VHCIP Project Status Reports
Payment Model Design and Implementation Focus Area
April 2016

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Focus Area: Payment Model Design and Implementation

Focus Area: Payment Model Design and Implementation
Project: ACO Shared Savings Programs (SSPs)

Project Summary: 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.

Project Timeline and Key Facts:

- January 2014 – Medicaid and commercial SSPs launched.
- July 2014 – ACOs and DVHA started sharing attribution files and claims data.
- August 2014 – ACOs and DVHA began meeting monthly to collaborate around clinical/quality improvement.
- March 2015 – Performance measures, quality benchmarks, and Gate and Ladder methodology reviewed and modified for Year 2.
- August 2015 – DVHA elected not to include additional categories of service in TCOC for Year 3.
- September 2015 – Shared savings/quality performance calculations and results made available for Performance Year 1 of program.
- October 2015 – Results of the SSP Year 1 were presented to the GMCB and VHCIP stakeholders.
- December 2015-January 2016 – VHCIP staff prepared for Year 3 Medicaid SSP SPA negotiations.
- March 2016 – Year 3 Medicaid SSP SPA submitted to CMS.

Status Update/Progress Toward Milestones and Goals:

- Medicaid SSP Year 2 contract negotiations between DVHA and Medicaid SSP ACOs are complete; contract amendments with participating ACOs have been executed.
- Expansion of Total Cost of Care for Year 3 of the Medicaid SSP was considered in 2015. DVHA reviewed all potential services to include in Year 3 before determining not to include them. DVHA notified the ACOs that it would not include additional services on September 1, 2015.
- The Green Mountain Care Board published the Year 1 (CY2014) quality, cost, and utilization performance results for each of the ACOs in the commercial SSP in Fall 2015.
- In Performance Period 2, the project focus is on continued program implementation and evolution of program standards based on cost and quality results from the first performance period of both the Medicaid and commercial SSPs.
- During Performance Period 3, the SSPs are targeting additional beneficiaries and focus on expanding the number of Vermonters served in this alternative payment model.
- The commercial SSP will not offer downside risk as originally proposed in Year 3.

Milestones:

Performance Period 1:

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).

Performance Period 1 Carryover: Continue implementation activities in support of the 2014 SSP performance year.

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

Performance Period 2: 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.

Performance Period 3: 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)

Metrics:

CORE_Beneficiaries impacted_[VT]_VTEmployees
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]
CORE_Diabetes Care_[VT] CORE_ED Visits_[VT]
CORE_Readmissions_[VT]
CORE_Tobacco Screening and Cessation_[VT]
CAHPS Clinical & Group Surveys

Additional Goals:

 # Lives Impacted: 192,636 (as of March 2016)

 # Participating Providers: 1016 (as of March 2016)

Key Documents:

- Shared Savings Program webpage
- Vermont Medicaid Shared Savings Program: Analyses of Utilization and Expenditure in the 2014 Performance Year

State of Vermont Lead(s): Amy Coonradt, Richard Slusky

Contractors Supporting: Bailit Health Purchasing; Bi-State Primary Care Association/Community Health Accountable Care; Burns and Associates; Deborah Lisi-Baker; Healthfirst; Policy Integrity; The Lewin Group; UVM Medical Center/OneCare Vermont; Vermont Medical Society Foundation; Wakely Actuarial.
To view executed contracts, please visit the **VHCIP Contracts** page.

Anticipated Risks and Mitigation Strategy:

- Plans for SSP evolution in 2016 could be inconsistent with activities proposed for the All-Payer Model in 2017.
    - Vermont will include key SSP operational staff in APM planning conversations to ensure alignment across related initiatives.

Focus Area: Payment Model Design and Implementation
Project: Episodes of Care (EOCs)

Project Summary: From 2014 through early 2016, Vermont worked to develop an episode-based payment model for the Medicaid population which would be implemented to best complement other payment models that are presently in operation in the state. In April 2016, following internal discussion and discussion with CMMI, Vermont's SIM leadership team elected to discontinue this activity.

Project Timeline and Key Facts:

- June-December 2014 – HCi3/Brandeis engaged to conduct preliminary analyses of EOCs in Vermont.
- January 2015 – Public-private stakeholder EOC sub-group of the VHCIP Payment Models Work Group launched to discuss the potential for development of episode-based payment models and analytics to support delivery system transformation.
- May 2015 – DVHA staff began Medicaid-specific analysis of potential EOCs, taking into consideration service volume, cost, and overall variation.
- August 2015 – Three EOCs tentatively selected for implementation in July 2016.
- September 2015 – Vendor selected to design Medicaid's episode-based payment model for 2016 launch.
- November 2015 – Pilot episodes brought before the Payment Model Design and Implementation Work Group.
- January 2016 – Following discussions with CMMI, Vermont developed new EOC milestones, below, which limit the number to one EOC.
- April 2016 – Following discussions with CMMI, Vermont elected to discontinue its work to develop an EOCs.

Status Update/Progress Toward Milestones and Goals:

- In April 2016, following internal discussion and discussion with CMMI, Vermont's SIM leadership team elected to discontinue this activity due to estimated episode launch date (7/1/17, following the end of Vermont's SIM Model Testing period) and inability to evaluate the model prior to the end of SIM. The initiative had been previously delayed; provider and stakeholder support for this work stream was never fully realized due to significant provider fatigue and concurrent competing payment reform priorities. The State will continue work on IFS program payment models through the Medicaid VBP (Medicaid Pathway) work stream.

Milestones:

Performance Period 1: At least 3 episodes launched by 10/2014.
Performance Period 1 Carryover: 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.
3. Convene stakeholder sub-group at least 6 times by 6/30/15.

Performance Period 2: Research, design, and draft implementation plan for one EOC based off of the IFS program by 6/30/16.
Performance Period 3: N/A

Metrics:

CORE_Beneficiaries impacted_[VT]_[EOC]_Commercial
CORE_Beneficiaries impacted_[VT]_[EOC]_Medicaid
CORE_Beneficiaries impacted_[VT]_[EOC]_Medicare
CORE_Participating Provider_[VT]_[EOC]
CORE_Participating Organizations_[VT]_[EOC]
CORE_Payer Participation_[VT]

Additional Goals:

 # Lives Impacted: 0
 # Participating Providers: 0

Key Documents: Episodes of Care Sub-Group Webpage

State of Vermont Lead(s): Alicia Cooper

Contractors Supporting: Bailit Health Purchasing; Burns and Associates; Pacific Health Policy Group.
To view executed contracts, please visit the **VHCIP Contracts** page.

Anticipated Risks and Mitigation Strategy: This project is complete.

Focus Area: Payment Model Design and Implementation
Project: Pay-for-Performance (Blueprint for Health)

Project Summary: The Blueprint for Health provides performance payments to advanced primary care practices recognized as patient centered medical homes (PCMHs), as well as providing multi-disciplinary support services in the form of community health teams (CHTs), a network of self-management support programs, comparative reporting from state-wide data systems, and activities focused on continuous improvement. The Blueprint aims to better integrate a system of health care for patients, improving the health of the overall population, and improving control over health care cost by promoting health maintenance, prevention, and care coordination and management. This Status Report is updated quarterly to align with the Blueprint's quarterly reports to CMMI.

Project Timeline and Key Facts:

- 2008 – Pilot programs in two Vermont communities.
- 2010 – Vermont selected to participate in CMS' Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration, through which Medicare becomes a participating insurer with the Blueprint, joining commercial insurers and Medicaid in providing financial support for the advanced primary care practices.
- 2011 – The Blueprint expanded and Community Health Teams implemented across the State.
- 2012 – The Blueprint reported that lower health care expenditures for participants offset the payments that insurers made for medical homes and community health teams.
- 2015 – Legislature approved funding to support Blueprint payment changes.
- 2016 – Continue to implement payment and quality measurement changes.

Status Update/Progress Toward Milestones and Goals:

- The Blueprint for Health engaged with its Executive Committee, DVHA and AHS leadership, and VHCIP stakeholders to discuss potential modifications to both the Community Health Team (CHT) and Patient-Centered Medical Home (PCMH) payments. Such modifications include shifting payers' CHT payments to reflect current market share (7/1/2015), increasing the base payments to PCMH practices (7/1/2015 for Medicaid, 1/1/2016 for commercial insurers), and adding an incentive payment for regional performance on a composite of select quality measures (1/1/2016).
- The legislature appropriated $2.4 million for Medicaid Blueprint payments (both CHT and PCMH) in State Fiscal Year 2016.
- **A number of quality measures have been selected as the basis for the performance incentive payment that will be incorporated in 2016; these measures are aligned with those being used for the Medicaid and commercial SSPs.**
- The Blueprint has approached a saturation point where the program has recruited most of the primary care practices in the state, and the rate of onboarding of new practices has slowed. It is anticipated that 6 new practices will join during 2016, and that the currently enrolled practice will maintain participation.
- Since 2015, the Blueprint has been working on a model for integrating efforts with the ACOs. In 2016 further decision will be made regarding the program's trajectory within finance models that are proposed for 2017.

Milestones:

Performance Period 1: Develop Medicaid value-based purchasing plan addressing pay-for-performance initiatives: Medicaid value-based purchasing plan developed.

Performance Period 1 Carryover:

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.

Performance Period 2: 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).

Performance Period 3:

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.

Metrics:

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]

Additional Goals:

 # Lives Impacted: 307,900 (as of March 2016)
 # Participating Providers: 712 providers across 111 participating practices (as of March 2016)

Key Documents:

- Blueprint for Health Webpage

State of Vermont Lead(s): Craig Jones

Contractors Supporting: Non-SIM supported.

Anticipated Risks and Mitigation Strategy: None at this time.

Focus Area: Payment Model Design and Implementation
Project: Health Home (Hub & Spoke)

Project Summary: 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. This Status Report is updated quarterly to align with the Hub & Spoke program's quarterly reports to CMS.

Project Timeline and Key Facts:

- January 2013 – Implementation across Vermont began.
- July 2013 – Start date of first State Plan Amendment for Health Home.
- January 2014 – Start date of second State Plan Amendment for Health Home.

Status Update/Progress Toward Milestones and Goals:

- Vermont is currently assessing and expanding state capacity to collect and report on performance metrics.
- Access to treatment has steadily expanded, from 2,867 Medicaid beneficiaries receiving treatment in January 2013 to 5,432 in March 2016.
- Program implementation and reporting are ongoing.

Milestones:

Performance Period 1: Health Homes.

Performance Period 1 Carryover: 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.

Performance Period 2: Reporting on program's transition and progress: Quarterly reporting of program progress to CMMI, VHCIP stakeholders.

Performance Period 3:

1. Expand the number of providers and beneficiaries participating in the Health Home program by 6/30/17:
   Number of providers participating in Health Home program target: 75 MDs each prescribing to >= 10 patients. (*Baseline as of December 2015:* 72)
   Number of beneficiaries participating in Health Home program target: 2,900 Hub + 2,300 Spoke = 5,200 total patients. (*Baseline as of December 2015:* 5,179)
2. Health Home program incorporated into Sustainability Plan by 6/30/17.

Metrics:

CORE_Provider Organizations_[VT]_[HH]
CORE_Participating Providers_[VT]_[HH]
CORE_Provider Organizations_[VT]_[HH]

Additional Goals:

 # Lives Impacted: 5,432 (as of March 2016)
 # Participating Providers: 73 (as of March 2016)

Key Documents:

State of Vermont Lead(s): Beth Tanzman

Contractors Supporting: Non-SIM supported.

Anticipated Risks and Mitigation Strategy: None at this time.

Focus Area: Payment Model Design and Implementation
Project: Accountable Communities for Health

Project Summary: This effort seeks to align programs and strategies related to integrated care and services for individuals and community-wide prevention efforts to improve health outcomes within a geographic community. 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 brings together multi-disciplinary teams from communities across the state in an Accountable Communities for Health Peer Learning Laboratory to further explore how this model might be implemented and develop community capacity. The ACH Peer Learning Laboratory seeks to support participating communities in increasing their capacity and readiness across the nine core elements of the ACH model through a curriculum that utilizes in-person and distance learning methods to support peer learning, as well as community facilitation to support each community's development; the project will result in a report that documents findings and lessons learned, and includes recommendations to inform future State decision-making, focusing on what infrastructure and resources are needed at the community/regional level and the State level.

Project Timeline and Key Facts:

- Fall 2014 – Population Health Work Group expressed interest in establishing an ACH in Vermont.
- January-June 2015 – ACH Phase I: Research to define ACH model and identify core concepts.
- July 2015 – Accountable Health Communities working group began meeting on a monthly basis.
- September-October 2015 – Recommended next steps discussed by Population Health Work Group and approved by Core Team.
- November-December 2015 – Further ACH Phase II (ACH Peer Learning Laboratory) development.
- January 2016 – ACH Peer Learning Laboratory soft launch: recruitment materials for interested communities released.
- February 2016 – An RFP was released seeking curriculum design and facilitation support for ACH Peer Learning Laboratory. A bidder was selected and contract negotiations kicked off. The State received twelve applications to participate; 10 communities from around Vermont were accepted.
- April 2016 – Curriculum design and facilitation support contract is pending.
- May 2016 – ACH Peer Learning Laboratory Needs Assessment survey to be released.
- June 2016 – ACH Peer Learning Laboratory Kick-Off Webinar; In-Person Learning Session #1 (of 3).
- September 2016 – ACH Peer Learning Laboratory In-Person Learning Session #2 (of 3).
- January 2017 – ACH Peer Learning Laboratory In-Person Learning Session #3 (of 3).
- February 2017 – ACH Peer Learning Laboratory final report expected.

Status Update/Progress Toward Milestones and Goals:

- Planning for an ACH Peer Learning Lab for interested communities is ongoing. The Peer Learning Lab had a soft launch in January 2016 with the release of recruitment materials and an informational webinar. Ten communities were selected to participate in February. Through an RFP process, the State has identified an apparently successful awardee to provide curriculum design and facilitation services to support participating communities and document lessons learned for the State; contract execution is pending as of April 2016.
- Work to identify opportunities to enhance new health delivery system models, such as the Blueprint for Health and Accountable Care Organizations (ACOs), to improve population health by better integration of clinical services, public health programs and community based services at both the practice and the community levels is ongoing.

Milestones:

Performance Period 1: N/A

Performance Period 1 Carryover: 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.

Performance Period 2: 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.

Performance Period 3:

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.

Metrics:

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]

Additional Goals:

 # Lives Impacted: TBD
 # Participating Providers: TBD

Key Documents:

- Integrating Population Health in VHCIP
- ACO/TACO/ACH
- Accountable Communities for Health, Opportunities and Recommendations
- Proposed Next Steps for Accountable Communities for Health

State of Vermont Lead(s): Heidi Klein

Contractors Supporting: Bailit Health Purchasing; Burns and Associates; Prevention Institute; Public Health Institute. To view executed contracts, please visit the **VHCIP Contracts** page.

Anticipated Risks and Mitigation Strategy:

- Delayed contract execution could delay full Peer Learning Lab launch.
    - Community recruitment has continued as planned, with a "soft launch" webinar to orient communities and ensure momentum is maintained while contractor procurement is finalized. Retroactive contract approval has been requested.

Focus Area: Payment Model Design and Implementation
Project: Choices for Care

Project Summary: Vermont's Choices for Care Program is a nationally recognized Medicaid program that serves both nursing home residents and those receiving home- and community-based services. Savings from decreased institutional utilization help to fund community-based services for participants who qualify for "nursing home-level of care". As a result, Vermont has been able to "shift the balance" of funding from institutional care to home- and community-based services; 55% of the Choices for Care participants are currently served in the community. Although this program has been very successful, there are opportunities for improvement. These include better coordination among providers, increased flexibility of service provision, a shift away from fee-for-service payments, and improved integration of services. Recognizing an opportunity to address these areas, Vermont has formed an LTSS/Choices for Care Medicaid Pathway sub-group whose goal is to focus on delivery system integration and payment reform, thereby improving quality of care and outcomes. This Subgroup will explore value-based payment models to achieve these improvements, and to this end will promote pilot project/s that are already under development. The St. Johnsbury pilot completed its research and feasibility analyses in March 2016 (see Status Update below); implementation steps will be identified through the sub-group process.

Project Timeline and Key Facts:

- July 2015-December 2015 – Meetings with sub-group to research implementation of a pilot program.
- January 2016 – Proposed project plan presented to VHCIP leadership and stakeholders.
- February-March 2016 – Continued research and feasibility analyses for a potential pilot that would incorporate a payment change (data analysis, financial analysis, stakeholder participation analysis).
- May-June 2016 – LTSS/Choices for Care Medicaid Pathway Subgroup to be formed.
- June-December 2016 – LTSS/Choices for Care Medicaid Pathway Subgroup to meet to identify goals and scope, discuss delivery system and payment models, develop a quality and oversight framework, promote and oversee pilot project(s), and identify necessary resources and policy changes.

Status Update/Progress Toward Milestones and Goals:

- Work on the Choices for Care (CFC) work stream continues through the Medicaid Pathway effort. Intensive planning and stakeholder engagement will pick up in June 2016.
- Research for one Vermont region, St. Johnsbury, was completed in March 2016.

Milestones: This work is part of the Accountable Communities for Health (ACH) work stream. The relevant piece of that initiative's milestones is included below.
Performance Period 1: N/A
Performance Period 1 Carryover: N/A
Performance Period 2: 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.
Performance Period 3: ACH Implementation Plan incorporated into Sustainability Plan by 6/30/17.

Metrics:
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]

Additional Goals:
 # Lives Impacted: N/A
 # Participating Providers: N/A

Key Documents: LTSS/CFC Medicaid Pathway Goals, Principles, and Objectives.

State of Vermont Lead(s): Bard Hill; Julie Wasserman

Contractors Supporting: Bailit Health Purchasing and PHPG

Anticipated Risks and Mitigation Strategy:

- Changes to the CFC system may require legislative approval.

Focus Area: Payment Model Design and Implementation
Project: Prospective Payment System – Home Health

Project Summary: As a result of stakeholder support in the state, legislation was passed in 2015 requiring that DVHA, in collaboration with the State's home health agencies, develop a prospective payment system (PPS) for home health payments made by DVHA under traditional Medicaid (exclusive of waivers) to be put in place by July 1, 2016. During their 2016 session, Vermont's Legislature is considering a delay in implementation of this model until July 1, 2017, at the request of home health providers around the state. In April 2016, after internal discussion and discussion with CMMI, Vermont's SIM project suspended this effort in response to this change and eliminated this milestone in Performance Period 3.

Project Timeline and Key Facts:

- May 2015 – Enabling legislation passed in Vermont's legislature.
- June 2015 – Planning for Home Health PPS began.
- April 2016 – After internal discussion and discussion with CMMI, Vermont's SIM project suspended this effort in response to this change and eliminated this milestone in Performance Period 3.

Status Update/Progress Toward Milestones and Goals:

- As a result of ongoing collaboration between DVHA and Vermont's home health agencies, partners reached consensus that the PPS would be comprised of episode-based payments (most likely 60 days in length, similar to Medicare) that will be adjusted for case acuity. DVHA developed five acuity groupings and presented them to the provider association for feedback. Based on that feedback, acuity adjustment factors were finalized and a fiscal impact was developed for each provider.
- DVHA and providers met to review the potential fiscal impact of the model change. Based on results of these analyses, it was agreed that more time was needed to develop an incremental approach to the implementation of the prospective payment system.
- During their 2016 session, Vermont's Legislature considered a delay in implementation of this model until July 1, 2017, at the request of home health providers around the state. In April 2016, after internal discussion and discussion with CMMI, Vermont's SIM project suspended this effort in response to this change and eliminated this milestone in Performance Period 3.

Milestones*:*
Performance Period 1: N/A
Performance Period 1 Carryover: N/A
Performance Period 2:

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.

Performance Period 3: N/A

Metrics:
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]

Additional Goals:
 # Lives Impacted: N/A
 # Participating Providers: N/A

Key Documents:

State of Vermont Lead(s): Aaron French

Contractors Supporting: N/A

Anticipated Risks and Mitigation Strategy: This project is complete**.**

Focus Area: Payment Model Design and Implementation
Project: Medicaid Value-Based Purchasing (Medicaid Pathway)[1]

Project Summary: The Medicaid Pathway is a companion project to the All-Payer Model, supported by SIM, that accelerates payment and delivery system reform for providers and services not initially subject to the proposed financial caps of the All-Payer Model, such as LTSS, mental health, substance abuse services and others. It incorporates previous work to initiate a feasibility assessment of current mental health and substance abuse spending within the Agency of Human Services. To launch this process, the State has convened providers from each these sectors along with other key partners to determine how best to serve Vermonters through a more integrated continuum of Mental Health, Substance Abuse and Developmental services. Future design considerations will be intended to and must work to support Medicaid alignment with the All-Payer Model.

Project Timeline and Key Facts:

- Fall 2015 – Leveraged existing contracts to start feasibility study.
- December 2016 – Implementation plan for presentation and approval by AHS leadership.
- January-March 2016 – Stakeholder group convened and identification of key project tasks completed. Built on prior work related to IFS.
- March-June 2016 – Development of new payment model and implementation plan.
- July-December 2016 – Operational planning for new payment model.

Status Update/Progress Toward Milestones and Goals:

- Developing a work plan for contractors.
- Parsing mental health and substance abuse funding to support more detailed analyses.
- Ongoing meetings with leadership from the Agency of Human Services and members of the provider community.
- Contractors continue to work with State to develop finalized project plan to implement new payment and delivery system by 1/1/17.
- Work group members and consultants have started to narrow in on the scope of services this work stream will target for payment and delivery reform.

Milestones:
Performance Period 1: N/A
Performance Period 1 Carryover: N/A
Performance Period 2: N/A
Performance Period 3:

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.

Metrics:
CORE_Beneficiaries impacted_[VT]_[ACO]_Medicaid
CORE_Participating Provider_[VT]_[ACO]_Medicaid
CORE_Provider Organizations_[VT]_[ACO]_Medicaid

Additional Goals:
 # Lives Impacted: N/A
 # Participating Providers: N/A

Key Documents:

State of Vermont Lead(s): Selina Hickman

Contractors Supporting: Bailit Health Purchasing, Burns and Associates, Pacific Health Policy Group.

Anticipated Risks and Mitigation Strategy: None at this time.

[1] This work stream was previously known as Prospective Payment System – Designated Mental Health Agencies and Medicaid Value-Based Purchasing – Mental Health and Substance Abuse. Milestones from these areas in previously performance periods have been consolidated here.

Focus Area: Payment Model Design and Implementation

Project: All-Payer Model

Project Summary: Vermont continues to explore an All-Payer Model. An All-Payer Model will build on existing all-payer payment alternatives to better support and promote a more integrated system of care and a sustainable rate of overall health care cost growth. Value-based payments that shift risk on to health care providers and that are aligned across all payers encourages collaboration across the care continuum and can result in better health outcomes for Vermonters. Through the legal authority of the Green Mountain Care Board (GMCB), the state can facilitate the alignment of commercial payers, Medicaid, and Medicare through a Medicare waiver. Over time, a Medicare waiver may also allow the GMCB to govern rates, on an all-payer basis, for those providers who elect not to participate in an ACO. To move away from FFS, the state will apply the Next Generation ACO payment model across all payers. The focus on the ACO and existing CMS ACO programming, along with Vermont's strong stakeholder network, SIM investments, and the current SSP program, is a timely and realistic evolution of Vermont's multi-payer reform. Eventually, an integrated ACO in Vermont could attract and involve the vast majority of people, payers, and providers.

Project Timeline and Key Facts: Vermont staff is engaged in ongoing discussions with CMMI staff. Key high level milestones are listed below:

- 2015 – Aligned on term sheet with CMMI that contains key elements of the APM, including high level models for rate setting, financial targets, waivers, ACO, and quality and performance measurement.
- 2015-ongoing – Engaged in stakeholder outreach and public process to vet term sheet and potential model design.
- November 2015-March 2016 – Further work on all phases of project, including ACO capacity development, rate-setting, and quality measurement methodologies. Begin implementation of functionality required to ensure operational readiness.
- March 15, 2016-January 1, 2017 – Continue implementation of APM.
- April 15, 2016 – Reach consensus with CMMI on major elements requiring clearance.
- April-September 2016 – Continue to refine elements necessary for inclusion in an APM agreement.
- January 1, 2017 – Launch model.

Status Update/Progress Toward Milestones and Goals:

- Negotiations between CMMI and SOV continue.
- SOV proposed a term sheet to CMMI on January 25, 2016. The term sheet sets out the basic outline for a potential all-payer model agreement, including the legal authority of the state to enter into such an agreement, the performance period for the agreement, waivers necessary to facilitate payment change and additional covered services, data sharing, and an evaluation of the demonstration.
- The stakeholder outreach and public process to vet the term sheet and potential model design began almost immediately, as the GMCB held two days of public meetings to discuss the proposed term sheet on January 28 and 29, 2016. The hearings were well attended by stakeholders. Concurrently, SOV staff has been testifying before relevant legislative committees to explain the term sheet and prospective model to Vermont's policy makers.
- SOV staff held an all-day work session at CMMI in Baltimore on March 22nd. Progress was made on the major elements of the project. The goal is to reach consensus on all major elements of the demonstration by April 15th so that CMMI can begin the federal clearance process.
- On April 7, the State's Medicaid agency published an RFP that seeks a contract with a risk-bearing ACO that utilizes a Next Generation payment model in anticipation of the all payer model. Four entities have submitted letters notifying the State of their intention to bid on the contract. Bids are due in early June.
- Sent second iteration of term sheet around April 15.
- On May 1, representatives from Community Health Accountable Care (CHAC), Health*first*/Vermont Collaborative Physicians (VCP), and OneCare Vermont Accountable Care (OneCare) voted unanimously to form a unified Accountable Care Organization ("Vermont Care Organization" (VCO)) by June 1, 2016.
- On April 29, Vermont's Senate Committee on Health and Welfare passed H.812, *An act relating to implementing an all-payer model and oversight of accountable care organizations*. The Administration does not need legislative approval for an all payer model; however, the bill is a positive step that shows support for reform. Also, the bill enhances state regulation of accountable care organizations. This was seen as important given their prominence in a proposed all payer model and CMS's commitment to ACOs as a vehicle for reform.

- State APM staff and Medicaid staff have been making joint presentations on the all-payer model and Medicaid Pathway to various internal and external stakeholder groups.

Milestones – All-Payer Model:

Performance Period 1: N/A

Performance Period 1 Carryover: N/A

Performance Period 2:

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.

Performance Period 3:

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.

Milestones – State Activities to Support Model Design and Implementation – GMCB:

Performance Period 1: N/A

Performance Period 1 Carryover: 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.

Performance Period 2:

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.

Performance Period 3: N/A (milestones in this category integrated into All-Payer Model for Performance Period 3)

Metrics:

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]

Additional Goals:

The goal is for the APM to include the maximum, prudent amount of services, providers, and spending. Generally, the APM is based on covered services. The State is discussing inclusion of all Medicare Part A and Part B spending, and their commercial and Medicaid equivalents, in the model. This is the majority of state health care spending. The project aims for maximum provider participation. Currently, the three Vermont based ACOs are formally discussing merger. Given current ACO participation, there is a significant opportunity to include all hospitals in Vermont along with Dartmouth-Hitchcock Medical Center in New Hampshire. Hospitals employ approximately 2/3 of physicians in Vermont. Additionally, ACO rosters include many independent doctors and the State's FQHCs.

Key Documents:

State of Vermont Lead(s): Michael Costa, Ena Backus

Contractors Supporting: Bailit Health Purchasing; Burns and Associates; Health Management Associates.
To view executed contracts, please visit the **VHCIP Contracts** page.

Anticipated Risks and Mitigation Strategy:

- The federal CPC+ program announced on April 11 may be a distraction that diverts provider attention and enthusiasm for the all payer model.
- Consensus on major elements and clearance process may not be concluded in time to provide sufficient information to allow for operational implementation by 1/1/17.
  - Risk mitigation is consistent with discussions with CMMI and ongoing communications with entities that would need to implement change by 1/1/17. Additionally, SIM staff and all-payer model leads are collaborating to draft an all-payer model communication plan that ensures no gaps in messaging about goals and expectations once term sheet is agreed upon.

Focus Area: Payment Model Design and Implementation
Project: State Activities to Support Model Design and Implementation – Medicaid

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

Project Timeline and Key Facts:

- February 2014 – Vermont submitted State Plan Amendment to CMS for Year 1 SSP.
- July 2014 – Established call center for Medicaid beneficiaries with queries or concerns specifically about the SSP.
- July 2014 – Established permissions and protocols to begin monthly data-sharing between Medicaid and ACOs participating in SSP; establish process for tracking ACO and Medicaid compliance with monthly contractual obligations.
- June 2015 – Vermont received State Plan Amendment approval from CMS for Year 1 SSP.
- August 2015 – Vermont submitted State Plan Amendment to CMS for Year 2 SSP.
- September 2015 – Vermont received State Plan Amendment approval from CMS for Year 2 SSP.
- March 2016 – Vermont submitted State Plan Amendment to CMS for Year 3 SSP.

Status Update/Progress Toward Milestones and Goals:

- Both Year 1 and 2 SSP State Plan Amendments were approved in 2015.
- Beneficiary call-center is operational and will continue through program duration.
- ACO data sharing is ongoing.
- Year 3 SSP State Plan Amendment submitted to CMS.

Milestones:

Performance Period 1: N/A

Performance Period 1 Carryover: 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.

Performance Period 2: 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.

Performance Period 3: 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.

Metrics:

CORE_Beneficiaries impacted_[VT]_VTEmployees
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
Additional Goals: *# Lives Impacted: N/A* *# Participating Providers: N/A*
Key Documents:
State of Vermont Lead(s): Alicia Cooper
Contractors Supporting: Bailit Health Purchasing; Burns and Associates; Wakely Actuarial. To view executed contracts, please visit the **VHCIP Contracts** page.
Anticipated Risks and Mitigation Strategy: None at this time.