, 2014.
	• The work group also considers what Vermont programs are already collecting this data.
	• The message from providers is that they want to be able to focus on fewer measures and do really well with those. There may be pushback if there are too many measures to collect.
	• Regarding informed consent/patient notification:
	    o Most ACOs do not send notices to patients at the point of service though CHAC is distributing at the point of service.
	    o Beneficiaries are given the choice to “opt out” of having their data shared with the ACOs but the beneficiary data is still used to measure ACO performance.
	    o Beneficiary data is protected and de-identified.	

4. Project Director	Georgia Maheras discussed the revised project timeline and reviewed attachments 4a & 4b.	

Agenda Item	Discussion	Next Steps
Report	Year 1 has been extended for three months and is now a 15 month year ending in Dec. 2014. Reporting deadlines have also changed (attachment 4a). Staffing update (attachment 4b). Changes/challenges are highlighted in yellow. Regarding Workforce analytics: this was initiallya contract at VDH but they did not receive qualified bids. It would be beneficial to have a staff person in house to do this work to keep consistency across other data work. They also have a robustcandidate pool at this time. Different data positions require different skill sets. Claims related data analysis is a highly coveted skill and the State positions do not fit the salary range offered in the private sector. Susan Wehry moved to approve the recommended changes to the staffing structure. Paul Bengtson seconded. The motion passed unanimously.	
5. Public Comment	No additional comments were offered.	
6. Next Steps, Wrap up	**Next meeting:** July 16, 2014, 1-3:00 pm, DFR 3rd Floor Conference Room, 89 Main St, Montpelier. **Agenda includes:** • Updates on HIE proposals • Sub-grant program discussion • Update on modifications to ACO standards	

Attachment 3a - Commercial SSP Standards Approved by GMCB w/ revisions

Vermont Commercial ACO Pilot
Compilation of Pilot Standards
Approved by the GMCB and VCHIP Core Team, October and November 2013
Reflecting Proposed Substantive Changes as of June 27, 2014

This document contains ACO commercial pilot standards originally reviewed and approved by the Green Mountain Care Board and the Vermont Health Care Improvement Project Steering Committee and Core Team during meetings that took place in October and November 2013.

ACO pilot standards are organized in the following four categories:

- Standards related to the ACO's structure:
  - Financial Stability
  - Risk Mitigation
  - Patient Freedom of Choice
  - ACO Governance

- Standards related to the ACO's payment methodology:
  - Patient Attribution Methodology
  - Calculation of ACO Financial Performance and Distribution of Shared Risk Payments

- Standards related to management of the ACO:
  - Care Management
  - Payment Alignment
  - Data Use Standards

- Process for review and modification of measures.

The objectives and details of each draft standard follow.

I. Financial Stability

Objective: Protect ACOs from the assumption of "insurance risk" (the risk of whether a patient will develop an expensive health condition) when contracting with private and public payers so that the ACO can focus on management of "performance risk" (the risk of higher costs from delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment of a particular condition).

For Discussion Only

A. Standards related to the effects of provider coding patterns on medical spending and risk scores

1. The GMCB's Analytics Contractor will assess whether changes in provider coding patterns have had a substantive impact on medical spending, and if so, bring such funding and documentation to the GMCB for consideration with participating pilot ACOs.

The Payers and ACOs shall participate in a GMCB-facilitated process to review and consider the financial impact of any identified changes in ACO provider coding patterns.

B. Standards related to downside risk limitation

1. The Board has established that for the purposes of the pilot program, the ACO will assume the following downside risk in each pilot program year:
   - Year 1: no downside risk
   - Year 2: no downside risk
   - Year 3: downside risk not less than 3% and up to 5%

2. ACOs are required to submit a Risk Mitigation Plan to the state that demonstrates that the ACO has the ability to assume not less than 3% and up to 5% downside risk in Year 3 and receive state approval. Such a plan may, but need not, include the following elements: recoupment from payments to participating providers, stop loss protection, reinsurance, a provider payment withhold provision, and reserves (e.g., irrevocable letter of credit, escrow account, surety bond).

3. The Risk Mitigation Plan must include a downside risk distribution model that does not disproportionately punish any particular organization within the ACO and maintains network adequacy in the event of a contract year in which the ACO has experienced poor financial performance.

C. Standards related to financial oversight.

1. The payer will furnish financial reports regarding each ACO's risk performance for each six-month performance period to the GMCB and DVHA in accordance with report formats and timelines defined by the GMCB, through a collaborative process with ACOs and payers.

For Discussion Only

D. Minimum number of attributed lives for a contract with a payer for a given line of business.

1. For Year 1 of the ACO pilot, an ACO participating with one commercial payer must have at least five thousand (5,000) commercial attributed lives as of June 30, 2014. For Year 1 of the ACO pilot, an ACO participating with two commercial payers must have three thousand (3,000) commercial attributed lives for each of the two payers, for an aggregate minimum of six thousand (6,000) commercial attributed lives, as of June 30, 2014.

   In order to establish the number of an ACO's commercial attributed lives, the payer will, on July 1, 2014, or as soon thereafter as possible, provide the ACO with an account of ACO's commercial attributed lives as of June 30, 2014. Based upon the number of an ACO's commercial attributed lives as of June 30, 2014, the ACO and payer may proceed as follows: if the commercial attributed lives are below the minimum number required for participation, the payer or the ACO may:
   a. terminate their agreement for cause as of June 30, 2014; or
   b. agree to maintain their agreement in full force and effect.

2. In Performance Years 2 and 3, a participating insurer may elect to not participate with an ACO, if: (1) that ACO is participating with one commercial insurer and that ACO's projected or actual attributed member months with that insurer fall below 60,000 annually; or (2) that ACO is participating with two commercial insurers and that ACO's projected or annual attributed member months with that insurer fall below 36,000 annually.

If an ACO falls below the attribution threshold required for participation in the pilot in Years 2 and 3, it may request that the relevant payers participate in a GMCB-facilitated process to determine whether one or more of the payers would find it acceptable to waive the enrollment threshold and either a) establish a contract with the ACO in the absence of meeting this requirement, or b) permit an already-contracted ACO eligibility to share in any generated savings. While the GMCB will facilitate this process, the decision regarding whether to waive the enrollment threshold and contract with the ACO, or to permit a contracted ACO to share in any savings, remains with the payer.

F. **The ACO will notify the Board if the ACO is transferring risk to any participating provider organization within its network.**

For Discussion Only

II. Risk Mitigation

The ACOs must provide the GMCB with a detailed plan to mitigate the impact of the maximum potential loss on the ACO and its provider network in Year 3 of the commercial ACO pilot. Such a plan must establish a method for repaying losses to the insurers participating in the pilot. The method may include recoupment from payments to its participating providers, stop loss reinsurance, surety bonds, escrow accounts, a line of credit, or some other payment mechanism such as a withhold of a portion of any previous shared savings achieved. The ACO must provide documentation of its ability to repay such losses 90 days prior to the start of Year 3.

Any requirements for risk mitigation, as noted above, will be the responsibility of the ACO itself, and not of the participating providers. The burden of holding participating providers financially accountable shall rest with the ACO, and the ACO must to exhibit their ability to manage the risk as noted above.

III. Patient Freedom of Choice

1. ACO patients will have freedom of choice with regard to their providers consistent with their health plan benefit.

IV. ACO Governance

1. The ACO must maintain an identifiable governing body that has responsibility for oversight and strategic direction of the ACO, and holding ACO management accountable for the ACO's activities.

2. The organization must identify its board members, define their roles and describe the responsibilities of the board.

3. The governing body must have a transparent governing process which includes the following:
    a. publishing the names and contact information for the governing body members;
    b. devoting an allotted time at the beginning of each in-person governing body meeting to hear comments from members of the public who have signed up prior to the meeting and providing public updates of ACO activities;
    c. making meeting minutes available to the ACO's provider network upon request, and
    d. posting summaries of ACO activities provided to the ACO's consumer advisory board on the ACO's website.

For Discussion Only

4. The governing body members must have a fiduciary duty to the ACO and act consistently with that duty.

5. At least 75 percent control of the ACO's governing body must be held by or represent ACO participants or provide for meaningful involvement of ACO participants on the governing body. For the purpose of determining if this requirement is met, a "participant" shall mean an organization that:

    a. has, through a formal, written document, agreed to collaborate on one or more ACO programs designed to improve quality, patient experience, and manage costs, and

    b. is eligible to receive shared savings distributions based on the distribution rules of the ACO or participate in alternative financial incentive programs as agreed to by the ACO and its participants.

   A "participant" does not need to have lives attributed to the ACO to be considered a participant. An organization may have lives attributed to one ACO but still participate in another ACO as per meeting conditions 5a and 5b above. So long as conditions 5a and 5b above are met, that organization will be considered a "participant" if seated on a governing body.

6. The ACO's governing body must at a minimum also include at least one consumer member who is a Medicare beneficiary (if the ACO participates with Medicare), at least one consumer member who is a Medicaid beneficiary (if the ACO participates with Medicaid), and at least one consumer member who is a member of a commercial insurance plan (if the ACO participates with one or more commercial insurers). Regardless of the number of payers with which the ACO participates, there must be at least two consumer members on the ACO governing body. These consumer members should have some personal, volunteer, or professional experience in advocating for consumers on health care issues. They should also be representative of the diversity of consumers served by the organization, taking into account demographic and non-demographic factors including, but not limited to, gender, race, ethnicity, socioeconomic status, geographic region, medical diagnoses, and services used. The ACO's governing board shall consult with advocacy groups and organizational staff in the recruitment process.

   The ACO shall not be found to be in non-conformance if the GMCB determines that the ACO has with full intent and goodwill recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

For Discussion Only

7. The ACO must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including the establishment of a consumer advisory board, with membership drawn from the community served by the ACO, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of ACO management and the governing body must regularly attend consumer advisory board meetings and report back to the ACO governing body following each meeting of the consumer advisory board. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

V. Patient Attribution Methodology

Patients will be attributed to an ACO as follows:

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all members who meet the following criteria as of the last day in the look back period:
   - Employer situated in Vermont or member/beneficiary residing in Vermont for commercial insurers (payers can select one of these options);
   - The insurer is the primary payer.

3. For products that require members to select a primary care provider, and for which the member has selected a primary care provider, attribute those members to that provider.

4. For other members, select all claims identified in step 2 with the following qualifying CPT Codes[1] in the look back period (most recent 24 months) for primary care providers where the provider specialty is internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, naturopathic medicine; or is a nurse practitioner, or physician assistant; or where the provider is an FQHC or Rural Health Clinic.

For Discussion Only

[1] Should the Blueprint for Health change the qualifying CPT codes to be other than those listed in this table, the VHCIP Payment Models Work Group shall consider the adoption of such changes.

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E & M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Newborn Care Services • Initial and subsequent care for evaluation and management of normal newborn infant: 99460-99463

For Discussion Only

CPT-4 Code Description Summary
• Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn: 99464 • Delivery/birthing room resuscitation: 99465
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form*)** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner • 0525 = Nursing home visit by RHC/FQHC practitioner

5. Assign a member to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the NPIs of the individual providers associated with it.

6. If a member has an equal number of qualifying visits to more than one practice, assign the member/beneficiary to the one with the most recent visit.

7. Insurers can choose to apply elements in addition to 5 and 6 above when conducting their attribution. However, at a minimum use the greatest number of claims (5 above), followed by the most recent claim if there is a tie (6 above).

8. Insurers will run their attributions at least monthly.

9. Using a GMCB-facilitated process, the participating ACOs and payers will reconsider during Year 1 whether obstetricians and gynecologists should be added to the attributing clinician list.

10. A qualified primary care practitioner to whom lives have been attributed by a payer may only participate as a primary care practitioner in one ACO. If a qualified primary care practitioner works under multiple tax ID numbers, the practitioner may not use a specific tax ID number with more than one ACO.

For Discussion Only

VI. Calculation of ACO Financial Performance and Distribution of Shared Risk Payments

(See attached spreadsheet.)

I. Actions Initiated Before the Performance Year Begins

Step 1: Determine the expected PMPM medical expense spending for the ACO's total patient population absent any actions taken by the ACO.

Years 1 and 2: The medical expense portion of the GMCB-approved Exchange premium for each Exchange-offered product, adjusted from allowed to paid amounts, adjusted for excluded services (see below), high-cost outliers[2], and risk-adjusted for the ACO-attributed population, and then calculated as a weighted average PMPM amount across all commercial products with weighting based on ACO attribution by product, shall represent the expected PMPM medical expense spending ("expected spending") for Years 1 and 2.

The ACO-responsible services used to define expected spending shall include all covered services except for:

1. services that are carved out of the contract by self-insured employer customers
    - prescription (retail) medications (excluded in the context of shared savings in Years 1 and 2, with potential inclusion in the context of shared (upside and downside) risk in Year 3 following VHCIP Payment Models Work Group discussion, and
2. dental benefits [3].

Year 3: The Year 3 expected spending shall be calculated using an alternative methodology to be developed through the Payment Models Work Group and recommended to the GMCB Board for approval. The employed trend rate will be made available to the insurers prior to the deadline for GMCB rate submission in order to facilitate the calculation of premium rates for the Exchange. It is the shared intent of the pilot participants and the GMCB that the methodology shall not reduce expected spending based on any savings achieved by the pilot ACO(s) in the first two years.

The GMCB will also calculate the expected spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific expected spending."

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[2] The calculation shall exclude the projected value of Allowed claims per claimant in excess of $125,000 per performance year.

[3] The exclusion of dental services will be re-evaluated after the Exchange becomes operational and pediatric dental services become a mandated benefit.

For Discussion Only

At the request of a pilot ACO or insurer and informed by the advice of the GMCB's actuary and participating ACOs and insurers, the GMCB will reconsider and adjust expected spending if unanticipated events, or macro-economic or environmental events, occur that would reasonably be expected to significantly impact medical expenses or payer assumptions during the Exchange premium development process that were incorrect and resulted in significantly different spending than expected.

Step 2: Determine the <u>targeted</u> PMPM medical expense spending for the ACO's patient population based on expected cost growth limiting actions to be taken by the ACO.

Targeted spending is the PMPM spending that approximates a reduction in PMPM spending that would not have otherwise occurred absent actions taken by the ACO. Targeted spending is calculated by multiplying PMPM spending by the **target rate**. The target rate(s) for Years 1 and 2 for the aggregate Exchange market shall be the expected rate minus the CMS Minimum Savings Rate for a Medicare ACO for the specific performance year, with consideration of the size of the ACO's Exchange population. The GMCB will approve the target rate.

As noted above, the Year 3 targeted spending shall be calculated using an alternative methodology to be developed by the VHCIP Payment Models Work Group and approved by the GMCB.

The GMCB will also calculate the targeted spending for the ACO population on an insurer-by-insurer basis in the same fashion, as described within the attached worksheet. The resulting amount for each insurer is called the "insurer-specific targeted spending."

<u>Actions Initiated After the Performance Year Ends</u>

Step 3: Determine actual spending and whether the ACO has generated savings.

No later than eight months (i.e., two months following the six-month claim lag period) following the end of each pilot year, the GMCB or its designee shall calculate the actual medical expense spending ("actual spending") by Exchange metal category for each ACO's attributed population using commonly defined insurer data provided to the GMCB or its designee. Medical spending shall be defined to include all paid claims for ACO-responsible services as defined above.

PMPM medical expense spending shall then be adjusted as follows:

- clinical case mix using the risk adjustment model utilized by Center for Consumer Information and Insurance Oversight (CCIIO) for the federal exchange. The GMCB may consider alternatives for future years;
- truncation of claims for high-cost patient outliers whose annual claims value exceed $125,000, and

For Discussion Only

- conversion from allowed to paid claims value.

For Years 1 and 2, insurers will assume all financial responsibility for the value of claims that exceed the high-cost outlier threshold. The GMCB and participating pilot insurers and ACOs will reassess this practice during Years 1 and 2 for Year 3.

The GMCB or its designee shall aggregate the adjusted spending data across insurers to get the ACO's "actual spending." The actual spending for each ACO shall be compared to its expected spending.

- If the ACO's actual aggregate spending is greater than the expected spending, then the ACO will be ineligible to receive shared savings payments from any insurer.
- If the ACO's actual aggregate spending is less than the expected spending, then it will be said to have "generated savings" and the ACO will be eligible to receive shared savings payments from one or more of the pilot participant insurers.
- If the ACO's actual aggregate spending is less than the expected spending, then the ACO will not be responsible for covering any of the excess spending for any insurer.

Once the GMCB determines that the ACO has generated aggregate savings across insurers, the GMCB will also calculate the actual spending for the ACO population on an insurer-by-insurer basis. This is called the "insurer-specific actual spending." The GMCB shall use this insurer-specific actual spending amount to assess savings at the individual insurer level.

Once the insurer-specific savings have been calculated, an ACO's share of savings will be determined in two phases. This step defines the ACO's eligible share of savings based on the degree to which actual PMPM spending falls below expected PMPM spending. The share of savings earned by the ACO based on the methodology above will be subject to qualification and modification by the application of quality performance scores as defined in Step 4.

In Years 1 and 2 of the pilot:

- If the insurer-specific actual spending for the ACO population is between the insurer-specific expected spending and the insurer-specific targeted spending, the ACO will share 25% of the insurer-specific savings.
- If the insurer-specific actual spending is below the insurer-specific targeted spending, the ACO will share 60% of the insurer-specific savings. (The cumulative insurer-specific savings would therefore be calculated as 60% of the difference between actual spending and targeted spending plus 25% of the difference between expected spending and targeted spending.)
- An insurer's savings distribution to the ACO will be capped at 10% of the ACO's insurer-specific expected spending and not greater than insurer premium approved by the Green Mountain Care Board.

For Discussion Only

In Year 3 of the pilot:
The formula for distribution of insurer-specific savings will be the same as in Years 1 and 2, except that the ACO will be responsible for a percentage of the insurer-specific excess spending up to a cap equal to an amount no less than 3% and up to 5% of the ACO's insurer-specific expected spending.

All participating ACOs shall assume the same level of downside risk in Year 3, as approved by the VHCIP Payment Models Work Group and the GMCB.

The calculation of the ACO's liability will be as follows:

- If the ACO's total actual spending is greater than the total expected spending (called "excess spending"), then the ACO will assume responsibility for insurer-specific actual medical expense spending that exceeds the insurer-specific expected spending in a way that is reciprocal to the approach to distribution of savings.
- If the insurer-specific excess spending is less than the amount equivalent to the difference between expected spending and targeted spending, then the ACO will be responsible for 25% of the insurer-specific excess spending.
- If the ACO's excess spending exceeds the amount equivalent to the difference between expected spending and targeted spending, then the ACO will be responsible for 60% of the insurer-specific excess spending over the difference, up to a cap equal to an amount no greater than 5% of the ACO's insurer-specific expected spending.

If the sum of ACO savings at the insurer-specific level is greater than that generated in aggregate, the insurer-specific ACO savings will be reduced to the aggregate savings amount. If reductions need to occur for more than one insurer, the reductions shall be proportionately reduced from each insurer's shared savings with the ACO for the performance period. Any reductions shall be based on the percentage of savings that an insurer would have to pay before the aggregate savings cap. [4]

Step 4: Assess ACO quality performance to inform savings distribution.

The second phase of determining an ACO's savings distribution involves assessing quality performance. The distribution of eligible savings will be contingent on demonstration that the ACO's quality meets a minimum qualifying threshold or "gate." Should the ACO's quality performance pass through the gate, the size of the distribution will vary and be linked to the ACO's performance on specific quality measures. Higher quality performance will yield a larger share of savings up to the maximum distribution as described above.

[4] A reciprocal approach shall apply to ACO excess spending in Year 3, such that excess spending calculated at the issuer-specific level shall not exceed that calculated at the aggregate level.

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Methodology for distribution of shared savings: For year one of the commercial pilot, compare the ACO's performance on the payment measures (see Table 1 below) to the PPO HEDIS national percentile benchmark[5] and assign 1, 2 or 3 points based on whether the ACO is at the national 25th, 50th or 75th percentile for the measure.

Table 1. Core Measures for Payment in Year One of the Commercial Pilot

#	Measure	Data Source	2012 HEDIS Benchmark (PPO)
Core-1	Plan All-Cause Readmissions NQF #1768, NCQA	Claims	Nat. 90th: .68 Nat. 75th: .73 Nat. 50th: .78 Nat. 25th: .83 *Please note, in interpreting this measure, a lower rate is better.
Core-2	Adolescent Well-Care Visits HEDIS AWC	Claims	Nat. 90th: 58.5 Nat. 75th: 46.32 Nat. 50th: 38.66 Nat. 25th: 32.14
Core-3	Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening Only for Year 1)	Claims	Nat. 90th: 89.74 Nat. 75th: 87.94 Nat. 50th: 84.67 Nat. 25th: 81.27
Core-4	Follow-Up After Hospitalization for Mental Illness: 7-day NQF #0576, NCQA HEDIS FUH	Claims	Nat. 90th: 67.23 Nat. 75th: 60.00 Nat. 50th: 53.09 Nat. 25th: 45.70
Core-5	Initiation and Engagement for Substance Abuse Treatment: Initiation and Engagement of AOD Treatment (composite) NQF #0004, NCQA HEDIS IET CMMI	Claims	Nat. 90th: 35.28 Nat. 75th: 31.94 Nat. 50th: 27.23 Nat. 25th: 24.09

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[5] NCQA has traditionally offered several HEDIS commercial product benchmarks, e.g., HMO, POS, HMO/POS, HMO/PPO combined, etc.

Core-6	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis NQF #0058, NCQA HEDIS AAB	Claims	Nat. 90th: 28.13 Nat. 75th: 24.30 Nat. 50th: 20.72 Nat. 25th: 17.98
Core-7	Chlamydia Screening in Women NQF #0033, NCQA HEDIS CHL	Claims	Nat. 90th: 54.94 Nat. 75th: 47.30 Nat. 50th: 40.87 Nat. 25th: 36.79

The Gate: In order to retain savings for which the ACO is eligible in accordance with Steps 1-3 above, the ACO must earn meet a minimum threshold for performance on a defined set of common measures to be used by all pilot-participating commercial insurers and ACOs. For the commercial pilot, the ACO must earn 55% of the eligible points in order to receive savings. If the ACO is not able to meet the overall quality gate, then it will not be eligible for any shared savings. If the ACO meets the overall quality gate, it may retain at least 75% of the savings for which it is eligible (see Table 2).

The Ladder: In order to retain a greater portion of the savings for which the ACO is eligible, the ACO must achieve higher performance levels for the measures. There shall be six steps on the ladder, which reflect increased levels of performance (see Table 2).

Table 2. Distribution of Shared Savings in Year One of Commercial Pilot

% of eligible points	% of earned savings
55%	75%
60%	80%
65%	85%
70%	90%
75%	95%
80%	100%

Eligibility for shared savings based on performance improvement.

For Discussion Only

Should the ACO, in Years 2 or 3, fail to meet the minimum quality score, it may still be eligible to receive shared savings if the GMCB determines, after providing notice to and accepting written input from the insurer and ACO (and input from ACO participants, if offered), that the ACO has made meaningful improvement in its quality performance as measured against prior pilot years. The GMCB will make this determination after conducting a public process that offers stakeholders and other interested persons sufficient time to offer verbal and/or written comments related to the issues before the GMCB.

Step 5: Distribute shared savings payments

The GMCB or its designee will calculate an interim assessment of performance year medical expense relative to expected and targeted medical spending for each ACO/insurer dyad within four months of the end of the performance year and inform the insurers and ACOs of the results, providing supporting documentation when doing so. If the savings generated exceed the insurer-specific targeted spending, and the preliminary assessment of the ACO's performance on the required measures is sufficiently strong, then within two weeks of the notification, the insurers will offer the ACO the opportunity to receive an interim payment, not to exceed 75% of the total payment for which the ACO is eligible.

The GMCB or its designee will complete the analysis of savings within two months of the conclusion of the six-month claim lag period and inform the insurers and ACOs of the results, providing supporting documentation when doing so. The insurers will then make any required savings distributions to contracted ACOs within two weeks of notification by the GMCB. Under no circumstances shall the amount of a shared savings payment distribution to an ACO jeopardize the insurer's ability to meet federal Medical Loss Ratio (MLR) requirements. The amount of the shared savings distribution shall be capped at the point that the MLR limit is reached.

VII. Care Management Standards (*under development*)

Objective: Effective care management programs close to, if not at, the site of care for those patients at highest risk of future intensive resource utilization is considered by many to be the linchpin of sustained viability for providers entering population-based payment arrangements. Any standards will be developed by the VHCIP Care Models Work Group. For Year 1 of the pilot emphasis will be placed upon member communication and care transitions.

For Discussion Only

VIII. Payment Alignment

Objective: Improve the likelihood that ACOs attain their cost and quality improvement goals by aligning payment incentives at the payer-ACO level to the individual clinician and facility level.

1. The performance incentives that are incorporated into the payment arrangements between a commercial insurer and an ACO should be appropriately reflected in those that the ACO utilizes with its contracted providers. ACOs will share with the GMCB their written plans for:
   a. aligning provider payment (from insurers or Medicaid) and compensation (from ACO participant organization) with ACO performance incentives for cost and quality, and
   b. distributing any earned shared savings.

2. ACOs utilizing a network model should be encouraged to create regional groupings (or "pods") of providers under a shared savings model that would incent provider performance resulting from the delivery of services that are more directly under their control. The regional groupings or "pods" would have to be of sufficient size to reasonably calculate "earned" savings or losses. ACO provider groupings should be incentivized individually and collectively to support accountability for quality of care and cost management.

3. Insurers shall support ACOs by collaborating with ACOs to align performance incentives by considering the use of alternative payment methodology including bundled payments and other episode-based payment methodologies.

IX. Vermont ACO Data Use Standards

ACOs and payers must submit the required data reports detailed in the "Data Use Report Standards for ACO Pilot" document in the format defined through a collaborative process led by the GMCB.

X. Process for Review and Modification of Measures Used in the Commercial and Medicaid ACO Pilot Program

1. The VHCIP Quality and Performance Measures Work Group will review all **Payment and Reporting measures** included in the Core Measure Set beginning in the second quarter of each pilot year, with input from the VHCIP Payment Models Work Group. For each measure, these reviews will consider payer and provider data availability, data quality, pilot experience reporting the measure, ACO performance, and any changes to national clinical guidelines. The goal of the review will be to determine whether each

For Discussion Only

measure should continue to be used as-is for its designated purpose, or whether each measure should be modified (e.g. advanced from Reporting status to Payment status in a subsequent pilot year) or dropped for the next pilot year. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to measures for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will include annual updates to the Payment and Reporting measures included in the Core Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes. In the interest of retaining measures selected for Payment and Reporting purposes for the duration of the pilot program, measures should not be removed in subsequent years unless there are significant issues with data availability, data quality, pilot experience in reporting the measure, ACO performance, and/or changes to national clinical guidelines.

2. The VHCIP Quality and Performance Measures Work Group and the VHCIP Payment Models Work Group will review all **targets and benchmarks** for the measures designated for Payment purposes beginning in the second quarter of each pilot year. For each measure, these reviews will consider whether the benchmark employed as the performance target (e.g., national x^{th} percentile) should remain constant or change for the next pilot year. The Work Group should consider setting targets in year two and three that increase incentives for quality improvement. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to benchmarks and targets for the next program year if the changes have the support of a majority of the voting members of the Work Group. Such recommendations will include annual updates to the targets and benchmarks for measures designated for Payment purposes as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). Such recommendations will be finalized no later than July 31st of the year prior to implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

3. The VHCIP Quality and Performance Measures Work Group will review all **measures designated as Pending** in the Core Measure Set and consider any new measures for addition to the set beginning in the first quarter of each pilot year, with input from the

For Discussion Only

VHCIP Payment Models Work Group. For each measure, these reviews will consider data availability and quality, patient populations served, and measure specifications, with the goal of developing a plan for measure and/or data systems development and a timeline for implementation of each measure. If the VHCIP Quality and Performance Measures Work Group determines that a measure has the support of a majority of the voting members of the Work Group and is ready to be advanced from Pending status to Payment or Reporting status or added to the measure set in the next pilot year, the Work Group shall recommend the measure as either a Payment or Reporting measure and indicate whether the measure should replace an existing Payment or Reporting measure or be added to the set by July 31st of the year prior to implementation of the changes. Such recommendations will include annual updates to measures designated as Pending in the Core Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). New measures should be carefully considered in light of the Work Group's measure selection criteria. If a recommended new measure relates to a Medicare Shared Savings Program (MSSP) measure, the Work Group shall recommend following the MSSP measure specifications as closely as possible. If the Work Group designates the measure for Payment, it shall recommend an appropriate target that includes consideration of any available state-level performance data and national and regional benchmarks. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

4. The VHCIP Quality and Performance Measures Work Group will review **state or insurer performance on the Monitoring and Evaluation measures** beginning in the second quarter of each year, with input from the VHCIP Payment Models Work Group. The measures will remain Monitoring and Evaluation measures unless a majority of the voting members of the Work Group determines that one or more measures presents an opportunity for improvement and meets measure selection criteria, at which point the VHCIP Quality and Performance Measures Work Group may recommend that the measure be moved to the Core Measure Set to be assessed at the ACO level and used for either Payment or Reporting. The VHCIP Quality and Performance Measures Work Group will make recommendations for changes to the Monitoring and Evaluation measures for the next program year if the changes have the support of a majority of the members of the Work Group. Such recommendations will include annual updates to the Monitoring and Evaluation measures included in the Monitoring and Evaluation Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures). Such recommendations will be finalized no later than July 31st of the year prior to

For Discussion Only

implementation of the changes. Recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Approval for any changes must be finalized no later than September 30th of the year prior to implementation of the changes.

5. The GMCB will release the **final measure specifications f**or **the next pilot year by no later th**an October 31st of the year prior to the implementation of the changes. The specifications document will provide the details of any new measures and any changes from the previous year.

6. If during the course of the year, a national clinical guideline for any measure designated for Payment or Reporting changes or an ACO or payer participating in the pilot raises a serious concern about the implementation of a particular measure, the VHCIP Quality and Performance Measures Work Group will review the measure and recommend a course of action for consideration, with input from the VHCIP Payment Models Work Group. If the VHCIP Quality and Performance Measures Work Group determines that a change to a measure has the support of a majority of the voting members of the Work Group, recommendations will go to the VHCIP Steering Committee, the VHCIP Core Team and the GMCB for review. Upon approval of a recommended change to a measure for the current pilot year, the GMCB must notify all pilot participants of the proposed change within 14 days.

For Discussion Only

Attachment 3b - Commercial SSP Substantive Changes to Standards

TO: GMCB and VHCIP Core Team
FROM: Richard Slusky
DATE: June 27, 2014
RE: Substantive Changes to the Commercial ACO Pilot Standards

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Since the VHCIP Core Team and Green Mountain Care Board (GMCB) approved the Commercial ACO pilot Standards in late 2013, the Green Mountain Care Board staff, DVHA staff and ACO SSP Operations Group members have found that sections within the Standards warrant additional clarification and changes. This memo describes the substantive changes to the Standards document that either GMCB and DVHA staff or the Operations Group have identified since Core Team and GMCB adoption of the Standards. The changes described in this memo address the following topics:

1. Minimum number of attributed lives for ACO participation in the pilot
2. Termination or continuation of agreement based on ACO attribution levels as of June 30, 2014
3. GMCB-facilitated process to waive the attribution threshold
4. Eligibility for shared savings based on performance improvement

1. Minimum number of attributed lives for ACO participation in the pilot

The approved XSSP Program Agreement contains language that more accurately reflects the collective understanding of the payers, ACOs and GMCB, but diverges from the approved Standards document. The approved Standards document allows an ACO to participate in the Pilot only if it has both 60,000 commercial Exchange member months in aggregate *and* at least 36,000 commercial Exchange member months attributed to one payer during a performance year. This language reflects an error in the Standards since the intent was to require a minimum of 60,000 attributed member months in the aggregate for an ACO participating with one insurer and a minimum of 36,000 attributed member months for each insurer (for a combined total of 72,000 member months) for an ACO participating with two insurers. In addition, after discussions in the Operations Group, the participating ACOs, payers and GMCB staff have agreed that criterion for Year One only should be for a member lives count as of 6-30-14, rather than for annual member months. Therefore, in order to address both of these changes, we have revised provision I.D.1 on page 3 of the Standards document to read as follows:

- For Year 1 of the ACO pilot, an ACO participating with one commercial payer must have at least five thousand (5,000) commercial attributed lives as of June 30, 2014. For Year 1 of the ACO pilot, an ACO participating with two commercial payers must have three thousand (3,000) commercial attributed lives for each of the two payers, for an aggregate minimum of six thousand (6,000) commercial attributed lives as of June 30, 2014.

- In Performance Years 2 and 3, a participating insurer may elect to not participate with an ACO, if: (1) that ACO is participating with one commercial insurer and that ACO's projected or actual attributed member months with that insurer fall below 60,000 annually; or (2) that ACO is participating with two commercial insurers and that ACO's projected or annual attributed member months with that insurer fall below 36,000 annually.

The approved Standards document has duplicative provisions regarding patient attribution under section V. on page 5. Therefore, we have removed the following duplicative provisions:

- ~~An ACO must have at least 60,000 member months attributed annually in the commercial Exchange pilot to the participating insurers in the aggregate and at least 36,000 member months attributed annually to each insurer in the commercial Exchange in order to participate in the pilot with that insurer.~~

2. **Termination or continuation of agreement based on ACO attribution levels as of June 30, 2014**

Since there is significant uncertainty around the attribution levels in Year One, the stakeholders and GMCB staff have agreed that there should be an opportunity for the payers and ACOs to reassess their contracts in light of the levels of attribution six months into the first year of the pilot. Language to this effect was included in the XSSP Program Agreement. Therefore we have added the following language to the Standards document:

- In order to establish the number of an ACO's commercial attributed lives, the payer will, on July 1, 2014, or as soon thereafter as possible, provide the ACO with an account of ACO's commercial attributed lives as of June 30, 2014. Based upon the number of an ACO's commercial attributed lives as of June 30, 2014, the ACO and payer may proceed as follows: if the commercial attributed lives are below the minimum number required for participation, the payer or the ACO may:
    1. terminate their agreement for cause as of June 30, 2014; or
    2. agree to maintain their agreement in full force and effect.

3. **GMCB-facilitated process to waive the attribution threshold**

Even with the change immediately above, the approved Standards document still includes a provision that prohibits payers from contracting with ACOs if an ACO fails to meet the attribution threshold in Years 2 and 3. The ACOs and the payers have since agreed that it would make sense to give the payers some ability to make an exception to the attribution threshold and contract with an ACO if the attributed patient count is just under the threshold. The GMCB has offered to facilitate this process to provide the payers and ACOs with anti-trust protection. Therefore, we have added the following language to page 3 of the Standards document as provision I.D.2:

If an ACO falls below the attribution threshold required for participation in the pilot in Years 2 and 3, it may request that the relevant payers participate in a GMCB-facilitated process to determine whether one or more of the payers would find it acceptable to waive the enrollment threshold and either a) establish a contract with the ACO in the absence of meeting this requirement, or b) permit an already-contracted ACO eligibility to share in any generated savings. While the GMCB will facilitate this process, the decision regarding whether to waive the enrollment threshold and contract with the ACO, or to permit a contracted ACO to share in any savings, remains with the payer.

4. Eligibility for shared savings based on performance improvement

Although the approved Standards document only included a provision to enable ACOs to earn shared savings based on achieving an acceptable level of performance relative to a target, the GMCB-approved Program Agreement states that ACOs should also be able to earn shared savings in Year Two and Year Three of the program should the ACO demonstrate meaningful improvement. The literature on pay-for-performance programs suggests that the inclusion of an improvement target (in addition to a performance target) can increase the effectiveness of the incentive and motivate providers to improve, particularly those providers that are significantly below the threshold for receipt of the incentive.[1] The GMCB incorporated language to allow ACOs to receive shared savings on the basis of performance improvement in Year Two and Year Three into Exhibit B of the Program Agreement. In order to be consistent with the Program Agreement, we have inserted comparable language into the Standards document on page 15 under Section VI:

Eligibility for shared savings based on performance improvement.

Should the ACO, in Years 2 or 3, fail to meet the minimum quality score, it may still be eligible to receive shared savings if the GMCB determines, after providing notice to and accepting written input from the insurer and ACO (and input from ACO participants, if offered), that the ACO has made meaningful improvement in its quality performance as measured against prior pilot years. The GMCB will make this determination after conducting a public process that offers stakeholders and other interested persons sufficient time to offer verbal and/or written comments related to the issues before the GMCB.

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[1] Rosenthal MB and Frank RG. "What is the empirical basis for paying for quality in health care?" *Med Care Res Rev*, 63(2):135-57, April 2006 and interview with Meredith Rosenthal, September 15, 2008.

Attachment 3c - Commercial SSP Technical Corrections to Standards

TO: GMCB and VHCIP Core Team
FROM: Richard Slusky
DATE: June 13, 2014
RE: Technical Corrections to the Commercial ACO Pilot Standards

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Since the Green Mountain Care Board (GMCB) approved the Commercial ACO pilot Standards on November 26, 2013, the Green Mountain Care Board staff and Operations Group members have found that sections within the Standards warrant additional clarification and changes. This memo describes the technical corrections to the Standards document that either the Green Mountain Care Board staff or the Operations Group members have identified since GMCB adoption of the Standards.

The technical changes described in this memo address the following topics:

1. Analysis of changes in provider coding patterns
2. Clarification of ACO financial report requirements
3. Clarification of Patient Attribution Methodology
4. Consideration of obstetricians and gynecologists as attributing clinicians
5. Clarification that a primary care provider to whom lives have been attributed by a payer may only participate as a primary care provider in one ACO
6. Clarification of the risk-adjustment methodology
7. Annual updating of measure set narrative specifications based on release of updates to national guidelines.

Additionally, the data use report standards were incomplete at the time of GMCB approval of the Standards document. We have therefore incorporated the "Data Use Report Standards for ACO Pilot" document by reference as indicated below:

8. Section IX: "Vermont ACO Data Use Standards"

1. **Analysis of changes to provider coding patterns:**

   While the approved Standards document assigned responsibility to the payers for assessing any changes to provider billing coding patterns, the GMCB and the Operations Group subsequently agreed that it would be more appropriate to have this analysis conducted by the GMCB's Analytics Contractor. Therefore, provision I.A.1 on page 2 of the Standards document now reads:

   - "~~Payers~~ The GMCB's Analytics Contractor will assess whether changes in provider coding patterns have had a substantive impact on medical spending, and if so, bring such funding and documentation to the GMCB for consideration with participating pilot ACOs."

While the original Standards document implied that a process would follow this assessment of changes to coding patterns, it was not explicitly stated in the document. Therefore, we have added the following language to page 2 of the Standards document as provision I.A.2:

- "The Payers and ACOs shall participate in a GMCB-facilitated process to review and consider the financial impact of any identified changes in ACO provider coding patterns."

2. Clarification of ACO financial report requirements:

While the approved Standards document required ACOs to submit financial reports to the VHCIP Payment Models Work Group (or its successor) and to the GMCB, the GMCB believes that it would be more appropriate for the GMCB and the Department of Vermont Health Access (DVHA) to review the ACO's financial reports. Additionally, while the approved Standards document specified that the semi-annual reports be submitted by June 30th and December 31st, the GMCB has since concluded that the ACOs will need time following the close of the financial period to close the books and develop the report. Finally, the GMCB finds that payers are better positioned to generate ACO financial reports than are ACOs. Therefore, we have revised provision I.C.1 on page 2 of the Standards document to read:

- The ~~ACO~~ payer will furnish financial reports regarding each ACO's risk performance for each six-month performance period to the GMCB and DVHA ~~to the VHCIP Payment Models Work Group or its successor and to the GMCB on a semi-annual basis by June 30th and December 31st~~ in accordance with report formats and timelines defined by the GMCB, through a collaborative process with ACOs and payers.

3. Clarification of Patient Attribution Methodology:

The approved Standards document established an attribution policy based on the understanding that PCP selection is an exchange product requirement. We have since learned that some individuals do not select a PCP when enrolling and the insurers are permitting enrollment by such persons. As a result, members may experience a time period when they are enrolled in an Exchange product, but have not yet selected a PCP. Therefore, we have revised provision V.3. on page 6 of the Standards document to read:

- For products that require members to select a primary care provider, and for which the member has selected a primary care provider, attribute those members to that provider.

4. **Consideration of obstetricians and gynecologists as attributing clinicians:**

   While the approved Standards document included a provision that assigned responsibility to the VHCIP Payment Models Work Group for reconsidering whether obstetricians and gynecologists should be added to the attributing clinician list, given the work plan in place for this Work Group, the GMCB recommends that this reconsideration occur with participating ACOs and payers in the context of a GMCB-facilitated process instead. Therefore, we have revised provision V.9 on page 8 to read:

   - Using a GMCB-facilitated process, t~~he~~ ~~VHCIP Payment Models Work Group~~ participating ACOs and payers will reconsider during Year 1 whether ~~OB/Gyns~~ obstetricians and gynecologists should be added to the attributing clinician list. ~~during Year 1 in the context of a GMCB-facilitated process.~~

5. **Clarification that a primary care ~~provider~~ practitioner to whom lives have been attributed by a payer may only participate as a primary care ~~provider~~ practitioner in one ACO:**

   While it is implicit in the attribution algorithm included in the approved Standards document that a primary care ~~physician~~ practitioner with lives attributed to him/her can only participate in one ACO, this is not explicitly stated. In order to avoid any confusion about this point going forward, we have added the following language as provision V.10 on page 8:

   - A qualified primary care ~~provider~~ practitioner to whom lives have been attributed by a payer may only participate as a primary care ~~provider~~ practitioner in one ACO.
   - ~~In the rare instance that~~ If a qualified primary care practitioner works under multiple tax ID numbers, the practitioner may not use a specific tax ID number with more than one ACO.

6. **Clarification of the risk-adjustment methodology:**

   Page 10 of the approved Standards document specifies that the PMPM medical expense spending shall be adjusted for "clinical case mix using a common methodology across commercial insurers." Subsequent to the drafting of this language the prior ACO Standards Work Group determined the methodology for risk adjustment. However, this language was not captured in the Standards document. Therefore, we have incorporated the decision of that work group into the Standards using the following language in Section VI. I. step 3:

   - clinical case mix using ~~a common methodology across commercial insurers~~ the risk adjustment model utilized by Center for Consumer Information and Insurance Oversight (CCIIO) for the federal exchange. The GMCB may consider alternatives for future years;

7. **Addition of provisions to Section X to allow for annual updating of measure set narrative specifications based on release of updates to national guidelines.**

   To reflect the need to update measure specifications based on changes to national guidelines, we have incorporated the following language into the Standards document as follows:

   - Page 17, Section X, paragraph 1: Such recommendations will include annual updates to the Payment and Reporting measures included in the Core Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures).
   - Page 17, Section X, paragraph 2: Such recommendations will include annual updates to the targets and benchmarks for measures designated for Payment purposes as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures).
   - Page 18, Section X, paragraph 3: Such recommendations will include annual updates to measures designated as Pending in the Core Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures).
   - Page 18, Section X, paragraph 4: Such recommendations will include annual updates to the Monitoring and Evaluation measures included in the Monitoring and Evaluation Measure Set narrative measure specifications as necessary upon release of updates to national guidelines (e.g., annual updates made by the National Committee for Quality Assurance to HEDIS® specifications for that year's performance measures).

8. **Addition of Section IX, the "Vermont ACO Data Use Standards:"**

   When the Standards were approved on November 26, 2013, the Data Use Subgroup had not completed its work. Therefore the Standards document only held a placeholder for Section IX. Most of the work of the Subgroup has since been completed and therefore we have incorporated the following language into the Standards document on page 16:

   - ~~The~~ ACOs and payers must submit the required data reports detailed in the "Data Use Report Standards for ACO Pilot" document in the format defined through a collaborative process led by the GMCB.
   - ~~The payers must submit the required data reports detailed in the "Data Use Report Standards for ACO Pilot" document in the format defined through a collaborative process led by the GMCB.~~

Attachment 4a - DRAFT VHCIP GP Application

Vermont Health Care Innovation Project Grant Program Application

Draft dated 12.23.2013

I. Background

The federal Centers for Medicare and Medicaid Innovation (CMMI) awarded the State Innovation Model (SIM) grant to Vermont. The grant provides funding and other resources to support health care payment and delivery system reforms aimed at improving care, improving the health of the population, and reducing per capita health care costs, by 2017. To maximize the impact of non-governmental entity involvement in this health care reform effort, Vermont identified funding within its SIM grant to directly support providers engaged in payment and delivery system transformation. The State has determined that a competitive grant process will foster innovation and promote success among those providers eager to engage in reforms. These grants will be reviewed by the VHCIP/SIM Core Team using the criteria found in the Grant Program (GP) Criteria.

Applicants can seek technical assistance support as well as direct funding. The total amount available for direct funding is $5,295,102 of which $xxx is available in this round.

GP grants will support provider-level activities that are consistent with overall intent of the SIM project, in two broad categories:

1. Activities that directly enhance provider capacity to test one or more of the three alternative payment models approved in Vermont's SIM grant application:
    a. Shared Savings Accountable Care Organization (ACO) models;
    b. Episode-Based or Bundled payment models; and
    c. Pay-for-Performance models.
2. Infrastructure development that is consistent with development of a statewide high-performing health care system, including:
    a. Development and implementation of innovative technology that supports advances in sharing clinical or other critical service information across different types of provider organizations;
    b. Development and implementation of innovative systems for sharing clinical or other core services across different types of provider organizations;
    c. Development of management systems to track costs and/or quality across different types of providers in innovative ways.

Preference will be given to applications that demonstrate:

- Support from and equitable involvement of multiple provider organization types that can demonstrate the grant will enhance integration across the organizations;
- A scope of impact that spans multiple sectors of the continuum of health care service delivery (for example, prevention, primary care, specialty care, mental health and long term services and supports);

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- Innovation, as shown by evidence that the intervention proposed represents best practices in the field;
- An intent to leverage and/or adapt technology, tools, or models tested in other States to meet the needs of Vermont's health system;
- Consistency with the Green Mountain Care Board's specifications for Payment and Delivery System Reform pilots. The Green Mountain Care Board's specifications can be found here: http://gmcboard.vermont.gov/PaymentReform.

II. What these grants will fund

Grants will fund activities in support of collaborative innovation in health care payment reform. Appendix B includes a detailed list of federal guidelines around this funding. Please review these federal guidelines before developing a project budget.

Applicants may seek funding for a maximum of 24 months for any of the following types of activities:

- Data analysis
- Facilitation
- Quality improvement
- Evaluation
- Project development

III. Grant submission requirements

Applicants will be expected to provide the following in support of their application:

- GP Application Cover Form. This form is found in Appendix A.
- Grant Narrative. The Grant Narrative should be a maximum of 12 pages double-spaced, 12 point font, with 1-inch margins, paginated in a single sequence. The Grant Narrative should contain the following information:
    a. A clear description of the activities for which the applicant is requesting funding or technical assistance;
    b. The number of providers impacted and the number of patients impacted;
    c. Explain how this proposal directly relates to the VHCIP goals, specifically how it relates to the payment and delivery system activities funded through the State Innovation Models Testing Grant.

    d. A clear description of alternative funding sources sought and rationale for requesting SIM funds;
    e. A description of technical assistance services sought. Appendix D provides more detail about the technical assistance services available under this grant.

f. A description of the project's potential return-on-investment in terms of cost savings and quality improvement, and plans for measuring both;
g. A description of how the project will avoid duplication and complement similar activities in Vermont that are currently underway (applicants may provide additional appendices that describe the research they did to respond to this question and listing any other similar initiatives around the state);
h. A summary of the evidence base for the proposed activities or technical assistance including information from Vermont and across the nation.

- A project plan, staffing structure, deliverables description, and timeline for completion of the proposed activities. This includes a project management plan with implementation timelines and milestones.
- Executed Memorandum of Understanding or other demonstration of support from partner providers, if applicable.
- Budget Narrative. Budget Narrative guidance is found in Appendices B and C. The Budget Narrative should contain the following:
  a. A budget for the proposed project, consistent with specified budget formats;
  b. A description of any available matching support, whether financial or in-kind;
  c. Information regarding on-going support that may be needed for work begun under this grant.

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IV. State resources available to grantees

Grant recipients may receive the following support, to the extent that a need has been clearly established in the grant application. More detail about the technical assistance can be found in Appendix D*:*

- Supervision to ensure compliance with federal antitrust provisions;
- Assistance in aligning with other testing models in the state;
- Assistance with appropriately attributing outcomes and savings to testing models;
- Overall monitoring of health care quality and access;
- Funding for specific activities;
- Technical Assistance:
  - Meeting facilitation
  - Stakeholder engagement
  - Data analysis
  - Financial modeling
  - Professional learning opportunities

V. Compliance and Reporting Requirements

As a responsible steward of federal funding, the state, through the Agency of Human Services, Department of Vermont Health Access (DVHA), monitors its sub-recipients utilizing the following monitoring tools:

1) Ensure that sub-recipient is not disbarred/suspended or excluded for any reason
2) Sub-award agreement
3) Sub-recipient meeting and regular contact with sub-recipients
4) Required pre-approval for changes to budget or scope of grant
5) Quarterly financial reports
6) Bi-annual programmatic reports
7) Audit
8) Desk Reviews
9) Site audits

In its use of these monitoring tools, the State emphasizes clear communication to ensure a feedback loop that supports sub-recipients in maintaining compliance with federal requirements. The State may at any time elect to conduct additional sub-recipient monitoring. Sub-recipients therefore should maintain grant records accurately in the event that the State exercises this right. The State may also waive its right to perform certain sub-recipient monitoring activities. If, at any

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time, the State waives its right to certain sub-recipient monitoring activities, it will note which activities were not completed and the reasons why that activity was not necessary. Each of the monitoring tools and policies regarding their use are described in detail below.

1) Sub-recipient status

When signing the sub-award agreement, Sub-recipient's certify that neither the Sub-recipient nor Sub-recipient principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs or programs supported in whole or in part by federal funds.

Additionally DVHA will utilize the Excluded Parties List System (www.epls.gov) to confirm that neither the Sub-recipient nor its principals are presently disbarred at least once during DVHA's fiscal year. DVHA will print a screen shot of its EPLS search, and place it in the Sub-recipient's files.

2) Sub-award agreement

A sub-award agreement is provided to each sub-recipient at the beginning of each grant. This sub-award agreement will detail the Catalog of Federal Domestic Assistance (CFDA) program name and number, the award name and number as assigned by the funder, the award period, and the name of the federal awarding agency. This sub-award agreement will also include: definitions, the scope of work to be performed, payment provisions, funder grant provisions, blank financial and programmatic reports, and a copy of this policy. Other information may be included if necessary.

Unless any changes are required, only one sub-award document will be generated for the term of a grant, even if that term spans several years. All sub-recipients must sign the sub-award agreement and any additional documents sent with the sub-award, or funding will be terminated.

3) Sub-recipient meeting/ sub-recipient contact

The State may decide, at the beginning of a grant or at any time during a grant, to host a meeting of grant partners in order to review grant goals and/or obligations. A sub-recipient meeting may be held with one individual sub-recipient, or with multiple sub-recipients.

The State will also maintain contact with sub-recipients. Sub-recipients are expected to notify the State if they are having any difficulty carrying out their grant responsibilities or if they need clarification of their grant responsibilities.

Sub-recipients meeting and sub-recipient contact will be noted on the sub-recipient checklist, with appropriate supporting documentation included it the sub-recipient's folder.

4) Required pre-approval for changes to budget or scope of grant

As stated above, all sub-recipients must seek prior approval from the grants manager at the State to utilize grant funding for any activities not explicitly described in the goals section of the narrative. Sub-recipients must also seek prior approval before making any changes to their section of the budget.

Notes regarding any prior approval requested by a sub-recipient, or a sub-recipient's failure to comply with this grant term, will be maintained on the sub-recipient checklist.

5) Quarterly financial reports

The Sub-recipient will submit accurate financial reports to the State no later than the tenth of the month following the quarter being reported (January 10th, April 10th, July 10th, and October 10th). A blank copy of the required financial report will be provided with the sub-award agreement. All questions regarding financial reports should be directed to Robert Pierce at robert.pierce@state.vt.us.

Financial reports will be reviewed by the State for accuracy and to ensure that all charges are eligible to be reimbursed by the grant. Sub-recipients are expected to respond promptly to all questions concerning financial reports.

Sub-recipient's submission of quarterly financial reports will be recorded and monitored on the sub-recipient checklist.

6) Bi-annual programmatic reports

The sub-recipient will submit accurate programmatic reports to the State no later than the tenth of the month following the 6-month period being reported (January 10th and July 10th). A blank copy of the required programmatic reports will be provided with the sub-award agreement. All questions regarding programmatic reports should be directed to Georgia Maheras at georgia.maheras@state.vt.us.

Programmatic reports will be reviewed by the State for accuracy and to ensure that all charges are eligible to be reimbursed by the grant. Sub-recipients are expected to respond promptly to all questions concerning programmatic reports

7) Audit

Sub-recipients who spent at least $500,000 in federal funds from all federal sources during their fiscal year must have an audit performed in accordance with OMB Circular A-133. The A-133 compliant audit must be completed within 9 months of the end of the sub-recipient’s fiscal year. The sub-recipient shall provide the State with a copy of their completed A-133 compliant audit including:

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- the auditor's opinion on the sub-recipient's financial statements,
- the auditor's report on the sub-recipient's internal controls,
- the auditor's report and opinion on compliance with laws and regulations that could have an effect on major programs,
- the schedule of findings and questioned costs,
- and the sub-recipients corrective action plans (if any).

The State will issue a management decision on audit findings within 6 months after receipt of the sub-recipient's A-133 compliant audit report.

If a sub-recipient's schedule of findings and questioned costs did not disclose audit findings relating to the Federal awards provided by the State and the summary schedule of prior audit findings did not report the status of audit findings relating to Federal awards provided by the State, the sub-recipient may opt not to provide the A-133 compliant audit report to the State. In this case, the State will verify that there were no audit findings utilizing the Federal Audit Clearinghouse database.

Any sub-recipient that, because it does not meet the $500,000 threshold or because it is a for-profit entity, does not receive an audit performed in accordance with OMB Circular A–133 may at its option and expense have an independent audit performed. The independent audit should be performed to obtain reasonable assurance about whether the sub-recipient's financial statements are free of material misstatement. The independent audit should also take into consideration the sub-recipient's internal control, but does not necessarily have to contain the auditor's opinion on the agency's internal control. If the sub-recipient elects to have an audit report that covers more than the sub-recipient's financial statements, the State requests that the entirety of the auditor's report be provided to the State.

If the sub-recipient chooses not have an independent audit and the sub-recipient will receive at least $10,000 during the current fiscal year, they will be subject to on-site monitoring during the award period.

Sub-recipients who are individual contractors will not be subject to on-site monitoring based solely on the lack of an independent audit.

8) Desk Reviews

All sub-recipients who are estimated to receive $10,000 or more during the fiscal year will undergo a desk review at least once during the grant period. If a sub-recipient receives less than $10,000, the State may at its discretion opt to conduct a desk review. During a desk review, sub-recipients might be expected to provide:

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- Adequate source documentation to support financial requests including but not limited to an income statement, payroll ledgers, cancelled checks, receipts ledgers, bank deposit tickets and bank statements, and timesheets.
- If salary is funded under the award and if the staff whose salary is funded under the award is charged to other funding sources, time distribution records to support the amounts charged to federal funding provided by the State.
- A statement verifying that the organization has a system in place for maintaining its records relative to federal funding provided by the State for the amount of time as specified in the sub-award document.
- Adequate documentation to support required match, if any.

9) Site visits

All sub-recipients who receive $50,000 or more in federal funding passed through the State for three consecutive fiscal years (July 1 – June 30), will undergo a site visit at least once during the three year period. Sub-recipient will be subject to desk monitoring during the intervening years. The State will arrange a suitable date and time for on-site monitoring with the sub-recipient. Recipients receiving a site visit will be expected to provide all of the back-up documentations as specified above, as well as:

- A written policy manual specifying approval authority for financial transactions.
- A chart of accounts and an accounting manual which includes written procedures for the authorization and recording of transactions.
- Documentation of adequate separation of duties for all financial transactions (that is, all financial transactions require the involvement of at least two individuals).
- If grant funds are utilized to purchase equipment, demonstration that the organization maintains a system for tracking property and other assets bought or leased with grant funds.
- A copy of the agency's Equal Opportunity Policy and Practices in Hiring.

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Appendix A: Application Cover Form

General Information:

Lead Organization Applying: ___________________________________

Collaborating Organizations: ___________________________________

Key Contact for Applicant: ________________________________

Relationship to Applicant: ________________________________

Key Contact Email:_________________________

Key Contact Phone Number:______________________

Key Contact Mailing Address: ___________________________________

Fiscal Officer (must be different from Key Contact): ___________________________

Relationship to Applicant: _________________

Fiscal Officer Email:_________________________

Fiscal Officer Phone Number:______________________

Fiscal Officer Mailing Address (if different from Key Contact):

Project Title and Brief Summary:

Project Title(limit to 40 characters):
____

Brief Summary of the Project (max. 150 words):

Budget Request Summary:

Please include proposed project start and end dates in this section.

Budget Category	Year 1	Year 2	**Total**
Personnel			
Fringe			
Travel			

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Equipment			
Supplies			
Indirect			
Contracts			
Other*			
Total			

*Applicants should identify what items are included in the Other category if used.

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Appendix B: CMMI Funding Restrictions

All funds expended through this grant program must comply with the federal guidelines found in the State Innovation Models FOA found here: http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf

The cost principles address four tests in determining the allowability of costs. The tests are as follows:

- *Reasonableness (including necessity).* A cost is reasonable if, in its nature or amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The cost principles elaborate on this concept and address considerations such as whether the cost is of a type generally necessary for the organization's operations or the grant's performance, whether the recipient complied with its established organizational policies in incurring the cost or charge, and whether the individuals responsible for the expenditure acted with due prudence in carrying out their responsibilities to the Federal government and the public at large as well as to the organization.
- *Allocability.* A cost is allocable to a specific grant, function, department, or other component, known as a cost objective, if the goods or services involved are chargeable or assignable to that cost objective in accordance with the relative benefits received or other equitable relationship. A cost is allocable to a grant if it is incurred solely in order to advance work under the grant; it benefits both the grant and other work of the organization, including other grant-supported projects or programs; or it is necessary to the overall operation of the organization and is deemed to be assignable, at least in part, to the grant.
- *Consistency.* Recipients must be consistent in assigning costs to cost objectives. They must be treated consistently for all work of the organization under similar circumstances, regardless of the source of funding, so as to avoid duplicate charges.
- *Conformance.* This test of allowability—conformance with limitations and exclusions contained in the terms and conditions of award, including those in the cost principles—may vary by the type of activity, the type of recipient, and other characteristics of individual awards. "Allowable Costs and Activities" below provides information common to most HHS grants and, where appropriate, specifies some of the distinctions if there is a different treatment based on the type of grant or recipient.

These four tests apply regardless of whether the particular category of costs is one specified in the cost principles or one governed by other terms and conditions of an award. These tests also apply regardless of treatment as a direct cost or an indirect cost. The fact that a proposed cost is awarded as requested by an applicant does not indicate a determination of allowability.

Direct Costs and Indirect Costs

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This is for illustrative purposes. We strongly recommend applicants review all of the federal guidance provided in the FOA found here: *http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf* .

Direct costs are costs that can be identified specifically with a particular award, project or program, service, or other organizational activity or that can be directly assigned to such an activity with a high degree of accuracy. Direct costs include, but are not limited to, salaries, travel, equipment, and supplies directly benefiting the grant-supported project or program. Indirect costs (also known as "facilities and administrative costs") are costs incurred for common or joint objectives that cannot be identified specifically with a particular project, program, or organizational activity. Facilities operation and maintenance costs, depreciation, and administrative expenses are examples of costs that usually are treated as indirect costs. There is a 10% cap on indirect costs. The organization is responsible for presenting costs consistently and must not include costs associated with its indirect rate as direct costs.

Examples of Unallowable Direct Costs:

- Alcohol
- Alteration and Renovation Costs
- Animals
- Bad Debts
- Bid and Proposal Costs
- Construction or Modernization
- Dues/Membership-Unallowable for Individuals (unless fringe benefit or employee development costs if applied as established organization policy across all funding sources).
- Entertainment
- Fines and Penalties
- Fundraising
- Honoraria- if this cost is for speaker fee that it is allowable as a direct cost.
- Invention, Patent or Licensing Costs-unless specifically authorized in the NOA.
- Land or Building Acquisition
- Lobbying
- Meals (Food)
- Travel

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Appendix C: Budget Narrative Guidance

INTRODUCTION

This guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by ensuring that the required or needed information is provided. In the budget request, awardees should distinguish between activities that will be funded under this agreement and activities funded with other sources.

A. Salaries and Wages

For each requested position, provide the following information: name of staff member occupying the position, if available; annual salary; percentage of time budgeted for this program; total months of salary budgeted; and total salary requested. Also, provide a justification and describe the scope of responsibility for each position, relating it to the accomplishment of program objectives.

Position Title and Name	*Annual*	*Time*	*Months*	*Amount Requested*
Project Coordinator Susan Taylor	*$45,000*	*100%*	*12 months*	*$45,000*
Finance Administrator John Johnson	*$28,500*	*50%*	*12 months*	*$14,250*
Outreach Supervisor (Vacant)*	*$27,000*	*100%*	*12 months*	*$27,000*

Sample Justification

The format may vary, but the description of responsibilities should be directly related to specific program objectives.

Job Description: Project Coordinator - (Name)

This position directs the overall operation of the project; responsible for overseeing the implementation of project activities; coordination with other agencies; development of materials, provisions of in service and training; conducting meetings; designs and directs the gathering, tabulating and interpreting of required data; responsible for overall program evaluation and for staff performance evaluation; and is the responsible authority for ensuring necessary reports/documentation are submitted to HHS. This position relates to all program objectives.

B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed. This can be done for all FTE in one table instead of itemizing per employee.

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Sample
Example: Project Coordinator — Salary $45,000

Retirement 5% of $45,000	=	*$2,250*
FICA 7.65% of $45,000	=	*3,443*
Insurance	=	*2,000*
Workers' Compensation	=	________
	Total:	

C. Consultant Costs

This category is appropriate when hiring an individual to give professional advice or services (e.g., training, expert consultant, etc.) for a fee but not as an employee of the awardee organization. Hiring a consultant requires submission of the following information:

1. Name of Consultant;
2. Organizational Affiliation (if applicable);
3. Nature of Services to be Rendered;
4. Relevance of Service to the Project;
5. The Number of Days of Consultation (basis for fee); and
6. The Expected Rate of Compensation (travel, per diem, other related expenses)—list a subtotal for each consultant in this category.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the body of the budget request, a summary should be provided of the proposed consultants and amounts for each.

D. Equipment

Provide justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the "Other" category. All IT equipment should be uniquely identified. As an example, we should not see a single line item for "software." Show the unit cost of each item, number needed, and total amount.

Item Requested	*How Many*	*Unit Cost*	*Amount*
Computer Workstation	*2 ea.*	*$2,500*	*$5,000*
Fax Machine	*1 ea.*	*600*	*600*

Sample Justification

Provide complete justification for all requested equipment, including a description of how it will be used in the program. For equipment and tools which are shared among programs, please cost allocate as appropriate. States should provide a list of hardware, software and IT equipment which will be required to complete this effort. Additionally, they should provide a list of non-IT equipment which will be required to complete this effort.

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E. Supplies

Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget

Supplies

General office supplies (pens, pencils, paper, etc.)

12 months x $240/year x 10 staff	*=*	*$2,400*
Educational Pamphlets (3,000 copies @) $1 each)	*=*	*$3,000*
Educational Videos (10 copies @ $150 each)	*=*	*$1,500*
Word Processing Software (@ $400—specify type)	*=*	*$ 400*

Sample Justification

General office supplies will be used by staff members to carry out daily activities of the program. The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Word Processing Software will be used to document program activities, process progress reports, etc.

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F. Other

This category contains items not included in the previous budget categories. Individually list each item requested and provide appropriate justification related to the program objectives.

Sample Justification

Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If the items are not self-explanatory and/or the cost is excessive, include additional justification. For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).

G. Total Direct Costs $__________

Show total direct costs by listing totals of each category.

H. Indirect Costs $______________

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement established with the Cognizant Federal agency. A copy of the most recent indirect cost rate agreement must be provided with the application.

Sample Budget

The rate is______% and is computed on the following direct cost base of $______________________.

Personnel *$*

Fringe *$*

Travel *$*

Supplies *$*

Other$________________

Total *$* *x_____% = Total Indirect Costs*

Appendix D: Technical Assistance

State resources available to grantees

Projects supported by the Provider Grants Program may be provided the following supports, to the extent that a need has been clearly established in the grant application:

- Supervision to ensure compliance with federal antitrust provisions;
- Assistance in aligning with other testing models in the state;
- Assistance with appropriately attributing outcomes and savings to testing models;
- Overall monitoring of health care quality and access;
- Funding for specific activities;
- Technical Assistance:
    - Meeting facilitation
    - Stakeholder engagement
    - Data analysis
    - Financial modeling
    - Professional learning opportunities

Attachment 4b - Grant Program Recs from VHCIP WGs

VERMONT

Vermont Health Care Innovation Project

State Innovation Model

109 State Street
Montpelier, VT 05609
http://healthcareinnovation.vermont.gov

To: Core Team
Fr: Georgia Maheras
Re: Grant Program Application
Date: July 11, 2014

The Core Team requested input from the VHCIP work groups on the grant program. The work groups provided detailed recommendations below. The majority of the recommendations are extremely helpful for the Core Team in the evaluation of grant applications and I recommend the Core Team take this information into account in their application review. I have included the full work group recommendations below.

There are some recommendations to the application text that I think the Core Team should incorporate into the application:

1. Request that the applicant indicate how their project impacts other similar projects. (HIE)
2. Request that the applicant provide information about the statewide applicability of the project learnings. (DLTSS)
3. Edit this portion of the application to include the new, underlined text: Innovation, as shown by evidence that the intervention proposed represents best practices in the field and that it is informed by service recipient experience and engagement. (DLTSS)
4. If the project involves data, make sure it can be shared easily across organizations and works within the existing health information infrastructure. (HIE)

A. CMCM Work Group Recommendation

I. Background:

At its recent June 10th, 2014 in-person work group meeting, the Care Models and Care Management Work Group reviewed the request of the VHCIP core team to "*recommend additional criteria for the next round of grant funding, to support care models and care management activities that will help achieve VHCIP goals*[1]*.*"

II. Recommendations:

After discussion of this request, the work group agreed to the following recommendations:

1. The Care Models and Care Management Work Group has identified the following as its top two priorities, and recommends that they be considered as criteria when reviewing Round Two Provider Grant proposals:

- In order to better serve all Vermonters (especially those with complex physical and/or mental health needs); reduce fragmentation with better coordination of provider/CHT/health plan and other care management activities (e.g., medication management, mental health and substance abuse transitions). Focus on improving transitions of care and communications between providers and care managers that offer services throughout the various domains of a person's life.

- Better integrate social services (e.g., housing, food, fuel, education, transportation) and health care services in order to more effectively understand and address social determinants of health (e.g., lack of housing, food insecurity, loss of income, trauma) for high-risk Vermonters.

2. Additionally, the work recommends that consideration be given to proposals for provider training that supports the above two criteria.

B. DLTSS Work Group Recommendation

[1] Presentation from Georgia Maheras to Care Models and Care Management. –"VHCIP Round Two Grant Award Background," June 10, 2014.

At the June DLTSS Work Group meeting, Georgia Maheras requested input regarding the criteria for Round Two of the VHCIP Provider Grant Program. As a result, the DLTSS Work Group had a lengthy discussion about the need to bridge the knowledge gap among providers between acute/medical care and disability and long term services and supports (DLTSS).

An estimated one in five Vermonters has a disability[2], and people with disabilities are more susceptible to preventable health problems that decrease their overall health and quality of life.[3] To be healthy, people with disabilities require health care that meets their needs as a whole person, not just as a person with a disability. Yet, people with disabilities experience significant barriers to health care and health disparities when compared with persons who do not have disabilities.[4,5] A primary source of this disparity is the lack of knowledge about disabilities among health care providers (e.g., communication and other accessibility needs, socio-economic factors associated with disabilities and health outcomes, resources for services and supports).[6]

The DLTSS Work Group submits that addressing this provider knowledge gap is paramount in order to achieve the VHCIP goals of improving the care and health of all Vermonters, and reducing per capita health care costs. As such, the DLTSS Work Group unanimously recommended that the following be adopted by the Core Team for incorporation into the Provider Grant Program Request for Proposals:

"Amend the Provider Grant Program criteria to support specific provider grant proposals that include provider training activities to achieve person-centered, cross-disciplinary and culturally sensitive care specific to the needs of people with disabilities and long term service and support needs, and which include consumer input/participation and statewide applicability."

Following are proposed changes (underlined) to the language on pages 2-3 of the Vermont Health Care Innovation Project Grant Program Application (released on 1.16.2014) to achieve this recommendation:

GP grants will support provider-level activities that are consistent with overall intent of the SIM project, in two broad categories:

1. Activities that directly enhance provider capacity to test one or more of the three alternative payment models approved in Vermont's SIM grant application:
    a. Shared Savings Accountable Care Organization (ACO) models;

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[2] http://www.cdc.gov/ncbddd/documents/Disability%20tip%20sheet%20_PHPa_1.pdf

[3] For example, adults with disabilities are 3 times more likely to have heart disease, stroke, diabetes, or cancer than adults without disabilities. http://www.cdc.gov/vitalsigns/disabilities/

[4] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6234a3.htm?s_cid=mm6234a3_w

[5] http://www.cdc.gov/vitalsigns/disabilities/

[6] http://www.cdc.gov/ncbddd/disabilityandhealth/hcp.html

    b. Episode-Based or Bundled payment models; and
    c. Pay-for-Performance models.
2. Infrastructure and workforce development that is consistent with development of a statewide high-performing health care system, including:
    a. Development and implementation of innovative technology that supports advances in sharing clinical or other critical service information across different types of provider organizations;
    b. Development and implementation of innovative systems for sharing clinical or other core services across different types of provider organizations;
    c. Development of management systems to track costs and/or quality across different types of providers in innovative ways;
    d. Provider training to achieve person-centered, cross-disciplinary and culturally sensitive care specific to the needs of people with disabilities and long term service and support needs.

Preference will be given to applications that demonstrate:

- Support from and equitable involvement of multiple provider organization types that can demonstrate the grant will enhance integration across the organizations;
- A scope of impact that spans multiple sectors of the continuum of health care service delivery (for example, prevention, primary care, specialty care, mental health and long term services and supports);
- Statewide applicability of the project learnings;
- Innovation, as shown by evidence that the intervention proposed represents best practices in the field and that it is informed by service recipient experience and engagement;
- An intent to leverage and/or adapt technology, tools, or models tested in other States to meet the needs of Vermont's health system;
- Consistency with the Green Mountain Care Board's specifications for Payment and Delivery System Reform pilots. The Green Mountain Care Board's specifications can be found here: http://gmcboard.vermont.gov/PaymentReform.

I. What these grants will fund

Grants will fund the following types of activities. Appendix B includes a detailed list of federal guidelines around this funding:

- Data analysis
- Facilitation
- Quality improvement, including provider training
- Evaluation
- Project development

C. HIE/HIT Work Group Recommendation

- Review the proposal for cost efficacy and return on investment.
- Require a more information about the specific project's sustainability. Specifically, what will the entity do once the grant is over?
- What is the impact of this program on other programs in the same field/part of the state/sector. Will this project have a positive or negative impact on those other programs?
- The applicants should demonstrate that the project is not only consistent with a generic high performing health system, but with the one we are building in Vermont. The applicants should look at the goals of each of the work groups (found in their Charters, which are posted on the website).
- What is their plan for scaling this project to the maximum number of Vermonters possible?
- If the project involves data, make sure it can be shared easily across organizations and works within the existing health information infrastructure (HIE)

D. Population Health Work Group Recommendation

The Vermont Health Care Innovation Project (VHCIP) is testing new payment and service delivery models as part of larger health system transformation based on the Triple Aim – reducing cost, improving quality, and improving health. The charge of the Population Health Work Group is to recommend ways the Project could better coordinate population health improvement activities and more directly impact population health[7].

The following proposed criteria align with the population health framework which recognizes the multiple factors that contribute to health outcomes, focuses on primary prevention, and seeks opportunities to impact upstream factors that affect health outcomes. The criteria are intended for use in reviewing the provider grant proposals for testing innovation in payment and care delivery models. Ideally, the criteria would be used for each individual application. Minimally, they would be used as a check to ensure that at least some of the proposals considered for funding meet population health objectives.

1. Focus and Funding Towards Primary Prevention and Wellness

[7] Population Health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart, 2003). While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors. **Working Definition of Population Health, Institute Of Medicine, Roundtable on Population Health Improvement** http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx

The proposal should reflect an explicit understanding of the determinants of health and include efforts aimed at primary prevention[8], self-care and maintaining wellness rather than solely on identifying and treating disease and illness. The model being tested should show intended investment of savings or budget in prevention and wellness activities and partners.

2. Focus on broader population and health outcomes

The innovation should include efforts to maintain or improve the health of all people – young, old, healthy, sick, etc. The proposal should consider the health outcomes of a group of individuals in a community in order to develop priorities and target action. Specific attention should be given to the maintenance of health and wellness of subpopulations and especially those most vulnerable due to disability, age, income, etc. – and not just those currently the sickest or most costly – in order to consider health benefit over the long term.

3. Connects Clinical Service Delivery with Broad Set of Community Partners

The proposed innovation in care delivery should build upon existing infrastructure (Blueprint Medical Homes, Community Health Teams, ACOs and public health programs), connect to a broad range of community based resources, and address the interconnection between physical health, mental health, and substance abuse.

[8] Primary prevention is a program of activities directed at improving general well-being while also involving specific protection for selected diseases, such as immunization against measles. Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier. Primary prevention aims to prevent disease from developing in the first place. Secondary prevention aims to detect and treat disease that has not yet become symptomatic. Tertiary prevention is directed at those who already have symptomatic disease, in an attempt to prevent further deterioration, recurrent symptoms and subsequent events.

Attachment 5a - VHCIP finance memo for 7.16.14 Meeting

To: Core Team
Fr: Georgia Maheras
Date: 7/10/14
Re: VHCIP Financial Update and Request for Approval of SIM Funding Actions

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

1. Proposal to increase the funding allocated for external evaluation. Initial Cost: $1,500,000. Current request: $1,800,000. Duration: August 1, 2014-September 30, 2017.
2. Proposal to contract for services to provide chart review in support of quality measure data collection. Cost: $150,000. Duration: September 1, 2014-August 31, 2015.
3. Proposal to contract with the ACOs to provide support for ACO analytics and quality-related activities. Cost: $3,135,000. September 1, 2014-August 31, 2015.

REQUEST #1- Type 2 Proposal to increase the funding allocated to external evaluation by $300,000 for a total of $1,800,000:

This proposal comes from the evaluation contracting team as a result of contract negotiations with the chosen external evaluation contractor. The Core Team previously approved entering into negotiations with this vendor and approved a not to exceed amount of $1,500,000. This request is for an addition $300,000 for this contract.

Proposal Summary:

This vendor provides external evaluation support to the VHCIP Evaluation Director in support of Vermont's required Self-Evaluation Plan. The contract negotiation process for this contract required multiple RFPs and protracted contract negotiations. In addition to this internal process, Vermont received more detailed guidance from CMMI regarding the Self-Evaluation Plan. Based on the revised federal guidance, the Vermont contract negotiation team made modifications to the scope of work. The modifications include: additional provider surveys that complement the RTI surveys, additional travel, and accommodation of additional presentations to VHCIP participants and interaction with CMMI and the federal evaluation team. The result of all of these activities is an increase in the not-to-exceed amount.

Recommendation: Authorize an increase in the evaluation contract amount to $1,800,000. The term is September 1, 2014-September 30, 2016.

<u>REQUEST #2- Type 1 Proposal to contract for services related to Chart Review for quality measures for Year One of the ACO Shared Savings Program: $395,000.</u>

The three ACOs request VHCIP funds (please see Attachment A) to support the collection of clinical quality measure data in the first performance year (CY 2014). The accurate measurement of clinical quality is central to the ACO Shared Savings Program (SSP) model. Although there has been an initial investment of VHCIP funds through the Health Information Exchange (HIE) Work Group to improve the ability of ACOs and providers to collect clinical data and measure clinical quality electronically, such capabilities will not be fully operational until later program years.

Without the ability to collect this information electronically, ACOs and participating providers must rely at least in part on medical record review and abstraction. This process is time-consuming, disruptive to practices, and costly. OneCare Vermont conducted an analysis of their clinical quality measure data collection efforts for their first year of participation in the Medicare SSP. The process of record abstraction, data entry, data validation, and reporting for their attributed Medicare population required an estimated 4,500 hours of effort during an eight week period.

The sampling strategy requires that 411 attributed beneficiaries for each payer population are sampled for each clinical measure. For ACOs participating in more than one SSP, it will be necessary to sample medical records for up to three distinct populations. For example, an ACO participating in the Medicare, Medicaid, and commercial SSPs would sample a total of 1,233 individuals for the 'Adult BMI Screening & Follow-Up' measure in order to meet the sampling requirements for all three programs.

Additional funding to support this process during the first program year would significantly offset the financial and administrative burden felt by the ACOs, while ensuring valid and comprehensive collection of clinical quality data for all SSP populations.

How Support Would Be Used: Each ACO requests flexibility in the allocation of financial support, such that resources may be directed in manners that best suit the needs of each organization, its providers, and attributed lives.

- ***OneCare Vermont*** requests financial assistance to defray the costs of data abstraction. Funding would support expanded training efforts to include Medicaid and commercial measures (measures not previously collected for the Medicare SSP). Funding would also allow OCV staff to provide support to individual practices in their data abstraction processes, and to develop expertise at the practice level to prepare data into a standardized file format for delivery to OCV.
- ***Community Health Accountable Care*** requests funding to support salaried and temporary employees in the implementation of a plan for data abstraction which includes: on-site chart review and data collection, ongoing coaching of practice staff in the collection of structured, reliable data through coding and workflow redesign, as well as the verification, analysis, and submission of data to state and national agencies.
- ***Vermont Collaborative Physicians*** requests financial support for the data collection process. Funds would be allocated across 28 practices (based on size of patient panel) to pay internal resources (nurses or other practice staff) to complete chart audits outside of their regularly scheduled work hours. Funding would also support the verification, analysis, and submission of data to state and national agencies.

ACO Estimated Attributed Populations (Performance Year 2014) & Requested Funding:

		OneCare Vermont (OCV)	**Community Health Accountable Care (CHAC)**	**Vermont Collaborative Physicians (VCP) *Accountable Care Coalition of the Green Mountains**
Estimated Attributed Lives	Medicare SSP	53,300	6,000	7,500*
	Medicaid SSP	29,000	21,000	*NA*
	Commercial SSP	18,400	8,900	7,200
	Total	**100,700**	**35,900**	**14,700**
Financial Support Requested		$150,000	$190,000	$55,000
Total		**$395,000**		

Recommendation: Execute agreements with each of the ACOs to provide support for chart review for the year one quality measures for the commercial and Medicaid Shared Savings ACO Program. The total project cost is: $395,000. The term is September 1, 2014- August 31, 2015.

REQUEST #3- Type 1a Proposal to contract for services supporting the ACOs in their analytics and quality measurement and improvement activities. Cost: $3,151,600. Duration: September 1, 2014-August 31, 2015.

As part of the Round One Grant Application process, the Core Team received applications from each of the ACOs participating in the Commercial, Medicare and Medicaid Shared Savings ACO Programs. These applications requested funding in support of a range of activities, including analytics and quality improvement. The Core Team provided some funding to Health*first* (ACCGM/VCP) and Community Health Accountable Care (CHAC) and requested that further work be done with the ACOs to determine the best way to support their data analytic and quality improvement work. This proposal is a result of that further work.

Project summary:
OneCare Vermont submitted a proposal to support their activities (it is appended to this memo as Attachment B). OneCare proposed the following:

> OneCare Vermont is requesting support from the State of Vermont through the State Innovation Model (SIM) project to further develop its capacity (and by extension to strengthen all three ACOs) to collect, analyze and use data for targeted health care performance improvement collaboratives that are consistent with the goals established by our Clinical Advisory Board. It should be evident through our actions to date that OneCare Vermont is committed to partnering with the full continuum of providers, the Blueprint and our ACO colleagues to develop a statewide population health "playbook" that will guide clinical performance improvement initiatives.
>
> The SIM project funds would be used to support local medical leadership, quality improvement training/project support, analytics and data, and clinical facilitation to benefit all ACOs in their local regions. OneCare Vermont proposes to capitalize on its success in establishing meaningful statewide capacity to directly facilitate and support clinical collaboration, improvement and payment reform. We will accomplish this by supporting the development of learning collaboratives in the form of 14 Regional Clinical Performance Committees (RCPCs) serving every community in Vermont. RCPCs

will receive direction and support from the OneCare Clinical Advisory Board (CAB). They will also use the CAB as the vehicle for sharing and disseminating clinical improvement results. RCPC collaboration and improvement efforts will be open to OneCare Vermont network providers as well as the other two Vermont ACOs and their providers, Blueprint teams, and other willing clinicians and organizations serving the health and wellness needs in their regions. Specifically financial support is specifically sought for our design which includes:

- 14 local physicians serving as part-time "clinical champions" in their region;
- OneCare's team of nurses with clinical and quality improvement consultation skills to be deployed to assigned regions;
- Our team of skilled data analysts delivering focused outputs for local learning and improvement;
- Quality improvement training programs expertly designed to benefit each region, and

Such support from the State of Vermont would advance efforts consistent with the vision of the Governor and the Core Team.

CHAC's grant application requested funding for similar activities:

> The analytics solution included in this proposal will be an essential link for CHAC participating organizations and community partners in managing high-cost, complex patients along the continuum of care. Since the shared savings that will be generated are based on data from the populations they serve, it is critical for them to have the ability to measure on a real time basis. CHAC members envision ramping up care coordination at each entity to assist with this management. For example, through a proactive approach, CHAC will divert patients from inappropriate use of the ED and assist with transitions in care.

Health*first's* grant application also highlighted the need for support for these activities.

The three ACO applications indicated the significant time, cost and effort required for them to appropriately support providers delivering care in Vermont. In particular, the staff time and the cost to develop provider dashboards and rapid-cycle reporting to support clinical transformation is significant.

In response to both of these requests, I propose the following:

The VHCIP provide support to each of the three ACOs distributing funds based on the number of attributed lives each ACO is serving. The per-attributed life payment would be $26. This is a one-time investment. If an ACO's attributed lives increase over the course of 2014, we would alter the amount paid to reflect the actual attributed lives retrospectively. Several funding methodologies were evaluated in the development of this proposal and this was deemed to be both simple to execute and fair. The Core Team has previously approved grants of $400,000 each to CHAC and Health*first.* This proposal requests additional funding to CHAC and OneCare and holding Health*first* at the initial $400,000 amount.

	Medicare	Medicaid	Commercial	Total Est Att Lives	$ Per Att Life	Total	Total requested in this memo
OCV	53,300	29000	18,400	**100,700**	26	2,618,200	2,618,200
HF	7,500	0	7,200	**14,700**	26	382,200	0
CHAC	6,000	21000	8,900	**35,900**	26	933,400	533,400

Recommendation: Approve execution of contracts with CHAC and OCV providing funding to support the above described activities. The funding will be a formula based on their estimated attribution multiplied by $26. The total amount is $3,151,600.

Attachment A:

Proposal for ACO Clinical Quality Measure Data Collection Support

To: VHCIP Core Team

From: Accountable Care Organizations (ACOs) participating in the Vermont Medicaid and/or Commercial Shared Savings Programs

- OneCare Vermont (OCV)
- Community Health Accountable Care (CHAC)
- Vermont Collaborative Physicians (VCP)

Summary: The three ACOs request VHCIP funds to support the collection of clinical quality measure data in the first performance year (CY 2014). The accurate measurement of clinical quality is central to the ACO Shared Savings Program (SSP) model. Although there has been an initial investment of VHCIP funds through the Health Information Exchange (HIE) Work Group to improve the ability of ACOs and providers to collect clinical data and measure clinical quality electronically, such capabilities will not be fully operational until later pilot program years.

Without the ability to collect this information electronically, ACOs and participating providers must rely at least in part on medical record review and abstraction. This process is time-consuming, disruptive to practices, and costly. OneCare Vermont conducted an analysis of their clinical quality measure data collection efforts for their first year of participation in the Medicare SSP. The process of record abstraction, data entry, data validation, and reporting for their attributed Medicare population required an estimated 4,500 hours of effort during an eight week period. OneCare anticipates that the level of effort will double next year with the addition of the Medicaid and commercial populations.

The sampling strategy requires that 411 attributed beneficiaries for each payer population are sampled for each clinical measure. For ACOs participating in more than one SSP, it will be necessary to sample medical records for up to three distinct populations. For example, an ACO participating in the Medicare, Medicaid, and commercial SSPs would sample a total of 1,233 individuals for the ‘Adult BMI Screening & Follow-Up’ measure in order to meet the sampling requirements for all three programs.

Additional funding to support this process during the first program year would significantly offset the financial and administrative burden felt by the ACOs, while ensuring valid and comprehensive collection of clinical quality data for all SSP populations.

How Support Would Be Used: Each ACO requests flexibility in the allocation of financial support, such that resources may be directed in manners that best suit the needs of each organization, its providers, and its attributed lives.

- ***OneCare Vermont*** requests financial assistance to defray the costs of data abstraction. Funding would support expanded training efforts to include Medicaid and commercial measures (measures not previously collected for the Medicare SSP). Funding would also allow OCV staff to provide support to individual practices in their data abstraction processes, and to develop expertise at the practice level to prepare data into a standardized file format for delivery to OCV.
- ***Community Health Accountable Care*** requests funding to support salaried and temporary employees in the implementation of a plan for data abstraction which includes: on-site chart review and data collection, ongoing coaching of practice staff in the collection of structured, reliable data through coding and workflow redesign, as well as the verification, analysis, and submission of data to state and national agencies.
- ***Vermont Collaborative Physicians*** requests financial support for the data collection process. Funds would be allocated across 28 practices (based on size of patient panel) to pay internal resources (nurses or other practice staff) to complete chart audits outside of their regularly scheduled work hours. Funding would also support the verification, analysis, and submission of data to state and national agencies.

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	Commercial SSP	18,400	8,900	7,200
	Total	**100,700**	**35,900**	**14,700**
Financial Support Requested		$150,000	$190,000	$55,000
Total		**$395,000**		

Attachment B:

Accountable Care Learning Collaborative

Clinical Performance Improvement

OneCare Vermont
June 24,2014

Table of Contents Clinical Performance Improvement

Table of Contents……………………………………………………………………………………………………......... 2
Section A: Executive Summary and note about the Blueprint for Health…………….…………….. 3
Section B: Proposal…………………………………………………………………………..…………..…………………... 8
Section C: Appendix- Performance ……………………………..………………………………………………… 18
Section D: Appendix- Regional Clinical Performance Committee……………………………………… 20
Section E: Appendix- PDSA Cycle for Improvement………………………………………………………… 23
Section F: Appendix- Annual Budget……………………………………………………………………………...25
Section G: Appendix- Project Plan/Timeline….……………………………………………………….…... 26
Section H: Appendix- "CMS Quality Measurement Training & Reporting Overview" slides…… 29
Section I: Appendix- OneCare Vermont Participants and Providers…………………………………... 47

Section A: Executive Summary

Statewide Clinical Performance Improvement Collaborative Proposal

Background:

OneCare Vermont is committed to becoming a population health management company, aligning providers across the state to improve the health of Vermonters. To make this happen, we have to move to population-based payment methods that provide incentives to appropriately temper expenditures on specialty and hospital care, increase spending on prevention and primary care, and result in overall improvements in Vermonters' health and experience of care. The shared savings programs established by the federal Centers for Medicare and Medicaid Services (CMS) and the State of Vermont are steps that build on Vermonters' long reform journey—from the Governor's Advisory Board on Health Programs in 1965, Vermont's Medicaid expansion through VHIP and Dr. Dynasaur in 1989, establishment of VITL in 2003, the Blueprint in 2006, and more recently the Green Mountain Care Board in 2011. Fifty years and counting, additional steps including shared savings strategies coupled to clinical performance improvement, will be necessary to make this vision a reality.

Each of Vermont's Accountable Care Organizations (ACOs) – OneCare Vermont, Community Health Accountable Care and the Healthfirst Physician Organization – has committed to a network approach to value-based care delivery including collecting and reporting on consistent measures of health care quality, patient satisfaction and cost. This data collection is required by both CMS and the State of Vermont under their Shared Savings Programs for ACOs and is meant to be the underpinning for clinical performance and population health improvement.

OneCare Vermont collected its first round of data under the requirements of the Medicare Shared Savings Program, reflecting performance during calendar year 2013. This involved collecting 22 of

the CMS "ACO-33" clinical and claims data measures from almost every Vermont hospital, their employed clinicians and 37 independent practices. The overall process was labor intensive for OneCare central office personnel and the network participants in terms of training on the measure set, learning the tools for measure collection, comprehending the measure set, and checking the reliability of the data collected. Results of the first round Medicare ACO data collection are valuable and actionable. They are presented in figure 1 of this proposal.

Statement of Need:

Collecting and analyzing these data are the first steps in establishing baseline performance, identifying areas of subpar performance, and implementing improvement initiatives. The data points to some clear opportunities for health care improvement in Vermont. Despite being a low-cost, high-quality state relative to national Medicare benchmarks, we need to improve if we are going to provide reliably affordable health care services to Vermonters, better manage the health of our population, and shift resources away from disease-treatment services toward disease prevention.

It is time to take the next steps to becoming a population health management company. Specifically we need to:

1. Develop a statewide, inclusive process, organized regionally, for engaging providers, Blueprint teams and others in addressing the identified clinical performance improvement targets.
2. Broaden the Medicare data collection efforts to encompass Medicaid and commercial populations;
3. Seek some economies of scale in training related to interpreting the measures and identifying best practice in clinical documentation across all of Vermont's ACOs;
4. Identify widely agreed-upon statewide clinical performance improvement targets that are apparent in the quality measurement data; and

OneCare Vermont has statewide reach, participating providers across the continuum of care and a nascent structure for implementing provider-driven clinical improvement efforts on a statewide basis. To avoid duplication of efforts and inefficiencies, we are already working with other ACOs toward shared clinical performance improvement goals. Ultimately, OneCare Vermont is uniquely positioned to take Vermont's clinical performance improvement efforts to the next level; across all regions of the state and across the three ACOs and other care deliverers including the Blueprint for Health. Because of our statewide reach and our dedication to partnering, we can demonstrate high value by measurably improving performance relative to the quality and patient satisfaction measures included in the three Shared Savings ACO Programs.

The question is: who will pay for these activities? The Shared Savings ACO Programs, across all payers, offer a weak incentive for major provider investments in data collection, data analysis and clinical performance improvement activities. In essence, if providers were only interested in economics, they would have to be convinced of three things:

1. They will lose more revenue in the long run without changing their practices or participating in any new organization;
2. They will achieve savings through the cross-provider efforts of the Shared Savings ACO Programs; and
3. The benefits will outweigh the investment necessary to achieve them.

OneCare Vermont, over the course of the year, has been trying to get providers to act on #3 before they are assured of the first two. Given, the current incentive structure, this effort has been very difficult. Shared savings calculations do not occur until the end of the performance period (i.e., they are retrospective to the prior year) and are subject to unpredictable outcomes based on the current state of the evolving Medicare methodology.

OneCare Vermont proposed a $9 million budget for PY 2015 (performance year), with a substantial portion of that amount to be divided among our 13 community hospital network

participants. We made the case to participating hospitals that they should shoulder the burden of these costs but hospitals want to see some demonstration of support from the State of Vermont that this is the desired state direction.

Summary Proposal:

OneCare Vermont is requesting support from the State of Vermont through the State Innovation Model (SIM) project to further develop its capacity (and by extension to strengthen all three ACOs) to collect, analyze and use data for targeted health care performance improvement collaboratives that are consistent with the goals established by our Clinical Advisory Board. It should be evident through our actions to date that OneCare Vermont is committed to partnering with the full continuum of providers, the Blueprint and our ACO colleagues to develop a statewide population health "playbook" that will guide clinical performance improvement initiatives.

The SIM project funds would be used to support local medical leadership, quality improvement training/project support, analytics and data, and clinical facilitation to benefit all ACOs in their local regions. OneCare Vermont proposes to capitalize on its success in establishing meaningful statewide capacity to directly facilitate and support clinical collaboration, improvement and payment reform. We will accomplish this by supporting the development of learning collaboratives in the form of 14 Regional Clinical Performance Committees (RCPCs) serving every community in Vermont. RCPCs will receive direction and support from the OneCare Clinical Advisory Board (CAB). They will also use the CAB as the vehicle for sharing and disseminating clinical improvement results. RCPC collaboration and improvement efforts will be open to OneCare Vermont network providers as well as the other two Vermont ACOs and their providers, Blueprint teams, and other willing clinicians and organizations serving the health and wellness needs in their regions. Specifically financial support is specifically sought for our design which includes:

- 14 local physicians serving as part-time "clinical champions" in their region;

- OneCare's team of nurses with clinical and quality improvement consultation skills to be deployed to assigned regions;
- Our team of skilled data analysts delivering focused outputs for local learning and improvement;
- Quality improvement training programs expertly designed to benefit each region, and
- Our costs for manual clinical data abstraction to support ACO reporting on data elements required by the Medicaid and commercial ACO programs

Such support from the State of Vermont would result in a 50 percent reduction in the community hospital participant fees budgeted by OneCare for PY 2015, and would advance efforts consistent with the vision of the Governor and the Core Team.

Section B Proposal- Statewide Clinical Performance Improvement Collaborative

Introduction:

OneCare Vermont's submission of its Medicare Shared Savings Program (MSSP) Quality Measures on March 21, 2014 represented a watershed moment in Vermont's healthcare reform journey. The successful collection and reporting of the ACO clinical data measures from almost every Vermont hospital, their employed clinicians and 37 independent practices has provided a unique opportunity to engage and unite health care providers throughout the state around a common goal. The CMS abstraction process was an 8-week process- opening on 1/27/2014 and ending on 3/21/2014. The overall process was labor intensive for central office personnel and the network participants in terms of training on the measure set, learning the tool for measure collection, comprehending the measure set, and checking the reliability of the data collected. For some practices, there was no resource available to assist with data abstraction and the OneCare Vermont clinical team provided that service. In most areas, telephonic and in-person support served to extend the resources that the facility/practice could provide.

Developing a process that was shared between participants and OneCare proved to be extremely successful. Relying on our network to have an understanding of the measure specifications served to improve their understanding of how their practice performed and gave them a window into opportunities for improvement. Benefit was observed in that providers/practices were able to see what services needed to be operationalized as part of their standard of care, or documented in a place that was easy to abstract or address work-flow issues that impeded successful completion of measures. The strong focus on the ACO quality measures at a local level led to high levels of provider engagement and we believe will ultimately contribute to a population-based healthcare system able to successfully limit cost growth. Such a system will be better prepared to succeed within a fixed revenue budget.

Central to our proposal is the OneCare Vermont statewide HSA "physician champion" model that will enhance the successful deployment of the targeted Choosing Wisely "avoidable/unnecessary care" concepts developed by the previously funded SIM/VHCIP grant project. These OneCare representatives with dedicated time will serve a conveners and communicators to each HSA medical community. Coordination with the Vermont Medical Society Education and Research Foundation (VMSERF) "Vermont Regional Hospital Medicine Leadership Community" and "Core Community Practices Clinician Leadership Community" will also be instrumental in gaining awareness and traction for the chosen Choosing Wisely projects.

Despite the high quality and low cost care provided by Vermont's medical community, the average clinician has yet to transform their thinking to an emphasis on the health of the population of patients who do not seek out medical services. The dedicated time of the local OneCare physician champions combined with the RCPC forums supported by this grant will promote open communication and coordination with the continuum of care providers in each community to maximize benefit to all individuals. The agenda of the RCPC committees will include promotion of Choosing Wisely initiatives. Only by continually reinforcing the legitimacy of changing care to avoid unnecessary interventions.

Vermont's ACOs see the collection and reporting on these measures as the first step in the establishment of a clinical performance improvement process that will target improvements in health care outcomes. OneCare Vermont relies on its quality and clinical data to identify ongoing areas of opportunity within the healthcare system. For OneCare Vermont, the CAB will set state-wide priorities based upon the clinical and quality data. Based on the 2013 CMS quality performance measurement sample and Medicare claims data (see Figure 1), the OneCare Vermont CAB has voted to focus on the following four areas in 2014:

- *Diabetes:* Improving hemoglobin A1c control (<8 percent), improving low density lipoprotein (LDL) control (<100 mg/dL), maintaining blood pressure (BP) < 140/90, encouraging people not to use tobacco, and assuring daily aspirin use

- *Coronary Artery Disease:* Increase drug therapy for lowering LDL cholesterol and ACE or ARB therapy for CAD and diabetes and/or LVSD
- *Readmissions:* Reducing preventable 30 day readmission rates
- *Emergency Room Use:* Reducing non-emergent, primary care preventable ER room use in high risk populations

Note: The OneCare slide deck for a related VHCIP-hosted webinar is attached as Appendix H.

Regional Clinical Performance Committees (RCPCs) will carry out priorities set forth by the CAB. With support from OneCare Vermont clinical consultants, each RCPC will be tasked with developing an infrastructure and competency to conduct continuum of care root cause analysis on the quality measures, readmission rates, and high emergency room use. RCPCs will also be accountable for setting aims, action plans, and goals for clinical performance improvement and for measuring progress towards those goals. These regional efforts will not be closed OneCare Vermont activities. Rather, they will be open to engagement by the other ACOs, the local Blueprint for Health teams, and other local individuals and organizations who share a commitment to improve the wellbeing of their communities. OneCare Vermont resources (statewide and local) will serve to convene, facilitate and lead these improvement efforts. The outcome will be a highly-reliable, evidence-based population healthcare system for Vermonters.

It should be noted that although stemming from Medicare's national priorities, these measures aim to improve the health and wellbeing of Vermonters in areas that have been previously targeted as also being Vermont priorities—thus not isolated federal quality targets—quoting the Vermont Health Department and the national CDC:

> "Diabetes is a disease that contributes significantly to death and disability among Vermonters. The national Healthy People Year 2000 objective is to reduce diabetes-related deaths to no more than 34 per 100,000 people. In Vermont, the rate for 1992-1996 was far worse, at 44. An estimated 28,000 Vermonters suffer from diabetes, about one-third of

> whom have not yet been diagnosed. Diabetes is a statewide public health problem; in nearly every county…. Diabetes is the 7th leading cause of death in Vermont. It is the major cause of lower limb amputations, blindness, and kidney disease. It is also a major contributor to high blood pressure, heart disease, stroke and infection. Diabetes results in about $37 million in hospital charges per year in Vermont. In 1992, Vermont spent an estimated $223 million on direct and indirect costs related to diabetes…" And, "about 600,000 people die of heart disease in the United States every year–that's 1 in every 4 deaths. Heart disease is the leading cause of death for both men and women. More than half of the deaths due to heart disease in 2009 were in men. Coronary heart disease is the most common type of heart disease…Coronary heart disease alone costs the United States $108.9 billion each year."

Furthermore, readmission rates and emergency room use are centrally located on the "improvement radar screen" for every Vermont hospital, home health agency and nursing home.

Regional Learning Collaboratives:

OneCare's proposal is to strengthen local Health Service Areas (HSAs) systems of care by providing the necessary broad spectrum resources to create a model for improvement that will optimize care delivery. OneCare will partner with stakeholders and tap into existing resources to facilitate learning collaborative approaches in diabetes, coronary artery disease, readmissions, and ER use. OneCare Vermont would do this by leveraging its statewide CAB and RCPCs and drawing upon the substantial expertise at both Fletcher Allen Health Care and Dartmouth-Hitchcock and the Blueprint's particular expertise in enhancing grass roots primary care practice.

Clinical Structure:

OneCare Vermont has designed a structure that allows participants significant input and a strong voice in governance and establishing the clinical and quality programs that form the basis for a result oriented network.

- ***Clinical Advisory Board:*** As the largest organized group of actively engaged clinicians, the CAB has emerged as a unique and valuable forum for sharing of best clinical practices, prioritizing network improvement projects, and catalyzing the formation of RCPC in each HSA.

- ***Regional Clinical Performance Committees:*** The local multidisciplinary RCPCs will carry out the priorities and engage in data driven process improvement activities. The established and emerging RCPC in each HSA will invite participation from the following entities:

    - Leaders from the CAB
    - Clinical and Quality Improvement experts from local or referring hospital systems
    - Representation from care coordination entitles (e.g., Blueprint Community Health Teams, commercial payers, SASH)
    - Continuum of care providers (home health, skilled nursing, hospice, designated agencies etc.)
    - Content experts (pediatric mental health, palliative care, chronic care etc.)
    - State agencies that serve the populations (e.g., VCCI and IFS)
    - Representation from the FQHC's and RHC's- affiliated with both OneCare Vermont and Community Health Accountable Care

  Members of the team shall foster involvement and ownership at the local level, leading the way on care and delivery transformation and, as stated previously, on furthering the goals of Choosing Wisely and related improvement efforts. (See Appendix D for a complete description of the RCPC).

Primary care in our ACO model:

OneCare Vermont's clinical model recognizes that where possible we will build on existing health care reform efforts towards creation of a high value health care delivery system that achieves the Triple Aim. OneCare with its full continuum of care providers and Blueprint for Health with its medical home recognition process represent a unique opportunity to further Vermont's reform goals.

OneCare's efforts build on the Blueprint's years of foundational work evidenced by Vermont's successful commitment to credentialed patient centered medical homes and to locally defined community health teams addressing locally determined needs. Notably, about 60% of the Blueprint practices are also OneCare Vermont network practices; and nearly 90% of the OneCare primary care practices are also Blueprint practices. With more than seventy "practices in common" across Vermont, there is substantial opportunity to coordinate work towards shared goals. Also, through its broad continuum network model, OneCare adds complementary value to the Blueprint's primary care focus through its statewide participating specialty physicians, hospitals, post-acute care organizations and behavioral health, substance use and long term services and supports providers; our proposal encourages participation by the Blueprint team in our described clinical performance improvement collaborative efforts. A listing of the current OneCare participants and providers is attached as Appendix I.

- ***OneCare Vermont Quality Committee:*** OneCare Vermont's proposed approach also envisions that it will form a Quality Committee made up of OneCare senior medical and nursing leadership, the directors of both the Jeffords Institute at Fletcher Allen Health Care and the Value Institute at Dartmouth-Hitchcock, and the HSA physician leads described in this proposal. The committee will meet monthly and help prioritize specific elements and measures of our quality improvement efforts under the learning collaborative approach, and provide an important "bridge" between our Clinical Advisory Board and the local RCPCs. This committee will be tasked with reviewing data on ACO performance and

framing interventions/resolutions for action by the CAB. In essence, the Quality Committee will act like an "executive committee" of the CAB.

OneCare Vermont further envisions that the Quality Committee would invite and welcome quarterly participation by an even broader set of clinical leadership to unite the senior clinician leaders in population-based health care delivery reform. Clinical leadership is envisioned to include at minimum representation from DVHA (Drs. Simpatico and Blueprint director Dr. Jones), the Vermont Department of Health (Dr. Chen), the GMCB (Drs. Hein, Ramsey, and Rambur), BCBSVT (Dr. Wheeler), MVP (Dr. Schneider or other designate), the Vermont Medical Society (Dr. Jordan – VMS Research and Education Foundation), CHAC (Dr. Matthews or other designate) and ACCGM/VCP (Dr. Reiss or other designate). With appropriate data sharing and confidentiality legal safeguards, the clinical priorities of the three ACO's, the commercial exchange ACO payers, the Administration, and the GMCB can leverage the various data sources that currently are not integrated in order to guide and prioritize clinical performance improvement efforts.

Clinical Performance Improvement Method:

OneCare Vermont will use a Performance Improvement Model based on the Plan-Do-Study-Act (PDSA) approach to achieve the desired levels of performance. Additionally we would propose maintaining those gains by standardizing and continuing to assess the redesign by integrating the well-established Standardize-Do-Study-Act (SDSA) method. We intend to employ the PDSA and SDSA approaches for clinical and operational improvement projects in each of the 14 health service areas as well as across the ACO as a whole where appropriate (See Appendix E for a complete description of the PDSA and SDSA method).

Clinical Measurement and Performance Improvement Training:

Since the ACO's shared savings potential is directly tied to accurately abstracting and reporting measures to the payers (CMS, DVHA and commercial payers), it is imperative that the providers understand the measures and know how to document them in a way that they can be easily

extracted (either manually or electronically). As such, OneCare Vermont is expanding its training efforts to include more rigorous training on the measures and to provide one-on-one consultation on how to prepare their data for delivery to OneCare Vermont. If funded, we would also provide the subject matter expertise and training tool-kits to the other ACO's.

In addition to training support on the measures, OneCare will leverage the organizational knowledge of its parents, Fletcher Allen/UVM and Dartmouth Hitchcock, and their extensive experience with clinial quality performance improvement activities to lauch clinical improvement iniatiives. Specific examples of programatic offerings and areas of expertise are listed below:

- ***Fletcher Allen Jeffords Institute for Quality and Operational Effectiveness:*** Resources and expertise in the execution of system level clinical and operational change that reside in the Jeffords Institute will be leveraged to accelerate improvement efforts across the OneCare Vermont participant network.

- ***Dartmouth Value Institute:*** OneCare Vermont clinical consultants and RCPC teams can be offered training in Dartmouth's clinical microsystems electronic Coach-the-Coach training with an overall aim to advance the skills of our clinical team and to guide the RCPC in successfully navigating the world of quality improvement.

Investments:

The SIM project already has committed to investments in data collection and quality. This proposal suggests a similar approach to development of a statewide broadly inclusive performance improvement infrastructure – invest SIM funds to create the capacity needed for long-term, continuous quality improvement across providers, across payers and across the regions of the state. If demonstrated successfully, the activities initiated through this proposal will become ongoing central elements of OneCare operations—and be included in its future annual operating budgets and supported through funding sources for overall ACO operations as those sources continue to

evolve. For example, we anticipate exploratory discussions that could lead to new alternatives for sustaining ACOs—perhaps from near "the top of the spend" as part of population-based payment methodologies for supporting health care for Vermonters.

Specifically, for the purposes of this proposal, we intent to:

- Use existing Clinical Advisory Boards and Regional Clinical Performance Committees to provide for a statewide governance/deliberative structure for quality performance improvement
- Provide systematic support to geographic regions in their areas needing improvement
- Leverage personnel and quality improvement training capabilities of the Fletcher Allen Health Care Jeffords Institute for Quality and Operational Effectiveness and Dartmouth Hitchcock's Value Institute
- Pay for physician champion time in 14 health service areas to lead clinical performance improvement initiatives
- Deploy Clinical Consultants to the communities to provide training and facilitate clinical performance improvement efforts
- Provide data analytic support for RCPC report requests
- Develop protocols and project plans for the annually targeted areas of performance improvement
- Follow recognized Quality Performance Improvement methods (PDSA and SDSA)
- Assess and track progress to the quality measurement goals
- Operationalize and sustain regional clinical performance improvement efforts on an annual basis

Conclusion:

OneCare Vermont is in a unique position to influence care across the continuum of providers in Vermont including building on existing health care reform efforts, such as the learning collaboratives guided by Blueprint for Health practice facilitators, the additional supports we are requesting will allow health care providers to improve health care outcomes, reduce unnecessary costs, and enhance the care experience for all Vermonters.

Section C   Appendix: Performance

Figure 1: OneCare Vermont Performance Reports

OCV Quality Measure Benchmarks and Scores

			2013	2014	2015										
Domain	**Measure**		PY1	PY2	PY3	**30th perc.**	**40th perc.**	**50th perc.**	**60th perc.**	**70th perc.**	**80th perc.**	**90th perc.**	**OCV Score**	**n**	**Quality Points**
Patient/Caregiver Experience	1	Getting Timely Care, Appointments, and Information	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00			
	2	How Well Your Doctors Communicate	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00			
	3	Patients' Rating of Doctor	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00			
	4	Access to Specialists	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00			
	5	Health Promotion and Education	R	P	P	54.71	55.59	56.45	57.63	58.22	59.09	60.71			
	6	Shared Decision Making	R	P	P	72.87	73.37	73.91	74.51	75.25	75.82	76.71			
	7	Health Status/Functional Status	R	R	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Care Coordination/ Patient Safety	8	Risk Standardized, All Condition Readmissions	R	R	P	16.62	16.41	16.24	16.08	15.91	15.72	15.45			
	9	ASC Admissions: COPD or Asthma in Older Adults	R	P	P	1.24	1.02	0.84	0.66	0.52	0.36	0.00			
	10	ASC Admission: Heart Failure	R	P	P	1.22	1.03	0.88	0.72	0.55	0.40	0.18			
	11	Percent of PCPs who Qualified for EHR Incentive Payment	R	P	P	51.35	59.70	65.38	70.20	76.15	84.85	90.91			
	12	Medication Reconciliation	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	73.81	547	1.70
	13	Falls: Screening for Fall Risk	R	P	P	17.12	22.35	27.86	35.55	42.32	51.87	73.38	46.30	432	1.70
Preventive Health	14	Influenza Immunization	R	P	P	29.41	39.04	48.29	58.60	75.93	97.30	100.00	71.36	398	1.55
	15	Pneumococcal Vaccination	R	P	P	23.78	39.94	54.62	70.66	84.55	96.64	100.00	77.73	440	1.55
	16	Adult Weight Screening and Follow-up	R	P	P	40.79	44.73	49.93	66.35	91.34	99.09	100.00	70.94	413	1.55
	17	Tobacco Use Assessment and Cessation Intervention	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	91.37	417	2.00
	18	Depression Screening	R	P	P	5.31	10.26	16.84	23.08	31.43	39.97	51.81	24.71	344	1.55
	19	Colorectal Cancer Screening	R	R	P	19.8	33.9	48.5	63.3	78.1	94.7	100	65.33	424	1.55
	20	Mammography Screening	R	R	P	28.6	42.9	54.6	65.7	76.4	88.3	99.56	68.04	413	1.55
	21	Proportion of Adults who had blood pressure screened in past 2 years	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	68.66	351	1.55
At-Risk Population Diabetes	Diabetes Composite 22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24. Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use	R	P	P	17.39	21.20	23.48	25.78	28.17	31.37	36.50	23.08	416	1.25
	27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	R	P	P	70.00	60.00	50.00	40.00	30.00	20.00	10.00	22.12	416	1.70
At-Risk Population Hypertension	28	Percent of beneficiaries with hypertension whose BP < 140/90	R	P	P	60.00	63.16	65.69	68.03	70.89	74.07	79.65	67.04	443	1.40
At-Risk Population IVD	29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	R	P	P	35.00	42.86	51.41	57.14	61.60	67.29	78.81	60.92	412	1.55
	30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	R	P	P	45.44	56.88	68.25	78.77	85.00	91.48	97.91	86.65	412	1.70
At-Risk Population HF	31	Beta-Blocker Therapy for LVSD	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	81.78	236	1.85
At-Risk Population CAD	CAD Composite 32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	R	R	P	54.1	61.4	66.1	70	72.3	76.4	79.84	58.95	458	1.10

The benchmarks are the performance rates the ACO must achieve to earn the corresponding quality points for each measure. Shown are the benchmarks for each percentile, starting with the 30th percentile (corresponding to the minimum attainment level) and ending with the 90th percentile (corresponding to the maximum attainment level). For 9 measures, benchmarks are set using flat percentages when the 60th percentile was equal to or greater than 80.00 percent, as required by the program regulations.
R = Reporting   P = Performance

OCV Medicare MSSP ACO Trends

	OneCare Vermont Assigned Beneficiaries							National MSSP ACOs
	2010	2011	2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	
Data for beneficiaries attributed to OCV for date range:	1/1/2010 - 12/31/2010	1/1/2011 - 12/31/2011	10/1/2011 - 9/30/2012	4/1/2012 - 3/31/2013	7/1/2012 - 6/30/2013	10/1/2012 - 9/30/2013	1/1/13 - 12/31/13	
Total Expenditures per Beneficiary Medicare Enrollment Type								
Total	$8,478	$8,582	$8,643	$8,488	$8,637	$8,591	$8,666	$9,825
End Stage Renal Disease	$56,244	$58,084	$59,918	$60,866	$79,256	$75,442	$70,865	$76,098
Disabled	$8,039	$7,920	$8,117	$7,876	$8,315	$8,151	$8,180	$9,331
Aged/Dual	$11,663	$11,468	$11,391	$11,460	$11,275	$11,340	$11,152	$12,944
Aged/Non-Dual	$7,879	$8,097	$8,113	$7,999	$8,102	$8,101	$8,244	$9,030
Component Expenditures per Assigned Beneficiary								
Inpatient	$2,820	$2,830	$2,832	$2,727	$2,807	$2,774	$2,775	$3,253
Skilled Nursing Facility	$969	$1,027	$916	$887	$880	$885	$941	$789
Home Health	$475	$445	$448	$464	$468	$466	$477	$530
Hospice	$119	$112	$140	$132	$133	$123	$122	$226
Institutional (Hospital) Outpatient [1]	$2,484	$2,577	$2,631	$2,569	$2,618	$2,637	$2,667	$1,719
Part B Physician/Supplier	$1,507	$1,516	$1,581	$1,596	$1,623	$1,614	$1,612	$3,224
Durable Medical Equipment	$250	$248	$247	$246	$245	$239	$231	$279
Transition of Care/Care Coordination Utilization								
30-Day All-Cause Readmissions Per 1,000 Discharges	134	137	127	131	138	130	135	142
30-Day Post-Discharge Provider Visits Per 1,000 Discharges	725	751	771	769	774	783	767	781
Ambulatory Care Sensitive Conditions Discharge Rates Per 1,000 Beneficiaries								
Diabetes, Short-Term Complications	0.75	1.12	1.15	1.02	1.23	1.02	1.14	0.81
Uncontrolled Diabetes	0.14	0.05	0.05	0.18	0.13	0.16	0.10	0.25
Chronic Obstructive Pulmonary Disease or Asthma	12.06	11.67	10.59	9.90	9.57	9.61	9.05	8.85
Congestive Heart Failure	11.92	10.12	8.72	8.29	8.89	9.27	10.01	11.19
Bacterial Pneumonia	17.47	16.54	15.78	14.02	13.81	13.79	12.77	8.85
Additional Utilization Rates (Per 1,000 Person Years)								
Hospitalizations [2]	304	295	282	266	265	264	258	330
Emergency Department Visits	775	777	788	737	736	737	712	661
Emergency Department Visits That Lead To Hospitalizations	132	133	131	132	135	135	133	217
Computed Tomography (CT) Events	554	454	465	428	440	442	434	653
Magnetic Resonance Imaging (MRI) Events	164	158	162	149	156	154	154	261
Primary Care Services [3]						8,771	8,791	9,917
With a Primary Care Physician [4]	3,144	3,030	2,987	2,858	2,865	2,831	2,794	4,122
With a Specialist Physician [5]	3,015	2,916	2,935	2,805	2,893	2,919	2,959	4,513
With a Nurse Practitioner/Physician's Assistant/ Clinical Nurse Specialist [6]	755	806	881	820	895	969	1,007	744
With a FQHC / RHC [7]	2,522	2,269	2,255	2,030	2,036	2,052	2,031	44

Section D Appendix: Regional Clinical Performance Committee

OneCare Vermont Regional Clinical Performance Committee

I. Introduction to the Clinical Model

OneCare Vermont will focus on the development of a provider-driven, integrated delivery system that is centered on the beneficiary and family. The OneCare Vermont clinical model supports decision-making power at the community level because we understand that providers closest to the point of care (including the Blueprint teams and long-term services and supports providers) most effectively drive clinical improvement activities, coordination of local microsystems, and reduce costs.

As described in our existing Medicare Shared Savings Program (MSSP) Clinical Model, our foundations for creating a successful ACO include:

- *Clinical Integration:* Development of a solid governance and accountability model, development and sharing of best practices, and utilizing shared information technology;
- *Care Coordination:* Emphasis on person centered care, beneficiary activation and engagement, systematic coordination, and strong community linkages that include clinical and non-clinical services; and
- *Health Informatics:* Identification of beneficiaries for outreach, monitoring key clinical and quality performance measures, benchmarking against local and national peers, and identifying gaps in care.

II. Regional Clinical Performance Committee Definition (RCPC)

The RCPC is the vehicle by which clinical dialogue occurs and decisions are made at the community level to develop and continually enhance the OneCare Vermont ACO Clinical Model.

III. RCPC Committee Membership

Each Health Service Area (HSA) is expected to form an RCPC. RCPCs where possible are encouraged to leverage existing committees and groups such as local Blueprint Community Health Teams. The RCPC is made up of ACO participants and affiliates. The OneCare Vermont ACO Clinical Advisory Board committee members and/or their appointed designee will convene the multidisciplinary entities to promote and support the Clinical Model.

IV. RCPC Scope

1. Each RCPC will review regional performance data and analytic outputs from OneCare Vermont to identify opportunities for clinical, quality, beneficiary satisfaction, and cost performance improvements specific to their locally attributed beneficiaries. The RCPC may also make use of additional data sources such as the Blueprint HSA report, reported state and regional trends from ACOs, VITL, SASH (Docsite), and any community specific self-audited studies.
2. Regionally identified opportunities will be brought up through the CAB.
3. Best practice learning from the RCPCs will be eligible for promotion to the network as a whole.

V. RCPC Principals and Proposed Composition

1. Principles:
   - Participation fosters involvement and ownership at the local level
   - Participants should have an equitable voice
   - Representatives are expected to be actively practicing clinicians and recognized leaders in their communities

- Representatives have the time, support from their system and the willingness to commit to the group
- Representatives will serve as the primary communicators for the actions to the Clinical Advisory Board

2. Proposed Composition:
   - OneCare Vermont Clinical Advisory Board voting and non-voting members
   - State agencies that serve the population (e.g., Vermont Agency of Human Services)
   - Representatives from the local Blueprint for Health teams
   - Clinical and Quality experts from the local or referring hospital system
   - Continuum of Care providers (e.g., home health, hospice, skilled nursing, designated agencies, etc.)
   - Representation from care coordination entities that serve the population (e.g., SASH)
   - Content Experts: A slate of high volume specialty service doctors will be solicited and selected to be involved when clinical issues require consultation
   - OneCare Vermont support staff (e.g., Clinical consultants and/or Network Liaisons)

VI. Proposed Frequency

1. Kick off– Charter development
2. At least quarterly to review new data provided by OneCare Vermont central support and other sources
3. Sub-groups or ad hoc committees charted as needed to carry out agreed to clinical and quality initiatives

Section E Appendix: PDSA Cycle for Improvement

OneCare Vermont plans on conducting these tests of change first using a PDSA approach. The PDSA cycle is an integral part of the Institute for Healthcare Improvement Model for Improvement, a widely demonstrated simple but powerful tool for implementing quality improvement.[1]

The literature has extensively borne out that IHI's PDSA model, which enables teams to conduct small tests of change in a disciplined and often rapid timeframe (i.e. rapid cycle improvement), is a valid and reliable approach to help the local care systems gain knowledge, quickly correct course when needed, and ultimately make measurable improvements in the delivery of care.[2] The other important benefit of using a PDSA approach is that it can be performed quickly and with limited resource expenditure. The rapid timeframe promotes early failure detection and enables the team to quickly get back on course. This model is not meant to replace models in place that health services utilize, but to accelerate improvement in their facilities and other practice settings. In order to properly carry out disciplined tests of change, OneCare Vermont will rely on its data and analytics team to identify where the opportunities within the local and statewide systems are. The data will be reviewed with the RCPCs physician leader(s) and their designated team as well as with their identified regional OneCare Clinical Consultant in order to set the aim and specific measurable targets for change. Once the specific aim, measures, and change targets have been selected we will utilize the OneCare clinical consultant's team to work in conjunction with the Medical Director lead and their designated team to carry out the improvement process.

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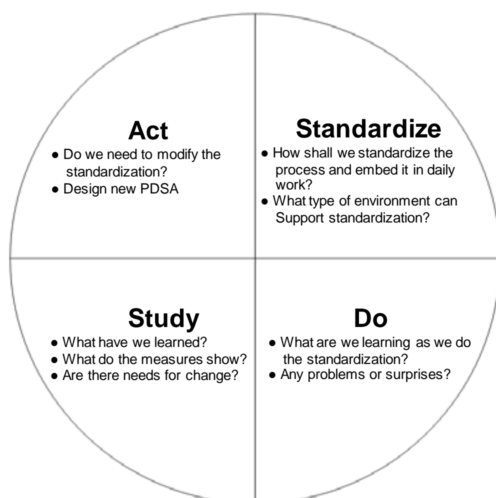
[1] Langley GL, Nolan KM, Nolan TW, Norman, CL, Provost, LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition) San Francisco: Jossey-Bass Publishers; 2009.
[2] Singh K, Sanderson J, Glaarneau D, Keister, T, Hickman D "Quality Improvement on the acute inpatient psychiatry unit using the Model for Improvement", The Oshsner Journal, Fall 2013; (13): 380-4.

Once the desired performance has been achieved, we propose using the SDSA to maintain the gains and use the knowledge to standardize and spread the redesigned clinical process across the delivery system. Like the PDSA approach the SDSA has also been validated by secondary research and proven to be a valuable approach in maintaing and spreading change throughout the system of care. After the change has been standardized and incorporated into the workflow of the system, it will still be necessary to monitor the change iniative for opportunities at various points, understanding that it may be necessary to revert to back to a PDSA approach based on the knowledge gained. For the purposes our of project we would propose using a Dartmouth-developed PDSA-SDSA worksheet to continously monitor performance.

PDSA Cycle for Improvement

Eugene Nelson, Paul Batalden & Marjorie Godfrey, Quality by Design: A Clinical Microsystems Approach. (San Francisco: Jossey-Bass, 2007).

SDSA Cycle for Improvement



Eugene Nelson, Paul Batalden & Marjorie Godfrey, Quality by Design: A Clinical Microsystems Approach. (San Francisco: Jossey-Bass, 2007).

Section F Appendix: Annual Budget

Position Title and Name	FTEs	Quality Measure Reporting		Improvement Initiatives		Totals	
		Time	Amount Requested	Time	Amount Requested	Time	Amount Requested
Clinical and Quality Consultant	8	30.0%	$216,000	55.0%	$396,000	**85.0%**	**$ 612,000**
Manager - Quality and Care Coordination	1	25.0%	$ 27,500	60.0%	$ 66,000	**85.0%**	**$ 93,500**
Clinical Improvement and Compliance Specialist	1	25.0%	$ 22,500	60.0%	$ 54,000	**85.0%**	**$ 76,500**
Director of Quality and Care Coordination	1	10.0%	$ 14,000	75.0%	$105,000	**85.0%**	**$ 119,000**
Quality and Care Coordination Lead	1	0.0%	$ -	10.0%	$ 14,000	**10.0%**	**$ 14,000**
Chief Medical Officer	1	0.0%	$ -	50.0%	$150,000	**50.0%**	**$ 150,000**
Executive Medical Director	1	0.0%	$ -	50.0%	$150,000	**50.0%**	**$ 150,000**
Senior Information Analyst	2	20.0%	$ 32,000	45.0%	$ 72,000	**65.0%**	**$ 104,000**
Information Analyst	1	20.0%	$ 12,000	45.0%	$ 27,000	**65.0%**	**$ 39,000**
Programmer Analyst Sr.	1	20.0%	$ 18,000	45.0%	$ 40,500	**65.0%**	**$ 58,500**
Manager of Analytics	1	20.0%	$ 18,000	45.0%	$ 40,500	**65.0%**	**$ 58,500**
Director of Analytics	1	20.0%	$ 28,000	45.0%	$ 63,000	**65.0%**	**$ 91,000**
Total Salary and Wages			**$ 388,000**		**$ 1,178,000**		**$ 1,566,000**
Fringe			$ 130,174		$ 395,219		**$ 525,393**
Total Salary and Wages (with fringe)			$ 518,174		$ 1,573,219		**$ 2,091,393**
Quality Measure Abstraction (VMSSP & XSSP)			$ 150,000		$ -		**$ 150,000**
Physician Champions (Contract)			$ -	100%	$ 350,000		**$ 350,000**
Quality Institute Training (Value Inst)			$ -	100%	$ 100,000		**$ 100,000**
Quality Institute Training (Jeffords)			$ -	100%	$ 100,000		**$ 100,000**
NNEACC Toolset etc.			$ -	50%	$ 240,000		**$ 240,000**
VITL Support			$ -	20%	$ 157,680		**$ 157,680**
General Overhead - 10%			$ 51,817		$ 157,322		**$ 209,139**
(travel, admin support, supplies, space etc.)							
Totals			**$ 719,991**		**$ 2,678,221**		**$ 3,398,212**

Section G Appendix: Project Plan/Timeline

VHCIP Project Plan

#	Deliverable/Milestone	Start Date	Due Date	Duration (days)	2014 Q1	2014 Q2	2014 Q3	2014 Q4	2015 Q1	2015 Q2	2015 Q3	2015 Q4
1	**Statewide Plan for all Initiatives**											
2	Document the Aim (goals)	10/1/2014	11/30/2014	60								
3	Identify measures of success	10/1/2014	11/30/2014	60								
4	What are the resulting changes?	10/1/2014	11/30/2014	60								
5	Identify team: physician champions and clinical and quality team, contacts in medical homes	10/1/2014	11/30/2014	60								
6	Identify resources: education, training, facilitators	10/1/2014	11/30/2014	60								
7	Develop training materials	10/1/2014	11/30/2014	60								
8	Identify Pilot Sites	10/1/2014	11/30/2014	60								
9	Identify stakeholders	10/1/2014	11/30/2014	60								
10	Identify Owners of each process improvement	10/1/2014	11/30/2014	60								
11	Create implementation plan and schedule	10/1/2014	11/30/2014	60								
12	Create communication plan (with status updates)	10/1/2014	11/30/2014	60								
13	**Plan by Health Service Area**											
14	**Phase 1 Initiatives - Diabetes**	12/1/2014	5/30/2015	180								
15	**Planning (Plan)**	12/1/2014	5/30/2015	180								
16	Distribute projects	12/1/2014	5/30/2015	180								
17	Assemble and prepare teams for the implementation phase	12/1/2014	5/30/2015	180								
18	**Implementation (Do)**	12/1/2014	5/30/2015	180								
19	Team engaged and carrying out the plan	12/1/2014	5/30/2015	180								
20	Meetings and status reported	12/1/2014	5/30/2015	180								
21	Identify risks and issues and resolving	12/1/2014	5/30/2015	180								
22	Following communication plan	12/1/2014	5/30/2015	180								
23	**Monitoring and Controlling (Study)**	12/1/2014	5/30/2015	180								
24	Reviewing quantitative and qualitative data	12/1/2014	5/30/2015	180								
25	Review lessons learned and identify improvements	12/1/2014	5/30/2015	180								
26	Continue with communication and execution of tasks	12/1/2014	5/30/2015	180								
27	**Closing - (Act)**	12/1/2014	5/30/2015	180								
28	Review pilot results	12/1/2014	5/30/2015	180								
29	Evaluate for implementation beyond pilot	12/1/2014	5/30/2015	180								

VHCIP Project Plan (pg 2)

#	Deliverable/Milestone	Start Date	Due Date	Duration (days)	2014 Q1	2014 Q2	2014 Q3	2014 Q4	2015 Q1	2015 Q2	2015 Q3	2015 Q4
30	**Initiative #2: Coronary Artery Disease**	1/1/2015	6/30/2015	180								
31	**Planning (Plan)**	1/1/2015	6/30/2015	180								
32	Distribute projects	1/1/2015	6/30/2015	180								
33	Assemble and prepare teams for the implementation phase	1/1/2015	6/30/2015	180								
34	**Implementation (Do)**	1/1/2015	6/30/2015	180								
35	Team engaged and carrying out the plan	1/1/2015	6/30/2015	180								
36	Meetings and status reported	1/1/2015	6/30/2015	180								
37	Identify risks and issues and resolving	1/1/2015	6/30/2015	180								
38	Following communication plan	1/1/2015	6/30/2015	180								
39	**Monitoring and Controlling (Study)**	1/1/2015	6/30/2015	180								
40	Reviewing quantitative and qualitative data	1/1/2015	6/30/2015	180								
41	Review lessons learned and identify improvements	1/1/2015	6/30/2015	180								
42	Continue with communication and execution of tasks	1/1/2015	6/30/2015	180								
43	**Closing - (Act)**	1/1/2015	6/30/2015	180								
44	Review pilot results	1/1/2015	6/30/2015	180								
45	Evaluate for implementation beyond pilot	1/1/2015	6/30/2015	180								
46	**Initiative #3: Readmissions**	2/1/2015	7/31/2015	180								
47	**Planning (Plan)**	2/1/2015	7/31/2015	180								
48	Distribute projects	2/1/2015	7/31/2015	180								
49	Assemble and prepare teams for the implementation phase	2/1/2015	7/31/2015	180								
50	**Implementation (Do)**	2/1/2015	7/31/2015	180								
51	Team engaged and carrying out the plan	2/1/2015	7/31/2015	180								
52	Meetings and status reported	2/1/2015	7/31/2015	180								
53	Identify risks and issues and resolving	2/1/2015	7/31/2015	180								
54	Following communication plan	2/1/2015	7/31/2015	180								
55	**Monitoring and Controlling (Study)**	2/1/2015	7/31/2015	180								
56	Reviewing quantitative and qualitative data	2/1/2015	7/31/2015	180								
57	Review lessons learned and identify improvements	2/1/2015	7/31/2015	180								
58	Continue with communication and execution of tasks	2/1/2015	7/31/2015	180								
59	**Closing - (Act)**	2/1/2015	7/31/2015	180								
60	Review pilot results	2/1/2015	7/31/2015	180								
61	Evaluate for implementation beyond pilot	2/1/2015	7/31/2015	180								

VHCIP Project Plan (pg 3)

#	Deliverable/Milestone	Start Date	Due Date	Duration (days)	2014				2015			
					Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
62	**Initiative #4: Emergency Room**	3/1/2015	8/28/2015	180								
63	**Planning (Plan)**	3/1/2015	8/28/2015	180								
64	Distribute projects	3/1/2015	8/28/2015	180								
65	Assemble and prepare teams for the implementation phase	3/1/2015	8/28/2015	180								
66	**Implementation (Do)**	3/1/2015	8/28/2015	180								
67	Team engaged and carrying out the plan	3/1/2015	8/28/2015	180								
68	Meetings and status reported	3/1/2015	8/28/2015	180								
69	Identify risks and issues and resolving	3/1/2015	8/28/2015	180								
70	Following communication plan	3/1/2015	8/28/2015	180								
71	**Monitoring and Controlling (Study)**	3/1/2015	8/28/2015	180								
72	Reviewing quantitative and qualitative data	3/1/2015	8/28/2015	180								
73	Review lessons learned and identify improvements	3/1/2015	8/28/2015	180								
74	Continue with communication and execution of tasks	3/1/2015	8/28/2015	180								
75	**Closing - (Act)**	3/1/2015	8/28/2015	180								
76	Review pilot results	3/1/2015	8/28/2015	180								
77	Evaluate for implementation beyond pilot	3/1/2015	8/28/2015	180								
78	**Statewide Review for all Initiatives**	9/1/2015	10/1/2015	30								
79	Review results of initiatives by HSA	9/1/2015	10/1/2015	30								
80	Design additional sprints and start planning for improvements to prior sprints	9/1/2015	10/1/2015	30								
81	Continuous process improvement cycle	9/1/2015	10/1/2015	30								
82	Establish mechanisms to sustain the improvements	9/1/2015	10/1/2015	30								
83	Create local and ACO wide policies and procedures “best practices"	9/1/2015	10/1/2015	30								
84	Monitor to make sure the activities becomes routinized	9/1/2015	10/1/2015	30								
85	Continuously review the practices to make sure that they don’t need to be changed	9/1/2015	10/1/2015	30								

Section H CMS Quality Measurement Training and Reporting Overview

CMS Quality Measurement Training
& Reporting Overview
June 25, 2014

Vermont Health Care Innovation Project Workgroups
Vicki Loner MHCDS, RN, CCM, PAHM
OneCare Vermont Clinical Operations Director

OneCareVermont

Agenda Objectives

Preparation- Understanding what it takes to prepare for the journey

- Readiness
- Training

Execution- Mapping out the 8 week journey and demand

- Timeline
- Level of Effort

Results- Understanding our baseline and continuing our journey

- ACO Scores
- ACO Report Card

Evaluation & Next Steps- Learning from our experience and planning for the future

- Survey findings

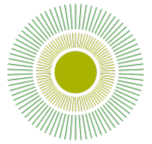
- Lessonslearned
- Future Planning

Preparation

Ready, Set, Go

Trimble

Preparation: Getting ready for our journey



Readiness- Fall 2013

- Identified and met with clinical, quality, and IS leaders in 14 health service areas
- Developed individualized plans for abstraction with each health service area
- Secured network abstractors access to NNEACC and GPRO
- Developed training tools for the measures and NNEACC quality module
- Formed a OneCare quality work-group for training and sharing of best practices
- Developed a state-wide quality abstraction plan

Training- Winter 2013

- State-wide quality measures training (web-ex)
- NNEACC quality module training in 12 health service areas

- One-on-one quality measure training in some of the offices

Execution

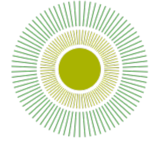
The 8 week Journey

Execution: Race to completion

Scope:

- 13 Health Service Areas- 37 TINS
- 4,378 beneficiaries across 15 quality modules

Execution: Level of effort



Internal OneCare Vermont Resource Demand

- Abstraction Time: >1,000 hours
- Validation Time: > 700 hours

External Network Resource Demand

- Abstraction time: > 1,000 hours

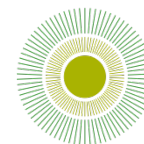
Total Level of Effort

- Training, Abstraction, Validation, Debriefing: > 4,500 hours

Results

The Journey Continues

Results: Statewide ACO Scores



OCV Quality Measure Benchmarks and Scores

Domain	Measure		PY1 (2013)	PY2 (2014)	PY3 (2015)	30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.	OCV Score	n	Quality Points
Patient/Caregiver Experience	1	Getting Timely Care, Appointments, and Information	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	Scores not available at this time for survey-based measures and CMS-calculated claims based measures.		
	2	How Well Your Doctors Communicate	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00			
	3	Patients' Rating of Doctor	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00			
	4	Access to Specialists	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00			
	5	Health Promotion and Education	R	P	P	54.71	55.59	56.45	57.63	58.22	59.09	60.71			
	6	Shared Decision Making	R	P	P	72.87	73.37	73.91	74.51	75.25	75.82	76.71			
	7	Health Status/Functional Status	R	R	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A			
Care Coordination/ Patient Safety	8	Risk Standardized, All Condition Readmissions	R	R	P	16.62	16.41	16.24	16.08	15.91	15.72	15.45			
	9	ASC Admissions: COPD or Asthma in Older Adults	R	P	P	1.24	1.02	0.84	0.66	0.52	0.36	0.00			
	10	ASC Admission: Heart Failure	R	P	P	1.22	1.03	0.88	0.72	0.55	0.40	0.18			
	11	Percent of PCPs who Qualified for EHR Incentive Payment	R	P	P	51.35	59.70	65.38	70.20	76.15	84.85	90.91			
	12	Medication Reconciliation	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	73.81	547	1.70
	13	Falls: Screening for Fall Risk	R	P	P	17.12	22.35	27.86	35.55	42.32	51.87	73.38	46.30	432	1.70
Preventive Health	14	Influenza Immunization	R	P	P	29.41	39.04	48.29	58.60	75.93	97.30	100.00	71.36	398	1.55
	15	Pneumococcal Vaccination	R	P	P	23.78	39.94	54.62	70.66	84.55	96.64	100.00	77.73	440	1.55
	16	Adult Weight Screening and Follow-up	R	P	P	40.79	44.73	49.93	66.35	91.34	99.09	100.00	70.94	413	1.55
	17	Tobacco Use Assessment and Cessation Intervention	R	P	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	91.37	417	2.00
	18	Depression Screening	R	P	P	5.31	10.26	16.84	23.08	31.43	39.97	51.81	24.71	344	1.55
	19	Colorectal Cancer Screening	R	R	P	19.8	33.9	48.5	63.3	78.1	94.7	100	65.33	424	1.55
	20	Mammography Screening	R	R	P	28.6	42.9	54.6	65.7	76.4	88.3	99.56	68.04	413	1.55
	21	Proportion of Adults who had blood pressure screened in past 2 years	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	68.66	351	1.55
At-Risk Population Diabetes	Diabetes Composite 22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24. Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use	R	P	P	17.39	21.20	23.48	25.78	28.17	31.37	36.50	23.08	416	1.25
	27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	R	P	P	70.00	60.00	50.00	40.00	30.00	20.00	10.00	22.12	416	1.70
At-Risk Population Hypertension	28	Percent of beneficiaries with hypertension whose BP < 140/90	R	P	P	60.00	63.16	65.69	68.03	70.89	74.07	79.65	67.04	443	1.40
At-Risk Population IVD	29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	R	P	P	35.00	42.86	51.41	57.14	61.60	67.29	78.81	60.92	412	1.55
	30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	R	P	P	45.44	56.88	68.25	78.77	85.00	91.48	97.91	86.65	412	1.70
At-Risk Population HF	31	Beta-Blocker Therapy for LVSD	R	R	P	30.00	40.00	50.00	60.00	70.00	80.00	90.00	81.78	236	1.85
At-Risk Population CAD	CAD Composite 32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	R	R	P	54.1	61.4	66.1	70	72.3	76.4	79.84	58.95	458	1.10

The benchmarks are the performance rates the ACO must achieve to earn the corresponding quality points for each measure. Shown are the benchmarks for each percentile, starting with the 30th percentile (corresponding to the minimum attainment level) and ending with the 90th percentile (corresponding to the maximum attainment level). For 9 measures, benchmarks are set using flat percentages when the 60th percentile was equal to or greater than 80.00 percent, as required by the program regulations. R = Reporting P = Performance

Report card

OCV Preliminary Quality Measure Score

ACO Performance Level	Quality Points
90+ percentile FFS data or 90+ percent	2.00 points
80+ percentile FFS data or 80+ percent	1.85 points
70+ percentile FFS data or 70+ percent	1.70 points
60+ percentile FFS data or 60+ percent	1.55 points
50+ percentile FFS data or 50+ percent	1.40 points
40+ percentile FFS data or 40+ percent	1.25 points
30+ percentile FFS data or 30+ percent	1.10 point
<30 percentile FFS data or <30+ percent	No points

This table shows the corresponding number of points that each level of performance earns on each measure. A maximum of 2 points can be earned for each scored individual or composite measure, except for the EHR measure. The EHR measure is double weighted and is worth up to 4 points to provide incentive for greater levels of EHR adoption.

The total points earned for measures in each domain will be summed and divided by the total points available for that domain to produce an overall domain score of the percentage of points earned versus points available. The percentage score for each domain will be averaged together to generate a final overall quality score for each ACO that will be used to determine the amount of savings it shares or, if applicable, the amount of losses it owes.

The following table shows the maximum possible points that may be earned by an ACO in each domain and for all domains. Quality scoring will be based on the ACO's actual level of performance on each measure.

Domain	Number of Individual Measures	Total Measures for Scoring Purposes	Total Possible Points	OCV Possible Points (using info currently available)	OCV Points Scored	OCV Domain Scores	Domain Weight	
Patient/Caregiver Experience	7	7 individual survey module measures	14	-	-		25%	
Care Coordination/ Patient Safety	6	6 measures, plus the EHR measure double-weighted (4 points)	14	4	3.40	85%	25%	
Preventive Health	8	8 measures	16	16	12.85	80%	25%	
At-Risk Population	12	7 measures, including 5-component diabetes composite measure and 2- component coronary artery disease composite measure	14	14	10.55	75%	25%	
Total in all Domains	**33**	**28**	**58**	**34**	**26.80**		**100%**	**80.2%**

Scores not available for survey-based measures and CMS-calculated claims based measures.

The percentage of Shared Savings we would be eligible for if we meet our minimum savings rate threshold based on currently available score information.

This is a PRELIMINARY score.
This percentage only includes the GPRO-based score. CMS will conduct the surveys and calculate the claims-based scores.

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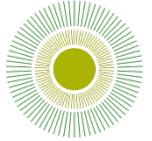
Evaluation & Next Steps

What did we learn and where do we go from here…..

Evaluation: Information from the debriefings and surveys



In-person debriefing and surveys sent to all quality leads and abstractors using a standardized format

Strengths

- Abstraction and training support from OneCare central clinical and coders team
- Help desk support from OneCare

Opportunities

- NNEACC tool (e.g., slowness; time-outs; errors)
- Training on the measures and tools

Lessons Learned

- Dedicated clinical, operational, and IT support needed for each site
- Daily huddles kept everyone moving forward
- Training needs to be started earlier in the process and more hands on
- Training materials need to streamlined and complement NNEACC tool
- QI testing in NNEACC prior to "go live date"
- Communication channels between NNEACC, OneCare VT central, and network end users' needs to be strengthened

Next Steps: Learning from experience

Measures and NNEACC Training

- Training materials to be updated and select HSAs to pilot materials
  - Materials finalized by July 2014
  - Training to occur in September-November 2014

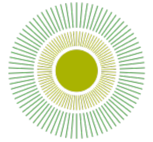
NNEACC System

- Merged product (Deloitte) planned for August is expected to provide improved performance and greater stability
- Work-groups are being assembled by NNEACC to address issues identified during the quality abstraction process

Internal Operations

- Dedicated team working on enhancing the current quality improvement work-plan to help guide next year's process
  - Work plan finalized by September 2014
  - Readiness assessments completed by October 2014

Next Steps: Using data to identify opportunities for clinical improvement



Clinical Advisory Board priorities selected:

- Coronary Artery Disease and Diabetes composite
- Readmissions and emergency visit utilization

Regional Clinical Performance Committees emerging:

- Data informing the processes
- Health service areas collaborating to do a deeper dive on the measures and to do root cause analysis
- Aims, action plan, and goals for clinical performance improvement evolving

Thank you and Questions

109 State Street
Montpelier, VT 05609

Section I OneCare Vermont Participants and Providers

As of 07-10-2014

Participants (TINs)	Providers
FLETCHER ALLEN HEALTH CARE	980
CENTRAL VERMONT MEDICAL CENTER, INC.	177
RUTLAND HOSPITAL INC.	139
NORTHWESTERN MEDICAL CENTER	118
SOUTHWESTERN VERMONT MEDICAL CENTER, INC.	106
PORTER HOSPITAL INC.	100
NORTHEASTERN VERMONT REGIONAL HOSPITAL, INC.	98
GIFFORD MEDICAL CENTER	86
WINDSOR HOSPITAL CORPORATION	84
BRATTLEBORO MEMORIAL HOSPITAL, INC.	82
SPRINGFIELD HOSPITAL INC.	66
NORTH COUNTRY HOSPITAL AND HEALTH CENTER INC.	64
BRATTLEBORO RETREAT	63
HOWARDCENTER	56
COPLEY HOSPITAL, INC	52
SPRINGFIELD MEDICAL CARE SYSTEMS, INC.	50
PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND	43
COMMUNITY HEALTH CENTERS OF THE RUTLAND REGION INC	41
PRIMARY CARE HEALTH PARTNERS- VT, LLP	36
NORTHWESTERN OCCUPATIONAL HEALTH, LLC	34
MATRIX HEALTH SYSTEMS, PC	32
RUTLAND REGIONAL MEDICAL CENTER ANESTHESIOLOGY	28
COPLEY PROFESSIONAL SERVICES GROUP, INC.	24
WASHINGTON COUNTY MENTAL HEALTH SERVICES, INC.	22
HEALTH CARE AND REHABILIATION SERVICES OF	20
CARLOS G. OTIS HEALTH CARE CENTER, INC.	18
CLARA MARTIN CENTER	17
COUNSELING SERVICE OF ADDISON COUNTY INC.	16

Section I OneCare Vermont Participants and Providers

NORTHWESTERN COUNSELING & SUPPORT SERVICES	14
UNITED COUNSELING SERVICE OF BENNINGTON COUNTY INC	11
MARK S HARRIS	9
NORTHEAST KINGDOM HUMAN SERVICES, INC.	9
RUTLAND MENTAL HEALTH SERVICES, INC.	8
EYECARE OF VERMONT, PLC	5
RADIOLOGY ASSOCIATES OF BENNINGTON, INC.	5
SHAFTSBURY MEDICAL ASSOCIATES, INC.	5
VALLEY RADIOLOGIST, PA	5
CHAMPLAIN VALLEY ORAL & MAXILLOFACIAL SURGERY PC	4
BENNINGTON FAMILY PRACTICE	3
EYE VERMONT	3
MARK YORRA DBA GRANITE CITY MEDICAL ASSOCIATES	3
MIDDLEBURY EYE ASSOCIATES, INC.	3
RUTLAND AREA VISITING NURSE ASSOCIATION	3
TIMBER LANE ALLERGY & ASTHMA ASSOCIATES, PC	3
VERMONT FAMILY EYECARE, INC	3
ANESTHESIOLOGY ASSOCIATES OF BENNINGTON, PC	2
ASSOCIATES IN PERIODONTICS, PLC	2
BATTENKILL VALLEY HEALTH CENTER, INC.	2
CENTRAL VERMONT HOME HEALTH & HOSPICE, INC	2
CHAMPLAIN CENTER FOR NATURAL MEDICINE	2
COLD HOLLOW FAMILY PRACTICE, P.C.	2
DR. ROBERT BAUMAN, PLLC	2
FRANKLIN COUNTY HOME HEALTH AGENCY, INC.	2
GREEN MOUNTAIN GENERAL SURGERY, INC	2
LAMOILLE COUNTY MENTAL HEALTH SERVICES	2
LAMOILLE HOME HEALTH AGENCY, INC.	2
NORTHERN VALLEY EYECARE, INC	2
ORLEANS- ESSEX VNA AND HOSPICE, INC.	2
PAUL KENWORTHY, DMD, PC	2
UPPER VALLEY PATHOLOGY, PLLC	2
VISITING NURSES ASSOCIATION OF CHITTENDEN AND	2
ADDISON COUNTY HOME HEALTH AND HOSPICE, INC.	1
ALLAN EISEMANN, MD	1

Section I OneCare Vermont Participants and Providers

AMBER MINTON	1
ANDREW MINKIN, MD	1
ANGELA WINGATE, MD	1
ARTHRITIS & RHEUMATOLOGY CENTER, PLC	1
AVERY WOOD, MD LLC	1
BARBARA BENTON	1
BENNINGTON HEALTH AND REHABILITATION CENTER, LLC	1
BERLIN HEALTH AND REHABILITATION CENTER, LLC	1
BRATTLEBORO CROSSINGS	1
BRATTLEBORO MUTUAL AID ASSOCIATION, INC DBA	1
BROOKSIDE NURSING HOME INC	1
BURLINGTON HEALTH AND REHABILITATION CENTER, LLC	1
CEDAR HILL HEALTH CARE CORPORATION	1
CRAIG E. GOLDBERG, DO	1
CRYSTAL VISION BY DRS OF OPTOMETRY	1
DARTMOUTH HITCHCOCK CLINIC	1
DAVID M. GORSON, MD	1
DH SPECIALTY SERVICES, LLC	1
DR JAY KIMBERLEY, PC	1
DTGC, PC DBA VERMONT DERMATOPATHOLOGY	1
ERIC ASNIS, MD	1
ERIC S. SEYFERTH, MD	1
FIVE NINETY SIX SHELDON ROAD OPERATIONS LLC DBA	1
FORTY SIX NICHOLS STREET OPERATIONS LLC DBA	1
FRANKLIN COUNTY REHAB CENTER, LLC	1
FRANKLIN COUNTY SURGICAL ASSOCIATES PC	1
GARY KELLER	1
JAMES E. GAYDOS, DO, PC	1
JOEL SILVERSTEIN MD	1
JOSEPH H. KRATZER, MD	1
KINDRED NURSING CENTERS EAST LLC	1
KINGDOM REHAB CENTER LLC	1
MANCHESTER HEALTH SERVICES, INC.	1
MARIA NOVAS-SCHMIDT	1

MARION E. PALERMO	1
MARTIN BRUTUS	1
MARY ANN YEATTS-PETERSON, MD, LLC	1
MARY HITCHCOCK MEMORIAL HOSPITAL	1
MAYO HEALTHCARE INC.	1
MICHAEL ALGUS, MD	1
MICHELE WEBSTER	1
MONUMENT UROLOGY, PC	1
MOUNT ANTHONY HOUSING CORPORATION DBA THE CENTERS	1
NEUROLOGICAL ASSOCIATES OF VT	1
NINE HAYWOOD AVENUE OPERATIONS LLC	1
PINE KNOLL NURSING HOME INC	1
PULMONARY INTERNISTS, INC	1
REDSTONE VILLA LLC	1
RICHARD C. LYONS, MD	1
RICHFORD HEALTH CENTER, INC.	1
ROGER B. KELLOGG, MD	1
ROWAN COURT HEALTH AND REHABILITATION CENTER LLC	1
RUTLAND CROSSINGS, LLC DBA THE PINES AT RUTLAND	1
RUTLAND EYE PHYSICIANS	1
SHARON Z. ALPER	1
SPRINGFIELD HEALTH AND REHABILITATION CENTER LLC	1
ST. JOHNSBURY HEALTH AND REHABILIATION CENTER LLC	1
STARR FARM PARTNERSHIP	1
STEPHEN J. WOODRUFF, MD	1
THE MANOR INC	1
THIRTY FIVE BEL-AIRE DRIVE SNF OPERATIONS LLC	1
TINA D'AMATO, DO	1
TSS LLC DBA GREEN MOUNTAIN NURSING HOME	1
UNION HOUSE NURSING HOME INC	1
VERMONT OROFACIAL PAIN ASSOCIATES PC	1
VERMONT ORTHOPAEDIC IMAGING, PLC	1
VERNON ADVENT CHRISTIAN HOME INC	1

VISTING NURSE ASSOCIATION & HOSPICE	1
WILLIAM J. SARCHINO, DPM	1
ZAIL S BERRY, MD, MPH, PLLC	1
Total Providers	2,852

Attachment 5b - VHCIP spending tracking as of 7.10.14

VHCIP Funding Allocation Plan

		Implementation (March-Oct 2013)	Year 1	Year 2	Year 3	Total grant period	
Type 1a	Type 1A						
Proposed type 1 without base work group or agency/dept support	*Proposed Type 1 without base work group or agency/dept support (subject to Core Team approval)*						**Green indicates the money has been committed through hiring or contracts. Blue indicates the money has been approved for spending, but the contract is pending. Red indicates pending Core Team Approval.**
	Personnel, fringe, travel, equipment, supplies, other, overhead	$ 107,898	$ 2,912,103	$ 3,412,103	$ 3,412,103	$ 9,844,207	Includes new .5FTE in AOA for work force.
	Duals personnel and fringe		$ 110,000			$ 110,000	Year 1 paid out of Carryover
	Project management	$ 30,000	$ 470,000	$ 275,000	$ 245,000	$ 1,020,000	**Request to transfer $850,000 to Analytics.**
	Evaluation		$ 200,000	$ 900,000	$ 900,000	$ 2,000,000	**Request approval of $1,800,000 for External Evaluator. $200,000 remains for Evaluation.**
	Outreach and Engagement		$ -			$ -	
	Interagency coordination		$ -	$ 110,000	$ 110,000	$ 220,000	
	Staff training and Change management		$ 15,000	$ 25,000	$ 20,000	$ 60,000	**Support Conferences and Educational Opportunities. Request to transfer $160,000 to Advanced Analytics.**
	VITL Contract		$ 1,177,846			$ 1,177,846	
	Grant program		$ 3,428,435	$ 933,333	$ 933,334	$ 5,295,102	**$2.6 million awarded.**
	Grant program- Technical Assistance		$ 500,000			$ 500,000	
	Chart Review		$ 50,000	$ 345,000	$ -	$ 395,000	**From several other line items**
	ACO Proposal: Analytics		$ 151,600	$ 3,000,000	$ -	$ 3,151,600	**From several other line items**
	Subtotal	**$ 137,898**	**$ 9,014,984**	**$ 5,655,436**	**$ 5,620,437**	**$ 20,227,155**	

VHCIP Funding Allocation Plan

Type 1b	Type 1 B		**Year 1**	**Year 2**	**Year 3**	**Grant Total**	
Proposed type 1 related to base work group support (subject to Core Team approval)	Proposed Type 1 related to base work group support (subject to Core Team approval)						
	Payment Models						
	Bailit		$ -	**$ 200,000**	**$ 200,000**	**$ 400,000**	**To support ACO work, Care Models Work.**
	Burns and Associates or other vendor		**$ 125,000**	$ 275,000	$ -	$ 400,000	**To develop EOC program and P4P programs.**
						$ -	
	Measures					$ -	
	General		$ -	**$ 200,000**	**$ 200,000**	**$ 400,000**	Bailit
	Patient Experience Survey		**$ 200,000**			**$ 200,000**	**Contract negotiations ongoing**
						$ -	
	HIT/HIE		**$ -**	**$ 120,000**	**$ 110,000**	**$ 230,000**	**Request to move $120,000 to Advanced Analytics.**
						$ -	
	Population Health		**$ 100,000**	$ 100,000	$ 100,000	$ 300,000	**28,000 expended on Hester contract in year one. 70,000 for RFP.**
						$ -	
	Workforce		$ -	$ 43,000	$ 43,000	$ 86,000	
						$ -	
	Care Models		**$ 50,000**	**$ 50,000**	**$ 50,000**	**$ 150,000**	**Support provided under Bailit Contract, reducing this because that funding was found elsewhere. Request to move 400,000 to Analytics.**
						$ -	
	DLTSS					$ -	
	Bailit/PHPG		**$ 180,000**	**$ 250,000**	**$ 250,000**	**$ 680,000**	**$100,000 each in years two and three for Bailit for DLTSS support.**
	Sub Total		**$ 655,000**	**$ 1,238,000**	**$ 953,000**	**$ 2,846,000**	

VHCIP Funding Allocation Plan

Type 1c	Type 1 C		**Year 1**	**Year 2**	**Year 3**	**Grant Total**	
Proposed type 1 related to base agency/dept support	Proposed Type 1 related to base agency/dept support						
	GMCB/DVHA						
	ACO Analytics Contractors		**$ 733,333**	**$ 748,333**	**$ 733,334**	**$ 2,215,000**	**This contractor would support the development of spending targets, whether an ACO met those targets. This contract is higher than anticipated. Recommend moving funds to provide additional $1.215 million**
						$ -	
	GMCB					$ -	
	Model testing support		$ 125,000	$ 125,000	$ 125,000	$ 375,000	Support GMCB analytics related to payment model development
						$ -	
	DVHA					$ -	
	Modifications to MMIS, etc...		$ 275,000	$ 150,000	$ -	$ 425,000	Resources to support updates to adjudication or analytic systems and processes like MMIS.
	Broad dissemination of programmatic information to providers and consumers		$ -	$ 100,000	$ 100,000	$ 200,000	Communications to providers and consumers regarding program/billing changes.
	Analytics support to implement models		$ -	$ 50,000	$ 50,000	$ 100,000	
	Technical support of web-based participation and attestation under the P4P program		$ 125,000	$ 100,000	$ 25,000	$ 250,000	Aimed to reduce administrative burden to implement and improve participation in P4P programs

	Analytic support		**$ 250,000**	$ 100,000	$ 100,000	$ 450,000	Support Medicaid analytics related to payment model development. **Moved $150,000 in exchange for data analyst position for workforce**.
	Sub-Total		**$ 1,508,333**	**$ 1,373,333**	**$ 1,133,334**	**$ 4,015,000**	

VHCIP Funding Allocation Plan

Type 2	Type 2		Year 1	Year 2	Year 3	Grant Total	
Total proposed type 2 (subject to staff planning, work group/steering committee review and Core Team approval)	Total proposed Type 2 (subject to staff planning, work group/steering committee review and Core Team approval)						
	HIT/HIE						
	Practice Transformation Teams		**$ 530,933**	**$ 856,666**	$ 856,667	$ 2,244,266	**$90,612 in year one is unallocated. Use 90,612 of year one and 856,666 of year two for ACTT Proposal.**
	Clinical Registry		**$ 466,666**	$ 466,666	$ 466,667	$ 1,399,999	**Use 466,666 of year one for ACTT Proposal.**
	Integrated Platform		**$ 515,066**	**$ 666,666**	**$ 666,667**	**$ 1,848,399**	**Request to move $151,600 to Analytics.**
	Expanded Connectivity between SOV and providers		**$ 833,333**	**$ 833,333**	**$ 446,237**	$ 2,112,903	**Use 387,097 of year three for ACTT Proposal. Reallocate between years. Balance of $446,237 remains.**
	Telemedicine		$ 416,666	$ 416,666	$ 416,667	$ 1,249,999	
	Expanded Connectivity HIE		**$ 346,346**	**$ 661,077**	**$ 661,077**	$ 1,668,500	**Use 661,077 of year three for ACTT Proposal. Reallocate between years.**
						$ -	
	Workforce					$ -	
	Surveys		$ -	**$ -**	**$ -**	**$ -**	**request to move $80,000 to Advanced Analytics.**
	Data analysis		$ -	$ -	$ -	$ -	**Request to move 300,000 to Analytics**
	System-wide analysis			**$ 98,332**	**$ 546,667**	**$ 644,999**	**Moved $150,000 to Data Analytics in exchange for position at June Core Team Meeting. Request to move 395,000 for Chart Review (analytics).**
						$ -	
						$ -	

VHCIP Funding Allocation Plan

	Care Models					$ -	
	Service delivery for LTSS, MH, SA, Children		**$ 133,333**	**$ 533,333**	**$ 533,334**	**$ 1,200,000**	**Request to move 400,000 to Analytics.**
	Learning Collaboratives		**$ -**	**$ 325,000**	**$ 325,000**	**$ 650,000**	**Request to move 350,000 to Analytics.**
	Analysis of how to incorporate LTSS, MH/SA		$ 100,000	$ 100,000	$ 100,000	$ 300,000	This includes technology support to Medicaid Home Health Initiatives including Hub and Spoke.
	Practice Facilitators		$ -	$ -	$ -	$ -	**Request to move $340,000 to Analytics.**
	Integration of MH/SA		$ 50,000	$ 50,000	$ 50,000	$ 150,000	
						$ -	
	Sub-Total		**$ 3,392,343**	**$ 5,007,739**	**$ 5,068,983**	**$ 13,469,065**	

VHCIP Funding Allocation Plan

Type 1a	$ 20,227,155	Type 1 A					
Type 1b	$ 2,846,000	Type 1 B					
Type 1c	$ 4,015,000	Type 1 C					
Type 2	$ 13,469,065	Type 2					
Unallocated (Year 1)	$ 4,451,950	Balance Avail.					
Grant Total	$ 45,009,170	Grant Total					