DAIL Advisory Board Meeting Minutes
March 10, 2016
Sally Fox Conference Center, Waterbury

ATTENDEES:

Board Members: Linda Berger, Robert Borden, Nancy Breiden, Peter Cobb, Nancy Lang, Nancy Metz, Gini Milkey, Diane Novak, Steve Pouliot, Beth Stern

Guests: Jackie Majoros, Ed Paquin, Marlys Waller, Michael Benevenuto

State Employees: Susan Aranoff, Clayton Clark, Michael Costa, Gabe Epstein, Joanne Fleurrey, Camille George, Selina Hickman, Monica Hutt, Joe Nusbaum

Motion to Approve Minutes: February 14th minutes: Approved:
Seconded:

I. Deputy Commissioner Updates
Camille George, Deputy Commissioner DAIL

Supported Decision Making Conference

Vermont Care Partners is holding a conference on Supported Decision Making on June 9th. This conflicts with the June DAIL Advisory Board Meeting. There was a show of hands of who would definitely be attending the conference and there were a few that will definitely be attending. It was suggested that the DAIL Advisory Board use June as the month to take off, but this may not be possible. Marlys Waller of Vermont Care Partners, was asked to provide more information about the cost of this conference when this information was available. We will discuss this conflict at a future meeting.

Governor's Award for Business Excellence in Supporting Mature Workers

In partnership with the Governor's Commission on Successful Aging, the Agency of Commerce and Community Development (ACCD) and the Vermont Department of Labor (VDOL) are co-sponsoring the Governor's Award for Business Excellence in Supporting Mature Workers. The award recognizes Vermont employers who demonstrate exceptional commitment to employment practices that benefit and support the inclusion and retention of mature workers.

The review committee for these awards are looking for a representative from the DAIL Advisory Board to join their team. The review committee will meet between mid-April through mid-May and

the award will be presented by the Governor at an awards ceremony in June. Nancy Metz volunteered to join the team.

Recruitment for New Members of the DAIL Advisory Board

The DAIL Advisory Board touched base about membership and a proposed orientation for new board members. Camille George reported that DAIL has received a number of inquiries in response to the letter that was sent out seeking potential new members for the DAIL Advisory Board. Once new members are appointed and on board, Camille would like to provide an orientation for new members. In addition, because many current members may not have received any kind of orientation, they, too, would be welcome to participate as well. It was also suggested that an orientation manual be developed, and/or that the current Operating Procedures be reviewed to see if that would suffice, or if there are other components of an orientation that would be important to have. Possible components that were suggested include: acronyms, unpacking each division, key legislation – how we got here, an organizational chart of the Department and how DAIL fits into the Agency of Human Services (AHS). Nancy Breiden, Linda Berger, Peter Cobb and Robert Borden volunteered to serve as a subcommittee of the DAIL Advisory Board to work with Camille to take a look at the current Operating Procedures and the need for an orientation manual or other approach. Peter Cobb will share the orientation manual that his organization developed; and there may be some helpful information there. The group will meet by teleconference, once they have had time to review the materials. In addition, Advisory Board members suggested that it would be helpful for both new and experienced members, if DAIL offered to meet with the Board either ½ hour before or ½ hour after some of the meetings to find out what questions people have and whether they have the information they need to provide the necessary input and advice to the Department.

Related to the discussion of orientation, members expressed that it would be helpful for all meetings to understand more clearly for each topic why the topic is important to know and if the Department wants something back related to the topic (advice, feedback, etc.). It was noted that the new format of the agenda is helping to move in that direction.

II. Conversation with the Commissioner

Monica Caserta Hutt, Commissioner DAIL

SFY17 DAIL Budget Update

The total change of the SFY 17 DAIL budget was $13.6 million, about a 3% change from last year. Of that total, $8.8 is the DAIL Budget and $4.7 is money that DAIL manages but sits in the DVHA budget. The budget summary sheet is organized by appropriations. The Administration and Support line item is the cost for all divisions. The increase for this line item includes salary increases, COLA, insurance increases and pay act. Aging and Adult Services grants encompass most grants to organizations and supports to AAA's, VCIL, Attendant Services Programs, SASH, the Home Share Programs, NSP. These grants have been level funded.

Vocational Rehabilitation (VR) and the Division for Blind and Visually Impaired (DBVI) operate almost exclusively on federal funds with a small state fund match. There was no change in either of these divisions for SFY 17. The budget request includes an increase for Developmental Disabilities Services due to caseload increases which includes general caseload and public safety – Act 248 – caseloads.

Choices for Care statutory nursing home rate increase – there are already two, if not more, structures in place that determine the rate paid to nursing homes. Commissioner Hutt explained that if we were not to do the statutory rate increase it would hurt the individuals that are on Medicaid and admitted to nursing homes, not the homes that have more private pay individuals. It was noted that other providers of long term services and supports do not have the same type of statutorily required increase and that further discussion about how to ensure the financial sustainability of the entire system is important. As a first step, it would be helpful for members of the Advisory Board to have an understanding of how rates are set for nursing homes.

Rate setting will be a future topic of the DAIL Advisory Board – tentatively scheduled for the April meeting.

III. Introduction of Joe Nusbaum
Assistant Director for Adult Protective Services (APS)

Clayton Clark, Director of the Division of Licensing and Protection (DLP), introduced Joe Nusbaum, Assistant Director for APS to the Advisory Board. Clayton and Joe have worked together in the past and DLP is very glad to have Joe in this role.

Joe has an investigative background while working for Homeland Security, but his heart is in human services. Joe will be responsible for the oversight of APS, including intake and 10 investigators. APS will also be bringing on an intake coordinator that will elevate investigation quality and create clear protocols. When the Board asked Joe what challenges he sees for his position, his response was to create clear policies and procedures, to provide more management and clarity when to close a case.

The APS caseload is at its lowest in 6-7 years. There are below 200 open investigations, which was more than double just 18 months ago. The cases that APS receives are typically jointly-handled cases – involving law enforcement, Department for Children and Families (DCF), various other agencies and providers. APS is usually the last to do their part of the investigation, because once APS' investigation is complete, the information is available to the perpetrator. This way the details of the case cannot be revealed to the perpetrator, thus reducing the risk of more harm done to the alleged victim.

Historical trends are not possible to track due to the lack of having a case management system in place. It is known that about 1/3 of cases are financial, about 40% of reports are referred to the field investigators and that SFY15 had over 4,300 intakes, which is the highest amount APS has ever recorded.

IV. CMS HSBS Rules – Developmental Disabilities Services Division (DDSD) Roll Out
Roy Gerstenberger, DDSD Director

An update was given on how DDSD will adapt and bring their system into alignment to support the new Home and Community Based Services (HCBS) rules. The rules support enhanced quality to

HCBS programs and reflects Centers for Medicare and Medicaid Services' (CMS) intent to ensure that individuals receiving services and supports under HVBS waivers have full access to the full benefits of community living and are able to receive services in the most integrated setting. The same process for that was used during the Choices for Care review is being used with DDSD. A desk review/audit has been completed. The transition plan is being developed and will be sent out for comments upon completion.

The Vermont regulatory framework for Developmental Services is progressive and comprehensive. In eight of CMS's areas of focus, DDSD is in full alignment of the federal guidelines and have four areas that need improvement. The DDS statutory and regulatory framework appears to substantially align with the values in the federal framework and requires many of the same safeguards. Vermont rules and guidelines expand beyond the federal framework and support independence, personal autonomy and choices. However, state budget limitations have resulted in a significant downsizing of functions in quality and policy oversight. In an effort to limit the impact on direct care appropriations in specialized programs, necessary reductions in state resources were made in infrastructure. Subsequently, monitoring adherence and improvement has been difficult. The state has been challenged with finding more efficient and automated ways to collect and monitor quality indicators, including consumer self-report data, grievance and appeals data and provider performance measures. Efforts at modernizing the IT infrastructure across AHS should result in the development of new business processes to support necessary quality monitoring and provider performance management in these critical areas.

Next steps to this process is to ask the Designated Agencies (DA's) to complete surveys that run down our alignment with the CMS rules. Policy will need to be created where it does not already exist. The process will also include a mandatory self-assessment by the DA's. DDSD is asking for a voluntary survey by folks that are receiving services to help get a better picture.

The DS State Program Standing Committee is the legislatively mandated advisory body to DAIL about the DS System of Care. Representative from this and other groups will be invited to participate in the advisory committee that will help guide this process. Input will also be sought from the DAIL Advisory Board. It will be important to have providers and self-advocates at the table to help create surveys. This will help close any gaps in information gathering. There are two primary areas of challenges. One, is the area of conflict-free case management. The rules around this topic do not look at the level of conflict of interest. Vermont includes case management in the services, so this will be an important focal point. The second area is to pay attention to organizations that are considered an "all-inclusive community". For a place like this to operate successfully, it needs to be designed correctly. People that are involved in and live at these facilities, will also be invited to participate at the advisory committee.

When asked if this committee would be duplicating efforts by creating these survey questions. It was made clear that there are brand new questions that are not currently included in the designation process. The advisory committee will focus on the best way to complete and submit the questions.

V. Integrated Health System Update - All Payer Model and Medicaid Pathway

Selina Hickman, Agency of Human Services and Michael Costa, Agency of Administration

It is important for us to know and understand the All Payer Model (APM), since we all pay a lot of money for health care today and we lag behind in quality and outcomes. This model would move away from the fee-for-service system that is now in place. It is meant to improve experience of care, improve the health of populations and reduce per capita cost.

There is a lot of discussion about an APM, but this is not the whole picture The State's big goal is an integrated health care system, with accountable providers, hospitals and doctors. We are working to achieve this goal via the APM and the Medicaid Pathway to create the whole system for everyone (providers and individuals

What is an All Payer Model (APM)? An all payer model is an agreement between the State and the Center for Medicare and Medicaid Services (CMS) that allows Vermont to explore new ways of financing and delivering health care. For the first time, Medicaid is saying "if you are willing to join the ACO, we will pay you differently". You align private health insurance, Medicaid, and Medicare and no benefits will change, just the way it is paid. It is aligned, not the same, because they are still different. Currently fee-for-service reimbursement systems are used. It has been shown that you pay a lot for this service without great results.

When the fee for service system was created fifty years ago, health care needs were very different than today's needs. The majority of our current health care costs are for chronic conditions. Care coordination and health promotion activities are not rewarded by fee-for-service compensation. The approach for care coordination and health promotion, may decrease the amount of patients with multiple chronic conditions. Thus, creating better results.

The federal government has created programs that encourage the use of ACO's. One option is that these ACO's are paid an all-inclusive population-based payment. CMS will allow ACO's some flexibility in certain payment rules in exchange for accepting this new type of payment. Joining an ACO is completely voluntary for the provider and the patient. For the providers, the ACO must be appealing enough to join. For patients, you may not notice any difference and it will not limit what doctor that you see. Consumers can choose to opt out of an ACO or find a provider that has not joined an ACO.

The Goals of a transformative All-Payer Model are:

- Improve experience of care for patients
- Improve access to primary, preventive services
- Reward high value care
- Construct a highly integrated system

- Empower provider-led health care delivery change
- Control the rate of growth in total health care expenditures
- Align measures of health care quality and efficiency across health care system

The results for year one have not yet been received. National results show better quality and some savings. Michael Costa will look into getting Vermont specific information to answer the question if there is any indication of how we are doing so far. It was noted that it takes shared savings and adds a bit more risk. The model is also a good way to hold ACO providers' feet to the fire.

How do we get there? It is not a huge leap since we already have health care reform in place – taking shared savings, payment model and the risks. Medicare offers a SSP for ACO's and there are Commercial and Medicaid SSP Standards. The Blueprint for Health has public and private participation. Now the work is to build the base of Primary Care Providers (PCP) that participate.

The performance period for ACO's is 5 years, which aligns with the Medicaid Waiver. The Medicare trust funds says "You can have this money, if you save us money". For example, if federal Medicare grows at 4% we would have to come in at 3.8% - this percentage is based on per capita. It also commits to all-payer caps. The Green Mountain Care Board (GMCB) would like health care spending at 3.5% or less – economic growth is 3.5%. The State of Vermont would never have to cut a check if the APM did not work out in this performance time period. We would return to fee-for-service reimbursement. If this is signed in SFY16 it could stay in place for 5 years regardless of changes in state of federal administrations. Both sides would have to give substantial prior notice if they did not want to continue.

The GMCB is not tied to the administration. If the provider systems want to do this, the next administration would have think carefully before trying to stop the program. Also, it is important to evaluate this concept not on where Medicare is today, but where they are going with their policies and payment models. The status quo may not be tenable.

This change will not offer coverage for additional recipients. But if we can get health care costs to stop growing at the current rate, more programs could be opened up.

Next steps to the APM are to assess and evaluate. All points of view are being taken into consideration - the right incentives and rewards, the promise of integrated high quality care. There will be continued negotiations with CMS.

The Medicaid Pathway refers to these critical ideas:

- There is payment and delivery system reform that must happen alongside the APM regulated revenue/cap conversation.
- There is a process for Medicaid providers to engage in with the State alongside the APM regulated revenue/cap conversation.

- This process is led by the Agency of Human Services (AHS) Central Office in partnership with the Agency of Administration and includes Medicaid service providers who provide services that are not included in the initial APM implementation, such as Long Term Services and Supports (LTSS), Mental Health and substance abuse services and others.
- The Medicaid Pathway advances payment and delivery system reform for services not subject to the additional caps and regulation required by the APM. The goal is alignment of payment and delivery principles that support a more integrated system of care.

There are going to be services and providers that are not part of the ACO system. Most of DAIL services fall into this category. In terms of what we are doing with Medicaid, this is about 65%. And we are asking what do we want out of this and we are asking the providers the same question. The system itself if moving forward – we know what changes we want and that we can do it – as much of the work itself is the same. But, there is a lot of work to be done.

It is not just a question of "Am I in or am I out?", the Medicaid Pathway is a process. We have the same principles and goals that are guiding us that will help keep us aligned. They are:

- Ensure access to care for consumers with special health needs
- Promote person and/or family centered care
- Ensure quality and promote positive health outcomes
- Ensure the appropriate allocation of resources and manage costs
- Create a structural framework to support the integration of services

It is not only about access to care, but also access to comprehensive care. We need to be sure we are connecting the two types of care for the patient – allowing for a full continuum. The approach is to be more holistic – to include a measurement of independence. The structural framework is the heart and basis of the implementation – a model of care and a payment system that we think will work.

The Medicaid Pathway process includes delivery system transformation based on the Vermont model of care (developed through the Statewide Innovation Model (SIM)), payment reform connected to an updated quality framework, and measurable outcomes. The model of care is how the providers will be giving services differently. The payment reform is all about how the state can incentivize providers to deliver services differently. When you pay differently and give providers more flexibility there is a change of quality to help understand the success.

Who is on the Medicaid Pathway? Group 1 are the providers of Mental Health and Substance Abuse services. Group 2 is the Disability and Long Term Services and Supports (DLTSS) – which is using the same tools, goals and principles as Group 1. Group 3 – AHS needs to engage with other community providers in a planning process to determine how and when other services and providers will enter the Medicaid pathway process. The Medicaid Waiver provides the broad policy authority to commit to this process, building off Integrating Family Services (IFS), a pilot that bundles payment and provides more flexibility in service delivery. We have learned from IFS that it is a very different

business model for providers under a global payment as opposed to fee for services. There is a real readiness stage that is needed.

Once we figure out what folks want for payment and a delivery system for those services, then we can figure out how to implement. Non-medical providers – things that add to the success and health of a patient. Things like nutrition and transportation. One of the assumptions of the model is that it would make it possible to receive the right services at the right time and place. Savings can be achieved in this under this assumption because quality goals look at the big picture. With an ACO there is nothing stopping the person from receiving the services they need to be health because there is more flexibility to do this. The focus would be on keeping people healthy.

While, it is all well and good to have a new system, there is nothing about the APM the fixes the amount of Medicaid dollars available in the system. A culture needs to be created to give Legislators a long term vision and give more dollars.

Advisory Board members agreed that a follow up conversation about the APM and Medicaid Pathway would be helpful, once people have had time to digest today's conversation.

Meeting was adjourned