VT Health Care Innovation Project - Payment Models Work Group Meeting Agenda
Monday, September 21, 2015 1:00 PM – 2:30 PM.
EXE-4th Floor Conference Room, Pavilion Building, Montpelier, VT
Call in option: 1-877-273-4202 Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	1:00 – 1:10	Welcome and Introductions Approve meeting minutes	Don George and Andrew Garland	Y – Approve minutes	Attachment 1: August Meeting Minutes
2	1:10-1:20	Project Updates • SSP Year 1 Final Calculation Update • VMSSP Yr 3 Total Cost of Care Decision	Richard Slusky, Alicia Cooper, Cecelia Wu	N	
3	1:25-1:55	Overview of other work groups	Tracy Dolan, Cathy Fulton	N	Attachment 3: Work Group Charters
4	1:55-2:25	Discussion: work group mergers and project rebasing		N	Attachment 4: Rebasing slides
5	2:25-2:30	Next Steps and Action Items		N	Next Meeting: TBD

Attachment 1: August Meeting Minutes

Vermont Health Care Innovation Project
Payment Models Work Group Meeting Minutes

Date of meeting: Monday, August 24, 2015, 1:00pm-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Don George called the meeting to order at 1:03pm. A roll call attendance was taken and a quorum was not present. A quorum was present after the second agenda item. Sue Aranoff moved to approve the June 2015 meeting minutes by exception. Catherine Fulton seconded. The motion carried with one abstention.	
2. Project Updates	Alicia Cooper and Cecelia Wu provided brief updates on Vermont Health Care Innovation Project activities. • *CMMI Site Visit:* Alicia Cooper discussed our CMMI site visit, which took place on July 23-24. The site visit included a broad stakeholder meeting to provide high-level updates on our work across three key areas: payment models, care models, and HIE/HIT, as well as closed meetings between CMMI project officers and VHCIP project leadership. The site visit also provided an opportunity to gather feedback from CMMI on what they expect over the next year. • *SSP Year 1 Final Calculations:* Alicia Cooper reported that Lewin, the analytics contractor for the Medicaid and Commercial Shared Savings Programs (SSPs), is completing calculations on ACOs' Year 1 performance this month. Following review by ACOs, the results will be presented to VHCIP Work Groups (expected late September). • *VMSSP Year 2 Contract Amendment Process:* Cecelia Wu provided an update on the contract amendment process. Contracts are close to final – DVHA and the ACOs are in agreement on overall content and are in the final stages of negotiating wording for the program integrity section (new this year). • *VMSSP Year 3 Total Cost of Care Process Update:* Cecelia Wu reminded the group that DVHA's research to-date on TCOC was presented at the last Payment Models Work Group meeting. DVHA received written comment from a number of members; comments are included in the meeting materials (Attachment 2) and have been presented to DVHA leadership. A decision will likely be made this week. o Don George thanked Work Group members for their thoughtful public comment on this topic.	

Agenda Item	Discussion	Next Steps
3. QPM Recommendations for Year 3 Commercial and Medicaid Shared Savings Program Measure Changes	Pat Jones presented the Quality and Performance Measures (QPM) Work Group's recommendations for measures changes for the Year 3 of the Commercial and Medicaid SSPs (Attachment 3). • Payment Measures: o *LDL Screening*: This measure is no longer supported by best practice. QPM recommends replacing this with a hypertension control measure that is part of the Medicare Shared Savings Program (MSSP) measure set. This change was already approved for Year 2; QPM recommends continuing the change in Year 3. • Reporting Measures: o *Diabetes Composite*: The 5-part diabetes care composite measure includes LDL screening, which is no longer considered best practice. QPM recommends moving from the five-part composite measure (known as the D5) to a two-part measure of diabetes care (D2). The D2 has replaced the D5 in the MSSP. This change was already approved for Year 2; QPM recommends continuing the change in Year 3. • Monitoring & Evaluation Measures: o *Appropriate Medications for People with Asthma*: This measure measure is being retired by the measure steward (NCQA). QPM recommends replacing this with a claims-based HEDIS measure, Medication Management for People with Asthma. o *ED Utilization for Ambulatory Care-Sensitive Conditions*: This measure is being retired by the measure steward (AHRQ). QPM recommends replacing this with Onpoint Health Data's Potentially Avoidable ED Utilization measure. The Onpoint measure is currently used in the Blueprint practice and health service area profiles. The group discussed the following: • Does the Onpoint measure look at the level of the ED visit? o ED visits that result in admissions are not counted for this measure. o MVP distinguishes Level 1 and Level 2 visits and uses this to support care coordination and treatment by identifying underlying conditions that might be affecting repeat offenders. The Onpoint measure only looks at primary diagnosis. It is at the ACO level – not actionable data, but rather an aggregate summary of ED utilization among ACO attributed lives. o The QPM Work Group requested the analytics contractor look at this measure for prior years to provide a baseline. • Is the Onpoint measure time-sensitive (is PCP office open or closed)? No. • Does the Onpoint measure take into account whether the patient has attempted to see the PCP? No – it's a claims-based measure. • Were there measures considered by the QPM Work Group but not brought forward as recommendations? No – all measures discussed achieved unanimous approval at the QPM Work Group.	

Agenda Item	Discussion	Next Steps
	Pat also noted that the patient experience survey we use, the PCMH CAHPS survey, will likely undergo some changes over the next few months. Project leadership requested the work group vote on whether to allow the state latitude to update measures based on changes to the national PCMH CAHPS survey instrument, rather than voting on each change to measure specifications. The Work Group agreed that changes to this survey or the Family Experience of Hospice survey could be integrated into our measure set to ensure our measures are consistent with national standards. • Last year, this group discussed that patient experience measures should be linked to payment, rather than just reporting. The QPM Work Group did not discuss changing these to payment measures due to the Green Mountain Care Board's request for a hiatus on measure changes (unless there is a change in the evidence base). Paul Harrington, reflecting on previous meetings, noted that Payment Models Work Group members have expressed the belief that patient experience measures are critical to the project's success; Richard Slusky suggested a conversation with Al Gobeille to assess whether movement of measures between measure sets is an option. Results from Year 1 are likely to be released in September 2015; this group can come back to this suggestion following review of Year 1 results. • We will have ACO-level patient experience results for all three ACOs this year. Paul Harrington moved to approve by exception the four suggested changes as well as to approve flexibility to make changes to the patient experience measures based on national measure changes. Bard Hill seconded. The motion carried unanimously.	
4. All-Payer Model Progress Report Summary	Richard Slusky provided a progress update on the All-Payer Model (Attachment 4). This presentation was also delivered to the Green Mountain Care Board on August 13th. • This model is significantly different than Maryland's APM. Vermont's circumstances are significantly different from Maryland's, in part stemming from different cost trends in the two states. Maryland had a high per-capita cost for Medicare beneficiaries, while Vermont's is relatively low – this may mean Vermont is able to negotiate different requirements with respect to producing savings for Medicare. • Secretary Burwell will make the final decision on whether to grant an all-payer waiver, with sign off from OMB. Lawrence Miller noted that the waiver might be only one piece of the APM – a package of waivers and other strategies might be necessary to effectively align Medicare, Medicaid, and commercial payers. • The model will be voluntary and could involve multiple payment options for participants. • 2016 will be a transitional year, preparing for APM implementation in 2017. • Assessing options for ACOs to continue separate operations or collaborate more closely. • Payment options for participating and non-participating providers are included in this presentation – one goal is to ensure that declining to participate is not a better deal for providers than participation in the new model. For some provider types, there are multiple options currently under review. • This will also attempt to align the consolidated Medicaid Global Commitment and Choices for Care waivers, which will need to be renegotiated this year. • This is likely to be a 5-year waiver.	

Agenda Item	Discussion	Next Steps
	The group discussed the following: • Members noted that engagement of community health providers – including mental health, substance abuse, long-term care services – and consumer advocates in decision-making is minimal. Richard noted that the ACO Payment Sub-Committee is a closed group but GMCB and AOA are working to share information on the process as appropriate. • NextGen ACO selection is expected in mid-September. • Why are payment reforms limited to hospitals, FQHCs, primary care, and specialty care? Richard noted that this is a huge effort to take on, and that these changes are likely to highlight the value of behavioral health and long-term care services – hospitals and ACOs are likely to change their relationships with these agencies as the value of services that can keep people healthy and out of the hospital becomes clearer. Richard suggested that readiness within these sectors is also not yet sufficient. • For the all-payer waiver, Medicare is limiting included services to Medicare Part A & B services. Lawrence Miller distinguished total cost of care and total cost of regulated care. He also noted that in the future, additional services could be included in rate review process, but that regulatory capacity to support this is not yet in place and provider sectors might not welcome that additional regulation. • Richard noted that this process is requiring leaps of faith on all parts – it will require culture change and different thinking across the system. Larry Goetschius agreed and requested that the current closed stakeholder group be reconsidered. Mike Hall commented that many behavioral health and long-term care providers are concerned that this will create a parallel delivery system if ACOs and hospitals choose to create mental health, home health, or other behavioral health and long-term care services internally. Richard argued that this is unlikely – in a fixed revenue model, it is unlikely hospitals will be able to do this as efficiently as existing organizations. • How will the new system encourage prospective selection of a PCP? ACOs will likely ask providers to open their practices to new patients. In addition, the new system will hopefully reduce the burden of paperwork, prior approval, etc. to allow providers to see more patients. The new system could also make primary care a more attractive profession for students by potentially increasing pay. • Sue Aranoff suggested that additional transparency around this initiative and the UCCs could broaden support from behavioral health and long-term care providers. Abe Berman commented that OneCare intended UCC meetings to be open and will check on this. • Lawrence Miller noted that it would be unwise to include all costs under the total cost of care, especially for services over which we have limited control of costs (for example, pharmacy) or that are historically underfunded (for example, behavioral health). Mike Hall agreed but suggested a roadmap toward expansion would be helpful and allow providers currently not included to plan ahead. Lawrence and Richard agreed but suggested that this is a task for the future, once the terms of the first waiver are in place.	

Agenda Item	Discussion	Next Steps
6. Public Comment	Lila Richardson commented that there is a proposal to reorganize the VHCIP governance structure that will be discussed at the Steering Committee on Wednesday, 8/26, and voted on at the Core Team on 8/31. Lawrence noted that this is driven by discussions with CMMI, and their expectations of what we will accomplish prior to the end of the grant. This is intended to streamline decision-making, and not intended to limit participation. More information on the proposed changes is available in the Steering Committee materials, available on the VHCIP website.	
7. Next Steps, and Action Items	**Next Meeting:** Monday, September 21, 2015, 1:00-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.	

Minutes Sue 4 1°
Cathy F 2°
Motion Carried Unanimously

Measures:
Paul Harrington 1°
Bard Hill 2°
Motion carried unanimously

VHCIP Payment Models Work Group Member List

Roll Call: 8/24/2015

Member		Member Alternate		Minutes	Yr 3 Measures	
First Name	Last Name	First Name	Last Name			Organization
Mary Alice	Bisbee ✓					Consumer Representative
Diane	Cummings ✓					AHS - Central Office
Michael	Curtis	Melissa	Bailey ✓			Washington County Mental Health Services Inc.
Mike	DelTrecco ✓	Bea	Grause			Vermont Association of Hospital and Health Systems
Catherine	Fulton ✓					Vermont Program for Quality in Health Care
Joyce	Gallimore					CHAC
Maura	Graff ✓					Planned Parenthood of Northern New England
Lynn	Guillett					Dartmouth Hitchcock
Mike	Hall ✓	Angela	Smith-Dieng ✓			Champlain Valley Area Agency on Aging / COVE
Paul	Harrington ✓					Vermont Medical Society
Bard	Hill ✓	Susan	Aranoff ✓			AHS - DAIL
Sara	King	Larry	Goetschius ✓			Rutland Area Visiting Nurse Association & Hospice
Kelly	Lange ✓	James	Mauro			Blue Cross Blue Shield of Vermont
David	Martini					DFR
Lou	McLaren ✓					MVP Health Care
Tom	Pitts					Northern Counties Health Care
Amy	Putnam ✓					Northwestern Counseling and Support Services, Inc.
Paul	Reiss					Accountable Care Coalition of the Green Mountains
Lila	Richardson ✓	Rachel	Seelig			Vermont Legal Aid
Greg	Robinson	Abe	Berman ✓			OneCare Vermont
Howard	Schapiro					University of Vermont Medical Group Practice
Julia	Shaw ✓	Rachel	Seelig			Health Care Advocate Project
Ted	Sirotta					Northwestern Medical Center
Richard	Slusky ✓	Pat	Jones ✓			GMCB
Jeremy	Ste. Marie	Jessica	Oski			Vermont Chiropractic Association
Shannon	Thompson					AHS - DMH
Sharon	Winn	Joyce	Gallimore			Bi-State Primary Care
	26		12			

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approved.

approved.

VHCIP Payment Models Work Group Participant List

Attendance: 8/24/2015

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

First Name	Last Name		Organization	Pymt Models
Susan	Aranoff	here	AHS - DAIL	S/MA
Ena	Backus		GMCB	X
Melissa	Bailey	here	Vermont Care Partners	MA
Michael	Bailit	phone	SOV Consultant - Bailit-Health Purchasing	S
Susan	Barrett		GMCB	X
Susan	Bartlett		AHS	X
~~Anna~~	~~Bassford~~		GMCB	A
Abe	Berman	phone	OneCare Vermont	MA
~~Susan~~	~~Besio~~		SOV Consultant - Pacific Health Policy Group	S
Mary Alice	Bisbee	phone	Consumer Representative	M
Martha	Buck		Vermont Association of Hospital and Health Systems	A
Heather	Bushey		Planned Parenthood of Northern New England	X
Gisele	Carbonneau		HealthFirst	A
Amanda	Ciecior	here	AHS - DVHA	S
Sarah	Clark		AHS - CO	X

Michael Bailit - Phone

Lori	Collins		AHS - DVHA	X
Amy	Coonradt	here	AHS - DVHA	S
Alicia	Cooper	here	AHS - DVHA	S
Michael	Counter		Visiting Nurse Association & Hospice of VT & NH	X
Diane	Cummings	here	AHS - Central Office	S/M
Michael	Curtis		Washington County Mental Health Services Inc.	M
Danielle	Delong		AHS - DVHA	X
Mike	DelTrecco	phone	Vermont Association of Hospital and Health Systems	M
Michael	Donofrio		GMCB	X
Gabe	Epstein	here	AHS - DAIL	S
Katie	Fitzpatrick		Bi-State Primary Care	A
Erin	Flynn		AHS - DVHA	S
Catherine	Fulton	here	Vermont Program for Quality in Health Care	M
Joyce	Gallimore		Bi-State Primary Care/CHAC	MA/M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Andrew	Garland		MVP Health Care	C
Christine	Geiler		GMCB	S
Don	George	here	Blue Cross Blue Shield of Vermont	C
Carrie	Germaine	phone	AHS - DVHA	X
Al	Gobeille		GMCB	X
Larry	Goetschius	here	Addison County Home Health and Hospice	MA
Maura	Graff	here	Planned Parenthood of Northern New England	M
Bea	Grause		Vermont Association of Hospital and Health Systems	MA
Lynn	Guillett		Dartmouth Hitchcock	M
Mike	Hall	here	Champlain Valley Area Agency on Aging / COVE	M
Thomas	Hall		Consumer Representative	X
~~Bryan~~	~~Hallett~~		GMCB	S
Paul	Harrington	phone	Vermont Medical Society	M
Carrie	Hathaway		AHS - DVHA	X
Carolynn	Hatin		AHS - Central Office - IFS	S
Erik	Hemmett		Vermont Chiropractic Association	X
Selina	Hickman		AHS - DVHA	X
Bard	Hill	here	AHS - DAIL	M
Con	Hogan		GMCB	X

Nancy	Hogue		AHS - DVHA	X
Craig	Jones		AHS - DVHA - Blueprint	MA
Pat	Jones	here	GMCB	S/MA
Joelle	Judge	here	UMASS	S
Kevin	Kelley		CHSLV	X
Melissa	Kelly		MVP Health Care	X
Sarah	King		Rutland Area Visiting Nurse Association & Hospice	M
Sarah	Kinsler	here	AHS - DVHA	S
Peter	Kriff		PDI Creative	X
Kelly	Lange	here	Blue Cross Blue Shield of Vermont	M
Carole	Magoffin	here	AHS - DVHA	S
Georgia	Maheras		AOA	S
David	Martini		DFR	M
Mike	Maslack			X
John	Matulis			X
James	Mauro		Blue Cross Blue Shield of Vermont	MA
Alexa	McGrath		Blue Cross Blue Shield of Vermont	A
Sandy	McGuire		Howard Center	X
Lee	McKenna		OneCare Vermont	X
Lou	McLaren	here	MVP Health Care	M
MaryKate	Mohlman	here	AHS - DVHA - Blueprint	X
Monica	Ogelby		AHS - VDH	X
Jessica	Oski		Vermont Chiropractic Association	MA
Annie	Paumgarten	here	GMCB	S
Tom	Pitts		Northern Counties Health Care	M
Luann	Poirer		AHS - DVHA	S
Rebecca	Porter		AHS - VDH	X
Amy	Putnam	here	Northwest Counseling and Support Services, Inc	M
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Lila	Richardson	here	VLA/Health Care Advocate Project	M
Greg	Robinson		OneCare Vermont	M
Howard	Schapiro		University of Vermont Medical Group Practice	M
Rachel	Seelig		VLA/Senior Citizens Law Project	MA
Julia	Shaw	here	VLA/Health Care Advocate Project	M
Tom	Simpatico		AHS - DVHA	X

Ted	Sirotta		Northwestern Medical Center	M
Shawn	Skafelstad		AHS - Central Office	X
Richard	Slusky	here	GMCB	S/M
Angela	Smith-Dieng	here	Area Agency on Aging	MA
Jeremy	Ste. Marie		Vermont Chiropractic Association	M
Beth	Tanzman		AHS - DVHA - Blueprint	X
Shannon	Thompson		AHS - DMH	M
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	X
Julie	Wasserman	here	AHS - Central Office	S
Spenser	Weppler	here	GMCB	S
Kendall	West		Bi-State	X
James	Westrich	here	AHS - DVHA	S
Bradley	Wilhelm		AHS - DVHA	S
Sharon	Winn		Bi-State Primary Care	M
Cecelia	Wu	phone	AHS - DVHA	S
Erin	Zink		MVP Health Care	X
Marie	Zura		DA - HowardCenter for Mental Health	MA
				101

Lawrence Miller - AOA - here

Attachment 3: Work Group Charters

Vermont Health Care Innovation Project
Payment Models Work Group
(Formerly ACO Standards Work Group)
Work Group Charter

EXECUTIVE SUMMARY

Garner public-private input on programs testing and implementation of three payment models. The payment models to be tested include Pay for Performance (P4P), Episodes of Care (Bundled Payments) and the Shared Savings Program Accountable Care Organization (SSP-ACO) Model.

PURPOSE/PROJECT DESCRIPTION

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

- Continue to develop and recommend standards for the commercial shared savings ACO (SSP-ACO) model
- Continue to develop and recommend standards for the Medicaid SSP-ACO model
- Develop and recommend standards for both commercial and Medicaid episode of care models
- Develop and recommend standards for additional pay-for-performance models
- Review the work of the duals demonstration work group on payment models for dual eligibles
- Recommend mechanisms for assuring consistency and coordination across all payment models
- Coordinate with other work groups, particularly the care models work group and the quality and performance work groups
- In developing standards, strive to ensure that the payment models implemented under the SIM grant enable the transformation of care delivery, improve the quality of health care delivery, improve patient experience of care, reduce the rate of growth of health care costs, and maintain the financial viability of the state's health care system
- Serve as the nexus for coordinating evaluation and next steps for all proposed state payment models
- Sub-groups will address risk adjustment, patient protections and appeals
- All actions will be advisory to the SIM Steering Committee and SIM Core Team

Scope of Work

Work Group Objectives/Success Criteria

Objectives should be SMART: Specific, Measurable, Attainable, Realistic and Time-bound. The work group must be able to track these objectives in order to determine if the project is on the path to success. Vague and unrealistic objectives make it difficult to measure progress and success. The objectives will feed into the work plan.

PROJECT JUSTIFICATION

Adapted from Section P of the SIM Operations Plan; only reflects the workgroup role and more recent updates.

This section describes Vermont's plans for completing the "model testing" proposed in our grant application – plans for implementation of payment models that are alternatives to fee-for-service and related health system innovations, including timelines for implementation and metrics for gauging progress.

The State has developed a project plan for testing and implementation of three payment models through 2016. The payment models to be tested include Pay for Performance (P4P), Episodes of Care (Bundled Payments) and the Shared Savings Program Accountable Care Organization (SSP-ACO) Model. More detailed plans and timelines are provided in attachments to the operations plan.

Episodes of Care Payment Model

There is growing evidence that the quality of care of some acute and chronic conditions can be greatly improved by developing a collaborative Episodes of Care (EOC) or "Bundled Payments" program. By providing a forum and data analytics, identifying an "accountable provider(s)" and including financial incentives, providers will have the tools to come together to transform care for certain EOCs thereby increasing quality and reducing variation in cost. After providers improve care and achieve efficiencies, payers may choose to implement a bundled payment for these episodes, which introduces downside performance risk in addition to rewarding good performance.

The SIM Payment Models Work Group will provide key input and make actionable recommendations on the details of the EOC program. Beginning in December the Work Group will provide guidance on the following key elements of the program:

- Defining Objectives of the EOC Program
- Defining the Criteria that will be used to Select Episodes
- Creating Episode Specifications
- Format for Year One of the EOC Program
- Defining Transition Plan to Bundled Payment
- Defining Process for Evaluating and Adding New EOCs

The goal of the Work Group will be to develop a consistent approach, have statewide support, and present opportunities for expansion to multiple sites. The Work Group will develop recommendations for both commercial and Medicaid EOCs. Vermont would expect that EOC initiatives would be considered throughout the 3 year SIM testing phase, and that a structured approach to considering specific EOCs will be developed by the Work Group with recommendations to the GMCB and the SIM Steering Committee for review and approval.

The Work Group will begin discussions of the EOCs in December 2013 and will recommend the implementation of at least three or more EOCs on a broad state-wide basis by Spring 2014. Year One October 1, 2014. This implementation will complement and be done in conjunction with other payment models such as an accountable care organization (ACO).

Shared Savings Accountable Care Organization Model

Vermont has proposed testing a Shared Savings ACO with commercial payers and Medicaid. Vermont providers already have organized ACOs to respond to the Medicare SSP-ACO program, and our testing will utilize those organizations that are willing, as well as any others that form and meet our programmatic guidelines, for an expansion to other payers.

The Work Group's recommendations to date and plans for further work to design and implement the Commercial and Medicaid ACOs are described below.

In addition, the Work Group has made recommendations regarding most elements of the model design, including standards for:

- ACO structure, including financial stability, primary care capacity and patient freedom of choice
- ACO payment methodology, including attribution, covered services, calculation of financial performance and risk adjustment
- ACO management, including alignment of provider payment with the ACO model and distribution of savings

The Work Group has referred two other issues – alignment of care management programs and data use standards – to other SIM work groups.

Pay-for-Performance Payment Model

A. Medicaid Pay-for-Performance Model Development and Implementation

Starting in SFY15, Medicaid plans to use the new annual funds to create a quality pool to fund the P4P programs created. The development of the Medicaid P4P models will leverage the SIM Payment Models Work Group (a reconstitution of the ACO standards work group) and Steering Committee to garner public-private input on Medicaid's P4P programs.

Medicaid plans to hire some contracting resources to assist with the development of its P4P plan in late 2013 followed by discussions of the P4P models within the Work Groups and Steering Committee to occur in the first quarter of 2014.

DELIVERABLES

Standardized set of rules for a Commercial and Medicaid ACO program, standardized rules for the episodes of care and subsequent bundled payments and standardized rules for pay-for-performance models. The areas for potential standards development are as follows:

SUMMARY MILESTONES

TBD

MEMBERSHIP REQUIREMENTS

Members of the Work Group are expected to be active, respectful participants in meetings; to consult with constituents, clients, partners and stakeholders as appropriate to gather input on specific questions and issues between meetings; and to alert SIM leadership about any actual or perceived conflicts of interests that could impede their ability to carry out their responsibilities. Selection is by invitation of self-nomination.

PARTICIPANT LIST (as of November 2013)

M	**Member**
C	**Chair**
MA	**Member Assistant**
S	**Staff/Consultants**
X	**Interested Parties**

Last Name	First Name	Title	Organization
George	Don	President and CEO	Blue Cross Blue Shield of Vermont
Rauh	Stephen		GMC Advisory Board
Austin	Carmone		MVP Health Care
Bailey	Melissa	Director of Integrated Family Services	AHS - Central Office
Barrett	Susan	Director of Vermont Public Policy	Bi-State Primary Care
Bushey	Heather	CFO	Planned Parenthood of Northern New England
Cioffi	Ron	CEO	Rutland Area Visiting Nurse Association & Hospice
Curtis	Michael	Director of Child, Youth & Family Services	Washington County Mental Health Services Inc.
DelTrecco	Mike		Vermont Association of Hospital and Health Systems
Fulton	Catherine	Executive Director	Vermont Program for Quality in Health Care
Giard	Martita		OneCare Vermont

Gobeille	Al	Chair	GMCB
Goetschius	Larry	CEO	Addison County Home Health & Hospice
Grause	Bea	President	Vermont Association of Hospital and Health Systems
Guillett	Lynn		OneCare Vermont
Harrington	Paul	President	Vermont Medical Society
Hill	Bard	Director - Policy, Planning & Data Unit	AHS - DAIL
Hogue	Nancy	Director of Pharmacy Services	AHS - DVHA
Jones	Craig	Director	AHS - DVHA
King	Sarah	CFO	Rutland Area Visiting Nurse Association & Hospice
Lange	Kelly	Director of Provider Contracting	Blue Cross Blue Shield of Vermont
Little	Bill	Vice President	MVP Health Care
Mauro	James		Blue Cross Blue Shield of Vermont
McDowell	Sandy		Vermont Information Technology Leaders
McGuire	Sandy	CFO	HowardCenter for Mental Health
Moore	Todd	CEO	OneCare Vermont
Pitts	Tom	CFO	Northern Counties Health Care
Real	Lori		Bi-State Primary Care
Reiss	Paul	Executive Director,	Accountable Care Coalition of the Green Mountains
Richardson	Lila	Staff Attorney	Vermont Legal Aid
Schapiro	Howard	Interim President	University of Vermont Medical Group Practice
Seelig	Rachel	Attorney	Vermont Legal Aid
Stout	Ray	Mental Health & Health Care Integration Liaison	AHS - DMH
Walters	Barbara	Chief Medical Director	OneCare Vermont
Zura	Marie	Director of Developmental Services	HowardCenter for Mental Health
Bassford	Anna		GMCB
Carbonneau	Gisele		HealthFirst
Fargo	Audrey	Administrative Assistant	Vermont Program for Quality in Health Care
Fischer	Cyndy		OneCare Vermont
Hall	Janie	Corporate Assistant	OneCare Vermont
Lee	McKenna		
McGrath	Alexa		Blue Cross Blue Shield of Vermont
Bailit	Michael	President	Bailit-Health Purchasing
Bazinsky	Kate	Senior Consultant	Bailit-Health Purchasing
Cooper	Alicia	Quality Oversight Analyst	SIM - AHS - DVHA
Cummings	Diane	Financial Manager II	SIM - AHS
Flynn	Erin	Health Policy Analyst	SIM - AHS - DVHA
Geiler	Christine	Grant Manager & Stakeholder Coordinator	SIM - GMCB

Lamothe	Nelson	Senior Associate	UMASS
Maheras	Georgia		SIM - AOA
Paumgerten	Annie	Evaluation Director	SIM - GMCB
Poirer	Luann	Administrative Services Manager I	SIM - AHS - DVHA
Reeves	Ann	Senior Policy Advisor	SIM - AHS - DVHA
Sales	George		UMASS
Slusky	Richard	Payment Reform Director	SIM - GMCB
Suter	Kara	Director of Payment Reform	SIM - AHS - DVHA
Wallack	Anya	Chair	SIM Core Team Chair
Weppler	Spenser	Health Care Reform Specialist	GMCB
Backus	Ena	Health Care Reform Specialist	GMCB
Berman	Abe		OneCare Vermont
Collins	Lori	Deputy Commissioner	AHS – DVHA
Donofrio	Michael	General Council	GMCB
Giffin	Jim	CFO	AHS - Central Office
Hall	Heidi	Financial Director	AHS – DMH
Hall	Thomas		
Hathaway	Carrie	Financial Director III	AHS – DVHA
Hickman	Selina	Policy Director	AHS – DVHA
Hindes	Churchill	COO	OneCare Vermont
Hogan	Con	Board Member	GMCB
Jones	Pat	Health Care Project Director	GMCB
Kelley	Kevin	CEO	CHSLV
Kerr	Trinka	Health Care Ombudsman	Vermont Legal Aid
Lovejoy	Nick	Analyst and Data Manager	AHS – DVHA
Martini	David		AOA – DFR
McCaffrey	Marybeth	Principal Health Reform Administrator	AHS – DAIL
Reynolds	David		AOA
Sirotta	Ted	CFO	Northwestern Medical Center
Tanzman	Beth	Assistant Director of Blueprint for Health	AHS – DVHA
Wasserman	Julie	VT Dual Eligible Project Director	AHS - Central Office

RESOURCES AVAILABLE FOR STAFFING AND CONSULTATION

Work Group Chairs: Stephen Rauh, Don George

Work Group Staff: Richard Slusky, Kara Suter

Consulting Support: Bailit Health Purchasing. Possibility of additional support available to the work group.

WORK GROUP PROCESSES:

1. The Work Group will regularly meet twice per month – teleconferencing utilized
2. The Work Group Co-Chairs plan and distribute the meeting agenda through project staff.
3. Related materials are to be sent to Work Group members, staff, and interested parties prior to the meeting date/time.
4. Work Group members, staff, and interested parties are encouraged to call in advance of the meeting if they have any questions related to the meeting materials that were received.
5. Minutes will be recorded at each meeting
6. The Work Group Co-Chairs will preside at the meeting.
7. Progress on the Work Group's work will be reported as the Monthly Status Report.
8. The Work Group's Status Reports and Recommendations are directed to the Steering Committee.

AUTHORIZATION

_____ Date: _____

Project Sponsor/Title

Population Health [1]Working Group Proposed Charter

The Population Health Working Group will leverage the opportunities available through the State Innovation Model project to enhance population health improvement efforts in Vermont and to achieve the health priorities in the State Health Improvement Plan. The Group will be a resource for the other SIM working groups and advise them on ways that their work can incorporate population health principles and contribute toward improving the population health of Vermonters. It will be proactive in identifying opportunities to create both the infrastructure to support improvements in population health and sustainable approaches to rewarding improvements. The Group will review products from the other working groups, participate in formative discussions with them, and develop recommendations for refinements to models, measures, and other elements that contribute to improved population health outcomes.

Recommendations will focus on the following:

- Consensus on population health measures to be used in tracking the outcomes of the Vermont Health Care Improvement Innovation Project (formerly known as SIM) and to be incorporated in the new payment models.

- How to pay for population health through modifications to proposed health reform payment mechanisms, and identification of promising new financing vehicles that promote financial investment in population health interventions.

- Identifying and disseminating current initiatives in Vermont and nationally where clinical and population health are coming together. Identifying opportunities to enhance new health delivery system models, such as the Blueprint for Health and Accountable Care Organizations (ACOs), to improve population health by better integration of clinical services, public health programs and community based services at both the practice and the community levels.

[1] **Working Definition of Population Health, Institute Of Medicine, Roundtable on Population Health Improvement**
http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx

Realizing that there is not uniform agreement on the definition of population health, the IOM Roundtable will use the following definition to guide its initial conversations.

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.

For additional details about defining population health, see the *Working Definition* here.
Kindig, D., and G. Stoddart. 2003. What is population health? *American Journal of Public Health* 93(3):380-383.

VT Health Care Innovation Project
"Disability and Long Term Services & Supports" Work Group
Charter

April 24, 2014

FINAL

EXECUTIVE SUMMARY

The Disability and Long Term Services and Supports Work Group will build on the extensive work of the Dual Eligible Demonstration Steering, Stakeholder, and Work Group Committees over the past two years. The goal of the Disability and Long Term Services and Supports Work Group (DLTSS) is to incorporate into Vermont's health care reform efforts specific strategies to achieve improved quality of care, improved beneficiary experience and reduced costs for people with disabilities, related chronic conditions and those needing long term services and supports. The VHCIP Disability and LTSS Work Group will:

- develop recommendations regarding the improvement of existing care models and the design of new care models to better address the needs of people with disabilities, related chronic conditions and those needing long term services and supports, in concert with VHCIP efforts;
- develop recommendations regarding the design of new payment models initiated through the VHCIP project to improve outcomes and reduce costs for people with disabilities, related chronic conditions and those needing long term services and supports;
- develop recommendations to integrate the service delivery systems for acute/medical care and long term services and supports;
- develop recommendations for IT infrastructure to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports;
- continue to address coordination and enhancement of services for the dually-eligible population and other Vermonters who have chronic health needs and/or disabilities through such mechanisms as the Medicaid ACO program, further design of Green Mountain Care, and other approaches.

SCOPE OF WORK

1. Recommend care model elements and strategies that improve beneficiary service and outcomes for people with disabilities, related chronic conditions and those needing long term services and supports.
2. Identify provider payment models that encourage quality and efficiency among the array of primary care, acute and long-term services and support providers who serve people with disabilities, related chronic conditions and those needing long term services and supports.

3. Identify mechanisms to incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports to achieve a more integrated and seamless delivery system.
4. Incorporate person-centered, disability-related, person-directed, and cultural competency issues into all VHCIP activities.
5. Identify Medicare/Medicaid/commercial insurance coverage and payment policy barriers that can be addressed through Vermont's health care reform efforts to improve integration of care for people with disabilities, related chronic conditions and those needing long term services and supports.
6. Identify mechanisms to minimize the incentives for cost-shifting between Medicare, Medicaid and commercial payers.
7. Incorporate representation from Commercial Insurers into the VHCIP Disability and Long Term Services and Supports Work Group.
8. Recommend incentives for ACOs to re-invest savings to address the needs of people with disabilities, related chronic conditions and those needing long term services and supports to prevent unnecessary hospitalizations, ER visits, and nursing home admissions.
9. Identify DLTSS quality and performance measures to evaluate the outcomes of people with disabilities, related chronic conditions and those needing long term services and supports. These quality and performance measures shall be consistent with the core principles articulated in State law and regulation: the Developmental Disabilities Act of 1996, Choices for Care regulations pursuant to Act 56 (2005), and the Mental Health Care Reform Act 79 (2012).
10. Identify technical and IT needs to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports.

DELIVERABLES

1. Inclusion of new members on the DLTSS Work Group, including representation from commercial payers.
2. Recommendations for model of care elements and strategies that can be integrated and aligned with other VHCIP models of care.
3. Recommendations for payment methodologies that: a) incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports; b) incentivize ACOs to re-invest savings to address the needs of people with disabilities, related chronic conditions and those needing long term services and supports to prevent unnecessary hospitalizations, ER visits, and nursing home admissions; and c) reduce the incentive to cost shift between Medicare, Medicaid and commercial payers.

4. Action plan for inclusion of identified person-centered, disability-related, person-directed, and cultural competency items in all VHCIP Work Group efforts.
5. Action plan to implement strategies addressing barriers in current Medicare, Medicaid, and commercial coverage and payment policies.
6. Action plan for inclusion of DLTSS quality and performance metrics to evaluate the outcomes of people with disabilities, related chronic conditions and those needing long term services and supports.
7. Recommendations regarding the technical and IT needs to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports.
8. Other activities as identified to assist successful implementation of payment and care models to best support people with disabilities, related chronic conditions and those needing long term services and supports.

MILESTONES (Timeline subject to change)

<u>March – August 2014</u>

- Review the core principles of the Developmental Disabilities Act of 1996, Choices for Care regulations pursuant to Act 56 (2005), and the Mental Health Care Reform Act 79 (2012) as they relate to quality and performance measures and desired outcomes.

- Complete action plan for inclusion of DLTSS quality and performance metrics to evaluate the outcomes of people with disabilities, related chronic conditions and those needing long term services and supports.

- Make recommendations for model of care elements and strategies for people with disabilities, related chronic conditions and those needing long term services and supports.

- Complete action plan for inclusion of identified person-centered, disability-related, person-directed, and cultural competency items in all VHCIP Work Group activities.

<u>September – December 2014</u>

- Make recommendations for payment methodologies that incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports; incentivize ACOs to reinvest savings to address the needs of people with disabilities, related chronic conditions and those needing long term services and supports; and reduce the incentive to cost shift between Medicare, Medicaid and commercial payers.

- Make recommendations regarding the technical and IT needs to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports.

January – April 2015

- Complete action plan to implement strategies addressing barriers in current Medicare, Medicaid, and commercial coverage and payment policies for people with disabilities, related chronic conditions and those needing long term services and supports.

- Other activities as identified to support successful preparation and implementation of payment and care models to best support people with disabilities, related chronic conditions and those needing long term services and supports.

MEMBERSHIP REQUIREMENTS

The Disability and Long Term Services and Supports Work Group will meet monthly, with possible additional sub-committee meetings. Members are expected to participate regularly in meetings and may be required to review materials in advance. Members are expected to communicate with their colleagues and constituents about the activities and progress of the Work Group and to represent their organizations and constituencies during work group meetings and activities.

RESOURCES AVAILABLE FOR STAFFING AND CONSULTATION

Work Group Chairs:

- Deborah Lisi-Baker, Disability Policy Analyst
  dlisibaker@gmail.com

- Judy Peterson, VNA of Chittenden & Grand Isle Counties
  Peterson@vnacares.org

Work Group Staff:

- Erin Flynn, Department of Vermont Health Access
  Erin.Flynn@state.vt.us

- Julie Wasserman, AHS Vermont Dual Eligible Project
  Julie.Wasserman@state.vt.us

Consultants:

- Susan Besio, Pacific Health Policy Group
  sbesio@PHPG.com

- Brendan Hogan, Bailit Health Purchasing
  bhogan@bailit-health.com

Additional resources may be available to support consultation and technical assistance to the Work Group.

WORK GROUP PROCESSES

1. The Work Group will meet monthly.
2. The Work Group Co-Chairs plan and distribute the meeting agenda through project staff.
3. Related materials are to be sent to Work Group members, staff, and interested parties prior to the meeting date/time.
4. Work Group members, staff, and interested parties are encouraged to call in advance of the meeting if they have any questions related to the meeting materials that were received.
5. Minutes will be recorded at each meeting.
6. The Work Group Co-Chairs will preside at the meetings.
7. Progress on the Work Group's work will be reported as the Monthly Status Report.
8. The Work Group's Status Reports and Recommendations are directed to the Steering Committee.

AUTHORIZATION

_____ Date: _____

Project Sponsor/Title

Vermont Health Care Innovation Project
Quality and Performance Measures Work Group Charter

DRAFT

PURPOSE

The purpose of the Quality and Performance Measures Work Group is to develop and recommend a standard set of performance measures, including metrics on quality, utilization, and cost to the VHCIP Steering Committee, the VHCIP Core Team, and the GMCB. The performance measures will allow the group to evaluate Vermont's payment reform models relative to public policy goals; to make recommendations regarding the manner in which quality performance will influence payments for payment models that are tested; and to make recommendations about how and when to communicate quality performance relating to payment reform to consumers.

SCOPE OF WORK

- Develop criteria and expectations for measure selection.
- Prioritize the use of nationally endorsed measures that can be benchmarked, to the extent possible.
- Develop consolidated and standardized sets of quality and performance measures for alternative payment and delivery system structures that are adopted for testing.
- Troubleshoot measurement collection and reporting barriers and support measurement issue resolution.
- Review performance measures on at least an annual basis and determine measures to be added, revised, retired, or replaced.
- Learn about, inform, and integrate relevant activities of other Vermont Health Care Innovation Project (VHCIP) work groups.
- Collaborate with other VHCIP work groups to achieve broader project goals.

DELIVERABLES

- Review selection criteria used to develop ACO shared savings measures and expand to episodes of care, pay-for-performance, and other payment models adopted for testing, as appropriate.
- Recommend how measurement should impact payment.

- Review and recommend for approval the "Process for Review and Modification of Measures" standard for ACO shared savings measures.
- Annually review measures for the SIM Driver Diagram, and modify or recommend measures as needed.
- Develop recommended measure sets for other payment models that are adopted for testing.
- Review and recommend measures to be added, revised, retired, or replaced as appropriate, on at least an annual basis.
- Review and recommend benchmarks to be used in conjunction with adopted measures for assessing and rewarding performance.
- Provide technical assistance to other multi-payer payment reform projects as requested and as work group resources allow.

MILESTONES

To be populated with specific tasks (and associated dates) included in the QPM WG Work Plan.

MEMBERSHIP REQUIREMENTS

The Quality and Performance Measures Work Group will meet monthly, with possible additional sub-committee meetings. Members are expected to participate regularly in meetings and may be required to review materials in advance. Members are expected to communicate with their colleagues and constituents about the activities and progress of the work group and to represent their organizations and constituencies during work group meetings and activities.

RESOURCES AVAILABLE FOR STAFFING AND CONSULTATION

Work Group Chairs:

- Catherine Fulton, Executive Director, Vermont Program For Quality in Health Care
  CatherineF@vpqhc.org
- Laura Pelosi, MacLean, Meehan & Rice
  Laura@mmrvt.org

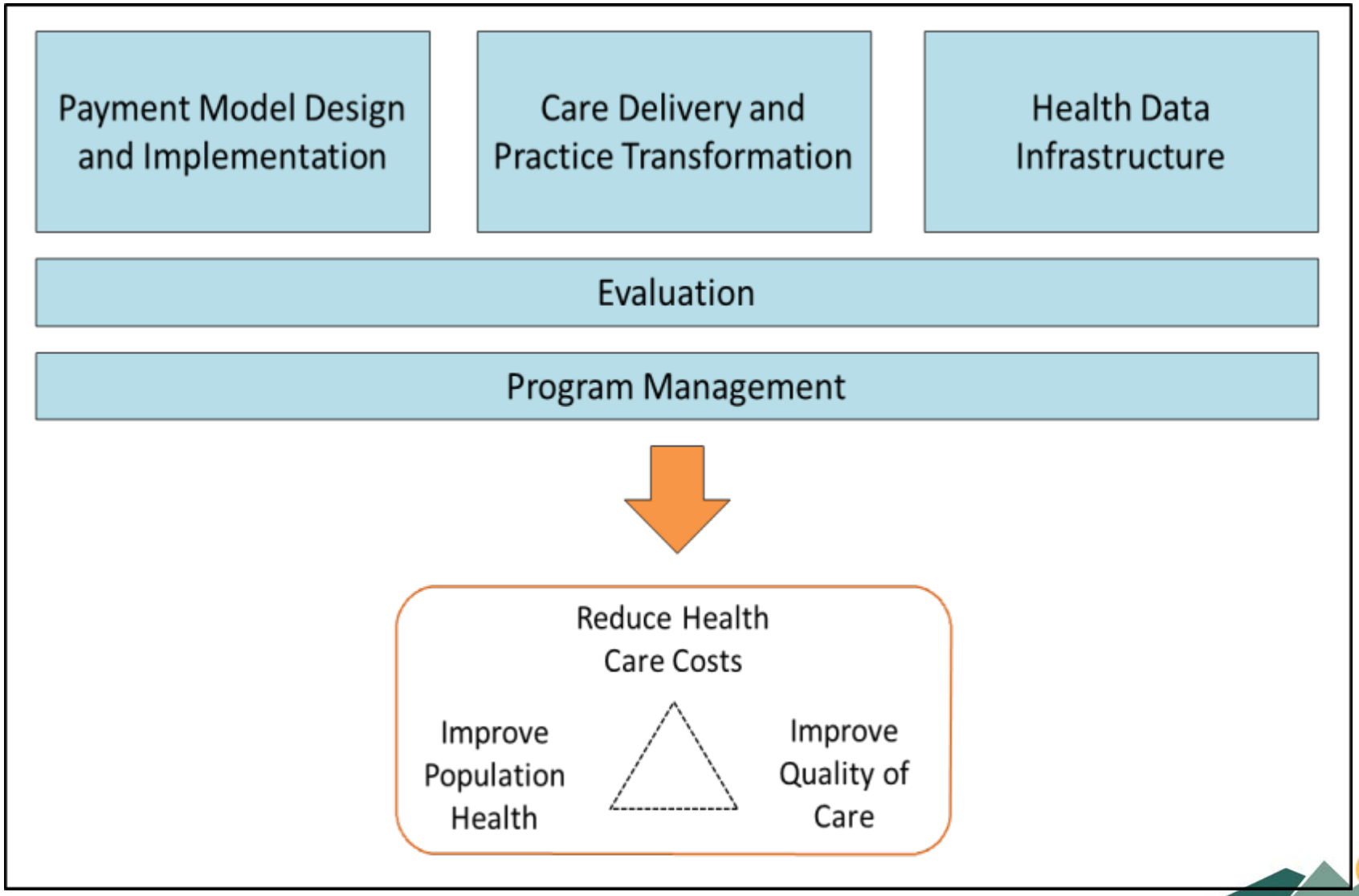
Work Group Staff:

- Pat Jones, Green Mountain Care Board
  Pat.Jones@state.vt.us
- Alicia Cooper, Department of Vermont Health Access
  Alicia.Cooper@state.vt.us

Additional resources may be available to support consultation and technical assistance to the work group.

Attachment 4: Rebasing slides

Vermont's SIM Focus Areas and Goal:



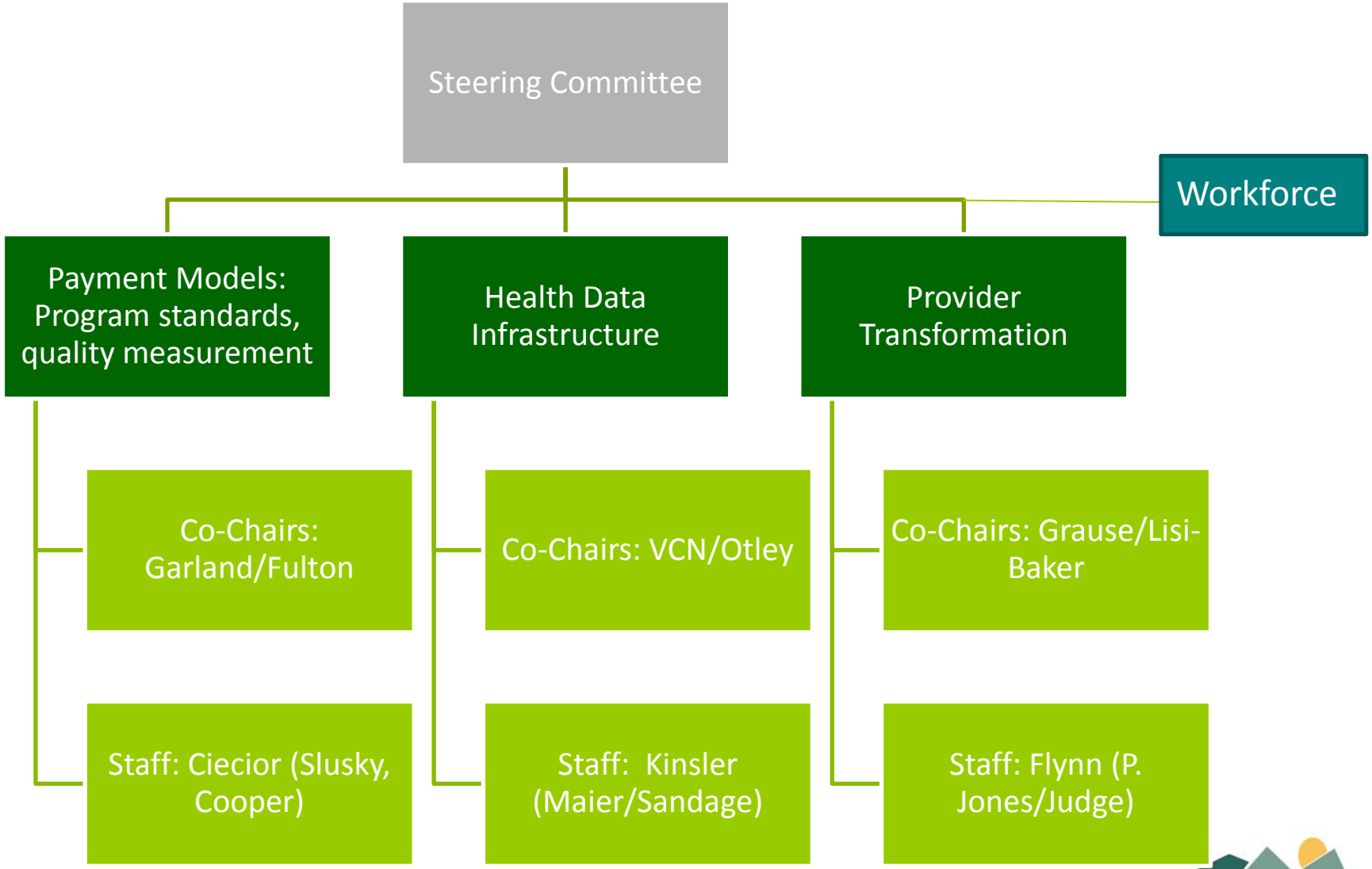
Remaining work to do:

Payment Models:

- Medicaid and commercial SSP: Year 3 implementation.
- Medicaid Episodes of Care implementation
- Feasibility/Analysis: Accountable Communities for Health and All-Payer Model.
- Home Health PPS

80% of Vermonters in alternatives to fee-for-service by 12/31/2015.

New Organization Structure:



Assumes Core Team above Steering-Committee-- removed to allow for easier depiction

Work stream leads: Payment Models

Project	SOV Lead
Shared Savings ACO Programs	Slusky/Wu
Episodes of Care	Cooper
PPS-DAs	Hickman
PPS-Home Health	Cooper
Pay-for-performance	C. Jones
Accountable Communities for Health	H. Klein

PAYMENT MODELS

Payment Model Milestones:

- 1: ACO Shared Savings Programs (SSPs);
- 2: Episodes of Care (EOCs);
- 3: Pay-for-Performance (Blueprint);
- 4: Health Home (Hub & Spoke);
- 5: Accountable Health Communities;
- 6: Prospective Payment System – Home Health;
- 7: Prospective Payment System – Designated Agencies;
- 8: All-Payer Model
- 9: State Activities to Support Model Design and Implementation – GMCB & Medicaid

1: ACO Shared Savings Programs

- Current activities to support this task:
  - Medicaid and Commercial SSPs in operation since 1/1/2014.
    - Medicare SSPs in operation since 2013.
  - Multiple contracts to support program design, operation, and evaluation
- Anticipated activities that would support this task:
  - Exploring opportunities to expand the number of attributed lives

2: Episodes of Care

- Current activities to support this task:
  - Launched multi-stakeholder EOC sub-group in 01/2015.
  - Exploring potential episodes for Vermont's Medicaid population.
  - Ongoing communication with other SIM states that have implemented episode-based payment models.

- Anticipated activities that would support this task:
  - Release RFP for vendor analytic support to implement this model in Vermont Medicaid.

3: Pay-for-Performance (Blueprint)

- Current activities to support this task:
  - Designing and implementing modifications to current Blueprint for Health program:
    - Increasing the base payments to PCMH practices.
    - Adding an incentive payment for regional performance on a composite of select quality & utilization measures.

- Anticipated activities that would support this task:
  - TBD

4: Health Home (Hub & Spoke)

- Current activities to support this task:
  - State reporting on program implementation
  - Preparation for PY 2014 quality reporting

- Anticipated activities that would support this task:
  - N/A

5: Accountable Health Communities

- Current activities to support this task:
  - Contract with the Prevention Institute to engage in national research; findings delivered in 2015.
  - Contract with Bailit Health Purchasing to research feasibility of implementing AHC pilot(s) in Vermont.

- Anticipated activities that would support this task:
  - Continued stakeholder engagement in potential communities.

6: Prospective Payment System – Home Health

- Current activities to support this task:
  - Legislation to support the design of a PPS program for Home Health was passed in 2015.

- Anticipated activities that would support this task:
  - Leverage contract support from Bailit, Burns, and PHPG to design a PPS program that complements other Vermont payment models.

7: Prospective Payment System – Designated Agencies

- Current activities to support this task:
  - Submitting a planning grant application to SAMHSA.

- Anticipated activities that would support this task:
  - This is a new grant and will have its own internal activities. VHCIP activity is alignment and collaboration with AHS departments and other stakeholders.

8: All Payer Model

- Current activities to support this task:
  - Negotiations between CMMI and Vermont (led by AOA and GMCB) are underway.
  - Contractor support from Bailit, Burns, and HMA to research feasibility and develop analytics to inform future conversations with CMMI.

- Anticipated activities that would support this task:
  - Meetings with payers and providers to develop a framework for participation in an all-payer model.
  - Consideration of a provider led governance structure that would support a state-wide integrated delivery system.
  - Expand the regulatory capacity of the GMCB.

9: State Activities to Support Model Design and Implementation (GMCB & Medicaid)

- Current activities to support this task:
  - GMCB: Identification components necessary to support APM regulatory activities.
  - Medicaid: Seeking SPA and other federal approvals for each payment model with contract support from Burns and Wakely.
  - Medicaid: Ongoing monitoring of program compliance.

- Anticipated activities that would support this task:
  - Medicaid SPA approvals for new programs and changes to existing programs

VHCIP Year 2 Milestones and Progress to Date
June 2015

CMMI-Required Milestones		
Milestone	*Specific Tasks*	*Progress Toward Milestones*
Payment Models *Year 2:* 60% of Vermonters in alternatives to fee-for-service. *Year 3:* 80% of Vermonters in alternatives to fee-for-service.		• Currently ~60% of Vermonters are in alternatives to fee-for-service.
Population Health Plan *Year 2:* Draft Plan submitted to CMMI. *Year 3:* Final Plan submitted to CMMI.		• Plan outline drafted.

Payment Model Design and Implementation		
Milestone	*Specific Tasks*	*Progress Toward Milestones*
ACO Shared Savings Programs (SSPs) *Year 2:* Expand the number of people in the Shared Savings Programs in Year 2. *Year 3:* Expand the number of people in the Shared Savings Programs in Year 3.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• Medicaid and Commercial SSPs launched on 1/1/2014. • Year 2 contract negotiations between DVHA and Medicaid SSP ACOs are in process. • Expansion of Total Cost of Care for Year 3 will be considered later in 2015. **Total Providers Impacted:** 977 **Total Vermonters Impacted:** 133,754
Episodes of Care (EOCs) *Year 2:* Design 3 EOCs for the Medicaid program with financial component. *Year 3:* Launch 3 Episodes in Year 3.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• A sub-group of the VHCIP Payment Models Work Group focused on Episodes launched in January 2015; the group has met five times. • Staff have conducted a series of one-on-one meetings with stakeholder organizations to understand opportunities and concerns related to this initiative. **Total Providers Impacted:** 0 **Total Vermonters Impacted:** 0
Pay-for-Performance (Blueprint) *Year 2:* Design modifications to this P4P program – dependent on additional appropriation in state budget. *Year 3:* TBD, based on Year 2.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• The Blueprint for Health has been engaging with its Executive Committee, DVHA and AHS leadership, and VHCIP stakeholders to discuss potential modifications to both the Community Health Team (CHT) and Patient-Centered Medical Home (PCMH) payment models. Such modifications include shifting payers' CHT payments to reflect each current market share, increasing the base payments to PCMH practices, and adding an incentive payment for regional performance on a composite of select quality measures • The legislature appropriated $2.4 million for Blueprint payments (both CHT and PCMH) in State Fiscal Year 2016. **Total Providers Impacted:** 694 **Total Vermonters Impacted:** 285,968

Health Home (Hub & Spoke) *Year 2:* Reporting on program's transition and progress. *Year 3:* Reporting on program's transition and progress.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• Program implementation and reporting are ongoing. **Total Participating Providers:** 123 **Total Vermonters Impacted:** 2706
Accountable Health Communities *Year 2:* Research and design feasibility. *Year 3:* TBD based on design/research in Year 2.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• Contractor selected to engage in national research; contract executed. Findings delivered to VHCIP in June 2015.
Prospective Payment System – Home Health *Year 2:* Design PPS program for Home Health. *Year 3:* Launch PPS on 7/1/2016.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• Legislation to support this effort passed in 2015.
Prospective Payment System – Designated Agencies *Year 2:* Submit planning grant application to SAMHSA. *Year 3:* If awarded SAMHSA planning grant, plan PPS program.	Planning grant application.	• Planning grant application being drafted with contractor support in collaboration with various AHS departments and stakeholders; application due in August 2015.
All-Payer Model *Year 2:* Research feasibility, develop analytics, and obtain information to inform decision-making for negotiations with CMMI. *Year 3:* TBD. APM launch anticipated for 2017.	Financial standards, care standards, quality measures, analyses for design and implementation, stakeholder engagement.	• Negotiations between CMMI and SOV (led by AOA and GMCB) are in process.
State Activities to Support Model Design and Implementation – GMCB *Year 2:* Obtain information and identify regulatory components necessary to support APM regulatory activities. Plan as appropriate based on negotiations. *Year 3:* TBD. APM launch anticipated for 2017.	GMCB-specific regulatory activities.	• Contractor selected to support this work.
State Activities to Support Model Design and Implementation – Medicaid *Year 2:* Pursue state plan amendments and other federal approvals as appropriate for each payment model (Year 2 SSP SPA, Year 1 EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate. *Year 3:* Pursue waivers as appropriate, ensure monitoring and compliance activities are performed.	Medicaid-specific design and implementation activities (SPAs, etc.).	• Year 1 SSP State Plan Amendment approved in June 2015. • Year 2 SSP State Plan Amendment draft to be developed in Summer 2015. • Beneficiary call-center is operational.