109 State Street
Montpelier, VT 05609
www.healthcareinnovation.vermont.gov

Vermont State Innovation Models (SIM) Quarterly Report
Year One Second Quarter Report to CMMI: January 1, 2014-March 31, 2014
April 30, 2014

1 Overview

Overview of Quarter's Project Activities

Achievements on milestones/metrics compared to projected accountability targets and achievements on aims and primary drivers

Vermont's SIM Project made significant progress in the second quarter of year one. We achieved many of our intended goals for this quarter. We launched the Medicaid and Commercial Shared Savings Accountable Care Organization Programs (see Appendix F for a summary of new articles related to this), awarded $2.6 million in sub-grants to providers throughout Vermont and made a significant investment in our Health Information Exchange infrastructure supporting payment and delivery system reforms. Vermont continues to be on track to complete our Year One milestones.

The aims of Vermont's SIM Project are to improve care, improve health and reduce costs. The primary drivers to achieve those aims are:

- Improving care delivery models by enabling and rewarding integration and coordination,
- Improving the exchange and use of health information by developing a health information system that supports improved care and measurement of value, and
- Improving payment models by aligning financial incentives with the three aims.

Notable achievements from January-March 2014 include:

- DVHA signed contracts with two ACOs for participation in the Vermont Medicaid Shared Savings Program.
- Vermont submitted a State Plan Amendment to CMS for the Vermont Medicaid Shared Savings Program.
- BCBS and MVP, the two Commercial payers in Vermont's small group and individual market, signed participation agreements with three ACOs as part of the Commercial Shared Savings Program. BCBS has agreements with each of the three ACOs and MVP has an agreement with OneCare.
- Vermont's SIM project approved a Health Information Exchange (HIE) investment that is intended to develop and implement a population-based infrastructure within Vermont's HIE capabilities, to better inform clinical decision making at the point of care, and to use clinical data for analytics and population health data management.

- Vermont released funding to eight innovators throughout Vermont as part of the sub-grant program. These eight innovators are working with dozens of other entities in Vermont on projects designed to support delivery system change throughout the health care system.
- Vermont began developing its second model for testing: Episodes of Care.
- Vermont convened three meetings each of its Payment Models, Quality and Performance Measures, Care Models and Care Management, Disability and Long Term Services and Supports, Population Health, and HIE/HIT Work Groups. The Workforce Work Group met twice. Each of these work groups made significant progress on their work plans for year one. The Steering Committee also met three times and the Core Team met five times.
- In January, the Governor's Office decided not to move forward with Vermont's Dual Eligible Demonstration but instead reconfigure the VHCIP Dual Eligible Work Group into the Disability and Long Term Services and Supports (DLTSS) Work Group. This new group will build off the extensive work of the Dual Eligible Demonstration Committees. The mission of the new DLTSS Work Group 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.

Staffing by Type and Number of FTEs:

Vermont's SIM Project includes 24 funded positions[1], of which 14.5 are filled and 9.5 are vacant. Of those, 2.25 of the positions are at the Green Mountain Care Board, 2 are at the Department of Aging and Independent Living, 3 are at the Agency of Human Services Central Office, 16.25 are at the Department of Vermont Health Access, and 1.5 is at the Agency of Administration. Below please find a list of filled and vacant positions:

Position Title	Agency	Employee Name	% dedicated to the project
Fiscal Manager: Financial Manager II	AHS	Diane Cummings	100%
Program Manager for Duals: Duals Director	AHS	Julie Wasserman	100%
Project Director	AOA	Georgia Maheras	100%
Payment Program Manager	DAIL	Jennifer Woodard	100%
Fiscal Manager:	DVHA	Robert Pierce	100%

[1] This number is different than previously reported. Vermont had not captured the positions approved as part of the Carryforward request in previous quarters.

Contract and Grant Administrator			
Payment Program Manager: Quality Oversight Analyst	DVHA	Alicia Cooper	100%
Quality Monitoring & Evaluation: Senior Policy Advisor	DVHA	Erin Flynn	100%
Payment and Policy Specialist: Health Policy Analyst	DVHA	Amy Coonradt	100%
Payment Reform Director	DVHA	Kara Suter	25%
Quality Monitoring & Evaluation: Senior Policy Advisor	DVHA	Bradley Wilhelm	100%
Service Delivery Specialist: Administrative Services Manager I	DVHA	Luann Poirier	100%
Service Delivery Specialist: Health Policy Analyst	DVHA	Amanda Ciecior	100%
Evaluation Director	GMCB	Annie Paumgarten	100%
Grant Program Manager: Grant Manager Coordinator	GMCB	Christine Geiler	100%
Payment Reform Director	GMCB	Richard Slusky	25%
Quality Monitoring & Evaluation: Business Administrator	IFS/AHS	Carolynn Hatin	100%
Workforce Work Group Manager	AOA	Recruiting at AOA	50%
Payment Program Manager	DAIL	Recruiting at DAIL	100%
Payment Initiative Director, Shared Savings	DVHA	Recruiting at DVHA	100%
Payment Initiative Director, Payment Pilots	DVHA	Recruiting at DVHA	100%

Payment Program Manager: Policy and Planning Chief	DVHA	Recruiting at DVHA	100%
Medicaid Data Analyst: Quality Oversight Analyst	DVHA	Recruiting at DVHA	100%
Medicaid Data Analyst: Health Care Statistical Information Administrator	DVHA	Recruiting at DVHA	100%
Medicaid Data Analyst: Health Care Statistical Information Administrator	DVHA	Recruiting at DVHA	100%
Medicaid Data Analyst: Health Care Statistical Information Administrator	DVHA	Recruiting at DVHA	100%
Quality Monitoring & Evaluation: Senior Policy Advisor	DVHA	Recruiting at DVHA	100%

Status of Medicaid waivers/SPAs, if applicable

The State Plan Amendment for the Vermont Medicaid Shared Savings Program was submitted to CMS on February 27th, 2014. The review process will continue during the next quarter. A kick-off call with CMS is scheduled for April 14, 2014.

2 Accomplishments

Year One Planned Activities:

Vermont's Operational Plan supplemental documents submitted on September 27, 2013 included a list of milestones and metrics. The milestones are divided into several categories: Advanced Analytics, Evaluation (External), Evaluation (Internal), Initiative Support, State Staff Training and Development, Model Testing, and Technology and Infrastructure. These are addressed below:

Advanced Analytics

1. *Procure contractor for internal Medicaid modeling*: Vermont executed a contract in the second quarter.

2. *Procure contractor for additional data analytics*: In order to support its oversight role, the Green Mountain Care Board (GMCB), in coordination with the Department of Vermont Health Access (DVHA), has issued a Request for Proposals (RFP) seeking an independent, third-party contractor to assume responsibility for statewide analytics activities related to the implementation, monitoring, reporting, and evaluation of the Vermont Health Care Innovation Project (VHCIP) Accountable Care Organization Commercial and Medicaid Shared Savings ACO pilot program. The required tasks of the Analytics Contractor include the following:
    a. Calculation of ACO Financial Performance and Calculation of the Distribution of Earned Savings Payments;
    b. Calculation of ACO Performance Measures;
    c. Calculation of the Impact of ACO Quality Performance on the Distribution of Shared Savings; and
    d. Report Design and Generation.

    The RFP is available here:
    http://gmcboard.vermont.gov/sites/gmcboard/files/Analytics_RFP_%20201401714.pdf.

    Bids from seven vendors were received and reviewed by a multi-agency review team that also included payer and ACO representatives. A vendor was selected in March 2014 and negotiations are ongoing with this vendor. The goal is for the vendor to begin work in June 2014.

3. *Define Analyses:* Vermont has designed three analyses for the Commercial and Medicaid Shared Savings ACO Programs and has several more proposed in the Analytics Contractor RFP discussed above. The analyses include attribution reports; summary statistics for attributed populations; analysis of the difference between core and non-core costs; calculation of performance measures; and calculation of shared savings.

    a. Attribution Reports: The Department of Vermont Health Access (DVHA) is currently working on developing attribution reporting tools for the Vermont Shared Savings Program. Both ACOs who have signed contracts with the State will be submitting provider rosters to DVHA by April 30th, 2014. These provider roster reports will include information on both attributing and non-attributing ACO participants, provider/suppliers, and other entities. Based on these provider rosters, DVHA will develop attribution reports which will be transmitted to both ACOs by May 31st, 2014. This report will take the form of a data file with a list of patients that are attributed to a particular ACO, with identification of PCP. The attribution reports will follow the VHCURES data submission format and will include three separate files: the enrollment file, the medical claims file, and the pharmacy claims file. Furthermore, DVHA will be adding additional Medicaid-specific variables as follows (specifications for these variables are being finalized): HCC risk score, new attribution flag, attributed in which step (specific to Medicaid attribution process), months

enrolled in Medicaid, Medicaid eligibility category, attributing provider ID, above 99th percent flag. Attribution reports will be updated on a monthly basis. The initial file will include 12 months of incurred claims for attributed enrollees. Every month thereafter the file will contain claims paid in the past month for currently attributed enrollees, and claims paid in the past 12 months for newly attributed enrollees.

b. Summary Statistics for attributed populations: DVHA is currently exploring data and designing programs to better understand the attributed populations of both ACOs. More concrete analysis will be possible once DHVA receives the finalized provider roster reports on April 30th that will drive beneficiary attribution to the VMSSP. Vermont's commercial payers are also exploring their data and designing programs related to attributed populations. DVHA and the Commercial payers are working together to ensure as much consistency as possible with these reports between programs.

c. Analysis of the difference between core and non-core services: DVHA is currently exploring data and designing programs to better understand the attributed populations of both ACOs. More concrete analysis will be possible once DHVA receives the finalized provider roster reports on April 30th that will drive beneficiary attribution to the VMSSP.

4. *Consult with Payment Models and DLTSS[2] Work Groups on definition of analyses:* Vermont consulted with the Payment Models Work Group on the Shared Savings ACO Program Analyses and on the scope of work for the Analytics Contractor RFP. The DLTSS Work Group began discussing analyses in December 2013 and will continue the discussion through the rest of Year One.

   The Disability and Long Term Services and Support (DLTSS) Work Group is exploring options for further integration of DLTSS related expenditures into the ACO Shared Savings program model. According to the Medicaid Shared Savings ACO Program (VMSSP) contracts, DVHA must notify ACOs of the non-core expenditures included in year two of the VMSSP (optional) and year three (mandatory) by October 1st, 2014. In addition to exploring additional expenditures for inclusion in the financial analysis of the VMSSP, the DLTSS work group has also made recommendations to the Quality and Performance Measures Work Group regarding the addition of DLTSS specific measures in performance year two of the VMSSP.

5. *Perform analyses, Procure contractor, Develop financial baselines and Develop trend models*: Vermont will procure several contractors to develop financial baselines and

[2] In conformance with the new work group name, this report refers to the Disability and Long Term Services and Supports (DLTSS) Work Group, rather than the Duals Work Group.

trends in Year One. The first contractor will provide financial baselines and trend models for the Medicaid and Commercial Shared Savings ACO Programs as described above. Vermont will procure other contractors as the Episode of Care and Pay-for-Performance Programs are launched in Year One.

The Department of Vermont Health Access (DVHA) is currently under contract with Burns and Associates to develop several of the initial reports related to the VMSSP including attribution reports, expenditures analysis, and financial baseline and trend modeling. DVHA will work with Burns and Associates to transfer any relevant reporting functions to the State-wide analytics contractor once a vendor has been selected and is fully functioning.

The Payment Models Work Group is leveraging an existing contract with Truven Analytics and its subcontractor Brandeis University. These consultants are currently working with Vermont's SIM staff and work group members to further explore the possible models and necessary decision points that the work group must make as they work to design an Episodes of Care (EOC) pilot in Vermont.

6. *Consult with Payment Models and Duals Work Groups on financial model design:* The Payment Models Work Group provided information on the Shared Savings ACO Program to the DLTSS Work Group during this quarter. The DLTSS Work Group will look more closely at this model in upcoming quarters.

7. *Produce quarterly and year-end reports for Commercial and Medicaid Shared Savings ACO program participants and payers*: These reports will be generated by the Analytics Contractor, who will begin work in June 2014. Vermont has established criteria for quarterly and annual reports and plans to work closely with the Analytics Contractor to ensure accurate compliance with report requirements.

Evaluation (External and Internal)[3]

1. *Procure External Evaluation Contractor:* Unfortunately, Vermont was not able to execute a contract with its selected vendor. Vermont is now negotiating with a different vendor and hopes to execute a contract in the third quarter.

2. *Develop Self-Evaluation Plan:* Due to the contracting challenges, Vermont's Self-Evaluation Plan is delayed. This should be completed within Year One.

3. *Consult with Performance Measures Work Group:* The draft Self-Evaluation Plan will be shared with each of Vermont's Work Groups in the fourth quarter. A status report on the external evaluation will be shared with the Quality and Performance Measures Work Group for input during its December 2014 meeting.

[3] Vermont is consolidating these two categories for ease of reporting.

4. *Input baseline data*: The baseline data will be identified upon contract execution.
5. *Hire Staff:* The Evaluation Director was hired in the second quarter.

Initiative Support

1. *Procure contractor for interagency coordination, Develop interagency and inter-project communications plan, and Implement the plan*: Vermont plans to release an RFP for this work in the third quarter.

State Staff Training and Development

1. *Hire Contractor and Develop Curriculum*: Vermont plans to release an RFP for this work in the third quarter of Year One.

Model Testing

1. *Develop ACO Model Standards*: Vermont continues to implement the Medicaid and Commercial Shared Savings ACO Programs. GMCB and DVHA participate in operational discussions with representatives of ACOs, payers, and providers. These programs are being carefully monitored for quality and access to ensure that these programs meet their intended purpose of benefitting Vermont consumers.

   Approved program standards relate to:

   - The ACO's structure:
     - Financial stability.
     - Risk mitigation.
     - Patient freedom of choice.
     - ACO governance.

   - The ACO's payment methodology:
     - Patient attribution methodology.
     - Calculation of ACO financial performance and distribution of shared savings payments.

   - Management of the ACO:
     - Care management.
     - Payment alignment.
     - Data use.

   The following sets of measures have been approved to evaluate the performance of Vermont's ACOs, to ensure quality of care for consumers, and to implement a measures scoring process to determine how ACO performance influences the amount of savings distributed to the ACO:

- Measures for payment; how the ACO performs on the measure impacts the amount of shared savings that the ACO receives.
- Measures for reporting; ACOs are required to report on these measures but their performance will not impact the amount of shared savings that they receive.
- Measures for monitoring and evaluation, including key utilization indicators and other statewide quality measures.
- Pending measures for future consideration.

During January-March 2014, the Quality and Performance Measures Work Group developed a process for review and modification of ACO Shared Savings Program measures. That process was reviewed and approved by the Steering Committee, Core Team and Green Mountain Care Board (see attached Process for Review and Modification of Measures). The Work Group has already begun reviewing measures for Year 2 (Calendar Year 2015) of the ACO Shared Savings Programs. Several entities, including the Population Health Work Group, the DLTSS Work Group, the Health Care Advocate at Vermont Legal Aid (representing consumers) and designated mental health agencies, have proposed Year 2 measures.

Vermont continues to address the many details and complexities involved in implementing the Commercial and Medicaid Shared Savings Programs, and will insure that these Standards and Performance Measures are being adhered to by the ACOs participating in the Shared Savings Programs. The HIE infrastructure investment is intended to support reporting of these measures by the ACOs. This will involve the work of the Analytics Contractor and the oversight role of the GMCB and DVHA. Examples of implementation guidance provided to ACOs and payers include reporting templates and timelines for ACO provider rosters, and payer lists of attributed patients and high risk patients.

2. *Execute Medicaid Shared Savings ACO Program Contracts*: Vermont Medicaid negotiated contracts with two ACOs for a performance year January 1, 2014-December 31, 2014. Vermont Medicaid Shared Savings Program contracts were signed in March 2014 with OneCare Vermont (OCV) and Community Health Accountable Care (CHAC). ACOs have distributed Participation Agreements to their network providers.

3. *Execute Commercial Shared Savings ACO Program Contracts*: ACOs and Commercial Payers have executed Commercial Shared Savings ACO Program Agreements. All three ACOs executed Program Agreements with Blue Cross Blue Shield, and one ACO (OneCare Vermont) executed a Program Agreement with MVP Health Care (the other two ACOs do not appear to have sufficient enrollment to participate with MVP). ACOs have distributed Participation Agreements to their network providers.

4. *Develop standards for bundled and episode-based payments*: The Episodes of Care model is being discussed by the Payment Models Work Group. The group is establishing criteria for evaluating possible episodes to test. At the March meeting of the Payment Models Work Group presentations were made on both the Arkansas Episodes of Care program, as well as by the Rutland Regional Hospital in Vermont who is currently participating in the Medicare Bundled Payment for Care Initiative. The Work Group will also decide on criteria they will use to evaluate the data for the purpose of identifying which episodes are of most interest to the State.

5. *Execute contracts for bundled and episode-based payments*: The Payment Models Work Group leveraged an existing state contract to support the development of Episodes of Care model. Truven Health Analytics began work in February 2014.

6. *Develop a Medicaid value-based purchasing plan addressing pay-for-performance initiatives*: A framework has been developed for a Medicaid pay-for-performance program. Work is ongoing to identify quality metrics to be used to assess performance for Medicaid providers (both primary and specialty). The Pay-for-Performance model will be finalized within the next quarter, with input from the Payment Models Work Group.

   Vermont is in process of executing a contract to evaluate Medicaid special programs against value-based criteria. The deliverable will include an evaluation of value-based design in current programs along with recommendations for strengthening those programs in the future. In addition, the Payment Models Work Group is establishing plans to develop state wide recommendations on pay-for-performance programs across all payers in the state. The State expects to execute this contract in June 2014.

7. *Procure learning collaborative and provider technical assistance contractor*: Learning collaboratives are under development for Vermont's payment models. Vermont's three ACOs are working with representatives from the state's Multi-payer Advanced Primary Care Practice demonstration project and Medicaid's Vermont Chronic Care Initiative to determine how best to collaborate and provide care management for high risk patients. This working group is exploring Institute for Healthcare Improvement (IHI) and Extension for Community Healthcare Outcomes (ECHO) learning collaborative initiatives to determine if they could provide beneficial technical assistance that could advance care management learning collaboratives in Vermont.

8. *Establish learning collaboratives for providers engaged in each of the testing models:* As noted above, Vermont's three ACOs are working with representatives from the state's Multi-payer Advanced Primary Care Practice demonstration project and Medicaid's Vermont Chronic Care Initiative to determine how best to collaborate and provide care management for high risk patients. This working group presented a conceptual outline

of a proposed learning collaborative to the Care Models and Care Management Work Group at its March meeting. The group also has reviewed data (statewide, and from three particular geographic areas) to identify high risk conditions and/or populations. Participants have shown initial interest in working on behalf of patients experiencing chronic pain, depression, and/or coronary artery disease (including cerebral vascular disease). During the next quarter, VHCIP staff, the working group and the Care Models and Care Management Work Group will further refine the proposed learning collaborative. It will most likely consist of a combination of in-person and webinar or other technology-assisted meetings to obtain expert input on best practices and evidence, refine interventions, develop measures of success and share results of interventions. The goal is to initiate this Shared Savings Program learning collaborative by July of 2014.

A proposed learning collaborative that would convene clusters of providers (e.g., hospital, home health, primary care, specialty care) to share data, identify best practices, and identify improvement opportunities for episodes of care will be presented to the Care Models and Care Management and Payment Models Work Groups by September 2014. That collaborative will be geared toward the episodes of care model. The goal is to hold the first meeting of the episodes of care payment model learning collaborative by December 2014.

In addition to these two learning collaboratives, the Care Models and Care Management Work Group will provide guidance to the Core Team to inform decision-making in the next round of the sub-grant program.

9. *Develop technical assistance program for providers implementing payment reforms*: Vermont launched the technical assistance program as a component of the VHCIP Sub-Grant Program. The Sub-Grant Program was submitted to CMMI in December 2013 with the technical assistance program a key feature. Vermont selected five technical assistance vendors to perform this work and is contract negotiations with each of them. Vermont expects these contractors to begin work in the third quarter. The technical assistance contractors will work with the State and the eight sub-grant program awardees to define projects that maximize the success of the sub-grantee projects.

10. *Number of providers participating in one or more testing models (goal = 2000):* We will update this in the next report after the Commercial and Medicaid Shared Savings ACO Programs are launched and participating provider agreements are executed. Provider participation agreements are due to the payers at the end of April 2014.

11. *Number of Blueprint practice providers participating in one or more testing models (goal = 500):* Through March of 2014, 627 unique providers in 126 PCMHs are electronically sharing care summaries with other providers, in the form of ambulatory CCDs directed

to the Blueprint Repository where they can be accessed. 126 Practices are participating. These practices and providers cover 511,557 people representing 82% of Vermont's population.

Technology and Infrastructure

1. *Provide input to update of state HIT plan*: A revised project plan has recently been approved for the development of a new Vermont Health Information Strategic Plan, which will include an updated State HIT Plan. The project is kicking off in January 2014 and initial input from the SIM HIE Work Group should occur in the first three quarters of 2014. Vermont is recognizing the primacy of information in the health care reform equation and will be calling its next plan the Vermont Health Information Strategic Plan (VHISP). There will still be an HIT plan, but the HIT planning component is a subset of the VHISP, as information derives from data, and data is generated and transported through the components of HIT and HIE. The HIE/HIT Work Group will have an active role in reviewing the HIT Plan. The current goal is to draft the phase 2 work of updating HIT, HIE, and privacy and security by June 30, 2014. The current goal is to also have a draft of the entire plan by December 31, 2014.

2. *Expand provider connection to HIE infrastructure:* Significant progress occurred in 2014 with provider connection to the HIE infrastructure. 65% of hospitals have live interfaces for: ADT (admission/discharge/transfer); laboratory results; radiology reports; transcribed reports; medication history; and pathology reports. 67% of physician practices have interfaces to the HIE for: ADT (admission/discharge/transfer); laboratory results; radiology reports; transcribed reports; medication history; and pathology reports as well. This represents 147 practices. For Home Health Agencies: 5 HIE agreements waere executed and progress was made on 5 others. For Mental Health Designated Agencies: 10 VHIE agreements were executed. For this reporting period, there were 110 new non-hospital health care organization interfaces.
   The HIT/HIE Work Group will be discussing this as part of the work in 2014. We anticipate significant collaboration between and among providers on this issue.

3. *Identify necessary enhancements to centralized clinical registry & reporting systems*: Vermont's SIM Project is currently reviewing options for how best to continue to provide registry and reporting analytic services.

4. *Procure contractor to develop initial use cases for the integrated platform and reporting system*: Vermont's SIM Project is currently working on use case identification and development and should complete the scope of this project for this project by the end of Year One.

5. *Design the technical use cases and determine the component of the integrated platform that is required to implement these use cases*: Vermont's SIM Project is currently

working on use case identification and development and should complete the scope of this project for this project by the end of Year One.

6. *Develop criteria for telemedicine sub-grants*: Vermont's SIM Project has not yet developed these criteria. The HIT/HIE Work Group will develop these criteria in early summer 2014.

7. *Expand the scope of VHCURES to support the integration of both claims and clinical data and provide this capability to ACOs/providers and potentially payers*: The GMCB is releasing an RFP in June 2014 for a new VHCURES warehousing contract. No providers have requested VHCURES data in the second quarter.

8. *Begin to incorporate long term care, mental health, home care and specialist providers into the HIE infrastructure*: The State of Vermont has a contract with VITL, the state's HIE contractor, to begin to incorporate these providers into the HIE infrastructure. Some SIM funds are being used for this purpose in Year One. VITL developed two interfaces with long term care providers and 21 interfaces with specialist providers into the HIE structure. Work is underway with home health and designated agencies.

   The HIT/HIE Work Group will also make recommendations regarding incorporating these providers. VITL has begun work with a few of the designated agencies around security compliance and meaningful use. VITL is also piloting lab information exchange at one of the designated agencies. The HIT/HIE Work Group has worked extremely hard vetting proposals that will further the incorporation of the long term care, mental health, home care and specialist providers into the HIT infrastructure. They have recommended two proposals for funding.

Table 1: January-March 2014 Aims and Drivers Accomplishments

Aims and primary drivers	**Secondary drivers**	**Accomplishments during January-March 2014 and current status of SIM aims and primary drivers**
VT Aims=Improve Care, Improve Health, and Reduce Costs Primary Driver #1: Improve care delivery models: enable and reward integration and coordination	Support the development of provider networks that coordinate preventive and acute health services across all sectors	Final negotiations for Medicaid and Commercial Shared Savings Program ACO/payer contracts and program agreements have been completed; the relevant commercial agreements were executed with Vermont's three ACOs by March 20, 2014, retroactive to January 1, 2014. The Medicaid contracts were executed with the two participating ACOs in March. Participation agreements between providers and the ACOs were finalized by March 31, 2014; ACOs will

		submit provider rosters that reflect their networks to the payers by April 30, 2014.
	Develop workforce planning that supports the needs of community networks	The Workforce Work Group began developing these plans at its November meeting. The work group commissioned additional data analyses to support their planning. This work group also established a subcommittee to look at the long term care workforce.
	Coordinate care process redesign and care management programs to maximize best practices and reduce duplication of effort or expense	The Care Models and Care Management Work Group continues to conduct an inventory of existing care management activities (including successes, gaps, and duplication), through a combination of narrative written submissions, verbal presentations at in-person meetings and webinars, and structured data collection. In addition to analyzing the supply of care management activities, the work group is evaluating the demand for care management activities by reviewing information from the Vermont Department of Health, the Population Health Work Group, and other stakeholders. We have developed ideas for learning collaboratives, and care models that pertain to care management. The work group will be reviewing these proposals during the remainder of 2014.
	Expand the use of telemedicine to support appropriate resource use and access to care	The HIE/HIT Work Group has been fielding inquiries and obtaining input from interested parties in anticipation of developing Telemedicine, Telehealth and Telemonitoring funding criteria in the third quarter.
VT Aims=Improve Care, Improve Health, and Reduce Costs Primary Driver #2: Improve exchange and use of health information: develop a health information system that supports improved care and measurement of value	Guide expansion of electronic health records to providers of long-term services and supports	The SIM grant is accelerating the expansion of EHRs; this expansion will be ongoing and continuous over the period of the grant. The HIE/HIT Work Group discussed a request entitled "The Advancing Care Through Technology Project", which will enable designated mental health and specialized service agencies and long term service and support providers to achieve population health goals through the use of technology. This proposal will be reviewed by the Steering Committee and

		Core Team in April 2014.
	Invest in enhancements to EHRs and other technology that supports integration of services and enhanced communication	The SIM grant is accelerating enhancement of EHRs and other technology to support integration of services and enhanced communication. This work will be ongoing and continuous over the period of the grant. 1. VITL is working with a variety of provider organizations (e.g., hospitals, practices, home health agencies, designated mental health agencies) to improve EHR functionality, integration of services, and communication. 2. SIM funding was approved for the Population-Based Collaborative HIE Project, to develop and implement a population-based infrastructure to better inform clinical decision making at the point of care, and to use clinical data for analytics and population health data management. This intends to build a common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients among organizations providing care.
	Enhance connectivity and data transmission from source systems including EHRs	The SIM grant is accelerating enhancement of connectivity and data transmission. This work will be ongoing and continuous over the period of the grant. 1. Vermont's Blueprint for Health, VITL, the DocSite clinical registry contractor, EHR vendors, and practice staff have been working together to enhance practice connectivity to the clinical registry and/or Vermont's HIE. 2. The same group has been working to improve the quality of data being transmitted to the clinical registry and Vermont's HIE. 3. VITL continues to work with the state's hospitals, practices and other providers to enhance connectivity and improve data transmission.
	Enhance data repository and	Vermont's goal is to create data

	data integration platform	repositories that can be accessed by multiple users for various purposes. The SIM grant is helping to accelerate this effort. 1. One example involves Patient Experience Surveys. During the last quarter of 2013, a scope of work was developed and an RFP was issued to procure a vendor to field the Patient Centered Medical Home Patient Experience Surveys to primary care practices engaged in the Blueprint for Health. These surveys will also be used to evaluate patient experience with ACOs, by flagging ACO-attributed members, and the data could potentially be made available for other users and purposes. A vendor has been selected and negotiations are underway. The intent is to field the survey during the summer of 2014. 2. Additional uses and access are envisioned for Vermont's multi-payer claims database (VHCURES). Data in VHCURES is currently de-identified. The state plans to issue an RFP during the next quarter that will result in the creation of a "lockbox" for identified claims data (and eventually other types of data); it would allow data from different sources to be merged on a person-level basis. Identified data would never be released from the lockbox, but it could be flagged for various analytic purposes in the lockbox and then released in a de-identified manner to be analyzed. It is expected to be released in by June of 2014. 3. Procurement is also underway for a clinical registry contractor. The clinical registry can provide actionable clinical data for providers and to the VHIE. The HIE Work Group is currently working on use case development to inform the scope of work for this project. They anticipate completing

		the scope of work and posting an RFP by August 2014.
	Develop advanced analytics and reporting system; enhance a statewide learning health system that provides reporting and analytics to support provider networks	Improvements in Vermont's HIE infrastructure will support the development of a learning health system in which advanced analytics, actionable reporting and provider/patient experiences are made available to providers and used to continuously improve quality. Aligning reporting between initiatives will help providers focus in key metrics. In addition to previous efforts to align metrics, the Population Health and DLTSS Work Groups requested presentations on the Shared Savings Program Measures, and are currently recommending additional measures for consideration. Furthermore, the evaluation activities supported by SIM may provide an opportunity to assess and improve alignment of metrics.
VT Aims=Improve Care, Improve Health, and Reduce Costs Primary Driver #3: Improve payment models: align financial incentives with the three aims	Implement all-payer value-based payment models that reward provider performance relative to the project aims	Accomplishments in implementing all-payer value-based payment models from January-March 2014 included: 1. Program agreements and contracts were executed between the payers and the ACOs, and implementation will be retroactive to January 1, 2014. Subsequently, the focus has been on ensuring implementation by ACOs and payers in accordance with program standards and performance measures. 2. Continued work on the Episodes of Care/Bundled Payments model by the Payment Models Work Group, including a presentation by providers from Rutland, Vermont who have experience implementing the Medicare Congestive Heart Failure Bundled Payment Initiative, Arkansas' episode of care models, and discussion of potential episodes of care in Vermont based on data analysis. 3. Vermont continued to build on the Blueprint for Health MAPCP demo, which includes a pay-for-performance

		model for participating primary care practices, shared capacity payments for Community Health Teams to provide multi-disciplinary services for patients with complex health and social needs, and bundled payments for the Hub and Spoke health home component to provide ambulatory medication assisted treatment and mental health care for people with opioid dependence.
	Support investments in primary care and prevention	1. The Blueprint for Health continues to provide multi-payer financial investment and multi-disciplinary support for primary care providers, as well as support for prevention. 2. The shared savings, HIE and care management infrastructure being developed collaboratively by ACOs, VITL, payers and other providers will support all providers, including primary care providers and will support good preventive care. 3. Vermont's sub-grant awards included several that will enable innovation within primary care across the State. 4. The Population Health Work Group has identified the following priorities that will impact primary care and prevention: • Obtaining consensus on population health measures to be used in tracking SIM outcomes and incorporated in the new payment models. In March of 2014, the Work Group provided recommendations to the Quality and Performance Measures Work Group on Year 2 population health measures for the Commercial and Medicaid Shared Savings Programs. • Determining how to pay for population health through modifications to proposed health reform payment mechanisms, and through identification of

		promising new financing vehicles that promote financial investment in population health interventions. • Identifying and disseminating current initiatives in Vermont and nationally that integrate clinical and population health. Identifying opportunities to enhance new health delivery system models (e.g., Blueprint for Health and ACOs) to improve population health through better integration of clinical services, public health programs and community based services at both the practice and the community levels.

3 Planned Activities Over the Next Quarter and Likelihood of Achievement

3.1 Planned Activities and likelihood of achieving next quarter's goals/objectives

Table 2: Planned Activities

Planned Year One Activities	Vermont's Year One Metrics	Planned Activities
Advanced analytics		
Procure contractor for internal Medicaid modeling	Contract for Medicaid modeling	Finalize Contract. **Completed** Contract executed on March 24th, 2014.
Procure contractor for additional data analytics	Contract for data analytics	Bids were due February 14th and the vendor was selected in March 2014. Vermont expects to finalize negotiations with the successful vendor in April 2014 and begin work in June 2014. **Likelihood of success is good.**
Define analyses	Number of analyses designed (goal = 5)	Vermont has designed three analyses for the Commercial and Medicaid ACO Shared Savings Programs and has several more proposed in the Analytics Contractor RFP discussed above. Analyses include: attribution reports; summary statistics for

		attributed populations; calculation of performance measures; calculation of shared savings; and analysis of the difference between core and non-core costs. Draft models of reports have been developed, and the VMSSP and Commercial SSP staff are working together to align analyses for both programs. After ACOs submit their provider roster reports on April 30th, VMSSP and Commercial SSP staff and consultants will be able to produce initial attribution reports which will be the foundation for all other analyses. **Likelihood of success in next three months is good.**
Consult with payment models and duals WGs on definition of analyses	Number of analyses performed (goal = 5)	Continued discussions in the first six months of 2014 to define analyses. **Likelihood of success in next three months is good.**
Perform analyses; Procure contractor for financial baseline and trend modeling; and Develop model.	Contract for financial baseline and trend modeling	Vermont will procure several contractors to develop financial baselines and trends in Year One. The first contractor will provide financial baselines and trend models for the Medicaid and Commercial Shared Savings ACO Programs as described above. Vermont will procure other contractors as the Episode of Care and Pay-for-Performance Programs are launched in Year One. **Likelihood of success is good.**
Consult with payment models and duals WGs on financial model design	Number of meetings held with payment models and duals WGs on the above designs (goal = 2)	Continued discussions with these two work groups in 2014. **Likelihood of success in the next nine months is good.**
Produce quarterly and year-end reports for ACO program participants and payers		These reports will be generated by the Analytics Contractor was selected in March (contract negotiations are underway). Vermont has established criteria for quarterly and annual reports and plans to work closely with the Analytics Contractor to ensure

		accurate compliance with report requirements. **Likelihood of success in next nine months is good.**
Evaluation (external and external)		
Procure contractor	Contract for external evaluation	Vermont has experienced contracting challenges. We expect to execute Contract in June 2014. Vermont will be using this contractor for several components of its self-evaluation plan. **Likelihood of success is good.**
Develop evaluation plan	Evaluation plan developed	The contractor will work in close collaboration with the VHCIP Evaluation Director and present a design plan for the self-evaluation; the goal date for this activity is August 014. **Likelihood of success in next six months is good.**
Consult with performance measures work group	Number of meetings held with performance measures WG on evaluation (goal = 2)	The draft self-evaluation plan will be shared with all of the project's work groups in July and August 2014. A status report on the self-evaluation will be shared with the Quality and Performance Measures Work Group for input during its December 2014 meeting. **Likelihood of success is good.**
Input baseline data	Baseline data identified	This will be developed with the Contractor upon contract execution in mid-2014. **Likelihood of success in next six months is good.**
Hire staff	Hire Staff	**Completed.**
Initiative Support		
Procure contractor	Contract for interagency coordination	Vermont plans to release an RFP for this work in the third quarter of Year One. **Likelihood of success in next three months is good.**
Develop interagency and inter-project communications plan	Interagency and inter-project communications plan developed	The plan will be developed once the contractor is selected. **Likelihood of success in next three months is good**.
Implement plan	Results of survey of project participants re: communications	The plan will be implemented once the contractor is selected. **Likelihood of success in next six months is good.**

State staff training and development		
Hire contractor	Contract for staff training and development	Vermont plans to release an RFP for this work in the third quarter of Year One. **Likelihood of success in next six months is good.**
Develop curriculum	Training and development curriculum developed	The curriculum will be developed once the contractor is selected. **Likelihood of success in next six months is good.**
Model Testing		
Develop ACO model standards	Approved ACO model standards	Vermont moved into the implementation phase of the programs on January 1, 2014. Vermont will also ensure that the ACO Standards and Performance Measures are being adhered to by the ACOs participating in the Commercial and Medicaid Shared Savings Programs. This will involve the work of the Analytics Contractor and the oversight role of the GMCB and DVHA. **Likelihood of success is good.**
Execute Medicaid ACO contracts	Number of Medicaid ACO contracts executed (goal = 2)	Two ACOs signed contracts with the Department of Vermont Health Access for participation in the VMSSP in Q1. The ACO Community Health Accountable Care (CHAC) executed a contract on March 14, 2014; and OneCare Vermont (OCVT) executed a contract on March 6th, 2014. **Completed.**
Execute commercial ACO contracts	Number of commercial ACO contracts executed (goal = 2)	Commercial Program Agreements were executed in March 2014. **Completed.**
Develop standards for bundled and episode-based payments	Approved standards for bundled and episode-based payments	The Episodes of Care model is being discussed by the Payment Models Work Group. The group is establishing criteria for evaluating possible episodes to test. **Likelihood of success in next six months is good.**
Execute contracts for bundled and episode-based payments		The Payment Models Work Group is expected to secure a contract for analytic support in development of

		Episodes of Care model and standards by the end of February 2014. **Likelihood of success for this contract is good.**
Develop Medicaid value-based purchasing plan addressing pay-for-performance initiatives	Medicaid value-based purchasing plan developed	The Pay-for-Performance model will be finalized within the next quarter, with input from the Payment Models Work Group. **Likelihood of success in next six months is good.**
Procure learning collaborative and provider technical assistance contractor	Contract for learning collaborative and provider technical assistance	Vermont is determining whether technical assistance from IHI, ECHO or a contractor procured through an RFP process would be helpful in designing and implementing learning collaboratives. **Likelihood of success is good.**
Establish learning collaboratives for providers engaged in each of the testing models	Number of learning collaboratives for providers conducted (goal = 3 day long meetings)	The first meeting of the shared savings program learning collaborative will be held by June 2014. A draft learning collaborative to convene clusters of providers (e.g., hospital, home health, primary care, specialty care) to share data, identify best practices, and identify improvement opportunities for episodes of care will be presented to the Care Models and Care Management and Payment Models Work Groups by September 2014. The collaborative will be geared toward the bundled payments model. The first in-person meeting of the episodes of care model learning collaborative will be held by December 2014. **Likelihood of success in next six months is good.**
Develop technical assistance program for providers implementing payment reforms	Number of providers served by technical assistance program (goal = 20)	Technical Assistance is part of Vermont's Sub-Grant Program. The Sub-Grant Program released its first round of awards and awarded technical assistance to these awardees. Technical Assistance will be provided to eight awardees and dozens of providers. **Completed.**
Number of providers participating in one or more testing models	goal = 2000	Vermont will update this in the next report after the Commercial and Medicaid ACO Shared Savings Programs are launched and

		participating provider agreements (due in April 2014) are executed. **Likelihood of success is good.**
Number of Blueprint practice providers participating in one or more testing models	goal = 500	Through March of 2014, 627 unique providers in 126 PCMHs are electronically sharing care summaries with other providers, in the form of ambulatory CCDs directed to the Blueprint Repository where they can be accessed. 126 Practices are participating. These practices and providers cover 511,557 people representing 82% of Vermont's population. **Goal achieved.**
Technology and Infrastructure		
Provide input to update of state HIT plan	Updated state HIT plan	The goal is to draft the phase 2 work of updating HIT, HIE, and privacy and security by June 30, 2014. The current goal is to also have a draft of the entire plan by December 31, 2014. **Likelihood of success is good.**
Expand provider connection to HIE infrastructure	Number of new interfaces built between provider organizations and HIE (goal = 18 additional hospital interfaces and 75 new interfaces to non-hospital healthcare organizations to include: at least 10 specialist practices; 4 home health agencies; and 4 designated mental health agencies)	VITL will continue to work with providers to build on the interfaces established in 2013. The HIT/HIE Work Group will be discussing this as part of the work in 2014. We anticipate significant collaboration between and among providers on this issue. **Likelihood of success in the next six months is good.**
Identify necessary enhancements to centralized clinical registry & reporting systems	Completed needs assessment for enhancements to centralized clinical registry and reporting systems	Vermont's SIM Project is currently reviewing options for how best to continue to provide registry and reporting analytic services. **Likelihood of success in the next six months is good.**
Procure contractor to develop initial use cases for the integrated platform and reporting system	Contractor hired	Vermont's SIM Project is currently working on use case identification and development and should complete the scope of this project for this project by August 2014. **Likelihood of success is**

		good.
Design the technical use cases and determine the components of the integrated platform that are required to implement these use cases	Contract for the development of 6 primary use cases for the integrated platform and reporting system	Vermont's SIM Project is currently working on use case identification and development and should complete the scope of this project for this project by August 2014. **Likelihood of success is good.**
Develop criteria for telemedicine sub-grants	Number of telemedicine initiatives funded (goal = 1)	The HIT/HIE Work Group will develop these criteria in early Summer 2014. **Likelihood of success in the next six months is good.**
Expand the scope of VHCURES to support the integration of both claims and clinical data and provide this capability to ACOs/providers and potentially payers	Number of providers approved for use of VHCURES data	The GMCB is releasing an RFP in 2014 for a new VHCURES warehousing contract that will expand the scope. **Likelihood of success in the next nine months is good.**
Begin to incorporate long term care, mental health, home care and specialist providers into the HIE infrastructure	Provide regional extension center (REC) like services to non-EHR providers to include long term care, mental health, home health and specialists and begin development of interfaces to the VHIE for these provider groups that currently have EHRs with the goal over three years of achieving 50 new interfaces.	The State of Vermont has a contract with VITL, the state's HIE contractor, to begin to incorporate these providers into the HIE infrastructure. Some SIM funds are being used for this purpose in Year One. The HIT/HIE Work Group will also make recommendations regarding incorporating these providers. **Likelihood of success is good.**

3.2 Projected quarterly accountability targets

This information is provided in Table 2 above.

Table 3: Aims and Drivers Projections for April-June 2014

Aims and primary drivers	Secondary drivers	Projections for April-June 2014 and beyond
VT Aims=Improve Care, Improve Health, and Reduce Costs	Support the development of provider networks that coordinate preventive and acute health services across all sectors	Now that contracts and program agreements have been executed, implementation of the Medicaid and Commercial ACO Shared Savings

Primary Driver #1: Improve care delivery models: enable and reward integration and coordination		Programs will continue throughout 2014.
	Develop workforce planning that supports the needs of community networks	Vermont's SIM Workforce Work Group began developing these at its November 2013 meeting. The Workforce Work Group will continue this work throughout 2014 and anticipates both an update to the Workforce Strategic Plan and a Fall Symposium on the topic of workforce planning within a reformed system.
	Coordinate care process redesign and care management programs to maximize best practices and reduce duplication of effort or expense	1. The state's three ACOs, the Blueprint for Health (VT's MAPCP demo), and Medicaid's Vermont Chronic Care Initiative are developing a joint proposal for coordinating care management activities that can be tested and supported by a Learning Collaborative; it will be further refined and presented to the CMCM Work Group by June 2014. 2. The CMCM Work Group will identify additional models for implementation and testing by September 2014.
	Expand the use of telemedicine to support appropriate resource use and access to care	Grant program criteria will be developed during the first and second quarter and will be reviewed and finalized by the HIE Work Group in the third quarter.
VT Aims=Improve Care, Improve Health, and Reduce Costs Primary Driver #2: Improve exchange and use of health information: develop a health information system that supports improved care and measurement of value	Guide expansion of electronic health records to providers of long-term services and supports	1. For Home Health Agencies, 3 VHIE agreements, 5 DSA agreements and 1 SRA agreement will be executed by June 2014. Interfaces for one home health agency will be established by June 2014. VITL executed 5 VHIE agreements with Home Health Agencies and 10 with DSA's. 2. For Mental Health Designated Agencies, 6 VHIE agreements, 2 DSA agreements, and 1 SRA agreement will be executed by June 2014. At least one Designated Agency will be identified for interface development by April 2014. VITL

		built two interfaces with long term care entities and 21 interfaces with Specialist organizations. VITL is working with home health and Designated Agencies on interfaces.
	Invest in enhancements to EHRs and other technology that support integration of services and enhanced communication	The HIE/HIT Work Group, SIM Core Team and GMCB will monitor implementation of the Population-Based Collaborative HIE Initiative. The Advancing Care Through Technology Proposal will also be reviewed at the Steering Committee and Core Team.
	Enhance connectivity and data transmission from source systems including EHRs	Vermont will continue the efforts by the Blueprint for Health, VITL, the DocSite clinical registry contractor, EHR vendors, and practice staff to enhance practice connectivity to the clinical registry and/or Vermont's HIE, and to improve the quality of data being transmitted to the clinical registry and/or Vermont's HIE. VITL will continue to work with the state's hospitals, practices and other providers to enhance connectivity and improve data transmission.
	Enhance data repository and data integration platform	1. A contract will be executed with the vendor selected to field the Patient Centered Medical Home Patient Experience Surveys to patients in primary care practices engaged in the Blueprint for Health and patients attributed to ACOs. A timeline for fielding the survey in the July-September quarter will be developed. 2. The state will issue an RFP that will result in the creation of a "lockbox" for identified claims data (and eventually other types of data); and allow data from different sources to be merged on a person-level basis. 3. The HIE/HIT Work Group will provide input on a scope of work for an RFP for the clinical registry and DVHA will post the RFP by

		August 2014.
	Develop advanced analytics and reporting systems; enhance a statewide learning health system that provides reporting and analytics to support provider networks	This work will be performed within the HIE/HIT Work Group as part of the State's HIT Plan development.
VT Aims=Improve Care, Improve Health, and Reduce Costs Primary Driver #3: Improve payment models: align financial incentives with the three aims	Implement all-payer value-based payment models that reward provider performance relative to the project aims	1. Implementation of Medicaid and Commercial Shared Savings Programs between payers and ACOs will continue in the April-June quarter of 2014. 2. The Episodes of Care/Bundled Payment model for testing will continue to be developed with the Payment Models Work Group during 2014.
	Support investments in primary care and prevention	1. The Population Health Work Group will provide input into the Quality and Performance Measures Work Group on suggested measures that support prevention and population health measurement during April and May 2014.

4 Substantive Findings

4.1 Substantive Findings

1. The "reform fatigue" among stakeholders that was noted in the last quarterly report is still a factor. A reasonably-paced approach to investigating and assessing additional payment models appears to be providing the necessary structure to establish forward momentum. As noted previously, maintaining momentum for the development of additional payment models will require everyone to focus on successes to date and the ways in which a variety of payment models can complement one another (rather than on how their co-existence could complicate the state's health care system).

2. Potential delivery system reforms, such as those envisioned by the Care Models and Care Management Work Group, could improve coordination, address gaps in service, and reduce duplication. However, these reforms appear to be of concern to stakeholders already engaged in care management activities. As a result, progress in this area has been slower than anticipated. Vermont is focusing on how current care management programs can be enhanced through delivery system reform and describing how current and proposed programs can be complementary rather than competitive to facilitate progress in this area. Vermont is using subgroups within the Care Models and Care Management Work Group to develop and propose concrete reforms and innovations.

3. When Vermont elected not to pursue a Memorandum of Understanding for a Duals Demonstration, the VHCIP Duals Work Group was recast as the VHCIP Disability and Long Term Services & Supports (DLTSS) Work Group. With this change in focus, the group has the opportunity to ensure that individuals in Vermont who are receiving DLTSS—many of whom are not dually eligible—are being adequately included, cared for, and measured in the payment reform models being tested.

4. Vermont's sub-grant program to foster innovation at the provider level received much more attention than initially expected. The applications submitted to the program demonstrate a high-level of provider engagement in the SIM project as well as a desire to innovate throughout the state. Vermont's SIM staff dedicated significant resources to build this program and will expand these resources as part of the implementation of these sub-awards.

4.2 Lessons Learned

Even with broad stakeholder involvement in programmatic design for the ACO SSP, securing buy-in from all stakeholders has been a continual challenge. This is particularly true of the Medicaid program. Reasons include:

- Payments that are traditionally lower than the market;
- Historic feelings of mistrust;
- Fear of state and federal funding cuts; and
- Patient populations considered difficult to manage

Implementation of complex payment models is a time-consuming and resource-intensive endeavor for all stakeholders. Adequate resources (including time, financial resources and staffing resources) need to be allocated to successfully operationalize payment models.

The Quality and Performance Work Group: It was noted in the last quarterly report that significant work remains before payers and providers will be able to measure value effectively and without undue administrative burden. The need for focused resources on improving the quality and ease of measurement of clinical data is paramount to these efforts. That is why Vermont has made such significant investments into the health information system infrastructure. It is also important to assess provider capacity to report measures that rely on clinical data when such measures are being considered, if possible. In the coming quarter, this work group will invite clinicians to speak to the group about collecting information during the clinical encounter and Health Information Exchange specialists will speak to the group about clinical data quality and flow. Balancing the desire for additional measures, the burden of reporting on more measures and the potential loss of focus if we have to many measures will remain a challenge.

The Care Models and Care Management Work Group continues to struggle slightly in its focus, direction, and momentum in moving forward the goals of its charter and work plan. Largely due to anxiety and concern over how reform efforts might affect the work of existing programs, work group members have expressed a certain degree of resistance to discussion about how the system could be further improved. That said, significant progress was made in the first quarter towards envisioning and planning a learning collaborative around care management activities in different locations throughout the State; and the topic of developing care management standards for potential inclusion into the ACO Shared Saving Programs Standards was introduced at the April in person meeting and will be further discussed in upcoming months.

Vermont's sub-grant program is a significant undertaking and resource intensive to implement. It also allows the project to foster innovation at the clinical level, which is critical for project success. Vermont will be making slight modifications to the program for a subsequent round based on the experience with the first round of applications. In particular, Vermont will augment the programmatic criteria based on suggestions from the various work groups.

4.3 Suggestions/Recommendations for Current/Future SIM States

Quality & Performance Measures Work Group: Early efforts to align ACO measures across payers and reporting requirements were helpful, but there is continued interest in improving the alignment of measures across care settings and provider types. Taking alignment into consideration as early as possible when selecting program measures may be a helpful approach for other states.

Care Models and Care Management Work Group: It is important to understand the existing landscape before attempting to facilitate conversation around change or improvement. Vermont has developed a care management inventory survey that could be utilized by other states to gather base-line data on what services are currently being offered and who is doing what. In Vermont's experience we have been hearing anecdotal information that the status quo is, for example, effectively meeting the needs of all Vermonters and that there is no need for improvement. Concrete data will assist in facilitating these difficult conversations, and demonstrating that there are in fact gaps that needs to be filled, or opportunities for further collaboration across existing programs.

4.4 Suggestions/Recommendations for CMMI SIM Team

The assistance offered to DVHA by CMMI and its partners at CHCS surrounding the production of materials to CMS including a concept paper and draft SPA pages in support of the VMSSP SPA proved to be extremely valuable. Vermont gained a lot of insight and perspective through this review process and would enthusiastically support other opportunities for technical assistance and review in the future.

5 Findings from Self-Evaluation

We continue to work on internal project communication among the state staff working on the project. Having recognized the need for planning meetings each week and frequent emails, we are also implementing more in-person meetings.

We also identified the need for state staff and work group co-chairs to engage in more frequent and intentional planning of work group activities. As a result, planning meetings, of varying frequency, were instituted. In addition to improving meeting preparation, these meetings have helped enhance relationships between state staff and co-chairs. We are also now convening multiple work group teams to strategize about activities where the groups overlap.

Vermont experienced a variety of delays through the contracting process and the SIM staff has worked to streamline that within the various business offices. The state staff also provided more detail about the contracting process to SIM participants to allow for a more streamlined approval process within the project work groups and steering committee.

6 Problems Encountered/Anticipated and Implemented or Planned Solutions

6.1 Problems Encountered/Anticipated

1. The problems encountered in enrolling individuals and small business subscribers onto the Exchange in Vermont created uncertainty as to whether we would have enough lives to implement a Commercial Shared Savings ACO Program for all three ACOs with each of the two commercial payers
2. The Medicaid Shared Savings ACO Program contract negotiations were lengthier than expected, but were executed in March. They required significant staff time and more legal support on both sides than anticipated.
3. The change in the focus for the DLTSS Work Group from a focus on the Duals Demonstration required a review of the work group's work plan and Charter as well as implementation timeline for activities.
4. Recruiting qualified staff remains a challenge, although some key hires have occurred.
5. "Reform fatigue" is still being experienced by many stakeholders.
6. Procurement processes are lengthy, which has delayed some programmatic implementation.
7. There is a tension between making quick decisions regarding SIM investments to reap the benefits within the grant period and getting adequate stakeholder input, which takes time. The Care Models and Care Management example provided above is a case in point on this issue.
8. To a certain degree, reform efforts are being met by resistance from various stakeholders, particularly when they have the impression that their role in the status quo will somehow be negatively impacted by reform efforts. Continued outreach, education and collaboration is necessary to address fears and anxiety moving forward.

6.2 Implemented or Planned Solutions

1. In response to the Governor's decision to no longer pursue a Duals Demonstration in Vermont, the former Dual Eligible Work Group has rebranded itself as the Disability and Long Term Services and Supports Work Group, and will make recommendations to all other work group about how to best incorporate and integrate a DLTSS focus into their work.
2. In response to a delayed kickoff of both the VMSSP and the Commercial SSP, several implementation deadlines were pushed back to later in Q1, or Q2. Financial calculations for performance year one will still be based on data going back to January 1st, 2014. The programs are expected to resume a normal implementation cycle for Q3 2014 and beyond.
3. Continue with recruiting and outreach activities to achieve full staffing.
4. Continue to provide a reasonable pace for adopting new reforms and reinforcing how the new reforms are complementary to existing initiatives.
5. Identification of ways to reduce the amount of time for procurement of contractors.

7 Work Breakdown Structure

This is provided in Appendix B. Please note that Vermont's standard interagency transfer of funds between state agencies is done quarterly in the fourth, seventh, tenth and first month. This transfer cycle means that there is insufficient information to provide a full report of those SIM-related expenses by both the Agency of Administration and the Green Mountain Care Board by the April 30, 2014 report date. The Work Breakdown Structure does not include the personnel costs within these two agencies. Vermont will be providing the information for both the October-December 2013 and January-March 2014 time periods in its next report.

There are also some out-of-state travel expenses listed on Vermont's travel report as being charged to SIM that are not actual expenses to SIM. Vermont's accounting practices require that even when a third-party entity pays for out-of-state travel, there is a record of the transaction related to SIM. The net result is an expense and then a reimbursement for that same amount without drawing on federal funds. Unfortunately, the timing of the third-party reimbursement does not always reflect both parts of the transaction in the quarterly reports.

8 Additional Information

9 Point of Contact

Georgia Maheras, Project Director
Georgia.maheras@state.vt.us
802-505-5137

Appendix

A Process for Review and Modification of Measures
B Work Breakdown Structure/Quarterly Financial Report (Excel)
C SF 425 (Excel)
D Travel Report (Excel)
E Master NOA Approved Contracts (Excel)
F Summary of News Articles