

**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
<p>1. Welcome and Introductions</p>	<p>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.</p>	
<p>2. All-Payer Model – Goals, Objectives, Desired Outcomes, and Next Steps</p>	<p>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.</p> <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> ○ 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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	<p>balance controlling health care costs with ensuring providers can continue to operate in our communities.</p> <ul style="list-style-type: none"> ○ 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. <p>Lawrence addressed a list of questions sent prior to the meeting by DLSS Work Group members (Attachment 2b):</p> <ol style="list-style-type: none"> 1. <i>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?</i> See presentation. 2. <i>How will an All-Payer Model affect costs, affordability, health outcomes, and population health? Where might we see savings?</i> 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. <i>Will an All-Payer Model improve the delivery of services for people in general and for those with DLSS needs? Will the All-Payer Model help expand community-based services for people with DLSS needs?</i> Yes, as described above. <ul style="list-style-type: none"> • <i>What about vulnerable adults and children with developmental disabilities, already hard hit by state budget cuts?</i> This is related to broader State budgetary factors, not the potential All-Payer Model. 4. <i>Under an All-Payer Model, will all payers (Medicare, Medicaid, Commercial insurers, Uninsured) pay providers the same rate for the same service?</i> Not necessarily – there will likely be variations based on population, risk, and other variables. 5. <i>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?</i> 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. <i>Are Commercial insurers supportive of the All-Payer concept?</i> At this time they are fully supportive. 7. <i>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</i> 	

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	<p><i>payment rates?</i></p> <p>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.</p> <p>8. <i>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?</i></p> <p>See Question 7.</p> <p>9. <i>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?</i></p> <p>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.)</p> <ul style="list-style-type: none"> • <i>Could this result in Medicare cuts?</i> 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. • <i>Don’t commercial insurers negotiate very reduced rates with providers?</i> 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. <p>10. <i>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.)</i></p> <p>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.</p> <p>11. <i>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?</i></p>	

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	<p>This is part of the negotiation with CMS and not yet decided.</p> <p>12. <i>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?</i> 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.)</p> <p>13. <i>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?</i> 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.</p> <p>14. <i>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?</i> 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.</p> <ul style="list-style-type: none"> • <i>Could there be regional systems in areas where providers are currently working together to provide coordinated and integrated care (for example, the Northeast Kingdom)?</i> 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. <p>15. <i>Will the development of an All-Payer Model incorporate SIM Payment Reform planning efforts on “episodes of care”?</i> 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.</p> <p>16. <i>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?</i> 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.</p> <p>17. <i>Will an All-Payer Model have any effect on out-of-pocket costs for beneficiaries?</i> 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.</p> <p>18. <i>The slide titled “Structure for leadership, staffing and stakeholder input on model agreement” includes a</i></p>	

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	<p><i>reference to “APM affected parties advisory group.” Who will this advisory group include? When will it be formed and begin meeting?</i></p> <p>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.</p> <p>19. <i>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?</i></p> <p>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.</p> <p>20. <i>Can you list the top 5 challenges in initiating, developing, and implementing an All-Payer Model in Vermont?</i></p> <p>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.</p> <p>The group discussed the following:</p> <ul style="list-style-type: none"> • <i>What is Medicare Shared Savings?</i> 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). • <i>Would Vermont’s model include only hospitals, as in Maryland, or other providers like mental health or home health?</i> 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. • <i>How will consistent rates be set? Based on historical reimbursement or historical cost or something else?</i> Not yet decided. Whatever solution is developed, it will be implemented with a transition period, not all at 	

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	<p>once.</p> <ul style="list-style-type: none"> • <i>What does it mean for this to “work” for us? Has the state developed criteria?</i> 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. • <i>What’s the State’s wish list for providers to potentially be included?</i> 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. • <i>What are the top benefits to doing this?</i> 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!”) 	
<p>3. Global Commitment Waiver and Recent Consolidation with Choices for Care Waiver</p>	<p>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.</p> <ul style="list-style-type: none"> • 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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	<p>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.</p> <ul style="list-style-type: none"> • 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. <p>Monica will share a link to the waiver documents, available online, via email.</p> <p>The group discussed the following:</p> <ul style="list-style-type: none"> • <i>Is there anything in particular that CMS is reacting to with their warnings about future negotiations?</i> 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. • <i>Where does the old developmental disability services waiver, incorporated a long time ago, live?</i> It is outside of the Choices for Care services package but within the broader Global Commitment waiver. • <i>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?</i> Yes. • <i>Are there two separate sets of special terms and conditions (STCs)?</i> Just one. • <i>It’s not clear from the STCs how people with developmental disabilities fit into the HCBS rule requirements. How does this fit in?</i> 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. • <i>How are different AHS departments working on this, for example, the Department of Mental Health (DMH)?</i> The current plan is that AHS will manage this through the CQS, not yet off the ground. • <i>How is DAIL going to coordinate with AHS?</i> DAIL will provide input into the CQS as part of the process. <i>DAIL is also doing work to demonstrate compliance that is separate from the CQS. Will each department do their own process?</i> It will be collaborative at the AHS-wide level. There will be work at the Department level, coordinated at the statewide level. • <i>How is this supporting improved services for beneficiaries, and specifically, the Developmental Services priority systems of care?</i> The waiver supports flexibility for the State and coordination among providers. 	

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	<ul style="list-style-type: none"> ○ Specific programs are impacted by legislative appropriations and the state budget process. Waiver consolidation won't impact these systemic issues. ● <i>What is the new Companion Aide Pilot?</i> 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. ● <i>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?</i> 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. ● <i>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.)</i> 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. 	
<p>4. Public Comment/Next Steps</p>	<p>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.</p> <p>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.</p> <p>Mary Alice Bisbee asked whether this relates to the universal primary system proposed.</p> <p>Georgia Maheras noted that there are currently three health care bills in process, all of which are different.</p> <p>Next Meeting: Thursday, April 30, 2015, 10:00am-12:30pm, EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier.</p>	