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

Vermont State Innovation Models (SIM) Annual Report
Test Year 1: October 1, 2013 – December 31, 2014
Submitted: March 30, 2015

Year 1: Summary of Major Accomplishments and Progress Toward Milestones and Metrics

During Test Year 1, Vermont's SIM Project made significant progress toward our goals. The aims of Vermont's SIM Project are to improve care, improve health, and reduce costs. The primary drivers to achieve those aims are:

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

Summary of Major Accomplishments

- ***Payment Model Development.***
  - *Shared Savings Programs.* Vermont finalized standards for the state's commercial and Medicaid Shared Savings Programs (SSPs), including operation standards and quality measures. Both programs launched retroactively on January 1, 2014, the start of the first performance year. Planning for updates to the SSPs for the second performance year also commenced during Test Year 1.Through the continuing collaborative efforts of the ACOs and Payers, both technical and substantive changes to the ACO SSP Standards were reviewed and approved by the Steering Committee, Core Team, and Green Mountain Care Board (GMCB) in 2014(Revised Standards are available on the GMCB Website: www.gmcboard.vermont.gov).
  - *Episodes of Care (EOC).* After discussion with stakeholders revealed that EOC incentive payment programs and/or bundled payment arrangements are not a priority for Year 1, Vermont decided not to pursue this path. However, Vermont's SIM project is continuing to expand use of EOC analytics to support care delivery transformation, leveraging an existing contract to perform statewide analysis of priority conditions in 2014 and chartering a sub-group of the Payment Models Work Group (launched in early 2015) to further study the potential of EOC analytics to improve care delivery and drive down costs. Efforts in Test Year 2 will focus on testing whether the use of EOC analytics can drive care delivery transformation and pave the way for renewed interest in bundled payment programs or payment incentives.

- *Pay-for-Performance (P4P).* Throughout Test Year 1, Vermont's SIM Project has worked with leadership from the state's Blueprint for Health to discuss options for the future of the Blueprint's P4P incentives, which have been in place since 2008. Efforts in Test Year 2 will focus on finalizing the design and implementation of a state-wide P4P program for primary care providers participating in the Blueprint for Health, which may include enhanced performance-based payments for Blueprint practices and enhanced payments for Community Health Teams.

- ***Care Models Development.*** During Test Year 1, Vermont made progress toward creating a unified regional structure to support clinician and other service provider collaboration across the health system. These groups bring together clinical leadership across payer, ACO, and Blueprint for Health activities, supporting increased coordination and aligning efforts. Vermont also made progress toward a unified system of sharing clinical and financial measurement data. In addition, Vermont launched two rounds of a sub-grant program for innovators throughout Vermont to work on projects designed to support delivery system change throughout the health care system, and developed a pilot learning collaborative to support integrated care management across health, community and social service organizations in three Vermont communities.

- ***Health Information Exchange.*** During Test Year 1, Vermont's SIM Project has made significant investments in health information technology (HIT) and health information exchange (HIE) infrastructure to support improvements to care and measurement/reporting. Vermont's SIM Project is working with Vermont Information Technology Leaders (VITL), which administers Vermont's Health Information Exchange (or VHIE), to launch an event notification system to support transitions of care, and ACO analytics vendors are connecting to the VHIE. In addition, Vermont launched a trio of projects to support improved HIT and HIE capabilities among providers who serve Disabilities and Long-Term Services and Supports (DLTSS) populations. These three projects will: improve and standardize data quality in electronic medical records systems for the state's Designated Mental Health Agencies and Specialized Service Agencies; identify gaps in data systems in both acute and non-acute providers; and design a Uniform Transfer Protocol to support transitions of care.

- ***Governance, Staffing and Project Management, Evaluation, and other Project Support Activities.***
  - During Test Year 1, Vermont's SIM staff and project management team fully implemented the SIM governance structure, forming seven work groups as well as a Steering Committee and Core Team.
  - Vermont's SIM Project has hired 17.5 staff to support project activities.
  - Vermont's SIM Project contracted with a vender to perform the state's SIM Self-Evaluation and began drafting an evaluation plan.

- Vermont completed a Risk Mitigation Plan, updated each quarter by project staff.

Vermont's major accomplishments during Test Year 1 are compiled in Table 1, below, which also lays out planned Test Year 2 activities, and are further described under the section entitled: Progress Toward Milestones and Metrics.

TABLE 1: Summary: Year One Proposed Activities and Progress, Planned Year Two Activities

Testing Models	Year One Proposed	Year One Progress	Year Two Proposed
Payment Models – *Shared Savings Programs*	1) Finalization of shared savings program (SSP) standards for commercial exchange and Medicaid programs. 2) Launch SSPs.	1) Standards completed and programs launched.	1) Preparation for movement from shared savings to two-sided risk in Year 3 of the SSP and consideration of possible population-based payment arrangements. 2) Adaptation of program standards for Years 2 & 3.
Payment Models – *Episode of Care Programs*	1) Examine options for, and explore financing of, incentive payment programs and/or bundled payment arrangements based on episodes of care (EOCs). 2) Examine utility of using analytics based on episodes of care (EOC) in regional care delivery transformation efforts.	1) EOC incentive programs and/or bundled payment arrangements are not a priority for stakeholders. 2) Statewide analysis confirmed provider-level and regional variation among priority conditions. 3) Integration and expansion of using EOC analytics in care delivery transformation continues to be a priority.	1) State to facilitate multi-stakeholder development of analytics to support regional care delivery activities including Blueprint and ACO collaborations and learning collaboratives. 2) SIM resources support development of provider-level and regional analytics of priority EOCs.
Payment Models – *P4P Programs*	1) Examine options for, and explore financing of, incentive and/or provider-specific P4P programs. 2) Examine utility of using additional analytics in regional care delivery transformation efforts.	1) Options for evolution of P4P under the Blueprint for Health examined.	1) If broad state support and financing for, implement changes to the P4P incentive program under the Blueprint for Health. 2) Develop plans for additional P4P programs under GMC payment regulations, if prioritized.
Care Models Development	1) Build framework for providers to unite under accountable care relationships. 2) Develop unified performance measurement across health care reform initiatives, and priority clinical and financial measurement targets. 3) Create provider-grant program to incent investment in building coalitions and infrastructure for care delivery transformation.	1) Progress towards a unified regional health, social and community service system integrating payer, ACO and Blueprint for Health activities. 2) Progress towards a unified system of sharing clinical and financial measurement data. 3) Launched two rounds of provider grant funding. 4) Development of three-site pilot Integrated Communities Care Management Learning Collaborative structure.	1) Strengthen and broaden regional unified systems. 2) Strengthen and broaden use of clinical and financial measurement data and incentive models. 3) Launch pilot learning collaboratives, and explore opportunities for expansion to additional communities. 4) Continue to support provider grant recipients and disseminate rapid cycle evaluation findings. 5) Evaluate the potential for state-wide health home model building on existing Blueprint for Health and Hub and Spoke program.
Health Information Exchange	1) Provide input to update of state HIT plan. 2) Expand provider connection to HIE infrastructure. 3) Identify necessary enhancements to centralized clinical registry & reporting systems. 4) Design the components of the integrated platform. 5) Develop criteria for telemedicine sub-grants. 6) Expand the scope of VHCURES to support the integration of both claims and clinical data and provide this capability to ACOs/providers and, potentially, to payers. 7) Begin to incorporate long-term care, mental health, home care, and specialist providers into the HIE infrastructure.	1) Invested in an event notification system to support transitions of care. 2) Expanded scope of VHCURES through new contract. 3) Connected ACO analytics vendors to Vermont's Health Information Exchange. 4) Began work to improve and standardize data quality in electronic medical records systems for the state's Designated Mental Health Agencies and Specialized Service Agencies. 5) Began work to identify gaps in data systems in both acute and non-acute providers. 6) Began work to design a Uniform Transfer Protocol to support transitions of care.	1) Continue implementation of solutions begun in year one. 2) Develop a data gap remediation plan. 3) Develop and begin to implement a data integration solution. 4) Update the state's HIT Plan. 5) Develop a telehealth plan and launch a telehealth pilot program.

Progress Toward Milestones and Metrics

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

Advanced Analytics:

1. *Procure Contractor for Internal Medicaid Modeling*: Vermont's Department of Vermont Health Access (DVHA) executed a contract in the second quarter.

2. *Procure Contractor for ACO Shared Savings Program Analytics*: In order to support its oversight role, the Green Mountain Care Board (GMCB), in coordination with DVHA, engaged a vendor to assume responsibility for statewide analytics activities related to the implementation, monitoring, reporting, and evaluation of Vermont's Commercial and Medicaid ACO Shared Savings Programs (SSPs). A vendor was selected in March 2014, and the contract was executed in July 2014. The required tasks of the Analytics Contractor include the following:
    a. Calculation of ACO financial performance and modeling the distribution of earned savings payments;
    b. Calculation of ACO performance measure results;
    c. Calculation of the impact of ACO performance measure results on the distribution of shared savings; and
    d. Report design and generation.

3. *Define ACO SSP Analyses for Reports:* Vermont's SIM project has designed several reports for the Commercial and Medicaid ACO SSPs. The reports include attribution reports; claims extracts; summary statistics for attributed populations; analysis of the difference between core and non-core costs; calculation of utilization metrics; calculation of performance measures; and calculation of shared savings.

    a. ACO SSP Attribution Reports: DVHA developed attribution reports, first sent to the ACOs in June 2014, based on ACO-submitted provider rosters. Attribution reports are shared as data files, and include a list of patients that are attributed to a particular ACO, their mailing addresses, and the PCPs through whom they were attributed to the ACO. The attribution reports allow the ACOs to notify newly attributed beneficiaries of their inclusion in the ACO's attributed population and their right to opt out of claims data sharing between DVHA and the ACO. The commercial carrier, Blue Cross Blue Shield of Vermont (BCBSVT), similarly developed attribution reports, but due to PCP identification challenges with the commercial program, this activity did not occur until late in the third quarter of Year 1. Commercial attribution reports do not include beneficiary mailing addresses because beneficiary notification is not an ACO requirement in

the commercial Shared Savings Program. Attribution reports are updated monthly for both the Medicaid and commercial programs, giving ACOs a "rolling snapshot" of their attributed populations.

b. ACO SSP Claims Extracts: Claims extracts from Medicaid and BCBSVT are required to follow the VHCURES data submission format, and include three separate files provided to ACOs and to the Analytics Contractor: the enrollment file, the medical claims file, and the pharmacy claims file[1]. DVHA adds additional Medicaid-specific variables as follows: HCC risk score, new attribution flag, attributed in which step (specific to Medicaid attribution process), months enrolled in Medicaid, Medicaid eligibility category, attributing provider ID, above 99th percent flag (for cost truncation). New claims extracts are provided by BCBSVT to ACOs on a monthly basis, and to the Analytics Contractor on a quarterly basis for monitoring and evaluation measures, and at six-month, nine-month, and 12-month time frames for quality measures. The initial Medicaid files were shared with the ACOs after the beneficiary notification and opt-out process was completed in August 2014, and included incurred claims for attributed enrollees from January 2013 through July 2014. ACOs receive updated extracts monthly with claims paid in the past month for currently attributed enrollees, and historical claims (going back to January 2013) for newly attributed enrollees. Similarly, the commercial files were also shared with the ACOs beginning in October 2014.

c. Summary Statistics for Attributed Populations: For the Medicaid Shared Savings Program (VMSSP), DVHA has developed a number of analyses to better describe the attributed populations of the ACOs, including breakdowns of the attributed populations by gender, age, eligibility category, hospital service area, and HCC risk score, and analyses that examine utilization across a variety of settings. BCBSVT is also exploring their data and designing reports related to attributed populations. DVHA and BCBSVT are working together to ensure as much consistency as possible with these reports between programs.

d. Analysis of the Difference Between Core and Non-Core Services: DVHA has also designed reports to better characterize the services being used by the attributed populations of the ACOs. As part of the VMSSP, DVHA assessed expansion of the Year 1 total cost of care (TCOC) calculation to include the cost of a broader set of Medicaid services in Year 2. To support this effort, DVHA worked with their consultant (Burns and Associates) to design analyses to inform the Payment Models Work Group, Steering Committee, and Core Team for the optional Year 2 TCOC expansion. In December 2014 and January 2015, the two VMSSP ACOs elected not to take on the optional Year 2 TCOC expansion; the analyses

[1] Note that the pharmacy claims are not used for the SSP calculation, but for other analyses.

developed to inform the Year 2 TCOC set of services will be further leveraged to develop the Year 3 TCOC set of services.

4. *Consult with Payment Models and DLTSS Work Groups on Definition of Analyses:* Vermont consulted with the Payment Models Work Group on the ACO SSP Analyses and on the scope of work for the Analytics Contractor RFP. The Disability and Long-Term Services and Supports (DLTSS) Work Group began discussing sub-population analyses of interest in March 2014 and continued the discussion through the rest of Test Year 1.

   According to the VMSSP contracts, DVHA was required to notify ACOs of the non-core expenditures included in total cost of care calculations for Year 2 of the VMSSP (optional) by October 1st, 2014; DVHA announced in October 2014 that these additional non-core expenditures would be pharmacy and non-emergency medical transportation. Vermont's two VMSSP ACOs announced in late 2014 and early 2015 that they would not take on the optional TCOC expansion for Year 2 of the VMSSP.

   The DLTSS work group also made recommendations to the Quality and Performance Measures Work Group regarding the addition of DLTSS-specific measures in Performance Year 2 of the VMSSP. In October 2014, the Quality and Performance Measures Work Group formally recommended the addition of DLTSS-specific survey questions to the surveys being fielded to Shared Savings Program enrollees, and the addition of a measure of LTSS Rebalancing by county.

5. *Perform Analyses, Procure Contractor, Develop Financial Baselines, and Develop Trend Models*: As noted above, Vermont procured contractors to develop financial baselines and trends in Year 1 through contracts executed by GMCB (financial baselines and trend models for the Medicaid and Commercial ACO SSPs) and DVHA (analyses related to Episode of Care and Pay-for-Performance models).

   DVHA is currently under contract with Burns and Associates and has developed several reports related to the VMSSP including attribution reports, expenditures analysis, and financial baseline and trend modeling. DVHA will continue to work with Burns and Associates to transfer any relevant reporting functions to the state-wide analytics contractor.

   The Payment Models Work Group has leveraged an existing GMCB contract with Truven Health Analytics and its subcontractor, Brandeis University, to work with SIM staff and work groups to explore the possible models and necessary decision points that the work group must make as they work to design an Episodes of Care (EOC) pilot in Vermont. Brandeis prepared a statewide Commercial and Medicaid analysis using the PROMETHEUS payment model, presented in August 2014 to the Payment Models Work Group to inform recommendations on EOC priorities. A sub-group of the Payment Models Work Group was convened in January 2015 to discuss EOC; the group is meeting tri-weekly.

6. *Consult with Payment Models and DLTSS Work Groups on Financial Model Design:* The Payment Models and DLTSS Work Groups will collaborate in Test Year 2 to share information on payment models being implemented and gather DLTSS Work Group feedback.

7. *Produce Quarterly and Year-End Reports for Commercial and Medicaid ACO SSP participants and Payers*: These reports are being generated by the Analytics Contractor, who began work in July 2014. Vermont's SIM project has established criteria for quarterly and annual reports and worked closely with the Analytics Contractor to ensure accurate compliance with report requirements. The annual report for 2014 is expected to be completed in September 2015.

Evaluation:

1. *Procure External Evaluation Contractor:* The State, through the GMCB, executed a contract with its selected Self-Evaluation vendor, IMPAQ International, in September 2014.

2. *Develop Self-Evaluation Plan:* The State spent several months developing the Self-Evaluation Plan and will continue efforts in 2015.

3. *Consult with Performance Measures Work Group:* A status report on the external evaluation will be presented to with the Quality and Performance Measures Work Group in the second quarter of 2015.

4. *Input Baseline Data*: The use of quantitative data, specifically baseline data being tracked over time, has been the subject of a great deal of recent discussion in Vermont. The State is concerned the scale and scope of innovations happening statewide could prevent evaluators from attributing statistically significant change to a specific VHCIP innovation due to the preponderance of confounding factors. The State is carefully considering a number of methodological approaches that will be selected when research questions are finalized.

5. *Hire Staff:* The Evaluation Director was hired in the second quarter of Test Year 1. A University of Vermont graduate student is serving as an intern to the Evaluation Director for the 2014/2015 academic year.

Initiative Support:

1. *Procure Contractor for Interagency Coordination, Develop Interagency and Inter-Project Communications Plan, and Implement the Plan*: Vermont's Agency of Administration executed an agreement with Arrowhead Health Analytics in August 2014.

State Staff Training and Development:

1. *Hire Contractor and Develop Curriculum*: Vermont's Core Team approved a contract for this work in May 2014. Vermont's DVHA executed an agreement with The Coaching Center in the fourth quarter of Test Year 1.

Model Testing:

1. *Develop ACO Model Standards*: Vermont continues to implement the Medicaid and Commercial Shared Savings ACO Programs. GMCB and DVHA participate in operational discussions with representatives of ACOs, payers, and providers. These programs are being carefully monitored through a series of required reports and other updates that demonstrate ACO and Payer compliance with the ACO-SSP Standards. These reports include evidence of compliance with governance standards, consumer participation, claims calculations, quality performance measures, and access to ensure that these programs meet their intended purpose of benefitting Vermont consumers.

   Approved program standards relate to:

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

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

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

   Care Management Standards were developed by the Care Models and Care Management Work Group, using NCQA standards related to care management in ACOs as a starting point. The Care Models and Care Management Work Group and other VHCIP Work Groups suggested additional standards to address care management in areas such as disability and long-term services and supports, and collaboration throughout the care management infrastructure. Final standards will be presented to the Care Models and Care Management Work Group, the VHCIP Steering Committee, and the VHCIP Core Team in the first quarter of 2015.

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

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

The Quality and Performance Measures Work Group recommended measures for Year 2 (Calendar Year 2015) of the Shared Savings ACO Programs in July 2014. The recommendations were then considered by the Steering Committee, Core Team, and Green Mountain Care Board for final adoption and approved in October 2014. Several entities, including the Population Health Work Group, the DLTSS Work Group, the Office of the Health Care Advocate at Vermont Legal Aid (representing consumers) and designated mental health agencies, contributed to this process.

Vermont continues to address the many details and complexities involved in implementing the Commercial and Medicaid ACO SSPs, and will ensure that these Standards and Performance Measures are being adhered to by the ACOs participating in the SSPs. This will involve the work of the Analytics Contractor and the oversight role of the GMCB and DVHA.

- Vermont's SIM Team provided examples of implementation guidance to ACOs and payers to support model testing and include:
    - Reporting templates and timelines for ACO provider rosters,
    - Reporting templates and timelines for payer lists of attributed patients and high risk patients,
    - Reporting templates and timelines for measures, and
    - Detailed measure specifications.

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

3. *Execute Commercial Shared Savings ACO Program Contracts*: ACOs and Commercial Payers have executed Commercial Shared Savings ACO Program Agreements for

performance year January 1, 2014 – December 31, 2014. All three ACOs executed Program Agreements with Blue Cross Blue Shield in March of 2014, retroactive to January 1, 2014. MVP Health Care (the other commercial payer that was planning to participate in the Commercial Shared Savings Program) does not have sufficient enrollment with any of the ACOs to participate. A summary of provider types and numbers can be found in Appendix A.

DVHA submitted a State Plan Amendment for the VMSSP in February 2014 and continued to work with CMS through Test Year 1. Most notably, following comments received by the OACT in October 2014, DVHA engaged an independent actuary in November 2014 to review and provide certification of the program's financial calculations in order to support discussions with CMS. DVHA received actuarial certification early in Test Year 2 and is awaiting CMS response and final approval. The focus of Test Year 2 will be to work through additional suggestions made by the actuaries as well as consideration of methodology compared to methodology changes being made under Medicare's Next Generation ACO program.

4. *Develop Standards for Bundled and Episode-Based Payments*: Episodes of Care was discussed by the Payment Models Work Group throughout Test Year 1. Numerous educational presentations were given to the Work Group in an effort to inform the Work Group members of national trends in the use of EOCs and bundled payments as part of payment reform strategies. Representatives from Rutland Regional Medical Center also presented on their experience participating in Medicare's Bundled Payment for Care Improvement (BPCI) demonstration program. In addition, the group developed a set of consensus priority criteria on how best to evaluate and promote the use of EOCs in care and payment system reform.

   At the June 2014 meeting of the Payment Models Work Group (PMWG), a presentation was given by François de Brantes of the Health Care Incentives Improvement Institute (HCi3) to learn about current initiatives and the challenges others are facing using the Episodes of Care model. Additionally, at the July 2014 meeting, a presentation was given to work group members of the goal to integrate care in the state and what that might look like in the future with new payment models in place. HCi3 prepared a statewide (commercial and Medicaid) data analysis using the PROMETHEUS payment model, with descriptive statistics including total and average cost of the 25 EOCs as well as potentially avoidable complication rates. State stakeholders did identify development of an episode-based payment program as a priority and launched a sub-group of the Payment Models Work Group, which is charged with developing a strategy for statewide Episodes of Care analytics use.

5. *Execute Contracts for Bundled and Episode-Based Payments*: The Payment Models Work Group leveraged an existing state contract to support the development of Episodes of Care model. Truven Health Analytics began work in February 2014.

6. *Develop a Medicaid Value-Based Purchasing Plan Addressing Pay-For-Performance Initiatives*: Primary care Pay-for-Performance (P4P) remains the focus of Vermont Medicaid's P4P activities. The Payment Models Work Group, as well as in other multi-stakeholder advisory groups, have discussed integration, continued support, and growth of Medicaid's participation in the Blueprint for Health throughout Test Year 1, supported by regular presentations from Blueprint for Health leadership. Recommendations in support of an October report to the legislature are expected by the end of the summer 2015. Vermont decided in August 2014 not to pursue additional P4P activities due to state budget constraints and the inability to guarantee sustainability in programming after the SIM grant has ended.

   DVHA executed a contract with Pacific Health Policy Group to evaluate Medicaid-specific programs against value-based criteria. Work on this began in July 2014. The deliverable will include an evaluation of value-based elements in current programs along with recommendations for strengthening those programs in the future.

7. *Procure Learning Collaborative and Provider Technical Assistance Contractor*: Vermont made major strides in planning and developing learning collaboratives in three pilot communities in 2014, building on the work of Vermont's three ACOs, the Blueprint for Health (the state's Multi-payer Advanced Primary Care Practice [MAPCP] demonstration project), and Medicaid's Vermont Chronic Care Initiative to determine how best to collaborate and provide integrated care management across health, community service, and social service organizations for at-risk patients. A proposal to establish and test "Integrated Communities" in three health service areas and to develop tools and training to assist care managers in those communities was presented to the Care Models and Care Management Work Group (July 2014), Steering Committee (August 2014), and Core Team (August 2014), and was approved with a budget of $300,000. The Integrated Communities Care Management Learning Collaborative planning group amended an existing DVHA RFP in August 2014 to hire two quality improvement facilitators to support pilot communities. A contract with one facilitator, Nancy Abernathy, was executed in December 2014; a contract for a second facilitator is still in process in early 2015.

8. *Establish Learning Collaboratives for Providers Engaged in Each of the Testing Models:* As noted above, Vermont's three ACOs are working with representatives from the Blueprint for Health and Medicaid's Vermont Chronic Care Initiative to determine how best to collaborate and provide integrated care management for at-risk patients. A planning group comprised of representatives from all three ACOs, the Blueprint for Health, VCCI, DVHA, the GMCB, AHS central office, the state's Support and Services at Home (SASH) program, and others worked closely to identify three prospective pilot communities – Burlington, Rutland, and St. Johnsbury –in late spring 2014 based on strong ACO and Blueprint for Health leadership. This group reviewed data (statewide, and from the three pilot communities) to identify at-risk conditions and populations.

This working group presented a conceptual outline of a proposed learning collaborative to the Care Models and Care Management Work Group at its March 2014 meeting, and presented a proposal for funding at the Work Group's July 2014 meeting. The proposal for funding was approved by the Steering Committee and Core Team in August 2014. The learning collaborative convenes clusters of health care and community and social service providers (e.g., mental health, home health, primary care, specialty care, hospital, area agencies on aging, housing organizations) to share data, identify and implement best practices, and identify improvement opportunities. The collaborative is using the Plan-Do-Study-Act (PDSA) model of quality improvement to test and refine interventions.

Two kick-off webinars were conducted in November 2014 to orient participants to the goals, benefits, expectations, and timeline of the learning collaborative, and to answer any outstanding questions from community members. The first in-person learning session was held in January 2015 with faculty from the Camden Coalition of Healthcare Providers and a Vermont pediatric practice; more than 90 people attended. The second in-person learning session was held in March 2015 with faculty from a high-performing Michigan health system's complex care management program, and from a Vermont FQHC. More than 70 people attended that session. With the help of contracted quality improvement facilitation resources, community teams meet between learning sessions to develop and implement interventions geared toward improving integration of care management services.

9. *Develop Technical Assistance Program for Providers Implementing Payment Reforms*: Vermont's SIM project launched a Sub-Grant Program in April 2014 with a first round of sub-grant awards to 8 organizations.[2] The Sub-Grant Program was submitted to CMMI in December 2013 with the technical assistance program as a key feature. Vermont's SIM project selected five technical assistance vendors to perform this work; contracts were executed throughout 2014 as individual sub-grantees identified their needs. The technical assistance contractors will work with the State and sub-grant program awardees to define projects that maximize the success of the sub-grantee.

   In June 2014, the Care Models and Care Management Work Group provided guidance to the Core Team to inform decision-making in the next round of the sub-grant program. The Work Group requested that the Core Team consider the following two priorities during the second round of the sub-grant program:

   - In order to better serve all Vermonters (especially those with complex physical and/or mental health needs), applications should aim to reduce fragmentation with better coordination of provider/CHT/health plan and other care management activities. Focus on improving transitions of care and

[2] Since these awards were made in April 2014, one recipient organization decided not to accept the award.

communications between providers and care managers that offer services throughout the various domains of a person's life.

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

A second round of sub-grantees was selected in October 2014; seven sub-grants were awarded, for a total of 14 awards in the program, totaling $4.9M. There were two awards in the second round that went to organizations who had also received awards in the first round, for a total of 12 individual awardee organizations.

The number of providers participating in the sub-grant program is approximately 2,522, although the participation of several hospitals across the state likely makes the actual number of individual practitioners much higher.

10. *Number of Providers Participating in One or More Testing Models (Goal = 2000):* As of December 31, 2014, there are 926 attributing providers (primary care) and approximately 8,146 non-attributing providers (all other providers) participating in the Medicaid Shared Savings Program's participating ACOs (OneCare Vermont and Community Health Accountable Care).

11. *Number of Blueprint Practice Providers Participating in One or More Testing Models (Goal = 500):* Through December 2014, 670 unique providers in 124 PCMH practices are electronically sharing care summaries with other providers, in the form of ambulatory CCDs directed to the Blueprint Repository where they can be accessed. These practices and providers cover 515,619 people representing 80% of Vermont's population.

Technology and Infrastructure:

1. *Provide Input to Update of State HIT Plan*: Vermont's SIM project is recognizing the primacy of information in the health care reform equation and will be calling its next plan the Vermont Health Information Strategic Plan (VHISP). The State HIT Plan will be included as a component of the VHISP. Work on the VHISP kicked off with initial input from the SIM HIE Work Group in June 2014. DVHA released an RFP for contractor support and selected a vendor in December 2014.

2. *Expand Provider Connection to HIE Infrastructure:* Significant progress occurred in 2014 with provider connection to the HIE infrastructure. Ninety-three percent of Vermont hospitals have live interfaces for: ADT (admission/discharge/transfer); laboratory results; radiology reports; transcribed reports; medication history; and pathology reports. Primary care and specialty practices have 342 interfaces to the HIE for some combination of: ADT (admission/discharge/transfer); clinical summaries, laboratory results; radiology reports; transcribed reports; medication history; pathology reports,

and immunizations as well. There are a total of 478 interfaces to non-hospital health care organizations, including practices, FQHCs, Home Health, and long term care facilities. For Home Health Agencies: 5 (50%) home health agencies have ADT (admission/discharge/transfer) interfaces. For Mental Health Designated Agencies: 4 of designated agencies are receiving lab results.

3. *Identify Necessary Enhancements to Centralized Clinical Registry & Reporting Systems*: Vermont's SIM Project and Vermont's Blueprint for Health are currently reviewing options for how best to continue to provide registry and reporting analytic service.

4. *Procure Contractor to Develop Initial Use Cases for the Integrated Platform and Reporting System*: Vermont's SIM Project is currently working on use case identification and development. This work has continued into Test Year 2 due the complexity of the proposed solutions and diverse stakeholder input. A solution should be identified by July 2015.

5. *Design the Technical Use Cases and Determine the Component of the Integrated Platform Required to Implement Use Cases*: Vermont's SIM Project is currently working on use case identification and development. This work has continued into Test Year 2 due the complexity of the proposed solutions and diverse stakeholder input. A solution should be identified by July 2015.

6. *Develop Criteria for Telemedicine Sub-Grants*: Vermont's SIM Project has engaged a contractor to develop a statewide telehealth and telemedicine strategy; make recommendations on technologies that could be used when implementing the strategy; and develop an RFP for pilot projects found to be appropriate for deployment of the strategy. Contract negotiations took place in December 2014 and January 2015 with a proposed start date of February 1, 2015.

7. *Expand the Scope of VHCURES to Support the Integration of Both Claims and Clinical Data and Provide This Capability to ACOs/Providers and Potentially Payers*: The GMCB released an RFP on May 28, 2014 to procure a vendor to improve the state's multi-payer claims database, the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). The RFP sought a vendor to provide:

    - Design and deploy a Secure MPI to enable de- identified analysis of claims data integrated with clinical data to determine long term results based measures
    - Development of data transmission, data storage and data warehousing. Data warehousing must be optimized for analytic solutions
    - Secure cloud based hosting services for data warehousing providing availability to all qualified members of user community.
    - Cloud-enabled analytic platform and reporting solutions that interface with the data warehouse while meeting all applicable security requirements i.e. HIPAA, NIST 800-53, IRS 1075 and GMCB Data Governance Standards.

This RFP was pulled back late in 2014 and the GMCB entered negotiations to extend the current VHCURES contract with OnPoint Health Analytics.

8. *Begin to Incorporate Long-Term Care, Mental Health, Home Care, and Specialist Providers into the HIE Infrastructure*: The State of Vermont has a contract with VITL, the state's HIE contractor, to begin to incorporate these providers into the HIE infrastructure. Some SIM funds were used for this purpose in Test Year 1 and will continue into Test Year 2.

   The HIT/HIE Work Group has made some recommendations regarding incorporating these providers into the HIE infrastructure. The work group recommended for approval a significant proposal for investment in expansion of connectivity of disability, mental health and long term services and supports providers, approved by the Steering Committee and Core Team in April 2014. This project is now known as Advancing Care Through Technology (ACTT). There are three major scopes of work:

   - Project 1: Data gathering, data quality & remediation for Designated Agencies (DAs) and Specialized Service Agencies (SSAs). This project has three parts: the Vermont Care Network (VCN) Data Quality project; the VCN Data Repository project; and the SSA EHR project.
     - Vermont Care Network (VCN) Data Quality project: This project focuses on improving data quality at Vermont's DAs and SSAs in partnership with VITL. During Test Year 1, an advisory team was established, and an initial data dictionary completed; data quality tools are in development. BAAs, QSOAs, and MOUs are being signed with DAs and SSAs.
     - VCN Data Repository project: This project will create a single location for DA and SSA data; decrease the number of interfaces agencies must interact with; provide analytics for the DA/SSA system of care for service quality improvement and population health improvement; and allow for 42 CFR Part 2-compliant data collection. During Test Year 1, business requirements for the data repository were defined; an RFP will be released in early 2015.
     - SSA EHR project: This project will create a unified EHR for SSAs. During Test Year 1, two finalist EHR products were selected, and an interoperability review conducted.
   - Project 2: Planning for Long Term Services and Supports Data Reporting and Provider IT Gap Analyses. This project has two parts: DLTSS Data Planning; and DLTSS Provider Gap Analysis. This project seeks to assess the HIE/HIT capabilities of DLTSS providers and create a preliminary budget to acquire technology needed to allow DLTSS providers to participate in health information exchange and report clinical quality measures. During Test Year 1, data was gathered from DLTSS providers and a scan of national efforts, EHR vendors, and standards performed.

- Project 3: Universal Transfer Protocol Planning. This project seeks to build a Universal Transfer Protocol (UTP) to support care transitions. During Test Year 1, contractors made significant progress on Phase I of this project, gathering information from providers and others and developing transitions of care use cases; they also worked to develop a charter for Phase II of this project (UTP Design), which will kick off in Year 2.

Year 1: Summary of Implementation Challenges

The State of Vermont has encountered challenges in a number of areas during Test Year 1, including: stakeholder "reform fatigue"; balancing quick decision-making and stakeholder inclusion; procurement and contracting processes; specific state and federal policy issues; slow evaluation start-up; and staff recruitment and turnover.

- *Stakeholder "Reform Fatigue."* Engaging health care and community service providers in collaborative initiatives requires persistence, particularly in an environment that is fostering significant health care reform. Partners recognize the importance of transformation, but are concerned about its impact on them and on the amount of additional resources required to be fully engaged. Continuous effort by Vermont SIM staff and other leadership team members is required to keep stakeholders, including payers, ACOs, individual providers, and other groups working together toward a common goal.

- *Balancing Quick Decision-Making and Stakeholder Inclusion.* There is tension between making quick decisions regarding SIM investments to reap the benefits within the grant period and allowing for sufficient time to attain adequate stakeholder input. VHCIP's governance structure emphasizes robust stakeholder engagement and public-private partnership. This process is extremely valuable, allowing opportunities for members of the public to weigh-in on and contribute to the project's direction and ensuring broad buy-in. However, robust stakeholder engagement can slow decision-making and prevent the project from being nimble in response to external events and policy developments.

- *State and Federal Procurement and Contracting Processes.* Lengthy State of Vermont procurement processes and CMMI contracting approval processes have prevented project leadership from implementing funding decisions as rapidly as desired to respond to project needs, and have prevented vendors from starting work. This has slowed our overall project timeline. The Project Director, the State's business office, and CMMI have worked together to streamline contract approval processes where possible while maintaining accountability.

- *State Budget Challenges.* Vermont is facing a significant state budget shortfall. This has caused the State to scale back some of our plans under SIM, including eliminating the incentive payment component of the Episode of Care payment model (as described in

our Q3 2014 Quarterly Progress Report) and limiting implementation of P4P payment models to the existing Blueprint for Health performance payments.

- *Data Challenges*. The ACO SSP has encountered difficulties in collecting and verifying the claims-based performance measures necessary to score ACO quality performance in 2014. These include measures that are "reporting only" and others that could affect earned shared savings distributions. Difficulties include the accurate transmission of claims from payers to the analytics contractor (a particular challenge for the Commercial payer), ensuring that the measures reports were done in accordance with the ACO SSP Standards, and arriving at appropriate numerators and denominators for the calculation. These issues are being addressed in Year 2 in advance of final calculation of the savings and performance measures.

- *Federal Policy Challenges.* Vermont has grappled with Federal rules and regulations governing health data sharing, specifically 42 CFR Part 2. Part 2 prohibits sharing of all data related to substance abuse without express written consent or without meeting one of three very specific exceptions to that prohibition. This is impacting data sharing within ACO networks, within the HIE, and between payers and providers. Vermont is working internally and with relevant stakeholders, to come up with a solution for managing these data in the future through a new, solution.

- *Slow Evaluation Startup:* Contracting challenges have resulted in delayed self-evaluation activities. After contract negotiations with Vermont's original selected self-evaluation vendor fell through, the state selected a new vendor and a contract was executed. This slowed work on the state's Self-Evaluation Plan.

- *Staff Recruitment and Turnover:* Recruiting qualified staff has presented a challenge since the start of Vermont's SIM grant, particularly during the first half of Test Year 1. The State has continued to put resources into staff recruitment and retention.

Year 1: Self-Evaluation Findings

During Test Year 1, Vermont's SIM Project contracted with a vendor to perform the state's self-evaluation; and launched self-evaluation activities.

With support from its contractor, the state began drafting its self-evaluation plan (completion is anticipated in the first quarter of 2015). The plan will include a complementary array of qualitative and quantitative analyses with the goals of: determining whether Vermont SIM is on track to achieve its intended outcomes; informing in a timely and in-depth fashion the development and targeting of continuous quality improvement activities; understanding downstream impacts; and making recommendations regarding the future diffusion of VHCIP initiatives. The evaluation team is working to:

- Develop a logic model to guide the operationalization of the evaluation plan;
- Refine research questions that will frame measure development;
- Develop a flexible strategy for collecting and reporting timely, in-depth qualitative and survey data; and
- Develop a strategy for gathering credible evidence regarding the impacts of VHCIP in the absence of a Vermont-based comparison group.

The current draft evaluation plan calls for the completion of the following:

1. Assessment of state-led implementation planning and stakeholder engagement activities;
2. Development of metrics to monitor implementation effectiveness;
3. Collection and analysis of qualitative data documenting the experiences and perceptions of frontline providers involved in VHCIP implementation and operation;
4. Collection and analysis of primary survey data documenting provider perceptions of Vermont SIM impacts and unintended consequences;
5. Use of secondary administrative (the Vermont Health Care Uniform Reporting and Evaluation System, or VHCURES) and survey data (e.g., the Behavioral Risk Factor Surveillance System, or BRFSS) to monitor trends in health care expenditures, care processes and population health on a state-wide basis and for subgroups based on demographic and clinical characteristics; and
6. Time series analysis informing the impact of VHCIP on health care expenditures, care processes, and population health.

Vermont SIM Work Group Survey Results Summary

The Vermont SIM Work Group Survey is a brief anonymous quality improvement survey that was given to all stakeholder work group participants over the period from July 2014 to March 2015. The survey asked stakeholders to rate various aspects of work group operations, provided a few brief questions designed take a crude point-in-time measure of stakeholder satisfaction with Vermont SIM, and allowed for open-ended textual comments. Results were used to tailor and fine-tune work group operations to better meet stakeholder needs, provide a point-in-time snapshot of stakeholder general perceptions of VHCIP and allow for generation of a set of themes culled from open-ended textual comments.

A total of 109 survey responses were received from participants in the project's seven work groups. The following provides a brief summary of work group operations quality improvement results, indicates respondents' levels of agreement with broad statements about Vermont SIM, and briefly lists themes that emerged across seventy-seven open-ended textual comments.

Work Group Quality Improvement Results

Table 2 displays ratings for each of the four work group operational areas assessed.

TABLE 2: Vermont SIM Work Group Survey Results: Work Group Operational Areas

	1-Poor	2	3-Fair	4	5-Excellent	N=
Balance between member and co-chairs/staff participation	0.94% (1)	6.60% (7)	20.75% (22)	43.40% (46)	28.30% (30)	106
Co-chairs/staff management of diverse perspectives	2.86% (3)	8.57% (9)	17.14% (18)	42.86% (45)	28.57% (30)	105
Co-chairs/staff management of meeting motions/order	0.94% (1)	3.77% (4)	17.92% (19)	52.83% (56)	24.53% (26)	106
Communication between meetings	2.83% (3)	4.72% (5)	33.96% (36)	43.40% (46)	15.09% (16)	106

As shown, a majority (nearly two-thirds) of respondents rated all four communication areas as better than fair. Suggestions for improvement included distributing materials at least one week prior to the meeting; this was instituted by Vermont SIM shortly after the first survey administration. Some respondents wanted more information shared between meetings and expressed a willingness to work on sub-tasks or on sub-committees to move things forward.

It was suggested that work group leadership could improve by seeking input from less active members via break-out sessions and other methods to elicit diverse viewpoints.

Table 3 presents stakeholder ratings of work group materials and documents.

TABLE 3: Vermont SIM Work Group Survey Results: Work Group Materials and Documents

	1-Poor	2	3-Fair	4	5-Excellent	N=
Work Group Materials: Relevance	2.83% (3)	0.94% (1)	15.09% (16)	53.77% (57)	27.36% (29)	106
Work Group Materials: Thoroughness	0.00% (0)	1.92% (2)	13.46% (14)	58.65% (61)	25.96% (27)	104
Work Group Materials: Timeliness of distribution	2.83% (3)	5.66% (6)	29.25% (31)	42.45% (45)	19.81% (21)	106
Communication about the work group work plan	2.83% (3)	4.72% (5)	35.85% (38)	39.62% (42)	16.98% (18)	106
Communication about the work group charter	0.94% (1)	7.55% (8)	32.08% (34)	47.17% (50)	12.26% (13)	106

While generally positive, responses indicate a need for increased communication about the work group goals and objectives, workplans, and charters. Vermont's SIM team embarked on a robust workplan development process in late 2014 to address these concerns.

Stakeholder Perceptions of Vermont SIM

Survey respondents were asked to indicate their level of agreement with two broad statements, presented in Table 4.

TABLE 4: Vermont SIM Work Group Survey Results: Stakeholder Perceptions of Vermont SIM

	Strongly Disagree	Disagree	Neither Agree, nor Disagree	Agree	Strongly Agree	N=
VHCIP adequately incorporates input from stakeholders including payers, providers, advocates and individuals.	0.92% (1)	18.35% (20)	21.10% (23)	39.45% (43)	20.18% (22)	109
Vermont Health Care Innovation Project (VHCIP) is providing an effective platform for aligning policy, investments and payments to support a high-performing health system in Vermont.	1.83% (2)	11.93% (13)	26.61% (29)	46.79% (51)	12.84% (14)	109

A slight majority of stakeholders 'agree' or 'strongly agree' that Vermont SIM adequately incorporates stakeholder input and is providing an effective platform for aligning policy, investments and payments to support a high-performing health system.

Respondents from each work group were then asked to indicate their level of agreement that Vermont SIM was adequately supporting the specific content area of their work group. Two

Open-Ended Comment Themes

- *Vermont SIM is large and complex.* Politics, diverse interests, and complex administrative, structural, and financial issues all converge to create a multi-dimensional, ever-shifting landscape. Further, the project funds a rather diverse set of innovations statewide. This complexity creates some necessary tension as invested and interested parties publically voice diverse perspectives which are sometimes at odds. Project leadership has to skillfully negotiate giving voice to diverse interests and moving steadily forward on project goals. Some key ways VHCIP leadership has managed this is through allowing ample work group time for work group discussion, public verbal/written comments and a highly structured voting process.

- *Vermont SIM staff is committed and hardworking, and the work of the grant is important.* Several survey respondents commented on the hard working and committed State staff and work group Co-chairs. Others describe the capacity-building that is occurring as "essential" to progress in Vermont.

- *The acute care system and provider agendas dominate in Vermont SIM.* Several stakeholders stated that Vermont SIM focuses primarily on the well-being of institutions and acute care medical providers rather than consumers. Several comments expressed the belief that there is not enough patient input into the process. There were several comments about the dominance of traditional medical services over the services that influence the social determinates of health as well. Commenters from the DLTSS and Population Health Work Groups noted that there should be more integration and collaboration in 2015 that reflects these groups' representation. Another sentiment

came from a number of respondents that expressed frustration that frontline providers most impacted by the changes do not have adequate say. Vermont SIM staff and work group co-chairs must carefully manage necessary balance required to support the triple aim for all Vermonters.

- *Integrate and build on existing infrastructure.* Vermont SIM's stakeholders feel it is important that existing infrastructure is built upon rather than "reinventing the wheel." The way this is occurring is through sharing of information in the work groups, cross-agency communication, care integration activities, and other multi-agency initiatives and projects.

Appendix A

MEDICARE SHARED SAVINGS PROGRAM (MSSP)								
ACO Name	**Start Date in Program**	**Geographic Area**	**ACO Network Participants[i,ii] (Providers with attributed lives)**	**ACO Network Affiliates[i] (Providers without attributed lives)**	**ACO Shared Savings Distribution with Provider Network[iii]**	**Estimated Medicare Attributed Lives**		
						# and % of Total VT Medicare Enrollees (Total N=126,081)[iv]	# and % of VT MSSP Eligible Enrollees (Total N=117,015)[v]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Health*first* - Accountable Care Coalition of the Green Mountains (ACCGM)	July 1, 2012	Approved Statewide; current network available in Greater Burlington and North Central Vermont	• 30 Physicians - 10 Primary Care Practices	Committee working on Collaborative Care Agreements (CCAs) with practitioners, including: • Specialists • Other specific entities (e.g., Visiting Nurses Association)	• 50% of shared saving distributed to Health*first* **Network Participants and CCA Practitioners** ○ Collaborative Care Agreements (CCAs) will specify responsibilities of CCA Practitioners in order to share in these savings, including patient and network engagement • 50% of shared savings to Collaborative Health Systems[vi]	7,509 6%	7,509 6%	583 3%
OneCare Vermont (OCV)	Jan 1, 2013	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All other VT hospitals • Brattleboro Retreat • 3 Federally Qualified Health Centers (FQHCs) • 4 Rural Health Centers • 400+ Primary Care Physician FTEs (VT & NH) • 2000+ Specialty Care Physicians (VT & NH)	• 29of 40 Skilled Nursing Facilities • 11 VNA/ Home Health • All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, no DS-only DA, no Children's MH Specialized Service Agency (SSA), and no DS SSAs	• 90% of shared savings distributed to OCV **Network Participants**; 10% retained by OCV • Separate Incentive Plan Provision for OCV Network **Affiliates** • Both depend on reporting and performance metrics	53,873[vii] 43%	53,873 46%	12,955 = 7,509 QMB only and QMB/Medicaid coverage +5,446 Other Dual Eligible Status 60%
Community Health Accountable Care (CHAC)	Jan 1, 2014	12 of 14 Counties (Addison, Chittenden, Grand Isle, Franklin, Orleans, Caledonia, Essex, Orange, Rutland, Washington, Windham, Windsor)	• 5 FQHCs and Bi-State Primary Care Association - 24 FQHC practice sites (includes dental and school based sites) - 97 Primary Care Providers	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 15 Community Designated Agencies • 5 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	5,980 5%	5,980 5%	unknown

Appendix A

TOTALS			~427 Primary Care Providers **~ 67% of 634 Primary Care Providers statewide**[viii]			68,225 **54% of all VT Medicare enrollees**	68,225 **58% of all VT MSSP Eligible enrollees**	At least 13,649 **At least 63% of all VT Duals**

Appendix A

VERMONT MEDICAID SHARED SAVINGS PROGRAM (VMSSP)								
ACO Name	**Start Date in Program**	**Geographic Area**	**ACO Network Participants[ix,x] (Providers with attributed lives)**	**ACO Network Affiliates[ix] (Providers without attributed lives)**	**ACO Shared Savings Distribution with Provider Network[xi]**	**Estimated Medicaid Attributed Lives**		
						# and % of Total VT Medicaid Enrollees (Total N= 153,315)[xii]	# and % of VT VMSSP Eligible Enrollees (Total N=95,000)[xiii]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
ACCGM/VCP		Statewide	• 31 Primary Care Physicians • 10 practice sites	0	NA	NA	NA	NA
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All but 2 other VT hospitals • Brattleboro Retreat • 2 Federally Qualified Health Centers (FQHCs) • 3 Naturopathic Centers • 650+ Attributing Physician FTEs • 29 Different Organizations • RN: 33; PA: 30; NP: 30; DO: 2; Primary: 227; Peds: 161; General: 2; Womens: 14; Internal: 142; Naturopathic: 8; Other: 2	• 11 of 15 developmental disability services providers8 Home Health and Hospice Agency • All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, the 1 DS-only DA, the 1 Children's MH Specialized Service Agency (SSA), and all 4 DS SSAs • RN: 129; Allergy/ Asthma: 7; Pathology: 72; ANES: 197; AUD: 16; Cardio: 127; DIAB: 4; Geriatric: 3; NUT: 27; Mental: 359; Pharm: 2; Social Work/ Counseling: 73; Women/ Children: 191; EMER: 241; Dental/ Oral: 14; Radiology: 146; DO: 5; ENDO: 31; Neuro: 71; Therapy: 88; Ortho: 124; PA: 61; NP: 17; Primary: 37; General: 167; Internal: 77; Other: 504	• 90% of shared savings distributed to OCV **Network Participants and Affiliates**; 10% retained by OCV • Provider amount depends on reporting and performance metrics	27,641 18%	27,641 29%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	14 of 14 Counties (with sites in or significant service to all counties except Bennington)	• 8 FQHCs and Bi-State Primary Care Association • 40 FQHC practice sites • 227 Primary Care Providers • EMER: 2; Family: 137; NP:24; Internal: 24; OB/ GYN: 2; PA: 19; PEDS: 19	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 8 of 9 State Designated Agencies • 5 hospitals (2 of these are under umbrella of FQHC) • RN: 8; Behavioral: 12;ANES: 7; AUD: 16; Cardio: 11; NUT: 4; Mental: 210; MA: 7; Social Work/ Counseling: 182; Women/ Children: 29; EMER: 57; Dental/ Oral: 21; Therapy: 11; Ortho: 25; PA: 18; NP: 22; Primary: 8; General: 14; Internal: 39; Other: 43	Distribution methodology to be determined.	19,682 13%	19,682 21%	0
TOTALS			900+ Attributing Providers			47,323 **30.9% of all current VT Medicaid enrollees**	47,323 **49.8% of all VMSSP Eligible enrollees**	0 **0% of all VT Dual Eligibles**

Appendix A

Appendix A

COMMERCIAL SHARED SAVINGS PROGRAM (XSSP) – Blue Cross Blue Shield of Vermont (BCBS-VT)								
ACO Name	**Start Date in Program**	**Geographic Area**	**ACO Network Participants[xiv] (Providers with attributed lives)**	**ACO Network Affiliates[xv] (Providers without attributed lives)**	**ACO Shared Savings Distribution with Provider Network[xv]**	**Estimated Commercial Plan Attributed Lives**		
						# and % of Total VT Commercial Plan Enrollees (Total N=155,479)[xvi]	# and % of VT XSSP Eligible Enrollees (Total N=70,000)[xvii]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Health*first* - - Vermont Collaborative Physicians (VCP)	Jan 1, 2014	Statewide	• 69 Physicians - 24 Primary Care Practices	Committee working on Collaborative Care Agreements (CCAs) with practitioners, including: • Specialists • Other specific entities (e.g., Visiting Nurses Association)	• **PCP's** to retain the majority of shared savings • VCP to retain a portion for administration and reserves • Collaborative Care Agreements (CCAs) will specify responsibilities of **CCA Practitioners** in order to share in these savings, including patient and network engagement	7,830 (BCBS only) 5%	7,830 (BCBS only) 11%	0
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • 10 Vermont Hospitals and 1 NH Hospital (Cheshire) • Brattleboro Retreat • 1 Federally Qualified Health Center (FQHC) • 3 Rural Health Clinics • 300+ Primary Care Physician FTEs (VT & NH Physicians) • 1,900+ Specialty Care Physicians (VT & NH Physicians)	• 19 Skilled Nursing Facilities • 10 VNA/Home Health • 11 Designated Agencies (DA)s	• 90% of shared savings distributed to OCV **Network Participants**; 10% retained by OCV • Separate Incentive Plan Provision for OCV **Network Affiliates** • Both depend on reporting and performance metrics	20,422 (BCBS Only) 13%	20,422 (BCBS Only) 29%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	13 of 14 Counties (with sites in or significant service to all counties except Lamoille)	• 9 Federally Qualified Health Centers (FQHCs) and Bi-State Primary Care Association - 45 FQHC practice sites - 218 Primary Care Providers	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 8 of 9 Comprehensive MH/DS DAs, the 1 MH-only DA, no DS-only DA, the 1 Children's MH SSA, and no DS SSAs • 5 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	8,900(BCBS Only) 5.7%	8,900 (BCBS Only) 12.7%	0
TOTALS			~587 Primary Care Providers **~ 93% of 634 Primary care Providers statewide[xviii]**			38,185 **25% of all VT Commercial Plan**	38,185 **55%of all VT XSSP Eligible**	0 **0% of all VT Dual Eligibles**

Appendix A

						enrollees	**enrollees**	

[i] Current Network Participants and Network Affiliates as of April, 2014; may change over time

[ii] ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicare performance and savings; Outcomes for each "life" can only relate to a single ACO.

[iii] Under the Medicare SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicare savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics

[iv] Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Downloads/2014/Mar/State-County-Penetration-MA-2014-03.zip

[v] MSSP does not include Medicare enrollees in Medicare Advantage Plans. In March 2014, 9,036 Vermonters were enrolled in these Plans. Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Downloads/2014/Mar/State-County-Penetration-MA-2014-03.zip

[vi] Healthfirst partnered with Collaborative Health Systems (CHS), a subsidiary of Universal American Corp., to form ACCGM for the Medicare SSP. CHS has partnered with 34 Independent Practice Associations across the country to form Medicare SSP ACOs and provides care coordination, analytics and reporting, technology and other administrative services for the ACOs.

[vii] Number of attributed lives is an estimate.

[viii] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013

[ix] Current Network Participants and Network Affiliates as of April, 2014; may change over time

[x] ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicaid performance and savings; outcomes for each "life" can only relate to a single ACO.

[xi] Under the Medicaid SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicaid savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics

[xii] Based on DVHA SFY'15 Budget Document Insert 2, using SFY '14 BAA enrollment figures; excludes Pharmacy Only Programs and VHAP ESI, Catamount, ESIA, Premium Assistance For Exchange Enrollees < 300%, and Cost Sharing For Exchange Enrollees < 350% (i.e., all programs that financially assist individuals to enroll in commercial products)

[xiii] Number provided in DVHA's VMSSP RFP; the following populations are excluded from being considered as attributed lives: Individuals who are dually eligible for Medicare and Medicaid; Individuals who have third party liability coverage; Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers; and Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.

[xiv] Current Network Participants and Network Affiliates as of April, 2014; may change over time

[xv] Under the Commercial SSP, ACOs can receive up to 25% of savings achieved between the expected amount and the minimum savings rate (MSR) (which is calculated based on # of attributed lives in the ACO), and up to 60% of their savings if they exceed the MSR, with a maximum savings of 10% of their expected expenditures. Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics

[xvi] Vermont residents covered in Private Insurance Market, 2012; Source: 2011 Vermont Health Care Expenditure Analysis, Green Mountain Care Board, page 14. Only includes individuals who have a Commercial plan as their primary insurance.

[xvii] The XSSP eligible population for attribution to an ACO includes individuals who have obtained their commercial insurance coverage through products available on the VT Health Connect Exchange (obtained through the exchange website or directly from the insurer).

[xviii] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013