VHCIP Project Status Reports
Payment Model Design and Implementation Focus Area
December 2015

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 launch.
- July 2014 – ACOs and DVHA start sharing attribution files and claims data.
- August 2014 – ACOs and DVHA begin meeting monthly to collaborate around clinical/quality improvement.
- March 2015 – Performance measures, quality benchmarks, and Gate and Ladder methodology are reviewed and modified for Year 2.
- August 2015 – DVHA elects not to include additional categories of service in TCOC for Year 3.
- September 2015 – Shared savings/quality performance calculations and results 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 – VHCIP staff are preparing for Year 3 SPA negotiations.

Status Update/Progress Toward Milestones and Goals:

- Medicaid SSP Year 2 contract negotiations between DVHA and Medicaid SSP ACOs are almost complete.
- 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 will target additional beneficiaries and focus on expanding the number of Vermonters served in this alternative payment model.
- The SSPs 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.

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: 176,100 (as of September 2015; December 2015 numbers expected in January 2016)

 # Participating Providers: 947 (as of September 2015; December 2015 numbers expected in January 2016)

Key Documents:

- Shared Savings Program webpage

State of Vermont Lead(s): Cecelia Wu, 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: Vermont is in the process of developing an episode-based payment model for the Medicaid population. The payment model will include a minimum of three episodes of care (EOCs), and will be implemented to best complement other payment models that are presently in operation in the state.

Project Timeline and Key Facts:

- June-December 2014 – HCi3/Brandeis are engaged to conduct preliminary analyses of EOCs in Vermont.
- January 2015 – Public-private stakeholder EOC sub-group of the VHCIP Payment Models Work Group launches to discuss the potential for development of episode-based payment models and analytics to support delivery system transformation.
- May 2015 – DVHA staff begin 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.
- December 2015 – Work on Vermont's Medicaid-specific EOCs has been put on a hold awaiting further instruction from CMMI.

Status Update/Progress Toward Milestones and Goals:

- A sub-group of the VHCIP Payment Models Work Group focused on EOCs was established in January 2015.
- Staff conducted a series of one-on-one meetings with stakeholder organizations to understand opportunities and concerns related to this initiative.
- Vendor will begin designing an episode-based payment model for Vermont's Medicaid program.
- The three pilot episodes were brought before the Payment Model Design and Implementation Work Group in November 2015, and a public comment period was open during the month of November.

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: 3 EOCs designed for Medicaid – implementation of data reports by 3/1/16.

Implementation of data reports means: episodes selected, outreach plan to providers designed, first run of historic data provided to providers participating in program.

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 (as of December 2015)
 # Participating Providers: 0 (as of December 2015)

Key Documents*:*

- Episodes of Care Sub-Group Webpage

State of Vermont Lead(s): Amanda Ciecior

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:

- Program will launch without sufficient time to implement or evaluate its potential prior to the end of SIM.
    - VHCIP leadership is in conversation with CMMI around the potential to scale back this demonstration.

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.

Project Timeline and Key Facts:

- 2008 – Pilot programs in two Vermont communities.
- 2010 – Vermont is 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 is expanded and Community Health Teams implemented across the State.
- 2012 – The Blueprint reports that lower health care expenditures for participants offset the payments that insurers made for medical homes and community health teams.
- 2015 – Legislature approves funding to support Blueprint payment changes.
- October 2015 – The Blueprint reports 126 PCMH qualified practices in Vermont.

Status Update/Progress Toward Milestones and Goals:

- The Blueprint for Health has been engaging 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) payment models. Such modifications include shifting payers' CHT payments to reflect current market share (7/1/2015), increasing the base payments to PCMH practices (5/1/2015 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. A stakeholder group with payer, ACO, and provider representation finalized the new payment model to go into effect January 1, 2015, which established appropriate performance targets and benchmarks linking practice performance to incentive payment eligibility.
- 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 by the end of 2016, and that the currently enrolled practice will maintain participation.
- In 2015, the Blueprint has been working on a model for integrating efforts with the ACOs. In early 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).

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:* 307,035 (as of September 2015; December 2015 numbers expected in January 2016) *# Participating Providers:* 700 (as of September 2015; December 2015 numbers expected in January 2016)
Key Documents*:* • Blueprint for Health Webpage
State of Vermont Lead(s): Craig Jones
Contractors Supporting: Bailit Health Purchasing. To view executed contracts, please visit the **VHCIP Contracts** page.
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.

Project Timeline and Key Facts:

- January 2013 – Implementation across Vermont begins.
- 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.
- Vermont is working with CMS to develop their quality reporting strategy for the 2014 performance year.
- Access to treatment has steadily expanded, from 2,867 Medicaid beneficiaries receiving treatment in January 2013 to 5,165 in September 2015.
- 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.

Metrics*:*
CORE_Provider Organizations_[VT]_[HH]
CORE_Participating Providers_[VT]_[HH]
CORE_Provider Organizations_[VT]_[HH]

Additional Goals*:*
 # Lives Impacted: 5,165 (as of September 2015; December 2015 numbers expected in January 2016)
 # Participating Providers: 72 (as of September 2015; December 2015 numbers expected in January 2016)

Key Documents*:*

State of Vermont Lead(s): Beth Tanzman

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

Anticipated Risks and Mitigation Strategy: None at this time.

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

Project Summary: This effort will 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 community. Some initial exploration has focused on the St. Johnsbury community, where leaders from across the health care continuum have expressed an interest in creating an Accountable Community for Health (ACH).

Project Timeline and Key Facts:

- Fall 2014 – Population Health Work Group expresses interest in establishing an ACH in Vermont.
- December 2014 – Prevention Institute is selected as vendor to begin research.
- June 2015 – Prevention Institute provides their findings to VHCIP.
- July 2015 – Accountable Health Communities working group begins meeting on a monthly basis.
- September 2015 – Recommended next steps are discussed by Population Health Work Group.
- October 2015 – Core Team approved next steps and budget for ACH Phase II.
- November and December 2015 – Continued work to develop ACH Phase II, called the ACH Peer Learning Lab, including an RFP for contractor support.

Status Update/Progress Toward Milestones and Goals:

- Contractor selected to engage in national research; contract executed. Findings delivered to VHCIP in June 2015.
- Identifying 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.
- Recommendations for next steps, developed to build upon the innovations being tested at the regional level in Vermont, were approved by the Core Team in October 2015.
- Development and planning for an ACH Peer Learning Lab for interested communities is in progress. An RFP to procure contractor support for the Learning Lab has been developed and will be released in early January. Recruitment will take place in January.

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.

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; TBD.
To view executed contracts, please visit the **VHCIP Contracts** page.

Anticipated Risks and Mitigation Strategy:

- Delayed contractor RFP release could delay full Peer Learning Lab launch.
    - Community recruitment will continue as planned, with a "soft launch" webinar to orient communities and ensuring momentum is maintained while contractor procurement is finalized.

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 Vermont 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.

Project Timeline and Key Facts:

- May 2015 – Enabling legislation passed in Vermont's legislature.
- June 2015 – Planning for Home Health PPS begins.

Status Update/Progress Toward Milestones and Goals:

- As a result of ongoing collaboration between DVHA and Vermont's home health agencies, there is presently consensus that the PPS will be comprised of episode-based payments (most likely 60 days in length, similar to Medicare) that will be adjusted for case acuity.
- DVHA has developed five acuity groupings and presented to the provider association for feedback. During recent meetings with the Home Health agencies, DVHA presented for discussion purposes several options for a quality-based component of the home health PPS, including metrics produced as part of the Consumer Assessment of Health Plans Survey (CAHPS) and specific measures based on actual claims experience.

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.

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*:*

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State of Vermont Lead(s): Aaron French

Contractors Supporting: N/A

Anticipated Risks and Mitigation Strategy: None at this time.

Focus Area: Payment Model Design and Implementation Project: Medicaid Value-Based Purchasing – Mental Health and Substance Use[1]
Project Summary: This new work stream initiates a feasibility assessment of current mental health and substance abuse spending within the Agency of Human Services and focuses primarily on the Designated Agency system of care. 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 – Leverage existing contracts to start feasibility study. • Winter/Spring/Summer2016 – TBD by leadership team. • December 2016 – Implementation plan for presentation and approval by AHS leadership.
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
Milestones*:* *Performance Period 1:* N/A *Performance Period 1 Carryover:* N/A *Performance Period 2:* N/A
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): Georgia Maheras
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 replaces a previous Performance Period 2 milestone in the Payment Model Design and Implementation area: Prospective Payment System – Designated Mental Health Agencies. Work in this area, and more significant updates to this Status Report, will ramp up in Performance Period 3.

Focus Area: Payment Model Design and Implementation

Project: All-Payer Model

Project Summary: Vermont is exploring an All-Payer Model to support and promote a more integrated system of care and a sustainable rate of overall health care cost growth. Consistent, value-based payments that are aligned across all payers will encourage collaboration among providers that results 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. The Next Generation ACO program is the model that the state will build on and apply 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:

- Current through December 31, 2015 – Align 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.
- Current through February 29, 2016 – Engage 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, rate-setting, and quality measurement methodologies. Begin implementation of functionality required to ensure operational readiness.
- March 15, 2016 – Sign agreement with CMS.
- March 15, 2016-January 1, 2017 – Continue implementation of APM.
- January 1, 2017 – Launch model.

Status Update/Progress Toward Milestones and Goals:

- Negotiations between CMMI and SOV continue.
- Progress in the negotiation includes Vermont sending CMMI draft proposals to be considered for inclusion in a term sheet between the State of Vermont and federal government on all potential term sheet elements: (1) performance period, (2) financial targets, (3) quality measures, (4) regulated services, (5) ACO milestones, (7) regulatory milestones, (8) potential waivers, and (9) structuring a pathway to align other services with the model over time.
- CMMI is leading a quality measure brainstorming session (12/23) to ensure Vermont and CMMI reach mutually agreeable, ambitious goals for quality measures within a transformative model. This follows a significant amount of quality-related work and discussion.
- The ACO Payment Sub Committee, a group of stakeholders convened by the GMCB and spanning a significant portion of the health care spectrum, completed a nine-month stakeholder process. The process produced several key documents, including a recommended framework to implement the all-payer model.
- The actuarial model to be used to evaluate all-payer model rate proposals and model performance made further progress. The actuaries for the project led a walk-through of the model with the negotiating team and key State staff.
- The negotiating teams for the all-payer model and the State's 1115 waiver, along with SIM leadership, traveled to Baltimore to meet with CMS staff. State and federal staff conducted meetings to ensure that everyone is on the same page regarding how to align these three projects and to test certain hypotheses. The meeting was very positive.

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.

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.

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:

- Term sheet 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 plans 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 submits State Plan Amendment to CMS for Year 1 SSP.
- July 2014 – Establish call center for Medicaid beneficiaries with queries or concerns specifically about the SSP.
- July 2014 – Establish 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 receives State Plan Amendment approval from CMS for Year 1 SSP.
- August 2015 – Vermont submits State Plan Amendment to CMS for Year 2 SSP.
- September 2015 – Vermont receives State Plan Amendment approval from CMS for Year 2 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.
- Draft of Year 3 SSP State Plan Amendment finalized for state public notice process.
- Draft of Year 1 EOC State Plan Amendment in development.
- Coordinating stakeholders to begin planning for expansion of Integrating Family Services program.

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.

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.