DLTSS Work Group Meeting

Agenda 3-26-15

VT Health Care Innovation Project

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

Thursday, March 26, 2015; 10:00 PM to 12:30 PM

DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

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

Item	Time Frame	Topic	Relevant Attachments	Decision Needed ?
1	10:00 – 10:10	**Welcome; Approval of Minutes** Deborah Lisi-Baker and Judy Peterson	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from February 19, 2015	Yes
2	10:10 - 11:15	**All-Payer Model – Goals, Objectives, Desired Outcomes and Next Steps** Lawrence Miller, Chief of Health Care Reform, Office of the Governor	• Attachment 2a: All-Payer Model Intro – 3/26/15 • Attachment 2b: All-Payer Model Discussion Questions	
3	11:15 – 12:15	**Global Commitment Waiver and Recent Consolidation with Choices for Care Waiver** Monica Light, AHS Director of Health Care Operations, Compliance, & Improvement	• Attachment 3: Global Commitment Waiver Overview	
4	12:15 – 12:30	**Public Comment/Updates/Next Steps** Deborah Lisi-Baker and Judy Peterson	• Next Meeting: Thursday, April 30, 2015, 10:00 am – 12:30 pm, 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier	

Attachment 1b

DLTSS 2-19-15 Minutes

Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, February 19, 2015; 10:00am-12:30pm, EXE - 4th Floor Conf Room, Pavilion Building, 109 State Street, Montpelier

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Deborah Lisi-Baker called the meeting to order at 10:05 am. A roll call attendance was taken and a quorum was present. Deborah Lisi-Baker entertained a motion to approve the December 4, 2014, meeting minutes. Julie Tessler moved to accept the minutes by exception. Sue Aranoff seconded. The minutes were approved with three abstentions. Kirsten Murphy moved to accept the minutes for the January 22, 2015, meeting. Sue Aranoff seconded. The minutes were approved with five abstentions.	
2. Central Vermont Health Service Area Collaborative: Informational Presentation and Progress to Date	Mary Moulton of Washington County Mental Health Services presented on the Central Vermont Health Services Area Collaborative (see Attachment #2). The group discussed the following: • How to ensure appropriate and cost-effective utilization? How can a one-door approach support this? Mary Moulton clarified that a "virtual" one door uses similar processes at multiple provider types/provider sites to make sure patients get the most appropriate care for their needs. • How are participating providers sharing medical information electronically in a way that protects patient health information and privacy? Data security is key, as are releases that allow sharing of patient data and ensure that patients understand what data will be shared and how. • How does this work interact with local Blueprint and ACO committees and projects? This has broadened the types of providers who are participating in local QI activities. • How does this relate to the idea of Totally Accountable Care Organizations, Coordinated Care Organizations, Accountable Communities for Health, or Unified Community Collaboratives? All of these concepts touch on	

Agenda Item	Discussion	Next Steps
	the same ideas – Central Vermont HSA is working to increase collaboration and coordination across providers through this model, which would also be a key component of TACOs, CCOs, ACHs, and UCCs. • How are consumers involved? Consumers will be involved in systems planning in the future (not patient case review). • Are all of the pilot patients living in community settings? Yes. • Do all have both physical health and mental health needs? No, many do not have mental health needs, though many have been referred to mental health services to better address psycho-social needs. • Did participating provider organizations need BAAs or other formal agreements to share patient information? Yes, they have BAAs in place. • Mary Moulton estimated that the group has achieved approximately 60% fidelity to the DLTSS model. There are some gaps: for example, it has been a challenge to have a single case manager that is the point person for all the individual's needs • How are people with substance use disorders being served by this work? A few of the pilot population have substance use disorders; those patients have been referred for treatment and substance abuse providers brought into the care team. • How is data being collected? Through the Blueprint practices. • Who is currently the lead care coordinator? Always the care coordinator at Blueprint physician's office. • How does this group support patients in taking prescribed medications? Partnerships with community providers support this. • Do Blueprint CHTs already include behaviorists or health coaches? They may in some areas. In Washington County, CHTs still expressed need for Motivational Interview training. • What's happening in other areas of the state? Mental health is represented on CHTs in other areas of the state. • Has this group connected with the ACTT Project, specifically the Universal Transfer Protocol design work? Vermont Care Partners is involved in the ACTT Project as well as this group. Mary Moulton closed her presentation with a brief description of other initiatives underway at Washington County Mental Health Services, including: Medical practice integration with medical practices; wellness programming; case review with community providers; a pediatrics pilot with medical practices; system integration with the local Health Center; a doula program with CVMC; and an initiative to create bi-directional care as part of a health home. WCMHS has also requested funds from the Susan G. Komen to support cancer pre-screening for people with serious and persistent mental illness. If members have additional comments, feedback, or questions, please contact the co-chairs or Julie Wasserman (Julie.Wasserman@state.vt.us).	

Agenda Item	Discussion	Next Steps
3. An Introduction to the All-Payer Waiver	Robin Lunge presented on Vermont's proposed All-Payer Model (see Attachment #3). Julie Wasserman noted that Lawrence Miller will be at this group's March meeting to present on this topic in more detail. The group discussed the following: • Will this waiver be time limited? Yes, as with other waivers, this would have a 5-year term, after which we must re-negotiate or extend. • Have we had any assurance that CMS will listen to this and negotiate on a waiver? CMS is excited to work with Vermont, but if the State and federal government aren't able to come to a compromise, we will not agree to a waiver. • How will we decide which providers will be included in the waiver? Robin Lunge suggested examples of possible providers that might be included, only intended for examples. The State is working with CMS to design a process for deciding which providers will be included. • What will the waiver do? Robin emphasized that the waiver would not affect eligibility, benefits or beneficiary protections. It would provide authority to change the Medicare reimbursement methodology; however, this will not result in more funding coming into the system, but rather it just changes the reimbursement model. • Is there a website or other public information out there on this? This presentation is the only public document available at this time. DLTSS members are invited to submit their follow up questions and comments to Julie Wasserman (Julie.Wasserman@state.vt.us) by COB next Friday, February 27th.	
4. ACTT Project Overview and Accomplishments to Date	Larry Sandage introduced the Advancing Care Through Technology (ACTT) Project, a project to support HIT development across the full continuum of care, including DA and SSA systems, and the DLTSS system. There are three projects within ACTT (see Attachment #4). The group discussed the following: Project 1: Data Quality Project • What is MSR data? Monthly Service Report, data already sent by Designated Agencies to DMH. This is something providers already collect and send and provided a starting point to test data quality. • Initial data dictionary is complete. What is a data dictionary? A data dictionary is an index of all the data elements within a database that describes what kind of data would be entered and how it is collected. The goal is consistency within the data entry, collection and reporting. • What is QSOA? Qualified Service Organization Agreement – an agreement between the agencies and Vermont Care Partners. • Three reasons to do this project:	

Agenda Item	Discussion	Next Steps
	o For efficiency purposes – to create a single point of access for reporting purposes and ultimately, connection to the VHIE (Vermont Health Information Exchange) o For quality improvement of services – ability to look at consistent, aggregated data with a lens toward population health improvement o A solution for the 42 CRF Part 2 data sharing restrictions (related to substance use and abuse) – ultimately, the goal is to find a way to aggregate data in a manner that is compliant with the rule • An RFP will be forthcoming Project 2: DLTSS Data Planning Project • The project is assessing the current state of technology tools for care management and care coordination. It is an inventory of HIT capabilities for a variety of DLTSS providers across the state. "Who's using what" in terms of already existing tools, or planned tools. This includes an assessment of interoperability with the VHIE. • A report will be forthcoming in March • A question was posed whether we will ultimately be able to compare data across systems? The response was that this is problematic because of how data is collected, stored and used from one entity to another. There is, however, some similarity in certain data related to payment and outcomes. Project 3: Universal Transfer Protocol (UTP) • The UTP is not just a form; it is a system to exchange data sets; it is a process. • The project is creating a charter for the next phase of the project, including creating a definition of UTP: "*Universal Transfer Protocol (UTP) is a process across the entire system that gives all partners who have a role in the patient's care access to the same standardized information and the responsibility to ensure that the information is accurate, current, and supports the patient's goals and quality of life*." Heather Johnson, ADRC project manager • Project focus has been to design, test and create standard data sets so they can be shared. Ultimately, a single data dictionary is needed to link anyone to everyone. • It is designed to prevent gaps in care, coverage and information sharing as patients move within the system of care. • Providers have been interviewed in Bennington, Rutland and St. Johnsbury to determine data criteria. • The solution needs to be technology-agnostic • The methodology has been to engage providers to determine: o The most basic information o Channels across which to share the data o Communication continuity (follows the patient through the care continuum) • The recommendation for next steps includes a 'harmonization period' in which to true-up the data.	

Agenda Item	Discussion	Next Steps
	• A question was posed – will the system be useable when sequencing makes a difference? The response is that data integrity – a shared, agreed-upon basis for information exchange is the key. • A question was posed related to some testing in Bennington and St. Johnsbury – the response is that the testing was related to clarifications around roles and responsibilities within the system of care so that persons in similar positions know who to contact and what to ask in another facility. The testing is related to correctly directing communications. • More information can be found at http://im21-utp-vt.com/	
5. Public Comment/Next Steps	There was no additional comment. **Next Meeting:** Thursday, March 26, 2015, 10:00am-12:30pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

VHCIP DLTSS Work Group Member List

Roll Call: 2-19-2014

Julie T 1°
Susan A 2°

Kirsten M 1°
Susan A 2°

Minutes approved
Motion by exception

A=Abstain

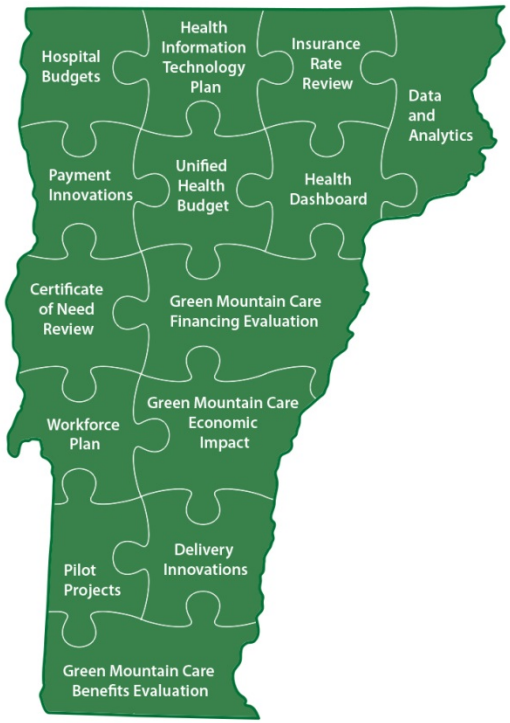
Member		Member Alternate		December Minutes	January Minutes	
First Name	Last Name	First Name	Last Name			Organization
Susan	Aranoff					AHS - DAIL
Debbie	Austin	Craig	Jones			AHS - DVHA
Molly	Dugan					Cathedral Square and SASH Program
Patrick	Flood					CHAC
Mary	Fredette					The Gathering Place
Joyce	Gallimore			No vote		Bi-State Primary Care
Martita	Giard	Susan	Shane		A	OneCare Vermont
Larry	Goetschius	Joy	Chilton			Home Health and Hospice
Dale	Hackett			A	A	None
Mike	Hall					Champlain Valley Area Agency on Aging
Jeanne	Hutchins					UVM Center on Aging
Pat	Jones	Richard	Slusky			GMCB
Dion	LaShay					Consumer Representative
Deborah	Lisi-Baker					SOV - Consultant
Sam	Liss					Statewide Independent Living Council
Jackie	Majoros	Barbara	Prine	A	A	VLA/Disability Law Project
Carol	Maroni					Community Health Services of Lamoille Valley
Madeleine	Mongan					Vermont Medical Society
Nick	Nichols					AHS - DMH
Ed	Paquin					Disability Rights Vermont
Laura	Pelosi					Vermont Health Care Association
Eileen	Peltier					Central Vermont Community Land Trust
Judy	Peterson				A	Visiting Nurse Association of Chittenden and Grand Isle Counties
Paul	Reiss	Amy	Cooper			Accountable Care Coalition of the Green Mountains
Rachel	Seelig	Trinka	Kerr			VLA/Senior Citizens Law Project
Julie	Tessler	Marlys	Waller			DA - Vermont Council of Developmental and Mental Health Services
Nancy	Warner	Mike	Hall			COVE
Julie	Wasserman				A	AHS - Central Office
Jason	Williams					UVM Medical Center
	29		9			

18 Quorum

Kirsten Murphy | Dec: A | Jan:

Mary Alice Bisbee

Attachment 2a
All-Payer Waiver Model
Introduction



Vermont's All Payer Model

Presentation to the DLTSS Work Group

March 26, 2015

Lawrence Miller, Chief of Health Care Reform,
Office of the Governor

VERMONT
GREEN MOUNTAIN CARE BOARD

What is an all-payer model?

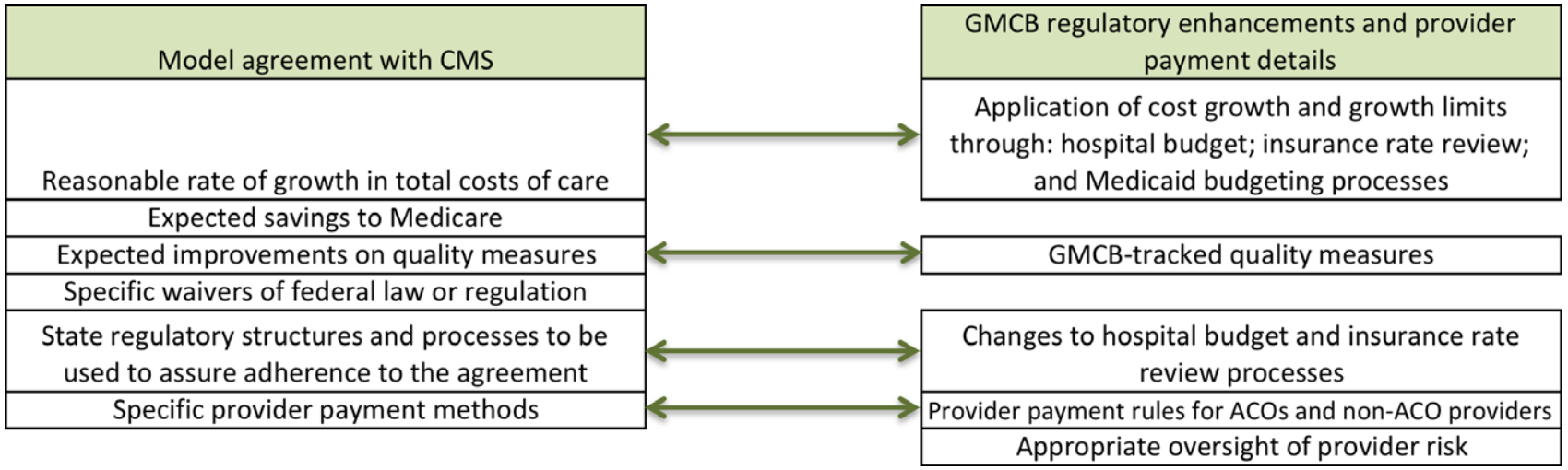
- A system of health care provider payment under which all payers – Medicare, Medicaid and commercial insurers such as Blue Cross and Blue Shield – pay doctors, hospitals and other health care providers on a consistent basis, within rules prescribed by a state or national government
- Can be used to promote desirable outcomes and reduce or eliminate cost-shifting between payers
- In the U.S., the only example of an all-payer model is in Maryland (currently only for hospital payments)
- A number of other countries use all-payer systems to assure that provider payments are fair, transparent and consistent with desired policies such as promoting primary care, prevention, quality of care and cost containment

One project, two major components

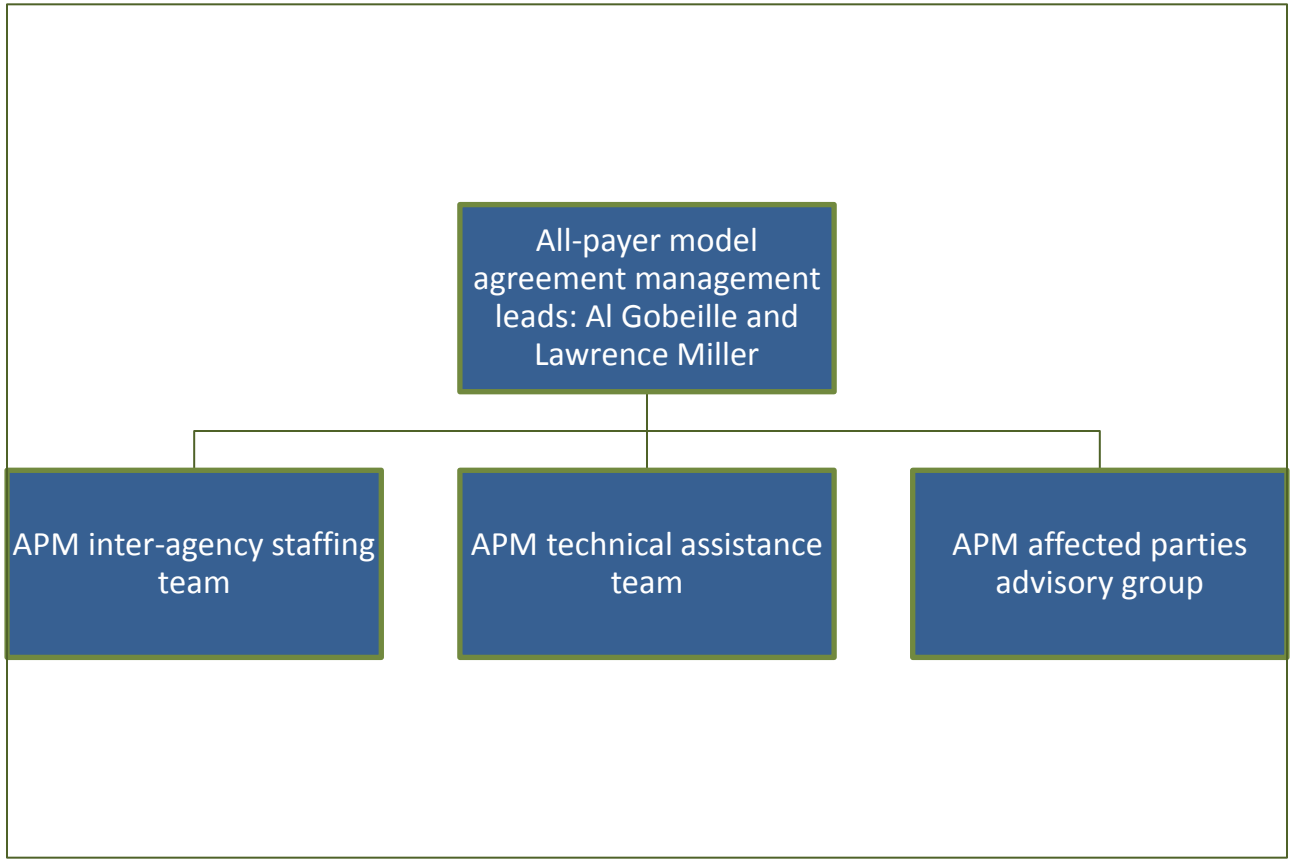
Vermont All-Payer Model Project Structure and Responsibilities		
	Model agreement with CMS	GMCB regulatory enhancements and provider payment details
Purpose	To establish the parameters of an agreement with the federal government that would permit Medicare inclusion in a Vermont all-payer system	To establish the specific rules and processes governing provider payment, ACO oversight and all-payer oversight
Lead agency(ies)	GMCB and AOA	GMCB
Coordinating agencies	AHS	DFR, AHS, AOA

Related processes
Legislative oversight: Regulatory and Medicaid budgets
Administrative rules process

Examples of technical issues to be addressed in each process, and inter-relationship between them



Structure for leadership, staffing and stakeholder input on model agreement



Attachment 2b

All-Payer Waiver Model

Discussion Questions

All-Payer Model
Lawrence Miller, Presenter
Disability and Long Term Services and Supports (DLTSS) Work Group
March 26, 2015

Questions Posed by the DLTSS Work Group

1. Can you give a brief overview of the All-Payer Model and describe the expected (high-level) timelines and associated processes for negotiating, developing and implementing Vermont's All-Payer Model?

2. How will an All-Payer Model affect costs, affordability, health outcomes, and population health? Where might we see savings?

3. Will an All-Payer Model improve the delivery of services for people in general and for those with DLTSS needs? Will the All-Payer Model help expand community-based services for people with DLTSS needs?

4. Under an All-Payer Model, will all payers (Medicare, Medicaid, Commercial insurers, Uninsured) pay providers the same rate for the same service?

5. In achieving consistency across payers, how will Medicare be affected? Please enumerate any anticipated changes. Will Medicare reimbursement mechanisms remain the same? Will Medicare payment rates stay the same? Will providers continue to bill Medicare directly and will Medicare still make the payments?

6. Are Commercial insurers supportive of the All-Payer concept?

7. Is it anticipated that Commercial reimbursement rates would be standardized to Medicare payment rates? As a result, would Commercial payment rates drop to Medicare levels? If Commercial insurers reimburse providers at lower rates than currently, will premiums drop accordingly? Will providers accept the lower Commercial payment rates?

8. Is it anticipated that Medicaid reimbursement rates would be standardized to Medicare payment rates? As a result, would Medicaid payment rates rise to Medicare levels? If Medicaid reimburses providers at higher rates, would that potentially offset the drop in Commercial payment rates for providers?

9. The GMCB recently stated that raising Medicaid reimbursement rates to Medicare levels would cost $51 million. If the Legislature does not approve expenditures to increase Medicaid rates to Medicare levels, are there other options that could be pursued to achieve an All-Payer Model?

10. Will the development of standardized fee-for-service hospital payment rates across all payers be the first step in moving toward standardizing *costs per case* (hospital inpatient and outpatient services) as Maryland has done? (As the cost per case tightened, Maryland witnessed an increase in the number of cases and is now developing an all-payer *cost per capita* growth limit for hospital inpatient and outpatient care for all Maryland residents.)

11. Slide 4 mentions "total costs of care". Which providers and services will be included in the total cost of care and how will this be decided? Will Developmental Services, CRT and Choices for Care Waivers (of the Consolidated Global Commitment) be contained in the total cost of care?

12. Will the All-Payer Model be piloted with one or more ACOs? What is meant by "ACO oversight" on Slide 3 under GMCB regulatory enhancements?

13. How does an All-Payer Model comport with Medicare and Medicaid ACO Shared Savings Programs given these SSPs are based on current fee-for-service reimbursement rates?

14. If some form of population-based payment methodology is used, and the ACO structure is used as the basis for total cost of care calculations, how will providers who are not affiliated with an ACO be included?

15. Will the development of an All-Payer Model incorporate SIM Payment Reform planning efforts on "episodes of care"?

16. Slide 4 mentions "quality measures". How will quality measures be developed? Will existing Medicare and Medicaid SSP quality measures be utilized? Will the VHCIP Quality and Performance Measures Work Group be involved? Will existing or future AHS Global Commitment quality measures be utilized?

17. Will an All-Payer Model have any effect on out of pocket costs for beneficiaries?

18. The slide titled "Structure for leadership, staffing and stakeholder input on model agreement" includes a reference to "APM affected parties advisory group". Who will this advisory group include? When will it be formed and begin meeting?

19. The Federal Government has been clear they expect a thorough vetting of proposals and discussion among Vermont stakeholders before any proposals rise to the level of discussion with the Feds. What mechanisms and processes will be used to ensure involvement of stakeholders statewide?

20. Can you list the top 5 challenges in initiating, developing, and implementing an All-Payer Model in Vermont?

Attachment 3

Global Commitment Waiver

GLOBAL COMMITMENT & MEDICAID MANAGED CARE

General Overview

March 2015

Global Commitment 1115 Waiver

- The Global Commitment Demonstration provides Vermont with the flexibility to apply managed care concepts in order to increase access to care, improve quality of care and control program costs

- Vermont's Global Commitment to Health Demonstration began October 1, 2005; the initial term ended December 31, 2010, it has been extended through December 31, 2016

- Our Choices for Care long-term care waiver (previously its own 1115 demo) is now part of our Global Commitment Demonstration (eff. 1/30/15)

Section 1115 Demonstration Waivers

- Federal government can “waive” many, but not all, of the laws governing Medicaid, including eligible people and services
- Section 1115 waiver authority is intended to encourage state innovation in the Medicaid program
- Often, states identify ways to save Medicaid funds and are permitted to use the savings to expand coverage
- The Federal government approves Section 1115 Demonstrations for five-year terms, and existing Demonstrations can be extended (typically three-year renewals)

Waiver Flexibilities, examples and limits

- Examples of requirements that can be “waived”:
  - Statewideness/Uniformity
  - Amount, Duration, Scope of Services
    - as long as the amount, duration and scope of covered services meets the minimum requirements under Title XIX of the Act
  - Payment to Providers
    - establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved state plan.
  - Freedom of Choice of Provider (restrict to “network”)
- Requirements that are not waived (require Medicaid State Plan approval):
  - New/changed provider types and qualifications
  - New benefits or services
  - Reimbursement for non-GC populations.

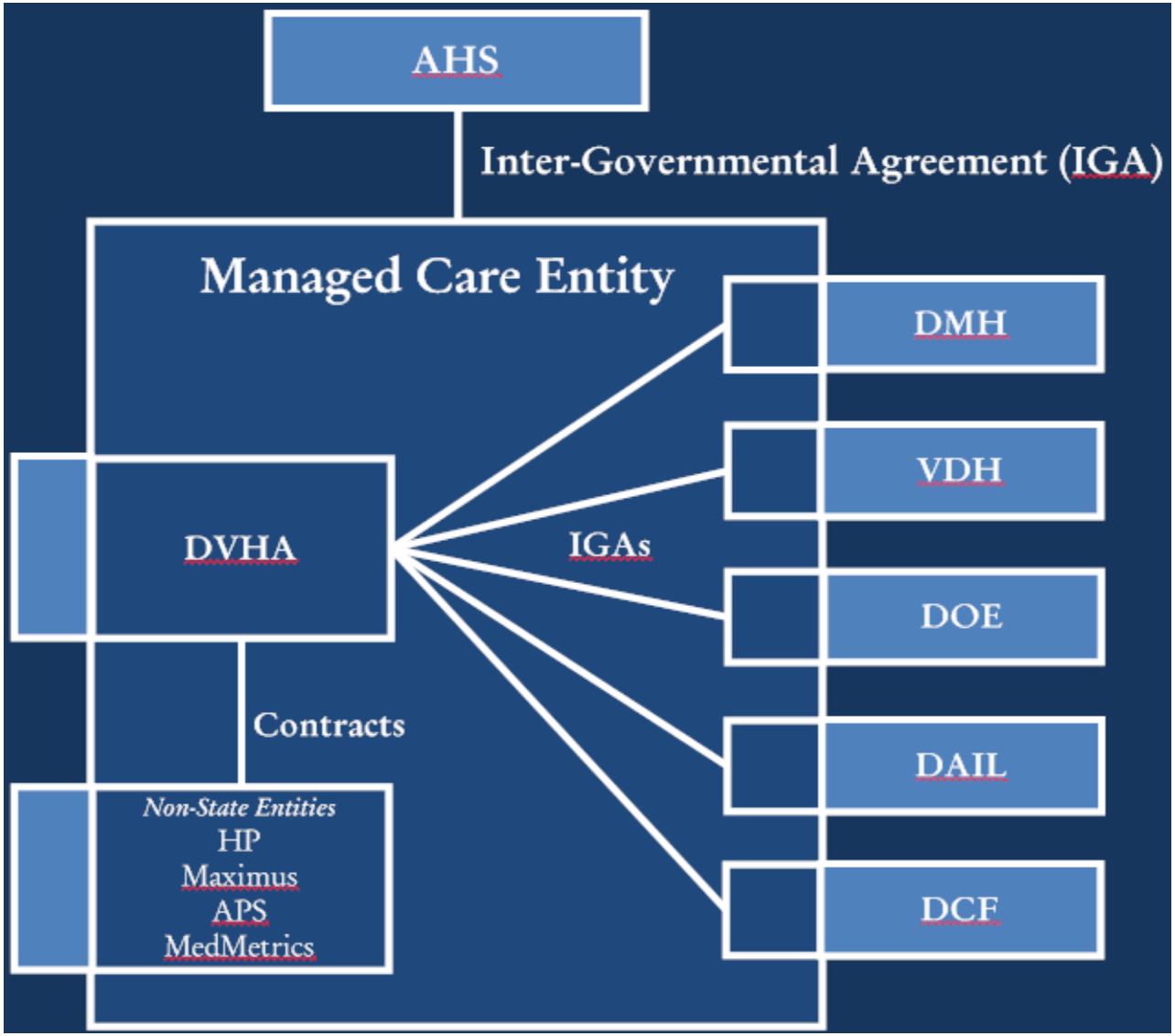
Global Commitment 1115 Waiver

- The Global Commitment Demonstration covers all Medicaid services in Vermont, including:
  - Acute Care Services
  - Long Term Care Services & Supports
  - Traumatic Brain Injury (TBI)
  - Children's Mental Health
  - Community Rehabilitation and Treatment (CRT)
  - Developmental Disability Services (DS)

Medicaid Managed Care Regulations

- The State must adhere to Medicaid managed care regulations for all GC funded programs and activities (42 CFR 438 et. seq.)
  - Enrollee Rights & Protections
  - Quality Assessment & Improvement
    - *Comprehensive State Quality Strategy*
  - Program Integrity
- Public Input Process

Medicaid Managed Care Structure



Flexibilities of Managed Care Delivery Model

- Greater flexibility in what can be reimbursed (cost effective alternatives & managed care investments).
- A holistic approach to serving individuals and families
- Better communication and collaborative planning when more than one service is being provided to a single consumer or family (Chronic Care, Community Health Teams, Integrated Family Services, etc.)

Impact of Global Commitment Model: Increased Integration

- Operational aspects of GC promote a more unified approach to managing program development or expansion across AHS Departments
- Accounting and budgeting for GC is done as a whole agency
- Elimination of duplicative business processes, program monitoring and reporting requirements
- More efficient and flexible reimbursement mechanisms (e.g., bundled rates, capitation payments, pay-for-performance and/or outcome based contracts)
- More effective data collection systems to support ongoing assessment of service quality and improvement
- Collective AHS-wide compliance with federal Medicaid managed care rules and other waiver requirements.

Global Commitment Financing

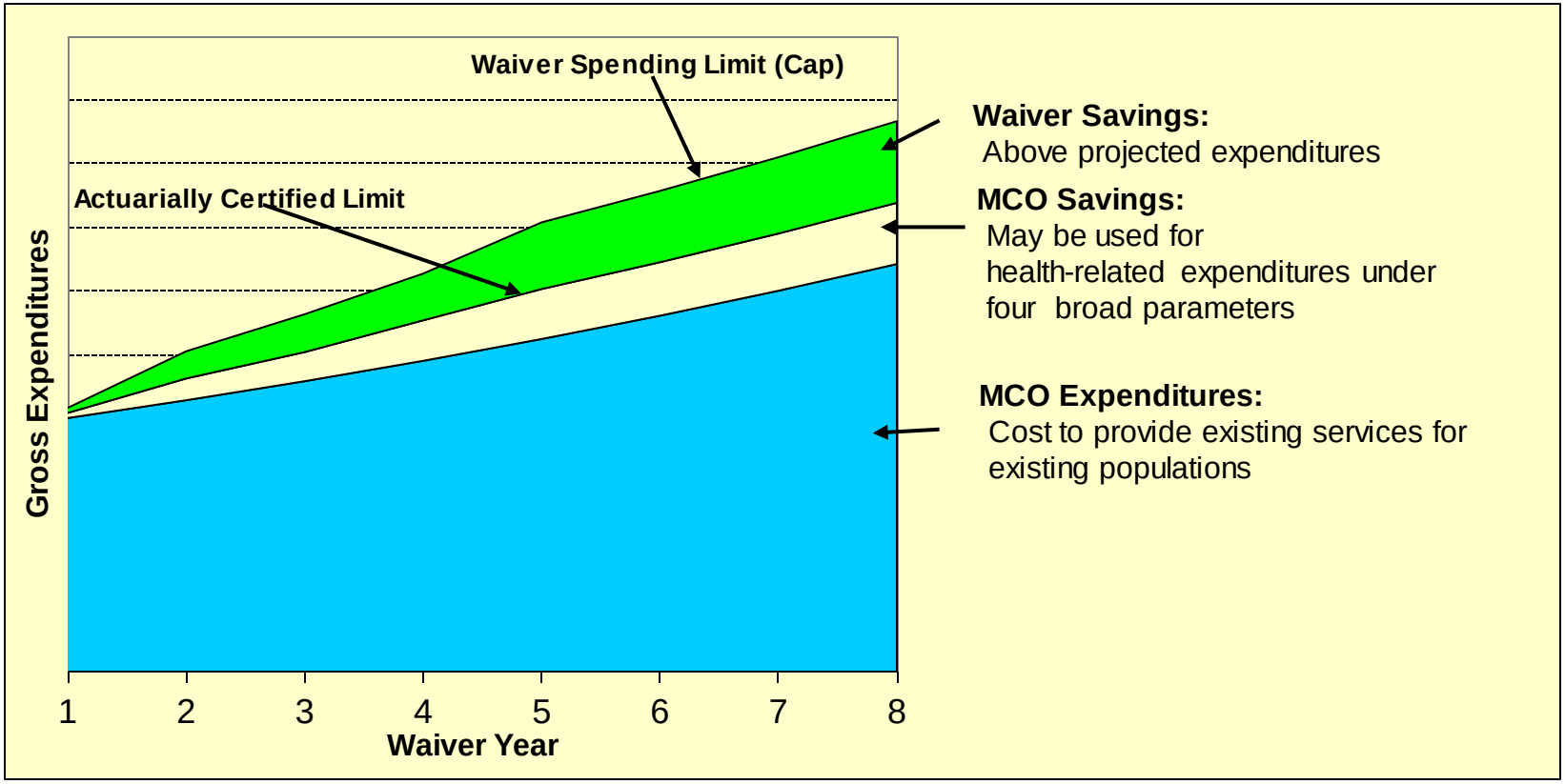
- Section 1115 Demonstrations must be budget neutral (Demonstration expenditures cannot exceed estimated program expenditures under traditional Medicaid rules)
  - Special Terms and Conditions establish aggregate spending limit ($13.7 Billion over 11.25 years)
- Managed care model design incorporates second spending limit
  - Program spending limited to Per Member, Per Month (PMPM) limits, established in accordance with federal managed care rate setting requirements

Managed Care Rate Setting

Calculation of the Per Member, Per Month (PMPM) Limit

- An independent actuary establishes rate ranges across several rate categories, based on a CMS-approved methodology
- AHS establishes a rate within the actuarially-certified rate ranges
- The PMPM limit cannot change once established. The opportunity to adjust for significant fluctuation is October of the following Federal Fiscal Year

Global Commitment



The Waiver Spending Limit excludes:

- CHIP (uninsured children with incomes between 225 and 300 percent of the Federal Poverty Level)
- Disproportionate Share Hospital (DSH) Payments
- Enhanced FFP for IT Infrastructure, Affordable Care Act initiatives

Managed Care Rate Setting

Program financing and the role of the PMPM limits were modified per GAO concerns:

	Original Waiver (Oct. 1, 2005 – Dec. 31, 2010)	Renewal (Jan. 1, 2011 – Dec. 31, 2016)
Role of PMPM	Payment Rate	Payment Limit
Federal Medicaid Funding	PMPM rate represented matching event; capitation payment paid into Global Commitment Fund	Actual program expenditures represent matching event (medical, administrative, managed care investments)

- Establishing a prospective per member per month payment under our old terms put the State at risk for caseload and utilization fluctuations. The new terms and conditions significantly reduce the state's risk for caseload increase and utilization spikes

Managed Care Investments

Expenditures within the per member per month limit (calculated over the life of the Demonstration) can include expenditures for the following purposes:

- Reduce the rate of uninsured and or underinsured in Vermont;
- Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
- Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system

1/30/2015 Waiver Consolidation

- Added Choices for Care; all Medicaid enrollees will be covered under GC terms
- Restores Medicaid member months lost with ACA – former VHAP/Catamount enrollees transitioned to VHC
- Retains stringent member protections for long-term care recipients
- Difficult negotiations with CMS; tenor of the conversation was markedly different than in prior years
    - Expect a challenging process for 1/1/2017

Questions/Discussion