VHCIP Steering Committee 4-16-14 Meeting Additional Materials

To: Members of the VHCIP Core Team

From: Deborah Lisi-Baker, Co-Chair, Disability and Long Term Services and Supports (DLTSS) Work Group (formerly the Dual Eligible Work Group)

Date: April 11, 2014

I recently had the pleasure of participating in a joint meeting of the Co-Chairs of both the Care Models and Care Management (CM/CM) Work Group and the DLTSS Workgroup, along with a few other key staff and consultants. Our goal was to develop a shared plan for integrating the DLTSS Work Group recommendations on care models and standards that will be used by the VHCIP partners, including Vermont ACOs. I am writing this letter at the suggestion of the Joint Chairs: Bea Grause, Nancy Eldridge, Judy Peterson; but it is my own letter, rather than a document written for the group.

In preparation for our Joint Co-Chairs meeting, I reviewed our work groups' charters and workplans, Federal and State documents related to the purpose of the ACO shared savings programs in Vermont, and the concerns and issues raised by advocates and providers in both the earlier Duals Stakeholder Group and the current DLTSS Work Group.

One of the documents the Joint Co-Chairs discussed that I reviewed was the language in the State's existing contract with Medicaid ACO's, specifically Section VI, Care Management Standards, Item C. The language of this section raised questions that have a direct impact on the role of our work groups, the role of AHS, and the emerging role of the ACOs, particularly with regard to Medicaid services and the role of Designated Agencies operating under contract with AHS. We discussed this language and the Joint Co-Chairs asked me to follow up with the Core Team, to gain greater clarity on the expected role of the Work Groups and the VHCIP Core Team, the role of the Agency of Human Services and the role of ACOs in establishing and overseeing the implementation of any care models and standards that emerge from our VHCIP work.

The language in question is from the OneCare Medicaid ACO Contract which states in Section VI <u>Care Management Standards,</u> item C. on page 22 (see attached for Section VI in full):

> "… Any AHS employee and/or contractor who provides care coordination services to Medicaid eligible persons shall, to the best of his/her ability, and so long as it is consistent with AHS programs or procedures and with Medicaid's legal obligations, cooperate with the Clinical Model or Care Model developed by the ACO."

Following the meeting, I was asked to contact Kara Suter who wanted to make sure I understood the intent of this language and did not take it out of context. I met with her and wrote up a summary for her review and edits, in order to make sure that I accurately understood and represented her explanation. Kara made

important points: that the contract is only intended to address implementation of the shared savings model, that the shared savings model does not even include most DLTSS services yet, and that it does not replace or supplant existing statutory roles and policies established by the State. She also noted that the State had started with more directive language, referring to the goal of having the ACOs adopt any care model and standards emerging from the VHCIP work groups and the Core Team, but had been advised by lawyers that this kind of aspirational language did not belong in contracts. I greatly appreciate the time Kara took to provide this background, which is very helpful; but I am left with many of my broader concerns unresolved.

Kara made it clear that the intention behind the language in question was that the State move quickly to develop the care management standards and models and that then these standards would become part of new language within the State's contracts with Medicaid ACOs. However, contracts are negotiated by both parties; there is nothing in place, that I know of, establishing the shared understanding that the VHCIP care model and/or standards will be adopted by the ACOs and the State.

Without the aspirational language, or some other policy document clarifying the State's intent and role in implementing care management standards or models, there is no formal requirement that the ACO and partnering providers abide by the model developed by the CM/CM team with input from other groups, including the DLTSS workgroup. The CM/CM Work Group and the DLTSS Work Group are moving forward in good faith, but even the language of the CM/CM Charter and Workplan is pretty vague and does not provide much clarity on how the State and ACOs will use the products of their work.

I believe the Care Management Standards in the State's Medicaid ACO Contract has had perhaps an unintended negative impact on the negotiations and language of ACO contracts with providers. Though I have not been able to review the actual contracts, I have heard providers express concern about the inappropriate role and authority of OneCare in care management decisions.

The lack of clarity on ACOs' role in implementing current statutory requirements leads to continual concern about the impact of the ACO model on existing systems and safeguards established for persons with disabilities receiving Medicaid-funded DLTSS services through AHS Departments and provider networks, as established in law, regulation and contract. There is uncertainty in terms of the role of AHS, and the commitment of the State to preserve programs and protections that have been built over the last 20 years.

The Joint CM/CM and DLTSS Co-Chairs have agreed that we need to disseminate overarching care model standards/criteria to guide all VHCIP Work Groups. The attached "Proposed DLTSS Model of Care Criteria" is a table of standards that can be used as a starting point.

I thank you for your consideration of these issues and ask that you reply with a written response.

With sincere thanks,

Deborah Lisi-Baker

Co-Chair, DLTSS Work Group

VI. Care Management Standards

A. The Contractor will maintain regular contact with Vermont Chronic Care Initiative (VCCI) to ensure that efforts around care management are well coordinated through regular and ad-hoc in-person and telephonic meetings; at minimum, the Contractor agrees to a meeting monthly but as frequently as both parties agree is needed.

B. The Contractor will maintain as needed contact with other Vermont Agency of Human Services (AHS) departments engaged in care management or care coordination activities particularly as it relates to federal mandates (e.g., Early Periodic Screening, Diagnosis, and Treatment) and vulnerable populations (e.g., Disabilities, Traumatic Brain Injury, Integrated Family Services). Examples of this contact will include but not be limited to: meetings (in-person and telephonic), educational outreach, partnering, launching or rolling out new or existing initiatives, and direct care coordination.

C. If requested, the Contractor will, no more frequently than annually and no sooner than 60 days from the request, participate with the State to create a written plan describing detailed approach to care management activities described above. Any AHS employee and/or contractor who provides care coordination services to Medicaid eligible persons shall, to the best of his/her ability, and so long as it is consistent with AHS programs or procedures and with Medicaid's legal obligations, cooperate with the Clinical Model or Care Model developed by the ACO. Should there be a conflict between the ACO's Clinical Model or Care Model and AHS programs or procedures, AHS employees and contractors shall cooperate with and implement the Clinical Model or Care Model of the ACO for a mutually agreeable time frame. DVHA and AHS acknowledge that this cooperation is critical to ACO in order to meet the quality, patient experience and financial performance thresholds under this Agreement. In the event of a dispute regarding the Clinical Model or Care Model, the parties may invoke the Dispute Resolution process set forth in Section 5 of Attachment A.

Basis for Design of Proposed DLTSS Model of Care

NATIONAL EVIDENCED-BASED DLTSS MODEL OF CARE ELEMENTS				
Core Elements	Commission on Long-Term Care, September 2013 Report to Congress	CMS & National Committee for Quality Assurance (NCQA) DLTSS Model of Care	Medicaid Health Homes (CMS)	Consumer-Focused Medicaid Managed Long Term Services and Supports (Community Catalyst)
Person Centered and Directed Process for Planning and Service Delivery	✓	✓	✓	✓
Access to Independent Options Counseling & Peer Support	✓	✓		✓
Actively Involved Primary Care Physician		✓	✓	
Provider Network with Specialized DLTSS Expertise	✓	✓	✓	✓
Integration between Medical & DLTSS Care	✓	✓	✓	✓
Single Point of Contact for person with DLTSS Needs across All Services	✓	✓	✓	
Standardized Assessment Tool	✓	✓		✓
Comprehensive Individualized Care Plan Inclusive of All Needs, Supports & Services		✓	✓	✓
Care Coordination and Care Management	✓	✓	✓	✓
Interdisciplinary Care Team		✓	✓	✓
Coordinated Support during Care Transitions	✓	✓	✓	✓
Use of Technology for Sharing Information	✓	✓	✓	✓