VT Health Care Innovation Project
Dual Eligible Work Group Meeting Agenda
Thursday, January 16th, 2014; 10:00 AM to 12:30 PM
AHS Training Room, 208 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	• Attachment 1: Meeting Agenda	
2	10:10-10:20	**Staff Housekeeping:** Erin Flynn 1. Conflict of Interest Policy 2. Grant Program	• Attachment 2a: COI Policy • Attachment 2b: Grant Program DRAFT Application	
3	10:20-11:20	**Decision on Signing the Duals MOU – Update and Discussion of Implications for the Work Group** Anya Rader Wallack and Robin Lunge		
4	11:20-12:00	**Overview of the Duals Model of Care** Julie Wasserman	• Attachment 3: Dual Eligible Model of Care PowerPoint	
5	12:00 – 12:15	**Public Comment** Deborah Lisi-Baker and Judy Peterson		
6	12:15 – 12:30	**Wrap up/Next Steps**		

CONFLICT OF INTEREST POLICY

For

VERMONT HEALTH CARE INNOVATION PROJECT (VHCIP) CORE TEAM, STEERING COMMITTEE AND WORK GROUPS

I. PURPOSE

The purpose of this Conflict of Interest Policy is to ensure the independence and impartiality of the VHCIP Governance Structure, including the Core Team, Steering Committee and Work Groups ("the Committee") when it is contemplating entering into a transaction or arrangement that might benefit the private interest of any Core Team, Steering Committee or work group member. Nothing in this policy shall relieve any person from compliance with additional conflict of interest policies such as the Executive Code of Ethics, state personnel policies, and Agency of Administration bulletins, including but not limited to Bulletin 3.5, Contracting Procedures.

II. DEFINITIONS

1. Interested person: Any member or subcommittee member or other individual in a position to exercise influence over the affairs of the Committee who has a direct or indirect interest, as defined below, is an "interested person."

2. Interest: A person has an "interest" if the person has, directly or indirectly, through business, investment, or family:

    a. An ownership or investment interest in any entity with which the Committee has an transaction or arrangement or is negotiating a transaction or arrangement, or

    b. A compensation or other pecuniary arrangement with the Committee or with any entity or individual with which the Committee has a transaction or arrangement or is negotiating a transaction or arrangement, or

    c. A potential ownership or investment interest in, or compensation or pecuniary arrangement with any entity or individual with which the Committee is negotiating a transaction or arrangement, or

    d. Any other relationship that the person determines may compromise his or her ability to render impartial service or advice to the Committee.

Compensation includes direct and indirect remuneration as well as gifts or favors that are substantial in nature.

An interest is not necessarily a conflict of interest and a conflict of interest does not arise where an individual's interest is no greater than that of other persons generally affected by the outcome of the matter.

III. PROCEDURES

1. Duty to Disclose: Any interested person must disclose the existence of his or her interest to the Committee and shall be given the opportunity to disclose all material facts to the Committee.

2. Duty to Voice Concerns: In the event any member becomes concerned that an interested person has an undisclosed interest or is exerting inappropriate influence related to an interest, this concern shall be raised with the Chair of the Core Team and the VHCIP Project Director.

3. Determining Whether a Conflict of Interest Exists: After disclosure of the interest and all material facts, and after any necessary discussion with the interested person, the Core Team shall determine whether the person has a conflict of interest that requires the interested person to remove him or herself from the matter under consideration. In no event shall an interested person participate in the deliberation and/or determination of any matter in which he or she will receive any compensation from the Committee for employment, professional contract, or otherwise.

4. Restriction on Participation: It shall be the responsibility of the Project Director to instruct an interested person on any restriction on his or her participation in any consideration of the subject matter of the conflict of interest, and it shall be the responsibility of the Project Director and all non-interested members of the Committee to enforce such restrictions.

5. Procedures for Addressing the Conflict of Interest:

    a. An interested person shall leave any Committee meeting during discussion of, and the vote on, any transaction or arrangement that involves a conflict of interest and shall otherwise not participate in the matter in any way.

    b. If necessary, the Chair of the Core Team shall appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.

    c. After exercising due diligence, including consideration of independent comparability data, valuations, estimates, or appraisals, the Committee shall determine whether the Committee can obtain a more advantageous transaction or arrangement with reasonable effort from a person or entity that would not give rise to a conflict of interest.

    d. If a more advantageous transaction or arrangement is not reasonably attainable under circumstances that would not give rise to a conflict of interest, the Core Team shall determine by majority vote (or quorum) of all of the disinterested members (regardless of the number present at the meeting): (1) whether the transaction or arrangement is in the public's best interest, (2) whether the transaction or arrangement is fair and reasonable to the Committee, and (3) whether to enter into the transaction or arrangement consistent with such determinations.

6. Records of Proceedings: The minutes of the Committee or affected sub-committee shall contain:

    a. The names of the persons who disclosed or otherwise were found to have an interest in connection with an actual or possible conflict of interest.

    b. The names of the persons who were present for the discussion and votes relating to the transaction or arrangement, the content of the discussion, including a summary of any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection with the discussion.

7. Violations of the Conflict of Interest Policy:

    a. If the Committee has reasonable cause to believe that an interested person has failed to disclose actual or possible conflicts of interest, it, through the Co-Chairs, shall inform the Core Team and the Core Team shall afford him or her an opportunity to explain the alleged failure to disclose.

    b. If, after hearing the response of the person and making such further investigation as may be warranted under the circumstances, the Core Team determines that he or she has in fact failed to disclose an actual or possible conflict of interest, it shall take appropriate action.

IV. ANNUAL STATEMENTS

a. Each Committee member shall annually sign a statement which affirms that he or she has received a copy of this Conflict of Interest Policy, has read and understands the Policy, and has agreed to comply with the Policy (Attachment A).

V. COMPLIANCE AND PERIODIC REVIEWS:

The Core Team shall make periodic reviews of compliance with this policy.

Adopted by the VHCIP Core Team

Date: 12.9.13

Attachment A:

CONFLICT OF INTEREST POLICY ACKNOWLEDGEMENT

I, _____, a participant in the Vermont Health Care Innovation Project (VHCIP) Grant governance process, acknowledge having received, read, and understood the VHCIP Grant Conflict of Interest Policy dated _____, and agree to adhere to it.

Date: _____ Signature: _____

Name: (print) _____

Vermont Health Care Innovation Project Grant Program Application

Draft dated 12.23.2013

I. Background

The federal Centers for Medicare and Medicaid Innovation (CMMI) awarded the State Innovation Model (SIM) grant to Vermont. The grant provides funding and other resources to support health care payment and delivery system reforms aimed at improving care, improving the health of the population, and reducing per capita health care costs, by 2017. To maximize the impact of non-governmental entity involvement in this health care reform effort, Vermont identified funding within its SIM grant to directly support providers engaged in payment and delivery system transformation. The State has determined that a competitive grant process will foster innovation and promote success among those providers eager to engage in reforms. These grants will be reviewed by the VHCIP/SIM Core Team using the criteria found in the Grant Program (GP) Criteria.

Applicants can seek technical assistance support as well as direct funding. The total amount available for direct funding is $3,377,102.

GP grants will support provider-level activities that are consistent with overall intent of the SIM project, in two broad categories:

1. Activities that directly enhance provider capacity to test one or more of the three alternative payment models approved in Vermont's SIM grant application:
    a. Shared Savings Accountable Care Organization (ACO) models;
    b. Episode-Based or Bundled payment models; and
    c. Pay-for-Performance models.
2. Infrastructure development that is consistent with development of a statewide high-performing health care system, including:
    a. Development and implementation of innovative technology that supports advances in sharing clinical or other critical service information across different types of provider organizations;
    b. Development and implementation of innovative systems for sharing clinical or other core services across different types of provider organizations;
    c. Development of management systems to track costs and/or quality across different types of providers in innovative ways.

Preference will be given to applications that demonstrate:

- Support from and equitable involvement of multiple provider organization types that can demonstrate the grant will enhance integration across the organizations;
- A scope of impact that spans multiple sectors of the continuum of health care service delivery (for example, prevention, primary care, specialty care, mental health and long term services and supports);

- Innovation, as shown by evidence that the intervention proposed represents best practices in the field;
- An intent to leverage and/or adapt technology, tools, or models tested in other States to meet the needs of Vermont's health system;
- Consistency with the Green Mountain Care Board's specifications for Payment and Delivery System Reform pilots. The Green Mountain Care Board's specifications can be found here: http://gmcboard.vermont.gov/PaymentReform.

II. What these grants will fund

Grants will fund the following types of activities. Appendix B includes a detailed list of federal guidelines around this funding.:

- Data analysis
- Facilitation
- Quality improvement
- Evaluation
- Project development

III. Grant submission requirements

Applicants will be expected to provide the following in support of their application:

- GP Application Cover Form. This form is found in Appendix A.
- Grant Narrative. The Grant Narrative should be a maximum of 12 pages double-spaced, 12 point font, with 1-inch margins, paginated in a single sequence. The Grant Narrative should contain the following information:
    a. A clear description of the activities for which the applicant is requesting funding or technical assistance;
    b. A clear description of alternative funding sources sought and rationale for requesting SIM funds;
    c. A description of technical assistance services sought. Appendix D provides more detail about the technical assistance services available under this grant .
    d. A description of the project's potential return-on-investment in terms of cost savings and quality improvement, and plans for measuring both;
    e. A description of how the project will avoid duplication where similar innovations in Vermont are currently underway;
    f. A summary of the evidence base for the proposed activities or technical assistance;

- A project plan, staffing structure, deliverables description, and timeline for completion of the proposed activities. This includes a project management plan with implementation timelines and milestones.

- Executed Memorandum of Understanding or other demonstration of support from partner providers, if applicable.
- Budget Narrative. Budget Narrative guidance is found in Appendices B and C. The Budget Narrative should contain the following:
    a. A budget for the proposed project, consistent with specified budget formats;
    b. A description of any available matching support, whether financial or in-kind;
    c. Information regarding on-going support that may be needed for work begun under this grant.

IV. State resources available to grantees

Grant recipients may receive the following support, to the extent that a need has been clearly established in the grant application. More detail about the technical assistance can be found in Appendix D*:*

- Supervision to ensure compliance with federal antitrust provisions;
- Assistance in aligning with other testing models in the state;
- Assistance with appropriately attributing outcomes and savings to testing models;
- Overall monitoring of health care quality and access;
- Funding for specific activities;
- Technical Assistance:
  - Meeting facilitation
  - Stakeholder engagement
  - Data analysis
  - Financial modeling
  - Professional learning opportunities

V. Compliance and Reporting Requirements

As a responsible steward of federal funding, the state, through the Agency of Human Services, Department of Vermont Health Access (DVHA), monitors its sub-recipients utilizing the following monitoring tools:

1) Ensure that sub-recipient is not disbarred/suspended or excluded for any reason
2) Sub-award agreement
3) Sub-recipient meeting and regular contact with sub-recipients
4) Required pre-approval for changes to budget or scope of grant
5) Quarterly financial reports
6) Bi-annual programmatic reports
7) Audit
8) Desk Reviews
9) Site audits

In its use of these monitoring tools, the State emphasizes clear communication to ensure a feedback loop that supports sub-recipients in maintaining compliance with federal requirements. The State may at any time elect to conduct additional sub-recipient monitoring. Sub-recipients therefore should maintain grant records accurately in the event that the State exercises this right. The State may also waive its right to perform certain sub-recipient monitoring activities. If, at any

time, the State waives its right to certain sub-recipient monitoring activities, it will note which activities were not completed and the reasons why that activity was not necessary. Each of the monitoring tools and policies regarding their use are described in detail below.

1) Sub-recipient status

When signing the sub-award agreement, Sub-recipient's certify that neither the Sub-recipient nor Sub-recipient principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs or programs supported in whole or in part by federal funds.

Additionally DVHA will utilize the Excluded Parties List System (www.epls.gov) to confirm that neither the Sub-recipient nor its principals are presently disbarred at least once during DVHA's fiscal year. DVHA will print a screen shot of its EPLS search, and place it in the Sub-recipient's files.

2) Sub-award agreement

A sub-award agreement is provided to each sub-recipient at the beginning of each grant. This sub-award agreement will detail the Catalog of Federal Domestic Assistance (CFDA) program name and number, the award name and number as assigned by the funder, the award period, and the name of the federal awarding agency. This sub-award agreement will also include: definitions, the scope of work to be performed, payment provisions, funder grant provisions, blank financial and programmatic reports, and a copy of this policy. Other information may be included if necessary.

Unless any changes are required, only one sub-award document will be generated for the term of a grant, even if that term spans several years. All sub-recipients must sign the sub-award agreement and any additional documents sent with the sub-award, or funding will be terminated.

3) Sub-recipient meeting/ sub-recipient contact

The State may decide, at the beginning of a grant or at any time during a grant, to host a meeting of grant partners in order to review grant goals and/or obligations. A sub-recipient meeting may be held with one individual sub-recipient, or with multiple sub-recipients.

The State will also maintain contact with sub-recipients. Sub-recipients are expected to notify the State if they are having any difficulty carrying out their grant responsibilities or if they need clarification of their grant responsibilities.

Sub-recipients meeting and sub-recipient contact will be noted on the sub-recipient checklist, with appropriate supporting documentation included it the sub-recipient's folder.

4) Required pre-approval for changes to budget or scope of grant

As stated above, all sub-recipients must seek prior approval from the grants manager at the State to utilize grant funding for any activities not explicitly described in the goals section of the narrative. Sub-recipients must also seek prior approval before making any changes to their section of the budget.

Notes regarding any prior approval requested by a sub-recipient, or a sub-recipient's failure to comply with this grant term, will be maintained on the sub-recipient checklist.

5) Quarterly financial reports

The Sub-recipient will submit accurate financial reports to the State no later than the tenth of the month following the quarter being reported (January 10th, April 10th, July 10th, October 10th). A blank copy of the required financial report will be provided with the sub-award agreement. All questions regarding financial reports should be directed to Robert Pierce at robert.pierce@state.vt.us.

Financial reports will be reviewed by the State for accuracy and to ensure that all charges are eligible to be reimbursed by the grant. Sub-recipients are expected to respond promptly to all questions concerning financial reports.

Sub-recipient's submission of quarterly financial reports will be recorded and monitored on the sub-recipient checklist.

6) Bi-annual programmatic reports

The sub-recipient will submit accurate programmatic reports to the State no later than the tenth of the month following the 6-month period being reported (January 10th and July 10th). A blank copy of the required programmatic reports will be provided with the sub-award agreement. All questions regarding programmatic reports should be directed to Georgia Maheras at georgia.maheras@state.vt.us.

Programmatic reports will be reviewed by the State for accuracy and to ensure that all charges are eligible to be reimbursed by the grant. Sub-recipients are expected to respond promptly to all questions concerning programmatic reports

7) Audit

Sub-recipients who spent at least $500,000 in federal funds from all federal sources during their fiscal year must have an audit performed in accordance with OMB Circular A-133. The A-133 compliant audit must be completed within 9 months of the end of the sub-recipient's fiscal year. The sub-recipient shall provide the State with a copy of their completed A-133 compliant audit including:

- The auditor's opinion on the sub-recipient's financial statements,
- the auditor's report on the sub-recipient's internal controls,
- the auditor's report and opinion on compliance with laws and regulations that could have an effect on major programs,
- the schedule of findings and questioned costs,
- and the sub-recipients corrective action plan (if any).

The State will issue a management decision on audit findings within 6 months after receipt of the sub-recipient's A-133 compliant audit report.

If a sub-recipient's schedule of findings and questioned costs did not disclose audit findings relating to the Federal awards provided by the State and the summary schedule of prior audit findings did not report the status of audit findings relating to Federal awards provided by the State, the sub-recipient may opt not to provide the A-133 compliant audit report to the State. In this case, the State will verify that there were no audit findings utilizing the Federal Audit Clearinghouse database.

Any sub-recipient that, because it does not meet the $500,000 threshold or because it is a for-profit entity, does not receive an audit performed in accordance with OMB Circular A–133 may at its option and expense have an independent audit performed. The independent audit should be performed to obtain reasonable assurance about whether the sub-recipient's financial statements are free of material misstatement. The independent audit should also take into consideration the sub-recipient's internal control, but does not necessarily have to contain the auditor's opinion on the agency's internal control. If the sub-recipient elects to have an audit report that covers more than the sub-recipient's financial statements, the State requests that the entirety of the auditor's report be provided to the State.

If the sub-recipient chooses not have an independent audit and the sub-recipient will receive at least $10,000 during the current fiscal year, they will be subject to on-site monitoring during the award period.

Sub-recipients who are individual contractors will not be subject to on-site monitoring based solely on the lack of an independent audit.

8) Desk Reviews

All sub-recipients who are estimated to receive $10,000 or more during the fiscal year will undergo a desk review at least once during the grant period. If a sub-recipient receives less than $10,000, the State may at its discretion opt to conduct a desk review. During a desk review, sub-recipients might be expected to provide:

- Adequate source documentation to support financial requests including but not limited to an income statement, payroll ledgers, cancelled checks, receipts ledgers, bank deposit tickets and bank statements, and timesheets.
- If salary is funded under the award and if the staff whose salary is funded under the award is charged to other funding sources, time distribution records to support the amounts charged to federal funding provided by the State.
- A statement verifying that the organization has a system in place for maintaining its records relative to federal funding provided by the State for the amount of time as specified in the sub-award document.
- Adequate documentation to support required match, if any.

9) Site visits

All sub-recipients who receive $50,000 or more in federal funding passed through the State for three consecutive fiscal years (July 1 – June 30), will undergo a site visit at least once during the three year period. Sub-recipient will be subject to desk monitoring during the intervening years. The State will arrange a suitable date and time for on-site monitoring with the sub-recipient. Recipients receiving a site visit will be expected to provide all of the back-up documentations as specified above, as well as:

- A written policy manual specifying approval authority for financial transactions.
- A chart of accounts and an accounting manual which includes written procedures for the authorization and recording of transactions.
- Documentation of adequate separation of duties for all financial transactions (that is, all financial transactions require the involvement of at least two individuals).
- If grant funds are utilized to purchase equipment, demonstration that the organization maintains a system for tracking property and other assets bought or leased with grant funds.
- A copy of the agency's Equal Opportunity Policy and Practices in Hiring.

Appendix A: Application Cover Form

General Information:

Organization Applying: _____

Key Contact for Applicant: _____

Key Contact Email and Phone Number: _____

Project Title and Brief Summary:

Project Title: _____

Brief Summary of the Project (max. 150 words):

Budget Request Summary:

Budget Category	Year 1	Year 2	Year 3
Personnel			
Fringe			
Travel			
Equipment			
Supplies			
Indirect			
Contracts			
Total			

Appendix B: CMMI Funding Restrictions

All funds expended through this grant program must comply with the federal guidelines found in the State Innovation Models FOA found here:
http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf

The cost principles address four tests in determining the allowability of costs. The tests are as follows:

- *Reasonableness (including necessity).* A cost is reasonable if, in its nature or amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. The cost principles elaborate on this concept and address considerations such as whether the cost is of a type generally necessary for the organization's operations or the grant's performance, whether the recipient complied with its established organizational policies in incurring the cost or charge, and whether the individuals responsible for the expenditure acted with due prudence in carrying out their responsibilities to the Federal government and the public at large as well as to the organization.
- *Allocability.* A cost is allocable to a specific grant, function, department, or other component, known as a cost objective, if the goods or services involved are chargeable or assignable to that cost objective in accordance with the relative benefits received or other equitable relationship. A cost is allocable to a grant if it is incurred solely in order to advance work under the grant; it benefits both the grant and other work of the organization, including other grant-supported projects or programs; or it is necessary to the overall operation of the organization and is deemed to be assignable, at least in part, to the grant.
- *Consistency.* Recipients must be consistent in assigning costs to cost objectives. They must be treated consistently for all work of the organization under similar circumstances, regardless of the source of funding, so as to avoid duplicate charges.
- *Conformance.* This test of allowability—conformance with limitations and exclusions contained in the terms and conditions of award, including those in the cost principles—may vary by the type of activity, the type of recipient, and other characteristics of individual awards. "Allowable Costs and Activities" below provides information common to most HHS grants and, where appropriate, specifies some of the distinctions if there is a different treatment based on the type of grant or recipient.

These four tests apply regardless of whether the particular category of costs is one specified in the cost principles or one governed by other terms and conditions of an award. These tests also apply regardless of treatment as a direct cost or an indirect cost. The fact that a proposed cost is awarded as requested by an applicant does not indicate a determination of allowability.

Direct Costs and Indirect Costs

This is for illustrative purposes. We strongly recommend applicants review all of the federal guidance provided in the FOA found here: *http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf* .

Direct costs are costs that can be identified specifically with a particular award, project or program, service, or other organizational activity or that can be directly assigned to such an activity with a high degree of accuracy. Direct costs include, but are not limited to, salaries, travel, equipment, and supplies directly benefiting the grant-supported project or program. Indirect costs (also known as "facilities and administrative costs") are costs incurred for common or joint objectives that cannot be identified specifically with a particular project, program, or organizational activity. Facilities operation and maintenance costs, depreciation, and administrative expenses are examples of costs that usually are treated as indirect costs. There is a 10% cap on indirect costs. The organization is responsible for presenting costs consistently and must not include costs associated with its indirect rate as direct costs.

Examples of Unallowable Direct Costs:

- Alcohol
- Alteration and Renovation Costs
- Animals
- Bad Debts
- Bid and Proposal Costs
- Construction or Modernization
- Dues/Membership-Unallowable for Individuals (unless fringe benefit or employee development costs if applied as established organization policy across all funding sources).
- Entertainment
- Fines and Penalties
- Fundraising
- Honoraria- if this cost is for speaker fee that it is allowable as a direct cost.
- Invention, Patent or Licensing Costs-unless specifically authorized in the NOA.
- Land or Building Acquisition
- Lobbying
- Meals (Food)
- Travel

Appendix C: Budget Narrative Guidance

INTRODUCTION

This guidance is offered for the preparation of a budget request. Following this guidance will facilitate the review and approval of a requested budget by ensuring that the required or needed information is provided. In the budget request, awardees should distinguish between activities that will be funded under this agreement and activities funded with other sources.

A. Salaries and Wages

For each requested position, provide the following information: name of staff member occupying the position, if available; annual salary; percentage of time budgeted for this program; total months of salary budgeted; and total salary requested. Also, provide a justification and describe the scope of responsibility for each position, relating it to the accomplishment of program objectives.

Position Title and Name	*Annual*	*Time*	*Months*	*Amount Requested*
Project Coordinator Susan Taylor	*$45,000*	*100%*	*12 months*	*$45,000*
Finance Administrator John Johnson	*$28,500*	*50%*	*12 months*	*$14,250*
Outreach Supervisor (Vacant)*	*$27,000*	*100%*	*12 months*	*$27,000*

Sample Justification

The format may vary, but the description of responsibilities should be directly related to specific program objectives.

<u>Job Description</u>: Project Coordinator - (Name)

This position directs the overall operation of the project; responsible for overseeing the implementation of project activities; coordination with other agencies; development of materials, provisions of in service and training; conducting meetings; designs and directs the gathering, tabulating and interpreting of required data; responsible for overall program evaluation and for staff performance evaluation; and is the responsible authority for ensuring necessary reports/documentation are submitted to HHS. This position relates to all program objectives.

B. Fringe Benefits

Fringe benefits are usually applicable to direct salaries and wages. Provide information on the rate of fringe benefits used and the basis for their calculation. If a fringe benefit rate is not used, itemize how the fringe benefit amount is computed. This can be done for all FTE in one table instead of itemizing per employee.

Sample
Example: Project Coordinator — Salary $45,000

Retirement 5% of $45,000	=	*$2,250*
FICA 7.65% of $45,000	=	*3,443*
Insurance	=	*2,000*
Workers' Compensation	=	_____
	Total:	

C. Consultant Costs

This category is appropriate when hiring an individual to give professional advice or services (e.g., training, expert consultant, etc.) for a fee but not as an employee of the awardee organization. Hiring a consultant requires submission of the following information:

1. Name of Consultant;
2. Organizational Affiliation (if applicable);
3. Nature of Services to be Rendered;
4. Relevance of Service to the Project;
5. The Number of Days of Consultation (basis for fee); and
6. The Expected Rate of Compensation (travel, per diem, other related expenses)—list a subtotal for each consultant in this category.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. In the body of the budget request, a summary should be provided of the proposed consultants and amounts for each.

D. Equipment

Provide justification for the use of each item and relate it to specific program objectives. Maintenance or rental fees for equipment should be shown in the "Other" category. All IT equipment should be uniquely identified. As an example, we should not see a single line item for "software." Show the unit cost of each item, number needed, and total amount.

Item Requested	*How Many*	*Unit Cost*	*Amount*
Computer Workstation	*2 ea.*	*$2,500*	*$5,000*
Fax Machine	*1 ea.*	*600*	*600*

Sample Justification

Provide complete justification for all requested equipment, including a description of how it will be used in the program. For equipment and tools which are shared among programs, please cost allocate as appropriate. States should provide a list of hardware, software and IT equipment which will be required to complete this effort. Additionally, they should provide a list of non-IT equipment which will be required to complete this effort.

E. Supplies

Individually list each item requested. Show the unit cost of each item, number needed, and total amount. Provide justification for each item and relate it to specific program objectives. If appropriate, General Office Supplies may be shown by an estimated amount per month times the number of months in the budget category.

Sample Budget

Supplies

General office supplies (pens, pencils, paper, etc.)

12 months x $240/year x 10 staff	=	*$2,400*
Educational Pamphlets (3,000 copies @) $1 each)	=	*$3,000*
Educational Videos (10 copies @ $150 each)	=	*$1,500*
Word Processing Software (@ $400—specify type)	=	*$ 400*

Sample Justification

General office supplies will be used by staff members to carry out daily activities of the program. The education pamphlets and videos will be purchased from XXX and used to illustrate and promote safe and healthy activities. Word Processing Software will be used to document program activities, process progress reports, etc.

F. Other

This category contains items not included in the previous budget categories. Individually list each item requested and provide appropriate justification related to the program objectives.

Sample Justification

Some items are self-explanatory (telephone, postage, rent) unless the unit rate or total amount requested is excessive. If the items are not self-explanatory and/or the cost is excessive, include additional justification. For printing costs, identify the types and number of copies of documents to be printed (e.g., procedure manuals, annual reports, materials for media campaign).

G. Total Direct Costs $_____

Show total direct costs by listing totals of each category.

H. Indirect Costs $_____

To claim indirect costs, the applicant organization must have a current approved indirect cost rate agreement established with the Cognizant Federal agency. A copy of the most recent indirect cost rate agreement must be provided with the application.

Sample Budget

The rate is_____% and is computed on the following direct cost base of $_____.

Personnel	*$*	
Fringe	*$*	
Travel	*$*	
Supplies	*$*	
Other$_____		
Total	*$*	*x____% = Total Indirect Costs*

Appendix D: Technical Assistance

State resources available to grantees

Projects supported by the Provider Grants Program may be provided the following supports, to the extent that a need has been clearly established in the grant application:

- Supervision to ensure compliance with federal antitrust provisions;
- Assistance in aligning with other testing models in the state;
- Assistance with appropriately attributing outcomes and savings to testing models;
- Overall monitoring of health care quality and access;
- Funding for specific activities;
- Technical Assistance:
    - Meeting facilitation
    - Stakeholder engagement
    - Data analysis
    - Financial modeling
    - Professional learning opportunities

Overview of Vermont Dual Eligible Demonstration Model of Care

Presentation for SIM/Duals Work Group

January 2014

Overview of Dually Eligible (DE) Vermonters

- Approximately 22,000 Vermonters are enrolled in both Medicare and Medicaid
- They are diverse in age and medical needs

Age	% of VT DE Population
18-39	14%
40-49	15%
50-59	15%
60-69	17%
70-79	17%
80-89	15%
90+	7%

Medical Conditions	% of VT DE Population
Depression	39%
Asthma/Chronic Obstructive Pulmonary Disease	28%
Diabetes	26%
Heart Disease	26%
Arthritis	21%
Stroke, Cardiovascular Disease	14%
Alzheimer's Disease, Dementia	12%
Alcohol/Substance Abuse	7%
Schizophrenia	6%

Overview of Dually Eligible Vermonters

- Many but not all dually eligible individuals have disabilities

VT DE Individuals who…	% of VT DE Population
Have a Mental Illness	53%
Have a Physical Disability	29%
Have a Neurological Disability	24%
Have a Sensory Disability	11%
Have a Development Disability	9%

Vermont Specialty Medicaid Programs	% of Program enrollees that are dually eligible
Choices for Care (excluding Moderate Needs Group)	93%
Community Rehabilitation and Treatment (CRT)	68%
Developmental Services	64%

Service Utilization by Dually Eligible Vermonters

(based on 2010 data)

Major Service Category	Population Count	% of Population	Total Payments (M'care & M'caid)	% of Total Payments
Day Health Rehabilitative Services	180	0.8%	$1,562,827	0.3%
Diagnostic Testing	19,051	88%	$19,862,937	3.4%
Durable Medical Equipment & Supplies	11,130	51%	$9,931,365	1.7%
Emergency Department	9,546	44%	$6,027,610	1.0%
Home Health Care	4,548	21%	$24,374,433	4.2%
Hospice	353	2%	$3,652,499	0.6%
Inpatient Hospital	4,319	20%	$76,328,470	13.1%
Mental Health/Substance Abuse Clinic	2,502	12%	$1,901,220	0.3%
Miscellaneous	1,603	7%	$1,668,299	0.3%
Non-Physician Practitioner	16,744	77%	$10,786,298	1.9%
Nursing Home	3,771	17%	$132,219,277	22.7%
Outpatient Hospital	18,894	87%	$13,839,402	2.4%
Pharmacy	20,082	93%	$67,822,149	11.6%
Physician	19,847	92%	$34,084,570	5.9%
Transportation	7,816	36%	$12,635,790	2.2%
CFC HCBS/ERC, DS, TBI, CRT	5,798	27%	$165,783,646	28.5%
Total	21,670	100.0%	$582,480,793	100.0%

MODEL OF CARE and CARE MANAGEMENT

Development of DE Model of Care

- **DE Workgroups and State Teams that have informed Model of Care Design:**
  - Person-Centered Care Workgroup
  - Essential Components of Person-Directed Approach Workgroup
  - Service Delivery Model Workgroup
  - Individual Assessment & Comprehensive Care Plan Workgroup
  - Pharmacy Program State Team
- **DE Products developed related to the Model of Care (MOC) Design:**
  - Profiles of 15 dual eligible beneficiaries compiled and adapted by Consultants (Sept, 2011)
  - Presentations on VT Medicaid "Non-Traditional" Programs for Community-based Services (Fall, 2011)
  - Web meeting with Commonwealth Care Alliance (Dec, 2011)
  - Questions added to DDAIL annual Long Term Care Consumer Survey regarding dual eligible beneficiaries' health care coverage and access to care; Report issued Dec 2011
  - Focus Groups and interviews conducted by consultants with dually eligible individuals and their family members (November, 2011); Final Report issued Feb, 2012
  - Model of Care flow charts from the Beneficiary Perspective (Feb, 2012)
  - Schematics of Provider Roles and Responsibilities (Feb, 2012– June, 2013)
  - Detailed Draft Criteria for ICP/ICP-Plus RFP (June, 2013)
  - DVHA Model of Care approved by CMS/NCQA (March, 2013)
  - Duals integrated Medicare/Medicaid Pharmacy benefit (under development)

DE Demonstration Model of Care (MOC) Overview

- **Consumer Direction and Choice are the foundation**
- **7 Core Model elements :**
  - Access to Enhanced Care Coordination (ECC) with a single point of contact
  - All enrollees will have a Primary Care Physician with priority for Blueprint medical/health homes and access to Blueprint Community Health Teams
  - Individual assessments resulting in comprehensive person-directed care plans across primary, acute, mental health, substance abuse, developmental, and long term care supports and services
  - Support during care transitions
  - Payment reform connecting provider payment with performance measures related to changes in utilization and quality
  - Improved sharing of health records, assessments, and information
  - A single integrated pharmacy benefit plan

DE Demonstration MOC Overview, cont.

- **Care Coordination:**
  - If beneficiary 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)
  - For beneficiaries with more complex needs, DVHA contracts with Integrated Care Partnerships (ICPs) for enhanced care coordination (ECC) to provide single point of contact, comprehensive assessments and care plans across all needs and services
    - ICPs-Plus (after Year 1 of the Demonstration): Contract with DVHA to assume management responsibility and financial risk for an agreed-upon array of services and supports (in addition to ECC)

- Design based on 4 Dual Eligible Sub-Populations:
  - Population 1: HCBS/LTC Waiver enrollees (CfC, CRT, DS, TBI): 8,100
    → Enhanced Care Coordination (ECC)
  - Population 2: High Cost/High Risk enrollees: 1,050
    → Enhanced Care Coordination (ECC)
  - Population 3: Moderate Cost/Moderate Risk enrollees: 3,700
    → Enhanced Care Coordination (ECC)
  - Population 4: PCP/Blueprint care managed enrollees: 8,800

DE Demonstration MOC Overview, cont.

- **Enhanced Care Coordination Includes:**
  - Single Point of Contact
  - Coordination across all Acute, Medical, HCBS & LTSS needs
  - Integrated Comprehensive Assessment and Care Plan
  - Support for the Enrollee's Care Team
  - Provision of Routine Individual Support to Enrollee
  - Support for Enrollee during Transitions in Care and Settings
  - Support for Enrollee to Self-manage Some or All Services

DE Demonstration MOC Overview, cont.

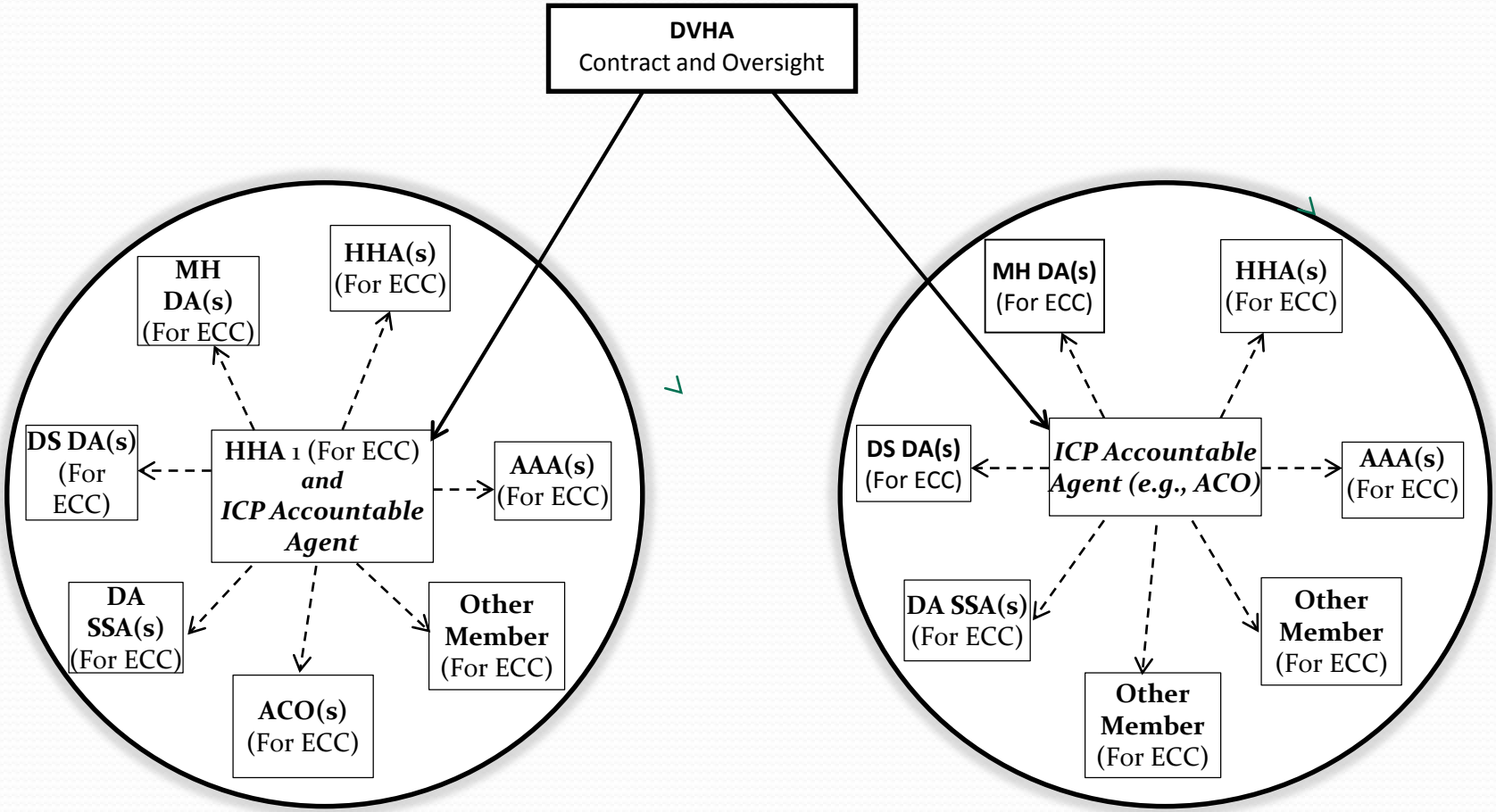
- Integrated Care Partnerships:
  - ICP(s) must agree to provide ECC to any enrollee who chooses an organization within their ICP, or who is assigned to one of them when no choice is made.
  - ICP(s) must include a sufficient quantity and variety of member organizations to create an integrated person-directed system of ECC, including statutorily and state designated organizations that provide specialty case management / care coordination for enrollees in Population 1. (Innovation and creativity is encouraged.)
  - There can only be one ICP in a given region; however, there could be multi-regional ICPs or a statewide ICP.
    - Region: a clearly identified geographic area with enough enrollees to make the ICP financially and administratively viable and efficient.

DE Demonstration MOC Overview, cont.

- **ICP Accountable Agent:**
  - ICP(s) must designate one entity within the ICP to act as the Accountable Agent with which DVHA will contract on behalf of the ICP member organizations
  - Must have formal relationships with all member organizations that form the ICP (i.e. organizations that will provide ECC)
  - Is the recipient of DVHA payments for the provision of ECC in the ICP geographic area, and pays the ICP member organizations for the provision of ECC
  - Is responsible for assisting enrollee selection of an ICP Member organization and ensuring the provision of ECC
  - Is the conduit for data exchanges between the State, DVHA and the ICP and for other communications regarding the DE Demonstration
  - Is the contractual entity accountable for ICP performance
  - The contract between DVHA and the ICP Accountable Agent for each ICP will clearly define the fidelity standards and performance expectations / outcome measures of the ICP and the Accountable Agent, and any payment incentives for meeting performance expectations.

Examples of Possible Integrated Care Partnership Configurations

(Note: Other permutations are possible)



One-region, Multiple-region or Statewide ICP with ECC-providing member organization as ICP Accountable Agent

One-region, Multiple-region or Statewide ICP with non-ECC-providing administrative entity as ICP Accountable Agent

DE Demonstration MOC Overview, cont.

- **Accountable Agent(s) / ICP Member Performance Expectations**
  - Adherence to State/DVHA-specified care coordination fidelity standards
  - Provision of all ECC functions (see Slide 9)
  - Utilization of State/DVHA-specified assessment tool(s)
  - Participation in Model of Care training
  - Participation in CMS and State evaluation activities and measurements
  - Data reporting (e.g., related to non-claims based performance measures)
  - Achievement of defined performance measures and outcomes
  - Adherence to State of Vermont Contract standards

DE Demonstration MOC Overview, cont.

- **Enrollee Selection of an ICP Member Organization**
  - Enrollees will choose their PCP and ICP member organization during the DE Demonstration enrollment process
  - For those individuals who do not choose an ICP member organization during enrollment in the Demonstration, DVHA will work with the relevant ICP Accountable Agent to assign an appropriate ICP member organization for the enrollee
  - If enrollees want to change their ECC provider, they can inform the ICP Accountable Agent who will assist them to select and enroll with a new ICP member organization
  - The enrollee's choice must always be honored
  - Once a new ECC provider is chosen, the ICP Accountable Agent must inform DVHA
  - Local ADRC/SHIP programs will be available to assist enrollees with the selection of an ICP member organization
  - Enrollees may also seek further assistance from DVHA if desired

DE Demonstration MOC Overview, cont.

- **Identification of Enrollees for Receiving ECC**
  - An enrollee's single point of contact will depend on the enrollee's needs, and will be either:
    - An ECC Coordinator employed by an ICP member organization (Populations 1, 2 and 3) or
    - Their primary care provider (Population 4)
  - Even those individuals with only primary and acute health needs will have an identified ECC Coordinator which they can access if they develop more complex needs
  - All DE Demonstration enrollees in CfC, CRT, DS and TBI will be offered ECC
  - DVHA will use data analytics to identify enrollees with high/moderate costs/risk factors and complex needs who will be offered ECC
  - DVHA also will accept referrals for ECC from others (e.g., PCPs, other medical providers, LTSS providers, VCCI and enrollees themselves)