Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, November 1, 2016, 10:00am-12:30pm, Ash Conference Room, Waterbury State Office Complex.

Agenda Item	Discussion	Next Steps
1. Welcome	Deborah Lisi-Baker called the meeting to order at 10:02am. 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. Sarah Kinsler requested an update to the October 6 minutes: the motion to approve the previous meeting's minutes was to approve the July minutes, not the October minutes. The October minutes were approved with 4 abstentions (Patty Launer Nancy Breiden, Julie Tessler, Jason Williams).	
2. DLTSS Data Gap Remediation Project	Larry Sandage provided an update. • This project is in collaboration with VITL and the Home Health Agencies (HHAs). This group previously received an update in July. • The project is intended to provide HHAs with connectivity to the Vermont Health Information Exchange (VHIE), allowing HHAs to a) submit data to the VHIE via EMR interfaces, and b) view patient records within the VHIE (with appropriate consents and permissions) at the point of care through the VITLAccess provider portal. • Four agencies currently have access to VITLAccess, the provider portal tool that allows providers to view patient records within the VHIE; seven more will be connected before the end of the year. • VHIE interfaces have moved more slowly due to required negotiations with EMR vendors. One interface is completed, five are scheduled for implementation prior to March 31, 2017, and five more are pending but expected to be completed by June 30, 2017. The group discussed the following: • Ed Paquin asked a question about provider workflow and consent. Larry clarified that if providers have consent to view a patient record, they can view all records for a patient in the VHIE – this is how the current consent policy is structured. Georgia Maheras added that we hoping to rewrite our consent policy, but are awaiting a	

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	final rule from the Substance Abuse and Mental Health Services Administration (SAMHSA). Ed suggested that this is not a specific enough consent policy. Georgia noted that technologies continue to advance, and that if there is a business case, technology can be developed to meet that case; we may explore changing our current technology to meet this need in the future. Julie Wasserman added that this is a critical issue, and if patients knew that VHIE consent meant providers could view all of their information, they might not consent to share their information. Georgia noted that the current policy was approved by the Green Mountain Care Board in a public meeting, but we can expect to revisit this topic in the future. Ed suggested that a key principle could be that individuals own their medical records, rather than providers owning the record. Susan Aranoff commented that the consent architecture development process will be critical, and noted that a sub-group of the HDI work group will be meeting about this. • Sam Liss asked about the difference between VITLAccess and an interface? VITLAccess is a provider portal to view information; the interface sends information from an EHR vendor to the VHIE. • Dale Hackett asked about our consent policy. Larry replied that there are two types of consent: consent to transfer information, and consent to view. To view information, providers must attest that only information that can be legally shared is transmitted. Information could be filtered at the source system, in transit, or once it is in the VHIE.	
3. All-Payer Model	Michael Costa provided an update. • Three agreements: o The All-Payer Model agreement was signed by CMS, the Green Mountain Care Board, and the Administration last week. This is a framework for ACO-based health care reform going forward. Final agreement: available here. o The State also finalized a renewal of the Global Commitment 1115 waiver last week. o DVHA is currently negotiating a contract for a NextGen-style ACO program to start 1/1/17. • Next steps: Stand up infrastructure, move ACOs from Shared Savings Program to NextGen-style program with all-inclusive population-based payment. ACOs must convince a critical mass of providers to participate. • Three goals: Improve health of Vermonters, hold to a sustainable cost trend, and test a statewide model. In addition, the APM is one of the first times Medicare and Medicaid will be truly aligned. • The APM is not the only payment and delivery system initiative underway in Vermont. • 2017: DVHA is not planning to offer a Medicaid SSP but instead will pursue a Medicaid Next Gen-style ACO program; providers will need to decide how (and whether) they will transition to a risk-based model. Transition will be a significant challenge and will require significant planning and reporting (quality and financial). GMCB will need to work collaboratively to plan for continued alignment and to bring additional services into the model (either through clinical integration or within financial caps). • The 1115 Global Commitment waiver provides capacity for financial investments: Continued Medicare participation in Blueprint and SASH (otherwise set to end 12/31/16), and up to $209 million in capacity for delivery system reform investments. AHS guidance on how these funds will be used and an application process to access them are to come in the next few weeks. These funds require State match, mostly at the standard	

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	Medicaid match rate (some HIT investments at an enhanced 90/10 match rate, initial rough estimate is ~64 federal/36 State match given mix of activities). CMS is making a strong case to reduce some types of MCO investments going forward for services that are not allowable elsewhere in the country; the next Administration will need to decide how to pay for some of these services as they phase down over time. • Dale Hackett commented that State investments are essential to ensuring success of the Medicaid Pathway. Michael noted that the ability to draw down federal match to support the Medicaid Pathway is embedded within the new waiver. Michael agreed that State investments will be necessary to support success of delivery system reforms, and noted that the Shumlin Administration has requested revenue increases to support efforts like these over the past few years without success. • What is a critical mass of providers? Vermont made three promises to CMS: Improve the health of Vermonters, hold costs to a sustainable trend, and ensure sufficient scale – at least 70% of Vermonters attributed by 2022. One of the reasons Medicare is making this investment is to see what happens with a statewide model, which is easier in Vermont than California. One of the ACO's jobs is to make this model compelling enough to encourage participation. • The $209 million in capacity is Medicaid-only. An additional $51 million is Medicare only (approximately equal to Medicare participation in Blueprint and SASH). Also a $2 million Medicare investment in ACOs in 2017. Michael deferred to Hal and Selina on the $209 million investment. There are broad investment categories within the agreement, but Vermont is not tied to those allocations. The Federal government has to approve uses of funds, and the State will need to have room in the budget for matching funds. • The DLTSS Work Group has long emphasized the importance of patient-centered and -directed model – how does the APM's "provider-led" model incorporate input from advocates and patients/clients? Act 113 requires ACOs to have a governance structure that is responsive to community concerns. For ACOs to make this model attractive, it will have to be collaborative. ACOs with more than 10,000 lives in 2018 will need to come before GMCB in a public meeting in 2017 to be approved, which is a key opportunity to provide input. The DVHA ACO contract is also an opportunity. • Where are the mechanisms for transparency and accountability in the Vermont Care Organization (VCO)? Michael clarified that the APM is not predicated on a single statewide ACO, though the DVHA contract will be with one ACO. GMCB will be reviewing ACO budgets and contracts through a robust regulatory process. In addition, the APM and DVHA NextGen contract will contain provisions to ensure that ACOs are not unjustly enriched. There will be significant added scrutiny on DVHA by the GMCB as well; DVHA payments to ACOs will be reviewed as part of ACO budgets, including a review of payer differential in rates. (Note that GMCB will not regulate DVHA.) There are also provisions of Act 113 that require open meetings and public participation and lays out requirements for ACO governing bodies (which currently include consumers and providers). • Susan Aranoff commented on the stakeholder process and suggested that the process has eroded trust. Michael commented that transparency and collaboration between DVHA and GMCB will be a critical factor for success. GMCB's dual role as negotiators and regulators has been a challenge.	

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	• Julie Tessler suggested that it would be nice to have the Administration, GMCB, and DVHA together to answer questions and provide a process for stakeholder participation. Michael replied that he's hoping to develop a "manual" or similar written tool to provide a common source of reference. Julie suggested that more coordination throughout the process could help the Administration get more buy-in at the Legislature. • Vermont's history of delivery system reform and readiness activities, including the Blueprint and SIM, were significant factors in convincing CMS to accept this agreement, but provider readiness to take on risk is still a critical factor. Some types of risk we already take on: Medicaid enrollment risk and utilization risk.	
4. Year 2 SSP 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%)	

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	○ 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). Strengths: ○ 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: ○ 4 of 14 measures were below the 50th percentile ○ Opportunity to improve Chlamydia Screening measure across both participating ACOs ○ Some variation among ACOs • Commercial SSP Quality Results: Payment Measures Strengths: ○ 16 of 22 measures were above the 50th percentile nationally; 15 of 22 were above the 75th percentile Opportunities: ○ 6 of 22 measures were below the 50th percentile ○ Opportunity to improve Alcohol and Other Drug Dependence Treatment measure across all ACOs ○ Even when performance compared to benchmarks is good, potential to improve some rates ○ Some variation among ACOs • Pat highlighted the LTSS Care Coordination composite measure, which was developed with the help of this work group. • Alicia described supplemental analyses of the Medicaid SSP. Martita Giard and Kate Simmons provided comments on behalf of the ACOs (Attachment 4b). Martita and Kate highlighted OneCare and CHAC's high quality scores within the Medicare SSP program, noting that both ACOs fall within the highest value quadrant (high quality, low cost) compared to national performance though spending was higher than target. • What are the ACOs doing to reduce unnecessary hospitalizations? Quality improvement efforts in collaboration with ACO providers to improve clinical pathways on issues like falls risk, documentation, workflow enhancement, and community collaboration. • Martita noted that it is important to allow communities to customize and implement qi interventions that work for them. • Kate described a CHAC remote monitoring initiative for Medicaid enrollees. • Martita described OneCare's Integrated Care Management workflow as well as WorkbenchOne, OneCare's population health management platform. Information from WorkbenchOne is shared with OneCare's clinical committees, Community Collaboratives, providers, and care coordinators to support work in local communities. WorkbenchOne includes PMPM analysis tools that track trends for various populations within OneCare's attributed lives.	

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	• CHAC and OneCare working together to align through VCO in the future. • How do CHAC and OneCare compare to past performance and to performance of ACOs of similar size? Vermont is already a low-cost state for Medicare. There is limited ability to make great leaps to improve cost within the Medicare SSP as currently designed. In addition, good performance in 2014 contributed to setting more challenging benchmarks in 2015. • Martita and Kate welcome additional questions via email.	
5. Global Commitment Renewal Update	Selina Hickman provided an update on the Global Commitment 1115 waiver renewal. She noted that the waiver is now renewed, and that this is the culmination of an enormous amount of work over the course of a year. • Reference: Waiver documents posted to the web. • Waiver term: 5 years (standard for renewals is 3 years). Begins 1/1/17, ends 12/31/21. • Goal: Provide coverage for current programming and services. This waiver is for the entire Medicaid program. o Secondary goals to advance health care reform and ensure Medicaid participation in and alignment with APM. This includes additional financial capacity through the Medicaid program to invest in health care reform concurrent with the APM. AHS is working on materials now that will describe this capacity – there will be a public webinar in addition to publicly available written materials. A webinar announcement will be shared through SIM and other channels. • Vermont's public managed care model has always allowed for investments in services that are not otherwise eligible for Medicaid match ("Investments"). The renewal adds definition related to delivery system investments, both for the ACO model and for Medicaid providers through the Medicaid Pathway process. There is an annual cap on spending for investments within the waiver terms. Some delivery system reform spending may also occur outside of this investment category (ex/some HIT costs, administrative costs). • CMS has added some guardrails in order to align Vermont's investments more closely with what is allowable nationally. This requires some investment expenditures to phase down over the term of the waiver agreement (the majority of these start in Year 3 of the waiver – CY 2019).	
6. Public Comment/Next Steps	**Next Meeting:** Thursday, December 1, 2016, 10:30am-12:00pm, Ash Conference Room, Waterbury State Office Complex	

VHCIP DLTSS Work Group Member List

Sue A 1° Kirsten 2° Motion carried; 4 abstentions

Member		Member Alternate		10/6/16 Minutes	1-Nov-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 Patty	West Launer ✓	A	Bi-State Primary Care
Martita	Giard ✓	Susan	Shane		OneCare Vermont
Joy	Chilton				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	Nancy	Breyden ✓	A	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	Alicia	Cooper ✓		AHS - DVHA
Julie	Tessler ✓	Marlys	Waller	A	DA - Vermont Care Partners
Julie	Wasserman ✓				AHS - Central Office
Jason	Williams ✓			A	UVM Medical Center
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	Meeting Name:	VHCIP DLTSS Work Group Meeting	
	Date of Meeting:	November 1, 2016	
	First Name	Last Name	
1	Susan	Aranoff	here
2	Debbie	Austin	
3	Ena	Backus	
4	Jessa	Barnard	phone
5	Susan	Barrett	
6	Bob	Bick	
7	Denise	Carpenter	
8	Alysia	Chapman	
9	Joy	Chilton	
10	Amy	Coonradt	
11	Amy	Cooper	
12	Alicia	Cooper	here
13	Julie	Corwin	
14	Michael	Costa	here
15	Molly	Dugan	
16	Erin	Flynn	here
17	Mary	Fredette	
18	Lucie	Garand	
19	Christine	Geiler	
20	Martita	Giard	here
21	Dale	Hackett	phone
22	Mike	Hall	
23	Selina	Hickman	here
24	Bard	Hill	

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

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

Kate Simmons - CHAC - here