State Innovation Model

Year 2 Operational Plan

For Health System Innovation

Prepared by the State of Vermont

For the Centers for Medicare and Medicaid Services

November 3, 2014

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Introduction Vermont State Innovation Model Operational Plan

This document is intended to inform readers, including reviewers from the federal Centers for Medicare and Medicaid Services (CMS), of Vermont's plans to utilize State Innovation Model (SIM) grant funds to support improvements in the state's health care system. In April 2013 Vermont was awarded a four-year, $45 million grant under the SIM program. To activate the state's grant, we were required to produce an acceptable operational plan for our SIM project (since named the Vermont Health Care Innovation Project, or VHCIP). We submitted that operational plan in July 2013 and received approval of the plan from CMS in September, triggering the launch of the VHCIP on October 1, 2013. This document is an updated version of our operational plan, which is required annually by CMS.

Our original operational plan described *how* Vermont would manage the VHCIP, and how high-level support from the executive and legislative branches, as well as from major stakeholders, will be assured. It also described *what* Vermont would manage through this project—expansion and integration of care models, payment models and health information technology, on a statewide and multi-payer basis, to support a high performing health system. That information is updated in this version of the plan. We also have updated the original operational plan to reflect both accomplishments in the first year of the project as well as necessary mid-course corrections in project plans to date, based on the operational realities we have encountered in the first project year.

In our initial operational plan, we indicated that grant funds would be used to accomplish three major project aims:

- Improve care;
- Improve population health; and
- Reduce health care costs.

Our specific goals for the project were described as:

- To increase the level of accountability for cost and quality outcomes among provider organizations;
- To create a health information network that supports the best possible care management and assessment of cost and quality outcomes, and informs opportunities to improve care;

- To establish payment methodologies across all payers that encourage the best cost and quality outcomes;
- To ensure accountability for outcomes from both the public and private sectors; and
- To create commitment to change and synergy between public and private culture, policies and behavior.

The above aims and goals remain the central focus of the project. In the first year of the project, our focus has been on implementing and/or evaluating the three "testing models" for innovative provider payment proposed in our original grant application: shared savings models for accountable care organizations (ACOs); episode of care payments; and pay-for-performance for selected providers. In addition, much of our effort in the first project year has been aimed at creating coherent and functional statewide structures for exchanging health information and care management. We have made progress on each of these fronts, have realized each is more challenging than anticipated, and have realized that coordination across payers, across provider organizations, and across the state's geography is even more critically important than we assumed at the outset of the project. Our revisions to our operational plan reflect these realizations and realities. These revisions provide a pragmatic roadmap for continued progress toward our project goals.

We were afforded the opportunity during year one to extend the timeline for the VHCIP. Due to front-end delays in both funding approval and hiring at the state level, we elected to avail ourselves of this opportunity, which means the project timeline was extended to December 31, 2016 and there are 25 months remaining in the project period.

Sections C through T of this plan respond to specific questions posed by CMS regarding operational aspects of the VHCIP. The reader will notice that sections are not necessarily in alphabetical order, as CMS allowed us to rearrange the sections in this update to form a more logical narrative. In its entirety, this version of the Operational Plan is intended to provide a description of how Vermont is approaching the VHCIP, our progress to date, and our plans for the remaining 25 months of the project.

Executive Summary

The Vermont Health Care Innovation Project (VHCIP) has three major aims:

- Improve care;
- Improve population health; and
- Reduce health care costs.

Our specific goals for the project are:

- To increase the level of accountability for cost and quality outcomes among provider organizations;
- To create a health information network that supports the best possible care management and assessment of cost and quality outcomes, and informs opportunities to improve care;
- To establish payment methodologies across all payers that encourage the best cost and quality outcomes;
- To ensure accountability for outcomes from both the public and private sectors; and
- To create commitment to change and synergy between public and private cultures, policies and behaviors.

To address the project aims and goals described above, the VHCIP has three main focus areas:

- Payment models—implementing provider payments that move away from straight fee-for-service and incorporate value measurement;
- Care models—creating a more integrated system of care management and care coordination for Vermonters; and
- Health information technology/Health information exchange (HIT/HIE)—building an interoperable system that allows for sharing of health information to support optimal care delivery and population health management.

Vermont's year one project activities included establishing project governance and operations, hiring project staff, and developing structures and processes for stakeholder engagement.

In addition, we made much progress in year one in each of the three project focus areas. Most notably: we launched shared savings programs for accountable care organizations (ACO SSPs) through commercial insurers and our Medicaid program; we began efforts to develop a

common care management infrastructure across ACOs, all payers, and our network of advanced primary care medical homes and community health teams (known collectively as the Blueprint for Health); and we ramped up the build-out of interfaces between providers and our health information exchange (HIE), and between our HIE and key care management and data analytics hubs.

We believe it is unique to Vermont that the vast majority of our health care providers—as well as many of our long-term services and supports providers—are involved in the shared savings programs as participants in ACOs. Accordingly, and due to the state's small size and its pre-existing health care provider and health information infrastructure, we have approached VHCIP activities with an eye toward creating statewide, shared resources that provide benefits to all Vermonters and all Vermont health care providers, regardless of their attribution to or participation in a particular organization.

Year one project activities are summarized in the table below. The table also summarizes plans in each focus area for project year two. Section P includes a more detailed description of both progress to date and plans for year two.

VHCIP funding specifically has supported multi-payer ACO SSP implementation, as well as initial learning collaboratives, and initial development of coordinated performance reporting and data analytics. Year one included significant investments in building capacity within each of Vermont's three ACOs to support quality improvement, data analyses and care redesign activities. We made additional investments in provider innovation through Vermont's sub-grant program for provider innovation. This program awarded $4,903,145 to 14 provider entities for projects that are consistent with the VHCIP project aims.

In addition, significant VHCIP health information system investments improved interoperability of health data throughout the state and expanded the reach of the health information exchange to providers of mental health services and long-term services and supports.

Table 1. Project Activities

	Year One Proposed	Year One Progress	Year Two Proposed
Payment Model Activities	• Launch commercial and Medicaid Shared Savings programs; • Examine options for, and explore financing of, incentive programs and/or bundled payment arrangements based on episodes of care (EOCs); • Examine options for, and explore financing of, incentive programs and/or pay-for-performance programs.	• Launched commercial Shared Savings ACO Program; • Launched Medicaid Shared Savings ACO Program; • Performed data analysis for Episode of Care Program; • Performed data analyses for pay-for-performance programs. • Development quality and financial measures for the shared savings programs.	• Implementation of year two Commercial and Medicaid Shared Savings ACO Programs; • Implement Episode of Care Program; • Evaluate clinical and financial measures, provide reports to providers and payers on these measures; • Pursue all-payer waiver.
Care Model Activities	• Build framework for providers to unite under accountable care relationships. • Develop priority clinical and financial measurement targets. • Create provider-grant program to incent investment in building coalitions and infrastructure for care delivery transformation.	• Analyzed existing care management activities; • Designed Learning Collaboratives to address at-risk Vermonters; • Awarded 14 sub-grants to innovative providers, including community initiatives & LTSS providers, around the State of Vermont; began alignment of Blueprint for Health and ACO care management activities.	• Launch three learning collaboratives in Rutland, St. Johnsbury, and Burlington; • Continue sub-grant program; • Align Blueprint for Health and ACO care management activities.

HIE/HIT Activities	• Expand connectivity of providers to the Health Information Exchange; • Design health IT solutions to support the payment models being implemented; • Pilot a telemedicine program; • Integrate claims and clinical data to support new payment models.	• Invested in an event notification system to support transitions of care; • Connect ACO analytics vendors to Vermont's Health Information Exchange; • 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; • Design a Uniform Transfer Protocol to support transitions of care.	• Continue implementation of solutions begun in year one; • Develop and implement a data gap remediation plan; • Develop and begin to implement a data integration solution; • Update the state's HIT Plan; • Develop a telehealth plan and launch a telehealth pilot program.

Vermont's SIM project also engaged in cross-cutting activities that support the three main areas discussed above. For example, an intense staff and stakeholder effort developed quality and performance measures for the shared savings programs, culminating in approval through the project governance structure. These efforts will guide the choice of priorities for care management activities through the statewide infrastructure, as well as data-gathering through health information systems. Additional work through project work groups will guide the design of payment models and care models and health information exchange development. Project work groups will also ensure that those in need of long term services and supports are appropriately integrated in and benefitting from our system improvements and we undergo appropriate population health and workforce measurement and planning. These activities are described in more detail in sections M, I, D, and E below, and will continue in project year two.

Year two focus

In project year two we will continue the implementation and evolution of the shared savings programs for ACOs. In particular, year two activities will include implementation of additional performance measures for these programs, and expansion of the definition of total costs of care for the Medicaid shared savings program.

We also will continue to work through the project governance structure to evaluate the potential use of the other two payment models originally proposed for this project – episodes of care and pay-for-performance. Our analysis to date suggests there may still be some added value from implementation of these models, on top of the shared savings programs, but the necessary work to implement them and the potential return-on-investment are not yet clear. During year two we will make a judgment about whether the EOC and P4P efforts are worth pursuing, in light of our assessments and developments in the environment.

In addition, in year two we will begin analysis and planning for an all-payer payment system in Vermont, supported in part by VHCIP funds and activities. In the past year, Vermont accelerated its efforts to plan for conversion to a statewide, unified provider payment system under the oversight of the Green Mountain Care Board (GMCB). The Governor has proposed that an all-payer payment model underpin any reformed health care system in Vermont, and the GMCB has the authority to implement such a system, subject to federal approval. Our goal will be to develop an all-payer design that evolves provider payment beyond shared savings to population-based payments that provide stronger incentives for providers and all Vermonters to improve health, manage illness optimally, improve patient experience and better coordinate across the entire spectrum of providers and services.

As described more fully in section P, two additional key areas of focus in year two will be creating a unified system of care management across the state and a unified approach to provider performance reporting and data analyses. These two areas span care management and HIT/HIE. Year two will begin a transition from multiple, often overlapping and duplicative, clinical leadership and support teams to regional unified systems of clinical and social supports providers.

Year two will also include additional expansions of HIT/HIE capacity. Specifically, we will build on year one investments and monitor progress of our contractors and sub-grantees to ensure that year one under-takings are proceeding apace, including:

- Build-out of HIE interfaces;
- Expansion of HIT and HIE interfaces to mental health and long-term services and supports providers; and

- Construction of gateways for ACO and other analytics.

We also will continue strategic planning around health information data collection, storage, and interoperability.

Key implementation activities in year two include:

- Develop a unified system of care management;
- Develop unified performance reporting and data analyses;
- Design Population-based payments for ACOs;
- Design alternative payment models for non-ACO providers; and
- Plan and implement HIT/HIE data integration.

Section P	Implementation Timeline for Achieving Participation and Metrics

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

Question 37. Has the state developed a project plan for completing Model Testing and implementing the proposed innovation model that is actionable by the project team (with assignments of responsibility) and provides detailed project tracking and reporting by the project oversight entity and CMS.

Vermont's Innovation Testing Model

Overview of Current and Future Status of Innovation Testing Models

In Vermont's original SIM application and our original operational plan, we theorized that the three types of payment incentives, in concert, would provide strong incentives for providers to change their practices, reduce inefficiencies and shift resources toward health management and health improvement. Our three testing models are:

- Shared savings programs for Accountable Care Organizations (ACOs);
- Episode-of-care payments to groups of providers; and
- Pay-for-performance to individual providers.

In the first project year, we launched shared savings programs for accountable care organizations through commercial insurers and our Medicaid program. Under these programs, groups of providers who have formed an accountable care organization that meets state standards can assume some responsibility for the costs and quality of care for Vermonters who have been "attributed" to them. Under Vermont's programs, ACOs have agreed to collect 34 measures of quality and they will be tracked on total costs of care relative to the state's

predictions of what those costs would be in the absence of the shared savings program. Under the programs, if total costs of care for Vermonters attributed to the ACOs are less than expected, and if the ACOs meet quality requirements, they will lose less revenue than would otherwise be the case. Three ACOs have formed in Vermont. Their composition and participation in each of the SSP programs are described in Table 2 below.

Table 2: Shared Savings Program Table

MEDICARE SHARED SAVINGS PROGRAM (MSSP)								
ACO Name	**Start Date in Program**	**Geographic Area**	**ACO Network Participants[1,2] (Providers with attributed lives)**	**ACO Network Affiliates[1] (Providers without attributed lives)**	**ACO Shared Savings Distribution with Provider Network[3]**	**Estimated Medicare Attributed Lives**		
						# and % of Total VT Medicare Enrollees (Total N=126,081)[4]	# and % of VT MSSP Eligible Enrollees (Total N=117,015)[5]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Health*first* - Accountable Care Coalition of the Green Mountains (ACCGM)	Jan 1, 2013	Approved statewide; current network available in Greater Burlington and North Central Vermont	• 30 Physicians - 10 Primary Care	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 Healthfirst Network Participants and CCA Practitioners o 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[6]	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 • 4 Federally Qualified Health Centers (FQHCs) • 4 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 28 of 40 Skilled Nursing Facilities • All but one Home Health and Hospice Agency • 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	54,736[7] 41%	54,736[7] 45%	13,066[8] 61%
Community Health Accountable Care (CHAC)	Jan 1, 2014	8 of 14 Counties (Chittenden, Grand Isle, Franklin, Orleans, Caledonia, Essex, Orange, Washington)	• 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) • 8 of 9 Comprehensive MH/DS DAs, the 1 MH-only DA, no DS-only DA, the 1 Children's MH SSA, and 1 of 4 DS SSAs • 4 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	5,980 4.7%	5,980 5.1%	unknown
TOTALS			~427 Primary Care Providers ~ 67% of 634 Primary Care Providers statewide[9]			68,235 54% of all VT Medicare enrollees	68,235 58% of all VT MSSP Eligible enrollees	At least 13,649 At least 63% of all VT Duals

VERMONT MEDICAID SHARED SAVINGS PROGRAM (VMSSP)								
ACO Name	**Start Date in Program**	**Geographic Area**	**ACO Network Participants[10,11] (Providers with attributed lives)**	**ACO Network Affiliates[9] (Providers without attributed lives)**	**ACO Shared Savings Distribution with Provider Network[12]**	**Estimated Medicaid Attributed Lives**		
						# and % of Total VT Medicaid Enrollees (Total N= 153,315)[13]	# and % of VT VMSSP Eligible Enrollees (Total N=95,000)[14]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
ACCGM/VCP	NA	NA	NA	NA	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 • 0 Federally Qualified Health Centers (FQHCs) • 3 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 22 of 40 Skilled Nursing Facilities • All but one 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	• 90% of shared savings distributed to OCV **Network Participants and Affiliates**; 10% retained by OCV • Provider amount depends on reporting and performance metrics	27,400 18%	27,400 29%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	13 of 14 Counties (with sites in or significant service to all counties except Bennington)	9 FQHCs and Bi-State Primary Care Association • 49 FQHC practice sites • 233 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, the 1 DS-only DA, the 1 Children's MH SSA, and all 4 DS SSAs • 5 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	20,068 13%	20,068 21%	0
TOTALS			~533Primary Care Providers **~84% of 634 Primary Care Providers statewide[15]**			Nearly 50,000 or Approximately 31% of all current VT Medicaid enrollees	Nearly 50,000 or Approximately 50% of all VMSSP Eligible enrollees	0 **0% of all VT Dual Eligibles**

COMMERCIAL SHARED SAVINGS PROGRAM (XSSP) – Blue Cross Blue Shield of Vermont (BCBS-VT) and MVP Health Care (MVP)								
						Estimated Commercial Plan Attributed Lives		
ACO Name	**Start Date in Program**	**Geographic Area**	**ACO Network Participants[16] (Providers with attributed lives)**	**ACO Network Affiliates[15] (Providers without attributed lives)**	**ACO Shared Savings Distribution with Provider Network[17]**	# and % of Total VT Commercial Plan Enrollees (Total N=155,479)[18]	# and % of VT XSSP Eligible Enrollees (Total N=70,000)[19]	# 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) 10%	0
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All but 3 other VT hospitals • Brattleboro Retreat • 1 FQHC • 2 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 23 of 40 Skilled Nursing Facilities • All but two Home Health and Hospice Agencies • All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, no DS-only DA, the 1 Children's MH Specialized Service Agency (SSA), and 1 of 4 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	20,449 (BCBS Only) 13%	20,449 (BCBS Only) 29%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	12 of 14 Counties (with sites in or significant	8 Federally Qualified Health Centers (FQHCs) and Bi-State Primary Care Association • 45 FQHC practice sites • 218 Primary Care	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 8 of 9 Comprehensive MH/DS DAs, the 1 MH-only	Distribution methodology to be determined.	9,906 (BCBS Only) 6%	9,906 (BCBS Only) 14%	0

		service to all counties except Bennington and Lamoille)	Providers	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)				
TOTALS			~587 Primary Care Providers **~ 93% of 634 Primary care Providers statewide**[20]			38,185 **25% of all VT Commercial Plan enrollees**	38,185 **55%of all VT XSSP Eligible enrollees**	0 **0% of all VT Dual Eligibles**

Vermont's SIM grant program is now named the Vermont Health Care Innovation Project (VHCIP). VHCIP year one funding specifically has supported multi-payer ACO SSP implementation, as well as initial learning collaboratives, and initial development of coordinated performance reporting and data analytics. Year one included significant investments in building capacity within each of Vermont's three ACOs to support quality improvement, data analyses, and care redesign activities. We made additional investments in provider innovation through Vermont's sub-grant program for provider innovation. This program awarded $4,903,145 to 14 providers for projects that are consistent with the VHCIP project aims.

In addition, significant VHCIP health information system investments laid the groundwork for interoperability of clinical health data while expanding the reach of the health information exchange to providers of mental health services and long-term services and supports.

Year one activities related to our testing models, and planned activities for year two, are described in table 3 below.

Table 3. Summary of Year One and Year Two Activities

Testing Models	Year One Proposed	Year One Progress	Year Two Proposed
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 population-based arrangements. 2) Adaptation of program standards for years two and three.
Episode of Care Programs	1) Examine options for, and explore financing of, incentive programs and/or bundled payment arrangements based on episodes of care (EOCs). 2) Examine utility of using analytics	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.	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

	based on episodes of care (EOC) in regional care delivery transformation efforts.	3) Integration and expansion of using EOC analytics in care delivery transformation continues to be a priority.	support development of provider-level and regional analytics of priority EOCs.
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 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 clinical health system integrating payer, ACO and Blueprint for Health activities. 2) Progress towards a unified system of sharing clinical and financial measurement data. 3) Launch two rounds of provider grant funding. 4) Development of three-site pilot learning collaborative structure.	1) Strengthen and broaden regional unified health systems. 2) Strengthen and broaden use of clinical and financial measurement data and incentive models. 3) Launch pilot learning collaboratives. 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 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) Connect ACO analytics vendors to Vermont's Health Information Exchange; 4) Improve and standardize data quality in electronic medical records systems for the state's Designated Mental Health Agencies and Specialized Service Agencies; 5) Identify gaps in data systems in both acute and non-acute providers; 6) 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 to Date: Shared Savings Program

The commercial and Medicaid Shared Savings Programs were implemented in January 2014 as planned. Approximately 150,000 lives are attributed to the Shared Savings ACO Programs for all payers in 2014. All three ACOs are participating in the commercial Shared Saving Program and two (OneCare and Community Health Accountable Care, or CHAC) are participating in the Medicaid Shared Savings Program. Because of technical challenges with the Health Care Marketplace, the number of lives that could be attributed to the commercial payers was lower than expected. As a result, one of the commercial payers selling plans on the Marketplace, MVP, did not have enough attributed lives to participate in the Shared Savings Program. One commercial payer, Blue Cross Blue Shield (BCBS) of Vermont, is currently participating. All three ACOs are continuing to participate in the Medicare Shared Savings Program.

In July, the state engaged an analytics contractor, The Lewin Group, and data is now being exchanged between the payers, the ACOs, and the analytics contractor. A six month interim progress report on expenditures, utilization, and quality performance is expected before the end of the year.

There is limited data available for the first nine months of the Shared Savings Programs and many implementation activities are just being completed. In the early part of year two, we expect to have preliminary findings available on year one performance. We anticipate a shift in focus from program implementation to a focus on care model transformation and performance monitoring and evaluation in year two.

Monitoring and evaluation data will be important in year two as the program continues to improve quality benchmarking and performance tracking. This data will also be essential in informing the design of alternative capitation rate setting methodologies and in federal all-payer waiver negotiations. We expect to use this data to simulate the impact on the state and ACOs under various risk sharing arrangements. Year two will also represent intensive examination of those services traditionally outside the medical benefit, often unique to Medicaid, for their appropriateness and the feasibility of inclusion in capitation models.

Key Implementation Activities

In year two Vermont will continue to evolve and monitor the Medicaid and commercial shared savings programs. In particular, we will implement additional performance measures in year two, work with our analytic contractor to develop regular reporting on ACO performance, monitor the results, and implement an expansion of the definition of total costs of care for the Medicaid SSP.

Also in year two, Vermont will engage in all-payer model development for payments to ACOs and for services not captured in ACO payments. We anticipate that these models will move closer to a capitated payment, on the spectrum of provider risk and reward, but many details are to be developed. The key activities in year two related to all-payer model development include:

- Define the set of services for which ACOs or other provider groups may elect to be accountable for cost and quality under a risk-sharing population-based payment model;
- Assess the impact of alternative risk-sharing arrangements on federal, state, ACOs or other providers;
- Streamline regulatory authorities under population-based payment arrangements;
- Identify methods for setting capitation rates and capturing encounter data; and
- Evaluate how best to incorporate costs traditionally outside the medical and pharmacy benefit, unique to Medicaid, into population-based payment arrangements.

Population-based payment arrangements with other provider types may also be desirable in the future, especially as payment for services for Vermonters who are not currently attributed to an ACO. The key activities in year two related to non-ACO capitation model development include:

- Exploration of value-based blended capitated arrangements could include, but are not limited to: community mental health clinics, primary care outside ACOs, hospitals, and/or home health; and
- Assessment of specialized service programs against value-based criteria will be conducted by Medicaid under a recently initiated project; this will aid in identification of targets for improvements in existing value-based payment systems.

Progress to Date: Episode of Care Groupers

While the primary focus of both the delivery system and payment models innovation will be through continued work with the ACOs, shared savings alone will not create a strong enough incentive to drive care delivery transformation—particularly among hospital participants and specialists. Another year one testing model component was to explore how episode of care (EOC) programs could complement the Shared Savings Programs and the Blueprint by targeting regional collaboration between hospitals, specialists, post-acute care, and specialized service providers around clinical care delivery transformation.

Conceptually, an EOC program alone does not offer direct volume disincentives. However, when such a program is combined with the incentives in the shared savings programs, the

cumulative effect is to create strong disincentives for high volume, variations in care practices, and uncoordinated care among settings and providers. This should result in improved quality and an improved patient experience of care.

Vermont continues to explore whether or not EOC-based programs can further drive care delivery transformation by:

- Rewarding team-based collaboration;
- Aligning with local-level and state-wide clinical priorities;
- Aligning financial and quality monitoring;
- Disseminating performance reports used in learning collaborative and regional advisory groups in partnership with ACOs, Blueprint for Health and Payers;
- Fillings gaps in incentives not addressed in current SSP program and P4P programs;
- Extending beyond primary care, EOCs link hospitals, post-acute and community specialized service providers, specialist physicians and primary care;
- Driving better results under the SSP for both payers and provider participants of the ACOs; and
- Offering opportunities to simulate and study alternative episodic-based payment arrangements.

The latest iterations of clinical episodic groupers are potentially useful for a variety of activities in support of health care reform. Commercial insurers, Medicare, and states are recognizing the potential of value-based payment systems based on broader clinical aggregations across providers, settings of care, and length of time. Episode-based payment systems can capture 20-30% of spending across clinically meaningful conditions and procedures.[21] While not yet proven, it is feasible that broad-based groupers could be used to further aggregate current prospective payment systems (e.g. combining DRG, APC, RBRVS, HHRG) across settings and providers both retrospectively and/or prospectively. At a minimum, the most recent generation of grouper analysis have broad applicability as the basis of performance metrics under value-based arrangements and in support of care delivery transformation at a regional level.

Key Implementation Activities

In year two, we will convene multiple stakeholders to review existing analytic tools and provide input into the design of EOC-based analytics to include in the unified care delivery systems and performance reporting activities.

The primary areas of focus will be:

- To incorporate EOC-based data and analytics into existing support of care management activities, quality improvement and value-based performance reporting activities;

- To design with multiple stakeholders, the use of this information into performance reporting activities;
- To select a vendor to create and disseminate additional provider and ACO performance reporting; and
- To use rapid cycle evaluation to understand impact of introducing this information into care delivery transformation efforts.

Vermont will continue to evaluate the utility of EOCs, though there are no plans for implementation of bundled payments in year two. The three areas of continued interest and study include using EOCs as:

- Financial management or physician compensation models for those providers under capitated arrangements;
- Benchmarking or reference pricing tools in alternative payment arrangements; and
- Value-based, retrospective or prospective payment systems of provider payment under Green Mountain Care (GMC) for the lives not attributed to an ACO arrangement.

A Request for Information (RFI) on the use of broad-based EOC groupers for care and financial management activities is under consideration for release in year two. The findings of the RFI, evidence emerging nationally, and other states' experiences will drive the focus of year two and three activities.

Progress to date: P4P Incentives (Provider-specific Penalties or Rewards)

In addition to model approaches described above, Vermont is evaluating individual provider pay-for-performance (P4P) models.

The development of any P4P models will leverage the VHCIP process in order to garner public-private input on Medicaid's P4P programs. To the extent possible, the state is trying to leverage existing or already planned value-based initiatives such as the Blueprint for Health Advanced Primary Care Practice framework, which makes payments based on NCQA Patient Centered Medical Home level achieved. In year one, we focused on how best to sustain and make more effective the P4P model currently used in the Blueprint. There is mounting pressure to increase financing to support continued primary care participation in the Blueprint. A key focus in year two will be on continued evolution of P4P programs targeted at primary care.

In addition to a focus on sustaining and improving outcomes under the Blueprint and continued support for year two of the shared savings ACO models, the state plans to continue to explore

strategies to provide additional supports or programs to further engage specialist and specialty providers across the continuum of care. This will be done through efforts related to episode of care groupers described above and also how to develop P4P innovations that can be implemented even under budget constraints.

A variety of options will be explored and potentially implemented in year two related to sustainability and enhancement of primary care P4P programs:

- Enhancements to the P4P payments and/or to the Community Health Team support for primary may be necessary to ensure continued participation by all 123 NCQA certified medical homes in Vermont in the Blueprint. The Blueprint submitted a report to the Legislature on October 1, 2014 describing some recommendations and options for enhancing payments to be considered by the legislature in its upcoming session. For more details, see Artifact 262;
- Consideration of for specialist National Committee for Quality Assurance NCQA accreditation;
- Consideration of an expansion of the Medicaid health home model;
- Identification of targets for P4P under GMC. Until such time as capitation models are implemented and for those providers likely to fall outside capitated arrangements, P4P will be an important component to a value based strategy under GMC; and
- Assessment of whether or not to align Medicaid with Medicare FFS P4P programs. Medicaid initiated work in year one to develop and evaluate its programs, including specialized service programs (LTSS, MH/SA), against criteria associated with strong value-based purchasing programs to help identify gaps and help develop recommendations for strengthening its value-based purchasing strategy. This work will continue under year two and result in the creation of a value-based roadmap for Medicaid.

Key Implementation Activities

As described above, year two payment model activities will focus on sustainability of existing P4P programs and evaluation of P4P incentives for their potential use in the value-based purchasing strategy under GMC. Specific activities include:

- Foster alignment around any changes to the P4P component of the Blueprint.
- Assess utility of extension of NCQA scoring as the basis for a P4P program targeted at specialists and begin implementation;
- Assess utility and begin implementation of expansion of health home initiative;
- Collaboratively build value-based roadmap for Medicaid;

- Based on findings from the RFI and other work described above, start drafting P4P plans under GMC value-based strategy including:
    - which specific provider types should be targeted for P4P programs?
    - what is the financing approach and design of the P4P model?
    - what data and analytics support are needed to ensure provide success under model?
    - what is the role of benchmark or reference pricing in alternative payment arrangements; and
- Align state P4P models with those planned by ACOs in their financial management or physician compensation models for those providers under capitated arrangements.

Additional Year Two Planned Activities

1. Creation of "Unified Care Delivery Systems"

As discussed more fully in Section M "Care Delivery Transformation", year two will focus on strengthening unified regional care delivery systems. This will directly address the care models and care management activities across the state.

At a regional level, payers, the Blueprint for Health, and ACO leadership will merge their workgroups and collaborate with stakeholders to form a single unified health system initiative. The collaborative will include medical and non-medical providers, including long-term services and support providers and mental health providers, a shared governance structure with local leadership. These groups will focus on improving the results of core ACO quality measures, support the introduction and extension of new service models, and provide guidance for medical home and community health team operations. This approach will establish a data-guided regional collaborative, result in more effective health and human services, and reduce the number of overlapping initiatives that currently exist. Existing Blueprint for Health and SIM resources will be used to support these collaboratives, including local project management, practice facilitators, self-management programs, shared evaluation and comparative reporting, and, shared learning forums.

Findings from Vermont's SIM sub-grant program, as well as other payer, ACO or Blueprint quality improvement and/or care delivery transformational activities would be disseminated through the unified system.

2. Creation of Unified Performance Reporting and Analytics

As discussed in detail in Section M, "Care Transformation Plans," and Sections D and E, "Information Systems and Data Collection Setup" and "Alignment with State HIT Plans and

Existing HIT Infrastructure" respectively, year two will also focus on strengthening unified performance reporting and analytics. The will enhance our health information sharing across the system. Payers, Blueprint for Health and ACO leadership will work to co-produce performance dashboards focusing on core ACO measure results as well as other analytics important to support care delivery transformation. These dashboards will present population level results and directly support the work of providers in regional care collaboratives. The dashboards will augment the suite of comparative profiles that are currently produced for practices, HSAs, and organizations, providing a focused set of measures that are important to all entities participating in ACO and patient-centered medical home activity. Specifically, these efforts will expand to include performance reporting to specialists and inclusion of episode of care (EOC) data analytics. Where possible, this approach should be generalized to include sharing data sets, collaborating on analytic activity, and planning for an advanced data infrastructure that can fuel the range of needs for Vermont's health system.

Year two will continue to focus on overcoming the challenge of measuring clinical data that is largely dependent on chart review for providers, ACOs, and insurers. While there are a few exceptions—such as common measurement across Federally Qualified Health Centers—it is still difficult to consistently measure clinical outcomes for a whole population in a service area, or statewide. Vermont's SIM project and Vermont Information Technology Leaders (VITL) are working together to improve clinical data quality that is being transmitted from source sites and the quality of existing electronic health record data is being analyzed. Where appropriate, payers, the Blueprint, and ACO leaders are considering opportunities to share analytic data sets (claims, clinical) in order to assure efficiencies and reduce the data-collection burden on ACOs and providers.

3. Movement to Population based Payments under Green Mountain Care

In the last year, Vermont has accelerated planning for an all-payer system of payments to providers. We see this planning and implementation as essential under any future scenario—with or without Green Mountain Care implementation—to assure cost constraint and support population health improvement and increased quality of care for Vermonters. Vermont is planning to pursue a federal all-payer waiver—which, in combination with the statutory authority vested in the Green Mountain Care Board (GMCB), would allow for implementation of a reformed payment system across all payers. Year two focus will be on how best to begin the transformation from current payment systems and payer methodologies to an all-payer provider payment system.

The all-payer waiver will be developed through a partnership between the GMCB, the Agency of Human Services, and the Agency of Administration (AOA/Governor's Office). Given its

statutory responsibility for health care cost containment and provider payment policy, the GMCB will be responsible for developing further details of the provider payment models over the next twelve months, with input from key stakeholders from the provider, payer, and beneficiary communities. The goals will be to ensure that:

- The payment methodologies the state is pursuing will be supported by the provider community and have a high likelihood of being successfully implemented;
- Vermonters will have adequate assurance that access to care and quality of care will not be compromised under the waiver; and
- The state has adequate mechanisms in place to ensure regulatory compliance with the terms and conditions of the waiver.

Building on these strengths, Vermont will propose a system of health care provider payment oversight with three central elements:

1. Continued regulatory oversight of the parameters of ACO/payer relationships, including payment levels, rates of increase in payment year-to-year and quality measurement;
2. Oversight of insurer payments to non-ACO providers, and a requirement for a fair, transparent, and standardized fee schedule for those providers;
3. Continued oversight of health insurance premiums and premium growth.

The state is currently assessing the interface between its existing regulatory processes for health insurer rates and hospital budgets, and considering a potential new system of regulation under an all-payer waiver.

Question 38. Are project activities specified/planned/structured appropriately in terms of sequencing and conducting activities in parallel to achieve results?

Actionable project plans have been developed for each of the models proposed in Vermont's SIM grant. The SIM Project Director and Project Management Team are responsible for identifying resource needs and tracking tasks, reporting, and oversight. A timeline of the major milestones of each initiative as well as staff resource plans can be found in artifact 137. Each initiative will be staffed by interdisciplinary teams comprised of a mix of new and existing staff and various levels of contracting support (see section K).

All implementation and evaluation milestones presented in the timelines are based on realistic assessments of both internal and external readiness. Artifact 265 includes a list of Vermont's year two milestones. The timing of all the activities across the models are designed to:

- align and coordinate with existing federal program milestones (see section B);
- allow for sufficient input from relevant workgroups and the steering committee (see section A);
- ensure multi-payer and provider collaboration;
- align with the sequencing of health information technology activities and milestones and reduce administrative burden where possible; and
- proceed in parallel.

While each model requires a tailored approach and cycle based on the task and resource requirements need for successful implementation and evaluation, there are common components to each model—which are color coded in the timelines presented in the artifact. Each of these major components will be used as process-oriented self-evaluation measures to track progress toward implementation. Each will be reported on as part of quarterly reporting to CMMI. We expect the process measures selected to report would change as Vermont moves along in its timelines.

These components include:

COLOR CODE	COMPONENT OF PROJECT PLAN	PROPOSED INTERIM SELF-EVALUATION PROCESS TRACKING MEASURE
	Staffing of Project Teams	% Open Positions
	Acquisition of Contracting Resources	% Open Consultant Contracts
	Release of Program RFPs and Contracts	% RFPs released by planned date % Contracts Signed by planned date
	CMCS Coordination and Approvals	% Concept Papers Submitted % SPAs Submitted
	Learning Collaborative Launch and Maintenance	% Learning Collaborative Launched
	Workgroup and Steering Committee Consensus	# Workgroup Meetings
	Broad Stakeholder Engagement	# Stakeholder Meetings Held

	Systems Readiness	# Change System Requests (CSRs) Completed
	Programmatic Launch and Maintenance	# Project Milestones met by planned date
	Monitoring and Evaluation Plans and Findings	# M&E Plans Finalized
	Coordination and Alignment Activities	Plan for 2015 Duals ACO Alignment Finalized
	Ensuring Connectivity and Clinical Measurement Capability	Recommendations for Clinical and Connectivity Priorities Adopted by planned date
	Staff Training and Capacity Building; Organizational Change Planning and Management	# of staff trainings on initiatives Post SIM Organization Plan Completed by Date Planned

See Timeline of Milestones through 2017, artifact 137.

Question 39. Are project activities specified/planned in a way that they can complete and produce measurable results during the project's period of performance?

See Timeline of Milestones through 2017, artifact 137, and additional description under question #37 above.

Key Artifacts:

Exhibit	Artifact	URL
137	SIM Milestone Timeline (2013-2016)	
106	Medicaid Operational Timelines	
152	Vermont Commercial ACO Pilot - Compilation of Pilot Standards	
127	Proposed Timeline for the Commercial XSSP ACO Implementation	
167	Vermont Proposed Episodes of Care (EOC) Program	
33	Act 50, Section E.307.2 (Reduction in Medicaid Cost Shift)	http://www.leg.state.vt.us/docs/2014/Acts/ACT050.pdf
180	VOP Annual Report	
181	VOP Annual Report Presentation for GMCB	
54	Blueprint 2012 Annual Report	http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf
53	Blueprint for Health 2011 Annual Report	http://hcr.vermont.gov/sites/hcr/files/Blueprint%20Annual%20Report%20Final%2001%2026%2012%20_Final_.pdf
52	Blueprint for Health 2010 Annual Report	http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf
51	Blueprint for Health 2009 Annual Report	http://hcr.vermont.gov/sites/hcr/files/pdfs/BP2009AnnualReport2010_03_29.pdf
28	ACO Measures Work Group Meeting Agendas and Minutes	
29	ACO Standards Work Group Meeting Agendas and Minutes	
	Year 2 Updated Artifacts	
258	SSP and ACO FAQ Chart	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/SSP_and_ACO_FAQ_and_Chart_7.8.14.pdf
262	Blueprint for Health Report	http://www.leg.state.vt.us/reports/2014ExternalReports/302606.pdf
265	Year Two Milestones	

Section M Care Transformation Plans

This section discusses Vermont's plans to provide support to providers throughout the transition to alternative payment models. This support will include training on continuous quality improvement.

Question 33. Has Vermont identified quality improvement supports for providers, including training on continuous quality improvement methodology or participation in learning collaboratives?

Question 34. What are the activities related to practice transformation training and care process redesign supports that leverage existing statewide learning and action networks (e.g. PCMH, Health Home, regional extension centers) and other communication vehicles engaging providers?

Vermont has a long history of developing and supporting quality improvement infrastructure for providers; the result is a rich array of learning collaboratives, skilled quality improvement specialists, and improvements in health information technology and data analysis to engage and support providers as they seek to transform the way they deliver services and improve patient care. Examples of these initiatives are described in table 4 below.

Table 4. Summary of Quality Improvement and Care Transformation Reform

Delivery System Reform or Provider Community	Summary of Reform	Status of Integration of SIM QI/Care Transformation Support
Vermont Blueprint for Health Advanced Primary Care Practices	Multi-payer Advanced Primary Care Practice (MAPCP) demonstration project, including 113 of the state's primary care practices that are currently recognized as PCMHs (approximately 3/4 of the total primary care practices in the state)	QI facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM is helping to expand and enhance those supports by providing

		additional quality improvement facilitators, expert faculty, and training.
Vermont Blueprint for Health Community Health Teams (CHTs)	There is a CHT in each of the state's 14 health service areas; they are part of the MAPCP demo. They are locally-designed, and include staff members such as care coordinators, social workers, mental health counselors, dieticians and health coaches. They offer individual care coordination, population management and outreach, and close integration with other social and economic support services. The goal is to provide patients and their families with seamless integration of person-centered care across the continuum of health, social, economic and community services.	QI facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports by providing additional quality improvement facilitators, expert faculty, and training. The Blueprint CHTs are participating in the Integrated Communities Learning Collaborative in all three pilot communities.
Blueprint Integrated Health Services (IHS) Workgroups	IHS Workgroups in each health service area identify gaps in care and plan the structure and staffing of CHTs. These Workgroups include representatives of community, economic and social service organizations (e.g. – community action agencies, housing organizations, area agencies on aging, educational organizations, transportation agencies) in addition to health care providers.	QI facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports. Vermont is considering offering CQI training to IHS Workgroups. Existing IHS workgroup meetings may offer a forum for teams participating in the Integrated Community Learning Collaborative.
Vermont's Health Home initiative for people experiencing opioid dependence ("Hub and Spoke")	This program provides registered nurse and mental health clinician support to augment the services of centers ("Hubs") and community physicians ("Spokes") who are prescribing methadone and buprenorphine to this population of patients. Vermont is planning to expand the health home concept to Vermont residents in need of mental health services and long term support services, which will result in further	QI facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports by providing additional quality improvement facilitators, expert faculty, and training.

	integration of care and services.	Several mental health and substance abuse providers are participating in the Integrated Communities Learning Collaborative.
Coalitions of hospitals, physicians and other service providers	Various provider communities participate in quality improvement projects facilitated by VPQHC, VCHIP and other coordinating entities.	QI facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports by providing additional quality improvement facilitators, expert faculty, and training.
Medicaid's Vermont Chronic Care Initiative (VCCI)	The VCCI program deploys care coordinators in local communities to assist high-risk Medicaid beneficiaries.	QI facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports by providing additional quality improvement facilitators, expert faculty, and training. VCCI staff are participating in the Integrated Communities Learning Collaborative in all three pilot communities.
Support and Services at Home (SASH)	SASH is a partnership led by housing providers that connects affordable housing with health and long term services, providing targeted support and services to help high-risk Medicare beneficiaries remain safely at home. It is part of the MAPCP demo. SASH sites are located in housing hubs throughout the state. Each site has a SASH Coordinator and a wellness nurse who work with a care coordination team consisting of staff from home health agencies, mental health agencies, area agencies on aging and other organizations to improve care coordination, care transitions, health promotion, and disease	QI facilitators, learning collaboratives, and HIT improvement strategies are in place; SIM will help expand and enhance those supports by providing additional quality improvement facilitators, expert faculty, and training. SASH is participating in the Integrated Communities Learning Collaborative in all three pilot communities.

	prevention.	
Practices, facilities and other providers developing electronic health record (EHR) and other HIT capability to drive care transformation and quality improvement	Development of a statewide health information network that connects providers and consumers, creates statewide master persons and master provider directories, integrates data from various sources on a common platform(s) to support measurement and analytics, ensures secure transmission networks, and continuously improves data mapping and normalization at the practice level to support patient care and quality improvement.	QI facilitators and HIT improvement strategies are in place; Vermont Information Technology Leaders [VITL] outreach staff are working directly with providers to establish interfaces between their EHRs and the state's Health Information Exchange, and with practice staff, Blueprint staff and facilitators to ensure that the data available to clinicians is timely, accurate, and reliable.

Year Two Update

We have learned much about supporting providers with care transformation during the first year of Vermont's SIM testing grant. The multi-stakeholder Care Models and Care Management Work Group identified two top priorities for transforming care:

- Reduce fragmentation with better coordination of provider/CHT/health plan and other care management activities in order to better serve all Vermonters (especially those with complex physical and/or mental health needs). The work group also has recommended a focus on improving transitions of care and 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.

During the work group's discussions, and as Vermont's commercial and Medicaid Shared Savings ACO Programs have begun to roll out, there were many questions about how those programs would interface with the Blueprint for Health.

We conducted an inventory survey of care management activities, with guidance from the work group, and the most commonly-cited challenges included insufficient funding, challenges in recruiting qualified staff, technical barriers to sharing information between organizations, and challenges in engaging individuals. A fragmented care management structure is not consistent with the population's needs, and does not support efficient and effective care.

These discussions, priorities, and challenges suggest that:

- Effective provider support for care transformation would need to encompass:
    - Alignment/coordination between ACOs and the Blueprint, and
    - Integration of services among a wide range of providers (medical, community, social services, etc.); and
- Quality improvement (QI) training and deployment of QI facilitator resources should be strategically designed and planned to address those priorities.

To these ends, the following quality improvement and care transformation efforts were initiated during Year one of the SIM Testing Grant and will continue into Year two:

- Establishing regional unified care delivery systems that engage and integrate a wider array of providers in care transformation, including physician specialists, mental health and substance abuse providers, long term services and supports providers, and home and community based providers:
    - In each Health Service Area in Vermont, Blueprint and ACO leaders are working to merge groups (e.g., Blueprint Integrated Health Services Work Groups and ACO Regional Clinical Advisory Groups) and work with stakeholders to form a single unified care delivery system;
    - The unified system will incorporate medical and non-medical providers, and a shared governance structure with local leadership;
    - The unified system will:
        - Identify the needs of the local population;
        - Ensure coordination of care management approaches that will meet those needs;
        - Provide guidance for Blueprint Community Health Team and PCMH operations;
        - Focus on improving the results of core ACO Shared Savings Program quality measures;
        - Support data-driven, community-based clinical innovation activities; and
        - Support the introduction and extension of new care delivery models.

- Exploring development of Medical Neighborhoods by engaging specialty practices in preparing for and scoring on NCQA Specialty Practice Standards. A statewide base of NCQA-recognized PCMHs and Specialty Practices increases the ability of ACOs to organize high quality, coordinated care.
- Supporting providers and aligning care transformation priorities by consolidating measurement activities, practice-level reports, and performance dashboards:
    - Measures for Vermont's commercial and Medicaid Shared Savings Programs are aligned; significant alignment exists between measure sets for the Vermont and Medicare Shared Savings Programs;
    - Practices will be supported with consolidated practice-level performance dashboards. The Blueprint for Health and ACO leadership are planning to co-produce performance dashboards focusing on core ACO measure results;
    - Consolidated, all-payer dashboards will present population-level results for the practices, and will directly support the quality improvement work of unified community collaboratives; and
    - Payers will be able to use Blueprint and ACO development and dissemination of these dashboards to meet many of the quality improvement requirements in Vermont's managed care regulation (Rule H-2009-03).

The result of these coordinated measurement and reporting activities will be unified message regarding quality improvement opportunities and priorities.

- Aligning the state, payers and providers around a shared vision of care management by developing care management standards for ACO SSPs;
- To better inform this shared vision, the Care Models and Care Management Work Group developed a common definition of care management: Care Management programs apply systems, science, incentives and information to improve services and outcomes in order to assist individuals and their support system to become engaged in a collaborative process designed to more effectively manage medical, social, and mental health conditions. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, evidence based or promising innovative and non-duplicative services.
- A sub-group of the Care Models and Care Management Work Group has met to develop draft care management standards. The draft standards have been disseminated to the full work group and will be discussed at the October and November 2014 meetings.

- Conducting a care management inventory survey to improve understanding of current care management activities, staffing, people served, and challenges:
    - The survey was designed and fielded in the summer of 2014;
    - Summary results were presented to the Care Models and Care Management Work Group at its August and September 2014 meetings; and
    - A more detailed report is under development.
- Establishing an "Integrated Communities Care Management Learning Collaborative" in three pilot communities (Burlington, Rutland and St. Johnsbury):
    - A planning group has been meeting for several months to conceptualize and design a proposal for funding and is moving to the implementation phase with a mid-November kick-off scheduled, and the first community wide learning session in mid-January 2015. The collaborative will begin by stratifying populations in the pilot communities and focusing on improving care management for at-risk people, and will be designed to support implementation of a population-based approach;
    - Using the PDSA quality improvement model, the collaborative will test promising care management tools, protocols, communication strategies and data sharing techniques to support integration of care management activities among health care, social service, and community organizations;
    - The collaborative will offer learning sessions focused on those promising interventions, which will also provide a skills training track for front-line care management staff;
    - Recruitment is underway for participating organizations in the three pilot communities, and for two statewide QI facilitators to support implementation of the collaborative; and
    - A model of care for people needing long term services and supports was presented to the Care Models and Care Management Work Group at its August 2014 meeting, and elements from that model are being incorporated into the learning collaborative.
- Establishing a vision for more fully integrated care management in a reformed health care system, as Vermont evolves from ACO Shared Savings Programs to an all-payer population-based payment system.

These priorities are reflected in our year two revision to this section of the plan, summarized in table 5 below.

Table 5. REVISED OPERATIONAL PLAN – Quality Improvement & Care Transformation (October 2014)

Goal/Action	Targeted Stakeholders	Provider Recruitment Strategy	Strategy for Stakeholder Participation	Start Date	End Date	Responsible Parties	Planned Deliverables/ Outputs	Status
Establish regional unified community health systems that engage and integrate a wider array of providers in care transformation, including physician specialists, mental health and substance abuse providers, and long term services and supports providers	Regional Blueprint Integrated Health Services Work Groups Regional ACO Clinical Advisory Groups Health care and community service provider organizations	Highlight fewer and better coordinated work groups, desire for representative work group, and opportunity for more integrated care for people needing services	Build on already existing infrastructure and efforts	January 2015	Ongoing	ACO leadership Blueprint leadership	Coordinated, inclusive, well-functioning regional groups that address the needs of their population and support clinical innovation and the introduction of and extension of effective service models	Discussions are occurring between leadership of Blueprint and 3 ACOs
Explore development of Medical Neighborhoods by engaging specialty practices in preparing for and scoring on NCQA	Specialist practices	Some early adopters have already been recruited; TBD for broader recruitment efforts (emphasize	Build on existing Blueprint efforts	2013	Ongoing	Blueprint leadership ACO leadership State health care reform leadership	Well established medical neighborhoods consisting of primary care and specialty providers that are	An OB-GYN practice in Newport has achieved specialty recognition, and work to achieve recognition is

Specialty Practice Standards		benefits of participation)					incorporated into Integrated Communities	underway in regional "Hubs" serving people with opioid dependence
Support providers and align care transformation priorities by consolidating measurement activities, practice-level reports, and performance dashboards	Primary care providers initially, could extend to physician specialists and other health care and community providers	Blueprint and ACO participants will be asked to participate	Ready access to no-cost data analytics; provide dashboards to Blueprint and ACO participants as part of periodic measurement and quality improvement cycles Ready access to QI facilitators	January 2015	Ongoing	Blueprint leadership ACO leadership	Consolidated performance dashboards are delivered to providers on a regular basis	ACO and Blueprint have agreed to consolidate reports; practice-level dashboards are in design phase
Align the state, payers and providers around a shared vision of care management by developing care management standards for ACO SSPs	ACOs Payers CMCM Work Group	Will be required of ACOs and their participating providers	Payers and ACOs have been involved in initial draft development	July 2014	January 2015	CMCM Sub-Group; CMCM Work Group; CMCM Work Group Co-Chairs and Staff; Steering Committee; Core Team; GMCB	Adopted care management standards Mechanisms to support implementation and monitoring	Draft standards developed by sub-group and disseminated to full work group
Establish the "Integrated Communities Care Management Learning	Health care and community service organization leaders and	Voluntary regions; leaders in each region will recruit participants;	Ensure that there are clear benefits and support for participation	January 2014	January 2016	Learning Collaborative Planning Group Regional leaders in	Well-functioning regional learning	Collaborative designed, proposal presented to work groups

Collaborative" in three pilot communities (Burlington, Rutland and St. Johnsbury)	front-line care management staff in 3 pilot communities	recruitment materials have been developed				3 communities QI Facilitators	collaboratives Statewide learning sessions and training for front-line staff Measures of success PDSA cycles to test interventions	and Core Team, funding approved, RFP posted for QI facilitators, facilitator bids received; interviews scheduled
Conduct an electronic inventory survey to obtain a snapshot of current care management activities, staffing, people served, and challenges	Organizations conducting care management	Importance of obtaining information on current care management landscape was emphasized; providers helped develop survey	Link to survey was widely disseminated; webinar was held to review the survey and address questions; support was provided to participating organizations in completing the survey	May 2014	January 2015	CMCM Work Group, co-chairs, staff and consultants	Report of results Recommendations based on results	Survey designed, fielded, results summarized
Establish a vision for more fully-integrated care management in a reformed health care system, as Vermont evolves	ACOs Organizations engaged in care management	TBD	TBD	TBD	Ongoing	State payment and delivery system reform staff	Well-articulated vision	In conceptual stage

from ACO Shared Savings Programs to an all-payer population-based payment system								

Key Artifacts:

Exhibit	Artifact	URL
	Vermont Blueprint for Health	
54	Blueprint for Health 2012 Annual Report	http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf
48	Blueprint Facilitator Grant Agreement Language	
45	**Blueprint 2013 Meeting Dates**	
	All Meetings	
	CHT	
	Payment	
	Project Managers	
	Facilitators	
	Self-Management	
	MAT Collaborative NW	
	MAT Collaborative SW	
	Asthma Collaborative	
	Cancer Collaborative	
70	**Facilitator-led PDSA summaries**	
	PDSA Blank Worksheet	
	Health Center in Northeastern Vermont	
	Northern Vermont Practice: Tobacco	
	Northern Vermont Practice: Diabetes	
	Vermont Practice: Hypertension	
50	Blueprint Facilitator Training Calendar	
49	**Blueprint Facilitator Meeting Notes**	
	Facilitator Meeting Notes 1/28/13	
	Facilitator Meeting Notes 2/11/13	
	Facilitator Meeting Notes 3/4/13	
	Facilitator Meeting Notes 4/1/13	
47	**Blueprint Facilitator Basecamp threads**	
	Full List of Threads (password protected)	
	Asthma	
	Medications	
45	Blueprint 2013 Meeting Dates (Learning	

	Collaboratives and others)	
59	Blueprint participating practices and entities (list)	
189	VPQHC continuous quality improvement initiatives	
	VCHIP Artifacts	
147	VCHIP quality improvement initiatives	http://www.uvm.edu/medicine/vchip/documents/2011VCHIPINSERT_QI.pdf
57	Blueprint Integrated Health Workshop Participants	
146	VCHIP Evaluation of Blueprint Adoption	http://hcr.vermont.gov/sites/hcr/files/Blueprint_QualitativeEval_VCHIP_July15_2011.pdf
	Statutes and Regulations	
129	Rule H 2009-03 (Part 6)	http://www.dfr.vermont.gov/sites/default/files/REG-H-09-03.pdf
17	18 V.S.A. § 9414	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=221&Section=09414
18	18 V.S.A. § 9416	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=221&Section=09416
	Additional Artifacts	
131	SASH sites and organizations	
176	VITL Outreach Staff	
148	VDH Health Care Acquired Infection Project Report	http://healthvermont.gov/prevent/HAI/documents/VTMDROCOLLABORATIVEFinalReport33112.pdf
66	DAIL Quality Improvement Examples	
107	Medicaid Vermont Chronic Care Initiative (VCCI) Staff	
	Blueprint Learning Collaboratives	
	Asthma Collaborative Materials	

41		Asthma Learning Collaborative Proposed Processes for Planning and Implementation
39		Asthma Collaborative Planning Team Meeting Notes - 2/15/2013
40		Asthma Learning Collaborative Presentation
	Cancer (Preventive Services) Collaborative Materials	
62	Cancer Burden Presentation	
63	**Cancer Screening Collaborative May 3, 2013 Meeting Materials**	
		Meeting Agenda - 5/3/2013
		Cervical Cancer Guidelines Presentation (Wegner)
		Best Practices for Increasing Screening Rates Presentation (Mallory)
		Cancer Screening Measures
		Vermont Department of Health Cancer Screening Guidelines
		Chart Audit Tool
		Chart Audit Instructions
		Chart Audit Data Data Collection and Display
		Session Evaluation
	Medication Assisted Treatment (MAT) Collaborative Materials	
102		MAT Collaborative Executive Summary
103		MAT Collaborative Evaluation
	Year 2 Updated Artifacts	
228		Care Models and Care Management (CMCM) Work Group Priorities
230		Minutes from various meetings discussing VHCIP/Blueprint Interface (1/14/2014;2/11/2014; 3/11/2014; 4/8/2014
231		Presentation from Blueprint Community Health Teams to CMCM Work Group
232		CMCM Work Group Problem Statement
233		Notes from CMCM Work Group Breakout Session on Population Health Goals

234	Presentation of Care Management Inventory Survey Findings
235	Crosswalk of Vermont and MSSP Measures
236	Blueprint Practice Profile
237	Presentation re Blueprint and OneCare Vermont Interface
238	Draft Care Management Standards for Accountable Care Organizations
239	Integrated Communities Care Management Learning Collaborative, Proposal
240	Integrated Communities Care Management Learning Collaborative, Executive Summary
241	Model of Care for People with Disabilities and Long-Term Services and Supports (DLTSS) Needs Supports (DLTSS) Needs

Section A Governance, Management Structure and Decision-making Authority

This section provides information regarding Vermont's governance and management structure for the SIM project which in Vermont is now named the Vermont Health Care Innovation Project (VHCIP), as well as clarification of the role of the Governor's Office in overseeing the project.

Question 1. Does the SIM initiative have sufficient executive support from state government, the Governor, the legislative branch of the state, and the private sector—with workable governance and management resources and processes and adequate authority to make decisions on the innovation model, project design, and implementation?

Vermont has designed structures for governance and management of the Vermont Health Care Innovation Project (VHCIP) to ensure appropriate representation of private sector partners as well as the multiple state agencies and departments involved in the project. The structure includes a strong linkage with the Governor's Office, shared public-private governance, and an effective project management organization.

Vermont's project structure will reinforce linkages with key related state and federally-supported initiatives, such as the state's primary care medical homes initiative, Medicare's Accountable Care Organization payment demonstrations, and Medicare's bundled payment initiative.

Public-private governance and private sector involvement in developing deliverables under the project also will reinforce coordination between grant-funded activities and related activities occurring in the private sector. We believe our project structure will allow us to:

- Effectively coordinate across these initiatives;
- Incorporate meaningful input from and communication with all involved; and
- Provide for clear project direction and effective decision-making.

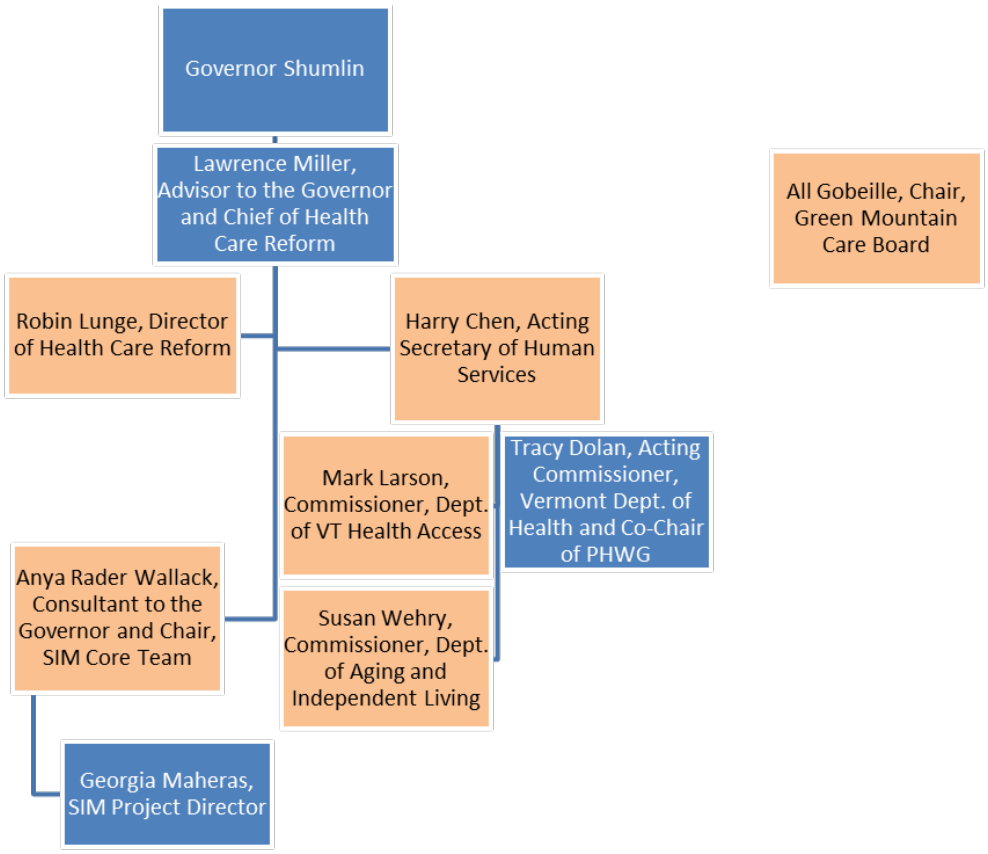
This project is consistent with the legislative authority granted to Vermont's executive branch and the Green Mountain Care Board (GMCB) to undertake comprehensive health care payment and delivery system reform activities. Project leaders will provide updates to legislative leadership throughout the life of the project to assure that the legislature is appropriately informed of our progress toward project aims.

Governor's Office Engagement

Governor Shumlin has made health care reform his top priority. While the Governor has an overall agenda of creating a unified, universal system of quality health care separated from employment and funded publicly, he has consistently recognized that cost control and improved outcomes must lead: without them, simply paying for the system in a different way will do little to achieve lasting and sustainable reform. The Governor included cost-containment and improving the value of health care as the central components of Act 48. This was his legislative priority in the first session of his first term and was passed by the Vermont General Assembly in 2011. This legislation created the GMCB and the state's Director of Health Care Reform and set a clear executive and legislative agenda for health care payment and delivery system reform. The GMCB is an independent five-member board appointed by the Governor with confirmation of appointments through the State Senate. The Director of Health Care Reform works within the Office of the Secretary of Administration, functioning essentially as an extension of the Governor's staff.

Act 48 also created Vermont's Health Benefit Exchange, called Vermont Health Connect (VHC) within the Department of Vermont Health Access (DVHA). Earlier this year the Governor appointed a new "Chief of Health Reform" to oversee and align both VHC operations and continued health reform planning within the Governor's Office and other Executive Branch departments. The organizational chart below depicts the relationship between the various entities involved in the VHCIP within Vermont state government. Figure 2 below depicts Vermont's Organizational Chart.

Figure 2. Vermont State Innovation Model/Health Care Reform Organizational Chart



NOTE: Orange indicates member of the VHCIP Core Team. Other members are Steve Voigt, Interim Executive Director ReThink Health and Paul Bengtson, CEO of Northeastern VT Regional Hospital.

The Governor's Office has been heavily engaged in planning for the VHCIP. The Governor authorized a joint application for the grant by the Agency of Human Services and the GMCB. He has met at regular intervals with the SIM/Vermont Health Care Innovation Project (VHCIP) Core Team (the top leadership of the project), has provided direct guidance to the group, and has provided indirect guidance through his Chief of Staff and Secretary of Administration. The Governor announced the SIM grant award via press release on February 21, 2013 and at a March, 27, 2013 press conference highlighted the grant as one example of how his overall

reform agenda is progressing. Since then he has held press conferences to announce the launch of Vermont's Medicaid and commercial shared savings programs for ACOs and to announce the distribution of provider innovation grants under VHCIP. In addition, the Governor consistently speaks publicly about the importance of cost containment and moving from a fee-for-service system to a payment system based on value. See press releases in the Appendix under Section A, Artifacts. The Governor also meets on a periodic basis with key stakeholders who are central to carrying out the VHCIP and participants on the VHCIP Steering Committee.

The Governor's Office has directed the VHCIP Core Team to organize the project management structure to:

- Include private sector partners in all levels of project decision-making;
- Integrate the state's demonstration project for individuals who are dually eligible for Medicare and Medicaid within the VHCIP governance structure and decision-making process to ensure that these efforts are aligned and providing consistent incentives for change;
- Provide for strong project management and clear decision-making related to three dimensions of potential project impact:
    - Distribution of SIM funds and other resources;
    - Changes in state policy necessary to support payment and delivery system innovation; and
    - Positive influence on private sector innovation.

The Governor's directives will be implemented through the project governance and management structures described below. The Governor and his top managers of health reform (his Chief of Staff, Secretary of Administration, and Director of Health Care Reform) will continue to be closely involved and frequently consulted in a meaningful manner, providing clear oversight throughout the life of the project. The Governor will meet with the VHCIP Core Team monthly to hear progress updates and his top managers will meet more frequently with project managers and leaders. The Director of Health Care Reform will serve as a member of the Core Team. In addition, the Governor assigned former aide and former Green Mountain Care Board Chair Anya Rader Wallack to chair the VHCIP Core Team.

The Chair and other members of the Core Team hired Georgia Maheras as VHCIP Project Director in October 2013. Georgia is responsible for day-to-day management and coordination of staff and contractors working under the grant. Georgia reports to the Chair of the Core Team, ensuring that the Core team is appropriately informed of project activities and issues and that the project work is aligned with the strategic direction set by the Core Team.

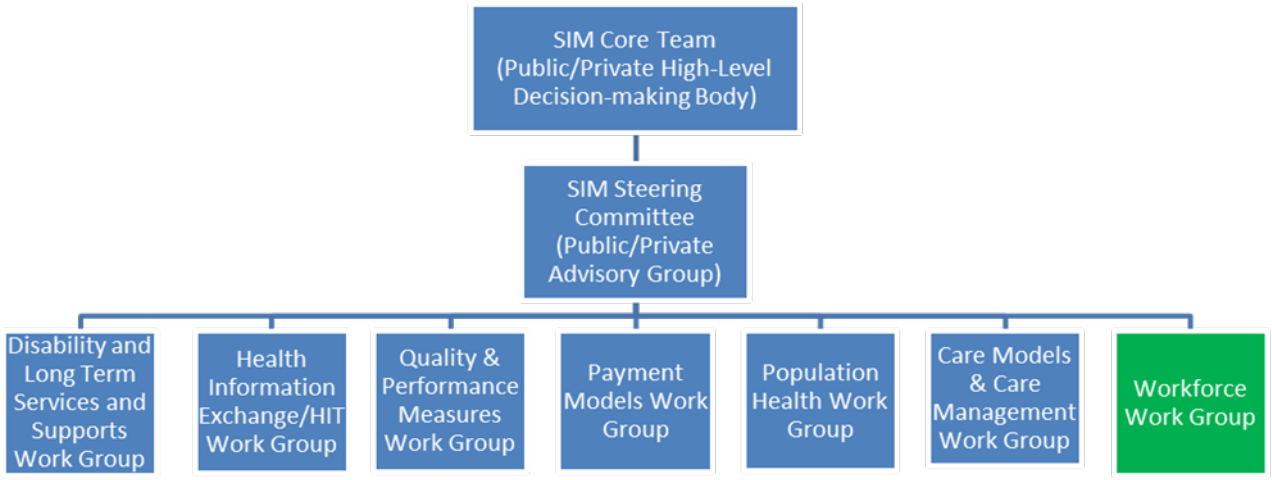
Project Governance

The VHCIP will be governed through a structure that integrates public and private oversight and consideration of the dually-eligible population at three levels:

- The Core Team
- The Steering Committee
- Six Work Groups

This structure is illustrated in the organizational chart below. The purpose and composition of each of these levels of governance also is described below in figure 3.

Figure 3. VHCIP Governance



The VHCIP, per the direction of the Governor, originally included oversight of the state's dual eligibles financial alignment demonstration project. Earlier this year, the state decided not to pursue the financial alignment demo. However, the VHCIP continues to include a Long Term Services and Supports Work Group to advise on efforts to better coordinate both care delivery and health care financing for Vermonters who are elderly and/or have chronic illnesses or disabilities.

The Core Team

This group provides overall direction to the VHCIP, synthesizes and acts on guidance from the Steering Committee, makes funding decisions, sets project priorities, and helps resolve any conflicts within the project initiatives. Members of the Core Team are:

Anya Rader Wallack, Ph.D., Chair

Anya Rader Wallack, President of Arrowhead Health Analytics, previously served as chair of the Green Mountain Care Board. The GMCB regulates hospital budgets, health insurer rates and major health care capital expenditures. It also has the authority to implement all-payer rate-setting. The GMCB also has broad responsibility for multi-payer payment reform efforts in Vermont, and has authorized pilot projects that test alternatives to fee-for-service payment. Prior to chairing the GMCB, Anya served as Governor Shumlin's Special Assistant for Health Care Reform and had primary responsibility for early implementation of his health reform agenda, including Act 48 of 2011, which created the framework for a single payer system in Vermont and created the GMCB. Wallack served in a similar role for Governor Howard Dean in the 1990s and has consulted with numerous states, non-profits and provider organizations on issues related to state-based health care reform.

Robin Lunge, Director of Health Care Reform

Robin Lunge has been Director of Health Care Reform for the Governor since July 1, 2011, after the passage of Act 48 in 2011. In her first position with the Governor, she assisted Anya Rader Wallack in writing and achieving passage of Act 48. Prior to the Governor's election, she served for approximately eight years as the lead staff attorney for the Vermont legislature on health care reform and health and human services policy, which involved supporting multiple legislative committees on these issues and authoring all major health reform legislation during that time. Lunge also worked at the Center on Budget and Policy Priorities in Washington D.C. as a senior policy analyst on welfare and poverty issues. Since joining the Governor's team as the Director of Health Care Reform, she is responsible for moving three major bills through the legislature in order to implement Act 48 and the Affordable Care Act. In this role, she oversees health reform efforts across the executive branch, including Vermont Health Connect, Vermont's state-based health benefit marketplace; Vermont's health information technology upgrades within state government; and Vermont's planning efforts to move to a unified, universal system.

Harry Chen, Acting Secretary of Human Services

Harry L. Chen, M.D. was appointed Acting Secretary of the Agency of Human Services on August 12, 2014; he served as Commissioner of the Vermont Department of Health from January 2011 until that date. Dr. Chen worked as an emergency physician at Rutland Regional Medical Center for over 20 years, through 2010, serving as Medical Director from 1998-2004. He is on the clinical faculty at the University of Vermont College of Medicine and served as Vice Chair of the University of Vermont Board of Trustees. From 2004-2008, Dr. Chen served in the Vermont House of Representatives; during his final term he was Vice Chair of the Health Care Committee.

Al Gobeille, Chair of the Green Mountain Care Board

Al Gobeille, chair of the GMCB, has served as a member of the Board since October of 2011. He owns and operates a hospitality business, which operates three restaurants and a cruise business on Lake Champlain. He has previously served on the board of the Visiting Nurse Association of Chittenden and Grand Isle Counties and was a member of the state's Payment Reform Advisory Council. Gobeille is currently a member of the Shelburne Town Selectboard, past chair of the Burlington Business Association, members of the Champlain Valley Exposition board, and a member of the Lake Champlain Regional Chamber of Commerce board.

Mark Larson, Commissioner of the Department of Vermont Health Access

Mark Larson is the Commissioner of the Department of Vermont Health Access (DVHA). The Department administers Vermont's public health care programs. It also is responsible for the development and implementation of Vermont's health insurance exchange and Green Mountain Care, Vermont's universal health care program. Prior to being appointed Commissioner by Governor Shumlin, Larson was a member of the Vermont House of Representatives serving as the Chair of the House Health Care Committee. He also previously served as Vice Chair of the House Appropriations Committee and Co-Chair of the Vermont Commission on Health Care Reform.

Susan Wehry, M.D., Commissioner of the Department of Disabilities, Aging, and Independent Living

Susan Wehry is Commissioner of the Department of Disabilities, Aging and Independent Living (DAIL). Wehry is a board-certified geriatric psychiatrist and advocate for seniors and persons with disabilities who has educated physicians, nurses, medical students, ombudsmen, policy makers and direct care workers from Alaska to Louisiana. She has

assisted the Centers for Medicare and Medicaid Services in the development of national web-casts on mental health needs and individualized care planning in nursing homes.

Paul Bengtson, CEO, Northeastern Vermont Regional Hospital

Paul Bengtson has been CEO of Northeastern Vermont Regional Hospital, located in one of the most rural areas of Vermont, since 1986. The hospital owns and manages several rural health clinics in Vermont's Northeast Kingdom and works closely with Northern Counties Health Care, a federally-qualified health center with a dominant presence in the area. Bengtson began his professional career in inner New York City, working in housing project health maintenance clinics. He also worked in large teaching hospitals in NYC in the 1970s. He is chair-elect of the American Hospital Association Governing Council for Small or Rural Hospitals and a member of the Green Mountain Care Board General Advisory Council.

Steve Voigt, Interim Executive Director of ReThink Health UCRV

Steve Voigt was President and CEO of King Arthur® Flour from 1999 to 2014. Hired in 1992 as Vice President of Finance, Steve became Chief Operating Officer in 1998. Prior to King Arthur Flour, Steve worked for Benedetto, Gartland & Greene in New York, where he raised private equity for venture, LBO and alternative asset funds. During his tenure there, Steve also supported his wife in founding, and later selling, Robin's Homemade Breads of Greenwich, CT. He also consulted out of Zurich, Switzerland and Cleveland for McKinsey & Company. Steve is a graduate of the Amos Tuck School of Business Administration at Dartmouth College, and Colgate University. Steve serves on the boards of Newport Harbor Corporation, Montshire Museum of Science, and Vermont Mutual Insurance Company. He has also been an active member of The ESOP Association serving on the Board of Governors from 2003-2009 and as its Chair and serves on Vermont's Governor's Business Advisory Council on Health Care Financing, the Vermont Health Care Innovation Project Core Team, and ReThink Health Upper Valley Initial Planning Team.

The Steering Committee

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

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

Work Groups

Six work groups will be established as part of the VHCIP Project. They are:

- Payment Models Work Group;
- Care Models and Care Management Work Group;
- Disability and Long Term Services and Supports Work Group;
- Health Information Exchange Work Group;
- Quality and Performance Measures Work Group; and
- Population Health Work Group.

In addition, the Agency of Administration established a Health Care Workforce Work Group through Executive Order; this work group leads workforce-related efforts under the grant.

Work groups have specific charters related to their scope of work and expected deliverables (see list of artifacts). Deliverables take the form of recommendations to the Steering Committee and Core Team. The general scope of each of the work groups is described below. Work groups are responsible not only for their own scope of work but, to a significant degree, for coordinating with other work groups to develop joint recommendations to the Steering Committee on cross-cutting issues related to care models, payment models, and quality measures.

The membership of the Steering Committee and co-chairs of the work groups are listed below.

State Innovation Model Project Leadership

Core team

Anya Rader Wallack, Ph.D., **Chair**

Paul Bengtson, CEO, Northeastern Vermont Regional Hospital

Harry Chen, Acting Secretary of Human Services

Al Gobeille, Chair of the Green Mountain Care Board

Mark Larson, Commissioner of the Department of Vermont Health Access

Robin Lunge, Director of Health Care Reform

Steve Voigt, Interim Executive Director of ReThink Health UCRV

Susan Wehry, M.D., Commissioner of the Department of Disabilities, Aging, and Independent Living

Steering Committee

Mark Larson, Commissioner, Department of Vermont Health Access **(co-chair)**

John Barbour, Executive Director, Champlain Valley Area Agency on Aging

Stephanie Beck, Director of Health Care Operations, Compliance, and Improvement, Agency of Human Services

Bob Bick, Director of Mental Health and Substance Abuse Services, Howard Center for Mental Health

Tracy Dolan, Acting Commissioner of the Department of Health

Peter Cobb, Director, Vermont Assembly of Home Health and Hospice Agencies

Elizabeth Cote, Area Health Education Centers Program

Susan Donegan, Commissioner of the Department of Financial Regulation

Paul Dupre, Commissioner of the Department of Mental Health

Nancy Eldridge, Cathedral Square and SASH Program

John Evans, President and CEO, Vermont Information Technology Leaders

Catherine Fulton, Executive Director, Vermont Program for Quality in Health Care

Don George, President and CEO, Blue Cross Blue Shield of Vermont

Bea Grause, President, Vermont Association of Hospital and Health Systems

Dale Hackett, Consumer Advocate

Paul Harrington, President, Vermont Medical Society

Debbie Ingram, Vermont Interfaith Action

Craig Jones, M.D., Director of the Vermont Blueprint for Health

Trinka Kerr, Health Care Ombudsman

Deborah Lisi-Baker, Disability Policy Expert

Bill Little, Vice President, MVP Health Care

Jackie Majoros, Long-term Care Ombudsman

Todd Moore, CEO, OneCare Vermont

Mary Val Palumbo, Associate Professor, University of Vermont

Ed Paquin, Disability Rights Vermont

Laura Pelosi, Vermont Health Care Association

Judy Peterson, Visiting Nurse Association of Chittenden and Grand Isle Counties (Invited)

Allan Ramsay, M.D., Member of the Green Mountain Care Board

Lori Real, Community Health Accountable Care, LLC.

Paul Reiss, M.D., Executive Director, Accountable Care Coalition of the Green Mountains

Simone Rueschemeyer, Director, Behavioral Health Network of Vermont

Howard Schapiro, M.D., Interim President of the University of Vermont Medical Group Practice

Julie Tessler, Executive Director, Vermont Council of Developmental and Mental Health Services

Barbara Walters, Chief Medical Director, OneCare Vermont

Sharon Winn, Director-Vermont Public Policy, Bi-State Primary Care

Ken Schatz, Interim Commissioner of the Department for Children and Families

Work Group Chairs

Payment Models

Don George, President and CEO, BCBSVT

Stephen Rauh, Health Policy Consultant and Member of GMCB Advisory Board

Care Models and Care Management

Bea Grause, President, Vermont Association of Hospitals and Health Systems

Nancy Eldridge, Executive Director, Cathedral Square and SASH Program

Health Information Exchange

Simone Rueschemeyer, Behavioral Health Network

Brian Otley, COO, Green Mountain Power

Disability and Long Term Services and Supports

Deborah Lisi-Baker, Disability Policy Expert

Judy Peterson, Visiting Nurse Association of Chittenden and Grand Isle Counties

Quality and Performance Measures

Catherine Fulton, Executive Director, Vermont Program for Quality in Health Care

Laura Pelosi, Vermont Health Care Association

Population Health Management

Tracy Dolan, Acting Commissioner of the Department of Health

Karen Hein, M.D., Adjunct Professor, Dept. of Family &Community Medicine, Geisel School of Medicine at Dartmouth

Workforce

Robin Lunge, Director of Health Care Reform, AOA

Mary Val Palumbo, Associate Professor, UVM

Work Group Charges

The charge to each of the work groups progress to date and their work plans for the coming year are described below:

Payment Models Work Group

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

- Continue to develop and recommend standards for the commercial shared savings ACO (SSP ACO) model;
- Continue to develop and recommend standards for the Medicaid SSP ACO model;
- Develop and recommend standards for both commercial and Medicaid episode of care models for use in conjunction with the SSP ACO model; and
- Develop and recommend standards, as appropriate, for Medicaid pay-for-performance models.

The group will recommend mechanisms for assuring consistency and coordination across all payment models.

Care Models and Care Management Work Group

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

- Launch learning collaboratives in three communities;
- Align Blueprint for Health and ACO care management activities; and
- Identify large-scale population-based care or health improvement models that might complement or integrate with the above.

The group will recommend mechanisms for assuring greater consistency and/or coordination across these programs and models in terms of service delivery, financial incentives, quality measurement, or other key model or program components. The goal will be to maximize effectiveness of the programs and models in improving Vermonters' experience of care, reducing unnecessary costs and improving health, and minimizing duplication of effort or inconsistencies between the models.

Disability and Long Term Services and Support Work Group

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

- Provide recommendation regarding provider payment models that encourage quality and efficiency among the array of primary care, acute and long-term services, and support providers who serve dually-eligible populations;

- Identify quality measures to be used to evaluate provider and overall project performance; and
- Provide recommendations for learning collaboratives that address the needs of those who are in need of long term services and supports.

Health Information Exchange Work Group

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

- Identify the desired characteristics and functions of a high-performing statewide information technology system;
- Explore and recommend technology solutions to achieve VHCIP's desired outcomes;
- Develop criteria for a telehealth pilot program and launch that program; and
- Guide investments in the expansion and integration of health information technology, as described in the SIM proposal, including:

    - support for enhancements to EHRs and other source data systems;
    - expansion of technology that supports integration of services and enhanced communication, including connectivity and data transmission from source systems such as mental health providers and long-term care providers;
    - implementation of and/or enhancements to data repositories; and
    - development of advanced analytics and reporting systems.

Quality and Performance Measures Work Group

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

- Evaluate the performance of Vermont's payment reform models relative to state objectives; and
- Provide recommendation about performance measures to be used within payment models as they are designed.

The overarching goal of quality and performance measurement is to focus health care reform and quality improvement efforts to control growth in health care costs, improve health care, and improve the health of Vermont's population.

Population Health Work Group

This group will examine current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs, and other provider and payer entities. The group will examine these initiatives and VHCIP initiatives for their potential impact on the health of

Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:

- Enhancement of state initiatives administered through the Department of Health;
- Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts; and
- Expansion of the scope of delivery models within the scope of VHCIP or pre-existing state initiatives to include population health.

Mechanisms to Coordinate Private and Public Efforts around Key Test Model Elements

Coordination of private and public sector efforts will be essential to the success of VHCIP. Figure 4 below was used at the first meeting of the steering committee to illustrate the importance of coordination across these sectors. The VHCIP will provide a forum for coordinating policy and resources to support development of the organizations, technology and financing necessary to achieve the shared public/private goals articulated in our State Health Care Innovation Plan: development of a high performance health care system for Vermont.

Figure 4. Coordination of policy and resources:

The Governor has made clear that he believes coordination is essential among public and private efforts to increase efficiency and quality in Vermont's health care system. A small and rural state must achieve economies of scale and other efficiencies to simultaneously provide the highest-quality care, improve health outcomes and meet the service needs of rural populations.

The primary mechanism for coordination of public and private efforts related to Vermont's testing models will be the State Innovation Model Governance Structure. The Core Team will provide overall project leadership and will have as one of its goals maximizing alignment between VHCIP activities and current and future private sector activity that is related to or in support of project goals. Through the Steering Committee, the Core Team will receive regular updates on private sector initiatives and guidance about how best to coordinate with project activities. In addition, each of the work groups will develop work products with an eye toward maximizing synergy between public and private sector activities

Additional coordination of private and public sector activities will occur through the regulatory authority of GMCB, which offers a clear nexus with hospital budgets, certificates of need, health insurer rates (including rates for plans offered through Vermont Health Connect) and benefit designs authorized for Vermont Health Connect. In general, Vermont Health Connect provides a very rare opportunity for unified policy approaches across a state's entire small group and individual health insurance marketplaces. Section G of this plan provides more information on the policy and regulatory levers available to support achievement of the goals of this project.

Finally, the state's effort to design and implement the shared savings ACO model includes a limited number of ACOs. Vermont does not have exclusive provider networks that are common in many other states. Most providers are not part of an exclusive network and serve commercial, Medicare, and Medicaid patients. We have no major private sector managed care presence in the state, for commercial or Medicaid business.

VHCIP is well-aligned with existing Legislative and Executive Authority. Act 48 of 2011 provided very broad responsibility and authority for the executive branch and the Green Mountain Care Board to implement health system innovation, including:

- Expansion of the pre-existing Blueprint for Health Program (the state's far-reaching advanced primary care medical home initiative);
- Expansion of the state's payment reform pilot activities;
- General authority for the GMCB to implement payment reform and all-payer payment methodologies;

- Creation of Vermont Health Connect as a single marketplace for Vermont's small and individual health insurance markets and a single "gateway" to health insurance for those markets and for Vermonters who are eligible for Medicaid coverage; and
- Consolidation and strengthening of regulatory processes relating to hospital budgets, major capital expenditures and health insurer rates under the GMCB.

Prior legislative action had given the Agency of Human Services and the Department of Vermont Health Access authority to implement the Blueprint and pursue a federal waiver for the initiative, as well as authority to pursue the state's "Global Commitment" and "Choices for Care" waivers under section 1115 of the Social Security Act. Also, the Legislature in 2011 gave general authority for the Agency to pursue the Dual Eligible Financial Alignment Demonstration Waiver, with appropriate report-back on developing specifics of the proposal.

Specific legislative action related to the SIM grant include approval of receipt of the grant after it was awarded through the Legislature's Joint Fiscal Committee and ongoing updates on project activities requested by the Legislature's Interim Health Care Oversight Committee.

Table 6. Key Individuals in State Innovation Model Project Leadership

Name	Organization	SIM/VHCIP Role
Anya Rader Wallack, Ph.D.	Agency of Administration/Governor's Office	Core team chair
Robin Lunge	Agency of Administration/Governor's Office	Core team member
Harry Chen, Acting Secretary	Agency of Human Services	Core team member
Mark Larson	Department of Vermont Health Access	Core team member
Al Gobeille	Green Mountain Care Board	Core team member
Steve Voigt	Interim Executive Director, ReThink Health	Core team member
Paul Bengtson	Northeastern Vermont Regional Hospital	Core team member
Susan Wehry, Commissioner	Department of Disabilities, Aging and Independent Living	Core team member
Georgia Maheras	Agency of Administration	Project Director
Paul Dupre, Commissioner	Department of Mental Health	Steering Committee Member
Tracy Dolan, Acting Commissioner	Department of Health	Steering Committee Member
Steve Schatz, Commissioner	Department for Children and Families	Steering Committee Member
Richard Slusky	Green Mountain Care Board	Director of Payment Reform
Kara Suter	Department of Vermont Health Access	Director of Payment Reform
Don George	CEO, Blue Cross Blue Shield of Vermont	Work Group co-chair

Stephen Rauh	Health policy consultant and member of the GMCB Advisory Committee	Work Group co-chair
Bea Grause	President, Vermont Association of Hospitals and Health Systems	Work Group co-chair
Nancy Eldridge	Cathedral Square and SASH Program	Work Group co-chair
Simone Rushemeyer	Behavioral Health Network	Work Group co-chair
Brian Otley	Green Mountain Power	Work Group co-chair
Deborah Lisi-Baker	Disability Policy Expert	Work Group co-chair
Judy Peterson	Visting Nursing Association of Chittenden and Grand Isle Counties	Work Group co-chair
Catherine Fulton	Vermont Program for Quality in Health Care	Work Group co-chair
Laura Pelosi	Vermont Health Care Association (Nursing Homes)	Work Group co-chair
Tracy Dolan	Interim Commissioner of Health	Work Group co-chair
Karen Hein, M.D.	Adjunct Professor, Dept of Family &Community Medicine, Geisel School of Medicine at Dartmouth	Work Group co-chair
Mary Val Palumbo	University of Vermont	Work Group co-chair

Key Artifacts:

Exhibit	Artifact	URL
144	Stakeholder Engagement Plan	
145	State Demonstration to Integrate Care for Dual Eligibles (Vermont Proposal)	https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/VermontProposal.pdf
69	Executive Order (DRAFT) Health Care Workforce	
88	Governor Shumlin's Health Care Press Releases	
	Legislation and Statutes	
32	Act 48	http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf
35	Act 171 (Section 33: Dual Eligible Project Proposal)	http://www.leg.state.vt.us/docs/2012/Acts/ACT171.pdf
35	Act 171 (Section 34: Global Commitment; Choices for Care; SCHIP)	
9	18 V.S.A. § 701 - 741 (Chapter 13: Chronic Care Infrastructure and Preventive Measures)	http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=18&Chapter=013
	Contracts and Budgets related to Governance and Management	
139	SIM Project Management RFP	http://gmcboard.vermont.gov/sites/gmcboard/files/SIM_PMO_RFP061413.pdf
140	SIM Project Management RFP Questions and Answers	http://gmcboard.vermont.gov/sites/gmcboard/files/SIM_PM_RFP_Questions.pdf
64	Contract - Bailit Health Purchasing (Payment Reform)	http://gmcboard.vermont.gov/sites/gmcboard/files/Bailit_23886.pdf
193	Pacific Health Policy Group (VBP)	healthcareinnovation.vermont.gov/sites/hcinnovation/files/PHPG_%2327087_Signed.pdf
194	Maximus Health Services, Inc.	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Maximus_Amendment_3_Signed.pdf
195	Bailit Health Purchasing LLC	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Bailit_Health_Amendment_2_Signed.pdf
196	Vermont Information Technology Leaders, Inc. Grant	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/VITL_SIM_Grant_Signed.pdf
197	VMSSP ACO Contract - Community Health Accountable Care, LLC	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/CHAC-Final.pdf

198	VMSSP ACO Contract - OneCare Vermont Accountable Care Organization, LLC	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/onecare-base-contract-signed.pdf
199	UMASS Contract	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/UMASS-Contract-%2325350.pdf
200	Burns and Associates	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/18211_Burns_Signed_Contract.pdf
201	Bi-State Primary Care Association	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/03410-1295-15_Bi-State_SIM%20Grant-Signed.pdf
202	Department of Aging and Independent Living	http://healthcareinnovation.vermont.gov/node/726#overlay-context=node/726
203	DataStat Inc	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/26412_DataStat-Signed.pdf
204	Health*first*, Inc	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/03410-1305-15_Healthfirst_Grant-signed.pdf
205	IMPAQ International, LLC	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27426_Impaq-signed.pdf
206	James Hester Jr.	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/26319_James_Hester_Jr._Contract-Signed.pdf
207	The Lewin Group, Inc	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27060_Lewin-%20signed.pdf
208	Deborah Lisi-Baker	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/26033_Lisi-Baker_Signed_Base.pdf
209	Northeastern Vermont Regional Hospital	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/03410-1300-15_.NVRH_.pdf
210	Policy Integrity	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/26294_Policy_Integrity-Signed.pdf
211	The Coaching Center of Vermont, Inc	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27383_The_Coaching_Center-Signed.pdf
212	Truven Health Analytics	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/26305_Truven_Health_Analytics-Signed.pdf
213	Vermont Medical Society Education and Research Foundation	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/03410-1315-15_VMS_Education-Signed.pdf
219	White River Family Practice	http://healthcareinnovation.vermont.gov/site

		s/hcinnovation/files/03410-1280-15_White_River-Signed.pdf
214	Behavioral Health Network of Vermont	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27379_BHN%20-%20Signed.pdf
215	Generating Community Driven Solutions	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27806_IM21-signed.pdf
216	Pacific Health Policy Group - DLTSS	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/26096_PHPG.pdf
217	University of Vermont	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27909_UVM-Signed%20Contract.pdf
218	HIS Professionals, LLC	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27511_H.I.S._Professionals-Signed.pdf

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

This section describes coordination between SIM and CMS/HHS/federal and other CMMI initiatives.

Question 5. Has the state coordinated SIM with:

- **1115(a) Medicaid Demonstrations;**
- **Medicaid-led transformation efforts, such as Health Homes, ACOs, and Patient Centered Medical Homes;**
- **Comprehensive Primary Care initiative;**
- **Duals integration;**
- **Medicare Advanced Primary Care;**
- **Initiatives from related agencies like CDC, HRSA and AHRQ?**

Question 6. Has the state determined how it will coordinate SIM with regional and local initiatives?

Vermont has underway a number of separate initiatives aimed at improving service delivery, testing new payment methodologies and expanding health information technology. Our goal under our SIM project—called the Vermont Health Care Innovation Project (VHCIP)—is to put in place an overarching framework and coordinated program of health care delivery models, payment structures and information technology that maximize system improvement and minimize duplication of effort or funding. Vermont's history of proactive involvement in federally-supported health reform on multiple fronts is a strength upon which we can build, rather than a problem to solve. The SIM grant provides a much-needed coordinating initiative to allow the design and implementation of our initiatives to proceed under an aligned model. Section A described how we would achieve that coordination, in the sense of describing a project governance and management structure that represents the people and groups affected by project activities and engaged in carrying them out, as well as leadership of related efforts outside of the grant. This section describes how we will utilize that decision-making structure to achieve coordination across separate initiatives.

Pre-existing initiatives that have been authorized by CMS include:

- Vermont's 1115 "Global Commitment" Medicaid waiver, under which the state's Agency of Human Services contracts with the Department of Vermont Health Access to function as a managed care entity on behalf of all Medicaid enrollees in the state. The state and CMS currently are negotiating a renewal of this waiver.
- Vermont's Multi-payer Advanced Primary Care Practice Demonstration Project (the Blueprint for Health or Blueprint), which has assisted 113 primary care practices serving approximately 483,000 Vermonters (of a total population of about 625,000) in meeting NCQA Patient Centered Medical Home standards, developed a statewide network of community health teams and practice facilitators, and developed a clinical data repository to support practice management and improvement. The Blueprint is the foundation of Vermont's health reform efforts and has made models planned under VHCIP more feasible. Given their efforts and expertise, Blueprint staff are involved in all work groups and on the Steering Committee to ensure coordination and leveraging of infrastructure and resources.
- Creation of two approved Medicare Accountable Care Organizations that are participating in the Shared Savings ACO program (OneCare Vermont and Accountable Care Coalition of the Green Mountains), as well as participation of Dartmouth-Hitchcock in the Pioneer ACO Model.
- Vermont's Choices for Care Medicaid Waiver, which provides flexibility to the state to shift long-term care spending toward home and community-based services.
- The Support and Services at Home (SASH) Project, which provides health care coordination and other support services, in coordination with Blueprint practices, for high-need individuals in public housing.
- The Bundled Payments for Care Improvement (BPCI) Program, under which providers from eight organizations in the Rutland area are coordinating care for congestive heart failure patients.
- State and federal investments in Vermont's health information infrastructure and "Learning Health System."
- CDC-supported initiatives, including the Community Transformation grant, which uses the Support and Services at Home (SASH) infrastructure developed as part of the Blueprint to support residents of housing communities with hypertension management and tobacco cessation. Several learning collaboratives described in Section M (Cancer Screening, Asthma Care, and MDRO/HAI Prevention) have been partially supported by CDC funding. CDC's support of Vermont's Behavior Risk Factor Surveillance Survey provides ongoing data on population health measures, including many of the measure recommended by CMMI for SIM evaluation.

The existence of such a broad range of programs illustrates Vermont's proactive stance on health care reform and the high level of interest from a variety of organizations in pursuing similar goals. Despite many of these efforts having similar goals, there is a clear potential for misalignment across these multiple initiatives, and for conflict between the rules governing the programs at the state and/or federal levels. Under the VHCIP, we have the opportunity to instead create alignment and coordination across our efforts and have designed the VHCIP governance and management model described in section A to fill a distinct need in Vermont for an identified structure that will achieve alignment. We will use the VHCIP governance and management structures described above to reach agreement on two general subjects:

- Core project components that should align and provide consistent incentives and operational models for health care providers, including:
    - Payment models and population attribution methodologies;
    - Quality and performance measures for both reporting and payment models;
    - Care models designed to support individuals and populations in health improvement, disease management and service coordination;
    - Population health improvement activities that address underlying factors affecting population health; and
    - Infrastructure investments in health information exchange, population-based analytics and new or transformed operational processes in the public and private sectors.
- Areas in which the federal or state rules governing the initiatives may be in conflict, and therefore state or federal policy change or flexibility may be necessary for the models to align.

Specifically, we will use the project governance structure described in section A to assure that decision-making by the VHCIP Steering Committee and VHCIP Core Team reflect awareness of potential conflict between initiatives, and reflect an effort to align policy and practice. In addition, the VHCIP work groups will have as a specific charge aligning their content areas with other work groups addressing the same substantive areas.

Coordination of VHCIP Activities with CDC and AHRQ Initiatives in Vermont

There are numerous CDC-supported initiatives in Vermont that coincide with the VHCIP Operational Plan. These initiatives fall into the areas of care transformation and quality improvement, and population health measures.

CDC grants for Community Transformation, Cancer Screening, Asthma Care, and Multi-Drug Resistant Organism/Healthcare Acquired Infection Prevention are all examples of care

transformation and quality improvement initiatives that will support the payment and delivery system reforms envisioned by Vermont's VHCIP Plan.

The Community Transformation work uses the Support and Services at Home (SASH) infrastructure developed as part of the Blueprint for Health to focus on hypertension management and tobacco cessation. SASH provides residents of housing communities with self-monitoring tools, self-management programs, support in developing self-management plans, and access to health screening.

As described in Section M of this Operational Plan, Vermont has implemented learning collaboratives for Cancer Screening, Asthma Care, and MDRO/HAI Prevention in order to improve care and ensure the adoption of best practices. All of these efforts have been partially supported by CDC funding.

The majority of the data collection systems in Vermont to track trends in population health contributors and outcomes are funded through various cooperative agreements with CDC. CDC's investments through the National Public Health Improvement Project supported the creation of the Healthy Vermonters' 2020 Tool Kit the Health Department's Performance Dashboard that is built on the concepts of *Results Based Accountability*™ and displays current information on:

Population Indicators (such as smoking prevalence) are measures for which the Health Department, with state government and community partners, shares responsibility for making change. All Healthy Vermonters 2020 indicators are displayed. The *Maps & Trends* section of the tool kit provides links to maps, tables and graphs for all Healthy Vermonters 2020 indicators and goals at the local level: by county, by district office area, and by hospital service area (HSA).

Performance Measures (such as the percentage of smokers registered with the Vermont Quit Network), are measures for which our programs are responsible for the performance of interventions—the things that, over time, will improve health—as reflected in the population indicators (such as reduced smoking prevalence). (http://healthvermont.gov/hv2020/index.aspx).

CDC's support of Vermont's Behavior Risk Factor Surveillance Survey and the other surveys and surveillance systems enables Vermont to collect, analyze and report the population health measures in the Healthy Vermonters Toolkit, which includes many of the measures recommended by CMMI for SIM evaluation overall. Additionally, some of these measures are also being used to evaluate ACO Performance Management and Quality Improvement.

We have established on-going technical assistance phone calls with CDC and provided a list of priorities to support the full integration of population health and primary prevention within the models being tested in Vermont. The key questions for exploration include:

- How do we use data on health trends and burden of illness to identify priorities?
- How do we ensure that the innovations tested focus on health outcomes for the whole population?
- How do we address the social determinants and environmental factors known to be major contributors to health outcomes?
- How can the innovations be designed to include sustainable funding for primary prevention and wellness?
- How do we build upon efforts with a broad set of community partners engaged in integrating clinical service delivery with population prevention activities?
- How do we include measures that matter; measure of accountability in the system design and its implementation for improved population health?

Question 6. Has the State determined how it will coordinate SIM with regional and local initiatives?

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

To ensure coordination with both state and local public health initiatives, a Population Health Work Group has been convened under VHCIP (see Section A). The forum will ensure coordination and identification of gaps in public health initiatives ongoing in the state, as well as to ensure that a population health focus is maintained throughout the project. There is similarly a Workforce Work Group charged with coordination activities at both a state and local level. These work groups have membership that represents a diverse array of stakeholders working at various levels across the state.

The Blueprint is implemented regionally in Vermont, in each of 14 health services areas. As described previously in this section, there is strong coordination in between VHCIP activities and the Blueprint; Blueprint representatives are included on VHCIP work groups, and many VHCIP activities are based on the Blueprint's foundation of patient centered medical homes and regional community health teams.

The Blueprint and local organizations offer self-management programs, including programs for people with diabetes, chronic illness, pain, mental illness and tobacco independence. Two of Vermont's VHCIP sub-grant awardees are focusing on enhancing these existing self-management programs. As appropriate, VHCIP activities relevant to self-management will coordinate with this already-existing infrastructure.

The learning collaborative described in Section M will support the care transformation that is essential for VHCIP success. Additional learning collaboratives will be supported by VHCIP in years two and three and input from work groups will be used to identify areas with quality gaps.

All of Vermont's hospitals are not-for-profit organizations; they have conducted local needs assessments and offer a variety of health care programs in their communities. The needs assessments are already being used by regional community health teams to identify gaps in services and by the GMCB to gauge hospital investments in community health improvement. Hospitals are well-represented on all VHCIP work groups, including the Population Health Work Group, providing opportunities for further use of the needs assessments and coordination with hospital-sponsored health care programs.

Question 7. Has the State fully-integrated or aligned its planned transformation with existing SPA and waiver authorities?

1115(a) Medicaid Waiver and the Choices for Care (CFC) Waiver

Vermont has submitted its application for renewal of its 1115(a) waiver and has proposed consolidating its CFC Waiver—its long term services and supports waiver—and its CHIP populations to fall all under the new 1115(a) waiver. Discussions have begun and while not a specific work group under the SIM grant, there is significant overlap with staff from the work groups, Steering Committee and the Core Team to ensure that decisions and standards made with regard to the waiver are communicated and incorporated into all VHCIP work related to Medicaid. See the appendix for artifacts related to Vermont's Medicaid waivers.

Question 8. Not relevant to Vermont's initiative.

Key Artifacts:

Exhibit	Artifact	URL
71	Global Commitment to Health Section 1115 Demonstration	
73	Global Commitment Waiver Evaluation Plan	
72	Global Commitment to Health Section 1115(a) Demonstration Waiver Extension Request	
163	Vermont Health Care Associated Infection Prevention Plan	http://www.cdc.gov/HAI/pdfs/stateplans/vt.pdf
228	Vermont Blueprint for Health: Working Together for Better Care	http://www.innovations.ahrq.gov/webevents/index.aspx?id=44

Section G Model Intervention, Implementation and Delivery

Policy and Regulatory Levers

Vermont can bring to bear a number of policy and regulatory levers to implement our innovation model and translate project learning into effective state policy after the life of the project. The innovation model we have proposed has three main areas of focus:

- Care models;
- Payment models; and
- Health information technology.

In each area of focus, the state has some authority to set policy. However, as noted in section A, we are placing a major emphasis under this project on including others, outside of government, in further development of policy. That approach has already been in evidence as the state has developed the Blueprint for Health and as the Green Mountain Care Board (GMCB) has implemented its responsibilities under Act 48.

The major policy and regulatory levers at the state's disposal include:

- Requirements for participation in the Blueprint for Health;
- Medicaid contracting requirements;
- Requirements of commercial health insurance carriers;
- Active solicitation for insurance products offered through Vermont Health Connect through a competitive bid process;
- Health insurer rate review;
- Requirements for payment reform pilot projects authorized by the GMCB;
- Requirements imposed through the hospital budgeting process, in which the GMCB sets the rate of increase in hospital net patient revenues annually, and also reviews hospital investments in innovation;
- Requirements for certificates of need for major health care capital expenditures;
- GMCB authority to establish all-payer rates;
- Requirements articulated in the state's Health Information Technology plan;
- Management of the state's HIT fund;

- Requirements articulated in the state's health care workforce plan;
- Provider licensing requirements administered through the Secretary of State's Office;
- Department of Health support for public health activities; and
- Specifications for the management contracts for the State Employees' health insurance program.

Through this project, we bring these levers to bear to encourage and accelerate project activities, and to align state policy across agencies. We also use the project as a forum for developing consensus among stakeholders, policy makers and regulators about how the policy and regulatory levers should best be used in the future to support a sustained high performance health system. Currently, the executive branch utilizes a Health Care Leadership Team, which meets every month, and a Health Care Cabinet, which meets quarterly, to coordinate policy across agencies and departments. There are numerous examples of departments coordinating across their jurisdictions, including:

- The Department of Financial Regulation (DFR) used its authority to convince one non-participating commercial insurer to begin participating in GMCB payment reform pilots;
- DFR, the Department of Vermont Health Access (DVHA), the GMCB and other relevant agencies have begun a full-scale review of the state's regulations for health care quality as it pertains to managed care entities, hospitals, insurers, and providers with the goal simplifying and aligning quality measurement; and
- The GMCB, DFR, DVHA and other departments have collaborated to operationalize regular data feeds to the state's all-payer claims dataset and have worked cooperatively on data analysis, evaluation and forecasting models, particularly across the Blueprint for Health (Vermont's Advanced Primary Care Medical Home Model, also referred to as the Blueprint) and the GMCB.

All of the above-described policy and regulatory activity is well-grounded in legislative authority. Act 48 of 2011 established a broad legislative mandate to pursue health delivery system transformation in Vermont through a variety of policy levers. This built on previous legislative action to establish and diffuse the Blueprint. Act 48 expanded the scope of payment reform efforts, but also established the GMCB and gave it the explicit responsibility for using policy levers to affect the policy goals of improved patient experience of care, improved population health and reduced per capita costs. Act 48 also established the position of Director of Health Care Reform in the Agency of Administration to oversee health reform efforts within the Executive Branch and to act as a liaison between the Governor's Office and the GMCB. In addition, the Director acts as the Governor's health policy advisor to ensure that health reform activities are closely monitored by the Governor.

Act 171 of 2012 further articulated the legislative intent to support health care system change. The law transferred additional regulatory functions to the GMCB, and made clear the state's approach to regulating the individual and small group insurance market, including providing for Vermont's individual and small-group markets purchasing exclusively through Vermont Health Connect beginning in 2014.

The legislature took additional action during the 2013 session through Act 79 to streamline the health insurer rate review process and to more closely link the state's all-payer claims dataset with regulatory and policy levers (by transferring responsibility for management of the dataset to the GMCB). Act 79 of the Acts of 2013 also improved the data collected by the Secretary of State, the Office of Professional Regulation, the Board of Medical Practice, and other bodies regulating scope of practice to improve Vermont's ability to plan for existing and new types of health care professionals needed in our workforce.

In addition, the entire executive branch is guided by the Health Reform Strategic Plan promulgated in 2012.

Incorporation of Policy Levers in SIM Initiative

We have incorporated within the VHCIP Governance Structure the leaders of all major departments possessing policy-making and regulatory powers related to health care system change. In doing so, we have aimed to ensure that the VHCIP is well-understood by the entire executive branch health-related leadership, and the results of policy development, consensus building, problem identification, and conflict resolution can effectively incorporated in the policy and practices of state departments.

Alignment of Policy Positions and Planned Action with Federal Positions

Vermont's current policy positions and planned actions are well-aligned with federal positions related payment and delivery system reform, particularly those of the Centers for Medicare and Medicaid Innovation. Vermont's Medicaid waiver, the Blueprint, our development of an all-payer claims dataset, our development of a health information exchange and, more recently, passage of Act 48 all are examples of how the state has for decades been committed to positive health system change consistent with the best thinking at the federal level, as well as to the innovative approaches promoted by CMS. The multitude of federally-supported innovation initiatives described in section B demonstrates our intent to pursue innovation in health care payment and delivery on numerous fronts. Act 48 and the state's health reform strategic plan make clear that these activities are part of a larger state strategy aimed at coordinated, statewide, public/private health system innovation.

Question 18. Has the state identified and engaged payers and providers with formal mechanisms (e.g. implementation work groups, stakeholder meetings, public comment processes) for communication, input, and shared decision making?

Question 19. Has the state implemented an engagement plan with mechanisms that engage a wide range of governmental stakeholders?

Question 20. Has the state implemented an engagement plan with mechanisms that engage a wide range of community/patient stakeholders?

Vermont has identified and engaged payers and providers with formal mechanisms for communication, input, and shared decision making. Vermont's governance structure, described in section A of this Operational Plan, shows the state's commitment to formal shared decision-making. Sections C and H of the Operational Plan describe stakeholder involvement in more detail.

Vermont has implemented a matrixed staffing approach to maximize efficiency in the VHCIP. Staff from the GMCB, Department of Health, DVHA, Department of Disabilities, Aging and Independent Living, Department of Mental Health, and the Agency of Administration work on VHCIP-related activities. These entities are represented on VHCIP committees and work groups in the Project's governance. The matrixed staffing structure is described in more detail in Section K of this Operational Plan.

Vermont has implemented an engagement plan with mechanisms that engage a wide range of community/patient stakeholders. Vermont's engagement plan is described in detail in Sections C and H of this Operational Plan and in the Stakeholder Engagement Plan submitted to CMMI in May, 2013.

Question 21: Has the state initiated implementation activities around public health integration?

As described in section A, the state has formed a VHCIP Population Health Work Group to address population health and public health integration. The original charge to the group was examining current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities. The group will examine these initiatives and SIM initiatives for their potential impact on the health of

Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:

- Enhancement of state initiatives administered through the Department of Health;
- Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts; and
- Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health.

The Population Health Work Group has met monthly since October 2013. The group is focused on three areas of work:

- Developing consensus on population health measures to be used in tracking the outcomes of the VHCIP and to be incorporated in the new payment models;
- Drafting recommendations on how to pay for population health and prevention through modifications to proposed health reform payment mechanisms, and identification of promising new financing vehicles that promote financial investment in population health interventions; and
- Identifying current initiatives where clinical and population health are coming together and the opportunities to enhance new health delivery system models, such as the Blueprint for Health and Accountable Care Organizations (ACOs), to improve population health by better integration of clinical services, public health programs and community based services at both the practice and the community levels.

The Population Health Work Group has committed to exploring the concept of an Accountable Care Community (ACC, also known as the Accountable Health Community or AHC) as a potential model. The Population Health Work Group is currently studying national and local exemplars to develop an understanding of the core features. Next, the work group hopes to support a pilot where healthcare community and public health partners in one region of the state would select priorities for addressing risk factors for chronic illness (e.g., obesity, tobacco use). Development of this model will be coordinated with the Care Models and Care Management Work Group to assure alignment across efforts.

The cumulative result of all three areas of work will be the state's population health plan, entitled: "Plan for Integrating Population Health and Prevention in Health Care Innovation in Vermont." The draft outline of this plan, artifact 254, identifies the work to be carried out the project in greater detail.

Additionally, the group may provide recommendations to the Commissioner of Health and the GMCB on how to expand the state's current health care expenditure analysis (under the purview of the GMCB) to include categories of spending that may have a demonstrated impact on population health but are not currently included in the analysis, as well as on how to align dashboard indicators and outcome measures between the GMCB and Department of Health.

Key Artifacts:

Exhibit	Artifact	URL
119	Payment Reform Models Overview (Status of Payment Models)	
110	National Governors' Association Technical Assistance Meeting Materials	
69	Executive Order (DRAFT) Health Care Workforce	
81	GMCB Hospital Budget Guidance FY14-16	http://gmcboard.vermont.gov/sites/gmcboard/files/Hospital_Budget_Guidance_FY14-16.pdf
	Contracts proposed or in force	
64	Contract - Bailit Health Purchasing (Payment Reform)	http://gmcboard.vermont.gov/sites/gmcboard/files/Bailit_23886.pdf
65	Contract - Burns and Associates	
	Secretary of State OPR statutes/rules	
112	Office of Professional Regulation Administrative Rules	http://www.vtprofessionals.org/opr1/opr/admnrule.pdf
1	3 V.S.A. § 121-131 (Office of Professional Regulation)	http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=03&Chapter=005
	IRS requirements for community needs assessments	
82	GMCB Hospital Budget Policy - Community Needs Assessments	http://gmcboard.vermont.gov/sites/gmcboard/files/HBP_ComHNAssesmt.pdf
100	IRS Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals	http://www.irs.gov/pub/irs-drop/n-11-52.pdf
99	IRS Form 990 Schedule H Instructions	http://www.irs.gov/pub/irs-pdf/i990sh.pdf
101	IRS Notice of Proposed Rulemaking - Community Health Assessments for Charitable Hospitals	

	Statutes	
15	18 V.S.A. § 9371 - 9392 (Chapter 221: Green Mountain Care Board)	http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=18&Chapter=220
9	18 V.S.A. § 701 - 741 (Chapter 13: Chronic Care Infrastructure and Preventive Measures)	http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=18&Chapter=013
24	33 V.S.A. § 401, 402 (Chapter 4: Department of Vermont Health Access)	http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=33&Chapter=004
2	3 VSA 2222a – Health care system reform; improving quality and affordability	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=03&Chapter=045&Section=02222a
	18 V.S.A. § 722. Pilot projects	Contained in 18 V.S.A. § 701 - 741 (Chapter 13)
16	18 V.S.A. § 9377. Payment reform; pilots	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=220&Section=09377
	18 V.S.A. § 706. Health insurer participation	Contained in 18 V.S.A. § 701 - 741 (Chapter 13)
7	18 V.S.A. § 1 - 11 (Chapter 1: Department of Health; General Provisions	http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=18&Chapter=001
	Press Releases	
86	GMCB Press Release - Vermont Oncology Pilot	
85	GMCB Press Release - RWJF Support for Payment Reform	
88	Governor Shumlin's Health Care Press Releases	
133	**SIM Application Letters of Support from payers and providers**	
	Behavioral Health Network of Vermont	
	Bi-State Primary Care Association	
	BlueCross BlueShield of Vermont	
	Brendan N. Buckley, MD	
	Dartmouth-Hitchcock Medical Center	
	Fletcher Allen Health Care	
	Healthfirst, Inc	
	MVP Health Care	
	Northeastern Vermont Regional Hospital	
	The Gathering Place	
	Vermont Assembly of Home Health and Hospice Agencies	

	Vermont Association of Area Agencies on Aging
	Vermont Association of Hospitals and Health Systems
	Vermont Council of Developmental and Mental Health Services, Inc.
	Vermont Federation of Nurses and Health Professionals
	Vermont Medical Society
	Year 2 Updated Artifacts
254	Population Health Plan Draft

Section I Quality, Financial and Health Goals and Performance Measurement Plan

This section of the Operational Plan is intended to provide information about the state's self-evaluation; endorsed performance measures; alignment across payers for the endorsed performance measures; and consumer, provider, and payer buy-in during the process of selecting measures. It is also intended to provide a plan for quality performance target-setting, with a schedule for routinely assessing performance against targets and benchmarks.

Question 24. Has the state defined a common set of performance measures, consistent with endorsed measures (e.g. NQF, Meaningful Use, CMMI Core measure set), including quality, patient satisfaction, financial and health outcomes, aligned with existing quality initiatives?

Vermont has several payment and delivery system reform initiatives that are either in place or proposed. These initiatives fall under the categories of Accountable Care Organization Shared Savings Programs (ACO SSPs), pay for performance models, episode of care payment models, broader value-based payment system reform, and advanced primary care delivery system reform that incorporates pay for performance and other payment reform. These initiatives are in varying stages of research, planning and implementation. For each model, the maturity of performance measure development is dependent on the stage of implementation, but the process of identifying common measure sets is essentially the same for all models. The Quality and Performance Measures Work Group undergoes a thorough measure review process, with opportunities for stakeholder input built into every step. As an example, this robust process occurred from January 2013 until December 2013 to create the Year 1 (Calendar Year 2014) Medicaid and commercial insurer ACO SSP measure set. The Year 2 (Calendar Year 2015) ACO SSP measure set discussion began in March 2014 and concluded in October 2014.

The measure development process involves:

- Convening work groups of interested stakeholders, including representatives of providers, consumers and payers;

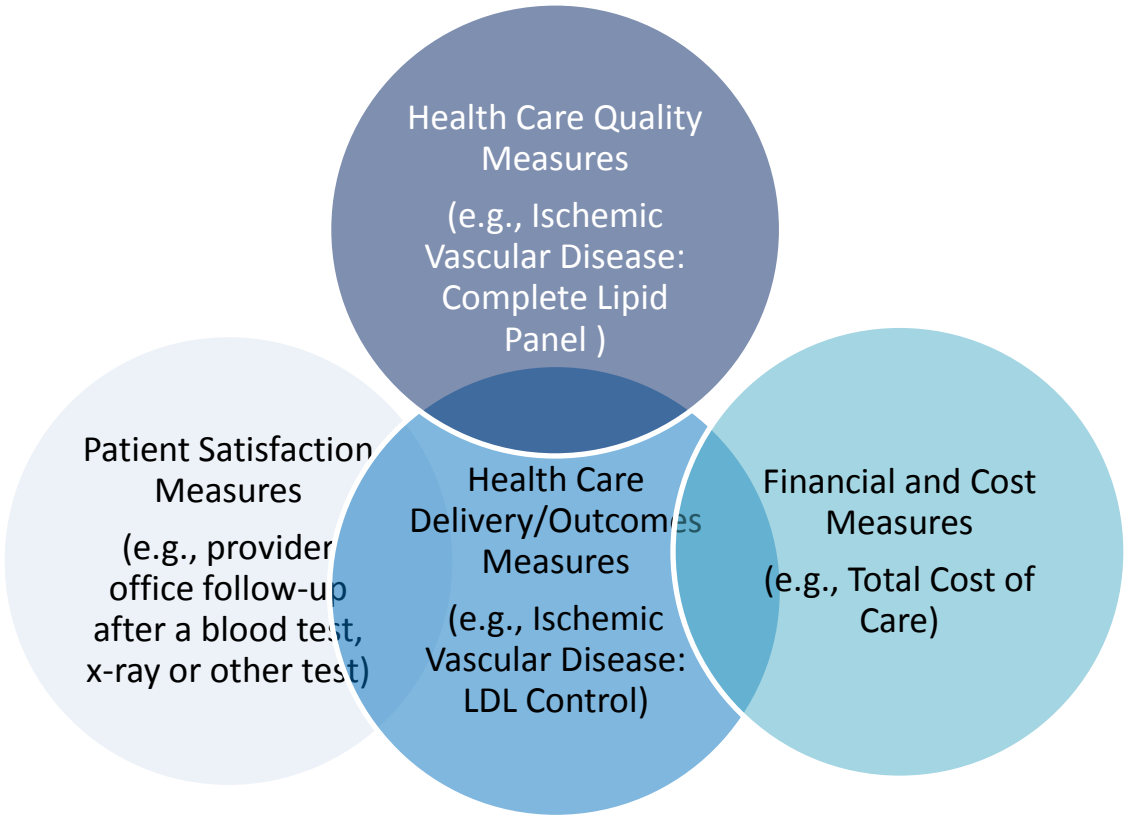
- Establishing measure criteria with stakeholders;
- Identifying potential measures with stakeholders, with a particular focus on measures that are endorsed and part of other measure sets (e.g. – NQF endorsed, CMMI Core Measure Set, meaningful use measures, HEDIS® or CAHPS® measures, measure sets in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

The most mature measure sets are currently found in the Commercial and Medicaid ACO SSPs and the Vermont Blueprint model. The Year 1 and Year 2 Commercial and Medicaid ACO SSP measures are found in the revised Excel Workbook containing Outcome Measures Selected, artifact X.

The Green Mountain Care Board's (GMCB) application process for Vermont payment and delivery system reform pilot proposals requires applicants to indicate how they will measure outcomes related to each pilot goal. As a GMCB pilot, the Northeastern Vermont Regional Hospital Oncology project has lists of proposed measures. Those measures can be found in the artifact entitled "Northeastern Vermont Oncology Pilot Proposed Measure Set".

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

Figure 5. Quality Measures by Domain



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

- Model evaluation (e.g., using measures related to cost, utilization, health outcomes or experience of care to evaluate whether payment and delivery system reform models are reducing growth in health care costs, improving health, and improving care);
- Payment reform (e.g., using results of measures on adolescent well care visits, chlamydia screening in women, avoidance of antibiotic treatment for adults with acute bronchitis, initiation and engagement of alcohol and other drug treatment, developmental screening, and follow-up after hospitalization for mental illness to determine whether commercial ACOs qualify for shared savings programs);
- Reporting (e.g., using ACO-level quality measures, such as tobacco use assessment and cessation intervention, influenza vaccination, all-cause readmissions, screening for diabetics, ambulatory care sensitive admissions, screening for depression, and adult weight screening and follow-up to assess ACO impact);

- Monitoring (e.g., using health plan or statewide quality indicators and ACO-level utilization indicators to monitor how the system and ACOs are performing);
- Quality improvement (e.g., in Vermont's asthma learning collaborative, using practice-level results on measures related to "assessment of severity," "assessment of control" and "asthma action plans completed" to design interventions to improve asthma care; in Vermont's office-based opioid treatment learning collaborative, using practice-level results on measures related to "unstable patients seen weekly," "documentation of opioid dependence," "accessed Vermont prescription monitoring services" and "outside care coordination" to design interventions to improve office-based treatment); and
- Provision of real-time clinical information to participating providers to improve patient care and drive delivery system transformation (e.g., using practice-level information from the Blueprint's DocSite clinical registry or reports on key hospital quality indicators from ACOs to identify patients in need of evidence-based services or to change hospital processes).

Question 25. Has state ensured that all payers are aligned across endorsed performance measures, including quality, patient satisfaction, financial and health outcomes (as well as with MSSP and CMMI recommended measures)?

Question 26. Was there provider, consumer and payer buy-in during process of selecting SIM performance measures?

There are three major mechanisms that Vermont uses to ensure that all payers are aligned across endorsed performance measures, and that there is provider, consumer and payer buy-in during the process of selecting SIM performance measures:

- Forming VHCIP payment and delivery system reform work groups that include the major payers in the state, provider representatives, and consumer representatives;
- Including payer and provider representatives in Blueprint advisory groups and individual Blueprint-payer meetings; and
- Including payers in an ACO Operations Group that works to ensure smooth implementation of the ACO SSPs. In addition to making refinements to operational details, this group strengthens the provider-insurer relationships that can serve as a basis for future payment and delivery system reforms.

Work Group Processes

Provider, consumer, and payer representatives on the Quality and Performance Measures Work Group reviewed and commented on measurement. The Payment Models, Population Health, and DLTSS Work Groups also provided comment on proposed measures.

To date, the Quality and Performance Measures Work Group has focused on developing, recommending and aligning performance measures in the Commercial and Medicaid ACO SSP model. Measure categories for the ACO SSP program include:

- Payment Measures: How the ACOs perform on these measures will impact the amount of shared savings they receive?
- Reporting Measures: ACOs are required to report on these measures (at the ACO level), but how they perform will not impact the amount of shared savings they receive?
- Monitoring and Evaluation Measures: These include quality indicators that are monitored at the health plan or statewide level, key utilization measures monitored at the ACO level, and statewide indicators reflecting social determinants of health?

Payers participating in the Quality and Performance Measures Work Group include Medicaid, Blue Cross Blue Shield of Vermont, and MVP Health Care. Their feedback has been critical in aligning proposed measures with other initiatives (including suggested CMMI and MSSP measures), clarifying measure specifications and potential data sources, and understanding federal, state, and accreditation requirements of payers.

Blueprint Advisory Groups and Insurer Meetings

Another example of alignment in performance measures is through the Vermont Blueprint for Health (the Blueprint), which includes payer and provider representatives on the Executive Committee, Payment Implementation Work Group, Expansion Design and Evaluation Work Group, and Analytic Work Group. The Blueprint also holds individual meetings with each of the major payers to present evaluation data, obtain feedback on program design and operations, and discuss future direction for the program. In these venues, the various stakeholders have opportunities to provide feedback on measure sets, as well as other aspects of model implementation. There are also strong efforts underway to align the Blueprint's measurement activities with the ACO SSP measures; in particular, the intent is for the next round of Blueprint practice and health service area profiles to include additional ACO measures, in order to emphasize the importance of those measures.

Question 27. Is there a formal plan in place for quality performance target-setting with a schedule for routinely assessing current performance against targets/benchmarks?

During Year 1, the Quality and Performance Measures Work Group recommended a Gate and Ladder methodology for the adopted ACO SSP Payment Measures, with targets and benchmarks, to assess ACO performance. In conjunction with the recently-procured ACO Analytics contractor, there will now be routine assessment of ACO performance on these Payment Measures, as well as the Reporting and Monitoring and Evaluation measures. It is important to note that Vermont's three ACOs are collaborating and investing significant resources to develop capacity to report on measures that rely on clinical data. In addition, VHCIP funds have been dedicated to enhance the ability to report those measures electronically. The VHCIP Evaluation Services contractor that was recently procured is developing an evaluation plan that will assist in developing performance measures, benchmarks, and an evaluation process for the ACO SSP and other payment reforms while also providing overall evaluation of the SIM grant.

The following Performance Measurement Plan shows activities that have already been implemented for the ACO shared savings payment reform project, as well as activities that need to be initiated.

Table 7. Performance Measurement Plan

Operational Area and Objectives	Implementation Action Items	Start Date	End Date	Responsible Parties	Milestones	Status
Performance Measures: Define common sets of performance measures	Convene work group, establish measure criteria, identify potential measures, crosswalk against existing measure sets, evaluate against criteria, identify data sources, determine how each measure will be used, seek input from CMMI and Vermont independent evaluation contractors, finalize measure set, identify benchmarks and performance targets, determine reporting requirements, revisit measure set on regular basis	1-1-13	Ongoing	GMCB Payment Reform Team, Work Group	Monthly meetings measure criteria, list of potential measures, measure crosswalk, feedback from CMMI contractor, final measure set, benchmarks and performance targets, reporting specifications and schedule, schedule for measure review	Work group is meeting regularly. Year 1 SSP measure set, benchmarks and targets completed during Q4 of calendar year 2013. Year 2 SSP measure set has been recommended and will be completed during Q4 of 2014; benchmarks and targets for Year 2 will be completed by Q1 of 2015.
Performance Measures: Ensure payer alignment across endorsed measures	Include formal payer approval in performance measures work group	1-1-13	Ongoing	GMCB Payment Reform Team, Work Group	Process for payer approval	Payers currently included in consensus process in performance measures work group

Performance Measures: Ensure provider, consumer and payer buy-in during measure selection	Seek ideas for enhancing consumer input mechanisms, seek ideas for enhancing provider input mechanisms	9-1-13	Ongoing	GMCB Payment Reform Team, Work Group	Identification of additional mechanisms for obtaining provider and consumer representation, input and buy-in	Consumer and provider representatives currently included in performance measures work group; SIM and GMCB have incorporated public processes for measure review and other aspects of payment reform; ACOs are developing consumer advisory boards and appointing consumers to their governing bodies
Performance Measures: Establish plan for target-setting with schedule for routine assessment	Build target-setting into performance measures work group and routine assessment into reporting requirements, develop analytic framework for routine assessment, create analytic reports	9-1-13	Ongoing	GMCB Payment Reform Team, Work Group, Analytics Contractor	Establish target-setting process, routine assessment process, and analytic framework and reports	ACO Analytics Contractor has been procured and timeline for assessing ACO performance has been developed. Similar processes will be part of ongoing measure development for other payment reform initiatives

Future Work Related to Performance Measurement

In addition to ongoing development of measure sets for the ACO SSP, there will be increasing focus on performance monitoring and evaluation as Year 1 ACO SSP performance data becomes available in mid-2015. The Quality and Performance Measures Work Group will have an opportunity to review and assess these performance measurement results. This data also could be used to inform the design of a broader, value-based payment system.

To aid in designing additional payment reforms, the Quality and Performance Measures Work Group may be asked to help:

- Develop metrics for broad-based Episode of Care (EOC) and other Pay for Performance models, for incorporation into provider data and analytic supports (e.g., practice profiles, learning collaboratives), benchmarking pricing and performance, and developing physician compensation models and/or performance tracking;
- Consolidate core performance measures to align care delivery transformation priorities and support a statewide value-based purchasing system for Green Mountain Care (GMC); and
- Integrate provider supports to practices by consolidating practice-level reports and dashboards.

Note that the timelines for developing and implementing quality and performance measures and engaging in additional payment reform activities may vary for different components of broader value-based payment system reform, based on start dates for the various components. However, the basic activities outlined above to ensure stakeholder engagement and a logical process will occur for all quality and performance measure activities. A crucial element for success—the formation of cohesive stakeholder groups and the resulting relationship-building needed to provide momentum for complex payment and delivery system transformation—is very well-established in Vermont.

Responses to specific CMMI Guidance for Section I

I.1 Describe how self-measurements will be used

Instructions: This section allows you to describe how you will use your measurements for your own self-improvement. How will data from the measurements be used to rapidly learn, identify, test and implement changes? What other uses do you anticipate? (Max 500 characters)

Measure sets will be used in Vermont for a variety of purposes, including model design and evaluation, payment reform, monitoring, quality improvement, and provision of real-time clinical information to participating providers to improve patient care and drive delivery system transformation (see above for examples). Performance measures also are used in Vermont's learning collaboratives, to assess baseline performance, evaluate results of interventions, and inform project design. More information about existing learning collaboratives can be found in Section M of this Operations Plan.

I.2 Programmatic and Operational Domains

Instructions: Each quarterly report will require some basic information regarding programmatic and operational progress. Please complete the table by noting any limitations (or "Not Applicable") you may have with these areas.

Table 8. Programmatic and Operational Domains

Update	Limitations
Accomplishments	Not Applicable
Planned Activities for the Next Quarter and Likelihood of Achievement	Not Applicable
Substantive Findings	Some measures that are based on medical records, including electronic medical records, may be challenging to produce in the short term. Vermont has significant initiatives underway to develop health information exchange capacity, the necessary interfaces, and improvement in data quality that will eventually allow the capture of accurate, reliable information for clinical use, as well as for evaluation and testing of payment reform models.

Update	Limitations
Findings from Self-Evaluation	In the initial phases of Vermont's SIM Testing grant, the self-evaluation will rely more heavily on claims-based measures and already existing data collection efforts to develop baseline results. Over time, clinical data should become more robust and there should be enhanced capacity to link changes over time to the payment reform models being implemented as part of the SIM Testing Grant.
Work Breakdown Structure	Not Applicable

I.3 and I.4 Outcome Measure Selection from Suggested CMS Core Measures and Custom Outcome Measures

As discussed above, the most mature measure sets are currently found in Vermont's Commercial and Medicaid ACO Shared Savings Program model and the Vermont Blueprint for Health model.

An Excel workbook has been developed that reflects the current status (Year 1) of Vermont's Medicare, Medicaid and Commercial ACO SSP measures, using the format contained in CMMI's State Innovation Model Operational Plan Guidance. There are separate worksheets for Outcome Measures Selected from the Suggested CMS Core Measures List, Custom Outcome Measures Selected for ACO Payment or ACO Reporting, and Custom Outcome Measures Selected for Health System Monitoring or Pending Status. That workbook has been updated and is attached.

The OneCare Vermont and Community Health Accountable Care ACOs proposed performance measurement approaches in their applications to the GMCB.

The Blueprint for Health Annual Report, clinical registry data dictionary, and Practice Profiles demonstrate that program's significant measurement activity.

A list of proposed measures for Vermont's Oncology Pilot Project has been developed by the payers, providers and care coordinators that participate in the project; those measures can be found in the attached document entitled Proposed VOP Measures. In addition, the the Rutland Regional Medical Center CHF bundled payment project describes that project's performance measurement approach.

Additional measures will be developed during the testing period and as new payment reform strategies are implemented, with assistance from Vermont's SIM Evaluation contractor, and CMMI's evaluation contractor.

Key Artifacts:

Exhibit	Artifact	URL
	Performance Measures Work Group	
28	ACO Measures Work Group Meeting Agendas and Minutes	
29	ACO Standards Work Group Meeting Agendas and Minutes	
146	Status of MSSP Measures (2/4/2013 Meeting)	
27	ACO Measure Set Overview Presentation (7-15-2013)	
26	ACO Commercial Measures Set Overview (6/2/2013)	
30	ACO Tentative Measures Set (4/2/2013)	
31	ACO Tentative Measures Set (5/16/2013)	
	Blueprint	
54	Blueprint 2012 Annual Report (Evaluation and Health Information Technology sections)	
60	Blueprint Practice Profile template	
61	Blueprint Practice Profile Supporting Documentation	
46	***Blueprint Clinical Registry (DocSite) Data Dictionary***	
	Suggested Changes	
	Primary Care	
	Performance Dashboard	
	New Measure Sets	
	SASH	
	Tobacco Cessation	
	Community Health Team	
55	**Blueprint for Health Executive Committee and Analytic and Evaluation Working Group Meeting Agendas and Minutes**	
	Executive Committee Agendas (4/9)	
	Executive Committee Agendas (5/15)	
	Executive Committee Minutes (4/9)	
	Analytic and Evaluation WG Agenda (5/22)	
	Analytic and Evaluation WG Members	
	Vermont Oncology Pilot	

180	VOP Annual Report	
181	VOP Annual Report Presentation for GMCB	
187	VOP Steering Committee Membership	
182	VOP Meeting Materials (Agendas, Minutes, Notes)	
188	VOP Steering Committee Meeting Presentation	
183	VOP Operations Committee Meeting Presentation	
186	VOP Proposed Measures	
184	VOP Participating Organizations and Providers	
185	VOP Primary Care Contact List	
179	VOP 2012 Milestones	
	Additional Applications	
121	Community Health Accountable Care application (Outcomes Measurement section, p. 11)	
123	Rutland Regional Medical Center Bundled Payment Application	
	Outcome Measures	
117	Outcome Measure Selection from Suggested CMS Core Measures List	
116	Outcome Measure Selection - ACO Payment or ACO Monitoring	
118	Outcome Measure Selection - Health System Monitoring or Pending Status	
142	SIM Steering Committee membership	http://gmcboard.vermont.gov/sim_grant/members
	Year 2 Updated Artifacts	
220	Summary of Gate and Ladder Methodology	
221	Analytics Contractor Timeline	
222	VITL Initiative Summary	
223	Blueprint 2013 Annual Report	http://hcr.vermont.gov/sites/hcr/files/pdfs/VTBlueprintforHealthAnnualReport2013.pdf

224	Outcome Measure Workbook
225	2014 Proposed SSP measures
226	Year One Measures Power Point
227	ACO Measure Review and Modification Standard
261	Yr 1 Gate and Ladder

Section C Outreach and Recruitment

The section details the importance of outreach and recruitment to ensure that Vermonters will purchase insurance through Vermont Health Connect, or the Exchange. The section also discusses the state's strategy for reaching out to beneficiaries about how they can change how they are involved in their own care.

Question 9. Is the outreach and recruitment program (per its Stakeholder Engagement Plan) consistent with the features of the innovation model?

Vermont's SIM project potentially encompasses the entirety of the state's population, and all Vermonters are considered "beneficiaries" by virtue of residency. The project will be implemented statewide and on an all-payer basis, to the greatest extent possible. By the conclusion of the model testing period, the state aims to have included 90 percent of the population in alternatives to fee-for-service payment models.

Vermont will test three alternative payment models: Pay-for-Performance, Episode-Based Payments, and Shared Savings models. None of these are enrolled models that change the experience of coverage from the patient perspective, nor do they restrict provider choice. If successful, the models will improve patients' experience of care in an "invisible" way—providers will have incentives to better coordinate care, shift resources toward prevention and primary care, and improve service without any new restrictions on access to services or providers.

Vermont's proposed payment models will be implemented through Medicaid, commercial payers, and Medicare. Therefore we will focus our outreach and recruitment efforts on enrolling Vermonters in coverage through which they can realize the benefits of their payer's participation in the VHCIP efforts. Vermont has designed its Health Insurance Marketplace, Vermont Health Connect, to be the single point of entry into coverage for Vermonters who are eligible for Medicaid, those who are enrolling in coverage through a small employer (employees of 50 or fewer) and those who are enrolling in coverage without employer sponsorship. A large

proportion of Vermonters potentially obtaining health care coverage through VHC, successful beneficiary outreach and recruitment through VHC will be critical to the success of the VHCIP. The state's goal will be to maximize coverage through VHC and reduce Vermont's uninsured population to the greatest extent possible. The efforts planned to maximize enrollment in VHC are described below. In addition, we describe outreach, education and recruitment planned specifically for enrollees in new health care delivery models.

Beneficiary Outreach, Education, and Recruitment for New Delivery Models

The alternative payment models that Vermont has proposed do not require beneficiary enrollment or a decision to "opt-in." However, some models that will be tested in Vermont have "opt-out" components where beneficiaries can choose not to participate. An example of an "opt-out" component is within the Medicare Shared Savings Program. In this model, beneficiaries have the choice not to have their claims data shared with the ACO that is managing their care. Although a beneficiary may opt-out of having their claims data shared with the ACO, the ACO will still be fully accountable for the beneficiary's care, costs, and outcomes. ACO beneficiaries who will be attributed to an ACO for the purposes of the Medicare Shared Savings program have been sent a letter describing the ACO and providing an opportunity to opt-out of having their Medicare claims data shared with the ACO. The Medicaid Shared Savings Program has a similar opt-out provision and those beneficiaries have been sent a letter describing the ACO and providing an opportunity to opt-out of having their Medicaid claims data shared with the ACO.

Although Vermont's proposed model testing program does not include enrolled models, some of the payment models are very directly linked with delivery system reforms that require outreach to beneficiaries to promote participation and engagement in these innovative care models. These models require that beneficiaries are activated in their care delivery. For example, if a model requires a beneficiary to select a care coordinator or access enhanced care coordination services, proper outreach and education must be included in the model to encourage participation. This approach to beneficiary outreach and education will build on Vermont's experience with the Blueprint for Health and the Vermont Oncology Pilot Project. These existing models provide us with evidence that this approach maximizes the patient and caregiver's roles on the health care team. These two programs have already implemented strategies for reaching out to beneficiaries about changes in the delivery of their care. These strategies include direct communications with patients about their care as well as communication materials targeted toward patient activation in care and self-management.

Year One Accomplishments Include:

The Blueprint for Health began major work in the area of shared-decision making, and the GMCB encouraged more providers to adopt this approach to patient care. By specifying shared-decision making as a delivery system reform model to be supported as a health reform cost in hospital budgets, the GMCB made this priority clear.

In its application for SIM funding, Vermont specified that it would use the "How's Your Health Tool" as a way to evaluate patient engagement and activation. The "How's Your Health Tool" asks patients questions that prompt them to improve their self-care along with questions that provide insight to providers on the patient's health status and satisfaction. Vermont's activity in this area was to fund a sub-grant to White River Family Practice. This team of clinicians is testing the "How's Your Health" tool among its patient population. The sub-grant began on July 1, 2014 and reporting began on the tool in September 2014.

Vermont engaged a contractor to develop a standardized process for reaching out to and educating beneficiaries, and beneficiary representatives across the stakeholder groups, about proposed delivery system reforms that will require changes in patient behavior or service delivery. In addition to this contractor, Vermont Medicaid engaged in outreach efforts regarding the opt-out of claims data sharing for the Shared Savings Program and initiated a customer assistance phone line for Medicaid beneficiaries who had questions regarding this process.

Vermont will continue to engage a diverse and widely representative group of beneficiaries through the activities specified in its Updated Stakeholder Engagement Plan.

Future Work on Beneficiary Outreach, Education, and Recruitment

- Continued encouragement by the Blueprint for Health and the GMCB to encourage providers to utilize shared decision-making. Specific outreach will be made to each of Vermont's ACOs;
- Continued reporting in 2015 on the "How's Your Health Tool" and evaluation of the tool. Vermont will determine if there should be an expansion of this tool to other providers by the end of 2015;
- Continued engagement of a diverse and widely representative group of beneficiaries through the activities specified in its Stakeholder Engagement Plan; and
- Development by the contractor of an outreach plan and a standardized process for reaching out to, and educating, beneficiaries. While procurement of an outreach and engagement contractor took longer than anticipated due to limited interest in the initial RFP solicitation, the contractor will also complete the following:

- Coordinate implementation of the Public Engagement and Outreach Plan with Vermont SIM staff;
- Design and schedule events, online public comment forums and other similar mechanisms through which Vermonters can have meaningful input into the VHCIP; and
- Develop materials such as:
    - Brochures
    - Website text
    - Newsletters
    - Email alerts

Key Artifacts:

Exhibit	Artifact	URL
	Stakeholder Engagement	
143	Stakeholder Engagement Plan	
140	SIM Stakeholder Meeting Schedule	
	Vermont Health Connect Outreach Plans	
153	Vermont Health Connect Education and Outreach Plan	http://healthconnect.vermont.gov/sites/hcexchange/files/For%20Websitevermont-health-connect-outreach-and-education-plan.pdf
160	Vermont Health Connect website	http://healthconnect.vermont.gov/
161	Vermont Health Connect YouTube Channel	http://www.youtube.com/user/VTHealthConnect?feature=watch
157	Vermont Health Connect Small Business Presentation	
	Vermont Health Connect Public Engagement Research	
154	Vermont Health Connect Focus Group Findings (Name/Logo)	
155	Vermont Health Connect Focus Group Findings (Public Education)	
159	Vermont Health Connect Survey Results (awareness, access, barriers)	
158	Vermont Health Connect Stakeholder Findings	
156	Vermont Health Connect Press Releases - Public Forums	

56	**Blueprint for Health Outreach Materials**	
	Smoking Cessation	http://www.vtquitnetwork.org/
	Chronic Disease Self-Management Program	http://hcr.vermont.gov/sites/hcr/files/Microsoft%20Word%20-%20CDSMPOverview.pdf
	Chronic Pain Self-Management Program	http://hcr.vermont.gov/sites/hcr/files/Microsoft%20Word%20-%20Chronic%20Pain%20Overview.pdf
	Diabetes Self-Management Program	http://hcr.vermont.gov/sites/hcr/files/Microsoft%20Word%20-%20Diabetes%20Overview.pdf
	Calendar of Healthier Living Workshops	http://hcr.vermont.gov/sites/hcr/files/2013%20HLW%20for%20the%20web-02-25-2013.pdf
143	**OneCare Participant Outreach Materials**	
	OneCare/Medicare Letter to Beneficiaries	
	Beneficiary Info Sheet	
	OneCare Patient Fact Sheet	
	Consent to Change Personal Health Information Preference	
	Additional Outreach Materials	
165	Vermont Oncology Pilot Project Brochure	
79	GMCB Guide - Rate Review	http://gmcboard.vermont.gov/sites/gmcboard/files/RRGuide.pdf
78	GMCB Guide - Hospital Budget Review	http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB%20Hospital%20Budget%20Review.pdf
77	GMCB Guide - Health system reform	http://gmcboard.vermont.gov/sites/gmcboard/files/Guide_VTHealth_System_Reform.pdf
98	How's Your Health? website (home page - howsyourhealth.org)	http://www.howsyourhealth.org/
	Year 2 Updated Artifacts	
219	White River Family Practice Grant Agreement	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/03410-1280-15_White_River-Signed.pdf
243	RFP for outreach coordinator	http://www.vermontbusinessregistry.com/BidPreview.aspx?BidID=10434

Section H Participant Retention Process

This section describes how participants are legally bound to participate in health reform, but also how the state and its partners have, and will continue to, foster voluntary participation and ownership of health care reform.

Question 22. How are participating payers required to implement key features of the proposed model? Also, how are they committed to participating for the duration of the model testing period?

Vermont recognizes that participant retention is essential to the success of its health reform efforts and has taken bold steps to partner with participants to establish public/private governance structures and accountability for improving the health care system in Vermont. Vermont encourages payer participation in health care and payment reform in two key ways:

- Payer participation in payment reforms is required by statute; and
- Payer participation in health care reforms is promoted through inclusive public/private governance and implementation structures.

Payer Participation Required in Statute

In the State of Vermont all insurance plans and Medicaid are required by statute to participate in payment reforms that:

- Support the Blueprint for Health (Blueprint); and
- Are approved by the Green Mountain Care Board (GMCB) as payment reform pilots.

Required Participation in the Blueprint for Health

Statute 8 V.S.A. § 4088h requires insurance plans in Vermont to participate in the Blueprint for Health as a condition of doing business in the state. [22]

Statute 18 V.S.A. § 706 specifies that the Blueprint payment reform methodologies include per-person-per-month payments to medical home practices by each health insurer and Medicaid for their attributed patients and for contributions to the shared costs of operating community

health teams. Consistent with the recommendation of the Blueprint Expansion, Design and Evaluation Committee, the Director of the Blueprint may change the payment amounts or the payment reform methodologies. If an insurer refuses to participate, the Commissioner of the Department of Financial Regulation has the authority to levy financial penalties and to suspend or revoke an insurer's license.

Required Participation in Payment Reform Pilots

Payment reform pilots are intended to test alternatives to fee-for-service payment and are to be developed by the GMCB in cooperation with health care professionals, health care facilities, and insurers. Act 48 of 2011 and Act 171 of 2012 lay out terms for insurer participation in payment reform pilots and hold insurance plans in Vermont to the same standards of participation in payment reform pilots as for the Blueprint.

Statute 18 V.S.A. § 9377 states:

> *The board shall be responsible for payment and delivery system reform, including the pilot projects established in this section.*
>
> *(2) Payment reform pilot projects shall be developed and implemented to manage the costs of the health care delivery system, improve health outcomes for Vermonters, provide a positive health care experience for patients and health care professionals, and further the following objectives:*
>
> *(a) Payment reform pilot projects should align with the Blueprint for Health strategic plan and the statewide health information technology plan;*
>
> *(b) Health care professionals should coordinate patient care through a local entity or organization facilitating this coordination or another structure which results in the coordination of patient care and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;*
>
> *(c) Health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for coordinating patient care through consistent payment methodologies, which may include a global budget; a system of cost containment limits, health outcome measures, and patient consumer satisfaction targets which may include risk-sharing or other incentives designed to reduce costs while maintaining or improving health outcomes and patient consumer satisfaction; or another payment method providing an incentive to coordinate care and control cost growth;*
>
> *(d) The scope of services in any capitated payment should be broad and comprehensive, including prescription drugs, diagnostic services, acute and sub-acute home health services, services received in a hospital, mental health and substance abuse services, and services from a licensed health care practitioner; and*

(e) Health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for providing the full spectrum of evidence-based health services.

(3) In addition to the objectives identified in subdivision (a)(2) of this section, the design and implementation of payment reform pilot projects may consider:

(a) Alignment with the requirements of federal law to ensure the full participation of Medicare in multipayer payment reform; and

(b) With input from long-term care providers, the inclusion of home health services and long-term care services as part of capitated payments.

(c) To the extent required to avoid federal antitrust violations, the board shall facilitate and supervise the participation of health care professionals, health care facilities, and insurers in the planning and implementation of the payment reform pilot projects, including by creating a shared incentive pool if appropriate. The board shall ensure that the process and implementation include sufficient state supervision over these entities to comply with federal antitrust provisions and shall refer to the attorney general for appropriate action the activities of any individual or entity that the board determines, after notice and an opportunity to be heard, violate state or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.[23]

Payer Participation Encouraged Through Inclusive Public/Private Governance and Work Group Structures

In addition to the statutory requirement that payers participate in payment reform initiatives in the State of Vermont, payers have been included as partners with the state and other stakeholders in carrying out the work of health reform and in implementing the models specified in the SIM. Payers are active participants in our work groups.

Question 23. How are participating <u>providers</u> required to implement key features of the proposed model?

In contrast to the payers in Vermont, health care providers are not required by statute to participate in the Blueprint or the payment reforms that are being tested as a part of the VHCIP.

Nevertheless, there are strong incentives for providers to both participate in and drive health care reform initiatives in Vermont. These incentives include:

- GMCB regulatory authority to contain costs;
- GMCB's payment reform pilot program and technical assistance offerings to support innovation in health care payment and delivery;
- The Blueprint's enhanced payments to providers and technical assistance to support providers in Health Care Reform;
- Provider participation through inclusive public/private governance and work group structure;
- Future work to encourage provider participation in payment model testing; and
- Development of a sub-grant program to support provider innovation in payment and delivery system reform.

GMCB regulatory authority to contain costs

The GMCB plays a key role in fostering provider involvement in payment and delivery system reforms. It has a variety of regulatory powers to contain health care cost growth in Vermont, some of which could meaningfully change how providers are paid. The GMCB has not executed its authority in every aspect, instead preferring to work with providers in a collaborative fashion to stimulate innovation. Providers in Vermont have already demonstrated that they are both cooperative and engaged in the implementation of the alternative payment models specified for testing in the VHCIP. The alternative to involvement in health reform activities is an unsustainable health care cost curve that weakens Vermont's health care infrastructure.

The following are GMCB regulatory powers that can be exerted to affect provider payment:

- Act 48 of 2011 specifies that, "In its discretion, the board may implement rate-setting for different groups of health care professionals over time and need not set rates for all types of health care professionals." Act 48 articulates that it is the responsibility of the GMCB to ensure that providers in Vermont are paid in a way that is efficient, economical, and that provides for high quality care; and
- Act 48 further specifies that it is the duty of the GMCB to review hospital budgets. In its guidance for the 2014-2016 Hospital Budget Review Process, the GMCB set a target for increases in hospital net patient revenue of three percent for the budget years of FY-14, FY-15 and FY-16. The three percent growth target is inclusive of any provider tax increases and any costs associated with unbudgeted capital investments for which the Board approves a certificate of need. The GMCB agreed to create an allowance for credible health reform proposals in the amount of one percent (above the base target of three percent) for FY-14, 0.8 percent for FY-15, and 0.6 percent for FY-16. Hospitals will need to

convince the board that expenditures listed as health reform are truly investments in a reformed delivery system. The following are areas that the GMCB may deem "credible":

- Collaborations to create a "system of care";
- Investments in shifting expenditures away from acute care;
- Investments in population health improvement;
- Participation in approved payment reform pilots;
- Enhanced primary care and Blueprint initiatives; and
- Shared decision making and "Choosing Wisely" programs.

The Board's hospital budget guidance also clearly encourages providers to do so through the budget allowance for such activities.

GMCB's payment reform pilot program and technical assistance offerings to support innovation in health care payment and delivery

Act 48 specifies that payment reform pilots approved by the GMCB will enjoy state supervision to ensure compliance with state and federal antitrust laws. Moreover, providers that participate in payment reform pilots that are approved by the GMCB will benefit from the statutory requirement (described in the answer to question 22) that all insurers doing business in the state of Vermont participate in payment reform pilots approved by the Board. The GMCB's authority to supervise payment reform pilots, specifically those that test the models proposed in the SIM project give health care providers a strong incentive through a structured framework, to participate in testing alternative payment models.

Current participation in payment reform is evidence that there are strong incentives for providers to participate, and that providers can be further engaged in the expansion of model testing activities supported by the SIM grant.

The Blueprint for Health's enhanced payments to providers and technical assistance to support providers in Health Care Reform

Providers participating in payment reform pilots and the Blueprint receive technical assistance and funding support for practice transformation and the adoption of HIT/HIE. Providers are paid on a scale per member per month (PMPM) depending on their NCQA PPC® PCMH™ score. Participating providers also benefit from Community Health Teams (CHTs). CHTs are attractive to providers because they help to coordinate care, services, referrals, transitions, and social services as well as provide self-management support and counseling to individuals with chronic

illness. Providers, including CHT members, also receive support and training in shared decision making and are being provided with access to decision aids to support implementation of shared decision making.

Provider participation encouraged through inclusive Public/Private Governance and Work Group structures

As described in #2 of the response to question #22, providers are represented in both the existing Vermont health reform governance and work group structures, as well as the VHCIP governance and work group structures. Provider participation has been fostered in the same groups that are detailed in the response #2 to question 22. In addition, the GMCB has done significant outreach to providers about health care reform, payment reform initiatives with an emphasis on provider led change.

Development of a sub-grant program to support provider innovation

To maximize the impact of non-governmental entity involvement in this health care reform effort, Vermont launched a sub-grant program to directly support providers engaged in payment and delivery system transformation. The state used a competitive bid review process to select the providers who are engaged in innovation. Description of the awardees is provided in artifact 247.

Sub-grants will support provider-level activities that are consistent with overall intent of the VHCIP, in two broad categories:

1. Activities that directly enhance provider capacity to test one or more of the three alternative payment models approved in Vermont's SIM grant application:
    a. Shared Savings Accountable Care Organization (ACO) models;
    b. Episode-Based or Bundled payment models; and
    c. Pay-for-Performance models.
2. Infrastructure development that is consistent with development of a statewide high-performing health care system, including:
    a. Development and implementation of innovative technology that supports advances in sharing clinical or other critical service information across different types of provider organizations;
    b. Development and implementation of innovative systems for sharing clinical or other core services across different types of provider organizations;
    c. Development of management systems to track costs and/or quality across different types of providers in innovative ways.

Preference was given to applications that demonstrated:

- Support from and equitable involvement of multiple provider organization types that can demonstrate the grant will enhance integration across the organizations;
- A scope of impact that spans multiple sectors of the continuum of health care service delivery (for example, prevention, primary care, specialty care, mental health and long term services and supports);
  Innovation, as shown by evidence that the intervention proposed represents best practices in the field and that it is informed by service recipient experience and engagement;
- An intent to leverage and/or adapt technology, tools, or models tested in other states to meet the needs of Vermont's health system; and
- Consistency with the GMCB specifications for Payment and Delivery System Reform pilots. The GMCB specifications can be found here: http://gmcboard.vermont.gov/PaymentReform.

Key Artifacts:

Exhibit	Artifact	URL
87	GMCB Provider Outreach and Public Engagement	
81	GMCB Hospital Budget Guidance FY14-16	http://gmcboard.vermont.gov/sites/gmcboard/files/Hospital_Budget_Guidance_FY14-16.pdf
54	Blueprint for Health 2012 Annual Report	
	Payment Reform Pilot Applications	
124	St. Johnsbury Oncology Pilot	
121	CHAC (FQHCs and Bi-State)	
122	OneCare Vermont	
	Statutes and Legislation	
32	Act 48	http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf
35	Act 171	http://www.leg.state.vt.us/DOCS/2012/ACTS/ACT171.PDF
3	8 V.S.A § 4087	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=08&Chapter=107&Section=04087
4	8 V.S.A. § 4088h	http://www.leg.state.vt.us/statutes/

		fullsection.cfm?Title=08&Chapter=107&Section=04088h
10	18 V.S.A. § 706	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=013&Section=00706
16	18 V.S.A. § 9377	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=220&Section=09377
	Year Two Updated Artifacts	
244	Round Two Sub-Grant Program Application	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Round_Two_Grant_Program_Application_7.24.14.final_.v2.pdf
245	Round One Sub-Grant Awardees	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/REVISED_Round_One_Awardees_Project_Summaries.pdf
246	Round Two Sub-Grant Program Awardees	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/VHCIP_GP_Awardee_Press_Release_10.24.14.pdf
247	VHCIP Sub-Grant Awardee Summary	

Section Q Communications Management Plans

This section describes how Vermont will engage in a multi-level, cross- agency effort to ensure appropriate communications to payers, providers and Vermonters.

Question 40. Describe the state's communication plan to reach the following stakeholders throughout the length of the project:

a) **Payers (public and private)**
b) **Providers and caregivers (including academic medical centers, hospitals, community-based practices, specialists/behavioral health, long-term care)**
c) **Public health organizations (DOH, CDC, etc.)**
d) **Social services (transportation, education, nutrition, housing)**
e) **Patients and their families**

In Year One, Vermont actively engaged hundreds of stakeholders as participants in the various SIM work groups. Additionally, SIM leadership and staff engaged numerous audiences throughout the year on both the project in general and specific topics. These audiences includes the Vermont State Legislature, provider associations, payers, regional community members and standing stakeholder committees convened by the Agency of Human Services, the Department of Vermont Health Access, the Department of Aging and Independent Living, the Department of Health, the Green Mountain Care Board and the Agency of Administration.

We engaged stakeholders through email communications, a new website, in-person meetings, and webinars. Of note, all of the project's meetings are open to the public and public comment is solicited at each meeting.

In year two, Vermont anticipates continuing existing efforts to engage stakeholders and also to expand our outreach utilizing an outreach contractor. The contractor will assist Vermont in ensuring we are reaching key stakeholders, such as providers and individuals, and also ensuring that our outreach is clear to audiences less familiar with our payment and delivery system reforms.

The State of Vermont's Stakeholder Engagement Plan describes each of the stakeholder groups that are instrumental to the implementation of the activities described in this Operational Plan. The Stakeholder Engagement Plan also describes the materials that have been and will be

developed to support communications with each of the stakeholder groups and details the meeting schedule for each.

Vermont has a history of actively engaging stakeholders in its health reform initiatives and health system governance, and the state will leverage the expertise of existing advisory bodies to inform the implementation of the Vermont Health Care Innovation Project (VHCIP). In addition to engaging Vermont's existing and diverse stakeholder groups, the state has created or reconstituted several additional work groups to address specific VHCIP tasks: Payment Models, Quality and Performance Measures, Care Models and Care Management, Health Information Exchange, Workforce Steering Committee, and Population Health.

The VHCIP Project Director will be responsible for directing communications about VHCIP project to the variety of stakeholder groups and will be supported in doing so by the VHCIP Stakeholder Engagement Coordinator. The information about the SIM project will be shared with stakeholder groups in a manner that is consistent with the existing stakeholder engagement plans for these entities. In addition, external stakeholders serve as co-chairs of each of the work group.

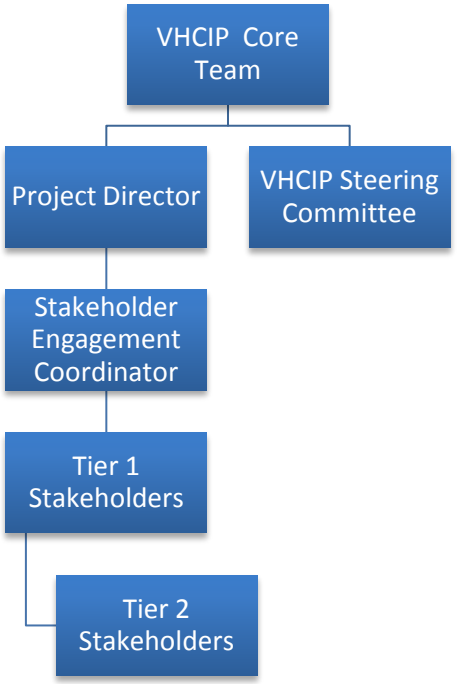
Question 41. Demonstration that the state has initiated external communications with each group of relevant stakeholders including:

a) **Payers (public and private)**
b) **Providers and caregivers (including academic medical centers, hospitals, community-based practices, specialists/behavioral health, long-term care)**
c) **Public health organizations (DOH, CDC, etc)**
d) **Social services (transportation, education, nutrition, housing)**
e) **Patients and their families.**

The VHCIP Project Director, supported by the VHCIP Stakeholder Engagement Coordinator will be responsible for overseeing and managing communications to the stakeholder groups that have been regularly meeting, and to those groups that will be formed. Outreach to multiple stakeholder groups has already been initiated and these groups have been activated in their capacity as advisory bodies for the VHCIP grant. As explained in the Stakeholder Engagement Plan, each state agency involved with the project has associated with it a number of stakeholder groups that provide input on a wide range of topics. Likewise, private payers and providers represented on the Stakeholder Engagement Plan have additional stakeholders that they communicate with about a variety of issues.

In order to manage communications with all stakeholder groups, the VHCIP Project Director will be responsible for communicating about grant activities to the first tier of stakeholders representing partner state agencies and partnering providers and payers. The first tier of stakeholders will then be responsible for communicating to their stakeholders, or the second tier, about the grant activities. First tier stakeholders will be expected to leverage the second tier stakeholders when their input is pertinent to a particular topic. The Project Director will also be responsible for communicating information from stakeholders to the VHCIP Engagement Coordinator who will work with the VHCIP work groups to implement and incorporate the feedback and information from stakeholders. The Project Director will be responsible for communicating with the staff and chairs of the VHCIP work groups to monitor their progress and structure appropriate reporting to the Steering Committee and Core Team. This is depicted in the figure 6 below.

Figure 6. VHCIP Stakeholder Engagement Structure



The VHCIP Stakeholder Engagement Coordinator will be responsible for tracking stakeholder engagement through scheduling project staff to brief key groups, collecting meeting minutes, materials, participation in webinars or other online learning forums, and management of the

Stakeholder Engagement Plan Group Membership (see Artifact 263). Communications that have already been initiated with Stakeholder groups are described in the list of key artifacts below.

In both the Updated Stakeholder Engagement Plan and in Section H of the Operational Plan, there are detailed descriptions of stakeholder groups and the ways in which they are communicated with. Consistent communications with the stakeholder groups, including providers and payers, is an essential component of the retention strategy described in Section H.

Question 42. Who is the entity overseeing and executing all components of the communications plan across the entire grant period?

The VHCIP Project Structure identifies the VHCIP Project Director as a position that reports to the VHCIP Core Team and works directly with staff and stakeholders. The VHCIP Project Director has been designated as the individual who will be responsible for the communications plan, assisted by the Stakeholder Engagement Coordinator.

Key Artifacts:

Exhibit	Artifact	URL
143	Stakeholder Engagement Plan	
140	SIM Stakeholder Meeting Schedule	
	Meeting Minutes:	
83	GMCB Mental Health Substance Abuse TAG Meeting Minutes (5 15 13)	http://gmcboard.vermont.gov/sites/gmcboard/files/MHSA_TAG051513.pdf
80	GMCB Health Care Professional Technical Advisory Group Minutes (6 5 13)	http://gmcboard.vermont.gov/sites/gmcboard/files/HCPTAG_MINUTES060513.pdf
75	GMCB ACO Patient Experience Survey Subgroup Meeting Summary	
104	Medicaid and Exchange Advisory Board Meeting Agendas and Minutes	http://healthconnect.vermont.gov/advisory_board/meeting_materials
	Meeting Materials:	

105	Medicaid and Exchange Advisory Board SIM Presentation	
141	SIM Steering Committee Initial Presentation	
	Communications Plans	
84	GMCB Outreach and Engagement Plan	
153	Vermont Health Connect Education and Outreach Plan	
134	SIM Engagement Coordinator Scope of Work	
	Year 2 Updated Artifacts	
247	VHCIP website	http://healthcareinnovation.vermont.gov/
243	Outreach RFP	http://www.vermontbusinessregistry.com/BidPreview.aspx?BidID=10434
263	Stakeholder Engagement Plan Group Membership	

Section D Information Systems & Data Collection Setup

This section provides a description of the information systems that support the meaningful exchange of information and provide timely data collection and analysis.

Question 10. Has the state developed an underlying IT infrastructure to support the intake of data for new payment and delivery reform initiatives?

Vermont is relying on several data sources to support the VHCIP, including: electronic health records, claims data, and clinical registry data. Vermont is using VHCIP's SIM funds to improve interoperability of clinical data to support our payment and delivery system reforms.

Year One Activities

Vermont engaged in several IT related activities through its HIE/HIT Work Group in year one. These included recommending specific investments in Vermont's health data infrastructure and planning for strategic investments in years two and three. In addition to the work group's activities, Vermont's Core Team used SIM resources to fund Vermont Information Technology Leaders so that we could expedite interface development between various providers and the Vermont Health Information Exchange (VHIE) to improve the quality of the clinical data.

The planning activities included a review of the state's HIT strategic plan, which will be updated in year two. The work group also discussed the need for a data repository to support both clinical decision making and state evaluation. The HIE/HIT Work Group delayed the implementation of a telemedicine pilot program in order to do strategic planning around investments in telehealth. To support this strategic planning, the work group will engage a contractor in year two to conduct an environmental landscape review of telehealth activities ongoing within the state and to help the work group establish criteria for additional investments.

This work group evaluated and recommended two large investments in our health information technology infrastructure that would further our payment and delivery system reform efforts:

- Population-Based HIE Collaborative. This project was developed collaboratively by Vermont's three ACOs: OneCare, CHAC and Health*first.* The purpose of this project is to develop and implement a population-based infrastructure within the VHIE and to further align this infrastructure with the emphasis of national and Vermont health care

reform on collaborative, clinically integrated providers held accountable for the cost and quality of health care delivered to the populations they serve. This project will:

- Development of technological gateways between Vermont's Health Information Exchange and each of the ACO's analytics vendors;
- Development of an Event Notification System;
- Gap Analysis of Shared Savings Program quality measures; and
- Customer Support.

- Advancing Care Through Technology. This project was developed collaboratively by Vermont's Designated and Specialized Agencies (DA/SSA) and long-term services and support (LTSS) providers as well as their advocacy organizations. The purpose of the project is to use integrated efforts and technology to enable: data quality, enhanced reporting, population and individual health management and improvement, and connectivity to the state-wide HIE for many of Vermont's essential community providers. This project will:
  - Engage in data quality improvement for the state's Designated Agency and Specialized Service Agency Data and build a data repository;
  - Update and/or conduct disability and long term service and support provider information technology gap analyses and develop a remediation budget; and
  - Plan for a Uniform Transfer Protocol between providers engaged in transitions of care.

Year Two Activities

In year two, the HIE/HIT Work Group will engage in strategic planning for the health information system. This will include an update to the state's HIT Plan and provide guidance for further IT investments that support a high-performing health care system. Specific year two activities include:

- Monitoring year one investments to ensure appropriate implementation;
- Establishing criteria for the telehealth pilot program and launch the telehealth pilot program;
- Continuing improvements in data quality within the VHIE;
- Continuing interface development to connect more providers to the VHIE;
- Engaging in efforts to determine the feasibility of a single portal so patients can access their health care information on one website; and
- Engaging in efforts to design and implement a data repository.

Background on Vermont's IT Infrastructure

Vermont is far along in its electronic health record process and the development of a statewide approach to sharing clinical and patient information for point of care decision making, analytics and population health management. Vermont Information Technology Leaders (VITL), the state's designated entity for developing and operating the statewide VHIE, has assisted health care providers with: 1) adopting and implementing electronic health records (EHR); 2) developing the interfaces necessary to exchange clinical and patient information; and 3) deploying the technology infrastructure to allow providers to obtain clinical data.

All Federally Qualified Health Centers (FQHCs) and all of Vermont's acute care facilities have EHRs. Additionally, approximately 90% of Vermont's primary care providers have EHRs, and 77% of all office based physicians have EHRs. All of Vermont's acute care facilities, most FQHCs, and nearly 150 practices and other health care organizations are connected to the VHIE, resulting in approximately 4.5 million transactions per month being processed by the VHIE. In summer 2014 the VHIE went live on a provider portal which will allow any health care provider (with internet capability, approved role-based access, and patient consent), to query and receive clinical data that was generated on their patients by other health care providers across Vermont. The provider portal will also include a master person index (MPI) containing over 1.5 million persons and offer pharmacy based medication history on Vermont patients.

The Vermont Health Care Claims Uniform Reporting & Evaluation System (VHCURES) includes a consolidated set of health care claims data from commercial payers and Medicaid. VHCURES has a subset of Medicare data, which will be expanded this year. Further improvements in the data set and data access are also planned. Vermont is in the process of further investing in a quality assurance program giving payers an expanded role in data validation.

Vermont has committed to continual review of its data systems to ensure we have the best data available for analysis of this project and the starting point for this is a gap analysis being performed by SHADAC as part of the CMMI technical assistance. All clinical and claims data in Vermont are confidential and private following both federal and state laws and policies. For more information regarding privacy protection, see Section J.

Question 11: What are the process(es)/mechanisms for data collection to support the state's delivery system and payment reform efforts?

Vermont has developed processes and mechanisms for data collection on a regularly defined basis to support its delivery system and payment reform efforts. The data and related processes used in the VHCIP is further described artifact 270. For procedures and processes around the claims database please see the statement of work with the data warehouse vendor and VHCURES Vermont State Rules & Carrier Working Documents. Information on the clinical data can be found in the VITL reports. Information on the Medicaid data can be found in the advanced planning documents as well as the claims database artifacts. Specific procedures and processes for collecting and reporting the population measures can be found on the Vermont Department of Health website.

Question 12: What is the formal measurement reporting mechanism across payers and providers?

The Quality and Performance Work Group created a plan for the measurement reporting mechanism across payers and providers for the Shared Savings Programs and will expand these plans as more payment models are implemented in 2015 and 2016. The state hired the Lewin Group to provide reporting to support the commercial and Medicaid Shared Savings Programs. Details about these reports are found in Section I.

In addition to the reports provided to support the Shared Savings Programs, the Blueprint and the ACOs are working together to leverage existing performance indicator reports. The Blueprint currently provides performance reports to patient-centered medical homes. The Blueprint and ACOs will expand these existing reports to include quality measurement information related to the Shared Savings Programs.

This Quality and Performance Work Group will also work with the state's evaluation contractor, IMPAQ International, to develop performance measures, benchmarks, and the evaluation process for the various payment reform programs. In addition to assessing measures of process and performance, the evaluation will also consider measures related to patient experience, provider experience, and caregiver experience, as well as access to care, quality of care, and reduction in the growth of health care expenditures. Vermont's self-evaluation plan is more fully described in Section R.

Key Artifacts:

Exhibit	Artifact	URL
76	GMCB Data Governance Plan	
135	SIM Grant Evaluation RFP	http://gmcboard.vermont.gov/sites/gmcboard/files/REVISED_SIM_RWJF_EvalRFP2.pdf
136	SIM Grant Evaluation RFP Q&A	http://gmcboard.vermont.gov/sites/gmcboard/files/EVALSIM_%20RFP_Q%26A.pdf
54	Blueprint 2012 Annual Report	http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf
132	SHADAQ Data Gap Analysis Preliminary Matrix	
	Department of Health Population Health Monitoring	
192	Youth Risk Behavior Survey Web Site	http://healthvermont.gov/research/yrbs.aspx
191	Youth Risk Behavior Survey Report	http://healthvermont.gov/research/yrbs/2011/documents/2011_YRBS_statewide_report_with_cover.pdf
43	Behavioral Risk Factor Surveillance System Web Site	http://healthvermont.gov/research/brfss/brfss.aspx
42	Behavior Risk Factor Surveillance System 2011 Summary Report	http://healthvermont.gov/research/brfss/documents/summary_brfss_2011_4.13_000.pdf
	VHCURES	
169	VHCURES Data Management Contract (Onpoint - attachment A)	
170	VHCURES Data Management Contract (Truven - Statement of Work)	
171	VHCURES Data Processing (consolidation) presentation	
173	VHCURES Vermont State Rules & Carrier Data Requirements	http://onpointcdm.org/cms/images/vt-dcrr/vt_carrier_mnl.pdf
	Health IT	
168	Vermont State Medicaid HIT Plan	http://hcr.vermont.gov/sites/hcr/files/VT%20SMHP%20V1.3%20FINAL%20110903.pdf
164	Vermont HIT Plan 2010	http://hcr.vermont.gov/sites/hcr/files/Vermont_HIT_Plan_4_6__10-26-

		10__0.pdf
178	VITL - Policy on Patient Consent for Provider Access to VHIE	http://www.vitl.net/sites/default/files/documents/HIE/Vermont%20Policy%20on%20Patient%20Consent.pdf
174	VITL 2013 Annual Report	http://hcr.vermont.gov/sites/hcr/files/pdfs/VTBlueprintforHealthAnnualReport2013.pdf
259	Data Collection Table	

Section E Alignment with State HIT Plans and Existing HIT Infrastructure

This section provides a description of Vermont's plan to align SIM Health Information Technology (HIT) initiatives with the existing HIT infrastructure.

Question 13. Are investments that have been made by Federal programs and State governments recognized and leveraged by SIM initiatives in a coordinated and economic fashion?

Vermont has a health Information technology (HIT) program that aligns with and leverages prior federal investments in the health information exchange (HIE), meaningful use of electronic health record technologies by various provider categories, and potential strategies and approaches to improve use and deployment of HIT. Vermont statute (provided in the artifact list) establishes the requirement for a comprehensive statewide health information technology plan, which outlines the strategic vision for Vermont health IT and the operational plan for making that vision a reality. The development and updating of the Vermont HIT Plan is the responsibility of the Secretary of Administration, who has delegated this authority to the Division of Health Care Reform in the Department of Vermont Health Access (DVHA). The HIT Plan is reviewed annually and any updates are approved by the Green Mountain Care Board (GMCB). The GMCB's review ensures the HIT Plan is consistent with overall health reform efforts and especially payment and delivery system reforms.

Under Vermont law, the Vermont Information Technology Leaders, Inc. (VITL) is designated to operate the exclusive statewide health information exchange network for the state. VITL is engaged in work in four major areas:

- Helping health care providers adopt and implement electronic health records systems (EHRs);
- Launching VITLAccess, a provider portal which will allow any health care provider (with internet capability, approved roles based access and patient consent), to query and receive clinical data that was generated on their patients by other health care providers across Vermont.

- Building interfaces enabling independent information systems to send and receive data over the health information network; and
- Deploying the network's core infrastructure, which stores data transmitted by interfaces and enables authorized users to search for and retrieve data.

In Vermont, all four of these components are in place—but not all are fully operational. More progress has been made on fully developing some components than others.

Background
To ensure sustainability of HIT, in 2008 the Vermont Legislature established a Health-IT Fund in the state treasury to be used for health care information technology programs and initiatives such as those outlined in the Vermont health information technology plan.

Vermont has strong alignment of HIT and HIE across the state, and across initiatives that have HIT or HIE components. That alignment includes careful attention to leveraging previous and current federal investments in Vermont's expansion efforts, which began in 2004 and are described in artifact 271.

The Vermont Health Care Innovation Project (VHCIP) is a logical expansion of the HIT and HIE progress that has been made so far in the state. The HIT and HIE investments will bring more providers into the health information exchange and close the gaps that have been identified with what can be considered full continuum providers—mental health, substance abuse, long-term care, and home health. Further, the VHCIP expands and advances the capture and utilization of data in support of both improved health care delivery and the payment reform models that are being implemented through the SIM Grant. Details of progress to date and year two activities are described above.

Key Artifacts:

Exhibit	Artifact	URL
	Reports	
174	2013 VITL Annual Report	http://hcr.vermont.gov/sites/hcr/files/pdfs/VTBlueprintforHealthAnnualReport2013.pdf
175	VITL July 1, 2013 Update	
	Plans	
168	Vermont State Medicaid HIT Plan	http://hcr.vermont.gov/sites/hcr/files/VT%20SMHP%20V1.3%20F

		INAL%20110903.pdf
164	Vermont HIT Plan 2010	http://hcr.vermont.gov/sites/hcr/files/Vermont_HIT_Plan_4_6__10-26-10__0.pdf
54	Blueprint Annual Report	http://hcr.vermont.gov/sites/hcr/files/Blueprint%20Annual%20Report%20Final%2001%2026%2012%20_Final_.pdf
162	Vermont Health Enterprise - Implementation Advance Planning Document (IAPD)	http://bgs.vermont.gov/sites/bgs/files/pdfs/purchasing/VT_Health_Enteprise_APD_v4.0.pdf
	Statutes	
5	8 V.S.A. § 4089k. Health care information technology reinvestment fee	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=08&Chapter=107&Section=04089k
13	18 V.S.A. § 9351. Health information technology plan	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=219&Section=09351
260	HIT HIE Alignment	

SECTION F IS NOT REQUIRED BY CMS

Section J Appropriate Consideration for Privacy & Confidentiality

This section provides information regarding Vermont's policies and procedures around privacy and confidentiality.

Question 28. What are the special protections related to diagnoses, conditions, and populations with privacy and confidentiality concerns?

Vermont has a robust array of privacy and data security protections in place—in law, regulation, and policy. The state will leverage these assets as it undertakes this planned transformation by applying them and, where necessary, revising them, to ensure that the privacy of personal health information (PHI) is maintained at all times and to promote the secure, efficient flow of data.

Recognizing that the integration of care will require information-sharing across medical, behavioral and other settings, Vermont has a number of legal and regulatory structures in place that can be incorporated into its Operational Plan for Model Testing. These are described below.

Vermont Law on Patient Consent

In some respects, Vermont law is stricter than the HIPAA Privacy Rule because it requires individual consent for a health care provider to make disclosures of information gathered and maintained for treatment of the patient in certain instances. For example, the patient privilege statute, 12 V.S.A. § 1612, prohibits physicians, chiropractors, dentists, nurses, mental health providers (and by implication the organizations who maintain their records) from disclosing protected health information without the patient's consent or an express requirement of law within court proceedings. Under the mental health care provisions, 18 V.S.A. § 7103(a), no disclosure may be made of the protected health information relating to an individual who has been involuntarily committed or to that individual's identity without the individual's written consent. Similarly, no protected health information which includes the results of genetic testing or the fact that an individual has been tested shall be disclosed without the written

consent of the individual under 18 V.S.A. § 9332(e). Drug test results subject to Vermont's drug testing law set forth in 21 V.S.A. § 516(a)-(b) may not be disclosed except as provided in the statute or with the written consent of the individual.

AHS HIPAA Privacy Protections for Personally Identifiable Health Information (PHI)

AHS has adopted a set of HIPAA Standards & Guidelines implementing the HIPAA Privacy Rule and governing the agency's receipt and handling of PHI. All AHS employees are required to comply with the Standards & Guidelines. *See* http://intra.ahs.state.vt.us/hipaa/hipaa-standards-and-guidelines. AHS also maintains HIPAA guidance and information for patients, providers, and researchers. *See* http://humanservices.vermont.gov/policy-legislation/hipaa/.

Department of Information & Innovation (DII) Policies

DII has promulgated policies that apply to all state agencies and departments governing security, hardware and media disposal, and information security best practices. *See* http://dii.vermont.gov/Policy_Central.

Vermont Health Information Technology Plan (VHITP)

Under 18 V.S.A. § 9351(a), the plan "shall include the implementation of an integrated electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payers, and patients." It must incorporate "standards and protocols designed to promote patient education, patient privacy, physician best practices, electronic connectivity to health care data, and, overall, a more efficient and less costly means of delivering quality health care in Vermont." *Id.* Among other specific statutory requirements, the plan must "ensure the use of national standards for the development of an interoperable system, which shall include provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols" and "address issues related to data ownership, governance, and confidentiality and security of patient information." 18 V.S.A. § 9351(b).

Vermont law also requires that "[t]he privacy standards and protocols developed in the statewide health information technology plan shall be no less stringent than applicable federal and state guidelines, including the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996 and contained in 45 C.F.R., Parts 160 and 164, and any subsequent amendments, and the privacy provisions established under Subtitle D of Title XIII of Division A of the American

Recovery and Reinvestment Act of 2009, Public Law 111-5, sections 13400 et seq. The standards and protocols shall require that access to individually identifiable health information is secure and traceable by an electronic audit trail." 18 V.S.A. § 9351(e).

The VHITP was developed with these legal requirements in mind. Indeed, the first "core value" in the plan itself states that "Vermonters will be confident that their health care information is secure and private and accessed appropriately." *See* VHITP at 7, *available at* http://hcr.vermont.gov/sites/hcr/files/Vermont_HIT_Plan_4_6__10-26-10__0.pdf To that end, Vermont Information Technology Leaders (VITL),[24] the designated health information exchange (HIE) for the state and a key collaborator on the creation and revision of the VHITP, VITL developed a set of six privacy and security policies to govern the operation of the HIE. These policies are consistent with federal and state laws and regulations, and reflect the privacy principles in the HHS Privacy and Security Framework.

The state has adopted a revised consent policy for information flowing through the VHIE. This policy was adopted at the end of 2012 and revised in March 2014. The revised policy specifies the use of a global "Opt-in" for patient consent. This means that a patient must sign a consent form to allow a health care providers to see and use medical records from other providers on the HIE and that signing one consent form will give such permission to all of a patient's current and future health care providers. The new policy is currently being implemented.

Trust Agreements – From the beginning the Vermont HIE Network has required that business associate agreements and contract terms be signed with each participating organization. In fact, technical work does not begin on an interface or other project until the agreements have been signed by all parties. These agreements spell out in detail how data is to be used between organizations. Our plan is to leverage current agreements to facilitate statewide expansion and work with counterparts in adjoining states to develop agreements in conformance with other state law, policies, and procedures.

Finally, in the event providers, individuals, or others fail to comply with state or federal law or policy regarding privacy, Vermont law provides several compliance mechanisms:

- 18 V.S.A. § 9437(8): In order to obtain a Certificate of Need, a permit from the state to develop a new HIT project with annual operating expense of more than $500,000 for either of the next two budgeted fiscal years, the applicant must show that the project conforms to the VHITP;

- 18 V.S.A. § 9352(h): VITL is authorized to require that HIT systems acquired under a VITL grant or loan comply with data standards for interoperability adopted by VITL and the VHITP; and
- 18 V.S.A. § 9352(i): VITL, following federal guidelines and state policies, if enacted, is authorized to certify the meaningful use of HIT and electronic health records by health care providers licensed in Vermont. Without meaningful use certification, providers will not qualify for the Medicaid incentives created in the ARRA/HITECH act.

Statutes, regulations, and policies governing the Vermont Health Care Claims Uniform Reporting and Evaluation System (VHCURES), Vermont's all-payer claims database

To the extent allowed by HIPAA, the Vermont Legislature has authorized the Green Mountain Care Board (GMCB) to collect health care eligibility and medical and pharmacy claims data from health insurers to be available as a resource for insurers, employers, providers, purchasers of healthcare, and state agencies in order to review health care utilization, expenditures, and performance in Vermont. 18 V.S.A. § 9410 (creating VHCURES); Vt. Gen. Assembly Act No. 79 (2013), § 40 (amending 18 V.S.A. § 9410 to move responsibility for VHCURES from the Department of Financial Regulation to the GMCB, effective on passage). Notwithstanding HIPAA or any other provision of law, Vermont law prohibits the public disclosure of any data from VHCURES that contains direct personal identifiers, e.g., information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number. 18 V.S.A. § 9410(h)(3)(D). Further, any person who knowingly fails to comply with data confidentiality requirements for VHCURES data is subject to administrative penalties of up to $50,000 per violation, 18 V.S.A. § 9410(g), in addition to any federal enforcement.

Regulation H-2008-01 sets out the requirements for the submission of health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities by health insurers, managed care organizations, third party administrators, pharmacy benefit managers and others to the state for use in VHCURES. The Regulation also contains conditions for the use and dissemination of such claims data, as required by and consistent with the purposes of 18 V.S.A. § 9410. In particular, Section 8 (Procedures for the Approval and Release of Claims Data) lays out the requirements, procedures and conditions under which persons other than the GMCB may have access to health care claims data sets and related information received or generated by the state. Such access depends upon the nature of the requestor and the characteristics of the

particular information requested. Appendix J of the Regulation classifies all data elements in the VHCURES database as either unrestricted (available for general use and public release), restricted (available only as part of a Limited Use Research Health Care Claims Data Set approved by the GMCB pursuant to the Regulation), or unavailable (not available for use or release outside the GMCB under any circumstances).

Vermont recently updated its VHCURES Policies and Procedures Manual for Data Release, Security, and Protection (VHCURES Manual) related to VHCURES to conform Vermont's practices to Data Use Agreement for Medicare data currently pending approval by CMS. *See* VHCURES Manual, Attachment 2. For example, Vermont has generated new tracking and accountability forms to meet CMS's standards as well as DII's standards. *See* VHCURES Manual, Attachment 6 (Hardware Chain of Custody Form), Attachment 7 (Certificate of Disposition).

Guidance Concerning Privacy and Security for Vermont Blueprint for Health and Other Providers

The Department of Vermont Health Access (DVHA), through the Blueprint for Health (Blueprint), recently developed this guidance document.[25] It includes information related to data sharing with business associates, patient consents, patient authorizations, and general patient information that practices may use to assist providers and others in complying with the state and federal privacy laws. It is intended for all Blueprint practices, whether or not they have implemented an electronic health record system or intend to use the Vermont HIE or the statewide clinical registry. The guidance document recognizes that HIPAA and the federal regulations governing the confidentiality of alcohol and drug abuse patient records (42 C.F.R. Part 2) contain mechanisms that allow programs to disclose information without the patient's consent to outside organizations that provide services to the program or to the program's patients.

Accountable Care Organizations

Vermont has three ACOs, participating in the Medicare and commercial Shared Savings Programs and two participating in the Medicaid Shared Savings Program. Each of these ACOs has established a data sharing, security, and privacy protocol that will enable data to flow securely between ACO participants.

OneCare Vermont (OneCare)

OneCare is a statewide ACO participating in the Track 1 Medicare, Medicaid, and commercial Shared Savings Program created by Fletcher Allen Health Care (FAHC) and Dartmouth Hitchcock

Medical Center (DHMC). OneCare identifies the Northern New England Accountable Care Collaborative Data Trust as the initial recipient of data from CMS. The Trust then transmits the data to FAHC and DHMC. All three entities have significant experience with and infrastructure for handling data securely. OneCare complies with all privacy and security specifications in the CMS Data Use Agreement, DVHA Medicaid Data Use Agreement and all HIPAA regulations. OneCare will also comply with data suppression policies in all analyses and presentation to external parties. *See* OneCare Vermont MSSP ACO Application – Section 10 Question 32.

Community Health Accountable Care (CHAC)

CHAC is a statewide ACO participating in the Track 1 Medicare, Medicaid, and commercial Shared Savings Program. CHAC has a Management Services Agreement with Bi-State Primary Care Association to provide leadership and staffing in the domains of administration, data repository and reporting, and clinical quality improvement. Bi-State staff in their roles under the Management Services Agreement request, retrieve, safeguard, and analyze CHAC's CMS data, Medicaid data, and BCBS data, complying with all privacy and security specifications in the CMS Data Use Agreement, DVHA Medicaid Data Use Agreement and all HIPAA regulations. CHAC may transmit data to selected vendors, as permitted through Business Associate Agreement, Data Use Agreements, etc. (CHAC has not had occasion to do this to date). CHAC will also utilize data sets and comply with applicable regulations in all analyses and presentation to external parties.

Healthfirst, Inc.

Health*first* is participating in the Track 1 Medicare and commercial Shared Savings Program. Health*first* identifies Collaborative Health Systems as the initial recipient of data from CMS. Collaborative Health Systems then provides reports to the Health*first* practices. This entity has significant experience with and infrastructure for handling data securely. Collaborative Health Systems complies with all privacy and security specifications in the CMS Data Use Agreement, DVHA Medicaid Data Use Agreement and all HIPAA regulations. They will also comply with data suppression policies in all analyses and presentation to external parties.

Key Artifacts:

Exhibit	Artifact	URL
37	AHS HIPAA Standards & Guidelines	http://intra.ahs.state.vt.us/hipaa/hipaa-standards-and-guidelines
36	AHS HIPAA guidance and information for patients, providers, and researchers	http://humanservices.vermont.gov/policy-legislation/hipaa/

	Information Technology Privacy Policies	
67	Department of Information and Innovation (DII) Policies	http://dii.vermont.gov/Policy_Central
164	Vermont Health Information Technology Plan (VHITP)	http://hcr.vermont.gov/sites/hcr/files/Vermont_HIT_Plan_4_6__10-26-10__0.pdf
177	VITL Policies & Procedures	http://www.vitl.net/health-information-exchange/policies-procedures
172	VHCURES Policies and Procedures Manual for Data Release, Security, and Protection (Rev. May 2013)	
	Statutes	
6	12 V.S.A. § 1612 (patient privilege)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=12&Chapter=061&Section=01612
8	18 V.S.A. § 1852 (Hospital Patient Bill of Rights)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=042&Section=01852
11	18 V.S.A. § 7103 (disclosure of information related to mental health care)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=171&Section=07103
12	18 V.S.A. § 9332 (disclosure of information related to genetic testing)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=217&Section=09332
14	18 V.S.A. § 9352 (VITL)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=219&Section=09352
19	18 V.S.A. § 9437 (certificate of need criteria)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=221&Section=09437
20	21 V.S.A. § 516 (confidentiality of drug testing information)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=21&Chapter=005&Section=00516
25	33 V.S.A. § 7301 (Nursing Home Resident Bill of Rights)	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=33&Chapter=073&Section=07301
13	18 V.S.A. § 9351	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=219&Section=09351
34	18 V.S.A. § 9410, as amended by Act 79 of 2013, § 40	http://www.leg.state.vt.us/docs/2014/Acts/ACT079.pdf
128	Regulation H-2008-01 (VHCURES)	http://gmcboard.vermont.gov/sites/gmcboard/files/REG_H-2008-01.pdf

Section R Evaluation Plan

This section describes Vermont's efforts to date regarding developing an Evaluation Plan for the SIM project. Vermont has experience in designing and implementing evidence-based evaluation frameworks, most recently as part of the MAPCP program.

Question 43: Has the state contracted with an entity for managing data collection and reporting processes (self-evaluation, reporting to CMMI, and financial data for multi-payer systems)?

Question 44: Has the State designed, planned and implemented an evidence-based evaluation framework to measure the progress and outcomes of the planned transformation?

Question 45: Has the State designed, planned and started to implement a meaningful self-evaluation and continuous improvement monitoring for the planned transformation?

Overview

The state is developing its self-evaluation plan with the support of a contractor, IMPAQ International and its subcontractor Brandeis University. We anticipate this plan will be finalized in early 2015. The intent of our self-evaluation is to conduct a formative self-evaluation of the Vermont Health Care Innovation Project (VHCIP). The self-evaluation plan will include a complementary array of qualitative and quantitative analyses with the goals of:

- Determining whether VHCIP 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 of VHCIP; and
- Making recommendations regarding the future diffusion of VHCIP initiatives.

To achieve these objectives, the team will employ a variety of best practices advocated by experts to promote the effective translation and implementation of evidence-based programs and reflected in CMMI's guidance to its grantees.[26]

In the first few months of the evaluation contract, the evaluation team has been 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 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 six complementary sets of activities in the following:

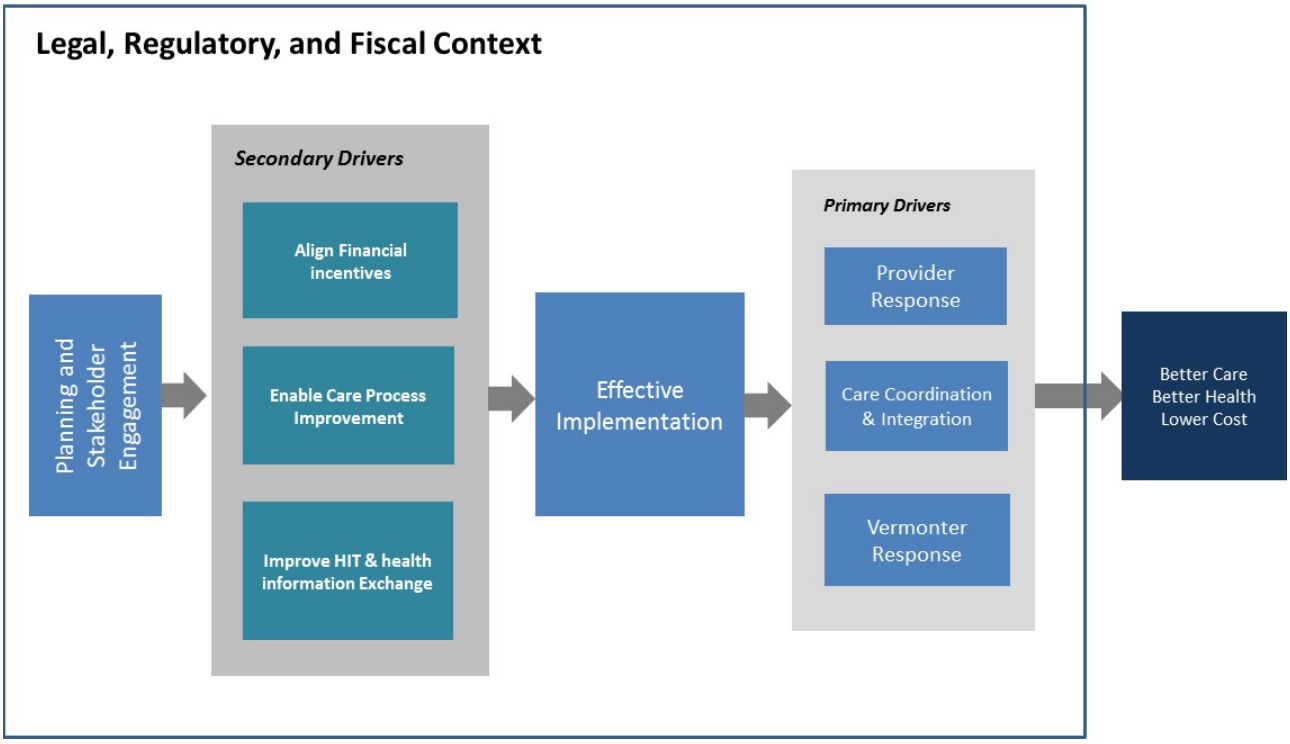
- Assessment of state-led implementation planning and stakeholder engagement activities;
- Development of metrics to monitor implementation effectiveness;
- Collection and analysis of qualitative data documenting the experiences and perceptions of frontline providers involved in VHCIP implementation and operation;
- Collection and analysis of primary survey data documenting provider perceptions of VHCIP impacts and unintended consequences;
- 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
- Time series analysis informing the impact of VHCIP on health care expenditures, care processes, and population health.

These activities will facilitate regular, robust reporting to CMMI, inform the need to adjust implementation activities as needed to maximize project impact, and provide a rigorous, empirical basis for recommendations to scale-up and broadly diffuse VHCIP initiatives. Activities related to measure development and report planning are scheduled to begin in November 2014 and continue through spring of 2015. In the coming months, the evaluation team will refine and finalize a plan to determine whether VHCIP is on track to achieve its intended activities and outcomes based on state and stakeholder priorities and the feasibility of meeting data requirements. We describe the status of evaluation planning in the paragraphs below.

Logic Model

Consistent with best evaluation practices, the evaluation plan will be guided by a logic model that is tightly aligned with the project's driver-related documents (see artifact 229). The logic model developed by the evaluation team is shown in Figure 7. The model relates the effective implementation of VCHIP initiatives (i.e., "Secondary Drivers") to upstream planning and stake holder engagement to downstream changes in the organization, delivery, and experience of care (i.e., "Primary Drivers") which in turn lead to progress toward the Triple Aim. Key concepts in the logic model and relationships among them frame the selection of research questions and performance measures, the design of qualitative data collection efforts, the content of qualitative interview guides, the analysis and interpretation of evaluation findings, and recommendations for scale-up and diffusion.

Figure 7: VHCIP Logic Model



Draft Approach

The sections below describe in detail the goals of each of the six evaluation-related task areas listed above, the evaluation questions they are intended to answer, the data and methods that will be employed, and the reporting approach, and preliminary timeline. Please note that this is not yet finalized. Table 5 below provides a summary of key activity areas that will be conducted to achieve the four evaluation objectives.

Table 9: Summary of Self-Evaluation Activities by Evaluation Objective

Objective	Activities
1. Determine whether VHCIP is on track to achieve its intended outcomes	• Monitoring trends in health care expenditures, care processes and population health outcomes • Qualitative findings documenting perceived effectiveness of VHCIP initiatives
2. Informing in a timely and in-depth fashion the development and targeting of continuous quality improvement activities	• Ongoing assessment of planning and stakeholder engagement activities • Qualitative findings documenting provider-level experiences and perceptions regarding implementation of VHCIP initiatives • Implementation monitoring
3. Understanding downstream impacts of VHCIP	• Provider survey results documenting perceived impacts and unintended consequences • Interpretation of time series analysis in the context of intervention inventory and timeline and qualitative results
4. Making recommendations regarding the future scale-up and diffusion of VHCIP initiatives	• Comprehensive review of evaluation findings and stakeholder perspectives

Investigation of Implementation Planning and Stakeholder Engagement

With input from the IMPAQ/Brandeis team, the Evaluation Director will collect and analyze a variety of data to monitor and assess the effectiveness of the state's implementation planning activities and stakeholder engagement processes. The results of this effort will provide context for assessing whether implementation planning and stakeholder involvement promoted

downstream programmatic goals, ensure transparency of VHCIP governance, and generate lessons for future efforts to implement state-wide initiatives in a consensus-driven manner. Questions addressed by this activity include the following:

- What are the roles and activities of various stakeholders? Did stakeholders have a good understanding of these roles?
- What are the criteria used for making decisions regarding VHCIP implementation?
- What information contributed to the decision making process, and what was of use or not of use?
- What are the roles of various staff in this process?
- What are the lessons learned so far?

The Evaluation Director will conduct interviews with work group chairs and staff members. The Evaluation Director will develop with input from the IMPAQ/Brandeis team an interview guide based on a document review and a survey documenting work group experiences and satisfaction. Findings will inform the development and interpretation of other data collection efforts conducted as part of the VHCIP self-evaluation.

Implementation Monitoring

The evaluation team will develop a set of metrics and benchmarks to provide ongoing documentation of implementation activities and to inform two key questions:

- Are VHCIP initiatives are being implemented according to plan?
- What types of refinements are required to strengthen implementation effectiveness?

The universe of potential metrics will be defined by an inventory of VHCIP initiatives and corresponding reporting requirements. From these, we will select a core set of implementation metrics to consolidate and use to follow the general progress of implementation across pilots and models. Metric development will involve the individuals who are responsible for each specific initiative in order to ensure that the metrics reflect the objectives of the initiative, are specific enough to focus in on critical steps in the implementation, and represent quantifiable goals. To the extent possible, implementation metrics will be focused three types of measures specific to each initiative:

- Input measures (e.g., the staffing hours focused on the initiative);
- Process measures (e.g., number of member providers engaged in care coordination activities); and
- Output measures (e.g., the number of individuals enrolled or the activities successfully accomplished, compared to goals).

We plan to apply the "SMART" criteria[27] to evaluate the quality of a particular implementation performance metric:

S = Specific: Clear and focused to avoid misinterpretation. Should include measure assumptions and definitions and be easily interpreted.

M = Measurable: Quantifiable and comparable to other data to allow meaningful statistical analysis. Avoid "yes/no" measures except in limited cases, such as start-up or systems-in-place situations.

A = Attainable: Achievable, reasonable, and credible under conditions expected.

R = Realistic: Fits into the organization's constraints and is cost-effective.

T = Timely: Doable within the time frame given.

The Evaluation Director will track and record the selected metrics for reporting to CMMI, as well as to guide selection of pilots or innovations for qualitative investigation.

Qualitative Investigations of VHCIP Initiatives

The evaluation team will conduct in-depth qualitative investigations into four distinct pilots/innovations. The central component of the qualitative evaluation is case studies that involve visits to a sample of care frontline care providers and managers. We expect these case studies to inform three sets of questions related to the overarching goals of the self-evaluation related to program improvement, behavior change, scale-up, and diffusion throughout the state:

- *Implementation.* Has the program been implemented as designed? If not, what are the changes that have taken place and why?
- *Outcomes.* Is clinical behavior responding to incentive systems and institutional changes as intended?
- *Learning and Replication.* Do front-line providers and program managers understand, use, and evaluate programmatic change in ways that can promote success in other settings and populations?

Below we describe our study methodology for the qualitative evaluation.

Assess Data and Program Components. The primary aim of VHCIP initiatives is to promote better, more cost-efficient provision of medical and complementary social services through changes in provider and patient behavior (i.e., the "primary drivers" in the evaluation's logic model). By improving communications and coordination among providers and between providers and patients, improved quality of care is expected, as is enhanced patient experience. The data collection—both documentary and interview based—will focus on the actual implementation activities and the broader conceptual model of the SIM and where these intersect.

Develop Interview Protocol. Our development of an interview guide will start with a specification of aims. This will allow us to track each decision regarding interview items on project goals and to determine if areas are being missed and/or unproductive questions are being contemplated. Our interviews will focus on the following:

- What do frontline providers know about the changes?
- How do the frontline providers evaluate these changes?
- How have clinicians adapted to the innovation in terms of clinical behaviors?

Interview Guide Format. Following our initial meetings with state staff and program leaders, the evaluation team will develop a draft interview protocol for the clinician interviews. We will develop semi-structured interview protocols employing the Lofland and Lofland model.[28] In this model, a series of relatively broad questions are asked of each respondent and they are encouraged to identify what information on the subject they see as most important. In this way it is possible to solicit information that might be missed by a more narrowly constructed instrument. It also allows us to determine what the respondents believe are the more important of the factors we wish to explore, rather than imposing the interviewers' priorities. Finally, this allows unanticipated issues to be revealed—issues that may be added to the protocol in subsequent interviews.

Interview Guide Preliminary Content. Preliminarily, we expect the interview to be structured around the rubrics below. Each is meant to operationalize our research aims into more concrete questions.

- Goals:
    - What is your understanding of the initiative's goals?

- Are these the right goals?
- Are some goals being neglected?

- Incentive Systems:
  - What do you understand to be the major incentive system changes?
    - Money?
    - Patient impacts?
    - Eased communication with other clinicians?
  - From your point of view how do these changes work?
  - Do these changes lead you to behave differently? Why and why not?

- Data Systems:
  - What are the important elements of the data being generated by the innovation?
  - Which elements do you use routinely?
    - Why do you make use of some and not others?
    - What is the valued added of different elements?

- Care Coordination:
  - What are the important elements of the care coordination innovations?
  - What is your perception of the value of care management assistance?
  - What is your perception of the value of information and support for referrals and feedback among clinicians?

- Workforce:
  - How has staffing changed as a result of this innovation?
  - What is your view of staff preparedness for these new roles?

- Participant Evaluation of the "valued added" by each innovation element:
  - Meetings and planning, including information shared and information learned, impact on patients;
  - Team building within and across organizations;
  - The "cost" of each innovation element from the clinician's point of view, including time and attention.

- Patient Feedback:
  - Do you perceive that these changes are visible to patients?
  - Have patients provided you with any feedback on program elements?
  - If yes, what has the feedback been and what lessons can be drawn

- Institutional Changes in support of the state-wide innovation:
  - What are the numbers and extent of additional institutional process changes?
  - How was clinicians' input incorporated into the institutional response to the innovation?

- What are the perceived barriers to success and changes in approach that might be of use?
- What are clinical behavioral changes, including decision-making and communication with colleagues, staff, management, families and patients?

- Learning Organization and feedback failures:

  - Feedback from providers not translated adequately to allow timely process changes;
  - Learnings not translated to providers adequately to alter perceptions or use new models.

Conduct of the site visits. Two-person research teams will conduct the interviews. We will attempt to interview between two and five clinicians and other relevant personnel in each organization involved in the pilot's innovation, depending on the organization. We will attempt to conduct these interviews face-to-face as much as possible. In cases of scheduling and resource challenges, we may conduct some interviews by telephone. Where possible, we plan to record the interviews conducted during the site visits.

Site Selection Methodology. Topics covered by the four qualitative investigations will be selected through a strategy planning process that considers a full inventory of VHCIP initiatives categorized by target population, geographic location, patient volume, program budgets, and potential to drive cost savings through direct spending on medical care and downstream savings in social and supportive services. During year one, the qualitative evaluation team will propose innovations for application to the qualitative investigations. This will be developed as we learn more about each innovation, and review initial metrics from first and second quarter. The final selections will be presented to the broader workgroups as part of the plan.

Provider Survey

Using contact information provided by state-based professional associations and provider organizations, the evaluation team will design and field a web-based survey to document the experiences and perceptions of non-primary care providers (PCPs) (i.e., physician specialists, nurses, social workers, and case managers) during the second year of the SIM grant. The survey is intended complement a survey of primary care physicians being conducted in the state by RTI as part of the VHCIP Initiative Evaluation. As such, the survey will help the state to obtain a broad set of perspectives on the effects of payment and care delivery reform initiatives beyond the primary care setting. The survey is intended to answer research questions, including:

- Has VHCIP increased coordination of care?
- Has VHCIP increased integration of care?
- How have VHCIP initiatives changed the ways that non-PCPs interact and communicate with PCPs?
- How has VHCIP influenced the use of health information technology and health information exchange?
- Is VHCIP benefiting patients? In what ways?
- What are the unintended consequences of VHCIP?

Once the survey is completed, the evaluation team will analyze results and report.

Monitoring Trends in Care Processes and Population Health

The evaluation team will use data from VHCURES, patient surveys, and population-based survey data to describe expenditure trends, the evolution of care processes and population health that VHCIP initiatives are intended to influence. As feasible, trend data are intended to answer the following questions at a state-wide level and for subgroups based on socio-demographics, clinical characteristics, and receipt of care from provider organizations participating in VHCIP models and pilots:

- Is VHCIP on track to reduce avoidable utilization of acute services?
- Is VHCIP on track to increase use of preventive care?
- Is VHCIP on track to reduce cost of care?
- Is VHCIP on track to improve quality of care?
- Is VHCIP on track to improve patients experience care?
- Is VHCIP on track to improve how Vermonters care for their health?

Measure selection. The evaluation team's first step will be to develop a core set of quantitative measures that: are relevant across all VHCIP initiatives; and reflect the effectiveness of VHCIP implementation and downstream impacts on cost, utilization, quality, and population health. This broad-based, VHCIP-wide approach will allow us to measure performance on a state-wide level, while providing the flexibility to compare performance of VHCIP initiatives across types of models and pilots and for subgroups formed on the basis of setting, provider characteristics, and the socio-demographic and clinical characteristics of patients.

To maximize timeliness and efficiency, our strategy is to build a core self-evaluation measure set building upon the existing shared savings measures developed by the Quality and Performance Measures Work Group, the RTI measure set developed for the SIM initiative evaluation, and CMMI's priority measure set.[29] As a first step, we will identify and categorize

the measure by mapping it to logic model components. We also will identify themes within this initial set such as hospitalization, wellness/screening, behavioral health, chronic medical conditions, and pediatric measures. We will use these categorizations to identify gaps and suggest other potential measures which would be identified through scans of the Agency for Healthcare Research & Quality (AHRQ) National Quality Measures Clearinghouse, the National Quality Forum approved and also pending measures, and CMS meaningful use measure sets. The potential new measures would be evaluated against a set of criteria that includes sample size, ability to attribute care to providers or care systems, and data availability, as well as discussion of importance of each measure and the overall set with the Quality and Performance Measures Work Group.

Data documentation and transfer. Concurrent with the measure inventory and gap analysis, the evaluation team will gather relevant documentation of electronic and survey data that will be used to generate claims-based measures of health care expenditures, care processes and population health metrics. Documentation includes data dictionaries and analytic file layouts for VHCURES claims data, data files extracted to support the RTI SIM Initiative evaluation, and survey data maintained by the Vermont Department of Health. The evaluation team has already begun the process of executing data use agreements intended to ensure that survey and electronic health are transferred, stored, and analyzed in a manner that is compliant with data safeguarding policies and procedures established by the state, CMS, and IMPAQ.

Measure construction. Once VHCURES analytic files and patient attribution data have been transferred to IMPAQ, the team will construct and test the core measure set based on specifications adopted by the Quality and Performance Measure Work Group to determine provider eligibility for ACO-related shared savings payments, those used by RTI in conducting the broad SIM evaluation, and those recommended by CMMI for constructing priority monitoring and evaluation measures.

Analytic and reporting strategy. Trend data will be reported in the fourth quarter late in years two and three and will include the pre-implementation baseline years from 2008. To the greatest extent possible, trend data will be generated on a quarterly basis and use the most recent data available. However, the time period unit and reporting frequency will be measure specific. This will allow the team to accommodate the natural look-back period of each measure (e.g., mammography screening is recommended annually) and the fact that survey data available to the evaluation team is reported annually (e.g., BRFSS).

Time Series Analysis

Vermont will extend trend monitoring activities by conducting an interrupted time series (ITS) analysis. Our goal in conducting ITS analysis is to detect impact effects that reasonably can be attributed to the VHCIP initiatives. ITS is a regression-based technique that allows the detection of intervention effects by focusing on before, during, and after intervention changes in the level and slope of a time series. Changes in level are usually triggered by policy modifications with specific start dates (e.g., changes in payment methods). A change in trend represents a gradual change in the outcome that may accelerate during later stages of implementation. This type of change is usually associated to frictional factors, such as the phased implementation of VHCIP initiatives and corresponding changes in the way the Vermonters interact with and experience the health care system over time.

Use of Self-Evaluation Data for Continuous Improvement

Vermont will employ the following activities to ensure that the state successfully engages in critical self-improvement activities supported by evaluation findings:

- Use the quarterly reports submitted to CMMI as an opportunity to critically review our progress towards the VHCIP goals;
- Provide the VHCIP Leadership with quarterly reports showing project goals and progress and seek their input on identifying areas for focused continuous improvement;
- Use the VHCIP work groups to identify areas for process and VHCIP Project improvement. The work groups will focus the efforts identified in each of their respective charters; and
- Use required reports on VHCIP progress to the Legislature throughout the year as an opportunity to ensure that the project is progressing and that all stakeholders have had opportunity to participate in its improvement.

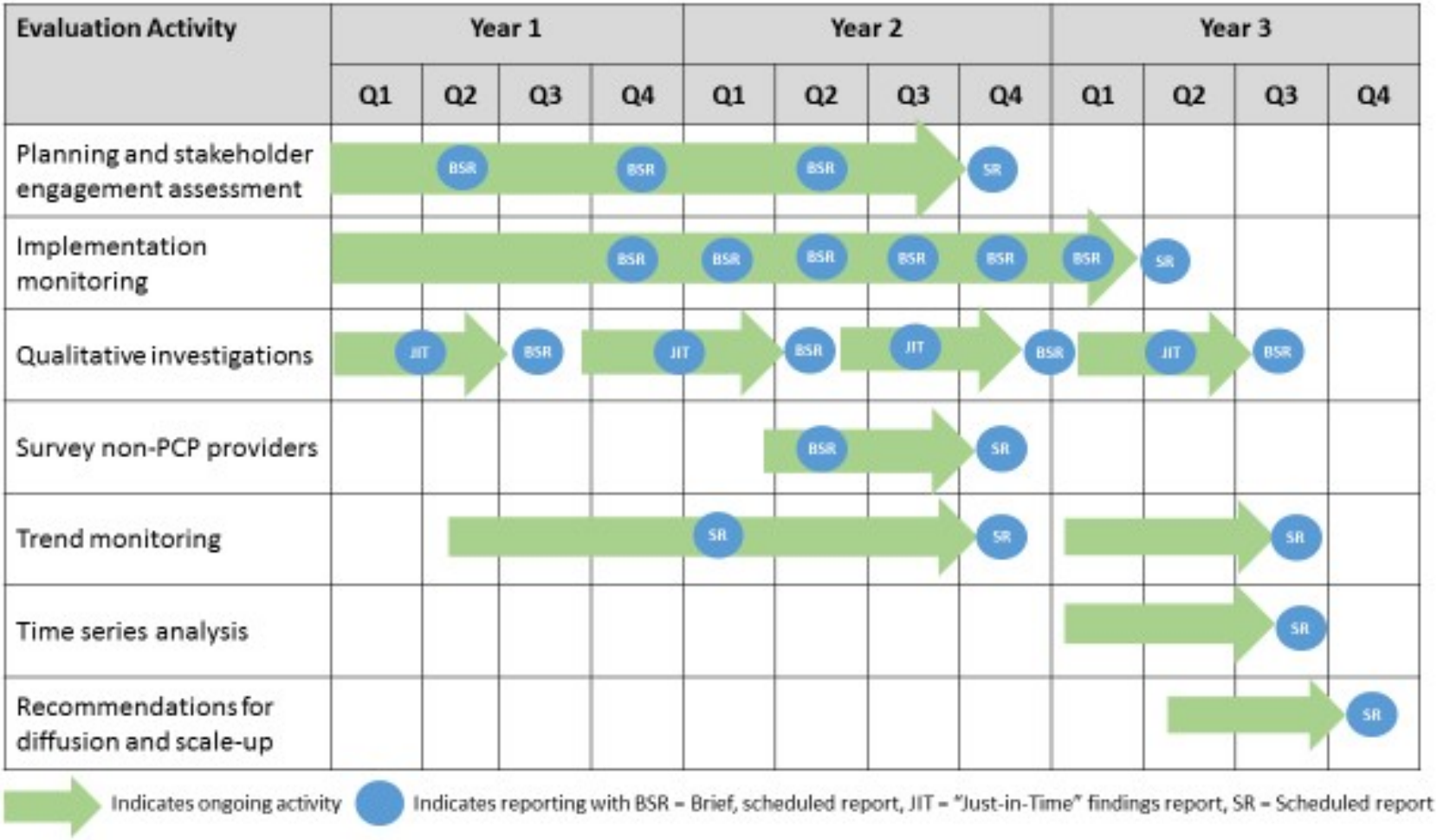
Preliminary Timeline and Reporting Plan

Just-in-time memos (JIT): For quickly reporting findings: high-interest, actionable findings from qualitative investigation (2-3 page memos).

Brief scheduled reports (BSR): Planning and stakeholder engagement, implementation monitoring, summaries of qualitative investigations (2-3 page memos).

Scheduled reports (SR): Trend measure selection, year one and year two trend reports, year three time series analysis, Comprehensive summary of findings and recommendations for scale-up, diffusion).

Table 10. Preliminary Evaluation Reporting Plan



Key Artifacts:

Exhibit	Artifact	URL
135	SIM Evaluation RFP	http://gmcboard.vermont.gov/sites/gmcboard/files/REVISED_SIM_RWJF_EvalRFP2.pdf
136	SIM Evaluation RFP Q&A	http://gmcboard.vermont.gov/sites/gmcboard/files/EVALSIM_%20RFP_Q%26A.pdf
54	Blueprint for Health 2012 Annual Report	http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf
	Health Department reports on population health measures	
96	Healthy Vermonters 2020	http://healthvermont.gov/hv2020/documents/hv2020_report_full_book.pdf
94	Health Status of Vermonters (2008)	http://healthvermont.gov/pubs/documents/HealthStatusRpt2008.pdf
95	Health Status of Vermonters (2008) Appendix	http://healthvermont.gov/pubs/documents/HealthStatusRpt2008_appendix.pdf
90	Health and Health Care Trends in Vermont (2010)	http://healthvermont.gov/research/documents/health_trends_vt_2010.pdf
131	Rule H 2009-03 Evaluation of the 2012 Managed Care Organization Data Filings	http://www.dfr.vermont.gov/sites/default/files/2012_Rule9-03_DataFilingRp.pdf
97	Hospital Community Reports (Act 53 Reporting) - Vermont DFR Website	http://www.dfr.vermont.gov/health-care/hospitals-health-care-practitioners/2011-hospital-report-card

149	VDH Population Health Measure Collection and Use
	Outcome Measures
117	Outcome Measure Selection from Suggested CMS Core Measures List
116	Outcome Measure Selection - ACO Payment or ACO Monitoring
118	Outcome Measure Selection - Health System Monitoring or Pending Status
	Year 2 Updated Artifacts
229	Driver Diagram

Section L Workforce Capacity Monitoring

This section addresses Vermont's efforts around ensuring an adequate workforce to deliver care once the payment and delivery system reforms are complete.

32. Has the State designed, planned and begun to implement a program to address the future health care workforce requirements of its proposed innovation model, consistent with the objectives established by HRSA?

The state has designed, planned and begun to implement a program to address the future health care workforce needs. Act 48 Section 12a directed the state's Director of Health Reform to develop a workforce strategic plan. Working for nearly a year, the Director engaged in-state and external stakeholders to craft a plan and recommendations for approval by the Green Mountain Care Board (GMCB). On January 9, 2013, the GMCB approved the Health Care Workforce Strategic Plan (see list of artifacts below), which outlines the recommendations to be accomplished in conformance with both Vermont's comprehensive health reform law, Act 48, and HRSA's workforce objectives. The plan was subsequently reviewed and accepted by the key legislative health committees during the session that ended in May. The plan is divided into four main sections, each with recommendations and indicators of success outlined. These are:

- Oversight and Planning for Workforce development with 3 recommendations and 11 sub-recommendations;
- Recruitment and Retention of the Workforce with 3 recommendations;
- Improving, Expanding, & Populating the Workforce Educational Pipeline with 11 recommendations; and
- Three recommendations to the GMCB and the Blueprint for Health for their assistance in supporting the Plan's implementation.

The plan outlines current workforce capacity issues and calls for ongoing workforce assessments through surveys of all health professions as part of licensure and through the development of Vermont-appropriate metrics for determining supply and demand. In fact, the Vermont Legislature passed Act 79 (included among artifacts), which makes the completion of health profession surveys a mandatory part of licensure. This was a major recommendation in the Health Care Workforce Strategic Plan. The surveys are being developed as each profession

comes up for their licensure renewal. The complete licensure renewal schedule from the Office of Professional Regulation is attached as an artifact.

In addition to these surveys, another useful and timely document that will be utilized to assess need is the annual statewide report of the primary care workforce conducted by the Area Health Education Centers (AHECs) in Vermont. The 2012 report is included among the artifacts. The first step in implementing our Health Care Workforce Strategic Plan was to form a permanent Workforce Work Group with Stakeholders from the health professions and key institutions and state agencies, as called for in the first recommendation in the Plan

The Governor appointed the Work Group in July 2013.

With the creation of the Workforce Work Group, Vermont has been able to create consensus on the implementation of workforce planning and to educate Stakeholders on the delivery system reform efforts underway. This Work Group meets on a monthly basis and includes representatives from a wide array of health care professions and entities in Vermont's public and private sectors, including:

UVM College of Medicine
Fletcher Allen Health Care
Dartmouth Hitchcock Medical Center
Agency of Administration
Department of Labor
Department of Education
VT Department of Health
Office of Professional Regulation
Vermont State Colleges
Primary Care Physicians
Specialty Care Physicians
Hospitals
Federally Qualified Health Centers
Home Health Agencies
RNs/LPNs
Nurse Practitioners
Physician Assistants
Community Mental Health Agencies
Allied Health Professionals
Pharmacists
Mental Health/Substance Abuse Providers

Blueprint for Health
Complementary/Alternative Medicine
Area Health Education Centers

Activities in Year One

The Workforce Work Group has focused on addressing the state workforce needs through two channels—supply and demand. In order to better meet the needs of the Vermont workforce as it undergoes advanced health care reforms, the group is seeking to assess the current supply of health care workers, as well as to gain a better understanding of what will be needed in the future as changes continue to occur.

In year one, the work group performed the following activities:

- Made a formal request for the work group to receive a $1 million allotment in the state FY 2016 budget to fund innovative projects in the state to increase, train or better utilize existing health care workers. Currently, this work group has no funding to support the work of potential initiatives. Unfortunately, the state budget has a deficit for FY16, so this funding request is unlikely to be successful. It was important to the group, however, to stress the need for funding now.

- Investigated current survey techniques being deployed in Vermont and across the country to scale and measure current workforce vacancies. If existing activities in the state do not capture this data, then the work group will seek a vendor to create and deploy a survey to state health care organizations in order to have a one-time view of current vacancies.

- Release an RFP for micro-simulation demand modeling. The selected vendor will build a model 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. Work group members will provide insight and their expertise to a chosen vendor around current workforce levels and anticipated needs in supplement to regional and national research.

In addition to these activities, the Workforce Work Group has undertaken the task of a administering a Statewide Workforce Symposium in November of 2014 to look at the topic of planning for a future workforce within a reformed health care system. This half day event will bring in knowledgeable speakers and panelist to deliver their insights to a broad audience of health care professionals in Vermont. The Workforce Work Group strongly supports forward thinking initiatives and orienting the state toward future needs.

Activities for Year two

Year two will include a continuation of the data collection activities begun in year one, as well as a review of the data to inform workforce policy and planning. To aid in determining future health care workforce needs in Vermont, the work group will do the following:

- Use information from the Vermont Department of Health: Office of Professional Licensure to measure the current number of licensed health care workers in the state through yearly licensure renewal. This will provide the Work Group with an accurate number of different health care professions in the state, including whether these professionals are full or part-time in practice or retired from practice.

- Use the findings and recommendations of the Workforce Subcommittee on Long Term Care (LTC) to identify areas of concern and opportunity in our direct care workforce to ensure an adequate supply of caretakers based on the projected future demand. The LTC Report provides information and recommendations to the larger work group on the topics of wages, training, recruitment, and retention of the direct care workforce.

- Work with the selected micro-simulation demand modeling vendor to develop the model.

In implementing the Workforce Plan, we will build on the expertise and experience of the wide variety of health professional training and education programs offered throughout the state. Those offered in the State College System and at the University of Vermont are outlined in the artifacts below. In terms of state employment training programs, the Vermont Department of Labor was directed by the Legislature to develop a comprehensive review of all such programs offered by each agency/department of state government. This assessment, due by the end of 2013, will be important in guiding consideration of increasing offerings for direct service and community health workers, an identified interest of our Blueprint and the VHCIP.

Key Artifacts:

Exhibit	Artifact Name	URL
93	Health Care Workforce Strategic Plan	http://hcr.vermont.gov/sites/hcr/files/workforce_Final%20Draft%20011520 13_mm.pdf
167	The Vermont Primary Care Workforce: 2012 Snapshot	http://www.uvm.edu/medicine/ahec/documents/AHEC_PCREPORT_1_16.

		pdf
38	APRN Task Force Final Report (2008)	
111	Naturopathic Physicians Prescribing Report	
89	Green Mountain Care Board Minutes, January 9, 2013	http://gmcboard.vermont.gov/sites/gmcboard/files/10913minutes.pdf
69	Executive Order (DRAFT) Health Care Workforce	
34	Act 79 (Sections 43-44, pp. 80-81)	http://www.leg.state.vt.us/docs/2014/Acts/ACT079.pdf
190	Workforce Capacity Programs/Curricula (State/Community Colleges & the University of Vermont)	
44	Biennial License Renewal Schedule: 2014-2015 (Office of Professional Regulation)	
113	Office of Professional Regulation Renewal Dates and Forms	
242	Workforce Symposium Flyer	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Symposium_Flyer.pdf

Section K Staff/Contractor Recruitment and Training

This section describes the process for developing a comprehensive staffing and contractor plan for implementing Vermont's SIM initiative. We anticipate completion of this detailed plan by early Fall 2013. As described below, we will rely on a combination of State staff and contractors to perform the tasks required for a successful SIM Project.

Question 29. How the state has or will recruit new/additional staff and/or contractors (as budgeted in SIM application) to adequately support SIM activities.

Question 30. How the state has or will recruit new/additional staff and/or contractors (as budgeted in SIM application) to adequately support SIM activities 2.

Question 31. How the state has trained all new and existing staff or contractors to fulfill their roles and defined supports for ongoing workforce development to ensure support of SIM activities throughout the grant period.

Resource Plan Overview

Due to the comprehensive nature and broad scope of the Vermont Health Care Innovation Project, the state will rely on a mix of existing and new staff and contractors to implement and evaluate the success of initiatives planned during the testing period. As described in Section A of this Operation Plan, Vermont intends to run the VHCIP as a public/private partnership. This partnership also will be reflected in our staffing and contracting plans.

The roles and responsibilities between the co-leading organizations, the Department of Vermont Health Access (DVHA) and the Green Mountain Care Board (GMCB) will be finalized in a Memorandum of Understanding (MOU). Similarly, any positions or contracts funded through the grant but located in different agencies, will also have a MOU with either DVHA or GMCB.

Any changes to the VHCIP-funded staffing and contract plans will be reviewed and approved by the VHCIP Core Team.

Staffing and Recruitment Plan

State staff involved in the VHCIP work in five state agencies: the Agency of Administration (AOA), the GMCB, the Agency of Human Services (AHs), DVHA, the Department of Health (VDH), and the Department of Aging and Independent Living (DAIL). In a matrixed staffing approach, the VHCIP staff will work under the general direction of the VHCIP Project Director who resides in the AOA. The table below provides a summary of positions currently working on the VHCIP. Additional staff will continue to be hired until the open positions are filled.

Recruitment for staff includes advertising in print and web-based job boards and special notice on state websites. Due to the specialized skills and small population and rural predominance of the state, timely recruitment of qualified staff is an identified challenge and the VHCIP leadership team is closely monitoring and putting resources towards these efforts.

Staff training, capacity building activities and organizational change management have been multi-faceted and phased-in over the course of the grant period. Initially for SIM-funded staff, training occurred by leveraging technical assistance resources, webinars, and conferences as well as direct mentorship by the VHCIP leadership. For broader state staff training, a set of educational slides about the care delivery and payment models planned under VHCIP were released and used for onboarding purposes. These slides will also be posted on a state website. As more models prepare for launch, more in-depth webinars and materials are being developed; these activities are included in the operational plans (see Section P).

Staff Evaluation and Sustainability

Initially, the focus of SIM-funded staff was to activate the full governance and management structure described in section A and on finalization of model design and implementation of the Shared Savings Programs with an emphasis on helping to accelerate and expand ongoing efforts. SIM staff will be evaluated using the state's well-defined process for providing feedback and performance review. As the models mature and as the grant period comes to a close, the SIM funded staff will transition their focus from implementation to training existing state staff and building their capacity to transform their roles and responsibilities to support the new care and payment delivery models identified as successful under the test period. In addition, a

contractor has been hired to do an assessment and make recommendations on reorganization of current state organizations in light of the new systems and models.

Table 11. Key State Personnel

Key State Personnel Please list the state staff who are assigned to VHCIP				
Name	**Organization/Title**	**SIM Role**	**Supervisor**	**Amount of time funded through SIM**
Anya Rader Wallack, Ph.D.	Agency of Administration/Governor's Office	Core team chair (on contract)	Governor	N/a
Robin Lunge	Agency of Administration/Governor's Office, Director of Health Care Reform	Core team member	Secretary of Administration	0%
Harry Chen	Agency of Human Services, Acting Secretary	Core team member	Governor	0%
Mark Larson	Department of Vermont Health Access, Commissioner	Core team member	Harry Chen	0%
Al Gobeille	Green Mountain Care Board, Chair	Core team member	N/A	0%
Susan Wehry, Commissioner	Department of Disabilities, Aging and Independent Living, Commissioner	Core team member	Harry Chen	0%
Georgia Maheras	Agency of Administration, Project Director	Project Director	Anya Rader Wallack/Core Team	100%
Paul Dupre, Commissioner	Department of Mental Health, Commissioner	Steering Committee Member	Harry Chen	0%

Tracy Dolan, Acting Commissioner	Department of Health, Commissioner	Steering Committee Member	Harry Chen	0%
Ken Schatz, Commissioner	Department for Children and Families, Interim Commissioner	Steering Committee Member	Harry Chen	0%
Monica Light, Director of Health Care Operations, Compliance & Improvement	Agency of Human Services, Director of Operations	Steering Committee Member	Harry Chen	0%
Richard Slusky	Green Mountain Care Board, Director of Payment and Delivery System Reform	SIM Project Manager	Al Gobeille	25%
Kara Suter	Department of Vermont Health Access, Director of Payment Reform	SIM Project Manager	Mark Larson	25%
Kate Jones	Green Mountain Care Board, Financial Director	Fiscal and Grant Manager	Susan Barrett	0%
Erin Flynn	DVHA, Senior Program Specialist	Program Specialist	Kara Suter	100%
Luann Poirier	DVHA, Administrative Services Manager	Project Administrator	Kara Suter	100%
Ena Backus	GMCB, Deputy Director of Policy & Evaluation	Data and Evaluation	Susan Barrett	0%
Spenser Weppler	GMCB, Health Care Reform Specialist	Work Group and Policy Support	Richard Slusky	0%
Pat Jones	GMCB, Health Care Project Director	Work Group and Policy Support	Richard Slusky	0%
Steve Maier	DVHA, HCR/HIT Integration Manager	Work Group and Policy Support	Mark Larson	0%

Christine Geiler	GMCB, SIM Grant & Stakeholder Coordinator	Grants & Stakeholder Coordinator	Ena Backus	100%
Diane Cummings	AHS, Fiscal Manager	Fiscal Manager II	Jim Giffin	100%
Julie Wasserman	Director, Vermont Dual Eligible Project	Work Group and Policy Support	Georgia Maheras	100%
Alicia Cooper	DVHA, Health Care Project Director	Quality Oversight Analyst	Kara Suter	100%
Amy Coonradt	DVHA, Health Policy Analyst	Work Group and Policy Support	Kara Suter	100%
Amanda Ciecior	DVHA, Health Policy Analyst	Work Group and Policy Support	Kara Suter	100%
Susan Aranoff	DAIL, Health Policy Analyst	Work Group and Policy Support	Georgia Maheras	100%
Jessica Mendizabal	DVHA, Fiscal Manager	Contract and Grant Administrator	Karen Wingate	100%
Bradley Wilhelm	DVHA, Senior Policy Advisor	Policy Advisor	Kara Suter	100%
Cecelia Wu	DVHA, Shared Savings Diector	Payment Initiative Director	Kara Suter	100%
James Westrich	DVHA, Senior Policy Advisor	Policy Advisor	Kara Suter	100%
Annie Paumgarten	GMCB, Evaluation Director	Evaluation Director	Georgia Maheras	100%
Carolynn Hatin	AHS IFS, Business Administrator	Business Administrator	Kara Suter	100%
Heidi Klein	VDH, Director of Health Surveillance	Work Group and Policy Support	Tracy Dolan	0%

Table 12 below details additional staff anticipated to be hired under the grant.

Table 12. Positions to Be Filled

Position	Role	Anticipated Date of Hire	Salary	Recruiting strategy
Workforce Work Group Manager	AOA-Core Staff		$34,805	State of VT HR website / Newspaper / UVM website
Payment Program Manager	DVHA / AHS – Core Staff		$69,610	State of VT HR website / Newspaper / UVM website
Payment Program Manager	DIAL/ AHS – Core Staff		$74,062	State of VT HR website / Newspaper / UVM website
Payment Program Manager: Quality and Oversight Analyst II	DVHA / AHS – Core Staff		$78,327	State of VT HR website / Newspaper / UVM website
Medicaid Data Analyst: Quality and Oversight Analyst II	DVHA / AHS – Core Staff		$74,062	State of VT HR website / Newspaper / UVM website
Medicaid Data Analyst: Health Care Statistical Information Administrator	DVHA / AHS – Core Staff		$61,513	State of VT HR website / Newspaper / UVM website
Medicaid Data Analyst: Health Policy Analyst	DVHA / AHS – Core Staff	11/1	$61,513	State of VT HR website / Newspaper / UVM website
Public Health Analyst III	VDH – Core Staff		$61,513	State of VT HR website / Newspaper / UVM website

Contractor Plan

Vermont has identified the key contracting categories, as described in our Year Two Budget Narrative submitted on November 1, 2014, to support the Project.

Table 13 below summarizes contracts executed to date related to this project.

Table 13. Key Contractors

Key Contractors involved in VHCIP			
***Advanced Analytics*: Policy and data analysis to support system design and research for all payers**			
Contractor	***Term***	***Responsible Agency***	***Scope***
Community Health Accountable Care # 03410-1456-15	11/1/14-10/31/15	*DVHA*	ACO operations: Data collection, analysis, operational implementation.
One Care Vermont #TBD	12/1/14-11/30/15	*DVHA*	ACO operations: Data collection, analysis, operational implementation.
Deborah Lisi-Baker #26033	2/7/14-6/30/15	*DVHA*	Support for DLTSS work group
The Lewin Group #27060	7/1/14-9/30/17	*GMCB*	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.

Pacific Health Policy Group #26096	3/1/14-9/30/14	*DVHA*	Assist with development of Care & Payment models, Quality measures, and identify barriers in current Medicare, Medicaid and commercial coverage and payment policies, and strategies to address them.
James Hester, Jr. #26319	4/22/14-2/28/15	*DVHA*	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.
TBD	3/1/15-2/28/16	*DVHA*	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.
Stone Environmental #TBD	11/30/14-12/31/15	*DVHA*	Provide an inventory and analysis of existing, health data systems, and development of a recommendation for a health information data, structure to facilitate greater access to Vermont's health information Pending.
Bailit Health Purchasing #26095	3/27/2014-1/31/17	*DVHA*	Supports policy development, payment model design, care model design and quality measurement identification for several VHCIP work groups.

Burns and Associates #1811	Contract ends 3/31/2015	*DVHA*	Conduct payment reform, financial modeling strategy development, rate setting work for Vermont Medicaid payment, methodologies, and other essential fiscal evaluations.
TBD	4/1/2015-5/31/2016	*DVHA*	Conduct payment reform, financial modeling strategy development, rate setting work for Vermont Medicaid payment, methodologies, and other essential fiscal evaluations.
Pacific Health Policy Group #27807	7/7/14-6/30/15	*DVHA*	Identify the major programs for which AHS procures direct care (as opposed to administrative) services from another entity, examine these programs regarding their utilization of value-based purchasing (VBP) methodologies, and make, recommendations to strengthen VBP within these programs.
Prevention Institute #TBD	11/1/14-4/30/15	*DVHA*	Assist with the development and potential application of the Accountable Health Community to Vermont's health care system

TBD	12/1/14-11/30/15	*DVHA*	Assist the HIE/HIT Work Group in developing policy and spending recommendations in the area of technology and infrastructure.
Pacific Health Policy Group #28062	11/1/14-10/31/15	*DVHA*	Assist the DLTSS Work Group in developing policy and spending recommendations.
TBD	12/1/14-11/30/15	*DVHA*	Development payment model related to frail elders
TBD	1/15/2015 - 12/31/2015	*GMCB*	Assist in development of an all-payer waiver proposal
Advanced Analytics: **Financial and other modeling for all payers**			
Contractor	***Term***	***Responsible Agency***	***Scope***
Wakely #26303	11/1/14-12/31/16	*DVHA*	Actuarial & Financial Analysis to support payment model development and all-payer waiver development.
Evaluation: **Self-Evaluation**			
Contractor	***Term***	***Responsible Agency***	***Scope***
IMPAQ #27426	9/12/14-9/30/17	GMCB	1. Design Vermont's Self-Evaluation Plan; 2. Execute Vermont's Self-Evaluation Plan

Initiative Support: **Interagency Coordination**			
Contractor	***Term***	***Responsible Agency***	***Scope***
Arrowhead #25312	8/27/14-8/26/15	AOA	Advise the Governor on policy matters related to the SIM project and to assist the Governor in deliberations and decision-making for the project and its implementation.
Initiative Support: **Staff Training and Change Management**			
Contractor	***Term***	***Responsible Agency***	***Scope***
Coaching Center #27383	8/22/14-2/28/15	DVHA	Provide team building and change management support to staff working on VHCIP.
Model Testing: **Quality Measures**			
Contractor	***Term***	***Responsible Agency***	***Scope***
Datastat #26412	7/28/14-7/25//15	DVHA	Administration of the Patient Centered Medical Homes Consumer Assessment of Health Care Providers and Systems (PCMH CAHPS®).
Bailit Health Purchasing #26905	3/27/2014-1/31/17	*DVHA*	Policy development, payment model design, care model design and quality measurement identification for several VHCIP work groups.

Community Health Accountable Care #TBD	11/1/14-10/31/15	*DVHA*	Chart Review for Shared Savings Program Measures
OneCare Vermont #TBD	12/1/14-11/30/15	*DVHA*	Chart Review for Shared Savings Program Measures
Healthfirst, Inc. #TBD	11/1/14-10/31/15	*DVHA*	Chart Review for Shared Savings Program Measures
Technical Assistance: **Learning Collaboratives**			
Contractor	***Term***	***Responsible Agency***	***Scope***
TBD	12/1/14-12/31/15	DVHA	Quality improvement facilitators supporting quality improvement activities in primary care practices, integrated care teams within communities and specialty addictions and mental health programs
Technical Assistance: **Practice Transformation & Data Quality Facilitation**			
Contractor	***Term***	***Responsible Agency***	***Scope***
Behavioral Health Network: ACTT Proposal #27379	10/1/14-7/31/16	*DVHA*	1) Unified EHR Procurement; 2) Data Quality Analysis and Remediation 3) Data Warehouse Planning and Development

HIS Professionals: ACTT Proposal #27511	10/1/14-8/31/16	*DVHA*	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.
VITL: ACO Gateway Population Health Proposal #03410-1275-14	7/2/14-6/30/16	*DVHA*	Develop and implement a population-based infrastructure within VHIE capabilities.
VITL: ACTT Proposal #03410-1275-14	7/2/14-6/30/16	*DVHA*	Conduct gap analysis for electronic health records, develop event notification system.
VITL: Data Quality #03410-1275-14	11/1/13-6/30/14	*DVHA*	Train practices on EHR usage and data collection to support state's clinical and business quality data measures.
Community Health Accountable Care #03410-1456-15	11/1/14-10/31/15	*DVHA*	Data quality initiatives
OneCare Vermont #TBD	12/1/14-11/30/15	*DVHA*	Data quality initiatives
Technical Assistance: **Technical assistance to providers implementing payment reforms**			
Contractor	***Term***	***Responsible Agency***	***Scope***

Bailit Health Purchasing #26095	3/27/2014-1/31/17	*DVHA*	Technical assistance for provider grant program. Analysis on Delivery System Design and Organization, Data & Financial Analysis.
Policy Integrity #26294	6/27/14-5/14/15	*DVHA*	Technical assistance for provider grant program. Analysis on Delivery System Design and Organization, Data & Financial Analysis.
Truven/Brandeis #26305	8/1/14-5/14/15	*DVHA*	Technical assistance for provider grant program. Analysis on Delivery System Design and Organization, Data & Financial Analysis.
Wakely #26303	Estimated contract term 11/1/14-12/31/16	*DVHA*	Actuarial & Financial Analysis
Vermont Program for Quality Health Care #27427	Estimated contract term 10/1/14-3/31/15	*DVHA*	Technical assistance for provider grant program. Advice on Delivery System Design and Organization, Advice on Payment Reform, Financial Analysis, Quality Reporting and Analysis, Planning and Model Design
Sub-grantees: NEED TO INSERT LIST HERE	Staggered 24-month terms	*DVHA*	Sub-grant awardees.
Technology and Infrastructure: **Expanded connectivity of HIE infrastructure**			

Contractor	***Term***	***Responsible Agency***	***Scope***
VITL #03410-256-14	11/1/13-6/30/14	*DVHA*	Develop interfaces between Vermont providers and the Health Information Exchange
HIS Professionals: ACTT Proposal #27511	10/1/14-8/31/16	*DVHA*	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.
VITL: ACO Gateway Population Health Proposal #03410-1275-14	7/2/14-6/30/16	*DVHA*	Develop and implement a population-based infrastructure within VHIE capabilities.
Technology and Infrastructure: **Enhancements to centralized clinical registry & reporting systems**			
Contractor	***Term***	***Responsible Agency***	***Scope***
HIS Professionals: ACTT Proposal #27511	10/1/14-8/31/16	*DVHA*	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.
Technology and Infrastructure: **Expanded connectivity between State of Vermont data sources and ACOs/providers**			
Contractor	***Term***	***Responsible Agency***	***Scope***

HIS Professionals: ACTT Proposal #27511	10/1/14-8/31/16	*DVHA*	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.
VITL: ACO Gateway Population Health Proposal #03410-1275-14	7/2/14-6/30/16	*DVHA*	Develop and implement a population-based infrastructure within VHIE capabilities.
Technology and Infrastructure: Analysis of how to incorporate long term support services, mental health and other areas of health			
Contractor	***Term***	***Responsible Agency***	***Scope***
Bailit: ACTT Proposal #26095	3/27/14-1/31/17	*DVHA*	Research related to the Transitions of Care Project for a Vermont Universal Transfer Protocol (UTP)
IM21: ACTT Proposal #27806	10/1/14-2/1/2015	*DVHA*	Planning phase of a Transitions of Care Project for a Vermont Universal Transfer Protocol (UTP)
Technology and Infrastructure: Telemedicine			
Contractor	***Term***	***Responsible Agency***	***Scope***

TBD	Estimated 1/1/15-6/30/2016	*DVHA*	Assist Vermont in assessing current telehealth practices in Vermont and planning for potential pilot programs
TBD	7/1/2015-6/30/2016	*DVHA*	Phase II of Telemedicine planning: Implementation of pilot programs
Project Management			
Contractor	***Term***	***Responsible Agency***	***Scope***
University of Massachusetts #25350	9/1/13-12/31/14	*GMCB and AOA (shifted from GMCB to AOA during year one)*	Project coordination and financial management assistance.
Stakeholder Engagement			
Contractor	***Term***	***Responsible Agency***	***Scope***
PDI Creative Consulting #TBD	*10/15/14-9/30/15*	*DVHA*	Design and implement a plan for structured outreach to the Vermont public
Workforce Assessment: **System-wide capacity**			
Contractor	***Term***	***Responsible Agency***	***Scope***

University of Vermont #27909	10/1/14-1/31/15	DVHA	Workforce symposium conference registrations and on-site management.
TBD	12 month term TBD	Dept. Of Labor or AOA	Demand Modeling: Construction of a micro-simulation health needs model for the State of Vermont.

Key Artifacts:

Exhibit	Artifact	URL
68	DHR Guide to Performance Management	http://humanresources.vermont.gov/sites/dhr/files/Documents/Labor%20Relations/DHR-Guide_Performance_Management.pdf
137	SIM Milestone Timeline (2013-2016)	
	Contracts	
138	SIM Project Management RFP	http://gmcboard.vermont.gov/sites/gmcboard/files/SIM_PMO_RFP061413.pdf
139	SIM Project Management RFP Questions and Answers	http://gmcboard.vermont.gov/sites/gmcboard/files/SIM_PM_RFP_Questions.pdf
64	Contract - Bailit Health Purchasing (Payment Reform)	http://gmcboard.vermont.gov/sites/gmcboard/files/Bailit_23886.pdf
193	Pacific Health Policy Group (VBP)	healthcareinnovation.vermont.gov/sites/hcinnovation/files/PHPG_%2327087_Signed.pdf
194	Maximus Health Services, Inc.	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Maximus_Amendment_3_Signed.pdf
195	Bailit Health Purchasing LLC	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Bailit_Health_Amendment_2_Signed.pdf
196	Vermont Information Technology Leaders, Inc. Grant	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/VITL_SIM_Grant_Signed.pdf
197	VMSSP ACO Contract - Community Health Accountable Care, LLC	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/CHAC-Final.pdf
198	VMSSP ACO Contract - OneCare Vermont Accountable Care Organization, LLC	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/onecare-base-contract-signed.pdf
199	UMASS Contract	http://healthcareinnovation.vermont.gov/si

		tes/hcinnovation/files/UMASS-Contract-%2325350.pdf
200	Burns and Associates	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/18211_Burns_Signed_Contract.pdf
201	Bi-State Primary Care Association	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/03410-1295-15_Bi-State_SIM%20Grant-Signed.pdf
202	Department of Aging and Independent Living	http://healthcareinnovation.vermont.gov/node/726#overlay-context=node/726
203	DataStat Inc	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/26412_DataStat-Signed.pdf
204	Healthfirst, Inc	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/03410-1305-15_Healthfirst_Grant-signed.pdf
205	IMPAQ International, LLC	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27426_IMPAQ-signed.pdf
206	James Hester Jr.	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/26319_James_Hester_Jr._Contract-Signed.pdf
207	The Lewin Group, Inc	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27060_Lewin-%20signed.pdf
208	Deborah Lisi-Baker	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/26033_Lisi-Baker_Signed_Base.pdf
209	Northeastern Vermont Regional Hospital	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/03410-1300-15_.NVRH_.pdf
210	Policy Integrity	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/26294_Policy_Integrity-Signed.pdf
211	The Coaching Center of Vermont, Inc	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27383_The_Coaching_Center-Signed.pdf
212	Truven Health Analytics	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/26305_Truven_Health_Analytics-Signed.pdf
213	Vermont Medical Society Education and Research Foundation	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/03410-1315-15_VMS_Education-Signed.pdf
219	White River Family Practice	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/03410-1280-15_White_River-Signed.pdf
214	Behavioral Health Network of Vermont	http://healthcareinnovation.vermont.gov/si

		tes/hcinnovation/files/27379_BHN%20-%20Signed.pdf
215	Generating Community Driven Solutions	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27806_IM21-signed.pdf
216	Pacific Health Policy Group - DLTSS	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/26096_PHPG.pdf
217	University of Vermont	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27909_UVM-Signed%20Contract.pdf
218	HIS Professionals, LLC	http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/27511_H.I.S._Professionals-Signed.pdf

Section N Sustainability Plans

This section addresses Vermont's plans for sustaining the new payment and delivery system models after the SIM grant program ends. Vermont will use SIM funding to transform the health care payment and delivery system. Any Vermont Health Care Innovation Project (VHCIP) initiatives that continue past the SIM funding period will be funded through savings in health care costs achieved by successful models.

Question 35: Has the state developed an evidence-based financial model for sustaining new payment and service delivery model(s) after the testing phase is complete, based on leveraging a comprehensive set of funding sources?

a. How is the program being structured to make it sustainable in the absence of SIM funds?

b. Has the state developed an evidence-based financial model to be put in place at the conclusion of the grant period?

c. Is the state looking at a comprehensive package of federal sources for beyond the SIM grant (ie. MMIS, other state and federal)?

The Vermont Health Care Innovation Project (VHCIP) is part of the state's health reform efforts. As described in Sections A and B of this Operational Plan, Vermont embarked on a bold set of reforms with the passage of Act 48 of the Acts of 2011. These reforms charge the Executive Branch and the Green Mountain Care Board (GMCB) with creating a high-performing health system that provides Vermonters with the highest quality of care at a sustainable cost. These reforms require that we use our regulatory and policy levers, as described in Section G of this Operational Plan, to develop evidence-based financial models for health system financing.

The GMCB is responsible for measuring health care costs and their annual growth in an evidence-based manner. This is accomplished through two major GMCB efforts: the retrospective expenditure analysis, and the prospective expenditure forecast. Under the GMCB's authority, these two efforts have been reframed to make them more robust and transparent. These tools provide the core of the evidence-based financial model that will be

used during the SIM funding period and after its conclusion. Vermont anticipates the need for additional financial modeling during the project to ensure these two tools are optimized.

Ongoing Funding Needs

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

Vermont will use SIM funding to support the development of tools and new models, while at the same time maintaining existing structures until they are no longer needed. As new payment mechanisms come online, we will no longer need staff and contracts to perform current tasks and will train those staff for their new roles. Vermont is intentionally seeking contract services to provide much of this transitional support as those contractors will provide subject matter and technical expertise and also enable us to use one-time funding more efficiently. The state will also become more efficient in its role as payer and regulator.

Vermont will use the funding to support the transition from the current payment and delivery system to alternative payment and delivery models. The models should be successful in producing savings and increasing quality. Vermont will sustain any personnel and tasks using model savings and through re-deployment of vacant positions in state government that may be no longer needed given new models of provider oversight and financing.

Vermont has determined that we will need ongoing support for a few of the personnel identified in the grant and three classes of contracts: data and infrastructure, ongoing evaluation and monitoring and the learning health system. We provide more detail on these below.

Personnel

Vermont expects to retain a small fraction of the staff hired under the SIM grant after the VHCIP/Duals Project ends. The SIM grant provides support for.25 FTE each for the two Directors of Payment Reform. Vermont will provide ongoing support for these staff through state budget appropriations subsequent to the grant period's conclusion. Of the remaining 22

positions, all are defined as limited service and any staff will be retained through re-deployment/retraining of existing state staff.

Contracts

Ongoing data and infrastructure needs

The State of Vermont is using SIM funds to develop a large portion of our data infrastructure. Specifically, we are doing the following:

- Building connections between providers and the state's data sources;
- Connecting more providers to our Health Information Exchange (HIE);
- Enhancing the clinical registry;
- Integrating the state's clinical registry and claims data reporting systems.

The funds provided through SIM are in addition to other funding the state has received through our health information technology claims assessment, Medicaid and HITECH. Vermont is aware of the complexity of federal IT funds available and, as described in Section A, is tasking the HIE/HIT Work Group to ensure all activities in this area are aligned.

The SIM funding allows Vermont to build the infrastructure necessary to support new payment models and educate providers on the new data systems. Once Vermont has developed the electronic connections, we will need to maintain those connections and improve them as new technologies emerge. As a data system, it also needs significant ongoing maintenance for upgrades. We anticipate that the remaining existing sources of funding will be sufficient to support the ongoing maintenance for the data systems described in the SIM grant proposal.

Learning Health System needs

Shifting to alternative payment systems requires collaboration among providers, payers and government. It also requires a willingness to continually learn and build towards a high performing health system. The State of Vermont will pull all of these entities together throughout the grant period to encourage discussion and shared learnings as part of a learning health system. Vermont will continue to support its learning health system after SIM funds are expended. The learning health system includes practice facilitators and learning collaboratives. The learning health system fosters delivery system transformation and supports the clinicians providing care to Vermonters. Vermont is committed to continued quality improvement efforts, and, as described in Sections I and M, has a strong track record of this work. These initiatives will be funded through existing learning health system mechanisms, like those currently in use by the Blueprint for Health, and model savings.

Evaluation and system monitoring

The state is committed to evaluating which VHCIP initiatives and models work, and to expanding those deemed successful. The state will also use evaluation to improve initiatives and eliminate those that are not success at improving health and lowering cost. The state will perform independent evaluation and internal evaluation in the SIM Project because we are testing new payment and delivery mechanisms. With SIM, we need to ensure that health is improving and costs are constrained. Assuming that we have success with the models tested, Vermont will need to maintain those successful models. The intrinsic nature of a testing period requires intense evaluation to ensure the project's goals are being met. Once the testing period is over, we will resume the standard evaluation and monitoring protocol in place in the state. In order to do this, Vermont will do a less intense, but ongoing evaluation and monitoring of the system built off of the existing surveys and evaluation. The state currently engages in high-level monitoring of the health care system through several mechanisms including, but not limited to:

- *The Household Health Insurance Survey,* a biennial survey measuring access to health care services;
- *The Behavioral Risk Factor Surveillance Survey*, an annual survey measuring the health of Vermont's population;
- *Funding for Health Utilization Analyses*, which supports a GMCB contract with Truven Health Analytics to provide health system utilization analyses;
- *Medicaid Monitoring & Evaluation Plans for Specific Pilot Programs and Contracts,* which support the he Department of Vermont Health Access's development of program- and/or contract-specific Monitoring and Evaluation (M&E) plans to ensure compliance of all involved parties with program terms and conditions while assessing the impact of the program on Vermont's Medicaid population (using both formative and summative evaluation strategies); and
- *Self-evaluation,* activities of which are described in Section R.

Vermont expects these would be sufficient to properly monitor and evaluate Vermont's health care system once the SIM funding is completed.

Federal funding beyond the SIM grant

Vermont continues to work with its federal partners to identify opportunities for funding to support federal and state health system goals. As described in Section B of this Operational

Plan, Vermont is committed to creating a health system that is of high quality and sustainable in the long term. Vermont will engage all payers, including Medicare, using program outcome data to engage participating payers in discussion about whether ongoing participation is a good investment in any of Vermont's payment and delivery system initiatives.

Key Artifacts:

Exhibit	Artifact	URL
91	Health Care Expenditure Analysis (2010)	http://gmcboard.vermont.gov/sites/gmcboard/files/2010EA040212.pdf
92	Health Care Expenditure Analysis (2011)	http://gmcboard.vermont.gov/sites/gmcboard/files/2011_Expenditure_Analysis_42313.pdf
	Year 2 Updated Artifacts	
248	2012 Expenditure Analysis	http://gmcboard.vermont.gov/sites/gmcboard/files/Large/2012VT_HC_EA.pdf
249	2012 Household Health Insurance Survey	http://www.dfr.vermont.gov/sites/default/files/VHHIS_2012_Final_Report.pdf
43	Behavioral Risk Factor Surveillance System Web Site	http://healthvermont.gov/research/brfss/brfss.aspx
251	VT Episodes of Care – Potentially Avoidable Costs Data Book	
252	Truven Studies Summary	http://gmcboard.vermont.gov/sites/gmcboard/files/Truven_Analyses_Summary.pdf
253	Price Variation Study	http://gmcboard.vermont.gov/sites/gmcboard/files/Meetings/Presentations/Price_Variation_Analysis_GMCB100214.pdf

Section O Administrative Systems and Reporting

This section describes Vermont's programmatic and financial oversight of Vermont Health Care Innovation Project (VHCIP) cooperative agreements. Overall oversight will be performed by the VHCIP Project Director under the general guidance of the VHCIP Core Team.

Question 36. Has the state identified and activated an office/entity responsible for the programmatic and financial oversight of cooperative agreements?

Vermont has assigned the VHCIP Project Director to oversee administration of the project, including management of the budget and financial reporting. Vermont's Agency of Human Services (AHS) is the official fiscal recipient of SIM funding according to the Notice of Award.

The Project Director will work with the VHCIP Staff and other state staff, described in Section A, to ensure all reporting is in compliance with federal and state requirements.

The Project Director, along with key state financial staff will ensure that all of the state agencies involved in the project are programmatically and fiscally responsible. This team will review federal reporting requirements and ensure funds allocated to VHCIP are in compliance with all SIM terms and conditions and that SIM funds are coordinated with any other relevant federal funding including, but not limited to: Medicaid funds, Vermont Health Connect (VHC) funds, and IAPD funds. The State of Vermont complies with federal auditing rules for all federal funding. The audit procedure is described in Bulletin 5.0, which can be found in the Artifacts for Section O.

At this time, we do not anticipate the need for additional fiscal policies related to SIM funding, but should the financial team determine additional forms and policies are necessary for appropriate fiscal operation of the VHCIP, they will develop these policies and present them to the Core Team for approval.

Key Artifacts:

Exhibit	Artifact	URL
151	Vermont Agency of Administration Bulletin 5: Single Audit Policy for Subgrants	http://aoa.vermont.gov/sites/aoa/files/pdf/AOA-Bulletin_5.pdf
150	Vermont Agency of Administration Bulletin 3.5: Contracting Procedures	http://aoa.vermont.gov/sites/aoa/files/pdf/AOA-Bulletin_3_5.pdf
74	GMCB - DVHA SIM Grant MOU	

Section Fraud and Abuse Prevention, Detection and Correction S

This section discusses Vermont's efforts to prevent fraud and abuse in the current reimbursement structure and how we will leverage that work to guard against future fraud and abuse.

Question 46. Has the state integrated sufficient protections into the planned transformation to guard against new fraud and abuse exposures introduced under new payment models?

The state recognizes the critical importance of preventing fraud and abuse (F&A), under current practice and as part of the state's transformation. As a result, the state has built practices and structures to protect its current reimbursement structure, and which will be leveraged to prevent F&A under new payment models.

Year One

In year one, this program focused on four successful fraud prosecutions, and identified specific program recommendations and strategies for identifying similar types of fraud going forward. *See, e.g.,* Attached presentations from 2013 Annual Meeting. *See also* MFRAU 2012 Annual Report at 7. MFRAU also formed a work group with various Vermont state agencies to refine program recommendations introduced at the June 2013 annual meeting regarding fraud in Vermont's home health/PCS Medicaid programs.

Year Two: Vermont will continue best practices in fraud and abuse prevention

In 2014, this program obtained 10 successful fraud convictions and continues to make recommendations to more quickly identify and better curtail their occurrences. Efforts around training and outreach activities, including participating with the USAO and other state and federal agencies in the Vermont Elder Justice Working Group, and the Vermont Health Care Fraud

Enforcement & Prevention Task Force will continue. Attached is the MFRAU 2014 Annual Report. In addition to ongoing efforts within Vermont's Medicaid fraud and abuse prevention program, Vermont will continue to leverage existing fraud and abuse programs for our payment and delivery system reforms. Vermont will also explore how existing programs can be applied as part of the conversations around the all-payer waiver.

Current Practice

As part of the provider enrollment process, Medicaid requires providers to maintain clinical documentation sufficient to support payment for services. The majority of payment models proposed under the grant require continued detailed submission of claims data so the methods used to prevent against F&A will remain relevant and useful tools to guard against F&A under new payment models. Moreover, as the new models increasingly rely on the use of additional clinical data from the state's clinical registry, it will be subject to the same standards of documentation. Therefore, the same tools can be extended for use with this new, evolving source of data as it is used to make payment adjustments. Additionally, all contracts with providers for new payment arrangements will include fraud and abuse protections, penalties, and performance-based terms and conditions.

Further, as the state moves forward with new payment models, it will also leverage the existing F&A structures and practices in place at the Vermont Attorney General's Office's Medicaid Fraud and Residential Abuse Unit (MFRAU), one of 50 Medicaid Fraud Control Units (MFCUs) nationwide that receive federal funding from HHS-OIG to investigate and prosecute fraud by Medicaid providers, and abuse/neglect of individuals in room-and-board facilities. Over the past three years, MFRAU has recouped more than $16 Million in state and federal funds, obtained more than two dozen criminal convictions, and processed almost 700 complaints. The unit has also performed significant training and outreach activities to both the provider and enforcement communities. These activities are described in more detail in MFRAU's annual reports. *See* 2012 & 2013 Annual Reports, attached.

In addition, MFRAU, jointly with the Program Integrity Unit at DVHA and the United States Attorney's Office (USAO), created the Vermont Health Care Fraud Enforcement Task Force in late 2011. The Task Force, comprising representatives from MFRAU, the USAO, OIG, FBI, and others, meets quarterly to discuss cases and potential referrals and holds an annual meeting each May or June. The Task Force's objectives are to:

- Improve collaboration and coordination of civil and criminal health care fraud cases among Vermont state and federal agencies;
- Identify trends in Vermont health care fraud;

- Share and leverage resources; and
- Develop new fraud enforcement tools and resources.

One area where the state plans to improve its fraud and abuse protections involves the use of non-service related payments (e.g., capacity payments). The payments are not service level payments and instead are used for the hiring of specific staff to perform a range of specified services across a given patient population. It is expected that the clinical registry and financial reports will be the primary data source to ensure program integrity related to these payments. As this model is one of the most innovative proposed (contained within the duals model of care, health homes and existing Multi-payer Advanced Primary Care Practices), the state will need to continue to refine and adapt its tools and resources to fully protect against F&A. Elements of the evaluation and monitoring plan will focus on assessing and improving program integrity around this payment model.

Question 47. Has the state addressed existing fraud and abuse protections that may pose barriers to implementing the proposed innovation model and have necessary waivers been obtained from OIG/Medicare?

Given the continued use of detailed claims and clinical data underlying all the models and current models in place under the state's Medicaid waivers, the state has not identified any barriers to implementation of the proposed innovation model related to existing fraud and abuse protections. As part of the planning process and in coordination with Medicaid program integrity staff as well as the VHCIP technical assistance contractor Manatt Health, the state will continue to work towards identification of whether waivers not yet anticipated are needed. Also, building protections against fraud and abuse will be included in the monitoring and evaluation plans supporting each model. Given the phased nature of the payment model implementation, the state believes there is sufficient time to continue to assess needs for any additional waivers.

Key Artifacts:

Exhibit	Artifact	URL
109	MFRAU 2012 Annual Report (July 1, 2011 — June 30, 2012)	

108	MFRAU 2011 Annual Report (July 1, 2010 — June 30, 2011)	
125	Powerpoint Presentation from Vermont Health care Fraud Enforcement Task Force 2013 Annual meeting entitled “Fraud in the Vermont Medicaid Program’s Home and Community Based Waiver Programs: A Case Study” (June 11, 2013)	
126	Powerpoint Presentation from Vermont Health care Fraud Enforcement Task Force 2013 Annual meeting entitled “State of Vermont v. McGRX, Inc.” (June 11, 2013)	
255	MFRAU 2014 Annual Report (July 1, 2013 — June 30, 2014)	http://ago.vermont.gov/assets/files/Criminal/Medicaid_Fraud/2014%20mfrau%20Annual%20Report%20-%20Complete.pdf
21	33 V.S.A. § 141	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=33&Chapter=001&Section=00141
22	33 V.S.A. § 143	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=33&Chapter=001&Section=00143
23	33 V.S.A. § 143a	http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=33&Chapter=001&Section=00143a

Section T Risk Mitigation Strategies

Vermont has identified several risks involved in this project. As indicated below, we have also developed strategies for mitigating those risks. We also anticipate the need to revise this risk/mitigation list over time as we implement the payment models in the Vermont Health Care Innovation Project (VHCIP).

Question 48. Has the state conducted a thorough study of the likelihood of success and the potential risk factors that must be addressed to increase the probability of success of the proposed innovation model, including recommendations for mitigating identified risks?

Question 49. Has the state planned and implemented a process for managing and mitigating risks over the course of the proposed transformation project?

Vermont's Risk Mitigation Plan is Artifact 256.

[1] Current Network Participants and Network Affiliates as of April, 2014; may change over time
[2] 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.
[3] 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
[4] Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Downloads/2014/Mar/State-County-Penetration-MA-2014-03.zip
[5] 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
[6] 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.
[7] Number of attributed lives is an estimate.
[8] Based on estimated attribution numbers as of June 30, 3014.
[9] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013
[10] Current Network Participants and Network Affiliates as of April, 2014; may change over time

[11] 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.
[12] 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
[13] 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)
[14] 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.
[15] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013
[16] Current Network Participants and Network Affiliates as of April, 2014; may change over time
[17] 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
[18] 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.
[19] 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).
[20] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013
[21] Based on HCi3 analysis of 23 commercial and Medicaid chronic and procedure-based episodes.
[22] http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=08&Chapter=107&Section=04088h
[23] http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=220&Section=09377
[24] VITL's mission is to collaborate with all stakeholders to expand the use of secure health information technology to improve the quality and efficiency of Vermont's health care system. VITL is both the designated HIE for the State of Vermont and the federally-designated regional extension center for the State of Vermont.
[25] The Blueprint Guidance document is currently in "Draft" form because the templates and examples for the final Appendix is still being developed. The content of the document is substantively complete.
[26] Virginia Tech University, What is RE-AIM? http://www.re-aim.hnfe.vt.edu/about_re-aim/what_is_re-aim/index.html; Weisman, SH et al, Getting to Outcomes: Ten Steps to Achieving Results-based Accountability (TR-101/2-CDC), http://www.rand.org/pubs/technical_reports/TR101z2.html; CMMI, SIM Test State Self-Evaluation: Guidance and Resources, June 5, 2014; Berry, SH et al. CMS Health Care Innovation Awards: Evaluation Plan (RR-376-CMS) http://www.rand.org/pubs/research_reports/RR376.html
[27] Centers for Disease Control and Prevention, Communities for Public Health: Develop SMART Objectives, http://www.cdc.gov/phcommunities/resourcekit/evaluate/smart_objectives.html.
[28] Lofland J and Lofland LH. *Analyzing Social Settings*, Third Edition. Belmont CA:Wadsorth Publishing Co, 1995.
[29] CMMI, Priority Measures for Monitoring and Evaluation, October 2014, http://innovation.cms.gov/Files/x/PriorityMsrMontEval.pdf.