Attachment 1a - DLTSS Meeting Agenda 11-21-14

VT Health Care Innovation Project
"Disability and Long Term Services and Supports" Work Group Meeting Agenda
Friday, November 21, 2014; 1:00 PM to 3:00 PM
DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT
Call-In Number: 1-877-273-4202; Passcode 8155970

Item	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	1:00 – 1:10	**Welcome; Introductions; Approval of Minutes** Deborah Lisi-Baker and Judy Peterson	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from July 24, 2014 • Attachment 1c: Minutes from September 11, 2014 • Attachment 1d: Minutes from October 9, 2014	 Yes Yes Yes
2	1:10 - 1:25	**SIM Payment Models Work Group Update** Kara Suter		
3	1:25 – 1:35	**VHCIP Year 2 Operational Plan** Georgia Maheras	• Link to: VHCIP Year 2 Operational Plan - November 2014	
4	1:35 - 2:50	**ACOs and the DLTSS System** Deborah Lisi-Baker and Judy Peterson	• Attachment 4a: ACOs and the DLTSS System - Questions Posed by VT Legal Aid and VCDMHS • Attachment 4b: VT SSP ACO Table Updated 11-12-14	
5	2:50 – 3:00	**Public Comment/Next Steps** Deborah Lisi-Baker and Judy Peterson	• Next Meeting: Thursday, December 4th 10:00 am - 12:30 pm Williston	

Attachment 1b - DLTSS Meeting Minutes 7-24-14

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Date of meeting: Thursday July 24th, 2014, 10am – 12:30 pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

Agenda Item	Discussion	Next Steps
1 Welcome; Introductions; Approval of Minutes	Judy Peterson kicked of the meeting at 10:05, welcomed the work group and moved to approval of the June meeting minutes. Kristen Murphy made a motion for approval and Jeanne Hutchins seconded. Nelson LaMothe collected a vote via roll call. The June meeting minutes were approved unanimously.	
2 DLTSS Quality and Performance Measures	Deborah Lisi-Baker began discussion of this agenda item and welcomed Catherine Fulton and Alicia Cooper from the Quality and Performance Measures (QPM) Work Group. Catherine Fulton indicated that the QPM work group plans to make decisions on the year 2 Medicaid and Commercial ACO SSP measures at their in person meeting on July 29th, and are accepting written comment on the proposals up until Monday July 28th. Catherine requested that comments from DLTSS work group members be submitted in writing. Catherine then reviewed all relevant attachments 2a, 2b, 2c and 2d. She discussed the work group's process for making recommendations and noted that the work group used agreed-upon criteria to score all of the proposed measures. In addition to scoring the measures against criteria, the process for approval of these recommendations will include review of written stakeholder comments and work group discussion. The QPM work group plans to finalize recommendations by September 30th and issue new measure specifications by	

Agenda Item	Discussion	Next Steps
	October 31st. Right now they are on track to meet these deadlines. They have not discussed targets and benchmarks, but this work will begin at an upcoming QPM work group meeting. Discussion ensued and the following comments were made: • Barbara Prine asked for clarification as to why the QPM work group did not accept all of the DLTSS recommendations. Catherine replied that the criteria and work group discussion was used to score each recommendation, and those that did not make it through likely did not have high enough scores. • Kirsten Murphy asked for clarification about developmental screening in the first three years of life, CDC guidance says that it should include counseling. Is this included in this measure? Alicia Cooper replied that the specifications are specific to the screening process and don't include a component of follow-up. This is an NQF-endorsed measure and is also used by CHIPRA. The work group did not review a measure that includes the screening component. • Barbara Prine asked for further clarification of the scoring methodology, and why some recommendations with low scores were still recommended. Catherine replied that the scoring process included a possible 16 points across all of the criteria. Regarding the recommendations, SBIRT is being recommended for monitoring and evaluation and is already being collected in the State. The second recommendation with a low score is for the DLTSS custom survey questions, which would be easier to incorporate than some of the other measures. Regarding those measures that were not recommended for status change, the QPM work group hopes that the work of VITL and other work groups will hopefully make collection more feasible in the near future. • Julie Tessler asked if there is another substance abuse measure that could be incorporated into the program other than SBIRT. Alicia responded that there wasn't an immediately available measure that was nationally recognized and approved that they were aware of, but that this could be possible in the future. • Barbara Prine commented that it is discouraging to say that since it hasn't been done, we can't do it, even though we recognize that it needs to be done and is important. • Madeleine Mongan asked for clarification on how the QPM work group is looking to incorporate the changes to MSSP measures. Catherine replied that they are looking	

Agenda Item	Discussion	Next Steps
	into it. Madeleine also commented that we need to recognize that at the current point in time, reporting can be burdensome. Hopefully EHR and HIE efforts will lighten this load. Furthermore, we have to have a threshold of data that is high quality and actionable. Catherine followed up by saying that this work is building a solid foundation upon which we can expand measurement efforts. • Vicki Loner commented that measures reporting can be extremely burdensome and recalled that some of the practices in OCV's network had to close for a day to do records extraction during the MSSP measure reporting process. • Jackie Majoris asked for clarification on how pending measures are considered by the groups working on HIT/HIE development. Alicia responded that VITL will be invited to QPM to give an update on their efforts to build the systems that will make collection of the ACO measures more feasible. The results of the gap analysis work that VITL is doing will be available soon and will help determine next steps. • Brendan Hogan commented that additional gap analyses will be funded through the ACTT proposal in nursing homes, designated agencies, and home health agencies. Another component of ACTT is to look at DLTSS measures and get a better sense of how the IT challenges to collecting data for DLTSS measures can be improved. • Rachel Seelig asked for clarification on how unknown information about "Opportunity for Improvement" factored in to measure scoring using the criteria. Alicia responded that scoring was based on State data for recent years. Rachel asked if there was a process to do a percentage scoring so a measure wouldn't be negatively impacted for not having past information. She also asked for clarification as to why blood pressure measures were not included. Cathy and Alicia responded that neither blood pressure measure was considered a priority candidate at this time, but that they welcomed written comment on any specific measures to be considered at the upcoming QPM meeting. • Joy commented that is important to consider administrative burden. Although we want to collect and measure as much as we can, there is a cost associated with all of this work. We have to find a balance between spending funds on data collection and spending funds on providing services. Deborah agreed and said that is why the work of creating electronically reported data is so important. • Judy Peterson asked if the group had considered any measures around Adverse Child Experience (ACEs). Catherine commented that the population health work group also	

Agenda Item	Discussion	Next Steps
	brought this consideration forward. Catherine said that right now it is so new that it is difficult to report, but that it is on the work group's radar and will continue to be considered. Deborah asked if DLTSS work group members chose to submit formal recommendation to the QPM work group, that they cc Erin and Julie so we can keep the co-chairs informed.	
3 AHS Survey Results	Deborah began reviewing this agenda item by drawing the work group's attention to attachment 3, AHS survey presentations – common format. Susan Besio reviewed the history behind this template and indicated that the work group had previously discussed the desire to learn more about AHS surveys and how they might inform the work group's goals. This is a proposed format that will ensure consistency amongst presenters. Discussion ensued and the following comments were made: • John Barbour commented that from an AAA perspective, only about 1/3 of the CFC population completes these surveys. It would be helpful to continue to expand the populations represented in these surveys. Deborah commented that this is exactly the type of recommendation she would hope would come out of this work. • Julie Tessler also supported this comment and said that the results may be skewed due to missing populations (such as the uninsured). • Brendan Hogan added that the state plan on aging includes the goals of AAA's and how they performed against these goals. This could be a good source of information. • Madeleine Mongan asked if VDH surveys were included. Susan responded that not at this point as they are more population based, and this group chose to focus on DLTSS based, but that they could be included if the work group chooses. • Jackie Majoris commented that in many cases it is not the (for example) nursing home resident who is completing the survey. It may be interesting to find a way to get a sense of who is actually completing the survey. • Judy Peterson asked if there is a way to judge the validity of all of the survey tools. Susan suggested adding a point about survey validity on the template. • Barbara Prine noted that after we have had a few presentations, we might have a better sense of how we could change the template to better collect the information. • Jackie Majoris suggested that we may want to judge the applicability of the surveys to	

Agenda Item	Discussion	Next Steps
	the general population as so many of them are service specific. Susan reminded the group that this framework is for the presenters to use. • Marie Zura commented that a 5 month time frame may be too stretched out to effectively retain information and make analysis and maybe the presentations could be shortened. Susan responded that it seems that the work group may want to have discussion regarding the findings and applicability of the surveys, and that we want to be sure we allow the necessary time for those conversations. • Madeleine Mongan recommended that in order to facilitate ease of discussion, numbers 1 and 2 could be received before the meeting and that a separate document tracking common elements from each presentation could be developed in order to track the discussion over time. • Barbara Prine asked for clarification on what the group may or may not do based on the results of this work. Deborah responded that there is information out there that may or may not be used, and once we see what it is we will have a better sense of what to do with it. • Joy commented that this exercise would provide information on the efficacy of long term services and supports, and if this group is going to make recommendations on how those services are delivered, this information would be helpful. Joy echoed that she would like to look at the tools side by side to compare and contrast.	
4 DLTSS Recommendation for Criteria for Second Round of Provider Grant Program	Georgia began review of this agenda item by summarizing the activity of the last core team meeting and indicated that the second round provider grant RFP will go out today and that decisions will be made by September 4th. As described in attachment 4, based on work group feedback to the Core Team, the provider grant application was edited to include four additional points. Furthermore, the additional recommendations will be included in the core teams scoring sheets. Georgia clarified that the reason this distinction was made is because the core team wanted to keep the application broad enough that they could receive proposals from many domains. Discussion ensued and the following comments were made: • Kirsten Murphy commented that she is concerned about how smaller organizations may be able to stay competitive against larger organizations in the provider grant program. Georgia commented that awards were given to small organizations in the	

Agenda Item	Discussion	Next Steps
	first round, and the core team is mostly interested in the quality of the organizations idea, and whether or not they will be able to implement the proposal. • Judy Peterson asked for clarification as to whether the applicants would be aware that the core team is considering work groups recommendations when completing their scoring sheets. Georgia indicated that this will be included in the FAQ.	
5 **Provider Training Discussion**	Deborah Lisi-Baker began conversation around this agenda item, summarizing that provider capacity and ability to effectively work with the DLTSS population is an important goal of this work group. She then began to review attachment 5 and asked for work group members to draw on their personal and professional experiences in order to provide feedback to the group about how to proceed with meeting this goal. Discussion ensued and the following comments were made: • Joy commented that awareness of the importance of effectively populating EHRs and other electronic information sources is important. • Kirsten Murphy suggested that this document focuses on the what, not the why. Some conversation about models and theory of disability might be helpful to start with. People with disabilities and clinicians may have different cultural views on this. • Julie Tessler suggested including case studies to help illustrate this topic. • Jackie Majoris suggested that we have to further define what it means to be person directed and person centered, more information needs to be presented on these concepts. • Dion LaShay commented that best practices in information sharing across providers should be incorporated. • Barbara Prine suggested that we consider mental disability, communication ability, and technological adeptness of the population. Not everyone communicates in the same way. • Kirsten suggested a focus on people who use augmentative and alternative forms of communication be included. • Judy Peterson suggested that language be included about seeing the person as an individual not as a disability. • Deborah summarized Ed Paquin and Sam Liss's comments (sent to Deborah before	

Agenda Item	Discussion	Next Steps
	the meeting) that you must look at the whole person and not let the disability dictate how the person is served. • Marie Zura commented that people with developmental disabilities and mental health issues are often judged on their disability rather than their legitimate health concern. Furthermore, protocols and admission procedures for people with disabilities need to be considered. • Marie Zura commented that including an advocate or other types of informal and formal support for navigating care is important for the DLTSS population. Furthermore, training on how to incorporate the broader DLTSS support team is important. • Jason Williams noted that he has been involved in conversations about how to educate and reeducate providers in other settings. He indicated that he supports this opportunity, but that it may be best to align with existing efforts in order to avoid duplication. Furthermore, he suggested that it is important to understand that this is fundamentally about culture change, and we have to be reasonable in the pace of progress that we expect to see (don't try for too much or you might end up with nothing). He then offered suggestions for tools to aid in this work including grand rounds, champions (nurses, doctors and other care providers), staff meeting presentations, etc. It is important to reach not only clinical staff but also support staff. Where possible we should leverage existing efforts, for example, possibly train community health teams which clinicians already support and rely on for a team based approach. OCVT has a regional clinical advisory board, we could bring concepts like this to them. Furthermore, offering continuing medical education credits would be helpful. FAHC/UVM has a clinical simulation lab could be a possible forum for this type of work. Jason offered to put the group in touch with any FAHC/UVM contacts to assist in these efforts. Finally conferences such as the UVM Jeffords Institute for Quality or the annual VAHHS conference could be utilized as forums for this conversation. • Jackie Majoris asked for clarification about grand rounds. Jason clarified that there are different approaches depending on specialty, but generally speaking at FAHC there are presentations on tools and resources and how these tools can be utilized. Georgia commented that this tool is very hands on and focuses on practical use of process improvement tools.	

Agenda Item	Discussion	Next Steps
	• John Barbour commented that we need to try to create a no wrong door approach. Dion LaShay commented that eligibility criteria for services can create a wrong door. • Barbara Prine commented that when technology is used, people have to understand how to use it. • Madeleine asked if there are models or examples of training that we could learn from to further reach our goals. • Kirsten Murphy commented that the transition from pediatric primary care to adult primary care is important. She further commented that training even in settings such as MRI is important so that technicians understand how to interact with certain disabilities and needs.	
6 DLTSS Consultant Support Contract – RFP Process	Georgia reviewed this agenda item and indicated that the AOA has required that existing contracts supporting this work group go out to bid. This will be a simple bid, which means it is a slightly shorter process, and that less information will be required from applicants allowing a decision to be made sooner. There is currently an RFP out for these services, and applications are expected in the first or second week of August. More information will be given to the work group at its next meeting.	
7 Public Comment/Updates/Next Steps	Deborah Lisi-Baker invited comment from the public, and hearing none thanked the group for participation and called the meeting adjourned.	

VHCIP DLTSS Work Group Attendence Sheet 7-24-14

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff
X	Interested Party

	First Name	Last Name		Title	Organization	DLTSS
1	April	Allen		Director of Policy and Planning	AHS - DCF	X
2	Debbie	Austin			AHS - DVHA	M
3	Ena	Backus			GMCB	X
4	John	Barbour		Executive Director	Champlain Valley Area Agency on Aging	M
5	Susan	Barrett		Executive Director	GMCB	X
6	Susan	Besio	Susan W Besio	Senior Associate	Pacific Health Policy Group	X
7	Bob	Bick		Director of Mental Health and Subs	HowardCenter for Mental Health	X
8	Denise	Carpenter		Business Manager	Specialized Community Care	X
9	Alysia	Chapman		Developmental Services	HowardCenter for Mental Health	X
10	Joy	Chilton	X (Phone)	Compliance Officer	Central Vermont Home Health and Hos	MA
11	Amanda	Ciecior		Health Policy Analyst	AHS - DVHA	S
12	Peter	Cobb		Executive Director	VNAs of Vermont	X
13	Pamela	Coleman				X
14	Amy	Coonradt	Amy Coonradt	Health Policy Analyst	AHS - DVHA	X

15	Amy	Cooper		Executive Director	Accountable Care Coalition of the Green	MA
16	Alicia	Cooper	X	Quality Oversight Analyst	AHS - DVHA	X
17	Molly	Dugan	X (phone)	SASH Program Director	Cathedral Square and SASH Program	M
18	Patrick	Flood		CEO - Northern Counties Health Car	CHAC	M
19	Erin	Flynn	Erin Flynn	Health Policy Analyst	AHS - DVHA	S
20	Mary	Fredette		Executive Director	The Gathering Place	M
21	Joyce	Gallimore		Director, Community Health Payme	Bi-State Primary Care/CHAC	M
22	Lucie	Garand		Senior Government Relations Speci	Downs Rachlin Martin PLLC	X
23	Christine	Geiler		Grant Manager & Stakeholder Coor	GMCB	S
24	Larry	Goetschius		CEO	Addison County Home Health & Hospic	M
25	Bea	Grause		President	Vermont Association of Hospital and He	X
26	Dale	Hackett		Consumer Advocate	None	M
27	Janie	Hall		Corporate Assistant	OneCare Vermont	A
28	Bryan	Hallett				X
29	Selina	Hickman		Policy Director	AHS - DVHA	X
30	Bard	Hill		Director - Policy, Planning & Data U	AHS - DAIL	X
31	Churchill	Hindes		COO	OneCare Vermont	X
32	Brendan	Hogan		Consultant	Bailit-Health Purchasing	X
33	Jeanne	Hutchins		Executive Director	UVM Center on Aging	M
34	Craig	Jones		Director	AHS - DVHA - Blueprint	MA
35	Pat	Jones			GMCB	M
36	Margaret	Joyal		Director of Adult Outpatient Service	Washington County Mental Health Serv	X

37	Trinka	Kerr		Chief Health Care Advocate	VLA/Health Care Advocate Project	MA
38	Tony	Kramer	X (phone)		AHS - DVHA	X
39	Nelson	Lamothe			UMASS	S
40	Kelly	Lange		Director of Provider Contracting	Blue Cross Blue Shield of Vermont	X
41	Dion	LaShay	X (phone)		Consumer Representative	M
42	Diane	Lewis			AOA - DFR	A
43	Deborah	Lisi-Baker		Disability Policy Expert	Unknown	C/M
44	Sam	Liss		Chairperson	Statewide Independent Living Council	M
45	Vicki	Loner	X (phone)	Director of Quality and Care Manage	OneCare Vermont	X
46	Georgia	Maheras	GM		AOA	S
47	Jackie	Majoros	JM	State Ombudsman	VLA/LTC Ombudsman Project	M
48	Carol	Maroni			Community Health Services of Lamoille	M
49	David	Martini			AOA - DFR	M
50	Lisa	Maynes		Associate Director of family Suppor	Vermont Family Network	X
51	Marybeth	McCaffrey		Principal Health Reform Administra	AHS - DAIL	M
52	Kimberly	McNeil		Payment Reform Policy Intern	AHS - DVHA	X
53	Madeleine	Mongan		Deputy Executive Vice President	Vermont Medical Society	M
54	Todd	Moore		CEO	OneCare Vermont	M
55	Mary	Moulton		CEO	Washington County Mental Health Serv	X
56	Kirsten	Murphy			AHS - Central Office - DDC	M
57	Floyd	Nease			AHS - Central Office	X
58	Nick	Nichols		Planning/Development/Policy Dire	AHS - DMH	M

59	Miki	Olszewski		Assistant Director of Blueprint for H	AHS - DVHA - Blueprint	X
60	Jessica	Oski			Sirotkin & Necrason	X
61	Ed	Paquin		Ed Paquin	Disability Rights Vermont	M
62	Annie	Paumgarten	Anne Paumgarten	Eveluation Director	GMCB	X
63	Laura	Pelosi		Executive Director	Vermont Health Care Association	M
64	Eileen	Peltier		Executive Director	Central Vermont Community Land Trus	M
65	Judy	Peterson		President and CEO	Visiting Nurse Association of Chittende	C/M
66	John	Pierce				X
67	Luann	Poirer		Administrative Services Manager I	AHS - DVHA	X
68	Barbara	Prine	Barb Prine	Attorney	VLA/Disability Law Project	MA
69	Paul	Reiss		Executive Director,	Accountable Care Coalition of the Greer	M
70	Virginia	Renfrew			Zatz & Renfrew Consulting	X
71	Rachel	Seelig	Rachel Seelig	Attorney	VLA/Senior Citizens Law Project	M
72	Julia	Shaw		Health Care Policy Analyst	VLA/Health Care Advocate Project	X
73	Richard	Slusky		Payment Reform Director	GMCB	MA
74	Kara	Suter		Reimbursement Director	AHS - DVHA	X
75	Beth	Tanzman		Assistant Director of Blueprint for H	AHS - DVHA - Blueprint	X
76	Julie	Tessler	Julie B Tessler	Executive Director	Vermont Council of Developmental and	M
77	Bob	Thorn		Executive Director	Counseling Services of Addison County	MA
78	Anya	Wallack		Chair	SIM Core Team Chair	X
79	Marlys	Waller			Vermont Council of Developmental and	MA
80	Norm	Ward		Medical Director	OneCare Vermont	X

81	Nancy	Warner		Board Member	COVE	M
82	Julie	Wasserman		VT Dual Eligible Project Director	AHS - Central Office	S/MA
83	Bradley	Wilhelm		Senior Policy Advisor	AHS - DVHA	X
84	Jason	Williams		Government Relations Strategist	Fletcher Allen Health Care	M
85	Jennifer	Woodard		Long-Term Services and Supports I	AHS - DAIL	X
86	Cecelia	Wu		Healthcare Project Director	AHS - DVHA	X
87	Dave	Yacovone		Commissioner	AHS - DCF	X
88	Marie	Zura		Director of Developmental Services	HowardCenter for Mental Health	M
						88

Attachment 1c - DLTSS Meeting Minutes 9-11-14

VT Health Care Innovation Project

DLTSS Work Group Meeting Minutes

Date of meeting: Thursday, September 11, 2014, 10am – 12:30 pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

Agenda Item	Discussion	Next Steps
1 Welcome; Introductions; Approval of Minutes	Deborah Lisi-Baker began the meeting and moved to approve the July 24th meeting minutes. Georgia Maheras said we did not have a quorum so a vote could not be taken. The group will approve the July minutes at the September meeting.	
2 Updates • **DLTSS Model of Care presentation to Care Models/Care Management Work Group**	Erin Flynn gave an overview of the DLTSS Team's presentation of the DLTSS Model of Care at the August Care Models/Care Management (CM/CM) meeting. The DLTSS Model of Care (Attachment 2a) is relevant to the CM/CM Learning Collaborative "Integrated Community Care Management", a 1-year initiative to improve integration of care management activities for at-risk people and provide learning opportunities for best practices for care management in at least 3 pilot communities. Erin gave an overview of the Learning Collaborative's potential Session Topics. Pat Jones said the RFP for the 2 Learning Collaborative Facilitators has been posted. Pat Jones discussed the care management standards for Accountable Care Organizations being developed for the Medicaid and Commercial shared savings programs. These Standards have been discussed and developed in the CM/CM Work Group and are currently under review by a small group of ACO and payer representatives. The current timeline indicates that the Standards will be discussed at the October CM/CM meeting, and that a vote will be taken in November. The CM/CM Work Group is also charged with developing a statewide Strategic Plan for care management.	

Agenda Item	Discussion	Next Steps
• **DLTSS Quality and Performance Measures** • **Provider Training: Available Resources**	Alicia Cooper presented the content and process to date for the Year 2 Medicaid and Commercial ACO Quality and Performance Measures – Attachment 2b. Alicia pointed out the summary on Slide 4 of this Attachment, with backup detail contained on the other slides. The Quality and Performance Measures (QPM) Year 2 recommendations were presented to the Steering Committee at their August meeting; this was followed by a 2-week public comment period. At the September Steering meeting, members voted to send the QPM Year 2 recommendations to the Core Team without support or opposition. The QPM presentation to the Core Team was followed by a second 2-week public comment period. It is not clear whether the Core Team will vote on the QPM Year 2 recommendations at their upcoming September 29th meeting. The QPM Year 1 data will be available in the summer of 2015 with a final report available in the Fall of 2015. Georgia Maheras presented her memo on DLTSS Provider Training – see Attachment 2c, and indicated that opportunity exists for the CM/CM and DLTSS Work Groups to collaborate on recommendations for learning collaborative funding moving forward. Deborah Lisi-Baker suggested that a meeting of the CMCM and DLTSS work groups would be helpful to gain a better understanding of opportunities for collaboration that can be brought back to the DLTSS Work Group. It was agreed that the Integrated Communities Care Management Learning Collaborative would be one vehicle to incorporate Provider Training input from the DLTSS Work Group in the short term.	
3 DAIL Long Term Care Consumer Survey: Choices for Care, Attendant Services	DLTSS participants had requested presentations on AHS Surveys to better capture quality of life and quality of care concerns that the Medicaid ACO quality and performance measures do not currently address. It was felt that this kind of information might be helpful for informing DLTSS Work Group discussions and decision-making. Bard Hill presented DAIL's Long Term Care Consumer Survey on Choices for Care (CFC) and Attendant Services – see Attachments 3a and 3b. The presentation was as follows: CFC Objectives include supporting individual choice; shifting the balance between the number and percentage of people served in nursing homes vs in home and community-based settings; and expanding the range of services options, to name a few. The survey instrument, methodology, population and sample size, evaluation, and survey results (posted online) were discussed. Bard described the key finding as "Yes, individuals' needs are being met." CFC	

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	services target needed personal care for people 18 to 100+ years old; however, there are scheduling challenges for delivering services on week nights and weekends. Survey results also show that participants have unmet transportation; hearing, dental and vision care; housing; and social needs yet those services are not included in the scope of the CFC program. More than half of the CFC participants hire their own caregivers. Barb Prine complimented DAIL on the implementation of such a successful program and asked, "Once CFC is merged into the Global Commitment Waiver, how can we operationalize the results of data related to utilization of savings?" Sam Liss asked whether DAIL has the authority and resources to improve CFC in terms of hospice care where VT ranks 49th in the nation. Bard explained that hospice care is not a CFC covered service. Work Group participants seemed interested in future Survey presentations on CRT (next meeting), Children's Mental Health, and Developmental Services.	
4 Next Steps for Updating the DLTSS Work Plan	Deborah Lisi-Baker gave an overview of the current DLTSS Work Plan and timeline– see Attachment 4. A more detailed review of the work plan is planned for the October Work Group meeting, however the work group began an initial discussion of potential adjustments and additions to the work plan for year two of the VHCIP. Georgia Maheras noted that the deadline for the submission of year two updates of the SIM Operational Plan to CMMI is November 1st, and that this process may also lead to additional updates to the work plan. Work group recommendations for adjustments to the work plan are as follows: Julie Tessler would like to hear from the Population Heath, Payment Models, and Workforce Work Groups. Payment Models is scheduled to present to the DLTSS Work Group at our November meeting. The Work Group was also interested in hearing from the HIE Work Group about the Federal rules contained in 42CFR Part 2 Confidentially Protections for people with mental health and substance abuse needs.	

Agenda Item	Discussion	Next Steps
5 Public Comment Updates/Next Steps	Barb Prine expressed concern about people who have multiple DLTSS needs but are siloed in one Waiver program. A question was posed: "How will ACOs and DApartners allocate savings?" Georgia Maheras answered, "It's spelled out in the contract between the ACO and the DAs." Another person voiced concern over how this will work for the "non-traditional" providers of care who do not have formal relationships with the ACOs but provide critical services. Next meeting will be on October 9th, 10:00 – 12:30 in the DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

VHCIP DLTSS Work Group Attendance 9-11-14

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff
X	Interested Party

First Name	Last Name		Title	Organization	DLTSS
April	Allen		Director of Policy and Planning	AHS - DCF	X
Debbie	Austin			AHS - DVHA	M
Ena	Backus			GMCB	X
Susan	Barrett		Executive Director	GMCB	X
Susan	Besio	here	Senior Associate	Pacific Health Policy Group	X
Bob	Bick		Director of Mental Health and Substa	HowardCenter for Mental Health	X
Denise	Carpenter		Business Manager	Specialized Community Care	X
Alysia	Chapman		Developmental Services	HowardCenter for Mental Health	X
Joy	Chilton		Compliance Officer	Central Vermont Home Health and Hospi	MA
Amanda	Ciecior		Health Policy Analyst	AHS - DVHA	S
Peter	Cobb		Executive Director	VNAs of Vermont	X
Amy	Coonradt		Health Policy Analyst	AHS - DVHA	X
Amy	Cooper		Executive Director	Accountable Care Coalition of the Green	MA
Alicia	Cooper	AC	Quality Oversight Analyst	AHS - DVHA	X
Molly	Dugan		SASH Program Director	Cathedral Square and SASH Program	M
Patrick	Flood		CEO - Northern Counties Health Care	CHAC	M
Erin	Flynn		Health Policy Analyst	AHS - DVHA	S
Mary	Fredette		Executive Director	The Gathering Place	M
Joyce	Gallimore		Director, Community Health Paymen	Bi-State Primary Care/CHAC	M
Lucie	Garand		Senior Government Relations Special	Downs Rachlin Martin PLLC	X
Christine	Geiler		Grant Manager & Stakeholder Coordi	GMCB	S
Larry	Goetschius		CEO	Addison County Home Health & Hospice	M
Bea	Grause		President	Vermont Association of Hospital and Hea	X
Dale	Hackett	Veh	Consumer Advocate	None	M
Mike	Hall		Executive Director	Champlain Valley Area Agency on Aging	M
Janie	Hall		Corporate Assistant	OneCare Vermont	A
Bryan	Hallett				X

Carolynn	Hatin			AHS - Central Office - iFS	X
Selina	Hickman		Policy Director	AHS - DVHA	X
Bard	Hill	here	Director - Policy, Planning & Data Un	AHS - DAIL	X
Churchill	Hindes		COO	OneCare Vermont	X
Brendan	Hogan		Consultant	Bailit-Health Purchasing	X
Jeanne	Hutchins		Executive Director	UVM Center on Aging	M
Craig	Jones		Director	AHS - DVHA - Blueprint	MA
Pat	Jones			GMCB	M
Margaret	Joyal		Director of Adult Outpatient Services	Washington County Mental Health Servic	X
Trinka	Kerr		Chief Health Care Advocate	VLA/Health Care Advocate Project	MA
Tony	Kramer			AHS - DVHA	X
Kelly	Lange		Director of Provider Contracting	Blue Cross Blue Shield of Vermont	X
Dion	LaShay	phone		Consumer Representative	M
Diane	Lewis			AOA - DFR	A
Deborah	Lisi-Baker		Disability Policy Expert	Unknown	C/M
Sam	Liss	Sam Liss	Chairperson	Statewide Independent Living Council	M
Vicki	Loner		Director of Quality and Care Manage	OneCare Vermont	X
Georgia	Maheras			AOA	S
Jackie	Majoros		State Ombudsman	VLA/LTC Ombudsman Project	M
Carol	Maroni			Community Health Services of Lamoille V	M
David	Martini			AOA - DFR	M
Mike	Maslack				X
Lisa	Maynes		Associate Director of family Support	Vermont Family Network	X
Kimberly	McNeil		Payment Reform Policy Intern	AHS - DVHA	X
Madeleine	Mongan	phone	Deputy Executive Vice President	Vermont Medical Society	M
Todd	Moore		CEO	OneCare Vermont	M
Mary	Moulton		CEO	Washington County Mental Health Servic	X
Kirsten	Murphy			AHS - Central Office - DDC	M
Floyd	Nease			AHS - Central Office	X
Nick	Nichols	NN	Planning/Development/Policy Direct	AHS - DMH	M
Miki	Olszewski		Assistant Director of Blueprint for He	AHS - DVHA - Blueprint	X
Jessica	Oski			Sirotkin & Necrason	X
Ed	Paquin	Ed Paquin	Ed Paquin	Disability Rights Vermont	M
Annie	Paumgarten		Eveluation Director	GMCB	X
Laura	Pelosi		Executive Director	Vermont Health Care Association	M
Eileen	Peltier		Executive Director	Central Vermont Community Land Trust	M

Judy	Peterson		President and CEO	Visiting Nurse Association of Chittenden	C/M
John	Pierce				X
Luann	Poirer		Administrative Services Manager I	AHS - DVHA	X
Barbara	Prine		Attorney	VLA/Disability Law Project	MA
Paul	Reiss		Executive Director,	Accountable Care Coalition of the Green	M
Virginia	Renfrew			Zatz & Renfrew Consulting	X
Rachel	Seelig		Attorney	VLA/Senior Citizens Law Project	M
Julia	Shaw		Health Care Policy Analyst	VLA/Health Care Advocate Project	X
Richard	Slusky		Payment Reform Director	GMCB	MA
Kara	Suter		Reimbursement Director	AHS - DVHA	X
Beth	Tanzman		Assistant Director of Blueprint for He	AHS - DVHA - Blueprint	X
Julie	Tessler		Executive Director	Vermont Council of Developmental and M	M
Bob	Thorn		Executive Director	Counseling Services of Addison County	MA
Anya	Wallack		Chair	SIM Core Team Chair	X
Marlys	Waller			Vermont Council of Developmental and M	MA
Norm	Ward		Medical Director	OneCare Vermont	X
Nancy	Warner		Board Member	COVE	M
Julie	Wasserman		VT Dual Eligible Project Director	AHS - Central Office	S/MA
Kendall	West				X
Bradley	Wilhelm		Senior Policy Advisor	AHS - DVHA	X
Jason	Williams		Government Relations Strategist	Fletcher Allen Health Care	M
Cecelia	Wu		Healthcare Project Director	AHS - DVHA	X
Marie	Zura		Director of Developmental Services	HowardCenter for Mental Health	M

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VHCIP DLTSS Work Group Roll Calls 9-11-14

Minutes 1°
2°

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate

minutes

First Name	Last Name						Title	Organization	DLTSS
Debbie	Austin							AHS - DVHA	M
Joy	Chilton						Compliance Officer	Central Vermont Home Health and Hospi	MA
Amy	Cooper						Executive Director	Accountable Care Coalition of the Green	MA
Molly	Dugan						SASH Program Director	Cathedral Square and SASH Program	M
Patrick	Flood						CEO - Northern Counties Health Care	CHAC	M
Mary	Fredette						Executive Director	The Gathering Place	M
Joyce	Gallimore						Director, Community Health Paymen	Bi-State Primary Care/CHAC	M
Larry	Goetschius						CEO	Addison County Home Health & Hospice	M
Dale	Hackett						Consumer Advocate	None	M
Mike	Hall						Executive Director	Champlain Valley Area Agency on Aging	M
Jeanne	Hutchins						Executive Director	UVM Center on Aging	M
Craig	Jones						Director	AHS - DVHA - Blueprint	MA
Pat	Jones							GMCB	M
~~Trinka~~	~~Kerr~~						Chief Health Care Advocate	VLA/Health Care Advocate Project	MA
Dion	LaShay							Consumer Representative	M
Deborah	Lisi-Baker						Disability Policy Expert	Unknown	C/M
Sam	Liss						Chairperson	Statewide Independent Living Council	M
~~Jackie~~	~~Majoros~~						State Ombudsman	VLA/LTC Ombudsman Project	M
Carol	Maroni							Community Health Services of Lamoille V	M
~~David~~	~~Martini~~							AOA - DFR	M
Madeleine	Mongan						Deputy Executive Vice President	Vermont Medical Society	M
Todd	Moore						CEO	OneCare Vermont	M
Kirsten	Murphy							AHS - Central Office - DDC	M
Nick	Nichols						Planning/Development/Policy Direct	AHS - DMH	M
Ed	Paquin						Ed Paquin	Disability Rights Vermont	M
~~Laura~~	~~Pelosi~~						Executive Director	Vermont Health Care Association	M
Eileen	Peltier						Executive Director	Central Vermont Community Land Trust	M
~~Judy~~	~~Peterson~~						President and CEO	Visiting Nurse Association of Chittenden	C/M
Barbara	Prine						Attorney	VLA/Disability Law Project	MA

	Paul	Reiss						Executive Director,	Accountable Care Coalition of the Green	M
✓	Rachel	Seelig						Attorney	VLA/Senior Citizens Law Project	M
	~~Richard~~	~~Slusky~~						Payment Reform Director	GMCB	MA
✓	Julie	Tessler						Executive Director	Vermont Council of Developmental and M	M
	Bob	Thorn						Executive Director	Counseling Services of Addison County	MA
✓	~~Marlys~~	~~Waller~~						member here, a	~~Vermont Council of Developmental and M~~ not needed	~~MA~~
	Nancy	Warner						Board Member	COVE	M
✓	Julie	Wasserman						VT Dual Eligible Project Director	AHS - Central Office	S/MA
	Jason	Williams						Government Relations Strategist	Fletcher Allen Health Care	M
✓	Marie	Zura						Director of Developmental Services	HowardCenter for Mental Health	M

Attachment 1d - DLTSS Meeting Minutes 10-09-14

VT Health Care Innovation Project

DLTSS Work Group Meeting Minutes

Date of meeting: Thursday, October 9, 2014, 10am – 12:30 pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

Agenda Item	Discussion	Next Steps
1 Welcome; Introductions; Approval of Minutes	Deborah Lisi-Baker began the meeting and asked to approve the July 24th and September 11th meeting minutes. Georgia Maheras determined there were an insufficient number of participants for a quorum so a vote was not taken. The group will approve the July, September and October minutes at the November meeting.	
2 DAIL - Developmental Disabilities Services: Participation in the National Core Indicators Project	June Bascom, DAIL, gave a brief overview of the DS system and a history of DS surveys. There are 10 Designated Agencies and 5 Specialized Service Agencies who are responsible for Developmental Disability Services for approximately 3,000 Vermonters. The goal of surveys is to obtain demographic data as well as collect information on consumer satisfaction. Surveys are anonymous and performed by independent contractors on a random sample of Developmental Services Waiver participants receiving home and community-based services. The National Core Indicators (Attachment 2) have recently been adopted by DAIL and are supported by the US Department of Health and Human Services Administration for Community Living (ACL). This survey measures quality of services and outcomes and can be used to inform decisions on programmatic funding. The Core Indicators address how well the public system aids adults with developmental disabilities to work, participate in their communities, have friends and sustain relationships, and exercise choice and self-determination; these indicators also measure how satisfied people are with their services and supports.	

Agenda Item	Discussion	Next Steps
3 DLTSS-Specific Core Competency Domains for Health Care Service Providers	Pat Jones gave an overview of the "Integrated Community Care Management" Learning Collaborative, a 1-year initiative to improve integration of care management activities for at-risk people and provide learning opportunities for best practices for care management in at least 3 pilot communities. Pat explained there are two tracts: one for plans of care, transitions of care and test results; and the other to provide core competency training for care managers. The DLTSS Core Competency Domains document (Attachment 3) lists a variety of domains in which disability competencies can be reflected. Pat said there was not time to train care managers in all of these domains; however, they can be built on in the future. The intent is to train care managers to integrate services across providers and disciplines. The Learning Collaborative will develop a model for best practices and utilize it for the broader provider network. The DLTSS Model of Care will be drawn upon as a resource in this effort. The group recommended the following additions to the list of ten DLTSS-Specific Core Competency Domains: • Disability Awareness Training • Understanding multiple challenges for an individual • Misdirected "kindness" ("I know what's best for you" attitude) • Attention to a person's day-to-day health needs Sam Liss pointed out the distinction between "person-centered" which can take a variety of forms and "person-driven". He felt the latter was the preferable approach. The objective of the Learning Collaborative is to broaden the network of support beyond what we think of as traditional medical services. Sam stated that the GMCB has agreed to hear a presentation on the social determinants of health (employment, education, and housing). Dale Hackett wondered if a social poverty index would be helpful. Others mentioned the need for a commitment to have team members working across settings in an integrated care coordination team-based approach.	

Agenda Item	Discussion	Next Steps
4 ACTT Project Update	Brendan Hogan gave an update on the ACTT Partnership's three projects: 1) DA/SSA Data Quality and Repository: Work with VITL to enable ARIS to procure a unified electronic health record for five Specialized Service Agencies. Improve the quality of data going into the existing systems and standardize it. Design and build a data repository to enable system-wide efficiencies, quality improvement, data analysis and connectivity to the VHIE. Work on an effort to share information for enhanced care coordination purposes while honoring the federal requirement under 42 CFR Part 2 which limits sharing of information pertaining to mental health and substance abuse services. 2) DLTSS Data Planning Project: Part 1 of project 2 - Review a short list of DLTSS measures that may require sharing of information electronically to determine the feasibility of sharing this information with Medicaid ACOs in the future. Part 2 of project 2 Follow up on technology assessments that had previously been conducted for Home Health Agencies, Nursing Homes and Designated agencies. The technology assessments will inform the state of current IT systems used by other DLTSS provider groups including; Area Agencies on Aging, Adult Day Centers, Vermont Center for Independent Living and Residential Care Homes. The purpose of the review is to get a baseline of information that can help inform the feasibility of and potential future funding needed for connecting data between DLTSS systems with medical providers through systems managed by Vermont Information Technology Leaders, VITL. 3) Universal Transfer Protocol Process: The objective of the UTP project is to enable the exchange of essential information between long-term support service (LTSS) providers, patients and their immediate caregiver, and other health care service providers. This project will develop an initial set of standardized data elements for exchange between providers and receivers of services as well as a method for continuously refining and enlarging that data set. The contractor will conduct a series of focused interviews starting with the Aging and Disabilities Resource Connections ADRC transitions of care pilot in Bennington. The contractor will take the information learned from the ADRC pilot and conduct additional focused interviews in another region of the state. The contractor will conclude the work with a comprehensive report which will include the results of the qualitative review process and information from best practices from other states.	

Agenda Item	Discussion	Next Steps
5 Update on SIM Operations Plan as it relates to the DLTSS Work Plan	Updates on the SIM Operational Plan for Year 2 as they relate to the DLTSS Work Plan will be forthcoming once the Operational Plan has been finalized and submitted to CMMI. The DLTSS Co-Chairs would like to hear from Work Group participants on any new Work Plan initiatives for next year.	
6 Public Comment Updates/Next Steps	The next meeting was to be held on November 6th but has been moved to Friday November 21st 1:00 – 3:00 pm in the DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

VHCIP DLTSS Work Group Attendance List 10-09-14

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff/Consultant
X	Interested Party

First Name	Last Name		Title	Organization	DLTSS
April	Allen		Director of Policy and Planning	AHS - DCF	X
Debbie	Austin			AHS - DVHA	M
Ena	Backus			GMCB	X
Susan	Barrett		Executive Director	GMCB	X
Susan	Besio	Susan W Besio	Senior Associate	Pacific Health Policy Group	X
Bob	Bick		Director of Mental Health and Subst	HowardCenter for Mental Health	X
Denise	Carpenter		Business Manager	Specialized Community Care	X
Alysia	Chapman		Developmental Services	HowardCenter for Mental Health	X
Joy	Chilton	phone	Compliance Officer	Central Vermont Home Health and Hosp	MA
Amanda	Ciecior		Health Policy Analyst	AHS - DVHA	S
Peter	Cobb		Executive Director	VNAs of Vermont	X
Amy	Coonradt	Amy Coonradt	Health Policy Analyst	AHS - DVHA	X
Amy	Cooper		Executive Director	Accountable Care Coalition of the Green	MA
Alicia	Cooper		Quality Oversight Analyst	AHS - DVHA	X
Molly	Dugan	Molly Dugan	SASH Program Director	Cathedral Square and SASH Program	M
Patrick	Flood		CEO - Northern Counties Health Care	CHAC	M
Erin	Flynn	Erin Flynn	Health Policy Analyst	AHS - DVHA	S
Mary	Fredette		Executive Director	The Gathering Place	M
Joyce	Gallimore		Director, Community Health Paymen	Bi-State Primary Care/CHAC	M
Lucie	Garand		Senior Government Relations Specia	Downs Rachlin Martin PLLC	X
Christine	Geiler		Grant Manager & Stakeholder Coord	GMCB	S
Larry	Goetschius		CEO	Addison County Home Health & Hospice	M
Bea	Grause		President	Vermont Association of Hospital and Hea	X
Dale	Hackett		Consumer Advocate	None	M
Mike	Hall		Executive Director	Champlain Valley Area Agency on Aging	M
Janie	Hall		Corporate Assistant	OneCare Vermont	A
Bryan	Hallett				X
Carolynn	Hatin			AHS - Central Office - IFS	X

Selina	Hickman		Policy Director	AHS - DVHA	X
Bard	Hill		Director - Policy, Planning & Data Un	AHS - DAIL	X
Churchill	Hindes		COO	OneCare Vermont	X
Brendan	Hogan		Consultant	Bailit-Health Purchasing	X
Jeanne	Hutchins		Executive Director	UVM Center on Aging	M
Craig	Jones		Director	AHS - DVHA - Blueprint	MA
Pat	Jones	phone		GMCB	M
Margaret	Joyal		Director of Adult Outpatient Services	Washington County Mental Health Servic	X
Trinka	Kerr		Chief Health Care Advocate	VLA/Health Care Advocate Project	MA
Tony	Kramer			AHS - DVHA	X
Kelly	Lange		Director of Provider Contracting	Blue Cross Blue Shield of Vermont	X
Dion	LaShay	phone		Consumer Representative	M
Deborah	Lisi-Baker		Disability Policy Expert	Unknown	C/M
Sam	Liss	Sam Liss	Chairperson	Statewide Independent Living Council	M
Vicki	Loner		Director of Quality and Care Manage	OneCare Vermont	X
Georgia	Maheras			AOA	S
Jackie	Majoros		State Ombudsman	VLA/LTC Ombudsman Project	M
Carol	Maroni			Community Health Services of Lamoille V	M
David	Martini			AOA - DFR	M
Mike	Maslack				X
Lisa	Maynes	LisaMaynes	Associate Director of family Support	Vermont Family Network	X
Kimberly	McNeil		Payment Reform Policy Intern	AHS - DVHA	X
Madeleine	Mongan	phone	Deputy Executive Vice President	Vermont Medical Society	M
Todd	Moore		CEO	OneCare Vermont	M
Mary	Moulton		CEO	Washington County Mental Health Servic	X
Kirsten	Murphy			AHS - Central Office - DDC	M
Floyd	Nease			AHS - Central Office	X
Nick	Nichols		Planning/Development/Policy Direct	AHS - DMH	M
Miki	Olszewski		Assistant Director of Blueprint for He	AHS - DVHA - Blueprint	X
Jessica	Oski			Vermont Chiropractic Association	X
Ed	Paquin		Ed Paquin	Disability Rights Vermont	M
Annie	Paumgarten		Eveluation Director	GMCB	X
Laura	Pelosi		Executive Director	Vermont Health Care Association	M
Eileen	Peltier		Executive Director	Central Vermont Community Land Trust	M
Judy	Peterson		President and CEO	Visiting Nurse Association of Chittenden	C/M
John	Pierce				X

Luann	Poirer		Administrative Services Manager I	AHS - DVHA	X
Barbara	Prine		Attorney	VLA/Disability Law Project	MA
Paul	Reiss		Executive Director,	Accountable Care Coalition of the Green	M
Virginia	Renfrew			Zatz & Renfrew Consulting	X
Ken	Schatz			AHS - DCF	X
Rachel	Seelig		Attorney	VLA/Senior Citizens Law Project	M
Julia	Shaw		Health Care Policy Analyst	VLA/Health Care Advocate Project	X
Richard	Slusky		Payment Reform Director	GMCB	MA
Kara	Suter		Reimbursement Director	AHS - DVHA	X
Beth	Tanzman		Assistant Director of Blueprint for He	AHS - DVHA - Blueprint	X
Julie	Tessler		Executive Director	Vermont Council of Developmental and I	M
Bob	Thorn		Executive Director	Counseling Services of Addison County	MA
Anya	Wallack		Chair	SIM Core Team Chair	X
Marlys	Waller			Vermont Council of Developmental and I	MA
Norm	Ward		Medical Director	OneCare Vermont	X
Nancy	Warner		Board Member	COVE	M
Julie	Wasserman		VT Dual Eligible Project Director	AHS - Central Office	S/MA
Kendall	West				X
Bradley	Wilhelm		Senior Policy Advisor	AHS - DVHA	X
Jason	Williams		Government Relations Strategist	Fletcher Allen Health Care	M
Cecelia	Wu		Healthcare Project Director	AHS - DVHA	X
Marie	Zura		Director of Developmental Services	HowardCenter for Mental Health	M

Attachment 4a - ACOs and the DLTSS System -Questions Posed by VT Legal Aid and VCDMHS

ACOs and the DLTSS System
Questions Posed by VT Legal Aid and VT Council of Developmental and Mental Health Services

DLTSS Work Group Discussion
November 21, 2014

1. How will any savings generated be shared with the Home Health Agencies (HHAs), Area Agencies on Aging (AAAs), Designated Agencies (DAs), and Skilled Nursing Facilities (SNFs) that are part of each Accountable Care Organization's (ACO) "network"?
    a) Are these entities expected to generate savings in any of the demonstration years in order to receive part of any savings achieved by the ACO?
    b) Is there a specific formula to determine how much of the savings these affiliated organizations receive? Does that formula vary by ACO or by organization type, and if so, how?

2. What are the contractual requirements between the ACOs and the affiliated providers (DA, AAA, HH, and SNF)? Specifically, what do the providers have to do (whether related, for example to quality performance, financial performance, etc.) to get the shared savings?
    a) Do the ACOs have the same contractual relationship with each type of affiliated provider (DA, SSA, AAA, HHA, SNF)?
    b) If not, is this because the ACOs have different contracts (so that the contractual relationships are the same within each ACO, but not across ACOs), or within an ACO do different providers (e.g. multiple HHAs) have different contracts?

3. How do ACO/affiliated provider agreements affect DAIL's role with respect to services funded through DAIL? What is DAIL's relationship to the ACO, which does not directly provide these services, but does so through its provider network? The same questions apply to DMH.

4. Do the current case managers in the DAs, AAAs, HHAs, and SNFs have the resources and capacity (including both time to provide services and training) to provide the medical/health home services in circumstances where the "health home" is not the Primary Care Practice? Will the ACOs provide support to these organizations to provide these services? Will extra funding be available to these organizations to provide these services?

5. Have any of the ACOs adopted new care management protocols or standards internally (while waiting on the Care Models/Care Management workgroup) that establish different expectations of DLTSS case managers than those in their existing roles?
    a) Are the draft CMCM standards going to have different expectations of the case managers at the affiliated agencies because of their contracts with the ACOs?
    b) What is the system by which the DAs, HHAs and AAAs will deliver the case management services? Will any changes be made only through the scope of work for existing case managers, or will there be additional specialized ACO case managers (housed either with the ACOs or with the affiliated providers)?

6. How will DLTSS providers manage to meet operational, financial and quality expectations of multiple ACOs and at the same time meet these expectations for individuals who are not covered by the ACOs (because they do not see an affiliated primary care physician) whose funding continues to come through AHS and its Departments? Will the ACOs provide support to the DLTSS providers to meet the ACO expectations? Are the ACOs providing support to other types of providers in their network (e.g., PCPs, specialty practices)?

7. Will disability and long term services and supports (DLTSS) providers have sufficient voice in the governance and operation of ACOs? How will this voice be operationalized?

Attachment 4b -
VT SSP ACO Table Updated 11-12-14

Vermont Shared Savings Program ACO Table - Updated 11-12-14

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

ACO Name	Start Date in Program	Geographic Area	ACO Network Participants[i, ii] (Providers with attributed lives)	ACO Network Affiliates[1] (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network[iii]	Estimated Medicare Attributed Lives		
						# and % of Total VT Medicare Enrollees (Total N=126,081)[iv]	# and % of VT MSSP Eligible Enrollees (Total N=117,015)[v]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Health*first* - Accountable Care Coalition of the Green Mountains (ACCGM)	Jan 1, 2013	Approved Statewide; current network available in Greater Burlington and North Central Vermont	• 30 Physicians - 10 Primary Care Practices	Committee working on Collaborative Care Agreements (CCAs) with practitioners, including: • Specialists • Other specific entities (e.g., Visiting Nurses Association)	• 50% of shared saving distributed to Healthfirst Network Participants and CCA Practitioners o Collaborative Care Agreements (CCAs) will specify responsibilities of CCA Practitioners in order to share in these savings, including patient and network engagement • 50% of shared savings to Collaborative Health Systems[vi]	7,509 6%	7,509 6%	583 3%
OneCare Vermont (OCV)	Jan 1, 2013	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All other VT hospitals • Brattleboro Retreat • 4 Federally Qualified Health Centers (FQHCs) • 4 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 28 of 40 Skilled Nursing Facilities • All but one Home Health and Hospice Agency • All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, no DS-only DA, no Children's MH Specialized Service Agency (SSA), and no DS SSAs	• 90% of shared savings distributed to OCV Network Participants; 10% retained by OCV • Separate Incentive Plan Provision for OCV Network Affiliates • Both depend on reporting and performance metrics	54,736[vii] 43%	54,736[7] 47%	13,066[viii] 60%
Community Health Accountable Care (CHAC)	Jan 1, 2014	8 of 14 Counties (Chittenden, Grand Isle, Franklin, Orleans, Caledonia, Essex, Orange, Washington)	• 5 FQHCs and Bi-State Primary Care Association - 24 FQHC practice sites (includes dental and school based sites) - 97 Primary Care Providers	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 8 of 9 Comprehensive MH/DS DAs, the 1 MH-only DA, no DS-only DA, the 1 Children's MH SSA, and 1 of 4 DS SSAs • 4 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	5,980 5%	5,980 5%	unknown
TOTALS			~427 Primary Care Providers ~ 67% of 634 Primary Care Providers statewide[ix]			68,225 54% of all VT Medicare enrollees	68,225 58% of all VT MSSP Eligible enrollees	At least 13,649 At least 63% of all VT Duals

Vermont Shared Savings Program ACO Table - Updated 11-12-14

VERMONT MEDICAID SHARED SAVINGS PROGRAM (VMSSP)								
ACO Name	Start Date in Program	Geographic Area	ACO Network Participants[x, xi] (Providers with attributed lives)	ACO Network Affiliates[9] (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network[xii]	Estimated Medicaid Attributed Lives		
						# and % of Total VT Medicaid Enrollees (Total N= 153,315)[xiii]	# and % of VT VMSSP Eligible Enrollees (Total N=95,000)[xiv]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
ACCGM/VCP	NA	NA	NA	NA	NA	NA	NA	NA
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All but 2 other VT hospitals • Brattleboro Retreat • 0 Federally Qualified Health Centers (FQHCs) • 3 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 22 of 40 Skilled Nursing Facilities • All but one Home Health and Hospice Agency • All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, the 1 DS-only DA, the 1 Children's MH Specialized Service Agency (SSA), and all 4 DS SSAs	• 90% of shared savings distributed to OCV Network Participants and Affiliates; 10% retained by OCV • Provider amount depends on reporting and performance metrics	27,400 18%	27,400 29%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	13 of 14 Counties (with sites in or significant service to all counties except Bennington)	• 9 FQHCs and Bi-State Primary Care Association - 49 FQHC practice sites - 233 Primary Care Providers	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 8 of 9 Comprehensive MH/DS DAs, the 1 MH-only DA, the 1 DS-only DA, the 1 Children's MH SSA, and all 4 DS SSAs • 5 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	20,068 13%	20,068 21%	0
TOTALS			~533Primary Care Providers **~84% of 634 Primary Care Providers statewide[xv]**			47,468 31% of all current VT Medicaid enrollees	47,468 50% of all VMSSP Eligible enrollees	0 **0% of all VT Dual Eligibles**

Vermont Shared Savings Program ACO Table - Updated 11-12-14

COMMERCIAL SHARED SAVINGS PROGRAM (XSSP) – Blue Cross Blue Shield of Vermont (BCBS-VT)								
						Estimated Commercial Plan Attributed Lives		
ACO Name	Start Date in Program	Geographic Area	ACO Network Participants[xvi] (Providers with attributed lives)	ACO Network Affiliates[15] (Providers without attributed lives)	ACO Shared Savings Distribution with Provider Network[xvii]	# and % of Total VT Commercial Plan Enrollees (Total N=155,479)[xviii]	# and % of VT XSSP Eligible Enrollees (Total N=70,000)[xix]	# and % of Dual Eligibles within Attributed Lives (Total N=21,670)
Health*first* - - Vermont Collaborative Physicians (VCP)	Jan 1, 2014	Statewide	• 69 Physicians - 24 Primary Care Practices	Committee working on Collaborative Care Agreements (CCAs) with practitioners, including: • Specialists • Other specific entities (e.g., Visiting Nurses Association)	• PCP's to retain the majority of shared savings • VCP to retain a portion for administration and reserves • Collaborative Care Agreements (CCAs) will specify responsibilities of CCA Practitioners in order to share in these savings, including patient and network engagement	7,830 (BCBS only) 5%	7,830 (BCBS only) 11%	0
OneCare Vermont (OCV)	Jan 1, 2014	Statewide	• 2 Academic Medical Centers (FAHC and DHMC) • All but 3 other VT hospitals • Brattleboro Retreat • 1 FQHC • 2 Rural Health Centers • 300+ Primary Care Physician FTEs • Most of VT Specialty Care Physicians	• 23 of 40 Skilled Nursing Facilities • All but two Home Health and Hospice Agencies • All 9 Comprehensive Mental Health (MH)/Developmental Service (DS) Designated Agencies (DA), the 1 MH-only DA, no DS-only DA, the 1 Children's MH Specialized Service Agency (SSA), and 1 of 4 DS SSAs	• 90% of shared savings distributed to OCV Network Participants; 10% retained by OCV • Separate Incentive Plan Provision for OCV Network Affiliates • Both depend on reporting and performance metrics	20,449 (BCBS Only) 13%	20,449 (BCBS Only) 29%	0
Community Health Accountable Care (CHAC)	Jan 1, 2014	12 of 14 Counties (with sites in or significant service to all counties except Bennington and Lamoille)	• 8 Federally Qualified Health Centers (FQHCs) and Bi-State Primary Care Association - 45 FQHC practice sites - 218 Primary Care Providers	• 9 VNA / Home Health and Hospice Agencies (1 is under umbrella of FQHC) • 8 of 9 Comprehensive MH/DS DAs, the 1 MH-only DA, no DS-only DA, the 1 Children's MH SSA, and no DS SSAs • 5 hospitals (2 of these are under umbrella of FQHC)	Distribution methodology to be determined.	9,906 (BCBS Only) 6%	9,906 (BCBS Only) 14%	0
TOTALS			~587 Primary Care Providers ~ 93% of 634 Primary care Providers statewide[xx]			38,185 25% of all VT Commercial Plan enrollees	38,185 55%of all VT XSSP Eligible enrollees	0 0% of all VT Dual Eligibles

Vermont Shared Savings Program ACO Table - Updated 11-12-14

[i] Current Network Participants and Network Affiliates as of April, 2014; may change over time
[ii] ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicare performance and savings; Outcomes for each "life" can only relate to a single ACO.
[iii] Under the Medicare SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicare savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics
[iv] Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Downloads/2014/Mar/State-County-Penetration-MA-2014-03.zip
[v] MSSP does not include Medicare enrollees in Medicare Advantage Plans. In March 2014, 9,036 Vermonters were enrolled in these Plans. Source: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Downloads/2014/Mar/State-County-Penetration-MA-2014-03.zip
[vi] Healthfirst partnered with Collaborative Health Systems (CHS), a subsidiary of Universal American Corp., to form ACCGM for the Medicare SSP. CHS has partnered with 34 Independent Practice Associations across the country to form Medicare SSP ACOs and provides care coordination, analytics and reporting, technology and other administrative services for the ACOs.
[vii] Number of attributed lives is an estimate.
[viii] Based on estimated attribution numbers as of June 30, 3014.
[ix] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013
[x] Current Network Participants and Network Affiliates as of April, 2014; may change over time
[xi] ACO Participants can only be in the network of one ACO because they could have lives attributed to them to calculate Medicaid performance and savings; outcomes for each "life" can only relate to a single ACO.
[xii] Under the Medicaid SSP, ACOs must meet a minimum savings rate (MSR) to qualify for savings (which is calculated based on # of attributed lives in the ACO); once this MSR is met, ACOs are eligible to receive up to 50% of the Medicaid savings; Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics
[xiii] Based on DVHA SFY'15 Budget Document Insert 2, using SFY '14 BAA enrollment figures; excludes Pharmacy Only Programs and VHAP ESI, Catamount, ESIA, Premium Assistance For Exchange Enrollees < 300%, and Cost Sharing For Exchange Enrollees < 350% (i.e., all programs that financially assist individuals to enroll in commercial products)
[xiv] Number provided in DVHA's VMSSP RFP; the following populations are excluded from being considered as attributed lives: Individuals who are dually eligible for Medicare and Medicaid; Individuals who have third party liability coverage; Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers; and Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.
[xv] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013
[xvi] Current Network Participants and Network Affiliates as of April, 2014; may change over time
[xvii] Under the Commercial SSP, ACOs can receive up to 25% of savings achieved between the expected amount and the minimum savings rate (MSR) (which is calculated based on # of attributed lives in the ACO), and up to 60% of their savings if they exceed the MSR, with a maximum savings of 10% of their expected expenditures. Actual amount of savings an ACO can receive is determined by ACOs performance regarding reporting on and meeting quality metrics
[xviii] Vermont residents covered in Private Insurance Market, 2012; Source: 2011 Vermont Health Care Expenditure Analysis, Green Mountain Care Board, page 14. Only includes individuals who have a Commercial plan as their primary insurance.
[xix] The XSSP eligible population for attribution to an ACO includes individuals who have obtained their commercial insurance coverage through products available on the VT Health Connect Exchange (obtained through the exchange website or directly from the insurer).
[xx] PCP Statewide total from Paul Harrington, Vermont Health Care Reform Update, Health*first* Annual Meeting, November 2, 2013