VT Health Care Innovation Project
Dual Eligible Work Group Meeting Agenda

Wednesday, October 23, 2013; 1:00 PM to 3:00PM
DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT
Call-In Number: 1-866-951-1151; Passcode 4554014

Item #	Time Frame	Topic	Relevant Attachments	Action #
1	1:00-1:10	Welcome, Introductions, and Recap of Dual Eligible Project History Deborah Lisi-Baker	• Attachment #1: Agenda	
2	1:10-1:50	Dual Eligible Project Overview - Julie Wasserman	• Attachment #2a: Dual Eligible Project Overview PowerPoint • Attachment # 2b: Dual Eligible Project Summary	
3	1:50-2:20	Work Group Goals and Activities - Deborah Lisi-Baker • Goals of Work Group • Review of Work Group Charter	• Attachment #3: Draft Work Group Charter	
4	2:20-2:40	Relationship of Work Group to Broader VHCIP (SIM) Governance Structure and Other Work Groups - Anya Rader Wallack • Solicit input on important points of overlap throughout all Work Groups	• Attachment #4: Vermont Health Care Innovation Project Overview • Attachment #5: Table of VHCIP Work Group Charge	
5	2:40-2:50	Review of Work Group Resources - Deborah Lisi-Baker • Staffing • Project Management Support • Membership List • Consulting Resources/Needs	• Attachment #6: Staff Contact Information, work group membership list	
6	2:50-3:00	Next Steps and Wrap-Up - Deborah Lisi-Baker/Judy Peterson • Next meeting: November 20, 2013, DVHA Large Conference Room, 312 Hurricane Lane, Williston, 10:00 am to 12:00 pm • Agenda for next meeting • Future meeting dates	• Attachment #7: Draft 2013 Calendar of Events	

Overview of Vermont Dual Eligible Demonstration To-Date and Key Milestones Ahead

Presentation for SIM/Duals Steering Committee and Workgroups

October 2013

Rationale for Dual Eligible Demonstration

Goal: Addressing System Barriers Affecting Beneficiaries

- Individuals dually eligible for both Medicare and Medicaid have low-incomes and among the most complex needs
- Dually eligible individuals are served by two programs (Medicare and Medicaid) that have not worked well together
- Medicaid & Medicare: Separate benefits, payment, rights and appeals processes, fragmented and difficult for beneficiaries and providers
- State integration of funds to provide more integrated and person directed services to dually eligible individuals who have often felt caught between two very different systems
- Medicaid has developed more flexible ways to provide services to individuals with disabilities and significant health conditions; Medicare has a more limited and rigid benefit plan and restrictions on how services are provided
- Retains beneficiaries' right to all Medicaid & Medicare entitlements but allows states to manage both Medicare and Medicaid funds to develop more integrated and flexible ways to provide mandated and other services while sharing savings with CMS (and providers)

Desired Changes

- Strong consumer rights and protections
- Consumer role in monitoring and evaluation (e.g., advisory committee)
- Eliminating or reducing some (but not all) longstanding Medicare problems affecting beneficiaries and providers (e.g., DME, pharmacy, etc.)
- New options: Flexible use of Medicare dollars to integrate services, self management of some services, improved preventive services, better outcomes
- Improved integration and coordination of services for each beneficiary across primary, acute, behavioral health and long-term supports and services
- Identify and validate delivery system and payment coordination models that improve quality of care and control costs

➔ Official CMS Demonstration Program: Medicare-Medicaid Capitated Financial Alignment Demonstration, administered by the Medicare/Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation

Unique Opportunities for Vermont through DE Demonstration Medicare / Medicaid Integration

- **State management of Medicare funds**
  - Enables State to keep Medicare savings
  - Enables State to put in place the administrative capacities for managing Medicare in preparation for Green Mountain Care
- **Pooled Medicare and Medicaid funding for Vermonters who are among the highest-cost, highest-users of healthcare**
  - Enables service coordination and integration
  - Facilitates the elimination of cost-shifting between Medicare and Medicaid
- **Integrated provider payment mechanisms** for Medicare and Medicaid
- **Consistent provider performance metrics** for Medicare and Medicaid
- **Potential elimination of conflicting and confusing Medicare and Medicaid coverage policies for beneficiaries**
- **One integrated pharmacy benefit plan**
- **Vehicle to explicitly incorporate needs of individuals with disabilities within state health care reform**

Overview of Dually Eligible (DE) Vermonters

- Approximately 22,000 Vermonters are enrolled in both Medicare and Medicaid
- They are diverse in age and medical needs

Age	% of VT DE Population
18-39	14%
40-49	15%
50-59	15%
60-69	17%
70-79	17%
80-89	15%
90+	7%

Medical Conditions	% of VT DE Population
Depression	39%
Asthma/Chronic Obstructive Pulmonary Disease	28%
Diabetes	26%
Heart Disease	26%
Arthritis	21%
Stroke, Cardiovascular Disease	14%
Alzheimer's Disease, Dementia	12%
Alcohol/Substance Abuse	7%
Schizophrenia	6%

Overview of Dually Eligible Vermonters

- Many but not all dually eligible individuals have disabilities

VT DE Individuals who…	% of VT DE Population
Have a Mental Illness	53%
Have a Physical Disability	29%
Have a Neurological Disability	24%
Have a Sensory Disability	11%
Have a Development Disability	9%

Vermont Specialty Medicaid Programs	% of Program enrollees that are dually eligible
Choices for Care (excluding Moderate Needs Group)	93%
Community Rehabilitation and Treatment (CRT)	68%
Developmental Services	64%

Service Utilization by Dually Eligible Vermonters

(based on 2010 data)

Major Service Category	Population Count	% of Population	Total Payments (M'care & M'caid)	% of Total Payments
Day Health Rehabilitative Services	180	0.8%	$1,562,827	0.3%
Diagnostic Testing	19,051	88%	$19,862,937	3.4%
Durable Medical Equipment & Supplies	11,130	51%	$9,931,365	1.7%
Emergency Department	9,546	44%	$6,027,610	1.0%
Home Health Care	4,548	21%	$24,374,433	4.2%
Hospice	353	2%	$3,652,499	0.6%
Inpatient Hospital	4,319	20%	$76,328,470	13.1%
Mental Health/Substance Abuse Clinic	2,502	12%	$1,901,220	0.3%
Miscellaneous	1,603	7%	$1,668,299	0.3%
Non-Physician Practitioner	16,744	77%	$10,786,298	1.9%
Nursing Home	3,771	17%	$132,219,277	22.7%
Outpatient Hospital	18,894	87%	$13,839,402	2.4%
Pharmacy	20,082	93%	$67,822,149	11.6%
Physician	19,847	92%	$34,084,570	5.9%
Transportation	7,816	36%	$12,635,790	2.2%
CFC HCBS/ERC, DS, TBI, CRT	5,798	27%	$165,783,646	28.5%
Total	21,670	100.0%	$582,480,793	100.0%

CMS Dual Eligible Demonstration Steps

- **State Letter of Intent:** Vermont submitted its Letter of Intent to CMS in Fall 2011.
- **State Planning & Design Process** : CMS awarded Vermont a $1m grant to initiate a comprehensive planning and design process.
- **Demonstration Proposal**: As a result of the design process, Vermont submitted a Demonstration proposal to CMS.
- **MOU:** Once CMS determined that Vermont met the standards and conditions, CMS and the State began the process of developing a MOU that provides the agreed-upon parameters for Vermont's Demonstration.
- **Health Plans:** DVHA, as Vermont's managed care "Health Plan", must apply and be approved by CMS to become the DE Medicare-Medicaid Plan.
- **Readiness Review**: Once an MOU is signed, CMS and the State (AHS) jointly conduct a Readiness Review of the Plan's (DVHA's) ability to accept enrollments, provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers, and fully meet the diverse needs of the Medicare-Medicaid population
- **3-way legal contract** signed between CMS, the State (AHS) and the DVHA Medicare/Medicare Plan to implement the Demonstration

CMS Dual Eligible Demonstration Financial Parameters

- **Payment:** Plans receive capitated payments for all Medicare Parts A, B, & D and Medicaid services.
  - Rates are calculated prospectively each year per baseline spending in both programs, absent the Demonstration, except:
    - Medicare Part D payments are set at the Part D national average monthly bid amount for the payment year.
  - The Medicare A/B and Part D Direct Subsidy components are risk adjusted for each enrollee. CMS pays the Medicare A/B and Part D rates directly to DVHA. The State (AHS) pays DVHA the Medicaid rate.
- **Savings:** CMS and the State establish a specific aggregate savings target for each year of the Demonstration which is specified in the MOU.
  - Vermont has proposed 1%, 1.5% and 2%, respectively
  - The savings target is subtracted from the Medicare A/B and Medicaid payment rates to DVHA
  - Savings targets are not applied to the Part D component of the rate.
- **Quality Withhold:** CMS and the State will withhold a portion of the capitation payments which DVHA can earn back if it meets certain quality thresholds. Vermont is working with CMS as part of the MOU negotiation to develop the quality withhold performance measures
  - The withhold amount will increase over three years (Year 1: 1%; Year 2: 2%; Year 3: 3%)
- **Risk-Sharing Agreements:** Vermont's MOU contains mechanisms to mitigate risk for all Demonstration Years in order to provide a level of protection to both the State and CMS against uncertainty in rate-setting that could result in either overpayment or underpayment.

Development of Vermont Dual Eligibles (DE) Demonstration – *Key Events to Date*

- **April 2011: Vermont awarded $1 million CMS Demonstration Grant to develop a proposal to serve the 22,000 dual eligible Vermonters**
  - AHS hired Project Director, contracted with Consultants via RFPs
- **June/July, 2011: AHS initiated groups to help develop Proposal**
  - Steering Committee (AHS/Departmental Leaders, Consultants)– bi-weekly /monthly meetings through August, 2013
  - Stakeholder Advisory Group – monthly meetings through August, 2013
  - Stakeholder Workgroups– bi-weekly meetings through September, 2011 (then content folded into Stakeholder meeting discussions):
    - Person-Centered Care
    - Service Delivery
    - Outcomes and Quality
    - Financing

Development of Vermont Dual Eligibles (DE) Demonstration – *Key Events to Date*

- **Fall 2011 – April 2012: Conducted Activities to Inform Design**
  - Activities to inform Model of Care (surveys, focus groups, handouts for Stakeholder discussion and input, etc. – see Slide 20 for further detail)
  - Additional Stakeholder workgroups formed for specific topics:
    - Grievance and Appeals
    - Performance / Outcomes Measures and Evaluation
    - Individual Assessment and Comprehensive Care Plan
    - Essential Components of Person-Directed Approach
  - Internal State Team meetings on:
    - Eligibility and Enrollment
    - Data Exchange
    - IT Process Mapping
    - Provider Payment
    - Pharmacy
  - Analyses on Integrated Medicare/Medicaid Data

Development of Vermont Dual Eligibles (DE) Demonstration– *Key Events to Date, cont.*

- **March, 2011: AHS issued DE Demonstration Draft Proposal for Formal Comment from Vermont Stakeholders and Interested Parties**
  - Held Public Hearing via Vermont Interactive Television at nine locations
  - Summarized Comments for Inclusion in Final Proposal to CMS
- **May, 2011: Submission of Proposal to CMS, which included:**
  - Utilization of Global Commitment framework (DVHA public managed care model as foundation for DVHA to be Vermont's DE Medicare-Medicaid Plan)
  - Data on Vermont Dual Eligible Beneficiaries by sub-populations
  - Model of Care Description (high-level)
  - Targeted Interventions for savings by sub-populations
  - AHS and DVHA Staffing Plans
  - Project Timeline
- **June, 2011 to Present: Interactions with CMS on Proposal and Next Steps**
  - Written Responses to CMS Questions
  - Bi-weekly/Monthly calls with CMS about Model of Care Design, Financing Mechanisms between CMS, AHS & DVHA, Project Timing, etc.

Development of Vermont Dual Eligibles (DE) Demonstration – *Key Events to Date, cont.*

- February, 2013: **DVHA Application to be DE Medicare /Medicaid Plan** – included:
  - Details on Provider Network
  - Plan Benefit Package that integrates Medicare and Medicaid
  - Pharmacy Program Information
  - Detailed Model of Care (239 pages) – covered 11 elements:

(1) Description of SNP-specific Target Population
(2) Measurable goals
(3) Staff structure and Care Management Roles
(4) Interdisciplinary Care Team
(5) Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols
(6) MOC Training for Personnel and Provider Network
(7) Health Risk Assessment
(8) Individualized Care Plan
(9) Communication Network
(10) Care Management for Vulnerable Subpopulations
(11) Performance and Health Outcome Measurement

  - ❖ Model of Care reviewed by the National Committee for Quality Assurance (NCQA) on CMS' behalf based on 11 elements and scoring standards. **NCQA approved DVHA's Model of Care for 3 years (thru 2017) with a score of 96%.**

Development of Vermont Dual Eligibles (DE) Demonstration – *Key Events to Date, cont.*

- April, 2013: **Vermont Submitted its Funding Application to CMS**
  - In response to CMS Funding Opportunity: *Implementation Support for State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees*
  - Provides funding to states that previously had design contracts and also have a signed Memorandum of Understanding (MOU) with CMS.
    - After signed MOU, funding application is reviewed by CMS and funds can be available within 4 weeks
  - Funding is for a two year project period.
    - CMS covers 100% of the cost of approved activities in the first year
    - CMS covers 75% of the costs of approved activities in the second year.

- **Changes to Implementation Date (initiated by Vermont)**
  - In March, 2013: Changed from *January 1, 2014* to *September 1, 2014*
  - In June, 2013: Changed from *September 1, 2014* to *January 1, 2015*

→ Revisions of Project Timeline to reflect new implementation date

Development of Vermont Dual Eligibles (DE) Demonstration – *Future Milestones*

- **Final Negotiations and Signing of MOU** between CMS and AHS
- **Receipt of 2-year CMS Funding** for Development and Implementation (1 month after MOU is signed)
- **Hire DE Demonstration staffing for AHS and DVHA** (as soon as CMS funding is available)
- **Develop State and DVHA Infrastructure, Policies and Procedures to implement Demonstration** (as soon as CMS funding is available and additional staff are hired)
- **Issue RFP and sign contracts with Integrated Care Partnerships (ICPs)**

Development of Vermont Dual Eligibles (DE) *Demonstration – Future Milestones, cont.*

- **CMS & AHS conduct Readiness Review of DVHA**
  - Purpose: to ensure that DVHA is ready to accept enrollments, provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers, and fully meet the diverse needs of the Medicare-Medicaid population
  - Areas for Review:

• **Assessment processes**	• **Performance and quality improvement**
• **Care coordination**	• **Program integrity**
• **Confidentiality**	• **Provider credentialing**
• **Enrollment**	• **Provider network**
• **Enrollee and provider communications**	• **Qualifications of first-tier, downstream, and related Entities**
• **Enrollee protections**	• **Utilization management**
• **Financial soundness**	• **Model of Care Training**
• **Organizational structure and staffing**	• **Testing of all IT operation systems (e.g., claims, enrollment, payment, pharmacy, care coordination, etc.)**

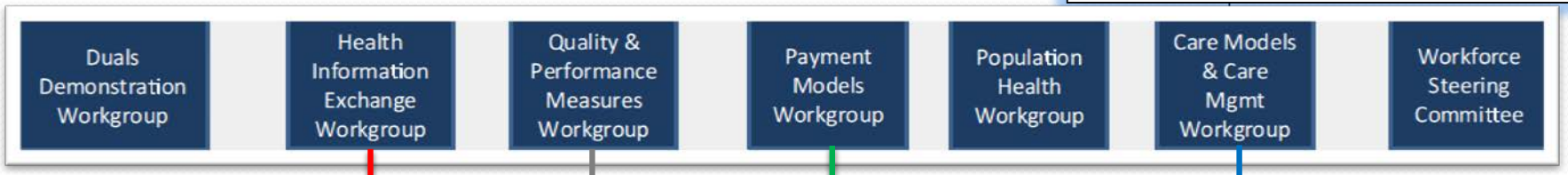
Development of Vermont Dual Eligibles (DE) Demonstration – *Future Milestones, cont.*

- **Negotiate and Sign 3-way Contract between CMS, AHS and DVHA**
- **Conduct Beneficiary Education and Outreach** (begins 4 months prior to Implementation Start-date)
- **Beneficiary notices and opt out period** (begins 4 months prior to Implementation Start-date)
- **Beneficiary chooses PCP and Enhanced Care Coordination Provider** (begins 4 months prior to Implementation Start-date)
- **Demonstration begins**

DUALS alignment with SIM

LEGEND

SIM Workgroup
DUALS State Teams
DUALS Workgroups
- DUALS deliverable completed
- * DUALS deliverable *in progress*



SIM Health Information Exchange Workgroup

DUALS Eligibility and Enrollment State team
DUALS Data Exchange State team
DUALS IT Process Mapping State team

- HIE Interface with Duals Individual Assessment Deliverables*
- Duals IT process flows and timelines developed by AHS IT, DVHA/COB, DCF/ESD, and contractors*
- Duals request for $1.5 million from CMS for Infrastructure Grants to help ICPs with internal capacity building
- Duals request for CMS funding to support LTSS provider connectivity to HIE (pro-rated based on % of Duals served by provider type)

SIM Quality and Performance Measures Workgroup

DUALS Person Centered Care Workgroup
DUALS Integrated Medicare and Medicaid Data State team
DUALS Performance & Outcome Measures and Evaluation State team

- Duals Quality Metrics, Quality Withholds, and Performance Measures (CMS required and State proposed in draft MOU)

SIM Payment Models Workgroup

DUALS Financing Models Workgroup
DUALS Provider Payment State team
DUALS Appeals and Grievance Workgroup (part of ACO standards)

- Duals Quality Incentive Pool, Quality Withholds, and Savings through the Duals Demonstration and Medicaid ACO SSP (in draft MOU)
- Duals Targeted Interventions for Savings
- Duals Payment Approach for Integrated Care Partnership Provision of Enhanced Care Coordination*
- Duals Bundled Services Payment Approach for Integrated Care Partnerships-Plus (ICP-Plus)*
- DAIL Payment Approach for Self-management of Services (adopted by Duals)

SIM Care Models and Care Management Workgroup

DUALS Person Centered Care Workgroup
DUALS Service Delivery Models Workgroup
DUALS Individual Assessment & Comprehensive Care Plan Workgroup
DUALS Essential Components of Person-Directed Approach Workgroup
DUALS Pharmacy Program State team

- Duals CMS/NCQA approved DVHA Model of Care as a "Medicare Advantage" Plan
- Duals Person-centered Policy
- Duals Integration of Self-management Services
- Duals Individual Assessment deliverables*
- Duals Draft RFP Criteria for ICP/ICP+
- Duals Integrated Medicare/Medicaid pharmacy benefit*

Overview of Vermont Medicare and Medicaid Financial Alignment Model for Dual Eligible Individuals

October 2013

Demonstration Purpose: The goal of this project is to integrate the financing and delivery of services for individuals who are dually eligible for Medicare and Medicaid. Many dually eligible individuals have complex health and disability-related needs and depend on two separate financing and service delivery systems. This fragmentation impedes access to and delivery of comprehensive, person-directed, effective and well-coordinated care.

Populations that will be served in the Duals Demonstration: Most Vermonters dually eligible for both Medicare and Medicaid will be automatically enrolled into the Demonstration, though they can then choose to opt out.[1] Approximately 21,600 Vermonters are enrolled in both Medicare and Medicaid. Of these, 38% percent currently are enrolled in long term care Medicaid waiver programs (e.g., Community Rehabilitation and Treatment Services, Developmental Services, Traumatic Brain Injury, and Choices for Care) representing approximately 75% of Vermont's total expenditures for the dual eligible population. An additional 1,051 (5%) dually eligible individuals are not eligible for Medicaid waiver programs but are high users of health care services (e.g., emergency room, inpatient, mental health, pharmacy, etc.) who could benefit from improved care coordination. The remaining 12,431 (57%) account for only 13% of expenditures but could still benefit from care coordination. Pharmacy costs are excluded from the table below; however, 93% of all dually eligible Vermonters use prescription medications which account for 26% of Medicare costs for this population.

Dual Eligibles (DE) in VT	Waiver (CfC, CRT, DS, TBI)	Non-waiver High Users	Non-waiver All Others	Total
DE Population	8,188*	1,051	12,431	21,670
% of DE Population	38%	5%	57%	100%
DE Expenditures**	$396,612,728	$63,121,256	$68,746,539	$528,480,593
% of Total DE Expenditures	75%	12%	13%	100%

* Individuals may be enrolled in more than one waiver program; as a result, this number does not represent the sum of enrollment in each of the waiver programs.

** Excludes pharmacy expenditures.

Elements of Service Delivery & Financing: The Demonstration will use person-directed interventions to improve care coordination, service delivery and health and social outcomes for enrolled Vermonters. Core elements of the integrated financing and service delivery system include: a single point of contact, individualized and integrated assessments, and one comprehensive care plan across all health and long term care needs; active involvement with a Blueprint or other medical health home and related community health team; effective support during care transitions; and access to a single, comprehensive pharmacy benefits program. The new pharmacy benefit will adhere to both Medicaid and Part D requirements but will be more inclusive than Part D formularies and take into account the special needs of individuals with chronic health conditions, cognitive impairment, mental health and substance abuse needs, and physical disabilities. Provider incentive payments will be tied to population-specific performance measures and linked to payment reform. As a result of these innovations, the Demonstration hopes to reduce utilization/expenditures and improve outcomes as well as achieve administrative savings for both the federal and state government.

Demonstration participant role: The project is designed to promote the active and optimal engagement of participants in the assessment, care planning and delivery of their services, recognizing

[1] Individuals who are in a Medicare Advantage plan or those who have access to third party Medicare Supplemental Insurance can opt into the program if they drop their existing coverage, but they will not be automatically enrolled in the Demonstration.

that individuals differ in their interest and ability to participate. Both formal and informal service providers and family members will support the participant's choices/preferences. The participant also will have the option to self-manage some of their services (e.g., personal attendant care). The participant will have a primary care provider (PCP); ideally the PCP will be part of a Blueprint Advanced Primary Care Practice. The participant also will have a single point of contact, someone who will ensure enhanced care coordination across all services in the participant's plan of care, including primary, acute, mental health, substance abuse, and long term care services and supports.

The Role of Community Providers: The Demonstration proposes the formation of regional or statewide ***Integrated Care Partnerships (ICPs)*** comprised of member organizations responsible for providing Enhanced Care Coordination for all enrollees in their geographic region. These entities will have the opportunity to function as ***Integrated Care Partnerships Plus (ICPs Plus)*** after Year 1 of the Demonstration.

> ***Integrated Care Partnerships (ICPs) member organizations*** will be responsible for working with the individual to assess their needs and provide a single point of contact to coordinate comprehensive and ongoing care across providers in the health care system, including medical (both Accountable Care Organizations and non ACO) providers; designated agencies and other long term care providers; other social services providers; and peer support organizations. The ICP will receive a payment from the State for ensuring the provision of Enhanced Care Coordination.
>
> ***Integrated Care Partnerships Plus (ICPs Plus) member organizations*** will be responsible for all ICP functions, and in addition will receive a capitation payment to ensure the provision of a bundled array of services. To be eligible to receive ICP-Plus payments, the ICP-Plus must demonstrate the capacity or contractual relationships necessary to manage the full spectrum of services included in the ICP-Plus "bundle," which will include in-home health services; home and community supports/services; and mental health and substance abuse treatment.

Payments to the State: The State will continue to receive federal matching funds for the Medicaid services received by this population. However, under this Demonstration, the State also will receive capitation payments from the federal government for the Medicare dollars attributed to this population. A pre-determined portion of any Medicaid and Medicare savings achieved by the State will be shared between the federal and State government. The State's share of the savings will be used for such things as infrastructure costs, supplemental benefits for Demonstration enrollees, and incentive payments for providers.

Payments to providers: The State will use the combined Medicaid and Medicare funds to pay providers for all services received by enrollees. The State will not reduce provider payments to achieve savings in this Demonstration. On the contrary, if quality outcomes are achieved and savings are generated, providers will receive quality incentive payments.

Outcomes from this project: The outcomes for participants include: active participation in the design and delivery of their services; individualized support from an ICP or ICP-Plus provider to improve coordination of care; improved access to necessary and appropriate levels and types of services; and improved participant satisfaction and quality of care. Outcomes for providers include increased provider satisfaction through working across disciplines on behalf of the participant to provide necessary and appropriate services, and the potential for flexibility in service provision through bundled payments. Outcomes for the State and federal government include having a more flexible, accessible and high quality system of care for participants across all providers, as well as fiscal savings. These fiscal savings result from improved beneficiary outcomes, reduced unnecessary service utilization, and administrative efficiencies such as the elimination of many of the incentives for cost shifting between Medicaid and Medicare which can serve as a deterrent to appropriate and integrated care.

DRAFT

VT Health Care Innovation Project
Dual Eligible Work Group Meeting Agenda

Wednesday, October 23, 2013; 1:00 PM to 3:00PM
DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT
Call-In Number: 1-866-951-1151; Passcode 4554014

Duals Demonstration Work Group Charter:

This group will build on the extensive work of the duals demonstration steering committee. The group will continue to develop recommendations for the design of the state's financial alignment demonstration regarding:

- A care model or models for dually-eligible Vermonters that improves beneficiary service and outcomes
- Provider payment models that encourage quality and efficiency among the array of primary care, acute and long-term services and support providers who serve dually-eligible populations
- Quality measures to be used to evaluate provider and overall project performance
- A financial model that allows for an assessment of the potential costs, benefits and risks of the project for the state, providers and beneficiaries
- Management structures necessary to administer the project at both the state and provider levels

The group also will recommend mechanisms for assuring alignment of the duals demonstration with other payment reform initiatives, including any flexibility from the federal government that is necessary to achieve such alignment. These recommendations will support the state's assessment of whether to pursue the demonstration as details of the federal terms and conditions are identified.

Specific tasks of this group will include:

- Identifying technical and IT needs
- Facilitating an updated and comprehensive financial analysis
- Developing a strategic plan for how Medicare's ACO Shared Savings Program, Medicaid's ACO Shared Savings Program, and a potential Duals Demonstration will align

Vermont Health Care Innovation Project

Overview for Dual Eligible Work Group

October 23, 2013

What are we trying to do through this project?

- Create/accelerate three things, on a statewide, all-payer basis:
  - An integrated system of value-based provider payment
  - An integrated system of care coordination and care management
  - An integrated system of electronic medical records

How will we do it?

- Input through 7 work groups on policy and spending
- Recommendations:
  - work groups → steering committee → core team
- On what?
  - Coordinated policy:
    - Payment
    - Care management
    - Health information exchange
  - Targeted funding:
    - Modeling and testing payment reforms
    - Expanding health information exchange
    - Supporting providers to change their business models

SIM grant requirements

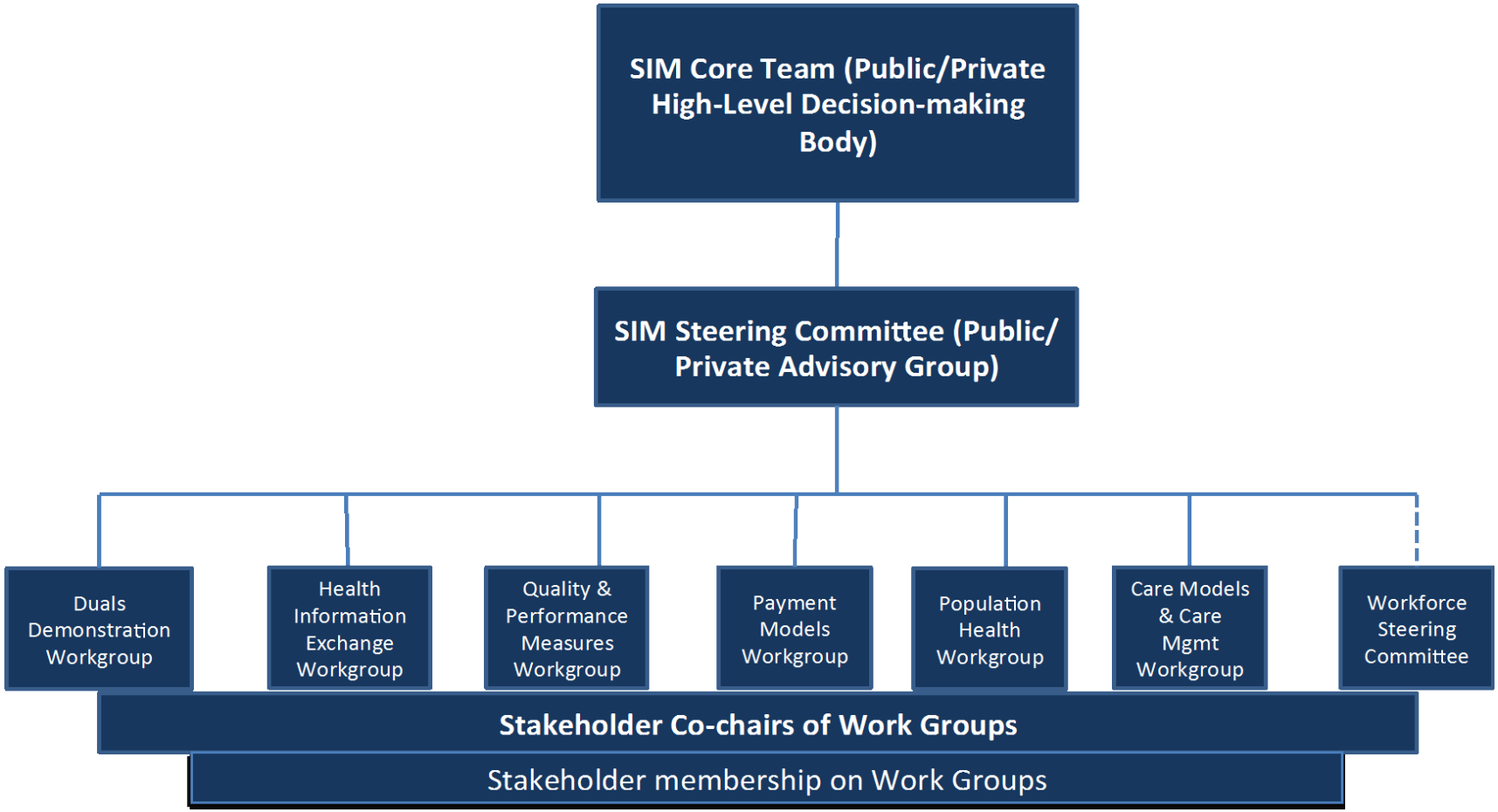
- Address the triple aim (cost, quality, patient experience)
- Include multiple payers
- Test models of value-based payment (if you are requesting a testing grant)
- Include a broad array of stakeholders
- Show strong support for the project from the Governor
- Align with other federal demonstrations and waivers
- Prove “readiness” to test by October 1
- Rigorous evaluation

Vermont Health Care Innovation Project

SIM grant history

- Application submitted in September 2012
- Grant awarded in March 2013
- JFC approved receipt of funds in May
- Steering committee launched in June
- Operational plan submitted July 31
- Approved for testing phase on September 30
- Reconstituting and launching work groups now

Vermont health care innovation project governance structure*



*In addition to the standing work groups, we have agreed to create a time-limited group to address the interface between designated mental health agencies and SIM activities/recommendations

Input on SIM Decisions

Core Team

- Anya Rader Wallack, Chair
- Robin Lunge, Director of Health Care Reform
- Doug Racine, Secretary of Human Services
- Al Gobeille, Chair of the Green Mountain Care Board
- Mark Larson, Commissioner of the Department of Vermont Health Access
- Susan Wehry, Commissioner of the Department of Disabilities, Aging and Independent Living
- Lisa Ventriss, President of the Vermont Business Roundtable (to be replaced by Steve Voigt in mid-October)
- Paul Bengtson, CEO of Northeastern Vermont Regional Hospital

Work Group Chairs

Payment Models

Don George, President and CEO, BCBSVT

Stephen Rauh, Health Policy Consultant and Member of GMCB Advisory Board

Care Models and Care Management

Bea Grause, President, Vermont Association of Hospitals and Health Systems

Susan Barrett, Director of Vermont Public Policy, Bi-State Primary Care

Health Information Exchange

Simone Rueschemeyer, Behavioral Health Network

Brian Otley, Chief Operating Officer, Green Mountain Power

Dual Eligibles

Deborah Lisi-Baker, Disability Policy Expert

Judy Peterson, Visiting Nurse Association of Chittenden and Grand Isle Counties

Quality and Performance Measures

Catherine Fulton, Executive Director, Vermont Program for Quality in Health Care

Laura Pelosi, Vermont Health Care Association

Population Health Management

Tracy Dolan, Deputy Commissioner, Department of Health

Karen Hein, M.D., Member of the Green Mountain Care Board

Workforce Steering Committee (a slightly different animal)

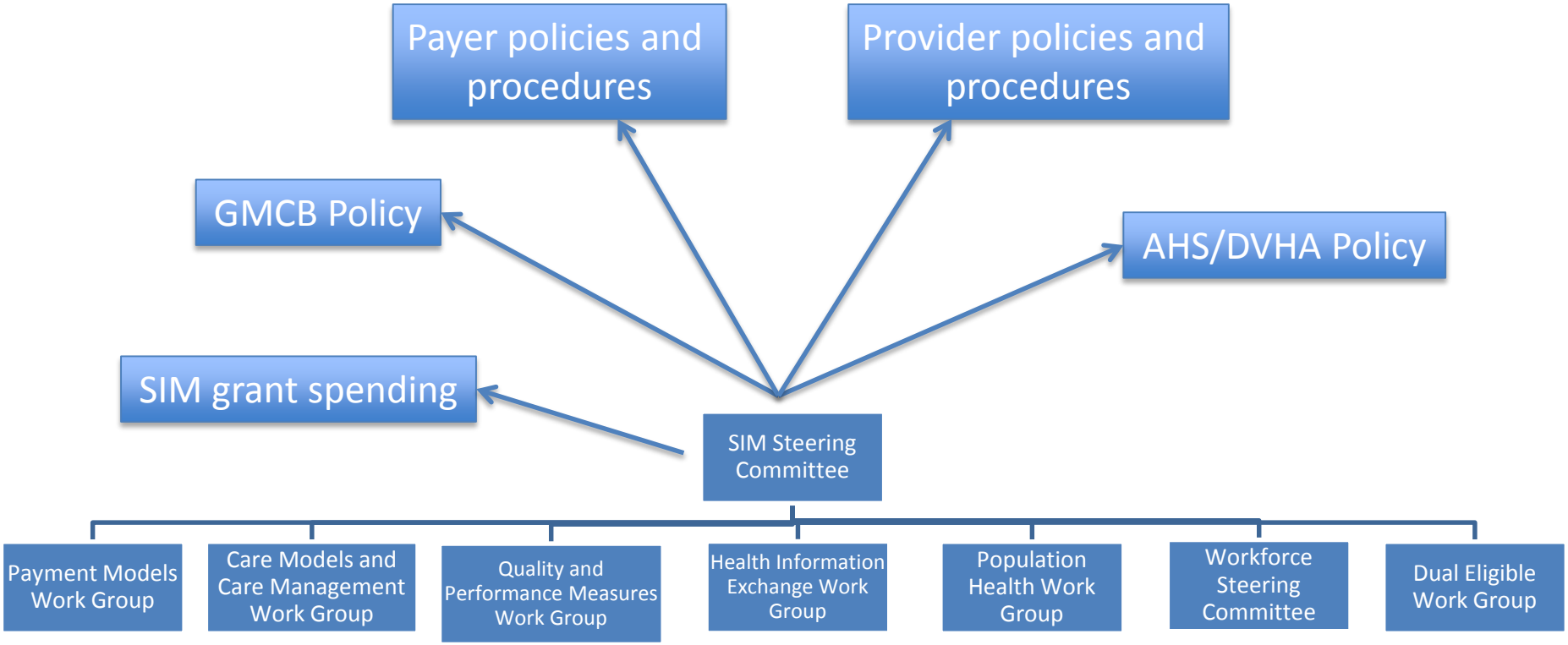
Mary Val Palumbo, R.N.

David Reynolds

Expectations for work groups

- Develop a formal charter
- Develop a work plan
- Meet at least monthly
- Report monthly to Steering Committee and Core Team
- Recommend contractor support for your work
- Recommend spending of certain SIM funds

Expected influence of the health care innovation project



Vermont Health Care Innovation Project

Vermont Health Care Innovation Project Work Group Overview	
Payment Models Work Group	This group will build on the work of the ACO standards work group to date and: • Continue to develop and recommend standards for the commercial shared savings ACO (SSP-ACO) model • Develop and recommend standards for the Medicaid SSP-ACO model • Develop and recommend standards for both commercial and Medicaid episode of care models • Develop and recommend standards for Medicaid pay-for-performance models • Review the work of the duals demonstration work group on payment models for dual eligibles • Recommend mechanisms for assuring consistency and coordination across all payment models
Care Models Work Group	This group will examine current or planned care management programs and care delivery models including: • The Blueprint for Health Advanced Primary Care Medical Home, including Community Health Teams • The Support and Services at Home (SASH) program • Care management programs of the commercial payers • Care management programs of Medicaid • Care models or care management implemented or contemplated by Medicare ACOs • Care models or care management contemplated as part of the duals demonstration • Large-scale population-based care or health improvement models that might complement or integrate with the above The group will recommend mechanisms for assuring greater consistency and/or coordination across these programs and models in terms of service delivery, financial incentives, quality measurement or other key model or program components. The goal will be to maximize effectiveness of the programs and models in improving Vermonters' experience of care, reducing unnecessary costs and improving health, and minimizing duplication of effort or inconsistencies between the models.
Performance Measures Work Group	This group will recommend standardized measures that will be used to: • Evaluate the performance of Vermont's payment reform models relative to state objectives; • Qualify and modify shared savings, episodes of care, pay for performance, and health home payments; and • Communicate performance to consumers through public reporting. The overarching goal of quality and performance measurement is to focus health care reform and quality improvement efforts to control growth in health care costs, improve health care, and improve the health of Vermont's population.

Dual Eligible Work Group	This group will build on the extensive work of the duals demonstration steering committee and will develop recommendations for the design of the state's financial alignment demonstration regarding: • A care model or models for dually-eligible Vermonters that improves beneficiary service and outcomes • Provider payment models that encourage quality and efficiency among the array of primary care, acute and long-term services and support providers who serve dually-eligible populations • Quality measures to be used to evaluate provider and overall project performance • A financial model that allows for an assessment of the potential costs, benefits and risks of the project for the state, providers and beneficiaries • Management structures necessary to administer the project at both the state and provider levels The group also will recommend mechanisms for assuring alignment of the duals demonstration with other payment reform initiatives, including any flexibility from the federal government that is necessary to achieve such alignment.
HIE Work Group	This group will: • Identify the desired characteristics and functions of a high-performing statewide information technology system. • Explore and recommend technology solutions to achieve SIM's desired outcomes. • Guide investments in the expansion and integration of health information technology, as described in the SIM proposal, including: o support for enhancements to EHRs and other source data systems o expansion of technology that supports integration of services and enhanced communication, including connectivity and data transmission from source systems such as mental health providers and long-term care providers o implementation of and/or enhancements to data repositories o implementation of and/or enhancements to data integration platform(s) o development of advanced analytics and reporting systems The group also will advise the development of the state's health information technology plan with regard to the above activities and expenditures.
Population Health Work Group	This group will examine current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities. The group will examine these initiatives and SIM initiatives for their potential impact on the health of Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including: • Enhancement of State initiatives administered through the Department of Health • Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts • Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health
Work Force Work Group	

VHCIP Dual Eligible Work Group Team		
Position	**Name/Contact Information**	**Function**
Co-Chairs	**Deborah Lisi-Baker** Disability Policy Expert dlisibaker@gmail.com (802) 244-5123	• Provide leadership and direction on work group activities.
	Judy Peterson President and CEO VNA of Chittenden & Grand Isle Counties Peterson@vnacares.org (802) 860-4431	
Staff	**Anya Rader Wallack, Ph.D.** Chair, Vermont State Innovation Model (SIM) Core Team Email: Anya.Wallack@state.vt.us	• Advise work group on overarching VHCIP structure and goals.
	Erin Flynn, MPA Health Policy Analyst, DVHA Email: erin.flynn@state.vt.us Phone: (802) 878-7852	• Provide administrative, logistical and technical support to work group. • Policy, planning and data analysis for the Duals initiative and work group.
	Julie Wasserman, MPH VT Dual Eligible Project Director Julie.Wasserman@state.vt.us (802) 871-3215	
	Christine Geiler SIM Grant Program Manager and Stakeholder Coordinator Email: christine.geiler@state.vt.us Phone: 802-828-1969	
Consultants	**Susan Besio, Ph.D.** Senior Associate Pacific Health Policy Group sbesio@PHPG.com (802) 522-2109	• Support work group with technical support surrounding research, policy briefing, and other technical support as defined by the work group
	Brendan Hogan, MSA Senior Consultant Bailit Health Purchasing Email: bhogan@bailit-health.com (802) 522.6740	

Work Group Contact List

	Last Name	First Name	Title	Organization	Email
1	Besio	Susan	Senior Associate	Pacific Health Policy Group	sbesio@PHPG.com
2	Chapman	Alysia	Developmental Services	Howard Center for Mental Health	Alysiac@howardcenter.org
3	Davis	Elizabeth		Consultant on Long Term Services and Supports	delizabethjdavis@msn.com
4	Dugan	Molly	SASH Program Director	Cathedral Square and SASH Program	Dugan@cathedralsquare.org
5	Flood	Patrick	CEO	Northern Counties Health Care	patrickf@nchcvt.org
6	Goetschius	Larry	CEO	Addison County Home Health & Hospice	Lgoetschius@achhh.org
7	Hill	Bard	Director - Policy, Planning & Data Unit	AHS - DAIL	bard.hill@state.vt.us
8	Joyal	Margaret	Director of Adult Outpatient Services	Washington County Mental Health Services Inc.	margaretj@wcmhs.org
9	Kerr	Trinka	Health Care Ombudsman	Vermont Legal Aide	tkerr@vtlegalaid.org
10	Lisi-Baker	Deborah	Disability Policy Expert		dlisibaker@gmail.com
11	Majoros	Jackie	Long-Term Care Ombudsman	Vermont Legal Aide	jmajoros@vtlegalaid.org
12	Mongan	Madeleine	Deputy Executive Vice President	Vermont Medical Society	mmongan@vtmd.org
13	Olszewski	Miki	Assistant Director of Blueprint for Health	AHS - DVHA	Olszewski.miki@state.vt.us
14	Peterson	Judy		Visiting Nurse Association of Chittenden and Grand Isle Counties	peterson@vnacares.org
15	Renfrew	Virginia		Zatz & Renfrew Consulting	renfrew@sover.net
16	Richardson	Lila	Staff Attorney	Vermont Legal Aide	Lrichardson@vtlegalaide.org
17	Stout	Ray	Mental Health & Health Care Integration Liaison	AHS - DMH	Ray.Stout@state.vt.us
18	Tessler	Julie	Executive Director	Vermont Council of Developmental and Mental Health Services	julie@vtcouncil.org

*****This list is subject to change/additions/updates as the work group continues to progress*****

VHCIP: DUAL ELIGIBLE WORK GROUP 2013 CALENDAR OF EVENTS

October 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23 1:00-3:00 SIM Duals Work Group Kick-Off Meeting; DVHA Large Conf. Room, 312 Hurricane Lane (call in: 1-866-951-1151, Conference Room: 4554014)	24	25	26
27	28	29	30	31		

November 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20 10:00-12:00 SIM Duals Work Group Meeting, DVHA Large Conference Room, 312 Hurricane Lane (Dial In: 1-866-951-1151; Conference Room: 4554014)	21	22	23
24	25	26	27	28	29	30

December 2013						
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

January 2014						
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	