DLTSS Work Group Meeting

Agenda 4-30-15

VT Health Care Innovation Project
"Disability and Long Term Services and Supports" Work Group Meeting Agenda
Thursday, April 30, 2015; 10:00 PM to 12:30 PM
4th Floor Conference Room, Pavilion Building
109 State Street, Montpelier
Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Decision Needed ?
1	10:00 – 10:10	**Welcome; Approval of Minutes** Deborah Lisi-Baker and Judy Peterson	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from February 19, 2015 • Attachment 1c: Minutes from March 26, 2015	 Yes Yes
2	10:10 - 10:45	**Review DLTSS Year 2 Work Plan** Deborah Lisi-Baker and Judy Peterson	• Attachment 2: DLTSS Draft Year 2 Work Plan 3-6-15	
3	10:45 – 11:20	**DLTSS/CMCM Collaboration on Learning Collaborative; and DLTSS-Specific Core Competency Curriculum Development and Training** Deborah Lisi-Baker	• Attachment 3: *Will be sent when available.*	
4	11:20 – 12:10	**Caledonia & Southern Essex Dual Eligible Project** Pam Smart, Northeastern Vermont Regional Hospital and Treny Burgess, North Countries Health Care	• Attachment 4: NEK Dual Eligible Presentation April 2015	
5	12:10 – 12:15	**Update on DLTSS Gap Analysis/Technology Assessment and Remediation (ACTT)** Beth Waldman, Bailit Consulting		

6	12:15 – 12:30	**Public Comment/Next Steps** Deborah Lisi-Baker and Judy Peterson	• Next Meeting: Thursday, May 28, 2015, 10:00 am – 12:30 pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston	

Attachment 1b

February Minutes

Vermont Health Care Innovation Project

Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, February 19, 2015; 10:00am-12:30pm, EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Deborah Lisi-Baker called the meeting to order at 10:05 am. A roll call attendance was taken and a quorum was present. Deborah Lisi-Baker entertained a motion to approve the December 4, 2014, meeting minutes. Julie Tessler moved to accept the minutes by exception. Sue Aranoff seconded. The minutes were approved with three abstentions. Kirsten Murphy moved to accept the minutes for the January 22, 2015, meeting. Sue Aranoff seconded. The minutes were approved with five abstentions.	
2. Central Vermont Health Service Area Collaborative: Informational Presentation and Progress to Date	Mary Moulton of Washington County Mental Health Services presented on the Central Vermont Health Services Area Collaborative (see Attachment #2). The group discussed the following: • How to ensure appropriate and cost-effective utilization? How can a one-door approach support this? Mary Moulton clarified that a "virtual" one door uses similar processes at multiple provider types/provider sites to make sure patients get the most appropriate care for their needs. • How are participating providers sharing medical information electronically in a way that protects patient health information and privacy? Data security is key, as are releases that allow sharing of patient data and ensure that patients understand what data will be shared and how. • How does this work interact with local Blueprint and ACO committees and projects? This has broadened the types of providers who are participating in local QI activities. • How does this relate to the idea of Totally Accountable Care Organizations, Coordinated Care Organizations, Accountable Communities for Health, or Unified Community Collaboratives? All of these concepts touch on	

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	the same ideas – Central Vermont HSA is working to increase collaboration and coordination across providers through this model, which would also be a key component of TACOs, CCOs, ACHs, and UCCs. • How are consumers involved? Consumers will be involved in systems planning in the future (not patient case review). • Are all of the pilot patients living in community settings? Yes. • Do all have both physical health and mental health needs? No, many do not have mental health needs, though many have been referred to mental health services to better address psycho-social needs. • Did participating provider organizations need BAAs or other formal agreements to share patient information? Yes, they have BAAs in place. • Mary Moulton estimated that the group has achieved approximately 60% fidelity to the DLTSS model. There are some gaps: for example, it has been a challenge to have a single case manager that is the point person for all the individual's needs • How are people with substance use disorders being served by this work? A few of the pilot population have substance use disorders; those patients have been referred for treatment and substance abuse providers brought into the care team. • How is data being collected? Through the Blueprint practices. • Who is currently the lead care coordinator? Always the care coordinator at Blueprint physician's office. • How does this group support patients in taking prescribed medications? Partnerships with community providers support this. • Do Blueprint CHTs already include behaviorists or health coaches? They may in some areas. In Washington County, CHTs still expressed need for Motivational Interview training. • What's happening in other areas of the state? Mental health is represented on CHTs in other areas of the state. • Has this group connected with the ACTT Project, specifically the Universal Transfer Protocol design work? Vermont Care Partners is involved in the ACTT Project as well as this group. Mary Moulton closed her presentation with a brief description of other initiatives underway at Washington County Mental Health Services, including: Medical practice integration with medical practices; wellness programming; case review with community providers; a pediatrics pilot with medical practices; system integration with the local Health Center; a doula program with CVMC; and an initiative to create bi-directional care as part of a health home. WCMHS has also requested funds from the Susan G. Komen to support cancer pre-screening for people with serious and persistent mental illness. If members have additional comments, feedback, or questions, please contact the co-chairs or Julie Wasserman (Julie.Wasserman@state.vt.us).	

Agenda Item	Discussion	Next Steps
3. An Introduction to the All-Payer Waiver	Robin Lunge presented on Vermont's proposed All-Payer Model (see Attachment #3). Julie Wasserman noted that Lawrence Miller will be at this group's March meeting to present on this topic in more detail. The group discussed the following: • Will this waiver be time limited? Yes, as with other waivers, this would have a 5-year term, after which we must re-negotiate or extend. • Have we had any assurance that CMS will listen to this and negotiate on a waiver? CMS is excited to work with Vermont, but if the State and federal government aren't able to come to a compromise, we will not agree to a waiver. • How will we decide which providers will be included in the waiver? Robin Lunge suggested examples of possible providers that might be included, only intended for examples. The State is working with CMS to design a process for deciding which providers will be included. • What will the waiver do? Robin emphasized that the waiver would not affect eligibility, benefits or beneficiary protections. It would provide authority to change the Medicare reimbursement methodology; however, this will not result in more funding coming into the system, but rather it just changes the reimbursement model. • Is there a website or other public information out there on this? This presentation is the only public document available at this time. DLTSS members are invited to submit their follow up questions and comments to Julie Wasserman (Julie.Wasserman@state.vt.us) by COB next Friday, February 27th.	
4. ACTT Project Overview and Accomplishments to Date	Larry Sandage introduced the Advancing Care Through Technology (ACTT) Project, a project to support HIT development across the full continuum of care, including DA and SSA systems, and the DLTSS system. There are three projects within ACTT (see Attachment #4). The group discussed the following: Project 1: Data Quality Project • What is MSR data? Monthly Service Report, data already sent by Designated Agencies to DMH. This is something providers already collect and send and provided a starting point to test data quality. • Initial data dictionary is complete. What is a data dictionary? A data dictionary is an index of all the data elements within a database that describes what kind of data would be entered and how it is collected. The goal is consistency within the data entry, collection and reporting. • What is QSOA? Qualified Service Organization Agreement – an agreement between the agencies and Vermont Care Partners. • Three reasons to do this project:	

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	o For efficiency purposes – to create a single point of access for reporting purposes and ultimately, connection to the VHIE (Vermont Health Information Exchange) o For quality improvement of services – ability to look at consistent, aggregated data with a lens toward population health improvement o A solution for the 42 CRF Part 2 data sharing restrictions (related to substance use and abuse) – ultimately, the goal is to find a way to aggregate data in a manner that is compliant with the rule • An RFP will be forthcoming Project 2: DLTSS Data Planning Project • The project is assessing the current state of technology tools for care management and care coordination. It is an inventory of HIT capabilities for a variety of DLTSS providers across the state. "Who's using what" in terms of already existing tools, or planned tools. This includes an assessment of interoperability with the VHIE. • A report will be forthcoming in March • A question was posed whether we will ultimately be able to compare data across systems? The response was that this is problematic because of how data is collected, stored and used from one entity to another. There is, however, some similarity in certain data related to payment and outcomes. Project 3: Universal Transfer Protocol (UTP) • The UTP is not just a form; it is a system to exchange data sets; it is a process. • The project is creating a charter for the next phase of the project, including creating a definition of UTP: "*Universal Transfer Protocol (UTP) is a process across the entire system that gives all partners who have a role in the patient's care access to the same standardized information and the responsibility to ensure that the information is accurate, current, and supports the patient's goals and quality of life*." Heather Johnson, ADRC project manager • Project focus has been to design, test and create standard data sets so they can be shared. Ultimately, a single data dictionary is needed to link anyone to everyone. • It is designed to prevent gaps in care, coverage and information sharing as patients move within the system of care. • Providers have been interviewed in Bennington, Rutland and St. Johnsbury to determine data criteria. • The solution needs to be technology-agnostic • The methodology has been to engage providers to determine: o The most basic information o Channels across which to share the data o Communication continuity (follows the patient through the care continuum) • The recommendation for next steps includes a 'harmonization period' in which to true-up the data.	

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	• A question was posed – will the system be useable when sequencing makes a difference? The response is that data integrity – a shared, agreed-upon basis for information exchange is the key. • A question was posed related to some testing in Bennington and St. Johnsbury – the response is that the testing was related to clarifications around roles and responsibilities within the system of care so that persons in similar positions know who to contact and what to ask in another facility. The testing is related to correctly directing communications. • More information can be found at http://im21-utp-vt.com/	
5. Public Comment/Next Steps	There was no additional comment. **Next Meeting:** Thursday, March 26, 2015, 10:00am-12:30pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

VHCIP DLTSS Work Group Member List

Roll Call: 2-19-2014

Julie T 1°
Susan A 2°

Kirsten M 1°
Susan A 2°

Minutes approved
Motion by exception

A=Abstain

Member		Member Alternate		December Minutes	January Minutes	
First Name	Last Name	First Name	Last Name			Organization
Susan	Aranoff ✓					AHS - DAIL
Debbie	Austin	Craig	Jones			AHS - DVHA
Molly	Dugan ✓					Cathedral Square and SASH Program
Patrick	Flood					CHAC
Mary	Fredette					The Gathering Place
Joyce	Gallimore ✓			No vote		Bi-State Primary Care
Martita	Giard ✓	Susan	Shane		A	OneCare Vermont
Larry	Goetschius	Joy ✓	Chilton			Home Health and Hospice
Dale	Hackett ✓			A	A	None
Mike	Hall					Champlain Valley Area Agency on Aging
Jeanne	Hutchins ✓					UVM Center on Aging
Pat	Jones	Richard	Slusky			GMCB
Dion	LaShay ✓					Consumer Representative
Deborah	Lisi-Baker ✓					SOV - Consultant
Sam	Liss ✓					Statewide Independent Living Council
Jackie	Majoros ✓	Barbara	Prine	A	A	VLA/Disability Law Project
Carol	Maroni					Community Health Services of Lamoille Valley
Madeleine	Mongan ✓					Vermont Medical Society
Nick	Nichols ✓					AHS - DMH
Ed	Paquin ✓					Disability Rights Vermont
Laura	Pelosi					Vermont Health Care Association
Eileen	Peltier					Central Vermont Community Land Trust
Judy	Peterson ✓				A	Visiting Nurse Association of Chittenden and Grand Isle Counties
Paul	Reiss	Amy	Cooper			Accountable Care Coalition of the Green Mountains
Rachel	Seelig ✓	Trinka	Kerr			VLA/Senior Citizens Law Project
Julie	Tessler ✓	Marlys	Waller			DA - Vermont Council of Developmental and Mental Health Services
Nancy	Warner	Mike	Hall			COVE
Julie	Wasserman ✓				A	AHS - Central Office
Jason	Williams ✓					UVM Medical Center
	29		9			

18 Quorum

Kirsten Murphy — Dec: A | Jan:

Mary Alice Bisbee

Attachment 1c

March Minutes

Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, March 26, 2015, 10:00am-12:30pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Deborah Lisi-Baker called the meeting to order at 10:08am. A roll call attendance was taken and a quorum was not present; the Work Group will vote on the February 19th meeting minutes at the April 30th DLTSS Work Group meeting, assuming a quorum is present.	
2. All-Payer Model – Goals, Objectives, Desired Outcomes, and Next Steps	Lawrence Miller, Chief of Health Care Reform, Office of the Governor, presented on Vermont's proposed All-Payer Model. This follows Robin Lunge's presentation on this topic at the February 19th DLTSS Work Group meeting. • All-Payer Waiver discussions are very early. Vermont is beginning discussions with the Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare & Medicaid Services (CMS). CMS also just introduced the Next Generation Accountable Care Organization (ACO) Model which indicates CMS willingness to change reimbursement systems toward paying providers based on the quality rather than the quantity. It remains to be seen how this could interact with Vermont's All-Payer Model, but it is an encouraging sign regarding CMS willingness to be flexible. • There is only one example of a statewide All-Payer Model in the U.S. (Maryland – hospital payments) but there are examples of the types of payment models that might be part of an All-Payer Model (capitation, global payments, etc.)in the U.S. and internationally. Vermont is not inventing new models, but instead being innovative and building on existing strategies. • What changes would this mean for Medicare? There will be no changes to Medicare benefits or eligibility, but Medicare is a big player in the room and Vermont will be negotiating with Medicare (via CMMI) for a potential waiver to implement an all-payer model to reimburse providers differently. • Green Mountain Care Board (GMCB) and the Agency of Administration (AOA) are taking the lead on negotiations in coordination with the Agency of Human Services (AHS). Negotiations will also be coupled with enhancements to GMCB's regulatory authority to support the potential All-Payer Model. o See Slide 4 for examples of technical issues which Vermont and CMMI will discuss as part of negotiations on terms for a potential All-Payer Waiver. Throughout negotiations, Vermont will	

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	balance controlling health care costs with ensuring providers can continue to operate in our communities. o The negotiation process is driven by Medicare. Medicare is laying out the negotiation path and parameters, and will outline areas where there are opportunities for flexibility and areas where flexibility is not an option. Al Gobeille from GMCB and Lawrence Miller from AOA are the lead negotiators, and will request stakeholder input at appropriate times during the negotiation process. If Vermont is unable to negotiate a beneficial agreement with CMS, the State will discontinue negotiations and end its pursuit of an All-Payer Waiver. Lawrence addressed a list of questions sent prior to the meeting by DLTSS Work Group members (Attachment 2b): 1. *Can you give a brief overview of the All-Payer Model and describe the expected (high-level) timelines and associated processes for negotiating, developing and implementing Vermont's All-Payer Model?* See presentation. 2. *How will an All-Payer Model affect costs, affordability, health outcomes, and population health? Where might we see savings?* An all-payer model – especially one that emphasizes capitation or global payment – aligns incentives for providers and encourages investment in services and strategies that prevent illness and support improved health, like primary care and population health. 3. *Will an All-Payer Model improve the delivery of services for people in general and for those with DLTSS needs? Will the All-Payer Model help expand community-based services for people with DLTSS needs?* Yes, as described above. • *What about vulnerable adults and children with developmental disabilities, already hard hit by state budget cuts?* This is related to broader State budgetary factors, not the potential All-Payer Model. 4. *Under an All-Payer Model, will all payers (Medicare, Medicaid, Commercial insurers, Uninsured) pay providers the same rate for the same service?* Not necessarily – there will likely be variations based on population, risk, and other variables. 5. *In achieving consistency across payers, how will Medicare be affected? Please enumerate any anticipated changes. Will Medicare reimbursement mechanisms remain the same? Will Medicare payment rates stay the same? Will providers continue to bill Medicare directly and will Medicare still make the payments?* We do not anticipate any changes to how Medicare benefits are delivered. The state will not take on the responsibility for the Medicare system, and Medicare will continue to be the payer. The All-Payer Model would align Medicare with other payers regarding provider reimbursement mechanisms. 6. *Are Commercial insurers supportive of the All-Payer concept?* At this time they are fully supportive. 7. *Is it anticipated that Commercial reimbursement rates would be standardized to Medicare payment rates? As a result, would Commercial payment rates drop to Medicare levels? If Commercial insurers reimburse providers at lower rates than currently, will premiums drop accordingly? Will providers accept the lower Commercial*	

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	payment rates? Provider payment rates will be standardized but not necessarily the same. In Maryland, there is a differential between Medicare, Medicaid, and commercial rates, and that would likely be the same here. The State does expect that by bringing Medicaid rates up, and overall system costs down, that medical charges to insurers will go down and cost growth will be restrained. Lawrence noted that total medical charges and the growth rate of total medical charges are only a few of the factors that impact insurance premiums for consumers. 8. *Is it anticipated that Medicaid reimbursement rates would be standardized to Medicare payment rates? As a result, would Medicaid payment rates rise to Medicare levels? If Medicaid reimburses providers at higher rates, would that potentially offset the drop in Commercial payment rates for providers?* See Question 7. 9. *The GMCB recently stated that raising Medicaid reimbursement rates to Medicare levels would cost $51 million. If the Legislature does not approve expenditures to increase Medicaid rates to Medicare levels, are there other options that could be pursued to achieve an All-Payer Model?* Lawrence does not anticipate the Legislature approving this proposed spending this year at that level. The State will continue to work to increase those rates. Even if this legislative initiative is not successful, it will not block an All-Payer Model, though success would improve our negotiating position. Commercial insurers are also concerned about this as they look toward the implementation of the "Cadillac Tax" in 2018 – minimizing the cost shift before 2018 would prevent the need to pay a large amount in federal taxes. (Please note we have no guarantee that higher Medicaid reimbursement rates would result in lower commercial premiums.) • *Could this result in Medicare cuts?* No. This money would support an increase in Medicaid provider rates to come closer to Medicare rates, and would not impact Medicare rates at all. • *Don't commercial insurers negotiate very reduced rates with providers?* Commercial insurers do negotiate rates that are less than hospitals' "charge master" rates – the charge master is a starting point for those negotiations and is not reflective of the actual cost of providing services. Commercial insurers still pay more than Medicare and Medicaid in most cases. Negotiations work differently with smaller independent providers, who hold far less bargaining power than hospitals and tend to have insurer-imposed rates. 10. *Will the development of standardized fee-for-service hospital payment rates across all payers be the first step in moving toward standardizing costs per case (hospital inpatient and outpatient services) as Maryland has done? (As the cost per case tightened, Maryland witnessed an increase in the number of cases and is now developing an all-payer cost per capita growth limit for hospital inpatient and outpatient care for all Maryland residents.)* Vermont is starting from a different place than Maryland and will not design the same model. Vermont also has less variation than Maryland in terms of providers and populations. Vermont will likely make a more substantive change in payment structures. 11. *Slide 4 mentions "total costs of care." Which providers and services will be included in the total cost of care and how will this be decided? Will Developmental Services, CRT and Choices for Care Waivers (of the Consolidated Global Commitment) be contained in the total cost of care?*	

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	This is part of the negotiation with CMS and not yet decided. 12. *Will the All-Payer Model be piloted with one or more ACOs? What is meant by "ACO oversight" on Slide 3 under GMCB regulatory enhancements?* GMCB already has oversight over ACOs. They can utilize it more robustly if they choose, but would need additional capacity to support that. Vermont has a very consolidated health care market, and the state needs stronger regulatory controls to sufficiently manage and oversee that. It's not yet clear whether the All-Payer Model will be piloted with ACOs or otherwise. (Please note that CMS has oversight over the Medicare ACOs, and DVHA/AHS have oversight over the Medicaid ACOs.) 13. *How does an All-Payer Model comport with Medicare and Medicaid ACO Shared Savings Programs (SSPs) given these SSPs are based on current fee-for-service reimbursement rates?* This model would build off of CMS experience with these programs. We would likely be comparing trends in fee-for-service costs to actual costs under the new all-payer model. Fee-for-service would not be totally eliminated – there would be comparison and benchmarking along the way. 14. *If some form of population-based payment methodology is used, and the ACO structure is used as the basis for total cost of care calculations, how will providers who are not affiliated with an ACO be included?* This is one of the key questions the State has. Lawrence anticipates that non-ACO providers would continue to operate on a largely fee-for-service basis as they do now. • *Could there be regional systems in areas where providers are currently working together to provide coordinated and integrated care (for example, the Northeast Kingdom)?* This is not decided – the State is starting with few preconceptions. Medicare is building off of its ACO programs, but ACOs are an innovative design element and success is not assured. Whatever waiver agreement is reached will need to maintain flexibility for the state's needs and for the needs of communities. 15. *Will the development of an All-Payer Model incorporate SIM Payment Reform planning efforts on "episodes of care"?* The purpose of SIM has been to inform what we do going forward – the State will be using what's been learned throughout SIM in developing the All-Payer Model. 16. *Slide 4 mentions "quality measures." How will quality measures be developed? Will existing Medicare and Medicaid SSP quality measures be utilized? Will the VHCIP Quality and Performance Measures Work Group be involved? Will existing or future AHS Global Commitment quality measures be utilized?* In reality, all of these Payers and organizations will likely continue to have slightly different quality measures, and the State will continue to try to rationalize them. The State hopes to be able to do a better job of harvesting data in a passive fashion from clinical and claims databases so that all necessary data can be collected while also decreasing the measurement and reporting burden on providers. 17. *Will an All-Payer Model have any effect on out-of-pocket costs for beneficiaries?* CMS has made it clear that there can be <u>no</u> degradation of benefits. We cannot change cost sharing to the detriment of beneficiaries. 18. *The slide titled "Structure for leadership, staffing and stakeholder input on model agreement" includes a*	

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	reference to "APM affected parties advisory group." Who will this advisory group include? When will it be formed and begin meeting? This stakeholder participation will be more sprawling than just an advisory group. This will be an important review once the State finds out what the federal government is willing to agree to and decides whether or not to continue pursuing a waiver. Lawrence anticipates this will begin in late 2015. 19. *The Federal Government has been clear they expect a thorough vetting of proposals and discussion among Vermont stakeholders before any proposals rise to the level of discussion with the Feds. What mechanisms and processes will be used to ensure involvement of stakeholders statewide?* Vermont is in an early negotiation phase. CMS has been very clear that they will provide a set of boundaries for negotiation – the State is not redesigning Medicare, and need to work within their system. Engagement will come once we know what those boundaries are. 20. *Can you list the top 5 challenges in initiating, developing, and implementing an All-Payer Model in Vermont?* First, there is a high level of skepticism among legislators and members of the public about our ability to do health reform well because of the Vermont Health Connect (VHC) experience. The State hopes that successful completion of Vermont Health Connect and other projects, including SIM, will go a long way toward allaying these concerns. CMS is very impressed by our progress, existing stakeholder engagement, and system-wide coordination. Other barriers: This process is driven by the federal government – the State may or may not get a deal negotiators and stakeholders like. The timeline is aggressive – CMS suggested we could implement in 2016, which feels too soon for the State. Change is hard – there will be winners and losers among providers, many of whom have already been through many changes over the past few years and are experiencing change fatigue. Overall, the federal government is in control, and though the State has a very cooperative relationship with the administration, federal Health and Human Services, and CMS, they acknowledge that there will be challenges in working this through. There are reasons that Maryland is the only state doing this now. The federal government needs to ensure that whatever they agree to with Vermont does not set a precedent that can be used to degrade care elsewhere. The group discussed the following: • *What is Medicare Shared Savings?* A program where an ACO enters a contract with Medicare under which, if the ACO saves money on a prescribed set of services and meets quality targets, the ACO will receive a share of the money saved. Vermont has two: OneCare and Community Health Accountable Care (CHAC). • *Would Vermont's model include only hospitals, as in Maryland, or other providers like mental health or home health?* A broader group. Lawrence noted that the Global Commitment waiver will be up for renewal in 2017, a similar timeline as for a potential All-Payer Waiver, and that the federal government intends to coordinate. • *How will consistent rates be set? Based on historical reimbursement or historical cost or something else?* Not yet decided. Whatever solution is developed, it will be implemented with a transition period, not all at	

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	once. • *What does it mean for this to "work" for us? Has the state developed criteria?* No, there are too many unknowns – the State doesn't even know what might be included. Those that are highly involved will need a reality check from stakeholders when the time comes, and will make their best judgement. • *What's the State's wish list for providers to potentially be included*? Nothing is off the table yet. It will depend on whether the State sets something up to include or anticipate including particular provider types – other parts of the system may decide that certain provider types are critical to their success and be motivated to include them. The State needs to set up a system for communities to come together to achieve the greatest success, and we don't want to restrict communities' abilities to do that. This will create a framework for local and community-specific needs to be met – and not just geographic communities. • Reaffirmed importance of adequately serving people with developmental disabilities in the current system and a future all-payer model. • *What are the top benefits to doing this?* The ability to really transform health care, to increase coordination in the system to improve peoples' lives. So much about the current system interferes with being able to align the ethical and moral interests of providers with their financial interests, and if we are able to do this together well we'll have more resources in focused in areas like preventive care, avoiding hospitalization and acute care, avoiding development of chronic conditions, and creating a system that helps people have better quality of life. ("Bravo!")	
3. Global Commitment Waiver and Recent Consolidation with Choices for Care Waiver	Monica Light, AHS Director of Health Care Operations, Compliance, & Improvement, presented on Vermont's Global Commitment Waiver and the recent consolidation with the former Choices for Care waiver. Monica will soon be moving to DAIL as Director of Operations. • Monica described the state's Global Commitment 1115 Waiver, including the waiver authority and the flexibilities it affords the state. • The waiver process requires robust public engagement and input. She noted that the state is still working on clarifying its response to home- and community-based service (HCBS) providers, a topic of particular interest to this group. • Vermont's Medicaid managed care structure provides the State with some flexibilities that encourage a holistic approach to serving individuals and families, and supports improved communication and collaboration across services. The Choices for Care program is now afforded flexibilities the program did not previously have as part of its consolidation with the Global Commitment waiver. For example, the Companion Aide Pilot for 5 skilled nursing facilities in the state was allowable under the new waiver but would not previously have been allowed by CMS. • Consolidation also supports efficient waiver administration at the Agency of Human Services (AHS)-level. • As with all 1115 waivers, Vermont's Global Commitment Waiver is budget neutral; the waiver's conditions	

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	establish an aggregate spending limit over the term of the waiver (see Slide 10). Spending limit excludes Vermont's Children's Health Insurance Program (CHIP), Disproportionate Share Hospital (DSH) payments, enhanced federal financial participation for IT infrastructure, and Affordable Care Act initiatives. • One of the biggest advantages to the State is the ability to make investments to meet four broad categories, described on Slide 14. • Slide 15 describes changes with the waiver consolidation, effective 1/30/2015. Monica noted that negotiations with CMS were challenging; CMS and CMMI have different styles and different priorities. CMS has indicated that negotiations for the 2017 waiver renewal also will be challenging. Monica will share a link to the waiver documents, available online, via email. The group discussed the following: • *Is there anything in particular that CMS is reacting to with their warnings about future negotiations?* CMS is not disappointed with our current performance, but is pressured on the federal budget side to reduce flexibility. Vermont is the only state that operates this type of Medicaid managed care model – the only state acting as the managed care entity and single state agency simultaneously. Even though we've operated well under the budget neutrality ceiling, the collective thought is that our current unique arrangement presents a challenge for federal staff to defend at the national level (OMB, GAO, etc.). The federal government does not want to set a precedent for other states that is unfavorable for overall Medicaid goals; even though Vermont is supportive of those goals, other states given that same flexibility may not be. • *Where does the old developmental disability services waiver, incorporated a long time ago, live?* It is outside of the Choices for Care services package but within the broader Global Commitment waiver. • *AHS is using the Comprehensive State Quality Strategy (CQS) as the public process for the HCBS rules. Is this consistent with the federal requirements about notice and participation?* Yes. • *Are there two separate sets of special terms and conditions (STCs)?* Just one. • *It's not clear from the STCs how people with developmental disabilities fit into the HCBS rule requirements. How does this fit in?* AHS is fleshing that out now in an information packet and will make that clear within the next few weeks. This will also describe the public input process and federal requirements. • *How are different AHS departments working on this, for example, the Department of Mental Health (DMH)?* The current plan is that AHS will manage this through the CQS, not yet off the ground. • *How is DAIL going to coordinate with AHS?* DAIL will provide input into the CQS as part of the process. *DAIL is also doing work to demonstrate compliance that is separate from the CQS. Will each department do their own process?* It will be collaborative at the AHS-wide level. There will be work at the Department level, coordinated at the statewide level. • *How is this supporting improved services for beneficiaries, and specifically, the Developmental Services priority systems of care?* The waiver supports flexibility for the State and coordination among providers.	

Agenda Item	Discussion	Next Steps
	o Specific programs are impacted by legislative appropriations and the state budget process. Waiver consolidation won't impact these systemic issues. • *What is the new Companion Aide Pilot?* This was expected to go through the State Plan Amendment process, but since it is not statewide, was incorporated into the waiver. Five nursing facilities were selected by DAIL and AHS to receive reimbursement to provide specific services for individuals with advanced dementia to support improved care. A protocol approved at the end of February details the pilot evaluation criteria among other things. • *There are special managed care regulations, some of which set up special grievance procedures. Will there be education on how this process relates to Choices for Care, since it's new to these providers and populations?* DAIL, AHS, and DVHA staff are working together to update the DAIL-DVHA intergovernmental agreement, which governs all aspects of their relationship under the demonstration. This will include procedural issues like the grievance process, which will be evaluated under this process and any changes communicated out. • *Do the STCs impact the current definition of settings for home- and community-based placement? Does the state need to address person-centeredness? (The rules contain a lot of other provisions, including conflict-free case management, and there are concerns in the Choices for Care world and settings about this.)* There is one STC condition specific to person-centeredness and one specific to setting characteristics. This was part of the discussion with CMS, but Monica does not recall where it landed in the STCs; she will relate a note to improve clarity on this. Deborah Lisi-Baker noted that this relates to some issues brought up during the Duals Demonstration planning process.	
4. Public Comment/Next Steps	Deborah Lisi-Baker noted that today's presentations hopefully provided group members with a common background on the All-Payer Model and Global Commitment waiver. Julie Tessler provided a brief description on the health care bill currently under discussion at the Legislature, and noted that this could be an opportunity for advocacy for organizations involved in this Work Group. Mary Alice Bisbee asked whether this relates to the universal primary system proposed. Georgia Maheras noted that there are currently three health care bills in process, all of which are different. **Next Meeting:** Thursday, April 30, 2015, 10:00am-12:30pm, EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP DLTSS Work Group Member List

Roll Call: 3/26/2015

Quorum not achieved

Member		Member Alternate		February Minutes		
First Name	Last Name	First Name	Last Name			Organization
Susan	Aranoff ✓					AHS - DAIL
Debbie	Austin ✓	Craig	Jones			AHS - DVHA
Mary Alice	Bisbee ✓					Consumer Representative
Molly	Dugan ✓					Cathedral Square and SASH Program
Patrick	Flood					CHAC
Mary	Fredette ✓					The Gathering Place
Joyce	Gallimore ✓					Bi-State Primary Care
Martita	Giard ✓	Susan	Shane			OneCare Vermont
Larry	Goetschius	Joy	Chilton			Home Health and Hospice
Dale	Hackett UTA					None
Mike	Hall					Champlain Valley Area Agency on Aging
Jeanne	Hutchins					UVM Center on Aging
Pat	Jones ✓	Richard	Slusky			GMCB
Dion	LaShay ✓					Consumer Representative
Deborah	Lisi-Baker ✓					SOV - Consultant
Sam	Liss ✓					Statewide Independent Living Council
Jackie	Majoros ✓	Barbara	Prine			VLA/Disability Law Project
Carol	Maroni					Community Health Services of Lamoille Valley
Madeleine	Mongan					Vermont Medical Society
Kirsten	Murphy					Developmental Disabilities Council
Nick	Nichols ✓					AHS - DMH
Ed	Paquin ✓					Disability Rights Vermont
Laura	Pelosi					Vermont Health Care Association
Eileen	Peltier					Central Vermont Community Land Trust
Judy	Peterson ✓					Visiting Nurse Association of Chittenden and Grand Isle Counties
Paul	Reiss	Amy	Cooper			Accountable Care Coalition of the Green Mountains
Rachel	Seelig ✓	Trinka	Kerr			VLA/Senior Citizens Law Project
Julie	Tessler ✓	Marlys	Waller			DA - Vermont Council of Developmental and Mental Health Services
Nancy	Warner	Mike	Hall			COVE
Julie	Wasserman ✓					AHS - Central Office
Jason	Williams					UVM Medical Center
	31		9			

UTA = Unable To Attend

VHCIP DLTSS Work Group Participant List

Attendance: 3/26/2015

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	VHCIP Staff/Consultant
X	Interested Party

First Name	Last Name		Organization	DLTSS
Susan	Aranoff	here	AHS - DAIL	S/M
Debbie	Austin		AHS - DVHA	M
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
Susan	Besio	phone	SOV Consultant - Pacific Health Policy Group	S
Bob	Bick		DA - HowardCenter for Mental Health	X
Mary Alice	Bisbee	here	Consumer Representative	M
Denise	Carpenter		Specialized Community Care	X
Alysia	Chapman	here	DA - HowardCenter for Mental Health	X
Joy	Chilton		Home Health and Hospice	MA
Amanda	Ciecior	here	AHS - DVHA	S
Peter	Cobb		VNAs of Vermont	X
Amy	Coonradt	here	AHS - DVHA	S
Amy	Cooper		Accountable Care Coalition of the Green Mountains	MA
Alicia	Cooper	here	AHS - DVHA	S
Molly	Dugan	here	Cathedral Square and SASH Program	M

Patrick	Flood		CHAC	M
Erin	Flynn	here	AHS - DVHA	S
Mary	Fredette		The Gathering Place	M
Joyce	Gallimore	Phone	Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Martita	Giard		OneCare Vermont	M
Larry	Goetschius		Home Health and Hospice	M
Bea	Grause		Vermont Association of Hospital and Health Systems	X
Dale	Hackett	Unable to attend	None	M
Mike	Hall		Champlain Valley Area Agency on Aging / COVE	M/MA
~~Janie~~	~~Hall~~		OneCare Vermont	A
Bryan	Hallett	here	GMCB	S
Carolynn	Hatin		AHS - Central Office - IFS	S
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	X
~~Churchill~~	~~Hindes~~		OneCare Vermont	X
Jeanne	Hutchins		UVM Center on Aging	M
Craig	Jones		AHS - DVHA - Blueprint	MA
Pat	Jones	here	GMCB	S/M
Margaret	Joyal		Washington County Mental Health Services Inc.	X
Joelle	Judge	here	UMASS	S
Trinka	Kerr		VLA/Health Care Advocate Project	MA
Sarah	Kinsler	here		S
Tony	Kramer		AHS - DVHA	X
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Dion	LaShay	Phone	Consumer Representative	M
Deborah	Lisi-Baker	here	SOV - Consultant	C/M
Sam	Liss	Phone	Statewide Independent Living Council	M
Vicki	Loner		OneCare Vermont	X
Georgia	Maheras	here	AOA	S
Jackie	Majoros	Phone	VLA/LTC Ombudsman Project	M
Carol	Maroni		Community Health Services of Lamoille Valley	M
Mike	Maslack			X

Lisa	Maynes		Vermont Family Network	X
Madeleine	Mongan		Vermont Medical Society	M
Todd	Moore		OneCare Vermont	X
Mary	Moulton		Washington County Mental Health Services Inc.	X
Kirsten	Murphy		AHS - Central Office - DDC	M
Floyd	Nease	here	AHS - Central Office	X
Nick	Nichols		AHS - DMH	M
Miki	Olszewski		AHS - DVHA - Blueprint	X
Jessica	Oski		Vermont Chiropractic Association	X
Ed	Paquin	here	Disability Rights Vermont	M
Annie	Paumgarten	here	GMCB	S
Laura	Pelosi		Vermont Health Care Association	M
Eileen	Peltier		Central Vermont Community Land Trust	M
Judy	Peterson	here	Visiting Nurse Association of Chittenden and Grand Isle Countie	C/M
John	Pierce			X
Luann	Poirer		AHS - DVHA	S
Barbara	Prine		VLA/Disability Law Project	MA
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Virginia	Renfrew		Zatz & Renfrew Consulting	X
~~Ken~~	~~Schatz~~		AHS - DCF	X
Rachel	Seelig	here	VLA/Senior Citizens Law Project	M
Susan	Shane		OneCare Vermont	MA
Julia	Shaw		VLA/Health Care Advocate Project	X
Richard	Slusky		GMCB	S/MA
Kara	Suter		AHS - DVHA	S
Beth	Tanzman		AHS - DVHA - Blueprint	X
Julie	Tessler	there/here	DA - Vermont Council of Developmental and Mental Health Serv	M
Bob	Thorn		DA - Counseling Services of Addison County	X
Beth	Waldman	Phone	SOV Consultant - Bailit-Health Purchasing	S
Marlys	Waller	here	DA - Vermont Council of Developmental and Mental Health Serv	MA
~~Norm~~	~~Ward~~		OneCare Vermont	X
Nancy	Warner		COVE	M
Julie	Wasserman	here	AHS - Central Office	S/M
Kendall	West			X
James	Westrich		AHS - DVHA	S

Bradley	Wilhelm	here	AHS - DVHA	S
Jason	Williams		UVM Medical Center	M
Cecelia	Wu		AHS - DVHA	S
Marie	Zura		DA - HowardCenter for Mental Health	X
				89

Lawrence Miller AOA
Cathy Fulton VPQHC
Monica Light AHS

Attachment 2

Work Plan

Vermont Health Care Innovation Project
Year 2 DLTSS Work Group Workplan
3/6/2015

	Objectives	Supporting Activities	Target Date	Responsible Parties	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Quality and Performance							
1	Provide input on various measure sets related to SIM and other relevant activities.	When requested by QPM Work Group, recommend Year 3 DLTSS Quality and Performance Measures for Medicaid and Commercial ACO SSPs.	Q1-Q2 2015	Work group members; co-chairs; staff; consultant.	Recommend Year 3 DLTSS measures for Medicaid and Commercial ACO SSPs when requested (QPM Work Group).	QPM Work Group		• Input provided to QPM Work Group. • VHCIP and AHS measures support optimal quality and performance measurement for DLTSS populations and providers.
2		Following sub-group presentation on possible approaches, recommend a process and methodology for the DLTSS sub-analyses of Year 1 Medicaid and Commercial ACO SSP quality and performance measures.	April-May 2015	Work group members; co-chairs; staff; consultant; DVHA staff.	Endorse (QPM Work Group).	DVHA	• Sub-group to be created in March/April 2015.	
3		When requested, provide input to QPM Work Group on Year 2 SSP and Year 3 recommendations.	TBD	Staff; co-chairs; work group members; consultant.	Draft measures and request input (QPM Work Group).	QPM Work Group		
4		When requested, provide input to QPM Work Group on measures for Episode of Care reforms.	TBD	Staff; co-chairs; work group members; consultant.	Draft measures and request input (QPM Work Group).	QPM Work Group		
5		When requested, provide input to QPM Work Group on measures for Pay-for-Performance reforms.	TBD	Staff; co-chairs; work group members; consultant.	Draft measures and request input (QPM Work Group).	QPM Work Group		
6		Provide input to AHS Performance Accountability Committee (PAC) on PAC's newly developed DLTSS-specific performance measures for Consolidated Global Commitment Waiver beneficiaries, as part of the public comment process.	Q3 2015	Staff; co-chairs; work group members; consultant; AHS/SIM staff.	N/A	N/A		
	Care Models & Care Management							
7	Provide input regarding VHCIP care models and care management structures.	Develop brief descriptive documents (to include definition, goals, and indicators) for DLTSS Work Group endorsement on each of the following: Cultural Competency, Disability Competency, Accessibility, and Universal Design. (For Model of Care Best Practices, see Slide 15 of DLTSS Model of Care.)	Q2 2015	Work group members; co-chairs; staff; consultant.	Develop documents to guide care models (CMCM Work Group).	N/A		• Input provided to CMCM Work Group. • DLTSS populations and providers are represented in care models and care management structures.
8		Continue Provider Training discussion and gather input for provider training initiative (team-based care, grand rounds, involvement of beneficiaries and their families, etc.).	Q2 2015	Work group members; co-chairs; staff; consultant; CMCM Work Group.	Collaborate with relevant stakeholders to continue Provider Training discussion (Providers; CMCM Work Group, or care management learning collaborative planning group and participants).	N/A		
9		Develop DLTSS-specific Core Competency Domains for service providers participating in the Integrated Communities Care Management Learning Collaborative.	Q2 2015	Work group members; co-chairs; staff; consultant; CMCM and Workforce Work Group members.	N/A	CMCM Work Group (with input from Learning Collaborative planning group) and Workforce Work Group	• Initial planning meetings held with DLTSS, Workforce, and CMCM work group staff. • Draft domains developed, need to be further refined.	
10		Recommend care management best practices to CMCM Work Group.	Ongoing	Work group members; co-chairs; staff; consultant; CMCM Work Group.	N/A	CMCM Work Group		

	Objectives	Supporting Activities	Target Date	Responsible Parties	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Payment Models							
11	Review current and planned payment methodologies and, as appropriate, recommend payment methodologies to encourage integration between DLTSS, acute care, and population health.	Review possible new payment models that reimburse for DLTSS-specific population outcomes. Make recommendations regarding implementation, as appropriate.	Q3-Q4 2015	Work group members; co-chairs; staff; consultant; Payment Models Work Group members.	N/A	Payment Models Work Group		Current and planned payment methodologies reviewed, and recommendations provided as appropriate.
12		Recommend payment methodologies that incentivize providers to bridge the service delivery gap between acute/medical care and long-term services and supports.	Q3-Q4 2015	Work group members; co-chairs; staff; consultant; Payment Models Work Group members.			May request CMMI TA on this topic.	
13		Continue collaboration with Population Health Work Group to develop policy, plans, and strategies to create a viable financial model that supports the broader goals of population health.	Ongoing 2015	Work group members; co-chairs; staff; consultant; Payment Models and Population Health Work Group members.	Collaborate to develop policy, plans, and strategies to create viable financial model to support population health goals (Population Health and Payment Models Work Groups).	N/A		
14		Collaborate with Payment Models Work Group on Nursing Home Initiatives, including Bundled Payments for Care Improvement (BPCI) Initiative.	Q1 and Q2 2015	Work group members; co-chairs; staff; consultant; Payment Models Work Group members.	Collaborate to develop Nursing Home Initiatives (AHS, DAIL).			
15	Provide recommendations to address payment issues and barriers relevant to DLTSS populations and providers.	Develop DLTSS recommendations regarding inclusion of Non-Core Service Expenditures for Year 3 Medicaid SSP total cost of care expansion.	August-September 2015	Work group members; co-chairs; staff; consultant; DLTSS providers; AHS Departments; ACOs.	Collaborate to develop recommendations regarding Non-Care Service Expenditures (Payment Models Work Group; AHS, AHS Departments); and to identify barriers and make recommendations for solutions to Medicare, Medicaid, and commercial coverage and payment policies (Payment Models Work Group; AHS, AHS Departments; CMS).	N/A		Recommendations provided to Payment Models Work Group, AHS, AHS Departments, and others.
16		Identify barriers and develop strategies to address them in Medicare, Medicaid, and commercial coverage and payment policies for people needing DLTSS services (e.g., DME approval process and coverage; curative and hospice benefits; commercial coverage for attendant care; coverage of medical and mental health services in nursing homes to reduce hospital admissions and improve outcomes). Make recommendations for implementation.	Q2-Q3 2015	Work group members; co-chairs; staff; consultant.				
	Health Information Exchange & Health Information Technology							
17	Provide recommendations on technical and IT needs to support new payment and care models that meet the needs of DLTSS populations and providers.	Recommend technical and IT needs to support: new payment and care models for integrated care, beneficiary portals, and accessibility and universal design in collaboration with HIE/HIT and Payment Models Work Groups.	Q2-Q4 2015	Work group members; co-chairs; staff; consultant; HIE/HIT and Payment Models Work Groups.	Collaborate to identify technical and IT needs (HIE/HIT Work Group).	N/A		Recommendations provided to HIE/HIT and Payment Models Work Groups.
18	Provide recommendations on informed consent and confidentiality issues, including 42 CFR Part 2.	Discuss a) Informed Consent and general confidentiality issues and b) Federal rules contained in 42 CFR Part 2 Confidentiality Protections and make recommendations to HIE/HIT Work Group.	Q3 2015	Work group members; co-chairs; staff; consultant; HIE/HIT Work Group, VITL.	Collaborate to discuss informed consent and confidentiality (HIE/HIT Work Group).	N/A		Recommendations provided to HIE/HIT Work Group.
19	Support other	Work with HIE/HIT Work Group to perform data quality	February	Staff; consultant; work	Coordinate on DA/SSA data quality	HIE/HIT Work	• In progress.	HIE/HIT Work

	Objectives	Supporting Activities	Target Date	Responsible Parties	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	HIE/HIT Work Group activities related to DLTSS providers and populations.	workflow analysis of DLTSS Providers (ACTT DLTSS Data Quality project).	2015 and ongoing	group members; contractors; co-chairs.	project (HIE/HIT Work Group; DLTSS providers; VITL).	Group		Group activities related to DLTSS providers and populations are informed by DLTSS Work Group members and staff.
20		Work with HIE/HIT Work Group to perform a data quality technical assessment of DLTSS Providers (ACTT DLTSS Data Quality project).	February 2015 and ongoing	Staff; consultant; work group members; contractors; co-chairs.	Coordinate on DA/SSA data quality project (HIE/HIT Work Group; DLTSS providers; VITL).	HIE/HIT Work Group	• In progress.	
21		Work with HIE/HIT Work Group to perform a technical assessment of DLTSS Providers to prepare for possible EHR adoption, where appropriate, in the future (ACTT DLTSS Data Quality project).	February 2015 and ongoing	Staff; consultant; work group members; contractors; co-chairs.	Coordinate on ACTT DLTSS project (HIE/HIT Work Group; DAIL; DLTSS providers; VITL).	HIE/HIT Work Group	• In progress.	
22		Collaborate with HIE/HIT Work Group on the planning, development and implementation of a Uniform Transfer Protocol (UTP).	February 2015 and ongoing	Staff; consultant; work group members; contractors; co-chairs.	Coordinate on ACTT DLTSS UTP project (HIE/HIT Work Group; DAIL; DLTSS providers; VITL).	HIE/HIT Work Group	• In progress.	
	Ongoing Updates, Education, & Collaboration							
23	Review and approve updated DLTSS Work Group Workplan.	Draft Workplan.	February-March 2015	Staff, co-chairs; consultant; work group members.	N/A	N/A		Updated workplan adopted.
24	Coordinate and collaborate with other VHCIP Work Groups on activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups.	Ongoing	Staff; co-chairs; work group members; other work groups; consultant.	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).			Well-coordinated and aligned activities among work groups.
25		Ensure DLTSS principles (person-centered, disability-related, person-directed, cultural competency) are incorporated into VHCIP Work Group activities. Provide information to VHCIP Work Groups on DLTSS populations and the service system as needed to inform achievements of their Work Group goals and activities.	Ongoing	Staff; consultant; co-chairs; work group members; other VHCIP Work Groups.				
26		Obtain information and updates on VHCIP Provider Grants and their relationship to the DLTSS Work Group.	Quarterly	Staff; co-chairs; work group members; sub-grantees; consultant.	Obtain regular updates on relevant sub-grantee projects (Sub-Grantees).	N/A		
27		Receive presentation from Washington County Mental Health Services and other Washington County providers.	Q1 2015	Staff; co-chairs; work group members; consultant.		N/A	Presentation received in February 2015.	
28		Obtain regular updates on Integrated Communities Care Management Learning Collaborative.	Quarterly, starting Q2 2015	Staff; co-chairs; work group members; consultant; CMCM Work Group.	Obtain regular updates on Learning Collaborative (CMCM Work Group).	N/A		
29		Obtain updates on Payment Models Work Group activities.	March and July 2015	Staff; co-chairs; work group members; consultant; Payment Models Work Group.	Obtain regular updates on Payment Models Work Group activities (Payment Models Work Group).	N/A		
30		Receive presentations on current and possible future use of flexible funds within Medicaid to prevent unnecessary hospitalizations, ER visits, and nursing home admissions, and to promote appropriate use of medications, as well as funding other social safety net services.	Q3 and Q4 2015	Work group members; co-chairs; staff; consultant; AHS and DVHA staff.	Receive presentations on use of flexible Medicaid funds (AHS and DVHA staff).	N/A	May request CMMI TA on this topic.	
31		Provide input to Population Health Work Group on activities related to DLTSS providers and populations. • Review draft Population Health Plan outline developed by		Staff; co-chairs; work group members; consultant; Population Health Work Group.	• Receive PHP outline (Population			

	Objectives	Supporting Activities	Target Date	Responsible Parties	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
		Population Health Work Group. • Receive presentation on "population health" definition and Population Health 101 materials developed by Population Health Work Group. • Collaborate with CMCM, Population Health, and Payment Models Work Groups to create materials that show connection between social determinants, population health, and clinical measures. • Provide input to Population Health Work Group as the group develops recommendations for the Payment Models Work Group on potential links between prevention financing and payment models being tested.	Q3 2015		Health Work Group). • Receive definition and materials (Population Health Work Group). • Collaborate to identify existing care models (Population Health Work Group; Blueprint). • Receive draft prevention financing recommendations (Payment Models and Population Health Work Groups).			
32			Q4 2014					
33			Q1 2015					
34			Q2 and Q3 2015					
35		Gather input on building workforce capacity; obtain update from Workforce Work Group and Workforce Sub-Committee on Long-Term Care.	Q2 2015	Staff; co-chairs; work group members; Workforce Work Group.	Obtain update on Workforce Work Group and Sub-Committee activities (Workforce Work Group).	N/A		
36		Obtain regular updates on the ACTT Project.	Monthly, starting Q1 2015	Work group members; co-chairs; staff; consultant; HIE/HIT Work Group.	Obtain regular updates on the ACTT Project (HIE/HIT Work Group).	N/A		
37	Coordinate with, update, and receive education from VHCIP Core Team, Steering Committee, other VHCIP leadership and stakeholders, and AHS Departments as appropriate.	Overall VHCIP project status updates.	Ongoing	Staff; co-chairs; work group members; consultant; VHCIP leadership.	N/A	N/A		Well-coordinated and aligned activities across VHCIP.
38		Update Steering Committee, Core Team, and other VHCIP groups and stakeholders as appropriate.	Ongoing	Staff; co-chairs; work group members; consultant; VHCIP leadership	N/A	N/A		
39		Present Medicaid Expenditure Analysis to Steering Committee and Core Team.	March 2015	Staff; consultants.	Steering Committee and Core Team	N/A		
40		Receive in-depth presentation on Global Commitment (GC) Waiver consolidation.	March 2015	Staff; co-chairs; work group members; consultant; AHS staff.	Receive presentation on GC Waiver Consolidation (AHS).	N/A	• Presentation scheduled for March 2015.	
41		Receive presentation on AHS surveys (DMH and DVHA).	Q1 2015	Staff; co-chairs; work group members; consultant; DVHA and DMH staff.	Receive presentation on DMH and DVHA surveys (DMH; DVHA).	N/A	• DMH presentation occurred in January 2015.	

Attachment 3

DLTSS/CMCM Learning Collaborative and DLTSS Core Competency Training

Attachment 4

Northeast Kingdom Dual Eligible Project Update

Caledonia & Southern Essex Dual Eligible Project

Date: April 30, 2015

Pam Smart & Treny Burgess

Project Overview

- Vermonters who are eligible for both Medicare and Medicaid are some of the most challenging and expensive persons to care for.
- Desired outcome is to provide better, person-centered care and reduce expenditures for Medicare and Medicaid by:
  - Hiring Health Coach to work with clients
  - Establish Dual Eligible Core Team to meet bi-monthly to discuss individuals' services, situations, and problem solve
  - Use flexible funds to fill gaps in service

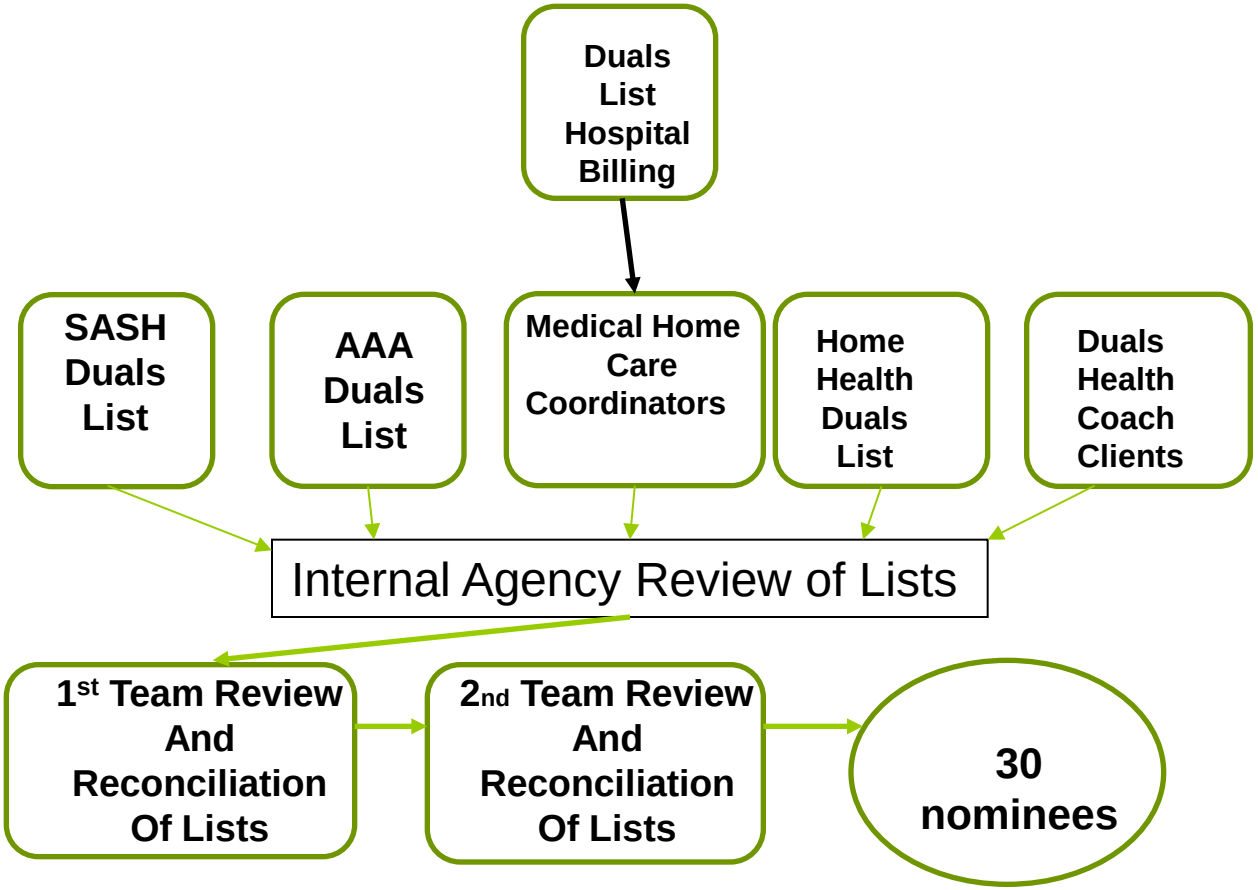
Project Objectives

- Identify dually eligible individuals at risk of harm, unnecessary nursing home stays or hospitalization
- Assign the individuals to a community interdisciplinary team
- Assign a lead case manager to be the primary contact with the individual and their support network
- Use a comprehensive assessment and care planning process to identify individual strengths and needs
- Develop a comprehensive person-centered plan of services

Our Community

- **30,000 people; Caledonia and s. Essex**
- **Collaborative Team:**
  - **AHS**
  - **Northeast Kingdom Human Services (mental health)**
  - **Northeastern VT Regional Hospital (primary care, inpatient, ER, Community Connections)**
  - **Northeastern Vermont Area Agency on Aging**
  - **Northern Counties Health Care (FQHC & home health)**
  - **RuralEdge (housing and SASH)**
  - **VCCI**

Identify Dual Eligible Individuals



Interdisciplinary Team and Lead Case Manager

- Team reviews all nominated individuals to determine community partner with closest relationship to act as lead case manager
- Lead case manager visits with individual to discuss project and get signed consent to participate

Identify Individual Strengths and Needs

- Discussion in bi-monthly meetings
- Shared Care Plan
- Camden Cards

Shared Care Plan

- Care Plan includes
  - Care Team members
  - Individual action plan and goal
  - Medical treatment plan
  - Identified lead case manager
  - Strengths of individual
  - Barriers for Individual

Camden Cards

- Health Education & Management
- Housing Assistance
- Mental Health
- Education
- Health Insurance
- Utilities
- Medication & Supplies
- Legal
- Family Relationships
- Relationship & Safety
- Budgeting/Finances
- Food & Nutrition
- Transportation
- Wild Card

Lessons Learned

- Some of most complex individuals do not have a case manager
- Lead case manager may change as individual's needs change
- Some individuals have many community partners working with them without realizing this
- Individuals may be reluctant to participate due to collaborative release

Challenges

- How do we share information across organizations
- Need for stronger partnership with VCIL
- Lack of funding for preventative wellness
- Lack of funding for Dental Needs
- More dual eligible individuals in the community than the health coach has the capacity to serve
- Need documentation from PCP to justify equipment needs
- Individuals may leave the project due to death, relocation, or choosing to remove themselves.

Opportunities

- Brings domains of medical/mental/social health together
- Find alternate funding sources when working together
- Green Mountain United Way/ VT211 Registry for emergency care now in use for all Duals seen by the Health Coach

Recent Accomplishments

- Alternative medicine (yoga) offered to a client with chronic pain from injury to spine
- One client regularly attending local fitness center for strength training for joint disease
- Another client seeing a personal trainer for weight loss and strength training (lost 15 more pounds)
- Partnership with VCIL improving e.g. ramp assessment done at client
- Health Coach has added more home visit clients; services include walking with clients in their neighborhoods

Case Study

- D.D.-55 year old morbidly obese female with hypertension, atrial fibrillation, seasonal depression and anxiety
  - Services:
    - Health Coach visited with Home Health PT to learn exercise program and assist with follow through
    - Flexible funds for seasonal lamp and cardiac monitor for use during exercise. Flexible funds for personal trainer in home ($690)
  - Outcome:
    - Weight loss of 85 pounds
    - Individual reports improvement in symptoms of depression

Case Study

- B.L.- 25 year old male, former athlete, paraplegic, recently returned to the area without PCP
  - Services:
    - Flexible Funds for shower seat and repairs to wheelchair lift on truck ($2163)
    - Health Coach has weekly interactions by phone or visits
    - Health Coach assisted in connecting with PCP and voc rehab
    - Health Coach assisted in obtaining benefits and appt at wheelchair clinic
  - Outcome:
    - Independent with activities of daily living
    - Independent transportation
    - Has been hospitalized once since returning to area, CCC at PCP office knows to contact individual if missed appt to prevent transportation or other factors from contributing to health decline

Case Study

- C.C.- 65 yr old female with Rheumatoid Arthritis, Respiratory Disease due to mold. Living in unsafe housing, no water, electricity, heating with small wood stove, leaking roof, mold and rodent infested. Individual is angry, frustrated, and lonely. Has restraining orders from most agencies. APS identified as not self-neglect. Referral from AHS to Community Connections.
  - Services:
    - Assisted individual with housing applications and appeals, set up transportation to Fletcher Allen for Infusions
    - Flexible funds purchased new therapeutic mattress that was mold-free and necessary for arthritis relief, gas and food cards, and gym membership ($1891)
  - Outcome:
    - Fewer ER visits- 6-8 visits yearly prior to intervention, 0 ER visits since intervention from Duals project