ACOs and the DLTSS System
Questions Posed by VT Legal Aid and
VT Council of Developmental and Mental Health Services
with Responses from ACOs – November 21, 2014

Questions	OneCare	CHAC	Health*first*
1. How will any savings generated be shared with the Home Health Agencies (HHAs), Area Agencies on Aging (AAAs), Designated Agencies (DAs), and Skilled Nursing Facilities (SNFs) that are part of each Accountable Care Organization's (ACO) "network"?	Under the Vermont Medicaid Shared Savings Program (VMSSP) ACO agreement, Home Health Agencies, Designated Agencies and Skilled Nursing Facilities are treated in the same manner as hospitals and specialty physicians. To summarize, if the overall OneCare ACO qualifies for VMSSP shared savings, 45% of those savings are distributed to participating home health agencies, designated agencies, skilled nursing facilities, hospitals and specialty physicians in proportion to their percentage of Vermont Medicaid net revenues received for care provided to individuals attributed to OneCare, as reported by DVHA. Another 45% is distributed to participating primary care physicians and the 10% remainder is retained by OneCare to partially offset operating costs. Under the federal MSSP (Medicare) and state XSSP (Commercial) ACO programs, if the overall OneCare ACO qualifies for MSSP and/or XSSP shared savings, OneCare would distribute financial incentive monies to participating home health agencies, designated agencies and skilled nursing facilities through a method that is separate from but quite consistent with the way Medicare or commercial ACO program savings are earned and distributed to participating hospitals and physicians. The particulars of the MSSP and XSSP financial incentives for participating home health agencies, designated agencies, and skilled nursing facilities are determined by the OneCare board and shared with the Green Mountain Care Board and DVHA.		HF is actively working with the above listed providers to assist in improving systems of care. HF does not have formal legal arrangements, or any expectation of sharing payments with affiliated non- physician providers. As examples: We are working with post-acute care providers (SNFs) to create standard discharge documents to rely information about stays back to a patient's primary care physician. We are also currently working with home health agencies on transitioning patients to the home from the hospital, rather than to post-acute care, when appropriate. Finally, we are taking advantage of community health team resources to connect patients with mental health and substance abuse resources more effectively, and forming liaisons with various mental health and substance abuse organizations to address resources. None of these partnerships with other providers include a payment element at this time, but all parties understand the need to work together to improve patient care, particularly care transitions, and believe that our work together in this area will keep the patients we co-manage healthier and the overall cost of care down.

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a) Are these entities expected to generate savings in any of the demonstration years in order to receive part of any savings achieved by the ACO?	No. In each year, savings are generated and measured at the collective level for all OneCare participants combined.	As a guiding principle, CHAC supports the need for a broad array of services and providers to meet the needs of the population to achieve and maintain good health. CHAC has been very inclusive of community based providers such as home health and visiting nursing agencies, behavioral health, substance abuse and designated agencies. Any providers that agreed to participate by signing the CHAC Participating Agreement whether primary care or non-primary care are considered to be an important part of providing quality care that contributes to positive health outcomes and to the savings that could and hopefully will be achieved within the demonstration years.	See the response to item 1 above. We do not have contractual relationships with affiliated providers, but are actively working together in the common interests of our patients.
b) Is there a specific formula to determine how much of the savings these affiliated organizations receive? Does that formula vary by ACO or by organization type, and if so, how?	See the response to item 1 above.	The Board has approved the outline of the method to share savings, but not all the specifics. The distribution would generally work as follows: • Cover outstanding expenses and obligations related to the CHAC operations; • Create a contribution to an ACO reserves as appropriate, and invest in infrastructure as deemed appropriate by the Governing Board; • The Balance of any shared savings would be divided 50%/-50% into two pools: one for the primary care and one for the non-primary care participating provider, and awarded based on attributed lives for the primary care providers and according to a formula such as geographic coverage for the non-primary care providers. The formula for the non-primary care distribution will be determined with the input of non-primary care participating providers.	See the response to item 1 above.
2. What are the contractual requirements between the ACOs and the affiliated providers (DA, AAA, HH, and SNF)? Specifically, what do the providers have to do (whether related, for example to quality performance, financial	Such requirements are specified in the contracts between OneCare and each participant. The contract form is a public document. In summary, the OneCare participants agree to the following (this is taken from the OneCare participation agreement for VMSSP):	CHAC has existing executed Participating Provider Agreements with the HHA/VNAs and DAs and offered participation to the AAA agencies through the same Agreement. CHAC has one Participating Provider Agreement, and participating providers are all eligible to be	See the response to item 1 above.

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performance, etc.) to get the shared savings?	General • Be accountable for the quality, cost and overall care of Attributed Lives; implement and follow processes and procedures to support that accountability. • Be bound by the terms and conditions of the participation agreement and materials it incorporates by reference, including but not limited to, all applicable terms and conditions of the VMSSP Agreement between the ACO and DVHA, duly adopted policies and procedures and all requirements of federal and Vermont law. • Be subject to the terms and conditions of any and all grant agreements and/or contracts with the Vermont Agency of Human Services as well as any state or federal authorities that are binding on the DAs or SSAs. Operations • Provide Attributed Lives with professional and/or facility services, as appropriate, in accordance with Vermont Medicaid program statutes, regulations and policies as well as the policies and procedures set forth in the VMSSP and policies created by ACO. • Seek reimbursement from Vermont Medicaid in accordance with applicable laws, regulations and policies. • Comply with and implement ACO's processes and policies to: (1) promote evidence based medicine; (2) promote patient engagement; (3) develop and implement infrastructure and reporting on quality and cost metrics to enable monitoring and feedback of performance in order to evaluate performance and improve care over time; and (4) coordinate care. • Cooperate with ACO's policies and procedures with regard to clinical coordination of care.	nominated and selected for Governing Board seats and to nominate representatives and participate in the standing committees of the Board, and to be part of a shared savings pool for distribution of shared savings when there is a shared savings awarded. Reviewing those contracts is a good way to review the contract expectations. The AAA is not contracting with CHAC at this time, but we have been meeting to explore how to integrate and fully make use of those services for the population served. All participating providers (defined as those who have signed the Participating Provider Agreement) are eligible for sharing savings. CHAC relevant expectations for performance for those providers as shown in the Participating Provider Agreement are as follows: • with respect to the CMS Shared Savings Program, agree to become accountable for and report to CMS on the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to the Company, if applicable; • with respect to the DVHA ACO Program, agree to become accountable for and report to the Company on the quality, cost and overall care of the Medicaid beneficiaries assigned to the Company, if applicable; • agree to become accountable for and report to Company on the quality, cost and overall care of beneficiaries as required by the Commercial ACO Program or any other Value-Based Payor Agreements, if applicable; • agree to comply with the requirements and conditions set forth in the laws and regulations governing the Shared Savings Programs, including those specified in the MSSP Participation Agreement, DVHA Participation Agreement and Commercial SSP Agreements; • Participant, through Practitioners, shall in good	

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	• Make best efforts to cooperate, comply with and implement the Clinical Model developed by ACO to meet the VMSSP Standards, including patient-centered criteria surrounding evidence-based medicine, promoting patient engagement, furtherance of internal quality and cost reporting structures, and coordination of care. • Make best efforts to cooperate with ACO's case management protocols, and to coordinate with hospital or other facility case managers regarding the care of attributed lives. • Make best efforts to implement such cost and quality control protocols or other interventions as may be adopted by ACO regarding the care of attributed lives. • Notify attributed lives at the point-of-care that they are participating with the ACO in the VMSSP. • Make participant's representative(s) available for participation on ACO committees related to the Clinical Model that might be established. • Participate in ACO and DVHA-sponsored provider education programs. • Cooperate and participate in any patient experience of care survey required by the VMSSP. <u>Data</u> • Measure, collect data for, exchange data for, report, evaluate and improve performance on the VMSSP Standards ACO quality performance measures and monitor and improve the cost effectiveness of services provided to attributed lives. • Make available, upon request, encounter data and other information specific to Medicaid covered services rendered to attributed lives. • Provide and report such data from its Electronic Health Records ("EHR") system or medical records as ACO may reasonably require to	faith collaborate and cooperate with the Company in the provision of the services set forth in Section 3 by the Company under this Agreement. • Participant shall make available to the Company in a timely manner information requested by the Company to enable the Company to provide the Covered Services, subject to the Health Insurance Portability and Accountability Act of 1996 and the rules and regulations promulgated thereunder ("HIPAA") or other statutes and regulatory restrictions • Participant authorizes the Company to consult with administrators and members of the medical staffs of hospitals, facilities and organizations with which Participant and/or any Practitioner has been associated and with others for credentialing purposes pursuant to the Authorization For Release Of Information, that each Practitioner and Participant will execute, annexed to this Agreement as Exhibit A. • Upon reasonable request by the Company, Participant shall provide to the Company select information and/or excerpts from Practitioners' executed contracts with Participant. CHAC's expectations for receiving shared savings are not limited beyond this. Changes would be developed and approved by the Governing Board at which the participating providers have representation. **<u>Provision of Participant Services</u>**. Participant agrees to provide, through its Practitioners, Covered Services to Covered Persons as required under the Value-Based Payor Agreements no later than sixty (60) days after receiving notice of the terms and conditions for such Agreement unless Participant opts out of participation in such	

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	monitor the cost and quality of services, including care management services, provided to attributed lives. • Give an opportunity for attributed lives to decline to have personal data shared with ACO. • Observe all relevant statutory and regulatory provisions regarding the appropriate use of data and confidentiality and privacy of individual health information as they apply to participant and providers, and which may be modified from time to time. • Implement all necessary requirements of HIPAA in the manner and time frame required by HIPAA. <u>Compliance</u> • Not discriminate or differentiate in treatment or access to health care on the basis of race, age, gender, gender identity medical history, religion, marital status, sexual orientation, color, national origin, place of residence, health status, creed, ancestry, disability, veteran status, type of illness or condition, or source of payment for services. • Comply with all applicable laws and regulations governing participation with the ACO which includes, but is not limited to, federal laws such as the False Claims Act, Anti-Kickback Laws, Civil Monetary Penalties Laws, HIPAA and Stark. • Participants that are themselves or who include Primary Care Providers may not participate in any other VMSSP participating as required by the VMSSP program.	Agreement. **<u>Standards of Care</u>.** Participant agrees, and shall cause Practitioners to agree, that all medical duties performed by Practitioners under the Value-Based Payor Agreements shall be consistent with the proper practice of medicine and shall be performed in conformance with the standards for performance of such services established by the Payor and the local medical community. Participant shall ensure that all Practitioners and other qualified personnel utilized by Participant, to the extent such personnel are permitted under the Value-Based Payor Agreements, are properly licensed and/or credentialed to perform the services which they perform. Participant, through its Practitioners, shall exercise independent medical judgment in providing medical services to all patients and the Company shall not interfere with such independent medical judgment.	
a. Do the ACOs have the same contractual relationship with each type of affiliated provider (DA, SSA, AAA, HHA, SNF)?	OneCare has the same contractual relationship with its participating designated agencies, LTSS providers, home health agencies and skilled nursing facilities.	CHAC has one Participating Provider Agreement for all participating provider types. Each participating provider identifies which product lines (Medicare, Medicaid, Commercial) it will participate in and whether it chooses to attribute lives as applicable.	See the response to item 1 above.

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b. If not, is this because the ACOs have different contracts (so that the contractual relationships are the same within each ACO, but not across ACOs), or within an ACO do different providers (e.g. multiple HHAs) have different contracts?	OneCare does not know the contractual relationships between the other Vermont ACOs and their participants.	This question is not applicable since CHAC has one provider agreement.	See the response to item 1 above.
3. How do ACO/affiliated provider agreements affect DAIL's role with respect to services funded through DAIL? What is DAIL's relationship to the ACO, which does not directly provide these services, but does so through its provider network? The same questions apply to DMH.	OneCare does not know the answer to the first question. OneCare assumes its VMSSP contract with DHVA is relevant for other units of the Agency of Human Services including DAIL. The Agency of Human Services' role has not changed. DAIL and DMH do not have financial contractual relationships with any of the ACOs. DAIL and DMH have the same relationships with providers who provide the services they fund. If, in the future, those services are funded differently, AHS will review all roles.	CHAC's participating providers receive reimbursement directly from payers as they currently do. CHAC's provider agreements do not address provider reimbursement by the applicable payers and thus do not affect DAIL's role with respect to services funded through DAIL. There is nothing in the CHAC participating agreements that would override the DAIL requirements. The same is true for DMH. The participating provider network, for example the federally qualified health centers, have a history and performance of working closely with the home health care/visiting nursing agencies, behavioral health, substance abuse and designated agencies to serve their patients with a variety of needs. These relationships, referral patterns and improved integration are the expected and planned approach of CHAC.	HF does not have a relationship with DAIL at this time.
4. Do the current case managers in the DAs, AAAs, HHAs, and SNFs have the resources and capacity (including both time to provide services and training) to provide the medical/health home services in circumstances where the "health home" is not the Primary Care Practice? Will the ACOs provide support to these organizations to provide these services? Will extra funding be available to these organizations to provide these services?	OneCare does not know the answer to this question.	This sounds like a question that should first be addressed by the HHAs and DAs. When the nature of the concern is more fully defined, CHAC can better address the issue. CHAC will work in a collaborative mode to provide appropriate care services and coordination with participating and community providers. CHAC has a modest budget for its operations from the founding FQHCs, and any shared savings will be determined in future years by the payers. We would like to know the extent or other details on the capacity issue you are identifying.	HF does not know the answer to this question.

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5. Have any of the ACOs adopted new care management protocols or standards internally (while waiting on the Care Models/Care Management workgroup) that establish different expectations of DLTSS case managers than those in their existing roles?	OneCare has not developed any internal standards; they will adopt those approved by the Care Models/Care Management workgroup. However, OneCare's Clinical Model, which was adopted by its Clinical Advisory Board, does include principals for care coordination which set the expectation that **c**are coordination activities should promote a holistic and person centered approach to ensure that a person's needs and goals are understood and shared as they move from one setting to another.	No we have not. CHAC's Clinical Committee has representation from the DAs and the HHA/VNA in addition to the FQHCs and hospitals. The policies that will be followed are general in nature and simply endorse following evidence based guidelines.	No.
a. Are the draft CMCM standards going to have different expectations of the case managers at the affiliated agencies because of their contracts with the ACOs?	OneCare does not know the answer to this question as the standards are not yet finalized and the payers have not set expectations on oversight.	As a member of the CMCM Workgroup, CHAC has supported standards that are general and not prescriptive. This may have been interpreted as not supporting the comprehensive needs of all populations. CHAC's model is consistent with the Blueprint's patient centered medical home model, so that each individual is understood to have multiple needs, and CHAC as an ACO is seeking to strengthen the integration of the full array of social, emotional and medical needed to restore and maintain patient's health. This does not change the care management standards but should enable the implementation of care management more smoothly and effectively.	See the response to item 1 above. We do not have contractual relationships with affiliated agencies, but are actively working together in the common interests of our patients.
b. What is the system by which the DAs, HHAs and AAAs will deliver the case management services? Will any changes be made only through the scope of work for existing case managers, or will there be additional specialized ACO case managers (housed either with the ACOs or with the affiliated providers)?	OneCare does anticipate deploying a limited number of Nurse Clinical Consultants to work with provider groups in local health service areas to promote: (1) evidence based practice; (2) patient engagement; (3) reporting on quality and cost performance metrics; and (4) better coordination of care.	CHAC expects to make improvements in the effectiveness of integration of services but not to add additional expectations on the case managers of these related providers. That said, the nature of this process is that we are all learning how to work together so there is constant change. CHAC, as an ACO is expected to determine what interventions will contribute to improved care with related savings. CHAC will be implementing the use of a telemonitoring initiative in likely close collaboration with VNA partners, that will impact high risk Medicare patients attributed to the ACO through seven FQHCs, so this will engage patients and provide information on the patients to their providers.	HF currently has a team of 1 Clinical Manager and 2 Care Coordinators working for our ACCGM to service our attributed Medicare ACO patients. This team has been coordinating with hospitals, SNFs, and Home Health Agencies to improve patient engagement and better coordination of care.

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6. How will DLTSS providers manage to meet operational, financial and quality expectations of multiple ACOs and at the same time meet these expectations for individuals who are not covered by the ACOs (because they do not see an affiliated primary care physician) whose funding continues to come through AHS and its Departments?	Not surprising, this challenge is shared by many of our OneCare participants. OneCare is committed to work with its network participants and with the other ACOs to assure that key expectations are similar or at least consistent. Through the VHCIP/SIM Clinical Models and Care Management work group we are participating in a multi-organization integrated community care management learning collaborative in three health service areas, with the intent to expand across the state. This collaborative is intended to develop and/or enhance an integrated and collaborative care coordination process for at-risk populations at community levels. Regarding service to persons not affiliated with OneCare, our general understanding is that providers will likely extend ACO-related service and practice improvements to others served by their organizations.	CHAC has been working with its community providers for many years as part of the Blueprint patient-centered medical home. This is a collaborative effort rather than a series of care management expectations for those providers. CHAC is not competing for the funding provided by AHS. CHAC's Participating Provider Agreement is not intended to interfere with reimbursement and regulatory requirements for DA s or VNA/HHA. CHAC currently does not have funding to provide to the FQHCs or other participating providers, but all the ACOs are working together with VITL and in the VHCIP workgroups to come up with common approaches to meeting the VHCIP expectations.	
a. Will the ACOs provide support to the DLTSS providers to meet the ACO expectations?	Similar to its other participants, OneCare will provide advice and counsel and in some cases (such as annual quality performance data collection) provide limited hands-on assistance. OneCare does not have a source of financial support for any of its participants other than its designated regional physician convener/collaborators.		HF has no contractual expectations of DLTSS providers.
b. Are the ACOs providing support to other types of providers in their network (e.g., PCPs, specialty practices)?	See 6a.		HF ACOs do provide support to participating primary care practice for quality measure education and collection. We also provide shared learning opportunities regarding best practices in population health management through our committee structure.
7. Will disability and long term services and supports (DLTSS) providers have sufficient voice in the governance and operation of ACOs? How will this voice be operationalized?	Our working assumption is that most DLTSS providers are closely affiliated with a Designated Agency and that the seat on the OneCare board representing the Designated Agencies and related providers will assure that the community of DLTSS providers has a voice in the governance of the ACO. Operationally, OneCare's most important work is	Yes, CHAC's Board includes representation for the HHAs/VNAs, the BH/DAs and consumer representatives. These agencies also participate in the four Governing Board standing committees: Clinical, Financial, Operations, and Beneficiary Engagement. The concerns of these agencies are discussed in Board and Committee meetings where collaboration contributes to better	DLTSS providers are welcome to attend any of our ACO Management or Consumer Advisory Board meetings. The schedule and summaries of those meetings can be found on our website on the VCP page http://vthealth1st.org/vermont-collaborative-physicians.php

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	conducted through its 14 broadly inclusive Regional Clinical Performance Committees (RCPCs) and through its statewide multidisciplinary Clinical Advisory Board (CAB). The RCPCs are encouraged to behave as "big tables" that include places for the persons and organizations engaged in meeting the needs of locally attributed populations.	solutions. This collaboration is also displayed in the FQHC service areas through specific collaboration and integration of services. Some FQHCs have mental health and substance abuse services co-located on site at the health centers. All FQHCs work with the Community Health Teams to better serve the needs of patients. CHAC's Board is determined to use the ACO format to improve the quality of care and the health status of the populations they serve.	