VT Health Care Innovation Project
Dual Eligible Work Group Meeting Agenda

Wednesday, November 20th, 2013; 10:00 PM to 12:00PM
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	• Attachment 1: Meeting Agenda	
2	10:10 – 10:15	**Overview of Project Reporter** Georgia Maheras and Nelson LaMothe		
3	10:15 – 10:45	**Review of Draft Charter and Draft Work Plan** Deborah Lisi-Baker and Judy Peterson	• Attachment 2: Draft Charter • Attachment 3: Draft Work Plan	
4	10:45 – 11:00	**ACO Shared Savings Program "101"** Anya Rader Wallack, ACO Reps.	• Attachment 4: ACO 101 (Power Point Hand Outs)	
5	11:00 – 11:45	**Strategic Plan for Alignment** Anya Rader Wallack and Brendan Hogan	• Attachment 5: Memo re The Need for Alignment • Attachment 6: Memo re Options for Alignment • Attachment 7: Duals/ACO SSP Alignment (Power Point Hand Outs)	
6	11:45 – 12:00	**Implications of Signing an MOU with CMS** Julie Wasserman	• Attachment 8: Overview/differences between MOU and Contract	
7		**Wrap up/Next Steps/Future Meeting Schedule**	• Attachment 9: 2013/2014 Dual Eligible Work Group Monthly Meeting Schedule	

VT Health Care Innovation Project
Dual Eligible Work Group Charter
November 20, 2013

DRAFT

EXECUTIVE SUMMARY

The Dual Eligible Work Group will build on the extensive work of the Dual Eligible Demonstration Steering, Stakeholder, and Work Group Committees over the last two years. The goal of Duals Demonstration is to integrate financing and service provision for people who are eligible for both Medicare and Medicaid to improve their care and service experience and avoid unnecessary costs. The VHCIP Dual Eligible Work Group will:

- further refine the elements of Vermont's approach to the Duals Demonstration;
- develop recommendations about whether and how to proceed with the demonstration;
- develop recommendations regarding the design of other payment and care models initiated through the VHCIP project, to improve outcomes and reduce costs for and for dually eligible Vermonters and other Vermonters with disabilities.

SCOPE OF WORK

1. Identify provider payment models that encourage quality and efficiency among the array of primary care, acute and long-term services and support providers who serve dually eligible populations.
2. Recommend a care model or models for dually eligible Vermonters that improves beneficiary service and outcomes.
3. Incorporate disability-related and cultural competency issues into all VHCIP activities.
4. Identify Medicare policy barriers that can be addressed through the Duals Demonstration and through integration of dually eligible Vermonters into other payment and delivery system reforms.
5. Develop a strategy to align the Duals Demonstration with other Vermont payment reform initiatives.
6. Identify management structures necessary to administer the Duals Demonstration at both the state and provider levels.
7. Identify quality and performance measures to be used to evaluate the Duals Demonstration and other payment models for their effect on Vermonters who are dually eligible and other Vermonters with disabilities.
8. Identify technical and IT needs of the Duals Demonstration.
9. Ensure a financial analysis of the Duals Demonstration that assesses the potential costs, benefits and risks of the project for the state, providers and beneficiaries, to support state decisions about whether to implement the initiative..

DELIVERABLES

1. Strategic plan for alignment of the Duals Demonstration and other Vermont payment and delivery system reform efforts.
2. Recommendations for a Dual Eligible model of care that is integrated and aligned with VHCIP models.
3. Recommendations for payment methodologies for the Duals Demonstration.
4. Recommendations for successful management structures for administration of the Duals Demonstration at the state and provider level.
5. Action plan for inclusion of identified disability-related and cultural competency items in all VHCIP Work Group efforts.
6. Action plan to implement strategies addressing barriers in current Medicare coverage or payment policy.
7. Identification of quality metrics that could be used to assess the impact of all VHCIP payment models on Vermonters who are dually eligible and other Vermonters with disabilities.
8. Recommendations regarding the technical and IT needs related to the Duals Demonstration.
9. Thorough analysis of the financial viability of the Duals Demonstration.
10. Other activities as identified to support successful preparation and implementation of payment and care models to best support dually-eligible Vermonters.

MILESTONES

<u>November / December 2013:</u>

- Develop strategic plan for alignment of Duals and other payment reforms

<u>January 2014:</u>

- Signed Dual Demonstration MOU

<u>January / February 2014:</u>

- Identify management structures for project administration at the state and provider level

<u>January – March 2014</u>

- Develop recommendations regarding the Dual Eligible model of care
- Complete action plan for inclusion of identified disability-related and cultural competency items into VHCIP Work Group efforts
- Complete action plan to implement strategies addressing current Medicare payment methodology and coverage barriers

- Identify Duals Demo technical and IT needs

First Quarter 2014

- Complete financial viability analysis

March – April 2014

- Recommend payment methodologies

Summer 2014 – Winter 2015

- Provide input as needed regarding activities necessary to prepare for alternative payment methodologies for dual eligible Vermonters

April 2015 – March 2018

- Provide input as needed during implementation of alternate payment methodologies.

MEMBERSHIP REQUIREMENTS

The Dual Eligible Work Group will meet monthly, with possible additional sub-committee meetings. Members are expected to participate regularly in meetings and may be required to review materials in advance. Members are expected to communicate with their colleagues and constituents about the activities and progress of the Work Group and to represent their organizations and constituencies during work group meetings and activities.

RESOURCES AVAILABLE FOR STAFFING AND CONSULTATION

Work Group Chairs:

- Deborah Lisi-Baker, Disability Policy Analyst
  dlisibaker@gmail.com

- Judy Peterson, VNA of Chittenden & Grand Isle Counties
  Peterson@vnacares.org

Work Group Staff:

- Erin Flynn, Department of Vermont Health Access
  Erin.Flynn@state.vt.us

- Julie Wasserman, AHS Vermont Dual Eligible Project
  Julie.Wasserman@state.vt.us

Consultants:

- Susan Besio, Pacific Health Policy Group
  sbesio@PHPG.com

- Brendan Hogan, Bailit Health Associates
  bhogan@bailit-health.com

Additional resources may be available to support consultation and technical assistance to the Work Group.

WORK GROUP PROCESSES

1. The Work Group will meet monthly.
2. The Work Group Co-Chairs plan and distribute the meeting agenda through project staff.
3. Related materials are to be sent to Work Group members, staff, and interested parties prior to the meeting date/time.
4. Work Group members, staff, and interested parties are encouraged to call in advance of the meeting if they have any questions related to the meeting materials that were received.
5. Minutes will be recorded at each meeting.
6. The Work Group Co-Chairs will preside at the meetings.
7. Progress on the Work Group's work will be reported as the Monthly Status Report.
8. The Work Group's Status Reports and Recommendations are directed to the Steering Committee.

AUTHORIZATION

_____ Date: _____

Project Sponsor/Title

Work Plan for Dual Eligible Work Group – DRAFT 11/13/13

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
Finalize Work Group logistics: charter, membership, meeting schedule, resource needs, etc.	• Redraft charter following VHCIP standardized template • Review membership list: each entity should assign 1-2 key Work Group members, others can be "interested parties" • Distribute 2013-2014 monthly meeting schedule • Develop resources identified as needed by Work Group	• Approve charter for official use • Provide input on and final approval of membership list • Identify information /resources needed to inform discussions and decision-making • Identify mechanisms for broader beneficiary engagement	October - November 2013 and on-going (for development of resources for Work Group)	• Charter re-drafted for November Work Group meeting • Membership list: needs to be refined (1-2 key members) • Meeting Schedule: is being developed through 2014	• Final Charter • Comprehensive membership list • 2013-14 meeting schedule • Resources are adequate to accomplish objectives • Successful beneficiary engagement
Develop a strategic plan for *alignment* of the Medicare Shared Savings Program, Medicaid Shared Savings Program, and Duals Demonstration	• Develop any additional information requested by Work Group • Draft a strategic plan for chosen alignment option • Obtain agreement from CMS for chosen alignment option and strategic plan • Implement strategic plan	• Review and discuss Alignment and Options documents • Identify any additional information needed to recommend an alignment option • Recommend an alignment option • Approve the strategic plan for alignment • Receive status reports and discuss implementation of strategic plan	November -December 2013 and on-going (for strategic plan implementation)	• Alignment and Options documents completed • Topic on agenda for November and December Work Group meetings	• Alignment option chosen with agreement by all Vermont parties • CMS agreement for chosen alignment option and strategy to achieve option • Alignment option reflected in MOU • Strategic plan implemented

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
Finalize Duals MOU	• Develop summary document of MOU content elements and comparison with future CMS/AHS/DVHA contract for Work Group • Finalize draft MOU with CMS • Provide status updates to Work Group throughout this process, including all relevant information and documentation • Finalize MOU	• Review final draft MOU when available from CMS • Receive status reports on negotiations of MOU with CMS • Make recommendations on whether or not to sign MOU	November 2013 - January 15, 2014	• Summary document of MOU and contract elements completed • Draft MOU in process with CMS	• Signed MOU between CMS and AHS
Finalize management structures for project administration at the state and provider level	• Develop agreement on proposed management structures for the DE Demonstration at the state level • Develop proposed structure for Demonstration-required Dual Eligible Consumer Advisory Committee • Develop agreement on proposed provider-level administrative structures for the DE Demonstration	• Discuss proposed management structures for the DE Demonstration at the state level • Review and provide input on proposed structure for Demonstration-required Dual Eligible Consumer Advisory Committee • Review and provide input on proposed management structures for the DE Demonstration at the provider level	January – February, 2014 *Must be completed by this date to be incorporated into CMS Funding Proposal (which will be negotiated during this timeframe after MOU is signed)*	• State–level project administration management structure and current and new state staff positions were included in May 2012 Demonstration Proposal to CMS and April 2013 Funding Proposal to CMS • Current model for provider–level administrative structure (i.e., Integrated Care Partnerships)	• Successful management structures for project administration at the state and provider level

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
				developed in spring/summer 2013	
Agree on Duals Care Model	• Review and update Work Group on the work of the DE "person-directed" Work Group and the Duals Model of Care (MOC) submitted to CMS in February 2013 • Convene sub-work group to refine Enhanced Care Coordination (ECC) staffing estimates (also feeds into update Duals Funding Proposal) • Present the work of the DE "person-directed" Work Group and the DE MOC to the VHCIP Care Model/Care Management Work Group to inform their work • Develop a plan for incorporating/adapting the elements of the Duals Care Model into the VHCIP Care Model/Care Management Work Group activities • Inform Duals Work	• Review and provide input on ECC sub-work group changes, if any • Review, provide input on, and approve a plan for incorporating /adapting the elements of the Duals Care Model into the VHCIP Care Model / Care Management Work Group activities • Provide input on any proposed changes to Duals Model of Care by VHCIP Care Model/Care Management Work Group	January -March 2014 *Must be completed by this date in order for ICP RFP to be developed in March/April and issued May 1*	• DVHA Duals Model of Care submitted to CMS in February 2013; approved for three years by NCQA (on behalf of CMS)	• DVHA Duals Model of Care approved for three years by NCQA (on behalf of CMS) • Successful implementation of DVHA Duals Model of Care

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
	Group of any proposed changes to Duals Model of Care by VHCIP Care Model/Care Management Work Group • If necessary, discuss with CMS the implications of any proposed changes to the Duals Care Model to the NCQA three-year approval				
Ensure that disability-related and cultural competency issues are incorporated into all VHCIP activities	• Develop a list of items (e.g. accessibility of information and services, training for professionals, etc.) • Develop a strategy for identified items, including incorporation into VHCIP Work Group efforts • Develop an approach to monitor whether incorporation of these items occurs over the long term	• Review, provide input on, and approve strategy for integration of disability-related and cultural competency issues into VHCIP activities • Receive status updates on incorporation of identified items	January -March 2014 and on-going (for status updates)	• Activities have not yet begun	• Completed list of disability-related and cultural competency items • Action plan for inclusion of identified items into VHCIP Work Group efforts • Vermont health care reform activities are disability and culturally sensitive
Identify current Medicare policy barriers that can be addressed through the Duals Demonstration or other means	• Further develop list of current Medicare barriers which impede the provision of integrated care	• Provide input on list of Medicare barriers • Review, provide input on, and approve strategies for	January -March 2014	• Initial list of barriers identified by DE Service Delivery workgroup in summer/fall 2011	• Completed list of current Medicare barriers • Action plan to implement

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
	• Develop strategies to address these barriers • Work with CMS to obtain approval to implement strategies, if applicable	overcoming Medicare barriers			strategies
Finalize Duals Demonstration Quality and Performance Measures	• Work with CMS to finalize the Quality Metrics, Quality Withholds, and Performance Measures outlined in the Duals MOU • Develop a plan to incorporate/adapt Duals Quality Metrics, Quality Withholds and Performance Measures into the VHCIP Quality and Performance Measures Work Group deliverables	• Discuss Duals Quality Metrics, Quality Withholds and Performance Measures in the draft Duals MOU and alignment with proposed Medicaid ACO measures • Make recommendations to incorporate Duals Quality Metrics, Quality Withholds and Performance Measures into the VHCIP Quality and Performance Measures Work Group	January - March 2014 *Must be completed by this date in order to be included in ICP RFP to be developed in March/April and issued May 1*	• CMS-required and state-proposed Quality Metrics, Quality Withholds, and Performance Measures are outlined in the draft Duals MOU • DAIL will utilize Duals Quality Metrics, Quality Withholds and Performance Measures to create a set of LTSS/HCBS measures to present to the VHCIP Quality and Performance Measures Work Group in December 2013	• Recommended Duals Quality Metrics, Quality Withholds and Performance Measures to be incorporated /adapted into the Medicaid ACO Standards in Years 2 and 3
Identify technical and IT needs of Duals Demonstration	• Draft a memo regarding the HIT needs relevant to the Duals project • Determine process for collaborating with the VHCIP HIE Work Group to include	• Review and provide input on final memo regarding Duals HIT needs for inclusion by the VHCIP HIE Work Group. • Receive status reports on progress	January - March 2014	• Memo in drafting phase	• Completed memo re: Duals HIT issues • Action plan for inclusion of these issues in work of HIE Work Group • Duals Demonstration IT needs met

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
	relevant Duals HIT needs. • Provide on-going status reports to Duals Work Group on progress regarding Duals HIT needs	regarding Duals HIT needs			
Facilitate an updated and comprehensive financial analysis of Duals Demonstration	• Review Wakely analysis and provide summative materials for Work Group consideration • Update Duals Funding Proposal (which focuses on administrative and operational costs) • Develop any additional items needed for a financial analysis • Identify next steps	• Provide feedback/comments on Wakely analysis • Review and provide input on updated funding proposal • Identify any additional information needed for financial analysis • Review, provide input on, and approve next steps	First Quarter 2014	• Initial Wakely analysis completed • Duals Funding proposal submitted to CMS in April 2013; needs updating based on state review and new Demonstration start date	• Thorough analysis of financial viability of Duals Demonstration • State decision about financial viability of Duals Demonstration
Finalize Duals Demonstration Provider Payment Models	• ICP and ICP-Plus Payments o Finalize the ICP payment model, underlying mechanisms, and rates o Determine the list of services included in the ICP-Plus bundled payment and develop ICP-Plus payment model/mechanisms	• Review and provide input on ICP and ICP-Plus payment models design (i.e., design of bundled payment, definition of EOC framework) • Review and provide input on proposed mechanisms for Integrated Medicare-Medicaid provider reimbursement for all dual eligible services	March, 2014 (final ICP payment design) *Must be completed by this date in order to be included in ICP RFP to be developed in March/April and issued May 1* April, 2014 (integrated Medicare-Medicaid provider reimbursement	• High-level ICP payment methodology identified in April 2013 Funding Proposal to CMS • Internal state DE working group began process of exploring integrated Medicare-Medicaid provider reimbursement methodologies in	• Finalized ICP and ICP-Plus payment methodology and design • Finalized blended payment methodologies for all dual eligible services

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
	o Collaborate with the VHCIP Payment Models Work Group to determine the methodology for ICP payments and ICP-Plus bundled payments • Develop integrated Medicare-Medicaid provider reimbursement mechanisms for all dual eligible services • Collaborate with the VHCIP Payment Models Work Group regarding proposed blended payment mechanisms for all dual eligible services	• Discuss goal of the CMS DE Demonstration program to integrate funding at the Plan level to enable the use of blended Medicare and Medicaid funds to reimburse providers for services in order to reduce incentives to cost shift and to increase service flexibility • Review and provide feedback on DVHA proposed blended payment mechanisms for each provider type	methodologies) *This provides one year to change the MMIS to accommodate the new methodologies prior to April 1, 2015 implementation start date* March, 2015 (final ICP-Plus payment design)	summer 2012	
Issue RFP for ICPs and Provider Infrastructure Grants	• Work with DVHA to draft RFP, proposal evaluation criteria, and proposal evaluation process	• Review and provide feedback on proposed timeline for developing and issuing the RFP • Review and provide feedback on draft RFP and proposal and proposal evaluation criteria • Review and provide feedback on proposal evaluation process	• May 1, 2014 (for RFP release) • July – August (for signed ICP contracts) *Latest possible dates for these activities in order to be in place before CMS Readiness Review in Fall 2014*	• Draft ICP RFP Criteria Response Template completed in June 2013	• Fully functioning ICPs throughout the state
Prepare for Readiness Review of DVHA as the	• Work collaboratively with CMS to develop	• Discuss CMS Readiness Review	• Fall 2014 (anticipated	• Activities have not yet begun	• CMS approves DVHA as the Duals

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
MMP Health "Plan"	Readiness Review Tool • Work with DVHA to develop a detailed work plan to prepare for CMS/AHS readiness review	Tool and DVHA's Work Plan	timeline for CMS Readiness Review) *This timeline has not been approved by CMS; they may want to start earlier on some of the Review items.*		Demonstration MMP "Plan" and signs three-way contract between CMS/AHS/DVHA to allow VT to begin implementation

Vermont Health Care Innovation Project

ACCOUNTABLE CARE ORGANIZATIONS 101

Dual Eligible Work Group
November 20, 2013
Anya Rader Wallack, Chair, VHCIP Core Team
(with much credit to Kara Suter, Director of Payment Reform, DVHA)

What is an ACO?

(Idealized Model)

Accountable Care Organizations (ACOs) are comprised of and led by health care providers who have agreed to be accountable for the cost and quality of care for a defined population.

These providers work together to manage and coordinate care for their patients and have established mechanisms for shared governance.

*SIM Payment Standards Work Group Definition 2013

What Does this Mean for Beneficiaries?

The potential to improve beneficiary outcomes and increase value of care by:

- Promoting accountability for the care of beneficiaries
- Requiring coordinated care
- Encouraging investment in data, infrastructure and redesigned care processes

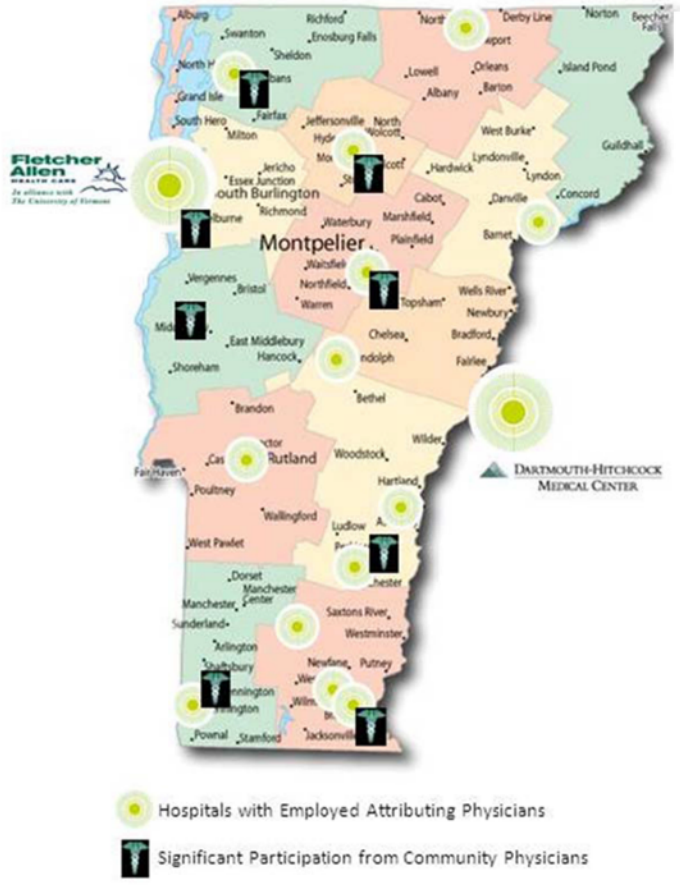
The Program **does not**:

- Restrict choice of provider
- Put providers on a “budget”
- Change coverage or benefits

An ACO Example

OneCare Vermont Network

OneCareVermont



Statewide ACO Provider Network

- 2 Academic Medical Centers
- 14 Community Hospitals
- 1 Behavioral Health/Substance Abuse Facility
- 2 Federally Qualified Health Centers
- 5 Rural Health Clinics
- 58 Private Practices
- 309 Primary Care Physicians across Network Participants

Version: 07/11/2013

Placeholder: CHAC Summary

Placeholder: ACCGM Summary

How are Patients Attributed to an ACO?

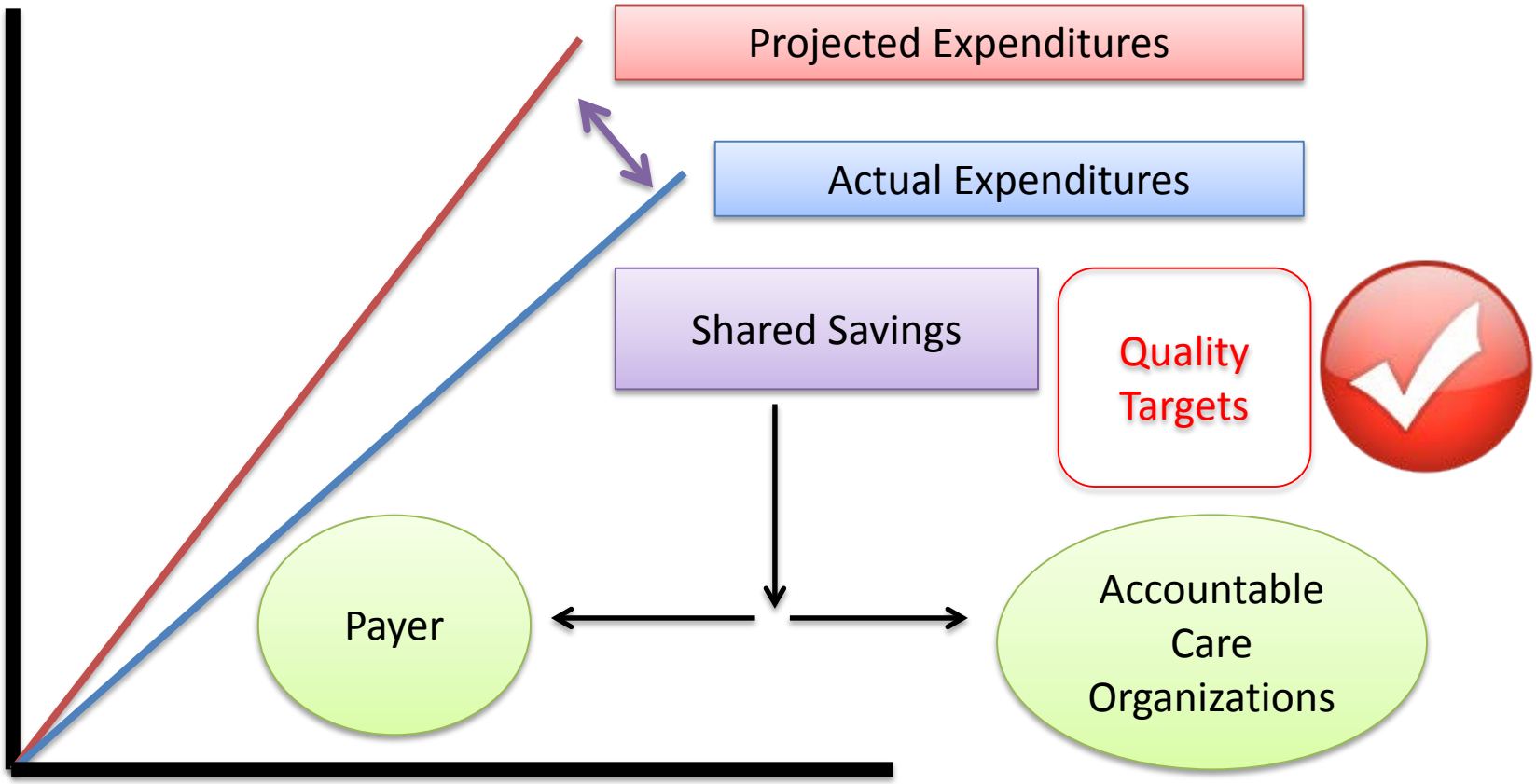
People see their PCP as they usually do

If their PCP belongs to an ACO, the ACO can share savings based on the cost and quality of services provided to that person

ACO

Providers bill as they usually do

Shared Savings Calculated Annually



Medicare ACO Programs

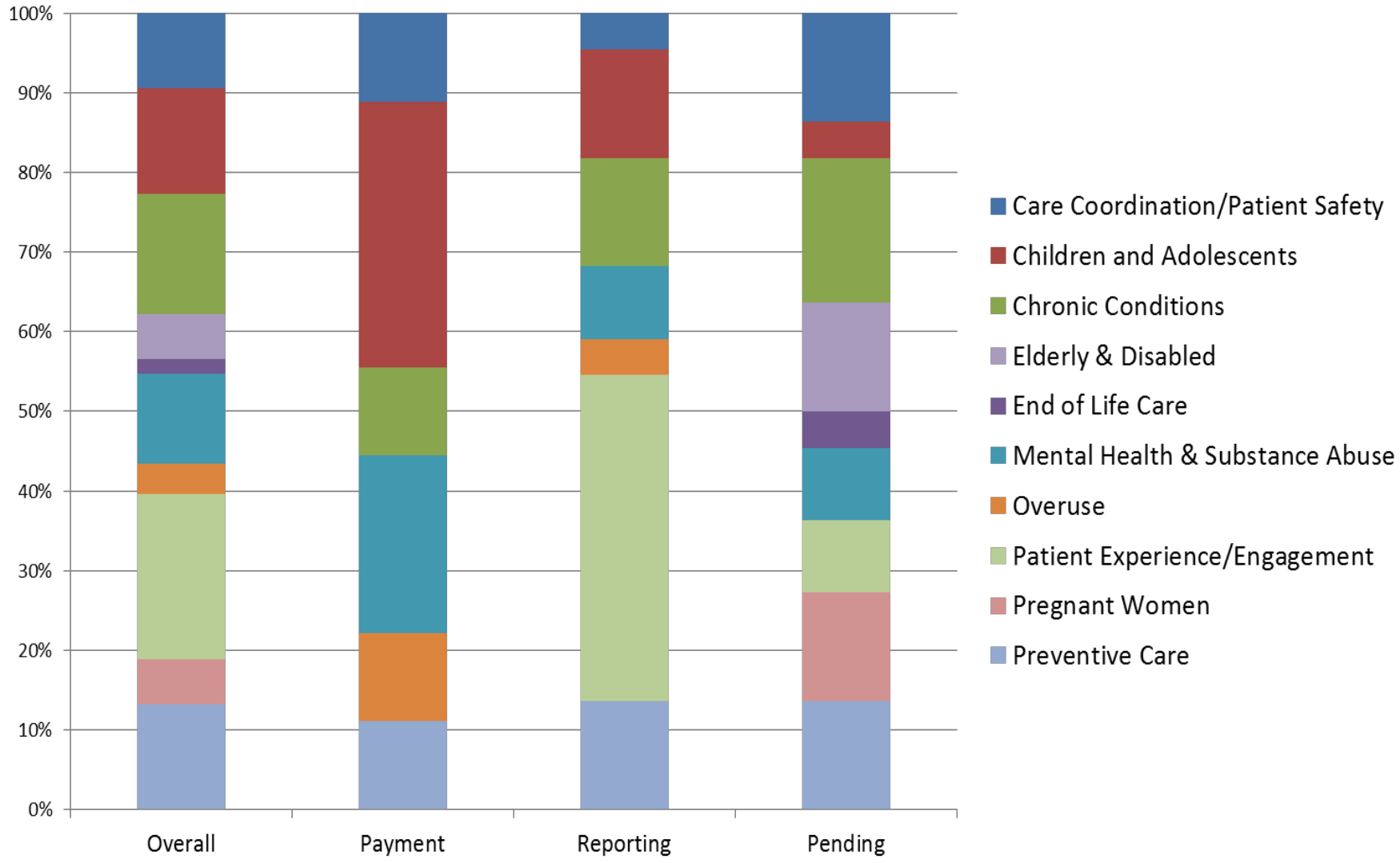
Type	Features	Number of ACOs
Medicare Shared Savings Program (MSSP, ACA Section 3022)	• At least 75% control of ACO's governing body by providers • 3-year agreement with Medicare • 2 models: One-sided model: ACO receives up to 50% savings and takes risk for losses in year three only Two-sided model: ACO receives up to 60% savings and takes risk for losses in years 1-3 • 3.2 million assigned beneficiaries in 47 states	220
Pioneer ACO (ACA Section 3021)	• Health care organizations and providers that have experience in population-based payment models (with same standards as MSSP) • Typically integrated health systems that operate a health plan and have the infrastructure to manage risk	23
Advanced Payment ACOs (ACA Section 3021)	• CMS provides upfront monthly capital based on expected shared savings for smaller ACOs • Targeted to partnerships between physician-based and rural providers to invest into their care coordination infrastructures	35
Private ACOs	• Clinically integrated groups of physicians, hospitals, and business partners (often health insurance plans) that contract with Medicaid or commercial plans on a risk basis	160+

Table 1. Deloitte Center For Health Solutions, July 22, 2013 Health Reform Update.

Why shared savings? Why not capitation?

- Concern about provider risk versus capacity to manage
- Desire to separate performance risk (less than optimum management of services) from insurance risk (sicker population or more unavoidable adverse events)
- Concern about “dumping” or avoidance of patients with high needs

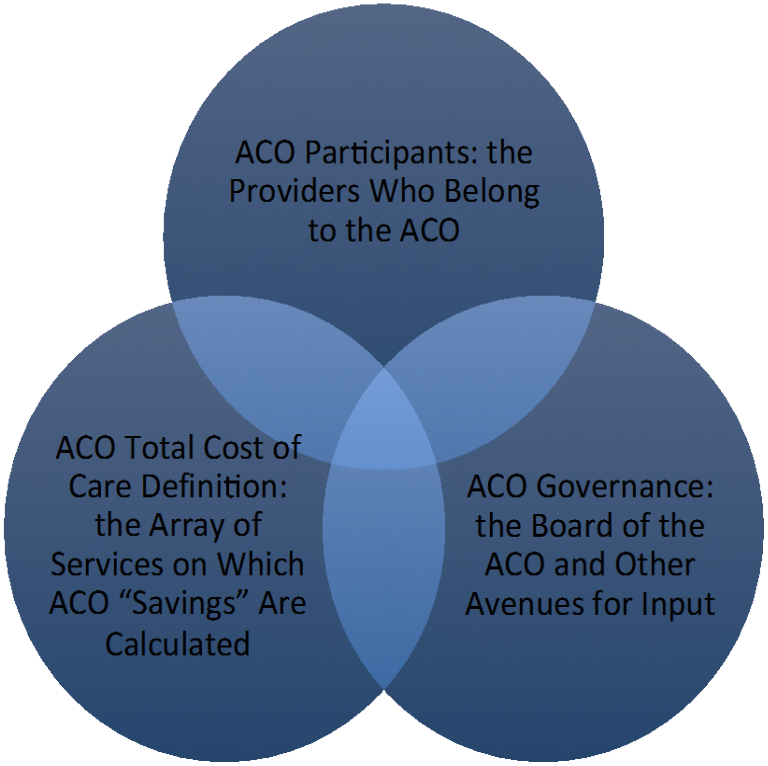
ACO Core Performance Measure Domains



Definitions

- **ACO Participant:** individual provider or provider organization that chooses to sign a participation agreement and join an ACO
- **ACO beneficiary:** An ACO beneficiary is a person who gets their health insurance from a payer (a public program such as Medicare or Medicaid or a private payer such as BCBS or MVP) that contracts with an ACO and gets their primary care from a provider who is an ACO participant.
- **Total costs of care:** Total costs of care are the costs on which an ACO will be tracked and evaluated for whether they reduce costs relative to the expected level.

ACO Participants, Total Costs of Care and Governance are Not Necessarily the Same



Proposed Timeline for Medicaid ACO SSP

Timeframe	Milestone
August	Proposed SSP Framework Discussed in Work Groups (Standards, Quality, Care Management)
August	Steering Committee Review and Recommendations Made to Core Team
October	Release RFP
November	Concept Paper to CMCS
November	Review Proposals
December	Sign Shared Savings Program Contract
December-January	Public Notice & SPA Submitted
January 1, 2014	Program Launch
December 31, 2014	End of Performance Year 1
March 2015	Interim Payment of Savings
June 2015	Final Reconciliation of Savings Payments

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.[i] 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

opportunity to align and rationalize Medicare and Medicaid financing and program rules and service delivery, while also realizing the benefits of provider integration, quality management and cost management that are the goals of the Medicare and Medicaid Shared Savings ACO programs.

Despite general consistency of the three programs with our overall health reform agenda, there are conflicts between them and complexities related to operating the programs simultaneously on a statewide basis. These include:

- Dually eligible beneficiaries can only be attributed to one of these federal demonstrations unless their primary care provider is not part of an ACO. However, the state is not precluded from using a shared savings ACO program as on approach to provider payment under the Duals Demo;
- For duals who could be attributed to a Medicare ACO, Medicare cost savings can only be allocated to one of these programs;
- Dually-eligible beneficiaries already are attributed to Medicare ACOs within Vermont that have been organized to participate in the Medicare Shared Savings ACO Program;
- Dually-eligible beneficiaries were included in Medicare ACO calculations of whether they met minimum federal standards for attribution and in their assumptions about potential savings to be derived from their efforts;
- Attribution of the beneficiaries to the Duals Demo could have adverse impacts on the already-formed Medicare ACOs – it could reduce their attributed population below the required federal threshold, or change the federal requirements about the savings they must achieve, or both;
- The State must decide within the next several months whether to enter into a memorandum of understanding with the federal government to pursue the Duals Demo;
- The State is in the process of designing and launching a Medicaid Shared Savings ACO Program, the design of which should complement the Medicare ACO and Duals Demonstration Programs. An RFP for the first year of the program was released last month and excluded dual eligible beneficiaries from year one of the program, but in years two and three, alignment between the Medicaid ACO program and Duals Demonstration will be necessary if the State pursues the Demo.

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

(ID, CO, OK, TX, IA, MO, WI, MI, SC, NC, CT and RI) continuing to pursue program participation.[ii]

Covered population
The Vermont Dual Eligible Demonstration would include almost all Vermonters dually-eligible for both Medicare and Medicaid. The only populations proposed for exclusion from the demonstration are individuals who are both dually eligible and have End Stage Renal Disease (ESRD). In addition, dual eligible individuals enrolled in Medicare Supplemental coverage through a private insurer, have third party coverage through an employer, or who are enrolled in a Medicare Advantage managed care plan may participate in this initiative, but only if they choose to disenroll from their existing program.

Covered services
The Demonstration Project would cover the full range of Medicaid and Medicare services, with the exception of Medicare-funded hospice services. In addition, if funding is sufficient, DVHA will have flexibility to offer additional benefits for all enrollees that exceed those currently covered by either Medicare or Medicaid, as well as flexible benefits that DVHA and its providers can offer to enrollees based on that person's plan of care. The Demonstration also proposes to offer dually eligible beneficiaries a single, comprehensive pharmacy benefits program that would provide coverage of all required outpatient prescription drugs.

Model of care/provider contracting
Vermont described in its application its intent to contract with so-called Integrated Care Partnerships (ICPs) to serve dually-eligible individuals who are enrolled in the program. ICPs would be new organizations made up of interested and qualified providers who agree to function, as a group, in accordance with program requirements. One provider member of the ICP would act as the contracting entity with DVHA on behalf of all ICP provider members. ICP provider members would be expected to include: home health agencies, area agencies on aging, developmental service agencies, mental health agencies among others. ICPs would be required to provide Enhanced Care Coordination- providing a single point of contact for coordinating and integrating a wide range of health, mental health and substance abuse, developmental, long-term care and support services for each enrollee as identified in their comprehensive Plan of Care.

Savings expectations
Anticipated primary areas for savings are: diagnostic testing services, emergency department services, inpatient hospital services, nursing home services and prescription drugs. CMS will automatically reduce its payments to the State by a negotiated amount (e.g., 1% in year one, 1.5% in year 2 and 2% in year 3), guaranteeing minimum Medicare savings for CMS, and placing the state at financial risk if no savings are achieved. On the other hand, the State will be able to keep any Medicare savings above the negotiated savings agreement with CMS.

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.[1]

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

[1] Email correspondence from Abe Berman of OneCare, September 24, 2013 and from Paul Reis of ACCGM, September 25, 2013.

participating providers, but must at least include primary care providers in order to have any attributed Medicare beneficiaries.

Savings expectations

ACOs participating in the MSSP are incentivized to improve quality and reduce costs with a shared savings model that allows the ACOs to earn 50% of any generated Medicare savings. Unlike the Duals Demonstration, the savings agreement is directly between the federal Medicare program and the ACOs, and Vermont state government does not directly benefit from any achieved savings. Before ACOs can share in savings, they have to meet a "minimum savings ratio" (MSR) requirement, which varies based on the size of the ACO's attributed population. The larger the attributed population, the lower the MSR.

Medicaid Shared Savings ACO Program

This initiative is being pursued through the design of a Medicaid Shared Savings Accountable Care Organization (ACO) program by the State of Vermont, with input from stakeholders through the Healthcare Innovation Project. A similar program is being designed for commercial insurers in Vermont. In the Medicaid Shared Savings ACO Program, DVHA will enter into a performance-based contract with qualified ACOs using an empirical approach to calculate and distribute shared savings for a defined set of beneficiaries and a defined range of service costs. DVHA has offered potential ACOs two track options for accepting downside risk identical to those used in the Medicare SSP. The program is currently scheduled for a January 1, 2014 launch.

Covered population

The population focus for the Medicaid ACO pilot includes all Medicaid enrollees, with the exception of dually eligible beneficiaries; individuals who have third party liability coverage; individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers; and individuals who are enrolled in Vermont Medicaid but receive a limited benefit package. Eligible beneficiaries must have at least ten months of non-consecutive coverage in the performance year. Like the Medicare shared savings program, in the Medicaid ACO program 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 a defined set of core services for their attributed population are less than expected in a given year. The range of core services included in total costs of care is similar to the Medicare definition in the first year of the program and expands over time, as described below.

Core services

In Year 1, Medicaid ACOs must include Core Services, as defined by DVHA. ACOs have the option to include all additional services beyond the Core Services in Year 2. In Year three, the Medicaid ACO pilot will cover the full range of Medicaid services, including

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;

- Misalignment between the programs could diminish provider incentives to improve the quality and reduce unnecessary costs of care;
- The patient population served by any one program may be too small to make the program viable, and will make confirmation of "true" savings more difficult.

Finally, other conflicts and inconsistencies in state policy are certain to arise and overall performance will be sub-optimized.

The Vermont State Innovation Model Operational Plan makes clear the State's intent to align the Duals Demonstration, the Medicare Shared Savings Program and the Medicaid Shared Savings Program. The state clearly recognizes the need for alignment across core project components to provide consistent incentives and operational models for health care providers and to ensure that Vermonters receive seamless, integrated and high quality services.

To assure maximum positive impact of these three programs for beneficiaries, providers and the State, it is important that the State develop a plan for coordinating the programs across multiple dimensions:

- Attribution
- Savings calculations
- Care models
- Provider contracting and payment methodologies
- Performance measures and provider quality incentive payments
- Information technology strategies and resources
- Beneficiary protections (e.g., grievance and appeals)

Creating alignment across these dimensions may require a change in the federal rules that apply to either the Duals Demo or the Medicare Shared Savings Program or both. The Dual Eligible Work Group of the Vermont Healthcare Innovation Project is charged with developing recommendations for integration along each of these dimensions. The Work Group's recommendations will be reviewed by other VHIP work groups and ultimately by the VHIP Steering Committee and Core Team. The results will inform the State's decision about whether and how to further pursue the Duals Demo.

[i] http://gmcboard.vermont.gov/dashboardcost & http://humanservices.vermont.gov/dual-eligibles-project/proposal-vermonts-demonstration-grant-to-integrate-care-for-dual-eligible-individuals/view

[ii] http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8426-03-financial-alignment-demonstrations.pdf & http://www.integratedcareresourcecenter.net/icmstatemou.aspx

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.

- The existing provider incentives to cost shift between Medicare and Medicaid will be maintained.

Action Steps: Under this option, the state would need to reduce its Duals Demonstration to only include those duals who are not attributed to a Medicare ACO. The state should take steps to formally evaluate whether there are increased savings on the acute side when Medicare and Medicaid services are integrated, versus when Medicare initiatives are done separately and without a focus on the long-term services and supports coordinated by Medicaid. However, the state's current financial analysis questions the sustainability of a smaller Duals Demonstration and would need to be reviewed again to see if there is sufficient potential for cost savings across Medicare and Medicaid if the dually eligible population is reduced by at least half. In addition, the state would need to continue to manage LTSS services for the Medicare ACO-attributed population since these LTSS services are primarily funded by Medicaid not Medicare.

Option Two: Attribute Dual Eligibles to Medicare ACOs for Medical Care and to the Duals Demonstration for LTSS

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 affiliated with a Medicare ACO are attributed to the Duals Demonstration for purposes of calculating Medicare savings related to long-term services and supports.
3. Dual eligibles whose primary care provider is not affiliated with a Medicare ACO network are attributed to the Duals Demonstration for *all* Medicare services, costs and potential savings.

Pros:

- All of the pros of Option One apply to Option Two.
- LTSS service provision could potentially be improved under the Dual Eligible Demonstration for the Medicare ACO-attributed duals since they would benefit from the Enhanced Care Coordination in the duals demo across all medical and LTSS needs. .

Cons:

- All of the cons of Option One apply to Option Two.
- Most of savings generated by LTSS are likely to be realized in reduced medical service expenditures.[1] As such, the Medicare ACO would benefit from these

[1] The Duals Demonstrations nationally are based on evidence that LTSS spending generates long-term cost savings for services covered by Medicare, including reduction in emergency room services and unnecessary inpatient admissions and re-admissions. Vermont's data submission as part of its Demonstration application showed savings primarily in medical services expenditures for: diagnostic testing, emergency room services, inpatient services, and prescription drugs. The non-medical area for savings was in reductions in skilled nursing facility services. The data submission is accessible at http://humanservices.vermont.gov/dual-

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.

---

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. 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.

- The state is able to share in some of the Medicare savings generated by the ACOs.
- Current Medicare ACOs retain and likely enhance their ability to generate shared savings payments, assuming they elect to participate as Medicaid ACOs.
- Medicare has included those dual eligibles attributed to Medicare ACOs within Duals Demonstrations in other states and therefore should be willing to do so in Vermont.[2]

Cons:

- ACOs may oppose the arrangement for multiple reasons, with expected downside risk assumption in the first contract year due to CMS reducing its expected spending by a fixed percentage under the Duals Demonstration (estimated at 1% in the first year)[3] - a special concern. ACOs may also have concerns about DVHA being a reliable partner in comparison to CMS.
- CMS may not support a non-voluntary attribution of Medicare beneficiaries from the Medicare Shared Savings Program to the Duals Demonstration should MSSP ACOs voice strong opposition.
- If duals are not attributed to Medicare ACOs then some ACOs may not be able to reach the Medicare Shared Savings Program minimum size of 5,000, although this does not appear to be true for OneCare at present. Even if each Medicare ACO does retain attribution above 5000, however, its MSSP Minimum Savings Rate will increase, making shared savings achievement significantly more difficult.
- CMS may not agree to not take savings off the top from Medicare payments to DVHA under the Duals Demonstration.
- Not all of the current Medicare ACOs may choose to participate as Medicaid ACOs.
- The ACOs may not have the required expertise to manage and provide the LTSS needs of dual beneficiaries.
- DVHA will have to manage two models of care for the dually eligible – ACO and non-ACO - since not all dual eligibles will be attributed to an ACO.

Action Steps: Under this option, the state would keep its Duals Demonstration fully intact, with the exception that DVHA would contract with ACOs rather than contract with Integrated Care Partnerships for the provision of Enhanced are Coordination. Dual eligibles would not continue to be within the Medicare MSSP but would be served by the same ACO. The state would need to share its financial analysis for overall savings within the Duals Demonstration with ACOs to convince them (and CMS) of their likelihood to maintain or increase the potential savings they would have under the

[2] See Appendix A for examples.

[3] The state could address this problem by absorbing any downside risk required by the Duals Demonstration that would otherwise be assigned to ACOs, but the state may not wish to take on this risk itself.

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.

- The Duals Demonstration model of care remains intact (i.e., contracts with integrated care partnerships for enhanced care coordination), maximizing utilization of existing providers/knowledge within the LTSS for assisting beneficiaries with complex and high cost needs.
- DVHA will not have to manage two models of care for the dually eligible – ACO and non-ACO - since not all dual eligibles will be attributed to an ACO.
- The state is able to keep any Medicare savings above the agreed-upon CMS share (e.g., 1 – 2%).
- The Medicare ACOs are not penalized by duals attribution to the Duals Demonstration
- The Medicare ACOs benefit from any Medicare savings in the Duals Demonstration above the agreed-upon CMS share (which is more than they would have received through the Medicare ACO program which must share 50% of any savings with CMS)
- Medicare has included those dual eligibles attributed to Medicare ACOs within Duals Demonstrations in other states and therefore should be willing to do so in Vermont.[4]
- The Duals Demonstration would allow unprecedented State control of Medicare dollars.
- The existing provider incentives to cost shift between Medicare and Medicaid will be eliminated.

Cons:

- Medicare ACOs may oppose the arrangement due to uncertainty about CMS agreement with safe harbor provisions and uncertainty about savings from the Duals Demonstration.
- CMS may not support a non-voluntary attribution of Medicare beneficiaries from the Medicare Shared Savings Program to the Duals Demonstration should MSSP ACOs voice strong opposition.
- If duals are not attributed to Medicare ACOs and CMS does not agree to proposed safe harbor provisions, some ACOs may not be able to reach the Medicare Shared Savings Program minimum size of 5,000, although this does not appear to be true for OneCare at present. Even if each Medicare ACO does retain attribution above 5000, however, its MSSP Minimum Savings Rate will increase, making shared savings achievement more difficult.

Action Steps: Under this option, the state would keep its Duals Demonstration fully intact, including the proposed model of care. The state would need to share its financial analysis for overall savings within the Duals Demonstration with ACOs to convince them (and CMS) of their likelihood to maintain or increase the potential savings they would have under the MSSP.

[4] See Appendix A for examples.

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?

Appendix :Attribution Methods in States with both a Duals Demonstration and ACOs Participating in the Medicare Shared Savings Program

	State	FFS, MC other	Resolved Medicare Attribution	Addressed in MOU	Comments
1	CA	MC	?	No	Call with CA being rescheduled[5]
2	IL	MC	?	No	Waiting to hear from Illinois[6]
3	MA	MC	Yes	Yes	MOU indicates that ACO-attributed beneficiaries will be enrolled in the Demo.[7]
4	MN	Other	Yes	No	Not applicable to VT as MN has agreed to an alternative arrangement with CMS.[8,9]
5	NY	MC	No	Yes	MOU language indicates that individuals in a Medicare ACO can't be moved into the Duals Demo through passive enrollment.[10] State staff indicates it is still an unresolved issue if someone chooses to enroll in a Dual Demonstration plan.
6	OH	MC	Yes	No	Ohio state staff indicated that if a participant is in a Medicare ACO and enrolls into the Duals Demo the Medicare attribution will shift to Duals Demo.[11,12]
7	VA	MC	NA	No	Virginia state staff indicated that they do not have Medicare ACOs.[13]
8	WA	FFS	Yes	Yes	If beneficiary in Duals Demo, removed from attribution to Medicare ACO[14]

[5] www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html Bailit contacted the state of California and will talk with the Duals Program Director 10-3-13.

[6] Ibid – CMS website for MOUs. Bailit reached out to the Illinois Dual Eligible Director on 9-11-13 with no response.

[7] Email on 9-16-13 from Stephanie Anthony, former consultant to Massachusetts. MOU contains the following language: "To best ensure continuity of beneficiary care and provider relationships, CMS will work with the Commonwealth to address beneficiary or provider participation in other programs or initiatives, such as Accountable Care Organizations (ACOs). A beneficiary enrolled in the Demonstration will not be attributed to an ACO or any other shared savings initiative for the purposes of calculating shared Medicare savings under those initiatives."

[8] Email on 9-12-13 from Jennifer Baron, CMS Duals program contact for Vermont to Julie Wasserman, Vermont Duals program director, about MN-CMS Duals MOU signed on 9-12-13.

[9] Alternative in MN agreed to because of the nearly 20-year history they have operating demonstrations and subsequent Fully Integrated Dual Eligible Special Needs Plans (FIDESNPs) according to emails with MN Dual Eligible Director on 9-13-13.

[10] Ibid – CMS website for MOUs. Bailit reached out to the New York Dual Eligible Director on 9-13-13 and was told the state had not resolved the issue of attribution if someone actively moves out of an ACO and into a Duals Demonstration plan.

[11] www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html

[12] Email messages from the Ohio Dual Eligible Director on 9-11-13 that attribution would switch from ACO to Duals.

[13] Email message on 9-25-13 from Suzanne Gore of Virginia Medicaid.

[14] Ibid – CMS website for MOUs. The language in the MOU is very clear about the process.

Options for Alignment of the Dual Eligible Demonstration with Medicare ACOs & Medicaid ACOs

Presentation for SIM/Duals Steering Committee and Workgroups

November 2013

November 20, 2013 Presentation for VHCIP Duals Work Group

Presented by:

- Anya Rader Wallack – Chair – Vermont State Innovation Model Core Team
- Brendan Hogan – Bailit Health Purchasing
- Susan Besio – Pacific Health Policy Group

Bailit Health Purchasing White Paper and Today's Presentation

- Bailit Health Purchasing was charged with the task of developing an options paper for the Green Mountain Care Board
- Analyze options for the Duals Demonstration to align with Medicare ACOs and Medicaid ACOs
- Paper has been edited and updated by Green Mountain Care Board, State Staff and Pacific Health Policy Group
- The presentation today is a collaborative effort

Why are we here?

- The State's process for deciding whether to pursue the Duals Demo got stalled for two reasons:
  - Insufficient analysis of the financial and operational risks and benefits to the State and providers
  - Insufficient alignment with other payment and delivery system reform efforts
- This group is being asked to address those shortcomings
- The Duals Work Groupwill:
  - Develop a strategic plan for alignment
  - Oversee additional financial and operational analyses
  - Provide input to the VHCIP Steering Committee about whether to proceed with the Demo
- The VHCIP Steering Committee will make a recommendation to the VHCIP Core Team about whether or not to proceed with the Dual Eligible Demonstration

Overview

- Approximately 22,000 Dual Eligible Individuals in Vermont (2010)
- Vermont dually-eligible individuals had average combined Medicare and Medicaid costs in of $26,880 per person per year compared with $7,876 per person per year for Vermonters in general (2010)
- Medicare pays for medical services
- Medicaid pays for medical services, but also is pays for long-term services and supports (LTSS)

Background – Status of Vermont and Duals Demonstrations around the Country

- 25 states originally developed proposals in 2011 to participate in the CMS program.
  - 15 states (including VT) received planning grants to help develop their proposals.
- Of the 25 original states, 8 states have signed Memorandums of Understanding with CMS (CA, IL, MA, NY, OH, VA, WA, MN)
- Of the 17 remaining states, 3 states (AZ, NM and TN) have withdrawn their proposals primarily due to high Medicare Managed Care Plan penetration in their state.
- Of the 14 states left, 1 state is pursuing an alternative demonstration approach (OR).
- This leaves Vermont with 12 other states (ID, CO, OK, TX, IA, MO, WI, MI, SC, NC, CT and RI) continuing to pursue program participation.

Background – Status of Vermont Duals Demonstration

- New anticipated start date for Vermont Duals Demonstration is April 1, 2015
- Next step in process is a Memorandum of Understanding between CMS and AHS regarding the Duals Demonstration
  - MOU defines broad parameters of the Demonstration
  - Is non-binding; either party can withdraw without penalty
- MOU must describe alignment between Vermont's 3 new programs that involve dual eligible individuals – Dual Eligible Demonstration, Medicare Shared Savings ACO Program and Medicaid Shared Savings ACO Program

Areas Needing Alignment across 3 Programs

- VHCIP and the Duals Work Group must look at all of the following areas for alignment opportunities:
  - Attribution for Savings Calculations – *focus of this presentation*
  - Care models
  - Provider contracting and payment methodologies
  - Performance measures and provider quality incentive payments
  - Information technology strategies and resources
  - Beneficiary protections (e.g., grievance and appeals)

Attribution Alignment Challenges - Overview

- Dual eligibles can only be attributed to one of these federal demonstrations – Dual Eligible Demonstration or Medicare Shared Savings ACO Program

- The State can operate a Medicaid Shared Savings ACO Program with or without the federal demonstrations

- Dual eligibles are only attributed to an ACO program if their primary care provider (PCP) is part of an ACO
  - Current Vermont ACO Programs do not include all PCPs in the state; as such, some dual eligibles will not be part of an ACO

Duals Demonstration – Savings Parameters

- DVHA will receive Medicare payments for alldual eligible Vermonters to blend with Medicaid funding to cover all Medicare and Medicaid services
- CMS and State will negotiate required savings amounts that the federal government keeps up front, which could be:
  - 1% year one
  - 1.5% year two
  - 2 % year three
- If the State gets Medicare savings beyond these amounts, the State can retain those savings and could share them with providers

Medicare ACOs

- Patient attribution in Medicare ACOs is tied to primary care providers in the ACO
- Vermont currently has two Medicare ACOs– OneCare Vermont and Accountable Care of the Green Mountains
  - A third ACO - Community Health Accountable Care - is expected to start on 1/1/14 as a coalition of the federally qualified health care centers
- Federal minimum attribution requirement for patients is 5,000 lives
  - OneCare has more than this but ACGM has approx. 5,000

Medicare ACOs – Savings Parameters

- Medicare ACOs 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
- Medicare ACOs earn 50% of any generated Medicare savings
- Before ACOs can share in savings, they have to meet a "minimum savings ratio" (MSR) requirement, which varies based on the size of the ACO's attributed population.
  - The larger the attributed population, the lower the MSR
- The savings agreement is directly between the federal Medicare program and the ACOs

Alignment Challenges - Medicare ACOs

- Dual eligibles currently are attributed to VT Medicare ACOs if their PCP is affiliated with the ACO
- Dual eligibles were included in Medicare ACO calculations of whether they met minimum federal standards for attribution (i.e., number of lives) and in their assumptions about potential savings to be derived from their efforts
  - Attribution of dual eligibles to the Duals Demo could have adverse impacts on these Medicare ACOs – it could reduce their attributed population below the required federal threshold, or change the federal requirements about the savings they must achieve, or both
  - Attribution of beneficiaries to the Duals Demo also could diminish the Medicare ACOs' incentives to improve outcomes and reduce unnecessary costs for this population

Medicaid ACOs

- Program begins January 1, 2014
  - OneCare VT and Community Health Accountable Care have submitted bids to DVHA
- Covered population includes all Medicaid enrollees except:
  - Dually eligible beneficiaries;
  - Individuals who have third party liability coverage;
  - Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers;
  - Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.
- Attribution in Medicaid ACOs is based on primary care providers in the ACO

Medicaid ACOs – Savings Parameters

- Savings parameters are similar to Medicare– ACO is eligible to share savings if the Total Costs of Care for their attributed population are less than expected in a given year
  - The Core Services included in the Total Costs of Care for Year 1 have been defined by DVHA – very similar to Medicare
  - Medicaid ACOs have the option to include additional services beyond the Core Services in Year 2 and thus can negotiate a lower minimum savings rate
  - In Year 3, the Medicaid ACO must cover the full range of Medicaid services, including long-term services and supports, pharmacy, dental, transportation, and mental health and substance abuse services

Problems with Not Aligning the 3 Programs

- Potential 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
- 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

Problems with Not Aligning the 3 Programs, cont.

- Duplicate activities will be likely (e.g., separate assessments and care plans)
- Misalignment between the programs could diminish provider incentives to improve the quality and reduce unnecessary costs of care
- It will be challenging to distinguish the source of savings from separate initiatives when the same providers serve individuals in all initiatives
- The patient population served by any one program may be too small to make the program viable
- Other problems we have missed?

Next Steps - Review Four Attribution Options

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

- 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
- 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

Next Steps - Review Four Attribution Options

Option Two: Attribute Dual Eligibles to Medicare ACOs for Medical Care and to the Duals Demonstration for LTSS

- 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
- Dual eligibles whose primary care provider is affiliated with a Medicare ACO are attributed to the Duals Demonstration for purposes of calculating Medicare savings related to the costs of long-term services and supports
- Dual eligibles whose primary care provider is not affiliated with a Medicare ACO network are attributed to the Duals Demonstration for *all* Medicare services, costs and potential savings

Next Steps - Review Four Attribution Options

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

- Dual eligibles are attributed to the Duals Demonstration
- DVHA issues a RFP and contractswith 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

Continued….

Next Steps - Review Four Attribution Options

Option Three, cont.: Include Dual Eligibles in the Duals Demonstration for All Services and Contract with ACOs

- The State negotiates safe harbor provisions with CMS for a Medicare ACO that does not participate in the Medicaid ACO program
- The State negotiates with CMS that there should be no 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 which are not required to share in downside risk for the first 3 years of 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

Next Steps - Review Four Attribution Options

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 attributed to 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.

Next steps - Decision Criteria

- All four options require significant compromise by one or more central stakeholders. Yet, each option could provide a potential path to continue the Duals Demonstration while also pursuing savings through Medicare and Medicaid ACOs.
- The following questions could be discussed 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 and maximize opportunity for savings?

Overview of CMS Dual Eligible Demonstration
Memorandum of Understanding (MOU) and Three-Way Contract
November 13, 2013

The process for Vermont to enter into an agreement with CMS to implement a Dual Eligible Demonstration involves multiple steps as described below. The MOU is a non-binding document while the legal Three-Way Contract commits Vermont to a combined Medicaid managed care and Medicare Advantage Part C program with the associated obligation of federal and state expenditures.

1. **Planning & Design Process** : Vermont submitted an application to CMS entitled "State Demonstration to Integrate Care for Dual Eligible Individuals" in January 2011 for funds to initiate a comprehensive planning and design process. Vermont received a $1 million planning grant from CMS to support this work in May 2011.

2. **Demonstration Proposal (May, 2012)**: The design process culminated in Vermont's Demonstration Proposal submission to CMS. Once CMS determined that the proposal met CMS' established standards and conditions, Vermont began negotiation of a Memorandum of Understanding (MOU) with CMS.

3. **Memorandum of Understanding**: ***The MOU is a formal, non-binding[1] state-specific document, signed by CMS and the State (AHS), which identifies the broad parameters of Vermont's Demonstration.*** CMS and AHS began working in August 2012 to develop the specific content to be included in the MOU. Drafts of the MOU document have been in development since January 2013, with questions, responses and editing occurring routinely since June 2013. Vermont's draft MOU document is still in an iterative feedback process between the State and CMS. Vermont's goal is to have a signed MOU by early 2014.

   Once the MOU is signed, Vermont will receive up to $15 million in CMS funding over a two-year period for more detailed project development (Year 1) and for project implementation after the Three-Way Contract is signed (Year 2). Execution of the MOU offers Vermont the following: a) funds for activities to explicitly incorporate the needs of individuals with disabilities into Vermont's health care reform efforts; b) launches the detailed planning and development of delivery systems that integrate acute care with long term services and supports; c) funds staff for the development of training plans/curricula, quality improvement initiatives, and a single pharmacy benefit; and d) enables Vermont Legal Aid, ADRC and SHIP organizations to apply for additional federal funding for member support activities.

4. **Identification of Demonstration Health Plan:** DVHA formalized its role as the Demonstration's proposed health plan through its submission of a Medicare-Medicaid Plan application to CMS in February 2013. CMS will perform a Readiness Review to assure that DVHA is able to meet federal and state requirements and is prepared to enroll and serve dually eligible beneficiaries.

5. **Three-Way Contract**: Once DVHA has successfully passed the Readiness Review, a ***legal three-way contract is signed by CMS, AHS, and DVHA to effectuate the broad principles agreed to in the MOU.*** The contract also reconciles Medicaid and Medicare fiscal and beneficiary requirements into a single contract that functions as both a Medicaid managed care contract and a Medicare Advantage Contract with a commitment of federal and state expenditures.

[1] In this document, the term "non-binding" means that the parties can end the Understanding at any point without legal or fiscal ramifications. Section III. L. of the draft Vermont MOU defines this in more detail and includes the following language: "Nothing in this MOU may be construed to obligate the Parties to any current or future expenditure of resources. This MOU does not obligate any funds by either of the Parties."

The following Table provides a comparison of the content of the non-binding MOU agreement between CMS and the State (AHS) describing the parameters of the Demonstration project, versus the legal Three-Way Contract between CMS, the State (AHS) and the Plan (DVHA) that binds the parties to specific parameters for operating the Dual Eligible Demonstration.

MOU (between CMS and AHS) Example Table of Contents	THREE-WAY CONTRACT (between CMS, AHS and DVHA) **Example Table of Contents** (excerpted from Massachusetts MOU)
I. **Statement Of Initiative** II. **Specific Purpose of Memorandum Of Understanding** III. **Demonstration Design / Operational Plan** A. Demonstration Authority B. Contracting Process C. Enrollment D. Delivery Systems and Benefits E. Enrollee Protections, Participation, and Customer Service F. Quality Management G. Financing And Payment H. Evaluation I. Extension of Agreement J. Modification or Termination of MOU K. Signatures Appendix 1: Definitions Appendix 2: CMS Standards and Conditions and Supporting State Documentation Appendix 3: Details of State Demonstration Area Appendix 4: Medicare Authorities and Waivers Appendix 5: Medicaid Authorities and Waivers Appendix 6: Payments to the Public Managed Care Model Appendix 7: Demonstration Parameters *NOTE: The language of the MOU can be modified when preparing the Three-Way Contract.*	**Section 1. Definition of Terms** **Section 2. Contractor Responsibilities** 2.1 Compliance 2.2 Contract Management and Readiness Review Requirements 2.3 Enrollment Activities 2.4 Covered Services 2.5 Care Delivery Model 2.6 Comprehensive Assessments and Individualized Care Plan 2.7 Provider Network 2.8 Network Management 2.9 Enrollee Access to Services 2.10 Enrollee Services 2.11 Enrollee Grievance 2.12 Enrollee Appeals 2.13 Quality Improvement Program 2.14 Marketing, Outreach, and Enrollee Communications Standards 2.15 Financial Requirements 2.16 Data Submissions, Reporting Requirements, and Surveys 2.17 Encounter Reporting **Section 3. CMS and EOHHS Responsibilities** 3.1 Contract Management 3.2 Enrollment and Disenrollment Systems **Section 4: Payment and Financial Provisions** 4.1 General Financial Provisions 4.2 Capitated Rate Structure 4.3 Payment Terms 4.4 Transitions Between Rating Categories and Risk Score Changes 4.5 Reconciliation 4.6 Risk Corridors 4.7 Payment in Full **Section 5: Additional Terms and Conditions** 5.1 Administration 5.2 Confidentiality 5.3 General Terms and Conditions 5.4 Record Retention, Inspection, and Audit 5.5 Termination of Contract 5.6 Order of Precedence 5.7 Contract Term 5.8 Amendments 5.9 Written Notices Appendix A: Covered Services Appendix B: Covered Services Definitions Appendix C: Enrollee Rights Appendix D: Relationship w/First Tier, Downstream,& Related Entities Appendix E: Quality Improvement Project Requirements Appendix F: Addendum to Capitated Financial Alignment Contract Pursuant to … the Operation of a Voluntary Medicare Prescription Drug Plan Appendix G: Data Use Attestation Appendix H: Applicable Data Use Attestation Information Systems Appendix I: Model File & Use Certification Form Appendix J: Medicare Mark License Agreement Appendix K: Service Area Appendix L: Foundational Elements of Primary Care & Behavioral Health Integration Appendix M: Acceptable Admitted Assets

	Appendix N: EOHHS Programmatic Reporting Requirements

VT Health Care Innovation Project
Dual Eligible Work Group Meeting Schedule

Conference Line Information (Group assigned line to be used at every meeting)

Call-in Number: 1-877-273-4202
Conference ID: 8155970
Moderator PIN: 5124343

Date	Time	Place
Thursday, 12/12/13	10am – 12pm	DVHA Large Conf. Room
Thursday, 1/16/14	10am – 12pm	AHS Training Room
Thursday, 2/20/14	10am – 12pm	AHS Training Room
Thursday, 3/13/14	10am – 12pm	DVHA Large Conf. Room
Thursday, 4/24/14	10am – 12pm	DVHA Large Conf. Room
Thursday, 5/22/14	10am – 12pm	DVHA Large Conf. Room
Thursday, 6/19/14	10am – 12pm	AHS Training Room