1 BALDWIN STREET,
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Joint Fiscal Committee members

From: Daniel Dickerson, Fiscal Analyst

Date: March 29, 2017

Subject: Grant Request #2878

Enclosed please find one (1) item that the Joint Fiscal Office has received from the administration. **The administration has requested expedited review of this grant**. Members will be contacted by April 5, 2017 for a decision unless the member has responded prior to that time.

JFO #2878 – $9,500,000 grant from the Centers for Medicare and Medicaid Services (CMMS) to the Department of Vermont Health Access (DVHA). The grant funds will be used as start-up funding in support of Vermont's All-Payer Accountable Care Organization (ACO) model. DVHA will receive quarterly grant payments from CMMS and the funds will go back out in the form of payments to Patient-Centered Medical Homes (PCMH) and Community Health Teams (CHT), and contracts with Support and Service at Home (SASH) organizations and the Vermont Care Organization. The budget and project period would begin retroactively on 3/2/2017 and would end on 3/1/2018. No state matching funds will be required for this grant. [*JFO received 3/28/17]*

Please review the enclosed materials and notify the Joint Fiscal Office (Daniel Dickerson at (802) 828-2472; ddickerson@leg.state.vt.us) if you have questions or would like an item held for legislative review.

VERMONT JFO 2878

State of Vermont
Department of Finance & Management
109 State Street, Pavilion Building
Montpelier, VT 05620-0401

[phone] 802-828-2376
[fax] 802-828-2428

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:	Grant of $9.5M start-up funding in support of Vermont's All Payer Model Cooperative Agreement				
Date:	3/13/2017				
Department:	DVHA - Vermont Blue Print for Health				
Legal Title of Grant:	Announcement: Start-up Funding in Support of the Vermont All Payer ACO Model Cooperative Agreement				
Federal Catalog #:	93.961				
Grant/Donor Name and Address:	CMS - Centers for Medicare & Medicaid Services 7500 Security Boulevard, Baltimore, MD 21244				
Grant Period: **From:**	3/2/2017	**To:**	3/1/2018		
Grant/Donation	$9,500,000				

	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	$4,444,583	$5,055,416	$0	$9,499,999	

	# Positions	Explanation/Comments
Position Information:		

Additional Comments:	(ATTN Dan Dickerson:) DVHA is seeking the approval process be expidited to align with year 0 primary care ACO infrastructure funding needs.

Department of Finance & Management		(Initial)
Secretary of Administration		(Initial)
Sent To Joint Fiscal Office	3/27/17	**Date**

STATE OF VERMONT REQUEST FOR GRANT (*) ACCEPTANCE (Form AA-1)

BASIC GRANT INFORMATION				
1. Agency:	Agency of Human Services			
2. Department:	Department of Vermont Health Access			
3. Program:	Vermont Blueprint for Health			
4. Legal Title of Grant:	Announcement: Start-up Funding in Support of the Vermont All-payer ACO Model Cooperative Agreement			
5. Federal Catalog #:	93.961			
6. Grant/Donor Name and Address: CMS - Centers For Medicare & Medicaid Services 7500 Security Boulevard, Baltimore, MD 21244				
7. Grant Period: **From:**	3/2/2017	**To:**	3/1/2018	

8. Purpose of Grant:

The purpose of this single source funding opportunity for the Start-up Funding in Support of Vermont's All-Payer ACO Model ("Model") cooperative agreement is to provide Vermont with the start-up funding component of the Model to assist Vermont in accomplishing the health outcomes, financial, and ACO scale targets required of Vermont under the Model. A single source award to the Agency for Human Services will enable CMS to expeditiously provide assistance to Vermont for the following specific activities: connect Medicare Fee-for-Service beneficiaries with community-based resources, coordinate transitions across care settings with appropriate involvement of the Medicare Fee-for-Service beneficiary's primary care provider, coordinate care across providers, support health promotion and self-management by Medicare Fee-for-Service beneficiaries, and support practice improvement and transformation. These activities are necessary for Vermont to achieve the goals of the Model. We note that the other components of the Model (e.g., Vermont-specific Medicare ACO initiative and statewide health outcomes, financial, and ACO scale targets) are governed by a separate State Agreement into which Vermont and CMS have entered.

9. Impact on existing program if grant is not Accepted:

DVHA runs the risk of introducing a gap year in which funding will not be provided for the primary care foundations and ACO infrastructure that will be funded through years 1-5 of the Model. Approximately 76,261 Medicare beneficiaries will not be attributed to 112 practies who have achieved certification as Patient Centered Medical Homes from the National Committee for Quality Assurance (NCQA) and 14 regional Community Health Teams. DVHA will no longer support the Support and Services at Home (SASH) program that has supported healthy aging at home since 2009 through the CMS Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration. DVHA will no longer support Vermont Care Organization (VCO) integration, which may have consequences for VCO readiness to accept their responsibilities in year 1 of the Model.

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	FY 2017	FY 2018	FY 2019	
Personal Services	$2,307,175.52	$2,852,200.00	$0	
Operating Expenses	$2,137,407.70	$2,203,216.78	$0	
Grants	$0	$0	$0	
Total	$4,444,583.22	$5,055,416.78	$0	
Revenues:				
State Funds:	$0	$0	$0	
Cash	$0	$0	$0	
In-Kind	$0	$0	$0	

MAR 1 3 2017

3/16/17

STATE OF VERMONT REQUEST FOR GRANT (*) ACCEPTANCE (Form AA-1)

Federal Funds:	$4,444,583.22	$5,055,416.78	$0	
(Direct Costs)	$4,444,583.22	$5,055,416.78	$0	
(Statewide Indirect)	$0	$0	$0	
(Departmental Indirect)	$0	$0	$0	
Other Funds:	$0	$0	$0	
Grant (source)	$0	$0	$0	
Total	$4,444,583.22	$5,055,416.78	$0	

Appropriation No:	03410010000	**Amount:**	$ $9,500,000.00
			$
			$
			$
			$
			$
			$
		Total	$ $9,500,000.00

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? ☒ Yes ☐ No
If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.

Appointing Authority Name: Cory Gustafson Agreed by: C.G. (initial)

12. Limited Service Position Information:	**# Positions**	**Title**
Total Positions		

12a. Equipment and space for these positions: ☐ Is presently available. ☐ Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):

Signature: e-Signed by Cory Gustafson on 2017-03-06 14:57:28 GMT — Date: March 06, 2017

Title: Commissioner, Department of Vermont Health Access

Signature: — Date: 5.9.17

Title: Secretary, AHS

14. SECRETARY OF ADMINISTRATION

☑ Approved: (Secretary or designee signature) — Date: 3/15/17

15. ACTION BY GOVERNOR

STATE OF VERMONT REQUEST FOR GRANT (*) ACCEPTANCE (Form AA-1)

☐	Check One Box: Accepted		
☐	Rejected	(Governor's signature)	Date: 3/24/17

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

☒ Request Memo	☐ Notice of Donation (if any)
☐ Dept. project approval (if applicable)	☐ Grant (Project) Timeline (if applicable)
☒ Notice of Award	☐ Request for Extension (if applicable)
☒ Grant Agreement	☐ Form AA-1PN attached (if applicable)
☒ Grant Budget	

End Form AA-1

(*) The term "grant" refers to any grant, gift, loan, or any sum of money or thing of value to be accepted by any agency, department, commission, board, or other part of state government (see 32 V.S.A. §5).

Daniel Dickerson

From: Gustafson, Cory <Cory.Gustafson@vermont.gov>
Sent: Wednesday, March 29, 2017 2:45 PM
To: Daniel Dickerson
Cc: Stephen Klein; Maheras, Georgia; Dragon, Paul
Subject: RE: JFO question Re: $9.5 million grant for ACO start-up

Daniel,

Thank you for your email. This request was sent over requesting JFC approval because we are asking for expedited review. This grant was authorized by CMMI on 3/2/17 with expectations that we begin work immediately. The first report for this is due at the end of April to the federal granting agency. Delays in approval will have significant impact on our ability to meet the grant requirements and risk slow down on the work.

Sincerely,

Cory Gustafson
DVHA
802.585.0041

From: Daniel Dickerson [mailto:ddickerson@leg.state.vt.us]
Sent: Wednesday, March 29, 2017 8:26 AM
To: Gustafson, Cory <Cory.Gustafson@vermont.gov>
Cc: Klein, Stephen <sklein@leg.state.vt.us>; Maheras, Georgia <Georgia.Maheras@vermont.gov>; Dragon, Paul <Paul.Dragon@vermont.gov>
Subject: JFO question Re: $9.5 million grant for ACO start-up

Commissioner Gustafson,

In reviewing the grant materials sent over from DVHA, a Joint Fiscal Committee member has asked that the Department give an explanation for why this grant was sent to JFC and not sent for full Legislative review. I will attach your response to the full grant packet.

Thank you.

Daniel Dickerson
Fiscal Analyst / Business Manager
Vermont Legislative Joint Fiscal Office
One Baldwin Street | Montpelier, VT 05633-5701
802.828.2472

Johnson, Jaye

From: Maheras, Georgia
Sent: Friday, March 24, 2017 12:59 PM
To: Dragon, Paul; Clark, Hope
Cc: Maksym, Martha; Johnson, Jaye
Subject: RE: $9.5 million CMS grant for All Payer Start-Up Funding

Hello!

Sorry for any confusion. The award begins 3/2/17. This initial hope was that it would be retroactive to 1/1/17. The contracts/grants/MMIS payments will conform to this start date.

Jaye: please feel free to give me a call if you want to talk more since this was delayed and so the dates are a bit confusing (802-505-5137).

Best,
Georgia

From: Dragon, Paul
Sent: Friday, March 24, 2017 12:54 PM
To: Maheras, Georgia <Georgia.Maheras@vermont.gov>; Clark, Hope <Hope.Clark@vermont.gov>
Subject: Fwd: $9.5 million CMS grant for All Payer Start-Up Funding

Hi Georgia. Can you get back to Jaye and CC me and Martha. Thanks

Sent from my iPhone

Begin forwarded message:

> **From:** "Johnson, Jaye" <Jaye.Johnson@vermont.gov>
> **Date:** March 24, 2017 at 11:38:31 AM EDT
> **To:** "Dragon, Paul" <Paul.Dragon@vermont.gov>
> **Cc:** "Ferland, Brad" <Brad.Ferland@vermont.gov>
> **Subject: $9.5 million CMS grant for All Payer Start-Up Funding**
>
> Hi Paul – I am reviewing these materials for the Governor's approval and the grant period recited is 3/2/17 to 3/1/18. The Budget and Budget Narrative recite, in different places, that the grant period is 1/1/17 to 12/31/17 and then that the contracting period will be 3/1/17 to 12/31/17. Could you please clarify? I would just like to confirm that the Governor's request has the correct information and confirm the basis for that information. I understand the federal processing took longer than expected, but what is the grant period, and will the related contracts/related grant agreements conform? Thanks. Jdaye
>
> Jaye Pershing Johnson
> State of Vermont
> Office of the Governor
> Legal Counsel
> 802-828-6410 (phone)
> jaye.johnson@vermont.gov

VERMONT

Department of Vermont Health Access
Agency of Human Services
312 Hurricane Lane Suite 201
Williston, VT 05495-2087
www.dvha.state.vt.us
[phone]802-879-5900

MEMORANDUM

TO: Brad Ferland, Deputy Secretary, Agency of Administration (AoA)

FROM: Cory Gustafson, Commissioner, Department of Vermont Health Access (DVHA)

DATE: March 2, 2017

e-Signed by Cory Gustafson
on 2017-03-08 19:44:21 GMT

REGARDING: Expedited Request for Grant Acceptance: Start-up Funding in Support of the Vermont All-Payer ACO Model Cooperative Agreement

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DVHA, with the support of the Blueprint for Health, ACO, and Blueprint for Health Partners, seeks to expedite acceptance of a grant awarded for $9.5 million which represents an opportunity for Vermont to strengthen its infrastructure and capacity to implement and evaluate health care payment and delivery system reforms. We are asking that it be expedited because this is to support activities for all of 2017 and the award was delayed on the federal level by several weeks. The All-Payer ACO Model ("Model") allows Vermont the opportunity to create a transformation payment model that moves all payers (Medicare, Medicaid, commercial) towards a prospective, value-based reimbursement system holding providers, operating through one or more ACOs, accountable for population health outcomes. This grant will provide funding during year 0 of the Model to support the Vermont's primary care infrastructure and continue to integrate and transform health care in Vermont.

The services / technical work to be implemented by Vermont in the Model are:

1. Connect Medicare Fee-for-Service beneficiaries with community-based resources;
2. Coordinate care transitions with involvement of beneficiaries' primary care providers;
3. Coordinate care across providers;
4. Support health promotion and self-management by Medicare Fee-for-Service beneficiaries; and
5. Support practice improvement and transformation.

DVHA will implement these services through two funding streams:

1. Patient-Centered Medical Homes (PCMHs), Community Health Teams (CHTs), and the Support and Services at Home (SASH) program.
2. Practice transformation activities performed by the Vermont Care Organization (VCO, a unifying entity of Vermont's two existing ACOs (OneCare Vermont and Community Health Accountable Care, known as CHAC).

The Agency of Human Services and the Green Mountain Care Board will be engaged in monitoring, evaluation, and reporting on the Model over the course of that agreement. As required under the Model, and separate from this specific funding opportunity, Vermont will submit to CMS regular reports on the Model's financial targets, health outcomes targets, and ACO scale targets. Specific to this funding opportunity, DVHA will collect data on the following on a quarterly basis:

1. List of PCMHs to whom funding is provided, and the associated payment

amounts.

2. List of CHT and SASH providers to whom funding is provided, and the associated payment amounts.
3. Estimate of the number of Medicare beneficiaries who were served by the PCMHs to whom funding was provided.
4. Estimate of the number of Medicare beneficiaries who were served by the CHT and SASH providers to whom funding was provided.
5. Number of Medicare beneficiaries impacted by the ACO investment.
6. Number of providers, by type, impacted by the ACO investment.
7. Number of decision aids and training modules deployed by the ACO.
8. Vermont will also provide quarterly summaries of the impact of ACO quality improvement efforts within each of the 14 Health Service Areas.

Vermont expects to report on additional metrics linked to project goals and to demonstrate project outcomes, including the Blueprint for Health semi-annual Hospital Service Area Healthcare Data Profiles and trend analyses, as included in the Blueprint for Health Annual Reports.

DVHA supports this work and feels that is it in in the best interest of the State at this time to establish a grant agreement for the work described above. If the grant award is not accepted, DVHA runs the risk of introducing a gap year in which funding will not be provided for the primary care foundations and ACO infrastructure that will be funded through years 1-5 in the Model.

1. DATE ISSUED MM/DD/YYYY	2. CFDA NO.	3. ASSISTANCE TYPE
03/02/2017	93.961	Cooperative Agreement

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
7500 Security Boulevard
Baltimore, MD 21244

NOTICE OF AWARD

AUTHORIZATION (Legislation/Regulations)
Affordable Care Act Section 3021

1a. SUPERSEDES AWARD NOTICE dated
except that any additions or restrictions previously imposed remain in effect unless specifically rescinded

4. GRANT NO.	5. ACTION TYPE
1R1CMS331555-01-00 Formerly	New

6. PROJECT PERIOD	MM/DD/YYYY		MM/DD/YYYY
From	03/02/2017	Through	03/01/2018
7. BUDGET PERIOD	**MM/DD/YYYY**		**MM/DD/YYYY**
From	03/02/2017	Through	03/01/2018

8. TITLE OF PROJECT (OR PROGRAM)
Start-up Funding in Support of the Vermont All-payer ACO Model Cooperative Agreement

9a. GRANTEE NAME AND ADDRESS
Vermont Agency of Human Services
208 Hurricane Ln Ste 103
-DUP
Williston, VT 05495-2069

9b. GRANTEE PROJECT DIRECTOR
Ms. Lisa Schilling
208 Hurricane Lane
Williston, VT 05495-2069
Phone: 802-241-0401

10a. GRANTEE AUTHORIZING OFFICIAL
Mr. Paul Dragon
208 Hurricane Lane
Williston, VT 05495-2069
Phone: 802-241-0422

10b. FEDERAL PROJECT OFFICER
Bridget Harrison
7500 Security Boulevard
Baltimore, MD 21244
Phone: 410-786-6542

ALL AMOUNTS ARE SHOWN IN USD

11. APPROVED BUDGET (Excludes Direct Assistance)

I Financial Assistance from the Federal Awarding Agency Only
II Total project costs including grant funds and all other financial participation — II

a. Salaries and Wages	0.00	
b. Fringe Benefits	0.00	
c. Total Personnel Costs		0.00
d. Equipment		0.00
e. Supplies		0.00
f. Travel		0.00
g. Construction		0.00
h. Other		4,340,624.48
i. Contractual		5,159,375.52
j. TOTAL DIRECT COSTS →		9,500,000.00
k. INDIRECT COSTS		0.00
l. TOTAL APPROVED BUDGET		9,500,000.00
m. Federal Share		9,500,000.00
n. Non-Federal Share		0.00

12. AWARD COMPUTATION

a. Amount of Federal Financial Assistance (from item 11m)	9,500,000.00
b. Less Unobligated Balance From Prior Budget Periods	0.00
c. Less Cumulative Prior Award(s) This Budget Period	0.00
d. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	9,500,000.00
13. Total Federal Funds Awarded to Date for Project Period	9,500,000.00

14. RECOMMENDED FUTURE SUPPORT
(Subject to the availability of funds and satisfactory progress of the project):

YEAR	TOTAL DIRECT COSTS	YEAR	TOTAL DIRECT COSTS
a. 2		d. 5	
b. 3		e. 6	
c. 4		f. 7	

15. PROGRAM INCOME SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:
a. DEDUCTION
b. ADDITIONAL COSTS
c. MATCHING
d. OTHER RESEARCH (Add / Deduct Option)
e. OTHER *(See REMARKS)*

b

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, THE FEDERAL AWARDING AGENCY ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:
a. The grant program legislation
b. The grant program regulations.
c. This award notice including terms and conditions, if any, noted below under REMARKS.
d. Federal administrative requirements, cost principles and audit requirements applicable to this grant.

In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS (Other Terms and Conditions Attached - ☒ Yes ☐ No)
Please see the attached Terms and Conditions.

GRANTS MANAGEMENT OFFICIAL: Michelle Feagins, Grants Management Officer

17. OBJ CLASS 41.45	18a. VENDOR CODE 1036000264D4	18b. EIN 036000264	19. DUNS 809376155	20. CONG. DIST. 00
FY-ACCOUNT NO.	DOCUMENT NO.	ADMINISTRATIVE CODE	AMT ACTION FIN ASST	APPROPRIATION
21. a. 7-5990848	b. 1R1331555A	c. VACO	d. $9,500,000.00	e. 78X0522
22. a.	b.	c.	d.	e.
23. a.	b.	c.	d.	e.

Attachment 4: Budget and Budget Narrative
Budget Period: January 1, 2017-December 31, 2017
Submitted: January 23, 2017

This budget narrative accompanies Vermont's project narrative (Attachment 3), which describes Vermont's goals related to the All-Payer ACO Model. Vermont's Agency of Human Services is seeking $9,500,000 in federal funds to support Vermont providers who will participate in a Vermont-specific Medicare ACO initiative (the "Vermont Medicare ACO Initiative"). This funding will assist Vermont's providers with care coordination and bolster their collaboration with community-based resources. These funds will assist Vermont in accomplishing the health outcomes, financial, and ACO scale targets required under the Vermont Medicare ACO Initiative. Funds will assist providers in performing the following activities: 1) Connect Medicare FFS beneficiaries with community-based resources; 2) Coordinate transitions across care settings with appropriate involvement of the Medicare FFS beneficiary's primary care provider; 3) Coordinate care across providers; 4) Support health promotion and self-management by Medicare FFS beneficiaries; and 5) Support practice transformation and improvement. These funds will support part of the necessary preparatory work in 2017.

I. Budget Request Overview

Table 1: Budget Request Summary

	1/1/17-12/31/17
Personnel	$0
Fringe Benefits	$0
Travel	$0
Equipment	$0
Supplies	$0
Other	$4,340,624.48
CAP	$0
Contractor	$5,159,375.52
Total:	**$ 9,500,000**

II. Budget Line Item Detail

C. CONTRACT AND VENDOR SERVICES

The total amount requested for contractual costs is $5,159,375.52. This section will discuss the various contractual costs associated with the project. A detailed summary of the scope of work for every contract is provided in **Appendix A**.

Table 2: Contracts: Detailed View

Contractor	Brief Scope	Proposed Milestone(s)	Requested Contract Start Date	Amount Request
Supports and Services at Home *(6 subcontractors:	Convening of SASH panels to provide care	Six SASH organization	1/1/2017	$3,159,375.52

Downstreet, Cathedral Square Corporation, Brattleboro Housing Partnerships, Shires Housing, Rutland Housing Authority, RuralEdge)	coordination activities for 5,000 Medicare beneficiaries.	providing services to 5,000 Medicare attributed lives.		
University of Vermont Medical Center/Vermont Care Organization	Promotion of effective preventative and chronic care interventions for populations with multiple chronic diseases to reduce variations and improve population health outcomes.	Quality improvement efforts, supported by data, provided to Medicare attributed population in 14 health service areas.	1/1/2017	$2,000,000
TOTALS				**$5,159,375.52**

G. OTHER

The total amount for the performance period requested for other expenses is $4,340,624.48. This category includes payments made to Patient-Centered Medical Homes (PCMH) and Community Health Team (CHT).

Table 3: Other Administrative Expenses

Category	FTE	Per FTE	Amount
PCMH and CHT			$4,340,624.48
TOTAL			**$ 4,340,624.48**

Patient-Centered Medical Home and Community Health Team Payments

As discussed in the project narrative, the state of Vermont has developed a statewide network of primary care practice based PCMHs, and CHTs which consist of multi-disciplinary members who work with PCMH providers to support patient needs across the care continuum. Both the CHTs and PCMH activities are supported by per member per month (PMPM) payments made by all major payers, including Medicare, Medicaid, and commercial payers. This request is for the Medicare portion of these payments only.

Patient-Centered Medical Home Payments

In 2016, 113 PCMHs served approximately 70,617 Medicare beneficiaries. In 2017, this number is expected to grow with 112 providing services to an estimated 76,261 Medicare beneficiaries. All payments are scaled based on the total number of attributed beneficiaries per each insurer using a 24 month look back period were each beneficiary received at least one preventive services visit with a provider (physician, advanced practice nurse practitioner, or physicians assist) within the practice. Each beneficiary is attributed to only one PCMH from which they received the most visits. If a beneficiary has equal number of visits, they are attributed to the

practice where they received care the most recently. Attribution for PCMH PMPMs is done individually by each payer. The payments supported by these federal funds will be based on a rounded three-month average patient attribution based on the attribution reported to the state by Medicare. Attribution numbers will consistent throughout the year for all currently participating practices. The attribution for the 5 new practices will be identified using Medicare claims data in the All-Payer Claims database using the same Blueprint attribution methodology. The Medicare PCMH PMPM uses the following methodology: scaled based on the practices' score on NCQA PCMH standards and ranges from $1.36 to $2.39 PMPM, prior to 2% sequestration. The specific payment methodology are outlined in the Vermont Blueprint for Health Manual.

In order to receive a payment, PCMH's must be recognized by NCQA[1], be integrated with the local Community Health Teams, participate in Community Collaboratives, and be supported by Quality Improvement Facilitators to implement on-going quality improvement. These benchmarks are consistent with the services outlined in the CMS Funding Opportunity and will be achieved in the PCMHs based on a combination of the efforts of the practice and CHT staff, which include:

- Connect Medicare Fee-for-Service beneficiaries with community-based resources.
- Coordinate transitions across care settings with appropriate involvement of the patient's primary care provider.
- Coordinate care across providers.
- Support health promotion and self-management by Medicare Fee-for-Service beneficiaries.
- Support practice improvement, practice transformation, and team-based care.

In 2017, payments will be made quarterly using Vermont Medicaid's Claims Processing System vendor Hewlett Packard. The amounts of the payments will be directed by the Blueprint through a quarterly report to Hewlett Packard. A detailed list of the organizations, number of attributed beneficiaries, and payment amounts is available upon request. Table 4 below gives a summary of the aggregate estimate payments.[2]

Table 4: Estimated PCMH Payments For Grant Quarters 1-4 (CY 2017)

Patient Centered Medical Homes (PCMH). Estimated Attributed Beneficiaries Rounded 3- Month Average Patient Attribution	**Payments in Q1 2017**	**Payments in Q2 2017**	**Payments in Q3 2017**	**Payments in Q4 2017**
76,261	$472,278.87	$475,850.60	$475,850.60	$482,926.76
			PCMH Expected Total Payments	$1,906,906.84

[1] The NCQA PCMH standards are: PCMH 1: Patient-Centered Access; PCMH 2: Team-Based Care; PCMH 3: Population Health Management; PCMH 4: Care Management and Support; PCMH 5: Care Coordination and Care Transitions; PCMH 6: Performance Measurement and Quality Improvement. Incorporated into these are six, must pass elements: PCMH 1, Element A: Patient-Centered Appointment Access; PCMH 2, Element D: The Practice Team; PCMH 3, Element D: Use Data for Population Management; PCMH 4, Element B: Care Planning and Self-Care Support; PCMH 5, Element B: Referral Tracking and Follow-Up; and PCMH 6, Element D: Implement Continuous Quality Improvement.

[2] These numbers are estimated and may fluctuate slightly based on the actual attributed lives. The total amount of $1,906,906.84 will not be exceeded, however.

Community Health Teams (CHTs)

In 2017, an estimated 76,261 Medicare beneficiaries will have access to CHTs. Statewide CHT payments in 2016 from all insurers are invested in staffing CHTs with 150.6 total FTEs, and are accessible to 70,617 Vermonters attributed to PCMHs, 22.5% of whom are Medicare beneficiaries. In 2017, we estimate an increase from 70,617 to 76,261 Medicare beneficiaries and a corresponding increase of the number of practices who will be receiving payments from 107 to 112 (5 additional eligible practices). In 2016, 113 practices were eligible to receive payment, but 6 of those practices did not receive payments.

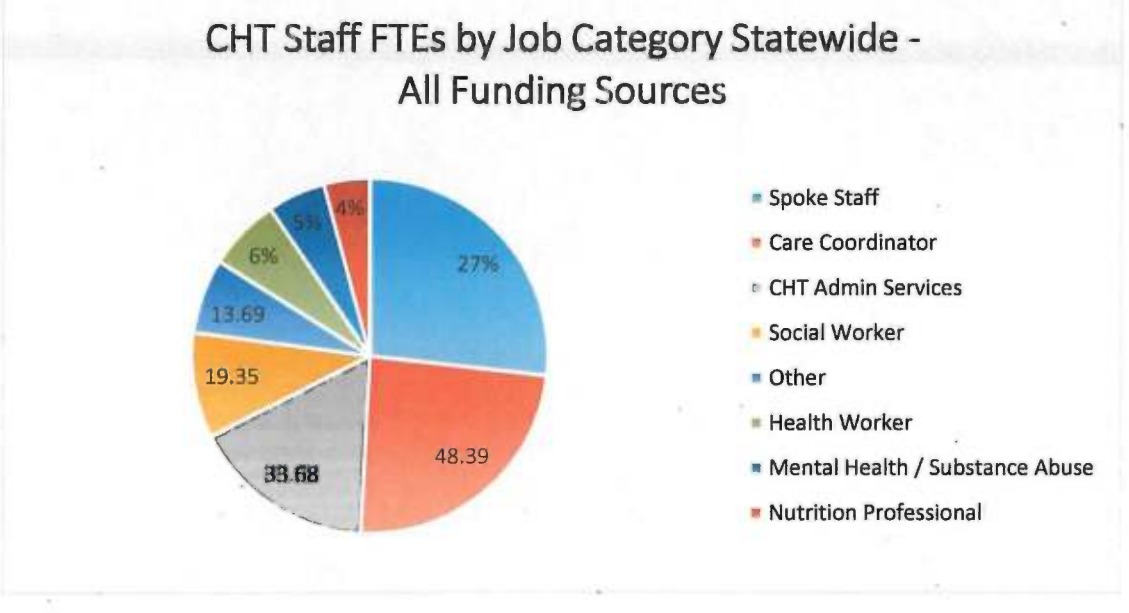
Community health teams strive to: 1) Connect Medicare FFS beneficiaries with community-based resource; 2) Coordinate transitions across care settings with appropriate involvement of the patient's primary care provider; 3) Coordinate care across providers; 4) Support health promotion and self-management by Medicare FFS beneficiaries; and 5) Support practice improvement, practice transformation, and team-based care.

More specific examples of services under each activity above can be found in the Project Narrative in Section 3: Capacity to Implement the Program.

CHTs are administered through 14 administrative entities, each of whom is responsible for population health activities in a specific geographic region. The responsibilities of administrative entities are specified in the current Blueprint Health Service Area (HSA) Grant Agreements and are further governed by the Blueprint for Health Manual, linked above. Decisions on the composition of the CHTs are made locally in each HSA, based on an assessment of care gaps and through a cross-organization planning committee or Community Collaborative. In additions to choosing the composition of the CHT, Community Collaboratives are tasked with identifying where the CHT staff provide services. In most cases, communities deploy a mixed model with a portion of CHT staff providing services both within practices and at community-based sites.

The below chart represents the current statewide makeup of the community health teams.

Figure 1: CHT Staff FTEs by Job Category Statewide – All Funding Sources



Each administrative entity receives quarterly payments from all payers (Medicaid, Medicare, and commercial) based on the insurer's market share and the total number of beneficiaries attributed to PMCHs in the HSA. Specific payment methodologies, including patient attribution and CHT market share allocations, are specified in the current Blueprint for Health Manual (or as posted here on the Blueprint website). Quarterly payments will be made to the administrative entities using Medicaid's Claims Processing System vendor (Hewlett Packard).

Table 5: Estimated CHT Payments for Grant Quarters 1-4 (CY 2017)

CHT Entity Name	Estimated Attributed Medicare FFS Lives	Payments in Q1 2017	Payments in Q2 2017	Payments in Q3 2017	Payments in Q4 2017	Expected 2017 Yearly Total
Brattleboro Memorial Hospital	3,598	29,216	29,216	29,216	29,216	$116,863.28
Central Vermont Medical Center	8,689	70,554	70,554	70,554	70,554	$282,214.51
Community Health Services of Lamoille Valley	4,011	32,566	32,566	32,566	32,566	$130,262.53
University of Vermont Medical Center	22,341	181,405	181,405	181,405	181,405	$725,618.69
Gifford Medical Center	2,600	21,112	21,112	21,112	21,112	$84,448.26
Little Rivers Health Center	923	0	7,725	7,725	7,725	$23,176.42
Mount Ascutney Hospital	2,199	17,854	17,854	17,854	17,854	$71,416.33
North Country Hospital	2,917	23,688	23,688	23,688	23,688	$94,752.57
Northeastern Vermont Regional Hospital	3,259	26,461	26,461	26,461	26,461	$105,844.87
Northwestern Medical Center	5,166	41,949	41,949	41,949	41,949	$167,794.15
Porter Medical Center	3,827	31,075	31,075	31,075	31,075	$124,298.35
Rutland Regional Medical Center	7,282	59,128	59,128	59,128	59,128	$236,512.26
Springfield Medical Care Systems	3,947	32,052	32,052	32,052	32,052	$128,208.30
United Health Alliance/ United Counseling Services	5,501	0	47,436	47,436	47,436	$142,307.13
CHT Expected Total Payments	**76,261**	**567,058**	**622,220**	**622,220**	**622,220**	$2,433,717.64

I. OTHER GRANTS

Vermont supports payment and delivery reforms through our 1115 Global Commitment to Health Waiver, the State's General Fund, and SIM Test grant. The additional resources provided for in this cooperative agreement are not supplanting these other existing funds. The 1115 Global Commitment to Health Waiver and the State's General Fund supports only the Medicaid population for PCMHs and CHTs. The Medicare population, which will be funded through this cooperative agreement, has never been funded through these two funding streams. The SIM Test grant has never been used to fund PCMHs, CHTs, and SASH at the service level for Medicare beneficiaries. This cooperative agreement additionally supports Medicare beneficiaries in the VCO and only other expenses in the VCO related to other beneficiaries are supported by the 1115 Global Commitment to Health Waiver, the State's General Fund, and SIM Test grant.

APPENDIX A: CONTRACT REQUEST

These contractors and subrecipients are critical for accomplishing project activities and for meeting milestones and metrics.

SASH Payments

Method of Selection: Simplified bid process.

Contract Amount:

SASH ENTITY NAME	Expected 2017 Yearly Total
Downstreet (formerly CVCLT)	$385,875.00
Cathedral Square Corporation	$1,615,875.52
Brattleboro Housing Partnerships	$308,700.00
Shires Housing (formerly RAHC)	$231,525.00
Rutland Housing Authority	$257,250.00
RuralEdge	$360,150.00
SASH Total Payments	**$3,159,375.52**

Contract Term: 3/1/17-12/31/17

Method of Accountability: This is a deliverables/performance-based contract where the contractor is required to perform specific tasks each month. The contract manager(s) review the invoices and work products each month before approving the invoices. The contract manager who will be overseeing the contracts that SASH will be administering is Beth Tanzman, Executive Director of the Blueprint for Health. The State is currently has an RFP posted to contract with the Designated Regional Housing Organizations through a standard bid process. The standard bid process for contracting for services is authorized under the Agency of Administration Bulletin Number 3.5, and can be accessed here.

Salary and Fringe: Please see itemized budget below. $17,150 per SASH panel (Note: Funds are Medicare only. Funding 1.0 FTE Care Coordinator and 0.25 FTE wellness nurse per panel. Panel sizes vary from 70 to 100 beneficiaries. Sub-recipients may provide financial support in addition to the Medicare funding to support the required staffing level.) The Designated Regional Housing Organizations' agreements with the Department of Vermont Health Access will be deliverables-based contracts. None of the positions supporting these deliverables are 100% funded by this contract and all of them are funded well within the uniform federal guidelines.

Summary Statement of Work:

1. Assess 5,000 beneficiaries needs through a standard set of nationally recognized screening tools. Establish healthy aging plan for each beneficiary and monitor progress toward goals. Through the healthy aging plan provide the following services to beneficiaries: 1) Connect Medicare FFS beneficiaries with community-based resources. 2) Coordinate transitions across care settings with appropriate involvement of the patient's primary care provider. 3) Coordinate care across providers. 4) Support health promotion and self-management by Medicare FFS beneficiaries. 5) Support practice improvement, practice transformation, and team-based care.
2. Analyze aggregate data and provide appropriate group health education and self-management support programs for beneficiaries/SASH participants at SASH sites, which may include but are not limited to: physical activity programs, nutrition workshops, Diabetes Prevention Programs, Chronic Disease Self-management programs, tobacco cessation.

3. Sub-recipients in each region will convene a 'SASH table' or partner organizations which include at minimum the Designated Mental Health Agency, home health agencies, housing organizations, and Area Agency on Aging in each geographic region. Sub-recipients will establish agreements with partner organizations to monitor the progress of SASH panels, review changes in beneficiary health status, and assist in developing cross-organization care plans to be integrated into healthy aging plans.
Coupled with knowledge of participants' and families' goals, an individual healthy aging plan is established and updated, and progress is monitored. Based on aggregate data, SASH provides group health education and self-management supports which may include but are not limited to: physical activity programs, nutrition workshops, Diabetes Prevention Programs, Chronic Disease Self-management programs, tobacco cessation.

Unique Qualifications, if Sole Source: SASH is administered through Designated Regional Housing Organizations (DROs) in each region in partnership with the SASH Partners, which include at minimum the Designated Mental Health Agency, home health agencies, housing organizations, and Area Agency on Aging in each geographic region. SASH partners, governed through agreements and shared resources, monitor the progress of SASH panels and review cases of beneficiaries whose health status has changed. All Vermont DRO's were offered the opportunity to participate in SASH. Individual housing sites were selected on a first-come basis based on their self-selected readiness up to the point where Medicare funds were fully expended, with a conscious effort to ensure SASH is available in all HSAs and DROs. This selection occurred in 2010, when the program was in the planning phase, and was based upon organizational capacity to provide fiduciary accountability, staff training, and accountability to program fidelity. The Designated Regional Housing Organizations have now been partners with the state since implementation of SASH in 2011 and are no longer selected on this basis.

SASH Designated Regional Housing Organizations Itemized Budget Table

SASH ENTITY NAME	Panels Per Quarter	Cost of Panel	2017Q2 Panels Payment	2017Q2 HIT - Hardware and Software	2017Q3 Panels Payment	2017Q4 Panels Payment	YEARLY TOTALS
Downstreet (formerly CVCLT)	7.5	$17,150.00	$128,625.00	$0.00	$128,625.00	$128,625.00	$385,875.00
Cathedral Square Corporation	24	$17,150.00	$411,600.00	$381,075.52	$411,600.00	$411,600.00	$1,615,875.52
Brattleboro Housing Partnerships	6	$17,150.00	$102,900.00	$0.00	$102,900.00	$102,900.00	$308,700.00
Shires Housing (formerly RAHC)	4.5	$17,150.00	$77,175.00	$0.00	$77,175.00	$77,175.00	$231,525.00
Rutland Housing Authority	5	$17,150.00	$85,750.00	$0.00	$85,750.00	$85,750.00	$257,250.00
RuralEdge	7	$17,150.00	$120,050.00	$0.00	$120,050.00	$120,050.00	$360,150.00
YEARLY TOTALS	54	$17,150.00	$926,100.00	$381,075.52	$926,100.00	$926,100.00	$3,159,375.52

UVMMC/Vermont Care Organization
Method of Selection: Sole Source
Contract Amount: $2,000,000
Contract Term: 3/1/17-12/31/17
Method of Accountability: This is a deliverables/performance-based contract where the contractor is required to perform specific tasks each month. The tasks are enumerated in Attachment A of the agreement and Attachment B of the agreement provides the payment schedule. The contract manager(s) review the invoices and work products each month before approving the invoices.
Itemized Budget: Please see below. *Note that this funding is to pay for a portion of the work being performed. Similar to the other budget items described above, this is a multi-payer effort and these funds support the Medicare portion.* This agreement is a deliverables-based contract. As such, the obligation is to submit monthly progress reports on the key deliverables outlined below that meet the contract scope of work. If the contractor does not meet the deliverables as identified in the table below, the contractor does not get paid. When the deliverables are met, the contractor gets paid. This is negotiated as a flat rate for these tasks. The deliverables-based contract enables the State of Vermont to avoid the potential high-cost of time and materials for this work. Quality improvement and chronic care intervention is labor intensive and this minimizes the risk of ballooning costs for the State of Vermont. A deliverables-based contract enables the State to manage this contract in this fashion to ensure that the goals of the FOA are met within the funding. None of the positions supporting these deliverables are 100% funded by this contract and all of them are funded well within the uniform federal guidelines. **Explanation of VITL Scope**: VITL is a subcontractor on this contract. They operate Vermont's Health Information Exchange (HIE). The subcontract supports a data mart that holds data for VCO attributed lives. The amount in the subcontract supports only Medicare beneficiary lives. The specific tasks in this subcontract include identity management, data quality management, message connectivity to the lead contractor's analytics vendor for: ADT (admission, discharge, transfer), labs, CCD (continuity of care document), and consent management.
Summary Statement of Work: The Vermont Care Organization will promote effective preventative and chronic care interventions for populations with multiple chronic diseases to reduce variations and improve population health outcomes.
Unique Qualifications, if Sole Source: Vermont historically had 3 ACOs. Those ACOs are in the process of unification. Vermont Care Organization (VCO) is the unifying entity of two of Vermont's existing ACOs (OneCare Vermont and Community Health Accountable Care Organization). VCO is working towards furthering a statewide, tightly integrated, clinical delivery system that provides for Population Health Management across the continuum of care with the goals of reducing variation and improving the health care of Vermonters. These funds will go to some of the activities necessary for the successful operation of an ACO as noted in last year's CMS announcement of the ACO Investment Model describing the necessary infrastructure investments required for these entities. Delaying execution of this contract so

that we can go through the standard Vermont RFP process, which is 4-6 months long, will cause significant delays in All-Payer Model activities and the ability of the VCO to meet the requirements of a Medicare risk-bearing ACO in Year 1 of the APM.

UVMMC/Vermont Care Organization Scope of Work:

1. The Vermont Care Organization will promote effective preventative and chronic care interventions for populations with multiple chronic diseases to reduce variations and improve population health outcomes. Specific interventions will include:
    i. Using data analytics that combine claims and clinical data, identify chronic conditions where select evidenced based interventions will support improved outcomes in populations with chronic disease.
    ii. Select quality measure(s) that align with Vermont's All-Payer model and CMS ACO measures to monitor variation.
    iii. Identify and convene subject matter experts within the ACO network of participating providers in an Expert Meeting to identify strategies and establish goals for network participants that, through the learning model described below, will reduce variation and improve outcomes.
    iv. Develop Change Packet(s) that are comprised of multiple evidenced-based changes that are critical to reduce variation and improve care for populations with chronic illness and that align with the selected quality measures.
    v. Construct a learning model that consists of:
        a. a pre-work period in which teams form and get organized to improve care,
        b. learning sessions where experts share information and approaches to improve care delivery and outcomes,
        c. action periods, following each learning session, in which changes are tested and implemented by the teams, and
        d. forums where successful teams share results of the collaborative.
    vi. Assess and track progress on goals as reflected in the Project Plan A
2. The Vermont Care Organization will promote shared decision making for preference sensitive care services through the development of disease specific care modules that include evidenced based guidelines and decision aides. Specific interventions will include:
    i. Using data analytics that combine claims and clinical data, identify top chronic conditions that would benefit from shared decision making interventions as well as analyze variation in treatment patterns for all patients for selected Episodes of Care (using episode definitions included in the CMMI Bundled Payments for Care Initiative or other episodes as defined by clinical leadership)
    ii. Select clinical, quality, cost, experience of care and utilization data to monitor success in reducing variance and improving outcomes.
    iii. Engage subject matter experts for consultation within the ACO network of participating providers to identify and prioritize evidenced based tools that are designed to reduce variation and improve outcomes.
    iv. Develop or adopt tools and decision aids that provide guidance and/or coaching in deliberations so that patient (beneficiary) involvement in decision making can be improved.
    v. Construct disease specific module(s) that consists of:
        a. Training materials for network providers

b. Patient (Beneficiary) resource library
c. Patient (Beneficiary) decision aids
d. Evidenced based guidelines and Change Packets
e. Disease specific care plans/ care pathways
f. Shared care plans

vi. Educate network providers and care coordinators on the disease management modules, patient (beneficiary) decision aides, evidenced based guidelines and shared care plan
vii. Embed disease management module into Care Management Platform (Care Navigator)
viii. Use John Hopkins Adjusted Clinical Groups (ACG) predictive risk system to stratify patients (beneficiaries) to identify disease-specific cohorts for specific management
ix. Conduct patient (beneficiary) outreach and engagement activities to enroll patients (beneficiaries) into the disease management program
x. Assess and track progress on goals as reflected in the Project Plan B

3. Identify and train local clinical champions and care coordinators in the use of population health management tools and evidenced based tool kits; working in cooperation with the Blueprint for Health Community Health Teams and Supports and Services at Home care coordinators.
4. Designate personnel to train care coordination staff in local communities and network participants on self-service care management and data analytic tools in order to actively monitor variation and outcomes.
5. Provide access to a provider help desk staff to trouble shoot both technical and process flow questions related to self-service tools.
6. Continue to evolve clinical governance structures to ensure broad representation from network providers, community, and State partners in order to refine the clinical model, share best practices, reduce variation, and evaluate outcomes.

Two project plans are provided below.

CMMI Project Plan A – Reducing Unwarranted Care Variation Learning Collaborative

#	Deliverable/Milestone	Start Date	Due Date	Q1	Q2	Q3	Q4
1	**Planning**						
	Identify Chronic conditions						
2	Document the Aim	1/1/2017	4/2/2017				
3	Identify measures of success	1/1/2017	4/2/2017				
4	Identify subject matter experts	1/1/2017	4/2/2017				
5	Convene subject matter experts to design change packets and establish specific goals for performance improvement	1/1/2017	4/2/2017				
6	Identify resources: education, training, facilitators	1/1/2017	4/2/2017				
7	Develop change packet materials	1/1/2017	4/2/2017				
8	Identify Sites	1/1/2017	4/2/2017				
9	Identify stakeholders	1/1/2017	4/2/2017				

10	Identify Owners of each process improvement	1/1/2017	4/2/2017				
11	Create implementation plan and schedule	1/1/2017	4/2/2017				
12	Create communication plan (with status updates)	1/1/2017	4/2/2017				
13	**Implementation of Learning Collaboratives**						
14	**Planning (Plan)**	4/2/2017	11/28/2017				
15	Distribute projects	4/2/2017	11/28/2017				
16	Assemble and prepare teams for the implementation phase	4/2/2017	11/28/2017				
17	**Implementation (Do)**	4/2/2017	11/28/2017				
18	Team engaged and carrying out the plan	4/2/2017	11/28/2017				
19	Meetings and status reported	4/2/2017	11/28/2017				
20	Identify risks and issues and resolving	4/2/2017	11/28/2017				
21	Following communication plan	4/2/2017	11/28/2017				
22	**Monitoring and Controlling (Study)**	4/2/2017	11/28/2017				
23	Reviewing quantitative and qualitative data	4/2/2017	11/28/2017				
24	Review lessons learned and identify improvements	4/2/2017	11/28/2017				
25	Continue with communication and execution of tasks	4/2/2017	11/28/2017				
26	**Closing - (Act)**	4/2/2017	11/28/2017				
27	Review results	4/2/2017	11/28/2017				
28	Evaluate for implementation beyond	4/2/2017	11/28/2017				
29	**Statewide Review for Learning Collaboratives**	11/28/2017	12/28/2017				
30	Review results of initiatives	11/28/2017	12/28/2017				
31	Design additional sprints and start planning for improvements to prior sprints	11/28/2017	12/28/2017				
32	Continuous process improvement cycle	11/28/2017	12/28/2017				
33	Establish mechanisms to sustain the improvements	11/28/2017	12/28/2017				
34	Create local and ACO wide policies and procedures "best practices"	11/28/2017	12/28/2017				

35	Monitor to make sure the activities becomes routinized	11/28/2017	12/28/2017				
36	Continuously review the practices to make sure that they don't need to be changed	11/28/2017	12/28/2017				

CMMI Project Plan B – Reducing Unwarranted Variation in Preference Sensitive Care

Deliverable/Milestone	Start Date	Due Date	Q1	Q2	Q3	Q4
Planning						
Identify Chronic conditions	1/1/2017	2/1/2017				
Identify measures of success	1/1/2017	2/1/2017				
identify subject matter experts	1/1/2017	2/1/2017				
Engage subject matter experts to identify and prioritize evidence-based tools	1/1/2017	3/3/2017				
Identify disease specific recommendations	1/1/2017	3/3/2017				
Identify resources: education, training, facilitators	1/1/2017	3/3/2017				
Identify Sites	1/1/2017	3/3/2017				
Identify stakeholders	1/1/2017	3/3/2017				
Identify patients (beneficiaries) for mgmt	1/1/2017	3/3/2017				
Identify Owners of each process improvement	1/1/2017	3/3/2017				
Create implementation plan and schedule	1/1/2017	3/3/2017				
Create communication plan (with status updates)	1/1/2017	3/3/2017				
Implementation						
Finalize Disease specific recommendations	3/3/2017	4/2/2017				
Disease specific recommendations loaded into CN	3/3/2017	4/2/2017				
Enroll patients in the DM program	4/2/2017	11/28/2017				
Educate care coordinators on patient resource library and self-management tools	4/2/2017	11/28/2017				

Educate care coordinators on disease management EBM recommendations and change packets	4/2/2017	11/28/2017				
Educate care coordinators on shared care plans	4/2/2017	11/28/2017				
Evaluation						
Assess disease management module tool use	11/28/2017	12/28/2017				
Assess Patient Satisfaction	11/28/2017	12/28/2017				
Assess core quality and utilization metrics	11/28/2017	12/28/2017				
Create local and ACO wide policies and procedures "best practices"	11/28/2017	12/28/2017				
Monitor to make sure the activities becomes routinized	11/28/2017	12/28/2017				
Continuously review the practices to make sure that they don't need to be changed	11/28/2017	12/28/2017				

Itemized Budget: UVMMC/Vermont Care Organization

	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter			
	Jan - 17	Feb - 17	Mar - 17	Apr - 17	May - 17	Jun - 17	Jul - 17	Aug- 17	Sep - 17	Oct - 17	Nov - 17	Dec - 17	**TOTAL**
Facilitate Statewide Learning Collaboratives *	*	*	*	*	*	*	*	*	*	*	*	*	
DETAIL	*Identify gaps in quality amenable to a LC change process*	*Select LC focus area and target population*	*Identify LC subject matter experts and metrics of success*	*Finalize implementation and communication plan*	*1 LC meeting/month*	*1 LC meeting/month*	*1 LC meeting/month*	*1 LC meeting/month*	*1 LC meeting/month*	*1 LC meeting/month*	*1 LC meeting/month*	*Identify best practices and lessons learned across communities*	
Develop Disease Specific care modules for populations with chronic conditions *	*	*	*	*	*	*	*	*	*	*	*	*	
DETAIL	*Identify top chronic conditions within the ACO and measures of success*	*Select first priority chronic condition; review possible interventions and workflow gaps*	*Finalize implementation and communication plan*	*Design disease specific recommendations for 1 chronic condition*	*Educate participating communities*	*Implement at least 1 chronic disease module in each participating community*	*Implement at least 1 chronic disease module in each participating community*	*Implement at least 1 chronic disease module in each participating community*	*Implement at least 1 chronic disease module in each participating community*	*Implement at least 1 chronic disease module in each participating community*	*Implement at least 1 chronic disease module in each participating community*	*Implement at least 1 chronic disease module in each participating community*	
Provide for self service population health tools and reports *	*	*	*	*	*	*	*	*	*	*	*	*	
DETAIL	*Identify sites and participants to be trained*	*Identify sites and participants to be trained*	*Finalize implementation and communication plan*	*Train participants on tools and reports*	*Train participants on tools and reports*	*Train participants on tools and reports*	*Train participants on tools and reports*	*Train participants on tools and reports*	*Train participants on tools and reports*	*Train participants on tools and reports*	*Train participants on tools and reports*	*Train participants on tools and reports*	
Develop and evolve clinical governance structures *	*	*	*	*	*	*	*	*	*	*	*	*	
DETAIL	*Identify refined clinical governance model*	*Identify refined clinical governance model*	*Identify membership criteria and charter for at least one committee*	*Recruit members*	*Recruit members*	*Host first meeting*	*Provide support and facilitation support during and in-between meetings*	*Provide support and facilitation support during and in-between meetings*	*Provide support and facilitation support during and in-between meetings*	*Provide support and facilitation support during and in-between meetings*	*Provide support and facilitation support during and in-between meetings*	*Provide support and facilitation support during and in-between meetings*	

Develop processes and procedures to identify and routinize best practices	*	*	*	*	*	*	*	*	*	*	*	*	*	
DETAIL		*Identify QI processes and procedures that need to be implemented*	*Identify QI processes and procedures that need to be implemented*	*Identify QI processes and procedures that need to be implemented*	*Develop processes and procedures to support best practices*	*Develop processes and procedures to support best practices*	*Develop processes and procedures to support best practices*	*Implement in participating communities*	*Implement in participating communities*	*Implement in participating communities*	*Implement in participating communities*	*Implement in participating communities*	*Evaluate and refine*	
Promote continuous quality improvement	*	*	*	*	*	*	*	*	*	*	*	*	*	
DETAIL		Support local QI activities through measurement, reporting, training, and education	Support local QI activities through measurement, reporting, training, and education	Support local QI activities through measurement, reporting, training, and education	Support local QI activities through measurement, reporting, training, and education	Support local QI activities through measurement, reporting, training, and education	Support local QI activities through measurement, reporting, training, and education	Support local QI activities through measurement, reporting, training, and education	Support local QI activities through measurement, reporting, training, and education	Support local QI activities through measurement, reporting, training, and education	Support local QI activities through measurement, reporting, training, and education	Support local QI activities through measurement, reporting, training, and education	Support local QI activities through measurement, reporting, training, and education	
Deliverables Payment	**$ 1,715,151**	**$ 142,929**	**$ 142,929**	**$ 142,929**	**$ 142,929**	**$ 142,929**	**$ 142,929**	**$ 142,929**	**$ 142,929**	**$ 142,929**	**$ 142,929**	**$ 142,929**	**$ 142,929**	***$ 1,715,151***
VITL	**$ 284,849**	**$ 23,737**	**$ 23,737**	**$ 23,737**	**$ 23,737**	**$ 23,737**	**$ 23,737**	**$ 23,737**	**$ 23,737**	**$ 23,737**	**$ 23,737**	**$ 23,737**	**$ 23,737**	***$ 284,849***
TOTAL PAYMENTS	**$2,000,000**	**$166,667**	**$166,667**	**$166,667**	**$166,667**	**$166,667**	**$166,667**	**$166,667**	**$166,667**	**$166,667**	**$166,667**	**$166,667**	**$166,667**	***$2,000,000***
Labor and Fringe Detail	$ 1,423,692	$ 118,641	$ 118,641	$ 118,641	$ 118,641	$ 118,641	$ 118,641	$ 118,641	$ 118,641	$ 118,641	$ 118,641	$ 118,641	$ 118,641	***$ 1,423,692***