# State Innovation Model
# Year 3 Update to Operational Plan
# For Health System Innovation


**Prepared by the State of Vermont**
**For the Centers for Medicare and Medicaid Services**
**April 28th, 2016**

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# Executive Summary

Vermont's Year 3 Operational Plan describes Vermont's plans to utilize State Innovation Model (SIM) grant funds to support improvements in the state's health care system in Performance Period 3. This document builds on our Performance Period 2 Operational Plan, submitted in November 2014; our Performance Period 2 Operational Plan Addenda, submitted in August 2015; our initial Year 3 Operational Plan, submitted in November 2015 (rescinded in November 2015); and our Year 2 No-Cost Extension request, submitted in December 2015. This document focuses on Vermont's project activities to date and planned activities for the coming year, with particular emphasis on Vermont's Performance Period 3 milestones and contractor resources to be used to achieve those milestones and meet accountability targets. It also provides an update on progress toward achieving our Performance Period 2 milestones, emphasizing activity since our No-Cost Extension submission in December.

## *Overall Goal*

Overall, Vermont's SIM project uses SIM funds to strive towards the Triple Aim:

- Better care;
- Better health; and
- Lower costs.

Within the framework of the Triple Aim, Vermont has four high-level goals that we are seeking to achieve through our SIM Testing Grant:

1. 80% of Vermonters in alternatives to fee-for-service (FFS), from 41% in 2013 to 80% in 2017.
2. By 12/31/2016, in adult Vermont residents attributed to an ACO, the % with diabetes HbA1c Poor Control will be 20% or less, 70% or more with an abnormal BMI will have a follow-up plan documented, and 85% or more identified as tobacco users will receive a cessation intervention.
3. The number of providers with at least one interface to the Vermont Health Information Exchange will increase from 130 to at least 400 by 6/30/17.
4. Cost avoidance of $45 million generated through payment models.

These goals are described in more detail in Attachment 1, Vermont SIM High-Level Goals – Supplemental Information, also submitted to our Project Officer via email on March 7, 2016.

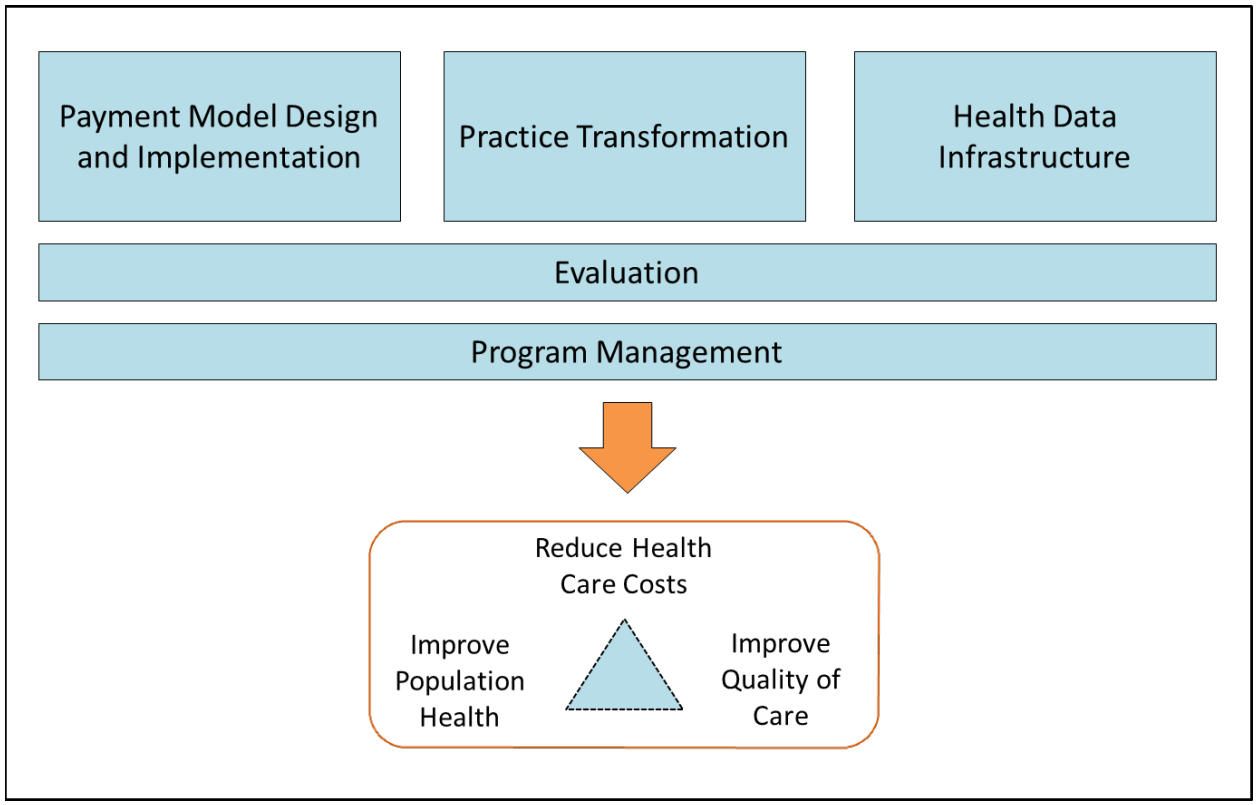
These goals, and the Triple Aim, are advanced through a series of tasks that fall under five major focus areas:

- **Payment Model Design and Implementation**: Supporting creation and implementation of value-based payments for providers in Vermont across all payers.

- **Practice Transformation**: Enabling provider readiness and encouraging practice transformation to support creation of a more integrated system of care management and care coordination for Vermonters.
- **Health Data Infrastructure**: Supporting provider, payer, and State readiness to participate in alternative payment models by building an interoperable system that allows for sharing of health information to support optimal care delivery and population health management.
- **Evaluation:** Assessing whether program goals are being met.
- **Program Management and Reporting:** Ensuring an organized project.

The project's five focus areas are depicted in *Figure 1* below:

*Figure 1: Vermont's SIM Focus Areas*




### *Performance Period 3*

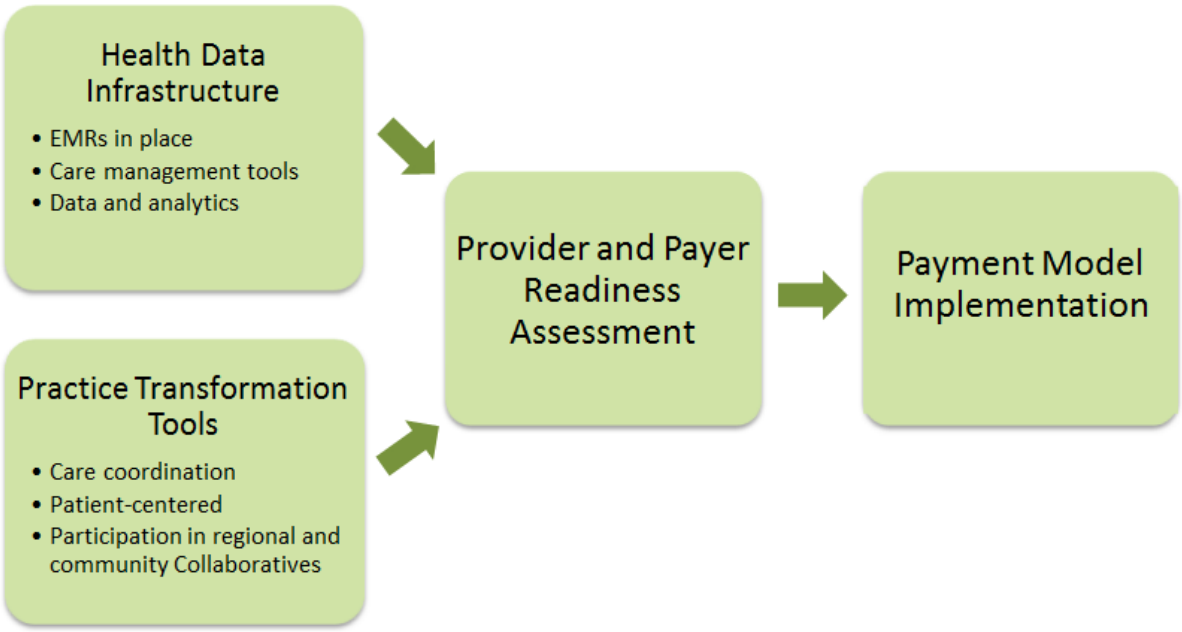
Performance Period 3 is the final Performance Period for Vermont's SIM project and concludes the three-year testing period. During Performance Period 3, Vermont will continue activities to support payment model design and implementation, care delivery and practice transformation, health data infrastructure investments, evaluation, and project management. Vermont will also

ramp up activities related to the Population Health Plan, which is due at the end of the project (see Attachment 2), and will continue our sustainability planning activities, ensuring that we appropriately transition key activities throughout the Performance Period (see Section M). At this time, Vermont is in conversation with CMMI regarding an All-Payer Model, with implementation tentatively planned for mid-Performance Period 3. Current SIM activities support provider, payer, and state readiness for implementation of this model. Vermont will identify additional activities on an on-going basis as the model and implementation plans continue to develop.

### Payment Model Design and Implementation

Work to design and implement new payment models must be tailored to provider capabilities and readiness. Some Vermont providers are better positioned to accept financial risk than others; Vermont's payment models are designed in a way that meets providers where they are. They are also designed to ensure that the payers can operationalize the new structure, and the State can evaluate the programs. Provider, State, and payer readiness is critical for success of alternative payment models in Vermont. See this depicted in *Figure 2* below:

*Figure 2: Alternative Payment Readiness*




By establishing a path for all providers to participate in alternative payment methodologies, we are phasing in reforms broadly, but responsibly.

Vermont's active payment model design activities are performed on a multi-payer basis as much as possible, and include:

- Medicaid and commercial **Shared Savings ACO Programs**, launched in 2014.
    - Vermont ACOs are also participating in the Medicare Shared Savings Program.
- Expansion of Vermont's **Advanced Primary Care Medical Home** initiative, known as the Blueprint for Health, launched in 2008.
    - In addition to Medicaid and Vermont's three largest commercial insurers, Medicare participates in the Blueprint for Health as a payer through the federal the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration.

These initiatives include the majority of Vermonters and Vermont providers: more than 60% of Vermonters are participating in the Shared Savings Programs and Blueprint for Health. Vermont's three[1] ACOs include the majority of our health care providers – including many of our long-term services and supports and mental health providers.

In addition to exploring ACO shared savings models and pay-for-performance (through the Blueprint for Health), Vermont is also analyzing and developing other value-based payment models intended to promote better sustainability of health care costs and higher quality. These include value-based purchasing in Medicaid and population-based payments for all payers.

As noted above, Vermont is exploring an All-Payer Model, which is informed by the Medicare Next Generation Accountable Care Organization model. An All-Payer Model would include an agreement between the State and the federal government to target a sustainable rate of spending growth for a specific set of regulated health care services in Vermont across Medicaid, Medicare, and commercial payers. The agreement would include strict quality and performance measurement and Medicare waivers if needed for restructuring payments. Provider payments would be structured using Next Generation's value-based payment models, such as population-based payments. Lastly, the Green Mountain Care Board would be the regulatory entity that would ensure that health care growth meets the targets through mechanisms such as hospital budget and payer rate reviews. The work done through the SIM grant to advance alternative payment models has helped to ensure that payers and providers are ready to move to a more aggressive payment model after the end of the grant, such as those being explored through the All-Payer Model.

Below is a list of SIM-supported projects and tasks planned for the Payment Model Design and Implementation focus area during Performance Period 3.

- Continued expansion of Vermont's *ACO Shared Savings Programs*;

[1] In February 2016, Vermont's three ACOs announced they were seeking to merge into one larger ACO. As of submission of Vermont's Performance Period 3 Operational Plan, the ACOs were still working towards the merger with an anticipated start of 1/1/17 for the new entity, to be known as Vermont Care Organization. Throughout this document, Vermont will refer to three ACOs, reflecting the current state.

- Continued expansion of a *Pay-for-Performance* program, implemented through the Blueprint for Health;
- Continued expansion of the *Medicaid Health Homes program*, also known as the Hub and Spoke program;
- Continued design and analysis related to *Accountable Communities for Health*;
- Design and analysis to support *Medicaid Value-Based Purchasing (Medicaid Pathway)* including mental health, substance abuse, developmental services, and other services;
- Design and analysis to support decision-making related to an *All-Payer Model* with CMMI.

### Practice Transformation

Vermont SIM's care delivery and practice transformation activities are designed to enable provider readiness to participate in alternative payment models and accept higher levels of financial risk and accountability, as well as to monitor Vermont's workforce and identify areas of current and future need. These activities impact a broad array of Vermont's providers and are undertaken as precursors to or in concert with alternative payment models. They are intended to ensure that the providers impacted by alternative financial models are supported in making the accompanying practice changes necessary for success, as well as to improve the health of individuals and the population through an integrated system of care management and care coordination.

Below is a list of SIM-supported projects and tasks planned for the Practice Transformation focus area:

- *Learning Collaboratives* to support improved and integrated care management in Vermont communities, including a Core Competency Training Series for front-line care management staff;
- A *Sub-Grant Program* for Vermont providers, including a *technical assistance* component;
- *Regional Collaborations* to support integration of the Blueprint for Health and Vermont's ACOs, and to enable community-wide governance and quality improvement efforts; and
- Workforce activities, including *Demand Modeling* and *Supply Data Collection and Analysis.*

### Health Data Infrastructure

Vermont SIM's health data infrastructure activities support the development of clinical, claims, and survey data systems to support alternative payment models. The State is making strategic investments in clinical data systems to allow for passive data collection to support quality

measurement – reducing provider burden while ensuring accountability for health care quality – and to support real-time decision-making for clinicians through improved information sharing. SIM is also working to strengthen Vermont's data warehousing infrastructure to support interoperability of claims and clinical data and to enhance our ability to produce predictive analytics. As with Vermont's Practice Transformation activities, the investments and activities in this focus area are intended to ensure providers, payers, and the State are prepared for and have timely and accurate information that is necessary to support alternative payment models.

These investments have yielded significant improvements in the quality and quantity of data flowing from providers' electronic medical records into Vermont's Health Information Exchange (VHIE). We have also identified data gaps for non-Meaningful Use-eligible providers to support strategic planning around data use for all providers across the care continuum.

Below is a list of SIM-supported projects and tasks planned for the Health Data Infrastructure focus area:

- Activities to expand provider connectivity to the VHIE, in particular *Gap Remediation* work that will build on gap analyses conducted during Performance Periods 1 and 2;
- Work to *Improve the Quality of Data Flowing into the VHIE*;
- Implementation of *Telehealth Pilots* aligned with the new Statewide Telehealth Strategy developed during Performance Period 2;
- Work on *Data Warehousing* to support the State and providers in aggregating, analyzing and improving the quality of health data;
- Discovery and design activities to develop *Care Management Tools*, including an event notification system, development of recommended revisions to the VHIE consent architecture, workflow transformation activities to support the goals of a universal transfer protocol, and continued implementation of care management solutions focused on high-priority non-Meaningful Use providers; and
- Various general activities, including *HIT/HIE Planning Activities* and *Expert Support* as needed to support health data initiatives.

### *Evaluation*

All of our efforts are evaluated to ensure the processes, as well as the outcomes, work for Vermont, its residents, payers, and providers. The evaluations occur by program, by population, and by region to identify successes, ensure that we are not inadvertently causing negative unintended consequences, and expand lessons learned quickly.

Below is a list of SIM-supported projects and tasks planned for the Evaluation focus area:

- Execution of our *Self-Evaluation Plan*;

- *Surveys* to measure patient experience and other key factors, as identified in payment model development; and
- *Monitoring and Evaluation Activities* within payment programs.

### *Project Management and Reporting*

SIM is supported by a project management team that oversees project-wide coordination and reporting, as well as communication and outreach. Project management is focused on achieving milestones and meeting accountability targets across the project. *Table 1* on the following page includes a summary of all Performance Period 3 milestones[2], lead staff, contractor support, and progress to date, which provides a global view of the project's current status and how Vermont believes it will achieve results. Section J, Staff/Contractor Recruitment and Training, provides additional detail by contractor.

[2] Attachment 3 includes a summary of all Performance Period Milestones and their status.

*Table 1: Performance Period 3 Milestone Summary*

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

| **Payment Model Design and Implementation** | | |
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| *Performance Period 3 Milestone* | *Lead(s) and Contractors Supporting* | *Progress Toward Milestones* |
| **ACO Shared Savings Programs (SSPs)**<br>Expand the number of people in the Shared Savings Programs in Performance Period 3 by 12/31/16:<br>Medicaid/commercial program provider participation target: 960. (Baseline as of December 2015: 940)<br>Medicaid/commercial program beneficiary attribution target: 140,000. (Baseline as of December 2015: 179,076). | *Lead(s):* Richard Slusky – GMCB (Commercial SSP); Amy Coonradt (Medicaid SSP)<br><br>*Contractors:*<br>Bailit Health Purchasing; Burns and Associates; The Lewin Group; Pacific Health Policy Group; Policy Integrity; Deborah Lisi-Baker; Wakely Consulting; Bi-State Primary Care Association/ Community Health Accountable Care (CHAC); UVM Medical Center (UVMMC)/OneCare Vermont. | • Modeled closely after the Medicare Shared Savings Program, this alternative payment model for commercial and Medicaid beneficiaries in Vermont was launched in 2014 as a three-year program. Beneficiaries are attributed to one of three accountable care organizations (ACOs) in the State. ACOs must meet quality targets to be eligible to share in any savings.<br>• Medicaid SSP Year 2 contract negotiations between DVHA and Medicaid SSP ACOs are complete.<br>• Expansion of Total Cost of Care for Year 3 of the Medicaid SSP was considered in 2015. DVHA reviewed all potential services to include in Year 3 before determining not to include them. DVHA notified the ACOs that it would not include additional services on September 1, 2015.<br>• The Green Mountain Care Board published the Year 1 (CY2014) quality, cost, and utilization performance results for each of the ACOs in the commercial SSP in Fall 2015.<br>• In Performance Period 2, the project focus has been on continued program implementation and evolution of program standards based on cost and quality results from the first performance period of both the Medicaid and commercial SSPs.<br>• During Performance Period 3, the SSPs will target additional beneficiaries and focus on expanding the number of Vermonters served in this alternative payment model.<br>• The commercial SSP will not offer downside risk as originally proposed in Year 3.<br><br>**Total Providers Impacted:** 1015; **Total Vermonters Impacted:** 191,784 (March 2016) |
| **Episodes of Care (EOCs):** *Activity discontinued; decision made in collaboration with CMMI in April 2016.* | | |

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| **Pay-for-Performance (Blueprint)**<br>1. Expand the number of providers and beneficiaries participating in the Blueprint for Health by 6/30/17:<br>Medicaid/ commercial/ Medicare providers participating in P4P program target: 715. (Baseline as of December 2015: 706)<br>Medicaid/ commercial/ Medicare beneficiaries participating in P4P program target: 310,000. (Baseline as of December *2015:* 309,713)<br>2. P4P incorporated into Sustainability Plan by 6/30/17. | *Lead(s):* Craig Jones<br><br>*Contractors:* Non-SIM funded. | • The Blueprint for Health provides performance payments to advanced primary care practices recognized as patient centered medical homes (PCMHs), as well as providing multi-disciplinary support services in the form of community health teams (CHTs), a network of self-management support programs, comparative reporting from state-wide data systems, and activities focused on continuous improvement.<br>• The Blueprint for Health engaged with its Executive Committee, DVHA and AHS leadership, and VHCIP stakeholders to discuss potential modifications to both the Community Health Team (CHT) and Patient-Centered Medical Home (PCMH) payments. Such modifications include shifting payers' CHT payments to reflect current market share (7/1/2015), increasing the base payments to PCMH practices (5/1/2015 for Medicaid, 1/1/2016 for commercial insurers), and adding an incentive payment for regional performance on a composite of select quality measures (1/1/2016). The legislature appropriated $2.4 million for Medicaid Blueprint payments (both CHT and PCMH) in State Fiscal Year 2016.<br>• A number of quality measures have been selected as the basis for the performance incentive payment that will be incorporated in 2016; these measures are aligned with those being used for the Medicaid and commercial SSPs.<br>• The Blueprint has approached a saturation point where the program has recruited most of the primary care practices in the state, and the rate of onboarding of new practices has slowed. It is anticipated that 6 new practices will join by the end of 2016, and that the currently enrolled practices will maintain participation.<br>• Since 2015, the Blueprint has been working on a model for integrating efforts with the ACOs.<br>• In early 2016 further decisions will be made regarding the program's trajectory within finance models that are proposed for 2017.<br><br>**Total Providers Impacted:** 712; **Total Vermonters Impacted:** 307,900 (March 2016) |
| **Health Home (Hub & Spoke)**<br>1. Expand the number of providers and beneficiaries participating in the Health Home program by 6/30/17:<br>Number of providers participating in Health Home program target: 75 MDs each prescribing to >= 10 patients. (Baseline as of December 2015: 72)<br>Number of beneficiaries participating in Health Home program target: 2,900 Hub + 2,300 Spoke = 5,200 total patients. (Baseline as of December 2015: 5,179)<br>2. Health Home program incorporated into Sustainability Plan by 6/30/17. | *Lead(s):* Beth Tanzman<br><br>*Contractors:* Non-SIM funded. | • The Hub and Spoke initiative is a Health Home initiative created under Section 2703 of the Affordable Care Act for Vermont Medicaid beneficiaries with the chronic condition of opioid addiction. The Health Home integrates addictions care into general medical settings and links these settings to specialty addictions treatment programs in a unifying clinical framework. Two payments are used: bundled monthly rate for Hubs and a capacity-based payment for Spokes.<br>• Access to treatment has steadily expanded, from 2,867 Medicaid beneficiaries receiving treatment in January 2013 to 5,179 in December 2015.<br>• Program implementation and reporting are ongoing.<br><br>**Total Participating Providers:** 72; **Total Vermonters Impacted:** 5,179 (December 2015) |

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

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| **All-Payer Model**<br>1. If negotiations are successful, assist with implementation as provided for in ALL-PAYER MODEL agreement through end of SIM grant.<br>2. Contribute to analytics related to all-payer model implementation design through end of SIM grant.<br>3. All-Payer Model incorporated into Sustainability Plan by 6/30/17. | *Lead(s):* Michael Costa; Ena Backus<br><br>*Contractors:* Bailit Health Purchasing, Burns and Associates, TBD. | • Vermont continues to explore an All-Payer Model. An All-Payer Model will build on existing all-payer payment alternatives to better support and promote a more integrated system of care and a sustainable rate of overall health care cost growth. Value-based payments that shift risk on to health care providers and that are aligned across all payers encourages collaboration across the care continuum and can result in better health outcomes for Vermonters.<br>• Negotiations between CMMI and SOV continue. SOV proposed a term sheet to CMMI on January 25, 2016. The term sheet sets out the basic outline for a potential all-payer model agreement, including the legal authority of the state to enter into such an agreement, the performance period for the agreement, waivers necessary to facilitate payment change and additional covered services, data sharing, and an evaluation of the demonstration.<br>• The stakeholder outreach and public process to vet the term sheet and potential model design began almost immediately, as the GMCB held two days of public meetings to discuss the proposed term sheet on January 28 and 29, 2016. The hearings were well attended by stakeholders. Concurrently, SOV staff has been testifying before relevant legislative committees to explain the term sheet and prospective model to Vermont's policy makers.<br>• Vermont's three major ACOs voted to form a single corporate entity in anticipation of an All-Payer Model.<br>• The State of Vermont would participate in the All-Payer Model as a payer via Medicaid. |
| **State Activities to Support Model Design and Implementation – Medicaid**<br>Pursue state plan amendments and other federal approvals as appropriate for each payment model; ensure monitoring and compliance activities are performed:<br>1. Obtain SPA for Year 3 of the Medicaid Shared Savings Program by 12/31/16.<br>2. Execute Year 3 commercial and Medicaid monitoring and compliance plans according to the predetermined plan through 6/30/17. | *Lead(s):* Alicia Cooper<br><br>*Contractors:* Burns and Associates; Pacific Health Policy Group; Maximus; Wakely Consulting; Policy Integrity; Vermont Care Network (VCN/BHN); Opiate Alliance; Kim Friedman; Deborah Lisi-Baker. | • For all Medicaid payment models that are designed and implemented as part of Vermont's State Innovation Model grant activity, there are a number of Medicaid-specific state activities that must occur. These activities ensure that Vermont Medicaid is in compliance with its Medicaid State Plan and its Global Commitment for Health (1115) waiver, and that newly established programs will be monitored for their impact on Medicaid beneficiaries.<br>• Both Year 1 and 2 SSP State Plan Amendments were approved in 2015.<br>• ACO data sharing is ongoing.<br>• Year 3 SSP State Plan Amendment was submitted to CMS in Q1 2016.<br>• Coordinating stakeholders to begin planning for expansion of Integrating Family Services program. |

| **Care Delivery and Practice Transformation** | | |
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| *Performance Period 3 Milestone* | *Lead(s) and Contractors Supporting* | *Progress Toward Milestones* |
| **Learning Collaboratives**<br>1. Target: 400 Vermont providers have participated in Learning Collaborative activities (including Integrated Communities Care Management Learning Collaborative or Core Competency Trainings) by 12/31/16. (*Baseline as of December 2015:* 200)<br>2. Report on program effectiveness to Steering Committee and Core Team by 12/31/16.<br>3. Incorporate Learning Collaborative lessons learned into Sustainability Plan by 6/30/17. | *Lead(s):* Erin Flynn; Pat Jones<br><br>*Contractors:* Deborah Lisi-Baker; Nancy Abernathey; Vermont Partners for Quality in Health Care; Developmental Disabilities Council; Primary Care Development Corporation. | • Vermont's Learning Collaboratives share and diffuse best practices for care coordination and to help multi-organizational teams deliver care most effectively. This work has grown to encompass two initiatives: The Integrated Communities Care Management Learning Collaborative and a Core Competency Training Series for front-line care management staff.<br>• The Integrated Communities Care Management Learning Collaborative works to engage as many patient-facing care providers within each community as possible, including nurses, care coordinators, social workers, mental health clinicians, physicians, and others, from a broad spectrum of health, community and social service organizations that includes primary care practices, community health teams, home health agencies, mental health agencies, Area Agencies on Aging, housing organizations, social service organizations, and others. Participants are convened for at least four in-person learning sessions and multiple webinars, as well as regular local meetings to support work. The fourth in-person learning session for the first cohort took place on September 29, 2015, where discussion of additional needs and sustainability within communities occurred. Two additional cohorts (8 additional communities) have joined the Learning Collaborative, with the first in-person learning sessions occurring in November 2015and additional sessions will take place throughout July-December 2016.<br>• The Core Competency Training initiative will offer a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities state-wide. Core curriculum will cover competencies related to care coordination and disability awareness. Trainings launched in March 2016; in total, 34 separate training opportunities will be made available to up to 240 participants state-wide. |

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| **Sub-Grant Program – Sub-Grants**<br>1. Provide SIM funds to support sub-grantees through 12/31/16.<br>2. Convene sub-grantees at least twice by 12/31/16.<br>3. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.<br>4. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17. | *Lead(s):* Joelle Judge; Georgia Maheras<br><br>*Contractors: Sub-Grantees (Vermont Medical Society Foundation; Healthfirst; UVM Health Network at Central Vermont Medical Center; Bi-State Primary Care Association/CHAC; Northwestern Medical Center; Northeastern Vermont Regional Hospital; White River Family Practice; Vermont Program for Quality in Health Care; InvestEAP; Vermont Developmental Disabilities Council; Rutland Area VNA and Hospice; Southwestern Vermont Health Care); University of Massachusetts.* | • The VHCIP Provider Sub-Grant Program was launched in 2014 and has provided 14 awards to 12 provider and community-based organizations who are engaged in payment and delivery system transformation. Awards range from small grants to support employer-based wellness programs, to larger grants that support state-wide clinical data collection and improvement programs. The overall investment in this program is nearly $5 million.<br>• Sub-grantees continue to report on activities and progress, highlighting lessons learned.<br>• All sub-grantees convened on October 7, 2015, for the second in a series of symposiums designed to share lessons learned and inform the SIM project overall. They will convene again June 15, 2016 with a final event planned for Fall 2016. |

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| **Sub-Grant Program – Technical Assistance**<br>Provide technical assistance to sub-grantees as requested by sub-grantees through 12/31/16:<br>1. Remind sub-grantees of availability of technical assistance on a monthly basis.<br>2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees.<br>3. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17. | *Lead(s):* Joelle Judge; Georgia Maheras<br><br>*Contractors:* Policy Integrity. | • The Sub-Grant Technical Assistance program was designed to support the awardees of provider sub-grants in achieving their project goals. Sub-grantee technical assistance contracts are executed; contractors are available for technical assistance as requested by sub-grantees and approved by project leadership according to a detailed SIM process. |
| **Regional Collaborations**<br>1. Support regional collaborations in 14 HSAs by providing sub-grants to ACOs and other technical assistance resources.<br>2. Develop a transition plan by 4/30/17 to shift all HSAs to non-SIM resources. | *Lead(s):* Jenney Samuelson<br><br>*Contractors:* Bi-State Primary Care Association/ Community Health Accountable Care (CHAC); UVM Medical Center (UVMMC)/ OneCare Vermont. | • Within each of Vermont's 14 Health Service Areas, Blueprint for Health and ACO leadership have merged their work groups and chosen to collaborate with stakeholders using a single unified health system initiative (known as a "Regional Collaborations"). Regional Collaborations include medical and non-medical providers (e.g., long-term services and supports providers and community providers), and a shared governance structure with local leadership. These groups focus on reviewing and improving the results of core ACO Shared Savings Program quality measures, supporting the introduction and extension of new service models, and providing guidance for medical home and community health team operations.<br>• Regional Collaborations have launched in each of the State's 14 Health Service Areas. There are weekly stakeholder meetings to discuss further development and direction of these Regional Collaborations. Regular presentations to SIM work groups on progress in each region highlight case studies from communities seeing positive outcomes on the ground. |
| **Workforce – Demand Data Collection and Analysis**<br>Submit Final Demand Projections Report and present findings to Workforce Work Group by 12/31/16. | *Lead(s):* Amy Coonradt<br><br>*Contractors:* IHSGlobal. | • A "micro-simulation" demand model will use Vermont-specific data to identify future workforce needs for the State by inputting various assumptions about care delivery in a high-performing health care system. The selected vendor for this work will create a demand model that identifies ideal workforce needs for Vermont in the future, under various scenarios and parameters<br>• Vermont's Agency of Administration expects to execute a contract with IHS for micro-simulation demand-modeling in Q2 2016, with work expected to begin in Q2 2016. |

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| **Workforce – Supply Data Collection and Analysis**<br>Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan:<br>1. Present data to Workforce Work Group at least 3 times by 12/31/16.<br>2. Publish data reports/analyses on website by 6/30/17.<br>3. Distribute reports/analyses to project stakeholders by 6/30/17.<br>4. Incorporate into Sustainability Plan by 6/30/17. | *Lead(s):* Amy Coonradt<br><br>*Contractors:* N/A. | • The Office of Professional Regulation and Vermont Department of Health (VDH) work in tandem to assess current and future supply of providers in the state's health care workforce for health care work force planning purposes, through collection of licensure and relicensure data and the administration of surveys to providers during the licensure/relicensure process.<br>• The Vermont Department of Health hired additional staff to develop and administer surveys to accompany provider re-licensure applications, and perform analysis on licensure data and develop provider reports on various health care professions.<br>• VDH staff reports analysis findings to the SIM work group on an ongoing basis. |

| **Health Data Infrastructure** | | |
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| *Performance Period 3 Milestone* | *Lead(s) and Contractors Supporting* | *Progress Toward Milestones* |
| **Expand Connectivity to HIE – Gap Remediation**<br>1. Remediate 65% of ACO SSP measures-related gaps as identified in Fall 2015/Spring 2016 by 6/30/17. (*Baseline as of December 2015:* 62%)<br>2. Remediate data gaps for LTSS providers according to remediation plan developed in Performance Period 2 by 6/30/17.<br>3. Incorporate Gap Remediation activities into Sustainability Plan by 6/30/17. | *Lead(s):* Georgia Maheras; Larry Sandage<br><br>*Contractors:* Vermont Information Technology Leaders (VITL); Vermont Care Network (BHN/VCN); H.I.S. Professionals; UVM Medical Center /OneCare Vermont. | • The Gap Remediation project addresses gaps in connectivity and clinical data quality of health care organizations to the Health Information Exchange. The ACO Gap Remediation component improves the connectivity and data quality for all Vermont Shared Savings Program measures among ACO member organizations. The Vermont Care Partners (VCP) Gap Remediation component will improve the data quality for the 16 Designated Mental Health and Specialized Service agencies (DAs and SSAs).<br>• ACO Gap Remediation work has been in progress since March 2015, with significant progress to date. In December 2015, VITL increased the percentage of total ACO data being transmitted to the VHIE to 62%-64%.<br>• As a result of findings of the DLTSS Information Technology Assessment, the HDI Work Group recommended further investment into connections for the Area Agencies on Aging and Home Health Agencies in the November Work Group meeting. A contract with VITL to provide connectivity interface discovery and implementation to Home Health Agencies is in development. This contract will also provide onboarding services to Home Health Agencies for access to VITL's provider portal, VITLAccess. |
| **Improve Quality of Data Flowing into HIE**<br>Engage in workflow improvement activities at designated mental health agencies (DAs) as identified in gap analyses. Start workflow improvement activities in all 16 DAs by 7/1/16 and complete workflow improvement by 12/31/16. Report on improvement over baseline by 6/30/17. | *Lead(s):* Georgia Maheras; Larry Sandage<br><br>*Contractors:* VITL; Vermont Care Network (BHN/VCN). | • The Data Quality Improvement Project is an analysis performed of ACO members' Electronic Health Record on each of sixteen data elements. Additional data quality work with Designated Agencies (DAs) to improve the quality of data and usability of data for this part of Vermont's health care system.<br>• There was a contract with VITL to work with providers and the ACOs to improve the quality of clinical data in the HIE for use in population health metrics within the Shared Savings Program. Data quantity and quality improvements resulted in the resolution of 64% of data gaps for SSP quality measures.<br>• Ongoing work with Vermont Care Network and VITL to improve data quality and work flows at Designated Mental Health Agencies (DAs). VITL will work with DAs to implement the workflow improvements in each agency through the development of a toolkit that will provide the necessary documentation, workflows, and answers to specific questions needed. |
| **Telehealth – Implementation**<br>1. Continue telehealth pilot implementation through contract end dates.<br>2. Incorporate Telehealth Program into Sustainability Plan by 6/30/17. | *Lead(s):* Jim Westrich<br><br>*Contractors:* VNA of Chittenden and Grand Isle Counties; Howard Center. | • Telehealth pilots will allow Vermont to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout the State of Vermont.<br>• A draft RFP scope was developed by the State and JBS International, drawing on the telehealth definition, guiding principles, and key Telehealth Strategy elements. Two bidders were selected in late 2015, based on demonstration of alignment with the health reform efforts currently being implemented as part of the SIM Grant process.<br>• Contract negotiations are underway; contract execution is expected in Spring 2016. |

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| **Data Warehousing**<br>1. Implement Phase 2 of DA/SSA data warehousing<br>2. Obtain approval of cohesive strategy for developing data systems to support analytics by 10/31/16. Operationalize the approved cohesive strategy for developing data systems to support analytics by 12/31/16. | *Lead(s):* Georgia Maheras; Craig Jones<br><br>*Contractors:* Vermont Care Network (VCN/BHN); Stone Environmental. | • Vermont Care Network (VCN/BHN) is working on behalf of Designated Mental Health Agencies (DAs) and Specialized Service Agencies (SSAs) to develop a behavioral health-specific data repository, which will to aggregate, analyze, and improve the quality of the data stored within the repository and to share extracts with appropriate entities.<br>• Data quality work, data dictionary development, training on analytic software, and other supporting tasks are all in progress to support the project once the team is ready for implementation. Implementation began in late 2015 and will continue through the end of 2016.<br>• |
| **Care Management Tools**<br>1. Event Notification System: Continue implementation of ENS according to contract with vendor through 12/31/16.<br>2. Shared Care Plan: Recommend revisions to the VHIE consent policy and architecture to better support shared care planning by 6/30/17.<br>3. Universal Transfer Protocol: Support workflow improvements at provider practices through existing contracts through 12/31/16.<br>4. Continue implementation of care management solutions, including VITLAccess, supporting Home Health Agencies and Area Agencies on Aging. | *Lead(s):* Georgia Maheras; TBD<br><br>*Contractors:* Stone Environmental; TBD. | *Event Notification System*<br>• During Performance Period 2, Vermont negotiated and executed contracts with VITL and an event notification system (ENS) vendor, to provide admissions, discharge, and transfer notifications to Vermont providers. To date, the project has connected the ENS vendor with the VHIE and launched the initial kickoff of the ENS service in April, with continued rollout throughout the first half of Performance Period 3.<br><br>*Shared Care Plan/ Universal Transfer Protocol*<br>• Throughout Performance Period 2, the SIM team performed discovery work on the feasibility and business requirements to support investment in a technology solution for the Shared Care Plans and Universal Transfer Protocol projects. This work culminated in the decision in March 2016 not to pursue technology solutions.<br>• The Shared Care Plan project work will focus on revisions to the VHIE consent policy and architecture in Performance Period 3, and Universal Transfer Protocol project goals will be pursued through workflow redesign support within practices leveraging our successful Learning Collaborative program. |
| **General Health Data – HIE Planning**<br>Finalize connectivity targets for 2016-2019 by 12/31/16. Incorporate targets into Sustainability Plan by 6/30/17. | *Lead(s):* Larry Sandage; TBD<br><br>*Contractors:* Stone Environmental. | • Contractor selected and kickoff meeting with outlined roles and responsibilities conducted; initial efforts to identify connectivity targets have begun. |
| **General Health Data – Expert Support**<br>Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments. | *Lead(s):* Georgia Maheras; TBD<br><br>*Contractors:* Stone Environmental. | • IT-specific support to be engaged as needed.<br>• Enterprise Architect, Business Analyst and Subject Matter Experts engaged to support identified research and development initiatives as appropriate. |

| **Evaluation** | | |
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| *Performance Period 3 Milestone* | *Lead(s) and Contractors Supporting* | *Progress Toward Milestones* |
| **Self-Evaluation Plan and Execution**<br>Execute Self-Evaluation Plan for 2016 and 2017 according to timeline for Performance Period 3 activities. | *Lead(s):* Annie Paumgarten<br><br>*Contractors:* Burns and Associates; JSI; The Lewin Group. | • Draft Self-Evaluation Plan submitted to CMMI for review in June 2015; a revised plan was finalized in November 2015.<br>• Vermont re-released the RFP for the State-led Study portion of the State-led Evaluation Plan in November 2015 due to significant differences between planned implementation activities and original contract scope. Vermont selected a bidder in December 2015; a contract with the new State-led Evaluation contractor was executed and work launched in March 2016. |
| **Surveys**<br>Conduct annual patient experience survey and other surveys as identified in payment model development: Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings Programs by 6/30/17. | *Lead(s):* Pat Jones, Jenney Samuelson<br><br>*Contractors:* Datastat. | • Patient experience surveys for the patient-centered medical home and shared savings program are fielded annually. |
| **Monitoring and Evaluation Activities Within Payment Programs**<br>1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications (bi-annual reporting to providers).<br>2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications (monthly, quarterly reports depending on report type).<br>3. TBD: APM, Medicaid VBP – Mental Health and Substance Use. | *Lead(s):* Alicia Cooper; Richard Slusky (GMCB)<br><br>*Contractors:* Burns and Associates; The Lewin Group. | • Ongoing activities including conducting surveys as identified in payment model development; analyses of the commercial and Medicaid Shared Savings Programs according to program specifications, and ongoing monitoring and evaluation by SOV staff and contractors occurring as needed according to project plan for each payment model. |

| **General Program Management** | | |
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| *Performance Period 3 Milestone* | *Lead(s) and Contractors Supporting* | *Progress Toward Milestones* |
| **Project Management and Reporting – Project Organization**<br>Ensure project is organized through the following mechanisms:<br>1. Project Management contract scope of work and tasks performed on-time.<br>2. Monthly staff meetings, co-chair meetings, and Core Team meetings with reporting on budget, milestones, and policy decisions presented and discussed at each meeting.<br>3. Submit quarterly reports to CMMI and the Vermont Legislature.<br>4. Population Health Plan finalized by 6/30/17.<br>5. Sustainability Plan finalized by 6/30/17. | *Lead(s):* Georgia Maheras<br><br>*Contractors:* University of Massachusetts. | • Project management contract in place to support project organization and reporting. |
| **Project Management and Reporting – Communication and Outreach**<br>Engage stakeholders in project focus areas by:<br>1. Convening 10 Core Team meetings between 7/1/16 and 6/30/17.<br>2. Convening 5 Steering Committee public meetings and 20 work group public meetings between 7/1/16 and 12/31/16.<br>3. Distributing all-participant emails at least once a month through 12/31/16.<br>4. Update website at least once a week through 12/31/16, and monthly through 6/30/17. | *Lead(s):* Christine Geiler<br><br>*Contractors:* University of Massachusetts. | • Communication and outreach plan drafted and implemented.<br>• SIM Work Groups and other stakeholder engagement activities ongoing.<br>• Website undergoing updates; new site expected to launch by June 2016 and then update on an ongoing basis. |

# Section A: Project Governance, Management Structure, and Decision-Making Authority

***Performance Period 3 Milestone:***

***Project Management and Reporting – Communication and Outreach: Engage stakeholders in project focus areas by:***

1. ***Convening 10 Core Team meetings between 7/1/16 and 6/30/17.***
2. ***Convening 5 Steering Committee public meetings and 20 work group public meetings between 7/1/16 and 12/31/16.***
3. ***Distributing all-participant emails at least once a month through 12/31/16.***
4. ***Update website at least once a week through 12/31/16, and monthly through 6/30/17.***

Vermont's SIM project is governed and supported by a combination of State officials (including SIM staff and non-SIM staff), SIM contractors, and private sector partners.

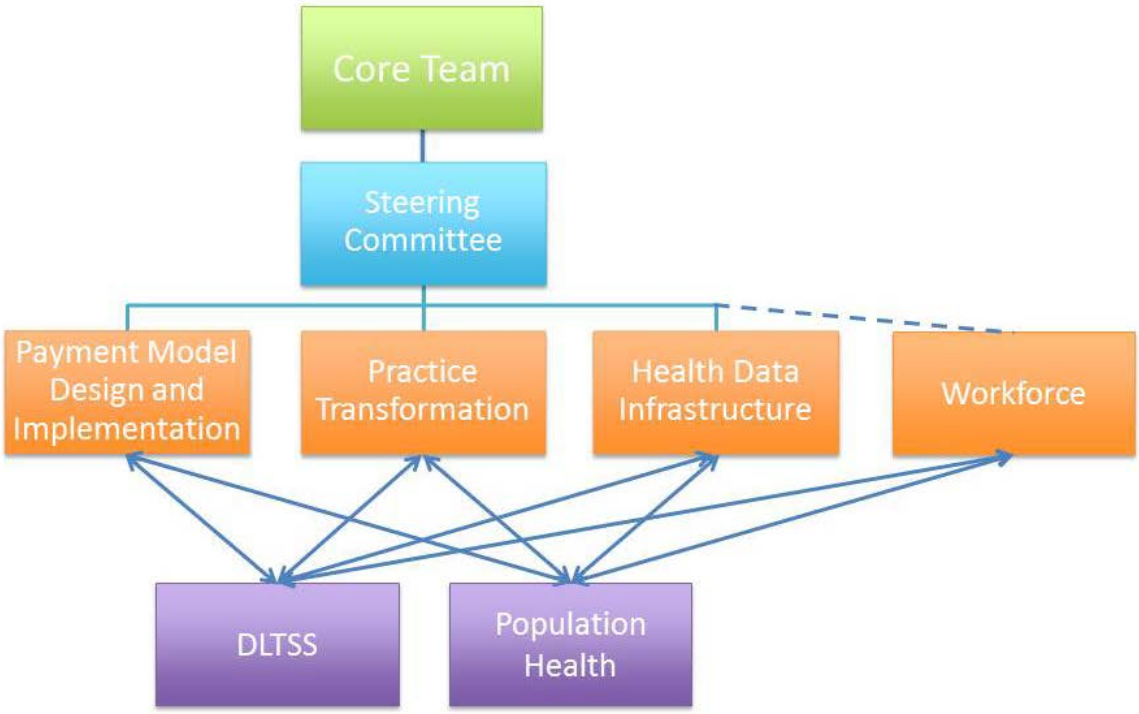
## *Project Governance Structure and Decision-Making Authority*

A robust public-private governance structure has been at the heart of Vermont's SIM project since launch. Careful planning at the outset of the project created a project structure that continues to include strong linkages with the Governor's Office, shared public-private governance, and an effective project management organization.

The core of this governance structure has remained consistent throughout the life of the project, though Vermont implemented changes to this structure during Summer 2015 in response to the results of a mid-project risk assessment. These changes were described in our REVISED - State Innovation Model Year 2 No-Cost Extension Request. Project leadership believes that the current project governance, management structure, and decision-making authority, in place since October 2015, are highly supportive of the high-level project goals and individual performance period milestones by maximizing integration of work across the project, using staff time efficiently, and ensuring streamlined communication about goals and progress.

*Figure 3* below depicts the SIM work group governance structure:

*Figure 3: Vermont SIM Project Governance Structure*




Vermont's SIM Core Team and Steering Committee meet monthly, along with the Payment Model Design and Implementation, Practice Transformation, and Health Data Infrastructure Work Groups. The Workforce Work Group meetings bi-monthly, and two additional groups, the Disability and Long-Term Services and Supports (DLTSS) Work Group and Population Health Work Group, meet quarterly to provide subject matter specific expertise on our milestones. These six work groups report up to the Steering Committee and Core Team, and make policy recommendations and funding recommendations to those groups.

The conclusion of many SIM project activities coincides with the end of Vermont's current Governor's administration. In 2015, Governor Peter Shumlin announced that he would not seek a fourth term in office; a new Governor will start his or her term in January 2017. This is likely to significantly impact Core Team membership, as five members are appointees of the Governor (Lawrence Miller, Chair, and Robin Lunge, Steven Costantino, Monica Hutt, and Hal Cohen, members serving in an *ex-officio* capacity). In the event that these individuals are no longer in State service in their current roles in January 2017, they will be replaced on the SIM Core Team by members of the new administration.

### The Core Team

This group meets monthly to provide overall direction to Vermont's SIM project, synthesizes and acts on guidance from the Steering Committee, makes funding decisions, sets project priorities, and helps resolve any conflicts within the project initiatives.

Core Team Membership

- Lawrence Miller – Chief of Health Care Reform, Chair
- Robin Lunge – Director of Health Care Reform
- Hal Cohen – Secretary of Human Services
- Al Gobeille – Chair of the Green Mountain Care Board
- Steven Costantino – Commissioner of the Department of Vermont Health Access
- Monica Hutt – Commissioner of the Department of Disabilities, Aging, and Independent Living
- Paul Bengtson – CEO, Northeastern Vermont Regional Hospital
- Steve Voigt – Executive Director, ReThink Health of the Upper Valley

### The Steering Committee

The Steering Committee meets monthly to inform, educate, and guide the Core Team in all of the work planned and conducted under the SIM grant. In particular, the group guides the Core Team's decisions about investment of project funds, necessary changes in state policy and how best to influence desired innovation in the private sector. See below for a list of Steering Committee members.

The membership of the Steering Committee brings a broad array of perspectives from multiple agencies within state government, and multiple groups and organizations from outside state government. The Steering Committee includes at least one of the co-chairs of each work group (described below), who are expected to report on the recommendations of those work groups in specific subject areas defined in their charters.

Steering Committee Membership

- Steven Costantino, Commissioner, Department of Vermont Health Access (co-chair)
- Al Gobeille, Chair, Green Mountain Care Board (co-chair)
- Susan Aranoff, Department of Disabilities, Aging, and Independent Living
- Rick Barnett, M.D., Vermont Psychological Association
- Bob Bick, M.D., Howard Center for Mental Health
- Peter Cobb, Vermont Assembly of Home Health and Hospice Agencies
- Elizabeth Cote, Area Health Education Centers Program
- Tracy Dolan, Department of Health
- Susan Donegan, Department of Financial Regulation
- John Evans, Vermont Information Technology Leaders

- Kim Fitzgerald, Cathedral Square
- Catherine Fulton, Vermont Program for Quality in Health Care
- Joyce Gallimore, Community Health Accountable Care (CHAC)
- Don George, Blue Cross Blue Shield of Vermont
- Lynn Guillett, Dartmouth Hitchcock Medical Center
- Dale Hackett, Consumer Advocate
- Mike Hall, Champlain Valley Area Agency on Aging
- Paul Harrington, Vermont Medical Society
- Selina Hickman, Agency of Human Services Central Office
- Debbie Ingram, Vermont Interfaith Action
- Craig Jones, M.D., Vermont Blueprint for Health
- Trinka Kerr, Office of the Health Care Advocate
- Deborah Lisi-Baker, Disability Policy Expert
- Jackie Majoros, Long-Term Care Ombudsman
- Todd Moore, OneCare Vermont
- Jill Olson, Vermont Association of Hospital and Health Systems
- Mary Val Palumbo, University of Vermont
- Ed Paquin, Disability Rights Vermont
- Laura Pelosi, Vermont Health Care Association
- Allan Ramsay, M.D., Green Mountain Care Board
- Frank Reed, Department of Mental Health
- Paul Reiss, M.D., Accountable Care Coalition of the Green Mountains
- Simone Rueschemeyer, Vermont Care Network
- Howard Schapiro, M.D., University of Vermont Medical Group Practice
- Julie Tessler, Vermont Council of Developmental and Mental Health Services
- Sharon Winn, Bi-State Primary Care

### Work Groups

As illustrated in Figure 3, Vermont's SIM project is supported and guided by six work groups. The Payment Model Design and Implementation, Practice Transformation, and Health Data Infrastructure Work Groups meet monthly, the Workforce Work Group meetings bi-monthly, and two additional groups – the Disability and Long-Term Services and Supports (DLTSS) Work Group and Population Health Work Group – meet quarterly to provide subject matter specific expertise regarding our milestones and the projects designed to meet those milestones. These work groups report up to the Steering Committee and Core Team, and make policy recommendations and funding recommendations to those groups. Member lists and workplans for Vermont's six SIM work groups are available on the project website: http://healthcareinnovation.vermont.gov.

Vermont's SIM Work Groups will phase out in December 2016 as many of the Vermont SIM work streams shift from design and implementation to monitoring and reporting; however, Vermont expects that much of the work undertaken by these groups will be continued in 2017 and beyond under other initiatives (see Section M, Sustainability Plans). The Core Team will continue to meet through the end of Performance Period 3 to guide the remaining six-months of the project.

### *Payment Model Design and Implementation Work Group*

This group, newly formed in October 2015, builds on the work and membership of the former Payment Models, Care Models and Care Management, and Quality Performance Measures Work Groups, as well as integrating members of the Population Health and DLTSS Work Groups. In Performance Period 3, the group will:

- Continue to monitor and make recommendations related to the commercial and Medicaid shared savings ACO (SSP ACO) model;
- Monitor activities related to Accountable Communities for Health and identify lessons learned based on this work;
- Review, develop, and recommend standards for Medicaid Value-Based Purchasing models;
- Assist with All-Payer Model implementation as appropriate; and
- Monitor implementation of Pay-for-Performance investments, Health Home (Hub & Spoke) program, and ensure these activities are included in Vermont's SIM Sustainability Plan as appropriate.

The group will continue to discuss mechanisms for assuring consistency and coordination across all payment models, including standardization of quality measures.

Visit Vermont's SIM project website to view the Payment Model Design and Implementation 2016 Workplan.

### *Practice Transformation Work Group*

This group, newly formed in October 2015, builds on the work and membership of the former Care Models and Care Management Work Group, as well as integrating members of the Population Health and DLTSS Work Groups. In Performance Period 3, the group will:

- Monitor implementation of Learning Collaborative, Sub-Grant program, Regional Collaborations, and Workforce Supply and Demand Data Collection and Analysis, and ensure these activities are included in Vermont's SIM Sustainability Plan as appropriate.

A major focus in Performance Period 3 will be identifying and spreading best practices and lessons learned from these efforts. The group will also recommend mechanisms for assuring greater consistency and/or coordination across these programs and models in terms of service

delivery or other key model or program components. The goal will be to maximize effectiveness of the programs and models in improving Vermonters' experience of care, reducing unnecessary costs and improving health, and minimizing duplication of effort or inconsistencies between the models.

Visit Vermont's SIM project website to view the Practice Transformation 2016 Workplan.

### *Health Data Infrastructure Work Group*

This group, newly formed in October 2015, builds on the work and membership of the former Health Information Exchange/Health Information Technology (HIE/HIT) Work Group, as well as integrating members of the DLTSS Work Group. In Performance Period 3, the group will:

- Explore and recommend technology and workflow solutions and best practices to achieve SIM's desired outcomes;
- Guide and monitor investments in the expansion and integration of health information technology, including:
    - Support for expanded connectivity to Vermont's Health Information Exchange, known as the VHIE, including remediation of identified data gaps;
    - Work to improve data quality within the VHIE;
    - Implementation of telehealth pilots;
    - Work around data warehousing and care management tools; and
    - Long-term HIE planning.

Visit Vermont's SIM project website to view the Health Data Infrastructure 2016 Workplan.

### *Workforce Work Group*

This group will build on its work to date, and in Performance Period 3 will:

- Monitor implementation of Workforce Supply and Demand Data Collection and Analysis, and ensure these activities are included in Vermont's SIM Sustainability Plan as appropriate.
- Continue to review and update Vermont's Workforce Strategic plan.

Visit Vermont's SIM project website to view the Health Care Workforce 2016 Workplan.

### *Disability and Long-Term Services and Supports (DLTSS) Work Group*

This group will build on its work to date, and in Performance Period 3 will:

- Provide recommendations regarding provider payment models that encourage quality and efficiency among the array of primary care, acute, and long-term services and support providers who serve dually-eligible populations;
- Identify quality measures to be used to evaluate provider and overall project performance;
- Provide recommendations for learning collaboratives that address the needs of individuals who utilize long-term services and supports, in particular the disability awareness component of the Core Competency trainings; and
- Support education across the SIM governance structure on issues relevant to DLTSS populations and providers.

Visit Vermont's SIM project website to view the DLTSS 2016 Workplan.

### *Population Health Work Group*

This group will build on its work to date, and in Performance Period 3 will:

- Contribute significantly to Vermont's Population Health Plan;
- Monitor and provide recommendations related to provider payment models and care delivery models to incorporate population health and prevention;
- Monitor activities related to Accountable Communities for Health and identify lessons learned based on this work; and
- Support robust linkages between Vermont's SIM work and other efforts, including State initiatives administered through the Department of Health and national activities.

Visit Vermont's SIM project website to view the Population Health Work Group 2016 Workplan.

### *Project Management*

Vermont's SIM project has contracted with the University of Massachusetts to provide project management. These contracted project managers (2 FTEs) which support individual work streams as well as the project as a whole. Additionally, Vermont has contracted with Stone Environmental to provide health data specific project management for the health data infrastructure focus area.

### *Reports to CMMI and the Vermont Legislature*

Project leaders continue to provide quarterly updates to CMMI and State legislative leadership to ensure that our federal partners and the legislature are appropriately informed of our progress. In addition, the SIM project developed monthly Project Status Reports in Fall 2015 to provide quick, high-level information on each identified "work stream". The most recent Project Status Reports, for March 2016, are attached (Attachment 4).

# Section B: Coordination with Other CMS, HHS, and Federal or Local Initiatives

The SIM grant supports coordination efforts to allow the design and implementation of Vermont's initiatives to proceed under an aligned model. This section describes how Vermont has utilized and will continue to utilize the SIM decision-making structure to achieve coordination across separate initiatives, including those underway prior to SIM and new activities in Performance Period 3.

### *Coordination with Other Federally-Sponsored Initiatives*

Vermont is engaged in a variety of initiatives sponsored by CMS and other areas of HHS, including but not limited to the following:

- Medicare joined Vermont's multi-payer Blueprint for Health program through the **Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration Project** in 2011. This includes Medicare participation in Vermont's **Support and Services at Home (SASH)** Project, which provides health care coordination and other support services, in coordination with Blueprint practices, for high-need individuals in public housing. The MAPCP Demonstration, and Medicare's participation in the Blueprint for Health and SASH programs, is scheduled to end in December 2016. Vermont proposes to extend Medicare's participation in these programs through the APM.
- There are two approved **Medicare Accountable Care Organizations** that are participating in the Medicare, Vermont Medicaid, and Vermont commercial Shared Savings ACO programs (OneCare Vermont and Community Health Accountable Care). Additionally, OneCare Vermont, the State's largest ACO, has been accepted into **Medicare's Next Generation Program** for 2017.
- State and federal information technology investments in Vermont's **health data information infrastructure**. These are described in more detail in Section E, Alignment with State HIT Plans and Existing HIT Infrastructure, and in Vermont's Health Information Technology Strategic Plan (Attachment 5).
- A variety of **CDC- and AHRQ-supported grants, learning collaboratives, population health tracking, ongoing technical assistance, and other initiatives** (see below).
- Vermont's **"Global Commitment" Medicaid 1115 waiver**, under which the state's Agency of Human Services has an inter-governmental agreement with the Department of Vermont Health Access to operate a managed care model on behalf of all Medicaid enrollees in the state. The State and CMS are currently negotiating a renewal of this waiver. In 2015, this waiver was consolidated with Vermont's **Choices for Care Medicaid Waiver**, which provides flexibility to the state to shift long-term care spending toward home and community-based services.

- The **Bundled Payments for Care Improvement (BPCI) Program**, under which providers from eight organizations in the Rutland area are coordinating care for congestive heart failure patients.

In Performance Period 3, Vermont's SIM project will continue to coordinate with these initiatives and new initiatives that develop. The major focus of Vermont's coordination efforts will be on the **All-Payer Model**. Vermont is currently negotiating with CMMI to come to agreement on terms for an agreement to implement this model. Negotiations are being led by Vermont's Agency of Administration and the Green Mountain Care Board. Vermont envisions the All-Payer Model as a critical next step in our efforts to transform health care payment and delivery, and intends to leverage federal investments in SIM and parallel State investments that have set a strong foundation on which the All-Payer Model can be built. The goals of SIM and Vermont's All-Payer Model are closely aligned, and have intentionally overlapping staffing to ensure continuous coordination. For more information on Vermont's vision for SIM/All-Payer Model alignment, please visit the Green Mountain Care Board website where you can find the Term Sheet and a one-page summary document. In addition, the All-Payer Model is discussed at greater length in Sections F and M of this Operational Plan.

The All-Payer Model is complemented by a newly renamed initiative known as the **Medicaid Pathway**, which includes and builds on Vermont's SIM-supported Medicaid Value-Based Purchasing efforts. Medicaid Value-Based Purchasing was an integral part of Vermont's SIM grant application, and the goal of incorporating new types of Medicaid providers into payment reform activities has been a central theme of Vermont's SIM Performance Period 1 and 2 activities. The Medicaid Pathway is a process, led by the Agency of Human Services Central Office in partnership with the Agency of Administration, that addresses payment and delivery system reforms that must happen in coordination with the All-Payer Model. This process focuses Medicaid services that are not provided exclusively (or at all) through the initial All-Payer Model implementation, such as mental health, substance abuse services, and long-term services and supports. The goal is alignment of payment and delivery principles that support a more integrated system of care.

As the next step on the Medicaid Pathway, Departments of the Agency of Human Services, along with the Agency of Administration, Designated Mental Health Agencies, Specialized Service Development Disability Agencies and private Substance Abuse providers are working together to determine how best to serve Vermonters through a more integrated continuum of mental health, substance abuse, and developmental services. The group is focused on care delivery and payment reform and is charged to create an implementation plan by the end of CY 2016. These efforts will be focused on models that are most able to align with current Vermont Health reform efforts under way including development around the All-Payer Model and merging work initiated for the Integrated Family Services (IFS) payment model.

### *Coordination of VHCIP Activities with CDC and AHRQ Initiatives in Vermont*

There are numerous CDC-supported initiatives in Vermont that coincide with and impact Vermont's SIM initiative. These initiatives fall into the areas of care transformation and quality improvement, and population health measures.

### Care Transformation and Quality Improvement

CDC grants for Community Transformation, Diabetes Prevention and Control, Cancer Screening, Asthma Care, and Multi-Drug Resistant Organism/Health Care Acquired Infection Prevention are all examples of care transformation and quality improvement initiatives that will support the payment and delivery system reforms envisioned by Vermont's SIM Operational Plan. The Community Transformation work supports the Support and Services at Home (SASH) infrastructure developed as part of the Blueprint for Health to focus on hypertension management and tobacco cessation. SASH provides residents of housing communities with self-monitoring tools, self-management programs, support in developing self-management plans, and access to health screening. Vermont has also implemented learning collaboratives for Cancer Screening, Asthma Care, and MDRO/HAI Prevention in order to improve care and ensure the adoption of best practices with partial support from CDC funding.

Each of these activities dovetails with Vermont's SIM-funded practice transformation supports, in particular the Learning Collaborative activities and Regional Collaborations described in Section L. These initiatives aim to weave together the diverse delivery system reform efforts in our state into a cohesive whole by increasing cross-sector collaboration and developing governance and stakeholder processes to guide priorities and identify projects of interest at both the State and local levels. Close connections to CDC- and AHRQ-supported prevention activities is evident in the stated goals of local Learning Collaborative and Regional Collaboration activities, many of which have identified diabetes, hypertension, and substance abuse as priorities.

### Population Health Indicators

The majority of the data collection systems in Vermont to track trends in population health contributors and outcomes are funded through various cooperative agreements with CDC. CDC's investments through the National Public Health Improvement Initiative supported the creation of the Healthy Vermonters 2020 performance management system. It is built on the concepts of *Results Based Accountability™* and Healthy People 2020 displays current and trend data for priority population indicators and program performance measures at statewide and regional levels. The Scorecard component focuses on performance accountability and narrative for program strategies and actions; the Maps &Trends component displays population data by three geographies: county, health district, and hospital service area. These indicators and measures inform our work, and will provide critical information to support development of Vermont's SIM Population Health Plan.

In addition, CDC's support of Vermont's Behavior Risk Factor Surveillance Survey and numerous other surveys and surveillance systems enables Vermont to collect, analyze and report many of the population health measures in the Healthy Vermonters Toolkit, including many of the measures recommended by CMMI for SIM evaluation. This data is highly valued by partners in the health system to monitor changes in health care and health outcomes.

### *Coordination with Other State and Local Initiatives in Performance Period 3*

As a small state, Vermont tends to have statewide initiatives with regional or local components, making coordination between these efforts easier than in most states. There is limited local government at the municipal level and virtually no county government structure in Vermont. Both the Vermont Department of Health and the Agency of Human Services have a regional presence throughout the state in order to implement public health efforts locally and provider services to the population in each health service area.

Vermont's SIM project is leveraging its governance structure and investments to ensure coordination across efforts that include:

- *The Blueprint for Health and Accountable Care Organizations:* The Blueprint for Health is implemented regionally in Vermont, in each of 14 health services areas. As described previously in this section, there is strong coordination in between Vermont SIM activities and the Blueprint; Blueprint representatives are included on Vermont SIM work groups, and many Vermont SIM activities are based on the Blueprint's foundation of patient-centered medical homes and regional community health teams.
    - Vermont is applying SIM resources to support integration and alignment between Blueprint activities and Vermont's ACOs by dedicating funds to support Regional Collaborations. These groups provide local governance co-led by Blueprint and ACO providers and sponsor regional quality improvement projects.
    - The Blueprint and local organizations offer self-management programs, including programs for people with diabetes, chronic illness, pain, mental illness and tobacco independence. Two of Vermont's VHCIP sub-grant awardees are focusing on enhancing these existing self-management programs. Vermont's Integrated Communities Care Management Learning Collaborative, the Core Competency trainings, and the Regional Collaborations, described below, are all implemented in collaboration with the Blueprint for Health. As appropriate, VHCIP activities relevant to self-management will coordinate with this already-existing infrastructure.
- *Learning Collaboratives:* In January 2015, SIM launched the first cohort Integrated Communities Care Management Learning Collaborative for three Vermont communities; two more cohorts launched with an additional 8 communities in July 2015. The Learning Collaborative seeks to improve care and reduce fragmentation for at-risk Vermonters and their families by enhancing integrated care management across multi-organizational teams of health and human services providers. In-person and web-based

learning sessions will continue through Performance Period 3. VHCIP staff and stakeholders are working to establish community-based sustainability of this collaborative model.

- *Core Competency trainings:* Building on the Learning Collaboratives launched in 2015, this initiative offers comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities state-wide. Core curriculum will cover competencies related to care coordination and disability awareness. Additional training opportunities include advanced care coordination training, care coordination training for managers and supervisors, and "train the trainer" training. In total, 34 separate training opportunities will be made available to up to 240 participants state-wide. In order to ensure sustainability of training materials beyond the initial training period, training sessions will be filmed and all materials will be made available in an online format.
- *Population Health Activities:* The Vermont Department of Health and Agency of Human Services-Central Office implement public health efforts locally and provide services to the population in each health service area through 12 district offices. Vermont's SIM project actively coordinates with these public health efforts through inclusion of Department and Agency representatives on the broader SIM staff team (as key personnel), and through inclusion of key leadership on various SIM work groups, the Steering Committee, and the Core Team. The Vermont SIM project is aligned with the State Health Improvement Plan (SHIP), which identified three primary goals for improving population health through coordinated prevention strategies: reducing chronic disease, addressing substance abuse, and improving immunization. The SHIP will also serve as the base for Vermont's Plan for Population Health Improvement, a required deliverable of the SIM grant. In addition, Vermont's SIM project is supporting increased integration between health care and public health at the local and regional level through the second phase of Vermont's Accountable Communities for Health work. This effort, known as the ACH Peer Learning Lab, will bring together multi-disciplinary teams from ten communities across the state to further explore how this model might be implemented and develop community capacity. The ACH Peer Learning Lab seeks to support participating communities in increasing their capacity and readiness across the core elements of the ACH model through a curriculum that utilizes in-person and distance learning methods to support peer learning, as well as community facilitation to support each community's development; the project will result in a report that documents findings and lessons learned, and includes recommendations to inform future State decision-making, focusing on what infrastructure and resources are needed at the community/regional level and the State level.
- *Workforce:* The Workforce Work Group, established by executive order, is charged with coordination activities at both a state and local level in partnership with various State agencies and departments as well as private sector members representing the medical, long-term care, and dental provider communities, and medical education. An example of the partnerships fostered is that Vermont's Department of Labor, in conjunction with

the Vermont Healthcare and Information Technology Education Center (HITEC), provides health care pre-apprenticeship-to-apprenticeship training programs with area providers.

- *Health Information Technology Investments:* Vermont is coordinating SIM-funded investments in health information technology and health information exchange infrastructure with related efforts underway in the state, including those based at the Department of Vermont Health Access and through the state's Meaningful Use incentive program around EHR adoption, Vermont's Health Information Exchange (the VHIE), and State's HIT planning activities.
- *Hospital Community Needs Assessments and Quality Improvement Efforts:* All of Vermont's hospitals are not-for-profit organizations; they have conducted local needs assessments and offer a variety of programs in their communities. The needs assessments are already being used by regional community health teams to identify gaps in services, and by the Green Mountain Care Board to gauge hospital investments in community health improvement. Hospitals are also well-represented on all Vermont SIM work groups, including the Population Health Work Group, providing opportunities for further use of the needs assessments and coordination with hospital-sponsored health care programs.

### *Coordination with State Legislative Activity*

Vermont's health reform efforts, including the SIM grant, are coordinated with applicable legislation. During the 2016 Legislative Session, currently underway and expected to last into May 2016, Vermont's Legislature has taken a strong interest in some SIM-related issues and activities. The proposed legislation is not necessary for any SIM implementation or sustainability activities. Vermont will provide CMMI with an update on the final status of applicable legislation in our Q2 2016 Quarterly Report.

## Section D: Information Systems and Data Collection Setup

Vermont is implementing a statewide approach toward achieving interoperability and accessibility of clinical and patient information at the point of care, and for use in population health management. As discussed in Section F of this Operational Plan, Vermont has identified sharing of high quality, timely data as a necessary component of a successfully reformed system. Health data infrastructure that allows for accurate, timely, and analyzable health information exchange supports providers' readiness to participate in alternative payment models by enabling high-quality, coordinated care across the care continuum. It also supports ACOs, payers, and the State in targeting interventions, making policy decisions, and evaluating the effectiveness of interventions. At the center of Vermont's health data infrastructure are the Vermont Health Information Exchange (VHIE), which is operated by Vermont Information Technology Leaders (VITL), and the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), which is housed at the Green Mountain Care Board. The VHIE is Vermont's exclusive health information exchange and serves as the hub of clinical information from various providers' electronic medical records. VHCURES is Vermont's all-payer claims database, which is a collection of claims data from commercial, Medicare, and Medicaid payers.

Vermont's SIM project has focused most of its health data activities on one-time investments to increase the utility of our clinical data. A significant portion has been use to support the VHIE through targeted efforts to increase connectivity to additional providers, identify and remediate data gaps, develop analytics functions, and improve data quality. In addition, SIM funds have supported Vermont in engaging in robust long-term health data planning in areas like data warehousing and data governance focusing on mental health and substance use data and data used by the Blueprint for Health. SIM funds have also been used to support telehealth efforts and delivering data to providers for clinical decision-making. When considering health data infrastructure investments, Vermont carefully assesses the need for health data, then identifies appropriate technical solution(s), ensuring the State and partners leverage existing technologies and include all providers who will be impacted by the payment reforms described in Section F to the extent feasible.

Vermont's Performance Period 3 health data infrastructure investments build on investments in this area in prior performance periods. These include:

- Continued *Gap Remediation* efforts that seek to expand connectivity and completeness of the VHIE;
- Continued work to *Improve Quality of Data Flowing into the VHIE*;
- Implementation of *Telehealth Pilots* in accordance with Vermont's Statewide Telehealth Strategic Plan, developed during Performance Period 2;
- Development and strategic planning related to *Data Warehousing*;
- Continued efforts to design and implement *Care Management Tools*; and
- Ongoing *HIE Planning*, with *Expert Support* as necessary.

Milestones for Performance Period 3 in each of these areas are described below:

### *Expand Connectivity to HIE – Gap Remediation*

***Performance Period 3 Milestone:***

***1. Remediate 65% of ACO SSP measures-related gaps as identified in Fall 2015/Spring 2016 by 6/30/17. (Baseline as of December 2015: 62%-64%)***

***2. Remediate data gaps for LTSS providers according to remediation plan developed in Performance Period 2 by 6/30/17.***

***3. Incorporate Gap Remediation activities into Sustainability Plan by 6/30/17.***

Vermont's gap remediation efforts fall into two categories: 1) Work to remediate data gaps for Shared Savings Program quality measures; and 2) Work to expand VHIE connectivity to disability and long-term services and supports (DLTSS) providers.

Gap remediation work for the Shared Savings Program quality measures launched in Performance Period 2 to build on gap analysis efforts in previous performance periods. Work in Performance Period 3 will build on the significant progress achieved during Performance Period 2, accelerating connectivity to the VHIE. During Performance Period 2, the ACOs and the State also worked with VITL to determine the optimal way to remediate data gaps; this work will continue during Performance Period 3.

In Performance Period 2, Vermont researched and identified DLTSS data gaps and produced recommendations. These recommendations resulted in gap remediation activities in Performance Period 2 and will continue in Performance Period 3. Efforts in Performance Period 3 focus on high-impact connectivity and accessibility targets with the goal of connecting Vermont's Home Health Agencies to the VHIE. Additionally, Vermont's SIM Team has distributed the DLTSS Health Information Technology Assessment remediation recommendations to DLTSS providers, consumers, and advocates, as well as other key stakeholders. Focus on the DLTSS recommendations was incorporated into Vermont's HIT Strategic Plan[3].

### *Expand Connectivity to HIE – Improve Quality of Data Flowing into HIE*

***Performance Period 3 Milestone: Engage in workflow improvement activities at designated mental health agencies (DAs) as identified in gap analyses. Start workflow improvement activities in all 16 DAs by 7/1/16 and complete workflow improvement by 12/31/16. Report on improvement over baseline by 6/30/17.***

[3] CMS, through the Office of the National Coordinator, recently released new guidance regarding HIT investments for these providers. Vermont is incorporating this new information into the planning for our future work.

In addition to work described above to increase provider connectivity to the VHIE, Vermont is also working to increase the quality of information flowing into the VHIE through improved workflow at provider practices. This work, launched in Performance Period 1, is performed in partnership with VITL. High quality data is a prerequisite for a health care system to accurately measure and assess performance against a broader patient population. It is essential that the Vermont's Designated Agencies (DAs) and Specialized Services Agencies (SSAs) develop a process to improve the quality of their data. In Performance Period 3, workflow improvement activities will continue to occur at DAs and SSAs and their representatives will identify providers for whom data quality workflow could be helpful. VITL will work with identified providers and practices to improve the data at the source.

### *Telehealth – Implementation*

***Performance Period 3 Milestone:***

***1. Continue telehealth pilot implementation through contract end dates.***
***2. Incorporate Telehealth Program into Sustainability Plan by 6/30/17.***

In Performance Period 2, Vermont contracted with JBS International to develop a Statewide Telehealth Strategy to guide future telehealth investments as part of the Telehealth – Strategic Plan work stream. The Strategy, developed in collaboration between the State of Vermont and private sector stakeholders, includes four core elements: a coordinating body to support telehealth activities; alignment of state policies relevant to telehealth; telehealth technology investments that are secure, accessible, interoperable, cloud-based, and aligned with Vermont's HIT infrastructure; and clinician engagement. The Strategy also includes a Roadmap based on Vermont's transition from volume-based to value-based reimbursement methodologies to guide prioritization of telehealth projects and their alignment with new clinical processes adopted as payment reform evolves.

An RFP for statewide telehealth pilots was developed based on the recommendations included in the strategy. The RFP was released in September 2015, and bids were received and two apparent awardees selected in late 2015. As of April 2016, contract negotiations are ongoing; Vermont expects to execute contracts and launch pilots before the end of the January-June 2016 Performance Period 2 no-cost extension period.

In Performance Period 3, Vermont will continue pilot implementation, monitoring, and evaluation, and focus on the sustainability of telehealth investments beyond the SIM period (discussed further in Section M).

### *Data Warehousing*

***Performance Period 3 Milestone:***

***1. Implement Phase 2 of DA/SSA data warehousing solution by 12/31/16.***

***2. Obtain approval of cohesive strategy for developing data systems to support analytics by 10/31/16. Operationalize the approved cohesive strategy for developing data systems to support analytics by 12/31/16.***

During Performance Period 2, Vermont has worked with Vermont Care Network (VCN/BHN) – the professional association of Vermont's DAs and SSAs – to identify requirements, perform discovery, and begin the procurement process to implement a mental health-specific data repository. Vermont's DAs and SSAs are 42 CFR Part 2-covered agencies and cannot, due to regulatory issues, share data within the VHIE. The data repository will aggregate, analyze, and improve the quality of stored data, as well as share extracts with appropriate entities to support policymaking and evaluation. VCN is working with a vendor and the State to develop the data warehouse and other supporting tools during the remainder of Performance Period 2 and the first half of Performance Period 3.

Vermont will continue to advance data warehousing planning during the remainder of Performance Period 2 with the support of a contractor. Vermont intends to build on this work in Performance Period 3, including beginning implementation of the cohesive strategy in the first half of the Performance Period.

### *Care Management Tools*

***Performance Period 3 Milestone:***

***1. Event Notification System: Continue implementation of ENS according to contract with vendor through 12/31/16.***

***2. Shared Care Plan: Recommend revisions to the VHIE consent policy and architecture to better support shared care planning by 6/30/17.***

***3. Universal Transfer Protocol: Support workflow improvements at provider practices through existing contracts through 12/31/16.***

***4. Continue implementation of care management solutions, including VITLAccess, supporting Home Health Agencies and Area Agencies on Aging.***

This milestone spans four active work streams supported by Vermont's SIM project: 1) An Event Notification System; 2) The Shared Care Plan project; and 3) The Universal Transfer Protocol project.

### *Event Notification System*

During Performance Period 2, Vermont negotiated and executed contracts with VITL and an event notification system (ENS) vendor, to provide admissions, discharge, and transfer notifications to Vermont providers. To date, the project has connected the ENS vendor with the VHIE and launched the initial kickoff of the ENS service in April, with continued rollout throughout the first half of Performance Period 3. Vermont will support participation of Vermont providers for the first year of implementation by subsidizing provider subscription fees; ENS will continue to be available to interested Vermont providers in the second half of Performance Period 3 and beyond.

### *Shared Care Plan and Universal Transfer Protocol*

Throughout Performance Period 2, the SIM team performed discovery work on the feasibility and business requirements to support investment in a technology solution for the Shared Care Plans and Universal Transfer Protocol projects. This work culminated in the decision in March 2016 not to pursue technology solutions for either of these work streams in part due to the numerous solutions already planned or implemented around Vermont (at least 6 are active as of this writing); instead the Shared Care Plan project work will focus on revisions to the VHIE consent policy and architecture in Performance Period 3, and Universal Transfer Protocol project goals will be pursued through workflow redesign support within practices leveraging our successful Learning Collaborative program. Work is currently underway to further develop plans for Performance Period 3 activities in these areas.

## *General Health Data – HIE Planning*

***Performance Period 3 Milestone: Finalize connectivity targets for 2016-2019 by 12/31/16. Incorporate targets into Sustainability Plan by 6/30/17.***

In Performance Period 3, Vermont's SIM Team will continue to finalize connectivity targets for 2016-2019. Work will build on HDI Work Group discussions during previous performance periods to identify connectivity targets; targets will be finalized with the support of a contractor during the first half of Performance Period 3. These targets will include all provider types in Vermont, including acute, non-acute, and community providers. These targets will then be incorporated into subsequent iterations of Vermont's Health Information Technology Strategic Plan.

## *General Health Data – Expert Support*

***Performance Period 3 Milestone: Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.***

During Performance Period 2, Vermont's SIM team identified the need for additional IT-specific knowledge and subject matter expertise to assist in research, discovery, and support to meet

the growing need across SIM related health information projects, and identified a team of experts to support this work. This team of experts will continue to provide these services throughout Performance Period 3 to support identified research and development initiatives as appropriate.

# Section E: Alignment with State HIT Plans and Existing HIT Infrastructure

Vermont's SIM Grant has aligned with numerous strategic health data initiatives throughout its lifecycle with particular focus on providing leadership, governance, and stakeholder engagement for its HIT investments through the HDI Work Group. Vermont's SIM Team has also continually focused on improving connectivity to the health information exchange and close the gaps that have been identified with mental health, substance abuse, long-term care, and home health providers. Further, the SIM Grant's support of clinical data quality initiatives has helped promote the use of health care data with the state's three ACOs and the Blueprint for Health to improve the information at the point of care and population health measurement.

Additionally, Vermont's SIM project has worked closely with the Agency of Human Service's Health Information Exchange (HIE) Program, which manages Vermont's HIT Fund. The HIT Fund was created in statute in 2008 to support programs that would provide electronic health information systems and practice management systems for health care and human service practitioners in Vermont; relevant statute can be found at 32 V.S.A. §10301. In coordination with the AHS HIE Program, the SIM Team was able to align its strategic goals and develop financial sustainability plans for much of the SIM Grant's Health Information investments. Sustainability of Vermont's SIM-funded HIT investments is discussed at length in Section M of this Operational Plan.

Central to the coordination of HIT initiatives and investments in Vermont is the Vermont Health Information Technology Plan (VHITP). Statute (18 V.S.A. §9352) requires that the VHITP is developed and updated by the Secretary of Administration and reviewed and approved by the Green Mountain Care Board (GMCB) to ensure the plan is consistent with the State's overall health care reform goals. The Secretary of Administration has delegated plan development and updates to the Department of Vermont Health Access (DVHA).

The first VHITP was released in 2007. It is updated periodically, with the most current update available in draft form (See Attachment 5) pending approval. Per statute, the VHITP must be developed to support the effective, efficient, statewide use of electronic health information to support health care reform goals. The current revision of the VHITP is targeted at the technology infrastructure and associated processes in support of Vermont's health care reform efforts. The focus of the revised VHITP is on the electronic collection, storage, and exchange of clinical and social services data. It includes an increased focus on less traditional health and human services providers, such as those in mental health, substance abuse, and long-term supports and services (including home health, nursing homes, and disability). These providers are generally less advanced in the adoption, use, and exchange of electronic information and have not, to date, received the same levels of federal and state assistance.

The current release of the VHITP was developed with broad stakeholder engagement including a Steering Committee made up of participants from the Green Mountain Care Board, the Agency of Human Services, members of the SIM Health Data Infrastructure (HDI) Work Group, Vermont Information Technology Leaders (VITL), Vermont's ACOs, provider representatives from across the care spectrum, and representatives from additional private and public entities who are key stakeholders in the State's health care reform efforts. Throughout the development of the 2016 VHITP, project leaders delivered presentations to the HDI Work Group for review and feedback on initiatives and strategic direction.

As a result of this broad stakeholder engagement, core initiatives were identified that Vermont believes will collectively accomplish the following:

- Establish strong, clear leadership and governance for statewide Health Information Technology/Health Information Exchange (HIT/HIE) with a focus on decision-making and accountability.
- Continue – and expand – stakeholder dialogue, engagement, and participation.
- Expand connectivity and interoperability.
- Provide high quality, reliable health information data.
- Ensure timely access to relevant health data.
- Continue the protection of a person's privacy as a high priority.

## Section F: Model Intervention, Implementation and Delivery

Vermont continues to bring to bear a variety of policy and regulatory levers to implement our innovation model and to translate project learning into effective state policy after the life of the grant period. All of the policy and regulatory levers noted in this section (formerly Section G) of Vermont's original Performance Period 2 Operational Plan remain in place, as has the SIM grant program's ongoing stakeholder engagement efforts. In addition, leadership from key public and private stakeholder organizations in Vermont continue to be actively involved in project guidance and decision-making.

Since the submission of Vermont's Performance Period 2 Operational Plan, additional work has been devoted to the development of the Population Health and Sustainability Plans. Activity has also intensified around planning for an All-Payer Model, the proposed next step in Vermont's payment reform efforts, along with a complementary set of proposed reforms known as the Medicaid Pathway. Finally, there has been significant stakeholder and policy-maker engagement in conversations about how best to translate lessons learned from the SIM testing period into the future health care landscape in the state.

All of Vermont's SIM payment models are designed collaboratively with stakeholders to ensure that providers, payers, and the State have sufficient readiness – (including practice transformation tools and necessary data infrastructure) – to support model success (see Figure 2, Executive Summary). Providers need to have the financial ability to take on risk, the capacity to adjust their operations, and access to the appropriate data and clinical information to support change. Launching a model without first assessing and ensuring readiness can result in significant challenges, or even failure to achieve the goals of the new payment program. Additionally, Vermont's providers need to trust the State's reform efforts and be supportive of an integrated model. Vermont's payers need to have the capacity to undertake new models, which can require significant data analytic resources not utilized within fee-for-service payment models and payment systems that can process non-fee-for-service payments.

As Vermont expands the breadth and depth of its alternative payment models, we ask several key questions to help assess readiness and identify work required on the road to successful reform:

1. Care Delivery: Are providers ready?
2. Health Data Infrastructure: Are providers ready?
3. What are the services we want to include? Who is covered by those services?
    a. What is the current financial methodology?
    b. What are the current program requirements?
4. Level of accountability: What value-based purchasing model could we employ?
    a. What level of risk can the providers take on?
5. Which quality measures should we use?
    a. Make sure they are aligned with the existing measures in use.

   b. Assess electronic collection/provider burden.
6. Should the new model be mandatory or voluntary?
7. Are there enough lives/money/services for this alternative to work in Vermont, where we have a smaller population?

Milestones for Performance Period 3 within Vermont's Payment Model Design and Implementation focus area are described below. These descriptions offer high-level overviews of progress since our Performance Period 2 No-Cost Extension Submission and planned activities in Performance Period 3. Project leadership, in partnership with staff and stakeholders, have developed more detailed workplans, status reports, and other documents to support project activities.

### *Population Health Plan*

***Performance Period 3 Milestone: Finalize Population Health Plan by 6/30/17.***

Work continues to develop the *Plan for Integrating Population Health and Prevention in Health Care Innovation in Vermont*. This plan will build upon the existing State Health Improvement Plan (SHIP), which identifies three strategic goals for population health improvement:

Goal 1: Reduce the prevalence of chronic disease.
Goal 2: Reduce the prevalence of individuals with or at risk of substance abuse or mental illness.
Goal 3: Improve childhood immunization rates.

Improvements made through evidence-based strategies for these three preventable conditions will have a positive impact on multiple health outcomes in the future. Goals 1 and 2 also informed the goals of the All-Payer Model, discussed in detail below.

The *Plan for Integrating Population Health and Prevention in Health Care Innovation in Vermont* will also offer a strategic pathway forward to systematically connect integrated care management efforts with community-wide prevention strategies to improve population health outcomes. It is being developed collaboratively by the SIM Population Health Work Group, Vermont Department of Health, and SIM staff, with support from contractors and key national subject matter experts. We will also work closely with the State's accountable care organizations, community providers, and acute care providers to ensure the plan is achievable. For more information on this work, please see Attachment 2, Plan for Improving Population Health.

### *ACO Shared Savings Programs (SSPs)*

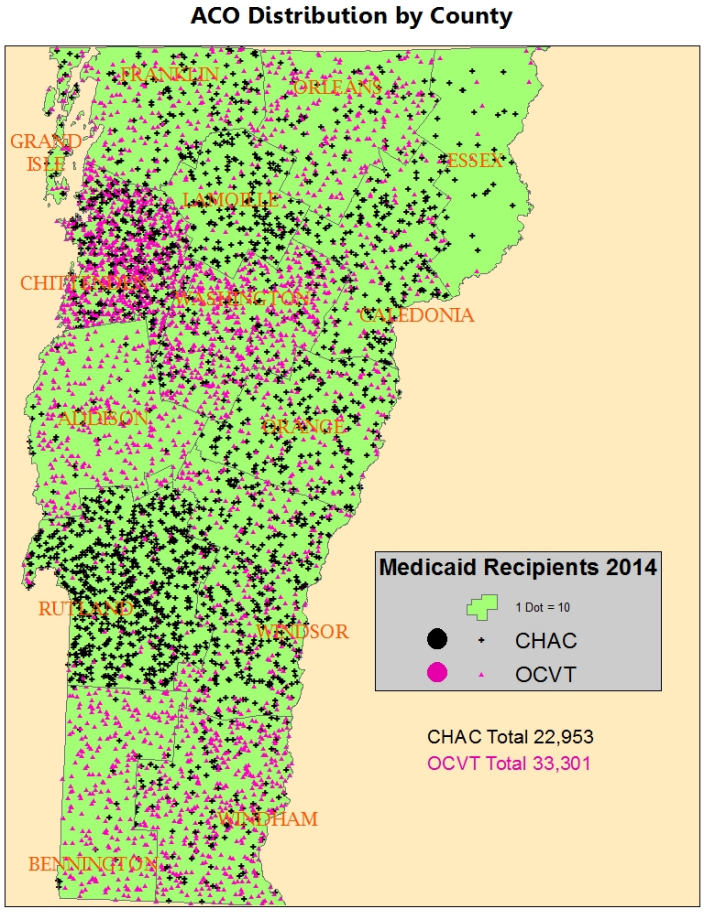
***Performance Period 3 Milestone: Expand the number of people in the Shared Savings Programs in Performance Period 3 by 12/31/16:***

***Medicaid/commercial program provider participation target: 960. (Baseline as of March 2016: 1015)***

***Medicaid/commercial program beneficiary attribution target: 140,000. (Baseline as of March 2016: 191,784)***

Modeled closely after the Medicare Shared Savings Program, this alternative payment model for commercial and Medicaid beneficiaries in Vermont was launched in 2014 as a three-year program. Beneficiaries are attributed to one of three accountable care organizations (ACOs) in the State. ACOs must meet quality targets to be eligible to share in any savings. *Figure 4* below illustrates the penetration the three ACOs within Year 1 of the Vermont Medicaid SSP (2014).

*Figure 4: Vermont Medicaid SSP ACO Distribution by County*




The third program year for both the Vermont Medicaid and commercial ACO Shared Savings Programs began on January 1, 2016. In Performance Period 3, project focus is on continued program implementation and evaluation of cost and quality results from the first and second Performance Periods. Additional focus during Performance Period 3 is on expanding the number of Vermonters served in this alternative payment model, in particular by targeting additional beneficiary populations for attribution. Performance Period 3 will also provide an

opportunity for payers, ACOs, and the provider community to discuss future movement toward population-based payments upon completion of the SIM testing period; see All-Payer Model, below, for further discussion of this issue.

### *Pay-for-Performance (Blueprint)*

***Performance Period 3 Milestone:***

1. ***Expand the number of providers and beneficiaries participating in the Blueprint for Health by 6/30/17:***

   ***Medicaid/commercial/Medicare providers participating in P4P program target: 715. (Baseline as of March 2016: 712)***

   ***Medicaid/commercial/Medicare beneficiaries participating in P4P program target: 310,000. (Baseline as of March 2016: 307,900)***

2. ***P4P incorporated into Sustainability Plan by 6/30/17.***

The Blueprint for Health provides per-member per-month performance payments to advanced primary care practices recognized as patient centered medical homes (PCMHs), as well as providing multi-disciplinary support services in the form of community health teams (CHTs), a network of self-management support programs, comparative reporting from state-wide data systems, and activities focused on continuous improvement. The Blueprint aims to better integrate a system of health care for patients, improving the health of the overall population, and improving control over health care cost by promoting health maintenance, prevention, and care coordination and management. Vermont Medicaid and the state's major commercial payers have been making performance payments to qualifying practices since 2007; Medicare joined as a payer through the Multi-payer Advanced Primary Care Practice (MAPCP) initiative in 2011.

In Performance Period 2, Vermont's Legislature appropriated $2.4 million for Medicaid Blueprint payments, a portion of which will be used for a Pay-for-Performance incentive. In previous years, the Blueprint payments to practices varied based on practices' NCQA PCMH recognition scores. The new payment structure sets a base rate for PCMH payments ($3 PMPM) based on achievement and maintenance of NCQA recognition and participation in a Regional Collaboration quality improvement initiative, and augments this with performance-based components designed to promote high-quality, high-value care: up to $0.25 for utilization and up to $0.25 for quality of care. To date, four quality measures have been selected as the basis for the performance incentive payment that will be in effect in Performance Period 3; these measures are aligned with those being used for the Medicaid and commercial SSPs. A stakeholder group with payer, ACO, and provider representation has worked to establish appropriate performance targets and benchmarks linking practice performance to incentive payment eligibility, and the new payment model was launched in 2016. The continuation of this model will be incorporated into the Sustainability Plan in Performance Period 3.

### *Health Home (Hub & Spoke)*

***Performance Period 3 Milestone:***

1. ***Expand the number of providers and beneficiaries participating in the Health Home program by 6/30/17:***

   ***Number of providers participating in Health Home program target: 75 MDs each prescribing to >= 10 patients. (Baseline as of December 2015: 72)***

   ***Number of beneficiaries participating in Health Home program target: 2,900 Hub + 2,300 Spoke = 5,200 total patients. (Baseline as of December 2015: 5,179)***

2. ***Health Home program incorporated into Sustainability Plan by 6/30/17.***

The Hub & Spoke initiative is a Health Home initiative created under Section 2703 of the Affordable Care Act for Vermont Medicaid beneficiaries with the chronic condition of opioid addiction. It has been in operation since July 2013, with statewide roll-out beginning in January 2014. The Health Home integrates addictions care into general medical settings and links these settings to specialty addictions treatment programs in a unifying clinical framework. Two payments are used: bundled monthly rate for Hubs and a capacity-based payment for Spokes.

The Hub & Spoke program will continue during Performance Period 3, with emphasis on further expanding the state's capacity to collect and report on performance metrics specific to this program.

### *Accountable Communities for Health*

***Performance Period 3 Milestone:***

***1. Continue implementation of ACH learning system (ACH Peer Learning Laboratory) to participating communities.***

***2. Develop ACH Implementation Plan based on lessons learned from ACH Peer Learning Laboratory by 6/30/17.***

***3. ACH Implementation Plan incorporated into Sustainability Plan by 6/30/17.***

Vermont's Accountable Communities for Health (ACH) work seeks to align programs and strategies related to integrated care and services for individuals with community-wide prevention efforts to improve health outcomes within a geographic community. The first phase of this work focused on research to further define the ACH model and identify core elements.

During Performance Period 3, Vermont's SIM project will continue the second phase that builds on previous efforts by bringing together multi-disciplinary teams from communities across the state to further explore how this model might be implemented and develop community capacity. This effort is known as the ACH Peer Learning Laboratory. The ACH Peer Learning Laboratory seeks to support participating communities in increasing their capacity and

readiness across the nine core elements of the ACH model through a curriculum that utilizes in-person and distance learning methods to support peer learning, as well as community facilitation to support each community's development; the project will result in a report that documents findings and lessons learned, and includes recommendations to inform future State decision-making, focusing on what infrastructure and resources are needed at the community/regional level and the State level. This work will also enable the state – in collaboration with communities, ACOs, providers, public health, and community services organizations – to develop an ACH Implementation Plan that will be incorporated into the Sustainability Plan in Performance Period 3.

Participation in the ACH Peer Learning Laboratory was solicited through Vermont SIM participant lists, direct outreach with Blueprint practice and ACO leaders, and presentations to the Regional Collaborations described in Section L. Ten community teams were selected from around the state, representing the majority of Vermont communities. Each of the teams includes broad representation of medical, community and public health partners; participating teams vary broadly in readiness for accountability in integrating population health and prevention within its community health reforms. The Peer Learning Laboratory will bring together core members of these teams for three statewide in-person learning sessions to learn with and from one another. Additionally, they will participate within their own communities in three web-based learning events which will include more didactic learning from national leaders in this field. The first in-person session will occur in June 2016, prior to the end of Performance Period 2, with a needs assessment and initial web-based gathering will occur in advance; additional learning sessions and web-based learning events are planned for Performance Period 3. All sessions will be evaluated, progress in the various communities tracked, and recommendations for state change documented. This work will culminate in a final report and curriculum due to the State in January 2017.This initiative seeks to align with and leverage two other SIM-supported learning opportunities available to Vermont communities, the Integrated Communities Care Management Learning Collaborative and Regional Collaborations (described in Section L). Figure 5, below, illustrates how these initiatives are intended to dovetail.

*Figure 5: Complementary Learning Opportunities*

| Integrated Communities Care Management Learning Collaborative | + | Regional Collaborations | + | Accountable Communities for Health Peer Learning Laboratory |
|---|---|---|---|---|
| How do we enhance team-based care for high risk individuals? | | How do we improve the quality of care, integrate services, and improve health outcomes? | | How do we connect integrated services for individuals with community-wide prevention strategies? |
| Focus on **integrated care for target individuals** | | Focus at **regional level on collaborative quality improvement across systems** | | Focus on planning for **community-wide systems and strategies to improve population health outcomes across a geographic area** |
| Support for **design and implementation of cross-organization, team-based care** | | Support for **design and implementation of cross-organization, team-based care and coordination of services** | | Support for high-level **convening, planning, and community level environmental and policy changes to address social determinants** |
| Working with **organizational leadership and front-line care managers** from health and social service organizations | | Working with **organizational leadership** from health and social service organizations | | Working with **organizational leadership** from health and social service organizations, and community prevention partners |
| Supported by Integrated Communities Care Management Learning Collaborative | | Supported by Blueprint and ACO facilitation and technical assistance | | Supported by Accountable Communities for Health Peer Learning Lab |

### *Medicaid Value-Based Purchasing (Medicaid Pathway)*

***Performance Period 3 Milestone:***

***1. Mental Health and Substance Abuse: Based on research and feasibility analysis, design an alternative to fee-for-service, for Medicaid mental health and substance use services by 12/31/16. Develop implementation timeline based on payment model design and operational readiness by 12/31/16.***

***2. Other Medicaid VBP Activities: Engage in research and feasibility analysis to support additional Medicaid Value-Based Purchasing activities.***

The Medicaid Pathway work stream, newly renamed in Performance Period 3, includes and builds on Vermont's SIM-supported Medicaid Value-Based Purchasing efforts. This work stream complements the All-Payer Model, described below. The Medicaid Pathway is a process led by the Agency of Human Services Central Office in partnership with the Agency of Administration that addresses payment and delivery system reforms that must happen in coordination with the All-Payer Model. It includes payment model development for mental health, substance abuse services, and developmental disability not subject to the All-Payer Model's financial caps, as well as additional research and feasibility for other potential Medicaid Value-Based Purchasing activities. These services are provided through specialized provider systems authorized under the State's Global Commitment to Health Section 1115 Demonstration. The initial outcome of Medicaid Pathway efforts related to mental health, substance abuse, and

developmental disability services will be a delivery system and payment reform proposal, as well as a financial model to evaluate the impact of alternative payments, followed shortly by an implementation plan to address operational changes needed for implementing changes statewide. Design considerations include the creation of an integrated and organized delivery system, while maintaining beneficiary protections and access to quality services necessary to support low income and vulnerable Medicaid enrollees. Additionally, a parallel planning process is under development for the comprehensive integration of physical and behavioral health with the long term support and services and supports provided to persons with physical disabilities and older Vermonters (i.e. Choices for Care). Future design considerations for this initiative will support comprehensive Medicaid alignment with the All-Payer Model, discussed below.

### *All-Payer Model*

***Performance Period 3:***

1. ***If negotiations are successful, assist with implementation as provided for in All-Payer Model (APM) agreement through the end of SIM grant.***
2. ***Contribute to analytics related to all-payer model implementation design through the end of SIM grant.***
3. ***All-Payer Model Incorporated into Sustainability Plan by 6/30/17.***

During Performance Period 2, SIM investments have allowed for crucial All-Payer Model (APM) progress, including researching feasibility, developing analytics, and obtaining information to support APM negotiating team decision-making as needed to complete term sheet and waiver terms and conditions negotiations. Further, SIM investments supported analytics related to All-Payer Model implementation design for the State, payers, and providers.

Performance Period 3 would, provided negotiations are successful, use SIM investments to assist with implementation as provided for in an APM agreement through the end of the grant term. Specific work would include, but not be limited to, finalization of a detailed ACO methodology (benchmark, attribution, risk levels, quality, overlaps), development of a plan to receive updated Medicare claims data on a regular basis for sufficient and timely measurement of model progress, further development of Vermont's rate-setting capability and methodologies, implementation of All-Payer Model specific quality targets and methodology, and the analyses to evaluate the feasibility of including additional services into the model over time. Additional investments would be made to ensure provider readiness (see Section L).

### *State Activities to Support Model Design and Implementation - Medicaid*

***Performance Period 3:***

1. ***Obtain SPA for Year 3 of the Medicaid Shared Savings Program by 12/31/16.***

### *2. Execute Year 3 commercial and Medicaid monitoring and compliance plans according to the predetermined plan through 6/30/17.*

During Performance Period 2, Vermont continued to conduct a number of Medicaid-specific state activities that must occur in support of payment models being tested, including development and submission of the Year 2 Medicaid SSP SPA, and execution of Year 1 and Year 2 Medicaid and commercial monitoring and compliance plans. These activities ensure that Vermont Medicaid is in compliance with its Medicaid State Plan and its Global Commitment for Health (1115) waiver, and that newly established programs will be monitored for their impact on Medicaid beneficiaries. These efforts will continue in Performance Period 3 as necessary and appropriate to support new and existing payment models.

# Section H: Quality, Financial, and Health Goals and Performance Measurement Plan

### *Performance Metrics to Support CMMI Program Monitoring and Evaluation Goals*

Throughout the life of the SIM grant, Vermont has worked with CMMI to support program monitoring and evaluation through a set of metrics reported quarterly and annually. *Table 2* below shows the performance metrics that Vermont reports to CMMI; this includes both SIM Core Metrics and the recommended Vermont-specific metrics that were approved by CMMI in the fall of 2014. Vermont relies on a variety of data, contractual, and programmatic resources to collect and report these metrics, including:

- Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all-payer claims database;
- The SIM State-Led Evaluation contractor;
- The Vermont Health Information Exchange (VHIE) and Vermont Information Technology Leaders (VITL);
- The state's annual Hospital and Managed Care Organization Report Cards and data filings;
- Medicare, Medicaid and Commercial results for shared savings program quality measures;
- Blueprint for Health analytics and patient experience surveys;
- The Behavioral Risk Factor Surveillance System survey, conducted by the Vermont Department of Health; and
- Payer and ACO data.

When applicable, metric-specific comments are provided in the following table. Caveats are outlined for some measures; examples include metrics for which there is a need to use a static annual denominator with quarterly numerator updates, and metrics for which there are questions about specifications. The Vermont SIM team will discuss questions about specifications and barriers to data collection with its CMMI Project Officer.

These metrics are augmented by project milestones (e.g., analyses conducted, procurement of key contractors) and model-specific measures (e.g., Medicaid and Commercial ACO Shared Savings Program quality, cost and utilization measures).

In Performance Period 3, Vermont will continue reporting on these metrics, modifying as appropriate and in collaboration with CMMI.

*Table 2: Performance Metrics to Support CMMI Program Monitoring and Evaluation Goals*

| | Reporting | Comments |
|---|---|---|
| *SIM Core Metrics* | | |
| Beneficiaries impacted (by type) | Quarterly | Vermont uses static denominator based on annual estimates of lives eligible for attribution; numerator fluctuates by estimates of program attribution on quarterly basis. |
| Participating Providers (by type) | Quarterly | Vermont uses static denominator based on annual VHCURES extract; numerator fluctuates by program participation on quarterly basis. |
| Participating Provider Organizations (by type) | Quarterly | Vermont uses static denominator based on annual VHCURES extract; numerator fluctuates by program participation on quarterly basis. |
| Health Information Exchange (number of providers with at least one interface to the VHIE) | Quarterly | The Vermont team works with Vermont Information Technology Leaders to determine consistent format for obtaining information; and is refining the denominator [4] (e.g., organizations, practices, interfaces). |
| Payer Participation | Quarterly | Vermont confirms payer participation in programs when it collects the number of beneficiaries participating in any of our alternative payment models. |
| Ambulatory Care: Emergency Department Visits (HEDIS) | Annually | This measure summarizes utilization of ambulatory care by calculating the number of ED visits per measurement year and is collected using the HEDIS specification for the measure and is provided at the State level. |
| Plan All-Cause Readmissions | Annually | Vermont's Medicaid and commercial SSPs use the HEDIS specification for this measure, and apply it at the ACO level. MSSP specification is used at the ACO level for Medicare beneficiaries. |
| HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems Survey: Patient's Rating of Hospital: Percentage of Survey Respondents Reporting a 9 or 10 | Annually | Vermont provides this data at the hospital level. The Vermont team will communicate the need to keep using this survey to the Vermont Department of Health. |
| Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention Measure Pair: A) Tobacco Use Assessment, B) Tobacco Cessation Intervention: Four Level Smoking Status | Annually | Vermont's Medicare, Medicaid and commercial SSPs use the MSSP specification for this measure, and apply it at the ACO level. |
| Diabetes Care: HbA1c Poor Control | Annually | Vermont's Medicare, Medicaid and commercial SSPs use the MSSP specification for this measure, and apply it at the ACO level. Measure specifications for the MSSP Diabetes Care composite measure have changed significantly since 2014: in 2015 and 2016, instead of a five-part measure, it is a two-part measure (HbA1c Poor Control, and Eye Exam |

[4] One of Vermont's Performance Period 3 milestones is to update our targets in this area.

| | Reporting | Comments |
|---|---|---|
| | | for Diabetics). This metric is one part of the composite measure in use. |
| Health Related Quality of Life—Physically and Mentally Unhealthy Days in the Past Month | Annually | Vermont can provide this data at the state level. Vermont will use the BRFSS to collect this measure. |
| Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up | Annually | Vermont's Medicare, Medicaid and commercial SSPs use the MSSP specification for this measure, and apply it at the ACO level. |
| *Vermont-Specific Metrics* | | |
| Total Cost of Care Population-based PMPM Index | Quarterly | Need to define specifications and data sources. The Vermont team will share proposed specifications with CMMI Project Officer. |
| CAHPS Clinician & Group Surveys (CG-CAHPS - PCMH version) | Annually | Vermont uses CG-CAHPS (the PCMH version with a few custom questions) to measure patient experience with advanced primary care practices (MAPCP demonstration) and ACOs. |
| Number of Provider Education and Engagement Efforts | Quarterly | Count consists of work group meetings, webinars, conferences, and trainings. |
| Unduplicated number of beneficiaries impacted by all reform activities | Quarterly | Vermont uses the beneficiaries impacted numbers and confirms duplicate counts with each payer. |

*Tables 3-7* below include results for all of Vermont's SIM Core Metrics and Vermont-Specific Metrics.

*Table 3: Beneficiary/Provider/Provider Organization Outputs*

| Metrics | Level of Reporting | Reported | Source | Baseline | Actual Q1 2016 | Performance Goal | % of Goal |
|---|---|---|---|---|---|---|---|
| CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial | VT | Q1 2016 | Payers | | 43,922 | 63,658 | 69% |
| CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid | VT | Q1 2016 | Payers | | 77,907 | 101,000 | 77% |
| CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare | VT | Q1 2016 | Payers | | 69,955 | 111,000 | 63% |
| CORE_Participating Providers_[VT]_[ACO]_Commercial | VT | Q1 2016 | Payers | | 1015 | 3832[5] | 26% |
| CORE_Participating Providers_[VT]_[ACO]_Medicaid | VT | Q1 2016 | Payers | | 504[6] | 3832 | 13% |
| CORE_Participating Providers_[VT]_[ACO]_Medicare | VT | Q1 2016 | Payers | | 939 | 3832 | 25% |
| CORE_Provider Organizations_[VT]_[ACO]_Commercial | VT | Q1 2016 | Payers | | 60 | 264 | 23% |
| CORE_Provider Organizations_[VT]_[ACO]_Medicaid | VT | Q1 2016 | Payers | | 59 | 264 | 22% |
| CORE_Provider Organizations_[VT]_[ACO]_Medicare | VT | Q1 2016 | Payers | | 80 | 264 | 30% |
| CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Commercial | VT | Q1 2016 | Payers | | 128,629 | 341,000 | 38% |
| CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicaid | VT | Q1 2016 | Payers | | 108,654 | 133,000 | 82% |
| CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicare | VT | Q1 2016 | Payers | 80538 | 70,617 | 111,000 | 64% |
| CORE_Participating Providers_[VT]_[APMH] | VT | Q1 2016 | Payers | | 712 | 3832 | 19% |
| CORE_Provider Organizations_[VT]_[APMH] | VT | Q1 2016 | Payers | | 128 | 264 | 48% |
| CORE_Provider Organizations_[VT]_[HH] | VT | Q1 2016 | Payers | | 5 | 5 | 100% |
| CORE_Payer Participation [VT] | VT | Q1 2016 | Internal | | 4 | 4 | 100% |
| Unduplicated number of beneficiaries impacted by all reform activities_[VT] | VT | Q1 2016 | Payers | 238931 | 318,575 | 573,360 | 56% |

[5] This number is the number of unique providers found in Vermont's all-payer claims database. It is subject to change as data are analyzed.
[6] This number is lower than previously reported because it is now an unduplicated count.

*Table 4: Clinical Metrics*[7]

| Metrics | MSSP | Reference | Level of Reporting | Reporting Period | Source | 2013 MSSP | 2014 Actual | SIM Goal | % of Goal |
|---|---|---|---|---|---|---|---|---|---|
| CORE_Diabetes Care_HbA1c Poor Control_ [VT]_ Commercial (lower rate is better) | 27 | NCQA HEDIS NQF#0059 | VT, ACOs | 2014 | EHR | | 14.62 | 20 | 137% |
| CORE_Diabetes Care_ HbA1c Poor Control _[VT]_ Medicaid (lower rate is better) | 27 | NCQA HEDIS NQF#0059 | VT, ACOs | 2014 | EHR | | 22.34 | 20 | 89% |
| CORE_Diabetes Care_ HbA1c Poor Control _[VT]_ Medicare (lower rate is better) | 27 | NCQA HEDIS NQF#0059 | VT, ACOs | 2013 & 2014 | EHR | 24.06 | 14.18 | 20 | 141% |
| CORE_BMI_Body Mass Screening and Follow Up_ [VT]_Commercial | 16 | NQF#0421 | VT, ACOs | 2014 | EHR | | 60.70 | 70 | 87% |
| CORE_BMI_ Body Mass Screening and Follow Up_ [VT]_ Medicaid | 16 | NQF#0421 | VT, ACOs | 2014 | EHR | | 57.92 | 70 | 83% |
| CORE_BMI_ Body Mass Screening and Follow Up_ [VT]_ Medicare | 16 | NQF#0421 | VT, ACOs | 2013 & 2014 | EHR | 66.90 | 69.08 | 70 | 99% |
| CORE_Tobacco_ Screening and Intervention_ [VT]_Commercial | 17 | NQF#0028 | VT ACOs | 2014 | EHR | | N/A | 85 | N/A |
| CORE_Tobacco_Screening and Intervention_ [VT]_ Medicaid | 17 | NQF#0028 | VT ACOs | 2014 | EHR | | N/A | 85 | N/A |
| CORE_Tobacco_ Screening and Intervention_ [VT]_ Medicare | 17 | NQF#0028 | VT ACOs | 2013 & 2014 | EHR | 87.68 | 94.49 | 85 | 111% |

*Table 5: Utilization Metrics*

| Metrics | Reference | Level of Reporting | Reporting Period | Source | 2014 Actual | SIM Goal | % of Goal |
|---|---|---|---|---|---|---|---|
| CORE_ED Visits_ Risk-adjusted, ED Visits/1000 Member Years [VT]_Medicaid | NCQA HEDIS | VT ACOs | 2014 | Claims | 1.2 | Not Set | N/A |
| CORE_Readmissions_[VT]_Commercial | NCQA HEDIS; NQF#1768 | VT ACOs | None | Claims | NA | Not Set | N/A |

[7] MSSP Clinical Metrics results can be found here: OneCare- https://www.onecarevt.org/doc/Quality%20Performance%20Results%20Table%20-%20Public%20Facing%20.pdf; CHAC- http://www.communityhealthaccountablecare.com/uploads/2/5/7/8/25784137/chac_2014_performance_stats_on_cms_template_2-3-15.pdf; Health*first*- http://vermonthealthfirst.org/pdf/files/40_2014_accgm_qual_perf_results_w_instructions.pdf.

| Metrics | Reference | Level of Reporting | Reporting Period | Source | 2014 Actual | SIM Goal | % of Goal |
|---|---|---|---|---|---|---|---|
| CORE_Readmissions_[VT]_Medicaid | NCQA HEDIS; NQF#1768 | VT ACOs | None | Claims | 16.69 | Not Set | N/A |

BR

*Table 6: Patient-Reported Metrics*

| Patient-Reported Metrics | Reference | Reporting Level | Reported Below | Source | 2013 | 2014 | SIM Goal | % of Goal |
|---|---|---|---|---|---|---|---|---|
| HRQL-Mental Health | CDC - BRFSS | Statewide | 2013 & 2014 | BRFSS 2013 | 10 | 10 | 10 | 100% |

*Table 7: Other Metrics*

| Metrics | Level of Analysis | Reported Below | Source | 2013 Baseline | Q4 2015 | SIM Goal | % of Goal |
|---|---|---|---|---|---|---|---|
| CORE_Health Info Exchange_[VT] | Statewide | Q4 2015 | Internal | 130 | 345 | 400 | 86% |

### *Performance Measurement to Support Payment and Delivery System Reforms*

Vermont's payment and delivery system reform initiatives, described in Sections F, K, L, and T of this Operational Plan, are currently at varied stages of research, development, and implementation. Table 1 in the Executive Summary of this Operational Plan provides a summary of all initiatives/work streams Vermont will undertake during Performance Period 3 of our SIM Model Testing grant; Attachment 3, Vermont SIM Milestone Summary and Driver Diagram, includes Vermont's programmatic milestones across all SIM Performance Periods.

Vermont's SIM Payment Model Design and Implementation Work Group (and previously the SIM Quality and Performance Measurement Work Group, prior to work group merger in 2015) has driven performance measurement design for SIM-supported initiatives since 2014. Performance measurement efforts for Vermont's SIM-supported initiatives vary based on stage of implementation, but the process of identifying common measure sets is essentially the same for all models and has included opportunities for stakeholder input built into every step. The majority of SIM-driven performance measure development has focused on the Medicaid and commercial ACO Shared Savings Programs (see Section F for more information).

The measure development process involves:

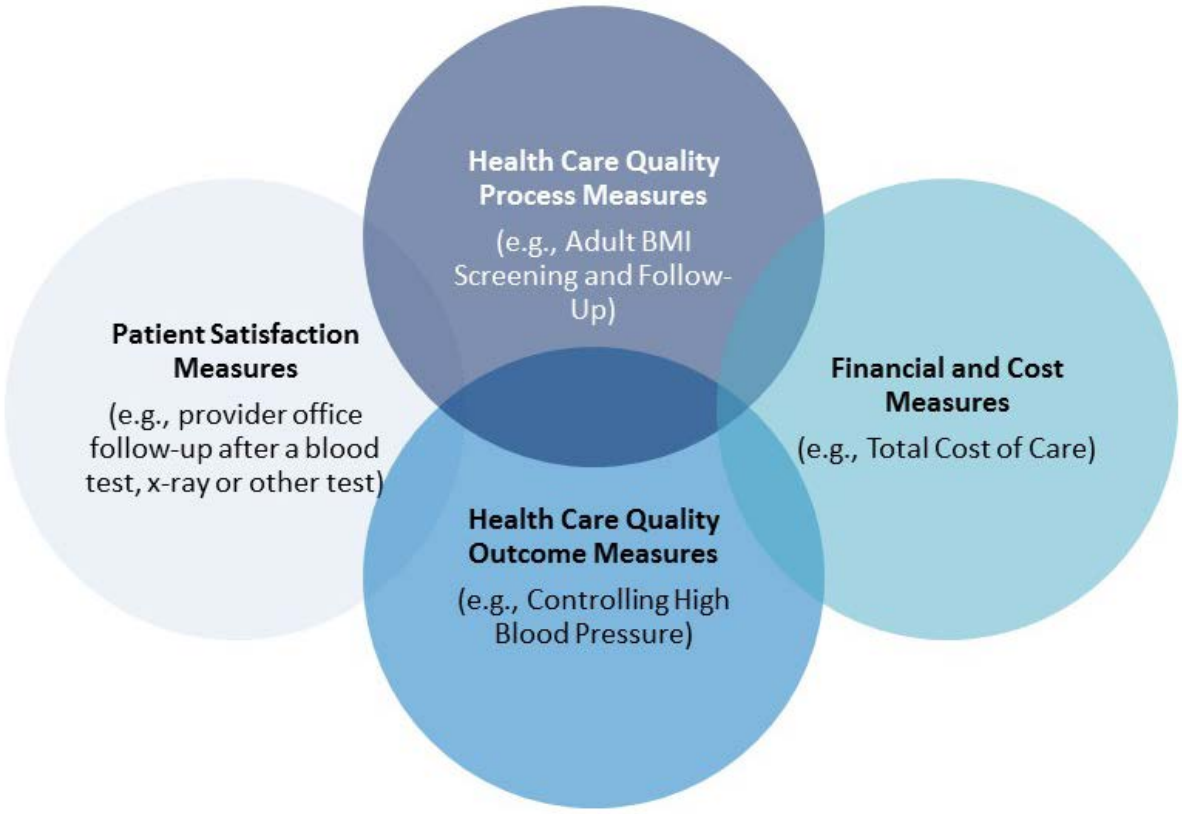
- Convening work groups of interested stakeholders, including representatives of providers, consumers and payers;
- Establishing measure criteria with stakeholders;
- Identifying potential measures with stakeholders, with a particular focus on measures that are endorsed and part of other measure sets (e.g., NQF endorsed, CMMI Core Measure Set, Meaningful Use measures, HEDIS® or CAHPS® measures, measure sets in place for other state or national initiatives);
- Comparing potential measures with other measure sets;
- Evaluating potential measures against established criteria with stakeholders;
- Identifying data sources for each measure;
- Determining how each measure will be used (e.g., for payment vs. reporting vs. monitoring/evaluation) with stakeholders;
- Determining reporting requirements and frequency with stakeholders;
- Finalizing the measure set with stakeholders;
- Determining benchmarks (if available) and performance targets with stakeholders;
- Revisiting the measure set on a regularly-scheduled basis with stakeholders; and
- Seeking feedback and guidance on proposed measure sets from CMMI's evaluation contractor and with Vermont's independent evaluation contractor, as appropriate.

The measure set for SSP Program Year 1 (CY 2014) was developed by the Quality and Performance Measures Work Group in 2013 and approved by the SIM Steering Committee and Core Team; it is annually revisited to identify changes needed due to changes to national

measure sets or specifications, programmatic lessons learned, or other factors. Additionally, Vermont's SIM project has partnered with the Blueprint for Health (which falls under the SIM Pay-for-Performance work stream) to support revisions to the Blueprint measure set and support alignment across programs; engaged with Vermont's Agency of Human Services and providers of mental health, substance abuse, and developmental services to align and consolidate measurement activities; and worked with pilot programs, including the SIM-supported Provider Sub-Grant Program, to support measure development and alignment.

These measure sets encompass metrics in the four recommended domains: health care quality process measures, patient satisfaction measures, financial and cost measures, and health care quality outcomes measures (identified measurable evidence-based quality metrics that address care delivery, health outcomes and patient experience). The following graphic shows the four types of measures and examples of each.

*Figure 6: Performance Measurement Domains*




Vermont's payment and delivery system measure sets are used for a variety of purposes, including:

- Model evaluation (e.g., using measures related to cost, utilization, health outcomes or experience of care to evaluate whether payment and delivery system reform models are reducing growth in health care costs, improving health, and improving care);
- Payment reform (e.g., using results of measures on adolescent well care visits, chlamydia screening in women, avoidance of antibiotic treatment for adults with acute bronchitis, initiation and engagement of alcohol and other drug treatment, developmental screening, and follow-up after hospitalization for mental illness to determine whether ACOs qualify for shared savings);
- Reporting (e.g., using ACO-level quality measures, such as tobacco use assessment and cessation intervention, eye exams for diabetics, ambulatory care sensitive admissions, screening for depression, and adult weight screening and follow-up to assess ACO impact);
- Monitoring (e.g., using health plan or statewide quality indicators and ACO-level utilization indicators to monitor how the system and ACOs are performing);
- Quality improvement (e.g., in Vermont's asthma learning collaborative, using practice-level results on measures related to "assessment of severity," "assessment of control" and "asthma action plans completed" to design interventions to improve asthma care); and
- Provision of clinical information to participating providers to improve patient care and drive delivery system transformation (e.g., using practice-level information from the Blueprint for Health clinical registry or reports on key hospital quality indicators from ACOs to identify patients in need of evidence-based services or to change hospital processes).

### *High-Level Goals*

In Quarter 4 of 2015, and at CMMI's request, Vermont identified and elaborated on the four high-level goals we proposed to achieve prior by the end of Vermont's SIM Model Testing period. The goal statements, tables identifying assigned metrics, and a narrative description of the State's progress towards the goal are found below. Vermont works to achieve these goals through our various focus areas and performance period milestones. Vermont will review our progress towards these goals as part of our State-Led evaluation activities.

The tables below show the weighted average across ACOs for each of Vermont's SSPs-Medicare, Medicaid, and commercial. Individual ACO performance is provided in the graphs below the tables. These graphs show performance against available benchmarks. Acronyms used to denote Vermont's three ACOs in these charts and graphs are: HF = Health*first*; OCV = OneCare Vermont; and CHAC = Community Health Accountable Care. Targets, where relevant, are shown using a thick, vertical, black line. Vermont's State-Led Evaluation Team continues to analyze these data and the information provided in here may be updated based on this subsequent analysis.

1. 80% of Vermonters will be in alternatives to fee-for-service (FFS), from 41% in 2013 to 80% in 2017.
2. By 12/31/2016, in adult Vermont residents attributed to an ACO, the % with diabetes HbA1c Poor Control will be 20% or less, 70% or more with an abnormal BMI will have a follow-up plan documented, and 85% or more identified as tobacco users will receive a cessation intervention.
3. The number of Vermont Health Information Exchange interfaces will increase from 130 to at least 400 by 6/30/17.
4. Cost avoidance of $45 million generated through payment models.

*Table 8: Vermont SIM High-Level Goal Statement Metrics*

| Goal | Metrics | Reference | Level of Analysis | Reported | Source |
|---|---|---|---|---|---|
| 1 | 80% of Vermonters in alternatives to FFS | | Statewide | Q1 2016 | Payers reporting |
| 2 | Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent) | MSSP-27 NQF #0024 | Across 3 SSPs | SSPs 2014 | Sample of Medical Records |
| | Body Mass Index (BMI) Screening and Follow-up | MSSP 16 NQF #0421 | Across 3 SSPs | SSPs 2014 | Sample of Medical Records |
| | Tobacco Use Assessment and Tobacco Cessation Intervention | MSSP-17 NQF #0028 | Across 3 SSPs | SSPs 2014 | Sample of Medical Records |
| 3 | VHIE Interfaces | | Statewide | Q4 2015 | VITL |
| 4 | Cost avoidance of $45 million generated through payment models | | • Shared Savings ACOs<br>• Expanded P4P in Blueprint<br>• All-Payer Model<br>• Medicaid VBP | Report in Q4 2017 | TBD |

*VHCIP High-Level Goal Metric Results to Date*[8]

**Goal 1: 80% of Vermonters will be in alternatives to fee-for-service (FFS), from 41% in 2013 to 80% in 2017.**

[8] Sources for High-level Goal Clinical Metric Results:
1) Commercial SSP Results and Benchmarks: http://gmcboard.vermont.gov/sites/gmcboard/files/PaymentReforp/Commercial-SSP-Year1-Quality-Results-2015-10-05%20FINAL.xls
2) Medicaid SSP Results and Benchmarks: http://gmcboard.vermont.gov/sites/gmcboard/files/PaymentReforp/Medicaid-SSP-Year1%20Quality-Results-2015-10-05%20FINAL.xls
3) Medicare SSP YR 1 Results: https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/yuq5-65xt
4)

*Table 9:*

| | Beneficiaries Impacted by Payment Models | | | |
|---|---|---|---|---|
| | **Baseline** | **Q1 2016 Actual** | **Performance Goal** | **% of Goal** |
| **Commercial SSP** | | 43,922 | 63,658 | 69% |
| **Medicaid SSP** | | 77,907 | 101,000 | 77% |
| **Medicare SSP** | | 69,955 | 111,000 | 63% |
| **Commercial P4P** | | 128,629 | 341,000 | 38% |
| **Medicaid P4P** | | 108,654 | 133,000 | 82% |
| **Medicare P4P** | 80,538 | 70,617 | 111,000 | 64% |
| **Unduplicated Total** | 238,931 | 318,575 | 573,360 | 56% |

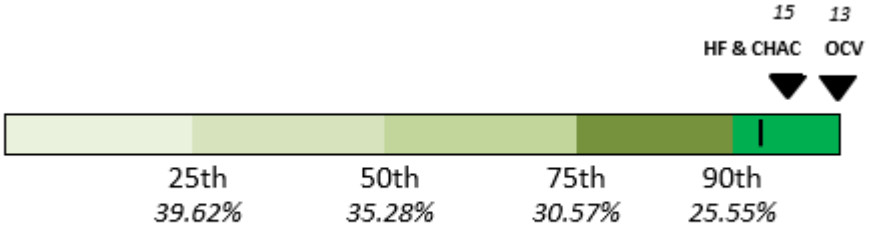
**Goal 2: By 12/31/2016, in adult Vermont residents attributed to an ACO, the % with diabetes HbA1c Poor Control will be 20% or less, 70% or more with an abnormal BMI will have a follow-up plan documented, and 85% or more identified as tobacco users will receive a cessation intervention.**

*Table 10:*

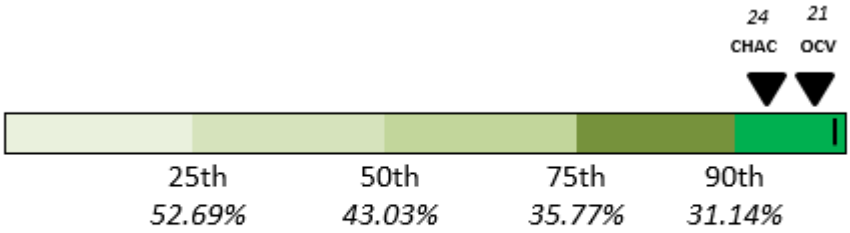
| **Diabetes Hemoglobin A1c Poor Control (>9 percent)[9]** | | | | |
|---|---|---|---|---|
| | **Baseline** | **SSPs 2014** | **SIM Goal** | **% of Goal** |
| **Vermont Commercial SSP** (weighted across ACOs by attributed lives) | | 14.62 | 20 | 137% |
| **Vermont Medicaid SSP** (weighted across ACOs by attributed lives) | | 22.34 | 20 | 89% |
| **CMS Medicare SSP** (weighted across ACOs by attributed lives) | 24.06 | 14.18 | 20 | 141% |
| **All SSPs** (weighted by # of attributed lives from each program) | | 17.32 | 20 | 115% |

[9] A lower number demonstrates better performance for this measures.

*Diabetes HbA1c Poor Control: Year 1 (2014) Commercial ACO Performance Against 2013 Commercial Benchmarks*




*Diabetes HbA1c Poor Control: Year 1 (2014) Medicaid ACO Performance Against 2012 Medicaid Benchmarks*




*Diabetes HbA1c Poor Control: 2014 Medicare ACO Performance Against 2014 MSSP Benchmarks*

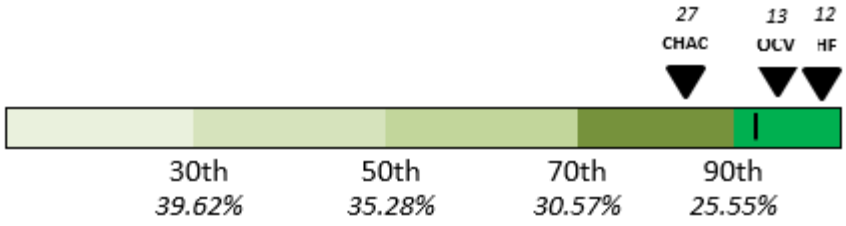


*Table 11:*

| Body Mass Index (BMI) Screening and Follow-Up[10] | | | | |
|---|---|---|---|---|
| | **Baseline** | **SSPs 2014** | **SIM Goal** | **% of Goal** |
| **VT Commercial SSP** (weighted across ACOs by attributed lives) | | 60.7% | 70% | 87% |
| **VT Medicaid SSP** (weighted across ACOs by attributed lives) | | 57.92% | 70% | 83% |
| **CMS Medicare SSP** (weighted across ACOs by attributed lives) | 66.9% | 69.08% | 70% | 99% |
| **All SSPs** (weighted by # of attributed lives from each program) | | 62.98% | 70% | 90% |

*BMI Screening and Follow-Up: Year 2 Medicare ACO Performance Against 2014 MSSP Benchmarks*

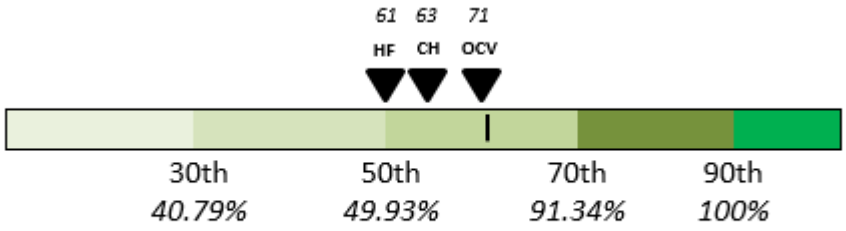
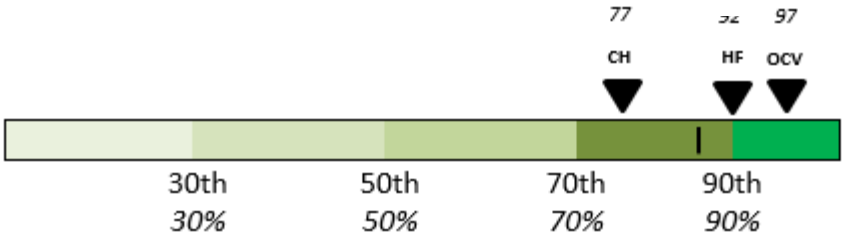



*Table 12:*

| Tobacco Use: Screening and Cessation Intervention | | | | |
|---|---|---|---|---|
| | **Baseline** | **SSPs 2014** | **SIM Goal** | **% of Goal** |
| **Commercial SSP** (weighted across ACOs by attributed lives) | | NA | 85% | NA |
| **Medicaid SSP** (weighted across ACOs by attributed lives) | | NA | 85% | NA |
| **Medicare SSP** (weighted across ACOs by attributed lives) | 87.68% | 94.49% | 85% | 111% |
| **All SSPs** (weighted by # of attributed lives from each program) | | NA | 85% | NA |

[10] There are no Medicaid and commercial benchmarks for this measure.

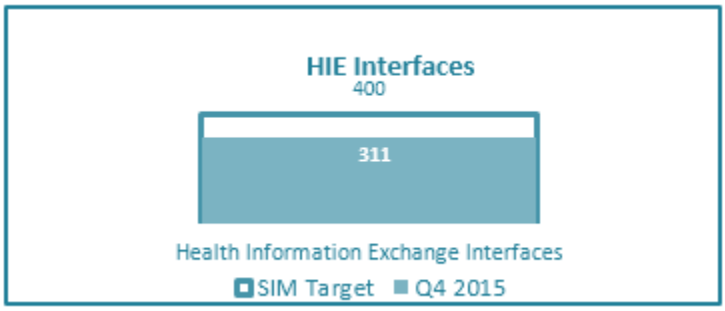
*Tobacco Use - Screening and Cessation Intervention: 2014 Medicare ACO Performance Against 2014 MSSP Benchmarks*




**Goal 3: The number of Vermont Health Information Exchange interfaces will increase from 130 to at least 400 by 6/30/17.**

*Table 13:*

| HIE Interfaces | | | | |
|---|---|---|---|---|
| | **Baseline** | **Q4 2015** | **SIM Goal** | **% of Goal** |
| **Interfaces** | 130 | 311 | 400 | 78% |




**Goal 4: Cost avoidance of $45 million generated through payment models.**

At the conclusion of Vermont's SIM testing period, project-wide cost avoidance will be calculated, taking into account costs avoided as a result of the implementation of a variety of value-based payment models. Aggregate savings will be calculated as the difference between a financial forecast projection (using a trend for what costs would be without SIM investments for attributed populations) and actuals for attributed populations over the 3-year evaluation period, and subtracting $45 million. Savings will be compared to the grant amount of $45 million to calculate an overall return on investment (ROI) for the initiatives. The approaches for measuring cost avoidance due to individual programs may vary by program, depending on the construction of the unique payment models and final implementation status. The following models will be included:

- Shared Savings ACOs
- Expanded Pay-for-Performance in Blueprint

- Episode-based Payment
- All-Payer Model
- Medicaid VBP

Vermont will engage the services of external vendor to assist in calculating and reporting cost avoidance in SIM final reporting in 2017. Cost avoidance methodology will be finalized per CMMI SIM final reporting guidelines and requirements.

## Section J: Staff/Contractor Recruitment and Training

This section of the Operational Plan provides detailed information on Vermont's Performance Period 3 milestones, the planned activities that support those milestones, and the contractor and staff resources needed to accomplish them. The State relies on a mix of staff and contractors to implement and evaluate the success of initiatives planned during the testing period supporting Vermont's SIM Project.

State staff involved in Vermont's SIM activities work in three state agencies: the Agency of Administration (AOA), the Green Mountain Care Board (GMCB), and the Agency of Human Services (AHS). AHS staff from three departments participate: DVHA, the Department of Health (VDH), and the Department of Disabilities, Aging, and Independent Living (DAIL). In a matrixed staffing approach, the SIM staff work under the general direction of the SIM Project Director, who works within the AOA.

*Figure 7* below is a project-wide organizational chart showing SIM-funded staff and non-SIM funded key personnel.

*Figure 8* below shows Vermont's program management structure.

*Figure 9* below depicts the flow of funds across the State of Vermont Agencies and Departments participating in the SIM project.

Figure 7: Vermont SIM Project Organizational Chart

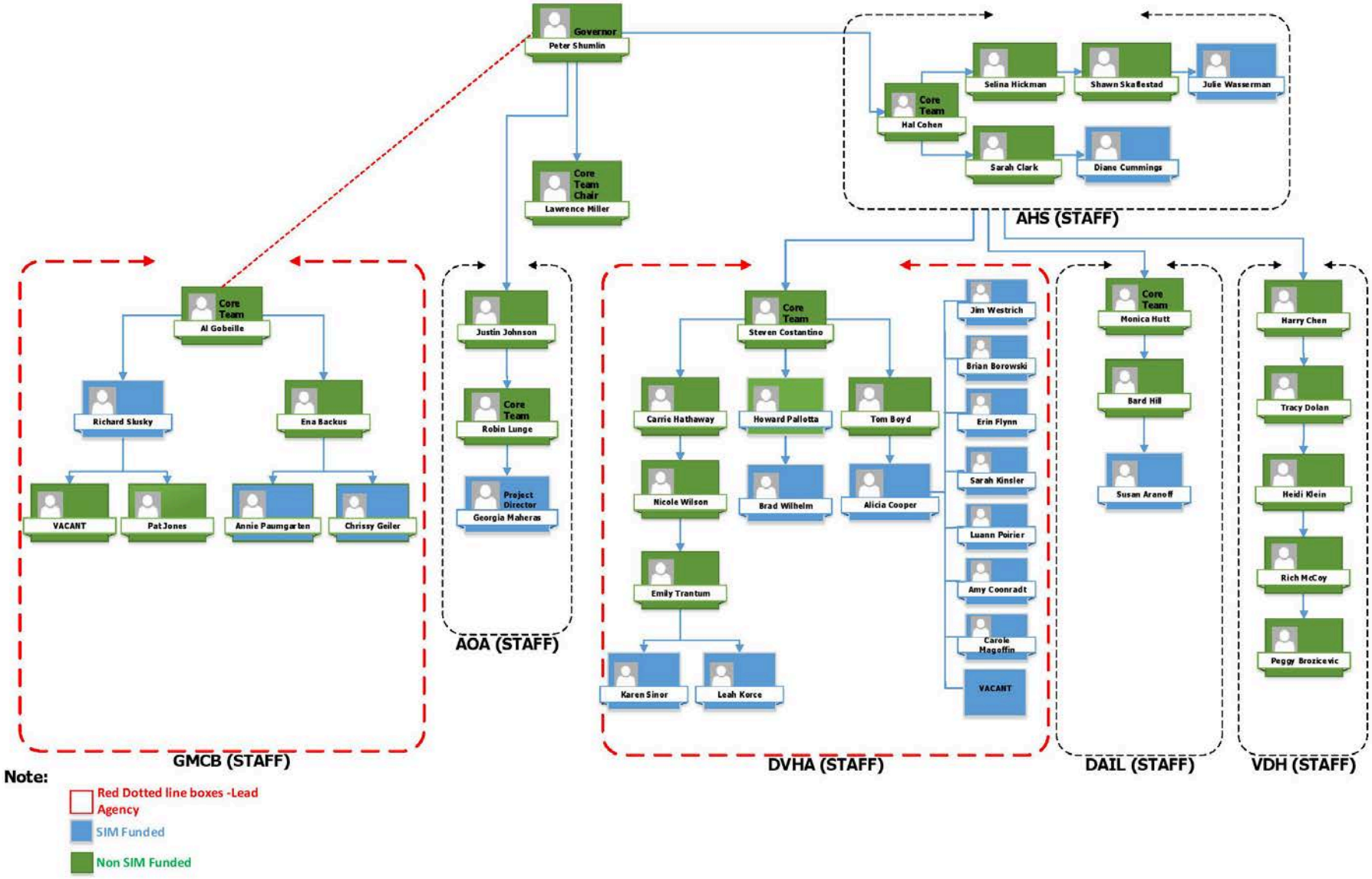


*Figure 8: Vermont SIM Project Program Management Structure*

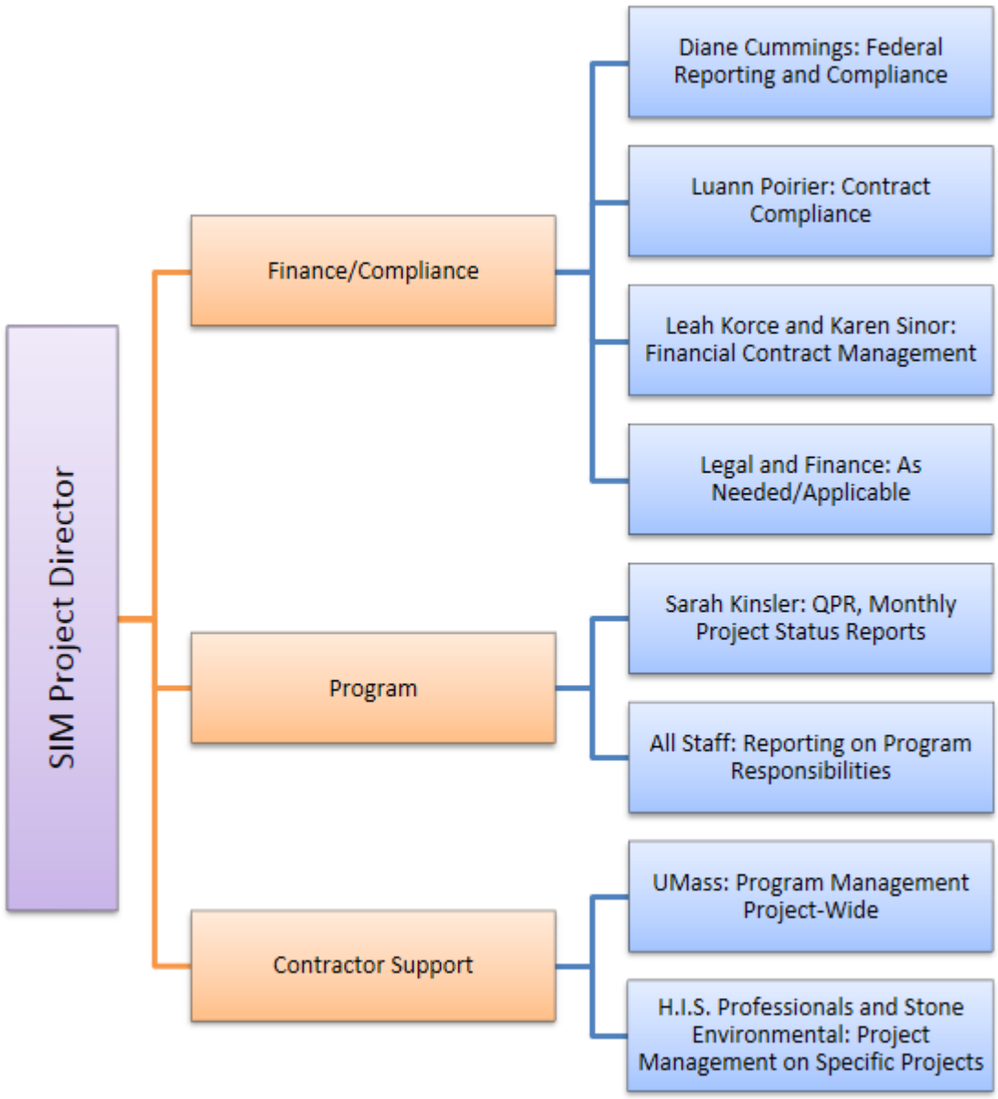
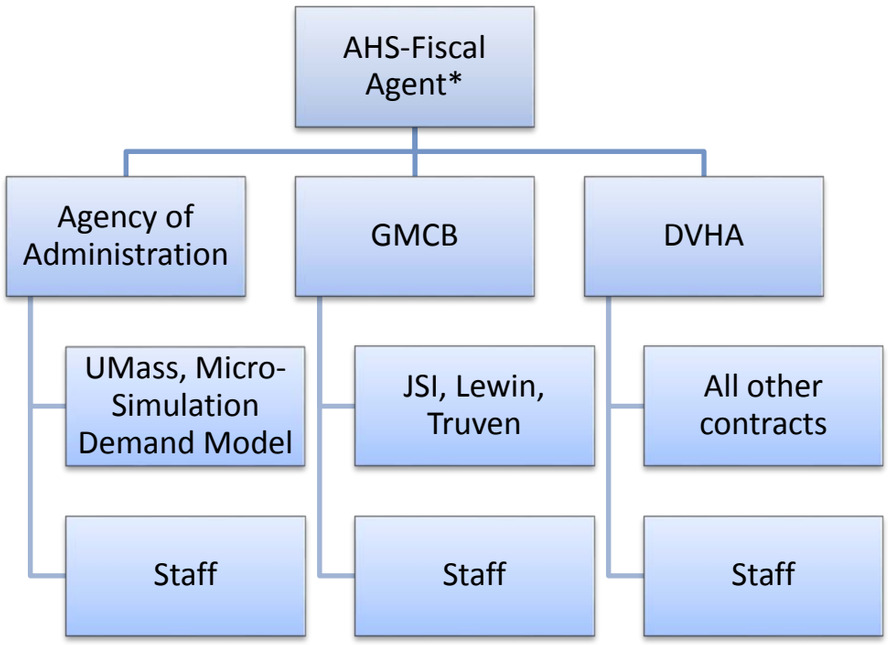


*Figure 9: Flow of SIM Funds between State of Vermont Agencies and Departments*




*AHS enters into Memoranda of Understanding with the other agencies/departments for staff and/or contracts.

*Table 13* below augments *Table 1, Performance Period 3 Milestone Summary*, found in the Executive Summary. Vermont's Performance Period 3 Budget Narrative includes additional detail about personnel and contractors. When reviewing the table, please note there are several State of Vermont Key Personnel and Staff who support all of Vermont's Performance Period 3 milestones:

- Lawrence Miller: Chief of Health Care Reform, Chair, Core Team;
- Robin Lunge: Director of Health Care Reform, Member, Core Team;
- Al Gobeille: Chair, Green Mountain Care Board, Member, Core Team;
- Steven Costantino, Commissioner, Department of Vermont Health Access, Member, Core Team;
- Hal Cohen, Secretary, Agency of Human Services, Member, Core Team;
- Monica Hutt, Commissioner, Department of Disabilities, Aging, and Independent Living, Member, Core Team;
- Georgia Maheras, Deputy Director for Health Care Reform, Project Director;
- Richard Slusky, Director of Payment and Delivery System Reform, Green Mountain Care Board, Lead – GMCB; and
- Alicia Cooper, Health Care Project Director, Department of Vermont Health Access, Lead – DVHA.

*Table 13: CMMI-Required Milestones and Accountability Metrics with Contractor, Line Item, and Staff Detail*

| **CMMI-Required Milestones** | | | | |
|---|---|---|---|---|
| *Milestones* | *Specific Tasks and Supporting Contractors* | *Line Item and Contractor* | *Staff* | *Accountability Metrics (Performance Period 3, reported in Quarterly Reports)* |
| **Project Implementation**<br>Continue to implement project statewide. Implement all Performance Period 3 Milestones by 6/30/17. | | All. | All SIM-funded staff | All metrics |
| **Payment Models**<br>80% of Vermonters in alternatives to fee-for-service by 6/30/17. | Research, alignment and design of payment models: *Burns and Associates; Bailit Health Purchasing* (Medicaid). | Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers – *Bailit Health Purchasing; Burns and Associates.* | All SIM-funded staff | CORE_Beneficiaries impacted_[VT]_VTEmployees<br>CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial<br>CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid<br>CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare<br>CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Commercial<br>CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicaid<br>CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicare |
| **Population Health Plan**<br>Finalize Population Health Plan by 6/30/17. | Research and writing population health plan: James Hester; Vermont Public Health Association. | Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers –*James Hester; Vermont Public Health Association.* | SIM-funded staff: Georgia Maheras; Sarah Kinsler<br><br>Key personnel: Tracy Dolan; Heidi Klein | Not reported on quarterly basis, but required reporting element by end of project. |
| **Sustainability Plan**<br>Finalize Sustainability Plan by 6/30/17. | Development of sustainability plan: TBD. | Advanced Analytics: Policy and Data Analysis to Support System Design and | All SIM-funded staff<br><br>All SIM key personnel | Not reported on quarterly basis, but required reporting element by end of project. |

| | | | | |
|---|---|---|---|---|
| | | Research for All Payers –TBD. | | |

| **Payment Model Design and Implementation** | | | | |
|---|---|---|---|---|
| *Milestone* | *Specific Tasks and Supporting Contractors* | *Line Item and Contractor* | *Staff* | *Accountability Metrics (Performance Period 3, reported in Quarterly Reports)* |
| **ACO Shared Savings Programs (SSPs)**<br>Expand the number of people in the Shared Savings Programs in Performance Period 3 by 12/31/16:<br>Medicaid/commercial program provider participation target: 960. (Baseline as of December 2015: 940)<br>Medicaid/commercial program beneficiary attribution target: 140,000. (Baseline as of December 2015: 179,076). | Facilitation: *Bailit Health Purchasing*; Medicaid: *Burns and Associates*; Analytics: *The Lewin Group*; DLTSS/Medicaid: *Pacific Health Policy Group*; DLTSS: *Deborah Lisi-Baker*; Actuarial: *Wakely Consulting*.<br><br>ACO Implementation: *Bi-State Primary Care Association/CHAC*; *UVMMC/OneCare Vermont*. | 1. Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers – *Bailit Health Purchasing*; *Burns and Associates*; *The Lewin Group*; *Pacific Health Policy Group*; *Deborah Lisi-Baker*; *Wakely Consulting*; *Bi-State Primary Care Association/CHAC*; *UVMMC/OneCare Vermont*. | SIM-funded staff: Amy Coonradt; Julie Wasserman; Erin Flynn; Susan Aranoff; James Westrich; Brian Borowski; Carole Magoffin.<br><br>Key personnel: Pat Jones. | CORE_Beneficiaries impacted_[VT]_VTEmployees<br>CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial<br>CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid<br>CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare<br>CORE_Participating Provider_[VT]_[ACO]_Commercial<br>CORE_Participating Provider_[VT]_[ACO]_Medicaid<br>CORE_Participating Provider_[VT]_[ACO]_Medicare<br>CORE_Provider Organizations_[VT]_[ACO]_Commercial<br>CORE_Provider Organizations_[VT]_[ACO]_Medicaid<br>CORE_Provider Organizations_[VT]_[ACO]_Medicare<br>CORE_Payer Participation_[VT]<br>CORE_BMI_[VT]<br>CORE_Diabetes Care_[VT]<br>CORE_ED Visits_[VT]<br>CORE_Readmissions_[VT]<br>CORE_Tobacco Screening and Cessation_[VT]<br>CAHPS Clinical & Group Surveys |
| **Episodes of Care (EOCs):** *Activity discontinued; decision made in collaboration with CMMI in April 2016.* | | | | |
| **Pay-for-Performance (Blueprint)**<br>1. Expand the number of providers and beneficiaries participating in the Blueprint for Health by 6/30/17:<br>Medicaid/ commercial/ Medicare providers participating in P4P program target: 715. (Baseline as of December 2015: 706)<br>Medicaid/ commercial/ Medicare beneficiaries participating in P4P program target: 310,000. (Baseline as of December *2015:* 309,713)<br>2. P4P incorporated into Sustainability Plan by 6/30/17. | 1. Financial standards: Non-SIM funded.<br>2. Care standards: Non-SIM funded.<br>3. Quality measures: Non-SIM funded.<br>4. Analyses for design and implementation: Non-SIM funded.<br>5. Stakeholder engagement: Medicaid and commercial: Non-SIM funded. | N/A | Key personnel: Craig Jones; Jenney Samuelson | CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Commercial<br>CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicaid<br>CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicare<br>CORE_Participating Providers_[VT]_[APMH]<br>CORE_Provider Organizations_[VT]_[APMH]<br>CORE_Payer Participation_[VT] |
| **Health Home (Hub & Spoke)** | 1. Financial standards: non-SIM funded. | N/A | Key personnel: Beth Tanzman | CORE_Provider Organizations_[VT]_[HH]<br>CORE_Participating Providers_[VT]_[HH] |

| | | | | |
|---|---|---|---|---|
| 1. Expand the number of providers and beneficiaries participating in the Health Home program by 6/30/17:<br>Number of providers participating in Health Home program target: 75 MDs each prescribing to >= 10 patients. (Baseline as of December 2015: 72)<br>Number of beneficiaries participating in Health Home program target: 2,900 Hub + 2,300 Spoke = 5,200 total patients. (Baseline as of December 2015: 5,179)<br>2. Health Home program incorporated into Sustainability Plan by 6/30/17. | 2. Care standards: non-SIM funded.<br>3. Quality measures: non-SIM funded.<br>4. Analyses for design and implementation: non-SIM funded.<br>5. Stakeholder engagement: non-SIM funded. | | | |
| **Accountable Communities for Health**<br>1. Continue implementation of ACH learning system (ACH Peer Learning Laboratory) to 10 participating communities.<br>2. Develop ACH Implementation Plan based on lessons learned from ACH Peer Learning Laboratory by 6/30/17.<br>3. ACH Implementation Plan incorporated into Sustainability Plan by 6/30/17. | Implement ACH Learning Systems: *James Hester; Public Health Institute*. | Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers – *James Hester; Public Health Institute*. | SIM-funded staff: Sarah Kinsler<br><br>Key personnel: Tracy Dolan; Heidi Klein | CORE_Provider Organizations_[VT]_[ACO]_Commercial<br>CORE_Provider Organizations_[VT]_[ACO]_Medicaid<br>CORE_Provider Organizations_[VT]_[ACO]_Medicare<br>CORE Participating Providers_[VT]_[ACO]_Commercial<br>CORE Participating Providers_[VT]_[ACO]_Medicaid<br>CORE Participating Providers_[VT]_[ACO]_Medicare<br>CORE_Payer Participation_[VT] |
| **Prospective Payment System – Home Health:** *Activity discontinued; decision made in collaboration with CMMI in April 2016.* | | | | |
| **Medicaid Value-Based Purchasing (Medicaid Pathway)**<br>1. Mental Health and Substance Abuse: Based on research and feasibility analysis, design an alternative to fee-for-service, for Medicaid mental health and substance use services by 12/31/16. Develop implementation timeline based on payment model design and operational readiness by 12/31/16.<br>2. Other Medicaid VBP Activities: Engage in research and feasibility analysis to support additional Medicaid Value-Based Purchasing activities. | 1. Feasibility, design, and implementation analyses: *Deborah Lisi-Baker; Burns and Associates; Pacific Health Policy Group*. | Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers – *Deborah Lisi-Baker; Burns and Associates; Pacific Health Policy Group*. | SIM-funded staff: Georgia Maheras<br><br>Key personnel: Selina Hickman; Nick Nichols; Barbara Cimaglio; Aaron French; Susan Bartlett; Melissa Bailey | CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid<br>CORE_Participating Provider_[VT]_[ACO]_Medicaid<br>CORE_Provider Organizations_[VT]_[ACO]_Medicaid |

| | | | | |
|---|---|---|---|---|
| **All-Payer Model**<br>1. If negotiations are successful, assist with implementation as provided for in APM agreement through end of SIM grant.<br>2. Contribute to analytics related to all-payer model implementation design through end of SIM grant.<br>3. All-Payer Model incorporated into Sustainability Plan by 6/30/17. | Research and analyses: *TBD*. | Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers – *TBD*. | SIM-funded staff: Michael Costa; Ena Backus<br><br>Key personnel: Susan Barrett | CORE_Provider Organizations_[VT]_[ACO]_Commercial<br>CORE_Provider Organizations_[VT]_[ACO]_Medicaid<br>CORE_Provider Organizations_[VT]_[ACO]_Medicare<br>CORE Participating Providers_[VT]_[ACO]_Commercial<br>CORE Participating Providers_[VT]_[ACO]_Medicaid<br>CORE Participating Providers_[VT]_[ACO]_Medicare<br>CORE_Payer Participation_[VT] |
| **State Activities to Support Model Design and Implementation – Medicaid**<br>Pursue state plan amendments and other federal approvals as appropriate for each payment model; ensure monitoring and compliance activities are performed:<br>1. Obtain SPA for Year 3 of the Medicaid Shared Savings Program by 12/31/16.<br>2. Execute Year 3 commercial and Medicaid monitoring and compliance plans according to the predetermined plan through 6/30/17. | Data Analyses: *Burns and Associates*; Waiver Analysis/Medicaid Analysis: *Pacific Health Policy Group*; Customer Service Support: *Maximus*; Data Analysis: *Policy Integrity, Opiate Alliance, Kim Friedman*; Actuarial Services: *Wakely Consulting;* Stakeholder Engagement: *Deborah Lisi-Baker, Vermont Care Network (BHN)*. | Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers – *Burns and Associates*; *Pacific Health Policy Group*; *Maximus*; *Deborah Lisi-Baker; Opiate Alliance; Kim Friedman; Policy Integrity*; *Wakely Consulting*.<br><br>Technical Assistance: Learning Collaboratives: *Vermont Care Network (BHN)*. | SIM-funded staff: Brad Wilhelm; Amy Coonradt; Luann Poirier; Susan Aranoff<br><br>Key personnel: Pat Jones; Bard Hill | CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid<br>CORE_Participating Provider_[VT]_[ACO]_Medicaid<br>CORE_Provider Organizations_[VT]_[ACO]_Medicaid |

| **Practice Transformation** | | | | |
|---|---|---|---|---|
| *Milestone* | *Specific Tasks and Supporting Contractors* | *Line Item and Contractor* | *Staff* | *Accountability Metrics (Performance Period 3, reported in Quarterly Reports)* |
| **Learning Collaboratives**<br>1. Target: 400 Vermont providers have participated in Learning Collaborative activities (including Integrated Communities Care Management Learning Collaborative or Core Competency Trainings) by 12/31/16. (*Baseline as of December 2015:* 200)<br>2. Report on program effectiveness to Steering Committee and Core Team by 12/31/16.<br>3. Incorporate Learning Collaborative lessons learned into Sustainability Plan by 6/30/17. | 1. Quality Improvement Facilitation: *Nancy Abernathey*; *Vermont Program for Quality Health Care (VPQHC)*.<br>2. Disability Core Competency: *Deborah Lisi-Baker; Vermont Developmental Disabilities Council*.<br>3. Care Management Core Competency: *Primary Care Development Corporation*. | Technical Assistance: Learning Collaboratives: *Nancy Abernathey*; *Vermont Program for Quality Health Care (VPQHC)*; *Vermont Developmental Disabilities Council; Primary Care Development Corporation*.<br><br>Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers: *Deborah Lisi-Baker.* | SIM-funded staff: Erin Flynn; Julie Wasserman<br><br>Key personnel: Jenney Samuelson | CORE_Participating Provider_[VT]_[ACO]_Commercial<br>CORE_Participating Provider_[VT]_[ACO]_Medicaid<br>CORE_Participating Provider_[VT]_[ACO]_Medicare<br>CORE_Provider Organizations_[VT]_[ACO]_Commercial<br>CORE_Provider Organizations_[VT]_[ACO]_Medicaid<br>CORE_Provider Organizations_[VT]_[ACO]_Medicare<br><br>CORE_Participating Providers_[VT]_[APMH]<br>CORE_Provider Organizations_[VT]_[APMH] |
| **Sub-Grant Program – Sub-Grants**<br>1. Provide SIM funds to support sub-grantees through 12/31/16.<br>2. Convene sub-grantees at least twice by 12/31/16.<br>3. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.<br>4. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17. | Sub-Grantees | Sub-Grantees | SIM-funded staff: Sue Aranoff; Julie Wasserman; Amy Coonradt<br><br>Key personnel: Joelle Judge; Heidi Klein | CORE_Participating Provider_[VT]_[ACO]_Commercial<br>CORE_Participating Provider_[VT]_[ACO]_Medicaid<br>CORE_Participating Provider_[VT]_[ACO]_Medicare<br>CORE_Provider Organizations_[VT]_[ACO]_Commercial<br>CORE_Provider Organizations_[VT]_[ACO]_Medicaid<br>CORE_Provider Organizations_[VT]_[ACO]_Medicare<br>CORE_Participating Providers_[VT]_[APMH]<br>CORE_Provider Organizations_[VT]_[APMH] |
| **Sub-Grant Program – Technical Assistance**<br>Provide technical assistance to sub-grantees as requested by sub-grantees through 12/31/16:<br>1. Remind sub-grantees of availability of technical assistance on a monthly basis.<br>2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees. | Sub-Grantee technical assistance: *Policy Integrity*. | Technical Assistance: Technical Assistance to Providers Implementing Payment Reform – *Policy Integrity.* | SIM-funded staff: Sue Aranoff; Julie Wasserman; Amy Coonradt<br><br>Key personnel: Joelle Judge; Heidi Klein | CORE_Participating Provider_[VT]_[ACO]_Commercial<br>CORE_Participating Provider_[VT]_[ACO]_Medicaid<br>CORE_Participating Provider_[VT]_[ACO]_Medicare<br>CORE_Provider Organizations_[VT]_[ACO]_Commercial<br>CORE_Provider Organizations_[VT]_[ACO]_Medicaid<br>CORE_Provider Organizations_[VT]_[ACO]_Medicare<br>CORE_Participating Providers_[VT]_[APMH]<br>CORE_Provider Organizations_[VT]_[APMH] |

| | | | | |
|---|---|---|---|---|
| 3. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17. | | | | |
| **Regional Collaborations**<br>1. Support regional collaborations in 14 HSAs by providing sub-grants to ACOs and other technical assistance resources.<br>2. Develop a transition plan by 4/30/17 to shift all HSAs to non-SIM resources. | ACO Activities: *Bi-State Primary Care Association/CHAC; UVMMC/OneCare Vermont*. | Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers – *Bi-State Primary Care Association/CHAC; UVMMC/OneCare Vermont*. | SIM-funded staff: Erin Flynn; Amy Coonradt<br><br>Key personnel: Pat Jones; Jenney Samuelson | CORE_Participating Provider_[VT]_[ACO]_Commercial<br>CORE_Participating Provider_[VT]_[ACO]_Medicaid<br>CORE_Participating Provider_[VT]_[ACO]_Medicare<br>CORE_Provider Organizations_[VT]_[ACO]_Commercial<br>CORE_Provider Organizations_[VT]_[ACO]_Medicaid<br>CORE_Provider Organizations_[VT]_[ACO]_Medicare<br>CORE_Participating Providers_[VT]_[APMH]<br>CORE_Provider Organizations_[VT]_[APMH] |
| **Workforce – Demand Data Collection and Analysis**<br>Submit Final Demand Projections Report and present findings to Workforce Work Group by 12/31/16. | Micro-simulation demand modeling: *IHSGlobal.* | Workforce Assessment: System-Wide Capacity – *IHSGlobal*. | SIM-funded staff: Amy Coonradt<br><br>Key personnel: Mat Barewicz | CORE_Participating Provider_[VT]_[ACO]_Commercial<br>CORE_Participating Provider_[VT]_[ACO]_Medicaid<br>CORE_Participating Provider_[VT]_[ACO]_Medicare<br>CORE_Provider Organizations_[VT]_[ACO]_Commercial<br>CORE_Provider Organizations_[VT]_[ACO]_Medicaid<br>CORE_Provider Organizations_[VT]_[ACO]_Medicare<br>CORE_Participating Providers_[VT]_[APMH]<br>CORE_Provider Organizations_[VT]_[APMH] |
| **Workforce – Supply Data Collection and Analysis**<br>Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan:<br>1. Present data to Workforce Work Group at least 3 times by 12/31/16.<br>2. Publish data reports/analyses on website by 6/30/17.<br>3. Distribute reports/analyses to project stakeholders by 6/30/17.<br>4. Incorporate into Sustainability Plan by 6/30/17. | *Staff Only.* | *Staff Only.* | SIM-funded staff: TBD; Amy Coonradt<br><br>Key personnel: VDH and OPR licensing staff | CORE_Participating Provider_[VT]_[ACO]_Commercial<br>CORE_Participating Provider_[VT]_[ACO]_Medicaid<br>CORE_Participating Provider_[VT]_[ACO]_Medicare<br>CORE_Provider Organizations_[VT]_[ACO]_Commercial<br>CORE_Provider Organizations_[VT]_[ACO]_Medicaid<br>CORE_Provider Organizations_[VT]_[ACO]_Medicare<br>CORE_Participating Providers_[VT]_[APMH]<br>CORE_Provider Organizations_[VT]_[APMH] |

| **Health Data Infrastructure** | | | | |
|---|---|---|---|---|
| *Milestone* | *Specific Tasks and Supporting Contractors* | *Line Item and Contractor* | *Staff* | *Accountability Metrics (Performance Period 3, reported in Quarterly Reports)* |
| **Expand Connectivity to HIE – Gap Remediation**<br>1. Remediate 65% of ACO SSP measures-related gaps as identified in Fall 2015/Spring 2016 by 6/30/17. (*Baseline as of December 2015:* 62%)<br>2. Remediate data gaps for LTSS providers according to remediation plan developed in Performance Period 2 by 6/30/17.<br>3. Incorporate Gap Remediation activities into Sustainability Plan by 6/30/17. | Remediation of Data Gaps: *VITL; Vermont Care Network(BHN); H.I.S.Professionals;UVMMC/OneCare Vermont.* | Technology and Infrastructure: Expanded Connectivity to the HIE Infrastructure -- *VITL; Vermont Care Network(BHN)*.<br><br>Technical Assistance: Practice Transformation & Data Quality Facilitation -- *Vermont Care Network(BHN); H.I.S. Professionals; UVMMC/OneCare Vermont*. | SIM-funded staff: Georgia Maheras; Susan Aranoff; Julie Wasserman<br><br>Key personnel: Larry Sandage; TBD. | CORE_Health Info Exchange_[VT] |
| **Improve Quality of Data Flowing into HIE**<br>Engage in workflow improvement activities at designated mental health agencies (DAs) as identified in gap analyses. Start workflow improvement activities in all 16 DAs by 7/1/16 and complete workflow improvement by 12/31/16. Report on improvement over baseline by 6/30/17. | Terminology Services: *VITL.*<br><br>Workflow Improvement: *VITL, Vermont Care Network(BHN); TBD.* | Technology and Infrastructure: Expanded Connectivity to the HIE Infrastructure– *VITL, Vermont Care Network (BHN); TBD.*<br><br>Technical Assistance: Practice Transformation and Data Quality Facilitation – *Vermont Care Network*. | Key personnel: Larry Sandage; TBD. | CORE_Health Info Exchange_[VT] |
| **Telehealth – Implementation**<br>1. Continue telehealth pilot implementation through contract end dates.<br>2. Incorporate Telehealth Program into Sustainability Plan by 6/30/17. | Telehealth Implementation: *VNA of Chittenden and Grand Isle Counties; Howard Center.* | Telehealth – *VNA of Chittenden and Grand Isle Counties; Howard Center.* | SIM-funded staff: Jim Westrich | CORE_Health Info Exchange_[VT] |
| **Data Warehousing**<br>1. Implement Phase 2 of DA/SSA data warehousing solution by 12/31/16.<br>2. Obtain approval of cohesive strategy for developing data systems to support analytics by 10/31/16. Operationalize the approved cohesive strategy for developing data systems to support analytics by 12/31/16. | Stakeholder Engagement: *Vermont Care Network (BHN)*; Cohesive Strategy Development: *Stone Environmental*. | Technology and Infrastructure: Enhancement to Centralized Clinical Registry & Reporting Systems – *Vermont Care Network (BHN); Stone Environmental.* | SIM-funded staff: Georgia Maheras<br><br>Key personnel: Craig Jones; Larry Sandage; TBD. | CORE_Health Info Exchange_[VT] |

| | | | | |
|---|---|---|---|---|
| **Care Management Tools**<br>1. Event Notification System: Continue implementation of ENS according to contract with vendor through 12/31/16.<br>2. Shared Care Plan: Recommend revisions to the VHIE consent policy and architecture to better support shared care planning by 6/30/17.<br>3. Universal Transfer Protocol: Support workflow improvements at provider practices through existing contracts through 12/31/16.<br>4. Continue implementation of care management solutions, including VITLAccess, supporting Home Health Agencies and Area Agencies on Aging. | Event Notification System: *PatientPing*.<br><br>Shared Care Plans and Universal Transfer Protocol – Research: *Stone Environmental*; Implementation: *TBD*. | 1. Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers – *Stone Environmental*. | SIM-funded staff: Georgia Maheras; Erin Flynn; Susan Aranoff<br><br>Key personnel: Larry Sandage; Joelle Judge; TBD | CORE_Health Info Exchange_[VT] |
| **General Health Data – HIE Planning**<br>Finalize connectivity targets for 2016-2019 by 12/31/16. Incorporate targets into Sustainability Plan by 6/30/17. | Support HIE Planning: *Stone Environmental*. | Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers – *Stone Environmental*. | Key personnel: Larry Sandage; TBD | CORE_Health Info Exchange_[VT] |
| **General Health Data – Expert Support**<br>Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments. | Research and analyses: *Stone Environmental*. | Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers – *Stone Environmental*. | Key personnel: Larry Sandage; TBD | CORE_Health Info Exchange_[VT] |

| **Evaluation** | | | | |
|---|---|---|---|---|
| *Milestone* | *Specific Tasks and Supporting Contractors* | *Line Item and Contractor* | *Staff* | *Accountability Metrics (Performance Period 3, reported in Quarterly Reports)* |
| **Self-Evaluation Plan and Execution**<br>Execute Self-Evaluation Plan for 2016 and 2017 according to timeline for Performance Period 3 activities. | Implementation of Self-Evaluation Plan (Monitoring and Evaluation): *The Lewin Group; Burns and Associates*; Implementation of Self-Evaluation Plan (Provider Surveys and Analyses): *JSI*. | Evaluation -- *JSI*.<br><br>Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers –*The Lewin Group; Burns and Associates.* | SIM-funded staff: Annie Paumgarten<br><br>Key personnel: Susan Barrett | All metrics |
| **Surveys**<br>Conduct annual patient experience survey and other surveys as identified in payment model development: Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings Programs by 6/30/17. | 1. Field patient experience survey: *Datastat*.<br>2. Develop survey report: *Datastat*. | Evaluation –*Datastat*. | SIM-funded staff: Annie Paumgarten<br><br>Key personnel: Pat Jones, Jenney Samuelson | CAHPS Clinical & Group Surveys_Commercial<br>CAHPS Clinical & Group Surveys_Medicaid<br>CAHPS Clinical & Group Surveys_Medicare<br>CORE_HCAHPS Patient Rating_[VT] |
| **Monitoring and Evaluation Activities Within Payment Programs**<br>1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications (bi-annual reporting to providers).<br>2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications (monthly, quarterly reports depending on report type).<br>3. TBD: APM, Medicaid VBP – Mental Health and Substance Use. | Financial and Quality Analysis for New Programs: *The Lewin Group* (SSP); *Burns and Associates* (Medicaid). | Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers –*The Lewin Group; Burns and Associates.* | SIM-funded staff: Amy Coonradt; James Westrich; Brian Borowski; Carole Magoffin<br><br>Key personnel: Pat Jones | CORE_BMI_[VT]_Commercial<br>CORE_BMI_[VT]_Medicaid<br>CORE_BMI_[VT]_Medicare<br>CORE_Diabetes Care_[VT]_Commercial<br>CORE_Diabetes Care_[VT]_Medicaid<br>CORE_Diabetes Care_[VT]_Medicare<br>CORE_ED Visits_[VT]_Commercial<br>CORE_ED Visits_[VT]_Medicaid<br>CORE_Readmissions_[VT]_Commercial<br>CORE_Readmissions_[VT]_Medicaid<br>CORE_Readmissions_[VT]_Medicare<br>CORE_Tobacco Screening and Cessation_[VT]_Commercial<br>CORE_Tobacco Screening and Cessation_[VT]_Medicaid<br>CORE_Tobacco Screening and Cessation_[VT]_Medicare<br>CAHPS Clinical & Group Surveys_Commercial<br>CAHPS Clinical & Group Surveys_Medicaid<br>CAHPS Clinical & Group Surveys_Medicare |

| **General Program Management** | | | | |
|---|---|---|---|---|
| *Milestone* | *Specific Tasks and Supporting Contractors* | *Line Item and Contractor* | *Staff* | *Accountability Metrics (Performance Period 3, reported in Quarterly Reports)* |
| **Project Management and Reporting – Project Organization**<br>Ensure project is organized through the following mechanisms:<br>1. Project Management contract scope of work and tasks performed on-time.<br>2. Monthly staff meetings, co-chair meetings, and Core Team meetings with reporting on budget, milestones, and policy decisions presented and discussed at each meeting.<br>3. Submit quarterly reports to CMMI and the Vermont Legislature.<br>4. Population Health Plan finalized by 6/30/17.<br>5. Sustainability Plan finalized by 6/30/17. | Project Management – *University of Massachusetts*. | Project Management: *University of Massachusetts*. | SIM-funded staff: Georgia Maheras; Christine Geiler; Sarah Kinsler | All metrics |
| **Project Management and Reporting – Communication and Outreach**<br>Engage stakeholders in project focus areas by:<br>1. Convening 10 Core Team meetings between 7/1/16 and 6/30/17.<br>2. Convening 5 Steering Committee public meetings and 20 work group public meetings between 7/1/16 and 12/31/16.<br>3. Distributing all-participant emails at least once a month through 12/31/16.<br>4. Update website at least once a week through 12/31/16, and monthly through 6/30/17. | Project Management – *University of Massachusetts*.<br><br>Outreach and engagement: *Staff only.* | 1. Project Management: *University of Massachusetts*.<br><br>2. Outreach: *Staff only*. | SIM-funded staff: Christine Geiler; Sarah Kinsler | All metrics |

# Section K: Workforce Capacity Monitoring

The Vermont SIM project, with support from the Governor's Health Care Workforce Work Group and other Vermont State agencies and departments, continues to advance initiatives to support health care workforce planning by assessing Vermont's current workforce and predict future needs. Given the environment of health care reform in our State, the ability to concurrently assess supply and demand, as well as project future supply of and demand for health care providers in Vermont, is of critical importance to reform initiatives.

Milestones for Performance Period 3 in each of these areas are described below:

### *Workforce – Demand Data Collection and Analysis*

***Performance Period 3 Milestone: Submit Final Demand Projections Report and present findings to Workforce Work Group by 12/31/16.***

The Health Care Workforce Work Group began discussing demand modeling in June 2014 as a way to project future health care demand for the state of Vermont. A "micro-simulation" demand model was determined to be the most suitable type of model for Vermont's needs, given the high degree of flexibility in this type of model to input various assumptions about care delivery in an "ideal" health care system. After a broad scope of work was approved by the Work Group, an RFP was released in January 2015. A vendor was selected in August 2015, and contract negotiations are nearing completion. The vendor will create a demand model using Vermont-specific data that identifies future workforce needs for Vermont under various scenarios and parameters. Workforce Work Group members, along with other key stakeholders, will inform development of model assumptions and scenarios. Performance Period 3 activities will focus on working with the vendor to build the demand model with Vermont-specific data. Activities will include inputting various state-level data and assumptions into the model, preparing preliminary and refined projections throughout the year, and presenting findings to stakeholders through monthly meetings, reports, and presentations. The contractor will present a finalized report of demand projections to the Work Group by December 2016.

### *Workforce –Supply Data Collection and Analysis:*

***Performance Period 3 Milestone: Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan:***

1. ***Present data to Workforce Work Group at least 3 times by 12/31/16.***
2. ***Publish data reports/analyses on website by 6/30/17.***
3. ***Distribute reports/analyses to project stakeholders by 6/30/17.***

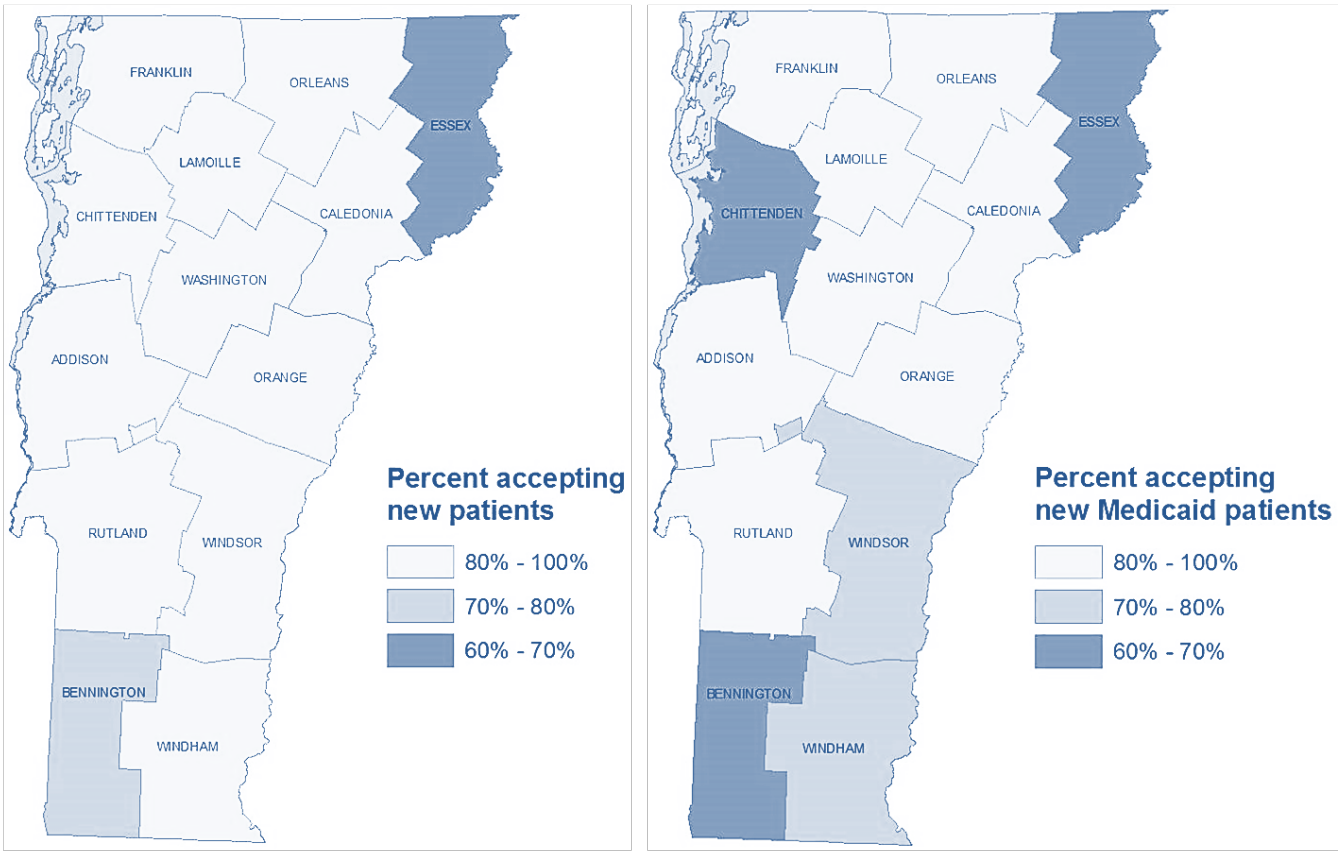
***4. Incorporate into Sustainability Plan by 6/30/17.***

Vermont's Office of Professional Regulation (OPR) and Vermont Department of Health (VDH) work in tandem to assess current and future supply of providers in the state's health care workforce for health care workforce planning purposes. OPR gathers licensure and relicensure data, which VDH analyzes. VDH also develops and deploys surveys to accompany relicensure applications, that give key information regarding demographics of providers. Legislation was passed in 2013 to mandate the collection of survey data from various professions during the relicensure process.

Reporting by profession is completed every two years for each health care profession tracked by the OPR, with surveys fielded by the Vermont Department of Health. Surveys for each profession are designed and approved by their respective licensing boards (if no prior survey exists), fielded, followed up on, cleaned, and analyzed, typically within a nine-month time-frame. Summary and more in-depth statistical reports were recently completed for the 2014 Physicians Survey, 2013 Dentists Survey, and 2014 Physician Assistants Survey. "Short" reports, containing more summary information, are nearing completion for 2014 Psychologists, 2014 Licensed Nursing Assistants, and 2014 Advanced Practice Registered Nurses.

2016 reports are currently in the field or follow up for the following professions: Clinical Social Workers, Psychologists, Acupuncturists, Acupuncture Detox Assistants, Licensed Practical Nurses, Physician Assistants, and Nursing Home Administrators. 2016 surveys for Occupational Therapists, Occupational Therapist Assistants, and Dietitians will launch mid-April (2016), and 2016 surveys for Optometrists and Opticians will go to their respective boards for review (through OPR) in April (2016).

*Figure 10* below is an example of information produced through these surveys:




A summary of work-to-date is below:

Summary and Statistical (In Depth) Reports Completed (Most recent summary and statistical reports can be found at: http://healthvermont.gov/research/HlthCarePrvSrvys/HealthCareProviderSurveys.aspx):

- 2014 Physicians
- 2013 Dentists
- 2014 Physician Assistants

Summary (Short) Reports Completed:

- 2014 Psychologists
- 2014 Licensed Nursing Assistants
- 2014 Advanced Practice Registered Nurses

Reports in Field or Follow Up:

- 2016 Clinical Social Workers
- 2016 Psychologists

- 2016 Acupuncturists
- 2016 Acupuncture Detox Assistants
- 2016 Licensed Practical Nurses
- 2016 Physician Assistants
- 2016 Nursing Home Administrators

Surveys to Launch:

- 2016 Occupational Therapists
- 2016 Occupational Therapist Assistants
- 2016 Dietitians

Surveys Out for Approval (at their respective boards):

- 2016 Optometrists
- 2016 Opticians

VDH presented provider supply data and analyses to the Workforce Work Group in February and April 2016, and will continue to present data to the Work Group in Performance Period 3 for recently surveyed providers as it becomes available. VDH will also work with the Work Group and subject matter experts from selected health care professions to synthesize data findings and distribute them to key stakeholders throughout Performance Period 3. The work group has created a standing agenda item at its meetings to examine data and reports on professions as they become available. Data and analyses are published on the VDH website and distributed to various stakeholders as provider reports are finalized.

While reports will be used for the purposes mentioned above, they will also be used by the Health Care Workforce Work Group to assess current supply and future supply trends, will inform future iterations of the Health Care Workforce Strategic Plan, and will be incorporated into Vermont's SIM Sustainability Plan.

## Section L: Care Transformation Plans

As described in Section F, Vermont's SIM care transformation activities are critical to supporting provider readiness to transition to, and participate in, alternative payment models. The overarching goal of all practice transformation activities is to maximize effectiveness of the programs and models in furthering the Triple Aim – improving Vermonters' experience of care, reducing unnecessary costs, and improving health – and minimizing duplication of effort or inconsistencies between care models in development and implementation across the state. Care delivery and practice transformation supports also help providers develop the skills and processes necessary to accept accountability for cost and quality of care, as discussed in Section F of this Operational Plan.

Practice transformation efforts in Vermont build on Vermont's Integrated Care Model, the first iteration of which was developed by Vermont's Duals Demonstration Work Group, the predecessor to the DLTSS Work Group, in 2013. Then known as the "Model of Care for Vermonter's with Disability and Long Term Services and Supports (DLTSS) Needs", it was reviewed and adopted by the SIM Care Models and Care Management Work Group (now the Practice Transformation Work Group). The model is being implemented and validated through the Integrated Communities Care Management Learning Collaborative, which identified similar foundational principles and best practices for achieving integrated care across all populations, as well as the core competency training initiative that has spun off of this work, described below. The Integrated Care Model is proliferating throughout the State as a foundational element for practice transformation.

Key elements of Vermont's Integrated Care Model include:

- Person-centered and person-directed process for planning and service delivery;
- Access to independent options counseling & peer support;
- Actively involved primary care physician;
- Provider network with diverse areas of expertise;
- Integration between medical and social services;
- Single point of contact/Lead Care Coordinator for person across all services;
- Standardized assessment tools;
- Comprehensive individualized care plan inclusive of all needs, supports and services made available to all members of the care team;
- Care coordination and care management;
- Interdisciplinary care team;
- Coordinated support during care transitions; and
- Use of technology for sharing information.

Vermont's Performance Period 3 care delivery and practice transformation goals are primarily targeted at the continued support of quality improvement activities that help providers better understand the workflows and processes needed to support news models of care; and then to

replicate and expand these findings across Vermont communities. In particular, this area of work includes supporting Vermont's Integrated Care Model with a particular focus on team-based care to facilitate care coordination across multiple provider settings in a community.

During Performance Period 3, Vermont's SIM project will maintain and expand successful initiatives. Activities during this period will include:

- Continuation and expansion of existing *Learning Collaborative* activities, including the addition of a comprehensive core competency training series for front-line care management staff;
- Continuation of Vermont's SIM-supported provider *Sub-Grant* program, including a *technical assistance* component;
- Further work to align Blueprint for Health and ACO care management activities through *Regional Collaborations*.

This work is guided by Vermont's SIM Practice Transformation Work Group and the SIM, All-Payer Model, and Medicaid Pathway leadership teams. The SIM, All-Payer Model, and Medicaid Pathway leadership teams provide high-level guidance and ensure the practice transformation activities align with SIM goals and Vermont's health care reform priorities. The leadership teams will continue to receive reports on implementation progress, with the goal of monitoring and recommending mechanisms for assuring consistency and/or coordination across these programs, models, and the project as a whole. Over the course of Performance Period 3, Vermont will evaluate progress, glean lessons learned, and assess what additional care transformation supports Vermont providers will need to successfully participate in future alternative payment models. Plans for continued care transformation activities following the end of the SIM grant are discussed in Section M.

Milestones for Performance Period 3 within Vermont's Practice Transformation focus area are described below. Activities to assess Vermont's current health care workforce supply and predict future workforce demand also support Vermont's Care Transformation goals are guided by Vermont's Health Care Workforce Work Group and are discussed in Section K, Workforce Capacity Monitoring.

### *Learning Collaboratives*

***Performance Period 3 Milestone:***

***1. Target: 400 Vermont providers have participated in Learning Collaborative activities (including Integrated Communities Care Management Learning Collaborative or Core Competency Trainings) by 12/31/16. (Baseline as of December 2015: 200)***

***2. Report on program effectiveness to Steering Committee and Core Team by 12/31/16.***

***3. Incorporate Learning Collaborative lessons learned into Sustainability Plan by 6/30/17.***

Vermont's Learning Collaboratives share and diffuse best practices for care coordination and help multi-organizational teams deliver care most effectively. This work has grown to encompass two initiatives:

- The Integrated Communities Care Management Learning Collaborative; and
- A Core Competency training series for front-line care management staff.

*Integrated Communities Care Management Learning Collaborative*

The Integrated Communities Care Management Learning Collaborative focuses on improving integrated, team-based care for at-risk Vermonters. From an initial rollout to three communities starting in Performance Period 1, these multi-community Learning Collaboratives have grown during Performance Periods 2 to include three cohorts of eleven communities from across the state. This initiative seeks to support providers and communities in implementing Vermont's Integrated Care Model through a variety of interventions, including: using data and experience to identify people with complex needs; supporting cross-organizational care coordination; using tools to document each person's story, goals, and care team; reviewing a person's health history; conducting root cause analyses; convening care team conferences; identifying lead care coordinators; and developing, implementing, and monitoring shared care plans. This work also helps Vermont validate the components of the Integrated Care Model, and allows providers and the State to develop best practices in each of these areas.

As best practices in the fields of care coordination, care management, and team based care continue to evolve nationwide, new and existing expert faculty have worked with participating communities to refine tools, processes, and workflows. All participants in the Learning Collaborative receive Continuous Quality Improvement (CQI) training, specifically utilizing the Plan-Do-Study-Act model. This initiative is implemented in partnership with the Blueprint for Health, which has worked to ensure alignment with existing Blueprint-supported practice facilitation and transformation activities, as well as leveraging its network within participating communities to encourage robust participation.

In the first half of Performance Period 3, Vermont will continue to implement and improve upon the Integrated Communities Care Management Learning Collaborative. The Learning Collaborative initiative will also continue to host monthly in-person learning sessions and webinars for participants. Participating communities will also continue to receive support from SIM-funded quality improvement facilitators to support continuous quality improvement goals. Staff, contractors, and key stakeholders are also working to develop a tool-kit to support providers in implementing Vermont's Integrated Care Model, which will be available for use state-wide in the near future. A training developed by Cohort 1 communities on tool-kit contents and models will be a companion resource for additional communities to expand knowledge to providers who did not participate directly in Learning Collaborative activities.

Evaluation of the Learning Collaborative program will continue throughout Performance Period 3. Vermont will field two program specific surveys: one to patients and one to providers. A

survey to assess participating patients' experience of care[11] is currently being fielded in small numbers across all eleven participating communities, with the goal of surveying all participating individuals receiving care by the end of 2016. A team-based care survey will be fielded to assess provider perception of the impact of the Learning Collaborative on characteristics of effective team-based care such as shared goals, trust, clear roles, effective communication, and measurement. Findings will build upon baseline data to help Vermont's SIM project and other key stakeholders better understand the impact of interventions such as the Learning Collaborative and Regional Collaborations (discussed below) over time. Finally, Vermont is currently exploring the possibility of conducting claims-based analysis of outcome measures, although small sample size may prevent this.

### *Core Competency Training Series*

A core competency training series for front-line care management staff kicked off in March 2016 and will continue through the first half of Performance Period 3. The training focuses on key competencies that support the implementation of Vermont's Integrated Care Model, and skills that are required to effectively apply the tools identified in the Learning Collaborative tool-kit mentioned above. The curriculum is split into fundamentals of care coordination and disability awareness competencies, and includes supplemental training components such as training for managers and supervisors and a train-the-trainer program to support sustainability beyond the life of the training series and the SIM grant. Overall, 34 days of training content will be delivered to 240 front-line providers of care coordination and care management services statewide. More information on the training series is available on Vermont's SIM website at http://healthcareinnovation.vermont.gov/node/884.

### *Sub-Grant Program – Sub-Grants*

***Performance Period 3 Milestone:***

1. ***Provide SIM funds to support sub-grantees through 12/31/16.***
2. ***Convene sub-grantees at least twice by 12/31/16.***
3. ***Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.***
4. ***Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.***

Vermont's SIM-supported provider Sub-Grant program is ongoing. This program launched in Performance Period 1, and provides funds to directly support Vermont provider organizations, consumer organizations, and other entities engaged in payment and delivery system transformation in pursuing innovative reforms in accordance with the terms and conditions of our SIM grant.

[11] This survey is different than the patient experience survey fielded annually.

Many sub-grantees have achieved significant accomplishments; highlights include:

- Southwestern Vermont Medical Center's INTERACT program, a long term care program for early identification of condition changes and prompt implementation of clinical interventions, was implemented at SVHC's Center for Living and Rehabilitation in 2015. INTERACT is now being integrated with area long term care facilities by the INTERACT Nurse. The program demonstrated a 7.7% decrease in the 30-day readmission rate in February 2016 compared with February 2015.
- Central Vermont Medical Center has integrated the SBIRT model into six primary care practices (five medical homes) and a women's health practice. To date, 6,192 patients have been screened for risky alcohol use and 5,488 have been screened for risky drug use. Of those patients screened, 332 have received Brief Interventions by participating clinicians, and of those, 228 were referred to Treatment. Regardless of whether a brief intervention was performed, since April of 2015, 742 SBIRT referrals were made by providers, 383 patients have engaged in a Treatment session, and 191 patients are currently engaged in either treatment or follow-up on referral concerns.
- RiseVT, a county-wide wellness initiative, has reached over 5,000 people across the community through a broad campaign that capitalizes on social media and in-person wellness events, including: 4,058 people have seen RiseVT at events across Franklin and Grand Isle Counties; 814 people have taken the RiseVT Pledge or taken the Health Assessment; 151 people have completed the RiseVT Individual Scorecard and know their score – 9 have followed up with Health Coach; 314 people are using the RiseVT Wellness Dashboard & Health Coaching; and 40 businesses, 15 schools, 7 municipalities are participating as partners.

In addition to submitting quarterly reports to SIM staff, updates on sub-grantee progress and findings are presented to Vermont's SIM Practice Transformation Work Group regularly, and other SIM work groups as requested. Sub-grantees will convene once during the remainder of Performance Period 2 to share best practices and lessons learned; a second convening will occur during the first half of Performance Period 3. Sub-grantees have staggered end dates for their respective projects. As projects conclude, Vermont will leverage a newly-designed website expected to launch by June 2016 and bi-monthly newsletters to disseminate final reports and key lessons learned. Lessons will also be incorporated into Vermont's SIM sustainability planning efforts, as described in Section M.

### *Sub-Grant Program – Technical Assistance*

***<u>Performance Period 3 Milestone</u>: Provide technical assistance to sub-grantees as requested by sub-grantees through 12/31/16:***

***1. Remind sub-grantees of availability of technical assistance on a monthly basis.***

***2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees.***

***3. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.***

Vermont will continue to support sub-grantees with technical assistance as requested through the end of the sub-grant program. As in past performance periods, contractors are available for technical assistance as requested by sub-grantees and approved by project leadership according to a detailed SIM process. Several sub-grantees have taken advantage of technical assistance available to support the design of evaluation methodologies, as well as data profiling and analytics services. We anticipate that this will be on-going work in Performance Period 3 as the provider Sub-Grant program concludes.

### *Regional Collaborations*

***Performance Period 3 Milestone:***

***1. Support regional collaborations in 14 HSAs by providing sub-grants to ACOs and other technical assistance resources.***

***2. Develop a transition plan by 4/30/17 to shift all HSAs to non-SIM resources.***

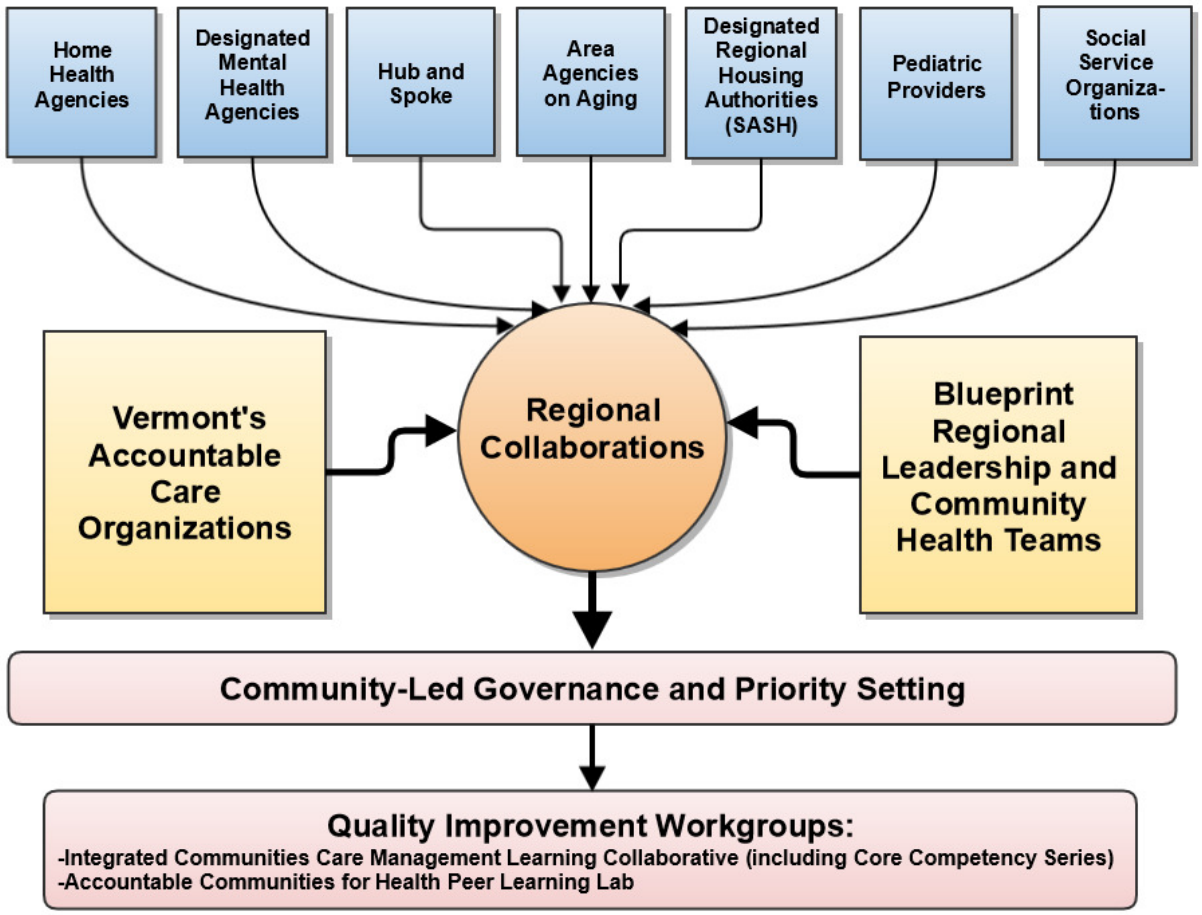
***3. Incorporate into Sustainability Plan by 6/30/17.***

Regional Collaborations are active and continue to mature in all 14 Health Service Areas (HSAs) with the goal of supporting integration of the Blueprint for Health and Vermont's three ACOs, and to enable community-wide governance, identification and setting of priorities, and quality improvement efforts. These efforts span Vermont's SIM project, the Blueprint for Health, and Vermont's ACOs, and requires intensive collaboration at the leadership and staff level among those partners.

Regional Collaborations act as a site for integration and alignment across Vermont's care transformation and quality improvement initiatives, both SIM-supported and otherwise: Regional Collaborations in 11 communities have adopted the Integrated Communities Care Management Learning Collaborative as a priority focus area and quality improvement project, and many have identified diabetes, hypertension, and substance abuse as priority conditions in alignment with ongoing CDC-supported prevention activities (described in Section B). Regional Collaborations have also identified additional quality improvement priorities and goals based on local needs and interests, including medication reconciliation, hospice utilization, transitions in care, opiate addiction and treatment, telemedicine, and wellness.

Figure 11, below, illustrates the structure of the Regional Collaborations.

*Figure 11: Regional Collaborations*




In Performance Period 3, the focus of this work stream will be on continued support for implementation of Regional Collaborations as communities continue to develop and formalize governance and decision-making structures and embark on quality improvement projects. Vermont's SIM project will continue to share findings and lessons learned and spread best practices throughout the state as they continue to emerge at the community and regional levels.

Vermont's Learning Collaborative and Regional Collaborations are intentionally aligned with the Accountable Communities for Health Peer Learning Laboratory described in Section F. Figure 5 in Section F illustrates how these initiatives are intended to dovetail.

# Section M: Sustainability

Vermont embarked on a bold set of reforms with the passage of Act 48 of 2011. These reforms charge the Executive Branch and the Green Mountain Care Board (GMCB) with creating a high-performing health system that provides Vermonters with the highest quality of care at a sustainable cost. These reforms require that we use our regulatory and policy levers to develop evidence-based financial models for health system financing. Vermont's SIM Testing Grant provides significant resources to support Vermont in achieving the goals set out in Act 48 by testing payment reforms, supporting delivery system transformation, and investing in health data infrastructure.

Vermont will use its final test year to engage in detailed planning around sustainability and provide specificity about the activities that will be supported after the end of our SIM testing period. A significant focus of this work will be SIM interaction with and transition to the planned All-Payer Model and related reforms such as the Medicaid Pathway.

***Performance Period 3 Milestone*: Finalize Sustainability Plan by 6/30/17.**

## *Sustainability Overview*

Vermont has been planning for post-SIM sustainability since the start of the Model Testing Grant in 2013. Broadly, Vermont's sustainability strategy is to sustain needed contract support and personnel using model savings and through re-deployment of vacant positions and changes in contractor scope in light of new models of provider oversight and financing. Vermont SIM leadership is currently engaged in a more granular sustainability planning process that includes review of each SIM activity and investment.

The State views SIM investments in three categories with respect to sustainability:

- **One-time investments** to develop infrastructure or capacity, with limited ongoing costs;
- **New or ongoing activities which will be supported by the State** after the end of the Model Testing period; and
- **New or ongoing activities which will be supported by private sector partners** after the end of the Model Testing period.

Project leadership will work with stakeholders and Vermont's SIM evaluation team to identify areas of successful investment in need of on-going support, areas of investment that have not furthered our goals, and areas of investment that have served their purpose and do not need on-going support.

One-time investments have been the intentional focus of the majority of Vermont's SIM work. This has included many of Vermont's health data infrastructure investments, as well as some

work to launch new payment models. Most project management activities are also included in this category.

As in any innovative testing opportunity, some areas of SIM investment have had mixed or limited success. Vermont's sustainability planning process will identify these activities, while ensuring lessons learned are harvested and incorporated into future planning. For example, we have supported provider sub-grants to foster innovation in the provider community. Not all of the funded efforts will be successful in meeting the stated goal of the intervention, but even so, will have furthered the learning of the State and the provider community.

Analysis to support sustainability planning, as well as drafting of the Sustainability Plan document, will be supported by a contractor as well as by a public-private sub-group of SIM stakeholders. The contractor will be procured by June 30, 2016, as required by Vermont's Sustainability Plan milestone for Performance Period 2; the sub-group will be formed in Summer 2016. Vermont's Sustainability Plan will be finalized by June 30, 2017, and will include specific next steps for all SIM-related activities; an outline will be finalized by the end of Performance Period 2 on June 30, 2016, and it is expected that drafts will be completed in time to share with SIM work groups in late 2016.

### *SIM Investments by Focus Area*

This section of Vermont's Operational Plan provides a summary of sustainability planning activities currently underway across each of the project's five focus areas:

- **Payment Model Design and Implementation**: Supporting creation and implementation of value-based payments for providers in Vermont across all payers.
- **Practice Transformation**: Enabling provider readiness and encouraging practice transformation to support creation of a more integrated system of care management and care coordination for Vermonters.
- **Health Data Infrastructure**: Supporting provider, payer, and State readiness to participate in alternative payment models by building an interoperable system that allows for sharing of health information to support optimal care delivery and population health management.
- **Evaluation:** Assessing whether program goals are being met.
- **Program Management and Reporting:** Ensuring an organized project.

This section also discusses sustainability and transition planning related to the SIM governance and stakeholder engagement structure and the SIM staff team.

Table 14 provides a high-level overview of SIM investments by focus area and SIM work stream across the three sustainability categories identified above. Vermont will populate this table

with specific sustainability recommendations during Performance Period 3 through the sustainability planning process described above.

*Table 14: High-Level Sustainability Overview by SIM Work Stream*

| | Sustainability Categories | | |
|---|---|---|---|
| **SIM Focus Areas and Work Streams** | **One-Time Investments** | **Ongoing Investments** *State-Supported* | **Ongoing Investments** *Private Sector* |
| **Payment Model Design and Implementation** | | | |
| ACO Shared Savings Programs | | | |
| Pay-for-Performance (Blueprint for Health | | | |
| Health Homes (Hub & Spoke) | | | |
| Accountable Communities for Health | | | |
| Medicaid Value-Based Purchasing | | | |
| All-Payer Model | | | |
| **Practice Transformation** | | | |
| Learning Collaboratives | | | |
| Sub-Grant Program | | | |
| Regional Collaborations | | | |
| Workforce – Care Management Inventory | | | |
| Workforce – Demand Data Collection and Analysis | | | |
| Workforce – Supply Data Collection and Analysis | | | |
| **Health Data Infrastructure** | | | |
| Expand Connectivity to HIE – Gap Analyses | | | |
| Expand Connectivity to HIE – Gap Remediation | | | |
| Expand Connectivity to HIE – Data Extracts from HIE | | | |
| Improve Quality of Data Flowing into HIE | | | |
| Telehealth – Strategic Plan | | | |
| Telehealth – Implementation | | | |
| EMR Expansion | | | |
| Data Warehousing | | | |
| Care Management Tools (Event Notification System) | | | |
| Care Management Tools (Shared Care Plan) | | | |
| Care Management Tools (Universal Transfer Protocol) | | | |
| General Health Data – Data Inventory | | | |
| General Health Data – HIE Planning | | | |
| General Health Data – Expert Support | | | |
| **Evaluation** | | | |
| Self-Evaluation Plan and Execution | | | |
| Surveys | | | |
| Monitoring and Evaluation Activities Within Payment Programs | | | |
| **Program Management and Reporting** | | | |
| Project Organization | | | |
| Communication and Outreach | | | |
| **Governance and Stakeholder Engagement** | | | |

### Payment Model Design and Implementation

The All-Payer Model and Medicaid Pathway (discussed in greater depth in Sections B, F,, and L of this Operational Plan) are the centerpiece of Vermont's SIM sustainability planning within the Payment Model Design and Implementation focus area. Vermont has been engaged in ongoing discussions with CMMI regarding a potential All-Payer Model in Vermont, which would build on SIM's investments in payment model design and implementation, practice transformation, and health data infrastructure to act as a next step in Vermont's efforts to achieve the Triple Aim. The model, if implemented, will be based on Medicare's Next Generation ACO model. Negotiations with CMMI and discussions with Vermont State officials and stakeholders have also revealed a mutual desire to consider how additional services could be included in the model over time, especially services where the majority of spending is by Medicaid; these accompanying reforms are known as the Medicaid Pathway.

This is currently an area of intensive work among State officials, key stakeholders, and contractors. Critical issues to resolve over the coming months will include analysis of which services to transition over time, transition of attributed lives between programs, quality measurement under the All-Payer Model and Medicaid Pathway, and continued practice transformation and readiness activities.

Vermont's sustainability planning will also collect lessons learned from the payment models researched, designed, and tested under the SIM grant and incorporates these into future activities. We have learned significant lessons with regard to Vermont has researched, developed, and/or tested the following payment models:

- Vermont's Medicaid and commercial Shared Savings Programs;
- Episodes of Care;
- Prospective Payment Systems for Home Health;
- A pay-for-performance program (the Blueprint for Health patient-centered medical home program);
- Vermont's Section 2703 Health Homes initiative (known as the Hub & Spoke program);
- Development and exploration of a Vermont-specific Accountable Communities for Health model; and
- Medicaid-specific value-based purchasing activities to support providers of mental health and substance abuse services that will feed into the Medicaid Pathway.

Currently, in concept and practice, SIM supports provider, payer, and State readiness for increased financial risk and delivery integration through an All-Payer ACO Model. We expect that the SIM investments through Performance Period 3 will continue to ensure that providers and ACOs are ready to accept more aggressive payment models such as capitation and global budgets, that Vermont's health data infrastructure has increased capacity for data integration,

and that the State is ready for any necessary modifications to regulatory and administrative processes within the Green Mountain Care Board or the Agency of Human Services. SIM investments also support readiness for the Medicaid Pathway through work on integration of behavioral/mental health, substance abuse, and long-term services and supports, specifically through the alternative payment models we are investigating for Medicaid, such as Integrated Family Services.

### Practice Transformation

Shifting to alternative payment systems requires collaboration among providers, payers, and government. It also requires a willingness to continually learn and build towards a high performing health system. Section L of this Operational Plan describes Vermont's Integrated Model of Care, a set of principles upon developed through the SIM process on which many of Vermont's current practice transformation activities are based. This model will act as a foundation for future work in this area, including work to support the All-Payer Model and Medicaid Pathway.

Vermont currently convenes entities from across these sectors and beyond, supported both by SIM funds and by other State and non-State activities, including the Blueprint for Health, Departments within the State's Agency of Human Services, the ACOs, hospitals, community-led quality improvement and integration projects, and others.

Vermont's SIM investments in this area have focused on:

- Launching Learning Collaboratives to support system integration and improve care management capacity;
- Developing regional collaborations across provider types and care settings to provide local governance across initiatives, identify community priorities, and tackle community-wide quality improvement;
- A sub-grant program to test innovative delivery system models; and
- A variety of workforce-related activities.

Some of these efforts were designed to develop provider capacity in a way that should be self-sustaining; for example, a Core Competency Training initiative launched under the Learning Collaborative work stream in Performance Period 2 uses a "train the trainer" model to ensure that our state's providers can continue to pass on their new knowledge.

Vermont will continue to support its learning health system after SIM funds are expended through both public and private programs. Some of this future support will be State-funded through our Blueprint for Health and AHS departments; the State's specific approach to these activities will depend on the outcome of All-Payer Model discussions with CMMI. We expect

that Vermont's ACOs, hospitals, and other private sector partners will also continue to invest in practice transformation activities.

### Health Data Infrastructure

The State of Vermont has used SIM funds to make sizeable investments in health data infrastructure. In addition to SIM funds, Vermont has leveraged a number of funding sources to support health data infrastructure investments, including Vermont's health information technology claims assessment, Medicaid, and HITECH. Vermont is aware of the complexity of federal IT funds available and, as described in Sections A, D, and E, is working with the HDI Work Group and other key stakeholders to ensure all activities in this area are aligned.

Specifically, Vermont has devoted funds to:

- Building connections between providers, the State's data sources, and the Vermont Health Information Exchange (VHIE);
- Improving the quality of data flowing into the VHIE;
- EMR expansion;
- Provision of care management tools;
- Work to enhance the clinical registry and integrating the state's clinical registry and claims data reporting systems; and
- A varied suite of smaller projects and activities, including telehealth pilots, a health data inventory, technical support for health data projects, and health data planning activities.

SIM funding allows Vermont to build the health data infrastructure necessary to support new payment models and educate providers on these new data systems. This infrastructure development has required large investments to develop key technologies, or complete critical project elements. Ongoing costs, though not insignificant, are a fraction of initial costs for many of these projects. Once Vermont has developed these electronic connections, we will need to maintain those connections and improve them as new technologies emerge; data systems also require significant ongoing maintenance for upgrades. We anticipate that the remaining existing sources of non-SIM funding will be sufficient to support the ongoing maintenance for the data systems developed during the 3-year SIM Testing Period. There is more information about Vermont's 5-year projections in this area in the HIT Plan included as Attachment 5.

### Evaluation

A key piece of Vermont's SIM Sustainability Plan will be to ensure we continue high-quality evaluation of our programs as we continue innovations over time. Vermont's SIM project currently supports three work streams related to evaluation:

- The State's SIM self-evaluation;
- Surveys to assess patient experience within SIM payment models; and
- Additional activities to monitor and evaluate SIM payment models.

As required by our SIM grant terms, Vermont is performing a State-Led -evaluation that covers all of our project areas – this allows for rapid-cycle and more intensive review of activities. Activities related to the SIM State-Led evaluation will conclude at the end of the Model Testing period.

Following the end of the Model Testing period, the State will resume the standard evaluation and monitoring protocol in place in the state that predated the project. For payment models that continue following SIM, surveys and evaluation and monitoring activities will be subsumed within those programs and the State agencies and departments with jurisdiction over those topics. Vermont expects that these activities will be sufficient to properly monitor and evaluate Vermont's health care system once the SIM funding is completed.

### Project Management and Reporting

SIM-related project management and reporting activities will largely conclude at the end of the Model Testing period; project-specific project management may be absorbed by State agencies if and when projects are continued beyond the SIM Model Testing period.

### Governance and Stakeholder Engagement

Vermont's SIM project has engaged in robust, formal, and frequent stakeholder engagement activities through the governance structure described in Section A of this Operational Plan. This has been an intentional investment of staff time and resources, ensuring that Vermont's SIM activities are driven by collaborative decision-making across the public and private stakeholders and allowing for regular reviews of provider readiness and change fatigue. Perhaps most importantly for our state's long-term health system reform goals, SIM provided an opportunity for high-level figures from across our health system and social services to interact on a regular basis, bridging services and programs which were previously siloed and helping to develop a collective vision for health system reform in the state.

Having successfully fostered these public/private relationships through SIM, we will continue to assess what governance and stakeholder engagement structure that would best support the All-Payer Model and Medicaid Pathway initiatives.

While most SIM governance is planned to transition to new structures in December 2016, the SIM Core Team will continue to meet through the end of the Model Testing period, providing direction to the project and making funding decisions.

## Staffing

Vermont's SIM implementation plan, as described in the SIM Timeline (Figure 12 in Section O), is to phase in alternative payment models over the SIM Model Testing period. The phased approach requires contract and staff resources to perform existing payment and delivery system tasks, while simultaneously innovating. Vermont's SIM budget includes funding for a combination of personnel and contracts to support transformations in the payment and delivery system. Vermont has structured its SIM funding to provide infrastructure and capacity for the transition from existing payment and delivery systems to alternate payment and delivery systems.

Vermont uses SIM funding to support the development of tools and new models, while at the same time maintaining existing structures until they are no longer needed. As new payment mechanisms come online, we will no longer need staff and contracts to perform current tasks and will reduce our SIM workforce or train those staff for new roles. Vermont is intentionally seeking contract services to provide the subject matter and technical expertise necessary to conduct this transition with staff and contractors.

At the end of the SIM grant, the majority of the positions funded by SIM will no longer exist. There are a handful of positions that will be retained by DVHA and the GMCB respectively and the funding to support those will come from other revenue sources.

### *Federal Funding Beyond the SIM Grant*

Vermont continues to work with its federal partners to identify opportunities for funding to support federal and State health system goals. Much of this work is currently focused on All-Payer Model discussions; however, Vermont will engage all payers, including Medicare, in discussions about ongoing engagement in Vermont's payment and delivery system initiatives regardless of the outcome of All-Payer Model discussions.

# Section O: Implementation Timeline for Achieving Participation and Metrics

### *Project Implementation Timeline*

Vermont's SIM project continues to develop and utilize -specific plans in place to guide the development, implementation, and sustainability of each of the models described above. Moreover, staff and contractor support have been assigned for each of these models to ensure that associated milestones and accountability targets will be met during the SIM testing period. *Figure 12* depicts a summary timeline for the models listed above, in addition to other project work streams.

Please see Sections D, F, K, and L; Attachment 3, Vermont SIM Milestone Summary and Driver Diagram; or Attachment 4, SOV Status Reports March 2016, for work stream detail and milestones.

*Figure 12: Implementation Timeline: April 2016-June 2017*[12]

| Work Stream | April 2016 | May 2016 | June 2016 | July 2016 | Aug 2016 | Sep 2016 | Oct 2016 | Nov 2016 | Dec 2016 | Jan 2017 | Feb 2017 | Mar 2017 | April 2017 | May 2017 | June 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Population Health Plan | | | | | | | | | | | | | | | |
| Sustainability Plan | | | | | | | | | | | | | | | |
| ***Payment Model Design and Implementation*** | | | | | | | | | | | | | | | |
| Shared Savings Program | | | | | | Year 2 Results available. | | | Meet SSP participation goals. | Possible All-Payer Model ACO payment launch.[13] | | | | | |
| Pay-for-Performance | | | | | | | | | | Maintained, but may be modified under APM. | | | | | Meet beneficiary and provider targets. |
| Health Home (Hub and Spoke) | | | | | | | | | | Maintained, but may be modified under APM. | | | | | Meet beneficiary and provider targets. |
| Accountable Communities for Health | | | | | | | | | | | | | | | Develop Implementation Plan |
| Medicaid Value-Based Purchasing (Medicaid Pathway) | | | | | | | | | | | | | | | TBD. Services likely outside of the APM[14]; will align with APM. |
| All-Payer Model[15] | | | | | | | | | | ★ | | | | | TBD – Sustainability Plan. |
| State Activities to Support Model Design and Implementation – Medicaid | | | | | | | | | | | | | | | |
| ***Practice Transformation*** | | | | | | | | | | | | | | | |

[12] The key to this table is provided on page 108.
[13] APM Model launch in January 2017 is dependent on a finalized waiver agreement between Vermont and CMMI. See Section F for more information.
[14] See Medicaid Value-Based Purchasing (Medicaid Pathway) work stream. The timeline for including services outside of the current Medicaid shared savings program in APM is under development.
[15] Model launch in January 2017 is dependent on a finalized waiver agreement between Vermont and CMMI. See Section F for more information.

| Work Stream | April 2016 | May 2016 | June 2016 | July 2016 | Aug 2016 | Sep 2016 | Oct 2016 | Nov 2016 | Dec 2016 | Jan 2017 | Feb 2017 | Mar 2017 | April 2017 | May 2017 | June 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Learning Collaboratives | | | | | | | | | Reach 500 VT Providers. | | | | | | TBD – Sustainability Plan. |
| Core Competency/ Disability Awareness Training[16] | | | | | | | | | | | | | | | |
| Sub-grant program: Sub-grants | | | Convene sub-grantees. | | | | Convene sub-grantees. | | | | | | | | Sub-Grant Program Final Report |
| Sub-grant Program: Technical Assistance | | | | | | | | | | | | | | | |
| Regional Collaborations | | | | | | | | | | | | | Develop transition plan. | | TBD – Sustainability Plan. |
| Workforce – Demand Data Collection/Analysis | ★ | | | | | | | | Submit Final Demand Projections Report. | | | | | | |
| Workforce – Supply Data Collection/ Analysis | | | | | | | | | | | | | | | Publish and distribute data reports/ analyses. |
| ***Health Data Infrastructure*** | | | | | | | | | | | | | | | |
| Expand Connectivity to HIE – Gap Remediation | | | | | | | | | | | | | | | Remediate 65% of ACO SSP measures-related gaps. |
| Improve Quality of Data Flowing into HIE | | | | ★ | | | | | Complete workflow improvement. | | | | | | Report on improvement over baseline. |
| Telehealth – Implementation | | ★ | | | | | | | | | | | | | TBD – Sustainability Plan. |
| Data Warehousing | | | | | | | | | ★ | | | | | | |
| Care Management: Event Notification System | ★ | | | | | | | | | | | | | | |

[16] Core Competency Training is part of the Learning Collaborative milestone, however, due to the amount of work being done for this specific work stream it is being illustrated in its own row.

| Work Stream | April 2016 | May 2016 | June 2016 | July 2016 | Aug 2016 | Sep 2016 | Oct 2016 | Nov 2016 | Dec 2016 | Jan 2017 | Feb 2017 | Mar 2017 | April 2017 | May 2017 | June 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Care Management Tools: Shared Care Plan | | | | | | | | | | | | | | | Revisions to VHIE consent policy and architecture |
| Care Management Tools: Universal Transfer Protocol | | | | | | | | | | | | | | | |
| General Health Data – HIE Planning | | | Develop Connectivity Targets | | | | | | | | | | | | TBD – Sustainability Plan. |
| General Health Data – Expert Support | | | | | | | | | | | | | | | |
| ***Evaluation*** | | | | | | | | | | | | | | | |
| Self-Evaluation Plan and Execution | | | | | | | | | | | | | | | |
| Surveys | | | | | | | | | | | | | | | |
| Monitoring and Evaluation Activities Within Payment Programs | | | | | | | | | | | | | | | |
| ***Program Management and Reporting*** | | | | | | | | | | | | | | | |
| Project Organization | | | | | | | | | | | | | | | Population Health Plan and Sustainability Plan Complete |
| Communication and Outreach | | | | | | | | | Convene 5 Steering Committee and 20 work group meetings. | | | | | | Convene 10 Core Team Meetings. |

***Timeline Key***

- Feasibility Study, Research/Program Design, or Plan Development (Pre-Launch)
- Launch Date
- Program Implementation and Monitoring
- Ongoing Monitoring and Reporting
- Update to Work Group, Steering Committee or Core Team
- Submit Key Document (SPA, Final Report, Sustainability Plan, or Population Health Plan)
- Evaluation
- Include in Sustainability Plan
- Quarterly Report to CMMI

# Section Q: Evaluation Plan

## *State-Led Evaluation Plan and Execution*

***Performance Period 3 Milestone: Execute Self-Evaluation Plan for 2016 and 2017 according to timeline for Performance Period 3 activities.***

Vermont's State-Led Evaluation has two primary goals:

- Provide timely feedback to inform mid-course corrections in the implementation and operation of SIM-sponsored-initiatives; and
- Generate actionable recommendations to guide State-leadership's decisions on scaling-up and diffusing SIM-supported initiatives and best practices.

Vermont's State-Led Evaluation efforts are guided by a logic model, *Figure 13* below, that outlines grant activities, identifies project milestones for each activity, and categorizes the outcomes Vermont's SIM project proposes to influence. This logic model includes metrics with specific targets such as Vermont's SIM high-level goal metrics and SIM Core Metrics, and other relevant ACO Shared Savings Program and population health outcome metrics. Logic model metrics are tracked and reported quarterly or annually to stakeholders (including Vermont's SIM Core Team, Steering Committee, and Work Groups), Vermont's Legislature, and CMMI. The metrics come from a variety of sources, including claims, electronic health records, and surveys. More information on metrics and performance reporting is included in Section H of this Operational Plan.

In addition to tracking metrics, Vermont is implementing a mixed-methods plan as indicated in the approved State-Led Evaluation Plan. Vermont's State-Led evaluation includes three categories of activity:

1. Activities performed by the self-evaluation contractor.
2. Monitoring and evaluation activities performed by SIM staff and key analytic contractors.
3. Patient experience surveys performed by our survey contractor.

Vermont proposes to answer research questions in three topical areas: Care Integration and Coordination; Use of Clinical and Economic Data to Promote Value-Based Care; and Payment Reform and Incentive Structures. Each of these areas is key to Vermont'

The *activities performed by the self-evaluation contractor* include: an environmental scan, site visits, interviews, focus groups, a statewide survey of care managers/care coordinators, and a statewide provider survey. The activities provide timely feedback to inform corrections in the implementation and operation of Vermont's SIM-sponsored activities and provide actionable recommendations to project leadership. Vermont's State-Led Evaluation also includes data

collection, analysis, and results from a diverse range of sub-grantees where SIM-funded innovations are being tested in the field.

Vermont supports rigorous continuous improvement by sharing evaluation results and project information through a diverse set of vehicles including: SIM work groups, learning collaboratives, stakeholder symposiums, public presentations, and Regional Collaboratives. The State-Led Evaluation Plan combines a review of information on various reporting cycles to assist in programmatic decisions within the SIM Testing period, as well as inform Vermont's sustainability planning. SIM continuous improvement learning activities help to inform SIM programmatic decision-making, facilitate shared learning across the project, and directly support quality improvement efforts at the regional, community, and organizational levels. The State-Led Evaluation Plan Findings, provided as Attachment 6 to this Operational Plan, provide examples of the rapid-cycle evaluation and decision-making Vermont has utilized to date.

*Figure 13a: Designing & Implementing New Payment Models Logic Model for SIM State-Led Evaluation*

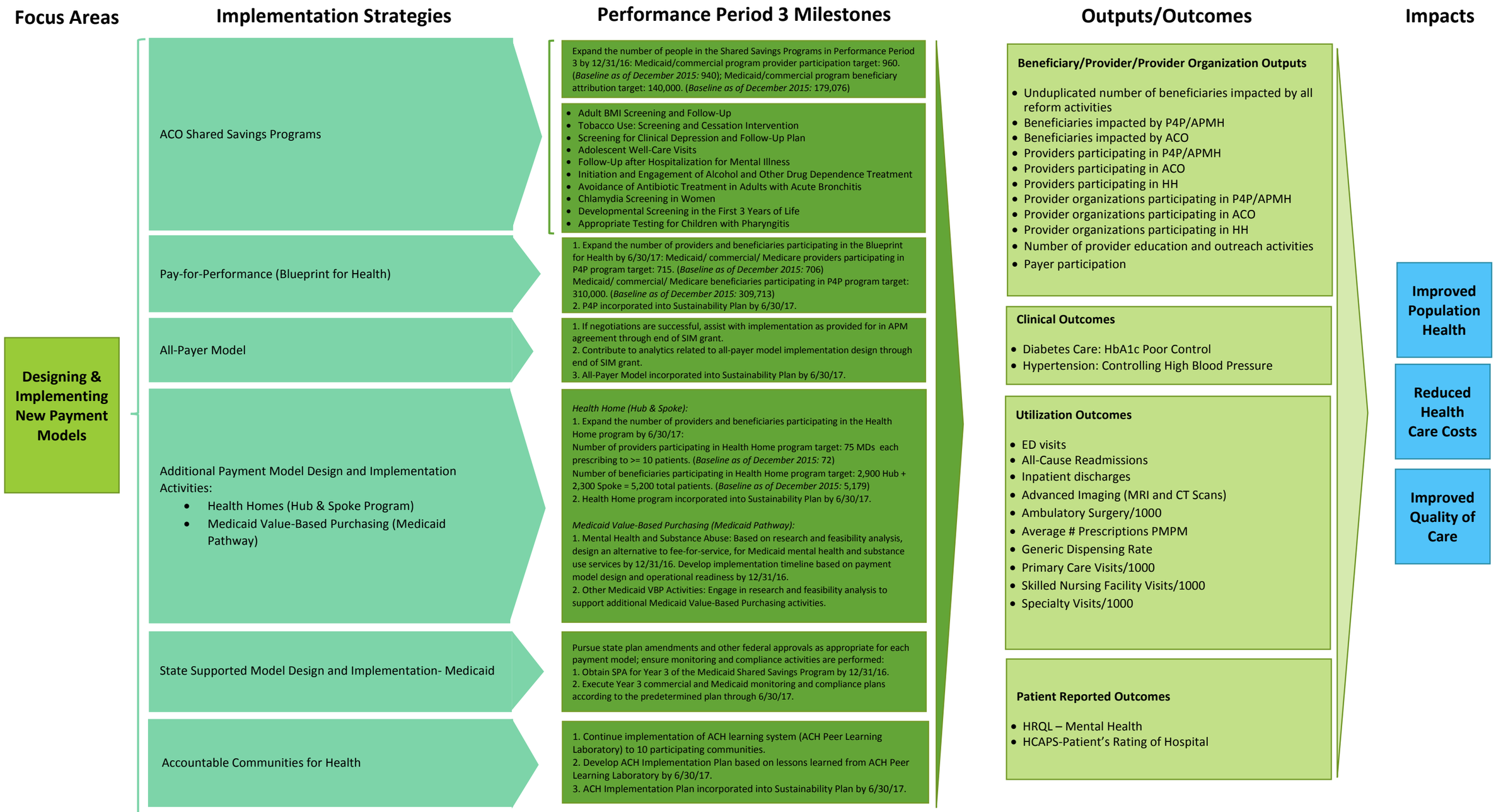


*Figure 13b: Transforming Care Delivery Logic Model for SIM State-Led Evaluation*

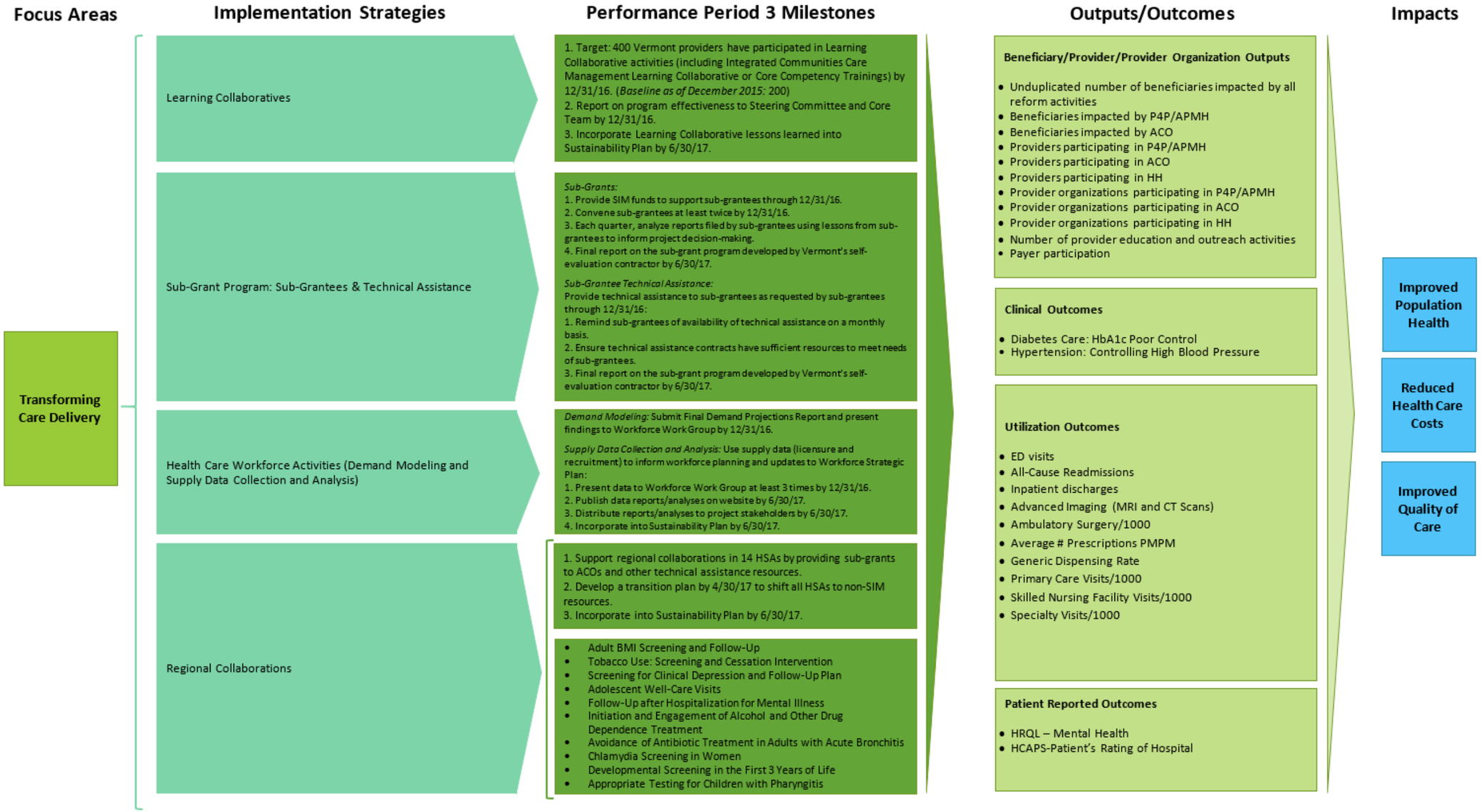
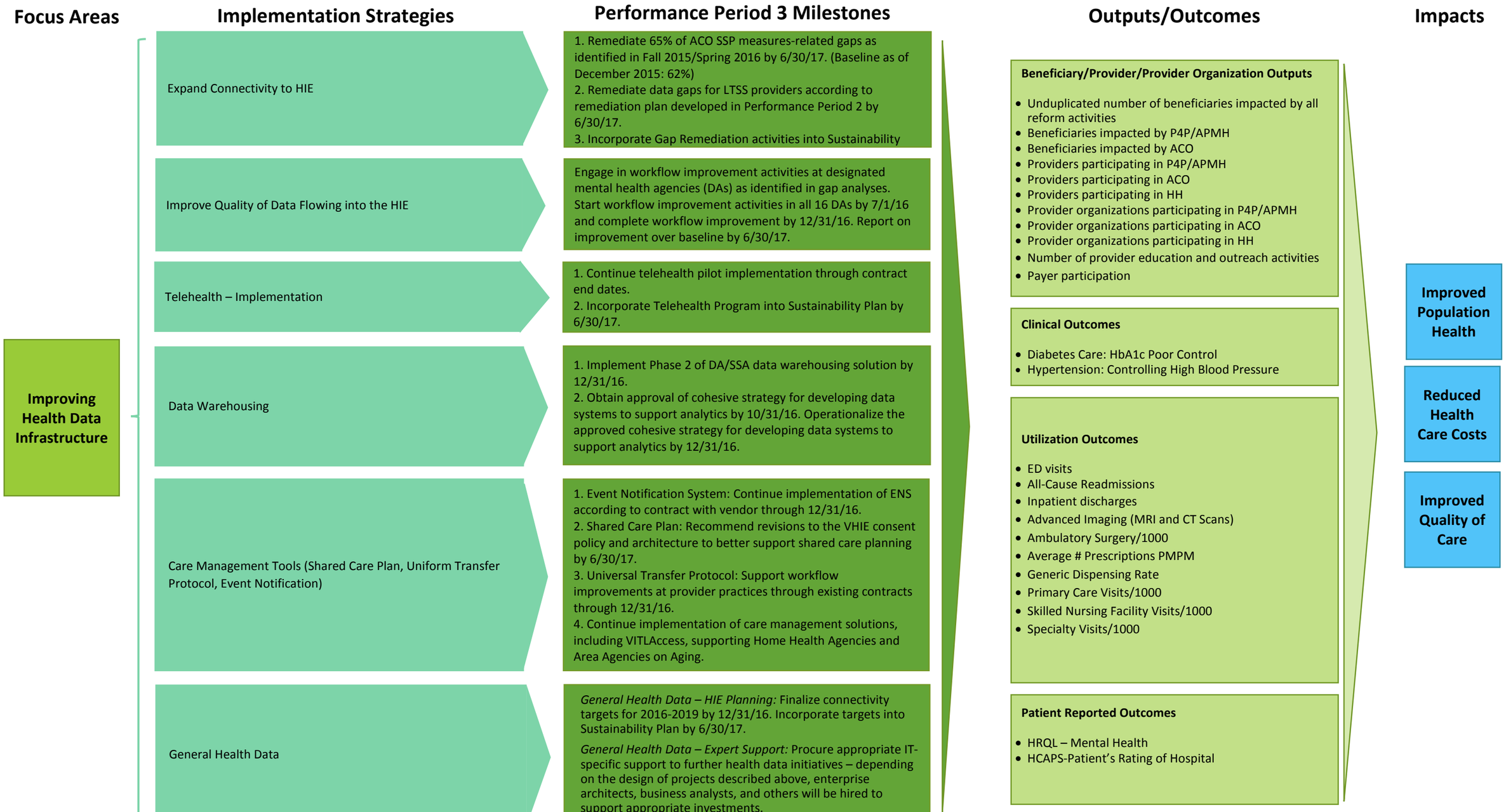


*Figure 13c: Improving Health Data Infrastructure Logic Model for SIM State-Led Evaluation*



### *Logic Model Metrics*

Logic model metrics were identified in consultation with Vermont's State-Led Evaluation vendor and are tracked in order to monitor the impact of Vermont's SIM-supported activities and interventions. The metrics are a combination of high-level goals (discussed in Section H and in Attachment 1), SIM Core Metrics (discussed in Section H), ACO Shared Savings Program metrics (commercial, Medicaid and Medicare SSPs), and population health metrics. Results for logic model metrics are reported in Attachment 6, Self-Evaluation Findings.

Logic Model metrics, also known as Core or VT Specific metrics, are reported to CMMI quarterly and used by project leadership to track SIM project progress towards reaching performance targets. Where Vermont's Logic Model metrics overlap with the SSP results, they are provided to the ACOs and used to support a variety of strategies for continuous quality improvement on the front lines of care. In addition, we provide metrics to the Regional Collaborations (see Section L) so our community partners can engage in regional, community-based, and practice-level strategies and work on continuous performance improvement. Regional Collaborations have been intentionally encouraged to use SIM data, hospital community needs assessments, Blueprint for Health practice profiles, SSP metrics, and other sources of data to design strategies that are specific to the individual regions and communities in which they operate.

Forty-five logic model outcomes are tracked across payer types (commercial, Medicaid and Medicare) and organized into five distinct metric categories: beneficiary/provider/provider organization outputs (9), clinical metrics (12), utilization metrics (11), patient-reported outcomes (11) and Other (2). These are provided in Section H above and in *Tables 15-19* below.

*Table 15: Logic Model Metrics – Beneficiary/Provider/Provider Organization Outputs*

| Metrics | Level of Reporting | Reported Above | Source |
|---|---|---|---|
| CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial | VT | Q1 2016 | Payers |
| CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid | VT | Q1 2016 | Payers |
| CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare | VT | Q1 2016 | Payers |
| CORE_Participating Providers_[VT]_[ACO]_Commercial | VT | Q1 2016 | Payers |
| CORE_Participating Providers_[VT]_[ACO]_Medicaid | VT | Q1 2016 | Payers |
| CORE_Participating Providers_[VT]_[ACO]_Medicare | VT | Q1 2016 | Payers |
| CORE_Provider Organizations_[VT]_[ACO]_Commercial | VT | Q1 2016 | Payers |
| CORE_Provider Organizations_[VT]_[ACO]_Medicaid | VT | Q1 2016 | Payers |
| CORE_Provider Organizations_[VT]_[ACO]_Medicare | VT | Q1 2016 | Payers |
| CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Commercial | VT | Q1 2016 | Payers |
| CORE_Beneficiaries impacted_[VT]_[ APMH/P4P]_Medicaid | VT | Q1 2016 | Payers |

| Metrics | Level of Reporting | Reported Above | Source |
|---|---|---|---|
| CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicare | VT | Q1 2016 | Payers |
| CORE_Participating Providers_[VT]_[APMH] | VT | Q1 2016 | Payers |
| CORE_Provider Organizations_[VT]_[APMH] | VT | Q1 2016 | Payers |
| CORE_Provider Organizations_[VT]_[HH] | VT | Q4 2015 | Payers |
| CORE_Payer Participation [VT] | VT | Q1 2016 | VITL |
| CORE_Unduplicated number of beneficiaries impacted by all reform activities_[VT] | VT | Q1 2016 | Payers |

*Table 16: Logic Model Metrics – Clinical Metrics*

| Metrics | MSSP | Reference | Level of Reporting | Reported Below | Source |
|---|---|---|---|---|---|
| CORE_Diabetes Care_HbA1c Poor Control_ [VT]_ Commercial | 27 | NCQA HEDIS NQF#0059 | VT, ACOs | 2014 | Sample of Medical Records |
| CORE_Diabetes Care_ HbA1c Poor Control _[VT]_ Medicaid | 27 | NCQA HEDIS NQF#0059 | VT, ACOs | 2014 | Sample of Medical Records |
| CORE_Diabetes Care_ HbA1c Poor Control _[VT]_ Medicare | 27 | NCQA HEDIS NQF#0059 | VT, ACOs | 2013 & 2014 | Sample of Medical Records |
| CORE_BMI_Body Mass Screening and Follow Up_ [VT]_Commercial | 16 | NQF#0421 | VT, ACOs | 2014 | Sample of Medical Records |
| CORE_BMI_ Body Mass Screening and Follow Up_ [VT]_ Medicaid | 16 | NQF#0421 | VT, ACOs | 2014 | Sample of Medical Records |
| CORE_BMI_ Body Mass Screening and Follow Up_ [VT]_ Medicare | 16 | NQF#0421 | VT, ACOs | 2013 & 2014 | Sample of Medical Records |
| CORE_Tobacco_ Screening and Intervention_ [VT]_Commercial | 17 | NQF#0028 | VT ACOs | 2014 | Sample of Medical Records |
| CORE_Tobacco_Screening and Intervention_ [VT]_ Medicaid | 17 | MSSP-17 | VT ACOs | 2014 | Sample of Medical Records |
| CORE_Tobacco_ Screening and Intervention_ [VT]_ Medicare | 17 | MSSP-17 | VT ACOs | 2013 & 2014 | Sample of Medical Records |
| Screening for Clinical Depression and Follow-Up Plan_Commercial | 18 | NQF#0418 | VT, ACOs | 2014 | Sample of Medical Records |
| Screening for Clinical Depression and Follow-Up Plan_ Medicaid | 18 | NQF#0418 | VT, ACOs | 2014 | Sample of Medical Records |
| Screening for Clinical Depression and Follow-Up Plan_ Medicare | 18 | NQF#0418 | VT, ACOs | 2013 & 2014 | Sample of Medical Records |
| Adolescent Well-Care Visits_Commercial | | NCQA HEDIS | VT, ACOs | 2014 | Claims |
| Adolescent Well-Care Visits_Medicaid | | NCQA HEDIS | VT, ACOs | 2014 | Claims |
| Follow-up after Hospitalization for Mental Illness_ Commercial | | NCQA HEDIS NQF#0576 | VT, ACOs | 2014 | Claims |

| Metrics | MSSP | Reference | Level of Reporting | Reported Below | Source |
|---|---|---|---|---|---|
| Follow-up after Hospitalization for Mental Illness_ Medicaid | | NCQA HEDIS NQF#0576 | VT, ACOs | 2014 | Claims |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment_Commercial | | NCQA HEDIS NQF#0004 | VT, ACOs | 2014 | Claims |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment_Medicaid | | NCQA HEDIS NQF#0004 | VT, ACOs | 2014 | Claims |
| Avoidance of Antibiotic Treatment in Adult with Acute Bronchitis_Commercial | | NCQA HEDIS NQF#0058 | VT, ACOs | 2014 | Claims |
| Avoidance of Antibiotic Treatment in Adult with Acute Bronchitis_Medicaid | | NCQA HEDIS NQF#0058 | VT, ACOs | 2014 | Claims |
| Clamydia Screening in Women_Commercial | | NCQA HEDIS NQF#0033 | VT, ACOs | 2014 | Claims |
| Clamydia Screening in Women_Medicaid | | NCQA HEDIS NQF#0033 | VT, ACOs | 2014 | Claims |
| Developmental Screening in the First 3 Years of Life_Medicaid | | NCQA NQF#1448 | VT, ACOs | 2014 | Claims |
| Appropriate Testing for Children with Pharyngitis_Commercial | | NCQA HEDIS NQF#0002 | VT, ACOs | 2014 | Claims |
| Appropriate Testing for Children with Pharyngitis_Medicaid | | NCQA HEDIS NQF#0002 | VT, ACOs | 2014 | Claims |
| Controlling High Blood Pressure_Commercial | 28 | NCQA NQF#0018 | VT, ACOs | 2014 | Sample of Medical Records |
| Controlling High Blood Pressure_Medicaid | 28 | NCQA NQF#0018 | VT, ACOs | 2014 | Sample of Medical Records |
| Controlling High Blood Pressure_Medicare | 28 | NCQA NQF#0018 | VT, ACOs | 2013 & 2014 | Sample of Medical Records |

*Table 17: Logic Model Metrics – Utilization Metrics*

| Metrics | Reference | Level of Reporting | Reported Below | Source |
|---|---|---|---|---|
| CORE_ED Visits_ Risk-adjusted, ED Visits/1000 Member Years _[VT]_Commercial | NCQA HEDIS | VT ACOs | 2014 | Claims |
| CORE_ED Visits_ Risk-adjusted, ED Visits/1000 Member Years [VT]_Medicaid | NCQA HEDIS | VT ACOs | 2014 | Claims |
| CORE_Readmissions_[VT]_Commercial | NCQA HEDIS; NQF#1768 | VT ACOs | None | Claims |
| CORE_Readmissions_[VT]_Medicaid | | VT ACOs | None | Claims |
| Risk-adjusted, All Cause Readmission_ Medicare | | VT, ACOs | 2013, 2014 | Claims |
| Risk Adjusted, Ambulatory Surgery/1000_Medicaid | NCQA HEDIS | VT, ACOs | 2014 | Claims |
| Risk-adjusted, Average # Prescriptions PMPM_Medicaid | | VT, ACOs | 2014 | Claims |
| Risk-adjusted, Advanced Imaging (MRI and CT Scans)/1000 Member Years_Medicaid | | VT, ACOs | 2014 | Claims |
| Risk-adjusted, Inpatient Discharges/1000 Member Years_ Medicaid | | VT, ACOs | 2014 | Claims |
| Risk-adjusted, Primary Care Visits/1000_Medicaid | | VT, ACOs | 2014 | Claims |
| Risk-adjusted, Skilled Nursing Facility Days/1000_Medicaid | | VT, ACOs | 2014 | Claims |
| Risk-adjusted, Specialty Visits/1000_Medicaid | NCQA HEDIS | VT, ACOs | 2014 | Claims |

*Table 18: Logic Model Metrics – Patient-Reported Metrics*

| Metrics | MSSP | Reference | Reporting Level | Reported Below | Source |
|---|---|---|---|---|---|
| CORE_HRQL_Mental_Health_[VT] | | CDC BRFSS | Statewide | 2014 | BRFSS |

*Table 19: Logic Model Metrics – Other Metrics*

| Metrics | Level of Analysis | Reported Below | Source |
|---|---|---|---|
| CORE_Number of Provider Education and Outreach_[VT] | Statewide | Q4 2015 | Internal |
| CORE_Health Info Exchange_[VT] | Statewide | Q4 2015 | Internal |

### *Mixed-Methods Study of Three Areas Key to the Success of Health System Transformation*

John Snow Inc. (JSI) has been selected by the state of Vermont to conduct the State-Led Evaluation Study[17]. The contractor will be directed by Vermont's SIM Evaluation Director. The SIM Evaluation Director has convened a stakeholder group to support this study. The stakeholder group is referred to as the Evaluation Steering Committee throughout this section.

#### Key Themes

The evaluation team will utilize a mixed-methods approach, analyzing a complementary combination of qualitative and quantitative data. Study research questions are organized into three themes identified as high priority by Vermont SIM stakeholders: *Care Integration, Use of Clinical and Economic Data to Promote Value-Based Care, and Payment Reform*.

#### *Care Integration*

As described in other Operational Plan sections, integrated care is a key feature of many of Vermont's SIM-funded activities, and a major activity contributing to the goals of better care, lower cost, and better health. The majority of health spending is driven by patients with multiple conditions, multiple providers, and complex care needs. Nationally, there is a growing literature that defines frameworks for care integration and coordination, and recommends measures for assessing its effectiveness. Vermont's focus on care integration is meant to be broad to capture patient-focused care integration and coordination activities performed by clinical and psychosocial providers.

[17] Other Vermont contractors and staff perform the other State-Led evaluation activities identified within this section.

Across Vermont, care integration and coordination supported by the SIM grant takes a variety of forms, including, for example, identifying, reaching out to, and offering enhanced services to vulnerable populations at risk of admission to a nursing home; coordinating care for patients with particular diseases across a spectrum of social service and medical providers; improving care transitions to avoid hospital readmissions; and building on activities of existing community-based care teams. These models vary, but understanding the features of each that are most effective is critical to guide scaling up of care integration and coordination.

The research questions outlined below will guide the evaluation for this theme:

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

Work on the *Care Integration* theme will incorporate perspectives from the field on how integrated care models are building from services, programs and models that already exist in local communities, as well as partnerships between clinical and non-clinical providers.

### *Use of Clinical and Economic Data to Promote Value-Based Care*

Data play a pivotal role in Vermont's SIM-supported efforts to transform its health system. Various project activities use clinical and economic (cost) data in different ways: to inform providers, for internal and external monitoring of population health data, for quality improvement, for payment, and to identify opportunities for efficiency. Clinical and cost data are shared with various audiences and come from a variety of sources including VHCURES, automated extracts from EMRs, and manual abstraction of medical records. Examples of clinical and economic data include: cost information regarding hospitalizations and hospital readmissions; services where utilization and spending vary across regions or providers; identifying opportunities for gaining efficiency; and quality metrics that inform clinical care. Knowledge of providers' interpretation, trust, and use of data allows, and will continue to allow the State, payers, contractors, and other "data owners" to develop reports and data in user-friendly formats.

To further investigate this theme, the State-Led Evaluation contractor will visit practices to examine the process of producing, communicating, and sharing data in support of transformation, as well as how these data are received, understood and applied by providers.

The research questions outlined below will guide the evaluation for this theme:

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

Work on this theme will incorporate inquiry into how providers monitored value and performance prior to VHCIP, whether/how health outcomes data at the community level impacts practice patterns, and the process by which providers learn and respond to results from measures communicated to them.

### *Payment Reform and Financial Incentive Structures*

Vermont's physicians are currently operating in a system which simultaneously employs multiple payment models and financial incentive structures across payers and populations, although individual provider experience varies. Models implemented or in development with SIM support are described in Section F of this Operational Plan.

The research questions outlined below will guide the evaluation for this theme:

- Under what financial and non-financial incentive structure(s) do providers practice in Vermont?
- Are providers aware of the incentive structure under which they practice? If so, how do providers view the current incentive structure(s) under which they practice? Why?
- What changes, if any, have taken place in the way providers practice as a result of these incentive structures? How does payment reform impact care integration, coordination, and provider collaboration?

- How do attitudes toward incentives and changes providers have made in practice (if any) differ across provider types (primary care, specialty care), practice sizes (solo, small and large group), and ownership (hospital-owned vs independent)?
- Are there non-financial provider incentives that influence patient care, quality, and provider collaboration?
- What further adaptations at the practice and provider level do providers anticipate in the transition to next generation payment models, such as shared savings with downside risk, episode-of-care based payment, and global budgeting? What additional support or technical assistance do providers anticipate needing in making this transition?

Work on this focus area will incorporate inquiry into whether and how payment reform impacts the practice of preventive medicine, and whether and how payment models are driving care integration.

### Environmental Scan & Site Visit Plan

The environmental scan is the first phase of the project starting in March 2016 and concluding in May 2016. This scan informs many of the subsequent activities of the evaluation; it collects information that will provide contextual framing to the evaluation findings. The environmental scan will:

1. Develop a picture of the provider landscape in Vermont to inform evaluation methods and provide context to evaluation results.
2. Identify the diverse site visit locations that will best inform the three research themes of the evaluation.
3. Inform content of the interviews during the site visits and development of the site visit guide.
4. Inform the sampling approach for the provider survey and survey for providers engaged in care integration.
5. Inform survey content and questions based on information found in the literature review and provider landscape.

The environmental scan will collect and synthesize information within each of the three research themes described above. The State-Led Evaluation contractor will produce a brief report documenting environmental scan key findings along with the Site Selection Matrix (see below).

### Site Visits, Interviews & Focus Groups

Following the environmental scan, the State-Led Evaluation contractor will then develop site visit tools including an interview guide to facilitate a productive discussion and assure consistent approaches across various contractor teams conducting site visits. A Master Site Visit Interview Guide will consist of questions and probes focused on understanding the core

research questions in care integration, use of clinical and economic data to promote value-based care, and payment reform and financial incentive structures. The Master Site Visit Interview Guide will seek to engage sites in a discussion to understand and document the context of their organization and work. In addition, the State-Led Evaluation contractor will explore inputs to learning dissemination, understanding the communication tools and venues that will assure broad distribution and availability of the overall evaluation findings and final report.

A Standardized Site Summary Tool (SST) will be developed for each of the selected sites and interviews. The SST will be used before the site visit or interview to capture and summarize site information and shared among the contractor's site visit team. The SST will serve as a profile of the site based upon the environmental scan and interviews with Vermont SIM leadership. Based upon the SST, the contractor will revise and tailor the Master Site Visit Interview Guide for each site in order to assure questions explore the specific nuances and context of the site visited. Following site visits, the State-Led Evaluation contractor will provide de-identified transcripts and report relevant and actionable findings to key Vermont staff and the Evaluation Steering Committee during Summer 2016.

The State-Led Evaluation contractor will also develop a focus group guide to address research/knowledge gaps and the project objectives and questions. The focus group guide will help to determine attitudes, beliefs, needs, and expectations for the consumer audiences in regards to the central research questions.

The State-Led Evaluation contractor will then conduct an analysis of site visit, interview and focus group data. The contractor will use NVivo 10 to manage and analyze the qualitative data. The contractor will prepare a draft report that documents the process and findings of each the site visits, interviews and focus groups respectively as well as insights regarding learning dissemination. This draft report will be an internal document which will inform future tasks and be included in a comprehensive report.

### Provider Surveys

The State-Led Evaluation contractor will conduct provider surveys. These surveys will be used to supplement information gathered from the federal evaluation regarding the impact of SIM activities on Vermont's providers. These will be fielded for two populations:

- A survey of physicians and mid-level practitioners; and
- A survey of providers involved in care integration and care coordination.

The physician and mid-level practitioner survey will use 2014 physician licensing census data and license data on advance practicing nurses from the Vermont Secretary of State as target lists for provider surveys. Vermont expects approximately 2,000 physicians/mid-level providers to be contacted to participate in this survey. Information gleaned during the environmental scan will contribute to the finalization of the list for survey purposes.

The survey of providers involved in care integration/coordination activities will use lists provided by the Blueprint for Health, Community Health Teams, and ACOs to build on Vermont's SIM-funded care management inventory research, conducted during Performance Period 1. The expectation is that 500 care integration professionals will be contacted to participate in the survey.

The State-Led Evaluation contractor will develop two separate surveys for the two target populations. The contractor will select questions for inclusion from a variety of sources: the research literature, topics that emerge from the qualitative site visits, and discussions with Vermont SIM leadership, as well as other topics identified during the Environmental Scan. The two surveys will be available in two modalities: a scannable paper and pencil version, and an on-line version.

The State-Led Evaluation contractor will also employ a secondary mechanism for collecting the data: asking for responses at the provider meetings that are concurrent with the data collection period or right after the mailings end. The contractor will provide the State a response rate report for physicians/mid-levels and response rate report for care integration professionals.

The State-Led Evaluation contractor will perform several analyses that compare differences in responses among different groups of providers as well as describing overall, state-wide results. The contractor will test for differences in answers by regions of the state, gender or age of provider; training of the provider; various practice characteristics (e.g. size or association with a hospital); and differences by roles of the providers. Categorical variables will be analyzed using chi-square, whereas continuous variables will use t-tests or ANOVAs. As multiple elements often influence program outcomes, the State-Led Evaluation will consider using general linear models to consider the contribution of multiple factors in predicting an "outcome."

### *Sub-Grantee Evaluation*

Sub-grantees within Vermont's Sub-Grant Program represent a variety of organizations, practices, and collaborations. As such, the individual projects have the flexibility to choose the evaluation metrics and methodologies that are most effective and feasible based on their capabilities and focus areas.

Common processes and metrics across the projects include claims and clinical data analysis to support the measurement of numbers of emergency department visits; in-patient utilization rates and hospital readmissions; numbers of patients referred into the various pilot programs; and quality of life and patient satisfaction surveys. Other projects cover specific areas such as testing optimization, and counting the reduction in the numbers of lab orders, needle sticks, and volume of blood drawn from patients.

Many of the sub-grantees have partnered with an agency or have availed themselves of SIM-provided technical assistance contractors for assistance with evaluation. The Vermont

Department of Health and the Department of Vermont Health Access are both providing claims and data analysis to support evaluation activities; several sub-grantees are using in-house (hospital based) data analysts to assist with programmatic data analysis, and evaluation. One sub-grantee has contracted with the Center for Rural Studies at the University of Vermont for assistance with data analytics and evaluation.

### *Other SIM Evaluation Efforts*

Progress on SIM milestones are tracked and reported externally to CMMI and internally to the SIM Core Team and other key stakeholders. The Core Team reviews funding requests in light of progress reporting and allocates accordingly. Meetings are used to present progress, discuss project strengths and challenges, and brainstorm ways to more efficiently and effectively meet program goals.

As described in Section S and Attachment 7, project leadership participates in regular on-going risk assessment activities. At the focus area level, each SIM work group has individual workplans with more detailed milestones and targets applicable to the content of the work group. Workplans are compared across groups and regularly updated to assess progress within the groups' area of focus. These comparisons allow for intentional linkages across work groups by topical area, and allows the work groups to benefit from receipt of information from each another. Often, subject matter experts inform work group activities, provide relevant information, help advise work group members when obstacles arise and make suggestions to maximize progress. Vermont also utilizes a monthly webinar series to highlight progress and shared lessons learned.

The Federal SIM evaluation and State-Led Evaluation reporting continuously inform Vermont's SIM project administration. The mixed-methods Federal SIM evaluation results include qualitative analysis of stakeholder interviews, consumer and provider survey results, and quantitative analysis of SIM impacts statewide and at the ACO level. Federal evaluation results are released and shared with SIM stakeholders annually. Other information used for continuous improvement includes monthly data reviews by payers, ACO operations team meetings, and All-Payer Model alignment meetings.

Vermont's SIM project actively facilitates shared learning through the work groups, an annual project-wide symposium, public presentations, provider grantee symposiums, and learning collaboratives. Shared learning mechanisms have directly contributed to the teamwork and team building that influences stakeholder willingness to engage in the significant transformation activities funded by the grant. Shared learning provides inspiration through case study presentations, shared programmatic successes, and results that demonstrate the effectiveness of innovations underway that create positive change in the lives of Vermonters. This willingness is a key ingredient in moving forward with sometimes difficult and novel changes in payment and delivery system reforms.

CMMI's annual site visits to Vermont also serve as an opportunity for stakeholders to summarize and share their progress on diverse fronts with each other and CMMI. The SIM project director and State staff give public presentations to the Legislature, Green Mountain Care Board, Administration Departments and Advisory Groups, ACOs, work groups and others with the level of specificity of metric or other results appropriate to the audience. Education about SIM activities has helped build connections and reduce duplication of efforts.

*Figure 14,* below visually depicts Vermont's key continuous improvement data sources, users and activities.

*Figure 14: Vermont SIM Evaluation*


## *Evaluation Data Synthesis and Learning Dissemination*

### Data Synthesis

In addition to the State-Led Evaluation Study, the self-evaluation contractor will review logic model results and a broad range of secondary data to assess the current status of the provider landscape and provide information for overall VHCIP evaluation findings and analysis. Some of

the data will be used as proxies to understand high-performing versus low-performing practices. Examples of the types of data that will be included are the following:

- PCMH certification status;
- Uniform Data System data for FQHCs;
- Participation in Accountable Care Organizations;
- Participation in behavioral health integration;
- Affiliation with hospital systems (large vs. small);
- Payer mix;
- Type of institution: institutional providers, hospitals, long term care facilities, primary care practices (representing variety of affiliation and ownership models), specialty practices;
- Health information exchange (HIE) participation status;
- Degree of SIM and/or Blueprint for Health involvement;
- Participation in innovative care management model: Community Health Teams, Vermont Chronic Care Initiative, and other interdisciplinary teams;
- Regional Collaborations, local interagency teams, or other interdisciplinary teams that drive care and service coordination at the policy level;
- Participation in ACOs' clinical and economic data communication;
- SIM provider sub-grantee status;
- Trans-provider organizations;
- Geographic location; and
- Size of organization.

The State-Led Evaluation contractor will combine qualitative, survey, and other secondary data for comprehensive findings. The contractor will be synthesizing, reporting on, and disseminating information as it is obtained on a monthly basis starting with the environmental scan through to the end of the seven quarter evaluation period. During monthly SIM Evaluation Steering Committee meetings, the contractor will present a list of data sources and elements being merged with findings. Each monthly SIM Evaluation Steering Committee meeting will include an evaluation findings agenda item where the contractor will report on sources added, activities, and learnings to date.

Sources for this information will include, but not be limited to: SSP and Blueprint Measure Results; SIM survey results; SIM provider grants evaluation results; CAHPS survey results; and RTI evaluation reports. The State-Led Evaluation contractor will complete a final report that integrates project-wide qualitative and quantitative findings and generates actionable recommendations to guide State leadership decisions to scale-up and diffuse SIM-supported initiatives by Q4 of 2017.

### Learning Dissemination

The State-Led Evaluation contractor will also work with Vermont to develop and finalize a Learning Dissemination Plan draft by Q3 of 2016. The plan will include detailed activities for sharing findings from both the State-Led Evaluation study, and the integration of findings from evaluation efforts across the state. The contractor will identify and finalize specific formats, dates for distribution, and audiences based on input from the VHCIP team regarding overarching objectives and available resources.

The Learning Dissemination Plan will do the following:

- Clearly identify target audiences and goals of dissemination activities for each audience (e.g., share lessons learned, communicate implications of evaluation findings for other settings, enhance transparency, build public awareness);
- Develop a learning-based communication strategy that will share lessons learned in near-real time to enable rapid-cycle process improvement and informed decision-making related to state-level and local initiatives;
- Use diffusion activities as an additional opportunity to solicit stakeholder feedback to inform ongoing evaluation efforts (e.g., asked audiences “has this been your experience?” or “does this data resonate with you?”)
- Use technology, clear communication, and data visualization to make findings easily digestible;
- Target diverse Vermont stakeholders including state agencies, payers, providers, consumer groups and community-based organizations;
- Target national audiences to share lessons in state-led health reform efforts in recognition of Vermont’s role as a leader in health care reform;
- Take advantage of existing forums to effectively engage audiences; and
- Support and enhance transparency of health reform efforts in Vermont.

The State-Led Evaluation contractor will work collaboratively with the State to assess and document the effectiveness of the Learning Dissemination plan and develop a sustainability plan to ensure that learning dissemination continues into 2018 and beyond.

#### *Surveys*

***<u>Performance Period 3 Milestone</u>: Conduct annual patient experience survey and other surveys as identified in payment model development:***

***Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings Programs by 6/30/17.***

Vermont’s SIM team fielded practice-level patient experience surveys that could be used for both patient-centered medical home recognition and ACO patient experience survey measures in Performance Periods 1 and 2. During Performance Period 3, Vermont will continue to field

patient experience surveys and develop practice-level, health service area-level, and ACO-level reports.

### *Monitoring and Evaluation Activities Within Payment Programs*

***Performance Period 3 Milestone:***

1. ***Conduct analyses of the PCMH program (non-SIM funded) according to program specifications (bi-annual reporting to providers).***
2. ***Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications (monthly, quarterly reports depending on report type).***
3. ***TBD: APM, Medicaid VBP – Mental Health and Substance Use.***

In Performance Period 3, Vermont will continue to perform ongoing monitoring and evaluation activities to support development and successful implementation of innovative payment models. In past performance periods, these activities have focused on Vermont's Medicaid and commercial Shared Savings Programs, as well as Vermont's SIM Pay-for-Performance investments (the Blueprint for Health patient-centered medical home program). These activities will continue in Performance Period 3, in addition to new activities in this area that will support the All-Payer Model and Medicaid Value-Based Purchasing work streams.

## Section S: Risk Mitigation Strategies

Vermont is engaged in regular and robust risk identification and mitigation processes. Using the template provided by CMMI, the Risk Register is thoroughly reviewed and updated on a quarterly basis. As risks arise during the project, they are added to the risk register, ranked according to impact and probability, and a mitigation plan is put into place

Vermont's Risk Mitigation Plan is included under separate cover as Attachment 7.

# Section T: Other Health Care Innovation Activity

This section of Vermont's Operational Plan provides a progress update on work performed since the submission of our Performance Period 2 no-cost extension request in December 2015. That request included a description of work planned during the January-June 2016 Performance Period 2 no-cost extension period.

### *Performance Period 2 No-Cost Extension Overview*

On December 3, 2015, Vermont formally requested a six-month no-cost extension, extending Performance Period 2 to 18 months (January 2014-June2016). Vermont's justification for the no-cost extension request was two-fold:

1. Vermont's Year Two budget and milestones were not approved until September 2015. Vermont's Performance Period 2 budget for the 2015 calendar year was approved on October 9, 2015. Delays in receipt of approvals for Performance Period 2 milestones and contracts resulted in significant delays in contract work in 2015; in order to be fiscally responsible and prudent, the state stopped or slowed the work of many contractors for which we had not yet received federal approval. Extending Performance Period 2 allowed Vermont the necessary time to accomplish our Performance Period 2 milestones.
2. Stakeholder fatigue has presented a significant challenge to Vermont's SIM project since the launch of the grant, and has resulted in an intentional slowdown of some payment model design and implementation activities. Extending the total length of the grant period allows Vermont to engage in additional design, implementation, testing, and evaluation of new payment models and other SIM activities.

Vermont's Performance Period 2 no-cost extension request was approved on December 9, 2015.

As part of this no-cost extension request, Vermont proposed activities for the January-June 2016 Performance Period 2 no-cost extension period and described how each would support achievement of Performance Period 2 milestones and overall SIM program goals. The activities span Vermont's five SIM focus areas. These activities are listed below. Attachment 3, Vermont SIM Milestone Summary and Driver Diagram, provides a summary view of progress by milestone for all performance periods, including the 6-month no-cost extension period; additional information on each milestone and progress to date can be found in earlier sections of this operational plan, or summarized by project in Attachment 4, March 2016 Project Status Reports.

### Milestones Supporting CMMI Requirements

Vermont is working to achieve four milestones which underpin all of our SIM activities. These milestones support specific CMMI requirements and meet SIM grant terms and conditions.

During the January-June 2016 Performance Period 2 no-cost extension period, Vermont has worked on the following projects and tasks within this focus area, each of which corresponds to a milestone (see Attachment 3, Vermont SIM Milestone Summary and Driver Diagram):

- Continued ***Program Implementation***: During the January-June 2016 Performance Period 2 no-cost extension period, Vermont has continued to implement our SIM project statewide. This milestone is inclusive of all other Performance Period 2 milestones, and is supported by all SIM contractors, staff, and key personnel.
- Continued implementation and expansion of ***Payment Models***: As of December 2015, approximately 55% of eligible Vermonters are in alternatives to fee-for-service. During the January-June 2016 Performance Period 2 no-cost extension period, Vermont has continued to expand existing payment models, as well as planning for the implementation of new payment models which will move more Vermonters into alternatives to fee-for-service in Performance Period 3 and beyond. For more information, see the Section F of this Operational Plan. This milestone is supported by all SIM contractors, staff, and key personnel.
- Work to support development of Vermont's ***Population Health Plan***: Led by our SIM project's Population Health Work Group, Vermont has been working to develop concepts that will support our Population Health Plan since 2014, and has developed a draft outline for the Plan. During the January-June 2016 Performance Period 2 no-cost extension period, Vermont has continued with stakeholders and State agencies and departments to further develop, refine, and finalize this outline, which will be completed by June 30, 2016. Writing will occur during Performance Period 3.
- Work to support development of a ***Sustainability Plan***: Vermont has increasingly focused on sustainability planning during the January-June 2016 Performance Period 2 no-cost extension period. Vermont has identified an overall sustainability planning strategy during this time, which will include consultation with State agencies and departments as well as project participants to identify lessons learned and activities, tools, and products to support sustainability. Vermont will develop a Sustainability Plan outline for submission to CMMI by June 30, 2016, and will procure a contractor to support sustainability planning activities to take place in Performance Period 3.

### Payment Model Design and Implementation

During the January-June 2016 Performance Period 2 no-cost extension period, Vermont has worked on the following projects and tasks within the Payment Model Design and Implementation focus area, each of which corresponds to a milestone (see Attachment 3, Vermont SIM Milestone Summary and Driver Diagram):

- Continued expansion of Vermont's ***ACO Shared Savings Programs***: The third program year for both the Vermont Medicaid and commercial ACO Shared Savings Programs began on January 1, 2016. In the January-June 2016 Performance Period 2 no-cost extension period, work has focused on continued program implementation and evaluation of cost and quality results from the first and second SSP program years. Additional focus during this period is on expanding the number of Vermonters served in this alternative payment model, in particular by targeting additional beneficiary populations for attribution. The January-June 2016 Performance Period 2 no-cost extension period has also provided an opportunity for payers, ACOs, and the provider community to discuss future movement toward population-based payments upon completion of the SIM testing period (see All-Payer Model, below).
- Launch of a Medicaid ***Episodes of Care Program***: In April 2016, following internal discussion and discussion with CMMI, Vermont's SIM leadership team elected to discontinue this activity due to estimated episode launch date (7/1/17, following the end of Vermont's SIM Model Testing period) and inability to evaluate the model prior to the end of SIM. The initiative had been previously delayed; provider and stakeholder support for this work stream was never fully realized due to significant provider fatigue and concurrent competing payment reform priorities. The State will continue work on IFS program payment models through the Medicaid VBP (Medicaid Pathway) work stream during Performance Period 3.
- Continuation of a ***Pay-for-Performance*** program, implemented through the Blueprint for Health: During the January-June 2016 Performance Period 2 no-cost extension period, Vermont has continued to implement and monitor the Blueprint for Health program. The Blueprint implemented a major payment change during this period (described in greater detail in Section F), in addition to supporting SIM-funded practice transformation activities including Learning Collaboratives and Regional Collaborations (described in Section L).
- Continued reporting and monitoring for the ***Medicaid Health Homes program***, also known as the Hub and Spoke program: Vermont Medicaid's Health Home initiative – the Hub and Spoke program for treatment of opioid addiction – has been in operation since July 2013, with statewide roll-out beginning in January 2014. During the January-June 2016 Performance Period 2 no-cost extension period, implementation activities for this program have continued, with emphasis on further expanding the state's capacity to collect and report on performance metrics specific to this program.
- Design and analysis related to ***Accountable Communities for Health***: During the January-June 2016 Performance Period 2 no-cost extension period, Vermont has built upon work completed in prior Performance Periods regarding Accountable Communities for Health (ACHs) by launching a collaborative peer learning opportunity for Vermont communities interested in becoming ACHs. This will allow for the dissemination of lessons learned from the state's work with the Prevention Institute to explore the ACH concept, identify communities in Vermont that are early leaders in this field, and develop recommendations to support Vermont in moving toward this model.

- Development of a ***Prospective Payment System for Home Health***: January-June 2016 Performance Period 2 no-cost extension period activities have also included the design of a Prospective Payment System (PPS) for home health services covered by Medicaid. The methodology for the PPS program was established in 2015; work in 2016 has focused on establishing a quality framework. Program launch was originally planned for 7/1/16; however, at the request of home health providers around the state, Vermont's Legislature is considering a delay in implementation of this model until July 1, 2017 (see Section B). In response to this change, Vermont's SIM project has suspended this effort and eliminated this milestone in Performance Period 3. SIM staff will work to coordinate with non-SIM-funded DVHA staff throughout planning and launch to ensure coordination and alignment with SIM efforts.
- Development of a ***Medicaid Value-Based Purchasing program (Medicaid Pathway)***: Development of a Medicaid value-based purchasing program to complement the All-Payer Model has been a significant focus of work during the January-June 2016 Performance Period 2 no-cost extension period. This work, known as the Medicaid Pathway, is led by the Agency of Human Services Central Office in partnership with the Agency of Administration that addresses payment and delivery system reforms that must happen in coordination with the All-Payer Model. This process focuses on engagement of Medicaid service providers who provide services that are not provided exclusively (or at all) through the initial APM implementation, such as LTSS, mental health, substance abuse services and others. To launch this process, the State has convened providers from each these sectors along with other key partners to determine how best to serve Vermonters through a more integrated continuum of Mental Health, Substance Abuse and Developmental services. This work is described in greater detail in Sections B, F, L, and M.
- Design and analysis to support decision-making related to an ***All-Payer Model***: During January-June 2016 Performance Period 2 no-cost extension period, SIM investments continued to support crucial All-Payer Model (APM) progress, including researching feasibility, developing analytics, and obtaining information to support APM negotiating team decision-making to complete term sheet and waiver terms and conditions. Further, SIM investments continue to support analytics related to APM implementation design for the State, payers, and providers.
- ***State Activities to Support Model Design and Implementation*** at Medicaid and GMCB: Activities to support model design and implementation ensure that Vermont State agencies have the infrastructure and regulatory capacity to implement and appropriately monitor new payment models. This area of work also ensures that appropriate federal approvals are in place, such as Medicaid State Plan amendments. During the January-June 2016 Performance Period 2 no-cost extension period, Vermont Medicaid has continued to implement and monitor our SSPs and perform other necessary tasks related to federal approval for these programs. Vermont Medicaid also submitted the Medicaid Shared Savings Program Year 3 State Plan Amendment in this time period. Activities to support model design and implementation at GMCB have been incorporated into the All-Payer Model work stream.

### *Practice Transformation*

During the January-June 2016 Performance Period 2 no-cost extension period, Vermont has worked on the following projects and tasks within the Practice Transformation focus area, each of which corresponds to a milestone (see Attachment 3, Vermont SIM Milestone Summary and Driver Diagram):

- Continued implementation of ***Learning Collaboratives*** to support improved and integrated care management in Vermont communities, and launch of ***Core Competency Trainings***: During the January-June 2016 Performance Period 2 no-cost extension period, Vermont continued to implement the Integrated Communities Care Management Learning Collaborative for three cohorts with eleven total communities. These multi-community learning collaboratives are rolling out statewide to share and diffuse best practices for care coordination and to help multi-organizational teams work most effectively with at-risk Vermonters, and provide communities with continuous quality improvement (CQI) training, local QI facilitation, and regular in-person learning sessions and webinars for participants. In addition, Vermont's SIM project launched a new Core Competency Training initiative during this period. The Core Competency Training initiative offers a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities state-wide. Core curriculum covers competencies related to care coordination and disability awareness. In total, 34 separate training opportunities will be made available to up to 240 participants state-wide.
- Continued implementation of A ***Sub-Grant Program*** for Vermont providers, including a ***technical assistance*** component: During the January-June 2016 Performance Period 2 no-cost extension period, Vermont continued its Sub-Grant program, which launched in 2014 and has provided 14 awards to 12 provider and community-based organizations who are engaged in payment and delivery system transformation. Sub-grantees have continued project implementation during the no-cost extension period, and have continued to receive technical assistance as requested and appropriate. In addition to submitting quarterly reports to SIM staff, sub-grantee progress and findings are reported to the Practice Transformation Work Group regularly, and other SIM work groups as requested. Sub-grant projects will wrap up during Performance Period 3. More information about this is found in Section M.
- Continued growth of ***Regional Collaboratives*** to support integration of the Blueprint for Health and Vermont's ACOs, and to enable community-wide governance and quality improvement efforts: Regional Collaborations are active in all 14 Health Service Areas (HSAs) to support integration of the Blueprint for Health and Vermont's ACOs, and to enable community-wide governance and quality improvement efforts. During the January-June 2016 Performance Period 2 no-cost extension period, SIM staff and partners (including the Blueprint for Health and ACOs) worked with Regional Collaboratives in all 14 HSAs to support continued development of governance

structures and decision-making processes. More information about this is found in Section M.

- Launch of ***Workforce Demand Modeling*** efforts: During the January-June 2016 Performance Period 2 no-cost extension period, Vermont worked to execute a contract with a vendor to perform micro-simulation workforce demand modeling using state-provided data. A "micro-simulation" demand model was selected based the Vermont's dynamic health care reform environment and the high degree of flexibility that this type of model affords in terms of inputting various assumptions about care delivery in a high-performing health care system. This contract was finalized in April 2016, and work will begin prior to the start of Performance Period 3.
- Progress on ***Workforce Supply Data Collection and Analysis***: Vermont has continued work to assess current workforce supply and model future workforce demand during the January-June 2016 Performance Period 2 no-cost extension period. SIM-supported workforce supply data collection and analysis efforts are situated at the Vermont Department of Health (VDH). VDH staff develop and administer surveys to accompany provider re-licensure applications, and perform analysis on licensure data and develop provider reports on various health care professions. The Workforce Work Group has received initial presentations on survey results and will continue to receive them through Performance Period 3; a sub-group was formed during the no-cost extension period to analyze VDH data and provide this analysis to the broader work group, with the goal of informing Work Group activities.

### *Health Data Infrastructure*

During the January-June 2016 Performance Period 2 no-cost extension period, Vermont has worked on the following projects and tasks within the Health Data Infrastructure focus area, each of which corresponds to a milestone (see Attachment 3, Vermont SIM Milestone Summary and Driver Diagram):

- Continued ***Gap Remediation*** efforts: The remediation recommendations for disability and long-term services and supports providers identified in the DLTSS Technology Assessment, completed in 2015, were leveraged in the January-June 2016 Performance Period 2 no-cost extension period to develop a remediation plan for the DLTSS provider community. Working with VITL and DLTSS providers, Vermont's SIM Team has identified high impact connectivity and accessibility targets among the Home Health Agencies and Area Agencies on Aging; planned work in Performance Period 3 is described in Section D.
- Improvements to the ***Quality of Data Flowing into the VHIE***: During the January-June 2016 Performance Period 2 no-cost extension period, Vermont's SIM Team continued work with VITL to improve workflow at provider practices. This practice-specific work results in higher quality clinical data flowing into Vermont's Health Information Exchange (VHIE). VITL has coordinated with Vermont's ACOs and the DAs/SSAs on data quality workflow improvement activities, and will continue to do so through the end of the Performance Period 2 extension period and into Performance Period 3. These

workflow and technology improvements and investments will have lasting effects in enhancing clinical data quality throughout the remainder of Performance Periods 2 and 3, as well as beyond the lifecycle of Vermont's SIM project.

- Launch of ***Telehealth Pilots*** aligned with the Statewide Telehealth Strategy: In calendar year 2015, Vermont completed a Statewide Telehealth Strategy and released an RFP for telehealth pilots which aligned with core strategy elements. During the January-June 2016 Performance Period 2 no-cost extension period, Vermont selected successful two bids for pilot implementation and negotiated contracts; contracts will be executed and pilot projects launched prior to the end of the no-cost extension period.
- Continued efforts to ***Expand Implementation of Electronic Medical Records*** to non-Meaningful Use-eligible providers: During Performance Period 2, Vermont's SIM Team has engaged with VITL and Vermont Care Network to provide technical assistance to both ARIS (Vermont's Specialized Service Agencies) and Vermont's Department of Mental Health in the procurement of new EMR solutions. Investments were also made with ARIS to support a new EMR for five State designated non-profit developmental service agencies. Work for Vermont's Department of Mental Health is completed. Work on the ARIS is not complete and will continue through the end of the no-cost extension period.
- Progress on ***Data Warehousing*** to support the State and providers in improving data quality, and aggregating and analyzing health data:
    - During Performance Period 2, Vermont has worked with Vermont Care Network (VCN) to identify requirements, perform discovery, and begin the procurement process to implement a mental health-specific data repository that is compliant with 42 CFR Part 2. This repository will aggregate, analyze, and improve the quality of stored data, as well as share extracts with appropriate entities. The contract was executed in late 2015, and VCN is now working with the vendor to develop the data warehouse and other supporting tools.
    - Also during the January-June 2016 Performance Period 2 no-cost extension period, Vermont is completing the migration of its hosted Clinical Registry tool (known as DocSite) to VITL's infrastructure. As described in Section D, Vermont acquired the Covisint DocSite clinical registry software in 2015. DocSite has been a key tool for the Blueprint for Health and Support and Services at Home (SASH) programs for over 5 years and contains significant historical data to support care management and evaluation activities. This project includes migrating the software and data from one hosted environment to another, which will support data aggregation and reporting initiatives for the Blueprint for Health; acquisition allows the Blueprint and SASH programs to continue to work with this tool and historical data as the State and partners work to develop a more comprehensive data warehousing solution.
    - Additionally, Vermont's SIM team is developing a comprehensive strategy for long-term data warehousing services. This work began in Performance Period 2 and has continued during the January-June 2016 Performance Period 2 no-cost extension period.

- Discovery and design activities to develop ***Care Management Tools***, including an electronic shared care plan solution, a universal transfer protocol, and an event notification system:
    - During the January-June Performance Period 2 no-cost extension period negotiated and executed contracts with VITL and PatientPing, an event notification system (ENS), to provide admissions, discharge, and transfer notifications to Vermont providers. PatientPing and VITL have completed implementation of all 15 VITL feeds in the PatientPing environment. The ENS project formally launched in mid-April.
    - During the January-June Performance Period 2 no-cost extension period, Vermont continued research and discovery related to the Shared Care Plan and Universal Transfer Protocol projects. This work culminated in the decision in March 2016 not to pursue technology solutions for either of these work streams; instead Shared Care Plan project work will focus on revisions to the VHIE consent policy and architecture, and Universal Transfer Protocol goals will be pursued through workflow redesign support within practices. Plans for both areas of work will be solidified during the remainder of the no-cost extension period, and work will continue in both areas during Performance Period 3.
- Various general health data activities, including a ***HIT/HIE Planning Activities*** and ***Expert Support*** as needed to support health data initiatives: During the January-June 2016 Performance Period 2 no-cost extension period, Vermont has continued to engage in HIT/HIE planning activities and to draw on expert support as needed. In particular, Vermont SIM leadership has provided ongoing input and regular review of the Vermont HIT Plan, and worked to assess baseline VHIE connectivity to support development of connectivity targets for 2016-2019.

In addition to the work streams described above, the scope of work associated with the Performance Period 2 milestone for the Expand Connectivity to HIE – Gap Remediation work stream was completed in December 2015.

### *Evaluation*

During the January-June 2016 Performance Period 2 no-cost extension period, Vermont has worked on the following projects and tasks within the Evaluation focus area, each of which corresponds to a milestone (see Attachment 3, Vermont SIM Milestone Summary and Driver Diagram):

- Execution of a ***State-Led Evaluation Study***: During the January-June 2016 Performance Period 2 no-cost extension period, Vermont executed a contract with a new state-led evaluation vendor, JSI, and re-launched this aspect of our evaluation work. JSI visited Vermont in late March 2016, and is currently engaging with State staff and key stakeholders to ramp up evaluation activities as outlined in Vermont's approved State-Led Evaluation Plan. Vermont has also continued to engage in continuous improvement activities during the January-June 2016 Performance Period 2 no-cost extension period

as described in the State-Led Evaluation Plan. As described in Sections H and Q and Appendix 1, Vermont continues to monitor its progress towards project goals and do rigorous continuous improvement by sharing information through a diverse set of vehicles, including SIM work groups, multi-community learning collaboratives, stakeholder symposiums, public presentations, and regional community collaboratives.

- Continued implementation of ***Surveys*** to measure patient experience and other key factors, as identified in payment model development: Patient experience survey implementation continued during the January-June 2016 Performance Period 2 no-cost extension period, with DataStat will be fielding a second wave of CAHPS PCMH surveys to primary care practices for 2015. The surveys will provide practice-level and ACO-level results.
- Continued ***Monitoring and Evaluation Activities*** within payment programs: Monitoring and evaluation activities during the January-June 2016 Performance Period 2 no-cost extension period support continued implementation of the Shared Savings Programs, as well as launch of the new SIM payment models. Vermont has engaged in additional analyses of Year 1 of the Medicaid Shared Savings Program, and this information will be used for targeted quality improvement at the ACO and practice level. In addition, Vermont has engaged in feasibility assessments and research related to new potential payment models including Episodes of Care (elected not to pursue), Prospective Payment System for Home Health Agencies (elected to delay until after the SIM testing period), and Medicaid Value-Based Purchasing activities known as the Medicaid Pathway. This work is ongoing and will continue into Performance Period 3.

### *Project Management and Reporting*

SIM is supported by a project management team that oversees project-wide coordination and reporting, as well as communication and outreach. Project management is focused on achieving milestones and meeting accountability targets across the project. These efforts continued during the January-June 2016 Performance Period 2 no-cost extension period.

# Glossary

ACG – Adjusted Clinical Groups
ACH – Accountable Communities for Health
ACO – Accountable Care Organization
ACS-NSQIP – American College of Surgeons National Surgical Quality Improvement Program
ADAP – Alcohol and Drug Abuse Programs
AHS – Agency of Human Services
AOA – Agency of Administration
APM – All-Payer Model
APMH – Advanced Practice Medical Home
BHN – Behavioral Health Network
BRFSS – Behavioral Risk Factor Surveillance System
CAGR – Cumulative Average Growth Rate
CAHPS – Consumer Assessment of Healthcare Providers and Systems
CBC – Complete Blood Count
CCHL – Community Committee on Healthy Lifestyle
CCIIO – The Center for Consumer Information & Insurance Oversight
CCMR – Care Coordination Medical Record
CCT – Community Care Team
CD – Clinical Director
CDM – Chronic Disease Management
CHA – Community Health Advocate
CHAC – Community Health Accountable Care, LLC
CHF – Congestive Heart Failure
CHIP – Children's Health Insurance Program
CHT – Community Health Team
CMMI – Center for Medicare and Medicaid Innovation
CMO – Chief Medical Officer
CMS – Centers for Medicare and Medicaid Services
COPD – Chronic Obstructive Pulmonary Disease
CSA – Community Supported Agriculture
DAIL – Department of Disabilities, Aging, and Independent Living
DAs – Designated (mental health) Agencies
DHMC – Dartmouth Hitchcock Medical Center
DID – Difference in differences
DLTSS – Disability and Long Term Services and Supports
DUA – Data Use Agreement
DVHA – Department of Vermont Health Access
ED – Emergency Department
EHR – Electronic Health Record
EMR – Electronic Medical Record
EMT – Emergency Medical Technician
EOC – Episodes of Care

ERG – Episode Risk Grouper
FAHC – Fletcher Allen Health Care
FEDU – Frequent ED Use
FICA – Federal Insurance Contributions Act
FQHC – Federally Qualified Health Center
FTE – Full Time Equivalent
GMCB – Green Mountain Care Board
HC – Health Care
HCM – Health Confidence Measures
HDI – Health Data Infrastructure
HF – Health*first*
HH – Health Home
HIE – Health Information Exchange
HIPPA – Health Insurance Portability and Accountability Act
HIT – Health Information Technology
HP – Hospital Readmissions
HPA – Health Promotion Advocate
HRQL – Health Related Quality of Life
HSA – Health Service Area
IBNR – Incurred But Not Reported
IFS – Integrated Family Services
INTERACT – Interventions to Reduce Acute Care Transfers
IOM – Institute of Medicine
IT – Information Technology
LS – Learning Session
LTSS – Long-Term Services and Supports
MA – Medical Assistant
MD – Medical Doctor
NAACO – National Association of ACO's
NMC – Northwestern Medical Center
NQF – National Quality Forum
OCV – OneCare Vermont
P4P – Pay for Performance
PCMH – Patient Centered Medical Home
PCP – Primary Care Physician
PPS – Prospective Payment System
PRG – Pharmacy Risk Grouper
QCCM – Quality and Care Coordination Manager
QI – Quality Improvement
RFP – Request for Proposal
RN – Registered Nurse
RUI – Resource Use Index
SAS – Statistical Analysis System
SBIRT – Screening, Brief Intervention, and Referral to Treatment

SC – Surgical Champion
SCR – Surgical Care Reviewers
SCÜP – Shared Care Plan/Universal Transfer Protocol
SIM – State Innovation Model
SMS – Short Message Service
SOV – State of Vermont
SPA – State Plan Amendment
SPC – Statistical Process Control
SSA – Specialized Service Agency
SSCPC – Statewide Surgical Collaborative Project Coordinator
SSP – Shared Savings Program
SVHC – Southwestern Vermont Health Care
SVMC – Southwestern Vermont Medical Center
SW – Social Worker
SWOT – Strengths, Weaknesses, Opportunities, and Threats
TACO – Totally Accountable Care Organization
TBD – To be determined
TCI – Total Cost Index
TCM – Transitional Care Model
TCN – Transitional Care Nurse
TCOC – Total Cost of Care
TCRRV – Total Care Relative Resource Value
UCC – Unified Community Collaborative
VCN – Vermont Care Network
VCP – Vermont Care Partners
VCP – Vermont Collaborative Physicians
VDH – Vermont Department of Health
VHCIP – Vermont Health Care Innovation Project
VHCURES – Vermont Healthcare Claims Uniform Reporting and Evaluation System
VHIE – Vermont's Health Information Exchange
VITL – Vermont Information Technology Leaders
VPQHC – Vermont Program for Quality in Health Care
VT – Vermont
WRFP – White River Family Practice
XSSP – Commercial Shared Savings Program