

Joint Meeting of the MyCare Vermont Community Advisory Committee and Core Planning Team October 30, 2006

Minutes

Attendees:

CAC: Sue Chase, Janice Clements, Peter Cobb, Janet Cramer, Larry Goetschius, Bea Grause (for Jill Olson), Jeanne Hutchins, Judith Kantorowski, Sarah Littlefeather, Jackie Majoros, Maureen Mayo, Dennis McCullough, Madeleine Mongan, Harold Nadeau, Darlene Saler, Mary Shriver, Beth Stern, and Julie Bushey Trevor.

Core Planning Team: Catherine Collins, Deborah Lisi-Baker, Heather Shlosser, Julie Trottier, and Lynn Whalen (also on CAC).

Guests: Lisa Dulsky Watkins, MD (from Vt. Dept. of Health), and Vi Hauver and Debra Hunt (both from NEK Home Care).

Consultants: Michael Bailit and Marge Houy.

DAIL Staff: Patrick Flood, Joan Senecal, Theresa Wood, Camille George, Joan Haslett and Cecile Sherburn.

Blueprint for Health

Lisa Dulsky Watkins, Public Health Physician from the Vermont Department of Health, presented an overview of the Vermont Blueprint for Health which is a statewide project designed to improve care for people with chronic illness. The project started with piloting a diabetes education program in two communities, and is targeted to be statewide in 2009. The project involves case management through physician's offices, patient empowerment through education, and activating a community. While everyone recognizes it is a long-term effort to transform the health care system, in the short term the project is focusing on improving care, and savings are targeted for the future.

Vermont is undertaking this project because of the escalating costs of chronic care. The project will include a focus on preventing chronic illness, as well as improving disease management for those with chronic illness. Costs will increase initially because of increased utilization, better utilization and self-management classes.

Sustainability is an on-going issue. The key question is how to get multiple stakeholders to make and sustain structural changes. The pilot program for diabetes is working out program structure changes and case management processes. At the moment the physician is the point person, but that is not the long-term goal. The current focus is to have a prepared provider, patient and team. The Blueprint for Health is also working on IT needs and practice organization models.

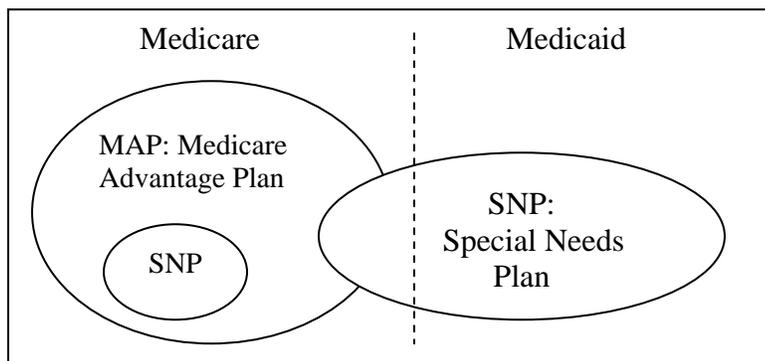
The legislature has allocated \$6 million this fiscal year. The Department of Health is changing its structure to incorporate the Blueprint for Health throughout its operations. One of the keys is to change reimbursement. Medicare is the big elephant in the room.

Presentation by and Discussion with Patrick Flood Regarding His Vision of MyCare Vermont, Informed by CPT and CAC Input To-Date

Commissioner Flood expressed his desire to bring closure to some of the work done by the CPT and CAC over the past year. He emphasized that everyone recognizes that Vermont needs a new system and stated three reasons for pursuing a new model: to obtain increased benefit flexibility, to reinvest savings to enable the state to provide more services, and to build off of the existing provider base. He believes that the funding must be through a global budget, and that savings should accrue to the state and be reinvested in additional services. He noted that studies out of Dartmouth have indicated that savings are primarily on the Medicare side.

He has learned from CMS that the state government cannot be the recipient of the Medicare capitation and function as a Special Needs Plan (“SNP”). He also explained that SNPs operating in other states are seeking to enter Vermont to offer Medicare benefits under a capitated arrangement from CMS. Some states are requiring Medicare Advantage plans (of which SNPs are a special type) to contract with the state so there is capitation of the Medicaid payment. Vermont would also want to make that a requirement of any SNP operating in this state.

Michael created a diagram to visually depict SNPs:



Joan explained that there are two types of SNP structures: a provider organization, which is required to have at least 500 members, and an HMO, which is required to have at least 1500 members. In addition, there are three types SNPs approved by CMS that specialize in serving individuals who are Institutional, Dually Eligible or Beneficiaries with Chronic Conditions. Recent CMS communication has indicated that CMS will allow SNPs to serve sub-populations of these SNPs and do not need to be statewide. Applications must be submitted annually to CMS at the end of March.

Commissioner Flood noted any SNP that wants to operate in Vermont will need to build on the existing provider network. This SNP activity could impact any networks that MyCare Vermont will be building. He stated that it is important for MyCare Vermont to have a critical mass of providers and consumers in order to be financially viable.

Commissioner Flood laid out the following proposal for the CAC and the CPT to consider:

- Create PACE programs statewide for those 55 and older. Under current federal regulations PACE programs may not be able to serve those under 55 years of age and those who are not nursing home eligible.
- The requirement for a PACE center especially in rural areas can be waived by CMS. This provides flexibility for Vermont to develop PACE programs statewide.
- Create a SNP to serve the younger adults with disabilities and those who can live in the community. There is a small number of younger adults with disabilities in Vermont, so he would prefer to contract with only one SNP. He is hoping that the PACE program would be interested in adding a SNP line of business.
- In the short term, he recommends not including those who are not nursing home eligible in the SNP program, but to do so in the long term. He thinks it would be too much to handle now.
- He emphasized that what is needed is a different type of medical model – a different mindset that looks at more than medical expenses.
- He supports the idea of sending a planning grant RFP to the communities to gauge interest. He believes that this will keep the project moving forward.

Attendees raised the following questions and/or areas of concern:

- If the State does not contract with a SNP, the SNP will offer only Medicare services, which raises the concern about shifting expenses to Medicaid.
- Would the SNP offer a broader set of services beyond those prescribed by the PACE program?
- When asked why a consumer would want to join a SNP, Commissioner Flood indicated that it was because of the flexible use of funding and integrated service configuration.
- Would the Vermont legislature require SNPs to do business with the state in order to do business in Vermont? Patrick is certain that the legislature will want to weigh in on this question.
- In responding to a question regarding the state's willingness to share risk, Commissioner Flood stated that risk sharing with a SNP could take several forms, including up-front assistance with building a risk reserve.
- How will MyCare Vermont interrelate with Blueprint for Health and Catamount Health?
- One attendee is concerned that there is no advantage to providers to create a SNP. No local providers are able to carry the risk. Commissioner Flood noted that in the PACE program the state provided the capital. The attendee expressed the belief that the state should take an active role in setting up a SNP. Vermont should look at the Wisconsin experience.
- When asked about the number of enrollees needed to be financially viable, Joan noted that the PACE experience is that 60 to 70 consumers are needed to break even, with 150 being the maximum number of enrollees with one team/center.

Commissioner Flood would like additional information from 2 or 3 programs that have done the best work with serving persons with disabilities and the elderly.

- Identify a local organization that wants to work with the state and implement the state's vision. He would like the CAC to talk about what kind of Vermont

- community organization might emerge to be jointly contracted with Medicare and Medicaid.
- If an existing organization is not interested, determine how to create a new organization.
 - Determine the minimum enrollment that will be needed for a SNP to be viable.
 - Address the question as to when MyCare Vermont will include in the target population duals who are not nursing-home eligible.

Discussion of Draft RFP for Planning Grants

Joan explained that the purpose of the RFP was to provide community groups with planning funds so that they could explore the financial and organizational feasibility of participating in MyCare Vermont. The RFP will include several other documents, including data broken down into five regions, and the Overview document that explains the guiding principles of the MyCare Vermont initiative. The state will consider awarding up to five planning grants. The state is open to starting with an entity that is limited to a specific region, but wants statewide coverage either through a group of regional organizations or one statewide organization.

The attendees expressed the following concerns:

- Whether any organization would come forward to participate in the MyCare Vermont program.
- That the RFP needs to clearly state that respondents need to specify what support and funding they will need in order to participate in MyCare Vermont.
- That the RFP needs to clearly state that creative solutions are wanted and the state will not close the door on any proposal that is reasonable.
- The RFP must explain that the MyCare Vermont delivery model is new to Vermont.
- The RFP needs to clearly state that MyCare Vermont services must be provided by an entity that can receive Medicare capitation, i.e., a PACE program or a SNP.
- Concern was expressed that an out-of-state organization will be large, and Vermont will be very small in terms of its total book of business.
- That an RFI might be more appropriate, since organizations cannot know if they are interested until they know the program details and costs.
- Whether it was too late to control SNPs' entry into Vermont.
- That with some providers turning down opportunities to share risk, PACE Vermont needs to be enticed to submit a MyCare Vermont proposal. MyCare Vermont would be offered as a separate product and not be subject to the PACE program limitations.
- That the "community well" were not being included. Julie Trottier suggested that OHVA could simply make a capitated payment to the MCO for the community well who enroll in MyCare Vermont.
- Whether the MyCare Vermont entity would need to provide services statewide immediately or eventually. Joan explained that it would not need to be statewide at the outset. The planning process will provide the state with information about what is economically feasible for a potential organization.
- That it will take more than \$50,000 (suggested amount of planning grants) to fund the development of a business plan. The PACE model had a very clear model, but it still

- took four-plus years to develop and required more than \$50,000 in development funds. It was suggested that \$75,000 would be more realistic.
- That an informational brainstorming session with all interested stakeholders would be very helpful, because MyCare Vermont is uncharted territory, both financially and from a regulatory perspective.

It was pointed out that six Medicare Advantage Plans would be offered in Vermont, starting January 1, 2007. These organizations can enroll any Medicare beneficiaries, including dual eligibles. There is nothing the state can do to control or regulate those entities.

It was suggested that the state reach out to specific organizations, such as Blue Cross/ Blue Shield and MVP, to encourage them to create a SNP. Joan pointed out that the state cannot select an entity to fund without going through an RFP process.

The attendees were of the opinion that nothing included in Commissioner Flood's vision and issues discussed today was inconsistent with MyCare Vermont using a SNP or Rural PACE to receive capitated Medicare funds, so long as everyone is very clear on the MyCare Vermont requirements.

A number of participants thought that the RFP did not include sufficient information to enable a community organization to develop a meaningful response. There was also continuing confusion regarding the relationship between MyCare Vermont, SNPs and PACE. There were a variety of opinions on what to do next to move the project forward. Joan stated that she would take the CAC's concerns and suggestions under advisement.

Three attendees asked why the September CAC meeting, which was to include a broad representation of stakeholders, was cancelled. It was explained that Commissioner Flood wanted to consider federal financing options, and the role of Vermont providers, before going out to stakeholders. He also felt that the CAC provided adequate representation of the various stakeholder groups, and did not think that further community involvement was necessary at that time.

Core Planning Team on 8-8-06 "Homework"

Core Planning Team Answers to Four Questions from the CAC

Marge Houy reported the work of the CPT with regard to each of the questions outlined below:

1. Revisit the definition and role of a non-medical member of the ICT

Answer: The function of that position on the ICT is to provide case management, and not counseling. The case manager must be a DAIL Certified Case Manager; therefore, anyone who is certified may provide the services regardless of the individual's educational background.

CAC Comments: Under DAIL's policies, a Certified Case Manager must be affiliated with a certified agency, currently limited to the Home Health Agencies and

AAAs. Certified Case Managers often have limited experience with younger persons with disabilities. DAIL may need to establish some training and certification processes for case managers so they will have greater skills and are able to serve younger persons with disabilities.

In contrast, the nurse will most likely be an RN, and will have some responsibilities for providing direct care to participants, but no case management. The direct care services are important for the nurse to provide so that s/he will have first-hand knowledge about the medical needs and condition of the participants. The nurse will be a permanent member of the team and responsible for serving multiple participants.

CAC Comments: none.

2. Revisit the question of involvement of the existing network: Should the involvement be specified by the state or left up to the program contractor (should it not be the state itself)?

Answer: The CPT stated a preference that the state would recommend—and strongly encourage—the contracted provider entity to utilize the existing network, but should not mandate or require them to do so. The CPT wanted to avoid the Massachusetts approach where the state legislature mandated that AAAs be under contract with their SCO contractors. We want to build on our existing provider network, but hope that individual community dynamics would ultimately determine which providers are used, especially since there are regional differences in availability of some services.

CAC Comments: The CAC wanted clarification as to where the CPT thought the decision should be made. It was explained that the CPT did not directly address that question, but that it most logically would be at the local level.

Follow-up: The CPT was asked to consider whether DAIL should specify the role of the AAAs in its RFP.

3. How will additional members be added to the Interdisciplinary Care Team (ICT)?

Answer: Marge explained that the ICT is responsible for developing an initial care plan and updating it as circumstances and conditions warrant. The individual care plan will specify the nature of specialists to be involved in the care of the participant. Members of the CPT thought that few specialists would want to be a member of the care team, and would be very willing to provide their expertise either over the phone or during an office visit. The CPT noted that if a specialist were to be part of the ICT, the program would need to develop an appropriate reimbursement arrangement for the specialist.

CAC Comments: CAC members suggested that the state think through what it wants to include in its contract with a SNP. It may be reasonable to require SNPs run by outside entities to use local case managers.

CAC members also noted that there is a basic tension underlying the ICT, which is to be a person-centered team and garner the advantages of the PACE model. This will be difficult if there are multiple teams with changing membership, and may result in more limited savings. Moreover, MyCare Vermont is targeting two diverse populations: frail elderly persons and younger persons with disabilities. A stable and consistent team will be particularly important for the frail elderly who also have family involvement. It was suggested that two separate models might be needed for the two target populations. A question was also raised as to whether the MyCare model will be viable in rural areas such as the NE Kingdom.

4. Why were specific waiver populations (i.e., people who receive services through individual TBI, CRT, or DS waivers) excluded from the target population?

This question was not addressed. However, the answer is because these people are already receiving individualized services, and we do not want to duplicate or overlap with existing waivers.

Consumer Representation:

The presentation by Scott Goyette, Consumer Advocate, was not made because Scott was unable to attend because of illness.

Definition of Person-centered Care:

Marge Houy, reporting on the work of the CPT, presented the following definition to the CAC for consideration and comment (the underlined words were recommended changes suggested by the CAC):

“Person-centered Care is individualized care that is respectful of and responsive to an individual’s circumstances, preferences, needs and values. Key attributes of Person-centered Care include:

1. Collaborative decision-making about care;
2. An informed and educated care team;
3. Coordination and integration of care among providers and the member, and across all settings;
4. Promotion of well-being including physical comfort and emotional support;
5. Involvement of an individual’s chosen support circle, and
6. Accountability for appropriate and efficient use of services.”

The CAC asked the CPT to add to the definition the importance of sharing information and having open communications. The CAC also asked the CPT to identify for each attribute: its characteristics; what needs to be covered by provider protocol; and what systems issues, if any, may arise around each attribute. It was suggested that the CPT look at a Kaiser Family Foundation publication on what is the meaning of integration, and at the PACE regulations. The final product will be an operational definition of Person-centered Care, which should include an executive summary.

In discussing how to ensure that providers are implementing Person-centered Care, the CAC made the following suggestions:

- Use a patient satisfaction survey.
- Bring in an outside evaluator.
- Have the MyCare organization do its own evaluation.
- Make sure that participants know about the state ombudsman
- Give everyone upon entry into a nursing home a statement of rights.
- Perform periodic audits.

When asked by Joan Haslett to think how to proactively ensure that Person-centered Care was being provided, CAC attendees made the following suggestions:

- Require providers to ask participants if the provider is providing Person-centered Care.
- Implement a Client Assistant Program (CAP).
- The entity makes periodic calls to participants to assess participant satisfaction.
- Require that a field person make weekly contact with the participant and his or her family; daily contact, if necessary.
- Submit an update to the centralized record by the last person seeing the individual.
- Hold mandatory monthly meetings with the individual participants. If the situation is not satisfactory for the participant, then send in an outside troubleshooter
- Train providers and members of the ICT to use language that encourages individuals to openly state dissatisfaction. Use phrases like, “you will help me by telling me what is not going well.”
- Create a culture of continuous quality improvement for the program. This must be done from the top down, starting with the state leaders. Hold educational sessions on a regular basis. Hold an annual conference. Bring in people from other agencies to explain how they implement Person-centered Care.
- Mandate monthly meetings with the ICT, which includes the participant and his or her chosen support system. Ask at every meeting whether the participant believes that s/he is receiving Person-centered Care, and what improvements could be made.
- Create a client advisory council.
- Create protocols that the ICT must follow, including the requirements that the ICT must always include the individual in meetings, that someone be identified to help the participant express his or her needs as necessary, and that the care plan be written from the participant’s perspective (“I receive 2 hours of PCA assistance daily”).
- Conduct an evaluation of the flexible services that are being provided: type and frequency.

Next Steps:

The next CAC meeting is scheduled to be held on December 11, 2006. (Note: this meeting was later cancelled, replaced by the December 19, 2006 seminar.)

The next communication with the Community Feedback Partners will be sent out by November 10, 2006. In addition to including update information, the communication will ask for input on the definition of Person-centered Care and suggestions on how to operationalize the concept.

The CAC asked that the CPT minutes be made available on a more timely basis. The August 22 CPT meeting minutes have been finalized and Michael committed to distribute them to the CAC promptly.

The attendees gave the meeting high marks, and expressed satisfaction in terms of how it was facilitated. The meeting was adjourned at 2:30 pm.