

# STATE OF VERMONT



## Agency of Human Services (AHS) Department of Vermont Health Access (DVHA)

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### Vermont Health Services Enterprise (HSE)

### Implementation Advance Planning Document (IAPD) - Update

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Version 2.5.1

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Submitted by: Joe Liscinsky for Mark Larson

Approved on: 5/14/2014

## HSE IAPD Version Tracking

<b><u>Title</u></b>	<b><u>Note</u></b>	<b><u>Submitted</u></b>	<b><u>Approved</u></b>
HSE IAPD	Original IAPD	3/13/2012	5/4/2012
HSE IAPDU1	Initial Update	7/5/2012	n/a
HSE IAPD v1.1	Updated template for IAPDU and resubmission – focusing mainly on SHMP needs	7/16/2013	n/a
HSE IAPDU v1.2	Updated IAPDU based on initial feedback of v1.1	7/26/2013	Interim Approval 8/29/2013
HSE IAPD v2.0	New HSE IAPD expanding scope of HSE work and alignment/realignment of funding sources (APD, Exchange Grants, etc.)	Unofficial - 8/28/2013	Interim Approval 01/31/2014
HSE IAPD v2.5	Official submit	Official – 3/17/2014	n/a
HSE IAPD v2.5.1	Official re-submit	Official – 4/25/2014	5/14/2014

## HSE APD Change Tracker

The following five table reflects changes made from the v2.5 submittal based on Federal inquiries and State’s desire to continue clarity with our APD.

Location of Change	Change	Date
Section 44 – CMS 37 & 64 tables	Added further information to header paragraph referencing Appendix E Added Appendix E for additional clarity Adjusted estimates based on refinement of budgets	4/3/2014
Section 2	Changed layout of pages to landscape for better clarity	4/3/2014
Figures 3.1 and 3.2	Made changes so language is more consistent	4/3/2014
Figures 2.1 and 2.2	Updated these tables with more current figures	4/14/2014
Pages 59 and 60	Updated team slides with Stephanie Beck as new Program Director	4/14/2014
Tables 4.1 -> 4.4	Updated tables and modified format for improved viewing	4/14/2014
SMHP Sections	Removed references to Tele-health with this APD and intent to resubmit in future APDs	4/16/2014
Table 4.1 – line 3	Change in wording of line to reflect the continued DDI work that’s included here	4/25/2014
Page 39	Added paragraph to reflect how the estimated costs in line 3 were calculated	4/25/2014
Appendix E	Added appendix E based on recent HITECH conversation regarding VITL work	4/25/2014

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## Section 1 - Executive Summary

The Vermont Health Services Enterprise (HSE) Advance Planning Document (APD) is a live document detailing a holistic view of Vermont's planning and budgeting for the Health Services Enterprise. It also represents requested Federal Financial Participation (FFP) for Medicaid Management Information System (MMIS), State Medicaid Health Information Technology Plan (SMHP) [sometimes referred to as Health Information Technology for Economic and Clinical Health (HITECH)] and Eligibility and Enrollment (E&E). Other funding spoken to in the APD, such as Vermont Health Connect (VHC) (Vermont's health insurance marketplace) Exchange Grants, State Innovation Model (SIM) Grants, and Office of National Coordinator (ONC) Grants, are a representation of Vermont's commitment to share costs as required by CMS, and not a request for additional funding. In relation to funding outside of MMIS, SMHP and E&E, the APD is used to display and track the budget and cost allocation information. Vermont's original Health Services Enterprise (HSE) Implementation Advance Planning Document (IAPD) [occasionally referred to as the Jumbo IAPD] was approved in May, 2012.

Vermont has been working with CMS on this specific APD (Version 2.0) and focuses on not only the Enterprise work to be done in the upcoming years but also focuses on the alignment of all the funding associated with the Enterprise. Vermont and CMS have made adjustments to Vermont's Cost Allocation, effective 10/1/2013, and this is reflected with the information in this APD. This 'holistic' APD also incorporates the engagement Vermont has with other Federal partners such as Administration for Children & Families (ACF) and Food and Nutrition Service (FNS).

The most recent Advance Planning Document (APD) (version 1.2) was an interim and condensed APD focusing on Vermont's State Medicaid Health Information Technology Plan (SMHP) activities and it was approved on August 29, 2013. Since that time, CMS and Vermont staff have been diligently working on the finer details of the HSE – the scopes of work, the contracts involved, the integration of work and the timelines. CMS approved an interim budget on January 31, 2014 that approved funding through March 31, 2014.

This APD (version 2.3) takes a broad view of the Vermont Health Services Enterprise and provides details from a project and financial standpoint in terms of communicating and addressing any matters associated with Vermont Health Connect (VHC), Eligibility and Enrollment (E&E) Solution (Integrated Eligibility (IE)), Medicaid Management Information Systems (MMIS) and the aforementioned SMHP. The utilization of one holistic APD challenges legacy processes and the State continues to work with CMS on improving the communication and the process of what/how items are submitted. The health care arena has changed with improvements in treatments and technology, and we (Government) have been changing how health care projects are implemented and funded. The overlap and integration of business, technology and financial aspects of sharing services continues to expand and long gone are the siloed approaches that used to be the norm for projects. Because of this, the State appreciates the commitment from CMS on continuing this 'bundled' (aka "Jumbo") HSE APD approach.

As noted, this Enterprise 'Jumbo' approach is a new way of collectively working on large integrated projects with varying funding sources, cost allocations, and administrative processes. Considering the wide reach of distinct Federal and State staff involved in the review and approval of the work Vermont has divided the APD into sections identifying and separating out specific program/work-stream details. This provides the opportunity for those interested in only specific work-stream information to follow and monitor those applicable details. For those interested in the vast scope of the Enterprise, the totality of the APD can be considered. While traditionally this APD has involved the Centers for Medicare and Medicaid Services (CMS), due to the Enterprise perspective, this APD will also be used by other Federal Partners to provide for the request and management of funding from their sources. For example, Food and Nutritional Services (FNS) has been involved due to the nature of the downstream impacts when considering the Integrated Eligibility (IE) planning.

The State has established a Program Management Office (PMO) that consists of representation from the Governor's direct staff through the Agency of Administration down to the Agency of Human Services (AHS) Secretary and multiple Departments within the AHS. The PMO is the 'hub' from which the various work-streams are governed and it operates under the guidance and support of the Executive Steering Committee (ESC). Refer to Appendix D for further information on Organizational Views of the staffing of HSE.

The table (Figure 1.1) below outlines the general timeline of the HSE project work streams and the dates associated with the HSE APD approval and any requested adjustments. With the continued support from CMS of the Enterprise vision, Vermont continues to manage projects and milestones in terms of the Enterprise. Considering this perspective, Vermont is requesting the following adjustments to their project end dates and the funding end dates for the HSE. Vermont fully acknowledges that updates to the APD will continue to take place at least twice annually and therefore dates and amounts will be adjusted based on actual facts and figures at that time. In light of our efforts for funding alignments and project dates, the State is requesting to use the following timeline for both the project work and the funding.

Project Funding*	Primary HSE Program	Project Start Date (Using HSE APD Effective Date)	Currently Approved Project End Date	Currently approved Funding End Date	Requested Project End Date	Requested Enhanced FFP Budget Period End Date
MMIS	MMIS Replacement	5/4/2012	12/31/2016	3/31/2014	12/31/2016	9/30/2015
E&E**	Integrated Eligibility (IE)	5/4/2012	12/31/2015	3/31/2014	12/31/2015	9/30/2015
HIX***	Vermont Health Connect (VHC)	5/4/2012	12/31/2014	12/31/2014	12/31/2014	12/31/2014
HITECH (VT SMHP)	EHRIP, MAPIR & HIE	5/4/2012	3/31/2014	3/31/2014	9/30/2015	9/30/2015
* HIX represents all CCIIO Exchange Grants and SMHP reflects all HITECH (HIE and HIT)						
** E&E timeframes represent health care eligibility project work ending 12/31/2015 (thus funding for h/c ends then) while non-health care (still part of IE) project work continues past 12/31/2015 and will be funded outside of HSE APD						
*** HIX timeframes are approved via CCIIO but are represented here to reflect Enterprise vision perspective						

Figure 1.1

## Section 2 – Results of IAPD funding

This section includes a summary of the funding for HSE APD that is to be effective 10/1/2013. This includes adjustments to the Cost Allocation methodology (explained further below), adjustments to the budget based on realignment of work activities to specific funding sources, changes to quarterly estimates, adjustments based on actual contract amounts rather than estimates, and changes in allocation of resources. This table reflects the agreed upon Cost Allocation (See Section 3 and Figure 3.3 for statistics and methodology) with CMS during 07/2013 timeframe. The agreement between CMCS, CCIIO and HITECH is that the agreed upon Cost Allocation would be effective 10/1/2013. Health Insurance Exchange grants have been realigned and re-submitted using this new methodology and Appendix B, ‘Cost Allocation History’, provides further information on Vermont’s cost allocation. NOTE: This APD engages other Federal Partners yet this submission is only requesting funding from CMS for their share of expenses for activities associated with the HSE. Vermont has preliminary estimates on human services expenses and is planning for a future APD request funding from FNS and ACF for their share once more confirmed estimates are known (after bids are received for the IE solution RFP that was just released).

This table on the next page (Figure 2.1) below provides details such as:

- What actuals have been claimed to date
  - These were calculated and funded using the prior approved Cost Allocation methodology – up until 10/1/2013
- What is the estimated budget for this APD (v2.5.1) request
  - These were calculated using the new approved Cost Allocation methodology – effective 10/1/2013
- What is the total project cost for the building of the HSE

Vermont Health Services Enterprise Budget Summary - Effective Program Date 07/01/2012 - 12/31/2016									
		GROSS FUNDING SOURCES WITHIN HSE-APD				EXTERNAL/ALLOCATED FUNDING SOURCES			
		MMIS*	E&E**	HIT (HITECH)***	HIE (HITECH)***	CCIO HIX Grants^	GC Waiver#	VT HIT Fund#	TOTAL
<b>Currently Approved APD Values</b>	see footnotes for source specific details	\$ 124,692,758	\$ 66,289,625	FFYs'12&'13 \$4,269,180 FFY'14 Q1&Q2 \$2,269,984	FFYs'12&'13 \$7,159,688 FFY'14 Q1&Q2 \$2,878,593	\$ 171,641,081	n/a	n/a	\$ 379,200,909
<b>Pre-HSE APD v2.5 Pre-1/1/2014</b>	Actuals claimed 7/1/2012 - 12/31/2013	\$ 5,261,118	\$ 8,053,400	FFYs'12&'13 \$1,940,058 FFY'14 Q1 \$187,830	FFYs'12&'13 \$2,949,449 FFY'14 Q1 \$483,192	\$ 51,149,525	n/a	n/a	\$ 70,024,573
<b>HSE APD v2.5 effective 1/1/2014</b>	Current Budget Realignment & Release Request	\$ 76,838,241	\$ 49,223,532	\$ 8,192,705	\$ 5,117,334	\$ 120,491,556	\$ 803,940	\$ 3,166,710	\$ 263,834,019
<b>Awarded Funding Not Requested for Release in this APD</b>	Release not requested beyond FFY 2015	\$ 42,593,398	\$ 9,012,692	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 51,606,090
<b>Request for Additional Funding</b>	Additional HITECH funding for FFYs 2014 & 2015	\$ -	\$ -	\$ 6,110,551	\$ 2,721,933	\$ -	\$ -	\$ -	\$ 8,832,485
<b>Grand Total - HSE Program Budget</b>	Total Program Budget by Funding Source	\$ 124,692,758	\$ 66,289,625	\$ 10,320,593	\$ 8,549,975	\$ 171,641,081	\$ 803,940	\$ 3,166,710	\$ 385,464,682

\*CMS-MMIS: HSE-IAPDv1.0 (approved May 4, 2012) included a request for \$124,692,758 though approval letter only noted an award of \$112,180,900. Vermont seeks recognition of the original \$124M request at this time. This is not a request for additional MMIS funding.

\*\*CMS-E&E: HSE-IAPDv1.0 (approved May 4, 2012) awarded \$21,470,560. An increase, total award of \$66,289,625, was most recently recognized in an interim approval letter dated January 31, 2014. No additional funding is request at this time.

\*\*\*CMS-HITECH: Awarded amounts reflect actuals claimed between July 1, 2012 and September 30, 2013 (balance of award from May 2012 APD approval was forfeited at the end of FFY2013; new award issued for FFYs 2014 and 2015). Award amount does include FFY2014 Q1 & Q2 interim approval dated January 2014. New request calculated by adding APDv2.5 forward budget and actuals claimed in Q1 then subtracting the interim approval for FFY2014 Q1 and Q2 from the sum. Grand total represents FFY2012Q4 through FFY2015Q4.

^CCIO Exchange (HIX) Establishment Grants: Vermont's HSE-APD fully represents the intended use of awarded Exchange grants, though line item details are only provided for costs that are allocated between both enhanced Medicaid sources HSE and Exchange grants. For additional HIX line item details, please refer to specific grant application materials.

# This is not intended to be a full representation of Global Commitment Waiver funding or Vermont's HIT Fund. These sources are shown, in this context, to represent the minimum forward looking need - because many existing Vermont contracts are leveraged for some portion of the HSE, the full associated value of "GC" and HIT Fund dollars is much higher

Figure 2.1

The table (Figure 2.2) below displays the breakout of the costs for the HSE APD and the associated Federal and State shares. Please note that Federal allocation for project specific work is a combination of various Federal Financial Participation (FFP) rates (Refer to Figure 3.3 for rates).

Federal / State Share Specific to HSE-APD v2.5 - Budget Period 01/01/2014 - 09/30/2015									
		MMIS	E&E	HIT (HITECH)	HIE (HITECH)	CCIO HIX Grants	GC Waiver	HIT Fund	TOTAL
<b>HSE APD v2.5</b>	Funding Release Request	\$ 76,838,241	\$ 49,223,532	\$ 8,192,705	\$ 5,117,334	\$ 120,491,556	\$ 803,940	\$ 3,166,710	\$ 263,834,019
<b>Federal Share</b>	Aggregate of match rates	\$ 69,154,417	\$ 44,282,733	\$ 7,373,435	\$ 4,605,601	\$ 120,491,555.66	\$ 453,744	\$ -	\$ 246,361,486
<b>State Share</b>		\$ 7,683,824	\$ 4,940,799	\$ 819,271	\$ 511,733	\$ -	\$ 350,196	\$ 3,166,710	\$ 17,472,533

Figure 2.2

1. The following information provides an update on benchmarks and performance measures for HIE on the progress of the SMHP project. Since this section was recently reviewed by CMS in the HSE APD v1.2 that was approved on August 29, 2013, the information depicted below is not new material.

### **Annual Benchmarks and Performance Measures for HIT Activities**

1. Identify all other payers and how much they have contributed to the Health Information Exchange (HIE) and whether it was direct funding and/or in-kind each year. Have there been successes and challenges with engaging with the other payers? Please provide details.
  - 1.1. Vermont passed legislation in 2008 to establish a Health IT Fund. A fee (2/10ths of 1%) paid on all health insurance claims generates annual revenues of about \$3 million for the state HIT Fund, which then provides grants to support HIT and HIE. While there are a small number of significant health insurance payers in the State, there are a lot of payers who are subject to this fee.
2. Provide the cumulative number and percentage of total providers successfully connected to the HIE each year overall, the same for total Medicaid providers and of those, broken out by how many are Medicare or Medicaid Eligible Hospitals and Eligible professionals as known to the State through registration and/or incentive payments. Please provide the cumulative number and percentage of total Medicaid covered lives with data in the HIE each year. Please provide any context for these numbers needed to understand the growth (or lack thereof).
  - 2.1. VITL reports 131 sites with interfaces receiving data from the network, at the end of 2013. This compares with 26 at the end of 2011 and 61 at the end of 2012. VITL also reports 13 of Vermont's 14 hospitals were connected to the network at the end of 2013, along with Dartmouth-Hitchcock Medical Center and two regional hospitals that border Vermont, all of which are Medicaid Eligible Hospitals. Of the 13 connected hospitals, all were storing data in the core infrastructure at the end of 2013. VITL also reports signing up 992 Vermont primary care providers to work on adopting and implementing EHRs, 99% of all the primary care providers in the state. This compares to 891 providers signed up at the end of 2012. At the end of 2013 there were 924 primary care providers using EHRs in Vermont, up 20% from the year before, and up 68% from two years ago. Also, VITL reports 800,000 persons in the master person index at the end of 2013, up from 543,500 at the end of 2012 and up from 300,000 at the end of 2011 (not all of whom are Vermont residents). VITL reports that it's REC team has now helped 571 providers achieve Stage 1 Meaningful Use, up from 176 at the end of 2012, an increase of 224%. Year-end data from the EHRIP program indicates that 970 payments have been made to Vermont Medicaid providers since the program began, while 500 payments have been made through the Medicare incentive payment program.
  - 2.2. Vermont's Blueprint for Health program has 601 ambulatory providers electronically sharing care summaries with other providers through the Blueprint repository, up from 466 at year-end 2012. In most cases, the data is transmitted to the repository through the HIE. These providers cover 514,385 of Vermont's 620,000 lives and represent approximately 60% of the primary care providers in the state. Approximately 30% of the primary care providers in the state meet the 30% Medicaid patient volume threshold for the incentive payment program, but many more providers are Medicaid providers.
  - 2.3. We do not have specific data on the cumulative number and percentage of total Medicaid covered lives with data in the HIE at this time.

3. Provide a status update for meeting the project schedule and timelines, as outlined in the IAPD.
  - 3.1. On-going MAPIR development and operations: on schedule. Meaningful Use Stage 1 is implemented and Meaningful Use Stage 2 has been implemented in sufficient time for the earliest possible attestations beginning with Eligible Hospitals in FFY14 and Eligible Professionals in CY14;
  - 3.2. EHR Incentive Payment Program: on schedule. Vermont has paid out almost \$29,000,000 to Eligible Hospitals and Eligible Professionals, including Meaningful Use Stage 1 payments;
  - 3.3. EHR Incentive Payment Program Audit Functions: Vermont's EHRIP Audit Plan has been approved and audits are beginning in the current quarter – Q1, FFY14;
  - 3.4. Medicaid Contribution to the Vermont HIE: On schedule. Vermont's Fair Share calculation was approved with the initial Jumbo IAPD and has been used to support the HIE. We are currently working with CMS to resolve funding clarification questions and to conduct contract agreement reviews;
  - 3.5. Support for e-RX Transactions: N/A. This proposed support was not approved in the initial Jumbo IAPD and is being withdrawn from this IAPD Update;
  - 3.6. Support for Public Health Initiatives related to Meaningful Use:
    - 3.6.1. Immunization Message updates to the Immunization Registry through the HIE are implemented. Additional outreach is required to add more practices and providers to this workflow. There are specific targets identified in the pending Grant Agreement with our HIE.
    - 3.6.2. A project is underway to implement Electronic Lab Reporting through the HIE in the coming year, with a goal of connecting 4 of the 14 hospital labs in the state using this transport. This work is also specified in the pending HIE agreement.
    - 3.6.3. The Vermont Department of Health has a plan for Syndromic Surveillance but it does not involve the HIE at this point in time.
4. Provide a status update for meeting each of the proposed activities:
  - 4.1. Enable exchange with the immunization registry and electronic exchange with lab results (please use the same data benchmarks as reported to ONC)
    - 4.1.1. Vermont's Immunization Registry update solution through the HIE was implemented in the first Quarter of 2013. The first 676 Immunization messages from the two practices participating in the startup were reported to ONC in the quarterly report. The most recent quarterly update to the ONC reported 15,513 Immunization records captured through the HIE. This represents 12.93% of total immunization records for the reporting period.
    - 4.1.2. Our current status with ONC for Electronic Lab Reporting reports that we are prepared to implement and have planned to connect 4 of the 14 hospital labs during the coming year. Once we announce this capability hospital labs will be required to connect to meet meaningful use requirements for incentive payments.
  - 4.2. Enhance follow-up support for disease management
    - 4.2.1. The Blueprint program began as an effort to manage chronic disease and this is still a component of the program. Care coordination is a significant aspect of getting to better outcomes with disease management and Community Health Teams (CHT) have been established in each of Vermont's 14 Health Service Areas. These teams are growing (almost 100 CHT personnel have been hired to date) and are funded by all the major private and public payers in the State through early payment reforms initiated by the State and supported by CMS through the Multi-Payer Advanced Primary Care Demonstration. The CHTs utilize the clinical data registry as a support tool and have access to an

Integrated Health Record which combines results for a patient from all providers. Consent is managed through the HIE.

4.3. Provide electronic access to medical records for auditing

4.3.1. Vermont has an all-payer claims database (APCD) and this resource is currently being reviewed as an appropriate support tool for the EHRIP. Some shortcomings have been noted and an initiative to make the necessary modifications to the APCD is included in this IAPD Update.

4.4. Capture quality data for medical home, ACOs, CHIPRA

4.4.1. The Blueprint for Health program has fully engaged the Vermont primary care community in being officially recognized as Patient-Centered Medical Homes, including the capture of clinical quality data into a registry or data repository. The data captured can be used to support ACOs but is not currently doing so.

4.5. Transition from Fee For Service to Pay For Performance – identify opportunities to reward providers who achieve quality outcomes

4.5.1. Vermont recently received a State Innovation Model (SIM) Grant from CMMI to develop and test three care delivery and payment reform models. HIE expansion, including the incorporation of full continuum providers (mental health; substance abuse providers; long term care; home health care), is a significant component of the proposed work.

5. Provide a status update for using the HIE to capture clinical quality measures electronically from EHRs for Medicaid providers participating in the Medicaid EHR Incentive Program

5.1. See item 2 above for a discussion providers and lives covered. The primary transport used to capture measures from Blueprint practices is through the HIE. More specifically, though, the State does want to accept eCQM data from Medicaid providers attesting for Meaningful Use. We are developing our plans to do so now, but we anticipate utilizing the same repository that holds the Blueprint clinical data and measures. We have identified an initiative in this IAPD Update to expand the existing clinical data registry to accommodate the eCQM data to be reported to the State from providers as supported by Meaningful Use Stage 2.

6. Please provide the prior year's financial statement for the HIE (acknowledging that these may be derived on the State fiscal year, not the federal fiscal year). Please add additional details as relevant to provide a full picture of financial status.

6.1. See attached PDF "VITL AFS Draft SEPT 12 2012" for a preliminary audit report of VITL's 2012 fiscal year finances (July 1, 2011 – June 30, 2012).

6.2. Also see VITL's 2013 Annual Report as required by 18 V.S.A. §9352(e) available at

<http://www.vitl.net/sites/default/files/documents/general/2013%20VITL%20Annual%20Report%201-31-2014%20final.pdf> A summary of revenues and expenses is presented on page 18 of this document.

7. Please identify any changes in HIE leadership (Executive Director, Executive Council, etc.) in the prior year

7.1. During the prior year David Cochran resigned as the CEO of VITL. John Evans was subsequently hired as the new CEO.

7.2. The State has appointed Robin Lunge, Director of Health Care Reform, VT Agency of Administration, to VITL's Board of Directors as the Governor's Appointee.

8. What services is the HIE Providing? Please provide data to demonstrate usage of these services. What services will be added in coming fiscal year?
  - 8.1. VITL is the designated HIE for the State of Vermont and the federally-designated REC for the State of Vermont. Their work revolves around meeting both of those requirements.
    - 8.1.1. Helping health care providers adopt and implement EHRs – 992 primary care providers signed up (99%); 924 using EHRs in Vermont, up 20% from previous year;
    - 8.1.2. Launching a Direct Messaging Product – VITLdirect was launched in 2012 as a secure messaging service. It follows the standards of the federal Direct Project. At year end there were 74 VITLdirect users;
    - 8.1.3. Building interfaces enabling independent information systems to send and receive data over the health information network – At the end of 2013 there were 131 sites with interfaces receiving data from the network, compared to 61 at the end of 2012. Of the 131 sites, almost all were primary care practices. At the end of the year, 13 of Vermont’s 14 hospitals were connected to the network, all of which were storing data in the core infrastructure. At the end of 2013 there were 121 physician practices sending data to the Blueprint for Health registry via the network, a 133 percent increase from the end of 2012.
    - 8.1.4. Deploying the network’s core infrastructure, which stores data transmitted by interfaces and enables authorized users to search for and retrieve data – At the end of 2013 there were 800,000 persons in the core infrastructure’s master patient index, up from 543,500 at the end of 2012. The core infrastructure was processing 2.2 million pieces of clinical and administrative data per month, an increase of 83% of the amount of data being processed per month at the end of 2012.
9. Please describe communication and outreach efforts to providers and/or patients and/or payers. Successes and challenges?
  - 9.1. The EHRIP Team maintains a website and we direct providers there for updated information;
  - 9.2. Jointly with VITL, the EHRIP Team utilizes a helpdesk solution to accommodate provider questions and issues. This has become an effective communications channel for 1:1 provider contact;
  - 9.3. The EHRIP Team, frequently with VITL, develops and presents webinars on changes to the incentive program. Most recently we did one on the 2013 changes that went into effect with a MAPIR software update. Others will be held on Meaningful Use Stage 2;
  - 9.4. Our HIE, VITL, holds an annual summit and we participate with presentations and panel discussions on all aspects of the incentive program.
  - 9.5. The Blueprint for Health program has several outreach efforts, including an Annual Conference, and the EHRIP team participates in that gathering by meeting with the providers we have worked with throughout the year. Keynote speakers this year included Kevin Larsen, MD, the Medical Director of Meaningful Use at the ONC.
  - 9.6. Additional Outreach and Education activity is proposed in this IAPD Update, with associated staff to do this critical work.

## Section 3 – Needs and Objectives

The State use of this section is two-fold:

- 1) Description and outline of the holistic view of the Enterprise; and
- 2) Details focusing on the specific work-streams that make-up the Enterprise.

### Health Services Enterprise (HSE)

#### Overview

Innovation is where creativity and passion intersect with opportunity, and Vermont continues to be at the forefront of innovation in health care transformation. Vermont's HSE vision is a multi-year, multi-phased approach that reshapes and integrates our current business processes, improves our public/private sector partnerships, enhances our utilization of information, modernizes our IT environment, and results in an end-to-end transformation of the health care experience for the Vermont populace as well as the State and private employees who support the HSE.

Vermont's aggressive agenda for change is built on providing Vermonters with improved access to their personal health data in a secure, timely and effective manner, enabling services and solutions that result in improved life situations and better health outcomes in conjunction with enhancing access to health care benefits. The HSE strategy is to invest in new and upgraded components and technology that serve the current and near-term needs, while being positioned to help the State continually evolve to an integrated Enterprise in the strategic timeframe. At the same time, these components will help the State transition to support Vermont's envisioned public-private universal health care system. As such, the HSE represents a holistic approach to innovation in Vermont's health care ecosystem.

The Health Services Enterprise (HSE) is the comprehensive collection of Health Information Technology (HIT) and Health Reform Information Technology systems. Together they are managed in the operational planning document known as the Vermont Health Information Technology Plan (VHITP). The HSE consists of the Vermont Health Connect (VHC) online health insurance exchange, the Integrated Eligibility & Enrollment (E&E) system, the Medicaid Management Information System (MMIS), and Clinical Public Health Information and Surveillance technologies (Health Information Exchange – HIE). These strategic components are incrementally deployed upon Vermont's new service-oriented architecture (SOA) that allows for a modular, flexible, interoperable and learning computing environment leveraging shared services, common technology, and detailed information. The new environment is designed consistent with CMS' Medicaid Information Technology Architecture (MITA) and Seven Standards & Conditions to ensure the State's ability to meet the goals of increasing electronic commerce and transitioning to a digital enterprise.

As depicted in Figure 3.1, the Vermont HSE is a combination of building blocks, using the HSE Platform (HSEP) as a foundation. The HSEP provides the infrastructure, services and functional components that each solution shares.

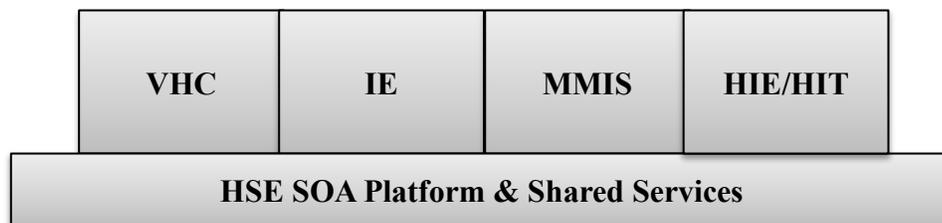
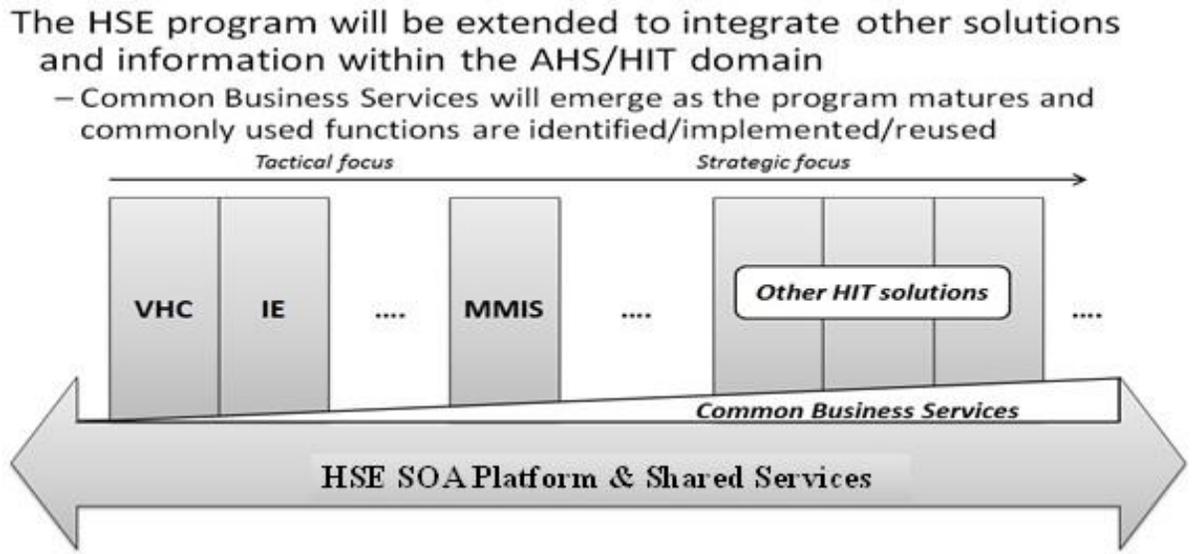


Figure 3.1

This integrated investment in functional solutions and standard computing platform are the key enablers for the State of Vermont to adopt an Enterprise approach and achieve true innovation in health care for the general population. Another important view of these solutions and platform reflects their respective deployment and relative maturity. This innovation began in Vermont with Vermont Health Connect and continues with the investment in remaining components. As common business services emerge,

there will be greater reuse downstream and should allow for downstream solutions to be less costly as greater reusability is in place. This is depicted below in Figure 3.2.



The procurement of services is vital to this success as it will provide the State with the ability to meet its goals and strategic initiatives leading the way in development of a health information network with seamless, transparent data liquidity. This transformation of health had the potential to generate tremendous positive impact and requires that all business, information and technical aspects of health work be evaluated and addressed in terms of efficiency, performance and customer service.

When considering the ambitious strategic goals and aggressive timelines the State of Vermont has, it’s understandable that there will be a large number of contracts associated with the work. The State adheres to not only CMS guidelines but also tight Vermont processes in terms of procurements and attempts to leverage options that do not place the State in a precarious situation for addressing work needs. Activities associated with the HSE work in terms of management, coordination, production and oversight include:

- Memorandums of Understanding (MOU) with fellow State entities that can include tasks associated with:
  - IT oversight and architecture; hospital and provider payment/reform; data gathering and analysis; eligibility and coverage functionality; performing services and support; etc.
- Contracts with various consulting, professional services and solution vendors to address needs including:
  - Functional system solutions; staff augmentation; guidance and expertise in new technology and processes; etc.

Vermont has an admirably expansive vision for its Health Services Enterprise (HSE) – indeed, we are national leaders in our ambitions – but the systems to implement that vision must be designed and built incrementally. Our HSE approach is not complicated but is rather cumbersome due to the choices related to phasing (selection of which components to implement in which order) must be made in a fluid, “just in time” or agile project management structure. There are many reasons for this including Federal mandates, State guidelines, funding deadlines, and procurement impacts.

The table (Figure 3.3) below depicts the major Vermont HSE work streams, their scope, and their Project Level Allocation. The Cost Allocation reflected here depicts an adjustment that was worked on between CMS and Vermont staff and is effective 10/1/2013. It is acknowledged that the figures here will/may be adjusted in the future as programs go from ‘development’ to ‘operational’; ‘actual’ data can be evaluated rather than estimates; and project financials are confirmed.

## HSE-IAPD Project Level Allocation Effective 10/1/13

Project Details		Enhanced Medicaid Sources 90% Federal/10% State			Exchange 100% Fed	Other Sources
		CMS-MES (MMIS)	CMS-E&E (IE)	CMS- HITECH (SMHP)	Levels 1 & 2 Grants	Various
Enterprise	Oracle SOASuite, Hosting, and Shared Applications	26.5%	26.5%		47.0%	
Benefit Exchange	Non leveraged IT build and 1 <sup>st</sup> Year Operations				100%	
Integrated Eligibility System	VHC ACCESS Integration				100%	
	IE – Healthcare		100%			
	IE – Human Services					100%
	IE – VHC E&E (MAGI)		53.0%		47%	
MMIS	Replacement MMIS	100%				
SMHP	EHRIP / MU Immun Regis			100%		
	Provider Directory	33.34%	33.33%	33.33%		
	MAPIR Customization	100%				
	Data Analytics Platform	50%		50%		
	Health Info Exchange Expansion			42.59%		57.41%

**Figure 3.3**

One of the more challenging aspects of this cost allocation was factoring in the impact of future planning and how to appropriately leverage the available funding. CMS and State staff worked diligently to better comprehend and agree on what population figures could be used and how downstream programs would benefit. It is understood that most Design, Develop and Implementation (DDI) costs use estimates based on population and functionality usage and this will likely change allocation percentages after programs become operational and more concrete numbers are confirmed.

For efforts where the State has to build something because of VHC and absent VHC, the build would not occur, these costs are targeted as 100% Exchange funded. Vermont used the allocation outlined in Figure 3.4 for determining how Exchange and Medicaid funding will share costs for shared services/components of the Enterprise system. These figures were established through an evaluation of population data applying CMS guidance. In these instances, the Exchange will fund 47% and Medicaid will fund 53% (split 26.5 each for MMIS and IE) for those particular efforts.

Population Description	# Vermonters		
QHP Enrollees	58,515		
Uninsured	24,872		
Small Group	24,205		
Medicare			
Large Group			
<b>Subtotal Exchange Funded Population</b>	<b>107,592</b>	<b>47.01%</b>	
Medicaid Enrollees	121,288	52.99%	26.50%
			26.50%
<b>Total Cost Allocable Population</b>	<b>228,880</b>	<b>100.00%</b>	
Medicare	108,395		
Large Group	119,253		
Federal Employees	17,173		
Military Employees	14,100		
Self Insured	140,979		
<b>Total Exempted Population</b>	<b>399,899</b>		
<b>Total Population</b>	<b>628,780</b>		

Figure 3.4

The interdependencies of the Health Services Enterprise work-streams are so intricate, successful implementation necessitates a series of tightly coupled design / build / test cycles to bring up components of the system incrementally, allowing for inevitable course correction mid-process rather than waiting for “completion” of the project to begin testing. Our Enterprise Architecture (EA) drives sharing and leveraging of services, components, system features and functionality and has a dramatic effect on the cost allocation for the Enterprise – with more of this explained further below. This approach [phasing] means that the forecasting of contract costs, resources, hardware, software, etc. are by definition refined on an on-going basis based on the experience garnered as the building out of the Enterprise matures.

Vermont’s Health Services Enterprise is all about “systemness” and manifesting the Agency of Human Services’ (AHS) “Agency of One” vision. The AHS has the widest reach of all Agencies in Vermont state government. Whether helping a family access health care or child care, protecting a young child from abuse, supporting youth and adults through addiction and recovery, providing essential health promotion and disease prevention services, reaching out to elder Vermonters in need of at-home or nursing home assistance, enabling individuals with disabilities to have greater independence, or supporting victims and rehabilitating offenders, AHS provides support to many Vermonters and seeks to assist all Vermonters in accessing any of the relevant services we offer. Our “Agency of One” goal focuses on securely sharing any and all applicable data in a timely and effective manner to ensure Vermonters:

- Receive all of the services they not only recognize as critical to ensuring their success but also identify additional supports that will help them prosper
- Receive cross-departmental referrals and awareness – “no wrong door” for Vermonters
- Policy and Public Health efforts have necessary data for program analysis and program service coordination

The HSE is creating an environment where the person is at the focal point, not the program. Vermont’s broad long-term health care goals are in-line with the “Triple Aim” - focus on improving the care experience, improving the health of the population, and reducing the cost of care. The overall cost to the State is offset by overall savings from an improved delivery model and Vermont has already seen some early results, based on the early years of Blueprint implementation, with data indicating fewer hospital readmissions and fewer emergency room visits.

Vermont Health Connect (VHC) launched its Health Benefits Exchange solution on October 1, 2013, and met its subsequent critical dates as well. The Integrated Eligibility (IE) system has finalized system design and requirements that build off VHC and our HSE Platform efforts. The Medicaid Management Information System (MMIS) has released 2 of 3 planned Requests for Proposals (RFPs) to modernize and expand the MMIS and vastly improve the sharing of provider and claims data. The

Electronic Health Record (EHR) Incentive Program is functioning at a high level of performance, with almost \$30,000,000 awarded to date, many providers transitioned from adoption to Meaningful Use, and an audit program was established to ensure quality and compliance. Vermont is one of the first-round of State Innovation Model Grant (SIM) recipients and will be demonstrating different payment reform models in the near future, with anticipated participation from our Health Information Exchange (HIE) to achieve the operational performance required to support these models.

Health Information Exchange, both the noun and the verb, are now being given early consideration in all new proposed projects and when workflow improvements are being considered. Examples of such include a project to improve outcomes and cost reductions with the dually eligible population, and a grant proposal was recently submitted to SAMHSA. Data liquidity remains a guiding principle for a key architectural component for the future, and HIE is one instrument to help achieve that flow of quality data. Vermont has started SIM efforts that will also contribute to the expanded use and utilization of data.

The “Totality” of these systems makes up the core pieces of the Enterprise. Each will appropriately share information (demographics, financials, benefits, etc.) to improve efficiencies in not only the services and benefits an individual receives but results in a ‘golden record’ on an individual. This ‘golden record’ will allow the Agency to meet its ‘Agency of One’ goal of making a difference in the lives of Vermonters through program effectiveness, integration, focus on outcomes and alignment of processes across the Agency and this will be accomplished by maximizing value out of every tax dollar; measuring outcomes; and moving from service delivery to service coordination.

The following provides greater detail as to how Vermont views the benefits of Federal legislation (Affordable Care Act), State Mandates (Act 48) and AHS Strategic Planning. Some of the work below has funding approved (VHC, MMIS, E&E, SMHP) with requested adjustments in this APD. There are also some work streams (SIM, etc.) that are in the development phase and funding for such will be reflected in future APD submissions as allowable. The focus here is to provide clarity around the current and future vision and goals of Vermont’s Enterprise.

**Health Information Technology** – expanding resources to address: time lines, dependencies, risk factors relating to Electronic Health Record adoption and implementation; Health Information Exchange connectivity; expansion and adoption of the Blueprint clinical data repository and registry; expansion/modernization/integration of Public Health IT registries, syndromic surveillance; and broadly available, integrated Personal Health Record and patient-driven Health IT applications and services.

**Financial Records / Transactions:** The MMIS procurement and implementation, which includes both Medicaid claims processing and information management to support Medicaid Operations and Program Management, Program Integrity, Provider Management and Member Management. A Claims Normalization Gateway, its relationship to existing and future-state insurance plans, claims clearinghouses, and the risks / opportunities associated with disintermediation and / or redesign of the claims “supply chain.” IT systems designed to support planning, analytics, and payment mechanisms for transition to and operation under Global Budgeting.

**Exchange/ Eligibility / Enrollment:** The initial work focuses on Vermont Health Connect implementation yet it folds into Integrated Eligibility – part of our phasing approach.

**Reporting / Evaluation:** this is a cross-cutting category that supports all of the three above, including the opportunity for leveraging information resources across clinical and claims records domains. Opportunities for enhancement of the VHCURES (Vermont Healthcare Claims Uniform Reporting & Evaluation System) multi-payer claims data base, further alignment with and development of the IRIS (Integrated Research Evaluation System) health informatics data platform at UVM, and enhanced integration of reporting and clinical quality measurement capacities of the Blueprint IT systems, state HIE, and Meaningful Use reporting by providers.

**State Technical Infrastructure:** consists of the AHS (and DII) implementation of the Service Oriented Architecture (SOA) core components, state Master Provider Directory and Master Persons Index, and IT systems to support a fully integrated approach to meeting the health related business needs of AHS Departments and programs.

Overall, we have divided the Health Services Enterprise into five major component areas:

1. Health Services Enterprise Platform (HSEP) – the core shared infrastructure (purple on the chart)
2. Vermont Health Connect (VHC) – Vermont’s Health Insurance Exchange (HIX) (dark blue)
3. Integrated Eligibility (IE) - Eligibility & Enrollment systems (light blue)
4. Medicaid Management Information System (MMIS) – claims processing, pharmacy, program integrity (green)
5. State Medicaid HIT Plan (SMHP) - Clinical Information Systems (orange)

The color scheme is consistent throughout all of the spreadsheets, tables, and associated documents with the HSE.

# To-Be Vision of the Digital Infrastructure of Vermont's Health Services Enterprise: High Level Enterprise Business Architecture

NOTE: this is only a suggestive schematic, not a definitive data flow diagram, for discussion purposes.

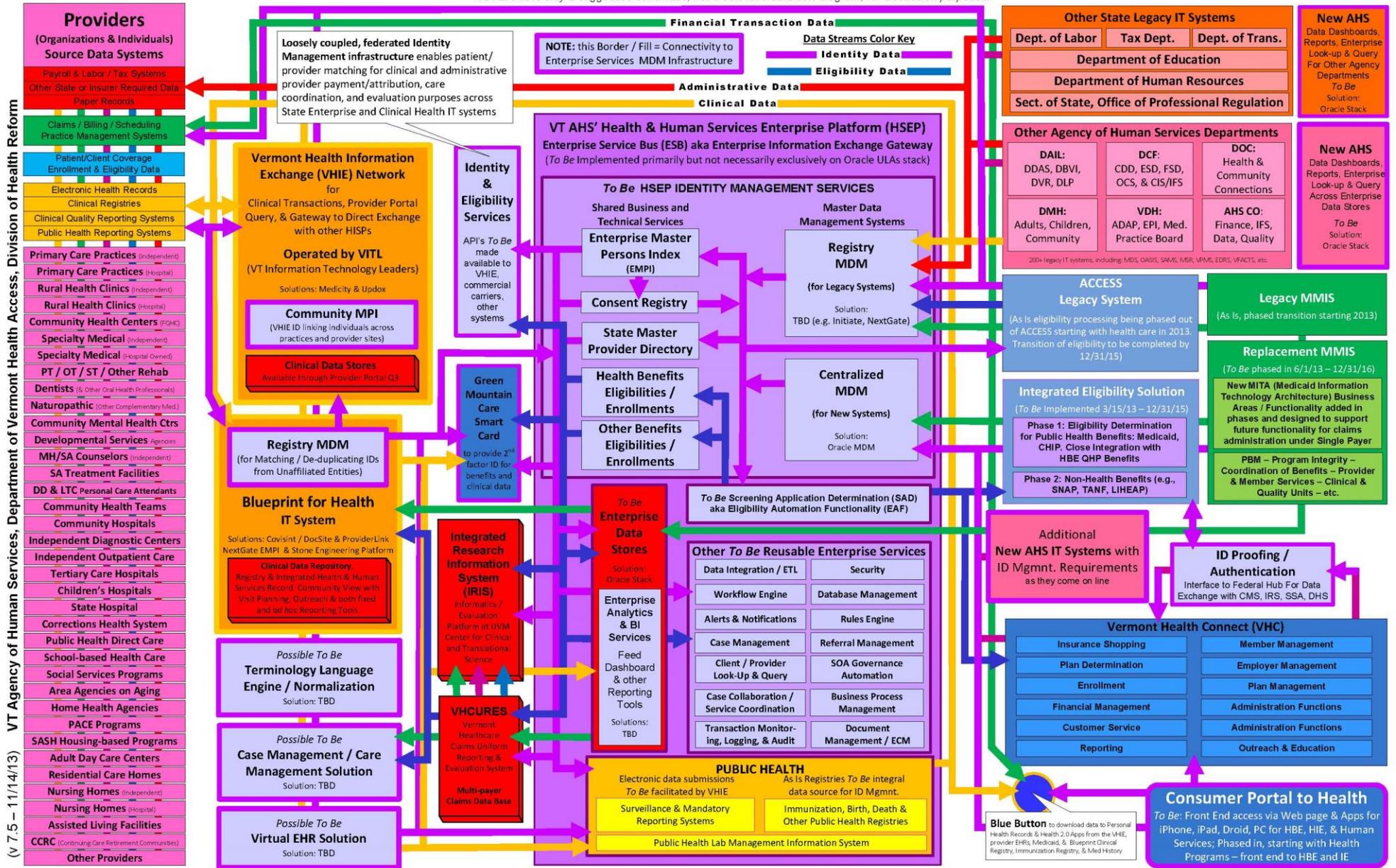


Figure 3.5

Both VHC and IE (#'s 2 and 3) are highly dependent upon the HSEP (#1). Portions of VHC (#2) are potentially able to be accomplished in combination or in parallel with IE (#3), but in all cases, our priority is going to be to advance work on those systems tied to the 2014 deadlines. Clinical information systems (not yet detailed on the timeline) move along a different track and affect an expanded government population (external customers and users), but it will also leverage the HSEP and the MMIS (#'s 1 and 4) where it can.

This all goes back to our cumbersome but not complicated statement. Our leveraging and reuse of services, components, and solutions all impact decisions on timing, cost allocation, resources and staffing. We are creating a robust 21st century enterprise that will empower people and not just treat symptoms.

We are building a foundation of integrated HIT components that will meet our near-term needs to operate the insurance exchange, to implement payment reforms, and to have the capacity to operate long term as a fully-enabled information and payer system. We will simplify and align administrative systems – like eligibility and claims adjudication – by moving them into a shared infrastructure. We will ultimately bring together Medicaid, the Exchange plans, and whatever other payers we incent or regulate into participation, by operating a single, common, interoperable infrastructure. This transformative system will be able to learn from itself with data feedback loops as it evolves. We are building a single system that can be viewed and managed globally to direct how we deliver and pay for care, moving from volume to value, and rewarding alignment and efficiency.

As noted, this will happen in stages, as the health information and health insurance exchanges are built out to reach every health care provider and health care consumer in Vermont. We will address all Federal and State Legislative mandates and ensure that as policy choices are made, we will have a flexible, reusable, reconfigurable Enterprise system to support it. The Enterprise will have at its core - the person – the individual. The HSE will record, track, link and share all necessary data in an efficient, effective and secure manner providing the user with a positive, informative and meaningful experience.

Timeline

The Vermont HSE is a multi-year project where the vision of downstream impact on modernization of systems, delivery of services and full, automated integration of data will run through 2017. The Design, Development and Implementation (DDI) cost of these HSE efforts consist of a mixed blend of Federal and State funding with the State taking advantage of the A-87 Exception along with maximizing cost allocation amounts when feasible.

The table (Figure 3.6) below displays the anticipated timelines identifying the releases (R#) and dates of HSE Implementations along with identifying which programs will be affected and when they will be live on the new platform.

		2013	2014				2015		2016		2017	
		Oct. 1	Jan. 1	Jul. 1	Dec. 31							
<b>HSE Release #</b>		R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	
	VHC*	X	X	X								
	E&E*				X	X	X					
	MMIS*					X	X	X	X	X		
	SMHP*						X	X	X	X		

Figure 3.6

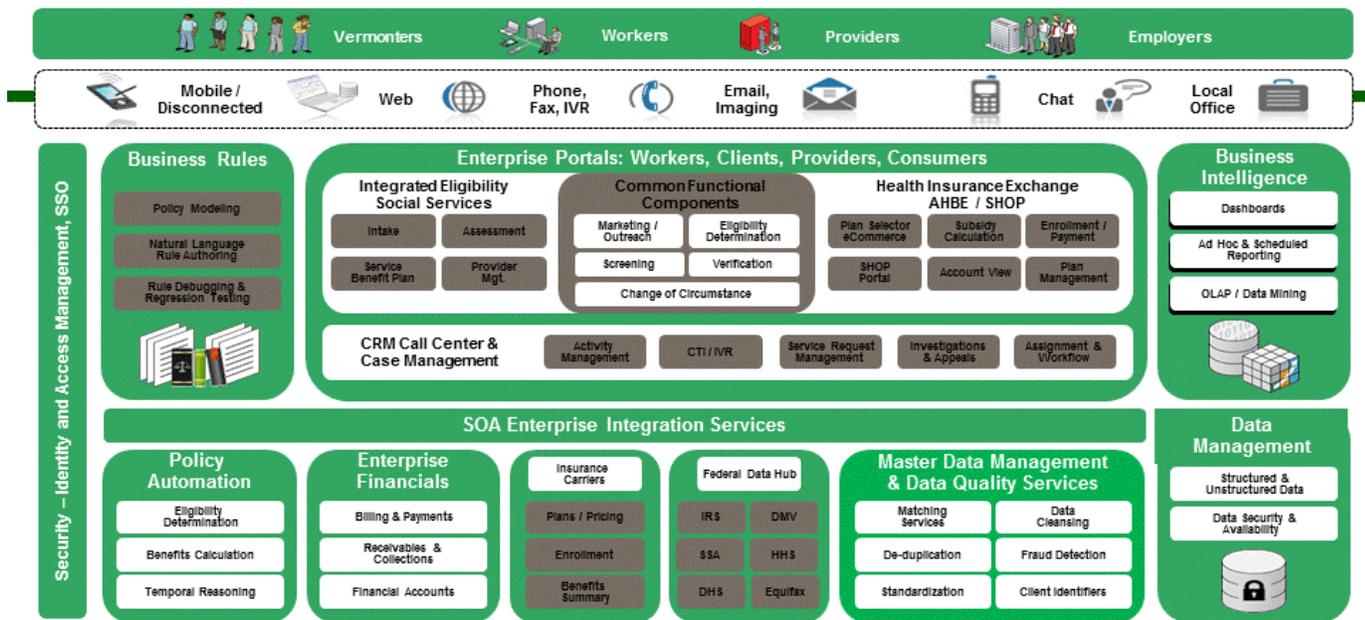
\*Currently, there are/will be DDI efforts for these programs, this table only represents when these will be live on the new platform.

The section below will provide additional details about each of the fundamental work steams associated with the Vermont Health Services Enterprise (HSE).

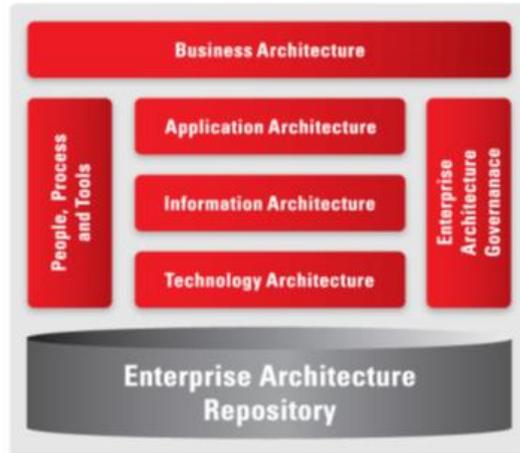
## Health Services Enterprise Platform (HSEP)

### Overview

In order to achieve reuse, sustainability and integration the HSEP is being delivered through the State of Vermont Enterprise Architecture program. By aligning both AHS business strategy and State of Vermont IT strategy we are able to leverage numerous perspectives, technologies and truly target citizens across the State Enterprise. As the required business capabilities include numerous communication channels, citizen self-service and integrated case management it becomes clear that technologies, business delivery and operations require many transformation activities. The anticipated and targeted business capabilities required by the Health Service Enterprise are provided in the pictorial below.



Driving reuse, limiting redundant technologies and enhancing business capabilities - while remaining agile and sustainable - takes a proven enterprise approach. The Enterprise Architecture Program consists of an EA framework (VEAF), governance, principles, standards, business capability strategies, SOA “Center of Excellence”, Cloud Hosting “Center of Excellence” and processes that ensure the Enterprise business vision can be realized. The VEAF framework focuses on four main domains: Business Architecture, Application Architecture, Information Architecture and finally Technical Architectures. Within each of these domains there are specific artifacts, processes that clearly link domain artifacts. Business Architecture includes business process models, business capabilities and requirements that business analysts produce and maintain under the Business Architecture domain of the EA program. Enterprise Architects utilize these deliverable to map these business capabilities and processes, to the Application Architecture, then the Information Architecture and finally to Technical Architecture. The Enterprise Architect Domains are pictured below with some example work streams/artifacts in each.

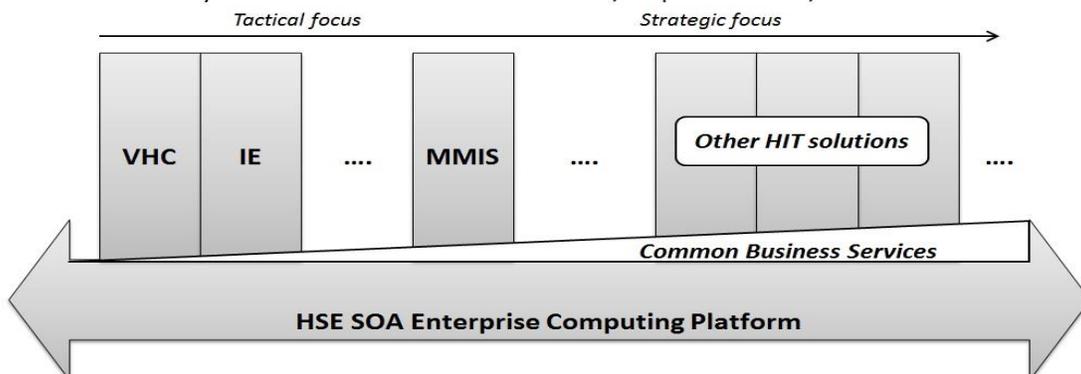


The Health Service Enterprise Platform (HSEP) provides the shared services architecture and governance through EA program on which HSE runs. The intent is for release 1 of the HSEP to host the Vermont Health Connect (VHC) from October 1 forward. Release 2 will augment the MDM base products that were in scope of VHC and delivered. Access Integration efforts were focused on integration both near real time and batch following EA guidelines. Rudimentary MDM functionality was established to match persons from VHC to Access at the enterprise level and will continue to be built out. The hosted platform is scalable vertically and horizontally to accommodate other upcoming projects. Once Integrated Eligibility is awarded, release 3 of the platform would scale up to accommodate the new scope with release 3 that will take the platform through 2014. The current assumption is that MMIS will be a ‘bolt on’ functionality that will run on the platform with implementation in 2014 through 2015. We anticipate being able to reuse Identity Management, Portal, Reporting/Business intelligence capabilities for MMIS initiatives. Close coordination with the MMIS team will allow the timing of this project to dovetail nicely into the overall HSE program.

The benefits of implementing the new platform will be shared services across the HSE. All future AHS projects will have the advantage of having integrated case management, Identity and Access Management, Portal, MDM, ECM, reporting, rules engine, database, SOA infrastructure in hosted environment run by a vendor to facilitate financial sustainability of the solutions. The requirements for high availability and run-time performance are the sole responsibility of the vendor. The HSEP coupled with the VHC will begin the modernization of the health service landscape in Vermont and will provide a stable, scalable, architecture that will accommodate growth and integration of programs that to date have been separate. As depicted below, the State’s Enterprise will mature and develop bringing about a greater leverage of shared components. The State will identify and expand the repertoire of common business services and therefore future implementations will utilize a larger pool of common services.

The HSE program will be extended to integrate other solutions and information within the AHS/HIT domain

- Common Business Services will emerge as the program matures and commonly used functions are identified/implemented/reused



## Milestones to Date:

The HSEP project is well underway and the milestones achieved to date include:

- Hosting Provider Established
  - CGI Federal : Phoenix
  - CGI Federal : SunGuard (Philadelphia) Disaster Recovery
- Environments Established
  - Development environment complete
  - Testing environment complete
  - Training Environment complete
  - Staging Environment complete (currently Production)
  - Production Environment complete (currently waiting for Staging migration)
  - Disaster Recovery Environment (currently being mirrored from Production)

## Upcoming Milestones and Activity Table:

- Enterprise Architecture
  - Start to expose Vermont Enterprise Architect Framework
    - OSC Governance, Guideline, Component Strategies, Principles, SOA “Center of Excellence”, etc.
  - Validation and Completion of System Design Documentation
  - Validation and Completion of System Security Plan Documentation
  - Validation and Completion of Interface Control Documentation
  - Validation and Completion of Non-Functional Requirements Matrix
    - Data Center, Component level (MDM, SOA, IDM, etc.)
- Environments
  - Complete Production Environment and Migration of Staging to new Production
  - Complete Disaster Recovery Environment build out
  - Complete DR cutover test scenario to validate RPO and RTO is met
- Additional EA Focus Areas
- Authority to Operate (Go Live on Oct 1)
- Release 2 of HSE (Access Integration)
- Release 3 of HSE (IE Functionality)

## Timeline

- The HSEP has been live since October 1, 2013 and will continue to be accessible and scalable as program and project plans dictate.

## Project Problems

- Because of the sheer velocity of the VHC deployment, the vendor did not follow EA guidance in several areas. Several point to point integrations were created versus loosely coupled approach dictated by EA guidelines, technical documentation is not adequate or accurate, SOA delivery has not included central security nor service registry implementation as required.

## Corrective Action

- Increased adherence to EA protocols for all current and future activities. No other HSEP corrective action plans to report at this time.

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## Health Insurance Exchange (HIX) / Vermont Health Connect (VHC)

### Overview

The State of Vermont has made significant progress in establishing Vermont Health Connect, a state-based health benefit exchange for individuals and small businesses in Vermont. The State has executed contracts to cover all major exchange functions, including systems integration and web portal, premium processing, and call center. The State completed an initial outreach and education campaign with key stakeholders, including insurance carriers, brokers, small business owners, and community partners ahead of the October 1 Go-Live and continues its efforts as open enrollment comes to a close.

The State's Health Benefit Exchange, Vermont Health Connect (VHC), has been successful in meeting grant requirements and engaging diverse stakeholders throughout Vermont. Vermont Health Connect will allow individuals and small businesses to compare and purchase qualified private health insurance plans, access federal and state tax credits and cost sharing reductions, and determine eligibility and enroll individuals in public health insurance plans.

Activities associated with this work involve contracted systems integration work with CGI as the primary contractor to address the building and implementing of an Exchange solution to meet Affordable Care Act (ACA) requirements. The Vermont Health Connect mission is to provide all Vermonters with the knowledge and tools needed to compare easily and choose a quality, affordable and comprehensive health plan.

Since the October 1, 2013 Go-live, SOV and CGI continue to execute systems integration delivery activities that had been deferred from the October scope. As of March 3<sup>rd</sup>, the state and CGI are working to amend the initial contract to re-baseline the plan to deliver the remaining components of the exchange.

### Milestones to Date:

- As of March 2014, the following major components have been completed by VHC and its partner vendors: Start of Open Enrollment Media Outreach
- Planning for End of Open Enrollment Media Outreach (Execution in-progress)
- Execution of Carrier Contracts for QHPs and Dental plans
- Training of Navigator and Broker Communities
- Completion of the following Core Exchange capabilities including:
  - MAGI Medicaid and QHP Pre-screening
  - Streamlined enrollment application (Paper and Online)
  - Robust, rules-driven MAGI Medicaid and QHP eligibility determination
  - Federal Hub Integration for SSA (H03), RIDP (H01), VLP (H04 and 07), Verify non-ESI MEC (H31), and Verify Household Income (H09)
  - Robust Plan Select and Compare features
  - Support of check and e-payment functions via the online portal
  - Integration with outsourced Billing Vendor to generate, delivery, collect, and remit VHC premiums
  - Enrollment and Billing Integration for Initial enrollment with Contracted Carriers
  - Online Broker and Navigator eligibility and enrollment support
  - Delivery of CRM solution and Outsourced Call Center for Level One call handling

### Upcoming Milestones:

As of March 2014, the following major components are in progress of delivery to be completed by VHC and its partner vendors:

- Full execution of Small Business Employer Eligibility and Plan Selection and Employee plan Selection
- Notices
- Rules driven Change of Circumstance for online, self-service and for Case workers
- Carrier Integration for changes in Enrollment
- Additional Federal Hub Integration (e.g., 834 and 820 delivery, Verify ESI MEC, IRS Monthly and Annual reporting, additional VLP Case services)
- Processing of Renewals
- State Financial Systems Integration for Accounting Capabilities

Timeline

VHC went Live on October 1<sup>st</sup>, enabling Vermonters to enroll in QHP and MAGI Medicaid benefit plans. Delivery of additional capabilities continues; a contract amendment to confirm the timeline for remaining work is pending.

Project Problems

- Any VHC issues are being addressed directly with CCIIO staff and are included in their reports and not here.

Corrective Action

- See above note regarding Project Problems.

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## Eligibility and Enrollment (E&E) / Integrated Eligibility (IE)

Overview

The IE project is one of many identified within AHS to facilitate Vermont’s transition from a legacy, siloed, program-centric approach to a person-centric philosophy supporting improved health care and human services delivery and outcomes via web-based services. AHS will serve its Vermont constituents more effectively within the new framework. This will benefit the state through improved accessibility, efficiency, and processes while reducing costs.

The business case for Integrated Eligibility (IE) is to utilize Federal CMS funding to leverage work done for the Health Benefits Exchange (QHP, MAGI, CHIP) and transform Vermont’s siloed legacy systems into a scalable, person-centric enterprise system that can support integrated case management for a multitude of Healthcare programs. The intent is to also produce a scalable, re-usable solution capable of supporting the subsequent migration of Vermont’s Human Services programs, which will produce the capability for integrated case management across all of Vermont’s Healthcare and Human Services programs.

Integrated Eligibility is a central component of HSE and will leverage what was produced for Vermont Health Connect. IE includes the following functionality that can be common to all Health and Human Services assistance programs:

- |  |                         |                           |
|--|-------------------------|---------------------------|
| 1. Eligibility Determination   | 6. Rules Engine         | 11. Financial Management  |
| 2. Re-determination  | 7. Case Management      | 12. Notification          |
| 3. Enrollment  | 8. Consent Management*  | 13. Workflow Management   |
| 4. Denials   | 9. Benefits Management  | 14. Business Analytics    |
| 5. Appeals and Grievances [Member]   | 10. Document Management | 15. Business Intelligence |
| 16. Interfaces to Other Programs, ACCESS, MMIS, External Systems, Federal, State and Private Data Hubs, etc. |                         |                           |

## 17. Reports

\* = Consent management is a new functionality to be provided by IE and does not exist for VHC today.

### Milestones to Date:

Current activities associated with this work involve an RFP and system implementation process, partnering with system integrators (SI) to:

- Analyze the existing legacy mainframe IE system (ACCESS) and create an inventory of interfaces, data flows, applications, programs, etc. to determine how to best phase the migration of functionality off the mainframe and/or the creation of better functionality on the IE Solution in support of CMS milestones for healthcare. (completed)
- Populate a Rules Database (already utilized for MAGI / CHIP / Health Benefits Exchange) to support eligibility determination for additional Medicaid programs.
- Populate a Rules Database to support program eligibility determination for Human Services' programs.
- Migrate data from the legacy mainframe (ACCESS) to the new IE Solution.
- Integrate the new IE Solution with the legacy mainframe system.
- Interface with other existing HHS systems to provide eligibility data visibility and to provide for 2-way communication as needed during transition.
- Interface with MMIS and PBM to provide Medicaid eligibility data for processing claims.
- Create new, real-time interfaces to external data sources such as the state systems, Federal Hub, State Hub and Private Hubs.
- Implement assistance programs in the new IE solution (rules, workflow, notifications, interfaces, reports, and business analytics).
  - Remove healthcare eligibility from ACCESS.
    - Migrate programs that use SSI-related Medicaid rules, which currently only exist in ACCESS. Eligibility for these programs will be directly determined by the IE Solution.
    - Migrate other healthcare programs with eligibility that will be directly determined by the IE Solution. Some of these programs are currently in ACCESS.
  - Migrate healthcare-related programs that have an application and/or eligibility process outside the IE Solution, and require the IE Solution to pass data to other entities. Most of these processes currently exist within ACCESS.
- Integrate & Enhance healthcare programs for which financial eligibility currently is determined by Vermont Health Connect.
- Place all healthcare-related programs in the IE Solution by migrating, integrating or creating healthcare-related programs.
- Leverage funding from FNS to mitigate ESD's currently high eligibility error rates in Vermont's 3SquaresVT program (SNAP). This item currently resides in ACCESS.
- Transition ESD from ACCESS by migrating the remaining ESD programs that currently reside in ACCESS

### Upcoming Milestones and Activity Table:

<b>Project/Program Schedule</b>	<b>Expected Finish Date</b>
ACCESS Remediation Procurement	Complete by Dec 2014
Solution Validation and Verification Procurement	Complete by Dec 2014
Contact finalization for IE (healthcare and non-healthcare)	Complete by Nov 2014
Requirements Validation for HSE Healthcare and Non Healthcare	Q1, 2015*
Solution Design for Healthcare	Q1, 2015*
DDI for Healthcare	Q2, Q3, and Q4 2015*

Healthcare programs go-live	Q3 and Q4 2015 +(phased)
Solution Design for Non-Healthcare	Q2, 2015*
DDI for Non-Healthcare	TBD by Vendor and SOV+
Non-Healthcare go-live	TBD by Vendor and SOV +
*= Estimated	
+ =Requested Deadline in IE RFP	

Timeline

- The IE project will have three procurements, IE DDI/SI Solution, ACCESS Integration, and Solution Validation and Verification. The procurement of all three is scheduled to complete by the end of November 2014. Based on the current funding timelines, the healthcare portion of IE should go-live in phases by December 2015 and the non-Healthcare by December 2016.
- Enterprise level Business Process Reengineering project is being planned.

Project Problems

- Overly aggressive schedule
- VT SME resource shortages
- Funding for non-Healthcare programs is not secured yet.

Corrective Action

- No IE corrective action plans to report at this time.

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## Medicaid Management Information System (MMIS)

Overview

The Vermont Medicaid Management Information System (MMIS) project is a core element of the AHS Health Service Enterprise (HSE) vision. The MMIS project will align Vermont’s Medicaid Management Information System with new Federal and State regulations stemming from the Federal Affordable Care Act and Vermont’s Health Care vision, Act 48. Vermont has undertaken an aggressive program to overhaul health care; dramatically changing health care facilitation, funding, and processes. The current system relies on data that is inefficiently stored and retrieved and is unable to establish a member-centric view across the range of services provided by the state. This lack of interoperability fosters a silo approach to Medicaid programs and beneficiary care management at the department level. Shortcomings in data management create limitations to Vermont staff when it comes to managing Fraud, Waste, and Abuse cases. The new MMIS will integrate with a Service Oriented Architecture

(SOA), creating a configurable, interoperable system, and be compliant with Center for Medicare and Medicaid Services (CMS) Seven Standards and Conditions.

The vision of Vermont's MMIS can be pictured as a contemporary SOA based system that efficiently and securely shares appropriate data with Vermont's Agencies, Providers, and other stakeholders involved in a citizen's care.

### Milestones to Date:

The MMIS project has begun procurement efforts and the milestones achieved to date include:

- May 2013 - Vermont signed contract with Gartner to support RFP development, proposal review, contract negotiations as well as a MITA 3.0 State Self-Assessment
- June 2013 – Gartner and MMIS Stakeholder team conducted a procurement kick off meeting where schedule, responsibilities, and scope were discussed
- July->February, 2014 – Gartner is working with Vermont MMIS users and business leaders to develop requirements for three MMIS work-streams:
  - Pharmacy Benefit Management
  - Care Management
  - Core Medicaid operations (inclusive of financial management, fiscal agent activities, TPL)

### Upcoming Milestones and Activity Table:

- Looking ahead, the Vermont's MMIS procurement schedule includes the completion of three RFPs focused on: Core Operations, Pharmacy Benefit Management (PBM) and Care Management (CM)

Pharmacy Benefit Management (PBM) RFP released December 2013  
PBM Contract signed May 2014  
PBM implemented January 2015

Care Management (CM) RFP released February 2014  
CM Contract Signed August 2014  
CM Phase 1: DVHA's VCCI Implemented December 2014  
Phase 2: Full implementation of all care management programs and full system functionality 2017

MMIS CORE RFP released May 2014  
MMIS CORE RFP contract signed November 2014  
MMIS CORE Contact Center Implemented July 2015  
MMIS CORE Operations Implemented January 2017

- The MMIS project also includes Vermont's participation in the MAPIR software interface to MMIS in support of the EHR incentive payment program. This includes a share in the core software development managed by Pennsylvania and all of the cost to do the custom interface work on Vermont's Medicaid system. This is ongoing development, as several releases of MAPIR software are currently projected.

### Timeline

- The MMIS is in the beginning stages of its project lifecycle with an anticipated completion date of Jan. 1, 2017 for a fully functionally-rich solution that will meet the State's anticipated goals. Vermont has contracted with Gartner to provide procurement assistance with this effort

### Project Problems

- No MMIS project problems to report at this time.

#### Corrective Action

- No MMIS corrective action plans to report at this time.

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## State Medicaid Health Information Technology Plan (SMHP)

### Overview

Vermont, though geographically small compared to most other states, is almost entirely rural in nature and features a rugged terrain and a challenging winter climate. As discussed in several places in Vermont’s SMHP, technological advances can play a major role in providing services to long term and primary care clients and patients. The health information technologies and transport protocols that are part of the SMHP are seen as essential to fully realizing the benefits of Vermont’s Blueprint for Health program (patient-centered medical home), as they can be utilized by both primary care practices and the community health teams now being established to coordinate services beyond the primary care practice domain.

The SMHP activity is where the true digital learning health network comes to fruition. It documents the many possibilities of taking clinical, beneficiary, demographic, and claims data and directing that data to the purpose of achieving the triple aim. Data liquidity is not only putting the person at the center of their experience with the necessary information to make the best possible choices and receive the best possible outcome, but also making the data available for provider and care coordination purposes, as well as for administrative and payment purposes.

The SMHP HITECH work for the APD period including FFY14 and FFY15 can be broadly categorized into HIT- and HIE-related work. The HIT work is focused on expanding the Meaningful Use (MU) of EHR provider systems- for hospitals and professionals in the State. Expanding MU consists of maintaining the EHRIP which includes participation in the 13-state MAPIR consortium for a core web-based attestation portal; customizing the MAPIR core software to work with the State’s MMIS; administering the program; and auditing the program. Significant outreach, education, and coordination work is also required to support providers as they enter the program and subsequently move through the various stages of MU. Achieving a high population of providers who meet MU requirements is critical to the success of Vermont’s Blueprint for Health program. Coordinating Blueprint and MU programs and activities is necessary to ensure common Clinical Quality Measures are being appropriately used in each program. Expanding MU also requires an All Payer Claims Database (APCD), a Clinical Data Repository (CDR), Provider Directory (PD), and access to an enterprise Master Person Index (eMPI). Expanding MU also involves establishing the Public Health systems and processes to support the public health MU measures associated with updating the immunization Registry, Electronic Lab Reporting of certain results, Syndromic Surveillance, and updating the Cancer and other Registries.

HIE-related work includes supporting the State’s designated HIE organization, VITL, which operates the State’s HIE platform. HIE, the verb, requires that data being exchanged is of sufficient quality to support the valid subsequent use of the data. It is in the area of information management that the realms of HIT and HIE overlap. The information-related work includes intensive data quality sprints involving a team of eHealth specialists from VITL, staff from the Blueprint program, staff from the provider organizations participating in each sprint, and vendor staff and support from the CDR and the HIE Software vendor (Medicity).

The HIT and HIE realms also overlap in our efforts to bring a full continuum providers (Mental Health (MH), Substance Abuse (SA), Long-term and post-acute care (LTPAC) providers, and Home Health) into MU and guaranteeing they are capable of exchanging appropriate data related to patient care. The HIT work for this population includes addressing the gaps in their use of EHR technology that prevent full MU and HIE. The State has performed gap analyses for these populations and is proposing next steps to achieve the desired participation. . For these full continuum providers the SMHP proposes an initial focus on those provider organizations who have Eligible Professionals who can attest for the ENRIP program. The State’s SIM efforts are supporting new pathways for Vermont providers to share information to better serve the public. Since Naturopaths are recognized primary care providers in the State’s Medicaid System, we also desire to address the EHR and HIE gaps that exist in this population as well. Telemedicine has been getting more recognition for its importance to covering full populations for better

health outcomes and Vermont is again proposing to create a coordinated comprehensive plan for the utilization of telemedicine in Vermont, to determine the potential benefits for Medicaid outcomes and administration. Note that Appendix A displays estimates for Provider Incentive Payments.

Milestones to Date:

The SMHP project has continued to progress and the milestones achieved to date include:

- EHRIP has awarded \$28,000,000 during the previous two FFY periods (\$32,000,000 was budgeted in the State’s first SMHP in the Fall of 2011);
- Of those providers who successfully attested for AIU in 2011, 58% have successfully attested for MU in 2012;
- Public Health measures of Immunization Registry messages, Electronic Lab Reporting, and Syndromic Surveillance are now all available for connection to Vermont Department of Health (VDH). Providers must go through an on-boarding process with VDH but they can no longer automatically take an exclusion in their MU attestations;
- EHR gap analyses have been performed for the MH, Home Health, and LTC agencies in Vermont;
- An audit plan for the EHRIP has been submitted and is now approved and is being implemented;
- Several data quality sprints have been conducted resulting in better provider utilization of their EHR systems in conjunction with the CDR, while providing more consistent population data necessary to demonstrate progress with that leg of the triple aim.

Upcoming Milestones and Activity Table:

- Maintain the EHRIP infrastructure (MAPIR) with updates and new versions (See comment under MMIS above; though MAPIR is necessary for the EHRIP it is considered MMIS development);
- Implement the approved audit plan for 2011 AIU attestations, to be followed by 2012 AIU and MU attestations;
- Expand the Data Quality Sprint program to improve provider adoption and MU of their EHR technology while better utilizing the benefits of the Blueprint program, including project management of Blueprint related HIE and MU activity;
- Implement an intensive outreach, education, and coordination program to help providers transition through the states of MU and to better overlay the EHRIP program with the Blueprint program;
- Develop an implementation plan for expanding MU and HIE to the full continuum providers organizations with Eligible Professionals for the EHRIP program;
- Expand HIE through coordinated activities with VITL;
- Implement public health MU measures through coordinated efforts with VDH and VITL, VDH development of necessary technical support, and provider outreach and education;
- Plan for and implement a solution to accept eCQM data from Medicaid providers attesting to MU;
- Maintain and expand the APCD and the CDR as necessary to better support the EHRIP program and eCQM data acquisition;
- Develop requirements for Provider Directory and eMPI solutions to better support the EHRIP and MU (these projects also support other State initiatives, including MMIS);

SMHP Initiatives							
Ref #	Title	Description	Resources	SMHP-HIT	SMHP-HIE	MMIS 90/10	HSE Spread
			S – Staff; C – Consulting / Contracting;				

			X – Funding Streams				
1	EHRIP Program Operations	Develop, operate, administer, and audit the EHRIP program for Vermont.	S, C	X			
2	MAPIR DDI	Design, develop, and implement MAPIR versions and interfaces to MMIS to support EHRIP	C			X	
3	Public Health MU DDI	DDI for modifications to Immunization Registry to support EHRIP MU requirements, Electronic Lab Reporting support for EHRIP MU data submissions, Syndromic Surveillance support for EHRIP MU submissions, and other registries to accept MU data from providers for EHRIP.	S, C	X			
4	Provider Directory DDI	Provider Directory for the enterprise: EHRIP; MMIS (May be combined with eMPI). A Medicaid provider directory will also support the EHRIP program since attesting providers are a subset of the Medicaid provider population.	S, C			X	
5	Enterprise Master Person Index (eMPI) DDI	eMPI reference source of person identification for the enterprise: EHRIP; MMIS; IE (May include Provider Directory). eMPI will also support EHRIP as eCQM data to be captured as part of Meaningful Use Stage 2 is identified at the individual level. Patient matching from a single source of reference is required.	S, C			X	
6	HIE Expansion – VITL <ul style="list-style-type: none"> <li>Refer to Appendix E for additional information on this work</li> </ul>	Initiative activities and components include contracted expansion projects (VITL – includes Public Health MU DDI support in the HIE); combined MU for EHRIP and HIE connectivity practice outreach and education; data quality projects associated with connecting new practices to insure MU for EHRIP while assuring care delivery and coordination outcomes through exchange of accurate ADT and CCD records	S, C		X		
7	HIE Expansion to Full Continuum Providers	DDI solutions to connect full continuum eligible professionals to the HIE for clinical data capture, coordination of care, Meaningful Use including Public Health registry updates, Transitions of care, and more. This expansion development is associated with the provider/practice environment. Work to consist of	C		X		

		planning, outreach and education, gap analysis, and interface development.					
8	All Payer Claims Database (APCD) DDI	Expand the APCD to support EHRIP, including Report development. The MMIS is an insufficient resource for validating the patient volume threshold for EHR incentive payments. Changes proposed for the APCD will provide a tool for validating total encounters for patient volume calculations. The resultant queries that can be supported by this development will also have additional benefits for overall Medicaid administration.	C	X		X	
9	Clinical Data Repository (CDR) DDI	Expand the CDR to support EHRIP for eQCM capture, analysis, and reporting.	S, C	X		X	
10	Medicaid Data Warehouse DDI	Replacement and expansion of the server environment for the DVHA Medicaid Data Warehouse.. Medicaid data in this warehouse is source data for the Medicaid portion of the APCD and is also extracted for HEDIS. This warehouse will be built in SQL Server 2012 on new AHS servers. (Note: This is a current need to replace an out of date server solution. This work is not part of the MMIS replacement project.	C			X	
11	Health Information Analytics Platform (HIAP) DDI	Analytics platform to support predictive and analytical modeling of health information from a variety of sources (CDR; APCD; MMIS; and more) for improved care delivery and cost reduction. This proposal will establish an analytics platform within Vermont to complement the benefits of the T-MSIS. This initiative will provide an analytics solution in support of Medicaid administration and outcomes. Once benefits are demonstrated and it makes sense to expand the solution to other populations an allocated shared funding model will be proposed to support any expansion.	S, C			X	
12	HIT-MU Program Expansion	Strategic Planning and Plan documentation for State HIT Plan and SMHP.	S, C	X			

Timeline

- The SMHP timeline is bursting with activities to expand the accessibility and use of the HSE. Refer to Figure 3.5 “Health Services Enterprise Architecture v7.4” and the ‘pipes’ or ‘interfaces’ are the mechanisms that a significant portion of the SMHP is building. Thus, activities for SMHP occur throughout the HSE effort and therefore run through January, 2017.

SMHP Initiative Timelines by FFY Quarter									
Reference No.	Initiative	FFY14 Oct 1, 2013 – Sep 30, 2014				FFY15 Oct 1, 2014 – Sep 30, 2015			
		1Q14 Dec	2Q14 Mar	3Q14 June	4Q14 Sept	1Q15 Dec	2Q15 Mar	3Q15 June	4Q15 Sept
		P – Plan; R – Requirements; Ds – Design; Dv – Develop; I - Implement							
1	EHRIP Program Operations	I	I	I	I	I	I	I	I
2	MAPIR DDI	Dv; I	Dv; I	I	I	I	I	I	I
3	Public Health MU DDI	Ds	Ds	Dv	Dv	I	I	I	I
4	Provider Directory DDI	P	R	Ds	Dv	Dv	Dv	I	I
5	eMPI DDI	P	P	R	Ds	Dv	Dv	Dv	I
6	HIE Expansion - VITL	DDI	DDI	DDI	DDI	DDI	DDI	DDI	DDI
7	HIE Expansion – Full Continuum Providers	P	R	Ds	Dv	DDI	DDI	DDI	DDI
8	APCD DDI	R	Ds	Dv	Dv	I	I	I	I
9	CDR DDI	R	Ds	Dv	Dv	I	I	I	I
10	MMIS Data Warehouse DDI		R	Ds	Ds	Dv	Dv	Dv	I
11	Analytics Platform DDI		P	R	R	Ds	Dv	Dv	Dv
12	Pharmacy Benefits Management EHR Improvements for Medicaid and Meaningful Uses	P	R	Ds	Dv	Dv	Dv	I	I

Project Problems

- No SMHP project problems to report at this time.

Corrective Action

- No SMHP corrective action plans to report at this time.

## Section 4 – Resource Funding State and Contractor

Vermont has worked with CMS to implement a robust process for ensuring consistent and concise communication regarding Requests for Proposals (RFP) and contract review/approval. Vermont’s HSE has over 130 active contracts/grants/amendments related to all of the work and integration that is taking place for the Enterprise of which almost 50% are Exchange funded only agreements. While an abundance of information is recorded and tracked (the associated spreadsheet is available upon request which contains all the detailed contractual information) only a portion of it is displayed below (Figure 4.1 through Figure 4.4) for the reporting of the procurement impacts on the Enterprise (non-Exchange) activities. The figures below, color coded according to project focus, display each of the work-streams and associated expenses identifying:

- Contract number (if known or else it’s identified as ‘estimate’)
- Vendor name (if known or it’s listed as scope of work)
- Contract start and end dates
- Maximum value of contract
- Current value that will be exercised during this APD period.

For Enterprise Architecture, Business Analyst, and Project Management the State addressed staff augmentation and resource needs using a ‘pool of resources’. This is utilizing multiple vendors who collectively address the State’s needs in these areas. This allows for the State to maximize its ability to select the best candidate possible to meet a particular need. For these ‘Pool Resources’, the State identifies the “Maximum” value of the contracts but they are controlled within the State business agreements to ensure any amendments to any of the contracts do not exceed the ‘pool total’ that is managed by Vermont’s Department of Information and Innovation (DII).

Within the funding tables we have ‘placeholders’ for those new in-progress or future agreements. For some of these there is a funding request for this APD and for others this is an acknowledgement of agreements that are forthcoming.

In Figure 4.1, the State revised line 3 to reflect the following:

- This is continued hosting environments and continued development work for getting the platform fully completed which MMIS and E&E will benefit from and need to fund. The work associated for these work streams and the costs associated with the work are accounted for on a quarterly basis.
- Adjusted the figures after consultation with CMS to provide more current estimated expenses to Exchange, MMIS and IE. The adjustment takes into account:
  - The line item is an overall total of \$7,965,757 and the State used the approved Cost Allocation (HIX-47%, E&E-26.5% and MMIS-26.5%) to determine the costs based on the length of this APD.
  - The State calculated developed anticipated quarterly expenses for HIX, E&E and MMIS based on timelines and milestones for the various work streams
    - So for example, the FFY 2014 request of MMIS is \$307, 237 and not until FFQ4.
- The State will continue to address this in monthly updates and will revisit on the next submission of the APD
- The following table provides a view at the estimated costs for this line item:

	CMS-MMIS	CMS-E&E	CCIIO-Exchange	
QE0314			\$ 1,784,787	QE0314
QE0614	-	\$ 824,129	\$ 1,236,194	QE0614
QE0914	\$ 307,237	\$ 1,030,162	\$ 722,925	QE0914
QE1214	\$ 1,803,689	\$ 256,634	-	QE1214
Source Balance	\$ 2,110,926	\$ 2,110,926	\$ 3,743,906	

**HSE Platform and PMO Contractual (Program Code 41632) - Budget Development Period 1/1/2014 - 12/31/2014**

Contract Number	Vendor - scope	start date	end date	max value	Current HSE-IAPD Budget Value	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	HIE 90/10	CCIO Grant(s)	Non HSE-APD Sources	
Contracted / Known Values as of APD Submission Date						26.5%	26.5%				47.0%		
18928	SOA licenses - Oracle Base, A1, A2 & A3 (A4 100% Exchange)	2/28/2011	2/27/2015	10,252,434	\$ 1,849,759	\$ 490,186	\$ 490,186				\$ 869,387		
23701	Hosting Services - CGI (through 09/30/2013) Environment Establishment	12/17/2012	12/31/2016	10,922,914	\$ 1,540,956	\$ 408,353	\$ 408,353				\$ 724,249		
23701	Hosting Services - CGI (through 12/31/2014) continued hosting DDI "Base Year"	12/17/2012	12/31/2016	7,965,757	\$ 7,965,757	\$ 2,110,926	\$ 2,110,926				\$ 3,743,906		
23701	Hosting Services - CGI (optional years) M&O	12/17/2012	12/31/2016	11,185,041	\$ -	\$ -	\$ -				\$ -		
23701	HBE SI (leverageable applications) - CGI	12/17/2012	12/31/2014	32,136,258	\$ 26,994,458	\$ 7,153,531	\$ 7,153,531				\$ 12,687,395		
22013	Initial SI IV&V, QA, and PMO Professional Services - Gartner	5/16/2012	5/15/2014	2,697,400	\$ 837,500	\$ 221,938	\$ 221,938				\$ 393,625		
22013A3	HSE Health Checks & PMO support - Gartner Amendment 2014	5/16/2012	td	902,000	\$ 902,000	\$ 239,030	\$ 239,030				\$ 423,940		
21256A1	Independent Review "Lessons Learned" - Berry Dunn McNeil & Parker	2/1/2014	4/30/2014	85,185	\$ 85,185	\$ 22,574	\$ 22,574				\$ 40,037		
23384	Procurement/Legal - Mintz Levin Cohn, et al (HBE SI) - Initial Contract with AoA	10/5/2012	9/30/2013	600,000	\$ 39,902	\$ 10,574	\$ 10,574				\$ 18,754		
26195	Procurement/Legal - Mintz Levin Cohn, et al (HBE SI) - 2014 Contract	3/7/2014		300,000	\$ 300,000	\$ 79,500	\$ 79,500				\$ 141,000		
HSE known subtotal						\$ 10,736,612	\$ 10,736,612	\$ -	\$ -	\$ -	\$ 19,042,293	\$ -	
"Pool Resources" Estimates as of APD Submission Date						26.5%	26.5%				47.0%		
see below	Enterprise Architecture Staff Augmentation Pool	MOU with VT DII		3,593,290	\$ 1,969,821	\$ 522,003	\$ 522,003				\$ 925,816		
24365	AdvizeX Technologies, LLC	4/15/2013	4/30/2015	989,802	596,335	\$ 158,029	\$ 158,029				\$ 280,277		
24363	Competitive Computing (C2)	4/15/2013	4/30/2015	534,801	492,396	\$ 130,485	\$ 130,485				\$ 231,426		
24369	Compliance Process Partners (CPP)	4/15/2013	4/30/2015	199,615	123,130	\$ 32,629	\$ 32,629				\$ 57,871		
22681	Oracle America, Inc (Oracle T&M)	7/11/2012	7/10/2014	1,869,072	757,960	\$ 200,859	\$ 200,859				\$ 356,241		
see below	Project Management & Business Analyst Staff Augmentation Pool	MOU with VT DII		2,037,890	\$ 1,422,410	\$ 376,939	\$ 376,939				\$ 668,533		
24332	22nd Century	4/1/2013	12/6/2014	88,400	88,400	\$ 23,426	\$ 23,426				\$ 41,548		
23736	Desai Management Consulting	1/4/2013	1/3/2015	1,377,490	762,010	\$ 201,933	\$ 201,933				\$ 358,145		
23737	Speridian	4/1/2013	12/6/2014	572,000	572,000	\$ 151,580	\$ 151,580				\$ 268,840		
HSE pool subtotal						\$ 898,941	\$ 898,941	\$ -	\$ -	\$ -	\$ 1,594,349	\$ -	
Future Need Estimates as of APD Submission Date						26.5%	26.5%				47.0%		
PLACEHOLD	HBE SI (leverageable applications) - CGI Change Orders - estimated			5,300,000	\$ 5,300,000	\$ 1,404,500	\$ 1,404,500				\$ 2,491,000		
PLACEHOLD	Business Process Re-engineering, Analysis and Change Management			1,500,000	\$ 1,500,000	\$ 397,500	\$ 397,500				\$ 705,000		
PLACEHOLD	Additional Professional Services - estimated			500,000	\$ 500,000	\$ 132,500	\$ 132,500				\$ 235,000		
PLACEHOLD	Procurement/Legal - Mintz Levin Cohn, et al (HBE)			300,000	\$ 300,000	\$ 79,500	\$ 79,500				\$ 141,000		
HSE estimated subtotal						\$ 7,600,000	\$ 7,600,000	\$ -	\$ -	\$ -	\$ 3,572,000	\$ -	
<b>TOTAL HSE PLATFORM &amp; PROGRAM MANAGEMENT OFFICE CONTRACTUAL COSTS</b>						<b>\$ 51,507,748</b>	<b>\$ 13,649,553</b>	<b>\$ 13,649,553</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 24,208,641</b>	<b>\$ -</b>

Figure 4.1

**VHC ACCESS Integration - Contractual (Program Code 37702) Budget Development Period 1/1/2014 - 6/30/2014**

Contract Number	Vendor - scope	start date	end date	max value	Current HSE-IAPD Budget Value	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	HIE 90/10	CCIO Grant(s)	Non HSE-APD Sources	
Contracted / Known Values as of APD Submission Date													
23392A1	ACCESS Integration - Mainframe - Maximus	11/13/2012	12/31/2013	2,898,000	\$ 2,271,837						100%		
	ACCESS Integration Added Scope and Extension - Mainframe - Maximus	1/1/2014	4/30/2014	884,000	\$ 884,000						\$ 2,271,837		
23701A2#3	ACCESS Integration - New System - CGI	5/1/2013	12/31/2014	18,836,650	\$ 15,232,470						\$ 884,000		
											\$ 15,232,470		
					VHC AI known subtotal	\$ 18,388,307	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 18,388,307	\$ -

**VHC E&E - Contractual (Program Code 41609) Budget Development Period 1/1/2014 - 6/30/14**

Contract Number	Vendor - scope	start date	end date	max value	Current HSE-IAPD Budget Value	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	HIE 90/10	CCIO Grant(s)	Non HSE-APD Sources	
Contracted / Known Values as of APD Submission Date													
23392	ACCESS analysis - Maximus	11/13/2012	5/31/2013	427,686	\$ -		53%	53%			47%		
24624	Natural Lanaguage Training - Software AG - PROGRAM CODE 37706	7/22/2013	2/28/2014	74,880	\$ 48,845		\$ -	\$ 25,888			\$ -		
	Adjustment needed to capture prior payment to Software AG at 50/50 funding				\$ -		\$ (13,799)	\$ 13,799			\$ 22,957		
22013	QA, IV&V, Procurement Support - Gartner	5/16/2012	5/15/2014	649,500	\$ -		\$ -				\$ -		
22013A3	Gartner Amendment 2014	5/16/2012	tbd	247,000	\$ 247,000		\$ 130,910				\$ 116,090		
					VHC E&E known subtotal	\$ 295,845	\$ -	\$ 117,111	\$ 39,686	\$ -	\$ -	\$ 139,047	\$ -
"Pool Resources" Estimates as of APD Submission Date													
see below	Project Management & Business Analyst Staff Augmentation Pool	MOU with VT DII		545567.18	\$ 192,047		53%				47%		
24332	22nd Century	4/1/2013	12/6/2014	0	\$ -		\$ 101,785				\$ 90,262		
23736	Desai Management Consulting	1/4/2013	1/3/2015	545,567	\$ 192,047		\$ -				\$ -		
23737	Speridian	4/1/2013	12/6/2014	0	\$ -		\$ 101,785				\$ 90,262		
							\$ -				\$ -		
					VHC E&E pool subtotal	\$ 192,047	\$ -	\$ 101,785	\$ -	\$ -	\$ 90,262	\$ -	
	<b>VHC E&amp;E - Contractual Total</b>					\$ 487,892	\$ -	\$ 218,896	\$ 39,686	\$ -	\$ 229,309	\$ -	

Continued on next page



**MMIS Replacement Contractual (Program Code 41613) - Budget Development Period 1/1/2014 - 9/30/2015**

Contract Number	Vendor - scope	start date	end date	max value	Current HSE-IAPD Budget Value	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	HIE 90/10	CCIO Grant(s)	Non HSE-APD Sources
Contracted / Known Values as of APD Submission Date						100%						
22013A2	Procurement Assistance & MITA SSA 3.0 - Gartner	5/15/2013	5/15/2014	1,440,500	\$ 1,384,500	1,384,500						
					MMIS known subtotal	\$ 1,384,500	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
"Pool Resources" Estimates as of APD Submission Date						100%						
see below	Enterprise Architecture Staff Augmentation Pool	MOU with VT DII		344,401	\$ 344,401	344,401						
24365	AdvizeX Technologies, LLC	4/15/2013	4/30/2015	108,425	\$ 108,425	108,425						
24363	Competitive Computing (C2)	4/15/2013	4/30/2015	78,976	\$ 78,976	78,976						
24369	Compliance Process Partners (CPP)	4/15/2013	4/30/2015	19,189	\$ 19,189	19,189						
22681	Oracle America, Inc (Oracle T&M)	7/11/2012	7/10/2014	137,811	\$ 137,811	137,811						
see below	Project Management & Business Analyst Staff Augmentation Pool	MOU with VT DII		789,997	\$ 519,597	519,597						
24332	22nd Century	4/1/2013	12/6/2014	0	\$ -	0						
23736	Desai Management Consulting	1/4/2013	1/3/2015	789,997	\$ 519,597	519,597						
23737	Speridian	4/1/2013	12/6/2014	0	\$ -	0						
					MMIS pool subtotal	\$ 863,998	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Future Need Estimates as of APD Submission Date						100%						
PLACEHOLD	Pharmacy Benefit Management DDI and transition			2,630,608	\$ 2,113,835	2,113,835						
PLACEHOLD	Care Management DDI and transition			12,600,000	\$ 10,500,000	10,500,000						
PLACEHOLD	Claims and Program Integrity DDI and transition			55,000,000	\$ 27,500,000	27,500,000						
PLACEHOLD	System Integrator? (like GC)			5,500,000	\$ 3,437,500	3,437,500						
PLACEHOLD	IV&V (high level - CMS reporting - validation of milestone and funding)			3,500,000	\$ 1,944,444	1,944,444						
PLACEHOLD	QA - Code Review / TA (Core and Integration) - tbd			2,020,140	\$ 1,010,070	1,010,070						
PLACEHOLD	BPR/Change Management/Legal/Procurement			2,500,000	\$ 1,500,000	1,500,000						
PLACEHOLD	Independent Review(s)			150,000	\$ 150,000	150,000						
					MMIS estimated subtotal	\$ 48,155,849	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL MMIS REPLACEMENT CONTRACTUAL COSTS</b>						<b>\$ 50,404,347</b>	<b>\$ 50,404,347</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Figure 4.3

**EHRIP & SMHP Related Projects (100% HITECH-HIT 90/10) - Contractual (Program Code 41694) Budget Development Period 1/1/2014 - 9/30/2015**

Contract Number	Vendor - scope	start date	end date	max value	Current HSE-IAPD Budget Value	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	HIE 90/10	CCIO Grant(s)	Non HSE-APD Sources
Contracted / Known Values as of APD Submission Date									100%			
25291	Immunization Registry Consulting - CY2014	1/1/2014	12/31/2014	87,000	\$ 87,000				\$ 87,000			
					HITECH known subtotal	\$ -	\$ -	\$ -	\$ 87,000	\$ -	\$ -	\$ -
"Pool Resources" Estimates as of APD Submission Date									100%			
see below	Project Management & Business Analyst Staff Aug	MOU with VT DII		556,860	\$ 535,500				\$ 535,500			
24332	22nd Century	4/1/2013	12/6/2014	0	\$ -				\$ -			
23736	Desai Management Consulting	1/4/2013	1/3/2015	556,860	\$ 535,500				\$ 535,500			
23737	Speridian	4/1/2013	12/6/2014	0	\$ -				\$ -			
					HITECH pool subtotal	\$ -	\$ -	\$ -	\$ 535,500	\$ -	\$ -	\$ -
Future Need Estimates as of APD Submission Date									100%			
PLACEHOLD	DVHA HIE Expansion to Blueprint - tbd			400,000	\$ 400,000				\$ 400,000			
PLACEHOLD	Plan Development (SMHP, SOP, HISP) - tbd			300,000	\$ 300,000				\$ 300,000			
PLACEHOLD	All Payers Claims Database (APCD) Development - tbd			250,000	\$ 250,000				\$ 250,000			
PLACEHOLD	Clinical Data Repository - tbd			250,000	\$ 250,000				\$ 250,000			
PLACEHOLD	Program Audit Consulting - tbd			400,000	\$ 400,000				\$ 400,000			
PLACEHOLD	PH Development Consulting - tbd			100,000	\$ 100,000				\$ 100,000			
PLACEHOLD	Immunization Registry Consulting - tbd			90,000	\$ 67,500				\$ 67,500			
					HITECH estimate subtotal	\$ -	\$ -	\$ -	\$ 1,767,500	\$ -	\$ -	\$ -
Future Need Estimates as of APD Submission Date - Leveraging MMIS Funding									100%			
PLACEHOLD	Telehealth Planning Consulting - tbd (REQUESTING MMIS FUNDING)			200,000	\$ -	\$ -						
PLACEHOLD	e-RX Improvement Program contuling and TA - tbd (REQUESTING MMIS FUNDING)			400,000	\$ -	\$ -						
					VT -SMHP (MMIS FUNDED) subtotal	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
					EHRIP & VT-SMHP Professional Services subtotal	\$ -	\$ -	\$ -	\$ 2,390,000	\$ -	\$ -	\$ -

**Analytics Platform(50%MMIS 90/10;50%HIT 90/10) - Contractual (Program Code 37718) Budget Development Period 1/1/2014 - 9/30/2015**

Contract Number	Vendor - scope	start date	end date	max value	Current HSE-IAPD Budget Value	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	HIE 90/10	CCIO Grant(s)	Non HSE-APD Sources
Future Need Estimates as of APD Submission Date						50%			50%			
PLACEHOLD	Analytics Platform DDI consulting/contracting - tbd			1,000,000	\$ 1,000,000	\$ 500,000			\$ 500,000			
					Analytics estimate subtotal	\$ 500,000	\$ -	\$ -	\$ 500,000	\$ -	\$ -	\$ -

**MAPIR (100%MMIS) - Contractual (Program Code 41637) Budget Development Period 1/1/2014 - 9/30/2015**

Contract Number	Vendor - scope	start date	end date	max value	Current HSE-IAPD Budget Value	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	HIE 90/10	CCIO Grant(s)	Non HSE-APD Sources
Contracted / Known Values as of APD Submission Date						100%						
8430A14	MAPIR Core and Customization - HP			368,093	\$ 286,464	\$ 286,464	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
					MAPIR known subtotal	\$ 286,464	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Future Need Estimates as of APD Submission Date												
PLACEHOLD	MAPIR Core and Customization - tbd			368,093	\$ 368,093	\$ 368,093	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
					MAPIR estimate subtotal	\$ 368,093	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
					MAPIR subtotal	\$ 654,557	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Continued on next page

**Provider Directory DDI (33.34%MMIS; 33.33%E&E; 33.33%HIT) - Contractual (Program Code 41612) Budget Development Period 1/1/2014 - 9/30/2015**

Contract Number	Vendor - scope	start date	end date	max value	Current HSE-IAPD Budget Value	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	HIE 90/10	CCIO Grant(s)	Non HSE-APD Sources
Future Need Estimates as of APD Submission Date						33.34%	33.33%		33.33%			
PLACEHOLD	Provider Directory DDI consulting/contracting - tbd			5,000,000	\$ 5,000,000	\$ 1,667,000	\$ 1,666,500		\$ 1,666,500			
				Provider Directory estimate subtotal	\$ 5,000,000	\$ 1,667,000	\$ 1,666,500	\$ -	\$ 1,666,500	\$ -	\$ -	\$ -

**HIE Expansion - (HIE 90/10) subject to Fair Share calculation - Contractual (Program Code 37704) Budget Development Period 1/1/2014 - 9/30/2015**

Contract Number	Vendor - scope	start date	end date	max value	Current HSE-IAPD Budget Value	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	HIE 90/10	CCIO Grant(s)	Non HSE-APD Sources
Contracted / Known Values as of APD Submission Date										42.59%		57.41%
03410-256-14	Health Information Exchange Grant - VITL (@42.59% FS)			5,157,649	\$ 3,684,044					\$ 1,569,034		\$ 2,115,010
				HIE known subtotal	\$ 3,684,044	\$ -	\$ -	\$ -	\$ -	\$ 1,569,034	\$ -	\$ 2,115,010
Future Need Estimates as of APD Submission Date										81.35%		18.65%
PLACEHOLD	Health Information Exchange Grant - VITL (@81.35% FS)			3,000,000	\$ 3,000,000					\$ 2,440,500		\$ 559,500
PLACEHOLD	Health Information Exchange Grant - VITL (@##.##% FS)			3,000,000	\$ -					\$ -		\$ -
PLACEHOLD	HIE Expansion to Full Consortium Consulting & DDI - tbd - OLD (42%)			with item below	\$ 500,000					\$ 212,950		\$ 287,050
PLACEHOLD	HIE Expansion to Full Consortium Consulting & DDI - tbd - NEW (81%)			1,600,000	\$ 1,100,000					\$ 894,850		\$ 205,150
				HIE estimate subtotal	\$ 4,600,000	\$ -	\$ -	\$ -	\$ -	\$ 3,548,300	\$ -	\$ 1,051,700
				HIE Expansion subtotal	\$ 8,284,044	\$ -	\$ -	\$ -	\$ -	\$ 5,117,334	\$ -	\$ 3,166,710

**TOTAL SMHP RELATED PROJECTS CONTRACTUAL COSTS \$ 17,328,601 \$ 2,821,557 \$ 1,666,500 \$ - \$ 4,556,500 \$ 5,117,334 \$ - \$ 3,166,710**

Figure 4.4



**IE - VHC E&E (MAGI) In-House - Budget Development Period 1/1/2014 - 3/31/2014**

FTEs	Functional Groupings	Blended Rate	Months	Salary Budget	Fringe	Loaded	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	CCIIO Grant(s)
0.50	Project Leadership	\$ 43.45	3	\$ 11,297	\$ 5,262	\$ 16,559					
1.00	IT Enterprise Architects	\$ 33.42	3	\$ 17,378	\$ 8,095	\$ 25,473					
3.00	Business Analysts	\$ 28.94	3	\$ 45,141	\$ 21,027	\$ 66,168					
2.25	Subject Matter Expert - Program Development Management	\$ 39.85	3	\$ 46,625	\$ 21,718	\$ 68,342					
19.50	Subject Matter Expert - Program Development Support	\$ 24.57	3	\$ 249,093	\$ 116,028	\$ 365,121					
26.25	HSEP & PMO Staffing Loaded Salary			\$ 369,534	\$ 172,129	\$ 541,663		\$ 287,081			\$ 254,582
						+					
	In-house Operating Expenses (Supplies, Equipment, etc)					\$ 349,439		\$ 185,203			\$ 164,237
<b>Total IE - VHC E&amp;E (MAGI) In-house Budget (1/1/2014 - 3/31/2014)</b>						<b>\$ 891,103</b>		<b>\$ 472,284</b>			<b>\$ 418,818</b>

**IE - VHC E&E (Exchange Level 1c Grant) In-House - Budget Development Period 1/1/2014 - 12/31/2014**

FTEs	Functional Groupings	Blended Rate	Months	Salary Budget	Fringe	Loaded	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	CCIIO Grant(s)
2.00	Subject Matter Expert - Program Development Support	\$ 23.32	12	\$ 97,011	\$ 45,188	\$ 142,199					
2.00	HSEP & PMO Staffing Loaded Salary			\$ 97,011	\$ 45,188	\$ 142,199		\$ 75,365			\$ 66,834
						+					
	In-house Operating Expenses (Supplies, Equipment, etc)					\$ 99,808		\$ 52,898			\$ 46,910
<b>Total IE - VHC E&amp;E (Level 1c) In-house Budget (1/1/2014 - 12/31/2014)</b>						<b>\$ 242,007</b>		<b>\$ 128,264</b>			<b>\$ 113,743</b>

**IE -VHC E&E Training In-House - Budget Development Period 1/1/2014 - 3/31/2014**

FTEs	Functional Groupings	Blended Rate	Months	Salary Budget	Fringe	Loaded	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	CCIIO Grant(s)
	Staff Training \$28/hr X 20 staff X 10 hours per month	\$ 28.00	1	\$ 5,600	\$ 2,608.48	\$ 8,208					
0.00	HSEP & PMO Staffing Loaded Salary			\$ 5,600	\$ 2,608	\$ 8,208			\$ 8,208		
						+					
	In-house Operating Expenses (Supplies, Equipment, etc)					\$ 3,920			\$ 3,920		
<b>Total IE - VHC E&amp;E Training In-house Budget (1/1/2014 - 3/31/2014)</b>						<b>\$ 12,128</b>		<b>\$ 12,128</b>			

**IE - VHC ACCESS Integration In-House - Budget Development Period 1/1/2014 - 3/30/2014**

FTEs	Functional Groupings	Blended Rate	Months	Salary Budget	Fringe	Loaded	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	CCIIO Grant(s)
1.00	Project Leadership	\$ 33.42	3	\$ 17,378	\$ 8,095	\$ 25,473					
1.00	Project Manager	\$ 33.42	3	\$ 17,378	\$ 8,095	\$ 25,473					
1.00	Business Analysts	\$ 27.75	3	\$ 14,430	\$ 6,721	\$ 21,151					
1.00	Subject Matter Expert - Program Development Support	\$ 24.65	3	\$ 12,818	\$ 5,971	\$ 18,789					
4.00	HSEP & PMO Staffing Loaded Salary			\$ 62,005	\$ 28,882	\$ 90,887					\$ 90,887
						+					
	In-house Operating Expenses (Supplies, Equipment, etc)					\$ 56,853					\$ 56,853
<b>Total IE - VHC ACCESS Integration In-house Budget (1/1/2014 - 4/30/2014)</b>						<b>\$ 147,740</b>					<b>\$ 147,740</b>

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**IE - Integrated Eligibility (Health Care) In-House - Budget Development Period 1/1/2014 - 9/30/2015**

FTEs	Functional Groupings	Blended Rate	Months	Salary Budget	Fringe	Loaded	MMIS 90/10	E&E 90/10	E&E 50/50	HIT 90/10	CCIIO Grant(s)
1.00	Project Leadership	\$ 43.45	21	\$ 158,158	\$ 73,670	\$ 231,828					
1.50	Project Leadership	\$ 36.76	18	\$ 172,052	\$ 80,142	\$ 252,194					
1.00	Project Manager	\$ 33.42	18	\$ 104,270	\$ 48,569	\$ 152,840					
1.00	IT Enterprise Architects	\$ 33.42	18	\$ 104,270	\$ 48,569	\$ 152,840					
2.00	Business Analysts	\$ 27.09	21	\$ 197,215	\$ 91,863	\$ 289,078					
4.00	Enterprise Business Analysts	\$ 28.64	18	\$ 357,427	\$ 166,490	\$ 523,917					
2.25	Subject Matter Expert - Program Development Management	\$ 39.85	18	\$ 279,747	\$ 130,306	\$ 410,053					
20.50	Subject Matter Expert - Program Development Support	\$ 24.57	18	\$ 1,571,466	\$ 731,989	\$ 2,303,455					
33.25	HSEP & PMO Staffing Loaded Salary			\$ 2,944,607	\$ 1,371,598	\$ 4,316,204		\$ 4,316,204			
						+					
	In-house Operating Expenses (Supplies, Equipment, etc)					\$ 2,754,543		\$ 2,754,543			
<b>Total IE - Integrated Eligibility (Health Care) In-house Budget (1/1/2014 - 9/30/2015)</b>						<b>\$ 7,070,748</b>		<b>\$ 7,070,748</b>			

Figure 4.6



The tables below provide information regarding resources in terms of contractual and in-house staff for the building of the HSE. The table reflects the alignment with the CMS-64 and CMS-37 reports and it shows the work broken down by funding source – enabling the State to connect specific work stream tasks and allocate to the appropriate funding source. The first table represents the overall total of the Enterprise budget – further clarity on this table is available in Appendix D. The second and third tables display the Federal and State share respectively.

HSE-IAPD BUDGET PROJECTIONS WITH PRIOR PERIOD ACTUALS, PER QUARTER BY FEDERAL FISCAL YEAR										
CMS 64 & 37 Line	MBES37.1_2A	MBES37.1_2B	MBES37.1_2B	MBES37.1_28A	MBES37.1_28B	MBES37.1_28 D	MBES37.1_28G	MBES37.1_28H	MBES37.1_24C	MBES37.1_24 D
Designation	In-House	Contractual	Contractual	In-House	Contractual	Contractual	In-House	Contractual	In-House	Contractual
CMS Funding Source	MMIS-90/10	MMIS-90/10	MMIS-75/25	E&E-90/10	E&E-90/10	E&E-75/25	E&E-50/50	E&E-50/50	HIT-90/10	HIT-90/10
Federal Fiscal Year 2012 - actuals										
Q1FFY12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Q2FFY12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Q3FFY12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Q4FFY12	\$ 43,401	\$ 129,145	\$ -	\$ 56,552	\$ 129,245	\$ -	\$ -	\$ -	\$ 231,314	\$ 84,482
FFY12 Total	\$ 43,401	\$ 129,145	\$ -	\$ 56,552	\$ 129,245	\$ -	\$ -	\$ -	\$ 231,314	\$ 84,482
Federal Fiscal Year 2013 - actuals										
Q1FFY13	\$ 54,930	\$ 67,109	\$ -	\$ 95,288	\$ 42,200	\$ -	\$ -	\$ -	\$ 296,449	\$ 342,644
Q2FFY13	\$ 68,713	\$ 158,801	\$ -	\$ 119,029	\$ 206,282	\$ -	\$ -	\$ -	\$ 357,678	\$ 992,273
Q3FFY13	\$ 80,201	\$ 1,347,141	\$ -	\$ 160,394	\$ 1,736,683	\$ -	\$ -	\$ -	\$ 331,687	\$ 945,294
Q4FFY13	\$ 120,867	\$ 2,215,874	\$ -	\$ 245,732	\$ 3,958,388	\$ -	\$ -	\$ -	\$ 265,944	\$ 1,041,741
FFY13 Total	\$ 324,711	\$ 3,788,925	\$ -	\$ 620,444	\$ 5,943,552	\$ -	\$ -	\$ -	\$ 1,251,759	\$ 3,321,952
Federal Fiscal Year 2014 - actuals and projections										
Q1FFY14 - actual	\$ 276,935	\$ 698,001	\$ -	\$ 605,489.88	\$ 685,902	\$ -	\$ 12,216	\$ -	\$ 170,730	\$ 500,292
Q2FFY14 - requested	\$ 1,562,531	\$ 4,757,025	\$ -	\$ 1,839,436	\$ 4,227,991	\$ -	\$ 6,428	\$ 39,686	\$ 519,458	\$ 971,667
Q3FFY14 - requested	\$ 1,562,531	\$ 6,160,913	\$ -	\$ 1,367,151	\$ 6,504,032	\$ -	\$ -	\$ -	\$ 519,458	\$ 1,353,667
Q4FFY14 - requested	\$ 1,562,531	\$ 7,353,611	\$ -	\$ 1,367,151	\$ 3,474,197	\$ -	\$ -	\$ -	\$ 519,458	\$ 1,697,605
FFY14 Total	\$ 4,964,529	\$ 18,969,550	\$ -	\$ 5,179,229	\$ 14,892,122	\$ -	\$ 18,644	\$ 39,686	\$ 1,729,104	\$ 4,523,232
Federal Fiscal Year 2015 - projections										
Q1FFY15 - requested	\$ 1,562,531	\$ 14,934,466	\$ -	\$ 1,367,151	\$ 2,830,604	\$ -	\$ -	\$ -	\$ 519,458	\$ 1,547,505
Q2FFY15 - requested	\$ 1,237,553	\$ 11,217,939	\$ -	\$ 1,010,107	\$ 6,067,276	\$ -	\$ -	\$ -	\$ 519,458	\$ 1,548,255
Q3FFY15 - requested	\$ 1,237,553	\$ 11,217,939	\$ -	\$ 1,010,107	\$ 8,187,300	\$ -	\$ -	\$ -	\$ 519,458	\$ 1,548,255
Q4FFY15 - requested	\$ 1,237,553	\$ 11,233,564	\$ -	\$ 1,010,107	\$ 8,914,807	\$ -	\$ -	\$ -	\$ 519,458	\$ 1,006,880
FFY15 Total	\$ 5,275,190	\$ 48,603,908	\$ -	\$ 4,397,472	\$ 25,999,988	\$ -	\$ -	\$ -	\$ 2,077,832	\$ 5,650,895
Federal Fiscal Year 2016 & 2017 - projections										
Future FFYs	\$ 6,187,764	\$ 36,405,635	\$ -	\$ 1,010,107	\$ 8,002,585	\$ -	\$ -	\$ -	\$ -	\$ -
Future FFYs Total	\$ 6,187,764	\$ 36,405,635	\$ -	\$ 1,010,107	\$ 8,002,585	\$ -	\$ -	\$ -	\$ -	\$ -
HSE APD TOTALS										
HSE-IAPD Total	\$ 16,795,595	\$107,897,163	\$ -	\$ 11,263,803	\$ 54,967,491	\$ -	\$ 18,644	\$ 39,686	\$ 5,290,008	\$ 13,580,560

FEDERAL SHARE - HSE-IAPD BUDGET, EFFECTIVE 10/01/2013, PER QUARTER BY FEDERAL FISCAL YEAR										
CMS 64 & 37 Line	MBES37.1_2A	MBES37.1_2B	MBES37.1_2B	MBES37.1_28A	MBES37.1_28B	MBES37.1_28 D	MBES37.1_28G	MBES37.1_28H	MBES37.1_24C	MBES37.1_24 D
Designation	In-House	Contractual	Contractual	In-House	Contractual	Contractual	In-House	Contractual	In-House	Contractual
CMS Funding Source	MMIS-90/10	MMIS-90/10	MMIS-75/25	E&E-90/10	E&E-90/10	E&E-75/25	E&E-50/50	E&E-50/50	HIT-90/10	HIT-90/10
Federal Fiscal Year 2012										
Q1FFY12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Q2FFY12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Q3FFY12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Q4FFY12	\$ 39,061	\$ 116,231	\$ -	\$ 50,897	\$ 116,320	\$ -	\$ -	\$ -	\$ 208,183	\$ 76,034
FFY12 Total	\$ 39,061	\$ 116,231	\$ -	\$ 50,897	\$ 116,320	\$ -	\$ -	\$ -	\$ 208,183	\$ 76,034
Federal Fiscal Year 2013										
Q1FFY13	\$ 49,437	\$ 60,399	\$ -	\$ 85,759	\$ 37,980	\$ -	\$ -	\$ -	\$ 266,804	\$ 308,380
Q2FFY13	\$ 61,842	\$ 142,921	\$ -	\$ 107,126	\$ 185,654	\$ -	\$ -	\$ -	\$ 321,910	\$ 893,046
Q3FFY13	\$ 72,181	\$ 1,212,427	\$ -	\$ 144,355	\$ 1,563,015	\$ -	\$ -	\$ -	\$ 298,519	\$ 850,765
Q4FFY13	\$ 108,780	\$ 1,994,286	\$ -	\$ 221,159	\$ 3,562,549	\$ -	\$ -	\$ -	\$ 239,350	\$ 937,567
FFY13 Total	\$ 292,240	\$ 3,410,033	\$ -	\$ 558,399	\$ 5,349,197	\$ -	\$ -	\$ -	\$ 1,126,583	\$ 2,989,757
Federal Fiscal Year 2014										
Q1FFY14	\$ 249,241	\$ 628,201	\$ -	\$ 544,941	\$ 617,312	\$ -	\$ 6,108	\$ -	\$ 153,657	\$ 450,263
Q2FFY14	\$ 1,406,278	\$ 4,281,322	\$ -	\$ 1,655,492	\$ 3,805,192	\$ -	\$ 3,214	\$ 19,843	\$ 467,512	\$ 874,500
Q3FFY14	\$ 1,406,278	\$ 5,544,822	\$ -	\$ 1,230,436	\$ 5,853,629	\$ -	\$ -	\$ -	\$ 467,512	\$ 1,218,300
Q4FFY14	\$ 1,406,278	\$ 6,618,250	\$ -	\$ 1,230,436	\$ 3,126,777	\$ -	\$ -	\$ -	\$ 467,512	\$ 1,527,845
FFY14 Total	\$ 4,468,076	\$ 17,072,595	\$ -	\$ 4,661,306	\$ 13,402,909	\$ -	\$ 9,322	\$ 19,843	\$ 1,556,193	\$ 4,070,908
Federal Fiscal Year 2015										
Q1FFY15	\$ 1,406,278	\$ 13,441,019	\$ -	\$ 1,230,436	\$ 2,547,544	\$ -	\$ -	\$ -	\$ 467,512	\$ 1,392,755
Q2FFY15	\$ 1,113,797	\$ 10,096,145	\$ -	\$ 909,096	\$ 5,460,549	\$ -	\$ -	\$ -	\$ 467,512	\$ 1,393,430
Q3FFY15	\$ 1,113,797	\$ 10,096,145	\$ -	\$ 909,096	\$ 7,368,570	\$ -	\$ -	\$ -	\$ 467,512	\$ 1,393,430
Q4FFY15	\$ 1,113,797	\$ 10,110,208	\$ -	\$ 909,096	\$ 8,023,327	\$ -	\$ -	\$ -	\$ 467,512	\$ 906,192
FFY15 Total	\$ 4,747,671	\$ 43,743,517	\$ -	\$ 3,957,725	\$ 23,399,989	\$ -	\$ -	\$ -	\$ 1,870,049	\$ 5,085,806
Federal Fiscal Year 2016 & 2017 - projections										
Future FFYs	\$ 5,568,987	\$ 32,765,071	\$ -	\$ 909,096	\$ 7,202,327	\$ -	\$ -	\$ -	\$ -	\$ -
Future FFYs Total	\$ 5,568,987	\$ 32,765,071	\$ -	\$ 909,096	\$ 7,202,327	\$ -	\$ -	\$ -	\$ -	\$ -
HSE APD TOTALS										
HSE-IAPD Total	\$ 15,116,035	\$ 97,107,447	\$ -	\$ 10,137,423	\$ 49,470,742	\$ -	\$ 9,322	\$ 19,843	\$ 4,761,008	\$ 12,222,504

STATE SHARE - HSE-IAPD BUDGET, EFFECTIVE 10/01/2013, PER QUARTER BY FEDERAL FISCAL YEAR										
CMS 64 & 37 Line	MBES37.1_2A	MBES37.1_2B	MBES37.1_2B	MBES37.1_28A	MBES37.1_28B	MBES37.1_28 D	MBES37.1_28G	MBES37.1_28H	MBES37.1_24C	MBES37.1_24 D
Designation	In-House	Contractual	Contractual	In-House	Contractual	Contractual	In-House	Contractual	In-House	Contractual
CMS Funding Source	MMIS-90/10	MMIS-90/10	MMIS-75/25	E&E-90/10	E&E-90/10	E&E-75/25	E&E-50/50	E&E-50/50	HIT-90/10	HIT-90/10
Federal Fiscal Year 2012										
Q1FFY12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Q2FFY12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Q3FFY12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Q4FFY12	\$ 4,340	\$ 12,915	\$ -	\$ 5,655	\$ 12,924	\$ -	\$ -	\$ -	\$ 23,131	\$ 8,448
FFY12 Total	\$ 4,340	\$ 12,915	\$ -	\$ 5,655	\$ 12,924	\$ -	\$ -	\$ -	\$ 23,131	\$ 8,448
Federal Fiscal Year 2013										
Q1FFY13	\$ 5,493	\$ 6,711	\$ -	\$ 9,529	\$ 4,220	\$ -	\$ -	\$ -	\$ 29,645	\$ 34,264
Q2FFY13	\$ 6,871	\$ 15,880	\$ -	\$ 11,903	\$ 20,628	\$ -	\$ -	\$ -	\$ 35,768	\$ 99,227
Q3FFY13	\$ 8,020	\$ 134,714	\$ -	\$ 16,039	\$ 173,668	\$ -	\$ -	\$ -	\$ 33,169	\$ 94,529
Q4FFY13	\$ 12,087	\$ 221,587	\$ -	\$ 24,573	\$ 395,839	\$ -	\$ -	\$ -	\$ 26,594	\$ 104,174
FFY13 Total	\$ 32,471	\$ 378,893	\$ -	\$ 62,044	\$ 594,355	\$ -	\$ -	\$ -	\$ 125,176	\$ 332,195
Federal Fiscal Year 2014										
Q1FFY14	\$ 27,693	\$ 69,800	\$ -	\$ 60,549	\$ 68,590	\$ -	\$ 6,108	\$ -	\$ 17,073	\$ 50,029
Q2FFY14	\$ 156,253	\$ 475,702	\$ -	\$ 183,944	\$ 422,799	\$ -	\$ 3,214	\$ 19,843	\$ 51,946	\$ 97,167
Q3FFY14	\$ 156,253	\$ 616,091	\$ -	\$ 136,715	\$ 650,403	\$ -	\$ -	\$ -	\$ 51,946	\$ 135,367
Q4FFY14	\$ 156,253	\$ 735,361	\$ -	\$ 136,715	\$ 347,420	\$ -	\$ -	\$ -	\$ 51,946	\$ 169,761
FFY14 Total	\$ 496,453	\$ 1,896,955	\$ -	\$ 517,923	\$ 1,489,212	\$ -	\$ 9,322	\$ 19,843	\$ 172,910	\$ 452,323
Federal Fiscal Year 2015										
Q1FFY15	\$ 156,253	\$ 1,493,447	\$ -	\$ 136,715	\$ 283,060	\$ -	\$ -	\$ -	\$ 51,946	\$ 154,751
Q2FFY15	\$ 123,755	\$ 1,121,794	\$ -	\$ 101,011	\$ 606,728	\$ -	\$ -	\$ -	\$ 51,946	\$ 154,826
Q3FFY15	\$ 123,755	\$ 1,121,794	\$ -	\$ 101,011	\$ 818,730	\$ -	\$ -	\$ -	\$ 51,946	\$ 154,826
Q4FFY15	\$ 123,755	\$ 1,123,356	\$ -	\$ 101,011	\$ 891,481	\$ -	\$ -	\$ -	\$ 51,946	\$ 100,688
FFY15 Total	\$ 527,519	\$ 4,860,391	\$ -	\$ 439,747	\$ 2,599,999	\$ -	\$ -	\$ -	\$ 207,783	\$ 565,090
Federal Fiscal Year 2016 & 2017 - projections										
Future FFYs	\$ 618,776	\$ 3,640,563	\$ -	\$ 101,011	\$ 800,259	\$ -	\$ -	\$ -	\$ -	\$ -
Future FFYs Total	\$ 618,776	\$ 3,640,563	\$ -	\$ 101,011	\$ 800,259	\$ -	\$ -	\$ -	\$ -	\$ -
HSE APD TOTALS										
HSE-IAPD Total	\$ 1,679,559	\$ 10,789,716	\$ -	\$ 1,126,380	\$ 5,496,749	\$ -	\$ 9,322	\$ 19,843	\$ 529,001	\$ 1,358,056

## Section 5 - Proposed Activity Schedule

The Section 5 – “Proposed Activity Schedule” is laid out below for each of the major work streams. There is additional information in Section 3 “Needs and Objectives” for each of the work streams.

### HSEP Proposed Activity Schedule

Project/Program Schedule	Start Date	Expected Finish Date
<b>Administer HSEP Program</b>		
Complete 6 Cloud environments (Dev, Test, Staging, Training, Production, Disaster Recover)	5/01/2013	09/04/2013
Non-functional testing complete	08/14/2013	09/15/2013
Authority to Operate/Go Live	10/01/2013	10/01/2013
Release 2 (Access Remediation incorporation)	10/02/2013	01/01/2014
Release 3 (Round 1 of Integrated Eligibility scope)	08/30/2013	07/01/2014
MMIS and beyond	1/1/2014	12/31/2016

### HIX/VHC Proposed Activity Schedule

Project Schedule	Start Date	Finish Date
<b>Information Technology Development</b>		
Production Environment Complete	5/29/13	8/24/13
Health Benefit Exchange Go Live	12/1/12	10/1/13
Help Desk Functions Start	10/1/2013	Ongoing
System Status Reporting	10/1/2013	Ongoing
<b>Outreach &amp; Education</b>		
Collateral Materials Complete & Printed	4/10/13	8/29/13
Launch Press Event	5/31/13	10/1/13
Online Content Complete	7/29/13	8/13/13
Assisters Training Complete	3/8/13	8/26/13

### E&E Proposed Activity Schedule

Project/Program Schedule	Expected Finish Date
Contract finalization for IE (healthcare and non-healthcare)	Q4, 2014
DDI for Healthcare	Q2, 2014
Healthcare programs go-live	Q4, 2015 (phased)
Requirements Validation for Non-Healthcare*	Q2, 2015
Solution Design for Non-Healthcare	Q2, 2015
DDI for Non-Healthcare	Q3, 2015
Non-Healthcare go-live	Q4, 2015

MMIS Proposed Activity Schedule

Project/Program Schedule	Release RFP	Sign Contract/DDI Start	Go Live
<b>Management of Vermont MMIS Procurement</b>			
Pharmacy Benefit Management	12/16/2013	5/1/2014	1/1/2015
Care Management (VCCI)	2/24/2014	09/01/2014	1/1/2015
Care Management (Medicaid funded programs after VCCI)	2/24/2014	09/01/2014	After VCCI – but all programs on boarded before end of 2017
Core Operations	4/14/2014	11/14/2014	1/1/2017

SMHP Proposed Activity Schedule

Project/Program Schedule	Start Date	Expected Finish Date
<b>HITECH Expansion – EHRIP, MU, eCQM, PD, eMPI, data and analytics, and related:</b>		
Maintain EHRIP infrastructure (MAPIR) with updates and new versions	10/01/2013	09/30/2021
Implement the approved audit plan for 2011 AIU attestations, to be followed by 2012 AIU and MU attestations	10/01/2013	09/30/2022
Expand the Data Quality Sprint program to improve provider adoption and MU of EHR technology while better utilizing the benefits of the Blueprint program (goals for sprints determined annually; SFY14 goal is 25 sprints)	10/01/2013	09/30/2014
Implement an intensive outreach, education, and coordination program to help providers transition through the states of MU and to better overlay the EHRIP program with the Blueprint program <ul style="list-style-type: none"> <li>Develop the program</li> <li>Implement the program</li> </ul>	10/01/2013 01/01/2013	12/31/2013 09/30/2019
Develop an implementation plan for expanding MU and HIE to full continuum providers <ul style="list-style-type: none"> <li>Develop the plan</li> <li>Implement Full continuum Program</li> </ul>	10/01/2013 01/01/2013	12/31/2013 09/30/2015
Expand HIE through coordinated activities with VITL <ul style="list-style-type: none"> <li>Execute the SFY14 VITL Agreement</li> <li>Develop and negotiate SFY15 Statement of Work</li> <li>Execute the SFY15 VITL Agreement</li> </ul>	10/01/2013 01/01/2014 10/01/2014	09/30/2014 05/01/2014 09/30/2015
Implement public health MU measures through coordinated efforts with VDH and VITL, VDH development of necessary technical support, and provider outreach and education	10/01/2013	12/31/2015
Plan for and implement a solution to accept eCQM data from Medicaid providers attesting to MU <ul style="list-style-type: none"> <li>Design the data solution for eCQM data</li> <li>Develop the data solution for eCQM data</li> <li>Implement the solution for eCQM data</li> </ul>	10/01/2013 01/01/2014 07/01/2014	12/31/2013 06/30/2014 09/30/2014
Maintain and expand the APCD and the CDR as necessary to better support the EHRIP program and eCQM data acquisition <ul style="list-style-type: none"> <li>Determine EHRIP, eCQM, and MU requirements for each of these databases</li> <li>Determine requirements for analytics framework and platform to support utilization of data from these systems</li> <li>Procure vendor contracts for expansion development and support of these databases</li> <li>Procure vendor contract for analytics platform implementation and</li> </ul>	10/1/2013	09/30/2014

Project/Program Schedule	Start Date	Expected Finish Date
support <ul style="list-style-type: none"> <li>• Implement database expansions and the analytics platform</li> </ul>		
Develop requirements for Provider Directory and eMPI solutions to better support the EHRIP and MU (these projects also support other State initiatives, including IE and MMIS)	12/1/2013	09/30/2014
Develop a comprehensive and coordinated Telemedicine program for the State <ul style="list-style-type: none"> <li>• Develop contract requirements to engage consulting assistance to develop the Telemedicine plan</li> <li>• Procure consulting assistance</li> <li>• Develop the Telemedicine Plan</li> </ul>	10/01/2013 01/01/2014 04/01/2014	12/31/2013 03/31/2014 09/30/2014

## Section 6 – Proposed Budget

1. There is a summary view in Section 2 of this APD that provides information regarding the HSE APD proposed budget. There is a **very** detailed spreadsheet available that provides a deeper dive into the granular details of what's behind the summary budget figures. For the complete budget spreadsheet, contact [Joe Liscinsky](#) or [Shawn Benham](#).

## Section 7 – Assurances, Security and Interfaces

Vermont assures that it is meeting or exceeding all Federal regulations outlined in Code of Federal Regulations (CFRs), CMS' Seven Standards and Conditions, CMS' Medicaid Information Technology Architecture (MITA) standards, and/or State Medicaid Manual (SMM) citations for this project.

The security and interface requirements pertaining to this IAPD are the same as they were for previous Vermont APDs that have been approved already by CMS. Vermont will build interfaces and security protocols for AHS systems following accepted National and Industry standards to ensure that Health Enterprise interactions exhibit data being stored and transmitted in a secure, timely and responsive manner.

## Appendix A – Estimates of Provider Incentive Payments

The following table presents our estimates of provider incentive payments broken out by FFY quarter, in thousands of dollars. These are current estimates and we expect revised future estimates to be strongly influenced by ongoing results of our EHRIP.

Category	FFY 2014				FFY 2015				Total
	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	
Eligible Professional	\$812	\$5,120	\$1,378	\$1,378	\$880	\$3,814	\$153	\$153	\$13,688
Eligible Hospital	\$1,350	\$1,350	\$1,350	\$1,350	\$200	\$200	\$200	\$200	\$6,200
<b>Total</b>	<b>\$2,162</b>	<b>\$6,470</b>	<b>\$2,728</b>	<b>\$2,728</b>	<b>\$1,080</b>	<b>\$4,014</b>	<b>\$353</b>	<b>\$353</b>	<b>\$19,888</b>

These estimates are based on a variety of data source considerations, including our awareness of EHR adoption rates in the provider community, indications of readiness to attest and/or continue on to Meaningful Use by a growing number of providers, direct contact with certain Vermont hospitals, and our subsequent projections. Hospital estimates take into account the 50% incentive amount in year 1 of Vermont’s payout model, followed by a 40% payout in the second year. The table above reflects years 3 and 4 of the program, with most hospitals attesting for their third and final payment of 10%. We project a surge of attestations for eligible professionals following the end of the calendar year, when these providers will be submitting full year reporting of EHR data for their Meaningful Use measures. Currently there is a 60-day grace period for these subsequent year attestations although our SMHP proposes a 180-day grace period to better manage this surge.

# Appendix B – Cost Allocation History for Health Services Enterprise (HSE)

NOTE: 'C' refers to contract, 'S' refers to staff and the number represents the internal code Vermont uses for direct reporting of time and cost for tracking and monitoring of budget. This list does not include all contracts but does represent some of the significant ones during a certain timeframe.

HEALTH SERVICES ENTERPRISE (HSE) COST ALLOCATION HISTORY						
HSE Platform & HSE PMO	Vermont Health Connect	Integrated Eligibility	MMIS Replacement	SMHP Projects	Contracts	Other Details
Prior to July 1, 2012 - Stand-alone project designs, independent funding approach						
"SOA APD" 41618 - S 41632 - C 100% MMIS 90/10	"CCIO Exchange Planning Grant" 41619 100% HIX Planning  January 1, 2012 - CCIO Exchange Establishment Grant Level 1 "CCIO Exchange Establishment Grant" 41696 - S&C 100 HIX Level 1	"VIEWS APD" 41607 100% E&E 90/10	"MES PAPP" S - 41499 C - 41520 100% MMIS 90/10		Accenture Oracle - Lisc OnPoint Maximus - Call Ctr PHPG Wakely Gartner	Infrastructure Components APD (MMIS)  Impact of Tropical Storm Irene
July 1, 2012 - Effective Start Date of HSE-IAPDv1.0 ("JUMBO"), HSE ALLOCATION V1						
"Core Components & Shared Services" 41618 - S 41632 - C 12.97% MMIS 90/10 12.98% E&E 90/10 74.05% HIX	"Health Insurance Exchange" 41696 - S 41760 - C 100% HIX Level 1	"Health Care Eligibility & Enrollment" 41607 - S 41609 - C 25.95% E&E 90/10 74.05% HIX Level 1	"Medicaid Enterprise Solution" 41642 - S 41613 - C 100% MMIS 90/10	EHRIP/MU/IZ 41693 - S 41694 - C 100% HIT 90/10		Jumbo APD (HSE APD v1.0)  Timing impact of HBE vendor onboarding and releasing of original IE RFP  Shift in 'hosting' strategy and increase in EA needs
"Provider Directory" 41634 - S 41612 - C 8.65% MMIS 90/10 8.65% E&E 90/10 8.65% HIT 90/10 74.05% HIX L1 IT				HIE Expansion 41694 - C 100% HIE 90/10 (after 42.59% "Fair Share" statistic applied)  MAPIR 41637 - C 100% HIT 90/10	HES Oracle T&M Desai Mintz, Levin	
October 1, 2012 - Effective Incorporation of CCIO Exchange Establishment Grant Level 2 & Exchange IT Specific Allocation						
"Core Components & Shared Services" 41618 - S 41632 - C 12.97% MMIS 90/10 12.98% E&E 90/10 74.05% HBE L1 IT --> 74.05% HBE L2 IT	"Health Insurance Exchange" Level 1 41696 - S Non IT 41760 - C Non IT 100% HBE L1 Non IT --> 100% HBE L2 Non IT  41702 - C IT 17.8% E&E 90/10 82.2% HBE L1 IT	"Health Insurance Exchange" Level 2 41704 - S Non IT 41706 - C Non IT Non IT  41701 - S IT 41705 - C IT 17.8% E&E 90/10 82.2% HBE L2 IT	"Health Care Eligibility & Enrollment" 41607 - S 41609 - C 25.95% E&E 90/10 74.05% HBE L2 IT	"Medicaid Enterprise Solution" 41642 - S 41613 - C 100% MMIS 90/10	EHRIP/MU/IZ 41693 - S 41694 - C 100% HIT 90/10	
April 1, 2013 - CCIO Exchange Establishment Grant Level 1b						
"Provider Directory" 41634 - S 41612 - C 8.65% MMIS 90/10 8.65% E&E 90/10 8.65% HIT 90/10 74.05% HIX		"Health Insurance Exchange" Level 1b 41768 - S 100% HBE L1b  41769 - C 100% GC Waiver  41770 - C 25.95% GC Waiver 74.05% HBE L1b			HIE Expansion 41694 - C 100% HIE 90/10 (after 42.59% "Fair Share" statistic applied)	Maximus (DCF) 22nd Century Sperridian CGI Ballit AdvizeX C2 HMC Deloitte Tuck Navigators
July 1, 2013 Introduction of VHC Access Integration; Consolidation of VHC IT Specific Allocation						
Level 1a Grant exhausted - FIFO - all staff and existing contracts now funded by Level 2	"Health Insurance Exchange" Level 2 41704 - S Non IT 41706 - C Non IT 100% VHC L2 Non IT  41701 - S IT 41705 - C IT 100% VHC L2 IT		Call Center Development, Premium Processing Development, and VHC ACCESS Integration determined to be "but for" the Exchange, costs charged 100% VHC - Remaining "IE" desiganted to be either VHC E&E (MAGI Medicaid) or IE (Non MAGI Health Care)		MAPIR 41637 - C 100% HIT 90/10	

October 1, 2013 - Effective Start Date of HSE-IAPDv2.0, HSE ALLOCATION V2, CCIIO Establishment Budgets Fully Alligned to APD, Effective Acceptance of Level 1c

<p>"Core Components &amp; Shared Services"</p> <p>41618 - S 41632 - C 26.5% MMIS 90/10 26.5% E&amp;E 90/10 47% VHC L2 IT</p>	<p>"Core Components &amp; Shared Services"</p> <p>w/ L1c 41761 - S 26.5% MMIS 90/10 26.5% E&amp;E 90/10 47% VHC L1c IT</p>		<p>"Health Insurance Exchange" Level 2</p> <p>41704 - S Non IT 41706 - C Non IT 100% VHC L2 Non IT</p> <p>41701 - S IT 41705 - C IT 100% VHC L2 IT</p>	<p>"Health Insurance Exchange" Level 1b</p> <p>41768 - S 100% VHC L1b</p> <p>41769 - C 100% GC Waiver</p> <p>41770 - C 25.95% GC Waiver 74.05% VHC L1b</p>	<p>"Health Insurance Exchange" Level 1c</p> <p>41763 - S Non IT 41764 - C Non IT 100% VHC L1c Non IT</p> <p>37703 - S IT 37702 - C IT 100% VHC L1c IT</p>	<p>"VHC Access Integration"</p> <p>41701 - S IT (VHC AI) 100% VHC L2 IT</p> <p>37702 - C IT (VHC AI) 100% VHC L1c IT</p>	<p>"VHC Eligibility &amp; Enrollment - QHP/MAGI"</p> <p>41607 - S 41609 - C 53% E&amp;E 90/10 47% VHC L2 IT</p>	<p>"VHC Eligibility &amp; Enrollment QHP/MAGI" w/ L1c</p> <p>37708 - S 41762 - C 53% E&amp;E 90/10 47% VHC L1c IT</p>	<p>"MMIS Replacement"</p> <p>41642 - S 41613 - C 100% MMIS 90/10</p>	<p>EHRIP/MU/IZ</p> <p>41693 - S 41694 - C 100% HIT 90/10</p>		
	<p>"Provider Directory"</p> <p>41634 - S 41612 - C 33.33% MMIS 90/10 33.34% E&amp;E 90/10 33.33% HIT 90/10</p>						<p>"VHC Eligibility &amp; Enrollment Training"</p> <p>37707 - S 37706 - C 53% E&amp;E 50/50 47% VHC L2 IT</p>			<p>"HIE Expansion"</p> <p>37704 - C 42.59% HIE 90/10 57.41% VT HIT Fund</p>		<p>Vermont Health Connect (VHC) LIVE!</p> <p>MMIS RFPs underway</p> <p>IE RFP cancelled and rewritten</p>
							<p>Integrated eligibility health care (Non MAGI)"</p> <p>37717 - S 37716 - C 100% E&amp;E 90/10</p>			<p>MAPIR</p> <p>41637 - C 100% HIT 90/10</p>		
<p>January 1, 2014 SOA Software guidance</p> <p>"SOA Software with 75/25"</p> <p>37719 - C 26.5% MMIS 75/25 26.5% E&amp;E 75/25 47% VHC L2 IT</p>										<p>Analytics Platform DDI</p> <p>37718 - C 50% MMIS 90/10 50% HIT 90/10</p>		
<p>Future State of Allocation - VHC operations, PMO development, SMHP clarification, IE Non Health Care</p>												

## Appendix C – Organizational Views of Vermont and the HSE

The following five diagrams depict organizational views of how the Health Services Enterprise (HSE) is structured and governed. These diagrams are followed up by an organizational view of the Governor’s Office and identification of the Agency of Human Services (AHS). There’s also a representation of the Agency of Human Services (AHS) and of the Department of Vermont Health Access (DVHA) due to their significant responsibilities associated with the HSE and the relationships with our Federal Partners.



# Health Services Enterprise (HSE) Organizational and Responsibility Structure

**Health Services Enterprise Executive Committee**

**Health Services Enterprise Operations Steering Committee**

**Medicaid  
Management  
Information  
Systems  
(MMIS)**

**Vermont  
Health  
Connect  
(VHC)**

**Integrated  
Eligibility  
(IE)**

**Health  
Services  
Enterprise  
Platform  
(HSE Platform)**

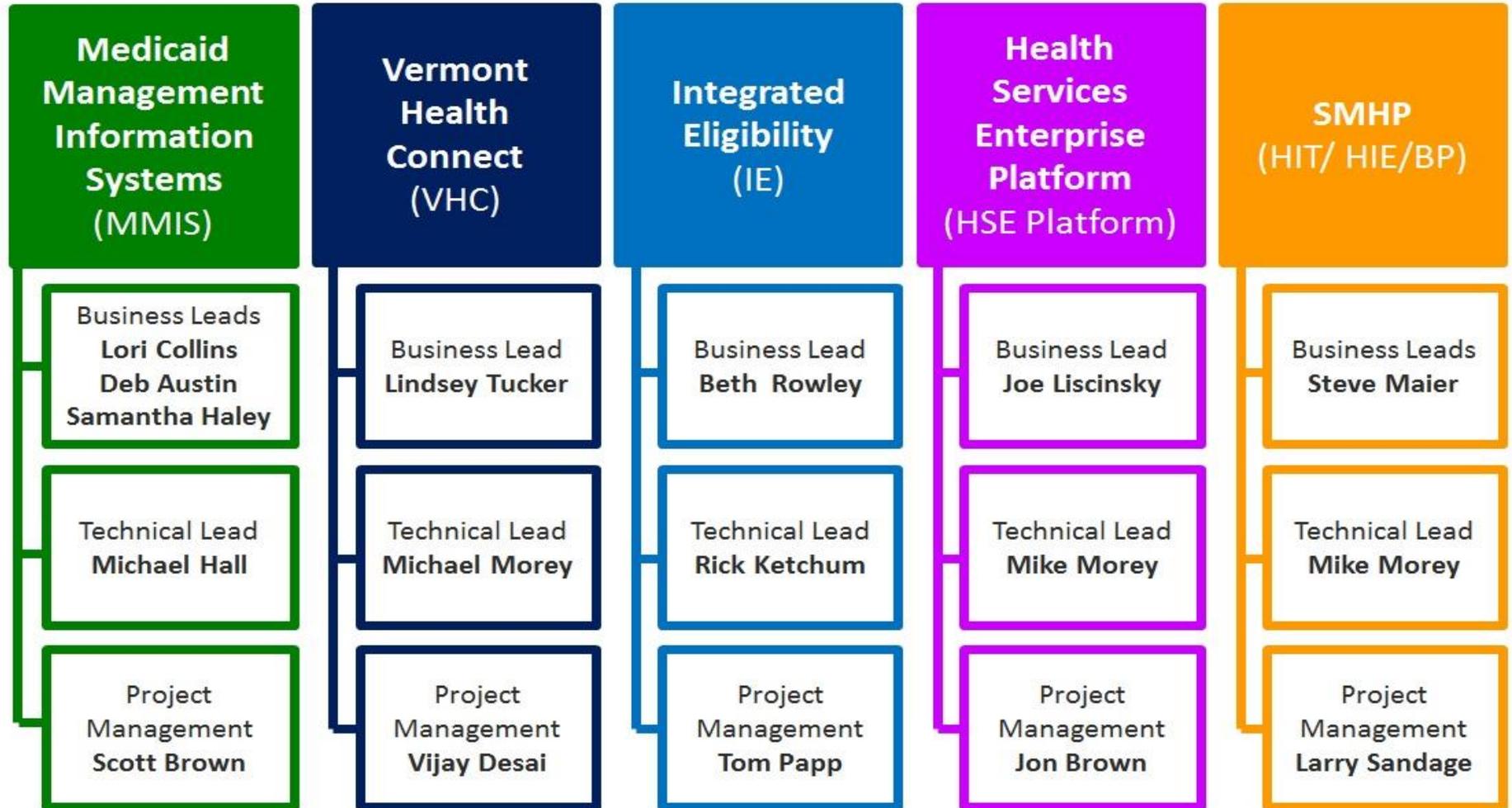
**SMHP  
(HIT/ HIE/BP)**

# HSE Organizational and Responsibility Structure

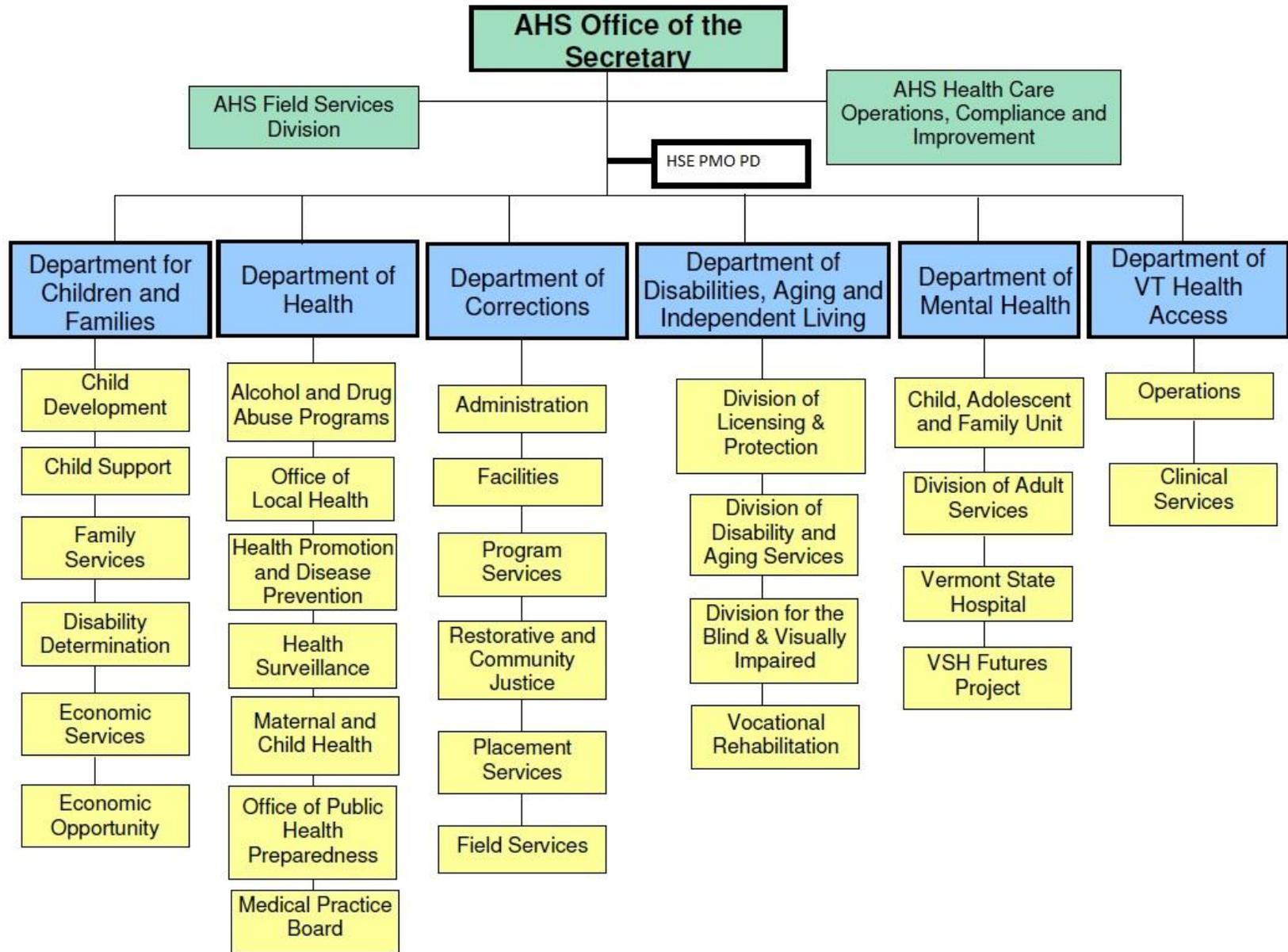
Health Services Enterprise Executive Committee										
Robin Lunge Director of Health Reform	Doug Racine Secretary, AHS	Mark Larson Commissioner, DVHA	David Yacovone Commissioner, DCF	Jim Reardon Commissioner, Finance & Mgmt	Richard Boes Commissioner, DII	Jeb Spaulding Secretary, Agency of Administration	Liz Miller Chief of Staff, Governor's Office			
Enterprise Operations Committee										
Lindsey Tucker DVHA	Lori Collins DVHA	Joe Liscinsky DVHA	Paul Pratt AHS PMO	Beth Rowley DCF	Darin Prail AHS CO	Jim Giffin AHS CO	Tom Jenny DII PMO	Mike Morey DII	Stephanie Beck HSE PMO Program Director	Steve Maier DVHA

# Team Roles and Responsibilities

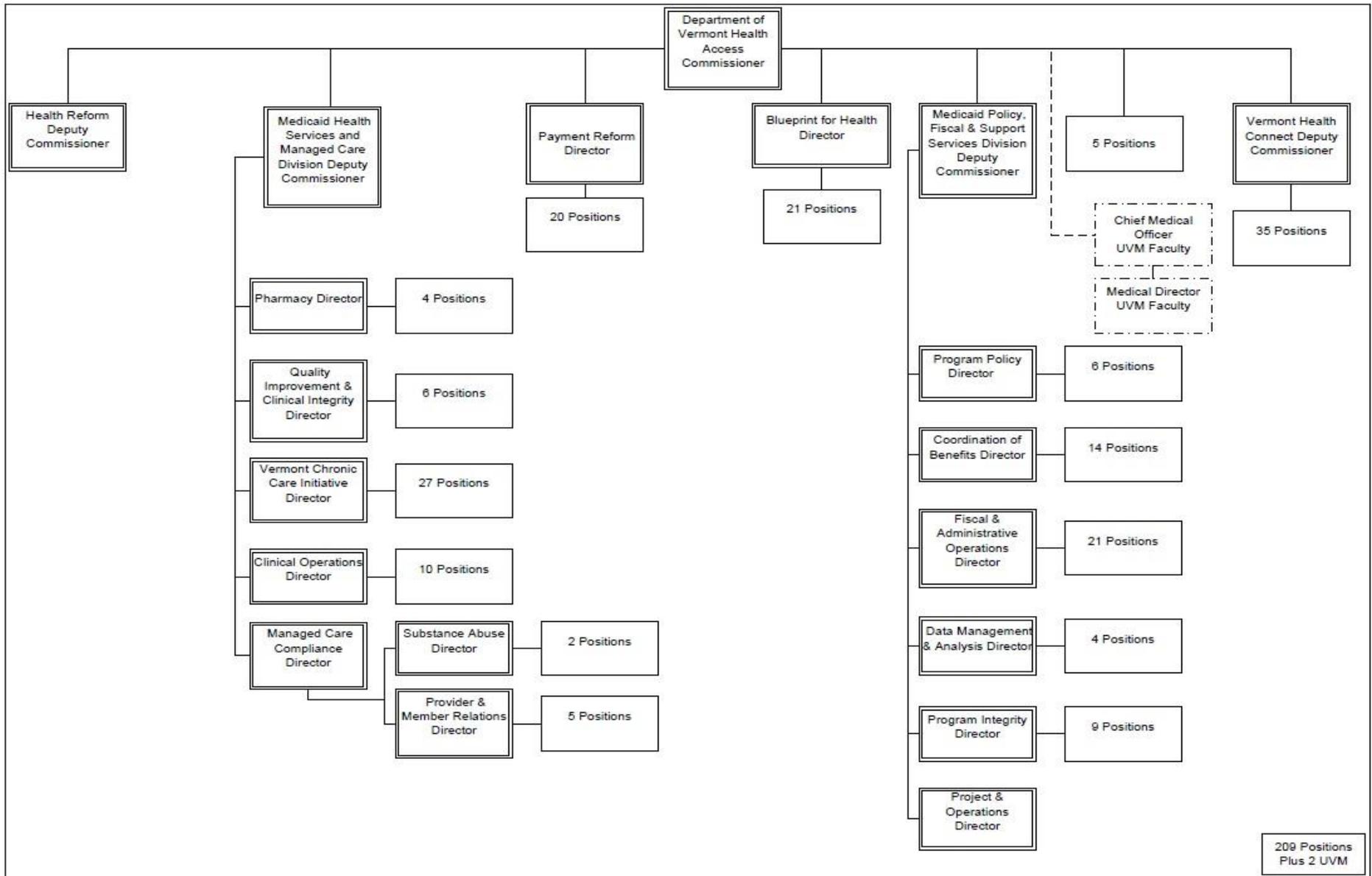
**Program Director: Stephanie Beck**



# Agency of Human Services



# Department of Vermont Health Access



## Appendix D – CMS 37 and 64 Reporting Clarity

- This table is the gross view of budget figures as reported/documentated on the CMS37 and CMS64 reports
- The blue box  represents the total enterprise budget for FFYs 2014 and 2015 and it includes:
  - Q1FFY14 ‘actual’ costs, and
  - Requested “ask” costs for the remaining 3 quarters of FFY2014 and all of FFY2015
- The yellow box  represents the MMIS portion of the ask for HSE APD v2.5 (10/1/2013-9/30/2015)
  - Our expectation is that the approval letter for example would say “MMIS staffing for FFY2014 is \$4.9M and MMIS contract for FFY2014 is \$20.3M” and “MMIS staffing for FFY2015 is \$5.2M and MMIS contract for FFY2015 is \$47.3M”. And the same (or similar) for the other funding streams.

HSE-IAPD BUDGET PROJECTIONS WITH PRIOR PERIOD ACTUALS, PER QUARTER BY FEDERAL FISCAL YEAR										
CMS 64 & 37 Line	MBES37.1_2A	MBES37.1_2B	MBES37.1_2B	MBES37.1_28A	MBES37.1_28B	MBES37.1_28D	MBES37.1_28G	MBES37.1_28H	MBES37.1_24C	MBES37.1_24D
Designation	In-House	Contractual	Contractual	In-House	Contractual	Contractual	In-House	Contractual	In-House	Contractual
CMS Funding Source	MMIS-90/10	MMIS-90/10	MMIS-75/25	E&E-90/10	E&E-90/10	E&E-75/25	E&E-50/50	E&E-50/50	HIT-90/10	HIT-90/10
Federal Fiscal Year 2012 - actuals										
Q1FFY12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Q2FFY12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Q3FFY12	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Q4FFY12	\$ 43,401	\$ 129,145	\$ -	\$ 56,552	\$ 129,245	\$ -	\$ -	\$ -	\$ 231,314	\$ 84,482
FFY12 Total	\$ 43,401	\$ 129,145	\$ -	\$ 56,552	\$ 129,245	\$ -	\$ -	\$ -	\$ 231,314	\$ 84,482
Federal Fiscal Year 2013 - actuals										
Q1FFY13	\$ 54,930	\$ 67,109	\$ -	\$ 95,288	\$ 42,200	\$ -	\$ -	\$ -	\$ 296,449	\$ 342,644
Q2FFY13	\$ 68,713	\$ 158,801	\$ -	\$ 119,029	\$ 206,282	\$ -	\$ -	\$ -	\$ 357,678	\$ 992,273
Q3FFY13	\$ 80,201	\$ 1,347,141	\$ -	\$ 160,394	\$ 1,736,683	\$ -	\$ -	\$ -	\$ 331,687	\$ 945,294
Q4FFY13	\$ 120,867	\$ 2,215,874	\$ -	\$ 245,732	\$ 3,958,388	\$ -	\$ -	\$ -	\$ 265,944	\$ 1,041,741
FFY13 Total	\$ 324,711	\$ 3,788,925	\$ -	\$ 620,444	\$ 5,943,552	\$ -	\$ -	\$ -	\$ 1,251,759	\$ 3,321,952
Federal Fiscal Year 2014 - actuals and projections										
Q1FFY14 - actual	\$ 276,935	\$ 698,001	\$ -	\$ 605,489.88	\$ 685,902	\$ -	\$ 12,216	\$ -	\$ 170,730	\$ 500,292
Q2FFY14 - re-quested	\$ 1,562,531	\$ 5,284,756	\$ -	\$ 1,839,436	\$ 4,755,722	\$ -	\$ 6,428	\$ 39,686	\$ 519,458	\$ 971,667
Q3FFY14 - re-quested	\$ 1,562,531	\$ 6,782,394	\$ -	\$ 1,367,151	\$ 6,207,634	\$ -	\$ -	\$ -	\$ 519,458	\$ 1,353,667
Q4FFY14 - re-quested	\$ 1,562,531	\$ 7,586,606	\$ -	\$ 1,367,151	\$ 2,971,767	\$ -	\$ -	\$ -	\$ 519,458	\$ 1,697,605
FFY14 Total	\$ 4,964,529	\$ 20,351,758	\$ -	\$ 5,179,229	\$ 14,621,025	\$ -	\$ 18,644	\$ 39,686	\$ 1,729,104	\$ 4,523,232
Federal Fiscal Year 2015 - projections										
Q1FFY15 - re-quested	\$ 1,562,531	\$ 13,652,258	\$ -	\$ 1,367,151	\$ 3,101,701	\$ -	\$ -	\$ -	\$ 519,458	\$ 1,547,505
Q2FFY15 - re-quested	\$ 1,237,553	\$ 11,211,689	\$ -	\$ 1,010,107	\$ 6,067,276	\$ -	\$ -	\$ -	\$ 519,458	\$ 1,548,255
Q3FFY15 - re-quested	\$ 1,237,553	\$ 11,211,689	\$ -	\$ 1,010,107	\$ 8,187,300	\$ -	\$ -	\$ -	\$ 519,458	\$ 1,548,255
Q4FFY15 - re-quested	\$ 1,237,553	\$ 11,246,064	\$ -	\$ 1,010,107	\$ 8,914,807	\$ -	\$ -	\$ -	\$ 519,458	\$ 1,006,880
FFY15 Total	\$ 5,275,190	\$ 47,321,701	\$ -	\$ 4,397,472	\$ 26,271,085	\$ -	\$ -	\$ -	\$ 2,077,832	\$ 5,650,895
Federal Fiscal Year 2016 & 2017 - projections										
Future FFYs	\$ 6,187,764	\$ 36,305,635	\$ -	\$ 1,010,107	\$ 8,002,585	\$ -	\$ -	\$ -	\$ -	\$ -
Future FFYs Total	\$ 6,187,764	\$ 36,305,635	\$ -	\$ 1,010,107	\$ 8,002,585	\$ -	\$ -	\$ -	\$ -	\$ -
HSE APD TOTALS										
HSE-IAPD Total	\$ 16,795,595	\$ 107,897,163	\$ -	\$ 11,263,803	\$ 54,967,491	\$ -	\$ 18,644	\$ 39,686	\$ 5,290,008	\$ 13,580,560

## Appendix E – Additional clarification regarding VITL work efforts

Workbook of Proposed VITL work for Vermont State Fiscal Year '15			
<i>Work</i>	<i>Description</i>	<i>Initial CMS Response Regarding Funding Eligibility</i>	<i>CMS Comments GO/NO GO/ HOLD OFF</i>
42 CFR Part 2	Implement a system that supports 42 CFR Part 2 data storage and access	maybe; sounds good but 1st time so need to check	GO
Claims Feeds for Clinical Use	R&D: Develop a model for getting claims into the VHIE for clinical purposes	need more information; e.g., claims info from where (payers or APCD?) for what use case(s); can we make some connection to MU EPs	HOLD OFF
Connectivity Criteria	Per H.107 develop Connectivity Criteria for annual presentation to the GMCB	maybe; sounds good but 1st time so need to check; can we send connectivity criteria document?	HOLD OFF
Data Warehouse	Build and operate a clinical data warehouse	yes (HIE)	GO
Install eCW hub for CCD	Install clinical documents exchange interface that enables eCW customers to generate a CCD	yes (HIE) if on the VHIE side; no if on the vendor side	GO
Interfaces - New Types	Develop capability to implement new types of interfaces for vendors	yes (HIE) for EHS and EHS if on the VHIE side; no if on the vendor side; interfaces to Public Health would be eligible	GO
Interfaces- Continue interface implementation for existing vendors and interface types of new interface capability	Implement interfaces at health care organizations: ADT, CCD, Lab, Radiology, Reports, immunizations.	yes (HIE) for EHS and EHS if on the VHIE side; no if on the vendor side; interfaces to Public Health would be eligible	GO- see comments to left.
Maintain medication history in VITLAccess	Continue to assess completeness of VITLAccess medication history	need additional information; may be OK if focus is on quality and completeness of Rx information	NO GO
Prescriber Data Base connected to VHIE	Create a two way interface which allows VITL access to query the Vermont Prescription Monitoring System in lieu of a direct query and to feed reportable data back to the Monitoring System for tracking purposes	yes (HIE)	GO
Replace MyVITL	Replace the MyVITL infrastructure for help desk ticketing with a PHI secure system	maybe; need to check	HOLD OFF
Security Enhancements	Perform penetration test and implement audit trail monitoring	yes (HIE)	GO
Statewide eHealth Consulting	In-practice, eHealth Consulting Services to assist VT providers in implementation of Health IT, defined as: - EHR selection, optimization and MU for PCP, Specialists and FCP;	maybe; sounds good but 1st time so need to check	HOLD OFF
Statewide eHealth Consulting	In-practice, eHealth Consulting Services to assist VT providers in implementation of Health IT, defined as: - ACO Data Quality; Initiatives;	maybe; sounds good but 1st time so need to check	HOLD OFF
Statewide eHealth Consulting	In-practice, eHealth Consulting Services to assist VT providers in implementation of Health IT, defined as: - BHN Data Quality Initiatives;	maybe; sounds good but 1st time so need to check	HOLD OFF
Summit '14	Annual health care summit	no	HIT, cost allocated
Terminology Services	Purchase and implement a terminology mapping service	yes (HIE)	GO
VITL Infrastructure Upgrades	Hardware, network, and software upgrades required	yes (HIE)	GO
VITLAccess (incl consent) Rollout	Marketing, pipeline generation, education, awareness, and workflow integration	yes (HIE)	HOLD OFF
VITLAccess eHealth Consulting	In-practice, eHealth Consulting Services to assist VT providers in implementation of Health IT: - Core VITL services (VITLAccess, VITLDirect, and VITLNotify);	maybe; sounds good but 1st time so need to check	HOLD OFF
VITLDirect Direct	Onboard providers to VITLDirect for provider to provider secure messaging	yes (HIE)	HOLD OFF
VITLDirect eHealth Consulting	In-practice, eHealth Consulting Services to assist VT providers in implementation of Health IT: - Core VITL services (VITLAccess, VITLDirect, and VITLNotify);	maybe; sounds good but 1st time so need to check	HOLD OFF

continued on next page

VITLDirect rollout	Marketing, pipeline generation, education, awareness, and workflow integration	yes (HIE)	HOLD OFF
VITLNotify Conduct an ENS pilot	Install an event notification system and conduct a pilot	maybe; sounds good but 1st time so need to check	HOLD OFF
VITLNotify eHealth Consulting	In-practice, eHealth Consulting Services to assist VT providers in implementation of Health IT: - EHR selection, optimization and MU for PCP, Specialists and FCP;	maybe; sounds good but 1st time so need to check	HOLD OFF
VITLNotify rollout	Marketing, pipeline generation, education, awareness, and workflow integration	yes (HIE)	HOLD OFF
Littleton Regional Health Care	Develop interfaces to Littleton Regional Hospital in NH	did not ask about this separately from other interfaces	Is this EP? Need to discuss further
Patient Portal	R&D: Determine feasibility of a patient portal	yes (HIE)	Go
Provider Directory	Participate with SOV in developing a Provider Directory	yes (HIE)	GO
Social Security Administration Connection	R&D: Connect to the SSA for determining eligibility of a patients disability benefits	sounds doubtful; need more information; can we make some connection to MU EPs	NO GO
Advanced Directive Registry connected to VHIE	R&D: Connect VITL access to the advanced directive registry so that information from the registry can assist physicians and providers with medical decision making in a timely and streamlined fashion.	yes (HIE)	HOLD OFF
Annual Provider Health IT Survey	Annual survey of providers to assess impact / effectiveness of VT Health IT efforts	yes (HIT)	
Annual Public Health IT Survey	Annual survey of VT public to assess impact / effectiveness of VT Health IT efforts	yes (HIT)	
Assessment of Uber-portal	R&D: Pilot project for a state-wide single provider portal which enables the integration of other systems (EHR, ACO, Immunizations, Blueprint, etc.) into a single user interface	yes (HIE)	GO
Claims/Clinical Integration Pilot	R&D: Perform an initial test of matching patients across claims and clinical data sources and a pilot of integrating clinical and claims data	need more information; e.g., claims info from where (payers or APCD?) for what use case(s); can we make some connection to MU EPs	HOLD OFF
Clinical Orders Interface	Implement recommendations of consultant for improving the ability of providers to generate electronic lab orders	No, if on EHR side; yes if on VHIE side	GO
Conduct an MPI assessment	Perform an MPI assessment to identify patient duplicates and improvements to the MPI	yes (HIE)	GO
FAHC Radiology Outreach	Work for FAHC on expanding radiology network to Central Vermont and Champlain Valley	need more information; can we make some connection to MU EPs	NO GO
HIXNY Implementation	Implement the connection with HIXNY to allow for sharing patient demographics, messaging and full query capability cross our two HIEs	yes (HIE)	GO
Provider Technology Readiness Census	R&D: Detailed census of VT provider Health IT technology implementation status. To be conducted by contracted market research firm.	yes (HIT)	
Shared Imaging Network	Develop a state-wide medical image network connecting imaging organizations with providers	maybe; need to check	HOLD OFF
State Psychiatric Hospital EHR Selection	Advise and guide VPCH through the processes of selecting and contracting for the purchase of an electronic health record (EHR)	no	NO GO
VITLAccess Single Sign On	R&D: Project to connect EHRs to VITLAccess with Single Sign On	maybe; sounds good but 1st time so need to check	HOLD OFF
VITLAccess Teenage Patient Consent	Study and propose technology solutions to manage complex consent process as it relates to adolescents aged 12 - 18.	maybe; sounds good but 1st time so need to check	HOLD OFF
HIT/HIE Planning Consultant	Consultant to assist with the development of the State HIT plan	yes (HIT)	
VITLAccess Impact to VT Healthcare Delivery System	Develop methodology for evaluating clinical and financial impact of VITLAccess	maybe; sounds good but 1st time so need to check	HOLD OFF