VT Health Care Innovation Project

"Disability and Long Term Services and Supports" Work Group Meeting Agenda

Thursday, October 15, 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	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from September 24, 2015	Yes
2	10:10 - 11:10	**A. VHCIP Year 2 New Merged Work Plans** • **Payment Models** • **Practice Transformation** • **Health Data Infrastructure** **B. Formal Mechanisms to Incorporate DLTSS Activities into the New Work Groups' Agendas and Work Initiatives** **C. DLTSS Membership on New Work Groups** • **Distribution of representation** • **Commissioner Hutt's request for supports and accommodations** Georgia Maheras, Sarah Kinsler, Deborah Lisi-Baker	• Attachment 2a: New Merged Year 2 Payment Models Work Plan • Attachment 2b: New Merged Year 2 Practice Transformation Work Plan • Attachment 2c: New Merged Year 2 Health Data Infrastructure Work Plan • Attachment 2d: List of current efforts to incorporate DLTSS activities into new work groups	
3	11:10 – 12:10	**Payment Models, Value Based Purchasing and DLTSS Design Considerations** Suzanne Santarcangelo, PHPG	• Attachment 3: Payment Models, Value Based Purchasing Design Elements and Vermont Models	
4	12:10 – 12:30	**Public Comment/Updates/Next Steps** Deborah Lisi-Baker	Next Meeting: Thursday, December 10, 2015 10:00 am – 12:30 pm, DVHA Large Conference Room 312 Hurricane Lane, Williston	

Attachment 1b: Minutes from September 24, 2015

Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, September 24, 2015, 10:00am-12:30pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.

Agenda Item	Discussion	Next Steps
1. Welcome, Approval of Minutes	Deborah Lisi-Baker called the meeting to order at 10:05am. A roll call attendance was taken and a quorum was not present. Deborah noted a few changes in agenda order. A quorum was present following the fourth agenda item. Deborah Lisi-Baker entertained a motion to approve the August meeting minutes. Ed Paquin moved to approve the minutes by exception. Julie Tessler seconded. The minutes were approved with one abstention.	
2. VHCIP Restructuring and Incorporation of DLTSS Work Plan Activities	Deborah Lisi-Baker introduced the agenda item. She noted that Attachment 2 shows how DLTSS workplan activities align with the project's Year 2 milestones. Julie Wasserman walked through Attachment 2. • Dale Hackett asked a question about evidence-based practices to serve people with disabilities. Deborah noted that many emerging practices do not yet have a large amount of research or evidence. Julie noted that on a recent webinar related to ACOs, Health Management Associates advocated for broadening the definition of "medically necessary" to include a broader range of services. • Dale Hackett asked whether learning collaboratives are meant to be just for ACOs, or are they meant to be a learning tool for DVHA or anyone else. Pat Jones clarified that the Integrated Communities Care Management Learning Collaborative focuses on high risk patients, and includes organizations that provide direct patient care and care management – including Medicaid care managers, among others. The Learning Collaboratives are not meant to be just for ACOs. • Sue Aranoff commented that the new Health Data Infrastructure workplan also includes additional activities relevant to DLTSS populations and providers that were never on the DLTSS Work Group workplan. • Sam Liss asked whether a plan would be developed to integrate input across all of the work groups, including the DLTSS Work Group, now meeting quarterly. Georgia Maheras responded that the cornerstone of that plan is that people on the DLTSS Work Group are also on our other work groups and can share	

Agenda Item	Discussion	Next Steps
	information – this is how we're ensuring information is shared and integrated. Georgia noted that the Core Team requested two sets of workplans – one for the remainder of 2015, and another for 2016. Workplans for 2016 will be presented to work groups in December for additions and modifications prior to the start of the year. The Core Team also requested that new work groups' membership lists are well balanced and no constituency is marginalized – in addition to asking participants to self-select, we have asked co-chairs and staff to review to make sure nothing has fallen through the cracks. New workplans will look slightly different than in the past, and will follow our Year 3 milestones. A new educational webinar series will also provide an opportunity for information sharing; we invite the DLTSS Work Group to suggest topics. • Dale Hackett noted that data so far is based on averages and could result in continued marginalization. People not at that average need representation and participation, and participation that is respected and listened to whether data represents marginalized groups or individuals or not. • Sue Aranoff commented that the Core Team approved governance changes contingent on the fact that the members and work of the Population Health and DLTSS Work Groups be integrated into new workplans. • Sue Aranoff commented that a new study by Families USA reviewed participation by advocates and self-advocates in governance and activities, and that Vermont scored highly on this review. • Sue Aranoff commented that the DLTSS Work Group has been unique in ensuring that people with disabilities and other needs can participate fully, and has made accommodations to ensure full participation. She requested that continued accommodations be made to ensure continued participation, and requested that individuals speak up if they need accommodations in new work groups. • Dale Hackett noted that it can be challenging to review a hundred page (or more) document, and hopes that summaries will be available. Georgia agreed and noted that project staff are working on this. • Nancy Briden asked what the process will be for integrating membership. Georgia responded that we have opened participation to any interested member of the public; membership is open, with the caveat that organizations/state agencies are limited to one voting member (plus alternates) per work group. (Legal Aid is the exception, with two voting members per work group.) Co-chairs and staff are now reviewing draft member lists to ensure there are no holes.	
3. DLTSS Feedback on Shared Care Plans	Deborah Lisi-Baker thanked participants for providing comments on shared care plans. • Dale Hackett thanked the group for this summary. • Sam Liss commented that language needs to be understandable and made clear to anyone who signs it. Deborah agreed, and noted these comments were seconded by Legal Aid. She commented that this is an area for confusion, because we're talking about two different parts of our system – what happens in the room, and what happens in our IT systems. Georgia responded that HIPAA, consent, and information sharing issues are now with DVHA's general counsel to ensure we're fully compliant. Pat Jones is also talking directly with Legal Aid. We will report back to this group on the results of those discussions when the right lawyers and VITL are in the room. • There are no proposed changes to the approved consent policy for the Vermont Health Information	

Agenda Item	Discussion	Next Steps
	Exchange. Georgia noted that we are doing some preliminary work around 42 CFR Part 2, but need to wait for SAMHSA for clarity on this. • Dale Hackett noted that information sharing is a balance between privacy and ensuring optimal care. Julie Wasserman noted that the current VITL consent policy is all or nothing – a global opt in. Georgia clarified that this is part of the Vermont HIT Plan. She also noted that 42 CFR Part 2 governs provider types and services, not just services – substance abuse services delivered at primary care practices, for example, are not covered by 42 CFR Part 2 because those are not SAMHSA governed providers. This consent policy was approved by the Green Mountain Care Board after extensive public comment. Georgia will convey this discussion to the Board and Steve Maier. • Pat Jones commented that the shared care plan is not the entire medical record; it is a high-level document including person-developed goals, including clinical goals, and ensuring this information is available to individuals involved in their care. The Learning Collaborative model is based on sharing learning across different communities. • Sam Liss asked whether there is a distinction in the care plans between person-centered and person-directed. Pat noted that the focus is on having person-directed goals. The shared care plan is a way of prioritizing person-developed goals. • Julie Wasserman noted that Annie Paumgarten shared the Self-Sufficiency Matrix tool, included as a separate attachment – this could be helpful to communities or other organizations.	
4. Nursing Home Bundled Payments for Care Improvement (BPCI) Initiative	Amanda Ciecior (DVHA) and Judy Morton (Vermont Health Care Association) presented on BPCI. • Dale Hackett asked whether this payment model could create gaps in patient care. Mandy clarified that the aim of this model is to ensure smooth continuity of care. • Mike Hall asked which of the options to deliver bundled services was selected by Vermont facilities. Mandy noted that Phase 1 was a planning phase, so each facility selected episodes for which they received analytics. • Episode options were selected by Medicare. • Dale Hackett asked whether the risk taken on through bundled payments is more predictable than other payment models. Mandy responded that she assumes organizations are selecting episodes in which they are confident and taking on minimal risk. Georgia noted that data availability is critical to allowing facilities to take on an amount of risk they are comfortable with. Medicare is doing this for the first time, and will evaluate this demonstration at the end of the demonstration period. • Mike Hall asked whether we have insights into why no Vermont facilities decided to move forward with optional conditions. Judy commented that few Vermont facilities have enough volume to balance the cost of additional reporting and administrative burden that this would require. In addition, Vermont's cost of care is already low compared to other states – it's less likely we can achieve savings than states that are currently high cost. Judy noted that it is particularly challenging for homes that are not owned by national organizations to participate. Partnership with home health after discharge is critical.	

Agenda Item	Discussion	Next Steps
	• Sam Liss asked a follow-up: Is the profit motive getting in the way of care improvement? Judy does not think so. Dale Hackett noted that Vermont doesn't have enough of a health care crisis for organizations to have the profit that they want, or to have an efficient system. • Sue Aranoff noted that small numbers is a problem across a number of our payment models. Georgia commented that Vermont's Medicaid Episodes of Care work has considered the BPCI experience, Arkansas's episodes work (also Medicaid focused), and commercial insurers' work in this area. Moving forward, we'll be relying on Vermont providers and insurers with experience in this area as well as Arkansas and other states as we get further along with different episodes – it's good not to be first sometimes! • Mike Hall commented that this is a less-than-impressive demonstration. Mike believes the payment model, rather than increased risk, is pushing providers away. Administrative burden is also an issue. Georgia commented that one of our goals is to decrease the administrative burden by increasing passive data collection. These lessons and others are informing our future work and sustainability plans. We can always have more discussions with providers about what's preventing them from participating.	
5. Public Comment/Next Steps	Ed Paquin observed that the Self-Sufficiency Matrix line on disability is very medically modeled, and suggested the "5" column should include "thriving with accommodations". Deborah and Georgia welcome comments on any part of this matrix; please send comments to Annie Paumgarten (annie.paumgarten@vermont.gov). Annie initially shared three versions of this with the DLTSS Work Group leadership team; she will share those with the entire group. Pat commented that this is a program capacity evaluation, not an evaluation tool for individuals. Pat agreed that the language in some sections is not what we might choose. Dale Hackett noted that providers' assumptions can negatively impact care for people with disabilities. Sue Aranoff pointed out that the DLTSS Core Competency Briefs are helpful tools for providers in helping them provide optimal care for and with people with disabilities. **Next Meeting:** Thursday, October 15, 2015, 10:00am-12:30pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier	

Ed Paquin 1°
Julie Tessler 2°
motion to approve minutes by exception
Carried w/ 1 Abstention

VHCIP DLTSS Work Group Member List

Roll Call: 9/24/2015

Member		Member Alternate		August 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				None
Mike	Hall	Angela	Smith-Dieng		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~~ Nancy	~~Prine~~ Breiden	A	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	Judy	Morton		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
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VHCIP DLTSS Work Group Participant List

Attendance: 9/24/2015

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~~		SOV Consultant - Pacific Health Policy Group	S
Bob	Bick		DA - HowardCenter for Mental Health	X
Mary Alice	Bisbee		Consumer Representative	M
Denise	Carpenter		Specialized Community Care	X
Alysia	Chapman		DA - HowardCenter for Mental Health	X
Joy	Chilton	Phone	Home Health and Hospice	MA
Amanda	Ciecior	phone	AHS - DVHA	S
Peter	Cobb		VNAs of Vermont	X
Amy	Coonradt		AHS - DVHA	S
Amy	Cooper		Accountable Care Coalition of the Green Mountains	MA
Alicia	Cooper		AHS - DVHA	S
Molly	Dugan		Cathedral Square and SASH Program	M

Gabe	Epstein	here	AHS - DAIL	S
Patrick	Flood		CHAC	M
Erin	Flynn		AHS - DVHA	S
Mary	Fredette		The Gathering Place	M
Joyce	Gallimore		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	phone	None	M
Mike	Hall	here	Champlain Valley Area Agency on Aging / COVE	M/MA
~~Bryan~~	~~Hallett~~		GMCB	S
Carolynn	Hatin		AHS - Central Office - IFS	S
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	X
Jeanne	Hutchins		UVM Center on Aging	M
Craig	Jones		AHS - DVHA - Blueprint	MA
Pat	Jones	phone	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
Nicole	LeBlanc	here	Green Mountain Self Advocates	X
Deborah	Lisi-Baker	here	SOV - Consultant	C/M
Sam	Liss	here	Statewide Independent Living Council	M
Vicki	Loner		OneCare Vermont	X
Carole	Magoffin	phone	AHS - DVHA	S
Georgia	Maheras	here	AOA	S
Jackie	Majoros		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	phone	Vermont Medical Society	M
Todd	Moore		OneCare Vermont	X
Mary	Moulton		Washington County Mental Health Services Inc.	X
Kirsten	Murphy	phone	AHS - Central Office - DDC	M
Floyd	Nease		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
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
Rachel	Seelig		VLA/Senior Citizens Law Project	M
Susan	Shane	here	OneCare Vermont	MA
Julia	Shaw		VLA/Health Care Advocate Project	X
Richard	Slusky		GMCB	S/MA
Angela	Smith-Dieng		Area Agency on Aging	MA
Beth	Tanzman		AHS - DVHA - Blueprint	X
Julie	Tessler	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		DA - Vermont Council of Developmental and Mental Health Serv	MA
Nancy	Warner		COVE	M
Julie	Wasserman	here	AHS - Central Office	S/M
Kendall	West			X
James	Westrich		AHS - DVHA	S
Bradley	Wilhelm		AHS - DVHA	S
Jason	Williams		UVM Medical Center	M

Cecelia	Wu		AHS - DVHA	S
Marie	Zura		DA - HowardCenter for Mental Health	X
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Nancy Breiden here

Suzanne Santarcangelo here

Judy Morton - here - Vt. Health Care Association

Attachment 2a: New Merged Year 2 Payment Models Work Plan

Vertical Health Care Innovation Project

Vermont Health Care Innovation Project
DRAFT Year 2 Payment Model Design and Implementation Work Group Work Plan
DRAFT 10/8/2015

	Objectives	Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	ACO Shared Savings Programs (SSPs – Commercial and Medicaid)						
1	Expand the number of people in the Shared Savings Programs.	Report on Year 1 commercial and Medicaid results (including data analyses). Use sub-analysis to identify cause(s) of savings.	October 2015			Results released; Report planned.	Stakeholders understand Year 1 results.
2		Year 3 Decision: Total Cost of Care (TCOC) for Medicaid; identify DLTSS implications and best practices for Year 3. Year 3 Decision: Down-side risk for Commercial; identify DLTSS implications and best practices for Year 3.	December 2015	N/A	Steering Committee	In progress.	Decisions made regarding Year 3 program design.
	Episodes of Care (EOCs)						
3	Design 3 EOCs for the Medicaid program with a financial component.	Hire contractor to assist in EOC development; identify DLTSS implications and best practices for Year 3. If possible: Recommend an EOC that bridges the gap between medical care and long-term services and supports. Recommend an EOC with DLTSS-specific outcomes.	November 2015	N/A	Steering Committee	In progress.	Contractor hired.
4		Implement data reports for 3 EOCs by 1/1/16.	January 2016		N/A	N/A	Draft reports available by January.
	Accountable Communities for Health (ACH)						
5	Assess ACH feasibility.	Design/creation of ACH learning system (as approved by the Population Health Work Group); identify DLTSS implications and best practices for Year 3.	December 2015	Receive approved plan (Population Health Work Group).	Steering Committee	Awaiting Core Team approval.	Learning system launched.
	Ongoing Updates, Education, and Collaboration						
6	Reporting on all payment models under development/launched; review DLTSS and Population Health activities and recommendations.	SSP Updates EOC Updates Blueprint Updates (P4P) Hub & Spoke Updates (Health Home) ACH Updates PPS-Home Health Updates PPS-CCBHC Grant Application Updates All-Payer Model Updates Frail Elderly Project Updates	Monthly	N/A	N/A	Ongoing.	Written and verbal monthly updates on all payment models.
7	Overview of Year 3 milestones.		December 2015	N/A	N/A	N/A	Overview provided.

	Objectives	Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
8	Review and approve 2016 Payment Model Design and Implementation Work Group Work Plan.	Draft Workplan with DLTSS and Population Health input.	December 2015-January 2016	N/A	N/A	N/A	Work plan approved.
9	Coordinate and collaborate with other VHCIP Work Groups on other activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups.	Ongoing	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).	N/A	Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities across VHCIP.
10		Provide updates to other work groups on Payment Model Design and Implementation Work Group activities.	Ongoing	N/A	N/A	Not yet started.	
11		Obtain regular updates from other work groups.	• Monthly starting October 2015 • Fall 2015 • Fall 2015	• Obtain regular updates on work groups' progress as appropriate. • Receive PHP outline (Population Health Work Group). • Receive definition and materials (Population Health Work Group).	N/A	Not yet started.	

Attachment 2b: New Merged Year 2 Practice Transformation Work Plan

Vermont Health Care Innovation Project
Year 2 Practice Transformation Work Group Work Plan
DRAFT 10/8/2015

	Objectives/Milestones	Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Sub-Grant Program						
1	Continue sub-grant program; convene sub-grantees at least once; use lessons from sub-grantees to inform project decision-making.	Provide quarterly reports to work group.	Ongoing	N/A	Steering Committee	Quarterly reports distributed project-wide.	Reports provided.
2		Sub-grantees present to work group.	At least 2 per meeting			Ongoing.	Presentations delivered.
3		Develop lessons learned distribution plan.	November 2015			Not yet started.	Distribution plan developed.
4	Provide technical assistance to sub-grantees as requested by sub-grantees.	Provide technical assistance to sub-grantees as requested; requests to be reviewed and approved by VHCIP staff according to written process currently in place.	Ongoing	N/A	N/A	Ongoing.	Technical assistance provided.
	Integrated Communities Care Management Learning Collaborative						
5	Offer at least two cohorts of Learning Collaboratives to 3-6 communities.	Launch in-person Learning Collaboratives.	September 2015	N /A	Steering Committee	• Launched in 8 additional communities in September 2015.	• Completion of learning collaborative. • Results used to design effective integrated care management strategies. • Measureable improvements in care and outcomes. • Scalable interventions. • Sustainable practice changes.
6		Release RFP for Core Competency Training (including DLTSS-specific Core Competencies).	September 2015			• RFP released.	
7		Expand release of disability briefs.	October 2015			• Not yet started.	
8		Engage faculty for learning sessions, including those focused on DLTSS-specific Core Competencies.	November 2014-Ongonig			• Faculty engaged for learning session.	
9		Develop measures based on interventions.	September 2014-February 2015			• Draft measures outlined, training for communities in data collection and reporting of measures planned.	
10		Conduct PDSA cycles.	March-June 2015			• PDSA trainings with community facilitator planned for February 2015.	
11		Evaluate results, including results for DLTSS competencies.	June-December 2015			In progress.	
12		Provide updates on progress, findings,	Ongoing			Ongoing.	

	Objectives/Milestones	Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
		and lessons learned to Steering Committee, Core Team, and relevant work groups; identify processes and tools to support continued work after SIM (i.e., shared care plan forms, HIPAA-compliant releases to support shared care planning process).					
	Regional Collaborations						
13	Establish 14 regional collaborations, each including a Charter, governing body, and decision-making process.			Blueprint for Health	N/A	Regional collaborations begun.	Regional collaborations established.
	Ongoing Updates, Education, and Collaboration						
14	Overview of Year 3 milestones		December 2015			Not yet started.	Overview provided.
15	Review and approve 2016 Practice Transformation Work Plan	Draft Workplan with DLTSS and Population Health input.	December 2015- January 2016	N/A	N/A	Not yet started.	Updated workplan adopted.
16	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	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).	N/A	Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities among work groups.
17		Provide regular updates to other work groups on Practice Transformation Work Group activities.	Monthly starting Oct 2015.				
18		Obtain regular updates from other work groups.	Monthly starting October 2015	Obtain regular updates on progress to design and test payment models we are implementing.			
19	Coordinate with, update, and receive	Overall VHCIP project status updates.	Ongoing	N/A	N/A	Ongoing.	Well-coordinated and aligned activities
20		Update Steering Committee, Core	Ongoing	N/A	N/A		

	Objectives/Milestones	Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	education from VHCIP Core Team, Steering Committee, other VHCIP leadership and stakeholders, and AHS agencies as appropriate.	Team, and other VHCIP groups and stakeholders as appropriate.					across VHCIP.

Attachment 2c: New Merged Year 2 Health Data Infrastructure Work Plan

Vermont Health Care Innovation Project
Year 2 Health Data Infrastructure Work Group Work Plan
DRAFT 10/8/2015

	Objective/Milestone	Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	Expand Connectivity to HIE						
1	*Gap Analyses* Perform gap analyses related to quality measures for each payment program, as appropriate; perform baseline gap analyses to understand connectivity of non-Meaningful Use providers.	Perform technical assessment of LTSS providers. Produce final report.	October 2015	Coordinate on DA/SSA data quality project (DLTSS Work Group; DLTSS providers; VITL).		• Draft report produced.	• Report distributed.
2	*Gap Remediation* Remediate data gaps that support new payment and care models, as well as quality measurement needed to support those models, as identified in gap analyses (ACO and LTSS Gap Analyses).	Provide data quality technical support to ACO member organizations (ACO Gap Analysis and Remediation project).	November 2015	Coordinate on Gap Analysis and Remediation project (VITL; ACOs).		• Remediation work is ongoing.	• 50% of gaps for SSP quality measures filled.
3		Develop data remediation plan for gaps identified in LTSS technical assessment. Launch Data Gap Remediation for non-MU providers, including LTSS providers.	December 2015			• Plan in development.	• Plan created. • Remediation work launched.
4	*Data Extracts from HIE* Completed development of ACO Gateways with OneCare Vermont (OCV) and Community Health Accountable Care (CHAC) to support transmission of data extracts from the HIE.	Provide efficient connections to the ACOs (ACO Gateway project).	December 2015	Coordinate on ACO Gateway project (VITL; ACOs; QPM and Payment Models WGs).	Steering Committee	• OCV gateway complete. • CHAC gateway nearly complete. • No gateway being built for Healthfirst.	• Completed gateways for two ACOs.
	Improve Quality of Data Flowing into HIE						
5	Engage in work flow improvement activities at provider practices to improve the quality of the data flowing into the VHIE. These will be identified in gap analyses and analytics, including the LTSS gap analysis.	Provide data quality workflow support to ACO member organizations. Improve data quality by providing data mapping and code set remediation. Improve quality of data sent to the ACOs (ACO Project Terminology Services).	December 2015	Coordinate on DA/SSA data quality project (VCN; DAs/SSAs; VITL).	Steering Committee	• Data quality being improved. • Terminology Services pending contract approval.	• Data quality workflow improved at DAs/SSAs. • Data quality workflow improved at ACO member organizations. • Data quality workflow improvements begun

	Objective/Milestone	Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
6	Data quality initiatives with the DAs/SSAs.	Conduct data quality improvement meetings with the DAs/SSAs to focus on the analysis of the current state assessments for each agency.	December 2015	Coordinate on Gap Analysis and Remediation project (VITL; ACOs).	Steering Committee	In final contract negotiations and approval.	for providers of disability and long-term services and supports.
	Telehealth						
7	*Telehealth Implementation* Launch a fully accessible telehealth program as defined in Telehealth Strategic Plan.	Release telehealth RFP, select pilot projects, launch 12-month pilot period.	September 2015		Steering Committee	• RFP released	• Contracts for pilot program executed.
	EMR Expansion						
8	Implement EMRs for non-MU providers; explore non-EMR solutions for providers without EMRs, including non-MU providers of disability long term services and supports.	Assist in implementation of an electronic health record (EHR) solution for five developmental disability agencies.	December 2015	Coordinate to procure DA/SSA EHR (VCN; DAs/SSAs; VITL).	Steering Committee	• Procurement underway.	• Procurement complete.
	Data Warehousing						
9	Research data warehousing needs; develop cohesive strategy for warehousing solutions supporting practices in care transformation; identify solutions for data registry and warehousing needs; implement solutions approved by the HIE/HIT Work Group according to timelines developed in design phase.	*DA/SSA Data Repository:* Improve integration of the DA/SSA data (ACTT DA/SSA Data Repository project).	December 2015	Coordinate on DA/SSA Data Repository project (VCN; DAs/SSAs; VITL).	Steering Committee	• Data dictionary complete. • Vendor procured.	• Phase 1 of DA/SSA data repository complete.
10		*Data Warehouse:* Develop a cohesive strategy for warehousing solutions.	December 2015		Steering Committee	• Planning begun	• Strategy proposed
11		*Clinical Registry:* Procure solution.	December 2015		Steering Committee	• Contract approval pending.	• Clinical registry solution procured.
	Care Management Tools						
12	Engage in discovery, design and testing of shared care plan IT solutions, an event notification system, and uniform transfer protocol. Create project plans for each of these projects and implement as appropriate, following SOV procedure for IT development.	*Shared Care Plan:* Gather business and technical requirements and, if appropriate, procure and implement an electronic solution to create and maintain shared care plans across community providers.	December 2015	Coordinate with Shared Care Plan Project and ENS Project (VITL; ACOs; providers).	Steering Committee	• Gathering requirements.	• Business and technical requirements gathered and, if appropriate, an electronic solution selected and implemented.
13		*Event Notification System:* Improve communication in the transition of care process among providers. Provide information on clinical events such as hospitalizations or discharges to providers.	December 2015	Coordinate with Shared Care Plan and Universal Transfer Protocol Projects (VITL; ACOs; providers).	Steering Committee	• In progress.	• Acquisition of ENS solution and plan for deployment.

	Objective/Milestone	Supporting Activities	Target Date	Endorsements/ Dependencies	Approving Entities	Status of Activity	Measures of Success
	General Health Data						
14	*Data Inventory*	Conduct health data inventory.	December 2015		Steering Committee	• Draft inventory completed.	• Data inventory conducted.
15	*HIE Planning* Identify HIE connectivity targets; provide input into HIT Plan.	Develop recommendations for support of a state "data utility."	December 2015	Coordinate on strategic direction for state "data utility" (AHS, DII, VITL, providers, ACOs, providers of long-term services and supports).	Steering Committee	• Proposed.	• Recommendations to support a state "data utility" developed. • Information and feedback provided to relevant stakeholders.
16		Develop recommendations for a Statewide HIE Governance structure.	December 2015	Coordination with GMCB, DVHA, VITL.	Steering Committee	• Proposed.	Report on Statewide HIE Governance.
17		Provide comment on HIT Plan	Ongoing				Comment provided at least two times.
18		Review connectivity targets for 2016	December 2015				Connectivity targets identified by 12/31/15.
	Ongoing Updates, Education, and Collaboration						
19	Overview of Year 3 milestones		December 2015		N/A		
20	Review and approve 2016 Health Data Infrastructure Work Plan	Draft Workplan.	Dec 2015-Jan 2016	N/A			Updated workplan adopted.
21	Coordinate and collaborate with other VHCIP Work Groups on other activities of interest.	Identify activities of interest and establish mechanisms for regular coordination and communication with other work groups.	Ongoing	Coordinate to identify activities of interest and establish regular communication (Other VHCIP Work Groups).		• Mechanisms established for monthly co-chair meetings and work group reports to Steering Committee.	Well-coordinated and aligned activities among work groups.
22		Provide updates to other work groups on Health Data Infrastructure Work Group activities.	Ongoing	N/A			
23		Obtain regular updates from other work groups.	Monthly starting Oct 2015	Obtain regular updates on progress as appropriate.			
24	Coordinate with, update, and receive education from VHCIP Core Team, Steering Committee, other VHCIP leadership and stakeholders, and AHS agencies as appropriate.	Overall VHCIP project status updates. Update Steering Committee, Core Team, and other VHCIP groups and stakeholders as appropriate.	Ongoing	N/A			Well-coordinated and aligned activities across VHCIP.

Attachment 2d: List of current efforts to incorporate DLTSS activities into new work groups

Vermont Health Care Innovation Project
Current Efforts to Incorporate DLTSS Activities into New Work Groups
October 15, 2015

Payment Model Design and Implementation Work Group

- DLTSS Work Group members incorporated into Payment Models Work Group participant list.
- Sue Aranoff has joined the Work Group leadership team, and will participate in regular planning meetings and calls to develop workplans and agendas.
- DLTSS implications and best practices will be identified and considered in developing 3 Medicaid-only Episodes of Care.
- DLTSS implications and best practices will be identified and considered in feasibility assessment of Accountable Communities for Health and in developing in the Accountable Communities for Health Learning System.
- Ongoing reporting and updates explicitly includes DLTSS and Population Health activities.
- DLTSS and Population Health Work Group input into Year 3 workplan activities explicitly called out; Year 3 workplan will include exploration of flexible funding models (previously included in the DLTSS Work Group workplan) as part of Integrated Family Services and Medicaid Value-Based Purchasing efforts.

Practice Transformation Work Group

- DLTSS Work Group members incorporated into Practice Transformation Work Group participant list.
- Deborah Lisi-Baker has been invited to join the Work Group as co-chair (decision forthcoming). Julie Wasserman has joined the Work Group leadership team, and will participate in regular planning meetings and calls to develop workplans and agendas.
- DLTSS Core Competency Training activities explicitly incorporated into Integrated Communities Care Management Learning Collaborative activities, with an emphasis on sustainability.
- (Additional DLTSS Core Competency Training activities to be included in Year 3 workplan as resources allow.)
- DLTSS and Population Health Work Group input into Year 3 workplan activities explicitly noted.

Health Data Infrastructure Work Group

- DLTSS Work Group members incorporated into Health Data Infrastructure Work Group participant list.
- Sue Aranoff has joined the Work Group leadership team, and will participate in regular planning meetings and calls to develop workplans and agendas.
- Gap analysis, gap remediation, and data quality improvement activities for LTSS providers continue to be included in the Year 2 workplan for this group (as they were for the HIE/HIT Work Group); these activities will continue into Year 3 as appropriate and as resources allow.
- DA/SSA Data Repository Project continues to be included in the Year 2 workplan for this group (as it was for the HIE/HIT Work Group); this work will continue into Year 3.
- SCÜP (Shared Care Plan and Universal Transfer Protocol) Project continues to be included in the Year 2 workplan for this group (as it was for the HIE/HIT Work Group). How SCÜP continues in Year 3 activities in this area will depend on the findings of this phase of the SCÜP project as well as the Event Notification System project.
- DLTSS and Population Health Work Group input into Year 3 workplan activities explicitly noted.

Attachment 3: Payment Models, Value Based Purchasing Design Elements and Vermont Models

Payment Models, Value Based Purchasing Design Elements and Overview of Vermont Models

VHCIP

DLTSS Work Group Discussion

October 15, 2015

Goals

- Presentation Goals
  - Review Base Payment Models
  - Review Design Elements related to Value Based Purchasing
  - Snapshots of Vermont Models
  - Discussion
- Ultimate goal to provide recommendations for payment models that:
  - Support DLTSS specific outcomes
  - Promote integration of medical (traditional) and disability and long term services and supports

Base Payment Models

A base payment model is the underlying method that defines how a provider gets paid for services. Value Based Purchasing designs can be used with any base payment model. There are three base payment models:

- Fee-for service (FFS) payments
- Bundled payments
- Population-Based payments

Fee For Service (FFS)

Operational Definition	Potential Impact	Financial Risk/Rates
Providers are paid for each service they render (e.g., an office visit, test, procedure or service). Payments are issued retrospectively, after the services are provided.	Pays providers for doing things to sick people, rather than getting and keeping people well. May be a barrier to coordinated and/or integrated care because it rewards individual clinicians for performing separate treatments. Over –utilization or up coding (coding the service to a category that pays a higher rate)	Payer is at risk for paying for all services Payers set rates based on the costs of providing the service, based on a percentage of what other payers reimburse for equivalent services, and/or based on negotiations with providers.

Bundled Payment

<table>
<tr><th>Operational Definition</th><th>Potential Impact</th><th>Financial Risk/Rates</th></tr>
<tr><td>Providers are paid a fixed dollar amount based on the expected costs for defined episode or bundle of related health care services.

Bundles can be defined in different ways, cover varying periods of time and include single or multiple health care providers of different types. Different types include:
• Case rate
• Episode-of-Care Payment
• Global Bundled Payment
• Prospective Payment System</td><td>Providers have flexibility to decide on necessary services.

Reduces the incentive to overuse or provide unnecessary services.

May create incentive to provide the lowest level of care possible, not diagnose complications of a treatment before the end date of the bundled payment, or delay care until after the end date of the bundled payment.

May not provide incentive to control the number of episodes that the person experiences.</td><td>Providers assume financial risk for the cost of services as well as costs associated with any preventable complications.

Historical expenditures typically used to determine rates. Rates can be set to increase, decrease, or maintain historical levels.

Rate determined by:
• Services included
• Time window (e.g., week, month, year, episode)
• Target group
• Provider type</td></tr>
</table>

Population Based Payment

Operational Definition	Potential Impact	Financial Risk
Providers are prospectively paid a set amount for all of the healthcare services needed by a specified group of people for a fixed period of time, whether or not that person seeks care. *Different types include:* • *Full Capitation* • *Risk Adjusted Capitation* • *Partial Capitation*	Removes incentive for volume. Providers have flexibility to decide what services should be delivered and when; and provides upfront resources to support services. Creates incentive to ensure quality care is delivered because providers receive no added payment for potentially avoided complications. May encourage a focus on preventive care. Unintended consequences may include: • Over stating caseload numbers • Creating incentives for enrollments • Underutilization of appropriate care • Avoidance of high-risk (potentially more expensive) individuals • Cumbersome appeal processes; ineffective grievance process; • Inadequate or unreasonable prior authorization requirements.	Provider is accountable for managing the total cost and quality of care. Historical expenditures are typically used to determine the initial bundled payment rates. The rate can be set to increase, decrease, or maintain historical levels. The amount of the payment may be adjusted based on the characteristics of the services expected and/or the target population. Special provisions may include outlier payments or other mechanisms to address unforeseen circumstances.

Value Based Purchasing (VBP)

- http://healthcareinnovation.vermont.gov/node/863
- Literature and research is still emerging
- No single definition or ‘one size fits all’ approach
- Value Based Purchasing can be used with any type of base payment model

Value Based Purchasing Definition

A broad set of performance-based payment strategies that ***link financial incentives to providers' performance*** *on a set of defined measures of quality and/or cost or resource use. The goal is to achieve better value by driving improvements in quality and slowing the growth in health care spending by encouraging care delivery patterns that are not only high quality, but also cost-efficient.*

- Definition derived from (1) the CMS Roadmap for Implementing Value Driven healthcare and (2) comprehensive 2013 research reports developed by the RAND Corporation on behalf of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS) to inform HHS about future policy-making related to VBP.

Value Based Purchasing Design Elements

Design considerations identified in literature

- Financial incentive and performance measurement
  - Type of incentive (e.g., bonus, holdback, performance, shared savings)
  - Type and breadth of measures
    - Process, structure and outcomes
    - Cost, quality, and patient experience

- Characteristics of the providers
  - Size, scope (e.g., type, specialty, infrastructure, percentage of clients for whom the incentive is relevant)
  - Single or multiple providers or provider types
  - Other regulatory requirements

- External factors that can enable or hinder provider response to the incentive.
  - Other payment policies or quality initiatives
  - Regulatory structure
  - Resources available to support the Value Based Purchasing Design (e.g., data analytics, IT, staff, incentive payments, provider transformation and technical assistance)

Vermont Model Snapshots

Project	Base Payment Model	Value Based Financial Incentive	Status
Accountable Care Organization	FFS	Shared savings	Pilot Statewide
Blueprint Patient Centered Medical Homes (PCMH) (supported by Community Health Teams)	Physicians: FFS CHT: Population Based	Quality bonus paid to practices based on National Committee for Quality Assurance (NCQA) recognition as a PCMH.	Implemented Statewide
Medication Assisted Treatment: (Hub and Spoke)	Bundled	None at this time	Implemented Statewide
Integrating Family Services	Bundled	None at this time	Pilot Two Regions
Community Rehabilitation and Treatment (CRT)	Bundled	None at this time	Implemented Statewide
Accountable Communities (St. Johnsbury)	Under Discussion	Under Discussion	Design Stage

Discussion

Objectives

- Promote person-centered/directed care
- Promote quality care
- Improve care coordination and integration
- Ensure access to care
- Ensure appropriate allocation of resources/manage costs

Principles

VBP should support DLTSS objectives through incentives that are:

- Specifically tailored to members and systems of care within each DLTSS program
- Designed to promote integration and coordination across the full array of healthcare services
- Designed to offer financial incentives that reward change but do not compromise other DLTSS objectives (e.g., access to care)

Discussion

Structural Considerations

- DLTSS are a relatively small part of Vermont's overall healthcare system but a large part of Vermont's Medicaid program
- Many DLTSS providers receive a majority of their funding from Medicaid
  - Medicaid is in a strong position to influence behavior
  - Reductions in Medicaid funding can have significant and immediate consequences; absent demonstrated savings, it is challenging to implement incentives that could create "winners and losers" (e.g., penalties, incentive pools)
- Parts of the DLTSS delivery system are subject to extensive regulatory requirements that define performance expectations
- Coordination and alignment of providers varies by program and region

Discussion Question

- How does the DLTSS delivery system present unique opportunities and challenges related to linking payment to performance?

Discussion

Design Considerations

- Entity receiving payment incentive (specific provider, risk-bearing entity, provider coalition)
- Payment type (risk-based, savings sharing, withhold)

Discussion Questions: Evaluation of VBP Model

- Does the model recognize the unique needs of members receiving DLTSS?
- Does the model recognize the unique nature of Vermont's DLTSS systems of care?
- Does the model create appropriate incentives for both medical and DLTSS providers?
- If incentive payments are based on demonstrated savings, how does the additional funding support system improvement? Who determines how additional funding is distributed and invested?

Discussion

Development of Performance Measures Specific to DLTSS

- Types of Measures
  - Structural (e.g., access to health information across providers)
  - Process (e.g., timeframe for completion of care plan, physician involvement in care planning)
  - Performance/Outcomes (e.g., beneficiary satisfaction, stable housing, employment, independence)
- Some Measures Specific to Each Program

Discussion Questions

- What measures are best achieved through VBP (rather than regulatory framework)?
- Are the values and outcomes measureable?
- Is there an existing Vermont framework for reliable and valid measurement?

Discussion

Next Steps: VBP Recommendations

- ❑ Identify specific measures by program
- ❑ Review and evaluate VBP Model and opportunities for the model to support DLTSS objectives

Discussion Question

- ❑ What is the process and timeline for informing the VBP model?