Vermont Health Care Innovation Project
Health Care Work Force Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Wednesday, February 22, 2017, 3:00-5:00pm, Oak Conference Room, Waterbury State Office Complex.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Mary Val Palumbo called the meeting to order at 3:03. A roll-call attendance was taken and a quorum was present.	
2. Approval of Meeting Minutes	Charlie McLean moved to approve minutes from the December 2016 meeting by exception. Peggy Brozicevic seconded. The minutes were approved with no abstentions.	
3. Updates: **- Work group status update (role of work group in future, co-chair update)** **- Administration update** **- Others**	Georgia Maheras provided updates: • The State has a new Director of Health Care Reform, Mary Kate Mohlman, who was previously a Health Services Researcher at the Blueprint for Health. The Office of Health Care Reform has also moved to the Agency of Human Services. The Executive Order that established this work group is still in force; the Administration is working to identify a new co-chair for this group. • The Governor's inaugural address suggested a significant focus on substance use disorder and mental health services, as well as the new risk-based ACO contract through Medicaid, both of which move toward a whole-person, integrated care model across the care continuum. Work force and the economy are also priorities of Governor Scott. Discussion: • Does this group still report to both the Governor and the SIM project? Yes. • Is there a date or deadline to present the Work Force Strategic Plan to the Green Mountain Care Board? Pat Jones and Melissa Miles will discuss this internally and report back. Updates: • Charlie McLean noted that the AHEC 5-year renewal grant is due next month, and includes a planned restructuring from 3 centers to 2 centers to support efficiency (though programming will not change), likely to start in the fall. • John Olson noted that VDH has a number of grants in process. Re-licensure surveys are going smoothly.	

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4. Presentation and Discussion: All Payer Model, ACO-based health reforms	Pat Jones and Melissa Miles presented on the All-Payer Model (Attachment 4). • Accountable Care Organizations (ACOs): Provider-led organizations that work together to be accountable for quality and cost for a defined population. Provider participation in ACOs is voluntary, as is ACO participation in contracts with payers. • All-Payer Model (APM) : Three major payers (Medicare, Medicaid, and commercial) will pay the ACO differently than through fee-for-service, so the ACO is accountable for cost as well as quality of care. Builds on the Blueprint for Health patient-centered medical home program, as well as the Vermont Medicaid and commercial Shared Savings Programs (SSPs). The APM aligns incentives across major payers, and pays prospectively, providing a predictable revenue source to allow for flexibility and investments to keep people healthy. • APM Goals: ○ Financial: All-payer cost growth under 3.5% per year, Medicare at least 0.1-0.2% below national growth trend (per capita). This recognizes that Vermont is already a low-cost Medicare state, compared to others nationally. ○ Scale: Grow to 70% of all Vermonters and 90% of Vermont Medicaid beneficiaries by Performance Year 5 (2022). (Currently: ~55-65% of Vermonters under Blueprint and SSPs.) ○ Quality: Three overarching population health goals: 1) Improving access to primary care; 2) Reducing deaths from suicide and drug overdose; 3) Reducing prevalence and morbidity of chronic disease (COPD, diabetes, hypertension). These are well aligned with our State Health Improvement Plan. The quality framework includes 20 measures to support improvement in these goals, and aligns with measurement activities already underway to limit reporting burden, especially for primary care providers. ○ Note: No financial penalties if Vermont fails to meet these goals (though there is down-side risk for the ACO if ACO-specific financial targets are not met). Vermont isn't required to meet all of the targets in every area. • APM Implementation: After signing the agreement, the next step is for the ACOs and payers to work together to develop ACO-level agreements, then for ACOs and providers to move toward delivery system implementation (establish ACO/provider agreements, improve care coordination and quality, meet scale targets). ○ DVHA recently signed a Medicaid ACO contract with OneCare Vermont for participation in a Vermont Medicaid Next Generation ACO program, which builds on the Medicaid SSP. ○ GMCB is responsible for regulatory implementation. Act 113 requires GMCB to certify ACOs, including review of ACO budgets and rate setting. GMCB is working to create an integrated regulatory approach across ACO regulation, hospital budgets, and more. • This agreement provides flexibility that could cover currently non-billable services and provider types, and support innovative work force arrangements. It also continues funding for Medicare's contributions to the Blueprint and SASH programs for 2017 (they will be built into ACO payments starting in 2018).	**Pat will share the APM quality measure specifications to this group.**

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	Discussion: • Are Medicare growth trend goals achievable for Vermont, as an already low-cost state? The State negotiated very hard on this item, understanding that dynamic – we want this target to be attainable. This goal is based on several years of actuarial modeling. • Are ACOs accountable for their members' out of state expenses? Yes, but only if they fall within the services included in the total cost of care (roughly Medicare Part A and Part B-type services). Excluded services include prescriptions, for example. Molly Backup noted that this is a particular challenge for snowbirds. • How is patient-reported data collected? Phone and mail surveys, like Behavioral Risk Factor Surveillance Survey (BRFSS – administered by VDH) or the Consumer Assessment of Healthcare Providers and Systems survey (CAHPS – administered by the ACO). • How are the population health goals being worked on within State government? VDH is doing a lot of work to collect data and establish programs to improve results – but this effort incudes all of State government (including VDH, GMCB, DVHA, and others), providers, private payers, and others. • Is there a target for participation in the prescription drug monitoring program? This is one of two measures without targets yet (the other is reductions in MH/SA ED visits) – data collected since last fall will support negotiations on these targets later this year. Molly noted that State law now requires all providers to use the Vermont Prescription Monitoring System for all opioid prescriptions. • Asthma Medication Management measure: Molly observed that asthma among her patients tends to be more episodic and less severe than in many other places. She suggested that a measure like this should be specific to more severe cases where regular medication (rather than occasional medication as needed) is beneficial. Pat will share the measure specifications with the group. • For Vermont Medicaid Next Generation Program: The Medicaid contract works to align as closely as possible with the Medicare services (Part A and B services) included in the APM agreement. Excludes services provided by non-DVHA AHS departments. Attribution for the pilot year is ~29,000 with primary care relationships in the initial four communities, and excludes dual eligibles, members with third party coverage, members with limited benefit packages, and members without any qualifying utilization in the two-year baseline period. • Measure alignment to decrease provider burden is a key goal. In negotiations, we specifically argued for measures already being collected that support the high-level goals of this agreement, or that are based on claims data. However, many of these measures still sit with primary care. There are some cross-organization measures (e.g., ED follow-up), but most measurement development activity has been primary care-focused. • The LADC issue (ie. Medicare covering MH/SUD services) is something that we want to discuss with CMS. Medicare does not currently allow for this because of the credentialing issue. Rick Barnett noted that there is another subset of providers that can bill for these services for Medicare already. That other work	

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	force group, which is pretty substantial, can do this already. Probably 500 providers in this state would be impacted by allowing this. Melissa: We are going to pursue this waiver. • Is the data broken down by area? While we want to meet the standards for the whole state, maybe we want to focus on the areas that are further from the target to start with, to raise everyone up. • Charlie commented that much of the strategic direction needs to come from the ACO, and emphasized that quality improvement is slow and requires continuous effort to product impactful change. • Mary Val asked how providers know what their work force should look like? Until we have some high-performing examples to hold up, this is hard to move forward. We may not have the provider skills needed to do this work in a new way. Pat noted that the State has worked with the ACO to produce some new tools to support this work, and has given providers around the state a chance to test these tools out in learning collaborative settings; the ACO has indicated it hopes to continue this work. We are asking what would be helpful to practices on the ground, and encouraging the ACO to try to meet these needs. Georgia commented that Vermont has historically used incentives rather than penalties to motivate providers to change, and that the State would appreciate any thoughts about how to best balance these. • Relationships between providers and ACO will be key – they will define which measures providers are responsible for, define what data providers will get and when, and more. Some measures will always be annual (i.e., BRFSS-based measures), but the bulk of claims runout is done within 3 months (appropriate for monitoring, though not for payment). It will be up to the ACO to provide this, in partnership with GMCB, and they have been making investments in analytics to support this. • Mary Val asked who is measuring deaths by suicide and overdose and ED follow-up now, and suggested this might link to findings in the micro-simulation demand model that suggests we may need fewer ED nurses in the future. Pat noted that the ED measure is a claims-based measure – but this will be driven by delivery system reforms that change work force or workflow to increase follow-up rates. Molly noted that this measure ties into funding and work force issues in other parts of the system that are outside the ACO, like the Designated Agencies and others. These providers were excluded in part due to historic underfunding, to avoid putting underfunded providers within a financial cap that limits growth. • Rick noted that despite major investments in opioid treatment over the past few years, overdose deaths are increasing. Pat agreed, and commented that we may not have reached the height of this epidemic. Preventing overdose deaths is complicated – overdoses are most common for new users or those who relapse, and this is hard to measure and target. Pat noted that Vermont's small size means that one bad batch of heroin can have a significant impact on the ability to meet this measure.	
5. Discussion: Micro-Simulation Demand Modeling	This agenda item was postponed for the next meeting. An update from IHS is expected in April, and will include a new scenario that includes lower chronic disease morbidity and longer lives, and the impact on work force needs. The April discussion will also include more discussion around mental health and substance use.	
6. Public Comment	There was no public comment.	

Agenda Item	Discussion	Next Steps
7. Next Steps, Wrap Up and Future Meeting Schedule	**Next Meeting:** Wednesday, April 26, 2017 – 3:00-5:00pm; Waterbury, VT	

(1) Charlie Maclean
(2) Peggy Brozicevic

Vermont Health Care Work Force Work Group: membership and delegate list

Updated 02.01.17

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