VT Health Care Innovation Project

"Disability and Long Term Services and Supports" Work Group Meeting Agenda

Thursday, December 1, 2016; 10:30 AM to 12:00 PM

Ash Conference Room

Waterbury State Office Complex

Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Decision Needed?
1	10:30 – 10:35	**Welcome; Approval of Minutes** Deborah Lisi-Baker	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from November 1, 2016	Yes
2	10:35 – 11:05	**DLTSS Sustainability Priorities and the SIM Sustainability Plan** Georgia Maheras, AOA / Sarah Kinsler, DVHA	• Attachment 2: SIM Sustainability Slides Nov 2016 • Link to draft Sustainability Plan	
3	11:05 – 11:25	**Updates:** a) **MH/SUD/DS Medicaid Pathway –** Selina Hickman b) **LTSS/CFC Medicaid Pathway –** Sue Aranoff c) **Consumer Engagement for Medicaid Pathways -** Deborah Lisi-Baker d) **Population Health Plan –** Georgia Maheras	• Link to draft Population Health Plan	
4	11:25 – 11:40	**DLTSS Work Group's Accomplishments** Julie Wasserman, AHS	• Attachment 4: Vermont Health Care Innovation Project Disability and Long Term Services and Supports Initiatives and Achievements January 2014 - December 2016	

5	11:40 – 11:50	**On-going Opportunities for Participant Involvement** Georgia Maheras, AOA	• Attachment 5: SIM Work Group Transitions: How to Stay Involved	
6	11:50 – 12:00	**Thank You and Public Comment** Deborah Lisi-Baker		

Attachment 1b: Minutes from November 1, 2016

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	

Agenda Item	Discussion	Next Steps
	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	

Agenda Item	Discussion	Next Steps
	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.	

Agenda Item	Discussion	Next Steps
	• 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%)	

Agenda Item	Discussion	Next Steps
	o Data collection and analysis is challenging, but there continues to be impressive collaboration among ACOs in clinical data collection • Medicaid SSP Quality Results: Payment Measures – (Slide 36). Strengths: o 10 of 14 measures of ACO results were above the 50th percentile nationally; 6 of 14 were above the 75th percentile Both ACOs met the quality gate and CHAC will receive shared savings Opportunities: o 4 of 14 measures were below the 50th percentile o Opportunity to improve Chlamydia Screening measure across both participating ACOs o Some variation among ACOs • Commercial SSP Quality Results: Payment Measures Strengths: o 16 of 22 measures were above the 50th percentile nationally; 15 of 22 were above the 75th percentile Opportunities: o 6 of 22 measures were below the 50th percentile o Opportunity to improve Alcohol and Other Drug Dependence Treatment measure across all ACOs o Even when performance compared to benchmarks is good, potential to improve some rates o Some variation among ACOs • 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.	

Agenda Item	Discussion	Next Steps
	• 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

SueA 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	West		Bi-State Primary Care
		Patty	Launer ✓	A	
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	Breiden ✓	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		DA - Vermont Care Partners
Julie	Wasserman				AHS - Central Office
Jason	Williams				UVM Medical Center
	24		5		

	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

Attachment 2: SIM Sustainability Slides Nov 2016

Vermont State Innovation Model (SIM) Draft Sustainability Plan

Georgia Maheras, Project Director,
Vermont Health Care Innovation Project
(SIM)

IT'S JUST A FIRST DRAFT.
©2009 BALOOCARTOONS.COM

Vermont SIM Sustainability Plan Overview

Purpose of the Plan

- Identify and document the process for sustainability.
- Consider the lessons learned from the various SIM investments, and how they might contribute to program sustainability.
- Determine activities and investments to sustain.
- Determine lead entities and key partners.

Vermont Health Care Innovation Project

Sustainability Defined

Sustainability is defined as an organization's ability to maintain a project over a defined period of time. Elements of sustainability include:

- Leadership support;
- Financial support;
- Legislative/regulatory/policy support;
- Provider-partner support;
- Stakeholder (community and advocacy) support;
- Data support;
- Health information technology (HIT) and health information exchange (HIE) system support;
- Project growth and change support;
- Administrative support; and
- Project management support.

(Program Sustainability Assessment Tool, https://sustaintool.org/understand, 2016)

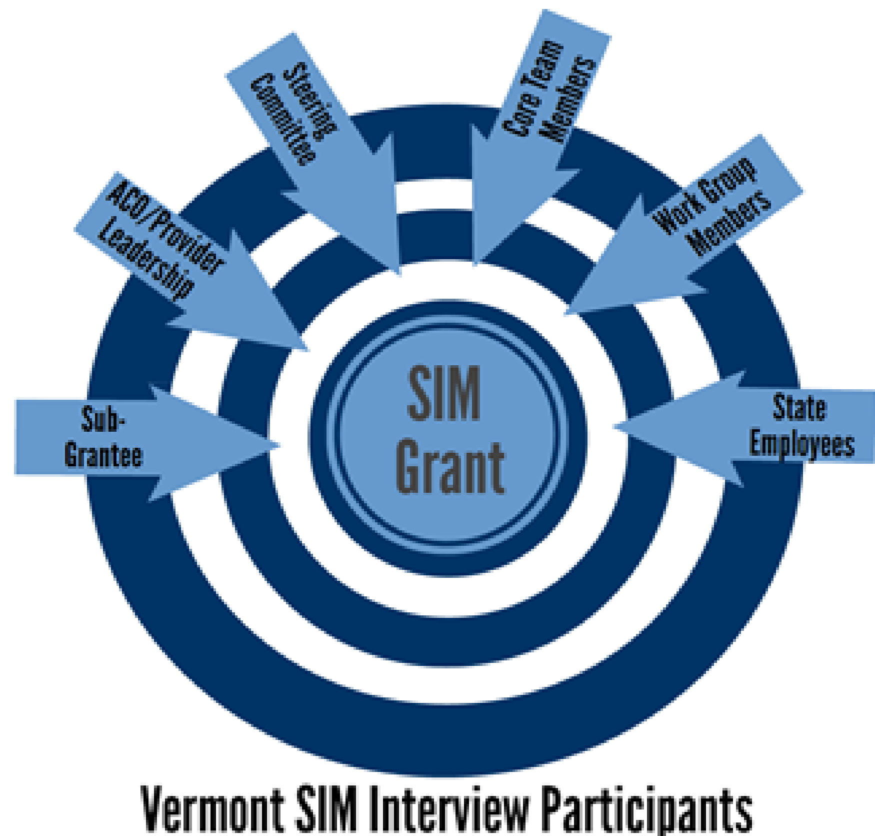
Plan Research and Development: Vermont SIM Research

Myers and Stauffer, a contractor with the State, used the following methods to assist in the development of the Sustainability Plan:

- Conducted research on Vermont’s Medicaid program, legislature, government structure, geography, relevant legislation, policy, and political environment.
- Met with JSI, the SIM State-Led Evaluation contractor, and reviewed available evaluation materials.
- Deployment of an electronic stakeholder survey. Survey was sent to over 300 SIM participants to seek input on the sustainability priorities within each focus area; 47 responses received. A copy of this survey, including results, can be found in Appendix B of the Plan.

Plan Research and Development: Vermont SIM Research (cont.)

Myers and Stauffer also conducted key informant interviews:



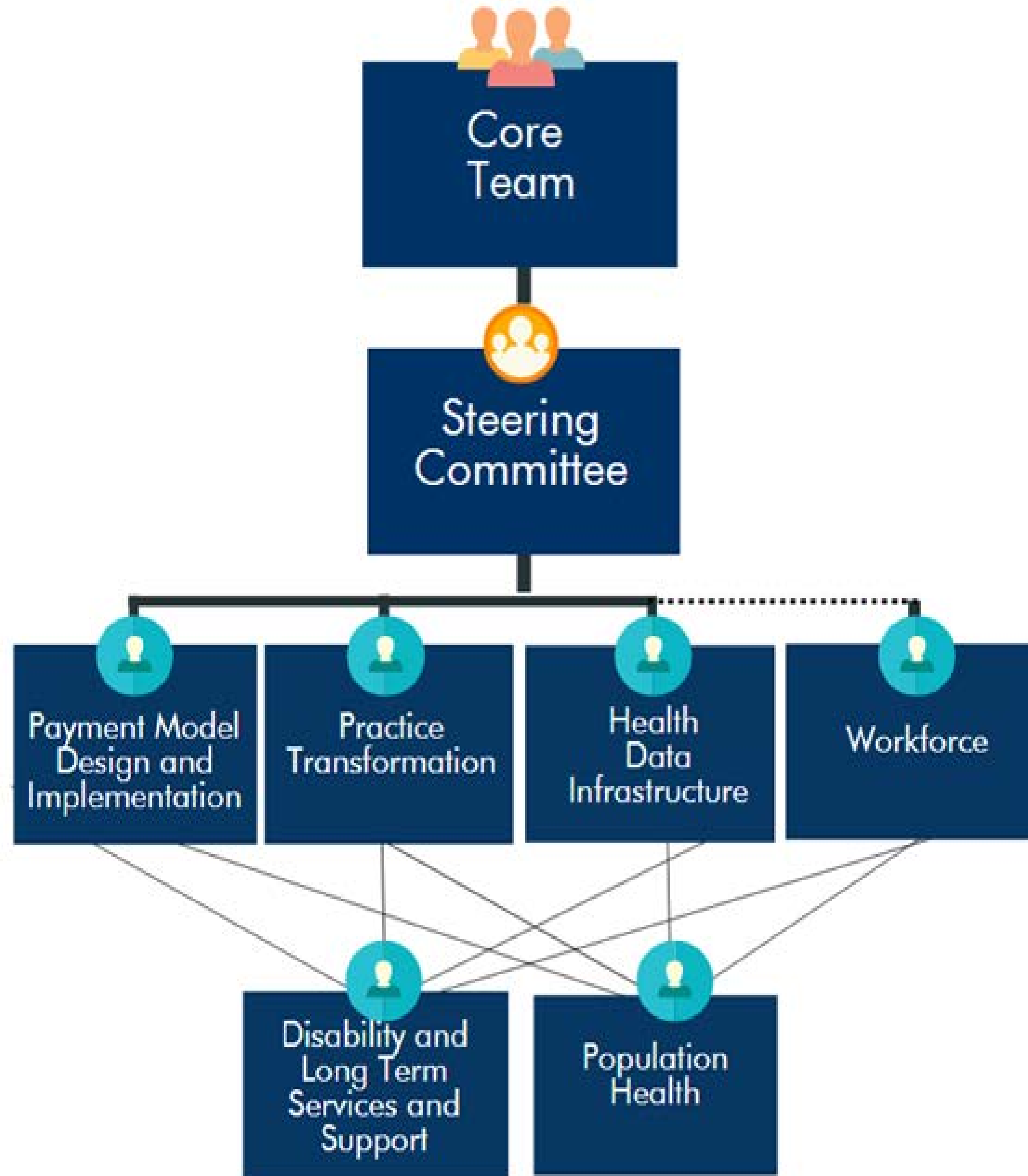
Vermont SIM Interview Participants

- 12 individuals from the private and public sector were interviewed.
- Interviews were performed to identify areas of successful SIM investment that should be sustained and barriers to sustainability.
- A comprehensive summary of the key informant interviews can be found in Appendix C of the Plan.

Plan Research and Development: Sustainability Sub-Group

- Lawrence Miller, Sub-Group Chair and Core Team Chair
- Paul Bengtson, Northeastern Vermont Regional Hospital (NVRH), Core Team Member
- Steve Voigt, ReThink Health, Core Team Member
- Cathy Fulton, VPQHC, Payment Model Design & Implementation Work Group Co-Chair
- Laural Ruggles, NVRH, Practice Transformation Work Group Co-Chair
- Simone Rueschemeyer, Vermont Care Network, Health Data Infrastructure Work Group Co-Chair
- Deborah Lisi-Baker, UVM, DLTSS Work Group Co-Chair
- Karen Hein, Population Health Work Group Co-Chair
- Mary Val Palumbo, Health Care Workforce Work Group Co-Chair
- Andrew Garland, BCBSVT, Payment Model Design and Implementation Work Group Co-Chair
- Lila Richardson, Office of the Health Care Advocate
- Vicki Loner, OneCare
- Kate Simmons, CHAC
- Holly Lane, Healthfirst
- Paul Harrington, Vermont Medical Society
- Dale Hackett, consumer, member of PMDI, PT, HDI, DLTSS, and PH Work Groups
- Stefani Hartsfield, Cathedral Square, HDI Work Group member
- Kim Fitzgerald, Cathedral Square, Steering Committee and PMDI Work Group member

SIM Governance



- Stakeholders have reported that the governance structure, particularly the Work Groups, are the cornerstone of Vermont's SIM experience and have served to bring about unprecedented collaboration, shared learning, and cross-program innovation.
- **The plan recommends that the functions of SIM governance be sustained, even if the SIM-specific governance structure is not continued.**

Sustainability Recommendations

Three Categories of Investment

The State views SIM investments in three categories with respect to sustainability:

- **One-time investments** to develop infrastructure or capacity, with limited ongoing costs;
- **New or ongoing activities** which will be supported by the State after the end of the Model Testing period; and
- **New or ongoing activities** which will be supported by private sector partners after the end of the Model Testing period.

Some projects remain ongoing at the time of the delivery of the initial draft report. In these cases, we have indicated sustainability status is pending the project's completion.

Lead Entities

Lead Entities – The organization recommended to assume ownership of a project once the SIM funding opportunity has ended.

A Lead Entity may be a public or private sector organization from the Vermont health care community. These entities may not have complete governance over a project, but they do have a significant leadership role and responsibility. This includes the responsibility to convene the Key Partners.

Lead Entities are likely to include, but are not limited to State Agencies, Departments, programs, and regulatory bodies, including:

It will also include the Vermont Care Organization (VCO).

Key Partners

Key Partners – A more comprehensive network of State partners, payers, providers, consumers, and other private-sector entities who will be critical partners in sustaining previously SIM-funded efforts.

Key Partners may be public or private sector entities within or outside of the Vermont health care community. These entities represent the broader community and overlapping concerns inherent in a project's mission and objectives.

Vermont's SIM efforts have relied on active participation and input from a diverse group of stakeholders. Consumer and consumer advocate engagement and input have been critical in accomplishing the goals and objectives of the SIM initiative. The State of Vermont, in continuing to champion transparency in health care reform, is committed to working with consumers and advocates to ensure they have a visible role and are collaborative partners in future activities.

Key Partners (cont'd)

Depending on the project, Key Partners may include those listed above as Lead Entities. Key Partners also are likely to include:

- Additional State Agencies and Departments, including the Vermont Department of Health (VDH), the Department of Labor (DOL), and the Department of Information and Innovation (DII);
- Payers, including commercial and public (Medicare and Medicaid)
- Providers and provider organizations;
- The Community Collaboratives active in each region of Vermont;
- Key statewide organizations and programs like the Vermont Program for Quality in Health Care, Inc. (VPQHC), Support and Services at Homes (SASH), and Vermont Information Technology Leaders (VITL); and
- Federal partners: CMS, the Center for Medicare & Medicaid Innovation (CMMI), and the Office of the National Coordinator for Health Information Technology (ONC).

BlueCross BlueShield of Vermont

Recommendations: Payment Model Design and Implementation

Investment Category			
SIM Focus Areas and Work Streams	One-Time Investment	Ongoing Investments *State-Supported*	Ongoing Investment *Private Sector*
Payment Model Design and Implementation			
ACO Shared Savings Programs (SSPs)		●	●
Pay-for-Performance (Blueprint for Health)		●	●
Health Home (Hub & Spoke)		●	●
Accountable Communities for Health		●	●
Prospective Payment System – Home Health		●	●
Medicaid Pathway		●	●
All-Payer Model		●	●

Recommendations: Payment Model Design and Implementation (cont'd)

On-Going Sustainability: Task Owner			
SIM Focus Areas and Work Streams	**Lead Entity** *(Primary Owner)*	**Key Partners**	**Special Notes**
ACO Shared Savings Programs (SSPs)	GMCB	Payers (DVHA, BCBSVT, CMS), ACOs, VCO	Activity continued through transitional period.
Pay-for-Performance (Blueprint for Health)	VCO	AHS (DVHA-Blueprint) and GMCB	Note that both VCO and AHS will be engaged in subsequent P4P activities.
Health Home (Hub & Spoke)	AHS	DVHA-Blueprint, VDH	Anticipating additional Health Home initiatives for different services. Leverage Blueprint experience.
Accountable Communities for Health	Blueprint/VCO	VDH, AOA	Aligned with Regional Collaborations/CCs. (See Practice Transformation.) Additional information can be found in Vermont's Population Health Plan.
Prospective Payment System – Home Health	AHS/DAIL	VNAs of Vermont and New Hampshire, HHAs	Anticipate additional PPS for different services.
Medicaid Pathway	AHS	Provider Partners	A comprehensive list of key partners can be found here.
All-Payer Model	GMCB	AOA, AHS, ACOs, CMMI, Payers (DVHA, BCBSVT, CMS), providers	

Payment Model Design and Implementation: ACO Shared Savings Programs (SSPs)

- Designed to align with the Medicare Shared Savings Program (SSP) Track 1, but will end after a transitional period.
- The State will implement a Medicare Next Generation ACO concept through the All-Payer Model framework.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** GMCB
  - **Recommended Key Partners:** DVHA, BCBSVT, CMS, ACOs, VCO

Payment Model Design and Implementation: Blueprint for Health (Pay-for-Performance)

- Provides performance payments to advanced primary care practices recognized as patient-centered medical homes (PCMHs).
- Provides multi-disciplinary support services in the form of community health teams (CHTs); a network of self-management support programs; comparative reporting from statewide data systems; and activities focused on continuous improvement.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** VCO
  - **Recommended Key Partners:** AHS, DVHA-Blueprint, and GMCB

Vermont Health Care Innovation Project

Payment Model Design and Implementation: Health Home / Hub and Spoke

- Health Home initiative created under Section 2703 of the Affordable Care Act for Vermont Medicaid beneficiaries with opioid addiction.
- Integrates addictions care into general medical settings (Spokes) and links these settings to specialty addictions treatment programs (Hubs) in a unifying clinical framework.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AHS
  - **Recommended Key Partners:** DVHA-Blueprint, VDH

Payment Model Design and Implementation: Accountable Communities for Health

- Provides peer learning activities to support integration of community-wide prevention and public health efforts with integrated care efforts through a Peer Learning Laboratory.
- Peer learning activities and local facilitation to support communities in developing ACH competencies began in June 2016 and will continue through the conclusion of the Peer Learning Laboratory in January 2017.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** Blueprint/VCO
  - **Recommended Key Partners:** VDH, AOA

Payment Model Design and Implementation: Medicaid Pathway

- Process designed to advance payment and delivery system reform for services not included in the initial implementation of Vermont's All-Payer Model.
- The goal is to support a more integrated system for all Vermonters; including integrated physical health, long-term services and supports, mental health, substance abuse treatment, developmental disabilities services, and children's service providers.

- **Sustainability Recommendation:** New activities and investments.
  - **Recommended Lead Entity:** AHS
  - **Recommended Key Partners:** Provider Partners

Payment Model Design and Implementation: All–Payer Model

- The All-Payer Model will build on Vermont's existing all-payer payment alternatives to better support and promote a more integrated system of care and a sustainable rate of overall health care cost growth.
- Through the legal authority of the Green Mountain Care Board (GMCB) and facilitated by an All-Payer Accountable Care Organization Model Agreement with CMMI, the state can enable the alignment of commercial payers, Medicaid, and Medicare in an Advanced Alternative Payment Model. Specifically, the State will apply the Next Generation ACO payment model, with modifications, and subsequently, a Vermont Medicare ACO Initiative model across all payers. The GMCB will set participating ACO rates on an all-payer basis to enable the model.

- **Sustainability Recommendation:** New activities and investments.
  - **Recommended Lead Entity:** GMCB
  - **Recommended Key Partners:** AOA, AHS, ACOs, CMMI, payers (DVHA, BCBSVT, CMS), and providers

Recommendations: Practice Transformation

SIM Focus Areas and Work Streams	One-Time Investment	Ongoing Investments *State-Supported*	Ongoing Investment *Private Sector*
Practice Transformation			
Learning Collaboratives		●	●
Sub-Grant Program		●	●
Regional Collaborations		●	●
Workforce – Care Management Inventory	●		
Workforce – Demand Data Collection and Analysis	*Project Delayed*		
Workforce – Supply Data Collection and Analysis		●	

(Table header: Investment Category)

Recommendations: Practice Transformation

On-Going Sustainability: Task Owner			
SIM Focus Areas and Work Streams	**Lead Entity** *(Primary Owner)*	**Key Partners**	**Special Notes**
Learning Collaboratives	Blueprint/VCO	Community Collaboratives, VPQHC, SASH	This work stream also includes the Core Competency Training. Aligned with Regional Collaborations/CCs. Note there are contract obligations related to this in the DVHA-ACO program for 2017.
Sub-Grant Program	AHS	AOA	
Regional Collaborations	Blueprint/VCO	AHS, VDH	Aligned with Learning Collaboratives, Accountable Communities for Health.
Workforce – Care Management Inventory	**One-time Investment**		
Workforce – Demand Data Collection and Analysis	AOA	DOL, VDH, GMCB, provider education, private sector.	AOA to coordinate across DOL, VDH, provider education, private sector.
Workforce – Supply Data Collection and Analysis	AOA		

Practice Transformation:
Learning Collaboratives and Core Competency Training

- The Integrated Communities Care Management Learning Collaborative is a hospital service area-level rapid cycle quality improvement initiative.
- It is based on the Plan-Do-Study-Act (PDSA) quality improvement model, and features in-person learning sessions, webinars, implementation support, and testing of key interventions.
- The Core Competency Training series provides a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities statewide.
- Core curriculum covers competencies related to care coordination and disability awareness.

- **Sustainability Recommendation:** On-going activities and investments.
  - **Recommended Lead Entity:** Blueprint/VCO
  - **Recommended Key Partners:** Community Collaboratives, VPQHC, and SASH

Practice Transformation: Sub-Grant Program

- The VHCIP Provider Sub-Grant Program launched in 2014, has provided 14 awards to 12 provider and community-based organizations who are engaged in payment and delivery system transformation.
- Awards range from small grants to support employer-based wellness programs, to larger grants that support statewide clinical data collection and improvement programs. The overall investment in this program is nearly $5 million. The Core Competency Training series provides a comprehensive training curriculum to front line staff providing care coordination (including case managers, care coordinators, etc.) from a wide range of medical, social, and community service organizations in communities statewide.
- Sub-grantees performed a self-evaluation and some have engaged in sustainability planning.

- **Sustainability Recommendation:** Status is pending project's completion. Ongoing evaluations of individual sub-grant projects continue.
  - **Recommended Lead Entity:** AHS
  - **Recommended Key Partner:** AOA

Practice Transformation: Sub-Grant Technical Assistance

- The Sub-Grant Technical Assistance program was designed to support the awardees of provider sub-grants in achieving their project goals.
- Direct technical assistance to sub-grant awardees has been valuable to the SIM experience, but will prove costly if sustained over a considerable period of time. Additionally, it will become less necessary as awardees get farther along in their programs. Sub-grantees performed a self-evaluation and some have engaged in sustainability planning.
- The State of Vermont will develop a contractor skills matrix as a resource for future awardees. Awardees would be responsible for selecting and securing contractor resources for technical assistance.

- **Sustainability Recommendation:** One-time Investment.

Practice Transformation: Regional Collaborations

- Within each of Vermont's 14 hospital service areas (HSAs), Blueprint for Health and ACO leadership have merged their regional clinical work groups and chosen to collaborate with stakeholders using a single unified health system initiative.
- These groups focus on reviewing and improving the results of core ACO Shared Savings Program quality measures; supporting the introduction and extension of new service models; and providing guidance for medical home and Community Health Team operations.

- **Sustainability Recommendation:** On-going activities and investments.
  - **Recommended Lead Entity:** Blueprint/VCO
  - **Recommended Key Partners:** AHS and VDH

Practice Transformation: Care Management Inventory

- Survey administered to provide insight into the current landscape of care management activities in Vermont.
- The survey aimed to better understand State-specific staffing levels and types of personnel engaged in care management, in addition to the populations being served.
- The project was completed as of February 2016.

- **Sustainability Recommendation:** One-time investment.

Practice Transformation: Demand Data Collection and Analysis

- A "micro-simulation" demand model uses Vermont-specific data to identify future workforce needs for the State by inputting various assumptions about care delivery in a high-performing health care system.
- The selected vendor for this work will create a demand model that identifies ideal workforce needs for Vermont in the future, under various scenarios and parameters.
- This project is delayed.

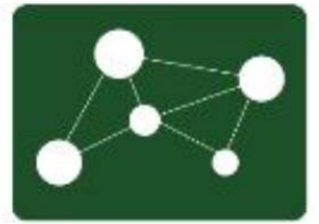
- **Sustainability Recommendation:** Status is pending project completion.

Practice Transformation: Supply Data Collection and Analysis

- The Vermont Office of Professional Regulation (OPR) and Vermont Department of Health (VDH) work in tandem to assess current and future supply of providers in the State's health care workforce for health care work force planning purposes, through collection of licensure and re-licensure data and the administration of surveys to providers during the licensure/re-licensure process.
- Surveys include key demographic information for providers, and are used for workforce supply assessment and predicting supply trends.
- Infrastructure to support the continued use of this data exists, and it will continue to be supported by the State of Vermont, OPR and VDH.

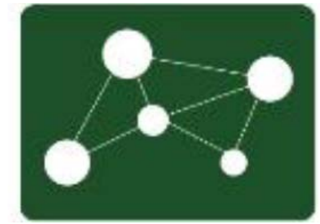
- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA
  - **Recommended Key Partners:** DOL, VDH, GMCB, provider education, and private sector

Recommendations: Health Data Infrastructure



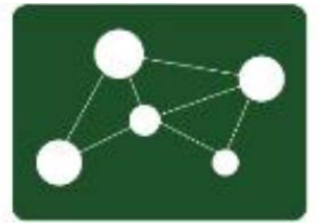
SIM Focus Areas and Work Streams	One-Time Investment	Ongoing Investments *State-Supported*	Ongoing Investment *Private Sector*
	Investment Category		
Health Data Infrastructure			
Expand Connectivity to HIT – Gap Analysis	●		
Expand Connectivity to HIT – Gap Remediation		●	●
Expand Connectivity to HIT – Data Extracts from HIE	●		
Improve Quality of Data Flowing into HIE		●	●
Telehealth – Strategic Plan	●		
Telehealth - Implementation		●	●
Electronic Medical Record Expansion		●	●
Data Warehousing		●	●
Care Management Tools –Event Notification System			●
Care Management Tools – Shared Care Plan		●	●
Care Management Tools –Universal Transfer Protocol	●		
General Health Data – Data Inventory		●	
General Health Data – HIE Planning	●		
General Health Data – Expert Support	●		

Recommendations: Health Data Infrastructure (cont'd)



On-Going Sustainability: Task Owner			
SIM Focus Areas and Work Streams	**Lead Entity** *(Primary Owner)*	**Key Partners**	**Special Notes**
Expand Connectivity to HIT – Gap Analysis	**One-Time Investment**		
Expand Connectivity to HIT – Gap Remediation	AOA*	ITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Expand Connectivity to HIT – Data Extracts from HIE	**One-Time Investment**		
Improve Quality of Data Flowing into HIE	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Telehealth – Strategic Plan	**One-Time Investment**		
Telehealth - Implementation	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Electronic Medical Record Expansion	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Data Warehousing	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Care Management Tools –Event Notification System	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Care Management Tools – Shared Care Plan	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
Care Management Tools –Universal Transfer Protocol	**One-Time Investment**		
General Health Data – Data Inventory	AOA*	VITL, AHS (and Departments); GMCB; providers across the continuum; ACOs; DII; HHS (CMS; ONC)	
General Health Data – HIE Planning	**One-Time Investment**		
General Health Data – Expert Support	**One-Time Investment**		

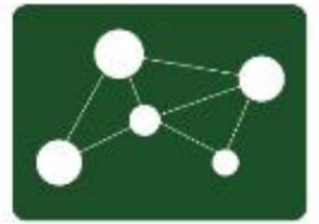
Health Data Infrastructure:
Expand Connectivity to HIE – Gap Analysis



- The Gap Analysis is an evaluation of the EHR system capability of health care organizations, interface ability of the EHR system, and the data transmitted within those interfaces.
- Created a baseline determination of the ability of health care organizations to produce Year 1 Medicare, Medicaid, and commercial Shared Savings ACO Program quality measure data. Evaluated data quality among the 16 designated and specialized service agencies.
- Reviewed the technical capability of DLTSS providers statewide.

- **Sustainability Recommendation**: One-time investment.

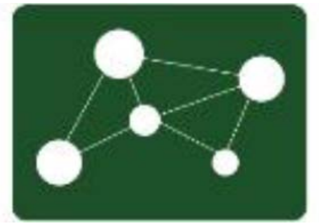
Health Data Infrastructure: Expand Connectivity to HIE – Gap Remediation



- The Gap Remediation project addresses gaps in connectivity and clinical data quality of health care organizations to the Health Information Exchange.
- The ACO Gap Remediation component improves the connectivity for all Vermont Shared Savings Program measures among ACO member organizations. The Vermont Care Partners (VCP) Gap Remediation improves the data quality for the 16 Designated Mental Health and Specialized Service agencies (DAs and SSAs). In addition, a DLTSS Gap Remediation effort to increase connectivity for Home Health Agencies was approved in January 2016 based on the results of the DLTSS Information Technology Assessment. Infrastructure to support the continued use of this data exists, and it will continue to be supported by the State of Vermont, OPR and VDH.
- Gap Remediation efforts for ACO member organizations and Vermont Care Partners dovetail with data quality improvement efforts.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Expand Connectivity to HIE – Data Extracts from HIE

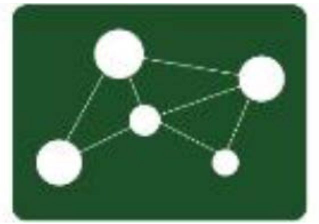


- This project provides a secure data connection from the VHIE to the ACOs' analytics vendors for their attributed beneficiaries.
- Allows ACOs direct access to timely data feeds for population health analytics.

- **Sustainability Recommendation:** One-time investment.

Vermont Health Care Innovation Project

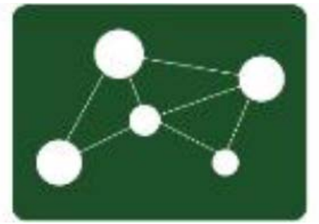
Health Data Infrastructure: Improve Quality of Data Flowing into the HIE



- The Data Quality Improvement Project is an analysis performed of ACO members' EHRs on each of 16 data elements. Allows ACOs direct access to timely data feeds for population health analytics.
- VITL engages providers and makes workflow recommendations to change data entry to ensure the data elements are captured. In addition, VITL performs comprehensive analyses to ensure that each data element from each health care organization (HCO) is formatted identically.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

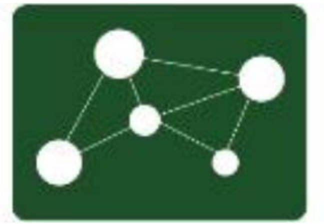
Health Data Infrastructure: Telehealth



- *Strategic Plan* - The strategy includes four core elements and a road map based on the prioritization of telehealth projects and their alignment with new clinical processes adopted as payment reform evolves.
  - **Sustainability Recommendation:** One-time investment.

- *Implementation* - Vermont is funding two pilot projects that can address a variety of geographical areas, telehealth approaches and settings, and patient populations. The primary purpose is to explore ways in which a coordinated and efficient telehealth system can support value-based care reimbursement throughout Vermont. Projects were selected in part based on demonstration of alignment with the health reform efforts currently being implemented as part of the SIM Grant process.
  - **Sustainability Recommendation:** Ongoing activities and investments in the area of telehealth; not necessarily these two pilots.
    - **Recommended Lead Entity:** AOA*
    - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

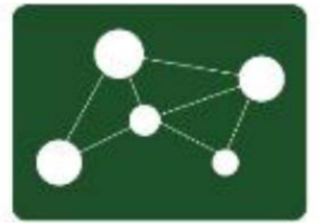
Health Data Infrastructure: Electronic Medical Record Expansion



- Electronic medical record (EMR) expansion focuses on assisting in the procurement of EMR systems for non-Meaningful Use (MU) providers.
- Includes technical assistance to identify appropriate solutions and exploration of alternative solutions.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: Data Warehousing

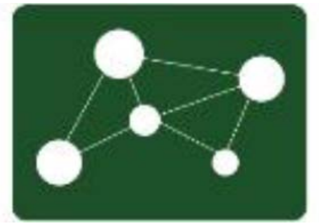


- The Vermont Care Network (VCN) Data Repository will allow the Designated Mental Health Agencies and Specialized Service Agencies to send specific data to a centralized data repository.
- Long-term goals of the data repository include accommodating connectivity to the Vermont Health Information Exchange (VHIE), as well as Vermont State agencies, other stakeholders, and interested parties.
- It is expected that this project will provide VCN members with advanced data analytic capabilities to improve the efficiency and effectiveness of their services.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

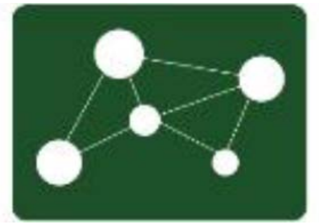
Vermont Health Care Innovation Project

Health Data Infrastructure: Care Management Tools



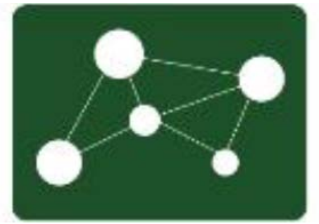
- *Shared Care Plan Project* - A planning activity that ensures that the components of a shared care plan are captured in a technical solution that allows providers across the care continuum to electronically exchange critical data and information as they work together in a team based, coordinated model of care.
  - **Sustainability Recommendation:** Ongoing activities and investments.
    - **Recommended Lead Entity:** AOA*
    - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, HHS (CMS, ONC).
- *Universal Transfer Protocol* - Sought to provide a Universal Transfer Protocol to Vermont's provider organizations. Pursued through provider workflow activities.
  - **Sustainability Recommendation:** One-time investment

Health Data Infrastructure: Care Management Tools (cont.)



- *Event Notification System* – A system to proactively alert participating providers regarding their patient's medical service encounters.
  - **Sustainability Recommendation:** Ongoing activities and investments.
    - **Recommended Lead Entity:** AOA*
    - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

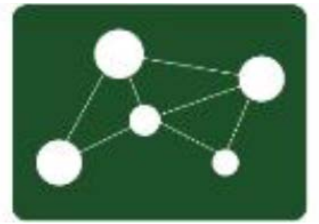
Health Data Infrastructure: General Health Data Inventory



- A health data inventory that will support future health data infrastructure planning.
- This project built a comprehensive list of health data sources in Vermont, gathered key information about each, and catalogued them in a web-accessible format.
- The resulting data inventory is a web-based tool that allows users (both within the State and external stakeholders) to find and review comprehensive information relating to the inventoried datasets.
- Periodic updates will be needed.

- **Sustainability Recommendation:** Ongoing activities and investments.
  - **Recommended Lead Entity:** AOA*
  - **Recommended Key Partners:** VITL, AHS (and Departments), GMCB, providers across the continuum, ACOs, DII, and HHS (CMS, ONC)

Health Data Infrastructure: HIE Planning



- The HIE planning project resulted from a perceived gap in high-level planning and research in local and nationwide best practices for providing a robust, interoperable ability to transmit accurate and current health information throughout the Vermont health care landscape.
- This project will conduct further research in best practices around improving clinical health data quality and connectivity resulting in recommendations to the HIE/HIT work group.
- Additionally, the HDI work group has participated on multiple occasions in the 2015 revision of Vermont HIT Plan.
- Plan is to finalize connectivity targets for 2016-2019 by December 31, 2016.

- **Sustainability Recommendation:** One-time investment.

Recommendations: Evaluation

Investment Category			
SIM Focus Areas and Work Streams	One-Time Investment	Ongoing Investments *State-Supported*	Ongoing Investment *Private Sector*
Evaluation			
Self-Evaluation Plan and Execution	**One-Time Investment**		
Surveys		●	●
Monitoring and Evaluation Activities within Payment Programs		●	●

On-Going Sustainability: Task Owner			
SIM Focus Areas and Work Streams	Lead Entity *(Primary Owner)*	Key Partners	Special Notes
Self-Evaluation Plan and Execution	**One-Time Investment**		
Surveys	VCO	Providers, AHS, Consumers, Office of the Health Care Advocate, GMCB	Patient experience surveys. Note that there are numerous patient experience surveys that are deployed annually in addition to the one used as part of the SSP.
Monitoring and Evaluation Activities within Payment Programs	AHS/GMCB	Payers, VCO, Office of the Health Care Advocate, AOA	Payers, State regulators, and VCO/providers will monitor and evaluate payment models. There are specific evaluation requirements for the GMCB and AHS as a result of the 1115 waiver and APM. Patient experience surveys are a tool for monitoring and evaluation.

Evaluation

- *Self-Evaluation Plan and Execution* - The State works with an independent contractor to perform a State-Led Evaluation of Vermont's SIM effort.
  - **Sustainability Recommendation:** One-time investment.
- *Surveys* - As part of broader payment model design and implementation and evaluation efforts, the State conducts annual patient experience surveys and other surveys as identified in payment model development. There are numerous patient experience surveys that are deployed annually, in addition to the one used as part of the SSP.
  - **Sustainability Recommendation:** Ongoing activities and investments.
    - **Recommended Lead Entity:** VCO
    - **Recommended Key Partners:** Providers, AHS, Consumers, OHCA, GMCB.

Evaluation

- *Monitoring and Evaluation Activities within Payment Programs* - The state conducts analyses as necessary to monitor and evaluate specific payment models. Monitoring occurs by payer and by program to support program modifications. Ongoing monitoring and evaluation by State of Vermont staff and contractors occurs as needed.
  - **Sustainability Recommendation:** Ongoing activities and investments.
    - **Recommended Lead Entity:** AHS/GMCB
    - **Recommended Key Partners:** Payers, VCO, OHCA, and AOA

Project Management

- Vermont SIM is managed through a combination of State personnel and outside vendors with project management expertise.
- The project management function under SIM considers both the program and administration functions of government such as soliciting public comment, ensuring appropriations, and managing resources; as well as managing the various projects, groups, and relationships that SIM initiated.
- As SIM projects transition from the demonstration phase to the program phase, project management functions will transition to program staff in Medicaid, or other partners.

- **Sustainability Recommendation:** Ongoing activities and investments.

Plan Timeline

- November and December 2016 – First draft complete and under review by SIM Work Groups and Steering Committee. Core Team will review a revised draft in late December.
- Spring 2017 – Second draft of the SIM Sustainability Plan will be developed based on feedback from SIM Work Groups, Steering Committee, Core Team, and Sustainability Sub-Group.
- June 2017 – Following Core Team approval, final SIM Sustainability Plan will be submitted to CMMI. The Sustainability Plan is due June 30, 2017.

The plan is currently in draft.
Please provide comments and questions to:

Georgia Maheras
(georgia.maheras@vermont.gov, 802-505-5137)
or **Sarah Kinsler**
(sarah.kinsler@vermont.gov, 802-798-2244)

Attachment 4: Vermont Health Care Innovation Project Disability and Long Term Services and Supports Initiatives and Achievements January 2014 - December 2016

VERMONT

Vermont Health Care Innovation Project

Vermont Health Care Innovation Project
Disability and Long Term Services and Supports
Initiatives and Achievements
January 2014 - December 2016

Presentation to the DLTSS Work Group

Julie Wasserman

Agency of Human Services

December 1, 2016

The Vermont Health Care Innovation Project's Disability and Long Term Services and Supports (DLTSS) Work Group originated from the Dual Eligible Initiative, a planning grant from CMS which allowed the State to identify ways to better serve individuals who are dually eligible for Medicaid and Medicare. These individuals have among the most complex care needs, yet the current system often fails in delivering comprehensive, effective and coordinated person-directed care. As beneficiaries of both Medicare and Medicaid, many dually eligible individuals have chronic illnesses and concurrent disabilities which span primary, acute, mental health, substance abuse, developmental, and long term service and support domains. The goal of the DLTSS Work Group was to incorporate best practices and expertise about person-centered and directed disability services into Vermont's health care reform efforts. Though the State chose not to apply for the Dual Eligible implementation funding, stakeholder involvement, recommendations and analysis from this earlier initiative became the foundation of the VHCIP Disability and Long Term Services and Supports Work Group.

A large and growing share of the population is affected by disability, with disability prevalence increasing considerably as people age. Vermont has the distinction of being one of the "oldest" states in the nation. Statistics from Cornell University's *2014 Disability Status Report* indicate that 15.5% of all Vermonters residing in the community have a disability compared to the nation's 12.6%. For Vermonters 75 years old and older, the rate climbs to 50.3%. Expenditures for Vermont's Specialized Services (which serve people with disability and long term service needs) accounts for approximately 55% of Vermont Medicaid claims.

The DLTSS Work Group has given rise to many significant accomplishments over the course of the Vermont Health Care Innovation Project's 3-year Demonstration Grant period. Highlights are listed below; see Appendix for links to complete reports.

1. *Model of Care for People with Disabilities and Long Term Services and Supports Needs, June 2014*. This 34-page DLTSS Model of Care report provides background, detail, and recommendations for creating a coordinated and integrated model of care for Vermont's service delivery system. It identifies essential "core elements" and identifies mechanisms for incorporating these elements into current practice. The DLTSS Model of Care has been renamed *The Vermont Integrated Model of Care* with the directive that it be embraced by Vermont's ACOs, Act 113 Medicaid Pathways, and the All Payer Model.

2. *Disability & Long Term Services and Supports Medicaid Expenditure Analysis, April 2015*. This PHPG report was produced in response to recurrent questions about the extent of Vermonters with DLTSS needs, the array of services in meeting those needs, and the cost to the State. A significant finding was that services to meet these individuals' specialized needs as well as their traditional medical needs comprise 72% of Vermont Medicaid claims expenditures, yet these individuals comprise only a quarter of all Vermont Medicaid beneficiaries.

3. *Disability Awareness Briefs, June 2015*. Disability Awareness Briefs were developed in an effort to improve quality of care and health outcomes for people with disabilities, including elders. The intent of these Briefs is to create foundational source documents on which to build training curricula, educational materials, and other products for care management practitioners and providers. The Briefs include:
    - Introduction to Disability Awareness
    - Disability Competency for Providers
    - Disability Competency for Care Management Practitioners
    - Cultural Competency
    - Accessibility
    - Universal Design

4. *Informed Consent, Privacy, Confidentiality, and Release Forms to Enable Information Sharing by Integrated Care Teams, April 2016.* This report describes the importance of a) having a legally valid consent form, b) ensuring that the client's choice to share information is informed and voluntary, and c) having a reliable procedure to communicate when the client's consent has been revoked. Important elements include readability, client engagement, disclosure, and the revocation process. Templates addressing these issues were developed for the VHCIP Integrated Community Learning Collaborative Care Management Teams.

5. *Overview of Shared Savings Programs (SSPs) and Accountable Care Organizations (ACOs) in Vermont, July 2014.* This report provides comprehensive and detailed explanations of ACOs, Shared Savings Programs, Shared Savings Program Standards, attribution methodology, provider participation in ACO networks, total cost of care, downside risk, beneficiary protections, ACO governance, beneficiary engagement, and the interface between ACOs and AHS. The report includes a table titled "Details of SSPs and ACOs in Vermont" which enumerates the specific Medicare, Medicaid and

Commercial SSP-ACO agreements operating in Vermont, including the ACOs' provider networks and the estimated percent of attributed lives within each SSP.

6. *ACOs and the DLTSS System, November 2014*. This table poses questions for Vermont's three ACOs − OneCare Vermont, CHAC and Health*first*. The questions were compiled by Vermont Legal Aid and the Vermont Council of Developmental & Mental Health Services. The table contains written responses from each of the ACOs.

7. *DLTSS Performance Measures Reference Document, May 2014.* This report documents the DLTSS Work Group's recommendations on the Medicaid and Commercial Shared Saving Programs Year 1 quality and performance measures for the VHCIP Quality and Performance Measures Work Group. The document provides background on the quality and performance measurement structure and suggests measures that could be promoted to a new status or newly included in the measure set for the Medicaid and Commercial Shared Savings ACO Programs.

8. *Vermont Medicaid Shared Savings Program Quality Measures: Year 1 DLTSS Sub-Analysis, October 2016.* The objective of this sub-analysis was to measure the quality of care of Medicaid beneficiaries who received disability and/or long term services and supports and who were also attributed to an ACO in the Vermont Medicaid Shared Savings Program. One of the most salient findings of this analysis involves avoidable hospitalizations for people with DLTSS needs. For two important measures (see below), DLTSS individuals in an ACO had a much higher likelihood of being unnecessarily hospitalized than people not affiliated with an ACO. Avoidable hospitalizations are of great concern regarding cost, quality and outcomes; this is especially true for individuals who are elderly and/or disabled and at greater risk of losing functional capacity as a result of being hospitalized.
    - Hospitalizations for COPD or Asthma in Older Adults
    - Hospitalizations for Ambulatory Care Sensitive Conditions

9. *DLTSS Information Technology Assessment, November 2015.* This HIS Professionals Study documents the health information technology (HIT) used by Disability and Long Term Services and Supports providers in Vermont. The report provides an initial assessment of DLTSS providers' HIT capacity, and updates prior assessments of Vermont's Long Term and Post-Acute Care providers. It also examines HIT adoption levels and health information

exchange capabilities, and recommends next steps for organizations to exchange health information and engage in analytics for population health management, and enhanced and efficient care coordination.

10. *DLTSS IT Gap Remediation Project, 2015-2016.* The DLTSS Data Gap Analysis and Remediation Project began as part of the VHCIP Accessing Care Through Technology (ACTT) suite of HIE/HIT projects. The goal of the DLTSS Gap Remediation Project is to increase the Health Information Technology capacity of Vermont's Disability and Long Term Services and Supports Providers and other "non-meaningful use providers". Home Health Agencies and possibly Area Agencies on Aging will be able to establish connections to VHIE allowing them to more actively participate in Vermont's health care reform efforts and comply with the Federal IMPACT Act.

11. *Promotion and funding for Core Competency and Disability Competency Trainings, 2015-2016.* The goal of the Core Competency and Disability Competency Trainings was to improve regional integration of health and social service organizations in order to optimize care management activities for at-risk individuals, and to provide learning opportunities for best practice care management in Vermont. These trainings complemented and enhanced the extensive work of the VHCIP Integrated Community Care Management Learning Collaborative initiative.

12. *Payment Models, Value-Based Purchasing, and DLTSS Design Considerations, October 2015.* This PHPG document reviews design elements related to Value Based Purchasing and provides recommendations for payment models that support DLTSS specific outcomes, promote integration of medical services with DLTSS services, and offer financial incentives that reward change but do not compromise access to care.

<u>VHCIP Sub-Grant Pilot Projects</u>

1. *The Caledonia and Essex Dual Eligible Project, 2014-2016.* This project provided flexible funding for health-related goods and services not normally covered by health insurance, enabling an integrated multi-disciplinary community care team to better care for Dually Eligible clients who are at risk for poor outcomes and high costs of medical care. The community care team involved a wide variety of service providers including the hospital, home health, housing, long term care, aging, and community mental health. Achievements include the successful services of a Health Coach, a focus on social determinants of health such as food security and housing needs, and supports for health promotion and disease prevention.

2. *The Inclusive Healthcare Partnership Project: Improving Health Care for Adult Vermonters with Intellectual and Developmental Disabilities, 2015*. The Vermont Developmental Disabilities Council in partnership with Green Mountain Self-Advocates produced a report with findings, recommendations, and opportunities for action to spark further consideration, investment, and innovation in the delivery of quality health care to adult Vermonters with intellectual and other developmental disabilities. This effort focused on transition services from pediatric to adult primary care; medical education and provider training; care models and practice transformation; and supports for health and wellness.

3. *Frail Elders Project, 2015-2016.* The Vermont Medical Society Foundation conducted the Frail Elders Project with the goal of improving the primary care delivery system for older Vermonters at risk of poor health outcomes or a decline in the quality of life. With the needs of older Vermonters as the paramount driver, the Frail Elders Project revealed a mismatch between reimbursable services and the needs of older Vermonters; and underscored the importance of older Vermonters remaining at home, retaining autonomy, being social engaged, and having a sense of purpose. These attributes were equal in importance to one's medical care. The Project advocated for a reform paradigm in which payment innovation for primary care supports practice innovation.

In conclusion, the analysis, collaboration, and products completed by the DLTSS Work Group reflect the opportunities and challenges involved in incorporating disability related issues and concerns in health care reform. Three years of planning have underscored the need for and importance of building a strong partnership between Vermont's community-based disability services and health care providers, while highlighting the value of person-centered and person-directed care.

The project owes a debt of gratitude to all the individuals, organizations, and consultants who have shared their commitment and expertise in shaping the resources summarized in this report. The longstanding members of the DLTSS Work Group infused the concerns and needs of individuals with disabilities (and their families) into the work of the Vermont Health Care Innovation Project. In so doing, they have helped to illuminate how these concerns must shape and inform the State's efforts to achieve the triple aim of enhancing quality of care, reducing unnecessary costs, and improving the health and social outcomes for Vermonters.

APPENDIX

1. Model of Care for People with Disabilities and Long Term Services and Supports Needs, June 2014: http://healthcareinnovation.vermont.gov/content/dltss-model-care-final-june-2014

2. Disability & Long Term Services and Supports Medicaid Expenditure Analysis, April 2015: http://healthcareinnovation.vermont.gov/content/medicaid-expenditure-analysis-final-april-2015

3. Disability Awareness Briefs, June 2015:
   - Introduction to Disability Awareness http://healthcareinnovation.vermont.gov/content/disability-awareness-brief-introduction-disability-awareness-june-2015
   - Disability Competency for Providers http://healthcareinnovation.vermont.gov/content/disability-awareness-brief-disability-competency-providers-june-2015
   - Disability Competency for Care Management Practitioners http://healthcareinnovation.vermont.gov/content/disability-awareness-brief-disability-competency-cm-practitioners-june-2015
   - Cultural Competency http://healthcareinnovation.vermont.gov/content/disability-awareness-brief-cultural-competency-june-2015
   - Accessibility http://healthcareinnovation.vermont.gov/content/disability-awareness-brief-accessibilty-june-2015
   - Universal Design http://healthcareinnovation.vermont.gov/content/disability-awareness-brief-universal-design-june-2015

4. Informed Consent, Privacy, Confidentiality, and Release Forms to Enable Information Sharing by Integrated Care Teams, April 2016: http://healthcareinnovation.vermont.gov/content/informed-consent-privacy-confidentiality-and-release-forms-enable-information-sharing

5. Overview of Shared Savings Programs (SSPs) and Accountable Care Organizations (ACOs) in Vermont, July 2014: http://healthcareinnovation.vermont.gov/content/july-2014-overview-shared-savings-programs-ssps-and-accountable-care-organizations-acos

6. ACOs and the DLTSS System, November 2014: http://healthcareinnovation.vermont.gov/content/acos-and-dltss-system-november-2014

7. DLTSS Performance Measures Reference Document, May 2014: http://healthcareinnovation.vermont.gov/content/dltss-performance-measures-reference-document-may-2014

8. Vermont Medicaid Shared Savings Program Quality Measures: Year 1 DLTSS Sub-Analysis, October 2016: http://healthcareinnovation.vermont.gov/content/vermont-medicaid-shared-savings-program-quality-measures-year-1-dltss-sub-analysis-october

9. DLTSS Information Technology Assessment, November 2015: http://healthcareinnovation.vermont.gov/content/dltss-information-technology-assessment-november-2015

10. DLTSS IT Gap Remediation Project, 2015-2016: http://healthcareinnovation.vermont.gov/content/dltss-it-gap-remediation-project-2015-2016

11. Promotion and funding for Core Competency and Disability Competency Trainings, 2015-2016: http://healthcareinnovation.vermont.gov/areas/practice-transformation/projects/core-competency-training

12. Payment Models, Value-Based Purchasing, and DLTSS Design Considerations, October 2015: http://healthcareinnovation.vermont.gov/content/value-based-purchasing-design-elements-dltss-presentation-october-2015

Sub-Grant Projects

1. The Caledonia and Essex Dual Eligible Project, 2014-2016: http://healthcareinnovation.vermont.gov/content/northeastern-vermont-regional-hospital

2. The Inclusive Healthcare Partnership Project: Improving Health Care for Adult Vermonters with Intellectual and Developmental Disabilities, 2015: http://healthcareinnovation.vermont.gov/content/developmental-disabilities-council

3. Frail Elders Project, 2015-2016: http://www.vmsfoundation.org/elders

Attachment 5: SIM Work Group Transitions: How to Stay Involved

SIM Work Group Transitions: How to Stay Involved

December 1, 2016

Purpose: *The purpose of this document is to provide information to individuals who have served on SIM Work Groups regarding new and existing opportunities to stay involved in Vermont health care reform work.*

Email distribution lists: Various State entities involved in health care reform maintain email distribution lists that provide information about Vermont's health care reform activities. Please contact the individuals below if you would like to be added to the distribution lists:

Email distribution list	Contact person
Agency of Human Services Global Commitment	Ashley Berliner[1]
Green Mountain Care Board	Jaime Fisher
Department of Disabilities, Aging, and Independent Living	Bard Hill

Websites: In addition to these email distribution lists, State Agencies and Departments maintain websites that provide information about health care reform and other activities:

- *Agency of Administration Office of Health Care Reform:* hcr.vermont.gov
- *Agency of Human Services:* humanservices.vermont.gov
- *AHS-Department of Disabilities, Aging, and Independent Living:* http://dail.vermont.gov/
- *AHS-Department of Health:* healthvermont.gov
- *AHS-Department of Vermont Health Access:* dvha.vermont.gov
- *Green Mountain Care Board:* gmcboard.vermont.gov

Advisory Boards and Committees: Some Agencies, Departments, and Divisions regularly consult stakeholders through formal Advisory Boards or other bodies. In many cases, members are appointed by the Governor following an application process. Below are a some examples of the boards and committees that may be of interest:

- *Agency of Human Services:* See http://humanservices.vermont.gov/boards-committees. Includes Human Services Board, Children and Family Council for Prevention Programs, Developmental Disabilities Council, Vermont Council on Homelessness, Institutional Review Board, and the Tobacco Evaluation and Review Board.
- *AHS-Department of Disabilities, Aging, and Independent Living:* See http://dail.vermont.gov/dail-boards. Includes DAIL Advisory Board, the Developmental Services State Program Standing Committee, the Governor's Commission on Alzheimer's Disease and Related Disorders, and numerous Division Advisory Boards and Committees.
- *AHS-Department of Vermont Health Access:* See http://dvha.vermont.gov/advisory-boards. Includes Medicaid and Exchange Advisory Board, Clinical Utilization Review, Drug Utilization Review Board, and multiple committees related to the Blueprint for Health.
- *Green Mountain Care Board:* See http://gmcboard.vermont.gov/board/advisory-committee. Includes GMCB Advisory Committee.

In addition to these groups, AHS' Medicaid Pathway process currently convenes two stakeholder groups. For more information about these groups, please contact Julie Corwin.

[1] All individuals listed use the State of Vermont email convention: firstname.lastname@vermont.gov.