

**Vermont State Innovation Models (SIM) Quarterly Report  
Year One Third Quarter Report to CMMI: April 1, 2014-June 30, 2014  
July 30, 2014****1 Overview****Overview of Quarter's Project Activities****Achievements on milestones/metrics compared to projected accountability targets and achievements on aims and primary drivers**

Vermont's SIM Project continues to make significant progress in the third quarter of year one. We achieved many of our intended goals for this quarter. We accelerated the implementation of our Medicaid and Commercial Shared Savings Accountable Care Organization Programs; committed to significant expansion in health data connectivity for designated mental health agencies, specialized service agencies and long term services and supports providers; and developed a process for defining the year two Shared Savings ACO Program measure set. Notably, Vermont hosted CMMI for a site visit in June 2014. The site visit provided Vermont with the chance to reflect on the year to date, note challenges and preview upcoming activities. Vermont continues to be on track to complete our Year One milestones.

The aims of Vermont's SIM Project are to improve care, improve health and reduce costs. The primary drivers to achieve those aims are:

- Improving care delivery models by enabling and rewarding integration and coordination,
- Improving the exchange and use of health information by developing a health information system that supports improved care and measurement of value, and
- Improving payment models by aligning financial incentives with the three aims.

Notable achievements from April-June 2014 include:

- Vermont's SIM project approved a Health Information Exchange (HIE) investment that is intended to expand the quality and connectivity of designated mental health and specialized service agencies, identify gaps in electronic data transmission for providers delivering long term services and supports and planning for the development of a uniform transfer protocol to improve transitions of care. This investment complements the earlier investment in the HIE infrastructure for ACOs and their provider networks.
- Vermont's Payment Models Work Group continued development of its second model for testing: Episodes of Care. This included developing criteria for this program.
- Vermont's Quality and Performance Measures Work Group developed a process and criteria for defining the year two Shared Savings ACO Program measure set. This work

group received input from the Population Health Work Group, the DLTSS Work Group and several stakeholders as part of their work.

- The Care Models and Care Management Work Group began defining Care Management Standards for the Shared Savings ACO Programs.
- The Workforce Work Group began designing scopes of work for workforce demand modeling.
- Vermont’s SIM project made significant progress on the Risk Mitigation Plan.
- Vermont’s SIM team convened three meetings each of its Payment Models, Quality and Performance Measures, Care Models and Care Management, Disability and Long Term Services and Supports, Population Health, Workforce and HIE/HIT Work Groups. Each of these work groups made significant progress on their work plans for year one including providing input into other work groups activities. The Steering Committee also met three times and the Core Team met three times.

**Staffing by Type and Number of FTEs:**

<b>Recruitment:</b>			
<b>VHCIP includes 25 funded positions, of which 18 are filled and 7 are vacant. Of those, 2.25 of the positions are at the Green Mountain Care Board, 2 are at the Department of Aging and Independent Living, 3 are at the Agency of Human Services Central Office, 16.25 are at the Department of Vermont Health Access, and 1.5 is at the Agency of Administration. Below please find a list of filled and vacant positions:</b>			
<b>Agency</b>	<b>Employee Name</b>	<b>Position Title</b>	<b>% dedicated to the project</b>
<b>AHS</b>	Diane Cummings	Fiscal Manager: Financial Manager II	100%
<b>AHS</b>	Julie Wasserman	Program Manager for Duals: Duals Director	100%
<b>AOA</b>	Georgia Maheras	Project Director	100%
<b>DAIL</b>	Jennifer Woodard	Payment Program Manager: Health Policy Analyst	100%
<b>DVHA</b>	Alicia Cooper	Payment Program Manager: Quality Oversight Analyst	100%
<b>DVHA</b>	Erin Flynn	Quality Monitoring & Evaluation: Senior Policy Advisor	100%
<b>DVHA</b>	Amy Coonradt	Payment and Policy	100%

		Specialist: Health Policy Analyst	
<b>DVHA</b>	Kara Suter	Payment Reform Director	25%
<b>DVHA</b>	Amanda Ciecior	Service Delivery Analyst: Health Policy Analyst	100%
<b>DVHA</b>	Luann Poirier	Service Delivery Specialist: Administrative Services Manager I	100%
<b>DVHA</b>	Jessica Mendizabal	Fiscal Manager: Contract and Grant Administrator	100%
<b>DVHA</b>	Bradley Wilhelm	Quality Monitoring & Evaluation: Senior Policy Advisor	100%
<b>DVHA</b>	Cecelia Wu	Payment Initiative Director, Shared Savings	100%
<b>DVHA</b>	James Westrich	Quality Monitoring & Evaluation: Senior Policy Advisor	100%
<b>DVHA</b>	William 'Joe' Hicks	Medical Data Analyst: Quality Oversight Analyst	100%
<b>GMCB</b>	Annie Paumgarten	Evaluation Director	100%
<b>GMCB</b>	Christine Geiler	Grant Program Manager: Grant Manager Coordinator	100%
<b>GMCB</b>	Richard Slusky	Payment Reform Director	25%
<b>AHS IFS</b>	Carolynn Hatin	Medicaid Data Analyst: Business Administrator	100%
<b>AOA</b>	Recruiting at AOA	Workforce Work Group Manager	50%
<b>DAIL</b>	Recruiting at DAIL	Payment Program Manager	100%
<b>DVHA</b>	Recruiting at DVHA	Payment Initiative Director, Payment Pilots	100%

<b>DVHA</b>	Recruiting at DVHA	Payment Program Manager: Policy and Planning Chief	100%
<b>DVHA</b>	Recruiting at DVHA	Medicaid Data Analyst: Health Care Statistical Information Administrator	100%
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**Status of Medicaid waivers/SPAs, if applicable**

The State Plan Amendment (SPA) for the Vermont Medicaid Shared Savings Program was submitted to CMS on February 27<sup>th</sup>, 2014, and the informal review process commenced on April 15<sup>th</sup>, 2014 with a kick-off call with CMS. Vermont’s SIM team at DVHA worked with CMS to answer questions and to provide additional information about the SPA between April and May. On May 28<sup>th</sup>, CMS sent DVHA a formal Request for Additional Information (RAI) and provided 90 days to complete and return the RAI and the revised SPA. The SIM DVHA team is currently compiling answers for the RAI and revising the SPA. We believe we are on track to complete them by August 28<sup>th</sup>. We anticipate another series of phone calls to discuss the answers to the RAIs, resolve any outstanding issues and would expect approval thereafter.

**2 Accomplishments**

**Year One Planned Activities:**

Vermont’s Operational Plan supplemental documents submitted on September 27, 2013 included a list of milestones and metrics. The milestones are divided into several categories: Advanced Analytics, Evaluation (External), Evaluation (Internal), Initiative Support, State Staff Training and Development, Model Testing, and Technology and Infrastructure. These are addressed below:

**Advanced Analytics**

1. *Procure contractor for internal Medicaid modeling:* Vermont’s Department of Vermont Health Access executed a contract in the second quarter.

2. *Procure contractor for additional data analytics:* In order to support its oversight role, the Green Mountain Care Board (GMCB), in coordination with the Department of Vermont Health Access (DVHA), issued a Request for Proposals (RFP) seeking an independent, third-party contractor to assume responsibility for statewide analytics activities related to the implementation, monitoring, reporting, and evaluation of the Vermont Health Care Innovation Project (VHCIP) Commercial and Medicaid Shared Savings ACO programs. The required tasks of the Analytics Contractor include the following:
  - a. Calculation of ACO Financial Performance and Calculation of the Distribution of Earned Savings Payments;
  - b. Calculation of ACO Performance Measures;
  - c. Calculation of the Impact of ACO Quality Performance on the Distribution of Shared Savings; and
  - d. Report Design and Generation.

The RFP is available here:

[http://gmcboard.vermont.gov/sites/gmcboard/files/Analytics\\_RFP\\_%20201401714.pdf](http://gmcboard.vermont.gov/sites/gmcboard/files/Analytics_RFP_%20201401714.pdf).

Bids from seven vendors were received and reviewed by a multi-agency review team that also included payer and ACO representatives. A vendor was selected in March 2014, negotiations were completed in June 2014, and we anticipate the contract will be executed in July 2014. A kickoff meeting with the vendor was held on July 15, 2015.

3. *Define Analyses:* Vermont's SIM project has designed several analyses for the Commercial and Medicaid Shared Savings ACO Programs and has several more in the Analytics Contract discussed above. The analyses include attribution reports; claims extracts; summary statistics for attributed populations; analysis of the difference between core and non-core costs; calculation of utilization metrics; calculation of performance measures; and calculation of shared savings.
  - a. Attribution Reports: The Department of Vermont Health Access (DVHA) has developed attribution reporting tools for the Vermont Medicaid Shared Savings Program. Both ACOs who have signed contracts with the State and submitted provider rosters to DVHA in April 2014. These provider roster reports included information on both attributing and non-attributing ACO participants, provider/suppliers, and other entities. Based on these provider rosters, DVHA developed attribution reports which were first transmitted to both ACOs in June 2014, and will be updated on a monthly basis to reflect changes in the attributed population over time. This report is shared as a data file, including a list of patients that are attributed to a particular ACO, their mailing address, and the PCP through whom they were attributed to the ACO. The attribution reports allow the ACOs to notify newly attributed beneficiaries of their inclusion in the ACO's attributed population and their

right to opt-out of claims data sharing between DVHA and the ACO. The commercial carriers are also working on attribution reports, but due to PCP identification challenges with the commercial program, this activity will occur later in year one.

- b. Claims extracts: The claims extracts will follow the VHCURES data submission format and will include three separate files: the enrollment file, the medical claims file, and the pharmacy claims file. Furthermore, DVHA will be adding additional Medicaid-specific variables as follows (specifications for these variables are being finalized): HCC risk score, new attribution flag, attributed in which step (specific to Medicaid attribution process), months enrolled in Medicaid, Medicaid eligibility category, attributing provider ID, above 99<sup>th</sup> percent flag. New claims extracts will be provided on a monthly basis. The initial Medicaid files will be shared with the ACOs after the beneficiary notification and opt-out process is complete (in August or September 2014), and will include 12 months of incurred claims for attributed enrollees. Every month thereafter the file will contain claims paid in the past month for currently attributed enrollees, and claims paid in the past 12 months for newly attributed enrollees. The commercial files will be shared in early fall as well.
  
- c. Summary Statistics for attributed populations: DVHA has developed a number of analyses to better describe the attributed populations of both ACOs. Initial analyses include breakdowns of the attributed populations by gender, age, eligibility category, hospital service area, and HCC risk score, and examine utilization across a variety of settings. Vermont's commercial payers are also exploring their data and designing programs related to attributed populations. DVHA and the Commercial payers are working together to ensure as much consistency as possible with these reports between programs.
  
- d. Analysis of the difference between core and non-core services: DVHA is currently exploring data and designing programs to better understand the attributed populations of both ACOs. As part of the VMSSP, DVHA will assess expansion of year one total cost of care (TCOC) calculation to include the cost of a broader set of Medicaid services. To support this effort, DVHA's is currently working with their consultant (Burns and Associates) to design analysis that will inform decisions at the Payment Models Work Group, Steering Committee and Core Team for year two TCOC expansion due to ACOs in October 2014.

4. *Consult with Payment Models and DLTSS<sup>1</sup> Work Groups on definition of analyses:* Vermont consulted with the Payment Models Work Group on the Shared Savings ACO Program Analyses and on the scope of work for the Analytics Contractor RFP. The Disability and Long Term Services and Supports (DLTSS) Work Group began discussing analyses in December 2013 and will continue the discussion through the rest of Year One.

The DLTSS Work Group is exploring options for further integration of DLTSS related expenditures into the ACO Shared Savings program model. According to the Medicaid Shared Savings ACO Program (VMSSP) contracts, DVHA must notify ACOs of the non-core expenditures included in year two of the VMSSP (optional) and year three (mandatory) by October 1<sup>st</sup>, 2014. In addition to exploring additional expenditures for inclusion in the financial analysis of the VMSSP, the DLTSS work group has also made recommendations to the Quality and Performance Measures Work Group regarding the addition of DLTSS specific measures in performance year two of the VMSSP. These recommendations are currently under consideration; a final decision about Year 2 measure changes is expected to be complete in October 2014.

5. *Perform analyses, Procure contractor, Develop financial baselines and Develop trend models:* Vermont will procure several contractors to develop financial baselines and trends in Year One. The GRCB released the RFP and will execute the first contract, which will provide financial baselines and trend models for the Medicaid and Commercial Shared Savings ACO Programs as described above. Vermont will procure other contractors as the Episode of Care and Pay-for-Performance Programs are launched in Year One. These subsequent contracts will be executed through DVHA.

The Department of Vermont Health Access (DVHA) is currently under contract with Burns and Associates and has developed several of the initial reports related to the VMSSP including attribution reports, expenditures analysis, and financial baseline and trend modeling. DVHA will continue to work with Burns and Associates to transfer any relevant reporting functions to the State-wide analytics contractor once a vendor has been selected and is fully functioning.

The Payment Models Work Group is leveraging an existing contract with Truven Analytics, held by the GRCB, and its subcontractor Brandeis University. These consultants are currently working with Vermont's SIM staff and work group members to further explore the possible models and necessary decision points that the work group must make as they work to design an Episodes of Care (EOC) pilot in Vermont. As a first deliverable, Brandeis is preparing a statewide (commercial and Medicaid) data analysis using the PROMETHEUS payment model. Descriptive statistics will include total and

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<sup>1</sup> In conformance with the new work group name, this report refers to the Disability and Long Term Services and Supports (DLTSS) Work Group, rather than the Duals Work Group.

average cost of the 25 EOCs as well as potentially avoidable complication rates. These data will be presented at the August 2, 2014 Payment Models Work Group meeting to inform recommendations on EOC priorities.

6. *Consult with Payment Models and Duals Work Groups on financial model design:* The Payment Models Work Group provided information on the Shared Savings ACO Program to the DLTSS Work Group during this quarter. The DLTSS Work Group will look more closely at this model in upcoming quarters.
7. *Produce quarterly and year-end reports for Commercial and Medicaid Shared Savings ACO program participants and payers:* These reports will be generated by the Analytics Contractor, who began work in July 2014. Vermont's SIM project has established criteria for quarterly and annual reports and plans to work closely with the Analytics Contractor to ensure accurate compliance with report requirements.

#### **Evaluation (External and Internal)<sup>2</sup>**

1. *Procure External Evaluation Contractor:* Vermont, through the GMCB, has selected a Self-Evaluation vendor and is in the contract negotiation process with that vendor.
2. *Develop Self-Evaluation Plan:* Due to the contracting challenges, Vermont's Self-Evaluation Plan is delayed. This should be completed within Year One.
3. *Consult with Performance Measures Work Group:* The draft Self-Evaluation Plan will be shared with each of Vermont's Work Groups in the late 2014. A status report on the external evaluation will be shared with the Quality and Performance Measures Work Group for input during its December 2014 meeting.
4. *Input baseline data:* The baseline data will be identified upon contract execution.
5. *Hire Staff:* The Evaluation Director was hired in the second quarter. A University of Vermont graduate student will serve as an intern to the Evaluation Director for the 2014/2015 academic year.

#### **Initiative Support**

1. *Procure contractor for interagency coordination, Develop interagency and inter-project communications plan, and Implement the plan:* Vermont's Agency of Administration plans to release an RFP for this work in the third quarter.

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<sup>2</sup> Vermont is consolidating these two categories for ease of reporting.

## State Staff Training and Development

1. *Hire Contractor and Develop Curriculum:* Vermont's Core Team approved a contract for this work in May 2014. Vermont's DVHA will execute this agreement in the fourth quarter of Year One.

## Model Testing

1. *Develop ACO Model Standards:* Vermont continues to implement the Medicaid and Commercial Shared Savings ACO Programs. GMCB and DVHA participate in operational discussions with representatives of ACOs, payers, and providers. These programs are being carefully monitored for quality and access to ensure that these programs meet their intended purpose of benefitting Vermont consumers.

Approved program standards relate to:

- The ACO's structure:
  - Financial stability.
  - Risk mitigation.
  - Patient freedom of choice.
  - ACO governance.
- The ACO's payment methodology:
  - Patient attribution methodology.
  - Calculation of ACO financial performance and distribution of shared savings payments.
- Management of the ACO:
  - Payment alignment.
  - Data use.

Care Management Standards are under development by the Care Models and Care Management Work Group. As a starting point, the group has been reviewing the NCQA ACO standards that relate to care management activities at the ACO level. Moreover, in order to address identified gaps in those standards, the work group members have been making suggestions for additional standards. These include suggestions relating to disability and long term services and supports and collaboration throughout the care management infrastructure in order to avoid duplication.

The following sets of measures have been approved to evaluate the performance of Vermont's ACOs, to ensure quality of care for consumers, and to implement a measures scoring process to determine how ACO performance influences the amount of savings distributed to the ACO:

- Measures for payment; how the ACO performs on the measure impacts the amount of shared savings that the ACO receives.

- Measures for reporting; ACOs are required to report on these measures but their performance will not impact the amount of shared savings that they receive.
- Measures for monitoring and evaluation, including key utilization indicators and other statewide quality measures.
- Pending measures for future consideration.

The Quality and Performance Measures (QPM) Work Group has already begun reviewing measures for Year 2 (Calendar Year 2015) of the Shared Savings ACO Programs. Several entities, including the Population Health Work Group, the DLTSS Work Group, the Office of the Health Care Advocate at Vermont Legal Aid (representing consumers) and designated mental health agencies, have proposed Year 2 measures. The QPM Work Group plans to adopt final Year 2 measure recommendations by August 2014. The recommendations will then be considered by the Steering Committee, Core Team, and Green Mountain Care Board for final adoption.

Vermont continues to address the many details and complexities involved in implementing the Commercial and Medicaid Shared Savings Programs, and will insure that these Standards and Performance Measures are being adhered to by the ACOs participating in the Shared Savings Programs. This will involve the work of the Analytics Contractor and the oversight role of the GMCB and DVHA.

Regarding Performance Measures, the HIE infrastructure investment is intended to support reporting of these measures by the ACOs; this support will not be in place until Year 2 of the project at the earliest. For Year 1, the ACOs have requested financial support for manual reviews needed to extract clinical data for those measures that require such data; the Core Team is currently considering this request.

Examples of Standards and Performance Measures implementation guidance provided to ACOs and payers include:

- Reporting templates and timelines for ACO provider rosters,
- Reporting templates and timelines for payer lists of attributed patients and high risk patients,
- Reporting templates and timelines for measures, and
- Detailed measure specifications.

2. *Execute Medicaid Shared Savings ACO Program Contracts:* Vermont Medicaid negotiated contracts with two ACOs for a performance year January 1, 2014-December 31, 2014. Vermont Medicaid Shared Savings Program contracts were signed in March 2014 with OneCare Vermont (OCV) and Community Health Accountable Care (CHAC). ACOs have distributed Participation Agreements to their network providers. Appendix A includes a chart of ACOs and their network providers.

3. *Execute Commercial Shared Savings ACO Program Contracts:* ACOs and Commercial Payers have executed Commercial Shared Savings ACO Program Agreements. All three ACOs executed Program Agreements with Blue Cross Blue Shield. MVP Health Care (the other commercial payer that was planning to participate in the Commercial Shared Savings Program) does not appear to have sufficient enrollment with any of the ACOs to participate. ACOs have distributed Participation Agreements to their network providers. A summary of provider types and numbers can be found in Appendix A.
  
4. *Develop standards for bundled and episode-based payments:* The Episodes of Care model is being discussed by the Payment Models Work Group. The Work Group is also considering the creation of a RFI around provider interest and current understanding of the EOC model in the state. At the June meeting of the Payment Models Work Group (PMWG) a presentation was given by François de Brantes, of the Health Care Incentives Improvement Institute to learn about current initiatives and the challenges others are facing using the Episodes of Care model. Additionally, at the July meeting, a presentation was given to refresh workgroup members of the goal to integrate care in the state and what that might look like in the future with new payment models in place. As a first deliverable, Brandeis is preparing a statewide (commercial and Medicaid) data analysis using the PROMETHEUS payment model. Descriptive statistics will include total and average cost of the 25 EOCs as well as potentially avoidable complication rates. This data will be presented in the August 2, 2014 PMWG to inform recommendations on EOC priorities.
  
5. *Execute contracts for bundled and episode-based payments:* The Payment Models Work Group leveraged an existing state contract to support the development of Episodes of Care model. Truven Health Analytics began work in February 2014.
  
6. *Develop a Medicaid value-based purchasing plan addressing pay-for-performance initiatives:* Primary care Pay-for-Performance (P4P) remains the focus of VT Medicaid's P4P activities during this quarter. In the July PMWG, as well as in other multi-stakeholder advisory groups, discussions about the integration, continued support and growth of Medicaid's participation in the Blueprint for Health will occur. Recommendations in support of an October report to the legislature are expected by the end of the Summer. Other individual or practice-targeted P4P activities are under discussion although no formal recommendations have been made. The PMWG will continue to develop state-wide recommendations on P4P programs across all payers in the state.

Vermont's DVHA is in the process of executing a contract to evaluate Medicaid special programs against value-based criteria. This contract is expected to be executed in July 2014. The deliverable will include an evaluation of value-based design in current programs along with recommendations for strengthening those programs in the future.

7. *Procure learning collaborative and provider technical assistance contractor:* Learning collaboratives are under development for Vermont's payment models. Vermont's three ACOs have been working with representatives from the state's Multi-payer Advanced Primary Care Practice demonstration project and Medicaid's Vermont Chronic Care Initiative to determine how best to collaborate and provide integrated care management for high risk patients. A proposal to establish and test "Integrated Communities" in three health service areas and to develop tools and training to assist care managers in those communities will be presented to the Care Models and Care Management Work Group in July 2014. The Work Group will decide whether or not to recommend funding of the proposal, which would build in-state capacity for ongoing supported delivery system transformation through contracts with two full-time community facilitators (one facilitator would be focused on design and implementation of transformational learning collaboratives, and the other would be focused on understanding and using data to support transformation).
  
8. Establish learning collaboratives for providers engaged in each of the testing models: As noted above, Vermont's three ACOs are working with representatives from the state's Multi-payer Advanced Primary Care Practice demonstration project and Medicaid's Vermont Chronic Care Initiative to determine how best to collaborate and provide integrated care management for high risk patients. This working group presented a conceptual outline of a proposed learning collaborative to the Care Models and Care Management Work Group at its March meeting, and a more detailed and refined proposal will be presented at the July meeting. The group also has reviewed data (statewide, and from three particular geographic areas) to identify high risk conditions and/or at risk populations. A proposed learning collaborative that would convene clusters of providers (e.g., hospital, home health, primary care, specialty care) to share data, identify best practices, and identify improvement opportunities for episodes of care will be presented to the Care Models and Care Management and Payment Models Work Groups by September 2014. That collaborative will be geared toward the episodes of care model. The goal is to hold the first meeting of the episodes of care payment model learning collaborative by December 2014.

In June 2014, the Care Models and Care Management Work Group provided guidance to the Core Team to inform decision-making in the next round of the sub-grant program. The Work Group requested that the Core Team consider the following two priorities during the second round of the sub-grant program:

- In order to better serve all Vermonters (especially those with complex physical and/or mental health needs), applications should aim to reduce fragmentation

with better coordination of provider/CHT/health plan and other care management activities. Focus on improving transitions of care and communications between providers and care managers that offer services throughout the various domains of a person's life.

- Better integrate social services (e.g., housing, food, fuel, education, transportation) and health care services in order to more effectively understand and address social determinants of health (e.g., lack of housing, food insecurity, loss of income, trauma) for high-risk Vermonters.

9. *Develop technical assistance program for providers implementing payment reforms:* Vermont SIM project launched the technical assistance program as a component of the VHCIP Sub-Grant Program. The Sub-Grant Program was submitted to CMMI in December 2013 with the technical assistance program a key feature. Vermont's SIM project selected five technical assistance vendors to perform this work and is in final contract negotiations with each of them. We expect these contractors to begin work in the third quarter. The technical assistance contractors will work with the State and the seven<sup>3</sup> sub-grant program awardees to define projects that maximize the success of the sub-grantee.
10. *Number of providers participating in one or more testing models (goal = 2000):* As of June 15, 2014, there are 816 attributing providers (primary care) and approximately 6,000 non-attributing providers (all other providers) participating in the Medicaid Shared Savings Program ACOs (OneCare Vermont and Community Health Accountable Care). Given the attribution challenges in the commercial Shared Savings ACO Program, we will have the commercial numbers in the next quarterly report.
11. *Number of Blueprint practice providers participating in one or more testing models (goal = 500):* Through June 2014, 635 unique providers in 121 PCMHs are electronically sharing care summaries with other providers, in the form of ambulatory CCDs directed to the Blueprint Repository where they can be accessed. 121 Practices are participating. These practices and providers cover 504,478<sup>4</sup> people representing 80% of Vermont's population.

## **Technology and Infrastructure**

1. *Provide input to update of state HIT plan:* A revised project plan has recently been approved for the development of a new Vermont Health Information Strategic Plan, which will include an updated State HIT Plan. The project has kicked off with initial input from the SIM HIE Work Group in June 2014. Vermont's SIM project is recognizing the primacy of information in the health care reform equation and will be calling its next plan the Vermont Health Information Strategic Plan (VHISP). There will still be an HIT

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<sup>3</sup> Vermont's SIM project awarded 8 sub-grants in April 2014. Since that award, one of the recipients has decided not to accept the award.

<sup>4</sup> This number is lower than in our previous reports because the Blueprint for Health is transitioning to a new methodology for counting people in PCMH's.

plan, but the HIT planning component is a subset of the VHISP, as information derives from data, and data is generated and transported through the components of HIT and HIE. The HIE/HIT Work Group will have an active role in reviewing the HIT Plan. The current goal is to have a first draft of the entire plan by December 31, 2014. Work will continue in 2015 to finalize the VHISP.

2. *Expand provider connection to HIE infrastructure:* Significant progress occurred in 2014 with provider connection to the HIE infrastructure. 78% of hospitals have live interfaces for: ADT (admission/discharge/transfer); laboratory results; radiology reports; transcribed reports; medication history; and pathology reports. Physician practices have 149 interfaces to the HIE for some combination of: ADT (admission/discharge/transfer); clinical summaries, laboratory results; radiology reports; transcribed reports; medication history; pathology reports, and immunizations as well. There are a total of 315 interfaces to non-hospital health care organizations. For Home Health Agencies: 4 (44%) home health agencies have ADT (admission/discharge/transfer) interfaces, and 1 home health agency is sending clinical summaries. For Mental Health Designated Agencies: 4 (40%) designated agencies are receiving lab results.
3. *Identify necessary enhancements to centralized clinical registry & reporting systems:* Vermont's SIM Project is currently reviewing options for how best to continue to provide registry and reporting analytic services.
4. *Procure contractor to develop initial use cases for the integrated platform and reporting system:* Vermont's SIM Project is currently working on use case identification and development and should complete the scope of this project for this project by the end of Year One.
5. *Design the technical use cases and determine the component of the integrated platform that is required to implement these use cases:* Vermont's SIM Project is currently working on use case identification and development and should complete the scope of this project for this project by the end of Year One.
6. *Develop criteria for telemedicine sub-grants:* Vermont's SIM Project has not yet developed these criteria. The HIT/HIE Work Group will develop these criteria in summer 2014.
7. *Expand the scope of VHCURES to support the integration of both claims and clinical data and provide this capability to ACOs/providers and potentially payers:* The GMCB released an RFP on May 28, 2014 to procure a vendor to improve the state's multi-payer

claims database, the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). The RFP seeks a vendor to provide:

- Services to collect personally identifiable information from payers and create a secure Master Person Index (MPI).
- Data consolidation services and development of a data warehouse
- Hosting services for the data warehouse.
- Web-enabled analytic and reporting solutions that interface with the data warehouse.

8. *Begin to incorporate long term care, mental health, home care and specialist providers into the HIE infrastructure:* The State of Vermont has a contract with VITL, the state’s HIE contractor, to begin to incorporate these providers into the HIE infrastructure. Some SIM funds are being used for this purpose in Year One.

The HIT/HIE Work Group has made some recommendations regarding incorporating these providers into the HIE infrastructure. The work group recommended for approval a significant proposal for investment in expansion of connectivity of disability, mental health and long term services and supports providers. This proposal was approved by the Steering Committee and Core Team. Vermont’s SIM project has begun executing several contracts as a result of this proposal. There are three major scopes of work:

- Project 1: Data gathering, data quality & remediation for Designated Agencies and Specialized Service Agencies. This project has two phases – a planning and an implementation phase.
- Project 2: Planning for Long Term Services and Supports Data Reporting and Provider IT Gap Analyses.
- Project 3: Universal Transfer Form Protocol Planning.

**Table 1: April-June 2014 Aims and Drivers Accomplishments**

Aims and primary drivers	Secondary drivers	Accomplishments during January-March 2014 and current status of SIM aims and primary drivers
VT Aims=Improve Care, Improve Health, and Reduce Costs  Primary Driver #1: Improve care delivery models: enable and reward integration and coordination	Support the development of provider networks that coordinate preventive and acute health services across all sectors	Program agreements for Vermont’s Commercial Shared Savings Program were executed between Blue Cross Blue Shield of Vermont and the state’s three ACOs in March 2014, retroactive to January 1, 2014. Contracts for the Medicaid Shared Savings Program were executed with the two participating ACOs, also in March, retroactive to January. Participation agreements between providers and the

		<p>ACOs were finalized by March 31, 2014; ACOs submitted provider rosters that reflected their networks to the payers during the April-June quarter, and initial attribution occurred. A summary of provider types and numbers in each ACO's network can be found in Appendix A. A summary of attribution numbers by ACO and by Shared Savings Program can also be found in Appendix A.</p>
	<p>Develop workforce planning that supports the needs of community networks</p>	<p>The Workforce Work Group began developing these plans at its November meeting. The work group commissioned additional data analyses to support their planning. This work group also established a subcommittee to look at the long term care workforce and this subcommittee has met monthly during this quarter.</p>
	<p>Coordinate care process redesign and care management programs to maximize best practices and reduce duplication of effort or expense</p>	<p>The Care Models and Care Management Work Group developed and conducted an on-line Care Management Inventory Survey to collect structured data on existing care management activities. The survey instrument can be found in Appendix B; it includes questions about staffing, number of people served, financing, interactions with other programs, and challenges. The results will augment written narrative and verbal presentations provided at Care Models and Care Management Work Group in-person meetings and webinars. In addition to analyzing the supply of care management activities, the work group is evaluating the demand for care management activities by reviewing information from the Vermont Department of Health, the Population Health Work Group, and other stakeholders. From that discussion, the Work Group has developed a Problem Statement and Priorities (see Appendices C and D). The Learning Collaborative that will be recommended for funding by the Work Group is intended to address the Problem Statement and Priorities. Looking ahead, the DLTSS Work Group will be</p>

		presenting a proposed model of care in August for the CCM Work Group’s consideration.
	Expand the use of telemedicine to support appropriate resource use and access to care	The HIE/HIT Work Group has been fielding inquiries and obtaining input from interested parties in anticipation of developing Telemedicine, Telehealth and Telemonitoring funding criteria. The Work Group began the criteria building discussion in June 2014 and will continue the conversation in August and September.
<p>VT Aims=Improve Care, Improve Health, and Reduce Costs</p> <p>Primary Driver #2: Improve exchange and use of health information: develop a health information system that supports improved care and measurement of value</p>	Guide expansion of electronic health records to providers of long-term services and supports	<p>The SIM grant is accelerating the expansion of EHRs; this expansion will be ongoing and continuous over the period of the grant. The HIE/HIT Work Group recommended funding for a proposal entitled “The Advancing Care Through Technology Project” (ACTT), which will enable designated mental health and specialized service agencies and long term service and support providers to achieve population health goals through the use of technology. ACTT proposes to improve health care in Vermont through 3 projects (<i>in no particular order or priority</i>):</p> <ol style="list-style-type: none"> <li>1. Data gathering, data quality &amp; remediation for Designated Agencies and Specialized Service Agencies. This project has two phases – a planning and an implementation phase.</li> <li>2. Planning for Long Term Services and Supports Data Reporting and Provider IT Gap Analyses.</li> <li>3. Universal Transfer Form Protocol Planning. This proposal was reviewed by the Steering Committee and approved by the Core Team in April 2014.</li> </ol>
	Invest in enhancements to EHRs and other technology that supports integration of services and enhanced communication	<p>The SIM grant is accelerating enhancement of EHRs and other technology to support integration of services and enhanced communication. This work will be ongoing and continuous over the period of the grant.</p> <ol style="list-style-type: none"> <li>1. VITL is working with a variety of provider organizations (e.g., hospitals,</li> </ol>

		<p>practices, home health agencies, designated mental health agencies) to improve EHR functionality, integration of services, and communication.</p> <ol style="list-style-type: none"> <li>2. SIM funding was approved for the Population-Based Collaborative HIE Project, to develop and implement a population-based infrastructure to better inform clinical decision making at the point of care, and to use clinical data for analytics and population health data management. The intent is to build a common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients among organizations providing care. This project is now in the implementation phase.</li> <li>3. The ACTT proposal discussed above includes significant investments in integration of EHRs.</li> </ol>
	<p>Enhance connectivity and data transmission from source systems including EHRs</p>	<p>The SIM grant is accelerating enhancement of connectivity and data transmission. This work will be ongoing and continuous over the period of the grant.</p> <ol style="list-style-type: none"> <li>1. Vermont’s Blueprint for Health, VITL, the DocSite clinical registry contractor, EHR vendors, and practice staff have been working together to enhance practice connectivity to the clinical registry and/or Vermont’s HIE.</li> <li>2. The same group has been working to improve the quality of data being transmitted to the clinical registry and Vermont’s HIE.</li> <li>3. VITL continues to work with the state’s hospitals, practices and other providers to enhance connectivity and improve data transmission.</li> </ol>
	<p>Enhance data repository and data integration platform</p>	<p>Vermont’s goal is to create data repositories that can be accessed by multiple users for various purposes. The SIM grant is helping to accelerate this effort.</p> <ol style="list-style-type: none"> <li>1. One example involves Patient</li> </ol>

		<p>Experience Surveys. During the last quarter of 2013, a scope of work was developed and an RFP was issued to procure a vendor to field the Patient Centered Medical Home CAHPS Patient Experience Surveys (with some custom questions related to chronic illness and specialty care) to primary care practices engaged in the Blueprint for Health. These surveys will also be used to evaluate patient experience with ACOs, by flagging ACO-attributed members, and the data could potentially be made available for other users and purposes. A vendor has been selected and the contract is in the final stages of approval. The intent is to field the survey to the first wave of practices during August of 2014.</p> <p>2. Additional uses and access are envisioned for Vermont’s multi-payer claims database (VHCURES). Data in VHCURES is currently de-identified. The state has issued an RFP to enhance VHCURES by improving data warehouse and data aggregation capability, allowing data from different sources to be merged on a person-level basis, and by creating an analytics platform. Identified data would never be released, but it could be flagged for various analytic purposes and then released in a de-identified manner to be analyzed. Proposals for this very complex procurement will be received in early August, and vendor demonstrations and selection are expected to occur in the fall.</p> <p>3. Procurement is also underway for a clinical registry contractor. The clinical registry can provide actionable clinical data for providers and to the VHIE. The HIE Work Group is currently working on use case development to inform the scope of work for this project. The Work Group anticipates</p>
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		<p>completing the scope of work and posting an RFP in late fall 2014.</p>
	<p>Develop advanced analytics and reporting system; enhance a statewide learning health system that provides reporting and analytics to support provider networks</p>	<p>Improvements in Vermont’s HIE infrastructure will support the development of a learning health system in which advanced analytics, actionable reporting and provider/patient experiences are made available to providers and used to continuously improve quality. Aligning reporting between initiatives will help providers focus on key metrics. In addition to previous efforts to align metrics, the Population Health and DLTSS Work Groups requested presentations on the Shared Savings Program Measures, and during the April-June 2014 Quarter, they recommended additional measures for consideration for Year 2 of the Shared Savings Program. The Blueprint and Vermont’s ACOs have initiated discussions on aligning measurement activities and collaborating to improve results on Shared Savings Program measures. Furthermore, the evaluation activities supported by SIM may provide an opportunity to assess and improve alignment of metrics.</p>
<p>VT Aims=Improve Care, Improve Health, and Reduce Costs</p> <p>Primary Driver #3: Improve payment models: align financial incentives with the three aims</p>	<p>Implement all-payer value-based payment models that reward provider performance relative to the project aims</p>	<p>Accomplishments in implementing all-payer value-based payment models from April-June 2014 included:</p> <ol style="list-style-type: none"> <li>1. With the execution of program agreements and contracts between the payers and the ACOs during the previous quarter, the pace of implementation of the Commercial and Medicaid Shared Savings Programs increased. Initial participating provider rosters were developed and beneficiary/member attribution occurred. Reporting templates and timelines for a number of standards have been created, and ACOs have begun implementing the standards.</li> <li>2. Continued work on the Episodes of Care/Bundled Payments model by the Payment Models Work Group,</li> </ol>

		<p>including a presentation by providers from Rutland, Vermont who have experience implementing the Medicare Congestive Heart Failure Bundled Payment Initiative, Arkansas' episode of care models, and discussion of potential episodes of care in Vermont based on data analysis. The PMWG will be reviewing data run through the PROMETHEUS model in late summer 2014.</p> <p>Vermont continues to build on the Blueprint for Health MAPCP demo, which includes a pay-for-performance model for participating primary care practices, shared capacity payments for Community Health Teams to provide multi-disciplinary services for patients with complex health and social needs, and bundled payments for the Hub and Spoke health home component to provide ambulatory medication assisted treatment and mental health care for people with opioid dependence. Efforts are underway to align the Blueprint with the ACO Shared Savings Programs.</p>
	<p>Support investments in primary care and prevention</p>	<ol style="list-style-type: none"> <li>1. The Blueprint for Health continues to provide multi-payer financial investment and multi-disciplinary support for primary care providers, as well as support for prevention. Efforts are underway to increase payer support for primary care providers, possibly as soon as January 2015.</li> <li>2. The shared savings, HIE and care management infrastructure being developed collaboratively by ACOs, VITL, payers and other providers will support all providers, including primary care providers, and will support good preventive care.</li> <li>3. Vermont's sub-grant awards included several that will enable innovation within primary care across the State.</li> <li>4. The Population Health Work Group has identified the following priorities that will impact primary care and</li> </ol>

		<p>prevention:</p> <ul style="list-style-type: none"><li>• Obtaining consensus on population health measures to be used in tracking SIM outcomes and incorporated in the new payment models. In May and June of 2014, the Work Group continued to advocate for its recommendations to the Quality and Performance Measures Work Group on Year 2 population health measures for the Commercial and Medicaid Shared Savings Programs, and also successfully advocated for Population Health-related additions to the measure selection criteria.</li><li>• Determining how to pay for population health through modifications to proposed health reform payment mechanisms, and through identification of promising new financing vehicles that promote financial investment in population health interventions.</li><li>• Identifying and disseminating current initiatives in Vermont and nationally that integrate clinical and population health. Identifying opportunities to enhance new health delivery system models (e.g., Blueprint for Health and ACOs) 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.</li></ul>
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### 3 Planned Activities Over the Next Quarter and Likelihood of Achievement

#### 3.1 Planned Activities and likelihood of achieving next quarter's goals/objectives –

**Table 2: Planned Activities**

Planned Year One Activities	Vermont's Year One Metrics	Planned Activities
<b>Advanced analytics</b>		
Procure contractor for internal Medicaid modeling	Contract for Medicaid modeling	Finalize Contract. <b>Completed</b> Contract executed on March 24 <sup>th</sup> , 2014.
Procure contractor for additional data analytics	Contract for data analytics	Bids were due February 14 <sup>th</sup> and the vendor was selected in March 2014. Vermont expects to finalize negotiations with the successful vendor in April 2014 and begin work in July 2014. <b>Likelihood of success is good.</b>
Define analyses	Number of analyses designed (goal = 5)	Vermont has designed three analyses for the Commercial and Medicaid ACO Shared Savings Programs and has several more proposed in the Analytics Contractor RFP discussed above. Analyses include: attribution reports; summary statistics for attributed populations; calculation of performance measures; calculation of shared savings; and analysis of the difference between core and non-core costs. Draft models of reports have been developed, and initial reports have been shared with participating ACOs. The VMSSP and commercial SSP staff are working together to align analyses for both programs. <b>Partially complete. Likelihood of success in next three months is good.</b>
Consult with payment models and duals WGs on definition of analyses	Number of analyses performed (goal = 5)	Continued discussions in the first six months of 2014 to define analyses. <b>Partially achieved. Likelihood of success in next three months is good.</b>

Perform analyses; Procure contractor for financial baseline and trend modeling; and Develop model	Contract for financial baseline and trend modeling	Vermont will procure several contractors to develop financial baselines and trends in Year One. The first contractor will provide financial baselines and trend models for the Medicaid and Commercial Shared Savings ACO Programs as described above. Vermont will procure other contractors as the Episode of Care and Pay-for-Performance Programs are launched in Year One. <b>Likelihood of success is good.</b>
Consult with payment models and duals WGs on financial model design	Number of meetings held with Payment Models and DLTSS WGs on the above designs (goal = 2)	Continued discussions with these two work groups in 2014. <b>Likelihood of success in the next nine months is good.</b>
Produce quarterly and year-end reports for ACO program participants and payers		These reports will be generated by the Analytics Contractor was selected in March (contract negotiations are almost finalized). Vermont has established criteria for quarterly and annual reports and plans to work closely with the Analytics Contractor to ensure accurate compliance with report requirements. <b>Likelihood of success in next nine months is good.</b>
<b>Evaluation (external and external)</b>		
Procure contractor	Contract for external evaluation	Vermont has experienced contracting challenges. We expect to execute Contract in Summer 2014. Vermont will be using this contractor for several components of its self-evaluation plan. <b>Likelihood of success is good.</b>
Develop evaluation plan	Evaluation plan developed	The contractor will work in close collaboration with the VHCIP Evaluation Director and present a design plan for the self-evaluation; the goal date for this activity in early fall 2014. <b>Likelihood of success in next three months is good.</b>
Consult with performance measures work group	Number of meetings held with Quality and Performance Measures	The draft self-evaluation plan will be shared with all of the project's work groups in the Fall of 2014. A status

	Work Group on evaluation (goal = 2)	report on the self-evaluation will be shared with the Quality and Performance Measures Work Group for input during its December 2014 meeting. <b>Likelihood of success is good.</b>
Input baseline data	Baseline data identified	This will be developed with the Contractor upon contract execution in mid-late 2014. <b>Likelihood of success in next six months is good.</b>
Hire staff	Hire Staff	<b>Completed.</b>
<b>Initiative Support</b>		
Procure contractor	Contract for interagency coordination	Vermont plans to release an RFP for this work in the third quarter of Year One. <b>Likelihood of success in next three months is good.</b>
Develop interagency and inter-project communications plan	Interagency and inter-project communications plan developed	The plan will be developed once the contractor is selected. <b>Likelihood of success in next three months is good.</b>
Implement plan	Results of survey of project participants re: communications	The plan will be implemented once the contractor is selected. <b>Likelihood of success in next six months is good.</b>
<b>State staff training and development</b>		
Hire contractor	Contract for staff training and development	Vermont approved a contractor for this work in May 2014. <b>Likelihood of success in next six months is good.</b>
Develop curriculum	Training and development curriculum developed	The curriculum will be developed once the contractor is selected. <b>Likelihood of success in next six months is good.</b>
<b>Model Testing</b>		
Develop ACO model standards	Approved ACO model standards	Vermont moved into the implementation phase of the programs on January 1, 2014. Vermont will also ensure that the ACO Standards and Performance Measures are being adhered to by the ACOs participating in the Commercial and Medicaid Shared Savings Programs. This will involve the work of the Analytics Contractor and the oversight role of the GMCB and DVHA. <b>Year One ACO model standards were approved by the GMCB and included</b>

		<b>in all ACO contract.</b>
Execute Medicaid ACO contracts	Number of Medicaid ACO contracts executed (goal = 2)	Two ACOs signed contracts with the Department of Vermont Health Access for participation in the VMSSP in Q1. The ACO Community Health Accountable Care (CHAC) executed a contract on March 14, 2014; and OneCare Vermont (OCVT) executed a contract on March 6 <sup>th</sup> , 2014. <b>Completed.</b>
Execute commercial ACO contracts	Number of commercial ACO contracts executed (goal = 2)	Commercial Program Agreements were executed in March 2014. <b>Completed.</b>
Develop standards for bundled and episode-based payments	Approved standards for bundled and episode-based payments	The Episodes of Care model is being discussed by the Payment Models Work Group. The group is establishing criteria for evaluating possible episodes to test. <b>Likelihood of success in next six months is good.</b>
Execute contracts for bundled and episode-based payments		The Payment Models Work Group is leveraged an existing state contract held by the GMCB to perform this work. <b>Completed.</b>
Develop Medicaid value-based purchasing plan addressing pay-for-performance initiatives	Medicaid value-based purchasing plan developed	The Pay-for-Performance model is under discussion and will be finalized within the next quarter, with input from the Payment Models Work Group. <b>Likelihood of success in next six months is good.</b>
Procure learning collaborative and provider technical assistance contractor	Contract for learning collaborative and provider technical assistance	The Care Models and Care Management Work Group has recommended that two community facilitator contractors be procured through an RFP process to help design and implement integrated care management learning collaboratives. An RFP is expected to be posted within one month after the funding for the learning collaborative is approved by the Core Team (goal is September 2014). <b>Likelihood of success is good.</b>
Establish learning collaboratives for providers engaged in each of the	Number of learning collaboratives for providers conducted	The first meeting of the shared savings program learning collaborative will be held by October 2014. A draft

testing models	(goal = 3 day long meetings)	learning collaborative to convene clusters of providers (e.g., hospital, home health, primary care, specialty care) to share data, identify best practices, and identify improvement opportunities for episodes of care will be presented to the Care Models and Care Management and Payment Models Work Groups by September 2014. The collaborative will be geared toward the bundled payments model. The first in-person meeting of the episodes of care model learning collaborative will be held by December 2014. <b>Likelihood of success in next six months is good.</b>
Develop technical assistance program for providers implementing payment reforms	Number of providers served by technical assistance program (goal = 20)	Technical Assistance is part of Vermont's Sub-Grant Program. The Sub-Grant Program released its first round of awards and awarded technical assistance to these awardees. Technical Assistance will be provided to seven awardees and dozens of providers. <b>Completed.</b>
Number of providers participating in one or more testing models	goal = 2000	The Medicaid Shared Savings ACO Program has 816 attributing providers and 6,000 non-attributing providers. The complete numbers are not yet available for the commercial Shared Savings ACO Program. <b>Likelihood of success is good.</b>
Number of Blueprint practice providers participating in one or more testing models	goal = 500	Through June 2014, there are: <ul style="list-style-type: none"> <li>• 635 unique providers</li> <li>• 121 PCMHs</li> <li>• Covering 504,478 people</li> <li>• Representing 80% of Vermont's population.</li> <li>• <b>Goal achieved.</b></li> </ul>
<b>Technology and Infrastructure</b>		
Provide input to update of state HIT plan	Updated state HIT plan	The revised goal is to draft the phase 2 work of updating HIT, HIE, and privacy and security by December 31, 2014. The current goal is to also have a first draft of the entire plan by December 31, 2014. <b>Likelihood of success in</b>

		<b>next six months good.</b>
Expand provider connection to HIE infrastructure	Number of new interfaces built between provider organizations and HIE (goal = 18 additional hospital interfaces and 75 new interfaces to non-hospital healthcare organizations to include: at least 10 specialist practices; 4 home health agencies; and 4 designated mental health agencies)	VITL will continue to work with providers to build on the interfaces established in 2013. The HIT/HIE Work Group will be discussing this as part of the work in 2014. We anticipate significant collaboration between and among providers on this issue. Vermont's SIM project is investing significant resources into this expansion over the next three years. <b>Likelihood of success in the next six months is good.</b>
Identify necessary enhancements to centralized clinical registry & reporting systems	Completed needs assessment for enhancements to centralized clinical registry and reporting systems	Vermont's SIM Project is currently reviewing options for how best to continue to provide registry and reporting analytic services. <b>Likelihood of success in the next six months is good.</b>
Procure contractor to develop initial use cases for the integrated platform and reporting system	Contractor hired	Vermont's SIM Project is currently working on use case identification and development and should complete the scope of this project for this project by fall 2014. <b>Likelihood of success is good.</b>
Design the technical use cases and determine the components of the integrated platform that are required to implement these use cases	Contract for the development of 6 primary use cases for the integrated platform and reporting system	Vermont's SIM Project is currently working on use case identification and development and should complete the scope of this project for this project by November 2014. <b>Likelihood of success in next six months good.</b>
Develop criteria for telemedicine sub-grants	Number of telemedicine initiatives funded (goal = 1)	The HIT/HIE Work Group will develop these criteria in Summer 2014. <b>Likelihood of success in the next six months is good.</b>
Expand the scope of VHCURES to support the integration of both claims and clinical data and provide this capability to ACOs/providers and potentially payers	Number of providers approved for use of VHCURES data	The GMCB released an RFP in May 2014 for a new VHCURES warehousing contract that will expand the scope. <b>Likelihood of success in the next nine months is good.</b>
Begin to incorporate long term care, mental health,	Provide regional extension center (REC)	The State of Vermont has a contract with VITL, the state's HIE contractor,

home care and specialist providers into the HIE infrastructure	like services to non-EHR providers to include long term care, mental health, home health and specialists and begin development of interfaces to the VHIE for these provider groups that currently have EHRs with the goal over three years of achieving 50 new interfaces.	to begin to incorporate these providers into the HIE infrastructure. Some SIM funds are being used for this purpose in Year One. The HIT/HIE Work Group made recommendations regarding incorporating these providers as part of the ACTT proposal discussed above. <b>Likelihood of success is good.</b>
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### 3.2 Projected quarterly accountability targets

This information is provided in Table 2 above.

**Table 3: Aims and Drivers Projections for July-September 2014**

Aims and primary drivers	Secondary drivers	Projections for April-June 2014 and beyond
VT Aims=Improve Care, Improve Health, and Reduce Costs  Primary Driver #1: Improve care delivery models: enable and reward integration and coordination	Support the development of provider networks that coordinate preventive and acute health services across all sectors	Now that contracts and program agreements have been executed, implementation of the Medicaid and Commercial ACO Shared Savings Programs will continue throughout 2014.
	Develop workforce planning that supports the needs of community networks	Vermont’s SIM Workforce Work Group began developing these at its November 2013 meeting. The Workforce Work Group will continue this work throughout 2014 and anticipates both an update to the Workforce Strategic Plan and a Symposium in November 2014 on the topic of workforce planning within a reformed system.
	Coordinate care process redesign and care management programs to maximize best practices and reduce duplication of effort or expense	1. The state’s three ACOs, the Blueprint for Health (VT’s MAPCP demo), and Medicaid’s Vermont Chronic Care Initiative developed a joint proposal for coordinating care management activities that can be tested and supported by a Learning Collaborative; it was refined and presented to the

		<p>CMCM Work Group in July 2014.</p> <p>2. The CMCM Work Group will identify additional models for implementation and testing by September 2014.</p>
	Expand the use of telemedicine to support appropriate resource use and access to care	Grant program criteria will be developed during the second and third quarter and will be reviewed and finalized by the HIE Work Group in the fourth quarter.
<p>VT Aims=Improve Care, Improve Health, and Reduce Costs</p> <p>Primary Driver #2: Improve exchange and use of health information: develop a health information system that supports improved care and measurement of value</p>	Guide expansion of electronic health records to providers of long-term services and supports	<p>Home Health: Interfaces for four home health agencies were established by June 2014.</p> <p>Mental Health Designated Agencies: Four Designated Agencies were receiving lab results by June 2014.</p> <p>Long term care: VITL built two interfaces with long term care entities and 21 interfaces with Specialist organizations. VITL continues to work with home health and Designated Agencies on interfaces.</p>
	Invest in enhancements to EHRs and other technology that support integration of services and enhanced communication	The HIE/HIT Work Group, SIM Core Team and GMCB will monitor implementation of the Population-Based Collaborative HIE Initiative. The Advancing Care Through Technology Proposal was approved and Vermont's SIM project will monitor the implementation of that proposal.
	Enhance connectivity and data transmission from source systems including EHRs	Vermont will continue the efforts by the Blueprint for Health, VITL, the DocSite clinical registry contractor, EHR vendors, and practice staff to enhance practice connectivity to the clinical registry and/or Vermont's HIE, and to improve the quality of data being transmitted to the clinical registry and/or Vermont's HIE. VITL will continue to work with the state's hospitals, practices and other providers to enhance connectivity and improve data transmission.
	Enhance data repository and data integration platform	1. A contract is about to be executed with the vendor selected to field the Patient Centered Medical Home CAHPS Patient Experience

		<p>Surveys to patients in primary care practices engaged in the Blueprint for Health and patients attributed to ACOs. A timeline for fielding the survey on an ongoing basis, beginning in the July-September quarter, has been developed.</p> <ol style="list-style-type: none"> <li>2. The state has issued an RFP that will result in improvements to VHCURES and allow data from different sources to be merged on a person-level basis. Vendor selection will occur in the fall of 2014.</li> <li>3. The HIE/HIT Work Group will provide input on a scope of work for an RFP for the clinical registry and DVHA will post the RFP in late 2014.</li> </ol>
	<p>Develop advanced analytics and reporting systems; enhance a statewide learning health system that provides reporting and analytics to support provider networks</p>	<p>This work will be performed within the HIE/HIT Work Group as part of the State's HIT Plan development. This work will begin in earnest in the fall.</p>
<p>VT Aims=Improve Care, Improve Health, and Reduce Costs</p> <p>Primary Driver #3: Improve payment models: align financial incentives with the three aims</p>	<p>Implement all-payer value-based payment models that reward provider performance relative to the project aims</p>	<ol style="list-style-type: none"> <li>1. Implementation of Medicaid and Commercial Shared Savings Programs between payers and ACOs will continue in the July-September quarter of 2014.</li> <li>2. The Episodes of Care/Bundled Payment model for testing will continue to be developed with the Payment Models Work Group during 2014.</li> </ol>
	<p>Support investments in primary care and prevention</p>	<ol style="list-style-type: none"> <li>1. The Population Health Work Group provided input into the Quality and Performance Measures Work Group on suggested measures that support prevention and population health measurement during April and May 2014.</li> <li>2. The Population Health Work Group will provide input to the</li> </ol>

		CDC and CMMI regarding the development of a population health plan for Vermont.
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**4 Substantive Findings**

**4.1 Substantive Findings**

- We are beginning to get preliminary results on Year 1 Medicare ACO Shared Savings Program performance measures for our largest ACO. If those results are similar for Vermont’s Medicaid and Commercial programs, there may be opportunities for improvement in diabetes and cardiovascular disease care. In general, however, Vermont’s providers continue to out-perform the national average in quality performance so the magnitude of improvement may be less than in other states who have more room for improvement.
- Engaging health care and community service providers in collaborative initiatives requires constant effort, particularly in an environment that is fostering significant health care reform. Partners recognize the importance of transformation, but are concerned about its impact on them and on the amount of additional resources required to be fully engaged.
- Preliminary financial analyses from Medicaid reveals that there is enough variation in the per-member, per-month payments among ACOs to suggest improvement and savings generation are possible.
- Identification of specific reports and transfer of information between ACOs and payers has been challenging, however those issues are now resolved. These reports will enable the GMCB and DVHA to monitor ACO performance and minimize unintended consequences.
- The commercial SSP had attribution issues due to lower than anticipated PCP selection. The carriers worked around this issue, but it delayed that aspect of program implementation by a few months.

**4.2 Lessons Learned**

- Allow adequate time for process and engagement around controversial topics (e.g., selection of performance measures, development of care models, allocation of HIE resources, presentation of sub-grant proposals), so that partners have an opportunity to express concerns and be heard.
- Seek alignment with other efforts (e.g., other health care reform initiatives being implemented in our state, performance measurement activities, quality improvement efforts) whenever possible, to better leverage scarce resources and partner engagement.

- Complex federal and state legislative and regulatory requirements and reporting systems, the breadth of Medicaid services and a legacy MMIS system make payment reform program design and implementation in Medicaid extremely complicated. Medicaid adoption of value-based purchasing programs would benefit from enhanced waiver authority, modernization of reporting and requirements of specialized service programs and modern MMIS functionality.
- Data collection for monitoring and evaluation of ACOs is a challenge and the conversations around it are complex. Data systems were not initially designed for this purpose and extracting discreet data elements for this purpose is not simple.
- Expansion in HIE integration is complex and requires significant resources to both understand that complexity and ensure that the expansion meets project goals. This work requires continual activity and expectation setting.

#### **4.3 Suggestions/Recommendations for Current/Future SIM States**

See lessons learned.

#### **4.4 Suggestions/Recommendations for CMMI SIM Team**

- Continue to provide opportunities for testing states to share their ideas with each other.
- Continue to work with states to establish realistic time frames for planning, implementation, evaluation, and expected results.

## **5 Findings from Self-Evaluation**

Vermont’s SIM project experienced some staff turnover in this quarter. This turnover required staff to work quickly to ensure key activities were not impacted during the transition. We did not anticipate this level of turnover and recognized the need for necessary redundancies and documentation so that key project work would not slow during times like this in the future. Vermont’s SIM staff developed some contingency plans, but identified this as a risk to be mitigated against in the future.

Vermont’s SIM project benefited significantly from the CMMI site visit. This visit allowed project leaders, staff and stakeholders to reflect on activities to date and identify areas of concern. Due to this visit, Vermont SIM team will engage in an all-day retreat at the beginning of October to engage in an in-depth review of the project thus far and make strategic decisions about the remainder of the project.

## 6 Problems Encountered/Anticipated and Implemented or Planned Solutions

### 6.1 Problems Encountered/Anticipated

- Contracting processes sometimes slow down the work.
- Stakeholder input is critical, but those concerns can also slow down the work.
- Encouraging collaboration among the ACOs is a constant activity.
- Ensuring providers and all stakeholders stay at the table to work through issues as part of the SIM process.
- The Federal regulation commonly referred to as “42 CFR Part 2” prohibits sharing of all data related to substance abuse without express written consent or without meeting one of three very specific exceptions to that prohibition. This will impact data sharing within ACO networks, within the HIE and between payers and providers. It will be necessary for Vermont to manage this data through new, formal mechanisms.
- It is unlikely, as of Summer 2014, that Vermont’s third ACO (VCP) will participate in the Vermont Medicaid SSP. Continued discussions are occurring about how best for Medicaid to partner with this ACO in the future.

### 6.2 Implemented or Planned Solutions

- Project Director, state business offices, and CMMI have streamlined the contract approval process while still maintaining accountability.
- Work Group Co-Chairs and Staff are developing processes and work plans that allow for stakeholder input and fidelity to time frames.
- Work Group Staff and Co-Chairs communicate frequently to maximize collaboration and minimize project fatigue.
- The State of Vermont, through DVHA, has been working on 42 CFR Part 2 issues related to the HIE for a couple of years. This work is being expanded in the new era of data sharing. In response to the anticipated problem of data sharing between DVHA and each of the ACOs, the SIM team created a Substance Abuse Data Confidentiality Policy. It includes a brief summation<sup>5</sup>, purpose, scope, definitions, procedure, and implementation sections, a sample qualifying opt-in form, and an attachment with the specific pharmacy claims data that CFR Part 2 prohibits the unauthorized sharing of. This policy will be shared with both ACOs well before they receive claims data from

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<sup>5</sup> “It is the policy of the Vermont Health Care Innovation Project (VHCIP) to fully comply with 42 CFR Part 2 – “Confidentiality of Alcohol and Drug Abuse Patient Records,” and to ensure that all entities working with VHCIP do so as well.”

the SIM team. It will be adhered to strictly by all parties involved in the demonstration. In the more distant future, it will also be used to ensure that those individuals who wish to consent to sharing of their substance abuse treatment data do so in a manner that adheres to the requirements set forth in 42 CFR Part 2.

## **7 Work Breakdown Structure**

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This is provided in Appendix E. Please note that Vermont's standard interagency transfer of funds between state agencies is done quarterly in the fourth, seventh, tenth and first month. This transfer cycle means that there is insufficient information to provide a full report of those SIM-related expenses by both the Agency of Administration and the Green Mountain Care Board by the June 30, 2014 report date. The Work Breakdown Structure does not include the personnel costs within these two agencies. Vermont will be providing the information for both the October-December 2013 and January-March 2014 time periods in its next report.

There are also some out-of-state travel expenses listed on Vermont's travel report as being charged to SIM that are not actual expenses to SIM. Vermont's accounting practices require that even when a third-party entity pays for out-of-state travel, there is a record of the transaction related to SIM. The net result is an expense and then a reimbursement for that same amount without drawing on federal funds. Unfortunately, the timing of the third-party reimbursement does not always reflect both parts of the transaction in the quarterly reports. The expenses for the ACO-LC are all of that nature. The April-June 2014 quarterly report also includes some incorrect travel expenses related to travel to: Atlanta, Georgia; Alabama and New York. These expenses are incorrectly being applied to SIM.

There is also a conference expense on our travel report for Capitol Plaza. This has been included incorrectly in this report.

The incorrect expenses will be removed in the next quarterly report.

## **8 Additional Information**

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## **9 Point of Contact**

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## **Appendix**

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- A SSP and ACO FAQ and chart 7.8.14
- B CMCM Instrument Survey (.pdf)
- C CMCM Problem Statement
- D CMCM Priorities Survey Results (.ppt)
- E Work Breakdown Structure/Quarterly Financial Report (Excel)
- F SF 425 (Excel)
- G Travel Report (Excel)
- H NOA Approved Contracts (Excel)