VT Health Care Innovation Project

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

Thursday, April 7, 2016; 10:00 PM to 12:30 PM

Oak Conference Room

Waterbury State Office Complex

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

Item	Time Frame	Topic	Relevant Attachments	Decision Needed ?
1	10:00 – 10:05	**Welcome; Approval of Minutes** Deborah Lisi-Baker	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from January 21, 2016	Yes
2	10:05 – 10:30	**Updates** **a) Integrated Communities Learning Collaboratives & Core Competency Trainings** **b) DLTSS-related HIE/HIT Initiatives**	• Attachment 2a: Core Competency Training for Front Line Care Coordination Staff • Attachment 2b: Health Data Infrastructure Update	
3	10:30 - 11:30	**All Payer Model & Medicaid Pathway** Michael Costa and Selina Hickman	• Attachment 3: All Payer Model and Medicaid Pathway	
4	11:30 – 12:25	**DLTSS Payment Reform Initiative** Scott Wittman, Suzanne Santarcangelo, PHPG	• Attachment 4: Vermont Integrated Care Model & Payment Reform Planning	
7	12:25 – 12:30	**Public Comment** Deborah Lisi-Baker	Next Meeting: Thursday, July 7, 2016 10:00 am – 12:30 pm, Waterbury State Office Complex, Ash Conference Room, Waterbury	

Attachment 1b: Minutes from January 21, 2016

Vermont Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Pending Work Group Approval

Date of meeting: Thursday, January 21, 2016, 10:00am-12:30pm, 4th Floor Conference Room, Pavilion Building, 109 State Street, Montpelier.

Agenda Item	Discussion	Next Steps
1. Welcome, Approval of Minutes	Deborah Lisi-Baker called the meeting to order at 10:10am. A roll call attendance was taken and a quorum was not present.	
2. VHCIP 2015 Year in Review	Georgia Maheras presented on VHCIP accomplishments in 2015, and planned activities for 2016 (Attachment 2). The group discussed the following: • Transition to all-payer model will be critical, as will sustainability for new models.	
3. VHCIP 2016 Draft Workplans	Deborah Lisi-Baker and Sarah Kinsler presented the 2016 workplans for the DLTSS, Payment Model Design and Implementation, Practice Transformation, and Health Data Infrastructure Work Groups (Attachments 3a-3d). The group discussed the following: • Jackie Majoros asked how this group will be able to provide input into the all-payer model. Georgia Maheras replied that we have a variety of opportunities and channels to provide feedback and input on the all-payer model, including public comment at GMCB, and less formal conversations with Secretaries, Commissioners, and others. Julie Tessler suggested All Payer Model presentations directly to this group would strengthen the process and take advantage of the great knowledge at the table. Sam Liss concurred. • Deborah Lisi-Baker noted that because this group is now meeting quarterly, we will continue to do a significant amount of work on our own and supported by Pacific Health Policy Group (PHPG) between meetings. She invited members to participate in this work. • Joy Chilton suggested aligning the workplan activities and timeline with the all-payer model timeline. Deborah replied that we don't know that timeline yet, but that we are trying to do that, and requested that members share information as appropriate. Julie Tessler offered to share what her organization has developed, and suggested talking with leaders from the DA/SSA/AAA organizations and others who are active in this area.	

Agenda Item	Discussion	Next Steps
	• Dale Hackett commented to focus on the individual receiving services is the most critical factor. Deborah Lisi-Baker suggested this be a key research question to guide our work this year. • Susan Aranoff noted that the Payment Models Work Group is interested in how DLTSS services are funded, and invited members to provide input on topics. Julie Tessler will share a presentation on DA financing.	
4. DLTSS Data Gap Remediation Funding Request	Susan Aranoff provided an update on the DLTSS Data Gap Remediation Funding Request. • The Health Data Infrastructure Work Group strongly supported the DLTSS Data Gap Remediation proposal. The Steering Committee also voted unanimously to support this work and move it forward to Core Team, along with a proposal for continued work with the DAs and SSAs. • Sue is currently working with Home Health Agency and Area Agency on Aging provider organizations and VITL to develop a more detailed budget and project plan. Provider response has been very positive thus far. A key issue is whether SIM funds can be used to support interface build-out on the provider-side, or whether providers will need to fund that work themselves. Sue noted that this can be very expensive, depending on the provider's EHR vendor. Another key issue is whether the Area Agencies on Aging can be connected to the VHIE, given that they are not strictly medical providers.	
5. Unified Community Collaboratives and Blueprint for Health Payments	Jenney Samuelson presented on the Unified Community Collaboratives (UCCs) and Blueprint for Health payment changes (Attachments 5a and 5b). The group discussed the following: • Susan Aranoff asked how UCCs are working on socioeconomic determinant issues. Jenney provided an example from the Burlington area, where the hospital and United Way are working together on housing. The hospital was struggling to discharge people not because they needed continued acute care, but because of lack of housing. These organizations worked with Champlain Housing Trust and Howard Mental Health to provide supportive housing beds to allow for discharge from the hospital. Morrisville is also working on transportation issues. • Sam Liss asked about focus on employment needs. Jenney replied that there is not an example of this yet, but that she expects it to emerge in the coming months as UCCs mature. She also noted that Medicare and Medicaid are starting to think about employment assistance. • Dale Hackett asked how this group balances non-medical needs that impact health with funding requests. Jenney noted that this is an ongoing challenge but that communities are increasingly creative in finding funding to support their work. In Burlington, funds came from the hospital and the housing trust. • Deborah Lisi-Baker asked about UCCs' focus on adults vs. pediatric populations. Jenney noted that UCCs and their focus areas are evolving. Many are currently focusing on individuals with high patterns of utilization, which are often adults; however, Integrated Family Services is also of great interest in many communities. Dale Hackett noted that adolescents are also a key group. Jenney commented the Blueprint payment changes include measures specific to adolescent well-child visit, which provides an opportunity to increase screening rates for adolescents as well as to improve screening quality across health service areas (HSAs). • Dave Yacovone asked how the Blueprint tracks the amount of money distributed in incentive payments versus	

Agenda Item	Discussion	Next Steps
	the amount being reinvested in community support. Jenney replied that the Blueprint does not track reinvestment. She also noted that analytics have shown that savings from the Blueprint are greater for commercial insurers than Medicaid – though savings from medical services were similar, Medicaid support services (like transportation and community-based services) were staying flat or increasing. Dave noted that aging populations aren't a focus in the new payment system. Jenney noted that this is a transitional year as we look ahead to the all-payer model. • UCCs are meant to pull together the regional Blueprint and ACO governance structures to avoid duplication and increase coordination and alignment. The Blueprint Community Health Teams continue to operate and support communities in providing care; UCCs build on this to perform cross-organization quality improvement projects under the guidance of a leadership team. While some UCCs have consumer representatives now, not all are ready yet. UCCs are also working to develop charters which document their governance and decision-making processes. Charters are locally-developed and housed at the local level. • Sam Liss asked Jenney whether UCCs are distinguishing between person-centered and person-directed care. Jenney replied that there is a growing understanding of this	
6. Updates/Next Steps	*HIPAA-Compliant Releases, Privacy, and Confidentiality (Gabe Epstein):* Gabe presented briefly on this topic to the Practice Transformation Work Group in January and will present again in February. He was invited to talk with the St. Johnsbury community about HIPAA compliant releases, privacy and confidentiality issues within their Integrated Communities Care Management Learning Collaborative process; and has met with representatives from DMH on this topic. Gabe will also be presenting a webinar for the other Learning Collaborative teams later in January. *Learning Collaborative Core Competency Trainings (Erin Flynn):* Contractors to support this work have been selected, and negotiations are in progress. Erin will have more updates at the Practice Transformation Work Group in February, and for this group in April. The trainings will run through 2016, with over 30 training opportunities in general care management and DLTSS-specific competencies. There will also be advanced care management training and training for supervisors available, and train-the-trainer opportunities for a subset of participants. Erin also invited members of this group to share information about the trainings with their networks. *DLTSS Payment Reform Efforts (Deborah Lisi-Baker):* Work Group leadership will be working with PHPG, the Payment Models Work Group, and State staff to support ongoing work and analyses in this area.	
7. Public Comment/Next Steps	**Next Meeting:** Thursday, April 7, 2016, 10:00am-12:30pm • Susan Aranoff introduced Dave Yacovone, former legislator, DAIL and DCF Commissioner, AHS Deputy Secretary, and now DAIL Dir. of Aging.	

VHCIP DLTSS Work Group Member List

Roll Call: 1/21/2016

Member		Member Alternate		December Minutes	
First Name	Last Name	First Name	Last Name		Organization
Susan	Aranoff				AHS - DAIL
~~Debbie~~ Jenney	~~Austin~~ Samuelson	Craig	Jones		AHS - DVHA
Molly	Dugan				Cathedral Square and SASH Program
Patrick	Flood				CHAC
Mary	Fredette				The Gathering Place
Joyce	Gallimore				Bi-State Primary Care
Martita	Giard	Susan	Shane		OneCare Vermont
~~Larry~~ Peter	~~Goetschius~~ Cobb	Joy	Chilton		Home Health and Hospice
Dale	Hackett				None
Mike	Hall	Angela	Smith-Dieng		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		VLA/Disability Law Project
Carol	Maroni				Community Health Services of Lamoille Valley
Madeleine	Mongan				Vermont Medical Society
Kirsten	Murphy				Developmental Disabilities Council
Nick	Nichols				AHS - DMH
Ed	Paquin				Disability Rights Vermont
Laura	Pelosi				Vermont Health Care Association
Eileen	Peltier				Central Vermont Community Land Trust
Judy	Peterson				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				AHS - Central Office
Jason	Williams				UVM Medical Center
	30		10		

14 No Quorum

VHCIP DLTSS Work Group Participant List

Attendance: 1/21/2016

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

First Name	Last Name		Organization	DLTSS
Susan	Aranoff		AHS - DAIL	S/M
Debbie	Austin		AHS - DVHA	M
Ena	Backus		GMCB	X
Susan	Barrett		GMCB	X
Bob	Bick		DA - HowardCenter for Mental Health	X
Denise	Carpenter		Specialized Community Care	X
Alysia	Chapman		DA - HowardCenter for Mental Health	X
Joy	Chilton		Home Health and Hospice	MA
Amanda	Ciecior		AHS - DVHA	S
Peter	Cobb		VNAs of Vermont	X
Amy	Coonradt		AHS - DVHA	S
Amy	Cooper		Accountable Care Coalition of the Green Mountains	MA
Alicia	Cooper		AHS - DVHA	S
Molly	Dugan		Cathedral Square and SASH Program	M
Gabe	Epstein		AHS - DAIL	S
Patrick	Flood		CHAC	M

Erin	Flynn	here	AHS - DVHA	S
Mary	Fredette		The Gathering Place	M
Joyce	Gallimore	phone	Bi-State Primary Care/CHAC	M
Lucie	Garand		Downs Rachlin Martin PLLC	X
Christine	Geiler		GMCB	S
Martita	Giard	phone	OneCare Vermont	M
Larry	Goetschius		Home Health and Hospice	M
Bea	Grause		Vermont Association of Hospital and Health Systems	X
Dale	Hackett	here	None	M
Mike	Hall		Champlain Valley Area Agency on Aging / COVE	M/MA
Carolynn	Hatin		AHS - Central Office - IFS	S
Selina	Hickman		AHS - DVHA	X
Bard	Hill		AHS - DAIL	X
Jeanne	Hutchins		UVM Center on Aging	M
Craig	Jones		AHS - DVHA - Blueprint	MA
Pat	Jones		GMCB	S/M
Margaret	Joyal		Washington County Mental Health Services Inc.	X
Joelle	Judge	here	UMASS	S
Trinka	Kerr		VLA/Health Care Advocate Project	MA
Sarah	Kinsler	here		S
Tony	Kramer		AHS - DVHA	X
Kelly	Lange		Blue Cross Blue Shield of Vermont	X
Dion	LaShay	phone	Consumer Representative	M
Nicole	LeBlanc		Green Mountain Self Advocates	X
Brenda	Lindemann		Consumer Representative	MA
Deborah	Lisi-Baker	here.	SOV - Consultant	C/M
Sam	Liss	phone	Statewide Independent Living Council	M
Vicki	Loner		OneCare Vermont	X
Carole	Magoffin		AHS - DVHA	S
Georgia	Maheras	phone	AOA	S
Jackie	Majoros	here	VLA/LTC Ombudsman Project	M
Carol	Maroni		Community Health Services of Lamoille Valley	M
Mike	Maslack			X
Lisa	Maynes		Vermont Family Network	X

Madeleine	Mongan		Vermont Medical Society	M
Todd	Moore		OneCare Vermont	X
Mary	Moulton		Washington County Mental Health Services Inc.	X
Kirsten	Murphy		AHS - Central Office - DDC	M
Floyd	Nease		AHS - Central Office	X
Nick	Nichols		AHS - DMH	M
Miki	Olszewski		AHS - DVHA - Blueprint	X
Jessica	Oski		Vermont Chiropractic Association	X
Ed	Paquin		Disability Rights Vermont	M
Annie	Paumgarten		GMCB	S
Laura	Pelosi		Vermont Health Care Association	M
Eileen	Peltier		Central Vermont Community Land Trust	M
John	Pierce			X
Luann	Poirer		AHS - DVHA	S
Barbara	Prine		VLA/Disability Law Project	MA
Paul	Reiss		Accountable Care Coalition of the Green Mountains	M
Virginia	Renfrew		Zatz & Renfrew Consulting	X
Suzanne	Santarcangelo	phone	PHPG	X
Rachel	Seelig		VLA/Senior Citizens Law Project	M
Susan	Shane	phone	OneCare Vermont	MA
Julia	Shaw		VLA/Health Care Advocate Project	X
Richard	Slusky		GMCB	S/MA
Angela	Smith-Dieng	phone	Area Agency on Aging	MA
Beth	Tanzman		AHS - DVHA - Blueprint	X
Julie	Tessler	here	DA - Vermont Council of Developmental and Mental Health Serv	M
Bob	Thorn		DA - Counseling Services of Addison County	X
Beth	Waldman		SOV Consultant - Bailit-Health Purchasing	S
Marlys	Waller		DA - Vermont Council of Developmental and Mental Health Serv	MA
Nancy	Warner		COVE	M
Julie	Wasserman	here	AHS - Central Office	S/M
Kendall	West		Bi-State Primary Care/CHAC	X
James	Westrich		AHS - DVHA	S
Bradley	Wilhelm		AHS - DVHA	S
Jason	Williams		UVM Medical Center	M
Marie	Zura		DA - HowardCenter for Mental Health	X

Dave Yacavone – here – DAIL
Jenney Samuelson – here – DVHA BluePrint

Attachment 2a: Core Competency Training for Front Line Care Coordination Staff

Core Competency Training for Front Line Care Coordination Staff

DLTSS Work Group Update
April 7th, 2016

Background:

- Participants in the Integrated Communities Care Management Learning Collaborative (ICCMLC) expressed the need for training on key core competencies related to delivering person-directed care coordination as part of an integrated care team.

- DLTSS work group members identified the need for training on key core competencies highlighted in the "Disability Awareness Briefs" http://healthcareinnovation.vermont.gov/node/863

- Care Models and Care Management Work Group Members, DLTSS Work Group Members, and ICCMLC participants provided input on desired training curriculum, which was incorporated into a Training RFP.

Background (cont'd):

- After a competitive bidding process, two apparently successful awardees have been selected and contract negotiation is nearing completion.

- Two organizations will deliver a comprehensive training series:
  - **Primary Care Development Corporation** (http://www.pcdc.org/), is a nonprofit organization dedicated to expanding and transforming primary care in underserved communities. PCDC will provide training on core competencies related to care coordination and care management.

  - **The Vermont Developmental Disabilities Council** (http://www.ddc.vermont.gov/) is a state-wide board that works to increase public awareness about critical issues affecting people with developmental disabilities and their families. VTDDC and its partners, including Green Mountain Self Advocates, Vermont Family Network, and Vermont Federation of Families for Children's Mental Health, will provide training on core competencies related to working with individuals with DLTSS needs.

Overview of Training Opportunities:

- **34** separate training events to be offered between March and December 2016 as part of a robust training curriculum.
- **240** training spots available for a 6 day core training series on care coordination and disability awareness offered in three training locations (Burlington, Waterbury/Montpelier, and Brattleboro) beginning on March 29th – 31st.
- Additional training opportunities for a smaller subset of participants include: Advanced Care Coordination Training, Care Coordination for Managers and Supervisors Training, and Train-the-Trainer Training.
- *Interest has been strong!* All training sites are currently at maximum capacity, including the addition of a second training section in Burlington.

Care Coordination Fundamentals Training for Front-Line Care Managers
In-Person Training #1

AGENDA

8:30 AM - 9:00 AM	Registration
9:00 AM - 9:15 AM	Welcome and Opening Remarks
9:15 AM - 10:30 AM	Roles and responsibilities of staff who provide care coordination
10:30 AM - 10:45 AM	Mid-Morning Break
10:45 AM - 11:45 PM	How care coordination is related to patient navigation
11:45 PM - 1:00 PM	Lunch
1:00 PM – 2:30 PM	Typical care coordination services
2:30 PM – 2:45 PM	Mid-Afternoon Break
2:45 PM – 4:00 PM	Qualities and skills needed by staff members providing care coordination
4:00 PM – 4:15 PM	Closing Remarks and Preview of Next Session

Vermont Health Care Innovation Project Core Competency Training Series
2016 Schedule of Training Events

Training Event	Tentative Date & Location	Tentative Curriculum Modules
6 Day "Core" Training Series ***(Participants are strongly encouraged to attend all 6 days of core training)***		
Day 1: Introductory Care Coordination Training, Part 1	**3/29/2016:** Burlington, Main Street Landing **3/30/2016:** Waterbury, State Office Complex **3/31/2016:** Brattleboro, Elks Lodge	• Roles and responsibilities of staff who provide care coordination • How care coordination is related to patient navigation • Typical care coordination services • Qualities and skills needed by staff members providing care coordination
Day 2: Disability Awareness Training, Part 1	**4/22/2016:** Brattleboro, TBD **4/25/2016:** Montpelier, Capitol Plaza Hotel **4/26/2016:** Burlington, Main Street Landing	• Introduction to disability awareness • Disability and wellness • Person Centered Care
Day 3: Introductory Care Coordination Training, Part 2	**5/17/2016**: Montpelier, Capitol Plaza Hotel **5/18/2016:** Burlington, Main Street Landing **5/19/2016:** Brattleboro, TBD	• Communication skills • Bias, culture and values • Accessing community and social supports • Transitions of care, home visits, and supporting care givers
Day 4: Disability Awareness Training, Part 2	**6/17/2016:** Burlington, Main Street Landing **6/22/2016**: Waterbury, State Office Complex **6/23/2016:** Brattleboro, TBD	• Universal design/accessibility • Communication and interaction • Tools for improved communication • Cultural competence • Facilitating inclusive and accessible training

Vermont Health Care Innovation Project Core Competency Training Series
2016 Schedule of Training Events (cont'd)

Day 5: Introductory Care Coordination Training, Part 3	**7/19/2016:** Burlington, Main Street Landing **7/20/2016:** Montpelier, Capitol Plaza Hotel **7/21/2016:** Brattleboro, TBD	• Development and implementation of care plans • Motivational Interviewing • Health coaching • Professional boundaries
Day 6: Disability Awareness Training, Part 3	**9/14/2016:** Montpelier, Capitol Plaza Hotel **9/16/2016:** Burlington, Main Street Landing **9/28/2016:** Brattleboro, TBD	• Transition from pediatric to adult care • Sexuality and reproductive health • Trauma-informed care
Webinar Series (5 one-hour webinars will offer supplemental content to 6-day core training series)	**Webinar 1:** April, date TBD **Webinar 2:** June, date TBD **Webinar 3:** August, date TBD **Webinar 4:** October, date TBD **Webinar 5:** December, date TBD	• Using data to identify people needing services • Principles of person centeredness • Care coordination by phone • Coordinating care for patients with specific chronic conditions such as DM, HTN, heart disease, asthma, and HIV and mental illnesses • Navigating the insurance system • Risk stratifying patient panels
Burlington "Section 2" **(In response to a greater than anticipated level of interest at the Burlington training site, a second section of 60 participants was added.)**	**Day 1**: April 27th , 2016 **Day 2:** June 16th , 2016 **Day 3**: August 17th, 2016 **Day 4:** August 18th , 2016 **Day 5:** August 19th , 2016 Day 6: September 27th , 2016	**A note about the Burlington Training Section 2 schedule:** Due to trainer availability, Section 2 training content is not offered in the same order as the Section 1 content. Training days 3, 4 and 5 correspond with Introductory Care Coordination training and will be offered on three consecutive days in August. Training days 1, 2 and 6 correspond with Disability Awareness training and will be offered in April, June, and September.

Vermont Health Care Innovation Project Core Competency Training Series
2016 Schedule of Training Events (cont'd)

Supplemental Training Opportunities		
Advanced Care Coordination Training	**9/20-9/21/2016:** Montpelier, Capitol Plaza Hotel	• Impact of adverse childhood events, mental illness, an addiction disorders on health status • Screening for substance abuse and domestic violence • Crisis management and suicide prevention • Coordinating care for patients with mental health conditions • Coordinating care for homeless patients • Care management for elderly patients • Palliative care and end of life care
Care Coordination for Managers & Supervisors	**10/27/2016:** Montpelier, Capitol Plaza Hotel	• Handling large case loads • Risk stratification • Supervision of staff • Setting up training systems • Working effectively with leadership and physicians • Identifying and serving as a lead care coordinator
Train the Trainer Training Workshop	**11/15-11/16/2016:** Montpelier, Capitol Plaza Hotel	• Preparing to facilitate group care management/coordination training • Framing topics to clarify roles of front line care managers • Best practices for facilitating group discussions and activities • Facilitating discussions about controversial or challenging topics • Managing conflict and multiple opinions among participants • Facilitating role play activities for motivational interviewing, health coaching, and communication skills

Questions?

- Please contact Holly Stone at holly.stone@partner.Vermont.gov with any follow up questions, and be sure to check out the VHCIP Core Competency Training Website for evolving information on this series including agendas, trainer bios, and schedules: http://healthcareinnovation.vermont.gov/node/884

Attachment 2b: Health Data Infrastructure Update

DLTSS Work Group: Health Data Infrastructure Update

April 2016

Agenda

- Update on Health Information Technology (HIT) Strategic Plan.
- Update on State Innovation Models (SIM)-funded health data infrastructure projects.
- Update on HIT Fund health data infrastructure projects.

Project Background

Vermont Statute: 18 V.S.A § 9351

The HIT Plan (VHITP) shall:

1) support the **effective, efficient, statewide use of electronic health information** in patient care, health care policymaking, clinical research, health care financing, and continuous quality improvements;
2) **educate** the general public and health care professionals about the value of an electronic health infrastructure for improving patient care;
3) ensure the **use of national standards** for the development of an interoperable system, which shall include provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols;
4) propose **strategic investments** in equipment and other infrastructure elements that will facilitate the ongoing development of a statewide infrastructure;
5) recommend funding mechanisms for **the ongoing development and maintenance** costs of a statewide health information system, including funding options and an implementation strategy for a loan and grant program;
6) **incorporate the existing health care information technology** initiatives to the extent feasible in order to avoid incompatible systems and duplicative efforts;
7) **integrate** the information technology components of the Blueprint for Health established in chapter 13 of this title, the Agency of Human Services' Enterprise Master Patient Index, and all other Medicaid management information systems being developed by the Department of Vermont Health Access, information technology components of the quality assurance system, the program to capitalize with loans and grants electronic medical record systems in primary care practices, and any other information technology initiatives coordinated by the Secretary of Administration pursuant to 3 V.S.A. § 2222a; and
8) address issues related to **data ownership, governance, and confidentiality and security of patient information**.

Purpose of the VHITP

- Set high-level strategy and roadmap for the statewide electronic collection, storage, and exchange of clinical or service data in support of improved patient care, improved health of Vermonters, and lower growth in health care costs – consistent with the Triple Aim
- Provide direction for future projects, initiatives, and funding
- Serve as a framework for regulatory authority such as GMCB review of IT projects within the Certificate of Need process or to support HIE connectivity/interoperability criteria

We're Not Starting from Scratch…

The 2010 version is the latest version – with minor revisions in 2012 and 2014 related to HIE consent

Significant Progress

- Adoption and Use of EHRs by providers
- Connections to and development of HIE by VITL
- Large and growing quantity of data in HIE
- Significant attention to data quality and reliability
- 2014 – beginnings of true exchange among providers – VITLAccess
- Other services around the corner

Vermont HIT Plan Objectives

1. People trust that health care data is secure, accurate, and current
2. Health care information can be appropriately and securely accessed by authorized people and providers
3. People have the information needed to make informed decisions about their care
4. Health care information is readily shareable across all provider organizations where people receive care
5. Integrated/Coordinated care is the norm
6. Consent for sharing physical health, mental health, substance use, and social services information is implemented consistently
7. High quality health care/services data are accessible and suitable for multiple uses
8. The cost of Health Information Technology/Health Information Exchange (HIT/HIE) is not a barrier to Vermont providers in implementing and using technology
9. Health information sharing in Vermont is sustainable
10. Reporting processes are streamlined to assist providers in complying with mandated reporting requirements
11. There is statewide transparency and coordination of all appropriate HIT/HIE projects
12. Health care and health services information collected and maintained by State agencies is easily shared
13. People have expanded access to health care services and providers through technology
14. People can manage the sharing of their health care information
15. There is active data governance in place for health care/services data
16. Vermont easily and appropriately shares health care information beyond its borders

VHITP Initiatives – Overview

Fully implementing the VHITP Initiatives will:

- Establish strong, clear leadership and governance for statewide Health Information Technology/Health Information Exchange (HIT/HIE) with a focus on decision-making and accountability.
- Continue – and expand – stakeholder dialogue, engagement, and participation.
- Expand connectivity and interoperability.
- Provide high quality, reliable health information data.
- Ensure timely access to relevant health data.
- Continue the protection of a person's privacy as a high priority.

VHITP Initiatives

Statewide HIT/HIE Governance & Policy

01 – Establish (and run) comprehensive statewide HIT/HIE governance.

02 – Strengthen statewide HIT/HIE coordination.

03 – Establish and implement a statewide master data management program (data governance) for health, health care, and human services data.

04 – Develop and implement an approach for handling the identity of persons that can be used in multiple situations.

05 – Oversee and implement the State's telehealth strategy.

06 – Provide bi-directional cross state border sharing of health care data.

Business, Process & Finance

07 – Continue to expand provider Electronic Health Record (HER) and HIE adoption and use.

08 – Simplify State-required quality and value health care related reporting requirements and processes.

09 – Establish and implement a sustainability model for health information sharing.

Stakeholder Engagement & Participation

10 – Centralize efforts for stakeholder outreach, education, and dialogue relating to HIT/HIE in Vermont.

VHITP Initiatives

Privacy & Security

11 – Ensure that statewide health information sharing consent processes are understood and consistently implemented for protected health information – including information covered by 42 CFR Part 2 and other State and federal laws.

12 – Ensure continued compliance with appropriate security and privacy guidelines and regulations for electronic protected health information.

Technology

13 – Ensure Vermont Health Information Exchange (VHIE) connectivity and access to health and patient information for all appropriate entities and individuals.

14 – Enhance, expand, and provide access to statewide care coordination tools.

15 – Enhance statewide access to tools (analytics and reports) for the support of population health, outcomes, and value of health care services.

16 – Design and implement statewide consent management technology for sharing health care information.

17 – Provide a central point of access to aggregated health information where consumers can view, comment on, and update their personal health information.

SIM-funded projects: completed

- **Gap Analyses** for Accountable Care Organization (ACO) and DLTSS providers completed.
  - Ongoing activity.
- **2015 Gap Remediation** for ACO member organizations and Designated Mental Health and Specialized Service Agencies.
  - Ongoing activity.
- **ACO Gateways** for OneCare and Community Health Accountable Care (CHAC) completed.
- **EMRs acquired** for five Specialized Services Agencies (SSAs) and for the Dept. of Mental Health/State Psychiatric Hospital.
- **Health Data Inventory** completed.
- **Telehealth Strategic Plan** finalized.

SIM-funded projects: Ongoing

- **Terminology Services** for the VHIE started.
- **Data Quality** improvement efforts for Designated Agencies.
- **Vermont Care Network Data Repository** work begun.
- **Event Notification System** launch scheduled.
- **ACO Gateway** for Health*first* started.
- Request for proposals for **Telehealth Pilots** released and vendors selected.

DLTSS Gap Remediation

- Phase 1: February 15, 2016 - June 30, 2016
  - VITLAccess Rollout (4 agencies, ~ 305 users)
  - Interface Technical Discovery
- Phase 2: July 1, 2016 – December 31, 2016
  - VITLAccess Rollout (3 agencies, ~170 users)
  - Interface Development (5 agencies; 6 interfaces)
- Phase 3: July 1, 2016 - December 31, 2016
  - VITLAccess Rollout (5 agencies, ~125 users)
  - Interface Development (4 Agencies; 4 interfaces)

HIT Fund Investments

- VITLAccess:
  - Brattleboro Retreat, Northwestern Counseling & Support Services, Howard Center, Bradley House, Cathedral Square, Central Vermont Home Health and Hospice, Addison County Home Health, Lamoille County Mental Health Services, Lamoille Home Health & Hospice, The Manor, Visiting Nurse Association of Chittenden County.
- Connections to the VHIE:
  - Three Lab interfaces for Skilled Nursing Facilities.
  - Five Admission, Discharge, Transfer (ADT) interfaces and One Continuity of Care Document (CCD) interface for Home Health and Visiting Nurse Associations.
  - Four Lab interfaces for Designated Agencies.

On the horizon: new CMS funding

- Eligibility for 90/10 federally matched funding to the VHIE.
- Provider types:
  - Behavioral Health
  - Substance Abuse Treatment
  - Long-Term Care (including nursing facilities)
  - Home Health
  - Pharmacies
  - Laboratories
  - Correctional Health
  - Emergency Medical
  - Public Health Providers
  - Other Medicaid providers including community based Medicaid providers

Attachment 3: All Payer Model and Medicaid Pathway

INTEGRATED HEALTH SYSTEM UPDATE

MEDICAID PATHWAY

VERMONT
HEALTH CARE REFORM

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?

Getting to the "Big Goal"

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

Implement Next Generation-type ACO:

- Requires all-inclusive population based 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 outside of financial caps of all-payer model.
- AHS led project that interacts with ongoing AHS reform efforts and SIM.

CRITICAL TAKE-AWAY:

The regulated revenue and financial cap deal with the feds and DVHA's implementation are part of the all-payer model and reforms, not the whole ballgame for payment and delivery system reform.

Why seek an Integrated Health System?

- Better quality for Vermonters
- Healthier Vermonters
- Happier providers
- Better stewardship of Vermont $

How?

- Provider receives payment that is aligned across payers (incentives are aligned).
- Provider payment is global and prospective. Allows for proactive, population-based health approach.
- Payment model rewards quality, care coordination and early intervention.

What is an All-Payer Model?

- 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 align payment for health care in an alternative to** fee-for-service reimbursement.

- Aligning delivery and payment reforms across payers increases the incentive for practice transformation and improved healthcare outcomes.

How Do We Pay Differently in APM?

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

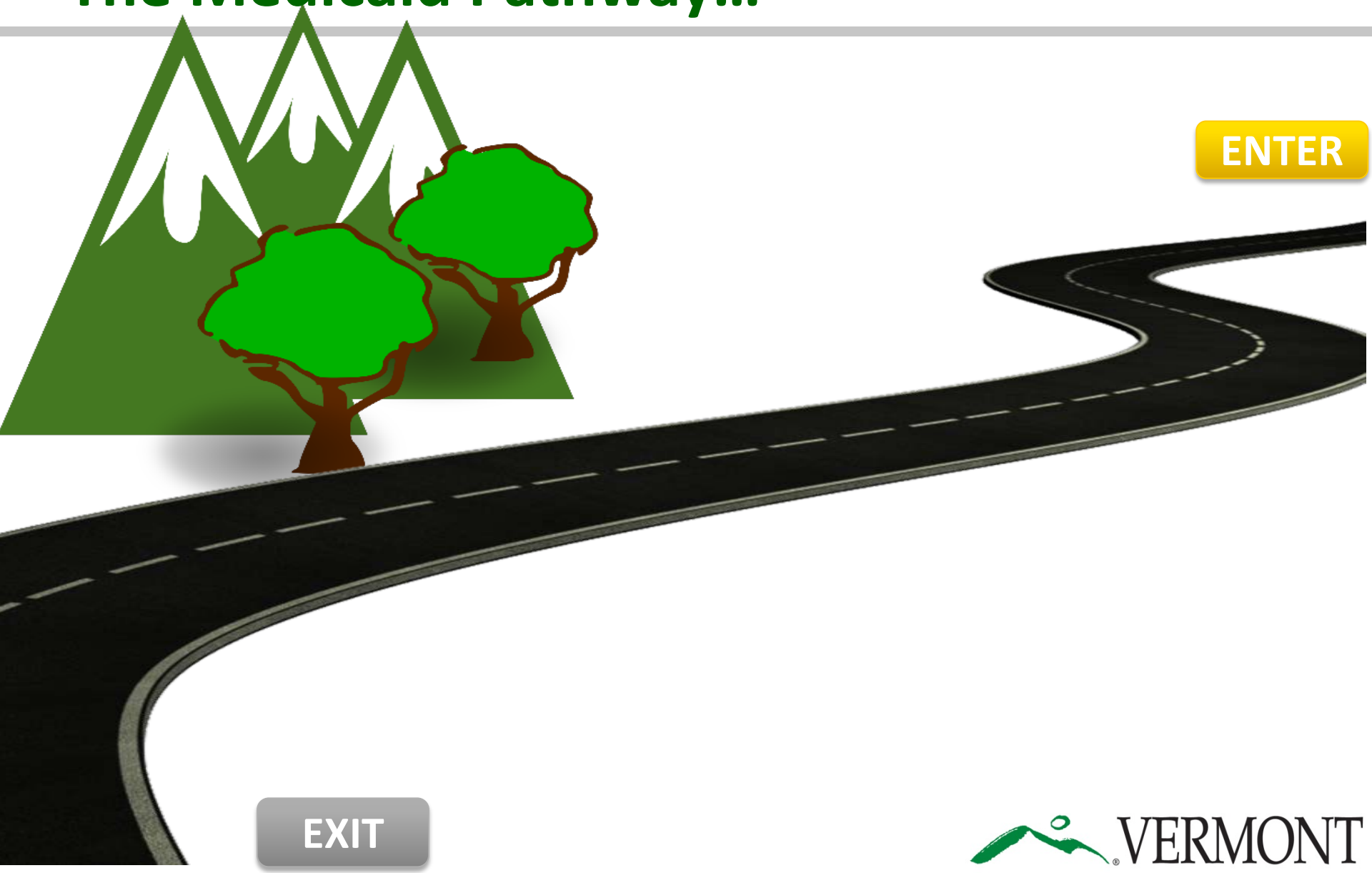
- The federal **Next Generation ACO program** allows ACOs to be paid an *all-inclusive population-based payment* for each Medicare beneficiary attributed to the ACO. CMS will allow ACOs some flexibility in certain payment rules in exchange for accepting this new type of payment.

- In Vermont, Medicare, Medicaid and Commercial Payers have established ACOs as a new provider type and are ready to move forward in implementing the Next Generation ACO model across payers.

How does the APM Contribute to an Integrated Health System?

- Control the rate of growth in total health care expenditures
- Align measures of health care quality and efficiency across health care system
- Increase accountability across ACO providers and services
- Reward high value care across payers
- Improved experience of care for patients
- Empower provider-led health care delivery change

The Medicaid Pathway…



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HEALTH CARE REFORM

Why is there a Medicaid Pathway?

- The All Payer Model is focused on an ACO delivery model for services that look like Medicare part A & B.

- The majority of Medicaid paid services (about 65%) are not equivalent to Medicare part A & B and/or will not be included in the initial ACO delivery model.

- To get to a truly integrated health system, AHS has to commit to delivery and payment reform for the 65% of cost that is not addressed yet through the all-payer model.

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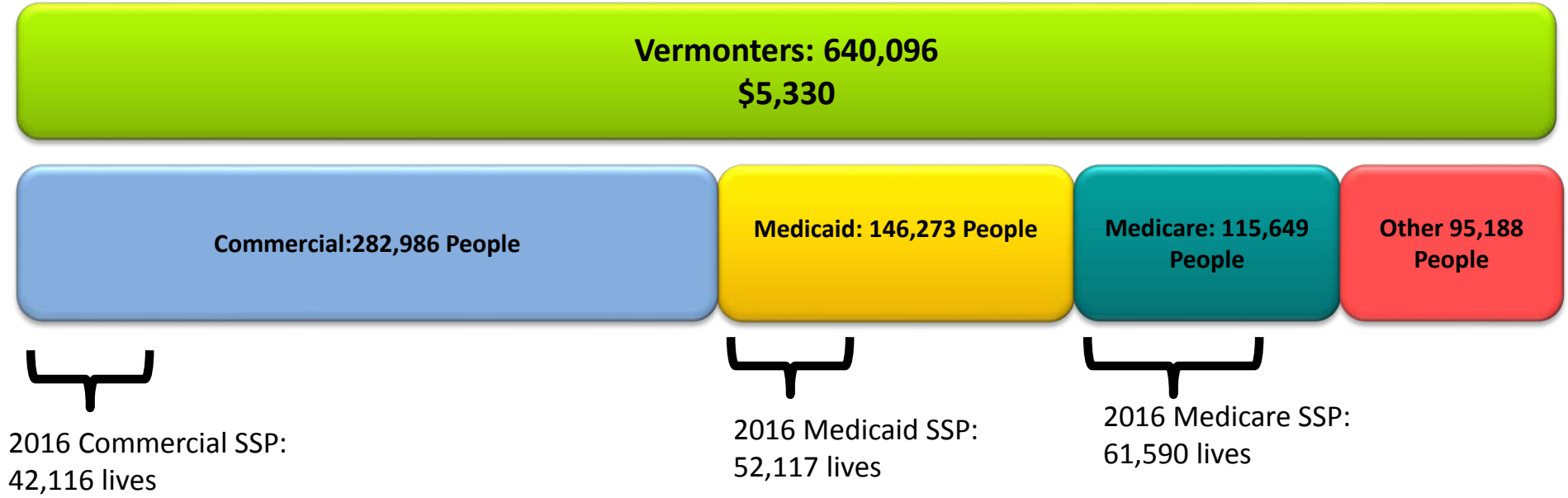
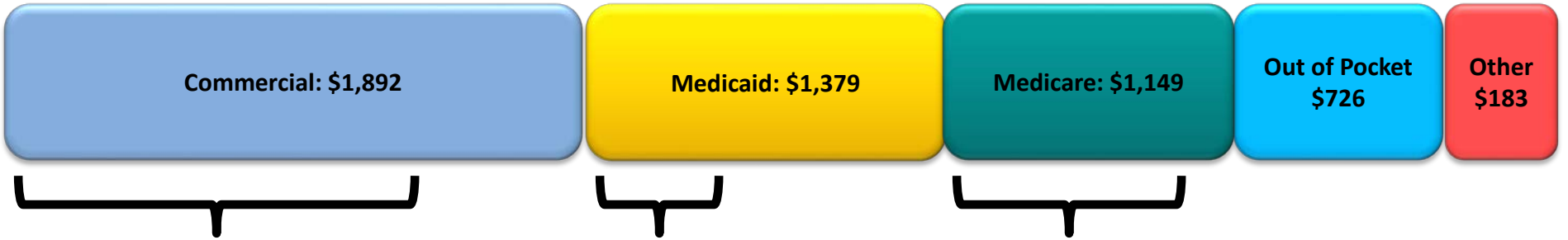
DRAFT Vermont Health System Reform in Perspective





Data Source: GMCB

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What is the Medicaid Pathway?

- The Medicaid Pathway is a Process.

- 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 wholly 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 and integration of payment and delivery principles that support a more integrated system of care.

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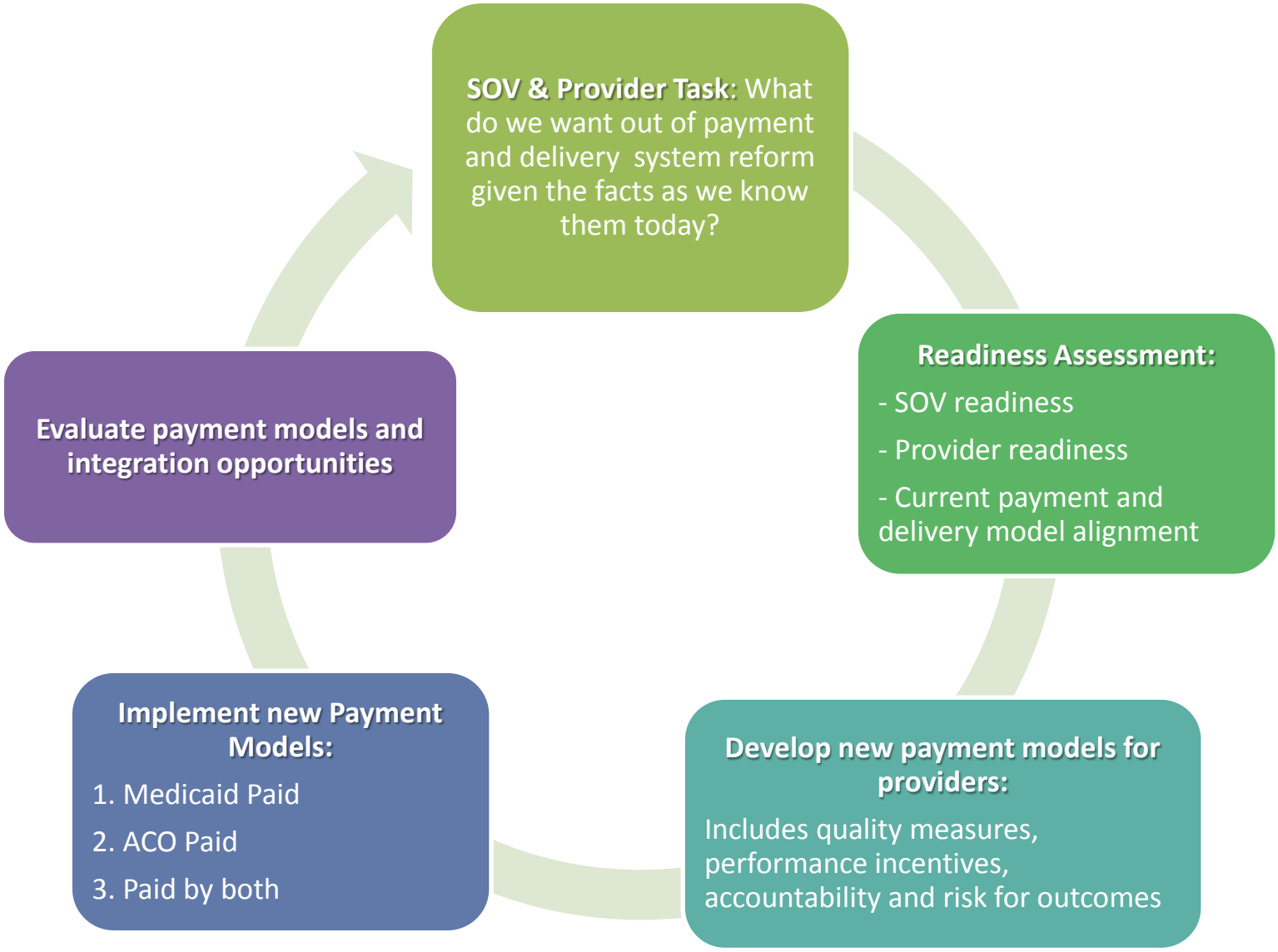
Steps in the Medicaid Pathway Process

1. **Delivery System Transformation (Model of Care)**
   - What will providers be doing differently?
   - What is the scope of the transformation?
   - How will transformation support integration?
2. **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
3. **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?
4. **Outcomes**
   - Is anyone better off?

SOV provides support with readiness assessment, resources and technical assistance

Medicaid Pathway: Payment and Delivery System Reform Continuous Cycle



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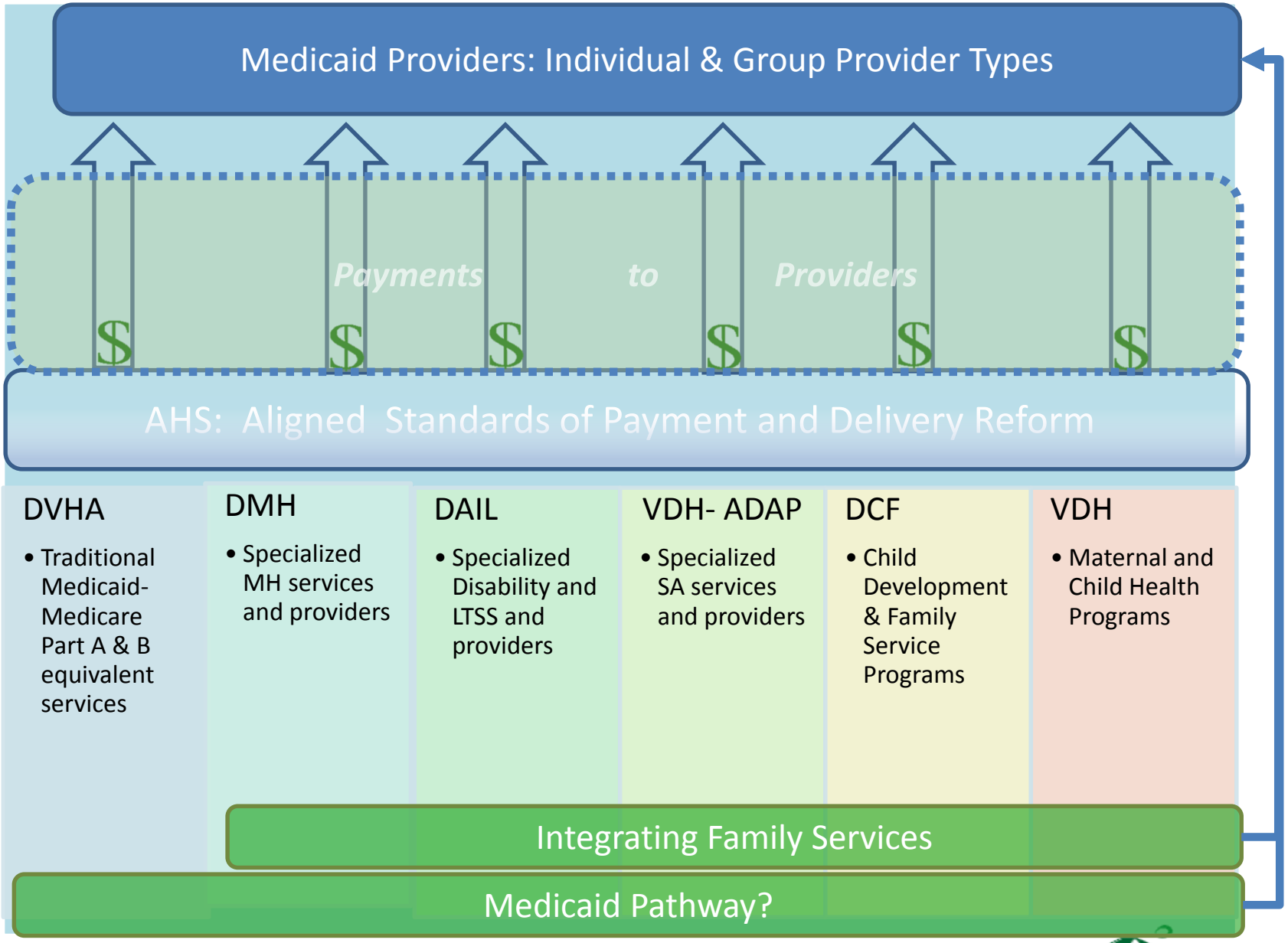
Medicaid Providers: Individual & Group Provider Types
Payments to Providers
$
AHS: Aligned Standards of Payment and Delivery Reform
DVHA
• Traditional Medicaid-Medicare Part A & B equivalent services
DMH
• Specialized MH services and providers
DAIL
• Specialized Disability and LTSS and providers
VDH- ADAP
• Specialized SA services and providers
DCF
• Child Development & Family Service Programs
VDH
• Maternal and Child Health Programs
Integrating Family Services
Medicaid Pathway?

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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

Who is on the Medicaid Pathway?

Group 1: Under the SIM demonstration Providers of MH, SA and DS 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 will engage with other community providers over time to determine how and when other services and providers will enter the Medicaid Pathway process.

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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 an all-inclusive, population-based 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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Attachment 4: Vermont Integrated Care Model & Payment Reform Planning

Stakeholder Update & Discussion: VT Integrated Care Model & Payment Reform Planning

PHPG Presentation for DLTSS Work Group Discussion
April 7, 2016.

Funding for this report was provided by the State of Vermont, Vermont Health Care Innovation Project, under Vermont's State Innovation Model (SIM) grant, awarded by the Center for Medicare and Medicaid Services (CMS) Innovation Center (CFDA Number 93.624) Federal Grant #1G1CMS331181-03-01.

Discussion Topics & Goals

- Medicaid Pathway Planning
- Delivery System Transformation
  - Goals and Principles
  - Elements of Transformation
  - Vermont Integrated Model of Care
  - Objectives
- Alternatives to Fee-for-Service Payment Models
- Opportunities for Payment Reform to Support Delivery Reform
  - Design Considerations
- Status and Next Steps

Medicaid Pathway Planning

Medicaid Accountable Care Organization (ACO)

- Aligned with Medicare Part A and B Services (Physicians, Hospitals, Outpatient Services)

Mental Health, Substance Abuse Treatment and Developmental Services

- Designated/Specialized Agency & Alcohol and Drug Treatment Preferred Provider Delivery System Transformation

LTSS - Choices for Care

- Under Construction

Goals & Principles

- **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 efforts

Elements Of Transformation

- **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**

VT Integrated Model of Care

- Created by DLTSS Work Group and agreed upon by stakeholders as foundational to reform efforts
- Adopted by Practice Transformation Work Group and utilized to inform transformation activities
- Foundational to Mental Health, Substance Abuse Treatment, Developmental Services, Choices for Care, and Accountable Care Organization discussions
- Vermont Specialized Programs support many of the model of care elements.
  - How can this reform effort preserve and enhance our ability to incorporate all elements across the health care delivery system?

VT Integrated Model of Care

Core Elements	Current Vermont DLTSS Models	Payment Reform Opportunities
Person-Centered and -Directed Process for Planning and Service Delivery	✓	Organized model could facilitate funding to support integration; performance-based payments could help to support care planning across the full array of services
Access to Independent Options Counseling & Peer Support	✓	Organized model could support multi-payer expansion of capacity of cost effective supports and services
Actively Involved Primary Care Physician	Variable	Payment flexibility for care coordination services could support interaction with PCP; Organized model could enable single clinical record, physician supports and training
Provider Network with Specialized Program Expertise	✓	Organized model could support multi-payer expansion of capacity and planning across the full continuum of services
Integration between Medical & Specialized Program Care	Variable	Organized model could facilitate funding to support integration; performance-based payments could help to support care planning across the full array of services
Single Point of Contact for person with Specialized Needs across All Services	Variable	Organized model could facilitate funding to support integration; performance-based payments could help to support care planning across the full array of services; opportunity to develop training protocols/best practices across care management entities
Standardized Assessment Tool	✓	Tool could be modified to include all medical and functional needs
Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services	Variable	Payment flexibility could expand range of services available to meet individual needs
Care Coordination and Care Management	✓	Organization and flexibility could create opportunities for integrated care coordination
Interdisciplinary Care Team	Variable	Organization and flexibility could create opportunities for integrated teaming such as Blueprint and other models
Coordinated Support during Care Transitions	Variable	Organized model could enhance communications and training
Use of Technology for Sharing Information	Variable	Organized model could facilitate integrated clinical record
* Elements Fully Align with CMS & National Committee for Quality Assurance DLTSS Model of Care		
✓ Currently required or supported through State or Federal Rule and/or Specialized Program Policies		

Objectives

- Develop an organized delivery system for serving individuals with specialized health service needs and promote integration of:
  - Physical Health
  - Mental Health
  - Substance Abuse Treatment
  - Long-Term Services and Supports
- The organized delivery system will support:
  - Vermont's Model of Care
  - Payment Reform, including value based purchasing
  - Service Delivery Reform, including population-based health and prevention, quality improvement and development of best practices
  - Medicaid Pathway and All-Payer Model (APM)
  - Efficient Operations and Oversight

Alternatives to Fee-for-Service

Alternative payment models historically have been used in Vermont to support desired models of care/delivery system reform for disability-specific services:

- Developmental Disabilities Services (DAIL)
- Community Rehabilitation & Treatment Services (DMH)
- Success Beyond Six - Clinicians in Schools (DMH)
- Enhanced Family Treatment (DMH)
- IEP Related School Health Services (AOE)
- Jump On Board for Success (JOBS) - Adolescent Supported - Employment (DMH/VR)
- Runaway/Homeless Youth Crisis Stabilization Services (DCF)
- Children's Integrated Services (DCF)
- Integrating Family Services (AHS)
- Medication Assisted Treatment Services (DVHA/ADAP)

Alternatives to Fee-for-Service

Potential Benefits	Potential Risk	Mitigation Strategies
Providers have flexibility to decide on necessary services. Reduces the incentive to overuse or provide unnecessary services. Allows providers to address prevention and also supports use of non-traditional services based on a person's unique treatment and/or support plan needs.	**Payer/Beneficiary Risk** *Underutilization* • May create incentive to provide the lowest level of care possible or delay care until after the end date of the bundled payment. • Avoidance of high-risk (potentially more expensive) individuals. *Under/Over Diagnose* • Not diagnose complications of a treatment before the end date of the bundled payment. • Over diagnosed cases to draw down case rate payments for an increased number of recipients. *Over or Other Utilization* • Increasing the number of bundles provided (e.g., encouraging surgery for individuals who are ambivalent between medical management and surgical treatment options). • Moving services in time or location to qualify for separate reimbursement ("unbundling") **Provider Risk** • Case Rate set to low to support complex needs • Unanticipated need drives costs higher than expected (e.g., natural disaster, under reported need).	**Quality Oversight & Measurement Strategies** *Outcome Tracking* - Delayed or low level care could lead to poor outcomes, tracking positive outcomes mitigates risk. *Utilization monitoring* - Using encounter data (i.e., information on the date and type of service rendered) to look for trends. Encounter data may include service type and location, wait times, dates of service, and client characteristics such as health status, diagnosis, other related conditions, experience of care and progress. *Recipient Experience* of Care Measures (Survey) Grievance and appeal (Trend Analysis) Critical Incident Data (Provider Report) – Using data to look for trends within or across providers that signal potential problems or support reports of consumer satisfaction. *Best Practice Guidelines* – Measuring provider fidelity to best practice **Process and Structure Strategies** Use of independent ombudsmen Desk audits and chart reviews **Financial Strategies** Retrospective adjustment to payment for positive or negative performance on any of the above Incentive payments in addition to the bundled payment.

Payment Reform Options

Option	Opportunities	Operational Considerations	
		MH/SAT/DS Alignment	LTSS/Choices for Care
Community, Population Based or Global Budget Develop total budget by community and require providers to collaborate in order to manage to budget.	• Maximizes flexibility to develop service options that meet individual needs • Could promote early intervention/prevention • Payments could be tied to performance • Creates more predictable funding level	• Would require organized delivery system across full array of services included in scope of services • Could be perceived as a model that "caps" specialized services	• Communities have relatively large numbers of community providers; would require high level of organization at community level
Case Rates Develop daily/weekly/monthly rates per enrollee (e.g. per member per month or PMPM) Rate could vary based on program or need.	• Provides additional flexibility to develop individualized service packages • Payments could be linked to performance rather than volume	• Some programs currently have case rates • Payment tied to active program participation • Potential service may overlap with APM (depending on scope of services)	• Diversity of delivery network may require development of complex risk adjustment model
Individual Budgets Develop individual budgets based on need.	• Care planning process/providers would have flexibility to offer alternative services • Payments could be tied to performance, depending on level of organization at the community level	• Would require development of complex needs assessment process and risk adjustment model • Less effective approach for promotion of early intervention/prevention	• Would require development of complex needs assessment process and risk adjustment model • Payments underlying budget may continue to be paid on fee-for-service basis
Care Coordination Case Rates/Enhanced Care Coordination Payments Develop payment model for care coordination that is fully compliant with Model of Care.	• Provides additional flexibility at the community level to coordinate care and adhere to Model of Care requirements • Funding potentially could be derived from projected savings/ACO	• Care coordination services reimbursed as part of current case rate models • Other approaches offer additional flexibility to promote service delivery reform and value-based purchasing	• Other approaches offer additional flexibility to promote service delivery reform and value-based purchasing

Design Considerations

What operational elements best support reform objectives?

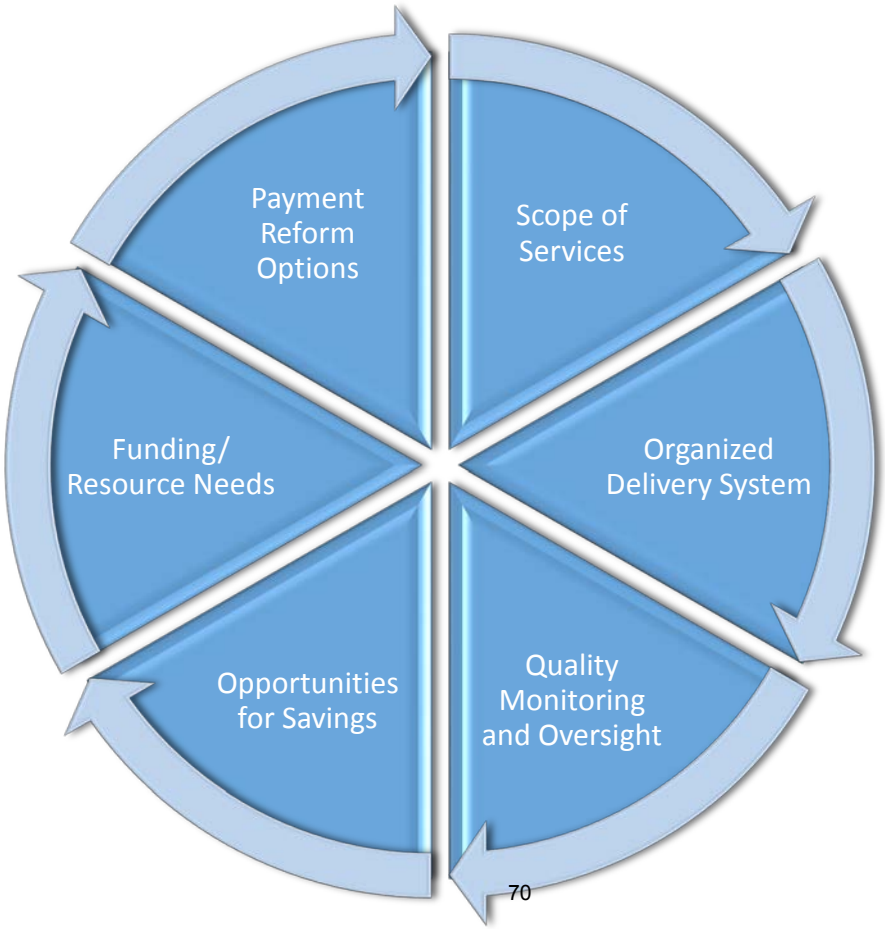
Design Element	Description	Design Objectives/Considerations

Scope of Services	Core set of services to be provided as part of the organized delivery model	• Meet all model of care principles, including integration across all services
		• Support full continuum or care, including prevention and intervention
		• Create Pathway to All-Payer Model
		• Current systems of care (e.g., provider characteristics, service coordination)
		• Uniformity/consistency with current and proposed initiatives
		• Accountability
		• Feasibility of model throughout the State
		• Implementation options
		  • Uniform v. community variances
		  • Voluntary versus mandatory provider participation
		  • Single entity or multiple entities in each region
		  • Phase-in of services, requirements, incentives, etc.
		• Funding and State administrative readiness

Organized Delivery System and Governance	Governance model and requirements for provider organization at the community level	
Payment Reform Options	Methodologies that promote the adoption of the model of care and other reform objectives	
Funding/ Resource Needs	Resources necessary to adequately fund activities and services, as well as State administrative functions	
Opportunities for Savings	Ability to contain costs (e.g., intervention/prevention, reductions in hospital/nursing facility utilization, service delivery efficiency, administrative efficiency)	
Quality Monitoring and Oversight	Activities to measure and promote program performance (including structure, process and outcomes)	

Relationship of Design Elements

- Program design elements are inter-related
- Preliminary design decisions will be established, then re-evaluated
- Models also will be re-evaluated as other program reform efforts emerge



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Status and Next Steps

1. Mental Health, Substance Abuse Treatment, Developmental Services alignment group working on options for organized delivery system and payment models
   - Reviewing scope and model considerations

2. DLTSS Written Comments on Integrated Delivery System & Payment Reform by April 30th to Julie Wasserman Julie.Wasserman@vermont.gov
   - Feedback and/or recommendations on Opportunities, Challenges and Design Considerations (Slides 11 and 12).

3. Convene a working group to address LTSS Medicaid Pathway

4. Next DLTSS Quarterly Meeting - July 7th 2016

Presentation Acronyms

ACO:	Accountable Care Organization
ADAP:	Alcohol and Drug Abuse Program
AHS:	Agency of Human Services
AOE:	Agency of Education
APM:	All Payer Model
CFC:	Choices for Care
DAIL:	Department of Disabilities, Aging and Independent Living
DCF:	Department for Children and Families
DLTSS:	Disability and Long Term Services and Supports
DMH:	Department of Mental Health
DS:	Developmental Services
DVHA:	Department of Vermont Health Access
LTSS:	Long Term Services and Supports
MH:	Mental Health
SAT:	Substance Abuse Treatment
VR:	Vocational Rehabilitation