

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

**Pending Core Team Approval**

**Date of meeting:** Monday, March 9, 2015, 12:30-2:00pm, EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
<b>1. Welcome and Chair's Report</b>	<p>Lawrence Miller called the meeting to order at 12:36. A roll call attendance was taken and a quorum was present.</p> <p>Lawrence Miller provided the Chair's report: Lawrence and Georgia will be doing a mid-point progress review and risk assessment. Lawrence invited members to offer suggestions of risks or concerns and encouraged them to contact him offline.</p>	
<b>2. Meeting Minutes</b>	<p>Lawrence Miller invited comment from members on the minutes from the previous meeting. There were no amendments. Susan Wehry moved to approve the February 2015 meeting minutes. Robin Lunge seconded. A roll-call vote was taken and the motion carried.</p>	
<b>3. Core Team Role</b>	<p>Lawrence Miller launched a discussion on the role of the Core Team, following up on earlier discussions on the role of the Steering Committee and Core Team. Georgia Maheras presented a decision-making process and slides on the Steering Committee and Core Team roles (Attachments 3a and 3b). Georgia emphasized that the Core Team does not have statutory authority to execute contracts or change policy; the Core Team makes recommendations for funding and policy change to GMCB, AHS, DVHA, private payers, and providers.</p> <p>The Core Team discussed the following:</p> <ul style="list-style-type: none"> <li>• How quickly have we been able to get contract approvals from CMMI? Georgia responded that this depends on CMMI workload; some are approved very quickly and others take time when CMMI has many other approvals on their plate. Georgia noted that CMMI has been willing to approve contracts retroactively to make up for this. Lawrence noted that it's important for the Core Team to recognize that work done while waiting for CMMI approval puts General Fund dollars at risk.</li> <li>• Do we expect an audit from CMMI this year? Unknown.</li> </ul>	

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<p><b>4. Policy Update</b></p>	<p>Lawrence Miller introduced two policy update items:</p> <ul style="list-style-type: none"> <li>• DLTSS Work Group Letter to the Governor</li> <li>• ACO Care Management Standards</li> </ul> <p><i>DLTSS Work Group Letter to the Governor (Attachments 4.1a and 4.1b):</i> This was discussed at the November and December 2014 meeting, as well as the January 2015 Steering Committee and Core Team meetings. At the January Core Team meeting, this group decided it was appropriate for this to go forward with caveats noting that state employees declined to participate in this process. Private sector members of the DLTSS Work Group also sent a letter under separate cover in December.</p> <ul style="list-style-type: none"> <li>• Is this different from other concerns about budget cuts? Lawrence commented that if a group wants to communicate something to the Governor and votes to do that, it's appropriate. He noted that this put state employees in an awkward position, but the current language notes this clearly and the aims are consistent with the project. He believes this is an appropriate level of advocacy. The Workforce Work Group is sending a similar letter in their role as an advisory group appointed by the Governor.</li> <li>• What would the Core Team's cover letter say? Susan Wehry expressed hesitation. While she supports the Work Group members speaking their mind, it may be outside the scope of SIM and the Core Team. The letter makes advocacy-style statements without data, and sending it on to the Governor may be read as an endorsement of these statements.</li> <li>• Did this go through the appropriate process? The letter was approved by the DLTSS Work Group with many abstentions from state employees, and passed through the Steering Committee.</li> <li>• Harry Chen suggested that the cover letter include a statement that the Core Team does not endorse the message in the letter rather than taking a position.</li> <li>• Could there be a potential issue with use federal funds that support the Work Groups for non-SIM activities and/or lobbying activities? Robin Lunge noted that she believes this meets the definition of advocacy under Vermont law; she is not worried about this letter, but about future activities.</li> <li>• Steve Costantino recommends informing the DLTSS Work Group of Robin's concern, perhaps following additional research into Robin's concern.</li> </ul> <p>Steven Costantino moved to pass the letter along with a cover memo describing the process, and to perform an analysis to address Robin's legal concerns. Robin Lunge seconded. The motion carried.</p> <p><i>ACO Care Management Standards:</i> Erin Flynn presented the ACO Care Management Standards as approved by the CMCM Work Group and Steering Committee (Attachment 4.2). The CMCM Work Group, with leadership from a sub-group, worked for 11 months to develop consensus standards. The CMCM Work Group voted to approve the standards at their February meeting with a small language change; it was approved by the Steering Committee at its February meeting.</p>	<p><b>Perform an analysis to address legal concerns raised by Robin Lunge; report back to the Core Team at 4/6/2015 meeting.</b></p>

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	<ul style="list-style-type: none"> <li>• What does culturally competent mean? Erin Flynn suggested that there could be many definitions, but that language was added at the suggestion of the DLTSS Work Group. Paul Bengtson suggested that for providers, this means understanding the needs of various populations, including people with disabilities, children, frail elders, people from other cultures, or others.</li> <li>• Who performs these functions in communities, and how can we prevent this care management structure from being duplicative? Pat Jones noted that many of the standards include language that state that “ACOs have a process for and/or support participating providers in” care management activities.</li> <li>• Paul Bengtson noted that ACOs are not necessarily the last stop on the train. Lawrence Miller noted that these standards will need to be worked into contracts, another hurdle.</li> <li>• When did the introductory language change from “agree to be guided by” to “agree to”? At the February 10<sup>th</sup> meeting. There was one dissenting vote on the language change, from one of the ACOs, but that ACO has since expressed that they have considered this further and have no objections. Julie Wasserman noted that the original language proposed did include “agree to” – it was then changed to “agree to be guided by” and back to “agree to.”</li> <li>• Does CMS have to approve these standards? No. The contracts with ACOs will need to meet CMS standards; for the Commercial Shared Savings Program, contracts will go to GMCB. Contracts between DVHA and ACOs will need to be amended, but Vermont’s Medicaid State Plan does not include this level of detail and will not need to be amended.</li> </ul> <p>Steve Voigt moved to approve the standards. Paul Bengtson seconded. The motion carried.</p>	
<b>5. Financial Update</b>	<p>Georgia Maheras presented a general financial update and two financial requests:</p> <ul style="list-style-type: none"> <li>• Frail Elders Proposal</li> <li>• Jim Hester Contract Amendment</li> </ul> <p><i>General Financial Update (Attachment 4a):</i> Georgia noted that we do not yet have 2014 actuals due to state financial processes. She also noted that she plans to request a reallocation in June or July, similar to Year 1. In addition, CMS has indicated that it will not fund HIT provider stipends; this line has been removed.</p> <ul style="list-style-type: none"> <li>• How much flexibility is there to move remaining funds to areas where it will be effectively applied? Quite a bit. Within a funding category (ex/Evaluation), it is easy to reallocate funds. If funds need to move between categories, federal approval is required. We will attempt to bring only one reallocation request to CMMI, as they have requested.</li> <li>• Can we look to other groups to identify potential areas for funding? There are some areas that we could pull into our work using these funds; however, Georgia and Lawrence prefer to complete their risk assessment first.</li> <li>• Can unexpended funds all be carried forward, or only some? We can carry forward all funds; however,</li> </ul>	

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	<p>we must identify specifically what the carryover funds will be used for. Our 2014 carryover request is still with CMMI pending approval. Funds must be spent in the next testing year (2015), however, we can also carry forward funds from 2015 to 2016. We expect to put funds in the 2016 budget that are intended to carry over to 2017 to complete our evaluation and retroactive SSP analyses.</p> <p><i>Frail Elders Proposal</i> (Attachment 5b): The conversation around this proposal began last spring, prompted by two rural FQHC providers who wanted to provide better care for frail elders. This was initially developed at the Payment Models Work Group, went to Steering Committee, was sent back for further work, and was revised by a sub-group. It was approved by the Steering Committee in February. The contractor would be the Vermont Medical Society Education Foundation. The scope has expanded since this was originally proposed: an Expert Panel was added, as well as additional interviews.</p> <ul style="list-style-type: none"> <li>• Does VMSF feel confident that they can perform all of the work included in this proposal, following the expanded scope? Yes, and members can find further details in the budget detail.</li> <li>• How would this link to Area Agencies on Aging, DAs, and others? Page 1 of the proposal describes these connections: the project would form an Expert Panel to inform this work and would include representatives from each of these provider groups and others.</li> <li>• How does this project deal with data and information sharing difficulties between different provider types? The project does not seek to solve this problem. There is separate work going on in the state to support these data connections; DAIL believes this project will help move this forward, even if it doesn't solve the problem.</li> <li>• How has DAIL been involved in this proposal? DAIL has been very involved, and feels confident that its provider network is well incorporated.</li> <li>• Susan Wehry noted that under the "Definition of areas of study" section, we identify a librarian doing billing claims. Georgia Maheras indicated that this was in error; this work will be done by a different contractor.</li> </ul> <p>Paul Bengtson moved to approve this proposal with the change suggested above by Susan Wehry. Susan Wehry seconded. The motion carried.</p> <p><i>Jim Hester Contract Amendment</i>: Georgia Maheras presented an amendment to Jim Hester's contract to work with the Population Health Work Group. These funds were specifically allocated to the Population Health Work Group; the Work Group had a remainder in their 2015 funds (they still have \$43,000 remaining).</p> <ul style="list-style-type: none"> <li>• What has Jim done so far in his work with the Population Health Work Group? Created several PowerPoints for presentation to the Work Group. He also participates in planning and strategy sessions for the Work Group, and provides support to the Work Group as requested on various research and analysis tasks, and lends his national expertise to our conversations. Under this amended contract, one</li> </ul>	

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	<p>of his tasks will be to investigate and report on models for funding population health activities.</p> <p>Steve Voigt moved to approve the contract amendment. Harry Chen seconded. There was no public comment. The motion carried.</p>	
<b>6. Public Comment</b>	No further public comment was offered.	
<b>7. Next Steps, Wrap Up and Future Meeting Schedule</b>	<p><i>Next Steps:</i></p> <ul style="list-style-type: none"> <li>• Progress summary and risk assessment is underway; it will be presented to this group after the legislative session.</li> </ul> <p>Paul Bengtson suggested a presentation on HIE/HIT would be helpful. He commented that money could be saved if data collection, analytics, and exchange efforts were aligned or combined across entities. Lawrence Miller noted that the State HIT Plan is currently being revised; this process has just started, so timing is good. He suggested that passive claims and clinical data collection will be critical for success.</p> <p><b>Next Meeting:</b> Monday, April 6, 2015, 1:00pm-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston</p>	