Vermont Health Care Innovation Project
Steering Committee Meeting Minutes

Pending Committee Approval

Date of meeting: Wednesday, March 30, 2016, 1:00pm-3:30pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions; Minutes Approval	Al Gobeille called the meeting to order at 1:03pm. A quorum not present. A quorum was present after the fourth agenda item. *Minutes Approval:* Bob Bick moved to approve the January 27, 2016, meeting minutes by exception. Kim Fitzgerald seconded. The minutes were approved with 5 abstentions (Abe Berman, Bob Bick, Trinka Kerr, Allan Ramsey, Simone Rueschemeyer).	
2. Core Team Update	Georgia Maheras provided a Core Team update. • *Performance Period 3 Milestones and Year 3 Operational Plan:* The Core Team approved proposed Year 3 milestones at their 3/14 meeting. o Attachment 2a: Purple column is PP3 milestones. These are very similar to what was approved by the Core Team last October; some due dates and milestones have changed. Project leadership will now negotiate with CMMI on the details of these milestones. Initial conversations with CMMI have been positive, though they would like additional information on baseline. Reach out to Georgia (georgia.maheras@vermont.gov) or Sarah Kinsler (sarah.kinsler@vermont.gov) with questions about milestones. This attachment will be updated in time for May meeting. o Year 3 Operational Plan due to CMMI on May 2. • *Recent Approvals:* The Core Team approved a few funding items at their 3/14 meeting: o Reallocations for Healthfirst, RiseVT, Southwestern Medical Center; reallocation and additional funds for Vermont Medical Society Foundation; and new requests for MMIS modifications, core competency training (Vermont Developmental Disability Council), and APM actuarial support for Medicaid (Wakely)	

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Public Comment	o Year 3 budget was not ready in time for 3/14 meeting; it will be presented at 4/11 Core Team meeting. As of 3/14, we were still waiting for some Year 2 approvals from CMMI – we have since received these. Update on Year 2 actuals to date is included in 3/14 Core Team materials. • *Performance Period 2 Budget Update:* We have received a number of federal approvals in the last few weeks – thanks to the finance team! There was no additional comment.	
3. Shared Care Plan and Universal Transfer Protocol Update	Georgia Maheras provided an update on the Shared Care Plan (SCP) project (Attachment 3). • This builds on significant work over the past year. Project team identified business and technical requirements through significant research and interviews with three communities around the state. There are at least six solutions in some phase of deployment in the state, with major barriers to implementation (sign-on fatigue, consent policy and architecture issues), and sustainability as a significant issue. • Possible solutions include a policy solution to address consent architecture and policy; or technical solutions. Field of technical solutions is crowded, with solutions from the State (MMISCare), ACOs (OneCare's Care Navigator solution), VCHIP at UVM, and individual communities (Windsor, Newport, and Bennington). • In November, the HDI Work Group approved continued research in this area but specified that we should not invest in a new technology solution not yet in development or implementation in the state. • Staff recommendation in March 2016: Do not pursue technology solution at this time; instead focus on consent and remaining HDI initiatives. The group discussed the following: • SAMHSA proposed rule: State comments are being submitted by AHS General Counsel. SIM participant organizations should free to share comments and thoughts with AHS. • Simone Rueschemeyer added that there has been a significant amount of discussion at the HDI Work Group about this. The choice not to make a recommendation related to a technology solution was a challenging one. • Consent: Georgia Maheras provided an example from the Area Agencies on Aging. AAAs are a part of multi-organizational care teams, but are not considered Health Care Organizations under federal frameworks – they require individual consent to receive/share information as part of a care team. Simone Rueschemeyer added that consent management is also a significant challenge – written consent is not consent forever, and we need a robust consent management system to deal with this on an ongoing basis. Dale Hackett commented that consent must be active for long enough to support ongoing treatment.	

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	• Al Gobeille noted that Health Information Exchanges around the country and internationally have a variety of policies to allow consumers to opt in or opt out of sharing information. John Evans added that the VHIE gets consent information (what information can be used for, and by whom) by providers. Some individuals are involved in patient care but who aren't licensed providers. In Vermont, we can aggregate information, which is a benefit. Vermont has an opt-in consent policy which requires consumers to actively provide consent to be included in the VHIE. Most US states have opt-out policies – patients are assumed to consent unless patients actively refuse. • Dale Hackett suggested we receive more information on opt-in vs. opt-out. Ed Paquin noted that care team members should not have a hard time asking individuals to provide consent. Al Gobeille agreed but noted that there are good arguments on both sides.	
4. Core Competency Training Update	Pat Jones provided an update on the Core Competency Training initiative, which grew out of the Integrated Communities Care Management Learning Collaborative (Attachment 4). • Pat thanked all of the organizations that have sent participants to attend trainings, as well as project staff and work group leadership from the Practice Transformation Work Group and DLTSS Work Group. • Agendas and materials are available on the VHCIP website at http://healthcareinnovation.vermont.gov/node/884 The group discussed the following: • Jay Batra asked who is doing these trainings. Pat replied that Primary Care Development Corporation (PCDC) is the contractor for the care management core competency trainings, and that they have tailored training materials and curriculum for the Vermont context. Vermont Development Disabilities Council (DDC, lead is Kirsten Murphy) is leading the disability awareness training. Both contractors had very well developed curriculums and content expertise. • Georgia Maheras added that the DDC contract is posted on the VHCIP website, and the PCDC contract will be soon – more details about curriculum are included in contract scope. • Cathy Fulton asked whether train-the-trainer programs would provide continual certification and recertification going forward. Pat replied that this is the idea – there may be people newly entering this field or who could not attend these trainings and wanted to have ways to continue to provide this going forward.	
5. Medicaid Pathway	Michael Costa and Selina Hickman provided an update on the Medicaid Pathway project (Attachment 4). • Big Goal: Integrated Health System to achieve the Triple Aim. All-Payer Model (APM) is only part of this; Medicaid Pathway work is pursuing integrated system for services not subject to APM's financial caps – thinking about what the future looks like for services and providers not included in the first phase of the All-Payer Model (~Medicare A and B services). • All-Payer Model is led by AOA and GMCB.	

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	o "Evolution, not revolution" – APM is building on existing all-payer reforms (i.e., SSPs, Blueprint) and working to align payers across the system. Model is based on the federal Next Generation ACO program. Continued work to align payment with quality/value while reducing cost. GMCB would be the regulating authority for the APM. o Working to agree on a "term sheet" with CMMI now; if agreement is reached, the State will seek to enter into a 5-year agreement later this year. Information on the terms and additional details are available on the GMCB website. o This work on payment models will tie to continued work to support practice transformation. • Medicaid Pathway work is led by AHS Central Office. o Ensuring delivery reform and work to increase payment reform readiness doesn't stop for providers not included under APM cap. o Continuous cycle, similar to Plan-Do-Study-Act. Building on SIM stakeholder engagement process. o DVHA has a key role as a payer and lead implementer for APM, which impacts ACO providers. Services covered by APM (equivalent of Medicare A&B services) accounts for ~35% of Medicaid's payments; the other 65% is outside of the APM cap. DMH, DAIL, and VDH ADAP services are a large part of this and will be part of the Medicaid Pathway; in addition, there are some TBD programs and services, including DCF Child Development & Family Service programs and VDH Maternal and Child Health programs. In addition, Integrating Family Services is an existing model we'll continue to expand – AHS isn't trying to recreate the wheel, but instead build off of success here. We have opportunities to thoughtfully work through how to work with each of these sectors as we go through the Medicaid Pathway process. o "All-inclusive population-based payment" = CMMI's preferred term for capitated payment. Under APM, this would apply to a subset of services – services provided by ACO providers that are provided to attributed ACO members that also fall within regulated services. The group discussed the following: • Dale Hackett asked whether the Next Generation model encourages community provider participation. Michael replied that this will hopefully incentivize provider investments in community services by giving providers predictable payments and cash flow. Al Gobeille added that taking on accountability will necessitate investing in primary care, substance abuse, and community services to reduce overall costs. • Jay Batra asked what "integrated health system" means in this context. Michael replied that to him, it means getting people the right care at the right time at the right place and creating financial incentives that support this, rather than financial incentives that support additional service volume. Jay agreed. • Allan Ramsay noted that fee-for-service, for all its faults, promotes delivery of care at high volumes. There are some areas where we need to promote volume, like primary care and substance abuse and	

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	mental health services. In addition, non-FFS payment models are hard to explain to patients. He also noted that cost-sharing is becoming a bigger issue for patients under the current FFS issue. He suggested these are issues we need to address and respect during this process. Michael replied that he thinks of the APM as a series of relationships between payers, ACOs, and providers. Allan added that the system needs to promote delivery of some services and reduce delivery of other services. Al Gobeille noted that some pieces of the system are already capitated – insurance premiums, some provider salaries are two examples. He noted Kaiser as an example of an organization that has separated revenues from workforce motivation/provider payment. Julie Wasserman added that Kaiser pays all providers constant salaries divorced from volume, and shares savings to the system with physicians at year end. Kaiser also reduces salary inequity between primary care and specialists. • Dale Hackett noted that under the Global Commitment waiver, we pay in the 5th year if we overspend compared to targets, which is a big challenge. • Susan Aranoff commented that Medicaid Pathway discussions have been helpful for raising understanding about parts of the system that are underfunded. • Dale Hackett asked about how this impacts very high level outcome measures like unintended pregnancy and graduation rates. Selina replied that quality measurement and performance expectations are a key piece, and these will look different in the future than they have under FFS. Al Gobeille added those are very high-level indicators that look much more broadly than APM. Cathy Fulton added that these are community and population health measures, which might be impacted by a better functioning health system but aren't how we'll measure the success of the APM. Al noted that there have been efforts in Vermont to look at high-level measures like these and link them to our work. • Julie Tessler asked how DVHA will be involved in the Medicaid Pathway. Michael replied that DVHA will also participate in Medicaid Pathway activities. Ed Paquin commented that there is another category of activities that are particularly sensitive to legislative appropriations; some categories (e.g., privately funded nursing home services) are not included here or in other health care reforms. Michael confirmed that there are some things that would not change within the APM, including legislative appropriations and the Medicaid budget process. Selina added that the Medicaid services covered through an ACO are well aligned with the Medicare and commercial services covered by an ACO – we expect that change will be profound for those providers for that set of services due to all-payer alignment. For services primarily funded by Medicaid, alignment doesn't offer the same benefits. • Mike Hall commended the administration for describing a Medicaid Pathway. He voiced concern that we are building a Medicaid Pathway that will be siloed from the main set of reforms. He suggested that the long-term objective should be to figure out how the Medicaid Pathway and APM merge, not creating a permanent parallel track. Where is there an "on-ramp" for Medicaid Pathway providers and services to join the main model? Selina agreed that these are challenges, but there are still too many unknowns to identify a date when some or all providers will join the main model. Al Gobeille added that the APM is	

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	still developing and infrastructure isn't in place yet, but that Medicaid Pathway has infrastructure in place. Michael agreed with Mike and Al and noted that this conversation is still developing. • Georgia Maheras suggested the team come back for a longer presentation at a future meeting.	
6. Public Comment, Next Steps, Wrap Up and Future Meeting Schedule	There was no additional public comment. **Next Meeting:** Likely to be cancelled.	

Bob Bick 1° Kim Fitzgerald 2° Minutes approved by exception 5 Abstentions

VHCIP Steering Committee Member List

Member		Member Alternate		Minutes	
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff ✓				AHS - DAIL
Rick	Barnett				Vermont Psychological Association
Bob	Bick ✓			✓	DA - HowardCenter for Mental Health
Peter	Cobb ✓				VNAs of Vermont
Steven	Costantino				AHS - DVHA, Commissioner
Elizabeth	Cote				Area Health Education Centers Program
Tracy	Dolan ✓	Heidi	Klein		AHS - VDH
Susan	Donegan	David	Martini ✓		AOA - DFR
John	Evans ✓	Kristina	Choquette		Vermont Information Technology Leaders
Kim	Fitzgerald ✓				Cathedral Square and SASH Program
Catherine	Fulton ✓				Vermont Program for Quality in Health Care
Joyce	Gallimore				Bi-State Primary Care/CHAC
Al	Gobeille ✓				GMCB
Lynn	Guillett				Dartmouth Hitchcock
Dale	Hackett ✓				Consumer Representative
Mike	Hall ✓	Angela	Smith-Dieng		Champlain Valley Area Agency on Aging / COVE
Paul	Harrington				Vermont Medical Society

Selina	Hickman ✓	Shawn	Skafelstad		AHS - DVHA
Debbie	Ingram				Vermont Interfaith Action
Craig	Jones				AHS - DVHA - Blueprint
Trinka	Kerr ✓			A	VLA/Health Care Advocate Project
Deborah	Lisi-Baker				SOV - Consultant
Jackie	Majoros ✓				VLA/LTC Ombudsman Project
Todd	Moore	Vicki	Loner		OneCare Vermont
		ARR	Berman ✓	A	
Jill	Olson	Mike	DelTrecco		Vermont Association of Hospital and Health Systems
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 ✓			A	GMCB
Frank	Reed	Jaskanwar	Batra ✓		AHS - DMH
Paul	Reiss				HealthFirst/Accountable Care Coalition of the Green Mountains
Simone	Rueschemeyer ✓			A	Vermont Care Network
Howard	Schapiro				University of Vermont Medical Group Practice
Julie	Tessler ✓	Marlys	Waller		Vermont Council of Developmental and Mental Health Services
Sharon	Winn				Bi-State Primary Care
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H 1st Q ✓

	Meeting Name:	VHCIP Steering Committee Meeting	
	Date of Meeting:	March 30, 2016	
	Last Name (a-z)	First Name	
1	Aranoff	Susan	Phone
2	Backus	Ena	
3	Bailey	Melissa	
4	Banks	Heidi	
5	Barnett	Rick	
6	Barrett	Susan	
7	Batra	Jaskanwar	here
8	Bick	Bob	here
9	Buck	Martha	
10	Choquette	Kristina	
11	Clark	Sarah	
12	Cobb	Peter	Phone
13	Collins	Lori	
14	Coonradt	Amy	
15	Cooper	Alicia	
16	Costantino	Steven	
17	Cote	Elizabeth	
18	Cummings	Diane	here
19	DelTrecco	Mike	
20	Dolan	Tracy	Phone
21	Donahey	Richard	
22	Donegan	Susan	
23	Epstein	Gabe	
24	Evans	John	Phone
25	Fisher	Jamie	
26	Fitzgerald	Kim	here
27	Fitzpatrick	Katie	
28	Flynn	Erin	
29	French	Aaron	
30	Fulton	Catherine	here
31	Gallimore	Joyce	
32	Garand	Lucie	
33	Geiler	Christine	
34	Gobeille	Al	here

35	Guillett	Lynn	
36	Hackett	Dale	here
37	Hall	Mike	here
38	Hall	Thomas	
39	Hall	Janie	
40	Harrington	Paul	
41	Hathaway	Carrie	
42	Hatin	Carolynn	
43	Hein	Karen	phone
44	Hickman	Selina	here
45	Ingram	Debbie	
46	Jones	Craig	
47	Jones	Kate	
48	Jones	Pat	here
49	Judge	Joelle	here
50	Kerr	Trinka	here
51	Kinsler	Sarah	here
52	Klein	Heidi	
53	Korce	Leah	
54	Laing	Andrew	
55	Lange	Kelly	
56	Lisi-Baker	Deborah	
57	Liss	Sam	
58	Loner	Vicki	
59	Lunge	Robin	
60	Magoffin	Carole	
61	Maheras	Georgia	here
62	Majoros	Jackie	here
63	Maloney	Carol	
64	Martini	David	here
65	McPherson	Darcy	
66	Mongan	Madeleine	
67	Moore	Todd	
68	Olson	Jill	
69	Otley	Brian	
70	O'Toole	Dawn	
71	Palumbo	Mary Val	phone

72	Paquin	Ed	here
73	Paumgarten	Annie	here
74	Pelosi	Laura	
75	Peterson	Judy	
76	Petrow	Anne	
77	Philibert	Dawn	
78	Poirer	Luann	
79	Ramsay	Allan	here
80	Reed	Frank	
81	Reiss	Paul	
82	Rueschemeyer	Simone	here
83	Samuelson	Jenney	
84	Sandage	Larry	
85	Santarcangelo	Suzanne	
86	Schapiro	Howard	
87	Shaw	Julia	
88	Skafelstad	Shawn	
89	Slusky	Richard	
90	Smith-Dieng	Angela	
91	Stone	Holly	
92	Tanzman	Beth	
93	Tessler	Julie	here
94	Waldman	Beth	
95	Waller	Marlys	
96	Wasserman	Julie	here
97	West	Kendall	
98	Westrich	James	
99	Wilhelm	Bradley	
100	Wilson	Nicole	
101	Winn	Sharon	
102	Yacovone	David	

Michael Costa - AOA