Attachment C: Vermont State Innovation Models Testing Grant: Performance Period 2 Budget Request

January 1, 2015-June 30, 2016

Budget Narrative

Vermont was awarded $45,009,074.92 in grant funding to support the state's preparedness to test and evaluate new payment and service delivery models that have the potential to lower costs for Medicare, Medicaid, commercial insurance, and the Children's Health Insurance Program (CHIP). The State will use this funding to support the development of tools and new models, while at the same time maintaining existing structures until they are no longer needed.

Vermont received approval of its Performance Period 2 Budget on October 9, 2015. On November 20, 2015, CMMI requested that Vermont submit a no-cost extension for Performance Period 2. CMMI confirmed that this no-cost extension should include a revised budget narrative in an email dated November 23, 2015.

This revised Performance Period 2 request proposes to reallocate funds within Performance Period 2 to accommodate a six-month no-cost extension period, from January 1-June 30, 2016. It also explicitly asks for retroactive approval for use of Performance Period 2 contractual funds for contracts in Performance Period 2. We request retroactive approval for January 1, 2016, for these agreements should we not receive federal approval by that date. Table 1 below provides a summary of Vermont's Performance Period 2 No-Cost Extension Request.

Table 1: Performance Period 2 No-Cost Extension Request Summary

Performance Period 2 No-Cost Extension Request								
	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
Personnel	**$699,111.00**	**$312,006.51**	**$387,104.49**	**$1,424,779.00**	**$725,668.00**	All	All	To perform PP2 tasks and achieve PP2 milestones.
Fringe	**$324,038.00**	**$139,783.12**	**$184,254.88**	**$660,385.00**	**$336,347.00**	All	All	To perform PP2 tasks and achieve PP2 milestones.
Equipment	**$18,290.00**	**$4,324.67**	**$13,965.33**	**$36,037.00**	**$17,747.00**	All	All	To perform PP2 tasks and achieve PP2 milestones.
Supplies	**$9,520.00**	**$679.03**	**$8,840.97**	**$14,300.00**	**$4,780.00**	All	All	To perform PP2 tasks and achieve PP2 milestones.
Travel	**$41,300.00**	**$5,281.13**	**$36,018.87**	**$81,375.00**	**$40,075.00**	All	All	To perform PP2 tasks and achieve PP2 milestones.
Construction	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	N/A	N/A	N/A
Other	**$267,620.00**	**$9,375.56**	**$258,244.44**	**$436,565.00**	**$168,945.00**	All	All	To perform PP2 tasks and achieve PP2 milestones.
Contractual	**$15,807,531.91**	**$1,012,774.82**	**$14,794,757.09**	**$14,223,702.91**	**$(1,583,829.00)**			
ARIS: ACTT Proposal #03410-1380-15	$275,000.00	$72,500.00	$202,500.00	$275,000.00	$ -	Health Data Infrastructure	EMR Expansion: Implement EMRs in non-meaningful use providers; explore non-EMR solutions for providers without EMRs.	Due to delays in federal contract approval, the procurement for non-MU providers: ARIS/ Developmental Disability Agencies was delayed. A no-cost extension will allow us to perform the tasks initially planned for the last half of 2015.

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Bailit Health Purchasing #26905	$ -	$ -	$ -	$255,080.00	$255,080.00	CMMI-Required Milestone: Payment Models Payment Models	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) ACO Shared Savings Program: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 3) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 6. Design modifications to existing Integrated Family Services (IFS) Program so it can expand to at least one additional community on 7/1/16.	1) Delays in PP2 Budget and Contracts resulted in delays in ability to achieve PP2 Milestones. 2) Several of Vermont's providers withdrew from the Medicare Shared Savings Program in early 2015. The no-cost extension offers the opportunity to provide additional information about ACO participant performance (2014 data released in late Fall 2015) that can be used to expand provider participation in this program. 3) A no-cost extension is needed due to delays in federal contract approval.

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	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
Behavioral Health Network #27380	$350,000.00	$ -	$350,000.00	$598,750.00	$248,750.00	Health Data Infrastructure	1) Improve Quality of Data Flowing into HIE: 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16. 2) Data Warehousing: 1. Implement Phase 1 of DA/SSA data warehousing solution by 12/31/15 (implementation follows implementation project plan). 2. Procure clinical registry software by 3/31/16. 3. Develop a cohesive strategy for developing data systems to support analytics by 3/31/16.	1) A no-cost extension will allow us to continue the workflow improvement activities begun in PP2 but delayed due to delays in PP2 contract approvals. 2) Clinical Registry: Vermont anticipates executing the clinical registry software procurement contract in Q1 2016. A no-cost extension is needed because the federal contract approval delays for this agreement delayed the registry software migration project several months. Cohesive Strategy: Due to the delays in the registry software migration project, Vermont started the cohesive strategy planning later than anticipated. A no-cost extension will allow Vermont SIM to meet this milestone.
Bi-State Primary Care Association #03410-1456-14	$ -	$ -	$ -	$447,686.00	$447,686.00	Payment Model Design and Implementation Practice Transformation	1) ACO Shared Savings Program: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) Regional Collaborations: Expansion of regional collaborations to all 14 Health Service Areas (HSAs) by 6/30/16.	1) Several of Vermont's providers withdrew from the Medicare Shared Savings Program in early 2015. The no-cost extension offers the opportunity to provide additional information about ACO participant performance (2014 data released in late Fall 2015) that can be used to expand provider participation in this program. 2) Each region is working at the local level to define these components, and some communities are not as advanced

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	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
							Expansion is complete when all HSAs have a Charter, governing body, and decision-making process.	in this work as others. The local nature of this work ensures better integration and buy-in by diverse providers, which optimizes the chance of success. A no-cost extension will enable all 14 regions to finalize Charters, governing and decision-making bodies.
Burns and Associates #28733	$25,000.00	$ -	$25,000.00	$378,000.00	$353,000.00	CMMI-Required Milestone: Payment Models Payment Model Design and Implementation Evaluation	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) ACO Shared Savings Program: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 3) Episodes of Care: 3 EOCs designed for Medicaid – implementation of data reports by 3/1/16. Implementation of data reports means: episodes selected, outreach plan to providers designed, first run of historic data provided to providers participating in program. 4) All-Payer Model: 1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI.	1) Delays in PP2 Budget and Contracts resulted in delays in ability to achieve PP2 Milestones. 2) Several of Vermont's providers withdrew from the Medicare Shared Savings Program in early 2015. The no-cost extension offers the opportunity to provide additional information about ACO participant performance (2014 data released in late Fall 2015) that can be used to expand provider participation in this program. 3) Contract support for this work was delayed due to delays in contract approval for PP2. Additionally, in conversations with CMMI regarding Vermont's EOC program, CMMI suggested that Vermont take additional time to develop. The no-cost extension will allow for more robust episode-specific stakeholder feedback, which is key to the design of this model. 4) Vermont continues to be engaged in negotiations with CMMI regarding this

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							5) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 1. Ensure appropriate customer service supports are in place for Medicaid SSP program for 2016 by 11/1/15. 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16. 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan. 5. Develop monitoring and compliance plan for Year 1 EOCs by 6/30/16. 6. Design modifications to existing Integrated Family Services (IFS) Program so it can expand to at least	model. Vermont moderated the work directed to the contractor supporting this effort to minimize state exposure, due to delay in PP2 budget and contract approval. 5) EOC Program SPA: Draft SPA submission will be developed in concert with the program (details above). As that program is delayed, this milestone moves with it. Delays in PP2 contract approvals delayed contractor work in this area. IFS Program: a no-cost extension is needed due to delays in federal contract approval. 6) A no-cost extension is necessary to allow Vermont to implement the self-evaluation plan activities approved by CMMI in late Fall 2015. This information will be used to further inform all other project activities and planning for PP3. 7) Monitoring and Evaluation are key support activities for all of Vermont's SIM work. As any of those activities are extended into 2016, the monitoring and evaluation need to be extended.

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	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
							one additional community on 7/1/16. 6) Self-Evaluation Plan and Execution: 2. Continue to execute self-evaluation plan using staff and contractor resources. 7) Evaluation and Monitoring Activities Within Payment Programs: 1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications: biannual reporting to providers. 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: monthly, quarterly reports depending on type.	
Covisint #29380	$1,000,000.00	$ -	$1,000,000.00	$1,000,000.00	$ -	Health Data Infrastructure	Data Warehousing: 2. Procure clinical registry software by 3/31/16.	Vermont anticipates executing the clinical registry software procurement contract in Q1 2016. A no-cost extension is needed because the federal contract approval delays for this agreement delayed the registry software migration project several months.
Datastat #26412	$80,000.00	$ -	$80,000.00	$145,000.00	$65,000.00	Evaluation	Surveys: Conduct annual patient experience survey and other surveys as identified in payment model development:	A no-cost extension will allow Vermont's SIM team to complete survey distribution. This activity was delayed as

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							Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings programs – phase 1 to determine impact of Performance Period 2 activities by 6/30/16.	part of the delays in federal approval of PP2 contracts.
Deborah Lisi-Baker #26033/#29534	$40,000.00	$ -	$40,000.00	$40,000.00	$ -	Payment Model Design and Implementation Practice Transformation	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) Learning Collaboratives: Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 1. Create expansion plan for remaining Vermont HSAs that want to participate in the Learning Collaborative program by 6/15/15. 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.	1) Several of Vermont's providers withdrew from the Medicare Shared Savings Program in early 2015. The no-cost extension offers the opportunity to provide additional information about ACO participant performance (2014 data released in late Fall 2015) that can be used to expand provider participation in this program. 2) Vermont's Learning Collaborative started with pilot communities; launch in additional communities was planned for after pilot communities were well established. The Learning Collaborative in the pilot community was a success, but this structure delayed implementation in PP2 several months. The NCE will allow us to finish the Learning Collaborative activities for the 8 new communities that were originally planned for the last 6 months of 2015.
Health Management Associates #28821	$698,000.00	$ -	$698,000.00	$898,000.00	$200,000.00	CMMI-Required Milestone: Payment Models	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) All-Payer Model:	1) Delays in PP2 Budget and Contracts resulted in delays in ability to achieve PP2 Milestones.

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						Payment Model Design and Implementation	1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI. 3) State Activities to Support Model Design and Implementation – GMCB: 1. Research and planning to identify the components necessary for APM regulatory activities by 6/30/16.	2) Vermont continues to be engaged in negotiations with CMMI regarding this model. Vermont moderated the work directed to the contractor supporting this effort to minimize state exposure, due to delay in PP2 budget and contract approval. 3) Vermont continues to be engaged in negotiations with CMMI regarding this model. Vermont moderated the work directed to the contractor supporting this effort to minimize state exposure, due to delay in PP2 budget and contract approval.
Health*first*, Inc. #03410-1457-15	$41,940.00	$41,560.00	$380.00	$55,000.00	$13,060.00	Payment Model Design and Implementation	ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000.	Several of Vermont's providers withdrew from the Medicare Shared Savings Program in early 2015. The no-cost extension offers the opportunity to provide additional information about ACO participant performance (2014 data released in late Fall 2015) that can be used to expand provider participation in this program.
HIS Professionals #27511	$ -	$ -	$ -	$50,000.00	$50,000.00	Health Data Infrastructure	General Health Data – Expert Support: 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.	This milestone provides general support for all of Vermont's Health Data Infrastructure activities. As those activities are extended through the NCE, Vermont needs to extend this general support milestone.

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IHS Global, Inc. #TBD	$250,000.00	$ -	$250,000.00	$350,000.00	$100,000.00	Practice Transformation	Workforce – Demand Data Collection and Analysis: 1. Execute contract for micro-simulation demand modeling by 1/15/16 (dependent on federal approval). 2. Provide preliminary data as defined by the contract to vendor for use in model by 3/15/16.	Due to delays in federal contract approvals, this contract execution was delayed several months. A no-cost extension will allow the work that was to be performed in late 2015 to be performed in early 2016.
James Hester, Jr. #28674	$7,000.00	$ -	$7,000.00	$7,000.00	$ -	Payment Model Design and Implementation	Accountable Communities for Health: Feasibility assessment – data analytics: 1. Discussion and planning of investments related to ACH feasibility based on research/report by 11/1/15. 2. Design/creation of ACH learning system for all 14 Vermont Health Service Areas by 1/31/16. 3. Start roll out ACH learning system to at least 3 health service areas by 2/1/16. 4. Research for implementation of a pilot incorporating a payment change (data analysis, financial analysis, stakeholder participation analysis) for at least 1 Vermont region by 2/1/16.	
JBS International #28389	$140,442.00	$92,385.72	$48,056.28	$108,000.00	$(32,442.00)	Health Data Infrastructure	Telehealth – Strategic Plan: Develop Telehealth Strategic Plan by 9/15/15.	N/A

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Nancy Abernathey #28243	$6,630.00	$ -	$6,630.00	$58,630.00	$52,000.00	Practice Transformation	Learning Collaboratives: Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.	Vermont's Learning Collaborative started with pilot communities; launch in additional communities was planned for after pilot communities were well established. The Learning Collaborative in the pilot community was a success, but this structure delayed implementation in PP2 several months. The NCE will allow us to finish the Learning Collaborative activities for the 8 new communities that were originally planned for the last 6 months of 2015.
Pacific Health Policy Group #28062	$ -	$ -	$ -	$90,000.00	$90,000.00	Payment Model Design and Implementation	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 2. Obtain SPA for Year 2 of the	1) Several of Vermont's providers withdrew from the Medicare Shared Savings Program in early 2015. The no-cost extension offers the opportunity to provide additional information about ACO participant performance (2014 data released in late Fall 2015) that can be used to expand provider participation in this program. 2) EOC Program SPA: Draft SPA submission will be developed in concert with the program (details above). As that program is delayed, this milestone moves with it. Delays in PP2 contract approvals delayed contractor work in this area.

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	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
							Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16. 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan.	
PatientPing	$100,000.00	$ -	$100,000.00	$500,000.00	$400,000.00	Health Data Infrastructure	Care Management Tools: Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development: 1. Event Notification System: Procure solution by 1/15/16 and implement according to project plan for phased roll out.	Due to the delays in federal milestone and contract approvals, Vermont delayed execution of a contract for the Event Notification System. A no-cost extension will allow Vermont to implement the initial phases of the project that would have previously occurred in 2015.
Policy Integrity #TBA	$ -	$ -	$ -	$30,000.00	$30,000.00	Payment Model Design and Implementation Practice Transformation	1) State Activities to Support Model Design and Implementation – Medicaid: 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan.	1) EOC Program SPA: Draft SPA submission will be developed in concert with the program (details above). As that program is delayed, this milestone moves with it. Delays in PP2 contract approvals delayed contractor work in this area.

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							2) Sub-Grant Program – Technical Assistance: Provide technical assistance to sub-grantees as requested by sub-grantees: 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.	IFS Program: a no-cost extension is needed due to delays in federal contract approval. Frail Elders: Due to delays in federal contract approval, this project did not start until November 2015. 2) Vermont's sub-grant program is a key feature of our SIM Test. The program fosters innovation at the provider level and lessons learned at the payer and policymaking levels. A no-cost extension will enable Vermont to continue supporting these sub-grantees and developing lessons learned and challenges for future decision-making. Vermont offers technical assistance to its sub-grantees in the areas of evaluation, data analysis, facilitation, and actuarial support.
Stone Environmental #28427	$80,000.00	$3,774.25	$76,225.75	$165,000.00	$85,000.00	Health Data Infrastructure	1) Data Warehousing: 3. Develop a cohesive strategy for developing data systems to support analytics by 3/31/16. 2) Care Management Tools: Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development:	1) Due to the delays in the registry software migration project, Vermont started the cohesive strategy planning later than anticipated. A no-cost extension will allow Vermont SIM to meet this milestone. 2) Due to delays in federal milestone approvals, Vermont delayed activities related to this project. A no-cost extension will allow Vermont to complete the PP2 activities.

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							2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16. 3) General Health Data – HIE Planning: 1. VHCIP will provide comment into the HIT Strategic Plan at least 4 times in 2015. 2. HDI work group will identify connectivity targets for 2016-2019 by 6/30/16. 4) General Health Data – Expert Support: 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.	3) A no-cost extension is necessary for Vermont SIM to complete connectivity targets. Due to delays in federal milestone and contract approval, Vermont was unable to start this work in 2015. 4) This milestone provides general support for all of Vermont's Health Data Infrastructure activities. As those activities are extended through the NCE, Vermont needs to extend this general support milestone.
The Lewin Group #27060	$ -	$ -	$ -	$293,000.00	$293,000.00	Payment Model Design and Implementation Evaluation	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target:	1) Several of Vermont's providers withdrew from the Medicare Shared Savings Program in early 2015. The no-cost extension offers the opportunity to provide additional information about ACO participant performance (2014 data released in late Fall 2015) that can

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							130,000. 2) Self-Evaluation Plan and Execution: 2. Continue to execute self-evaluation plan using staff and contractor resources. 3) Monitoring and Evaluation Activities Within Payment Programs: Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: Monthly, quarterly reports depending on type.	be used to expand provider participation in this program. 2) A no-cost extension is necessary to allow Vermont to implement the self-evaluation plan activities approved by CMMI in late Fall 2015. This information will be used to further inform all other project activities and planning for PP3. 3) Monitoring and Evaluation are key support activities for all of Vermont's SIM work. As any of those activities are extended into 2016, the monitoring and evaluation need to be extended.
University of Massachusetts #25350	$ -	$ -	$ -	$230,000.00	$200,000.00	Project Management and Reporting	1) Project Management and Reporting – Project Organization: Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2) Project Management and Reporting – Communication and Outreach: Engage stakeholders in project focus areas. Engage stakeholders in project focus areas by: 1. Convening 5 Core Team, 5 Steering Committee, and 10 work group public meetings by 6/30/16. 2. Distributing all-participant emails at least once a month.	1) Project Management is a key support activity of Vermont's SIM Testing Grant. As any activities above are extended, project management is needed to support them. 2) As Vermont SIM extends PP2 through a no-cost extension, we will need to communicate and perform outreach and engagement activities. These activities provide critical information to inform investments, policy decisions, and planning for PP3.

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UVM Medical Center/ OneCare Vermont #28242	$826,281.00	$155,859.85	$670,421.15	$1,806,762.75	$980,481.75	Payment Model Design and Implementation Practice Transformation Health Data Infrastructure	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) Regional Collaborations: Expansion of regional collaborations to all 14 Health Service Areas (HSAs) by 6/30/16. Expansion is complete when all HSAs have a Charter, governing body, and decision-making process. 3) Improve Quality of Data Flowing into HIE: 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16.	1) Several of Vermont's providers withdrew from the Medicare Shared Savings Program in early 2015. The no-cost extension offers the opportunity to provide additional information about ACO participant performance (2014 data released in late Fall 2015) that can be used to expand provider participation in this program. 2) Each region is working at the local level to define these components, and some communities are not as advanced in this work as others. The local nature of this work ensures better integration and buy-in by diverse providers, which optimizes the chance of success. A no-cost extension will enable all 14 regions to finalize Charters, governing and decision-making bodies. 3) A no-cost extension will allow us to continue the workflow improvement activities begun in PP2 but delayed due to delays in PP2 contract approvals.
Vermont Medical Society Foundation #28675	$130,329.00	$ -	$130,329.00	$140,658.00	$10,329.00	Payment Model Design and Implementation	State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and	Due to delays in federal contract approval, this project did not start until November 2015.

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							compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 7. Research and design related to Frail Elders (timeline dependent upon federal contract approval) – final recommendations by 6/30/16.	
Vermont Program for Quality Health Care #28362	$102,526.67	$46,695.00	$55,831.67	$183,656.67	$81,130.00	Practice Transformation	Learning Collaboratives: Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.	Vermont's Learning Collaborative started with pilot communities; launch in additional communities was planned for after pilot communities were well established. The Learning Collaborative in the pilot community was a success, but this structure delayed implementation in PP2 several months. The NCE will allow us to finish the Learning Collaborative activities for the 8 new communities that were originally planned for the last 6 months of 2015.
VITL/Dept of Mental Health MOU #28236	$11,087.50	$ -	$11,087.50	$11,087.50	$ -	Health Data Infrastructure	EMR Expansion: 1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and ARIS (Developmental Disability Agencies) (by 6/30/16).	Due to delays in federal contract approval, the procurement for non-MU providers: ARIS/ Developmental Disability Agencies was delayed. A no-cost extension will allow us to perform the tasks initially planned for the last half of 2015.
VITL: ACO/ACTT #03410-1275-14	$1,312,588.00	$600,000.00	$712,588.00	$1,126,261.00	$(186,327.00)	Health Data Infrastructure	1) Expand Connectivity to HIE – Gap Remediation: Remediate data gaps that support payment model quality measures, as identified in gap analyses:	1) N/A 2) Terminology Services: Delays in federal contract approvals delayed launch of terminology services. Additionally, the cost changed. A no-

Performance Period 2 No-Cost Extension Request								
	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
							1. Remediate 50% of data gaps for SSP quality measures by 12/31/15. 2. Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15. 2) Improve Quality of Data Flowing into HIE: 1. Implement terminology services tool to normalize data elements within the VHIE by TBD. 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16. 3) EMR Expansion: 1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and ARIS (Developmental Disability Agencies) (by 6/30/16). 2. Explore non-EMR solutions for providers without EMRs: develop plan based on LTSS technical gap analysis.	cost extension will allow Vermont SIM to redefine this tool, costs, and timeline. Workflow Improvement: A no-cost extension will allow us to continue the workflow improvement activities begun in PP2 but delayed due to delays in PP2 contract approvals. 3) Due to delays in federal contract approval, the procurement for non-MU providers: ARIS/ Developmental Disability Agencies was delayed. A no-cost extension will allow us to perform the tasks initially planned for the last half of 2015.
Wakely Consulting #26303	$ -	$ -	$ -	$30,000.00	$30,000.00	Payment Model Design and Implementation	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in	1) Several of Vermont's providers withdrew from the Medicare Shared Savings Program in early 2015. The no-

Performance Period 2 No-Cost Extension Request								
	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
							Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16.	cost extension offers the opportunity to provide additional information about ACO participant performance (2014 data released in late Fall 2015) that can be used to expand provider participation in this program. 2) EOC Program SPA: Draft SPA submission will be developed in concert with the program (details above). As that program is delayed, this milestone moves with it. Delays in PP2 contract approvals delayed contractor work in this area.
Truven/Brandeis #TBD	$ -	$ -	$ -	$32,500.00	$32,500.00	Evaluation	Self-Evaluation Plan and Execution: 2. Continue to execute self-evaluation plan using staff and contractor resources. 3. Streamline reporting around other evaluation activities not performed by Impaq within 30 days of CMMI approval of self-evaluation plan.	A no-cost extension is necessary to allow Vermont to implement the self-evaluation plan activities approved by CMMI in late Fall 2015. This information will be used to further inform all other project activities and planning for PP3.
Grant Provider Program - Year				**$1,872,468.99**	**$1,872,468.99**	Practice Transformation	Sub-Grant Program – Sub-Grants: Continue sub-grant program:	Vermont's sub-grant program is a key feature of our SIM Test. The program fosters innovation at the provider level

Performance Period 2 No-Cost Extension Request								
	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
2 (Grantees listed below):							1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.	and lessons learned at the payer and policymaking levels. A no-cost extension will enable Vermont to continue supporting these sub-grantees, and identifying lessons learned and challenges for future decision-making.
Bi-State Primary Care	$ -	$ -	$ -	$139,650.00	$139,650.00			
Central Vermont Medical Center (CVMC) SBIRT	$ -	$ -	$ -	$192,381.00	$192,381.00			
HealthFirst	$ -	$ -	$ -	$257,874.21	$257,874.21			
InvestEAP	$ -	$ -	$ -	$161,902.94	$161,902.94			
Northeastern Vermont Regional Hospital	$ -	$ -	$ -	$31,400.00	$31,400.00			
Northwestern Medical Center, Inc RiseVT	$ -	$ -	$ -	$172,821.20	$172,821.20			
Rutland VNA & Hospice	$ -	$ -	$ -	$52,896.72	$52,896.72			
Southwestern Vermont Health Care	$ -	$ -	$ -	$150,000.00	$150,000.00			

Performance Period 2 No-Cost Extension Request								
	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
VT Medical Society & FAHC	$ -	$ -	$ -	$160,918.26	$160,918.26			
Vermont Developmental Disabilities Council (VTDDC)	$ -	$ -	$ -	$16,341.89	$16,341.89			
Vermont Program for Quality in Health Care	$ -	$ -	$ -	$459,737.93	$459,737.93			
White River Family Practice	$ -	$ -	$ -	$76,544.84	$76,544.84			
TBD: Accountable Communities for Health	$ -	$ -	$ -	$50,000.00	$50,000.00	Payment Model Design and Implementation	Feasibility assessment – data analytics: 1. Discussion and planning of investments related to ACH feasibility based on research/report by 11/1/15. 2. Design/creation of ACH learning system for all 14 Vermont Health Service Areas by 1/31/16. 3. Start roll out ACH learning system to at least 3 health service areas by 2/1/16. 4. Research for implementation of a pilot incorporating a payment change (data analysis, financial analysis, stakeholder participation	ACH Learning System: Program design is in progress, but an additional month will allow for the contractor to be in place for activities to start. Delays in PP2 contract approvals and budget delayed release of this RFP. Pilot Implementation: There is intense work with one stakeholder community that involved more complex stakeholder participation than initially anticipated due to diversity of stakeholder goals. These issues have been worked through, but data analytics were delayed while consensus was reached to avoid wasted resources.

Performance Period 2 No-Cost Extension Request								
	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
							analysis) for at least 1 Vermont region by 2/1/16.	
TBD: HIE Design and Testing	$150,000.00	$ -	$150,000.00	$351,550.00	$201,550.00	Health Data Infrastructure	Care Management Tools: Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development: 2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16.	Due to delays in federal milestone approvals, Vermont delayed activities related to this project. A no-cost extension will allow Vermont to complete the PP2 activities.
TBD: QI Facilitators	$20,000.00	$ -	$20,000.00	$259,612.00	$239,612.00	Practice Transformation	Learning Collaboratives: Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 1. Create expansion plan for remaining Vermont HSAs that want to participate in the Learning Collaborative program by 6/15/15. 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.	Vermont's Learning Collaborative started with pilot communities; launch in additional communities was planned for after pilot communities were well established. The Learning Collaborative in the pilot community was a success, but this structure delayed implementation in PP2 several months. The NCE will allow us to finish the Learning Collaborative activities for the 8 new communities that were originally planned for the last 6 months of 2015.

Performance Period 2 No-Cost Extension Request								
	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
TBD: Telehealth Pilots	$155,000.00	$ -	$155,000.00	$455,000.00	$300,000.00	Health Data Infrastructure	Telehealth – Implementation: 2. Award at least one contract to implement the scope of work in the telehealth program RFP by 1/15/16.	RFP release and selection of vendors was delayed due to delays in federal contract approvals for the telehealth strategic plan (noted above). The no-cost extension will allow contracts to be executed and contractors to perform work originally planned for the last half of 2015.
TBD: Evaluation	$ -	$ -	$ -	$400,000.00	$400,000.00	Evaluation	Self-Evaluation Plan and Execution: 1. Procure new self-evaluation contractor by 2/28/16 to execute contractor-led self-evaluation plan activities. 2. Continue to execute self-evaluation plan using staff and contractor resources.	A no-cost extension is necessary to allow Vermont to implement the self-evaluation plan activities approved by CMMI in late Fall 2015. This information will be used to further inform all other project activities and planning for PP3.
TBD: Evaluation -- Onpoint	$ -	$ -	$ -	$60,000.00	$60,000.00	Evaluation	Self-Evaluation Plan and Execution: 2. Continue to execute self-evaluation plan using staff and contractor resources. 3. Streamline reporting around other evaluation activities within 30 days of CMMI approval of self-evaluation plan.	A no-cost extension is necessary to allow Vermont to implement the self-evaluation plan activities approved by CMMI in late Fall 2015. This information will be used to further inform all other project activities and planning for PP3.
TBD: Technical Assistance to Providers Implementing Payment Reform	$ -	$ -	$ -	$800,000.00	$800,000.00	CMMI-Required Milestone: Payment Models	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate	1) Delays in PP2 Budget and Contracts resulted in delays in ability to achieve PP2 Milestones. 2) EOC Program SPA: Draft SPA submission will be developed in concert with the program (details above). As that program is delayed, this milestone

Performance Period 2 No-Cost Extension Request								
	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
						Payment Model Design and Implementation	for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed.	moves with it. Delays in PP2 contract approvals delayed contractor work in this area. IFS Program: a no-cost extension is needed due to delays in federal contract approval. Frail Elders: Due to delays in federal contract approval, this project did not start until November 2015.
TBD: Technology & Infrastructure: Expanded Connectivity HIE Infrastructure	$ -	$ -	$ -	$700,000.00	$700,000.00	Health Data Infrastructure	1) Expand Connectivity to HIE – Gap Remediation: Remediate data gaps that support payment model quality measures, as identified in gap analyses. 1. Remediate 50% of data gaps for SSP quality measures by 12/31/15. 2. Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15. 2) Improve Quality of Data Flowing into HIE: 1. Implement terminology services tool to normalize data elements within the VHIE by TBD. 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16.	1) N/A 2) Terminology Services: Delays in federal contract approvals delayed launch of terminology services. Additionally, the cost changed. A no-cost extension will allow Vermont SIM to redefine this tool, costs, and timeline. Workflow Improvement: A no-cost extension will allow us to continue the workflow improvement activities begun in PP2 but delayed due to delays in PP2 contract approvals.

Performance Period 2 No-Cost Extension Request								
	Total Budget	**Liquidated as of 11/30/2015**	**Balance**	**12/02/2015 Realigned Budget**	**Difference**	**Focus Area**	**Milestone(s)**	**No-Cost Extension Justification(s)**
TBD: Other	$10,005,707.74	$ -	$10,005,707.74	$ -	$(10,005,707.74)	TBD	TBD	TBD
Indirect	**$279,645.00**	**$ -**	**$279,645.00**	**$569,912.00**	**$290,267.00**			
Total	**$17,447,055.91**	**$1,484,224.84**	**$15,962,831.07**	**$17,447,055.91**	**$ -**			

I. Budget Request Overview

The total State Innovation Models: Model Testing Assistance, Track 2 establishment budget request for January 1, 2015-June 30, 2016 is $**17,447,055.91.** This section outlines Vermont's budget estimate and the specific assumptions and key variables underlying this budget estimate. **Table 2a** below provides an overview of Vermont's current budget request for Performance Period 2 of the grant, and **Table 2b** sets forth an estimated total model testing budget.

Table 2a: Performance Period 2 Budget Request Summary

	Performance Period 2 1/1/15 - 12/31/15	Expenses Paid through 11/23/2015[1]	Unliquidated Obligations as of 11/30/2015 (invoices in hand)	Performance Period 2 Remaining amount as of 11/30/2015
Personnel	$1,424,779.00	$312,006.51		$1,112,772.49
Fringe Benefits	$660,385.00	$139,783.12		$520,601.88
Travel	$81,375.00	$5,281.13		$76,093.87
Equipment	$36,037.00	$4,324.67		$31,712.33
Supplies	$14,300.00	$679.03		$13,620.97
Other	$436,575.00	$9,375.56		$427,199.44
CAP	$569,912.00	$0.00*[2]		$569,912.00
Contractor	$14,223,702.91	$1,012,774.82	$190,002.64	$13,020,925.45
Total:	$**17,447,055.91**	$1,484,224.84	$190,002.64	$15,772,838.43

[1] Vermont received federal approval for its Performance Period 2 budget on 10/9/15. We are still awaiting invoices for Performance Period 2 work.

[2] CAP is assessed each quarter, these expense and unliquidated obligations amounts are through 11/30/2015 and the 12/31/2015 CAP amounts are not yet available.

Table 2b: Estimated Model Testing Budget and Expenditure Plan 2012-2017

ESTIMATED BUDGET						
	Implementation (2/1/2013-9/30/2013)-Actuals	Performance Period 1 (10/1/2013-12/31/2014)-Actuals	Performance Period 1 Carryforward (1/1/2015-12/31/2015) Budget	Performance Period 2 (1/1/2015-6/30/2016)-Budget	Performance Period 3 (7/1/2016-6/30/2017)-Budget	Total
Personnel	$53,417.70	$969,594.59	$784,374.71	$1,424,779.00	$1,596,575.77	4,828,741.77
Fringe Benefits	$20,507.79	$390,311.48	$422,653.29	$660,385.00	$740,012.87	2,233,870.43
Travel	$3,831.62	$33,974.87	$46,775.13	$81,375.00	$82,075.00	248,031.62
Equipment	$21,398.75	$22,096.04	$16,128.96	$36,037.00	$36,347.50	132,008.25
Supplies	$ -	$6,918.78	$831.22	$14,300.00	$14,380.00	36,430.00
Other	$ -	$116,645.10	$49,029.90	$436,565.00	$347,495.00	949,735.00
CAP	$20,458.45	$282,985.44	$418,601.78	$569,912.00	$638,630.31	1,930,587.98
Contractor	$ -	$2,199,337.54	$10,244,431.37	$14,223,702.91	$7,982,198.05	34,649,669.87
Total:	$119,614.31	$4,021,863.84	$11,982,826.36	$17,447,055.91	$11,437,714.50	45,009,074.92

II. Budget Line Item Detail

A. PERSONNEL

The total amount requested for personnel costs in Performance Period 2 is $1,424,779.00. **Table 3** contains an itemized breakdown of Performance Period 2 personnel costs. Personnel costs for Performance Period 2 are for an 11-month period. The Vermont Agency of Human Services is the signatory to this agreement with CMMI, with two state agencies leading the effort: the Green Mountain Care Board (GMCB) and the Department of Vermont Health Access (DVHA). Project staff work in multiple departments within Vermont's Agency of Human Services (AHS), Agency of Administration (AOA), and at the GMCB. A matrixed approach is used to manage resources and staff across agencies to maximize efficiency by leveraging existing agency expertise and administrative infrastructure. The overall staffing footprint is reflected in **Table 3** below.

The Chair of the GMCB and the Commissioner of DVHA co-lead the project and provide overall direction to the staff. VHCIP includes 26 funded positions (23.30 FTEs), of which 24 are filled (22.05 FTEs) and 2 are vacant (1.25 FTEs). Of the 26 total positions, 3 (3 FTEs) are at the Green Mountain Care Board, 2 (2 FTEs) are at the AHS Central Office, 14 (13.15 FTEs) are at AHS/Department of Vermont Health Access, 2 (2 FTEs) are at AHS/Department of Disabilities, Aging and Independent Living, 1 (1 FTE) is at AHS/Department of Health, 1 (1 FTE) is at AHS/Integrated Family Services, and 2 (1.15 FTEs) are at the Agency of Administration. Position descriptions are described in **Table 3**.

The State of Vermont understands that in accordance with FY 2012 Consolidated Appropriations Act, 2012 (Public Law 112-74, "direct salary, and institutional base salary" are limited to the **Executive Level II of the Federal Executive Pay scale**. **The Executive Level II salary is $179,700**. We will commit to complying with this provision in any contractual agreement which we enter into for this work.

Table 3: Summary of Performance Period 2 Personnel Costs and Staff Detail[3]

Position Title / Employee / Agency / Rationale for position	% FTE Allocated	Year Two Amount Requested[4]
Director of Payment Reform (Position #737009) / TBA / AHS, DVHA The PR&R Director is responsible for coordinating all of the Medicaid payment reforms. She serves as the liaison between Medicaid and the Duals program. She is responsible for coordinating efforts with the Payment Reform Director at GMCB to ensure the incentives and evaluations are aligned.	25%	13,268.00
Payment Reform Director (Position #277008) / Richard Slusky / GMCB The Payment Reform Director is responsible for coordinating all of the Commercial payment reforms and Medicare reforms. He is responsible for coordinating efforts with the PR&R Director to ensure incentives and evaluation are aligned.	100%	84,363.00
Director, VT DLTSS (Position #720139) / Julie Wasserman / AHS CO Vermont's SIM project is a combination of the SIM testing project and Duals project. As described in the Operational Plan, this is to ensure alignment between these two programs at the state level and ensure that Vermonters receive the quality health care they need. One of the reasons that Vermont needs to ensure specific alignment of these two programs is because some Duals are currently attributing to MSSP ACOs. Vermont's providers are eager to participate in reforms and one of the goals of the SIM/Duals integration is to make sure all providers can participate to the great extent possible without conflicts or concerns. The State has identified the need for additional staffing support of this work in Performance Period 1. *(Please note this position is filled at .8 FTE*).	100%	84,643.00
Financial Manager II (Position #720175) / Diane Cummings / AHS CO Provides fiscal analysis & oversight of grant related to state and federal reporting; Analysis of payment models for impact on state budgeting and payment systems; grant compliance monitoring. Work within AHS and DVHA financial offices to ensure no unintended consequences, overall consistency of modeling and compliance with all grant requirements, fiscal oversight, federal and state reporting. Liaison as needed with state budget staff, finance and management staff and commissioners.	100%	58,565.00
Health Care Project Director (Position #730241) / Cecilia Wu / AHS, DVHA Ensures standards, methodology and consistency of all pilot and reforms efforts with overall model. Provides overall project oversight to ensure timely and efficient program administration. Supports provider relations, negotiations, stakeholder facilitation overall design and oversight. *(Please note this position is currently being filled at .8 FTE*).	100%	78,499.00
Health Care Project Director (Position #730242) / Alicia Cooper / AHS, DVHA Ensures standards, methodology and consistency of all pilot and reforms efforts with overall model. Provides overall project oversight to ensure timely and efficient program administration. Supports provider relations, negotiations, stakeholder facilitation overall design and oversight.	100%	73,457.00
Contract & Grant Admin. (Position #730243) / TBA / AHS, DVHA	100%	48,880.00

[3] Please note that previous SOV SIM budgets included two tables and we have combined them for ease of review.
[4] Amount requested includes salary estimates prorated for Performance Period 2. 46.35% fringe is not included.

Provides fiscal analysis & oversight of grant related to state and federal reporting; Analysis of payment models for impact on state budgeting and payment systems; grant compliance monitoring. Work within AHS and DVHA financial offices to ensure no unintended consequences, overall consistency of modeling and compliance with all grant requirements, fiscal oversight, federal and state reporting. Liaison as needed with state budget staff, finance and management staff and commissioners.		
Contract & Grant Coordinator (Position #730253) / Leah Korce/ AHS, DVHA		
Provides fiscal analysis & oversight of grant related to state and federal reporting; Analysis of payment models for impact on state budgeting and payment systems; grant compliance monitoring. Work within AHS and DVHA financial offices to ensure no unintended consequences, overall consistency of modeling and compliance with all grant requirements, fiscal oversight, federal and state reporting. Liaison as needed with state budget staff, finance and management staff and commissioners.	100%	44,014.00
Quality Oversight Analyst II (Position #730245) / James Westrich / AHS, DVHA		
The Data Analysts will work to create analytic framework for: track expenditures, utilization and costs in key areas; calculate and tracking savings; be expert in analytic techniques necessary for the implementation and/or monitoring and evaluation of payment reforms under the State Innovation Plan; identify and works with AHS staff, payment reform managers and directors, policy leaders, consultants, contractors and technical advisors to implement, evaluate and continuously improve payment reform programs. The Analysts will work under the general direction of the Payment Director(s).	100%	62,389.00
Quality Oversight Analyst II (Position #730246) / Carole Magoffin / AHS, DVHA		
The Data Analysts will work to create analytic framework for: track expenditures, utilization and costs in key areas; calculate and tracking savings; be expert in analytic techniques necessary for the implementation and/or monitoring and evaluation of payment reforms under the State Innovation Plan; identify and works with AHS staff, payment reform managers and directors, policy leaders, consultants, contractors and technical advisors to implement, evaluate and continuously improve payment reform programs. The Analysts will work under the general direction of the Payment Director(s).	100%	59,731.00
Health Senior Policy Analyst (Position #730249) / Sarah Kinsler / AHS, DVHA		
Supports enhancement and maintenance of best practice models. Works with team to ensure incentives drive physicians and other health care providers to utilize best practices in care of person with chronic conditions such as dementia. Provides information and helps crafts best practice/evidence based care models across all primary and secondary settings.	100%	57,283.00
Medicaid Data Analyst (Position #730248) / Brian Borowski / AHS, DVHA		
The Data Analysts will work to create analytic framework for: track expenditures, utilization and costs in key areas; calculate and tracking savings; be expert in analytic techniques necessary for the implementation and/or monitoring and evaluation of payment reforms under the State Innovation Plan; identify and works with AHS staff, payment reform managers and directors, policy leaders, consultants, contractors and technical advisors to implement, evaluate and continuously improve payment reform programs. The Analysts will work under the general direction of the Payment Director(s).	100%	53,523.00
Public Health Analyst III (Position #740882) / Matthew Bradstreet / AHS, VDH	100%	51,893.00

The Data Analysts will work to create analytic framework for: track expenditures, utilization and costs in key areas; calculate and tracking savings; be expert in analytic techniques necessary for the implementation and/or monitoring and evaluation of payment reforms under the State Innovation Plan; identify and works with AHS staff, payment reform managers and directors, policy leaders, consultants, contractors and technical advisors to implement, evaluate and continuously improve payment reform programs. The Analysts will work under the general direction of the Payment Director(s).		
Business Administrator (Position #720185) / Carolynn Hatin / AHS, IFS	100%	44,224.00
Provides fiscal analysis & oversight related to the Integrated Family Services Program. Works within AHS and DVHA financial offices to ensure overall consistency of modeling and compliance with all grant requirements, fiscal oversight, federal and state reporting. Liaison between Integrated Family Services program and other State Innovation Models grant activities as needed, including with state budget staff, finance and management staff and commissioners.		
Senior Policy Advisor (Position#730252) / Bradley Wilhelm / AHS, DVHA	90%	44,758.00
The Senior Policy Advisor #730252 will work on legal questions and issues related to the project. Including, but not limited to, contracting, HIPAA, 42 CFR part 2, data sharing, and program integrity. The Senior Policy Advisor #730252 works under the general direction of DVHA's General Counsel.		
Senior Policy Advisor (Position #730251) / Erin Flynn / AHS, DVHA	100%	49,982.00
Supports enhancement and maintenance of best practice models. Works with team to ensure incentives drive physicians and other health care providers to utilize best practices in care of person with chronic conditions such as dementia. Provides information and helps crafts best practice/evidence based care models across all primary and secondary settings.		
Health Senior Policy Analyst (Position #730255) / Amy Coonradt / AHS, DVHA	100%	46,940.00
Ensures that necessary technical systems and program changes are made to support the payment reforms. Including but not limited to: ensuring changes and information is communicated to providers in timely manner; provide technical assistance as needed to resolve problems; Supports development of common language and helps in translation of medical and social models of care; ensures systems remain person-centered and LTSS retain commitment to self- directed care. The Payment and Policy Specialists will work under the general direction of the Payment Director(s).		
Grant Program Manager (Position #730256) / Luann Poirier / AHS, DVHA	100%	49,982.00
Ensures appropriate collection, maintenance, and sharing of contractual information for State Innovation Model testing grant. Responsible for documentation and collection of all contractual information related to Vermont's federal State Innovation Model testing grant. Ensures that all contract and grant files are complete, including all documents related to procurement, contracting, amendments, and close-out. Provide documentation related to the state audit of this federal program to the auditors by maintaining SharePoint repository of all relevant documentation, and by providing electronic and hard-copy versions of all materials to auditors as required. Ensure compliance with all programs audits.		
Health Senior Policy Analyst (Position #730254) / Amanda Ciecior / AHS, DVHA	100%	46,940.00

Supports enhancement and maintenance of best practice models. Works with team to ensure incentives drive physicians and other health care providers to utilize best practices in care of person with chronic conditions such as dementia. Provides information and helps crafts best practice/evidence based care models across all primary and secondary settings.		
Health Policy Analyst (Position #760331) / Susan Aranoff / AHS, DAIL Health Integration Quality Analyst will work to: ensure the integration of services for people who are aging and or living with disabilities with acute and primary care services to the greatest extent possible and will create standards for service definitions, provider types, payment methodologies, rate setting, definitions of savings, as needed across payers and programs; ensure proper documentation of model and coordination of statewide efforts as needed; coordinate with data and analytics/evaluation staff to create performance measures and management reports that will support policy and program decision making; help with additional new administration due to implementation of payment models. The Program Managers will work under the general direction of the Payment Director(s).	100%	64,167.00
Health Policy Analyst (Position #760332) / David G Epstein / AHS,DAIL Health Policy Analyst will work to: create standards for service definitions, provider types, payment methodologies, rate setting, definitions of savings, as needed across payers and programs; ensure proper documentation of model and coordination of statewide efforts as needed; coordinate with data and analytics/evaluation staff to create performance measures and management reports that will support policy and program decision making; help with additional new administration due to implementation of payment models; gather information and perform outreach to facilitate incorporation of health service reforms for those serving individuals who are aging and or living with disabilities. The Program Managers will work under the general direction of the Payment Director(s).	100%	44,224.00
Payment Reform Program Evaluator (Position#270017) / Annie Paumgarten / GMCB The State of Vermont's application for a SIM Grant includes a robust and detailed evaluation plan. In order to enable the State to work with CMMI evaluators and the independent evaluation team, the State needs appropriate staff. The State seeks funding for a staff person to work as a liaison with CMMI's evaluation team and with the independent evaluation team.	100%	73,457.00
Grant Program Manager (Position #270016) / Christine Geiler / GMCB This person will act as a liaison to the federal government, coordinate reporting, and ensure staff time and contractors are appropriately bill to the grant. Duties may focus on some or all of the following: Grants management and program development, on-site compliance monitoring, financial audits management, environmental review, and programs clearance. This initiative is based on the premise that Governor-sponsored, multi-payer models that have broad stakeholder input and engagement, and are set in the context of broader state innovation, will achieve sustainable delivery system transformation that significantly improves health system performance. This position will enable us to properly engage stakeholders in the work of this grant.	100%	74,816.00
Health Care Reform Deputy Director (Position #010016) / Georgia Maheras / AOA This person will work with the entire staff and will ensure standards, methodology and consistency of all pilot and reforms efforts with overall model. Provides overall project	90%	80,521.00

oversight to ensure timely and efficient program administration for Commercial and Medicare programs.		
Deputy Director for Health Care Reform- Finance (Position #027004) / Michael Costa / AOA	25%	34,260.00
This person will work with the Project Director to support SIM alignment with the All-Payer Model. This includes research, analysis and coordination of effort across SIM work groups, and various state agencies.		

Positions can be divided into limited term assignments requiring specific temporary expertise or contractor and staff management. Specifically, the majority of these positions, approximately 14.0 FTE, are for a limited time period. The State of Vermont anticipates that it will need to support eight positions and a limited amount of contract money on an ongoing basis. More permanent staff includes two payment Directors, four Quality Evaluation and Monitoring Managers, and two fiscal staff. Our goal is to implement a successful model that produces savings and increasing quality that allows these positions to be funded with savings and through re-deployment of vacant positions given new models of provider oversight and financing.

B. FRINGE BENEFITS

The total amount requested for fringe costs for the Performance Period 2 period is$660,385.00. Fringe benefits are estimated using a factor of 46.35%, which is standard for budgeting State of Vermont employee positions. **Table 3** below provides fringe benefits detail.

Table 4: Performance Period 2 Fringe Benefits

Fringe Benefit	Percentage	Total	
FICA	7.78%	$	110,848.00
Health Insurance	18.79%	$	267,716.00
Retirement	17.54%	$	249,906.00
Dental	1.20%	$	17,098.00
Life	0.40%	$	5,699.00
Long Term Disability	0.04%	$	570.00
Employee Assistance Program	0.05%	$	712.00
Workers Compensation	0.55%	$	7,836.00
Total	**46.35%**	**$**	**660,385.00**

C. CONTRACT AND VENDOR SERVICES

The total amount requested for contractual costs is $14,223,702.91. This section will discuss the various contractual costs associated with Performance Period 2 of the project.

The State of Vermont's SIM project relies on augmenting state staff temporarily, adding ongoing

internal state staff capacity, and using contractors. Vermont will rely more heavily on contract resources for technical expertise and analytic capacity since Vermont does not have the same staffing and analytic capacity as Massachusetts, Washington D.C. and other larger SIM jurisdictions. Additionally, due to its size and location, Vermont needs to recruit individuals and contractors from outside the State to perform many tasks. Vendors must travel to Vermont and we have to provide additional compensation for this travel and to recruit them to the State. The revised budget narrative provides information on all contractors associated with project Performance Period 2, including prospective contract projects where a vendor is still to be determined.

Table 5: Performance Period 2 Contract Sub-Totals by Line Item.

In **Table 5** below, please find sub-totals by line item for Vermont's Performance Period 2 contract request, detailed below in Table 7.

Budget Line Item	**Performance Period 2 Budget**
Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers	2,680,781.20
Advanced Analytics: Financial and Other Modeling for All Payers	479,000.00
Program Management	230,000.00
Workforce Assessment: System-Wide Capacity	350,000.00
Model Testing: Quality Measures	828,362.35
Technical Assistance: Learning Collaboratives	501,898.67
Technical Assistance: Practice Transformation & Data Quality Facilitation-	2,399,130.70
Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms	1,872,468.99
Technology and Infrastructure : Practice Transformation; Expanded Connectivity of HIE Infrastructure; Enhancements to Centralized Clinical Registry & Reporting Systems; Expanded Connectivity between State of Vermont Data Sources and ACOs/Providers	50,000.00
Technology and Infrastructure: Expanded Connectivity of HIE Infrastructure	1,826,261.00
Technology and Infrastructure: Enhancements to Centralized Clinical Registry & Reporting Systems	1,598,750.00
Technology and Infrastructure: Telemedicine	563,000.00
Technology and Infrastructure: Analysis of How to Incorporate Long-Term Support Services, Mental Health, and Other Areas of Health	351,550.00
Evaluation	492,500.00
TOTAL	**14,223,702.91**

The budget narrative provides contractor expense information three ways.

First, **Table 6** below is a summary table of Performance Period 2 spending by contractor. The table includes the following information:

- Contractor
- Performance Period 2 Request
- Out-of-State Travel Request

Second, **Table 7** provides a more expansive view of the project by connecting each contractor and contract with their substantive work within the project. **Table 7** features the following fields:

- Contractor
- Brief Scope
- Focus Area(s)
- Performance Period 2 Proposed Milestone(s)
- Line Item
- Requested Performance Period 2 Contract Start Date
- Performance Period 2 Request (excludes Out-of-State Travel)
- Performance Period 2 Out-of-State Travel Request
- Total Performance Period 2 Request (includes Performance Period 2 Out-of-State Travel)

Third, a detailed summary of the scope of work for every Performance Period 2 contract is provided in **Appendix A**.

Please note that Vermont has identified tasks that do not yet have contracted vendors in place. These to be determined contracts are listed in table 6 and valued at$3,076,162.00. Vermont used rates from a variety of vendors, current experience, and information from other states to develop budget assumptions.

Table 6: Performance Period 2 Contracts Pending CMMI Approval: Summary View

Contractor	Performance Period 2 Request (excludes Out-of-State Travel)	Performance Period 2 Out-of-State Travel Request	Total Previously Approved Performance Period 2 Request (includes Performance Period 2 Out-of-State Travel)	New Performance Period 2 Reallocation (excludes Out-of-State Travel)	New Performance Period 2 Reallocation Out-of-State Travel	New Performance Period 2 Reallocation (includes Out-of-State Travel)	Total Performance Period 2 – Previously Approved amount plus the New Requested Amount	Performance Period 2 Amount Expended through 11/03/2015	Unliquidated Obligations as of 11/30/2015
ARIS: ACTT Proposal #03410-1380-15	$275,000.00	$0.00	$275,000.00	$0.00	$0.00	$0.00	$275,000.00	$72,500	
Bailit Health Purchasing #26905	$0.00	$0.00	$0.00	$245,000.00	$10,080.00	$255,080.00	$255,080.00		
Behavioral Health Network #27380	$350,000.00	$0.00	$350,000.00	$248,750.00	$0.00	$248,750.00	$598,750.00		
Bi-State Primary Care Association #03410-1456-14	$0.00	$0.00	$0.00	$444,000.00	$3,686.00	$447,686.00	$447,686.00		
Burns and Associates #28733	$24,000.00	$1,000.00	$25,000.00	$350,000.00	$3,000.00	$353,000.00	$378,000.00		
Covisint #29380	$1,000,000.00	$0.00	$1,000,000.00	$0.00	$0.00	$0.00	$1,000,000.00		
Datastat #26412	$80,000.00	$0.00	$80,000.00	$65,000.00	$0.00	$65,000.00	$145,000.00		
Deborah Lisi-Baker #26033/#29534	$40,000.00	$0.00	$40,000.00	$0.00	$0.00	$0.00	$40,000.00		
Health Management Associates #28821	$698,000.00	$0.00	$698,000.00	$200,000.00	$0.00	$200,000.00	$898,000.00		$184,002.64
Health*first*, Inc. #03410-1457-15	$41,940.00	$0.00	$41,940.00	$13,060.00	$0.00	$13,060.00	$55,000.00	$41,560.00	
HIS Professionals #27511	$0.00	$0.00	$0.00	$50,000.00	$0.00	$50,000.00	$50,000.00		
IHS Global, Inc. #TBD	$250,000.00	$0.00	$250,000.00	$100,000.00	$0.00	$100,000.00	$350,000.00		
James Hester, Jr. #28674	$7,000.00	$0.00	$7,000.00	$0.00	$0.00	$0.00	$7,000.00		
JBS International #28389	$138,114.40	$2,327.60	$140,442.00	($32,442.00)	$0.00	($32,442.00)	$108,000.00	$92,385.72	
Nancy Abernathey #28243	$6,630.00	$0.00	$6,630.00	$52,000.00	$0.00	$52,000.00	$58,630.00		
Pacific Health Policy Group #28062	$0.00	$0.00	$0.00	$90,000.00	$0.00	$90,000.00	$90,000.00		
PatientPing #TBA	$100,000.00	$0.00	$100,000.00	$400,000.00	$0.00	$400,000.00	$500,000.00		
Policy Integrity #TBA	$0.00	$0.00	$0.00	$30,000.00	$0.00	$30,000.00	$30,000.00		
Stone Environmental #28427	$80,000.00	$0.00	$80,000.00	$85,000.00	$0.00	$85,000.00	$165,000.00	$3,774.25	
The Lewin Group #27060	$0.00	$0.00	$0.00	$293,000.00	$0.00	$293,000.00	$293,000.00		
UVM Medical Center/OneCare Vermont #28242	$826,281.00	$0.00	$826,281.00	$980,481.75	$0.00	$980,481.75	$1,806,762.75	$155,859.85	
University of Massachusetts #25350	$0.00	$0.00	$0.00	$200,000.00	$0.00	$200,000.00	$230,000.00		
Vermont Medical Society Foundation #28675	$130,329.00	$0.00	$130,329.00	$10,329.00	$0.00	$10,329.00	$140,658.00		
Vermont Program for Quality Health Care #28362	$98,097.67	$4,429.00	$102,526.67	$81,130.00	$0.00	$81,130.00	$183,656.67	$46,695.00	$6,000.00
VITL/Dept of Mental Health MOU #28236	$11,087.50	$0.00	$11,087.50	$0.00	$0.00	$0.00	$11,087.50		
VITL: ACO/ACTT #03410-1275-14	$1,312,588.00	$0.00	$1,312,588.00	($186,327.00)	$0.00	($186,327.00)	$1,126,261.00	$600,000.00	
Wakely Consulting #26303	$0.00	$0.00	$0.00	$30,000.00	$0.00	$30,000.00	$30,000.00		
Truven/Brandeis #TBA	$0.00	$0.00	$0.00	$32,500.00	$0.00	$32,500.00	$32,500.00		
Sub-Grant Program (Sub-Grantees provided in Table 8 below)	$0.00	$0.00	$0.00	$1,872,468.99	$0.00	$1,872,468.99	$1,872,468.99		
TBD: Accountable Communities for Health	$0.00	$0.00	$0.00	$50,000.00	$0.00	$50,000.00	$50,000.00		
TBD: HIE Design and Testing	$150,000.00	$0.00	$150,000.00	$201,550.00	$0.00	$201,550.00	$351,550.00		
TBD: QI Facilitators	$20,000.00	$0.00	$20,000.00	$239,612.00	$0.00	$239,612.00	$259,612.00		
TBD: Telehealth Pilots	$155,000.00	$0.00	$155,000.00	$300,000.00	$0.00	$300,000.00	$455,000.00		
TBD: Evaluation	$0.00	$0.00	$0.00	$400,000.00	$0.00	$400,000.00	$400,000.00		
TBD: Evaluation – Onpoint	$0.00	$0.00	$0.00	$60,000.00	$0.00	$60,000.00	$60,000.00		
TBD: Technical Assistance to Providers Implementing Payment Reform	$0.00	$0.00	$0.00	$770,000.00	$0.00	$770,000.00	$770,000.00		
TBD: Technology & Infrastructure: Expanded Connectivity HIE Infrastructure	$0.00	$0.00	$0.00	$700,000.00	$0.00	$700,000.00	$700,000.00		
TBD Other: Sub-Total	$10,005,707.74	$0.00	$10,005,707.74	($10,005,707.74)		($10,005,707.74)	$0.00		
TOTAL	**$15,799,775.31**	**$7,756.60**	**$15,807,531.91**	**($1,600,595.00)**	**$16,766.00**	**($1,583,829.00)**	**$14,223,702.91**	**$1,012,774.82**	**$190,002.64**

Table 7: Performance Period 2 Contracts Pending CMMI Approval: Detailed View

In **Table 7** below, please find the Performance Period 2 contract request by contractor. The table indicates the focus area as well as the Performance Period 2 milestone(s) that each contract supports.

Contractor	Brief Scope	Focus Area(s)	Performance Period 2 Milestone(s)	Line Item	Requested Performance Period 2 Contract Start Date	Performance Period 2 Request (excludes Out-of-State Travel)	Performance Period 2 Out-of-State Travel Request	Total Performance Period 2 Request (includes Performance Period 2 Out-of-State Travel)	New Performance Period 2 Reallocation/ Carryforward (excludes Out-of-State Travel)	New Performance Period 2 Reallocation/ Carryforward Out-of-State Travel	New Performance Period 2 Reallocation/ Carryforward (includes Out-of-State Travel)	Total Performance Period 2 - This Request	Amount Expended through 11/30/2015	Unliquidated Obligations as of 11/30/2015
ARIS: ACTT Proposal #03410-1380-15	Unified Electronic Health Record Procurement for five Specialized Service Agencies.	Health Data Infrastructure	EMR Expansion: Implement EMRs in non-meaningful use providers; explore non-EMR solutions for providers without EMRs.	*Technical Assistance*: Practice Transformation & Data Quality Facilitation	1/1/2015	$275,000.00	$ -	$275,000.00	$ -	$ -	$ -	$275,000.00	$72,500.00	
Bailit Health Purchasing #26905	Policy development, payment model design, care model design and quality measurement identification for several VHCIP work groups.	CMMI-Required Milestone: Payment Models Payment Models	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) ACO Shared Savings Program: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 3) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 6. Design modifications to existing Integrated Family Services (IFS) Program so it can expand to at least one additional community on 7/1/16.	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers	1/1/2015			$ -	$245,000.00	$10,080.00	$255,080.00	$255,080.00		

Contractor	Brief Scope	Focus Area(s)	Performance Period 2 Milestone(s)	Line Item	Requested Performance Period 2 Contract Start Date	Performance Period 2 Request (excludes Out-of-State Travel)	Performance Period 2 Out-of-State Travel Request	Total Performance Period 2 Request (includes Performance Period 2 Out-of-State Travel)	New Performance Period 2 Reallocation/ Carryforward (excludes Out-of-State Travel)	New Performance Period 2 Reallocation/ Carryforward Out-of-State Travel	New Performance Period 2 Reallocation/ Carryforward (includes Out-of-State Travel)	Total Performance Period 2 - This Request	Amount Expended through 11/30/2015	Unliquidated Obligations as of 11/30/2015
Behavioral Health Network: ACTT Proposal #27380	1) Data Quality Analysis and Remediation. 2) Data Warehouse Planning and Development.	Health Data Infrastructure	1) Improve Quality of Data Flowing into HIE: 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16. 2) Data Warehousing: 1. Implement Phase 1 of DA/SSA data warehousing solution by 12/31/15 (implementation follows implementation project plan).	*Technology and Infrastructure:* Enhancements to Centralized Clinical Registry & Reporting Systems	8/1/2015	$350,000.00	$ -	$350,000.00	$248,750.00		$248,750.00	$598,750.00		
Bi-State Primary Care Association #03410-1456-14	ACO operations: Data collection, analysis, operational implementation.	Payment Model Design and Implementation Practice Transformation	1) ACO Shared Savings Program: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) Regional Collaborations: Expansion of regional collaborations to all 14 Health Service Areas (HSAs) by 6/30/16. Expansion is complete when all HSAs have a Charter, governing body, and decision-making process.	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers	1/1/2015			**$ -**	$444,000.00	$3,686.00	$447,686.00	$447,686.00		
Burns and Associates #28733	Conduct payment reform, financial modeling strategy development, rate setting work for Vermont	CMMI-Required Milestone: Payment Models	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) ACO Shared Savings Program: Expand the number of people in the Shared Savings Programs in	*Advanced Analytics:* Policy and Data Analysis to Support System Design and	4/1/2015	$24,000.00	$1,000.00	$25,000.00	$350,000.00	$3,000.00	$353,000.00	$378,000.00		.

Contractor	Brief Scope	Focus Area(s)	Performance Period 2 Milestone(s)	Line Item	Requested Performance Period 2 Contract Start Date	Performance Period 2 Request (excludes Out-of-State Travel)	Performance Period 2 Out-of-State Travel Request	Total Performance Period 2 Request (includes Performance Period 2 Out-of-State Travel)	New Performance Period 2 Reallocation/ Carryforward (excludes Out-of-State Travel)	New Performance Period 2 Reallocation/ Carryforward Out-of-State Travel	New Performance Period 2 Reallocation/ Carryforward (includes Out-of-State Travel)	Total Performance Period 2 - This Request	Amount Expended through 11/30/2015	Unliquidated Obligations as of 11/30/2015
	Medicaid payment, methodologies, and other essential fiscal evaluations.	Payment Model Design and Implementation Evaluation	Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 3) Episodes of Care: 3 EOCs designed for Medicaid – implementation of data reports by 3/1/16. Implementation of data reports means: episodes selected, outreach plan to providers designed, first run of historic data provided to providers participating in program. 4) All-Payer Model: 1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI. 5) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 1. Ensure appropriate customer service supports are in place for Medicaid SSP program for 2016 by 11/1/15. 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA	Research for All Payers										

Contractor	Brief Scope	Focus Area(s)	Performance Period 2 Milestone(s)	Line Item	Requested Performance Period 2 Contract Start Date	Performance Period 2 Request (excludes Out-of-State Travel)	Performance Period 2 Out-of-State Travel Request	Total Performance Period 2 Request (includes Performance Period 2 Out-of-State Travel)	New Performance Period 2 Reallocation/ Carryforward (excludes Out-of-State Travel)	New Performance Period 2 Reallocation/ Carryforward Out-of-State Travel	New Performance Period 2 Reallocation/ Carryforward (includes Out-of-State Travel)	Total Performance Period 2 - This Request	Amount Expended through 11/30/2015	Unliquidated Obligations as of 11/30/2015
			documents for Year 1 of the EOC program by 4/1/16. 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan. 5. Develop monitoring and compliance plan for Year 1 EOCs by 6/30/16. 6. Design modifications to existing Integrated Family Services (IFS) Program so it can expand to at least one additional community on 7/1/16. 6) Self-Evaluation Plan and Execution: 2. Continue to execute self-evaluation plan using staff and contractor resources. 7) Evaluation and Monitoring Activities Within Payment Programs: 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: monthly, quarterly reports depending on type.											
Covisint #29340	Acquire or license clinical registry software.	Health Data Infrastructure	Data Warehousing: 2. Procure clinical registry software by 3/31/16.	*Technology and Infrastructure*: Enhancements to Centralized Clinical Registry & Reporting Systems	8/31/2015	$1,000,000.00		$1,000,000.00	$ -	$ -	$ -	$1,000,000.00		
Datastat #26412	Administration of the Patient Centered Medical Homes Consumer Assessment of	Evaluation	Surveys: Conduct annual patient experience survey and other surveys as identified in payment model development:	*Model Testing:* Quality Measures	8/1/2015	$80,000.00	$ -	$80,000.00	$65,000.00	$ -	$65,000.00	$145,000.00		

Contractor	Brief Scope	Focus Area(s)	Performance Period 2 Milestone(s)	Line Item	Requested Performance Period 2 Contract Start Date	Performance Period 2 Request (excludes Out-of-State Travel)	Performance Period 2 Out-of-State Travel Request	Total Performance Period 2 Request (includes Performance Period 2 Out-of-State Travel)	New Performance Period 2 Reallocation/ Carryforward (excludes Out-of-State Travel)	New Performance Period 2 Reallocation/ Carryforward Out-of-State Travel	New Performance Period 2 Reallocation/ Carryforward (includes Out-of-State Travel)	Total Performance Period 2 - This Request	Amount Expended through 11/30/2015	Unliquidated Obligations as of 11/30/2015
	Healthcare Providers and Systems (PCMH CAHPS®).		Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings programs – phase 1 to determine impact of Performance Period 2 activities by 6/30/16.											
Deborah Lisi-Baker #26033/#29534	Support for DLTSS work group. Stakeholder engagement related to long-term services and supports and Vermonters with disabilities.	Payment Model Design and Implementation Practice Transformation	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) Learning Collaboratives: Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers	7/1/2015	$40,000.00	$ -	$40,000.00	$ -	$ -	$ -	$40,000.00		
Health Management Associates #28821	Assist in development of an all-payer waiver proposal.	CMMI-Required Milestone: Payment Models Payment Model Design and Implementation	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) All-Payer Model: 1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI. 3) State Activities to Support Model Design and Implementation - GMCB: 1. Research and planning to identify the components necessary for APM regulatory activities by 6/30/16.	*Advanced Analytics:* Financial and Other Modeling for All Payers	4/8/2015	$349,000.00	$ -	$349,000.00	$100,000.00	$ -	$100,000.00	$449,000.00		

Contractor	Brief Scope	Focus Area(s)	Performance Period 2 Milestone(s)	Line Item	Requested Performance Period 2 Contract Start Date	Performance Period 2 Request (excludes Out-of-State Travel)	Performance Period 2 Out-of-State Travel Request	Total Performance Period 2 Request (includes Performance Period 2 Out-of-State Travel)	New Performance Period 2 Reallocation/ Carryforward (excludes Out-of-State Travel)	New Performance Period 2 Reallocation/ Carryforward Out-of-State Travel	New Performance Period 2 Reallocation/ Carryforward (includes Out-of-State Travel)	Total Performance Period 2 - This Request	Amount Expended through 11/30/2015	Unliquidated Obligations as of 11/30/2015
Health Management Associates #28821	Assist in development of an all-payer waiver proposal.	CMMI-Required Milestone: Payment Models Payment Model Design and Implementation	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) All-Payer Model: 1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI. 3) State Activities to Support Model Design and Implementation - GMCB: 1. Research and planning to identify the components necessary for APM regulatory activities by 6/30/16.	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers	4/8/2015	$349,000.00	$ -	$349,000.00	$100,000.00	$ -	$100,000.00	$449,000.00		$184,002.64
Healthfirst, Inc. #03410-1457-15	Chart Review for Shared Savings Program Measures.	Payment Model Design and Implementation	ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000.	*Model Testing*: Quality Measures	1/1/2015	$41,940.00	$ -	$41,940.00	$13,060.00		$13,060.00	$55,000.00	$41,560.00	
HIS Professionals #27511	Program management, project management and subject matter support of long term services and supports providers and mental health agencies	Health Data Infrastructure	General Health Data – Expert Support: 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.	*Technology and Infrastructure:* Expanded Connectivity of HIE Infrastructure.	1/1/2015				$50,000.00		$50,000.00	$50,000.00		
IHS Global, Inc.	Demand Modeling: Construction of a micro-simulation health needs model for the state of Vermont.	Practice Transformation	Workforce – Demand Data Collection and Analysis: 1. Execute contract for micro-simulation demand modeling by 1/15/16 (dependent on federal approval).	*Workforce Assessment: System-Wide Capacity*	10/1/2015	$250,000.00	$ -	$250,000.00	$100,000.00		$100,000.00	$350,000.00		

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			2. Provide preliminary data as defined by the contract to vendor for use in model by 3/15/16.											
James Hester, Jr. #28674	Research population health models in other states, identify population health measures and measurement systems required to support the population health financing system; help formulate an approach to creating Vermont pilots of Accountable Health Communities.	Payment Model Design and Implementation	Accountable Communities for Health: Feasibility assessment – data analytics: 1. Discussion and planning of investments related to ACH feasibility based on research/report by 11/1/15. 2. Design/creation of ACH learning system for all 14 Vermont Health Service Areas by 1/31/16. 3. Start roll out ACH learning system to at least 3 health service areas by 2/1/16. 4. Research for implementation of a pilot incorporating a payment change (data analysis, financial analysis, stakeholder participation analysis) for at least 1 Vermont region by 2/1/16.	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers	7/1/2015	$7,000.00	$ -	$7,000.00	$ -	$ -	$ -	$7,000.00		
JBS International #28389	Assist Vermont in assessing current telehealth practices in Vermont and planning for potential pilot programs.	Health Data Infrastructure	Telehealth – Strategic Plan: Develop Telehealth Strategic Plan by 9/15/15.	*Technology and Infrastructure*: Telemedicine	2/1/2015	$138,114.40	$2,327.60	$140,442.00	$(32,442.00)[5]	$ -	$(32,442.00)	$108,000.00	$92,385.72	
Nancy Abernathey #28243	Quality improvement facilitators supporting quality improvement activities in primary care practices, integrated care	Practice Transformation	Learning Collaboratives: Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.	*Technical Assistance:* Learning Collaboratives	1/1/2015	$6,630.00	$ -	$6,630.00	$52,000.00	$ -	$52,000.00	$58,630.00		

[5] Milestone achieved. Cost less than anticipated.

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	teams within communities and specialty addictions and mental health programs.													
Pacific Health Policy Group #28062	To provide consulting support for policy development, payment and care model design and quality measurement identification as it relates to the Disability and Long Term Service and Supports (DLTSS) work group for the Vermont Health Care Innovation Project (VHCIP).	Payment Model Design and Implementation	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16. 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan.	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers	1/1/2015				$90,000.00	$ -	$90,000.00	$90,000.00		
PatientPing #TBA	To provide notification to Vermont's	Health Data Infrastructure	Care Management Tools: Engage in discovery, design and testing of shared care plan IT solutions, an	*Technology and Infrastructure:* Practice	TBD	$100,000.00		$100,000.00	$400,000.00		$400,000.00	$500,000.00		

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	providers about admissions, discharges, and transfer[6] of Vermonters to and from hospitals, skilled nursing facilities, and other health care settings. The notification will be to those providers sending and receiving patients, as well as, a patient's primary care clinical team and an ACO.		event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development: 1. Event Notification System: Procure solution by 1/15/16 and implement according to project plan for phased roll out.	Transformation										
Policy Integrity #TBA	Technical assistance for provider grant program. Analysis on Delivery System Design and Organization, Data & Financial Analysis.	Payment Model Design and Implementation Practice Transformation	1) State Activities to Support Model Design and Implementation – Medicaid: 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan. 2) Sub-Grant Program – Technical Assistance: Provide technical assistance to sub-grantees as requested by sub-grantees: 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.	*Technical Assistance:* Technical Assistance to Providers Implementing Payment Reforms	5/15/2015				$30,000.00	$ -	$30,000.00	$30,000.00		

[6] The ADT data is provided by VITL through the State's VHIE.

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Stone Environmental #28427	Assist the HIE/HIT Work Group in developing policy and spending recommendations in the area of technology and infrastructure.	Health Data Infrastructure	1) Data Warehousing: 3. Develop a cohesive strategy for developing data systems to support analytics by 3/31/16. 2) Care Management Tools: Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development: 2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16. 3) General Health Data – HIE Planning: 1. VHCIP will provide comment into the HIT Strategic Plan at least 4 times in 2015. 2. HDI work group will identify connectivity targets for 2016-2019 by 6/30/16. 4) General Health Data – Expert Support: 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.	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers	2/15/2015	$80,000.00	$ -	$80,000.00	$85,000.00	$ -	$85,000.00	$165,000.00	$3,774.25	
The Lewin Group #27060	Build a model for multiple ACOs that accepts key	Payment Model Design and Implementation	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in	*Advanced Analytics:* Policy and Data	1/1/2015				$293,000.00	$ -	$293,000.00	$293,000.00		

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	inputs, such as total shared savings, quality scores and scoring criteria, and calculate the final shared savings to be delivered to each ACO.	Evaluation	Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) Self-Evaluation Plan and Execution: 2. Continue to execute self-evaluation plan using staff and contractor resources. 3) Monitoring and Evaluation Activities Within Payment Programs: Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: Monthly, quarterly reports depending on type.	Analysis to Support System Design and Research for All Payers										
University of Massachusetts #25350	Project coordination and financial management assistance.	Project Management and Reporting	1) Project Management and Reporting – Project Organization: Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2) Project Management and Reporting – Communication and Outreach: Engage stakeholders in project focus areas. Engage stakeholders in project focus areas by: 1. Convening 5 Core Team, 5 Steering Committee, and 10 work group public meetings by 6/30/16. 2. Distributing all-participant emails at least once a month.	*Project Management*	1/1/2015				$230,000.00	$ -	$230,000.00	$230,000.00		

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UVM Medical Center/ OneCare Vermont #28242	ACO operations: Data collection, analysis, operational implementation.	Payment Model Design and Implementation Practice Transformation	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) Regional Collaborations: Expansion of regional collaborations to all 14 Health Service Areas (HSAs) by 6/30/16. Expansion is complete when all HSAs have a Charter, governing body, and decision-making process.	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers	1/1/2015	$371,826.45	$ -	$371,826.45	$441,216.75	$ -	$441,216.75	$813,043.20	$155,859.85	
UVM Medical Center/One Care Vermont #28242	Chart Review for Shared Savings Program Measures.	Payment Model Design and Implementation	ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000.	*Model Testing:* Quality Measures	1/1/2015	$82,628.10	$ -	$82,628.10	$98,048.25	$ -	$98,048.25	$180,676.35		
UVM Medical Center/One Care Vermont #28242	Data quality initiatives.	Health Data Infrastructure	Improve Quality of Data Flowing into HIE: 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16.	*Technical Assistance:* Practice Transformation & Data Quality Facilitation.	1/1/2015	$371,826.45	$ -	$371,826.45	$441,216.75	$ -	$441,216.75	$813,043.20		

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Vermont Medical Society Foundation #28675	Development of a payment model related to frail elders.	Payment Model Design and Implementation	State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 7. Research and design related to Frail Elders (timeline dependent upon federal contract approval) – final recommendations by 6/30/16.	Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers.	8/1/2015	$130,329.00	$ -	$130,329.00	$10,329.00	$ -	$10,329.00	$140,658.00		
Vermont Program for Quality in Health Care #28362	Quality improvement facilitators supporting quality improvement activities in primary care practices, integrated care teams within communities and specialty addictions and mental health programs.	Practice Transformation	Learning Collaboratives: Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.	*Technical Assistance:* Learning Collaboratives.	3/1/2015	$98,097.67	$4,429.00	$102,526.67	$81,130.00	$ -	$81,130.00	$183,656.67	$46,695.00	$6,000.00

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VITL/Dept of Mental Health MOU #28236	Assist the Department of Mental Health in the procurement of an EHR system and EHR implementation for the State's Mental Health Hospital.	Health Data Infrastructure	EMR Expansion: 1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and ARIS (Developmental Disability Agencies) (by 6/30/16).	*Technical Assistance:* Practice Transformation & Data Quality Facilitation.	1/1/2015	$11,087.50	$ -	$11,087.50	$ -	$ -	$ -	$11,087.50		
VITL: ACO/ACTT Proposals #03410-1275-14	Data gathering, data quality & remediation for Designated Agencies and Specialized Service Agencies.	Health Data Infrastructure	1) Expand Connectivity to HIE – Gap Remediation: Remediate data gaps that support payment model quality measures, as identified in gap analyses: 1. Remediate 50% of data gaps for SSP quality measures by 12/31/15. 2. Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15. 2) Improve Quality of Data Flowing into HIE: 1. Implement terminology services tool to normalize data elements within the VHIE by TBD. 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16. 3) EMR Expansion: 1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and	*Technology and Infrastructure:* Expanded Connectivity of HIE Infrastructure	1/1/2015	$1,312,588.00	$ -	**$1,312,588.00**	$(186,327.00)[7]		$(186,327.00)	$1,126,261.00	$600,000.00	

[7] This is a deliverables based and time and materials hybrid contract. All milestones met to date; some time and materials actuals are less than the amount budgeted for 2015.

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			ARIS (Developmental Disability Agencies) (by 6/30/16). 2. Explore non-EMR solutions for providers without EMRs: develop plan based on LTSS technical gap analysis.											
Wakely Consulting #26303	Actuarial and financial analysis as well as technical assistance for the provider grant program.	Payment Model Design and Implementation Practice Transformation	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16. 2) Sub-Grant Program – Technical Assistance: Provide technical assistance to sub-grantees as requested by sub-grantees: 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	*Advanced Analytics:* Financial and Other Modeling for All Payers. *Technical Assistance:* Technical Assistance to Providers Implementing Payment Reforms.	TBD				$30,000.00		$30,000.00	$30,000.00		

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			sub-grantees.											
Truven/Brandeis #TBD	Contract to provide data files to federal evaluator, RTI. Truven will create a VHCURES MarketScan-like database for use by RTI in its evaluation of the SIM initiative.	Evaluation	Self-Evaluation Plan and Execution: 2. Continue to execute self-evaluation plan using staff and contractor resources.[8] 3. Streamline reporting around other evaluation activities not performed by Impaq within 30 days of CMMI approval of self-evaluation plan.	*Evaluation*	TBD				$32,500.00		$32,500.00	$32,500.00		
Sub-Grant Program (See Table 8 below)	Grant Provider Program	Practice Transformation	Sub-Grant Program – Sub-Grants: Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.	*Technical Assistance:* Technical Assistance to Providers Implementing Payment Reforms	TBD				$1,872,468.99		$1,872,468.99	$1,872,468.99		
TBD: Accountable Communities for Health	Application of the Accountable Community for Health (ACH) to Vermont's health care system	Payment Model Design and Implementation	Feasibility assessment – data analytics: 1. Discussion and planning of investments related to ACH feasibility based on research/report by 11/1/15. 2. Design/creation of ACH learning system for all 14 Vermont Health Service Areas by 1/31/16. 3. Start roll out ACH learning system to at least 3 health service areas by 2/1/16. 4. Research for implementation of a pilot incorporating a payment change (data analysis, financial analysis, stakeholder participation analysis) for at least 1 Vermont region by 2/1/16.	*Advanced Analytics*: Policy and Data Analysis to Support System Design and Research for All Payers	TBD				$50,000.00		$50,000.00	$50,000.00		

[8] Vermont's self-evaluation plan relies on numerous staff and contractors, which are described in the Evaluation Remediation Plan submitted on November 25, 2015 and resubmitted on December 3, 2015.

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TBD: HIE Design and Testing	HIE Design and Testing for Shared Care Plans and Uniform Transfer Protocol.	Health Data Infrastructure	Care Management Tools: Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development: 2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16.	*Technology and Infrastructure*: Analysis of How to Incorporate Long-Term Support Services, Mental Health, and Other Areas of Health	TBD	$150,000.00	$ -	$150,000.00	$201,550.00	$ -	$201,550.00	$351,550.00		
TBD: QI Facilitators	Learning Collaborative activities. Care management core competency and disability core competency training.	Practice Transformation	Learning Collaboratives: Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 1. Create expansion plan for remaining Vermont HSAs that want to participate in the Learning Collaborative program by 6/15/15. 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.	*Technical Assistance*: Learning Collaboratives	TBD	$20,000.00	$	$20,000.00	$239,612.00	$ -	$239,612.00	$259,612.00		
TBD: Telehealth pilot program	Phase II of Telemedicine planning: Implementation of pilot programs.	Health Data Infrastructure	Telehealth – Implementation: 2. Award at least one contract to implement the scope of work in the telehealth program RFP by 1/15/16.	*Technology and Infrastructure*: Telemedicine	TBD	$155,000.00	$ -	**$155,000.00**	$300,000.00	$ -	$300,000.00	$455,000.00		
TBD: Evaluation	Perform provider surveys; engage in qualitative interviews of those participating in Vermont's SIM activities.	Evaluation	Self-Evaluation Plan and Execution: 1. Procure new self-evaluation contractor by 2/28/16 to execute contractor-led self-evaluation plan activities. 2. Continue to execute self-	*Evaluation:* Internal Evaluation	TBD	$200,000.00		$200,000.00	$200,000.00	$ -	$200,000.00	$400,000.00		

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			evaluation plan using staff and contractor resources.											
TBD: Onpoint Evaluation	Onpoint	Evaluation	Self-Evaluation Plan and Execution: 2. Continue to execute self-evaluation plan using staff and contractor resources. 3. Streamline reporting around other evaluation activities within 30 days of CMMI approval of self-evaluation plan.	*Evaluation:* Internal Evaluation	TBD				$60,000.00	$ -	$60,000.00	$60,000.00		
TBD: Technical Assistance to Providers	TBD	CMMI-Required Milestone: Payment Models Payment Model Design and Implementation	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed.	*Technical Assistance:* Practice Transformation & Data Quality Facilitation	TBD				$770,000.00	$ -	$770,000.00	$770,000.00		
TBD: Expanded Connectivity to the HIE Infrastructure	TBD	Health Data Infrastructure	1) Expand Connectivity to HIE – Gap Remediation: Remediate data gaps that support payment model quality measures, as identified in gap analyses. 1. Remediate 50% of data gaps for SSP quality measures by 12/31/15. 2. Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15. 2) Improve Quality of Data Flowing into HIE:	*Technology and Infrastructure:* Expanded Connectivity HIE Infrastructure	TBD				$700,000.00	$ -	$700,000.00	$700,000.00		

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			1. Implement terminology services tool to normalize data elements within the VHIE by TBD. 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16.											
TBD	The State of Vermont has identified the need to perform advanced analytics to support the SIM initiatives. The policy and data analysis will support system design and planning for all payers. This will include claims data analysis of Vermont's all-payer claims database.	TBD	TBD	Advanced Analytics: Policy and data analysis to support system design and research for all-payers	TBD	$9,605,707.74		**$9,605,707.74**	$(9,605,707.74)[9]		$(9,605,707.74)	$ -		
TOTALS						**$15,799,775.31**	**$7,756.60**	**$15,807,531.91**	**$(1,600,595.00)**	**$16,766.00**	**$(1,583,829.00)**	**$14,223,702.91**	**$1,012,774.82**	**$190,002.64**

[9] This row was previously in Vermont's Performance Period 2 submissions. This is retained in this version to show this movement from this broad TBD to all of the other contracts indicated.

Table 8: Sub-Grant Program Detail

Organization	Brief Scope of Work	Award Amount	Term	Performance Period 2 Requested Amount:
	SUB GRANT PROGRAM –Total Estimate to Fund Program for January-June 2016			**$1,872,468.99**
Bi-State Primary Care	Eleven Federally Qualified Health Centers (FQHCs) and Bi-State Primary Care Association have formed a primary care centric Accountable Care Organization (ACO), Community Health Accountable Care, LLC (CHAC), to participate in shared savings programs with Medicare, Medicaid, and at least one commercial payer. CHAC will implement the ACO model to monitor quality of care through data, promote evidence-based medicine, and coordinate care with participating community providers. The outcome will be improved quality and reduced cost of care, particularly for high risk patients.	$400,000.00	7/15/2014 - 6/30/2016	$139,650.00
Central Vermont Medical Center (CVMC) **SBIRT**	SBIRT is an evidence-based practice to identify, reduce and prevent substance misuse and co-occurring disorders. Following on the success of the recent implementation of SBIRT in the Emergency Department (ED), this project will extend SBIRT to seven patient centered medical homes by incorporating SBIRT screening, intervention strategies and SBIRT clinician staffing into chronic disease management practices. This project aims to prevent and reduce substance misuse, reduce healthcare costs and increase care coordination through increased patient participation in referral and addiction treatment programs and to demonstrate a regional model of care that can be promoted statewide.	$500,000.00	1/8/2015 - 11/30/2016	$192,381.00
HealthFirst	Health*first* is an Independent Practice Association that includes 139 physicians in 63 independent practices in Vermont. Health*first* has formed ACOs to participate in both the Medicare and commercial shared savings programs. This capacity grant will allow Health*first* to further develop their	$400,000.00	8/15/2014 - 6/30/2016	$257,874.21*(includes request for HealthFirst listed below)

	ACO infrastructure to manage patient care. Their specific focus will be increasing coordination in medical homes between primary care and other clinical practitioners and increasing communication between primary care and specialty physicians.			
HealthFirst	This project is to enhance HealthFirst's capacity to participate in meaningful collaborations with OneCare Vermont and Community Health Accountable Care (CHAC) with the shared vision and goals of collecting, analyzing and using data for targeted healthcare performance improvement throughout Vermont. The project will support independent physician members in developing, implementing and improving care delivery strategies. The project aims to reduce non-emergent Emergency Room use and hospitalizations for ambulatory care sensitive conditions.	$200,000.00	11/1/2014 - 11/30/2016	Budget Request for this portion of HealthFirst is included above
InvestEAP	InvestEAP, Vermont's public/private employee assistance program, and a federally-qualified health center, will partner to demonstrate the impact of integrating an innovative stress prevention and early intervention program with traditional primary care delivery. The project embodies the core belief that early intervention aimed at the social determinants of health and the root causes of stress will improve health outcomes and reduce medical expenditures.	$249,942.00	7/1/2014 - 8/31/2016	$161,902.94*(includes request for InvestEAP listed below)
InvestEAP	Through this project, Invest EAP will partner with WellSys, a physician-owned business dedicated to helping healthcare professionals bring Behavioral Screening and Intervention to their clinical settings, and the Vermont-based employer, King Arthur Flour. Invest EAP will provide behavioral screening and interventions to demonstrate its effectiveness in the workplace as a means to improve health outcomes and reduce medical expenditures, by working closely with the Human Resource Department of King Arthur Flour to: • create an incentive for workers to access our behavioral health screening; • educate employees; and • provide employees with clear directions to access the program.	$60,145.00	11/30/2014-11/30/2016	Budget Request for this portion of InvestEAP is included above
Northeastern Vermont Regional Hospital	This project will provide flexible funding for goods and services not normally covered by insurance, enabling an integrated multi-disciplinary community	$179,400.00	8/8/14 - 11/30/2015	$31,400.00

	care team to better care for clients who are at risk for poor outcomes and high costs of medical care.			
Northwestern Medical Center, Inc. RiseVT	RiseVT is a collaborative, community-wide campaign designed using the Vermont Prevention Model (socio-ecological model). This broad community campaign intends to impact the health of Franklin County residents by targeting policies, infrastructure, education, the environment, and culture within municipalities, worksites, schools and families. The program is integrated with Patient Centered Medical Homes in Franklin County and will include development of a central clearinghouse for "all things health and wellness." As a focus, three key indicators were selected that will continually work to increase physical activity and healthy eating in the community: • Increase the overall health of residents by decreasing the percentage of overweight and obese individuals; • Increase the number of employers offering a wellness program in which greater than 50% of the employees participate; and • Expand resources for biking and walking	$400,000.00	1/15/2015 - 11/30/2016	$172,821.20
Rutland VNA & Hospice	This project will support design and implementation of a supportive care program for seriously ill patients with congestive heart failure and /or chronic lung disease. The program will improve communication between the multiple providers and organizations involved in the care of these patients and advance a patient-centered model for care planning and shared decision-making. The project is expected to reduce use of hospital and emergency department care, improve patient quality of life and save money.	$112,063.43	7/25/14 - 6/30/2016	$52,896.72
Southwestern Vermont Health Care	This project seeks to reduce health care costs in a small rural community through the implementation of an innovative adaptation of a transitional care model (TCM) that supports patient self-care, through care management and patient outreach. An earlier pilot project involving a team of nurse specialists deployed to three primary care practices and the emergency department has demonstrated reductions in hospital admissions and emergency department utilization; this project builds upon those early	$400,000.00	1/1/2015 - 11/30/2016	$150,000.00

	successes and will implement this innovative TCM across a rural service area to test the model's impact on population health and to inform research on its application to the Accountable Care Organization (ACO) model in Vermont.			
VT Medical Society & FAHC	This project will support an effort to decrease waste and potential harm in the hospital setting based on evidence behind the national "Choosing Wisely" campaign that estimates 30 percent of U.S. health care spending is avoidable and potentially harmful. Physicians from Vermont hospitals and Dartmouth-Hitchcock Medical Center will work together to reduce unnecessary lab testing, and in doing so will create a statewide provider network to lead additional waste reduction and care improvement efforts.	$548,829.00	8/29/14 - 11/30/2015	$160,918.26
Vermont Developmental Disabilities Council (VTDDC)	This program works with adult Vermonters with intellectual and developmental disabilities (I/DD) that support good health and positive encounters with health care professionals in the delivery of high quality, cost effective care. Specifically, the project will create a work group that will review best practices in healthcare delivery to the adult developmentally disabled population, collect and analyze qualitative and quantitative data that describes the health status and care experience of these individuals, hold focus groups and structured interviews with adults with I/DD, family caregivers and health and disabilities and long terms support services providers. Informed and supported by this collaboration, the project will create a White Paper that will incorporate the work group's findings and provide actionable recommendations that stakeholders can implement on a pilot basis.	$193,000.00	12/1/2014 - 12/31/2015	$16,341.89
Vermont Program for Quality in Health Care	This statewide provider-led initiative will support the collection, submission, and reporting of surgical procedure data. Quality assessment and improvement has long been a cornerstone of surgical practice and is central to the professional identity of surgeons. By implementing a nationally-recognized clinical database (ACS-NSQIP), this project will identify areas in need of improvement within current systems and deliver improved surgical outcomes, enhanced patient safety, and reduced costs across Vermont.	$900,000.00	1/1/2015 - 11/30/2016	$459,737.93

White River Family Practice	White River Family Practice is an innovative, progressive family medicine practice that has developed a culture of quality improvement that creates an ideal platform to model and disseminate health reform initiatives. This project will further develop an already sophisticated clinical care system to achieve the following aims: • measure and reduce emergency room utilization and hospital readmission among patients; • track patient confidence and utilize this metric to stratify patients with chronic disease to achieve improved disease outcomes and reduced utilization; and • deploy team based care protocols targeting patients with chronic disease.	$363,070.00	7/30/14 - 5/31/2016	$76,544.84
Totals:		**$4,906,449.43**		**$1,872,468.99**

D. EQUIPMENT

The total amount requested for equipment costs to support staff for Performance Period 2 is $36,037.00. Estimated equipment costs include computer hardware and software, telephones, fax machines, and other office equipment, as itemized below. These are standard estimates for State of Vermont employees.

- Work Station and Business Software – There will be a $2,000 start-up cost with ongoing costs of $750 per year for workstations and software per FTE.
- Telephone Equipment – The total expense for telephone equipment costs is estimated at $750 per FTE per year.
- Office Furniture & Fixtures – We estimate the total cost of office furniture and fixtures to be a one-time cost of $600 per FTE and an ongoing cost of $50 per FTE per year.

E. TRAVEL

The total amount requested for employee travel reimbursement for this performance period is $81,375.00. This amount is inclusive of an estimated$1,500 per full-time employee for out-of-state trips. In-state travel is budgeted at $2,000 per year per FTE, which is standard when budgeting State of Vermont employee costs. Out-of-state travel is based upon the need for staff to travel out of state for conferences, meetings, and collaborations pertaining to SIM Model Testing.

F. SUPPLIES AND MISCELLANEOUS

Supplies costs for this performance period of $14,300.00 are based on an estimated rate of $100 per staff member per year plus incidental cost for supplies for symposia, conference, and convenings. These are standard estimates for State of Vermont employees.

G. SYSTEM AND/OR DATA COLLECTION COSTS

The state is contracting for these services. Please see Section C, Contract Costs.

H. STATE EVALUATOR COSTS

The state is contracting for these services. Please see Section C, Contract Costs.

I. OTHER ADMINISTRATIVE

The total amount for the performance period requested for other administrative expenses is $436,575.00. Detailed assumptions for other administrative expenses are itemized below. These are standard estimates for State of Vermont employees.

- Printing & Reproduction – Each FTE will incur$50 in printing and reproduction costs per year.
- Dues & Subscriptions – This includes fees for professional associations and subscriptions. The total estimated cost is$504 per FTE per year.
- Professional Development – Training and professional development costs and fees will amount to$996 per FTE per year.
- Space – Workspace will cost$5,500 per FTE per year.
- Acquisition of Medicare data files for use in developing evaluation measures, core measure set and determination of progress in project goals.
- Faculty fees and conference space for the Learning Collaborative program.[10]

[10] Standard State of Vermont procurement identifies these expenses as “Other”.

Table 9: Other Administrative Expenses

Category	FTE	Per FTE	Amount
Printing & Reproduction	23.25	$100.00	$2,325.00
Dues & Subscriptions	23.25	$504.00	$11,718.00
Professional Development	23.25	$996.00	$23,157.00
Space	23.25	$5,500.00	$127,875.00
Medicare Data			$112,500.00
Facility Fees & Conference Space: Learning Collaboratives			$159,000.00
TOTAL			**$436,575.00**

Vermont's SIM project requires that we use all-payer claims data to inform decision-making. The State receives an annual data extract from Medicare so that we can use it in addition to our Medicaid and Commercial claims data. The data extract files would cost approximately $75,000 per year. OAGM indicated that this should be considered an expense under "Other" in 2014.

Vermont has launched a robust Learning Collaborative program to engage providers in practice transformation related to at-risk Vermonters. Vermont has a long history of collaboration in health care and community/social services delivery, and has implemented significant delivery system reforms aimed at strengthening coordination of care and services, including the Blueprint for Health and Accountable Care Organizations. Nonetheless, people with complex care needs and their families and providers still experience fragmentation, duplication and gaps in care and services. Vermont's year-long "Integrated Communities Care Management Learning Collaborative" was launched in January 2015 to test interventions based on promising national models such as Integrated Communities, Medical Neighborhoods, and Effective Team-Based Care across multiple health and social services organizations in a community. The project started in three communities: Burlington, Rutland and St. Johnsbury; and was recently approved for expansion to teams of health care and service providers from all interested communities in the State. The Learning Collaborative utilizes a Plan-Do-Study-Act quality improvement model punctuated with periodic in-person and virtual learning sessions. The near-term goals are to determine if the interventions improve coordination of care and services; establish improved communication and care protocols; reduce fragmentation, duplication, and gaps in care and services; and improve the care experience and outcomes for people in need of services and their families. The longer-term goals are to reduce growth in health care costs, improve care, and improve the health of the population. The costs for this program include: contractual, facility, faculty, and videography.

J. INDIRECT

The total amount requested for indirect expenses is $569,912.00 inclusive of staff, facilities costs and other ancillary business and staff expenses required for SIM Model Testing. An estimate of 40% of personnel costs are applied according to the State's Cost Allocation Plan, which reflects administrative and overhead costs borne by the state for items not included in the direct cost estimates itemized above (e.g., HR, accounting, and other overhead cost items). This allocation follows standard DVHA budget development practices and unit cost assumptions.

K. OTHER GRANTS

The State of Vermont supports payment and delivery reforms through our 1115 Global Commitment to Health Waiver, the State's General Fund, and a Robert Wood Johnson Foundation grant. This funding has allowed for small pilot programs focused on discrete populations, but not statewide efforts encompassing all payers. The additional resources provided for in the SIM Opportunity allow us to expand the scope of our reforms and implement them more quickly.

L. FEDERAL SOURCES

The State may pursue a one-year SAMHSA planning grant opportunity (Planning Grants for Certified Community Behavioral Health Clinics), which would support the State in developing Certified

Community Behavioral Health Clinic certification criteria and an associated Prospective Payment System for Medicaid, in preparation for participation in demonstration programs to improve community mental health services. The application for this planning grant opportunity is due on August 5, 2015. In order to participate in this alternative payment arrangement in compliance with SAMHSA rules, the State must apply for, and be awarded this planning grant. If the State is awarded this planning grant, we will leverage SIM as much as possible understanding the programmatic constraints of the planning grant. Otherwise, the State does not currently expect or need additional funding from other Federal sources for work to be performed on Model Implementation and Testing as described in this application.

M. ATTESTATION

The State of Vermont attests that it is not supplanting federal funds with this request. The State of Vermont attests that SIM Cooperative Agreement funds will not be used to supplement or supplant existing State, local, or private funding of infrastructure or services, such as staff salaries, etc., except for the two positions noted in the personnel table (Directors of Payment Reform). The State of Vermont attests that it will not use SIM Cooperative Agreement funds to support food and beverages for any conferences or meetings. The State of Vermont attests that it will use SIM funds to pay for cell or smart phone purchases, plans or service fees as previously approved by OAGM.

N. BUDGET TO COLLECT DATA

The state is seeking additional resources to support collection and evaluation of the additional data needed for the SIM project. These resources will supplement existing state resources invested in the all-payer claims database, clinical registry and evaluation infrastructure. The additional resources are needed to support inclusion of new claims, enrollment, quality and patient experience data for Medicare and Medicaid beneficiaries, as indicated in the Project Plan for Performance Reporting, Continuous Improvement, and Evaluation Support. Details are in **Table 10** below.

Table 10: Cost to Collect Data Over Entire Grant Term

Source	Cost	
Medicaid Data Analysts (4)	$	979,048.73
Program Manager for Evaluation	$	296,069.02
Evaluation Contractors	$	2,000,000.00
Technology and Infrastructure Contractors	$	11,387,293.00
TOTAL	**$**	**14,662,410.75**

APPENDIX A: Performance Period 2 CONTRACT REQUEST

These contractors are critical for accomplishing Performance Period 2 activities and meeting Performance Period 2 milestones and metrics. This request is a supplement to the submission dated 9/3/2015 that was approved on 10/9/2015.I. Vermont requests that all of these contracts be approved retroactively to the date requested in the tables below. .

Due to Vermont's contracting process, there are a handful of contractors with multiple executed contracts with the same scope but different contract terms (James Hester - #26319/#28674; Deborah Lisi-Baker - #26033/#29534). These contracts are combined for ease of review.

Where contractors have multiple executed contracts with different scopes, they are listed in separate tables (Vermont Program for Quality in Health Care - #27427/#28362; VITL-DMH/Other).

There are some activities for which Vermont will need new contracts, in line with the TBD categories in **Table 6** above. For these TBD categories, Vermont is providing the procurement plan including hyperlinks to the RFPs for these scopes of work. These are listed as TBD here and included at the end of the contractor list.

In this submission, there are two contractors for whom the Performance Period 2 amount requested is less than previously submitted and approved. The reason is that the Performance Period 2 milestones were met using fewer resources than anticipated. Those contractors are: JBS International and VITL. These contracts are deliverables based using time and materials billing. It took less time to achieve the milestones than initially anticipated.

ARIS Solutions, Inc. #03410-1380-15	
Method of Selection	Sole Source
Contract Amount	**Total Contract Amount (all years):**$275,000 **Performance Period 2 Total Amount (including Travel):**$275,000 **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	1/1/15-6/30/16
Method of Accountability	This is a fixed price contract to pay for a portion of the acquisition of an electronic health record system for Vermont's five Specialized Service Agencies.
Itemized Budget	The total maximum amount payable under this agreement shall not exceed$275,000. The maximum amount is calculated based on a percentage of the overall project budget below.

Year	# Users	Per User	Total
Year 1	300	$ 38.00	$ 136,800
Year 2	300	$ 38.00	$ 136,800
Year 3	300	$ 38.00	$ 136,800
Year 4	300	$ 38.00	$ 136,800
Year 5	300	$ 38.00	$ 136,800
Total Subscription fees			**$ 684,000**
One time fee - system			$ 99,450
One time fee - additional training			$ 20,000
One-time fee - ePrescribing			$ 9,000
One-time Hosting set up fee			$ 1,500
Total One time fees			**$ 129,950**
System Adminstrator fees (5 year)			**$ 298,383**
E-prescribing (2400/year)			**$ 12,000**
GRAND TOTAL 5 YEAR COST			**$ 1,124,333**

Budget Category	*Technology and Infrastructure:* Expanding Connectivity to the HIE
Summary Statement of Work	Unified Electronic Health Record Procurement for five Specialized Service Agencies.
Unique Qualifications (if Sole Source)	The Subrecipient was created in 1996 as a cooperative effort among social service agencies to reduce expenses in the face of state-wide budget cuts without diminishing the level of valuable supports within the community. The Subrecipient operates as a consortium of developmental disability services agencies. Although the agencies are separate legal entities, they share resources and utilize a team-based approach to providing services throughout the State of Vermont, including aggregating outcomes data and reporting to the State of Vermont. The project ties directly into the overall goal of the Vermont Health Care Innovation Project (VHCIP) Work Group for the HIE which is to ensure the availability of clinical health data or information necessary to support the care delivery and payment models being tested by the VHCIP, including those associated with the Shared Savings/Accountable Care Organizations (ACOs), Episode of Care, Pay-for-Performance, and other Care Delivery models. The Subrecipient will work toward that overall goal by impacting three of the identified VHCIP HIE Work Plan goals, including: • To improve the utilization, functionality & interoperability of the source systems providing data for the exchange of health information. • To improve the ability of health and human services professionals to appropriately exchange health information. • To align and integrate Vermont's electronic health information systems, both public and private, to enable the comprehensive and secure exchange of personal health and human services records.
Retroactive Start	**Funding is requested to be retroactive to January 1, 2015.**

Justification (if applicable)	This agreement was submitted to CMMI on November 25, 2014, with a request that the funding begin January 1, 2015. It was not approved pending approval of Vermont's Performance Period 1 Carryforward. This contract was not in force in 2014 and not part of the approved carryforward. This contract is fully funded by Performance Period 2 contract funds. Retroactive funding is requested to support the nature of the Subrecipient's work, which is time sensitive and critical to the success of the VHCIP.
Travel Justification	Travel is not a billable expense under this agreement.
Performance Period 2 Applicable Milestones	EMR Expansion: Implement EMRs in non-meaningful use providers; explore non-EMR solutions for providers without EMRs.

Contract Attachment A, Scope of Work for ARIS Solutions, Inc. #03410-1380-15

Electronic Health Record Procurement:

The Subrecipient is procuring an EHR solution for five (5) developmental disability agencies. Procurement is expected to be complete by January 1, 2015. The State will reimburse the Subrecipient for a portion of the costs related to this procurement up to the maximum amount allowable according to Attachment B.

The Subrecipient will provide the State with monthly updates on the selection and implementation of the EHR solution. These monthly updates will include:

- Whether installation is proceeding according to the specified timeline.
- Challenges faced with the installation.

Deliverables

- 30 days after the EHR Subcontract has been executed, the Subrecipient will provide the State with a work plan and timeline for implementation to be accepted or modified by the State's authorized representative
    - Should the State require revisions to the proposed project plan it will notify the Subrecipient in writing by the 10th business day after receiving the plan.
- The Subrecipient shall include with each monthly invoice an updated work plan outlining achievements to milestones.

Subrecipient Requirements

Performance Expectations:

The Subrecipient shall develop quarterly reports updating the State on the procurement, including whether the EHR solution is being installed on time and within the budget.

No work shall be undertaken or reimbursed pursuant to this Agreement, other than obligations specifically set forth in this Attachment A.

All work under this Agreement shall be directed by the State's Authorized Representative.

The Subrecipient's single point of contact or designee will be present at monthly status meetings at a time and date agreed upon by the State and Subrecipient.

<table>
<tr><th colspan="2">Bailit Health Purchasing #26905</th></tr>
<tr><td>Method of Selection</td><td>RFP and Sole Source</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$1,130,272
Total Amount (including Travel and Approved Carryover):$255,080.00
Out-of-State Travel:$10,080</td></tr>
<tr><td>Contract Term</td><td>7/1/14-1/31/17 (1/1/15-6/30/16)</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based contract where the contractors are required to submit monthly task order forms for monthly activities. Once the task order forms are approved, the contractor can commence work for that month. The contract manager(s) review the invoices, task order forms and work products each month before approving the invoices. Vermont is engaging in this contracting structure for professional services contracts to ensure that we have the skills necessary for the work to be done, but also allowing for some flexibility in a changing health care environment. Additionally, Vermont does not want to pay for unnecessary services and finds this method of accountability and management to allow for maximum benefit in contracting with entities for professional services.</td></tr>
<tr><td>Itemized Budget</td><td>The billing for this contract is time and materials. Specifically, the State of Vermont has developed a task order approval structure where the Contractor receives prior approval for all tasks. Once the task order is approved, the vendor does the work and then bills for it. The Contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the hourly rate for each staff person assigned to the contract. The Contractor’s hourly rates are competitive within the health care consultant sector and fall within the midrange of hourly rates for contractors involved in this work across the country

<table>
<tr><th>Key Personnel</th><th>Hourly Rate</th></tr>
<tr><td>Michael Bailit</td><td>$239.00</td></tr>
<tr><td>Mary Beth Dyer</td><td>$239.00</td></tr>
<tr><td>Beth Waldman</td><td>$239.00</td></tr>
<tr><td>Marge Houy</td><td>$214.00</td></tr>
<tr><td>Kate Bazinsky</td><td>$152.00</td></tr>
<tr><td>Erin Taylor</td><td>$152.00</td></tr>
<tr><td>Christine Hughes</td><td>$152.00</td></tr>
<tr><td>Michael Joseph</td><td>$152.00</td></tr>
<tr><td>Margaret Trinity</td><td>$152.00</td></tr>
</table></td></tr>
<tr><td>Budget Category</td><td>Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers
Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms
Model Testing: Quality Measures
Technology and Infrastructure: Analysis of How to Incorporate Long-Term Support Services, Mental Health, and Other Areas of Health</td></tr>
<tr><td>Summary Statement of Work</td><td>• Policy development, payment model design, care model design and quality measurement identification for several VHCIP work groups.
• Technical assistance for provider grant program. Analysis on Delivery System Design and Organization, Data & Financial Analysis.
• Research related to the Transitions of Care Project for a Vermont Universal Transfer Protocol (UTP).</td></tr>
<tr><td>Unique Qualifications (if</td><td>Bailit Health Purchasing is uniquely qualified to perform these tasks for several reasons:</td></tr>
</table>

Sole Source)	1. Bailit has provided consulting support to all of these groups over the past year. The work groups have approved continued support from Bailit for specific tasks and will be monitoring performance and will recommend any future changes in scope. Bailit is familiar with Vermont's payment and delivery system models and key personnel can draw on that expertise to inform this work. This allows Vermont to maximize efficiencies in contracting. 2. Bailit has contracts with other SIM states and entities across the country engaged in payment and delivery system reform work. They bring this knowledge back to Vermont for our discussion, which ensures we have the broadest available set of information upon which to base policy decisions. 3. Michael Bailit and the other staff at Bailit Health Purchasing have been working with Vermont on its payment and delivery system reforms since 2011. This work has involved development of payment and quality recommendations for use by the State and health care stakeholders. The Bailit Team's engaged with Vermont in this area enables us to leverage their expertise and not have to educate a new vendor on our work and progress to date. 4. Bailit Health Purchasing also has contracts with other SIM states and entities across the country engaged in payment and delivery system reform work. They bring this knowledge back to Vermont for our discussions, which ensures we have the broadest available set of information upon which to base policy decisions. 5. Bailit Health Purchasing also has other staff familiar with Vermont's payment and delivery system models and key personnel can draw on that expertise to inform this work. This allows Vermont to maximize efficiencies in contracting. 6. Bailit Health Purchasing is able to begin this work immediately. The SIM Project requires Vermont adhere to extremely tight timeframes for payment and care model development. Delaying procurement of a vendor to conduct this work would significantly jeopardize the ability of Vermont to meet critical milestones and metrics.
Retroactive Start Justification (if applicable)	This agreement was previously approved by CMMI in 2014 is part of the carryover. The travel was not clear in the previous submission. The request is for the travel to be retroactive to January 1, 2015.
Travel Justification	**The estimated travel for this contract per year is:$10,080.** *Estimated cost per trip:$420* • Mileage: 412* miles round trip @$.575/mile =$237.00 (rounded) • Hotel:$140.00** • Per Diem for 1 person ($40/day x 1 day):$40.00 • Tolls and parking:$3.00 *Average number of trips per month: 2* * 412 miles represents the average of round trip mileage to Colchester, Williston, and Montpelier, the three rotated meeting locations of the all-payer waiver work group ** This is the average of billed room charges during recent stays at the Colchester Hampton Inn, the Williston Courtyard by Marriott, and the Berlin Comfort Inn.
Performance Period 2 Applicable Milestones	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) ACO Shared Savings Program: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 3) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate:

	6. Design modifications to existing Integrated Family Services (IFS) Program so it can expand to at least one additional community on 7/1/16.

Contract Attachment A, Scope of Work for Bailit Health Purchasing #26095

1. The Contractor shall provide support for Disability and Long Term Services and Supports (DLTSS) Work Group tasks, activities and decision-making, including, but not limited to, the following areas:
    a. Care models to support integrated care for people with disabilities, chronic conditions and those needing long term services and supports.
    b. Payment models to support integrated care for people with disabilities, chronic conditions and those needing long term services and supports.
    c. LTSS quality and performance measures to evaluate the outcomes of people with disabilities, chronic conditions and those needing long term services and supports.
    d. IT infrastructures to support new payment and care models for integrated care for people with disabilities, chronic conditions and those needing long term services and supports.
    e. Strategies to incorporate person-centered, disability-related, person-directed, and cultural competency issues into all VHCIP activities.
    f. Identification of barriers in current Medicare, Medicaid and commercial coverage and payment policies, and strategies to address them.
    g. Other activities as identified by the Work Group to assist successful implementation of payment and care models to best support people with disabilities, chronic conditions and those needing long term services and supports.

2. The Contractor shall support the DLTSS Work Group and leadership (i.e., VHCIP and DLTSS Project Staff, Work Group Chairs and other Consultants) by performing the following activities:
    a. Work closely with VHCIP and DLTSS Work Group leadership to strategize and develop agendas for Work Group meetings, preparing handouts and preparing discussion materials.
    b. Actively participate in DLTSS Work Group meeting discussions.
    c. Conduct research on specific topics and developing summary documents and / or presentations.
    d. Provide ad hoc support for project leadership and achievement of VHCIP goals via telephone calls and electronic mail communications (e.g., exchange of information about project developments and updates, sharing of information regarding relevant topics, new publications and/or national news; discussion of recent events and implications for project direction; contributing to discussion about policy or operational decisions; etc.).
    e. Participate in Health Information Technology /Health Information Exchange (HIT/HIE) Work Group Meetings.
    f. Attend VHCIP Steering Committee meetings and other VHCIP Work Group meetings as necessary to support the goals of the DLTSS Work Group.

3. The Contractor shall provide support for the Payment Models Work Group tasks, activities and decision-making, including, but not limited to, the following areas:

    a. Medicaid and Commercial Shared Savings ACO Program payment design and implementation;
    b. Episode of Care program payment design and implementation;
    c. Pay-for –Performance program payment design and implementation;
    d. Development of manuals, glossaries and other documents to support the three models being tested in Vermont: Shared Savings ACO Programs, Episodes of Care and Pay-for-Performance;
    e. Providing support to VHCIP staff and sub-groups of the Payment Models Work Group;
    f. Research, white paper development and documentation related to the three payment models being tested in Vermont;
    g. Development of timelines, agendas, workplans and other materials needed to support the work

group activities;

h. Identification of barriers in current Medicare, Medicaid and commercial coverage and payment policies, and strategies to address them; and
i. Other activities as identified by the Work Group to assist successful implementation of payment models.

4. The Contractor shall provide support for the Care Models Work Group tasks, activities and decision-making, including, but not limited to, the following areas:

   a. Medicaid and Commercial Shared Savings ACO Program care model and care management design and implementation;
   b. Episode of Care program care model and care management design and implementation;
   c. Pay-for-Performance program care model and care management design and implementation;
   d. Development of manuals, glossaries and other documents to support the care models and care management standards related to the three payment models being tested in Vermont: Shared Savings ACO Programs, Episodes of Care and Pay-for-Performance;
   e. Providing support to VHCIP staff and sub-groups of the Care Models and Care Management Work Group;
   f. Research, white paper development and documentation related to the care management and care models in Vermont;
   g. Development of timelines, agendas, workplans and other materials needed to support the work group activities;
   h. Identification of barriers in current Medicare, Medicaid and commercial policies, and strategies to address them; and
   i. Other activities as identified by the Work Group to assist successful implementation of payment models, care management standards and care models.

5. The Contractor shall provide support for the Quality and Performance Measures Work Group tasks, activities and decision-making, including, but not limited to, the following areas:

   a. Medicaid and Commercial Shared Savings ACO Program quality measure identification;
   b. Episode of Care program care model and care management quality measure identification;
   c. Pay-for –Performance program quality measure identification;
   d. Development of manuals, glossaries and other documents to support the quality measures identified for each of the three payment models being tested in Vermont: Shared Savings ACO Programs, Episodes of Care and Pay-for-Performance;
   e. Providing support to VHCIP staff and sub-groups of the Quality and Performance Measures Work Group;
   f. Research, white paper development and documentation related to potential quality measures in Vermont;
   g. Development of timelines, agendas, workplans and other materials needed to support the work group activities;
   h. Identification of barriers in current Medicare, Medicaid and commercial policies, and strategies to address them; and
   i. Other activities as identified by the Work Group to assist successful implementation of quality measures.

6. The Contractor shall provide support for two IT projects. The first project will review existing DLTSS measures. The review of the DLTSS measures is in advance of the measures that are being proposed for use in the Medicaid Shared Savings Program in 2015 and 2016. This project will determine if any non-claims based measures need IT support for use in 2016. The second project aims to improve integration of

communication among acute and post-acute health care providers and community based supportive service providers to enable Vermont to reach the next level of performance and service integration, with lower total medical expenditure (TME) and higher patient satisfaction. Today, modes of communication among different provider types vary from electronic to manual modes such as fax, telephone, and paper. Significant constraints on improved care integration and coordination include the lack of common information exchange processes, agreed upon content, and access to a shared health information exchange. This project will consider the data sets and impact on workflow processes and behavior for provider needs, which must convey both medical and social information. The work described here will focus on several provider types, some of which have EMR systems, and at least one will not. Mandating a form or protocol does not guarantee that people will use it well, or even that they will use it at all. This project will result in the creation of a detailed project charter for the technical design of the actual Universal Transfer Protocol. The Contractor shall provide support for the these two IT projects tasks, activities and decision-making, including, but not limited to, the following areas:

a. Providing support to VHCIP staff and the HIE/HIT Work Group;
b. Research, white paper development and documentation related to DLTSS quality measures and the Universal Transfer Protocol in Vermont;
c. Development of timelines, agendas, workplans and other materials needed to support these two projects' activities; and
d. Other activities as identified by VHCIP Staff and the HIE/HIT Work Group to assist successful implementation of these two projects.

7. Deliverables:
    a. Submit monthly task order and progress reports indicating what work is to be done and confirming what work was accomplished each month.
    b. Develop and/or contribute to agendas, white papers, presentations and other materials for the VHCIP Work Groups as requested.
    c. Participate in monthly VHCIP work group meetings, and sub work-group meetings as needed.
    d. Participate in monthly VHCIP work group planning meetings.
    e. Attend VHCIP Steering Committee meetings and other VHCIP work group meetings as needed.
    f. Provide research and summary documents to support VHCIP work group work plan and decision-making.
    g. Work with VHCIP Project Staff regarding IT infrastructure needs by providing research, papers and documents that support Work Group recommendations and decision-making.
    h. Work with VHCIP Project Staff to develop care models that support integrated care.
    i. Work with VHCIP Project Staff to develop payment models that support integrated care.
    j. Provide ad hoc research, analyses and communications to support VHCIP work group tasks and activities.

8. Develop Scopes of Work with Grant Program Awardees:
    a. The Contractor shall develop detailed scopes of work, including timeline and total cost, with awardees and the State. The State will pay the Contractor for the time spent on the development of each scope of work as outlined in the approved task order.
    b. The Contractor shall create a work-plan for providing the technical assistance necessary for all of the approved scopes of work.

9. Technical Assistance Support to Grant Program Awardees:
    c. The Contractor shall provide consultative support to the approved Grant Program Awardees. The Contractor will not begin work on any scopes of work without express written approval by the State.

    d. The areas of consultation that may be necessary in order to accomplish this task may include, but

are not limited to:

i. Advice on Delivery System Design and Organization
ii. Advice on Payment Reform
iii. Financial Analysis
iv. Quality Reporting and Analysis
v. Planning and Model Design

e. The Contractor shall provide monthly reports to the State regarding progress on each of these technical assistance scopes of work. The Contractor should be prepared to consult with the State of Vermont in development of written documentation and presentations to State and Center for Medicare & Medicaid Innovation in order to support this effort.

f. The Contractor's level of effort will vary according to the needs of each Awardees reform agenda and the degree to which state staff or consultants retained are capable of providing all needed support.

10. Task Orders:

All work must be reviewed and accepted by the State Authorized Representative(s) in the form of a task order before the Contractor shall submit an invoice to the State.

Changes to a Task Order shall be accomplished by written modification as agreed to by both parties listed below and will be reflected in a new Task Order.

Georgia J. Maheras, Esq.
Project Director
Vermont Health Care Innovation Project
georgia.maheras@state.vt.us
802-505-5137

Jessica Mendizabal
Contract and Grants Administrator
Department of Vermont Health Access
Jessica.mendizabal@state.vt.us
802-878-7958

11. Monthly Reporting

a. The Contractor shall participate in a conference call each month with the State regarding work under this agreement. The purpose of these calls is to discuss administrative and project issues as they arise and to report preliminary findings of analyses as they become available.
b. More frequent calls may be needed during active periods of the project.

c. The Contractor shall submit monthly Status Reports outlining all work accomplished during the previous month. The Report should detail hours expended against the Task Order for each staffing category identified:

i. Total hours authorized under the Task Order
ii. Hours expended during the previous week
iii. Total hours expended under the Task Order to date

These reports are to be submitted electronically to the VHCIP Project Director within five business days after the end of the month. These monthly progress reports shall be consistent with the work billed on the monthly vouchers.

   d. At a minimum, monthly progress reports shall cover the following items:
      i. Activities related to consultation and support related to each Awardee supported by this contract
      ii. Activities planned for the forthcoming month
      iii. Contractor's expectations of the State Staff during the forthcoming month (e.g., review of deliverables submitted, delivery of data or other items)
      iv. Any problems or delays – encountered or foreseeable – that may affect contract performance
      v. Budget discrepancies greater than ten percent, i.e., cost overruns or underruns.
   e. Additional planning and coordination meetings may be required during the course of the contract, depending on the State's needs.

12. Contract Administration Data – Key Personnel (See Attachment B for key personnel list and hourly rates)
    a. The key personnel specified in this contract are considered to be essential to work performance. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the VHCIP Project Director and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the State of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The State may modify the contract to add or delete key personnel at the request of the Contractor or Government.

13. Ad Hoc Tasks:
    The State shall define deliverables as aligned in the scope of work by meeting with the Contractor on a bi-weekly basis in order to define and confirm inclusion of additional deliverable development as identified by the State. Ad hoc tasks shall be reduced to writing and approved by both parties on a task order form and added to the work plan on a bi-weekly basis.

14. Performance Expectations:
    The scopes of work and technical assistance provided by the Contractor shall contain specific deliverables, due dates and performance measures, and shall serve as the basis for quality assurance and a means for monitoring the contractor's performance throughout the duration of this contract.

    The Contractor shall provide a single point of contact who will manage all aspects of the contract including the assignment of qualified personnel to perform the work outlined herein.

    The Contractor's single point of contact or designee will be present at bi-weekly status meetings at a time and date agreed upon by the State and Contractor.

    The Contractor shall work with other State staff and State Contractors as requested by the State.

    The number of personnel and level of expertise required, as well as the scheduled hours to be worked will be determined by the State and the Contractor on a bi-weekly basis as part of the status meetings and shall be included on the task order form. The assignment of additional personnel, hours, or the substitution of personnel with a higher level of expertise shall require pre-approval by the State.

    The Contractor accepts full responsibility for any personnel assigned to perform the work herein. It is understood that the State will provide minimal oversight of personnel assigned to this contract.

    The State shall notify the Contractor's single point of contact to discuss remediation if it is determined by the State that personnel assigned are not performing as expected. The State has the

right to request a change in personnel assigned. The State shall not request a change in personnel without reason. The Contractor is obligated to provide a change in personnel, within 2 business days of a request by the State.

Behavioral Health Network #27379	
Method of Selection	Sole Source
Contract Amount	**Total Contract Amount (all years):**$1,318,577 **Performance Period 2 Total Amount (including Travel):**$598,750 (note that$350,000 was previously approved so the requested amount is$248,750). **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	8/1/14-7/31/16 (Performance Period 2: 1/1/15-6/30/16)
Method of Accountability	This is a deliverables/performance-based contract where the contractors are required to submit monthly task order forms for monthly activities. These task order forms will provide specific information as it relates to the project work plan in the agreement. Once the task order forms are approved, the contractor can commence work for that month. The contract manager(s) review the invoices, task order forms and work products each month before approving the invoices. Vermont is engaging in this contracting structure for professional services contracts to ensure that we have the skills necessary for the work to be done, but also allowing for some flexibility in a changing health care environment. Additionally, Vermont does not want to pay for unnecessary services and finds this method of accountability and management to allow for maximum benefit in contracting with entities for professional services.
Itemized Budget	The billing for this contract is time and materials. Specifically, the State of Vermont has developed a task order approval structure where the Contractor receives prior approval for all tasks. Once the task order is approved, the vendor does the work and then bills for it. The Contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the hourly rate for each staff person assigned to the contract. The Contractor's hourly rates are competitive within the health care consultant sector and fall within the midrange of hourly rates for contractors involved in this work across the country. **Hourly Rates:** **Executive Director:**$150/hour **HIT Director:**$115/hour **Quality Manager:**$35/hour
Budget Category	*Technology and Infrastructure:* Practice Transformation & Data Quality Facilitation *Technology and Infrastructure:* Enhancements to Centralized Clinical Registry & Reporting Systems
Summary Statement of Work	1) Unified EHR Procurement for five developmental disability agencies; 2) Data Quality Analysis and Remediation for all agencies that need to build internal infrastructures with system-wide uniformity; 3) Data Warehouse Planning and Development for a data repository that will eventually enable the consumption of uniform data across a variety of payer sources for quality improvement, the exchange of health information, and reporting purposes. 4) Date Repository Information.
Unique Qualifications (if Sole Source)	1. The State of Vermont relies on independent, non-profit DAs/SSAs to provide mental health, substance use and developmental services throughout the state. State and federal sources, particularly Medicaid, fund DA/SSA services at approximately$360 million annually.

	The DAs/SSAs enable many Vermonters to secure and maintain employment, keep their families intact, secure and maintain housing and avoid hospitalization, institutionalization and incarceration. Each year over 45,000 Vermonters use these services and over 6,000 Vermonters are employed by the DA/SSA agencies. The DA/SSA system provides comprehensive services, including case management to adults who have severe and persistent mental illness (CRT program), individuals with significant developmental disabilities (DS waiver program), assessment and treatment for substance abuse disorders and children with severe emotional disturbance (SED waiver program) who would otherwise be at risk of institutional placements. Additionally we provide a range of child, youth and family services, crisis services and outpatient services. 2. BHN was created by Vermont's Community Mental Health Centers in 1994 and serves to provide strategic return on investment by serving as a vehicle for collaboration, systems integration and improvement, economies of scale and new opportunities and markets. BHN provides centralized, efficient activities to support the DAs and SSAs across the state. BHN is responsible for providing research and data collection and electronic health record support to the DAs and SSAs. They are the statewide entity responsible for data efforts by our DAs and SSAs. 3. BHN was able to begin this work immediately. The VHCIP requires Vermont adhere to extremely tight timeframes for payment and care model development and the underlying HIT systems upon which the models rely. Delaying procurement of a vendor to conduct this work would significantly jeopardize the ability of Vermont to meet critical milestones and metrics. 4. One of the major objectives of the BHN work will be to help manage and coordinate the work across all of the DAs and SSAs. BHN was on board by August 1, 2014.
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to November 12, 2015.**
Travel Justification	Hourly rates are inclusive of travel.
Performance Period 2 Applicable Milestones	1) Improve Quality of Data Flowing into HIE: 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16. 2) Data Warehousing: 1. Implement Phase 1 of DA/SSA data warehousing solution by 12/31/15 (implementation follows implementation project plan). 2. Procure clinical registry software by 3/31/16.

Contract Attachment A, Scope of Work for Behavioral Health Network #27379

Background

The purpose of this contract is to enable Vermont's sixteen designated and specialized service agencies (DAs/SSAs) to have structured, reliable and complete data that can be used to: strengthen communication with community partners; enhance care coordination with primary care; improve the quality of care across the network; promulgate best practices of integration; demonstrate value; and increase their ability to report to Affordable Care Organizations ("ACOs"), the State and other entities to which they are in partnership or accountable. This work will have a significant impact statewide as it relates to cost control, funding mechanisms, care delivery models and population health improvement. It will also have a tremendous impact at the local level enabling individual DAs/SSAs to utilize data to improve the care provided at their agency and to work with other community- based providers such as federally qualified health centers ("FQHCs"), home health agencies, employment agencies and housing

organizations to enhance care coordination and care delivery. This is inclusive of the care provided that impacts the social determinants of health.

Scope of Work

There are three parts to this project: Unified Electronic Health Record (EHR) Procurement, Data Quality Analysis and Remediation and Planning and Developing a Data Warehouse for Vermont's sixteen (16) Designated and Specialized Service Agencies. The Contractor shall utilize Primmer Piper Eggleston & Cramer PC for legal consultation as an approved sub-contractor to this agreement

1) **Unified EHR Procurement**

This is a Unified EHR platform for five (5) developmental disability agencies. This work shall include a planning stage in consultation with Vermont Information Technology Leaders (VITL) to ensure the future ability to exchange information. The Contractor shall support the five developmental disability agencies in planning and implementing a Unified EHR platform. The Contractor shall convene and facilitate conversations with the agencies and the State.

2) **Data Quality Analysis and Remediation**

All DAs/SSAs need to build internal infrastructures that have system-wide uniformity. The Contractor shall develop a data dictionary and a toolkit comprised of a common measurement grid, common element grid, workflow, and staffing structure that can be utilized statewide. The process for development shall be based on the best practice quality work implemented by the federally qualified health centers.

3) **Data Warehouse Planning and Development**

In parallel with the data quality work, the Contractor shall enable the designated and specialized service agencies to plan and design, in consultation with VITL and the State, a data repository that will eventually enable the consumption of uniform data across a variety of payer sources for quality improvement, the exchange of health information, and reporting purposes. The Contractor shall also enable the designated and specialized service agencies to implement the data repository. This will be done in conjunction with the work being proposed by the State and VITL for compliance with 42 CFR Part 2.

The Contractor shall be responsible for ensuring that the project meets the scope and requirements of Vermont's sixteen designated and specialized service agencies (DAs/SSAs) and providing appropriate guidance and support towards that scope. The full scope of the project including the tasks to be completed, specific deliverables, responsible parties, and timelines are listed in the table below in Table A: "Scope and Schedule of the

4) **Data Repository Implementation**

In parallel with the ongoing data quality work, the Contractor shall subcontract with a vendor to build and implement the data repository. The Contractor shall go out to bid for the repository in compliance with SOV procedures. Because of constraints involving SAMHSA 42 CFR Part 2, the Contractor shall use a phased approach to importing and exporting data to and from the repository. In phase 1 the Contractor shall begin importing data that the majority of VCN members already produce. In phase 2 the Contractor shall intend to implement HL7 messaging from our members to the repository. Finally, for phase 3, contingent on regulatory challenges being met, the Contractor shall implement export connections from the repository to the Vermont Health Information Exchange.

The Contractor shall ensure that the repository is developed in a way that enables portability and interoperability. The Contractor and its member agencies shall own and have complete access to the data in the repository and shall develop a data governance document to be provided to the State of Vermont. A plan for the sustainability of the repository shall be developed prior to the completion of Phase 3. The Contractor shall provide a yearly report on the operations of the repository.

TABLE A: Scope and Schedule of the Project.

In the table below Year One refers to August 2014-August 2015 and year two refers to August 2015-August 2016 (with quarters as Aug-Oct., Nov-Jan, Feb-April, May-July).

Activities	Measureable Process	Outcome Measures	Performance Period	Evaluation Method	Responsible Org/Person
NEED: All designated agencies in Vermont are using electronic health records (at different levels of functionality), but due to inconsistent and non- standard data capture, reporting from these systems is difficult within the agencies and comparative reporting across the network is difficult.					
GOAL A: Ensure high quality clinical data for population health and quality/outcome reporting from DA/SSAs					
STRATEGY: Provide system-wide support and promulgate best practices to ensure that agencies' EHR data is structured, reliable and complete.					
OJECTIVE A.1: Identify data and reporting needs and create data dictionary					
Convene network members and stakeholders to bring them up to speed on the data environment. Engage project management.		Majority members attend kick off meeting	Qtr 1, Year 1	Meeting attendance	BHN
Engage Statewide HIT Director and Quality Staff	Contract signed, within budget		Qtr 1, Year 1	Contract signed	BHN
Identify most critical data elements and required data structure based on information needed for reporting and improvement.	List of current reporting requirements gathered; structured list of critical data elements developed and accepted by the State		Qtr 2, Year 1	Review of work documents	BHN
Create Data Dictionary	Data dictionary created, accepted by the State, and distributed	Outcome measures align with requirements	Qtr 3, Year 1	Review of work documents	BHN

Activities	**Measureable Process**	**Outcome Measures**	**Performance Period**	**Evaluation Method**	**Responsible Org/Person**
OBJECTIVE A.2: To develop toolkit for statewide use					
Create measure spreadsheets	Numerator and denominator for all performance measurements are developed and accepted by the State		Qtr 2, Year 1	Review of work documents	BHN
Create tool to identify points within workflows	Visit and staff structures are developed and accepted by the State		Qtr 2, Year 1	Review of work documents	BHN
OBJECTIVE A.3: To utilize tools statewide and conduct current state EHR capability analysis for DAs/SSAs					
Conduct trainings on toolkit		100% of DA/SSAs receive training	Qtr 3, Year 1		BHN
Conduct agency specific review and identify gaps in data quality		≥80% complete	Year 1	Review of work documents	BHN
Coordinate with ARIS and VITL on behalf of the developmental disability agencies to identify a common EHR platform to allow for efficiencies	Electronic health record selected and procured		Qtr 1, Year 1	Review of work documents	BHN
Document and report to stakeholders	Ongoing reporting to stakeholders following communication plan		Year 1		BHN

Activities	Measureable Process	Outcome Measures	Performance Period	Evaluation Method	Responsible Org/Person
OBJECTIVE A.4: To remediate data quality					
Work with each agency on improving data quality (structured, complete, semantic standards compliant)		Increase in # agencies able to provide quality data (baseline to be established in Qtrs 1 & 2 of Year 1)	Qtr 3, 4 Year 1 Qtr 1,2 Year 2	Review of work documents	BHN
Develop system-wide policies and procedures as needed for data quality	Policies and procedures are documented in writing and consistently applied across stakeholders	# or % policies developed and consistently applied across stakeholders	Qtr 3, 4 Year 1	Review of work documents	BHN
Re-evaluate agency-specific data quality	Review of agency data systems		Qtr 2,3 Year 2	Review of work documents	BHN
OBJECTIVE A.5: To inform the network providers of documentation requirements moving forward					
Develop communication plan	Review plan by network members	Plan developed and accepted by the State	Qtr 4, Year 1		BHN
Provide DA/SSA specific education around workflow redesign	Presentation developed and accepted by the State	75% satisfied with educational opportunity	Year 2	Survey	BHN
NEED: Access to a reliable data source of up-to-date and standardized data for all DAs/SSAs is essential for all network members and stakeholders (reporting, enhanced care management, inclusion in ACOs, benchmarking, quality improvement)					

Activities	Measureable Process	Outcome Measures	Performance Period	Evaluation Method	Responsible Org/Person
GOAL B: Aggregate data for individual agency and network-wide analysis and reporting through adoption of a data repository					
STRATEGY: Design and implement a secure data repository with data from agencies EHR systems.					
OBJECTIVE B.1: To conduct a needs assessment to identify characteristics of a desired solution for data repository					
Convene network members and other stakeholders	Monthly meetings	% stakeholders attending	Quarterly	Review of minutes	BHN
Research and resolve issues related to 42CFR Part 2(Link to Part 2 Project) *Not the responsibility of BHN.*	Policy related to 42CFR Part 2 written and accepted by the State		See ACTT 42 CFR Part 2 Proposal	Review of work documents	BHN Director in conjunction with Part 2 Team *Part of a separate proposal but linked
Confirm, finalize and document data analytic and reporting needs and review in subsequent years	Final documents developed and accepted by the State		Qtr 3, Year 2	Final documents presented to key stakeholders	BHN
Assess cost and benefit of repository options and conduct architectural design process	Options and cost benefit documented and accepted by the State		Qtr 1,2 Year 1	Review of minutes and structural design	BHN
Agree on direction and roadmap for repository		Majority approval by stakeholders	Qtr 3 Year 1	Signed agreements in place	BHN
Confirm, approve and document scope, cost and timeline of repository		Majority approval by stakeholders	Qtr 4 Year 1	Signed agreements in place	BHN
OBJECTIVE B.2: To execute repository project					
Develop RFP through Advisory Group and with SME TA	**RFP written, developed and approved by**		Qtr. 3 Year 1	Review of minutes	BHN

Activities	Measureable Process	Outcome Measures	Performance Period	Evaluation Method	Responsible Org/Person
	Advisory Group				
Post RRP and hold bidder conference	**RFP posted and bidders conference held**		Qtr. 3 Year 1	Final RFP posted and responses received	BHN
Review and select vendor	**Review team identified, scoring template designed, responses scored, vendor chosen.**		Qtr. 4 Year 1	Review of template and selection process	BHN
Develop contract with vendor	**Contract signed by BHN and vendor.**		Qtr. 4 Year 1	Signed contract in place	BHN
Develop sustainability Plan	**Sustainability Plan developed and presented at Board meeting for vote**		Qtr. 1 Year 2	Review of Board minutes	BHN
Build and execute data repository	**First phase of data repository built.**		Qtr. 4 Year 2	Repository build presented to VHCIP HIE Workgroup	BHN

Progress Reports and Expenditure Reports
Contractor shall file monthly progress and expenditure reports with the State with the month-end request for payment in accordance with Attachment B. The State and Contractor will develop a mutually agreed upon format for the Progress Reports and Expenditure Reports within 30 days of contract execution. This report shall include a plan to develop baseline data for outcomes specified in the work plan above. The State reserves the right to request within 10 days of submission that the Contractor provides additional information in the Progress Reports and Expenditure Reports that may be necessary to document deliverables or other progress prior to release of month-end payment. Payment against deliverables constitutes approval. For any deliverables not so approved, the Contractor shall make all necessary changes required by the State for approval within 30 days of notice from the State.

All work under this contract shall be directed by the State's Authorized Representative. Authorized State Representative and VHCIP Project Director:

Georgia J. Maheras, Esq.
Project Director
Vermont Health Care Innovation Project
Georgia.maheras@state.vt.us
802-505-5137

The Contractor shall provide a single point of contact who will manage all aspects of the Grant including the assignment of qualified personnel to perform the work outlined herein. The Contractor's single point of contact is:

Simone Rueschemeyer, Director
Behavioral Health Network of Vermont, Inc.
137 Elm Street
Montpelier, VT 05602
simoner@bhnvt.org
802-262-6124

The Contractor's single point of contact or designee will be present at bi-weekly status meetings at a time and date agreed upon by the State and Contractor.

Bi-State Primary Care Association #03410-1456-14	
Method of Selection	Sole Source
Contract Amount	**$728,400**
Year 2Performance Period 2 Request	**$447,686.00**
Performance Period 2 Out-of-State Travel	**$3,686.00**
Contract Term	Nov 10, 2014 – June 30, 2016
Method of Accountability	This is a deliverables/performance-based contract where the contractor is required to perform specific tasks each month. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The contract manager(s) review the invoices and work products each month before approving the invoices.
Itemized Budget	The billing for this contract is fixed price based on the scope of work. The contractors will be paid through monthly invoices as described in Attachment B. Attachment B includes the cost for each component of the work. The work will be performed in phases and each phase has a specific price. The Contractor's hourly rates are competitive within the health care evaluation sector and fall within the midrange of hourly rates for contractors involved in this work across the country.

Budget Category	Amount
Finance Office Staff	$15,000
Quality Manager (Patty Launer)	$15,331
Project Manager (Heather Skeels)	$12,629
Administrative Assistant /Data Coordinator (TBH)	$17,500
total salaries	$60,460
total fringe @23%	$13,906
total personnel	$74,366
Conference/travel	$ 6,135
Mileage	$ 1,535
Meetings	$ 250
Other IT (server, etc.)	$ 14,636
Supplies	$ 6,069
Compliance expertise	$ -
Telemonitoring vendor (Pharos Innovations, LLC)	$355,000
Temporary agency (data extraction nurses)	$61,800
Triage care coordination (VNA of VT)	$147,000
Support for data extraction FQHC T&E	$20,000
Legal	$ 1,800
Business insurance	$ 7,000
Facility	$ 25,372
Total direct	$720,964
Indirect 10% of personnel	$ 7,437
TOTAL	$728,400

Budget Category	
Summary Statement of Work	This agreement supports the Contractor's efforts to identify and improve health for at risk populations through building the administrative and leadership capacity of Community Health Accountable Care, LLC (CHAC) Accountable Care Organization and through developing a care management model, including acquiring care management tools, for CHAC. This agreement additionally supports Contractor's work to report CHAC's ACO quality measures for Program Performance Period 2014 and preparation for Program Performance Period 2015.
Unique Qualifications (if Sole Source)	This request for sole source is because: 1 There are only three ACOs within Vermont and each has unique provider networks; 2. BiState is uniquely positioned to perform the tasks described in the agreement; and 3. Delaying the execution of these contracts so that we can go through a standard Vermont RFP process (4-6 months long) will cause significant delays in our Shared Savings Accountable Care Organization Programs. These funds will go to activities necessary for the successful operator of Accountable Care Organizations, as noted in CMS' recent announcement of the ACO Investment Model describing the necessary infrastructure investments required for these entities.

Retroactive Start Justification (if applicable)	
Travel Justification	
Performance Period 2 Applicable Milestones	1) ACO Shared Savings Program: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) Regional Collaborations: Expansion of regional collaborations to all 14 Health Service Areas (HSAs) by 6/30/16. Expansion is complete when all HSAs have a Charter, governing body, and decision-making process.

Scope of Work for*:* Bi-State Primary Care Association #03410-1456-14

This grant agreement relates to health care innovation services provided by the Subrecipient. In 2013, the State was awarded a State Innovation Model (SIM) federal grant to support the work outlined below as part of the Vermont Health Care Innovation Project (VHCIP).

This agreement supports the Contractor's efforts to identify and improve health for at risk populations through building the administrative and leadership capacity of Community Health Accountable Care, LLC (CHAC) Accountable Care Organization and through developing a care management model, including acquiring care management tools, for CHAC. This agreement additionally supports Contractor's work to report CHAC's ACO quality measures for Program Performance Period 2014 and preparation for Program Performance Period 2015.

Subrecipient Shall:

1. Provide leadership for CHAC's activities regarding budget, quality improvement, data repository and reporting services in collaboration with CHAC's senior management staff.

2. Develop and implement a care management model. Such work shall include:

   a. Identification, selection, and acquisition of care management tools;

   b. Implementation of telemonitoring intervention. i. Contractor shall engage (1) vendor Pharos Innovations, LLC and (2) a care coordination vendor organization to implement a telemonitoring clinical intervention focusing on Medicare beneficiaries with complex conditions with the goal of reducing hospitalizations. This intervention will provide approximately 20 phone calls/month/enrolled patient, and include technology to flag patients at risk for hospitalization who require clinical follow up.

3. Prepare ACO quality reporting submissions for the 2014 Program Year for the:

   a. Medicare Shared Savings Program
   b. Medicaid Shared Savings Program

c. Commercial Shared Savings Program

4. Support systems development for ongoing ACO quality reporting for all programs as resources permit
5. Prepare and submit to the State quarterly programmatic status reports no later than the 10th of the month following the 3 month period being reported.The reports shall include a narrative summary outlining specific progress on projects as directed by the reporting templates provided. The reporting schedule is as follows:
   a) 2015: Jan 10 (for the months of Nov and Dec 2014), April 10, July 10, Oct 10
   b) 2016: Jan 10, April 10
   c) Final Report Due Date: July 30, 2016
6. Prepare and present programmatic reports to the VHCIP work groups, steering committee and core team as requeted
7. Adhere to the following work plan and timeline as it appears below:

Deliverables and Implementation Timeline				
Activities	**Anticipated Outcomes**	**Milestone**	**Implementation Timeline**	**Person Responsible**
Need: Vermont and the nation have identified the need to develop new systems and structures to reduce rising health expenditures while maintaining and improving the quality of care				
Goal: Improve health outcomes for CHAC's "rising risk" population				
Objective: Develop and implement a care management model for CHAC designed to improve coordination and impact total cost of care for "rising risk" population.				
Contract with Pharos Innovations, LLC, a telemonitoring services vendor to implement clinical intervention targeting rising risk population	Vendors engaged	Vendor contract executed	By 12/1/2014	Director of VT Operations
		Vendor contract executive or staff hired	By 12/31/2014	
Contract for staff to support care coordination component of telemonitoring intervention	300+ patients enrolled by 6/30/15	300+ patients enrolled by 6/30/15	By 6/30/2015	
Implement Intervention	Intervention rolled out at 3+ FQHCs by 6/30/15	Intervention rolled out at 3+ FQHCs by 6/30/15	By 6/30/2015	
Evaluate Intervention	Clinical intervention will reduce hospitalizations for enrolled patients, impacting quality and total cost of care.	Evaluate claims data	By 3/30/2016	

Need: CHAC must complete ACO quality reporting as part of participation in the Medicare, Medicaid, and Commercial Shared Savings Programs.				
Goal: Implement an ACO quality reporting process that is compliant and enables CHAC to identify QI opportunities				
Objective: Complete ACO quality reporting for Program Year 2014 (and, if resources allow) develop systems for ongoing ACO reporting, per program deadlines.				
Develop ACO QI Reporting Plan	Plan identified that is as efficient as possible and customized to needs of individual health centers.	Workplan developed	By 1/26/15	Project Manager
Identify and procure resources needed to implement plan.	IT and human resources are identified and procured.	IT purchases made; temp agency contract executed; individual temp workers identified	By 1/26/15	Director VT Operations
Conduct data abstraction for PY2014	PY14 data aggregated, per program specific guidelines	PY14 data submitted, per program specific guidelines	By 4/30/15	Director VT Operations
Resource permitting, develop systems for ongoing measure reporting	Supportive systems developed	Supportive systems developed	By 4/30/16	Director VT Operations

<table>
<tr><th colspan="2">Burns and Associates #28733</th></tr>
<tr><td>Method of Selection</td><td>RFP</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$925,000
Performance Period 2 Total Amount (including Travel):$378,000 (note that$25,000 was previously approved so the requested amount is$353,000).
Performance Period 2 Out-of-State Travel:$4,000 (note$1,000 was previously approved so the new request is$3,000)</td></tr>
<tr><td>Contract Term</td><td>4/1/15-12/31/16 (Performance Period 2: 4/1/15-6/30/16)</td></tr>
<tr><td>Method of Accountability</td><td>This is a contract for professional services where the contractors are required to perform specific tasks as outlined in the Amendment and will not be paid if those tasks are not accomplished. The contract manager(s) review the invoices and work products each month before approving the invoices. The contractor will not be paid if tasks are not accomplished.</td></tr>
<tr><td>Itemized Budget</td><td>The billing for this contract is project based. The Contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the hourly rate for each staff person assigned to the contract. The Contractor’s hourly rates are competitive within the health care consultant sector and fall within the mid-range of hourly rates for contractors involved in this work across the country.
<table>
<tr><th>Staffing Category</th><th>Project Director</th><th>Lead SAS Programmer</th><th>Senior Consultant</th><th>SAS Programmer</th></tr>
<tr><td>Proposed Staff</td><td>M.Podrazik</td><td>C.Weller</td><td>D.Saxe, B.Kehoe
D.Leavitt</td><td>J.Eng
J.Meadke</td></tr>
<tr><td>Hourly Rate</td><td>$240.00</td><td>$220.00</td><td>$220.00</td><td>$200.00</td></tr>
</table></td></tr>
<tr><td>Budget Category</td><td>Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers</td></tr>
<tr><td>Summary Statement of Work</td><td>Conduct payment reform, financial modeling strategy development, and rate setting work for Vermont Medicaid payment, methodologies, and other essential fiscal evaluations.</td></tr>
<tr><td>Retroactive Start Justification (if applicable)</td><td>Funding is requested to be retroactive to November 12, 2015.</td></tr>
<tr><td>Travel Justification</td><td>The total estimated travel for this contract is: $8,000

This contractor will travel to Vermont from Washington, D.C., for services related to this agreement. The estimated travel is below:</td></tr>
</table>

	Washington, D.C. to Vermont:$8,000 16 trips at$500/trip: Includes estimated$250 airfare,$125 hotel, and$125 for ground transportation and mileage.
Performance Period 2 Applicable Milestones	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) ACO Shared Savings Program: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 3) Episodes of Care: 3 EOCs designed for Medicaid – implementation of data reports by 3/1/16. Implementation of data reports means: episodes selected, outreach plan to providers designed, first run of historic data provided to providers participating in program. 4) All-Payer Model: 1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI. 5) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 1. Ensure appropriate customer service supports are in place for Medicaid SSP program for 2016 by 11/1/15. 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16. 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan. 5. Develop monitoring and compliance plan for Year 1 EOCs by 6/30/16. 6. Design modifications to existing Integrated Family Services (IFS) Program so it can expand to at least one additional community on 7/1/16. 6) Self-Evaluation Plan and Execution: 2. Continue to execute self-evaluation plan using staff and contractor resources. 7) Evaluation and Monitoring Activities Within Payment Programs: 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: monthly, quarterly reports depending on type.

Contract Attachment A, Scope of Work for Burns and Associates #28733

1. Perform monthly member attribution based on the ACOs' monthly provider roster submission, and prepare monthly reports and claims data extracts for the ACOs as described in the VMSSP contract and as specified by the State.
2. Support VHCIP's analytics contractor by supplying data, VMSSP background knowledge (including programming logic and analytics to date), VMSSP claims data.
3. Conduct data validation of analysis completed by the statewide analytics contractor for the VMSSP.
4. Provide technical assistance as required for DHVA with the Centers for Medicare and Medicaid Services (CMS) and CMMI related to the VMSSP.
5. Conduct analysis related to monitoring and evaluation shadow payments expanded Total Cost of Care and performance measures.
6. Assist the State with requests put forth by the Legislature.
    i. Answer proposed questions, collect and analyze claims information, and perform related research.
7. Assist the State in its pursuit of a Medicaid State Planning Amendment (SPA) for the VMSSP by

providing technical expertise and supporting documentation that reflects the new financial methodologies the State is utilizing as described in the VMSSP contract.

8. Work with DVHA and the ACOs to generate analyses, reports, and educational materials to support the ongoing development and implementation of the VMSSP on an ad hoc basis.
9. Participate in VHCIP meetings to support the work of VMSSP.

I. Monthly Reporting

a. The Contractor shall participate in a conference call each month with the State regarding work under this agreement. The purpose of these calls is to discuss administrative and project issues as they arise and to report preliminary findings of analyses as they become available. More frequent calls may be needed during active periods of the project.

b. The Contractor shall submit monthly Status Reports outlining all work accomplished during the previous month. At a minimum, monthly progress reports shall cover the following items:
   i. Activities related to consultation and support related to each Awardee supported by this contract.
   ii. Activities planned for the forthcoming month.
   iii. Contractor's expectations of the State Staff during the forthcoming month (e.g., review of deliverables submitted, delivery of data or other items).
   iv. Any problems or delays – encountered or foreseeable – that may affect contract performance.
   v. Budget discrepancies greater than ten percent, i.e., cost overruns or underruns.

c. Additional planning and coordination meetings may be required during the course of the contract, depending on the State's needs.

II. Contract Administration Data – Key Personnel (See Attachment B for key personnel list and hourly rates):

a. The key personnel specified in this contract are considered to be essential to work performance. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the VHCIP Project Director and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the State of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The State may modify the contract to add or delete key personnel at the request of the Contractor or Government.

III. Ad Hoc Tasks:

The State shall define deliverables that align with the scope of work by meeting with the Contractor on a bi-weekly basis. Ad hoc tasks shall be reduced to writing and approved by both parties and added to the work plan on a monthly basis.

Covisint Corporation #29340	
Method of Selection	Sole Source
Contract Amount	**Total Contract Amount (all years):**$1,000,000 **Performance Period 2 Total Amount (including Travel):**$1,000,000 **Performance Period 2 Out-of-State Travel:** n/a
Contract Term	9/30/2015-6/30/16
Method of Accountability	This contract is for a perpetual source code license for DocSite, with unlimited use for State of Vermont operational purposes, and a migrated operational instance of the system with success criteria to be validated by the State upon contract execution. Upon successful validation of the operational system and submission of a deliverable acceptance form by the contract manager, the Contractor may invoice for the full contract amount. The contract manager will review the final invoice prior to approval. The Contractor will not be paid if an operational instance of the system cannot be validated against the stated success criteria by the State.
Itemized Budget	The billing for this contract is a one-time perpetual source code license fee of$1,000,000. The Contractor will be paid via a single final invoice. The Contractor may invoice for the one-time source code license fee for DocSite of$1,000,000 upon State acceptance of deliverables for Task #1 of Attachment A of the contract via a Deliverable Acceptance form signed by the Blueprint for Health Executive Director or designated Assistant Director.
Budget Category	*Technology and Infrastructure*: Enhancements to Centralized Clinical Registry & Reporting Systems
Summary Statement of Work	Acquire or license clinical registry software.
Unique Qualifications (if Sole Source)	Covisint Corporation (Covisint) is the current owner of all rights and title to the DocSite source code application. Under their current contract #23945, the vendor has also provided product and technical documentation and migration support services for standing up the operational instance of the system for the State. Blueprint for Health primary care practices across the State have been populating the DocSite clinical data registry with patient health measures for over seven years. As of August 31, 2015, Covisint will no longer support the DocSite product. Under direction from the Agency of Administration and the Governor’s Office, the State has been instructed to purchase a perpetual software license and to migrate the clinical registry to an alternate hosting location. This registry will hereafter be referred to as the Blueprint registry. The Blueprint registry is targeted to be migrated and functional by November 30, 2015. A sole-source agreement for a perpetual DocSite source code license and an operational migrated instance of the system will allow the clinical data aggregation, ACO measure generation, and other outcomes reporting work of the Blueprint to continue with minimal interruption.
Travel Justification	Travel is not an allowable cost under this agreement.
Performance	Data Warehousing:

Period 2 Applicable Milestones	2. Procure clinical registry software by 3/31/16.

Contract Attachment A, Scope of Work for Covisint Corporation #29340

The purpose of this contract is to deliver a perpetual source code, software and documentation license for DocSite to the State. The Contractor agrees to complete the following tasks:

Task 1: Provide Perpetual Source Code, Software and Documentation License and Deliver an Operational Instance of DocSite.

The Contractor shall deliver an operational instance of the DocSite system (the "System"), hosted in a data center designated by the State, and the Contractor shall transfer ownership and use of the instance in accordance with the perpetual source code license (the terms of which are contained in Exhibit 2 of this agreement).

Upon delivery, the State shall have five (5) business days to validate that the System works as expected based on the following success criteria:

1. Manual entry users can successfully log in to the System, navigate the System and enter data. Manual entry users include:
    a. Support and Services at Home (SASH) program users
    b. Community Health Team (CHT) program users
    c. Tobacco Cessation Counselor (TCC) program users
    d. Self-Management Support Programs (SMSP) users
2. The full DocSite database can be successfully extracted.

Upon validation of these success criteria, the State shall take ownership of the fully operational instance of DocSite and shall comply with all terms of the source code license agreement as detailed in Exhibit 2 of this agreement.

Deliverables:

The Contractor shall:

1. Deliver one copy of Licensed Software (DocSite) to State or designee within five (5) business days of contract start date, inclusive of access to source code and documentation.

2. Deliverable 1 above is subject to review, validation and acceptance by the State within five (5) business days of delivery ("deliverable review period"), based on the success criteria as defined above in Task 1. The Contractor shall make the appropriate resources available from 8:00 AM -5:00 PM, Eastern Standard Time for the deliverable review period to address questions from the State or its designee.
    a. If the Contractor is unavailable during the deliverable review period or if the State or its designee deems the delivered materials incomplete or flawed at any time during the deliverable review period, then the applicable deliverables will be rejected in writing with a list of specific issues that need to be fixed and subject to review based upon a remediation plan that the State and the Contractor agree upon within 2 business days of the rejection notice. The remediation plan and its execution shall be limited to the issues identified in writing by the State and may not include additional issues that were not initially identified and communicated during the deliverable

review period, unless the State identifies additional issues encountered during validation of the remediated issues caused by the remediation solution provided by Covisint to fix the issue.

b. In the event that the State fails to provide acceptance or rejection within the deliverable review period five (5) business days after delivery, the Contractor shall notify the State in writing requesting formal acceptance or rejection of the deliverables within 24 hours. Parties notified shall include the Blueprint Executive Director and Assistant Director, the Business Office contract manager, and the Blueprint Migration Project Manager. If the State does not respond to the Contractor's written request within 24 hours, then the scope and deliverables of this Task 1 shall be deemed accepted.

DataStat #26412	
Method of Selection	RFP
Contract Amount	**Total Contract Amount (all years):**$347,278.16 **Performance Period 2 Total Amount (including Travel):**$145,000 (note that$80,000 was previously approved so the requested amount is$65,000). **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	7/28/14-7/26/16 (Performance Period 2: 1/1/15-6/30/16)
Method of Accountability	This is a deliverables -based contract where the contractors are required to submit monthly invoices that identify activities performed under the contract. The contract manager(s) reviews the invoice and work products each month before approving the invoices.
Itemized Budget	The billing for this contract is divided by the type of service provided. Specifically, the State will pay for Sampling Services, which includes a set-up fee to cover professional costs. This is$347.70 per practice and is estimated at$41,724 as is indicated in Chart A of the agreement. The State will pay for Data Collection Services on a per sample case at$1.44. This is estimated at$50,204.16 as is indicated in Chart A of the agreement. The State will pay for Reporting Services according to Chart B of the agreement. This contractor was selected through a competitive bid process and the rates charged are competitive when compared to other bidders.

Total Survey Field Costs

# Providers at Site	Sample size (per NCQA)	Cost per practice per sample group*		
		Set-up fee	Field cost	Total / site
1	128	$347.70	$184.32	$532.02
2-3	171	$347.70	$246.24	$593.94
4-9	343	$347.70	$493.92	$841.62
10-13	429	$347.70	$617.76	$965.46
14-19	500	$347.70	$720.00	$1,067.70
20-28	643	$347.70	$925.92	$1,273.62
29+	686	$347.70	$987.84	$1,335.54

Reporting Costs

Report type	Development		Production		Total
	Cost	Number	Cost	Number	
State	$2,450	1	$1,000	1	$3,450
Health Service Area	$2,450	1	$1,000	14	$16,450
ACO	$2,450	1	$1,000	3	$5,450
				TOTAL REPORT COSTS:	**$25,350**

Budget Category	*Model Testing:* Quality Measures
Summary Statement of Work	Administration of the Patient Centered Medical Homes Consumer Assessment of Healthcare Providers and Systems (PCMH CAHPS®).
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to November 12, 2015**
Travel Justification	No travel is billed under this agreement.
Performance Period 2 Applicable Milestone	Surveys: 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 – phase 1 to determine impact of Performance Period 2 activities by 6/30/16.

Contract Attachment A, Scope of Work for DataStat #26412

A. Sampling Services

1. The Contractor shall provide a sample format, in Excel, and request a test sample from each practice prior to finalizing production schedules for each wave of data collection. The Contractor shall work with each practice, supported by the State, to resolve any problems with content or format of the test sample. The Contractor shall schedule the practice for the next wave if the problems are not able to be resolved in a timely fashion. Once the Contractor has approved the practice's test sample, the Contractor shall ask the practice to use the sample format to prepare the actual sample frame submitted for the sample selection process.
2. The Contractor shall accept practice sample frame files that are submitted to the Contractor by practices in the format specified in the most recent version of *Specifications for the CAHPS® PCMH Survey*, in Excel with all required data file elements included in the sample frame and an accompanying data file layout. The Contractor shall accept optional data elements that are appended to the end of the standard set of elements.
3. The Contractor shall provide a transfer center for practice submission of sample frames; the transfer center is a website utilizing 128-bit encryption through SSL that allows for secure transfer of files using a web browser. The Contractor shall also accept files submitted on physical media (e.g., diskette, CD-ROM) or by e-mail that is compressed, encrypted, and secured by a password.
4. The Contractor shall instruct practices on patient eligibility and that sample frames should represent all eligible patient files, using guidelines in *Specifications for the CAHPS® PCMH Survey* to define

eligibility. The Contractor shall also instruct practices that practices are responsible for ensuring that any patient who does not meet these criteria is removed from the sample frame.

5. Upon receiving the sample frame, the Contractor shall check the file for accuracy and completeness. The Contractor shall review and refine the list for its appropriateness as a sampling frame, following guidelines in *Specifications for the CAHPS® PCMH Survey*. The Contractor shall work with practices, as needed, to resolve any sample frame data file issues.
6. The Contractor shall de-duplicate the data files to ensure that each patient is represented only once in the sampling frame.
7. The Contractor shall remove from the data files any patient who does not meet the age criterion for the adult or child survey, as appropriate, using the designated cutoff date, which shall be the last day of the measurement period, per NCQA guidelines. The specific date shall be determined by the Contractor and the State. The measurement period is defined as the 12 months prior to the date when the eligible population file is generated by the practice.
8. From all eligible cases in the sample frame at each practice, the Contractor shall draw the number of cases corresponding to the number of eligible clinicians in the practice found in the received sample frame, using standard random selection procedures. If fewer than the required number of sample cases are available at a practice, the Contractor shall ensure that the sample includes all eligible patients in the practice.
9. The Contractor shall conduct oversampling for practices, as requested in writing by the State or the practice.
10. Based on estimated eligible provider counts from participating practices, the Contractor shall identify the total sample to be selected. Additional samples or oversampling may be requested by the State after consultation with individual practices. The Contractor and the State shall update practice and sample sizes prior to beginning work on any wave.
11. The Contractor shall secure NCQA approval, if needed, for any enhanced sampling options.
12. After the sample has been randomly selected, the Contractor shall employ a National Change of Address (NCOA) service to update address information.
13. The Contractor shall de-duplicate the selected samples to ensure that only one member of a household is included.
14. The Contractor shall merge a flag identifying respondents who are attributed to each of the Vermont's ACO Shared Savings Programs and other health care reform initiatives. The State shall ensure that the Contractor receives the information needed to accomplish such flagging or identification.

B. Data Collection Services

Once selection is completed, the Contractor shall incorporate the selected sample cases into a mail-only field protocol consisting of one survey packet mailing to all selected cases, and a second survey packet mailing to non-respondents, over a 6-week field period. The Contractor shall customize mail materials with logos, if available, and signatures from each participating practice. In cases where no logo is provided by a practice, the Contractor shall print the name of the practice in black, or a logo may be provided by the State. In cases where no signature is provided by a practice, the State shall designate the appropriate representative signature to be used. The Contractor shall communicate with each practice regarding the transfer of the logo and signature to the Contractor.

Survey instrument

1. The Contractor shall utilize the current version of the CAHPS® PCMH adult survey instrument (the questionnaire), made available by NCQA, with 52 items, or the current version of the CAHPS® PCMH child survey instrument, made available by NCQA, with 64 items, as appropriate.
2. The State anticipates adding up to10 supplemental items to the questionnaire. The State and the Contractor shall ensure that the addition of supplemental items shall follow guidelines in the

Specifications for the CAHPS® PCMH survey. Since questionnaire length is a key element in project costs, the Contractor and the State understand that the addition of supplemental items may incur additional costs if their inclusion requires additional pages.

3. For mail surveys, the Contractor shall print questionnaires in English. The Contractor shall customize the questionnaires with the Contractor's logo and the practice logo, if available, and the name of the clinician who provided care at the patient's most recent visit during the measurement period. If the practice logo is not available, the Contractor shall print the practice name in black on the survey. The Contractor shall deliver a proof of the final logo image or practice name to the practice for approval. The Contractor shall format the questionnaires using the Contractor's current standard layout and design, which is expected to produce an 8-page booklet.

Cover Letter

1. The Contractor shall obtain cover letter text from NCQA CAHPS® PCMH materials and provide them to the State for review and possible revision. The State and the Contractor shall ensure that the length of the text shall allow for the Contractor's standard formatting and shall accommodate use of the Contractor's standard outgoing envelope. The State shall approve the cover letter template within one week of receipt.
2. The Contractor shall customize and print cover letters in English. The Contractor shall customize each cover letter with the name and address of the selected respondent ("To the Parent/Guardian of" for a child survey). The Contractor shall ensure that cover letters include a practice logo, if available, printed in black. If no practice logo is available, the Contractor shall print the practice name in black on the cover letter.
3. The Contractor shall ensure that each cover letter contains one signature block of the appropriate practice representative. The Contractor shall communicate with each practice regarding the transfer of the signature, full name and title of practice representative to the Contractor. In cases where no signature is provided by a practice, the Contractor shall print the full name and title of the practice representative in black on the cover letter. The Contractor shall deliver a sample of the full name and title and/or the signature image, to the practice, for approval.
4. The Contractor shall provide practice staff with examples of all survey materials for final approval, before submitting materials to NCQA for approval, for practices submitting to NCQA. The State will assist in obtaining such approval within two weeks of the materials being provided to practice staff.

Initial Outgoing Survey Packet

1. Using its mail production equipment, the Contractor shall create and mail to each individual in the sample his or her customized CAHPS® PCMH adult or child questionnaire, as appropriate, in a personalized survey packet with the following format:
    a. Outgoing Envelope:
        - White, appropriately-sized envelope provided by the Contractor
        - Black printing of practice name, the Contractor's return address, respondent name and address ("To the Parent/Guardian of" for child survey)
        - First class postage imprint
        - The USPS "Electronic Address Service" printed on the envelope
    b. Questionnaire:
        - Formatted Microsoft Word file based on NCQA CAHPS® PCMH adult or child vendor materials, as appropriate
        - Produced in English
        - All printing done in-house by the Contractor
        - Two 11" X 17" white sheets of paper, folded to produce an 8-page booklet
        - Customized to individual respondent level with insertion of bar-coded tracking data

c. Cover Letter:
    - Custom laser printing for text insertions, respondent name and address, official signature and logo printed in black
    - Text from NCQA CAHPS® PCMH vendor materials

d. Return Envelope:
    - Appropriately-sized, white return envelope with the Contractor's address inserted into each outbound packet
    - Business reply imprint using the Contractor's business reply account

Follow-up Outgoing Survey Packet

By 21 days after the initial survey packet mailing, the Contractor shall prepare and mail a follow-up survey packet to non-responders. The format of this mailing shall be the same as that of the initial mailing, except for the cover letter text, which shall be appropriate for a second mailing. Text for this second cover letter shall be taken from NCQA survey materials.

Processing Incoming Mail

1. As undeliverable surveys and alternate addresses are returned to the Contractor by the postal service, the Contractor shall update internal records accordingly.
2. As surveys are returned, the Contractor shall enter all received data into the appropriate computer system. After data entry has been completed, the Contractor shall conduct data cleaning and perform both format and outlier checks, according to Contractor standards with input from the State
3. Based on NCQA CAHPS® PCMH guidelines, the Contractor shall consider a survey to be complete and valid if the following two criteria are met:
    - The respondent answers at least one survey question.
    - Responses indicate that the respondent meets the eligible population criteria.
4. The Contractor shall cease all follow-up efforts to any individual having expressed a desire not to participate in the survey project.
5. The Contractor shall ensure that the duration of the field period is 42 days (6 weeks).
6. The Contractor shall ensure that final data is cleaned and coded, following NCQA PCMH guidelines and specifications.

C. Respondent Support Services

Throughout the mail and telephone follow-up phases of this project, the Contractor shall maintain a toll-free Respondent Assistance Telephone Line from 10am to 8pm (EST) Monday through Friday, for English-speaking respondents. The Contractor shall ensure that calls outside these hours shall be referred to voicemail. The Contractor's toll-free number shall appear on the cover letter and the questionnaire.

D. Data Consolidation and Delivery of Data to the State's Analytic Vendor

The Contractor shall collect CAHPS Clinician & Group Survey (CG-CAHPS) survey results from survey vendors for primary care practices that use the CG-CAHPS Visit Survey as an alternative to CAHPS PCMH. The Contractor shall investigate the methods for merging and/or reporting both the CAHPS PCMH and CG-CAHPS data. The Contractor shall communicate required action steps, strategies for addressing challenges, and a timeline for achieving action steps. The Contractor shall report on progress during regular weekly communication with the State. Datasets will be submitted at a point in time and on a schedule agreed upon by the Contractor and the State. The Contractor will provide the required standard data file layout that submitting vendors must adhere to for the successive transfer of data. The

submitted data from the CG-CAHPS Visit Survey datasets will be merged into the PCMH dataset collected in this State sponsored project.

E. Reporting Services

1. The Contractor shall provide the State with a project plan for sampling and data collection services. The project plan shall include a detailed timeline of activities showing all major activities and deliverables. The project plan is due two weeks after contract execution.

2. On a weekly basis, the Contractor shall provide the State with project status reports. The schedule for status report deliveries shall be determined by project milestones and by mutual agreement of the State and the Contractor. Financial reports and invoices shall be provided at least quarterly. During the field period, the Contractor shall report on a weekly basis the total survey completions to date and a summary of sample dispositions resolved since the previous report was issued.

3. After data collection, data entry and data consolidation have been completed, the Contractor shall prepare a dataset for the State, using the data file layout specified by NCQA. The dataset shall include values for each questionnaire item by completed case and shall be purged of any patient identification information (i.e., name, address, and telephone number). Both response and non-response data shall be included. The dataset shall be submitted in a choice of format (e.g., SAS, SPSS, Excel), organized as a single record for each member composed of a string of fields containing data values. Weighting of the data is not included, but weights provided by the practice or the State can be applied, at additional cost, if desired. The Contractor shall ensure that a data file layout with defined labels and values accompanies the dataset.

4. The Contractor shall produce and deliver a standard PCMH CAHPS® practice-level report for each participating practice, in an Excel file format to allow practices to track their results over time. The Contractor shall also transmit the data to the State, in a format decided on by the Contractor and State, in order for the State to develop reports. This option may involve working with a third-party vendor chosen by the State. These reports shall present scores and descriptive statistics for all scored measures and composites, with comparison of practice scores to an overall score.

5. In addition to the practice reports, the Contractor shall develop and produce aggregate reports for the State, each of the health service areas, and each of the ACOs, or shall transmit the data to the State, in a format decided on by the Contractor and State, in order for the State to develop the reports. This option may involve working with a third-party vendor chosen by the State. It is anticipated that these reports shall present scores and descriptive statistics for all scored measures and composites, with comparison of State, health service area, and ACO scores to overall score(s) and available benchmarks. Trending over time shall be added for the second year of the contract, if requested by the State. Any reports shall be delivered as PDF files and as Word documents.

6. For practices interested in seeking NCQA PCMH Recognition or the Distinction in Patient Experience Reporting, the Contractor shall submit datasets to NCQA, in the required format, organized as a single record for each respondent, composed of a string of fields containing data, and following submission protocols and guidelines specified by NCQA in *Specifications for the CAHPS® PCMH survey*.

7. Post-project, the Contractor shall maintain all records and returned, completed surveys as specified by NCQA. Upon expiration of the specified contract period, the Contractor shall contact the State to discuss the disposition of these documents. The Contractor shall shred all returned questionnaires, unless other arrangements are made between the State and the Contractor.

Deborah Lisi-Baker #26033/ #29534	
Method of Selection	Sole Source
Contract Amount	**Total Contract Amount (all years):**$95,000 **Performance Period 2 Total Amount (including Travel):**$40,000 **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	2/7/14-6/30/15 (Performance Period 2: 1/1/15-6/30/16) **Current contract #26033 expired 6/30/2015; due to lack of CMMI approval, the State of Vermont was unable to amend the contract term. A new contract (#29534) was executed, with the start date of 7/1/2015.**
Method of Accountability	This is a deliverables/performance-based contract where the contractor is required to perform specific tasks each month. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The contract manager(s) review the invoices and work products each month before approving the invoices. The contract manager is also responsible for monthly communications with the contractor to ensure tasks are planned for appropriately
Itemized Budget	The billing for this contract is time and materials. Specifically, the State of Vermont provides prior approval for all tasks performed under this contract. The Contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the hourly rate for each staff person assigned to the contract. The Contractor's hourly rates are competitive within the health care consultant sector and fall within the midrange of hourly rates for contractors involved in this work across the country. Lisi-Baker Hourly Rate:$125
Budget Category	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers
Summary Statement of Work	Consultation support for DLTSS related activities.
Unique Qualifications (if Sole Source)	Ms. Lisi-Baker's skills and background are unique and will enable Vermont's SIM/Health Care Innovation Project (VHCIP) to make significant strides in developing payment and care models that address those with complex care needs. A key component of Ms. Lisi-Baker's work is that the SIM/VHCIP efforts are on a very fast federally-required timeline. Ms. Lisi-Baker is able to begin this work immediately and enable this section of the work plan to be done in accordance with federal timelines.
Retroactive Start Justification (if applicable)	
Travel Justification	Hourly rates are inclusive of travel.
Performance Period 2 Applicable Milestone	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) Learning Collaboratives: Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.

Contract Attachment A, Scope of Work for Deborah Lisi-Baker #26033 (expired), #29534 (new)

The Contractor will work with VHCIP Project Staff to ensure that the work group's tasks, Work Plan and Charter

are aligned with the overall VHCIP project. In particular the Contractor shall ensure that information and decisions made by the work group are shared with other project work groups, Steering Committee and with Project Staff. The Contractor will serve in a facilitation role during work group meetings encouraging discussion and communication among work group participants.

Contractor Shall:

1. Provide monthly facilitation as Co-Chair of the DLTSS work group meetings and participate in monthly work group planning meetings.
    a. Work with the VHCIP Core Team Chair and Project Staff at least monthly, but more frequently if necessary, to develop meeting agendas and documents.
2. Work with DLTSS Co-Chair, work group members, Project Staff and consultants on revisions to the DLTSS Charter and Work Plan.
    a. Work with work group participants and VHCIP Project Staff on modifications and implementation of tasks resulting from the development of the Work Plan.
3. Research and provide information on current initiatives and best practices on DLTSS services and integrated systems of care relevant to the work of the DLTSS work group.
4. Communicate in writing, in-person or by phone with DLTSS work group members between meetings as needed to support effective communication and decision-making at the DTLSS work group meetings.
5. Participate in planning meetings with other VHCIP work groups' staff and Co-Chairs to ensure coordination of information and activities between the DLTSS work group and those other groups.
6. Provide monthly updates to the VHCIP Core Team Chair and Project Staff on work group efforts.
7. Provide monthly updates to the VHCIP Steering Committee on the work group Charter, Work Plan and tasks undertaken by the work group.
8. Serve as a member on the VHCIP Steering Committee and attend the meetings in person or by phone. If theContractor is unable to attend one of these meetings, the Contractor shall notify the VHCIP Core Team Chair and Project Director.
9. Participate in Co-Chair phone calls and meetings, providing updates on the work group to other VHCIP Co-Chairs.
10. Attend additional VHCIP related meetings at the request of the VHCIP Core Team Chair.
11. Participate in other activities and tasks as requested and mutually agreed upon with the VHCIP Project Director and DLTSS Work group staff such as review of contract bids.

I. <u>Monthly Reporting:</u>

- The Contractor shall participate in a conference call each month with the State of Vermont regarding this work. The purpose of these calls is to discuss administrative and project issues as they arise and to report preliminary findings of analyses as they become available.
    a. More frequent calls may be needed during active periods of the project. The Contractor shall participate in all such calls as requested by the State and mutually agreed upon by the State and Contractor.
- The Contractor shall submit monthly progress reports outlining all work accomplished during the previous month. The reports should be concise and in a simple format (e.g., bulleted list) approved by the State of Vermont. These reports are to be submitted electronically to the program contract manager with each invoice. These monthly progress reports shall be consistent with the work billed on the monthly invoices.

    a. At a minimum, monthly progress reports shall cover the following items:

i. Activities related to consultation and support related to each Awardee supported by this contract;
ii. Any problems or delays – encountered or foreseeable – that may affect contract performance;
iii. Budget discrepancies greater than ten percent, i.e., cost overruns or underruns.

- Additional planning and coordination meetings may be required during the course of the contract, depending on the needs of each SIM Demonstration.

Health Management Associates #28821	
Method of Selection	RFP
Contract Amount	**Total Contract Amount (all years):**$898,000 **Performance Period 2 Total Amount (including Travel):**$898,000 (note that$698,000 was previously approved so the requested amount is$200,000). **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	4/8/15-4/7/16 (Performance Period 2: 4/8/15-6/30/16)
Method of Accountability	This is a contract for professional services where the contractors are required to perform specific tasks as outlined the scope of work. The contractor will not be paid if those tasks are not accomplished. The contract manager(s) review the invoices and work products each month before approving the invoices. The contractor will not be paid if tasks are not accomplished.
Itemized Budget	The billing for this contract is time and materials. The Contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the hourly rate for each staff person assigned to the contract. The Contractor's hourly rates are competitive within the health care consultant sector and fall within the mid-range of hourly rates for contractors involved in this work across the country.

Name	Title	Hourly rate
Tom Dehner	Managing Principal	$323
Rob Buchanan	Senior Consultant	$264
Theresa LaPera	Managing Principal	$323
Jack Meyer	Managing Principal	$357
Chad Perman	Consultant	$179
Michealle Gady	Senior Consultant	$264
TBD as necessary and approved	Principal	$306
TBD as necessary and approved	Senior Consultant	$264
Steve Schramm	Subcontractor, Optumas	$431
Zach Alters	Subcontractor, Optumas	$374
Tim Doyle	Subcontractor, Optumas	$374
Joseph Costa	Subcontractor, Optumas	$288

Budget Category	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers
Summary Statement of Work	Assist in development of an all-payer waiver proposal.
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to November 12, 2015**.
Travel Justification	Hourly rate is inclusive of travel.
Performance Period 2 Applicable Milestone	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) All-Payer Model: 1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI. 3) State Activities to Support Model Design and Implementation – GMCB: 1. Research and planning to identify the components necessary for APM regulatory activities by 6/30/16.

Contract Attachment A, Scope of Work for Health Management Associates #28821

Deliverables

The Contractor shall perform seven major functions for the State:

1. Project management;
2. Work plan development;
3. Data collection and assessment;
4. Vetting and developing of financial and actuarial models as necessary;
5. Assisting the State with the development of a negotiating position prior to submission of application;
6. Preparation, version management, and assistance with submission of waiver agreement; and
7. Preparation and submission of final report.

Within each of these major areas, the Contractor will engage in multiple activities, as described in the Scope of Work below:

Scope of Work

1. Project Management

The project shall start with an in-person kick-off meeting between the Contractor and the State. The purpose of the meeting will be to establish a relationship between the Contractor team and the state's management structure for the project. The Contractor will work with the state project coordinators to develop an agenda for the meeting, including discussion of a draft work plan to include milestones and timelines. The in-person meeting will also be a time for the Contractor to clarify objectives and priorities, refine the scope of work and technical approach, clarify contract requirements and expectations, and establish an overall communication plan (including regularly scheduled calls with the State to provide project updates). The in-person meeting will also include time for the Contractor to react to and advise on the most appropriate approach for the project. The kick-off meeting will allow the Contractor team to understand the broader context of the effort in Vermont and to define the major issues that will shape the model design and possible model agreement.

2. Work Plan Development

Based on feedback received during the kick-off meeting and from the project coordinators, the Contractor shall develop and provide a work plan that details milestones and time lines. The work plan will be developed to meet any deadlines established by the State. The Contractor shall be responsible for monitoring, modifying and gaining State approval of the project work plan as necessary. The work plan shall include additional meeting dates and times, and how the Contractor will interact with existing committees and other State contractors on particular topics relevant to

the development of an All-Payer Model and model agreement.

3. Data Collection and Assessment
The Contractor shall collect and assemble expenditure and other financial data requested by CMMI/CMS in appropriate formats to support requests and inquiries by CMMI/CMS. The Contractor shall review and analyze the data to identify the information that is most germane to the project and most accurately conveys the goals of the State. The Contractor shall conduct an independent analysis of the data for inclusion in the application, including but not limited to, analysis and assessment of appropriate quality and performance measures for the model agreement.

4. Vetting and Developing Financial and Actuarial Models as necessary
The Contractor shall review payment and delivery models for a risk bearing ACO or ACOs, and participating providers inside and outside of an ACO or ACOs (Hospitals, FQHCs, Physician Owned Practices, Specialists, etc). The Contractor shall assist in calculating and/or confirming base year expenditures for Medicare, Medicaid, and Commercial payers. The Contractor shall be expected to work with other State contractors with expertise and experience with the Medicaid 1115 Global Commitment Waiver as well as Medicaid reimbursement. The Contractor shall also identify any boundaries in regard to trend, achievable Medicare savings, if any, and other considerations that would make an all-payer model and Medicare wavier agreement acceptable or unacceptable to Vermont. The Contractor shall test healthcare expenditure data to be certain it is accurate and appropriate for model inclusion.

Further, the Contractor shall recommend a growth trend for incorporation in the all-payer model agreement, based on historical trends examining various time series. The Contractor shall also conduct actuarial or other financial analyses including, but not limited to, those necessary to develop various additional financial models and confirm their reasonableness. This process shall involve documentation and review to make sure that modeling matches the proposed program's plan design. The Contractor shall analyze the potential effect of alternative waiver terms and conditions on Vermont. Throughout the process, the Contractor shall provide State project leaders and coordinators with ongoing feedback and updates regarding model testing and or development.

5. Assisting the State with a Negotiating Position prior to Submission of Application
The Contractor shall serve as an advisor for the application process and advise on the application template most advantageous to meet the State's needs. As necessary, during the course of the negotiations between CMS and the State, the Contractor shall analyze the potential effect of alternative terms and conditions on Vermont. The Contractor shall monitor agreements made during negotiations and verify those agreements in writing, as well as track issues decided and maintain a list of issues still under discussion. This process will also include intensive preparation for scheduled CMS meetings, and post-meeting debriefings to identify appropriate next steps.

6. Preparation, Version Management, and Submission of Waiver Agreement
The Contractor shall assemble an application from existing materials and draft sections of the application as necessary in coordination with the State's APM staff. The Contractor shall serve as general editor of the final written document and ensure that all relevant attachments are included. The Contractor shall produce a professional version of the final document for submission to CMS/CMMI. Some aspects of the model agreement will need to be finalized post-negotiation, and the Contractor shall be responsible for ensuring that the final agreement reflects decisions made and negotiations with CMS.

7. Preparation and Submission of Final Report
The Contractor shall submit to the Green Mountain Care Board a final report documenting the activities described above, including descriptions of analytical methodologies.

Ad-Hoc Deliverables

- The State shall define deliverables as aligned in the scope of work by meeting with the Contractor on a bi-weekly basis in order to define and confirm inclusion of additional deliverable development as identified by

the State. Ad hoc tasks shall be reduced to writing and approved by both parties on a task order form and added to the work plan on a bi-weekly basis. Ad Hoc tasks will be billed at the hourly rates identified in Attachment B of this contract.

- At the discretion of the State, develop alternative payment models for the risk bearing ACO, and participating providers within the ACO (Hospitals, FQHCs, Physician Owned Practices, Specialists, etc), as well as providers outside of the ACO

<table>
<tr><th colspan="2">Healthfirst, Inc. #03410-1457-15</th></tr>
<tr><td>Method of Selection</td><td>Sole Source</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$55,380
Performance Period 2 Total Amount (including Travel):$55,000 (note that$41,940 was previously approved so the requested amount is$<u>13,060).</u>
Performance Period 2 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>1/1/15-6/30/16 (Performance Period 2: 1/1/15-6/30/16)</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based agreement where the contractors are required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The contract manager(s) review the invoices and work products each month before approving the invoices.</td></tr>
<tr><td>Itemized Budget</td><td>The billing for this agreement is fixed price based on the scope of work. The Subrecipient will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the cost for each component of the work. The work will be performed in phases and each phase has a specific price. The Subrecipient’s hourly rates are competitive within the health care evaluation sector and fall within the midrange of hourly rates for contractors involved in this work across the country.
<table>
<tr><th>Expense</th><th>Amount</th><th>Notes</th></tr>
<tr><td>Direct Payments to Practices</td><td>$45,780</td><td>2,289 charts views @$20/view for payments to practices to support staff overtime to pull clinical data off EHR and enter into ACO Audit Tool; will be distributed pro-rate based on number of chart pulls required per practice.</td></tr>
<tr><td>Consultant Fee (clinical data auditing)</td><td>$9,220</td><td>Fee for a consultant/auditor to selectively audit clinical data submitted to HF so HF can validate results before submitting to the GMCB.</td></tr>
<tr><td>Total</td><td>$55,000</td><td></td></tr>
</table></td></tr>
<tr><td>Budget Category</td><td>Model Testing: Quality Measures</td></tr>
<tr><td>Summary Statement of Work</td><td>Chart Review for Shared Savings Program Measures.</td></tr>
<tr><td>Unique Qualifications (if Sole Source)</td><td>This request for sole source is because:
• There are only three ACOs within Vermont and each has unique provider networks;
• Healthfirst is uniquely positioned to perform the tasks described in the agreement; and
• Delaying the execution of these agreements so that we can go through a standard Vermont RFP process (4-6 months long) will cause significant delays in our Shared Savings Accountable Care Organization Programs. These funds will go to activities necessary for the successful operation of Accountable Care Organizations, as noted in CMS’ recent announcement of the ACO Investment Model describing the necessary infrastructure investments required for these entities.</td></tr>
<tr><td>Retroactive Start</td><td>Funding is requested to be retroactive to November 12, 2015.</td></tr>
</table>

Justification (if applicable)	
Travel Justification	Travel is not a billable expense under this agreement.
Performance Period 2 Applicable Milestones	ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000.

Contract Attachment A, Scope of Work for Health*first*, Inc. #03410-1457-15

1. Work with The Lewin Group (Lewin), Contractor to the Green Mountain Care Board (GMCB) to:
    a. Identify samples for Core 14-20 "Clinical Measures." Samples will be drawn from the EBM Connect population denominator, with the exception of the "Screening for Clinical Depression" measure.
    b. Write SAS code, using the Centers for Medicaid and Medicare Services specifications, to identify the denominator.
    c. Use the Medicaid Shared Savings Program (MSSP) sampling methodology, which specifies, when possible, to populate a 50% oversample. According to the MSSP sampling methodology, the sample size varies on the number of eligible professionals in the ACO.
        i. For ACOs with 100 or more professionals, the sample plus oversample will contain 616 enrollees (411+205).
        ii. For ACOs with 25-99 professionals, the sample plus oversample will be 327 enrollees (218 + 109). If there are fewer than 327 enrollees matching the specifications, then all enrollees will be included.
        iii. From the samples, Lewin will randomly order the enrollees and number them 1 to 616, or the maximum sample size and identify those from the sample who are identified as numerator positive for the measure from EBM Connect results.
        iv. Numerator positives will not require a chart review.

2. Adhere to the following timeline for Clinical Measure selection:

Dates	Actions
January 15, 2015	Lewin will pull first sample, including 2014 claims data received by December 15, 2014
Dec 2014/Jan 2015	Target for training practices on Commercial ACO auditing tool currently being developed jointly by OneCare Vermont, Community Health Accountable Care, Vermont Collaborative Physicians (VCP)
Feb 1, 2015	Healthfirst/VCP distributes list of records needed to each VCP Participating practice
March 1, 2015	Audit must be completed by practice staff
March 20, 2015	After validating results, HF/VCP submits quality measure data to GMCB/Lewin
TBD	Results for 2014 performance year returned to ACOs/published by GMCB/Lewin

H.I.S. Professionals, LLC #27511	
Method of Selection	Sole Source
Contract Amount	**Total Contract Amount (all years):**$475,370 **Performance Period 2 Total Amount (including Travel):**$50,000 **Performance Period 2 Out-of-State Travel:**$0
Contract Term	7/1/14-8/31/16 (Performance Period 2: 1/1/15-6/30/16)
Method of Accountability	This is a deliverables/performance-based contract where the contractors are required to submit monthly task order forms for monthly activities. Once the task order forms are approved, the contractor can commence work for that month. The contract manager(s) review the invoices, task order forms and work products each month before approving the invoices. Vermont is engaging in this contracting structure for professional services contracts to ensure that we have the skills necessary for the work to be done, but also allowing for some flexibility in a changing health care environment. Additionally, Vermont does not want to pay for unnecessary services and finds this method of accountability and management to allow for maximum benefit in contracting with entities for professional services.
Itemized Budget	The billing for this contract is time and materials. Specifically, the State of Vermont has developed a task order approval structure where the Contractor receives prior approval for all tasks. Once the task order is approved, the vendor does the work and then bills for it. The Contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the hourly rate for each staff person assigned to the contract.

Task/Role	**Estimated Hours**	**Rate**	**Extension**
Program Management Hours	114	$215.00	**$24,510.00**
Project 1 - DA/SSA Data Quality and Repository			
DA/SSA Data Quality and Repository Planning & Stakeholder Engagement			
Project Management	175	$205.00	$35,875.00
DA/SSA Reporting Needs Assessment			
Project Management	120	$205.00	$24,600.00
Subject Matter Expert	48	$225.00	$10,800.00
DA/SSA Data Workbook			

Project Management	100	$205.00	$20,500.00
Subject Matter Expert	288	$225.00	$64,800.00
DQR Repository			
Project Management	325	$205.00	$66,625.00
Subject Matter Expert	400	$225.00	$90,000.00
DA/SSA Data Quality work			
Project Management	144	$205.00	$29,520.00
Subject Matter Expert	144	$225.00	$32,400.00
Sub-Total Project Management	864	$205.00	$177,120.00
Sub-Total Subject Matter Expert	880	$225.00	$198,000.00
Total Project 1	**1744**		**$375,120.00**
Project 2 - LTSS Data Review and Planning			
Subject Matter Expert	288	$225.00	$64,800.00
Total Project 2	**288**		**$64,800.00**
Project 3 - Uniform Transfer Protocol Planning and Charter			
Subject Matter Expert	120	$225.00	$27,000.00
Total Project 3	**120**		**$27,000.00**
42 CFR Part 2			
Subject Matter Expert	192	$225.00	$43,200.00
TOTAL - 42 CFR Part 2	**192**		**$43,200.00**

ACTT Program Summary	Hours	Rate	Extension
Total Program Management hours	114	$215.00	$24,510
Total Project Management hours	864	$205.00	$177,120

	Total Subject Matter Expert hours	1480	$225.00	$333,000
	Total Program Hours	**2458**		**$534,630**
	Estimated Travel Expense			$16,040
	Total Cost			**$550,670**
Budget Category	*Technology and Infrastructure:* Practice Transformation *Technology and Infrastructure:* Expanded Connectivity of HIE Infrastructure *Technology and Infrastructure:* Enhancements to Centralized Clinical Registry & Reporting Systems *Technology and Infrastructure:* Expanded Connectivity between State of Vermont Data Sources and ACOs/Providers			
Summary Statement of Work	Program management, project management and subject matter support of long term services and supports providers and mental health agencies to achieve population health goals through the use of technology.			
Unique Qualifications (if Sole Source)	HIS Professionals, LLC is uniquely qualified to perform these tasks for several reasons: *1.* Elise Ames, key personnel for this contract, has over 20 years of extensive experience with health information technology (HIT), both in Vermont and elsewhere. She has provided consultant expertise to Vermont Health Information Technology Leaders (VITL), Bi-State Primary Care Association, and across Vermont mental health, home health, and long-term care provider networks. As a result of this work, Elise Ames brings a broad and unique understanding of the current state of HIT installations in virtually all Vermont settings of care (acute care, homecare, long term care, and ambulatory) and the challenges healthcare providers face as they implement technology. Elise Ames is a certified Project Management Professional (PMP) and is skilled in project/program management processes including: project planning, stakeholder reporting, resource management, budgeting and costing, risk management, and sustainability planning. She has extensive experience managing concurrent related projects, and large projects involving team members from multiple organizations. *2.* Katie McGee, key personnel for this contract, is also uniquely qualified for this project because of her strong project/program management skills, technical background, and knowledge of the development and inner workings of Vermont's HIT/HIE infrastructure and health reform initiatives. She has worked closely with Vermont's hospitals, physicians' practices, electronic health records, Health Information Exchange and clinical registry vendors to develop the technical structure and workflow processes to populate the Vermont Health Information Exchange (HIE) and successfully capture data in the reporting registry. Katie McGee played an integral role in Vermont's HIE infrastructure conversion and in the development of standard practices for developing data interfaces between electronic health records and the HIE. In addition to her work in Vermont, Katie McGee has worked with other states to provide immunization registry services, laboratory orders development, public health reporting, and initiatives for 42 CFR Part 2 substance abuse treatment data collection and distribution. *3.* H.I.S. Professionals, LLC is able to begin this work immediately. The VHCIP requires Vermont adhere to extremely tight timeframes for payment and care model development and the underlying HIT systems upon which the models rely. Delaying			

	procurement of a vendor to conduct this work would significantly jeopardize the ability of Vermont to meet critical milestones and metrics. *4.* One of the major objectives of the H.I.S. Professionals, LLC work will be to help manage and coordinate the work across the other contracts and vendors, so H.I.S. needs to be onboard and ready to prior to a projected July 1, 2014, kick-off of the projects. *5.* H.I.S. Professionals, LLC is able to begin this work immediately. The SIM Project requires Vermont adhere to extremely tight timeframes for payment and care model development. Delaying procurement of a vendor to conduct this work would significantly jeopardize the ability of Vermont to meet critical milestones and metrics.
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to November 12, 2015.**
Travel Justification	**The estimated travel for this contract per year is:$10,461** *Estimated cost per trip, Western Mass. to Burlington:$808* • Hotel (Vermont) for 1 person ($225 x 2 nights):$550 • Mileage (1 trip x 1 person x .575/mile x 275 miles roundtrip):$158 • Per diem for 1 person ($50/day x 2 days):$100 *Total number of trips estimated: 12* • Mileage (1 trip x 1 person x .575/mile x 90 miles roundtrip):$51.75 *Total number of trips estimated: 14* • Tolls/Parking:$40
Performance Period 2 Applicable Milestones	General Health Data – Expert Support: 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.

Contract Attachment A, Scope of Work for H.I.S. Professionals, LLC #27511

The VHCIP Core Team approved funding for several projects to enable Vermont's Designated Agencies and Specialized Service Agencies (DA/SSAs) and other Disability and Long Term Services and Supports (DLTSS) providers to collaborate with local and state partners to achieve population health goals through the ·use of technology. As part of this approval, the VHCIP Core Team approved project management and subject matter expertise support to ensure those projects are appropriately implemented. This contract provides for those two services.

The Contractor will provide overall program management for three projects, as described below, and report to the VHCIP Project Director on these projects. These projects involve the transfer of 42 CFR Part 2 data and the Contractor will coordinate these projects with the State's concurrent effort around appropriate transfer of those data. The projects, performed over a period of two years, for which this Contractor will provide project management and subject matter expertise are:
The projects, performed over a period of two years, for which this Contractor will provide program management, project management and subject matter expertise are:

1. Project 1: DA/SSA Data Quality and Repository
   This project will take place over a two year period and has two distinct phases. Phase One will include: Work

with all of the Designated and Specialized Service Agencies (DA/SSA) toward the development of a data dictionary; DA/SSA agency assessment against the data set; planning and architectural design for the data warehouse; and procurement of a unified Electronic Health Record for five developmental disability agencies. The selection process for choosing an Electronic Health Record/Vendor for the DA/SSAs will be done in consultation with VITL. The DA/SSA data warehouse planning and architectural design will be done in consultation with VITL, the State and other necessary stakeholders. The planning and design work will lead to Phase Two which will include the DA/SSA data warehouse implementation and testing. Phase Two will also include data quality work and remediation with DA/SSAs in conjunction with VITL and other necessary stakeholders.

2. Project 2: LTSS Data Review and Planning
   This project will review existing DLTSS measures. The review of the DLTSS measures is in advance of the measures that are being proposed for use in the Medicaid Shared Savings Program in 2015 and 2016. This project will determine if any non-claims based measures need IT support for use in 2016. Additionally, if after the planning phase it is determined that the IT support exceeds the phase 1 budget a comprehensive plan and budget for a Phase 2 request to the HIT/HIE workgroup will be developed.

3. Project 3: Uniform Transfer Protocol Planning and Charter
   This project aims to improve integration of communication among acute and post-acute health care providers and community based supportive service providers to enable Vermont to reach the next level of performance and service integration, with lower total medical expenditure (TME) and higher patient satisfaction. Today, modes of communication among different provider types vary from electronic to manual modes such as fax, telephone, and paper. Significant constraints on improved care integration and coordination include the lack of common information exchange processes, agreed upon content, and access to a shared health information exchange.

   This project will consider the data sets and impact on workflow processes and behavior for provider needs, which must convey both medical and social information. The work described here will focus on several provider types, some of which have EMR systems, and at least one will not. Mandating a form or protocol does not guarantee that people will use it well, or even that they will use it at all. This project will result in the creation of a detailed project charter for the technical design of the actual Universal Transfer Protocol.

I. Scope of Work:

This is a professional services contract and the Contractor will perform three types of tasks: Program Management, Project Management and Subject Matter Expertise.

The Contractor will provide the state with Task Orders for the work performed each month under this scope of work. The Contractor will provide this Task Order to the State five business days before the start of the month. The State must approve these Task Orders for any work to commence.

A. Project Management.
The Contractor will create the following documents and provide the following services for managing each of the three projects described above:

i. Team Member Directory;
ii. Project Risks;
iii. Communications Matrix/Plan;
iv. Issues Log;
v. Action Items Log;
vi. Business Requirements;
vii. Test Cases;

viii. Change Requests;
ix. Remote and on-site participation in group and one-on-one planning and status meetings;
x. Report status, barriers, risks and needs for each project to the Program Leadership Team;
xi. Meet with project managers weekly;
xii. Review detailed project plans prior to approval process;
xiii. Creating additional program reports and documents as needed;
xiv. Develop and maintain an integrated schedule and budget reporting for the entire program;
xv. Communicate with stakeholders and customers regarding plans and progress across the program;
xvi. Provide interface between project managers and stakeholders so that all understand the big picture;
xvii. Report on measures of success for each project and for the program as a whole;
xviii. Identify, communicate and manage dependencies across projects to mitigate risk;
xix. Identify, communicate and manage synergies across projects in order to maximize benefit and share best practices;
xx. Ensure project documentation is developed and maintained in standard format;
xxi. Ensure that project managers supply regular updates;
xxii. Coordinating efforts of project staff working on multiple projects within the program;
xxiii. Report on program outcomes;
xxiv. Report on lessons learned.

B. Subject Matter Expertise
The Contractor will provide the state with Subject Matter Expertise in the following areas:
a. Clinical information data quality analysis;
b. Data integration;
c. 42 CFR Part 2 clinical data integration, storage and sharing.

II. Reporting Requirements

- The Contractor shall participate in a conference call each month with the State of Vermont regarding this work. The purpose of these calls is to discuss administrative and project issues as they arise and to report preliminary findings of analyses as they become available.
- More frequent calls may be needed during active periods of the project. The Contractor shall participate in all such calls as requested by the State. The State shall not unreasonably request the Contractor to participate in such calls.
- The contractor shall submit monthly progress reports outlining all work accomplished during the previous month. The reports should be concise and in a simple format approved by the State of Vermont. These reports are to be submitted electronically to the VHCIP Project Director within five business days after the end of the month. These monthly progress reports shall be consistent with the work billed on the monthly vouchers. At a minimum, monthly progress reports shall cover the following items:
  i. Activities related to consultation and support related to each effort supported by this contract;
  ii. Activities planned for the forthcoming month (this can be provided separately in the Task Order submitted by the Contractor described above);
  iii. Contractor's expectations of the State staff during the forthcoming month (e.g., review of deliverables submitted, delivery of data or other items);
  iv. Any problems or delays – encountered or foreseeable – that may affect contract performance;
  v. Budget discrepancies greater than ten percent, i.e., cost overruns or underruns.

- The Contractor may also be requested to provide reports to the VHCIP Core Team, HIE/HIT Work Group or Steering Committee regarding the progress of this work.

The Contractor will meet, in person, with the State and key stakeholders at least quarterly for the duration of the contract.

III. Contract Administration, Key Personnel (See Attachment B for key personnel list and hourly rates)
The key personnel specified in this contract are considered to be essential to work performance under this Agreement. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the Contracting Officer and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the State of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The State may modify the contract to add or delete key personnel at the request of the contractor or Government.

IV. Contract Administration, Performance Expectations:
The Contractor shall develop monthly Task Orders. Each Task Order will include deliverables. Deliverables shall consist of quantifiable products or services resulting from activities performed pursuant to this Agreement. Such deliverables may include, but are not limited to the following:

1. Scopes of Work
2. Work Plan Development
3. Ad Hoc Tasks
4. Technical Assistance tasks

No work shall be undertaken or reimbursed pursuant to this Agreement, other than obligations specifically set forth Part B of this Attachment A, without a Task Order approved in writing by the State's designated representatives. The State's designated representatives are:

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

Jessica Mendizabal
VHCIP Contract Administrator
jessica.mendizabal@state.vt.us
802-878-7958

The Contractor shall provide a single point of contact who will manage all aspects of the contract including the assignment of qualified personnel to perform the work outlined herein. The Contractor's single point of contact is:

Elise Ames
Principal, H.I.S. Professionals, LLC
eames@hispros.com
413-634-4720

The number of personnel and level of expertise required, as well as the scheduled hours to be worked will be determined by the State and the Contractor as part of the status meetings and shall be included on the task order form. The assignment of additional personnel, hours, or the substitution of personnel with a higher level of expertise shall require pre-approval by the State.

The Contractor accepts full responsibility for any personnel assigned to perform the work herein. It is understood that the State will provide minimal oversight of personnel assigned to this contract

The State shall notify the Contractor's single point of contact to discuss remediation if it is determined by the State that personnel assigned are not performing as expected. The State has the right to request a change in personnel assigned. The State shall not request a change in personnel without reason. The Contractor is obligated to remove personnel within 2 business days of a request by the State, and provide a qualified replacement within 30 days.

<table>
<tr><th colspan="2">IHS Global, Inc. #TBD</th></tr>
<tr><td>Method of Selection</td><td>RFP</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$377,000
Performance Period 2 Total Amount (including Travel):$350,000 (note that$250,000 was previously approved so the requested amount is$100,000).
Performance Period 2 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>11/1/2015-6/30/2016</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based agreement where the contractors are required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The contract manager(s) review the invoices and work products each month before approving the invoices.</td></tr>
<tr><td>Itemized Budget</td><td>The billing for this contract is based on hourly rates for the Contractor. The contractor will be paid through monthly invoices as described in Attachment B of the agreement of the agreement.
<table>
<tr><th>Title</th><th>Staff</th><th>Hourly Rate</th></tr>
<tr><td>Project Director 1</td><td>Tim Dall</td><td>$293</td></tr>
<tr><td>Project Director 2</td><td>Terry West</td><td>$251</td></tr>
<tr><td>Economist</td><td>April Semilla</td><td>$119</td></tr>
<tr><td>Senior Economist</td><td>Ritashree Chakrabarti</td><td>$130</td></tr>
<tr><td>Associate Economist</td><td>William Iacobucci</td><td>$85</td></tr>
</table></td></tr>
<tr><td>Budget Category</td><td>Workforce Assessment: System-Wide Capacity</td></tr>
<tr><td>Retroactive Start Justification (if applicable)</td><td>Funding is requested to be retroactive to November 12, 2015.</td></tr>
<tr><td>Summary Statement of Work</td><td>Utilizing data collected through the all-payer claims database, surveys and licensure, deliverables in this section include developing a micro-simulation demand model to better inform workforce-related policymaking and investments.

Workforce planning is about getting the right staff with the right skills in the right place at the right time. This is a complex undertaking. In Vermont, health workforce planning becomes even more difficult, given that payment and delivery system reform is a work in progress. While such planning is difficult, it is also urgently needed if Vermont's movement toward universal health care is to be successful. Coverage for care without an adequate workforce to assure access will result in a failure of reform.</td></tr>
</table>

Travel Justification	Travel is not a billable expense under this agreement.
Performance Period 2 Applicable Milestones	Workforce – Demand Data Collection and Analysis: 1. Execute contract for micro-simulation demand modeling by 1/15/16 (dependent on federal approval). 2. Provide preliminary data as defined by the contract to vendor for use in model by 3/15/16.

Contract Attachment A, Scope of Work for IHS Global, lnc. #TBD

I. Background

The State has been awarded a$45 million State Innovation Model Testing Grant from the federal Center for Medicare and Medicaid Innovation (CMMI). This project, entitled Vermont Health Care Innovation Project (VHCIP), provides a forum for coordinating policy and resources to achieve the shared public/private goals articulated in Vermont's State Health Care Innovation Plan, including the development of a high performance health care system for the State's residents.

The VHCIP Operational Plan outlines several tasks in conjunction with Vermont's Health Care Workforce Strategic Plan, including the development of Vermont-specific metrics for determining supply and demand projections for Vermont's health care workforce. Vermont is seeking to build a microsimulation demand model that is flexible enough to address Vermont's unique and changing health care workforce needs and aging population, and will provide a framework to help the state better predict and prepare for future health care workforce demand.

II. Scope of Work

A. Contractor shall assist the State by conducting modeling and analysis and constructing a micro-simulation health needs model.
B. The model shall perform the following:
    a. Assess and forecast the health requirements of Vermont residents on an individual scale to aid the state in the understanding of workforce requirements under an ideal, universal, health care delivery system.
    b. Account for multiple aspects of a professionally staffed health workforce, these may include and are not limited to:
        i. Primary care physicians currently defined as Family Medicine, General internists, OB/GYN, and Pediatrics;
        ii. Specialty physicians, including Surgeons;
        iii. Nurse Practitioners;
        iv. Physicians Assistants;
        v. Registered nurses;
        vi. Naturopathy;
        vii. Mental health;
        viii. Dental professions;
        ix. Health care support staff, such as direct care workers, medical assistants, nutritionists, panel managers, data analysts and IT staff;
        x. Community Health Workers;
        xi. Substance Abuse Professionals;

xii. All licensed complementary and alternative medicine providers: chiropractors, acupuncturists, certified nurse midwives, naturopaths, massage therapists;
xiii. Physical Therapists, Occupational Therapists, Skilled Licensed Professionals;
xiv. Licensed Psychologist-Master, Licensed Psychologist-Doctorate, Licensed Independent Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Alcohol/Drug Counselor, and Licensed Clinical Mental Health Counselor;
xv. Pharmacists.

c. Consider population growth and aging, Vermont's high degree of population migration, and the various reform measures being implemented.
d. Asses State's projected economic growth, and its expected contributions to an expanding health delivery system.
e. Assign measures to account for the changing degree of substitutability between physicians, and mid-level care givers.
f. Use information at the county level to help develop a better understanding of the variance of health care utilization throughout the state.
g. Ability to run annual updates to track longitudinal changes throughout a period of health care reform.
h. Assess the degree to which patients currently use integrative medicine providers (i.e. chiropractors, acupuncturists, massage therapists, etc…) as first contact and continuing management of both primary and specialty health care, and assess the impact of a more systemic integration of these and other provider types into health models.
i. Ability to adjust to a demand-based micro-simulation in order to capture the actual utilization of health care providers by Vermonters include the effects of economic, social, and other barriers to access in order to provide an accurate depiction of the usage of health services.
j. Assess and identify a future ideal level of health care utilization by provider type. Contractor shall identify a baseline or current level of health care utilization based on existing factors currently influencing the Vermont population.
k. Assess complex demand determinants, such as developments in science and technology, and projected changes in disease and chronic illness rates that accompany shifting demographics.

C. Contractor shall work with the State to ensure the model is detailed but flexible, to allow policy makers to apply assumptions and expectations and observe various outcomes.
D. The Contractor shall engage Vermont's health care workforce stakeholders including the VHCIP Workforce Work Group.
E. The final model shall include sufficient supporting material related to the project for future state usage.

III. <u>Contractor Deliverables</u>

a. *Task 1:* Conduct Project Kickoff Meeting
  i. Within the first month of contract execution Contractor shall conduct an in-person kickoff meeting with the VHCIP Workforce Work Group staff and Vermont stakeholders.
  ii. Contractor shall conduct two additional in-person meetings throughout the project.

b. *Task 2:* Monthly Project Stakeholder Meetings and Status Reports
  i. Contractor shall coordinate monthly meetings with State representatives and project stakeholders via conference call.
  ii. By the 10th of each month Contractor shall submit monthly status report for the previous month.
  iii. The Status report shall include:

1. A table containing a schedule of milestones and deliverables, status updates (percent complete), and key dates (planned start date, planned end date, actual start date, actual end date, planned percent complete).
2. A summary of work completed during the previous month.
3. Next steps on the project and work to be completed during the upcoming month.
4. Any issues that have arisen, anticipated problems, and our proposed solution.

c. *Task 3:* Prepare Preliminary Projections of Demand

i. Within three months of project inception Contractor will submit draft projections of demand through the year 2025 for those health occupations chosen for inclusion in the analysis.

ii. Contractor will create the population database for each county using the method descried previously.

1. The population database will take into consideration health risk factors among the population in Vermont (e.g., smoking prevalence, obesity prevalence, and prevalence of chronic diseases).
2. The database will reflect current rates of insured (Medicare, Medicaid, and commercially insured). The dataset will reflect other factors used to model demand for health care services (residing in a metro or non-metropolitan area, and household income).

d. *Task 4:* Prepare Refined Projections of Demand

i. Within five months of project inception Contractor will provide refined projections of demand. The model shall incorporate features regarding health care use patterns of people in Vermont (such as care provided outside of Vermont to Vermont residents), and care patterns of people in neighboring states who might seek health care within Vermont.

e. *Task 5:* Prepare and Submit Draft Report

i. Within six months of project inception, Contractor will submit a draft report that describes the work completed and demand projections. Contractor will work with the State to determine the structure of the report to: (1) provide information to be shared with a public (non-technical) audience, and (2) provide information on the technical aspects of work completed (i.e., methods, data, and assumptions).

f. *Task 6:* Prepare and submit Final Demand Projections Report

i. Contractor shall revise the draft report based on State feedback and shall submit a final report within three weeks of receiving State feedback.

g. *Task 7:* Conduct Close-Out Meeting and Presentation

i. Upon acceptance of the final report by the State, Contractor will arrange an in-person presentation to present the findings to the Workforce Work Group and other key stakeholders.

ii. Contractor shall engage Stakeholders for input on the findings prior to the presentation.

IV. <u>State Deliverables</u>

A. To the extent possible the State will provide the following data sources to the Contractor:

1. County level population projections by age and gender (and preferably also by race/ethnicity if available).
2. Insurance information by demographic group and county
3. Vermont health care use through the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) all-payer claims database.

4. Current active supply of health workers by county and occupation (and if possible by employment setting and medical/surgical specialty).

V. Contract Administration Data – Key Personnel (See Attachment B for key personnel list and hourly rates):

The key personnel specified in this contract are considered to be essential to work performance. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the VHCIP Project Director and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the State of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The State may modify the contract to add or delete key personnel at the request of the Contractor or Government.

VI. Performance Expectations:

The scope of work and technical assistance provided by the Contractor shall contain specific deliverables, due dates and performance measures, and shall serve as the basis for quality assurance and a means for monitoring the contractor's performance throughout the duration of this contract.

The Contractor shall provide a single point of contact who will manage all aspects of the contract including the assignment of qualified personnel to perform the work outlined herein.

The Contractor's single point of contact or designee will be present at monthly status meetings at a time and date agreed upon by the State and Contractor.

The Contractors single point of contact is:

Tim Dall, Managing Director
IHS Global, Inc.
1150 Connecticut Ave, NW
Washington, DC 20036
tim.dall@ihs.com

Contract business matters contact is:

Duyen Phan
IHS Global, Inc. 5515 Security Lane, Suite 800
1150 Connecticut Ave, NW
Washington, DC 20036
duyen.phan@ihs.com

The Contractor shall work with other State staff and State Contractors as requested by the State.

The number of personnel and level of expertise required, as well as the scheduled hours to be worked will be determined by the State and the Contractor on a monthly basis as part of the status meetings. The assignment of additional personnel, hours, or the substitution of personnel with a higher level of expertise shall require pre-approval by the State.

The Contractor accepts full responsibility for any personnel assigned to perform the work herein. It is understood that the State will provide minimal oversight of personnel assigned to this contract.

The State shall notify the Contractor's single point of contact to discuss remediation if it is determined by the State that personnel assigned are not performing as expected. The State has the right to request a change in personnel assigned. The State shall not request a change in personnel without reason. The Contractor is obligated to provide a change in personnel, within 2 business days of a request by the State.

James Hester, Jr. #28674	
Method of Selection	Sole Source
Contract Amount	**Total Contract Amount (all years):**$70,000 **Performance Period 2 Total Amount (including Travel):**$7,000 **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	**#26319:** 3/1/14-2/28/15 (Performance Period 2: 1/1/15-2/28/15) **#28674:** 3/1/15-2/28/16 (Performance Period 2: 3/1/15-2/28/16)
Method of Accountability	This is a deliverables/performance-based contract where the contractors are required to submit monthly task order forms for monthly activities. Once the task order forms are approved, the contractor can commence work for that month. The contract manager(s) review the invoices, task order forms and work products each month before approving the invoices. Vermont is engaging in this contracting structure for professional services contracts to ensure that we have the skills necessary for the work to be done, but also allowing for some flexibility in a changing health care environment. Additionally, Vermont does not want to pay for unnecessary services and finds this method of accountability and management to allow for maximum benefit in contracting with entities for professional services.
Itemized Budget	The billing for this contract is time and materials. Specifically, the State of Vermont has developed a task order approval structure where the Contractor receives prior approval for all tasks. Once the task order is approved, the vendor does the work and then bills for it. The Contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the hourly rate for each staff person assigned to the contract. The Contractor's hourly rates are competitive within the health care consultant sector and fall within the low range of hourly rates for contractors involved in this work across the country. Hester's Hourly Rate:$175
Budget Category	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers
Summary Statement of Work	Research population health models in other states, identify population health measures and measurement systems required to support the population health financing system; help formulate an approach to creating Vermont pilots of Accountable Health Communities.
Unique Qualifications (if Sole Source)	Mr. Hester is familiar with both the population health work at the federal level and the work in Vermont. At the federal level, he was the Acting Director responsible for the initial work on the Pioneer ACO shared saving model, the Comprehensive Primary Care Initiative Model and the Bundled Payment models. Significantly, he served as the Acting Director of the Population Health Models Group overseeing the development of enhanced measures and strengthening the population health component of the payment models. He has a strong set of working relationships with public and private partners, especially CMS and CDC. His Vermont experience includes serving as director of the Health Care Reform Commission for the state legislature for four years, the Blueprint Executive Committee since its inception and the VITL board for three years. Mr. Hester provides Vermont with all of the leading population health policy through his national contacts. His federal and state relationships are unparalleled and bring the best ideas, newest innovations and population health concepts to Vermont. Mr. Hester attends numerous national conferences and brings these ideas and learnings back to Vermont for use by the Population Health Work Group.

Retroactive Start Justification (if applicable)	*New Request:* **New contract to extend term through December 31, 2015. Due to delays in federal approvals the State will develop a new agreement. Funding for the new agreement is requested to begin 7/1/2015.** Retroactive funding is requested to support the nature of the Contractor's work, which is time sensitive and critical to the success of the VHCIP.
Travel Justification	Hourly rate is inclusive of travel.
Performance Period 2 Applicable Milestones	Accountable Communities for Health: Feasibility assessment – data analytics: 1. Discussion and planning of investments related to ACH feasibility based on research/report by 11/1/15. 2. Design/creation of ACH learning system for all 14 Vermont Health Service Areas by 1/31/16. 3. Start roll out ACH learning system to at least 3 health service areas by 2/1/16. 4. Research for implementation of a pilot incorporating a payment change (data analysis, financial analysis, stakeholder participation analysis) for at least 1 Vermont region by 2/1/16.

Contract Attachment A, Scope of Work for James Hester, Jr. #28674

<u>**Scope of Work:**</u>

A. The Contractor shall assist the State of Vermont with the population health workgroup related to the State Innovation Model (SIM) Grant. The SIM grant, entitled Vermont Health Care Innovation Project (VHCIP), requires the State of Vermont to work towards improving overall population health.

B. Contractor shall:
   1. Assist the co-chairs of the Population Health workgroup in developing the strategy, work plan, and resource needs for the workgroup;
   2. Assist in developing agendas for the workgroup;
   3. Support/oversee project staff in analyzing payment models being tested and opportunities for integration of population health;
   4. Through ongoing work with CDC, IOM and others, identify models and resources in other states and communities that could inform the design of sustainable financing models for improving population health;
   5. Assist in identifying the population health measures and measurement systems required to support the population health financing system;
   6. Assist in developing the Population Health Improvement plan, particularly the elements for a sustainable financial model;
   7. Help formulate an approach to creating Vermont pilots of Accountable Health Communities by drawing on expertise in models being tested in other states and building on the work of the Prevention Institute.

II. <u>Deliverables:</u>

1. Prioritize payment models for analysis by the Population Health Work Group:
   a. Review payment models being considered for testing by the VHCIP;
   b. Identify strengths and limitations in planned integration of population health;
   c. Identify best strategy to include payment for and/or activity related to population health;

d. Prepare presentation for workgroup review of payment models.

2. Recommend Financing Options related to Paying for Prevention:
    a. Identify promising financing vehicles that promote financial investment in population health interventions;
    b. Prepare presentation on the options being explored in other communities and nationally;
    c. Oversee conduct of SWOT in Vermont and written summary of analysis and recommendations
    d. Facilitate workgroup review of financing vehicles;
    e. Provide recommendations to other VHCIP committees to consider link with payment models being tested.

3. Integrate Population Health into the VHCIP:
    a. Participate in work group planning meetings;
    b. Create list of key leaders to brief and/or engage in the population health work;
    c. Facilitate introductions to enable set up meetings with key leaders in the state to share population health goals;
    d. Brief planning group on all meetings with key leaders;
    e. Assist in engaging other VHCIP workgroups in population health.

III. <u>Task Orders</u>

Services performed pursuant to a task order clarify and expand upon the Scope of Work otherwise already described in this Agreement. Task orders shall not be used to change the maximum amount under this agreement, nor to add to the Scope of Work. Both parties recognize that the task order process does not obviate the need for State or federal regulatory review of amendments to the scope, budget, or maximum amount of this agreement.

A request for a task order proposal shall be submitted to the Contractor by the State or to the State from the Contractor. Upon review of the proposal, the State and Contractor must complete the Task Order Form (Appendix I). The Contractor has the right to submit modifications or deny any Task Order submitted by the State. The State can submit modifications or deny proposed Task Order submitted by the Contractor. The final Task Order document shall not be effective until it is signed by the Contractor, the State Authorized Representative, the Office of the Attorney General, and the DVHA Business Office. The Task Order must indicate: scope, source of funds, payment provisions, points of contact, ownership of data and any applicable data use agreement, and project specifics. No task order may increase the maximum amount payable under this contract, deviate from or add to the scope of this contract, or deviate from any term in any part or attachment to or of this contract. The task order process shall not be used in lieu of the amendment process where in the sole discretion and judgment of the State an amendment is appropriate. Each Task Order must clearly define payment either by rate per hour or deliverable received and approved. Each Task Order must be pre-approved before any work shall begin. Services performed pursuant to a Task Order shall not be eligible for reimbursement unless the Task Order is signed by all representatives listed within this section.

A Task Order may assign a Project Manager, who will act as the Authorized State Representative, solely per that task and up to the maximum amount per that task. The Project Manager assigned to a specific Task Order is the sole person authorized to assign work to the Contractor under that particular Task Order.

Changes to a Task Order shall be accomplished by written modification as agreed to by both parties and will be reflected in

a new Task Order.

IV. Monthly Reporting

- The Contractor shall participate in a conference call each month with the State of Vermont regarding this work. The purpose of these calls is to discuss administrative and project issues as they arise and to report preliminary findings of analyses as they become available.
  a. More frequent calls may be needed during active periods of the project. The Contractor shall participate in all such calls as requested by the State and mutually agreed upon by the State and Contractor.

- The Contractor shall submit monthly progress reports outlining all work accomplished during the previous month. The reports should be concise and in a simple format (e.g., bulleted list) approved by the State of Vermont. These reports are to be submitted electronically to the VHCIP Project Director within five business days after the end of the month. These monthly progress reports shall be consistent with the work billed on the monthly vouchers.

  a. At a minimum, monthly progress reports shall cover the following items:

     i. Activities related to consultation and support related to each Awardee supported by this contract;
     ii. Activities planned for the forthcoming month;
     iii. Contractor's expectations of the State Staff during the forthcoming month (e.g., review of deliverables submitted, delivery of data or other items);
     iv. Any problems or delays – encountered or foreseeable – that may affect contract performance;
     v. Budget discrepancies greater than ten percent, i.e., cost overruns or underruns.

- Additional planning and coordination meetings may be required during the course of the contract, depending on the needs of each SIM Demonstration.

- Contract Administration Data – Key Personnel (See Attachment B for key personnel list and hourly rates)

  a. The key personnel specified in this contract are considered to be essential to work performance under this Agreement. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the State's designated representative and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the State of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The State may modify the contract to add or delete key personnel at the request of the Contractor or Government.

V. Performance Expectations:

The scopes of work and technical assistance provided by the Contractor shall contain specific deliverables, due dates and performance measures, and shall serve as the basis for quality assurance and a means for monitoring the Contractor's performance throughout the duration of this contract.

The Contractor shall provide a single point of contact who will manage all aspects of the contract including the assignment of qualified personnel to perform the work outlined herein.

The Contractor's single point of contact or designee will be present at bi-weekly status meetings at a time and date agreed upon by the State and Contractor.

The number of personnel and level of expertise required, as well as the scheduled hours to be worked will be determined by the State and the Contractor as part of the status meetings and shall be included on the task order form. The assignment of additional personnel, hours, or the substitution of personnel with a higher level of expertise shall require pre-approval by the State.

The Contractor accepts full responsibility for any personnel assigned to perform the work herein. It is understood that the State will provide minimal oversight of personnel assigned to this contract.

The State shall notify the Contractor's single point of contact to discuss remediation if it is determined by the State that personnel assigned are not performing as expected. The State has the right to request a change in personnel assigned. The State shall not request a change in personnel without reason. The Contractor is obligated to provide a change in personnel, within 2 business days of a request by the State.

JBS International #28389	
Method of Selection	RFP
Contract Amount	**Total Contract Amount (all years):**$140,442 **Performance Period 2 Total Amount (including Travel):**$108,000(reduced by$32,442 because milestone completed with fewer resources than budgeted). **Performance Period 2 Out-of-State Travel:$**2,327.60
Contract Term	2/1/15-12/31/15 (Performance Period 2 Only)
Method of Accountability	This is a deliverables/performance-based contract where the contractors are required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The contract manager(s) review the invoices and work products each month before approving the invoices.
Itemized Budget	The billing for this contract is based on hourly rates for the Contractor. The contractor will be paid through monthly invoices as described in Attachment B of the agreement. Hourly rates: Project Director -$202.13 Subject Matter Expert -$148.84 Data Analyst -$52.64
Budget Category	*Technology and Infrastructure:* Telemedicine
Summary Statement of Work	Assist Vermont in assessing current telehealth practices in Vermont and planning for potential pilot programs.
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to February 1, 2015.** This agreement was submitted to CMMI on February 4, 2015, with a request that the funding begin February 1, 2015. It was not approved pending approval of Vermont's Performance Period 1 Carryforward. This contract was not in force in 2014 and not part of the approved carryforward. This contract is fully funded by Performance Period 2 contract funds. Retroactive funding is requested to support the nature of the Contractor's work, which is time sensitive and critical to the success of the VHCIP.
Travel Justification	**The estimated travel for this contract is:$2,327.60.** *Estimated cost for four trips from Boston, MA, to Burlington for 1 person:$1793.60* • Hotel (1 night @$125/night x 6 trips):$800 • Mileage (Boston to Burlington = 432 miles roundtrip x$0.575/mile x 4 trips):$993.60 *Estimated cost for one trip from Washington, D.C., to Burlington for 1 person:$534* • No lodging • Ground transportation ($40 parking at Reagan National Airport +$120 rental car:$140 • Mileage in Vermont (72 miles roundtrip x$0.575/mile x 1 trip):$82.80 • Airfare for 1 person:$311.20 roundtrip
Performance Period 2 Applicable Milestones	Telehealth – Strategic Plan: Develop Telehealth Strategic Plan by 9/15/15.

Contract Attachment A, Scope of Work for JBS International #28389

The Contractor will support the Health Information Exchange (HIE)/Health Information Technology (HIT) Work Group in developing a telehealth pilot program as part of the federally funded Vermont Health Care Innovation Project (VHCIP).

A. Contractor shall:
   1. Conduct a statewide assessment of the status of current telehealth technology equipment and services in state including the following areas: Dartmouth, Bi-State Primary Care Association, Home Health, Mental Health and Specialized Agencies, public and private providers, payers, and education/research. Contractor will assess the degree to which the equipment is implemented and used, and barriers to expanded use.
      a. The scope will include: medical (traditional, mental health and substance abuse, and more), human services, monitoring, distance learning.
      b. The assessment will include current telehealth practices within the State and innovation around the country.
      c. Format shall be such that it can be amended with new information in future years.

   2. Investigate telehealth data systems, analyze options for a common statewide solution, and recommend steps or phases to implement such a solution over time.

   3. Develop a statewide telehealth/telemedicine strategy by 7/1/15.
      a. Identify goals and objectives; address barriers and issues (such as interstate licensing, payment, allowable originating sites, remote patient monitoring, culture and practice patterns, security/privacy, and broadband); and make recommendations for future projects and initiatives.
      b. Convene a telehealth/telemedicine steering committee to guide the development of statewide telehealth/telemedicine strategies and projects.

   4. Develop the SOW portion of an RFP and a proposal evaluation tool for an RFP for telehealth pilot projects that would test or further one or both of the following goals:
      a. Broad and coordinated telehealth programs or initiatives should lead to better access to care and services, better care experiences for patients, better health outcomes for populations, and lower costs, especially in rural areas.
      b. Common statewide telehealth solutions should lead to more efficient data sharing and more successful programs.

II. The Contractor will perform these tasks according to the following timeline on Pages 4 and 5 of this agreement.

Deliverables:

1. Submit a Task Order for the first month of the contract one week prior to the official start date.
2. Submit the following documents on the 15th of each month:
   a. Monthly Task Order indicating what work is to be done (for example, on March 15, submit the Task Order for April)
   b. Monthly progress report confirming what work was accomplished in the prior month (for example, on March 15, submit the progress report for February)
3. Participate in monthly HIE/HIT work group meetings, and sub work-group meetings as needed.

III. Task Orders

Services performed pursuant to a task order clarify and expand upon the Scope of Work otherwise already described in this Agreement. Task orders shall not be used to change the maximum amount under this agreement, nor to add to the Scope of Work. Both parties recognize that the task order process does not obviate the need for State or federal regulatory review of amendments to the scope, budget, or maximum amount of this agreement.

A request for a task order proposal shall be submitted to the Contractor by the State or to the State from the Contractor. Upon review of the proposal, the State and Contractor must complete the Task Order Form (Appendix I). The Contractor has the right to submit modifications or deny any Task Order submitted by the State. The State can submit modifications or deny proposed Task Order submitted by the Contractor. The final Task Order document shall not be effective until it is signed by the Contractor, the State Authorized Representative, the Office of the Attorney General, and the DVHA Business Office. The Task Order must indicate: scope, source of funds, payment provisions, points of contact, ownership of data and any applicable data use agreement, and project specifics. No task order may increase the maximum amount payable under this contract, deviate from or add to the scope of this contract, or deviate from any term in any part or attachment to or of this contract. The task order process shall not be used in lieu of the amendment process where in the sole discretion and judgment of the State an amendment is appropriate. Each Task Order must clearly define payment either by rate per hour or deliverable received and approved. Each Task Order must be pre-approved before any work shall begin. Services performed pursuant to a Task Order shall not be eligible for reimbursement unless the Task Order is signed by all representatives listed within this section.

A Task Order may assign a Project Manager, who will act as the Authorized State Representative, solely per that task and up to the maximum amount per that task. The Project Manager assigned to a specific Task Order is the sole person authorized to assign work to the Contractor under that particular Task Order.

Changes to a Task Order shall be accomplished by written modification as agreed to by both parties and will be reflected in a new Task Order.

IV. Monthly Reporting

a. The Contractor shall participate in a conference call each month with the State regarding work under this agreement. The purpose of these calls is to discuss administrative and project issues as they arise and to report preliminary findings of analyses as they become available.

b. More frequent calls may be needed during active periods of the project.

c. The Contractor shall submit monthly Status Reports outlining all work accomplished during the previous month. The Report should detail hours expended against the Task Order for each staffing category identified:

i. Total hours authorized under the Task Order.
ii. Hours expended during the previous month.
iii. Total hours expended under the Contract to date.

These reports are to be submitted electronically to the VHCIP Project Director within 15 business days after the end of the month. These monthly progress reports shall be consistent with the work billed on the monthly vouchers.

d. At a minimum, monthly progress reports shall cover the following items:

i. Activities related to consultation and support related to each Awardee supported by this contract.
ii. Activities planned for the forthcoming month.
iii. Contractor’s expectations of the State Staff during the forthcoming month (e.g., review of deliverables submitted, delivery of data or other items).
iv. Any problems or delays – encountered or foreseeable – that may affect contract performance.
v. Budget discrepancies greater than ten percent, i.e., cost overruns or underruns.

e. Additional planning and coordination meetings may be required during the course of the contract, depending on the State’s needs.

V. Contract Administration Data – Key Personnel (See Attachment B for key personnel list and hourly rates):

a. The key personnel specified in this contract are considered to be essential to work performance. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the VHCIP Project Director and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the State of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The State may modify the contract to add or delete key personnel at the request of the Contractor or Government.

VI. Ad Hoc Tasks:

The State shall define deliverables as aligned in the scope of work by meeting with the Contractor on a bi-weekly basis in order to define and confirm inclusion of additional deliverable development as identified by the State. Ad hoc tasks shall be reduced to writing and approved by both parties on a task order form and added to the work plan on a bi-weekly basis.

VII. Performance Expectations:

The scopes of work and technical assistance provided by the Contractor shall contain specific deliverables, due dates and performance measures, and shall serve as the basis for quality assurance and a means for monitoring the contractor's performance throughout the duration of this contract.

The Contractor shall provide a single point of contact who will manage all aspects of the contract including the assignment of qualified personnel to perform the work outlined herein.

The Contractor's single point of contact or designee will be present at bi-weekly status meetings at a time and date agreed upon by the State and Contractor.

The Contractor shall work with other State staff and State Contractors as requested by the State.

The number of personnel and level of expertise required, as well as the scheduled hours to be worked will be determined by the State and the Contractor on a bi-weekly basis as part of the status meetings and shall be included on the task order form. The assignment of additional personnel, hours, or the substitution of personnel with a higher level of expertise shall require pre-approval by the State.

The Contractor accepts full responsibility for any personnel assigned to perform the work herein. It is understood that the State will provide minimal oversight of personnel assigned to this contract.

The State shall notify the Contractor's single point of contact to discuss remediation if it is determined by the State that personnel assigned are not performing as expected. The State has the right to request a change in personnel assigned. The State shall not request a change in personnel without reason. The Contractor is obligated to provide a change in personnel, within 2 business days of a request by the State.

Nancy Abernathey #28243	
Method of Selection	RFP
Contract Amount	**Total Contract Amount (all years):**$108,630 **Performance Period 2 Total Amount (including Travel):**$58,630 (note that$6,630 was previously approved so the requested amount is$52,000). **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	12/15/14-12/31/16 (Performance Period 2: 1/1/15-6/30/16)
Method of Accountability	This is a deliverables -based contract where the contractors are required to submit monthly invoices that identify activities performed under the contract. The contract manager(s) reviews the invoice and work products each month before approving the invoices.
Itemized Budget	The billing for this contract is divided by the type of service provided and is fixed price. The Contractor will be paid for satisfactory work performed in each month of this contract. The Contractor will also be reimbursed for in-state travel up to$10,000. Facilitation: $81,000 (13 payments of$6,230.77) Milestones: $9,000 Travel: $10,000 **Total**: $100,000
Budget Category	*Technical Assistance:* Learning Collaboratives
Summary Statement of Work	Quality improvement facilitators supporting quality improvement activities in primary care practices, integrated care teams within communities and specialty addictions and mental health programs.
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to November 12, 2015**.
Travel Justification	No out-of-State travel is anticipated.
Performance Period 2 Applicable Milestones	Learning Collaboratives: Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.

Contract Attachment A, Scope of Work for Nancy Abernathey #28243

I. Role of the Contractor

The Contractor will serve as a Quality Improvement (QI) facilitator providing support to "integrated care teams" in communities across the state participating in the Integrated Communities Care Management Learning Collaborative. QI facilitation requires competencies including implementing quality improvement methods, team facilitation, group dynamics, understanding and using data, and project management.

Vermont's interdisciplinary integrated care teams will consist of care coordinators and leaders from various medical and social service organizations, such as Primary Care and Specialty Practices**;** Designated Mental Health Agencies**;** Visiting Nurse Associations and Home Health Agencies; Hospitals and Skilled Nursing Facilities; Area Agencies on Aging**;** Blueprint Community Health Teams and Practice Facilitators; Support and Services at Home (SASH); Accountable Care Organizations (OneCare Vermont, Community Health Accountable Care, and Vermont Collaborative Physicians); Medicaid; Vermont Chronic Care Initiative (including care coordinators); commercial insurers; and people in need of care management services and their families.

As a QI facilitator, the Contractor will work with these integrated care teams to build capacity for effective team-based care, coordinate learning opportunities related to integration of services on behalf of people who need the services, implement promising interventions to enhance integration, and measure results of those interventions. The primary mechanism for learning and quality improvement will be a Learning Collaborative utilizing the Plan-Do-Study-Act (PDSA) model. The QI facilitator will provide primary support to selected communities. This will include attendance and participation in regularly scheduled meetings in each community, as well as meetings with its project leaders as needed. The QI facilitator will provide support for data collection, management, and interpretation to all pilot communities. This involves assisting teams with a) understanding data sources and using them to identify at-risk people and engage in effective panel management, b) identifying measures for and measuring the impact of selected interventions, and c) promoting an environment of collaborative learning between integrated care teams and across the health system.

The QI facilitator will attend and participate in regularly scheduled meetings of the leadership team of the ICCMLC, as well as state government planning committee and workgroup meetings as requested. The QI facilitator will also participate as a member of the ICCMLC leadership team in the planning, design and presentation of in-person learning sessions and webinars for all pilot communities to enhance their knowledge of processes, methods and tools for integrated care management. The Contractor will also assist the leadership team in the overall evaluation of the ICCMLC efforts across the state. This includes reviewing current literature on recipient of care and provider experience surveys, identifying process and outcome measures, and participating in survey design, testing, and rollout.

The State and the Contractor recognize that communities will initiate and end the Learning Collaborative according to different time frames; not all communities will be active at the same time. The workload has been estimated at a total level of effort that should not exceed 40 hours per week, on average. If the total level of effort exceeds an average of 40 hours per week, the Contractor shall provide the State with documentation of the time allocated to this agreement in a manner that is agreed upon by both the State and Contractor. If the State determines that an effort beyond an average of 40 hours per week is warranted, either party can initiate an amendment review process to this agreement in order to expand capacity to the Contractor for the additional communities. Alternatively, the Contractor and the State can agree that the Contractor will not be responsible for working with additional communities until the level of effort drops below 40 hours per week.

II. Contractor Activities

The Contractor's work with integrated care teams and the State will include:

A. Supporting Change Management

1. Facilitate meetings of the planning group team.
2. Coach community leaders in forming multi-disciplinary integrated care teams with a focus on quality improvement.
3. Foster integrated care teams' ownership for improving patient care and changing the way the services are provided.
4. Work with integrated care teams to assess their performance and establish project goals and parameters.

5. Use integrated care team data to assist in establishing sequences and timelines for quality improvement initiatives, and to evaluate the impact of changes.
6. Train integrated care teams in conducting PDSA cycles.
7. Coach integrated care teams in measuring and interpreting results of change.
8. Facilitate communication around evolving roles and relationships.
9. Recognize, reinforce, and celebrate success.
10. Provide feedback and coaching for integrated care team leaders.

B. Providing Technical Assistance and Training

1. Identify skills-based training needs for integrated care teams and front-line care managers, and work with the State to ensure that training occurs.
2. Provide technical assistance in identifying models of care, innovative strategies and evidence-based guidelines that support integrated care management.
3. Assist in implementing promising interventions.
4. Support integrated care teams in using data to identify people in need of integrated care management.
5. Assist integrated care teams in measuring and evaluating the results of interventions.

C. Supporting the Effective Use of Information Technology

1. Support integrated care teams in using technology to improve patient care and efficiency.
2. As appropriate, assist integrated care teams in implementing data collection tools (e.g., clinical registry, care coordination modules, risk stratification tools) and using them to improve panel management, care management, and other aspects of patient care.

D. Creating a Learning Health System

1. Foster a shared learning environment through organization-to-organization mentoring.
2. Design and implement collaborative learning sessions.
3. Participate in shared learning activities of the Expansion and Quality Improvement Program (EQuIP) facilitator group (team meetings, conference calls, training and one-on-one meetings).

E. Connecting Integrated Care Teams with the Community

1. Support the incorporation of integrated care teams into organization workflow.
2. Link integrated care teams with outside resources.

III. Deliverables

A. During the term of this contract, in collaboration with other contractor(s) and a Learning Collaborative Planning Team, the Contractor will provide:

1. A written project management plan including key project milestones and activities, to be submitted to State Authorized Representative no later than one month after execution of this agreement.
    a. The Contractor will update the project management plan at least quarterly.
    b. The State Authorized representative is:

Erin Flynn, Senior Policy Analyst
Department of Vermont Health Access

erin.flynn@state.vt.us

2. A monthly written progress report submitted to State Authorized Representative, highlighting goals, activities, outcomes, timelines, deadlines, progress in each community, progress across all communities, and general progress against the project management plan.

   Progress reporting for each community will include information such as accomplishments, setbacks, challenges, plans for overcoming challenges, opportunities, and planned next steps/action items for both the short term (next month) and long term (next quarter). Specific examples should be incorporated to better illustrate progress in each community. The State will provide a template for the monthly written progress report.

   The following documentation will be included as attachments to the report:

   a. Evidence of Local meetings with each integrated community team at least monthly as determined by community teams.
   b. Documentation of all relevant PDSA cycles initiated in each community.
   c. Evidence of all regular and ad hoc review and analysis of data provided from members of integrated community teams, State staff or others in support of the PDSA cycles.

3. Facilitation, coordination, planning and implementation of:

   a. Local meetings with each integrated community team at least monthly as determined by community teams.
   b. Statewide webinars on an every-other-month basis.
   c. In-person learning sessions on an every-other-month basis for the first six months, then at a frequency determined by the State.

   Examples of this work include obtaining faculty, developing and documenting collaborative curriculum, planning agendas, developing and delivering presentations, facilitating sessions, scheduling, planning, coordinating and other meeting logistics. The State and Learning Collaborative Planning Group will provide guidance for these activities.

4. Participation in bi-weekly conference calls with State Authorized Representative, EQuIP program director or his/her designee, other State staff as appropriate, and key leadership from pilot communities to discuss general progress and next steps, mitigate challenges, and generally ensure project milestones are being met.

5. Participation in regular meetings of EQuIP facilitators (generally 2 times monthly).

6. Support for measurement and evaluation of Learning Collaborative results. Examples include:

   a. Participation in designing and developing QI measures based on curriculum.
   b. Assisting integrated teams in collecting data and analyzing results.
   c. Aggregating measures across communities.
   d. Providing input into the Learning Collaborative evaluation.

7. Identification of future curriculum items based on the first three learning sessions and creation of a toolkit and materials to be used in future collaboratives, as well as an outline for use by future QI facilitators.

ATTACHMENT B

PAYMENT PROVISIONS

The maximum dollar amount payable under this agreement is not intended as any form of a guaranteed amount. The Contractor will be paid for products or services actually performed as specified in sections I-III in Attachment A up to the maximum allowable amount specified in this agreement. State of Vermont payment terms for this contract are Net 00 days from receipt date of invoice. The payment schedule for delivered products or rates for services performed, and any additional reimbursements, are included in this agreement.

The following provisions specifying payments are:

1. FUNDING and PERIOD OF PERFORMANCE AUTHORIZATON REQUIREMENT: This contract is funded by a federal grant and subject to federal approval. No reimbursement shall be provided under this agreement without federal approval for the task, service, or product for which reimbursement is claimed.
    a. Funding for this agreement has been sought between for the time period of January 1, 2016- June 30, 2016 in the amount of $52,000. Contractor may not begin work for the time period of January 1, 2016- June 30, 2016 without written authorization from the State of Vermont. Approval for funding is contingent on CMMI authorization.

2. Contractor invoices shall be submitted monthly (using templates in Appendix 1: Required Forms) and shall include billing for the following line items:

    Facilitation
    The Contractor shall invoice the State $6,750per month for facilitation based on reporting requirements outlined in Attachment A.

    These requirements will be considered complete when the State has received the deliverables identified in the scope of work, including:

    a. Facilitation of the planning group team on an as needed basis.
    b. Monthly progress report covering progress in each community, progress across all communities, and general progress against the project management plan.
    c. Evidence of Local meetings with each integrated community team at least monthly as determined by community teams.
    d. Facilitation, coordination, planning and implementation of statewide webinars and in-person learning sessions.
    e. Participation in bi-weekly conference calls with State staff, key leadership from pilot communities, and meetings of EQuIP facilitators.

    Financial reports are due by the time the monthly invoice is submitted (see Appendix I- Required Forms).

    Milestones
    In addition to the monthly payments, milestone payments of up to $9,000, for which the Contractor can invoice the State at any point during the Contract period, will be paid as follows:
    a. Completion of an integrated community PDSA cycle: $500 per community for each cycle

b. Completion of an in-person community-wide learning session: $1000/session
c. Completion of a statewide webinar: $500/webinar
d. Creation of a toolkit and materials to be used in future collaboratives, as well as an outline for use by future QI facilitators: $1,000

Travel/Training

The Contractor may invoice the State for actual miles traveled to and from in-person meetings in-state at the most current State mileage reimbursement rate. Any out of state travel or training must be pre-approved by the State, and total travel/training must not exceed $10,000 during the contract period.

Pacific Health Policy Group #28062	
Method of Selection	RFP
Contract Amount	**Total Contract Amount (all years):**$395,000 **Performance Period 2 Total Amount (including Travel):**$90,000 **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	11/15/14-12/31/16 (Performance Period 2: 1/1/15-6/30/16)
Method of Accountability	This is a deliverables/performance-based contract where the contractors are required to submit monthly task order forms for monthly activities. Once the task order forms are approved, the contractor can commence work for that month. The contract manager(s) review the invoices, task order forms and work products each month before approving the invoices. Vermont is engaging in this contracting structure for professional services contracts to ensure that we have the skills necessary for the work to be done, but also allowing for some flexibility in a changing health care environment. Additionally, Vermont does not want to pay for unnecessary services and finds this method of accountability and management to allow for maximum benefit in contracting with entities for professional services.
Itemized Budget	The billing for this contract is time and materials. Specifically, the State of Vermont has developed a task order approval structure where the Contractor receives prior approval for all tasks. Once the task order is approved, the vendor does the work and then bills for it. The Contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the hourly rate for each staff person assigned to the contract. a. Scott Wittman:$265/hour b. Suzanne Santarcangelo:$235/hour c. Jeff Dodson:$235/hour
Budget Category	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers
Summary Statement of Work	To provide consulting support for policy development, payment and care model design and quality measurement identification as it relates to the Disability and Long Term Service and Supports (DLTSS) work group for the Vermont Health Care Innovation Project (VHCIP).
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to November 12, 2015.**
Travel Justification	Hourly rates are inclusive of travel.
Performance Period 2 Applicable Milestone	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure

	beneficiaries have access to call-center as appropriate: 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16. 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan.

Contract Attachment A, Scope of Work for Pacific Health Policy Group #28062

I. **Scope of Work:**

A. The Contractor shall provide support for the Disability and Long Term Services and Supports (DLTSS) Work Group of the Vermont Health Care Innovation Project (VHCIP). Contractor shall provide support for activities and decision-making, including, but not limited to, the following areas:
1. Care models to support integrated care for people with disabilities, chronic conditions and those needing long term services and supports.
2. Payment models to support integrated care for people with disabilities, chronic conditions and those needing long term services and supports.
3. LTSS quality and performance measures to evaluate the outcomes of people with disabilities, chronic conditions and those needing long term services and supports.
4. IT infrastructures to support new payment and care models for integrated care for people with disabilities, chronic conditions and those needing long term services and supports.
5. Strategies to incorporate person-centered, disability-related, person-directed, and cultural competency issues into all VHCIP activities.
6. Identification of barriers in current Medicare, Medicaid and commercial coverage and payment policies, and strategies to address them.
7. Other activities as identified by the Work Group to assist successful implementation of payment and care models to best support people with disabilities, chronic conditions and those needing long term services and supports.

B. The Contractor also shall support the DLTSS Work Group and leadership (i.e., VHCIP and DLTSS Project Staff, Work Group Chairs and other Consultants) by performing the following activities:
1. Work closely with VHCIP and DLTSS Work Group leadership to strategize and develop agendas for Work Group meetings, preparing handouts and preparing discussion materials
2. Actively participate in DLTSS Work Group meeting discussions
3. Conduct research on specific topics and developing summary documents and/or presentations
4. Provide ad hoc support for project leadership and achievement of VHCIP goals via telephone calls and electronic mail communications (e.g., exchange of information about project developments and updates, sharing of information regarding relevant topics, new publications and/or national news; discussion of recent events and implications for project direction; contributing to discussion about policy or operational decisions; etc.)
5. Attend VHCIP Steering Committee meetings and other VHCIP Work Group meetings as necessary to support the goals of the DLTSS Work Group.

II. **Deliverables:**

a. Submit monthly Task Orders and progress reports indicating what work is to be done and confirming what work was accomplished each month.
b. Develop and/or contribute to agendas, white papers, presentations and other materials for the VHCIP Work Groups as requested.
c. Participate in monthly VHCIP Steering Committee and work group meetings, and sub work-group meetings as needed.
d. Participate in monthly VHCIP work group planning meetings.

e. Provide research and summary documents to support VHCIP work group work plan and decision-making.
f. Work with VHCIP Project Staff regarding IT infrastructure needs by providing research, papers and documents that support Work Group recommendations and decision-making.
g. Work with VHCIP Project Staff to develop care models that support integrated care.
h. Work with VHCIP Project Staff to develop payment models that support integrated care.
i. Provide ad hoc research, analyses and communications to support VHCIP work group tasks and activities.

III. <u>Task Orders</u>

Services performed pursuant to a task order clarify and expand upon the Scope of Work otherwise already described in this Agreement. Task orders shall not be used to change the maximum amount under this agreement, nor to add to the Scope of Work. Both parties recognize that the task order process does not obviate the need for State of federal regulatory review of amendments to the scope, budget, or maximum amount of this agreement

A request for a task order proposal shall be submitted to the Contractor by the State or to the State from the Contractor. Upon review of the proposal, the State and Contractor must complete the Task Order Form (Appendix I). The Contractor has the right to submit modifications or deny any Task Order submitted by the State. The State can submit modifications or deny proposed Task Order submitted by the Contractor. The final Task Order document shall not be effective until it is signed by the Contractor, the State Authorized Representative, the Office of the Attorney General, and the DVHA Business Office. The Task Order must indicate: scope, source of funds, payment provisions, points of contact, ownership of data and any applicable data use agreement, and project specifics. No task order may increase the maximum amount payable under this contract, deviate from or add to the scope of this contract, or deviate from any term in any part or attachment to or of this contract. The task order process shall not be used in lieu of the amendment process where in the sole discretion and judgment of the State an amendment is appropriate. Each Task Order must clearly define payment either by rate per hour or deliverable received and approved. Each Task Order must be pre-approved before any work shall begin. Services performed pursuant to a Task Order shall not be eligible for reimbursement unless the Task Order is signed by all representatives listed within this section.

A Task Order may assign a Project Manager, who will act as the Authorized State Representative, solely per that task and up to the maximum amount per that task. The Project Manager assigned to a specific Task Order is the sole person authorized to assign work to the Contractor under that particular Task Order.

Changes to a Task Order shall be accomplished by written modification as agreed to by both parties and will be reflected in a new Task Order.

The State Authorized Representative is:

Georgia J. Maheras, Esq.
Project Director
Vermont Health Care Innovation Project
georgia.maheras@state.vt.us
802-505-5137

IV. <u>Monthly Reporting</u>

a. The Contractor shall participate in a conference call each month with the State regarding work under this agreement. The purpose of these calls is to discuss administrative and project issues as they arise and to report preliminary findings of analyses as they become available.

b. More frequent calls may be needed during active periods of the project.

c. The Contractor shall submit monthly Status Reports outlining all work accomplished during the previous month. The Report should detail hours expended against the Task Order for each staffing category identified:

i. Total hours authorized under the Task Order.
ii. Hours expended during the previous month.
iii. Total hours expended under the Contract to date.

These reports are to be submitted electronically to the VHCIP Project Director within five business days after the end of the month. These monthly progress reports shall be consistent with the work billed on the monthly vouchers.

d. At a minimum, monthly progress reports shall cover the following items:

i. Activities related to consultation and support related to each Awardee supported by this contract.
ii. Activities planned for the forthcoming month.
iii. Contractor's expectations of the State Staff during the forthcoming month (e.g., review of deliverables submitted, delivery of data or other items).
iv. Any problems or delays – encountered or foreseeable – that may affect contract performance.
v. Budget discrepancies greater than ten percent, i.e., cost overruns or underruns.

e. Additional planning and coordination meetings may be required during the course of the contract, depending on the State's needs.

V. Contract Administration Data – Key Personnel (See Attachment B for key personnel list and hourly rates):

a. The key personnel specified in this contract are considered to be essential to work performance. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the VHCIP Project Director and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the State of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The State may modify the contract to add or delete key personnel at the request of the Contractor or Government.

VI. Ad Hoc Tasks:

The State shall define deliverables as aligned in the scope of work by meeting with the Contractor on a bi-weekly basis in order to define and confirm inclusion of additional deliverable development as identified by the State. Ad hoc tasks shall be reduced to writing and approved by both parties on a task order form and added to the work plan on a bi-weekly basis.

VII. Performance Expectations:

The scopes of work and technical assistance provided by the Contractor shall contain specific deliverables, due dates and performance measures, and shall serve as the basis for quality assurance and a means for monitoring the contractor's performance throughout the duration of this contract.

The Contractor shall provide a single point of contact who will manage all aspects of the contract including the assignment of qualified personnel to perform the work outlined herein.

The Contractor's single point of contact or designee will be present at bi-weekly status meetings at a time and date agreed upon by the State and Contractor.

The Contractors single point of contact is:

Susan W. Besio, Ph.D.
Senior Associate
Pacific Health Policy Group

The Contractor shall work with other State staff and State Contractors as requested by the State.

The number of personnel and level of expertise required, as well as the scheduled hours to be worked will be determined by the State and the Contractor on a bi-weekly basis as part of the status meetings and shall be included on the task order form. The assignment of additional personnel, hours, or the substitution of personnel with a higher level of expertise shall require pre-approval by the State.

The Contractor accepts full responsibility for any personnel assigned to perform the work herein. It is understood that the State will provide minimal oversight of personnel assigned to this contract.

The State shall notify the Contractor's single point of contact to discuss remediation if it is determined by the State that personnel assigned are not performing as expected. The State has the right to request a change in personnel assigned. The State shall not request a change in personnel without reason. The Contractor is obligated to provide a change in personnel, within 2 business days of a request by the State.

<table>
<tr><th colspan="2">Patient Ping, #TBD</th></tr>
<tr><td>Method of Selection</td><td>RFI</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$846,900
Performance Period 2 Total Amount (including Travel):$500,000 (note that$100,000 was previously approved so the requested amount is$400,000)
Performance Period 2 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>11/1/15-12/31/16 (Performance Period 2: 11/1/15-6/30/16)</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based contract where the contractors are required to submit monthly reports identifying roll out targets and accomplishments. The vendor will only be paid for the providers that are connected to the event notification system.</td></tr>
<tr><td>Itemized Budget</td><td>The billing for this contract is a set subsidy for a service based on the service rate schedule in Attachment B of the agreement.

Expected State Subsidy costs:
<table>
<tr><th></th><th>2015
(Nov & Dec)</th><th>2016</th></tr>
<tr><td>Group 1</td><td></td><td></td></tr>
<tr><td>ACOs……………………………………………….</td><td>$100,000</td><td>$126,000</td></tr>
<tr><td>Other……………………………………………….</td><td>$0</td><td>$63,000</td></tr>
<tr><td>Group 2</td><td></td><td></td></tr>
<tr><td>Hospitals………………………………………….</td><td>$0</td><td>$200,900</td></tr>
<tr><td>Sub-acute care……………………………….</td><td>$0</td><td>$357,000</td></tr>
<tr><td>Total</td><td>$100,000</td><td>$746,900</td></tr>
</table></td></tr>
<tr><td>Budget Category</td><td>Technology and Infrastructure: Practice Transformation</td></tr>
<tr><td>Summary Statement of Work</td><td>To provide notification to Vermont's providers about admissions, discharges, and transfer[11] of Vermonters to and from hospitals, skilled nursing facilities, and other health care settings. The notification will be to those providers sending and receiving patients, as well as, a patient's primary care clinical team and an ACO.</td></tr>
<tr><td>Retroactive Start Justification (if applicable)</td><td>Funding is requested to be retroactive to November 12, 2015.</td></tr>
<tr><td>Travel Justification</td><td>Travel is not an allowable expense.</td></tr>
<tr><td>Performance Period 2 Applicable Milestone</td><td>Care Management Tools:Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development:
1. Event Notification System: Procure solution by 1/15/16 and implement according to project plan for phased roll out.</td></tr>
</table>

[11] The ADT data is provided by VITL through the State's VHIE.

Contract Attachment A, Scope of Work for Patient Ping #TBD

Contractor will make available its web-based software service to Partner Health Care Entities so that Partner HealthCare Entities can share (*i.e.*, send to and receive from) information with other Partner Health Care Entities. Contractor will make the following services available to Partner Health Care Entities for the fees agreed between Patient Ping and each Partner Health Care Entity.

Contractor's service shall allow Partner Health Care Entities to share critical timely data on patients when patients are receiving care. Contractor's services are broken into two categories:

- **Pings:** real-time notifications to Partner Health Care Entities whenever their patients receive care anywhere (ED, hospital, SNF, HHA, and elsewhere)
- **Point-of-Care Guidelines:** information delivered to Partner Health Care Entities at the point-of-care that allows admissions coordinators to access information from the patient's full care team. Information includes the name of the patient's Accountable Care Organization ("ACO") or other care program affiliation (e.g. bundles, PCMH, other), the name/contact information of the patient's Patient Care Provider ("PCP") and other care team members, a complete visit history, and other helpful information from the patient's care team.

These two services combined are intended to produce strong network effects among Partner Health Care Entities. As Partner Health Care Entities increase visibility into the other Partner Health Care Entities caring for their patients (acute, post-acute, and others), it enables greater coordination. This in turn is intended to create an incentive for others to join, connecting a greater number of Partner Health Care Entities with patients.

The State and the Contractor expect demand for these services by a wide variety of Partner Health Care Entities types in the State of Vermont. Broadly, they are categorized in two groups:

- **Group 1: Any** Partner Health Care Entity **with a pre-defined patient panel.** Partner Health Care Entities will benefit from receiving real-time notifications when their patients are admitted to or discharged from the acute and post-acute facilities at which they receive care. Partner Health Care Entities will also send guidelines to these points-of-care to share how those Partner Health Care Entities should work with their care teams to coordinate care for the patient. Guidelines may include an instruction to call an ACO care coordinator within 24 hours for certain high risk patients.
    - Examples: ACOs, Primary Care Practices, and Health Plans
- **Group 2: Any** Partner Health Care Entity **with an episode-based patient panel.** These Partner Health Care Entities will be able to access a portal that, upon admission to their facility, allows them to see the patient's complete visit history, care program affiliation, and care team contacts. Additionally, Partner Health Care Entities will be able to automatically notify the patient's care team outside their facility of an admission or discharge. Finally, Partner Health Care Entities will receive notifications when their discharged patients receive care at facilities outside their own for a pre-determined time period.
    - Examples: Hospitals, Skilled Nursing Facilities, Long-Term Acute Care Hospitals, Specialist Clinics, Home Health Agencies, Bundled Payment Risk Conveners, and other Admission Sites

Planned Implementation
PatientPing's deployment is expected to occur in three phases.

1. PatientPing will enter into the appropriate agreements to establish connectivity with Vermont Information Technology Leaders (VITL) to begin receiving VITL's Admission/Discharge/Transfer ("ADT") feeds.

2. PatientPing will receive patient rosters from early Group 1 Partner Health Care Entities (e.g. the 3 Vermont ACOs). Shortly after these rosters are configured, these providers will begin receiving notifications
3. In parallel to step 2, PatientPing will begin marketing to and contracting with Group 2 Partner Health Care Entities to access the Point-of-Care Guidelines. PatientPing shall offer Welcome Summits educating Group 2 Providers about the value of joining the PatientPing Community. Steadily over time, PatientPing expects to contract with Group 2 Partner Health Care Entities to become Ping receivers.

PatientPing will deploy its commercialization team comprised of sales, marketing, service, product, and community development to drive adoption of these services among Partner Health Care Entities in Vermont.

Prior to any patient data sharing, PatientPing will develop a solution in compliance with all applicable state and federal laws and regulations and the VHIE consent policy. The parties currently anticipate that:

a. VITL will continue to collect and maintain state-wide patient consent information.
b. HL7 data inbound to VITL will be matched by VITL to determine if the patient has given consent for their data to be shared. In the event that consent has been obtained, the HL7 message will be enriched by existing identifiers in VITL and then transmitted to PatientPing. If no consent is found, the message will not be sent to PatientPing

PatientPing will obtain patient rosters from Partner Health Care Entitiesand will use a secure service provided by VITL to determine, patient by patient, the consent status of each patient. The list of patients without consent in the VITL system will be returned to the Partner Health Care Entities to encourage patient outreach.

<table>
<tr><th colspan="2">Policy Integrity #29266</th></tr>
<tr><td>Method of Selection</td><td>Sole Source</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$92,225
Performance Period 3 Total Amount (including Travel):$30,000
Performance Period 3 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>5/15/15-11/30/16, Performance Period 3 1/1/16-11/30/16</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based contract where the contractors are required to submit monthly task order forms for monthly activities. Once the task order forms are approved, the contractor can commence work for that month. The contract manager(s) review the invoices, task order forms and work products each month before approving the invoices. Vermont is engaging in this contracting structure for professional services contracts to ensure that we have the skills necessary for the work to be done, but also allowing for some flexibility in a changing health care environment. Additionally, Vermont does not want to pay for unnecessary services and finds this method of accountability and management to allow for maximum benefit in contracting with entities for professional services.</td></tr>
<tr><td>Itemized Budget</td><td>The billing for this contract is time and materials. Specifically, the State of Vermont has developed a task order approval structure where the Contractor receives prior approval for all tasks. Once the task order is approved, the vendor does the work and then bills for it. The Contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the hourly rate for each staff person assigned to the contract. The Contractor’s hourly rates are competitive within the health care consultant sector and fall within the midrange of hourly rates for contractors involved in this work across the country.

<table><tr><th>Key Personnel</th><th>Hourly Rate</th></tr><tr><td>Steven Kappel</td><td>$200.00</td></tr></table></td></tr>
<tr><td>Budget Category</td><td>Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms</td></tr>
<tr><td>Summary Statement of Work</td><td>Technical assistance for provider grant program. Analysis on Delivery System Design and Organization, Data & Financial Analysis.</td></tr>
<tr><td>Unique Qualifications (if Sole Source)</td><td>Policy Integrity is uniquely qualified to perform these tasks for several reasons:
1. Steve Kappel of Policy Integrity has been working with Vermont’s data systems for over two decades. His experience with Vermont’s health care landscape began as a regulator of hospitals and insurance companies. He has worked in the private sector and for the state and has focused his consulting work on Vermont’s claims and expenditure data. It is the combination of his familiarity with Vermont’s health care system, in-depth knowledge of health care reform initiatives and the unique nature of Vermont’s large data sets is unparalleled.
2. Policy Integrity also has other staff familiar with Vermont’s payment and delivery system models and key personnel can draw on that expertise to inform this work. This allows Vermont to maximize efficiencies in contracting.
Policy Integrity is able to begin this work immediately. The SIM Project requires Vermont adhere to extremely tight timeframes for payment and care model development. Delaying procurement of a vendor to conduct this work would significantly jeopardize the ability of Vermont to meet critical milestones and metrics.</td></tr>
<tr><td>Retroactive Start</td><td>1/1/16</td></tr>
</table>

Justification (if applicable)	
Travel Justification	Hourly rates are inclusive of travel.
Applicable Y2 Milestone	1) State Activities to Support Model Design and Implementation – Medicaid: 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan. 2) Sub-Grant Program – Technical Assistance: Provide technical assistance to sub-grantees as requested by sub-grantees: 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.

Contract Attachment A, Scope of Work for Policy Integrity #29266

1. Develop Scopes of Work with Grant Program Awardees
   a. The Contractor shall develop detailed scopes of work, including timeline and total cost, with awardees and the State of Vermont. The State will pay the Contractor for the time spent on the development of each scope of work.
   b. Once the detailed scopes of work are completed, and approved by the State of Vermont, the Contractor shall create a work-plan for providing the technical assistance necessary for all of the approved scopes of work.
   c. The State shall work with the Contractor to develop a work plan to identify the prioritization and scheduling of the development of deliverables as prioritized by the State. Before any work may begin, Contractor shall submit a task order outlining performance of work. Task orders are to be approved and signed by the designated representative of the State prior to any work commencement.

2. Technical Assistance Support to Grant Program Awardees
   a. The Contractor shall provide consultative support to the approved Grant Program Awardees. The Contractor will not begin work on any scopes of work without express written approval by the State of Vermont.
   b. The areas of consultation that may be necessary in order to accomplish this task may include, but are not limited to:
      i. Advice on Delivery System Design and Organization
      ii. Data Analysis
      iii. Financial Analysis
   c. The Contractor shall provide monthly reports to the State of Vermont regarding progress on each of these technical assistance scopes of work. The Contractor should be prepared to consult with the State of Vermont in development of written documentation and presentations to State and CMMI in order to support this effort.
   d. The Contractor's level of effort will vary according to the needs of each Awardees reform agenda and the degree to which state staff or consultants retained are capable of providing all needed support.
   e. The level of effort for each individual Awardee shall be agreed upon between the state and SIM staff upon award of the grant.

3. Monthly Reporting
   - The Contractor shall participate in a conference call each month with the State of Vermont regarding this work. The purpose of these calls is to discuss administrative and project issues as they arise and to report preliminary findings of analyses as they become available.
   - More frequent calls may be needed during active periods of the project.
   - The contractor shall submit monthly progress reports outlining all work accomplished during the previous

month. The reports should be concise and in a simple format (e.g., bulleted list) approved by the State of Vermont. These reports are to be submitted electronically to the VHCIP Project Director within five business days after the end of the month. These monthly progress reports shall be consistent with the work billed on the monthly vouchers.

- At a minimum, monthly progress reports shall cover the following items:
    i. Activities related to consultation and support related to each Awardee supported by this contract
    ii. Activities planned for the forthcoming month
    iii. Contractor's expectations of the State Staff during the forthcoming month (e.g., review of deliverables submitted, delivery of data or other items)
    iv. Any problems or delays – encountered or foreseeable – that may affect contract performance
    v. Budget discrepancies greater than ten percent, i.e., cost overruns or underruns.
- Additional planning and coordination meetings may be required during the course of the contract, depending on the needs of each SIM Demonstration.

4. Contract Administration Data – Key Personnel (See Attachment B for key personnel list and hourly rates)
    a. The key personnel specified in this contract are considered to be essential to work performance under this Agreement. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the Contracting Officer and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the State of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The State may modify the contract to add or delete key personnel at the request of the contractor or Government.

5. Performance Expectations:
The Contractor shall develop monthly Task Orders. Each Task Order will include deliverables. Deliverables shall consist of quantifiable products or services resulting from activities performed pursuant to this Agreement. Such deliverables may include, but are not limited to the following:

    1. Technical Assistance Scopes of Work
    2. Work Plan Development
    3. Ad Hoc Tasks
    4. Technical Assistance tasks

No work shall be undertaken or reimbursed pursuant to this Agreement, other than obligations specifically set forth in section 3 of this Attachment A, without a Task Order approved in writing by the State's designated representative. The State's designated representative is:

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

Jessica Mendizabal
Grants & Contract Administrator
jessica.mendizabal@state.vt.us
802-878-7958

The scopes of work and technical assistance provided by the Contractor shall contain specific deliverables, due

dates and performance measures, and shall serve as the basis for quality assurance and a means for monitoring the contractor's performance throughout the duration of this contract.

The Contractor shall provide a single point of contact who will manage all aspects of the contract including the assignment of qualified personnel to perform the work outlined herein.

The Contractor's single point of contact or designee will be present at bi-weekly status meetings at a time and date agreed upon by the State and Contractor.

The number of personnel and level of expertise required, as well as the scheduled hours to be worked, will be determined by the State and the Contractor during the status meetings and shall be included on the task order forms. The assignment of additional personnel, hours, or the substitution of personnel with a higher level of expertise shall require pre-approval by the State.

The Contractor accepts full responsibility for any personnel assigned to perform the work herein. It is understood that the State will provide minimal oversight of personnel assigned to this contract.

The State shall notify the Contractor's single point of contact to discuss remediation if it is determined by the State that personnel assigned are not performing as expected. The State has the right to request a change in personnel assigned. The State shall not request a change in personnel without reason. The Contractor is obligated to provide a change in personnel, within 2 business days of a request by the State.

6. Ad Hoc Tasks:
   The State shall define deliverables as aligned in the scope of work by meeting with the Contractor on a bi-weekly basis in order to define and confirm inclusion of additional deliverable development as identified by the State. Ad hoc tasks shall be reduced to writing and approved by both parties on a Task Order form and added to the work plan on a bi-weekly basis.

<table>
<tr><th colspan="2">Stone Environmental #28427</th></tr>
<tr><td>Method of Selection</td><td>RFP</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$250,000
Performance Period 2 Total Amount (including Travel):$165,000 (note that$80,000 was previously approved so the requested amount is$<u>85,000</u>)
Performance Period 2 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>2/15/15-12/31/16 (Performance Period 2: 2/15/15-6/30/16)</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based contract where the contractors are required to perform specific tasks according to a timeline and project plan. Contractors are required to submit monthly task order forms for monthly activities. Once the task order forms are approved, the contractor can commence work for that month. The contract manager(s) review the invoices, task order forms and work products each month before approving the invoices. Vermont is engaging in this contracting structure for professional services contracts to ensure that we have the skills necessary for the work to be done, but also allowing for some flexibility in a changing health care environment. Additionally, Vermont does not want to pay for unnecessary services and finds this method of accountability and management to allow for maximum benefit in contracting with entities for professional services.</td></tr>
<tr><td>Itemized Budget</td><td>The billing for this contract is based on hourly rates for the Contractor as well as several subcontractors selected to perform writing and design work. The contractor will be paid through monthly invoices as described in Attachment B of the agreement of the agreement.

Hourly Rate:
<table><tr><th>Title</th><th>Hourly Rate</th></tr><tr><td>Principal/Program Manager</td><td>177</td></tr><tr><td>Senior Professional 1</td><td>134</td></tr><tr><td>Project Professional 1</td><td>103</td></tr><tr><td>Accountant 1</td><td>62</td></tr><tr><td>Subject Matter Expert</td><td>150</td></tr><tr><td>Project Management</td><td>150</td></tr><tr><td>Subject Matter Expert 2</td><td>125</td></tr></table></td></tr>
<tr><td>Budget Category</td><td>Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers</td></tr>
<tr><td>Summary Statement of Work</td><td>Assist the HIE/HIT Work Group in developing policy and spending recommendations in the area of technology and infrastructure.</td></tr>
<tr><td>Retroactive Start Justification (if applicable)</td><td>Funding is requested to be retroactive to November 12, 2015.</td></tr>
<tr><td>Travel Justification</td><td>Hourly rates are inclusive of travel.</td></tr>
<tr><td>Performance Period 2 Applicable</td><td>1) Data Warehousing:
3. Develop a cohesive strategy for developing data systems to support analytics by 3/31/16.</td></tr>
</table>

Milestones	2) Care Management Tools: Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development: 2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16. 3) General Health Data – HIE Planning: 1. VHCIP will provide comment into the HIT Strategic Plan at least 4 times in 2015. 2. HDI work group will identify connectivity targets for 2016-2019 by 6/30/16. 4) General Health Data – Expert Support: 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.

Contract Attachment A, Scope of Work for Stone Environmental #28427

I. **Scope of Work:**

A. The Contractor shall provide support for the HIE/HIT Work Group of the Vermont Health Care Innovation Project (VHCIP). Contractor shall provide support for activities and decision-making, including, but not limited to, the following areas:

1. Industry and cross-industry best practices for improving the interoperability of data in source systems;
2. Technologies that improve the integration of health care services and enhance communication among providers;
3. Advanced analytics and data systems;
4. Methods and technologies for improved extraction of data elements;
5. Technology options for providing health information to consumers;
6. Subject matter expertise in the areas of Health Information Exchange, Health Information Technology, health care data, Project Management, and Information Technology;
7. Contract and vendor management support for the HIE/HIT Work Group's major funding initiatives including, but not limited to: Advancing Care through Technology (ACTT) Project; Population Health ACO project, and Telemedicine;

B. The Contractor also shall support the HIE/HIT Work Group and leadership (i.e., VHCIP and HIE/HIT Project Staff, Work Group Chairs and other Consultants) by performing the following activities:

1. Work closely with VHCIP and HIE/HIT Work Group leadership to strategize and develop agendas for Work Group meetings, preparing handouts and preparing discussion materials
2. Actively participate in HIE/HIT Work Group meeting discussions
3. Conduct research on specific topics and developing summary documents and/or presentations
4. Provide ad hoc support for project leadership and achievement of VHCIP goals via telephone calls and electronic mail communications (e.g., exchange of information about project developments and updates, sharing of information regarding relevant topics, new publications and/or national news; discussion of recent events and implications for project direction; contributing to discussion about policy or operational decisions; etc.)
5. Attend VHCIP Steering Committee meetings and other VHCIP Work Group meetings as necessary to support the goals of the HIE/HIT Work Group.

II. **Deliverables:**

a. Submit monthly Task Orders and progress reports indicating what work is to be done and confirming what work was accomplished each month.

b. Develop and/or contribute to agendas, presentations and other materials for the VHCIP Work Groups as requested.
c. Participate in monthly VHCIP Steering Committee and work group meetings, and sub work-group meetings as needed.
d. Participate in monthly VHCIP work group planning meetings.
e. Provide research and summary documents to support VHCIP work group work plan and decision-making.
f. Work with VHCIP Project Staff regarding IT infrastructure needs by providing research, papers and documents that support Work Group recommendations and decision-making.

III. Task Orders

Services performed pursuant to a task order clarify and expand upon the Scope of Work otherwise already described in this Agreement. Task orders shall not be used to change the maximum amount under this agreement, nor to add to the Scope of Work. Both parties recognize that the task order process does not obviate the need for State of federal regulatory review of amendments to the scope, budget, or maximum amount of this agreement.

A request for a task order proposal shall be submitted to the Contractor by the State or to the State from the Contractor. Upon review of the proposal, the State and Contractor must complete the Task Order Form (Appendix I). The Contractor has the right to submit modifications or deny any Task Order submitted by the State. The State can submit modifications or deny proposed Task Order submitted by the Contractor. The final Task Order document shall not be effective until it is signed by the Contractor, the State Authorized Representative, the Office of the Attorney General, and the DVHA Business Office. The Task Order must indicate: scope, source of funds, payment provisions, points of contact, ownership of data and any applicable data use agreement, and project specifics. No task order may increase the maximum amount payable under this contract, deviate from or add to the scope of this contract, or deviate from any term in any part or attachment to or of this contract. The task order process shall not be used in lieu of the amendment process where in the sole discretion and judgment of the State an amendment is appropriate. Each Task Order must clearly define payment either by rate per hour or deliverable received and approved. Each Task Order must be pre-approved before any work shall begin. Services performed pursuant to a Task Order shall not be eligible for reimbursement unless the Task Order is signed by all representatives listed within this section.

A Task Order may assign a Project Manager, who will act as the Authorized State Representative, solely per that task and up to the maximum amount per that task. The Project Manager assigned to a specific Task Order is the sole person authorized to assign work to the Contractor under that particular Task Order.

Changes to a Task Order shall be accomplished by written modification as agreed to by both parties and will be reflected in a new Task Order.

Monthly Reporting

a. The Contractor shall participate in a conference call each month with the State regarding work under this agreement. The purpose of these calls is to discuss administrative and project issues as they arise and to report preliminary findings of analyses as they become available.
b. More frequent calls may be needed during active periods of the project.
c. The Contractor shall submit monthly Status Reports outlining all work accomplished during the previous month. The Report should detail hours expended against the Task Order for each staffing category identified:
    i. Total hours authorized under the Task Order.
    ii. Hours expended during the previous month.
    iii. Total hours expended under the Contract to date.

These reports are to be submitted electronically to the VHCIP Project Director within five business days after the end of the month. These monthly progress reports shall be consistent with the work billed on the monthly vouchers.

d. At a minimum, monthly progress reports shall cover the following items:
   i. Activities related to consultation and supported by this contract.
   ii. Contractor's expectations of the State Staff during the forthcoming month (e.g., review of deliverables submitted, delivery of data or other items).
   iii. Any problems or delays – encountered or foreseeable – that may affect contract performance.
   iv. Budget discrepancies greater than ten percent, i.e., cost overruns or underruns.

e. Additional planning and coordination meetings may be required during the course of the contract, depending on the State's needs.

IV. Contract Administration Data – Key Personnel (See Attachment B for key personnel list and hourly rates):

a. The key personnel specified in this contract are considered to be essential to work performance. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the VHCIP Project Director and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the State of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The State may modify the contract to add or delete key personnel at the request of the Contractor or Government.

V. Ad Hoc Tasks:

The State shall define deliverables as aligned in the scope of work by meeting with the Contractor on a monthly basis in order to define and confirm inclusion of additional deliverable development as identified by the State. Ad hoc tasks shall be reduced to writing and approved by both parties on a task order form and added to the work plan on a bi-weekly basis.

VI. Performance Expectations:

The Contractor shall provide a single point of contact who will manage all aspects of the contract including the assignment of qualified personnel to perform the work outlined herein.

The Contractor's single point of contact or designee will be present at monthly status meetings at a time and date agreed upon by the State and Contractor.

The Contractor shall work with other State staff and State Contractors as requested by the State.

The number of personnel and level of expertise required, as well as the scheduled hours to be worked will be determined by the State and the Contractor on a bi-weekly basis as part of the status meetings and shall be included on the task order form. The assignment of additional personnel, hours, or the substitution of personnel with a higher level of expertise shall require pre-approval by the State.

The Contractor accepts full responsibility for any personnel assigned to perform the work herein. It is understood that the State will provide minimal oversight of personnel assigned to this contract.

The State shall notify the Contractor's single point of contact to discuss remediation if it is determined by the State that personnel assigned are not performing as expected. The State has the right to request a change in personnel assigned. The State shall not request a change in personnel without reason. The Contractor is obligated to provide a change in personnel, within 2 business days of a request by the State.

The Lewin Group #27060	
Method of Selection	RFP
Contract Amount	**Total Contract Amount (all years):**$2,200,000 **Total Amount (including Travel):**$293,000.00 **Out-of-State Travel:**$0
Contract Term	7/1/14-9/30/17 (Performance Period 2: 1/1/15-6/30/16)
Method of Accountability	This is a deliverables/performance-based contract where the contractors are required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The contract manager(s) review the invoices and work products each month before approving the invoices.
Itemized Budget	The billing for this contract is fixed price based on the scope of work. The contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the cost for each component of the work. There is an optional ad hoc provision for additional reports and the payment structure for this is hourly rate by staff person category. The Contractor’s hourly rates are competitive within the health care consultant sector and fall within the midrange of hourly rates for contractors involved in this work across the country.

Labor Category	Hourly Rate
Vice President	$275.00
Managing Consultant	$250.00
Senior Consultant	$225.00
Consultant	$165.00
Research Consultant	$140.00
Senior Research Consultant	$90.00

January 1, 2015-December 31, 2015		
Task	**Name**	**Fixed Price**
3.2.A	ACO Financial Performance	$ 127,134
3.2.B	ACO Performance Measures	$ 219,895
3.2.C	Impact of ACO Quality Performance	$ 37,350
3.2.D	Report Design and Generation	$ 75,032
3.2.E.1	Assessment VHCURES Database	$ 9,818
3.2.E.2	Assessment ACO Expenditures	$ 12,300
3.2.E.3	Annual Sample Measure-Eligible Patients	$ 12,277
3.2.E.4	Ad-hoc Reports	$ 16,160
3.2.E.5	VHCIP Work Group	$ 11,480
3.2.E.6	Review Results and Reconcile Inconsistencies	$ 14,240
3.2.E.7	Provide Feedback and Advice	$ 39,040
Fixed Price		**$ 574,725**
Travel Costs		**$ 9,743**

July 1, 2015 – June 30, 2016		
Contract Section	Name	Fixed Price
4	ACO Financial Performance	$ 110,930
5, 6	ACO Performance Measures	$ 218,020
7	Impact of ACO Quality Performance	$ 53,800
8	Report Design and Generation	$ 83,240
3b	Assessment VHCURES Database	$ 6,930
4	Assessment ACO Expenditures	$ 12,300
3	Annual Sample Measure-Eligible Patients	$ 12,250
8	Ad-hoc Reports	$ 16,160
1,5,8	VHCIP Work Group	$ 11,480
4,5,6,8,1	Review Results and Reconcile Inconsistencies	$ 14,240
1	Provide Feedback and Advice	$ 39,040
Fixed Price		**$ 558,400**
Travel Costs		**$ 9,743**

Budget Category	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers
Summary Statement of Work	Build a model for multiple ACOs that accepts key inputs, such as total shared savings, quality scores and scoring criteria, and calculate the final shared savings to be delivered to each ACO.
Retroactive Start Justification (if applicable)	This agreement was previously approved by CMMI in 2014 and re-submitted on November 20, 2014, for work to continue in 2015. The approval for 2015 work is requested to be retroactive to January 1, 2015.
Travel Justification	**The estimated travel for is:$9,743** The contract personnel (estimated 3 people/trip) will travel to Vermont twice in Performance Period 2 from Washington D.C. (Virginia). *Estimated cost per trip, Washington, D.C., to Burlington:$4,762.13* • Ground transportation for 3 person:$500 • Taxi/Local Travel/Parking at Base Airport:$350 • Airfare for 1 person/each:$350 (ORD),$650 (IAD) and$650 (PHX) round trip • Hotel (Vermont) for 1 person ($125 x 3 nights):$375 • Per diem 1 person/trip:$48.57
Performance Period 2 Applicable Milestones	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) Self-Evaluation Plan and Execution: 2. Continue to execute self-evaluation plan using staff and contractor resources. 3) Monitoring and Evaluation Activities Within Payment Programs: Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: Monthly, quarterly reports depending on type.

Contract Attachment A, Scope of Work for The Lewin Group #27060

The Contractor will build a model for multiple ACOs that accepts key inputs, such as total shared savings, quality scores and scoring criteria, and calculate the final shared savings to be delivered to each ACO. The Contractor will detail key calculations in a series of Excel workbook tabs. There will be a quality measure tab in which the user can enter the quality score percentile. There will be a scoring assumption tab which will map ranges of quality scores to actual points. These tabs will both be easily updatable, should the scoring criteria change. There will be a scoring tab which will calculate both the total points available and the points achieved by the specific ACO. On the scoring assumption tab, Contractor will provide a table to translate the percentage of total points to a percentage of total savings. Finally, there will be a savings distribution tab, in which the user can enter the total shared savings, which will calculate the earned savings by multiplying the total shared savings by the percentage of total savings earned.

The Contractor will provide the State with opportunities to review the model and the results during and after model development and after the calculation of the shared savings distribution . The assumptions, input values, and calculations will be reviewed by the Contractor and the State on a consistent basis to ensure accuracy.

The Contractor will automate the current steps defined by the State, review the methodology and review the initial results. This will be described in the work plan. The Contractor will test the assumptions. The Contractor will make any changes requested by the State based on the State's methodology review.

The Contractor will document the final results for quality and financial measures in a summary document for the State and individual documents for each ACO. The Contractor will include detail about the methodology used and include quality scores, scoring criteria and total shared savings.

1. **<u>Project Management, Organization and Communication Strategy:</u>**

This project shall start with an in-person kick-off meeting between the Contractor and the State. The purpose of the meeting, which will occur within two weeks of the contract signing, will be to establish a partnership between the Contractor and the State to support a shared understanding of State goals and the approach to completing project tasks. The Contractor will also clarify project objectives and priorities, refine the scope of work and technical approach, clarify contract requirements and expectations, establish an overall communication plan (including regularly scheduled calls with the State to provide project updates), and discuss timelines for completing each task. The kick-off meeting will provide an opportunity for the State to offer feedback on recommended technical approaches, share background information on Vermont's health care environment and providers participating in payment and delivery system reform pilots, and provide initial specifications of the content and time line for project deliverables. The Contractor's Project Director will participate in on-site meetings that pertain to this contract, as requested and will attend additional meetings either in person or via conference call or webinar as reasonably requested.

a. Key Personnel

Project Director: Steve Johnson, PhD, MS, Vice President
Sub ject Matter Expert: Nancy Walczak, FSA, PhD, Vice President Actuarial Analysis:
Scott Smith (Lead), Senior Consultant Colby Schaeffer, Actuarial Consultant Lia Bunch, Consultant
Tanya Disney, Research Consultant Michael Holcomb, Actuarial Analyst
Performance Measures:
Linda Shields (Lead), RN, BSN, Vice President Tim Prinz, Senior Consultant
Julie Trottier, Senior Consultant
Dave Schafer, Solutions Manager OPTUM Sailaja Prakriya, Senior Consultant
Dan Labson, Senior Research Analyst
Reporting:
Michael Cristiani (Lead), Senior Consultant Matt Trott, Actuarial Research Consultant Dan Labson, Senior Research Analyst

2. Work Plan Development

The Contractor will develop and provide a work plan that details contract deliverables and timelines. The work plan will be developed to meet the deadlines in the timeline provided in Attachment G. If the Contractor identifies a need to change some of the deadlines, the Contractor will notify the State and a new, mutually agreed upon date will be established. The work plan is due four weeks after the kick-off meeting.

3. Data Collection and Assessment

The Contractor will sign Data Use Agreements (DUAs) and comply with all applicable state requirements to obtain data. The Contractor will develop a data security plan and provide a secure file transfer protocol.

The Contractor will rely on the following data:

i. Claims data from the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)
ii. Claims member demographics and member term data from BlueCross & BlueShield of Vermont, MVP Health Care, Inc. and Vermont Medicaid
iii. Clinical measures (numerator and denominator) data from OneCare Vermont, Accountable Care Coalition of the Green Mountains, and Community Health Accountable Care and the providers within each of those Accountable Care Organizations (ACOs).
iv. Survey data provided by the State including, but not limited to: patient experience survey data, BRFSS data and Household Health Insurance Survey Data.

a. Data Validity

The Contractor will ensure data are valid each year. The Contractor will detail measurement requirements, data availability, and alignment with project timelines. The Contractor's data validation process will identify any potential timing problems. The Contractor will begin data validation at contract execution and depending on the data issues identified, the Contractor expects this phase to take three months, including the preparation of the validation report. The Contractor's data validation process will include the following validations:

i. Standardized Data Checks

After loading the data and verifying control totals, the Contractor will run existing SAS programs to provide several standard validation analyses. These analyses will include:

- Date of Service Volume Analyses: The Contractor will trend claim volume by category of service and time to identify any potential gaps in submissions, as well as provide an initial view of data completeness.
- Analysis of Valid Values: The Contractor will generate simple frequencies for key fields by payer to potentially identify anomalies or differences in how fields are populated by payer.
- Claim to Provider and Member Linkage Analysis: The Contractor will ensure that all provider identifiers found in claims match to providers found in the corresponding provider table.
- Analysis of Quality of Diagnosis Reporting: A key driver of the risk scores computed for each payer will be the quality of the diagnosis information it reports on its claims. The Contractor will compute the percentage of claims for each major category of service with 1, 2, 3, and 4 or more diagnosis codes for each payer.
- Analysis of Risk Score Credibility: If the prior analyses raise data completeness or quality concerns for any payer, the Contractor will independently validate scores using the Symmetry Pharmacy Risk Grouper (PRG) using only pharmacy data.

ii. Actuarial Analyses

The Contractor will create standard actuarial measures of data completeness such as lag triangles on a category-of-service

basis that measure the length of time from when a service was provided to when a service was paid. If variation in the data requires manual adjustments to lag factors for large claims, asymmetric information or other volatility in claims processing, the Contractor will make such adjustments. The Contractor will apply professional judgment in assessing data completeness and making necessary adjustments to the claim lag triangles.

The Contractor will provide the State with a written report summarizing the primary data issues and the methodology used to select data for savings calculations, along with detailed supporting validation results. This report will summarize the standard data checks, show comparison to reference totals, and include actuarial analyses. The Contractor will provide payer-specific data validation results.

iii. Medical Coding Assessment

The Contractor will identify and evaluate the impact of improvements in medical coding practices on member risk scores. The Contractor will provide a proposed methodology for this analysis to the State for review and approval no later than December 1, 2014. The proposed methodology will incorporate three different testing strategies to determine the financial effect of changes in medical coding practices:

- Constant Cohort Test
- Pharmacy Risk Grouper (PRG)/ Episode Risk Grouper (ERG) Risk Score Test
- Diagnosis Frequency Test

For the Constant Cohort Test, the Contractor will select a continuously enrolled population sample using two years of complete claims data. Using the Symmetry ERG, the Contractor will calculate risk scores for the population for Year One and compare that with the risk scores in Year Two. The ERG scores are based on the mix of diagnosis codes documented on claims. The population risk scores from year one will be the baseline. Using this same cohort population, the Contractor will calculate risk scores for Year Two and compare that score with Year One. The Contractor would consider risk score increases in excess of 1-2% as one indication of improvements in coding impacting risk scores.

The Contractor will conduct a PRG/ERG Risk Score Test that uses both the Symmetry PRG and the ERG over two years to measure the change in coding practices. Based on the expectation that providers are not changing prescribing patterns due to payment methodology changes, the change in the PRG risk score from year one to year two will provide a baseline for observed acuity change in the population. ERG risk scores, on the other hand, will be impacted by changes in medical coding practices. The Contractor will compare the change in ERG scores with the change in PRG risk scores from Year One to Year Two and evaluate whether the ERG scores were impacted by a change in medical coding practices.

The Contractor will also perform an analysis of diagnosis code position frequencies . Using two years of data, the Contractor will calculate the number of claims with one, two, three and four or more diagnosis codes reported on each claim. The Contractor will then compare these Year One frequencies with Year Two frequencies. Similarly, the Contractor will calculate the number of disease conditions identified for each patient using the chronic/clinical indicators generated by the ERG grouper. Based upon an evaluation of diagnosis codes, the ERG grouper creates 239 variables that identify the acute and chronic/clinical conditions that were reported for on the medical claims for a member. The Contractor will use these variables to identify the number of members with 1,2,3,4 or more chronic/clinical conditions in Year One and Year Two. Increases in the number of diagnoses reported on claims and increases in the number of chronic/ clinical conditions identified for the average member will be indicative of improvements in medical coding.

iv. ACO Medical Record Sampling

The Contractor will draw statistically valid samples from the claims data provided by the payers in each performance year. The Contractor will generate a sample in the size specified by the State that contains only measure-eligible patients and provides all information in a statistically valid sample that can be used by the ACOs to perform the medical records review. These samples will be used by the State for medical record review.

v. Comparison to Reference Totals

The Contractor will compare total expenditures and member months to other existing data sources, such as health plan financial reports, to ensure that the correct subset of data has been included for calculation of ACO savings. The Contractor will verify totals in VHCURES (VHCURES contains a Use Flag field that should assist in identifying the correct subset of data). The Contractor will work with commercial insurers to obtain comparable reference totals and to resolve any identified differences.

b. VHCURES

The Contractor will assess the VHCURES as a source for both ACO financial performance measurement and claims based cost, quality, and utilization measures. The Contractor will assess the timeliness and completeness of VHCURES, beyond an analysis of claims lag or simple frequencies.

4. Calculation of ACO Financial Performance and Calculation of the Distribution of Earned Savings Payments:

The Contractor will calculate finance performance and distribution of earned savings payments for both the Medicaid and Commercial programs. The Contractor will use the State's methodology as identified in the Medicaid Contracts for the Medicaid program (found here: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/onecare-base-contract-signed.pdf) and as identified in the "Compilation of Pilot Standards" for the Commercial program (Attachment F). The Contractor will perform this process in conformance with the timeline provided in "Timeline for Process of ACO Calculations of Financial Performance and Payment Distribution" (Attachment H). The Contractor will perform different steps for the Commercial and Medicaid programs. These processes for both programs are described below:

a. **Medicaid Program:** The Contractor will follow several steps for this activity. The Contractor will inform the state if any of these steps need to be adjusted:

i. Step 1 : Patient Attribution

The Contractor will attribute patients using the State's attribution methodology as found in the Medicaid Contracts for the Medicaid program and will work with the State and Medicaid to identify any steps necessary to complete these tasks in addition to those listed below for attribution:

- Initial attribution will be through claims;
- Subsequently by the member's selected or assigned PCP; and
- The Contractor will utilize a 12-month look-back period to verify that ACO members are appropriately assigned.

The Contractor will perform a final eligibility check that ensures that members may be attributed to only one ACO per month, which eliminates the risk of duplicate records.

ii. Step 2: Aggregate Claims Experience

The Contractor will match eligible ACO members' member identification numbers with the claims data for the measurement period. The Contractor will classify claims into service categories based on the core services for the Medicaid program. The Contractor will exclude claims not within the core services.

iii. Step 3: Validate Data

The Contractor will validate the data. The Contractor will ensure input sources are appropriate, control totals reconcile with summary data, data fields are imported correctly and reasonable values are found within each of the fields. The Contractor will compute the total number of claims and unduplicated recipients for each month of enrollment and for each category of service . The Contractor will determine if the volume of data received is consistent and meets expected benchmarks. The Contractor will identify outlier months within the data that could be erroneous due to potential errors in claims processing or enrollment rosters. The Contractor will discuss data anomalies with the State and payers to ensure issues are addressed as soon as possible.

iv. Step 4: Utilization Adjustments

The Contractor will adjust the completed claims data following the method prescribed by DVHA. The Contractor will also explore other steps to normalize the data prior to modeling. The Contractor will not do any additional normalizing of the data without consultation with Medicaid. After the base data has been adjusted to reflect expected utilization and prices for the Total Cost of Care (TCOC) calculation period, the Contractor will risk adjust the claims experience, apply utilization and unit cost trends, and truncate the data to smooth the impact of outliers such as large claims.

v. Step 5: Apply Risk Adjustment

The Contractor will risk adjust the base data to take into account the acuity of the population, expected changes in utilization and unit cost by applying trend projections, and smooth the data by smoothing outlier claims and members. The Contractor will use diagnosis codes in the CMS' hierarchical condition category found in the most current community version of the software (CMS-HCC) for the Medicaid program. The Contractor will work with the State to ensure the risk adjustment is performed appropriately.

vi. Step 6: Trend Adjusted Experience Forward

For the expected TCOC calculations, the Contractor will apply trend to the base data to bring it to the same period (performance year) as actual costs when calculating shared savings. The Contractor will calculate Cumulative Average Growth Rate (CAGR) at the category of service level for each ACO population.

vii. Step 7: Ad just for Pricing Changes

The Contractor will advise the State as to whether this step should be performed at this stage or a different stage based on review of the data. The Contractor will apply pricing changes to the data to keep it on the same basis as actual data in the performance year. Such pricing changes may include shifts in the Medicaid fee schedule, benefit adjustments, program changes, and other regulatory or economic factors.

viii. Step 8: Truncate Costs at Member Level

Using the State defined methodology, the Contractor will truncate Medicaid expenses at the ggth percentile of annual cost per member. The Contractor will notify the State of any additional outliers and the impact of various smoothing techniques.

ix. Step 9: Summarize TCOC Figures to Determine Savings

The Contractor will provide the expected and actual TCOC figures to the State for review and determination of whether the ACO generated savings. The Contractor will perform this activity twice for each performance year. The first will be an interim analysis in April prior to complete claims data run-out. The second will be in August after six months of claims run-out.

b. Commercial Program

The Contractor will follow several steps for this activity. The Contractor will inform the state if any of these steps need to be adjusted:

i. Step 1 : Patient Attribution

The Contractor will attribute patients using the State's attribution methodology as identified in Attachment F.

The Contractor will engage in the following Commercial program attribution activities:

- Verify that the employer is situated in Vermont or the commercial member is a Vermont resident;
- Ensure that the insurer participating in the ACO is the primary payer for the commercial member;
- Allocate selected primary care providers (PCPs) to members; and
- Use the Blueprint for Health (Blueprint) list of qualifying current procedural terminology (CPT) codes to attribute other members and using the Blueprint attribution methodology to assign those members to the practice in which they have the greatest number of qualifying claims.
- The Contractor will utilize a 24-month look-back period to verify that ACO members are appropriately assigned.

The Contractor will perform a final eligibility check that ensures that members may be attributed to only one ACO per month, which eliminates the risk of duplicate records.

ii. Step 2: Aggregate Claims Experience

The Contractor will match eligible ACO members' member identification numbers with the claims data for the measurement period. The Contractor will classify claims into service categories based on the core services for the Commercial program. The Contractor will exclude claims not within the core services.

iii. Step 3: Validate Data

The Contractor will validate the data. The Contractor will ensure input sources are appropriate, control totals reconcile with summary data, data fields are imported correctly and reasonable values are found within each of the fields. The Contractor will compute the total number of claims and unduplicated recipients for each month of enrollment and for each category of service. The Contractor will determine if the volume of data received is consistent and meets expected benchmarks. The Contractor will identify outlier months within the data that could be erroneous due to potential errors in claims processing or enrollment rosters. The Contractor will discuss data anomalies with State and payers to ensure issues are addressed as soon as possible.

iv. Step 4: Apply Incurred But Not Reported (IBNR } Factors

The IBNR factor is only applicable for the Commercial Program. The Contractor will develop an ACO-specific IBNR completion factor for categories of service for each participating insurer. The IBNR factor is not applicable for the Medicaid program. The State may ask the Contractor to develop an IBNR factor for the Medicaid program for years two and three of that program. If the State makes this request, the Contractor will develop an ACO-specific IBNR factor for the Medicaid program.

v. Step 5: Utilization Adjustments

The Contractor will adjust the completed claims data for unanticipated events that would impact medical expenses or payer assumptions.

The Contractor will also explore other steps to normalize the data prior to modeling. The Contractor will not do any additional normalizing of the data without consultation with the State. After the base data has been adjusted to reflect expected utilization and prices for the Total Cost of Care (TCOC) calculation period, the Contractor will risk adjust the claims experience, apply utilization and unit cost trends, and truncate the data to smooth the impact of outliers such as large claims.

Step 6 : Apply Risk Adjustment

The Contractor will risk adjust the base data to take into account the acuity of the population, expected changes in utilization and unit cost by applying trend projections, and smooth the data by smoothing outlier claims and members. The Contractor will use diagnosis codes in The Center for Consumer Information & Insurance Oversight (CCIIO) risk adjustment methodologies for the Commercial program. The Contractor will work with the State to ensure the risk adjustment is performed appropriately.

vi. Step 7: Trend Adjusted Experience Forward

For the expected TCOC calculations, the Contractor will apply trend to the base data to bring it to the same period (performance year) as actual costs when calculating shared savings. The Contractor will calculate Cumulative Average Growth Rate (CAGR) at the category of service level for each ACO population.

vii. Step 8: Adjust for Pricing Changes

The Contractor will advise the State as to whether this step should be performed at this stage or a different stage based on review of the data. The Contractor will apply pricing changes to the data to keep it on the same basis as actual data in the performance year. Such pricing changes may include shifts in benefit adjustments, program changes, and other regulatory or economic factors.

viii. Step 9: Truncate Costs at Member Level

Using the State defined methodology, the Contractor will truncate commercial expenses through a stop-loss provision by excluding the projected value of allowed claims per claimant in excess of$125,000 per year. The Contractor will notify the State of any additional outliers and the impact of various smoothing techniques.

ix. Step 10: Summarize TCOC Figures to Determine Savings

The Contractor will provide the expected and actual TCOC figures to the State for review and determination of whether the ACO generated savings. The Contractor will perform this activity twice for each performance year. The first will be an interim analysis in April prior to complete claims data run-out. The second will be in August after six months of claims run-out.

S. **Calculation of ACO Performance Measures**

The Contractor will calculate and provide the State with measures of ACO performance on clinical, claims-based, and survey-based measures. For all measures, the Contractor will document its processes, calculate the measures, and provide reports to the State. If the ACO has generated savings, the Contractor will use the results of this analysis to determine if participating ACOs meet the "Gate" to achieve any shared savings, and the ACOs' positions on the shared savings "Ladder" to determine the amount of shared savings they will receive. The

Contractor will utilize the "ACO Shared Savings Methodology Worksheet" (Attachment I) for the Commercial Shared Savings ACO Program. The Contractor will adjust or add measures at the State's request.

a. Clinically-Based Measures in Core Measure Set (Measures #14-#20)

After the Contractor has cleaned and validated the data, the Contractor will perform calculations of the clinically-based performance measures. The State will provide the measure results to the Contractor as numerators and denominators beginning in August 2014. The Contractor will calculate the measures for the first six months of 2014 with these data. The Contractor will prepare a preliminary report for the State in October 2014. The Contractor will follow the data definitions provided by State in the Core Measure Set Narrative Specifications provided as Attachment F to this contract.

b. Claims-Based Measures in Core Measure Set (Measures #1-8; #10-13)

The Contractor will use EBM Connect as the primary analytic software application for 10 of the 12 claims-based measures. For Core Measure 8 (Developmental Screening in the First Three Years of Life), the Contractor will use SAS to produce measure results. For Core Measure 12 (PQI Composite), the Contractor will write logic for the hypertension and heart failure admission rate sub-measures of this measure in SAS and calculate the sub-measures in the external data mart. The Contractor will append the results for Core Measure 8 and the two Core Measure 12 sub-measures with the EBM Connect output file and present them in the report template in a framework that is consistent with the other measures.

c. **Survey-Based Measures in Core Measure Set (Measures #21-27}**
The Contractor will work with State and its patient experience survey vendor to ensure timely and complete submission of the patient experience survey data needed to calculate these measures, and will conduct basic data validation to ensure accuracy and completeness. The Contractor will perform the necessary composite calculations needed to report these measures, identifying missing data or other issues that might bias or otherwise influence the creation of these index-based or scale indicators.

6. Monitoring and Evaluation Measures

The State will provide data to the Contractor for Monitoring and Evaluation measures. These data sources include: VHCURES, the Vermont Department of Education and the Vermont Department of Labor.

The Contractor will use the NQF-endorsed HealthPartners Total Cost of Care Index measures for this analysis. The Contractor will calculate the TCI and RUI measures following the HealthPartners specifications, while maintaining consistency with the ACO financial performance and earned savings payments described above. Contractor will use the following six steps to calculate and report the TCI and RUI measures.

i. Step 1 : Data Comparison

The Contractor will ensure the aggregated data from payers is consistent, reasonable and complete; that comparable use of diagnosis coding is used, CPT code frequencies fall within expected ranges, categories of service are consistently represented, and case-mix differences between different payer groups are evaluated.

ii. Step 2: Person Attribution

The Contractor will use the same attribution methodology described above to verify that ACO members are appropriately assigned.

iii. Step 3: Risk Adjustment

The Contractor will use the Symmetry Episode Risk Grouper (ERG) for risk scores and the Total Care Relative Resource Values (TCRRVs) to quantify resource use, if this grouper is comparable to the ACGs used by HealthPartners. The Contractor will independently validate these ERG risk scores using the Symmetry Pharmacy Risk Grouper (PRG) to compute risk scores for each payer using pharmacy data only. The Contractor will use these risk scores to compute the relative ERG and PRG risk score for each payer. If the State requires the contractor to use the ACG risk grouper, the State will pay the licensing fee for this grouper.

iv. Step 4: Apply TCRRV Weights

The Contractor will use TCRRV tables provided by HealthPartners to facilitate comparisons within and across procedures, peer groups, and health care settings, in order to objectively quantify and identify overuse and inefficiency, as well as measure price variations.

v. Step 5: Person-Level Claims Truncation

The Contractor will truncate costs at the person level to remove the effect of outliers. The Contractor and the State will determine the appropriate level for truncating to ensure consistency with financial performance and earned savings payment calculation methodology.

vi. Step 6: Calculate and Stratify TCI and RUI

The Contractor will calculate and stratify the TCI and RUI. The Contractor will recommend variables for stratification and the State will select the variables. The Contractor will compare TCI and RUI scores by Participating ACO, Participating Payer,

geography, place of services, and other variables. The Contractor will use interactive reporting tools to allow State and other stakeholders to perform their own analysis on the TCI and RUI measures, as well as the quality, utilization, and other measures in the Monitoring and Evaluation Set.

7. Calculation of the Impact of ACO Quality Performance on the Distribution of Shared Savings

The Contractor will calculate ACO performance relative to the benchmarks. For measures with no national benchmark data, the Contractor will calculate baselines specific to each ACO using data from the base period, and compare ACO performance over time to that baseline. The Contractor will calculate specific ACO point values based on the percentile of the national benchmark or the amount of improvement from the baseline.

The Contractor will compare point values to scoring levels to determine eligibility for payment and levels of payment.

8. Reports

The Contractor will work with the State to develop customized reports to evaluate the performance of the ACOs participating in the Shared Savings Programs. The Contractor will use SAS software and Tableau Desktop / Tableau Reader for these reports. The Contractor will ensure that reports are interactive and flexible, and built using a collaborative design process with State. The Contractor will establish a process for developing ad hoc reports in conjunction with State.

a. Report Generation Process

The Contractor will develop a report generation process that includes frequent review of report design requirements. The process will include the following steps:

i. Collaborative metadata resolution session(s):

The Contractor will clarify the use of terms and labels, etc., and specify/confirm the calculations being used to develop measures included in the reports. The Contractor will schedule and facilitate at least 3 of these sessions. The Contractor will manage the agenda for each session to guarantee that all outstanding topics are resolved. Contractor will develop a compliance checklist to insure that all reports meet standards in place among and between State and other stakeholders.

ii. Collaborative report storyboarding sessions :
The Contractor will schedule and facilitate sessions to include the real-time testing of report formats. For these sessions, the Contractor will develop draft measure results reports to initiate discussion. The Contractor will facilitate discussion of appropriate story telling language for tool tips, and any integrated help messages embedded in the report.

iii. Sharing of draft reports:
The Contractor will share draft report, via a secure protocol, using Tableau Reader or other vehicles that allow efficient collaboration with the State and other stakeholders on report design.

iv. Testing:
The Contractor will develop and manage a testing regime for all report designs that includes compliance and usability checklists. The State and other stakeholders and Contractor will participate in the testing process.

v. Publishing:
The Contractor will publish final report formats for approval by State.

vi. Report release:

The Contractor will consult with the State and other stakeholders to develop a formal approval process that incorporates anticipated and current approval procedures.

Contractor will insure final approval of report formats and any derivative materials prior to release. Following approvals, Contractor will work with the State and other stakeholders to release reports as appropriate.

vii. Post-release feedback:

The Contractor will develop and manage a process for considering and communicating feedback after each report is released.

viii. Report editing:

The Contractor will edit reports at the request of State.

b. Delivery, Implementation and Training

The Contractor will provide the following Tableau enabled reports:

- One baseline quality and utilization report
- Twelve quarterly Monitoring and Evaluation utilization measures reports
- Twelve quarterly claims-based payment measures reports
- Three annual quality measures reports
- Three ACO Quality Performance and Distribution of Shared Savings reports
- Collaborative ad hoc reports. To produce the ad hoc reports, Contractor will use the same process described in Section C of this contract. When appropriate, Contractor will engage stakeholders during ad hoc report development.

The Contractor will develop a plan with the State for training in how to use Tableau Reader.

c. Review of Results with Stakeholders

The Contractor will document all steps and calculations used to obtain quality and financial results. The Contractor will clearly and transparently report on the steps performed to obtain those results to the State.

At such times as the State requests, the Contractor will provide a detailed explanation of results at forum(s) attended by stakeholders. Stakeholders include, but are not limited to: ACOs, payers, consumers and clinicians. The Contractor will use multiple methods to both confirm understanding and allow for questions, such as meetings to walk through the documentation detailing the rate calculations which the stakeholders receive prior to the meeting and a question and answer log which is updated frequently and shared with the State and all stakeholders. The Contractor will review stakeholder concerns and issues with the State to ensure that the proposed responses are appropriate.

9. Ad Hoc Tasks

The State shall define deliverables as aligned in the scope of work by meeting with the Contractor on a monthly basis in order to define and confirm inclusion of additional deliverable development as identified by the State. Ad hoc tasks shall be reduced to writing and approved by both parties on a task order form and added to the work plan on a monthly basis.

University of Vermont Medical Center/OneCare Vermont #28242	
Method of Selection	RFP
Contract Amount	**Total Contract Amount (all years):**$4,984,140 **Performance Period 2 Total Amount (including Travel):**$1,806,762.75 (note that$826,281 was previously approved so the requested amount is$980,481.75) **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	12/22/14-12/31/16 (Performance Period 2: 1/1/15-6/30/16)
Method of Accountability	This is a deliverables/performance-based contract where the contractors are required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. These are also included below for your reference. The contract manager(s) review the invoices and work products each month before approving the invoices.
Itemized Budget	The billing for this contract is fixed price based on the scope of work. The contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the cost for each component of the work. The work will be performed in phases and each phase has a specific price. The Contractor's hourly rates are competitive within the health care evaluation sector and fall within the midrange of hourly rates for contractors involved in this work across the country.

STRATEGY FOR REPORTING AND PAYMENT

	1st Quarter			2nd Quarter			3rd Quarter Amended			4th Quarter Amended				
	Dec - 14	Jan - 15	Feb - 15	Mar - 15	Apr - 15	May - 15	Jun - 14	Jul - 15	Aug - 15	Sep - 14	Oct - 15	Nov - 15	Dec - 15	*TOT*
GENERAL CONTINUOUS PAYMENTS														
Develop and initiate statewide Clinical Advisory Board & Regional Clinical Performance Committees	*	*	*	*	*	*	*	*	*	*	*	*	*	
Assess, track, and sustain improvement efforts	*	*	*	*	*	*	*	*	*	*	*	*	*	
Identify statewide clinical improvement targets	*	*	*	*	*	*	*	*	*	*	*	*	*	
Develop protocols and project plans for improvement targets	*	*	*	*	*	*	*	*	*	*	*	*	*	
	79,500	79,500	79,500	79,500	79,500	79,500	79,500	79,500	79,500	79,500	79,500	79,500	79,500	***1,033***
General Overhead	8,710	8,710	8,710	8,710	8,710	8,710	8,710	8,710	8,710	8,710	8,710	8,710	8,710	***113***
GENERAL CONTINUOUS PAYMENTS SUBTOTAL	**88,210**	**88,210**	**88,210**	**88,210**	**88,210**	**88,210**	**88,210**	**88,210**	**88,210**	**88,210**	**88,210**	**88,210**	**88,210**	***1,146***
DISCRETE PAYMENTS														
Provide data analytic support for Regional Clinical Performance Committees *(VITL, Health Catalyst & Qlik Technologies as they are paid)*	60,233	-	-	30,777	-	-	37,306	158,713	166,045	43,415	43,415	43,415	43,415	***626***
Contract with 14 Regional Clinician Representatives *(each as they are contracted)*	162,500	-	-	-	-	6,250	-	175,000	-	-	-	-	-	***343***
Employ 6 Clinical and Quality Consultants *(each as they are employed)*	382,500	-	-	-	-	-	-	76,500	-	-	-	-	-	***459***
Regional Care Coordinator *(Karen Ploof at 75% as utilized for RCPC support)*	-	-	-	-	-	-	-	4,781	4,781	4,781	4,781	4,781	4,781	***28***
Complete Medicaid and Commercial data collection *(upon completion)*	-	-	-	-	-	150,000	-	-	-	-	-	-	-	***150***
Training program to support Regional Clinical Performance Committees *(Value Inst & Jeffords as they are paid)*	-	-	-	-	-	13,301	-	-	-	-	-			***13***
DISCRETE PAYMENTS SUBTOTAL	**605,233**	**-**	**-**	**30,777**	**-**	**169,551**	**37,306**	**414,994**	**170,826**	**48,196**	**48,196**	**48,196**	**48,196**	***1,621***
TOTAL BUDGET	**693,443**	**88,210**	**88,210**	**118,987**	**88,210**	**257,761**	**125,516**	**503,204**	**259,036**	**136,406**	**136,406**	**136,406**	**136,406**	***2,768***
ORIGINAL QUARTERLY BUDGET			**832,799**			**1,075,134**			**442,634**				**417,634**	
REVISED AMOUNT			**869,863**			**464,959**			**887,756**				**545,623**	

Budget Category

Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers
Model Testing: Quality Measures
Technical Assistance: Practice Transformation & Data Quality Facilitation

Summary Statement of Work

- Data quality initiatives.
- Chart Review for Shared Savings Program Measures.
- ACO operations: Data collection, analysis, operational implementation

Unique Qualifications (if Sole Source)

This request for sole source is because:
- There are only three ACOs within Vermont and each has unique provider networks;
- UVM Medical Center is uniquely positioned to perform the tasks described in the agreement; and
- Delaying the execution of these contracts so that we can go through a standard Vermont RFP process (4-6 months long) will cause significant delays in our Shared Savings Accountable Care Organization Programs. These funds will go to activities necessary for the successful operation of Accountable Care Organizations, as noted in CMS' recent announcement of the ACO Investment Model describing the necessary infrastructure investments required for these entities.

Retroactive Start Justification (if applicable)

Funding is requested to be retroactive to November 12, 2015.

Travel Justification	N/A
Performance Period 2 Applicable Milestones	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) Regional Collaborations: Expansion of regional collaborations to all 14 Health Service Areas (HSAs) by 6/30/16. Expansion is complete when all HSAs have a Charter, governing body, and decision-making process. 3) Improve Quality of Data Flowing into HIE: 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16.

Contract Attachment A, Scope of Work for University of Vermont Medical Center/OneCare Vermont #28242

A. Contractor shall perform the following activities according to the timeline on page 5 of this agreement:

1. Facilitate each RCPC's development of infrastructure and competency to conduct continuum of care root cause analysis on quality measures, readmissions rates and high emergency use.
2. Identify, train and deploy fourteen (14) local providers to serve as part-time Regional Clinician Representatives (RCRs), one in each HSA. Each RCR is expected to facilitate/guide the RCPC in his/her HSA and to lead clinical performance improvement initiatives.
3. Deploy Clinical Consultants to HSAs, as appropriate, to provide training and facilitate clinical performance improvement efforts.
4. Provide data analytic support to RCPCs by developing reports they request (to the extent that is consistent with data policies and Data Use Agreements) to be used to support local learning and health system improvement within each region.
5. Collect clinical quality measure data for OneCare in the first performance year (CY 2014). This will include training efforts in support of collecting Medicaid and commercial measures (measures not previously collected for the Medicare SSP). Contractor's staff will provide support to individual practices in their data abstraction processes, and endeavor to develop expertise at the practice level to organize data into a standardized file format for delivery to OneCare.
6. Leverage personnel and quality improvement training capabilities of the University of Vermont Medical Center Jeffords Institute for Quality and Operational Effectiveness and Dartmouth Hitchcock's Value Institute.
7. Follow recognized Quality Performance Improvement methods: Plan-Do-Study-Act (PDSA) and Standardize-Do-Study-Act (SDSA).
8. Assess and track progress to the quality measurement goals as reflected in the table on page 5 of this agreement.

B. Ongoing obligations

1. <u>Reporting:</u>
   - The Contractor shall participate in at least one conference call each month with the State of Vermont regarding its work under this agreement. The purpose of these calls is to discuss administrative and project issues as they arise.
   - More frequent calls may be needed during active periods of the project. The Contractor shall participate in all calls requested by the State. The State and Contractor shall determine a reasonable level of participation in such calls.
   - The Contractor shall submit monthly progress reports outlining all work accomplished during the previous month. The reports shall be concise and in a simple format (e.g., bulleted list) approved by the State. These reports are to be submitted electronically to the VHCIP Project Director within five business days

after the end of the month. These monthly progress reports shall be consistent with the work billed on the monthly invoices. At a minimum, monthly progress reports shall cover the following items:

i. Activities related to consultation and support related to each task supported by this contract;
ii. Activities planned for the forthcoming month;
iii. Contractor's expectations of the State staff during the forthcoming month (e.g., review of deliverables submitted, delivery of data or other items);
iv. Any problems or delays – encountered or foreseeable – that may affect contract performance;
v. Budget discrepancies greater than ten percent, i.e., cost overruns or underruns.

- The Contractor shall provide reports to the VHCIP Core Team, Work Groups or Steering Committee regarding the progress of this work as requested by the VHCIP Project Director.

2. Contract Administration Data – Key Personnel (See Attachment B for key personnel list):
   a. The key personnel specified in this contract are considered to be essential to work performance under this Agreement. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the Contracting Officer and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the State of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The State may modify the contract to add or delete key personnel at the request of the contractor or Federal government.

3. Performance Expectations:

No work shall be undertaken or reimbursed pursuant to this Agreement, other than obligations specifically set forth in Attachment A, without written approval by the State's designated representative.

Attachment A contains specific deliverables, due dates and performance measures, and shall serve as the basis for quality assurance and a means for monitoring the contractor's performance throughout the duration of this contract.

The Contractor shall provide a single point of contact who will manage all aspects of the contract including the assignment of qualified personnel to perform the work outlined herein.

The Contractor accepts full responsibility for any personnel assigned to perform the work herein. It is understood that the State will provide minimal oversight of personnel assigned to this contract.

University of Massachusetts #25350	
Method of Selection	RFP
Contract Amount	**Total Contract Amount (all years):**$841,816 **Performance Period 2 Total Amount (including Travel):**$230,000 **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	9/1/13-12/31/16 (Performance Period 2: 1/1/15-6/30/16)
Method of Accountability	This is a deliverables/performance-based contract where the contractors are required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B provides the payment schedule. The contract manager(s) review the invoices and work products each month before approving the invoices.
Itemized Budget	The billing for this contract is time and materials. The Contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the hourly rate for each staff person assigned to the contract. The Contractor's hourly rates are competitive within the project management sector and fall within the low range of hourly rates for contractors involved in this work across the country.
Budget Category	*Project Management*
Summary Statement of Work	Project coordination and financial management assistance.
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to November 12, 2015.**
Travel Justification	Out-of-State travel is not a billable expense under this agreement.
Performance Period 2 Applicable Milestones	1) Project Management and Reporting – Project Organization: Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2) Project Management and Reporting – Communication and Outreach: Engage stakeholders in project focus areas. Engage stakeholders in project focus areas by: 1. Convening 5 Core Team, 5 Steering Committee, and 10 work group public meetings by 6/30/16. 2. Distributing all-participant emails at least once a month.

Itemized Budget (continued):

Personnel	**Hourly Rate**
Program Manager-Joelle Judge	
Jan 2015-June 2015	$88.78
July 2015-December 2016	$90.49
Project Manager-TBD	$88.78
Project Coordinator	$54.48
Travel (in-state only)	$3,982
Cell Phones (2)	$1,319.74

Contract Attachment A, Scope of Work for University of Massachusetts #25350

The Contractor shall complete the following deliverables and is directly responsible for the following project tasks and outcomes:

a. Program management of sub-grant program,

i. Facilitate grant agreement process: prepare documents; oversee grantee communications and document routing.
ii. Monitor sub-grantee reporting: support grantees in the development of reports; compile and report to other SIM stakeholders.
iii. Manage grantee interactions: schedule and facilitate grantee forums.

b. Develop and implement program communication and collaboration strategy to align sub-grant and workgroup progress and outcomes;

c. Develop and maintain project status reporting tools (i.e. Dashboard and other reports) to report status of overall SIM project as well as various components;

d. Complete Conflict of Interest program for all SIM staff;

e. Assistance with the maintenance of the Project Risk Plan;

f. Develop and maintain project contracting matrix and timelines to proactively manage contract execution and maintenance schedule;

g. Workgroup support as needed, including refining work plans and facilitation of cross-project communications, as such opportunities are identified;

h. Assistance with the procurement process related to SIM;

i. Change requests;

j. Participate and support meetings with project staff;

k. Collaboration with project staff;

l. Other duties as assigned

Vermont Medical Society Foundation #28675	
Method of Selection	Sole Source
Contract Amount	**Total Contract Amount (all years):**$140,658 **Performance Period 2 Total Amount (including Travel):**$140,658 (note that$130,329 was previously approved so the requested amount is$10,329) **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	4/1/15-6/30/16 (Performance Period 2: 4/1/15-12/31/15)
Method of Accountability	This is a deliverables/performance-based contract where the contractors are required to perform specific tasks as enumerated in the contract. If appropriately performed, the contractor will be paid for those tasks.
Itemized Budget	(see table below)
Budget Category	*Advanced Analytics:* Policy and Data Analysis to Support System Design and Research for All Payers
Summary Statement of Work	Development of a payment model related to frail elders.
Unique Qualifications (if Sole Source)	The VMSF is uniquely qualified to perform these tasks for several reasons: 1. VMSF is a leading physician foundation in the State providing legal, administrative and educational support to increase the effectiveness of health care delivery thereby providing better care to patients. 2. They will leverage existing groups of clinicians who are willing to be engaged in payment reform discussions. 3. They are a trusted, knowledgeable and neutral convener for Vermont clinicians and are able to encourage frank, open discourse.

Itemized Budget

Pursuing High Value Care for Vermonters		
Frail Elderly VHCIP Payment Models		
April - October 2015		
Personnel		
Director	$	62,352
Business Manager	$	3,741
Operations Director	$	3,741
Administrative Assistant	$	1,871
Personnel subtotal	$	71,705
Fringe		
	$	-
Travel		
Mileage	$	848
Parking and Tolls	$	25
Equipment		
	$	-
Supplies, meetings		
Conference calls; webinars	$	500
Website	$	500
Supplies subtotal	$	1,000
Indirect		
	$	-
Contracts		
Clinical champion	$	6,126
Clinical content expert	$	3,063
Clinical content expert	$	3,063
Qualitative Researcher	$	40,500
QI and Measurement content expert	$	3,000
Patient and Family surveyor	$	10,000
UVM Dana Library	$	1,000
Contracts subtotal	$	66,751
Total		
	$	140,329

	4. They have a history of developing clear, actionable policy recommendations. Most recently they produced a series of white papers to improve care delivery and resource planning across the state. 5. They can begin work immediately.
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to November 12, 2015**
Travel Justification	N/A
Performance Period 2 Applicable Milestones	State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 7. Research and design related to Frail Elders (timeline dependent upon federal contract approval) – final recommendations by 6/30/16.

Contract Attachment A, Scope of Work for Vermont Medical Society Foundation #28675

1. Conduct a literature review utilizing the library professionals at the University of Vermont. The review will target three areas of interest:
   a. Identification, attribution of patients to providers, and utilization characterization of frail elderly patients using billing claims and clinical data bases;
   b. Regional and national models for care – successes, failures and innovation;
   c. Regional and national investigations of patient and family medical care preferences.

2. Draft study questions and conduct three sets of key informant interviews:
   a. *Community based health care professionals.* Contractor will conduct interviews with community based health care professionals in each of the two target communities.
      i. Identification of providers will be informed by consultation with the Project Expert Panel.
      ii. Contractor will interview approximately fifteen providers in each of two primary care service areas, Gifford Health Care and Little Rivers Health Care, spanning all or parts of Orange, Washington, Caledonia and Windsor counties.

   b. *State and private sector policy experts*. Contractor shall conduct interviews with public and private professionals with expertise in the field of aging and support and care-giving for the elderly.
      i. Informants will include those who determine eligibility for Vermonters for publicly funded programs.

   c. *Patients, families and caregivers.* Contractor will conduct interviews with patients, families and caregivers in each of two targeted primary care service areas.
      i. Interviews will be conducted in a variety of face to face settings including home based interviews and public community settings.
      ii. Interviews will take advantage of existing community structures and activities; and may include focus groups. Choice of informants will be advised by input from the community based health care professional(s) interviews.

3. Perform billing and clinical data set analytics using existing public claims databases to identify the following:
   a. If the frail elderly population be identified using claims data;
   b. If utilization patterns of the population be characterized;
   c. If claims data be used proactively to identify the target population.

I. Deliverables

A. Contractor shall deliver a written report and a formal presentation to the VHCIP Payment Models Work Group on findings and recommendations for next steps to increase the value of health care to frail elders.

B. The report will include:

1. Literature reviews summarizing and highlighting key pertinent writings in the following areas:
   a. Billing and Clinical Data Set Analytics;
   b. Regional and national models for care;
   c. Regional and national investigations of patient and family medical care preferences.

2. Aggregate and separate analyses of three sets of key informant interviews with direct care providers and policy experts:
   a. Gifford Primary Care Service Area (PCSA) providers;
   b. Little Rivers PCSA providers;
   c. State and regional policy and content experts.

3. Aggregate and separate analyses of two sets of key informant interviews and community focus groups in two PCSAs:
   a. Gifford PCSA patients, families and caregivers;
   b. Little Rivers PCSA patients, families and caregivers.

4. Findings of billing and clinical data set analyses related to the following:
   a. If the frail elderly population can be identified using claims data;
   b. If utilization patterns of the population can be characterized;
   c. If claims data can be used proactively to identify the target population.

II. Reporting Requirements

- The Contractor shall participate in a conference call each month with the State of Vermont regarding this work. The purpose of these calls is to discuss administrative and project issues as they arise and to report preliminary findings of analyses as they become available.
- More frequent calls may be needed during active periods of the project. The Contractor shall participate in all such calls as requested by the State. The State and Contractor shall determine a reasonable level of participations in such calls.
- The Contractor shall participate in monthly VHCIP work group and planning meetings and actively engage private sector stakeholders in the data assessments.
- The Contractor shall submit monthly progress reports outlining all work accomplished during the previous month. The reports should be concise and in a simple format approved by the State of Vermont. These reports are to be submitted electronically to the VHCIP Project Director within five business days after the end of the month. These monthly progress reports shall be consistent with the work billed on the monthly vouchers. At a minimum, monthly progress reports shall cover the following items:
  - i. Activities related to consultation and support related to each effort supported by this contract;
  - ii. Activities planned for the forthcoming month;
  - iii. Contractor's expectations of the State staff during the forthcoming month (e.g., review of deliverables submitted, delivery of data or other items);
  - iv. Any problems or delays – encountered or foreseeable – that may affect contract performance;

v. Budget discrepancies greater than ten percent, i.e., cost overruns or underruns.

- The Contractor may also be requested to provide reports to the VHCIP Core Team or Steering Committee regarding the progress of this work.
- The Contractor will meet, in person, with the State and key stakeholders at least quarterly for the duration of the contract.

III. Contract Administration, Key Personnel (See Attachment B for key personnel list and rates)

The key personnel specified in this contract are considered to be essential to work performance under this Agreement. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the Contracting Officer and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the State of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The State may modify the contract to add or delete key personnel at the request of the Contractor or Government.

IV. Contract Administration, Performance Expectations:

The number of personnel and level of expertise required, as well as the scheduled hours to be worked will be determined by the State and the Contractor as part of the status meetings. The assignment of additional personnel, hours, or the substitution of personnel with a higher level of expertise shall require pre-approval by the State.

The Contractor accepts full responsibility for any personnel assigned to perform the work herein. It is understood that the State will provide minimal oversight of personnel assigned to this contract.

The State shall notify the Contractor’s single point of contact to discuss remediation if it is determined by the State that personnel assigned are not performing as expected. The State has the right to request a change in personnel assigned. The State shall not request a change in personnel without reason. The Contractor is obligated to remove personnel within 2 business days of a request by the State, and provide a qualified replacement within 30 days.

Vermont Program for Quality in Health Care #28362	
Method of Selection	RFP
Contract Amount	**Total Contract Amount (all years):**$204,526.67 **Performance Period 2 Total Amount (including Travel):**$183,656.67 (note that$102,526.67 was previously approved so the requested amount is$81,130) **Performance Period 2 Out-of-State Travel:$**4,429
Contract Term	3/1/15-12/31/16 (Performance Period 2: 3/1/15-6/30/16)
Method of Accountability	This is a deliverables/performance-based contract where the contractors are required to perform specific tasks according to a timeline and project plan. The contractor must meet certain deliverables and meet certain milestones in order for payment.
Itemized Budget	The billing for this contract is based on deliverables and milestones as identified in Attachment B of the agreement and will be paid through monthly invoices as described in Attachment B.

Salary and Benefits:	**Annual**	**FTE**	**Project Budget**
Quality Improvement Facilitator(Start date March 24,2015)	$63,750	1.0	$61,817
Benefits	$24,225	1.0	$23,490
Total Salaries and Benefits			**$85,307**
Travel- 2 times per month to each community plus collaboratives			**$10,434**
Professional Development - 1 out of state conference			**$4,429**
Professional Development -One Webinar			**$750**
Organizational Support:			
IT and Office Support			$3,938
Sr. Program Mgr.		0.05	$4,180
Organizational Support Salaries			$8,118
Benefits			$3,085
Organizational Support Salaries and Fringe			**$11,203**
Support Expenses			
IT - computer			$1,500
Internet access			$281
HIPPA compliant Security /software and hardware			$1,320
Telephone			$561
Office Space			$3,457
Accounting and Legal			$2,833

	Office Expenses - Copier and Supplies			$1,890
	Total Support Expenses			**$11,842**
	Total Budget for Blue Print Regional Facilitator Project			**$123,215**
Budget Category	*Technical Assistance:* Learning Collaboratives			
Summary Statement of Work	Quality improvement facilitators supporting quality improvement activities in primary care practices, integrated care teams within communities and specialty addictions and mental health programs.			
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to November 12, 2015.**			
Travel Justification	**The estimated travel for this contract is:$4,429 for two out-of-state conferences.** *Estimated cost for two trips from Burlington or nearby airport to conference site:* *Airfare:$300/trip or$600* *Transportation to airport and parking:$82* *Hotel: 125/night for an estimate of 3 nights per trip or$750* *Total Per Diem:$192 ($32 per day for 3 days per trip ($96/per trip)* *Conference Fees:$2,805*			
Performance Period 2 Applicable Milestones	Learning Collaboratives: Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.			

Contract Attachment A, Scope of Work for Vermont Program for Quality in Health Care #28362

The Contractor will assist teams with a) understanding data sources and using them to identify at-risk people and engage in effective panel management, b) identifying measures for and measuring the impact of selected interventions, and c) promoting an environment of collaborative learning between integrated care teams and across the health system. During the first quarter of the contract period, the Contractor will recruit and hire personnel, with input and approval from the State, to conduct the full range of Contractor Activities outlined below. Those activities will include working with integrated care teams and the State in:

A. Supporting Change Management

1. Facilitate meetings of the planning group team.
2. Coach community leaders in forming multi-disciplinary integrated care teams with a focus on quality improvement.
3. Foster integrated care teams' ownership for improving patient care and changing the way the services are provided.
4. Work with integrated care teams to assess their performance and establish project goals and parameters.
5. Use integrated care team data to assist in establishing sequences and timelines for quality improvement initiatives, and to evaluate the impact of changes.
6. Train integrated care teams in conducting PDSA cycles.

7. Coach integrated care teams in measuring and interpreting results of change.
8. Facilitate communication around evolving roles and relationships.
9. Recognize, reinforce, and celebrate success.
10. Provide feedback and coaching for integrated care team leaders.

B. Providing Technical Assistance and Training

1. Identify skills-based training needs for integrated care teams and front-line care managers, and work with the State to ensure that training occurs.
2. Provide technical assistance in identifying models of care, innovative strategies and evidence-based guidelines that support integrated care management.
3. Assist in implementing promising interventions.
4. Support integrated care teams in using data to identify people in need of integrated care management.
5. Assist integrated care teams in measuring and evaluating the results of interventions.

C. Supporting the Effective Use of Information Technology

1. Support integrated care teams in using technology to improve patient care and efficiency.
2. As appropriate, assist integrated care teams in implementing data collection tools (e.g., clinical registry, care coordination modules, risk stratification tools) and using them to improve panel management, care management, and other aspects of patient care.

D. Creating a Learning Health System

1. Foster a shared learning environment through organization-to-organization mentoring.
2. Design and implement collaborative learning sessions.
3. Participate in shared learning activities of the Expansion and Quality Improvement Program (EQuIP) facilitator group (team meetings, conference calls, training and one-on-one meetings).

E. Connecting Integrated Care Teams with the Community

1. Support the incorporation of integrated care teams into organization workflow.
2. Link integrated care teams with outside resources.

Deliverables

A. During the term of this contract, and in collaboration with other contractor(s) and a Learning Collaborative Planning Team, the Contractor will provide:

1. A written project management plan including key project milestones and activities, to be submitted to State Authorized Representative by April 15, 2015.
    a. The Contractor will update the project management plan at least quarterly.

2. Starting May 15, 2015, semi-monthly written progress reports submitted to State Authorized Representative, highlighting goals, activities, outcomes, timelines, deadlines, progress in each community, progress across all communities, and general progress against the project management plan.

    Progress reporting for each community will include information such as accomplishments, setbacks, challenges, plans for overcoming challenges, opportunities, and planned next steps/action items for both the short term (next month) and long term (next quarter). Specific examples should be incorporated to better

illustrate progress in each community. The State will provide a template for the semi-monthly written progress report.

The following documentation will be included as attachments to the report:

a. Evidence of local meetings with each integrated community team at least twice a month unless otherwise indicated by the State.
b. Documentation of all relevant PDSA cycles initiated in each community.
c. Evidence of all regular and ad hoc review and analysis of data provided from members of integrated community teams, State staff or others in support of the PDSA cycles.

3. Facilitation, coordination, planning and implementation of:

    a. Local meetings with each integrated community team at least twice a month unless otherwise indicated by the State.
    b. Statewide webinars on an every-other-month basis.
    c. In-person learning sessions on an every-other-month basis for the first six months, then at a frequency determined by the State.

    Examples of this work include obtaining faculty, developing and documenting collaborative curriculum, planning agendas, developing and delivering presentations, facilitating sessions, scheduling, planning, coordinating and other meeting logistics. The State and Learning Collaborative Planning Group will provide guidance for these activities.

4. Participation in bi-weekly conference calls with State Authorized Representative, EQuIP program director or his/her designee, other State staff as appropriate, and key leadership from pilot communities to discuss general progress and next steps, mitigate challenges, and generally ensure project milestones are being met.

5. Participation in regular meetings of EQuIP facilitators (generally 2 times monthly).

6. Support for measurement and evaluation of Learning Collaborative results. Examples include:

    a. Participation in designing and developing QI measures based on curriculum.
    b. Assisting integrated teams in collecting data and analyzing results.
    c. Aggregating measures across communities.
    d. Providing input into the Learning Collaborative evaluation.

7. Identification of future curriculum items based on the first three learning sessions and creation of a toolkit and materials to be used in future collaboratives, as well as an outline for use by future QI facilitators.

<table>
<tr><th colspan="2">Vermont Information Technology Leaders/Department of Mental Health (DMH) #28236</th></tr>
<tr><td>Method of Selection</td><td>Sole Source</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$11,087.50
Performance Period 2 Total Amount:$11,087.50
Performance Period 2 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>1/1/15-6/30/15</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based contract where the contractors are required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. These are also included below for your reference. The contract manager(s) review the invoices and work products each month before approving the invoices.</td></tr>
<tr><td>Itemized Budget</td><td>The billing for this contract is fixed price based on the scope of work. There is one component where the contractor will bill hourly for subject matter expertise. This component is constructed in this manner to avoid over-billing. The contractor will provide monthly estimates of activities in this area to the State and the State will approve these activities and estimated cost before any activity can be undertaken under this provision. The contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the cost for each component of the work. The work will be performed in phases and each phase has a specific price. The Contractor’s hourly rates are competitive within the health care IT sector and fall within the low-midrange of hourly rates for contractors involved in this work across the country.

<table>
<tr><th>Item description</th><th>Hourly Rate</th></tr>
<tr><td>Consulting Services</td><td></td></tr>
<tr><td>- eHealth Specialist</td><td>$125.00</td></tr>
<tr><td>- Project Manager or Technical Staff</td><td>$125.00</td></tr>
<tr><td>- CTO or other VITL Leadership</td><td>$200.00</td></tr>
</table></td></tr>
<tr><td>Budget Category</td><td>Technical Assistance: Practice Transformation & Data Quality Facilitation</td></tr>
<tr><td>Summary Statement of Work</td><td>This contract is between Vermont’s Department of Mental Health (DMH) and Vermont Information Technology Leaders, Inc. (VITL), Vermont’s statutorily designated Health Information Exchange entity. VITL will support the Department of Mental Health in their procurement of a new Electronic Medical Record System effective January 1, 2015.</td></tr>
<tr><td>Unique Qualifications (if Sole Source)</td><td>A Request for Proposal (RFP) for the new EHR was issued in 2014 by DMH and a number of vendors responded. Consistent with legislative committee requests, DMH would like to enter into a contract with VITL to assist in the selection a vendor given their statutory authority as the State’s designated HIE.</td></tr>
<tr><td>Retroactive Start Justification (if applicable)</td><td>Funding is requested to be retroactive to January 1, 2015.

This agreement was submitted to CMMI on December 29, 2014 with a request that funding begin January 1, 2015. It was not approved pending approval of Vermont’s Performance Period 1 Carryforward. This contract was not in force in 2014 and not part of the approved carryforward. This contract is fully funded by Performance Period 2 contract funds.

Retroactive funding is requested to support the nature of the Subrecipient’s work, which is time sensitive and critical to the success of the VHCIP.</td></tr>
<tr><td>Travel Justification</td><td>Hourly rates are inclusive of travel.</td></tr>
</table>

Performance Period 2 Applicable Milestones	EMR Expansion: 1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and ARIS (Developmental Disability Agencies) (by 6/30/16).

Contract Attachment A, Scope of Work for Vermont Information Technology Leaders/Department of Mental Health (DMH) #28236

A. PROGRAM BACKGROUND

As a key requirement for the Certificate of Need established under 18 V.S.A. § 9351 for the rebuilding of a new State hospital and integrating physical, behavioral, pharmacy, dietary, billing and lab functions in a single system, the State of Vermont is required to have an Electronic Health Record (EHR) in place.

B. SERVICE OUTCOMES

1. Vendor selection process.

a. Participate in bidder-vendor presentations and demonstrations.

b. Provide assessment/gap analyses for each bidder-vendor's EHR interface/connectivity and interoperability.

c. Provide bidder-vendor selection assessment criteria to assist in final vendor selection related to interoperability with Vermont Health Information Exchange (VHIE) through Vermont Information Technology Leader (VITL).

2. Development of the EHR contract.

a. Assist in the development of an EHR contract related to VHIE interoperability/connectivity functional & nonfunctional requirements and deliverables.

b. Provide subject matter expertise and guidance through the independent review and the negotiation process for vendor selection.

3. DMH EHR Vendor planning, implementation and go-live.

a. Participate in Vendor Planning, implementation and go-live phases related to interoperability with Vermont Health Information Exchange (VHIE) through Vermont Information Technology Leaders (VITL).

b. Provide guidance/review of chosen vendor's project plan, testing plan, VHIE deliverables.

c. Deliverable validation related to interoperability with Vermont Health Information Exchange (VHIE) through Vermont Information Technology Leader (VITL).

C. DELIVERABLES

1. The Contractor shall develop monthly work plans and task orders;
2. Monthly updates, including statement of expenditures ;
3. Gap analysis/assessment for vendor's EHR interface/connectivity to VHIE;
4. Assessment/scoring criteria for final vendor selection;
5. Contract Language, deliverables and Non-functional requirements relating to interoperability with VHIE;
6. Review of, and provision of recommendations for, final contract with chosen vendor;
7. Availability as the VHIE SME during the contract review process, as necessary;
8. Test plan and scenario testing relating to interoperability with VHIE through VITL.

D. PERFORMANCE EXPECTATIONS

1. For matters involving the failure of Contractor to perform in accordance with this Contract shall result in a

reduction in payment of 10% of the total monthly invoice for the month in which nonperformance occurred.

E. **SPECIFICATIONS**

1. Contractor shall provide subject matter expertise and guidance on sharing 42 Code of Federal Regulations Part 2 data, interoperability/connectivity to VHIE, and State & Federal policy, law and requirements related to VHIE.

2. Schedule of Rates:

Item description	*Hourly Rate*
Consulting Services	
- eHealth Specialist	$125.00
- Project Manager or Technical Staff	$125.00
- CTO or other VITL Leadership	$200.00

3. Contractor will bill monthly for work done each month.

F. PROGRAM ADMINISTRATION AND PERFORMANCE EXPECTATION

The Contractor shall develop monthly Task Orders. Each Task Order will include deliverables. Deliverables shall consist of quantifiable products or services resulting from activities performed pursuant to this Agreement. Such deliverables may include, but are not limited to the following:

-Scopes of Work
-Work Plan Development
-Ad Hoc Tasks
-Technical Assistance tasks

No reimbursement or other payment shall be provided for any work performed without prior State approval both of a cost estimate and of the item in the Task Order associated with that cost estimate. The State reserves the right to refuse payment for work performed without prior approval.

Task Orders are a tool for managing the work described in this Attachment A. They may clarify or expand upon an item included in the Scope of Work, but a Task Order is not intended to supplement or otherwise amend it. Task Orders shall not be used to change the maximum amount under this Agreement, or to add to the Scope of Work. Task Orders may not change the maximum amount payable under this contract, deviate from or add to the scope of this contract, or deviate from any term in any part or attachment to or of this contract. Task Orders shall not be used in lieu of the contract amendment process where in the sole discretion and judgment of the State an amendment is appropriate.

No work shall be undertaken or reimbursed pursuant to this Agreement, other than obligations specifically set forth in the Fee Schedule in Attachment B.

Re-imbursement shall be reviewed and approved during Monthly status updates between the State designees and Contractor single point of contact.

The Contractor shall provide a single point of contact who will manage all aspects of the contract including the assignment of qualified personnel to perform the work outlined herein.

Vermont Information Technology Leaders (VITL) ACO/ACTT Proposal #03410-1275-14	
Method of Selection	Sole Source, as the State's designated HIE
Contract Amount	**Total Contract Amount (all years):**$4,444,989 **Performance Period 2 Total Amount (including Travel):**$1,126,261 (note that$1,312,588 was previously approved so the reduction amount is ($186,327)) **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	7/2/14-5/1/17 (Performance Period 2: 1/1/15-6/30/16)
Method of Accountability	This is a deliverables/performance-based contract where the contractors are required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The contract manager(s) review the invoices and work products each month before approving the invoices.
Itemized Budget	The billing for this contract is fixed price based on the scope of work. There is one component where the contractor will bill hourly for subject matter expertise. This component is constructed in this manner to avoid over-billing. The contractor will provide monthly estimates of activities in this area to the State and the State will approve these activities and estimated cost before any activity can be undertaken under this provision. The contractors will be paid through monthly invoices as described in Attachment B of the agreement. Attachment B includes the cost for each component of the work. The work will be performed in phases and each phase has a specific price. The Contractor's hourly rates are competitive within the health care IT sector and fall within the low-midrange of hourly rates for contractors involved in this work across the country. **Personnel** / **Rate**: **VITL Leadership: John Evans, Mike Gagnon, Sandy McDowell, Rob Gibson, Judith Franz, Nancy Rowden Brock, Kristina Choquette** — **$200** **VITL Project Managers and technical staff: TBD** — **$125**
Budget Category	*Technology and Infrastructure:* Expanded Connectivity of HIE Infrastructure *Technical Assistance:* Practice Transformation & Data Quality Facilitation *Technology and Infrastructure:* Expanded Connectivity between State of Vermont Data Sources and ACOs/Providers
Summary Statement of Work	• Data gathering, data quality & remediation for Designated Agencies and Specialized Service Agencies. • Develop and implement a population-based infrastructure within VHIE capabilities.
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to November 12, 2015.**
Travel Justification	Travel is not a billable expense under this agreement.

Performance Period 2 Applicable Milestones	1) Expand Connectivity to HIE – Gap Remediation: Remediate data gaps that support payment model quality measures, as identified in gap analyses: 1. Remediate 50% of data gaps for SSP quality measures by 12/31/15. 2. Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15. 2) Improve Quality of Data Flowing into HIE: 1. Implement terminology services tool to normalize data elements within the VHIE by TBD. 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16. 3) EMR Expansion: 1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and ARIS (Developmental Disability Agencies) (by 6/30/16). 2. Explore non-EMR solutions for providers without EMRs: develop plan based on LTSS technical gap analysis.

Contract Attachment A, Scope of Work for Vermont Information Technology Leaders (VITL) ACO/ACTT Proposal #03410-1275-14)

Scope of Work

Gap Remediation

There are five parts to the Gap Remediation: Interface and Electronic Health Record Installation, Data Analysis, Data Formatting, Terminology Services, and the Solutions Enablement Team (SET). The ACO shall take reasonable steps to ensure that their Members comply with the Subrecipient's recommendations with regards to the five parts of the Gap Remediation.

a. Interface and Electronic Health Record Installation:
   i. The Subrecipient, in collaboration with the ACOs, will propose the appropriate infrastructure for health care organizations (HCO) that do not have Electronic Health Records (EHRs). The Subrecipient will provide a proposal to the State and the ACOs to remediate these organizations. In each instance, the Subrecipient will recommend options to improve health data interoperability. There are three categories of organization:
      1. The HCO does not have the staff, client population, or expertise to support an Electronic Health Record.
      2. The HCO is capable of supporting an EHR, but does not have the funds for ongoing support.
      3. The HCO has the funding to support an EHR.
   ii. The Subrecipient, in collaboration with the ACOs, will determine what interfaces are required for HCOs that have EHRs. The Subrecipient will develop interfaces and shall provide interface development work designed to develop connectivity between the VHIE networks and ACO member organizations. Subrecipient may subcontract with Medicity to provide services dedicated to the Subrecipient. Interface development shall include:
      1. Subrecipient staff shall be trained to perform aspects of interface development
      2. Provision of HCO onsite resources for interface development
      3. The deliverables for this work are defined in the "Project Deliverables and Target Dates" Section and include expansion of:
         a) Connectivity to Hospitals;
         b) Connectivity to patient-centered medical homes and other primary care providers;
         c) Connectivity to Physician/Ambulatory providers; and

d) Connectivity to Community Providers including: Home health, skilled nursing facilities, mental health, and specialized agencies.

b. Data Analysis:

The Subrecipient will perform an analysis of ACO members' Electronic Health Record on each of sixteen data elements. The Subrecipient will engage providers and make workflow recommendations to change data entry to ensure the data elements are captured. The Subrecipient will use the following questions in their analysis:

i. Is the HCO capturing the measure at all?
ii. Is the HCO capturing the measure, but in a custom field that is not picked up by the clinical summary
iii. Is the HCO capturing the measure in the vendor's specified field, but the clinical summary is not picking it up.

c. Data Formatting:

Data formatting builds on tasks 5(a) and 5(b) above. The Subrecipient will perform comprehensive analyses to ensure that each data element from each HCO is formatted identically. The specific activities performed to ensure uniform data formatting vary based on vendor and HCO. The Subrecipient will work with HCOs to perform some or all of the following:

i. The HCO can change their method of data entry
ii. The HCO's vendor can change their format used to capture data
iii. A third party could use a terminology service to transform the data

The Subrecipient will also investigate other approaches to data formatting to ensure data uniformity.

d. Terminology Services:
The Subrecipient will engage a subcontractor to perform terminology services. The Subrecipient will release an RFP for these services and select a vendor based on bid responses. The Subrecipient will engage this subcontractor for 24 months. The terminology services enhance clinical data quality in the VHIE by translating clinical data elements into standardized code sets. Specifically, these convert the data elements from source code to standard clinical classifications and codes readable by all electronic health records.

e. Solutions Enablement Team (SET) Services:
The Subrecipient will subcontract with Medicity to provide SET services which are dedicated Medicity resources. These Medicity resources are Vermont specific and allow for rapid interface development. The SET will start with one Vermont hospital while developing priority interfaces throughout the State. The Subrecipient will identify priority interfaces in consultation with the ACOs and the State.

Project Deliverables and Target Dates:

The tasks to be completed, specific deliverables, and timelines are listed in the table below.

Task	Scope	Deliverable	Due No Later Than
5) Gap Remediation			

Task	Scope	Deliverable	Due No Later Than
Interface and Electronic Health Record Installation	Identify members who do not have an EHR or are planning to replace an EHR.	Propose for each identified member the options for an EHR including but not limited to: no EHR; potential shared hosted system, or propose a vendor's system. Identify and initiate work on installing new interfaces.	Jan 16
Data Analysis	Identify the data capability of each HCO	Work with each ACO and their respective ACO members to enable data capability across all quality measures.	Jan 16
Data Formatting	Increase the percentage of data that can meet the ACO quality measures through identifying appropriate data elements in messages, recommending EHR vendor updates, and facilitating practice workflow improvements.	ACO member organizations will be capable of sending the 22 clinical data measures electronically to cover 62% of the aggregate beneficiary population. The baseline beneficiary populations were established October 1, 2014 for the ACOs.	Jan 16
Terminology Services[12]	Implement systems with the capability to provide terminology services including, but not limited to, mapping data, code set remediation.	Provide terminology services for 24 months.	24 months beginning August 1, 2015
SET Team and new interface development	Provide Medicity dedicated resources to develop interfaces ACO participants, selected in collaboration with the ACOs and the State.	Provide SET Team resources for 8 months.	November 2014-June 2015

The Subrecipient shall:

1) Subject-matter expertise related to health information integration and data transfer and storage that supports the deliverables of this agreement. The Subrecipient will submit monthly invoices to the State. The Subrecipient will invoice the State on an hourly basis for the following subject-matter experts:

Personnel	Rate
VITL Leadership: John Evans, Mike Gagnon, Sandy McDowell, Rob Gibson, Judith Franz, Nancy Rowden Brock, Kristina Choquette	**$200**
VITL Project Managers and technical staff: TBD	**$125**

[12] This item is currently under more research due to delays and change in cost.

<table>
<tr><th colspan="2">Wakely Consulting Group #26303</th></tr>
<tr><td>Method of Selection</td><td>Sole Source</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$210,000
Performance Period 2 Total Amount (including Travel):$30,000
Performance Period 2 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>11/12/14-12/31/16 (Performance Period 2: 1/1/15-6/30/16)</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based contract where the contractors are required to submit monthly task order forms for monthly activities. Once the task order forms are approved, the contractor can commence work for that month. The contract manager(s) review the invoices, task order forms and work products each month before approving the invoices. Vermont is engaging in this contracting structure for professional services contracts to ensure that we have the skills necessary for the work to be done, but also allowing for some flexibility in a changing health care environment. Additionally, Vermont does not want to pay for unnecessary services and finds this method of accountability and management to allow for maximum benefit in contracting with entities for professional services.</td></tr>
<tr><td>Itemized Budget</td><td>The billing for this contract is time and materials. Specifically, the State of Vermont has developed a task order approval structure where the Contractor receives prior approval for all tasks. Once the task order is approved, the vendor does the work and then bills for it. The Contractors will be paid through monthly invoices as described in Attachment B. Attachment B includes the hourly rate for each staff person assigned to the contract. The Contractor’s hourly rates are competitive within the health care consultant sector and fall within the midrange of hourly rates for contractors involved in this work across the country.
<table>
<tr><th>Wakely Consulting</th><th>Name</th><th>2014 Hourly Rate</th></tr>
<tr><td>Director and Senior Consulting Actuary</td><td>Julie Peper, Julia Lambert</td><td>$415.00</td></tr>
<tr><td>Senior Consulting Actuary</td><td>As Assigned</td><td>$355.00</td></tr>
<tr><td>Consulting Actuary</td><td>As Assigned</td><td>$275.00</td></tr>
<tr><td>Associate Actuary</td><td>As Assigned</td><td>$210.00</td></tr>
<tr><td>Senior Actuarial Analyst</td><td>As Assigned</td><td>$190.00</td></tr>
<tr><td>Actuarial Analyst</td><td>As Assigned</td><td>$170.00</td></tr>
</table></td></tr>
<tr><td>Budget Category</td><td>Advanced Analytics: Financial and Other Modeling for All Payers
Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms</td></tr>
<tr><td>Summary Statement of Work</td><td>Actuarial and financial analysis as well as technical assistance for the provider grant program.</td></tr>
<tr><td>Unique</td><td>Wakely is uniquely qualified to perform these tasks for several reasons:</td></tr>
</table>

Qualifications (if Sole Source)	• Wakely has been working with Vermont's claims data for the past three years. They provided the actuarial memoranda for Vermont's SIM application to CMMI. In this capacity, they have developed a high level of knowledge about Vermont's claims data. Wakely has also assisted Vermont in analyses related to our insurance marketplace. • Vermont will pursue an all-payer waiver and will need actuarial support for that waiver application. Wakely's familiarity with both Vermont's payment and delivery system reforms and insurance marketplace unmatched by any other health actuary. Having Wakely perform these tasks is the most efficient way to access these services. • Wakely has experience working across several states and in particular is experienced in using claims data to support innovative payment and delivery system change. Wakely brings this knowledge to its work in Vermont and allows Vermont to maximize efficiencies in contracting. • Wakely is able to begin this work immediately. The SIM Project requires Vermont adhere to extremely tight timeframes for payment and care model development. Delaying procurement of a vendor to conduct this work would significantly jeopardize the ability of Vermont to meet critical milestones and metrics.
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to November 12, 2015.**
Travel Justification	Hourly rates are inclusive of travel.
Performance Period 2 Applicable Milestones	1) ACO Shared Savings Programs: Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000. 2) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16.

Contract Attachment A, Scope of Work for Wakely Consulting Group #26303

A. Technical Assistance to VHCIP Sub-Grant Program Awardees.

In early 2014, the VHCIP launched a sub-grant program to foster innovation at the provider level. The technical assistance part of the VHCIP Grant Program is a key aspect and will enhance the awards and maximize the success of the awardees projects. The program supports five different technical assistors, one of whom is the Contractor.

1. The State will assign a technical assistor to work with an awardee. The technical assistance team will:
   a. Provide technical assistance of a specific nature (briefly described below) to grant awardees.
   b. Work with VHCIP Staff and awardees to refine project-specific scopes of work with clear parameters and costs.
   c. Provide detailed monthly reports of this work to VHCIP Staff.
2. Once the assignment is made, the Contractor will be paid for two services:
   a. Assisting Grant Program awardees to develop detailed scopes of work, including cost estimates; and;
   b. Execution of a specific scope of work for an awardee upon explicit, written approval by the State. The Contractor cannot commence any tasks under the second category of services without express, written approval of a Task Order from the State of Vermont's designated representative.
3. Pursuant to a Task Order, the Contractor may perform work in, but not limited to, the following areas:
   a. Develop Scopes of Work with Grant Program Awardees.

i. The Contractor shall develop detailed scopes of work, including timeline and total cost, with awardees and the State of Vermont. The State will pay the Contractor for the time spent on the development of each scope of work.
ii. Once the detailed scopes of work are completed, and approved by the State of Vermont, the Contractor shall create a work-plan for providing the technical assistance necessary for all of the approved scopes of work. The State will pay the Contractor for the time spent developing the work plan.
iii. The Contractor shall incorporate the work plan into the monthly Task Order submitted to the State.

b. Provide Technical Assistance Support to Grant Program Awardees.
   i. The Contractor shall provide consultative support to the approved Grant Program Awardees.
   ii. The areas of consultation that may be necessary in order to accomplish this task may include, but are not limited to actuarial and financial analyses.
   iii. When a Task Order requires technical assistance support as described in this section, the Contractor shall provide monthly reports to the State of Vermont regarding progress on each of the areas of consultation required by the Task Order. The Contractor should be prepared to consult with the State of Vermont in development of written documentation and presentations to State and CMMI in order to support this effort.
   iv. The Contractor's level of effort will vary according to the needs of each Awardees' reform agenda and the degree to which state staff or consultants retained are capable of providing all needed support.

B. Actuarial Support to VHCIP for development of forms required by CMMI as part of the reporting process for the State Innovation Models Testing Grant.

1. The State of Vermont is required to provide CMMI with actuarially supported documents as part of its State Innovation Models Testing (SIM) Grant. These forms include templates provided by CMMI and certified by actuaries that indicate the potential savings of Vermont's SIM Grant.
   a. The Contractor will complete these forms on behalf of the State of Vermont and provide actuarial memos describing the methodology used to complete them.
   b. The Contractor will only perform this activity if requested by the State of Vermont and will provide the documents by the federal deadline.

C. Actuarial Support to VHCIP for the development of an all-payer waiver pursuant to section 3021 of the Affordable Care Act.

1. The State of Vermont is pursuing an all-payer waiver pursuant to section 3021 of the Affordable Care Act. The State will require actuarial analyses to support its waiver request.
   a. The Contractor will only perform this activity if requested by the State.
   b. The Contractor will provide an estimate for the cost and time necessary to complete this work as requested by the State.
   c. The State will provide explicit written approval of these activities.

D. Ad-Hoc Tasks

1. The State shall define deliverables as aligned in the scope of work by meeting with the Contractor on a bi-weekly basis in order to define and confirm inclusion of additional deliverable development as identified by the State.
2. Ad hoc tasks shall be reduced to writing and approved by both parties on a Task Order form and added to the work plan on a bi-weekly basis.

III. Reporting Requirements

A. Monthly Reporting:

1. The Contractor shall participate in a conference call each month with the State of Vermont regarding this work. The purpose of these calls is to discuss administrative and project issues as they arise and to report preliminary findings of analyses as they become available.

2. More frequent calls may be needed during active periods of the project. The Contractor shall participate in all such calls as requested by the State. The State and Contractor shall determine a reasonable level of participations in such calls.
3. The contractor shall submit monthly progress reports outlining all work accomplished during the previous month. The reports should be concise and in a simple format (e.g., bulleted list) approved by the State of Vermont. These reports are to be submitted electronically to the VHCIP Project Director within five business days after the end of the month. These monthly progress reports shall be consistent with the work billed on the monthly vouchers. At a minimum, monthly progress reports shall cover the following items:

    a. Activities related to consultation and support related to each Awardee supported by this contract
    b. Activities planned for the forthcoming month
    c. Contractor's expectations of the State Staff during the forthcoming month (e.g., review of deliverables submitted, delivery of data or other items)
    d. Any problems or delays – encountered or foreseeable – that may affect contract performance
    e. Budget discrepancies greater than ten percent, i.e., cost overruns or underruns.
    f. Additional planning and coordination meetings may be required during the course of the contract, depending on the needs of each SIM Demonstration.

IV. Contract Administration, Key Personnel (See Attachment B for key personnel list and hourly rates)

The key personnel specified in this contract are considered to be essential to work performance under this Agreement. At least 30 days prior to diverting any of the specified individuals to other programs or contracts (or as soon as possible, if an individual must be replaced, for example, as a result of leaving the employ of the Contractor), the Contractor shall notify the Contracting Officer and shall submit comprehensive justification for the diversion or replacement request (including proposed substitutions for key personnel) to permit evaluation by the State of the impact on performance under this contract. The Contractor shall not divert or otherwise replace any key personnel without the written consent of the Contracting Officer. The State may modify the contract to add or delete key personnel at the request of the contractor or Government.

A. Performance Expectations

The State will develop monthly Task Orders with the Contractor and each Task Order will include deliverables that align with the work outlined in this Attachment A. Task orders are to be approved and signed by the designated representative of the State prior to any work commencement.

Deliverables shall consist of quantifiable products or services resulting from activities performed pursuant to this Agreement. Such deliverables may include, but are not limited to the following:

1. Technical Assistance Scopes of Work
2. Work Plan Development
3. Ad Hoc Tasks
4. Technical Assistance tasks

No work shall be undertaken or reimbursed pursuant to this Agreement without a Task Order approved in writing by the State's designated representatives. The State's designated representatives are:

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

Jessica Mendizabal
VHCIP Contract Administrator
jessica.mendizabal@state.vt.us

802-878-7958

The scopes of work and technical assistance provided by the Contractor shall contain specific deliverables, due dates and performance measures, and shall serve as the basis for quality assurance and a means for monitoring the contractor's performance throughout the duration of this contract.

The Contractor shall provide a single point of contact who will manage all aspects of the contract including the assignment of qualified personnel to perform the work outlined herein. The Contractors single point of contact is:

Julie Peper, Director
Wakely Consulting Group
Phone: 720-226-9814
Email: juliep@wakely.com

The Contractor's single point of contact or designee will be present at bi-weekly status meetings at a time and date agreed upon by the State and Contractor.

The number of personnel and level of expertise required, as well as the scheduled hours to be worked will be determined by the State and the Contractor as part of the status meetings and shall be included on the task order form. The assignment of additional personnel, hours, or the substitution of personnel with a higher level of expertise shall require pre-approval by the State.

The Contractor accepts full responsibility for any personnel assigned to perform the work herein. It is understood that the State will provide minimal oversight of personnel assigned to this contract.

The State shall notify the Contractor's single point of contact to discuss remediation if it is determined by the State that personnel assigned are not performing as expected. The State has the right to request a change in personnel assigned. The State shall not request a change in personnel without reason. The Contractor is obligated to provide a change in personnel, within 2 business days of a request by the State.

Below please find contracts that we will submit later to CMMI/OAGM for approval. We have identified the contractors and basic scope, but are still negotiating specific terms with the contractors.

Vermont will submit specific requests to un-restrict funds for these contracts:

Truven/Brandeis #TBD	
Method of Selection	Sole Source
Contract Amount	**Total Contract Amount (all years):**$65,975 **Performance Period 2 Total Amount (including Travel):**$32,500 **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	12/1/15-12/31/16 (Performance Period 2 1/1/16-6/30/16)
Method of Accountability	This is a deliverables/performance-based agreement where the Contractor is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The contract manager(s) review the invoices and work products each month before approving the invoices.
Itemized Budget	TBD
Budget Category	Evaluation
Summary Statement of Work	Contract to provide data files to federal evaluator, RTI. Truven will create a VHCURES MarketScan-like database for use by RTI in its evaluation of the SIM initiative.
Unique Qualifications (if Sole Source)	Truven is uniquely positioned to perform this work because as part of their existing Analytic Services contract with the Green Mountain Care Board they developed a series of programs in SAS to transform the VHCURES data from its native format into one that is similar to our Truven MarketScan Research Databases. RTI has licensed the MarketScan data from us for their national SIM evaluation work and has accurately described the structure and content.
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to November 12, 2015.**
Travel Justification	Travel is not an allowable expense under this agreement.
Applicable Y2 Milestone	Self-Evaluation Plan and Execution: 2. Continue to execute self-evaluation plan using staff and contractor resources.[13] 3. Streamline reporting around other evaluation activities not performed by Impaq within 30 days of CMMI approval of self-evaluation plan.

[13] Vermont's self-evaluation plan relies on numerous staff and contractors, which are described in the Evaluation Remediation Plan submitted on November 25, 2015.

Onpoint Evaluation: TBA	
Method of Selection	Sole Source
Budget Amount	$60,000
Contract Term	
Method of Accountability	TBD depending on contract terms. Contract will be executed at the GMCB.
Itemized Budget	TBD depending on contract terms.
Budget Category	Evaluation
Summary Statement of Work	Create data extracts to for both state and federal evaluation, using the Vermont Healthcare Claims Uniform Reporting and Evaluation System's (VHCURES) data.
Unique Qualifications (if Sole Source)	Onpoint is uniquely positioned to perform this work because as part of their existing all-payer claims data base management contract, they develop extracts for use by the Green Mountain Care Board. This extract will be provided to Truven Analytics to create a MarketScan data file. That file will then be shared with RTI, the federal evaluator for use as part of the federal evaluation. RTI has licensed the MarketScan data from us for their national SIM evaluation work and has accurately described the structure and content.
Retroactive Start Justification (if applicable)	**Funding is requested to be retroactive to January 1, 2016.**
Travel Justification	Travel is not an allowable expense under this agreement.
Performance Period 2 Applicable Milestones	Self-Evaluation Plan and Execution: 2. Continue to execute self-evaluation plan using staff and contractor resources. 3. Streamline reporting around other evaluation activities within 30 days of CMMI approval of self-evaluation plan.

The following contracts are TBD as of the date of this submission.

Vermont will submit separate requests for un-restriction of these funds.

TBD- Accountable Communities for Health	
Method of Selection	Will comply with SOV procurement requirements
Budget Amount	$50,000
Contract Term	TBD – activity in Performance Period 2
Method of Accountability	TBD depending on contract terms. Contract(s) will be executed at DVHA.
Itemized Budget	TBD depending on contract terms.
Budget Category	Advanced Analytics: Policy and Data Analysis to Support System Design and Research for All Payers
Summary Statement of Work	Application of the Accountable Health Community to Vermont's health care system
Performance Period 2 Applicable Milestones	Feasibility assessment – data analytics: 1. Discussion and planning of investments related to ACH feasibility based on research/report by 11/1/15. 2. Design/creation of ACH learning system for all 14 Vermont Health Service Areas by 1/31/16. 3. Start roll out ACH learning system to at least 3 health service areas by 2/1/16. 4. Research for implementation of a pilot incorporating a payment change (data analysis, financial analysis, stakeholder participation analysis) for at least 1 Vermont region by 2/1/16.
Procurement Plan	Procurement Plan: This project is in the final design phase. Contract negotiations will begin late December will contract start date anticipated for 2/1/16. More detailed information about this project can be found here: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Core_Team/10.13.15.CT_.Meeting.Materials.pdf (pp. 41-52)

TBD: HIE Design and Testing	
Method of Selection	RFP
Budget Amount	$351,550
Contract Term	TBD
Method of Accountability	TBD depending on contract terms. Contract(s) will be executed at DVHA.
Itemized Budget	TBD depending on contract terms
Budget Category	*Technology and Infrastructure*: Analysis of How to Incorporate Long-Term Support Services, Mental Health, and Other Areas of Health
Summary	TBD

Statement of Work	
Performance Period 2 Applicable Milestones	Care Management Tools: Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development: 2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16.
Procurement Plan	The SCUP Team is engaged in further discovery for this week based on work group feedback. The current procurement plan will leverage a shared care plan solution being purchased by OneCare Vermont. The planning phase will conclude in January 2016, will a contract start date by 3/31/16 at the latest. More information about this project can be found here: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/HIE/HDI_11.18.15.Merged.Meeting.Materials.v2.pdf (pp.28-32).

TBD: QI Facilitators	
Method of Selection	RFP
Budget Amount	$259,612
Contract Term	TBD
Method of Accountability	TBD depending on contract terms. Contract(s) will be executed at DVHA.
Itemized Budget	TBD depending on contract terms
Budget Category	*Technical Assistance*: Learning Collaboratives
Summary Statement of Work	Learning Collaborative activities.
Performance Period 2 Applicable Milestones	Learning Collaboratives: Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 1. Create expansion plan for remaining Vermont HSAs that want to participate in the Learning Collaborative program by 6/15/15. 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.
Procurement Plan	Bids were received for this RFP on time. The Bid review team has met several times and is in negotiations with bidders regarding budget adjustments for the two apparent awardees. Contracts will be sent to CMMI as soon as they are ready and the expected contract start date is 1/1/16. The RFP can be found here: http://dvha.vermont.gov/administration/vhcip-lc-dltss-trainer-rfp.pdf.

TBD: Telehealth Pilots	
Method of Selection	RFP
Budget Amount	$455,000
Contract Term	TBD
Method of Accountability	TBD depending on contract terms. Contract(s) will be executed at DVHA.

Itemized Budget	TBD depending on contract terms
Budget Category	Health Data Infrastructure: Telehealth – Implementation
Summary Statement of Work	Phase II of Telemedicine planning: Implementation of pilot programs.
Performance Period 2 Applicable Milestones	Telehealth – Implementation: 2. Award at least one contract to implement the scope of work in the telehealth program RFP by 1/15/16.
Procurement Plan	Bids were received on time, 10/23/15. The Bid review team has met several times and is in negotiations with the bidders regarding budget adjustments for the apparent awardees. There will be at least two contracts awarded as a result of this RFP. Contracts will be sent to CMMI as soon as they are ready and the expected contract start date is 1/1/16. The RFP can be found here: http://dvha.vermont.gov/administration/1revised-sim-telehealth-pilots-rfp-9-22-15.pdf.

TBD: Technical Assistance: Technical assistance to providers implementing payment reforms	
Method of Selection	RFP
Budget Amount	$770,000
Contract Term	TBD
Method of Accountability	TBD depending on contract terms. Contract will be executed at DVHA.
Itemized Budget	TBD depending on contract terms.
Budget Category	*Advanced Analytics*: Policy and Data Analysis to Support System Design and Research for All Payers
Summary Statement of Work	TBD
Performance Period 2 Applicable Milestones	1) Payment Models: 60% of Vermonters in alternatives to fee-for-service by 6/30/16. 2) State Activities to Support Model Design and Implementation – Medicaid: Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed.
Procurement Plan	A proposal will be reviewed at the Core Team meeting on 12/9 for this work. Once approved, we will begin contract negotiations. Anticipated start date is 1/15/16. A contract will be sent to CMMI as soon as it is ready. Materials related to this proposal will be available on this webpage on 12/4/15: http://healthcareinnovation.vermont.gov/core_team.

TBD: Technology and Infrastructure: Expanded Connectivity of HIE Infrastructure	
Method of Selection	RFP
Budget Amount	$700,000
Contract	TBD

Term	
Method of Accountability	TBD depending on contract terms. Contract will be executed at DVHA.
Itemized Budget	TBD depending on contract terms.
Budget Category	Health Data Infrastructure: Care Management Tools
Summary Statement of Work	TBD
Performance Period 2 Applicable Milestones	1) Expand Connectivity to HIE – Gap Remediation: Remediate data gaps that support payment model quality measures, as identified in gap analyses. 1. Remediate 50% of data gaps for SSP quality measures by 12/31/15. 2. Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15. 2) Improve Quality of Data Flowing into HIE: 1. Implement terminology services tool to normalize data elements within the VHIE by TBD. 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16.
Procurement Plan	There are several technology and infrastructure proposals that are under development. These proposals have been reviewed at the Health Data Infrastructure Work Group, in October and November, and at the Steering Committee, in December. We anticipate a start date of February 1, 2016. More details about these proposals can be found here: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/HIE/HDI_11.18.15.Merged.Meeting.Materials.v2.pdf.

TBD: Evaluation	
Method of Selection	RFP
Budget Amount	$400,000.00
Contract Term	TBD depending on contract terms. Contract(s) will be executed at the GMCB.
Method of Accountability	TBD depending on contract terms
Itemized Budget	TBD
Budget Category	Evaluation
Summary Statement of Work	State-led Evaluation to focus on activities that facilitate continuous improvement and evaluation of Vermont-specific pilots and innovations. The evaluation has two primary goals: 1. Provide timely feedback to inform corrections in the implementation and operation of VHCIP sponsored-initiatives, and 2. Generate actionable recommendations to guide Vermont state-leadership's decisions to scale-up and diffuse VHCIP-supported initiatives.
Performance Period 2 Applicable Milestones	Self-Evaluation Plan and Execution: 1. Procure new self-evaluation contractor by 2/28/16 to execute contractor-led self-evaluation plan activities. 2. Continue to execute self-evaluation plan using staff and contractor resources.
Procurement Plan	Evaluation RFP: Bids are due 12/11/15. A bid review team has been selected. Awardee notification is 12/15/15. Contract negotiation will start on 12/15/15 and contract will be sent to CMMI as soon as it is ready. Anticipated start date is 1/22/16.

	The RFP can be found here: http://gmcboard.vermont.gov/sites/gmcboard/files/Contracts/RFP-SIM-SEval_FINAL2.pdf.

SUB GRANT PROGRAM Contracts:

TOTAL Contracts (all years):$4,903,449.43; Performance Period 2 Total Amount (including travel):$1,872,468.99

Bi-State Primary Care Association/ Community Health Accountable Care #03410-1295-15	
Method of Selection	RFP-**Sub-Grant Program Awardee**
Contract Amount	**Total Contract Amount (all years):**$400,000 **Performance Period 2 Total Amount (including Travel):**$139,650 **Performance Period 2 Out-of-State Travel:$**3,686
Contract Term	7/15/14-6/30/16, **Performance Period 3**, 1/1/16-6/30/16
Method of Accountability	This is a deliverables/performance-based agreement where the Subrecipient is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The program manager(s) review the invoices and work products each month before approving the invoices.
Itemized Budget (total project)	(see table below)
Budget Category	*Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms*
Summary Statement of Work	Federally Qualified Health Centers (FQHCs) and Bi-State Primary Care Association have formed a primary care centric Accountable Care Organization (ACO), Community Health Accountable Care, LLC (CHAC), to participate in shared savings programs with Medicare, Medicaid, and at least one commercial payer. Bi-State/CHAC will implement the ACO model to monitor quality of care through data, promote evidence-based medicine, and coordinate care with participating community providers. The outcome will be improved quality and

Itemized Budget (total project):

Category	Budgeted Amount
CHAC Director	141,923.00
Project Coordinator	80,007.00
Accounting	11,839.00
Director, HC Informatics	15,942.00
Administrative Assistant	2,000.00
Total Salary	251,711.00
Fringe	57,894.00
Conference/Travel	8,876.00
Meetings	7,000.00
Contractural: Admin Support	6,888.00
Professional Services	8,790.00
Facility Costs	10,000.00
Other Beneficiary Engagement	10,000.00
Supplies	7,881.00
Indirect	30,960.00
Totals	400,000.00

	reduced cost of care, particularly for high risk patients.
Unique Qualifications (if Sole Source)	N/A
Retroactive Start Justification (if applicable)	1/1/16
Travel Justification	Travel for 1 FTE estimated in Spring of 2016 to attend the NAACO conference. This conference directly supports the aim of creating a robust ACO in Vermont through sharing best practices with ACOs around the country. Total estimated travel cost:$3,686 Conference Fee:$1,690 Ground Transportation:$50 Roundtrip Airfare Burlington to Chicago:$550 Per Diem:$32 per day for 3 days or$96 Lodging:$1,300 (based on 2015 costs for lodging for same conference)
Applicable Y2 Milestone	Sub-Grant Program – Sub-Grants: Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.

Grant Attachment A, Scope of Work for Bi-State Primary Care Association/ Community Health Accountable Care #03410-1295-15

Subrecipient Shall:

1. Hire and maintain appropriate staffing for project, including a Community Health Accountable Care LLC (CHAC) Director and Project Coordinator.
2. Execute and monitor activities, including a quality compliance program, to ensure compliance with CHAC's Medicaid and Commercial Shared Savings Program and regulatory Agreements and requirements.
3. Recruit providers who will participate and collaborate with CHAC.
4. Provide leadership for CHAC's activities regarding budget, quality improvement, data repository and reporting services in collaboration with CHAC's senior management staff.
5. Complete reporting for CHAC's Medicaid and Commercial Shared Savings Program Agreements according to schedule.
6. Plan, and begin reporting on quality measures by 2015.
7. Plan, staff and support CHAC's Board of Directors Meetings.
8. Plan, staff and support CHAC's Clinical, Financial, Beneficiary Engagement, and Operations Committees in collaboration with the respective Chairs.
9. Maintain CHAC's website to meet compliance requirements, and provide general information for beneficiaries and the public.
10. Represent CHAC at State meetings.
11. Prepare and submit to the State quarterly programmatic status reports no later than the 10th of the month following the 3 month period being reported. The reports shall include a narrative summary outlining specific progress on projects as directed by the reporting templates provided. The reporting schedule is as follows:
    a. 2014: October 10
    b. 2015: January 10, April 10, July 10, October 10

c. 2016: January 10, April 10
d. Final Report Due: July 30, 2016

12. Prepare and present programmatic reports to the VHCIP work groups, Steering Committee or Core Team as requested.
13. Adhere to the following work plan and timeline:

Deliverables and Implementation Timeline for VCHIP Provider Grant Proposed Activities Key for Work Plan Performance Periods: Q1: January – March; Q2: April-June. Q3: July-September. Q4: October-December.					
Activities	**Anticipated Outcomes**	**Milestone**	**Implementation Timeline**	**Person Responsible**	**Comment**
Need: Vermont and the nation have identified the need to develop new systems and structures to reduce rising health expenditures while maintaining and improving the quality of care					
Goal : Increase provider collaboration across the continuum of care in local communities					
Objective 2.1: Grow and strengthen Community Health Accountable Care, LLC (CHAC), a Shared Savings Accountable Care Organization					
Implement Medicare, Medicaid, and Commercial Shared Savings Programs (SSPs)	CHAC will be operating under the program requirements of the Medicaid, Medicare, and Commercial SSPs	Reports on quality SSPs will be and a Compliance Work Plan will be developed	Data reports submitted beginning in Q1 2015 Work Plan Developed between Q1 and Q2-2014	Director of Community Health Payment Systems (CHAC Director); and Project Coordinator for ACO Implementation	CHAC executed Medicare in 2013 executing Medicaid and 2014.
Complete recruitment of an inclusive Board of Directors to govern CHAC	Regular meetings of the 18 Board members will be held to lead CHAC's work	Public comment periods will be available at board meetings	Monthly starting Q1 2014	Director of Community Health Payment Systems	CHAC will also implement a committee structure
Develop an inclusive structure of four CHAC committees (Finance, Clinical, Operations, and Beneficiary Engagement)	Quarterly meetings of the committees will be held to direct CHAC priorities	Charters and work plans for the Clinical, Operations, Financial, and Beneficiary committees will be available	Quarterly starting Q2 2014	Director of Community Health Payment Systems; CHAC Project Coordinator; CHAC Medical Director	Items in charters will include requirements of the SSPs, e.g. adopting evidence based protocols, beneficiary engagement, and others

Continue active participation in payment reform conversations	Subrecipient will test the ACO model (and consider the feasibility of global payment, bundled payment, or pay for performance) in conjunction with the state and payers	Attendance at Payment Reform meetings	Quarterly starting Q1 2014	Director of Community Health Payment Systems; COO	
Continue to engage with the other 2 ACOs in Vermont	The multi-ACO group will develop economies of scale and/or reduce duplication, where appropriate	Attendance at proposals and ways to collaborate be developed	Monthly starting Q1 2014	Director of Community Health Payment Systems; Director of VT Operations	

Central Vermont Medical Center #03410-1458-15	
Method of Selection	RFP-**Sub-Grant Program Awardee**
Contract Amount	**Total Contract Amount (all years):**$500,000 **Performance Period 2 Total Amount (including Travel):**$192,381 **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	12/1/15-11/30/16, **Performance Period 2** 1/1/16-11/30/16
Method of Accountability	This is a deliverables/performance-based agreement where the Subrecipient is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The program manager(s) review the invoices and work products each month before approving the invoices.
Itemized Budget (total project)	(see table below)
Budget Category	*Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms*
Summary Statement of Work	SBIRT is an evidence-based practice to identify, reduce and prevent substance misuse and co-occurring disorders. Following on the success of the recent implementation of SBIRT in the Emergency Department (ED), this project will extend SBIRT to seven patient centered medical homes by incorporating SBIRT screening, intervention strategies and SBIRT clinician staffing into chronic disease management practices. This project aims to prevent and reduce

Category	Performance Period 1 – begins	Performance Period 2 – begins	Total
Personnel	180,485	180,485	360,970
Fringe	49,200	49,200	98,400
Consultants	5,000	1000	6,000
Equipment	3,960	0	3,960
Supplies	5,335	5,335	10,670
Other Costs	10,000	10,000	20,000
Indirect			
Total	253,980	246,020	500,000

	substance misuse, reduce healthcare costs and increase care coordination through increased patient participation in referral and addiction treatment programs and to demonstrate a regional model of care that can be promoted statewide.
Unique Qualifications (if Sole Source)	N/A
Retroactive Start Justification (if applicable)	1/1/16
Travel Justification	No travel estimated.
Applicable Y2 Milestone	Sub-Grant Program – Sub-Grants: Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.

Grant Attachment A, Scope of Work for Central Vermont Medical Center #03410-1458-15

Subrecipient Shall:

1. Implement current SBIRT strategies within patient centered medical homes via the following activities:
    a. Develop a Short Message Service (SMS) protocol to monitor substance use and engage and extend patient activation.
    b. Promote the SBIRT model statewide through presentations and targeted outreach to professional associations.
2. Utilize SMHSA's Technical Assistance Systems-Level Implementation manual to develop a systemic training model to promote clinical skills learning, practice competency and fidelity in SBIRT.
    a. Trainings will be provided to provider health care teams, hospital management and other stakeholders through courses, webinars, onsite coaching and clinical toolbox resources.
3. Conduct outreach to identify an SBIRT MGP Champion Team at each site to support SBIRT adoption and implementation.
4. Integrate the SBIRT measure set into eClinicalWorks (eCW) software, including: initial screening items (AUDIT C, 3 NIDA questions; secondary screening tools (AUDIT-10 and DAST-10); stratified risk scores; and clinical intervention tracking to improve care coordination and to expedite billing for reimbursement.
5. Increase and enhance current linkages to the ED and specialty behavioral health and addiction treatment providers in Central Vermont to facilitate the exchange of patient information, improve safety, care coordination and quality of health care.
6. Explore the utility of the current SBIRT reimbursement practices across differing settings statewide and differing provider disciplines.
7. Collaborate with ADAP, DVHA, and commercial insurers via the Department of Financial Regulation, to develop a VT-SBIRT financial model to be adopted statewide and ultimately to ensure same-day billing for two services and that SBIRT codes are activated for an expanding workforce.
8. Educate and guide medical providers in substance abuse coding and billing.
    a. Subrecipient shall work with VHCIP staff to coordinate several meetings with the State and third party payers to fully understand the potential billing mechanisms across differing care settings and provider types.
9. Program Status Reporting

a. Prepare and submit to the State quarterly programmatic status reports no later than the 10th of the month following the 3 month period being reported. The reports shall include a narrative summary outlining specific progress on projects as directed by the reporting templates provided. The reporting schedule is as follows:
    i. 2015: April 10 (to include the month of December, 2014), July 10, October 10
    ii. 2016: January 10, April 10, July 10, October 10, December 10 (for the months of October and November, 2016)
    iii. Final Report Due: December 10, 2016
b. Programmatic reports shall be submitted to:
Joelle Judge
VHCIP Project Management Office
Agency of Administration
joelle.judge@partner.state.vt.us
(o) 802-828-1979

10. Prepare and present programmatic reports to the VHCIP work groups, Steering Committee or Core Team as requested.
11. Adhere to the following work plan and timeline below:

Deliverables	Quarter	Phase	Implementation Timeline	Person Responsible	Complete?	Milestones
Post initial SBIRT clinician positions to cover pilot sites.	1	Planning	Completed	AS	Yes	1. EHR SBIRT template build completed 2. SBIRT Clinicians Hired
Create SBIRT Shared Folder on Root.	1	Planning	Completed	AS	Yes	
Schedule weekly SBIRT Planning Meetings.	1	Planning	Ongoing	AS/PM	Yes	
Develop training proposal to share with MD Champions.	1	Planning	12/15/2014	PM		
Screen and interview candidates.	1	Planning	Week of 1/5/15	AS/PM		
Train pilot site clinicians and staff on SBIRT.	1	Planning	Pilot site Staff January/	PM		
Develop clinical data collection plan (Primary Screens, DAST-10, AUDIT-10, SBIRT Interventions).	1	Planning	1/4/2015	PM		
Collect baseline data.	1	Planning	2/15/2015	PM/IT		
Build SBIRT screening tools in ECW.	1	Planning	2/5/2015	AS/PM		
Hire initial SBIRT clinicians.	1	Planning	1/20/2015	AS/PM		
Create site schedules and workflows – where will the clinician sit on each day? What will the practice work flow look like?	1	Planning	2/9/2015	AS/PM		
Train initial SBIRT clinicians.	2	Pilot Implementation	Week of 2/16/2015	PM		1. All SBIRT pilot training completed
Weekly huddles with leadership at	2	Pilot	Starting 2/2/15	AS/PM		
Data collection to evaluate initial progress and effectiveness of pilot.	3	Initial Evaluation	5/18/2015	PM/IT		
Weekly huddles with leadership at	3	Initial	Starting 2/2/15	PM		
Data collection to evaluate initial 6 months of pilot project.	4	Full Pilot Evaluation	8/18/2015	PM/IT		1. SBIRT pilot completed 2. WCMHS SBIRT clinicians contracted and implemented 3. All SBIRT training completed
Identify 2 WCMHS clinicians to provide SBIRT services to non-pilot practices.	4	Full Pilot Evaluation	8/28/2015	PM/AS/WCMHS		
Obtain Contractor access for WCMHS Clinicians.	4	Full Pilot Evaluation	9/15/2015	AS/PM		
Train WCMHS SBIRT clinicians.	4	Full Pilot Evaluation	10/7/2015	PM		
Train clinicians and staff at non-pilot practices.	4	Full Pilot Evaluation	Week of 10/5/15	PM		
Collect baseline data for non-pilot practices.	4	Full Pilot Evaluation	Week of 10/5/2015	PM/IT		

Full SBIRT implementation begins for remaining practices.	5	Full Implementation	11/15/2015	PM/WCMHS		1. SBIRT live in all practices
Weekly huddles with practice leadership to address any operational issues.	5	Sustainability	Weekly	PM		
Full SBIRT activity continues within the practices.	6	Sustainability				
Full SBIRT activity continues within the practices.	7	Sustainability				
Full SBIRT activity continues within the practices.	8	Sustainability				

<table>
<tr><th colspan="2">Department on Aging and Independent Living (DAIL)- Invest EAP MOU #03410-13-15</th></tr>
<tr><td>Method of Selection</td><td>RFP-Sub-Grant Program Awardee</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$310,087
Performance Period 2 Total Amount (including Travel):$161,902.94
Performance Period 2 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>7/1/2014-11/30/2016, Performance Period 2 1/1/16-11/30/16</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based agreement where the Subrecipient is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The program manager(s) review the invoices and work products each month before approving the invoices.</td></tr>
<tr><td>Itemized Budget (total project)</td><td>
<u>Resilient Vermont:</u>
<table>
<tr><th>Budget Category</th><th>Total</th></tr>
<tr><td>Personnel</td><td>$ -</td></tr>
<tr><td>Fringe</td><td>$ -</td></tr>
<tr><td>Travel</td><td>$6,500.00</td></tr>
<tr><td>Equipment</td><td>$1,900.00</td></tr>
<tr><td>Supplies</td><td>$1,000.00</td></tr>
<tr><td>Other</td><td>$21,560.00</td></tr>
<tr><td>Contracts</td><td>$196,260.00</td></tr>
<tr><td>Total Direct Costs</td><td>$227,220</td></tr>
<tr><td>Indirect</td><td>$22,722.00</td></tr>
<tr><td>Total</td><td>$249,942.00</td></tr>
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<u>Behavioral Health Screening Intervention:</u>
<table>
<tr><th>Budget Category</th><th>Total</th></tr>
<tr><td>Personnel</td><td>$17,796</td></tr>
<tr><td>Fringe</td><td>$8,431</td></tr>
<tr><td>Travel</td><td>$ -</td></tr>
<tr><td>Equipment</td><td>$5,400</td></tr>
<tr><td>Supplies</td><td>$370</td></tr>
<tr><td>Other</td><td>$1,680</td></tr>
<tr><td>Contracts</td><td>$21,000</td></tr>
<tr><td>Total Direct Costs</td><td>$54,677</td></tr>
<tr><td>Indirect</td><td>$5,468</td></tr>
<tr><td>Total</td><td>$60,145</td></tr>
</table>
</td></tr>
<tr><td>Budget Category</td><td>Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms</td></tr>
</table>

Summary Statement of Work	InvestEAP, Vermont's public/private employee assistance program, and a federally-qualified health center, will partner to demonstrate the impact of integrating an innovative stress prevention and early intervention program with traditional primary care delivery. The project embodies the core belief that early intervention aimed at the social determinants of health and the root causes of stress will improve health outcomes and reduce medical expenditures. Invest EAP will also partner with WellSys, a physician-owned business dedicated to helping healthcare professionals bring Behavioral Screening and Intervention to their clinical settings, and the Vermont-based employer, King Arthur Flour. Invest EAP will provide behavioral screening and interventions to demonstrate its effectiveness in the workplace as a means to improve health outcomes and reduce medical expenditures.
Unique Qualifications (if Sole Source)	N/A
Retroactive Start Justification (if applicable)	1/1/16
Travel Justification	Travel budgeted in this agreement is for in-State travel only.
Applicable Y2 Milestone	Sub-Grant Program – Sub-Grants: Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.

Grant Attachment A, Scope of Work for Department on Aging and Independent Living (DAIL)- Invest EAP #03410-13-15

Deliverables and Timeline

1. *Resilient Vermont* will provide the following comprehensive services to patients of Northern Counties Health Care:
   a. Toll-free hotline to be answered live 24 hours per day, 7 days per week by a licensed counselor.
   b. Provide short-term (1-5 sessions), solution-focused counseling to build resiliency and resolve problems.
   c. Access to research and resource information for help with daily life challenges such as: Daycare; Eldercare; Parenting and; Adoption.
   d. Access to a Life Resource counselor for help with issues such as: Credit problems; Transportation; Housing; Fuel Assistance; Economic Services; Social Services; Legal problems, and Employment.
   e. Consultation with a Vermont-based attorney for legal problems coupled with a 25% fee reduction when needing to retain such an attorney for a court case.
   f. Consultation with a licensed financial professional to help with debt problems, budgeting, retirement planning and related matters.
   g. Disability management resources, including access to assistive technologies to help with job accommodations; help with employment; benefits counseling, and certain paid services to ensure the success of people with disabilities already in the workplace.
   h. Wellness and resource workshops that we will offer at local community health centers.
   i. Whole-life bio-psycho-social assessment with recommendations and help building resiliency.
   j. Facilitate warm referrals for ongoing mental health and substance abuse counseling.

2. *Behavioral Health Screening and Intervention:* Invest EAP will implement a demonstration site at King Arthur Flour in Norwich, Vermont.
   a. Implement an outreach plan to inform potential participants of the program. The outreach plan will include:
      i. An introductory letter that introduces the new benefit;
      ii. Informational brochures that describe the program;
      iii. Quarterly prevention newsletter for participants;
      iv. Comprehensive website with health and wellness videos and other tools compelling for members.

v. Participation incentive in the form of a State-approved gift card or monetary payment to participants in the amount of$10 to be issued upon completion of a three and six month assessment.
vi. In-person orientation and training for all employees.

b. Treatment will consist of a range of behavioral techniques supported by the demonstrated approaches used by the University of Wisconsin School of Medicine and Public Health, including: Motivational Interviewing, Behavioral Activation and Problem-Solving Therapy.
i. BHI counselors will perform in-person screenings of all participants.

3. The appended timeline on page 6 of this agreement is subject to modifications and shall be updated as necessary.

Evaluation and Expected Outcomes

Invest EAP will evaluate the success of the programs utilizing pre-test and post-test instruments that measure both: health behaviors known to be correlated with reduced healthcare expenditures and; specific health outcomes.

Invest EAP will also perform a qualitative analysis utilizing audiotape interviews with select patients to be transcribed and analyzed.

Anticipated Outcomes include:

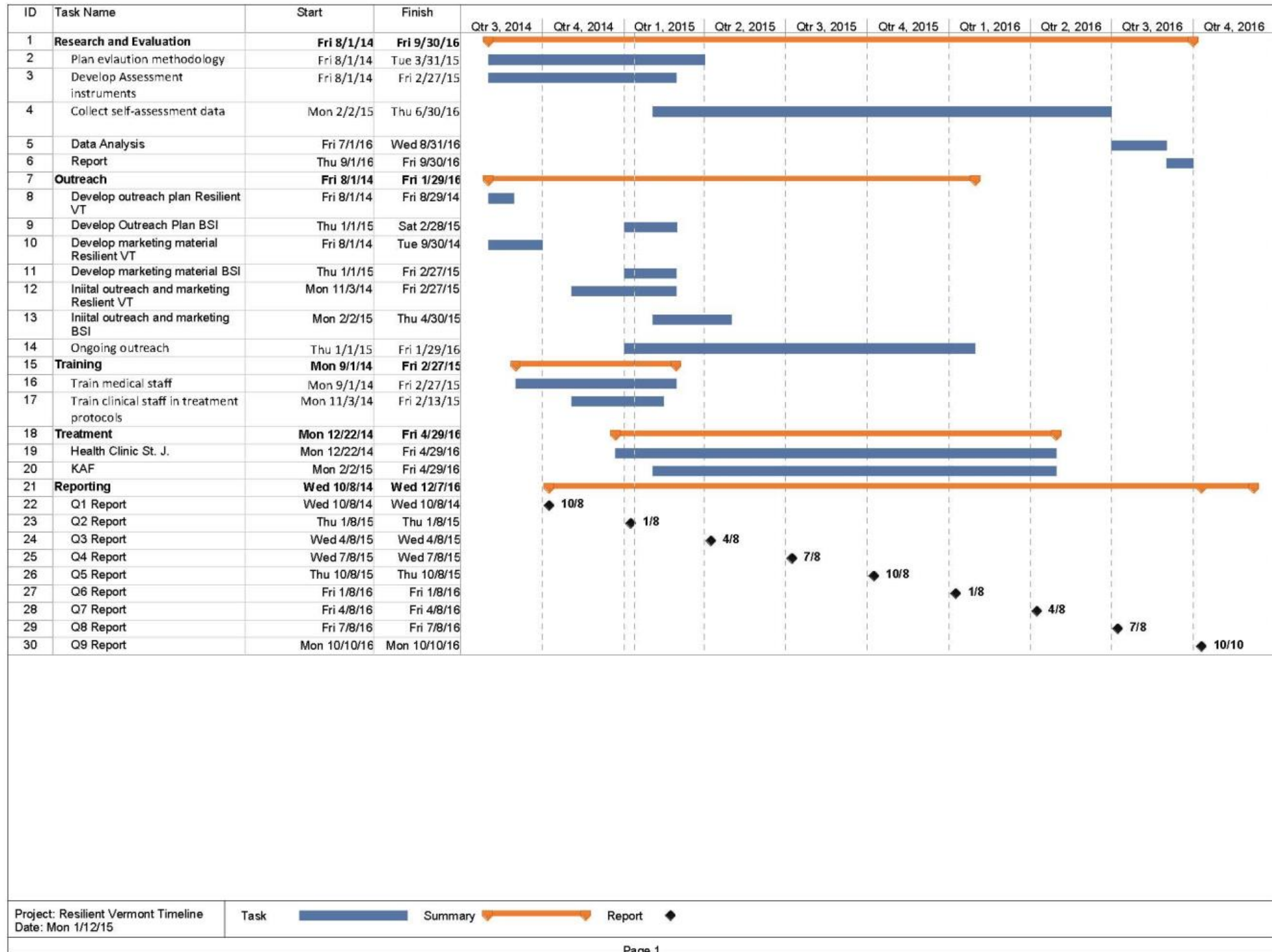
1. Reduced severity and frequency of chronic health conditions.
2. Improved overall self-perception of health.
3. Improved self-perception of stress.
4. Reduced expenditures on chronic health conditions (for both individuals and dependents).
5. Reduced overall expenditures on health care (for both individuals and dependents).

Reporting Provisions

1. Quarterly and programmatic status reports shall be submitted to DVHA no later than the 10th of the month following the 3 month period being reported. The reports shall include a narrative summary outlining specific progress on projects as directed by the reporting templates provided.

   The reporting schedule is as follows:
   a. 2014: October 10
   b. 2015: January 10, April 10, July 10, October 10
   c. 2016: January 10, April 10, July 10, October 10, December 10 (for the months of October and November, 2016
   d. Final Report Due: December 10, 2016
   e. Programmatic reports shall be submitted to:
   Joelle Judge
   VHCIP Project Management Office
   Agency of Administration
   joelle.judge@partner.state.vt.us
   (o) 802-828-1979

2. Invest EAP shall prepare and present programmatic reports to the VHCIP work groups, Steering Committee or Core Team as requested.



ID	Task Name	Start	Finish
1	**Research and Evaluation**	**Fri 8/1/14**	**Fri 9/30/16**
2	Plan evlaution methodology	Fri 8/1/14	Tue 3/31/15
3	Develop Assessment instruments	Fri 8/1/14	Fri 2/27/15
4	Collect self-assessment data	Mon 2/2/15	Thu 6/30/16
5	Data Analysis	Fri 7/1/16	Wed 8/31/16
6	Report	Thu 9/1/16	Fri 9/30/16
7	**Outreach**	**Fri 8/1/14**	**Fri 1/29/16**
8	Develop outreach plan Resilient VT	Fri 8/1/14	Fri 8/29/14
9	Develop Outreach Plan BSI	Thu 1/1/15	Sat 2/28/15
10	Develop marketing material Resilient VT	Fri 8/1/14	Tue 9/30/14
11	Develop marketing material BSI	Thu 1/1/15	Fri 2/27/15
12	Iniital outreach and marketing Reslient VT	Mon 11/3/14	Fri 2/27/15
13	Iniital outreach and marketing BSI	Mon 2/2/15	Thu 4/30/15
14	Ongoing outreach	Thu 1/1/15	Fri 1/29/16
15	**Training**	**Mon 9/1/14**	**Fri 2/27/15**
16	Train medical staff	Mon 9/1/14	Fri 2/27/15
17	Train clinical staff in treatment protocols	Mon 11/3/14	Fri 2/13/15
18	**Treatment**	**Mon 12/22/14**	**Fri 4/29/16**
19	Health Clinic St. J.	Mon 12/22/14	Fri 4/29/16
20	KAF	Mon 2/2/15	Fri 4/29/16
21	**Reporting**	**Wed 10/8/14**	**Wed 12/7/16**
22	Q1 Report	Wed 10/8/14	Wed 10/8/14
23	Q2 Report	Thu 1/8/15	Thu 1/8/15
24	Q3 Report	Wed 4/8/15	Wed 4/8/15
25	Q4 Report	Wed 7/8/15	Wed 7/8/15
26	Q5 Report	Thu 10/8/15	Thu 10/8/15
27	Q6 Report	Fri 1/8/16	Fri 1/8/16
28	Q7 Report	Fri 4/8/16	Fri 4/8/16
29	Q8 Report	Fri 7/8/16	Fri 7/8/16
30	Q9 Report	Mon 10/10/16	Mon 10/10/16

<table>
<tr><th colspan="2">Healthfirst, Inc. #03410-1305-15</th></tr>
<tr><td>Method of Selection</td><td>RFP-Sub-Grant Program Awardee</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$600,000
Performance Period 2 Total Amount (including Travel):$257,874.21
Performance Period 2 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>8/15/2014-10/31/2016, Performance Period 2 1/1/16-10/31/2016</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based agreement where the Subrecipient is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The program manager(s) review the invoices and work products each month before approving the invoices.</td></tr>
<tr><td>Itemized Budget (total project)</td><td>
<table>
<tr><th>Category</th><th>Budgeted Amount</th></tr>
<tr><td>Exec Director</td><td>147,000.00</td></tr>
<tr><td>Admin Asst</td><td>50,750.00</td></tr>
<tr><td>Ops Director</td><td>63,000.00</td></tr>
<tr><td>Quality and Care Coordination Manager</td><td>65,000.00</td></tr>
<tr><td>Fringes</td><td>-</td></tr>
<tr><td>Total Salary & Fringes</td><td>325,750.00</td></tr>
<tr><td><u>Consulting:</u></td><td></td></tr>
<tr><td>Local Physician Liaison Team</td><td>52,000.00</td></tr>
<tr><td>Clinical Lead, Other MD</td><td>60,900.00</td></tr>
<tr><td>Legal services, HR, other</td><td>100,864.00</td></tr>
<tr><td><u>Office:</u></td><td></td></tr>
<tr><td>Rent</td><td>28,400.00</td></tr>
<tr><td>Utilities</td><td>4,200.00</td></tr>
<tr><td>Bi-annual meeting</td><td>3,236.00</td></tr>
<tr><td>Computers, communication, IT support</td><td>14,000.00</td></tr>
<tr><td>Meetings and travel</td><td>8,250.00</td></tr>
<tr><td>Outreach</td><td>2,400.00</td></tr>
<tr><td>Total</td><td>$600,000.00</td></tr>
</table>
</td></tr>
<tr><td>Budget Category</td><td>Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms</td></tr>
<tr><td>Summary Statement of Work</td><td>This capacity grant will allow Healthfirst to further develop their ACO infrastructure to manage patient care. Their specific focus will be increasing coordination in medical homes between primary care and other clinical practitioners and increasing communication between primary care and specialty physicians.</td></tr>
<tr><td>Unique Qualifications (if Sole Source)</td><td>N/A</td></tr>
<tr><td>Retroactive Start Justification (if applicable)</td><td>1/1/16</td></tr>
<tr><td>Travel Justification</td><td>Travel budgeted in this agreement is for in-State travel only.</td></tr>
</table>

Applicable Y2 Milestone	Sub-Grant Program – Sub-Grants: Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.

Grant Attachment A, Scope of Work for Healthfirst Inc., #03410-1305-15

The Subrecipient Shall:

1. Provide representation of Vermont's independent medical practices in healthcare reform efforts and SIM grant initiatives, provision of valuable input and assistance in Vermont's reform efforts that will further the chances of successful implementation.
    a. Independently test and examine the value of private practice as a comparison group in healthcare delivery pilots and innovations.
    b. Create a network of private specialty medical practices supporting patient centered medical homes in a formally integrated manner and the development and application of a rationale for inclusion of those specialists in shared savings initiatives; this inclusion will be based on operational standards of collaborative care that include access, communication, and shared decision making.
    c. Develop alternatives for after-hours care and high value alternatives for testing and procedures.
    d. Support the build-out of patient centered medical homes to more fully engaged practices, integrated with shared community resources, mental health, and substance abuse providers.
2. Hire an Executive Director (ED) responsible for network development, integration, coordination, and the measurement of outcomes in the Vermont Collaborative Physicians (VCP) Commercial Shared Savings Program (XSSP), as well as the Subrecipient's other healthcare delivery programs (Q3 2014).
   The ED shall:
    a. Manage quality measures that will impact shared savings outcomes for the Subrecipient.
    b. Oversee and support the Collaborative Care Committee, refining standards and finalizing an agreement that links specialty physicians and other health care professionals to the ACO.
    c. Represent the Subrecipient on VHCIP committees, in healthcare reform workgroups, and with other provider groups.
    d. Coordinate initiatives with the Medicare Shared Savings program and commercial staff, the Subrecipient's physicians, and other healthcare organizations and providers (e.g. SNF, Hospital, Home Health).
3. Hire a Staff Assistant to coordinate Subrecipient's participation in the XSSP (Q3 2014).
4. Hire a Clinical Quality Director to oversee clinical programs and appoint practicing physicians to serve on clinical and operational committees (Q4 2014).
    a. The Subrecipient will provide stipends to support physician time away from direct patient care.
    b. Clinical Quality Director shall:
        i. Report to, or serve on, the Care Coordination and Quality Committee of their ACO.
        ii. Work directly with the ED, leading initiatives and activities in their assigned areas.
        iii. Attend bi-annual network practitioner meetings.
5. Form the following:
    a. ACO Governance Board (Q3 2014)
    b. Consumer Advisory Board (Q3 2014)
    c. Clinical Quality Board (Q3 2014)
    d. Primary Care Physician and Specialist subcommittee to create a network collaboration agreement outlining communication protocols and enable specialists to financially benefit from potential shared savings (Q2 2014).
6. Secure office space for ACO and board meetings (Q4 2014).
7. Obtain Board and membership approvals for Collaboration Agreement (Q4 2014-Q1 2015).
8. Create stipend policy for physicians representing Subrecipient in State health care reform meetings to encourage broad participation (Q3 2014).
9. Develop processes for collection of clinical quality measures from member physicians' Electronic Medical Records in collaboration with payers and other entities (Q3 2014-Q3-2015).

10. Redesign Subrecipient's website to increase member physician usage and public outreach (Beginning Q1 2015)
11. Engage consultant(s) as needed on matters related to legal expertise for network agreements, contracting, financial and/or tax accounting. Staffing consultants may be used to assist with hiring and staff benefits.
12. Prepare and submit to the State quarterly programmatic status reports no later than the 10th of the month following the 3 month period being reported. The reports shall include a narrative summary outlining specific progress on projects as directed by the reporting templates provided. The reporting schedule is as follows:
    a. 2014: October 10
    b. 2015: January 10, April 10, July 10, October 10
    c. 2016: January 10, April 10
    d. Final Report Due: July 30, 2016
13. Prepare and present programmatic reports to the VHCIP work groups, Steering Committee or Core Team as requested.
14. Hire a 1.0 FTE Quality and Care Coordination Manager, as an employee.
15. Establish a Local Physician Liaison Team comprising four local independent practitioners at .05 FTE each (approximately 8 hours each per month).
16. Develop and distribute templates and educational materials to Health*first* members to guide delivery of high-quality care and related data tracking.
17. Adhere to the following work plan on pages 2-4 of this agreement.

Deliverables and Implementation Timeline for VCHIP Provider Grant Proposed Activities Key for Work Plan Performance Periods: Q1: January – March; Q2: April-June; Q3: July-September; Q4: October-December.					
Activities	**Anticipated Outcomes**	**Milestone**	**Implementation Timeline**	**Person Responsible**	**Comment**
Need: Vermont and the nation have identified the need to develop new systems and structures to reduce rising health expenditures while maintaining and improving the quality of care.					
Goal: Enhance the capacity of Health*first* (HF) to participate in meaningful collaborations with OneCare Vermont and Community Health Accountable Care (CHAC) with the shared vision of goals of collecting, analyzing, and using data for targeted healthcare performance improvement throughout Vermont.					
Objective 1: Build capacity to support clinical performance improvement activities among independent medical practices to ensure the interests of independent physicians are represented in the statewide conversation about accountable care.					
Hire a Quality and Care Coordination Manager (QCCM)	QCCM's work will increase HF's capacity to attend meetings with OneCare, CHAC, and other partners.	Represent HF at clinical pods sponsored by OneCare and other partners and at SIM Learning Collaborative meetings	Hire position Q1-2105; report meeting outcomes to CMO, CD, and ED following meetings	Hiring: Executive Director (ED), Clinical Director (CD), Chief Medical Officer (CMO) Reporting: QCCM	

Architect disease management programs for independent practices	Based on research-based best practices, HF will create additional disease management protocols for HF member practices.	Implement in member practices	Begin Q2-2015, then ongoing	CD, QCCM	
Recruit local physician liaison team	Team members will attend local clinical advisory meetings along with representatives from OneCare and CHAC.	Liaisons will report back to staff and their own practices; HF will update members with relevant information.	Recruit team members beginning mid-Q2-2015; reporting to HF staff, ongoing; HF staff reporting to board of directors, ongoing	Recruiting: QCCM, CMO, CD, HF board of directors Reporting to HF ED, CMO, CD: liaisons	
Develop materials, identify resources and provide training opportunities to support practices in implementing research-based quality care standards	CD and QCCM will work with practices to help them develop and implement effective and efficient mechanisms for data tracking, reporting, and analysis.	Member practices will implement research-based quality care standards based on HF recommendations.	Begin Q4-2014, then ongoing	CD, QCCM	
Objective 2: Reduce non-emergent ER use and hospitalizations for ambulatory care sensitive conditions, as tracked in ACO and other quality performance contracts in which HF members participate.					
Monitor hospital admission/discharge records	Develop strategies and protocols to support practices in engaging in effective patient communication and delivery of high-quality care			QCCM, CD	
Work with member nurses and practice managers to implement and/or hone best practices for aiding patients through care transitions	Meetings with practice managers and other key staff at member practices at least quarterly to review quality measure reporting capabilities	Quarterly status reports to ED, CMO, HF board of directors outlining implementation progress of member practices	Q4-2104, then ongoing	CD, QCCM	

Objective 3: Grow network-wide, team-based chronic disease management programs by continuing to support established committee- based information exchanges.					
Continue to support the shared learning clinical implementation committee	HF clinical and executive staff will continue to host and moderate quarterly meetings for RNs and practice managers of primary care practices.	Quarterly progress reports	Committee has been meeting quarterly since Q3-2013; meetings will be ongoing.	CD, CMO, ED	Currently this activity is supported with ACCGM funds, which will likely be cut in the 2015 FY budget.

<table>
<tr><th colspan="2">Northeastern Vermont Regional Hospital, #03410-1459-15</th></tr>
<tr><td>Method of Selection</td><td>RFP-Sub-Grant Program Awardee</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$176,400
Performance Period 2 Total Amount (including Travel):$31,400
Performance Period 2 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>8/8/14-11-30/16, Performance Period 2 1/1/16-11-30-16</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based agreement where the Subrecipient is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The program manager(s) review the invoices and work products each month before approving the invoices.</td></tr>
<tr><td>Itemized Budget (total project)</td><td>
<table>
<tr><th>Category</th><th>Amount</th></tr>
<tr><td>Personnel</td><td>$54,000.00</td></tr>
<tr><td>Fringe</td><td>$18,900.00</td></tr>
<tr><td>Travel</td><td>$2,000.00</td></tr>
<tr><td>Non-Covered Programs*</td><td>$100,000.00</td></tr>
<tr><td>Equipment</td><td>$1,500.00</td></tr>
<tr><td>Total Budget</td><td>$176,400.00</td></tr>
</table>
*Non-covered programs may include extended in-home nursing visits and mental-health case management and quicker access to medical equipment. These programs are typically not covered or have limited funding through Medicare and Medicaid. A specific list of programs will be defined within the first month of the project as specified in Attachment A.</td></tr>
<tr><td>Budget Category</td><td>Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms</td></tr>
<tr><td>Summary Statement of Work</td><td>Provide flexible funding for goods and services not normally covered by insurance, enabling an integrated multi-disciplinary community care team to better care for clients who are at risk for poor outcomes and high costs of medical care.</td></tr>
<tr><td>Unique Qualifications (if Sole Source)</td><td>N/A</td></tr>
<tr><td>Retroactive Start Justification (if applicable)</td><td>1/1/16</td></tr>
<tr><td>Travel Justification</td><td>Travel budgeted in this agreement is for in-State travel only.</td></tr>
<tr><td>Applicable Y2 Milestone</td><td>Sub-Grant Program – Sub-Grants: Continue sub-grant program:
1. Convene sub-grantees at least once by 6/30/16.
2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.</td></tr>
</table>

Subrecipient shall:

1. Employ a Health Coach to work with clients to improve their chronic disease self-management skills: conduct health assessments; reinforce provider-initiated treatment plans; provide hands-on assistance in support of chronic disease self-management plans; provide cooking lessons; and teach stress management and coping techniques.
2. Employ a Community Health Team (CHT) Coordinator to serve as overall project coordinator and work with Health Coach to identify and assess clients.
3. Develop data-sharing agreement between Subrecipient and the State regarding data sharing of expenditures for the dually eligible persons in the served area to compare past and current expenditures. Data will be used to identify at risk individuals and request referrals from primary care providers and CHT members.
4. Hold Dual Eligible Core Team (Duals Team) meetings on a semi-monthly basis to:
    a. Discuss individuals' services and situations to solve issues;
    b. Evaluate current support structure, including existing care managers;
    c. Designate the lead case manager for each individual if there is not one in place;
    d. Determine needs for flexible funding;
    e. Discuss and develop innovative solutions for individual problems;
    f. Work with the patient to set self-management goals health and wellness;
    g. Modify existing assessments if necessary to assure comprehensive assessments;
    h. Develop client information protocols to ensure smooth transitions of care.
    i. The team shall include: CHT coordinator; medical home care coordinators; medical home behavioral health specialist; case managers; Choices for Care case manager; community health workers from Community Connections; the patient and family or support persons; and additional CHT members as necessary.
5. Identify system issues that affect dually eligible persons that are beyond the scope of this project.
6. Within 30 days of the execution of this grant, identify specific programs to be funded that are typically not covered or have limited funding through Medicare and Medicaid. Such programs may include: extended in-home nursing visits; mental-health case management; and quicker access to medical equipment.
7. Prepare and submit to the State quarterly programmatic status reports no later than the 10th of the month following the 3 month period being reported. The reports shall include a narrative summary outlining specific progress on projects as directed by the reporting templates provided.
   The reporting schedule is as follows:
    f. 2014: October 10
    g. 2015: January 10, April 10, July 10, October 10
    h. Final Report Due: December 30, 2015
8. Prepare and present programmatic reports to the VHCIP work groups, Steering Committee or Core Team as requested.
9. Report on expected outcomes. Baseline data will relate to specific episodes and/or populations to be determined within thirty (30) days of the execution of this grant. Outcomes include:
    a. Fewer nursing home days
    b. Fewer incarcerations
    c. Reduction in homelessness
    d. Improved customer satisfaction
    e. Improved measures of medical well-being, identified for each individual through the assessment and care planning process.
10. By the tenth (10) business day of execution of this grant, the Subrecipient shall provide the State with a project plan detailing the Strategy to achieve the eight (9) areas outlines above. The State shall have five (5) business days to review and provide written approval of the proposed project plan. Should the State require revisions to the proposed project plan it will notify the Subrecipient in writing by the 5th business day. Upon approval this agreement shall be amended to include the work plan.

11. The Subrecipient shall include with each monthly invoice an updated work plan outlining achievements to milestones.

<table>
<tr><th colspan="2">Northwestern Medical Center #03410-1459-15</th></tr>
<tr><td>Method of Selection</td><td>RFP-Sub-Grant Program Awardee</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$400,000
Performance Period 3 Total Amount (including Travel):$172,821.20
Performance Period 3 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>2/6/15-11/30/16, Performance Period 3 1/1/16-11/30/16</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based agreement where the Subrecipient is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The program manager(s) review the invoices and work products each month before approving the invoices.</td></tr>
<tr><td>Itemized Budget (total project)</td><td>
<table>
<tr><th>Category</th><th>SIM Performance Period 1</th><th>SIM Performance Period 2</th></tr>
<tr><td>Personnel (Salaries)</td><td>$45,000</td><td>$70,000</td></tr>
<tr><td>Fringe*</td><td>$63,000</td><td>$70,000</td></tr>
<tr><td>Travel/Mileage</td><td>$10,000</td><td>$10,000</td></tr>
<tr><td>Equipment</td><td>$16,000</td><td>$6,000</td></tr>
<tr><td>Supplies</td><td>$19,500</td><td>$0</td></tr>
<tr><td>Other**</td><td>$46,500</td><td>$44,000</td></tr>
<tr><td>Indirect</td><td>See Notes</td><td></td></tr>
<tr><td>Contracts</td><td>N/A</td><td></td></tr>
<tr><td>Total Per Year</td><td>$200,000</td><td>$200,000</td></tr>
<tr><td>Total Expenses for 2 Year Grant Period</td><td></td><td>$400,000</td></tr>
</table>
*Fringe is calculated based on the combined total cost of salaries covered by the Subrecipient and this agreement.

**Other costs include:
1. Enhancing Resources of Community Partners - Co-branding support for project partners will be required to make the program partnerships succeed. Subrecipient will work with several existing programs within the area to develop cobranding/educational materials to be distributed through their programs, this will include, Building Bright Futures, the Tobacco Coalition, etc.</td></tr>
</table>

	2. Community Challenges - Community Challenges Incentives will include small health related prizes for communities and participants who meet the goals of the program will be provided. This will include local farm CSAs, 1 month memberships to local gyms, etc. 3. Communication Efforts & Materials – In order to solicit the greatest response to the program given the remote nature of our region, extensive marketing activities will need to take place. Branding development will be contracted out as needed to local advertising agencies and printers. This will include radio/print advertising, pamphlets, flyers, banners.
Budget Category	*Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms*
Summary Statement of Work	RiseVT is a collaborative, community-wide campaign designed using the Vermont Prevention Model (socio-ecological model). This broad community campaign intends to impact the health of Franklin County residents by targeting policies, infrastructure, education, the environment, and culture within municipalities, worksites, schools and families. The program is integrated with Patient Centered Medical Homes in Franklin County and will include development of a central clearinghouse for "all things health and wellness."
Unique Qualifications (if Sole Source)	N/A
Retroactive Start Justification (if applicable)	1/1/16
Travel Justification	Travel budgeted in this agreement is for in-State travel only.
Applicable Y2 Milestone	Sub-Grant Program – Sub-Grants: Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.

Grant Attachment A, Scope of Work for Northwestern Medical Center #03410-1459-15

Subrecipient Shall:

1. Hire a Coordinator, three (3) part-time Coaches and three (3) part-time Advocates to carry out project deliverables.
    a. One (1) Coach and one (1) Advocate will be assigned per each of the predetermined/specified groups of municipalities, identified by the Subrecipient.
2. Create and execute a Communication and Marketing Plan to bring Rise VT awareness and brand recognition to Northwestern Vermont.
    a. Such plans may include news releases, social media, publications and local organizations.
3. Activate a team of community health advocates to implement policy change; provide technical assistance; and leverage community interest, involvement and ownership in improving health.
4. Launch Branded Membership Program using the Vermont Prevention Model (Socio-Ecological Model) to enhance the potential of RISE VT.
    a. Impact the health of the community by targeting policies, infrastructure, education, the environment and culture across the community.
    b. Target three-month rolling cycles throughout the grant: March–May; June–August; Sept.–Nov.; Dec-Feb.
5. Expand access to Worksite Wellness Programs by creating work plans for wellness coaches, identifying local businesses to participate in the program and implementing evidence-based wellness programs.
6. Integrate key community partners to expand reach and reinforce messages such as local businesses, schools, municipalities, families and community partners.

7. Establish free access for individual participants to Cerner Wellness, a centralized wellness portal. The Subrecipient will use the portal to automate the administration and management of an individual's wellness activities.
    a. Wellness coaches will target outreach information to an individual's specific health risks and will populate the individual's personal portal page with risk specific information.
8. Report on the following expected outcomes:
    a. Increase the overall health of residents by decreasing the percent of overweight and obese individuals
    b. Increase the number of employers offering a wellness program in which 50% of employees participate
    c. Expand resources for biking and walking
    d. Increase access to smoke-free and/or tobacco free environments from 43% to 60%
    e. Increase fruit and vegetable consumption by 10%
    f. Decrease the number of people with no leisure time physical activity from 26% to 19%
    g. Increase the number of students walking/biking to school from 15% to 20%
9. Program Status Reporting:
    a. Prepare and submit to the State quarterly programmatic status reports no later than the 10th of the month following the 3 month period being reported. The reports shall include a narrative summary outlining specific progress on projects as directed by the reporting templates provided. The reporting schedule is as follows:
        i. 2015: April 10 (to include the month of December, 2014), July 10, October 10
        ii. 2016: January 10, April 10, July 10, October 10, December 10 (for the months of October and November, 2016)
        iii. Final Report Due: December 10, 2016
    b. Programmatic reports shall be submitted to:
       Joelle Judge
       VHCIP Project Management Office
       Agency of Administration
       joelle.judge@partner.state.vt.us
       (o) 802-828-1979
10. Prepare and present programmatic reports to the VHCIP work groups, Steering Committee or Core Team as requested.
11. Adhere to the following work plan and timeline on page 5 of this agreement

RISE VT Work Plan

Activity	Anticipated Outcomes	Milestone	Implementation Timeline	Responsible Party	Comments
Hire Coordinator and Coaches and Advocates	The coordinator, coaches, and advocates are the driving force of the project deliverables.	• Job Descriptions Created • Position Approved • Job Posted • Onboarding of Staff	Dec. 2014- January 2015	Lifestyle Medicine, Community Committee on Healthy Lifestyle (CCHL) Subgroup	Coordinator position has already been posted and positioned to be hired in December. The coaches and advocates will follow with an anticipated hire time of January 2015.

Communication & Marketing plan creation and execution	Communications and marketing are integral to the success of the Rise VT point based membership initiative. RISE VT Brand Recognition and Awareness will be the result of this process.	• Phase I: Announce Grant (In process)
		• Phase II: Promotion and adoption of the Rise VT points initiative
		• Phase III: Roll Out RISE VT Membership Initiatives
		• Phase IV: Create and Maintain Momentum
		• Phase V: Celebrate Outcomes and Success
			Dec. 2014- Oct. 2016	NMC Community Relations, Lifestyle Medicine, (CCHL) Subgroup	**Phase I**: communications are already underway
					• News release
					• Column
					• Social Media
					• Publications
					• Organizations
					Phase II
					• Introduce Coordinator
					• Build relationships
					  ○ Businesses
					  ○ Schools
					  ○ Municipalities
					  ○ Families
					  ○ Community Partners
					Phase III: 3 month, rolling cycle, March – May; June – August; Sept. –Nov.; Dec-Feb.
					• **Distribute cards** (and online card link) immediately
					• **Promote/explain** program beginning immediately
					• **First deadline:** June 2015

					• **First Celebration:** August • **Second deadline:** December 2015 • Rolling enrollment works like this – if you turn in your card before June, we celebrate you in August. If you turn in a card before December, we celebrate you in February. • **Second celebration:** February 2016 **Phase IV: After Each 2 month cycle** • Culminating Events Planned • APPs • Success Stories ○ Doctors Corner Highlights ○ School Nurses Referral highlights ○ School Coaches Highlighted
Activating a Team of Community Health Advocates	NMC will hire six part time specially Trained Community Health Advocates to implement policy change; provide technical assistance; and	• Create specific work plan for Advocates • CHAs will organize, facilitate, and mobilize grass-roots efforts regarding population health, based on the needs of that specific community (inform	Jan. 2015-Oct. 2016	Coordinator, Coaches, CCHL Subgroup	They will help organize, facilitate, and mobilize grass-roots efforts regarding population health, based on the needs of that specific community by encouraging participation in an upcoming program, taking on a community challenge, passing a smoke-free parks ordinance, building a bike

	leverage community interest, involvement and ownership in improving health. These advocates will actively engage municipal leaders, employers, and other organizations within their community on policy changes and resource development.	local policy changes, link community resources, promote participation)			path, increasing safe routes to school, etc. By having these initiatives emerge from within the community, ownership and sustainability are enhanced. Encouraging communities to expand access to recreational facilities and programming has proven effective in northwestern VT with a variety of efforts, including Fit & Healthy Swanton and Fit & Healthy Enosburg.
Launch Branded Membership Program: RISE VT encourages and celebrates healthy behaviors, targeting families, schools, worksites and municipalities. Participants can work to achieve higher RISE VT status levels.	RISE VT was designed using the Vermont Prevention Model (Socio-Ecological Model) in order to enhance its potential to impact the health of our community by targeting policies, infrastructure, education, the environment and culture within municipalities, worksites, schools and families.	• Work Plan creation for membership initiative • 3 month, rolling cycle, March – May; June –August; Sept. –Nov.; Dec-Feb. • **Distribute cards** (and online card link) immediately • **Promote/explain** program beginning immediately • **First deadline:** May 2015 • **First Celebration:** June 2015 • **Second deadline:** August 2015 • **Second celebration:** Sept. 2015 Etc.			Simple actions earn bronze level status (See Attachment C), but as RISE VT participants implement stronger or more impactful changes, they move up the continuum earning silver, gold and platinum RISE VT level status. For example, a school providing education promoting walking/biking to school would earn a bronze level, while fully implementing a Safe Routes to School Travel Plan including the 5 E's (Education, Enforcement, Engineering, Encouragement, and Evaluation) could achieve a platinum level. The same would be true at a worksite level. A worksite that offers worksite

					wellness classes only, would earn a bronze level. A worksite that implements a comprehensive wellness program with financial incentives and supportive policies for employees to actively engage, along with those classes, would achieve platinum level recognition.
Expand Access to Worksite Wellness Programs	National research shows, long-term, reduced health risk correlates with reduced health care costs. Utilizing NMC's proven program as a model for other worksites eliminates much of the effort to create new programs.	• Create Specific work plan for coaches • Wellness coaches to facilitate the expansion and access to Worksite Wellness Programs • Using the Franklin-Grand Isle Worksite Wellness Survey, identify small businesses and local non-profits interested in participating in improving the health of their employees • Implementation of evidence-based wellness programs	Jan. 2015- Oct. 2016	Coordinator, Coaches, CCHL Subgroup	This initiative will involve going on-site to companies, conducting bio-metric screenings, enrolling employees in health risk appraisals, providing targeted educational and support based on identified risks, creating challenges to boost participation and morale, assisting employers with implementation of best practices supported in the VT Worksite Wellness Guide, and other such initiatives. Risk factors and health improvements will be quantified for the individual as well as in the aggregate to allow for the clear identification of measurable results.

Integrate with Key Community Partners to Expand Reach and Reinforce Messages.	In a further effort to expand reach and to ensure that key messaging is delivered from a variety of	• Assess target populations and determine which partners have the most direct and significant connection with those populations.	January 2015- Oct. 2016	Coordinator, Health Advocates, CCHL Subgroup	**Building relationships**
					• Businesses
					  ○ VPT
					  ○ NMC
					  ○ Peoples Trust
					  ○ Messenger
					  ○ Rotary Group Presentations

	sources to nurture and reinforce behavioral change: integrate with a variety of key community partners beyond the medical community.	• Engage them in sharing the messaging and encouraging the target population to engage in the population health efforts.			○ Chamber Board Meetings (2nd Wed. of every month) ○ Young Business Professionals meetings • Schools ○ Superintendents meeting ○ Principal meetings ○ School nurses meetings ○ Schools with existing Safe Routes to School Travel Plans Developed • Municipalities • Families • Community Partners ○ NCSS ○ Building Bright Futures ○ Notch ○ Home Health ○ United Way ○ FGI Community Prevention Collaborative and its members ○ NRPC ○ Community Partnership

Establish a Robust Local Wellness Portal and Access to Cerner	A central clearing house for all things health and wellness, addressing a long term community need. This will involve a robust and engaging online presence, available for free, around-the-clock	• RFP from Web Developers Nov. & Dec. 2014
		• Implement Web Site Feb. 2015
		• Cerner Contracting Nov. & Dec. 2014
		• Implement Cerner Feb. 2015
		• Develop Central Clearing House for community wellness resources: On-going efforts to keep the website up to date and fresh
		  ○ Collaborative calendar creation
		  ○ Walk and Bike Maps
		  ○ Guides to Local Resources
		  ○ Links to credible resources
		• Website Maintenance and Up Keep
		• Cerner Up keep and Maintenance
			Dec. 2014-June. 2015	(CCHL) Subgroup, Coordinator, Coaches, Health Advocates, VDH, NMC	A comprehensive shared collaborative calendar of health and wellness related events-Downloadable/printable walking maps for various municipalities, a guide to local resources such as parks, trails, bike paths, ski areas, fitness clubs, farmers' markets, libraries, municipal websites, etc.-notices of local meetings, which focus on improving health resources or refining health policy- links to credible sources of information, both locally, within the State, and nationally; everything from 802Quits to Vermont Health Connect will be accessible.

Conduct end of grant analysis and compile report		• Production of reports such as: ○ Participation ○ Outcomes ○ Cost saving • Possible research publication and project replication guide/technical assistance	Oct. 2016	Coordinator, Coaches, Health Advocates, CCHL Sub Group	

<table>
<tr><th colspan="2">Rutland Area Visiting Nurse Association and Hospice, Inc. #03410-1460-15</th></tr>
<tr><td>Method of Selection</td><td>RFP-Sub-Grant Program Awardee</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$38,472.81
Performance Period 2 Total Amount (including Travel):$52,896.72
Performance Period 2 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>7/25/15-6/30/16, Performance Period 3 1/1/16-6/30/16</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based agreement where the Subrecipient is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The program manager(s) review the invoices and work products each month before approving the invoices.</td></tr>
<tr><td>Itemized Budget (2016 only)</td><td>
<table>
<tr><th>Category</th><th>Budgeted Amount</th></tr>
<tr><td>Personnel</td><td></td></tr>
<tr><td>Nurse Practitioner</td><td>1615.43</td></tr>
<tr><td>Registered Nurse</td><td>$17,985.85</td></tr>
<tr><td>Medical Social Worker</td><td>$8,564.50</td></tr>
<tr><td>Total Personnel</td><td>$28,165.78</td></tr>
<tr><td>Fringe</td><td>$5,775.35</td></tr>
<tr><td>Conference Travel</td><td>$4,031.68</td></tr>
<tr><td>Supplies</td><td>$500.00</td></tr>
<tr><td>Total Budget</td><td>$38,472.81</td></tr>
</table>
</td></tr>
<tr><td>Budget Category</td><td>Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms</td></tr>
<tr><td>Summary Statement of Work</td><td>Support design and implementation of a supportive care program for seriously ill patients with congestive heart failure and /or chronic lung disease. The program will improve communication between the multiple providers and organizations involved in the care of these patients and advance a patient-centered model for care planning and shared decision-making. The project is expected to reduce use of hospital and emergency department care, improve patient quality of life and save money.</td></tr>
<tr><td>Unique Qualifications (if Sole Source)</td><td>N/A</td></tr>
<tr><td>Retroactive Start Justification (if applicable)</td><td>1/1/16</td></tr>
<tr><td>Travel Justification</td><td>Travel budgeted in this agreement is for in-State travel only.</td></tr>
<tr><td>Applicable Y2 Milestone</td><td>Sub-Grant Program – Sub-Grants: Continue sub-grant program:
1. Convene sub-grantees at least once by 6/30/16.
2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.</td></tr>
</table>

Grant Attachment A, Scope of Work for Rutland Area Visiting Nurse Association and Hospice, Inc. #03410-1460-15

Subrecipient Shall:

1. Perform comprehensive assessment in the home of palliative care needs for the patient and caregiver(s) related to physical, social, emotional and spiritual elements.
    a. Provide in–home consultative support for patients upon referral. If patient does not require a home visit, the coordinator will refer the patient to other appropriate community services.
2. Identify patient/caregiver goals and formulate a care plan to address the patients' needs with the patient and caregiver(s).
    a. Perform ongoing team-based consultations in-home or by phone depending on patient needs.
    b. Provide program access 24 hours a day, 7 days a week via telephone to respond to off-hour crisis.
3. Facilitate patient decision making around advanced care planning, establishing patient and family/caregiver goals through the use of proven tools such as Start the Conversation and Speak Sooner.
4. Collaborate and coordinate with other community medical, social and volunteer resources as needed, especially to assist and support transitions of care or referrals for services.
5. Make a recommendation to the primary care provider when the patient is appropriate for hospice.
6. Conduct monthly meetings of the Oversight Committee to discuss progress, barriers, evaluation and improvements.
7. Perform monthly review of active Supportive Care Program cases with the program staff, supervisor(s) and primary care provider(s).
8. Prepare and submit to the State quarterly programmatic status reports no later than the 10th of the month following the 3 month period being reported. The reports shall include a narrative summary outlining specific progress on projects as directed by the reporting templates provided. The reporting schedule is as follows:
    a. 2014: October 10
    b. 2015: January 10, April 10, July 10, October 10
    c. 2016: January 10, April 10
    d. Final Report Due: July 30, 2016
9. Prepare and present programmatic reports to the VHCIP work groups, Steering Committee or Core Team as requested.
10. Adhere to following work plan:

Timeframe	Activity	Milestone
Feb-April 2014	Formalize Oversight Committee meeting schedule and expectations	Meeting schedule approved by 5/15/14
April 2014 – May 2014	Develop and adopt program forms for referrals, intake and documentation of visits	Form approved and printed by 5/15/14
	Develop referral pathways and decision chart with Blueprint Practice Facilitator	Process developed and approved by 5/15/14
	Identify program staff from within RAVNAH	RN and SW identified by 5/31/14
May 2014 – Jun 2014	Training of program staff by RRMC inpatient palliative care program and RAVNAH Hospice program	RN and SW trained by 6/15/14
May 2014 – Jun 2014	Finalize eligibility criteria for pilot project with CHF / COPD Collaborative	Criteria approved by 6/15/14
Apr 2014 - Jun 2014	Establish and test information sharing pathways between RRMC inpatient palliative care program, primary care provider(s), RAVNAH and Community Health Team	Methods approved and tested by 6/1/14
May 2014 – Jun 2014	Establish weekly program staff case review meeting schedule	Schedule adopted by 5/31/14

May 2014 – Jun 2014	Identification of COPD/CHF patients at highest risk for hospitalization with Collaborative partners	
Jul 2014 – Dec 2015	Intake of referrals and enrollment of patients in pilot project	Enroll 20 pts by 12/31/14; Enroll 50 pts by 12/31/15
	Conduct home visits and follow-up consultations with patients	
	Baseline Quality of Life surveys at initial visit	
	Review records of patients to document hospitalization(s), emergency room visit(s), and extended care facility utilization to establish baseline health care utilization and associated costs	
Sep 2014 – Mar 2016	Patient Satisfaction surveys and Quality of Life survey at 3 months	
	Primary Care Provider Satisfaction surveys at 6 month intervals	
	Analyze and summarize evaluation of Quality of Life, Satisfaction, review with CHF/COPD Collaborative and Oversight Committee	Quarterly
	Analyze and summarize utilization and cost/savings for patients at 6 and 12 months post enrollment in supportive care; Review with CHF/COPD Collaborative and Oversight Committee	Review with committees Dec 2014; June 2015; Dec 2015; June 2016
Sept 2014	Review referral and communication pathways and incorporate improvements	
June 2016	Completion of project and evaluation.	Report citing accomplishments, barriers, evaluation assessment and recommendations

11. Evaluate the project on the following:
    a. **Organization** (Process measures of implementing the project). Subrecipient will track and report on patients in the pilot program to measure its effectiveness in achieving the goals outlined above, including:
        i. Enrollment in the program: target of 50 participants enrolled in the pilot program.
        ii. Length of stay in the program. Monitor and measure the number of patients who complete the care plan with goals, and advance directives, to ascertain if the project process is working and meeting the needs of patients.
        iii. Transition to hospice as part of care plan with accompanying advance directive. Monitor care planning to assess how many incorporate hospice services [% citing].
    b. **Customer.** Asses outcome measures of patient satisfaction, quality of life and satisfaction of the primary care providers
        i. Patient Satisfaction surveyed three months post enrollment with a program target of 75% rating 4 or higher on scale of 1 to 5.
        ii. Patient Quality of Life with a target to improve a minimum of 75% from baseline. Baseline survey to be completed at the initial visit with a three month follow up survey.
        iii. Primary Care Provider satisfaction with a program target of 75% rating 4 or higher on scale of 1 to 5. Primary Care Provider project staff will complete a questionnaire to assess the value of the program.
    c. **Systemic.** Evaluation of projected impact of the service on the health system in terms of costs and potential savings will be evaluated by monitoring and conducting financial analysis of patient outcomes by comparing the patient records for one year pre-participation to the records six months post-enrollment:
        i. Estimated cost savings realized, both hospitalization and emergency room visits.

<table>
<tr><th colspan="2">Southwestern Vermont Health Care #03410-1460-15</th></tr>
<tr><td>Method of Selection</td><td>RFP-Sub-Grant Program Awardee</td></tr>
<tr><td>Contract Amount</td><td>Total Contract Amount (all years):$500,000
Performance Period 2 Total Amount (including Travel):$150,000.00
Performance Period 2 Out-of-State Travel: N/A</td></tr>
<tr><td>Contract Term</td><td>1/1/2014-11/30/2016, Performance Period 3 1/1/16-11/30/2016</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based agreement where the Subrecipient is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The program manager(s) review the invoices and work products each month before approving the invoices.</td></tr>
<tr><td>Itemized Budget (total budget)</td><td>
<table>
<tr><th>Category</th><th>December 1, 2014 – November 30, 2015</th><th>December 1, 2015 – November 30, 2016</th><th>Total</th></tr>
<tr><td>Personnel**</td><td>$246,435</td><td>$40,875</td><td>$287,310</td></tr>
<tr><td>Fringe Benefits</td><td>$73,931</td><td>$12,262</td><td>$86,193</td></tr>
<tr><td>Supplies</td><td>$97</td><td>$3,000</td><td>$3,097</td></tr>
<tr><td>Contracts/Other*</td><td>$18,400</td><td>5,000</td><td>$23,400</td></tr>
<tr><td>TOTAL</td><td>$338,863</td><td>$61,137</td><td>$400,000</td></tr>
</table>

*Educational Programs/Training for$8,400 and Audit services for$15,000.</td></tr>
<tr><td>Budget Category</td><td>Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms</td></tr>
<tr><td>Summary Statement of Work</td><td>Reduce health care costs in a small rural community through the implementation of an innovative adaptation of a transitional care model (TCM) that supports patient self-care, through care management and patient outreach. An earlier pilot project involving a team of nurse specialists deployed to three primary care practices and the emergency department has demonstrated reductions in hospital admissions and emergency department utilization; this project builds upon those early successes and will implement this innovative TCM across a rural service area to test the model's impact on population health and to inform research on its application to the Accountable Care Organization (ACO) model in Vermont.</td></tr>
<tr><td>Unique Qualifications (if Sole Source)</td><td>N/A</td></tr>
<tr><td>Retroactive Start Justification (if applicable)</td><td>1/1/16</td></tr>
<tr><td>Travel Justification</td><td>Travel is not budgeted for in this agreement.</td></tr>
<tr><td>Applicable Y2 Milestone</td><td>Sub-Grant Program – Sub-Grants: Continue sub-grant program:
1. Convene sub-grantees at least once by 6/30/16.
2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.</td></tr>
</table>

Grant Attachment A, Scope of Work for Southwestern Vermont Health Care #03410-1460-15

Subrecipient Shall:

1. Provide data on the effectiveness of the TCM on reducing preventable admissions and readmissions, reducing Emergency Department (ED) use, and improving patient quality of life and patient satisfaction.
2. Test communication tools for collaborative huddles that bring a multidisciplinary team of caregivers and community partners together to create patient-centered care plans.
3. Host a regional conference to educate other professionals on TCM and share best practices.
4. Create a TCM tool box for rural hospitals with available clinicians to network and guide healthcare facilities with implementation.
5. Disseminate project results at state and national conferences and through peer reviewed publications.
6. Grant project outcomes expected include:
    a. Reduction in the rate of preventable hospital readmission among the target population by 25%.
    b. Reduction in emergency room utilization by the target population by 10%.
    c. Improvement in patient quality of life by 50% using Quality of Life scoring pre and post TCM intervention.
7. Program Status Reporting:
    a. Prepare and submit to the State quarterly programmatic status reports no later than the 10th of the month following the 3 month period being reported. The reports shall include a narrative summary outlining specific progress on projects as directed by the reporting templates provided. The reporting schedule is as follows:
        i. 2015: April 10 (to include the month of December, 2014), July 10, October 10
        ii. 2016: January 10, April 10, July 10, October 10, December 10 (for the months of October and November, 2016)
        iii. Final Report Due: December 10, 2016
    b. Programmatic reports shall be submitted to:
    Joelle Judge, VHCIP Project Management Office
    Agency of Administration
    joelle.judge@partner.state.vt.us
    (o) 802-828-1979
8. Prepare and present programmatic reports to the VHCIP work groups, Steering Committee or Core Team as requested.
9. Adhere to the following work plan and timeline on page 6 of this agreement:

Deliverables and Implementation Timeline for VHCIP Grant Proposed Activities					
Activities	**Anticipated Outcomes**	**Milestone**	**Implementation Timeline**	**Person Responsible**	**Comment**
Need: Vermont and the nation have identified the need to develop new systems and structures to reduce rising health expenditures while maintaining and improving the quality of care					
Goal 1: Assess and implement plans of care for the gaps identified in the delivery of integrated healthcare in the Bennington Service Area					
Objective 1.1: Expand transitional care team and deploy throughout the Bennington service area to provide consistent level of care					
*Complete **Strengths, Weaknesses, Opportunities, and Threats (SWOT)** analysis of existing Transitional Care Nurse (TCN) program (conducted by TCN team)*	Strengths and opportunities for improvement reviewed and incorporated in plan	Creation of edited TCN implementation plan prior to roll out to all practices	January 2015	Billie Allard, RN	
Review job description and post position; interview and select candidate	Additional Transitional Care Nurse hired	Complete team of TCN in place for expansion	February 2015	Billie Allard, RN	
Confer with data analyst and initiate plans for expansion of practices, patient satisfaction and quality of life data	Resources to assist in data collection process identified; use of Midas tool and Meditech functionality	Completion of data set with plan for collection, analysis and reporting	February 2015	Avis Hayden	
Provide training for new TCN	New TCN will understand the program and the responsibilities of the position	Training completed	March 2015	Billie Allard	
Schedule meetings with community agencies, medical home, nursing home and home care agencies to present TCN expansion plan	Input and feedback gathered with improved understanding by partners re: TCN plan	Implementation plan created utilizing feedback and suggestions	April 2015	Billie Allard	

Plan for office practice/TCN team deployment completed and shared	Meetings with primary care practices for introduction of TCN and program	TCN orientation in primary care practice completed and visits begin	May 2015	Billie Allard Trey Dobson	
Objective 1.2: Review progress of the transition care team program and collaborate with community stakeholders to develop tools and strategies to address gaps in the delivery of care and to create a continuous improvement system to gather data and incorporate feedback on the program.					
Convene steering team for VHCIP grant implementation plan	Input obtained from primary care providers, community agencies, medical home, nursing home and VNA	Meeting held with involvement from multiple stakeholders	January 2015	Billie Allard, RN	
Finalize patient satisfaction survey and measure patient feedback, communication and quality of life	Implementation plan created for use of tool, how it is provided, data collected and analyzed	TCNs utilize Patient Survey tool for all new patients	January 2015	Billie Allard	
Complete SWOT analysis of existing TCN plan by focus group (physicians, medical home, TCNs, community agencies)	Weakness and barriers to success (aka gaps) identified	Creation of edited TCN implementation plan prior to roll out to all practices	February 2015	Billie Allard, RN	
Collect data for first six months	Data is compiled and analyzed by data analyst; reports generated	Data shared across the health system and PCP partners	January-June 2015	Avis Hayden Billie Allard	
Rounding on physician practices, hospitalists, nursing home, and home care to get feedback on program	Feedback shared with TCN team	Update to PCP care team, hospitalists and other care team members with any changes	October 2015	Billie Allard	
Data collected for second six months	Data is compiled and analyzed by data analyst; reports generated	Summary of results shared across the healthcare	July-Dec 2015	Billie Allard Avis Hayden	

		system			
Convene focus group of TCNs, reps from PCP, nursing home, community agency, home care, medical home and repeat SWOT and gap analyses	Weaknesses, gaps and barriers to success identified. Progress report compiled.	Share results with users; implement recommended changes	January 2016	Billie Allard	
Update Gap Analysis document with completed work plan	New items added to proposed plan	Share across the continuum	June 2016	Billie Allard	
Goal 2: Create an interdisciplinary team to better meet the needs of behavioral health/drug and alcohol addicted patients that seek frequent assistance from the Emergency Department					
Objective 2.1: Convene a weekly meeting with representation from across the healthcare and social support network to assist in coordination of care for behavioral health and addicted patient populations					
Creation of Community Care team steering group and first meeting held	Shared observations from Connecticut site visit presented to team.	Implementation plan created , communication with team members assigned	Completed	Billie Allard	COMPLETED
Data management of ED frequent users designed and implemented	Kinks worked out with assistance of IT support team	Data flowing with daily and weekly reports available	December 2014	Chris Barsotti, MD Karen Hewson, RN	
Review of form "Authorization to Obtain or Release Information for Behavioral Health"	Reviewed by hospital attorney, risk manager and HIPPA director	Approval for use of form for Community Care Team meeting	December 2014	Billie Allard	
Kick off meeting scheduled with community care team members	Support from across the community	Majority of team members agree to participate; weekly date scheduled	January 2015 (first care team meeting)	Billie Allard, RN	
Weekly data summary reports designed for CCT meetings	Identified problem areas and remedied	Steering team review final product and endorse for use	January 2015	Karen Hewson, RN Chris Barsotti, MD	

		in January			
Create Implementation plan for getting release forms completed prior to weekly team meetings	Reviewed with involved parties	Team completes process of obtaining consent for first identified group of patients	January 2015	Susan Robbins Billie Allard	
Data set chosen for progress from weekly meeting and quarterly summary reports	Format for data analysis established and time frames for reports set	Flow of data in place and collected monthly and shared with team	February 2015	Avis Hayden	
Feedback collected from Community Care team members re: how is this working, how could it be improved	Team actively engaged in continuous improvement of program.	Changes instituted and shared with team	February 2015	Billie Allard	
Check in with Community Care team members re ; suggestions for improvement, sharing concerns	Candid feedback in group meeting	Changes implemented	June 2015	Billie Allard	
Data collected for 6 month period and compiled by data analyst	Reviewed by steering team	Data shared with CCT	January-July 2015	Avis Hayden	
Data collected for 12 month period and compiled by data analyst	Reviewed by steering team	Data shared with CCT, Medical Staff, EMT and VHCIP team	Jan-Dec 2015	Avis Hayden	
Check in with Community Care Team on what is working, what could be better	Active participation by team	Suggestions implemented where appropriate and possible	March 2016	Billie Allard	
Interviews with ED patients participating in benefits of Community Care Team	Rounding, paper surveys, phone calls	Share results with team and make appropriate	May 2016	Susan Robbins Karen Hewson	

		changes to program			
Interviews with ED MDs and nurses re: HPA effectiveness and impact of CCT program	Survey monkey with high participation	Results shared across continuum	Sept 2016	Billie Allard	
Celebration event with Community Care Team, ED care team, hospital administration and patients to announce final data from program	Open house held	Decision made by SVHC on continuing program, and from community care team to attend and participate	Dec. 2016	All	
Objective 2.2: Create a new position of Health Promotion Advocate to support patients who visit the emergency department.					
Create job description and post position; interview candidates for Heath Promotion Advocate position	Health Promotion Advocate (HPA) hired	Health Promotion advocate oriented to role and responsibilities	March 2015	Billie Allard, RN	
Develop and implement orientation plan with input from steering group	HPA spends time with partners across the continuum	HPA begins duties in ED position	May 2015	Susan Robbins. RN	
Weekly scheduled check-ins with HPA with Community Care Team co-leads	Feedback addressed with appropriate parties	Resolution of road blocks, barriers, HPA education needs	Ongoing for first two months that HPA is in position	Susan Robbins, RN Billie Allard, RN	
Review of HPA position, data year to date and assessment for including in 2016 budget	Decision on continuation of role in ED	Accepted in proposed ED Budget for 2016	May 2016	Susan Robbins	
Goal 3: Decrease the high readmission rate and number of visits to the Emergency Department of nursing home residents in our Bennington Service Area					
Objective 3.1: To provide support to area Nursing Homes through the implementation of the INTERACT (Interventions to Reduce Acute Care Transfers) program by a SVHC educator					
Review job description and job posting; interview and select INTERACT educator	INTERACT educator hired	Educator oriented to role and	March 2015	Billie Allard, RN	

		responsibilities			
Training and orientation plan for INTERACT educator created	Orientation and training plan finalized.	Orientation complete	March 2015	Peg Daly, RN	
Schedule meeting with area nursing home clinical directors to discuss opportunity for assistance with INTERACT.	Nursing homes schedule training time with INTERACT educator	Agreements with proposed time lines signed with nursing homes.	April 2015	Billie Allard, RN	
Implementation plan created with input from nursing home contacts, CLR educator, SVMC education team	Sign off on plan by each nursing home leader	Implementation plan in place.	April 2015	Peg Daly, RN	
Launch Phase One of INTERACT education program; education of staff and leadership	Program embraced by nursing home team	Phase 1 of INTERACT program completed in 2 settings	July 2015	Billie Allard RN	
Plan for communication with Bennington service area MDs re: INTERACT implementation in nursing homes designed	MDs enthusiastic about the program, plan for concerns and questions being addressed	Communication completed in all MD office setting	April 2015	Billie Allard, RN	
Monitoring tool for program implementation measures designed with input from front line users	Tools being utilized at 2 settings	First results shared with steering team	Sept 2015	Avis Hayden	
Weekly check in and rounds by INTERACT educator with nursing homes with active INTERACT program	Assess readiness to expand program to second phase	Decision made on expansion	October 2015	Peg Daly, RN	
Launch Phase Two of INTERACT education program	Program expanded in participating nursing homes	Phase 2 rolled out in first two settings	November 2015	Billie Allard, RN	
Staff and leader education begun in two additional nursing home settings	Program embraced by nursing team	Phase 1 of INTERACT program launched in two additional	December 2015	Peg Daly, RN	

		settings			
Monitoring tool for program implementation measures deployed at two new settings	Tools actively used by new settings	Results shared with steering team	January 2016	Avis Hayden	
Weekly check in and rounds by INTERACT with 2 new nursing home settings	Assess readiness to expand program	Phase 2 rolled out in second two settings	March 2016	Peg Daly	
Data collection on ED visit and hospital admissions for first 2 INTERACT nursing home participants	Compare data pre and post program implementation	Share results with steering team, nursing home, EMT and VSCHIP	April 2016	Avis Hayden	
Survey MDs and nursing team at 2 nursing homes re: INTERACT program effectiveness, suggestions, concerns	Complete on survey monkey, walking rounds and interviews	Collate results and share with steering team	May 2016	Billie Allard	
Data collection on ED visits and hospital admissions for second 2 INTERACT nursing home participants	Compare data pre and post program implementation	Share results with steering team, nursing home, EMT and VSCHIP	August 2016	Avis Hayden	
Survey MDs and nursing teams at second two nursing homes re: INTERACT program effectiveness, suggestions and concerns	Complete on survey monkey, walking rounds and interviews	Collate results and share with steering team	September 2016	Billie Allard	
Celebratory meeting with all area nursing homes, hospital administration and nursing staff	Share success stories from *INTERACT* program roll out, patient satisfaction, caregiver appreciation and cost savings/avoidance	Presentation an Transitional Care conference at Mount snow, submitted for publication at national journal	December 2016	Billie Allard	
Goal 4: Create required reports and disseminate information on project progress and lessons learned through toolkit and regional conference					
Goal 4.1: Plan and execute a regional conference for healthcare professionals on adaptation of the transitional care					

model and application in a rural setting					
Convene planning team for Transitional Care Regional Conference	Event date and location selected; potential presenters invited.	Complete proposed budget and submit to EMT for approval	April 2015	Beth Dillard	
Monthly meeting of conference team	Monthly work plan developed	Assignments to key players completed on time	May 2015 through conference date (Anticipated for early Fall 2016)	Beth Dillard	
Create concise, transferrable tools to assist other health systems	Toolkit of communication tools, implementation plans, project structures, and lessons learned created.	Toolkit share with other health systems at regional conference	Ongoing refinement of tools throughout project	Billie Allard Beth Dillard	
Goal 4.2: Adhere to State timetable for reporting					
Create reports for VHCIP reviewers. submitted in accordance with State schedule	Reports completed in accordance with State schedule	Reports accepted.	April 10, July 10, October 10, 2015; January 10, April 10, July 10, 2016	Billie Allard Beth Dillard	
Create final grant report for State	Report completed	Report accepted	Nov 30, 2016	Beth Dillard Billie Allard	

Vermont Medical Society Foundation #03410-1315-15	
Method of Selection	RFP-**Sub-Grant Program Awardee**
Contract Amount	**Total Contract Amount (all years):**$548,828 **Performance Period 2 Total Amount (including Travel):**$160,918.26 **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	8/29/14-11/30/15, **Performance Period 3** 1/1/16-6/30/16
Method of Accountability	This is a deliverables/performance-based agreement where the Subrecipient is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The program manager(s) review the invoices and work products each month before approving the invoices.

Itemized Budget (total project)

Name:		
Cyrus Jordan	Director	108,598.33
Colleen Mange	Business Manager	12,462.00
Stephanie Winters	Operations Manager	12,462.00
Deb Fernandez	Administrative Support	7,000.00
Total Salary & Fringes		140,522.33
In state travel		3,390.00
Website		4,000.00
Conference Call service		3,000.00
Printing/Supplies		-
Consulting - UVM Dept of Pathology		98,401.00
FAHC Pre-op Lab Effort		78,783.00
Clinical content expert for hospital medicine		10,671.00
UVM Indirect (F&A)		8,947.00
Consulting - UVM Dept of Medicine		273,301.00
Dr. Repp-Hospital Medicine champion		44,386.00
Dr. Hood-Choosing Wisely champion		31,957.00
Dr. Pasanen- Choosing Wisely Hospitalist champior		5,213.00
OneCare -Community Hospital expert		39,325.00
Tupelo Group-QI consultant/Project manager		127,000.00
FAHC Jeffords Center		9,847.00
UVM Indirect		15,573.00
Hospital teams grant support		26,213.67
RRMC		14,500.00
Other		11,713.67
Totals :		**548,828.00**

Budget Category	*Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms*
Summary Statement of Work	Support an effort to decrease waste and potential harm in the hospital setting based on evidence behind the national "Choosing Wisely" campaign that estimates 30 percent of U.S. health care spending is avoidable and potentially harmful. Physicians from Vermont hospitals and Dartmouth-Hitchcock Medical Center will work together to reduce unnecessary lab testing, and in doing so will create a statewide provider network to lead additional waste reduction and care improvement efforts.
Unique Qualifications (if Sole Source)	N/A

Retroactive Start Justification (if applicable)	1/1/16
Travel Justification	Travel budgeted in this agreement is for in-State travel only.
Applicable Y2 Milestone	Sub-Grant Program – Sub-Grants: Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.

Grant Attachment A, Scope of Work for Vermont Medical Society Foundation #03410-1315-15

Subrecipient Shall:

1. Work with Vermont Hospitalist Leaders Community to provide guidance and support for this project.
2. Convene two Learning Collaboratives based on the IHI Break Through Series Collaborative to assemble hospital and/or clinic teams to create improvements in a focused area.
    a. Each Collaborative will consist of an initial three month planning and pre-work phase followed by a nine month improvement effort consisting of three day-long Learning Sessions and an Outcomes Congress and three intervening Action Periods.
    b. During Action Periods, teams will meet regularly at their hospital to design and test improvement concepts and interventions
    c. Distance learning, conference calls, webinars and list serves will be offered during action periods.
    d. Develop a project website to include team progress reports and key clinical and improvement information pertinent to the effort.
    e. Learning session and the Outcomes Congress will offer teams and the Collaborative as a whole to share and celebrate their accomplishments.
3. Reduce the number of CBC's (complete blood count) and chemistries ordered per inpatient day and estimated cost of CBC's and chemistry studies per inpatient admission. Repetitive laboratory testing can be reduced by adhering to the following protocols:
    f. Don't perform repetitive CBC and chemistry testing in the face of clinical and lab stability;
4. Pursue a sub-contract with the University of Vermont's Department of Pathology and Laboratory Medicine at Fletcher Allen Health Care to explore the reduction of routine pre-operative testing in low risk surgical patients:
    g. Perform analysis of FAHC data (FAHC data warehouse);
    h. Survey and interview of ordering providers;
    i. Develop and pilot new interventions/educational initiatives;
    j. Assess improvements in test utilization.
5. Prepare and submit to the State quarterly programmatic status reports no later than the 10th of the month following the 3 month period being reported. The reports shall include a narrative summary outlining specific progress on projects as directed by the reporting templates provided. The reporting schedule is as follows:
    a. 2014: October 10 (to include the months of June, July, August and September)
    b. 2015: January 10, April 10, July 10, October 10
    c. 2016: January 10, April 10
    d. Final Report Due: July 30, 2016
6. Prepare and present programmatic reports to the VHCIP work groups, Steering Committee or Core Team as requested.

7. Adhere to the following work plan and timeline:

Collaborative One - Repetitive Lab Testing, May 2014 - June 2015

Time period	Activity	Staffing	Deliverable	Milestones
May-August 2014	Pre-Work	Faculty	Collaborative curriculum Change concepts Visit hospital teams	Pre-Work packets Project website
		Hospital teams	Complete pre-work	Post team goals
October 2014	Learning Session 1	Faculty	Clinical best practice Model for Improvement Action Period 1 goals	All teams attend LS
November 2014 - January 2015	Action Period 1	Faculty	QI support for teams Distance Learning	Monthly distance learning Visit teams
		Hospital teams	Team meetings Tests of change Monthly reports	Posted progress reports Distance learning sessions participation
February 2015	Learning Session 2	Faculty	Clinical best practice QI tools Collaborative work	All teams attend LS
March 2015	AP 2	Faculty	QI support for teams Distance Learning	Monthly distance learning Visit teams
		Hospital teams	Team meetings Tests of change Monthly reports	Posted progress reports Distance learning sessions participation
April 2015	Learning Session 3	Faculty	Clinical best practice QI tools	All teams attend LS
May 2016	AP 3	Faculty	QI support for teams Distance Learning	Monthly distance learning Visit teams
		Hospital teams	Team meetings Tests of change Monthly reports	Posted progress reports Distance learning sessions participation
June 2015	Outcomes Congress	Faculty	QI tools Collaborative work among teams	All teams attend Congress

Collaborative Two – Clinical areas to be determined, July 2015 – June 2016

Time period	Activity	Staffing	Deliverable	Milestones
July-August 2015	Pre-Work	Faculty	Collaborative curriculum Change concepts	Pre-Work packets Project website
		Hospital teams	Complete pre-work	Post team goals
September 2015	Learning Session 1	Faculty	Clinical best practice Model for Improvement Action Period 1 goals	All teams attend LS
October 2015 - January 2016	Action Period 1	Faculty	QI support for teams Distance Learning	Monthly distance learning Visit teams
		Hospital teams	Team meetings Tests of change Monthly reports	Posted progress reports Distance learning sessions
February 2016	Learning Session 2	Faculty	Clinical best practice QI tools Collaborative work	All teams attend LS
March 2016	AP2	Faculty	QI support for teams Distance Learning	Monthly distance learning Visit teams
		Hospital teams	Team meetings Tests of change Monthly reports	Posted progress reports Distance learning sessions
April 2016	Learning Session 3	Faculty	Clinical best practice QI tools	All teams attend LS
May 2016	AP3	Faculty	QI support for teams Distance Learning	Monthly distance learning Visit teams
		Hospital teams	Team meetings Tests of change Monthly reports	Posted progress reports Distance learning sessions participation
June 2016	Outcomes Congress	Faculty	QI tools Collaborative work among teams	All teams attend Congress

Vermont Program for Quality Health Care #03410-1275-14	
Method of Selection	RFP-**Sub-Grant Program Awardee**
Contract Amount	**Total Contract Amount (all years):**$900,000 **Performance Period 2 Total Amount (including Travel):**$459,737.93 **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	1/26/15-11/30/16, **Performance Period 3** 1/1/16-11/30/16
Method of Accountability	This is a deliverables/performance-based agreement where the Subrecipient is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The program manager(s) review the invoices and work products each month before approving the invoices.
Itemized Budget (total project)	

Personnel:	
Project Coordinator	$136,267
Surgical Care Reviewers	$220,000
Total VPQ Support Staff	$59,468
Quality Improvement and Infection Control Staff in 6 hospitals	
IT Support in Hospital in 6 hospitals	$ -
6 Surgical Champions	$ -
Total Salaries	$415,735
Fringe @ 30%	$130,059
Salaries and Fringe	$545,794

Program Costs:	
Training fee for Coordinator	$2,500
Travel to hospitals and meetings by VPQHC Statewide SS Collabortative Coordinator staff; Avg. 5 trips per month Avg 200 miles RT @.$56 per mile	$7,728
Computer Equipment -6 computers for SCRs	$6,000
Meetings including one Statewide All Day Collaborative	$10,723
Conference sponsorship for collaborative leaders (6 Surgical Champions+6SCR's+2 VPQHC) to present at National NSQIP Conference San Diego	$42,000
	$ -

	Data Integration into VHIE - Contractors- VITL, Midas, NSQIP — $71,000 Enrollment fees -annual — $137,000 Total Program Costs — $276,951 9.39% Indirect Costs — $77,256 **Total Costs** — **$900,000**
Budget Category	*Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms*
Summary Statement of Work	Funding to build statewide infrastructure to support the collection, submission and reporting of surgical clinical data via the ACS-NSQIP clinical database. The goal is to improve surgical outcomes, enhance patient safety, and reduce costs.
Unique Qualifications (if Sole Source)	N/A
Retroactive Start Justification (if applicable)	1/1/16
Travel Justification	Travel budgeted in this agreement is for in-State travel only.
Applicable Y2 Milestone	Sub-Grant Program – Sub-Grants: Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.

Grant Attachment A, Scope of Work for Vermont Program for Quality Health Care #03410-1275-14

A. Subrecipient Shall:

1. Hire a Statewide Surgical Collaborative Project Coordinator (SSCPC) to assist hospitals in recruiting and hiring Surgical Care Reviewers (SCRs).
    a. The SSCPC will be able to provide both technical and clinical advice and support to the hospital-based SCRs.
    b. The SSCPC will provide short term chart abstraction services in the event of an unanticipated absence of any participating hospital's designated SCR.
    c. The SSCPC will make periodic site visits to the hospitals to provide strong implementation support to the SCRs and Surgical Champions (SC) at their worksites.
2. Assist hospitals with mentoring SCRs in compliance with the ACS-NSQIP program FTE requirements based on each of the twelve (12) hospitals' assessed needs. Each SCR will:
    a. Complete required 160 hour ACS-NSQIP training and take the certification exam in order to submit data into the database.
    b. Collect clinical data on variables, including preoperative risk factors, intraoperative variables and 30-day postoperative mortality and morbidity outcomes for patients undergoing surgical procedures as defined by ACS-NSQIP data collection specifications.
    c. Validate and submit the data to the ACS-NSQIP database through a secure, web-based system.
    d. Conduct data audits as indicated by ACS-NSQIP technical specifications.
    e. Meet regularly with the SCs and quality team to review results.
3. Work with hospitals to establish and engage a SC at each participating hospital, as required by ACS-NSQIP.

4. Provide on-going education for surgeons, surgical services staff, administration, as to role and function of SCR in hospital organization; Provide support for NSQIP integration into organization's quality improvement plan.
5. Collaborate with SCs and SCRs to troubleshoot and identify best practices opportunities.
6. Program Status Reporting:
   a. Prepare and submit to the State quarterly programmatic status reports no later than the 10th of the month following the 3 month period being reported. The reports shall include a narrative summary outlining specific progress on projects as directed by the reporting templates provided. The reporting schedule is as follows:
      i. 2015: April 10 (to include the month of December, 2014), July 10, October 10
      ii. 2016: January 10, April 10, July 10, October 10, December 10 (for the months of October and November, 2016
      iii. Final Report Due: December 10, 2016
   b. Programmatic reports shall be submitted to:
      Joelle Judge
      VHCIP Project Management Office
      Agency of Administration
      joelle.judge@partner.state.vt.us
      (o) 802-828-1979
7. Prepare and present programmatic reports to the VHCIP work groups, Steering Committee or Core Team as requested.
8. Adhere to the following work plan and timeline on page 5 of this agreement.

Project Scope and Purpose: (Overall Goal)	**To collect and submit surgical clinical data to the ACS- NSQIP database for the purpose of improving surgical outcomes and performance through data analysis and comparative performance monitoring**				
Project Objectives:	**Objective Statement**	**Implementation Activities (see Task tab for additional detail)**	**Responsible Staff**	**Start Date**	**Target Completion Date**
1. Phase 1 - Program Introduction	Initiate Vermont's Statewide Surgical Services Collaborative activities under the VHCIP Award program	Hire SSCPC for VPQHC to coordinate grant administration and project activities Outreach/education for hospital partners Create MOU for hospital partners participation in the Statewide Collaborative	VPQHC SSCPC (TBD)	December 1, 2014	April 15, 2015
2. Phase 2 - ACS-NSQIP Enrollment Process	Complete enrollment checklist activities upon payment of enrollment fees for participating hospitals	Surgical volumes and FTEs calculators; program enrollment option; SCR hiring, training, certification; submit completed application to ACS-NSQIP; complete Participation Agreement; submit participation fee; begin IT file creation & testing	Hospital participants with SSCPC support	March 1, 2015	May 20, 2015
3. Program Implementation	Begin data collection cycles with all Vermont Surgical Services Collaborative members	Complete data collection cycles for identified volumes as directed by the NSQIP program Provide on-going technical	Hospital Surgical Case Reviewers (SCRs) Implementation support from the SSCPC	May 1, 2015	Ongoing

		support, education and implementation assistance			
4. Phase 4 - Analysis and Best Practice Dissemination	Utilize ACS-NSQIP comparative performance reports and continuing collaborative analyses to support improvement activities	Utilize comparative reports to identify best practice and opportunities for improvement; provide continuing support and assistance to access performance data and information; broadly disseminate best practice solutions	VPQHC SSCPC ALL Collaborative members	June 1, 2016	Ongoing

<table>
<tr><th colspan="2">VT DDC #03400-VHCIP</th></tr>
<tr><td>Method of Selection</td><td>RFP-Sub-Grant Program Awardee</td></tr>
<tr><td>Contract Amount</td><td>$193,000
Total for Performance Period 2:$16,341.89</td></tr>
<tr><td>Contract Term</td><td>12/1/2014 – 6/30/16</td></tr>
<tr><td>Method of Accountability</td><td>This is a deliverables/performance-based agreement where the Subrecipient is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The program manager(s) review the invoices and work products each month before approving the invoices.</td></tr>
<tr><td>Itemized Budget (total project)</td><td>
<table>
<tr><th>Budget Category</th><th>Total</th></tr>
<tr><td>Personnel</td><td>19,400.00</td></tr>
<tr><td>Fringe</td><td>6,402.00</td></tr>
<tr><td>Travel</td><td>5,000.00</td></tr>
<tr><td>Equipment</td><td>1,830.00</td></tr>
<tr><td>Supplies</td><td>5,060.00</td></tr>
<tr><td>Contracts</td><td>151,408.00</td></tr>
<tr><td>Other</td><td>3,900.00</td></tr>
<tr><td>Total</td><td>193,000.00</td></tr>
</table>
</td></tr>
<tr><td>Budget Category</td><td>Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms</td></tr>
<tr><td>Summary Statement of Work</td><td>The Agency of Human Services Central Office (AHS CO) and the Vermont Developmental Disabilities Council (VTDDC) will enter into an agreement for collaboration on planning activities to establish a set of best practices in the delivery of health services to adult Vermonters with developmental disabilities that support good health and positive encounters with health care professionals in the delivery of high quality, cost effective care.</td></tr>
<tr><td>Unique Qualifications (if Sole Source)</td><td>N/A</td></tr>
<tr><td>Retroactive Start Justification (if applicable)</td><td></td></tr>
<tr><td>Travel Justification</td><td>Travel budgeted in this agreement is for in-State travel only.</td></tr>
<tr><td>Applicable Y2 Milestone</td><td>Sub-Grant Program – Sub-Grants: Continue sub-grant program:
1. Convene sub-grantees at least once by 6/30/16.
2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.</td></tr>
</table>

Scope of Work for VT DDC #03400-VHCIP

The Project Team will be prepared to engage individuals with I/DD and their family caregivers in a fully inclusive planning process that bridges gaps in understanding between stakeholders from traditional medical services and those who either provide or receive DLTSS.

- Develop job descriptions or request to bid that outlines qualifications for project staff consultants.
- Use existing staff and/or contract with consultants.
- Finalize terms of agreement with Green Mountain Self-Advocates for providing support to Work Group members with I/DD.

- Develop charge to the Project Work Group with expectation for its 8 participants. Establish application and selection process for potential participants.
- Recruit applicants and conduct selection process for Work Group of 8 members.
- Provide orientation for Planning Team member's including accessible materials.
- Identify and recommend a set of best practices that will improve the healthcare experience of adults with I/DD and reduce the disproportionate burden of illness experienced by this population.
- Identify evidence based and/or promising practices to improve the care experience of individuals with complex disabilities.
- Work Group to meet 6 times (1x/month) to review best practices.
- Work Group to receive input collected by Project Staff through research activities and outreach.
- Draft white paper to summarize the findings and recommendations of the Project Work Group.
- Planning Team meets to review draft white paper and incorporate a plan for next steps.
- Collect and analyze qualitative and quantitative data that describes the health status and care experience of adults with I/DD in Vermont.
- Develop a profile of healthcare utilization and cost by adults with I/DD in Vermont using Medicaid claims or other data.
- Hold 3 to 4 focus groups that represent subpopulations of adults with I/DD and family caregivers.
- Hold 8 to 10 structured interviews with a broad range of health and DLTSS providers.

By sharing information and soliciting input, the Project Team builds relationships with other collaborative healthcare groups (including Blueprint, Regional Learning Collaborative, etc.) that are working toward the triple aims of healthcare reform.

- Presentation of project concept and solicitation of input from each of Vermont's 3 "Integrated Communities" Learning Collaboratives, at least 2 Blueprint Regional Teams and similar groups.
- Project Staff presents their findings and recommendations to selected collaborative healthcare groups.
- Solicit input, endorsement and suggestions for Next Steps.

Evaluation and Expected Outcomes

Project White Paper that will be informed and supported by collaborative teams feedback and will include actionable recommendations that stakeholders can implement on a pilot basis.

Reporting Provisions

1. Quarterly and programmatic status report shall be submitted to Jessica Mendizabal at DVHA no later than the 1O"' of the month following the 3 month period being reported. The reports shall include a narrative summary outlining specific progress on projects as directed by the reporting templates provided (Attachment B).
   The reporting schedule is as follows:
   a. 2015: April 10 (to include December, 2014),July 10, October I 0
   b. Final Report Due: March 30, 2016
2. VTDDC shall prepare and present programmatic reports to the VHCIP work groups, Steering Committee or Core Team as requested.

White River Family Practice #03410-1280-15

Method of Selection	RFP-**Sub-Grant Program Awardee**
Contract Amount	**Total Contract Amount (all years):**$363,070 **Performance Period 2 Total Amount (including Travel):**$55,000 **Performance Period 2 Out-of-State Travel:** N/A
Contract Term	7/30/2014-5/31/2016, **Performance Period 2** 1/1/16-5/31/16
Method of Accountability	This is a deliverables/performance-based agreement where the Subrecipient is required to perform specific tasks according to a timeline and project plan. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The program manager(s) review the invoices and work products each month before approving the invoices.
Itemized Budget (total project)	(see table below)
Budget Category	*Technical Assistance: Technical Assistance to Providers Implementing Payment Reforms*
Summary Statement of Work	Develop an already sophisticated clinical care system to achieve the following aims: 1.) Measure and reduce emergency room utilization and hospital readmission among patients; 2.) Track patient confidence and utilize this metric to stratify patients with chronic disease to achieve improved disease outcomes and reduced utilization; and deploy team based care protocols targeting patients with chronic disease.

Category	Budgeted Amount
Personnel[14]	
RN Coordinator	$99,008
Mental Health	$20,000
MD Oversight	$23,100
Total Personnel	$120,816
Fringe*	$17,168
Consultant Fees	$122,700
Equipment	$36,818
Training/Curriculum Development	$7,770
Travel	$3,000
Supplies	$500
Indirect Costs	$33,006
Total Budget	$363,070

For RN Coordinator Only

[14] The clinicians involved in this project are doing so in compliance with federal anti-kickback and Stark law.

Unique Qualifications (if Sole Source)	N/A
Retroactive Start Justification (if applicable)	1/1/16
Travel Justification	Travel budgeted for this agreement is for in-State travel only.
Applicable Y2 Milestone	Sub-Grant Program – Sub-Grants: Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.

Grant Attachment A, Scope of Work for White River Family Practice #03410-1280-15

Subrecipient Shall:

1. Reduce non-emergent utilization and hospital readmission among Subrecipient's patients.
    a. Identify the cohort of Subrecipient's patients whose non-emergent use of the emergency room (ER) could be prevented with improved outpatient care.
    b. Identify the patient cohort whose hospital readmission might be prevented with improved transitional care management.
    c. Employ the Subrecipient's Care Coordinator in direct outreach to these patients to improve their care coordination and reduce associated hospital costs.
    d. Collaborate with Dartmouth Hitchcock Medical Center (DHMC) to assist in patient identification, care coordination, and transitional care management.
2. Use patient self-reported measures of experience of care and health-confidence in practice and design.
    a. Broaden existing use of patient self-assessment of health confidence tool by employing patient-reported measures of self-confidence to stratify patient populations.
    b. Employ structured collection of patient self-reported self confidence among target populations of patients.
3. Obtain and implement additional data analytics software to focus on care management and coordination of high risk patients.
    a. Subrecipient will use Care Coordination Medical Record (CCMR) software available from eClinicalWorks to assist in managing risk, improve quality, reduce cost of care, and improve the patient experience.
4. Develop Team-based care initiatives for chronic disease management.
    a. Use diabetes as a model of chronic disease and develop team-based patient care initiatives concentrating on patients with low self-confidence, suboptimal clinical metrics, and high risk for deterioration or hospital use.
5. Submit a formal evaluation plan to the state for review and approval. The plan will include the following:
    a. Evaluation of patient confidence for all hospital readmissions, repeated ER utilization and all Diabetes Mellitus (DM) patients.
    b. Reduce or maintain ER utilization below benchmark
    c. Evaluate cost savings achieved from reduction in ER utilization.
    d. Monitoring of and reduction in unnecessary ER visits.
    e. Number of patients readmitted within 30 days (or "days since a readmission" analogous to "number of days since an industrial accident" in Statistical Process Control (SPC).
    f. Improvement in use of self-management tools in chronic disease (i.e. the use of Asthma Action Plans).
    g. Evaluation of patient reported experience of care utilizing patient reported measures of self-confidence as well as the eClinicalWorks CCMR software.
6. Prepare and submit to the State quarterly programmatic status reports no later than the 10th of the month following the 3 month period being reported. The reports shall include a narrative summary outlining specific

progress on projects as directed by the reporting templates provided. The reporting schedule is as follows:

   a. 2014: October 10
   b. 2015: January 10, April 10, July 10, October 10
   c. 2016: January 10, April 10
   d. Final Report Due: June 30, 2016

7. Prepare and present programmatic reports to the VHCIP work groups, Steering Committee or Core Team as requested.
8. Adhere to the work plan and timeline presented on pages 5-7. Modifications and progress updates to the work plan shall be submitted on a monthly basis with program invoices

WRFP SIM Grant Initiatives

WBS	Task	Lead	Predecessors	Start	End	% Done
1	HEALTH CONFIDENCE MEASUREMENT (HCM)	[name]		Mon 5/12/14	Fri 1/01/16	9%
1.1	Trial of Self-Confidence Assessment Cards (Dr. Uiterwyk)			Mon 6/16/14	Thu 7/10/14	100%
1.2	Revise Health Confidence Measurement (HCM) Cards			Mon 7/28/14	Mon 8/11/14	
1.3	Discuss Use of HCM Cards with all Practitioners and Clinical Staff			Mon 8/11/14	Fri 8/22/14	
1.4	Trial of HCM Cards by all WRFP providers (in selected patients)			Mon 8/18/14	Fri 9/12/14	
1.5	Meet with John Wasson, MD, to discuss trial & use of Health Confidence in SIM Grant.			Mon 9/15/14	Mon 9/22/14	
1.6	Decide how to obtain HCM from DHMC (& APD) WRFP Patients			Mon 7/28/14	Fri 9/05/14	
1.7	Decide where HCM responses are recorded (in eCW as structured data, separate XL file, HYH Registry, other?)			Mon 6/30/14	Fri 8/15/14	
1.8	Expand use of HCM and MI approach to patient care as appropriate (other Chronic Diseases, etc.)			Thu 1/01/15	Fri 1/01/16	
1.9	Implement new HYH in Hospital Admissions, Frequent ED-Use (FEDU) Patients, CDM patients, (and Annual Wellness Visits). ?			Tue 9/02/14	Thu 1/01/15	
1.10	[Level 2 Task]			Wed 1/01/14	Wed 1/01/14	
1.11	[Level 2 Task]			Wed 1/01/14	Wed 1/01/14	
1.12	*[Insert Rows above this one, then Hide or Delete this row]*					
2	HOSPITAL READMISSIONS & TCM	[name]		Mon 5/12/14	Wed 12/31/14	4%
2.1	Obtain historic DHMC WRFP Pts' readmission data for baseline.			Mon 5/12/14	Fri 6/13/14	100%
2.2	Collaborate with DHMC Data staff to obtain best monthly reports of hospital admissions & ED visits			Fri 6/13/14	Fri 8/01/14	50%
2.3	Obtain historic APD WRFP Pts' readmission data for baseline.			Tue 7/08/14	Fri 8/08/14	10%
2.4	Collaborate with APD to obtain best monthly reports of hospital admissions.			Mon 8/11/14	Fri 9/05/14	
2.5	Develop SPC charting for hospital readmissions.			Mon 6/02/14	Fri 8/01/14	
2.6	Implement Health Confidence Assessment with all Hospital Readmits		1.3	Tue 9/02/14	Wed 12/31/14	
2.7	Sort Patients with frequent Hospital Readmissions by PCP		2.2	Fri 7/25/14	Fri 8/01/14	
2.8	All WRFP Practitioners review the PCP-specific list of HR patients. (Note: Some HR patients may be beyond current ability to manage without readmission - e.g., trauma, specialty care, etc.)		2.7	Mon 8/04/14	Mon 8/25/14	
2.9	Obtain Health Confidence Assessments from Readmit Cohort			Mon 5/12/14	Fri 8/29/14	
2.10	Merge Frequent Readmit Cohort with Confidence Assessments to identify Hospital Readmissions (HR) pts with Low HCM		2.7 2.9	Tue 9/02/14	Mon 9/15/14	
2.11	Practitioners meet to review these patients and identify HR/LowHCM cohort for focused TCM & Team Management		2.10	Tue 9/16/14	Tue 9/30/14	
2.12	Discuss processes of focused TCM care for hospital readmits with practitoners and staff (mapping process for post-hospitalization office visits, pre-visit planning, intensive TCM, medication reconciliation, etc., & identification of Clinical Staff involved in team-care.)			Mon 8/04/14	Tue 9/30/14	
2.13	[Level 2 Task]			Wed 1/01/14	Wed 1/01/14	
2.14	[Level 2 Task]			Wed 1/01/14	Wed 1/01/14	
2.15	*[Insert Rows above this one, then Hide or Delete this row]*					
3	EMERGENCY DEPARTMENT (ED) VISITS & TCM (Frequent, recurring, or non-emergent)	[name]		Mon 5/12/14	Tue 10/28/14	0%
3.1	Request algorithm for determination of "non-emergent use" from payers			Mon 7/14/14	Fri 7/18/14	

Timeline columns: 2014 May, 2014 Jun, 2014 Jul, 2014 Aug, 2014 Sep, 2014 Oct, 2014 Nov, 2014 Dec, 2015 Jan, 2015 Feb, 2015 Mar, 2015 Apr, 2015 May, 2015 Jun, 2015 Jul, 2015 Aug, 2015 Sep, 2015 Oct, 2015 Nov, 2015 Dec, 2016 Jan

ID	Task	Lead	Predecessors	Start	End	% Complete
3.2	Determine whether to include non-emergent use pts in addition to frequent ED users (FEDU) in ED Cohort for focused team care			Mon 7/28/14	Fri 8/15/14	
3.3	Complete baseline analysis of ED utilization.			Mon 7/07/14	Mon 9/15/14	
3.4	Sort Hospital data base to identify patients with frequent returns to the ED (FEDU's) & decide initial cut-off defining "frequent."			Fri 7/25/14	Fri 8/01/14	
3.5	Develop SPC charting for patients with frequent ED use (FEDU)			Mon 7/28/14	Fri 8/29/14	
3.6	Obtain Health Confidence Assessments from FEDU Cohort			Mon 8/04/14	Fri 10/03/14	
3.7	Merge FEDU Cohort with Confidence Assessments to identify FEDU/Low HCM patients.			Mon 10/06/14	Fri 10/10/14	
3.8	Sort FEDU/LowHCM Patients by PCP			Mon 9/15/14	Fri 10/10/14	
3.9	Practitioners meet to review these patients and identify FEDU/LowHCM cohort for focused TCM & Team Management		3.7	Mon 10/13/14	Tue 10/28/14	
3.10	Discuss processes of focused TCM care for FEDU patients with practitoners and staff (mapping process for post-hospitalization office visits, pre-visit planning, intensive TCM, medication reconciliation, etc., & identification of Clinical Staff involved in team-care.)			Mon 8/04/14	Tue 10/28/14	
3.11	[Level 2 Task]			Wed 1/01/14	Wed 1/01/14	
3.12	[Level 2 Task]			Wed 1/01/14	Wed 1/01/14	
3.13	*[Insert Rows above this one, then Hide or Delete this row]*					
4	CHRONIC DISEASE MANAGEMENT (CDM)	[name]		Mon 5/12/14	Fri 4/03/15	9%
4.1	Decide where HCM is recorded for WRFP CDM Patients (in eCW as structured data, separate XL file, HYH Registry, other?) (as in 1.7)		1.7	Mon 6/30/14	Fri 8/15/14	
4.2	Obtain HCM from all patients targeted for CDM (Diabetes visits)			Fri 8/15/14	Fri 11/28/14	
4.3	Identify subset of CDM patients with Low HCM			Mon 10/13/14	Fri 11/28/14	
4.4	Sort Patients with CDM/LowHCM by PCP		2.15	Tue 9/02/14	Fri 11/28/14	
4.5	Practitioners meet to review these patients and identify HR/LowHCM cohort for focused TCM & Team Management		4.4	Mon 10/27/14	Fri 11/28/14	
4.6	Discuss processes of focused Team-care for CDM/LowHCM patients with practitoners and staff (mapping process for post-hospitalization office visits, pre-visit planning, intensive TCM, medication rec.onciliation, etc., & identification of Clinical Staff involved in team-care.)			Mon 8/04/14	Tue 9/30/14	
4.7	Recruit and hire an additional RN.			Mon 5/12/14	Fri 8/01/14	80%
4.8	Train MA's as Level 1 Certified Diabetic Educators.			Mon 7/14/14	Fri 10/10/14	60%
4.9	Coordinate additional Mental Health Provider capacity in screening for depression in CDM.			Mon 6/30/14	Fri 8/15/14	
4.10	Develop Motivational Interviewing skills among staff (MA's, Health Coaches, etc.).			Tue 9/02/14	Fri 2/27/15	
4.11	Train MA's in Team-care for between-visit patient contact for MI & Care Plan follow-up			Mon 5/12/14	Wed 12/31/14	20%
4.12	Expand MA roles in CDM (e.g., Asthma, CVD, Smoking Cessation).			Mon 1/05/15	Fri 4/03/15	
4.13	[Level 2 Task]			Wed 1/01/14	Wed 1/01/14	
4.14	[Level 2 Task]			Wed 1/01/14	Wed 1/01/14	
4.15	*[Insert Rows above this one, then Hide or Delete this row]*					
5	TEAM CARE of HIGH-RISK COHORTS	[name]		Wed 1/01/14	Wed 12/10/14	0%
5.1	Merge patient populations from hospital readmits, FEDU's and CDM's with Low HCM into one cohort for focused TCM and MI Team Care		2.10 3.7 4.3	Fri 11/28/14	Wed 12/10/14	
5.2	Identify Patient Cohort from step 5.2 as 4th Relevant Visit with color coding in eCW			Mon 5/12/14		
5.3	Discuss processes of focused Team-care for High Risk patient cohorts with practitoners and staff (mapping process for office visits, pre-visit planning, intensive TCM, medication reconciliation, etc., & identification of Clinical Staff involved in team-care.) As in 2.12, 3.11, & 4.4 above.			Mon 8/04/14	Tue 9/30/14	
5.4	[Level 2 Task]			Wed 1/01/14	Wed 1/01/14	
5.5	[Level 2 Task]			Wed 1/01/14	Wed 1/01/14	
5.6	*[Insert Rows above this one, then Hide or Delete this row]*					

6	ANALYTICS	[name]	Wed 1/01/14	Thu 1/01/15	30%
6.1	Evaluate available Analytics.		Wed 5/21/14	Mon 6/30/14	100%
6.2	Complete contract negotiation for Analytics of choice.		Mon 6/30/14	Thu 7/03/14	100%
6.3	Implement and train on Analytics.		Mon 7/28/14	Fri 8/15/14	
6.3.1	Include HCM in Analytics Training	1.7	Mon 8/18/14	Fri 8/15/14	
6.4	Request Split Claims Data from major insurance payers.		Mon 6/02/14	Fri 6/13/14	100%
6.5	Coordinate with BCBSofVT to obtain data feed for Analytics.		Sun 6/01/14	Fri 8/01/14	
6.6	Follow-up with other major payers to request split claims data (again)		Mon 7/14/14	Fri 7/25/14	
6.7	[Level 2 Task]		Wed 1/01/14	Wed 1/01/14	
6.8	Use Analytics in Cohort Identification for CDM, Hospital Admission Risk, and Frequent ED-Visit Risk.	6.3	Mon 8/18/14	Wed 12/31/14	
6.9	Obtain devices for patient-entered HYH assessments for use in Waiting Room		Wed 1/01/14	Wed 1/01/14	
6.10	Broaden use of HYH throughout patient population with input to HYH Registry?		Wed 9/02/15	Thu 1/01/15	
6.11	Develop use of HYH registry output for cohort identification.		Tue 9/02/14	Wed 12/31/14	
6.12	[Level 2 Task]		Wed 1/01/14	Wed 1/01/14	
6.13	[Level 2 Task]		Wed 1/01/14	Wed 1/01/14	
6.14	*[Insert Rows above this one, then Hide or Delete this row]*				
7	ACTmd in TRANSITIONAL CARE MANAGEMENT?		Mon 5/12/14	Fri 10/24/14	1%
7.1	WRFP decision on use of ACTmd in population management. (Yes, conditional on use by VNA's, DHMC, etc.)		Mon 5/12/14	Mon 5/12/14	100%
7.2	Discuss Test of ACTmd with Bayatta.		Mon 6/16/14	Fri 7/11/14	100%
7.3	Implement ACTmd with Bayatta for Home Care Patients.		Mon 6/30/14	Fri 10/24/14	
7.4	Discuss use of ACTmd on trial basis with DHMC Leadership and select DHMC Hospitalists. (No willing partner for discussions until end-of-summer.)		Tue 9/02/14	Fri 10/17/14	
7.5	Implement ACTmd with DHMC Hospitalist / Discharge Contact(s).		Mon 10/20/14	Fri 12/12/14	
7.6	Contract with ACTmd for WRFP use (?)		Mon 11/17/14	Fri 12/12/14	
7.7	Enroll High-Risk Patient Cohorts in ACTmd (Hospital readmits, Frequent ED users, and CDM patients with low HCM's)	7.6	Sat 12/13/14	Wed 6/10/15	
7.8	Discuss integration of HYH self-confidence assessment into ACTmd as Patient assignment.	7.6	Mon 12/15/14	Mon 12/29/14	
7.9	[Level 2 Task]		Wed 1/01/14	Wed 1/01/14	
7.10	[Level 2 Task]		Wed 1/01/14	Wed 1/01/14	
7.11	*[Insert Rows above this one, then Hide or Delete this row]*				
8	EVALUATION & DISSEMINATION	[name]	Wed 1/01/14	Sun 2/22/15	0%
8.1	Evaluate impact of interventions on WRFP at Monthly Management Meetings		Wed 1/01/14	Wed 1/01/14	
8.2	Evaluate impact of interventions on High Risk Patient Cohort at Monthly WRFP Provider Management Meetings. (Review SPC reports.)		Thu 7/10/14	Thu 7/10/14	
8.3	Evaluate Patient Experience-of-Care.		Wed 1/01/14	Wed 1/01/14	
8.4	Share Lessons Learned at eCW NUC.		Fri 10/17/14	Tue 10/21/14	
8.5	Share Lessons Learned at Dartmouth Primary Care COOP Meeting.		Fri 2/20/15	Sun 2/22/15	
8.6	[Level 2 Task]		Wed 1/01/14	Wed 1/01/14	
8.7	[Level 2 Task]		Wed 1/01/14	Wed 1/01/14	
8.8	*[Insert Rows above this one, then Hide or Delete this row]*				