VHCIP Steering Committee Meeting Agenda 2-25-2015

Vermont Health Care Innovation Project
DRAFT Steering Committee Meeting Agenda

February 25, 2015, 1:00pm-3:00 pm
4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier, VT
Call-In Number: 1-877-273-4202; Passcode: 8155970

Item #	Time Frame	Topic	Presenter	Relevant Attachments	Action Needed?
1	1:00-1:05pm	Welcome and Introductions	Al Gobeille and Steven Costantino		
2	1:05-1:10pm	Core Team Update *Public comment*	Lawrence Miller		
3	1:10-1:15pm	Minutes Approval	Al Gobeille and Steven Costantino	Attachment 1: November Meeting Minutes	Approval of Minutes
4	1:15-1:35pm	2014 Year in Review: Progress and Major Activities *Public comment*	Georgia Maheras	Attachment 2: Project Update	
5	1:35-2:15pm	Discussion: Steering Committee Roles and Decision-Making Process *Public comment*	Al Gobeille and Steven Costantino	Attachment 3: Memo: Steering Committee Agendas and Role Clarity	
6	2:15-2:45pm	Work Group Policy Recommendations: • ACO Care Management Standards • Letter to the Governor on DLTSS Funding *Public comment*	Pat Jones and Erin Flynn; Georgia Maheras	Attachment 4: ACO Care Management Standards Attachment 5: Cover Memo and Letter to the Governor on DLTSS Funding	Approval of ACO Care Management Standards and Letter to the Governor on DLTSS Funding

7	2:45-2:55pm	Work Group Funding Proposals: • Frail Elders Proposal • Jim Hester Contract *Public comment*	Georgia Maheras; Heidi Klein	Attachment 6: Steering Committee Financial Proposals, February 25, 2015 Attachment 6a: Frail Elders Proposal and Budget Attachment 6b: Jim Hester Contract	Approval of Frail Elders Proposal and Jim Hester Contract
8	2:55-3:00pm	Next Steps, Wrap-Up and Future Meeting Schedule	Al Gobeille and Steven Costantino	Next Meeting: April 1, 2015, 1:00pm-3:00pm, Williston	

Attachment 1 –
VHCIP Steering Committee Meeting Minutes 11-21-2014

VT Health Care Innovation Project
VT Health Care Innovation Project
Steering Committee Meeting Minutes

Pending Approval

Date of meeting: November 21, 2014 at 4th Floor Large Conference Rm – Pavilion Building, Montpelier 9 am - 11 am

Agenda Item	Discussion	Next Steps
Welcome and Introductions	Al Gobeille called the meeting to order at 9:03 am.	
Public Comment	None provided at this time	
Minutes Approval	John Evans moved to approve the minutes. Bob Dale Hackett seconded the motion. A roll call was taken and the minutes were approved with five abstentions.	
Core Team Update *Public comment*	Anya Rader Wallack provided an update on Core Team activities: 1. Update on the Medicaid SSP Contract renewal: DVHA extended the deadline for the decision around expansion of the year two total cost of care until December 31st. This will allow their boards to review the impact of a potential expansion. 2. We submitted the Year Two Operational Plan to CMMI at the beginning of November. It is posted on our website, and Georgia will provide more info later in the agenda. 3. The VHCIP hosted a Workforce Symposium on November 10th- thanks to those to attended and participated in this great meeting. 4. The Core Team approved seven more sub-grants as part of	

	the sub-grant program. These grant agreements are now being executed and details about the projects are available on our website. 5. We convened a retreat for co-chairs and staff and the Core Team to discuss activities to date and year two activities.	
Financial Request: 1. Payment Models Work Group: Frail Elderly Proposal *Public comment*	Georgia Maheras provided a brief overview of this proposal and then turned it over to Dr. Cy Jordan. Cy provided background on the project, which is to identify the challenges with appropriately treating the rural frail elder population and come up with recommendations. The key is to identify what matters to the patients and their families. Numerous questions were asked focusing on the purpose of the proposal, who would be involved, how the project is structured. Cy indicated that the hope is to involve AAAs, DAIL, VNAs, SASH, FQHCs, local departments of health and others who interact with these Vermonters. The project would start with defining who is in the frail elder population, interview frail elders and interview providers (primary care, speciality, and LTSS). The Steering Committee clarified that the budget was for Cy Jordan to direct the work and for two contractors to perform the surveys and qualitative research. The Steering Committee agreed that there is a problem that needs to be more completely identified and that the proposal should be further developed to more accurately reflect the request. Nancy Eldridge moved to table this proposal to the January 7th meeting. This was second by Mary Val Palumbo and approved by roll call.	A small group will convene to work on this proposal and bring it back to the Steering Committee on January 7th.

Financial Request: HIE/HIT Work Group: Population-Based Collaboration Remediation Plan *Public Comment*	Georgia briefly introduced this proposal and handed it off to Simone Rueschemeyer. Simone provided background on the work group process and then asked John Evans and Kristina Choquette to present the proposal. The Steering Committee asked clarifying questions about the potential impact of this gap remediation, the timeline, who will have access to these data and the budget. Kristina confirmed that the data flowing through would be available to all providers, with appropriate access, who use the Vermont Health Information Exchange. Additionally, this will significantly reduce the need for manual chart pull for quality measures and provide quality data for analyses. The technical architecture allows for additional data elements to be added, or removed, as the quality measure sets get modified over time. Simone moved to approve this proposal. Dale Hackett seconded it. The motion was approved, with one recusal, through a roll call.	
Policy Update: Operational Plan	This item was not discussed due to lack of time, but Steering Committee members are encouraged to review the Operational Plan and contact Georgia with any questions.	
Next Steps, Wrap-Up and Future Meeting Schedule	Next Meeting: January 7, 2015 1pm-3pm, Montpelier	

VHCIP Steering Committee Participant List

Attendance: | 11/21/2014

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

First Name	Last Name		Organization	Steering Committee
Susan	Aranoff		AHS-DAIL	X
Ena	Backus		GMCB	X
Melissa	Bailey	MBailey	VT Care Network / VT Careparthers	X
Heidi	Banks		Vermont Information Technology Leaders	X
Rick	Barnett		Vermont Psychological Association	M
Susan	Barrett		GMCB	X
Anna	Bassford		GMCB	A
Jaskanwar	Batra		AHS - DMH	MA
Abe	Berman		OneCare Vermont	MA
Susan	Besio		SOV Consultant - Pacific Health Policy Group	S
Bob	Bick		HowardCenter for Mental Health	M
Martha	Buck		Vermont Association of Hospital and Health Systems	A
Amanda	Ciecior		AHS - DVHA	S
Peter	Cobb	Peter C	VNAs of Vermont	M
Lori	Collins		AHS - DVHA	X
Amy	Coonradt		AHS - DVHA	S
Alicia	Cooper		AHS - DVHA	S
Elizabeth	Cote		Area Health Education Centers Program	M
Diane	Cummings	DCummings	AHS - Central Office	S
Susan	Devoid		OneCare Vermont	A

Tracy	Dolan		AHS - VDH	M
Richard	Donahey		AHS - Central Office	X
Susan	Donegan		AOA - DFR	M
Paul	Dupre		AHS - DMH	M
Nancy	Eldridge		Cathedral Square and SASH Program	M
John	Evans		Vermont Information Technology Leaders	M
Katie	Fitzpatrick		Bi-State Primary Care	A
Erin	Flynn		AHS - DVHA	S
Aaron	French		AHS - DVHA	X
Catherine	Fulton		Vermont Program for Quality in Health Care	M
Joyce	Gallimore		Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Don	George		Blue Cross Blue Shield of Vermont	M
Jim	Giffin		AHS - Central Office	X
Al	Gobeille		GMCB	C
Bea	Grause		Vermont Association of Hospital and Health Systems	M
Sarah	Gregorek		AHS - DVHA	A
Lynn	Guillett		Dartmouth Hitchcock	M
Dale	Hackett		None	M
Mike	Hall		Champlain Valley Area Agency on Aging	M
Janie	Hall		OneCare Vermont	A
Thomas	Hall		Consumer Representative	X
Bryan	Hallett		GMCB	S
Paul	Harrington		Vermont Medical Society	M
Carrie	Hathaway		AHS - DVHA	X
Diane	Hawkins		AHS - DVHA	X
Karen	Hein			X
Debbie	Ingram		Vermont Interfaith Action	M
Craig	Jones		AHS - DVHA - Blueprint	M

Kate	Jones		AHS - DVHA	S
Pat	Jones		GMCB	S
Joelle	Judge		UMASS	S
Trinka	Kerr		VLA/Health Care Advocate Project	M
Heidi	Klein		AHS - VDH	S/MA
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Mark	Larson		AHS - DVHA	C
Monica	Light		AHS - Central Office	M
Deborah	Lisi-Baker		Unknown	M
Sam	Liss		Statewide Independent Living Council	X
Robin	Lunge		AOA	X
Georgia	Maheras		AOA	S
Steven	Maier		AHS - DVHA	S
Jackie	Majoros		VLA/LTC Ombudsman Project	M
Carol	Maloney			X
Mike	Maslack			X
Alexa	McGrath		Blue Cross Blue Shield of Vermont	A
Darcy	McPherson		AHS - DVHA	X
Marisa	Melamed		AOA	A
Madeleine	Mongan		Vermont Medical Society	X
Todd	Moore		OneCare Vermont	M
Brian	Otley		Green Mountain Power	X
Dawn	O'Toole		AHS - DCF	X
Mary Val	Palumbo		University of Vermont	M
Ed	Paquin		Disability Rights Vermont	M
Annie	Paumgarten		GMCB	S
Laura	Pelosi		Vermont Health Care Association	M
Judy	Peterson		Visiting Nurse Association of Chittenden and Grand Isle Countie	M
Luann	Poirer		AHS - DVHA	S
Allan	Ramsay		GMCB	M

Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Simone	Rueschemeyer		Vermont Care Network	M
Jenney	Samuelson		AHS - DVHA - Blueprint	X
Larry	Sandage		AHS - DVHA	S
Howard	Schapiro		University of Vermont Medical Group Practice	M
Ken	Schatz		AHS - DCF	M
Julia	Shaw		VLA/Health Care Advocate Project	X
Shawn	Skaflestad		AHS - Central Office	X
Mary	Skovira		AHS - VDH	A
Richard	Slusky		GMCB	S
Kara	Suter		AHS - DVHA	S
Beth	Tanzman		AHS - DVHA - Blueprint	X
Julie	Tessler		Vermont Council of Developmental and Mental Health Services	M
Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	S
Anya	Wallack		SIM Core Team Chair	X
Julie	Wasserman		AHS - Central Office	S
Spenser	Weppler		GMCB	S
Kendall	West			X
James	Westrich		AHS - DVHA	S
Bradley	Wilhelm		AHS - DVHA	S
Sharon	Winn		Bi-State Primary Care	M
Cecelia	Wu		AHS - DVHA	S
				102

to table
2° Mary Val appʼd
1° Nancy 2° Dale
1° Simone

approved
2° Dale
1° John Evans
minutes

VHCIP Steering Committee Member List

Roll Call: 11/21/2014

Member		Member Alternate		Frail Elders	HIE	
First Name	Last Name	First Name	Last Name			Organization
Rick	Barnett					Vermont Psychological Association
Bob	Bick					HowardCenter for Mental Health
Peter	Cobb ✓			✓	✓	VNAs of Vermont
Elizabeth	Cote					Area Health Education Centers Program
Tracy	Dolan	Heidi	Klein			AHS - VDH
Susan	Donegan					AOA - DFR
Paul	Dupre ✓	Jaskanwar	Batra	✓	✓	AHS - DMH
Nancy	Eldridge ✓			✓	x	Cathedral Square and SASH Program
John	Evans ✓			✓	pre WSE	Vermont Information Technology Leaders
Catherine	Fulton					Vermont Program for Quality in Health Care
Joyce	Gallimore ✓			✓	✓	Bi-State Primary Care/CHAC
Don	George					Blue Cross Blue Shield of Vermont
Al	Gobeille ✓			✓	✓	GMCB
Bea	Grause					Vermont Association of Hospital and Health Systems
Lynn	Guillett					Dartmouth Hitchcock
Dale	Hackett ✓			✓	✓	None
Mike	Hall					Champlain Valley Area Agency on Aging
Paul	Harrington					Vermont Medical Society
Debbie	Ingram					Vermont Interfaith Action
Craig	Jones ✓			✓	✓	AHS - DVHA - Blueprint
Trinka	Kerr ✓			✓	✓	VLA/Health Care Advocate Project
Mark	Larson x					AHS - DVHA
Monica	Light ✓			✓	✓	AHS - Central Office
Deborah	Lisi-Baker ✓			✓	✓	Unknown
Jackie	Majoros ✓			✓	✓	VLA/LTC Ombudsman Project
Todd	Moore ✓	Abe	Berman	✓	✓	OneCare Vermont
Mary Val	Palumbo ✓			✓	✓	University of Vermont
Ed	Paquin ✓			✓	✓	Disability Rights Vermont
Laura	Pelosi					Vermont Health Care Association
Judy	Peterson					Visiting Nurse Association of Chittenden and Grand Isle Counties
Allan	Ramsay x					GMCB
Paul	Reiss					Accountable Care Coalition of the Green Mountains
Simone	Rueschemeyer ✓			✓	✓	Vermont Care Network
Howard	Schapiro					University of Vermont Medical Group Practice
Ken	Schatz					AHS - DCF
Julie	Tessler ✓			✓	✓	Vermont Council of Developmental and Mental Health Services
Sharon	Winn					Bi-State Primary Care
	37		3			

Attachment 2 – Project Update

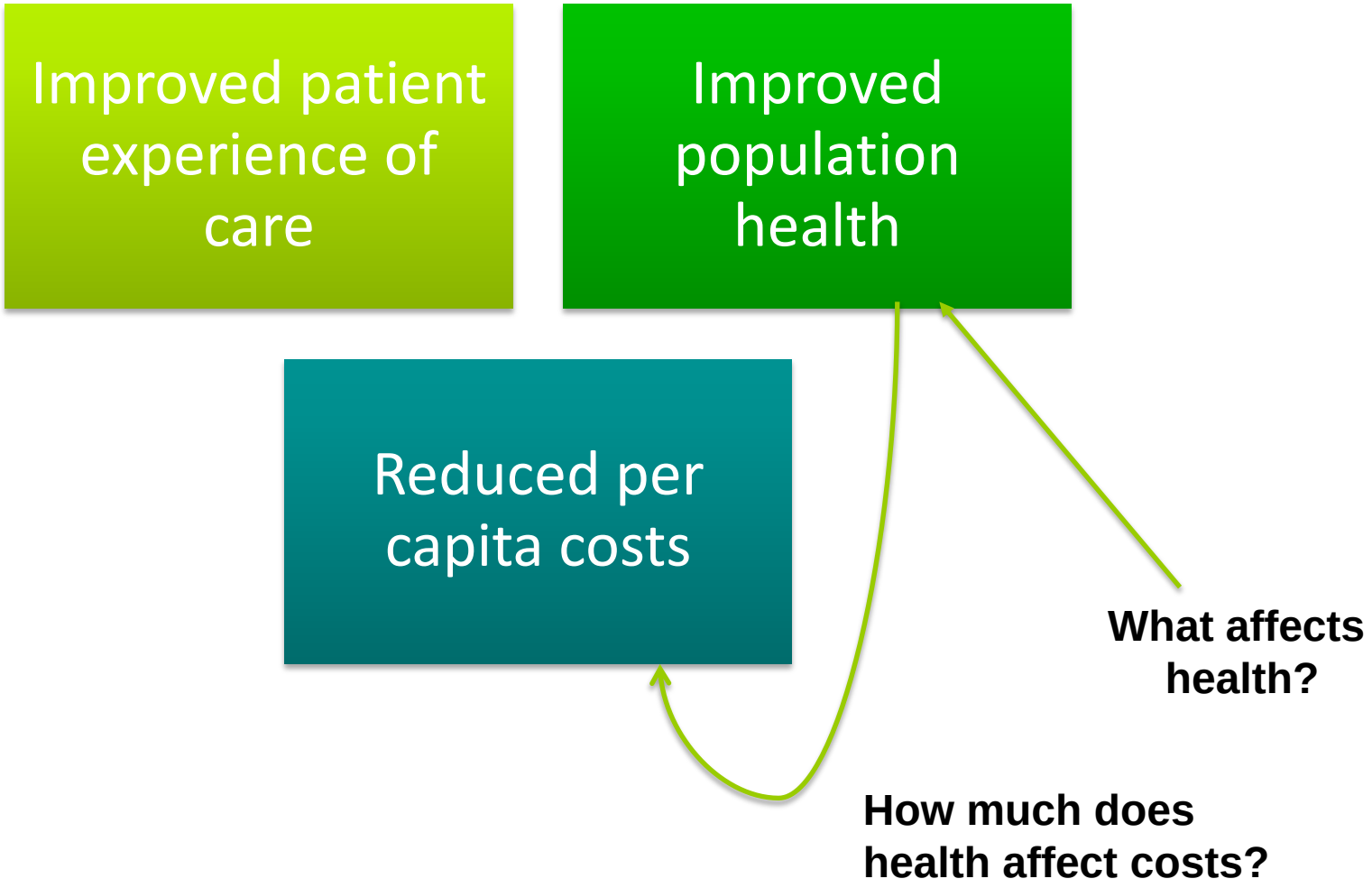
VHCIP Update to the Steering Committee

Georgia Maheras, Project Director

Vermont Health Care Innovation Project

February 2015

VHCIP's goal: the "triple aim"

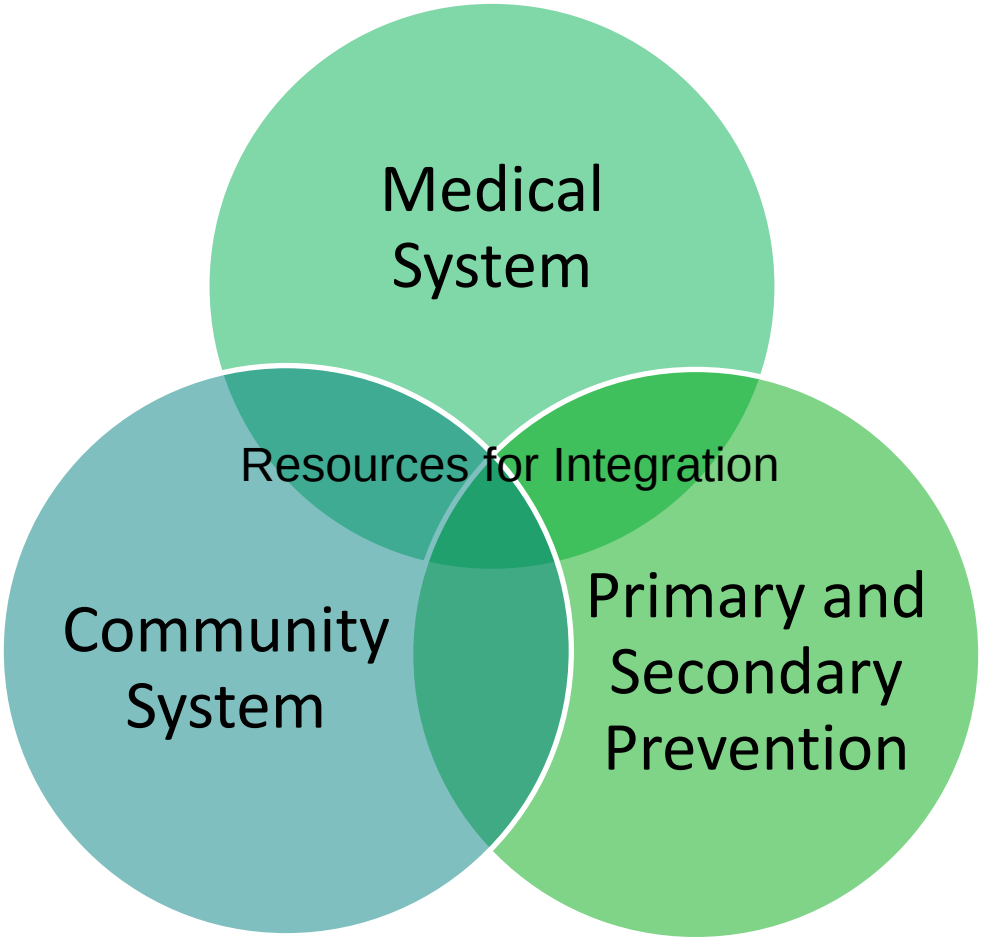


Three Main Goals:

- Care Delivery: enable and reward care integration and coordination;
- HIT/HIE Investments: develop a health information system that supports improved care and measurement of value; and
- Payment Models: align financial incentives with the three aims.

- Public/Private Partnership

Inter-related systems



What would constitute success?

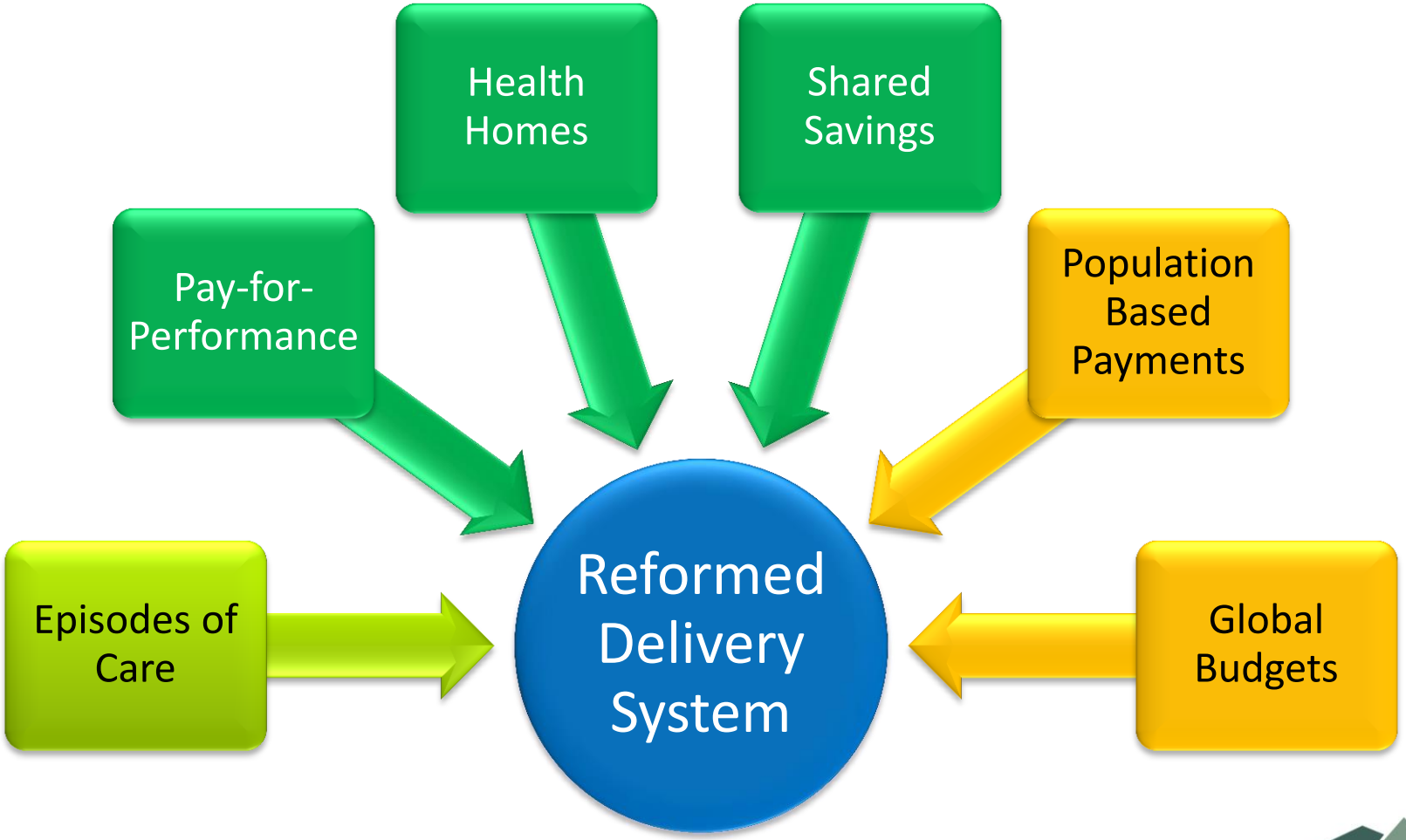
A health information technology and health information exchange system that works, that providers use, and that produces analytics to support the best care management possible.

A predominance of payment models that reward better value.

A system of care management that is agreed to by all payers and providers that:

- utilizes Blueprint and Community Health Team infrastructure to the greatest extent possible
- fills gaps the Blueprint or other care models do not address
- eliminates duplication of effort
- creates clear protocols for providers
- reduces confusion and improves the care experience for patients
- follows best practices

Payment Model Development



2014 Accomplishments

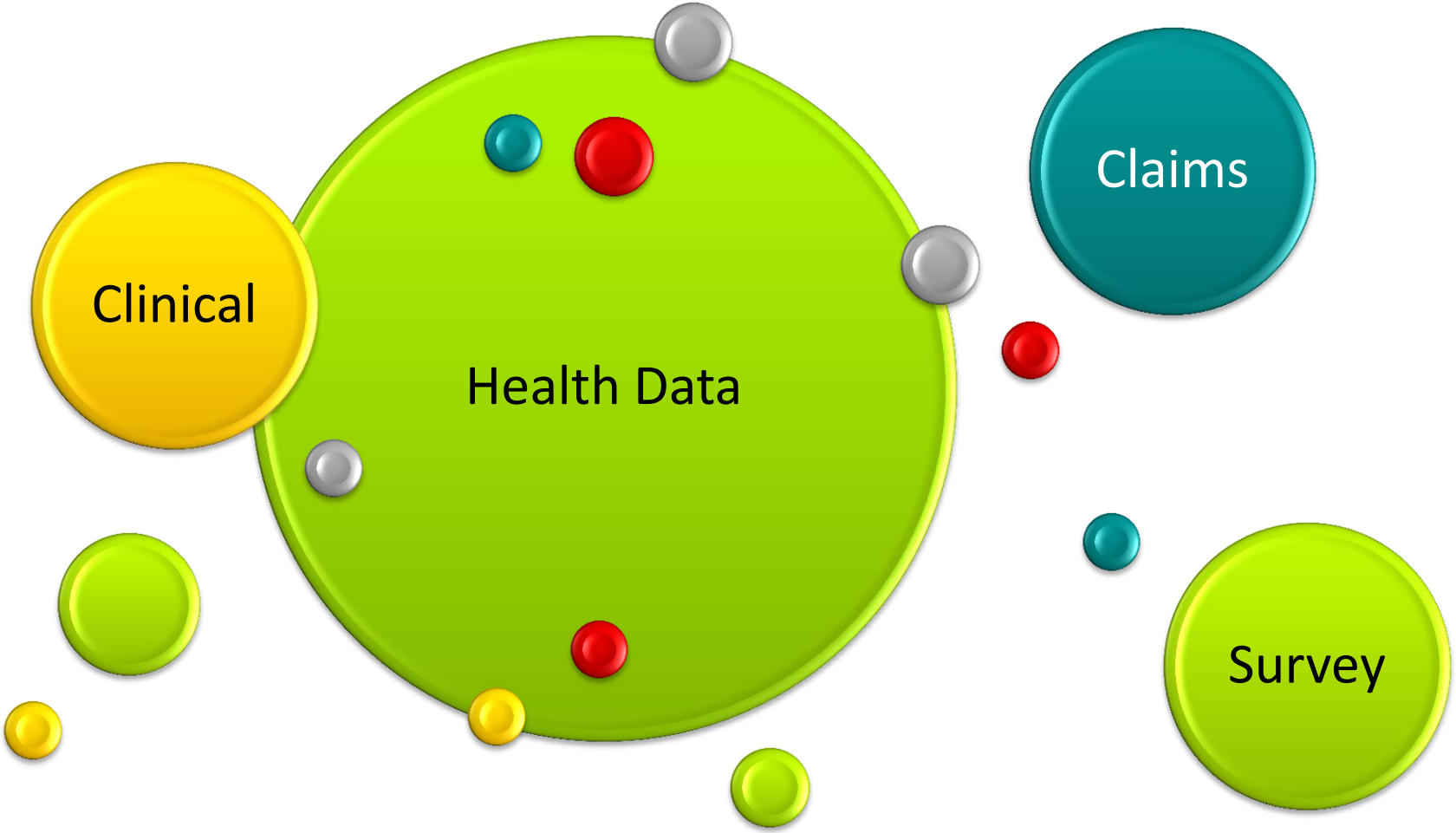
- Medicaid and commercial Shared Savings ACO Programs Launched
  - Attributing Providers: ~427-500*
  - Beneficiaries: 153,878*
- Blueprint for Health (P4P)
  - Attributing Providers: 638*
  - Beneficiaries: 274,558*
- Episode of Care Planning

*all numbers include Medicare, Medicaid and commercial programs

Coming up in 2015

- Year 2 of the Shared Savings Program
- Episode of Care Design
- Blueprint for Health program changes
- Health Homes – new opportunities
- Population-Based Payment Design
  - ACO providers
  - Non-ACO providers
- Accountable Health Community exploration
  - NVRH, Brattleboro, NMC

HIE/HIT Infrastructure



Progress in 2014

- **Providers Impacted by 2014 investments: 399**
- Electronic Medical Record Installation and Interoperability
  - Providers connected with at least one interface to the VHIE: 177
- Event Notification System: testing
- ACO Gateways: 1 built
- Data Quality Initiatives: Designated Agencies; ACOs; Blueprint
- Uniform Transfer Protocol- supports transitions
- DLTSS Data Analysis-electronic reporting capability

Coming up in 2015

- HIT Strategic Plan
- ACO Gateways: Finish building
- Data Warehousing: Begin build
- Data Quality Initiatives continue
- Uniform Transfer Protocol and DLTSS Data Analysis next steps
- Continue expanding provider connectivity to the VHIE
- Event Notification System: Test and launch

Delivery System

- Build on the Blueprint for Health foundation
- Integrate care management efforts across payers and providers
- Address gaps in care management/care coordination

Progress in 2014

- Landscape analysis
- Learning Collaboratives soft-launch:
  - Providers: 58
  - Vermonters: TBD
- Sub-Grant Program: Delivery System Focus
  - Providers: 692
  - Vermonters: 281,808
- ACO/Blueprint Alignment begins

Coming up in 2015

- Learning Collaboratives:
  - Providers: over 100
  - Vermonters: TBD
- Sub-Grant Program: Delivery System Focus
- Further alignment towards unified or aligned system of care management

Attachment 3 – Memo: Steering Committee Agendas and Role Clarity

To: Mark Larson and Al Gobeille, Co-Chairs, VHCIP Steering Committee
Fr: Georgia Maheras, Project Director and Sarah Kinsler, Health Policy Analyst
Date: January 18, 2015
Re: Steering Committee Agendas and Role Clarity

This memo is in response to a request made at the December 3, 2014, Core Team meeting. At that meeting, the Core Team requested that Georgia Maheras work with the Steering Committee Co-Chairs to develop a proposal that would provide clarity about the Steering Committee's agendas and its role within VHCIP.

According to the 2015 Operational Plan, "the Steering Committee informs, educates and guides the Core Team in all of the work planned under the SIM grant. In particular, the group guides the Core Team's decisions about investment of project funds, necessary changes in state policy and how best to influence desired innovation in the private sector."

In order to ensure the Steering Committee has the information necessary to guide the Core Team, we recommend the following:

1. At the February Steering Committee meeting, provide a comprehensive update on activities that occurred in 2014 and a preview of what is to come in 2015. Additionally, the Steering Committee will participate in a process identifying criteria with which the group will review policy and funding proposals in 2015. A key aspect of this is to ensure the Steering Committee understands its role in terms of guiding policy and funding decisions and that the Steering Committee is not a place to re-litigate the decisions made by a work group.
    a. The comprehensive update will focus on the big picture with an emphasis on the three core areas of VHCIP activity: Payment Models, HIE/HIT infrastructure and Care Management and Care Models. The update will, at a minimum, cover:
        i. Financial update
        ii. Project evaluation update
        iii. Provider participation
        iv. Beneficiary participation
    b. Potential criteria the Steering Committee could use include to review policy and funding proposals in 2015 include:
        i. Is the recommendation consistent with the goals[1] and objectives of the grant?
        ii. Is the recommendation inconsistent with any other policy or funding priority that has been put in place[2] within the VCHIP project?
        iii. Has the recommendation been reviewed by all appropriate workgroups?
2. The Steering Committee will then be provided updates throughout the year on the following:
    a. A minimum of three updates per year for each work group and the sub-grantee program.
3. In addition to these periodic updates, the Steering Committee will continue to receive requests for approval of policy and funding recommendations on an as-needed basis.

[1] The goals as described in the Operational Plan are:

- To increase the level of accountability for cost and quality outcomes among provider organizations;
- To create a health information network that supports the best possible care management and assessment of cost and quality outcomes, and informs opportunities to improve care;
- To establish payment methodologies across all payers that encourage the best cost and quality outcomes;
- To ensure accountability for outcomes from both the public and private sectors; and
- To create commitment to change and synergy between public and private culture, policies and behavior.

[2] The Steering Committee will be provided with a summary of these activities at their meetings.

DRAFT

Attachment 4 – ACO Care Management Standards

Care Models and Care Management Work Group
Proposed ACO Care Management Standards
As Approved by CMCM Work Group
February 10, 2015

Definition of Care Management:
Care Management programs apply systems, science, incentives and information to improve services and outcomes in order to assist individuals and their support system to become engaged in a collaborative process designed to manage medical, social and mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, evidence based or promising innovative and non-duplicative services. It is understood that in order to support individuals and to strengthen community support systems, care management services need to be culturally competent, accessible and personalized to meet the needs of each individual served.

In order for care management programs to be effective, we recommend that ACOs agree to the following standards:

A. Care Management Oversight (based partially on NCQA ACO Standards PO1, Element B, and PC2, Element A)

#1: The ACO has a process and/or supports its participating providers in having a process to assess their success in meeting the following care management standards, as well as the ACO's care management goals.

#2: The ACO supports participating primary care practices' capacity to meet person-centered medical home requirements related to care management.

#3: The ACO consults with its consumer advisory board regarding care management goals and activities.

B. Guidelines, Decision Aids, and Self-Management (based partially on NCQA ACO Standards PO2, Elements A and B, and CM4, Elements C)

#4: The ACO supports its participating providers in the consistent adoption of evidence-based guidelines, and supports the exploration of emerging best practices.

#5: The ACO has and/or supports its participating providers in having methods for engaging and activating people and their families in support of each individual's specific needs, positive health behaviors, self-advocacy, and self-management of health and disability.
#6: The ACO provides or facilitates the provision of and/or supports its participating providers in providing or facilitating the provision of: a) educational resources to assist in self-management of health and disability, b) self-management tools that enable attributed people/families to record self-care results, and c) connections between attributed people/families and self-management support programs and resources.

C. Population Health Management (based partially on NCQA ACO Standards CM3, Elements A and B, and CT1, Elements A, B, D, and E)

#7: The ACO has and/or supports its participating providers in having a process for systematically identifying attributed people who need care management services, the types of services they should receive, and the entity or entities that should provide the services. The process includes but is not limited to prioritizing people who may benefit from care management, by considering social determinants of health, mental health and substance

abuse conditions, high cost/high utilization, poorly controlled or complex conditions, or referrals by outside organizations.

#8: The ACO facilitates and/or supports its participating providers in facilitating the delivery of care management services. Facilitating delivery of care management services includes:

- Collaborating and facilitating communication with people needing such services and their families, as well as with other entities providing care management services, including community organizations, long term service and support providers, and payers.
- Developing processes for effective care coordination, exchanging health information across care settings, and facilitating referrals.
- Recognizing disability and long terms services and supports providers as partners in serving people with high or complex needs.

#9: The ACO facilitates and/or supports its participating providers in facilitating:

- Promotion of coordinated person-centered and directed planning across settings that recognizes the person as the expert on their goals and needs.
- In collaboration with participating providers and other partner organizations, care management services that result in integration between medical care, substance use care, mental health care, and disability and long term services and supports to address attributed people's needs.

D. Data Collection, Integration and Use (partially based on NCQA ACO Standard CM1, Elements A, B, C, E, F and G)

#10: To the best of their ability and with the health information infrastructure available, and with the explicit consent of beneficiaries unless otherwise permitted or exempted by law, the ACO uses and/or supports its participating providers in using an electronic system that: a) records structured (searchable) demographic, claims, and clinical data required to address care management needs for people attributed to the ACO, b) supports access to and sharing of attributed persons' demographic, claims and clinical data recorded by other participating providers, and c) provides people access to their own health care information as required by law.

#11: The ACO encourages and supports participating providers in using data to identify needs of attributed people, support care management services and support performance measurement, including the use of:

- A data-driven method for identifying people who would most benefit from care management and for whom care management would improve value through the efficient use of resources and improved health outcomes.
- Methods for measuring and assessing care management activities and effectiveness, to inform program management and improvement activities.

Attachment 5 –
Cover Memo and Letter to the Governor on DLTSS Funding

109 State Street

Montpelier, VT 05609

www.healthcareinnovation.vermont.gov

To: Steve Costantino and Al Gobeille, Co-Chairs VHCIP Steering Committee
Fr: Georgia Maheras, Project Director, VHCIP
Date: February 17, 2015
Re: Letter from the DLTSS Work Group

This memo is to provide background on a letter to the Governor that the DLTSS Work Group is recommending be sent.

On December 4, 2014, the DLTSS Work Group approved a letter related to Medicaid funding. This letter, attached herein, requests for appropriate levels of Medicaid funding as well as development of alternative payment methods for long term services and supports providers. This letter was approved on a 9-4 vote, with one abstention by the work group with all state employees either recusing themselves or opposing the letter. In addition to this letter, a separate, but similar letter was sent to the Governor in December from Vermont Legal Aid with several co-signers.

DRAFT LETTER FROM DLTSS WORK GROUP

DATE

The Honorable Peter Shumlin
109 State Street
Montpelier VT

Dear Governor Shumlin,

Several members of the Disability and Long Term Services and Support (DLTSS) Work Group of the Vermont Health Care Innovation Project (VHCIP), those who do not work for state government, would like to share our perspective on how the services that our group represents are of critical importance to both health care reform and the State's current and future fiscal status. The population that receives DLTSS is responsible for 72% of Medicaid claims, utilizing both acute and long term care services.

Given the State's fiscal projections, we want to ensure that the State is strategically utilizing health care resources for the best return on investment in order to achieve our shared goals of health care reform: better outcomes, better health care experience and reduced costs. We are particularly concerned about any proposed reductions to services for Medicaid recipients who utilize long term services and supports (developmental, mental health, elderly and disabled home-based health care). In order to achieve savings, health care reform depends on staff in these programs to manage and coordinate health care, with the stated goal that managing health care will reduce costs, by reducing the cycle in and out of more expensive settings. We therefore make the following recommendations:

1. Medicaid rates should be high enough to recruit and retain quality staff across the full continuum of health care providers to provide access to quality care. At this point, there is insufficient room left in commercial insurance rates to continue the shifting of costs from public programs to the private payers. Providers who rely solely or significantly on Medicaid for their funding are in even greater need for improved Medicaid rates as they are not able to cost shift.
2. Further, it is essential that reimbursement rates from our public programs increase on a predictable and reliable basis in order to sustain quality services.
3. The State should not delay in working with willing community-based providers to develop bundled payment models that reimburse for specific population outcomes. The current fee-for-service payment model from siloed funding streams, which come with multiple bureaucratic requirements, wastes state resources and doesn't have the flexibility to best meet the needs of Vermonters. The experience to date with Integrated Family Services (IFS), a bundled payment pilot in two areas of the State, has shown improved services, reduced administrative expenses and savings.

4. The VHCIP should move forward in developing payment models for DLTSS services which will complement the Medicaid Accountable Care Organization (ACO) Shared Savings Program, with a commitment to achieve comprehensive services and supports for individuals who have been attributed to an ACO as well as for those who have not. Many of these individuals need access to care management to achieve better health outcomes.

While we are fully cognizant of revenue shortfalls for fiscal years 2015 and 2016, we are certain that any reductions in Medicaid funding for services to individuals with DLTSS needs will only lead to higher health care costs for the entire system, most likely through increases in inpatient and institutional care. Many of the state's health care providers are already stressed and cannot further reduce expenditures without also reducing services to people with DLTSS needs. Further reductions in funding will cause detrimental impacts on vulnerable Vermonters.

There is consensus from a diverse cross-section of consumers, advocates, providers and other stakeholders on these recommendations. More importantly, we have commitment, determination and innovative ideas to move health care reform forward.

Sincerely,

The non-governmental members of the DLTSS Work Group

Cc: Secretary Cohen
Secretary Johnson
Chairman Gobeille

Attachment 6 – Steering Committee Financial Proposals 2-25-2015

Financial Proposals

February 25, 2015

Georgia Maheras, JD

Project Director

AGENDA

1. Payment Models Work Group: Frail Elderly Proposal
2. Population Health Work Group: Hester Contract Amendment

Payment Models Work Group: Frail Elderly Proposal

- Request from the Work Group :
  - Project timeline: May 1, 2015-January 31, 2016
  - Project estimated cost: $140,329
  - Project Summary: To develop findings and recommendations for next steps to increase the value of health care to frail elders.
  - Budget line item: Type 1b Payment Models Work Group (Advanced Analytics: Policy)
- The Payment Models Work Group is responsible for providing spending and policy recommendations about the design for value-based payment models.

Intent of Contract/Relationship to VHCIP Goals

- *VHCIP's Operational Plan outlines the following tasks:*

Payment Models Work Group

This group will build on the work of the work group to date and:

- Continue to develop and recommend standards for the commercial shared savings ACO (SSP ACO) model;
- Continue to develop and recommend standards for the Medicaid SSP ACO model;
- Develop and recommend standards for both commercial and Medicaid episode of care models for use in conjunction with the SSP ACO model; and
- Develop and recommend standards, as appropriate, for Medicaid pay-for-performance models.

Scope of Work

- Perform data analyses, surveys and interviews
  - Expert Panel to advise
  - 3 types of interviews
- Develop a written report
- Present findings and recommendations related to improving health outcomes for frail elders to the Payment Models Work Group

Population Health Work Group: Hester Contract Amendment

- Request from the Population Health Work Group :
  - Project timeline: 12 months
  - Project estimated cost: $25,000 (new not-to-exceed of $56,000)
  - Project Summary: Jim Hester to provide support to the population health workgroup related to the SIM Grant/VHCIP.
  - Budget line item: Population Health Work Group Support Line Item
- The Population Health Work Group is responsible for developing the Population Health Plan and examines current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs, and other provider and payer entities.

Intent of Contract/Relationship to VHCIP Goals

Population Health Work Group

This group will build on the work of the work group to date and:

- This work group will examine initiatives for their potential impact on the health of Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:
  - Enhancement of State initiatives administered through the Department of Health;
  - Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts; and
  - Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health .

Scope of Work

- Assist the co-chairs of the workgroup in developing the strategy, work plan, and resource needs for the workgroup
- Assist in developing agendas for the workgroup
- Support/oversee project staff in analyzing payment models being tested and opportunities for integration of population health
- Through ongoing work with CDC, IOM and others, identify models and resources in other states and communities that could inform the design of sustainable financing models for improving population health
- Assist in identifying the population health measures and measurement systems required to support the population health financing system
- Assist in developing the Population Health Improvement plan, particularly the elements for a sustainable financial model
- Help formulate an approach to creating Vermont pilots of Accountable Health Communities by drawing on expertise in models being tested in other states and building on the work of the Prevention Institute

Attachment 6a –
Frail Elders Proposal and Budget

VMS Education & Research Foundation
pursuing high value care for Vermonters

Frail Elders Project

Purpose, Methods, Deliverables and Budget

Purpose

The purpose of this improvement effort is to identify barriers to best care for high-risk elders in two rural communities and recommend counter measures utilizing payment innovation. The principal method for problem identification is interviews with patients, families, caregivers and community based health care professionals.

The Frail Elders Project is a clinician-led quality improvement initiative designed to increase the value of the health care system – focusing on things that matter to patients, reducing harm, conserving resources and increasing system efficiencies. Redesigning how high-risk rural elders are cared for offers opportunity to improve health outcomes for a particularly high-need population while decreasing the cost of care for the target population.

> ***Frail Elders Definition:*** Frailty is a geriatric syndrome characterized by weakness, weight loss, and low activity that is associated with adverse health outcomes. Frailty manifests as an age-related, biological vulnerability to stressors and decreased physiological reserves yielding a limited capacity to maintain homeostasis. The validated and widely utilized five-item frailty criteria for screening: self-reported exhaustion, slowed performance (by walking speed), weakness (by grip strength), unintentional weight loss (10 lbs. in past year), and low physical activity are composite outcomes of multiple organ systems. (Developed by DAIL, January 2015)

Methods

1. Literature review

This project will begin with a literature review utilizing the library professionals at the University of Vermont. The review will target three areas of interest: 1) Identification, attribution of patients to providers, and utilization characterization of frail elderly patients using billing claims and clinical data bases; 2) Regional and national models for care – successes, failures and innovation; and 3) Regional and national investigations of patient and family medical care preferences.

2. Definition of areas of study

Drawing on the published literature, the Project Team will draft study questions for three sets of key informant interviews: 1) community based health care professionals; 2) State and private sector policy experts; and 3) Patients, families and caregivers. The Project Team will solicit feedback from a Project Expert Panel. The Expert Panel will include, but not be limited to, representatives from the following: AAAs, SASH, AHS departments, VNAs, Nursing Homes, FQHCs, primary care providers, specialists (including a geriatrician), the LTC Ombudsman, and others currently engaged in delivering care to rural elders in Vermont.

3. Key Informant Interviews

a. *Community based health care professionals* – Structured telephone interviews will be conducted with up to 15 community based health care professionals in each of the two target communities. Identification of providers will be informed by consultation with the Project Expert Panel. Approximately

15 providers will be interviewed in each of two primary care service areas, Gifford Health Care and Little Rivers Health Care, spanning all or parts of Orange, Washington, Caledonia and Windsor counties.

Illustrative examples of focus areas in the provider interviews include:

- What things matter to the frail elderly and their families?
- What are some of the unique challenges faced by your frail elderly patients and their families? What works well and what doesn't in addressing these challenges?
- What practice redesigns could improve care?
- What are the financial and regulatory barriers to giving needed care?
- What are practical, meaningful measures of value?

b. *Patients, families and caregivers* – Interviews will be conducted with approximately 15 patients, families and caregivers in each of two targeted primary care service areas. Interviews will be conducted in a variety of face to face settings including home based interviews and public community settings. Interviews will take advantage of existing community structures and activities; and may include focus groups. Choice of informants will be advised by input from the community based health care professionals interviews.

Illustrative examples of focus areas in the patient/family interviews include:

- What things matter to the frail elderly and their families? What are their concerns and challenges? What programs or resources exist in your communities to support frail elders in meeting these challenges, and do they meet your/your family's needs? Possible sub-areas include:
    - Care transitions and discharge planning
    - Access to regular health screenings and immunizations
    - Fall prevention
    - Memory health
    - Advanced directives
    - Wellness activities
    - Transportation
    - Personal care/homemaking needs
    - Financial management

c. *State and private sector policy experts* – Structured telephone interviews will be conducted with public and private professionals with expertise in the field of aging and care giving for the elderly. Informants will include those who determine eligibility for Vermonters for publicly funded programs. Approximately 10 policy experts will be interviewed.

The results of the three sets of interviews will generate three separate analyses as well as a single overview summary.

4. Billing and Clinical Data Set Analytics

The analytic component will look principally at existing public claims data bases. Analytic foci will address: 1) Can the frail elderly population be identified using claims data; 2) Can utilization patterns of the population be characterized; and 3) Can claims data be used proactively to identify the target population? Investigation will be directed at issues of attributing patients to various providers. If possible, reconciliation between private billing data and/or private clinical data with the results of

claims-based analyses will be studied. The claims and clinical data analyses will be performed by in-state experts, including Steve Kappel from Policy Integrity.

Deliverables

The Project Team will deliver a written report and a formal presentation to the VHCIP Payment Models Work Group on findings and recommendations for next steps to increase the value of health care to frail elders. The expected length of the effort is six months.

Budget

Pursuing High Value Care for Vermonters		
Frail Elderly VHCIP Payment Models		
April - October 2015		
Personnel		
Director	$	62,352
Business Manager	$	3,741
Operations Director	$	3,741
Administrative Assistant	$	1,871
Personnel subtotal	$	71,705
Fringe		
	$	-
Travel		
Mileage	$	848
Parking and Tolls	$	25
Equipment		
	$	-
Supplies, meetings		
Conference calls; webinars	$	500
Website	$	500
Supplies subtotal	$	1,000
Indirect		
	$	-
Contracts		
Clinical champion	$	6,126
Clinical content expert	$	3,063
Clinical content expert	$	3,063
Qualitative Researcher	$	40,500
QI and Measurement content expert	$	3,000
Patient and Family surveyor	$	10,000
UVM Dana Library	$	1,000
Contracts subtotal	$	66,751
Total		
	$	140,329

Attachment 6b –
Jim Hester Contract

109 State Street
Montpelier, VT 05609
www.gmcboard.vermont.gov/sim_grant

To: Population Health Work Group
Fr: Georgia Maheras
Re: Renewal of a Contract for Population Health Technical Services provided by Jim Hester
Date: January 26, 2015

This request is to renew an existing contract with Jim Hester to provide support to the population health workgroup related to the SIM Grant/VHCIP. This contract would be funded by the SIM/VHCIP funds allocated to the Population Health Work Group for work group support.

Background

The SIM grant requires the State of Vermont work towards improving overall population health.

The Population Health Work Group examines current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities. This work group will examine these initiatives and SIM/VHCIP initiatives for their potential impact on the health of Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:

- Enhancement of State initiatives administered through the Department of Health
- Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts
- Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health

In 2013, the VHCIP determined the need for assistance with the development of the population health workgroup described in the SIM Operational Plan. Jim Hester as uniquely positioned to continue to perform this work.

Vendor Qualifications

Dr. Hester has been working with Vermont's Population Health Work Group for over a year. He provides research and information in the area of sustainable financing models for improving population health and in identifying best practices from around the country. He also assists other states and entities in their population health work. He brings knowledge from other states and at the national level to the population health work group. Prior to his work with Vermont, and others, he completed two and a half years assisting in the start up of the Center for Medicare and Medicaid Innovation at CMS. He is familiar with both the population health

work at the federal level and the work in Vermont. At the federal level, he was the Acting Director responsible for the initial work on the Pioneer ACO shared saving model, the Comprehensive Primary Care Initiative Model and the Bundled Payment models. Significantly, he served as the Acting Director of the Population Health Models Group overseeing the development of enhanced measures and strengthening the population health component of the payment models. He has a strong set of working relationships with public and private partners, especially CMS and CDC. His Vermont experience includes serving as director of the Health Care Reform Commission for the state legislature for four years, the Blueprint Executive Committee since its inception and the VITL board for three years.

Scope of Work

The specific tasks for this contract would be:

- assist the co-chairs of the workgroup in developing the strategy, work plan, and resource needs for the workgroup
- assist in developing agendas for the workgroup
- support/oversee project staff in analyzing payment models being tested and opportunities for integration of population health
- through ongoing work with CDC, IOM and others, identify models and resources in other states and communities that could inform the design of sustainable financing models for improving population health
- assist in identifying the population health measures and measurement systems required to support the population health financing system
- assist in developing the Population Health Improvement plan, particularly the elements for a sustainable financial model
- help formulate an approach to creating Vermont pilots of Accountable Health Communities by drawing on expertise in models being tested in other states and building on the work of the Prevention Institute

The Deliverables under this contract would include:

Topic	Specific Tasks	Percent of Time allocated
Payment Models: Review payment models being considered for testing by VHCIP; prioritize models for analysis by the PHWG	• Review models being tested • Identify strengths and limitations in planned integration of population health • Identify best strategy to include payment for and/or activity related to population health • Prepare presentation for workgroup review of payment models	40%

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Montpelier, VT 05609
www.gmcboard.vermont.gov/sim_grant

Financing Options-Paying for Prevention:	• Identify promising financing vehicles that promote financial investment in population health interventions • Prepare presentation on the options being explored in other communities and nationally • Oversee conduct of SWOT in Vermont and written summary of analysis and recommendations • Facilitate workgroup review of financing vehicles • Provide recommendations to other VHCIP committees to consider link with payment models being tested	40%
Integration of Population Health in VHCIP	• Participate in work group planning meetings • Create list of key leaders to brief and/or engage in the population health work • Facilitate introductions to enable set up meetings with key leaders in the state to share population health goals • Brief planning group on all meetings with key leaders • Assist in engaging other VHCIP workgroups in population health	20%

Recommendation:
Approve a renewal of the existing contract with Jim Hester for another 12 months adding $25,000 to the overall not-to-exceed amount (the total not-to-exceed will now be $56,000). Dr. Hester will bill the State on a time and materials basis at the rate of $175/hour. This price is competitive in relation to the other contracts held by the State for support for workgroups and other technical areas.