State Innovation Model
Performance Period 3 Annual Report

Prepared by the State of Vermont
For the Centers for Medicare and Medicaid Services
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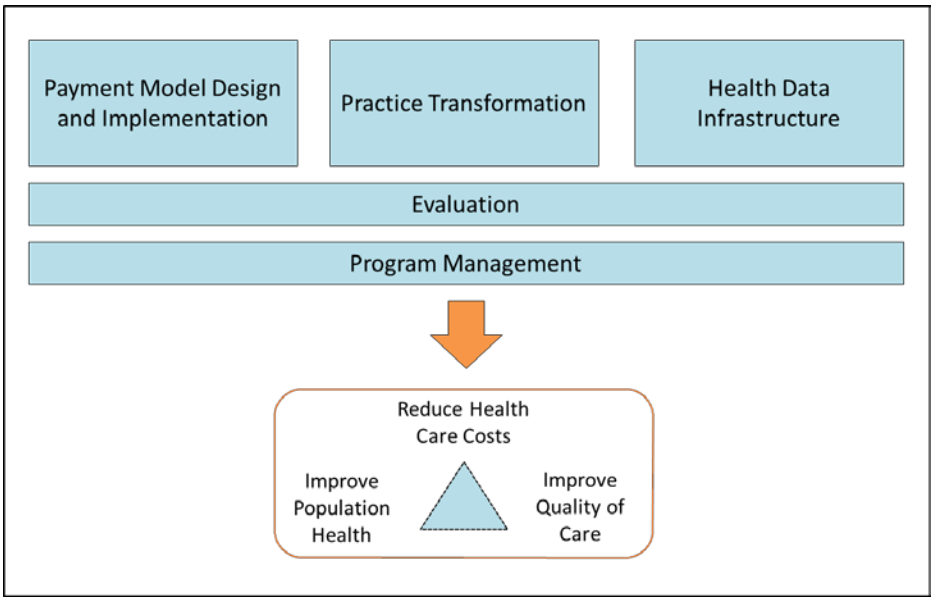
Introduction

Vermont's Performance Period 3 Annual Report describes Vermont's progress toward improvements in the state's health care system supported by the State Innovation Models (SIM) grant in Performance Period 3 (July 2016-June 2017). This document builds on our Performance Period 2 Operational Plan, submitted in November 2014; our Performance Period 2 Operational Plan Addenda, submitted in August 2015; our initial Performance Period 3 Operational Plan, submitted in November 2015 (rescinded in November 2015); our Performance Period 2 No-Cost Extension request, submitted in December 2015; and our Performance Period 2 Annual Report, submitted in September 2016. This document reports on activities undertaken during Performance Period 3 to meet our programmatic milestones, as well as major accomplishments and challenges during that period. It also includes a summary of all project milestones; evaluation findings for the project as a whole; and a complete list of reports and evaluation documents developed by project staff and contractors.

Vermont organizes its SIM activities and programmatic milestones into five focus areas:

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

Figure 1: Vermont's SIM Focus Areas



Throughout Performance Period 3, Vermont worked to achieve milestones that are required as part of our grant terms and conditions. These milestones are summarized in Table 1 below, with narrative provided in the sections to follow.

The remainder of this introduction describes a few of Vermont's major accomplishments and challenges that impacted the project as a whole during Performance Period 3. Table 1, which begins on Page 6, provides a summary of Vermont's Performance Period 3 milestones across all focus areas and indicates whether the milestone was achieved, delayed, or discontinued.

Major Accomplishment

Completed Sustainability Plan. Project staff drafted the Sustainability Plan in partnership with a contractor throughout Performance Period 3. The creation of this document was supported by a group of private sector stakeholders who have participated in a wide spectrum of SIM activities. This group included co-chairs from each of the Vermont SIM work groups as well as representatives from payers, ACOs, the Vermont Medical Society, business, a hospital, consumer, and a consumer advocate. The sustainability plan also went out for several rounds of public comment resulting in approval by the Core Team in June 2017 and submission to CMMI at the end of June.

Completed Population Health Plan. The Population Health Plan was developed and vetted through a months-long stakeholder engagement process. The process involved multiple rounds of public comment and resulted in a final document that was approved by the Core Team in June 2017 and was submitted to CMMI on June 28, 2017.

Launch of the Vermont Medicaid Next Generation Program. Halfway through Performance Period 3, Vermont Medicaid launched the Next Generation Program, which is a successor to the Shared Savings Program tested under SIM. This program is a first step in Vermont's All-Payer ACO Model implementation. In February 2017, the State and OneCare Vermont signed a contract to launch a risk-bearing Medicaid ACO under a Vermont Medicaid Next Generation program for a pilot performance period of CY2017. The program is aligned with the CMS Next Generation ACO program. It has the following features: nearly 30,000 attributed lives, a payment model aligned with Next Generation Payment Model 4, upside and downside risk for the ACO, quality measures aligned with the APM agreement, and a portion of payment contingent on quality. The contract can be extended up to four additional years.

Continuation and Maturation of the Integrated Communities Care Management Learning Collaborative. The 11 communities participating in the Integrated Communities Care Management Learning Collaborative have made a great deal of progress since program launch in 2014. In many communities, the learning collaborative experience has helped to build a strong and permanent foundation for team-based care coordination, and many of the tools, processes and interventions introduced through the Learning Collaborative have been embedded in standard practice. In PP3, the community teams participating in the Learning Collaborative continued to engage in the learning collaborative model by attending in-person learning sessions and webinars, while at the same time strengthening their roles within their local communities.

VCN Data Repository Implementation. Performance Period 3 included significant work on the VCN Data Repository, which allows the Designated Mental Health Agencies (DAs) and Specialized Service Agencies (SSAs) to send specific data to a secure centralized data repository, and to perform advanced data analytics to improve the efficiency and effectiveness of care. This has generated an enthusiasm for the data analytics as well as an enhanced appreciation for the role that data can play in care delivery and improved outcomes. There are two main phases for the repository: Phase 1-Vermont Monthly Service Report (MSR) Data Imports; and Phase 2- automated expanded data set interfaces.

Phase 1: As each of the member agencies submit their monthly service report (MSR) for the State of Vermont, they also submit a copy to the VCN data repository through our secure web site. In addition to uploading MSR files, this site is also the source for status reports for those file uploads as well as the status reports for the automated file uploads that run on a regular basis from each member agency.

Phase 2: VCN, in conjunction with NORC, created an interface specification that covers a much broader set of data than the MSR. In addition to demographic and service information, the VCN Repository Interface Specification, includes assessment, treatment planning, and clinical data about the people we serve. This will allow the network agencies to use their data to better understand their services, the people they serve, and provide some additional insight into the efficacy of their programming. In cases where there will be need for aggregated reporting, VCN will be able to aggregate the data in the repository to provide a network wide perspective that includes all of the agencies' data when appropriate.

Table 1: Performance Period 3 Milestone Status Summary – All Milestones

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status**
Project Implementation	Continue to implement project statewide. Implement all Performance Period 3 Milestones by 6/30/17.	Achieved: Implementation complete as of 6/30/17.
Payment Models	80% of Vermonters in alternatives to fee-for-service by 6/30/17.	Partially achieved: 55% of Vermonters in alternatives to fee-for-service as of 6/30/17, based on unduplicated counts.
Population Health Plan	Finalize Population Health Plan by 6/30/17.	Achieved: Population Health Plan submitted by 6/30/17. • The Population Health Plan is a required deliverable of Vermont's SIM grant. • The Population Health Plan proposes a strategic pathway forward to systematically connect integrated care management efforts with community-wide prevention strategies to improve population health outcomes, building on Vermont's existing State Health Improvement Plan. The plan builds on the work of the Population Health Work Group, and outlines principles for integrating population health and prevention into broader health reform efforts and identifies policy options to support population health integration. • During 2014 and 2015, the Population Health Work Group and staff developed a definition of population health, came to consensus on core concepts, and developed key documents to communicate core concepts. • Project staff and contractors worked during July-September 2016 to draft the Population Health Plan. Successive drafts of the plan were distributed for public comment and presented to stakeholders for vetting between September 2016 and May 2017. • The Population Health Plan was finalized in May 2017 and approved by the Core Team and submitted to CMMI in June 2017.
Sustainability Plan	Finalize Sustainability Plan by 6/30/17.	Achieved: Sustainability Plan submitted by 6/30/17.

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status**
		• The Sustainability Plan is a required deliverable of Vermont's SIM grant and builds on ongoing conversations between State leadership, project stakeholders, and CMMI. • Vermont's Sustainability Plan reviews all SIM work streams and identifies one-time investments and ongoing activities assigning each ongoing activity to a Lead Entity who will assume ownership over the activity, as well as a suite of Key Partners who will support and guide future work. It also considers lessons learned from SIM activities. • Contractors and project staff worked together during July-October 2016 to draft the Sustainability Plan in collaboration with a work group of private-sector stakeholders. Successive drafts of the plan were distributed for public comment and presented to stakeholders for vetting between October 2016 and May 2017. • The Sustainability Plan was finalized in May 2017 and approved by the Core Team and submitted to CMMI in June 2017.
Payment Model Design and Implementation Focus Area		
ACO Shared Savings Programs (SSPs)	Programs in Performance Period 3 by 12/31/16: Medicaid/commercial program provider participation target: 960. (Baseline as of December 2016: 940) Medicaid/commercial program beneficiary attribution target: 140,000. (Baseline as of December 2016: 179,076)	Partially achieved: Exceeded provider scale targets, partially achieved beneficiary scale targets. Medicaid and commercial provider participation was 1,105 as of 12/31/16 (incl. Medicare: ~933); Medicaid and commercial beneficiary attribution was 112,237 as of 12/31/16 (incl. Medicare: 176,244). • Modeled closely after the Medicare Shared Savings Program, this alternative payment model for commercial and Medicaid beneficiaries in Vermont was launched in 2014 as a three-year program. Beneficiaries are attributed to one of three accountable care organizations (ACOs) in the State. ACOs must meet quality targets to be eligible to share in any savings. • Shared savings and quality performance results for the 2015 performance year (Year 2) of the SSPs were presented in October 2016 to various VHCIP stakeholder work group meetings and webinars

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status**
		• The Medicaid SSP ended after the 2016 performance year (Year 3) and transitioned into the Vermont Medicaid Next Generation (VMCN) ACO Program in four communities for the 2017 Vermont Medicaid Next Generation (VMNG) pilot year (see All-Payer Model section). The commercial and Medicare SSPs continue with a fourth performance year in 2017. • Shared savings and quality performance results for the 2016 performance year (Year 3) of the SSPs were made public in Q3 2017.
Pay-for-Performance	1. Expand the number of providers and beneficiaries participating in the Blueprint for Health by 6/30/17: Medicaid/ commercial/ Medicare providers participating in P4P program target: 715. (*Baseline as of December 2015:* 706) Medicaid/ commercial/ Medicare beneficiaries participating in P4P program target: 310,000. (*Baseline as of December 2015:* 309,713) 2. P4P incorporated into Sustainability Plan by 6/30/17.	1. Achieved: Provider participation was 787 as of 6/30/17; beneficiary attribution was 306,460 as of 6/30/17. 2. Achieved: P4P incorporated into Sustainability Plan. • The Blueprint for Health provides performance payments to advanced primary care practices recognized as patient centered medical homes (PCMHs), as well as providing multi-disciplinary support services in the form of Community Health Teams (CHTs), a network of self-management support programs, comparative reporting from statewide data systems, and activities focused on continuous improvement. • In January 2016, the Blueprint added an incentive payment component to PMCH payments based on a combination of practice and regional performance on a composite of select quality measures. Quality measures were selected as the basis for the performance incentive payment in the summer of 2015; these measures were aligned with those being used for the Medicaid and commercial SSPs. • Medicare began participation in the Blueprint in 2011 through the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, which ended in December 2016. Medicare will continue to participate in the Blueprint in 2017 through one-time funds included the All-Payer ACO Model agreement; after 2017, funding for the Blueprint will flow through the ACO as part of population-based payments.

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status**
Health Home (Hub & Spoke)	1. Expand the number of providers and beneficiaries participating in the Health Home program by 6/30/17: Number of providers participating in Health Home program target: 75 MDs prescribing to ≥ 10 patients. (*Baseline as of December 2015:* 67) Number of beneficiaries participating in Health Home program target: 2,900 Hub + 2,300 Spoke = 5,200 total patients. (*Baseline as of December 2015:* 5,179) 2. Health Home program incorporated into Sustainability Plan by 6/30/17.	1. Partially achieved: Partially achieved provider scale targets, exceeded beneficiary scale targets. As of 6/30/17, 58 MDs prescribing to ≥ 10 patients[1]; 5,714 total patients participating. 2. Achieved: Health Home program incorporated into Sustainability Plan. • The Hub and Spoke initiative is a Health Home initiative created under Section 2703 of the Affordable Care Act for Vermont Medicaid beneficiaries with the chronic condition of opioid addiction. The Health Home integrates addictions care into general medical settings and links these settings to specialty addictions treatment programs in a unifying clinical framework. Two payments are used: bundled monthly rate for Hubs and a capacity-based payment for Spokes. • Access to treatment has steadily expanded, from 2,867 Medicaid beneficiaries receiving treatment in January 2013 to 5,714 in June 2017. • The Hub & Spoke program transitioned from enhanced 90/10 federal match to Vermont's usual Medicaid match rate after an initial eight quarters of implementation through two Health Home State Plan Amendments in July 2015 and January 2016, respectively. • Program implementation and reporting are ongoing.
Accountable Communities for Health	1. Continue implementation of ACH learning system (ACH Peer Learning Laboratory) to 10 participating communities. 2. Develop ACH Implementation Plan based on lessons learned from ACH Peer Learning Laboratory by 6/30/17. 3. ACH Implementation Plan incorporated into Sustainability Plan by 6/30/17.	1. Achieved: Peer Learning Laboratory implementation continued during PP3. 2. Achieved: ACH Implementation Plan developed by 6/30/17. 3. Achieved: ACH Implementation Plan is incorporated into SIM Sustainability Plan. • The Accountable Community for Health (ACH) is an aspirational model where the ACH is accountable for the health and well-being of the entire population in its defined geographic area, and not limited to a defined group of patients. Vermont's ACH efforts seek to align programs and strategies related to integrated care and services for individuals and

[1] There was a baseline error in establishing the number of MDs for this milestone. The baseline should have been 67 rather than 75.

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		community-wide prevention efforts to improve health outcomes within a geographic community. Phase I of this work, which took place during 2015, focused on research to further define the Accountable Communities for Health (ACH) model and identify core elements. • Phase II, the Accountable Communities for Health Peer Learning Laboratory, brought together multi-disciplinary teams from communities across the state to further explore how this model might be implemented and develop community capacity. The ACH Peer Learning Laboratory, which held its first convening in June 2016, supported participating communities in increasing their capacity and readiness across the nine core elements of the ACH model through a curriculum that utilized in-person and distance learning methods to support peer learning, as well as community facilitation to support each community's development. A final report, delivered in March 2017, documents findings and lessons learned, and includes recommendations to inform future State decision-making, focusing on what ACH-related infrastructure and resources are needed at the community/regional level and the State level. • Though the SIM contract to support the ACH Peer Learning Laboratory ended in March 2017, Vermont is working to continue convening ACH Peer Learning Laboratory communities for periodic peer-learning sessions going forward. • There is ongoing work to identify population health improvement opportunities to enhance Vermont's health delivery system models, such as the Blueprint for Health and ACOs. This would include better integration of clinical services, public health programs, and community-based services at both the practice and the community levels.
Medicaid Value-Based Purchasing	1. Mental Health and Substance Abuse: Based on research and feasibility analysis, design an alternative to fee-for-service, for Medicaid mental health and substance use services by 12/31/16. Develop implementation timeline based on payment	1. Achieved: Several alternative payment models for mental health and substance use disorder services were researched, analyzed, and in draft design by 6/30/2017; Draft operational timelines were developed. 2. Achieved: Research and feasibility analyses for other Medicaid VBP were performed during 2016.

	Performance Period 3 (PP3)	
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	model design and operational readiness by 12/31/16. 2. Other Medicaid VBP Activities: Engage in research and feasibility analysis to support additional Medicaid Value-Based Purchasing activities.	• The Agency of Human Services (AHS), in collaboration with the Agency of Administration (AOA), launched the Medicaid Pathway in the Fall of 2015. The Medicaid Pathway supported Medicaid payment and delivery system reforms, with the goal of moving away from traditional fee-for-service payment models in alignment with the All-Payer ACO Model. The Medicaid Pathway was designed to systematically review payment models and delivery system values identified in Vermont's Model of Care across AHS to refine State and local operations to better support the integration of physical health, long-term services and supports, mental health, developmental disabilities, substance use disorder treatment, and children's service providers. The project included two cohorts: o *Mental Health/Substance Use Disorder*: This work stream focused on mental health and SUD providers, incorporating previous work to assess feasibility of current mental health and SUD spending within the Agency of Human Services. In 2016, the State convened providers from each of these sectors along with other key partners to determine how best to serve Vermonters through a more integrated continuum of mental health, SUD, and developmental services. The State convened internal partners and relevant providers throughout 2016 to gather feedback and input, and worked with contractors to design alternative payment models for these providers. o *Long-Term Services and Supports*: This work stream focused on delivery system integration and payment reform with the goal of improving outcomes and quality of care for people who receive long-term services and supports, in particular through Vermont's Choices for Care program. The State convened internal partners and relevant providers in an LTSS/Choices for Care Medicaid Pathway Subgroup from May-December 2016. The Subgroup worked to identify goals and scope, discuss delivery system and payment models, develop a quality and oversight framework, promote, and identify necessary resources and policy changes.

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status**
		• The State and partners made significant progress across both work streams in PP3, including identification of policy goals, feasibility analysis, and draft design of alternative payment models for both provider sectors. The timeline for continued model development and implementation was delayed due to the change in Administration; however, State leadership still recognizes that Medicaid reform is critical to Vermont's ability to achieve its health reform goals and meet our obligations under the All-Payer ACO Model Agreement. Continued Medicaid Value-Based Purchasing efforts are integrated into Vermont's SIM Sustainability Plan and All-Payer ACO Model implementation plans.
All-Payer Model	1. If negotiations are successful, assist with implementation as provided for in APM agreement through end of SIM grant. 2. Contribute to analytics related to All-Payer Model implementation design through end of SIM grant. 3. All-Payer Model incorporated into Sustainability Plan by 6/30/17.	1 and 2. Achieved: SIM funds supported sustainability-related regulatory activities and analytics through 6/30/17. 3. Achieved: All-Payer Model is incorporated into SIM Sustainability Plan. • Agreement with CMMI: o The agreement was signed on October 27. Staff and federal partners also worked together to ensure alignment between the All-Payer ACO Model and Vermont's 1115 Medicaid waiver renewal, also finalized in late October 2016. • Vermont Medicaid Next Generation ACO Program: o Vermont selected OneCare Vermont as the successful bidder for this program for 2017. o Vermont Medicaid and OneCare Vermont signed a contract in February to launch the Vermont Next Generation (VMNG) ACO program for calendar year 2017. The program is aligned with the CMS Next Generation ACO program. It has the following features: nearly 30,000 attributed lives, a payment model aligned with Next Generation Payment Model 4, upside and downside risk for the ACO, quality measures aligned with the APM agreement, and a portion of payment contingent on quality. The contract can be extended up to four additional years.

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		○ The Green Mountain Care Board (GMCB) conducted a *Medicaid Rate Case* where they reviewed the all-inclusive population based payment to be paid by Vermont Medicaid to the ACO OneCare Vermont. GMCB will conduct similar reviews during the performance years 1-5 of the All-Payer ACO Model. ○ Staff are working to prepare Medicaid for the All-Payer ACO Model in its role as a payer, including developing reports to track ACO and State performance in implementing the model. • All-Payer Model Implementation: ○ In May 2016, *An act relating to implementing an All-Payer Model and oversight of accountable care organizations* was enacted as Act 113 of 2016. The law tasks the Green Mountain Care Board with formal state regulation of accountable care organizations. ○ The Green Mountain Care Board continues to prepare for All-Payer ACO Model implementation, including developing regulatory oversight and policy development mechanisms. This regulatory capacity building includes creating the framework for reviewing a Medicaid all-inclusive population-based payment to an ACO in 2017 and for all payers beginning in 2018.
State Activities to Support Model Design and Implementation – Medicaid	Pursue state plan amendments and other federal approvals as appropriate for each payment model; ensure monitoring and compliance activities are performed: 1. Obtain SPA for Year 3 of the Medicaid Shared Savings Program by 12/31/16. 2. Execute Year 3 commercial and Medicaid monitoring and compliance plans according to the predetermined plan through 6/30/17.	1. Achieved: SPA for Year 3 of the Medicaid Shared Savings Program approved in June 2016. 2. Achieved: Year 3 commercial and Medicaid monitoring and compliance plans executed throughout 2016. • This milestone supported Medicaid-specific state activities to support Medicaid payment model development and implementation. These activities ensure that Vermont Medicaid's SIM-supported activities are in compliance with its Medicaid State Plan and its Global Commitment for Health (1115) waiver, and that newly established programs will be monitored for their impact on Medicaid beneficiaries.
Practice Transformation Focus Area		

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status**
Learning Collaboratives	1. Target: 400 Vermont providers have participated in Learning Collaborative activities (including Integrated Communities Care Management Learning Collaborative or Core Competency Trainings) by 12/31/16. (*Baseline as of December 2015:* 200) 2. Report on program effectiveness to Steering Committee and Core Team by 12/31/16. 3. Incorporate Learning Collaborative lessons learned into Sustainability Plan by 6/30/17.	1. Achieved: 440 providers participated in Learning Collaborative Activities (including Integrated Communities Care Management Learning Collaborative, Core Competency Training, or both). 2. Achieved: Core Team and Steering Committee received regular updates on program progress and impact. Formal evaluation of program effectiveness was included in the State-Led Evaluation presentation to Core Team in June 2017. 3. Achieved: Learning Collaborative and Core Competency Training lessons learned incorporated into Sustainability Plan by 6/30/17. • Vermont's Learning Collaboratives share and diffuse best practices for care coordination and help multi-organizational teams deliver care most effectively. This work has grown to encompass two initiatives: the Integrated Communities Care Management Learning Collaborative and a Core Competency Training Series for front-line care management staff. o The Integrated Communities Care Management Learning Collaborative has worked to engage as many patient-facing care providers within each community as possible, including: nurses; care coordinators; social workers; mental health clinicians; physicians; and others from a broad spectrum of health, community, and social service organizations. This includes primary care practices, Community Health Teams, home health agencies, mental health agencies, Area Agencies on Aging, housing organizations, and social service organizations. Participants were convened for four in-person learning sessions and multiple webinars within a 12-month period, as well as regular local meetings to support transformation. The first cohort of 3 communities joined the Learning Collaborative in November 2014, and a cohort of 8 additional communities joined the Learning Collaborative in September 2015. Activities supporting this phase of the Integrated Communities Care Management Learning

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	Performance Period 3 Milestone	**Current Status**
		Collaborative continued through December 2016. Informed by the SIM sustainability plan, SIM staff worked closely with Blueprint for Health and ACOs to successfully transition the Integrated Communities Care Management Learning Collaborative to a second phase of activities led by Blueprint for Health and ACO leadership and staff. o The Core Competency Training initiative offered a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities statewide. Core curricula included competencies related to care coordination and disability awareness. Trainings launched in March 2016 and wrapped up in December 2016. These trainings used a "train the trainer" model with the goal of embedding training staff throughout the state to continue training others in the Core Competency curriculum beyond 2016. As with the Integrated Communities Care Management Learning Collaborative, the Core Competency Training initiative will continue into a next phase led by Blueprint for Health and ACO leadership and staff.
Sub-Grant Program – Sub-Grants	1. Provide SIM funds to support sub-grantees through 12/31/16. 2. Convene sub-grantees at least twice by 12/31/16. 3. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making. 4. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.	1. Achieved: Sub-grant project work was completed by 12/31/16. 2. Partially achieved: Sub-grantees were convened in late PP2, in June 2016; the State chose not to convene sub-grantees again due to short timeframe prior to grant close-out. Sub-grantees shared information throughout PP3 through quarterly reports, which were distributed widely, and through numerous updates to SIM work groups. 3. Achieved: Sub-grantee quarterly reports received and reviewed. 4. Achieved: Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status**
		• Sub-grantees reported on activities and progress, highlighting lessons learned. • All sub-grant projects have concluded; final reports are available here. • Sub-grantees submitted Q4 2016 Quarterly Reports during the month of December, available here. • As the programs ended, project staff have engaged the evaluation team and the self-evaluation contractor to develop a robust plan for the dissemination of lessons learned. Vermont's self-evaluation contractor conducted an in-depth analysis of sub-grantee activities including: project reach reported by each sub-grantee; reported effectiveness of outcomes; assessment of strength of effectiveness; potential for scale and/or sustainability; and likelihood of sustainability through existing infrastructure.
Sub-Grant Program – Technical Assistance	Provide technical assistance to sub-grantees as requested by sub-grantees: 1. Remind sub-grantees of availability of technical assistance on a monthly basis. 2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees. 3. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.	1. Achieved: Reminded sub-grantees of availability of technical assistance throughout PP3. 2. Achieved: Technical assistance contracts were reviewed on a periodic basis and amended as necessary to ensure that resources were fully available to meet the needs of sub-grantees. 3. Achieved: Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17. • Vermont supported sub-grantees with technical assistance as requested through the end of the sub-grant program.
Regional Collaborations	1. Support regional collaborations in 14 HSAs by providing sub-grants to ACOs and other technical assistance resources. 2. Develop a transition plan by 4/30/17 to shift all HSAs to non-SIM resources. 3. Incorporate into Sustainability Plan by 6/30/17.	1. Achieved: Regional collaborations in 14 HSAs supported by ACOs and other technical assistance resources. 2. Achieved: Transition plan developed. 3. Achieved: Regional collaborations included in SIM Sustainability Plan. • Within each of Vermont's 14 Health Service Areas, Blueprint for Health and ACO leadership have merged their work groups and chosen to collaborate with stakeholders under a single unified health system

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	Performance Period 3 Milestone	**Current Status**
		initiative. Regional Collaborations, also known as Community Collaboratives, include medical and non-medical providers (e.g., long-term services and supports providers and community providers), and a shared governance structure with local leadership. These groups focus on reviewing various data sources with the goal of improving outcomes on key statewide indicators, such as those included in the Vermont Medicaid Next Generation Program, the All-Payer ACO Model or the ACO clinical priority areas. Additionally, these groups, support the introduction and extension of new delivery system models (including Learning Collaboratives and Accountable Communities for Health), and provide guidance for medical home and Community Health Team operation. • With the support of trained staff, teams continue to implement quality improvement projects with a wide range of foci including: disease management, care coordination, mental health and substance use disorder treatment integration, addressing social determinants of health, increasing hospice and palliative care utilization, reducing ED utilization, reducing readmissions, improving care for people with chronic illness, improving care for those with congestive health failure, reducing hospital admissions, improving immunization rates for adults, improving developmental screening rates for adolescents, reducing medication assisted treatment (MAT) wait times, and implementing the Integrated Communities Care Management Learning Collaborative. Community Collaborative teams have and will continue to strengthen relationships and align and standardize processes and workflows for addressing quality improvement initiatives on a community-wide basis.
Workforce – Demand Data Collection and Analysis	Submit Final Demand Projections Report and present findings to Workforce Work Group by 12/31/16.	Achieved (with delay): Final Demand Projections Report completed and findings presented to Workforce Work Group in May 2017. A micro-simulation demand model uses Vermont-specific data to identify future workforce needs for the State by inputting various assumptions about care delivery in a high-performing health care system. The contractor for this

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		work created a demand model that identifies ideal workforce needs for Vermont in the future, under various scenarios and parameters. • Work began on the demand model project just before the end of PP2, and work carried over through the end of PP3 (June 2017). • The vendor (IHS Markit/IHS) ran preliminary projections for RNs, MDs, APRNs, and PAs by sub-specialty and HSA in July 2016 • IHS and Vermont, with input from key stakeholders from the public and private sectors, drafted a prioritized list of demand modeling scenarios in an "ideal" Vermont health care environment, which IHS began running through the model in late summer/early fall 2016. • IHS presented an initial draft report of demand projections and modeling scenarios to Vermont stakeholders at the December 2016 Workforce Work Group meeting and incorporated feedback, as well as more Vermont-specific claims datasets and additional demand scenarios, into model refinements through early 2017. • IHS presented a second draft of demand projections and modeling scenarios to Vermont stakeholders at the May 2017 Workforce Work Group meeting, and incorporated feedback into model refinements and a final project report. • A final report demand projections report was submitted to Vermont on June 30, 2017.
Workforce – Supply Data Collection and Analysis	Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan: 1. Present data to Workforce Work Group at least 3 times by 12/31/16. 2. Publish data reports/analyses on website by 6/30/17. 3. Distribute reports/analyses to project stakeholders by 6/30/17. 4. Incorporate into Sustainability Plan by 6/30/17.	1. Achieved: Supply data was presented to the Workforce Work Group twice by 12/31/16. Additional presentations in 2017. 2 and 3. Achieved: Survey and statistical reports for each profession are published on the VDH website on a rolling basis, as they are finalized. 4. Achieved: Workforce supply data activities included in the SIM Sustainability Plan. • Vermont's Office of Professional Regulation (OPR) and Vermont Department of Health (VDH) work in tandem to assess current and future supply of providers in the state's health care workforce through the collection of licensure and relicensure data and the administration of

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		surveys to providers during the licensure/relicensure process. Surveys include key demographic information for providers, and are used for workforce supply assessment and predicting supply trends, as well as informing future iterations of Vermont's Health Care Workforce Strategic Plan. • Representatives from OPR and VDH present data to and obtain feedback from Vermont's Health Care Workforce stakeholder work group on a regular basis. Updates were given to the work group in August and October 2016. • Staff, work group stakeholders, and VDH began conducting "deep dive" analyses on specific professions, beginning in PP2. In PP2, the work group examined data on physician assistants (PAs) and discussed ways of utilizing PAs to increase access to primary care in Vermont. In PP3, deep dive analyses and discussions have focused on the mental health and substance use disorder treatment provider professions in Vermont. • Survey and statistical reports for each profession are published on the VDH website on a rolling basis, as they are finalized.
Health Data Infrastructure Focus Area		
Expand Connectivity to HIE – Gap Remediation	1. Remediate 65% of ACO SSP measures-related gaps as identified in Fall 2015/Spring 2016 by 6/30/17. (Baseline as of December 2015: 62%) 2. Remediate data gaps for LTSS providers according to remediation plan developed in Performance Period 2 by 6/30/17. 3. Incorporate Gap Remediation activities into Sustainability Plan by 6/30/17.	1. Achieved: More than 65% of ACO SSP measures-related gaps as identified in Fall 2015/Spring 2016 remediated by 6/30/17. 2. Achieved: DLTSS Gap Remediation activities with Home Health Agencies completed by 6/30/17. 3. Achieved: Gap Remediation activities incorporated into in SIM Sustainability Plan. • The Gap Remediation project addressed gaps in connectivity and clinical data quality of health care organizations (HCOs) to Vermont's Health Information Exchange. • The ACO Gap Remediation component worked to improve VHIE connectivity for all Vermont Shared Savings Program measures among ACO member organizations.

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		• The Vermont Care Network (VCN/BHN) Gap Remediation improves the data quality for the 16 Designated Mental Health and Specialized Service Agencies (DAs and SSAs). • The DLTSS Gap Remediation effort to increase connectivity for Home Health Agencies was completed on 6/30/17 with connections established for 9 Home Health Agency Electronic Medical Record systems via ADT and/or CCD interfaces. • Gap Remediation efforts for ACO member organizations and Vermont Care Partners dovetail with the data quality improvement efforts described under the "Improve Quality of Data Flowing into HIE" work stream.
Improve Quality of Data Flowing into HIE	Engage in workflow improvement activities at designated mental health agencies (DAs) as identified in gap analyses. Start workflow improvement activities in all 16 DAs by 7/1/16 and complete workflow improvement by 12/31/16. Report on improvement over baseline by 6/30/17.	Achieved: DA data quality work completed in December 2016; final report submitted in July 2017. • VITL and BHN/VCN produced multiple training materials, recommendations, and findings as tools for the Designated Agencies to use for future training exercises. These efforts will result in information being entered appropriately to meet standard data formats for development of consistent and accurate ADT and CCD interfaces.
Telehealth – Implementation	1. Continue telehealth pilot implementation through contract end dates. 2. Incorporate Telehealth Program into Sustainability Plan by 6/30/17.	1. Achieved: Telehealth pilots implemented through 6/30/17. 2. Achieved: Telehealth program incorporated into Sustainability Plan. • Vermont funded telehealth pilot projects in PP2 and PP3 to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout the State of Vermont. • Project summaries: o The VNA of Chittenden and Grand Isle Counties is developing telehealth infrastructure by building connections among providers and enabling the timely sharing of clinical information. This telehealth pilot is enabling VNA and Central Vermont Home Health & Hospice (CVHHH) to connect their point of care systems (Honeywell Lifestream) to their EMR systems (McKesson) so that

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	Performance Period 3 Milestone	**Current Status**
		vitals taken by visiting nurses are available in the EMR. These results (in HL7's ORU format) can also be sent from the EMR into the Vermont Health Information Exchange (VHIE). Point of care information is now shared within the organization as well as with any provider accessing the VHIE through VITLAccess. This enables the home health organizations to be integral partners with numerous providers, including the University of Vermont Health Network, for the care of people with a wide range of chronic conditions. o The Howard Center, a major mental health and substance use disorder treatment provider in the state, is using telehealth technology to expand access to medication-assisted treatment (MAT) for people with opioid dependence. The Howard Center is using live video and secure, tamperproof medication dispensers to allow qualifying individuals to receive MAT in their homes with staff supervision.
Data Warehousing	1. Implement Phase 2 of DA/SSA data warehousing solution by 12/31/16. 2. Obtain approval of cohesive strategy for developing data systems to support analytics by 10/31/16. Operationalize the approved cohesive strategy for developing data systems to support analytics by 12/31/16.	1. Achieved (with delay): Phase 2 of DA/SSA data warehousing solution completed in June 2017. 2. Partially Achieved: Developed proposal for cohesive strategy for developing data systems to support analytics by 12/31/16. There are two parts to Vermont's Data Warehousing work: • The VCN Data Repository will allow the Designated Mental Health Agencies (DA) and Specialized Service Agencies (SSA) to send specific data to a centralized data repository. Long-term goals of the data repository include ensuring connectivity to the Vermont Health Information Exchange (VHIE), as well as Vermont State Agencies, other stakeholders, and interested parties. In addition to connectivity, it is expected that this project will provide VCN members with advanced data analytic capabilities to improve the efficiency and effectiveness of their services,

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		to demonstrate value, and to participate in payment and delivery system reforms. • Statewide planning activities focused on developing a long-term strategy for data systems to support analytics. Vermont convened a team of State stakeholders to discuss strategies for developing data systems to support the State's analytic needs and developed a proposal by 6/30/17.
Care Management Tools	1. Event Notification System: Continue implementation of ENS according to contract with vendor through 12/31/16. 2. Shared Care Plan: Recommend revisions to the VHIE consent policy and architecture to better support shared care planning by 6/30/17. 3. Universal Transfer Protocol: Support workflow improvements at provider practices through existing contracts through 12/31/16. 4. Continue implementation of care management solutions, including VITLAccess, supporting Home Health Agencies and Area Agencies on Aging.	1. Achieved: Event Notification System implementation continued through 6/30/17. 2. Achieved: Staff reviewed VHIE consent policy and architecture to better support shared care planning throughout PP3, and the HDI Work Group made recommendations in December 2016. 3. Achieved: Supported workflow improvements at provider practices to support Universal Transfer Protocol goals through existing contracts. 4. Achieved: Continued implementation of care management solutions, including VITLAccess, and supporting Home Health Agencies. (Work with Area Agencies on Aging discontinued due to legal issues.) • The Event Notification System (ENS) project implemented a system to proactively alert participating providers regarding their patient's medical service encounters. The selected ENS solution provides admission, discharge, and transfer data to participating providers and as of June 2017, notifications are being generated for 61,339 Vermonters. • The Shared Care Plan (SCP) project (formerly part of the SCÜP project) sought to provide a Shared Care Plan solution to Vermont's provider organizations. After electing not to pursue a technical Shared Care Plan solution, the project refocused on reviewing and recommending revisions to consent policy and architecture to better enable shared care planning in the future. • The Universal Transfer Protocol (UTP) project (formerly part of the SCÜP project) sought to provide a Universal Transfer Protocol to Vermont's provider organizations. During PP3, the project provided support services through the Integrated Communities Care Management Learning

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		Collaborative to transform practice workflows to support UTP goals by helping providers across the care continuum to exchange critical data and information. Work with Home Health Agencies to support VITLAccess onboarding and VHIE interface development is discussed above under Expand Connectivity to HIE – Gap Remediation.
General Health Data – HIE Planning	Finalize connectivity targets for 2016-2019 by 12/31/16. Incorporate targets into Sustainability Plan by 6/30/17.	Achieved. Connectivity targets presented and approved by Core Team in December 2016; this work stream is included in the SIM Sustainability Plan. • During review, analysis extended from a 3-year projection to a 10-year projection.
General Health Data – Expert Support	Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.	Achieved: IT-specific support procured as needed to further health data initiatives throughout PP3. • This is a companion project to all of the projects within the Health Data Infrastructure focus area. Due to the nature of those projects, Vermont needs specific skills to support the State and stakeholders in decision-making and implementation. The specific skills needed are IT Enterprise Architects, Business Analysts, and Subject-Matter Experts.
Evaluation Focus Area		
Self-Evaluation Plan and Execution	Execute Self-Evaluation Plan for 2016 and 2017 according to timeline for Performance Period 3 activities.	Achieved: Self-Evaluation Plan for 2016 and 2017 completed according to timeline for Year 3 activities through June 2017. • Vermont implemented a mixed-methods study that included site visits, focus groups, and provider and care integration surveys. The surveys focused on: care integration, use of clinical and economic data for performance improvement, and payment reform incentive structures. The public-private VHCIP Evaluation Steering Committee was established and continued to meet during PP3, providing valuable feedback on self-evaluation activities. • Vermont's State-Led Evaluation contractor completed and submitted all required PP3 deliverables by the end of the performance period,

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		including: final focus group report; final provider and care integration survey report and the final overall evaluation report.
Surveys	Conduct annual patient experience survey and other surveys as identified in payment model development: Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings Programs by 6/30/17.	Achieved: Vermont's patient experience contractor (DataStat) fielded the Year 3 patient experience survey from July 2016 to June 2017. • The PCMH version of the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey was fielded by DataStat to patients from more than 90 primary care practices from July 2014 to July 2015; July 2015 to June 2016; and July 2016-June 2017. Most primary care practices opted to participate in the survey, though it is not compulsory. Results from this survey are used as part of the monitoring and evaluation of the Shared Savings Programs.
Monitoring and Evaluation Activities within Payment Programs	1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications (bi-annual reporting to providers). 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications (monthly, quarterly reports depending on report type). 3. TBD: APM, Medicaid VBP – Mental Health and Substance Use.	1. Achieved: PCMH program (non-SIM funded) analyses completed according to program specifications (bi-annual reporting to providers). 2. Achieved: Final analysis of Year 2 of the commercial and Medicaid Shared Savings Programs were provided during Performance Period 3. Final analysis of Year 3 of the commercial and Medicaid Shared Savings Programs was complete in Q3 2017. 3. Achieved: information provided in the All-Payer Model and Medicaid Value-Based Payment workstreams above. • Reports on the Blueprint for Health included results for quality measures, patient experience measures, and cost of care measures for each Hospital Service Area (HSA), with comparisons to other HSAs and the state as a whole. A key innovation is the linkage of clinical and claims data for some of the measures. The reports have been adapted to include ACO Shared Savings Program measures, reinforcing the importance of these measures to providers. HSA-level reports are publicly reported on the DVHA website. • Analyses and accompanying reports for the 2015 ACO Shared Savings Programs were finalized and released publicly in October 2016, and included quality measures, patient experience measures, and savings

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status**
		calculations. These reports are publicly reported on the GMCB website. 2016 results were publicly posted on both the GMCB website and the VHCIP website in Q3 2017.
Project Management Focus Area		
Project Management and Reporting – Project Organization	Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2. Monthly staff meetings, co-chair meetings, and Core Team meetings with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Submit quarterly reports to CMMI and the Vermont Legislature. 4. Population Health Plan finalized by 6/30/17. 5. Sustainability Plan finalized by 6/30/17.	1. Achieved: Project Management contract scope of work and tasks performed on-time. 2. Achieved: Staff meetings, co-chair meetings, and Core Team meetings convened approximately bi-monthly with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Achieved: Quarterly reports to CMMI and the Vermont Legislature on time each quarter. 4. Achieved: Population Health Plan submitted on 6/30/17. 5. Achieved: Sustainability Plan submitted on 6/30/17. • Vermont's SIM project was supported by a project management team that oversaw project-wide coordination and reporting, as well as communication and outreach. Project management was focused on achieving milestones and meeting accountability targets across the project.
Project Management and Reporting – Communication and Outreach	Engage stakeholders in project focus areas by: 1. Convening 10 Core Team meetings between 7/1/16 and 6/30/17. 2. Convening 5 Steering Committee public meetings and 20 work group public meetings between 7/1/16 and 12/31/16. 3. Distributing all-participant emails at least once a month through 12/31/16. 4. Update website at least once a week through 12/31/16, and monthly through 6/30/17.	1. Partially achieved: 9 Core Team meetings convened during PP3. 2. Partially achieved: 3 Steering Committee meetings convened and 24 work group meetings convened during PP3. 3. Achieved: All-participant emails distributed once per month through 12/31/16, and on an ad hoc basis in 2017. 4. Achieved: Website updated at least once a week through 12/31/16, and monthly through 6/30/17.

Milestones Achieved, Major Accomplishments, and Challenges: Milestones Supporting CMMI Requirements

The terms of Vermont's SIM grant include requirements that have been translated into four overarching milestones that support CMMI requirements:

- Ongoing *Project Implementation*;
- Increasing the number of Vermonters included in non-fee-for-service *Payment Models*;
- Development of a *Population Health Plan*; and
- Development of a *Sustainability Plan* that looks beyond the end of the SIM grant.

Table 2, below, summarizes progress across these milestones during Performance Period 3. The remainder of this section details accomplishments and challenges within the Population Health Plan and Sustainability Plan work streams.

Table 2: Performance Period 3 Milestone Summary – CMMI Required Milestones

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
Project Implementation	Continue to implement project statewide. Implement all Performance Period 3 Milestones by 6/30/17.	Achieved: Implementation complete as of 6/30/17.
Payment Models	80% of Vermonters in alternatives to fee-for-service by 6/30/17.	Partially achieved: 55% of Vermonters in alternatives to fee-for-service as of 6/30/17, based on unduplicated counts.
Population Health Plan	Finalize Population Health Plan by 6/30/17.	Achieved: Population Health Plan submitted by 6/30/17. • The Population Health Plan is a required deliverable of Vermont's SIM grant. • The Population Health Plan proposes a strategic pathway forward to systematically connect integrated care management efforts with community-wide prevention strategies to improve population health outcomes, building on Vermont's existing State Health Improvement Plan. The plan builds on the work of the Population Health Work Group, and outlines principles for integrating population health and prevention into broader health reform efforts and identifies policy options to support population health integration. • During 2014 and 2015, the Population Health Work Group and staff developed a definition of population health, came to consensus on core concepts, and developed key documents to communicate core concepts. • Project staff and contractors worked during July-September 2016 to draft the Population Health Plan. Successive drafts of the plan were distributed for public comment and presented to stakeholders for vetting between September 2016 and May 2017. • The Population Health Plan was finalized in May 2017 and approved by the Core Team and submitted to CMMI in June 2017.
Sustainability Plan	Finalize Sustainability Plan by 6/30/17.	Achieved: Sustainability Plan submitted by 6/30/17. • The Sustainability Plan is a required deliverable of Vermont's SIM grant and builds on ongoing conversations between State leadership, project stakeholders, and CMMI. • Vermont's Sustainability Plan reviews all SIM work streams and identifies one-time investments and ongoing activities assigning each ongoing activity to a Lead Entity who will assume ownership

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
		over the activity, as well as a suite of Key Partners who will support and guide future work. It also considers lessons learned from SIM activities. • Contractors and project staff worked together during July-October 2016 to draft the Sustainability Plan in collaboration with a work group of private-sector stakeholders. Successive drafts of the plan were distributed for public comment and presented to stakeholders for vetting between October 2016 and May 2017. • The Sustainability Plan was finalized in May 2017 and approved by the Core Team and submitted to CMMI in June 2017.

Population Health Plan

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

The Population Health Plan is a required deliverable of Vermont's SIM grant, and proposes a strategic pathway forward to systematically connect integrated care management efforts with community-wide prevention strategies to improve population health outcomes, building on Vermont's existing State Health Improvement Plan. The plan builds on the work of the Population Health Work Group, and outlines principles for integrating population health and prevention into broader health reform efforts and identifies policy options to support population health integration.

During Performance Period 3, Vermont drafted the Population Health Plan with contractor support, vetted the Plan with key stakeholders, and received public comment from a broad array of project participants. The Population Health Plan was finalized, approved by the Core Team, and submitted to CMMI in June 2017.[2]

Major Accomplishments

Completed Population Health Plan. Project staff worked during July-September 2016 to draft the Population Health Plan in partnership with a contractor (selected during Performance Period 2). The first draft was completed in September 2016 and was presented to each SIM work group in October, and a revised draft considered by the Core Team in November. The draft Population Health Plan was further revised during September-April 2017, and presented to the Core Team again in April 2017. The final plan was approved by the Core Team in June 2017 and was submitted to CMMI on June 28, 2017.

Sustainability Plan

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

The Sustainability Plan is a required deliverable of Vermont's SIM grant, and builds on ongoing conversations between State leadership, project stakeholders, and CMMI. During Performance Period 3, Vermont drafted the Sustainability Plan with contractor support and private-sector input, vetted the Plan with key stakeholders, and received public comment from a broad array of project participants. The Sustainability Plan was finalized, approved by the Core Team, and submitted to CMMI in June 2017.[3]

[2] The approved Population Health Plan is available here: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/SIM-PopulationHealthPlan-Final-Web.pdf.
[3] The approved Sustainability Plan is available here: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/Final%20Vermont%20SIM%20Sustainability%20Plan%206.30.17.pdf.

Major Accomplishments

Convening of SIM Sustainability Sub-Group. In September 2016, the State convened a group of private sector stakeholders who have participated in a wide spectrum of SIM activities to inform Sustainability Plan development in concert with State-side planning and priority-setting. This group, called the Sustainability Sub-Group, included co-chairs from each of the SIM work groups as well as representatives from payers, ACOs, the Vermont Medical Society, business, a hospital, and a consumer and consumer advocate. The group met six times from September to December 2016 to provide input on which projects to sustain within each focus area and for the project overall, and developed a set of consensus recommendations for consideration by the Core Team.

Completed Sustainability Plan. Project staff worked during July-October 2016 to draft the Sustainability Plan in partnership with a contractor (selected during Performance Period 2). The first draft was completed in October 2016 and was presented to each SIM work group in November, and a revised draft considered by the Core Team in December. The draft Sustainability was further revised during December-April 2017, and presented to the Core Team again in April 2017. The final version was approved by the Core Team in June 2017, and was submitted to CMMI on June 30, 2017.

Milestones Achieved, Major Accomplishments, and Challenges: Payment Model Design and Implementation

Payment reforms are a central feature of Vermont's SIM activities. The payment reforms Vermont has pursued under SIM have evolved over the course of the grant, with planned activities discontinued and new activities added based on State and private-sector stakeholder feedback and the changing needs of our state.

Activities during this period included:

- Continuing Vermont's existing Medicaid and commercial *Shared Savings Programs* and transitioning them to new programs under the All-Payer ACO Model;
- Continued implementation of the Blueprint for Health *Pay-for-Performance* investments;
- Continued implementation of Vermont's *Health Home (Hub & Spoke)* program;
- Launch of an *Accountable Communities for Health* peer learning opportunity for regions around the state;
- Efforts to advance *Medicaid Value-Based Payment* for mental health services, substance use disorder treatment, developmental disability services, and long-term services and supports in alignment with the All-Payer ACO Model;
- Execution of the *All Payer Model* agreement and early model implementation; and
- Ongoing *State Activities to Support Model Design and Implementation.*

Table 3, below, summarizes progress across the Payment Model Design and Implementation Focus Area for all Performance Period 3 milestones; the remainder of this section details accomplishments and challenges within each work stream.

Table 3: Performance Period 3 Milestone Summary – Payment Model Design and Implementation Focus Area

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
ACO Shared Savings Programs (SSPs)	Programs in Performance Period 3 by 12/31/16: Medicaid/commercial program provider participation target: 960. (Baseline as of December 2016: 940) Medicaid/commercial program beneficiary attribution target: 140,000. (Baseline as of December 2016: 179,076)	Partially achieved: Exceeded provider scale targets, partially achieved beneficiary scale targets. Medicaid and commercial provider participation was 1,105 as of 12/31/16 (incl. Medicare: ~933); Medicaid and commercial beneficiary attribution was 112,237 as of 12/31/16 (incl. Medicare: 176,244). • Modeled closely after the Medicare Shared Savings Program, this alternative payment model for commercial and Medicaid beneficiaries in Vermont was launched in 2014 as a three-year program. Beneficiaries are attributed to one of three accountable care organizations (ACOs) in the State. ACOs must meet quality targets to be eligible to share in any savings. • Shared savings and quality performance results for the 2015 performance year (Year 2) of the SSPs were presented in October 2016 to various VHCIP stakeholder work group meetings and webinars • The Medicaid SSP ended after the 2016 performance year (Year 3) and transitioned into the Vermont Medicaid Next Generation (VMNG) ACO Program in four communities for the 2017 pilot year (see All-Payer Model section). The commercial and Medicare SSPs continue with a fourth performance year in 2017. • Shared savings and quality performance results for the 2016 performance year (Year 3) of the SSPs were made public in Q3 2017.
Pay-for-Performance	1. Expand the number of providers and beneficiaries participating in the Blueprint for Health by 6/30/17: Medicaid/ commercial/ Medicare providers participating in P4P program target: 715. (*Baseline as of December 2015:* 706) Medicaid/ commercial/ Medicare beneficiaries participating in P4P program target: 310,000. (*Baseline as of December 2015:* 309,713)	1. Achieved: Provider participation was 787 as of 6/30/17; beneficiary attribution was 306,460 as of 6/30/17. 2. Achieved: P4P incorporated into Sustainability Plan. • The Blueprint for Health provides performance payments to advanced primary care practices recognized as patient centered medical homes (PCMHs), as well as providing multi-disciplinary support services in the form of Community Health Teams (CHTs), a network of self-management support programs, comparative reporting from statewide data systems, and activities focused on continuous improvement. • In January 2016, the Blueprint added an incentive payment component to PMCH payments based on a combination of practice and regional performance on a composite of select quality measures. Quality measures were selected as the basis for the performance incentive

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
	2. P4P incorporated into Sustainability Plan by 6/30/17.	payment in the summer of 2015; these measures were aligned with those being used for the Medicaid and commercial SSPs. • Medicare began participation in the Blueprint in 2011 through the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, which ended in December 2016. Medicare will continue to participate in the Blueprint in 2017 through one-time funds included the All-Payer ACO Model agreement; after 2017, funding for the Blueprint will flow through the ACO as part of population-based payments.
Health Home (Hub & Spoke)	1. Expand the number of providers and beneficiaries participating in the Health Home program by 6/30/17: Number of providers participating in Health Home program target: 75 MDs prescribing to ≥ 10 patients. (*Baseline as of December 2015:* 67) Number of beneficiaries participating in Health Home program target: 2,900 Hub + 2,300 Spoke = 5,200 total patients. (*Baseline as of December 2015:* 5,179) 2. Health Home program incorporated into Sustainability Plan by 6/30/17.	1. Partially achieved: Partially achieved provider scale targets, exceeded beneficiary scale targets. As of 6/30/17, 58 MDs prescribing to ≥ 10 patients; 5,714 total patients participating. 2. Achieved: Health Home program incorporated into Sustainability Plan. • The Hub and Spoke initiative is a Health Home initiative created under Section 2703 of the Affordable Care Act for Vermont Medicaid beneficiaries with the chronic condition of opioid addiction. The Health Home integrates addictions care into general medical settings and links these settings to specialty addictions treatment programs in a unifying clinical framework. Two payments are used: bundled monthly rate for Hubs and a capacity-based payment for Spokes. • Access to treatment has steadily expanded, from 2,867 Medicaid beneficiaries receiving treatment in January 2013 to 5,714 in June 2017. • The Hub & Spoke program transitioned from enhanced 90/10 federal match to Vermont's usual Medicaid match rate after an initial eight quarters of implementation through two Health Home State Plan Amendments in July 2015 and January 2016, respectively. • Program implementation and reporting are ongoing.
Accountable Communities for Health (ACH)	1. Continue implementation of ACH learning system (ACH Peer Learning Laboratory) to 10 participating communities. 2. Develop ACH Implementation Plan based on lessons learned from ACH Peer Learning Laboratory by 6/30/17.	1. Achieved: Peer Learning Laboratory implementation continued during PP3. 2. Achieved: ACH Implementation Plan developed by 6/30/17. 3. Achieved: ACH Implementation Plan is incorporated into SIM Sustainability Plan. • The Accountable Community for Health (ACH) is an aspirational model where the ACH is accountable for the health and well-being of the entire population in its defined geographic area, and not limited to a defined group of patients. Vermont's ACH efforts seek to align programs and strategies related to integrated care and services for individuals and community-wide prevention efforts to improve health outcomes within a geographic

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
	3. ACH Implementation Plan incorporated into Sustainability Plan by 6/30/17.	community. Phase I of this work, which took place during 2015, focused on research to further define the Accountable Communities for Health (ACH) model and identify core elements. • Phase II, the Accountable Communities for Health Peer Learning Laboratory, brought together multi-disciplinary teams from communities across the state to further explore how this model might be implemented and develop community capacity. The ACH Peer Learning Laboratory, which held its first convening in June 2016, supported participating communities in increasing their capacity and readiness across the nine core elements of the ACH model through a curriculum that utilized in-person and distance learning methods to support peer learning, as well as community facilitation to support each community's development. A final report, delivered in March 2017, documents findings and lessons learned, and includes recommendations to inform future State decision-making, focusing on what ACH-related infrastructure and resources are needed at the community/regional level and the State level. • Though the SIM contract to support the ACH Peer Learning Laboratory ended in March 2017, Vermont is working to continue convening ACH Peer Learning Laboratory communities for periodic peer-learning sessions going forward. • There is ongoing work to identify population health improvement opportunities to enhance Vermont's health delivery system models, such as the Blueprint for Health and ACOs. This would include better integration of clinical services, public health programs, and community-based services at both the practice and the community levels.
Medicaid Value-Based Purchasing	1. Mental Health and Substance Abuse: Based on research and feasibility analysis, design an alternative to fee-for-service, for Medicaid mental health and substance use services by 12/31/16. Develop implementation timeline based on payment model design and operational readiness by 12/31/16. 2. Other Medicaid VBP Activities: Engage in research and feasibility	1. Achieved: Several alternative payment models for mental health and substance use disorder services were researched, analyzed, and in draft design by 6/30/2017; Draft operational timelines were developed. 2. Achieved: Research and feasibility analyses for other Medicaid VBP were performed during 2016. • The Agency of Human Services (AHS), in collaboration with the Agency of Administration (AOA), launched the Medicaid Pathway in the Fall of 2015. The Medicaid Pathway supported Medicaid payment and delivery system reforms, with the goal of moving away from traditional fee-for-service payment models in alignment with the All-Payer ACO Model. The Medicaid Pathway was designed to systematically review payment models and delivery system values identified in Vermont's Model of Care across AHS to refine State and local

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
	analysis to support additional Medicaid Value-Based Purchasing activities.	operations to better support the integration of physical health, long-term services and supports, mental health, developmental disabilities, substance use disorder treatment, and children's service providers. The project included two cohorts: o *Mental Health/Substance Use Disorder*: This work stream focused on mental health and SUD providers, incorporating previous work to assess feasibility of current mental health and SUD spending within the Agency of Human Services. In 2016, the State convened providers from each of these sectors along with other key partners to determine how best to serve Vermonters through a more integrated continuum of mental health, SUD, and developmental services. The State convened internal partners and relevant providers throughout 2016 to gather feedback and input, and worked with contractors to design alternative payment models for these providers. o *Long-Term Services and Supports*: This work stream focused on delivery system integration and payment reform with the goal of improving outcomes and quality of care for people who receive long-term services and supports, in particular through Vermont's Choices for Care program. The State convened internal partners and relevant providers in an LTSS/Choices for Care Medicaid Pathway Subgroup from May-December 2016. The Subgroup worked to identify goals and scope, discuss delivery system and payment models, develop a quality and oversight framework, promote, and identify necessary resources and policy changes. • The State and partners made significant progress across both work streams in PP3, including identification of policy goals, feasibility analysis, and draft design of alternative payment models for both provider sectors. The timeline for continued model development and implementation was delayed due to the change in Administration; however, State leadership still recognizes that Medicaid reform is critical to Vermont's ability to achieve its health reform goals and meet our obligations under the All-Payer ACO Model Agreement. Continued Medicaid Value-Based Purchasing efforts are integrated into Vermont's SIM Sustainability Plan and All-Payer ACO Model implementation plans.
All-Payer Model	1. If negotiations are successful, assist with implementation as provided for in APM agreement through end of SIM grant.	1 and 2. Achieved: SIM funds supported sustainability-related regulatory activities and analytics through 6/30/17. 3. Achieved: All-Payer Model is incorporated into SIM Sustainability Plan. • Agreement with CMMI:

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
	2. Contribute to analytics related to All-Payer Model implementation design through end of SIM grant. 3. All-Payer Model incorporated into Sustainability Plan by 6/30/17.	o The agreement was signed on October 27. Staff and federal partners also worked together to ensure alignment between the All-Payer Model and Vermont's 1115 Medicaid waiver renewal, also finalized in late October 2016. • Vermont Medicaid Next Generation ACO Program: o Vermont selected OneCare Vermont as the successful bidder for this program for 2017. o Vermont Medicaid and OneCare Vermont signed a contract in February to launch the Vermont Next Generation (VMNG) ACO program for calendar year 2017. The program is aligned with the CMS Next Generation ACO program. It has the following features: nearly 30,000 attributed lives, a payment model aligned with Next Generation Payment Model 4, upside and downside risk for the ACO, quality measures aligned with the APM agreement, and a portion of payment contingent on quality. The contract can be extended up to four additional years. o The Green Mountain Care Board (GMCB) conducted a *Medicaid Rate Case* where they reviewed the all-inclusive population based payment to be paid by Vermont Medicaid to the ACO OneCare Vermont. GMCB will conduct similar reviews during the performance years 1-5 of the All-Payer Model. o Staff are working to prepare Medicaid for the All-Payer ACO Model in its role as a payer, including developing reports to track ACO and State performance in implementing the model. • All-Payer Model Implementation: o In May 2016, *An act relating to implementing an All-Payer Model and oversight of accountable care organizations* was enacted as Act 113 of 2016. The law tasks the Green Mountain Care Board with formal state regulation of accountable care organizations. o The Green Mountain Care Board continues to prepare for All-Payer Model implementation, including developing regulatory oversight and policy development mechanisms. This regulatory capacity building includes creating the framework for reviewing a Medicaid all-inclusive population-based payment to an ACO in 2017 and for all payers beginning in 2018.
State Activities to Support	Pursue state plan amendments and other federal approvals as appropriate	1. Achieved: SPA for Year 3 of the Medicaid Shared Savings Program approved in June 2016.

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
Model Design and Implementation – Medicaid	for each payment model; ensure monitoring and compliance activities are performed: 1. Obtain SPA for Year 3 of the Medicaid Shared Savings Program by 12/31/16. 2. Execute Year 3 commercial and Medicaid monitoring and compliance plans according to the predetermined plan through 6/30/17.	2. Achieved: Year 3 commercial and Medicaid monitoring and compliance plans executed throughout 2016. • This milestone supported Medicaid-specific state activities to support Medicaid payment model development and implementation. These activities ensure that Vermont Medicaid's SIM-supported activities are in compliance with its Medicaid State Plan and its Global Commitment for Health (1115) waiver, and that newly established programs will be monitored for their impact on Medicaid beneficiaries.

ACO Shared Savings Programs (SSPs)

Performance Period 3 Milestone: ACO Shared Savings Programs (SSPs): Expand the number of people in the Shared Savings Programs in Performance Period 3 by 12/31/16:

Medicaid/commercial program provider participation target: 960.

Medicaid/commercial program beneficiary attribution target: 140,000.

In Performance Period 3, Vermont continued to operate two Shared Savings Programs, both in their final performance year. During PP3, the SSPs targeted additional beneficiaries and focused on expanding the number of Vermonters served in this alternative payment model. Shared savings and quality performance results for both SSP Year 2 (2015) were both released during this performance period. SSP Year 3 (2016) results were released in Q3 2017 (see Appendix B: Evaluation, for full results tables). The Vermont Medicaid SSP concluded at the end of 2016, following the conclusion of SSP Year 3, and DVHA launched a risk-based Vermont Next Generation ACO Pilot Program in four communities for CY2017. The Commercial SSP continue with a fourth performance year in CY2017, and Vermont ACOs continue to participate in the Medicare Shared Savings Program in 2017.

Major Accomplishments

Successful Program Closeout. Performance Period 3 saw the successful closeout of the Medicaid SSP at the end of CY 2016, with data analytics continuing through June 2017 to allow for completion of data through the claims lag period. The claims lag period was shortened from 6 months (in Years 1-2) to 4 months due to the end of Vermont's SIM funding in June 2017.

The two ACOs participating in the Medicaid SSP – CHAC and OneCare – did not receive shared savings as a result of performance during Year 3 of the program. CHAC did achieve a small amount of savings, but did not meet the minimum savings threshold of 2% required to receive shared savings payments. Of the three ACOs participating in the Commercial SSP (CHAC, OneCare, and Vermont Collaborative Physicians [VCP]), none received shared savings payments as a result of performance during Year 3 of the program. CHAC did achieve a small amount of savings, but will not receive shared savings payments because savings payouts in the Commercial SSP are contingent on BCBSVT achieving a surplus in its Qualified Health Plan business. All ACOs had high quality scores across the Medicaid and Commercial SSPs in Year 3, which would have allowed them to receive 90% or more of savings had savings been achieved.

Tables 4-6 on page 40 provide a summary of financial and quality results across for each SSP across all program years. CHAC and OneCare have moved progressively closer to the Commercial financial targets since 2014. CHAC, OneCare, and VCP all showed movement toward Commercial Per Member Per Month financial targets from 2015 to 2016. CHAC and OneCare

have progressively improved quality scores across all programs from 2014-2016. VCP has maintained its very high-quality scores in the Commercial program from 2014-2016.

In addition, both the Medicaid and commercial Shared Savings Programs demonstrated the ability to expand and retain high numbers of providers throughout the life of the program and exceeded the provider participation target in Vermont's PP3 milestone, though Vermont did not achieve the PP3 beneficiary participation target through the Medicaid and commercial programs. By 12/31/16, the number of providers participating in Vermont SSPs reached 1,005; Medicaid and commercial beneficiary attribution was 112,237, and attribution across all payers at this date was 176,244.

Vermont ACOs have continued to participate in Commercial and Medicare ACO SSPs for a fourth program year, CY2017. Commercial SSP analytic and monitoring activities, formerly supported by Vermont's SIM grant, are being supported with non-SIM funds in 2017 and beyond. OneCare Vermont is participating in the more advanced Vermont Medicaid Next Generation ACO program in 2017.

Table 4: Summary of Medicaid SSP Financial Results: 2014-2016

	Medicaid								
	Actual PMPM			PMPM Savings (Loss)			Quality Score		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
CHAC	$189.83	$182.06	$180.53	$24.85	$7.03	$0.75	46%	57%	70%
OneCare	$165.66	$171.55	$168.88	$14.93	$(2.18)	$(3.41)	63%	73%	77%
VCP									

Table 5: Summary of Commercial SSP Financial Results: 2014-2016

	Commercial								
	Actual PMPM			PMPM Savings (Loss)			Quality Score		
	2014	2015	2016*	2014	2015	2016	2014	2015	2016
CHAC	$350.03	$369.68	$496.01	$(25.94)	$(14.02)	$2.38	56%	61%	74%
OneCare	$349.01	$348.81	$496.74	$(23.38)	$(13.57)	$(6.50)	67%	69%	88%
VCP	$286.08	$303.95	$430.01	$(19.36)	$(34.62)	$(17.91)	89%	87%	88%

* Commercial SSP PMPMs for 2016 are not directly comparable to 2014-2015 PMPMs. In 2016, allowed amounts were used to calculate expected and actual PMPMs for the Commercial SSP (vs. paid amounts in prior years), which led to a large increase in both expected and actual PMPMs. Expected and actual PMPMs for 2016 also incorporate a 12% trend adjustment.

Table 6: Summary of Medicare SSP Financial Results: 2014-2016

	Medicare								
	Actual Aggregated Total			Savings as % of Expected			Quality Score		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
CHAC	$45,957,103	$56,658,198	Not Yet Reported	2.36%	-7.83%	Not Yet Reported	Reporting	97%	Not Yet Reported
OneCare	$470,417,853	$511,835,661		-0.89%	-5.56%		89%	96%	
VCP	$59,486,632			-4.87%			92%		

Challenges

Potential Conflict with All-Payer ACO Model Plans. One challenge identified during PP3 involved potential inconsistencies between current payment models and activities proposed for future payment models in the state, especially the All-Payer ACO Model. SSP Year 3 (2016) activities of the shared savings program included plans for evolving the SSP model in Vermont, which had the potential to conflict with activities proposed for Vermont's All-Payer ACO Model in 2017. Vermont mitigated this risk by including key Shared Savings Program operational staff in All-Payer ACO Model planning conversations to ensure alignment across related initiatives.

Vermont Medicaid Member Attribution Attrition. A challenge that impacted Vermont's ability to achieve PP3 milestone goals for beneficiary attribution involved a significant drop in Medicaid attribution to the Shared Savings Program in SSP Year 3 (2016). As a result of Vermont Medicaid eligibility redetermination activities, ~10,000 Medicaid beneficiaries who had previously been attributed to the SSPs in 2015 were deemed ineligible for Medicaid, which in turn made them ineligible for attribution to the Medicaid Shared Savings Program. This drop corresponds to Medicaid member decreases in the Vermont Medicaid program as a whole from CY 2015 to CY 2016, and was not unanticipated.

Pay-for-Performance

Performance Period 3 Milestone:

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

   Medicaid/ commercial/ Medicare providers participating in P4P program target: 715. (Baseline as of December 2015: 706)

   Medicaid/ commercial/ Medicare beneficiaries participating in P4P program target: 310,000. (Baseline as of December 2015: 309,713)

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

During Performance Period 3, Vermont continued to report quarterly on the Blueprint for Health. which provides performance payments to advanced primary care practices recognized as patient centered medical homes (PCMHs), as well as providing multi-disciplinary support services in the form of Community Health Teams (CHTs), a network of self-management support programs, comparative reporting from statewide data systems, and activities focused on continuous improvement.

For more information on the Blueprint for Health program, visit the program website or view the 2016 Blueprint Annual Report.

Major Accomplishments

Continued Collaboration with ACOs. The Blueprint continues to partner with ACOs on delivery system reform, including care management (through the Integrated Communities Care Management Learning Collaborative), development of community capacity for multi-sector leadership of population health (through the Accountable Communities for Health Peer Learning Lab), and improvement on clinical priority measures including hypertension (through a new Hypertension Learning Collaborative). Since January 2017, the Blueprint has worked with the OneCare Vermont to incorporate tools from the Integrated Communities Care Management Learning Collaborative into that ACO's care model, and to draft a PCMH-Continuum Care Shared Interest Payment.

Health Homes (Hub & Spoke)

Performance Period 3 Milestone:

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

Number of providers participating in Health Home program target: 75 MDs prescribing to ≥ 10 patients. (Baseline as of December 2015: 67)

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

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

During Performance Period 3, Vermont continued to report quarterly on the Health Home initiative, known as the Hub & Spoke initiative.

For more information on the Vermont's Health Home (Hub & Spoke) program, visit the Blueprint for Health program website or view the 2016 Blueprint Annual Report or the Hub & Spoke Data Profiles.

Major Accomplishments

Increased access to treatment for patients with opioid use disorder. As of June 30, 2017, 5,714 individuals were receiving medication-assisted treatment (MAT) for opioid use disorder: 3,114 clients enrolled in Regional Opioid Treatment Programs (OTPs – Hubs) and 2,600 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT – Spoke) programs. Medication assisted treatment is being offered across more than 77 different practices and by 203 medical doctors and 62.5 FTE registered nurses and Master's-prepared, licensed mental health/substance use disorder clinicians working as a team to offer Office-Based Opioid Treatment (as of May 2017).

Expanding Education. Learning collaboratives were convened from January-April 2017, including:

- For providers and practice teams that are new to office-based opioid treatment;
- For advanced providers and practice teams to address best practices and emerging topics like complex care considerations associated with medication assisted treatment patients; and
- Regionally (Chittenden) to identify and improve transition issues, including referral and consultation, between the OTP (Hub) and OBOT (Spoke) practices.

Challenges

Expanding MDs Prescribing to 10 or more patients. As of June 30, 2017, there were 58 MDs each prescribing to 10 or more patients, which is below the PP3 goal of 75. There are a variety of reasons for this discrepancy:

- *Inaccurate Baseline:* In December 2016, the Health Home Data Team learned that their previous system of reporting the number of MDs each prescribing to 10 or more patients was double-counting prescribers who were prescribing in more than one region. In addition to this reporting error, the previous system erroneously counted out-of-state prescribers in addition to in-state prescribers. The correction of these two errors corrected the baseline for December 2015 to 67 rather than the previously reported figure of 75. Given these past reporting errors, the program target of 75 MDs each prescribing to greater than or equal to 10 patients was not feasible.
- *Provider Readiness:* Furthermore, as Vermont continues to expand the number of new prescribers providing medication assisted treatment, the State has observed that a majority of new prescribers are conservative in their first several years and prefer to keep their patient count under 10 patients as they continue to enhance the care provided through office-based medication assisted treatment to patients with opioid use disorder.

Accountable Communities for Health

Performance Period 3 Milestone:

1. Continue implementation of ACH learning system (ACH Peer Learning Laboratory) to 10 participating communities.

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

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

The Accountable Community for Health (ACH) is an aspirational model where the ACH is accountable for the health and well-being of the entire population in its defined geographic

area, and not limited to a defined group of patients. An ACH supports the integration of high-quality medical care, mental health services, substance use disorder treatment, and long-term services and supports, and incorporates social services (governmental and non-governmental) for those in need of care. It also supports community-wide primary and secondary prevention efforts across its defined geographic area to improve the health of the population, and to reduce disparities in the distribution of health and wellness.

Phase I of this work, which took place during 2015 (PP1 Carryover), focused on research to further define the Accountable Communities for Health (ACH) model and identify core elements. Phase II, the Accountable Communities for Health Peer Learning Laboratory, brought together multi-disciplinary teams from communities across the state to further explore how this model might be implemented and develop community capacity. Figure 2, below, provides a visual of Vermont's ACH efforts in alignment with the Community Collaboratives and other state and local efforts.

Figure 2: Accountable Communities for Health in Context

Major Accomplishments

Continued ACH Peer Learning Laboratory Implementation. The ACH Peer Learning Laboratory supported participating communities in increasing their capacity and readiness across the nine core elements of the ACH model through a curriculum[4] that utilized in-person and distance learning methods to support peer learning, as well as community facilitation to support each community's development.

The first in-person convening was held in June 2016 (PP2), with two additional in-person convenings during PP3, in September 2016 and January 2017. In-person convenings focused largely on helping teams develop a collective vision for their ACH efforts, and providing a space for group learning within communities and learning across communities. Six web-based learning events focused on core elements of the ACH model.

Between learning events, communities worked within their groups on activities like meeting with key stakeholders, analyzing community data, identifying priorities, and developing and implementing action plans. These activities were supported by local facilitators, who received support and coaching from the Peer Learning Laboratory contractor.

Development of Recommendations for Continued ACH Efforts. A final report developed by the ACH Peer Learning Laboratory contractor, delivered in March 2017, documents findings and lessons learned, and includes recommendations to inform future State decision-making.[5] This report focuses on what ACH-related infrastructure and resources are needed at the community/regional level and the State level, and has supported State planning for continued ACH efforts.

Challenges

Alignment and Reform Fatigue. This effort is aligned with ongoing work to identify population health improvement opportunities to enhance Vermont's health delivery system models, such as the Blueprint for Health and ACOs, in collaboration with Vermont's Department of Health. During early stages of the Peer Learning Laboratory, participating communities expressed confusion and concern about the number of simultaneous regional reform initiatives underway in Vermont, including the SIM-supported initiatives like the Peer Learning Laboratory, Community Collaboratives, and the Integrated Communities Care Management Learning Collaborative. Through collaborative work across Departments and external stakeholders, staff and partners were able to communicate a more cohesive vision for these reforms, and to coordinate activities and approach to minimize community confusion.

[4] Curriculum is available on the SIM Website: ACH Peer Learning Laboratory Curriculum; Curriculum Appendix
[5] The final report for the contractor supported phase of the ACH Peer Learning Laboratory is available on the SIM website: ACH Peer Learning Laboratory Final Report, March 2017

Medicaid Value-Based Purchasing

Performance Period 3 Milestone:

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

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

The Agency of Human Services (AHS), in collaboration with the Agency of Administration (AOA), launched the Medicaid Pathway in the fall of 2015. The Medicaid Pathway supported Medicaid payment and delivery system reforms, with the goal of moving away from traditional fee-for-service payment models in alignment with the All-Payer ACO Model. The Medicaid Pathway was designed to systematically review payment models and delivery system values identified in Vermont's Model of Care across AHS to refine State and local operations to better support the integration of physical health, long-term services and supports, mental health, developmental disabilities, substance use disorder treatment, and children's service providers. The Medicaid Pathway process sought to develop provider-led reforms, and emphasized public-private partnerships through intensive dialogue with providers, consumers and consumer advocates, and other stakeholders. It was based on the premise that through payment and delivery system reform, the State can enable Medicaid providers to better serve Vermonters by providing higher quality, more efficient care that is better integrated into the broader health system.

The project included two cohorts:

- *Mental Health/Substance Use Disorder*: This work stream focused on mental health and SUD providers, incorporating previous work to assess feasibility of current mental health and SUD spending within the Agency of Human Services. In 2016, the State convened providers from each of these sectors along with other key partners to determine how best to serve Vermonters through a more integrated continuum of mental health, SUD, and developmental services. The State convened internal partners and relevant providers throughout 2016 to gather feedback and input, and worked with contractors to design alternative payment models for these providers.
- *Long-Term Services and Supports*: This work stream focused on delivery system integration and payment reform with the goal of improving outcomes and quality of care for people who receive long-term services and supports, in particular through Vermont's Choices for Care program. The State convened internal partners and relevant providers in an LTSS/Choices for Care Medicaid Pathway Subgroup from May-December 2016. The Subgroup worked to identify goals and scope, discuss delivery system and payment models, develop a quality and oversight framework, promote, and identify necessary resources and policy changes.

The State and partners made significant progress across both work streams in PP3, including identification of policy goals, feasibility analysis, and draft design of alternative payment models

for both provider sectors. Medicaid Pathway activities undertaken in 2016 are described in detail in a January 2017 report to the Vermont Legislature, as required by Act 113 pf 2016, Section 12.[6]

The timeline for continued model development and implementation was delayed due to the change in Administration; however, State leadership still recognizes that Medicaid reform is critical to Vermont's ability to achieve its health reform goals and meet our obligations under the All-Payer ACO Model Agreement. By 2020, the All Payer Model Agreement provides that AHS, in collaboration with the Green Mountain Care Board, shall submit a plan to include Medicaid behavioral health services and Medicaid home and community-based services in the all-payer financial targets in the APM. Continued Medicaid Value-Based Purchasing efforts are integrated into Vermont's SIM Sustainability Plan and All-Payer ACO Model implementation plans.

Major Accomplishments

Mental Health/Substance Use Disorder Financial Analyses and Payment Model Development. AHS reviewed numerous reimbursement methodologies related to the Mental Health/ Substance Use Disorder cohort. Those analyses continued through early 2017 resulting in several proposed alternative payment models.

AHS, through its contractor, has been performing a series of financial analyses of DA and SSA data. These financial analyses include consolidating the majority of payments made to DAs and SSAs into an Excel analytic model. Using this analytic file, the State is able to model alternative payment design and policy options. The information contained in the model is a compilation of most recent available sources of data, including: audited financials of DAs and SSAs; claims data; financial transaction data; and the DMH-managed MSR data repository. A series of validation exercises with AHS department staff and DA fiscal experts are ongoing to ensure data integrity. This exercise has resulted in a proposed standardization of financial and utilization data from nearly 30 disparate programmatic sources. This is a key step towards value-based payments for providers delivering these services.

LTSS Financial Analyses. The LTSS Medicaid Pathway cohort was launched later in 2016. The group initiated its work with a focus on the Model of Care and the Choices For Care (CFC) service delivery reforms that would more fully implement and embrace the Vermont Model of Care. This was intended to create a foundation for future payment reform discussions, such that CFC payment reforms would support CFC service delivery reforms and the Model of Care. During PP3, the State worked with contractors to perform preliminary review of current reimbursement methodologies and perform reimbursement analyses for this cohort, though a full payment model has not yet been developed.

[6] The Act 113 Section 12 report is available on the Vermont Legislature website: Medicaid Pathway 2016 Report.

Challenges

Barriers to Payment Model Implementation for Mental Health/Substance Use Disorder Cohort. Three key assessments were conducted at the start of the project:

1. A review of the available data upon which to support alternative, value-based payment model design;
2. A financial review of DA and SSA system financing across AHS; and
3. The feasibility of including of substance use disorder treatment preferred providers in initial payment model implementation.

These assessments surfaced a number of barriers to implementing payment reforms with DAs and SSAs:

- There is not uniformity across DAs and SSAs in the types and intensity of services provided.
- Financing is not uniform and can be provided by numerous, disparate funding streams.
- The adequacy of financing (known as "cost coverage") is not uniform and incents DAs to shift costs between programs to cover expenses.
- Claims data limitations result in limited information upon which to determine case-mix independently among programs and DAs and SSAs.
- Traditional risk adjustment scores are meant to predict differences in future medical benefit expenditures, and do not predict DA and SSA spending accurately.
- Both among providers and within State programs, there is room for improvement in reporting of standardized financial, utilization, and outcomes data. There needs to be additional collaboration between DAs and SSAs and AHS around eligibility, services, and reporting requirements.
- Given the diversity of services, the current financing, and the focus of the new Substance Use Disorder 1115 Waiver, inclusion of substance use disorder (SUD) preferred providers—primarily the Hubs, Spokes, and Recovery Centers— would be challenging.

Barriers to Financial Analyses and Payment Model Development for LTSS Cohort. A number of complicating factors have made these analyses particularly challenging:

- A significant majority of CFC participants (approximately 97%) are dually eligible for Medicaid and Medicare and receive services reimbursed by both payers. This requires additional consideration and analysis to maximize integration of service delivery and payment reform across payers.
- Many CFC participant move across settings (home, residential care, assisted living, nursing facility, hospital) and payment sources (Medicaid, Medicare, hospice) during the course of a given year.

All-Payer Model

Performance Period 3 Milestone:

1. If negotiations are successful, assist with implementation as provided for in APM agreement through end of SIM grant.

2. Contribute to analytics related to All-Payer Model implementation design through end of SIM grant.

3. All-Payer Model incorporated into Sustainability Plan by 6/30/17.

On October 27, 2016, after approximately two years of discussion and negotiation, the "Vermont All-Payer ACO Model Agreement" was signed between CMS and Vermont's Governor, Secretary of the Agency of Human Services, and Chair of the Green Mountain Care Board (GMCB). The All-Payer ACO Model builds on existing all-payer payment alternatives to better support and promote a more integrated system of care and a sustainable rate of overall health care cost growth. Value-based payments that move away from fee-for-service payment, shift some risk to health care providers, and are aligned across all payers can encourage collaboration across the care continuum, result in better health outcomes for Vermonters, and improve financial predictability for providers.

During Performance Period 3, Vermont has focused on implementation of the Model, not only in response to the Agreement, but also in response to Vermont's Act 113 of 2016. The Vermont General Assembly passed Act 113, which was signed into law by Governor Shumlin in May 2016, to establish principles and requirements to guide the state in ACO oversight and implementation of a value-based payment model (such as the All-Payer Model). Act 113 complements the Agreement by providing the GMCB with regulatory authority over ACOs in Vermont. In addition, the State of Vermont plans to participate in the Model as a payer via Medicaid. To prepare for that participation, DVHA has designed, negotiated, and implemented the Vermont Medicaid Next Generation (VMNG) ACO program.

Major Accomplishments

Vermont Medicaid Next Generation ACO Pilot Program Launch. The Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) Pilot program represents the initial phase of Medicaid's participation in the integrated health care system envisioned by the Vermont All-Payer Accountable Care Organization Model agreement. The VMNG program allows the Department of Vermont Health Access (DVHA) to partner with a risk-bearing Accountable Care Organization. For Calendar Year 2017, DVHA has partnered with OneCare Vermont (OneCare) ACO to manage the quality and cost of care for approximately 29,000 Medicaid members in four communities. Together, DVHA and OneCare are piloting a financial model designed to support and empower the clinical and operational capabilities of the ACO provider network in support of the Triple Aim of better care, better health, and lower costs. Primary goals of the program are to increase provider flexibility and support health care professionals to deliver the care they know to be most effective in promoting and managing the

health of the population they serve. The VMNG ACO Pilot program was designed with the goal of supporting the implementation of Vermont's All-Payer ACO Model, and to align closely with the Medicare Next Generation ACO program. Most notably, the included services, attribution, and payment methodologies are aligned with the Medicare Next Generation ACO program. Additionally, the majority of quality measures align with the All-Payer ACO Model agreement.

Since executing the Vermont Medicaid Next Generation contract in February of 2017, DVHA and OneCare Vermont have partnered in the launch and ongoing implementation of this pilot program. The state is currently working with OneCare to finalize terms for a 2018 contract year.

Preparation for All-Payer ACO Model Implementation Activities. With extensive help from SIM-supported contractors, Vermont engaged in the following implementation activities:

- *Act 113 ACO Oversight Rule:* GMCB began developing the ACO Oversight Rule (GMCB Rule 5.000) in Fall 2016, and convened a stakeholder group in January 2017 to provide input on drafts of the rule. The group is comprised of representatives of ACOs, the Office of the Health Care Advocate, Blue Cross Blue Shield of Vermont (BCBSVT), MVP Health Care, DVHA, and the Vermont Association of Hospitals and Health Systems. GMCB voted at its April 27, 2017, Board meeting to proceed to the statutory rulemaking process with the current draft, and filed the proposed rule with the Office of the Secretary of State on May 19, 2017. Public hearings and the public comment process took place in June and July 2017, and GMCB filed a final proposed rule with the Secretary of State and the Legislative Committee on Administrative Rules (LCAR) in August, after a Board vote. LCAR heard the rule on September 14, 2017. Rulemaking should be completed by the end of 2017.
- *Act 113 ACO Annual Reporting and Budget Guidance:* As required by Act 113, OneCare Vermont, CHAC, and any other qualifying ACOs will annually submit to GMCB their budgets and reports on how they meet ACO certification criteria. GMCB and the ACOs agreed to use 2017 as a 'test' year in preparation for required reporting in 2018. GMCB issued guidance asking the ACOs to report on governance, payer contracts, participating providers, care models, and their budgets. The ACOs submitted these reports by June 23, 2017, and presented their budgets on July 13, 2017 so that the GMCB could consider the potential impact of ACO activities on hospital budgets and insurance premium rates for qualified health plans (QHPs). The Agreement allows GMCB to set the Medicare growth rate for ACOs participating in the Vermont Modified Medicare Next Generation Program, making it essential to review a participating ACO's budget in order to arrive at the most appropriate Medicare growth rate, within the Agreement's parameters.
- *Act 113 ACO Certification:* In drafting the ACO Oversight rule, GMCB has identified the types of documents and information an ACO will need to submit as part of its application for certification. GMCB will develop an application form by Fall 2017. ACOs must be certified by the Board by January 1, 2018, in order to receive payments from Medicaid or a commercial insurer through any payment reform program or initiative. If

the rule is not adopted and effective prior to December, the Board will begin reviewing materials from ACOs in anticipation of the final rule.

- *Integration of GMCB Regulatory Activities:* The GMCB is working to integrate Act 113 regulatory activities and requirements from the Agreement with its other regulatory processes, including hospital budget review and health insurance rate review for Qualified Health Plans.
- *ACO and Payer Implementation Activities:* Vermont's ACOs and major commercial payers have also been focused on implementation. The state's three ACOs voted to explore the formation of a single corporate entity in anticipation of an All-Payer ACO Model. While discussions regarding a single ACO are continuing, as of June 2017 the two largest ACOs are pursuing separate arrangements with payers. BCBSVT, Vermont's largest commercial insurer, has continued to participate in the ACO Shared Savings Program in 2017 and is in active discussions with ACO representatives regarding a value-based payment program to support participation in the Model in 2018 and beyond.

Refining Total Cost of Care and Quality Measure Specifications. GMCB and DVHA staff, with the help of SIM-supported contractors, are working with CMS to define the All-Payer Total Cost of Care (TCOC) measure that is a critical reporting metric in the Agreement. State staff have identified the financial target services for Medicaid and Commercial spending that will serve as the basis for the All-Payer TCOC calculation. To accomplish this, staff and contractors:

1. Carefully reviewed the description of included and excluded services contained in the Agreement.
2. Met with colleagues from DVHA and BCBSVT to obtain information on covered services, and how they compare to the included services identified in the Agreement.
3. Worked with staff from DVHA to analyze Medicaid expenditures at a category of service level. Medicaid is the most complex payer because of the variation and scope of services provided to Medicaid beneficiaries and because the Agreement explicitly excludes certain Medicaid services. Staff and contractors identified included services that correspond with the services outlined in the Agreement, and cross-walked those services with commercial services, to demonstrate how the two payers will be aligned in defining financial target services.
4. Initiated the development of detailed specifications to calculate All-Payer Total Cost of Care, using code level specifications from payers when available, and exploring existing expenditure measures that might be helpful.

The quality measures outlined in the Agreement are specified in Appendix 1, with corresponding targets established for most of the measures. Of the twenty measures in Appendix 1, Vermont and CMS were responsible for establishing targets for two measures by June 30, 2017: provider utilization of the Vermont Prescription Monitoring System (a new measure), and emergency department visits for mental health and substance abuse conditions. Lack of baseline data for the Vermont Prescription Monitoring System measure prevented target-setting during Performance Period 3; however, GMCB recently received baseline data for CY2016 from VDH and proposed a target for CMS consideration in June 2017. A target was also

not established for the measure related to reducing the rate of growth in emergency department visits for mental health and substance abuse conditions due to Vermont concerns about the impact on access to needed care. GMCB staff have obtained input from emergency department medical directors and a community psychiatrist and have provided a summary to CMS, which indicates that Vermont should carefully consider any target that results in a reduction in the growth of visits. GMCB is actively working with CMS on this issue.

Continued Analytics and Actuarial Modeling to Support APM Planning and Implementation. Vermont has worked with SIM-supported contractors to develop a decision-support tool that will assist regulators in determining the appropriate rate of growth for Vermont's health care providers, consistent with the All-Payer ACO Model Agreement targets. A SIM-supported contractor also provided actuarial modeling to support Model design. In addition, Vermont developed and posted an RFP for an All-Payer ACO Model analytics vendor. Ten proposals were received in June 2017, and GMCB entered negotiations with an apparently successful bidder in Summer 2017.

Challenges

Implementation Capacity Development. The All-Payer ACO Model is a complex project that spans multiple State agencies, the federal government, and private sector partners. In addition, many of the accomplishments listed above describe areas where Vermont is breaking new ground in partnership with CMS. As such, this initiative has required and will continue to require significant capacity development within State government, in the provider sector, and with key State contractors who will support the initiative. Specific challenges have included:

- *Regulatory Framework Development:* Act 113 mandates that Vermont build a regulatory framework for ACO oversight.
- *Developing a Unique Quality Framework:* As described above, Vermont has worked with CMS to develop a complex quality framework that is unique to the All-Payer ACO Model. In doing so, the State has had to establish analytic capacity for gathering, updating and processing baseline and performance year data from multiple sources, as well as setting appropriate targets for each measure in the framework.
- *Identifying and Understanding Data Sources:* All-Payer ACO Model measurement activities have required the State to identify and understand existing and new data sources, and to work with dataset managers to ensure that these complex datasets are ready for analysis to meet the needs of all parties participating in this initiative.
- *Ensuring ACO and Provider Readiness:* DVHA and GMCB have been working closely with ACOs and providers since prior to the start of the APM planning process. In particular, the GMCB convened stakeholders over a period of many months to build relationships and help with Model design, and DVHA conducted a formal readiness review of OneCare Vermont in late 2016 to ensure that the ACO was operationally capable of participating in a Medicaid version of the Next Generation ACO program. The readiness review included several weeks of desk audits and a full week of in-person review. OneCare

passed the readiness review, with 76% of items complete; 100% of items were complete by the end of March 2017.

While the State is confident in its internal readiness and in ACO and provider capacity to implement the All-Payer ACO Model, we also recognize that the complexity, scale, and uniqueness of this initiative will require continuous learning and adaptation.

State Activities to Support Model Design and Implementation – Medicaid

<u>Performance Period 3 Milestone</u>: Pursue state plan amendments and other federal approvals as appropriate for each payment model; ensure monitoring and compliance activities are performed:

1. ***Obtain SPA for Year 3 of the Medicaid Shared Savings Program by 12/31/16.***
2. ***Execute Year 3 commercial and Medicaid monitoring and compliance plans according to the predetermined plan through 6/30/17.***

For all Medicaid payment models that are designed and implemented as part of Vermont's SIM grant activity, there are a number of Medicaid-specific state activities that must occur. These activities ensure that Vermont Medicaid's SIM-supported activities are in compliance with its Medicaid State Plan and its Global Commitment for Health (1115) waiver, and that newly established programs will be monitored for their impact on Medicaid beneficiaries.

During Performance Period 3, milestones in support of this work stream were specifically related to the Vermont Medicaid Shared Savings Program. In addition to ensuring that policies and procedures were in place for appropriate member service and support (i.e. having an operational call center to address inquiries about the program) and implementing an ongoing, data-driven monitoring and compliance plan, Vermont also obtained State Plan Amendment approval for Year 3 of the program.

Milestones Achieved, Major Accomplishments, and Challenges: Practice Transformation

Practice Transformation activities are critical for supporting provider readiness to transition to, and participate in, alternative payment models. During Performance Period 3, Vermont's SIM project maintained successful initiatives, with a focus on smoothly transitioning many activities to the leadership identified through the SIM sustainability planning process. Activities during this period included:

- Continuing and expanding existing *Learning Collaborative* activities;
- Concluding the *Sub-Grant Program* including sub-grant projects and technical assistance for grantees;
- Expansion and continued development of *Community Collaboratives,* formerly known as *Regional Collaborations,* to align Blueprint for Health and ACO governance and quality improvement activities; and
- *Workforce* activities, including continued analyses of workforce supply data and completion of a micro-simulation workforce demand modeling effort.

Table 7, below, summarizes progress across the Practice Transformation Focus Area for all Performance Period 3 milestones. The remainder of this section details accomplishments and challenges within each work stream.

Table 7: Performance Period 3 Milestone Summary – Practice Transformation Focus Area

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
Learning Collaboratives	1. Target: 400 Vermont providers have participated in Learning Collaborative activities (including Integrated Communities Care Management Learning Collaborative or Core Competency Trainings) by 12/31/16. (*Baseline as of December 2015:* 200) 2. Report on program effectiveness to Steering Committee and Core Team by 12/31/16. 3. Incorporate Learning Collaborative lessons learned into Sustainability Plan by 6/30/17.	1. Achieved: 440 providers participated in Learning Collaborative Activities (including Integrated Communities Care Management Learning Collaborative, Core Competency Training, or both). 2. Achieved: Core Team and Steering Committee received regular updates on program progress and impact. Formal evaluation of program effectiveness was included in the State-Led Evaluation presentation to Core Team in June 2017. 3. Achieved: Learning Collaborative and Core Competency Training lessons learned incorporated into Sustainability Plan by 6/30/17. • Vermont's Learning Collaboratives share and diffuse best practices for care coordination and help multi-organizational teams deliver care most effectively. This work has grown to encompass two initiatives: the Integrated Communities Care Management Learning Collaborative and a Core Competency Training Series for front-line care management staff. o The Integrated Communities Care Management Learning Collaborative has worked to engage as many patient-facing care providers within each community as possible, including: nurses; care coordinators; social workers; mental health clinicians; physicians; and others from a broad spectrum of health, community, and social service organizations. This includes primary care practices, Community Health Teams, home health agencies, mental health agencies, Area Agencies on Aging, housing organizations, and social service organizations. Participants were convened for four in-person learning sessions and multiple webinars within a 12-month period, as well as regular local meetings to support transformation. The first cohort of 3 communities joined the Learning Collaborative in November 2014, and a cohort of 8 additional communities joined the Learning Collaborative in September 2015. Activities supporting this phase of the Integrated Communities Care Management Learning Collaborative continued through December 2016. Informed by the SIM sustainability plan, SIM staff worked closely with Blueprint for Health and ACOs to successfully transition the Integrated Communities Care Management Learning Collaborative to a second phase of activities led by Blueprint for Health and ACO leadership and staff. o The Core Competency Training initiative offered a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators,

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
		etc.) from a wide range of medical, social, and community service organizations in communities statewide. Core curricula included competencies related to care coordination and disability awareness. Trainings launched in March 2016 and wrapped up in December 2016. These trainings used a "train the trainer" model with the goal of embedding training staff throughout the state to continue training others in the Core Competency curriculum beyond 2016. As with the Integrated Communities Care Management Learning Collaborative, the Core Competency Training initiative will continue into a next phase led by Blueprint for Health and ACO leadership and staff.
Sub-Grant Program – Sub-Grants	1. Provide SIM funds to support sub-grantees through 12/31/16. 2. Convene sub-grantees at least twice by 12/31/16. 3. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making. 4. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.	1. Achieved: Sub-grant project work was completed by 12/31/16. 2. Partially achieved: Sub-grantees were convened in late PP2, in June 2016; the State chose not to convene sub-grantees again due to short timeframe prior to grant close-out. Sub-grantees shared information throughout PP3 through quarterly reports, which were distributed widely, and through numerous updates to SIM work groups. 3. Achieved: Sub-grantee quarterly reports received and reviewed. 4. Achieved: Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17. • Sub-grantees reported on activities and progress, highlighting lessons learned. • All sub-grant projects have concluded; final reports are available here. • Sub-grantees submitted Q4 2016 Quarterly Reports during the month of December, available here. • As the programs ended, project staff have engaged the evaluation team and the self-evaluation contractor to develop a robust plan for the dissemination of lessons learned. Vermont's self-evaluation contractor conducted an in-depth analysis of sub-grantee activities including: project reach reported by each sub-grantee; reported effectiveness of outcomes; assessment of strength of effectiveness; potential for scale and/or sustainability; and likelihood of sustainability through existing infrastructure.
Sub-Grant Program – Technical Assistance	Provide technical assistance to sub-grantees as requested by sub-grantees:	1. Achieved: Reminded sub-grantees of availability of technical assistance throughout PP3. 2. Achieved: Technical assistance contracts were reviewed on a periodic basis and amended as necessary to ensure that resources were fully available to meet the needs of sub-grantees. 3. Achieved: Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
	1. Remind sub-grantees of availability of technical assistance on a monthly basis. 2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees. 3. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.	• Vermont supported sub-grantees with technical assistance as requested through the end of the sub-grant program.
Regional Collaborations	1. Support regional collaborations in 14 HSAs by providing sub-grants to ACOs and other technical assistance resources. 2. Develop a transition plan by 4/30/17 to shift all HSAs to non-SIM resources. 3. Incorporate into Sustainability Plan by 6/30/17.	1. Achieved: Regional collaborations in 14 HSAs supported by ACOs and other technical assistance resources. 2. Achieved: Transition plan developed. 3. Achieved: Regional collaborations included in SIM Sustainability Plan. • Within each of Vermont's 14 Health Service Areas, Blueprint for Health and ACO leadership have merged their work groups and chosen to collaborate with stakeholders under a single unified health system initiative. Regional Collaborations, also known as Community Collaboratives, include medical and non-medical providers (e.g., long-term services and supports providers and community providers), and a shared governance structure with local leadership. These groups focus on reviewing various data sources with the goal of improving outcomes on key statewide indicators, such as those included in the Vermont Medicaid Next Generation Program, the All-Payer ACO Model or the ACO clinical priority areas. Additionally, these groups, support the introduction and extension of new delivery system models (including Learning Collaboratives and Accountable Communities for Health), and provide guidance for medical home and Community Health Team operation. • With the support of trained staff, teams continue to implement quality improvement projects with a wide range of foci including: disease management, care coordination, mental health and substance use disorder treatment integration, addressing social determinants of health, increasing hospice and palliative care utilization, reducing ED utilization, reducing readmissions, improving care for people with chronic illness, improving care for those with congestive health failure, reducing hospital admissions, improving immunization rates for adults, improving developmental screening rates for

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
		adolescents, reducing medication assisted treatment (MAT) wait times, and implementing the Integrated Communities Care Management Learning Collaborative. Community Collaborative teams have and will continue to strengthen relationships and align and standardize processes and workflows for addressing quality improvement initiatives on a community-wide basis.
Workforce – Demand Data Collection and Analysis	Submit Final Demand Projections Report and present findings to Workforce Work Group by 12/31/16.	Achieved (with delay): Final Demand Projections Report completed and findings presented to Workforce Work Group in May 2017. A micro-simulation demand model uses Vermont-specific data to identify future workforce needs for the State by inputting various assumptions about care delivery in a high-performing health care system. The contractor for this work created a demand model that identifies ideal workforce needs for Vermont in the future, under various scenarios and parameters. • Work began on the demand model project just before the end of PP2, and work carried over through the end of PP3 (June 2017). • The vendor (IHS Markit/IHS) ran preliminary projections for RNs, MDs, APRNs, and PAs by sub-specialty and HSA in July 2016 • IHS and Vermont, with input from key stakeholders from the public and private sectors, drafted a prioritized list of demand modeling scenarios in an "ideal" Vermont health care environment, which IHS began running through the model in late summer/early fall 2016. • IHS presented an initial draft report of demand projections and modeling scenarios to Vermont stakeholders at the December 2016 Workforce Work Group meeting and incorporated feedback, as well as more Vermont-specific claims datasets and additional demand scenarios, into model refinements through early 2017. • IHS presented a second draft of demand projections and modeling scenarios to Vermont stakeholders at the May 2017 Workforce Work Group meeting, and incorporated feedback into model refinements and a final project report. • A final report demand projections report was submitted to Vermont on June 30, 2017.
Workforce – Supply Data Collection and Analysis	Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan:	1. Achieved: Supply data was presented to the Workforce Work Group twice by 12/31/16. Additional presentations in 2017. 2 and 3. Achieved: Survey and statistical reports for each profession are published on the VDH website on a rolling basis, as they are finalized. 4. Achieved: Workforce supply data activities included in the SIM Sustainability Plan.

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
	1. Present data to Workforce Work Group at least 3 times by 12/31/16. 2. Publish data reports/analyses on website by 6/30/17. 3. Distribute reports/analyses to project stakeholders by 6/30/17. 4. Incorporate into Sustainability Plan by 6/30/17.	• Vermont's Office of Professional Regulation (OPR) and Vermont Department of Health (VDH) work in tandem to assess current and future supply of providers in the state's health care workforce through the collection of licensure and relicensure data and the administration of surveys to providers during the licensure/relicensure process. Surveys include key demographic information for providers, and are used for workforce supply assessment and predicting supply trends, as well as informing future iterations of Vermont's Health Care Workforce Strategic Plan. • Representatives from OPR and VDH present data to and obtain feedback from Vermont's Health Care Workforce stakeholder work group on a regular basis. Updates were given to the work group in August and October 2016. • Staff, work group stakeholders, and VDH began conducting "deep dive" analyses on specific professions, beginning in PP2. In PP2, the work group examined data on physician assistants (PAs) and discussed ways of utilizing PAs to increase access to primary care in Vermont. In PP3, deep dive analyses and discussions have focused on the mental health and substance use disorder treatment provider professions in Vermont. • Survey and statistical reports for each profession are published on the VDH website on a rolling basis, as they are finalized.

Learning Collaboratives

Performance Period 3 Milestone:

1. ***Target: 400 Vermont providers have participated in Learning Collaborative activities (including Integrated Communities Care Management Learning Collaborative or Core Competency Trainings) by 12/31/16. (Baseline as of December 2015: 200).***
2. ***Report on program effectiveness to Steering Committee and Core Team by 12/31/16.***
3. ***Incorporate Learning Collaborative lessons learned into Sustainability Plan by 6/30/17.***

During Performance Period 3, Vermont continued to implement all learning collaborative activities, while simultaneously planning a transition to a post-SIM structure. The Integrated Communities Care Management Learning Collaborative (Learning Collaborative) launched in three pilot communities during Performance Period 1. Based on early success and high community demand, the Learning Collaborative expanded statewide to an additional 8 communities to share tools and diffuse best practices for care coordination for Vermonters with complex needs.

In PP3, the Integrated Communities Care Management Learning Collaborative continued to engage teams in 11 communities through a series of in-person sessions followed by action periods in which communities implement the Plan-Do-Study-Act (PDSA) model for quality improvement. Topics included: transitions of care, care management, and electronic shared care plans. Learning Collaborative teams also sought to expand existing knowledge, tools, and processes to additional community partners. Several communities developed and delivered local care coordination trainings to new community partners based on the care coordination toolkit developed by the Integrated Communities Care Management Learning Collaborative.[7] The toolkit covered basic care coordination interventions developed through the learning collaborative, including identification of a lead care coordinator, person-centered goals assessment, root cause analysis, shared care plans, and care conferences. In response to the current demand for this type of training, two care coordination toolkit trainings led by local learning collaborative team members were offered for participants statewide in December 2016 and April 2017. These statewide events doubled as a "train-the-trainer" opportunity for less experienced team members to practice facilitating trainings alongside more advanced team members. Ultimately, this will build ongoing capacity at the local level to meet care coordination training needs.

Learning Collaborative activities were complemented by a Core Competency Training series, launched in Performance Period 2. The Core Competency Training initiative has provided a comprehensive training curriculum to front line staff from a wide range of medical, social, and

[7] Care management toolkit is available on the Blueprint for Health website: Integrated Communities Care Management Learning Collaborative Toolkit.

community service organizations conducting care coordination in communities statewide. Core curricula cover competencies related to care coordination and disability awareness, and reinforce and expand upon the disability awareness briefs and the Integrated Communities Care Management Learning Collaborative curriculum.

Planning for continued learning collaborative activities following the end of the SIM grant began in early 2017. All lead entities identified in the SIM sustainability plan for learning collaborative activities were already key partners in implementation of SIM-supported learning collaborative activities and this provides a strong platform from which to transition learning collaborative activities, including Core Competency Trainings, to lead entities in 2017.

Major Accomplishments

Continuation and Maturation of the Integrated Communities Care Management Learning Collaborative. The 11 communities participating in the Integrated Communities Care Management Learning Collaborative have made a great deal of progress since program launch. In many communities, the learning collaborative experience has helped to build a strong and permanent foundation for team-based care coordination, and many of the tools, processes and interventions introduced through the Learning Collaborative have been embedded in standard practice. In PP3, the community teams participating in the Learning Collaborative continued to engage in the learning collaborative model by attending in-person learning sessions and webinars, while at the same time strengthening their roles within their local communities.

By the end of 2016, 135 organizations reported participation across the 11 learning collaborative teams, serving 311 high-needs individuals. Program evaluation efforts suggest that the Learning Collaborative had a tangible impact, both on the lives of the individuals served and on relationships between care team members. From a process measurement perspective, many of the key care coordination interventions were successfully implemented: for example, 100% of participating individuals had been assigned a lead care coordinator in all but one community, and partially or fully complete shared care plans were reported for 83% of participants across all communities. Work remains to expand this work and bring it to scale for the full population, and to permanently embed principles of care coordination and team-based care into the delivery system moving forward.[8]

Completion of the Core Competency Training Series. In PP3, the Core Competency Training initiative (launched in PP2) continued to offer a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities statewide. The curriculum covered competencies related to care coordination and disability awareness, with the goal of reinforcing and expanding upon the disability awareness briefs and the Integrated

[8] The Integrated Communities Care Management Learning Collaborative Evaluation is available on the VHCIP website: ICCMLC Evaluation Report.

Communities Care Management Learning Collaborative curriculum. In total, 337 providers participated in one or more of the 36 separate training opportunities available throughout the state. To ensure sustainability of training materials beyond the initial training period, training sessions were filmed and all materials are available in an online format.[9] Additionally, 25 individuals across the state were trained using a "train-the-trainer" model to embed capacity to train others in communities across the state.

Planning for Learning Collaborative Sustainability. Learning Collaborative activities have benefited from strong and active participation from key partners, including those listed as lead entities in the SIM sustainability plan, since the early planning stages. SIM staff began convening key partners in late 2016 to establish commitment around a common path forward for the next phase of care coordination activities. Additionally, Blueprint and ACO partners will continue to host statewide care coordination toolkit trainings to meet current demand, while at the same time working to embed capacity to host trainings at the local level.

Challenges

Ongoing Quality Improvement Efforts. Despite the great progress made to date, the need for continuous quality improvement around care management and care coordination remains, particularly as many of the key skills tools and interventions of the Integrated Communities Care Management Learning Collaborative are brought to scale. Lead entities identified in the SIM Sustainability Plan are working together to envision and plan future activities to support communities in continued care delivery transformation efforts.

Alignment with the ACO Care Coordination Model. Many of the tools developed through Learning Collaborative activities have been built into the ACO care coordination model. It will be critical to continue to build upon these efforts in the future in order to reduce community confusion and duplication of effort, and to maintain the skills and tools developed through the Learning Collaborative process. Examples of this include: building the use of care management software for electronic shared care planning on top of existing processes; and aligning resources (financial or other) to support the role of the lead care coordinator.

Sub-Grant Program

Performance Period 3 Milestone:

1. ***Provide SIM funds to support sub-grantees through 12/31/16.***
2. ***Convene sub-grantees at least twice by 12/31/16.***
3. ***Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.***

[9] Core Competency Training materials are available on the VHCIP website: Core Competency Training Materials.

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

The VHCIP Sub-Grant Program launched in 2014, and provided nearly $5 million in funding to directly support Vermont providers to promote provider-led innovation. Fourteen organizations received sub-grants and worked on a range of projects, including developing strategies to support adults with developmental disabilities, running surgical services and lab optimization collaboratives, and implementing a variety of care coordination and integration models. Each of the state's three ACOs – Community Health Accountable Care (CHAC), Vermont Collaborative Physicians/Health*first*, and OneCare Vermont (OCV) – also received sub-grant funding to further build their infrastructure and ready their participating practices and providers for alternative payment models. During Performance Period 3, Vermont continued to implement the VHCIP Provider Sub-Grant Program as the individual grants ended.

Sub-grantees reported on activities and progress, highlighting lessons learned; final reports are available here. As the sub-grant projects ended, project staff engaged the evaluation team and the self-evaluation contractor to conduct an analysis of the sub-grants, assessing reach of their activities, evidence of effectiveness, and potential for scalability/sustainability. This analysis informed the overall evaluation findings.[10]

Overall, sub-grants had mixed success achieving sustainability. Sub-grantees articulated a cost of maintaining these programs that could not be covered by current payment models and a hope that this will change with on-going health reform efforts. However, despite this challenge some sub-grant programs will continue as organizations make strategic investments to integrate specific elements into current practice models.

Major Accomplishments

Sub-Grantee successes are summarized below:

Northeastern Vermont Regional Hospital – Caledonia and Essex Dual Eligible Project. The Caledonia and Essex Dual Eligible Project was a project of Northeastern Vermont Regional Hospital, focused on the Medicare/Medicaid dually-eligible population. The goals of this project were: reduction in overall health care costs; more efficient use of Medicaid special services; and improved well-being of clients. Health coaches worked with clients to improve their chronic disease self-management skills through: health assessments, reinforcing provider-initiated treatment plans, providing hands-on assistance in support of chronic disease self-management plans, providing cooking lessons, and teaching stress management and coping techniques. A Community Health Team (CHT) Coordinator served as project coordinator and worked with

[10] The final Vermont Health Care Innovation Project State-Led Evaluation Final Report is available on the SIM Website: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/VHCIP_Final_State-led_Evaluation_Report_0.pdf

health coaches to identify and assess clients. More than fifty providers participated in this project including PCPs, palliative care MDs, nurse care coordinators, ophthalmologists, home health and hospice nurses, Area Agency on Aging case managers, SASH coordinators, vocational rehabilitation case managers, tobacco cessation counselors, and hospital care managers. Overall, this project reached 80 people through health coaching and funded several projects to allow people to stay in their homes. Participating patients self-reported increased satisfaction with quality of life, and improved access to health care and mental health services. Although Medicaid claims were higher overall for patients participating in this program, this was largely due to targeted case management and home health services. Many of the tools and processes learned from this project have been integrated into existing regional infrastructure and will continue. The region plans to focus on Chronic Obstructive Pulmonary Disorder next.

Bi-State Primary Care Association/Community Health Accountable Care – Furthering Community Health Accountable Care. Furthering Community Health Accountable Care, conducted by Bi-State Primary Care Association was a project designed to increase provider collaboration across the continuum of care in local communities, and to grow and strengthen the Community Health Accountable Care (CHAC) ACO, which participated in Vermont's Medicaid and commercial SSPs as well as Medicare's Shared Savings Program. During the grant period, CHAC developed a website with a provider portal, established a network newsletter, a web-based project communications tool, and encouraged network peer-to-peer collaboration to enhance communication and the sharing of best practices. CHAC participated in all VHCIP work groups and provided a voice in statewide care management standards, quality reporting and data requirements, legislative policies, and population health projects. An example of practice improvement designed to reduce costs while improving quality of care is CHAC's Falls Risk Assessment. On CHAC's recommendation, CHAC member organizations increased their screening rate for patients over the age of 65 who have a history of falls from 26.9% to over 80% at their sites. This increase in screening helps providers identify patients for whom fall care plans are needed, enhancing the likelihood of reduced overall admissions. Going forward, CHAC plans to continue collaboration with community partners, other ACOs in Vermont, the State, and other organizations. CHAC anticipates maintaining peer-to-peer opportunities for sharing of evidence-based best practices and identifying areas for quality improvement efforts.

Health*First* – Capacity and Infrastructure Building Grant. The Capacity and Infrastructure Building Grant allowed Health*First* to achieve a number of concrete goals such as hiring staff to support the independent physician commercial ACO named Vermont Collaborative Physicians (VCP), securing office space, establishing policies and procedures for governance, developing a collaborative care agreement for their network of independent providers, increasing public awareness of Health*First*, creating educational materials, providing educational opportunities for members and consumers, engaging in regional and statewide committees, developing and supporting efficient data management and using quality data to inform development of disease management programs. Health*First* is now focusing on a few core elements including: maintaining service and support for its members, identifying opportunities for value-based payment program opportunities for member practices, and ensuring that independent

providers have the information they need to continue delivering the highest quality care to their patients. They continue to be involved in the development of the All-Payer ACO Model. They also continue to explore partnership opportunities with other organizations interested in developing population health management systems.

Vermont Developmental Disabilities Council – Inclusive Health Care Partnership Project (IHPP). The Inclusive Health Care Partnership Project (IHPP) was a one-year planning project conducted by the Vermont Developmental Disabilities Council. The Developmental Disabilities Council, in collaboration with Green Mountain Self-Advocates (GMSA), conducted an inclusive planning process to identify barriers that adult Vermonters with intellectual/developmental disabilities (I/DD) face in accessing quality care and engaging in health promotion activities. IHPP made recommendations for improving their health care experience and outcomes, while reducing the high cost of care for this population. In addition to IHPP staff, the project included a nine-member planning team that oversaw the work of the project. In all, one hundred individuals from across Vermont participated in the project. Rather than developing new programs, the project aimed to work with community partners to develop strategies within existing programs and systems. The project connected with leaders in medical education, health care, developmental services, special education, and public health. They identified barriers to care and invited organizations and networks to detect opportunities to improve health outcomes for adult Vermonters with I/DD. Learning generated by this project will be sustained through committed allies that are expanding training for health care providers, developing better transition practices and innovative approaches to care, and supporting participation in community health and wellness programs.

InvestEAP – Resilient Vermont and Workplace Behavioral Health. InvestEAP is a public Employee Assistance Program (EAP) that operates within Vermont's Division of Vocational Rehabilitation and provides services to public and private employers across Vermont. Two InvestEAP programs were funded through sub-grants. Both programs integrated Behavioral Screening Interventions (BSI) to improve health and decrease total health care costs. Through one sub-grant – Resilient Vermont – InvestEAP provided services to Northern Counties Health Care, a Federally Qualified Health Center (FQHC), while the other sub-grant – Workplace Behavioral Health – provided services to employees of King Arthur Flour. The goals of the Resilient Vermont sub-grant were to provide EAP prevention/early intervention services including behavioral health screening and short-term evidence based treatment for FQHC patients to mitigate life stressors that would otherwise lead to chronic disease, to improve health outcomes, and reduce future health care expenditures. The goals of the Workplace Behavioral Health sub-grant were to screen employees for poor nutrition, lack of exercise, depression, tobacco, and other substance use, and provide short-term evidence-based treatments for employees who screen positive to improve their overall health and wellbeing, and reduce future health care expenditures. Sub-Grantee developed evaluation results for both sub-grants showed that EAP counseling had a positive impact on improving general physical and mental health, reducing nuisance health symptoms, reducing concerns in key areas of personal and family relationships, and on worktime productivity. Based on these

improvements, there was an estimated 19 hours less of unproductive time per month, and an average savings per case of $1,515 for health care, totaling an estimated $227,250 in cost reduction for all 150 participants. To sustain efforts, Invest EAP is exploring partnerships with Blue Cross Blue Shield of Vermont as well as several large health insurance trusts and hospitals.

Vermont Program for Quality in Health Care (VPQHC) – NSQIP Statewide Surgical Services Collaborative. The NSQIP Statewide Surgical Services Collaborative was a surgeon-run effort to improve surgical performance and patient safety. The overall goal of the project was to collect and submit surgical clinical data to the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). Prior to NSQIP, sites were only contacting patients immediately following surgery and not capturing longer-term complications. Data collected show that a total of 2,549 surgical cases were entered over the course of the project and of those, 147 cases had a preventable surgical complication. Five hospitals indicated they would continue activity with ACS NSQIP beyond the grant period to improve surgical outcomes.

White River Family Practice – Patient Self-Confidence and Chronic Disease Management**.** The Patient Self-Confidence and Chronic Disease Management grant targeted "at-risk" patients identified through enhanced self-confidence screening and population health analytic software and surveillance. The goals of this program were: 1) to reduce non-emergent Emergency Department visits and hospital readmissions; 2) to improve patient experience and health confidence; 3) to develop team-based care for chronic disease management; and 4) to employ software to improve population health management. Identified patients were eligible for care coordination and mental health counseling, and all providers and staff were trained in motivational interviewing. The program identified 59 patients as “at-risk” for potentially avoidable hospital care (admissions and/or emergency department visits) or for clinical deterioration, defined as a combination of low health confidence and presence of a chronic disease. Because of this project, at-risk cohort Emergency Department visits and hospital admissions declined to less than half of baseline, and there was a statistically significant increase in health confidence. Additionally, there was a slight improvement in HbA1c levels.

Northwestern Medical Center – RiseVT. The goal of RiseVT was to increase the overall health of the population and reduce the prevalence of chronic disease including cardiovascular disease, cancer, chronic obstructive pulmonary disease, diabetes, and asthma in Franklin and Grand Isle counties. RiseVT engaged with over 16,000 individuals through individual scorecards, an online wellness portal, health coaching offered at worksites, social media, and attendance at community events. More than 12,600 individuals have connected with RiseVT, which is approximately 10% of the population in northwestern Vermont. RiseVT supported more than 40 businesses in policy change actions, 32 of which have over 50% of their employees involved in RiseVT activities. In addition, 15 schools and 9 municipalities were engaged in RiseVT activities.

University of Vermont Health Network Central Vermont Medical Center – SBIRT in the Medical Home. The goal of this project was to implement Screening, Brief Intervention, and Referral to

Treatment (SBIRT) into seven medical homes in Central Vermont. For this grant, SBIRT focused on tobacco, alcohol, and drug misuse. Through this project: 6,162 patients were screened for alcohol, drug, and tobacco use; 219 patients received a brief intervention by SBIRT on-site clinicians; 614 patients engaged in brief treatment services; and 900 patients were referred to SBIRT treatment services. Most providers had a positive perception of the project's focus on tobacco use, drinking and drug use, and having SBIRT treatment providers available at the site to engage with patients who were referred.

Rutland Area Visiting Nurse Association & Hospice – Supportive Care Pilot Program. The Supportive Care Pilot Program assisted in supporting patients and their caregivers in patients' homes to clearly identify their goals and incorporate these goals into a suitable treatment plan by collaborating with their primary care providers earlier in the disease trajectory. The Rutland Area Visiting Nurse Association & Hospice Congestive Heart Failure and Chronic Obstructive Pulmonary Disorder Collaborative of Rutland used this pilot program to bridge the gap between inpatient palliative care and hospice. The goals of this project were: to integrate supportive care and end-of life decision making earlier in the disease process; expand upon collaborative approaches with primary care, Rutland Regional Medical Center, and the Rutland Community Health Team to facilitate patient care decisions based upon patients' own values; avoid unnecessary hospitalization and/or re-hospitalization for patients with complex conditions and needs; improve symptom management and quality of life for the patient and caregivers; promote earlier referrals to hospice; and support the Blueprint for Health goals for improving care for patients with chronic illness. Although this program has not continued past the end of the grant, the collaborative has started a subcommittee on palliative and hospice care which has been educating providers and community members through film and presentations.

Southwestern Vermont Medical Center – System-Wide Transitional Care Model. The Transitional Care Model (TCM) was an expansion of an existing program at Southwestern Vermont Medical Center (SVMC) which sought to improve outpatient care through a Transitional Care model. In this model, inpatient clinical nurses partnered with primary care providers and provided patients with care navigation, education, medication management, and symptom identification. This pilot reduced hospital admissions and Emergency Department visits. A Community Care Team was established and a Health Promotion Advocate (HPA) was stationed in the Emergency Department to provide support 40 hours a week. Additionally, during the pilot, the team identified a high rate of readmissions from skilled nursing facilities (SNFs), and a program was created to educate SNFs in identifying changing patient needs and providing appropriately early intervention, named Interventions to Reduce Acute Care Transfers (INTERACT). In this program, four transitional care nurses covered all physician practices in the service area, serving 436 patients. The Community Care Team reached more than 20 community agencies and 66 patients. The program targeted high risk individuals who experienced acute and chronic mental health issues and/or substance use disorder with high emergency department utilization. There were 569 referrals to a total of 60 community agencies. SVMC also partnered with nursing schools to develop a curriculum for the "Transitions in Care" course taught at Southern Vermont College. To achieve financial

sustainability, SVMC conducted financial analysis of the Transitional Care Nursing Program as well as the Community Care Team/Health Promotion Advocate and the programs were included in the 2017 SVMC operational budget.

Vermont Medical Society – Vermont Hospital Medicine 'Choosing Wisely' Program. The Vermont Hospital Medicine 'Choosing Wisely Program' was a Lab Optimization program of the Vermont Medical Society's Education and Research Foundation. The initial goal was to optimize laboratory testing in hospitalized adults to reduce waste in health care, and it was expanded to develop a standardized diagnostic and treatment pathway for patients with Chronic Obstructive Pulmonary Disorder. Participating hospitals saw a 10-20% decline in utilization, both over the course of the program, comparing first quarter of 2014 to first quarter of 2016, including approximately 81,000 discharges. As an indication of institutionalization and broad-based support these participating hospitals and providers have chosen to participate in a second initiative, despite an end to the sub-grant, focused on Chronic Obstructive Pulmonary Disorder. A new entity called "Vermont High Value Care Network" has been proposed and would be sustained by payer/provider members.

Challenges

Scale and Sustainability. Overall most grantees addressed sustainability as the major challenge facing them. The factors sub-grantees identified which hindered opportunities for scale and/or sustainability include: limited institutional resources necessary to support the program and/or limited partner organization resources; inefficient information sharing across partners; lack of collaborative sustainability plans; model fit versus practice size; difficulties absorbing breaks in funding or self-sustaining staff costs beyond the grant period; measure quantity and alignment fatigue; clinical and administrative bandwidth; access to ongoing data monitoring; data management of multiple programs; and sustaining engagement with leadership and administration during times of staff turnover.

Sub-Grants – Technical Assistance

Performance Period 3 Milestone: Provide technical assistance to sub-grantees as requested by sub-grantees:

1. ***Remind sub-grantees of availability of technical assistance on a monthly basis.***
2. ***Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees.***

Vermont supported sub-grantees with technical assistance as requested through the end of the sub-grant program. As in past performance periods, contractors were available for technical assistance as requested by sub-grantees and approved by project leadership. Sub-grantees did not take advantage of technical assistance available in Performance Period 3.

Regional Collaborations

Performance Period 3 Milestone:

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

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

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

During Performance Period 3, Regional Collaborations – also known as Community Collaboratives – continued to thrive within each of Vermont's 14 Health Service Areas. Community Collaboratives, led by Blueprint for Health and ACO leadership, work together with local stakeholders to develop a single unified regional health system. Community Collaboratives include medical and non-medical providers (e.g., long-term services and supports providers and community providers), and follow a shared governance structure with local leadership. These groups focus on reviewing various data sources with the goal of improving outcomes on key statewide indicators, such as those included in the Vermont Medicaid Next Generation Program, the All-Payer ACO Model, or the ACO clinical priority areas. Additionally, these groups support the introduction and extension of new delivery system models (including Learning Collaboratives and Accountable Communities for Health), and provide guidance for medical home and Community Health Team operations. Blueprint for Health and ACO staff provide facilitation and support of monthly Community Collaborative meetings to support quality improvement teams in essential functions of team building, measurement/data analysis, and quality improvement strategies to move towards success.

Major Accomplishments

Integration and Collaboration Across ACO and Blueprint Staff. ACO and Blueprint leadership continue to meet and collaborate on a regular basis to ensure community collaborative improvement projects continue to move forward and keep resources from all agencies up to date and aligned. Monthly field staff meetings bring together ACO, Blueprint, and various community partner organization staff to report on progress, share ideas, and seek alignment across activities and improvement tools (e.g., the A3 quality improvement tool, which continues to be rolled out to all Community Collaborative initiatives statewide).

Alignment of Quality Improvement Projects with Key Statewide Priorities. Blueprint, ACO and community partner staff continue to work to align quality improvement projects with statewide priorities. In May, staff mapped existing community collaborative quality improvement initiatives and illustrated alignment with key ACO clinical priorities and statewide All-Payer ACO Model measures. The exercise showed excellent alignment in the following areas: high-risk patient care coordination, episode of care variation, chronic disease management optimization, prevention, and wellness. Future meetings will afford staff the opportunity to join statewide focus groups targeted at specific priority areas.

Improving Data Literacy and Analytics Capabilities to Drive Effective Quality Improvement**.** Clinical and analytics staff are meeting monthly to participate in data literacy training. These trainings review key concepts in data analysis and explore best ways to use all available sources of informatics to assist communities with project selection and community-wide analysis, using the various data sources available to them. Additionally, the ACOs' continue to support their participant networks in interpreting data and identifying information that is actionable for change and improvement.

Challenges

Aligning Existing and New Infrastructure Around Common Reform Goals. With the establishment and maturation of ACOs in Vermont, work was needed to understand how to align the ACO model with existing infrastructure and established programs in communities statewide. While communities have come a long way in unifying as a common team with shared goals and vision for the future, moving to implement that vision in a strategic manner is an ongoing process.

Workforce – Demand Data Collection and Analysis

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

During Performance Period 3, Vermont staff worked with a vendor, IHS Markit (IHS), to complete a microsimulation demand model that would predict the demand for various health care professions in an "ideal" state health care reform environment. Workforce Work Group members, along with other key stakeholders, informed development of model assumptions and scenarios.

Major Accomplishments

Work with Vendor to Refine Modeling Scenarios. Over the course of the project, State of Vermont staff worked with key internal stakeholders to draft a long list of modeling scenarios that would represent an ideal, high-functioning health care system. SOV and IHS staff then created a prioritized list that represented feasible scenarios appropriate for Vermont-specific needs and dropped scenarios that did not meet these criteria (for example, one scenario modeling demand for provider FTEs after the implementation of a new patient navigator program was not pursued due to an already-existing, robust network of Community Health Teams in Vermont). Scenarios ultimately modeled by IHS can be categorized by four components: scenarios that model integrated care delivery, scenarios that model improved care transitions, scenarios that model improved team-based care, and scenarios that model evidence-based strategies to improve health outcomes.

Specific scenarios and demand implications include:

- Modeling the effects of integrated care delivery entities;
- Modeling the effects of improved emergency department care triage for at-risk populations;
- Modeling the effects of increased integration of primary care and mental health/substance use disorder treatment services;
- Modeling the effects of evidence-based strategies to improve management of cardiovascular disease; and
- Modeling physician demand implications of achieving population health goals (in this case: sustained weight loss for overweight/obese adults; improved blood pressure, cholesterol, and blood glucose levels for adults with elevated levels; and smoking cessation).

Presentation of Draft Results and Submission of Final Demand Report. The final Vermont Demand Modeling Report was submitted at the end of Performance Period 3. Before submission, the vendor (IHS Markit) presented drafts of the report and data to the Health Care Workforce Work Group at both its December 2016 and May 2017 meetings. IHS incorporated feedback received from stakeholders and subject matter experts at these meetings into its modeling assumptions and refinements before submitting a final report to project staff.

The final Demand Modeling Report was submitted to Vermont on June 30, 2017.[11] The report describes modeling scenarios and demand projections for the following professions:

- Physicians (including various specialties and sub-specialties), advanced practice registered nurses, and physician assistants;
- Registered nurses and licensed practical nurses; and
- Other health professions in areas including pharmacy services, imaging and diagnostic services, direct care services, vision services, dental services, and mental health services.

Workforce – Supply Data Collection and Analysis

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

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

[11] The final Vermont Demand Modeling Report is available on the SIM Website: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/Vermont Health Care Demand Modeling Final Report 6-16-17 FINAL.pdf.

In Performance Period 3, Vermont staff worked closely with VDH and the Workforce Work Group to coordinate presentations of licensure data to the work group and provide opportunities for VDH to obtain stakeholder feedback on formatting and content of surveys and statistical reports. During this time, VDH staff continued engaging work group members as subject matter experts representing different professions to further analyze data and present findings to the larger work group. These "deep dive" analyses will be used to inform the Workforce Strategic Plan, as well as identify potential areas (geographic and programmatic) for care delivery and workforce supply improvement. Survey and statistical reports for each profession are published on the VDH website on a rolling basis, as they are finalized.[12]

Major Accomplishments

Data Presentations to Work Group. During Performance Period 3, VDH staff and work group subject matter experts continued to conduct deeper dive analyses into a number of health professions based on recent VDH/OPR-collected survey and licensure data. Specifically, the group continued its extensive review of Physician Assistant data in August 2016, and began examining mental health and substance use disorder professions in October 2016. Provider data presented at that time included Psychiatrists, Psychiatric Nurse Practitioners, Alcohol and Drug Abuse Counselors, Social Workers, Marriage and Family Therapists, Mental Health Counselors, Psychoanalysts, Psychologists (master and doctoral level), and Psychotherapists. The discussion around addressing workforce-related issues for these provider types continued through the end of PP3.

[12] VDH Health Care Workforce Supply Data is available on the VDH website: Health Care Workforce Data.

Milestones Achieved, Major Accomplishments, and Challenges: Health Data Infrastructure

With SIM support, Vermont has implemented a statewide approach that seeks to advance interoperability and accessibility of clinical and patient information at the point of care and for use in population health management. Vermont identified sharing of high quality, timely data as a necessary component of a successfully reformed system. Health data infrastructure that allows for accurate, timely, and analyzable health information exchange supports providers' readiness to participate in alternative payment models by enabling high-quality, coordinated care across the care continuum. It also supports ACOs, payers, and the State in targeting interventions, making policy decisions, and evaluating the effectiveness of interventions.

During Performance Period 3, Vermont's SIM project maintained and expanded successful initiatives. Activities during this period included:

- Continued *Gap Remediation* efforts to expand connectivity and completeness of the data within the VHIE;
- Continued work to *Improve Quality of Data Flowing into the VHIE*;
- Continued implementation of *Telehealth Pilots*;
- Continued development and strategic planning related to *Data Warehousing*;
- Continued efforts to design and implement *Care Management Tools*; and
- Ongoing *HIE Planning*, with *Expert Support* as necessary.

Table 8, below, summarizes progress across the Health Data Infrastructure Focus Area for all Performance Period 3 milestones; the remainder of this section details accomplishments and challenges within each work stream.

Table 8: Performance Period 3 Milestone Summary – Health Data Infrastructure Focus Area

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
Expand Connectivity to HIE – Gap Remediation	1. Remediate 65% of ACO SSP measures-related gaps as identified in Fall 2015/Spring 2016 by 6/30/17. (Baseline as of December 2015: 62%) 2. Remediate data gaps for LTSS providers according to remediation plan developed in Performance Period 2 by 6/30/17. 3. Incorporate Gap Remediation activities into Sustainability Plan by 6/30/17.	1. Achieved: More than 65% of ACO SSP measures-related gaps as identified in Fall 2015/Spring 2016 remediated by 6/30/17. 2. Achieved: DLTSS Gap Remediation activities with Home Health Agencies completed by 6/30/17. 3. Achieved: Gap Remediation activities incorporated into in SIM Sustainability Plan. • The Gap Remediation project addressed gaps in connectivity and clinical data quality of health care organizations (HCOs) to Vermont's Health Information Exchange. • The ACO Gap Remediation component worked to improve VHIE connectivity for all Vermont Shared Savings Program measures among ACO member organizations. • The Vermont Care Network (VCN/BHN) Gap Remediation improves the data quality for the 16 Designated Mental Health and Specialized Service Agencies (DAs and SSAs). • The DLTSS Gap Remediation effort to increase connectivity for Home Health Agencies was completed on 6/30/17 with connections established for 9 Home Health Agency Electronic Medical Record systems via ADT and/or CCD interfaces. • Gap Remediation efforts for ACO member organizations and Vermont Care Partners dovetail with the data quality improvement efforts described under the "Improve Quality of Data Flowing into HIE" work stream.
Improve Quality of Data Flowing into HIE	Engage in workflow improvement activities at designated mental health agencies (DAs) as identified in gap analyses. Start workflow improvement activities in all 16 DAs by 7/1/16 and complete workflow improvement by 12/31/16. Report on improvement over baseline by 6/30/17.	Achieved: DA data quality work completed in December 2016; final report submitted in July 2017. • VITL and BHN/VCN produced multiple training materials, recommendations, and findings as tools for the Designated Agencies to use for future training exercises. These efforts will result in information being entered appropriately to meet standard data formats for development of consistent and accurate ADT and CCD interfaces.
Telehealth – Implementation	1. Continue telehealth pilot implementation through contract end dates.	1. Achieved: Telehealth pilots implemented through 6/30/17. 2. Achieved: Telehealth program incorporated into Sustainability Plan.

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
	2. Incorporate Telehealth Program into Sustainability Plan by 6/30/17.	• Vermont funded telehealth pilot projects in PP2 and PP3 to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout the State of Vermont. • Project summaries: o The VNA of Chittenden and Grand Isle Counties is developing telehealth infrastructure by building connections among providers and enabling the timely sharing of clinical information. This telehealth pilot is enabling VNA and Central Vermont Home Health & Hospice (CVHHH) to connect their point of care systems (Honeywell Lifestream) to their EMR systems (McKesson) so that vitals taken by visiting nurses are available in the EMR. These results (in HL7's ORU format) can also be sent from the EMR into the Vermont Health Information Exchange (VHIE). Point of care information is now shared within the organization as well as with any provider accessing the VHIE through VITLAccess. This enables the home health organizations to be integral partners with numerous providers, including the University of Vermont Health Network, for the care of people with a wide range of chronic conditions. o The Howard Center, a major mental health and substance use disorder treatment provider in the state, is using telehealth technology to expand access to medication-assisted treatment (MAT) for people with opioid dependence. The Howard Center is using live video and secure, tamperproof medication dispensers to allow qualifying individuals to receive MAT in their homes with staff supervision.
Data Warehousing	1. Implement Phase 2 of DA/SSA data warehousing solution by 12/31/16. 2. Obtain approval of cohesive strategy for developing data systems to support analytics by 10/31/16. Operationalize the approved cohesive strategy for developing data systems to support analytics by 12/31/16.	1. Achieved (with delay): Phase 2 of DA/SSA data warehousing solution completed in June 2017. 2. Partially Achieved: Developed proposal for cohesive strategy for developing data systems to support analytics by 12/31/16. There are two parts to Vermont's Data Warehousing work: • The VCN Data Repository will allow the Designated Mental Health Agencies (DA) and Specialized Service Agencies (SSA) to send specific data to a centralized data repository. Long-term goals of the data repository include ensuring connectivity to the Vermont Health Information Exchange (VHIE), as well as Vermont State Agencies, other stakeholders, and interested parties. In addition to connectivity, it is expected that this project will provide VCN members with advanced data analytic

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
		capabilities to improve the efficiency and effectiveness of their services, to demonstrate value, and to participate in payment and delivery system reforms. • Statewide planning activities focused on developing a long-term strategy for data systems to support analytics. Vermont convened a team of State stakeholders to discuss strategies for developing data systems to support the State's analytic needs and developed a proposal by 6/30/17.
Care Management Tools	1. Event Notification System: Continue implementation of ENS according to contract with vendor through 12/31/16. 2. Shared Care Plan: Recommend revisions to the VHIE consent policy and architecture to better support shared care planning by 6/30/17. 3. Universal Transfer Protocol: Support workflow improvements at provider practices through existing contracts through 12/31/16. 4. Continue implementation of care management solutions, including VITLAccess, supporting Home Health Agencies and Area Agencies on Aging.	1. Achieved: Event Notification System implementation continued through 6/30/17. 2. Achieved: Staff reviewed VHIE consent policy and architecture to better support shared care planning throughout PP3, and the HDI Work Group made recommendations in December 2016. 3. Achieved: Supported workflow improvements at provider practices to support Universal Transfer Protocol goals through existing contracts. 4. Achieved: Continued implementation of care management solutions, including VITLAccess, and supporting Home Health Agencies. (Work with Area Agencies on Aging discontinued due to legal issues.) • The Event Notification System (ENS) project implemented a system to proactively alert participating providers regarding their patient's medical service encounters. The selected ENS solution provides admission, discharge, and transfer data to participating providers and as of June 2017, notifications are being generated for 61,339 Vermonters. • The Shared Care Plan (SCP) project (formerly part of the SCÜP project) sought to provide a Shared Care Plan solution to Vermont's provider organizations. After electing not to pursue a technical Shared Care Plan solution, the project refocused on reviewing and recommending revisions to consent policy and architecture to better enable shared care planning in the future. • The Universal Transfer Protocol (UTP) project (formerly part of the SCÜP project) sought to provide a Universal Transfer Protocol to Vermont's provider organizations. During PP3, the project provided support services through the Integrated Communities Care Management Learning Collaborative to transform practice workflows to support UTP goals by helping providers across the care continuum to exchange critical data and information. Work with Home Health Agencies to support VITLAccess onboarding and VHIE interface development is discussed above under Expand Connectivity to HIE – Gap Remediation.

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
General Health Data – HIE Planning	Finalize connectivity targets for 2016-2019 by 12/31/16. Incorporate targets into Sustainability Plan by 6/30/17.	Achieved. Connectivity targets presented and approved by Core Team in December 2016; this work stream is included in the SIM Sustainability Plan. • During review, analysis extended from a 3-year projection to a 10-year projection.
General Health Data – Expert Support	Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.	Achieved: IT-specific support procured as needed to further health data initiatives throughout PP3. • This is a companion project to all of the projects within the Health Data Infrastructure focus area. Due to the nature of those projects, Vermont needs specific skills to support the State and stakeholders in decision-making and implementation. The specific skills needed are IT Enterprise Architects, Business Analysts, and Subject-Matter Experts.

Expand Connectivity to HIE – Gap Remediation

Performance Period 3 Milestone:

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

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

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

The Gap Remediation project addressed gaps in connectivity and clinical data quality of health care organizations (HCOs) to Vermont's Health Information Exchange.

This work included three components:

- The *ACO Gap Remediation* component worked to improve VHIE connectivity for all Vermont Shared Savings Program measures among ACO member organizations.
- The *Vermont Care Network (VCN/BHN) Gap Remediation* project improved data quality for the 16 Designated Mental Health and Specialized Service Agencies (DAs and SSAs).
- The *DLTSS Gap Remediation* project sought to improve data quality and reduce data gaps among DLTSS providers by addressing data and connectivity gaps identified through the DLTSS Gap Analysis project in PP1 and PP2. The result of this effort was the Home Health Agency connectivity project, which sought to increase connectivity and access to client information for Vermont's Home Health Agencies through VHIE interface development and onboarding to the VHIE's provider portal, known as VITLAccess.

The ACO and VCN Gap Remediation projects are aligned with the clinical data quality improvement efforts described under the Improve Quality of Data Flowing into HIE work stream.

Major Accomplishments

Successful Completion of ACO Gap Remediation According to PP3 Milestone. In Performance Period 3, no additional funding or resource was allocated to the ACO component of the Gap Remediation project. However, during Performance Period 3, over 200 additional interfaces from Vermont Health Care Organizations were connected to the VHIE under non-SIM funding sources.

VCN Gap Remediation. This work is discussed in the Improve Quality of Data Flowing into the HIE section, below.

DLTSS Gap Remediation – Home Health Agencies. In late 2015, planning began for the remediation of connectivity gaps identified in the DLTSS Information Technology Assessment completed in early 2015. In January 2016, the DLTSS Gap Remediation project was approved to address challenges to connecting the Home Health Agencies (HHAs) to the VHIE. The first phase of the HHA connectivity project was completed between January and June 2016, and work to onboard HHAs to VITLAccess and develop VHIE interfaces continued during PP3. By the end of Performance Period 3, 11 HHAs were onboarded to VITLAccess, and 9 HHA EHR systems were connected to the VHIE via ADT and/or CCD interfaces. Efforts to connect Area Agencies on Aging (AAAs) were also initiated but were discontinued due to legal barriers.

Sustainability recommendations for on-going Gap Remediation activities were included in the SIM Sustainability Plan with Vermont's Agency of Human Services named as the Lead Entity.

Improve Quality of Data Flowing into HIE

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

Improving the data workflow activities for Vermont's Designated Agencies (DAs) and Specialized Services Agencies (SSAs) is an essential component of Vermont's data quality work. These data improvement activities enhance the information entered into the source systems, which in turn allows for better information at the point of care and the ability to provide more reliable population health measurements and analytics.

Major Accomplishments

Continued Data Quality Improvement Activities. VITL, the designated operator of the State's HIE, provided data quality improvement services to the DAs and SSAs during Performance Period 3. During that period, several trainings, documentation exercises, and additional analyses occurred with the DAs and SSAs. Analysis included reviewing workflows, reviewing the Monthly Service Reports (MSRs), and the data dictionaries used by the Designated Agencies. Additionally, VITL produced multiple training materials, recommendations, and findings for use as tools by the DAs for future training exercises. These efforts will result in information being entered appropriately to meet standard data formats for development of consistent and accurate Admission, Discharge, Transfer (ADT) and Continuity of Care Document (CCD) interfaces.

This project resulted in a number of reports and other resources developed by Vermont Care Partners, which can be found here.

Telehealth – Implementation

Performance Period 3 Milestone:

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

In Performance Period 2, Vermont contracted with JBS International to develop a Statewide Telehealth Strategy to guide future telehealth investments. The Strategy, developed in collaboration between the State of Vermont and private sector stakeholders, includes four core goals: a coordinating body to support telehealth activities; alignment of state policies relevant to telehealth; telehealth technology investments that are secure, accessible, interoperable, cloud-based, and aligned with Vermont's HIT infrastructure; and clinician engagement.

In September 2015, Vermont released an RFP seeking telehealth pilot projects to meet the principles and roadmap described in the Statewide Telehealth Strategic Plan and address a variety of geographical areas, telehealth approaches and settings, and patient populations. The primary purpose was to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout the State of Vermont. Pilots began in April and June 2016, and ended in June 2017.

Telehealth Pilot Project Summaries[13]:

- The VNA of Chittenden and Grand Isle Counties developed a telehealth infrastructure by building connections among providers and enabling the timely sharing of clinical information. This telehealth pilot is enabling VNA and Central Vermont Home Health & Hospice (CVHHH) to connect their point of care systems (Honeywell Lifestream) to their EMR systems (McKesson) so that vitals taken by visiting nurses are available in the EMR. These results (in HL7's ORU format) can also be sent from the EMR into the Vermont Health Information Exchange (VHIE); point of care information is now shared within the organization as well as with any provider accessing the VHIE through the VITLAccess.
- The Howard Center, a major mental health and substance use disorder treatment provider in the state, is using telehealth technology to expand access to medication-assisted treatment (MAT) for people with opioid dependence. The Howard Center is using live video and secure, tamperproof medication dispensers to allow qualifying individuals to receive MAT in their homes with staff supervision.

Note that these activities fall under a PP3 milestone, but utilized PP2 funds. This activity is also discussed in the Performance Period 2 Carryover Activities section of this report.

[13] Final reports for both telehealth pilots are available on the VHCIP website: VNA of Chittenden and Grand Isle Counties Telehealth Final Report: http://healthcareinnovation.vermont.gov/content/vna-telehealth-oru-project-overview; Howard Center Telehealth Final Report: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/Telehealth%20Final%20Report%20-%2006292017.pdf.

Major Accomplishments

Vital Clinical Connections from the VNA to other Providers. The connections established through the VNA of Chittenden and Grand Isle Counties pilot have enabled the timely sharing of clinical information to support patient care. New connections enabled by this project allowed vital sign data collected by visiting nurses to be shared with partnering providers through the VHIE and VITLAccess, which supports more coordinated care for clients with chronic conditions served by the VNA. All this has made the home health organizations integral partners with numerous providers, including the University of Vermont Health Network, for the care of people with a wide range of chronic conditions.

Novel use of Telehealth Technology for Treating People with Opioid Dependence. The Howard Center's use of telehealth technology to allow qualifying individuals to receive MAT in their homes with staff supervision. Standard care requires that patients visit their provider daily so that they can receive medication on-site. While this standard protocol ensures that patients are taking medication and prevents diversion of MAT drugs, it is also challenging for patients who live in rural areas, have inconsistent access to transportation, or whose jobs or family lives make daily visits challenging. This pilot sought to test a safe and secure way to dispense medication remotely, which is an innovative use of telehealth technology.

Challenges

Howard Center. The Howard Center faced numerous challenges in developing this novel use of telehealth technology and bringing it to scale. This pilot required a unique combination of staff, software, and technology and changes to clinical protocols and client training. The biggest challenge was identifying clients who could work with the required hardware and software to participate, and getting them trained in using the devices and the protocol. The program will continue after the contract ends.

Data Warehousing

Performance Period 3 Milestone:

1. ***Implement Phase 2 of DA/SSA data warehousing solution by 12/31/16.***
2. ***Obtain approval of cohesive strategy for developing data systems to support analytics by 10/31/16. Operationalize the approved cohesive strategy for developing data systems to support analytics by 12/31/16.***

For Performance Period 3, the Data Warehouse work stream included on-going development of the Vermont Care Network (VCN/BHN) Data Repository for the DAs and SSAs, and statewide strategic planning for data systems to support analytics.

- The *Vermont Care Network Data Repository Project*: This project allows the Designated Agencies and Specialized Service Agencies (DAs and SSAs) to send specific data to a secure, centralized data repository. Vermont's DAs and SSAs are 42 CFR Part 2-covered agencies and cannot currently share data within the VHIE due to technical and regulatory issues. This project provides VCN members with advanced data analytic capabilities, including dashboard performance reports, to improve the efficiency and effectiveness of their services. This project supports the agencies as Vermont transitions from a fee-for-service reimbursement structure to a value-based payment methodology.
- *Statewide Data Warehousing Planning Activities*: Through work with a broad group of stakeholders, Vermont has identified key strategic steps toward data aggregation, management, and analytics to support reporting, measurement, and clinical care. These strategic planning activities resulted in a proposal and will continue with stakeholders with the goal of implementing a cohesive plan for data management and analytics.

Major Accomplishments

VCN Data Repository Completion. During PP3, Vermont Care Network continued work with their warehousing vendor and the Vermont DAs & SSAs to further develop the VCN Data Repository. This project was completed in June 2017. Member data has progressed from a historical load using member Master Service Record (MSR) files to implementing, on a limited basis, more frequent data feeds using ADT and CCD interfaces to the repository. Additionally, the project has developed auto-updating member dashboard reports, data governance policies, and training materials for members.

Challenges

42 CFR Part 2 and Other Legal Barriers. There are numerous federal and state rules surrounding mental health and substance use data sharing and aggregation, and they are not universally understood by all Vermont stakeholders. Throughout the lifecycle of the VCN Data Repository development and subsequent operations there is a continual need for education efforts around the legal parameters regarding technical solutions in this area. The Office of the National Coordinator (ONC) has provided support to Vermont in this area throughout PP3.

Care Management Tools

Performance Period 3 Milestone:

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

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

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

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

During PP3, Vermont continued to support providers and the individuals they serve by encouraging the development and deployment of care management tools to support timely communication and coordination across provider organizations, especially during care transitions. This work stream encompasses three projects: an Event Notification System, a Shared Care Plan project, and a Universal Transfer Protocol project. (Note: Work with Home Health Agencies to support VITLAccess onboarding and VHIE interface development is discussed above under Expand Connectivity to HIE – Gap Remediation.)

- The *Event Notification System* provides notification to Vermont's providers about admissions, discharges, and transfers of patients to and from hospitals, skilled nursing facilities, and other health care settings. Vermont selected a contractor for this work in PP2, and the ENS launched in April 2016.
- The *Shared Care Plan* and *Universal Transfer Protocol* projects performed exploration and planning to support development of Shared Care Plan and Universal Transfer Protocol solutions during PP1 and PP2.
    - The Shared Care Plan (SCP) project worked to identify the information most needed by providers and social services organizations to serve high-needs clients across the care continuum and to gather business and technical requirements for a possible technical solution. After electing not to pursue a technical Shared Care Plan solution, the project focused on reviewing and recommending revisions to consent policy and architecture to better enable shared care planning in the future.
    - The Universal Transfer Protocol (UTP) project identified the critical data and information needed to ease the transition of care between facilities, or between a health care setting and home. During PP3, the project provided support services through the Integrated Communities Care Management Learning Collaborative to transform practice workflows to support UTP goals by helping providers across the care continuum to exchange critical data and information.

Major Accomplishments

Continued ENS Implementation. Vermont's ENS vendor launched an ambitious and successful implementation and rollout in collaboration with the Vermont SIM team, VITL, and the Blueprint. As of June 2017, one ACO (CHAC), 15 hospitals (including all of Vermont's 14 hospitals plus Dartmouth-Hitchcock Medical Center in New Hampshire), 9 Home Health

Agencies and Visiting Nurse Associations, 16 skilled nursing facilities, the entire SASH program, and over 250 individual practices were connected to the service and continue to engage the full continuum of care in enrollment. As of June 2016, notifications are being generated for 61,339 Vermonters.

Shared Care Plans. From March 2016 to December 2016, project staff worked to review consent requirements and develop recommendations for the Health Data Infrastructure (HDI) Work Group. Staff presented a project plan to define consent requirements and for discovery work for a consent management system to the HDI Work Group in October 2016. The HIE Consent Management Statement of Work was proposed to the HDI Work Group in December 2016 and work continues in 2017.

Universal Transfer Protocol. During PP3, UTP efforts continued through the Integrated Communities Care Management Learning Collaborative. The Learning Collaborative hosted a learning session that focused on UTP goals and supported workflow transformation in participating communities to improve communications related to care transitions.

Challenges

Crowded Field and Rapidly Changing Technology. The primary challenge across the Care Management Tools work stream has been the crowded field and rapid advances in technology. These factors caused Vermont to elect not to pursue a technical solution for the SCP and UTP projects during PP2. As reported in PP2, many health care organizations are waiting and observing carefully to better understand the potential solutions available and to see how this crowded environment plays out.

General Health Data – HIE Planning

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

In Performance Period 3, Vermont's SIM Team finalized an analysis and recommendation for connectivity targets to the Vermont Health Information Exchange (VHIE). During the analysis, the targets were expanded from a three-year outlook (2016-2019) to a ten-year outlook (2016-2026). The target analysis was developed with input from the HDI Work Group and based off of the June 2016 Connectivity Report provided by the Vermont Information Technology Leaders. During this process, Vermont also redefined how it would count connections. The resulting methodology is more precise, but reset the interface baseline established in 2013.

Major Accomplishments

The developed target analysis included projected connections for all connection types as well as all provider types in Vermont, including acute, non-acute, and community providers. The results

detailed attainable connection goals from the Health Care Organization Electronic Health Record systems to the VHIE, including all hospital clinical connections completed by 2022 and all Home Health Agency clinical connections by 2023. Overall, if the target analysis was closely adhered to, the connections would increase from 902 in June 2016 to 2866 in June 2026.[14] The connectivity targets were presented to the HDI Work Group and approved in October 2016. The SIM Core Team reviewed and approved these criteria in December 2016.

Challenges

These targets assume funding levels are maintained over the next 10 years and that providers continue to expand Electronic Health Record (EHR) use in that same time period. The funding levels could ebb and flow over the next decade resulting in challenges in the State's ability to meet these targets. Additionally, changes in EHR technology could impact provider adoption. These challenges can be mitigated through implementation of continued monitoring of connectivity targets over time.

General Health Data – Expert Support

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

This is a companion project to the projects within the Health Data Infrastructure focus area. Due to the nature of those projects, Vermont needs specific skills to support the State and stakeholders in decision-making and implementation. The specific skills needed are IT Enterprise Architects, Business Analysts, and Subject-Matter Experts.

During Performance Period 3, Vermont utilized both contract and personnel support to provide these services. Specifically, a contract with Stone Environmental included Subject Matter Experts who provided research, recommendations, and planning support. Additionally, Vermont utilized several Business Analysts, Enterprise Architects, and Project Managers who work within Vermont's Agency of Human Services Health Services Enterprise and provide overall support to health information technology projects. Finally, Vermont benefitted greatly from the technical assistance support offered by the Office of the National Coordinator.

[14] Connectivity Targets for 2016-2019 are available on the VHCIP website: http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/10-28-16%20HDI%20Meeting%20Materials.pdf.

Milestones Achieved, Major Accomplishments, and Challenges: Evaluation

All of Vermont's SIM efforts have been evaluated to assess processes, experiences, and outcomes of innovation efforts for Vermont, its residents, payers, and providers. Evaluation has occurred by program, by population, and by region to guide our work, support future planning, and to allow rapid dissemination of lessons learned and expansion of best practices.

Table 9, below, summarizes progress across the Evaluation focus area for all Performance Period 3 milestones; the remainder of this section details accomplishments and challenges within each work stream.

Table 9: Performance Period 3 Milestone Summary – Evaluation Focus Area

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
Self-Evaluation Plan and Execution	Execute Self-Evaluation Plan for 2016 and 2017 according to timeline for Performance Period 3 activities.	Achieved: Self-Evaluation Plan for 2016 and 2017 completed according to timeline for Year 3 activities through June 2017. • Vermont implemented a mixed-methods study that included site visits, focus groups, and provider and care integration surveys. The surveys focused on: care integration, use of clinical and economic data for performance improvement, and payment reform incentive structures. The public-private VHCIP Evaluation Steering Committee was established and continued to meet during PP3, providing valuable feedback on self-evaluation activities. • Vermont's State-led Evaluation contractor completed and submitted all required PP3 deliverables by the end of the performance period, including: final focus group report; final provider and care integration survey report; learning dissemination plan; and final overall evaluation report.
Surveys	Conduct annual patient experience survey and other surveys as identified in payment model development: Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings Programs by 6/30/17.	Achieved: Vermont's patient experience contractor (DataStat) fielded the Year 3 patient experience survey from July 2016 to June 2017. • The PCMH version of the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey was fielded by DataStat to patients from more than 90 primary care practices from July 2014 to July 2015; July 2015 to June 2016; and July 2016-June 2017. Most primary care practices opted to participate in the survey, though it is not compulsory. Results from this survey are used as part of the monitoring and evaluation of the Shared Savings Programs.
Monitoring and Evaluation Activities within Payment Programs	1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications (bi-annual reporting to providers). 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications (monthly, quarterly reports depending on report type).	1. Achieved: PCMH program (non-SIM funded) analyses completed according to program specifications (bi-annual reporting to providers). 2. Achieved: Final analysis of Year 2 of the commercial and Medicaid Shared Savings Programs were provided during Performance Period 3. Final analysis of Year 3 of the commercial and Medicaid Shared Savings Programs was complete in Q3 2017. 3. Achieved: Information is provided above in the All-Payer Model and Medicaid Value-Based Payment workstreams above. • Reports on the Blueprint for Health included results for quality measures, patient experience measures, and cost of care measures for each Hospital Service Area (HSA), with comparisons to other HSAs and the state as a whole. A key innovation is the linkage of clinical and claims data for some of

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
	3. TBD: APM, Medicaid VBP – Mental Health and Substance Use.	the measures. The reports have been adapted to include ACO Shared Savings Program measures, reinforcing the importance of these measures to providers. HSA-level reports are publicly reported on the DVHA website. • Analyses and accompanying reports for the 2015 ACO Shared Savings Programs were finalized and released publicly in October 2016, and included quality measures, patient experience measures, and savings calculations. These reports are publicly reported on the GMCB website. 2016 results were publicly posted on the GMCB website in Q4 2017.

Self-Evaluation Plan and Execution

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

During Performance Period 3, Vermont's SIM project completed the implementation of the State-Led Evaluation to study care integration, use of clinical and economic data for performance improvement, and payment reform incentive structures. Activities conducted by State-led evaluation contractor John Snow, Inc. (JSI) included: conducting a state-led evaluation study, providing evaluation findings, and creating a learning dissemination plan.[15]

Through the State-Led Evaluation Plan, Vermont answered research questions in three topical areas, all key to Vermont's progress towards achieving an integrated delivery system that rewards value-based care:

- *Care Integration and Coordination*: Integrated care is a key feature of many SIM-funded activities, and a major activity contributing to the goals of improving patient experience, improving population health, and reducing the per capita cost of health care. Across Vermont, care integration and coordination supported by the SIM grant takes a variety of forms, such as identifying, reaching out to, and offering enhanced services to vulnerable populations at-risk of admission to nursing homes; coordinating care for patients with particular diseases across a spectrum of social service and medical providers; improving care transitions to avoid hospital readmissions; and building on activities of existing Community Health Teams. These models vary, but understanding the features of each that are most effective is critical to guide scaling up effective innovations related to care integration and coordination.

- *Use of Clinical and Economic Data to Promote Value-Based Care*: Data collection, aggregation, sharing, analysis, and utilization play pivotal roles in Vermont's efforts to transform its health system. Various Vermont SIM project activities address the different uses of clinical and cost data: to inform providers; for internal and external monitoring and improvement of population health; for quality improvement initiatives; for payment; and to identify opportunities for efficiency. Clinical and cost data are shared with various audiences and come from a variety of sources including: VHCURES, Vermont's multi-payer claims database, and other sources of claims data; automated extracts from EMRs; manual abstraction of medical records; and surveys. Data may not always be perceived by providers as interpretable or actionable, and data collection may impose a burden on providers. It is important to understand the ways in which providers

[15] Final State-Led Evaluation products, including the Environmental Scan, Provider Surveys (survey tools and results), Site Visit Interview and Focus Group Summary Report, Learning Dissemination Plan, and Data Visualization products are available on the VHCIP website: State-Led Evaluation Projects.

interpret, perceive, and use data to ensure that needed data is provided accurately and effectively.

- *Payment Reform and Incentive Structures*: As new payment models are in various stages of implementation, providers find themselves operating in a system that employs multiple—and sometimes conflicting—financial incentive structures. As SIM accelerates Vermont's health system transformation, payment models and incentives confronting providers may become more complex, adding additional models and incentives even while fee-for-service payment remains in place for some care. For successful payment reform structures to take hold, it is important to understand providers' awareness of financial and non-financial incentive structures, how payment reform impacts care delivery (including integration and coordination of care), and attitudes toward incentives and practice transformation.

Major Accomplishments

Completion of State-Led Evaluation Activities. Vermont's State-led evaluation contractor conducted numerous activities to study Vermont's progress toward achieving an integrated delivery system that rewards value-based care. The major activities of the State-led evaluation included:

- An environmental scan to understand the state and federal landscape related to VHCIP activities;
- Site visits and key informant interviews to collect stakeholder input on the evaluation questions;
- Focus groups to assess consumer experience related to their health care;
- Primary care provider (PCP) survey and care coordinator survey to understand perspectives on VHCIP of these two key stakeholder groups;
- Secondary data analysis;
- A plan for disseminating learning, and
- A comprehensive final evaluation report.

Overall, the relationship-building and strengthening of community connections are a critical outcome of VHCIP that seeded stronger collaborative relationships for providing integrated care in the future. Training (Learning Collaborative and Core Competency Trainings) provided common language, understanding, and structure for more consistent and predictable care coordination processes and information sharing across organizations. These infrastructure activities are likely to continue and be sustained, at least to some extent, post VHCIP. In addition to facilitating care integration and coordination of clinical care, these infrastructure activities have the potential to address the urgent social determinants of health that focus group participants and providers noted must be addressed prior to treating specific health needs. Parallel to the community level collaborative structure development, there is hope that the payment models will continue to innovate to be more inclusive of reimbursement of

specialized services and non-traditional partners that are so critical to addressing social determinants of health. VHCIP accomplished its goal of implementing SSPs for Medicaid and commercial products. All three ACOs participated and represented PCPs across the spectrum – FQHC, hospital-owned, and independent practice. VHCIP built upon the advanced primary care program established by the Blueprint and learned lessons from the SSPs to inform the development of the All-Payer ACO Model. VHCIP has created a data and data infrastructure environment which enables low capacity practices to more effectively participate in health care reform. It has also fostered an environment of innovation among higher capacity practices which has resulted in the creation of data and data infrastructure demand to continue to raise the bar on practice effectiveness in the use of data.

Additional information on findings from the State-led evaluation are available in Appendix B, Evaluation Findings.

Challenges

Evaluation Implementation. Some activities proposed and conducted throughout PP3 required a longer timeframe than anticipated. Focus groups were challenging to schedule, but by April 2017, all five planned focus groups were conducted. Development and piloting of the provider and care integration surveys took longer than anticipated, but once fielded, response rate was more robust than expected (35% advanced practice professionals and 31% care coordinators). Plans for data visualization to enhance learning dissemination did not come to fruition during PP3 as anticipated.

Surveys

Performance Period 3 Milestone: Conduct annual patient experience survey and other surveys as identified in payment model development: Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings Programs by 6/30/17.

Vermont fields the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey annually. The survey evaluates the experiences of Vermonters participating in the Patient Centered Medical Home (PCMH) and ACO Shared Savings Programs. Most primary care practices opted to participate in the survey, though it is not compulsory.

Major Accomplishments

Fielded Patient Experience Surveys as Planned. Vermont's contractor, DataStat, fielded patient experience surveys to evaluate the experiences of Vermonters who are patients of practices participating in the Blueprint for Health and/or ACO Shared Savings Programs. The survey instrument is the PCMH version of the CG-CAHPS survey, with the addition of eight custom questions related to care from specialists, long-term services and supports, and chronic illness.

DataStat provided practice-level results to participating practices after each round of surveys. DataStat also provided results to the State and contractors after each round to support aggregation of results for ACOs, HSAs, and the State overall.

Challenges

Practice Recruitment and Administrative Burden. Recruiting practices to participate in this voluntary initiative and trying to minimize administrative burden for practices and patients has continued to present challenges during Performance Period 3. Most eligible primary care practices have opted to participate in this survey, which is a positive outcome given that they have expressed concerns about burden in the past and may be affiliated with organizations that have been using different surveys. The State decided to use the same survey for the PCMH and ACO programs specifically to minimize the burden of having multiple surveys in the field. Using the same survey for the two programs requires extra steps for the State and its contractors in order to flag the subset of respondents who are attributed to each ACO for analysis of ACO-level results, but it has helped with practice recruitment. It should be noted that Vermont's largest hospital-owned primary care system has decided to continue to use a slightly different survey (the CG-CAHPS visit-based survey) for its practices, but has been willing to add questions to its survey during a few weeks of the year and to report results to the State. An additional challenge is that the State's smallest ACO did not attain an adequate number of responses from ACO-attributed patients affiliated with its participating primary care practices.

Monitoring and Evaluation Activities within Payment Programs

Performance Period 3 Milestone:

1. ***Conduct analyses of the PCMH program (non-SIM funded) according to program specifications (bi-annual reporting to providers).***
2. ***Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications (monthly, quarterly reports depending on report type).***
3. ***TBD: APM, Medicaid VBP – Mental Health and Substance Use.***[16]

In Performance Period 3, Vermont performed ongoing monitoring and evaluation activities to support development and successful implementation of innovative payment models. These activities focus on Vermont's Medicaid and commercial Shared Savings Programs, as well as Vermont's Pay-for-Performance investments (the Blueprint for Health). In addition, new activities in this area support the All-Payer Model work stream.

[16] Information about these programs is found in the Payment Models Design and Implementation Focus Area earlier in the document.

Major Accomplishments

Development of Performance Reports for Blueprint for Health Program. During Performance Period 3, Vermont provided two performance reports for its Pay-for-Performance PCMH program to providers and to health service area leaders, in December 2016 and June 2017. These robust reports are publicly reported at the hospital service area level.[17] These reports use data from claims (including VHCURES), the Blueprint Clinical Registry, and the CG-CAHPS survey noted above to provide results for quality measures, financial measures, utilization measures, and patient experience measures. Practice and regional leaders use them to assess performance and drive quality improvement.

Completion of ACO Shared Savings Program Analyses for Years 2 and 3 (2015-2016). In addition, commercial and Medicaid ACO Shared Savings Program results for calendar year 2015 were provided to ACOs and the public in October 2016.[18] Final results for calendar year 2016 were made available to the ACOs, payers, and the public in Q3 and Q4 of 2017.

Challenges

Obtaining Timely and Complete Claims Data to Support ACO Shared Savings Program Analyses. During Performance Period 3, Vermont experienced fewer challenges than in prior years in collecting and analyzing data from the Medicaid and commercial ACO Shared Savings Programs, including obtaining timely and complete claims data from payers, reconciling that data and the analysis between the payers and the Lewin Group (Vermont's Shared Savings Program analytics contractor), collecting clinical data, and compiling results in an understandable fashion. Vermont worked with its contractors, payers, and ACOs to: implement process improvements for clinical data collection; shorten the claims runout period for interim reports; and to begin reconciliation and validation activities during interim calculations in preparation for final calculations.

[17] Hospital Service Area (HSA)-level reports are available on the Blueprint for Health website: http://blueprintforhealth.vermont.gov/reports_and_analytics/hospital_service_area_profiles.

[18] Year 2 SSP results were presented on a public webinar on October 28, 2016. Slides and recording are available here: http://healthcareinnovation.vermont.gov/webinars/vhcip-webinar-vermonts-year-2-medicaid-and-commercial-aco-shared-savings-program-results.

Milestones Achieved, Major Accomplishments, and Challenges: Project Management

The Vermont SIM project has been supported by a project management team that oversaw project-wide coordination and reporting, as well as communication and outreach. Table 10, below, summarizes efforts across the Project Management focus area for all Performance Period 3 milestones.

Table 10: Performance Period 3 Milestone Summary – Project Management Focus Area

	Performance Period 3 (PP3)	
	Performance Period 3 Milestone	**Current Status and Progress Update**
Project Management and Reporting – Project Organization	Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2. Monthly staff meetings, co-chair meetings, and Core Team meetings with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Submit quarterly reports to CMMI and the Vermont Legislature. 4. Population Health Plan finalized by 6/30/17. 5. Sustainability Plan finalized by 6/30/17.	1. Achieved: Project Management contract scope of work and tasks performed on-time. 2. Achieved: Staff meetings, co-chair meetings, and Core Team meetings convened approximately bi-monthly with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Achieved: Quarterly reports to CMMI and the Vermont Legislature on time each quarter. 4. Achieved: Population Health Plan submitted on 6/30/17. 5. Achieved: Sustainability Plan submitted on 6/30/17. • Vermont's SIM project was supported by a project management team that oversaw project-wide coordination and reporting, as well as communication and outreach. Project management was focused on achieving milestones and meeting accountability targets across the project.
Project Management and Reporting – Communication and Outreach	Engage stakeholders in project focus areas by: 1. Convening 10 Core Team meetings between 7/1/16 and 6/30/17. 2. Convening 5 Steering Committee public meetings and 20 work group public meetings between 7/1/16 and 12/31/16. 3. Distributing all-participant emails at least once a month through 12/31/16. 4. Update website at least once a week through 12/31/16, and monthly through 6/30/17.	1. Partially achieved: 9 Core Team meetings convened during PP3. 2. Partially achieved: 3 Steering Committee meetings convened and 24 work group meetings convened during PP3. 3. Achieved: All-participant emails distributed once per month through 12/31/16, and on an ad hoc basis in 2017. 4. Achieved: Website updated at least once a week through 12/31/16, and monthly through 6/30/17.

Performance Period 2 Carryover Activities: Milestones Achieved, Major Accomplishments, and Challenges

This section of Vermont's Performance Period 3 Annual Report reports on Performance Period 2 milestones for which Vermont received a no-cost extension which were not completed prior to the submission of our Performance Period 2 Annual Report in September 2016. This includes two work streams:

- Activities to support the *All-Payer Model* performed by contractors Health Management Associates, Hewlett Packard Enterprise, Burns & Associates, and Wakely Actuarial; and
- Continued implementation of two *Telehealth Pilots* at VNA of Chittenden and Grand Isle Counties and the Howard Center, whose contracts were extended to accommodate contracting and implementation delays.

Table 11, below, summarizes progress on both of these Performance Period 2 milestones during Performance Period 3; more narrative on both work streams is provided in the Payment Model Design and Implementation and Health Data Infrastructure sections, respectively, above.

Table 11: Performance Period 2 Carryover Milestone Summary – Evaluation Focus Area

	Performance Period 2 (PP2) Carryover	
	Performance Period 2 Milestone	**Performance Period 2 Milestone**
All-Payer Model	1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI. 2. Work with CMMI on mutually-agreed upon timeline for 2016 decision-making by 12/31/15.	1. Achieved: Research, feasibility, and analyses informed SOV decision-making resulting in signed APM in October 2016. 2. Achieved: Timelines developed and implemented throughout 2016. • *Note: A more comprehensive narrative about Vermont's APM activities is included in the Payment Model Design and Implementation Section for PP3, above.*
Telehealth – Implementation	1. Release telehealth program RFP by 9/30/15. 2. Award at least one contract to implement the scope of work in the telehealth program RFP by 1/15/16.	1. Achieved: RFP released on 9/18/15. 2. Achieved (with delay): Bidders selected in November 2015; contracts executed in July 2016. • *Note: A more comprehensive narrative about Vermont's Telehealth Implementation activities is included in the Health Data Infrastructure Section for PP3, above.* • Vermont funded telehealth pilot projects to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout the State of Vermont. The two pilots seek to address a variety of geographical areas, telehealth approaches and settings, and patient populations. Pilot projects were selected in November 2015, with contracts executed in July 2016. Pilots began in April and June 2016, and ended in June 2017.

All-Payer Model

Performance Period 2 Milestone:

1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI.

2. Work with CMMI on mutually-agreed upon timeline for 2016 decision-making by 12/31/15.

A more comprehensive description of Vermont's APM activities is included in the Payment Model Design and Implementation section for PP3, above.

Telehealth – Implementation

Performance Period 2 Milestone:

1. Release telehealth program RFP by 9/30/15.

2. Award at least one contract to implement the scope of work in the telehealth program RFP by 1/15/16.

A more comprehensive narrative about Vermont's Telehealth Implementation activities is included in the Health Data Infrastructure section for PP3, above.

Glossary

AAA	Area Agencies on Aging
ACA	Affordable Care Act
ACH	Accountable Community for Health
ACO	Accountable Care Organization
AHEC	Area Health Education Center
AHS	Agency of Human Services (VT)
AOA	Agency of Administration (VT)
APM	All-Payer Model
ARIS	Area Resources for Individualized Services
BCBSVT	Blue Cross and Blue Shield of Vermont
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Centers for Disease Control and Prevention
CHAC	Community Health Accountable Care (VT ACO)
CMMI	Center for Medicare and Medicaid Innovation (federal)
CMS	Centers for Medicare and Medicaid Services (federal)
DA	Designated Agency for Developmental and Mental Health Services
DAIL	Department of Disabilities, Aging and Independent Living (VT)
DCF	Department for Children and Families (VT)
DD	Developmental Disability
DMH	Department of Mental Health (VT)
DVHA	Department of Vermont Health Access
EHR	Electronic Health Record
EMR	Electronic Medical Record
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
GMCB	Green Mountain Care Board
HCBS	Home and Community-Based Services
HCBW	Home and Community-Based Waiver
HCO	Health Care Organization
HDI	Health Data Infrastructure
HEDIS	Health Plan Employer Data and Information Set
HHA	Home Health Agency
HIE	Health Information Exchange (Also Vermont SIM Work Group)
HIPAA	Health Insurance Portability & Accountability Act (federal)
HIT	Health Information Technology
HRSA	Health Resources and Services Administration
HSA	Health Service Area (VT)
IFS	Integrating Family Services (VT)

LTC	Long Term Care
LTSS	Long Term Services and Supports
MH	Mental Health
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
NCQA	National Committee for Quality Assurance
P4P	Pay for Performance
PCMH	Patient Centered Medical Home
PCP	Primary Care Physician
PMPM	Per-Member Per-Month
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration (federal)
SNF	Skilled Nursing Facility
SSA	Specialized Service Agency
SSP	Shared Savings Program
VAHHS	Vermont Association of Hospitals & Health Systems
VCHIP	Vermont Child Health Improvement Project
VCN	Vermont Care Network
VCP	Vermont Care Partners
VDH	Vermont Department of Health
VHCIP	Vermont Health Care Innovation Project
VHCURES	Vermont Healthcare Claims Uniform Reporting and Evaluation System
VITL	Vermont Information Technology Leaders
VNA	Visiting Nurse Association
VPQHC	Vermont Program for Quality in Health Care

Appendix A: Milestones, Progress, Metrics, Contractors, and Staff – All Performance Periods

	Performance Period 1 (PP1)[19]	Performance Period 1 (PP1)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 2 (PP2)	Performance Period 2 (PP2)	Performance Period 3 (PP3)	Performance Period 3 (PP3)	Metrics	Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
	Performance Period 1 Milestone	Current Status and Reporting	Performance Period 1 Carryover Milestone	Current Status, Reporting, and Contractors	Performance Period 2 Milestone	Current Status, Reporting, and Contractors	Performance Period 3 Milestone[20]	Current Status, Reporting, and Contractors				
Project Implementation	**Project Implementation:** Project will be implemented statewide.	Achieved: Project is implemented statewide, implementation is ongoing. *Reporting:* Monthly reports to Core Team, quarterly reports to CMMI and Vermont Legislature.	**Project Implementation:** Continue to implement project statewide. Implement all Performance Period 1 Carryover Milestones.	Ongoing. Will be complete by 12/31/15. *Reporting:* Monthly reports to Core Team, quarterly reports to CMMI and Vermont Legislature. *Contractors:* All contractors	**Project Implementation:** Continue to implement project statewide. Implement all Performance Period 2 Milestones by 6/30/16.	Ongoing. Anticipated completion 6/30/16. *Reporting:* Monthly reports to Core Team, quarterly reports to CMMI and Vermont Legislature. *Contractors:* All contractors.	**Project Implementation:** Continue to implement project statewide. Implement all Performance Period 3 Milestones by 6/30/17.	Achieved: Implementation complete as of 6/30/17. *Reporting:* Monthly reports to Core Team, quarterly reports to CMMI and Vermont Legislature. *Contractors:* All contractors.	All metrics	All contractors.	Georgia Maheras	All SIM-funded staff and SIM key personnel
Payment Models	N/A	N/A	**Payment Models:** 50% of Vermonters in alternatives to fee-for-service.	Achieved: 55% of Vermonters in alternatives to fee-for-service as of November 2015, based on unduplicated counts. *Contractors:* Bailit Health Purchasing; Burns and Associates	**Payment Models:** 60% of Vermonters in alternatives to fee-for-service by 6/30/16.	In progress: 55% of Vermonters in alternatives to fee-for-service as of November 2015, based on unduplicated counts. *Contractors:* Bailit Health Purchasing; Burns and Associates; Health Management Associates.	**Payment Models:** 80% of Vermonters in alternatives to fee-for-service by 6/30/17.	Partially achieved: 55% of Vermonters in alternatives to fee-for-service as of 6/30/17, based on unduplicated counts. *Reporting:* Ad hoc. *Contractors:* Bailit Health Purchasing; Burns and Associates; Health Management Associates.	CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Commercial CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicaid CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicare CORE_Beneficiaries impacted_[VT]_[EOC]_Commercial CORE_Beneficiaries impacted_[VT]_[EOC]_Medicaid CORE_Beneficiaries impacted_[VT]_[EOC]_Medicare	Research, Alignment and Design of Payment Models: Burns and Associates (Medicaid); Bailit Health Purchasing (all payers); Health Management Associates (all-payers).	Georgia Maheras	All SIM-funded staff and SIM key personnel
Population Health Plan	N/A	N/A	N/A	N/A	**Population Health Plan:** Finalize Population Health Plan outline by 6/30/16.	In progress: Draft outline developed; RFP for contractor support released. *Reporting:* Monthly status reports. *Contractors:* Vermont Public Health Inst.	**Population Health Plan:** Finalize Population Health Plan by 6/30/17.	Achieved: Population Health Plan submitted on 6/30/17. *Reporting:* Monthly status reports. *Contractors:* Vermont Public Health Inst.	Not reported on quarterly basis, but required reporting element by end of project.	Population Health Plan Development: James Hester; Population Health Plan Writing Support: Vermont Public Health Inst.	Heidi Klein and Sarah Kinsler	SIM-funded staff: Sarah Kinsler, Georgia Maheras Key personnel: Tracy Dolan, Heidi Klein
Sustainability Plan	N/A	N/A	N/A	N/A	**Sustainability Plan:** Finalize Sustainability Plan outline and procure contractor to support Plan development by 6/30/16.	In progress: Work to refine sustainability strategy is underway; RFP for contractor support to be released in Q1 2016. *Reporting:* Monthly status reports. *Contractors:* Myers & Stauffer LC.	**Sustainability Plan:** Finalize Sustainability Plan by 6/30/17.	Achieved: Sustainability Plan submitted on 6/30/17. *Reporting:* Monthly status reports. *Contractors:* Myers & Stauffer LC.	Not reported on quarterly basis, but required reporting element by end of project.	Sustainability Plan Development: Myers & Stauffer LC.	Georgia Maheras	All SIM-funded staff All SIM Key Personnel
Focus Area: Payment Model Design and Implementation												

[19] Vermont's milestone table organization changed as part of the discussions with CMMI around the Year One Carryover milestones. Milestones were grouped into topic areas matching Vermont's core program areas.
[20] All beneficiary and provider participation targets included in Performance Period 3 Milestones are *inclusive* of pre-Performance Period 3 baseline. Process targets (e.g., meetings held during PP3) are *not inclusive* of previous work.

	Performance Period 1 (PP1)[19]	Performance Period 1 (PP1)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 2 (PP2)	Performance Period 2 (PP2)	Performance Period 3 (PP3)	Performance Period 3 (PP3)	Metrics	Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
	Performance Period 1 Milestone	**Current Status and Reporting**	**Performance Period 1 Carryover Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 2 Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 3 Milestone[20]**	**Current Status, Reporting, and Contractors**				
ACO Shared Savings Programs (SSPs)	**ACO Shared Savings Programs (SSPs):** 1. Implement Medicaid and Commercial ACO SSPs by 1/1/14. 2. Develop ACO model standards: Approved ACO model standards. 3. Produce quarterly and year-end reports for ACO program participants and payers: Evaluation plan developed. 4. Execute Medicaid ACO contracts: Number ACO contracts executed (goal = 2). 5. Execute commercial ACO contracts: Number of commercial ACO contracts executed (goal = 2).	1. Achieved: SSPs launched 1/1/2014. 2. Achieved: ACO model standards approved. 3. Achieved: Quarterly and year-end reports produced, and evaluation plan developed. 4. Achieved: 2 Medicaid ACO contracts executed during PP1. 5. Achieved: 3 commercial ACO contracts executed during PP1. *Reporting:* Reporting to SIM Work Groups, GMCB, and DVHA, measured quarterly.	**ACO Shared Savings Programs (SSPs):** 1. Continue implementation activities in support of the initial SSP performance period according to the SSP project plan. 2. Modify program standards by 6/30/15 in preparation for subsequent performance periods. Finalize contract amendments for subsequent performance periods. 3. Complete final cost and quality calculations for initial SSP performance period by 9/15/15. 4. Maintain 2 contracts with ACOs Year 1 Medicaid ACO-SSP. 5. Maintain 3 contracts with ACOs Year 1 commercial ACO-SSP. 6. Modify initial quality measures, targets, and benchmarks for Y2 program periods by 6/30/15 (based on stakeholder input and national measure guidelines). 7. Medicaid/commercial program provider participation target: 700 Medicaid/commercial program beneficiary attribution target: 110,000	1. In progress: Implementation is ongoing through 12/31/15. 2. Achieved: Program standards modified and contract amendments finalized. 3. Achieved: Final cost and quality calculations for SSP Year 1 completed by 9/15/15. 4. In progress: Medicaid SSP Year 2 contracts will be executed by 12/31/15. 5. In progress: Commercial SSP Year 2 contracts are ongoing through 12/31/15. 6. Achieved: measures, targets, and benchmarks modified for SSP Year 2 based on stakeholder input and national guidelines. 7. Achieved: 947 providers participating and 176,100 beneficiaries attributed as of September 2015. *Reporting:* Reporting to SIM Work Groups, GMCB, and DVHA, measured quarterly. *Contractors:* Bailit Health Purchasing; Burns and Associates; The Lewin Group; Wakely Consulting; Pacific Health Policy Group; Deborah LIsi-Baker; UVM Medical Center/ OneCare Vermont; Bi-State Primary Care Association/ Community Health Accountable Care	**ACO Shared Savings Programs (SSPs):** Expand the number of people in the Shared Savings Programs in Performance Period 2 by 6/30/16: Medicaid/commercial program provider participation target: 950. Medicaid/commercial program beneficiary attribution target: 130,000.	In progress. *Reporting:* Reporting to GMCB, and DVHA, measured quarterly. *Contractors:* Bailit Health Purchasing; Burns and Associates; The Lewin Group; Pacific Health Policy Group; Deborah Lisi-Baker; Wakely Consulting; Bi-State Primary Care Association/ Community Health Accountable Care (CHAC); UVM Medical Center (UVMMC)/OneCare Vermont; Health*first*.	**ACO Shared Savings Programs (SSPs):** Expand the number of people in the Shared Savings Programs in Performance Period 3 by 12/31/16: Medicaid/commercial program provider participation target: 960. (*Baseline as of December 2015:* 940) Medicaid/commercial program beneficiary attribution target: 140,000. (*Baseline as of December 2015:* 179,076)	Partially achieved: Exceeded provider scale targets, partially achieved beneficiary scale targets. Medicaid and commercial provider participation was 1,105 as of 12/31/16 (incl. Medicare: ~933); Medicaid and commercial beneficiary attribution was 112,237 as of 12/31/16 (incl. Medicare: 176,244). *Reporting:* Reporting to GMCB and DVHA, measured quarterly. *Contractors:* Bailit Health Purchasing; Burns and Associates; The Lewin Group; Pacific Health Policy Group; Deborah Lisi-Baker; Wakely Consulting; Bi-State Primary Care Association/ Community Health Accountable Care (CHAC); UVM Medical Center (UVMMC)/OneCare Vermont; Health*first*.	CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Payer Participation_[VT] CORE_BMI_[VT]_Commercial CORE_BMI_[VT]_Medicaid CORE_BMI_[VT]_Medicare CORE_Diabetes Care_[VT]_Commercial CORE_Diabetes Care_[VT]_Medicaid CORE_Diabetes Care_[VT]_Medicare CORE_ED Visits_[VT]_Commercial CORE_ED Visits_[VT]_Medicaid CORE_Readmissions_[VT]_Commercial CORE_Readmissions_[VT]_Medicaid CORE_Readmissions_[VT]_Medicare CORE_Tobacco Screening and Cessation_[VT]_Commercial CORE_Tobacco Screening and Cessation_[VT]_Medicaid CORE_Tobacco Screening and Cessation_[VT]_Medicare CAHPS Clinical & Group Surveys_Commercial CAHPS Clinical & Group Surveys_Medicaid CAHPS Clinical & Group Surveys_Medicare	ACO Implementation: Bi-State Primary Care Association/ CHAC; Health*first*; and UVMMC/ OneCare Vermont. Facilitation: Bailit Health Purchasing; Medicaid: Burns and Associates; Analytics: The Lewin Group; DLTSS/ Medicaid: Pacific Health Policy Group; DLTSS: Deborah Lisi-Baker; Actuarial: Wakely Consulting.	Pat Jones – GMCB (Commercial SSP); Amy Coonradt – DVHA (Medicaid SSP)	SIM-funded staff: Amy Coonradt; Erin Flynn; Alicia Cooper; Julie Corwin; Jim Westrich, Sarah Kinsler; Julie Wasserman; Susan Aranoff; James Westrich; Brian Borowski; Carole Magoffin; Carolynn Hatin Key personnel: Pat Jones
Episodes of Care	**Episodes of Care:** At least 3 episodes launched by 10/2014.	Not achieved: This activity delayed for Performance Period 2/CY2016. *Reporting:* Monthly status reports.	**Episodes of Care:** EOC feasibility analyses: 1. Analyze 20 episodes for potential inclusion in Medicaid EOC program by 7/31/15. 2. Develop implementation plan for EOC program by 7/31/15.	1. Achieved: 50 episodes analyzed by 7/31/15. 2. Achieved: EOC implementation plan finalized on 11/16/15. 3. Achieved: Sub-group convened 6 times by 6/15/15.	**Episodes of Care:** Research, design, and draft implementation plan for one EOC based off of the IFS program by 6/30/16.	In progress: This milestone was modified by the Core Team in January 2016. Under this reduced scope, work is to support episode design and preparation for implementation is ongoing.	**N/A**	**N/A**	*Activity discontinued; decision made in collaboration with CMMI in April 2016.*			

	Performance Period 1 (PP1)[19]	Performance Period 1 (PP1)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 2 (PP2)	Performance Period 2 (PP2)	Performance Period 3 (PP3)	Performance Period 3 (PP3)	Metrics	Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
	Performance Period 1 Milestone	**Current Status and Reporting**	**Performance Period 1 Carryover Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 2 Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 3 Milestone[20]**	**Current Status, Reporting, and Contractors**				
			3. Convene stakeholder sub-group at least 6 times by 6/30/15.	*Reporting:* Monthly status reports. *Contractors:* Burns and Associates.		*Reporting:* Monthly status reports. *Contractors:* Burns and Associates; Pacific Health Policy Group.						
Pay-for-Performance	**Pay-for-Performance:** Develop Medicaid value-based purchasing plan addressing pay-for-performance initiatives: Medicaid value-based purchasing plan developed.	1. Not achieved: In PP1, the Vermont Legislature appropriated additional Medicaid funds to support this milestone. Due to budget constraints, this activity was rescinded. 2. Achieved: Vermont began development of value-based purchasing plan. *Reporting:* Monthly status reports.	**Pay-for-Performance:** 1. Design modifications to the Blueprint for Health P4P program – dependent on additional appropriation in state budget. Modification design completed by 7/1/15 based on Legislative appropriation. 2. Medicaid value-based purchasing case study developed with Integrating Family Services program completed by 6/30/15.	1. Achieved: Blueprint for Health P4P modification design completed on 7/1/15. 2. Achieved: Medicaid value-based purchasing case study developed by 6/30/2015. This case study included a rubric for Medicaid value-based purchasing that will be used for Medicaid-specific reforms moving forward. *Reporting:* Monthly status reports. *Contractors:* N/A	**Pay-for-Performance:** Roll-out of new P4P investments for Blueprint Community Health Teams (CHTs) by 7/1/15 and enhanced direct payments to Blueprint practices by 1/1/16, according to approved P4P plan (using new funds that were appropriated by the legislature).	Achieved: New P4P investments launched on 7/1/15 and 1/1/16, respectively, according to approved P4P plan. *Reporting:* Quarterly reports to CMMI and Vermont Legislature. *Contractors:* N/A	**Pay-for-Performance:** 1. Expand the number of providers and beneficiaries participating in the Blueprint for Health by 6/30/17: Medicaid/ commercial/ Medicare providers participating in P4P program target: 715. (*Baseline as of December 2015:* 706) Medicaid/ commercial/ Medicare beneficiaries participating in P4P program target: 310,000. (*Baseline as of December 2015:* 309,713) 2. P4P incorporated into Sustainability Plan by 6/30/17.	1. Achieved: Provider participation was 787 as of 6/30/17; beneficiary attribution was 306,460 as of 6/30/17. 2. Achieved: P4P incorporated into Sustainability Plan. *Reporting:* Reporting to GMCB and DVHA, measured quarterly. *Contractors:* Bailit Health Purchasing; Burns and Associates; The Lewin Group; Pacific Health Policy Group; Deborah Lisi-Baker; Wakely Consulting; Bi-State Primary Care Association/ Community Health Accountable Care (CHAC); UVM Medical Center (UVMMC)/OneCare Vermont; Health*first*.	CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Commercial CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicaid CORE_Beneficiaries impacted_[VT]_[APMH/P4P]_Medicare CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH] CORE_Payer Participation_[VT]	1. Financial Standards: Non-SIM funded. 2. Care Standards: Non-SIM funded. 3. Quality Measures: Non-SIM funded. 4. Analyses for Design and Implementation: Non-SIM funded. 5. Stakeholder Engagement: Medicaid and commercial: Non-SIM funded.	Beth Tanzman; Craig Jones	Key personnel: Craig Jones; Beth Tanzman; Jenney Samuelson, Candace Elmquist
Health Home (Hub & Spoke)	**Health Home (Hub & Spoke):** Health Homes.	Achieved: Model expanded statewide. *Reporting:* Quarterly reports to CMMI and Vermont Legislature.	**Health Home (Hub & Spoke):** State-wide program implementation: 1. Implement Health Home according to Health Home State Plan Amendment and federal plan for 2015. 2. Report on program participation to CMMI.	1. In progress: Implementation ongoing through 12/31/15. 2. In progress: Reporting ongoing through 12/31/15. *Reporting:* Quarterly reports to CMMI and Vermont Legislature. *Contractors:* N/A	**Health Home (Hub & Spoke):** Reporting on program's transition and progress: Quarterly reporting of program progress to CMMI, VHCIP stakeholders.	Ongoing: Reporting ongoing as required by CMCS and CMMI. *Reporting:* Quarterly reports to CMMI and Vermont Legislature. *Contractors:* N/A	**Health Home (Hub & Spoke):** 1. Expand the number of providers and beneficiaries participating in the Health Home program by 6/30/17: Number of providers participating in Health Home program target: 75 MDs prescribing to ≥ 10 patients. (*Baseline as of December 2015:* 67[21]) Number of beneficiaries participating in Health Home program target: 2,900 Hub + 2,300	1. Partially achieved: Partially achieved provider scale targets, exceeded beneficiary scale targets. As of 6/30/17, 58 MDs prescribing to ≥ 10 patients; 5,714 total patients participating. 2. Achieved: Health Home program incorporated into Sustainability Plan. *Reporting:* Quarterly reports to CMMI and Vermont Legislature; ongoing as required by CMCS and CMMI.	CORE_Provider Organizations_[VT]_[HH] CORE_Participating Providers_[VT]_[HH]	1. Financial Standards: Non-SIM funded. 2. Care Standards: Non-SIM funded. 3. Quality Measures: Non-SIM funded. 4. Analyses for Design and Implementation: Non-SIM funded. 5. Stakeholder Engagement: Non-SIM funded.	Beth Tanzman	Key personnel: Beth Tanzman, Candace Elmquist

[21] There was a baseline error in establishing the number of MDs for this milestone. The baseline should have been 67 rather than 75.

	Performance Period 1 (PP1)[19]	Performance Period 1 (PP1)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 2 (PP2)	Performance Period 2 (PP2)	Performance Period 3 (PP3)	Performance Period 3 (PP3)	Metrics	Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
	Performance Period 1 Milestone	Current Status and Reporting	Performance Period 1 Carryover Milestone	Current Status, Reporting, and Contractors	Performance Period 2 Milestone	Current Status, Reporting, and Contractors	Performance Period 3 Milestone[20]	Current Status, Reporting, and Contractors				
							Spoke = 5,200 total patients. (*Baseline as of December 2015:* 5,179) 2. Health Home program incorporated into Sustainability Plan by 6/30/17.	*Contractors:* N/A				
Accountable Communities for Health (ACH)	N/A	N/A	**Accountable Communities for Health:** Feasibility assessment – research ACH design. 1. Convene stakeholders to discuss ACH concepts at least 3 times to inform report. 2. Produce Accountable Community for Health report by 7/31/15.	1. Achieved: Stakeholders convened 3 times to inform report (April 2014, March 2015, June 2015). 2. Achieved: Report finalized in June 2015. *Reporting:* Monthly status reports. *Contractors:* Prevention Institute; James Hester.	**Accountable Communities for Health:** Feasibility assessment – data analytics: 1. Discussion and planning of investments related to ACH feasibility based on research/report by 11/1/15. 2. Design/creation of ACH learning system for all 14 Vermont Health Service Areas by 1/31/16. 3. Start roll out ACH learning system to at least 3 health service areas by 2/1/16. 4. Research for implementation of a pilot incorporating a payment change (data analysis, financial analysis, stakeholder participation analysis) for at least 1 Vermont region by 2/1/16.	1. Achieved: ACH feasibility discussed in September and October 2015. 2. In progress: Basic design for an ACH peer learning opportunity for interested communities complete; work to refine and plan peer learning activities is ongoing; a contractor to support this work was selected in February 2016. 3. Achieved: Applications from interested communities received in February 2016. 4. In progress: Research with St. Johnsbury community ongoing through 2/1/16. *Reporting:* Monthly status reports. *Contractors:* James Hester; Public Health Institute.	**Accountable Communities for Health:** 1. Continue implementation of ACH learning system (ACH Peer Learning Laboratory) to 10 participating communities. 2. Develop ACH Implementation Plan based on lessons learned from ACH Peer Learning Laboratory by 6/30/17. 3. ACH Implementation Plan incorporated into Sustainability Plan by 6/30/17.	1. Achieved: Peer Learning Laboratory implementation continued during PP3. 2. Achieved: ACH Implementation Plan developed by 6/30/17. 3. Achieved: ACH Implementation Plan is incorporated into SIM Sustainability Plan. *Reporting:* Monthly status reports. *Contractors:* James Hester; Public Health Inst.	CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE Participating Providers_[VT]_[ACO]_Commercial CORE Participating Providers_[VT]_[ACO]_Medicaid CORE Participating Providers_[VT]_[ACO]_Medicare CORE_Payer Participation_[VT]	Model Development and Curriculum Design: James Hester; Prevention Institute Public Health Institute.	Heidi Klein	SIM-funded staff: Sarah Kinsler. Key personnel: Tracy Dolan; Heidi Klein; Jenney Samuelson
Prospective Payment System – Home Health	N/A	N/A	N/A	N/A	**Prospective Payment System – Home Health:** 1. Creation of a project plan and begin Phase 1 activities as required by project plan for PPS-HH by 12/31/15. 2. Design PPS program for home health for launch 7/1/16.	1. Achieved: Project plan created. 2. In progress: PPS design is ongoing through 6/30/16. *Reporting:* Monthly status reports. *Contractors:* N/A	**N/A**	**N/A**	*Activity discontinued; decision made in collaboration with CMMI in April 2016.*			
Prospective Payment System – Designated Agencies	N/A	N/A	N/A	N/A	**Prospective Payment System – Designated Agencies:** Submit planning grant for Certified Community Behavioral Health Clinics to SAMHSA by 8/5/15. If awarded, begin alignment of new opportunity with SIM activities. (Note: No SIM	Achieved: Planning grant submitted by 8/5/15. Vermont has decided not to pursue this opportunity, and will replace this work with the Medicaid Value-Based Purchasing milestone category (below) in PP3.	N/A	N/A	*Activity discontinued; Vermont will replace this activity with the Medicaid Value-Based Purchasing milestone category (below) in PP3.*			

	Performance Period 1 (PP1)[19]	Performance Period 1 (PP1)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 2 (PP2)	Performance Period 2 (PP2)	Performance Period 3 (PP3)	Performance Period 3 (PP3)	Metrics	Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
	Performance Period 1 Milestone	Current Status and Reporting	Performance Period 1 Carryover Milestone	Current Status, Reporting, and Contractors	Performance Period 2 Milestone	Current Status, Reporting, and Contractors	Performance Period 3 Milestone[20]	Current Status, Reporting, and Contractors				
					funds used to support this effort.)							
Medicaid Value-Based Purchasing (Medicaid Pathway)	N/A	N/A	N/A	N/A	N/A	*This milestone category developed in PP2 as a result of conversations with CMMI regarding Vermont's mental health and substance use integration needs.*	**Medicaid Value-Based Purchasing (Medicaid Pathway):** 1. Mental Health and Substance Abuse: Based on research and feasibility analysis, design an alternative to fee-for-service, for Medicaid mental health and substance use services by 12/31/16. Develop implementation timeline based on payment model design and operational readiness by 12/31/16. 2. Other Medicaid VBP Activities: Engage in research and feasibility analysis to support additional Medicaid Value-Based Purchasing activities.	1. Achieved: Alternative payment model for mental health and substance use disorder services designed by 12/31/16; operational timeline developed. 2. Achieved: Research and feasibility analyses for other Medicaid VBP performed during 2016. *Reporting:* Monthly status reports. *Contractors:* Bailit Health Purchasing, Burns and Associates, Pacific Health Policy Group	CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicaid	Financial Analyses and Model Design: Bailit Health Purchasing; Burns and Associates; Pacific Health Policy Group	Georgia Maheras; Selina Hickman; Mary Kate Mohlman	SIM-funded staff: Georgia Maheras; Michael Costa Key personnel: Selina Hickman; Nick Nichols; Barbara Cimaglio; Aaron French; Susan Bartlett; Melissa Bailey; all AHS Commissioners; Beth Tanzman
All-Payer Model	N/A	N/A	N/A	N/A	**All-Payer Model:** 1. Research feasibility, develop analytics, and obtain information to inform decision-making with CMMI. 2. Work with CMMI on mutually-agreed upon timeline for 2016 decision-making by 12/31/15.	1. In progress: Research, analytic development, and information gathering are ongoing to support discussions with CMMI. 2. In Progress: An initial timeline is established with CMMI; timeline will change as negotiations are completed to reflect final term sheet. *Reporting:* Monthly status reports. *Contractors:* Burns and Associates, Health Management Associates.	**All-Payer Model:** 1. If negotiations are successful, assist with implementation as provided for in APM agreement through end of SIM grant. 2. Contribute to analytics related to All-Payer Model implementation design through end of SIM grant. 3. All-Payer Model incorporated into Sustainability Plan by 6/30/17.	**All-Payer Model:** 1 and 2. Achieved: SIM funds supported sustainability-related regulatory activities and analytics through 6/30/17. 3. Achieved: All-Payer Model is incorporated into SIM Sustainability Plan. *Reporting:* Monthly status reports. *Contractors:* Burns and Associates, Health Management Associates.	CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE Participating Providers_[VT]_[ACO]_Commercial CORE Participating Providers_[VT]_[ACO]_Medicaid CORE Participating Providers_[VT]_[ACO]_Medicare CORE_Payer Participation_[VT]	Analyses: Health Management Associates (actuarial, model design); Burns and Associates (Medicaid financial analyses).	Michael Costa; Ena Backus; Mary Kate Mohlman	SIM-funded staff: Michael Costa; Alicia Cooper; Jim Westrich; Amy Coonradt; Julie Corwin; Erin Flynn; Sarah Kinsler Key personnel: Ena Backus; Susan Barrett; Pat Jones; TBD at GMCB
State Activities to Support Model Design and Implementation - GMCB	N/A	N/A	**State Activities to Support Model Design and Implementation – GMCB:** Identify quality measurement alignment opportunities. (in another section previously – the quality section): 1. Review new Blueprint (P4P) measures related to new investments by 7/1/15.	Achieved. *Reporting:* Monthly status reports (reported with Blueprint activities). *Contractors:* N/A	**State Activities to Support Model Design and Implementation – GMCB:** 1. Research and planning to identify the components necessary for APM regulatory activities by 6/30/16. 2. Specific regulatory activities and timeline are dependent on discussions with CMMI.	1. In progress: Research, analytic development, and information gathering are ongoing to support discussions with CMMI. 2. In progress: Negotiations are ongoing. *Reporting:* Monthly status reports (reported with All-Payer Model activities).	N/A (milestones in this category integrated into All-Payer Model milestone for Performance Period 3).	N/A (milestones in this category integrated into All-Payer Model milestone for Performance Period 3).	CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare	Research and Analyses: Health Management Associates (actuarial, model design).	Ena Backus and Pat Jones	SIM-funded staff: Michael Costa; Georgia Maheras Key personnel: Ena Backus; Pat Jones; Susan Barrett

	Performance Period 1 (PP1)[19]	Performance Period 1 (PP1)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 2 (PP2)	Performance Period 2 (PP2)	Performance Period 3 (PP3)	Performance Period 3 (PP3)	Metrics	Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
	Performance Period 1 Milestone	Current Status and Reporting	Performance Period 1 Carryover Milestone	Current Status, Reporting, and Contractors	Performance Period 2 Milestone	Current Status, Reporting, and Contractors	Performance Period 3 Milestone[20]	Current Status, Reporting, and Contractors				
						Contractors: Health Management Associates.						
State Activities to Support Model Design and Implementation - Medicaid	N/A	N/A	**State Activities to Support Model Design and Implementation – Medicaid:** Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate. 1. Obtain SSP Year 1 State Plan Amendment by 7/31/15. 2. Procure contractor for SSP monitoring and compliance activities by 4/15/15. 3. Procure contractor for data analytics related to value-based purchasing in Medicaid by 9/30/15. 4. Ensure call center services are operational for Medicaid SSP for SSP Year 2.	1. Achieved: SPA approved in June 2015. 2. Achieved: Contractor procured. 3. Achieved: Contractor procured. 4. Achieved: Call center services operational. *Reporting:* Monthly status reports. *Contractors:* Burns and Associates; Wakely Consulting; Pacific Health Policy Group.	**State Activities to Support Model Design and Implementation – Medicaid:** Pursue state plan amendments and other federal approvals as appropriate for each payment model (SSP SPA, EOC SPA); ensure monitoring and compliance activities are performed. Ensure beneficiaries have access to call-center as appropriate: 1. Ensure appropriate customer service supports are in place for Medicaid SSP program for 2016 by 11/1/15. 2. Obtain SPA for Year 2 of the Medicaid Shared Savings Program by 3/31/15. 3. Create draft SPA documents for Year 1 of the EOC program by 4/1/16. 4. Execute Year 1 and Year 2 commercial and Medicaid monitoring and compliance plans throughout Performance Period 2 according to the predetermined plan. 5. Develop monitoring and compliance plan for Year 1 EOCs by 6/30/16. 6. Design modifications to existing Integrated Family Services (IFS) Program so it can expand to at least one additional community on 7/1/16. 7. Research and design related to Frail Elders (timeline dependent upon federal contract approval) – final recommendations by 6/30/16.	1. Achieved: Maximus contract in place. 2. Achieved: SPA for Year 2 of the Medicaid SSP was approved in September 2015. 3. Revised: SPA is no longer required for revised EOC milestone. 4. Will be achieved by 12/31/15: SSP Year 1 and Year 2 monitoring and compliance plan implementation. 5. In progress: EOC work has been rolled into the Medicaid Pathway work stream. 6. In progress: The IFS delivery and payment model has since been rolled into the Medicaid Pathway work stream which will target providers across the entire state. Contractors are working with SIM staff and stakeholders to create a system ready for implementation on 1/1/17. 7. In progress: project kicked off in November 2015 after federal contract approval was received. *Reporting:* Monthly status report (and embedded in other reports by topic). *Contractors:* Bailit Health Purchasing; Burns and Associates; Pacific Health Policy Group; Maximus; Wakely Consulting; Vermont Medical Society Foundation; Policy Integrity.	**State Activities to Support Model Design and Implementation – Medicaid:** Pursue state plan amendments and other federal approvals as appropriate for each payment model; ensure monitoring and compliance activities are performed: 1. Obtain SPA for Year 3 of the Medicaid Shared Savings Program by 12/31/16. 2. Execute Year 3 commercial and Medicaid monitoring and compliance plans according to the predetermined plan through 6/30/17. *Other Medicaid-specific tasks in this work stream may be identified throughout Performance Period 3.*	1. Achieved: SPA for Year 3 of the Medicaid Shared Savings Program approved in June 2016. 2. Achieved: Year 3 commercial and Medicaid monitoring and compliance plans executed throughout 2016. *Reporting:* Monthly status report (and embedded in other reports by topic). *Contractors:* Bailit Health Purchasing; Burns and Associates; Pacific Health Policy Group; Maximus; Wakely Consulting; Vermont Medical Society Foundation; Policy Integrity.	CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicaid	Facilitation and Data Analyses: Burns and Associates; Waiver Analysis/ Medicaid Analysis: Pacific Health Policy Group; Customer Service Support: Maximus; Frail Elders: Vermont Medical Society Foundation; Data Analysis: Policy Integrity; Actuarial Services: Wakely Consulting.	Alicia Cooper (SPAs; EOC); Susan Aranoff (Frail Elders and Choices for Care);	SIM-funded staff: Alicia Cooper; Brad Wilhelm; Amy Coonradt; Luann Poirier; Susan Aranoff Key personnel: Pat Jones; Bard Hill
All Models	**All Models:** 1. Consult with Payment Models and Duals Work Groups on financial	1. Achieved: ACO model standards developed with work group input.	**All Models:** 1. Consult with stakeholders in all	1. Achieved: Stakeholders consulted on payment model	N/A (milestones in this category integrated into above categories for PP2).	N/A	N/A (milestones in this category integrated into above categories for PP2).	N/A (milestones in this category integrated into above categories for PP2).	CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare CORE_Participating Provider_[VT]_[ACO]_Commercial	N/A (milestones in this category integrated into	N/A (milestones in this category	N/A (milestones in this category integrated into

	Performance Period 1 (PP1)[19]	Performance Period 1 (PP1)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 2 (PP2)	Performance Period 2 (PP2)	Performance Period 3 (PP3)	Performance Period 3 (PP3)	Metrics	Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
	Performance Period 1 Milestone	**Current Status and Reporting**	**Performance Period 1 Carryover Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 2 Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 3 Milestone[20]**	**Current Status, Reporting, and Contractors**				
	model design: Develop ACO model standards. 2. Consult with Payment Models and Duals Work Groups on definition of analyses. 3. Define analyses: Number of meetings held with payment models and duals Work Groups on the above designs (goal = 2). 4. Procure contractor for internal Medicaid modeling: Contract for Medicaid modeling. 5. Procure contractor for internal Medicaid modeling: Number of analyses performed (goal = 5). 6. Procure contractor for additional data analytics: Contract for data analytics. 7. Define analyses: Number of analyses designed (goal = 5). 8. Procure contractor for additional data analytics: Contract for financial baseline and trend modeling. 9. Perform analyses, procure contractor for financial baseline and trend modeling, and develop model.	2. Achieved: Analyses defined with work group input. 3. Achieved: 5 meetings held with work groups on this topic. 4. Achieved: Contractor procured. 5. Achieved: 5 analyses performed. 6. Achieved: Contractor procured. 7. Achieved: 5 analyses defined. 8. Achieved: Contractor procured. 9. Achieved: Analyses performed, contractor procured, model developed. *Reporting:* Monthly status reports.	payment models design; implementation. 2. Consult with stakeholders in any additional design revision or analyses. 3. Maintain contract for ongoing Medicaid modeling. 4. Maintain contract for additional data analytics. 5. Maintain contract for ongoing financial baseline and trend modeling.	design through SIM work group meetings. 2. Achieved: Stakeholders consulted on payment model revision and analyses through SIM work group meetings. 3. In progress: Contract for Medicaid modeling ongoing. 4. In progress: Contract for data analytics ongoing. 5. In progress: Contract for ongoing financial baseline and trend modeling ongoing. *Reporting:* Monthly status reports. *Contractors:* Burns and Associates; Bailit Health Purchasing; Wakely Consulting; The Lewin Group; Policy Integrity; Pacific Health Policy Group; Maximus.					CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare	above categories for PP2).	integrated into above categories for PP2 and PP3)	above categories for PP2)
All-Models: Quality Measurement	**All-Models: Quality Measurement:** 1. 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,	1. Achieved: Performance measures defined. 2. Achieved: Provider, consumer, and payer buy-in maintained during measure selection. 3. Achieved: Payers aligned across measures, measures approved by payers. 4. Achieved: Target setting process established, along with routine assessment process and analytic framework and reports. *Reporting:* Monthly status reports.	**All-Models: Quality Measurement:** 1. Modify initial quality measures, targets, and benchmarks for subsequent program periods (based on stakeholder input and national measure guidelines). 2. Maintain monthly meeting schedule for multi-stakeholder Quality & Performance Measures Work Group. 3. Identify additional opportunities for measure alignment across programs (e.g. ACO SSPs and Blueprint for Health P4P).	1. Achieved: Initial quality measures modified based on stakeholder input and national measure guidelines. 2. Achieved: QPM Work Group met monthly prior to incorporation into new Payment Model Design and Implementation Work Group in October 2015. 3. In progress: Work to identify additional opportunities for measure alignment with Blueprint will be complete by 12/31/15 as part of new payment (see pay-for-	N/A (milestones in this category integrated into above categories for PP2).	N/A	N/A (milestones in this category integrated into above categories for PP2).	N/A (milestones in this category integrated into above categories for PP2).	CORE_Beneficiaries impacted_[VT]_[ACO]_Commercial CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid CORE_Beneficiaries impacted_[VT]_[ACO]_Medicare CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare	N/A (milestones in this category integrated into above categories for PP2).	N/A (milestones in this category integrated into above categories for PP2)	N/A (milestones in this category integrated into above categories for PP2)

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	Performance Period 1 Milestone	**Current Status and Reporting**	**Performance Period 1 Carryover Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 2 Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 3 Milestone[20]**	**Current Status, Reporting, and Contractors**				
	determine reporting requirements, revisit measure set on regular basis. 2. Ensure provider, consumer and payer buy-in during measure selection: Identification of additional mechanisms for obtaining provider and consumer representation, input and buy-in. 3. Ensure payer alignment across endorsed measures: • Process for payer approval. 4. Establish plan for target-setting with schedule for routine assessment: • Establish target-setting process, routine assessment process, and analytic framework and reports.		4. Complete final quality calculations for initial SSP performance period and report results. Begin interim analytics for subsequent performance period.	performance row above). 4. Achieved: SSP Year 1 quality calculations finalized; interim analytics for SSP Year 2 begun. *Reporting:* Monthly status reports. *Contractors:* Bailit Health Purchasing; Deborah LIsi-Baker; Pacific Health Policy Group.							
Focus Area: Practice Transformation												
Learning Collaboratives	**Learning Collaboratives:** 1. Provide quality improvement and care transformation support to a variety of stakeholders. 2. Procure learning collaborative and provider technical assistance contractor.	1. Achieved: Quality improvement and care transformation support provided through development of Care Management Learning Collaborative and sub-grant technical assistance. 2. Achieved: Contractor procured. *Reporting:* Monthly status reports.	**Learning Collaboratives:** Launch 1 cohort of Learning Collaboratives to 3-6 communities (communities defined by Vermont's Health Service Areas) by 1/15/15: 1. Convene communities in-person and via webinar alternating format each month for 12 months. 2. Assess impact of Learning Collaborative monthly. 3. Propose expansion of Learning Collaborative as appropriate by 5/31/15.	Achieved: First Learning Collaborative cohort launched to 3 communities. 1. Achieved: Communities convened monthly for in-person or web events monthly for 12 months. 2. Achieved: Impact assessed monthly by community-based learning collaborative leaders and SIM staff. 3. Achieved: Expansion proposed in April 2015. *Reporting:* Monthly status reports. *Contractors:* Nancy Abernathey.	**Learning Collaboratives:** Offer at least two cohorts of Learning Collaboratives to 3-6 communities: 1. Create expansion plan for remaining Vermont HSAs that want to participate in the Learning Collaborative program by 6/15/15. 2. Expand existing Learning Collaborative program to at least 6 additional health service areas by 6/30/16.	Achieved: Learning Collaborative cohorts 2 and 3 launched in 8 communities in September 2015. 1. Achieved: Expansion plan proposed in April 2015. 2. Achieved: Expansion launched to 8 new communities began in September 2015. *Reporting:* Monthly status reports. *Contractors:* Deborah Lisi-Baker; Nancy Abernathey; Vermont Partners for Quality in Health Care; Developmental Disabilities Council; Primary Care Development Corporation.	**Learning Collaboratives:** 1. Target: 400 Vermont providers have participated in Learning Collaborative activities (including Integrated Communities Care Management Learning Collaborative or Core Competency Trainings) by 12/31/16. (*Baseline as of December 2015:* 200) 2. Report on program effectiveness to Steering Committee and Core Team by 12/31/16. 3. Incorporate Learning Collaborative lessons learned into Sustainability Plan by 6/30/17.	1. Achieved: 440 Vermont providers participated in Learning Collaborative activities (including Integrated Communities Care Management Learning Collaborative, Core Competency Trainings, or both). 2. Achieved: Core Team and Steering Committee received regular updates on program progress and impact. Formal evaluation of program effectiveness was included in Evaluation presentation to Core Team in June 2017. 3. Achieved: Learning Collaborative and Core Competency Training lessons learned incorporated into Sustainability Plan.	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] _Medicaid CORE_Provider Organizations_[VT]_[EOC] _Medicaid CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	1. Quality Improvement Facilitation: Nancy Abernathey; Vermont Program for Quality Health Care (VPQHC). 2. Disability Core Competency Research and Implementation: Lisi-Baker; Developmental Disabilities Council. 3. Care Management Core Competency: Primary Care Development Corporation.	Erin Flynn and Pat Jones	SIM-funded staff: Erin Flynn; Julie Wasserman; Julie Corwin; Luann Poirier Key personnel: Pat Jones; Jenney Samuelson

	Performance Period 1 (PP1)[19]	Performance Period 1 (PP1)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 2 (PP2)	Performance Period 2 (PP2)	Performance Period 3 (PP3)	Performance Period 3 (PP3)	Metrics	Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
	Performance Period 1 Milestone	Current Status and Reporting	Performance Period 1 Carryover Milestone	Current Status, Reporting, and Contractors	Performance Period 2 Milestone	Current Status, Reporting, and Contractors	Performance Period 3 Milestone[20]	Current Status, Reporting, and Contractors				
								Reporting: Monthly status reports. *Contractors:* Deborah Lisi-Baker; Nancy Abernathey; Vermont Partners for Quality in Health Care; Developmental Disabilities Council; Primary Care Development Corporation.				
Sub-Grant Program – Sub-Grants	**Sub-Grant Program – Sub Grants:** Develop technical assistance program for providers implementing payment reforms.	Achieved: 14 sub-grant awards made to 12 awardees, technical assistance program developed, and technical assistance contractors procured. *Reporting:* Monthly status reports.	**Sub-Grant Program – Sub Grants:** Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/15. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.	Achieved: 1. Achieved: Sub-grantees convened on 5/27/15. 2. Achieved: Sub-grantee quarterly reports reviewed quarterly to gather lessons learned to inform project decision-making. *Reporting:* Monthly status reports. *Contractors:* Sub-Grantees (Vermont Medical Society Foundation; *Healthfirst*; Central Vermont Medical Center Bi-State Primary Care Association/ Community Health Accountable Care; Northwest Medical Center; Northern Vermont Medical Center; White River Family Practice; Vermont Program for Quality in Health Care; InvestEAP; Vermont Developmental Disabilities Council; Rutland VNA; Southwest Medical Center).	**Sub-Grant Program – Sub Grants:** Continue sub-grant program: 1. Convene sub-grantees at least once by 6/30/16. 2. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making.	Ongoing: 1. Not yet started: Plan to convene sub-grantees at least once in Spring 2016. 2. Ongoing: Analysis and incorporation of lessons learned will continue through 6/30/16. *Reporting:* Monthly status reports. *Contractors:* Sub-Grantees (Vermont Medical Society Foundation; Health*first*; Central Vermont Medical Center; Bi-State Primary Care Association/ CHAC; Northwest Medical Center; Northern Vermont Medical Center; White River Family Practice; Vermont Program for Quality in Health Care; InvestEAP; Vermont Developmental Disabilities Council; Rutland VNA; Southwest Medical Center).	**Sub-Grant Program – Sub Grants:** 1. Provide SIM funds to support sub-grantees through 12/31/16. 2. Convene sub-grantees at least twice by 12/31/16. 3. Each quarter, analyze reports filed by sub-grantees using lessons from sub-grantees to inform project decision-making. 4. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.	1. Achieved: Sub-grant project work was completed by 12/31/16. 2. Partially achieved: Sub-grantees were convened in late PP2, in June 2016; the State chose not to convene sub-grantees again due to short timeframe prior to grant close-out. 3. Achieved: Sub-grantee quarterly reports received and reviewed. 4. Achieved: Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17. *Reporting:* Monthly status reports. *Contractors:* Sub-Grantees (Vermont Medical Society Foundation; Health*first*; Central Vermont Medical Center; Bi-State Primary Care Association/ CHAC; Northwest Medical Center; Northern Vermont Medical Center; White River Family Practice; Vermont Program for Quality in Health Care; InvestEAP; Vermont Developmental Disabilities Council; Rutland VNA;	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] _Medicaid CORE_Provider Organizations_[VT]_[EOC] _Medicaid CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	Sub-Grantees (Vermont Medical Society Foundation; Health*first*; Central Vermont Medical Center; Bi-State Primary Care Association/ CHAC; Northwest Medical Center; Northern Vermont Medical Center; White River Family Practice; Vermont Program for Quality in Health Care; InvestEAP; Vermont Developmental Disabilities Council; Rutland VNA; Southwest Medical Center).	Joelle Judge and Georgia Maheras	SIM-funded staff: Susan Aranoff; Amy Coonradt Key personnel: Heidi Klein

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	Performance Period 1 Milestone	Current Status and Reporting	Performance Period 1 Carryover Milestone	Current Status, Reporting, and Contractors	Performance Period 2 Milestone	Current Status, Reporting, and Contractors	Performance Period 3 Milestone[20]	Current Status, Reporting, and Contractors				
								Southwest Medical Center).				
Sub-Grant Program – Technical Assistance	N/A	N/A	**Sub-Grant Program – Technical Assistance:** Provide technical assistance to sub-grantees as requested by sub-grantees: 1. Remind sub-grantees of availability of technical assistance on a monthly basis. 2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees.	Achieved: 1. Achieved: Sub-grantees reminded of technical assistance availability monthly. 2. Achieved: Technical assistance contracts sufficiently resourced to meet sub-grantee TA requests. *Reporting:* Monthly status reports. *Contractors:* Policy Integrity; Wakely Consulting; Truven.	**Sub-Grant Program – Technical Assistance:** Provide technical assistance to sub-grantees as requested by sub-grantees: 1. Remind sub-grantees of availability of technical assistance on a monthly basis. 2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees.	Ongoing: 1. Ongoing: Sub-grantees will be reminded of technical assistance availability monthly through 6/30/16. 2. Ongoing: Technical assistance contracts sufficiently resourced to meet sub-grantee TA requests through 6/30/16. *Reporting:* Monthly status reports. *Contractors:* Policy Integrity; Wakely Consulting.	**Sub-Grant Program – Technical Assistance:** Provide technical assistance to sub-grantees as requested by sub-grantees through 12/31/16: 1. Remind sub-grantees of availability of technical assistance on a monthly basis. 2. Ensure technical assistance contracts have sufficient resources to meet needs of sub-grantees. 3. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.	1. Achieved: Reminded sub-grantees of availability of technical assistance throughout PP3. 2. Achieved: Technical assistance contracts were reviewed on a periodic basis and amended as necessary to ensure that resources were fully available to meet the needs of sub-grantees. 3. Final report on the sub-grant program developed by Vermont's self-evaluation contractor by 6/30/17.	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] _Medicaid CORE_Provider Organizations_[VT]_[EOC] _Medicaid CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	Sub-Grantee Technical Assistance: Policy Integrity; Wakely Consulting.	Joelle Judge and Georgia Maheras	SIM-funded staff: Susan Aranoff; Julie Wasserman; Amy Coonradt Key personnel: Heidi Klein
Regional Collaborations	N/A	N/A	**Regional Collaborations:** Establish regional collaborations in health services areas by beginning to develop a Charter, governing body, and decision-making process: 1. Develop Charter, decision-making process, and participants for 6 HSAs by 11/30/15. 2. Require monthly updates from ACOs/Blueprint for Health.	Achieved: 1. Achieved: Charters, decision-making process, and participants for 6 HSAs developed by 11/30/15. 2. Achieved: Monthly updates from ACOs/Blueprint required. *Reporting:* Monthly status reports. *Contractors:* Bi-State Primary Care Association/ Community Health Accountable Care.	**Regional Collaborations:** Expansion of regional collaborations to all 14 Health Service Areas (HSAs) by 6/30/16. Expansion is complete when all HSAs have a Charter, governing body, and decision-making process.	Ongoing: Regional collaborations active in all HSAs; as of February 2016, 14 of 14 communities had a charter in place and had defined one or more focus area. Work continues to support development of governing body and decision-making process. *Reporting:* Monthly status reports. *Contractors:* Bi-State Primary Care Association/ Community Health Accountable Care (CHAC); UVM Medical Center (UVMMC)/ OneCare Vermont.	**Regional Collaborations:** 1. Support regional collaborations in 14 HSAs by providing sub-grants to ACOs and other technical assistance resources. 2. Develop a transition plan by 4/30/17 to shift all HSAs to non-SIM resources. 3. Incorporate into Sustainability Plan by 6/30/17.	1. Achieved: Regional collaborations in 14 HSAs supported by ACOs and other technical assistance resources. 2. Achieved: Transition plan developed. 3. Achieved: Regional collaborations included in SIM Sustainability Plan. *Reporting:* Monthly status reports. *Contractors:* Bi-State Primary Care Association/ Community Health Accountable Care (CHAC); UVM Medical Center (UVMMC)/ OneCare Vermont.	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] _Medicaid CORE_Provider Organizations_[VT]_[EOC] _Medicaid CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	ACO Activities: Bi-State Primary Care Association/ CHAC; UVMMC/OneCare Vermont.	Jenney Samuelson	SIM-funded staff: Erin Flynn; Amy Coonradt Key personnel: Pat Jones; Jenney Samuelson
Workforce – Care Management Inventory	N/A	N/A	**Care Management Inventory:** Obtain snapshot of current care management activities, staffing, people served, and challenges: 1. Obtain Draft Report by 3/31/15. 2. Present to 2 work groups by 5/31/15. 3. Final Report due by 9/30/15.	Achieved: 1. Achieved: Draft report results presented to CMCM Work Group in February 2015. 2. Achieved: presented to CMCM Work Group and Workforce Work Group. 3. Achieved.	N/A	N/A	N/A	N/A	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] _Medicaid CORE_Provider Organizations_[VT]_[EOC] _Medicaid CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	Care Management Inventory: Bailit Health Purchasing.	Pat Jones and Erin Flynn	SIM-funded staff: Erin Flynn Key personnel: Pat Jones

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	Performance Period 1 Milestone	Current Status and Reporting	Performance Period 1 Carryover Milestone	Current Status, Reporting, and Contractors	Performance Period 2 Milestone	Current Status, Reporting, and Contractors	Performance Period 3 Milestone[20]	Current Status, Reporting, and Contractors				
				Reporting: Monthly status reports. *Contractors:* Bailit Health Purchasing.								
Workforce – Demand Data Collection and Analysis	N/A	N/A	N/A	N/A	**Workforce – Demand Data Collection and Analysis:** 1. Execute contract for micro-simulation demand modeling by 1/15/16 (dependent on federal approval). 2. Provide preliminary data as defined by the contract to vendor for use in model by 3/15/16.	1. In progress: Contract for demand modeling approved by CMMI in October. Pending execution. Anticipate execution by Q2 2016. 2. Not yet started: DVHA expects to provide data to demand modeling vendor in Q2 2016. *Reporting:* Monthly status reports; reports from vendor. *Contractors:* IHS.	**Workforce – Demand Data Collection and Analysis:** Submit Final Demand Projections Report and present findings to Workforce Work Group by 12/31/16.	Achieved (with delay): Final Demand Projections Report completed and findings presented to Workforce Work Group in May 2017. *Reporting:* Monthly status reports; reports from vendor. *Contractors:* IHS.	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] _Medicaid CORE_Provider Organizations_[VT]_[EOC] _Medicaid CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	Micro-Simulation Demand Model: IHS.	Amy Coonradt	SIM-funded staff: Amy Coonradt Key personnel: Mat Barewicz; Peggy Brozicevic
Workforce – Supply Data Collection and Analysis	N/A	N/A	**Workforce – Supply Data Collection and Analysis:** Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan: 1. Present data to Workforce Work Group at least 3 times by 9/30/15. 2. Publish data reports/analyses on website by 12/31/15. 3. Distribute reports/analyses to project stakeholders by 12/31/15.	1. Achieved. 2. Achieved: Posted on the VDH website. 3. Achieved: Achieved as part of Workforce Work Group presentations. *Reporting:* Monthly status reports. *Contractors:* N/A	**Workforce – Supply Data Collection and Analysis:** Continue to use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan: 1. Present data to Workforce Work Group at least 4 times between 1/1/15 and 6/30/16. 2. Publish data reports/analyses on website by 12/31/15. 3. Distribute reports/analyses to project stakeholders by 12/31/15.	In progress: VDH presented to Health Care Workforce Work Group in February 2016 and proposed forming a sub-group of the Health Care Workforce Work Group and other key subject matter experts. The subgroup will analyze VDH data and provide this analysis to the broader work group, with the goal of informing work group activities. *Reporting:* Monthly status reports. *Contractors:* N/A (staff only).	**Workforce – Supply Data Collection and Analysis:** Use supply data (licensure and recruitment) to inform workforce planning and updates to Workforce Strategic Plan: 1. Present data to Workforce Work Group at least 3 times by 12/31/16. 2. Publish data reports/analyses on website by 6/30/17. 3. Distribute reports/analyses to project stakeholders by 6/30/17. 4. Incorporate into Sustainability Plan by 6/30/17.	1. Achieved: Data presented to Workforce Work Group twice by 12/31/16. Additional presentations in 2017. 2 and 3. Achieved: Survey and statistical reports for each profession are published on the VDH website on a rolling basis as they are finalized. 4. Achieved: Workforce supply data activities included in SIM Sustainability Plan. *Reporting:* Monthly status reports. *Contractors:* N/A (staff only).	CORE_Participating Provider_[VT]_[ACO]_Commercial CORE_Participating Provider_[VT]_[ACO]_Medicaid CORE_Participating Provider_[VT]_[ACO]_Medicare CORE_Provider Organizations_[VT]_[ACO]_Commercial CORE_Provider Organizations_[VT]_[ACO]_Medicaid CORE_Provider Organizations_[VT]_[ACO]_Medicare CORE_Participating Providers_[VT]_[EOC] _Medicaid CORE_Provider Organizations_[VT]_[EOC] _Medicaid CORE_Participating Providers_[VT]_[APMH] CORE_Provider Organizations_[VT]_[APMH]	*Staff Only.*	Matt Bradstreet	SIM-funded staff: Matt Bradstreet; Amy Coonradt Key personnel: VDH and OPR licensing staff
	Vermont Department of Labor to develop a comprehensive review of all such programs offered by each agency/department of state government - due by the end of 2013.	Achieved. *Reporting:* PP1 Annual Report.	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A
	SIM will expand all existing efforts (Blueprint, VITL, providers, VCCI, SASH, Hub and Spoke).	Achieved. *Reporting:* PP1 Annual Report. These activities are now found in the Payment Model Design and Implementation	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A

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	Performance Period 1 Milestone	Current Status and Reporting	Performance Period 1 Carryover Milestone	Current Status, Reporting, and Contractors	Performance Period 2 Milestone	Current Status, Reporting, and Contractors	Performance Period 3 Milestone[20]	Current Status, Reporting, and Contractors				
		section above for subsequent project periods.										
Focus Area: Health Data Infrastructure												
Expand Connectivity to HIE – Gap Analyses	**Expand Connectivity to HIE – Gap Analyses:** Perform gap analyses related to quality measures for each payment program, as appropriate; perform baseline gap analyses to understand connectivity of non-Meaningful Use (MU) providers.	Achieved: Two gap analyses launched in 2014: ACO program and non-MU long-term services and supports providers. *Reporting:* Monthly status reports.	**Expand Connectivity to HIE – Gap Analyses:** Perform gap analyses related to quality measures for each payment program, as appropriate; perform baseline gap analyses to understand connectivity of non-Meaningful Use (MU) providers: 1. Complete DLTSS technical gap analysis by 9/30/15. 2. Conduct bimonthly SSP quality measure gap analyses for ACO providers.	Achieved: 1. Achieved: DLTSS technical gap *analysis* finalized in October 2015. 2. In progress: bimonthly analyses completed to date; final analysis will be complete by 12/31/15. *Reporting:* Monthly status reports. *Contractors:* VITL (Vermont Information Technology Leaders); H.I.S. Professionals.	N/A	N/A	N/A	N/A	CORE_Health Info Exchange_[VT]	Perform Gap Analyses: VITL; H.I.S. Professionals.	Georgia Maheras (ACO); Sarah Kinsler (DLTSS)	SIM-funded staff: Georgia Maheras; Sarah Kinsler; Susan Aranoff; Julie Wasserman Key personnel: Larry Sandage
Expand Connectivity to HIE – Gap Remediation	N/A	N/A	N/A	N/A	**Expand Connectivity to HIE – Gap Remediation:** Remediate data gaps that support payment model quality measures, as identified in gap analyses: 1. Remediate 50% of data gaps for SSP quality measures by 12/31/15. 2. Develop a remediation plan for gaps identified in LTSS technical gap analysis by 12/31/15.	Achieved: 1. Achieved: Over 50% of gaps remediated. 2. Achieved: Remediation plan developed. *Reporting:* Monthly status reports. *Contractors:* Vermont Information Technology Leaders (VITL); Vermont Care Partners; H.I.S. Professionals; Pacific Health Policy Group.	**Expand Connectivity to HIE – Gap Remediation:** 1. Remediate 65% of ACO SSP measures-related gaps as identified in Fall 2015/Spring 2016 by 6/30/17. (*Baseline as of December 2015:* 62%) 2. Remediate data gaps for LTSS providers according to remediation plan developed in Performance Period 2 by 6/30/17. 3. Incorporate Gap Remediation activities into Sustainability Plan by 6/30/17.	1. Achieved: More than 65% of ACO SSP measures-related gaps as identified in Fall 2015/Spring 2016 remediated by 6/30/17. 2. Achieved: DLTSS Gap Remediation activities with Home Health Agencies completed by 6/30/17. 3. Achieved: Gap Remediation activities incorporated into SIM Sustainability Plan. *Reporting:* Monthly status reports. *Contractors:* Vermont Information Technology Leaders (VITL); Vermont Care Partners	CORE_Health Info Exchange_[VT]	Remediation of Data Gaps – VITL; Vermont Care Partners; H.I.S. Professionals; Pacific Health Policy Group.	Georgia Maheras	SIM-funded staff: Georgia Maheras; Susan Aranoff; Julie Wasserman Key personnel: Emily Yahr; Larry Sandage
Expand Connectivity to HIE – Data Extracts from HIE	N/A	N/A	**Expand Connectivity to HIE – Data Extracts from HIE:** Completed development of ACO Gateways with OneCare Vermont (OCV) by 3/31/15 and Community Health Accountable Care (CHAC) by 12/31/15 to support transmission of data extracts from the HIE.	Delayed: OCV Gateway and CHAC Gateway completed as of December 2015; work on Health*first* Gateway is ongoing. *Reporting:* Monthly status reports. *Contractors:* VITL	N/A	N/A	N/A	N/A	CORE_Health Info Exchange_[VT]	ACO Gateway: VITL.	Georgia Maheras	SIM-funded staff: Georgia Maheras Key personnel: Larry Sandage

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Expand Connectivity to HIE	**Expand Connectivity to HIE:** 1. Begin to incorporate long-term care, mental health, home care and specialist providers into the HIE infrastructure. 2. Number of new interfaces built between provider organizations and HIE (goal = 18 additional hospital interfaces and 75 new interfaces to non-hospital health care organizations to include: at least 10 specialist practices; 4 home health agencies; and 4 designated mental health agencies).	1. Achieved (note some PP1 Carryover). 2. Achieved: 16 hospital interfaces built; 75 new interfaces to non-hospital health care organizations built. *Reporting:* Monthly status reports.	**Expand Connectivity to HIE:** Begin to incorporate long-term care, mental health, home care and specialist providers into the HIE infrastructure and expand provider connection to HIE infrastructure: 1. Number of new interfaces built between provider organizations and HIE: Total goal for Y1 = 20 hospital interfaces and 150 interfaces to non-hospital health care organizations by 12/31/15.	1. Achieved: 20 hospital interfaces and 193 non-hospital interfaces built. *Reporting:* Monthly status reports. *Contractors:* VITL.	N/A	N/A	N/A	N/A	CORE_Health Info Exchange_[VT]	Interface Development: VITL.	Georgia Maheras	SIM-funded staff: Georgia Maheras Key personnel: Larry Sandage
Improve Quality of Data Flowing into HIE	**Improve Quality of Data Flowing into HIE:** Clinical Data: 1. Medication history and provider portal to query the VHIE by end of 2013. 2. State law requires statewide availability of Blueprint program and its IT infrastructure by October 2013.	1. Achieved: 129 queries. 2. Achieved. *Reporting:* Monthly status reports and contractor reports.	**Improve Quality of Data Flowing into HIE:** 1. Data quality initiatives with the DAs/SSAs: Conduct data quality improvement meetings with the DAs/SSAs to focus on the analysis of the current state assessments for each agency: at least 4 meetings per month with DA/SSA leadership and 6 meetings per month with individual DAs/SSAs to review work flow. 2. Access to medication history to support care: 150 medication queries to the VHIE by Vermont providers by 12/31/15.	1. Achieved. 2. In progress: will be achieved by 12/31/15. *Reporting:* Monthly status reports and contractor reports. *Contractors:* VITL; Behavioral Health Network.	**Improve Quality of Data Flowing into HIE:** 1. Implement terminology services tool to normalize data elements within the VHIE by TBD. 2. Engage in workflow improvement activities at provider practices to improve the quality of the data flowing into the VHIE as identified in gap analyses. Start workflow improvement activities in 30% of ACO attributing practices by 6/30/16.	1. In progress. 2. In progress: Workflow improvement activities begun. *Reporting:* Monthly status reports and contractor reports. *Contractors:* VITL; Behavioral Health Network; UVM Medical Center (UVMMC)/ OneCare Vermont.	**Improve Quality of Data Flowing into HIE:** Engage in workflow improvement activities at designated mental health agencies (DAs) as identified in gap analyses. Start workflow improvement activities in all 16 DAs by 7/1/16 and complete workflow improvement by 12/31/16. Report on improvement over baseline by 6/30/17.	Achieved: DA data quality work completed in December 2016; final report submitted in Summer 2017. *Reporting:* Monthly status reports and contractor reports. *Contractors:* VITL; Behavioral Health Network; UVM Medical Center (UVMMC)/ OneCare Vermont.	CORE_Health Info Exchange_[VT]	Terminology Services: VITL. Workflow Improvement: VITL; Behavioral Health Network; UVMMC/OneCare Vermont.	Georgia Maheras	Key personnel: Larry Sandage
Telehealth – Strategic Plan	N/A	N/A	N/A	N/A	**Telehealth – Strategic Plan:** Develop telehealth strategic plan by 9/15/15.	Achieved: Telehealth Strategic Plan finalized in September 2015. *Reporting:* Report completed by deadline. *Contractors:* JBS International.	N/A	N/A	CORE_Health Info Exchange_[VT]	Telehealth Strategic Plan: JBS International.	Sarah Kinsler	SIM-funded staff: Sarah Kinsler
Telehealth – Implementation	N/A	N/A	N/A	N/A	**Telehealth – Implementation:** 1. Release telehealth program RFP by 9/30/15. 2. Award at least one contract to implement	1. Achieved: RFP released on 9/18/15. 2. In process. Bidders selected in December 2015; as of February, contract negotiations still underway.	**Telehealth – Implementation:** 1. Continue telehealth pilot implementation through contract end dates.	1. Achieved: Telehealth pilot implementation completed. 2. Achieved: Telehealth pilots included in SIM Sustainability Plan.	CORE_Health Info Exchange_[VT]	Telehealth Implementation: VNA of Chittenden and Grand Isle Counties; Howard Center.	Jim Westrich	SIM-funded staff: Jim Westrich

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					the scope of work in the telehealth program RFP by 1/15/16.	*Reporting:* RFP released on time; monthly status reports. *Contractors:* VNA of Chittenden and Grand Isle Counties; Howard Center.	2. Incorporate Telehealth Program into Sustainability Plan by 6/30/17.	*Reporting:* Monthly status reports. *Contractors:* VNA of Chittenden and Grand Isle Counties; Howard Center.				
EMR Expansion	N/A	N/A	N/A	N/A	**EMR Expansion:** 1. Assist in procurement of EMR for non-MU providers: Vermont State Psychiatric Hospital (by 6/30/15) and ARIS (Developmental Disability Agencies) (by 6/30/16). 2. Explore non-EMR solutions for providers without EMRs: develop plan based on LTSS technical gap analysis.	1. In progress: Achieved – State Psychiatric Hospital EMR guidance provided in Jan-Mar 2015. On track – ARIS/ Developmental Disability Agencies procurement will be complete by 6/30/16. 2. Achieved: Remediation plan to support VHIE connection for home health agencies developed and approved; this work will be pursued in PP3 under the Care Management Tools work stream. *Reporting:* Monthly status reports. *Contractors:* ARIS; VITL/Department of Mental Health.	N/A	N/A	CORE_Health Info Exchange_[VT]	EMR Procurement: ARIS; VITL/Dept of Mental Health. Non-EMR Solutions: ARIS; VITL.	Georgia Maheras	SIM-funded staff: Georgia Maheras Key personnel: Joelle Judge
Data Warehousing	N/A	N/A	**Data Warehousing:** Prepare to develop infrastructure to support the transmission, aggregation, and data capability of the DAs and SSAs data into a mental health and substance abuse compliant Data Warehouse: 1. Develop data dictionary by 3/31/15. 2. Release RFP by 4/1/15. 3. Execute contract for Data Warehouse by 10/15/15. 4. Design data warehousing solution so that the solution begins implementation by 12/31/15.	1. Achieved. 2. Achieved. 3. In progress: SOV amended contract with vendor for this work. Contractor will have sub-contract by 11/30/15. 4. Achieved. *Reporting:* Monthly status reports. *Contractors:* Behavioral Health Network.	**Data Warehousing:** 1. Implement Phase 1 of DA/SSA data warehousing solution by 12/31/15 (implementation follows implementation project plan). 2. Procure clinical registry software by 3/31/16. 3. Develop a cohesive strategy for developing data systems to support analytics by 3/31/16.	1. Achieved. 2. Achieved. 3. In progress: Will be completed by 3/31/16. *Reporting:* Monthly status reports. *Contractors:* Behavioral Health Network; Covisint; Stone Environmental.	**Data Warehousing:** 1. Implement Phase 2 of DA/SSA data warehousing solution by 12/31/16. 2. Obtain approval of cohesive strategy for developing data systems to support analytics by 10/31/16. Operationalize the approved cohesive strategy for developing data systems to support analytics by 12/31/16.	**Data Warehousing:** 1. Achieved (with delay): Phase 2 of DA/SSA data warehousing solution completed in June 2017. 2. Partially Achieved: Developed proposal for cohesive strategy for developing data systems to support analytics by 12/31/16. *Reporting:* Monthly status reports. *Contractors:* Behavioral Health Network; Stone Environmental.	CORE_Health Info Exchange_[VT]	Stakeholder Engagement: Behavioral Health Network. Clinical Registry Procurement: Covisint. Cohesive Strategy Development: Stone Environmental.	Georgia Maheras; Craig Jones; Emily Yahr	SIM-funded staff: Georgia Maheras Key personnel: Craig Jones; Emily Yahr; Larry Sandage

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	Performance Period 1 Milestone	**Current Status and Reporting**	**Performance Period 1 Carryover Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 2 Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 3 Milestone[20]**	**Current Status, Reporting, and Contractors**				
Care Management Tools	N/A	N/A	**Care Management Tools:** 1. Discovery project to support long- term care, mental health, home care and specialist providers through a Universal Transfer Protocol solution: Report due 4/15/15. 2. Engage in research and discovery to support selection of a vendor for event notification system in Vermont by 10/1/15.	1. Achieved: Report received in February 2015. 2. Achieved: Research and discovery launched in March 2015; vendor selected in September 2015. State, VITL, and vendor currently in contract negotiations. *Reporting:* Monthly status reports. *Contractors:* im21.	**Care Management Tools:** Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development: 1. Event Notification System: Procure solution by 1/15/16 and implement according to project plan for phased roll out. 2. SCÜP (shared care plans and uniform transfer protocol): Create project plan for this project that includes business requirements gathering by 9/30/15; technical requirements by 10/31/15; and final proposal for review by 1/31/16.	1. In progress: Vendor selected. Federal approval received. State contract pending. 2. In progress: Business and technical requirements gathered; final proposal in development for release in March 2016. *Reporting:* Monthly status reports. *Contractors:* PatientPing; Stone Environmental; TBD.	**Care Management Tools:** 1. Event Notification System: Continue implementation of ENS according to contract with vendor through 12/31/16. 2. Shared Care Plan: Recommend revisions to the VHIE consent policy and architecture to better support shared care planning by 6/30/17. 3. Universal Transfer Protocol: Support workflow improvements at provider practices through existing contracts through 12/31/16. 4. Continue implementation of care management solutions, including VITLAccess, supporting Home Health Agencies and Area Agencies on Aging.	**Care Management Tools:** 1. Achieved: Event Notification System implementation continued through 6/30/17. 2. Achieved: Staff reviewed VHIE consent policy and architecture to better support shared care planning throughout PP3, and the HDI Work Group made recommendations in December 2016. 3. Achieved: Supported workflow improvements at provider practices to support Universal Transfer Protocol goals through existing contracts. 4. Achieved: Continued implementation of care management solutions, including VITLAccess, and supporting Home Health Agencies. (Work with Area Agencies on Aging discontinued due to legal issues.) *Reporting:* Monthly status reports. *Contractors:* PatientPing; Stone Environmental; VITL.	CORE_Health Info Exchange_[VT]	Event Notification System: PatientPing. Shared Care Plans and Universal Transfer Protocol – Research: im21; Stone Environmental	Georgia Maheras; Sarah Kinsler; and Larry Sandage	SIM-funded staff: Georgia Maheras; Erin Flynn; Susan Aranoff; Gabe Epstein; Sarah Kinsler Key personnel: Larry Sandage; Joelle Judge
General Health Data – Data Inventory	**General Health Data – Health Data Inventory:** Conduct data inventory.	Achieved: Data inventory launched in December 2014 following contract execution. *Reporting:* Monthly status report.	**General Health Data – Health Data Inventory:** Complete data inventory: 1. Draft analysis of health care data sources that support payment and delivery system reforms by 4/15/15. 2. Final data inventory due by 10/31/15.	Achieved: 1. Achieved: Draft analysis of data sources completed in Spring 2015. 2. Achieved: Data inventory data collection and final report with recommendations completed in December 2015. *Reporting:* Monthly status reports. *Contractors:* Stone Environmental	N/A	N/A	N/A	N/A	CORE_Health Info Exchange_[VT]	Data Inventory: Stone Environmental.	Sarah Kinsler	SIM-funded staff: Sarah Kinsler. Key personnel: Larry Sandage.

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	Performance Period 1 Milestone	**Current Status and Reporting**	**Performance Period 1 Carryover Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 2 Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 3 Milestone[20]**	**Current Status, Reporting, and Contractors**				
General Health Data – HIE Planning	**General Health Data – HIE Planning:** Provide input to update of state HIT Plan.	Achieved: Project staff and stakeholders have provided ongoing input into Vermont HIT Plan update since 2014. *Reporting:* Monthly status report.	N/A	N/A	**General Health Data – HIE Planning:** 1. VHCIP will provide comment into the HIT Strategic Plan at least 4 times in 2015. 2. HDI Work Group will identify connectivity targets for 2016-2019 by 6/30/16.	1. Achieved: VHCIP has provided ongoing input into HIT Strategic Plan in 2015. 2. In progress: This work is occurring throughout January-June 2016. *Reporting:* Monthly status reports. *Contractors:* Stone Environmental.	**General Health Data – HIE Planning:** Finalize connectivity targets for 2016-2019 by 12/31/16. Incorporate targets into Sustainability Plan by 6/30/17.	Achieved. Connectivity targets for 2016-2019 by approved by Core Team in December 2016; this work stream is included in the SIM Sustainability Plan. *Reporting:* Monthly status reports. *Contractors:* Stone Environmental.	CORE_Health Info Exchange_[VT]	Support HIE Planning: Stone Environmental.	Larry Sandage	Key personnel: Larry Sandage
General Health Data – Expert Support	N/A	N/A	N/A	N/A	**General Health Data – Expert Support:** Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.	Ongoing: Vermont is deploying IT-specific support for health data initiatives as necessary and appropriate. *Reporting:* Monthly status reports. *Contractors:* Stone Environmental; H.I.S. Professionals.	**General Health Data – Expert Support:** Procure appropriate IT-specific support to further health data initiatives – depending on the design of projects described above, enterprise architects, business analysts, and others will be hired to support appropriate investments.	Achieved. IT-specific supports procured as needed to further health data initiatives throughout PP3. *Reporting:* Monthly status reports. *Contractors:* Stone Environmental; H.I.S. Professionals.	CORE_Health Info Exchange_[VT]	Research and Analyses: Stone Environmental. Project Management and Subject Matter Expertise: H.I.S. Professionals.	TBD	Key personnel: TBD; Larry Sandage
	VHCURES: 1. Update rule to include VHC information (Fall 2013). 2. Incorporate Medicare data (Fall 2013). 3. Improve data quality procedures (Fall 2014). 4. Improve data access to support analysis (Fall 2014).	1. Not met: SOV is not using these data in VHCURES due to data limitations. This was previously conveyed to CMMI. 2. Achieved. 3. Achieved. 4. Achieved. *Reporting:* 2014 Annual Report and Milestones Met/Not Met response to CMMI in May 2015.	N/A	N/A	N/A	N/A	N/A	N/A	CORE_Health Info Exchange_[VT]	N/A	N/A	N/A
	Medicaid Data: A combined advanced planning document for the funding to support the TMSIS is completed and submitted to CMS in July 2013.	Achieved. *Reporting:* 2014 Annual Report and Milestones Met/Not Met response to CMMI in May 2015.	N/A	N/A	N/A	N/A	N/A	N/A	CORE_Health Info Exchange_[VT]	N/A	N/A	N/A
Focus Area: Evaluation												
Self-Evaluation Plan and Execution	**Self-Evaluation Plan and Execution:** 1. Procure contractor: Hire through GMCB in Sept 2013. 2. Evaluation (external): • Number of meetings held with Quality and	1. Achieved: Initial self-evaluation contract (Impaq) executed in September 2014. 2. Achieved: Regular meetings with QPM Work Group and other stakeholders; self-	**Self-Evaluation Plan and Execution:** 1. Design Self-Evaluation Plan for submission to CMMI by 6/30/15. a. Elicit stakeholder feedback prior to submission.	1. Achieved: Draft self-evaluation plan submitted to CMMI in June 2015, incorporating stakeholder feedback. 2. In progress: Plan resubmitted to CMMI on November 11, 2015.	**Self-Evaluation Plan and Execution:** 1. Procure new self-evaluation contractor by 2/28/16 to execute contractor-led self-evaluation plan activities.[22]	1. In progress: RFP released in November 2015; contract is submitted to CMMI and awaiting approval. 2. Ongoing: Self-evaluation plan execution is ongoing	**Self-Evaluation Plan and Execution:** Execute Self-Evaluation Plan for 2016 and 2017 according to timeline for Year 3 activities.	Achieved: Self-Evaluation Plan for 2016 and 2017 completed according to timeline for Year 3 activities through June 2017.	All metrics	1. Development of Self-Evaluation Plan: Impaq International. 2. Implementation of Self-Evaluation Plan (Monitoring and Evaluation): The	Annie Paumgarten; Kate O'Neill	SIM-funded staff: Annie Paumgarten; Kate O'Neill Key personnel: Susan Barrett

[22] Vermont requested modification to this milestone by email, dated 11/23/15.

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	Performance Period 1 Milestone	**Current Status and Reporting**	**Performance Period 1 Carryover Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 2 Milestone**	**Current Status, Reporting, and Contractors**	**Performance Period 3 Milestone[20]**	**Current Status, Reporting, and Contractors**				
	Performance Measurement Work Group on evaluation (goal = 2). • Evaluation plan developed. • Baseline data identified.	evaluation plan submitted as draft to CMMI in June 2015. *Reporting:* Monthly status reports (contractor weekly reports).	2. Once approved by CMMI, engage in Performance Period 1 Carryover activities as identified in the plan.	*Reporting:* Monthly status reports (contractor weekly reports). *Contractors:* Impaq International.	2. Continue to execute self-evaluation plan using staff and contractor resources.[23] 3. Streamline reporting around other evaluation activities within 30 days of CMMI approval of self-evaluation plan.	using staff and contractor resources. 3. In progress: This is delayed pending final approval of self-evaluation plan. *Reporting:* Monthly status reports. *Contractors:* Burns and Associates; Impaq International; Onpoint; The Lewin Group; Truven.		*Reporting:* Monthly status reports. *Contractors:* Burns and Associates; John Snow Inc.; Onpoint; The Lewin Group; Truven.		Lewin Group; Burns and Associates. 3. Implementation of Self-Evaluation Plan (Provider Surveys and Analyses): JSI.		
Surveys	N/A	N/A	**Surveys:** Conduct annual patient experience survey (Performance Period 1 surveys only): 1. Surveys are completed by 6/30/15 for reporting as part of the first performance period for the Medicaid and commercial Shared Savings Programs.	Achieved: Surveys fielded. *Reporting:* Monthly status reports. *Contractors:* Datastat.	**Surveys:** Conduct annual patient experience survey and other surveys as identified in payment model development: Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings programs – phase 1 to determine impact of Performance Period 2 activities by 6/30/16.	In progress: Surveys distributed. Collection of data and reports are not yet complete. They will be complete by 6/30/16. *Reporting:* Monthly status reports (contractor reports). *Contractors:* Datastat.	**Surveys:** Conduct annual patient experience survey and other surveys as identified in payment model development: Field patient experience surveys to Vermonters participating in the PCMH and Shared Savings Programs by 6/30/17.	Achieved: Vermont's patient experience contractor (DataStat) fielded the Year 3 patient experience survey from July 2016 to June 2017. *Reporting:* Monthly status reports (contractor reports). *Contractors:* Datastat.	CAHPS Clinical & Group Surveys_Commercial CAHPS Clinical & Group Surveys_Medicaid CAHPS Clinical & Group Surveys_Medicare CORE_HCAHPS Patient Rating_[VT]	1. Field Patient Experience Survey: Datastat. 2. Develop Survey Report: Datastat.	Pat Jones; Jenney Samuelson	SIM-funded staff: Annie Paumgarten; Kate O'Neill Key personnel: Pat Jones, Jenney Samuelson
Monitoring and Evaluation Activities Within Payment Programs	N/A	N/A	**Monitoring and Evaluation Activities Within Payment Programs:** Conduct analyses as required by payers related to specific payment models. • Number of meetings held with Quality and Performance Measurement Work Group on evaluation (goal = 2 by 6/30/15). • Payer-specific evaluation plan developed for Medicaid Shared Savings Program as part of State Plan Amendment approval. • Baseline data identified for monitoring and evaluation of Medicaid and commercial Shared Savings Programs by 6/30/15.	Achieved: QPM Work Group met monthly prior to consolidation with Payment Model Design and Implementation Work Group in October 2015; payer-specific evaluation plan included in approved SPA; baseline data identified for monitoring and evaluation of SSPs and included in initial analyses. *Reporting:* Monthly status reports. *Contractors:* Burns and Associates; Bailit Health Purchasing; The Lewin Group.	**Monitoring and Evaluation Activities Within Payment Programs:** 1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications: biannual reporting to providers. 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications: monthly, quarterly reports depending on type.	Monitoring plans are complete; monitoring activities are ongoing: 1. Ongoing: Non-SIM funded analyses of PCMH program are conducted twice annually. 2. Ongoing: Monthly and quarterly SSP reports are ongoing. *Reporting:* Monthly status reports (embedded in SSP reports). *Contractors:* Burns and Associates; The Lewin Group.	**Monitoring and Evaluation Activities Within Payment Programs:** 1. Conduct analyses of the PCMH program (non-SIM funded) according to program specifications (bi-annual reporting to providers). 2. Conduct analyses of the commercial and Medicaid Shared Savings Programs according to program specifications (monthly, quarterly reports depending on report type). 3. TBD: APM, Medicaid VBP – Mental Health and Substance Use.	1. Achieved: PCMH program (non-SIM funded) analyses completed according to program specifications (bi-annual reporting to providers). 2. Achieved: Final analysis of Year 2 of the Commercial and Medicaid Shared Savings Programs were provided during Performance Period 3. Final Analysis for Year 3 of the Medicaid and commercial Shared Savings Programs was completed in Q3 2017. *Reporting:* Monthly status reports (embedded in SSP reports).	CORE_BMI_[VT]_Commercial CORE_BMI_[VT]_Medicaid CORE_BMI_[VT]_Medicare CORE_Diabetes Care_[VT]_Commercial CORE_Diabetes Care_[VT]_Medicaid CORE_Diabetes Care_[VT]_Medicare CORE_ED Visits_[VT]_Commercial CORE_ED Visits_[VT]_Medicaid CORE_Readmissions_[VT]_Commercial CORE_Readmissions_[VT]_Medicaid CORE_Readmissions_[VT]_Medicare CORE_Tobacco Screening and Cessation_[VT]_Commercial CORE_Tobacco Screening and Cessation_[VT]_Medicaid CORE_Tobacco Screening and Cessation_[VT]_Medicare CAHPS Clinical & Group Surveys_Commercial CAHPS Clinical & Group Surveys_Medicaid CAHPS Clinical & Group Surveys_Medicare	Financial and Quality Analysis for New Programs: The Lewin Group (SSP); Burns and Associates (Medicaid).	Pat Jones – GMCB; Erin Flynn – DVHA	SIM-funded staff: Amy Coonradt; James Westrich; Brian Borowski; Carole Magoffin Key personnel: Pat Jones

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

	Performance Period 1 (PP1)[19]	Performance Period 1 (PP1)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 2 (PP2)	Performance Period 2 (PP2)	Performance Period 3 (PP3)	Performance Period 3 (PP3)	Metrics	Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
	Performance Period 1 Milestone	Current Status and Reporting	Performance Period 1 Carryover Milestone	Current Status, Reporting, and Contractors	Performance Period 2 Milestone	Current Status, Reporting, and Contractors	Performance Period 3 Milestone[20]	Current Status, Reporting, and Contractors				
								Contractors: Burns and Associates; The Lewin Group.				
Focus Area: Program Management and Reporting												
Project Management and Reporting – Project Organization	**Project Management and Reporting – Project Organization:** 1. Procure contractor: Contract for interagency coordination. 2. Hire contractor: Contract for staff training and development. 3. Develop curriculum: Training and development curriculum developed. 4. Develop interagency and inter-project communication plan: Interagency and inter-project communications plan developed. 5. Implement plan: Results of survey of project participants re: communications.	1. Achieved: Contractor procured. 2. Achieved: Contractor hired. 3. Achieved: Training and development curriculum developed. 4. Achieved. Plan developed. 5. Achieved: Survey deployed; results compiled. *Reporting:* Monthly status reports, monthly staff meetings, monthly Core Team meetings.	**Project Management and Reporting – Project Organization:** 1. Ensure project is organized by procuring sufficient staff and contractor resources on an ongoing basis. 2. Continue interagency coordination across the departments and agencies involved in VHCIP activities. 3. Continue staff training and development- assess quarterly. 4. Continue to deploy training and development curriculum- assess curriculum quarterly. 5. Implement communications plan by 12/31/15.	1. Achieved: Staff and contractor resources procured as needed on an ongoing basis. 2. Ongoing: Interagency coordination is ongoing. 3. Ongoing: Staff training and development activity is ongoing through 12/31/15. 4. Ongoing: Staff training and development activity is ongoing through 12/31/15. 5. In progress: Communications plan developed and will be implemented by 12/31/15. *Reporting:* Monthly status reports, monthly staff meetings, monthly Core Team meetings. *Contractors:* The Coaching Center; PDI Creative; University of Massachusetts; Arrowhead Health Analytics; University of Vermont.	**Project Management and Reporting – Project Organization:** Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2. Monthly staff meetings, co-chair meetings, and Core Team meetings with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Submit quarterly reports to CMMI and the Vermont Legislature.	1. Ongoing: Project Management contract scope of work and tasks performed on time. 2. Achieved: Meetings held, reporting presented and discussed. 3. Achieved: Reports submitted. *Reporting:* Monthly report to Core Team. *Contractors:* University of Massachusetts.	**Project Management and Reporting – Project Organization:** Ensure project is organized through the following mechanisms: 1. Project Management contract scope of work and tasks performed on-time. 2. Monthly staff meetings, co-chair meetings, and Core Team meetings with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Submit quarterly reports to CMMI and the Vermont Legislature. 4. Population Health Plan finalized by 6/30/17. 5. Sustainability Plan finalized by 6/30/17.	1. Achieved: Project Management contract scope of work and tasks performed on-time. 2. Achieved: Staff meetings, co-chair meetings, and Core Team meetings convened approximately bi-monthly with reporting on budget, milestones, and policy decisions presented and discussed at each meeting. 3. Achieved: Quarterly reports to CMMI and the Vermont Legislature on time each quarter. 4. Achieved: Population Health Plan submitted on 6/30/17. 5. Achieved: Sustainability Plan submitted on 6/30/17. *Reporting:* Monthly report to Core Team. *Contractors:* University of Massachusetts.	All metrics	Project Management: University of Massachusetts.	Georgia Maheras	SIM-funded staff: Georgia Maheras; Christine Geiler; Sarah Kinsler; Luann Poirier
Project Management and Reporting – Communication and Outreach	**Project Management and Reporting – Communication and Outreach:** Stakeholder engagement: Work groups and more broadly.	Achieved: Robust public and private stakeholder engagement in project activities and decision-making through project work groups, sub-groups, project-specific steering committees, bid review teams, key informant interviews, and more. *Reporting:* Monthly status reports, monthly staff meetings, monthly Core Team meetings.	**Project Management and Reporting – Communication and Outreach:** 1. Engage stakeholders in project focus areas through work groups, Steering Committee, Core Team, Symposia, and other convenings. 2. Target convening 10 Core Team; 5 Steering Committee, and 10 Work Group meetings during this period. 3. Stakeholder engagement plan developed and implemented – revised plan due 8/31/15.	1. Achieved: Robust public and private stakeholder engagement in project focus areas through work groups, Steering Committee, Core Team, Symposia, and other convenings. 2. Achieved. 3. Achieved. *Reporting:* Monthly status reports, monthly staff meetings, monthly Core Team meetings. *Contractors:* PDI Creative; University of Massachusetts.	**Project Management and Reporting – Communication and Outreach:** Engage stakeholders in project focus areas by: 1. Convening 5 Core Team, 5 Steering Committee, and 10 work group public meetings by 6/30/16. 2. Distributing all-participant emails at least once a month. 3. Updating website at least once a week.	1. Achieved: Meetings held in 2015. Additional meetings needed in the NCE period. 2. Achieved: All-participant emails distributed as needed, at least monthly. Additional communications needed in the NCE period. 3. Achieved: Website updated continually, at least weekly. Additional updates needed in the NCE period. *Reporting:* Monthly report to Core Team; quarterly report to CMMI.	**Project Management and Reporting – Communication and Outreach:** Engage stakeholders in project focus areas by: 1. Convening 10 Core Team meetings between 7/1/16 and 6/30/17. 2. Convening 5 Steering Committee public meetings and 20 work group public meetings between 7/1/16 and 12/31/16. 3. Distributing all-participant emails at least once a month through 12/31/16. 4. Update website at least once a week	1. Partially achieved: 9 Core Team meetings convened during PP3. 2. Partially achieved: 3 Steering Committee meetings convened and 24 work group meetings convened during PP3. 3. Achieved: All-participant emails distributed once per month through 12/31/16, and on an ad hoc basis in 2017. 4. Achieved: Website updated at least once a week through 12/31/16, and monthly through 6/30/17.	All metrics	Project Management: University of Massachusetts. Outreach and Engagement: PDI Creative.	Christine Geiler; Luann Poirier	SIM-funded staff: Christine Geiler;Luann Poirier; Julie Corwin; Sarah Kinsler

	Performance Period 1 (PP1)[19]	Performance Period 1 (PP1)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 1 Carryover (PP1 Carryover)	Performance Period 2 (PP2)	Performance Period 2 (PP2)	Performance Period 3 (PP3)	Performance Period 3 (PP3)	Metrics	Contractor Role	Lead Staff	SIM-Funded Staff and Key Personnel
	Performance Period 1 Milestone	Current Status and Reporting	Performance Period 1 Carryover Milestone	Current Status, Reporting, and Contractors	Performance Period 2 Milestone	Current Status, Reporting, and Contractors	Performance Period 3 Milestone[20]	Current Status, Reporting, and Contractors				
						Contractors: University of Massachusetts; PDI Creative.	through 12/31/16, and monthly through 6/30/17.					
	Implement "How's Your Health" Tool by June 2014.	Achieved: Implemented through sub-grant to White River Family Practice Sub-Grant.	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A

Appendix B: Evaluation Findings

During PP3, the State-led evaluation contractor conducted site visits of a diverse scope of stakeholders that considered geographic location, scope of project, and partnerships. The contractor conducted site visits and key informant interviews with community groups, provider organizations, state and local health care leaders, and other stakeholders throughout the state. Five focus groups were conducted to learn perspectives from persons with disabilities, families receiving services through Vermont's Integrated Family Services, individuals participating in Support and Services at Home (SASH), as well as older Vermonters, and the general care coordination population. In addition, care integration and primary care provider surveys were fielded to more than 500 care coordinators and 1000 advanced practice professionals. The contractor aggregated and assessed multiple secondary data sources, and submitted a comprehensive final evaluation report.

General Evaluation Findings

Health Reform/SIM Generally

The goals of VHCIP were to achieve better care, better health, and lower health care costs. Within the three areas that were evaluated, significant strides were made that ultimately contribute to those goals. VHCIP continued Vermont's rich history of health care innovation and built upon successful strategies and structures. VHCIP built upon previous health reform successes and learnings and provides further successes and learnings that will inform Vermont's continued efforts toward better care, better health, and lower health care costs. An examination of the implementation successes and challenges revealed cross-cutting VHCIP strategies common to all and worth replicating in future undertakings, including the following:

- Emphasizing stakeholder engagement at all levels and in all VHCIP efforts and supporting transparency;
- Building on previous efforts and previous established infrastructure;
- Establishing vision at state level but enabling/encouraging local adaptation and implementation;
- Emphasizing relationships, including between VHCIP leadership and stakeholders and across stakeholders; and
- Building understanding that health reform is complex, takes time, and is an iterative process.

Payment Reform

ACOs were strong partners to VHCIP leadership in the development and roll-out of payment initiatives, in part due to VHCIP investments in ACO capacity building and infrastructure development. The three ACOs served as the mechanism through which providers became aware of and participated in VHCIP payment reform activities. Substantial work was conducted

by stakeholders through VHCIP to better align quality measures across payers to facilitate collection and reporting. The quality measures used in VHCIP informed the list of quality measures agreed upon for the All Payer ACO Model. All three ACOs participated in the SSPs, and two of the three were eligible for distribution of savings (based on cost savings and sufficient quality scores), although not from all payers. Beyond the success in implementing SSPs, the greater value was to enhance system and providers' capacities to engage with alternative payment models. Through participation in SSPs, providers developed a better understanding of financial risk and costs of care, what it takes to shift organizational culture toward value-based payments from volume-based payments, how to track and use quality metrics, and best practices to optimize quality. VHCIP served as a foundation for developing and moving to agreement on the All-Payer ACO Model (APM) designed to encourage delivery of well-coordinated, high quality person-level care within a defined all-inclusive population-based payment. Additional work is still needed, however, to engage providers in connecting payment reform to practice operations to achieve desired reductions in costs of care and quality improvement. Standard quality measures, better tools for monitoring and tracking, and better cost analytics for performance monitoring would help providers feel better prepared. Engaging community-based providers was challenging for many reasons, including sharing patient data, lack of existing contracts with insurers, and variation in benefits across payers.

Care Coordination

Regional Community Collaboratives (RCCs) in each HSA had a history of inter-organizational collaboration, particularly around care coordination. Membership in the RCCs continued to expand under VHCIP, with more community-based providers joining in. Continued support for the RCCs through VHCIP enhanced their status as important convening structures within the HSAs, especially with regard to their care coordination role. VHCIP instituted the successful strategy of using the ICCMLC and Core Competency Trainings to develop care coordination capacity. The ICCMLC promoted a shared language around care coordination and shared best practices, such as identifying a "lead care coordinator" and other strategies for cross-agency collaboration. The RCCs are becoming increasingly sophisticated in the use of data to identify high need and high-risk patients in need of services and to monitor these patients over time. Capacity building with regard to data use for decision making was part of the ICCMLC capacity development. Vermont's State-led efforts at health reform have historically emphasized local buy-in and transparency, and these core implementation strategies carried over to VHCIP, especially with regard to care integration. Another way buy-in and transparency occurred through VHCIP was through supporting the infrastructure development of the three Accountable Care Organizations (ACOs), which enabled them to engage their member organizations in meaningful ways. The sub-grants that focused on care coordination created or expanded innovative approaches to care integration. Some to all of the care management activities and structures (training, RCCs) may be picked up by other entities or supported at some level through the state, given how critical they are to providing high-quality services and serving patients. However, coordination still primarily occurs by fax and phone rather than electronically, which created barriers to data sharing. While some systems, such as Patient Ping,

were being used by some, IT generally was not seen as facilitating care integration work. Alternative payment models will facilitate financial support of care management, but there is still substantial work to do before such models are fully implemented. There is also uncertainty in the shorter term about how these services and structures will be supported. While the RCCs have had good success in engaging multi-disciplinary and cross-agency groups, PCPs tend to be less involved. PCPs have a powerful voice and can be strong advocates for care management with higher engagement leading to stronger advocacy. While financial incentives exist to provide care coordination, incentives that enhance cooperation have not been leveraged in significant ways. The Medicaid Pathway discussions as well as the Accountable Communities for Health Peer Learning Lab have been important forums to explore better financial alignment.

Data and Data Infrastructure

VHCIP has created a data and data infrastructure environment which enables low capacity practices to more effectively participate in health care reform. It has also fostered an environment of innovation among higher capacity practices which has resulted in the creation of data and data infrastructure demand to continue to raise the bar on practice effectiveness in the use of data. While health care organization and workforce proficiency in, and perceived value of, these resources was lower than desired, they were central to building capacity to perform in a shared risk and value-based health care environment. Continuing efforts to engage stakeholders regarding data and data infrastructure initiatives is necessary. This includes continued engagement of organizations traditionally involved such as VITL and Blueprint, as well as organizations with emerging roles such as ACOs. Developing strategies that improve data systems and data use at the health care organization level, HSA level, and state level that increase the capacity of health care organizations, and are tailored to local and regional needs should be considered. Health care organizations were hesitant to build or maintain capacity without a clear understanding of how it will be sustained. This is specifically true for organizations participating in SSPs where organizations consider investing resources for data infrastructure and data support up front without guarantee of obtaining shared savings.

Patient Experience Surveys Implemented in Performance Period 3

CAHPS Patient-Centered Medical Home Annual Adult Survey

As noted in the Practice Transformation Milestones section of the PP3 Annual Report, Vermont's contractor, DataStat, fielded patient experience surveys to evaluate the experiences of Vermonters who are patients of practices participating in the PCMH and/or ACO Shared Savings Programs. The survey instrument is the PCMH version of the CG-CAHPS survey, with the addition of eight custom questions related to care from specialists, long-term services and supports, and chronic illness. Datastat provided practice-level results to participating practices after each round of surveys. Datastat also provided results to the State and contractors after each round to support aggregation of results for ACOs, HSAs, and the State as a whole. Results

from patient experience surveys fielded during Performance Periods 2 and 3 are presented below. Performance Period 2 results became available in October 2016, following the submission of Vermont's Performance Period 2 Annual Report.

2015 Combined Commercial/Medicaid Patient Experience Results

Adult Patient Exp. Composite	CHAC Rate/ Percentile (Commercial + Medicaid)	OneCare Rate/Percentile* (Commercial + Medicaid)
Access to Care	50%/Below 25th	59%/Above 25th
Communication	83%/Above 25th	80%/Below 25th
Shared Decision-Making	65%/At 50th	64%/Above 25th
Self-Management Support	53%/Above 50th	44%/Above 25th
Comprehensiveness	56%/Above 50th	53%/Above 50th
Office Staff	76%/At 25th	73%/Below 25th
Information	65%/No Benchmark	66%/No Benchmark
Coordination of Care	76%/No Benchmark	69%/No Benchmark
Specialist Care	49%/No Benchmark	48%/No Benchmark
LTSS Care Coordination	53%/No Benchmark	55%/No Benchmark

2016 Combined Commercial/Medicaid Patient Experience Results

Adult Patient Exp. Composite	CHAC Rate/Percentile (Commercial + Medicaid)	OneCare Rate/Percentile* (Commercial + Medicaid)
Access to Care	58%/Above 25th	51%/Below 25th
Communication	79%/Below 25th	83%/Above 25th
Shared Decision-Making	65%/At 50th	62%/Above 25th
Self-Management Support	55%/At 75th	48%/Above 25th
Comprehensiveness	62%/Above 75th	59%/Above 75th
Office Staff	75%/Below 75th	72%/Below 75th
Information	69%/No Benchmark	68%/No Benchmark
Coordination of Care	73%/No Benchmark	72%/No Benchmark
Specialist Care	49%/No Benchmark	47%/No Benchmark
LTSS Care Coordination	54%/No Benchmark	51%/No Benchmark

ACO Shared Savings Program (SSP) Results

Results from Years 2 (CY 2015) and 3 (CY 2016) of the ACO Shared Savings Programs are presented below. Results from Year 2 of the Shared Savings Programs became available in October 2016, following the submission of Vermont's Performance Period 2 Annual Report.

Year 2 Shared Savings Program Results

Financial Results. Although there were no savings in commercial and Medicare SSPs, two ACOs (CHAC and OneCare) showed movement toward commercial targets. For the CHAC ACO, financial results were positive in the Medicaid SSP. Two ACOs (CHAC and OneCare) showed improvements in overall quality scores one ACO (VCP) had continued high performance in quality scores overall. All ACOs are working to develop data collection, analytic capacity, care management strategies, and population health approaches. Detailed ACO Shared Savings Program reports can be found here.

Summary of 2015 Financial PMPM Results for the Medicaid SSP

	Medicaid		
	CHAC	**OneCare**	**VCP**
Actual Member Months	342,772	599,256	N/A
Expected PMPM	$189.09	$169.37	N/A
Target PMPM	N/A	N/A	N/A
Actual PMPM	$182.06	$171.55	N/A
Shared Savings PMPM	$7.03	$(2.18)	N/A
Total Savings Earned	$2,409,687.72	$ -	N/A
Potential ACO Share of Earned Savings	$603,278.72	$ -	N/A
Quality Score	57%	73%	N/A
% of Savings Earned	75%	95%	N/A
Achieved Savings	**$452,459.00**	**$ -**	**N/A**

2015 Medicaid Payment Measures

Payment Measure	CHAC Rate/Percentile/Points*	OCV Rate/Percentile/Points*
All-Cause Readmission* **	18.31/**/2 Points	18.21/**/2 Points
Adolescent Well-Care Visits	40.16/Below 25th/0 Points	48.09/Above 50th/2 Points
Mental Illness, Follow-Up After Hospitalization	50.26/Above 50th/2 Points	57.91/Above 75th/3 Points
Alcohol and Other Drug Dependence Treatment	28.82/Above 50th/2 Points	26.86/Above 50th/2 Points
Avoidance of Antibiotics in Adults with Acute Bronchitis	20.28/Above 25th/1 Point	30.50/Above 75th/3 Points
Chlamydia Screening	48.03/Below 25th/0 Points	50.09/Below 25th/0 Points
Developmental Screening	12.51/**/2 Points	44.80/**/2 Points
Rate of Hospitalization for People with Chronic Conditions (per 100,000)	424.52/**/2 Points	624.84/**/2 Points
Blood Pressure in Control	67.64/Above 75th/3 Points	67.92/Above 75th/3 Points
Diabetes Hemoglobin A1c Poor Control* **	22.77/Above 90th/3 Points	21.83/Above 90th/3 Points

*Maximum points/measure = 3. **No national benchmark; awarded points based on change over time. ***Lower rate is better.

2015 Medicaid Reporting Measures

Reporting Measures	CHAC Rate/ Percentile	OCV Rate/Percentile
COPD or Asthma in Older Adults	347.70/No Benchmark	412.57/No Benchmark
Cervical Cancer Screening	57.67/No Benchmark	62.35/No Benchmark
Tobacco Use Assessment & Cessation	86.74/ No Benchmark	95.65/No Benchmark
Pharyngitis, Appropriate Testing for Children	76.23/Above 50th	80.91/Above 75th
Childhood Immunization	26.91/Above 25th	56.49/Above 90th
Weight Assessment and Counseling for Children/Adolescents	49.85/Above 25th	57.50/Above 50th
Optimal Diabetes Care Composite	36.31/No Benchmark	41.00/No Benchmark
Colorectal Cancer Screening	59.77/No Benchmark	66.39/No Benchmark
Screening for Clinical Depression & Follow-Up Plan	29.68/No Benchmark	36.94/No Benchmark
Body Mass Index Screening & Follow-Up	78.65/No Benchmark	71.39/No Benchmark

Summary of 2015 Financial PMPM Results for the Commercial SSP

	Commercial		
	CHAC	OneCare	VCP
Actual Member Months	103,836	278,863	104,570
Expected PMPM	$355.66	$335.24	$269.33
Target PMPM	$345.03	$327.09	$261.25
Actual PMPM	$369.68	$348.81	$303.95
Shared Savings PMPM	$(14.02)	$(13.57)	$(34.62)
Total Savings Earned	$ -	$ -	$ -
Potential ACO Share of Earned Savings	$ -	$ -	$ -
Quality Score	61%	69%	87%
% of Savings Earned	80%*	85%*	100%*
Achieved Savings	**$ -**	**$ -**	**$ -**

*If shared savings had been earned.

2015 Commercial Payment Measures

Payment Measure	CHAC Rate/Percentile/ Points*	OCV Rate/Percentile/ Points*	VCP Rate/Percentile/ Points*
ACO All-Cause Readmission***	0.83/Below 25th/ 0 Points	1.05/Below 25th/ 0 Points	0.58/Above 90th/ 3 Points
Adolescent Well-Care Visits	47.89/Above 75th/ 3 points	57.23/Above 75th/ 3 Points	54.81/Above 75th/ 3 Points
Mental Illness, Follow-Up After Hospitalization	N/A (denominator too small)	62.75/Above 75th/ 3 Points	N/A (denominator too small)
Alcohol and Other Drug Dependence Treatment	21.48/Below 25th/ 0 Points	19.55/Below 25th/ 0 Points	22.17/Above 25th/ 1 Point

Payment Measure	CHAC Rate/Percentile/ Points*	OCV Rate/Percentile/ Points*	VCP Rate/Percentile/ Points*
Avoidance of Antibiotics in Adults with Acute Bronchitis	15.18/Below 25th/ 0 Points	31.60/Above 75th/ 3 Points	46.27/Above 90th/ 3 Points
Chlamydia Screening	48.96/Above 75th/ 3 Points	50.49/Above 75th/ 3 Points	52.22/Above 75th/ 3 Points
Rate of Hospitalization for People with Chronic Conditions (per 100,000)	197.11/**/ 2 Points	99.23/**/ 0 Points	12.76/**/ 2 Points
Blood Pressure in Control	65.81/Above 75th/ 3 Points	70.70/Above 90th/ 3 Points	61.29/Above 50th/ 2 Points
Diabetes Hemoglobin A1c Poor Control***	20.57/Above 90th/ 3 Points	15.13/Above 90th/ 3 Points	12.50/Above 90th/ 3 Points

*Maximum points/measure=3, except as noted below.
** No national benchmark; awarded maximum of 2 points based on change over time. ***Lower rate is better.

2015 Commercial Reporting Measures

Reporting Measure	CHAC Rate/Percentile	OCV Rate/Percentile	VCP Rate/Percentile
Developmental Screening	12.73/No Benchmark	56.25/No Benchmark	70.66/No Benchmark
Hospitalizations for COPD or Asthma in Older Adults***	75.53/No Benchmark	83.01/No Benchmark	19.78/No Benchmark
Pharyngitis, Appropriate Testing for Children	N/A (denominator too small)	88.75/Above 75th	90.70/Above 90th
Immunizations for 2-year-olds	N/A (denominator too small)	74.24/Above 90th	56.92/Above 75th
Weight Assessment and Counseling for Children/Adolescents	57.28/Above 50th	67.97/Above 75th	70.16/Above 90th
Colorectal Cancer Screening	70.25/Above 90th	70.92/Above 90th	77.42/Above 90th
Depression Screening and Follow-Up	42.25/No Benchmark	41.38/No Benchmark	34.27/No Benchmark
Adult BMI Screening and Follow-up	77.27/No Benchmark	74.24/No Benchmark	68.95/No Benchmark
Cervical Cancer Screening	52.92/Below 25th	71.78/Above 25th	76.61/Above 50th
Tobacco Use Assessment and Cessation	92.68/No Benchmark	96.77/No Benchmark	72.18/No Benchmark
Diabetes Composite	40.82/No Benchmark	47.48/No Benchmark	42.34/No Benchmark

***Lower rate is better.

Year 3 Shared Savings Program Results

Summary of 2016 Financial PMPM Results for the Medicaid SSP

	Medicaid		
	CHAC	**OneCare**	**VCP**
Actual Member Months	329,661	443,894	N/A
Expected PMPM	$181.28	$165.47	N/A
Target PMPM	N/A	N/A	N/A
Actual PMPM	$180.53	$168.88	N/A
Shared Savings PMPM	$0.75*	$(3.41)	N/A
Total Savings Earned	$ -	$ -	N/A
Potential ACO Share of Earned Savings	329,661	443,894	N/A
Quality Score	70%	77%	N/A
% of Savings Earned	90%**	95%**	N/A
Achieved Savings	**$ -**	**$ -**	**N/A**

*ACOs in the Medicaid SSP must meet a 2% Minimum Savings Rate (MSR) in order to qualify for savings. The ACO is not eligible for payout if savings does not meet the 2% MSR.
** If shared savings had been earned.

2016 Medicaid Payment Measures

Payment Measure	CHAC Rate/Percentile/Points*	OCV Rate/Percentile/Points*
All-Cause Readmission* **		
Adolescent Well-Care Visits	48.82/Above 50th/3 Points	51.27/Above 50th/3 Points
Mental Illness, Follow-Up After Hospitalization	39.69/Above 25th/1 Point	52.30/Above 50th/2 Points
Alcohol and Other Drug Dependence Treatment	29.51/Above 50th/2 Points	27.56/Above 50th/2 Points
Avoidance of Antibiotics in Adults with Acute Bronchitis	24.63/Above 50th/2 Points	32.46/Above 75th/3 Points
Chlamydia Screening	44.47/Below 25th/0 Points	50.51/Below 25th/0 Points
Developmental Screening	30.13/**/3 Points	57.15/**/3 Points
Rate of Hospitalization for People with Chronic Conditions (per 100,000)	449.87/**/2 Points	504.12/**/2 Points
Blood Pressure in Control	64.74/Above 75th/3 Points	68.42/Above 75th/3 Points
Diabetes Hemoglobin A1c Poor Control* **	21.52/Above 90th/3 Points	18.77/Above 90th/3 Points

*Maximum points/measure = 3. **No national benchmark; awarded points based on change over time. ***Lower rates are better.

2016 Medicaid Reporting Measures

Reporting Measures	CHAC Rate/Percentile	OCV Rate/Percentile
COPD or Asthma in Older Adults	340.87/No Benchmark	459.70/No Benchmark

Reporting Measures	CHAC Rate/Percentile	OCV Rate/Percentile
Cervical Cancer Screening	57.10/Above 50th	64.74/Above 75th
Tobacco Use Assessment & Cessation	89.08/ No Benchmark	97.82/No Benchmark
Pharyngitis, Appropriate Testing for Children	83.89/Above 75th	84.35/Above 75th
Childhood Immunization	38.11/Above 50th	50.27/Above 90th
Weight Assessment and Counseling for Children/Adolescents	61.52/Above 25th	69.46/Above 50th
Optimal Diabetes Care Composite	39.39/No Benchmark	43.47/No Benchmark
Colorectal Cancer Screening	56.81/No Benchmark	63.04/No Benchmark
Screening for Clinical Depression & Follow-Up Plan	47.20/No Benchmark	46.60/No Benchmark
Body Mass Index Screening & Follow-Up	70.61/No Benchmark	71.74/No Benchmark

Summary of 2016 Financial PMPM Results for the Commercial SSP

	Commercial		
	CHAC	**OneCare**	**VCP**
Actual Member Months	132,175	304,495	104,340
Expected PMPM	$498.39	$490.24	$412.10
Target PMPM	$483.74	$478.24	$399.20
Actual PMPM	$496.01	$496.74	$430.01
Shared Savings PMPM	$2.38	$(6.50)	$(17.91)
Potential ACO Share of Earned Savings	$0.49	$ -	**$ -**
Quality Score	74%	88%	88%
% of Savings Earned	90%	100%*	100%*
Achieved Savings	**$0.44****	**$ -**	**$ -**

*If shared savings had been earned.
** CHAC may not receive shared savings payments; savings payouts in the Commercial SSP are contingent on BCBSVT achieving a surplus in its Qualified Health Plan business.

2016 Commercial Payment Measures

Payment Measure	CHAC Rate/Percentile/ Points*	OCV Rate/Percentile/ Points*	VCP Rate/Percentile/ Points*
ACO All-Cause Readmission* **	1.17/Below 25th/ 0 Points	0.86/Above 25th/ 1 Point	0.86/Above 25th/ 1 Point
Adolescent Well-Care Visits	51.78/Above 75th/ 3 points	55.91/Above 75th/ 3 Points	57.18/Above 75th/ 3 Points
Mental Illness, Follow-Up After Hospitalization	*N/A (denominator too small)*	59.26/Above 75th/ 3 Points	*N/A (denominator too small)*
Alcohol and Other Drug Dependence Treatment	23.93/Above 50th/ 2 Points	26.89/Above 75th/ 3 Points	32.61/Above 90th/ 3 Points
Avoidance of Antibiotics in Adults with Acute Bronchitis	33.66/Above 75th/ 3 Points	34.33/Above 75th/ 3 Points	44.26/Above 90th/ 3 Points
Chlamydia Screening	38.34/Above 25th/ 1 Point	43.87/Above 50th/ 2 Points	50.75/Above 75th/ 3 Points

Payment Measure	CHAC Rate/Percentile/ Points*	OCV Rate/Percentile/ Points*	VCP Rate/Percentile/ Points*
Rate of Hospitalization for People with Chronic Conditions (per 100,000)	99.88/**/ 2 Points	101.02/**/ 2 Points	36.15/**/ 2 Points
Blood Pressure in Control	70.52/Above 90th/ 3 Points	66.20/Above 75th/ 3 Points	*Not Provided (VCP did not report clinical measures for Year 3)*
Diabetes Hemoglobin A1c Poor Control* **	17.54/Above 90th/ 3 Points	13.02/Above 90th/ 3 Points	

*Maximum points/measure=3, except as noted below.
** No national benchmark; awarded maximum of 2 points based on change over time.
***Lower rates are better.

2016 Commercial Reporting Measures

Reporting Measure	CHAC Rate/Percentile	OCV Rate/Percentile	VCP Rate/Percentile
Developmental Screening	28.33/No Benchmark	53.25/No Benchmark	74.23/No Benchmark
Hospitalizations for COPD or Asthma in Older Adults* **	46.79/No Benchmark	70.58/No Benchmark	18.53/No Benchmark
Pharyngitis, Appropriate Testing for Children	82.22/Above 50th	87.18/Above 50th	93.75/Above 90th
Immunizations for 2-year-olds	*N/A (denominator too small)*	60.87/Above 90th	*Not Provided (VCP did not report clinical measures for Year 3)*
Weight Assessment and Counseling for Children/Adolescents	72.49/Above 90th	73.74/Above 90th	
Colorectal Cancer Screening	66.67/Above 75th	72.09/Above 9th	
Depression Screening and Follow-Up	56.72/No Benchmark	48.07/No Benchmark	
Adult BMI Screening and Follow-up	74.11/No Benchmark	75.20/No Benchmark	
Cervical Cancer Screening	71.21/Above 25th	79.26/Above 90th	
Tobacco Use Assessment and Cessation	92.15/No Benchmark	98.09/No Benchmark	
Diabetes Composite	45.23/No Benchmark	52.08/No Benchmark	

***Lower rates are better.

Appendix C: Reports and Evaluation Documents

Population Health Plan	• VPHA, Population Health Plan (June 2017) • Population Health Work Group Essential Resources (October 2014) • Population Health Integration in VHCIP (November 2014) • ACOs, TACOs, and Accountable Communities for Health (February 2015)
Sustainability Plan	• Myers & Stauffer, Vermont SIM Sustainability Plan (June 2017)
Payment Model Design and Implementation Focus Area	
ACO Shared Savings Programs (SSPs)	• Shared Savings Program Webpage • Year 1 ACO Shared Savings Program Results Slides (October 2015) • Year 2 ACO Shared Savings Program Results Slides and Recording (October 2016) • Year 3 ACO Shared Savings Program Results • Vermont Medicaid Shared Savings Program Quality Measures Year 1 DLTSS Sub-Analysis (October 2016)
ACO-Specific Documents	• CHAC Summary Slides (May 2017) • Healthfirst, PTOP Website Feasibility Report (June 2017)
Episodes of Care	• Episodes of Care Webpage
Pay-for-Performance	• Blueprint for Health Webpage
Health Home (Hub & Spoke)	• Blueprint for Health Webpage • Chittenden County Regional Planning Commission, Chittenden County Opiate Alliance Final Report (May 2017)
Accountable Communities for Health	• Prevention Institute, Accountable Communities for Health: Opportunities and Recommendations (July 2015) • Public Health Institute, Accountable Communities for Health Peer Learning Lab Final Report (March 2017) • Public Health Institute, Accountable Communities for Health Peer Learning Lab Curriculum (March 2017) • Public Health Institute, Accountable Communities for Health Peer Learning Lab Curriculum Appendix (March 2017) • Public Health Institute, Accountable Communities for Health Peer Learning Lab Evaluation Report (March 2017) • ACH Peer Learning Lab Recruitment Packet (January 2016)
Prospective Payment System – Home Health	No reports or evaluation documents associated with this work stream.
All-Payer ACO Model	• VMNG ACO Quarterly Report to Legislature Q1 (June 2017) • VMNG ACO Quarterly Report to Legislature Q2 (September 2017) • GMCB APM Quarterly Report to Legislature Q1 (June 2017) • GMCB APM Quarterly Report to Legislature Q2 (September 2017) • All-Payer ACO Model Agreement (October 2016) • All-Payer ACO Model Summary • All-Payer ACO Model Frequently Asked Questions • GMCB APM All Payer Financial Targets Fact Sheet (April 2017) • GMCB APM Medicare Financial Target Fact Sheet (March 2017

Medicaid Value-Based Purchasing (Medicaid Pathway – Mental Health/Substance Use)	• Medicaid Pathway Report, Act 113 Section 12 (December 2016) • Medicaid Pathway Information Gathering Process (September 2016) • Medicaid Pathway Information Gathering Process: Stakeholder Feedback and State Response (November 2016) • State of Vermont Goals: Medicaid Pathway - DA/SSAs and Preferred Providers (September 2016) • Burns and Associates, Alternative Payment Models Final Report: Payment Reform Options for Designated and Specialized Service Agencies (June 2017)
Medicaid Value-Based Purchasing (Medicaid Pathway – LTSS/Choices for Care)	• Inclusive Healthcare Partnership Project Final Report (March 2016)
State Activities to Support Model Design and Implementation – Medicaid	• VMS Education and Research Foundation, Frail Elders Project Final Report (June 2016)
Practice Transformation Focus Area	
Learning Collaboratives	• Integrated Communities Care Management Learning Collaborative Toolkit • OneCare Vermont Care Coordination Toolkit • VPQHC, ICCMLC Evaluation Report (December 2016) • Core Competency Training Materials • Vermont Developmental Disabilities Council, Disability Core Competency Training Final Report (April 2016) • Disability Awareness Core Competency Training Toolkit
Sub-Grant Program – Sub-Grants	• VHCIP Provider Sub-Grant Program Q4 2016 Reports • Sub-Grant Program Final Reports • RAVNAH VCHIP Sub-grant Final Report (July 2016) • NVRH - VHCIP Provider Sub-grant Final Report (June 2016) • Bi-State - VHCIP Provider Sub-grant Final Report (August 2016) • RISE Coalition - VHCIP Provider Sub-grant Final Report (December 2016) • HealthFirst - VHCIP Provider Sub-grant Final Report (November 2016) • SVMC - VHCIP Provider Sub-grant Final Report (December 2016) • WRFP - VHCIP Provider Sub-grant Final Report (November 2016) • VPQHC - VHCIP Provider Sub-grant Final Report (December 2016) • InvestEAP - VHCIP Provider Sub-grant Final Report (December 2016) • CVMC - VHCIP Provider Sub-grant Final Report (December 2016) • VT DDC - VHCIP Provider Sub-grant Final Report (March 2016) • VMS Foundation - VHCIP Provider Sub-grant Final Report (June 2016)
Sub-Grant Program – Technical Assistance	• VHCIP Contracts

Regional Collaborations	No reports or evaluation documents associated with this work stream.
Workforce – Care Management Inventory	• Bailit, Care Management in Vermont: Gaps and Duplication (September 2015)
Workforce – Demand Data Collection and Analysis	• IHS, Demand Modeling Report (June 2017) • Summary of Key Findings
Workforce – Supply Data Collection and Analysis	• Health Care Workforce Data
Health Data Infrastructure Focus Area	
Expand Connectivity to HIE – Gap Analyses, Gap Remediation, Data Extracts from HIE	• HIS Professionals, DLTSS Information Technology Assessment (October 2015) • ACO Gap Analysis (December 2014)
Improve Quality of Data Flowing into HIE	No reports or evaluation documents associated with this work stream.
Telehealth – Strategic Plan	• JBS International, Statewide Telehealth Strategy (September 2015)
Telehealth – Implementation	• Telehealth Project Summary • VITL - Home Health Telehealth Project Overview • Telehealth Opiate Treatment Pilot Project (June 2017)
EMR Expansion	No reports or evaluation documents associated with this work stream.
Data Warehousing	• Data Warehousing Materials
Care Management Tools	• im21, Universal Transfer Protocol Project Phase 1 Final Report (February 2015) • Shared Care Plan and Universal Transfer Protocol Final Report (May 2016)
General Health Data – Data Inventory	• Stone Environmental, Vermont Health Data Inventory Report (December 2015) • Data Source Collection Portal
General Health Data – HIE Planning	• Stone Environmental, Summary of State Governance Models and HIE Services (December 2016) • Stone Environmental, Vermont Health Data Utility: Governance and Strategic Priorities (December 2016) • Connectivity Target Proposal (December 2016)
General Health Data – Expert Support	No reports or evaluation documents associated with this work stream.
Evaluation Focus Area	

Self-Evaluation Plan, Execution, and Surveys	• State-Led Evaluation Projects Webpage • JSI, Environmental Scan (August 2016) • JSI, Vermont SIM State-Led Evaluation Survey Report (June 2017) • JSI, Final State Led Evaluation Report (September 2017) • State-Led Evaluation Summary and Process Update Slide Deck (June 2017) • Site Visit and Interview Guide • JSI, Vermont SIM State-Led Evaluation Focus Group Report (June 2017) • JSI, Care Management Survey Tool • JSI, Advanced Practice Professionals Survey Tool • JSI, Vermont SIM State-Led Evaluation Survey Report (June 2017)
Monitoring and Evaluation Activities within Payment Programs	• Community Health Profiles (includes section on CAHPS survey, conducted by DataStat) • Commercial ACO Shared Savings Program Quality Results: Year 1 – Excel format (2014) • Commercial ACO Shared Savings Program Quality Results: Year 2 – Excel format (2015) • Medicaid ACO Shared Savings Program Quality Results: Year 1 – Excel format (2014) • Medicaid ACO Shared Savings Program Quality Results: Year 2 – Excel format (2015) • Medicaid ACO Shared Savings Program Quality Results: Year 3 – Excel format (2016)
Project Management Focus Area	
Project Management and Reporting – Project Organization	• VHCIP Project Management Webpage • VHCIP Contract List (July 2017)
Project Management and Reporting – Communication and Outreach	No reports or evaluation documents associated with this work stream.
Webinars	
VHCIP Webinar Series	• VHCIP Webinar Series: Sustainability Plan (November 2016) • VHCIP Webinar Series: VT Year 2 Medicaid and Commercial ACO SSP Results (October 2016) • VHCIP Webinar Series: Mental Health & Substance Abust Integration: Strategies & Lessons Learned (September 2016) • VHCIP Webinar Series: Value-Based Payment for Pharmacy (July 2016) • VHCIP Webinar Series: VT Year 1 Medicaid and Commercial ACO SSP Results (May 2016) • VHCIP Webinar Series: Vermont's ACO SSP in a National Context (April 2016)

	• VHCIP Webinar Series: Opportunities to Improve Models of Care for People with Complex Needs (March 2016) • VHCIP Webinar Series: Defining Population Health (February 2016) • VHCIP Webinar Series: Payment Reform 101 (January 2016)
ICCMLC Webinars	• ICCMLC Webinar: Using, Sharing and Updating the Shared Care Plan (January 2016) • ICCMLC Webinar: Community Progress with Care Navigator (November 2016) • ICCMLC Webinar: Informing Clients, Documenting Consent, and Resolving Disagreements When Sharing Confidential Client Information as a Team (February 2016) • ICCMLC Webinar: Practicing Root Cause Analysis (December 2015) • ICCMLC Webinar: Eco-Mapping (October 2015) • ICCMLC Webinar: Record Review for Shared Care Plans (August 2015) • CCT Webinar: Responding to Disclosures of Trauma Tips and Tools (December 2016) • CCT Webinar: Facilitating Trainings that are Inclusive for People with Disabilities (October 2016) • CCT Webinar: Delivering Culturally Competent Care to LGBTQ Individuals (November 2016) • CCT Webinar: Radical Accompaniment-Tools and Frameworks for Walking with our Complex Clients (August 2016) • CCT Webinar: Sexuality and Reproductive Health (August 2016) • CCT Webinar: Domestic and Sexual Violence (July 2016) • CCT Webinar: Coordinating Care Across Organizations (June 2016)
Work Force Webinars	• VHCIP Workforce Work Group Meeting (December 2016) • VHCIP Workforce Work Group Meeting (May 2017)