Attachment 1a - DLTSS Meeting Agenda 4-24-14

VT Health Care Innovation Project
"Disability and Long Term Services and Supports" Work Group Meeting Agenda
Thursday, April 24th 2014; 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; Introductions; Approval of Minutes; Membership List and Roles** Deborah Lisi-Baker and Judy Peterson	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from March meeting • Attachment 1c: DLTSS Member List	
2	10:10– 10:20	**Approval of DLTSS Charter** **Discussion and Approval of DLTSS Work Plan** Deborah Lisi-Baker and Judy Peterson	• Attachment 2a: Draft DLTSS Charter • Attachment 2b: Draft DLTSS Work Plan	
3	10:20 – 10:45	**DLTSS Medicaid Expenditure Overview** Scott Wittman, PHPG	• Attachment 3: DLTSS Medicaid Expenditures Calendar Year 2012	
4	10:45 – 11:35	**DLTSS Quality and Performance Measures Recommendations to the QPM Work Group** Deborah Lisi-Baker and Judy Peterson	• Attachment 4a: Existing Core Payment Measures Subpopulation Analyses • Attachment 4b: Pending Measures – DLTSS-Specific for Year 2 • Attachment 4c: Potential New DLTSS Payment Measures	
5	11:35 – 12:20	**Proposed DLTSS Model of Care** Susan Besio, PHPG	• Attachment 5: Proposed DLTSS Model of Care	
6	12:20 – 12:30	**Public Comment/Updates/Next Steps** Deborah Lisi-Baker and Judy Peterson		

Attachment 1b - DLTSS Minutes 3-20-14

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Date of meeting: March 20, 2014, 9-11 am; AHS Training Room, 208 Hurricane Lane, Williston, VT

Call in: 877-273-4202, Passcode: 8155970

Attendees: Deborah Lisi-Baker and Judy Peterson, Co-Chairs; John Barbour, CVAAA; Molly Dugan, SASH; Larry Goetschius, Trinka Kerr and Jackie Majoros, VT Legal Aid; Norman Ward and Vicki Loner, One Care; Madeline Mongan, Vermont Medical Society; Marlys Waller, VT Council of Developmental and Mental Health Services; Jason Williams, Fletcher Allen; Joy Chilton, CVHHH; Ed Paquin, Disability Rights Vermont; Dion LeShay, Consumer; Paul Bengtson, Core Team; Georgia Maheras, AoA; Marybeth McCaffrey, Jen Woodard, DAIL; Julie Wasserman, AHS; Pat Jones, GMCB; Alicia Cooper and Erin Flynn, Amy Coonradt, DVHA; Dale Hackett, Consumer; Brendan Hogan, Bailit Health Purchasing; Susan Besio, PHPG, Kirsten Murphy, VT Developmental Disabilities Council; Nelson LaMothe, Jessica Mendizabal, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome and Introductions	Deborah Lisi-Baker called the meeting to order at 9:09 am. Judy Peterson stated that there would be no votes because the majority of voting members were not present.	
2 Approval of DLTSS Charter	Judy Peterson referenced the DLTSS Charter (attachment 2a). Julie Wasserman addressed concerns from previous meetings and incorporated new language in item #9 relating to DLTSS Core Principles outlined in Attachment 2b. Deborah asked the group to please review and the vote will take place at the April meeting.	

Agenda Item	Discussion	Next Steps
3 Draft DLTSS Work Plan	The group discussed the DLTSS Work Plan (attachment 3), which is based on the goals in the Charter. The following points were addressed and further discussion will take place at the next meeting: • The DLTSS work group will recommend DLTSS quality and performance measures to the VHCIP Quality and Performance Measures Work Group. The Work Plan will reflect which measure recommendations initiate with DLTSS • Anya Radar Wallack is working on a VHCIP master work plan that shows work groups products, where they originated and which work groups must review them before going to the steering committee and core team. The DLTSS work plan will be consistent with the overall project master work plan. • One purpose of the work plan is to ensure that efforts across work groups relate to each other and there is no duplication of effort. The Core Team is comprised of agency leaders to ensure cohesion and streamline outcomes. • A question was asked about how the SIM grant projects differ from those of the "Imagine the Future Taskforce" of the Department of Aging and Independent Living. The response was that the Imagine the Future Taskforce is planning for developmental services 20 years in the future and the SIM grant projects are more immediate. Staff that participate in both SIM work and the Imagine the Future Taskforce are looking to see how to link projects together and make recommendations on health care reform. • Broader beneficiary engagement is a core function of this work group. The group will develop a process for public engagement to understand the needs in the community (page 1, 3rd column, 3rd bullet of work plan).	
4 DLTSS Quality and Performance Measures	Julie Wasserman began by stating that the Medicaid ACOs have the option to include DLTSS services in their Total Cost of Care Calculations beginning in Year 2 (nine months from now), and that this inclusion will be mandatory in Year 3. In order to be prepared, we need DLTSS quality and performance measures included in the measure set developed by the VHCIP Quality and Performance Measures (QPM) Work Group. (reference Attachment 4a). Georgia Maheras explained measure recommendations are made to the QPM Work Group and evaluated. The QPM work group then recommends to the Steering Committee, who recommends to the Core Team, who then makes a recommendation to the implementing agency:	**Chrissy will share the QPM work group measures standard proposal.**

Agenda Item	Discussion	Next Steps
	Green Mountain Care Board for commercial insurance and DVHA for Medicaid. The Core team recently approved the QPM work group's new Process for Review and Modification of Measures, which has a tight timeline but will allow flexibility for work group recommendations. Currently there are pending measures related to disability and long term services and Deborah is presenting to the QPM work group on March 24. The ACOs must meet defined quality and performance measures in order to qualify for shared savings, and the amount of shared savings an ACO receives will be adjusted based on performance (known as the gate and ladder). There is a provision in the VMSSP contract that states that the parties intend to amend the contract for performance years 2 and 3 to maintain consistency with any changes to relevant standards adopted by the VHCIP, and that any such amendments must be mutually agreed upon by the parties in writing. Any changes to the ACO measures set will go through the standard for review and modification of measures described above. The QPM work group is making efforts to align measures between Medicare, Medicaid and commercial shared savings programs and many measures are similar. As care models are developed, the group will test how the measures are working, and how they align with other measure sets outside the SIM work. Alicia Cooper presented Quality and Performance Measures (attachment 4a). There were two decision points posed to the group to be made at this meeting (slides 23 and 24). The group discussed the decision points and the following issues were identified: • The group would like to see a summary of metrics that are already being collected through other efforts to help identify what should be included for ACOs. A draft summary of DLTSS measures and surveys being used by AHS was provided to the group (attachment 4c); an updated version will be provided for discussion at the next meeting. • The DLTSS Work Group may want to recommend analysis of existing Core Payment measures for DLTSS subpopulations attributed to Medicaid ACOs. • There are currently 2 measures in the "Payment" measure set pertaining to mental health and substance abuse for commercial and Medicaid populations. Within "Reporting" measures, there is "screening for clinical depression and follow up plan", on which ACOs are required to report. The QPM work group would want to look more at developmental disabilities. The "Payment" measure set already includes a measure assessing developmental screening for children in the first three years of life.	

Agenda Item	Discussion	Next Steps
	• The QPM group purposely selected claims-based measures in year 1 to facilitate collection. Data collection can be burdensome to providers and the QPM Work Group has as one of its goals to reduce administrative burden. The work group purposely selected measures in areas which could show improvement. • To assess patient experience, the QPM work group will be relying on several ongoing surveys such as the Patient Centered Medical Home CAHPS survey rather than developing new surveys. Regarding Medicare beneficiaries: • Medicare beneficiaries were automatically attributed to ACOs participating in the Medicare Shared Savings Program. • 45% of Vermont Medicare beneficiaries are not attributed to a Medicare ACO, and the federal partners are working with VT to increase attribution of these beneficiaries. There are some number of dually eligible individuals who are not attributed to a Medicare ACO. Ed Paquin noted the potential loss of revenue for LTC service providers and asked if there is a built-in mechanism for ACOs to share the savings. Pat Jones stated that it depends on the relationship with the ACOs; some ACOs are entering into agreements with LTC providers, and it's the intent of quality measures to ensure that care meets a certain level of quality. The group referenced slide 23 of Attachment 4a and discussed the idea of analyzing DLTSS sub-populations. The following points were presented: • The DLTSS work group may want to look at certain subpopulations for one or more Core Payment measures to see if there is the potential to measure improvement. Core Payment measure data will be collected and analyzed as part of this pilot and the subpopulation analyses would not be administratively burdensome. • Two ACOs have currently signed contracts for the VMSSP (Medicaid) and three for the XSSP (commercial). The DLTSS work group would like to review the ACO contracts to understand the plan for shared savings. • The DLTSS work group would like to address DLTSS needs that are not currently being met. Integration of DLTSS services with medical services could yield savings and result in better care; hospitalization rates will likely decrease, however, some services such as preventive care could increase.	

Agenda Item	Discussion	Next Steps
	Judy Peterson noted that the ACOs are working together to determine how they will improve care and transform the system. One goal is to decrease costs. Marybeth McCaffrey suggested that presentations from this meeting could be offered as webinars and made available to participants who were not able to attend so that during the next work group meeting the group can reach decisions on these matters.	
5 DLTSS HIE ACTT Grant Proposal	To be discussed at next meeting.	
6 Work Group Membership List and Roles	To be discussed at next meeting.	
7 Review of Meeting Minutes	To be discussed at next meeting.	
8 Public Comment/Updates/ Next Steps	Regarding identification of measures to recommend to the Quality & Performance Measures work group: Marybeth McCaffrey suggested offering the group complete information so they can review and provide their feedback in accordance with the timeline for considering new and existing ACO measures, possibly structuring the information in a Q&A format. Kirsten Murphy stated that members of this work group would want to understand the health status within subpopulations and 70% of the public with a disability don't receive services because they don't have a funding priority attached. She encouraged the group to think about specificity for each of the systems. Julie Wasserman clarified that 55% of all VT Medicare beneficiaries are attributed to one of the Medicare ACOs. Marlys Waller asked if providers have information on whom they are serving since there are fewer Medicaid beneficiaries in Medicaid ACOs. Julie responded that providers don't have this information up front but it is data that they have access to, though it should not affect the quality of care. Marlys reiterated that providers should know which beneficiaries they're serving. Next meeting: Thursday, April 24, 2014 10:00 AM – 12:30 PM, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

Attachment 1c - DLTSS Member List

VHCIP DLTSS Work Group Member List

C	Chair
IC	Interim Chair
M	Member
MA	Member Alternate
A	Assistant
S	Staff
X	Interested Party

Bad Email Address
Missing Information

	First Name	Last Name	Title	Organization	Email	Support for:	DLTSS	Affliation
1	April	Allen	Director of Policy and Planning	AHS - DCF	April.Allen@state.vt.us		MA	Gov Ops
2	John	Barbour	Executive Director	Champlain Valley Area Agency on Aging	john@cvaa.org		M	External
3	Susan	Besio	Senior Associate	Pacific Health Policy Group	sbesio@PHPG.com		X	External
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6	Alysia	Chapman	Developmental Services	HowardCenter for Mental Health	Alysiac@howardcenter.org		M	External
7	Joy	Chilton	Compliance Officer	Central Vermont Home Health and Hos	jchilton@cvhhh.org		MA	External
8	Peter	Cobb	Executive Director	Vermont Assembly of Home Health and	vahha@comcast.net		X	External
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12	Amy	Cooper	Executive Director	Accountable Care Coalition of the Green	Amy.Cooper@UniversalAmerican.com		MA	External
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18	Christine	Geiler	Grant Manager & Stakeholder Coor	GMCB	christine.geiler@state.vt.us		S	Gov Ops
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26	Brendan	Hogan	Consultant	Bailit-Health Purchasing	Bhogan@bailit-health.com		X	Contractor
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34	Dion	LaShay	Consumer Advocate	Consumer Advocate	**No Email Address**		M	External
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55	Eileen	Peltier	Executive Director	Central Vermont Community Land Trus	EPeltier@cvclt.org		M	External
56	Judy	Peterson	President and CEO	Visiting Nurse Association of Chittende	peterson@vnacares.org		C/M	External
57	John	Pierce			johnepierce@comcast.net MS Society		X	External
58	Luann	Poirer	Administrative Services Manager I	AHS - DVHA	Luann.Poirier@state.vt.us	Kara Suter	X	Gov Ops
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60	Paul	Reiss	Executive Director,	Accountable Care Coalition of the Greer	preiss@evergreenhealth.org		M	External
61	Virginia	Renfrew		Zatz & Renfrew Consulting	renfrew@sover.net		X	External
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							77	77

Attachment 2a - DLTSS Charter

VT Health Care Innovation Project
"Disability and Long Term Services & Supports" Work Group
Charter

March 20, 2014

FINAL DRAFT

EXECUTIVE SUMMARY

The Disability and Long Term Services and Supports Work Group will build on the extensive work of the Dual Eligible Demonstration Steering, Stakeholder, and Work Group Committees over the past two years. The goal of the Disability and Long Term Services and Supports Work Group (DLTSS) is to incorporate into Vermont's health care reform efforts specific strategies to achieve improved quality of care, improved beneficiary experience and reduced costs for people with disabilities, related chronic conditions and those needing long term services and supports. The VHCIP Disability and LTSS Work Group will:

- develop recommendations regarding the improvement of existing care models and the design of new care models to better address the needs of people with disabilities, related chronic conditions and those needing long term services and supports, in concert with VHCIP efforts;
- develop recommendations regarding the design of new payment models initiated through the VHCIP project to improve outcomes and reduce costs for people with disabilities, related chronic conditions and those needing long term services and supports;
- develop recommendations to integrate the service delivery systems for acute/medical care and long term services and supports;
- develop recommendations for IT infrastructure to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports;
- continue to address coordination and enhancement of services for the dually-eligible population and other Vermonters who have chronic health needs and/or disabilities through such mechanisms as the Medicaid ACO program, further design of Green Mountain Care, and other approaches.

SCOPE OF WORK

1. Recommend care model elements and strategies that improve beneficiary service and outcomes for people with disabilities, related chronic conditions and those needing long term services and supports.
2. 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 people with disabilities, related chronic conditions and those needing long term services and supports.

3. Identify mechanisms to incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports to achieve a more integrated and seamless delivery system.
4. Incorporate person-centered, disability-related, person-directed, and cultural competency issues into all VHCIP activities.
5. Identify Medicare/Medicaid/commercial insurance coverage and payment policy barriers that can be addressed through Vermont's health care reform efforts to improve integration of care for people with disabilities, related chronic conditions and those needing long term services and supports.
6. Identify mechanisms to minimize the incentives for cost-shifting between Medicare, Medicaid and commercial payers.
7. Incorporate representation from Commercial Insurers into the VHCIP Disability and Long Term Services and Supports Work Group.
8. Recommend incentives for ACOs to re-invest savings to address the needs of people with disabilities, related chronic conditions and those needing long term services and supports to prevent unnecessary hospitalizations, ER visits, and nursing home admissions.
9. Identify DLTSS quality and performance measures to evaluate the outcomes of people with disabilities, related chronic conditions and those needing long term services and supports. These quality and performance measures shall be consistent with the core principles articulated in State law and regulation: the Developmental Disabilities Act of 1996, Choices for Care regulations pursuant to Act 56 (2005), and the Mental Health Care Reform Act 79 (2012).
10. Identify technical and IT needs to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports.

DELIVERABLES

1. Inclusion of new members on the DLTSS Work Group, including representation from commercial payers.
2. Recommendations for model of care elements and strategies that can be integrated and aligned with other VHCIP models of care.
3. Recommendations for payment methodologies that: a) incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports; b) incentivize ACOs to re-invest savings to address the needs of people with disabilities, related chronic conditions and those needing long term services and supports to prevent unnecessary hospitalizations, ER visits, and nursing home admissions; and c) reduce the incentive to cost shift between Medicare, Medicaid and commercial payers.

4. Action plan for inclusion of identified person-centered, disability-related, person-directed, and cultural competency items in all VHCIP Work Group efforts.
5. Action plan to implement strategies addressing barriers in current Medicare, Medicaid, and commercial coverage and payment policies.
6. Action plan for inclusion of DLTSS quality and performance metrics to evaluate the outcomes of people with disabilities, related chronic conditions and those needing long term services and supports.
7. Recommendations regarding the technical and IT needs to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports.
8. Other activities as identified to assist successful implementation of payment and care models to best support people with disabilities, related chronic conditions and those needing long term services and supports.

MILESTONES (Timeline subject to change)

<u>March – August 2014</u>

- Review the core principles of the Developmental Disabilities Act of 1996, Choices for Care regulations pursuant to Act 56 (2005), and the Mental Health Care Reform Act 79 (2012) as they relate to quality and performance measures and desired outcomes.

- Complete action plan for inclusion of DLTSS quality and performance metrics to evaluate the outcomes of people with disabilities, related chronic conditions and those needing long term services and supports.

- Make recommendations for model of care elements and strategies for people with disabilities, related chronic conditions and those needing long term services and supports.

- Complete action plan for inclusion of identified person-centered, disability-related, person-directed, and cultural competency items in all VHCIP Work Group activities.

<u>September – December 2014</u>

- Make recommendations for payment methodologies that incentivize providers to bridge the service delivery gap between acute/medical care and long term services and supports; incentivize ACOs to reinvest savings to address the needs of people with disabilities, related chronic conditions and those needing long term services and supports; and reduce the incentive to cost shift between Medicare, Medicaid and commercial payers.

- Make recommendations regarding the technical and IT needs to support new payment and care models for integrated care among people with disabilities, related chronic conditions and those needing long term services and supports.

January – April 2015

- Complete action plan to implement strategies addressing barriers in current Medicare, Medicaid, and commercial coverage and payment policies for people with disabilities, related chronic conditions and those needing long term services and supports.

- Other activities as identified to support successful preparation and implementation of payment and care models to best support people with disabilities, related chronic conditions and those needing long term services and supports.

MEMBERSHIP REQUIREMENTS

The Disability and Long Term Services and Supports 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 Purchasing
  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

Attachment 2b - DLTSS Work Plan

Work Plan for DLTSS Work Group – DRAFT 3/20/14

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 voting member (+ backup), others can be "interested parties" • Identify representation from commercial payers and other entities • Distribute 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	February - April 2014 and on-going (for development of resources for Work Group)	• Charter scheduled for March Work Group approval • Membership list: 1. Need to identify representation from commercial payers, others 2. Need to finalize membership list • 2014 Meeting Schedule has been distributed	• Final Charter • Comprehensive membership list • 2014 meeting schedule • Resources are adequate to accomplish objectives • Successful beneficiary engagement
Complete Action Plan for Inclusion of DLTSS Quality and Performance Metrics and review performance on an on-going basis	• Develop on-going list of currently collected AHS measures • Develop timeline (short and long-term) for incorporating DLTSS input into Quality and Performance Measures Work Group activities • Identify DLTSS quality and performance measures for Years 2	• Review core principles of Developmental Disabilities Act, Choices for Care regulations, and Mental Health Care Reform Act as they relate to quality and performance measures and desired outcomes • Review list of currently collected	February - July 2014 and on-going (for performance measure review)	• Initial list of currently collected AHS measures needs to be fleshed out • Timeline and recommendations to be presented at March DLTSS Work Group meeting • Initial list of DLTSS quality and performance measures needs to be discussed,	• Recommended DLTSS Quality and Performance Measures to be incorporated /adapted into the Medicaid ACO Standards for Years 2 and 3 • Reduction of preventable hospitalizations, ER visits and nursing home admissions;

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
	and 3 of Medicaid ACO • Develop a plan to incorporate/adapt DLTSS Quality and Performance Measures into the VHCIP Quality and Performance Measures Work Group deliverables • Develop materials for Work Group Review of ACO / provider performance on DLTSS-specific measures and DLTSS-related measures (e.g., preventable hospitalizations, ER visits, and nursing home admissions; appropriate use of medications; and rebalancing the use of institutional vs home and community-based care)	AHS measures • Review Quality and Performance Measures Work Group process, criteria, and accomplishments to date • Discuss timeline (short and long-term) for incorporating DLTSS input into Quality and Performance Measures Work Group activities • Make recommendations to incorporate DLTSS Quality and Performance Measures into the VHCIP Quality and Performance Measures Work Group • On an on-going basis, review ACO and provider performance on DLTSS-specific measures and DLTSS-related measures and provide input to VHCIP leadership regarding performance		critiqued, and refined • Action plan for inclusion of quality and performance metrics needs to be developed	appropriate use of medications; and rebalancing the use of institutional vs home and community-based care

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
Recommend DLTSS Model of Care Elements	• Review DVHA Duals Model of Care with Work Group • Develop DLTSS Model of Care PowerPoint • Develop a plan for incorporating/adapting the elements of the Duals Care Model into the VHCIP Care Models/Care Management Work Group activities	• Review DLTSS Model of Care Elements; elicit feedback and approval • Review, provide input on, and approve a plan for incorporating /adapting the elements of the DLTSS Care Model into the VHCIP Care Models/ Care Management Work Group activities	January - July 2014	• DVHA Duals Model of Care presented to DLTSS Work Group in January 2014 • DLTSS Model of Care Elements to be presented at April DLTSS Work Group • DLTSS Model of Care Elements to be presented at May Care Models/Care Management Work Group	• Successful incorporation of DLTSS Model of Care into service delivery for people with disabilities, related chronic conditions and those needing long term services and supports
Recommend technical and IT needs to support new payment and care models for integrated care	• Collaborate with the VHCIP HIE Work Group on development and approval of the ACTT proposal for DLTSS providers • Draft memo regarding HIT needs to support new payment and care models for DLTSS integrated care to include both high-tech and low-tech solutions/options • Determine process for collaborating with the VHCIP HIE Work Group to include relevant DLTSS HIT needs.	• Review ACTT grant proposal • Review and provide input on memo regarding DLTSS HIT needs for inclusion by the VHCIP HIE Work Group. • Review and provide input on process for collaborating with the VHCIP HIE Work Group to include relevant DLTSS HIT needs. • Receive status reports on progress regarding DLTSS HIT needs	March - December 2014 and on-going	• ACTT grant proposal to be presented at March DLTSS Work Group • VCHIP HIE Work Group recommended ACTT grant proposal (with conditions) to be sent to VHCIP Steering Committee March 5, 2014	• Initial planning funding and subsequent implementation funding of the ACTT proposal and successful completion of grant activities • Completed memo on DLTSS HIT issues • Action plan for inclusion of these issues in HIE Work Group activities

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
	• Provide on-going status reports to DLTSS Work Group on progress regarding HIT needs				
Complete Action Plan for inclusion of person-centered, disability-related, person-directed, and cultural competency items in all VHCIP Work Group 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 inclusion of person-centered, disability-related, person-directed, and cultural competency issues into VHCIP activities • Receive status updates on incorporation of identified items	March – August 2014 and on-going (for status updates)	• Dual Eligible Work Group list of person-centered, disability-related, person-directed and cultural competency items will inform this work	• List of person-centered, disability-related, person-directed, and cultural competency items • Action plan for inclusion of identified items into VHCIP Work Group efforts • Action plan for monitoring whether items are incorporated into VHCIP activities • Vermont health care reform initiatives are person-centered, disability-related, person-directed and culturally sensitive
Recommend payment methodologies that incentivize providers to bridge the service delivery gap between acute/medical care and	• Collaborate with the VHCIP Payment Models Work Group as it determines the methodology for bundled payments,	• Review and provide input on payment model designs as they relate to DLTSS (i.e., design of bundled payment, blended	September -December 2014	• Activities have not yet begun	• Finalized payment methodologies that incentivize providers to integrate medical care with DLTSS service delivery

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
long term services and supports	blended payment mechanisms, and Episodes of Care • Research payment methodologies that promote flexible service delivery models that integrate medical/DLTSS care • List current DLTSS provider payments that may prove challenging to bundle and describe the challenges (e.g. nursing home payments, CRT/DS payments, others) • Develop recommendations for integrated provider reimbursement mechanisms for medical/LTSS services	payment mechanisms, Episodes of Care, and integrated reimbursement mechanisms) • Review and provide input on payment methodologies that promote flexible service delivery models • Provide recommendations to VHCIP Payment Models Work Group for integrated provider reimbursement mechanisms for medical/LTSS services			• Incorporation of payment models in VHCIP Payment Models Work Group that enable flexible service delivery models into VHCIP Care Models and Care Management Work Group deliverables.
Recommend incentives for ACOs to reinvest savings to prevent unnecessary hospitalizations, ER visits, and nursing home admissions; and promote appropriate use of medications	• Research and develop a list of incentives that encourage ACOs to reinvest savings to prevent unnecessary hospitalizations, ER visits, and nursing home admissions; and promote appropriate use of medications	• Review and provide input on list of incentives developed by supporting staff • Recommend strategies for incorporation of incentives into the Payment Models and Care Models/Care Management Work Groups' deliverables	September -December 2014	• Activities have not yet begun	• Incorporation of ACO incentives into payment and service delivery models

Objectives	Supporting Staff Activities	Supporting Work Group Activities	Target Date	Status of Activity	Measures of Success
Recommend mechanisms to reduce the incentive to cost shift between Medicare, Medicaid and commercial payers.	• Research and develop a list of mechanisms to reduce the incentive to cost shift among payers • Develop indicators to gauge level of cost shifting among payers	• Review and provide input on list of mechanisms to reduce the incentive to cost shift • Review and provide input on indicators of cost shift	September-December 2014	• Activities have not yet begun	• Finalized list of mechanisms to reduce the incentive to cost shift among payers • Indicators to measure cost shift • Reduction of cost shifting among Medicare, Medicaid and commercial payers
Complete Action Plan to implement strategies addressing barriers in current Medicare, Medicaid, and commercial coverage and payment policies for people needing DLTSS services	• Research and develop list of current barriers in Medicare, Medicaid and commercial coverage and payment policies • Prioritize the barriers that can be acted upon dependent upon federal or state statutory and or regulatory requirements • Develop strategies to address these barriers • Work with CMS, DVHA and commercial insurers to obtain approval to implement strategies, if applicable	• Review and provide input on list of current barriers • Review, provide input on, and approve strategies for addressing coverage and payment barriers	January - April 2015	• Initial list of barriers identified by Dual Eligible Service Delivery workgroup in summer/fall 2011	• Completed list of current Medicare, Medicaid, and commercial coverage and payment barriers • Action plan to implement strategies to address coverage and payment barriers

Attachment 3 - DLTSS Medicaid Expenditures Calendar Year 2012

State of Vermont
DLTSS Medicaid Expenditures
Calendar Year 2012

April 24, 2014

Introduction

- Purpose of Discussion
  - Review role of Medicaid related to funding of both “traditional” health services as well as specialized programs and services (Slides 4 through 10)
  - Review Medicaid expenditures on behalf of individuals receiving specialized services versus all other Medicaid program participants (Slides 11 & 12)
  - Review Medicaid expenditures on the basis of eligibility (Slides 13 & 14)

- *Data Notes*
  - *Dates of service between 1/1/12 and 12/31/12*
  - *Includes individuals eligible for full Medicaid benefits*
  - *Pharmacy includes rebate factor of 44%*
  - *Claims only; excludes:*
    - *Payments made outside the claims system*
    - *Managed care investments*
    - *Medicare Buy-in*
  - *For Planning Only – Data have not been validated against secondary sources*

Role of the Vermont Medicaid Program

The Vermont Medicaid program essentially has two roles. The Medicaid program's policies related to both service coverage and eligibility reflect these two roles. Medicaid provides coverage for:

"*Traditional Services*"

Like commercial health insurance policies, the Vermont Medicaid program provides coverage for traditional services, such as hospital, physician, pharmacy, and dental services

"*Specialized Programs and Services*"

The Vermont Medicaid program is the primary funding source for several specialized health programs, including long-term care, Developmental Services, and the public mental health and substance abuse treatment systems; these programs receive limited financial support outside of the Vermont Medicaid program. Medicaid also is an important financial resource for supporting public care systems, including Department for Children and Families (DCF) and school-based health services.

Expenditure Summary by Program

In recognition of the Medicaid program's two roles, services were categorized as follows:

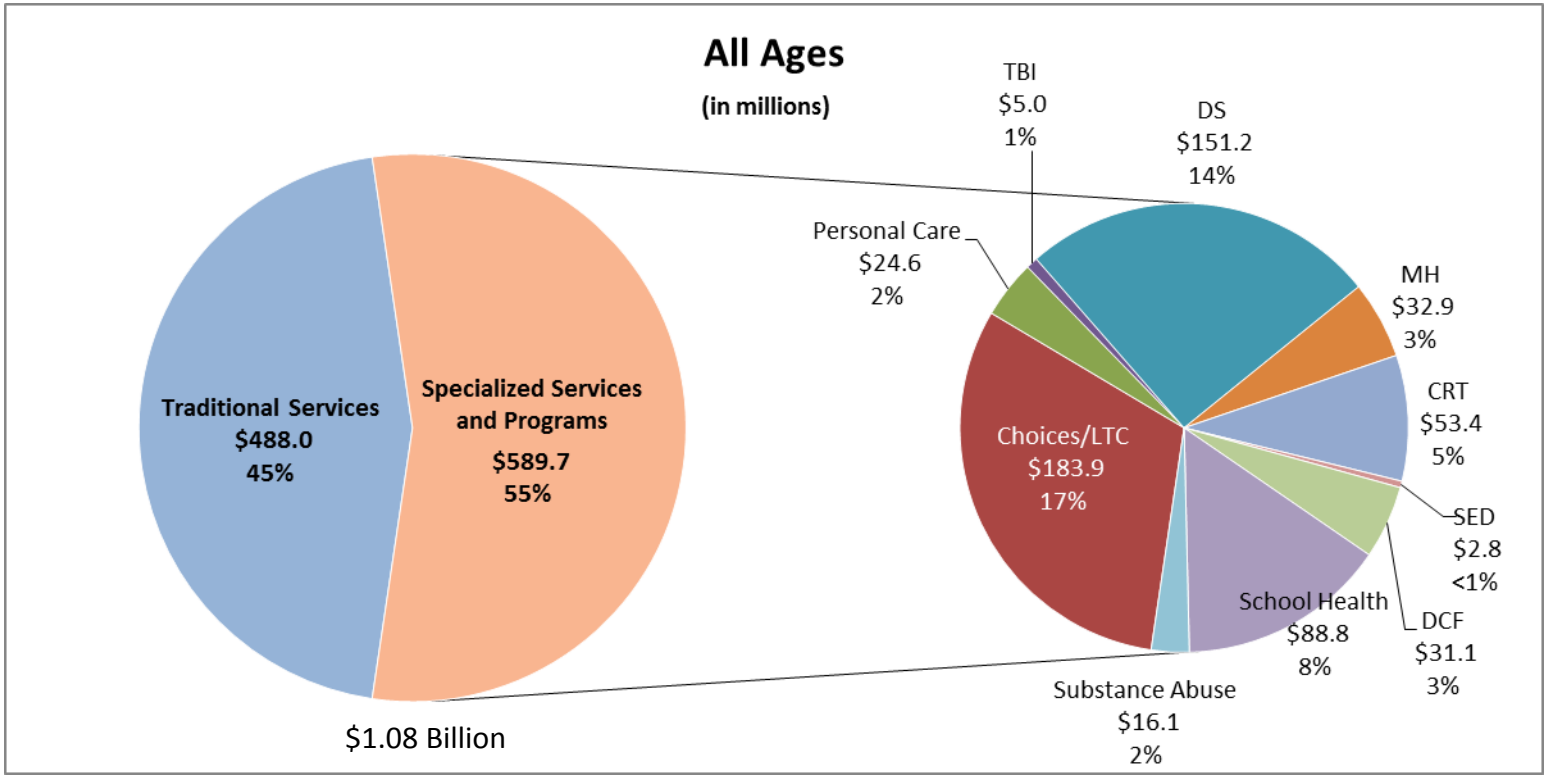
Traditional

- Ambulance
- Dental
- Durable Medical Equipment
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)
- Home Health
- Hospice
- Independent Lab
- Inpatient Hospital
- Medical Supplies
- Other
- Other Practitioner
- Outpatient Hospital
- Pharmacy
- Physician
- Prosthetic/Orthotic
- Therapy Services
- Transportation

Specialized Services and Programs

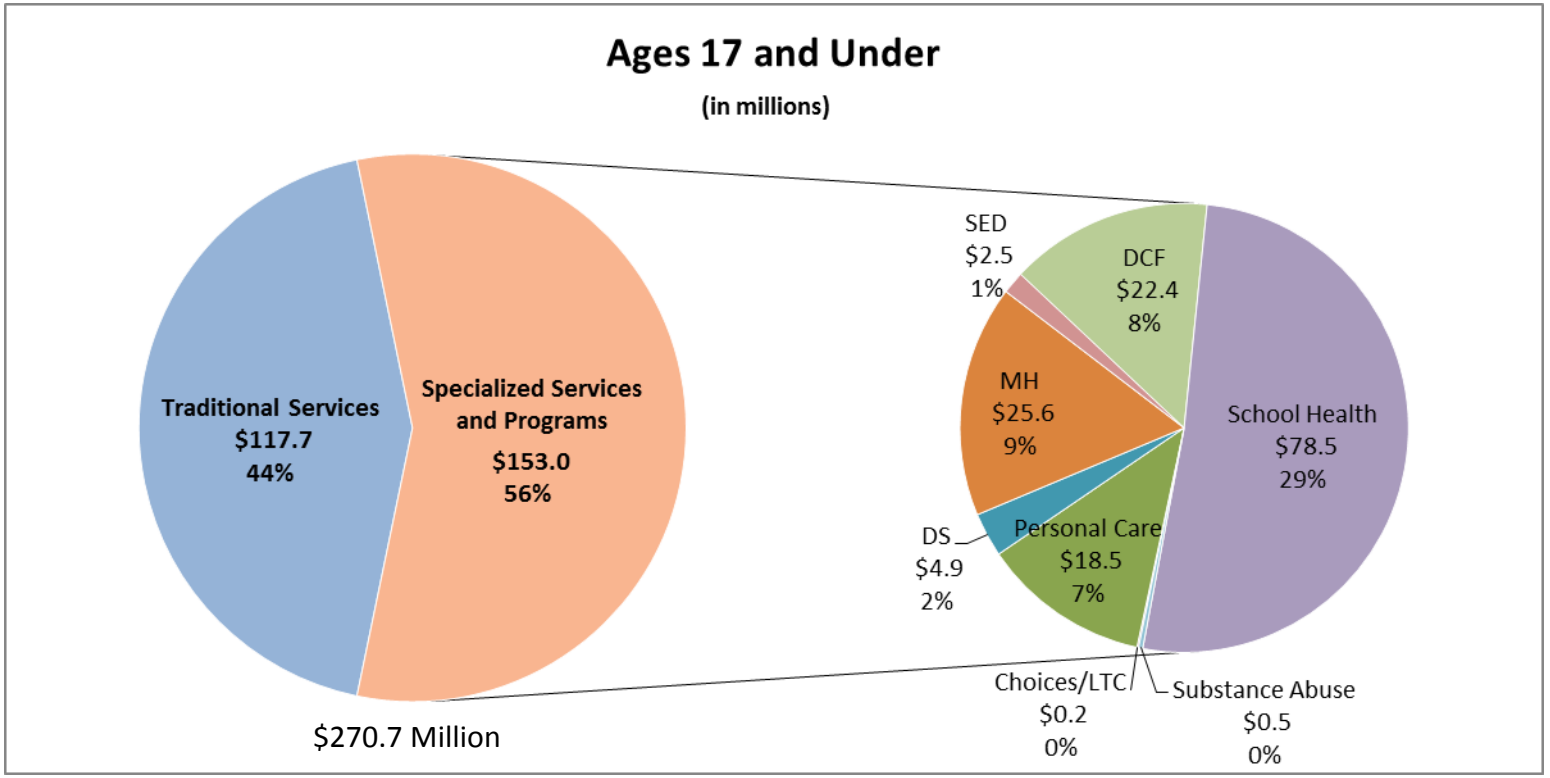
- Choices for Care/Long-Term Care
  Assistive Community Care, Choices for Care Home and Community Based Services (HCBS), Nursing Home
- Personal Care
- Traumatic Brain Injury (TBI) Program
- Developmental Services
  Developmental Services, Intermediate Care Facility/Intellectual Disabilities (ICF/ID)
- Mental Health Treatment
  Community Rehabilitation Treatment, Day Treatment, Day Treatment/Private Non-Medical Institution (PNMI), Children and Adolescents with Serious Emotional Disturbances (SED), Mental Health Facility, Targeted Case Management
- Department for Children and Families - Case Management
- School Health
  Department of Health, School-Based Health Services (DOE), Success Beyond Six
- Substance Abuse Treatment

Medicaid Expenditure Summary by Program: All Ages



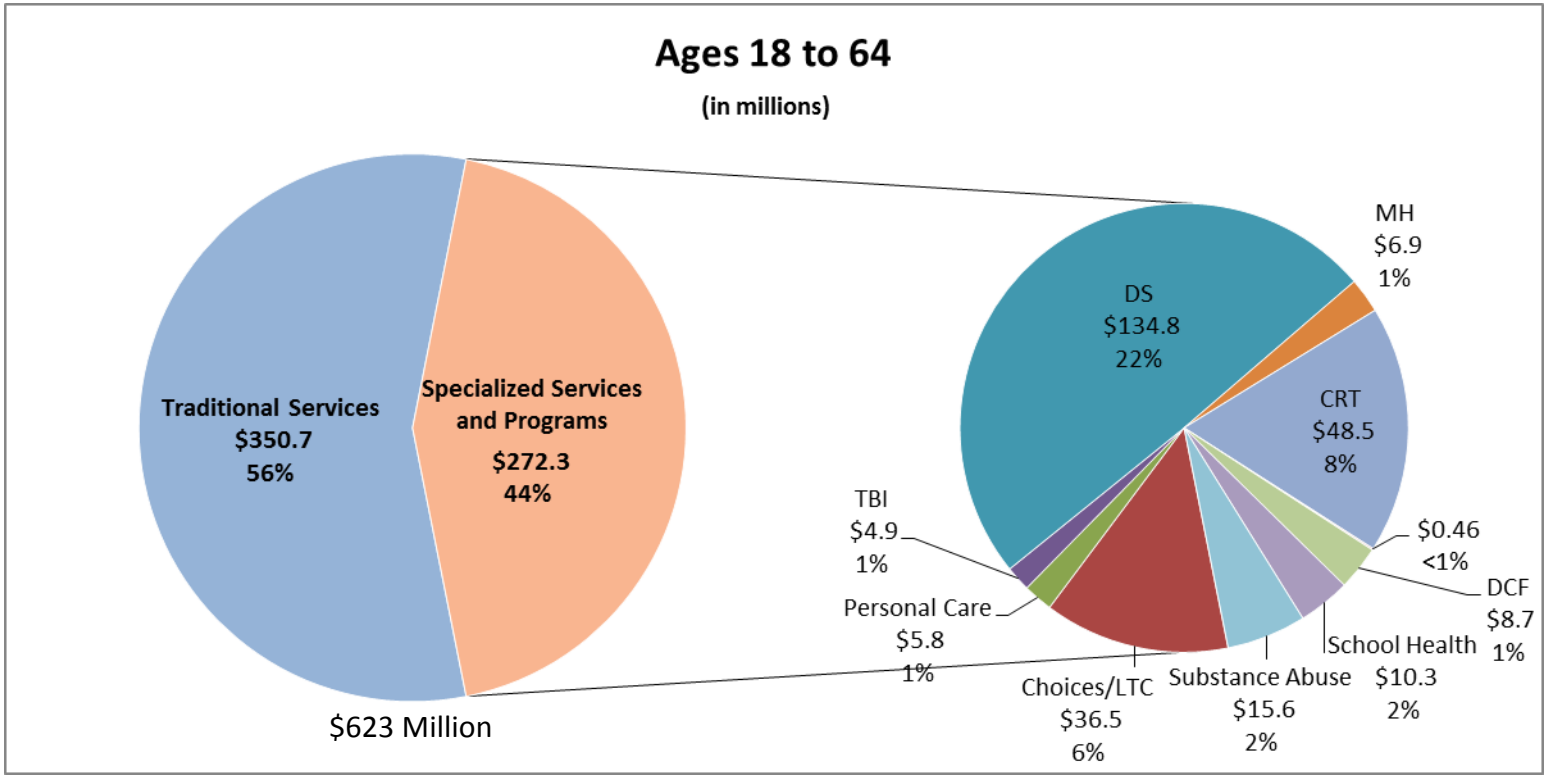
The Vermont Medicaid program spends approximately $488 million **(45%)** for coverage of traditional services and approximately $590 million **(55%)** to support specialized services and programs

Medicaid Expenditure Summary by Program: Ages 17 and Under



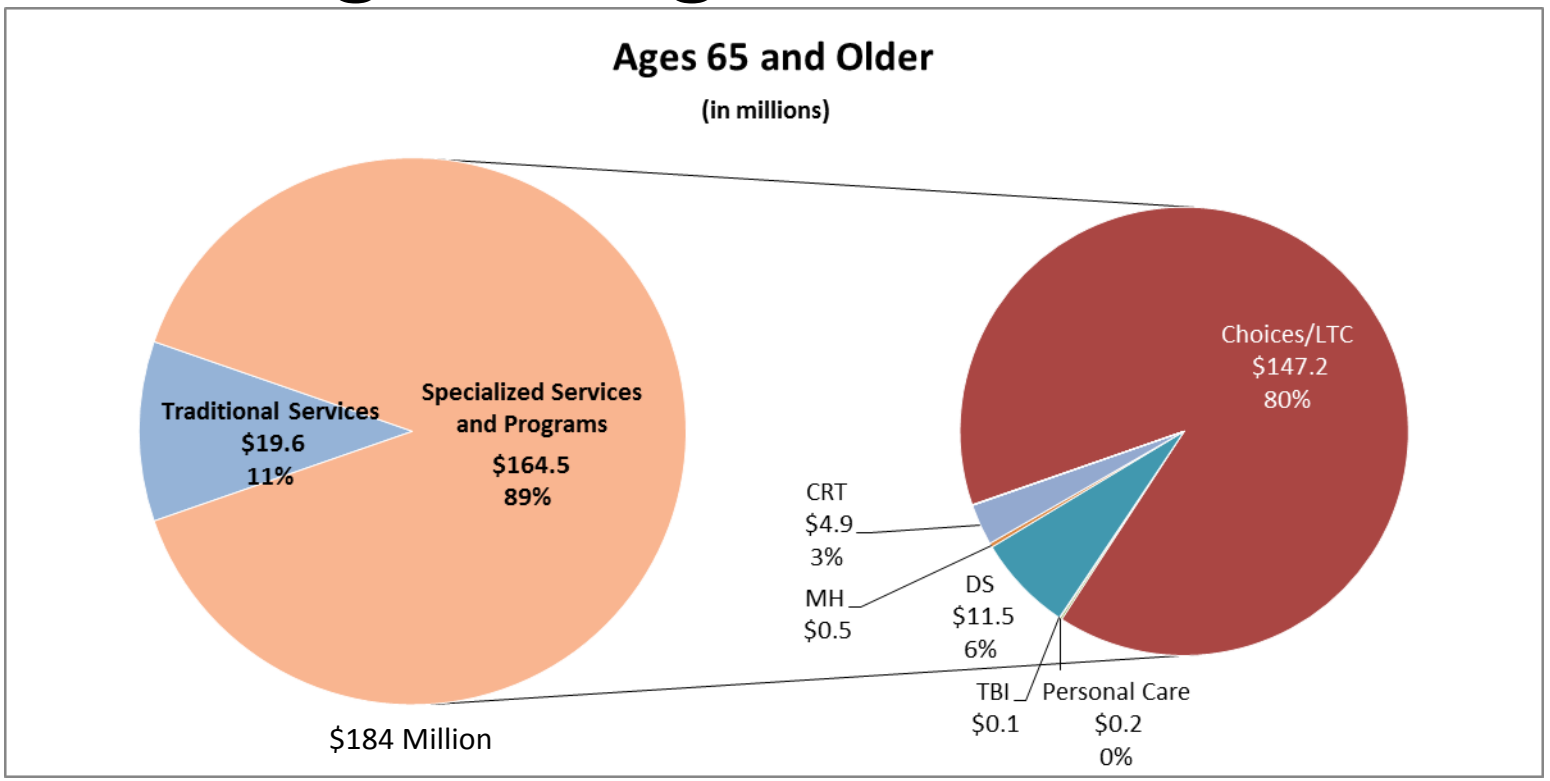
Specialized services for children and adolescents represent more than one-half of total program spending on behalf of children

Medicaid Expenditure Summary by Program: Ages 18 to 64



Developmental Services funding on behalf of adults between the ages of 18 and 64 accounts for approximately one-half of specialized service expenditures for this age group and approximately 90 percent of total Developmental Services spending on behalf of all ages (see Slide 10)

Medicaid Expenditure Summary by Program: Ages 65 and Over



Most Vermonters who are 65 years and older have Medicare coverage for traditional services. For individuals who are dually eligible, Medicaid provides financial assistance to meet Medicare cost sharing obligations and provides coverage for some services not covered by Medicare. Long term care represents eighty percent of total Medicaid expenditures on behalf of individuals ages 65 and older. *(Note: Figures do not include Medicaid payments for Medicare premiums)*

Medicaid Expenditure Detail: Traditional Services

($ millions)

Traditional Services	Age Range			
	Less than 18	18 to 64	65 and Older	Total Paid
Ambulance	$ 0.5	$ 2.7	$ 0.7	$ 3.9
Dental	$ 12.2	$ 7.1	$ 0.4	$ 19.6
Durable Medical Equipment	$ 1.5	$ 5.1	$ 1.2	$ 7.8
FQHC/RHC	$ 7.2	$ 16.0	$ 0.7	$ 23.9
Home Health	$ 1.8	$ 4.2	$ 1.3	$ 7.3
Hospice	$ 0.0	$ 0.3	$ 0.5	$ 0.8
Independent Lab	$ 0.3	$ 5.0	$ 0.0	$ 5.3
Inpatient Hospital	$ 26.8	$ 90.4	$ 3.0	$ 120.2
Medical Supplies	$ 0.2	$ 0.5	$ 0.1	$ 0.8
Other	$ 0.1	$ 1.3	$ 0.3	$ 1.7
Other Practitioner	$ 9.9	$ 16.3	$ 0.5	$ 26.7
Outpatient Hospital	$ 15.8	$ 78.8	$ 5.3	$ 99.9
Pharmacy	$ 16.3	$ 59.1	$ 0.6	$ 76.0
Physician	$ 22.8	$ 56.5	$ 2.8	$ 82.1
Prosthetic/Orthotic	$ 1.3	$ 1.5	$ 0.0	$ 2.9
Therapy Services	$ 0.7	$ 2.2	$ 0.2	$ 3.1
Transportation	$ 0.3	$ 3.9	$ 2.1	$ 6.2
Total	**$ 117.7**	**$ 350.7**	**$ 19.6**	**$ 488.0**

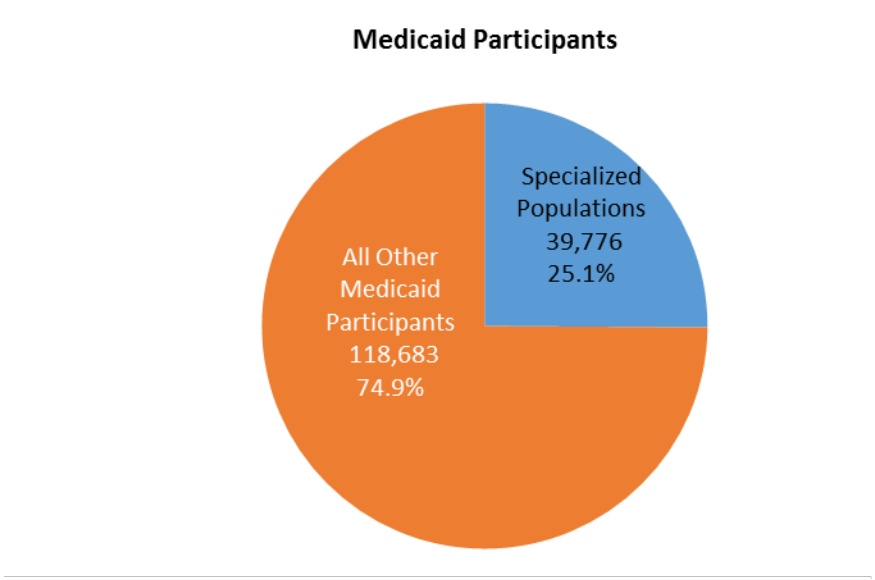
Coverage of traditional services on behalf of non-elderly (ages 18 to 64) adults accounts for approximately 70 percent of Medicaid spending for traditional services. Payments for inpatient and outpatient hospital services total approximately $220 million for all age groups, approximately 45 percent of total spending for traditional services.

Expenditure Detail: Specialized Services and Programs

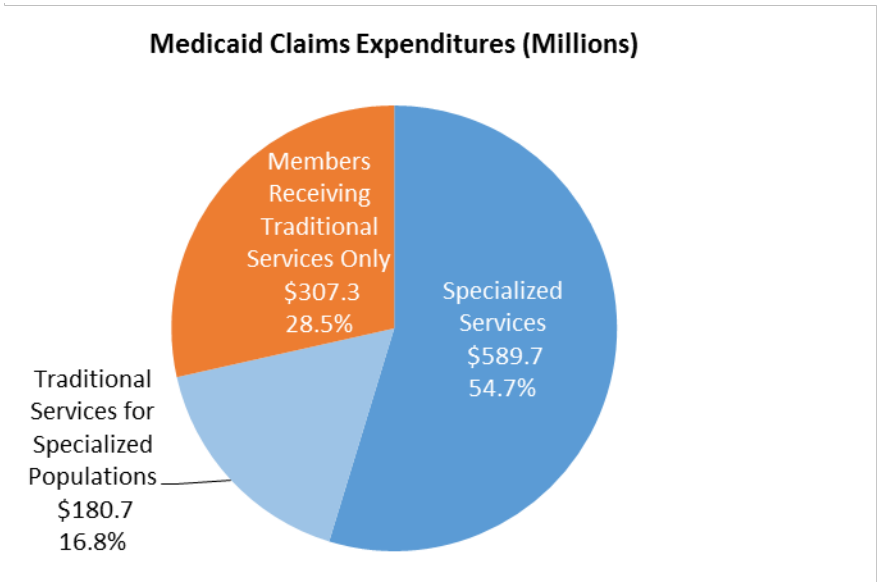
($ millions)

Specialized Services and Programs	Age Range			
	Less than 18	18 to 64	65 and Older	Total Paid
Choices for Care/Long Term Care				
Assistive Community Care	$ -	$ 4.9	$ 10.6	$ 15.4
Choices for Care HCBS	$ -	$ 17.8	$ 33.7	$ 51.5
Nursing Home	$ 0.2	$ 13.7	$ 103.0	$ 116.9
Subtotal	*$ 0.2*	*$ 36.5*	*$ 147.2*	*$ 183.9*
Personal Care Services	$ 18.5	$ 5.8	$ 0.2	$ 24.6
Traumatic Brain Injury (TBI) Program	$ -	$ 4.9	$ 0.1	$ 5.0
Developmental Services				
Developmental Services HCBS	$ 4.9	$ 133.6	$ 11.4	$ 149.9
ICF/ID (DS)	$ -	$ 1.2	$ 0.1	$ 1.3
Subtotal	*$ 4.9*	*$ 134.8*	*$ 11.5*	*$ 151.2*
Mental Health Treatment				
Community Rehabilitation and Treatment (CRT)	$ -	$ 48.5	$ 4.9	$ 53.4
Day Treatment/Private Non-Medical Institution	$ 9.7	$ 1.5	$ 0.2	$ 11.4
HCBS SED Children and Adolescents	$ 2.5	$ 0.3	$ -	$ 2.8
Mental Health Facility	$ 11.8	$ 4.8	$ 0.2	$ 16.8
Targeted Case Management -MH	$ 4.1	$ 0.6	$ 0.0	$ 4.7
Subtotal	*$ 28.0*	*$ 55.7*	*$ 5.4*	*$ 89.1*
Department for Children and Families	$ 22.4	$ 8.7	$ 0.0	$ 31.1
School Health				
Department of Health	$ 1.0	$ 0.1	$ -	$ 1.1
School-Based Health Services (DOE)	$ 35.1	$ 5.1	$ -	$ 40.2
Success Beyond Six	$ 42.4	$ 5.1	$ -	$ 47.5
Subtotal	*$ 78.5*	*$ 10.3*	*$ -*	*$ 88.8*
Substance Abuse Treatment	$ 0.5	$ 15.6	$ 0.0	$ 16.1
Total	**$ 153.0**	**$ 272.3**	**$ 164.5**	**$ 589.7**

Expenditure and Enrollment Summary: Individuals Receiving Specialized Services v. All Other Medicaid Program Participants



158,459 Service Recipients



$1.08 Billion

Individuals receiving specialized services represent approximately 25 percent of total Medicaid participants receiving services, but coverage of services to meet their DLTSS and traditional medical needs comprises more than 70 percent of the Medicaid budget

Medicaid Expenditures: Individuals Receiving Specialized Services v. All Other Medicaid Participants

$ millions

Program	Program Participants	Percent of Total	Traditional Services		Specialized Services		All Services	
			Expenditures	Percent of Total	Expenditures	Percent of Total	Expenditures	Percent of Total
Primary Specialized Programs								
Choices for Care/LTC	6,673	4.2%	$ 31.2	6.4%	$ 184.7	31.3%	215.9	20.0%
Personal Care	1,555	1.0%	$ 10.4	2.1%	$ 22.3	3.8%	32.7	3.0%
Traumatic Brain Injury	71	0.0%	$ 0.4	0.1%	$ 5.0	0.8%	5.4	0.5%
Developmental Services	2,952	1.9%	$ 11.8	2.4%	$ 155.8	26.4%	167.6	15.6%
MH Treatment	3,799	2.4%	$ 15.3	3.1%	$ 27.1	4.6%	42.4	3.9%
CRT	2,215	1.4%	$ 17.4	3.6%	$ 55.5	9.4%	72.9	6.8%
SED	95	0.1%	$ 0.7	0.1%	$ 2.8	0.5%	3.5	0.3%
Substance Abuse Treatment	5,186	3.3%	$ 32.7	6.7%	$ 15.9	2.7%	48.6	4.5%
Subtotal	*22,546*	*14.2%*	*$ 120.0*	*24.6%*	*$ 469.1*	*79.5%*	*589.0*	*54.7%*
Other Specialized Programs								
DCF Case Management	6,791	4.3%	$ 32.9	6.7%	$ 29.6	5.0%	62.6	5.8%
Department of Health	164	0.1%	$ 1.3	0.3%	$ 0.5	0.1%	1.8	0.2%
School-Based Health Services	7,141	4.5%	$ 15.6	3.2%	$ 37.6	6.4%	53.1	4.9%
Success Beyond Six	3,134	2.0%	$ 10.9	2.2%	$ 53.0	9.0%	63.9	5.9%
Subtotal	*17,230*	*10.9%*	*$ 60.7*	*12.4%*	*$ 120.7*	*20.5%*	*181.4*	*16.8%*
Subtotal: All Specialized Programs	***39,776***	***25.1%***	***$ 180.7***	***37.0%***	***$ 589.7***	***100.0%***	***770.4***	***71.5%***
All Other Medicaid Participants	***118,683***	***74.9%***	***$ 307.3***	***63.0%***	***$ -***	***0.0%***	***307.3***	***28.5%***
Total	**158,459**	**100.0%**	**$ 488.0**	**100.0%**	**$ 589.7**	**100.0%**	**1,077.8**	**100.0%**

Summary of Expenditures: Basis for Eligibility

- Medicaid eligibility rules reflect the important role of Medicaid in meeting the coverage needs of individuals with specialized needs
- Eligibility rules extend coverage to individuals with specialized needs and extensive health care needs
- Individuals enrolled on the basis of their medical needs represent approximately one-fourth of all Medicaid program participants
- Expenditures on behalf of individuals eligible due to medical needs represent 58 percent of total program expenditures *(Detail provided on next slide)*

Expenditures by Basis of Eligibility and Age *($ millions)*

Service Description	Non-Disability Related Aid Codes				Disability Related Aid Codes				Total: All Participants	Percentage of Expenditures: Disability-Related Aid Codes
Age:	Less than 18	18 to 64	65 and Older	Total	Less than 18	18 to 64	65 and Older	Total		
Program Recipients	58,429	57,500	3,512	**119,441**	4,326	28,056	6,636	**39,018**	**158,459**	
Percentage of Total	*37%*	*36%*	*2%*	***75%***	*3%*	*18%*	*4%*	***25%***		
Traditional Services										
Ambulance	$ 0.4	$ 1.1	$ 0.2	$ 1.8	$ 0.1	$ 1.5	$ 0.5	$ 2.1	$ 3.9	*54%*
Dental	$ 11.2	$ 3.5	$ 0.2	$ 14.9	$ 1.0	$ 3.6	$ 0.2	$ 4.7	$ 19.6	*24%*
Durable Medical Equipment	$ 0.6	$ 1.5	$ 0.4	$ 2.5	$ 0.9	$ 3.6	$ 0.8	$ 5.3	$ 7.8	*68%*
FQHC/RHC	$ 6.7	$ 10.9	$ 0.3	$ 17.9	$ 0.5	$ 5.1	$ 0.4	$ 5.9	$ 23.9	*25%*
Home Health	$ 1.2	$ 1.0	$ 0.3	$ 2.5	$ 0.6	$ 3.2	$ 0.9	$ 4.8	$ 7.3	*66%*
Hospice	$ 0.0	$ 0.1	$ 0.0	$ 0.1	$ -	$ 0.2	$ 0.5	$ 0.7	$ 0.8	*89%*
Independent Lab	$ 0.2	$ 3.9	$ 0.0	$ 4.1	$ 0.0	$ 1.1	$ 0.0	$ 1.1	$ 5.3	*21%*
Inpatient Hospital	$ 22.3	$ 59.7	$ 1.3	$ 83.3	$ 4.5	$ 30.7	$ 1.7	$ 36.9	$ 120.2	*31%*
Medical Supplies	$ 0.1	$ 0.2	$ 0.0	$ 0.3	$ 0.1	$ 0.3	$ 0.0	$ 0.5	$ 0.8	*58%*
Other	$ 0.1	$ 0.4	$ 0.1	$ 0.5	$ 0.0	$ 0.9	$ 0.2	$ 1.2	$ 1.7	*68%*
Other Practitioner	$ 7.1	$ 9.5	$ 0.1	$ 16.7	$ 2.8	$ 6.8	$ 0.4	$ 10.0	$ 26.7	*37%*
Outpatient Hospital	$ 14.1	$ 50.7	$ 2.4	$ 67.2	$ 1.7	$ 28.1	$ 2.9	$ 32.7	$ 99.9	*33%*
Pharmacy	$ 11.4	$ 36.1	$ 0.1	$ 47.6	$ 4.9	$ 23.0	$ 0.5	$ 28.4	$ 76.0	*37%*
Physician	$ 20.5	$ 38.9	$ 1.2	$ 60.6	$ 2.3	$ 17.6	$ 1.6	$ 21.5	$ 82.1	*26%*
Prosthetic/Orthotic	$ 0.4	$ 0.7	$ 0.0	$ 1.2	$ 0.9	$ 0.9	$ 0.0	$ 1.8	$ 2.9	*61%*
Therapy Services	$ 0.5	$ 1.6	$ 0.1	$ 2.2	$ 0.2	$ 0.6	$ 0.1	$ 0.9	$ 3.1	*29%*
Transportation	$ 0.2	$ 0.5	$ 0.5	$ 1.3	$ 0.1	$ 3.3	$ 1.5	$ 4.9	$ 6.2	*79%*
Subtotal: Traditional Services	***$ 97.1***	***$ 220.3***	***$ 7.3***	***$ 324.7***	***$ 20.6***	***$ 130.4***	***$ 12.3***	***$ 163.4***	***$ 488.0***	***33%***
Specialized Services										
Assistive Community Care	$ -	$ 0.4	$ 3.0	$ 3.4	$ -	$ 4.5	$ 7.5	$ 12.1	$ 15.4	*78%*
Choices for Care HCBS	$ -	$ 0.0	$ 4.2	$ 4.3	$ -	$ 17.8	$ 29.5	$ 47.3	$ 51.5	*92%*
Nursing Home	$ -	$ 0.2	$ 3.4	$ 3.6	$ 0.2	$ 13.5	$ 99.6	$ 113.3	$ 116.9	*97%*
Personal Care Services	$ 4.8	$ 0.4	$ 0.1	$ 5.3	$ 13.8	$ 5.4	$ 0.1	$ 19.3	$ 24.6	*79%*
Traumatic Brain Injury (TBI)	$ -	$ -	$ -	$ -	$ -	$ 4.9	$ 0.1	$ 5.0	$ 5.0	*100%*
Developmental Services HCBS	$ 0.8	$ 0.5	$ 1.5	$ 2.8	$ 4.1	$ 133.1	$ 9.9	$ 147.0	$ 149.9	*98%*
ICF/ID (DS)	$ -	$ -	$ -	$ -	$ -	$ 1.2	$ 0.1	$ 1.3	$ 1.3	*100%*
CRT	$ -	$ 3.1	$ 1.4	$ 4.5	$ -	$ 45.4	$ 3.5	$ 48.9	$ 53.4	*92%*
Day Treatment/Private Non-Medical Inst (PNMI)	$ 6.6	$ 1.2	$ 0.1	$ 7.9	$ 3.1	$ 0.3	$ 0.1	$ 3.5	$ 11.4	*31%*
HCBS SED Children and Adolescents	$ 1.7	$ 0.1	$ -	$ 1.8	$ 0.8	$ 0.2	$ -	$ 1.0	$ 2.8	*36%*
Mental Health Facility	$ 7.8	$ 1.6	$ 0.1	$ 9.4	$ 4.0	$ 3.2	$ 0.1	$ 7.4	$ 16.8	*44%*
Targeted Case Management -MH	$ 2.9	$ 0.2	$ 0.0	$ 3.1	$ 1.2	$ 0.3	$ 0.0	$ 1.6	$ 4.7	*34%*
DCF - Case Management	$ 18.9	$ 5.4	$ 0.0	$ 24.2	$ 3.5	$ 3.3	$ 0.0	$ 6.9	$ 31.1	*22%*
Department of Health	$ 0.5	$ 0.0	$ -	$ 0.5	$ 0.5	$ 0.1	$ -	$ 0.5	$ 1.1	*49%*
School-Based Health Services (DOE)	$ 18.3	$ 1.0	$ -	$ 19.4	$ 16.8	$ 4.0	$ -	$ 20.8	$ 40.2	*52%*
Day Trmt - Success Beyond Six	$ 24.9	$ 1.7	$ -	$ 26.6	$ 17.6	$ 3.4	$ -	$ 20.9	$ 47.5	*44%*
Substance Abuse Treatment	$ 0.4	$ 11.5	$ 0.0	$ 11.9	$ 0.1	$ 4.1	$ 0.0	$ 4.2	$ 16.1	*26%*
Subtotal: Specialized Services	***$ 87.5***	***$ 27.4***	***$ 13.9***	***$ 128.7***	***$ 65.5***	***$ 244.9***	***$ 150.6***	***$ 461.0***	***$ 589.7***	***78%***
Total	**$ 184.6**	**$ 247.6**	**$ 21.2**	**$ 453.4**	**$ 86.1**	**$ 375.4**	**$ 162.9**	**$ 624.4**	**$ 1,077.8**	**58%**

Attachment 4a - Existing Core Payment Measures-DLTSS Subpop

Existing Core Payment Measures

The DLTSS Work Group will recommend analysis of one or more of the following existing Core Payment measures for DLTSS subpopulations within the people attributed to Medicaid ACOs.

- All-Cause Readmission
- Follow-Up After Hospitalization for Mental Illness (7-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis
- Chlamydia Screening in Women
- Cholesterol Management for Patients with Cardiovascular Disease (LDL Screening)

Why should we look at these measures for DLTSS subpopulations?

This will inform DLTSS providers, ACOs, and payers about the overall quality of care among DLTSS beneficiaries before ACOs have the option (or are required) to include additional services in the Total Cost of Care definition. In addition, these claims-based analyses can be conducted with minimal added administrative burden.

Under what circumstances would we not recommend these subpopulation analyses?

There may be concerns about the validity of estimates when sample sizes are small. In keeping with NCQA public reporting requirements, measures will not be calculated for DLTSS subpopulations when there are fewer than 30 eligible individuals per measure in an ACO. Without more detailed information about the populations attributed to each ACO at this time, we recommend subpopulation reporting on the above measures. Measures should be excluded from DLTSS subpopulation analyses if sample sizes are too small to produce valid estimates.

Attachment 4b - Pending Measures Review DLTSS Specific

VT Quality and Performance Measures Work Group
Review of 22 Pending Measures
April 11, 2014 Draft
DLTSS-Specific Pending Measures for Year 2
Yellow = potential with challenges; green = feasible; pink = not feasible at this time

#	Measure name	Reason designated as Pending	Considerations for Review
Core-32	Proportion Not Admitted to Hospice (Cancer Patients)	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #215 • No national benchmark available. **Could potentially gather measure information from administrative data if it is possible to ascertain cause of death from claims. Successful implementation of measure may also depend on whether hospice care is being covered by Medicaid, Medicare, or both. This merits further investigation, but could be a candidate for serious consideration by QPM.**
Core-35/ MSSP-14	Influenza Immunization	• Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• NQF #0041 • MSSP • No national benchmark available. • Need to consider how to capture immunizations that were given outside of the PCP's office (e.g., in pharmacies, at public health events, etc.) **This is a measure already being used by the ACOs for the Medicare Shared Savings Program. In addition, it applies to the full population. Good candidate for QPM consideration.**
Core-37	Care Transition-Transition Record Transmittal to Health Care Professional	• Clinical data-based measure. Need to develop HIT systems to be able to pull data	• NQF #0648 • No national benchmark available. **Considerable administrative burden to collect this**

#	Measure name	Reason designated as Pending	Considerations for Review
		directly from EHRs.	**information, so this measure is likely to face opposition. It *may* be a candidate for consideration if we could make the argument that this would provide valuable information that relates to the future work planned under the ACTT proposal. In addition, closely related to Core-44 (could likely use the same sample of charts for both measures).**
Core-44	~~*Percentage of Patients with Self-Management Plans (Medicaid only)*~~ *RECOMMEND:* Transition Record with Specified Elements Received by Discharged Patients	• ~~Need to develop measure specifications based on the NCQA standard.~~ • Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• Medicaid only measure. • ~~Not NQF endorsed~~ NQF #0647 • No national benchmark available. **Considerable administrative burden to collect this information, so this measure is likely to face opposition. It *may* be a candidate for consideration if we could make the argument that this would provide valuable information that relates to the future work planned under the ACTT proposal. In addition, closely related to Core-37 (could likely use the same sample of charts for both measures).**
Core-45	*Screening, Brief Intervention, and Referral to Treatment (Medicaid only)*	• Need to develop measure specifications. • Likely a clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs. • If using claims-based specifications, work with providers to implement new codes.	• Medicaid-only measure. • Not NQF endorsed • No national benchmark available. **Vermont (through VDH) has been awarded an SBIRT grant to develop a pilot program. Activities are already underway, and the QPM work group plans to have conversations with the SBIRT team about how ongoing efforts could inform the ACOs' work. There are no clear measure specifications at this time, so it is unlikely that the work group would be able to recommend it for ACO use.**
Core-47/ MSSP-13	*Falls: Screening for Future Fall Risk (Medicaid only)*	• Not to be implemented until individuals who are dually eligible for Medicare and Medicaid	• Medicaid-only measure. • NQF #0101 • MSSP

#	Measure name	Reason designated as Pending	Considerations for Review
		are eligible to participate in the ACO pilot program. • Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• No national benchmark available. • Duals-specific measure (consider denominator size without duals) **This measure applies to the 65+ population. There will likely not be enough people in this age range attributed to ACOs through the Medicaid or Commercial Shared Savings Programs for this to be measured validly. (Individuals 65+ who are attributed to an ACO through the Medicare Shared Savings Program will be assessed for this measure separately.)**
Core-48/ MSSP-15	*Pneumococcal Vaccination for Patients 65 Years and Older (Medicaid only)*	• Not to be implemented until individuals who are dually eligible for Medicare and Medicaid are eligible to participate in the ACO pilot program. • Clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• Medicaid-only measure. • NQF #0043 • MSSP • Duals-specific measure (consider denominator size without duals) • There is a survey-based HEDIS benchmark available but not a clinical data-based measure. **This measure applies to the 65+ population. There will likely not be enough people in this age range attributed to ACOs through the Medicaid or Commercial Shared Savings Programs for this to be measured validly. (Individuals 65+ who are attributed to an ACO through the Medicare Shared Savings Program will be assessed for this measure separately.)**
Core-49	*Use of High Risk Medications in the Elderly (Medicaid only)*	• Not to be implemented until individuals who are dually eligible for Medicare and Medicaid	• Medicaid-only measure. • NQF# 0022 • HEDIS • Duals-specific measure (consider denominator

#	Measure name	Reason designated as Pending	Considerations for Review
		are eligible to participate in the ACO pilot program.	size without duals) **This measure applies to the 65+ population. There will likely not be enough people in this age range attributed to ACOs through the Medicaid or Commercial Shared Savings Programs for this to be measured validly. (Individuals 65+ who are attributed to an ACO through the Medicare Shared Savings Program will be assessed for this measure separately.)**
Core-50	*Persistent Indicators of Dementia without a Diagnosis (Medicaid only)*	• Not to be implemented until individuals who are dually eligible for Medicare and Medicaid are eligible to participate in the ACO pilot program. • Likely a clinical data-based measure. Need to develop HIT systems to be able to pull data directly from EHRs.	• Medicaid-only measure. • NQF #2091/2092 • No national benchmark available. • Duals-specific measure (consider denominator size without duals) **This measure applies to the 65+ population. There will likely not be enough people in this age range attributed to ACOs through the Medicaid or Commercial Shared Savings Programs for this to be measured validly. (Individuals 65+ who are attributed to an ACO through the Medicare Shared Savings Program will be assessed for this measure separately.)**

Attachment 4c - Potential DLTSS Measures

Potential New Payment Measures -- DLTSS

3/19/14

Measure Source	Measure	Measure Description	Information Source	Notes
Duals Demo Quality Withhold Measure Y2-3	LTSS Rebalancing	Ratio of HCBS utilization to institutional utilization (number of people and expenditures) in identified LTSS subpopulations	Claims	This measure is claims-based, and is already being used by the state. No benchmarks exist; would need to develop an associated performance target.
LTSS Scorecard	Percent of new Medicaid LTSS users first receiving services in the community	Proportion of Medicaid LTSS beneficiaries in measurement year who did not receive any LTSS in the previous year who in the first calendar month of receiving LTSS received HCBS only and not institutional services.	Claims	This measure is claims-based. No benchmarks exist; would need to develop an associated performance target.
LTSS Scorecard	Percent of home health patients with a hospital admission	Percent of home health care patients who were hospitalized for an acute condition.	Claims/OASIS	This is a claims-based/OASIS measure. Would need to develop an associated performance target.
LTSS Scorecard	Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities	Proportion of Medicaid LTSS and home health spending for older people and adults with physical disabilities (defined as nursing homes, personal care, aged/disabled waivers, home health, and other programs used primarily by older people and adults with physical disabilities) going to HCBS, including Medicaid and state-funded services.	Claims	This measure is claims-based, and is related to the LTSS rebalancing measure. This is more of a financial metric, so **may be more appropriate for inclusion in the Monitoring & Evaluation measure set.**
LTSS Scorecard	Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community	The number of participant-months (divided by 12) of Medicaid LTSS for **adults age 65+ or age 21+ with a physical disability** divided per 100 persons age 21+ with a self-care difficultly at or below 250% of the poverty threshold, or of any age living in a nursing home. 250% of poverty was chosen in order to fully capture the effect of state policies extending Medicaid eligibility for LTSS up to 300% of SSI.	Claims	This measure is fairly complicated to interpret, and as defined ("adults age 65+ or age 21+ with a physical disability") may not apply to a large enough portion of the population to generate valid estimates. Claims-based.
LTSS Scorecard	Percent of long-stay nursing home residents with a hospital admission	Percent of long-stay residents (residing in a nursing home relatively continuously for 100 days prior to the second quarter of the calendar year) who were ever hospitalized within six months of baseline assessment.	Claims/Clinical Record	May not apply to a large enough portion of the population to generate valid estimates. Clinical measure.
LTSS Scorecard	Percent of high-risk nursing home residents with pressure sores	Percent of long-stay nursing home residents impaired in bed mobility or transfer, comatose, or suffering malnutrition who have pressure sores (stage 1–4) on target assessment.	Clinical Record/MDS	May not apply to a large enough portion of the population to generate valid estimates. Clinical measure/MDS measure.
LTSS Scorecard	Percent of long-stay nursing home residents who were physically restrained	Percent of long-stay nursing home residents who were physically restrained daily on target assessment.	Clinical Record/MDS	May not apply to a large enough portion of the population to generate valid estimates. Clinical measure/MDS measure.
Duals Demo Quality Withhold Measure Y1	Percent of Enrollees stratified to medium or high risk with a completed initial assessment within 90 days of enrollment	Proportion of beneficiaries receiving an initial assessment within 90 days of enrollment who were classified as being either medium or high risk.	Claims/Clinical Record	Not clear which assessment is being used for this measure. Risk level would most likely be ascertained from clinical records. Administrative burden.
Duals Demo Quality Withhold Measure Y2-3	Reducing the risk of falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	Clinical Record	This information will be difficult to collect. The MSSP measure relating to Fall Risk Screening is already being used by the ACOs for the 65+ population.
LTSS Scorecard	Percent of home health episodes of care in which interventions to prevent pressure sores were included in the plan of care for at-risk patients	Percent of home health episodes of care in which interventions to prevent pressure ulcers were included in the physician-ordered plan of care for patients assessed to be at risk for pressure ulcers.	Clinical Record/OASIS	This information will be difficult to collect without considerable administrative burden. May not apply to a large enough portion of the population to generate valid estimates. Clinical measure/OASIS measure.
	Others	DLTSS Work Group participants have requested the addition of other measures, to be determined		

Feasible
Potential, with challenges
Not feasible at this time

Attachment 5 - Proposed DLTSS Model of Care

PROPOSED MODEL OF CARE FOR PEOPLE WITH DISABILITIES AND LONG-TERM SERVICES AND SUPPORTS (DLTSS) NEEDS

Presentation for VHCIP DLTSS Work Group

April 24, 2014

Description of DLTSS Population

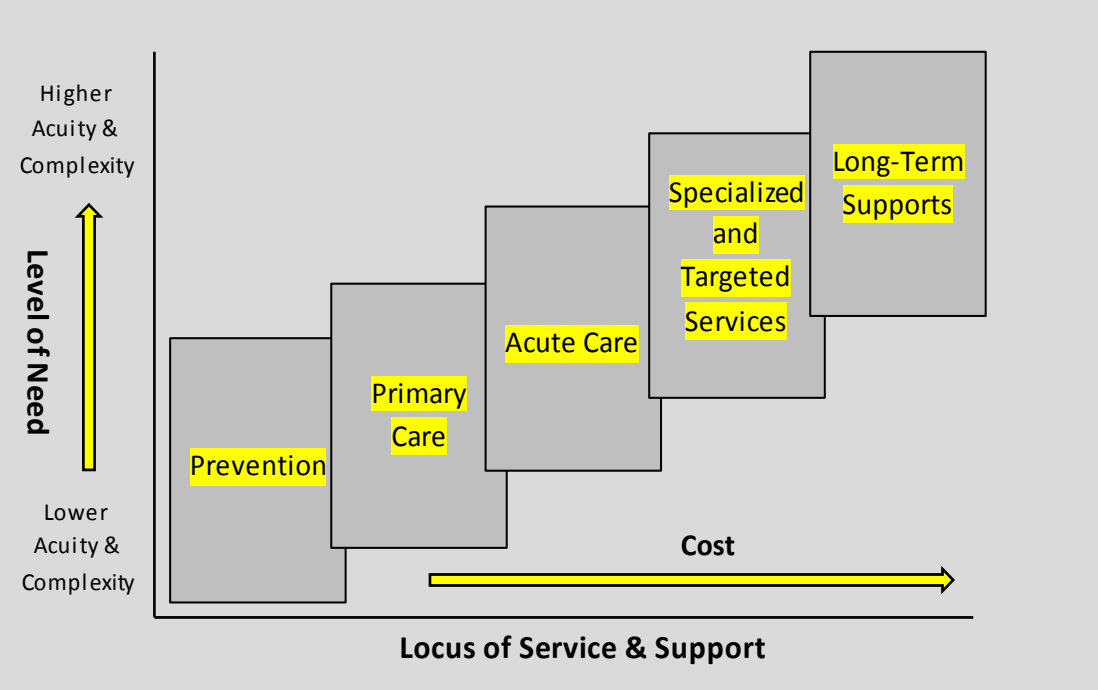
- People with disability and long-term services and supports (DLTSS) needs are…
  - Individuals of all ages who have a physical, cognitive or mental condition who need services and supports to assist with the limitations related to their condition
    - An individual's DLTSS support needs may be simple or complex
- Total number of all Vermonters with DLTSS needs is undetermined
  - Approximately 40,000 are **Medicaid** enrollees (some of whom also are enrolled in Medicare):
    - Defined as Medicaid enrollees who receive DLTSS-related specialized services and programs [i.e., Choices for Care (CfC); Personal Care; Traumatic Brain Injury (TBI) Program; Developmental Services (DS); Community Rehabilitation Treatment (CRT), Children and Adolescents with Serious Emotional Disturbances (SED), and other Mental Health Treatment; Substance Abuse Treatment; Department for Children and Families (DCF) Case Management; School-Based Health Services; and Success Beyond Six]
    - These individuals represent approximately **25% of total Medicaid enrollees**, but coverage of services to meet their **DLTSS needs represents 55% of the Medicaid budget** and **more than 70% of the Medicaid budget when traditional medical services are included** *(Source: State of Vermont DLTSS Medicaid Expenditures CY12, S. Wittman/PHPG presentation to DLTSS Work Group, April 24, 2014)*
  - Others are enrolled in **Medicare only** (people over 65 who have DLTSS needs but do not qualify for Medicaid)
  - Others have **private / commercial insurance**

Why are DLTSS Fundamental to Health Care Reform?

- For at least a decade, there has been consensus that older people and those with disabilities or multiple chronic conditions are the most complex and expensive populations that Medicaid supports. *(Sources: Kaiser, Robert Wood Johnson, Center for Health Care Strategies, CMS)*
- Evidence suggests that integration of care (primary care, acute care, chronic care, mental health, substance abuse services, and disability and long-term services and supports) is an effective approach to pursuing the triple aim: improved health quality, better experience of care, and lower costs. (*Sources: Commonwealth Care Alliance, SNPs)*
- DLTSS helps prevent the need for care in more expensive, acute care settings - thus improving a person's well-being, improving quality of care, and controlling health care costs.
- Research has shown that environmental and socio-economic factors are crucial to people's overall health. DLTSS provide assistance related to these factors on an individualized basis.
  - For example, people that are employed tend to be healthier and therefore have lower utilization of health care services. Other social determinants of health include financial resources, housing, education, safety, and nutrition. *(Source: IBM Cúram Research Institute, 2013)*

DLTSS Needs Vary by Individual and Situation

- The full continuum of care must be available for people with DLTSS needs:
  - From prevention through lifelong supports
  - Including a diverse range of medical, mental health, substance abuse, developmental disability, personal care, employment, housing and social services and supports
  - Specific needs can vary at any given time



DLTSS-Related Services Covered by Medicaid

- DLTSS-related specialized services funded by Medicaid include, but are not limited to:
  - Assistance with activities of daily living (e.g. personal care, eating, grocery shopping, food preparation, money management)
  - Mental health counseling
  - Crisis services
  - Medication management
  - Substance abuse treatment
  - Assistive Technologies
  - Employment and Housing Supports
  - Residential Services
  - Nursing Home Care
  - Support during medical services (primarily DS)
  - Assistance to make connections in the community
  - Case Management & Coordination
- Some individuals who meet stringent clinical/level of care and/or funding priority criteria receive DLTSS through Medicaid-funded specialized programs (CfC, DS, CRT, TBI, and SED)
- Any Medicaid enrollee can receive some of these DLTSS on an as-needed basis through Medicaid fee-for-service benefits

DLTSS Providers

- Specialized mental health, developmental disability, and substance abuse treatment services and supports are provided by:
  - 11 Designated Agencies and 6 Specialized Service Agencies
- Other long term services and supports are provided by diverse groups:
  - 112 Residential Care Homes
  - 36 Therapeutic Community Residences
  - 40 Nursing Homes
  - 12 Home Health Agencies
  - 5 Area Agencies on Aging
  - 14 Adult Day Providers
  - Substance Abuse Providers
  - Traumatic Brain Injury Providers
  - Durable Medical Equipment Providers
  - Vocational Rehabilitation
  - 6 Designated Regional Housing Organizations and 16 Housing Authorities and Land Trusts
  - Vermont Center for Independent Living and other peer support and advocacy providers and organizations
  - Guardians
  - Thousands of direct care/personal care workers who work directly for elderly and disabled individuals or their family
  - Other independent practitioners and providers (e.g., mental health, rehabilitation, physical and occupation therapy)

Traditional Medical Services Covered by Medicaid

- Individuals who receive DLTSS-related Medicaid specialized services and programs (see definition on Slide 2) *also* utilize approximately $180 million annually in traditional medical services funded by Medicaid
  - This $180 million represents 37% of the total $488 million in Medicaid expenditures for traditional medical services across all Medicaid enrollees
  - Traditional Medical Services include but are not limited to):
    - Inpatient and Outpatient Hospital
    - Primary Care Physicians
    - Specialists
    - Federally Qualified Health Centers (FQHCs)
    - Pharmacy
    - Dental
    - Laboratory Tests
    - Medical supplies
    - Occupational, Physical, Speech Therapy
    - Home Care
    - Hospice
    - Ambulance

(Source: State of Vermont DLTSS Medicaid Expenditures CY12, S. Wittman/PHPG presentation to DLTSS Work Group, April 24, 2014)

Interactions with Other Programs and Providers

- People with DLTSS needs also may receive other support and case management services from:
  - **Blueprint Community Health Teams (CHTs)**
    - Provide care coordination, education and support as needed to patients of Hospital Owned Primary Care Practices, Independent Single Site Primary Care Practices, Independent Multi-Site Primary Care Practices and Federally Qualified Health Centers (FQHCs)
      - These practices served 514,385 Vermonters (82%) as of December, 2014 *(Blueprint 2013 Annual report)*
    - Focused on medical issues / needs
    - Time limited (due to focus and staffing)
  - **Hub and Spoke Health Home for Opioid Addiction**
    - Provides targeted services for people with Opioid addictions
    - Services include:
      - An established medical home, including comprehensive care management/care coordination
      - A single medication-assisted treatment prescriber and pharmacy home
      - Access to CHT resources
      - Access to Hub and Spoke nurses and clinicians
  - **Federally Qualified Health Centers (FQHCs)**
    - Provide comprehensive services for underserved areas or populations
      - Must provide primary care services and the following services on site or by arrangement with another provider: preventive care, dental, mental health and substance abuse, transportation necessary for adequate patient care, hospital and specialty care
    - Not time limited (intensity of services adapted as needed)

Interactions with Other Programs and Providers, cont.

- People with DLTSS needs also may receive other support and case management services from:
  - **Support and Services at Home (SASH)**
    - Focused on Medicare beneficiaries of all ages and low income residents of affordable housing regardless of payer
    - Provides a care coordinator and wellness nurse who work in partnership with a team of community providers to assist SASH participants to access the care and support they need to stay healthy while living comfortably and safely at home.
    - Not time limited (intensity of services adapted as needed)
  - **Vermont Chronic Care Initiative (VCCI)**
    - Provides care coordination for Medicaid beneficiaries who have chronic health conditions and/or high utilization of medical services to access clinically appropriate health care information and services and educates and empowers them to eventually self-manage their conditions.
    - Time limited (3 months)
    - Excludes:
      - Children
      - Individuals who are dually eligible for Medicare and Medicaid
      - People enrolled in Medicaid-funded specialized programs (CfC, DS, CRT, TBI)
  - **Commercial Insurance case management for special cases**
  - **Commercial Long Term Care Insurance programs**
  - **Veterans Administration and other Military benefit programs**

What is Working Well for People with DLTSS Needs

- For those enrolled in Medicaid Specialized Programs (i.e., CfC, CRT, DS, TBI, SED):
  - Receive services and supports based in the values of self-determination and community integration
  - Each program specializes in unique needs
    - Service and supports are provided by staff who understand the complexities and subtleties of the individual's issues and needs, such as:
      - Communication barriers
      - Intellectual / cognitive barriers
      - Physical barriers
      - Symptoms and coping mechanisms related to severe mental illness
      - Medical needs related to their disability or functional limitations
      - Isolation due to the individual's functional limitations

Gaps, Barriers and Disincentives in Receiving Services

- The traditional medical system has not been designed to meet the diverse needs of people with DLTSS needs
  - Lack of understanding regarding how to address disability or functional issues
  - Lack of understanding about availability and effectiveness of specialized services and supports
  - Private health insurance typically does not cover some DLTSS-related services or non-medical expenses beyond short-term, rehabilitation-oriented care (e.g., PT/OT, DME, assistive technology, hearing aids, supplies, personal care)
  - Medicare which covers people over 65 and those with a disability under 65, does not cover long-term services and supports
  - When the need for LTSS arises in the wake of a medical event – a hospitalization for an accident or illness, or a transition from a post-acute stay to long-term care – the planning and organization of LTSS for an individual is often handled separately from the health care planning, and there are few incentives for health care providers to integrate LTSS with medical care planning or service delivery.
    (*Excerpted from Commission on Long-Term Care, September 2013 Report to Congress*)

Gaps, Barriers and Disincentives in Receiving Services

- For most people, DLTSS for individuals with more than one condition are managed by different state agencies and community providers
- Many individuals (and their families) must navigate through different provider systems (e.g., Medical, Mental Health, Developmental Disability, Home Health, DME, Area Agencies on Aging, Centers for Independent Living, Vocational Rehabilitation, Housing Providers) to try to get all their needs met
- The network of DLTSS providers is complex, multifaceted, specialized, isolated from other service providers, and confusing to the average consumer. Few providers in the DLTSS network evaluate a person's overall situation in order to arrange for the right combination of services based on one's actual needs. Instead, access to services is often organized in relationship to their funding streams. (*Commission on Long-Term Care, September 2013 Report to Congress*)
- Many people with DLTSS needs do not have needed on-going case management because:
  - They do not meet clinical and/or financial criteria for Medicaid Specialized Program eligibility (i.e., based on high level of need)
  - There may be limitations on the availability of Medicaid resources for case management
  - Medicare and Commercial insurance do not typically cover case management
- Those enrolled in Medicaid Specialized Programs (i.e., CfC, CRT, DS, TBI, SED):
  - May have multiple case managers and treatment plans that do not inform each other (e.g., medical care vs DLTSS needs)

PROPOSED MODEL OF CARE and CASE MANAGEMENT for VERMONTERS with DLTSS NEEDS

Basis for Design of Proposed DLTSS Model of Care

- Person-Centeredness and Person-Direction as the Foundation
  - Builds on Vermont's DLTSS current emphasis on self-determination and that people have a right to live meaningful lives in their communities
- Builds on Strengths of Existing Vermont System of Care and Health Care Reform Elements (e.g., Blueprint, Community Health Teams, SASH, Medicaid Health Home "Hub and Spoke" model; DLTSS system of care)
  - Utilizes existing Vermont Waiver population care models and guidelines promulgated by the State departments (i.e., DAIL, DMH, DOH) responsible for these specific populations (i.e., CFC, DS, TBI, CRT and Substance Abuse)
  - Augments and develops additional mechanisms to address identified barriers, using national evidence-based strategies
- Vermont Dual Eligible Demonstration Work Group Discussions and Products:
  - Person-Centered Care Work Group, Person-Directed Work Group and Essential Components of Person-Directed Approach Report
  - Service Delivery Model Workgroup
  - Individual Assessment & Comprehensive Care Plan Workgroup
- DVHA Medicare-Medicaid Plan Model of Care Submission to CMS (as part of DE Demonstration)
  - DVHA Model of Care approved by CMS and NCQA (March, 2013) for three years (highest approval range) with a score of 96%

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	✓	✓	✓	✓

Possible Over-arching Framework: Integrated Health Home

- Medicaid Health Home Model as possible model
  - Purpose of Medicaid health homes: To provide whole-person care coordination and facilitate access to, and collaboration with, primary care and long-term services and supports
    - Health Homes complement but do not supplant traditional healthcare treatment services
    - Health homes are responsible for all of the person's care management and care coordination
      - Presents an opportunity to rationally organize and integrate multiple parallel case/care management programs for special needs populations
      - Supports community providers to provide services in an integrated manner, across special needs and primary care
      - Must include six core services: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support, and Referral to Community and Support Services
  - States have flexibility to designate health home providers
    - May include community mental health organizations, addiction treatment providers, home health agencies, and other provider groups
    - Distinct from "medical homes" that focus on PCP practices as the locus of care
  - In the Medicaid health home program, states can draw down enhanced (90%) federal match for these services for two years – this might provide a mechanism to fund the more enhanced single point of contact/care coordination role that is being proposed, and to gain support from other payers where applicable
  - Caution: Health homes must be designed to provide better care for all individuals with diverse DLTSS needs, not just special populations

Description of Core Elements in Proposed DLTSS Model of Care

Person-Centered and Person-Directed Services and Supports

- Definition: Care that is life-affirming, comprehensive, continuous and respectful in its focus on health needs (medical, behavioral, long term care) as well as social needs (housing, employment), while promoting empowerment and shared decision-making through enduring relationships.
- Key Principles of Delivering Person-Centered and Person-Directed Services and Supports
  - Individuals feel welcome and heard and their choices are supported;
  - Informed decision-making and rights protection;
  - Availability of stable well-trained workforce and contractor network, including access to alternative providers and peer run services;
  - Commitment & capacity to promote self-help and person-directed services for individuals with diverse and multiple disabilities, over time, and across service settings;
  - "One size does not fit all": organizational/systemic capacity to effectively respond to a range of preferences regarding service information & assistance and service coordination; and
  - Assessment, planning, coordination and service delivery practices are shaped by the interests, needs and preferences of individuals rather than agencies.
  - Supports are provided, as needed, to assist individuals with DLTSS to participate in all aspects of society

(Primary Source: Dual Eligible Demonstration Person-Directed Work Group)

Person-Centered and Person-Directed Services and Supports: Care Management Roles

- Ensure that the individual is at the center of all planning and decision-making regarding their services and supports.
- Educate, empower and facilitate the individual to exercise his or her rights and responsibilities on an ongoing basis
- Provide information and support to the individual in making choices, including connections with options counseling, peer-support
- Involve the individual as an active team member and stress person-centered collaborative goal setting
- Ensure that all needed accommodations for planning participation and access to services are identified and provided when needed
- As appropriate, represent the individual's point of view when the individual is unable to participate in discussions
- Adhere to and respect all policies regarding individual rights, anonymity, and confidentiality

Access to Independent Options Counseling & Peer Support

- Provide independent, easy-to-access information and assistance to assist individuals and families/caregivers to:
  - Understand insurance options, eligibility rules and benefits
  - Understand specialized program eligibility rules
  - Choose services
  - Choose providers
  - Navigate the delivery system
  - Obtain information and on-going peer support regarding self-management of services and supports
  - Make decisions about appropriate long-term care choices
- Examples:
  - Aging and Disability Resource Connections (ADRCs) Member Organizations, such as:
    - Area Agencies on Aging
    - Vermont Center for Independent Living
    - Green Mountain Self Advocacy
    - Vermont Family Network
    - Brain Injury Association of Vermont
  - Peer-run Mental Health Programs
  - Health Care and Long-term Care Ombudsmen

Involved Primary Care Physician (PCP)

- Ensure that all people with DLTSS needs have an identified PCP that is actively involved in their care
  - Provide routine medical care
  - As medical needs change
  - Who has knowledge about DLTSS service options (via training, resource materials, etc.), and helps make connections (but does not function as a gatekeeper) to these options
- Encourage individuals to choose Blueprint practices via Health Plan enrollment process and web-site information
  - Provides access to:
    - Blueprint Community Health Teams for short-term interventions and support regarding medical needs
    - PCP practices that utilize technology (e.g., EHRs, care management tools, information exchange) to support patients and improve care
    - Blueprint Leadership and Community Service Networks (which enhances PCP knowledge and networking to support patient care)

Single Point of Contact (Case Manager)

- Role of Single Point of Contact (Case Manager within Health Home):
  - Ensures Individual Self-Direction and Self-Management, as desired
  - Coordination across *all* of the individual's medical, mental health, substance abuse, developmental, and long-term care service needs
  - Assure that all relevant assessments are completed
  - Develop and maintain the Individual Comprehensive Care Plan
  - Communicate with and convene the Individual's Care Team as needed
  - Provide Routine Individual Support, as requested
  - Ensure Support during Transitions in Care and Settings

Single Point of Contact (Case Manager)

- Identification of Single Point of Contact
  - If individual mainly has primary or acute health care needs, their single point of contact (and health home) would be their PCP and CHT (if involved)
  - For individuals with more complex DLTSS needs, their single point of contact (and health home) should have knowledge about the individual's DLTSS needs, such as:
    - Designated Agencies for Mental Health
    - Designated Agencies for Developmental Services
    - Home Health Agencies
    - Area Agencies on Aging
    - Traumatic Brain Injury providers
    - Preferred Providers for Substance Abuse Treatment
    - SASH
    - Others with specialized DLTSS expertise
  - For individuals enrolled in Vermont state specialized programs(i.e., CFC, CRT, DS, and TBI), their single point of contact should be someone who has experience with the care models and guidelines promulgated by the State departments (i.e., DAIL, DMH, DOH) responsible for these specific populations
  - For individuals without an existing case manager, the individual's PCP should be responsible for identifying the need for a DLTSS case manager (via a brief DLTSS screening tool) and work with the individual to identify and refer to an appropriate health home organization
    - May need payers to include this as PCP requirement
    - Will require ACO / PCP education regarding DLTSS Provider network and triage protocols
    - Referrals could also occur via other sources, such as VCCI

Medical Assessments and DLTSS Screening by PCPs, Medical Specialists

- PCPs and other medical specialists conduct medical assessments during routine exams and other patient visits
  - CHTs may conduct additional assessments regarding medical needs, if warranted
- If person has functional or cognitive impairments, PCP should be informed about DLTSS services, use a brief DLTSS screening tool (if necessary) and refer to DLTSS providers for more in depth assessments as necessary to determine if there are unmet DLTSS needs
  - VHCIP DLTSS Work Group should review the existing inventory of screening tools that could help inform the VHCIP Care Models & Care Management Work Group
  - If screening indicates need, PCP works with the individual to identify and then make referral to appropriate provider in DLTSS network

DLTSS-specific Assessments

- DLTSS needs-specific assessments already exist:
  - DAIL Independent Living Assessment (used for CfC)
  - Developmental Services Assessment
  - Community Rehabilitation and Treatment Assessment
  - SASH Assessment
- Consistent elements should be assessed for all individuals with DLTSS needs
  - An analysis and listing of questions that would need to be added to these assessments has been developed via planning for the Dual Eligible Demonstration Project.
  - Some initial DLTSS intake screening will lead to the above comprehensive assessments, as needed
- The Individual’s Single Point of Contact (Case manager) is responsible for assuring that:
  - All screening and assessment results (medical and DLTSS-related) should be included in and inform the individual's Comprehensive Care Plan and be shared with the Individual's Care Team members
  - Necessary assessments are updated when a significant change occurs in the beneficiary’s medical, DLTSS, or life situation

Comprehensive Care Plan

- Current Situation
  - PCPs currently develop and maintain an individual's Care Plan related to their medical needs
    - The CHT may re-evaluate the patient Care Plan and initiate appropriate modifications in collaboration with the individual and members of the healthcare team
  - DLTSS providers develop and maintain an individual's Care Plan related to their DLTSS needs
  - An individual may have multiple Care Plans:
    - For medical and for DLTSS services and supports
    - If individual receives multiple DLTSS services
    - If individual is transitioning across care settings

Comprehensive Care Plan

- Proposed Model
  - PCPs and CHTS continue to develop and maintain an individual's Care Plan related to their ***medical*** needs
  - DLTSS providers develop and maintain an individual's Care Plan related to their ***DLTSS*** needs
  - For individuals with DLTSS needs that go beyond PCP care, the Individual's Single Point of Contact (case manager) is responsible for:
    - Developing and maintaining a single Comprehensive Care Plan that includes ***all*** identified needs, goals, preferences, services and supports
      - Requires communication and coordination with the Individual's PCP
    - Identifying the individual's informal support systems/networks in relationship to his or her functional and safety needs, and including this information in the Comprehensive Care Plan as appropriate
    - Reviewing the effectiveness of the care plan with the individual, and implementing modifications as needed in collaboration with other providers as appropriate
    - Revising the Care Plan during and after Care Transitions
    - Ensuring that all key members of the Individual's Care Team have the most current Comprehensive Care Plan

Individual Care Team (ICT)

- For individuals with DLTSS needs that go beyond PCP care, the Individual's Single Point of Contact (case manager) is responsible for:
  - Ensuring that the Individual Care Team (ICT) includes providers associated with the needs identified in the Individual Care Plan, including the individual's PCP.
  - Establishing a routine working relationship with the individual's PCP / CHT member(s), and with other ICT providers as appropriate
  - Convening the ICT (in person or by phone) when needed to integrate and coordinate care, especially during care transitions
  - Provide links/coordination/integration with care providers across settings
  - Reporting new information to ICT members and other appropriate providers as needed

Interdisciplinary Care Team- Working Principles

- Mutual respect for the expertise of all members of the team, including the individual with DLTSS needs
- Knowledge and trust among all parties establishes quality working relationships
- Shared responsibility which leads to joint decision-making
- Equal participation and responsibility on the part of team members to ensure the beneficiary's needs and goals are met, with "shifting" responsibility determined by the nature of the problem to be solved.
- Communication that is not hierarchical, but rather multi-directional - facilitating sharing of information and knowledge
- Cooperation and coordination which promote the use of the skills of all team members, prevent duplication, and enhance productivity
- Emphasis by the team on "health care, environmental determinants of health and public health" rather than the more narrow focus of "medical care"
- Optimism that the ICT process is the most effective method to achieve quality care and improved outcomes

Support During Care Transitions

- For individuals with DLTSS needs that go beyond PCP care, the Individual's Single Point of Contact (case manager) is responsible for:
  - Initiating and maintaining contact at the care transition point of service
    - At the beginning, during, and at the end of the care transition
  - Identifying barriers to follow-up treatment, services, supports, and medication adherence and working with the individual, family and providers to overcome barriers
  - Ensuring the individual has the relevant information specific to their new condition
  - Coordinating linkages and follow-up with targeted services
    - Assuring that PCP, specialty care, home health, community mental health center, or other appointments are scheduled within 7 days of discharge, or more quickly if clinically indicated
  - Changing the Individual Care Plan to reflect any new needs
  - Communicating changes in Individual Care Plan with the individual's care team

Use of Technology for Information-Sharing

- Ultimate goal: A technological infrastructure that would:
  - House a common case management database/system
  - Enable integration between the case management database and electronic medical records and between all providers of an Individual's ICT
  - Allow for communication and sharing of information within a secure, confidential environment which allows for both low-tech and high-tech communication options
  - Adheres to Federal and State / AHS consumer information and privacy rules and standards, including informed consent

- The Population-Based Collaborative (ACO) Proposal is designed to "effectively build a single common infrastructure to electronically report on quality measures, notify providers of transitions in care, and exchange relevant clinical information about patients."

- The ACTT Proposal for the DLTSS Network "builds on the ACO work to broaden responsive, integrated, person-centered services across additional parts of the full continuum of care" to:
  - Ensure high quality clinical data for population health and quality/outcome improvement and reporting from ACTT providers
  - Enable ACTT to securely transmit, exchange and store health information
  - Enable a 42 CFR Part 2 compliant database system/repository for designated and specialized service agencies
  - Develop a uniform and efficient EHR infrastructure for 4 Developmental Disability Specialized Service Agencies (SSAs) and 1 Designated Agency
  - Develop and implement an ACTT transitions of care/uniform care transfer protocol

What should improve under this MOC?

- Beneficiary experience:
  - Increased involvement in decision-making
  - Decreased frustration regarding care coordination and access to services and supports due to integrated service delivery
  - Routine and timely primary care visits
  - Support during care transitions
  - Increased overall satisfaction with services and supports
  - Decreased out-of-pocket costs (e.g., fewer co-pays for ER, other services)
- Staff experience:
  - Increased efficiency regarding assisting consumers
  - Improved collaboration and communication between the medical and DLTSS systems of care
- Improved Consumer Outcomes:
  - Decreased emergency room utilization
  - Decreased avoidable hospital admissions / re-admissions
  - Decreased nursing home utilization
  - Increased appropriate use of medication
- Decreased Provider Cost-shifting across Payers
  - Due to more service oversight and coordination across all of the individual's medical and DLTSS needs via a single point of contact, comprehensive care plan, and integrated care team
- Decreased Overall Costs for Health Care System

Case Study

Peter is 50. Fifteen years ago he had a very difficult two years dealing with severe depression and was unable to work for several years. He no longer receives cash benefits but he is dually eligible for Medicaid and Medicare. He sees a mental health counselor and receives medication management by a psychiatrist at his local designated mental health agency. He has tried to get a primary care physician but has been told that practices are not taking new patients. For the last 5 years he has worked part time as a data entry clerk for a local business. He is good at his job and enjoys it but worries that his continuing problems with depression, the side effects of his medication, and repeated bouts of pneumonia may put his job in jeopardy.

Under the proposed DLTSS MOC, Peter's designated mental health agency case manager is Peter's single point of contact for coordinating his care and ensuring that all his care and treatment planning is integrated.

Peter's Case Manager finds a PCP that is taking new patients and assists him to get to the appointment. The PCP, who is part of a Blueprint Advanced Primary Care Practice, conducts a thorough physical and discovers Peter has diabetes, which has compromised his immune system and is causing the repeated pneumonia. The PCP prescribes an antibiotic for the pneumonia, and schedules routine visits for evidenced-based diabetes care, including blood work and foot exams. The PCP gives Peter some information about diabetes and how to control it, but also suggests that Peter could access the practice-affiliated Blueprint Community Health Team (CHT) if he would like additional information and support in managing his diabetes. Peter agrees, and the PCP office sets up appointments for that afternoon. Peter meets with the CHT Nurse who further explains diabetes symptoms and management, and with the CHT Nutritionist who provides information about nutrition related to diabetes.

In the meantime, Peter's Case Manager has notified the PCP office of her role (providing a signed agreement from Peter to release information to her on his behalf). As such, Peter's diagnosis of diabetes and other CHT action steps are entered into his Individual Care Plan.

With Peter's permission, Peter's Case Manager arranges for Peter and his mental health counselor to talk with the CHT staff regarding how to integrate diabetes management with the management of his depression. In addition, Peter' Case Manager ensures that Peter's PCP and DA psychiatrist are both aware of all of Peter's medications and that Peter understands the side effects and potential interactions for all of them. Peter and his Case manager then meet to update his Individual Care Plan to reflect the new goals and action steps related to his diabetes, and the revised Plan is shared with all the members of his care team.

Glossary of Acronyms

- ACCT: Advancing Care through Technology
- ACO: Accountable Care Organization
- ADRC: Aging and Disability Resource Connections
- BP: Blueprint for Health
- CfC: Choices for Care
- CHT: Community Health Teams
- CMS: Centers for Medicare and Medicaid Services
- CRT: Community Rehabilitation and Treatment Program
- DA: Designated Agency
- DAIL: Department of Disabilities, Aging and Independent Living
- DCF: Department for Children and Families
- DLTSS: Disability and Long-Term Services and Supports
- DOH: Department of Health
- DME: Durable Medical Equipment
- DMH: Department of Mental Health
- DS: Developmental Services
- DVHA: Department of Vermont Health Access
- EHR: Electronic Health Record
- ER: Emergency Room
- FQHC: Federally Qualified Health Center
- HHA: Home Health Agency
- ICT: Interdisciplinary Care Team
- IT: Information Technology
- MOC: Model of Care
- NCQA: National Committee for Quality Assurance
- OT: Occupational Therapy
- PCP: Primary Care Physician
- PT: Physical Therapy
- SASH: Support and Services at Home
- SSA: Specialized Services Agency
- SED: Serious Emotional Disturbance
- TBI: Traumatic Brain Injury
- VCCI: Vermont Chronic Care Initiative
- VHCIP: Vermont Health Care Innovation Project

VHCIP DLTSS
4-24-14 Meeting Additional Materials

Changes to DLTSS Model of Care Power Point Presentation Draft 4-1-14 Based on Comments from DLTSS Work Group Members

April 15, 2014

Comments were received from Deborah Lisi-Baker, Bob Bick, Joy Chilton, Nancy Eldridge, Mary Fredette, Sam Liss, Ed Paquin, Laura Pelosi, Judy Peterson, Barb Prine, Dion LaShay (via Deborah Lisi-Baker), and Julie Tessler (on behalf of the Vermont Council of Developmental and Mental Health Services)

Note: In some cases, Work Group member comments were slightly revised to better fit the format of this document. Also, due to edits based on Work Group member comments, slides have been added to the Power Point presentation to accommodate new content. As such, the comments and responses below are numbered using the new slide number in the revised version rather than the slide number in the April 1, 2014 draft.

Comments on the Overall Model of Care

- I had suggested previously to the MOC team upon request that employment parameters be included on the rationale, with some recent studies confirming that people who are employed are healthier and thus less expensive to care for.

  Response: A new Slide 3 was added titled: "Why are DLTSS fundamental to Health Care Reform?" and one of the bullets discusses the importance of environmental and socio-economic factors to people's overall health, using employment as an example. We also added "employment and housing" to the full continuum of care list on Slide 4 and added Vocational Rehabilitation to the list of Other DLTSS Providers on Slide 7 and in the examples on Slide 12. Employment also is included on Slides 6 and 18.

- Now it looks like instead of ICP or ICP + , we are looking at Case Management services designed to bridge the gap between medical care and LTSS. And it looks like the Case Management Single Point of Contact would not replace any existing efforts, but would be in addition to the current operations for medical and LTSS. Are these assumptions correct? (I guess that ICP or ICP + could still resurface in terms of payment models?)

  Response: The ICP/ICP+ models were proposed as a new service (and payment approach) that would be funded under the Dual Eligible Demonstration via expected Medicare and Medicaid savings that the State could keep. Since that is no longer relevant, this new proposed DLTSS Model of Care has been developed to apply to all people with DLTSS needs (not just duals). The core elements of the ICP model are still contained within the new proposed DLTSS model (e.g., an actively involved primary care physician for everyone; a single point of contact for people with complex needs who coordinates their care and maintains a comprehensive car plan across their entire medical, DLTSS and other needs). The new DLTSS model is being proposed with the hope that the relevant VHCIP Work Groups and other health care reform activities (e.g., care management being developed by ACOs) will include this framework. At this point, it is not clear if this will happen, and if it does, how it would be operationalized or funded. (The first step is to assist people outside of the DLTSS world to understand what DLTSS people need and the importance of providing it to improve individual and overall health care system outcomes).

- Under this model healthy people with developmental disabilities will get an "integrated health home". Will that be a developmental service agency? Would that DS agency then coordinate the medical care later on when the person with a DD gets sick? Is that appropriate, and will the DS providers know how to do that?

  Response: The integrated health home is suggested as a possible overarching framework for this model of care. If the State were to proceed in this direction, the federal Medicaid guidelines give States the flexibility to designate providers that can serve as health homes, which could potentially include developmental service (DS) agencies. (The state would need to negotiate the parameters of the Health Home program with the federal government). In this case, that DS agency would coordinate the individual's medical care later on when the person with a DD gets sick, in collaboration with the individual's primary care physician and other relevant medical professionals. DS agencies often perform this role currently for the individuals they serve.

- Under this model people with complex medical and physical care needs will get an "integrated health home". Will this be a PCP? And will the PCP then coordinate the personal care needs of the individual instead of this care being coordinated by a home health agency?

  Response: As noted above, the integrated health home is suggested as a possible overarching framework for this model of care. If the State were to proceed in this direction, the federal Medicaid guidelines give States the flexibility to designate providers that can serve as health homes, which could potentially include an array of providers, including PCPs and DLTSS providers. The specific health home for an individual would depend on the choice of the individual and the individual's core needs. Regardless of the health home provider, its role would be to coordinate across all the needs for the individual.

- My main concern in reading this is to wonder whether the high level of emphasis and organization that has gone on around ACOs has sucked all the oxygen (and money) out of the room. In other words, is there any reason to think that this level of coordination will happen while we already, year after year, starve the system of resources?

  Response: This was considered an editorial comment; no changes were made to the proposed Model of Care. That said, as noted above, this new proposed DLTSS Model of Care has been developed with the hope that the relevant VHCIP Work Groups and other health care reform activities (e.g., care management being developed by ACOs) will include this framework.

- I note a marked absence of direct references to FQHC's which increasingly play a role in the larger system of care. They are both primary and specialty care providers and have a profound ability to influence both services access and availability but impact costs, especially as regards potential redundancies vs. collaborations. While I am not sure exactly how and where reference needs to occur I am convinced it should.

  Response: Thank you for pointing out this oversight. FQHCs have been added to Slides 5 and 8.

- Please add a glossary of the acronyms used in this document.

  Response: A glossary of the acronyms is now on the last slide.

Comments regarding Specific Slides

Slide 2:

- The definition of individuals with DLTSS needs is cumbersome with repeated words.

  Response: This definition has been refined.

Slide 4:

- Should "employment" and "housing" be listed in the second bullet?

  Response: Yes. These were added to the continuum of care for people with DLTSS needs.

- Is "Cos" in the chart supposed to be cost?

  Response: Yes. The label in the chart has been corrected.

Slide 5:

- While some people receive fee for service Medicaid services outside the waiver through fee for service, people enrolled in CRT have some of these services included in their waiver packages.

  Response: The slide has been revised to include a list of DLTSS-related services, and then note that some individuals receive some of these services and supports through the CfC, CRT, DS, TBI and SED programs and others may receive them as needed on a fee-for-service basis.

- I think it should better reflect the full scope of services provided by nursing homes, and residential care. For example, it reads as though nursing homes "just" provide 24 hour medical.

  Response: The revised text on this slide includes the phrase "nursing home care."

- For the second bullet, in DS this includes medical supports and community integration

  Response: These Items have been added in the now first bullet.

- Children with severe emotional disabilities (SED) should be included in the first bullet.

  Response: This has been added to what is now the second bullet.

Slide 6:

- The DA/SSA numbers are incorrect - it should be 11 DAs and 6 SSAs

  Response: These numbers have been corrected.

- Should the number of Therapeutic Care Residences be included? I think they aren't in the res care number and there're probably around 30 in the state.

  Response: A bullet was added to reference the 36 Therapeutic Community Residences in Vermont.

- Under the second bullet, bullet 12 should probably say "or their family."

  Response: This has been added.

Slide 7:

- Should (MH&SA) be included in parentheses next to "Specialists"? Does mental health fall under the list of "traditional" medical services?

  Response: In these analyses, mental health and substance abuse services are not considered traditional medical services.

Slide 8

- Should include '(CHT)' right after Blueprint Community Health Teams since the acronym is used throughout but never connected directly to "Blueprint" till the smaller print case example at the end.

  Response: This acronym was added.

- Should "Hub & Spoke" be listed below "Blueprint Community Health Teams?"

  Response: Yes, a description of the Hub and Spoke Program was added, since people with DLTSS needs may receive care management and supports through this program.

Slide 9:

- Include a sub-bullet that SASH is not time limited - intensity of services adapted as needed.

  Response: This information was added.

Slide 10:

- There ought to be something more about the Medicaid LTC system's elements being driven by a balance between medical and social orientation with an underpinning of values related to civil rights….Under the heading "What is Working Well……" perhaps the bullet could read something like: "Receive services and supports based in the values of self-determination and community integration."

  Response: The requested change was made.

- Please add SED program to the list on top.

  Response: SED has been added.

- Please add 'medical needs' to the list.

  Response: We added "medical needs related to their disability or functional limitations" since this list is intended to be representative of the unique characteristics of people with DLTSS needs.

Slide 11:

- Is the issue that the traditional system "has not" been designed… or should it be "is not designed?"

  Response: The words "has not been" rather than "is not" were used intentionally because recent developments (e.g., the Blueprint Community Health Teams and their utilization of community extenders and partners) have started to make inroads into addressing some of the issues listed.

Slide 12:

- Please modify the first bullet with "some people", as DS works with lots of people who have MH needs, some SA, some offenders.

  Response: The words "For most people" were added at the beginning of the bullet.
- The second bullet does not acknowledge the role DAs play in supporting the navigation to meet all support needs.

  Response: The word "Many" was added at the beginning of the bullet to acknowledge that some individuals with DLTSS needs have care managers who navigate across all the needs; however, this is the exception, not the norm, especially as it relates to the interface between DLTSS and medical care.
- Is the list of barriers for the whole of the VT population or referring to Medicaid eligible folks only? If reflecting barriers for the whole should bullet 4 include "and financial" after clinical in bullet 4, item 1?

  Response: This slide is intended to reflect barriers for all Vermonters with DLTSS needs. As suggested, the word "financial" was added to bullet 4 since this also may be an eligibility criterion for enrollment in the Medicaid specialized programs that this bullet references.

- In the fourth bullet, another limitation is that Case Management is sometimes capped.

  Response: This has been added.

- "The network of LTSS providers is complex, multifaceted, specialized, isolated from other service providers, and confusing to the average consumer. Few providers in the LTSS network evaluate a person's overall situation in order to arrange for the right combination of services based on one's actual needs. Instead, access to services is often organized in relationship to their funding streams." At least DLTSS has SOME things in common with the acute care system! (Sorry, I couldn't resist!)

  Response: This was considered an editorial comment; no changes were made.

Slide 14:

- If I were designing this, the first "basis" would be the principle of self-determination and the idea that people have a right to live meaningful lives in their communities, hence the emphasis in Vermont on non-institutional care. Person-centered and person-directed have less meaning if they are add-ons to a system that is fundamentally structured to meet the needs of providers first.

  Response: Agreed that this is the foundation of the model. A new bullet was added at the top of the slide to reflect this.

- Add SASH to list of Strengths of Existing Vermont System of Care and Health Care Reform Elements

  Response: This change was incorporated.

Slide 16:

- Is this seen in Vermont as something "new under the sun" or something that should be demanded of agencies that are already providing case management, etc.?

  Response: This slide was included because Medicaid currently has a program that provides enhanced (90%) federal match for two years so it might provide an opportunity to fund the more enhanced single point of contact/care coordination role that is being proposed, and to gain support from other payers where applicable. This explanation was added to the slide.

Slide 18:

- The definition is good, but it could make it clear that the system of care should be insuring that people with disabilities have an equal opportunity to all that society has to offer. Medical care is oriented to preventing and healing particular illness. When long-term disability is a factor the orientation needs to change to maximizing function (fairly consistent with the common goals of the system) and to supports that assist individuals with participation in all aspects of society on their own terms.

  Response: A bullet was added at the end of this slide to reflect this important element of delivering person-centered and person-directed services and supports.

Slide 19:

- To the first sentence add "on an ongoing basis".

  Response: This was added.

- Bullet 3 could be strengthened by putting the individual at the center of the team.

  Response: Excellent point. This was added.

Slide 20:

- There are a number of peer-run entities in the state. Since the document has not routinely relied on identifying specific corporate examples, I prefer to not do so here (sic).

  Response: The reference to specific organizations has been deleted.

Slide 21:

- I think there is value for everyone to have access to primary care, but its centrality in decision making may not be appropriate when disability is involved. I hope what comes out of this sort of structure is not the PCP as gate-keeper.

  Response: Revisions were made on this slide to reflect that the proposed role of PCPs is to help make connections with DLTSS services but not to be a gatekeeper for these services.

Slide 22:

- The way this is described it is a role considerably beyond that of current case management – at least the way it often works today.

  Response: We agree that this s not the way case management often works today; this is a <u>proposed</u> model of care to improve the case management that individuals receive and how they receive it.

Slide 23:

- Should “Preferred Providers for Substance Abuse” be bulleted under the second bullet listing? And, under the 3rd bullet should “DOH” be listed with DAIL and DMH?

  Response: Yes, both of these have been added.

- I recommend that consumers have choice of health home.

  Response: Excellent point. This was added. It also was added to Slide 24.

- I am a little confused over how beneficiaries would be screened for the LTSS. On Slide 23 there is reference to the PCP referring to DLTSS providers for screenings & assessments. On Slide 24 it mentions a screening tool to be done by the PCP that may lead to a referral to a Health Home Case Manager. Was there a specific reason for the two paths? I think it might be preferable to have the PCP always make LTSS referrals to one place - the Health Home. The beneficiary would then need to get a Case Manager if they didn't already have one. The Case Manager would then create a Comprehensive Care Plan or update it to include the LTSS that get started as a result of the referral.

  Response: The proposed model is intended to function as the commenter describes. We have revised these slides to try to clarify the intent.

Slide 24:

- There may be some questions about whether this is an appropriate community assessment tool.

  Response: The assessment tools listed are those that are currently being used within the Medicaid specialized programs and by SASH.

- Differentiate screening from assessment. The assessment process shouldn't become too arduous.

  Response: The intent is these are two separate processes. Slides 24 and 25 have been edited.

Slide 28:

- The individual care team should be identified prior to developing the plan.

  Response: This has been reworded to: "Ensuring that the Individual Care Team (ICT) includes providers associated with the needs identified in the Individual Care Plan, including the individual's PCP."

- Slide 28 has a tangible structure in mind with the Individual Care Team. Unlike what we are seeing with the ACOs (shared savings), I don't see where the financial incentive for this to function comes from.

  Response: This new proposed DLTSS Model of Care has been developed with the hope that the relevant VHCIP Work Groups and other health care reform activities (e.g., care management being developed by ACOs) will include this framework. At this point, it is not clear if this will happen, and if it does, how it would be operationalized or funded.

Slide 29:

- The 7th bullet should include social not just health.

  Response: Thank you. This phrase "environmental determinants to health" has been added.

Slide 33:

- It should be intolerable that we allow a psychiatrist to prescribe the sort of meds they do and he didn't catch that his client was at risk for getting diabetes! And it doesn't say how many times he was hospitalized, which is a requirement to qualify for CRT level of case management. Medicaid will pay for case management to some limited extent under Outpatient services, though I don't hear about it being particularly widespread.

  Response: The person in this case study is real, but the events were modified to reflect the proposed new model of care. It was not intended to contain all the details regarding eligibility criteria for services or service availability.