VT Health Care Innovation Project
Dual Eligible Work Group Meeting Agenda
Thursday, December 12th, 2013; 10:00 AM to 12:30 PM
DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT
Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item #	Time Frame	Topic	Relevant Attachments	Action #
1	10:00 – 10:10	**Welcome and Introductions** Deborah Lisi-Baker and Judy Peterson	• Attachment 1: Meeting Agenda	
2	10:10 – 10:20	**Key Questions** Julie Wasserman	• Attachment 2: Key Questions Document	
3	10:20 – 11:50	**Strategic Plan for Alignment** Brendan Hogan and Susan Besio • Unique Opportunities of Duals Demo • Recap Options • Report on Sub-Group meeting	• Attachment 3a: Unique Opportunities of Duals Demo • Attachment 3b: Memo re: The Need for Alignment • Attachment 3c: Memo re: Options for Alignment	
4	11:50 – 12:10	**Decision on Signing the Duals MOU** Anya Rader Wallack	• Attachment 4: Description of MOU • CMS Link to all Dual Eligible signed MOUs: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html	
5	12:10 – 12:25	**Public Comment** Deborah Lisi-Baker and Judy Peterson		
6	12:25 – 12:30	**Wrap up/Next Steps/Future Meeting Schedule**	Next Meeting: January 16 10-12p	

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

1. Why is the Duals important? The "why" of the Duals needs to be discussed prior to discussion of the four Alignment Options. (Larry Goetschius)

2. How do you reconcile the ACO Shared Savings model with funding for the Designated Agencies who will be asked to provide more services while they are held to the Designated Agency funding cap? (Ray Stout)

3. Given the existence of multiple Medicare Shared Savings ACOs, multiple Medicaid Shared Savings ACOs and multiple ICPs, can you explain to a provider how this will work; it seems a bit complicated. Will a provider have separate contracts with each of these entities? (Julie Tessler)

4. Request to review the plans and capacity for an integrated Duals pharmacy plan at a future Duals Work Group meeting. (John Barbour)

Unique Opportunities for Vermont through DE Demonstration Medicare / Medicaid Integration

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

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

There are approximately 22,000 Vermonters enrolled in both Medicare and Medicaid whose annual expenditures totaled almost $600 million in 2010. Many, but not all, of these individuals have a disability, all are low income and about half are elderly. Dually-eligible individuals are among the most intense users of health care and long-term services and supports, and their costs are, on average, very high: dually-eligible individuals had health care costs in of $26,880 per person per year in 2010 on average compared with $7,876 per person per year in 2010 for Vermonters in general.[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.

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eligibles-project. In addition, Holahan et al. have quantified potential savings to both state and federal governments of enhanced care management, including for dual eligibles. See Holahan, J., Schoen, C., and McMorrow, S., 2011, *The Potential Savings from Enhanced Chronic Care Management*; Urban Institute, November; accessible at: www.urban.org/uploadedpdf/412453-The-Potential-Savings-from-Enhanced-Chronic-Care-Management-Policies-Brief.pdf. 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.

TO: Vermont Health Care Innovation Project Duals Work Group Members

FROM: Anya Rader Wallack, Chair, VHCIP Core Team

DATE: December 4, 2013

SUBJECT: Memorandum of Understanding between the State Of Vermont and the Centers for Medicare and Medicaid Services

---

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

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

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

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

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

1. Clarification regarding how the document addresses attribution of Medicare beneficiaries between the duals Demonstration and the Medicare shared savings ACO program

The following language is included in the draft MOU related to attribution:

> To best ensure continuity of Enrollee care and provider relationships, CMS will work with AHS to address Enrollee or provider participation in other programs or initiatives, such as current or planned Medicare Shared Savings Program (MSSP) and/or Medicaid ACOs, Blueprint for Health, and Health Homes. An Enrollee enrolled in the Demonstration will not be enrolled in, or have costs attributed to, an ACO or any other shared savings initiative for the purposes of calculating Medicare savings under those initiatives.

I clarified in a phone call with CMS staff that the second sentence means their standard operating procedure will be to attribute duals to the Duals Demo, if Vermont pursues it, and not to the MSSP. The policy underlying this rule is that they want to attribute beneficiaries to the "most integrated" model, and they assume this will be the Duals Demonstration. However, Vermont can propose an alternative attribution methodology, and CMS is aware that we are considering alternatives.

2. Links to MOUs signed by other states, which include information very similar to what will likely be included in any final MOU with Vermont.

There are two types of financial alignment models under the CMS Demonstration –Capitated and Managed Fee for Service; Vermont is pursuing the Capitated alignment model. You can access other capitated model states' MOUs on the MMCO Financial Alignment Initiative website, to get a sense of MOU format and content, at:

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html

3. Description of the contents of the MOU and how the MOU addresses issues of key importance to stakeholders.

Key sections of the MOU include:

A. A general description of the Demonstration

This section of the MOU describes how AHS and CMS will establish a Federal-State partnership to implement the Vermont Medicare-Medicaid Alignment Initiative (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid Enrollees)

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

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

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

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

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

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

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

developmental services, and long-term services and supports (LTSS);
4. Support during care transitions;
5. Payment reform connecting provider payment with performance measures related to changes in utilization and quality;
6. Improved sharing of health records, assessments, and information; and
7. A single, integrated pharmacy benefit plan.

As part of this Demonstration, CMS and AHS will implement a new Medicare and Medicaid payment methodology designed to support DVHA in serving Medicare-Medicaid Enrollees in the Demonstration. This financing approach will minimize cost-shifting, align incentives between Medicare and Medicaid, and support the best possible health and functional outcomes for Enrollees.

CMS, in collaboration with AHS, will allow for certain flexibilities that will further the goal of providing a seamless experience for Medicare-Medicaid Enrollees, utilizing a simplified and unified set of rules. Flexibilities will be coupled with specific Enrollee safeguards. DVHA will have full accountability for managing the capitated payment to best meet the needs of Enrollees. Enrollees' service needs will be outlined in Individualized Plans of Care developed by Enrollees, their caregivers, and interdisciplinary care teams (ICTs) using a person-centered planning process. CMS, in collaboration with AHS, expects DVHA to achieve savings through better integrated and coordinated care. Subject to CMS and AHS oversight and available resources, DVHA will have significant flexibility to innovate around care delivery and to provide a range of community-based services as alternatives to or means to avoid high-cost traditional services if indicated by the Enrollee's wishes, needs, and Individualized Plan of Care.

B. A general description of the design and operational plan for the Demonstration

This section describes how CMS and AHS will enter into a Demonstration Contract with DVHA to serve in a Medicare-Medicaid managed care capacity for this Demonstration. DVHA is also required to submit a Capitated Financial Alignment Demonstration application to CMS and meet all of the Medicare requirements for participation in the Capitated Financial Alignment Model. (Note: DVHA submitted this application in spring 2013 and will only need to re-submit information that has changed since the original application; the exception is that pharmacy information must be submitted annually). This section also describes how CMS will conduct a Readiness Review of DVHA. Prior to Demonstration Contract execution, both CMS and AHS must agree that DVHA has satisfied all readiness requirements. The Readiness Review will include an evaluation of the capacity of DVHA and its ability to meet all program requirements, including having an adequate network that addresses the full range of Enrollee needs and the capacity to uphold all Enrollee safeguards and protections. CMS also will conduct a Readiness Review of the enrollment systems, staffing capacity, and processes and its ability to meet enrollment and programmatic requirements.

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

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

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

C. A description of payment arrangements under the Demonstration

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

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

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

CMS will develop Medicare baseline spending for Parts A/B services, which will be a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration.

The Medicare baseline spending will be risk adjusted based on the risk profile of each enrolled beneficiary. The existing CMS-HCC risk adjustment methodology will be utilized for the Demonstration. The State will analyze utilization and functional data and, if determined appropriate, will work on the development of an enhanced risk adjustment methodology for the Medicaid component of the rate during the course of the Demonstration.

Once baseline costs have been established, CMS will expect the percentage savings in each year of the Demonstration. Vermont has proposed the following savings percentages which have not yet been negotiated with CMS:

a. Year 1: 1%

b. Year 2: 1.5%

c. Year 3: 2%

Under the Demonstration, Medicare and Medicaid also will withhold a percentage of their respective components of the capitation rate from DVHA, which will be repaid subject to DVHA's performance consistent with established quality thresholds. The withhold will be 1% in year 1, 2% in year 2 and 3% in year 3. Performance measures to be used to calculate whether withholds will ultimately be paid out to providers will be specified in the MOU.

To mitigate the risk to the State under this Demonstration, Vermont has proposed language in the MOU to include limits on the total state exposure for Medicare costs that exceed projections.

D. A description of delivery system requirements under the Demonstration

The MOU will include specification of requirements for various entities and individuals contemplated in the State's model of care, including:

> **Integrated Care Partnerships (ICPs**), which will be an affiliation of member organizations in a defined geographic region that is responsible for the provision of enhanced care coordination for Enrollees across all of their health care and support needs. At a minimum, each ICP must include a sufficient quantity and variety of member organizations to create an integrated, person-centered system of enhanced care coordination, including but not limited to statutorily and state-designated organizations

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

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

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

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

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

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

TO: Vermont Health Care Innovation Project Duals Work Group Members

FROM: Anya Rader Wallack, Chair, VHCIP Core Team

DATE: December 4, 2013

SUBJECT: Memorandum of Understanding between the State Of Vermont and the Centers for Medicare and Medicaid Services

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

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

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

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

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

CMS will develop Medicare baseline spending for Parts A/B services, which will be a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration.

The Medicare baseline spending will be risk adjusted based on the risk profile of each enrolled beneficiary. The existing CMS-HCC risk adjustment methodology will be utilized for the Demonstration. The State will analyze utilization and functional data and, if determined appropriate, will work on the development of an enhanced risk adjustment methodology for the Medicaid component of the rate during the course of the Demonstration.

Once baseline costs have been established, CMS will expect the percentage savings in each year of the Demonstration. Vermont has proposed the following savings percentages which have not yet been negotiated with CMS:

a. Year 1: 1%

b. Year 2: 1.5%

c. Year 3: 2%

Under the Demonstration, Medicare and Medicaid also will withhold a percentage of their respective components of the capitation rate from DVHA, which will be repaid subject to DVHA's performance consistent with established quality thresholds. The withhold will be 1% in year 1, 2% in year 2 and 3% in year 3. Performance measures to be used to calculate whether withholds will ultimately be paid out to providers will be specified in the MOU.

To mitigate the risk to the State under this Demonstration, Vermont has proposed language in the MOU to include limits on the total state exposure for Medicare costs that exceed projections.

D. A description of delivery system requirements under the Demonstration

The MOU will include specification of requirements for various entities and individuals contemplated in the State's model of care, including:

> **Integrated Care Partnerships (ICPs**), which will be an affiliation of member organizations in a defined geographic region that is responsible for the provision of enhanced care coordination for Enrollees across all of their health care and support needs. At a minimum, each ICP must include a sufficient quantity and variety of member organizations to create an integrated, person-centered system of enhanced care coordination, including but not limited to statutorily and state-designated organizations

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

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

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

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

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

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