VT Health Care Innovation Project - Payment Model Design and Implementation Work Group Meeting Agenda
Monday, February 1, 2016 1:00 PM – 3:00 PM.
EXE - 4th Floor Conf Room, Pavilion Building 109 State Street, Montpelier
Call in option: 1-877-273-4202 Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Decision Needed?	Relevant Attachments
1	1:00 – 1:05	Welcome and Introductions Approve meeting minutes	Cathy Fulton Andrew Garland	Y – Approve minutes	Attachment 1: January Meeting Minutes
2	1:05-1:20	Program Updates	Georgia Maheras	N	
3	1:20-1:50	APM Update	Lawrence Miller	N	
4	1:50-2:20	Frail Elder Project	Cyrus Jordan	N	Attachment 4: Frail Elder Project
5	2:20-2:50	Financing 101	Bard Hill and Sue Aranoff	N	Attachment 5: Financing DLTSS in VT
6	2:50-2:55	Public Comment		N	
7	2:55-3:00	Next Steps and Action Items		N	Next Meeting: Monday, March 21 DVHA Large Conference Room 312 Hurricane Lane, Williston

Attachment 1: January Meeting Minutes

Vermont Health Care Innovation Project
Payment Model Design and Implementation Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Monday, January 4, 2016, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Catherine Fulton called the meeting to order at 1:03pm. A roll call attendance was taken and a quorum was present. Lou McLaren moved to approve the December meeting minutes by exception. Bard Hill seconded. The minutes were approved with 3 abstentions (Mark Burke, Ed Paquin, and Jenney Samuelson). Cathy noted changes to the meeting agenda: Lawrence Miller was unable to attend the meeting and will present on the All-Payer Model in February; a PowerPoint presentation on the topic developed by Michael Costa and Ena Backus was distributed just prior to the meeting and will be resent in a different format following the meeting.	**The All-Payer Model PowerPoint will be resent following the meeting.**
2. 2015 Year in Review	Georgia Maheras presented on the project's work and accomplishments in 2015 (Attachment 2). The group discussed the following: • Paul Harrington asked whether we've made progress on deciding whether to pursue Medicaid Episodes of Care. Georgia replied that this is the subject of ongoing discussions with our federal partners, and this group will be updated when we have additional information. • Maura Graff asked what Integrated Communities Care Management Learning Collaborative wrap up means. Georgia replied that this is a year-long collaborative that provides support for a finite period. A part of wrapping up will include working with communities to understand ongoing needs and ensure communities can continue their work. Pat Jones and Erin Flynn added that while community work is ongoing, the collaborative is intended to be self-sustaining eventually. Jenney Samuelson noted that sustainability has been a part of the conversation from the start; in particular, local facilitators will continue to work with communities following the end of the collaborative. • Susan Aranoff asked how the VHCIP work groups will be involved in conversations around the All-Payer	

Agenda Item	Discussion	Next Steps
	Model, Next Generation Medicare ACO model, or single ACOs. Georgia responded that this is a topic of ongoing discussion with the State team working on All-Payer Model development and negotiation. • Lila Richardson asked for more information on EOCs. She expressed frustration that EOCs were selected without much input from this group, and does not believe this group has approved of this stream of work. Georgia replied that this is the subject of ongoing discussion with our federal partners. We are currently waiting to hear whether they will hold us to our initial commitment to pursue EOCs. If they do not require us to pursue episodes, we may elect to no longer focus on this work stream. If they do require us to pursue episodes, we will move forward to develop episodes with significant stakeholder (especially provider and advocate) input and guidance. While EOCs have been selected, EOC design is not complete and would incorporate significant stakeholder input in collaboration with DVHA leadership.. Lila responded that this is helpful and reassuring.	
3. Population Health Financing	Jim Hester presented on population health financing models (Attachments 3a and 3b). • This is an exciting time in the development of population health financing models both locally and nationally. Jim noted that we are starting to think about population health as an explicit outcome of our health system transformation, and that many across the country are starting to work toward sustainability (i.e., not time limited or grant-based) financing for population health and prevention activities. • Key concept: Capturing and reinvesting savings. • UCLA Health Delivery System Transformation Critical Path: Moving from episodic acute care (1.0), to person-centered care focused on patient panels (2.0), to care for a population in a geographic area (3.0). These stages are cumulative – we still need to be able to do acute care and patient-centered care, in addition to broader accountability for populations. We're mostly moving from 1.0 to 2.0 now, with a few communities working toward 3.0. • Differentiating between health care quality improvement focused on patient panel and population health improvement. • Concern that population health measures and payment model rewards may be locked out of future payment models if they are not explicitly and intentionally incorporated. o Paul Harrington asked whether population health measures would be in addition to or replacing current clinical quality measures. Jim replied that he expects these new measures will be additional, but that they won't be focused on clinician practice and wouldn't add to physician burden. o Richard Slusky commented that future capitated models or fixed revenue budgets incentivize improvements to population health in order to reduce hospital and specialty utilization. Jim agreed but noted that we also need to redirect attention to measures that are more distant from clinical care. o Mark Burke commented that we want to move away from proxy measures of health, like the shared savings measure set, and toward direct measures of population health outcomes that go beyond clinical outcomes.	

Agenda Item	Discussion	Next Steps

	• Medical care only accounts for a small portion of health outcomes.
	• Financing models: Where does the money come from to support population health activities? We often think about this for "2.0" clinical services.
	  o Innovative funding sources being developed include: hospitals (including hospital community benefit, and general investments), community development, social capital (social impact bonds), foundations, employers/businesses, prevention and wellness trusts.
	  o Backbone organizations.
	
	The group discussed the following:
	• Mark Burke asked if any of these financing mechanisms have been tested in small communities like Vermont's. Jim responded that some have, such as Community Development Financial Institutions (CDFIs) – he envisions our communities/regions as ACHs. Julie Tessler noted that it's challenging for small communities to take on risk. Jim replied that we have some learning to do, but that OneCare has good scale and is statewide – we need to figure out how this interacts with a community on the ground. We'll work out many of these details by trying them out and learning by doing.
	• Melissa Bailey praised this model and noted that just as this is an opportunity to change how we think about measures, it's also an opportunity to change how we deliver care and integrate social services.
	• Maura Graff asked for examples of population health measures. Jim responded that many of the BRFSS measures on risk behaviors are good examples. Heidi Klein added that the VHCIP Population Health Work Group and VDH are looking at this as well. This work focuses on measures we already collect. Karen Hein added that the Green Mountain Care Board Dashboard 2.0 also takes a population health approach. Melanie Sheehan from Mt. Ascutney added that a great deal of population health work is already being done through community prevention coalitions and VDH, and we need a mechanism to bring those players into these conversations in the future.	

4. All-Payer Model Update	Lawrence Miller was unable to attend this meeting; this item will be rescheduled for the February meeting of this Work Group.	
5. Public Comment	Cathy invited brainstorming and ideas about expanded scopes of service that could be included in future payment reform activities.	
6. Next Steps, and Action Items	For next meeting: • Brainstorm topics for future payment reform activities. • Review All-Payer Model presentation and send questions to Mandy Ciecior at Amanda.ciecior@vermont.gov **Next Meeting:** Monday, February 1, 2016, 1:00-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.	**Send questions about All-Payer Model presentation to Mandy Ciecior**

VHCIP Payment Model Design and Inplementation Work Group Member List

Mov 1° Bard 2° minutes approved 3 abstentions by exception

Monday, January 04, 2016					
Member		**Member Alternate**			
First Name	**Last Name**	**First Name**	**Last Name**	**Minutes**	**Organization**
Melissa	Bailey ✓	Shannon	Thompson ✓		AHS - DMH
	Joined late	Jaskanwar	Batra		AHS - DMH
		Kathleen	Hentcy		AHS - DMH
		Frank	Reed		AHS - DMH
Jill Berry	Bowen	Stephanie	Breault		Northwestern Medical Center
		Jane	Catton		Northwestern Medical Center
		Diane	Leach		Northwestern Medical Center
		Don	Shook		Northwestern Medical Center
		Ted	Sirotta		Northwestern Medical Center
Michael	Counter				VNA & Hospice of VT & NH
Diane	Cummings ✓	Shawn	Skafelstad ✓		AHS - Central Office
Mike	DelTrecco	Bea	Grause		Vermont Association of Hospital and Health Systems
Tracy	Dolan ✓	Heidi	Klein ✓		AHS - VDH
		Cindy	Thomas ✓		AHS - VDH
		Julie	Arel		AHS - VDH
Rick	Dooley ✓	Susan	Ridzon		HealthFirst
	Joined late	Paul	Reiss		HealthFirst
Kim	Fitzgerald	Stefani	Hartsfield		Cathedral Square and SASH Program
		Molly	Dugan		Cathedral Square and SASH Program
Aaron	French	Erin	Carmichael ✓		AHS - DVHA
		Nancy	Hogue ✓		AHS - DVHA
		Megan	Mitchell		AHS - DVHA
Catherine	Fulton ✓				Vermont Program for Quality in Health Care

VHCIP Payment Model Design and Inplementation Work Group Member List

Monday, January 04, 2016

Member		Member Alternate			
First Name	Last Name	First Name	Last Name	Minutes	Organization
Peter	Cobb	Beverly	Boget		VNAs of Vermont
Steve	Gordon	Mark	Burke	IA	Brattleboro Memorial Hopsital
Maura	Graff (joined late)	Heather	Bushey		Planned Parenthood of Northern New England
Dale	Hackett				Consumer Representative
Mike	Hall	Sandy	Conrad		Champlain Valley Area Agency on Aging / COVE
		Angela	Smith-Dieng		V4A
Paul	Harrington				Vermont Medical Society
Karen	Hein				University of Vermont
Bard	Hill	Patricia	Cummings		AHS - DAIL
		Susan	Aranoff		AHS - DAIL
		Gabe	Epstein		AHS - DAIL
Jeanne	Hutchins				UVM Center on Aging
Kelly	Lange	Teresa	Voci		Blue Cross Blue Shield of Vermont
Ted	Mable	Kim	McClellan		DA - Northwest Counseling and Support Services
		Amy	Putnam		DA - Northwest Counseling and Support Services
David	Martini				AOA - DFR
Lou	McLaren				MVP Health Care
MaryKate	Mohlman	Jenney	Samuelson	IA	AHS - DVHA - Blueprint
Ed	Paquin			IA	Disability Rights Vermont
Lila	Richardson	Kaili	Kuiper		VLA/Health Care Advocate Project

VHCIP Payment Model Design and Inplementation Work Group Member List

Monday, January 04, 2016					
Member		**Member Alternate**			
First Name	**Last Name**	**First Name**	**Last Name**	**Minutes**	**Organization**
Greg	~~Robinson~~	Miriam	Sheehey ✓		OneCare Vermont
		Abe	Berman ✓		OneCare Vermont
		Vicki	Loner		OneCare Vermont
Laural	Ruggles				Northeastern Vermont Regional Hospital
Julia	Shaw	Rachel	Seelig		VLA/Health Care Advocate Project
Kate	Simmons	Kendall	West		Bi-State Primary Care/CHAC
		Patricia	Launer ✓		Bi-State Primary Care
		Melissa	Miles		Bi-State Primary Care
		Heather	Skeels		Bi-State Primary Care
Richard	Slusky ✓	Pat	Jones ✓		GMCB
		Spenser	Weppler		GMCB
Julie	Tessler ✓				VCP - Vermont Council of Developmental and Mental Health Services
		Sandy	McGuire ✓		VCP - Howard Center
	32		45		

- Melanie Sheehy
- Joyce Gallimore
- Mike Nix
- Cindy Thompson
- Chris Smith
- Sandy McGuire
- Jesse De la Rosa

all on phone

VHCIP Payment Model Design and Inplementation Work Group

Attendance Sheet 1/4/2016

	First Name	Last Name		Organization	Payment Model Design and Implementation
1	Peter	Albert		Blue Cross Blue Shield of Vermont	X
2	Susan	Aranoff	here	AHS - DAIL	MA
3	Julie	Arel		AHS - VDH	MA
4	Bill	Ashe		Upper Valley Services	X
5	Lori	Augustyniak		Center for Health and Learning	X
6	Debbie	Austin		AHS - DVHA	X
7	Ena	Backus		GMCB	X
8	Melissa	Bailey		Vermont Care Partners	M
9	Michael	Bailit		SOV Consultant - Bailit-Health Purchasing	X
10	Susan	Barrett		GMCB	X
11	Jaskanwar	Batra		AHS - DMH	MA
12	Abe	Berman	phone	OneCare Vermont	MA
13	Bob	Bick		DA - HowardCenter for Mental Health	X
14	Mary Alice	Bisbee		Consumer Representative	X
15	Charlie	Biss		AHS - Central Office - IFS / Rep for AHS - DM	X
16	Beverly	Boget		VNAs of Vermont	MA
17	Mary Lou	Bolt		Rutland Regional Medical Center	X
18	Jill Berry	Bowen		Northwestern Medical Center	M
19	Stephanie	Breault		Northwestern Medical Center	MA
20	Martha	Buck		Vermont Association of Hospital and Health	A
21	Mark	Burke	here	Brattleboro Memorial Hopsital	MA
22	Donna	Burkett		Planned Parenthood of Northern New Engla	X
23	Catherine	Burns		DA - HowardCenter for Mental Health	X
24	Heather	Bushey		Planned Parenthood of Northern New Engla	MA
25	Giselc	Carbonneau		HealthFirst	A
26	Erin	Carmichael		AHS - DVHA	MA
27	Jan	Carney		University of Vermont	X
28	Denise	Carpenter		Specialized Community Care	X

29	Jane	Catton		Northwestern Medical Center	MA
30	Alysia	Chapman		DA - HowardCenter for Mental Health	X
31	Joshua	Cheney		VITL	A
32	Joy	Chilton		Home Health and Hospice	X
33	Amanda	Ciecior	here	AHS - DVHA	S
34	Barbara	Cimaglio		AHS - VDH	X
35	Daljit	Clark		AHS - DVHA	X
36	Sarah	Clark		AHS - CO	X
37	Peter	Cobb	phone	VNAs of Vermont	X
38	Judy	Cohen		University of Vermont	X
39	Lori	Collins		AHS - DVHA	X
40	Connie	Colman		Central Vermont Home Health and Hospice	X
41	Sandy	Conrad		V4A	MA
42	Amy	Coonradt		AHS - DVHA	S
43	Alicia	Cooper	here	AHS - DVHA	S
44	Janet	Corrigan		Dartmouth-Hitchcock	X
45	Brian	Costello			X
46	Michael	Counter		VNA & Hospice of VT & NH	M
47	Mark	Craig			X
48	Diane	Cummings	phone	AHS - Central Office	M
49	Patricia	Cummings		AHS - DAIL	MA
50	Michael	Curtis	here	Washington County Mental Health Services	X
51	Jude	Daye		Blue Cross Blue Shield of Vermont	A
52	Jesse	de la Rosa	phone	Consumer Representative	X
53	Danielle	Delong		AHS - DVHA	X
54	Mike	DelTrecco		Vermont Association of Hospital and Health	M
55	Yvonne	DePalma		Planned Parenthood of Northern New Engla	X
56	Trey	Dobson		Dartmouth-Hitchcock	X
57	Tracy	Dolan	phone	AHS - VDH	M
58	Michael	Donofrio		GMCB	X
59	Kevin	Donovan		Mt. Ascutney Hospital and Health Center	X
60	Rick	Dooley		HealthFirst	M
61	Molly	Dugan		Cathedral Square and SASH Program	MA
62	Lisa	Dulsky Watkins			X
63	Robin	Edelman	~~here~~	AHS - VDH	X
64	Jennifer	Egelhof	here	AHS - DVHA	MA

65	Suratha	Elango		RWJF - Clinical Scholar	X
66	Gabe	Epstein	here	AHS - DAIL	S/MA
67	Jamie	Fisher		GMCB	A
68	KIm	Fitzgerald		Cathedral Square and SASH Program	M
69	Katie	Fitzpatrick		Bi-State Primary Care	A
70	Patrick	Flood		CHAC	X
71	Erin	Flynn	here	AHS - DVHA	S
72	LaRae	Francis		Blue Cross Blue Shield of Vermont	X
73	Judith	Franz		VITL	X
74	Mary	Fredette		The Gathering Place	X
75	Aaron	French		AHS - DVHA	M
76	Catherine	Fulton	here	Vermont Program for Quality in Health Care	C
77	Joyce	Gallimore	phone	Bi-State Primary Care/CHAC	X
78	Lucie	Garand		Downs Rachlin Martin PLLC	X
79	Andrew	Garland	phone	MVP Health Care	M
80	Christine	Geiler		GMCB	S
81	Carrie	Germaine		AHS - DVHA	X
82	Al	Gobeille		GMCB	X
83	Larry	Goetschius		Home Health and Hospice	M
84	Steve	Gordon	phone	Brattleboro Memorial Hopsital	M
85	Don	Grabowski		The Health Center	X
86	Maura	Graff	here	Planned Parenthood of Northern New Engl	M
87	Wendy	Grant		Blue Cross Blue Shield of Vermont	A
88	Bea	Grause		Vermont Association of Hospital and Health	MA
89	Lynn	Guillett		Dartmouth Hitchcock	X
90	Dale	Hackett	here	Consumer Representative	M
91	Mike	Hall		Champlain Valley Area Agency on Aging / C	M
92	Thomas	Hall		Consumer Representative	X
93	Catherine	Hamilton		Blue Cross Blue Shield of Vermont	X
94	Paul	Harrington	phone	Vermont Medical Society	M
95	Stefani	Hartsfield		Cathedral Square	MA
96	Carrie	Hathaway		AHS - DVHA	X
97	Carolynn	Hatin		AHS - Central Office - IFS	S
98	Karen	Hein	phone	University of Vermont	M
99	Kathleen	Hentcy		AHS - DMH	MA
100	Jim	Hester	here	SOV Consultant	S

101	Selina	Hickman		AHS - DVHA	X
102	Bard	Hill	here	AHS - DAIL	M
103	Con	Hogan		GMCB	X
104	Nancy	Hogue	here	AHS - DVHA	M
105	Jeanne	Hutchins	here	UVM Center on Aging	M
106	Penrose	Jackson	here	UVM Medical Center	X
107	Craig	Jones		AHS - DVHA - Blueprint	X
108	Pat	Jones	here	GMCB	MA
109	Margaret	Joyal		Washington County Mental Health Services	X
110	Joelle	Judge	here	UMASS	S
111	Kevin	Kelley		CHSLV	X
112	Melissa	Kelly		MVP Health Care	X
113	Trinka	Kerr		VLA/Health Care Advocate Project	X
114	Sarah	King		Rutland Area Visiting Nurse Association & H	X
115	Sarah	Kinsler	here	AHS - DVHA	S
116	Heidi	Klein	here	AHS - VDH	MA
117	Tony	Kramer		AHS - DVHA	X
118	Peter	Kriff		PDI Creative	X
119	Kaili	Kuiper		VLA/Health Care Advocate Project	MA
120	Norma	LaBounty		OneCare Vermont	A
121	Kelly	Lange	phone	Blue Cross Blue Shield of Vermont	M
122	Dion	LaShay		Consumer Representative	X
123	Patricia	Launer	Phone	Bi-State Primary Care	MA
124	Diane	Leach		Northwestern Medical Center	MA
125	Mark	Levine		University of Vermont	X
126	Lyne	Limoges		Orleans/Essex VNA and Hospice, Inc.	X
127	Deborah	Lisi-Baker		SOV - Consultant	X
128	Sam	Liss		Statewide Independent Living Council	X
129	Vicki	Loner		OneCare Vermont	MA
130	Nicole	Lukas	here	AHS - VDH	X
131	Ted	Mable		DA - Northwest Counseling and Support Ser	M
132	Carole	Magoffin	phone	AHS - DVHA	S
133	Georgia	Maheras	phone	AOA	S
134	Jackie	Majoros		VLA/LTC Ombudsman Project	X
135	Carol	Maloney		AHS	X
136	Carol	Maroni		Community Health Services of Lamoille Vall	X

137	David	Martini	here	AOA - DFR	M
138	Mike	Maslack			X
139	John	Matulis			X
140	James	Mauro		Blue Cross Blue Shield of Vermont	X
141	Lisa	Maynes		Vermont Family Network	X
142	Kim	McClellan	here	DA - Northwest Counseling and Support Ser	MA
143	Sandy	McGuire	phone	VCP - HowardCenter for Mental Health	M
144	Jill	McKenzie			X
145	Lou	McLaren	phone	MVP Health Care	M
146	Darcy	McPherson		AHS - DVHA	X
147	~~Jessica~~	~~Mendizabal~~		AHS - DVHA	S
148	Anneke	Merritt		Northwestern Medical Center	X
149	Melissa	Miles		Bi-State Primary Care	MA
150	Robin	Miller		AHS - VDH	X
151	Megan	Mitchell		AHS - DVHA	MA
152	MaryKate	Mohlman	phone	AHS - DVHA - Blueprint	M
153	Madeleine	Mongan		Vermont Medical Society	X
154	Kirsten	Murphy		AHS - Central Office - DDC	X
155	Chuck	Myers		Northeast Family Institute	X
156	Floyd	Nease		AHS - Central Office	X
157	Nick	Nichols		AHS - DMH	X
158	Mike	Nix	phone	Jeffords Institute for Quality, FAHC	X
159	Miki	Olszewski		AHS - DVHA - Blueprint	X
160	Jessica	Oski		Vermont Chiropractic Association	X
161	Ed	Paquin	here	Disability Rights Vermont	M
162	Annie	Paumgarten	here	GMCB	S
163	Laura	Pelosi		Vermont Health Care Association	X
164	Eileen	Peltier		Central Vermont Community Land Trust	X
165	John	Pierce			X
166	Tom	Pitts		Northern Counties Health Care	X
167	Luann	Poirer		AHS - DVHA	S
168	Sherry	Pontbriand		NMC	X
169	Alex	Potter		Center for Health and Learning	X
170	Amy	Putnam		DA - Northwest Counseling and Support Ser	MA
171	Betty	Rambur		GMCB	X
172	Allan	Ramsay		GMCB	X

173	Frank	Reed		AHS - DMH	MA
174	Paul	Reiss		HealthFirst/Accountable Care Coalition of tl	MA
175	Virginia	Renfrew		Zatz & Renfrew Consulting	X
176	Lila	Richardson	phone	VLA/Health Care Advocate Project	M
177	Susan	Ridzon		HealthFirst	MA
178	Carley	Riley			X
179	Laurie	Riley-Hayes		OneCare Vermont	A
180	Greg	Robinson		OneCare Vermont	M
181	Brita	Roy			X
182	Laural	Ruggles		Northeastern Vermont Regional Hospital	M
183	Jenney	Samuelson	here	AHS - DVHA - Blueprint	MA
184	Howard	Schapiro		University of Vermont Medical Group Pract	X
185	seashre@msn	seashre@msn.com		House Health Committee	X
186	Rachel	Seelig		VLA/Senior Citizens Law Project	MA
187	Susan	Shane		OneCare Vermont	X
188	Julia	Shaw		VLA/Health Care Advocate Project	M
189	Melanie	Sheehan	phone	Mt. Ascutney Hospital and Health Center	X
190	Miriam	Sheehey	phone	OneCare Vermont	MA
191	Don	Shook		Northwestern Medical Center	MA
192	Kate	Simmons		Bi-State Primary Care/CHAC	M
193	Colleen	Sinon		Northeastern Vermont Regional Hospital	X
194	Ted	Sirotta		Northwestern Medical Center	MA
195	Shawn	Skafelstad	here	AHS - Central Office	MA
196	Heather	Skeels		Bi-State Primary Care	MA
197	Richard	Slusky	phone	GMCB	M
198	Chris	Smith	phone	MVP Health Care	X
199	Angela	Smith-Dieng		V4A	MA
200	Jeremy	Ste. Marie		Vermont Chiropractic Association	X
201	Jennifer	Stratton		Lamoille County Mental Health Services	X
202	Beth	Tanzman		AHS - DVHA - Blueprint	X
203	JoEllen	Tarallo-Falk		Center for Health and Learning	X
204	Julie	Tessler	here	VCP - Vermont Council of Developmental ar	M
205	Cindy	Thomas	phone	AHS - VDH	MA
206	Shannon	Thompson	phone	AHS - DMH	MA
207	Bob	Thorn		DA - Counseling Services of Addison County	X
208	Win	Turner			X

209	Karen	Vastine		AHS-DCF	X
210	Teresa	Voci	Phone	Blue Cross Blue Shield of Vermont	MA
211	Nathaniel	Waite		VDH	X
212	Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	X
213	Marlys	Waller		DA - Vermont Council of Developmental an	X
214	Nancy	Warner		COVE	X
215	Julie	Wasserman	here	AHS - Central Office	S
216	Monica	Weeber		AHS - DOC	X
217	~~Spenser~~	~~Weppler~~		GMCB	MA
218	Kendall	West		Bi-State Primary Care/CHAC	MA
219	James	Westrich	here	AHS - DVHA	S
220	Robert	Wheeler		Blue Cross Blue Shield of Vermont	X
221	Bradley	Wilhelm		AHS - DVHA	S
222	Jason	Williams		UVM Medical Center	X
223	Sharon	Winn		Bi-State Primary Care	X
224	Stephanie	Winters		Vermont Medical Society	X
225	Mary	Woodruff			X
226	Cecelia	Wu		AHS - DVHA	S
227	Erin	Zink		MVP Health Care	X
228	Marie	Zura		DA - HowardCenter for Mental Health	X
229	Joshua	Plavin		Blue Cross Blue Shield of Vermont	X
230	Sarah	Relk			X
231	Hillary	Wolfley			X
					231

Attachment 4: Frail Elder Project

VHCIP Frail Elders Project

Josh Plavin MD MPH
Brian Costello MD
Cyrus Jordan MD MPH

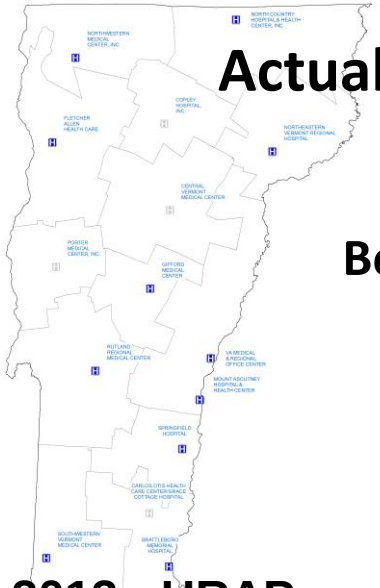
Fay Homan MD
Milt Fowler MD
Erica Garfin MA
Randy Messier MT, MSA, PCMH CCE
Steve Kappel
Nancy Bianchi MSLIS

February 1, 2016

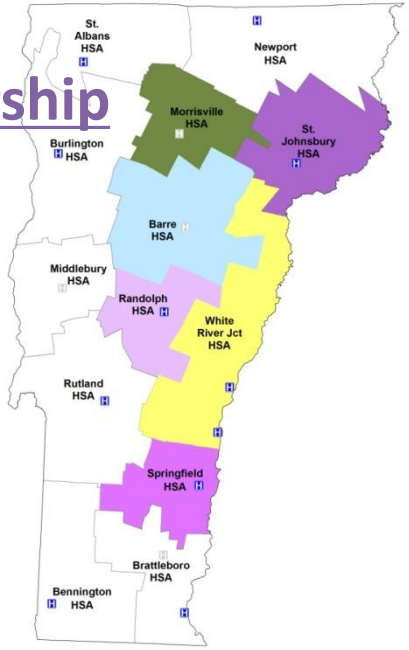
VMS Education & Research Foundation

helping physicians help patients & communities

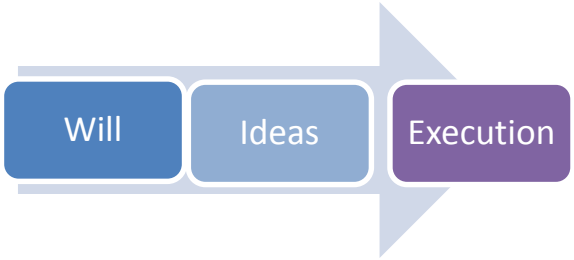
The Green Mountain Care Board
and
VMS Education and Research Foundation



Actualizing reform thru clinician leadership



Better quality, Better health, Lower costs



June 2013 - HRAP
Health Resource Allocation Plan

VMS Education & Research Foundation

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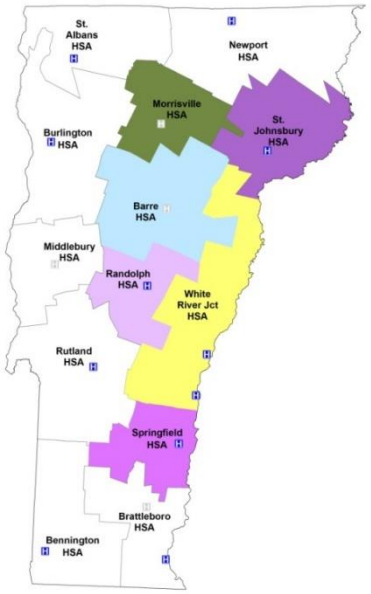
Thursday December 12th, 2013

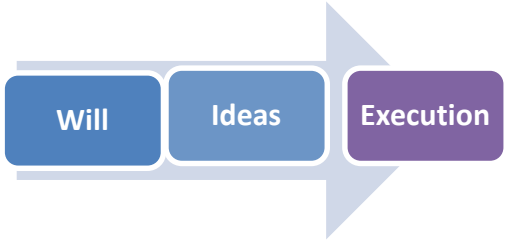
Rural Clinicians Community
GMCB Presentation



Better care, better health, lower costs

How can leaders accelerate innovation?

"You have to have the *will* to improve; You have to have *ideas* about alternatives to the status quo; and then you have to make it real through *execution*. All three have to be arranged by leaders – they are not automatic."



1. Actualize 3 planned levels of care
2. Make VT a magnet for the workforce
3. Become the national benchmark for measurement
4. Reduce the gap between practice and policy

Saturday January 25th, 2014

Vermont Academy of Family Physicians

VERMONT DEPARTMENT OF HEALTH

Actualizing reform thru clinician leadership

Better quality, Better health, Lower costs

1. **Core community based and planned regionalized clinical services**
2. **Integrating social and community services with clinical services**
3. **Measuring things that matter to patients, practices and policymakers**

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VHCIP Frail Elders Project

Target Population

Seniors at risk of a decline in the quality of their lives or a poor health outcome

Frail Elderly Global Aim

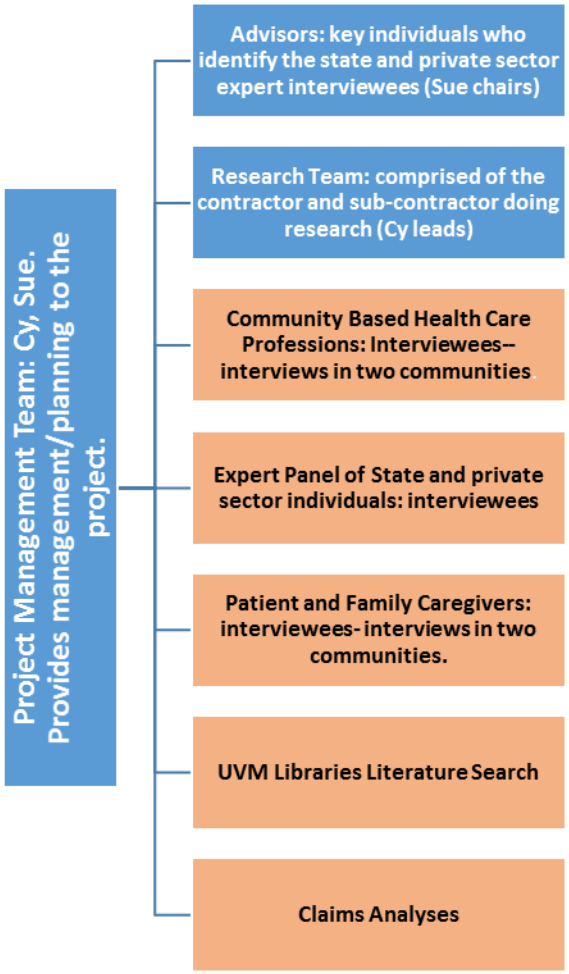
We aim to identify barriers to providing the best primary care for high-risk elders in two rural communities; and recommend: 1) Practice changes to primary care, community based care and supportive services which will improve outcomes that matter to patients; 2) Payment innovations to support the redesigns; and 3) Measures to track changes in outcomes that matter to patients.

The project begins with a literature search serving as the cornerstone for our research and recommendations. The principal method for problem identification will be structured interviews with patients, families, caregivers and community based health care professionals. State and regional policy and content experts will be interviewed. Analysis of public claims data bases will complement the qualitative research.

The effort ends with a written report and public presentation of our findings and recommendations to the VHCIP Payment Models Work Group in June 2016.

By undertaking this effort we expect to increase the value of the health care system – focusing on outcomes that matter to patients, reducing harm, conserving resources and increasing system efficiencies.

VHCIP Frail Elders Project



VHCIP Frail Elders Project

Research Focus Areas

1. **What characterizes a frail or high risk senior?**
2. **What are the characteristics of their service utilization?**
3. **What matters to seniors?**
4. **Are there care models known to produce better value (outcomes/cost)?**
5. **What systemic barriers to providing care exist?**
6. **What aspects of the delivery system are and are not working locally?**
7. **How could the local delivery system be improved?**
8. **What are practical and meaningful measures of value? (things that matter to patients/cost of meaningful episodes of care)**
9. **How can seniors be attributed to medical homes?**
10. **What are unnecessary costs and how could they be reduced?**
11. **How can payment reform support the achievement of things that matter to patients?**

VHCIP Frail Elders Project

Potential Provider Informant Categories

Category	Gifford	Little Rivers
Medical clinicians – at multiple clinic sites		
• Primary care MDs/DOs	**X**	**X**
• PAs and APRNs	**X**	**X**
• Office nurses	**X**	**X**
• Mental health clinicians	**X**	**X**
• Hospitalists/discharge planners	**X**	**?**
FQHC Care coordinator	**X**	**X**
SASH	**X**	**X**
Adult Day	**X**	**X**
Area Agency on Aging	**X**	**X**
Blueprint project manager	**X**	**X**
Home health	**X**	**X**
Senior center	**X**	**X**
Assisted living/residential care/ Sr. housing provider	**X**	**X**

VHCIP Frail Elders Project

Workplan and Responsibilities

November 13 thru December 2, 2015 — 20 days

Overall intent of project, deliverables and recommendations - Team consensus

Identification of overarching research questions - Team consensus

Interview tools – Erica and Brian; approved by team consensus

Identification of policy informants – Cy and Sue

Identification of provider informants – Milt, Fay,
Identification of patient, family and caregiver informants – Milt, Fay

December 3 thru December 31, 2015 —28 days

Begin utilization data analysis – Steve

Preliminary analysis and report of Literature Review – Brian and Nancy

January 2, 2016 thru February 28, 2016 – 60 days

Schedule interviews — Erica and Brian

Conduct policy expert interviews – Erica

Conduct community provider interviews - Erica

Conduct patient, family/caregiver interviews – Brian/Cy

Conduct utilization data analyses – Steve

March 1 thru March 31 – 30 days

Analysis and written report of policy and community provider interviews – Erica

Analysis and written report of patient, family and caregiver interviews – Brian

Final report of utilization data analyses - Steve

Final analysis and report of Literature Review – Brian and Nancy

April 1 thru May 30 – 60 days

Aggregate analysis prepared – Cy/Josh/Randy

Approved by team consensus process

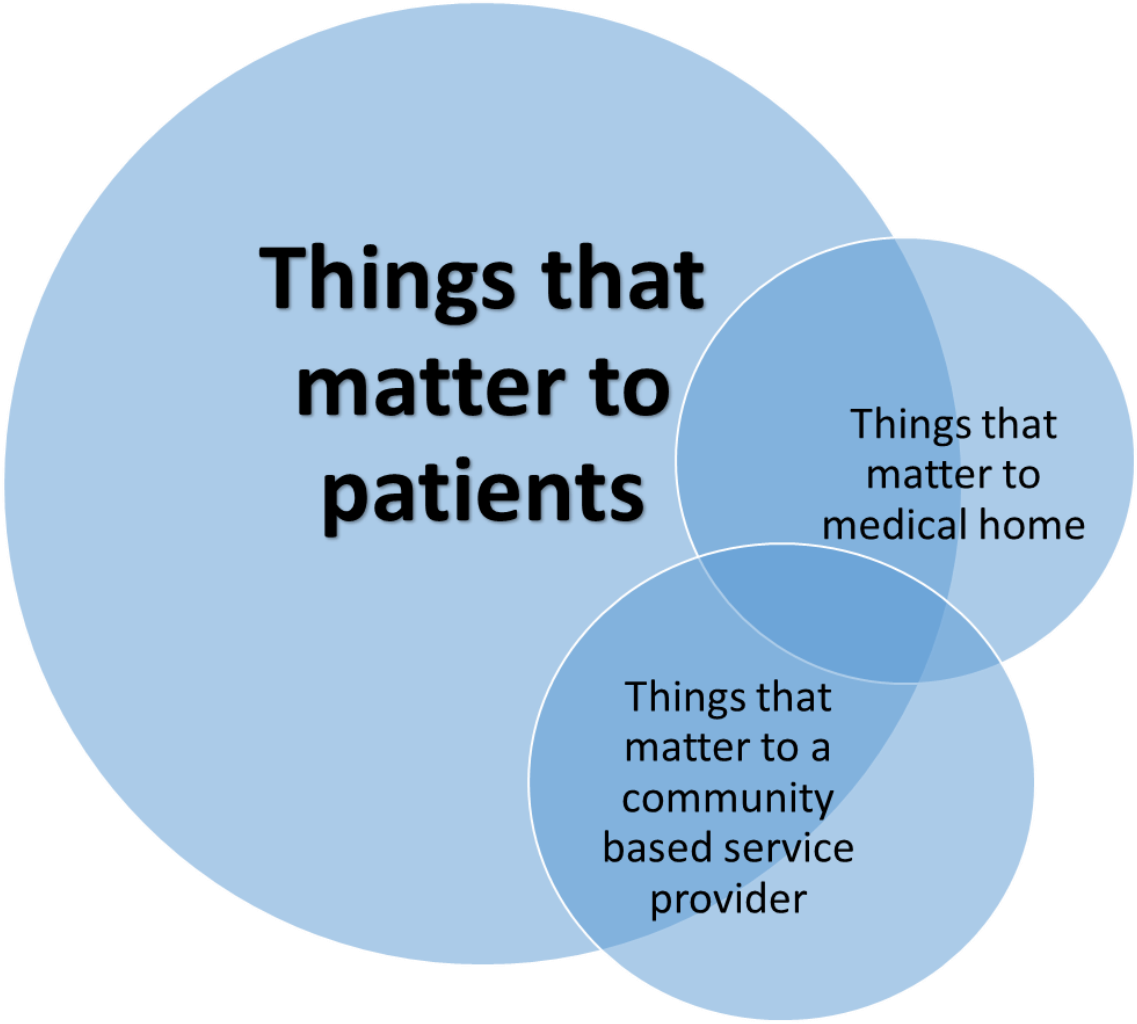
Final report and presentation prepared – Cy/Josh/Randy

Approved by team consensus process

June 1, 2016

Final written report and PowerPoint presentation complete and ready for distribution

VHCIP Frail Elders Project



VHCIP Frail Elders Project

Josh Plavin MD MPH
Brian Costello MD
Cyrus Jordan MD MPH

Fay Homan MD
Milt Fowler MD
Erica Garfin MA
Randy Messier MT, MSA, PCMH CCE
Steve Kappel
Nancy Bianchi MSLIS

February 1, 2016

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Attachment 5: Financing DLTSS in VT

The Basics of Financing Disability and Long Term Services and Supports In Vermont

What are Disability and Long-term Services and Supports (DLTSS):

- A diverse range of services that support people with physical, cognitive or mental health conditions.
- These services help people maximize and maintain their health and independence in settings and ways they desire.

What kinds of services are they?

- DLTSS include medical, mental health, substance use, developmental disability, and socioeconomic services and supports.
- An individual's DLTSS needs may be simple or complex, and can vary over time.
- DLTSS can improve a person's well-being, prevent the need for care in more expensive, and control health care costs.

DLTSS Services include:

- Personal Care
- Employment support
- Housing support
- Transportation support
- Therapies e.g. Psychiatry, counseling, occupational therapy, substance use
- Crisis support services
- Assistive technology
- Long-term care provided in home and community-based settings or in nursing homes (in Vermont, the majority of DLTSS are provided in community settings).
- Care management / service coordination

DLTSS services are Person - Centered

- DLTSS strongly emphasizes individual choice and control.
- DLTSS services vary according to individual needs and preferences.
- Some people may receive medical services- others not. Some people receive personal care - others not. Some people receive vocational support – others not.
- Each person’s unique needs and goals are captured in individualized service plans.

DLTSS and Health Care Reform

- For at least a decade, there has been consensus that older people and those with disabilities or multiple chronic conditions are the most complex and expensive populations that Medicaid supports.

(Sources: Kaiser, Robert Wood Johnson, Center for Health Care Strategies, CMS)

DLTSS Expenditures

- In 2012, Vermont spent approximately $770 million on DLTSS services for approximately 40,000 Medicaid enrollees.
- Those 40,000 Vermonters comprised 25% of the Medicaid enrollees and yet accounted for more than 70% of the total Medicaid expenditures.
- Likewise, they accounted for more then 1/3 of the total $488 million in Medicaid expenditures for traditional medical services for all Medicaid enrollees.
- In sum, DLTSS expenses accounted for 55% of the total 1.1 billion Medicaid expenditure.

(Source: State of Vermont DLTSS Medicaid Expenditures CY12, S. Wittman/PHPG presentation to Payment Models Work Group, November, 2015)

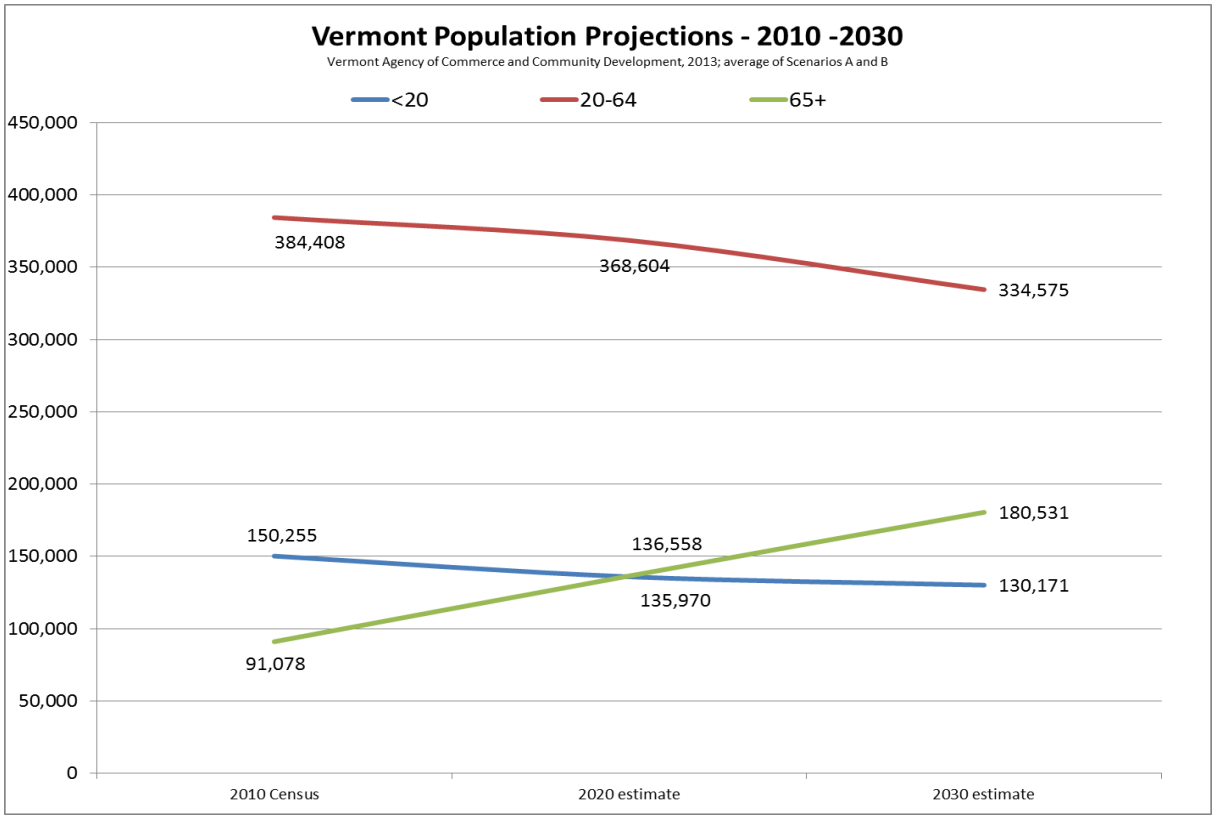
DLTSS and Health Reform:

The integration of care (primary care, acute care, chronic care, substance use services, disability and long-term services and supports) is an effective approach to pursuing the triple aim: improved health quality, better experience of care, and lower costs. (*Source: Commonwealth Care Alliance).*

In order to achieve the triple aim in Vermont, responsive, community-based, integrated, person-centered services need to be available across the full continuum of care – from prevention through life-long supports.

What are some of the DLTSS demographic pressures in Vermont?

A growing percentage of Vermonters are aging and many will need supports in the future. The proportion of Vermont's population that is 65 and older is growing more rapidly than other components of the population. The Vermont Agency of Commerce and Community Development population projections show that 28 percent of Vermont's population will be 65 and older by the year 2030, an increase of 98 percent from 2010.



Disability and Poverty:

What we know, and what we don't know…

Estimated percentage of Vermont population age 65+ with a disability or in poverty													
US Census American Community Survey: three-year estimates													
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2020	2030	2040
disability	39.4%	37.8%*	35.6%*	35.6%	34.9%	33.6%	33.4%	34.5%*	?	?	?	?	?
poverty	9.0%	8.3%	8.0%	8.0%	7.4%	7.1%	7.3%	7.1%*	?	?	?	?	?
* *one-year estimate; three-year estimate not available*													

Medicaid, Medicare, and DLTSS

Financing and Administration

- Medicare
  - Medicare Benefits are funded by the federal government.
  - Medicare is administered by the federal government.
- Medicaid
  - States are free to design their programs as they choose, subject to federal rules and guidelines.
  - The federal government pays a portion of the cost of benefits and states pay a portion of the cost.

Medicaid

- States must serve certain groups of people and provide certain basic services.
- States may also include optional groups of people and optional services and still receive federal funding.
- Services and people that the federal government will not pay for include housing and people with high incomes.

Beneficiaries and Benefits

- Medicare
  - Serves people 65 and over and people with disabilities.
  - Pays for basic medical care: e.g. Hospitals, physicians, prescription drugs, short-term rehabilitation.
- Medicaid
  - Serves people who cannot afford to pay for their care:
    - Based on percent of federal poverty limits and/or specific health conditions: Blindness/visual impairment, pregnancy, children with disabilities.
  - Provides benefits not available through Medicare:
    - E.g. Community-based DLTSS, nursing home based DLTSS, modest dental care, non-emergency transportation.

Medicaid pays for services that are not available through Medicare or most commercial health insurance* e.g.

- Personal Care Services
- Non-emergency Medical Transportation
- Long term services and supports in home and community based settings and in skilled nursing facilities*
- High tech services for children and adults*
- Behavioral Health*
- Dental Care*
- Supported employment
- Respite for Care-Givers
- Assistive devices
- Home modification

* Commercial insurance may cover some services

Table 2. Items and services covered by Medicare and Medicaid

Category	Medicare	Medicaid
Inpatient and institutional	Inpatient hospital services, with limits on covered days in a benefit period (see Table 3)	Mandatory: Inpatient hospital services
	Inpatient psychiatric services, with limits on covered days and a lifetime limit on total covered days in a psychiatric hospital (see Table 3)	Optional: Inpatient psychiatric services for individuals under age 21 and mental health facility services for individuals ages 65 and older
	SNF, long-term care hospital, and inpatient rehabilitation facility services (all limited to post-acute care); SNF coverage has a limit on covered days (see Table 3), and other settings are subject to hospital covered-day limits	Mandatory: Nursing facility services (for both post-acute and long-term care)
		Optional: Intermediate care facility services for individuals with intellectual disabilities
Outpatient and home- and community-based	Home health services (limited to individuals who require skilled care)	Mandatory: Home health (not limited to individuals who require skilled care)
	Outpatient hospital, federally qualified health center, rural health clinic, ambulatory surgical center, and dialysis facility services	Mandatory: Outpatient hospital, federally qualified health center, rural health clinic, and freestanding birth center services
		Optional: Other clinic services
	Services of physicians and other practitioners and suppliers	Mandatory: Physician, nurse practitioner, nurse midwife, lab and X-ray, and family planning services and supplies
		Optional: Chiropractor and other licensed-practitioner services
	Durable medical equipment	Optional: Durable medical equipment; hospice; prescription drugs; personal and other home- and community-based care; targeted case management; rehabilitation; private-duty nursing; dental; vision; speech and hearing; occupational and physical therapy; and other diagnostic, screening, preventive, and rehabilitative services
	Hospice services	
	Prescription drugs	
Other	Not applicable	Mandatory: Nonemergency transportation to medical care
		See Table 1 for Medicaid coverage of Medicare premiums and cost sharing for dual-eligible beneficiaries. See Table 3 for Medicare premium and cost-sharing amounts.

Note: *SNF (skilled nursing facility). Certain Medicaid beneficiaries are not entitled to full benefits and receive a more limited set of services (see Table 1 for information on dual-eligible beneficiaries who receive limited Medicaid benefits). With certain exceptions, states may place limits on the coverage of mandatory and optional Medicaid benefits for beneficiaries, including those who are dually eligible.*

Source: *Social Security Act and Centers for Medicare & Medicaid Services 2013c.*