# VHCIP Core Team Agenda 5-19-14

# *VT Health Care Innovation Project*
# *Core Team Meeting Agenda*

**May 19, 2014 1:00-3:30 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 | 1:00-1:10 | Welcome and Chair's Report | Anya Rader Wallack | Attachment 1: Memo from A. Gobeille dated 11/11/13. |
| **Core Team Processes and Procedures** | | | | |
| 2 | 1:10-1:15 | Approval of meeting minutes | Anya Rader Wallack | Attachment 2: April 21, 2014 meeting minutes. |
| 3 | 1:15-2:00 | Project Director Report:<br>a. Progress Report and six-month preview:<br>Staffing Update<br>Year One Milestones<br>Website<br>b. CMMI Update:<br>Site Visit- June 18-19<br>Risk Mitigation Plan<br>c. Grant Program Discussion<br><br>*Public Comment* | Georgia Maheras | Attachment 3a: VHCIP Progress Report (PowerPoint).<br>Attachment 3b: VHCIP Milestones as of April 30, 2014.<br>Link to VHCIP Quarterly Report to CMMI:<br>http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/SOV_Y1_Q2_Report_to_CMMI_4.30.14.pdf<br>Attachment 3c: VHCIP Grant Program Process dated 5/5/14. |

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|---|---|---|---|---|
| | | | | Attachment 3d: Proposed Grant Program Application dated 5/5/14. |
| **Policy recommendations and decisions** | | | | |
| | | No policy recommendations or decisions this month | | |
| **Spending recommendations and decisions** | | | | |
| 4 | 2:00-3:10 | Financial Update:<br>a. Overview of VHCIP Contract spending to date<br>b. Population Health Work Group Proposal: RFP to support development of Accountable Health Care pilots<br>c. Amendment to Bailit Health Purchasing, Inc. contract: $1,000,000 to support three VHCIP work groups.<br>d. Sole Source Contract with the Coaching Center: $15,000 to support team building and change management.<br><br>*Public Comment* | Georgia Maheras | Attachment 4a: Finance memo from G. Maheras dated April 14, 2014.<br>Attachment 4b: VHCIP spending tracking as of May 12, 2014 (Excel). |
| 5 | 3:10-3:20 | Public Comment | Anya Rader Wallack | |
| 6 | 3:20-3:30 | Next Steps, Wrap-Up and Future Meeting Schedule:<br>6/16: 1:00-3:30 pm at DFR in Montpelier | Anya Rader Wallack | |

# Attachment 1 - Gobeille Memo 11.11.13

VERMONT

**Green Mountain Care Board**
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To: Vermont Health Care Innovation Project Core Team
From: Al Gobeille, Chair, Green Mountain Care Board
Date: November 11, 2013
Re: Allocation of authority re: payment and delivery system reform

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The purpose of this memo is to clarify how authority with respect to payment and delivery system reform is allocated among the Green Mountain Care Board, the Agency of Human Services (AHS), the Department of Vermont Health Access (DVHA), and the state's Health Care Innovation Project (HCIP).

Put simply, the GMCB, AHS, and DVHA each has statutory responsibility and authority over matters within their areas of jurisdiction while the HCIP, through the Core Team, has the authority under the terms of the State Innovation Model (SIM) grant to determine the use of grant funds to support reform projects and the responsibility to make sure that its funding decisions are consistent with the policy decisions of the GMCB, AHS, and DVHA. In addition, the HCIP is a mechanism for gathering input and reaching consensus among stakeholders. The composition of the HCIP Core Team reflects this reality by including the Chair of the GMCB, the Secretary of AHS, the Commissioners of DVHA and DAIL, and two stakeholder representatives—the CEOs of Northeastern Vermont Regional Hospital and King Arthur Flour.

The Legislature has delegated general authority to oversee the development and implementation of payment and delivery system reform to the GMCB. *See* 18 V.S.A. §§ 9375(b)(1) & 9377(b). Placing that authority in the context of the above-described division of labor, the GMCB has the statutory duty and power to review, approve, and evaluate proposed reform initiatives, *id.,* and rulemaking authority to establish those "methodologies for achieving payment reform and containing costs" that prove capable of system-level, sustainable reform. *Id.* § 9375(b)(1)(A). AHS and DVHA retain authority to "engage in additional cost-containment activities to the extent permitted by state and federal law." *Id.* § 9375(b)(1)(D).

Several benefits flow from the Legislature's decision to give general oversight of payment reform and pilot projects to the GMCB. First, by allocating this role to the Board, the Legislature provided for review and oversight designed to ensure that pilot projects "achieve the principles stated in section 9371" of Title 18. *Id.* § 9377(a). Second, the Legislature also

empowered the GMCB to actively facilitate and supervise the planning and implementation of pilot projects, in order to avoid antitrust violations. *Id.* § 9377(c).

Finally, the Board's role in payment reform ensures that Vermont will "achieve health care reform through the coordinated efforts of an independent board, state government, and the citizens of Vermont, with input from health care professionals, businesses, and members of the public." 2011 Vt. Acts & Resolves, No. 48, § 1(a) (legislative intent). As an independent public body, the Board can assess payment reform proposals from a systemwide perspective. Because the Board members have defined statutory terms, the Board can apply an institutional memory over time to proposals it reviews. Board members are also insulated from the political process in that they cannot be replaced with a change in administration. Finally, as a public body, the Board's review processes must be open and transparent and must allow Vermonters to be heard. *See, e.g.,* 18 V.S.A. § 9371(3) (Vermont's "health care system must be transparent in design, efficient in operation, and accountable to the people it serves. The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system."); 18 V.S.A. § 9375(a) (Board must execute its duties consistent with principles in 18 V.S.A. § 9371).

From the GMCB's perspective, the commercial and Medicaid ACO programs currently being developed help illustrate the division of labor outlined above. As a threshold matter, these initiatives are most accurately viewed as pilot projects, within the meaning of 18 V.S.A. § 9377, because each project is an opportunity to implement and evaluate the effectiveness of payment and delivery system reforms.[1] The tables and discussions below attempt to allocate approval authority and review responsibilities with respect to these initiatives.

[1] Because each project applies to a discrete, identifiable subset of Vermonters, not to our health care system as a whole, neither project requires an exercise of the GMCB's rule-making authority set out in 18 V.S.A. § 9375(b)(1)(A).

**Commercial ACO program:**

| Commercial ACO decision points | Who creates/reviews | Who approves |
|---|---|---|
| **Standards** | Workgroup, SIM steering comm., SIM core team | GMCB approves, per 18 V.S.A. § 9377 |
| **Measures** | Workgroup, SIM steering comm., SIM core team | GMCB approves, per 18 V.S.A. § 9377 |
| **Program Agreement** | Standards workgroup | Payers, ACOs |
| **ACO formation (participation agreements)** | ACO, Providers | ACO, Providers |
| **ACO Pilot application** | GMCB | GMCB approves, per 18 V.S.A. § 9377 |
| **Evaluation/ enforcement**[2] | GMCB | GMCB, per 18 V.S.A. § 9377 |

- The Standards and Measures workgroups, initially convened by the GMCB and later integrated into the HCIP governance structure, have largely completed developing standards and measures for the commercial and Medicaid ACO programs. The standards and measures will be reviewed by the SIM Steering Committee and the SIM Core Team. The core team will then forward the standards and measures, with any changes by the Steering Committee and Core Team, to the GMCB for approval.

- The payers and potential ACOs will enter into program agreements reflecting the standards and measures approved by the GMCB.

- Each group of providers intending to form a commercial ACO will enter into a participation agreement between the providers and the ACO.

- Each ACO will submit a payment reform pilot application to the GMCB, pursuant to 18 V.S.A. § 9377 and the GMCB's pilot policy and application process. Among other things, the GMCB will review each application to ensure that the proposed ACO will abide by the standards and will use the measures approved by the GMCB. Approval will

[2] The program agreements between payers and ACOs and the participation agreements between ACOs and providers in both the commercial and Medicaid ACO programs will presumably provide additional enforcement mechanisms among the parties to those agreements.

also be conditioned on GMCB evaluation of the ACO's adherence to those standards and measures.

**Medicaid ACO program:**

| Medicaid ACO decision points | Who creates/reviews | Who approves |
|---|---|---|
| **Standards** | Workgroup, SIM steering comm., SIM core team | GMCB approves, per 18 V.S.A. § 9377 |
| **Measures** | Workgroup, SIM steering comm., SIM core team | GMCB approves, per 18 V.S.A. § 9377 |
| **RFP** | DVHA | DVHA |
| **ACO formation (RFP responses)** | Providers, Payers | Providers, Payers |
| **ACO Pilot application** | GMCB; DVHA | GMCB approves, per 18 V.S.A. § 9377 |
| **Evaluation/ enforcement** | GMCB; DVHA | GMCB, per 18 V.S.A. § 9377; DVHA |

- DVHA has issued a Request for Proposals to providers wishing to form Medicaid ACOs. The RFP contains standards and measures substantially similar to the commercial standards and measures developed by the workgroups. Through the RFP process, DVHA will enter into contracts with ACOs according to standard Medicaid contracting procedures.

# Attachment 2 - Core Team Minutes 4-21-14

***VT Health Care Innovation Project***
***Core Team Meeting Minutes***

**Date of meeting: April 21, 2014 Location: DVHA Large Conference Room, 312 Hurricane Lane, Williston**

**Members:** Anya Rader Wallack, Chair; Robin Lunge, AOA; Susan Wehry, DAIL; Steve Voigt, King Arthur Flour; Paul Bengtson, NVRH; Al Gobeille, GMCB; Doug Racine, AHS; Mark Larson, DVHA.

**Attendees:** Georgia Maheras, AOA; David Martini, DFR; Richard Slusky, Spenser Weppler, GMCB; Diane Cummings, AHS; Kara Suter, Steve Maier, Carrie Hathaway, DVHA; Bea Grause, VT Association of Hospital and Health Systems; Lila Richardson, VT Legal Aid, Brendan Hogan, Bailit Health Purchasing, Simone Rueschemeyer, Behavioral Health Network; Jessica Mendizabal and Nelson LaMothe, Project Management Team.

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| **1. Welcome and Chair's report** | Anya Rader Wallack called the meeting to order at 1:07 pm. She stated that the Governor held two press conferences last month and that the grant program was covered in *Modern Healthcare*. Paul Bengtson stated he appreciated the work group status reports. Anya noted that the Project Management staff was working on getting those out to the groups in an easy to understand format and they should be sent out more in advance in the future. Questions can be directed to Georgia.<br><br>Anya referenced a memo she sent to Jeb Spaulding about her contractual work with Dartmouth and Jim Weinstein. If the group has any questions they should direct those to Anya and Georgia. Anya will avoid conflicts of interest by recusing herself from voting. The work she is doing with Dartmouth will not affect the work she performs under the SIM grant. Dartmouth put a grant application into CMMI for their long term vision for payment reform which would have implications for OneCare and next generation ACOs in Northern New England. The project is in the beginning phases and Anya's job is to help operationalize these efforts. | |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| **2. Approval of Minutes** | Anya asked the group to review the minutes from the March meetings, noting her name was misspelled in the March 14th minutes. The minutes were approved unanimously (Mark Larson was not present for this motion). | **The minutes will be updated and reposted to the website.** |
| **3. Project Director Report** | A. Grant Program Update<br>The grant contracts are currently being written and expect to be completed by the middle or end of May.<br><br>B. Staffing Report (attachment 3)<br>Overall recruitment efforts are going well. Data Analyst positions have been challenging to fill. Kara Suter and Georgia Maheras are working on more innovative recruitment efforts in this area.<br><br>C. Medicaid Shared Savings Program Update (including a discussion of the email sent from Deb Lisi-Baker, Co-Chair of the DLTSS work group, found under additional meeting materials).<br><br>Susan Wehry presented the memo and the group discussed some overall concerns.<br><br>Deb's letter questions which team or organization is accountable if the programs are not successful. Anya noted the Core Team is advisory and in charge of overall SIM funding but ultimately not responsible for contracts, which are the responsibility of the lead agency.<br><br>Susan referenced page two of the contract noting the contract belongs with AHS. The group discussed the following points:<br>• Care Management Standards, excerpted from the current contract, are included in the additional materials.<br>• The general concern is that there might not be sufficient protection against an ACO changing a proposed model of care. More discussion on this topic needs to take place in the CMCM work group. | • **Susan will work with Doug on contract language.**<br><br>• **Anya will draft a written response to Deb Lisi-Baker's letter and share with group for comment before sending to Deb.**<br><br>• **Al will share the letter that details what the GMCB role as an independent evaluator (previously distributed to group) and Anya will work on edits/updates to that letter.** |
| **4. Finance Update** | Paul Bengtson referred to the overall health care reform budget and asked if there was a way to see how projects are connecting or overlapping in a diagram format. Robin responded that the information exists in different forms and will work on putting it together one document after the legislative session. Paul asked how the money is being accounted for and how the results measure | **Al and Robin will diagram the overall system health care budget and how the** |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| | against the promises that are being made. Al Gobeille offered to have the GMCB put something together to diagram that. The idea of the SIM grant is meant to test health care reform theories and see what works. Paul referred to Dr. Hsaio's report noting the expected savings by 2015. Robin stated the plan did not pass the legislature, but the GMCB and the Administration is doing work around looking at costs without change and what are savings related to costs. They are working on improving the expenditure analysis over the next several months. They are seeing savings associated with different efforts. For the purposes of the SIM application the State used Wakely to look at current expenditures and make an assumption about what reform efforts are going to affect: making sure that the cost in grant dollars is still less than what the savings will be. Current data sources used to track total health care expenditures don't often capture the investments.<br><br>**A. <u>HIE/HIT Work Group Proposals (attachment 4a):</u>**<br>The Advancing Care Through Technology (ACTT) proposal has gone to the Steering Committee twice and this is an updated version. Recommendations have resulted from discussions with AHS and VITL, making it a more solid proposal. Simone Rueschemeyer reviewed the following:<br><br>1. *Project 1:* Data gathering, data quality & remediation for Designated Agencies (DAs) and Specialized Service Agencies (SSAs). This project applies to all the services provided even if it's not a mandated service by that agency (and needs to include children not just adults). This project has two phases – a planning and an implementation phase. Cost: $1,949,046 (which includes funding for VITL and the state's Health Information Exchange (HIE)).<br><br>2. *Project 2:* Planning for Long Term Services and Supports Data Reporting and Provider IT Gap Analyses. Cost: $178,000<br><br>3. *Project 3:* Universal Transfer Form Protocol Planning. Cost: $215,072<br><br>The Finance Memo submitted by Georgia Maheras was discussed (attachment 4c):<br>• Georgia asked for an increase in funds for data quality as a place holder in case it's needed in the future.<br>• Data remediation refers to making sure data is entered consistently with no spelling errors, etc.<br>• Steve Maier and Georgia will make sure there is no duplication of payments for this project. | **different projects overlap or connect.**<br><br>**Georgia will provide a list of contracts that may be extended.** |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| | • The proposal addresses what AHS asks for, reporting to the numerous government entities and ACOs, and trying to mitigate administrative burdens for the DAs.<br>• This project involves a lot of coordinated effort where there is some overlap in existing contracts to maximize services. DA participants need to indicate when it's becoming unmanageable.<br>• Project management will occur at Behavioral Health Network.<br>• Simone is confident the funding requested will get the job done.<br>• SIM funding is the most likely federal funds for these entities.<br><br>Steve Voigt moved to approve items 1-5 of the Finance Memo dated April 21, 2014 and Susan Wehry seconded. Steve asked if it reflects negatively not to seek funding elsewhere. Georgia responded that the funding request mobilizes resources as quickly as possible and we've learned how to do in a way that takes advantage of excitement from federal partners, noting there is always up to a 30 day delay for federal approval. Anya noted the resource planning at VITL has been an issue and it is better to make more decisions up front. Simone would come back to the group before Phase 2 Implementation with a new proposal and request for more funding.<br><br>HIE Work Group co-chairs and staff are meeting to discuss the HSE and how it connects to the Data Warehouse proposed by VITL. Carrie Hathaway stated that DVHA is contracting with Pacific Health Policy Group and identifying necessary reporting requirements for designated agencies.<br><br>The motion passed unanimously. Anya noted that throughout this process Simone has not voted on this proposal at either the HIE Work Group or at the Steering Committee meetings (since Behavioral Health Network is a beneficiary).<br><br>**B. <u>Evaluation contract update and Revisions to Overall Grant Budget</u>**<br>Georgia gave the following update: contract negotiations with the selected evaluation contractor broke down. GMCB has gone with the second highest scoring vendor in the RFP bid process, and is starting negotiations with that vendor (though they can't disclose at this time). The contract total is still within the "not to exceed" amount previously approved by the Core Team.<br><br>Georgia reviewed the requested changes to the VHCIP Funding Allocation Plan (attachment 4b) and her Finance Memo (attachment 4c): | |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| | Regarding the RFP for a new analytics contract at the GMCB, the original bids all came in higher than previously approved $1.2 million. GMCB recently approved to increase the total allowable maximum to $2.2 million to be spent over three years. Richard Slusky confirmed they are trying to actively negotiate to bring the costs down under that amount. The cost increased because there is a lot of work to do around financial analysis and quality management in the State and the team estimated their best guess when releasing the RFP. Georgia noted this is an effort toward finding an alternative to all parties doing their own analytics and they had payers and ACOs on the bid review team. There may be some duplication but the GMCB has worked to minimize it and the State won't pay for any duplication. Payers may want to check our data against theirs but the information will not be duplicated.<br><br>Robin Lunge moved to approve item 6 of attachment 4c, a $1.2 million increase in funding for statewide analytics activities. Steve Voigt seconded the motion.<br><br>Susan asked why funding was being moved out of year one for *Outreach* and *Broad dissemination of programmatic information to providers and consumers*. Georgia responded that for the latter, it was timed incorrectly and scheduled to happen in year two. The incremental costs will not increase in year two. They've received bids for Outreach efforts but they were not acceptable. They need to revise the language in the RFP and re-release it, making sure they depict the exact needs of the grant. Most original responses were marketing related.<br><br>The motion passed unanimously.<br><br>Regarding item 7 in attachment 4c: additional funds for the grant program are reallocated from year one funds that will not be spent, including funding for the learning collaborative, surveys to MMIS and work group support. $1 million is also taken out of the Evaluation line item. This was over budgeted initially and Georgia is confident about reallocating at this time.<br><br>Susan Wehry moved to approve reallocating $1,918,000 into the grant program and Steve Voigt seconded. The motion passed unanimously. | |

| Agenda Item | Discussion | Next Steps |
|---|---|---|
| | **C. <u>Federal timeline and no-cost extension (attachment 4d).</u>**<br>Georgia reviewed a separate memo requesting approval to extend the SIM grant by three months to allow for model testing. The extension does not increase the award. The offer was extended to all states by CMMI to allow for three full years of testing. Five out of the six states will most likely extend their grants. The extension will give leeway in the timeline and grant program goals, allowing grant awardees complete work and will align better with 2017 goals. The new grant end date will be December 31, 2016 and CMMI has indicated that it will be possible to extend the evaluation contract beyond that time.<br><br>Susan Wehry moved to approve the request to increase the grant timeline and Steve Voigt seconded. The motion passed unanimously. | |
| **5. Public Comment** | Lila Richardson asked when grant program details would be available. Georgia stated that we are waiting for some information back from the grantees and will have more information soon on the VHCIP website.<br><br>She also echoed the DLTSS work group's concerns on how the DLTSS population will be treated because they don't fit into the medical model. These are lifelong, not episodic conditions. She wanted the Core Team to keep in mind that the care is very different. Anya stated that DVHA, AHS and DAIL are working on this effort. | |
| **6. Next Steps, Wrap up** | Next meeting: May 19, 2014, 1-3:30 pm, DFR 3rd Floor Conference Room, 89 Main St, Montpelier. | |

# Attachment 3a - VHCIP Progress Report

# VHCIP Progress Report and Six-Month Outlook

May 19, 2014

Georgia Maheras, JD

Project Director

# PROGRESS REPORT: OCT-APR

# Personnel

24 funded positions

- 14.5 are filled and 9.5 are vacant
- Recruitment efforts continue with several offers in process

# Budget (contracts through 5/1/14)

| Contract Title | Amount | Duration |
|---|---|---|
| ACTT Proposal: all contracts together | 2,662,118 | 7/1/14-6/30/16 |
| Baker | 15,000 | 1/1/14-12/31/14 |
| Bailit Health Purchasing* | 1,180,000 | 3/31/14-1/31/17 |
| Burns and Associates | 125,000 | 2/24/14-12/31/14 |
| Grant Program Awards | 5,295,102 | 6/1/14-9/30/16 |
| Hester | 28,000 | 3/1/14-2/28/15 |
| Evaluation | 1,500,000 | 7/1/14-7/31/17 |
| PHPG-Value Based Purchasing | 57,820 | 6/1/14-5/31/15 |
| PHPG-DLTSS | 90,000 | 3/1/14-2/28/15 |
| Policy Integrity (TA) | 100,000 | 4/1/14-3/31/14 |

*Includes items pending approval as of 5/19/14

# Budget (contracts through 5/1/14)

| Contract Title | Amount | Duration |
|---|---|---|
| Patient Experience Survey | 300,000 | 7/1/14-6/30/15 |
| Population Health WG RFP* | 70,000 | 7/1/14-2/28/15 |
| Shared Savings ACO Analytics | 2,200,000 | 7/1/14-7/31/15 |
| Team Building* | 15,000 | 7/1/14-12/31/14 |
| UMass | 500,000 | 9/1/13-12/31/14 |
| Workforce WG RFP- data analysis | 150,000 | 7/1/14-6/30/15 |
| VITL-Population Collaborative | 3,023,79 | 1/1/14-4/30/15 |
| VITL- interfaces and REC | 1,170,000 | 11/4/13-6/30/14 |
| VPQHC(TA) | 100,000 | 7/1/14-6/30/14 |
| **TOTAL** | **15,858,040** | |

*Includes items pending approval as of 5/19/14

# Work Groups

- Payment Models:
  - Shared Savings ACO Programs launched 1/1/14
  - Episodes of Care: criteria development and data analyses
- Care Models:
  - Care model inventory
  - Shared Savings ACO Program Care Management Criteria
  - Learning Collaboratives
- HIE/HIT:
  - Two proposals funded:
    - Connecting LTSS and MH providers
    - Connections for SSP data
  - Telehealth/telemonitoring criteria

# Work Groups

- DLTSS:
  - Quality measure recommendations
  - Model of care review
- Workforce:
  - Data analyses
  - Workforce Strategic Plan review
- Population Health:
  - Quality measure recommendations
  - Landscape review of population health activities
- Quality and Performance Measures:
  - Shared Savings ACO Program year one and year two measures

# Work Groups

- Quality and Performance Measures:
  - Shared Savings ACO Program year one and year two measures
  - EOC Program year one measures
  - P4P Program year one measures

# Evaluation and Monitoring

- Patient Experience Survey (fielded in Summer and Fall)
- Self-Evaluation Plan
  - Vendor #2: work to commence July 1
- RTI:
  - Getting data
  - Interviews
  - Focus groups

# SIX-MONTH PREVIEW

# Personnel and Budget

- Year One: re-budgeting
- Overall project re-budgeting
  - Includes Year two budget
- Continued recruitment and retention efforts including:
  - Retreat on June 17th
  - Team building

# June 2014

- CMMI Site Visit: June 18 or 19
- Grant Program: discuss changes to program
- Risk Mitigation Plan review
- Finance:
  - Update

# July 2014

- Grant Program: finalize application-CT approval needed
- Evaluation:
  - Update
- Work Groups:
  - HIE/HIT: update on VITL and ACTT activities
  - Care Models: Learning Coll. recommendations-CT approval needed
- Finance:
  - Submit year one reallocation to CMMI- CT approval needed
  - Submit full project (and year two) proposed budget to CMMI-CT approval needed
- Misc. follow up:
  - Health care system costs (Al and Robin)

# August 2014

- Quarterly Progress Report and Six-Month Preview
- Work Groups:
  - Care Models: Care Management Standards recommendations-CT approval needed
  - QPM: Year 2 SSP measures recommendations-CT approval needed
- Finance:
  - Contracts: review RFP list for year two contracts-CT approval needed

# September 2014 (two meetings)

- Evaluation:
  - Self-Evaluation Plan discussion
- Grant Program: review applications
- Work Groups:
  - HIE/HIT: Telemedicine/Telemonitoring recommendations- CT approval needed
- Finance:
  - Update

# October 2014 (two meetings)

- Grant Program: review applications and announce awards
- Work Groups:
  - Workforce: Strategic Plan Update
  - HIE/HIT: Strategic Plan Update
- Finance:
  - Update
- ***Annual Report Due to the feds on October 30th!***

# November 2014

- Year One Progress Report and Six-Month Update
- Grant Program: Round one grantee update
- Work Groups
  - DLTSS: recommendations around barriers in current payment and coverage structures-CT approval needed
  - Payment Models: EOC and P4P Program Recommendations CT approval needed
- Finance:
  - Update

# Attachment 3b: VHCIP Milestones as of April 30, 2014

| Planned Year One Activities | Vermont's Year One Metrics | Status as of April 30, 2014 |
|---|---|---|
| **Advanced analytics** | | |
| Procure contractor for internal Medicaid modeling | Contract for Medicaid modeling | COMPLETE |
| Procure contractor for additional data analytics | Contract for data analytics | Bids were due February 14th and the vendor was selected in March 2014. Vermont expects to finalize negotiations with the successful vendor in May 2014 and begin work in June 2014. |
| Define analyses | Number of analyses designed (goal = 5) | Vermont has designed three analyses for the Commercial and Medicaid ACO Shared Savings Programs and has several more proposed in the Analytics Contractor RFP discussed above. Analyses include: attribution reports; summary statistics for attributed populations; calculation of performance measures; calculation of shared savings; and analysis of the difference between core and non-core costs. Draft models of reports have been developed, and the VMSSP and Commercial SSP staff are working together to align analyses for both programs. After ACOs submit their provider roster reports on April 30th, VMSSP and Commercial SSP staff and consultants will be able to produce initial attribution reports which will be the foundation for all other analyses. |
| Consult with payment models and duals WGs on definition of analyses | Number of analyses performed (goal = 5) | Continued discussions in the first six months of 2014 to define analyses. |
| Perform analyses; Procure contractor for financial baseline and trend modeling; and Develop model. | Contract for financial baseline and trend modeling | Vermont will procure several contractors to develop financial baselines and trends in Year One. The first contractor will provide financial baselines and trend models for the Medicaid and Commercial Shared Savings ACO Programs as described above. Vermont will procure other contractors as the Episode of Care and |

| | | |
|---|---|---|
| | | Pay-for-Performance Programs are launched in Year One. |
| Consult with payment models and duals WGs on financial model design | Number of meetings held with payment models and duals WGs on the above designs (goal = 2) | Continued discussions with these two work groups in 2014. |
| Produce quarterly and year-end reports for ACO program participants and payers | | These reports will be generated by the Analytics Contractor was selected in March (contract negotiations are underway). Vermont has established criteria for quarterly and annual reports and plans to work closely with the Analytics Contractor to ensure accurate compliance with report requirements. |
| **Evaluation (external and external)** | | |
| Procure contractor | Contract for external evaluation | Vermont has experienced contracting challenges. We expect to execute Contract in June 2014. Vermont will be using this contractor for several components of its self-evaluation plan. |
| Develop evaluation plan | Evaluation plan developed | The contractor will work in close collaboration with the VHCIP Evaluation Director and present a design plan for the self-evaluation; the goal date for this activity is August 2014. |
| Consult with performance measures work group | Number of meetings held with performance measures WG on evaluation (goal = 2) | The draft self-evaluation plan will be shared with all of the project's work groups in July and August 2014. A status report on the self-evaluation will be shared with the Quality and Performance Measures Work Group for input during its December 2014 meeting. |
| Input baseline data | Baseline data identified | This will be developed with the Contractor upon contract execution in mid-2014. |
| Hire staff | Hire Staff | COMPLETE |
| **Initiative Support** | | |
| Procure contractor | Contract for interagency coordination | Vermont plans to release an RFP for this work in the third quarter of Year One. |

| | | |
|---|---|---|
| Develop interagency and inter-project communications plan | Interagency and inter-project communications plan developed | The plan will be developed once the contractor is selected. |
| Implement plan | Results of survey of project participants re: communications | The plan will be implemented once the contractor is selected. |
| **State staff training and development** | | |
| Hire contractor | Contract for staff training and development | Vermont plans to execute a contract for this work in the third quarter of Year One. |
| Develop curriculum | Training and development curriculum developed | The curriculum will be developed once the contractor is selected. |
| **Model Testing** | | |
| Develop ACO model standards | Approved ACO model standards | COMPLETE |
| Execute Medicaid ACO contracts | Number of Medicaid ACO contracts executed (goal = 2) | COMPLETE |
| Execute commercial ACO contracts | Number of commercial ACO contracts executed (goal = 2) | COMPLETE |
| Develop standards for bundled and episode-based payments | Approved standards for bundled and episode-based payments | The Episodes of Care model is being discussed by the Payment Models Work Group. The group is establishing criteria for evaluating possible episodes to test. |
| Execute contracts for bundled and episode-based payments | | COMPLETE |
| Develop Medicaid value-based purchasing plan addressing pay-for-performance initiatives | Medicaid value-based purchasing plan developed | The Pay-for-Performance model will be finalized within the next quarter, with input from the Payment Models Work Group. |
| Procure learning collaborative and provider technical assistance contractor | Contract for learning collaborative and provider technical assistance | Vermont is determining whether technical assistance from IHI, ECHO or a contractor procured through an RFP process would be helpful in designing and implementing learning collaboratives. |
| Establish learning collaboratives for providers engaged in each of the testing models | Number of learning collaboratives for providers conducted (goal = 3 day long meetings) | The first meeting of the shared savings program learning collaborative will be held by June 2014. A draft learning collaborative to convene clusters of providers (e.g., hospital, home health, |

| | | |
|---|---|---|
| | | primary care, specialty care) to share data, identify best practices, and identify improvement opportunities for episodes of care will be presented to the Care Models and Care Management and Payment Models Work Groups by September 2014. The collaborative will be geared toward the bundled payments model. The first in-person meeting of the episodes of care model learning collaborative will be held by December 2014. |
| Develop technical assistance program for providers implementing payment reforms | Number of providers served by technical assistance program (goal = 20) | Established the program.<br><br>Note: this goal is still 20, but only 8 awards were made in round one so we may not meet the overall goal. |
| Number of providers participating in one or more testing models | goal = 2000 | Will update once we have confirmation of providers participating in the SSPs (lists due at end of April). |
| Number of Blueprint practice providers participating in one or more testing models | goal = 500 | 627 unique providers in 126 PCMHs. COMPLETE |
| **Technology and Infrastructure** | | |
| Provide input to update of state HIT plan | Updated state HIT plan | The goal is to draft the phase 2 work of updating HIT, HIE, and privacy and security by June 30, 2014. The current goal is to also have a draft of the entire plan by December 31, 2014. |
| Expand provider connection to HIE infrastructure | Number of new interfaces built between provider organizations and HIE (goal = 18 additional hospital interfaces and 75 new interfaces to non-hospital healthcare organizations to include: at least 10 specialist practices; 4 home health agencies; and 4 designated mental health agencies) | VITL will continue to work with providers to build on the interfaces established in 2013. The HIT/HIE Work Group will be discussing this as part of the work in 2014. We anticipate significant collaboration between and among providers on this issue.<br><br>1. For Home Health Agencies, 3 VHIE agreements, 5 DSA agreements and 1 SRA agreement will be executed by June 2014. Interfaces |

| | | |
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| | | for one home health agency will be established by June 2014. VITL executed 5 VHIE agreements with Home Health Agencies and 10 with DSA's.<br>**2.** For Mental Health Designated Agencies, 6 VHIE agreements, 2 DSA agreements, and 1 SRA agreement will be executed by June 2014. At least one Designated Agency will be identified for interface development by April 2014.<br>**3.** VITL built two interfaces with long term care entities and 21 interfaces with Specialist organizations. VITL is working with home health and Designated Agencies on interfaces. |
| Identify necessary enhancements to centralized clinical registry & reporting systems | Completed needs assessment for enhancements to centralized clinical registry and reporting systems | VHCIP is currently reviewing options for how best to continue to provide registry and reporting analytic services. |
| Procure contractor to develop initial use cases for the integrated platform and reporting system | Contractor hired | VHCIP is currently working on use case identification and development and should complete the scope of this project for this project by August 2014. |
| Design the technical use cases and determine the components of the integrated platform that are required to implement these use cases | Contract for the development of 6 primary use cases for the integrated platform and reporting system | VHCIP is currently working on use case identification and development and should complete the scope of this project for this project by August 2014. |
| Develop criteria for telemedicine sub-grants | Number of telemedicine initiatives funded (goal = 1) | The HIT/HIE Work Group will develop these criteria in early Summer 2014. |
| Expand the scope of VHCURES to support the integration of both claims and clinical data and provide this capability to ACOs/providers and | Number of providers approved for use of VHCURES data | The GMCB is releasing an RFP in 2014 for a new VHCURES warehousing contract that will expand the scope. |

| | | |
|---|---|---|
| potentially payers | | |
| Begin to incorporate long term care, mental health, home care and specialist providers into the HIE infrastructure | Provide regional extension center (REC) like services to non-EHR providers to include long term care, mental health, home health and specialists and begin development of interfaces to the VHIE for these provider groups that currently have EHRs with the goal over three years of achieving 50 new interfaces. | The State of Vermont has a contract with VITL, the state's HIE contractor, to begin to incorporate these providers into the HIE infrastructure. Some VHCIP funds are being used for this purpose in Year One. The HIT/HIE Work Group will also make recommendations regarding incorporating these providers. |

# Attachment 3c: VHCIP Grant Program Process dated 5/5/14

**State Innovation Model**

109 State Street
Montpelier, VT 05609
http://healthcareinnovation.vermont.gov

To: Core Team
Fr: Georgia Maheras
Date: May 5, 2014
Re: Proposed VCHIP Grant Program Roll-Out Process and Timeline- Second Round of Funding

In March 2014, the Core Team approved the first round of grant program awards. This memo discusses the timeline and proposed process for the second, and final, round of awards.

***Proposed Process:***

Step 1. Core Team discusses grant program at May Core Team meeting. (Proposed revisions in attached draft application).

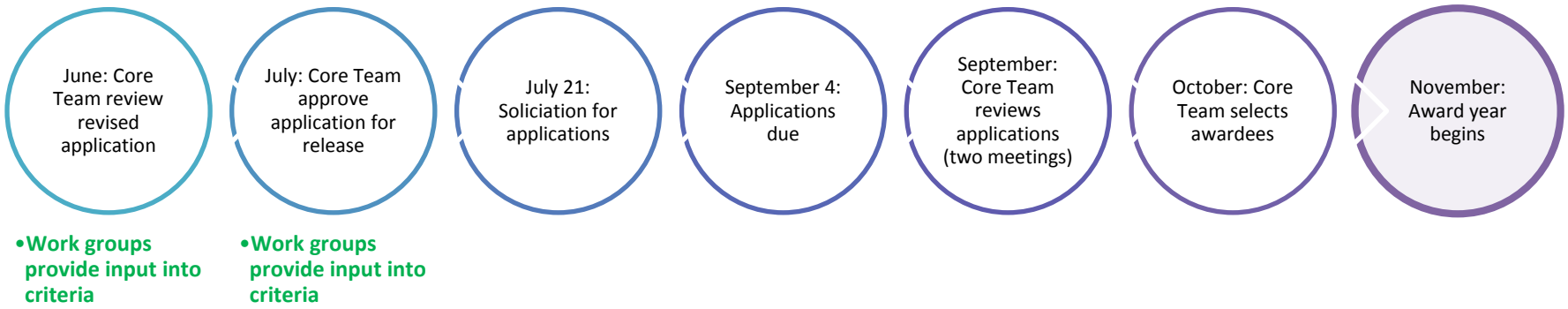
Step 2: VHCIP work groups provide input to Core Team regarding Grant Program criteria: June and July 2014.

Step 3: Core Team approval of and suggested changes to the Grant Program criteria and application: June and July 2014.

Step 4: Grant Program Application released: late July 2014.

Step 5: Grant applications accepted. DVHA is the agency responsible for the operational act of grant application receipt and distribution of funds. DVHA will receive applications then the VHCIP Project Director will work with staff to assemble application packets with executive summaries.

Step 6: Core team review of applications and selection of grantees.


June: Core Team review revised application
July: Core Team approve application for release
July 21: Soliciation for applications
September 4: Applications due
September: Core Team reviews applications (two meetings)
October: Core Team selects awardees
November: Award year begins
•Work groups provide input into criteria
•Work groups provide input into criteria

# Attachment 3d: Proposed Grant Program Application dated 5/5/14

# Vermont Health Care Innovation Project Grant Program Application

Draft dated 05-05-14~~12.23.2013~~

## 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~~5,295,102 of which $xxx is available in this round.

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~~activities in support of collaborative innovation in health care payment reform. Appendix B includes a detailed list of federal guidelines around this funding. Please review these federal guidelines before developing a project budget.

Applicants may seek up to $400,000 of funding for a maximum of 24 months for any of the following types of activities:

- 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. The number of providers impacts and the number of patients impacted;
  ~~a.~~c. Explain how this proposal directly relates to the VHCIP goals, specifically how it relates to the payment and delivery system activities funded through the State Innovation Models Testing Grant.

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  ~~b.~~d. A clear description of alternative funding sources sought and rationale for requesting SIM funds;
  ~~c.~~e. A description of technical assistance services sought. Appendix D provides more detail about the technical assistance services available under this grant~~.~~.

~~d.~~f. A description of the project's potential return-on-investment in terms of cost savings and quality improvement, and plans for measuring both;

~~e.~~g. A description of how the project will avoid duplication and complement ~~where~~ similar ~~innovations~~ activities in Vermont that are currently underway (applicants may provide additional appendices that describe the research they did to respond to this question and listing any other similar initiatives around the state);

~~f.~~h. A summary of the evidence base for the proposed activities or technical assistance including information from Vermont and across the nation.~~;~~

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- 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 10$^{th}$ and July 10$^{th}$). 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:

- ~~T~~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:*

Lead Organization Applying: _____

Collaborating Organizations: _____

Key Contact for Applicant: _____

Relationship to Applicant: _____

Key Contact Email: _____

Key Contact Phone Number: _____

Key Contact Mailing Address: _____

Fiscal Officer (must be different from Key Contact): _____

Relationship to Applicant: _____

Fiscal Officer Email: _____

Fiscal Officer Phone Number: _____

Fiscal Officer Mailing Address (if different from Key Contact): ~~Key Contact Email and Phone Number:~~ _____

*Project Title and Brief Summary:*

Project Title(limit to 40 characters):

_____

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

*Budget Request Summary:*

Please include proposed project start and end dates in this section.

| Budget Category | Year 1 | Year 2 | ~~Year 3~~Total |
|---|---|---|---|
| Personnel | | | |

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| | | | |
|---|---|---|---|
| Fringe | | | |
| Travel | | | |
| Equipment | | | |
| Supplies | | | |
| Indirect | | | |
| Contracts | | | |
| Other* | | | |
| ***Total*** | | | |

*Applicants should identify what items are included in the Other category if used.

**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*

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
- 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.

**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.*

*Job Description: 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:

- 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

# Attachment 4a: Finance memo from G. Maheras dated April 14, 2014

109 State Street
Montpelier, VT 05609

To: Core Team
Fr: Georgia Maheras
Date: 5/14/14
Re: VHCIP Financial Update and Request for Approval of SIM Funding Actions

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

1. Proposal to release an RFP for services to assist Vermont in exploring the development and potential application of the Accountable Health Community to Vermont's health care system. Cost: $70,000. Duration: July 1-December 31, 2014.
2. Proposal to contract for services with The Coaching Center of Vermont related to VHCIP staff team building. Cost: $15,000. Duration: July 1-January 31, 2014.
3. Proposal to contract with Bailit Health Purchasing, Inc. for services supporting the following work groups: Care Models and Care Management, Payment Models, Quality and Performance Measures and DLTSS. Cost: $1,000,000. July 1, 2014-January 31, 2017.

***REQUEST #1- Type 2 Proposal to release an RFP for services to assist Vermont in exploring the development and potential application of the Accountable Health Community to Vermont's health care system for an amount not to exceed $70,000:***

This proposal comes from the Population Health Work Group and uses funds from the work group support line item for that work group. It was recommended for Core Team approval by the Steering Committee on 5/14/14. The project timeline is July 1, 2014-December 31, 2014 and estimated cost is $70,000.

**Proposal Summary:**

The intent of this proposal is to support the Population Health Work Group in fulfilling its charge in the VHCIP Operational Plan. This work group is required to "(e)xamine current population health improvement efforts administered throughout Vermont and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:

- Enhancement of State initiatives administered through the Department of Health;
- Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts; and
- Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health"

The contractor would perform the following activities:

- Research promising community level innovations, known as Accountable Health Communities, in payment and service delivery in others parts of the country to coordinate health improvement activities and more directly impact population health;

  *An AHC would be accountable for the health of the population in a geographic area, including reducing disparities in the distribution of health. Its major functions could include:*

  - *convening a broad set of key stakeholders*
  - *assessing the needs of the community, identifying gaps and potential interventions and prioritizing actions to achieve shared goals*
  - *managing a diverse portfolio of interventions and allocating resources*
  - *creating the information systems and capability to assess performance and implement rapid cycle changes*
- Identify key features to consider in developing recommendations for VT;
- Determine which features are present in the innovations currently underway through VHCIP and other health system reforms and what expansion in the scope of delivery models would be recommended;
- Identify initiatives in Vermont that have some of the features necessary to improve population health by better integration of clinical services, public health programs and community based services at both the practice and the community levels.

***Recommendation:*** Authorize a request for proposals to assist Vermont in exploring the development and potential application of the Accountable Health Community to Vermont's health care system. The total project cost is an amount not to exceed $70,000. The term is July 1, 2014-December 31, 2014.

***REQUEST #2- Type 1 Proposal to contract for services with the Coaching Center of Vermont related to VHCIP staff team building. Cost: $15,000. Duration: July 1, 2014-January 31, 2015.***

I propose executing a sole source contract with the Coaching Center of Vermont for the purpose of strengthening the VHCIP staff. As we have discussed, due to the matrixed staffing approach of this project, it is challenging to get folks on the same page, to share the workload, and to collaborate in ways that will foster a climate of innovation at all levels of the process.

The Coaching Center of Vermont is a leader in transforming cultures and teams into highly functioning teams that support themselves in environments of diversity, shared vision and values, collaboration, and innovation. The Coaching Center of Vermont will use its A2B tool to foster a stronger VHCIP team. The Coaching Center will perform these tasks in three stages:

Stage – 1, Leadership Coaching:

Beginning July 1, 6 months of intensive 1-on-1 individual coaching for the Project Leader, focusing on coach training for leading the group with the A2B coaching methodology.

Stage -- 2, Staff Leadership Retreat:

In August, half-day coach training, the entire team will come together to learn the tools and techniques necessary for transforming how work together so that they leverage each other strengths, create a shared experience and vision for guiding their work together, and learning how to engage their creative centers of thinking and communicating, building their innovation muscle.

Stage – 3, Staff Leadership Retreat:

In September, 1 half-day follow-up coaching to celebrate successful application of new learning, negotiate any barriers or blocks that arose with integration of new learning, and build on/further develop the skills learned in the 1st group training. Additionally, this session will focus on how to foster a climate of innovation and ensure successful project outcomes that are free of old structures/thinking that traditionally impede progress.

***Recommendation:*** Execute a new contract with The Coaching Center of Vermont for staff. The total project cost is: $15,000. The term is July 1, 2014- January 31, 2015.

***REQUEST #3- Type 1b Proposal to contract for services supporting work performed in the following VHCIP work groups: Care Models and Care Management, Quality and Performance Measures, Payment Models and DLTSS. Cost: $1,000,000. Duration: July 1, 2014-January 31, 2017.***

This proposal comes from several VHCIP work groups: Care Models and Care Management, Quality and Performance Measures, Payment Models and DLTSS. This proposal was discussed at the Steering Committee on May 14, 2014 and approved for recommendation to the Core Team. The project timeline is July 1, 2014-January 31, 2017 for an amount not to exceed $1,000,000. This would be an amendment to the existing contract with Bailit Health Purchasing, Inc. (Bailit) and brings Bailit's VHCIP-related activities into one agreement for ease of managing and reporting.

**Project summary:**
Bailit Health Purchasing (Bailit) to support policy development, payment model design, care model design and quality measurement identification for several VHCIP work groups. Specifically, Bailit staff will perform: research and analysis, document development, meeting facilitation, assist the work group staff in carrying out the work plan approved by the work group, and assist the staff with any sub-groups of work groups.

This contractor will support VHCIP's goals because it provides direct assistance to four of the project's work groups. Bailit has provided consulting support to all of these groups over the past year. The work groups have approved continued support from Bailit for specific tasks and will be monitoring performance and will recommend any future changes in scope. Bailit is familiar with Vermont's payment and delivery system models and key personnel can draw on that expertise to inform this work. This allows Vermont to maximize efficiencies in contracting. Bailit has contracts with other SIM states and entities across the country engaged in payment and delivery system reform work. They bring this knowledge back to Vermont for our discussion, which ensures we have the broadest available set of information upon which to base policy decisions. Bailit is able to begin this work immediately. The SIM Project requires Vermont adhere to extremely tight timeframes for payment and care model development. Delaying procurement of a vendor to conduct this work would significantly jeopardize the ability of Vermont to meet critical milestones and metrics.

Bailit has assigned the following key staff to Vermont's VHCIP work:

- Michael Bailit
- Mary Beth Dyer
- Kate Bazinsky
- Marge Houy
- Beth Waldman
- Megan Burns
- Christine Hughes
- Michael Joseph
- Margaret Trinity
- Brendan Hogan

***Recommendation:*** Amend the existing contract with Bailit Health Purchasing, Inc. to perform work in support of work group activities. The total project cost is: $1,000,000. The term is July 1, 2014- January 31, 2017.

# Attachment 4b: VHCIP spending tracking as of May 12, 2014

# 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** | **$ 470,000** | $ 700,000 | $ 670,000 | $ 1,870,000 | **Year 1 paid out of Carryover. Run rate is lower than expected in year one. Moved $305,000 to ACO Analytics.** |
| | Evaluation | | **$ 200,000** | **$ 900,000** | **$ 900,000** | **$ 2,000,000** | **Contracting delays. Estimated new cost of $1.5million on different timeline. Moved 1,000,000 from Evaluation to Grant Program.** |
| | Outreach and Engagement | | **$ -** | | | **$ -** | **Year 1 paid out of Carryover Moved these funds to ACO Analytics- $100,000** |
| | Interagency coordination | | **$ -** | $ 110,000 | $ 110,000 | $ 220,000 | **Moved these funds to ACO Analytics- 110,000** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Staff training and Change management | | **$ 20,000** | $ 100,000 | $ 100,000 | $ 220,000 | **Support Conferences and Educational Opportunities. Reduced this to $20,000 for Year 1 and using remainder for ACO Analytics- $80,000** |
| | VITL Contract | | **$ 1,177,846** | | | **$ 1,177,846** | |
| | Grant program | | **$ 3,428,435** | **$ 933,333** | **$ 933,334** | **$ 5,295,102** | **Increase of $1,918,000 from other categories. $2.6 million awarded.** |
| | Grant program- Technical Assistance | | **$ 500,000** | | | **$ 500,000** | **500,000 from personnel due to unspent funds in that category.** |
| | **Subtotal** | **$ 137,898** | **$ 8,818,384** | **$ 6,155,436** | **$ 6,125,437** | **$ 21,237,155** | |

# 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 | | $ - | **$ 200,000** | **$ 200,000** | **$ 400,000** | **To support ACO work, Care Models Work.** |
| | 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. Anticipate needing the remainder in year two.** |
| | | | | | | $ - | |
| | **Measures** | | | | | $ - | |
| | Bailit | | $ - | **$ 200,000** | **$ 200,000** | **$ 400,000** | |
| | Patient Experience Survey | | **$ 300,000** | | | **$ 300,000** | **Contract negotiations ongoing** |
| | | | | | | $ - | |
| | **HIT/HIE** | | **$ 50,000** | $ 150,000 | $ 150,000 | $ 350,000 | **No contractor identified. Moved $100,000 to Grant Program** |
| | | | | | | $ - | |
| | **Population Health** | | **$ 100,000** | $ 100,000 | $ 100,000 | $ 300,000 | **28,000 expended on Hester contract in year one. 70,000 for RFP.** |
| | | | | | | $ - | |
| | **Workforce** | | $ - | $ 43,000 | $ 43,000 | $ 86,000 | **No contractor identified. Moved 43,000 to Grant Program.** |
| | | | | | | $ - | |
| | **Care Models** | | **$ 50,000** | $ 250,000 | $ 250,000 | $ 550,000 | **No contractor identified. Moved $200,000 to ACO Analytics.** |
| | | | | | | $ - | |
| | **Duals** | | | | | $ - | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Bailit/PHPG | | $ 180,000 | $ 250,000 | $ 250,000 | $ 680,000 | $180,000 identified in year one for PHPG and Hogan. Moved $70,000 to ACO Analytics. $100,000 each in years two and three for Bailit for DLTSS support. |
| | **Sub Total** | | **$ 880,000** | **$ 1,393,000** | **$ 1,193,000** | **$ 3,466,000** | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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 | | **$ 733,333** | **$ 748,333** | **$ 733,334** | **$ 2,215,000** | **This contractor would support the development of spending targets, whether an ACO met those targets. This contract is higher than anticipated. Recommend moving funds to provide additional $1.215 million** |
| | | | | | | $ - | |
| | **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… | | **$ 275,000** | $ 150,000 | $ - | $ 425,000 | Resources to support updates to adjudication or analytic systems and processes like MMIS. **Moved 75,000 to Grant Program.** |
| | Broad dissemination of programmatic information to providers and consumers | | $ - | $ 100,000 | $ 100,000 | $ 200,000 | Communications to providers and consumers regarding program/billing changes. **Moved 100,000 to ACO Analytics Contract.** |
| | Analytics support to implement models | | $ - | $ 50,000 | $ 50,000 | $ 100,000 | **Moved 250,000 to ACO Analytics Contract.** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 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** | | **$ 1,358,333** | **$ 1,373,333** | **$ 1,133,334** | **$ 3,865,000** | |

# 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 | | **$ 530,933** | **$ 856,666** | $ 856,667 | $ 2,244,266 | **$90,612 in year one is unallocated. Use 90,612 of year one and 856,666 of year two for ACTT Proposal.** |
| | Clinical Registry | | **$ 466,666** | $ 466,666 | $ 466,667 | $ 1,399,999 | **Use 466,666 of year one for ACTT Proposal.** |
| | Integrated Platform | | $ 666,666 | $ 666,666 | $ 666,667 | $ 1,999,999 | |
| | Expanded Connectivity between SOV and providers | | **$ 833,333** | **$ 833,333** | **$ 446,237** | $ 2,112,903 | **Use 387,097 of year three for ACTT Proposal. Reallocate between years. Balance of $446,237 remains.** |
| | Telemedicine | | $ 416,666 | $ 416,666 | $ 416,667 | $ 1,249,999 | |
| | Expanded Connectivity HIE | | **$ 346,346** | **$ 661,077** | **$ 661,077** | $ 1,668,500 | **Use 661,077 of year three for ACTT Proposal. Reallocate between years.** |
| | | | | | | $ - | |
| | **Workforce** | | | | | $ - | |
| | Surveys | | $ - | $ 80,000 | $ - | $ 80,000 | **Moved 80,000 to Grant Program** |
| | Data analysis | | $ - | $ 150,000 | $ 150,000 | $ 300,000 | |
| | System-wide analysis | | **$ 96,666** | $ 546,666 | $ 546,667 | $ 1,189,999 | **$150,000 request for year one data analysis- RFP is pending. Moved 300,000 to Grant Program. Remainder is 96,666 in Year One.** |
| | | | | | | $ - | |
| | | | | | | $ - | |
| | **Care Models** | | | | | $ - | |
| | Service delivery for LTSS, MH, SA, Children | | $ 533,333 | $ 533,333 | $ 533,334 | $ 1,600,000 | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Learning Collaboratives | | **$ 350,000** | $ 325,000 | $ 325,000 | $ 1,000,000 | This item could support outreach and mailings associated with notification and education on new care delivery and payment reform models. **Moved 150,000 to Grant Program** |
| | 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 | $ 340,000 | **Moved 170,000 to Grant Program.** |
| | Integration of MH/SA | | $ 50,000 | $ 50,000 | $ 50,000 | $ 150,000 | |
| | | | | | | $ - | |
| | **Sub-Total** | | **$ 4,390,609** | **$ 5,856,073** | **$ 5,388,983** | **$ 15,635,665** | |
| | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| **Type 1a** | $ 21,237,155 | Type 1 A | | | | | |
| **Type 1b** | $ 3,466,000 | Type 1 B | | | | | |
| **Type 1c** | $ 3,865,000 | Type 1 C | | | | | |
| **Type 2** | $ 15,635,665 | Type 2 | | | | | |
| **Unallocated (Year 1)** | $ 805,350 | Balance Avail. | | | | | |
| **Grant Total** | $ 45,009,170 | Grant Total | | | | | |
| | | | | | | | |