VT Health Care Innovation Project - Payment Model Design and Implementation Work Group Meeting Agenda
Monday, March 21, 2016 1:00 PM – 3:00 PM.
DVHA Large Conference Room 312 Hurricane Lane, Williston
Call in option: 1-877-273-4202 Conference Room: 2252454

Web-ex Registration – https://attendee.gotowebinar.com/register/2236809445413883907

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: February Meeting Minutes
2	1:05-1:25	Program Updates	Georgia Maheras/Heidi Klein	N	
3	1:25-1:45	OneCare VT Red Cap	Miriam Sheheey	N	Web-ex Presentation
4	1:45-2:50	Medicaid Pathway and Q&A	Georgia Maheras and Selina Hickman	N	Attachment 4: Medicaid Pathway Presentation
5	2:50-2:55	Public Comment		N	
6	2:55-2:50	Next Steps and Action Items		N	Next Meeting: Monday, April 18, 2016 1:00 PM – 3 PM. DVHA Large Conference Room 312 Hurricane Lane, Williston

Attachment 1: February Meeting Minutes

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

Pending Work Group Approval

Date of meeting: Monday, February 1, 2016, 1:00-3:00pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Approve Meeting Minutes	Andrew Garland called the meeting to order at 1:02pm. A roll call attendance was taken and a quorum was present. Ed Paquin moved to approve the January 2016 meeting minutes by exception. Rick Dooley seconded. The minutes were approved with no abstentions.	
2. Program Updates	Georgia Maheras provided a series of program updates. • The Core Team met twice in January, and approved several health data infrastructure investments over the next five months. They were able to approve these investments due to savings in other areas. See the Core Team materials and minutes for details. • The Core Team also approved a change to the milestone for Episodes of Care for Performance Periods 2 and 3. This comes after a series of conversations with CMMI; they agreed that alignment of any EOC program with other payment models was a high priority, and supported our goal of not launching a new program for only a few months before it would likely need to change for implementation of an All-Payer Model. The new milestone decreases the number of episodes we are pursuing from three (perinatal, neonatal, and repeat emergency depart visits, as well as Integrating Family Services work) to one; future EOC efforts will focus on the Integrating Family Services program, rather than the three episodes this group had focused on in earlier discussions. New milestones: o *Performance Period 2*: Research, design, and draft implementation plan for one EOC based off of the IFS program by 6/30/16. o *Performance Period 3*: Implement EOC Payment Model impacting IFS Program's Service by 7/1/17. • Project leadership is beginning work on a draft budget for Performance Period 3. A budget will be proposed to the Core Team later this winter to allow development of our federal budget submission in April 2016. Previous Core Team decisions allocating funds provide a starting place for the budget.	
3. APM Update	Robin Lunge provided an update on the All-Payer Model.	

Agenda Item	Discussion	Next Steps
	• The Administration sees significant benefit to the state generally and the State through changing the payment system in a way that will support improved quality and reduced cost. Doing this through a provider-led initiative is preferable to doing this through a payer-led initiative. • Some revenue and market segments will continue to fall outside of the waiver due to federal law (ERISA) and other factors. Members commented that providers and services excluded from the waiver are critical players in decreasing costs. Robin clarified that being outside of the financial scope of the waiver is not the same as being outside of system reforms more broadly, and the Administration is working with those providers to develop a "Medicaid pathway" to support reform among these providers and services. Part of the delivery system will remain in the fee-for-service system for now, but it's important to remember that this is not the only piece of payment and delivery system reform underway. There is a great deal of work within AHS right now for providers who are not participating in ACOs. The Medicaid pathway is for providers who are not included in ACOs or financial caps, and is looking at which payment and delivery system reforms are most appropriate for these provider groups and service types, and avoids bringing provider groups and service types under the waiver's financial cap where there isn't readiness. One member also contested the assertion that this is a provider-led initiative, noted that it looks a lot like managed care, and commented that not all providers have been involved in development. • Several documents related to the APM were released last Monday: the term-sheet, an explanatory companion paper, and a one-page summary. • Process for public comment: AoA is accepting public comment in writing for the next 2 weeks – see http://www.hcr.vermont.gov for instructions on how to submit writing. Interested parties can also submit written comment to GMCB or provide verbal comment at GMCB meetings. GMCB and AoA are sharing all comments with each other, so there is no need to submit written comment to both, though participants are welcome to do that if they prefer. GMCB is holding a series of meetings to gather stakeholder input over the next 2 weeks – there was an all-day hearing on Thursday, as well as a Friday morning stakeholder meeting. • Process between CMMI and Vermont: Vermont submits the term sheet; CMMI will proceed with federal clearance process, which will include various parts of HHS, Secretary Burwell, and the White House. They will come back with questions and comments, followed by another round of negotiations if necessary. o Simultaneously, Vermont will gather public comment and comment from SOV agencies and departments that are interested, which could also be incorporated into a further round of negotiation. • The waiver and term-sheet: The waiver would be a three-way agreement between AoA, GMCB, and the federal government. GMCB will have a public vote to approve (or not) the term sheet, and public comment will be incorporated into this decision. o The term-sheet is a high-level document which describes the major provisions of the agreement; the real agreement will be a much longer waiver document. This will be written based on the approved term sheet. o Under the APM, Medicare payments would continue to go from the federal government to providers; for ACO providers (providers participating in the APM), this would be governed by an	

Agenda Item	Discussion	Next Steps
	ACO participation agreement between CMS and the ACOs and will also be written after agreement on the waiver (similar to the Next Generation ACO model). For providers not participating in ACOs, there would be a different type of agreement as there is now for providers who participate in Medicare fee-for-service. Medicare will stay the same for providers not participating in ACOs. o Estimated start date is still January 2017. Medicare and DVHA operations are gearing up in preparation for this; Robin declined to speak for private payers or ACOs. o Term sheet outlines some of the waivers included in the APM that are intended to remove recognized barriers within the Medicare program. o Impact on existing ACO programs: Medicare, Medicaid, and Commercial SSPs are aligned as much as possible/appropriate now. Part of APM planning and implementation will require additional alignment across the new programs. o Hospital revenue is currently regulated by the GMCB, which includes 60% of physician revenue. The GMCB also regulated commercial insurance rates for all services. This does not include ERISA plans or TRICARE. ERISA plans may voluntarily participate and TRICARE will continue to be excluded by federal law. The State will be reaching out to self-insured employers to encourage them to voluntarily participate in payment reform activities. Some large employers the State is talking with or is planning to talk with are state employees, teachers and hospitals. o This is not predicated on a single ACO. o Is this planned to expand to all fully-insured commercial populations? This is a question for GMCB. o We expect a federal decision within 2 months. If we do not agree on an APM, OneCare has still been accepted to the Medicare Next Generation ACO program, which would start on January 1, 2017. • <u>Term sheet highlights</u>: o Financial Caps: Target of 3.5%, with a cap of 4.3%. This was developed by look at the 15-year state growth average. 4.3% is 1% above economic growth. Medicare target is 0.2% below national trend at the end of the 5-year agreement (2017-2021). o There are terms that allow either party to withdraw, which will be spelled out in detail. o Regulated Services: Services to which cap applies. Currently based on SSPs (Medicare = Medicare A&B; Medicaid and Commercial = current SSP scopes). Caps apply to statewide all-payer spending for those services, not to individual providers. o Rate Setting: Terms allow the GMCB to do all-payer rate setting if the vision isn't successfully keeping costs within targets, including Medicare rate setting for the FFS system based on reference pricing. The GMCB may not use this authority initially, although may use it if trends are not being met after a certain period of time. • Term sheet will be complemented by GMCB regulatory structure to manage the relationship between State and ACOs. GMCB has regulatory authority beyond what it pursues, and could expand authority to develop a more robust regulatory system to support the APM. • How will the waiver ensure utilization isn't being harmfully limited? Consumer surveys and quality metrics will be a starting place for this, and the Board has kicked off an internal work group process to develop an	

Agenda Item	Discussion	Next Steps
	internal framework to support the APM, including consumer protection as well as rates and other issues.	
4. Frail Elders	Cy Jordan provided an update on the Frail Elders project (Attachment 4). • This project has been in development since 2013, coming out of a series of qualitative interviews with inpatient and rural providers. • Target population is not limited to frail elders – frailty has a specific medical definition. Rather, work focuses on high-risk elders. • Qualitative interviews are not limited to clinical needs. The group discussed the following: • This research targets a larger group than dual eligibles. Bard Hill noted that many duals are past frailty or high-risk, but rather, a negative event has already happened. • This work could advise or strengthen our existing work with primary care providers, including the Blueprint for Health. • This research could also be applied to other patient groups with similar needs. • One challenge has been linking qualitative interviews with national claims datasets.	
5. Financing 101	Bard Hill and Susan Aranoff presented a Financing 101 presentation (Attachment 5) about financing of disability and long-term services and supports (DLTSS) in Vermont. • This is an area of cost-shift from commercial payers and Medicare *toward* Medicaid, since Medicaid pays for services in this category that are not covered by other payers. • There is significant variation in the DLTSS population and in needs and services; person-centeredness is a key concept in care planning and service delivery. • A high percentage of people receiving DLTSS services are dually eligible for Medicare and Medicaid; costs are hard to calculate and manage in part because spending is split across programs. The group discussed the following: • Ed Paquin pointed out that it's not surprising that people who need more care cost more to care for. He noted that many DLTSS services are delivered on a very basic, low-cost level, but volume is high because people need a great deal of care. • Bard noted that Medicaid eligibility for people in need of DLTSS services is a combination of income (including medical spend-down), assets, and disability. • Some disabilities and chronic conditions are preventable through optimal prevention activities, care, and intervention, and investments in these areas could decrease overall costs – but other disabilities and chronic conditions are not avoidable. In both cases, improved coordination and integration will support better outcomes and decreased costs.	
6. Public Comment	There was no additional comment.	
7. Next Steps, and	**Next Meeting:** Monday, March 21, 2016, 1:00-3:00pm, DVHA Large Conference Room, 312 Hurricane Lane,	

Agenda Item	Discussion	Next Steps
Action Items	Williston	

VHCIP Payment Model Design and Inplementation Work Group Member List

1/4/16 Ed 1° Rick 2° motion carried unanimously

Monday, February 01, 2016

Member		Member Alternate			
First Name	Last Name	First Name	Last Name	Minutes	Organization
Melissa	Bailey	Shannon	Thompson		AHS - DMH
		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
		Lou	Longo		Northwestern Medical Center
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
		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
Peter	Cobb ✓	Beverly	Boget		VNAs of Vermont

VHCIP Payment Model Design and Inplementation Work Group Member List

Monday, February 01, 2016

Member		Member Alternate			
First Name	Last Name	First Name	Last Name	Minutes	Organization
		Michael	Counter		VNA & Hospice of VT & NH
Steve	Gordon	Mark	Burke		Brattleboro Memorial Hopsital
Maura	Graff	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		AHS - DVHA - Blueprint
Ed	Paquin				Disability Rights Vermont
Abe	Berman	Miriam	Sheehey		OneCare Vermont

VHCIP Payment Model Design and Inplementation Work Group Member List

Monday, February 01, 2016					
Member		**Member Alternate**			
First Name	**Last Name**	**First Name**	**Last Name**	**Minutes**	**Organization**
		Vicki	Loner		OneCare Vermont
Laural	Ruggles				Northeastern Vermont Regional Hospital
Julia	Shaw	Rachel	Seelig		VLA/Health Care Advocate Project
Lila	Richardson ✓	Kaili	Kuiper		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
Julie	Tessler ✓				VCP - Vermont Council of Developmental and Mental Health Services
		Sandy	McGuire ✓		VCP - Howard Center
	31		44		

VHCIP Payment Model Design and Inplementation Work Group

Attendance Sheet 2/1/2016

	First Name	Last Name		Organization	Payment Model Design and Implementation
1	Peter	Albert		Blue Cross Blue Shield of Vermont	X
2	Susan	Aranoff		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		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		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	Gisele	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		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	here	AHS - Central Office	M
49	Patricia	Cummings		AHS - DAIL	MA
50	Michael	Curtis		Washington County Mental Health Services	X
51	Jude	Daye		Blue Cross Blue Shield of Vermont	A
52	Jesse	de la Rosa		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 Engl	X
56	Trey	Dobson		Dartmouth-Hitchcock	X
57	Tracy	Dolan		AHS - VDH	M
58	Michael	Donofrio		GMCB	X
59	Kevin	Donovan		Mt. Ascutney Hospital and Health Center	X
60	Rick	Dooley	here	HealthFirst	M
61	Molly	Dugan		Cathedral Square and SASH Program	MA
62	Lisa	Dulsky Watkins			X
63	Robin	Edelman		AHS - VDH	X
64	Jennifer	Egelhof		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		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		Bi-State Primary Care/CHAC	X
78	Lucie	Garand		Downs Rachlin Martin PLLC	X
79	Andrew	Garland	here.	MVP Health Care	M
80	Christine	Geiler		GMCB	S
81	Carrie	Germaine	Phone	AHS - DVHA	X
82	Al	Gobeille		GMCB	X
83	~~Larry~~	~~Goetschius~~		Home Health and Hospice	M
84	Steve	Gordon		Brattleboro Memorial Hopsital	M
85	Don	Grabowski		The Health Center	X
86	Maura	Graff	Phone	Planned Parenthood of Northern New Engla	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	Phone	Consumer Representative	M
91	Mike	Hall	Phone/here	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	here.	Vermont Medical Society	M
95	Stefani	Hartsfield	here	Cathedral Square	MA
96	Carrie	Hathaway		AHS - DVHA	X
97	Carolynn	Hatin		AHS - Central Office - IFS	S
98	Karen	Hein		University of Vermont	M
99	Kathleen	Hentcy		AHS - DMH	MA
100	Jim	Hester		SOV Consultant	S

101	Selina	Hickman		AHS - DVHA	X
102	Bard	Hill	here	AHS - DAIL	M
103	Con	Hogan		GMCB	X
104	Nancy	Hogue		AHS - DVHA	M
105	Jeanne	Hutchins	phone	UVM Center on Aging	M
106	Penrose	Jackson		UVM Medical Center	X
107	Craig	Jones		AHS - DVHA - Blueprint	X
108	Pat	Jones	phone	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	phone	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		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	Lou	Longo		Northwestern Medical Center	MA
131	Nicole	Lukas		AHS - VDH	X
132	Ted	Mable		DA - Northwest Counseling and Support Ser	M
133	Carole	Magoffin		AHS - DVHA	S
134	Georgia	Maheras	here	AOA	S
135	Jackie	Majoros		VLA/LTC Ombudsman Project	X
136	Carol	Maloney		AHS	X

137	Carol	Maroni		Community Health Services of Lamoille Vall	X
138	David	Martini	Phone	AOA - DFR	M
139	Mike	Maslack			X
140	John	Matulis			X
141	James	Mauro		Blue Cross Blue Shield of Vermont	X
142	Lisa	Maynes		Vermont Family Network	X
143	Kim	McClellan	Phone	DA - Northwest Counseling and Support Ser	MA
144	Sandy	McGuire		VCP - HowardCenter for Mental Health	M
145	Jill	McKenzie			X
146	Lou	McLaren	here	MVP Health Care	M
147	Darcy	McPherson		AHS - DVHA	X
148	Anneke	Merritt		Northwestern Medical Center	X
149	Melissa	Miles		Bi-State Primary Care	MA
150	Robin	Miller		AHS - VDH	X
151	Megan	Mitchell	Phone	AHS - DVHA	MA
152	MaryKate	Mohlman	here	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		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	Joshua	Plavin		Blue Cross Blue Shield of Vermont	X
168	Luann	Poirer		AHS - DVHA	S
169	Sherry	Pontbriand		NMC	X
170	Alex	Potter		Center for Health and Learning	X
171	Amy	Putnam		DA - Northwest Counseling and Support Ser	MA
172	Betty	Rambur		GMCB	X

173	Allan	Ramsay		GMCB	X
174	Frank	Reed		AHS - DMH	MA
175	Paul	Reiss		HealthFirst/Accountable Care Coalition of t	MA
176	Sarah	Relk			X
177	Virginia	Renfrew		Zatz & Renfrew Consulting	X
178	Lila	Richardson	here	VLA/Health Care Advocate Project	M
179	Susan	Ridzon		HealthFirst	MA
180	Carley	Riley			X
181	Laurie	Riley-Hayes		OneCare Vermont	A
182	Brita	Roy			X
183	Laural	Ruggles		Northeastern Vermont Regional Hospital	M
184	Jenney	Samuelson		AHS - DVHA - Blueprint	MA
185	Howard	Schapiro		University of Vermont Medical Group Pract	X
186	seashre@msn	seashre@msn.com		House Health Committee	X
187	Rachel	Seelig		VLA/Senior Citizens Law Project	MA
188	Susan	Shane		OneCare Vermont	X
189	Julia	Shaw		VLA/Health Care Advocate Project	M
190	Melanie	Sheehan		Mt. Ascutney Hospital and Health Center	X
191	Miriam	Sheehey		OneCare Vermont	MA
192	Don	Shook		Northwestern Medical Center	MA
193	Kate	Simmons		Bi-State Primary Care/CHAC	M
194	Colleen	Sinon		Northeastern Vermont Regional Hospital	X
195	Shawn	Skafelstad		AHS - Central Office	MA
196	Heather	Skeels		Bi-State Primary Care	MA
197	Richard	Slusky		GMCB	M
198	Chris	Smith		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 a	M
205	Cindy	Thomas		AHS - VDH	MA
206	Shannon	Thompson		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	Kendall	West		Bi-State Primary Care/CHAC	MA
218	James	Westrich	here	AHS - DVHA	S
219	Robert	Wheeler		Blue Cross Blue Shield of Vermont	X
220	Bradley	Wilhelm		AHS - DVHA	S
221	Jason	Williams		UVM Medical Center	X
222	Sharon	Winn		Bi-State Primary Care	X
223	Stephanie	Winters		Vermont Medical Society	X
224	Hillary	Wolfley			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
					228

Holly Stone
Cy Jordan
Brian Costello
Randy Messier
Josh Flavin

Attachment 4: Medicaid Pathway Presentation

INTEGRATED HEALTH SYSTEM UPDATE

ALL PAYER MODEL & MEDICAID PATHWAY

PAYMENT MODELS DESIGN AND IMPLEMENTATION WORK GROUP

VHCIP

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HEALTH CARE REFORM

Medicaid Pathway: Payment and Delivery System Reform Continuous Cycle

Key questions for today?

1. What is the all payer model?
2. What is the Medicaid Pathway?
3. How does the State pivot from idea to action?
   a) Project plan
   b) Stakeholder engagement
4. How do we know if this is working for SOV? Providers?
5. What are we missing?

One Goal, Two Projects

Big Goal:

Integrated health system able to achieve the triple aim

- ✓ Improve patient experience of care
- ✓ Improving the health of populations
- ✓ Reduce per capita cost

Implementing Next Generation ACO Type Capitated Payment Model:
Way to pursue goal of integrated system for certain services and providers.

Implementation led by DVHA with support from others.

Medicaid Pathway:

Task of pursuing goal of integrated system for services not subject to financial caps of all-payer model.

AHS led project that interacts with ongoing AHS reform efforts and SIM.

CRITICAL TAKE-AWAY: Implementation of a Medicaid Next-Gen ACO that provides a sub-set of Medicaid services and is subject to financial caps is only one piece of the all-payer model and envisioned delivery system reforms.

All-Payer Model

- An **all-payer model** is an agreement between the State and the Center for Medicare and Medicaid Services (CMS) that allows Vermont to explore new ways of financing and delivering health care.

- The all-payer model enables the three main payers of health care in Vermont – **Medicaid, Medicare, and commercial insurance, to pay for health care differently** than through fee-for-service reimbursement.

Why Pay Differently Than Fee-for-Service?

- Health care cost growth is not sustainable.
- Health care needs have evolved since the fee-for-service system was established more than fifty years ago.
  - More people are living today with multiple chronic conditions.
  - CDC reports that treating chronic conditions accounts for 86% of our health care costs.
- Fee-for-service reimbursement is a barrier for providers trying to coordinate patient care and to promote health.
  - Care coordination and health promotion activities are not rewarded by fee-for-service compensation structure.

How Do We Pay Differently in APM?

- The federal government has created programs that encourage the use of **Accountable Care Organizations** (ACOs).

- The federal **Next Generation ACO program** allows ACOs to be paid an all-inclusive population-based payment for each Medicare beneficiary attributed to the ACO. CMS will allow ACOs some flexibility in certain payment rules in exchange for accepting this new type of payment.

- Health care providers' participation in ACOs is voluntary; the ACO must be attractive to providers and offer an alternative health care delivery model that is appealing enough to join.

Goals of a Transformative All-Payer Model

- Improve experience of care for patients
- Improve access to primary, preventive services
- Reward high value care
- Construct a highly integrated system
- Empower provider-led health care delivery change
- Control the rate of growth in total health care expenditures
- Align measures of health care quality and efficiency across health care system

Can We Get There?

- Vermont has all-payer reforms in place today
  - Shared Savings Program (SSP) for Accountable Care Organizations (ACOs)
    - Medicare offers a SSP for ACOs
    - Commercial SSP Standards
    - Medicaid SSP Standards
  - The Blueprint for Health
    - Medicare participates through a demonstration waiver
    - Commercial participation
    - Medicaid participation
- Fee-For-Service is still the underlying payment mechanism in these models

Vermont's Proposed Term Sheet

- The term sheet includes all of the basic legal, policy, and enforcement provisions that would be in a Model Agreement.
- In some cases, terms refer to appendices which will have greater technical detail or to processes that will occur during 2016.

	Term
1.	Legal Authority
2.	Performance Period
3.	Medicare Beneficiary Protections
4.	Medicare Basic Payment Waivers
5.	Medicare Innovation Waivers
6.	Infrastructure Payment Waivers
7.	Fraud and Abuse Waivers
8.	Request for Additional Waivers
9.	Revocation of Waivers
10.	All-Payer Rate Setting System
11.	Provider Participation in Alternative Payment
12.	Regulated Services
13.	Financial Targets
14.	Quality Monitoring and Reporting
15.	Data Sharing
16.	All Payer Model Evaluation
17.	Modification
18.	Termination and Corrective Action Triggers

Steps Toward an APM

- Develop All-Payer Model and Financial Targets
- Create Standards for Accountable Care Organization Program
- Exercise GMCB Rate and Regulatory Authority
- Attain Quality Improvement and Cost Control

VERMONT HEALTH CARE REFORM

Next Steps

- Assess and Evaluate All-Payer Model Proposal
  - Taking all points of view into consideration, the Green Mountain Care Board and the Agency of Administration must independently assess the potential of the all-payer model to build a system that offers the right incentives and rewards providers for delivering on the promise of integrated, coordinated, high quality care.

- Based on evaluation of term sheet,
  - Continue negotiations with CMS on All-Payer Model
  - If Vermont decides the final agreement is not better than today's system, it can end the negotiation with CMS.
  - Similarly, if CMS is not satisfied that the overall proposal meets its policy and financial goals, it can decline to enter into the agreement.

Medicaid Pathway

What is it?

- It refers to several critical ideas:
  - There is payment and delivery system reform that must happen alongside the all-payer model (APM) regulated revenue/cap conversation.
  - There is a process for Medicaid providers to engage in with the State alongside the APM regulated revenue/cap conversation.
  - This process is led by AHS-Central Office in partnership with the Agency of Administration and includes Medicaid service providers who provide services that are not included in the initial APM implementation, such as LTSS, Mental Health, substance abuse services and others.
  - The Medicaid Pathway advances payment and delivery system reform for services not subject to the additional caps and regulation required by the APM. The goal is alignment of payment and delivery principles that support a more integrated system of care.

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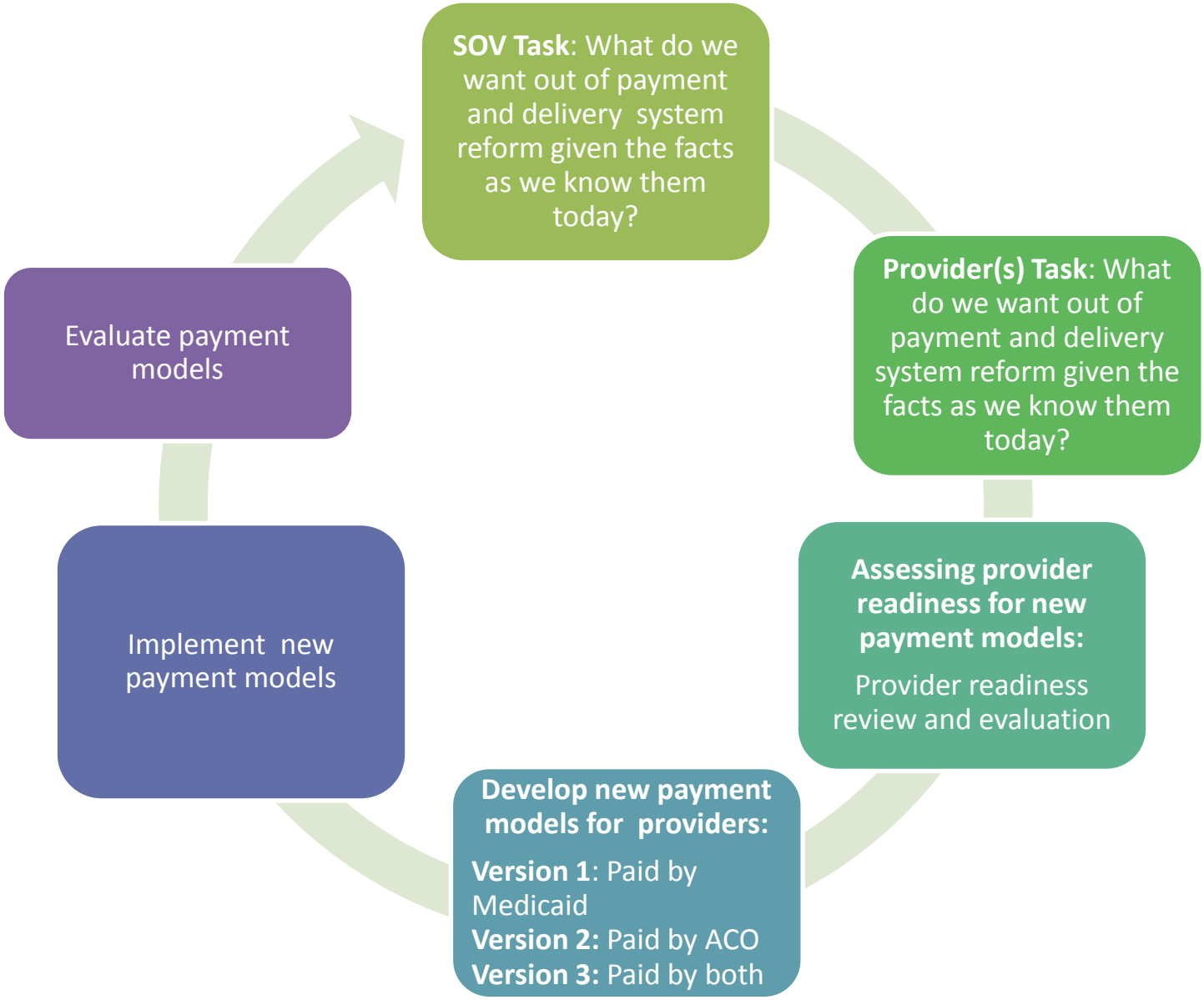
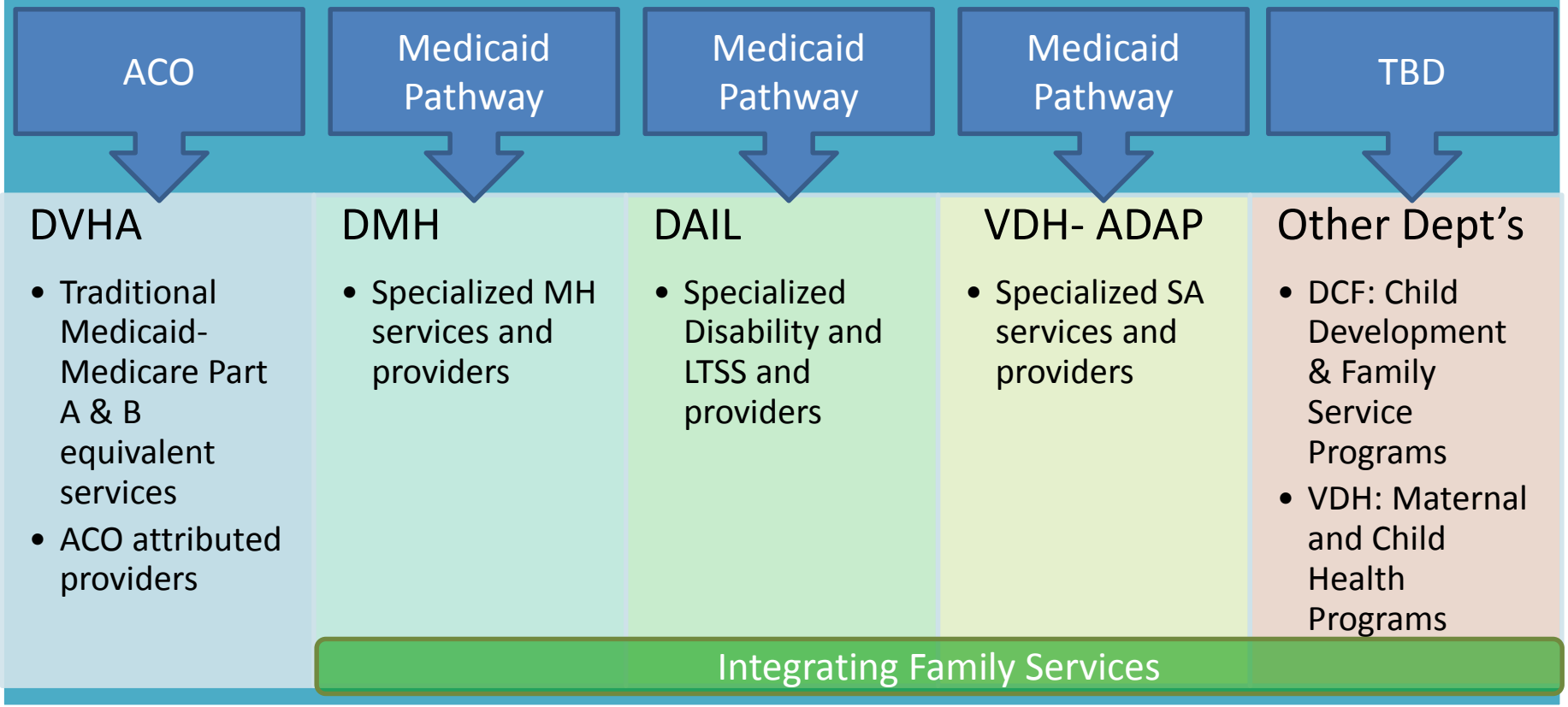
Medicaid Pathway: Payment and Delivery System Reform Continuous Cycle

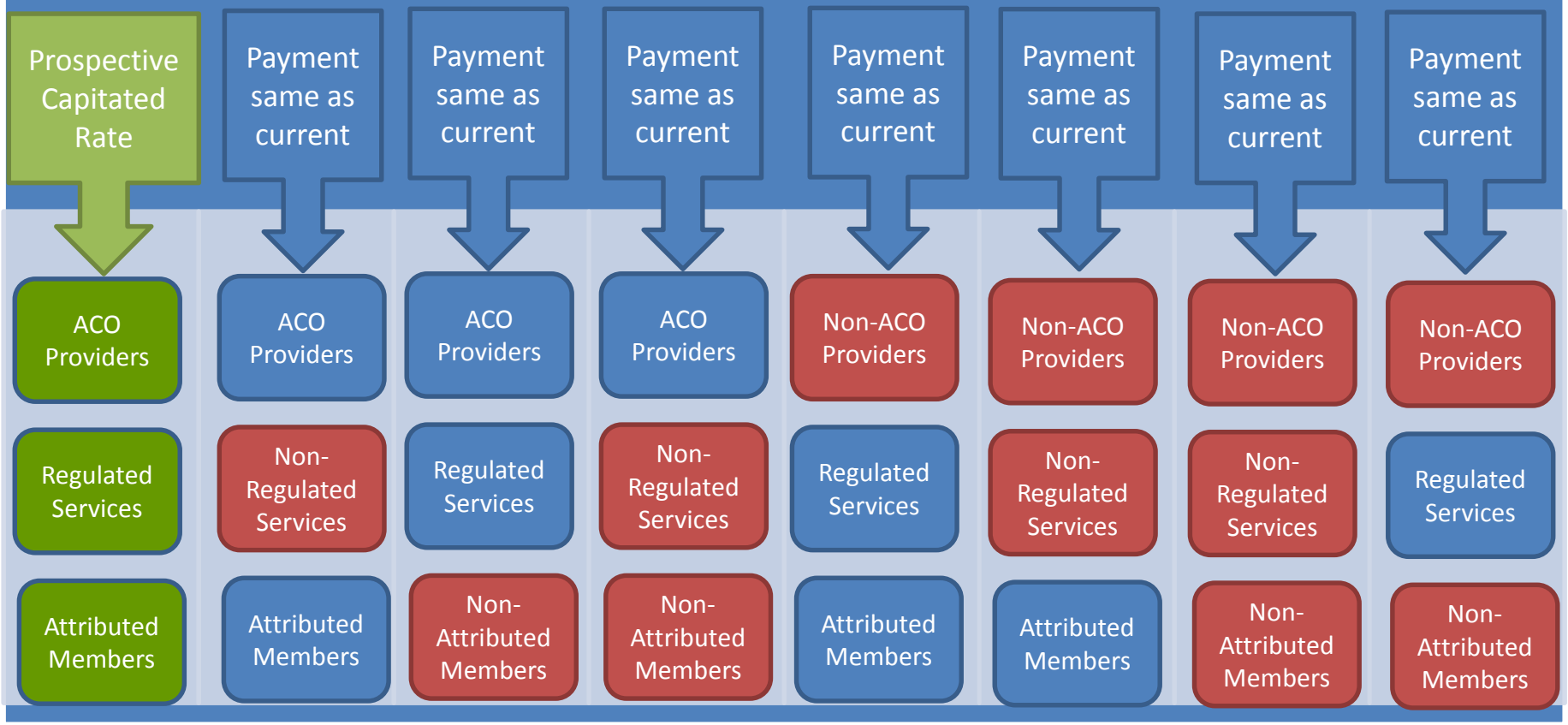


Current Medicaid APM payment reform efforts



DVHA and the Medicaid Pathway

DVHA is implementing a new payment model that impacts some, but not all, providers, services and members.



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Medicaid Pathway Principles and Goals

Ensure Access to Care for Consumers with Special Health Needs

- Access to Care includes availability of high quality services as well as the sustainability of specialized providers
- Ensure the State's most vulnerable populations have access to comprehensive care

Promote Person and/or Family Centered Care

- Person and/or Family Centered includes supporting a full continuum of traditional and non-traditional Medicaid services based on individual and/or family treatment needs and choices
- Service delivery should be coordinated across all systems of care (physical, behavioral and mental health and long term services and supports)

Ensure Quality and Promote Positive Health Outcomes

- Quality Indicators should utilize a broad measures that include structure, process and experience of care measures
- Positive Health Outcomes include measures of independence (e.g., employment and living situation) as well as traditional health scores (e.g., assessment of functioning and condition specific indicators)

Ensure the Appropriate Allocation of Resources and Manage Costs

- Financial responsibility, provider oversight and policy need to be aligned to mitigate the potential for unintended consequences of decisions in one area made in isolation of other factors

Create a Structural Framework to Support the Integration of Services

- Any proposed change should be goal directed and promote meaningful improvement
- Departmental structures must support accountability and efficiency of operations at both the State and provider level
- Short and long term goals aligned with current Health Care Reform effort

Medicaid Pathway Process

Delivery System Transformation (Model of Care)

- What will providers be doing differently?
- What is the scope of the transformation?
- How will transformation support integration?

Payment Model Reform (Reimbursement Method, Rate Setting)

- What is the best reimbursement method to support the Model of Care (e.g. fee for service, case rate, episode of care, capitated, global payment)?
- Rate setting to support the model of care, control State cost and support beneficiary access to care
- Incentives to support the practice transformation

Quality Framework (including Data Collection, Storage and Reporting)

- What quality measures will mitigate any risk inherent in preferred reimbursement model (e.g. support accountability and program integrity); allow the State to assess provider transformation (e.g. structure and process); and assure beneficiaries needs are met?

Outcomes

- Is anyone better off?

Readiness, Resources and Technical Assistance

Who is on the Medicaid Pathway?

Group 1: Under the SIM demonstration Providers of MH and SA are working with State reps to answer the MP process questions. This group started meeting 11/2015 and aims to have an implementation proposal by 7/2016.

ENTER

Group 2: The DLTSS Work Group under SIM has also started to engage in a similar planning process.

Group 3: AHS needs to engage with other community providers in a planning process to determine how and when other services and providers will enter the Medicaid Pathway process.

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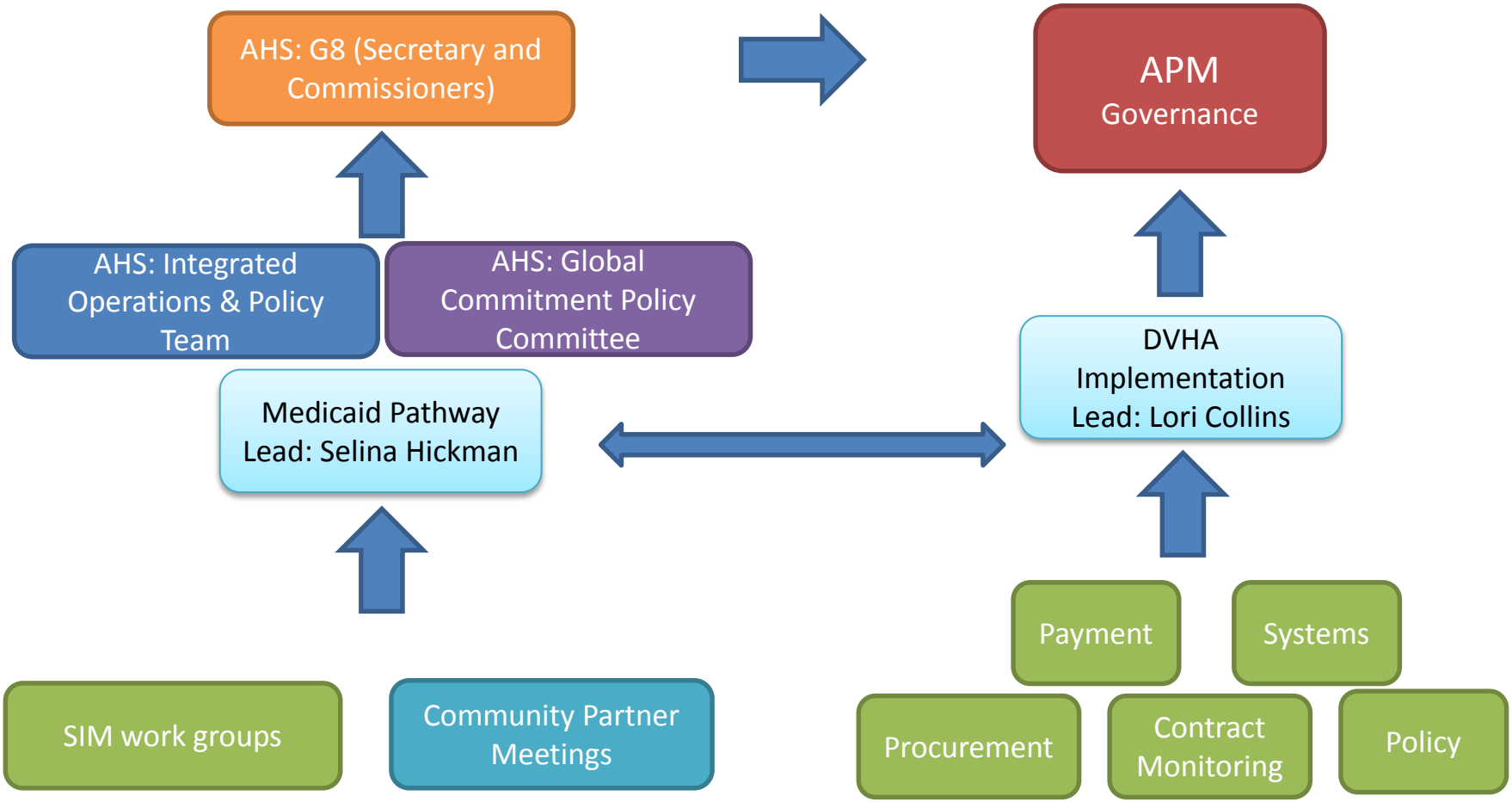
Medicaid Pathway DRAFT Governance



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Resource Slide: Key Terms and Concepts

- **All-payer model: catch all term to describe (1) an agreement with CMS that waives federal laws so that (2) Medicare will pay a capitated payment to an ACO for hospital and physician services in exchange for (3) a State commitment to meet financial targets and quality goals. The State would then (4) align commercial insurers and Medicaid to pay the ACO the same way as Medicare.**
- **Next Generation: a Medicare ACO program that offers several waivers and four payment models, including a capitated payment. Next Generation provides the programmatic base for the all-payer model.**
- **Regulated revenue: the covered services and revenue within the all-payer model and subject to the financial and quality targets.**
- **Medicare infrastructure waivers: a fancy way of saying that we are asking Medicare to (1) keep making Blueprint payments, (2) expand SASH, and (3) invest in Hub and Spoke.**
- **All-payer financial targets: Limitation on spending for services and spending inside the all-payer model. The target is 3.5% and ceiling 4.3%. These numbers are limits, not guaranteed annual revenue increases to providers participating in the model. The State proposed a floor as well, a minimum rate of Medicare growth. This protects the State against unexpectedly low Medicare growth.**
- **Medicaid Pathway: a process through which AHS advances payment and delivery system reform outside of the additional caps and regulation required by the APM. The goal is alignment of payment and delivery principles that support a more integrated system of care**

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