VHCIP Project Status Reports
Payment Model Design and Implementation Focus Area
February 2017

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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. 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 VMNG pilot year (see All-Payer Model status report). The commercial SSP continues with a fourth performance year in 2017.

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.
- June 2016 – Year 3 Medicaid SSP SPA approved by CMS.
- July-September 2016 – DVHA and GMCB staff worked with analytics contractor to prepare quality and financial performance data for Year 2. Preliminary results sent to ACOs/payers for data validation in September.
- October 2016 – Shared savings/quality performance calculations and results made available for Performance Year 2 of program. Results of SSP Year 2 results were presented to VHCIP stakeholders at work group meetings and webinars.
- 2017 – Pilot year of Vermont Medicaid Next Generation ACO Pilot Program; Year 4 of Commercial SSP.

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.
- In Performance Period 2, the project focused 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 targeted additional beneficiaries and focused on expanding the number of Vermonters served in this alternative payment model.
- The commercial SSP did not offer downside risk as originally proposed in Year 3.
- The Vermont Medicaid SSP concluded following the end of Year 3, and DVHA launched a risk-based Vermont Next Generation ACO Pilot Program in four communities for CY2017; the commercial SSP continues with a fourth performance year in CY2017.

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: 167,474 (as of December 2016)
 # Participating Providers: 1,007 (as of December 2016)

Key Documents:

- Shared Savings Program webpage
- Vermont Medicaid Shared Savings Program: Analyses of Utilization and Expenditure in the 2014 Performance Year
- Webinar: Vermont's Year 2 Medicaid and Commercial ACO Shared Savings Program Results

State of Vermont Lead(s): Amy Coonradt, Pat Jones

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: None at this time.

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

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 care for patients, improve the health of the overall population, and improve 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 – Blueprint model piloted 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.
- 2017 – MAPCP Demonstration ends; Blueprint practices, CHTs, and SASH teams will continue to receive Medicare funding through one-time funds included All-Payer Model agreement.

Status Update/Progress Toward Milestones and Goals:

- The Blueprint for Health engaged with its Executive Committee, DVHA and AHS leadership, and VHCIP stakeholders in 2015 to discuss modifications to both the Community Health Team (CHT) and Patient-Centered Medical Home (PCMH) payments. Modifications implemented 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 SFY 2016. Quality measures selected for the performance incentive payment are aligned with Medicaid and commercial SSPs measure sets.
- The Blueprint has reached a 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. In 2016, 6 new practices joined, and currently enrolled practices maintained participation. In 2017, it is anticipated that 8 more primary care practices will join the Blueprint.
- Since 2015, the Blueprint has been working to align efforts with ACOs. (See Regional Collaborations)
- 2016 Blueprint Community Health Teams convened local organizations to implement cross-organization care coordination strategies across the state. In 2017, CHTs will sustain and continue to expand the use of care coordination tools and to support ACO care coordination. (See Learning Collaboratives.)
- 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 Model agreement; after 2017, funding for the Blueprint will flow through the ACO as part of population-based payments.
- On January 1, 2017, fourteen women's health practices (OB/GYN, family planning and midwifery practices) began participating in the Blueprint Women's Health Initiative.

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: 307,658 (as of December 2016)

 # Participating Providers: 795 providers across 128 participating practices (as of December 2016)

Key Documents:

- Blueprint for Health Webpage

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: 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 program sits within the Blueprint for Health. 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 – Hub & Spoke implementation began across Vermont.
- 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 5,858 in January 2017.
- December 2015 baseline for providers prescribing to ≥10 patients included in Performance Period 3 milestone (below) includes duplicates where providers are prescribing in multiple regions; the de-duplicated count is 67.
- 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:* 67 *Note this figure is corrected from previous versions because the previous figure was not de-duplicated)
   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]

Additional Goals:
 # Lives Impacted: 5,858 (as of January 2017)
 # Participating Providers: 196 + 5 Hubs (as of January 2017)

Key Documents:
- Blueprint for Health Webpage

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 for individuals and community-wide prevention efforts to improve health outcomes within a geographic community. Phase I of this work (2015) focused on research to further define the Accountable Communities for Health (ACH) model and identify core elements. Phase II brought together multi-disciplinary teams from communities across the state in an Accountable Communities for Health Peer Learning Laboratory, which sought to support participating communities in increasing their capacity and readiness across the nine core elements of the ACH model. The Peer Learning Lab curriculum 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 from this project will document findings and lessons learned, and will include 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.
- January-February 2016 – ACH Peer Learning Laboratory soft launch; 10 communities from around Vermont were accepted for participation.
- May 2016 – ACH Peer Learning Laboratory Needs Assessment survey 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).
- March 2017 – ACH Peer Learning Laboratory final report expected.

Status Update/Progress Toward Milestones and Goals:

- 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. A kick-off webinar was held on June 1.
- Three in-person convenings with participating communities were held in June and September 2016, and January 2017. Local facilitation to support communities in developing ACH competencies also began in June and will continue through the conclusion of this phase of work in March 2017.
- Work with the Blueprint for Health, Accountable Care Organizations (ACOs), and other partners to identify opportunities to improve population health through better integration of clinical services, public health programs, and community based services at both the practice and the community levels is ongoing, as are efforts to incorporate Accountable Communities for Health into Vermont's SIM Sustainability Plan.

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
- Accountable Communities for Health Peer Learning Laboratory Recruitment Packet

State of Vermont Lead(s): Heidi Klein, Sarah Kinsler

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:

- Lack of coordination could result in siloed improvement initiatives across clinical care, social services, and primary prevention.
    - Key project staff and contractors are working with State and private sector leaders engaged in related initiatives, including the Integrated Communities Care Management Learning Collaborative and the Regional Collaborations, to ensure initiatives dovetail and develop a coordinated plan for sustainability that bridges all three of these levels.

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

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: All-Payer Model

Project Summary: The Vermont All-Payer ACO Model builds on existing all-payer payment models to better support and promote a more integrated system of care and a sustainable rate of overall health care cost growth in Vermont. Value-based payments that shift risk on to health care providers and that are aligned across all payers encourage 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) and facilitated by an All-Payer Accountable Care Organization Model Agreement with CMMI, the state can enable the alignment of commercial payers, Medicaid, and Medicare in an Advanced Alternative Payment Model. Specifically, the State will apply the Next Generation ACO payment model across all payers with modifications, with all-payer rates set by the GMCB to enable the model. 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 and All-Payer Model 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.

- 2015 – Achieved alignment with CMMI on term sheet 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 – 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 – Capacity building to prepare for implementation of an APM.
- April 15, 2016 – Reached consensus with CMMI on major elements requiring clearance.
- April-September 2016 – Continued to refine elements necessary for inclusion in an APM agreement.
- September 2016-October 2016 – Agreement with CMMI on APM agreement achieved. Draft agreement publicly released for comment, with GMCB holding meetings and joint public forums on this topic in October. Agreement document and aligned Medicaid 1115 waiver renewal signed at the end of October.
- January 1, 2017-December 31, 2017 – Pilot year for Vermont Medicaid Next Generation (VMNG) ACO program.
- September 2016-January 1, 2018 – Begin model and prepare for first year of financial and quality measure accountability.

Status Update/Progress Toward Milestones and Goals:

- Agreement with CMMI:
  - SOV proposed a term sheet to CMMI on January 25, 2016. The term sheet set 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 in January 2016, with public meetings at GMCB to discuss the proposed term sheet on January 28 and 29. The hearings were well attended by stakeholders. Concurrently, SOV staff testified before relevant legislative committees to explain the term sheet and prospective model to Vermont's policymakers.
  - Agreement on terms was reached in September 2016. Vermont distributed the draft agreement and companion documents to a broad group of stakeholders on September 28 and held a series of GMCB meetings and joint public forums with the Administration to explain the draft agreement and gather public comment in October. 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.
- Vermont Medicaid Next Generation ACO Program:
  - On April 7, the State's Medicaid agency published an RFP seeking a contract with a risk-bearing ACO that utilizes a Next Generation payment model in anticipation of the All-Payer Model. Four entities submitted letters of intent, with bids due in early June.
  - Vermont selected OneCare Vermont as the successful bidder. The State performed a readiness review in November-December, and a contract was signed in early February 2017 for a pilot performance period of calendar year 2017.

- In December 2016, Vermont Medicaid conducted a readiness review to ensure that OneCare Vermont was operationally capable of participating in a Medicaid version of the Next Generation ACO program. This included both several weeks of desk audits and a full week of in-person review. OneCare passed the readiness review, with 76% of items complete and a commitment to have 100% of items complete by the end of March 2017.
    - 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.
    - 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. This presages the type of review the GMCB will conduct during the performance years 1-5 of the All-Payer Model.
    - Staff are working to prepare Medicaid for the All-Payer Model in its role as a payer.
- ACO Merger:
    - 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 ACO ("Vermont Care Organization" (VCO)) by June 1, 2016; VCO will act as an umbrella organization that would create a unified structure to coordinate the work of Accountable Care Organizations in Vermont.
- All-Payer Model Implementation:
    - In May 2016, Governor Shumlin signed *An act relating to implementing an all-payer model and oversight of accountable care organizations* into law 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 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.
    - The Funding Opportunity Announcement for Start-Up Funding in Support of the Vermont All-Payer ACO Model Cooperative Agreement, worth up to $9.5 million, was released in late November 2016. The State submitted a non-competitive application for these funds in December 2016.
    - In November 2016, the Agency of Human Services released a process by which the State will accept provider applications for Delivery System Reform Investment funds, capacity for which was built into Vermont's renewed 1115 Medicaid Global Commitment Waiver. The State held an information session and released a webinar regarding this application process in December. The new Administration is reviewing the process by which these investments are made.
- Vermont submitted an application to the CPC+ program on June 8. Vermont submitted this application as a placeholder in case the All-Payer Model does not come to fruition. CMS denied this application on July 28.

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 agreement includes 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 also aims for maximum provider participation. 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 ~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 transition to a new federal Administration in January 2017 created risk.
  - The APM agreement was signed in October 2016. Since then, both the state and federal administrations have changed. In Vermont, the Administration has taken specific and timely steps toward implementation. Vermont will work with federal partners to ensure as seamless a transition as possible with respect to the All-Payer Model, acknowledging that some uncertainty is inevitable during this time.

Focus Area: Payment Model Design and Implementation Project: Medicaid Value-Based Purchasing (Medicaid Pathway – Mental Health/Substance Use)[1]
Project Summary: The Medicaid Pathway is a companion project to the All-Payer Model that seeks to accelerate 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 use disorder (SUD) services and others. This work stream has 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 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.
Project Timeline and Key Facts: • Fall 2015 – Leveraged existing contracts to start feasibility study. • December 2015 – Implementation plan for presentation and approval by AHS leadership. • January-March 2016 – Stakeholder group convened and identification of key project tasks completed. • March-June 2016 – Development of potential payment model and implementation plan with stakeholders. • July-December 2016 – Operational planning for new payment model with stakeholders. • January 2017 – Internal planning to refine project focus in line with State goals.
Status Update/Progress Toward Milestones and Goals: • Ongoing meetings with leadership from the Agency of Human Services and members of the provider community. • In September 2016, an Information Gathering Process was released to solicit feedback on proposed reforms. Four responses were received; and the State released a response to feedback in November 2016. • In November 2016, a survey was distributed to consumers and advocates; 17 responses were received. • In December 2016, legislative reports in accordance with Act 113, Sec. 11 and Act 113, Sec. 12 were submitted by the Agency of Human Services to the Senate Committee on Health and Welfare, the House Committee on Health Care, and the House Committee on Human Services.
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: • Information Gathering Process • Information Gathering Process Stakeholder Feedback and State Response – November 2016 • State of Vermont Goals: Medicaid Pathway – DAs, SSAs, and Preferred Providers – September 2016
State of Vermont Lead(s): Georgia Maheras, Selina Hickman
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: None at this time.

[1] This work stream consolidates milestones from two previous work streams: Prospective Payment System – Designated Mental Health Agencies and Medicaid Value-Based Purchasing – Mental Health and Substance Abuse.

Focus Area: Payment Model Design and Implementation
Project: Medicaid Value-Based Purchasing (Medicaid Pathway – LTSS/Choices for Care)

Project Summary: The Medicaid Pathway is a companion project to the All-Payer Model 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 use disorder services and others. This work stream focuses 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. Choices for Care 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." This project has explored value-based payment models to achieve these improvements. 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 – Sub-Group convened to research implementation of a St. Johnsbury pilot program.
- January 2016 – Proposed St. Johnsbury project plan presented to VHCIP leadership and stakeholders.
- February-March 2016 – Continued research and feasibility analyses for a potential St. Johnsbury pilot.
- May-December 2016 – LTSS/Choices for Care Medicaid Pathway Subgroup formed. Subgroup is working 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.
- January 2017 – Internal planning to refine project focus in line with State goals.

Status Update/Progress Toward Milestones and Goals:

- Intensive planning and stakeholder engagement began in June 2016.
- Research for one Vermont region, St. Johnsbury, was completed in March 2016.

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_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

Contractors Supporting: Bailit Health Purchasing, PHPG
To view executed contracts, please visit the **VHCIP Contracts** page.

Anticipated Risks and Mitigation Strategy:

- Changes to the CFC system may require legislative approval.

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's SIM-supported activities are in compliance with its Medicaid State Plan and its Medicaid 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.
- June 2016 – Vermont received State Plan Amendment approval from 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; the Year 3 SSP State Plan Amendment was approved in 2016.
- Beneficiary call-center is operational and will continue through program duration.
- ACO data sharing is ongoing.
- Frail Elders project recommendations presented to VHCIP work groups and Steering Committee in June 2016.

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: • Frail Elders Project Website
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.