Vermont Health Care Innovation Project
Steering Committee Meeting Minutes

Pending Committee Approval

Date of meeting: Wednesday, October 26, 2016, 1:00pm-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Minutes Approval	Steven Costantino called the meeting to order at 1:03PM. A quorum was not present.	
2. Core Team Update	*All-Payer Model Update:* Lawrence Miller provided an update on the All-Payer Model. • The public comment period for the All-Payer Model closed. The GMCB and Administration received a few specific comments on the agreement, which went to CMS; the agreement was updated and returned earlier this week with CMS's signature. • The Green Mountain Care Board voted affirmatively this morning, authorizing Chairman Gobeille to sign. • Governor Shumlin and Secretary Cohen will officially sign tomorrow afternoon at the Governor's Ceremonial Office. • Responses to comments are completed and posted on the GMCB website and the Office of Health Care Reform website. This includes responses general responses to most verbal comments. • CMS confirmed today that under their Quality Payment Program, they have designated the Vermont ACO Model as an Advanced Alternative Payment Model (AAPM) for MIPS/MACRA purposes. The group discussed the following: • Susan Aranoff asked whether the Green Mountain Care Board was presented with the Shared Savings Program (SSP) results prior to voting. Lawrence replied that the SSP results have been public for a few weeks, but noted that there is a substantial difference between the two models. Pat Jones confirmed that Board members have seen results. *Brief Sustainability Update:* Lawrence Miller provided a brief sustainability update. We received a first draft of the plan this week; it will be reviewed by the Sustainability Sub-Group on Friday, and released to all VHCIP	

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	participants next week (expected 11/2) following a first round of edits. The draft plan will be reviewed and discussed at all Work Groups in November, and will also be the subject of a webinar on 11/17. Written and verbal comments are also welcome; please send them to Georgia Maheras (georgia.maheras@vermont.gov) or Sarah Kinsler (sarah.kinsler@vermont.gov).	
3. Overview: Year 2 Shared Savings Program Results	Pat Jones and Alicia Cooper presented high-level results from Year 2 of Vermont's Medicaid and Commercial Shared Savings Programs (SSPs) as well as the Medicare Shared Savings Program. • The Shared Savings Programs (SSPs) are part of a broader context in Vermont and nationally: in 2015, the federal government passed the Medicare Access and Children Health Insurance Program Reauthorization Act (MACRA). MACRA creates 2 tracks for payment reform under Medicare: 1) Merit-Based Incentive Payment System (MIPS) – reimburses providers based on results of quality measures (upside or downside); 2) Advanced Alternative Payment Models – provides financial incentives for providers who chose to participate and disincentives for those who do not. Vermont's current SSPs do not qualify as Advanced Alternative Payment Models; however, the All-Payer Model would qualify. • Cautions in interpreting results: The three ACOs have different populations and different SSP start dates/levels of maturity. In addition, Commercial targets continue to be based on Vermont Health Connect premiums, rather than actual claims experience. • Takeaways from the 2015 SSP results: Medicaid SSP: CHAC earned modest savings; PMPM declined from 2014 to 2015. Overall quality scores improved. Commercial SSP: CHAC and OneCare PMPM financial results closer to targets; no change in OneCare's PMPM from 2014 to 2015; VCP's farther away from target. Targets still based on premiums in 2015, rather than claims experience. Overall quality scores improved by 5 percentage points for CHAC and 2 percentage points for OneCare; VCP overall quality score declined by 2 percentage points (still would have qualified VCP for 100% of savings). Medicare SSP: CHAC and OneCare aggregate financial results farther away from targets; Medicare doesn't report PMPM results. Quality improved by 7 percentage points for OneCare; 2015 was first reporting year for CHAC; both had quality scores greater than 90%. • A few notes regarding Medicaid and Commercial payment measures: o Medicaid and Commercial payment measure set was mostly stable between 2014 and 2015; outcome measures added in 2015 o Multiple years of data for Commercial SSP members resulted in adequate denominators for measures with look-back periods o Medicaid "Quality Gate" more rigorous in 2015 (35% to 55%) o Data collection and analysis is challenging, but there continues to be impressive collaboration among ACOs in clinical data collection • Medicaid SSP Quality Results: Payment Measures – (Slide 36).	

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	Strengths: o 10 of 14 measures of ACO results were above the 50th percentile nationally; 6 of 14 were above the 75th percentile Both ACOs met the quality gate and CHAC will receive shared savings Opportunities: o 4 of 14 measures were below the 50th percentile o Opportunity to improve Chlamydia Screening measure across both participating ACOs o Some variation among ACOs • Commercial SSP Quality Results: Payment Measures Strengths: o 16 of 22 measures were above the 50th percentile nationally; 15 of 22 were above the 75th percentile Opportunities: o 6 of 22 measures were below the 50th percentile o Opportunity to improve Alcohol and Other Drug Dependence Treatment measure across all ACOs o Even when performance compared to benchmarks is good, potential to improve some rates o Some variation among ACOs The group discussed the following: • Dr. Batra asked how 2015 Medicaid SSP targets were set. Alicia replied that 2015 expenditure targets were set based on a three-year baseline period, from 2011-2013. • Dale Hackett asked if OneCare and Healthfirst could speak to why they exceeded targets. Alicia replied the 10/28 webinar on this topic will expand on this theme. Dale noted that CHAC's quality score was lower than OneCare's, yet CHAC achieved savings and OneCare did not. Pat recommended caution in interpreting the relative quality scores. • Dr. Batra noted that CHAC saw an actual reduction in PMPM costs for the Medicaid SSP in Year 2. • Dale again noted that as quality scores rose across the ACOs within the commercial program, costs rose. Steven Costantino and Pat replied that different populations (and risk adjustment) make it challenging to compare across ACOs. • Susan Aranoff asked what percent of Vermont's Medicare lives are attributed to an ACO. Pat estimated a bit more than half. Pat noted that a recent Health Affairs blog reported that nationally, lower-cost ACOs are not as likely to achieve savings in the Medicare SSP (Vermont's Medicare expenses are on the low side). • Dr. Batra noted that common wisdom is that Medicaid is the leanest of health insurers, but the Medicaid SSP is achieving savings. Alicia replied that SSP design is not exactly the same across payers, which makes it hard to compare. She added that the Medicaid expansion in 2014 had an impact as new	

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	Medicaid enrollees began using more services. Lawrence suggested that new enrollees expanded the population, and skewed young and healthy. • Dale noted that Exchange premiums increased across the country for the coming plan year. Lawrence cautioned against equating these two conversations. He commented that total enrollment was approximately as anticipated and actuarial data was fairly good for Vermont's exchange population. In other states, actuarial error in early years resulted in artificially low premiums; major price increases were necessary to correct this. In addition, claims on the federal co-insurance pool (which was intended to help participating insurers recoup some costs if, for example, Exchange enrollees were significantly sicker than the general population) for Exchange plans was 8.7 times higher than input into that pool, which left insurers to make up losses by increasing premiums over the first few years of the exchanges. • Julie Wasserman noted that Dr. Batra's comment related to savings in the Medicaid SSP might link to public concern about Medicaid within the All-Payer Model – why are savings being achieved only for a program that some consider underfunded, and are these savings funding ACO operations within the other SSP programs? Dr. Batra commented that Julie describes the reverse of the actual cost-shift we see between payers. Lawrence replied that no one has presented a business argument for this scenario– we need real, specific concerns so that we can put appropriate language in contracting to protect against issues like these. Steven added that the SSP model is very different from the APM, and noted that no insurer wants to subsidize another – there will be contractual firewalls to prevent this. • Susan noted that we are moving away from fee-for-service and that the SSP model doesn't have downside risk. She asked why OneCare chose to delay NextGen launch and when they will be able to take on financial risk. Lawrence noted that OneCare will start NextGen for Medicare in 2018; the DVHA program based on NextGen is expected to begin in 2017, with commercial in 2018 or 2019 depending on readiness. • Dale noted that MACRA/MIPS penalizes providers for remaining in FFS payment. Pat clarified that there could be a penalty or a payment increase depending on reported quality measures. Up to 9% of payments will be at risk once the program has fully scaled up. Pat clarified that FFS is changing with the advent of MACRA/MIPS – providers will either end up in FFS with MIPS or join an alternative payment model. Dale asked whether FFS rates will become more expensive if providers are assessed penalties. Lawrence replied that within their Medicare base (where MIPS/MACRA applies), Medicare has a rate they are going to pay – those rates are set by Medicare. Individual practices are unlikely to be able to negotiate better rates with commercial payers to make up for this, and instead would have to work more hours/see more patients or improve quality. Dr. Batra noted that providers could choose not to participate in Medicare or to stay with current FFS rates with no inflation, which means rates will decrease compared to inflation over time. • Susan asked about the implications of declining Medicare ACOs performance compared to previous years. She suggested that research on whether ACOs work is mixed. Older ACOs might perform better	

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	over time; Susan indicated that she thinks Vermont's ACOs are mature and not necessarily getting better. Pat replied that this is still a relatively recent initiative; today's presentation is based on 2014 and 2015 performance years, when ACOs and SSPs were just starting up. Some results seem potentially promising: The reduced PMPM for CHAC in Medicaid SSP and the flat PMPM for OneCare in Commercial SSP, and ACO PMPM movement towards the Commercial SSP target. Quality scores seem to be improving to some degree. It's early to draw conclusions about overall results and their implications. o Lawrence commented that complacency is not an option – the All-Payer Model will take a great deal of work to move forward, but the framework agreement is the start of the work. Susan replied that the data from the SSPs give her concerns. Lawrence replied that the evolution of contract arrangements is very important. Lack of two-sided risk might have limited change, and if we didn't have partners who were ready to move to two-sided risk he would not be confident. Significant areas we need to work on include mental health and substance abuse treatment; this agreement gives us some resources to support work in those areas. The model is intended to bring resources into behavioral health and other sectors. o Steven noted that he has been critical of the SSPs in the past, but the quality measure results are impressive and that is a critical piece. o Dale agreed with Steven regarding quality results – this is a priority. He asked whether the 3.5% cap on spending growth can fluctuate, whether this is a true cap on all health care spending, and how this will impact the Legislature's ability to make new investments in some sectors where additional funding is needed. Lawrence noted that not everything is included in the cap – only Medicare Part A and B-like services. This excludes behavioral health to allow for needed growth in that sector. Measurement of the model is based on compound annual growth rate over the demonstration period, rather than year to year. This is based on per-member per-month spend, adjusted for age and acuity on the Medicare side, and doesn't include benefit limits if we "run out of budget" in the agreement – Medicare and other payers are required to provide benefits, based on their reserves if necessary. If we fail to meet the targets, the agreement ends – Vermont doesn't write a check to CMS. DVHA increased primary care rates as of October 1. The Administration has been lobbying for rate increases for behavioral health and other sectors to support baseline increases in funding. This model will support better alignment across the system, but we do need additional support for underfunded sectors – this is why they're excluded from the model. Steven noted that results will be further discussed on a webinar from 12-1pm on 10/28.	
4. Population Health Plan	Tracy Dolan presented the draft Population Health Plan, noting that the draft Plan (summarized in Attachment 4; full draft plan available here: Population Health Plan) is a draft; we hope and expect to have comments and feedback from a broad stakeholder group.	

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	• This is the culmination of two years of work from the Population Health Work Group. • Most attendees have seen the Plan presented previously. She gave a very high-level overview of the plan to allow additional time for discussion. • Tracy recommended reviewing the Plan draft itself for more detail. • Karen Hein suggested three ideas to keep in mind: This plan looks longer (over time), earlier (in lifespan), and wider (in terms of determinants and populations). The group discussed the following: • J Batra agreed with the tenets of the plan. He asked how he would know that a concrete idea fit within this framework (or not). He suggested getting more specific about actions. Tracy commented that this plan is meant to be a broader framework, and suggested we could be more specific about how we utilize policy levers called out in the plan. J provided an example based on mental illness prevention, which mostly relies on supporting better child development. That aligns philosophically, but how would we move forward? Cathy Fulton asked how new stakeholders could arrive at a governance table, for example, or does a stakeholder group have the power to look at data and based on this, bring new topics to the conversation and make plans based on that. Karen Hein provided an analogy based on the All-Payer Model – both are high-level guideposts or frameworks, but regional/local/individual decisions driven by this. Over time, population health representation at the local and regional levels will start to unfold. Tracy added that this is feedback we've heard elsewhere, and suggested we could find a way to represent these concerns in the plan. This plan points us to decision-points where population health can be included so that we don't need to decide these things topic-by-topic or issue-by-issue or population-by-population. J replied that layering illness prevention and health promotion that have previously ignored primary and secondary prevention, it can be challenging to keep it at the forefront. He suggested we also need outside structures to ensure primary prevention continues to be represented. Tracy noted that this has been an ongoing discussion in this field – to integrate with health care (where money is) or to remain apart? J suggested both are necessary. • Dale Hackett commented that culture has a profound impact on substance abuse rates, for example. Karen commented that this plan has an emphasis on systems – sometimes the most effective intervention is not individual counseling, for example, but making the healthy choice the easy choice. A system-wide intervention may need to emphasis and support. Dale added that it's not just the choice, but what leads individuals to make a choice. He commented that population health activities need to be responsive to local culture as well as the cultures of subpopulations within local areas or regions. Karen agreed and responded that we want to create a culture of health. • Cathy Fulton provided a patient example related to hunger and social determinants. She commented that it is the work of this group to ensure that patients' basic needs are met, including social needs/upstream needs. Tracy agreed and noted that the work of this group might be to set up systems	

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	for this, so connections don't need to be made anew each time. Mike Hall commented that the AAAs, HHAs, ACOs, and other partners have been discussing how to integrate social services, health coaching, and mental health more securely into health care. Tracy agreed and suggested we want every new system to have this integrated fully. She also suggested that financing and reinvestment of savings may be key to making this work in the long-term. Mike commented that Act 113 includes language on parameters for how APM and ACO models should be built out to include these. Sarah Kinsler added that this plan seeks to identify those linkages as well as how we can ensure community-wide population health and primary prevention activities are integrated. • Dale Hackett provided another example of a town where officials have set up regular open discussions with community members over coffee, and suggested this was a positive model. Tracy commented that regional models where many groups are invited and represented that haven't previously participated in conversations about health has created some new discussions. The plan seeks to broaden the lens of what impacts health and broaden the group of stakeholders included in these conversations. Please feel free to send additional comments to Sarah Kinsler, Heidi Klein, or Georgia Maheras.	
5. Public Comment, Next Steps, Wrap Up and Future Meeting Schedule	There was no additional public comment. **Next Meeting:** Wednesday, November 30, 2016, 1:00pm-3:00, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.	

VHCIP Steering Committee Member List

Member		Member Alternate		Minutes	Wednesday, October 26, 2016
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff				AHS - DAIL
Rick	Barnett				Vermont Psychological Association
Bob	Bick				DA - HowardCenter for Mental Health
Beverly	Boget				VNAs of Vermont
Steven	Costantino				AHS - DVHA, Commissioner
Elizabeth	Cote				Area Health Education Centers Program
Tracy	Dolan	Heidi	Klein		AHS - VDH
David	Martini				DFR
John	Evans	Kristina	Choquette		Vermont Information Technology Leaders
Kim	Fitzgerald				Cathedral Square and SASH Program
Catherine	Fulton				Vermont Program for Quality in Health Care
Kate	Simmons				Bi-State Primary Care/CHAC
Al	Gobeille	Kate	O'Neill		GMCB
Lynn	Guillett				Dartmouth Hitchcock
Dale	Hackett				Consumer Representative
Mike	Hall				Champlain Valley Area Agency on Aging / COVE
Paul	Harrington				Vermont Medical Society

Selina	Hickman	Shawn	Skafelstad		AHS - DVHA
Debbie	Ingram				Vermont Interfaith Action
~~Craig~~	~~Jones~~ ✓	Beth	Tanzman		AHS - DVHA - Blueprint
Julia	Shaw	(Interim)			VLA/Health Care Advocate Project
Deborah	Lisi-Baker				SOV - Consultant
(vacant)					VLA/LTC Ombudsman Project
Todd	Moore	Vicki	Loner		OneCare Vermont
Jeffrey	Tieman				Vermont Association of Hospital and Health Systems
Mary Val	Palumbo				University of Vermont
Ed	Paquin				Disability Rights Vermont
Judy	Peterson				Visiting Nurse Association of Chittenden and Grand Isle Counties
Allan	Ramsay				GMCB
Frank	Reed	Jaskanwar	Batra ✓		AHS - DMH
Paul	Reiss				HealthFirst/Accountable Care Coalition of the Green Mountains
Simone	Rueschemeyer ✓				Vermont Care Network
Howard	Schapiro				University of Vermont Medical Group Practice
Julie	Tessler	Marlys	Waller		Vermont Council of Developmental and Mental Health Services
Sharon	Winn				Bi-State Primary Care
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14 No Quorum

	Meeting Name:	VHCIP Steering Committee Meeting	
	Date of Meeting:	October 26, 2016	
	First Name	Last Name	
1	Susan	Aranoff	here
2	Ena	Backus	
3	Melissa	Bailey	
4	Heidi	Banks	
5	Rick	Barnett	
6	Susan	Barrett	
7	Jaskanwar	Batra	here
8	Bob	Bick	
9	Martha	Buck	
10	Kristina	Choquette	
11	Sarah	Clark	
12	Lori	Collins	
13	Amy	Coonradt	here
14	Alicia	Cooper	here
15	Steven	Costantino	here
16	Elizabeth	Cote	
17	Diane	Cummings	
18	Mike	DelTrecco	
19	Tracy	Dolan	here
20	Richard	Donahey	
21	John	Evans	Phone
22	Jamie	Fisher	
23	Kim	Fitzgerald	here
24	Katie	Fitzpatrick	

25	Erin	Flynn	here
26	Aaron	French	
27	Catherine	Fulton	here
28	Lucie	Garand	
29	Christine	Geiler	
30	Al	Gobeille	
31	Lynn	Guillett	
32	Dale	Hackett	here
33	Mike	Hall	here
34	Paul	Harrington	here
35	Carrie	Hathaway	
36	Karen	Hein	here
37	Selina	Hickman	
38	Debbie	Ingram	
39	Craig	Jones	
40	Kate	Jones	
41	Pat	Jones	here
42	Joelle	Judge	here
43	Sarah	Kinsler	here
44	Heidi	Klein	
45	~~Leah~~	~~Korce~~	
46	Andrew	Laing	
47	Deborah	Lisi-Baker	
48	Sam	Liss	
49	Vicki	Loner	
50	Robin	Lunge	
51	Carole	Magoffin	

52	Georgia	Maheras	
53	David	Martini	here.
54	Todd	Moore	
55	Kate	O'Neill	here.
56	Brian	Otley	
57	Dawn	O'Toole	
58	Mary Val	Palumbo	
59	Ed	Paquin	
60	Judy	Peterson	
61	Anne	Petrow	
62	Luann	Poirer	
63	Allan	Ramsay	
64	Frank	Reed	
65	Paul	Reiss	
66	Simone	Rueschemeyer	phone
67	Jenney	Samuelson	
68	Larry	Sandage	
69	Suzanne	Santarcangelo	
70	Howard	Schapiro	
71	Julia	Shaw	phone
72	Shawn	Skafelstad	
73	Holly	Stone	
74	Beth	Tanzman	
75	Julie	Tessler	
76	Beth	Waldman	
77	Marlys	Waller	
78	Julie	Wasserman	here.

79	Kendall	West	
80	James	Westrich	
81	Sharon	Winn	
82	David	Yacovone	

Karen Snior - DVHA - phone
Lawrence Miller - AOA - here