Vermont's Demonstration Grant to Integrate Care for Dual Eligible Individuals

Proposal to the Center for Medicare and Medicaid Innovation

May 10, 2012

Agency of Human Services

VERMONT

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A. Executive Summary

The goal of this Demonstration is to fully integrate the delivery and financing of Medicare and Medicaid services for Vermont's 22,000 dual eligible individuals. Many of these people have chronic illnesses and concurrent disabilities which span primary, acute, mental health, substance abuse, developmental, and long term care and support domains. These individuals have among the most complex care needs, yet the current system often fails in delivering comprehensive, effective and coordinated person-directed care. With annual costs of almost $600 million, failure to coordinate and integrate services for this population drives unnecessary hospitalizations, nursing facility placements, poly-pharmacy and other needless health care expenditures. Vermont's Demonstration will focus on providing person-directed interventions to improve care coordination and service delivery, with performance measures and outcomes linked to payment reform.

Vermont will utilize the State's public Managed Care Entity (MCE) to serve the dual eligible population rather than contracting with a private Managed Care Organization (MCO). The MCE will contract with existing qualified providers to serve as Integrated Care Providers (ICP) responsible for providing, coordinating and integrating a wide range of health, mental health, substance abuse, developmental, long term care and support services for these individuals. The same providers could also opt to be Integrated Care Providers PLUS (ICP-PLUS) under which they assume financial risk for some services in exchange for more financial and/or service flexibility. This new ICP/ICP-PLUS structure will improve beneficiaries' experience through a person-directed comprehensive individual assessment and one point of contact responsible for ensuring that beneficiary needs are met.

The Demonstration will cover the full range of Medicaid and Medicare services, with the addition of supplemental benefits (through project savings and/or provider reimbursement mechanisms) designed to improve health outcomes and support people at home and in their community. A capitated financial alignment model will be employed by Vermont's MCE to serve all of the 22,000 dual eligible individuals, with the exception of those enrolled in *PACE Vermont*. The Demonstration also will provide access to Vermont's comprehensive MCE pharmacy benefit plan which will replace the 30 different Medicare Part D commercial drug plan options currently offered to dually eligible Vermonters.

Vermont is uniquely situated to implement a Dual Eligible Demonstration Project given the State's current health care reform efforts, and innovative statewide initiatives such as Medicaid's Global Commitment to Health and the Blueprint for Health. This Demonstration provides Vermont the opportunity to pilot a fundamental redesign of the delivery system for those with the greatest needs and highest costs.

Target Population	Full Benefit Dual Eligible Vermonters
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	Approximately 22,000
Total Number of Beneficiaries Eligible for Demonstration	Approximately 22,000
Geographic Service Area	Statewide
Summary of Covered Benefits	Medicaid and Medicare Parts A, B, D
Financing Model	Capitated Financial Alignment model

Summary of Stakeholder Engagement/Input	* Close to 50 consumer, advocacy, and provider groups participating in bi-weekly meetings and "work groups" since July 2011. * Dual Eligible Focus Groups conducted. Finch Summary Report, February 2012. * VT Department of Disabilities, Aging, & Independent Living Long Term Care Consumer Survey, Dual Eligible Section, December 2011.
Proposed Implementation Date(s)	January 1, 2014

B. Background

i. Overall Vision and/or Rationale

Vermont's approach to integrating care for dual eligible individuals builds upon previous and ongoing integration efforts including: prior dual eligible initiatives, ongoing Medicaid Waiver programs, the Blueprint for Health Multi-payer Demonstration Project, and Vermont's significant and ongoing investments in health information technology.

In the 1990's Vermont was part of a six-state, New England-wide effort for managing the care for dual eligible individuals funded by the Robert Wood Johnson Foundation entitled the Medicare Medicaid Integration Program. The focus of this effort was to physically co-locate Area Agency on Aging Social Workers in primary care offices to better coordinate the care for individuals dually eligible for Medicare and Medicaid in 3 Vermont counties. This effort led to Vermont being awarded a John A. Hartford Foundation Accelerating States Access to PACE (Program for All Inclusive Care for the Elderly) grant in 2002. This planning grant involved hospitals, primary care providers, and long term care providers in two Vermont counties (Rutland and Chittenden). As a result, Vermont created *PACE Vermont,* one of the most rural PACE centers in the country. In 2005, Vermont received a multiyear Real Choices Systems Change Planning grant known as *My Care* to plan and implement an integrated care model for Vermonters dually eligible for both Medicare and Medicaid. Unfortunately the model did not come to fruition because a provider large enough to take on the full risk of implementation was not identified. However, this planning process was extremely valuable, contributing to a deeper understanding of the opportunities and obstacles for integrated care for people who are dually eligible. Vermont also participated in a Center for Health Care Strategies Transforming Care for Dual Eligible grant during 2008-2010. These diverse but solidifying experiences position Vermont to now create an integrated system of care for Medicare and Medicaid enrollees.

Vermont currently manages an innovative 1115 Medicaid Waiver known as Global Commitment to Health (renewed until 12/31/13), making Vermont the first Medicaid program in the nation operating as a statewide public Medicaid Managed Care Entity. Under the Global Commitment to Health 1115 waiver, Vermont has negotiated with the Centers for Medicare and Medicaid Services to fund the public managed care entity subject to actuarially certified per member, per month (PMPM) limits. This negotiation process and subsequent agreement provides a model for a similar agreement between Vermont and CMS for a Medicare actuarially certified capitation payment for dually eligible individuals. Vermont's second 1115 Medicaid waiver, Choices for Care (renewed until 9/30/15), is the first in the nation to allow individuals eligible for Long Term Care Medicaid to have full choice between nursing home care and home and community based care services. All dually eligible Vermonters are either in the Global Commitment to Health 1115 waiver or the Choices for Care 1115 waiver.

Vermont is uniquely positioned to coordinate services and streamline Medicaid and Medicare financing for dually eligible individuals, many of whom have both substantial needs and high health care costs. These 22,000 beneficiaries are currently enrolled in Vermont's Medicaid program and represent 11-12% of all Medicaid beneficiaries, yet account for 30% of all expenditures. A majority of these individuals have multiple complex chronic illnesses and concurrent disabilities. Many have continuous care needs that span medical, mental health, substance abuse, developmental, and long term care domains, underscoring the need for more proactive care coordination. Examples abound of failures to coordinate physical health care with long term care supports. As a result, missed opportunities for effective intervention become the main driver of unnecessary emergency room visits, hospitalizations, nursing home placements, and other needless health care expenditures. Furthermore, Medicare and Medicaid differences in reimbursement, coverage, benefits, regulations, and claims processing lead to lower quality of care and higher costs. The goal of this Demonstration proposal is to achieve seamless integrated care, better outcomes, and improved quality of life for this high need population whose expenditures were almost $600 million in 2010. The Demonstration will address beneficiaries' full range of needs through current Medicaid and Medicare services as well as providing enhanced services through re-investments.

ii. Description of the Population

This proposal focuses on all Vermonters who are full benefit dual eligible individuals. Vermont will not exclude any full benefit dually eligible individual, with the single exception of *PACE Vermont* participants (approximately 120 people) who will have a choice to enroll in one or the other program. A person is not considered a Dual Eligible individual until both Medicare and Medicaid eligibility have been confirmed.

Table A	Overall	Individuals receiving LTSS in institutional[a] settings	Individuals receiving LTSS in HCBS[b] settings
Overall Total	21,670	3,026	5,810
Individuals age 65+	10,147	2,797	2,529
Individuals under age 65	11,523	229	3,281
Individuals with serious mental illness[c]	6,674	1,049	2,489
Other (See Tables below)			

Notes: 1. Version 032312, Source: iMMRS, VT 2004-2010 PayDatIDyymmUnityNHFix0213 AEK 3/20/2012

2. Long Term Services and Supports (LTSS) are the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications (Hilltop Institute, 2012).

[a.] An individual received LTSS in an Institutional setting during a year if he or she received 3 or more months of care in a setting such as a nursing home, skilled nursing facility, psychiatric hospital, rehabilitation hospital, or intermediate care facility.

[b.] An individual received LTSS in an HCBS setting if she or he received services from Choices for Care Home and Community Based Services, Enhanced Residential Care, Developmental Services, Traumatic Brain Injury, or Community Rehabilitation and Treatment Services during the 2010 calendar year.

[c.] See Appendix 1 for list of serious mental health diagnosis codes

The tables below display combined 2010 Medicare and Medicaid utilization and spending by major service category for dually eligible Vermonters. Table 1 describes service utilization for the entire dual eligible population. Tables 2-7 describe utilization of services by participants in Vermont's "Specialized Programs": Choices for Care Nursing Facility, Choices for Care Home and Community Based Services, Choices for Care Enhanced Residential Care, Developmental Services (DS), Community Rehabilitation and Treatment (CRT) for people with severe and persistent mental illness, and Traumatic Brain Injury. Table 8 describes utilization of services by people who used services costing more than $25,000 per year, but were not enrolled in a "Specialized Program". Because people included in Table 8 had high use of services without the benefit of case management services, they are of particular interest to this Demonstration. Individuals not enrolled in a "Specialized Program" who used services costing less than $25,000 per year are included in Table 1 but not in subsequent tables. Due to delays in accessing complete data, this analysis lacks clarity regarding simultaneous versus sequential use of services. See Appendix 2 for Table Footnotes and Appendix 3 for Major Service Category definitions.

Highlighted service categories in the following tables denote potential opportunities for targeted intervention to integrate care, improve outcomes, and reduce costs. See Section F-Outcomes for a detailed discussion of targeted interventions for individuals in these highlighted service categories.

1. Vermont Dual Eligible Population – ALL

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Day Health Rehabilitative Services	180	0.8%	$1,562,827	0.3%	$8,682	$72
Diagnostic Testing	19,051	87.9%	$19,862,937	3.4%	$1,043	$917
Durable Medical Equipment & Supplies	11,130	51.4%	$9,931,365	1.7%	$892	$458
Emergency Department	9,546	44.1%	$6,027,610	1.0%	$631	$278
Home Health Care	4,548	21.0%	$24,374,433	4.2%	$5,359	$1,125
Hospice	353	1.6%	$3,652,499	0.6%	$10,347	$169
Inpatient Hospital	4,319	19.9%	$76,328,470	13.1%	$17,673	$3,522
Mental Health/Substance Abuse Clinic	2,502	11.5%	$1,901,220	0.3%	$760	$88
Miscellaneous	1,603	7.4%	$1,668,299	0.3%	$1,041	$77
Non-Physician Practitioner	16,744	77.3%	$10,786,298	1.9%	$644	$498
Nursing Home	3,771	17.4%	$132,219,277	22.7%	$35,062	$6,101
Outpatient Hospital	18,894	87.2%	$13,839,402	2.4%	$732	$639
Pharmacy[b]	20,082	92.7%	$67,822,149	11.6%	$3,377	$3,130
Physician	19,847	91.6%	$34,084,570	5.9%	$1,717	$1,573
Transportation	7,816	36.1%	$12,635,790	2.2%	$1,617	$583
CFC HCBS/ERC, DS, TBI, CRT	5,798	26.8%	$165,783,646	28.5%	$28,593	$7,650
Total	**21,670**	**100.0%**	**$582,480,793**	**100.0%**	**$26,880**	**$26,880**

2. Vermont Dual Eligible Population – Choices for Care Nursing Facility

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Day Health Rehabilitative Services	16	0.6%	$82,892	0.0%	$5,181	$29
Diagnostic Testing	2,619	91.5%	$1,959,544	1.2%	$748	$685
Durable Medical Equipment & Supplies	1,284	44.9%	$1,064,760	0.6%	$829	$372
Emergency Department	1,439	50.3%	$1,090,016	0.7%	$757	$381
Home Health Care	473	16.5%	$2,317,304	1.4%	$4,899	$810
Hospice	107	3.7%	$1,061,211	0.6%	$9,918	$371
Inpatient Hospital	894	31.2%	$14,179,357	8.5%	$15,861	$4,954
Mental Health/Substance Abuse Clinic	50	1.7%	$14,787	0.0%	$296	$5
Miscellaneous	93	3.2%	$14,002	0.0%	$151	$5
Non-Physician Practitioner	2,021	70.6%	$987,698	0.6%	$489	$345
Nursing Home	2,861	100.0%	$119,803,290	71.9%	$41,875	$41,860
Outpatient Hospital	2,608	91.1%	$1,560,063	0.9%	$598	$545
Pharmacy[b]	2,817	98.4%	$8,984,319	5.4%	$3,189	$3,139
Physician	2,758	96.4%	$3,954,161	2.4%	$1,434	$1,382
Transportation	1,489	52.0%	$3,095,646	1.9%	$2,079	$1,082
CFC HCBS/ERC, DS, TBI, CRT	511	17.9%	$6,538,901	3.9%	$12,796	$2,285
Total	**2,862**	**100.0%**	**$166,707,950**	**100.0%**	**$58,249**	**$58,249**

3. Vermont Dual Eligible Population – Choices for Care Home & Community Based Svcs

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Day Health Rehabilitative Services	57	2.1%	$359,987	0.3%	$6,316	$134
Diagnostic Testing	2,498	93.2%	$3,161,220	2.4%	$1,266	$1,180
Durable Medical Equipment & Supplies	2,203	82.2%	$3,443,831	2.6%	$1,563	$1,285
Emergency Department	1,645	61.4%	$1,417,169	1.1%	$862	$529
Home Health Care	1,878	70.1%	$11,904,033	9.1%	$6,339	$4,442
Hospice	140	5.2%	$1,167,809	0.9%	$8,341	$436
Inpatient Hospital	1,011	37.7%	$18,238,733	13.9%	$18,040	$6,805
Mental Health/Substance Abuse Clinic	171	6.4%	$85,390	0.1%	$499	$32
Miscellaneous	174	6.5%	$58,547	0.0%	$336	$22
Non-Physician Practitioner	2,114	78.9%	$1,338,450	1.0%	$633	$499
Nursing Home	763	28.5%	$18,917,470	14.4%	$24,794	$7,059
Outpatient Hospital	2,498	93.2%	$2,591,515	2.0%	$1,037	$967
Pharmacy[b]	2,608	97.3%	$12,744,724	9.7%	$4,887	$4,755
Physician	2,584	96.4%	$5,536,266	4.2%	$2,143	$2,066
Transportation	1,746	65.1%	$4,964,007	3.8%	$2,843	$1,852
CFC HCBS/ERC, DS, TBI, CRT	2,671	99.7%	$45,079,267	34.4%	$16,877	$16,821
Total	**2,680**	**100.0%**	**$131,008,420**	**100.0%**	**$48,884**	**$48,884**

4. Vermont Dual Eligible Population – Choices for Care Enhanced Residential Care

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Day Health Rehabilitative Services	5	1.1%	$1,858	0.0%	$372	$4
Diagnostic Testing	405	92.5%	$364,587	1.8%	$900	$832
Durable Medical Equipment & Supplies	352	80.4%	$275,149	1.4%	$782	$628
Emergency Department	266	60.7%	$194,908	1.0%	$733	$445
Home Health Care	437	99.8%	$4,460,751	22.2%	$10,208	$10,184
Hospice	32	7.3%	$209,519	1.0%	$6,547	$478
Inpatient Hospital	141	32.2%	$1,853,879	9.2%	$13,148	$4,233
Mental Health/Substance Abuse Clinic	22	5.0%	$4,987	0.0%	$227	$11
Miscellaneous	5	1.1%	$159	0.0%	$32	$0
Non-Physician Practitioner	321	73.3%	$140,968	0.7%	$439	$322
Nursing Home	127	29.0%	$3,391,670	16.8%	$26,706	$7,744
Outpatient Hospital	410	93.6%	$267,644	1.3%	$653	$611
Pharmacy[b]	431	98.4%	$1,459,553	7.3%	$3,386	$3,332
Physician	418	95.4%	$574,566	2.9%	$1,375	$1,312
Transportation	261	59.6%	$487,740	2.4%	$1,869	$1,114
CFC HCBS/ERC, DS, TBI, CRT	438	100.0%	$6,442,101	32.0%	$14,708	$14,708
Total	**438**	**100.0%**	**$20,130,040**	**100.0%**	**$45,959**	**$45,959**

5. Vermont Dual Eligible Population – Developmental Services

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Day Health Rehabilitative Services	5	0.3%	$29,378	0.0%	$5,876	$19
Diagnostic Testing	1,464	92.9%	$784,313	0.7%	$536	$498
Durable Medical Equipment & Supplies	780	49.5%	$706,941	0.7%	$906	$449
Emergency Department	266	16.9%	$194,908	0.2%	$733	$124
Home Health Care	225	14.3%	$1,487,037	1.4%	$6,609	$944
Hospice	11	0.7%	$94,442	0.1%	$8,586	$60
Inpatient Hospital	141	8.9%	$1,853,879	1.7%	$13,148	$1,176
Mental Health/Substance Abuse Clinic	225	14.3%	$51,623	0.0%	$229	$33
Miscellaneous	84	5.3%	$47,808	0.0%	$569	$30
Non-Physician Practitioner	1,437	91.2%	$1,763,737	1.7%	$1,227	$1,119
Nursing Home	37	2.3%	$711,454	0.7%	$19,228	$451
Outpatient Hospital	410	26.0%	$267,644	0.3%	$653	$170
Pharmacy[b]	431	27.3%	$4,318,231	4.0%	$10,019	$2,740
Physician	1,491	94.6%	$1,606,696	1.5%	$1,078	$1,019
Transportation	400	25.4%	$737,736	0.7%	$1,844	$468
CFC HCBS/ERC, DS, TBI, CRT	1,576	100.0%	$92,035,254	86.3%	$58,398	$58,398
Total	**1,576**	**100.0%**	**$106,691,082**	**100.0%**	**$67,697**	**$67,697**

6. Vermont Dual Eligible Population – Community Rehabilitation & Treatment

(For people with severe and persistent mental illness)

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Day Health Rehabilitative Services	15	1.0%	$78,527	0.1%	$5,235	$50
Diagnostic Testing	1,429	91.6%	$1,682,752	2.8%	$1,178	$1,079
Durable Medical Equipment & Supplies	725	46.5%	$505,232	0.8%	$697	$324
Emergency Department	785	50.3%	$549,752	0.9%	$700	$352
Home Health Care	360	23.1%	$2,500,057	4.1%	$6,945	$1,603
Hospice	5	0.3%	$62,953	0.1%	$12,591	$40
Inpatient Hospital	338	21.7%	$6,150,392	10.2%	$18,196	$3,943
Mental Health/Substance Abuse Clinic	868	55.6%	$377,093	0.6%	$434	$242
Miscellaneous	165	10.6%	$125,076	0.2%	$758	$80
Non-Physician Practitioner	1,281	82.1%	$874,167	1.5%	$682	$560
Nursing Home	98	6.3%	$2,662,447	4.4%	$27,168	$1,707
Outpatient Hospital	1,419	91.0%	$841,218	1.4%	$593	$539
Pharmacy[b]	1,538	98.6%	$10,500,617	17.4%	$6,827	$6,731
Physician	1,439	92.2%	$2,777,311	4.6%	$1,930	$1,780
Transportation	786	50.4%	$1,155,082	1.9%	$1,470	$740
CFC HCBS/ERC, DS, TBI, CRT	1,557	99.8%	$29,442,636	48.8%	$18,910	$18,873
Total	**1,560**	**100.0%**	**$60,285,314**	**100.0%**	**$38,644**	**$38,644**

7. Vermont Dual Eligible Population – Traumatic Brain Injury

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Day Health Rehabilitative Services	0	0.0%	$0	0.0%	$0	$0
Diagnostic Testing	48	96.0%	$28,264	1.3%	$589	$565
Durable Medical Equipment & Supplies	26	52.0%	$21,001	1.0%	$808	$420
Emergency Department	16	32.0%	$12,953	0.6%	$810	$259
Home Health Care	5	10.0%	$17,729	0.8%	$3,546	$355
Hospice	0	0.0%	$0	0.0%	$0	$0
Inpatient Hospital	5	10.0%	$175,613	8.2%	$35,123	$3,512
Mental Health/Substance Abuse Clinic	5	10.0%	$4,363	0.2%	$873	$87
Miscellaneous	5	10.0%	$81	0.0%	$16	$2
Non-Physician Practitioner	47	94.0%	$36,939	1.7%	$786	$739
Nursing Home	5	10.0%	$18,355	0.9%	$3,671	$367
Outpatient Hospital	46	92.0%	$21,490	1.0%	$467	$430
Pharmacy[b]	47	94.0%	$303,329	14.2%	$6,454	$6,067
Physician	48	96.0%	$69,191	3.2%	$1,441	$1,384
Transportation	24	48.0%	$14,967	0.7%	$624	$299
CFC HCBS/ERC, DS, TBI, CRT	50	100.0%	$1,413,670	66.1%	$28,273	$28,273
Total	**50**	**100.0%**	**$2,137,945**	**100.0%**	**$42,759**	**$42,759**

8. Vermont Dual Eligible Population – "Non-Specialized Program" High Users

(Not served by a "Specialized Program" that included case management, and used a high volume of services totaling more than $25,000 per year.)

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Day Health Rehabilitative Services	15	1.2%	$125,580	0.2%	$8,372	$102
Diagnostic Testing	1,216	98.3%	$3,334,172	4.6%	$2,742	$2,695
Durable Medical Equipment & Supplies	1,006	81.3%	$1,519,946	2.1%	$1,511	$1,229
Emergency Department	960	77.6%	$1,391,645	1.9%	$1,450	$1,125
Home Health Care	576	46.6%	$2,362,129	3.3%	$4,101	$1,910
Hospice	57	4.6%	$970,347	1.3%	$17,024	$784
Inpatient Hospital	995	80.4%	$30,488,260	42.2%	$30,641	$24,647
Mental Health/Substance Abuse Clinic	121	9.8%	$176,423	0.2%	$1,458	$143
Miscellaneous	127	10.3%	$278,581	0.4%	$2,194	$225
Non-Physician Practitioner	1,142	92.3%	$1,220,685	1.7%	$1,069	$987
Nursing Home	373	30.2%	$5,898,356	8.2%	$15,813	$4,768
Outpatient Hospital	1,192	96.4%	$3,105,429	4.3%	$2,605	$2,510
Pharmacy[b]	1,205	97.4%	$12,552,662	17.4%	$10,417	$10,148
Physician	1,225	99.0%	$6,972,135	9.7%	$5,692	$5,636
Transportation	846	68.4%	$1,801,907	2.5%	$2,130	$1,457
CFC HCBS/ERC, DS, TBI, CRT	0	0.0%	$0	0.0%	$0	$0
Total	**1,237**	**100.0%**	**$72,198,256**	**100.0%**	**$58,366**	**$58,366**

C. Care Model Overview

i. Proposed Delivery System

Overview of Geographic Area and Provider Network

This Demonstration is designed to achieve seamless integrated care, better outcomes, and improved quality of life for dual eligible individuals throughout the entire state of Vermont. To achieve this, the State will utilize its current State and provider infrastructure since all 22,000 dual eligible individuals are Medicaid beneficiaries served by the Department of Vermont Health Access (DVHA), the State's public Managed Care Entity (MCE), in collaboration with sister departments through Intergovernmental Agreements.

DVHA has a strong statewide network of Medicaid and Medicare enrolled providers. All hospitals, all skilled nursing facilities, all federally-qualified health centers and almost all primary care providers and specialists in the state are enrolled in the Medicaid and Medicare networks. A centerpiece of Vermont's primary and acute care system is the Blueprint for Health, which is a multi-payer Advanced Primary Care Practice (APCP) program mandated to be statewide prior to the Demonstration start date. The Blueprint for Health program includes monthly payments to providers for meeting nationally-established performance measures, and multi-disciplinary Community Health Teams (often co-located) to support APCP patients when more follow-up support is needed to augment the APCP services, including shared health records between the APCP and Community Health Teams (CHTs). The Blueprint CHTs also work closely with two Vermont Programs that provide care coordination for specific populations: Support for Seniors at Home (SASH) and Vermont Chronic Care Initiative (VCCI). The Blueprint, SASH and VCCI are described in more detail in Section C.V. (f).

Vermont also has a robust system of home and community-based providers in each geographic area of the state, including Designated Agencies for Mental Health Services, Designated Agencies and Specialized Agencies for Developmental Services, Substance Abuse Treatment Providers, Home Health Agencies, Area Agencies on Aging, Adult Day Centers, Traumatic Brain Injury Providers, Residential Care Homes, and Assistive Living Providers. These entities have a long and successful history of operating service models founded on value-based principles. Vermont also has peer-to-peer organizations and networks that will be integral to the success of this Demonstration. A graphic depiction of DVHA's statewide provider network is in Appendix 4.

The Vermont system of care is robust, value-driven, and operates within the context of a history of state health and long term care reform efforts (see Sections B and Section C-subsections iv. and v.a. and b.). However, from an individual's perspective the system is confusing and fragmented, especially for those with multiple needs. For example, each individual served by one or more specialized home and community-based providers has a case manager and care plan associated with the services provided by that provider. As a result, the individual may have to meet with different case managers to get needed services. They also may have different care plans that are not integrated across the individual's providers and frequently do not contain or even reference the individual's medical treatment plan. This fragmentation can result in frustration, potentially serious health consequences, and inefficient use of system resources (e.g. poly-pharmacy, unnecessary ER visits or hospitalizations, redundant or conflicting interventions or support systems). Vermont's Demonstration is designed to address this fragmentation in care for dual eligible individuals through new provider expectations, performance measures and payment approaches within the system of care.

Core Care Model Elements

The foundation of this Demonstration is creating an integrated person-directed support system, defined by Vermont's Dual Eligible Person Centered Workgroup as follows:

> *A person-directed support system is life-affirming, strength-based, satisfying, humane, and meaningful. Core values include choice, dignity, respect, self-determination, and purposeful living.*

Vermont proposes to introduce seven new Core Care Model elements into Vermont's service delivery system for individuals enrolled in this Demonstration, with the above definition of a person-directed support system as their foundation:

1) *Enhanced care coordination with a single point of contact.* A common complaint among dual eligible individuals is the conflicting, fragmented and unmanaged system of care. Each dually eligible individual will have a single point of contact, chosen by the individual, to ensure coordination and integration of care across primary, acute, mental health, substance abuse, developmental, and long term care supports and services.
2) *Active involvement with a Blueprint medical/health home and a Blueprint Community Health Team (CHT).* Each individual will have an identified health home, preferably with a Blueprint advanced primary care practice (APCP), which includes access to a Blueprint CHT when needed. The Blueprint program is a population-based public health approach to prevention and evidence-based programs. The Demonstration will ensure that all dual eligible Vermonters will have access to prevention and intervention services through their health home with the goal of reducing adverse outcomes and costs.
3) *Individual assessments resulting in comprehensive person-directed care plans across primary, acute, mental health, substance abuse, developmental, and long term care supports and services.* An individual assessment will be performed to develop a Comprehensive Care Plan that reflects all the individual's needs and strengths to define specific service and treatment goals and objectives, proposed interventions, and measurable outcomes to be achieved.
4) *Support during care transitions.* Assisting individuals during their care transitions (e.g. between providers and/or settings) enhances opportunities to improve continuity of care, sustain people at home and in the community, avoid unnecessary re-admissions, and assure that key supports are not lost during transitions.
5) *Payment reform connecting provider payment with performance measures related to changes in utilization and quality.* A core element of Vermont's proposal is to identify and address patterns of over-utilization / under-utilization, and link provider payment to desired quality outcomes. Payment incentives will be used to help providers meet performance and outcome measures, and decrease the tendency for cost-shifting across providers and services.
6) *Improved sharing of health records, assessments, and information.* In support of broad health care reform efforts, Vermont is actively working to improve statewide HIT/HIE infrastructure for both consumers and providers through a complex set of integrated activities led by the DVHA Health Care Reform Division. This includes the development of a statewide data-sharing infrastructure being created by Vermont Information Technology Leaders; supporting implementation of a statewide network of Electronic Health Records (EHRs); developing the connectivity to enable individuals and their chosen medical and support providers to access this information on-line; and incorporating federal and state privacy components. Improving HIT/HIE infrastructure provides a foundation for this project by supporting improved care coordination, reducing unnecessary costs, and improving health outcomes.
7) *A single integrated pharmacy benefit plan.* Individuals will use the existing Vermont Medicaid pharmacy benefit and preferred drug list, including a new medication therapy management program. Medicaid's comprehensive drug list will replace the 30 different commercial insurance drug plan options currently offered to dual eligible individuals through Medicare Part D. Providing a single pharmacy benefit plan is expected to improve medication adherence and effectiveness, lower administrative costs for providers, and positively impact utilization of high-cost services such as emergency and inpatient visits. DVHA will work with CMS to assure that the DVHA pharmacy benefit program meets CMS expectations for Medicare Part D requirements.

<u>Integrated Care Provider Continuum</u>

In order to build a system that guarantees these core elements to all dual beneficiaries, Vermont will assure that every individual has access to a single point of contact who also provides person-centered care coordination and a Comprehensive Care Plan, based on individual needs. If the dual eligible individual only has primary or acute health care needs, the single point of contact will be the Blueprint Advanced Primary Care Practice (APCP) or other primary

care provider (PCP) health home for the few individuals who do not have access to an APCP. The APCP/PCP also will be responsible for developing the Comprehensive Care Plan which will comprise primary and acute health needs.

The single point of contact for dual eligible Individuals who need more intensive mental health, substance abuse, developmental, and long term services will be an identified Care Coordinator within an Integrated Care Provider (ICP) or an Integrated Care Provider PLUS (ICP-PLUS) organization. Potential ICP and ICP-PLUS providers include existing providers of mental health, substance abuse, developmental, long term care services, and specialized care coordination programs. This will ensure that the care coordination for these individuals is provided by an organization with sensitivity to the complexity of community-based and long term care services and supports.

For these individuals with more complex needs, their ICP/ICP-PLUS Care Coordinator will be their single point of contact across all their primary, acute, mental health, substance abuse, developmental, and long-term care service needs. The Care Coordinator will be responsible for creating an individualized needs assessment used to develop a person-directed Comprehensive Individual Care Plan; for assuring that the individual receives the services in the Plan; and for providing support for the individual as he/she transitions across providers and/or care settings. This includes ensuring that the individual is seen by their APCP/PCP when needed, and coordinating with the Blueprint Community Health Team (extensions of the APCP) as appropriate. With the individual's permission, the APCP/PCP Treatment Plan will be embedded in their ICP/ICP-PLUS Comprehensive Care Plan, which will be updated and shared across providers as the individual's needs or situation change.

As described below in the Enrollment section, all individuals will select both an APCP/PCP and an ICP/ICP-PLUS upon Demonstration enrollment. As such, even those individuals with only primary and acute health needs will have an identified ICP/ICP-PLUS which they can access if they develop more complex needs. If the individual's needs increase, the ICP/ICP-PLUS would assume the role of single point of contact and care coordination. The already existing care coordination triage protocols between the Blueprint CHTs, SASH and VCCI will be augmented to include ICPs and ICP-PLUS Care Coordinators to ensure a seamless system from the perspective of the individual. Care Coordinators will not be gate-keepers but rather will be responsible for integrating care and improving access to the full range of services needed by the individual at any point in time.

The primary distinction between an ICP and an ICP-PLUS is that an ICP-PLUS will operate under a model in which it assumes management responsibility and financial risk for an agreed-upon array of services and supports (in addition to care coordination as described above). DVHA will bear the risk for all other services (e.g., inpatient hospital, outpatient hospital, nursing facility, physician, pharmacy). ICP-PLUS organizations will be required to develop formal relationships with other providers to create a collaborative and coordinated delivery system. It should be noted that Vermont has State rules which require special designation to deliver a set of specific services; examples include designation to provide CRT, DS and Home Health Services. If an ICP-PLUS organization does not have the relevant State designation, the ICP-PLUS must have signed agreements with the relevant designated agency to provide the specialized services if these services are included in the ICP-PLUS contract with DVHA. See Appendix 5 for a schematic depiction of ICP and ICP-PLUS organizations.

Opportunities and advantages for the ICP-PLUS include capitation reimbursement methodologies (for both enhanced care coordination and services) that focus on quality and outcomes rather than volume of services, and provide additional flexibility regarding the types of services offered. Such approaches also can reduce administrative costs related to fee-for-service claim activities and coordination of benefits.

DVHA will contract with selected ICP and ICP-PLUS organizations, identified through a Request for Proposal (RFP) process before Demonstration implementation. The intent is to ensure that all dual eligible enrollees have close geographic access to an ICP and/or ICP-PLUS organization. If an adequate number or distribution of ICP or ICP-PLUS organizations is not identified though the RFP process, DVHA may elect to utilize its VCCI program to provide the enhanced care coordination for enrollees who do not have access to an ICP or ICP-PLUS in their geographic region. DVHA will delineate standards, guidelines, and measurable outcomes in contracts with all ICP and ICP-PLUS organizations. In reviewing ICP-PLUS proposed contracts, DVHA will consider such factors as: demonstrated capacity to provide or arrange for the included services; demonstrated formal relationships with other organizations;

organizational financial stability; impact of proposed bundling of services on service provision for non-dual populations in the geographic area; and projected impact on overall health care system costs. In addition, ICP and ICP-PLUS organizations will be required to support individuals who want to self-manage some or all of their services. DVHA will employ clear mechanisms for oversight, monitoring and holding ICP and ICP-PLUS organizations accountable to ensure the provision of adequate and high quality services.

In summary, this new single point of contact and enhanced care coordination across the full range of services, embedded with the provider most familiar with the individual's needs, is intended to improve enrollee experience with the system of care and improve health and life outcomes (e.g., avoided hospitalizations and readmissions, reduced institutional placements, appropriate pharmacy utilization, stable home and community-based living situations, and maintenance of employment and other community involvements). See Appendix 6 for a depiction of the expected beneficiary experience as a result of the new ICP and ICP-PLUS organizational structure, contrasted with the current system.

Enrollment Methods

Enrollment in the Demonstration

Enrollment in the Dual Eligible Demonstration Project will be automatic with a monthly opt-out option. Those who opt-out will remain under or return to Medicaid, Medicare, and Medicare Part D Pharmacy coverage. DVHA will provide information to all dual eligible members that will include a description of the Demonstration program, highlighting the differences between enrollment in the Demonstration versus remaining in their current separate Medicaid, Medicare, and Medicare Part D Pharmacy programs. The materials also will describe *PACE-Vermont* as an alternative option. The materials will highlight the functions of an ICP and ICP-PLUS, the new single pharmacy benefit plan under the Demonstration, and information about member rights. The materials will clearly provide instructions on how to opt-out of the Demonstration by mail, on-line or through the DVHA Consumer Call Center.

Enrollment with a ICP or ICP-PLUS and Primary Care Provider

Enrollment with an ICP or ICP- PLUS organization and a Primary Care Provider (PCP) will be requirements of participation in the Demonstration program. Ensuring that provider options and services are available and allowing individuals to choose from among them are central to Vermont's commitment to choice. The Demonstration materials will provide a list of the ICP and ICP-PLUS organizations in the individual's geographic region, and provide instructions on how to choose one of these as their enhanced care coordination organization. Similarly, the materials will list the PCPs in their region, highlighting those that are part of the Blueprint APCP, and provide instructions to indicate their choice of a PCP. Individuals will have the same right to choose providers (including specialists) as they currently have under Federal law. Enrollees will be able to retain their current Primary Care Physician (PCP) or choose freely when none exists. Individuals whose PCP is not an APCP will be able to remain in that practice.

Individuals will be given sufficient time to make an informed choice about opting out of the Demonstration and enrolling with an ICP or ICP-PLUS and PCP. DVHA will confirm the individual's choices before coverage begins. Any individual who does not communicate his or her choice (to opt out, enroll with an ICP or ICP-PLUS and with a PCP) will be contacted by DVHA with clear information stating that DVHA will assign the member to a particular provider, effective on a specific future date. (Auto assignment by DVHA will be supported by the individual's provider utilization claims/encounter data.) This communication will again make clear how the member can choose an ICP or ICP-PLUS, a PCP, change either of these at any given time, or opt out of the Demonstration at any time.

Vermont wants to ensure that all individuals have timely and understandable information about the Demonstration in order to make an educated choice. All materials intended for enrollees will be developed with input from stakeholders, including beneficiaries and advocacy organizations. They also will be available in

multiple formats, including the availability of oral interpreter services, translated materials, and other accommodations as needed. These materials also will be available on multiple web-sites, including those of the Agency of Human Service, DVHA, Vermont's new Health Insurance Exchange, and stakeholder organizations. DVHA also will work with provider organizations, the Health Care Ombudsman and other consumer protection and advocacy organizations to ensure that all eligible individuals have access to and receive these Demonstration materials. Vermont will work closely with CMS to ensure that the information provided is in adherence with federal timelines and standards.

ii. Benefit Design and Accountability

In order for the Dual Demonstration to be successful, Integrated Care Providers and Integrated Care Providers PLUS will need to adopt the new core care model elements as a foundation for service delivery. The State will contract with DVHA, Vermont's Managed Care Entity, who, in concert with other AHS departments, will be responsible for assuring the provision of the full range of Medicaid and Medicare services such as primary and acute care; long term care services and supports; mental health, substance abuse, and developmental services; and prescription drug benefits. This approach builds on Vermont's current model under the Global Commitment Medicaid Demonstration.

The State of Vermont continues to work to improve the effectiveness and efficiency of work within state government, including coordination among departments and coordination between departments and providers. Several related activities will contribute to the performance of the Dual Demonstration project:

- Planned upgrades to the Medicaid Management Information System (MMIS) and Medicaid eligibility system, including improved electronic communication between departments and providers. This is intended to improve performance in determining and communicating Medicaid eligibility, and will support Vermont's broad health reform initiative and the Dual Eligible Demonstration project.
- Expanded use of electronic health records under the VITL initiative. This will improve access to health records for enrollees, coordination of care across providers, and support a comprehensive approach to health outcomes.
- More ambitious standards, performance expectations and incentives for providers to achieve comprehensive health outcomes. This will directly support the integration of care envisioned in the Dual Eligible project, and will support Vermont's intended health reform outcomes.
- Development of performance metrics to measure coordination across AHS Departments.
- Development of performance and outcome measures linked to payment reform for providers. This will build on current approaches such as the Blueprint for Health designed to ensure that (a) standards of practice and performance are followed and (b) desired outcomes are achieved.

iii. Supplemental Benefits

The addition of new supplemental benefits to current Medicaid and Medicare covered services is envisioned through project savings and / or provider reimbursement mechanisms. As savings are achieved in the Demonstration, Vermont's Managed Care Entity (DVHA) will have the ability to invest the savings to improve the statewide system of care for dual eligible beneficiaries. Potential investments could be made in several different areas, including new or enhanced infrastructure (e.g., additional peer supports, additional care coordinators, more staff training); new benefits not currently covered by Medicaid or Medicare (e.g., dentures, home modifications, non-medical transportation); and enhancements to existing benefits (e.g. relaxation of utilization limits or prior authorization requirements on specific services). DVHA will work with the Stakeholder Advisory Group to prioritize how to use savings as they become available at the end of each Demonstration year.

In addition, under their capitated arrangement ICP-PLUS organizations will have the ability to provide services flexibly based on individual's needs to improve their outcomes. Examples could include providing non-medical transportation, providing a gym membership or purchasing an air conditioner. Also, as described in Section E.

Payments to Providers, if an ICP or ICP-PLUS meets the quality performance measures as agreed upon by CMS and AHS, it will be allowed to retain a certain percentage of the savings they achieve within their capitated payment. This will only be allowed, however, if DVHA approves the ICP or ICP-PLUS plan to reinvest the savings to improve access, quality or cost for dual eligible enrollees.

iv. Evidence-based Practice

Vermont is a nationally recognized leader in using evidenced-based practices to support individuals with complex needs to live in their homes and other community-based settings. These evidence-based practices will be the foundation for services provided to enrollees in this Dual Eligible Demonstration who have primary, acute, mental health, substance abuse, developmental, and long term care and support needs.

For example, evidence-based and promising practices are the cornerstone of Vermont's system of care for adults with severe and persistent mental illnesses.[1] Key components of the statewide Community Rehabilitation and Treatment (CRT) programs run by Designated Agencies (DAs) in each geographic area include evidence-based treatment and practices such as intensive case management, assertive community treatment, dialectical and cognitive behavioral therapy, integrated mental health and substance abuse services, supported employment, and supported housing. The Vermont system of care also emphasizes other evidence-based practices including peer-to-peer support, recovery education, and family psycho-education.[2] As a result, these individuals are able to live and be fully involved in their communities, and the State has reduced its use of involuntary inpatient care to fewer than 58 individuals at any given time.

Vermont's substance abuse system simultaneously focuses on education, prevention, treatment and recovery and relies on evidence-based practices. For example, in FY12 the State is funding 16 community-based coalitions/partnerships to support the continuation of at least one evidence-based substance abuse prevention strategy already underway, such as the Healthy Retailers Initiative and obesity prevention programs. The system also systematically uses the SBIRT model for screening and brief intervention, co-occurring mental health and substance abuse disorders best practices, methamphetamine prevention, and peer recovery, among others.

Vermont was the second state in the nation to eliminate institutionalization of people with developmental disabilities with the closure of Brandon Training School in 1991. Using flexible, individualized care plans and budgets for each enrollee based on their personal needs, people with developmental disabilities live in their own homes or with developmental home providers (Vermont has one six-bed Intermediate Care Facility). In addition, evidence-based and best practices such as self-determination and supports for employment and other meaningful community involvement enable people with developmental disabilities to achieve their goals.[3]

Another example is the Choices for Care (CFC) long term care 1115 Medicaid Demonstration which provides an entitlement to both home and community based services and nursing home care for low-income seniors and people with disabilities.[4] (CFC is described in more detail in Section C.v.a. and b.). Vermont was the first state to create such a program, which is founded on evidence-based practices such as in-home supports. CFC also includes the Flexible Choice (FC) program which gives enrollees an option to have self-or-surrogate-managed flexible use of the resources associated with their home and community-based care. As a result of the CFC design and underlying evidence-based services, nursing home enrollment has decreased 12 percent, while enrollment in community-based alternatives has increased 59 percent since its initiation in October 2005.

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[1] http://mentalhealth.vermont.gov/ebp

[2] Drake, R., H. Goldman, et.al. (2001). *Implementing Evidence-Based Practices in Routine Mental Health Service Settings*. Psychiatric Services 52:179–182.

[3] Schalock,R., S. Borthwick-Duffy, et al. (2010). *Intellectual Disability: Definition, Classification, and Systems of Supports, Eleventh Edition*. American Association on Intellectual and Developmental Disabilities Manual.

[4] Crowley, J. (2008). *Vermont's Choices for Care Medicaid Long-Term Services Waiver: Progress and Challenges as the Program Concluded its Third Year.* Kaiser Commission on Medicaid and the Uninsured.

Vermont also is a national leader in promoting evidence-based practices for acute health care through Blueprint for Health advanced primary care practice medical homes (described in more detail in Section C.v.f.).[5] Dual Eligible Demonstration enrollees will receive primary care through the Blueprint ACPC network, which is expected to include at least 95% of all Vermont PCPs by 2014. The Blueprint provides resources to support primary care practices to adhere to well-established national, and Vermont-specific, evidence-based practice guidelines for primary care. These include evidence-based clinical guidelines for preventative health care, as well as those relevant to populations with chronic conditions, such as diabetes, depression, chronic obstructive pulmonary disease (COPD) and asthma. Practices also receive PMPM payments based on their adherence to National Committee for Quality Assurance (NCQA) standards regarding evidence-based primary care medical home processes. In addition, individuals receive education for self- managing their chronic conditions. Recent evaluations of the Blueprint indicate success in achieving better clinical and systems outcomes though its multi-payer advanced primary care practice model, community health teams, patient self-education and payment reform components.[6]

Similarly, Medicaid beneficiaries who received VCCI services during SFY 2010 demonstrated better adherence to evidence-based clinical guidelines for medications (6% to 26% higher fulfillment rates) and testing (12% to 16% higher rates) than did beneficiaries with the same health conditions who did not participate in VCCI. Adhering to evidence-based medication and medical testing guidelines prevents acute episodes of chronic conditions and reduces preventable hospital utilization. Hospital inpatient utilization declined by 11% and emergency room use by 6.5% compared with the baseline year for VCCI-eligible Medicaid beneficiaries.
SASH, another component of the Vermont system of care, is designed to provide evidenced-based and promising practices to address five key areas: 1) lifestyle barriers to good health (e.g., lack of good nutrition, physical activity, access to regular health screenings, immunizations, transportation, advance directives, and isolation); 2) falls prevention; 3) medication management; 4) chronic conditions management, transitions between settings (hospital or nursing home to home), and care coordination; and 5) cognitive deficits and mental health concerns.[7]

The above existing evidence-based practices will be core elements of this Demonstration care model. However, most are provided in a silo approach, focusing on a specific population or on specific needs. Research confirms that there is significant co-morbidity of medical, mental health and disabling conditions among dual eligible individuals, resulting in a complex array of service and support needs.[8] In addition, due to the separate benefits covered by Medicaid and Medicare, most of these individuals receive fragmented care with little or no coordination between their medical, mental health, substance abuse, developmental, and support services.[9]

To address this gap, this Demonstration will add key evidence-based and promising practices to Vermont's system of care for all Demonstration enrollees as described in more detail in Section C.i.. Evidenced based research references for these new core elements are provided in Appendix 7.

1. Enhanced care coordination with a single point of contact
2. Active involvement with a Blueprint medical/health home and a Blueprint Community Health Team (CHT)
3. Individual assessments resulting in comprehensive person-directed care plans across primary, acute, mental health, substance abuse, and long term care supports and services
4. Support during care transitions

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[5] Bielaszka-DuVernay, C. (2011). *Vermont's Blueprint for Medical Homes, Community Health Teams, and Better Health at Lower Cost.* Health Affairs, 30(4): 383-386.

[6] Available at: http://hcr.vermont.gov/sites/hcr/files/Blueprint%20Annual%20Report%20Final%2001%2026%2012%20_Final_.pdf.

[7] SASH Evidenced-based Practices Directory, January 2012. Available at: http://cathedralsquare.org/files/SASH%20Evidence%20Based%20Practices%20Director%20Jan%202012.pdf

[8] Kasper, J. M. O'Malley-Watts and B. Lyons. (2010). *Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*. Kaiser Commission on Medicaid and the Uninsured.

[9] Hamblin, A., J. Verdier, and M. Au. (2011). *State Options for Integrating Physical and Behavioral Health Care*. Technical Assistance Brief, Integrated Care Resource Center.

5. Payment reform connecting provider payment with performance measures related to changes in utilization and quality
6. Improve sharing of health records, assessments, and information
7. A single integrated pharmacy benefit plan

v. Context of Other Medicaid Initiatives and State Health Care Reform

This Demonstration builds on Vermont's long history of health care reform efforts and is an essential element of Vermont's bold agenda for future health care reform. The State's current health reform agenda builds on progress already made over more than two decades to expand and improve health insurance coverage in Vermont, improve fairness in our insurance market, and fundamentally redesign and improve our primary care system. Core components of this progress include two 1115 Medicaid demonstration waivers (Global Commitment to Health and Choices for Care), establishment of a PACE program, multi-payer state payment / delivery reform efforts through the Blueprint for Health, and Medicare participation in the Blueprint through the Medicare Multi-payer Advanced Primary Care Practice Demonstration Project. A description of how the proposed Demonstration model fits with each of these existing initiatives is provided below.

In January 2011, Vermont Governor Shumlin announced his goal of implementing a single payer system of health insurance coverage for Vermonters by 2017, or earlier if permitted by federal law. Specific objectives of this reform are to: 1) reduce health care cost growth; 2) assure coverage for all; 3) reduce administrative cost and complexity; and 4) assure greater fairness in health care financing in Vermont.[10] Core strategies of Governor Shumlin's reform plan include changing how care is delivered to Vermonters, moving from volume based to value based reimbursement, and moving from a fragmented and overly complex financing system to a unified system that supports integration of service delivery and payment reform.

This Demonstration for dually eligible individuals is an integral component of Vermont's comprehensive and innovative health care reform agenda, by improving the integration, quality, and cost effectiveness of care delivered to Vermonters with the greatest need and highest cost.[11] This Demonstration also moves Vermont one step closer to the ultimate goal of having a single universal health care system by 2017.

(a) current Medicaid waivers and/or State plan services available to this population, and
(b) existing managed long term care programs

Global Commitment to Health 1115 Demonstration

In October, 2005, the State of Vermont partnered with the Centers for Medicare and Medicaid Services (CMS) to develop and operate an innovative and comprehensive health reform model under Section 1115 Demonstration authority. The majority of Vermont's Medicaid program operates under the Global Commitment to Health Demonstration, with the exception of its Children's Health Insurance Program (CHIP), individuals enrolled in Vermont's Section 1115 Long Term Care Demonstration (Choices for Care) and Vermont's Disproportionate Share Hospital (DSH) program. More than 95 percent of Vermont's program participants are enrolled in the Global Commitment (GC) Demonstration. The GC Demonstration was recently renewed to extend until December 31, 2013 with the expectation that it will be continued after that date once the terms are revised to reflect changes under the Affordable Care Act. The GC Demonstration will also provide the foundation for this Dual Eligible Demonstration.

[10] http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf
[11] See *2012–2014 Strategic Plan for Vermont Health Reform, page 12 at:* http://hcr.vermont.gov/sites/hcr/files/Strategic%20plan%201%2016%2012.pdf.

The GC Demonstration operates under a managed care model that is designed to provide flexibility with regard to the financing and delivery of health care in order to promote access, improve quality and control program costs. The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care model. The Department of Vermont Health Access (DVHA) is the managed care entity (MCE), and has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services).

Under the current waiver structure, AHS pays DVHA a monthly per member per month (PMPM) estimate using prospectively derived actuarial rates for the waiver year. This capitation payment reflects the State's monthly need for federal funds based on estimated GC expenditures. On a quarterly basis, AHS reconciles the federal claims from the payments to the underlying Global Commitment expenditures on the CMS-64 filing. As such, Vermont's payment mechanisms function similar to those used by state Medicaid agencies that contract with traditional managed care organizations to manage some or all of the Medicaid benefits.

According to the GC's Special Terms and Conditions (STCs), Vermont operates its managed care model in accordance with federal managed care regulations, found at 42 CFR 438. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. CMS reviews and approves the IGA annually to ensure compliance with Medicaid managed care contract requirements. As such, since the inception of the GC Demonstration, DVHA has modified operations to meet managed care program requirements, including requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance and quality improvement. Per the EQRO's findings, DVHA has achieved a very high rate of compliance with these requirements. Additionally, in its role as the designated unit responsible for operation of the traditional Medicaid program (including long term care, CHIP and DSH), DVHA is responsible for meeting requirements defined in federal regulations at 42 CFR 455.

One of the major drivers for entering into the GC waiver was to help bend the curve on Vermont's Medicaid costs – a goal that has been achieved. Vermont's actual spending over the 8.25 years of the waiver is projected to be $8.4 billion -- $500 million less in expenditures than projected without the waiver (i.e. Demonstration savings). There are a number of ways the GC Demonstration has helped Vermont achieve this success. First, the waiver provides the State with the ability to be more flexible in the way it uses its Medicaid resources, which has enabled Vermont to fund creative alternatives to traditional Medicaid services to improve quality of care and control costs. Examples of this flexibility include new payment mechanisms (e.g., case rates, capitation, combined funding streams) rather than fee-for-service, the ability to pay for services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatric consultation), and investments in programmatic innovations for Medicaid beneficiaries (e.g., the Vermont Blueprint for Health Community Health Teams).

In addition, provided that DVHA meets its contractual obligation to the populations covered under the Demonstration, any excess in the PMPM limit may be used to support expenditures that 1) reduce the rate of uninsured and or underinsured in Vermont; 2) increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries; 3) provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid eligible individuals in Vermont; and 4) encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system. Examples of services supported through this mechanism include respite services for families of children with disabilities; substance abuse treatment services for uninsured and underinsured Vermonters; tuition support for health professionals under short supply in Vermont, such as nurses, primary care physicians, and dentists; and support for development of standards and training for medical emergency care.

The managed care model also encourages inter-departmental collaboration and consistency across programs, which have enabled the State to support a holistic approach to serving individuals and families and ensure the coordination of services when multiple interrelated needs exist.

Choices for Care Long Term Care 1115 Demonstration

In October 2005, the State of Vermont also entered into another Section 1115 Demonstration authority that created fundamental changes to how long term services and supports are provided to low-income seniors and people with disabilities. Called Choices for Care (CFC), this waiver is designed to increase access to home and community-based services (HCBS) while reducing the use of institutional services and controlling overall costs. The CFC Demonstration has been renewed until September 30, 2015.

Vermont was the first state to create such an entitlement to both home and community based services and nursing home care, and the first state to commit to a global cap ($1.2 billion over five years) on federal financing for long term care services. CFC assigns beneficiaries into three groups based on level of need—a "highest need" group that is entitled to both nursing home and community services; a "high need" group that qualifies for nursing home and community services as State resources permit; and an expansion "moderate need" group of people who do not yet meet the eligibility requirements for nursing home care but receive limited services (as State resources permit). The "moderate need" program was intended to test the theory that early interventions can be cost-effective by helping to prevent increased disability and maintain people in community settings. Currently, individuals enrolled in CFC have a choice of using a home health agency or an Area Agency on Aging as their case management provider.

CFC has led to a significant rebalancing of where individuals receive services and where the State spends its resources. Since October 2005, nursing home enrollment has decreased 12 percent, while enrollment in community-based alternatives has increased 59 percent. Vermont now provides a limited package of services to nearly 1000 "moderate need" individuals who were not receiving Medicaid long term services prior to CFC. In its first month of operation, only 19 percent of State spending was in community settings; in State Fiscal Year 2012 (year to date), 33 percent of State spending was in community settings.

Interaction with the Dual Eligible Demonstration

The State's successful experience with the GC and CFC Demonstrations, and the effectiveness of DVHA as a statewide Managed Care Entity, provides a solid foundation for embarking on a Demonstration to manage blended Medicare and Medicaid services and funding for dually eligible Vermonters. As such, Vermont is seeking to combine the CFC Demonstration with the GC Demonstration as part of the GC renewal process, and to connect the Dual Eligible Demonstration to this combined Medicaid Demonstration – creating one framework for all Medicaid enrollees, and a special program for those who are dually enrolled in Medicaid and Medicare.

(c) existing specialty mental health and substance abuse health plans

Vermont does not have specialty mental health and substance abuse health plans. All mental health and substance abuse health services are fully managed by DVHA as the State's sole public Managed Care Entity in collaboration with sister departments through Intergovernmental Agreements.

(d) integrated programs via Medicare Advantage Special Need Plans (SNPs) or PACE programs

There are no Medicare Advantage Special Need Plans in Vermont. There are two PACE sites with a total of approximately 120 enrollees at any given time. To be eligible for *PACE Vermont*, an individual must:

- Be at least 55 years old
- Live in one of the following areas: Chittenden County (plus the towns of South Hero and Grand Isle) or Rutland County (plus the towns of Dorset, Rupert and Manchester)
- Meet clinical eligibility criteria for nursing home level of care (same as Choices for Care clinical eligibility)
- Be certified eligible for long term care Medicaid by the Department of Children and Families or be able to privately pay
- Be able to live safely in the community with services from PACE

PACE Vermont will continue to be an available option separate from the Dual Eligible Demonstration program; however, a PACE participant could easily "opt in" to the Demonstration program. Likewise, a Dual eligible individual could join the PACE program. A person would have to disenroll from one program in order to participate in the other. Protocols will be developed to link consumers to both *PACE Vermont* and the Duals Demonstration program.

(e) other State payment/delivery reform efforts underway (e.g., bundled payments, multi-payer initiatives)

Vermont has undertaken several initiatives, discussed in other sections of this proposal, to improve service delivery and coordination, improve health outcomes and control program cost growth. These include the Blueprint for Health, VCCI, SASH and several other provider payment reform initiatives. Through the 2011 passage of Act 48, an Act Related to a Universal and Unified Health System, Vermont seeks to continue its efforts to reform health care delivery and financing. The Act established the Green Mountain Care Board, responsible for continuing Vermont payment reform efforts, including development of a state health care budgeting system and a financing plan for a single payer system.

According to Act 48, payment reform methodologies shall be developed and implemented to manage the costs of the health care delivery system, improve health outcomes, and provide a positive health care experience for individuals, families and health care professionals. The principles of any new payment approach would be to move away from fee-for-service payments to the extent possible, and begin to incorporate payment methodologies that would reward providers for the value and quality of services provided rather than the volume of services. The Blueprint for Health has begun to incorporate new payment streams for primary care providers through enhanced payments on a PMPM basis according to the NCQA quality scores their practice achieves. This provides incentives for the practice to adopt and follow clinical standards of care, to implement electronic health records, order prescriptions electronically, and provide better access for their patients. In addition to these enhanced payments, the practices also benefit from Community Health Teams who work closely and are often co-located with the providers to better coordinate care for their patients.

More comprehensive payment methodologies now under consideration in Vermont include additional enhanced payments to PCPs and Specialists who agree to better coordinate care for individuals who have one or more chronic conditions; bundled payments to hospitals and post-acute providers for specific episodes of care; hospital/physician global budgets; and population-based payments to hospitals or other providers who are willing to take financial risk for comprehensive services to specific populations. All of these methodologies would shift incentives from volume-based payments to payments based on quality, efficiency, and access.

(f) other CMS payment/delivery initiatives or demonstrations (e.g., health home, accountable care organizations, multi-payer advanced primary care practice demonstrations, demonstration to reduce preventable hospitalizations among nursing home residents, etc.).

<u>Blueprint for Health</u>

The Blueprint is a state-led multi-payer initiative to transform the way health care services are delivered through comprehensive, well-coordinated care to improve health outcomes while controlling costs. The Blueprint is based on advanced primary care practices (APCPs) that serve as medical homes for the patients they serve, with comprehensive support from Community Health Teams, an integrated information technology infrastructure, and multi-insurer payment reforms to drive quality improvement. Since its inception in 2008, the Blueprint has been financially supported by Vermont's three major commercial insurers and Medicaid. With Vermont's recent designation as one of 8 states to be part of the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration through the Center for Medicare and Medicaid Innovation, Medicare is now also a fully participating insurer. As of the end of 2011, the Blueprint program included 78 APCPs which serve over 50% of the State's population. Expansion is in progress to involve all willing providers statewide by October 2013.

A core component of the Blueprint is the establishment and funding of Community Health Teams (CHTs) - multidisciplinary, locally based teams that work closely with and often located in the APCP setting. The CHT effectively expands the capacity of the APCP practice by providing people with direct access to an enhanced range of services, and with closer and more individualized follow up. CHT services are available to all individuals in the APCPs they support, regardless of their health insurance status.

Each community health team is staffed by five fulltime-equivalent employees and serves a population of approximately 20,000. (The size of the core CHT in each community is scaled based on the population being served in the APCP, with a half time position added for every 2,000 patients). The CHT is led by a registered nurse, who performs clinical duties and supervises the team. The remaining composition of any particular community health team is determined locally, with input from area practices and hospitals, but teams typically include additional registered nurses, mental health and substance abuse counselors, social workers and dieticians. CHT members assist patients and families with care coordination; mental health and substance abuse counseling; health and wellness coaching; enhanced self-management and education; and transitions of care including coordinated linkages with targeted specialty services (e.g. specialty care, mental health, substance abuse treatment, social services, and economic services). Enhanced self-management and informed decision making is firmly embedded in the CHT approach. The team's role is to enhance patient care both directly and indirectly through individual services performed on the patient's behalf and through their support of the APCP. In addition, they perform community outreach to support public health initiatives.

The "core" CHT members that work directly with APCPs meet regularly with other service providers in their community. This has resulted in a continuum of coordinated health services and a much larger "functional" CHT, referred to as Community Health Team Extenders. These Extenders work closely with the core CHT to support more targeted subpopulations, providing more intensive services to individuals with higher needs while the core CHT members support the general population. The APCPs, core CHT members, and CHT Extenders establish a flexible continuum of preventive and wellness oriented services in a community that can respond to changing needs of individuals and families. Examples of CHT Extenders include:

Vermont Chronic Care Initiative (VCCI)

DVHA (Medicaid) Care Coordinators, who are registered nurses and social workers, provide care coordination and case management services to high risk beneficiaries through a holistic approach that addresses physical, mental health, substance abuse, and socioeconomic barriers to health improvement. They assist these Medicaid beneficiaries to access clinically appropriate health care information and services; coordinate the efficient delivery of health care by addressing barriers to care, bridging care gaps, and avoiding duplication of services; and educate and empower these beneficiaries to eventually self-manage their conditions.

DVHA VCCI care coordinators are fully integrated core members of existing Blueprint for Health CHTs and are co-located in many Blueprint provider practices. VCCI care coordinators also are co-located in specialty practices, and hospitals to assure high quality, integrated, and cost effective health care. When not co-located with the Blueprint CHTs, VCCI staff and the CHT staff are in frequent communication with joint care conferences as the norm. Once the patient no longer requires these intensive services, or no longer qualifies for Medicaid, he or she will continue to be followed in the APCP and supported by the CHT as necessary, moving back into the VCCI if indicated. DVHA is expanding the number of these skilled case managers as the Blueprint expands statewide, and also to provide support for individuals with specific needs such as buprenorphine management.

Support and Services at Home Program (SASH)

Medicare participation in the Blueprint is supporting SASH Teams statewide in conjunction with Blueprint APCPs and core CHTs. The SASH program provides support and services to Medicare beneficiaries, so that individuals can live and age safely in their own homes. Dedicated SASH staff, including a full time SASH Coordinator and a 0.25 time Wellness Nurse for every 100 participants in the program, is embedded in housing organizations and provides services to elderly and Medicare beneficiaries with a disability living at subsidized housing sites and

elsewhere in the community. The SASH Teams focus on three areas of intervention that have proven most effective in reducing unnecessary Medicare expenditures. These include:

a) Support for transitions after a hospital or rehabilitation facility stay
b) Self-management education and coaching particularly relating to chronic health conditions
c) Care Coordination

As of January 2012, there are twelve SASH Teams providing services to Medicare beneficiaries in communities throughout the State. This number will be expanded over the next year as the Blueprint expands to more APCPs.

Innovative payment reforms that align fiscal incentives with health care goals are also key to the Blueprint model. While primary care practices participating in the Blueprint receive fee-for-service payments, they also receive a per person per month (PPPM) payment based on their National Committee for Quality Assurance score against patient-centered medical home standards. The NCQA PPC/PCMH standards are designed to assure high quality primary care that provides improved access for patients, improved communication and follow-up, more consistent care based on national guidelines for prevention and control of chronic diseases, improved coordination of care and linkages with other services (medical and non-medical), support patient-level self-management, and enhanced use of health information technology and decision support systems.

The NCQA monthly payments and the costs for each community health team - $350,000 per team of five full-time-equivalent staff members – are shared among Vermont's three major commercial insurers, as well as Medicaid and Medicare (via the MAPCP Demonstration). Payment streams to both the APCPs and the CHTs are oriented towards meeting the needs of patients ("patient-centric") by supporting a system-wide focus on healthcare quality rather than on volume.

<u>HHS Health Care Innovation Challenge: Vermont Proposals</u>

The following proposals have been submitted by Vermont organizations in response to the Health Care Innovation Challenge opportunity. If funded, the Vermont Dual Eligible Demonstration will work closely with the Innovation Challenge grantee(s) to ensure that the projects are well aligned to further integrate care and improve quality for dually eligible Vermonters.

- *Healthy Minds:* The Vermont Assembly of Home Health and Hospice, Behavioral Health Network of Vermont, Albany College of Pharmacy, Cathedral Square Corporation, and the Vermont Association of Area Agencies on Aging submitted a joint proposal entitled: *Healthy Minds… Better Care, Lower Costs.* This proposal builds upon the Vermont Blueprint for Health and the Support and Services at Home (SASH) programs to address unmet mental health and medication management needs for individuals with depression, cognitive impairment, and other mental health issues.

- *Vermont Association of Mental Health and Addictions Recovery:* This project is aimed at the prevention of mental, emotional, and related medical illnesses and family recovery by training the current workforce in evidence-based practices and developing a large workforce of family navigators and recovery coaches to provide peer-to-peer support for parents, caregivers and their children.

- *University of Vermont (UVM):* The UVM proposal builds upon the Vermont Blueprint for Health by providing a new workforce of specially-trained nurse practitioners to coordinate health care across primary care medical homes, community health teams, and hospital and specialty care sites. In the second phase, UVM, Fletcher Allen Health Care and IBM will utilize sophisticated computer platforms and predictive modeling to match these resources to patients with the greatest risk of adverse and costly manifestations of disease.

- *Grand Memory Care Assisted Living :* Grand Senior Living has proposed a three-year project in collaboration with Mackenzie Architects, Long Term Care Trade Associations, Alzheimer's Association Chapters, and State Licensing agencies in New England to provide better health care and outcomes for seniors with Alzheimer's disease and other forms of dementia by creating person-centered care neighborhoods in affordable, high quality secure residential care settings and structured programming.

- *OASIS:* The University of Massachusetts has submitted a proposal to rigorously evaluate and disseminate an innovative person-centered workforce training curriculum to rural and urban long term care institutions. OASIS trains staff and leadership to address the unmet needs of the high-cost, high-utilization population of institutionalized persons with challenging behaviors by focusing on the personhood rather than the patient-hood of individuals.

D. Stakeholder Engagement and Beneficiary Protections

i. Design Phase; and
ii. Plan for Ongoing Involvement

Stakeholder engagement in the Dual Eligible Project has been active and robust, with four different Work Groups meeting every two weeks from late July to October 2011. The Work Groups were Service Delivery, Financing Model, Outcomes and Quality, and Person-Centered Care. The four Work Groups merged into one Stakeholder Advisory Group in October 2011 which continues to meet every two weeks. Work Group participants include approximately 50 advocate, consumer, and provider groups. Internal stakeholders consist of AHS / DAIL / DMH and DVHA representatives. For a list of participating stakeholder organizations, see Appendix 8. The Stakeholder Advisory Group will meet on an ongoing basis for the duration of the Demonstration. Meeting agendas and minutes can be found at http://humanservices.vermont.gov/dual-eligibles-project. In addition to these routine meetings, Stakeholders and beneficiaries will be informed of changes relating to this initiative through website postings, beneficiary notifications, legislative reports, and marketing and outreach.

To further solicit consumer input, the Dual Eligible Project hired a contractor in November 2011 to conduct focus groups and interviews with Dually Eligible individuals and their family members. The Focus Group Final Report dated February 2012 can be found at http://humanservices.vermont.gov/dual-eligibles-project/person-centered-materials/finch-focas-group-summary-report-1-24-12/view In addition, the Project has incorporated responses from the Vermont Department of Disabilities, Aging & Independent Living Long Term Care Consumer Survey, Dual Eligible Section O, p. 276, December 2011. http://humanservices.vermont.gov/dual-eligibles-project/person-centered-materials/market-decision-survey-for-dual-eligibles/view

iii. Beneficiary Protections

The State of Vermont, through the Agency of Human Services, has a grievance and appeal process for Global Commitment that will serve as the basis upon which appeals and grievances will occur for the Dual Eligible Demonstration. This single grievance and appeal process also will include the preferred requirements in the guidance from the Centers for Medicare and Medicaid Services. Vermont will collaborate with CMS to determine which state regulations and federal requirements will need to be revised to reflect a coordinated appeals process. The State of Vermont is working with advocates from Vermont Legal Aid to address concerns they may have about changes in the appeal process, and to elicit feedback in developing the appeals and grievance process of the model. The goal is to streamline processes that both protect beneficiaries and allow adequate access to supports and services. These meetings include representation from the following projects of Vermont Legal Aid: Disability Law Project, Health Care Ombudsmen, Long Term Care Ombudsmen, and the Senior Citizen Law Project.

The Demonstration will benefit from DVHA's experience and capacity as Vermont's Medicaid managed care entity. DVHA has extensive experience in producing materials that are accessible and understandable to Medicaid beneficiaries and are Section 508 compliant. The current Internal Governmental Agreement (IGA) includes specific requirements regarding methods of communicating with enrollees who do not speak English as a first language, enrollees who are visually and hearing impaired, and accommodating enrollees with physical disabilities and different learning styles and capacities. All DVHA enrollees and potential enrollees are informed that information is available in alternative formats and how to access those formats. The DVHA enrollee

handbook includes information regarding the availability of oral interpreter services, translated written materials, and materials in alternative formats. Enrollee materials, including the enrollee handbook, are available in all prevalent non-English languages. In-person and telephonic interpreter vendors, written translation vendors, American Sign Language (ASL) interpreters, and Braille materials are provided. Notices include language clarifying that oral interpretation is available for all prevalent languages and how to access it. The External Quality Review Organization (HSAG) has favorably reviewed DVHA's compliance with MCO standards for cultural competence and accessibility. (There are no federally-recognized Indian tribes or groups in Vermont.)

Vermont is committed to robust beneficiary protections in both the Demonstration and health care reform efforts. Under this Demonstration, Vermont will maintain Medicare and Medicaid financial and clinical eligibility standards that currently exist, and ensure privacy of enrollee health records. Vermont Bill H.559 Section 33 (See Appendix 9) was recently passed by the Vermont Legislature and provides clear direction for specific beneficiary protections, many of which are described below:

1. eligibility standards, methodologies, and procedures that are neither more restrictive than the standards, methodologies, and procedures in effect as of January 1, 2012 nor more restrictive than the standards, methodologies, and procedures for dual eligible individuals who are not enrolled in this consolidated program.
2. does not reduce the amount, duration, or scope of services covered by Medicaid and Medicare or impose limits on enrollment or access to services that are more restrictive than those for individuals not enrolled in the consolidated program.
3. ensures that an individual in the consolidated program receives a level of service that is equivalent to or greater than the individual would have received if he or she were not in the consolidated program.
4. provides reasonable opportunity for an individual to disenroll from the consolidated program and transition to traditional Medicaid and Medicare coverage.
5. includes an independent advocacy system for all participants and applicants in the consolidated program which includes, at a minimum, access to area agency on aging advocacy, legal services, and the long-term care and health care ombudsmen.
6. if the agency contracts with an integrated care provider (ICP) then, at a minimum, as required under 42 U.S.C. § 1395a(a), guarantees individuals a choice of health care providers who offer the same service or services within the individual's ICP and a choice of providers for services that are not offered through the individual's ICP.
7. unless otherwise appropriated by the general assembly, and after reconciling savings as required by the federal government, invests at least 50 percent of the remaining funds at the end of the state fiscal year to enhance the consolidated program.
8. provides individuals enrolled in the consolidated program who become ineligible for Medicaid or Medicare or who choose to opt out of the program with a seamless transition process between coverage provided by the consolidated program and traditional Medicaid coverage, Medicare coverage, or both to ensure that the process does not result in a reduction or loss of services during the transition.
9. if the agency of human services contracts with an ICP on a risk-sharing basis for services other than care coordination, the following provisions shall be included in the ICP contract:
   (A) A broad range of services for individuals, to be provided by the ICP or through contracts between the ICP and other service providers, and coordination between the ICP and other service or health care providers who are not participants in the ICP, as appropriate.
   (B) An enforcement mechanism to ensure that the ICP and any subcontractors provide integrated services as required by the waiver and the contract provisions.
   (C) Transparent quality assurance measures for evaluating the performance of the ICP and any subcontractors and a method for making the measures public.
10. provides dual eligible individuals with meaningful information about their care options, including services through Medicaid, Medicare, and the consolidated program established in this section. The agency shall develop enrollee materials and notices that are accessible and understandable to those individuals who will

be enrolled in the consolidated program, including individuals with disabilities, speech and vision limitations, or limited English proficiency.

11. establish by rule a comprehensive and accessible appeals process, including an opportunity for an individual to request an independent clinical assessment of medical or functional limitations when appealing an eligibility determination, a denial in services, or a reduction in services.
12. implement the program approved by CMS by rule. Prior to filing proposed rules, the agency shall seek input on the proposed rules from a workgroup that includes providers, beneficiaries, and advocates for beneficiaries.

E. Financing and Payment

i. State-level Payment Reforms

The State of Vermont is a recognized leader in the reform of publicly-funded health programs. As described in Section C.v., Vermont has operated the majority of its Medicaid program under Section 1115 Demonstration Authority since 2005 through the Global Commitment to Health and the Choices for Care programs. Both of these Demonstrations are innovative in their state-level payment reforms.

Budget neutrality terms define total permissible Medicaid spending for each of the two Demonstrations, and their Special Terms and Conditions identify a maximum spending limit over the life of each Demonstration. (Vermont was the first state to undertake long term care reform with an overall cap on federal funding). Program spending for both Demonstrations has remained within established budget neutrality limits. Furthermore, the Global Commitment to Health Demonstration operates under the nation's only statewide public managed care model, whereby AHS pays the Vermont Managed Care Entity (MCE), DVHA, a monthly per member per month (PMPM) estimate using prospectively derived actuarial rates for the waiver year. DVHA is responsible for operating the Medicaid program within these PMPM limits in exchange for flexibility to adopt reform approaches designed to improve quality of care, access to care and control program cost growth. Like privately-operated Medicaid managed care organizations, the DVHA as the MCE complies with federal Medicaid managed care regulations.

Vermont seeks to build on the successes of its Medicaid reform efforts and move toward a unified health system by integrating Medicaid and Medicare funding and service delivery for individuals who are dually eligible. For this Dual Eligible Demonstration, Vermont proposes to use the capitated approach outlined in the July 8, 2011 State Medicaid Director (SMD) letter. Under this capitated model, CMS, the State, and health plans (i.e., DVHA) enter into a three-way contract. The plans receive a prospective blended capitated rate that is actuarially developed for the full continuum of benefits provided to Medicare-Medicaid enrollees across both programs. The capitated model also targets aggregate savings within these blended rates to provide a new savings opportunity for both the State and the Federal government.

While Vermont proposes to use the Duals Demonstration capitated model, the current financial arrangement between CMS and the State for the GC Medicaid Demonstration does not fully align with this approach; however, the overlaps in methodology and intent are significantly similar. Specifically, as described in Section C.v., while AHS pays DVHA (as the public MCE) monthly capitated payments, AHS must reconcile the federal claims from the payments to the underlying GC expenditures on the quarterly CMS-64 filing, similar to a fee-for-service approach. As such, although, Vermont's payment mechanisms function similar to those used by state Medicaid agencies that contract with traditional managed care organizations to manage some or all of the Medicaid benefits, the State is not truly receiving a prospective capitated payment in the current GC Demonstration. Nonetheless, Vermont believes that the Dual Eligible Demonstration capitated model is a much better fit for the State and the existing GC model than the alternative Fee for Service (FFS) model, which would rely on true fee-for-service mechanisms and establish a retrospective performance payment to the states based on Medicare savings achieved for Medicare-Medicaid enrollees.

Although Vermont's proposed managed care model will operate in a similar manner to models that contract with privately-operated managed care organizations, the State of Vermont ultimately bears the financial risk assumed by the public MCE. Vermont understands that one of the fundamental goals of funding integration is to remove existing barriers to delivery of the most appropriate types of care. Once the apportionment of Medicare and Medicaid funding has been established, the Public MCE effectively will receive a single payment and its fiscal management and reporting responsibilities likewise will reflect the integrated financing model. Vermont requests the opportunity to work with CMS to examine potential risk sharing arrangements that recognize the unique nature of Vermont's public managed care model and create incentives for savings.

Payments to Public Managed Care Entity (MCE)

The proposed model will integrate Medicare and Medicaid funding by making risk-adjusted, capitated payments to DVHA as the public MCE. DVHA will be responsible for meeting all contractual obligations, including payment for all covered services provided to participants enrolled under the program. In addition, DVHA will be required to meet established quality thresholds.

As referenced previously, since 2005, an independent actuary has established and certified PMPM limits for all Vermont Medicaid participants who are dually eligible, with the exception of individuals who are enrolled in the Choices for Care program. Vermont proposes to build on this foundation for development of the Medicaid component of integrated payments made to the Public MCE. Vermont proposes to collaborate with CMS to make adjustments to this model in order to incorporate a capitated rate setting approach for services provided under Choices for Care, evaluate risk adjustment options and adjust payment rates in accordance with the agreed-upon shared savings model.

Vermont and CMS staff have been engaged in a review of historical expenditure data and exploration of approaches for making payments to the Public MCE. Vermont believes that one option that warrants further consideration is the use of the existing Medicare payment system for Medicare Advantage Plans, the CMS hierarchical condition category (CMS-HCC) methodology. Implemented in 2004, the CMS-HCC methodology is a highly researched model that makes risk-adjusted payments to Medicare Advantage Plans serving approximately thirteen million Medicare Beneficiaries nationally. Vermont understands that the Integrated Care Demonstrations are intended to not only improve the quality of care for enrolled individuals but also produce savings. Vermont intends to work with CMS to explore use of the CMS-HCC methodology with actual payment amounts adjusted to reflect the Medicare-Medicaid shared savings model contemplated by CMS.

ii. Payments to Providers

The public MCE will build on current payment methodologies and payment reform initiatives to develop integrated payment methodologies and rates for all covered services. The Vermont Medicaid program already has developed prospective payment methodologies that mirror Medicare payment approaches for payment of outpatient hospital services (OPPS), inpatient hospital services (DRGs), and physician services (RBRVS).

A fundamental benefit of financial integration is overcoming the inefficiencies related to management and coordination of separate benefits and coverage policies under the two programs. Vermont is committed to ensuring that integrated funding does not adversely impact provider payment rates. Vermont does not intend to produce program savings by reimbursing providers at the lesser of the Medicaid payment rate or Medicare payment rate. However, Vermont intends to avoid development of payment approaches for this Demonstration that require the continued distinction between Medicare and Medicaid covered services. Vermont intends to evaluate payment rates and coverage policies for each type of provider and develop equitable payment approaches that account for differences in Medicare and Medicaid payment rates.

The public MCE will develop provider payment approaches to achieve the following:

- Permit providers to deliver services, on a solvent basis, that are consistent with efficiency, economy, access and quality of care
- Are at least comparable to the average weighted payment rates that eligible providers would have received from Medicaid and Medicare in the absence of the initiative (subject to changes to federal Medicare rates, provider rates as established by the Green Mountain Care Board, rate negotiations between DVHA and the ICP / ICP-PLUS, and meeting or failing to meet specified performance measures).

As part of Vermont's broad payment reform initiative, the public MCE will move towards performance-based reimbursement methodologies that focus on quality and outcomes rather than volume of services. Vermont will collaborate with community providers and organizations to establish funding approaches that promote service integration and coordination and create incentives to promote early intervention and prevention. Performance measures aimed at achieving specific outcomes will be developed from program specific logic models, and payment incentives and shared savings opportunities and will be linked to achieving identified outcomes.

Payments to Integrated Care Providers (ICPs)

Under the proposed model, the public MCE will pay Integrated Care Providers (ICPs) who will be responsible for coordinating and integrating a wide range of primary, acute, mental health, substance abuse, developmental, and long term supports and services, based on the needs identified in the person's Comprehensive Individual Care Plan. DVHA will pay for this Enhanced Care Coordination using a capitation (PMPM) methodology that is tiered based on level of care coordination need.

Payments to Integrated Care Providers-PLUS (ICP-PLUS)

The public MCE will be at-risk for payment of all services, care coordination and other contractual responsibilities in the Demonstration. However, the Vermont Demonstration contemplates the opportunity for Integrated Care Providers (ICPs) to participate on a sub-capitated risk basis, designated by the term Integrated Care Providers-PLUS (ICP-PLUS). Under the proposed model, the public MCE will negotiate contracts with organizations interested in assuming financial responsibility for providing or arranging for all covered services within certain service bundles, as required by their enrollees' Individual Plans. These service bundles could include in-home health services, home and community support services, mental health services, substance abuse services, hospice and palliative care, durable medical equipment and medically-necessary transportation. The State will bear the risk for all other services not included in ICP-PLUS contracts (e.g., inpatient hospital, outpatient hospital, nursing facility, physician services, pharmacy).

DVHA will reimburse ICP-PLUS organizations using a tiered capitation (PMPM) methodology that includes Enhanced Care Coordination and the defined set of services in their risk-based contract. This arrangement will provide ICP-PLUS organizations with flexibility to develop innovative service delivery approaches to best meet the needs of individuals.

Vermont previously developed case rate approaches that are similar to the ICP-PLUS model. Examples include the Developmental Services (DS) program and the Community Rehabilitation and Treatment (CRT) program for people with severe and persistent mental illnesses, whereby providers receive a "bundled" payment in exchange for its commitment to provide an array of services to program participants. The ICP-PLUS model seeks to expand flexibility for service delivery and promote care coordination across program participants' full array of primary, acute, mental health, substance abuse, and long term supports and service needs.

In reviewing proposed ICP-PLUS contracts, DVHA will consider such factors as: demonstrated capacity to provide or arrange for the included services; demonstrated formal relationships with other organizations; organizational financial stability; impact of proposed bundling of services on service provision for non-dual populations in the geographic area; and projected impact on overall health care system costs. It should be noted that Vermont has State rules which require special designation to deliver a set of specific services; examples include designation to provide CRT, DS and Home Health Services. As such, if an ICP-PLUS organization does not have this state

designation, the ICP-PLUS must have signed agreements with designated entities to provide these types of services if they are included in the ICP-PLUS contract with DVHA. Recognizing this complexity and the unique nature of the state's long-standing collaboration with community providers and organizations, the public MCE could serve as a fiscal agent for the ICP-PLUS organizations; at their request, the MCE would process claims on behalf of the ICP-PLUS.

Shared Savings/Performance Incentive Opportunities:
Vermont wants to ensure that the Demonstration provider payment approaches under the Demonstration deter cost-shifting between providers, promote service integration and coordination, and create incentives to promote early intervention and prevention. As such, Vermont proposes to use two Incentive Pools and an Expenditure Reconciliation and Gain/Loss Mechanism to accomplish these goals.

Quality Threshold Incentive Pool
CMS and AHS will determine quality thresholds for each demonstration year. A % of DVHA's payment will be with-held until the end of the year, and DVHA will receive this amount if it meets the quality standards. DVHA will monitor provider performance based on the agreed upon CMS/AHS quality standards, and will share the quality with-hold payment with the ICP and ICP-PLUS if DVHA meets the CMS/AHS standards, based on the provider's relative performance on the measures. It is expected that these quality standards will include measures of enrollee access, outcomes and satisfaction.

DVHA Savings Incentive Pool
DVHA will identify additional projected savings targets for specific areas of expenditures, and will share a % of the year-end actual savings with the ICP and ICP-PLUS.

Expenditure Reconciliation and Gain/Loss Mechanisms
At the end of each demonstration year, DVHA will reconcile ICP and ICP-PLUS revenues (including any earned incentive funding) and expenditures.

- Loss Provisions: In Year 1 of the Demonstration, an ICP or ICP-PLUS will not be at financial risk for loss in their capitated payment if they meet the CMS/AHS performance standards and its incurred expenses are determined by DVHA to be reasonable and appropriate. However, the ICP or ICP-PLUS will be required to submit, for DVHA review and approval, a Corrective Action Plan to reduce future losses and will be subject to quarterly financial monitoring by DVHA. DVHA retains the right to take any actions it deems appropriate to address program losses, including but not limited to: revising the list of services for which an ICP-PLUS is at risk; capping or reducing ICP/ICP-PLUS enrollment; and terminating the ICP/ICP-PLUS agreement.

  In subsequent years of the Demonstration, an ICP or ICP-PLUS will be required to absorb losses up to A% within their capitated payment and DVHA will equally share in losses between B% and C%. DVHA will absorb all losses above C%, subject to an aggregate ceiling on additional payment equal to $xxx. The ICP or ICP-PLUS will be required to submit, for DVHA review and approval, a Corrective Action Plan to reduce future losses and will be subject to quarterly financial monitoring by DVHA. DVHA retains the right to take any actions it deems appropriate to address program losses, including but not limited to: revising the list of services for which an ICP-PLUS is at risk; capping or reducing ICP/ICP-PLUS enrollment; and terminating the ICP/ICP-PLUS agreement. *Note: Specific %s to be determined at a later date.*

- Gain Provisions: Beginning in Year 1 of the Demonstration, subject to meeting the CMS/AHS quality standards, providers will be permitted to retain up to A% of savings within their capitated payment, and to equally share with DVHA savings between B% and C%. However, the ICP or ICP-PLUs must agree that the funds be used in accordance with a DVHA- provider negotiated reinvestment plan to improve access, quality or cost. (Additional savings revert to DVHA). *Note: Specific %s to be determined at a later date.*

In summary, Vermont believes that the above provide payment financing and payment structures coupled with required adherence to performance measures will hold providers accountable for providing the services and

care needed by individuals. In addition, the incentive pools provide a financial motivation to think more broadly about system outcomes, and to negate possible cost-shifting that might otherwise occur. Appendix 5 provides an overview of the ICP and ICP-PLUS expectations and fiscal provisions.

F. Expected Outcomes

i. The State's ability to monitor, collect and track data on key metrics

Vermont agrees to collect and provide to CMS beneficiary level expenditure data and all available encounter data. Vermont has extensive experience identifying, defining, collecting and analyzing data related to the proposed model's expected quality and cost outcomes. Examples include the external evaluations of Vermont's Global Commitment and Choices for Care 1115 Medicaid waivers which rely on State data collection activities such as beneficiary experience, access to care, and service utilization; Blueprint for Health data collection, analyses and outcome evaluation components; and similar data collection and analysis related to Vermont Chronic Care Initiative performance. Vermont's contract with JEN Associates allows the State to create linked Medicare and Medicaid datasets to analyze costs and utilization by population subgroups. The tables in Section B and Section F.ii. provide evidence of the State's capacity to perform these types of integrated data analyses.

Vermont agrees to provide CMS with information that describes changes to the State plan that affect people enrolled in the Demonstration including changes in payment rates, benefit design, and addition or expiration of waivers. Vermont also agrees to provide CMS with information regarding State supplemental payments to providers, including DSH and UPL, during the three year period.

Vermont will develop a comprehensive performance measurement strategy that fosters smooth access, improved quality and health status, positive beneficiary experience, more effective utilization of services, and reduced overall spending. The strategy will include (1) analyses of how desired outcomes are achieved, (2) regular feedback of findings to State staff, providers, and other stakeholders in order to improve policies and service systems, and (3) more comprehensive analyses of broader, long term transformations of care and outcomes for dual eligible beneficiaries.

ii. Potential improvement targets

Vermont anticipates that the Demonstration will improve a range of outcomes, such as avoidable hospitalizations and readmissions, as well as quality, access and satisfaction in both the home and community-based and medical care sectors. Due to delays in accessing integrated data, Vermont has yet to develop specific baseline measures and performance improvement targets. Based on experience with other groups and other services, Vermont anticipates significant variations among different providers and geography. This makes the task of establishing baselines and performance targets more complex but also more focused and effective.

Improved outcomes will be achieved through maturation and spread of Vermont's APCP medical home initiative (Blueprint for Health and Community Health Teams), expansion of the Vermont Chronic Care Initiative model to include people who are dually eligible, and improved integration of medical care and home and community-based services through care coordinators with interdisciplinary and interagency collaboration. The service system sectors addressed in the logic models below, as well as related performance targets and measures, will be monitored during implementation and operation. Ongoing performance feedback will be given to State staff, care coordinators, provider staff and other stakeholders to support real-time assessment of performance and performance improvements.

The tables below display the highlighted service categories from the tables in Section B–Description of the Population. Highlighted service categories denote potential opportunities for targeted intervention to integrate care, improve outcomes, and reduce costs. Each table is followed by a logic model that identifies inputs, activities, outputs, and outcomes. Tables 1, 2, 3, 6, and 8 are featured since they offer promising opportunities

to affect utilization, outcomes, and spending. The following tables were excluded because of their current relatively integrated systems of care and desirable utilization of services: Table 4 Choices of Care Enhanced Residential Care, Table 5 Developmental Services, and Table 7 Traumatic Brain Injury.

Table 1 displays highlighted areas for targeted intervention and a logic model for the Demonstration as a whole. The data show more than half of combined Medicare and Medicaid spending occurs in diagnostic testing, emergency department, inpatient acute, nursing facility, and pharmacy categories. The logic model summarizes expected utilization changes in these five domains, as well as other related outcomes, that will be experienced by all dual eligible individuals. The Demonstration model will help control utilization and spending in all these areas by adding care coordination, incentives to integrate, protocols to collaborate, and rapid-cycle feedback to convey best practices. The new activities by care coordinators will lead to broader use of interdisciplinary care plans, better coordination, and increased individualized support during transitions. Expected outcomes of the more integrated system and a single point of contact relate not only to reductions in utilization and costs in these service categories but also to smoother access to services, as well as improved quality of life, health status, and satisfaction.

Table 1: Vermont Dual Eligible Population – ALL (See Appendix 2 for Table Footnotes)

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Diagnostic Testing	19,051	87.9%	$19,862,937	3.4%	$1,043	$917
Emergency Department	9,546	44.1%	$6,027,610	1.0%	$631	$278
Inpatient Hospital	4,319	19.9%	$76,328,470	13.1%	$17,673	$3,522
Nursing Home	3,771	17.4%	$132,219,277	22.7%	$35,062	$6,101
Pharmacy[b]	20,082	92.7%	$67,822,149	11.6%	$3,377	$3,130

Inputs	Activities	Outputs	Outcomes
- Care coordination funds for ICPs, ICPs-PLUS, CHTs - Incentives to APCPs, CHTs, ICPs, ICPs-PLUS, and other providers for achieving comprehensive outcomes and performance targets - New protocols for referrals, comprehensive assessment and care planning, communications, coordination, sharing clinical information, and medication therapy management (MTM) - Integrate care management for multiple conditions - Improve use of HIT/EHR to share health records - Rapid-cycle feedback to measure and improve performance and outcomes	- ICPs/ICPs-PLUS connect beneficiaries with medical homes - Develop and implement comprehensive/interdisciplinary joint care plans - Collaboration among primary care, other medical care, and home and community-based care (HCBC) - Shared management of hospital discharges, prevention of readmissions, medications, health promotion - Improve and expand management of chronic conditions including self-management	- Increased prevalence of interdisciplinary care plans with individualized goals and measures - Increased care coordination by specialized care managers at ICPs, ICPs-PLUS - Closer working relationships between primary care physicians, other medical providers, ICP, ICP-PLUS care coordinators, MTM, other service providers, and consumers - Increased individualized supports to consumers in their homes and communities, directly intended to reach health-related goals - Increased supports during care transitions (home>facility, facility>facility, facility>home) - Increased use of performance and outcome measures	- Improved use of pharmacy; reduced number of medications used and medication complications - Improved adherence with medication plans and chronic conditions management plans - Lower hospital, nursing home, and medication utilization and spending - Reduce unnecessary and duplicative diagnostic tests - Improved access, health status, quality of life, and satisfaction

Table 2 shows highlights of spending for nursing home residents in the CFC program, followed by a logic model identifying interventions. In addition to the inputs and activities described for the Demonstration as a whole, Vermont anticipates performance measures with related incentives for nursing facilities to reduce unnecessary (re)hospitalizations. About 9% of total payments were for hospitalizations.

Table 2: Vermont Dual Eligible Population – Choices for Care Nursing Facility

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Diagnostic Testing	2,619	91.5%	$1,959,544	1.2%	$748	$685
Emergency Department	1,439	50.3%	$1,090,016	0.7%	$757	$381
Inpatient Hospital	894	31.2%	$14,179,357	8.5%	$15,861	$4,954
Nursing Home	2,861	100.0%	$119,803,290	71.9%	$41,875	$41,860
Pharmacy[b]	2,817	98.4%	$8,984,319	5.4%	$3,189	$3,139

Inputs	Activities	Outputs	Outcomes
- Incentives for nursing homes to reduce avoidable hospital admissions and readmissions - Protocols for nursing homes to treat common conditions linked to hospitalizations (e.g. UTI, decubiti, pneumonia)	- Hire and train staff, including medical providers - Implement protocols and monitor results - Learn from successes and shortcomings in system	- Primary and secondary care teams in nursing facilities - Increased number of individuals staying in nursing homes for needed care rather than transferring to a hospital	- Lower hospital, nursing home, and medication utilization and spending - Improved health status, quality of life, and satisfaction from avoidance of unneeded transfers to hospitals

Table 3 shows highlights of spending for the CFC Home and Community Based Services program, followed by a logic model regarding new initiatives. In addition to the inputs and activities described for the Demonstration as a whole, Vermont anticipates incentives for home health agencies to improve the coordination/integration of traditional home health services with CFC Home and Community Based Services. This will be achieved by developing and implementing integrated care plans. This may result in more satisfaction among individuals receiving services since they will have fewer people in their home, a factor directly related to higher levels of satisfaction.

Table 3: Vermont Dual Eligible Population – Choices for Care Home & Community Based Services

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Diagnostic Testing	2,498	93.2%	$3,161,220	2.4%	$1,266	$1,180
Emergency Department	1,645	61.4%	$1,417,169	1.1%	$862	$529
Home Health Care	1,878	70.1%	$11,904,033	9.1%	$6,339	$4,442
Inpatient Hospital	1,011	37.7%	$18,238,733	13.9%	$18,040	$6,805
Nursing Home	763	28.5%	$18,917,470	14.4%	$24,794	$7,059
Pharmacy[b]	2,608	97.3%	$12,744,724	9.7%	$4,887	$4,755

Inputs	Activities	Outputs	Outcomes
- Incentives for home health agencies to improve coordinated delivery of personal care and homemaking - Protocols to eliminate duplication - Incentives to provider agencies for achieving performance outcomes/targets	- Develop joint care plans for home health and other home and community based services - PCAs and Homemakers meet more of individuals' total needs	- Coordinated, less duplicative home care - Less burden on and confusion for individuals and families - More continuity in providers - Fewer different paid caregivers in individual homes	- Lower use of emergency departments, hospitals, and nursing homes - Improved use of pharmacy - Lower combined spending on RNs, LNAs, PCAs and Homemakers - Improved health status, quality of life, and satisfaction - More satisfied workers

Table 6 shows highlights of spending for individuals served by the Community Rehabilitation and Treatment (CRT) program. In addition to the inputs and activities described for the Demonstration as a whole, a major focus for this group is to reduce utilization and expenditures for psychotropic medications which often have adverse health effects on individuals and lead to acute illness, obesity, and other problems. Better identification of these individuals and coordination of integrated care plans with health care providers, individuals, and families can control symptoms with alternative and often less expensive medication, while also reducing hospitalizations. For this group, reductions in inpatient hospitalizations include two types of hospital use: inpatient psychiatric admissions, and other types of admissions related to co-occurring conditions. Reducing both types of admissions will require an approach to improving management of chronic conditions that is holistic, comprehensive, interdisciplinary, and person-directed.

Table 6: Vermont Dual Eligible Population – Community Rehabilitation and Treatment
(For people with severe and persistent mental illness)

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Diagnostic Testing	1,429	91.6%	$1,682,752	2.8%	$1,178	$1,079
Emergency Department	785	50.3%	$549,752	0.9%	$700	$352
Inpatient Hospital	338	21.7%	$6,150,392	10.2%	$18,196	$3,943
Nursing Home	98	6.3%	$2,662,447	4.4%	$27,168	$1,707
Pharmacy[b]	1,538	98.6%	$10,500,617	17.4%	$6,827	$6,731

Inputs	Activities	Outputs	Outcomes
- Protocols for identification monitoring, intervention, and coordination of interventions for individuals with (1) potentially adverse effects from medications, (2) potentially avoidable hospitalizations, and (3) crisis indicators	- Identify groups of targeted individuals - Assign ICP/ICP-PLUS team members to identified clients - Develop and implement individualized care plans - Coordinate interventions across physicians, CHT, CRT, individuals, and families	- Increased care coordination to implement and assess alternative medication regimens to control psychiatric symptoms - Increased caregiver support and training (for both families and formal providers), e.g., around symptom monitoring and control - Intensive case management and coordination to reduce readmissions - Alternative community-based approaches to crisis support and crisis intervention - Changes in medication regimens to reduce long-term risks to health - Improved management of multiple chronic conditions	- Decreases (long term) in disease, e.g., diabetes and obesity - Lower use of emergency departments, hospitals, and nursing homes - Improved use of pharmacy - Increased use of community-based crisis supports - Improved access, health status, quality of life, and satisfaction

Table 8 shows highlights of spending for individuals who are not in one of the "Specialized Programs" but who have been identified as high users. The focus of the logic model for reducing utilization and expenditures for this subgroup is on chronic conditions that could be better managed by system coordination and self-management. This will lead to increased use of evidence-based protocols, increases in self-efficacy, improvements in medication management, and reductions in use of emergency departments and hospitals.

Table 8: Vermont Dual Eligible Population – "Non-Specialized Program" High Users
(Not served by a "Specialized Program" that included case management, and used a high volume of services totaling more than $25,000 per year.)

Major Service Category	Population Count[a]	% of Population	Service Payments	% of Total Payment	$ Per User	$ Per Capita
Diagnostic Testing	1,216	98.3%	$3,334,172	4.6%	$2,742	$2,695
Emergency Department	960	77.6%	$1,391,645	1.9%	$1,450	$1,125
Inpatient Hospital	995	80.4%	$30,488,260	42.2%	$30,641	$24,647

Nursing Home	373	30.2%	$5,898,356	8.2%	$15,813	$4,768
Pharmacy[b]	1,205	97.4%	$12,552,662	17.4%	$10,417	$10,148
Physician	1,225	99.0%	$6,972,135	9.7%	$5,692	$5,636

Inputs	Activities	Outputs	Outcomes
- Protocols to identify, monitor, intervene, and coordinate care for individuals with high use/high cost diagnoses (ICP, ICP-PLUS management), e.g., serious mental illness, multiple chronic conditions - Criteria and systems to search data for individuals with targeted profiles	- Identify clients with target profiles - Assign CHT, ICP, ICP-PLUS team members to identified clients - Develop and implement individualized care plans with clients - Coordinate interventions across physicians, CHT, ICP, ICP-PLUS, and families	- Increased care coordination by specialized providers and teams to support improved management of conditions - Increased participation in chronic disease self-management programs, e.g., diabetes self-management	- Improvements in following care protocols for conditions - Increases in individual self-efficacy - Improvements in medication management - Lower use of emergency departments, hospitals, and nursing homes - Improved use of pharmacy - Improved access, health status, quality of life, and satisfaction

iii. Expected impact on Medicare and Medicaid costs

As noted above in sections F.i. and F.ii., this Demonstration is designed to reduce the overall Medicare and Medicaid costs for dually eligible Vermonters through implementation of the seven core practices noted in the Care Model Overview (Section C), as well as through specific strategies aimed at the subgroups. In sum, the implementation of a single contact and one integrated plan for each beneficiary will lead to more effective prevention and early intervention and less duplication across the individual's medical, mental health, substance abuse, developmental, and long term care settings and providers.

In addition, the Vermont model includes a single pharmacy benefit plan and medication therapy management program for all enrollees, which is expected to lower pharmacy costs through improved medication management, lower administrative costs for providers, and positively impact utilization of high-cost services such as emergency and inpatient visits.

Vermont also anticipates achieving long-term administrative savings through mechanisms such as reduction in the complexity of claims processing, including cross-over claims; simplifying the purchase of Durable Medical Equipment; and elimination of cost-shifting practices and incentives such as coverage of and payment for home health services. On the other hand, there must be initial administrative investments for key model components, such as health information technology, enhanced care coordination staffing, and state staffing to support the performance measurement strategy. However, it is expected that these investments will ultimately result in long-term savings and improved quality of care and life for dual eligible individuals.

Vermont is still in the process of analyzing and refining the integrated Medicare and Medicaid data set necessary to develop detailed financial projections related to potential cost savings. Vermont looks forward to collaborating with CMS over the coming months to analyze these cost and utilization data to identify specific projections for cost reductions and savings.

G. Infrastructure and Implementation

i. State infrastructure/capacity to implement and oversee the Demonstration

Overall Project Responsibility

The Vermont Agency of Human Services (AHS), under the leadership of Secretary Doug Racine, is comprised of a Central Office and the following departments: Department of Vermont Health Access (DVHA); Department of

Disability, Agency and Independent Living (DAIL); Department of Mental Health (DMH); Department for Children and Families (DCF); Department of Health (VDH); and Department of Corrections (DOC). Leadership and staff from AHS, DVHA, DAIL, and DMH have been integrally involved in the development of this Demonstration project and will be directly involved in program implementation.

DVHA Commissioner Mark Larson will oversee this Demonstration in conjunction with AHS staff who have been hired specifically to design and implement the project. Commissioner Larson has been actively involved in the development of this Demonstration proposal, and is perfectly situated to direct the successful implementation of the Demonstration. DVHA is the state department responsible for the management of Medicaid, the Children's Health Insurance Program (CHIP), and other publicly funded health insurance programs in Vermont. With the expected request to consolidate the CFC Demonstration into the GC Demonstration by the end of 2013, DVHA will be the locus of federal accountability for all Medicaid services. In addition, as previously noted in Section C.iv., DVHA is the GC Managed Care Entity (MCE) which has all the administrative functions necessary to perform as a public managed care organization. As the MCE, DVHA also has sub-agreements with the other state entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services). Finally, DVHA is the organizational home for much of Vermont's health care reform initiatives, including Vermont's Blueprint for Health; the VCCI program; health information technology (HIT) strategic planning, coordination and oversight; and development and implementation of the Health Insurance Exchange (Exchange) required by the Patient Protection and Affordable Care Act (ACA). Commissioner Larson reports directly to the AHS Secretary and is a member of the Governor's health care reform leadership team.

The following formal linkages will be the foundation for strategic direction, information exchange and support throughout the Demonstration implementation phases:

- Interagency Duals Steering Committee: The Committee is chaired by the DVHA Commissioner and is comprised of leadership and staff from the Agency of Human Services (AHS), DVHA, the Department of Disabilities, Aging and Independent Living, the Department of Mental Health, the Blueprint for Health, the Vermont Office of Payment Reform, the Vermont Chronic Care Initiative, Duals Project staff, and the contractors hired to work on the Dual Eligible Demonstration plan. The purpose of the Steering Committee is to develop the details of the Demonstration plan which are then shared and discussed at the Stakeholder meetings; identify issues that need to be resolved for moving forward on planning; and assuring integration across multiple State departments and initiatives. This Committee has been meeting weekly or bi-weekly for one to two hours since the beginning of the Demonstration planning process, and is very well attended. It will continue to meet routinely throughout implementation.
- Ongoing monthly Duals Stakeholders meetings, which include open meetings for all interested parties, will continue to meet throughout implementation. Meaningful engagement with Stakeholders will also include the formation of "Work Groups" to advise in the development of enrollee materials, targeted intervention strategies for specific populations, and care coordination training curricula, among others. For a full list of activities, see Appendix 10 - Work Plan and Timeline under "Responsible Parties".
- Weekly AHS Leadership meeting, convened by the Secretary, that includes the Department Commissioners; the Director of AHS Healthcare Operations, Compliance & Improvement; the AHS Chief Information Officer; and the AHS Chief Financial Officer
- Vermont Health Care Reform Leadership meetings

Staffing Specific to the Duals Demonstration Project

Overall leadership of the Demonstration will be provided by the Secretary of AHS (the single State agency) and the DVHA Commissioner. This includes coordination with other aspects of health reform, the Green Mountain Care Board, legislative and congressional staff; and other AHS and DVHA initiatives. Reflecting the scope of the project and intersection with other initiatives, Vermont plans to manage the design and implementation of the Demonstration through a combination of existing State staff, additional State staff, and contractors. See Appendix 11 for an overview of Vermont's existing state infrastructure related to the implementation of this Demonstration.

Additional State Staff

While current State infrastructure provides a solid foundation for this Project, increased workload and workload complexity associated with the development and initial implementation of the Demonstration will require additional State staff. Vermont intends to request federal Demonstration Administrative Support Funding to support the costs for 9.5 positions during development and initial implementation, and for five positions following implementation. Other future staff costs are expected to be supported by administrative funding through the MCE Plan. Actual funding and staffing are contingent on negotiations between CMS and Vermont.

# FTE	Position	Description
1	Project Director	A full time Project Director to oversee the development and initial implementation of the Demonstration. *(Also ongoing support for this position to ensure State compliance with Demonstration requirements including reporting and evaluation activities.)*
0.5	Administrative Assistant	Administrative support during the development and initial implementation of the Demonstration.
1	Policy Unit Attorney	One attorney responsible for specific elements of design including coverage (i.e., benefits) policy, formal processes such as rulemaking, beneficiary rights such as the oversight and administration of grievances, appeals, fair hearings and coverage exception requests, and coordination with the Office of the Ombudsman.
1	Information Technology Manager	One position responsible for ensuring successful design and construction of elements in new eligibility and enrollment systems to support identification of dual beneficiaries and status of enrollment, as well as new beneficiary notices. Includes ongoing business process analysis and improvement, maintaining procedures, and managing business rules engine, improvement in coordination/integration of processes across departments.
2	Payment Reform and Provider Relations specialists	Two positions to develop new provider performance standards; address integration of reimbursement methods and payment reform, including performance incentives; support development of related guidelines and regulations; and develop and manage new contracts with ICP and ICP+ providers.
1	Quality Improvement Specialist	One full-time position to design, provide and coordinate training to care coordinators and other providers in new practices of integrated care. Support development of outcome and performance measures. Support design of quality assurance/quality improvement activities for the Demonstration in conjunction with existing quality improvement staff.
1	Policy Analyst	One policy analyst will be added to the AHS-CO to ensure single state agency oversight and adherence to applicable Medicaid/Medicare standards. *(Also ongoing support for one position to ensure State compliance with Demonstration requirements including ongoing adherence to standards.)*
1	Data Analyst	One data analyst to refine data reporting tools and methods for measuring access, quality, cost, and effectiveness. Support outcome and performance measures and payment incentives in provider contracts. *(Also ongoing support for one position to ensure State compliance with Demonstration requirements including activities related to federal reporting and evaluation.)*
1	Financial Analyst	One financial analyst to refine financial reporting tools and methods. *(Also ongoing support for two positions to ensure State compliance with Demonstration requirements including reporting and evaluation activities.)*

Expected Use of Contractors

The State currently relies on contractors for some core functions. Increased workload and workload complexity associated with the development and initial implementation of the Demonstration will require additional activities from contractors. Vermont intends to request federal Demonstration Administrative Support Funding

to support the contractor costs during development and initial implementation. Other future contractor costs are expected to be supported by administrative funding through the MCE Plan. Actual funding and contracting is contingent on negotiations with CMS.

- Outreach and Education: Develop and distribute materials to beneficiaries, providers, and stakeholders that describe the Demonstration, including enrollment/disenrollment procedures and benefits. This must occur before enrollment begins.
- Customer Service/ Call Center: Vermont currently contracts for customer support related to eligibility and enrollment, including a 1-800 number for beneficiaries to call regarding questions about enrollment and benefits, as well as assisting beneficiaries to select a primary care provider (PCP). The contractor's activities will become more complex due to new opt in/opt processes and the selection of an integrated care provider (ICP/ICP+). This will require the contractor to develop new beneficiary materials and staff training before the enrollment period begins.
- MMIS and claims processing: Vermont currently contracts with an MMIS vendor to process Medicaid claims, make provider payments, collect and manage encounter data, etc. This vendor will need to make significant systems changes to: 1) process new types of claims; 2) pay providers using different rates and/or a blended payment methodology; 3) create payment methodologies linked with performance measures and outcomes as incentives; and 4) track individuals as they opt out of (or back into) the Demonstration; 5) identify PCPs and ICP's for each individual in the Demonstration; 6) modify provider eligibility verification processes to include new beneficiary information for those who have opted out of the Demonstration; 7) create new management, performance and outcome reporting; 8) create new payment methodologies; 9) storage and maintenance of additional Medicare fee schedules; 10) produce management and financial reports to meet the needs of the State for this Demonstration; 11) establish processing logic, discrete funding sources and financial reporting tools to facilitate claims processing on behalf of ICP/ICP+ organizations; and 12) provide technical assistance and support to providers regarding claims submissions. The contractor will need to make these changes to systems and processes before the Demonstration begins.
- Pharmacy: Vermont intends to contract with a pharmacist to guide the development of clinical and operational features that meet all applicable CMS requirements including Medication Therapy Management, coordination with the VCCI program, coordination of DUR initiatives to assure appropriate prescribing, utilization management programs, and integration of the Duals pharmacy benefit from Parts B, D & Medicaid into a unified benefit. Vermont currently contracts with a Pharmacy Benefits Manager (PBM) to assist with pharmacy claims processing and clinical management of the Medicaid pharmacy benefit. The PBM will require a new benefit program for the Demonstration population, including a revised formulary, to meet applicable CMS standards. All pharmacy reporting will have to be modified. These changes must be in place before the Demonstration begins.
- Provider Education and Training: Two core elements of the Vermont Demonstration model are: 1) self-determination/self-directed care, and 2) care coordination that supports holistic treatment and service provision across provider boundaries. These elements are not adequately embedded in the current Vermont service delivery culture. Vermont intends to request funding to contract with a vendor to design and implement an on-going training program and curricula to support provider organizations in making this cultural shift in practice. These activities should occur before the Demonstration begins.
- Technical Assistance for Design and Implementation: Vermont has engaged several contractors to assist with the planning for this Demonstration. Some continued support will be needed in specific areas of design and initial implementation, including:
    - Rate setting and/or 'integration' of Medicaid and Medicare reimbursement mechanisms and rates
    - Actuarial analysis for CMS>Vermont payment structure and DVHA> ICP/ICP+ payment structure
    - Assistance with materials for CMS submission (e.g. MA-PD application, Benefit Package)
    - ICP/ICP-PLUS RFP development and selection criteria
    - Performance / Quality / Outcome measures, targets, and incentives
    - Preparation for CMS Readiness Review
    - Assistance with development of Member Outreach and Marketing materials

Capacity to Receive and Analyze Medicare data
Vermont has the capacity to manage large volumes of Medicaid data, including eligibility and Medicaid claims for people who are dually eligible and coordination of benefits between Medicare and Medicaid. Vermont will expand this capacity to include Medicare data, as described in Staffing and Expected Use of Contractors.

ii. Need for waivers from Medicaid and Medicare Rules

Appendix 12 provides a detailed analysis of the waiver authorities Vermont seeks in order to implement this Demonstration. This list may be amended during negotiations with CMS if approved for implementation.

iii. Plans to expand to other populations and/or service areas if the model is focused on a subset of dual eligibles or is less than statewide

As previously noted, Vermont intends to include all individuals who are full benefit dually eligible for Medicare and Medicaid from the outset of this statewide Demonstration project (with the exception of *PACE Vermont*). As such, there will be no need for a plan to expand to other dually eligible individuals not originally covered.

iv. Overall implementation strategy and anticipated timeline

See Appendix 10 for Vermont's proposed Work Plan and Timeline. Vermont intends to have a Demonstration effective enrollment date of January 1, 2014. Although this timeframe is more than 18 months from the submission of this proposal, Vermont intends to immediately begin an intensive effort to assure that the State is ready to implement the program fully and on time. More specifically, upon submission of the proposal to CMS, Vermont will immediately begin to:

- Develop specific criteria for Integrated Care Providers (ICP) and Integrated Care Providers PLUS (ICP+)
- Continue analyses of Integrated Medicare – Medicaid data to inform areas for targeted intervention to improve quality of care and control costs
- Develop specific State and provider performance and outcome measures, and measures for any evaluation activities required by CMS
- Identify general reimbursement methodologies and parameters for MCE contractual relationships with ICPs and ICPs-PLUS

On November 1, 2012, the MCE will issue a Request for Proposals (RFP) to identify existing Vermont entities with the interest and demonstrated capacity to become a ICP or ICP-PLUS for dual eligible enrollees. The MCE will select entities with which to pursue contractual agreements no later than February 28, 2013, and will develop contacts with these entities no later than April 30, 2013. If an adequate number or distribution of ICP or ICP-PLUS is not identified though this RFP process, DVHA may elect to utilize its VCCI program to provide the enhanced care coordination for dual eligible enrollees who do not have access to an ICP or ICP-PLUS in their geographic region.

Other activities that the State will undertake prior to the CMS readiness review in August 2013 include, but are not limited to:

- Establishing a single integrated DVHA-Medicare pharmacy program
- Establishing specific provider payment methodology and rates between MCE and providers
- Establishing the Demonstration grievance and appeals processes
- Developing the operational capacity to implement State and provider performance and outcomes metrics
- Identifying and then implementing the Information Technology (IT) business processes and requirements for the eligibility, claims, notices, grievance and exit points that are possible for a client. In addition, IT systems will be adapted to implement all financial management steps and reporting for the performance measurement systems

- Developing and providing enhanced care coordination training
- Renew / re-negotiating the Global Commitment to Health and Choices for Care Medicaid 1115 Demonstrations, and incorporate the Dual Eligible Demonstration as appropriate
- Obtaining any necessary additional Vermont legislative approval for implementing the Dual eligible Demonstration program

H. Feasibility and Sustainability

i. Potential Barriers/Challenges

A challenge and an opportunity for the implementation of the Duals Demonstration is the planning and implementation of the Vermont Health Care exchange by 2014 as well as the goal of a single payer health care system in Vermont by 2017. The challenges are related to focusing on multiple significant projects simultaneously and ensuring that all are implemented in an integrated and seamless manner. The Duals Demonstration aligns well with the single payer health care system planning in Vermont as it is, in essence, a proof of concept for the single payer plan. The barriers/challenges involve information technology changes, potential programmatic and/or waiver changes as well as extensive public education. The strategies for addressing all of these challenges involve communication across State government and to consumers, family members, providers and advocates about how changes will impact Vermonters dually eligible for both Medicare and Medicaid. Additionally, to mitigate the implementation challenge of information technology issues, the State has been engaging State IT staff as part of the Duals Steering Committee (internal) to document and plan for changes to various IT systems (MMIS, Eligibility, PBM and other systems).

ii. Statutory/Regulatory Changes

After a review of current State statutes and regulations, no changes have been identified as being necessary in order to move forward with implementation. However, State health care exchange legislation recently passed in the Vermont State Legislature supports implementation of a Dual Eligible Demonstration and provides direction about program design and consumer protections as highlighted in Section D of this proposal. For the full text of H. 559 Section 33 Dual Eligible Project Proposal, see Appendix 9.

iii. New State funds; Contracting prior to implementation

At this time, Vermont has not identified any new State funds that will be required to implement the Demonstration Project. Any new State funds, if needed, will be identified during the remainder of Calendar Year 2012 as Vermont works with CMS on the federal – state financial agreement and the availability of federal Demonstration administrative support funding.

Vermont anticipates successful negotiations with CMS to combine the Global Commitment (GC) to Health Waiver and the Choices for Care Waiver into a single 1115 Medicaid waiver demonstration, effective January 2014. Under the GC framework, Vermont's Agency of Human Services will contract with DVHA as the managed care entity for the dual eligible population. In addition, DVHA will enter into contracts with provider organizations to serve as Integrated Care Providers (ICPs) and Integrated Care Providers PLUS (ICPs-PLUS) prior to implementation of the Demonstration project.

iv. Discussion of the scalability of the proposed model and its replicability in other settings/States

Vermont's model could be easily adapted to other states, including both the delivery system and the financing model. Rather than promoting integration through a private managed care organization, Vermont is proposing a delivery system that builds on the Home and Community-Based Service (HCBS) delivery infrastructure and provider organizations that exist in all states. The model links that infrastructure to the medical care

infrastructure through primary care medical homes, a care model that is being rapidly expanded throughout the country. Rather than fully capitating provider organizations, the model allows for partially capitating providers for home and community-based services, and uses shared savings and quality incentives to spur changes in practice and utilization for both the HCBS system and medical homes. This approach is synchronous with the larger health reform efforts (Accountable Care Organizations - ACO) which will be paid through shared savings and quality incentives rather than full-risk capitation payments. As ACOs develop in Vermont and elsewhere, being able to collaborate with a pre-existing medical home/HCBS partnership is an effective way to expand the scope of ACOs. There is also evidence that maintaining and strengthening existing HCBS agencies may be a more effective and efficient way to deliver and manage home and community-based services rather than giving that responsibility to private MCOs.[12, 13]

v. Letters of support

Please see Appendix 13 for letters of support.

I. CMS Implementation Support—Budget Request

Vermont's budget request is divided into two distinct columns, one for "Implementation" activities occurring in the 18 months prior to startup, and the other for the ongoing 3-year "Demonstration" costs related to management, oversight and reporting activities not covered by the Plan. Staff positions (and activities) are described in the staffing section based on standard State budgeting elements including prevailing pay grades, wages, benefits, fringe costs, and cost allocation. Staff equipment and supplies include the purchase of computer hardware and software, office space, office furniture and equipment, and supplies. Staff travel includes a standard estimate of instate travel, as well as estimated costs for attending future quarterly out-of-state Demonstration project meetings. Anticipated contractor cost estimates are based on current contract rates and anticipated scope of work. See Section G.i. for a description of staffing requests and expected use of contractors. See Appendix 14 for the itemized Budget Request.

J. Additional Documentation (as applicable)

Vermont will provide additional documentation as requested by CMS.

K. Interaction with the Following HHS/CMS Initiatives

The **Partnership for Patients** is a new public-private partnership, supported by Affordable Care Act funding, to make care for Medicare beneficiaries safer, more reliable, and less costly by focusing on two areas: 1) decreasing preventable hospital-acquired conditions; and 2) decreasing preventable complications during transitions from acute-care hospitals to other care settings. There are currently no Partnership-funded Hospital Engagement Networks or Community Based Care Transitions Program (CCTP) sites in Vermont. However, several key Vermont stakeholders have signed the Partnership for Patients Pledge, including the Vermont Association of Hospital and Health Systems, the Area Agency on Aging for Northeastern Vermont, and the Community of Vermont Elders (statewide advocacy and education organization for Vermont seniors). Vermont will work directly with those organizations to incorporate their efforts into the Dual Eligible Demonstration.

Providing more seamless and medically appropriate care during transitions is a stated goal of the Vermont Dual Eligible Demonstration, and this is a required function for the care coordination entities. Vermont will specifically include key aspects of CCTP in the ICP/ICP-PLUS contracts, including but not limited to requiring that

[12] Mitchell, G., J. R. Salmon, et al. (2006). *The relative benefits and cost of Medicaid home and community based services in Florida*. Gerontologist **46**(4): 483-94.
[13] Polivka, L. and H. Zayac (2008). *The aging network and managed long-term care*. Gerontologist **48**(5): 564-72.

ICPs/ICPs-PLUS have formal relationships with acute care hospitals and other providers along the continuum of care, which may include at least one of the following features:

- Initiating care transition services no later than 24 hours prior to discharge
- Providing timely, culturally, and linguistically competent post-discharge education regarding symptoms that may indicate additional health problems or a deteriorating condition;
- Providing assistance to ensure timely and productive interactions between enrollees and post-acute and outpatient providers;
- Providing patient-directed self-management support and relevant information specific to the beneficiary's condition; and
- Conducting comprehensive medication review and management (including, if appropriate, counseling and self-management support).

The Demonstration will build upon the strategies and activities in the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities (Action Plan**). As noted on page 2 of this Action Plan:

> *Individuals, families and communities that have systematically experienced social and economic disadvantage face greater obstacles to optimal health. Characteristics such as race or ethnicity, religion, SES, gender, age, mental health, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to exclusion or discrimination are known to influence health status. While this HHS Disparities Action Plan focuses primarily on health disparities associated with race and ethnicity, many of the strategies can also apply across a wide array of population dimensions.*

Vermont takes this issue seriously. In 2010, the Vermont Department of Health issued ***The Health Disparities of Vermonters Report*** to highlight health disparities in the State, as well as recommended actions to reduce these disparities.[14] These recommendations, which mirror the HHS Action Plan, are embedded in the State's overall health care reform strategies.[15] Examples include increasing the percentage of people who have comprehensive health insurance coverage (Action Plan Strategy I.A.); increasing access to primary care services, medical home and care coordination (Action Plan Strategy I.B.); increasing policies and services focused on prevention and evidence-based public health activities (Action Plan Strategy III.A.); and strengthening the health and human services infrastructure by addressing the gaps in workforce diversity and shortages (Action Plan Goal II).

This Demonstration includes the above strategies, with specific activities designed to ensure that: all beneficiaries have a medical home, with a focus on prevention and evidence-based practice; there is seamless care coordination across all providers that touch a beneficiary; and all services are provided in a manner that is sensitive to the individual's unique circumstance, including ethnicity, cultural background, limited English proficiency, and communication limitations due to disability.

Through its integration with the Blueprint for Health, the Vermont Dual Eligible Demonstration will directly align with the goal of the **Million Hearts Campaign** to aggressively prevent heart attacks and strokes. The Blueprint is designed to promote evidence-based care for the prevention and treatment of chronic disease, including a specific focus on cardiovascular health and the "ABCs" of clinical prevention (appropriate aspirin therapy, blood pressure control, cholesterol control, and smoking cessation). A major goal of this Demonstration is to ensure that all dually eligible Vermonters have routine access to this evidence-based care.

[14] http://healthvermont.gov/research/healthdisparities.aspx
[15] http://hcr.vermont.gov/sites/hcr/files/Strategic%20plan%201%2016%2012.pdf

Appendices

Appendix 1: Principal Diagnoses for "Serious Mental Illness" Analysis (Table A)

Code	*Diagnosis Description*	*Code*	*Diagnosis Description*
29601	MANIC DISORDER-MILD	29523	CATATONIA-SUBCHR/EXACERB
29602	MANIC DISORDER-MOD	29524	CATATONIA-CHR/EXACERB
29603	MANIC DISORDER-SEVERE	29525	CATATONIA-REMISSION
29604	MANIC DIS-SEVERE W PSYCH	29530	PARANOID SCHIZO-UNSPEC
29605	MANIC DIS-PARTIAL REMISS	29531	PARANOID SCHIZO-SUBCHR
29606	MANIC DIS-FULL REMISSION	29532	PARANOID SCHIZO-CHRONIC
29610	RECUR MANIC DIS-UNSPEC	29533	PARAN SCHIZO-SUBCHR/EXAC
29611	RECUR MANIC DIS-MILD	29534	PARAN SCHIZO-CHR/EXACERB
29612	RECUR MANIC DIS-MOD	29535	PARANOID SCHIZO-REMISS
29613	RECUR MANIC DIS-SEVERE	29540	AC SCHIZOPHRENIA-UNSPEC
29614	RECUR MANIC-SEV W PSYCHO	29541	AC SCHIZOPHRENIA-SUBCHR
29615	RECUR MANIC-PART REMISS	29542	AC SCHIZOPHRENIA-CHR
29616	RECUR MANIC-FULL REMISS	29543	AC SCHIZO-SUBCHR/EXACERB
29620	DEPRESS PSYCHOSIS-UNSPEC	29544	AC SCHIZOPHR-CHR/EXACERB
29621	DEPRESS PSYCHOSIS-MILD	29545	AC SCHIZOPHRENIA-REMISS
29622	DEPRESSIVE PSYCHOSIS-MOD	29550	LATENT SCHIZOPHREN-UNSP
29623	DEPRESS PSYCHOSIS-SEVERE	29551	LAT SCHIZOPHREN-SUBCHR
29624	DEPR PSYCHOS-SEV W PSYCH	29552	LATENT SCHIZOPHREN-CHR
29625	DEPR PSYCHOS-PART REMISS	29553	LAT SCHIZO-SUBCHR/EXACER
29626	DEPR PSYCHOS-FULL REMISS	29554	LATENT SCHIZO-CHR/EXACER
29630	RECURR DEPR PSYCHOS-UNSP	29555	LAT SCHIZOPHREN-REMISS
29631	RECURR DEPR PSYCHOS-MILD	29560	RESID SCHIZOPHREN-UNSP
29632	RECURR DEPR PSYCHOS-MOD	29561	RESID SCHIZOPHREN-SUBCHR
29633	RECUR DEPR PSYCH-SEVERE	29562	RESIDUAL SCHIZOPHREN-CHR
29634	REC DEPR PSYCH-PSYCHOTIC	29563	RESID SCHIZO-SUBCHR/EXAC
29635	RECUR DEPR PSYC-PART REM	29564	RESID SCHIZO-CHR/EXACERB
29636	RECUR DEPR PSYC-FULL REM	29565	RESID SCHIZOPHREN-REMISS
29640	BIPOL AFF-MANIC-UNSPEC	29570	SCHIZOAFFECTIVE-UNSPEC
29641	BIPOLAR AFF-MANIC-MILD	29571	SCHIZOAFFECTIVE-SUBCHR
29642	BIPOLAR AFFEC-MANIC-MOD	29572	SCHIZOAFFECTIVE-CHRONIC
29643	BIPOL AFF-MANIC-SEVERE	29573	SCHIZOAFF-SUBCHR/EXACER
29644	BIPOL MANIC-SEV W PSYCH	29574	SCHIZOAFFECT-CHR/EXACER
29645	BIPOL AFF MANIC-PART REM	29575	SCHIZOAFFECTIVE-REMISS
29646	BIPOL AFF MANIC-FULL REM	29580	SCHIZOPHRENIA NEC-UNSPEC
29650	BIPOLAR AFF-DEPR-UNSPEC	29581	SCHIZOPHRENIA NEC-SUBCHR
29651	BIPOLAR AFFEC-DEPR-MILD	29582	SCHIZOPHRENIA NEC-CHR
29652	BIPOLAR AFFEC-DEPR-MOD	29583	SCHIZO NEC-SUBCHR/EXACER
29653	BIPOL AFF-DEPR-SEVERE	29584	SCHIZO NEC-CHR/EXACERB
29654	BIPOL DEPR-SEV W PSYCH	29585	SCHIZOPHRENIA NEC-REMISS
29655	BIPOL AFF DEPR-PART REM	29590	SCHIZOPHRENIA NOS-UNSPEC
29656	BIPOL AFF DEPR-FULL REM	29591	SCHIZOPHRENIA NOS-SUBCHR
29660	BIPOL AFF-MIXED-UNSPEC	29592	SCHIZOPHRENIA NOS-CHR
29661	BIPOLAR AFF-MIXED-MILD	29593	SCHIZO NOS-SUBCHR/EXACER
29662	BIPOLAR AFFEC-MIXED-MOD	29594	SCHIZO NOS-CHR/EXACERB
29663	BIPOL AFF-MIXED-SEVERE	29595	SCHIZOPHRENIA NOS-REMISS
29664	BIPOL MIXED-SEV W PSYCH	29600	MANIC DISORDER-UNSPEC
29665	BIPOL AFF-MIX-PART REM	30110	AFFECTIV PERSONALITY NOS
29666	BIPOL AFF-MIX-FULL REM	30111	CHRONIC HYPOMANIC PERSON
2967	BIPOLAR AFFECTIVE NOS	30112	CHR DEPRESSIVE PERSON

Code	*Diagnosis Description*	*Code*	*Diagnosis Description*
29680	MANIC-DEPRESSIVE NOS	30113	CYCLOTHYMIC DISORDER
29681	ATYPICAL MANIC DISORDER	30120	SCHIZOID PERSONALITY NOS
29682	ATYPICAL DEPRESSIVE DIS	30121	INTROVERTED PERSONALITY
29689	MANIC-DEPRESSIVE NEC	30122	SCHIZOTYPAL PERSONALITY
29690	AFFECTIVE PSYCHOSIS NOS	3013	EXPLOSIVE PERSONALITY
29699	AFFECTIVE PSYCHOSES NEC	3014	COMPULSIVE PERSONALITY
2970	PARANOID STATE-SIMPLE	30150	HISTRIONIC PERSON NOS
2971	PARANOIA	30151	CHR FACTITIOUS ILLNESS
2972	PARAPHRENIA	30159	HISTRIONIC PERSON NEC
2973	SHARED PARANOID DISORDER	3016	DEPENDENT PERSONALITY
2978	PARANOID STATES NEC	3017	ANTISOCIAL PERSONALITY
2979	PARANOID STATE NOS	30181	NARCISSISTIC PERSONALITY
2980	REACT DEPRESS PSYCHOSIS	30182	AVOIDANT PERSONALITY
2981	EXCITATIV TYPE PSYCHOSIS	30183	BORDERLINE PERSONALITY
2982	REACTIVE CONFUSION	30184	PASSIVE-AGGRESSIV PERSON
2983	ACUTE PARANOID REACTION	30189	PERSONALITY DISORDER NEC
2984	PSYCHOGEN PARANOID PSYCH	3019	PERSONALITY DISORDER NOS
2988	REACT PSYCHOSIS NEC/NOS	3060	PSYCHOGEN MUSCULSKEL DIS
2989	PSYCHOSIS NOS	3061	PSYCHOGENIC RESPIR DIS
3010	PARANOID PERSONALITY	3062	PSYCHOGEN CARDIOVASC DIS
2930	ACUTE DELIRIUM	3063	PSYCHOGENIC SKIN DISEASE
2931	SUBACUTE DELIRIUM	3064	PSYCHOGENIC GI DISEASE
29381	ORGANIC DELUSIONAL SYND	30650	PSYCHOGENIC GU DIS NOS
29382	ORGANIC HALLUCINOSIS SYN	30651	PSYCHOGENIC VAGINISMUS
29383	ORGANIC AFFECTIVE SYND	30652	PSYCHOGENIC DYSMENORRHEA
29384	ORGANIC ANXIETY SYNDROME	30653	PSYCHOGENIC DYSURIA
29389	TRANSIENT ORG MENTAL NEC	30659	PSYCHOGENIC GU DIS NEC
2939	TRANSIENT ORG MENTAL NOS	3066	PSYCHOGEN ENDOCRINE DIS
29500	SIMPL SCHIZOPHREN-UNSPEC	3067	PSYCHOGENIC SENSORY DIS
29501	SIMPL SCHIZOPHREN-SUBCHR	3068	PSYCHOGENIC DISORDER NEC
29502	SIMPLE SCHIZOPHREN-CHR	3069	PSYCHOGENIC DISORDER NOS
29503	SIMP SCHIZ-SUBCHR/EXACER	3100	FRONTAL LOBE SYNDROME
29504	SIMPL SCHIZO-CHR/EXACERB	3101	ORGANIC PERSONALITY SYND
29505	SIMPL SCHIZOPHREN-REMISS	3102	POSTCONCUSSION SYNDROME
29510	HEBEPHRENIA-UNSPEC	3108	NONPSYCHOT BRAIN SYN NEC
29511	HEBEPHRENIA-SUBCHRONIC	3109	NONPSYCHOT BRAIN SYN NOS
29512	HEBEPHRENIA-CHRONIC	311	DEPRESSIVE DISORDER NEC
29513	HEBEPHREN-SUBCHR/EXACERB	31200	UNSOCIAL AGGRESS-UNSPEC
29514	HEBEPHRENIA-CHR/EXACERB	31201	UNSOCIAL AGGRESSION-MILD
29515	HEBEPHRENIA-REMISSION	31202	UNSOCIAL AGGRESSION-MOD
29520	CATATONIA-UNSPEC	31203	UNSOCIAL AGGRESS-SEVERE
29521	CATATONIA-SUBCHRONIC	31223	SOCIAL CONDUCT DIS-SEV
29522	CATATONIA-CHRONIC		

Appendix 2: Footnotes for Tables 1 through 8

Table 1: Vermont Dual Eligible Population – ALL

Notes:

1. Dual eligibility is determined by enrollment at the month level and requires concurrent Medicare A, B, or A/B with full Medicaid Benefits
2. Major Service Category is a JEN Associates defined flag that represents both setting and service type and uses institutional provider type, revenue codes, provider specialty, procedure codes and other data types from claims records to define the category. See Appendix 3 for definitions.
3. PACE Vermont excluded from all data.

a. Population counts ≥ 1 and < 11 are considered sensitive data and have been assigned a "5" to maintain table continuity.

b. Medicare Pharmacy payment data is based on projections from 2006-2008 actual data. 2010 reflects projection forward 11.4% annually since 2008.
Version 03222012, Source: iMMRS, VT 2004-2010 PayDatIDyymmUnityNHFix0213 AEK 3/20/2012

Table 2: Vermont Dual Eligible Population – Choices for Care Nursing Facility

Notes:

1. Dual eligibility is determined by enrollment at the month level and requires concurrent Medicare A, B, or A/B with full Medicaid Benefits
2. An Individual is assigned to CFC Nursing Facility if he or she utilizes category of service 0501, 0502, or 0503 services during the 2010 calendar year. An individual may be eligible for multiple subgroups depending on annual service utilization.
3. Major Service Category is a JEN Associates defined flag that represents both setting and service type and uses institutional provider type, revenue codes, provider specialty, procedure codes and other data types from claims records to define the category. See Appendix 3 for definitions.
4. PACE Vermont excluded from all data.

a. Population counts ≥ 1 and < 11 are considered sensitive data and have been assigned a "5" to maintain table continuity.

b. Medicare Pharmacy payment data is based on projections from 2006-2008 actual data. 2010 reflects projection forward 11.4% annually since 2008.
Version 03222012, Source: iMMRS, VT 2004-2010 PayDatIDyymmUnityNHFix0213 AEK 3/20/2012

Table 3: Vermont Dual Eligible Population – Choices for Care Home and Community-Based Services

Notes:

1. Dual eligibility is determined by enrollment at the month level and requires concurrent Medicare A, B, or A/B with full Medicaid Benefits
2. An Individual is assigned to CFC HCBS if he or she utilizes category of service 2701 during the 2010 calendar year. An individual may be eligible for multiple subgroups depending on annual service utilization.
3. Major Service Category is a JEN Associates defined flag that represents both setting and service type and uses institutional provider type, revenue codes, provider specialty, procedure codes and other data types from claims records to define the category. See Appendix 3 for definitions.
4. PACE Vermont excluded from all data.

a. Population counts ≥ 1 and < 11 are considered sensitive data and have been assigned a "5" to maintain table continuity

b. Medicare Pharmacy payment data is based on projections from 2006-2008 actual data. 2010 reflects projection forward 11.4% annually since 2008.
Version 03222012, Source: iMMRS, VT 2004-2010 PayDatIDyymmUnityNHFix0213 AEK 3/20/2012

Table 4: Vermont Dual Eligible Population – Choices for Care Enhanced Residential Care

Notes:

1. Dual eligibility is determined by enrollment at the month level and requires concurrent Medicare A, B, or A/B with full Medicaid Benefits
2. An Individual is assigned to the CFC ERC if he or she utilizes category of service 2717 during 2010 calendar year. An individual may be eligible for multiple subgroups depending on annual service utilization.
3. Major Service Category is a JEN Associates defined flag that represents both setting and service type and uses institutional provider type, revenue codes, provider specialty, procedure codes and other data types from claims records to define the category. See Appendix 3 for definitions.
4. PACE Vermont excluded from all data.

a. Population counts ≥ 1 and < 11 are considered sensitive data and have been assigned a "5" to maintain table continuity

b. Medicare Pharmacy payment data is based on projections from 2006-2008 actual data. 2010 reflects projection forward 11.4% annually since 2008.
Version 03272012, Source: iMMRS, VT 2004-2010 PayDatIDyymmUnityNHFix0213 AEK 3/20/2012.
Questions: tony.kramer@state.vt.us

Table 5: Vermont Dual Eligible Population – Developmental Services

Notes:

1. Dual eligibility is determined by enrollment at the month level and requires concurrent Medicare A, B, or A/B with full Medicaid Benefits
2. An individual is assigned to DS HCBS if he or she utilizes category of service 2703 during the 2010 calendar year. An individual may be eligible for multiple subgroups depending on annual service utilization.
3. Major Service Category is a JEN Associates defined flag that represents both setting and service type and uses institutional provider type, revenue codes, provider specialty, procedure codes and other data types from claims records to define the category. See Appendix 3 for definitions.
4. PACE Vermont excluded from all data.

a. Population counts ≥ 1 and < 11 are considered sensitive data and have been assigned a "5" to maintain table continuity

b. Medicare Pharmacy payment data is based on projections from 2006-2008 actual data. 2010 reflects projection forward 11.4% annually since 2008.
Version 03272012, Source: iMMRS, VT 2004-2010 PayDatIDyymmUnityNHFix0213 AEK 3/20/2012.
Questions: tony.kramer@state.vt.us

Table 6: Vermont Dual Eligible Population – Community Rehabilitation & Treatment

Notes:

1. Dual eligibility is determined by enrollment at the month level and requires concurrent Medicare A, B, or A/B with full Medicaid Benefits
2. An individual is assigned to the CRT if he or she utilizes category of service 0916 during the calendar year 2010. An individual may be eligible for multiple subgroups depending on annual service utilization.
3. Major Service Category is a JEN Associates defined flag that represents both setting and service type and uses institutional provider type, revenue codes, provider specialty, procedure codes and other data types from claims records to define the category. See Appendix 3 for definitions.
4. PACE Vermont excluded from all data.

a. Population counts ≥ 1 and < 11 are considered sensitive data and have been assigned a "5" to maintain table continuity

b. Medicare Pharmacy payment data is based on projections from 2006-2008 actual data. 2010 reflects projection forward 11.4% annually since 2008. Version 03272012, Source: iMMRS, VT 2004-2010 PayDatIDyymmUnityNHFix0213 AEK 3/20/2012. Questions: tony.kramer@state.vt.us

Table 7: Vermont Dual Eligible Population – Traumatic Brain Injury

Notes:

1. Dual eligibility is determined by enrollment at the month level and requires concurrent Medicare A, B, or A/B with full Medicaid Benefits
2. An individual is assigned to TBI if he or she utilizes category of service 2713 during the 2010 calendar year. An individual may be eligible for multiple subgroups depending on annual service utilization.
3. Major Service Category is a JEN Associates defined flag that represents both setting and service type and uses institutional provider type, revenue codes, provider specialty, procedure codes and other data types from claims records to define the category. See Appendix 3 for definitions.
4. PACE Vermont excluded from all data.

a. Population counts ≥ 1 and < 11 are considered sensitive data and have been assigned a "5" to maintain table continuity

b. Medicare Pharmacy payment data is based on projections from 2006-2008 actual data. 2010 reflects projection forward 11.4% annually since 2008.

Version 03272012, Source: iMMRS, VT 2004-2010 PayDatIDyymmUnityNHFix0213 AEK 3/20/2012.
Questions: tony.kramer@state.vt.us

Table 8: Vermont Dual Eligible Population – "Non-Specialized Program" High Users

Notes:

1. Dual eligibility is determined by enrollment at the month level and requires concurrent Medicare A, B, or A/B with full Medicaid Benefits
2. The "Non-Specialized Program" High Users consist of any individual who did not receive services through Choices for Care, Developmental Services, Community and Rehabilitation Treatment, or Traumatic Brain Injury programs during calendar year 2010. Individuals in this group are also associated with aggregate Medicare claims paid exceeding $25,000 for the calendar year.
3. Major Service Category is a JEN Associates defined flag that represents both setting and service type and uses institutional provider type, revenue codes, provider specialty, procedure codes and other data types from claims records to define the category. See Appendix 3 for definitions.
4. PACE Vermont excluded from all data.

a. Population counts ≥ 1 and < 11 are considered sensitive data and have been assigned a "5" to maintain table continuity

b. Medicare Pharmacy payment data is based on projections from 2006-2008 actual data. 2010 reflects projection forward 11.4% annually since 2008.
Version 03272012, Source: iMMRS, VT 2004-2010 PayDatIDyymmUnityNHFix0213 AEK 3/20/2012.
Questions: tony.kramer@state.vt.us

Appendix 3: Major Service Category Definitions

Major Service Category	Definition
Day Health Rehabilitative Services	Includes charges from Day Health Rehabilitative Services
Diagnostic Testing	Laboratory and radiology charges from physician/supplier claims and outpatient hospital revenue center codes
Durable Medical Equipment & Supplies	Medical supplies from Physician/Supplier and DME procedure codes and Outpatient Hospital revenue center codes
Emergency Department	Includes emergency department charges only
Home Health Care	All Home Health charges or selected charges based on revenue center codes
Hospice	All Hospice charges
Inpatient Hospital	All hospital charges associated with an inpatient hospital stay
Mental Health/Substance Abuse Clinic	All charges from outpatient mental health and substance abuse providers
Miscellaneous	Unclassifiable charges that include services without procedure codes, specific provider or service type classifications.
Non-Physician Practitioner	Non-physician professional charges from Physician/Supplier claims and professional components of Outpatient Hospital charges
Nursing Home	All nursing home and SNF claim charges
Outpatient Hospital	Selected Outpatient Hospital charges for use of facilities, includes dialysis and ambulatory surgery center charges
Pharmacy[b]	Pharmacy charges from Physician/Supplier procedure codes and Outpatient Hospital revenue center codes
Physician	Physician charges from Physician/Supplier claims and professional components of Outpatient Hospital charges
Transportation	Ambulance charges from Physician/Supplier procedure codes and Outpatient Hospital revenue center codes
CFC HCBS/ERC, DS, TBI, CRT	Includes charges under Choices for Care Home and Community Based Services, Enhanced Residential Care, Developmental Services, Traumatic Brain Injury, and Community Rehabilitative Treatment programs.

Note: Major service category assignments depend on setting and service combinations and on whether the line item is from an institutional claim type or a non-institutional claim type and is also based on provider type, provider specialty, procedure codes, revenue codes, and other data types. JEN Associates designed this categorization algorithm with the intention to support both the areas of overlap between Medicaid and Medicare as well as the unique benefits offered by each program.

Appendix 4: Vermont Public Managed Care Entity (DVHA) Statewide Network for Adult/Elder Services

Primary & Acute Medical Care

Blueprint for Health Multi-payer Advanced Primary Care Practices
- 95% of PCPs in 2014
- Includes FQHCs

Blueprint Community Health Teams (CHT)

Support and Services at Home (SASH)

DVHA Vermont Chronic Care Initiative (VCCI)

Health Care Specialists

Non-Blueprint Primary Care Practices
- Fewer than 5% of PCPs in 2014

14 Hospitals

Emergency Rooms

Inpatient Hospital Care

Outpatient Hospital Care

Psychiatric Hospitalization

Home Health Agencies / Visiting Nurse Assoc.
- Care Management / Medical Social Worker
- Skilled Nursing
- PT/OT/ST
- Home Health Aid
- Home Environment Assessments

Skilled Nursing Facilities – Post Acute Care

PACE

Mental Health & Substance Abuse Treatment

Designated Agencies (DAs) for Mental Health Services
- MH Emergency /Crisis Stabilization
- Adult Outpatient MH
- Community, Rehabilitation & Treatment (CRT)
  - Case Management
  - Community & Employment Supports
  - Housing and Home Supports
  - MH Counseling / Therapy / Diagnosis-specific Treatment
  - Medication Evaluation & Management
  - Psycho-education and Peer Support

Substance Abuse Treatment Services
(50% of providers are MH DAs)
- Education
- Prevention
- Office-based and residential individual / group assessment & treatment
- Recovery programs

Private Mental Health Practitioners
- Office-based individual / group assessment & treatment
- Medication Evaluation and Management

Long-term Services & Supports
(Includes Choices for Care)

Designated Agencies (DAs) & Specialized Service Agencies (SSAs) for Developmental Services
- Case Management
- Community & Employment Supports
- Home and Family Supports
- Respite
- Clinical Interventions & Crisis Services

Home Health Agencies / Visiting Nurse Assoc.
- Case Management
- Personal Care / Personal Care Attendants
- Homemaker Services
- Community-based Health & Wellness Services / Clinics

Area Agencies on Aging
- Case Management
- Information and referral
- Home-delivered and congregate meals
- Transportation
- Senior centers

Adult Day Providers

Traumatic Brain Injury Providers
(Provided by DAs, HHAs/VNAs & Others)
- Case management
- Rehabilitation Services
- Community & Employment Supports
- Crisis Supports
- Respite
- Long-term Supports

Residential Care / Assistive Living Providers

Skilled Nursing Facilities - LTC

PACE

Consumer-run and Peer Support Organizations
(Examples: Vermont Center for Independent Living, Vermont Psychiatric Survivors, Another Way, Green Mountain Self-Advocates, Catalyst, Pathways to Housing.

Appendix 5

Overview of ICP and ICP-PLUS Organizations in Vermont Dual Eligible Demonstration		
Organizational Entity:	**Integrated Care Providers (ICP)**	**Integrated Care Providers PLUS (ICP-PLUS)**
New Service Expectations: ***Enhanced Care Coordination:*** • Provide a designated care coordinator as a **single point of contact** for enrollee across all needs • Develop a comprehensive individualized needs assessment and **Comprehensive Individual Care Plan** with enrollee across primary, acute, mental health, substance abuse and long term supports and services • **Coordinate all services** in the enrollee's Comprehensive Individual Care Plan • Assure enrollee has **access to and contact with a Primary Care Physician**, preferably in a Blueprint practice if available • Support enrollee during **transitions** • Assist enrollee to **access public benefits** • If desired by the enrollee, **support self-management** of some or all services in enrollee's Individual Plan	✓	✓
In-home Health Services (*e.g.* in-home health services; in-home PT/OT/ST services; medication management support; individually-identified flexible supports)		●
Home and Community Support Services (e.g., attendant care services; assistance in daily living; support to participate in community activities; employment supports; respite; family supports; peer supports; individually-identified flexible supports; adaptive equipment and home modifications; housing supports; DS shared living, group homes and ICF-MR)		●
Mental Health and Substance Abuse Treatment (e.g., counseling / therapy; emergency care/ crisis stabilization; mental health /substance abuse medication management; psycho-education; mental health/substance abuse peer support)		●
Hospice and Palliative Care		●
Durable Medical Equipment		●
Medically-necessary Transportation		●
Assistive Community Care Program (ACCS) and Enhanced Residential Care Program (ERC) for people living in Assistive Living Residences and Level III Residential Care Homes	○	○
Skilled Nursing Facilities	○	○
Blueprint pmpm/ CHT /SASH payments	○	○
Primary and Specialist Medical Care, Private Practice Mental Health Care	○	○
Inpatient / Outpatient Hospital Care	○	○
Psychiatric Hospitalizations	○	○
Laboratory and Diagnostic Tests	○	○
Pharmacy	○	○

KEY:

✓ ***Included in DVHA-ICP and ICP-PLUS contracts, using tiered capitated payment with performance measures.***

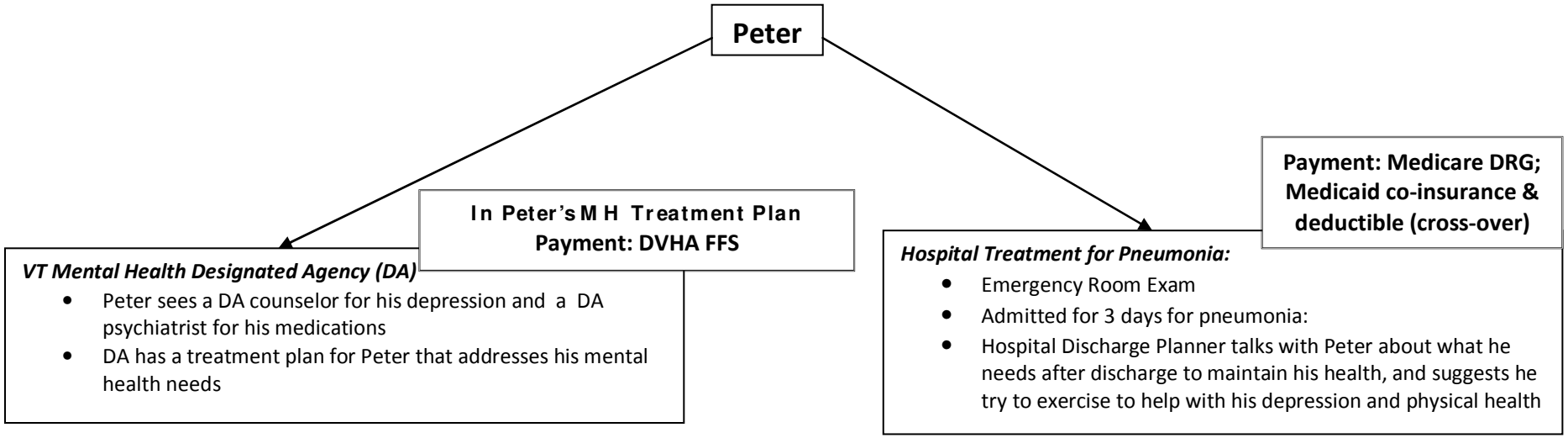
● ***Can be included in DVHA-ICP-PLUS contracts, using tiered capitated payment with performance measures. Provider fiscally responsible for providing or arranging for all covered services within category, as required by Individual Plans. In reviewing ICP-PLUS proposed contracts, DVHA will consider such factors as: demonstrated capacity to provide or arrange for the included services; demonstrated formal relationships with other organizations; organizational financial stability; impact of proposed bundling of services on service provision for non-dual populations in the geographic area; and projected impact on overall health care system costs. Note: Where existing State rules require special designation to deliver a set of services, the ICP-PLUS provider must have signed agreements with those entities to provide services if they are included in the ICP-PLUS contract with DVHA.***

○ ***Not envisioned as part of ICP / ICP-PLUS contracts***

Overview of ICP and ICP-PLUS Organizations in Vermont Dual Eligible Demonstration		
	Integrated Care Providers (ICP)	**Integrated Care Providers PLUS (ICP-PLUS)**
Payment Mechanism	Risk-adjusted (Tiered) Capitated Payment for Enhanced Care Coordination	Risk-adjusted (Tiered) Capitated Payment for Enhanced Care Coordination and Other Agreed-upon Services
Performance Incentive Opportunities And Gain / Loss Mechanisms	***Quality Threshold Incentive Pool*** CMS and AHS will determine quality thresholds for each demonstration year. A % of DVHA's payment will be with-held until the end of the year, and DVHA will receive this amount if it meets the quality standards. DVHA will monitor provider performance based on the agreed upon CMS/AHS quality standards, and will share the quality with-hold payment with the ICP and ICP-PLUS if DVHA meets the CMS/AHS standards, based on the provider's relative performance on the measures. It is expected that these quality standards will include measures of enrollee access, outcomes and satisfaction. ***DVHA Savings Incentive Pool*** DVHA will identify additional projected savings targets for specific areas of expenditures, and will share a % of the year-end actual savings with the ICP and ICP-PLUS. ***Expenditure Reconciliation and Gain / Loss Mechanisms*** At the end of each demonstration year, DVHA will reconcile ICP and ICP-PLUS revenues (including any earned incentive funding) and expenditures. • Loss Provisions: In Year 1 of the Demonstration, an ICP or ICP-PLUS will not be at financial risk for loss in their capitated payment if they meet the CMS/AHS performance standards and its incurred expenses are determined by DVHA to be reasonable and appropriate. However, the ICP or ICP-PLUS will be required to submit, for DVHA review and approval, a Corrective Action Plan to reduce future losses and will be subject to quarterly financial monitoring by DVHA. DVHA retains the right to take any actions it deems appropriate to address program losses, including but not limited to: revising the list of services for which an ICP-PLUS is at risk; capping or reducing ICP/ICP-PLUS enrollment; and terminating the ICP/ICP-PLUS agreement. In subsequent years of the Demonstration, an ICP or ICP-PLUS will be required to absorb losses up to A% within their capitated payment and DVHA will equally share in losses between B% and C%. DVHA will absorb all losses above C%, subject to an aggregate ceiling on additional payment equal to $xxx. The ICP or ICP-PLUS will be required to submit, for DVHA review and approval, a Corrective Action Plan to reduce future losses and will be subject to quarterly financial monitoring by DVHA. DVHA retains the right to take any actions it deems appropriate to address program losses, including but not limited to: revising the list of services for which an ICP-PLUS is at risk; capping or reducing ICP/ICP-PLUS enrollment; and terminating the ICP/ICP-PLUS agreement. *Note: Specific %s to be determined at a later date.* • Gain Provisions: Beginning in Year 1 of the Demonstration, subject to meeting the CMS/AHS quality standards, providers will be permitted to retain up to A% of savings within their capitated payment, and to equally share with DVHA savings between B% and C%. However, the ICP or ICP-PLUs must agree that the funds be used in accordance with a DVHA- provider negotiated reinvestment plan to improve access, quality or cost. (Additional savings revert to DVHA). *Note: Specific %s to be determined at a later date.*

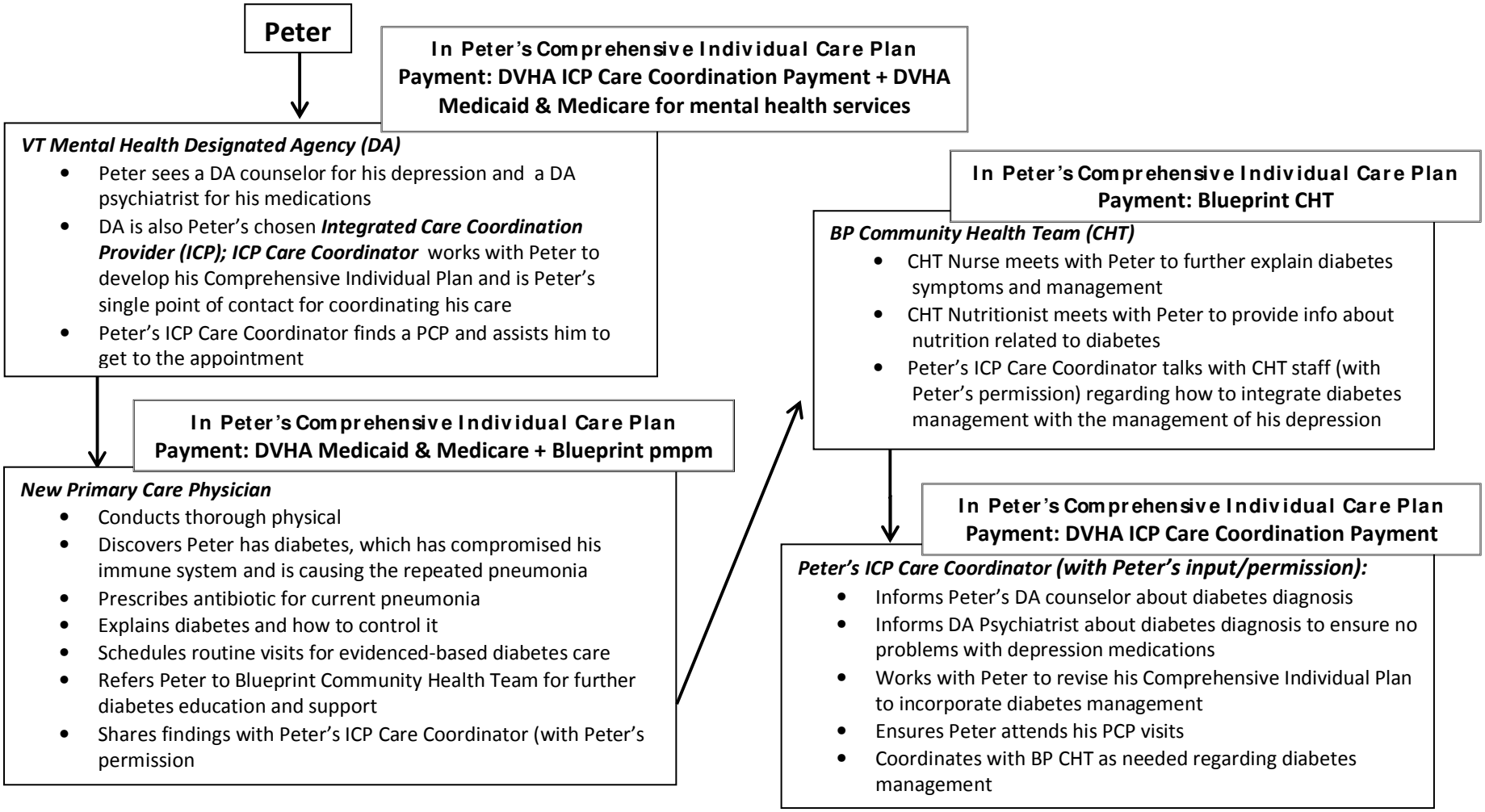
Current Scenario - Peter

Peter is 50. He and his wife rent an apartment and share a car. They both work and take turns driving each other to work. Fifteen years ago he had a very difficult two years dealing with severe depression and was unable to work for several years. He no longer receives cash benefits but he is dually eligible for Medicaid and Medicare. He has tried to get a primary care physician but has been told that practices are not taking new patients. For the last 5 years he has worked part time as a data entry clerk for a local business. He is good at his job and enjoys it but worries that his continuing problems with depression, the side effects of his medication, and repeated bouts of pneumonia may put his job in jeopardy. He recently ended up in the emergency room and was subsequently hospitalized with severe pneumonia. He receives counseling and depression medication management from the local mental health agency.



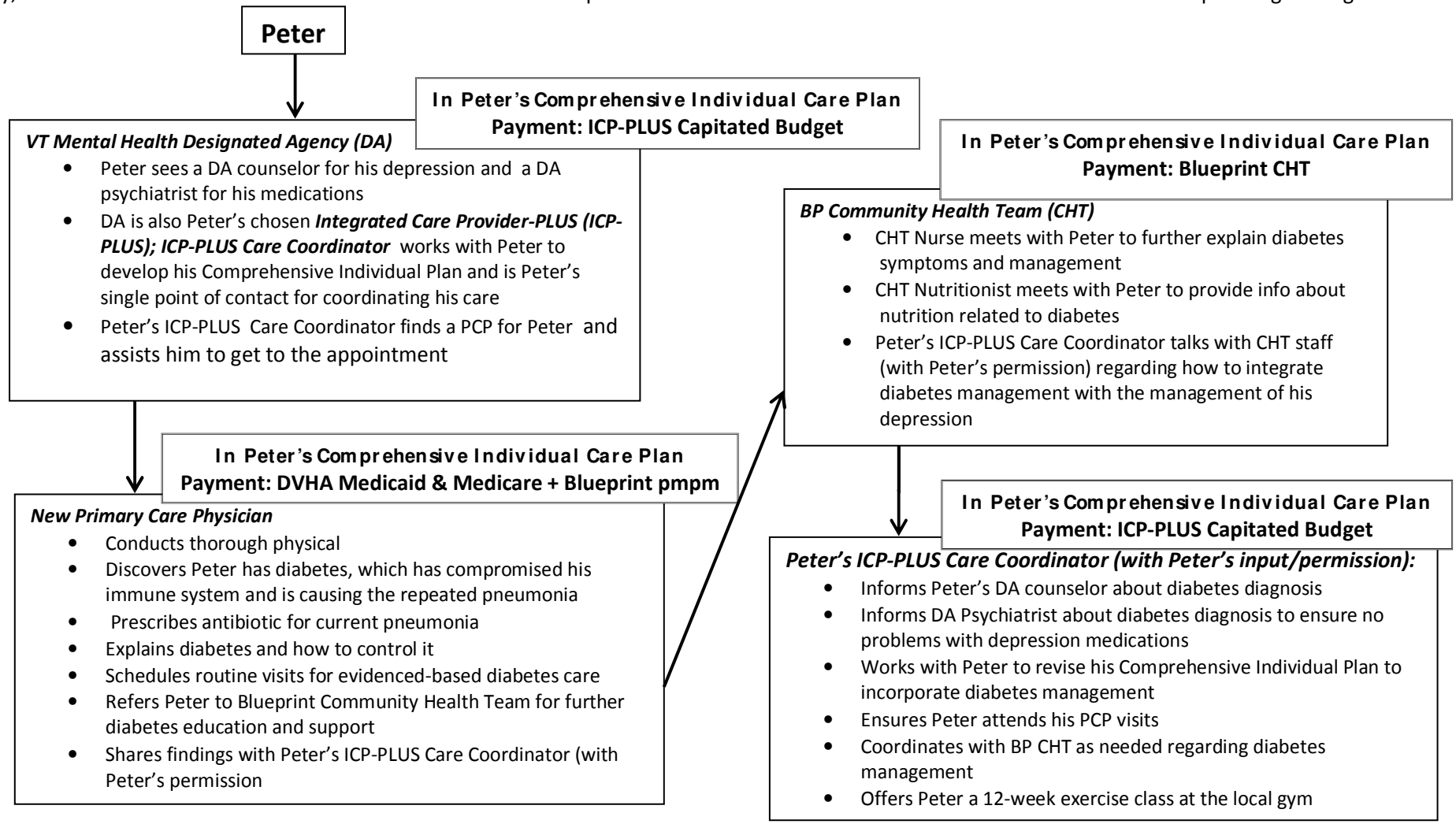
ICP Scenario - Peter

Peter is 50. He and his wife rent an apartment and share a car. They both work and take turns driving each other to work. Fifteen years ago he had a very difficult two years dealing with severe depression and was unable to work for several years. He no longer receives cash benefits but he is dually eligible for Medicaid and Medicare. He has tried to get a primary care physician but has been told that practices are not taking new patients. For the last 5 years he has worked part time as a data entry clerk for a local business. He is good at his job and enjoys it but worries that his continuing problems with depression, the side effects of his medication, and repeated bouts of pneumonia may put his job in jeopardy. He receives counseling and medication management from the local mental health agency, which also is his ICP. His ICP Care Coordinator helps him find a new PCP and ensures that all his care and treatment planning is integrated.



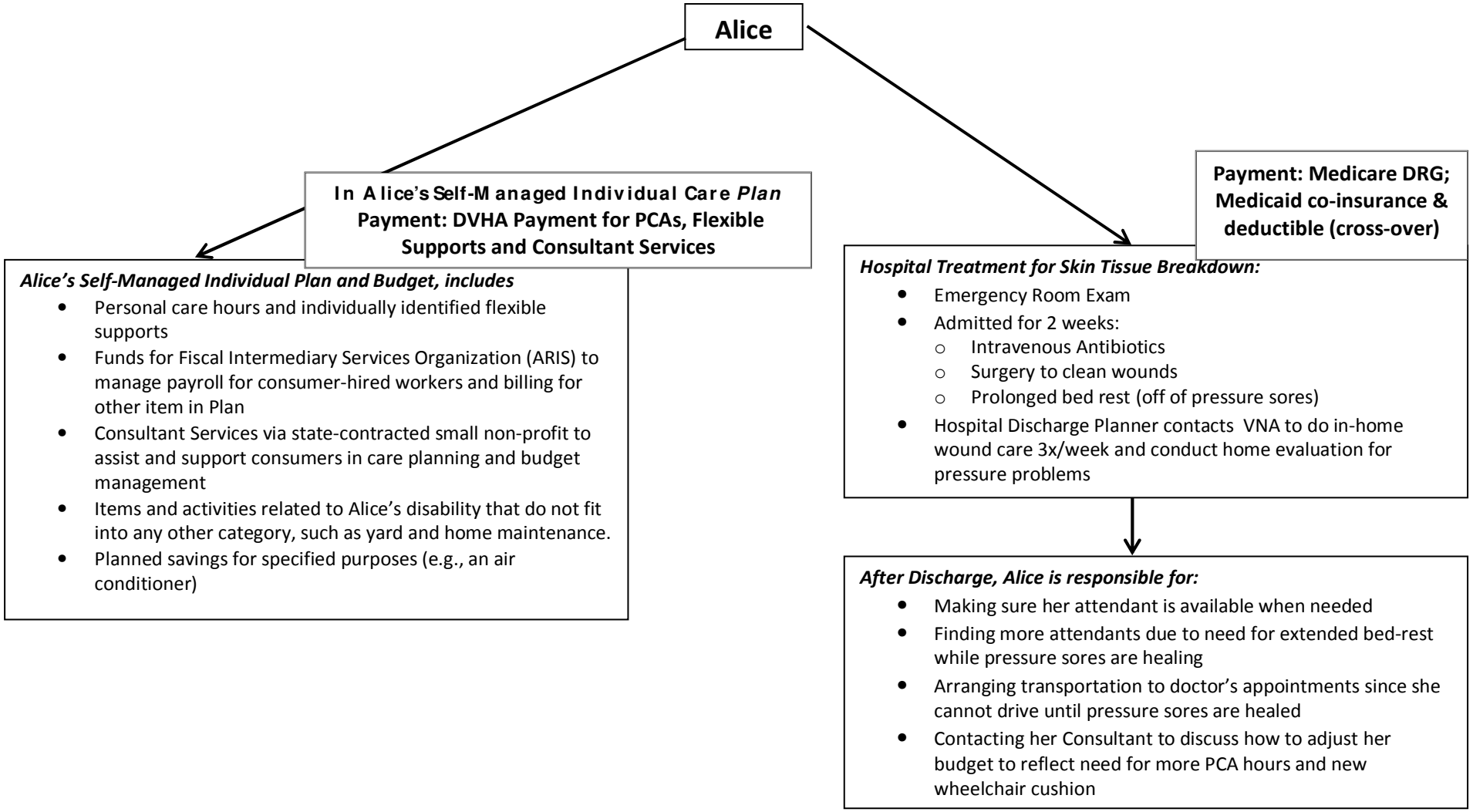
ICP-PLUS Scenario - Peter

Peter is 50. He and his wife rent an apartment and share a car. They both work and take turns driving each other to work. Fifteen years ago he had a very difficult two years dealing with severe depression and was unable to work for several years. He no longer receives cash benefits but he is dually eligible for Medicaid and Medicare. He has tried to get a primary care physician (PCP) but has been told that practices are not taking new patients. For the last 5 years he has worked part time as a data entry clerk for a local business. He is good at his job and enjoys it but worries that his continuing problems with depression, the side effects of his medication, and repeated bouts of pneumonia may put his job in jeopardy. He receives counseling and medication management from the local mental health agency, which also is his ICP-PLUS. His ICP-PLUS Care Coordinator helps him find a new PCP and ensures that all his care and treatment planning is integrated.



Current Scenario - Alice

Alice is enrolled in the Choices for Care 1115 Medicaid Long-term Care Waiver and uses the Flexible Choices (self-management) option. She has pretty reliable personal care; but a few weeks ago her evening Personal Care Attendant (PCA) got sick. She was not able to find good backup coverage and spent a couple nights sleeping in her wheelchair. As a result, she has had trouble with skin breakdown and an infection. She called her primary care physician right away, but the practice was slow to refer her to a specialist. She was admitted to the hospital because of the skin breakdown and a fever and they are having trouble getting the infection under control. Alice wants to start planning for going home.



ICP Scenario - Alice

Alice is enrolled in the Dual Eligibles Demonstration which includes the Flexible Choices (self-management) option. She has pretty reliable personal care; but a few weeks ago her evening PCA got sick. She was not able to find good backup coverage and spent a couple nights sleeping in her wheelchair. As a result, she has had trouble with skin breakdown and an infection. She called her ICP Care Coordinator who contacted Alice's PCP to get a referral to a skin specialist. Her ICP Care Coordinator assisted her to get to the Specialist appointment, and then helped Alice coordinate her follow-up care and obtain additional personal care hours and availability.

Alice

In Alice's Comprehensive Individual Care *Plan*
Payment: DVHA ICP Care Coordination Payment; DVHA Payment for PCAs and Flexible Supports

Alice's Self-Managed Individual Plan and Budget, includes

- Personal care hours and individually identified flexible supports
- Funds for Fiscal Intermediary Services Organization to manage payroll for consumer-hired workers
- Items and activities related to Alice's disability that do not fit into any other category, such as yard and home maintenance
- Planned savings for specified purposes (e.g., an air conditioner)

Home Health Agency X is Alice's chosen ***Integrated Care Provider (ICP)*** and her ***ICP Care Coordinator*** is her single point of contact for coordinating her care, as requested, and is responsible for working with Alice to:

- Develop her Comprehensive Individual Plan across all acute and long-term needs
- Develop her Self-Managed Individual Plan and Budget, if requested, and assuring she gets the services she needs

Alice's Care Coordinator contacts her PCP to get a referral to a skin specialist that day, and then assists her to get to the specialist appointment

In Alice's Comprehensive Individual Care *Plan*
Payment: DVHA Medicaid & Medicare

Specialist Visit for Skin Tissue Breakdown:

- Cleans wounds in office
- Prescribed oral antibiotics
- Extended bed rest (off of pressure sores) , gradually decreasing over 4 weeks
- Suggests PT home evaluation for pressure problems
- Prescribes VNA Nurse for in-home wound care 2x/week
- Scheduled follow-up appointment

In Alice's Comprehensive Individual Care *Plan*
Payments: DVHA ICP Care Coordination Payment; DVHA Payment for PCAs and Services

Alice's ICP Care Coordinator assists her with:

- Arranging for PT home evaluation for pressure problems (bed, wheelchair, shower bench, etc.)
  - Assisting her to obtain a new wheelchair cushion
- Arranging for VNA Nurse to do in-home wound care 2x/week
- Revising her Individual Plan to incorporate need for more personal care hours
- Developing a plan to ensure PCAs are present as scheduled, and she has pre-arranged emergency back-up PCAs in case of a no-show
- Finding PCAs to fill additional hours while on extended bed rest
- Providing requested assistance to Alice to attend scheduled appointments with skin specialist

ICP-PLUS Scenario - Alice

Alice is enrolled in the Dual Eligibles Demonstration which includes the Flexible Choices (self-management) option. She has pretty reliable personal care; but a few weeks ago her evening PCA got sick. She was not able to find good backup coverage and spent a couple nights sleeping in her wheelchair. As a result, she has had trouble with skin breakdown and an infection. She called her ICP-PLUS Care Coordinator who contacted Alice's PCP to get a referral to a skin specialist. Her ICP-PLUS Care Coordinator assisted her to get to the Specialist appointment, and then helped Alice coordinate her follow-up care and obtain additional personal care hours and availability.

Alice

In Alice's Comprehensive Individual Care Plan
Payment: ICP-PLUS Capitated Budget

Alice's Self-Managed Individual Plan and Budget, includes

- Personal care hours and individually identified flexible supports
- Funds for Fiscal Intermediary Services Organization to manage payroll for consumer-hired workers
- Items and activities related to Alice's disability that do not fit into any other category, such as yard and home maintenance
- Planned savings for specified purposes (e.g., an air conditioner)

Home Health Agency X is Alice's chosen ***Integrated Care Provider-PLUS (ICP-PLUS)*** and her ***ICP-PLUS Care Coordinator*** is her single point of contact for coordinating her care, as requested, and is responsible for working with Alice to:

- Develop her Comprehensive Individual Plan across all acute and long-term needs
- Develop her Self-Managed Individual Plan and Budget, if requested, and assuring she gets the services she needs

Alice's Care Coordinator contacts her PCP to get a referral to a skin specialist that day, and then assists her to get to the specialist appointment.

In Alice's Comprehensive Individual Care *Plan*
Payment: ICP-PLUS Capitated Budget

Specialist Visit for Skin Tissue Breakdown:

- Cleans wounds in office
- Prescribed oral antibiotics
- Extended bed rest (off of pressure sores) , gradually decreasing over 4 weeks
- Suggests PT home evaluation for pressure problems
- Prescribes VNA Nurse for in-home wound care 2x/week
- Scheduled follow-up appointment

In Alice's Comprehensive Individual Care *Plan*
Payment: ICP-PLUS Capitated Budget

Alice's ICP-PLUS Care Coordinator assists her with:

- Arranging for PT home evaluation for pressure problems (bed, wheelchair, shower bench, etc.)
  - Assisting her to obtain a new wheelchair cushion
- Arranging for VNA Nurse to do in-home wound care 2x/week
- Revising her Self-Managed Plan to incorporate need for more personal care hours
- Developing a plan to ensure PCAs are present as scheduled, and she has pre-arranged emergency back-up PCAs in case of a no-show
- Finding PCAs to fill additional hours while on extended bed rest
- Providing requested assistance to Alice to attend scheduled appointments with skin specialist
- Using capitation flexibility, Alice's ICP-PLUS coordinator funds a second ramp for Alice.

Appendix 7: Evidence-based Practices Citations

The seven new Core Care Model elements to be introduced into Vermont's system of care through the Demonstration project for Dual Eligible individuals are all based on evidence-based and promising practices defined in the research literature. Following is a sample of this literature and citations that reference them as evidenced-based or promising practices:

Overall Approach across Most or All New Core Model Elements

- Thorpe, K. (2011). *Estimated Federal Savings Associated with Care Coordination Models for Medicare-Medicaid Dual Eligible.* Report sponsored by America's Health Insurance Plans (AHIP), page 2.
- Lind, A. and S. Gore (2010). *From the Beneficiary Perspective*: *Core Elements to Guide Integrated Care for Dual Eligibles.* Technical Assistance Brief, Center for Health Care Strategies.
- Medicare Payment Advisory Commission (2011). *Report to the Congress: Medicare and the Health Care Delivery System, Chapter 5.*

Enhanced Care Coordination with a Single Point of Contact

- Brown, R. (2009). *The Promise of Care Coordination*. Las Vegas, NV: American Society on Aging and the New York Academy of Medicine National Forum on Care Coordination.
- http://www.hhs.gov/secretary/about/priorities/promote.html
- Kodner, D. (2006). *Whole-system approaches to health and social care partnerships for the frail elderly: an exploration of North American models and lessons.* Health & Social Care in the Community 14: 384–390.

Integration with Blueprint Medical/Health Home and a Community Health Team

- Rittenhouse, D., S. Shortell, and E. Fisher (2009). *Primary care and accountable care—two essential elements of delivery-system reform*. New England Journal of Medicine, 361(24): 2301-3
- Peikes, D., A. Zutshi, et al. (2012). *Early Evidence on the Patient-Centered Medical Home.* Final Report (Prepared by Mathematica Policy Research, under Contract Nos. HHSA290200900019I/HHSA29032002T and HHSA290200900019I/HHSA29032005T). AHRQ Publication No. 12-0020-EF. Rockville, MD: Agency for Healthcare Research and Quality.
- Bodenheimer, T. and K. Grumbach (2007). *Improving Primary Care: Strategies and Tools for a Better Practice*. New York: McGraw-Hill.

Individual Assessments resulting in Comprehensive Person-centered Care Plans across Acute, Long-term Care and Social Support Systems

- Kasper, J., M. O'Malley-Watts, and B. Lyons (2010). *Chronic Disease and Co-Morbidity among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*. Kaiser Commission on Medicaid and the Uninsured.
- Komisar, H. and J. Feder (2011). *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*. Georgetown University. Available at: http://www.cahpf.org/docuserfiles/georgetown_trnsfrming_care.pdf.
- Fontenot, T. and A. Stubblefield, co-chairs (2011). *Caring for Vulnerable Populations*. American Hospital Association. 2011 Committee on Research, Chicago: American Hospital Association.

Support during Care Transitions

- Epstein, A. (2009). *Revisiting Admissions – Changing the Incentives for Shared Accountability*. New England Journal of Medicine 360(14): 1457-59.

- Phillips, C., S. Wright, et al. (2004). *Comprehensive discharge planning with post discharge support for older patients with congestive heart failure: a meta-analysis*. Journal of the American Medical Association 291: 1358-67.

- Naylor,M., D. Brooten, et al. (2004). *Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial*. Journal of the American Geriatrics Society 52:675-84.

- Brown, R. (2009). *The Promise of Care Coordination*,. Las Vegas, NV: American Society on Aging and the New York Academy of Medicine National Forum on Care Coordination.

A Single Integrated Pharmacy Benefit Plan

- Wilk, J., J. West, et al. (2008). *Medicare Part D prescription drug benefits and administrative burden in the care of dually eligible psychiatric patients*. Psychiatric Services 59:34–39.

- Prentice, J., S. Pizer, and A. Houranieh, (2011). *Changing Source of Prescription Fills and Medication Gaps.* The American Journal of Pharmacy Benefits 3(2): e14-e22. Available at: http://www.ajpblive.com/media/pdf/AJPB_11mar_PrenticeWebX_e14to23.pdf

- Giberson, S., S. Yoder and M. Lee (2011). *Improving patient and health system outcomes through advanced pharmacy practice.* A report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service.

- W. Doucette, R. McDonough, D. Klepser, R. McCarthy (2005). *Comprehensive Medication Therapy Management: Identifying and Resolving Drug-Related Issues in a Community Pharmacy*. Clinical Therapeutics 27(7): 1104-1111.

- Smith, M., M. Giuliano and P.Starkowski (2011). *In Connecticut: Improving Patient Medication Management In Primary Care*. Health Affairs 30(4): 646 -654.

Payment Reform Connecting Provider Payment with Performance Measures related to Changes in Utilization

- Komisar, H. and J. Feder (2011). *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*. Georgetown University. Available at: http://www.cahpf.org/docuserfiles/georgetown_trnsfrming_care.pdf.

- Maeng, D., J. Graham, et al. (2012). *Reducing Long-Term Cost by Transforming Primary Care: Evidence from Geisinger's Medical Home Model*. American Journal of Managed Care 18(3): 149-155.

- Clemans-Cope, L. and T. Waidmann. (2011). *Improving Care for Dual Eligibles through Innovations in Financing*. New England Journal of Medicine (http://www.nejm.org/doi/full/10.1056/NEJMp1108571).

Improve sharing of health records, assessments, and information

- Komisar, H. and J. Feder (2011). *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*. Georgetown University. Available at: http://www.cahpf.org/docuserfiles/georgetown_trnsfrming_care.pdf.

- Williams, C., F. Mostashari, et al. (2012). From the Office of the National Coordinator: The strategy for advancing the exchange of health information. Health Affairs 31(3): 527-536.

Appendix 8: Dual Eligible Project – Participating Organizations

- Addison County Home Health & Hospice
- Albany School of Pharmacy
- APS Health Care
- Area Agencies on Aging Executive Directors
- Berlin Health & Rehabilitation Center
- Bi-State Primary Care Association
- Burlington Housing Authority
- Cathedral Square Corporation
- Central Vermont Home Health & Hospice
- Champlain Community Services
- Champlain Valley Agency on Aging (CVAA)
- Clara Martin Center
- Community of Vermont Elders (COVE)
- Developmental Services Standing Committee
- Developmental Disabilities Council
- Disability Law Project of Vermont Legal Aid (VLA)
- Fletcher Allen Health Care
- Genesis Healthcare
- Green Mountain Self-Advocates
- Hewlett Packard
- Howard Center for Human Services
- Kittell, Branagan & Sargent, CPA
- Lamoille Community Connections
- Lamoille Home Health Agency
- Mountain View Care Center
- Area Agency on Aging for Northeastern Vermont (NEVAAA)
- Northwestern Counseling and Support Services
- Orleans-Essex County Visiting Nurse Association & Hospice
- PACE Vermont
- Revera Burlington Health & Rehabilitation
- Rutland Area Visiting Nurse Association & Hospice
- Rutland Housing Authority
- Senior Citizen's Law Project of Vermont Legal Aid (VLA)
- Starr Farm Nursing Center
- State Independent Living Council (SILC)
- Support and Services at Home (SASH)
- University of Vermont Center on Aging
- Vermont Assembly of Home Health Agencies
- Vermont Association of Hospitals and Health Systems
- Vermont Center for Independent Living (VCIL)
- Vermont Council of Developmental & Mental Health Services
- Vermont Health Care Association
- Vermont Legal Aid
- Vermont State Medical Society
- Vermont Office of Health Care Ombudsman
- Vermont Psychiatric Survivors
- Visiting Nurse Association of Chittenden and Grand Isle
- Washington County Mental Health Services
- Yankee Medical

Appendix 9

Vermont Legislative 2012 Session

Bill H.559

Subject: Health; health care reform; health insurance; health benefit exchange; Green Mountain Care

Sec. 33. DUAL ELIGIBLE PROJECT PROPOSAL

(a) It is the intent of the general assembly to provide the agency of human services with the authority to enter into negotiations with the Centers for Medicare and Medicaid Services (CMS) to seek waivers as needed to operate an integrated system of coverage for individuals who are eligible for Medicare and Medicaid, and to provide the agency of human services with the authority to implement the program approved by CMS. Any waivers sought pursuant to this section shall promote the health care reform goals established in No. 48 of the Acts of 2011, including universal coverage; integration of health, mental health, and substance abuse treatment; administrative simplification; and payment reform.

(b)(1) The agency of human services may seek a waiver or waivers from CMS to enable the agency to better serve individuals who are eligible for both Medicare and Medicaid ("dual eligibles") through a consolidated program operated by the agency of human services or by a department of the agency of human services. The waiver or waivers sought pursuant to this section may be consolidated with or filed in conjunction with Vermont's Medicaid Section 1115 Global Commitment to Health waiver renewal, any Choices for Care waiver modifications, or a state children's health insurance program (SCHIP) waiver. Any modifications of the Choices for Care waiver shall be consistent with No. 56 of the Acts of 2005.

(2) The agency may seek permission to serve the dual eligibles population through a public managed care organization or through another administrative mechanism that enables the agency to integrate services for the dual eligibles, pursue administrative flexibility and simplification, or otherwise align health coverage programs. The agency shall seek permission to implement payment mechanisms that ensure the health coverage provided under the waiver or waivers is consistent with and supportive of the payment reform initiatives established by the Green Mountain Care board.

(3) The agency shall seek a waiver to create a consolidated program which:

(A) includes eligibility standards, methodologies, and procedures that are neither more restrictive than the standards, methodologies, and procedures in effect as of January 1, 2012 nor more restrictive than the standards, methodologies, and procedures for dual eligible individuals who are not enrolled in this consolidated program.

(B) does not reduce the amount, duration, or scope of services covered by Medicaid and Medicare or impose limits on enrollment or access to services that are more restrictive than those for individuals not enrolled in the consolidated program.

(C) ensures that an individual in the consolidated program receives a level of service that is equivalent to or greater than the individual would have received if he or she were not in the consolidated program.

(D) provides reasonable opportunity for an individual to disenroll from the consolidated program and transition to traditional Medicaid and Medicare coverage.

(E) as provided in the terms and conditions for the Choices for Care Section 1115 waiver, includes an independent advocacy system for all participants and applicants in the consolidated program which includes, at a minimum, access to area agency on aging advocacy, legal services, and the long-term care and health care ombudsmen.

(F) if the agency contracts with an integrated care provider (ICP) then, at a minimum, as required under 42 U.S.C. § 1395a(a), guarantees individuals a choice of health care providers who offer the same service or services within the individual's ICP and a choice of providers for services that
are not offered through the individual's ICP.
(G) unless otherwise appropriated by the general assembly, and after reconciling savings as required by the federal government, invests at least 50 percent of the remaining funds at the end of the state fiscal year to enhance the consolidated program.
(H) maintains state provider payment rates in the consolidated program that:
(i) permit providers to deliver services, on a solvent basis, that are consistent with efficiency, economy, access, and quality of care; and (ii) are at least comparable to the average weighted payment rates that eligible providers would have received from Medicaid and Medicare in the
absence of the consolidated program, subject to modifications as a result of:
(I) changes to federal Medicare rates;
(II) provider rates set by the Green Mountain Care board pursuant to18 V.S.A. § 9376;
(III) rate negotiations between the integrated care provider and the public managed care organization; or
(IV) meeting or failing to meet specified performance measures.
(4) The agency of human services shall enter into a waiver only if it provides individuals enrolled in the consolidated program who become ineligible for Medicaid or Medicare or who choose to opt out of the program with a seamless transition process between coverage provided by the consolidated program and traditional Medicaid coverage, Medicare coverage, or both to ensure that the process does not result in a reduction or loss of services during the transition.
(5) If the agency of human services contracts with an ICP on a risk-sharing basis for services other than care coordination, the following provisions shall be included in the ICP contract:
(A) A broad range of services for individuals, to be provided by the ICP or through contracts between the ICP and other service providers, and coordination between the ICP and other service or health care providers who are not participants in the ICP, as appropriate. Examples of entities that are
unlikely to be part of an ICP include the individual's medical home and the Blueprint for Health community health teams.
(B) An enforcement mechanism to ensure that the ICP and any subcontractors provide integrated services as required by the waiver and the contract provisions.
(C) Transparent quality assurance measures for evaluating the performance of the ICP and any subcontractors and a method for making the measures public.
(6) The agency of human services shall provide dual eligible individuals with meaningful information about their care options, including services through Medicaid, Medicare, and the consolidated program established in this section. The agency shall develop enrollee materials and notices that are accessible and understandable to those individuals who will be enrolled in the
consolidated program, including individuals with disabilities, speech and vision limitations, or limited English proficiency.
(7) The agency of human services shall establish by rule a comprehensive and accessible appeals process, including an opportunity for an individual to request an independent clinical assessment of medical or functional limitations when appealing an eligibility determination, a denial in services, or a reduction in services.
(c)(1) The agency of human services shall implement the program approved by CMS by rule.
(2) Prior to filing proposed rules, the agency shall seek input on the proposed rules from a workgroup that includes providers, beneficiaries, and advocates for beneficiaries.
http://www.leg.state.vt.us/database/status/summary.cfm?Bill=H%2E0559&Session=2012
http://www.leg.state.vt.us/docs/2012/journal/HJ120504.pdf#page=1

Appendix 10: Vermont Work Plan and Timeline

Gray highlighted activities designate official CMS processes and timelines

Timeframe	Key Activities/Milestones	Responsible Parties
July, 2011 – May, 2012 (similar meetings will continue at least until CMS – VT contract approval)	**Twenty-four Stakeholder Advisory Group meetings** • Presentations to consumer representatives, provider and other advocacy groups • Interactive discussions about key elements of the Vermont proposal, including the care model design	VT Duals Project staff
January, 2012	**Beneficiary focus groups** • Eight focus groups to gather information on participants' experience with Medicare, Medicaid and health and community-based service providers • Report sent to all Stakeholder Advisory Group members and published on VT Duals web-site	Finch Network LLC (under contact with VT Duals Project)
February – April, 2012	**Secure state legislative approval for proposal submission**	VT Secretary of Agency Human Services (AHS), Commissioner of Department of Vermont Health Access (DVHA)
February – April, 2012	**Begin analyses of integrated Medicare – Medicaid data to inform proposal to CMS**	VT Duals Project staff & consultants
April 2 – May 1, 2012	**Vermont official public comment period on draft proposal** • Proposal available for submitting public comments to VT	VT Duals Project staff
May 1 – May 9, 2012	**Incorporate Public Comments, Revise Proposal**	VT Duals Project staff & consultants
May 2, 2012	**Submit State Readiness Review Assessment (re: data capabilities) to RTI** • May 7, 2012: Follow-up call with RTI	VT Duals Project staff & consultants
May 10, 2012	**Submit Final Proposal to CMS**	AHS Secretary, DVHA Commissioner

Timeframe	Key Activities/Milestones	Responsible Parties
May 10 – June 8, 2012	**CMS public notice of Vermont Proposal** • Proposal available for submitting public comments to CMS	CMS
May 10 – September 30, 2012	**Develop criteria for Integrated Care Providers (ICPs) and Integrated Care Providers PLUS (ICP-PLUS)**	VT Duals Project staff & consultants, with stakeholder input
May 10 – September 30, 2011	**Continue analyses of Integrated Medicare – Medicaid data to inform areas for targeted intervention to improve quality of care and control costs**	VT Duals Project staff & consultants
May 10 – September 30, 2012	**Develop specific state and provider performance and outcome measures, and measures for any evaluation activities required by CMS**	VT Duals Project staff & consultants, with stakeholder input
May 10 – September 30, 2012	**Identify general reimbursement methodologies and parameters for MCE and ICP / ICP-PLUS contractual relationships**	VT Duals Project staff & consultants, with stakeholder input
June 11 – June 29, 2012	**CMS/State review of public comments, State revisions to proposal**	CMS, VT Duals Project staff & consultants
June – September 11, 2012	**Establish CMS / Vermont payment methodology and rates** • Conduct actuarial analysis • Negotiate rates /risk adjustment methodology • Develop agreement re: how to adjust for service claims that occur before but are paid after the Demonstration begins, and for service claims that occur during the Demonstration but must be paid after the Demonstration ends (claims lag) • Agree on projected savings and shared savings amounts • Agree on quality with-hold amounts • Set rates	CMS, AHS CFO, DVHA Commissioner, VT Duals project staff & consultants

Timeframe	Key Activities/Milestones	Responsible Parties
June – September 11, 2012	**Establish requirements for Vermont financial reporting to CMS** • Identify population and sub-population categories • Identify types / levels of service data for Medicaid and Medicare • Develop mechanisms to adjust for service claims that occur before but are paid after the Demonstration begins, and for service claims that occur during the Demonstration but must be paid after the Demonstration ends (claims lag)	CMS, AHS CFO, DVHA Commissioner, VT Duals project staff & consultants
July 2 – September 11, 2012	**CMS / Vermont MOU Finalization**[16] • Draft MOU/contract terms • Finalize MOU between CMS and Vermont that outlines specific programmatic design elements, technical parameters, waiver requests, and approval package for necessary Medicare and Medicaid authorities and payment/financial models • MOU package goes through CMS approval process; approved MOU signed by CMS and Vermont.	CMS, DVHA Commissioner, VT Duals staff & consultants
July, 2012	**Submit Plan to CMS for Global Commitment enrollees to transition to ACA coverage options by January 1, 2014**	AHS Secretary and DVHA Commissioner
July, 2012 – December, 2013	**Retain / Hire key project staff and consultants** • Obtain CMS Demonstration Administrative Support funds for Vermont project refinement and implementation • Obtain VT legislative authority for continuation of existing and new limited service positions • Develop new job descriptions • Recruit and hire new positions • Retain / establish contracts with consultants	AHS Secretary and DVHA Commissioner VT Duals Project Director
Mid-September, 2012	**MOU signed by CMS and Vermont**	CMS, AHS Secretary and DVHA Commissioner
September, 2012 – February, 2013	**Establish integrated DVHA-Medicare pharmacy program** • Ensure single program meets CMS drug coverage requirements • Ensure program meets MA-PD plan requirements • Develop provider and patient education materials	DVHA Pharmacy Unit and PBM contractor, with stakeholder input

[16] Draft template MOU for capitated model: http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf: appendices to be developed through planning activities with the state include 1) Definitions, 2) CMS Standards & Conditions Checklist/Supporting State Documentation, 3) Details of State Initiative/Geographic Area, 4) Medicaid Authorities and Variances, 5) Medicare Authorities and Variances, 6) Payments to Participating Plans, 7) Operation Manual. Note: work will occur on the MOUs, but no decisions will be made during the public comment period.

Timeframe	Key Activities/Milestones	Responsible Parties
October 1 – 31, 2012	**Draft Request for Proposals (RFP) to identify entities with the interest and demonstrated capacity to become an ICP or ICP-PLUS**	VT Duals Project staff & consultants
October, 2012 – July, 2013	**IT/Systems adaptations for eligibility determination, claims processing and reporting** • Update VIEWS enrollment logic to flag demonstration and opt-out beneficiaries • Modify MMIS - Develop and implement encounter data specs - To accept new ICOs/reflect global payments - To process Medicare claims • Update federal reporting specifications and necessary reporting interfaces	DCF, AHS IT DVHA MMIS contractor AHS Financial Unit VT Duals staff
November, 2012	**State submits Notice of Intent to Apply (NOIA) as a Medicare Health Plan and Medicare Advantage Prescription Drug Plan to CMS**	DVHA Commissioner
November 1, 2012 – February 28, 2013	**Issue Request for Proposals (RFP) to identify entities with the interest and demonstrated capacity to become an ICP or ICP-PLUS** • Release RFP – November 1, 2012 • Responses due – January 1, 2013 • Review responses and select entities with which to pursue contractual agreements – February 28, 2013	DVHA Commissioner, VT Duals Project staff & consultants
December 15, 2012	**State Submits letter of intent to CMS to renew / re-negotiate Global Commitment to Health and Choices for Care Medicaid 1115 Demonstrations** • GC Waiver is approved through December 30, 2013; letter of intent is due at least 1 year before end of Demonstration approval timeframe • VT intends to combine GC and CFC demonstrations through GC renewal / renegotiation process • Duals Demonstration will be included in these discussions	AHS Secretary, CMS
January 1, 2013	**Responses to ICP / ICP-PLUS RFP due to State**	Interested 0rganizations
January 1 – February 28, 2013	**DVHA reviews responses to ICP / ICP-PLUS RFP and selects entities with which to pursue contractual agreements**	DVHA Commissioner

Timeframe	Key Activities/Milestones	Responsible Parties
January – May, 2013	**Obtain VT legislative approval for projected Duals program state expenditures for SFY2014** • Includes any new VCCI staff needed for Duals project	AHS Secretary and DVHA Commissioner
January – May, 2013	**Establish specific provider payment methodology and rates between MCE and providers, including shared savings** • Use integrated data to conduct actuarial analyses	VT Duals Project staff & consultants
January – May, 2013	**Develop the format for the Comprehensive Needs Assessment tool to be used by all ICPs and ICP-PLUS**	VT Duals Project staff , consultants, with stakeholder input
January – May, 2013	**Develop triage protocols between various care coordination entities (BP CHTs, VCCI, SASH, other ICPs and ICP-PLUS)**	Duals Project staff, consultants, care coordination staff
January – May, 2013	**Establish Demonstration grievance and appeals processes**	Duals Project staff, with stakeholder input
January – July, 2013	**Develop operational capacity to implement state and provider performance and outcomes metrics** • Develop mechanisms for capturing data • Develop new analytic views/reports • Implement state infrastructure to collect, monitor and report data	DVHA Commissioner & Dual Project staff
January – December, 2013	**Health Information Technology (HIT) system development** • Ensure that the statewide HIT system incorporates the connectivity and tools necessary to enable individuals and their chosen medical and support providers to access their integrated care plan information on-line.	DVHA Health Care Reform Division – HIT section
Mid-February, 2013	**Submit MA-PD application to CMS** • Applications reviewed between late February and mid-May	AHS Secretary and DVHA Commissioner

Timeframe	Key Activities/Milestones	Responsible Parties
March 1 – April 30, 2013	**Develop ICP / ICP-PLUS contracts**	DVHA Commissioner
Mid-April, 2013	**Submit pharmacy program information to CMS**[17] • Information reviewed by CMS between mid-April and July	AHS Secretary and DVHA Commissioner
May, 2013	**Submit Part D Medication Therapy Management Program (MTMP) to CMS**[18]	AHS Secretary and DVHA Commissioner
Early June, 2013	**Submit VT Demonstration benefit package to CMS**[19] • Information reviewed by CMS in June and July	AHS Secretary and DVHA Commissioner
Mid-June, 2013	**Submit Pharmacy Supplemental Formulary Files, Free First Fill File, Partial Gap Coverage File, Excluded Drug File, Over-the-Counter Drug File, and Home Infusion File to CMS**	DVHA Commissioner
June, 2013 – on-going	**Develop and provide enhanced care coordination training**	VT Duals Provider Education and Training Staff, with stakeholder input
June, 2013 – September, 2013	**Develop Member outreach/marketing and enrollment support materials** • Work with beneficiary representatives to ensure materials are accessible for all beneficiaries	VT Duals Project Staff, with stakeholder input

[17] As provided under 42 CFR 423.120(b) and in Chapter 6 of the Prescription Drug Benefit Manual (refer to http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf), a Part D sponsor that uses a formulary under its qualified prescription drug coverage must meet requirements for the following: Pharmacy and Therapeutics committee; provision of an adequate formulary; a transition process; limitation on changes in therapeutic classification; provision of notice regarding formulary changes; limitation of formulary changes prior to beginning of contract year; provider and patient education; and formulary changes during the contract year.

[18] As provided under 42 CFR 423.153(d) and in Chapter 7 of the Prescription Drug Benefit Manual (refer to http://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter7.pdf), a Part D sponsor must establish an MTMP that is designed to ensure that covered Part D drugs prescribed to targeted beneficiaries (those that have multiple chronic conditions, are taking multiple Part D drugs, and are likely to incur annual drug costs above a certain threshold) are appropriately used to optimize therapeutic outcomes through improved medication use; is designed to reduce the risk of adverse events, including adverse drug interactions, for targeted beneficiaries; may be furnished by a pharmacist or other qualified provider; and may distinguish between services in ambulatory and institutional settings. While services and interventions may vary across setting, the criteria for identifying targeted beneficiaries eligible for MTMP cannot.

[19] For non-demonstration MA plans and PDPs, bids and plan benefit packages are submitted to CMS using standardized software by the first Monday in June preceding the contract year they are bidding for. Plan benefit package submissions detail all the benefits – and associated cost-sharing and limitations – offered under the plan. Demonstration plans will only be required to submit plan benefit packages; no competitive bid will be required.

Timeframe	Key Activities/Milestones	Responsible Parties
June 18 – September 18, 2013	**Three-way contract documents finalized between CMS, State and MCE**	CMS, AHS Secretary, DVHA Commissioner
Mid-July, 2013	**Test IT process for auto assignment of eligible beneficiaries into Duals Demonstration**	AHS IT DCF ESD DVHA MMIS
August 1 – September 19, 2013	**CMS and State readiness review / final preparations** • Review of state, and DVHA capacity and state oversight and monitoring capabilities • Test all operational systems	CMS VT Duals Project Staff
September 20, 2013	**Sign three-way contract between CMS, AHS and MCE** • Contingent on satisfying readiness requirement • Ensure all required waivers and/or state plan amendments are in place. • Ensure all required legislative and budget authority is in place	CMS, AHS Secretary, DVHA Commissioner
Mid-September – early October, 2013	**Medicare roll-out of Medicare plan options** • Will include Vermont Duals Project information	CMS
September 20 - October 1, 2013	**Vermont Marketing and Outreach begins** • Beneficiary notification of Demonstration and information about opt-out procedures (must be received by beneficiaries no later than October 1)	VT Duals Project Staff
October 15 – December 7, 2103	**Annual CMS Coordinated Election period** • Vermont beneficiaries may choose to opt-out of the Demonstration (and on an on-going monthly basis after Demonstration begins)	CMS
October 15 – December, 2013	**VT Duals Demonstration beneficiary selection of PCP and ICP / ICP-PLUS**	Beneficiaries with assistance from VT Duals Project staff and Stakeholder Organizations

Timeframe	Key Activities/Milestones	Responsible Parties
Early December, 2013	**Begin auto assignment of eligible beneficiaries into Duals Demonstration, with an effective date of 1/1/14**	AHS IT DCF ESD DVHA MMIS
January 1, 2014	**New Combined Global Commitment to Health and Choices for Care 1115 Medicaid Demonstration and associated Dual Eligibles Demonstration are effective**	CMS, AHS Secretary
January 1, 2014	**Member enrollment in Duals Demonstration is effective**	

Appendix 11: Vermont Existing State Infrastructure

Vermont will manage many functions associated with the Demonstration through the existing AHS or DVHA state staff infrastructure, such as the following:

- *AHS Secretary's Oversight:* AHS is the designated single state agency in Vermont. The Secretary has designated DVHA as the state unit responsible for the operations of Medicaid program. The Secretary's office provides oversight for waiver operations, including but not limited to creation of an annual intergovernmental agreement (risk contract) with DVHA; contracts for annual independent monitoring by an external quality review organization (EQRO); support for fair hearings, appeals and grievances; review of rules, program enhancement and processes for compliance and improvement.
- *AHS Quality Improvement:* In its role as single State agency the AHS Quality staff review and approve the DVHA quality strategy, EQRO corrective plans and performance improvement projects.
- *AHS Finance Office:* Responsible for all financial, budgetary, accounting, and federal reporting for the Medicaid program; AHS will be responsible for the required federal reporting for this Demonstration.
- *DVHA Data Management and Analysis Unit:* Medicaid/GC data analysis for program operations, policy and budget development, and ad hoc requests; annual Healthcare Effectiveness Data and Information Set (HEDIS) reporting; and other federal and state reporting requiring Medicaid data.
- *DVHA Fiscal and Administrative Operations Unit:* Responsible for all aspects of DVHA fiscal planning, including vendor payments, grants, contracts, purchasing, financial monitoring, budgeting, human resource support, space and operational duties.
- *DVHA Payment Reform and Reimbursement Unit:* Oversees all provider payments and reimbursement methodologies; actively works with the Green Mountain Care Board, Medicaid providers and other stakeholders to transition Vermont's Medicaid program to a system of value based reimbursements.
- *DVHA Coordination of Benefits Unit:* Works with providers, beneficiaries, and other insurance companies (including Medicare Plans) to ensure that Medicaid is the payer of last resort.
- *DVHA Program Policy Unit:* Responsible for coverage rules, fair hearings, grievances and appeals, Health Insurance Portability and Accountability Act (HIPAA) compliance, legislative activities, public record requests, requests for non-covered services, State Plan Amendments, and the Children's Health Insurance Program (CHIP).
- *DVHA Pharmacy Unit:* In conjunction with a Pharmacy Benefit Management (PBM) contractor, manages the pharmacy benefit programs to ensure beneficiaries receive medically necessary medications in the most cost-effective manner. Routinely analyzes drug utilization trends and impact on pharmaceutical costs; resolves benefit and claims processing issues and facilitates appeals related to prescription drug coverage; manages all the state and federal drug rebate programs; and manages the activities of the Drug Utilization Review (DUR) Board, whose members evaluate drugs on the basis of clinical appropriateness and net cost to the State, and make recommendations regarding a drug's clinical management and status on the State's Preferred Drug List (PDL).
- *DVHA Medicaid Health Services and Managed Care Division:* Responsible for all medical and health services provided to beneficiaries by the Managed Care Entity (MCE), including clinical policies and procedures; managing the medical benefits, including utilization management activities; program integrity; provider and member services; measurement and improvement standards; and performance improvement projects.
- *DVHA Health Insurance Exchange Division:* This Division was added to DVHA in 2011 as a result of the ACA. The Exchange Division is tasked with creating the Health Insurance Exchange to provide Vermonters with the means to compare information on available health benefits plans, including private insurance plans and Medicaid; enroll in plans; and receive tax credits or public assistance, if eligible.
- *Department for Children and Family (DCF) Health Access Eligibility Unit:* Responsible for all Medicaid eligibility determinations; Medicare eligibility is provided to DCF through a tape match with Social Security; has a formal MOU with DVHA to ensure interdepartmental coordination and the alignment of all operational and policy decisions impacting Vermont's publically-funded health-care programs; this unit will ultimately be linked to Vermont's Health Insurance Exchange.

Appendix 12: Authorities Needed

The following is a list of specific authorities, as identified by CMS to date, that will be required by Vermont in order to implement its proposed Demonstration:	Medicare Waiver	Medicaid Waiver
In order to implement its Vermont Dual Eligible Demonstration plan, CMS has indicated that Vermont will be required to secure both a waiver of Medicare Advantage payment rules and a waiver of Medicaid actuarial soundness. Specifics in this regard will be further developed during the ongoing negotiations.	X	X
CMS has indicated that a Medicare waiver is necessary to allow Vermont to passively enroll into the Vermont Dual Eligible Demonstration plan and a Medicaid waiver is also necessary to allow for mandatory enrollment in the MAO/MCE.	X	X
CMS has indicated that, in order to implement its proposal, Vermont may require an extension to the Medicare Advantage deadline to demonstrate network adequacy in order to be consistent with the plan selection process in the Dual Eligible Demonstration.	X	
Quality Reporting: CMS has indicated that in order to implement Vermont's proposal, the state may require a Medicare waiver or exemption from existing Medicaid standards, and this could require waiver of certain Medicare and/or Medicaid reporting requirements.	X	X
To implement its proposal, Vermont will require a Medicare waiver to contract solely with DVHA as the plan.	X	
CMS has indicated that there may need to be a waiver of Medicare requirements related to timing (i.e., to meet solvency standards) and that the state should consider any necessary Medicare exemption from MLR.	X	
Appeals: States have the authority under Federal Medicaid regulations to make any necessary changes; however, such regulatory changes and related legislative approval under Medicaid would need to be secured in time for Demonstration implementation. A waiver of Medicare statutory appeal timeframe requirements would be needed to follow State requirements if they are more generous than Medicare standards (e.g., allowable filing time greater than 60 days) and a Medicare waiver to require the plan to pay for service during internal appeal will also be required. Part D appeal standards will remain unchanged and may serve as the basis and model for a unified appeals rule.	X	X
CMS indicates that Vermont requests a Medicare waiver of Part D payment methodologies – (including direct subsidy, reinsurance subsidy, premium for subsidy and cost sharing for subsidy).	X	

Appendix 13: Letters of Support

Congressional Delegation, Senator Patrick Leahy, Senator Bernie Sanders, Congressman Peter Welch

Governor Peter Shumlin

Senate Committee on Health & Welfare, Senator Claire Ayer, Chair

House Committee on Health Care, Representative Michael Fisher, Chair

Green Mountain Care Board, Anya Rader Wallack – Chair

Agency of Human Services, Douglas Racine, Secretary

Department of Mental Health, Patrick Flood, Commissioner

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

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

Vermont Association of Area Agencies on Aging, Ken Gordon, President

Vermont Association for Mental Health and Addiction Recovery, Floyd Nease, Executive Director

Vermont Assembly of Home Health & Hospice Agencies, Peter Cobb, Director

Vermont Medical Society, Paul Harrington, Executive Vice President

Vermont Center for Independent Living, Sarah Launderville, Executive Director

Vermont Council of Developmental & Mental Health Services, Julie Tessler, Executive Director

Vermont Statewide Independent Living Council, Sam Liss, Chairperson

Cathedral Square, Nancy Eldridge, Executive Director

Community of Vermont Elders, Virginia Milkey, Executive Director

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Appendix 14: Budget Request

	Implementation costs (*18 months*)		Demonstration costs (*36 months*)	
		July 2012- December 2013		January 2014-December 2016
Staff salaries and benefits	*fte*		*fte*	
Project Director	*1*	$99,195	*1*	$310,204
Administrative Assistant	*0.5*	$38,735	*0*	*via plan*
Policy Unit Attorney	*1*	$123,377	*0*	*via plan*
Information Technology Manager	*1*	$115,825	*0*	*via plan*
Payment Reform/Provider Relations	*2*	$159,974	*0*	*via plan*
Quality Improvement Specialist	*1*	$109,073	*0*	*via plan*
Policy Analyst	*1*	$43,629	*1*	$274,241
Data Analyst	*1*	$69,995	*1*	$218,891
Financial Analyst	*1*	$69,647	*2*	$437,781
Subtotal	*9.5*	$829,450	*5*	$1,241,117
Cost allocation plan (CAP)		$226,703		$339,219
Subtotal		$1,056,154		$1,580,336
Staff equipment/supplies				
Computer Hardware and Software		$12,958		$11,250
Other Equipment/Space/Printing/ Supplies		$47,944		$74,250
Staff travel				
Quarterly national meetings		$4,000		$12,000
In-state		$12,958		$30,000
Contractor costs				
Outreach and education		$100,000		*via plan*
Customer service/call center		$100,000		*via plan*
MMIS and claims processing		$100,000		*via plan*
Pharmacy		$40,000		*via plan*
Provider education and training		$150,000		*via plan*
Technical assistance		$800,000		$300,000
Subtotal		$1,290,000		$300,000
TOTAL		**$2,424,013**		**$2,007,836**