VT Health Care Innovation Project
Core Team Meeting Agenda

February 18, 2014 10:00 am-12:30 pm
DFR - 3rd Floor Large Conference Room, 89 Main Street, Montpelier
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	10:00-10:10	Welcome and Chair's Report	Anya Rader Wallack	
Core Team Processes and Procedures				
2	10:10-10:15	Approval of meeting minutes	Anya Rader Wallack	Attachment 2: February 4, 2014 Meeting minutes
Policy recommendations and decisions				
		No policy recommendations or decisions this month		
Spending recommendations and decisions				
3	10:15-10:40	Financial Update: 1. Contracting Request Memo: a. Workforce WG proposal b. HIE/HIT WG proposal	Georgia Maheras	Attachment 3a: Memo from G. Maheras Attachment 3b: VHCIP Spending Tracking as of 1.27.14 (Excel)

				Attachment 3c: HIE/HIT WG Proposal Attachment 3d: HIE/HIT WG Motion and Objection Attachment 3e: Steering Committee presentation (PowerPoint)
4	10:40-10:50	Public Comment	Anya Rader Wallack	
5	10:50-12:15	Continued Discussion about Grant Program (Executive Session)	Georgia Maheras	Attachment 5a: Grant Program Application (*previously distributed)* Attachment 5b: Grant Program FAQs dated 1.27.14 *(previously distributed)* Attachment 5c: Memo from G. Maheras on distribution and scoring methodology. *(previously distributed)* Attachment 5d: Application Summary Sheet (to be sent to the Core Team on 2/16/14)
6	12:15-	Public Comment	Anya Rader	

	12:20		Wallack	
7	12:20- 12:30	Next Steps, Wrap-Up and Future Meeting Schedule: 3/10: 1:00-3:30 pm at DFR in Montpelier 3/14: 10:00-12:00 Conference Call: 1-877-273-4202 Conference ID: 8155970	Anya Rader Wallack	

VT Health Care Innovation Project
Core Team Meeting Minutes

Date of meeting: February 4, 2014 1:30pm to 4pm: Conference Call: 877-273-4202 Passcode 8155970

Attendees: Anya Rader Wallack Chair; Al Gobeille; Paul Bengtson; Mark Larson; Robin Lunge; Doug Racine; Steve Voigt; Susan Wehry.

Staff: Georgia Maheras, Kara Suter and Nelson LaMothe

Agenda Item	Discussion	Next Steps
1 Welcome & Chair's Report	Anya called meeting to order 1:04. *Chair's Report*: The Provider Grant Program has been fully launched and the Core team will review at its next meeting. Significant budget proposals from the HIE Work Group will be shared with the Core Team before the next meeting. The Medicaid and Commercial Shared Savings ACO Programs' contracts in final negotiations. A Staff retreat is scheduled for Feb 19 (11am -1pm); the Core Team is welcome to attend. Concerns about the decision process Work Groups will use to recommend spending SIM Grant money to the Steering Committee were expressed. A prescribed a process for Work Groups to propose SIM grant spending will be developed over time and informed by the types of requests. Due diligence will be taken with each step forward.	
2 Approval of Jan 13, 2014 Minutes	Paul moved to accept the minutes and Robin seconded. The motion passed unanimously with Steve abstained because he was not at the January meeting. Susan and Anya were not present	

Agenda Item	Discussion	Next Steps
	for the vote.	
3 Financial Update	Georgia Maheras provided an update spending tracking chart to the Core Team. *Georgia presented Proposed Budget re-allocation and contract request:* 1) Request a reallocation of Year #1 SIM (Type 1a) funds from the personnel category to a new category: Grant Program-Technical Assistance. This would reallocate $500,000 of unspent salary and fringe dollars due to vacancies. The funds would be used to provide technical assistance to Provider Grant awardees. Providing technical assistance to awardees of Provider Grants will support their outcomes; it is assumed that many of the providers will seek actuarial and/or data analysis and the bandwidth of known and capable contractors will leverage results. The maximum allowable contract amount for each of five technical assistance contracts is $100,000. Paul moved to approve, Steve seconded. Passed unanimously. 2) Request for approval of contractor support (Type 1b) for the Disability and Long Term Support Services (DLTSS) Work Group (formerly Duals): This work group has benefited from work performed by two contractors, Bailit Health Purchasing and Pacific Health Policy Group (PHPG) and it was always assumed that at some point SIM funds would be used to fund these contractors. Conditional funding for PHPG at a maximum not to exceed amount of $90,000 and Bailit at a maximum not to exceed amount of $90,000 is proposed pending subsequent approval by the DLTSS Work Group. Should the DLTSS Work Group raise any issues, this proposal will be withdrawn. Please note that the contractor budget for Wakely at $25,000 has been withdrawn since the Duals Demonstration will not go forward. Susan moved to approve; Steve seconded the motion. Al asked for clarification about the term. Georgia confirmed it is March 1, 2014-February 28, 2014. Motion passed unanimously. *Provider Grant Program Discussion:*	

Agenda Item	Discussion	Next Steps
	Application Review Process: Applications are due Feb 14, 2014 and a summary of requests will be prepared for the Core Team by Monday morning the 17th. The Core Team's next meeting is February 18th and during that meeting, will review and discuss applications in executive session. Award announcements are planned for March 25, 2014. It is estimated that a range of 25 to 40 applications will be submitted for review, with a dollar range of $2,000 to $750,000. Applicants are aware that technical assistance support will be provided, and will submit a prescriptive plan for technical requirements in the application. Scoring Methodology: At the last Core Team meeting modifications to a proposed scoring methodology were requested. A revised scoring approach included in the attached materials weights the ability to perform at 60 points and the quality of the idea at 40 points. Review Process: Anya said that Core Team Members may delegate some of the review and assessment of provider grant applications, it should be noted that the applications are confidential in nature, and that award recommendations must come from Core Team Members. The DVHA business office does not have unlimited bandwidth to manage these sub-awards and indicated it could capably handle approximately 25 awards. The Core Team does need to be sensitive to the required financial and programmatic monitoring. Conflict of Interest: There was some discussion about the protocol for declaring conflict of interest and whether and how individuals should raise these concerns. Anya said that this is one of the challenges of the project and that the variety of stakeholders was incredibly important to ensure a successful project. If there is any concern, the prescribed path forward is to speak with Georgia Maheras and/or Anya directly.	

109 State Street
Montpelier, VT 05609

To: Core Team
Fr: Georgia Maheras
Date: 2/13/14
Re: Approval of contract proposal

I am requesting Core Team approval for two SIM funding actions:

1. Proposal for services contract supporting the collection of data on the Vermont Health Care Workforce for an amount not to exceed $150,000.
2. Proposal for services contract supporting Population-Based Health Information Exchange Collaboration for an amount not to exceed $3,023,798.

REQUEST #1- Type 2 Proposal for services contract supporting the collection of data on the Vermont Health Care Workforce for an amount not to exceed $150,000:

The Workforce Work Group recommended approval of a proposal for services contract to perform analysis of workforce data. This recommendation was moved forward by the Steering Committee on February 12, 2014. *Funding for this proposal is in the SIM-approved budget under Workforce: system-wide analysis.*

Description of Need: The Vermont Department of Health (VDH) has been collecting, analyzing and publishing health care provider workforce data since 1994. The data have historically been collected in conjunction with the relicensing process, and included physicians, dentists and physician assistants. Among other uses, the information has been essential to designating geographic regions within the state as medically underserved; for this purpose a complete census of licensed providers, rather than a partial survey is required. Despite there being interest in performing analyses of other health professions beyond those listed above, the VDH has not had adequate staff to take on this work.

In 2013, Act 79, Sec.44 mandated the collection of these data for all health professions in order to assist with health care planning. At the same time at the national level, the National Center for Health Workforce Analysis has been collaborating with national professional organizations and state licensure boards to develop Minimum Data Sets (MDS) to answer questions on the supply and distribution of the U.S. healthcare workforce. In general the MDS consists of health professional demographic information, educational pathway, specialization, location of practice, and percent effort. The MDS will provide comparable data across states.

The data to be collected in Vermont will need to meet these related albeit distinct needs: provide information needed for workforce development planning; determine medically underserved areas; and collect information consistent with the national Minimum Data Set. For those professions that have been surveyed in the past, it will also be important to collect information that is consistent with prior years to allow for comparisons across time. In addition

to the standard questions included in the MDS, there will be other questions that may be unique for newly surveyed professions.

Scope of Work: The Contractor will provide the following activities and deliverables, in accordance with Act 79, Sec 44:

- For each of the health professions: Familiarize themselves with the information needed for planning purposes, for purposes of determining medical underservice, the MDS for that profession, if one exists, and any previous surveys conducted for that profession, and the relicensing schedule.

- Design a set of questions to meet the various requirements and review with interested parties.

- Collaborate with the appropriate Licensing Organization to incorporate the form into the relicensing process. This might include working with the Licensing Organization who will incorporate the questions directly into the relicensing forms, or developing a separate survey that is linked to the relicensing form.

- If needed, prepare paper forms using the software determined by the Department of Health, for individuals who do not relicense on-line.

- Analysis of the survey data, including identifying any limitations of the data.

- Produce one or more reports for each health care profession that can be used for planning purposes and to provide summarized data for the public.

- Provide special analyses as needed for interested parties such as the *Workforce Development Committee,* or the *State Office of Primary Care and Rural Health.*

Benefits Derived: As a result of this contract, detailed information about the current health care workforce will be available and can be used for workforce development planning. In addition, the information will be used to determine if there are areas of the state that are medically underserviced, and if so will be used to obtain a designation of medical underservice, which can be used to develop assistance such as Federally Qualified Health Centers and Rural Health Centers. The information will be collected in a manner that is consistent with national standards, and therefore can be compared to other states and the nation.

Recommendation: Release an RFP to execute a contract for up to $150,000 for workforce data analysis with the above referenced Scope of Work. The term is one year with an option to renew.

REQUEST #2- Type 2 Proposal for services contract supporting Population-Based Health Information Exchange Collaboration for an amount not to exceed $3,023,798:

The HIE/HIT Work Group recommended approval of a proposal for services contract supporting Population-Based Health Information Exchange Collaboration. This recommendation was moved forward by the Steering Committee on February 12, 2014. The proposal provides technological infrastructure to support the Shared Savings ACO Programs. The motion includes several stipulations. The stipulations require that additional information be provided to the Core Team. This information is still under development and will be provided to the Core Team ahead of the February 18th meeting. *The funding for this proposal bridges year one and year two SIM funding and is in the approved categories of: Expanded Connectivity between SOV and providers and Expanded Connectivity HIE.*

The HIE/HIT Work Group reviewed this proposal at its January and February meetings. This work group requested clarifications of VITL and the ACOs, who made the proposal. These clarifications are appended to the proposal. The work group passed a motion on February 11, 2014. This motion, which was accompanied by one written objection, was sent to the Steering Committee for review at their February 12th meeting. The work group noted that this proposal met three of the goals outlined in their work plan.

The Steering Committee received a PowerPoint presentation and reviewed the proposal, motion and objection at their February 12th meeting. The Steering Committee passed the motion, as proposed by the work group on February 12th.

The presentation, proposal, motion and objection are appended to this memo.

Proposal Summary

The proposal includes four components:

- Gap Analysis
  - Identify the gap among state-wide ACO data requirements and data capacity
- ACO Gateway Build
  - Build the technical architecture to support movement of data from source systems to analytics destinations (next slide)
- Event Notification
  - Install a system that improves quality and timeliness of transitions of care through real-time notification of important clinical encounters
- Support
  - Provide system and customer support

These four components include the expansion of Vermont Information Technology Leader's (VITL) infrastructure to support the exchange of clinical data for analytics. VITL will build 'gateways' that allow the clinical data of specific beneficiary populations to be sent to analytics sources (as directed by provider groups) for population health management. An additional aspect of this proposal is the development of an Event Notification System (ENS) designed to inform both ACO member organizations and any authorized healthcare provider statewide choosing to participate, that a patient involved in their care has been admitted, discharged or transferred by an acute care hospital in Vermont or by Dartmouth Hitchcock Medical Center in New Hampshire. The last aspect of this proposal is designed to recognize the need to provide on-going customer and system support once the technical infrastructure and technology service investments have been made.

VHCIP Funding Allocation Plan

		Implementation (March-Oct 2013)	Year 1	Year 2	Year 3	Total grant period	
Type 1a	Type 1A						
Proposed type 1 without base work group or agency/dept support	*Proposed Type 1 without base work group or agency/dept support (subject to Core Team approval)*						**Green indicates the money has been committed through hiring or contracts. Blue indicates the money has been approved for spending, but the contract is pending. Red indicates pending Core Team Approval.**
	Personnel, fringe, travel, equipment, supplies, other, overhead	**$ 107,898**	**$ 2,912,103**	$ 3,412,103	$ 3,412,103	$ 9,844,207	Includes new .5FTE in AOA for work force. **Transfer $500,000 unspent personnel to grant program-technical assistance.**
	Duals personnel and fringe		**$ 110,000**			**$ 110,000**	Year 1 paid out of Carryover
	Project management	**$ 30,000**	**$ 775,000**	$ 700,000	$ 670,000	$ 2,175,000	Year 1 paid out of Carryover
	Evaluation		**$ 1,000,000**	$ 1,000,000	$ 1,000,000	$ 3,000,000	**$478,889 per year committed.**
	Outreach and Engagement		$ 100,000			$ 100,000	Year 1 paid out of Carryover
	Interagency coordination		$ 110,000	$ 110,000	$ 110,000	$ 330,000	
	Staff training and Change management		$ 100,000	$ 100,000	$ 100,000	$ 300,000	Support Conferences and Educational Opportunities
	VITL Contract		**$ 1,177,846**			**$ 1,177,846**	
	Grant program		$ 1,510,435	$ 933,333	$ 933,334	$ 3,377,102	
	Grant program- Technical Assistance		$ 500,000				500,000 from personnel due to unspent funds in that category.
	Subtotal	**$ 137,898**	**$ 7,795,384**	**$ 6,255,436**	**$ 6,225,437**	**$ 20,414,155**	

VHCIP Funding Allocation Plan

Type 1b	Type 1 B		**Year 1**	**Year 2**	**Year 3**	**Grant Total**	
Proposed type 1 related to base work group support (subject to Core Team approval)	Proposed Type 1 related to base work group support (subject to Core Team approval)						
	Payment Models						
	Bailit/Murray		$ -	$ 200,000	$ 200,000	$ 400,000	To develop EOC program and P4P programs
	Burns and Associates or other vendor		**$ 200,000**	$ 200,000	$ -	$ 400,000	**To develop EOC program and P4P programs. Note that only 125,000 has been approved by CT.**
						$ -	
	Measures					$ -	
	Bailit/Murray		$ -	$ 200,000	$ 200,000	$ 400,000	
	Patient Experience Survey		**$ 300,000**			**$ 300,000**	
						$ -	
	HIT/HIE		$ 150,000	$ 150,000	$ 150,000	$ 450,000	No contractor identified
						$ -	
	Population Health		$ 100,000	$ 100,000	$ 100,000	$ 300,000	No contractor identified
						$ -	
	Workforce		$ 43,000	$ 43,000	$ 43,000	$ 129,000	No contractor identified
						$ -	
	Care Models		$ 250,000	$ 250,000	$ 250,000	$ 750,000	No contractor identified
						$ -	
	Duals					$ -	
	Hogan/Besio/Wakely		$ 180,000	$ 250,000	$ 250,000	$ 680,000	**$180,000 identified in year one for PHPG and Hogan**
	Sub Total		**$ 1,223,000**	**$ 1,393,000**	**$ 1,193,000**	**$ 3,809,000**	

VHCIP Funding Allocation Plan

Type 1c	Type 1 C		**Year 1**	**Year 2**	**Year 3**	**Grant Total**	
Proposed type 1 related to base agency/dept support	Proposed Type 1 related to base agency/dept support						
	GMCB/DVHA						
	ACO Analytics Contractors		**$ 400,000**	$ 400,000	$ 200,000	$ 1,000,000	**This contractor would support the development of spending targets, whether an ACO met those targets and how potential savings are distributed. RFP released.**
						$ -	
	GMCB					$ -	
	Model testing support		$ 125,000	$ 125,000	$ 125,000	$ 375,000	Support GMCB analytics related to payment model development
						$ -	
	DVHA					$ -	
	Modifications to MMIS, etc...		$ 350,000	$ 150,000	$ -	$ 500,000	Resources to support updates to adjudication or analytic systems and processes like MMIS.
	Broad dissemination of programmatic information to providers and consumers		$ 100,000	$ 100,000	$ 100,000	$ 300,000	Communications to providers and consumers regarding program/billing changes.
	Analytics support to implement models		$ 250,000	$ 50,000	$ 50,000	$ 350,000	
	Technical support of web-based participation and attestation under the P4P program		$ 125,000	$ 100,000	$ 25,000	$ 250,000	Aimed to reduce administrative burden to implement and improve participation in P4P programs
	Analytic support		$ 100,000	$ 100,000	$ 100,000	$ 300,000	Support Medicaid analytics related to payment model development
	Sub-Total		**$ 1,450,000**	**$ 1,025,000**	**$ 600,000**	**$ 3,075,000**	

VHCIP Funding Allocation Plan

Type 2	Type 2		Year 1	Year 2	Year 3	Grant Total	
Total proposed type 2 (subject to staff planning, work group/steering committee review and Core Team approval)	Total proposed Type 2 (subject to staff planning, work group/steering committee review and Core Team approval)						
	HIT/HIE						
	Practice Transformation Teams		**$ 440,321**	$ 856,666	$ 856,667	$ 2,153,654	**Part of 3,023,798 Proposal: remainder of $90,612 is unallocated.**
	Clinical Registry		$ 466,666	$ 466,666	$ 466,667	$ 1,399,999	
	Integrated Platform		$ 666,666	$ 666,666	$ 666,667	$ 1,999,999	
	Expanded Connectivity between SOV and providers		**$ 833,333**	**$ 833,333**	$ 833,334	$ 2,500,000	**Part of 3,023,798 Proposal**
	Telemedicine		$ 416,666	$ 416,666	$ 416,667	$ 1,249,999	
	Expanded Connectivity HIE		**$ 346,346**	**$ 661,077**	$ 661,077	$ 1,668,500	**Part of 3,023,798 Proposal**
						$ -	
	Workforce					$ -	
	Surveys		$ 80,000	$ 80,000	$ -	$ 160,000	
	Data analysis		$ -	$ 150,000	$ 150,000	$ 300,000	
	System-wide analysis		**$ 546,666**	$ 546,666	$ 546,667	$ 1,639,999	**$150,000 request for year one data analysis. Remainder unallocated.**
						$ -	
						$ -	
	Care Models					$ -	
	Service delivery for LTSS, MH, SA, Children		$ 533,333	$ 533,333	$ 533,334	$ 1,600,000	
	Learning Collaboratives		$ 500,000	$ 325,000	$ 325,000	$ 1,150,000	This item could support outreach and mailings associated with notification and education on new care delivery and payment reform models.
	Analysis of how to incorporate LTSS, MH/SA		$ 100,000	$ 100,000	$ 100,000	$ 300,000	This includes technology support to Medicaid Home Health Initiatives including Hub and Spoke.
	Practice Facilitators		$ 170,000	$ 170,000	$ 170,000	$ 510,000	

	Integration of MH/SA		$ 50,000	$ 50,000	$ 50,000	$ 150,000	
						$ -	
	Sub-Total		**$ 5,149,997**	**$ 5,856,073**	**$ 5,776,080**	**$ 16,782,150**	

VHCIP Funding Allocation Plan

Type 1a	$ 20,414,155	Type 1 A					
Type 1b	$ 3,809,000	Type 1 B					
Type 1c	$ 3,075,000	Type 1 C					
Type 2	$ 16,782,150	Type 2					
Unallocated (Year 1)	$ 928,865	Balance Avail.					
Grant Total	$ 45,009,170	Grant Total					

Vermont Health Care Innovation Project (VHCIP)

DRAFT Project Proposal

Population-Based Collaborative Health Information Exchange (HIE) Project

Version 1.0 - Presented to VHCIP HIE Work Group

February 5, 2013

DRAFT

Prepared by:

Accountable Care Coalition of the Green Mountains

Community Health Accountable Care

OneCare Vermont Accountable Care Organization

Vermont Information Technology Leaders

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IX. Appendix D: PowerPoint Presentation of Concept to HIE Work Group January 10, 2014

X. Appendix E: February 2, 2014 Q and A from HIE Work Group Leaders/Members

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I. Project Purpose, Background and Summary

Purpose Statement

The purpose of the project is to develop and implement a population-based infrastructure within Vermont HIE capabilities, to fully align with national health care reform through CMS and to fully align with Vermont healthcare reform which emphasizes that collaborative clinically integrated providers are held accountable for the cost and quality of health care delivered to the populations they serve.

Background

The work plan for the VHCIP/HIE Work Group states:

> "Vermont's strategy for health system innovation emphasizes several key operational components of high-performing health systems: integration within and between provider organizations, movement away from fee-for-service payment methods toward population-based models, and payment based on quality performance."

Four Vermont organizations have partnered to develop a collaborative, statewide approach designed to support this strategy. These organizations include:

- The Accountable Care Coalition of the Green Mountains (ACCGM)
- Community Health Accountable Care (CHAC)
- OneCare Vermont (OCV)
- Vermont Information Technology Leaders (VITL)

The proposal developed by the above organizations is intended to be in direct alignment with the goals of the VHCIP grant.

Over the last nine years VITL has worked closely with Vermont's healthcare providers, many of whom are members of the three ACOs, to assist them with the shift from a paper to an electronic environment (see Appendix A, ACO Participants). The result is that Vermont enjoys one of the highest electronic health record (EHR) adoption rates in the United States. At the same time, VITL has worked with these providers to build the infrastructure to connect EHRs as the source systems for clinical documentation to the Vermont Health Information Exchange (VHIE).

This progress can now be leveraged broadly to better inform clinical decision making at the point of care and to utilize clinical data for analytics and population health data management.

The advent of specific ACOs measures requires that the four organizations perform a Data Gap Analysis that aligns with the HIE Workgroup's goal 'to improve the utilization, functionality and interoperability of the source systems providing data for the exchange of health information'. A second purpose of the analysis also aligns directly with the HIE Workgroup objective to identify gaps related to EHR usage as well as the ability of source systems to provide information such as

lab results, admission/discharge/transfer (ADT) and other data needed to achieve the ACO measures.

VITL's work with healthcare provider members of the three ACOs has closed many technology gaps. However, a thorough analysis based on the ACO measures will identify gaps in technology that still exist and will result in future recommendations also aligned with the HIE Workgroup's objective to 'invest in technologies that improve the integration of health care services'. These recommendations will be submitted as part of a second proposal for 'remediation' through investments in EHRs and the development of interfaces between the EHR and the VHIE, thereby supporting the HIE Workgroup objective to 'facilitate connectivity to the HIE for ACOs and their participating providers and affiliates'.

This proposal also includes the expansion of VITL's infrastructure to support the exchange of clinical data for analytics. VITL will build 'gateways' which allow the clinical data of specific beneficiary populations to be sent to analytics sources (as directed by provider groups) for population health management. A diagram for the ACO application of these 'gateways' is included in Appendix B, ACO Gateway Architecture. It is important to stress that this technology is useful for any future population based management program. Analytics will include a combination of clinical and payer specific claims data designed to assist ACO provider members report and perform against the ACO measures.

An additional aspect of this proposal is the development of an Event Notification System (ENS) designed to inform both ACO member organizations and any authorized healthcare provider statewide choosing to participate, that a patient involved in their care has been admitted, discharged or transferred by an acute care hospital in Vermont or by Dartmouth Hitchcock Medical Center in New Hampshire. This service achieves the HIE Workgroup's related objective that technology investments result in 'enhanced communication among providers'.

The last aspect of this proposal is designed to recognize the need to provide on-going customer and system support once the technical infrastructure and technology service investments have been made. A per member per month methodology based on the total number of ACO beneficiaries has been development to sustain these support costs.

The three ACOs and VITL believe that collaborating to effectively build a single common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients directly supports the goals of the VHCIP.

The following table demonstrates the strong alignment of this project with the VHCIP HIE Workgroup objectives.

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HIE Goals	VHCIP/HIE Work Group Objectives	Alignment with Population-Based Collaborative HIE Project
To improve the utilization, functionality & interoperability of the source systems providing data for the exchange of health information	• Explore and, as appropriate, invest in technologies that improve the integration of health care services and enhanced communication among providers • Identify core requirements for source systems to meet SOV HIE standards	→ Event Notification System → Data Gap Analysis
To improve data quality and accuracy for the exchange of health information	• Increase resources to facilitate improved EHR utilization at the provider practice level • Identify and resolve gaps in EHR usage, lab result, ADT, and immunization reporting, and transmission of useable CCDs. • Improve consistency in data gathering and entry • Support the Development of advanced analytics and reporting systems as needed	→ Data Gap Analysis → Data Gap Remediation → ACO Gateways
To improve the ability of all health and human services professionals to exchange health information	• Facilitate connectivity to the HIE for ACOs and their participating providers and affiliates • Standardize technical connectivity requirements to participating provider entities • Facilitate EHR adoption to current non-adopters • Facilitate connectivity to providers who are not yet connected to the HIE regardless of ACO participation	→ Data Gap Remediation → Data Gap Remediation → Date Gap Remediation → Data Gap Remediation

The benefits we intend to achieve as a result of funding this proposal include:

- Making rapid progress against the state HIE plan
- Providing a path for 2014 patient care benefits of healthcare information exchange across providers and through ACO population approaches
- Exploits the efficiencies of a collaborative project effort involving all three Vermont ACOs, their providers, VITL and the VHCIP work group
- Provides a mechanism for the VHCIP work group to measure and demonstrate tangible progress

We are excited with the opportunity to advance healthcare reform efforts in Vermont and believe this proposal assures that a health care system is affordable and sustainable through coordinated efforts to lower overall costs and improve health and health care for Vermonters.

II. Scope of Work

Project Activity Scope

There are three major threads to the project we are proposing:

1) **Connect Providers (Information from Providers to VITL)**
    a. Hospitals – Various Systems Interfaced to VITL
    b. Physician/Ambulatory EHRs Interfaced to VITL
    c. Community Providers Information Interfaced to VITL
    d. Home Health, Skilled Nursing Facilities, Designated Agencies for Mental Health, Substance Abuse, and Developmental Disabilities, and other Designated and Specialized Service Agencies.
    e. Potential – Other Information Sources Interfaced to VITL
2) **Make Information Available (Information from VITL to providers, ACOs, others)**
    a. Complete development and implementation of electronic population 'gateway' to GMCB/State Analytic Vendors/ACOs/Payers
        i. Supports analytic systems and payment reform efforts
        ii. Enables full-functionality NNEACC tool for OneCare Vermont ACO and its providers
        iii. Enables full functionality tool for CHAC and ACCGM analytics vendors
3) **Install and activate an Event Notification System (ENS)**
    a. Select a vendor and install an ENS
        i. Provides notification to health care providers of medical events that might trigger interventional care, e.g., an ED admission or a hospital discharge.
        ii. The ENS can be used by any health care provider in Vermont

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Project Data Scope

CHAC, OneCare, and ACCGM have collectively identified several Health Information Exchange needs. It will prove imperative for the ACOs to receive at the ACO level real-time admission, discharge, and transfer information re: ACO beneficiaries, wherever they are in the health system. The ACOs would also find value in receiving real-time lab results, discharge summaries, radiology reports, and immunization results. The tasks to be completed, specific deliverables, and timelines are listed in the table below.

		Task	Deliverable	Target Date
Gap Analysis			**The analysis is for all year 1 measures, inclusive of Medicare, Medicaid and Commercial**	
		Who has an EHR	VITL will identify for each participant for whom we have EHR data the EHR used by that participant.	Q1 2014
		Those who are unknowns	Based on the outcome of Task #1, VITL will contact each participant for whom VITL has no EHR information. VITL will update its customer base to reduce the number of OCV participants with unknown EHRs.	Q1 2014
		Hospitals sending lab results	VITL has knowledge of which hospitals are sending lab results to the VHIE. There is not a dependency on practices.	Q1 2014
		Health care organizations sending ADT	VITL has knowledge of which health care organizations are sending ADT to the VHIE. This includes hospitals and practices. VITL will also indicate which organizations could technically send an ADT but are not in the process of building an ADT interface.	Q1 2014

		Task	Deliverable	Target Date
		Health care organizations sending immunization	VITL has knowledge of which health care organizations are sending VXU (immunizations) to the VHIE. This includes hospitals and practices. VITL will also indicate which organizations could technically send a VXU but are not in the process of building a VXU interface.	Q1 2014
		Health care organizations sending CCDs	VITL knows which organizations are sending clinical data through the VHIE. VITL will be able to identify which organizations are sending CCDs that could be parsed and forwarded to NNEACC in a flat file for NNEACC analytics. VITL will also indicate which organizations could technically send a CCD but are not in the process of building a CCD interface.	Q1 2014
		For those organizations ending CCDs, what quality measures are included	VITL will review data in Docsite to identify which of the quality measure data elements are included in a CCD for those organizations sending CCDs.	Q1 2014
Gateway				
	OCV Medicare			
		Build Medicity functionality - Beneficiary file	A OCV master person index is created for Medicare beneficiaries	Q1 2014

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		Task	Deliverable	Target Date
		OCV Labs	OCV Medicare filtering on labs is complete, and sent to NNEACC	Q1 2014
		OCV ADT, CCD, VXU	OCV Medicare filtering on ADT, CCD and VXU is complete, and sent to NNEACC	Q2 2014
		Build NNEACC CCD Interfaces	Convert inbound CCDs to a flat file for NNEACC	Q3 2014
	OCV Medicaid			
		Build Medicity functionality - Beneficiary file	A OCV master person index is created for Medicaid beneficiaries	Q3 2014
		OCV Labs, ADT, CCD, VXU	OCV Medicaid filtering on lab, ADT, CCD and VXU is complete, and sent to NNEACC	Q3 2014
	OCV Commercial			
		Build Medicity functionality - Beneficiary file	A OCV master person index is created for commercial beneficiaries	Q3 2014
		OCV Labs, ADT, CCD, VXU	OCV commercial filtering on lab, ADT, CCD and VXU is complete, and sent to NNEACC	Q3 2014
	CHAC			

		Task	Deliverable	Target Date
		Build Medicity functionality - Beneficiary file	A CHAC master person index is created for CHAC beneficiaries	Q4 2014
		OCV Labs, ADT, CCD, VXU	CHAC beneficiary Medicare filtering on lab, ADT, CCD and VXU is complete, and sent to NNEACC	Q4 2014
	ACCGM			
		Build Medicity functionality - Beneficiary file	An ACCGM master person index is created for ACCGM Medicare and commercial beneficiaries	Q4 2014
		OCV Labs, ADT, CCD, VXU	ACCGM beneficiary Medicare and commercial filtering on lab, ADT, CCD and VXU is complete, and sent to NNEACC	Q4 2014
	ENS		An Event Notification System (ENS) delivers real-time ADT information about a patient's medical services encounter, for instance at the time of hospitalization, to a permitted recipient with an existing relationship to the patient, such as a primary care provider. The functionality is not limited to ACOs, but is open to any health care provider.	
		One time software license purchase	Software license fee	Q4 2014

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		Task	Deliverable	Target Date
		One time ENS Implementation	Implementation fee	Q4 2014
		One time hosting environment setup	Build the hosting infrastructure	Q4 2014
		Onboarding per provider organization	Onboarding the organization that will receive event notifications	Q4 2014
First Year Support				
		OCV Medicare		Feb 2014
		OCV Medicaid		June 2014
		Commercial		July 2014
		CHAC		November 2014
		ACCGM		[not live 2014]

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III. Health Care Delivery System Impact

There is broad agreement on the power and importance of health information exchange (HIE) in providing well-coordinated, high quality healthcare which avoids waste. Both Vermont and national reform have focused on new programs and incentives for networks of health care providers to take accountability for populations of patients they serve. In Vermont, the formation of these networks and participation in available programs has been very strong, and this is now a part of the unique Vermont story growing nationally. The types of providers across the continuum of care and services represented at the table are also expanding. Appendix A shows the three ACO organizations in Vermont and the very broad network of participation they have today.

Given the strong ACO participation, we are envisioning many cross-collaborative relationships which further supports this multi-ACO approach to HIE. Although some providers have not decided to participate with any of the ACOs to date, we expect this project and approach to connect and support providers who may end up taking an independent path under reform. We believe that incentives to be a part of an ACO network should exist, but would expect some pathway will be available to those who choose independence but wish to collaborate on patient care.

ACO-based programs use a model of "attribution" of patients based on physician relationships with patients and are strongly focused on primary care relationships. As the table indicates, there are nearly 450 primary care physicians representing a strong majority of all the primary care physicians in the state of Vermont participating across the three ACO organizations. With the payer programs in place or expected to be in place for Medicare, Medicaid, and across the Vermont Health Connect plans from Blue Cross Blue Shield of Vermont and MVP Healthcare, we expect over 100,000 Vermonters to be attributed in 2014 and grow over time.

To proactively coordinate care and measure quality, Vermont's ACOs envision the availability of the key information tools described earlier from VITL to support our efforts. We plan to make great use of the population-based pipeline of information to (a) feed our ACO analytic and care management systems, and (b) support collaborative processes across the continuum of care, especially as patients transition from one setting of care to another. Specific examples of tools and processes that will be enabled by the project requested in this document, with its additive HIE infrastructure developed by VITL, are anticipated to include:

- Combined cost, utilization, quality, and clinical reporting to fully capture the current performance and opportunities for improving care to a population of patients
- Generation of such population-based analysis at any level desired: compare among ACOs, ACO wide, regional, local community, or individual practice or provider

- More refined and accurate reports identifying specific "capturable" opportunities for improvement; an example would be greatly expanding analysis on metrics based on national physician associations guidelines on avoiding waste and unnecessary care based on evidenced based research (example: "Choosing Wisely" campaign)
- Real time quality metric performance monitoring for the designated population measures in ACO programs; an ACOs population "score" can be known through the year giving us an opportunity to improve
- Automated annual submissions of quality information to CMS, DVHA, Commercial Payers, and the GMCB for the selected patient samples rather than relying on retrospective (and costly) chart or EHR audits
- Movement beyond simple and incomplete registries of patients with chronic illness into a much richer and effective chronic disease management program based on complete clinical information and risk analysis
- Drive evidenced-based care "gap analysis" by patient to ensure no patient falls through the cracks who would benefit from specific approaches based on clinical outcomes research
- Drives systems to better assign patients needing care coordination to "work lists" for those most able to engage with that patients and coordinate their care, whether they be staff in the PCMH, hospital, community based provider, home health agency, designated agency, other support services programs, or at the ACO itself.
- Provides those assigned a "care manager" the tools and combined visit history and clinical snapshot of the patient to jump start and monitor that patient's care
- Provide a single real time source alerting those involved in a patient's care about a major clinical event (such as a hospital admission or Emergency Room visit); this will allow more proactive coordination and planning for that patient's needs given the acute nature of the major events

Please note that these are all systems and processes in development, and to be deployed using the underlying capabilities from this project. Some including the Event Notification System are included in the project scope, but others are being developed by the ACOs and their providers. Not all the tools and processes above will be defined and in place by the end of the project and may vary in scope and design by each ACO. Additional VHCIP assistance for an ACO or among the ACOs in developing and deploying the systems and processes described above may be included in other projects proposals for VHCIP work groups.

Overall, the three ACOs and non-ACO estimates are given in Appendix A.

IV. Project Budget

Project Budget

A table summarizing the project budget by components is as follows:

		Item	Units	Rate	Labor	Purchased Service	Total	Justification
Salaries and Wages								
		Project Managers	3,470.40	$ 125	$ 433,800		$ 433,800	These are fuly loaded rate, incldung salary, benefits, overhead, and contingency. There are 2-3 project managers almost full time. No costs have been inlcuded for ENS implementation and eHealth Secialists for gap analysis.
Subtotal Salaries							**$ 433,800**	
Systems								
	OCV Medicare							
		Build Medicity functionality - Beneficiary file	1			$ 12,650	$ 12,650	
		OCV Labs	1			$ 132,250	$ 132,250	
		OCV ADT, CCD, VXU	1			$ 250,700	$ 250,700	
		Build NNEACC CCD	1			$ 34,500	$ 34,500	
	OCV Medicaid							
		Build Medicity functionality - Beneficiary file	1			$ 12,650	$ 12,650	
		OCV Labs, ADT, CCD, VXU	1			$ 172,500	$ 172,500	
	OCV Commercial							
		Build Medicity functionality - Beneficiary file	1			$ 12,650	$ 12,650	
		OCV Labs, ADT, CCD, VXU	1			$ 172,500	$ 172,500	
	CHAC							
		Build Medicity functionality - Beneficiary file	1			$ 12,650	$ 12,650	
		OCV Labs, ADT, CCD, VXU	1			$ 172,500	$ 172,500	
	ACCGM							
		Build Medicity functionality - Beneficiary file	1			$ 12,650	$ 12,650	
		OCV Labs, ADT, CCD, VXU	1			$ 172,500	$ 172,500	

		Item	Units	Rate	Labor	Purchased Service	Total	Justification
Systems								
	ENS							
		One time software license purchase	1			$ 125,000	$ 125,000	
		One time ENS Implementation	1			$ 156,250	$ 156,250	
		One time hosting environment setup	1			$ 31,250	$ 31,250	
		Onboarding per provider organization	100			$ 312,500	$ 312,500	
Subtotal Systems							**$ 1,795,700**	
First Year Support								
		OCV Medicare	1				$ 465,740	Prorated at # of beneficiaries * number of months expected to be live * $.73 PMPM
		OCV Medicaid	1				$ 127,020	
		Commercial	1				$ 118,552	
		CHAC	1				$ 82,986	
		ACCGM	1				$ -	
Subtotal First Year Suport							**$ 794,298**	
Total First Year							**$ 3,023,798**	

The hours for project managers are spread across all projects.

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V. **Sustainability Plan**

This proposal identifies specific investments in four key aspects of developing and sustaining health information exchange capabilities and services needed by Vermont's ACOs to achieve their goals as part of Vermont's healthcare reform efforts.

The four organizations have managed to move the collaboration along through a common goal for a unified system, with open and positive discussion, and facilitation by state representatives and VITL staff. Governance discussions have continued, topics including a potential steering committee consisting of the collaboratives' representatives, and appropriate state membership (tbd).

The gap analysis will identify the gaps that exist among state-wide ACO data requirements and data capacity. The prioritization and costs associated with the remediation of those gaps will be part of a second proposal. The building of ACO 'gateways' leverages the existing infrastructure of the VHIE by deploying the technical architecture to support movement of data from source systems to analytics destinations. Installing a system that improves quality and timeliness of transitions of care through real-time notification of important clinical encounters leverages and expands the VHIE's capabilities to provide a service for all Vermont healthcare providers.

Once investments are made in technology and services, the on-going costs associated with providing customer and system support need to be sustained financially.

These costs include customer support to ACO participants and encompass: patient identity management; interface maintenance, upgrades and replacement; continuously measuring and improving data quality; and the provision of a 24x7 support center.

Sustaining costs for system infrastructure support include: interface monitoring; monitoring message routing; maintaining beneficiary matching rules; maintaining message transformers to include consent flags; resolving errors and performing testing on new interfaces; and maintaining provider profiles and other aspects of an Event Notification System.

The investments recommended in this proposal are minimal in comparison to the investments made to develop and maintain the VHIE, yet are designed to leverage current technological capabilities to directly support ACO needs as part of healthcare reform efforts. It is anticipated that accountable care approaches to the Medicare beneficiary population will be expanded over the next few years to include Medicaid and commercially insured beneficiary populations. The VHIE and the investments recommended in this proposal will continue to be leveraged to support the data exchange and measures based analytic services required to support these additional ACO and other beneficiary populations.

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In 2014 the proposed technology investments will shift from implementation to the need to provide ongoing customer and system support. As a result, these costs will occur incrementally and can be linked to the specific capabilities and functions the investments generate.

VITL is undertaking these technologies based on both the existing infrastructure of the VHIE and its internal capabilities, expertise and experience with the exchange of health information. Some of the requested services are at the forefront of HIE technology so precise costs associated with deployment and sustainability are not completely known. As a result, a range for the costs of sustaining the technology have been developed within the total not to exceed investment request.

The methodology used to develop a framework for estimating the costs of sustaining customer and system support was based on expectations of growth in the ACO beneficiary population. VITL's costs for sustaining the VHIE, as a subset of its total expenses, was used to determine customer and system support costs. The development of a per member per month rate was developed by dividing the total potential number of ACO beneficiary population members by the costs associated with sustaining the VHIE.

This proposal's request for support cost funding encompasses a range from $570,000 to $800,000 based on the computed per member per month rate, estimates of timelines for technology shifting from implementation to support and estimates of increases in ACO beneficiary populations over the first year of the VHCIP.

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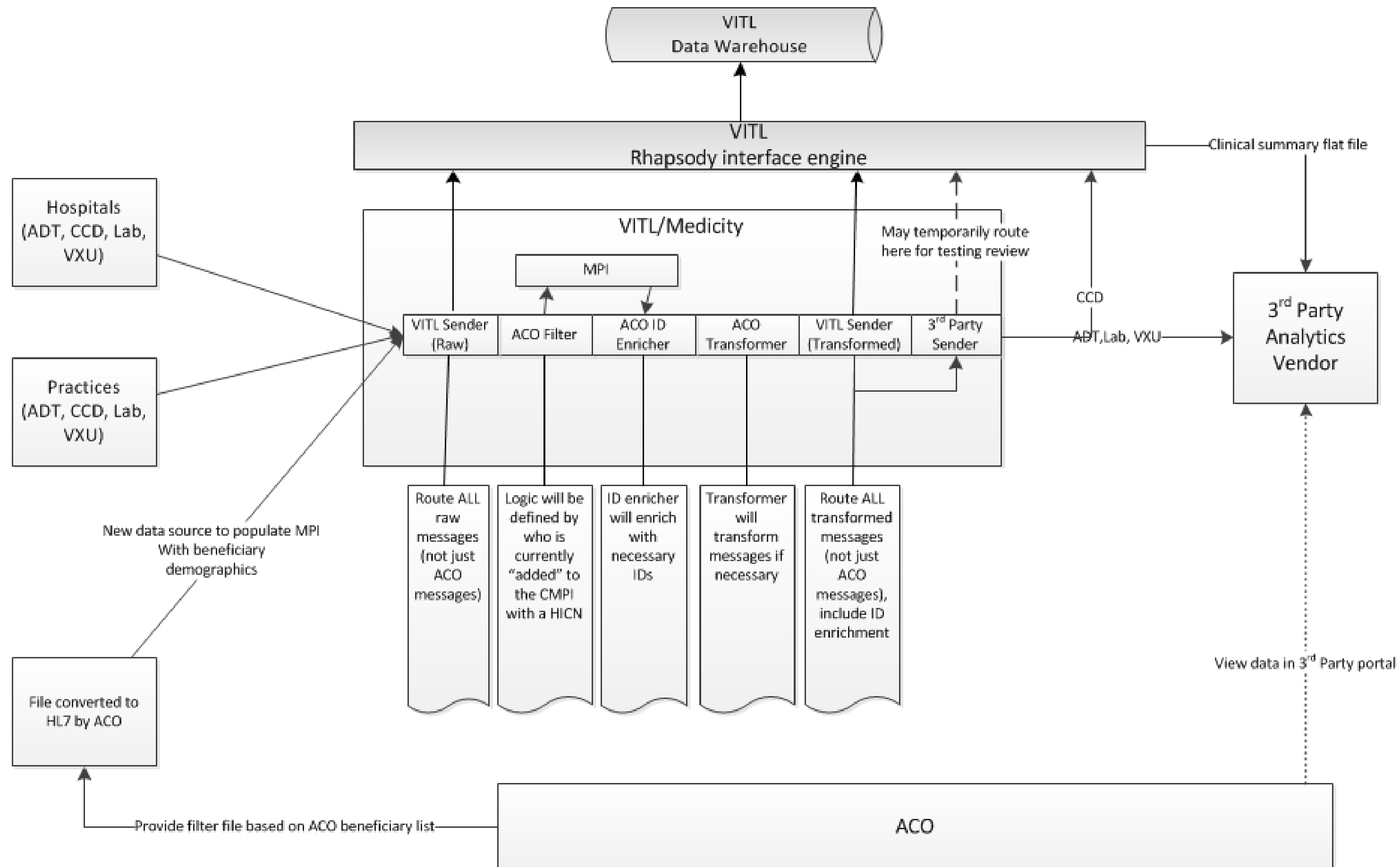
Appendix A – ACO Participants

Accountable Care Organization (ACO) Networks in Vermont

ACO/Network	Hospitals	Federally Qualified Health Centers (FQHC)	Primary Care Physicians (PCP)	Specialty Care Physicians (SCP)	Skilled Nursing Facility (SNF)	Home Health Agencies (HH)	Designated Agencies (DA) for Mental Health & Substance Abuse (MH & SA)	Other Designated Agencies (DA) and/or Long Term Supports & Services (LTSS)
OneCare Vermont (OCV)	2 AMCs 5 Community PPS 8 CAH 1 MH Specialty Hospital	3 FQHCs	All Hospital employed (60 Practices) Participating FQHC Practice Sites (8 Practices) 12 Independent Practices **TOTAL: 300+ PCP FTEs**	All Hospital Employed (1800 Physicians) 30 Independent Specialty Practices (60 Physicians)	All Hospital Owned SNF included Additional Affiliate Agreements with 29 Independent SNF	Affiliate Agreements with 10 Local Home Health Agencies	Affiliate Agreements with 10 Mental Health and Substance Abuse Agencies	Network Affiliate Agreements Expected
Community Health Accountable Care (CHAC)	Expected Local Collaboration	7 FQHCs	Participating FQHC Practice Sites (35 Practice Sites) **TOTAL: 100+ PCP FTEs**	Any FQHC Employed	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected
Accountable Care Coalition of the Green Mountains (ACCGM) for Medicare SSP **Vermont Collaborative Physicians (VCP) for Commercial Exchange SSP** NOTE: Both in collaboration with HealthFirst Independent Physician Network	Expected Local Collaboration	None	15 Independent Practices **TOTAL: 45+ PCP FTEs**	Independent Specialty Practices Collaboration through HealthFirst	Expected Local Collaborations	Expected Local Collaborations	Expected Local Collaborations	Expected Local Collaborations
Vermont Sub-Total in ACOs	100%	91%	70% (Approx.)	85% (Approx.)	80% (Approx.)	80% (Approx.)	100%	TBD

Appendix B – ACO Gateway Architecture



Appendix C - HIE Work Group Q & A

Questions for the Population-Based Collaborative Health Information Exchange (HIE) Project Presenters - January 17, 2014

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Introduction

Several of the questions relate to the statewide impact to non-ACO providers. Briefly, this is how non-ACO providers would envision their participation in health care reform.

VITL sends and receives data from health care organizations throughout Vermont, including all hospitals, most FQHCs, a majority of primary care providers, and other specialists and long term care. The data is not specific to ACOs and beneficiary populations. The patient care goals of ACOs are to collect quality clinical data electronically. Their facilitation for their members to achieve these goals in turn expands quality clinical data in the Vermont Health Information Exchange (VHIE). The VHIE is not restrictive to ACO providers, but is accessible to any health care provider who has signed the appropriate legal agreements with VITL. Providers may access the VHIE through a provider portal. In addition, any health care provider may participate in the Event Notification System, again, not restrictive to ACO providers. In summary then, the emphasis on quality clinical electronic data by the ACO and an Event Notification System accrues to both ACO and non-ACO providers.

The questions below were submitted by the VHCIP/HIE Work Group.

Questions related to budget:

1. *[This question was submitted by the Work Group leadership team]* Your budget has a range of $2,110,000 to $3,045,000. In order for the HIE Work Group to consider a recommendation, you will either need to provide a specific budget number or a "not to exceed" number that can be incorporated into an Agreement/Contract and a statement of work to support the estimated budget. Please provide a more detailed statement of work and the specific amount or "not to exceed number" you would like the work group to consider.
   The ACOs and VITL are in an early planning phase. Although we believe the range provided is sound based on significant experience by VITL leadership, we are working on more firm specifications from which a more detailed model of timing and use of funds by VITL, including obtaining firm quotes by third party technology partners, can be developed. The desire is to be as specific and cost

conscious as possible once the quotes have been obtained, but some patience and understanding of the pioneering nature of this work is requested. Our formal request for the system build currently outlined at this point can be considered as a not to exceed $3M budget.

2. *[This question was submitted by the Work Group leadership team]* Is it the intention of the PAN ACO group to seek additional SIM/VHCIP funding for Gap Remediation and support costs in 2015 and 2016? In this regard, the work group is also interested in the sustainability plan for supporting the costs of this infrastructure beyond 2016. As part of the sustainability plan, please indicate which parts of the project will be on-going operational expenses as opposed to developmental expenses.

   Would you please provide the group with an estimate of additional costs that you will be asking the work group to support, if any, and what other sources of funding you intend to pursue to insure the sustainability of this infrastructure beyond 2016.
   - **We envision this system becoming the back bone data system for much of the health reform effort during the next number of years. Once built, many participants, the state and commercial insurers included, in addition to the ACOs, are likely to derive benefits through more information and better coordination of care and cost management. Consequently, the ACOs envision full funding of system maintenance support through VHCIP until at least 2016 or at least until shared savings begin to occur. This would come from either (or a combination of) additional SIM/VHCIP funds in 2015/2016 or through a separate sustainable ACO operational funding model (with VITL support fees included) as developed through other mechanisms and implemented for 2015 or 2016. VITL is looking for confirmation that support costs will continue after development and implementation of the infrastructure.**
   - **Funding of maintenance and system enhancements beyond 2016 will, in all likelihood, need to be funded by all of the participants and beneficiaries of an improved care coordination model. We envision this sustainable model of ACO funding (again, with VITL support fees included) must be fully developed (negotiated) and implemented before the end of 2016 to ensure sustainability of the system. These discussions should begin in the second half of 2014.**
     - **To specify the funds needed in the 2015/2016, and beyond, the ACOs will need to provide attributed lives for 3 years to VITL**
   - **We will also provide targeted funds needed for Gap Remediation (currently TBD) by June 2014**

3. As with the FQHCs, the IT resources at DA/SSAs and other full spectrum provider agencies are limited. The Pan ACO proposal will require quite a bit of agency IT staff time. Will the Pan ACO proposal provide incentive payments/stipends/subsidies for these agencies?
   No incentive payments/stipends/subsidies were included in the initial proposal for either the current or prospective ACO members. We envisioned that these sorts of

additional resources, if needed, would be identified in the Gap Remediation plan. Separate funding can then be requested either as part of an expanded ACO request or by the organizations themselves.

4. Does the $0 figure for gap analysis in the "Support Costs" section assume that all gaps/challenges will be identified initially and that no others will be discovered in subsequent project years? What happens when there are changes in ACO-provider affiliations after the gap analysis is complete?
   Gap analysis will be used to determine plans for gap remediation. Gaps will continue to be generated, e.g., EHR replacement in the future. This funding request is for ACO gaps that currently exist. A reasonable level of change in ACO programs and subsequent HIE needs are part of the ongoing support payments model, but any major changes in approach, number of measures, or other ACO requirements may require additional one-time projects and new gap analysis and remediation.

5. It seems there are still questions about the feasibility of funding Gap Remediation activities. In the event that VHCIP funding is not available (or not sufficient to cover all remediation activity), how will remediation be funded? If only *limited* funding is available for remediation, how will providers/practices be prioritized for EHR upgrades & related activities? This is particularly relevant for provider types known to have large gaps at present. In the absence of a plan for addressing the costs of subsequent phases, the initial investment of $2-3M is concerning. [The major investment is in the gateway build, but the utility of a gateway seems limited if there are still problems with capturing and transmitting data accurately.]
   Most likely, the ACO proposal will as we've indicated create the backbone for a system which will be expanded to other users over some number of years, and through a variety of funding sources in addition to those we have now. We envision handling this problem as it arises and with the clarity of the results of the gap analysis. In general, if needs are beyond resources and such limits are placed, priority will be set based on attributed lives and the providers holding the source data elements for the required quality measures of ACO programs. Subsequent funding sources will likely need to be found and employed for further rounds of gap remediation.

Questions related to vendor selection:

6. *[This question was submitted by the Work Group leadership team]* We assume that you are recommending that this contract, if approved, would be with VITL as the provider of the services you have described. Please confirm, and please also confirm that VITL agrees with this arrangement.
   We agree and third party contracts required would be sub-contractors to VITL.

Questions related to scope of work and/or existing contracts:

7. *[This question was submitted by the Work Group leadership team]* We are aware that VITL has an existing contract with DVHA to fund specific work that is related to what the PAN ACO Group is proposing. Please describe the specific work that is being funded under the current DVHA contract, what the status of that work is, and specifically how the PAN ACO proposal would supplement, not duplicate the work that is already under contract. The Work Group wants to be very clear that it does not intend to recommend funding for work that is already under contract.
   The grant agreement between DVHA and VITL covers, in general:

   - **New interfaces to hospitals, designated agencies, home health, and specialists**
   - **Provide "REC-like" services to organizations other than primary care**
   - **Expand the VITL in-house infrastructure**
   - **Conduct several exploratory projects that would facilitate faster interface implementation**

   None of these services would be funded through SIM. The Pan ACO work is focused on filtering data based on a beneficiary population against membership of an entity (ACO), which had not been envisioned when the DVHA-VITL agreement was developed in the spring of 2013. This new work will primarily include both a general clinical data feed (ACO Gateway) for a beneficiary population and an event notification system (ENS). The budget for the Event Notification System is for license and implementation which does not overlap labor estimates in the DVHA grant, which is focused on proof of concept and will include RFP development, and vendor evaluation and selection. Additional focus is also being added for the ACO program-specific data elements for the new Vermont Shared Savings programs which were approved by the VHCIP and not known previously. To emphasize, the SIM funding will not fund any work defined previously in the DVHA grant.

8. *[This question was submitted by the Work Group leadership team]* The State requires specific statements of deliverables and timelines in all contracts that it executes. In order to develop a contract with you, we will need you to provide a written estimate of the deliverables related to your Scope of Work, and the timelines associated with each of those deliverables.
   Yes, we understand and agree.

9. Broadly, it would be helpful to see significantly more detail about how the project will proceed, and how the work group /VHCIP governance will be kept apprised of progress and challenges on a regular basis.
   The Pan ACOs and VITL recommend summary updates at each HIE workgroup and more detailed and substantial updates quarterly. We anticipate HIE work group chairs will provide SIM Steering Committee updates on the project and sponsor (if desired) our quarterly updates onto the Steering Committee agenda. In addition, a more detailed project plan and budget are being prepared to help all committees involved in the recommendation and approval process to be clearer on proposed deliverables, timelines, and cost estimates.

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10. How will provider types be prioritized for assessment during the gap analysis? Has a schedule been developed for this component, and what activities will the gap analysis include?
No prioritization is necessary and all ACO provider participants including affiliate participants are included. A schedule exists and the analysis is underway. Scope:

Task	**Description**
1. Who has an EHR	VITL maintains customer information on all ACO participants. VITL will identify for each participant for whom we have EHR data the EHR used by that participant.
2. Those who are unknowns	Based on the outcome of Task #1, VITL will contact each participant for whom VITL has no EHR information. VITL will update its customer base to reduce the number of ACO participants with unknown EHRs.
3. Hospitals sending lab results	VITL has knowledge of which hospitals are sending lab results to the VHIE. There is not a dependency on practices.
4. Health care organizations sending ADT	VITL has knowledge of which health care organizations are sending ADT to the VHIE. This includes hospitals and practices. VITL will also indicate which organizations could technically send an ADT but are not in the process of building an ADT interface.
5. Health care organizations sending VXU	VITL has knowledge of which health care organizations are sending VXU (immunizations) to the VHIE. This includes hospitals and practices. VITL will also indicate which organizations could technically send a VXU but are not in the process of building a VXU interface.
6. Organizations sending CCDs (clinical summaries) through the VHIE (does not specify what they are sending)	VITL knows which organizations are sending clinical data through the VHIE. VITL will be able to identify which organizations are sending CCDs that could be parsed and forwarded to NNEACC in a flat file for NNEACC analytics. VITL will also indicate which organizations could technically send a CCD but are not in the process of building a CCD interface.

Task	Description
7. The GMCB approved quality measure data elements include measures that may be included in a Blueprint CCD. For those organizations sending CCDs VITL will identify which of the ACO-Blueprint measures are actually being sent.	VITL will review data in Docsite to identify which of the quality measure data elements are included in a CCD for those organizations sending CCDs.

11. I'm somewhat concerned about the scope of the gap analysis with respect to measures. Though the list of measures to be considered is substantial, it is by no means comprehensive. This investment may well improve providers' abilities to capture quality information for a finite set of (largely primary care) measures, but achieving near-perfect electronic collection of these measures—as currently specified—after several years won't necessarily be sufficient in an ever-evolving measure environment, nor will it aid other provider types in collection of measures relevant to their services.
We are working on the existing scope of work for the gap analysis based on the VHCIP Data Subgroup measures. We believe that building the documentation methods and HIE connections focused on this important and varied set of measures will pave the way for additional measures (i.e. let's prove we can do it for these measures and not get bogged down with too many competing information elements).

12. Could you provide a description of the longer-term impacts of the proposed work in a post-ACO context? Given that the ACO model is designed to be a transitional model, and considering the size of the investment and the projected duration of this effort, it would be helpful to know how the products and benefits will translate to subsequent models or systems.
Although "Shared Savings Programs" with quality and satisfaction measures are generally considered to be transitional models, we anticipate that clinically integrated networks of providers (whether called ACOs or not) taking accountability for the total cost and quality of populations will be a long term model of healthcare delivery. Data sharing will remain a key and will continue post SIM funding. As indicated previously, we believe we are building the foundation data engine for the State of Vermont, and this model will be useful for any population of attributed lives. We think subsequent rounds of funding will very readily provide expansion for other stakeholders.

13. On slide 7, "Well designed tools and interfaces to access that information subject to data use agreements and patient consent model." What I see as potentially missing is a view to the aggregate state data. I think the outlined efforts assist in getting a more complete data set by increasing the network effect, but I don't see in the proposal a plan to create and analyze the data at a state aggregate level. It serves a mutual purpose to all ACOs to build the platform so they can take their own data out for use by their analytic tools for their patient population, but from a payment and quality perspective there may be a need for a tool to look at it from a more global perspective. Is that one of things considered in the "3rd Party Analytics Vendors?" Medicity isn't positioned to provide analytics at a population level. That said, the project underway as mentioned before, may be a catalyst that is beneficial to the State if it is done well. There is a benefit to the ACOs to ensure quality (they don't want garbage out).
The scope of the request does not include designing or providing, or allocating funds for ACOs to obtain and deploy analytics systems. The scope provides a foundation for improvements of data quality, to feed into the analytics vendors. We do believe a separate dialogue on this is a worthwhile discussion however, and in all probability, this project will provide the pathway for statewide analytics.

14. Event notification is missing in the current HIE system, and needed. An overlay with the Care Models group should be a discussion of what should happen for patients who have a triggering event, but aren't engaged in the current care system. That won't be a question the ACOs are primarily focused on. For them, it's a person, but not one of their members for whom they are responsible. It may come down to the State who is looking out to the common good to pursue that question.
The Event Notification System is important to the success of the ACOs and better patient management, so it is being requested by the ACOs as part of the scope of the project. However, ENS is global, not specific to ACOs. We expect this to be used by providers regardless of their participation in an ACO.

15. On Slide 9, in order to understand how care transitions will be impacted by event notification, please provide descriptions (e.g. use case examples) describing how "Event notification" will benefit people receiving services from providers working in the following settings:
    - private homes –case manager or family member managing person's services
    - residential care home manager
    - adult day center director
    - designated agency case managers
    - nursing facility discharge planners

    Providers in each of the aforementioned settings will have access to the Event Notification System once they have signed a data sue agreement with VITL. This type of design and use of case process will be a part of the ACO work with its network and with the VHCIP Care Models and Care Management subgroup where common

approaches across ACOs is warranted. We expect the ENS system once created to expand as needed within the entire health care delivery system.

16. Can you provide specific clinical examples of how this grant will improve the delivery of care in Vermont? And for care delivered by practices not in the ACO?
    - **This will provide data to analytics vendors to enable ACOs to do central analysis and identification of population-level improvement opportunities, as well as deploy patient-level systems to providers identifying specific gaps in care and evidence-based suggestions for clinical interventions to reduce more costly services and improve quality.**
    - **This will allow more progress more rapidly than other approaches for providers to see aggregated data on their patients across the Vermont network in support of patient management and site of service care delivery**
    - **The emphasis on data quality for ACOs to achieve their cost savings benefits patients regardless of their insurance coverage. Practices not in an ACO may have access to that data.**
    - **Practices not in an ACO will be able to fully utilize the Event Notification System.**

17. Will this proposal provide resources to individual practices to develop interfaces with the HIE or the ACO or others?
    Additional resources may be identified in gap remediation. This is specific to the defined scope of the Pan ACOs, including Participating Providers and Affiliates. Some work on HIE interfaces is already within the scope of VITLs contracts with DVHA, other work required outside the scope of this project will most likely require other VHCIP or other funding

18. How does this proposal implement efficient, cost-effective bi-directional solutions for sharing key information across provider types, since many LTSS providers lack EHR.
    a. On Slide 8, is bi-directional communication between all types of providers participating in an ACO implied in the phrase "electronic data to be routed to ACOs"? Please explain and give examples.

    We will include assessment of data elements needed from these providers and they will be able to participate in an ENS and can access data in VITL Access. We expect the gap analysis to identify where gaps exist and the extent of remediation work and funding required.

19. Could this work be expanded to include processes to share information across provider types through web portals that support common tools (e.g. uniform transition of care form)?
    Yes, it could be expanded through VITL Access or ACO-based analytic and care management systems. We fully expect this work to lead directly to increased ability to share information. It is not however in the current scope of this proposal.

20. On Slide 3 what is meant by "relevant clinical information"

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At a minimum the data elements required to support CMS-defined and VHCIP-developed and GMCB approved quality measures and events.

21. On Slide 6, Please describe the benefits of "the Gateway Build" for people receiving services from providers working in community based settings (e.g. private homes, Area Agencies on Aging, residential care homes, adult day centers).
    a. On Slide 9, how will the "Gateway Build" be used to connect long-term services and support providers with primary care and hospital providers? Please provide descriptions (e.g. use case examples) describing which "source systems" will be connected (e.g. OASIS? MDS? DA/EHR? etc.)
    b. On Slide 10, can a more detailed explanation of the ACO Gateway Architecture be shared?

    VITL is glad to provide more detail on what functionality is provided by a gateway, as a data disseminator. Again, this proposed system and project form the foundation upon which we think much of the statewide data sharing will ultimately occur. Gap remediation is intended to identify where further work will be needed and to frame some discussions as to priorities and resources needed. Ultimately, the success of the system and the benefits which accrue to patients will be dependent on the universality of coverage, so the long term goal is to connect all providers.

Questions related to data, including potential data collection restrictions:

22. *[This question was submitted by the Work Group leadership team]* Specific concerns have been raised by members of the work group regarding the ability of the Designated Mental Health Agencies to share information with VITL and other providers given the privacy restrictions related to the exchange of sensitive health information, including especially from federally regulated substance abuse treatment programs (42 CFR Part 2). How do you intend to address those restrictions in your proposal?
    The scope of work for the ACOs does not include addressing 42 CFR Part 2. VITL is pursuing some options with DVHA that are parallel and independent of the Pan ACO work. A formal plan for addressing the issue is being developed jointly among VITL, DVHA, FQHCs, and the Designated Agencies.

23. What about Specialized Service Agencies? How does their client data fit in? (NFI, small Developmental Disability stand-alone agencies)
    The proposed scope is ACO membership and affiliates at this time but we hope to involve all who touch ACO-attributed patients in the discussion

24. What kind of access will affiliate providers have to the data analytics for their clients? There are a number of platforms so that may differ from one ACO to the other.
    This is the outcome of ACO specific decisions. ACOs intend to deploy analytics to providers across the continuum of care community.

25. What will be the impact on existing infrastructure? I see the work with the VHIE allowing for a more robust clinical data set that can enhance the current claims data set. I'm not sure alone whether either, VHIE or claims, paints a full picture, so the statement "build a single common infrastructure to electronically report on quality measures" stands out to me.
It will expand and improve the existing infrastructure by matching claims and clinical data to enable the exchange of clinical data for analytics and event notification system. This approach mitigates the need for multiple identical infrastructures, by building a single cost effective infrastructure.

Questions related to the ACO structure and/or VITL relationships:

26. How many of the DA/SSA clients will be attributed to the ACOs?
Patients are attributed to the ACOs by the patient attribution methodology. The ACOs at this time do not know the number of attributed patients for the new programs
27. How many full spectrum clients will be attributed?
Same as previous answer.
28. How are SASH teams working with VITL and the ACOs?
The providers are working with SASH directly, through Blueprint initiatives, and through the VHCIP Care Model and Care Management workgroup. This is an area that is likely to get more attention either in the gap analysis or in the next generation of the project.
29. How will the individual practices that are not part of the ACO be represented in this process?
The scope of work includes ACO providers and affiliates for the ACO gateway routing of data. It also includes an event notification system encompassing all providers in Vermont. It will also form the foundation for future expansion. We support a similar effort by VITL for all providers to have the richest data set available for ACO-attributed patients, and in a next generation system, for all providers to have access.
30. How will project be administered among the ACOs given they are very different in their size, scale, governance, and makeup?
This is in process among the ACOs and VITL. So far, we have managed to move the collaboration along through a common goal for a unified system, discussion, and facilitation by state representatives and VITL staff. If we find the need to create a more formal decision making process, then we'll have to draft one. Discussions and work sharing has been extremely collegial to this point.
31. Is (or would) the PAN ACO group be willing to include staff familiar with the technology systems supporting the following LTSS providers:

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- Home Health
- Area Agencies on Aging
- Nursing Facilities
- Developmental Disabilities services

VITL has and will continue to work with any and all providers in Vermont. The ACOs and VITL want to be open and collaborative with these LTSS providers as this project works with them. The ACOs are actively working on participation agreements with a number of providers and agencies and that activity in combination with the gap analysis will quite naturally bring LTSS providers to the table either on this round or the next.

32. On Slide 6, are the ACO participants in the Designated Agencies limited to Mental Health ($199M) and Substance Abuse ($20M)?
The ACOs are interested in discussions related to any organizations involved with attributed members. The Medicaid Shared Savings Program (and Medicare and Commercial as well) as developed and approved by the VHCIP Payment Models work group contains information on which patient populations are attributed and which specific spending items are included in the cost targets and when.

33. On Slide 6, are developmental disabilities services ($160M) and Traumatic Brain Injury providers included within the ACO participant network?
Same as previous answer.

34. On Slide 8, which “care managers” are within the scope of those being notified of important clinical events?
A primary goal of this project is sharing clinical data in support of care management.
This type of design and use case process will be a part of ACO work with its network and with the VHCIP Care Models and Care Management subgroup where common approaches across ACOs is warranted. While this effort is starting among the three ACOs, the goal is that each ACO “network” will encompass a very broad scope of care managers. Any health care provider in Vermont who has a data use agreement with VITL may participate in the Event Notification System.

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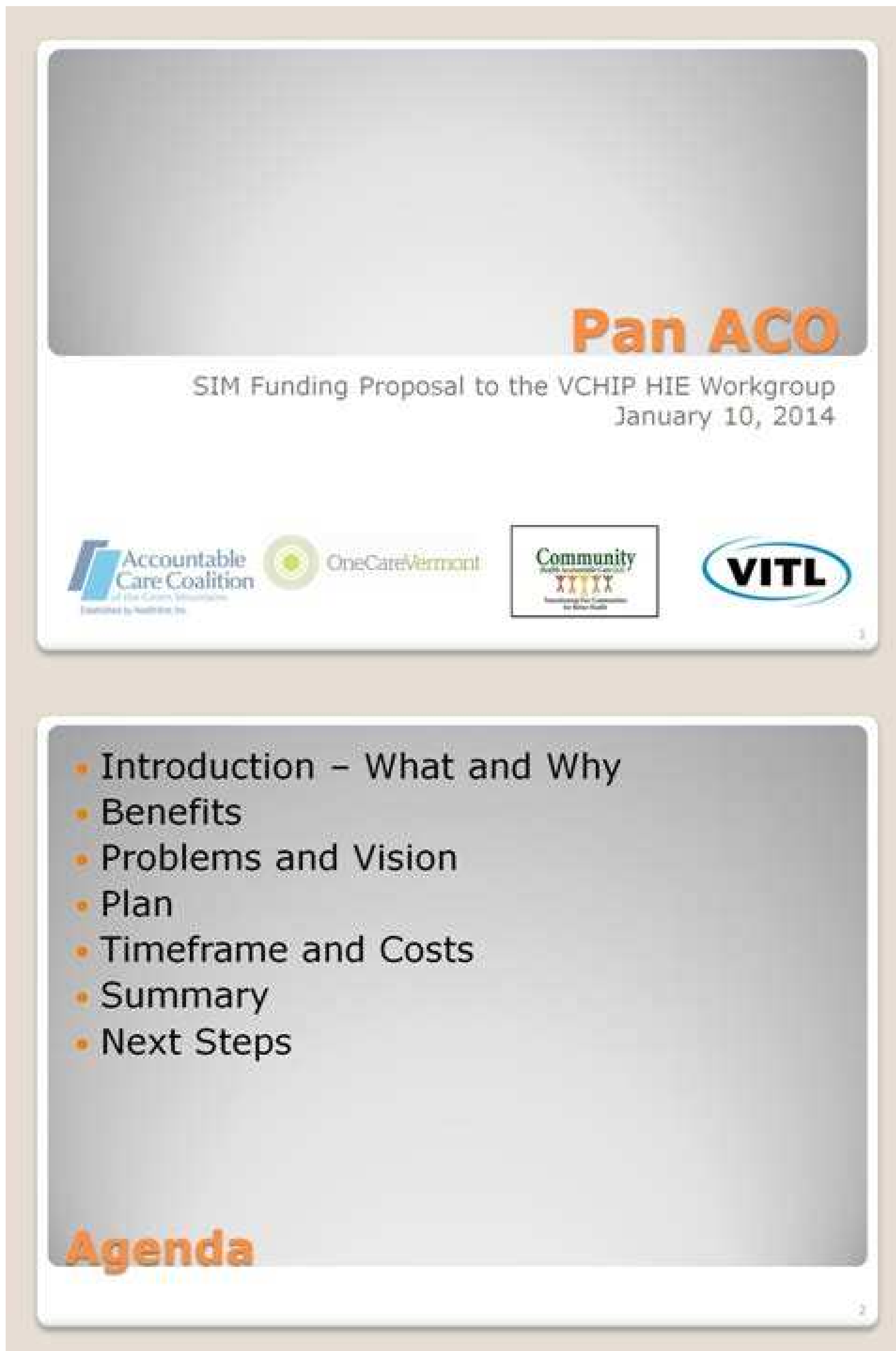
V. Appendix D – PowerPoint to HIE Work Group



- There are **three Accountable Care Organizations** in Vermont, whose members comprise a large and growing majority of the healthcare delivery system in the state:
  - OneCare Vermont (OCV)
  - Community Health Accountable Care (CHAC)
  - Accountable Care Coalition of the Green Mountains (ACCGM)
- **Collaborating** to effectively build a single common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients.
  - **Key Message: Heavily aligns with the state HIE Plan and Priorities**

What Are We Doing?

- The Pan ACO collaboration is to support health care payment and delivery system reforms aimed at improving care, improving the health of the population, and reducing per capita health care costs, by 2017.
- The **3 ACOs are collaborating** on aligned processes and infrastructure where it makes sense including **with VITL to build technology infrastructure** that is consistent with a state-wide **high performing healthcare system**.

Why Are We Collaborating?

- Make **rapid progress against state HIE plan**
  - Faster than other approaches
- Provide **path for 2014 patient care benefits** of healthcare information exchange across providers and through ACO population approaches
  - Clinically more impactful, earlier than other approaches
- **Exploit the efficiencies of a collaborative project effort** involving all three Vermont ACOs, their providers, VITL, and the VHCIP work group
  - Less expensive than other approaches
- Provide a mechanism for the VHCIP work group to **measure and demonstrate tangible progress**
  - More concrete to show progress to CMS/CMMI, VHCIP Steering Committee, Core Team, GMCB

Benefits

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	Hospitals	FQHC	PCPs - Blueprint PCMH	PCP - Non-Blueprint Practices	Specialty Physician	SNF	HH	MH & SA
OCV	2 AMCs 5 Community PPS 8 CAH 1 MH Specialty Hospital	3 FQHCs	All Hospital employed (60 Practices) Participating FQHC Practice Sites (8 Practices) 12 Independent Practices	2 Independent Practices	All Hospital Employed (1000 Physicians) 30 Independent Specialty Practices (60 Physicians)	All Hospital Owned Affiliate Agreements with 29 Independent SNF	Affiliate Agreements with 10 Local Home Health Agencies	Affiliate Agreements with 10 Mental Health and Substance Abuse Providers
CHAC	Expected Local Collaborations	7 FQHCs	Participating FQHC Practice Sites(35 Practice sites); 100+ PCP FTEs	None	Any FQHC Employed	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected
ACCGM	Expected Local Collaborations	None	10 Independent Practices	2 Independent Practices	6 Independent Practices	Expected Local Collaborations	Expected Local Collaborations	Expected Local Collaborations
Sub-Total in ACOs	**100%**	**91%**	**70%**	**40%**	**85%**	**80%**	**80%**	**100%**
Remaining Providers	None	None	30%	60%	15%	20%	20%	None

ACO Participants

6

- All providers **seamlessly contributing a full range of accurate clinical information** electronically to VITL
- **Well designed tools and interfaces** to access that information subject to data use agreements and patient consent models
- **Designed to serve a range of customers** including providers, ACOs, GMCB, other regulators, DVHA/payers, others where appropriate

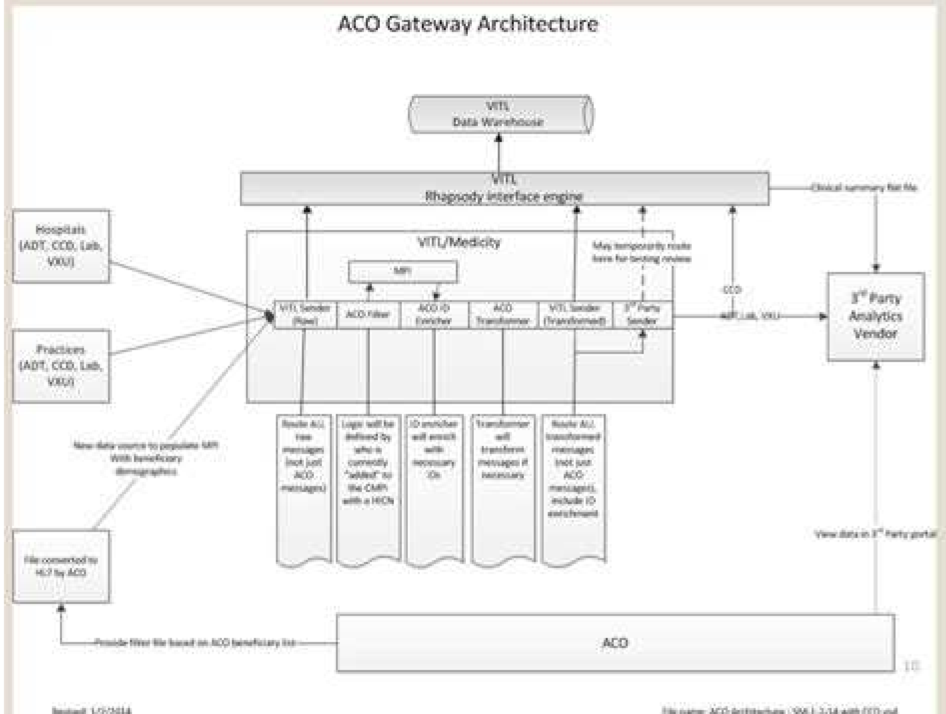
Vision of the Future

- We **don't know the current baseline status** of provider ability to capture and electronically transmit the clinical information needed for ACO/VCHIP Quality Measure data elements
- We need a way for **electronic data to be routed to ACOs** for Care Management and Analytic processes to support patient care
- We don't have the ability to **notify our Providers and Care Managers real time** when our patients have an important clinical event
- We still need to **fill some basic gaps** in HIE interfaces and data element exchange from hospitals and other providers

Problems to be Addressed

- **Gap Analysis**
  - Identify the gap among state-wide ACO data requirements and data capacity
- **Pan ACO Gateway Build**
  - Build the technical architecture to support movement of data from source systems to analytics destinations *(next slide)*
- **Event Notification**
  - Install a system that improves quality and timeliness of transitions of care through real-time notification of important clinical encounters
- **Gap Remediation**
  - Expand data capacity of the State for improved population management

Scope of Work



Initiative	Timeframe[1]
Gap Analysis	• Estimated Start – Q1 2014 • Estimated complete Q3 2014
Pan ACO Gateway Build	• Estimated Start - Q1 2014 • Estimated complete –Q2 2015
Event Notification	• Estimated Start – Q1 2014 • Estimated complete – Q4 2014
Gap Remediation	• Estimated Start – Q1 2015 • Estimated complete – Q3 2016

[1] Start dates dependent on release of SIM funds

Timeframe

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Initiative	Low Estimate[1]	High Estimate
Gap Analysis	$50,000	$75,000
Pan ACO Gateway Build	$1,115,000	$1,545,000
Event Notification	$375,000	$625,000
Gap Remediation (full)	TBD	TBD
Support	$570,000	$800,000
Total	**$2,110,000**	**$3,045,000**

[1] Based on preliminary pricing

Implementation Costs & 1st Year Support

12

Support Costs (multiple sources of funding)

Initiative	Annual Support[1] (2015 and ongoing)
Gap Analysis	$0
Pan ACO Gateway (annual)	50,000 Beneficiaries: $438,000 100,000 Beneficiaries: $876,000 200,000 Beneficiaries: $1,752,000
Event Notification	Range of $82,100 - $136,800
Gap Remediation (full)	TBD

[1] Based on preliminary pricing

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Summary

- **Collaboration** of 3 ACOs
- Providing **care to majority of Vermont residents**
- Collaborating with VITL to build single common patient data infrastructure to:
  - Better **manage patient care** (Improve Care)
  - Report on **quality of care** (Improve Care)
  - Notify and **manage care transitions** (Improve Care)
  - **Exchange relevant clinical information** among caregivers (Improve Care)
  - **Reduce healthcare costs**

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- **Support from the VCHIP HIE Workgroup** for the vision and collaborative effort
- **Approve for release of SIM funds** for committed initiatives
  - **Implementation: $2,110,000 - $3,045,000**
  - **Support: Ongoing funding of support requires additional discussion of funding sources**
- **Support for refinement of costs** and well-defined funding requirements
  - Pan ACO to refine Implementation and Support Costs: **June 2014**
- **Timing is critical**

Next Steps

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Appendix E: February 2, 2014 Q and A from HIE Work Group Leaders/Members

Questions for the Population-Based Collaborative Regarding their Proposal

2/2/2014

Responses from the Population-Based Collaborative

2/4/14

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GAP ANALYSIS

Can you provide more detail on the gap analysis? Does it include data quality work at individual provider sites? Will the gap analysis include an overview of which sites are sending what data? And the quality of that data?

The gap analysis will include the following:

1. **Which EHR an organization has if they have one. Some of this is new work, as we have not done an assessment of all healthcare organizations in Vermont.**
2. **For each organization that has an EHR, we will determine if they do have any of an ADT, VXU or CCD interface. For those who do not have one of those interfaces, we will determine if the organization is capable of developing that interface. This is new work.**
3. **For those organizations sending a compliant CCD, we will determine what data being sent matches the quality measures. This is new work.**

The gap analysis does not include a data quality analysis as the term is used by Blueprint. For example, an HgA1C is useful data to the ACOs – we wouldn't necessarily do a data quality assessment on the HgA1C results.

How does this gap analysis differ from the gap analyses that have already taken place? What is the gap between what has already been done in previous analyses by VITL and others versus the end goal for this analysis?

VITL has not historically performed gap analyses. Generally VITL is approached by healthcare organization to install interfaces, or VITL is directed to work with practices to install interfaces (e.g., Blueprint). VITL has not done a statewide survey of healthcare organizations' capacities. We are doing it in a limited capacity under DVHA for home health and designated agencies, but not as a statewide

comprehensive survey. However based on the amount of work completed we have a good database of what does exist which is a useful base for a gap analysis. The gap analysis is to identify what doesn't exist, and what it would take to eliminate the gap.

What is the deliverable? It would be good to document that we will have quarterly reports (if not more) regarding the work the PAN ACO group is doing to the workgroup and to have a written document of the gap analysis.

The deliverable is a matrix of gaps. The data being evaluated covers identification of EHR vendor or lack thereof; what interfaces are - in production/pending/or unavailable – by organization; and what clinical data is being sent or lacking compared to the quality measures. The gap analysis template is provided in a separate document.

REMEDIATION

What do you anticipate the data remediation to consist of? What are the deliverables? Is data quality work a part of the anticipated remediation process? Does it, in your mind, include "human interaction"? In other words do you anticipate the involvement of Sprint Teams, E-health specialists and others?

The gap analysis will identify:

- **Healthcare organizations that don't have EHRs**
- **For organizations that do have EHRs, what is their capacity to send any of ADT, CCD, or VXU?**
- **For organizations that can send CCDs, what effort is necessary for them to send quality measure data?**

Each of these gaps will have a cost to remediate. It is the purview of the ACOs in conjunction with SIM to determine which and how many gaps to address. We anticipate the sprint teams and eHealth specialist to be involved in the data remediation.

Based on the assumption that a significant amount of the gap analysis should already be completed, can you estimate the amount needed for remediation? It would be helpful to have more of an estimate on future build-out.

There is still more work to be completed for the gap analysis. There have been additional organizations for CHAC and ACCGM, and additional measures. A significant amount of work has been completed. Most data has been collected – it is presently being consolidated. The collaboration will complete the gap analysis, and project a budget for remediation. The gaps exist whether or not there is a plan to remediate them, so we don't believe a remediation budget would be necessary for

approval of the builds and gap analysis. The SIM HIE Workgroup can determine how much, if any, remediation should be funded.

TIMELINE

Please redefine the timeline based on an April 1 2014 timeframe (QTR 1, etc.). Specifically, does your proposed timeline start as soon as the funds are released or are you still anticipating having the Q1 work done in Q1 2014?

This is new information to the collaborative. Our understanding was that this work could be charged against the SIM grant as of last November 2013. Further discussions are required as to who funds the work that is completed or underway.

BUDGET

Support: Please detail this line item out – what is the VHCIP "buying" here? How is it different from what the state pays for in the DVHA grant to support VITL and the operation of the VHIE?

There are three components to the proposal: gap analysis; build of the gateways, and event notification.

Gap Analysis

The scope of this has been answered in previous questions, i.e., VITL does not conduct gap analyses, so this work is specific to this project and not covered under the DVHA grant.

Gateway

Building the gateways- there are three tasks to this work which are specific to this project and not covered under the current DVHA grant:

1. **The logic that matches inbound interface data to a beneficiary file and to a participant file, perform some data transformation on the interface messages, and send matched and processed interface messages to the correct analytics destination.**
2. **Medicity adds the logic to approximately 65 physical interfaces. Each interface is a complex software program.**
3. **VITL tests each interface to make sure the matching logic is correct. As each interface can support more than one healthcare organization, the testing exceeds the number of physical interfaces.**

Event notification

This is a new project and not funded by DVHA.

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Please breakdown personnel expenses, a bit more detail on what program managers would be doing and if these positions are current employees or contractors, names for those positions. If the positions are yet to be filled or contracted, please so indicate.

> **Project managers make sure that a project has a plan, the timeframes are met, and the appropriate resources are available when necessary. As project work increases to meet the proposed scope of work, the identified project managers will become dedicated to the associated work. VITL also has subject matter experts who do data analysis and test interfaces. This work is done predominantly by three existing VITL staff. There may be other tasks that get assigned to eHealth Specialists, but presently this is seen to be consistent with their current responsibilities in the DVHA grant and is not included in the estimate.**
>
> **The personnel expenses include their hourly rate, plus benefits, plus overhead, plus an administrative expense. Note that an administrative expense has not been applied to any of the other costs in the proposal.**
>
> **The rate in the proposal is the low end of the rate VITL pays for consulting services. As a private enterprise the service rate is consistent with consulting rates and VITL personnel expenses.**
>
> **There needs to be a transition from DVHA funding supporting healthcare reform, and SIM funding supporting healthcare reform (see answer to SUSTAINABILTY). As the work requirements preceded the SIM funding the only option without incurring additional expense was to use VTL staff.**

ACO GATEWAY:

> **?**

ENS

Who are the 100 provider organizations referenced – breakdown by provider group? What technology does a provider need in order to participate in an ENS?

> **VITL and the ACOs have not selected a vendor or product, so the required technology is an unknown. The intent is that a provider organization would have minimal technology requirements in order for the service to have as wide an audience as possible.**
>
> **The 100 provider organization is a placeholder to build a budget. Given the number of hospitals, FQHCs, designated agencies, home health agencies, long term care and existing practices, 100 organizations seemed like a reasonable placeholder to**

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represent the initial number of benefitting entities. The service is planned to be offered to all eligible healthcare providers in Vermont.

SUSTAINABILITY

We understand that there is no formal sustainability plan in place for the years beyond 2016, but we would like to understand your thoughts about how such a plan might be structured, and which organizations or state departments would be expected to contribute to the sustainability plan, and how costs might be allocated

Over the next five years VITL will seek to transition from predominantly state and federal grant revenue to non-governmental revenue. This transition is based on the assumption that government funding is in effect an investment used to assess, build and deploy technology (Gap Analysis, Remediation and the Gateways) and that once it is implemented, the costs for both the services offered as a result of the technology (Event Notification System) as well as the on-going support and customer costs associated with the technology (PMPM Support Costs) should be borne by those organizations/individuals that receive the benefit of the services and the technology over the long term.

This transition will not occur immediately. Government funding needs to continue at its current level for a period of time to ensure that the technology needs of both the beneficiaries and the State's health care reform initiatives are met. Funding under the VHCIP is a component of this technology investment, albeit of a time limited nature and for specific aspects of health care reform goals.

Over the next five years the expected non-government revenue sources are expected to be based on the following: use of VITLAccess, the provider portal; ACO customer service and support; use of the Event Notification System; and potentially other services/capabilities currently in the planning stages to include an image sharing network, connectivity to the Health Information Exchange of NY (HIXNY) and clinical analytics services.

SUPPORT

You should clarify what this "support "actually covers, and how you calculated the number of lives for each ACO. We need to understand this in more detail.

Each ACO provided VITL with the number of covered lives in the first year. Based on when VITL thinks the gateway will be complete for the ACO, the annual support fees were prorated to number of months of usage by the ACO.

Support covers the following:

Customer Support

- **Customer support (patient identity management)**
- **Interface maintenance (upgrade, replacements)**
- **Data quality (missing, inaccurate)**
- **Support center (I forgot my password)**

System Support

- **Interface monitoring (messages not processing)**
- **Monitor message routing**
- **Maintain beneficiary matching rules**
- **Maintain message transformer (consent flags, EVN fields)**
- **Error resolution and testing (new interface)**
- ***Event notifications (TBD)***

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Move that we recommend approval of VITL's proposal, scope of work and funding as described in the documents entitled: Population Based Collaborative Health Information Exchange Project to the VHCIP Steering Committee and Core Team for consideration and approval at an amount not to exceed $3,023,798 with the following stipulations:

That prior to bringing this proposal to the VHCIP Core Team:

a) At a minimum, representatives from VHCIP, DVHA, and VITL meet to resolve any outstanding questions regarding the proposed budget, ensure that there is no duplication of payments, work products, or activities, and establish deliverables and milestones for payment for this project.

b) At a minimum, representatives from VHCIP, DVHA, and VITL develop a plan to prioritize VITL's work products and develop timelines with milestones for the work.

c) Identify a Committee inclusive of representation from each of the three ACOs, VHCIP, and DVHA to monitor the implementation of the project, establish a timeline for required reports, and develop a plan to engage a consultant to assist with this monitoring role which will include recommendations for payment on milestones. The committee shall also be responsible for recommending adjustments to work plans and milestones to be responsive to the changing landscape of HIE and needs of Vermont providers.

d) Define and codify through a formal agreement, the accountability and responsibilities of the ACOs and VITL as they relate to this project.

e) Ensure efficiencies are maximized. For example, there may be efficiencies to be gained in the Gateway design that would reduce the project cost.

MEMORANDUM

TO: VHCIP HIE Workgroup
FR: Nancy Marinelli, HIE Workgroup Member, Dept. of Disabilities, Aging & Independent Living DT: February 11, 2014
RE: DAIL Comment to Accompany Feb 11 Vote on Motion for funding

---

I am offering DAIL's comments on this Motion to be included as part of the vote to inform the Steering Committee and Core Team of the basis for our position. We do not intend that these comments be for discussion today.

DAIL intends to vote NAY on the Motion for these 7 reasons:

1. Effective care integration requires the investment of significant resources to **expand the skeleton of Vermont's HIE foundation.** It is critical to shift the focus of the $3M in HIE Year One funding investments to broadening connectivity across more types of providers in support of care integration.

2. In order to meet the VHCIP and HIE goal of integrating care, it is essential that VHCIP funds support
sharing information across more types of providers in the health continuum.

3. Significant opportunities to meet the Triple Aim are available if we focus our limited resources on integrating care for the approximately **40,000 Vermonters** with the most complex, chronic, and long- term needs for services and support.
    - Vermont spends an estimated **$850M per year** on this cohort.
        - 55.2% VT Medicaid costs ($1.18 billion)
        - and roughly 25% of VT Medicare costs

4. The **proposal** in this Motion **does not focus enough on care integration**. Instead, it adds resources to deepening the acute and primary care parts of the health continuum foundation.

5. **The part of the health care continuum** represented by this proposal has **already received a significant $50M infusion** and investment of HIE funding.
    - Of the more than $50M in incentive fund awards to Vermont to date
        - $28.2M has gone to VT hospitals and VT primary care providers
        - $22.3M has gone to Medicare providers

6. We appreciate what VITL and these providers have done to build the foundation for a robust infrastructure. We would like to work with VITL to **add more provider types** to the skeletal HIE structure. We have not reached enough of the provider base yet.

7. DAIL recommends that the Steering and Core teams support VITL to expand the skeleton of Vermont's HIE foundation by **shifting the focus of the $3M in HIE Year One funding investments to broadening connectivity across more types of providers in support of care integration**.

Population-Based Collaborative HIE Project

SIM Funding Proposal
February 12, 2014

- There are **three Accountable Care Organizations** in Vermont, whose members comprise a large and growing majority of the healthcare delivery system in the state:
  - OneCare Vermont (OCV)
  - Community Health Accountable Care (CHAC)
  - Accountable Care Coalition of the Green Mountains (ACCGM)

- **Collaborating** to effectively build a single common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients.
  - **Key Message: Heavily aligns with the state HIE Plan and Priorities**

What Are We Doing?

ACO Participants

	Hospitals	FQHC	PCPs - Blueprint PCMH	PCP - Non-Blueprint Practices	Specialty Physician	SNF	HH	MH & SA
OCV	2 AMCs 5 Community PPS 8 CAH 1 MH Specialty Hospital	3 FQHCs	All Hospital employed (60 Practices) Participating FQHC Practice Sites (8 Practices) 12 Independent Practices	2 Independent Practices	All Hospital Employed (1800 Physicians) 30 Independent Specialty Practices (60 Physicians)	All Hospital Owned Affiliate Agreements with 29 Independent SNF	Affiliate Agreements with 10 Local Home Health Agencies	Affiliate Agreements with 10 Mental Health and Substance Abuse Providers
CHAC	Expected Local Collaborations	7 FQHCs	Participating FQHC Practice Sites(35 Practice sites) 100+ PCP FTEs	None	Any FQHC Employed	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected	Network Affiliate Agreements Expected
ACCGM	Expected Local Collaborations	None	10 Independent Practices	2 Independent Practices	6 Independent Practices	Expected Local Collaborations	Expected Local Collaborations	Expected Local Collaborations
Sub-Total in ACOs	**100%**	**91%**	**70%**	**40%**	**85%**	**80%**	**80%**	**100%**
Remaining Providers	None	None	30%	60%	15%	20%	20%	None

- **Designed to serve a range of customers** including providers, ACOs, GMCB, other regulators, DVHA/payers, others where appropriate

- All providers **seamlessly contributing a full range of accurate clinical information** electronically to VITL

- **Well designed tools and interfaces** to access that information subject to data use agreements and patient consent models

What will this do?

- **Reduce duplicate** medical tests, procedures, medications and admissions
- **Improve** patient **safety**
- **Reduce time away from work**
- **Reduce lost or unavailable medical records**
- **Reduce having to share the same information** over and over with different providers

Patient Benefits

Collaborating with VITL to build single common patient data infrastructure to:

- Better **manage patient care** (Improve Care)
- Report on **quality of care** (Improve Care)
- Notify and **manage care transitions** (Improve Care)
- **Exchange relevant clinical information** among caregivers (Improve Care)
- **Reduce healthcare costs**

Provider Benefits

- We **don't know the current baseline status** of provider ability to capture and electronically transmit the clinical information needed for ACO/VCHIP Quality Measure data elements **->** ***Gap Analysis***

- We need a way for **electronic data to be routed to ACOs** for Care Management and Analytic processes to support patient care **->** ***ACO Gateway***

- We don't have the ability to **notify our Providers and Care Managers real time** when our patients have an important clinical event **->** ***Event Notification System***

- We need to transition from implementation to system and customer support -> ***First Year Support***

- We still need to **fill some basic gaps** in HIE interfaces and data element exchange from hospitals and other providers -> ***Remediation***

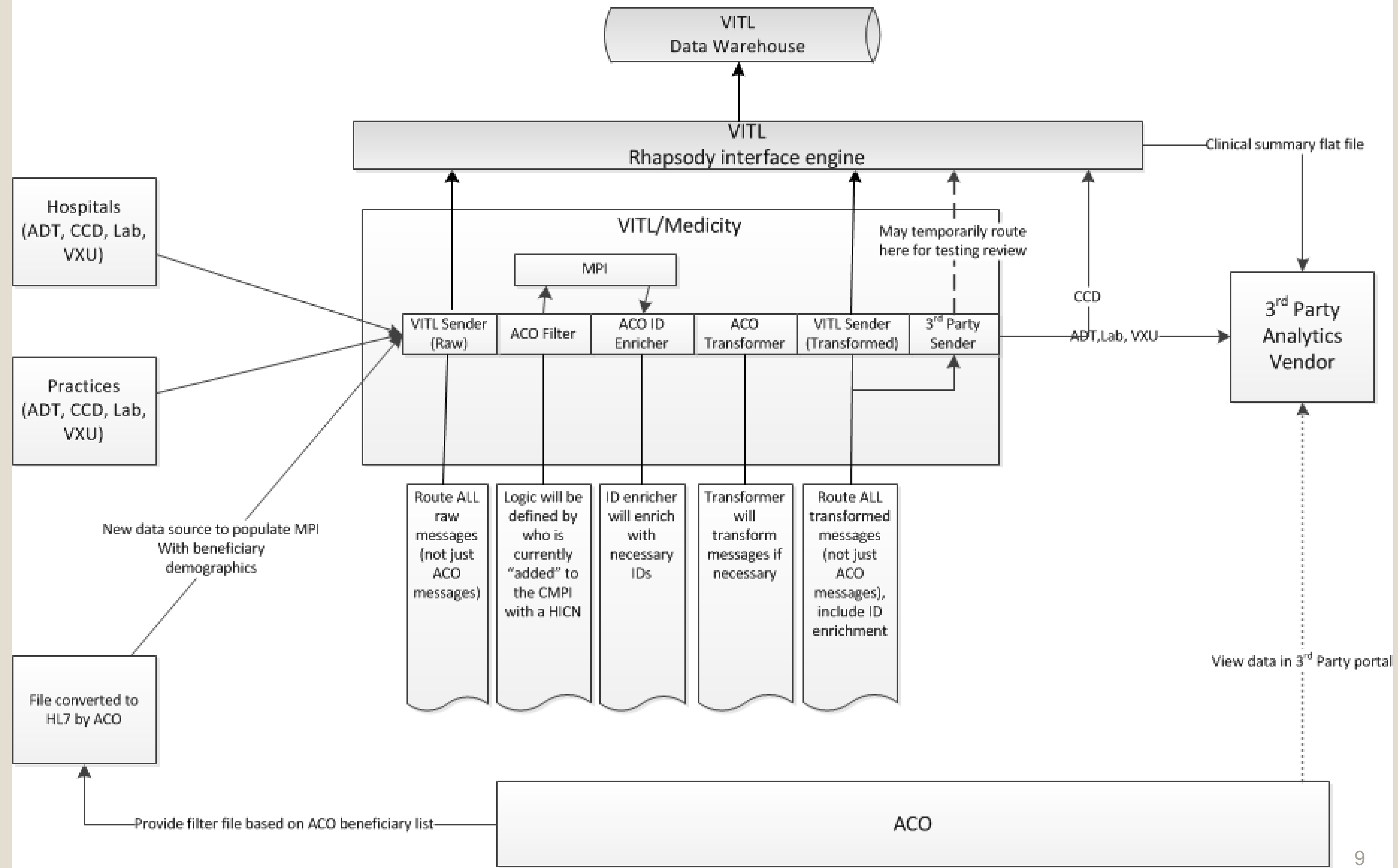
- We need to deliver on expected patient benefits

Problems to be Addressed

Scope of Work

- **Gap Analysis**
  - Identify the gap among state-wide ACO data requirements and data capacity
- **ACO Gateway Build**
  - Build the technical architecture to support movement of data from source systems to analytics destinations (next slide)
- **Event Notification**
  - Install a system that improves quality and timeliness of transitions of care through real-time notification of important clinical encounters
- **Support**
  - Provide system and customer support
- **Gap Remediation**
  - Expand data capacity of the State for improved population management

ACO Gateway Architecture



Revised: 1/2/2014

File name: ACO Architecture - SM-1-2-14 with CCD.vsd

Timeframe

Initiative	Timeframe[1]
Gap Analysis	• Estimated Start – Q1 2014 • Estimated complete Q3 2014
ACO Gateway Build	• Estimated Start - Q1 2014 • Estimated complete –Q2 2015
Event Notification	• Estimated Start – Q1 2014 • Estimated complete – Q4 2014
Gap Remediation	• Estimated Start – Q1 2015 • Estimated complete – Q3 2016

Gap remediation will be a separate project.

[1] Start dates dependent on release of SIM funds

Implementation Costs & 1st Year Support

Initiative	High Estimate[1]
Gap Analysis	$75,000
ACO Gateway Build	$1,545,000
Event Notification	$625,000
Support	$800,000
Total	**$3,045,000**

Gap remediation will be a separate project.

[1] Based on preliminary pricing

Initiative	Annual Support[1] (2015 and ongoing)
Gap Analysis	$0
ACO Gateway (annual)	50,000 Beneficiaries: $438,000 100,000 Beneficiaries: $876,000 200,000 Beneficiaries: $1,752,000
Event Notification	Range of $82,100 - $136,800

[1] Based on preliminary pricing

Support Costs

Questions?

Vermont Health Care Innovation Project Grant Program Application

Approved 1.15.2014 and released 1.16.2014

Expected Grant Program Schedule Summary:

DATE ISSUED	**January 16, 2014**
QUESTIONS DUE	**January 24, 2014**
BIDDERS' CONFERENCE CALL: 1-877-273-4202 Conference Room Number: 2252454	**January 27, 2014 at 10am EST**
FAQs Posted Here: http://gmcboard.vermont.gov/sim_grant	**January 20, 2014 and January 29, 2014**
APPLICATIONS DUE	**February 14, 2014 by 2pm EST**
AWARD ANNOUNCEMENTS	**March 25, 2014**

PLEASE BE ADVISED THAT ALL NOTIFICATIONS, RELEASES, AND AMENDMENTS ASSOCIATED WITH THIS OPPORTUNITY WILL BE POSTED AT:

http://gmcboard.vermont.gov/sim_grant

Any questions related to this grant program should be directed to:
Georgia Maheras, Project Director, Vermont Health Care Innovation Project
Georgia.maheras@state.vt.us or 802-505-5137.

All applications should be submitted in hard copy and electronically by February 14, 2014 at 2pm. Hard copy submissions should be delivered to Georgia Maheras, Project Director, VHCIP, 109 State Street, Montpelier, VT, 05620. Electronic submissions should be sent to: Georgia.maheras@state.vt.us.

I. Background

The federal Centers for Medicare and Medicaid Innovation (CMMI) awarded the State Innovation Model (SIM) grant to Vermont. The grant provides funding and other resources to support health care payment and delivery system reforms aimed at improving care, improving the health of the population, and reducing per capita health care costs, by 2017. To maximize the impact of non-

governmental entity involvement in this health care reform effort, Vermont identified funding within its SIM grant to directly support providers engaged in payment and delivery system transformation. The State has determined that a competitive grant process will foster innovation and promote success among those providers eager to engage in reforms. These grants will be reviewed by the VHCIP/SIM Core Team using the criteria found in the Grant Program (GP) Criteria.

Applicants can seek technical assistance support as well as direct funding. The total amount available for direct funding is $3,377,102.

GP grants will support provider-level activities that are consistent with overall intent of the SIM project, in two broad categories:

1. Activities that directly enhance provider capacity to test one or more of the three alternative payment models approved in Vermont's SIM grant application:
    a. Shared Savings Accountable Care Organization (ACO) models;
    b. Episode-Based or Bundled payment models; and
    c. Pay-for-Performance models.
2. Infrastructure development that is consistent with development of a statewide high-performing health care system, including:
    a. Development and implementation of innovative technology that supports advances in sharing clinical or other critical service information across different types of provider organizations;
    b. Development and implementation of innovative systems for sharing clinical or other core services across different types of provider organizations;
    c. Development of management systems to track costs and/or quality across different types of providers in innovative ways.

Preference will be given to applications that demonstrate:

- Support from and equitable involvement of multiple provider organization types that can demonstrate the grant will enhance integration across the organizations;
- A scope of impact that spans multiple sectors of the continuum of health care service delivery (for example, prevention, primary care, specialty care, mental health and long term services and supports);
- Innovation, as shown by evidence that the intervention proposed represents best practices in the field;
- An intent to leverage and/or adapt technology, tools, or models tested in other States to meet the needs of Vermont's health system;
- Consistency with the Green Mountain Care Board's specifications for Payment and Delivery System Reform pilots. The Green Mountain Care Board's specifications can be found here: http://gmcboard.vermont.gov/PaymentReform.

II. What these grants will fund

Grants will fund the following types of activities. Appendix B includes a detailed list of federal guidelines around this funding:

- Data analysis
- Facilitation
- Quality improvement
- Evaluation
- Project development

III. Grant submission requirements

Applicants will be expected to provide the following in support of their application:

- GP Application Cover Form. This form is found in Appendix A.
- Grant Narrative. *The Grant Narrative should be a maximum of 12 pages double-spaced, 12 point font, with 1-inch margins, paginated in a single sequence.* The Grant Narrative should contain the following information:
    a. A clear description of the activities for which the applicant is requesting funding or technical assistance;
    b. A clear description of alternative funding sources sought and rationale for requesting SIM funds;
    c. A description of technical assistance services sought. The applicant should provide technical assistance scopes of work, type of work requested, type of person needed to do the work, number of hours estimated to complete the work. Applicants seeking data should indicate this in the technical assistance portion of their application. Appendix D provides more detail about the technical assistance services available under this grant.
    d. A description of the project's potential return-on-investment in terms of cost savings and quality improvement, and plans for measuring both;
    e. A description of how the project will avoid duplication where similar innovations in Vermont are currently underway;
    f. A summary of the evidence base for the proposed activities or technical assistance;

- A project plan, staffing structure, deliverables description, and timeline for completion of the proposed activities. This includes a project management plan with implementation timelines and milestones.
- Executed Memorandum of Understanding or other demonstration of support from partner providers, if applicable.
- Budget Narrative. Budget Narrative guidance is found in Appendices B and C. The Budget Narrative should contain the following:

a. A budget for the proposed project, consistent with specified budget formats;
b. A description of any available matching support, whether financial or in-kind;
c. Information regarding on-going support that may be needed for work begun under this grant.

IV. State resources available to grantees

Grant recipients may receive the following support, to the extent that a need has been clearly established in the grant application. More detail about the technical assistance can be found in Appendix D*:*

- Supervision to ensure compliance with federal antitrust provisions;
- Assistance in aligning with other testing models in the state;
- Assistance with appropriately attributing outcomes and savings to testing models;
- Overall monitoring of health care quality and access;
- Funding for specific activities;
- Technical Assistance:
    - Meeting facilitation
    - Stakeholder engagement
    - Data analysis
    - Financial modeling
    - Professional learning opportunities

V. Compliance and Reporting Requirements

As a responsible steward of federal funding, the state, through the Agency of Human Services, Department of Vermont Health Access (DVHA), monitors its sub-recipients utilizing the following monitoring tools:

1) Ensure that sub-recipient is not disbarred/suspended or excluded for any reason
2) Sub-award agreement
3) Sub-recipient meeting and regular contact with sub-recipients
4) Required pre-approval for changes to budget or scope of grant
5) Quarterly financial reports
6) Bi-annual programmatic reports
7) Audit
8) Desk Reviews
9) Site audits

In its use of these monitoring tools, the State emphasizes clear communication to ensure a feedback loop that supports sub-recipients in maintaining compliance with federal requirements. The State may at any time elect to conduct additional sub-recipient monitoring. Sub-recipients

therefore should maintain grant records accurately in the event that the State exercises this right. The State may also waive its right to perform certain sub-recipient monitoring activities. If, at any time, the State waives its right to certain sub-recipient monitoring activities, it will note which activities were not completed and the reasons why that activity was not necessary. Each of the monitoring tools and policies regarding their use are described in detail below.

1) Sub-recipient status

When signing the sub-award agreement, Sub-recipient's certify that neither the Sub-recipient nor Sub-recipient principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs or programs supported in whole or in part by federal funds.

Additionally DVHA will utilize the Excluded Parties List System (www.epls.gov) to confirm that neither the Sub-recipient nor its principals are presently disbarred at least once during DVHA's fiscal year. DVHA will print a screen shot of its EPLS search, and place it in the Sub-recipient's files.

2) Sub-award agreement

A sub-award agreement is provided to each sub-recipient at the beginning of each grant. This sub-award agreement will detail the Catalog of Federal Domestic Assistance (CFDA) program name and number, the award name and number as assigned by the funder, the award period, and the name of the federal awarding agency. This sub-award agreement will also include: definitions, the scope of work to be performed, payment provisions, funder grant provisions, blank financial and programmatic reports, and a copy of this policy. Other information may be included if necessary.

Unless any changes are required, only one sub-award document will be generated for the term of a grant, even if that term spans several years. All sub-recipients must sign the sub-award agreement and any additional documents sent with the sub-award, or funding will be terminated.

3) Sub-recipient meeting/ sub-recipient contact

The State may decide, at the beginning of a grant or at any time during a grant, to host a meeting of grant partners in order to review grant goals and/or obligations. A sub-recipient meeting may be held with one individual sub-recipient, or with multiple sub-recipients.

The State will also maintain contact with sub-recipients. Sub-recipients are expected to notify the State if they are having any difficulty carrying out their grant responsibilities or if they need clarification of their grant responsibilities.

Sub-recipients meeting and sub-recipient contact will be noted on the sub-recipient checklist, with appropriate supporting documentation included it the sub-recipient's folder.

4) Required pre-approval for changes to budget or scope of grant

As stated above, all sub-recipients must seek prior approval from the grants manager at the State to utilize grant funding for any activities not explicitly described in the goals section of the narrative. Sub-recipients must also seek prior approval before making any changes to their section of the budget.

Notes regarding any prior approval requested by a sub-recipient, or a sub-recipient's failure to comply with this grant term, will be maintained on the sub-recipient checklist.

5) Quarterly financial reports

The Sub-recipient will submit accurate financial reports to the State no later than the tenth of the month following the quarter being reported (January 10th, April 10th, July 10th, October 10th). A blank copy of the required financial report will be provided with the sub-award agreement. All questions regarding financial reports should be directed to Robert Pierce at robert.pierce@state.vt.us.

Financial reports will be reviewed by the State for accuracy and to ensure that all charges are eligible to be reimbursed by the grant. Sub-recipients are expected to respond promptly to all questions concerning financial reports.

Sub-recipient's submission of quarterly financial reports will be recorded and monitored on the sub-recipient checklist.

6) Bi-annual programmatic reports

The sub-recipient will submit accurate programmatic reports to the State no later than the tenth of the month following the 6-month period being reported (January 10th and July 10th). A blank copy of the required programmatic reports will be provided with the sub-award agreement. All questions regarding programmatic reports should be directed to Georgia Maheras at georgia.maheras@state.vt.us.

Programmatic reports will be reviewed by the State for accuracy and to ensure that all charges are eligible to be reimbursed by the grant. Sub-recipients are expected to respond promptly to all questions concerning programmatic reports

7) Audit

Sub-recipients who spent at least $500,000 in federal funds from all federal sources during their fiscal year must have an audit performed in accordance with OMB Circular A-133. The A-133 compliant audit must be completed within 9 months of the end of the sub-recipient's fiscal year. The sub-recipient shall provide the State with a copy of their completed A-133 compliant audit including:

- The auditor's opinion on the sub-recipient's financial statements;
- The auditor's report on the sub-recipient's internal controls;
- The auditor's report and opinion on compliance with laws and regulations that could have an effect on major programs;
- The schedule of findings and questioned costs; and
- The sub-recipients corrective action plan (if any).

The State will issue a management decision on audit findings within 6 months after receipt of the sub-recipient's A-133 compliant audit report.

If a sub-recipient's schedule of findings and questioned costs did not disclose audit findings relating to the Federal awards provided by the State and the summary schedule of prior audit findings did not report the status of audit findings relating to Federal awards provided by the State, the sub-recipient may opt not to provide the A-133 compliant audit report to the State. In this case, the State will verify that there were no audit findings utilizing the Federal Audit Clearinghouse database.

Any sub-recipient that, because it does not meet the $500,000 threshold or because it is a for-profit entity, does not receive an audit performed in accordance with OMB Circular A–133 may at its option and expense have an independent audit performed. The independent audit should be performed to obtain reasonable assurance about whether the sub-recipient's financial statements are free of

material misstatement. The independent audit should also take into consideration the sub-recipient's internal control, but does not necessarily have to contain the auditor's opinion on the agency's internal control. If the sub-recipient elects to have an audit report that covers more than the sub-recipient's financial statements, the State requests that the entirety of the auditor's report be provided to the State.

If the sub-recipient chooses not have an independent audit and the sub-recipient will receive at least $10,000 during the current fiscal year, they will be subject to on-site monitoring during the award period.

Sub-recipients who are individual contractors will not be subject to on-site monitoring based solely on the lack of an independent audit.

8) Desk Reviews

All sub-recipients who are estimated to receive $10,000 or more during the fiscal year will undergo a desk review at least once during the grant period. If a sub-recipient receives less than $10,000, the State may at its discretion opt to conduct a desk review. During a desk review, sub-recipients might be expected to provide:

- Adequate source documentation to support financial requests including but not limited to an income statement, payroll ledgers, cancelled checks, receipts ledgers, bank deposit tickets and bank statements, and timesheets.
- If salary is funded under the award and if the staff whose salary is funded under the award is charged to other funding sources, time distribution records to support the amounts charged to federal funding provided by the State.
- A statement verifying that the organization has a system in place for maintaining its records relative to federal funding provided by the State for the amount of time as specified in the sub-award document.
- Adequate documentation to support required match, if any.

9) Site visits

All sub-recipients who receive $50,000 or more in federal funding passed through the State for three consecutive fiscal years (July 1 – June 30), will undergo a site visit at least once during the three year period. Sub-recipient will be subject to desk monitoring during the intervening years. The State will arrange a suitable date and time for on-site monitoring with the sub-recipient. Recipients receiving a site visit will be expected to provide all of the back-up documentations as specified above, as well as:

- A written policy manual specifying approval authority for financial transactions.
- A chart of accounts and an accounting manual which includes written procedures for the authorization and recording of transactions.
- Documentation of adequate separation of duties for all financial transactions (that is, all financial transactions require the involvement of at least two individuals).
- If grant funds are utilized to purchase equipment, demonstration that the organization maintains a system for tracking property and other assets bought or leased with grant funds.
- A copy of the agency's Equal Opportunity Policy and Practices in Hiring.

Appendix A: Application Cover Form

General Information:

Organization Applying: ___________________________________

Key Contact for Applicant: ________________________________

Key Contact Email and Phone Number: ____

Project Title and Brief Summary:

Project Title: ____

Brief Summary of the Project (max. 150 words):

Budget Request Summary:

Budget Category	Year 1	Year 2	Year 3
Personnel			
Fringe			
Travel			
Equipment			
Supplies			
Indirect			
Contracts			
Total			

Appendix B: CMMI Funding Restrictions

All funds expended through this grant program must comply with the federal guidelines found in the State Innovation Models FOA found here: http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf

Funds cannot be used for activities engaged in prior to the grant approval period.

The cost principles address four tests in determining the allowability of costs. The tests are as follows:

- *Reasonableness (including necessity).* A cost is reasonable if, in its nature or amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The cost principles elaborate on this concept and address considerations such as whether the cost is of a type generally necessary for the organization's operations or the grant's performance, whether the recipient complied with its established organizational policies in incurring the cost or charge, and whether the individuals responsible for the expenditure acted with due prudence in carrying out their responsibilities to the Federal government and the public at large as well as to the organization.
- *Allocability.* A cost is allocable to a specific grant, function, department, or other component, known as a cost objective, if the goods or services involved are chargeable or assignable to that cost objective in accordance with the relative benefits received or other equitable relationship. A cost is allocable to a grant if it is incurred solely in order to advance work under the grant; it benefits both the grant and other work of the organization, including other grant-supported projects or programs; or it is necessary to the overall operation of the organization and is deemed to be assignable, at least in part, to the grant.
- *Consistency.* Recipients must be consistent in assigning costs to cost objectives. They must be treated consistently for all work of the organization under similar circumstances, regardless of the source of funding, so as to avoid duplicate charges.
- *Conformance.* This test of allowability—conformance with limitations and exclusions contained in the terms and conditions of award, including those in the cost principles—may vary by the type of activity, the type of recipient, and other characteristics of individual awards. "Allowable Costs and Activities" below provides information common to most HHS grants and, where appropriate, specifies some of the distinctions if there is a different treatment based on the type of grant or recipient.

These four tests apply regardless of whether the particular category of costs is one specified in the cost principles or one governed by other terms and conditions of an award. These tests also apply regardless of treatment as a direct cost or an indirect cost. The fact that a proposed cost is awarded as requested by an applicant does not indicate a determination of allowability.

Direct Costs and Indirect Costs

This is for illustrative purposes. We strongly recommend applicants review all of the federal guidance provided in the FOA found here: *http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf* .

Direct costs are costs that can be identified specifically with a particular award, project or program, service, or other organizational activity or that can be directly assigned to such an activity with a high degree of accuracy. Direct costs include, but are not limited to, salaries, travel, equipment, and supplies directly benefiting the grant-supported project or program. Indirect costs (also known as “facilities and administrative costs”) are costs incurred for common or joint objectives that cannot be identified specifically with a particular project, program, or organizational activity. Facilities operation and maintenance costs, depreciation, and administrative expenses are examples of costs that usually are treated as indirect costs. There is a 10% cap on indirect costs. The organization is responsible for presenting costs consistently and must not include costs associated with its indirect rate as direct costs.

Examples of Unallowable Direct Costs:

- Alcohol
- Alteration and Renovation Costs
- Animals, excluding service animals
- Bad Debts
- Bid and Proposal Costs
- Construction or Modernization
- Dues/Membership-Unallowable for Individuals (unless fringe benefit or employee development costs if applied as established organization policy across all funding sources).
- Entertainment
- Fines and Penalties
- Fundraising
- Honoraria- if this cost is for speaker fee that it is allowable as a direct cost.
- Invention, Patent or Licensing Costs-unless specifically authorized in the NOA.
- Land or Building Acquisition
- Lobbying
- Meals (Food)
- Travel

Appendix C: Budget Narrative Guidance

INTRODUCTION

This guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by ensuring that the required or needed information is provided. In the budget request, awardees should distinguish between activities that will be funded under this agreement and activities funded with other sources. There is no page limit on the budget narrative, but applicants should provide information in 12 point font, with one-inch margins.

A. Salaries and Wages

For each requested position, provide the following information: name of staff member occupying the position, if available; annual salary; percentage of time budgeted for this program; total months of salary budgeted; and total salary requested. Also, provide a justification and describe the scope of responsibility for each position, relating it to the accomplishment of program objectives.

Position Title and Name	*Annual*	*Time*	*Months*	*Amount Requested*
Project Coordinator Susan Taylor	*$45,000*	*100%*	*12 months*	*$45,000*
Finance Administrator John Johnson	*$28,500*	*50%*	*12 months*	*$14,250*
Outreach Supervisor (Vacant)*	*$27,000*	*100%*	*12 months*	*$27,000*

Sample Justification

The format may vary, but the description of responsibilities should be directly related to specific program objectives.

<u>*Job Description*</u>*: Project Coordinator - (Name)*

This position directs the overall operation of the project; responsible for overseeing the implementation of project activities; coordination with other agencies; development of materials, provisions of in service and training; conducting meetings; designs and directs the gathering, tabulating and interpreting of required data; responsible for overall program evaluation and for staff performance evaluation; and is the responsible authority for ensuring necessary reports/documentation are submitted to HHS. This position relates to all program objectives.

B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of

fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed. This can be done for all FTE in one table instead of itemizing per employee.

Sample
Example: Project Coordinator — Salary $45,000

Retirement 5% of $45,000	=	*$2,250*
FICA 7.65% of $45,000	=	*3,443*
Insurance	=	*2,000*
Workers' Compensation	=	________
	Total:	

C. Consultant Costs

This category is appropriate when hiring an individual to give professional advice or services (e.g., training, expert consultant, etc.) for a fee but not as an employee of the awardee organization. Hiring a consultant requires submission of the following information:

1. Name of Consultant;
2. Organizational Affiliation (if applicable);
3. Nature of Services to be Rendered;
4. Relevance of Service to the Project;
5. The Number of Days of Consultation (basis for fee); and
6. The Expected Rate of Compensation (travel, per diem, other related expenses)—list a subtotal for each consultant in this category.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the body of the budget request, a summary should be provided of the proposed consultants and amounts for each.

D. Equipment

Provide justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the "Other" category. All IT equipment should be uniquely identified. As an example, we should not see a single line item for "software." Show the unit cost of each item, number needed, and total amount.

Item Requested	*How Many*	*Unit Cost*	*Amount*
Computer Workstation	*2 ea.*	*$2,500*	*$5,000*
Fax Machine	*1 ea.*	*600*	*600*

Sample Justification

Provide complete justification for all requested equipment, including a description of how it will be used in the program. For equipment and tools which are shared among programs, please cost allocate as appropriate. States should provide a list of hardware, software and IT equipment which will be required to complete this effort. Additionally, they should provide a list of non-IT equipment which will be required to complete this effort.

E. Supplies

Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget

Supplies

General office supplies (pens, pencils, paper, etc.)

12 months x $240/year x 10 staff	=	*$2,400*
Educational Pamphlets (3,000 copies @) $1 each)	=	*$3,000*
Educational Videos (10 copies @ $150 each)	=	*$1,500*
Word Processing Software (@ $400—specify type)	=	*$ 400*

Sample Justification

General office supplies will be used by staff members to carry out daily activities of the program. The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Word Processing Software will be used to document program activities, process progress reports, etc.

F. Other

This category contains items not included in the previous budget categories. Individually list each item requested and provide appropriate justification related to the program objectives.

Sample Justification

Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If the items are not self-explanatory and/or the cost is excessive, include additional justification. For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).

G. Total Direct Costs $__________

Show total direct costs by listing totals of each category.

H. Indirect Costs $______________

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement established with the Cognizant Federal agency. A copy of the most recent indirect cost rate agreement must be provided with the application.

Sample Budget

The rate is______% and is computed on the following direct cost base of $______________________.

Personnel $

Fringe $

Travel $

Supplies $

Other$________________

Total $ x_____% = Total Indirect Costs

Appendix D: Technical Assistance

State resources available to grantees

Projects supported by the Provider Grants Program may be provided the following supports, to the extent that a need has been clearly established in the grant application. Applicants requesting data should identify one-time or on-going data needs including type of data, ie. Claims or survey, whether reports are being requested and how the data will enhance their project. The following supports are available:

- Supervision to ensure compliance with federal antitrust provisions;
- Assistance in aligning with other testing models in the state;
- Assistance with appropriately attributing outcomes and savings to testing models;
- Overall monitoring of health care quality and access;
- Funding for specific activities;
- Technical Assistance:
    - Meeting facilitation
    - Stakeholder engagement
    - Data analysis
    - Financial modeling
    - Professional learning opportunities

An example of a request for technical assistance follows:

The applicant requests a neutral meeting facilitator to convene a clinical review board. The goal of Project Quality is to reduce unnecessary and costly hospitalizations for diabetics and provide better care management for diabetics and pre-diabetics. The clinical review board for Project Quality is responsible for reviewing all ED visits, admissions, discharges and transfers of patients presenting with complications from diabetes. The neutral meeting facilitator needs to have peer review protection and skills in leading a group of clinicians efficiently through these weekly discussions. Estimated need is for 8 hours/work per week for 52 weeks.

Scope of Work:

-review all ED visits, admissions, discharges and transfers of patients each week from Doctor 1 Practice, IPA 89 Practice and Hospital.

-prepare meeting agendas including case summaries

-facilitate weekly meetings

VHCIP Grant Program Frequently Asked Questions

For questions submitted by 1.27.14

This Grant Program is offered as a Sub-Award to VHCIP's federal State Innovation Models Grant and all applicants are reminded that all awards must comply with HHS' Grant Policy Statement, which is provided in Attachment A to this FAQ. All applicants are also encouraged to review the State of Vermont's Operational Plan and the Federal Funding Opportunity Announcement found here: http://gmcboard.vermont.gov/sites/gmcboard/files/Vermont_SIM_Operational_Plan_FINAL_for_distribution_10.2013.pdf , and here: http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf.

Note that there is a 10% cap on the indirect allocation for this Grant Program.

Criteria Related Questions:

1) How important is "size" of project in the evaluation process? If we will only affect a smaller % of the population should we even try?

   a) My main question is that the grant application appears to be structured for larger organizations and health systems. We are a small, independent, highly functional innovative practice. We believe we have a tremendous amount to offer not only our own patients but also the state as a model practice. We just need the support.

   b) Do you intend to fund small practices (assuming we can also demonstrate an intention and means to disseminate our results)?

   The grant program is intended to support providers who are engaged in health care innovation that promotes higher value health care for Vermonters. All providers engaged in activities that meet the Grant Program criteria are encouraged to apply. There are no specific requirements regarding size of the project.

2) How many organizations are "multiple"?

   The grant program encourages collaboration among providers engaged in health care innovation. There are no specific requirements regarding number of collaborators. Applicants are encouraged to develop relationships that provide high value, coordinated care for Vermonters.

3) Must there be public/private collaboration?

   Public/private collaboration is encouraged, but not required.

4) Will the projects require GMCB approval before or after submission since they will emphasize payment reform?

The VHCIP Core Team is reviewing all applications and will determine awardees. The GMCB will not be reviewing applications in addition to this review.

5) Will evaluation scores be available?

   Application scores will not be available as this is a confidential application process and resubmissions are allowed if awardees are not granted funding in the first round.

6) Will there be a cut-off for re-submission consideration?

   There will be more than one round of applications accepted. Applicants who are not awarded funds in the first round are encouraged to resubmit in a subsequent round. Guidance around subsequent rounds will be available to applicants at time of first round awards.

7) If we do not submit anything in the first cycle does our likelihood of funding in the second cycle significantly decrease?

   No.

8) Will projects that focus on the dual-eligible population have priority?

   All applications will be evaluated based on how they meet grant program criteria. The VHCIP Core Team has not prioritized any one population of Vermonters over any others for this program.

9) On page 2, section 2, you use the word 'Development' to describe infrastructure development activities. Do you mean project and program development, or actual development of a new product (such as software)?

   Development refers to project and program development, not to software development.

10) We are excited to have an opportunity to apply for a grant and would like to approach our application from a population health standpoint focusing on collaborative community health initiatives across a broad spectrum of activities with the goal being to generate a scope of impact that would span multiple sectors of the continuum of health care service delivery and is easily replicated. We are seeking any guidance you might be able to provide with regards to how a program such as this might fit into the key focus areas for the grant listed in the application package. Where might you see such a program fitting into either the payment model spectrum or the infrastructure development focus of the grant?

    All applicants should review the VHCIP Operations Plan and Grant Program criteria for guidelines regarding potential projects. Proposed projects should address these criteria explicitly.

11) Who will review this grant application? Who is the "VHCIP/SIM Core Team"?

The SIM Grant is issued under the auspices of the Green Mountain Care Board (GMCB).

- What role will the members of the Board play in reviewing the applications and overseeing the activities of the successful applicants?

The VHCIP/SIM Core Team is the leadership body within the VHCIP structure as described in the VHCIP Operations Plan. The current members of this body are: Anya Rader Wallack, Chair; Paul Bengtson, CEO, Northeastern Vermont Regional Hospital; Al Gobeille, Chair, Green Mountain Care Board; Mark Larson, Commissioner of the Department of Vermont Health Access; Robin Lunge, Director of Health Care Reform; Doug Racine, Secretary of the Agency of Human Services; Susan Wehry, Commissioner of the Department of Aging and Independent Living; and Steve Voigt, CEO, King Arthur Flour.

The Green Mountain Care Board will not be reviewing these applications as they are not the entity releasing this grant opportunity.

12) What entities or individuals are considered eligible to apply for funding through the VHCIP SIM Grant Program? Can a Department of the State Government partner with other entities as an applicant? Can some of these monies flow to a Department within the State Government?

    This program is intended to support provider innovation and integration. It is possible for a state agency to partner with other entities as an applicant, but the support must be for provider innovation and integration and address all of the criteria in the grant application.

13) The GMCB includes a "State Innovation Model (SIM) Steering Committee". What role will the members of the Steering Committee play in reviewing these SIM Grant applications? Are members of the Steering Committee eligible to apply for these funds?

    This grant program is released by the VHCIP/SIM, not the GMCB. The VHCIP/SIM Steering Committee will not be reviewing these applications due to conflict of interest challenges. Members of the VHCIP/SIM Steering Committee are eligible to apply for these funds.

14) These funds are federal money, sourced from CMS. Should the focus of the application be on Medicaid recipients as opposed to other clients?

    As explained in the VHCIP Operations Plan, the federal award is for multi-payer initiatives and not specific to any one payer.

15) There is an expectation to demonstrate a savings in health care costs. Will savings realized through early disease detection and reduced morbidity and mortality be credited as valid?

These will be considered as valid; however they do need to be measurable.

16) Will the VHCIP Core Team use the same criteria and scoring as in the federal FOA?

No.

17) Where are the grant program criteria?

They are on p. 2 of the grant program application.

18) Does an applicant have two apply for both categories on the top of page 2:

"Activities that directly enhance provider capacity to test one or more of the three alternative payment models approved in Vermont's SIM grant application:

a) Shared Savings Accountable Care Organization (ACO) models;
b) Episode-Based or Bundled payment models; and
c) Pay-for-Performance models.

Infrastructure development that is consistent with development of a statewide high-performing health care system, including:

a) Development and implementation of innovative technology that supports advances in sharing clinical or other critical service information across different types of provider organizations;
b) Development and implementation of innovative systems for sharing clinical or other core services across different types of provider organizations;
c) Development of management systems to track costs and/or quality across different types of providers in innovative ways."

May a single grant application incorporate both "activities that directly enhance provider capacity" and "infrastructure development"? Or must separate applications be submitted for each eligible category?

Applicants can choose to apply for either broad category or both, but they are not required to apply for both. Applicants are requested to submit one application covering all funding requests that relate to a specific project.

19) Will you fund proposals for entities not located in Vermont?

This grant program is intended to result in benefits for Vermonters. If an entity is located outside of Vermont, but can develop a proposal that benefits Vermonters and supports provider innovation and integration it will be reviewed.

20) What is available from successful applications?

This is the first solicitation for this grant program and therefore there are no successful applications.

21) Can projects have phases?

    Yes, projects can be phased.

22) May grant funds be sub-granted to parent entities to be expended on behalf of the ACO?

    Yes.

Budget-Related Questions:

23) Can grant funds be used to purchase technology (e.g., telemonitors, telemedicine carts, etc.)?

    Grant funds can be used to purchase technology. The VHCIP also has separate funding available for telemedicine. The VHCIP HIE/HIT Work Group has responsibility for making recommendations about how to spend this telemedicine-specific funding.

24) Are LLCs eligible grantees for this funding opportunity?

    Yes.

25) Our organization is an LLC that has a Management Services Agreement in place for all staffing. Will contractual expenses related to this MSA to increase staffing at the organization that has the MSA be an eligible expense?

    The federal sub-award restricts indirect to 10% of the total sub-award. Contractual expenses of the nature described above are considered indirect costs.

26) Under Appendix B, CMMI Funding Restrictions – p. 13, there is a statement about indirect costs having a 10% cap. Is this 10% of the overall proposed budget?

    - The amount listed is specified as "available for direct funding". What level of institutional overhead, or "indirect funding", will be allowed?

    This is 10% of the personnel budget, not the overall proposed budget. Indirect only applies to personnel, fringe, etc. Applicants are encouraged to review the federal guidelines regarding the budget.

    Direct funding in this instance refers to funding made available through the grant program directly to providers engaged in health care innovation and integration. The Budget Narrative should include costs broken down by category including the financial categories of direct and indirect.

27) If we can appropriately identify facility costs to the project, can these be listed as direct costs? Both CMS and HRSA have allowed this.

Yes, pending explicit CMMI approval. This grant program is funded through the Affordable Care Act and has some different restrictions than traditional HRSA or CMS funding opportunities.

28) Section H., p. 17 says one must have an indirect cost rate from the cognizant federal agency. We do not have one. Can we just do direct and indirect costs?

Yes, you can just do direct and indirect noting the 10% indirect cap.

29) The application states that there will be **$3,377,102** available for funding of these grants. Do you have a projected grant amount range that you would recommend applicants stay within or is there a desired number of applications you are seeking to fund? How much would you anticipate being available to a particular applicant?

There is no range nor is there a desired number of applicants. Applicants engaged in innovation and integration are encouraged to apply.

30) There is no mention in the application about any specific expectation for matching funds, either direct or in-kind, to be provided for by the applicant. Is there some expectation regarding a percentage range that might desirable or advantageous?

Section III Grant Submission Requirements indicates: "A description of any available matching support, whether financial or in-kind". There is no expectation for a percentage range that might be desirable.

31) The money available for direct funding is listed as $3,377,102. Will this be awarded in *one* grant to a *single* bidder, or will it be divided among several bidders with smaller budgets?

This will be divided among several bidders.

32) Is the announced $3.4 million the amount for only the first year or for a longer budget period?

The $3.37 million is for the entire grant program. There will be more than one round of funding for this program.

33) Is it appropriate to budget small amounts of money for quality improvement projects to improve the program?

Yes.

34) Is it OK that we spend grant money on staff and affiliate providers who will deliver these prevention/early intervention resource counseling? I saw nothing in the RFP that precluded that but wanted to be sure.

Grant funds cannot be used to pay for existing, reimbursable health care services per federal requirements. Applicants should review these federal guidelines carefully to ensure proposals are in compliance.

35) Is there a required ratio for staffing versus contractual in the budget?

No.

36) Can this grant program pay for direct services to patients?

Federal restricts payment to only those direct services that are not already being reimbursed for by a payer. For example, if Medicaid pays for a service with certain providers, these funds cannot be used to pay for that same service at a different provider.

37) How should the ROI be calculated? Must it be only a financial return on investment?

Applicants should describe the return on investment in terms of both clinical and health quality returns and financial returns to the best of their ability.

Technical Assistance-Related Questions:

38) As part of the technical assistance, can VHCIP obtain payment waivers from CMS (e.g., allow billing to Medicare in non-rural areas for telemedicine)?

VHCIP could pursue waivers from CMS billing rules; however this would be done through activities separate from this grant program.

39) We want to evaluate both health outcomes and expenditures before and after intervention and compare this same data between population groups. What is reasonable to ask for technical assistance in terms of evaluation? Would it be better if we partnered with a university or research firm to do the evaluation component?

Applicants must develop a plan for evaluating whether their proposed project is successful. They can request technical assistance or direct funding to support this activity.

40) Please provide more information regarding the technical assistance around: “Supervision to ensure compliance with federal antitrust provisions”.

Act 48 of the Acts of 2011 provides statutory authority to the Green Mountain Care Board and the Department of Vermont Health Access to allow them to use the state action doctrine to support collaboration and work with providers to ensure compliance with federal

law. Applicants can request the state develop a plan for this as part of their technical assistance request.

Application Format-Related Questions:

41) Will there be a standard format for the MOU for all projects or does each applicant prepare separately?

a) Are Letters of Support necessary?

There is no standard format for the MOUs for projects. Letters of Support are not necessarily required. Applicants should provide whatever documents are deemed appropriate to demonstrate collaboration.

42) On page 2 there is a statement that the grant narrative is 12 pages, double spaced. Is there an overall page limit for the application, to include appendices and budget?

No.

43) Should applications be submitted in hard copy and electronic copy?

Yes. State contracting law requires hard copy submission of applications. We are also requiring electronic copies be submitted to Georgia.maheras@state.vt.us. Both the hard copy and the electronic copies are due by 2pm on February 14th.

44) The grant application package states we are limited to 12 pages for the narrative and budget documents. Does this include the cover page and any supporting documents such as partnership agreements, letters of support/need, etc? If not, what are your expectations or limitations regarding supporting documents?

a) Under the grant submission requirements on page 3 of the RFP, the project plan, staffing structure, deliverable and timeline are listed separate from the 12-page narrative. Just confirming that we can describe these aspects of project after (above and beyond) the 12-page narrative?

The 12 page limit is for the project narrative only. There are no limitations for the additional application components.

45) The application cover page asks for the organization name that is applying and contact person's information. We have a community coalition with a large group of individuals from various fields that has been meeting regularly. Could we have the coalition itself listed as the applicant with one main contact person listed or perhaps have two of its major participants apply for the grant jointly with both listed as contacts? We would of course have a longtime, well established 501c3 non-profit that participates heavily in the coalition serve as the fiscal manager. Or are you looking for the applicant to be a specific entity with specific registrations/recognitions such as a 501c3?

The applicant should be an entity that can receive and manage funds. The cover letter and/or application should describe any collaborators in the project. The applicant does not have to be a 501(c)(3) non-profit.

46) There is no signature line on the cover sheet. Should the applicant provide a letter or support to actually document their commitment with a signature or should they just sign the cover page at the bottom?

    The applicant can sign the cover page at the bottom.

47) Do workplan charts and other charts need to be in 12 pt. font?

    No. These can be in 10 pt. font.

48) Does this need to look like a Federal research grant application?

    No.

49) Do applicants need to submit biographies of each participant?

    Applicants may submit biographies if it is helpful to explain how the work of the proposal will get done. Applicants can also provide information about organizational capacity in other formats.

Notification and Grant Period-Related Questions:

50) When would we expect to receive a draft contract?

    - In order to build a timeline it would be helpful to know when the grant funds will be available. When do you anticipate you will be able to make funds available to those applicants that are selected and will the funds be based on a reimbursement system or made available via some other means?

    - When will grant funds actually be available to start a demonstration project and when do you expect proposed projects to begin?

    Draft grant awards will be drafted between March 25th and April 25th. Funds will be available as soon as grant agreements are signed between March 25th and May 25th. Proposed projects should begin as soon as grant agreements are signed.

51) What is the expected start date?

    a) What is the project period for a written proposal submitted?

    b) What is the anticipated project duration you would like built into these programs in terms of the grant funding component? Is a multi-year project feasible or is there a certain deadline by which time the grant funds must be expended?

c) How much time should the grant span?

d) What is the funding period for this grant?

e) May the proposed budget reflect a preponderance of activity in the first year and limited or no activity in the third year?

Applicants can expect projects to begin as soon as grant agreements are signed between March 25th and May 25th. There is no specific period for the grant, however all projects must end by June 2016 to ensure final reporting by September 2016. Applicants can propose multi-year projects within this time period and can structure their funding request to provide a majority of the funds earlier in their project. Applicants should not assume they will receive funding in subsequent rounds of this grant program. Applicants proposed project and budget should address sustainability of the project once these grant funds end.

f) When will the 3-year project term begin and end and/or is there flexibility here (e.g., propose a 3-year project beginning Oct 1, 2014)?

There is no set project term. Projects can only last until June 2016 and can begin later in 2014. Projects cannot be retroactive.

52) What are the reporting requirements?

Programmatic and financial reports are described in Section V of the Grant Program Application. Successful awardees will also be required to submit a final report 30-90 days after the end of the sub-award period.

APPENDIX A

HHS Grant Policy Statement – Sub-Awards (pg. II-78)

The recipient is accountable to the OPDIV for the performance of the project, the appropriate expenditure of grant funds by all parties, and all other obligations of the recipient, as specified in the HHS GPS. In general, the requirements that apply to the recipient, including the intellectual property and program income requirements of the award, also apply to sub-recipients. The recipient is responsible for including the applicable requirements of the HHS GPS in its sub-award agreements.

The recipient must enter into a formal written agreement with each subrecipient that addresses the arrangements for meeting the programmatic, administrative, financial, and reporting requirements of the grant, including those necessary to ensure compliance with all applicable Federal regulations and policies. **At a minimum, the sub-award agreement must include the following:**

- Identification of the PI/PD and individuals responsible for the programmatic activity at the sub-recipient organization along with their roles and responsibilities.
- Procedures for directing and monitoring the programmatic effort.
- Procedures to be followed in providing funding to the sub-recipient, including dollar ceiling, method and schedule of payment, type of supporting documentation required, and procedures for review and approval of expenditures of grant funds.
- If different from those of the recipient, a determination of policies to be followed in such areas as travel reimbursement and salaries and fringe benefits (the policies of the sub-recipient may be used as long as they meet HHS requirements).
- Incorporation of applicable public policy requirements and provisions indicating the intent of the sub-recipient to comply, including submission of applicable assurances and certifications.

For research sub-awards, inclusion of the following:

- Statement specifying whether the financial conflict of interest requirements of the collaborating organization or those of the recipient apply.
- Provision addressing ownership and disposition of data produced under the agreement.
- Provision making the sharing of data and research tools and the inventions and patent policy applicable to the sub-recipient and its employees in order to ensure that the rights of the parties to the agreement are protected and that the recipient can fulfill its responsibilities to the OPDIV. This provision must include a requirement to report inventions to the recipient and specify that the recipient has the right to request and receive data from the sub-recipient on demand.

- Provisions regarding property (other than intellectual property), program income, publications, reporting, record retention, and audit necessary for the recipient to fulfill its obligations to the OPDIV.

Federal Funding Accountability and Transparency Act (FFATA) Sub-Award Reporting Requirement:

New awards issued under this funding opportunity announcement are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006

(Pub. L. 109–282), as amended by section 6202 of Public Law 110–252 and implemented by 2 CFR Part 170. **Grant and cooperative agreement recipients must report information for each**

first-tier sub-award of $25,000 or more in Federal funds and executive total compensation for the recipient's and sub-recipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (available online at www.fsrs.gov).

109 State Street
Montpelier, VT 05609
www.gmcboard.vermont.gov/sim_grant

To: VHCIP Core Team
Fr: Georgia Maheras
Date: January 27, 2014
Re: Proposed VHCIP Grant Program Processes- REVISED from 1.5.14 version

In this memo, I am providing the Core Team with three things:

1. A new proposed scoring methodology for the VHCIP Grant Program;
2. A summary of distribution for sub-award funds from other states engaged in similar activities; and
3. The first round Grant Program approval timeline.

1. Scoring Methodology:

Process: VHCIP Financial Staff will ensure that applications are complete and are in compliance with all federal and state funding rules. I will provide the Core Team with scoring sheets, summary sheets and applications at least one week prior to the March 10th Core Team meeting. Each Core Team member will score the applications individually. At the March 10th meeting, the Core Team will meet together and go over the applications and their individual scoring and come up with a final score for each application through a consensus process. Based on the scores given, the Core Team will award grants.

Proposed Scoring Methodology:

Scoring will be based on the ability to meet the Grant Program criteria:

1. Presenting a good idea which reflects to goals of the grant program. Up to 40 points for this category. Items reviewed in this category include:
    a. Idea is consistent with SIM/VHCIP;
    b. Responsive to the Grant Program application;
    c. Demonstrates collaboration and integration.
2. Ability to perform, which clearly shows capability to do the work in the first category. Up to 60 points. Items reviewed in this category include:
    a. Current and past experience relevant to payment and delivery system reform;
    b. Organizational capacity of applicant;
    c. Availability to perform the work described in #1 above.

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2. Distribution methodology in other programs:

At the January 10, 2014 Core Team Meeting, the Core Team requested a summary of distribution methodologies used by other programs. While doing this research, I discovered two things that differentiate our VHCIP from other state's efforts at payment and delivery system reform: 1. Vermont is much better at posting on our website and updating people about our project than other states; and 2. We are the only SIM test state to launch a Grant Program on this scale.

The summary of distribution methodologies is provided in the table below:

Entity Awarding the Funds	Brief Program Description	Funding Distribution
Arkansas SIM	Expands interfaces and event notification in the Arkansas HIE for certain providers	Supplies 10% match to 90/10 HITECH funding.
CMMI- SIM Test Awards	Testing payment and delivery system innovation in states.	First Round: 6 state awards. Up to $60 million for each state. Contract negotiations resulted in approx. $45 million for each of the 6 states.
Maine- SIM	Paying fees on behalf of providers to participate in Maine's HIE	Similar to federal meaningful use funding. Pays for EHRs and then interconnectivity costs, but not 100% of the costs.
Massachusetts SIM	Technical Assistance to providers only	N/A
Minnesota SIM	Small transformation grants to providers to support activities such as clinical system redesign.	Awards range from $10,000-$20,000.
Oregon Transformation Center (SIM)	HIE/HIT Infrastructure Awards to CCOs.	$30 million to be distributed among the 16 CCOs. The distribution was: a base award for each CCO and then additional dollars awarded based on the number of individuals served by the CCO.
Oregon Transformation	Regional Coalitions for Health	3 awards of up to $130,000

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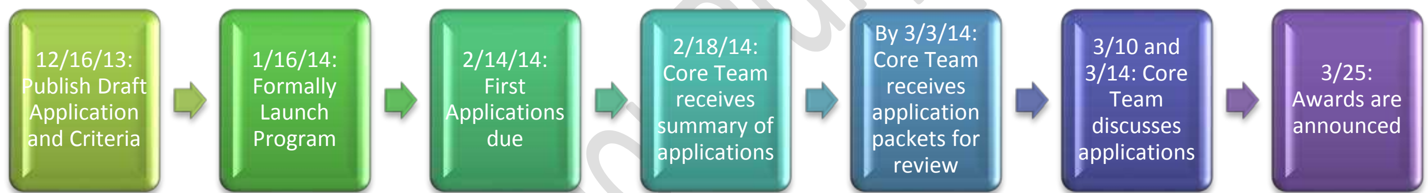
Entity Awarding the Funds	Brief Program Description	Funding Distribution
Center (SIM)	Equity	each.
RWJF	Various programs	Overall maximum for grant program area. Identify a number of awards for that given area and establish funding ranges for applicants.

3. First round timeline:



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