2013 Report of the Health Care Oversight Committee
January 2014

In Accordance with 2 V.S.A. § 852

Senator Ginny Lyons, Chair
Senator Claire Ayer
Senator Sally Fox
Senator Jane Kitchel
Senator Kevin Mullin

Representative Jill Krowinski, Vice Chair
Representative Francis "Topper" McFaun
Representative Anne Theresa O'Brien
Representative Christopher Pearson
Representative George Till

Prepared by:

Jennifer Carbee, Esq.
Legislative Council
State House
Montpelier, VT 05602
802-828-2231
jcarbee@leg.state.vt.us

Table of Contents

I. Statutory Authority and Responsibilities of the Health Care Oversight Committee

During the 1995 session of the Vermont General Assembly, the Legislature authorized the creation of the Vermont Health Access Plan (VHAP), taking one of the first steps in health care reform by offering health care coverage to uninsured low-income Vermonters (1995 Acts and Resolves No. 14). At the same time, the Health Access Oversight Committee was created to monitor the development, implementation, and ongoing operation of VHAP and to ensure improved access to health care. In 2006, the General Assembly broadened the Committee's jurisdiction to include the operation of the Medicaid program and all Medicaid waiver programs that may affect the administration and beneficiaries of these programs.

In 2011, the General Assembly again expanded the Committee's jurisdiction, this time to encompass all health care and human services programs in the State, including programs and initiatives related to mental health, substance abuse, and health care reform. The General Assembly also renamed the Committee the Health Care Oversight Committee (HCOC). The changes took effect on July 1, 2012. (See Appendix 1 to view the statutory authority for the HCOC.)

II. Summary of Committee Activities

The Committee met six times during the summer and fall of 2013, hearing from individuals and organizations representing a broad spectrum of perspectives and interests. The Committee developed recommendations on the following topics as provided in this report:

- Vermont Health Benefit Exchange (Vermont Health Connect)
- Payment reform
- Choices for Care
- Adult Protective Services
- Health information technology
- Public health – prevention
- Substance abuse treatment
- 3SquaresVT

The Committee heard testimony regarding other topics, including the Blueprint for Health and the Dual Eligibles project, but did not develop specific recommendations related to these topics.

On November 8, 2013, the Committee met in a joint meeting with the Mental Health Oversight Committee to discuss capacity and personnel needs at the State's level 1 mental health system. The two Committees' recommendations resulting from that meeting are included in this report at Appendix 2.

(See Appendix 3 for the 2013 Witness List.)

III. Vermont Health Benefit Exchange (Vermont Health Connect)

The Vermont Health Benefit Exchange, known as Vermont Health Connect (VHC), launched on October 1, 2013 as required by the federal Patient Protection and Affordable Care Act of 2010 and Vermont law. The Committee received regular updates throughout the summer and fall from the Department of Vermont Health Access (DVHA) regarding the Department's readiness to launch VHC on schedule. Members of the Committee repeatedly expressed concerns about the VHC's readiness to begin enrolling qualified individuals and small businesses in qualified health benefit plans. Although the VHC website did launch on October 1 as planned, a number of technical problems plagued the program's rollout, as many Vermonters could not access the VHC website, received error messages, or were otherwise unable to complete the application process. In addition, while DVHA had notified the Committee that applicants would not be able to pay their premiums through VHC until November 1, as of mid-December, the premium payment system was still not operational.

Along with worries about VHC readiness, members of the Committee also expressed concerns regarding the lower than expected numbers of Vermonters enrolling in health benefit plans through the VHC. Exchange enrollment was slower than expected nationally, both for the troubled federal exchange and for other state-run exchanges. Comparison data did show, however, that measured per capita, Vermont's Exchange enrollment far outpaced that of any other state-run exchange.

Members of the Committee were disappointed with the performance of Vermont's information technology contractor for the Exchange, CGI. They were curious about the potential penalties included in the CGI contract for missed benchmarks and deadlines.

Recommendations

The Committee recommends that the standing committees of jurisdiction continue to monitor closely the rollout of VHC, including the ability of Vermonters to enroll in and pay for health benefit plans offered through VHC and any penalties that the Department of Vermont Health Access may impose on CGI for its failure to meet contractual

benchmarks and deadlines. The Committee also recommends identifying the State and federal dollars needed and anticipated for VHC and the timeline for transition to full State responsibility.

IV. Payment Reform

The Committee heard extensive testimony from the Green Mountain Care Board (GMCB) and DVHA regarding payment reform activities planned and under way in Vermont. The GMCB told the Committee about accountable care organizations (ACOs), which are networks of health care providers who coordinate care, achieve efficiencies, and agree to be held accountable for the cost and quality of a certain group of lives. The Committee also heard about shared savings programs, in which an entity that pays health care providers (Medicare, Medicaid, or a commercial insurer) offers participating providers the opportunity to share in savings realized through the efficient, coordinated delivery of high-quality health care services. ACOs and shared savings programs often work together.

In Vermont, a Medicare shared savings program is already in effect, and efforts are under way to begin similar programs with Medicaid and the commercial insurers. Two ACOs are participating in the Medicare shared savings program: OneCare Vermont and the Accountable Care Coalition of the Green Mountains. A third has filed for approval. The GMCB, Medicaid, BlueCross BlueShield of Vermont, and MVP Health Care are aiming to get the Medicaid and commercial shared savings programs operational by January 1, 2014 and include one or more ACOs as participating providers.

The Green Mountain Care Board has authorized several other payment reform pilot projects and is engaged with provider groups to launch more. As of October 2013, payment reform pilot projects under way in Vermont included OneCare Vermont's shared savings program with Medicare and the St. Johnsbury Oncology Project, which involves Northeastern Vermont Regional Hospital and its primary care practices, Norris Cotton Cancer Center North (affiliated with Dartmouth-Hitchcock Medical Center), the Northern Counties Health Care FQHC, and the Blueprint Community Health Team staff, as well as Medicaid and commercial payers. In addition, on January 1, 2014, Northwestern Medical Center's Emergency Department will begin a pilot project designed to reduce avoidable visits to the emergency room, with Medicaid and commercial payers participating. Other payment reform efforts are also under way, including a congestive heart failure bundled payment initiative for 80 patients in the Rutland area.

The State Innovation Model (SIM) project is another major factor in payment reform in Vermont. The federal SIM grant provides $45 million over four years while requiring Vermont to test different models of value-based payment and to include multiple payers and a broad range of stakeholders. The project is led by the decision-making SIM Core Team chaired by Anya Rader Wallack, former Chair of the GMCB. The Core Team is

advised by the SIM Steering Committee, which is co-chaired by the current Chair of the GMCB and the Commissioner of DVHA and includes representatives of a number of different constituencies across both the public and private sectors. In addition, there are six standing work groups:

1. Duals Demonstration Work Group
2. Health Information Exchange Work Group
3. Quality & Performance Measures Work Group
4. Payment Models Work Group
5. Population Health Work Group
6. Care Models & Care Management Work Group

In the SIM project, Vermont will test several payment and delivery system models, beginning with the shared savings program ACOs for Medicaid and the commercial payers, followed by episode-based payments or bundled payments, or both, and pay-for-performance models. The Medicaid and commercial shared savings program models are expected to launch on January 1, 2014. The details of the later models have yet to be announced.

The Committee was concerned about the lack of a defined role for the General Assembly in the State's payment reform activities. Members learned about the upcoming launch of the Medicaid ACO from stakeholders, who expressed concerns about the rapidity of the development process and the lack of coordination with mental health and long-term care providers. The Committee wrote to the Chair of the GMCB and the Commissioner of DVHA to express its frustration and concerns about the pace of the process and the level of inclusiveness.

Recommendations

The Committee recommends that the committees of jurisdiction:

1. Identify the role of the General Assembly in payment reform, particularly with respect to the SIM grant and ACO development and governance.
2. Request information regarding sustainability of the pilot programs and initiatives developed with federal funds from the SIM grant.
3. Determine methods for measuring the outcomes of payment reform and how to attribute success to individual programs or initiatives.

V. Choices for Care

Choices for Care, a Section 1115 Medicaid waiver program, provides patients with a choice between receiving long-term care services in a nursing home or through home- and community-based services. Under Choices for Care, an individual must first meet certain financial eligibility criteria, the person's needs are then evaluated through a

clinical assessment, and he or she is assigned to a risk group ranging from "Highest Needs" to "High Needs" to "Moderate Needs." The needs determination establishes priority for services, with those in the "Highest Needs" category enrolled as soon as Medicaid eligibility is established. Individuals assigned to the "High Needs" group are enrolled as soon as funds are available to pay for their treatment option. To the extent funds are available, "Moderate Needs" individuals receive preventive services, such as adult day care, homemaker, and case management services.

Changes to the Choices for Care provisions made during the 2013 legislative session provided some clarity on the use of "savings" realized in the program, but also led to a difference of opinion between the Committee and the Joint Fiscal Committee regarding the circumstances in which these savings could be used. While there is no wait for services in the Highest Needs and High Needs Groups, the Committee heard considerable testimony about the waiting lists for services from home health agencies and adult day centers for the Moderate Needs Group. Concerns were raised about the current allocation of funds across the State and whether there was a more accurate way to allocate the funds so that there would not be waiting lists for services in some geographic areas while surplus funds went unused in others. In addition, it seems that many people who are not currently eligible for services are on waiting lists for the Moderate Needs Group in order to hold a spot for possible future need. This may present confusing information regarding the number of people actually waiting for these services. Finally, it may be appropriate to consider adding transportation as a covered service in the Moderate Needs Group, as many individuals who are eligible for services from an adult day center lack the necessary transportation to and from the service providers.

Recommendations

The Committee recommends that the committees of jurisdiction:

1. Move quickly to address the problem of the Moderate Needs Group waiting lists.
2. Review the formula for Moderate Needs Group allocations to determine whether changes should be made.
3. Review the covered services for the Moderate Needs Group and consider whether additional services, such as transportation, should be added.
4. Review the eligibility criteria for the Moderate Needs Group and consider whether they are appropriate or should be revised.
5. Clarify (and codify):
    a. what is meant by "savings"—need to revisit 2013 definition;
    b. how to determine the amount to be reinvested;
    c. what are permissible uses of savings, and whether those permissible uses of savings differ from permissible uses of unspent appropriations; and
    d. the process for determining how to reinvest the savings and unspent appropriations, including whether it should be in the Administration's sole discretion or whether there should be a role for the General Assembly.

VI. Adult Protective Services

In its 2013 report, the Committee raised a number of concerns about the Adult Protective Services (APS) program and access to information regarding reports of abuse, neglect, and exploitation of vulnerable adults and the investigation of those reports. During the 2013 legislative session, the General Assembly passed Act 46, An act relating to adult protective services reporting requirements.[1] The act requires the Commissioner of Disabilities, Aging, and Independent Living (DAIL) to provide quarterly reports for two years regarding DAIL's APS activities, including the number of reports of abuse, neglect, and exploitation that DAIL received and assigned for investigation and the reasons that some cases were not investigated. DAIL presented its first quarterly report at the Committee's July meeting, covering the period from April 1 to June 30, 2013. Members of the Committee were pleased to have the information but requested earlier data as well for comparison purposes. They also wanted data regarding the length of time investigations remain open.

In December 2011, Disability Rights Vermont and Vermont Legal Aid filed suit against the State, alleging that DAIL had not followed statutory requirements and was failing to protect vulnerable adults. On August 27, 2013, the parties who were engaged in litigation regarding the APS program settled their lawsuit with the State and the action was dismissed by the Superior Court. Pursuant to the settlement agreement:

1. DAIL must make specific revisions to its APS Policy and Procedure Manual;
2. representatives of the plaintiffs in the case, the Community of Vermont Elders, Disability Rights Vermont, the Southwestern Vermont Council on Aging, and Senior Solutions, will join the DAIL Advisory Board, with two as full members and two as ad hoc members; and
3. an agreed-upon panel will conduct quarterly file review.

Recommendations

The Committee recommends that the committees of jurisdiction review DAIL's quarterly reports on APS in order to monitor DAIL's timely response to reports of abuse, neglect, and exploitation. In particular, the Committee recommends requesting comparison data in order to evaluate improvements over time.

VII. Health Information Technology

The Committee heard testimony from the Vermont Information Technology Leaders, Inc. (VITL) about the status of health information technology (HIT) in Vermont. During the past year, VITL has helped primary care providers create electronic health records and

[1] http://www.leg.state.vt.us/DOCS/2014/ACTS/ACT046.PDF

meet meaningful use requirements, connected all but one of Vermont's hospitals to the Vermont Health Information Exchange Network, implemented six provider portal pilot sites, enhanced infrastructure development, and made significant progress on the development and completion of hospital interfaces for a variety of reports, images, and other information. OneCare Vermont selected VITL to develop its HIT infrastructure. In addition, VITL is designing and developing a statewide imaging network and has applied with Fletcher Allen Health Care, Dartmouth Hitchcock Medical Center, and lifeIMAGE, an imaging exchange company, for an $8.5 million Health Care Innovation Award Grant from the Centers for Medicare and Medicaid Services.

Recommendations

The Committee recommends that the standing committees of jurisdiction continue to monitor HIT implementation, including:

1. Requesting from VITL a timeline of the rollout of the Health Information Exchange Network over the next 24 months.
2. Understanding and expanding, as appropriate, the role of the Department of Information and Innovation in health information technology in Vermont.

VIII. Public Health – Prevention

The Committee heard from the Department of Health about a number of its public health and prevention initiatives. The Department distributed copies of Healthy Vermonters 2020: The State Health Assessment Plan[2], a 2012 document identifying goals, objectives, and baseline data to allow progress to be tracked into the year 2020. The report identifies goals and indicators in areas such as maternal and infant health, early childhood screening, access to health services, substance abuse, nutrition and weight, and a variety of diseases and conditions. It measures Vermont data against national data and identifies goals for the State for the year 2020.

The Department also distributed the 2013–2017 State Health Improvement Plan,[3] which identifies three statewide strategic health priorities for the next five years:

1. Reduce the prevalence of chronic disease
2. Reduce the prevalence of individuals with or at risk of substance abuse or mental illness
3. Improve childhood immunization rates

For each of these goals, the plan provides data and evidence-based strategies for addressing the problem identified. The Department also described initiatives such as the

[2] Available online at http://healthvermont.gov/hv2020/report.aspx
[3] Available online at http://healthvermont.gov/hv2020/ship.aspx

Nurse Family Partnership, in which specially trained nurses visit first-time mothers on Medicaid during and after pregnancy.

The Department recently applied for accreditation from the Public Health Accreditation Board, a national, nonprofit accreditation body that accredits public health departments. The Department believes accreditation may ultimately become a prerequisite for receiving funds from the Centers for Disease Control and Prevention.

Recommendations

The Committee recommends that the standing committees of jurisdiction:

1. Identify methods for coordinating prevention with or into health care programs and payments to improve health outcomes.
2. Consider a requirement that proposed legislation be evaluated for its impact on public health and prevention, similar to the way that legislation is currently evaluated for its fiscal impact or that proposed rules are evaluated for their impact on small businesses, because public health and prevention have broad implications that transcend all committees.
3. Look at existing standards for expertise and measurement of success for co-occurring mental health and substance abuse conditions.
4. Evaluate school health education, including whether expectations are being tracked, what outcome measures exist, and what connections exist between the Blueprint for Health and school nurses.

IX. Substance Abuse Treatment

In September, the Joint Fiscal Committee approved the Department of Health's federal Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant, which embeds into primary care practices screening for persons with or at risk for substance abuse problems. The grant, which provides $2 million per year for a total of $10 million over five years, will help identify and reduce substance misuse in Vermont adults. The SBIRT services will be delivered around the State in five federally qualified health centers, three clinics for the uninsured, the University of Vermont's Student Health Center, Central Vermont Medical Center and its satellite primary care clinics, and the Vermont National Guard's Camp Johnson Medical Center. The federal government also requires that 30 percent of the grant be used to expand electronic health records at the State and local level.

Another new initiative comes from the Partnerships for Success Prevention Grant, a three-year grant from the federal government with three goals:

1. reduce underage and binge drinking among persons aged 12 to 20 years;
2. reduce prescription drug misuse and abuse among persons aged 12 to 25 years; and

3. increase State, regional, and community capacity to prevent underage drinking and prescription drug misuse.

The grant award of $3.5 million over three years will be distributed in part among districts in Barre, Brattleboro, Burlington, Morrisville, Rutland, and Windsor County (led by the White River Junction district) to engage in regional interventions.

Other substance abuse initiatives currently under way are funded by community-based prevention grants, school-based substance abuse services grants, and a four-year federal State Youth Treatment grant. In addition, Vermont's "Hub and Spoke" initiative, now called the Care Alliance for Opioid Addiction, provides comprehensive opioid services to Vermonters and operates in four regions of the State. The fifth and final region, serving Caledonia, Essex, and Orleans Counties, is expected to be operational by January 1, 2014. In the Care Alliance model, an individual with substance abuse treatment needs is referred to a regional opioid treatment center (called a "hub"), where patients are stabilized, assessed to determine whether treatment with methadone or buprenorphine is appropriate, and placed in either a hub (for methadone treatment and for patients with complex needs) or "spoke" (for buprenorphine treatment).

Recommendations

The Committee recommends that the standing committees of jurisdiction continue to monitor substance abuse treatment, prevention, and intervention programs in Vermont, including the Care Alliance for Opioid Addiction (formerly known as the "Hub and Spoke" initiative). In addition, the Committee recommends that the standing committees consider how substance abuse programs and initiatives can be sustained when the grants that create them are time-limited.

X. Supplemental Nutrition Assistance Program (3SquaresVT)

The Committee heard testimony from the Department for Children and Families (DCF) about continuing problems with the error rates in Vermont's Supplemental Nutrition Assistance Program, known as 3SquaresVT. For the third year in a row, Vermont will be subject to sanctions from the federal government for an excessive payment error rate, which is an error rate in excess of six percent. Vermont's error rate for federal fiscal year 2012 was approximately 8.5%. DCF will not know the details of the sanctions for its payment errors until the summer of 2014, but it plans to discuss with the federal government the creation of a reinvestment plan instead of payment of a monetary penalty. Maine was successful in a similar effort.

In addition to the sanctions the State must pay to the federal government, the Committee learned that beneficiaries who received excess benefits in error must repay the amount of the overpayment, even though in most cases it was DCF's error that resulted in the overpayment. According to DCF, Vermont has an agreement with the federal

government that the State does not have to recoup overpayments from beneficiaries if doing so is not cost-effective – a threshold currently set at anything under $400.00. While DCF says Vermont's cost-effectiveness standard is comparable to other New England states, the Department hopes to raise the threshold to $600.00. There are a few exceptions to the repayment rules. Overpayments discovered through the quality review process must be recouped, regardless of the amount. And beneficiaries who have received an overpayment may be eligible for a "compromise," or forgiveness of some of the overpayment amount, if they request one. DCF is hoping to establish an automatic compromise for anyone up to 185% of the federal poverty level by deeming repayment an automatic "hardship," which is the federal standard for compromise. Beneficiaries who received overpayments can use a combination of compromise and a payback plan to repay the excess benefits. Federal law prohibits the State from forgiving the entire overpayment, though members of the Committee were hopeful that DCF would seek – and receive – a waiver to do so. No state has received such a waiver to date.

Recommendations

The Committee recommends that the standing committees of jurisdiction monitor DCF's 3SquaresVT error rate and ensure that DCF is as aggressive as possible in its negotiations with the federal government to reduce the impact of the Department's errors on 3SquaresVT beneficiaries. The Committee suggests that DCF should explore all possible options with respect to resolving the overpayment penalties and look at its internal systems, such as training programs and information technology, to prevent more such errors.

XI. Additional Recommendations

Legislative Oversight

The Committee discussed the appropriate role of interim and standing committees in providing oversight of health care and human services issues when the General Assembly is not in session. The Committee recommends that the standing committees of jurisdiction consider:

1. The future of oversight for mental health, including whether the Health Care Oversight Committee and the Mental Health Oversight Committee should be integrated into a single committee.
2. Whether the standing committees of jurisdiction should meet a few times over the summer and fall instead of having one or more oversight committees.
3. How to address the disconnect between the subject matter addressed by the House Committee on Human Services, the House Committee on Health Care, and the Senate Committee on Health and Welfare to determine whether restructuring is appropriate.

4. Whether the Committee's prior recommendations have been followed and what the results have been.

Systemic Evaluation

The Committee had concerns about the extent to which existing reform efforts and responses to previous recommendations are being evaluated. The Committee recommends that the standing committees of jurisdiction look at:

1. How the General Assembly and the State measure which initiatives are working and which are not.
2. Where efforts may overlap, leading to unnecessary duplication.
3. The specific roles and responsibilities over emerging health care initiatives for the General Assembly, the Green Mountain Care Board, the Department of Vermont Health Access, and the Department of Financial Regulation.
4. How to sustain programs and initiatives that are established using time-limited grant funds.
5. How to strengthen oversight and responsibility in State government.
6. Prior recommendations and actions in order to see what was done, how they worked, and what monies were used.

2013 Report of the Health Care Oversight Committee to the Vermont General Assembly and the Governor of the State of Vermont

Senator Ginny Lyons, Chair	*Representative Jill Krowinski, Vice Chair*
Senator Claire Ayer	*Representative Francis McFaun*
Senator Sally Fox	*Representative Anne O'Brien*
Senator Jane Kitchel	*Representative Christopher Pearson*
Senator Kevin Mullin	*Representative George Till*

Appendix 1.
Health Care Oversight Committee Charge
2 V.S.A. §§ 851–853

§ 851. CREATION OF COMMITTEE

(a) A legislative health care oversight committee is created. The committee shall be appointed biennially and consist of ten members: five members of the house appointed by the speaker, not all from the same political party, and five members of the senate appointed by the senate committee on committees, not all from the same political party. The house appointees shall include one member from the house committee on human services, one member from the house committee on health care, one member from the house committee on appropriations, and two at-large members. The senate appointees shall include one member from the senate committee on health and welfare, one member from the senate committee on finance, one member from the senate committee on appropriations, and two at-large members.

(b) The committee may adopt rules of procedure to carry out its duties.

§ 852. FUNCTIONS AND DUTIES

(a) The health care oversight committee shall monitor, oversee, and provide a continuing review of health care and human services programs in Vermont when the general assembly is not in session, including programs and initiatives related to mental health, substance abuse treatment, and health care reform.

(b) In conducting its oversight and in order to fulfill its duties, the committee may consult with consumers, providers, advocates, administrative agencies and departments, and other interested parties.

(c) The committee shall work with, assist, and advise other committees of the general assembly, members of the executive branch, and the public on matters relating to health care and human services programs. Annually, no later than January 15, the committee shall report its recommendations to the governor and the committees of jurisdiction.

§ 853. MEETINGS AND STAFF SUPPORT

(a) The committee may meet during a session of the general assembly at the call of the chair or by a majority of the members of the committee. The committee may meet during adjournment subject to the approval of the speaker of the house and the president pro tempore of the senate.

(b) For attendance at meetings which are held when the general assembly is not in session, the members of the committee shall be entitled to the same per diem compensation and reimbursement for necessary expenses as those provided to members of standing committees under section 406 of this title.

(c) The staff of the legislative council and the joint fiscal office shall provide professional and administrative support to the committee. The department of financial regulation, the agency of human services, and other agencies of the state shall provide information, assistance, and support upon request of the committee.

Appendix 2.
Recommendations from Joint Meeting of Mental Health Oversight Committee and Health Care Oversight Committee

In November 2013, the Mental Health Oversight Committee and Health Care Oversight Committee (Committees) met to discuss the capacity of the State's level 1 mental health system and to make recommendations on both the number of personnel needed at the new Vermont Psychiatric Care Hospital and whether the General Assembly overestimated the number of beds needed at the new hospital. The Committees made the following recommendations to the Joint Fiscal Committee:

- The General Assembly should fully fund the 25-bed Vermont Psychiatric Care Hospital
- The Department of Mental Health should prepare and present a plan to the committees of jurisdiction regarding the opening of the Vermont Psychiatric Care Hospital prior to the budget adjustment process
- The Vermont Psychiatric Care Hospital should be completely operational with all 25 beds by July 1, 2014 or as soon as possible
- The General Assembly should develop contingency plans in case the need for overflow beds in the level 1 system arises
- The Department of Mental Health should develop specific plans and timelines for the hiring and training of Vermont Psychiatric Care Hospital employees, which should commence immediately to ensure staff are ready for patients when construction of the new facility is complete
- Any revisions to its original staffing proposal should be presented by the Department of Mental Health to the committees of jurisdiction once it has conducted a review of national standards and protocols

Appendix 3.
2013 Witness List

Bob Atlas, Vice President, Avalere Health, LLC

Richard Boes, Commissioner, Department of Information & Innovation

Jennifer Carbee, Legislative Counsel, Office of Legislative Council

Todd Centybear, Director, Howard Center

Sue Chase, Vermont Association of Adult Day Services (VAADS)

Barbara Cimaglio, Deputy Commissioner, Alcohol and Drug Abuse Program, Department of Health

Peter Cobb, Director, VT Assembly of Home Health and Hospice Agencies

Albert Coccagna, User Support Specialist, Office of Legislative Council

Michael Costa, Deputy Director of Health Care Reform- Finance, Agency of Administration

Jonathan Dao, User Support Specialist, Office of Legislative Council

Tracy Dolan, Deputy Commissioner, Department of Health

Brian Erickson, MA, Attending Physician, Center for Pain Medicine, Fletcher Allen Health Care

John Evans, CEO, Vermont Information Technology Leaders (VITL)

Karen Garbarino, Director, Children's Integrated Services, Agency of Human Services

Richard Giddings, Deputy Commissioner, Department for Children and Families

Al Gobeille, Chair, Green Mountain Care

Bea Grause, President and CEO, Vermont Association of Hospitals and Health Systems

Dale Hackett, Consumer

Eric Hammelman, Avalere Health, LLC

Paul Harrington, Executive Vice-President, Vermont Medical Society

Penrose Jackson, Director, Community Health Improvement, Fletcher Allen Health Care

Craig Jones, Director, Blueprint for Health, Department of Vermont Health Access (DVHA)

Trinka Kerr, Health Care Ombudsman, Office of Health Care Ombudsman

Nolan Langweil, Senior Fiscal Analyst, Joint Fiscal Office

Mark Larson, Commissioner, Department of Vermont Health Access (DVHA)

Robin Lunge, Director of Health Care Reform, Agency of Administration

Veda Lyon, Adult Protective Services Chief, Department of Disabilities, Aging & Independent Living

Georgia Maheras, Executive Director, Green Mountain Care

Jackie Majoros, Long Term Care Ombudsman, Vermont Legal Aid

Dr. Kate McIntosh, Medical Director, Vermont Information Technology Leaders (VITL)

Katie McLinn, Legislative Counsel, Office of Legislative Council

David Mickenberg, Lobbyist, Drug Policy Alliance Network

Kate O'Neill, Tobacco Use Prevention Education Program Coordinator, Agency of Education

Ed Paquin, Director, Disability Rights Vermont

Judy Peterson, President and CEO, Visiting Nurse Association of Chittenden and Grand Isle Counties

Barbara Prine, Attorney, Vermont Legal Aid

Sandy Rousse, President and CEO, Central Vermont Home Health and Hospice

Michael Sirotkin, Lobbyist, Patient Choices Vermont

Richard Slusky, Director of Payment Reform, Green Mountain Care Board

Beth Tanzman, Assistant Director, Blueprint for Health, Department of Vermont Health Access

Julie Tessler, Director, Vermont Council of Developmental and Mental Health Services

Anya Rader Wallack, Ph.D, Chair, Vermont State Innovation Model (SIM) Core Team

Susan Wehry, Commissioner, Department of Disabilities, Aging & Independent Living

David Yacovone, Commissioner, Department for Children and Families