Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, October 6, 2016, 10:00am-12:30pm, Elm Conference Room, Waterbury State Office Complex.

Agenda Item	Discussion	Next Steps
1. Welcome	Deborah Lisi-Baker called the meeting to order at 10:05am. A roll call attendance was taken and a quorum was present. Susan Aranoff moved to approve the October 2016 meeting minutes by exception. Sam Liss seconded. The minutes were approved with 2 abstentions (Alicia Cooper, Joy Chilton).	
2. Home and Community-Based Rules/ Independent Options Counseling	Megan Tierney-Ward and Roy Gerstenberger from DAIL presented on Home- and Community-Based Services (HCBS) rules and Independent Options Counseling. Deborah Lisi-Baker reminded the group that this is a brief overview; the State may convene a longer discussion at a later date. • Federal rules governing HCBS Medicaid funds were recently revisited. New rules address three areas: settings, person-centered planning, and conflict-free case management. Vermont's HCBS program sits within the Global Commitment for Health waiver. • Megan described the process to assess alignment within Choices for Care (CFC). In CFC alignment report, describes how State is structured and why this is through the comprehensive quality strategy, and how it relates to Vermont. Megan walked through various federal requirements and provided examples (e.g., "home-like" setting). DAIL assesses how each provision of the rule applies to three settings (Adult Family Care, Adult Day, and Home-Based Case Management). Person-Centered Planning Requirements: Describes process for person-centered care plan development. Still awaiting federal guidance on "conflict-free" provisions. DAIL will look at other programs once assessment of CFC is done – CFC is the first step in the process. This rule applies now and will apply into the future, so will continue to guide DAIL and providers. o Barb Prine asked how DAIL will solve the conflict-free case management issue. Megan replied that the State is working to get clarification from the federal government on various provisions of the rule. Vermont is a small state without many providers that emphasizes provider choice for beneficiaries.	

Agenda Item	Discussion	Next Steps
	• Roy briefly discussed the process for aligning developmental disabilities services with the new HCBS rules. DAIL is also responding to Act 140, which required some rule changes. A transition advisory committee engages individuals who receive services, advocates, and providers, to discuss how to take action. Working to be sensitive to provider needs and burden. Additionally, Vermont has long been a leader in providing HCBS and avoiding institutional settings for people with developmental disabilities. Some settings receive heightened scrutiny (farmsteads – only one in Vermont). This group is ahead of the process. o Barb Prine requested a public forum as DAIL comes to decisions, especially conflict-free case management, to ensure public input. Megan agreed and noted that DAIL knows this is a critical issue that must be addressed in partnership with stakeholders.	
3. DLTSS Sub-Analysis of ACO Performance Measures	Alicia Cooper presented a DLTSS sub-analysis of ACO performance measures in Year 1 of Vermont's Medicaid Shared Savings Programs (MSSP). Sub-analysis was a request from this group at the start of the MSSP. • Bard Hill noted that 97% of Choices for Care participants are dually eligible for Medicare and Medicaid and are attributed to Medicare ACOs rather than through Medicaid, so this sub-analysis does not include many CFC recipients. • Bard clarified that Assistive Community Care services fall under Vermont's Medicaid State Plan, not Choices for Care (slide 5). • The designation of "eligible but unattributed" are individuals who were eligible for ACO attribution but did not meet utilization-based attribution criteria (control population for this analysis). • Individuals in the DLTSS sub-population are also included in total calculations (Attachment 3a, slide 8). Attachment 3b includes data from which charts in slide deck were developed. • Julie Wasserman highlighted data from Attachment 3b showing that for 2 important avoidable hospitalization measures (COPD & Asthma, and Ambulatory Care Sensitive Conditions), DLTSS individuals in an ACO had a much higher likelihood of being unnecessarily hospitalized than people who were not affiliated with an ACO. In other words, DLTSS individuals in an ACO had worse outcomes on these measures than DLTSS individuals not associated with an ACO. Julie recommended we work with the ACOs to help them reduce "avoidable" hospitalizations for their DLTSS population. • Data from future performance years will allow the State to start assessing trends over time. • Alicia concluded by noting that for many measures, sub-population quality measures were similar to or better than full ACO population. Alicia also noted that individuals in the ACO DLTSS sub-population experienced proportionally more hospital admissions than the full ACO populations; and that individuals in the ACO DLTSS sub-population experienced more (avoidable) hospital admissions than DLTSS individuals not attributed to an ACO. Kirsten Murphy suggested a recent white paper by Green Mountain Self Advocates includes information on how attitudes might impact care received by this sub-population in Vermont.	
4. Medicaid Pathway Updates	*Mental Health, Substance Abuse, and Developmental Services:* Selina Hickman and Melissa Miles were unavailable today. Roy Gerstenberger provided an update on the Developmental Services piece of this initiative, noting that services paid for by the Department of Mental Health have been an initial focus of this effort; DS will be included later.	

Agenda Item	Discussion	Next Steps
	• A sub-group has been working to identify appropriate measures of success. Outcome measures for DLTSS sub-populations and people with developmental disabilities are somewhat different. • DS system has unique readiness for integrated approach. Funding has been bundled from the State, with individualized budgets based on individual needs. • No history of national or standardized system of measures for DS. Questions are standard, but information collection is not standardized. • Inclusion of people with disabilities living in the community is a key principle. Measuring this is a challenge. Bard Hill added that socioeconomic factors are also a driver of health status and health utilization, and measures are starting to develop in this area. There is also momentum now about person-centered outcomes and results around issues like social isolation, housing, and employment. • Dale Hackett suggested we need measures that help us assess both outcomes and current performance of programs like Medicaid Pathway. Bard described some measures that are used to assess person-centered outcomes. *Long-Term Services and Supports/Choices for Care*: Bard provided an update on the CFC leg of the Medicaid Pathway effort, including key goals and opportunities identified through a group process. • Barb Prine noted that CFC payment rates are low, and that she sees this as the biggest problem in the system. She asked why this isn't a goal. Bard replied that he can't solve that problem on the current program budget, and noted that this is a problem across programs and settings. He added that this is both a wage problem and a workforce problem, and that this is true across programs as well. CFC and related programs include over 10,000 workers – this is a system-wide problem. CFC is trying to give people more flexibility in how to use their money so that individual needs can be met and good outcomes achieved. Suzanne Santarcangelo commented that more information about staffing is included in detailed notes. Bard added that many CFC enrollees pay for services from friends or family members, who are not otherwise part of the health care workforce.	
4. All-Payer Model	Robin Lunge provided an update on the All-Payer Model. • All-Payer Model: A draft agreement with the federal government was released last week. This is currently under legal review at both state and federal levels. Documents and information on how to provide comments are available at: http://gmcboard.vermont.gov/payment-reform/APM. • Global Commitment 1115 Medicaid Waiver: The State filed a waiver renewal earlier this year following a public process last winter; a verbal agreement has been reached and legal review is underway. CMS does not allow the State to release draft terms before they are approved. • Susan Aranoff asked how comments and questions about the All Payer Model are being gathered and responded to. Information on forums and GMCB meetings are on the GMCB website. Individuals are asking questions verbally and receiving verbal responses at forums; GMCB written comment period is open. Each AHS Commissioner has a process for internal staff to provide feedback through Commissioners and the AHS Secretary. State employees can speak as private citizens at public events outside of work time.	

<table>
<tr><th>Agenda Item</th><th>Discussion</th><th>Next Steps</th></tr>
<tr><td></td><td>

Deadline for initial comments is 10/13 at noon; GMCB meets on 10/13.
The State received a great deal of comments on the APM Term Sheet in January, which includes most of the terms of the agreement; there were some changes in response to that feedback. Major changes since January: Floor on financial model, quality measures. These would be the best areas to focus comments.

Slide 8 describes the roles of the APM agreement and Global Commitment 1115 Waiver renewal, which are aligned but serve different purposes.
APM includes a financial target roughly equivalent to Medicare A&B services – equals approximately 35% of total Medicaid spending. Spending on services outside this are not included in the overall financial goal. This limits growth in hospital and medical services but allows for growth in other service sectors.
Sam Liss asked where pharmacy services fit in. Robin noted that these are excluded for the moment due to data system issues at Medicare, as well as challenges for controlling pharmacy spending.
Financial targets compare sending on total cost of care (Medicare A&B-like services) attributed to an ACO in years 1-2 to 3.5%. In Year 3 there is an analysis of scale, which determines whether total cost of care across Medicare, Medicaid and commercial will be compared to 3.5%. There is also a Medicare-specific growth target compared to national trend (calculations defined in waiver terms). Medicare savings target is a very modest savings goal of .1-.2% depending on national Medicare trend (this is different from Medicare SSP/Next Generation ACO minimum savings requirements for ACOs).
There are three levels of measures in the model: population health measures assessed statewide, ACO measures by which ACOs are assessed, and process measures assessed at the ACO level. These are defined in an agreement appendix in great detail, and summarized in GMCB slides at the website linked above.
Population health goals: Improve access to primary care; reduce deaths due to suicide and drug overdose; and reduce prevalence and morbidity of chronic disease. Other measure levels build up to these goals.
Dale Hackett commented that these measures are significantly impacted by long-term factors and life experiences of individuals. Robin agreed and suggested that aligned measures at all three levels will help the system as a whole work toward these goals over the long-term.
The APM agreement does not include any Medicare waivers at this time, but does include Medicare beneficiary protections like choice of provider, accessing out-of-state providers, maintaining the same cost sharing, and more. The areas that CMMI are allowed to waive under federal law are related to not paying fee-for-service, and can include benefit enhancements.
Barb Prine asked how this relates to low Medicare rates that discourage some providers from participating. How will APM solve that problem? Robin explained that fee-for-service Medicare will stay the same, and the State will not be involved in Medicare FFS rate setting now or in the future unless the agreement is amended. In the Vermont Medicare ACO program (NextGen), GMCB can set a Vermont-specific payment trend/benchmark for Medicare NextGen ACO program. They also have the ability to set Vermont-specific quality measures for that program. This is a narrow State authority that

</td><td></td></tr>
</table>

Agenda Item	Discussion	Next Steps
	allows us to customize the NextGen ACO program for Vermont. This could help address that challenge if the ACO could find a way to add value to those services (e.g., if DME expenditures would reduce the overall health care costs for an ACO, the ACO could be incentivized to invest in DMEs). • New federal law passed in 2015 (MACRA) imposes quality targets and potentially FFS rate reductions for providers that stay in FFS Medicare (Merit-Based Incentive Payment System, or MIPS). Providers can also pursue Medicare payment reforms or join an Advanced Alternative Payment Model (AAMP) to avoid these penalties (APM would qualify under this provision). An important point for providers – the current status quo is changing no matter what. • Susan Aranoff commented that she understood that CHAC and OneCare did not perform well under the Medicare SSP this year. What are the implications of low ACO performance? Robin replied that NextGen (which moves toward capitation with robust quality measurement and risk adjustment) are different programs – shared savings is training wheels to help providers get started on changing care but doesn't include strong enough financial incentives for robust change. Both ACOs will continue to participate in the Medicare Shared Savings Program for 2017. The Vermont Care Organization (VCO) would enter NextGen in 2018. In the APM, Vermont has negotiated a 2017 baseline for the ACO program (instead of the currently offered 2014). This ensures a more realistic base. • Dale Hackett asked about workforce changes required to participate in AAMPs. Robin replied is that MIPS is designed to be budget neutral for Medicare and to push providers into value-based programs, which will redistribute some payments but it's hard to predict how it will shape out.	
5. Population Health Plan and Accountable Communities for Health	Heidi Klein (VDH, staff of Population Health Work Group) presented the draft Population Health Plan and provided an update on the Accountable Communities for Health work stream. • This is a draft plan; we hope to receive substantive feedback from every work group. The report not only represents the work done in the Population Health Work Group, but the collective work done on recommendations to ensure that population health is adequately addressed moving forward. The final report will be submitted to CMMI and will be used in the State. • Vermont's State Health Improvement Plan (SHIP – a requirement for every state with an accredited Public Health Department) addresses specific health improvement goals for the State (e.g., addressing tobacco use or heart disease). The Population Health Plan (PHP – a requirement of the SIM grant) takes a systems approach and identifies structural opportunities within health system reform to integrate prevention, public health and community-wide strategies. • Key Principles: Developed by Population Health Work Group to guide efforts. (Slide 8) • Policy Levers: Builds on a framework from the Center for Health Care Strategies (CHCS). Four levers to identify opportunities to move toward improved population health. The PHP makes recommendations for each of these levers at the State and regional levels. Heidi walked through examples of recommendations. Discussion:	

Agenda Item	Discussion	Next Steps
	• Sam Liss asked how capitation serves as a limiting parameter for improving population health and individual health in that it eventually might limit services across the board. Bard Hill responded with the idea of a balanced portfolio: money is limited and we will have to make choices about that investment portfolio because there are so many competing interests; he sees a value in investing in prevention. Heidi encouraged people to look at Elizabeth Bradley's research on why we spend so much money in health care services but with such poor results, compared with other countries. The conversation on spending more on social services has started robustly in Vermont. • Barb Prine asked where would elimination of poverty fit in the principles. Heidi responded that it would be in principle number 3 ("Address the multiple contributors to health outcomes"). Barb noted that poverty should be front and center, as per her own experience with clients. Heidi mentioned that many of the groups in the ACH Peer Learning Lab have identified that and discussed how it will be addressed. It's part of the conversation but not yet fully developed. Email comments on the Population Health Plan draft to Heidi Klein (Heidi.klein@vermont.gov), Sarah Kinsler (Sarah.kinsler@vermont.gov), or Georgia Maheras (Georgia.maheras@vermont.gov). Comments are due by October 31, 2016.	
6. Public Comment/Next Steps	**Next Meeting:** Tuesday, November 1, 2016, 10:00am-12:30pm, Ash Conference Room, Waterbury State Office Complex	

VHCIP DLTSS Work Group Member List

Sue 1°
Sam 2°
- Motion Carried
- 2 abstentions

Member		Member Alternate		July Minutes	6-Oct-16
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff ✓				AHS - DAIL
Molly	Dugan ✓				Cathedral Square and SASH Program
Mary	Fredette				The Gathering Place
Kate	Simmons	Kendall	West		Bi-State Primary Care
Martita	Giard	Susan	Shane ✓		OneCare Vermont
Joy	Chilton ✓			X	Home Health and Hospice
Dale	Hackett ✓				Consumer Representative
Mike	Hall				Champlain Valley Area Agency on Aging
Jeanne	Hutchins				UVM Center on Aging
Pat	Jones ✓				GMCB
Dion	LaShay ✓				Consumer Representative
Deborah	Lisi-Baker ✓				SOV - Consultant
Sam	Liss ✓				Statewide Independent Living Council
Barbara	Prine ✓				VLA/Disability Law Project
Jessa	Barnard				Vermont Medical Society
Kirsten	Murphy ✓				Developmental Disabilities Council
Nick	Nichols				AHS - DMH

Ed	Paquin				Disability Rights Vermont
Eileen	Peltier				Central Vermont Community Land Trust
Paul	Reiss	Amy	Cooper		Accountable Care Coalition of the Green Mountains
Jenney	Samuelson	Craig	Jones		AHS - DVHA
Rachel	Seelig				VLA/Senior Citizens Law Project
Julie	Tessler	Marlys	Waller		DA - Vermont Care Partners
Julie	Wasserman				AHS - Central Office
Jason	Williams				UVM Medical Center
	25		5		

	Meeting Name:	VHCIP DLTSS Work Group Meeting	
	Date of Meeting:	October 6, 2016	
	First Name	**Last Name**	
1	Susan	Aranoff	here
2	Debbie	Austin	
3	Ena	Backus	
4	Jessa	Barnard	
5	Susan	Barrett	
6	Bob	Bick	
7	Denise	Carpenter	
8	Alysia	Chapman	
9	Joy	Chilton	Phone
10	Amy	Coonradt	here
11	Amy	Cooper	~~[illegible]~~
12	Alicia	Cooper	here
13	Julie	Corwin	
14	Michael	Costa	
15	Molly	Dugan	phone
16	Erin	Flynn	
17	Mary	Fredette	
18	Lucie	Garand	
19	Christine	Geiler	
20	Martita	Giard	
21	Dale	Hackett	here
22	Mike	Hall	
23	Selina	Hickman	
24	Bard	Hill	here

25	Jeanne	Hutchins	
26	Craig	Jones	~~Phone~~
27	Pat	Jones	Phone
28	Margaret	Joyal	
29	Joelle	Judge	here
30	Sarah	Kinsler	here
31	Tony	Kramer	
32	Andrew	Laing	
33	Dion	LaShay	Phone
34	Deborah	Lisi-Baker	here
35	Sam	Liss	here
36	Carole	Magoffin	here
37	Georgia	Maheras	here
38	Lisa	Maynes	
39	Mary	Moulton	
40	Kirsten	Murphy	here
41	Nick	Nichols	
42	Miki	Olszewski	
43	Kate	O'Neill	here
44	Ed	Paquin	
45	Eileen	Peltier	
46	John	Pierce	
47	Luann	Poirer	
48	Barbara	Prine	here
49	Paul	Reiss	
50	Virginia	Renfrew	
51	Jenney	Samuelson	

52	Suzanne	Santarcangelo	here
53	Rachel	Seelig	
54	Susan	Shane	phone
55	Julia	Shaw	
56	Angela	Smith-Dieng	
57	Beth	Tanzman	
58	Julie	Tessler	
59	Bob	Thorn	
60	Beth	Waldman	
61	Marlys	Waller	
62	Julie	Wasserman	here
63	Kendall	West	
64	James	Westrich	
65	Jason	Williams	
66	Scott	Whittman	
67	David	Yacovone	
68	Marie	Zura	

Sarah Freeman - RTI (federal evaluation team)
Megan Tierney-Ward - DAIL
Roy Gerstenberger - DAIL
Heidi Klein - VDH
Robin Lunge - HCR