

Vermont Health Care Innovation Project DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, May 28, 2015, 10:00am-12:30pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston

Agenda Item	Discussion	Next Steps
1. Welcome, Approval of Minutes	<p>Deborah Lisi-Baker called the meeting to order at 10:03am. A roll call attendance was taken and a quorum was not present. A quorum was present after the second agenda item.</p> <p>Deborah Lisi-Baker entertained a motion to approve the April 30, 2015, meeting minutes. Susan Aranoff moved to approve the minutes by exception. Ed Paquin seconded. The minutes were approved with three abstentions.</p>	
2. DLTSS-Specific Core Competencies	<p>Deborah Lisi-Baker introduced the six draft DLTSS-Specific Core Competency briefs, authored by Susan Besio of PHPG. These drafts incorporate initial feedback and edits by Julie Wasserman and Deborah Lisi-Baker, and further feedback and edits from Erin Flynn, Sarah Kinsler, Sue Aranoff, and Beth Waldman. (See Attachments 2a-2f.) Susan Besio requested specific feedback from the DLTSS Work Group members in writing by June 8th.</p> <p>Susan reminded the group of the intent of these briefs: to create six foundational/source documents on which to build training curriculums, educational materials, and other products for providers and other audiences. Format and framing could change for each purpose and audience. The briefs focus on providing definitions and explaining key concepts, with concrete examples. While the original intent was to provide information targeted to medical care providers, the briefs were written so they could be relevant to all health care, services and support providers. Regarding specific briefs, Susan noted that the term “care management practitioners” was used because this is a catch-all term to refer to any professional that is performing functions around care coordination and integration, recognizing that this may include many different job titles. Susan also noted that the brief regarding Universal Design incorporates accessibility but is conceptually broader.</p> <p>The group discussed the following.</p> <ul style="list-style-type: none"> • Susan Aranoff suggested that providers need resources like this and are likely to appreciate them – Allan Ramsay of GMCB remarked yesterday that he is excited to see these resources. Susan Besio noted that the 	<p>Members will provide feedback on the briefs by Monday, June 8th; please track all changes in Word documents or send bulleted comments via email.</p> <p>Joelle Judge will resend the briefs following the meeting.</p>

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	<p>DLTSS Work Group leadership team intends to request provider feedback on these, and would love recommendations on providers who might be willing to review.</p> <ul style="list-style-type: none"> • Erin Flynn suggested posting these on our website once final; though they are not training materials in their current form, they may be useful resources. Susan Besio suggested we may want to make GMCB, the Medical Society, and others aware of these resources. • Mike Hall noted that disability literacy and competency of managed care entities is a critical issue as more states move to managed long-term care; MCOs often do not have a history of working with individuals with disabilities or elders. States have addressed this through MCO selection processes and contracts with MCOs. Mike suggests that these could also be a helpful resource for ACOs. Julie Wasserman noted that DAIL is advocating for language about disability competency and universal design in ACO contracts currently being negotiated. Mike noted that a number of states have developed contract language that could be helpful to review; Truven has created model contract language that is publicly available. • Susan Aranoff noted that Care Management Standards developed by the CMCM Work Group, which include language about accessibility and universal design, are also being discussed in Year 2 Medicaid ACO contract negotiations. DAIL is working to get standard definitions from these briefs included in ACO contracts, and suggested that it would be very helpful to use consistent definitions across VHCIP and in other applications where possible. • Nick Nichols noted that recent Vermont legislation addressed the use of person-first and respectful language regarding disabilities within Vermont Statutes, and suggested Susan Besio review this legislation to ensure the briefs are consistent with it. • Mary Alice Bisbee suggested Susan Besio review the Secretary of State’s disability awareness pamphlet. • Dale Hackett commented that education is great, but that changing practice is more important. He suggested that in-service trainings would be a good next step, perhaps through the Integrated Communities Care Management Learning Collaborative. Deborah Lisi-Baker noted that these briefs could be a foundation for that future training among others. Dale suggested that UVM Medical School could be a good opportunity for training future clinicians. Susan Besio and Suzanne Santarcangelo noted that UVM residency training does include mock sessions and interviews – this could be a good opportunity. Jason Williams noted that the residency is open to feedback and is happy to connect us. • Barb Prine suggested new sections to specifically note traumatic brain injury (TBI) and autism-spectrum disorder. She also suggested discussing refugee status in the cultural competency brief. Barb noted that there is also overlap between refugee/New American populations and people with disabilities. Deborah Lisi-Baker agreed. Susan Besio noted that the writing group considered creating a separate brief for people with mental health disorders but felt this was stigmatizing, and felt they would have needed to write a full set of six briefs specifically for mental health disorders; she invited input on how to strengthen that aspect within the existing briefs. • Dale Hackett noted that the intent is as important as the wording and needs to be clear. • The term “invisible or hidden disabilities” was suggested to refer to mental health disorders and autism- 	

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	spectrum disorder.	
3. DAIL Timeline for Addressing CMS’s New Home- and Community-Based Services (HCBS) Waiver Regulations	<p>Susan Aranoff presented on CMS’s new Home- and Community-Based Services (HCBS) waiver regulations, and provided an update on DAIL’s timeline for addressing them. (See Attachment 3.)</p> <ul style="list-style-type: none"> • Review Draft with External Stakeholders at DAIL Advisory Board: June 11 • Review Draft with External Stakeholders at DDS Standing Committee: June 18 • Develop Final Draft: June 30 • Public Comment Process Begins: July 1 • Review Final Draft with AHS Performance Accountability Committee: July 3 • Review Final Draft with Medicaid and Exchange Advisory Board: July 15 • Public Hearing: July 23 • Draft of Revised Comprehensive Quality Strategy Submitted to CMS: July 31 <p>The group discussed the following.</p> <ul style="list-style-type: none"> • Julie Tessler asked which parts of the new regulations are mandated by CMS and which are a result of Vermont’s priorities. Susan Aranoff responded that there are others working on this who might be able to answer. She suggested that comment be submitted through the official comment process. Deborah Lisi-Baker noted that the June meeting may include a more in-depth presentation on this topic but that it would be “educational” in nature, providing background information on the regulations, as Georgia has clarified that any broader discussions on the State’s implementation of these regulations should be done outside the SIM/VHCIP activities. • Dale Hackett expressed concern that this might not capture services that are needed but not currently covered. Susan Aranoff noted that unpaid services are included in “services provided.” • Nicole LeBlanc commented that it is critical to avoid siloes in service delivery, and that the HCBS regulations address conflict-free case management. • Jackie Majoros noted that conflict-free case management provisions may require changes; also, definitions of home- and community-based settings are critical. Jackie believes this requires a broader discussion to see how these new rules fit into broader waivers, not just Choices for Care, and to plan for how to ensure Vermont is in compliance. Susan Aranoff noted that the Transition Plan is the process by which the State will determine whether it is in compliance; the phase-in period is lengthy. • Deborah Lisi-Baker suggested that this discussion be tabled for another forum when more information is available from DAIL/AHS. • Mike Hall noted that CMS criteria and standards are critical to understanding the changes and Vermont’s interpretation/response. He hopes the draft will be available for public review soon. Susan Aranoff noted that the public comment period is the ideal time for this review. • Georgia Maheras noted that this issue is outside of VHCIP’s jurisdiction, but that it is appropriate to use the distribution list for this group to disseminate information. 	
4. Payment	Alicia Cooper provided an update on the activities of the Payment Models Work Group. (See Attachments 4a and	Joelle Judge will

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Models Work Group Presentation	<p>4b.) She briefly reviewed major topics of discussion of the Payment Models Work Group over the past year:</p> <ul style="list-style-type: none"> • <i>Proposed changes to the Blueprint for Health payment methodology.</i> Recommendations were made prior to this issue being decided at the Legislature. Additional funding from the Legislature ended up being less than originally hoped. Recommendations will go to the Blueprint Executive Committee next week. • <i>Changes to Vermont Medicaid Shared Savings Program (VMSSP) Year 2 Gate & Ladder Methodology.</i> Changes align with Medicare Shared Savings Program (MSSP) and reflect Year 1 experience. Three major changes: increase to minimum threshold for savings eligibility (aligns VMSSP with Commercial Shared Savings Program); switch from percentage of points earned to absolute points earned; and introduction of bonus point for significant improvement over past performance in addition to points for performance compared to national standards (aligns with MSSP). • <i>Episodes of Care (EOC) Sub-Group.</i> Formed to consider how EOCs could be implemented going forward. <ul style="list-style-type: none"> ○ Are there any episodes that have risen to the top? Alicia clarified that there are successful examples of EOC analytics as well as payment models based on EOCs. Conversations have been high level so far, but early analyses looking at 2012 data for the State showed key areas with high variation and opportunities to improve quality, including heart disease/congestive heart failure and diabetes-related conditions. ○ Susan Aranoff noted that she’s been pushing for at least one chronic condition to be included if the State moves forward with a contract to perform more analyses. ○ Dale Hackett noted that variation and care delivery models might impact variation in cause and utilization and suggested that the CCM Work Group could provide valuable input. ○ Alicia noted that staff are gathering more information before the sub-group reconvenes. ○ Dion LaShay asked what EOCs cover – medical only? Alicia responded that it depends on the episode – additional services could be included depending on the episode. • <i>Next Generation ACO Overview.</i> CMS recently introduced a new ACO model, which includes higher risk and higher potential reward for ACOs that choose to participate and are selected by CMS. There are various tracks ACOs can choose, each with different methodologies. <ul style="list-style-type: none"> ○ What kind of flexibility is available for Next Gen ACOs? There is summary information available; it will be distributed following this meeting. • <i>Monitoring Year 1 VMSSP Payments.</i> Analyses to be completed this summer will determine whether ACOs are eligible for savings, and how much; compare projected per-beneficiary spending and actual spending; and provide information on quality performance. <ul style="list-style-type: none"> ○ Is Lewin planning to do population-specific sub-analyses? Yes, but they’re currently focused on getting the methodology right for the full population. The DLSS Work Plan includes providing input on this; Alicia will put it on Lewin’s radar once the population-wide calculations are completed. • In the coming months: <ul style="list-style-type: none"> ○ Update on Year 3 Total Cost of Care for the ACOs ○ Vermont Bundled Payment for Care Improvement (BPCI) Nursing Home Bundled Payment 	distribute the Next Generation ACO Summary

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	<p style="padding-left: 40px;">presentation (also in the DLSS Work Group Workplan and others; perhaps a combined presentation or webinar)</p> <ul style="list-style-type: none"> ○ Value-Based Purchasing Report from PHPG ○ EOC discussions continue ○ Continued work to align Payment Models Work Group plans with All-Payer Model discussions <p>The group discussed the following.</p> <ul style="list-style-type: none"> ● EOC/bundled payment definitions. Mike Hall noted that bundles are a form of capitation because providers can realize savings if they spend less to provide services than expected; he suggests bundled payments include a “warranty” to ensure complications or readmissions are addressed within the bundle or episode cost. Dale Hackett suggested that EOCs are based on fee-for-service, but that as an individual, he cares most about receiving the services he needs and that this could be a rate setting issue. Alicia noted that there are a lot of details about model and episode design that can impact it, and that she hopes to learn more from BPCI/Nursing Home Bundled Payment Initiative and others. ● Sam Liss asked whether, if EOCs/bundled payments are extended to long-term and chronic care, bundles will be more complex than for acute episodes. Alicia agreed and noted that there are other places that have done this and developed strategies for this: Arkansas focuses mostly on acute episodes to avoid these complexities, but others use a calendar year as a recurring period for chronic care episodes. ● Ed Paquin noted that some long-term services are already paid for using bundles. He noted that in acute care, fee-for-service payment rewards complications, but with a large population we should be able to figure out how much to budget per episode – this is how insurance works. Deborah Lisi-Baker noted that bundles will hopefully discourage unnecessary care and encourage comprehensive care. ● Mike Hall commented that fee-for-service payments are volume driven, as are HCBS waiver services. Mike feels there are possibilities to do bundled payment, or per-member per-month (PMPM) payment, for certain types of long-term services across providers. ● Deborah Lisi-Baker noted that we’ve had initiatives to work with practices on chronic care for years, but the materials on best practices in dealing with conditions like diabetes and COPD, for example, need not include guidance on best practices or interventions to address caring for patients with other chronic conditions and disabilities, such as mental health conditions, for example – these differentials would be helpful for episode planning. Alicia responded that this is a common challenge that many are still working to find a good solution to. Some episode models have criteria that exclude individuals from episodes if an individual has co-morbidities that require more care than the standard. Alicia suggested that there are other ways to approach this, and that there are opportunities to do Vermont-specific episode construction ● Dale Hackett asked for more information about how payments would work; Alicia responded that there are options for payers, and that this is still to be determined. ● Sam Liss and Mike Hall discussed how bundles and PMPM payment could incentivize preventive care. Mike suggested that bundles need severity or risk adjustment to avoid provider cherry picking. 	

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	<ul style="list-style-type: none"> • Deborah Lisi-Baker hopes that the Payment Models Work Group is considering these disability-specific concerns. • Susan Aranoff noted that including bundles for common/linked co-morbidities would be a good step for reducing overall costs, even though this is challenging for analytics. • Joy Chilton commented that early intervention opportunities should be included in EOCs. 	
5. Public Comment/Next Steps	<p>There was no additional public comment.</p> <p>Next Meeting: Thursday, June 18, 2015, 10:00am-12:30pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.</p>	