

**VT Health Care Innovation Project**

**Dual Eligible Work Group Meeting Agenda**

Thursday, December 12th, 2013; 10:00 AM to 12:30 PM

DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT

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

Item #	Time Frame	Topic	Relevant Attachments	Action #
1	10:00 – 10:10	Welcome and Introductions Deborah Lisi-Baker and Judy Peterson	<ul style="list-style-type: none"> <li>• <u>Attachment 1</u>: Meeting Agenda</li> </ul>	
2	10:10 – 10:20	Key Questions Julie Wasserman	<ul style="list-style-type: none"> <li>• <u>Attachment 2</u>: Key Questions Document</li> </ul>	
3	10:20 – 11:50	Strategic Plan for Alignment Brendan Hogan and Susan Besio <ul style="list-style-type: none"> <li>• Unique Opportunities of Duals Demo</li> <li>• Recap Options</li> <li>• Report on Sub-Group meeting</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Attachment 3a</u>: Unique Opportunities of Duals Demo</li> <li>• <u>Attachment 3b</u>: Memo re: The Need for Alignment</li> <li>• <u>Attachment 3c</u>: Memo re: Options for Alignment</li> </ul>	
4	11:50 – 12:10	Decision on Signing the Duals MOU Anya Rader Wallack	<ul style="list-style-type: none"> <li>• <u>Attachment 4</u>: Description of MOU</li> <li>• CMS Link to all Dual Eligible signed MOUs: <a href="https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html">https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsInCareCoordination.html</a></li> </ul>	
5	12:10 – 12:25	Public Comment Deborah Lisi-Baker and Judy Peterson		
6	12:25 – 12:30	Wrap up/Next Steps/Future Meeting Schedule	Next Meeting: January 16 10-12p	

## VT Health Care Innovation Project Duals Work Group Meeting Minutes

**Date of meeting:** December 12, 2013 - 10am – 12:30pm; DVHA Lg Conf Rm – 312 Hurricane Lane, Williston

**Attendees:** Deborah Lisi-Baker, Judy Peterson Co-Chairs: Dion LaShay, Judy Peterson, Alysia Chapman, Julia Shaw, Jason Williams, Todd Moore, Larry Goetschius, Trinka Kerr, Rachel Sedis, Patrick Flood, Matt McMahan, Brendan Hogan, Dale Hackett, Julie Wasserman, Joy Chilton, Mariys Waller, Marybeth McCaffrey, Betsy Davis, Jeanne Hutchins, Jessica Oski, Bea Grause, Tony Kramer, Anya Rader Wallack, Susan Besio, Margaret Joyal, Selina Hickman, Madeleine Mongan, Kara Suter, Julie Tessler.

Agenda Item	Discussion	Next Steps
<b>1 Welcome and introductions</b>	Deborah Lisi-Baker and Judy Peterson called the meeting to order. Introductions around the room.	
<b>2 Key Questions</b>	<u>Document Att #2:</u> Key Questions raised by stakeholders at November 20 meeting, as tracked by Julie Wasserman. Purposed to distill answers at this or future meetings.	
<b>3 Strategic Plan for Alignment</b>	<p><u>Document Att #3a Unique Opportunities for VT DE Demonstration:</u> Brendan Hogan &amp; Susan Besio presented:</p> <p>The benefits of a Dual Eligible Demonstration are:</p> <ul style="list-style-type: none"> <li>- Enables the state to keep Medicare Savings</li> <li>- Pools Medicare and Medicaid funds for DE population</li> <li>- Integrates provider payment mechanisms</li> <li>- Eliminates conflicting and confusing Medicare Medicaid coverage policies for beneficiaries</li> <li>- One integrated pharmacy benefit by the State's PBM</li> <li>- Incorporates needs of individuals with disabilities within state health care reform</li> </ul> <p><u>Document Att3b The Need to Align Duals with Medicare Shared Savings Program &amp; Medicaid SSP:</u></p> <p>Vermont State government supports all 3 initiatives and CMS has supported 2 that are relevant to Medicare: Dual Demonstrations and Medicare ACO program. All 3 programs anticipate a cost savings and improved health outcomes. Alignment of all 3 will :</p>	

Agenda Item	Discussion	Next Steps
	<p><u>Option 3: Include Dual Eligibles in the Duals Demonstration for ALL services, and Contract with the ACO's:</u> DVHA issues RFP and contracts with ACO's that are both Medicare and Medicaid ACO's to provide both medical care and LTSS. DVHA negotiates with CMS a) for safe harbor provisions for a Medicare ACO not participating in the Medicaid ACO program; b) to avoid any downside risk ("-\$'s off the top") to the State under the Duals Demo, since ACO's will not be asked to share in any downside risk for the first 3 years. <b>Pros:</b> the Duals Demo project will encompass all Dual Eligible participants, allowing for true service and financial integration; the State is able to share in some of the Medicare savings generated; Medicare ACO's are likely to enhance their ability to produce shared savings. <b>Cons:</b> ACO's may oppose the arrangement due to expected downside risk connected to CMS reduced spend at a fixed 1% in year #1; fewer Duals will attribute to MCare ACO's making it more difficult for the ACO to reach the minimum 5000 covered lives required for shared savings; DVHA will have to manage 2 models of care, ACO and non-ACO, since not all Duals will be attributed to an ACO. <b>Action steps required:</b> State would maintain its Dual Demo program intact, with the exception that DVHA would have to contract with ACO's for coordination of services that would have been provided by ICP's. Dual Eligibles would not continue to be within the Medicare SSP, but would be served by the same ACO. The State would need to share its financial analysis with ACO's and offer a convincing argument that the potential savings to the MCare SSP would not be adversely affected. The State may wish to negotiate with CMS to eliminate the 1% off the top for the first year, since ACO's are not being asked to share downside risk for the first 3 years. The State would also have to take a leadership position in facilitating a partnership between ACOs and LTSS providers including the development of operational and contractual terms for the parties to work together.</p> <p><u>Option 4: Include Dual Eligibles in the Duals Demonstration programs for ALL Services and negotiate agreements with CMS that make this option Acceptable to the Medicare ACO's:</u> In the 4<sup>th</sup> option, the State would negotiate safe harbor provisions with CMS for Medicare ACO's so they are not penalized by the reduced attribution size or the required minimum savings rate. DVHA would agree to share savings from the Duals Demo with Medicare</p>	

Agenda Item	Discussion	Next Steps
	MOU in support of the Duals project; 2 <sup>nd</sup> by Patrick Flood. Yeas: 9; Nays: 2 by Jason Williams and Margaret Joyal ; and 1 abstention by Todd Moore.	
<b>5 Public Comment</b>	No public comment.	
<b>6 Wrap up/Next steps</b>	Next meeting date : January 16, 2014 10:00 am to 12:30 AHS Training Rm 208 Hurricane Lane - Williston	

*VT Health Care Innovation Project*  
*Dual Eligible Work Group*  
*Key Questions raised by Stakeholders at November meeting*  
**December 12, 2013**

1. Why is the Duals important? The “why” of the Duals needs to be discussed prior to discussion of the four Alignment Options. (Larry Goetschius)
2. How do you reconcile the ACO Shared Savings model with funding for the Designated Agencies who will be asked to provide more services while they are held to the Designated Agency funding cap? (Ray Stout)
3. Given the existence of multiple Medicare Shared Savings ACOs, multiple Medicaid Shared Savings ACOs and multiple ICPs, can you explain to a provider how this will work; it seems a bit complicated. Will a provider have separate contracts with each of these entities? (Julie Tessler)
4. Request to review the plans and capacity for an integrated Duals pharmacy plan at a future Duals Work Group meeting. (John Barbour)

# **Unique Opportunities for Vermont through DE Demonstration Medicare / Medicaid Integration**

- **State management of Medicare funds**
  - Enables State to keep Medicare savings
  - Enables State to put in place the administrative capacities for managing Medicare in preparation for Green Mountain Care
- **Pooled Medicare and Medicaid funding for Vermonters who are among the highest-cost, highest-users of healthcare**
  - Enables service coordination and integration
  - Facilitates the elimination of cost-shifting between Medicare and Medicaid
- **Integrated provider payment mechanisms for Medicare and Medicaid**
- **Consistent provider performance metrics for Medicare and Medicaid**
- **Potential elimination of conflicting and confusing Medicare and Medicaid coverage policies for beneficiaries**
- **One integrated pharmacy benefit plan**
- **Vehicle to explicitly incorporate needs of individuals with disabilities within state health care reform**

**THE NEED TO ALIGN THE VERMONT DUAL ELIGIBLE DEMONSTRATION,  
MEDICARE SHARED SAVINGS PROGRAM  
AND MEDICAID SHARED SAVINGS PROGRAM**

There are approximately 22,000 Vermonters enrolled in both Medicare and Medicaid whose annual expenditures totaled almost \$600 million in 2010. Many, but not all, of these individuals have a disability, all are low income and about half are elderly. Dually-eligible individuals are among the most intense users of health care and long-term services and supports, and their costs are, on average, very high: dually-eligible individuals had health care costs in of \$26,880 per person per year in 2010 on average compared with \$7,876 per person per year in 2010 for Vermonters in general.<sup>1</sup> Moreover, Vermonters who are elderly and/or have chronic illnesses or disabilities experience some of the greatest gaps in care, diminished quality of services and potentially avoidable costs of care of all Vermonters. This population is an obvious focus for improvements in health care value (desired outcomes/cost), given their intense and complex needs, and given that their services are paid for, and governed by the rules of two major payers. In fact, three initiatives are currently underway or in development in Vermont that would potentially improve service delivery for dually-eligible individuals: the Dual Eligible Demonstration, the Medicare Shared Savings ACO Program and the Medicaid Shared Savings ACO Program.

The purpose of this paper is to explain the need to align the Dual Eligible Demonstration, the Medicare Shared Savings ACO Program and the Medicaid Shared Savings ACO Program within Vermont. Vermont state government has supported all three efforts, and the federal government has supported the two that are relevant to Medicare (the Dual Eligible Demonstration and the Medicare ACO Program). These initiatives are consistent with Vermont's health reform efforts, in that they:

- Move away from fee-for-service, volume-based payments for health care services under both Medicare and Medicaid;
- Reward providers for performance relative to meaningful quality measures;
- Focus care and service improvements on some of the highest-cost and highest-need Vermonters.

All three of these programs assume cost savings resulting from their activities based on provision of greater levels of care management and coordination, resulting in improved health outcomes and reductions in inpatient hospitalizations, nursing home stays, and emergency department utilization. While all three programs address these goals, the Dual Eligible Demonstration (the Duals Demo) is unique in that it allows for management of Medicare funds at the state level. The Duals Demo also allows the state to relax certain rules regarding covered services that have long undermined continuity of care and optimal service delivery for dually-eligible individuals. Pursuit of the Duals Demo therefore offers advantages to Vermont that are not available under the other two programs. Pursuit of all three programs could provide Vermont with a unique

## I. Background on the Three Programs

### *Dual Eligible Demonstration*

The Financial Alignment (“Dual Eligible”) Demonstration was authorized through the federal Affordable Care Act to test two financial models designed to improve the delivery and quality of services for Medicare-Medicaid enrollees. In the capitated financial alignment model (which is the model Vermont has chosen), the state, CMS, and a health plan enter into a three-way contract where the plan will provide seamless and comprehensive coverage for integrated Medicare and Medicaid services in return for a combined prospective payment. The state and CMS jointly develop actuarially sound rates for both Medicare and Medicaid funds; and the demonstration provides a new savings opportunity for both the state and CMS. Plans will be paid on a capitated basis for all Medicare Parts A, B, and D and Medicaid services. Rates will be calculated per baseline spending in both programs and anticipated savings that will result from integrated managed care.

The Agency of Human Services (AHS) submitted a proposal to the Centers for Medicare and Medicaid Services (CMS) in May 2012 to participate in the Dual Eligible Demonstration. Under Vermont’s proposal, the Department of Vermont Health Access (DVHA), DVHA would receive funding from Medicare to blend with its current Medicaid funding to provide comprehensive coverage to Vermont’s 22,000 dually eligible beneficiaries as a public Medicaid/Medicare managed care plan. DVHA’s status as a public managed care plan makes a Vermont Dual Eligible Demonstration distinct from those being pursued by other states, where states are contracting with private managed care plans to manage services for dually-eligible individuals. The next step in the process is a non-binding signed Memorandum of Understanding between AHS and CMS that would describe the parameters of the demonstration. After a thorough readiness review conducted by CMS, the demonstration would be officially authorized through a three-way contract between CMS, AHS, and DVHA (as the Medicare-Medicaid Plan).

The Vermont demonstration is tentatively scheduled for April 1, 2015 implementation. The specific terms of the three-way contract are yet to be spelled out, and the State is still assessing the potential costs and benefits of the demonstration program. Twenty-five states originally developed proposals for participating in the program. Fifteen of those states (including VT) received planning grants to help with developing the proposals. Of the 25 original states 8 states have signed Memorandums of Understanding (CA, IL, MA, NY, OH, VA, WA, MN) of these 8 states 6 are managed care demonstrations (CA, IL, MA, NY, OH, and VA) 1 is a fee for service demonstration (WA) and one is an alternative demonstration (MN). Of the 17 states remaining 3 states (AZ, NM and TN) have all withdrawn their proposals primarily due to high Medicare Managed care penetration in their state. Of the 14 states left, 1 other state is pursuing an alternative demonstration approach (OR). This leaves Vermont with 12 other states

### *Medicare Shared Savings Program*

The Medicare Shared Savings Program (MSSP) also was created under the federal Affordable Care Act. Two Vermont ACOs – OneCare Vermont and the Accountable Care Collaborative of the Green Mountains – began participating in the MSSP on January 1, 2013. In addition, a third ACO, organized by five Federally Qualified Health Centers in Vermont, has submitted an application to CMS to become a Medicare ACO starting in 2014 under the name Community Health Accountable Care (CHAC).

Under the MSSP, Medicare beneficiaries with a history of utilizing the services of Medicare ACO primary care providers are “attributed” to an ACO’s network. Beneficiaries are not locked into this network, but the network assumes some accountability for the cost and quality of some of their services.

In order to participate in the MSSP, an ACO must have a minimum of 5,000 attributed lives. OneCare far exceeds this minimum, while ACCGM has approximately 5,000 lives. Approximately half of Vermont’s dually-eligible population is estimated currently to be attributed to one of the two existing Vermont Medicare ACOs. OneCare and ACCGM report that 25% and 4% respectively of their MSSP populations consist of dually eligible beneficiaries.<sup>1</sup>

#### *Covered services*

Medicare shared savings ACOs are not responsible for managing any particular array of services, but rather are eligible to share savings if the “total costs of care” for their attributed population, for Medicare part A (hospital services) and part B (physician services), are less than expected in a given year. The ability to share savings creates, in theory, an incentive to better manage any factors that affect total costs of care.

#### *Covered population*

Medicare beneficiaries are “attributed” to an ACO if their primary care physician is an ACO participant.

#### *Model of care/provider contracting*

Under the MSSP, Medicare contracts with ACOs that have received approval from CMS. To receive approval, an ACO has to demonstrate that it can perform certain administrative and managerial functions. The ACO can include a broad array of

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<sup>1</sup> Email correspondence from Abe Berman of OneCare, September 24, 2013 and from Paul Reis of ACCGM, September 25, 2013.

long-term services and supports, pharmacy, dental, transportation and mental health and substance abuse services.

*Model of Care/provider contracting*

The Medicaid Shared Savings ACO Program will contract with those ACOs that respond to DVHA's fall 2013 RFP and meet state requirements. As explained above, there are currently two operating Medicare ACOs in Vermont and one in development. Two of the three submitted letters of intent in response to the Medicaid ACO procurement and have submitted proposals to participate in the program.

*Savings expectations*

Anticipated primary areas for targeted savings are comparable to those of the Duals Demonstration, with the possible exception of nursing home services. DVHA does not intend to require any savings of the ACOs, although it will only share savings if the ACO savings exceed a minimum threshold and if quality-based performance thresholds are met or exceeded.

## **II. Problems Caused by Non-Alignment across the Three Initiatives and Development of an Integrated plan for the Duals Demonstration, Medicare Shared Savings ACO and Medicaid Shared Savings ACO**

The Dual Eligible Demonstration, the Medicare Shared Savings ACO Program and the Medicaid Shared Savings ACO Program all are intended to work toward the same goals, but they have been developed until recently on separate paths. The state has recognized that their ultimate alignment is essential to eventual success of state health reform and improved care for individuals. Should these three projects continue to proceed independently, a number of challenges should be expected:

- There will be conflicts in assignment of enrollees to one of the three initiatives, especially if individuals move between eligibility categories in a given year;
- Programs could be operating at cross-purposes and attempting to shift costs between them;
- It will be challenging to distinguish the source of savings from separate initiatives when the same providers serve individuals in all initiatives. However, if the Duals Demo and Medicaid SSP were aligned, we would have one source of measurement for savings, and the effectiveness of the interventions could be evaluated based on their own merits.
- Misalignment between the Dual Eligible Demonstration and the Medicaid Shared Savings Program could perpetuate long-standing points of divisiveness across the Medicaid program (e.g., medical care vs. long-term care service and supports) and inhibit a whole-person approach;
- Duplicate activities will be likely, e.g., separate assessments and care plans;

**Analysis of Options for Aligning Attribution between the Dual Eligible Demonstration and the Medicare ACO Program (MSSP)**

Developed by Bailit Health with input from other consultants and staff

We believe that there are four attribution options available to AHS, DVHA, GMCB and the SIM Steering Committee for consideration. They are discussed beginning on the following page with pros and cons discussed for each strategy and relative to the state's objectives as a whole.

**Option One: Continue Existing Attribution to Medicare ACOs for Dual Eligibles**

1. Dual eligibles whose primary care provider is affiliated with a Medicare ACO continue to be attributed to the Medicare ACO for purposes of calculating savings for Medicare Part A and B service costs.
2. Dual eligibles whose primary care provider is not affiliated with a Medicare ACO are attributed to the Duals Demonstration for all Medicare services, costs and potential savings.

**Pros:**

- Medicare ACOs will support the approach, as they would maintain their current opportunity to generate shared savings from the Medicare program for this population of high-cost beneficiaries.
- Both programs continue along current paths.
- State staff can make use of the extensive planning that has gone into the Duals Demonstration.
- The state will not be required to obtain CMS approval of a change in Medicare ACO requirements, or ACO concurrence to modify their CMS Medicare Shared Savings Program agreements.

**Cons:**

- The state's ability to generate Medicare savings through the Duals Demonstration will be diminished due to an approximate 50% significant reduction in the attributed population to the Demonstration, as suggested by a Wakely analysis.
- This reduction in attributed lives may, in turn, reduce overall demonstration financial feasibility as certain administrative costs (e.g., operation of a Medicare claims payment system) will be spread over fewer covered lives.
- With the development of CHAC as a third ACO and anticipated efforts by all three ACOs to grow their attributed population, the Duals Demonstration population is likely to continue to shrink over time.
- Medical care and long-term services and supports are unlikely to be as integrated in a person-centered approach as would hopefully be the case under an integrated Medicare/Medicaid financing model, reducing opportunities for improved care and reduced overall costs.

Medicare savings and the Dual Eligibles Demonstration would not (since the latter would only have LTSS costs associated with it).

**Action Steps:** Under this option, the state would keep its Duals Demonstration fully intact and include dual eligibles who are enrolled in a Medicare ACO. However, because most of the savings for the dual eligibles enrolled in the Medicare ACO are likely to accrue to Medicare, the state would need to conduct a financial analysis to determine whether there is sufficient potential for cost savings across Medicare and Medicaid for the state to provide managed LTSS for dual eligibles within the Medicare ACO if the state is not sharing in any of those savings that it would be helping to generate.

### **Option Three: Include Dual Eligibles in the Duals Demonstration for All Services and Contract with ACOs**

- Dual eligibles are included in the Duals Demonstration.
- DVHA issues a RFP and contracts on behalf of AHS with ACOs that are participants in both the Medicare ACO and the Medicaid ACO programs to be responsible for the full continuum of service needs ( i.e., medical and LTSS) for duals whose primary care provider is affiliated with the ACOs.
- DVHA develops an internal capacity to better integrate the services for those duals whose primary care provider is not affiliated with an ACO.
- The State negotiates safe harbor provisions with CMS for a Medicare ACO that does not participate in the Medicaid ACO program
- DVHA negotiates with CMS that there should not be any downside risk (i.e., x% “off the top”) to the state under the Duals Demonstration since the state will be contracting with current MSSP ACOs and MSSP ACOs are not being asked to share in any downside risk for the first three years of their participation in the program.
- DVHA’s contracts with the ACOs permit a sharing of savings based on an assessment of total cost with consideration of quality measures and a phased transition over time to downside financial risk.

#### **Pros:**

- The Duals Demonstration includes all dual eligibles, allowing for true service and financial integration.

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eligibles-project. In addition, Holahan et al. have quantified potential savings to both state and federal governments of enhanced care management, including for dual eligibles. See Holahan, J., Schoen, C., and McMorrow, S., 2011, *The Potential Savings from Enhanced Chronic Care Management*; Urban Institute, November; accessible at: [www.urban.org/uploadedpdf/412453-The-Potential-Savings-from-Enhanced-Chronic-Care-Management-Policies-Brief.pdf](http://www.urban.org/uploadedpdf/412453-The-Potential-Savings-from-Enhanced-Chronic-Care-Management-Policies-Brief.pdf). See Avalere Health, LLC. “Comparing CMS Spending for a Special Needs Plan’s Enrollees with Medicare Fee-for-Service.” Washington, DC: Avalere Health, LLC. 2010. Finally, states that implemented demonstrations with Evercare found that patients had a lower incidence of hospitalizations, fewer preventable hospitalizations, and less emergency room utilization compared with two control groups. See Kane, R., G. Keckhafer, and J. Robst. 2002. *Evaluation of the Evercare demonstration program final report, contract no. 500-96-0008*. Prepared for the Centers for Medicare & Medicaid Services.

MSSP. The state would also want to make an argument with CMS that there should not be any downside risk (i.e., x% "off the top") to the state under the Duals Demonstration for at least the first year since the state will be contracting with current MSSP ACOs and MSSP ACOs are not being asked to share in any downside risk for the first three years of their participation in the program.

Regardless of whether there is downside risk, the state would also need to come to agreement with the ACOs on the level of savings that would be shared with the ACOs. The ACOs will likely push to stay whole and continue to receive the full 50% of the savings they may now earn under the MSSP; however, the state *may* be able to convince the ACOs to accept a lower percentage of the savings if its financial analysis shows strong likelihood for increased cost savings.

In addition, under this option, it will important for the state to take a leadership role in facilitating partnerships between the ACOs and LTSS providers, including development of operational and contractual terms for the parties to work together. To ensure collaboration, the state should require ACOs to participate in such discussions as part of the Medicaid ACO RFP that was released by DVHA.

**Option Four: Include Dual Eligibles in the Duals Demonstration for All Services and Negotiate Agreements with CMS that Make this Option Acceptable to the Medicare ACOs**

- Dual eligibles are included in the Duals Demonstration.
- The State negotiates safe harbor provisions with CMS for Medicare ACOs so they are not penalized by reduced attribution size or the required minimum savings rate.
- DVHA agrees to share Medicare savings from the Duals Demonstration with the Medicare ACOs.
  - The Duals Demonstration could adopt a shared savings model either identical to, or substantially similar to, the Medicare shared savings model. Under this approach, the DE Demonstration would establish a Medicare spending target (including a minimum savings rate) for individuals attributable to each ACO. If actual Medicare spending is below the spending target, the DE Demonstration would share the savings with the ACO.
  - As an alternative, the Duals Demonstration could agree to provide pro rata payments to ACOs by specifically determining the ratio of dual to non-dual members within each ACO and multiplying the Medicare savings by this ratio.

**Pros:**

- The Duals Demonstration includes all dual eligibles, allowing for true service and financial integration.

Regardless of whether there is downside risk, the state would also need to come to agreement with the ACOs on the level of savings that would be shared with the ACOs. The ACOs will likely push to stay whole and continue to receive the full 50% of the savings they may now earn under the MSSP; however, the state *may* be able to convince the ACOs to accept a lower percentage of the savings if its financial analysis shows strong likelihood for increased cost savings.

In addition, under this option, it will important for the state to take a leadership role in facilitating partnerships between the ACOs and LTSS providers to improve the coordination and quality of care for beneficiaries and maximize savings under both programs.

### **Decision Criteria**

All four of the options that we have identified require significant compromise by one or more central stakeholders. Yet, each of the options delineated above provides the state with a potential path to continue with its Duals Demonstration while also pursuing savings through Medicare ACOs.

In considering these options, we recommend the state consider the following questions when determining which option to pursue:

- Does the option build on existing ACO infrastructure and duals development work?
- Does the option integrate financing and delivery of medical, behavioral health and LTSS services at the *state level*?
- Does the option integrate financing and delivery of medical, behavioral health and long-term services and supports at the *provider level*?
- Does the option allow opportunity for savings?

ATT #4

**TO:** Vermont Health Care Innovation Project Duals Work Group Members  
**FROM:** Anya Rader Wallack, Chair, VHCIP Core Team  
**DATE:** December 4, 2013  
**SUBJECT:** Memorandum of Understanding between the State Of Vermont and the Centers for Medicare and Medicaid Services

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At the last meeting of the Duals Work Group we discussed the pending Memorandum of Understanding (MOU) between the Vermont Agency of Human Services (AHS) and the federal Centers for Medicare & Medicaid Services (CMS), and asked whether the Work Group supported AHS signing an MOU. Julie Wasserman explained the difference between the MOU and an eventual three-way contract between CMS, AHS and the Department of Vermont Health Access (DVHA). The contract will be necessary if the State ultimately pursues the Dual Eligible Demonstration. Julie pointed out that, unlike the contract, the MOU is not binding on the State of Vermont, and allows us to decide not to pursue the Demonstration, prior to signing a contract, without penalty. She also pointed out that:

- Signing the MOU will make the State eligible for additional funding from CMS for 2 years to prepare for the Demonstration (year 1 funding) and to implement the Demonstration (year 2 funding) if we choose to pursue it;
- Signing the MOU will make Vermont Legal Aid and other organizations eligible to apply for federal funding to inform and educate beneficiaries about the Demonstration. There is a deadline of January 14 by which these organizations can apply for the funding. To clarify, in response to a question raised by the Work Group: the organizations can apply for the funds without a signed MOU, but cannot receive funds until a MOU is signed.

Several members of the Work Group requested that they be able to see the actual draft MOU. That seemed like a reasonable request, but I have since come to accept (begrudgingly) that we cannot share the actual document. The document is subject to multiple approvals at the state and federal levels before we can share it. We can, however, share three things:

1. Clarification regarding how the document addresses attribution of Medicare beneficiaries between the Duals Demonstration and the Medicare shared savings ACO program;
2. Links to MOUs signed by other states, which include information very similar to what will likely be included in any final MOU with Vermont;
3. Descriptions of the contents of the MOU and how the MOU addresses issues of key importance to stakeholders.

This document is meant to provide information on all three issues.

through fully integrated service delivery and financing. The partnership will include a Demonstration Contract with the Department of Vermont Health Access (DVHA--the "Plan"), which functions as a public managed care model that will provide integrated benefits to Medicare-Medicaid Enrollees statewide. The individuals who will be eligible to participate in the Demonstration are those beneficiaries who are entitled to benefits under Medicare Part A, enrolled under Medicare Parts B and D, and are receiving full Medicaid benefits, and who have no other comprehensive private or public health insurance.

Individuals who meet at least one of the following criteria will be excluded from the Demonstration:

- Individuals enrolled in partial benefit programs;
- Individuals enrolled in both Medicare and Medicaid who have Comprehensive Third Party Insurance; and
- Individuals with end-stage renal disease (ESRD).

Beneficiaries enrolled in a Medicare Advantage plan who meet the eligibility criteria for the Demonstration may participate in this initiative if they choose to disenroll from their existing program. Beneficiaries who have creditable coverage or Medicare Supplement coverage through a private insurer, and who meet the eligibility criteria for the Demonstration may also participate in this initiative if they choose to disenroll from that coverage.

Under this initiative, DVHA, in a managed care capacity, will be required to provide for, either directly or through subcontracts, Medicare and Medicaid Covered Services, including Part D benefits, and will be encouraged to provide Flexible Benefits, under a capitated model of financing. DVHA will contract with one statewide or multi-region Integrated Care Partnerships (ICPs) responsible for providing enhanced care coordination and integrating a range of physical health, behavioral health and substance abuse, long-term supports and services (LTSS), and developmental services for Medicare-Medicaid Enrollees. Demonstration Enrollees will access prescription drugs through the new Duals Integrated Formulary (DIF) that DVHA will administer, and which will adhere to both Medicare Part D and Medicaid requirements.

Vermont will introduce seven new elements into the service delivery system for Demonstration enrollees:

1. Enhanced care coordination with a single point of contact;
2. Active involvement with a medical/health home and a Community Health Team (CHT), under the Vermont Blueprint for Health advanced primary care practice (APCP) initiative;
3. Individual assessments resulting in comprehensive person-centered, Individualized Plans of Care across physical health, behavioral health and substance abuse,

In addition, AHS will be required to review implementation of Vermont's State Innovation Model (SIM), and other existing or planned initiatives [e.g. Medicare Shared Savings Program (SSP) and/or Medicaid Accountable Care Organizations (ACOs), Blueprint for Health Initiative, modifications to the State's section 1115(a) demonstrations] in an effort to build on lessons learned and improve the implementation of the Dual's Demonstration. This AHS review will include areas such as performance measures, care delivery models, and payment reform mechanisms to ensure alignment across programs where relevant and beneficial.

The State's Health Care Ombudsmen, Long Term Care Ombudsmen, the Disability Law Project, and the Senior Citizens Law Project (all housed in Vermont Legal Aid) will comprise the State's Ombudsman program for this Demonstration. The Ombudsman program will assist Enrollees and prospective Enrollees with questions about the Demonstration, including grievances and appeals. CMS will support Ombudsman training on the Demonstration and its objectives, and CMS and AHS will provide ongoing technical assistance to the Ombudsman.

CMS, AHS, and DVHA will ensure that all medically necessary, covered benefits are provided to Enrollees and are provided in a manner that is sensitive to the individual's functional and cognitive needs, language, and culture, and allows for involvement of the Enrollee and caregivers (as permitted by the Enrollee). CMS, AHS, and DVHA shall ensure that care is person-centered and can accommodate and support self-direction. DVHA also will ensure that Enrollees have the option to receive LTSS in the least restrictive setting when appropriate, with a preference for the home and the community, and in accordance with the Enrollee's wishes and Individualized Plan of Care.

### *C. A description of payment arrangements under the Demonstration*

DVHA will use blended Medicare and Medicaid funds to pay for Enrollee services. CMS will make separate payments to DVHA for the Medicare Parts A/B and Part D components of the rate. AHS will make a payment to DVHA for the Medicaid component of the rate, using the existing Global Commitment mechanisms.

To calculate payment rates from CMS to AHS for the purposes of the Demonstration, CMS and AHS will first calculate baseline expenditures for Medicare and Medicaid. Baseline spending is an estimate of what would have been spent in the payment year had the Demonstration not existed. The baseline costs include three components: Medicaid, Medicare Parts A/B, and Medicare Part D. Payment rates will be determined by applying required savings percentages to the baseline spending amounts (see below).

Prior to implementation of the Demonstration, AHS will be responsible for establishing the baseline spending for Medicaid services that will be included under the Demonstration using the most recent data available. AHS will use the same methodology used for the Global Commitment Medicaid Demonstration.

that provide specialty case management/care coordination for Enrollees in the existing CfC, Developmental Services (DS), Community Rehabilitation (CRT), and Traumatic Brain Injury (TBI) programs. There will be only one ICP serving a given geographic area.

**ICPs-Plus**, which may be implemented after year one of the Demonstration. ICPs-Plus would receive a capitation payment from DVHA for a bundled array of services, in addition to providing enhanced care coordination.

**ICP Accountable Agents**, which will contract with DVHA on behalf of all their ICP members.

**Enhanced Care Coordinators (ECCs)**, who will be employed by an ICP or ICP-Plus, and will be the single point of contact for all of an Enrollee's physical health, behavioral health and substance abuse, LTSS, and developmental services. The ECC must develop a comprehensive individualized care plan and ensure that Enrollees receive necessary services in a person-centered and integrated manner to enhance their quality of life, health outcomes, and well-being.

**Interdisciplinary Care Teams (ICTs)**, which will be comprised of members according to the specific needs of each Enrollee at any given time, as defined in the Enrollee's CIPC.

All language included in the current draft of the MOU is subject to change, but I am happy to describe these sections or additional sections in more detail if needed. Please call me at (617) 694-0424 if you have questions or want more detail.