

Options for Structuring the *MyCare Vermont* Integrated Care Model



Report prepared by:

The Pacific Health Policy Group

Submitted to:

**Joan Haslett, Real Choice Systems Change Project Director
State of Vermont
Agency of Human Services
Department of Disabilities, Aging and Independent Living**

Revised September 27, 2007

**Produced with funding from the Real Choice Systems Change
Comprehensive Systems Reform Effort Grant # 11-P-92461/1-01
from the U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services**

Table of Contents

	Page
1. Introduction	2
2. Integrated Care Options	4
Expanded (Stand Alone) PACE.....	6
Combination PACE/PIHP	10
PIHP First.....	14
Combination Private SNP/PIHP	17
Public SNP	22
3. Summary Findings/Recommendation.....	26
Appendix I – Comparison of PACE & PIHP Requirements	27
Appendix II – Implementation Tasks & Timeline	44

Section 1: Introduction

Vermont, like the country as a whole, is facing a demographic wave in the form of a growing elderly population. Although the number of non-elderly adults in the state is remaining relatively flat, the number of Vermonters ages 65 and older is projected to grow from 77,000 in 2005 to 101,000 in 2015 and 138,000 in 2025.

The Department of Disabilities, Aging and Independent Living (DAAIL) estimated that in 2005 there were about 7,500 Vermonters in need of some level of long term care assistance. Approximately 4,500 of these individuals lived in the community rather than nursing facilities, and about 2,500 of the 4,500 received home- and community-based waiver services through Medicaid.

Based on overall population trends, the number of persons in need of some type of long term care will increase from 7,500 in 2005 to 9,500 in 2015 and 12,300 in 2025. If the Medicaid population receiving community-based waiver services grows at the same rate (a conservative assumption, since the state's goal is to shift away from the institutional model), this will mean 3,000+ Medicaid recipients in the community in 2015 and 4,000+ in 2025. Most of these persons will be dually eligible for Medicaid and Medicare.

Recognizing the demographic trends in recent years, Vermont has introduced new models for delivering acute and long term care services to the frail elderly and adults with disabilities. One model, Choices for Care, grants additional flexibility with regard to how services are delivered. Another, PACE Vermont, permits residents of Chittenden county ages 55 and older to enroll in a long term care system that integrates Medicare and Medicaid funding streams. (The program is scheduled to be expanded to Rutland County in January 2008.)

Choices for Care and PACE, along with several smaller initiatives, represent important first steps toward making consumer-centered, coordinated systems of care available to Vermont's most vulnerable citizens. As now constituted; however, both have important limitations: Choices is funded with Medicaid dollars only and has no formal linkage to Medicare; PACE does combine Medicaid and Medicare funding streams, but is available only to older Vermonters in the two most populous counties of the state. Accordingly, Vermont is exploring options for expanding its integrated care offerings through the *MyCare* initiative.

MyCare will be available to the frail elderly and younger adults with physical disabilities who qualify for Medicare and who also meet Vermont's current financial and clinical eligibility criteria for Medicaid long term care. This is a population whose care, historically, has been fragmented between Medicare and Medicaid and lacking in meaningful coordination; failures that *MyCare* is designed to address.

The state has defined five key concepts, or operating principles, for *MyCare*, around which the actual delivery system model is to be constructed. Specifically:

1. Coordinating all care planning through a *Person-Centered Interdisciplinary Care Team*, comprised of the participant, the participant's primary care provider, a non-medical service coordinator, and a registered nurse;
2. Facilitating communication and coordination through the use of a common *Centralized Comprehensive Record* (preferably electronic);
3. Providing far greater *flexibility of covered services* than is allowed under traditional Medicare or Medicaid through capitated payments (Medicaid and Medicare) to the entity operating the program;
4. *Integrating Medicare and Medicaid funding* to eliminate existing perverse incentives and complexities for those who are eligible for both programs; and
5. Producing *program savings* to reinvest in services for participating Vermonters.

The next section of the report looks at options for constructing the *MyCare* program and evaluates them against a uniform set of criteria.

Section 2: Evaluating Integrated Care Models

The state has identified five alternative models under which *MyCare* could be implemented. Although the models represent distinct approaches to meeting the state's operating principles, they each contain some mixture of three operating platforms: PACE, Pre-Paid Inpatient Health Plans (PIHPs) and Medicare Special Needs Plans (SNPs).

The models are:

1. *Expand Existing PACE Program* – Under this option, the existing PACE Vermont program, or its equivalent, would be expanded into additional sections of the state for adults ages 55 and older. AHS also would pursue authority, through a Medicare waiver or federal legislation, to extend enrollment to adults under age 55.
2. *Combine PACE Expansion with PIHP for under 55 Year Olds* - Under this option, PACE Vermont would expand geographically (as in Model 1) and also would contract with the state to serve as a PIHP for the under age 55 population. As a PIHP, the organization would be able to enroll under 55 year olds and receive capitation for Medicaid benefits, while Medicare would not be capitated.
3. *Expand first through PIHP for Adults of all Ages* – Under this option, PACE Vermont (and/or other organizations) would contract with the state to serve as a PIHP. The PIHP, or “pre-PACE” plan, would enroll adult Vermonters of all ages who meet long term care criteria and reside in the community. The organization would receive capitation for Medicaid benefits, while Medicare would not be capitated. (Ultimately, the PIHPs could be converted to PACE programs for the 55 and older population, or for adults of all ages, if authorized by waiver or legislation.)
4. *Combine Private SNP with PIHP* – Under this option, a private Special Needs Plan would contract with CMS for Medicare benefits. AHS would then contract with the same plan to serve as a PIHP for Medicaid benefits. The plan would be responsible for integrating Medicare/Medicaid benefits.
5. *Develop Public SNP* – Under this option, AHS would become a Medicare SNP and directly oversee the integration of Medicare and Medicaid benefits.

The models are described in greater detail later in the section and then rated “high”, “moderate” or “low” with respect to six criteria. The ratings are based on PHPG’s professional judgment, consultation with state representatives and published information on the performance of existing programs in other states that share characteristics with one of the models.

The six criteria are:

- **Accessibility to Potential Enrollees** – The extent to which the option makes integrated care available to all age groups and geographic areas of the state
- **Integration of Care** - The extent to which the model supports a truly integrated, patient-centered system of care, including multi-disciplinary care teams and centralized electronic records
- **Flexible Benefits** – The degree to which the entity operating the program has the freedom to structure benefits/services outside the constraints of traditional Medicare/Medicaid rules
- **Program Savings** – The potential for savings to the state, in terms of Medicaid expenditures, and associated dollars available for reinvestment into the system
- **Administrative Simplicity** – The manageability of the administrative tasks to be assumed by the Agency of Human Services (AHS). This includes contracting and procurement, member enrollment, capitation rate setting, information systems and quality oversight and reporting
- **Feasibility/Stability** – The likelihood that the model will garner the necessary support and participation of providers and regulators for implementation, as well as its prospects for long term stability

The comparison of the models begins on the next page. Although the models differ in their relative strengths, it is important to note that none offer surety of success. Vermont's small size, combined with the voluntary nature of the program, will make it a challenge to draw sufficient enrollment to ensure the program's viability. The state's outreach and education efforts, which are addressed in the implementation plan at the end of the report, will be critical to the program's ultimate success.

Model 1 – Expand Existing PACE Program (Stand Alone PACE)

The traditional PACE model is designed for individuals who are age 55 or older, certified by their state to need nursing home care, able to live safely in the community and residing within a PACE service area. PACE is open to non-Medicaid beneficiaries, but nearly all have Medicaid, and most are dually eligible for Medicare and Medicaid.

The traditional PACE model is site-based, consisting of a PACE center which houses an interdisciplinary care team as well as adult day services. In July 2007, there were close to 50 PACE sites in operation around the country. PACE Vermont Inc. currently operates sites in Chittenden County and is due to open a Rutland County site in January 2008.

The Deficit Reduction Act of 2003 authorized CMS to award grants to fifteen PACE sites interested in developing “Rural PACE” programs. The intent of the Rural PACE model, also known as “PACE without walls”, is to replicate the team-centered approach to care in a lightly populated area lacking the full complement of site-based services. PACE Vermont was one of the fifteen grantees selected in September 2006.

Under this option, the PACE Vermont program would be expanded to as many areas of the state as possible, through some combination of rural networks and (where practicable) establishment of additional sites. There is no precedent for this sort of statewide PACE expansion, but there is nothing to preclude such a strategy in Medicare or Medicaid rules.

In conjunction with developing an expansion plan, Vermont could explore with CMS the possibility of securing Medicare and Medicaid waivers to permit enrollment of adults with physical disabilities under the age of 55. If CMS is unwilling or unable to grant a waiver, the state could seek to have legislation introduced in Congress by Vermont’s delegation directing CMS to approve such a demonstration in the state. (There is precedent for this sort of targeted legislation.) However, because approval cannot be guaranteed, the state should evaluate this model with the expectation that it will only be available to adults ages 55 and older.

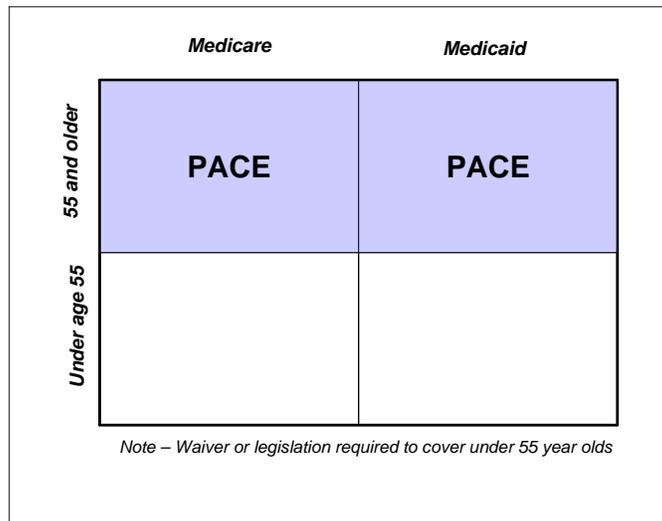
(A third, and transitional, option for enrolling the under 55 year olds is presented in Model 2.)

Rating the Model’s Relative Potential (High/Moderate/Low)

Accessibility to Potential Enrollees – *Moderate*

Expanding PACE as a stand alone initiative would leave adults between 18 and 55 without the opportunity to enroll in an integrated care model (absent a waiver or federal legislation). These adults comprise only about ten percent of the 2,500 Medicaid long term care recipients living in the community, and their exclusion would not render the model unviable. However, the model would fail to meet the state’s objective of making integrated care available to all age groups.

Stand Alone PACE



Integration of Care – *High*

PACE is a patient-centered that has at its core the interdisciplinary team model. It also is fully-integrated in terms of Medicare and Medicaid funding streams.

Flexible Benefits – *High*

The PACE site is a managed care organization and has the freedom to use its capitation payment in the manner deemed most appropriate for its enrolled population. This flexibility is important, because while states with managed care waiver programs can mandate enrollment of Medicaid beneficiaries into managed care (for Medicaid covered services), enrollment into Medicare managed care must be voluntary. Since PACE combines Medicare and Medicaid service delivery into a single “decision point”, enrollment must be voluntary for dual eligibles.

PACE Vermont’s menu of covered services includes, but is not limited to, primary care and specialist physicians, inpatient hospital, adult day care and other long term care services. Subject to availability of funds, and agreement of the PACE contractor, the state could structure the PACE benefit package to include benefits/services not otherwise available under traditional Medicare or the general Choices for Care waiver program and use the additional services as an inducement for enrolling. Examples

from other states of such services include adult dental care, vision care and enhanced drug benefits.

Program Savings – *Low*

The potential for state savings in any managed care system depends to a large degree on the methodology used to set capitation rates. PACE Vermont's capitation rates were developed using a commonly accepted approach for PACE contractors. Specifically, the Medicaid portion of capitation rates was established by calculating the average cost for long term care beneficiaries in the fee-for-service program, and discounting the amount by ten percent. The rates included cost data for both nursing facility and HCBS beneficiaries in direct proportion to their size within the long term care program.

However, over 90 percent of PACE enrollees nationally live in the community and, on average, have significantly lower costs than their nursing facility counterparts. PACE programs therefore do not typically generate savings for Medicaid. Indeed, they can be more costly than the fee-for-service program in practice, even though they show savings on paper¹.

Because this methodology has already been employed in Vermont (and is endorsed by the national PACE association), it would likely be very difficult to convince PACE Vermont or another provider to accept rates that have been further discounted through an adjustment for the likely HCBS/nursing facility enrollment mix². It may, however, be possible to arrange for a modest set of additional benefits to be provided under the contract, assuming PACE Vermont's capitation rates include a sufficient cushion to cover the cost of these benefits.

Administrative Simplicity – *Moderate*

The Balanced Budget Act of 1997 made PACE a State Plan Service. Once the program has been added to the State Plan, new sites can be created through execution of a program agreement between the state, PACE provider and CMS. Vermont already has contractual, rate setting and quality oversight templates for PACE, which could be replicated around the state. Similarly, the Medicaid Management Information System already has been programmed to accommodate PACE enrollment and payments. The day-to-day operation of the program is responsibility of the PACE site.

One complicating factor could be the number of PACE organizations with which AHS would have to contract as part of a statewide expansion. If PACE Vermont

¹ This can occur because the PACE organization is paid a capitation rate that includes significant dollars for nursing facility care, which is seldom provided to PACE enrollees, whereas in the fee-for-service system funds are only expended when a service is provided. The programs appear cost effective on paper, however, because the comparison is between the capitation rate, with its ten percent discount, and the fee-for-service claims history for the entire long term care population – both institutionalized and HCBS.

² The state intends to monitor PACE Vermont's profitability, and adjust future Medicaid payments in accordance with the plan's operating surplus. However, it is unclear when – and to what degree – such an adjustment will actually be made.

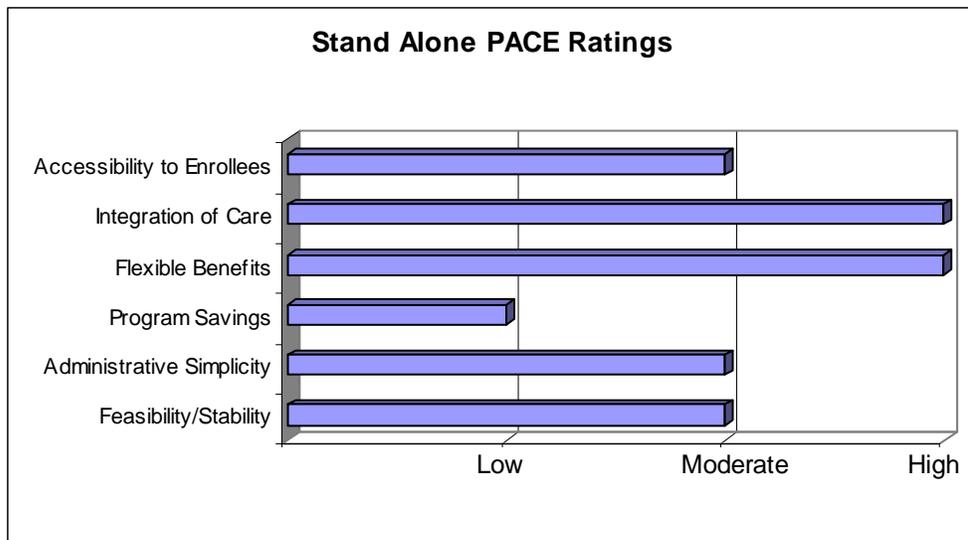
serves as an umbrella contractor, or if the total number statewide can be limited to two or three, the administrative burden will be manageable. If the number of organizations exceeds three, the administrative burden on the state may become an issue. (For purposes of this analysis, it is assumed that the number of PACE providers would be three or less.)

Feasibility/Stability – Moderate

The PACE model is provider-based and, by definition, must have the support of a critical mass of providers within a service area before it can be implemented. This can make for a laborious and time consuming development process; many PACE sites take years to move from initial expressions of interest on the part of providers to actual enrollment. However, with a PACE program already operating in the state, the expansion process should be manageable, particularly if PACE Vermont serves as an umbrella contractor or, at a minimum, as a “development consultant” to later programs, perhaps under contract to the state.

Once in place, the prospects would be favorable for the program’s continued stability. The nation’s first PACE-like program – On Lok SeniorHealth in San Francisco – is two decades old. The relatively generous capitation rates also should enable PACE Vermont and its counterparts to operate profitably, subject to it amassing a sufficient level of enrollment.

The ratings for the Stand Alone PACE model are summarized below.



Model 2 – Combine PACE Expansion with PIHP for under 55 Year Olds

The most serious limitation of the expanded PACE model is that it excludes individuals under age 55 who would otherwise be eligible for enrollment. As discussed under Model 1, the state could seek authority to enroll the younger age cohort, either through a Medicare waiver or federal legislation. However, even if successful, either approach could take a considerable amount of time and effort to accomplish. (Medicare advises waiver applicants to “prepare for (an) intensive review process” and “be prepared for modifications”.)

Either as a permanent solution or as a transitional step, the state could collaborate with PACE Vermont in the development of a “pre-PACE” model for the under 55 year olds, whereby they would be enrolled – and PACE Vermont capitated – for Medicaid benefits only. This would leave Medicare benefits such as physician and acute care hospital services outside of the plan’s direct sphere of responsibility.

The state could elect to include Medicare cost sharing dollars (co-payments and deductibles) in the Medicaid capitation or process these payments directly through the MMIS. Placing cost sharing dollars in the capitation would help to keep the plan in the loop with respect to the enrollee’s non-capitated services, unless the enrollee joined a Medicare Advantage plan with no cost sharing requirements.

In order to receive Medicaid capitation, PACE Vermont (or another organization) would contract with the state as a Pre-paid Inpatient Health Plan, or PIHP. This plan type, which was created under the Balanced Budget Act of 1997, is similar to a traditional full-risk Health Maintenance Organization, but has a more limited scope of capitated benefits. Specifically, 42CFR Part 438 states:

Prepaid inpatient health plan (PIHP) means an entity that--

- (1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;*
- (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and*
- (3) Does not have a comprehensive risk contract.*

The CFR goes on to define different options under which a plan can be classified as a PIHP. One option, which could be adopted by Vermont, would be to capitate the plan for Nursing Facility services (although few enrollees would require this benefit) but not for inpatient hospital care, which in the case of dual eligibles is primarily covered through Medicare. The state then could include any other services it chose under the capitation

while still meeting the PIHP definition³. OVHA could add the PIHP option through a state plan amendment, a process that usually only takes a few months to complete.

The state and PIHP would be required to comply with federal health plan contracting requirements contained in 42 CFR Part 438. These requirements mimic to some extent PACE requirements specified in 42 CFR Part 460, which would ease the development process somewhat for PACE Vermont. (Appendix I to this report contains a matrix comparing federal PIHP and PACE requirements.)

At the state level, the PIHP could potentially be treated by BISHCA as a modification to the existing PACE plan, for state regulatory purposes. PACE Vermont is exempt from Rule 10 requirements – an exemption that would then be extended under the PIHP model.

Failing that, the plan still might avoid some of what BISHCA refers to as the “strenuous” Rule 10 reporting requirements for MCO’s. Although Rule 10 applies to all managed care organizations (including PIHP’s), BISHCA imposes only a subset of its reporting requirements on other less than comprehensive plans, such as behavioral health organizations.

Assuming PACE Vermont became the PIHP, the plan’s service area could be drawn to match the PACE program’s, and could be expanded in tandem with the growth of the Stand Alone PACE “without walls”. If and when PACE Vermont receives approval to enroll under 55 year olds, the PIHP’s contract with the state would be modified to reflect the model’s transition.

Rating the Model’s Relative Potential (High/Moderate/Low)

Accessibility to Potential Enrollees – *High*

Assuming the PACE model is expanded geographically to cover large portions of the state, and enrollment is opened-up to younger adults through the PIHP, this option will achieve a high level of accessibility for long term care beneficiaries.

Integration of Care – *High*

This model is not optimal in terms of integrating Medicare and Medicaid funding, as younger adults would be capitated only for their Medicaid benefits. However, these individuals – who comprise about ten percent of the 2,500 Medicaid long term care recipients living in the community -- would be voluntarily enrolling into the plan. As such, they likely would be motivated to cooperate with their interdisciplinary care team to ensure the coordination of Medicare and Medicaid services.

³ Alternatively, the state could include inpatient hospital services in the capitation and still meet the PIHP standard as long as the capitation included no more than two additional services from the following list: (1) Outpatient hospital services; (2) Rural health clinic services; (3) FQHC services; (4) Other laboratory and X-ray services; (5) Nursing facility (NF) services; (6) Early and periodic screening, diagnostic, and treatment (EPSDT); services; (7) Family planning services; (8) Physician services; and 9) Home health services. The state of Pennsylvania opted for this approach for its PIHP contracts and selected Nursing Facility and Physician services as its two capitated benefits.

PACE/PIHP

	<i>Medicare</i>	<i>Medicaid</i>
<i>55 and older</i>	PACE	PACE
<i>Under age 55</i>		PIHP

Flexible Benefits – High

The PACE/PIHP would have flexibility to use the Medicaid capitation payment in the manner deemed most appropriate for its enrolled population, regardless of age. It would have the same flexibility with regard to its Medicare capitation payments for persons age 55 and older. The only exception would be the small portion of total care dollars associated with Medicare-covered services for persons under age 55.

Program Savings – Low

As discussed under Model 1, PACE programs do not typically yield significant savings for states because of the methodology used to set the Medicaid portion of capitation rates.

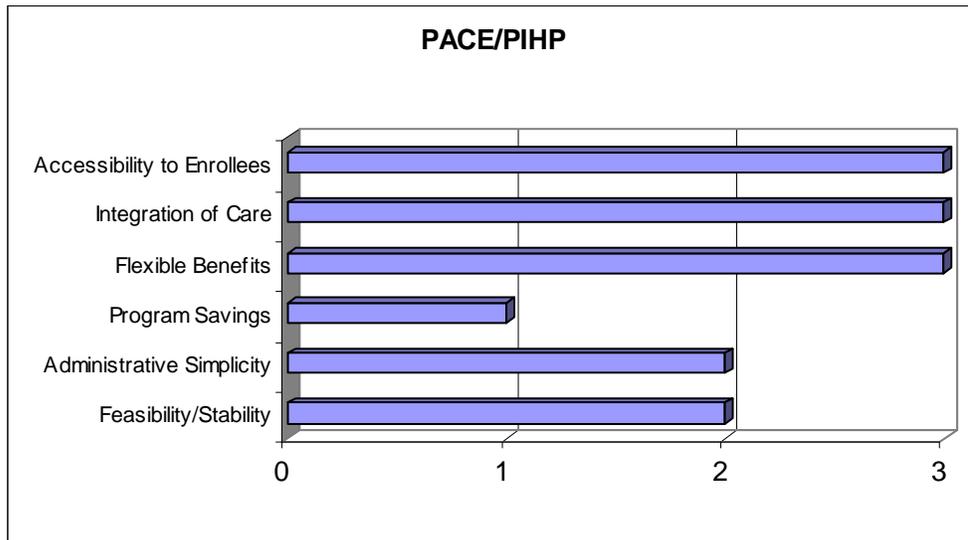
Administrative Simplicity – Moderate

If the PIHP portion of the plan is exempted from Rule 10 requirements, the administrative complexity of this model will not be significantly greater than the Stand Alone PACE, which was rated “moderately complex”.

Feasibility/Stability – Moderate

The feasibility and stability of the PACE/PIHP model would also be equivalent to the Stand Alone PACE (“Moderate”) assuming PACE Vermont is willing to take-on the task of becoming a PIHP as a transitional step, and coordinating Medicare benefits with fee-for-service providers and Medicare Advantage plans.

The ratings for the PACE/PIHP model are summarized below.



Model 3 – Expand first through PIHP for Adults of all Ages

The Pre-Paid Inpatient Health Plan (PIHP), or “pre-PACE” option described in Model 2 could be used as the initial vehicle for expanding integrated care to adult Vermonters of all ages, not just those under age 55. Under such an approach, the PIHP (PACE Vermont and/or other contracted organizations) would enroll and serve adults living in the community who qualify for long term care and would be capitated for Medicaid benefits only. PACE Vermont also would continue to operate a Medicare/Medicaid capitated model within its current service area and could gradually expand the PACE model, under the rural PACE initiative, into areas being served by the PIHP. Where this expansion occurs, the (pre-PACE) PIHP would convert to PACE status for the 55 and older cohort (or all ages, if authorized through a federal waiver or legislation).

Although the PIHP would have to conform to the state and federal requirements described in Model 2, its ability to expand throughout the state would be simplified by its separation from PACE. Whereas in Model 2, the PIHP would be established concurrently with new PACE service areas, under Model 3 it could expand without awaiting CMS approval of the Medicare component.

As with Model 2, the state could elect to include Medicare cost sharing dollars (co-payments and deductibles) in the Medicaid capitation or process these payments directly through the MMIS. Placing cost sharing dollars in the capitation would help to keep the plan in the loop with respect to the enrollee’s non-capitated services, unless the enrollee joined a Medicare Advantage plan with no cost sharing requirements.

Rating the Model’s Relative Potential (High/Moderate/Low)

Accessibility to Potential Enrollees – *High*

The PIHP would be the easiest model to expand geographically, as it would require contract(s) only with the state. The plan also would not have to build as comprehensive a network, since it would not be capitated for hospital and physician services.

Integration of Care – *High*

Although PIHP enrollees would be capitated only for their Medicaid benefits, they would be voluntarily enrolling into the plan. As such, they likely would be motivated to cooperate with their interdisciplinary care team to ensure the coordination of Medicare and Medicaid services. Note also that the existing PACE program would continue to operate in its current service area, meaning that some Vermonters would be capitated for both Medicare and Medicaid (see exhibit on next page).

PIHP First

	<i>Medicare</i>	<i>Medicaid</i>
<i>55 and older</i>	PACE*	PACE*/PIHP
<i>Under age 55</i>		PIHP

* PACE will furnish Medicare and Medicaid benefits to enrollees in current PACE service area. Enrollees outside of the current PACE service area will be capitated for Medicaid benefits only.

Flexible Benefits – High

The PIHP would have flexibility to use the Medicaid capitation payment in the manner deemed most appropriate for its enrolled population, regardless of age.

Program Savings – Moderate

The state would have the opportunity through its contract with the PIHP to construct capitation rates below historical fee-for-service expenditures. It also could devise risk sharing arrangements whereby the plan would return a portion of its year-end surplus to the state, in return for a cap on its potential losses (an arrangement that is not permissible under PACE). Although the plan would not have direct control over Medicare-reimbursed services, it also would not be at financial risk for those services.

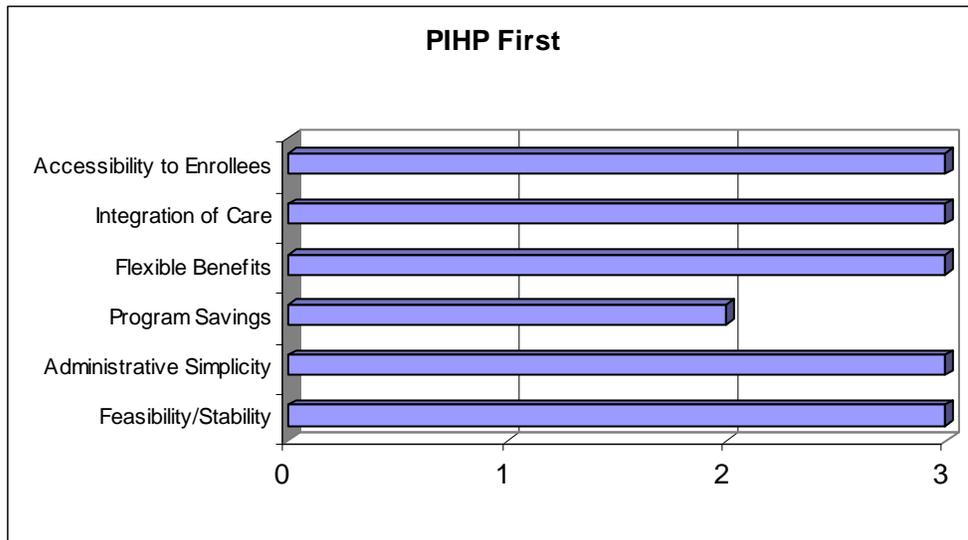
Administrative Simplicity – High

This model requires only a contract between the state and the PIHP and no ongoing coordination with CMS/Medicare. (CMS will have to approve the draft contract, but this is not typically a difficult process for Medicaid-only plans.)

Feasibility/Stability – High

There are no serious hurdles to implementing this option, assuming PACE Vermont or another willing contractor, or contractors, can be found. The number of potential enrollees are such that the state might be able to attract two contractors, thereby ensuring the program's continuation should one decide to limit enrollment or exit the program.

The ratings for the PIHP First model are summarized below.



Model 4 – Combine Private SNP with PIHP

There are currently a handful of private Medicare Advantage organizations operating in Vermont, though all are “Private Fee-for-Service” models with no active care coordination or disease management. Their total enrollment is only about 1,400 and none offer Special Needs Plans among their products. Outside of Vermont, there were 469 SNP contracts awarded in 2007, of which 85 were institutional SNP’s. The nearest institutional SNP’s to Vermont operate in Massachusetts, Rhode Island and portions of Maine.

If an Institutional Special Needs Plan⁴ were to be established and awarded a contract by CMS, the Medicare portion of the enrolled population’s benefits would become the organization’s responsibility, while Medicaid benefits (including most long term care services) would remain unmanaged. To complete the circle, AHS would seek to contract with the SNP as a Pre-paid Inpatient Health Plan and capitate it to manage the Medicaid benefits of any dually-eligible enrollees.

There are precedents for this type of integrated model around the country, some of which date back to before Medicare Advantage. For example:

- *Arizona Long Term Care System (ALTCS)* – Arizona has mandatorily enrolled its long term care population – both community-based and institutional – into private and county-operated managed care plans since 1989. The plans are responsible for both acute and long term care benefits. Dual eligible beneficiaries have been enrolled into ALTCS since its inception, but plans were responsible only for picking-up Medicare cost sharing amounts.

Starting with the most recent contracting cycle, Arizona required that its private plans begin the process of obtaining Institutional SNP designation (county-operated plans were exempted). The programs two largest contractors obtained SNP designation in time to qualify for the one-time only passive enrollment provision and were rewarded with over 8,000 enrollees.

- *Massachusetts Senior Care Options (SCO)* – The Senior Care Options program was developed in conjunction with CMS prior to introduction of the SNP model, although its three contractors have since obtained SNP status at the request of CMS. Unlike ALTCS plans, SCO contractors enroll both long term care and non-long term care (“community well”) dual eligible beneficiaries. As part of ensuring interdisciplinary teams play an appropriate role in care planning and delivery, SCO contractors are required to contract with state Aging Services Access Point providers to serve on the team and furnish HCBS services. Total enrollment stands at about 4,500.

⁴ As previously noted, the term “Institutional” is somewhat of a misnomer, as Institutional SNP’s are permitted to enroll and serve persons living in the community, so long as they are at risk of nursing facility placement.

- *New York Medicaid Advantage Plus*- New York is in the process of implementing Medicaid Advantage Plus, under which the state will contract with private Special Needs Plans to enroll and serve a portion of the long term care population. New York's model contract incorporates Medicare Advantage requirements in areas such as benefit packages into the document, obligating plans to meet these Medicare requirements as part of their contractual agreement with the state. The program has attracted the interest of several private contractors, although it has not yet been implemented.
- *Texas STAR+PLUS* – Texas has operated a Medicaid long term care managed care program in Harris County (Houston) since the 1990's; the program has recently been expanded to other counties, including in the Dallas-Fort Worth metropolitan area. The two STAR+PLUS plans in Harris County obtained SNP status in 2006. Primarily through passive enrollment, STAR+PLUS serves over 20,000 dual eligible long term care beneficiaries. To encourage enrollment, and discourage disenrollment, STAR+PLUS includes an enhanced prescription drug benefit.
- *Wisconsin Partnership Program* – The Partnership Program began as a combined Medicaid Section 1115a/Medicare Section 222 waiver program, integrating acute and long term care benefits. The program has included a mixture of private and county-operated plans. The private plans have converted to SNP status, while the county plans have not.

Rating the Model's Relative Potential (High/Moderate/Low)

Accessibility to Potential Enrollees – Moderate

The private SNP/PIHP model would result in all services being capitated for all populations. The private SNP model also potentially could operate statewide, assuming an interested contractor could be identified. However, many of the existing institutional SNP's are sub-state in nature and it is possible that interest in a Vermont SNP would be limited to the same areas served today by PACE Vermont.

Integration of Care – Moderate

The private SNP/PIHP would hold two contracts – one with CMS and one with Vermont Medicaid. Vermont, through its contact, could seek to address whatever integration requirements the state deems essential, similar to what New York has done. Ultimately, however, the state would be reliant on the private plan's ability to successfully weave the two contracts together in a seamless manner. While this has been accomplished elsewhere in the country, it has not been achieved in a state as rural, and as lacking in managed care, as Vermont.

Private SNP/PIHP

	Medicare	Medicaid
55 and older	SNP	PIHP
Under age 55	SNP	PIHP

Flexible Benefits – Moderate

The SNP is a managed care organization and has the freedom to use its capitation payment in the manner deemed most appropriate for its enrolled population. However, its willingness to tailor the Medicare portion of the benefit package in accordance with Vermont's desires would be out of the state's control. New York took the approach of including specific requirements for usage of Medicare capitation in its Medicaid Advantage Plus contracts, but it has much greater potential enrollment to offer contractors than does Vermont.

Program Savings – Low

Vermont's history with private Medicaid managed care contractors has not been favorable. Both VHAP contractors exited the program after failing to make a profit. Since any savings associated with the Medicare portion of the capitation would accrue to the plan, Medicaid's only opportunity for achieving savings under this model would come in the form of adjusting the Medicaid portion of the capitation rate downward in later years of the program, to recoup some portion of profits garnered in earlier years. In the face of such an adjustment, the plan(s) could, and likely would, exit the program.

Administrative Simplicity – Moderate

The private SNP/PIHP model would be relatively simple to administer, assuming one or two contractors stepped forward to cover the entire state. AHS would enter into a contract with the plan(s) for Medicaid benefits and, as part of the contract, also address whatever care management requirements it wishes to impose with respect to Medicaid beneficiaries (dual eligibles and otherwise). There are contracts in place in programs such as Senior Care Options that could serve as useful templates when developing Vermont's contract.

Presumably, the existing PACE Vermont program would continue to operate, which is positive in terms of providing service options to long term care beneficiaries. At the same time, the state will have to balance its treatment of the two models, with respect to enrollment and benefits, to ensure neither has a distinct competitive advantage.

Feasibility/Stability – Low

The private SNP/PIHP model faces challenges both in terms of initial implementation and long term stability. To be implemented, the state must identify a partner willing and able to meet CMS requirements for Special Needs Plans. One potential source would be among the existing Medicare Advantage organizations operating in the state today. However, these organizations offer only the least managed of the Medicare Advantage plan options – Private Fee-for-Service – which are not eligible to operate as SNP's. CMS requires that SNP's be one of two coordinated care plan types, either an HMO or PPO; making the leap to SNP status would require a significant re-tooling and enhancement of the existing plans' operations.

Even if a commercial health plan contractor steps forward to become a SNP and agrees to contract with the state⁵, the program's long term stability will be dependent on the continued participation of that contractor. The prospects for such a commitment are questionable. Vermont's two previous Medicaid managed care contractors – Kaiser Permanente and BCBS Vermont – both dropped out after a few years when confronted with the challenge of serving non-long term care beneficiaries with disabilities. (Kaiser dropped out as part of a complete withdrawal from the Northeast, but likely would have abandoned the program at the same time that BCBS withdrew, even if it had remained in operation.) Vermont's other major plan – MVP – declined to join the program even to serve relatively healthy TANF beneficiaries.

The other potential source for a SNP contractor would be a provider-based organization, such as Fletcher Allen's Vermont Health Plan. The state has provided grant funding to a number of provider organizations, for them to use in exploring the feasibility of becoming a SNP. Pending the results of these studies, the provider-sponsored approach will remain an open question. However, Vermont's track record with grass roots, provider-sponsored organizations has also been mixed. The state has made several attempts in recent years to implement locally-based long term managed care initiatives, none of which have borne fruit.

If the feasibility studies being conducted by the provider organizations yield unpromising findings, the state might consider encouraging one or more organizations to seek SNP status in partnership with a Massachusetts SCO contractor. However, any SCO contractor likely would seek to model its Vermont offering on the SCO template. While SCO includes many of the features sought under *MyCare*,

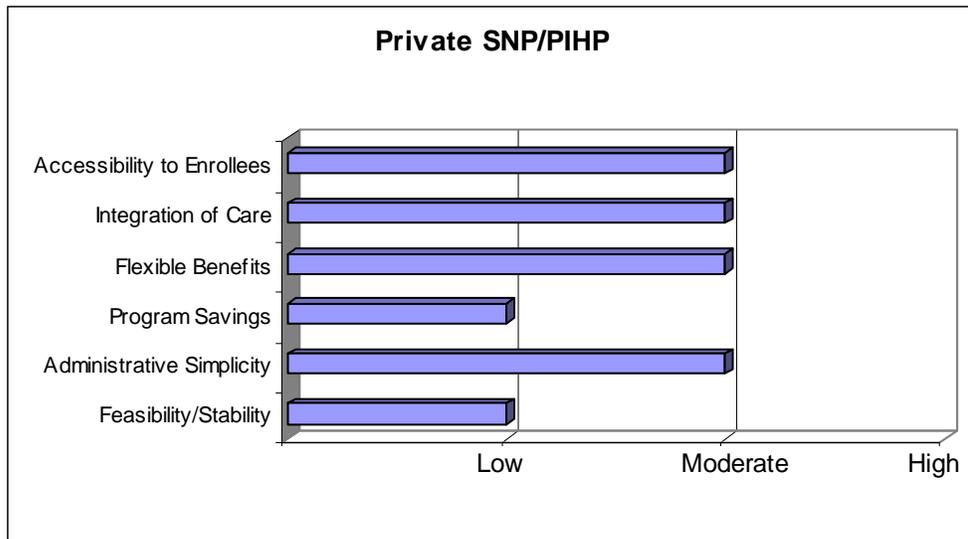
⁵ An organization could apply to the federal government to become a SNP even if the state chose not to pursue this option. Although the SNP would be capitated for Medicare benefits only, there likely would be greater integration of Medicare and Medicaid benefits through the plan's routine care management activities.

Vermont likely would take a back seat to Massachusetts in terms of its importance to any contractor.

Another potential issue for SNP's is their temporary status in law. The authorization for SNP's under Medicare Advantage is due to sunset at the end of 2008. While it is unlikely Congress will fail to reauthorize the plans before that time, until that happens new entrants would be wary of taking on the costs associated with developing and launching a new plan that potentially could face termination within a year of opening its doors.

Finally, it should be noted that the Medicare risk program has historically shown a high degree of instability. The number of participating organizations under the Medicare+Choice program (the predecessor to Medicare Advantage) rose and fell cyclically in response to changes in federal policy that affected their profitability. The industry may be on the verge of another down cycle, as federal legislation pending in Congress would reduce payment rates to Medicare Advantage plans in an effort to recoup what some view as excessive profits.

The ratings for the private SNP/PIHP model are summarized below:



Model 5 – Develop a Publicly-Operated SNP

The Special Needs Plan concept is promising in terms of its potential accessibility and attractiveness to the target population. However, the integration of care under a private SNP model would be accomplished through separate Medicare/Medicaid contracts, a relatively complicated process. This assumes a willing and reliable partner for the state could even be identified.

One option for leapfrogging over this obstacle would be for the state to seek authority from CMS under the Choices for Care waiver to develop a public Special Needs Plan and receive Medicare capitation payments for dually eligible long term care enrollees. The state would directly control both the Medicare and Medicaid capitation dollars.

A state-operated SNP would be without a direct precedent, although there are county-based Special Needs Plans in operation today. Two County-Organized Health Systems in California – the CalOptima program in Orange County and the Health Plan of San Mateo County (HPSM) – operate SNP's for dually eligible beneficiaries. CalOptima and HPSM are not directly operated by their county governments, but both have government representation on their boards and are considered “quasi public” entities. (Conversely, the county-operated long term care plans in Arizona and Wisconsin both declined to seek SNP status following enactment of Medicare Advantage.)

The CalOptima and HPSM programs were granted SNP contracts through the regular application process. One option for Vermont would be to explore establishing a quasi-public entity, with governmental, provider and community representation to oversee a long term care SNP. Alternatively, the state could seek to be directly licensed as a SNP.

If the state pursues the latter course, it may want to seek SNP designation through an amendment to the Real Choices program. One potential advantage of such an approach would be to shelter the state from the potential elimination of SNP's following expiration of their legal status in 2009, in the event they are not reauthorized by Congress.

Rather than hire state employees to perform plan administrative functions, AHS could retain a third party administrator to process enrollments, adjudicate claims and perform other back office functions. The state, in conjunction with the administrator, would also subcontract with providers and interdisciplinary care teams for service delivery.

There likely would be several candidates willing to serve as third party administrators on a strict fee basis. The state might be able to find a willing partner to perform TPA duties on a shared risk basis, with payments tied at least partially to performance.

Rating the Model’s Relative Potential (High/Moderate/Low)

Accessibility to Potential Enrollees – High

The state contracts today with long term care providers throughout Vermont and could, as part of selective contracting under a waiver, link continued Medicaid participation to participation in the SNP. Similarly, the state could use its SNP status as a mechanism for subsuming the PACE program, while supporting other provider-sponsored initiatives. This degree of freedom would potentially yield geographic coverage greater than would be achieved under any other model.

Integration of Care – High

As the sole contractor responsible for both Medicare and Medicaid services, the state – through its subcontracts – would be able to effectively integrate services. The state has been building care management expertise through its Chronic Care Initiative (Blueprint for Health) that also could be used as a platform for the SNP’s interdisciplinary teams.

Public SNP through Choices for Care

	<i>Medicare</i>	<i>Medicaid</i>
<i>55 and older</i>	Public SNP through Choices for Care	Public SNP through Choices for Care
<i>Under age 55</i>	Public SNP through Choices for Care	Public SNP through Choices for Care

Flexible Benefits – Moderate

As a managed care entity, the state would have the same flexibility as the private SNP and PACE programs to tailor services to the needs of its enrolled population. This includes offering additional benefits to SNP enrollees not available outside of the plan. However, a private organization facing a budgetary shortfall might be able to act more swiftly with respect to managing utilization.

Program Savings – *High*

The public SNP model outperforms all other options on this criterion for two reasons. First, private organizations require a return on investment and contingency funds that together can account for five percent of capitation, or more.

Second, Medicare employs a rate setting methodology for Medicare Advantage plans that yields higher payments in Vermont than occur under fee-for-service (due to the historically low Vermont Medicare fee-for-service claims experience). CMS estimates that, in 2007, Medicare Advantage payments in the state are generating an average of \$62.79 in additional “value” PMPM, as compared to the fee-for-service program.

The differential would be even greater for a Special Needs Plan, whose payment rates under Medicare are risk adjusted. The state would be in the position of receiving higher than historical payments, a portion of which could be shared with providers. The remainder could be reinvested in the program or treated as savings.

Administrative Simplicity – *Moderate*

The public SNP model would potentially be the most challenging to administer, but only if the state chose to directly oversee day-to-day operations. If a third party administrator is used, the administrative burden would be no greater than Model 2, though the nature of the contract would differ.

This model would potentially be advantageous to the state in terms of developing a centralized record and generating the necessary data for effective quality oversight. As the sole contractor, the state would have direct access to both Medicare and Medicaid utilization and expenditure data, and greater leverage with providers than would exist under the other models.

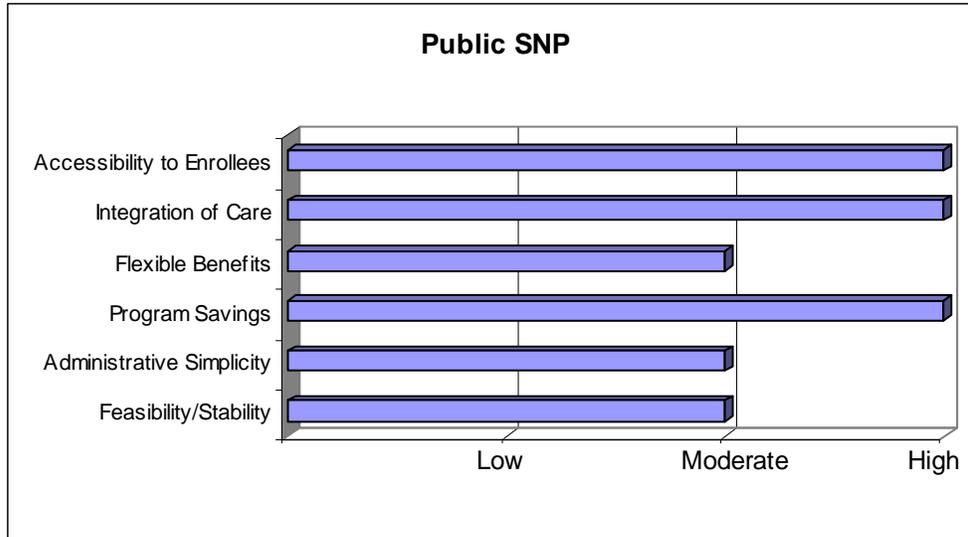
Feasibility/Stability – *Moderate*

The degree of difficulty in developing a public SNP would depend on CMS’ reaction to the state’s proposal. In discussions with CMS representatives over the past two years about the prospects for approval of a state-operated plan, Vermont has received conflicting signals – some inviting and others discouraging. The state does have a precedent in Global Commitment to Health, which treats OVHA as a managed care plan, though for Medicaid benefits only. In Arizona, the state Department of Economic Security serves as the managed care contractor for persons with developmental disabilities, including dual eligibles, but again solely for Medicaid.

The public SNP would presumably operate alongside the PACE program, with individuals living in the PACE service area having a choice of enrollment options. This competitive environment would be less problematic under the public SNP model than the private SNP, since the state would be less in need of quickly ramping up to an actuarially stable enrollment, particularly if the program was part of the larger Choices waiver.

Once the public SNP was in place, its permanence would up to the state. In this regard, it would be the most stable of the four options.

Ratings for the public SNP model are summarized below:



Section 3: Summary Findings/Recommendations

The ratings assigned to the five models are summarized in the table below. Each is viable and relatively strong in one or more categories, with the exception of option 4. However, Model 3 (PIHP First) stands out as the most promising approach, particularly if introduced as a stepping-stone to model 1.

Model 3 affords the state the best opportunity to expand the integrated care model to Vermonters of all ages in a timely fashion. By limiting its scope to Medicaid services, the PIHP First option will have a streamlined implementation process, as outlined in Appendix II of the report. The option also has brighter prospects than most of the other models in terms of potential cost effectiveness and long term stability.

The major drawback of Model 3 is that integration of Medicare benefits will have to occur through means other than merging of capitation dollars. However, since enrollment will be voluntary, the state and PIHP should be able to “market” the program in terms of integration, and use the intake process to educate new enrollees about the importance of coordinating their Medicare and Medicaid benefits.

Ultimately, the state can integrate Medicare funding through the gradual expansion of PACE into areas being served by the PIHP. Adults age 55 and older will transition to PACE, while younger adults will continue to be served by the PIHP unless and until the state is granted authority to enroll adults of all ages into PACE.

Criteria	Model 1 – Stand Alone PACE	Model 2 – PACE/PIHP	Model 3 – PIHP First	Model 4 – Private SNP/PIHP	Model 5 – Public SNP
Accessibility	Moderate	High	High	Moderate	High
Integration of Care	High	High	High	Moderate	High
Flexible Benefits	High	High	High	Moderate	Moderate
Program Savings	Low	Low	Moderate	Low	High
Administrative Simplicity	Moderate	Moderate	High	Moderate	Moderate
Feasibility & Stability	Moderate	Moderate	High	Low	Moderate

Appendix I – Comparison of Federal Requirements for PACE and PIHP Models

Reader Note: This matrix compares contractual requirements for PACE organizations and Prepaid Inpatient Health Plans, as delineated in federal regulations and other guidelines issued by CMS. The matrix is organized in accordance with the 2007 PACE application, as updated to reflect 42CFR Part 460 PACE regulations issued in December 2006. The PIHP requirements have been taken directly from 42CFR Part 438 managed care regulations, except where noted otherwise, and are placed alongside the corresponding PACE sections.

The listing of requirements is not intended to be exhaustive, but rather to capture major contractual components as identified by the federal government. The requirements themselves differ somewhat between the two organizations due to the fact that PACE is a CMS-contracted provider, while the PIHP is treated as a state-regulated administrative entity. Many of the PIHP mandates are therefore directed at the state, in the form of general oversight requirements, rather than at the PIHP itself. States are given leeway in many areas to structure contract requirements in the manner they deem most appropriate for their program. In Vermont’s case, the contractual language could, in many instances, be written to correspond to PACE requirements.

Program Area		PACE Requirements	PIHP Requirements
General Requirements			
1	Non-Profit Status	PACE Organization must be either an entity of city, county, State or tribal government or a private, not-for-profit entity organized for charitable purposes	No federal requirement.
2	Governing Board	Governing body of the PACE Organization must provide oversight of the following functions: <ul style="list-style-type: none"> • Governance and operation. • Management and provision of all services, including the management of subcontractors. • Fiscal operations. • Personnel policies. • Development of policies on participant health and safety. Quality assessment and performance improvement program.	Federal expectation that governing body provide oversight of quality assessment and performance improvement plan contained within quality assurance guidelines.

Program Area		PACE Requirements	PIHP Requirements
3	Advisory Committee	Participant Advisory Committee must be established to provide advice to the governing board on matters of concern to participants	No federal requirement.
4	CMS Sanctions	CMS may impose sanctions (including suspension of enrollment and civil money penalties) if it determines that a PACE organization commits any of the acts delineated in 42CFR460.40, including but not limited to: Substantial failure to provide to a participant medically necessary items and services that are covered PACE services, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the participant; involuntarily disenrolling a participant in violation of federal regulations or discriminating in enrollment or disenrollment.	Equivalent provision for PIHP's.
Administration			
5	Training Program	PACE must establish a staff training program, including specifically for Personal Care Attendants to verify their competency.	See Program Integrity provisions below with respect to PIHP employees. In addition, federal quality assurance guidelines require PIHP to have a credentialing process for practitioners.

Program Area		PACE Requirements	PIHP Requirements
6	Program Integrity	<p>PACE must ensure no employees or contractors have been convicted of criminal involvement in Medicaid, Medicare, other health insurance or health care programs, or social service programs under Title XX of the Social Security Act.</p> <p>Also must have procedures for addressing potential conflicts of interest among board members.</p>	<p>Equivalent provision for PIHP's. In addition, the plan must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The arrangements or procedures must include the following:</p> <ol style="list-style-type: none"> (1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and state standards. (2) The designation of a compliance officer and a compliance committee that are accountable to senior management. (3) Effective training and education for the compliance officer and the organization's employees. (4) Effective lines of communication between the compliance officer and the organization's employees. (5) Enforcement of standards through well-publicized disciplinary guidelines. (6) Provision for internal monitoring and auditing. (7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the PIHP's contract.
7	Oversight of Direct Participant Care	<p>Must have a process for ongoing competency program, background checks, health screening, and credential verification for all direct care staff (employees, contractors and volunteers).</p>	<p>Federal quality assurance guidelines include expectations that practitioners will be credentialed by the PIHP.</p>
8	Physical Environment	<p>Must ensure PACE center is designed, constructed, equipped and maintained to provide for the physical safety of participants, personnel, and visitors including, but not limited to the areas of infection control, emergency readiness, equipment maintenance, transportation safety and dietary services.</p>	<p>Not applicable to PIHP. However, PIHP's are expected to conduct site reviews to provider offices as part of initial credentialing activities.</p>

Program Area		PACE Requirements	PIHP Requirements
Financial			
9	Capitation and Coordination of Benefits	PACE receives Medicare capitation payment from CMS (for dual eligibles) and Medicaid capitation payment from state. Organization integrates funding.	PIHP receives Medicaid capitation payment from state. Plan must coordinate benefits with Medicare, in the case of dual eligibles.
10	Medicaid Capitation and Risk Sharing	The PACE organization must accept the capitation payment amount as payment in full for Medicaid participants and may not bill, charge, collect, or receive any other form of payment from the state administering agency or from, or on behalf of, the participant, except for payment with respect to any applicable spend down liability and any amounts due under the post-eligibility treatment of income.	Medicaid capitation rates must be certified an independent actuary. As part of their payment arrangements, the PIHP and state may enter into an agreement that includes provisions for sharing of financial risk. The structure of any risk-sharing arrangement is left to the discretion of the state and PIHP.
11	Fiscal Soundness	<p>Organization must have a fiscally sound operation, as demonstrated by the following:</p> <ul style="list-style-type: none"> (1) Total assets greater than total unsubordinated liabilities. (2) Sufficient cash flow and adequate liquidity to meet obligations as they become due. (3) A net operating surplus or a financial plan for maintaining solvency that is satisfactory to CMS and the State administering agency. <p>Must also comply with reserve requirements, as established by the state</p>	General rule is that PIHP must meet the solvency standards established by the state for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity. However, the federal government permits states to waive this requirement in the case of a PIHP that does not provide both inpatient hospital services and physician services; is a public entity; is controlled by one or more FQHC's and meets solvency standards established by the state for those centers; or has its solvency guaranteed by the State.

Program Area		PACE Requirements	PIHP Requirements
12	Insolvency Plan	<p>As part of a mandatory insolvency plan, organization must demonstrate that it has arrangements to cover expenses in the amount of at least the sum of the following in the event it becomes insolvent:</p> <ul style="list-style-type: none"> (i) One month's total capitation revenue to cover expenses the month before insolvency. (ii) One month's average payment to all contractors, based on the prior quarter's average payment, to cover expenses the month after the date it declares insolvency or ceases operations. <p>(2) Arrangements to cover expenses may include, but are not limited to, the following:</p> <ul style="list-style-type: none"> (i) Insolvency insurance or reinsurance. (ii) Hold harmless arrangement. (iii) Letters of credit, guarantees, net worth, restricted State reserves, or State law provisions. 	<p>PIHP that is not a Federally qualified HMO (as defined in section 1310 of the Public Health Service Act) must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the PIHP's debts if the entity becomes insolvent.</p>
Marketing			
13	Marketing Materials	Marketing Materials must be approved by CMS and the state.	Marketing materials must be approved by the state in consultation with the Medical Care Advisory Committee.
14	Marketing Practices	PACE must comply with marketing guidelines specified in 42CFR§460.82(e). The guidelines specify prohibited practices, such as door-to-door marketing.	PIHP must comply with similar guidelines specified in 42CFR§438.104. Plans that violate guidelines are subject to sanctioning.
15	Marketing Plan	Must develop a marketing plan with enrollment projections and a system for tracking actual performance.	No federal requirement. However, states typically require marketing plans to be developed in accordance with 42CFR§438.104 guidelines.

Program Area		PACE Requirements	PIHP Requirements
Services			
16	Required Services	Benefit package for dual eligibles includes both Medicare- and Medicaid-covered services. Specifically, it must include, for all members, all services delineated in 42CFR460.92. Benefit package for Medicare enrollees must also include services delineated in 42CFR460.94.	Benefit package includes a subset of Medicaid-covered services only. Specifically, PIHP is defined as organization that provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees and does not have a comprehensive risk contract. The specific menu of covered services is defined by the state.
17	Excluded Services	Excluded services are those listed in 42CFR460.96, as well as any service that is not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service. The exclusion list addresses services typically not covered under Medicaid, such as cosmetic surgery, private inpatient rooms and experimental treatments and drugs.	Excluded services are defined by the state and typically address the same types of services excluded under PACE.
18	Service Delivery	Must have a plan for providing care 24 hours a day, 7 days a week, including an on-call process. Also must have a plan for integrating the participant's care and services across all settings (nursing facility, home, acute care, rehab.).	<p>PIHP must meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services. As part of this, the PIHP must ensure that the network providers: offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees and make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.</p> <p>The PIHP also must establish mechanisms to ensure compliance by providers; monitor providers regularly to determine compliance; and take corrective action if there is a failure to comply.</p>

Program Area		PACE Requirements	PIHP Requirements
19	PACE Centers/Delivery Network	Must document that PACE center location(s) and capacity are sufficient for the service area and expected enrollment.	<p>There are no specific site requirements for the PIHP. Instead, state is responsible for ensuring that the PIHP, through its contracts provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care</p> <p>The PIHP must maintain a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO, PIHP, and PAHP must consider the following:</p> <ul style="list-style-type: none"> (i) The anticipated Medicaid enrollment. (ii) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, PIHP, and PAHP. (iii) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. (iv) The numbers of network providers who are not accepting new Medicaid patients. (v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

Program Area		PACE Requirements	PIHP Requirements
20	Emergency Care	Must have a written plan to handle emergency care, including hold harmless and prudent layperson standard provisions.	Must cover and pay for emergency services (including post-stabilization) regardless of whether the provider that furnishes the services has a contract with the PIHP, as long as the services meet prudent layperson standard provisions or the individual sought care at the PIHP's instruction.
21	Interdisciplinary Team	Must have interdisciplinary team(s) that meet requirements of 42CFR§460.64, comprised of required disciplines (PCP, RN, MSW, Therapists, Dietician, Home Care Coordinator, PCA, Driver, PACE Manager)	<p>Generally, health plans must implement procedures to deliver primary care to and coordinate health care service for all enrollees. These procedures must meet state requirements and must do the following: ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee; coordinate the services the PIHP furnishes to the enrollee with the services the enrollee receives from any other MCO; and share with other MCO's serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.</p> <p>Exception – The regulations specify that in the case of PIHP's, the state may determine, based on the scope of the entity's services, and on the way the state has organized the delivery of managed care services, whether a particular PIHP is required to meet the primary care requirement and implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs.</p>

Program Area		PACE Requirements	PIHP Requirements
22	Participant Assessment	PACE must conduct an initial comprehensive assessment on each participant and promptly consolidate discipline-specific assessments into a single plan of care for each participant.	General requirement is that plans must implement mechanisms for identifying, assessing, and producing a treatment plan for individuals with special health care needs, as identified by the state. However, states may exempt PIHP's from this provision, as discussed above.
23	Women's Health	Must permit female participants to choose a qualified specialist for women's health services from the PACE Organization's provider network to furnish routine or preventive women's health services	Equivalent provisions for PIHP's.
24	Reassessment	Must reassess participants semi-annually, annually, whenever the participants health or psychosocial status changes or at the request of the participant or designated representative. Reassessments must be conducted in accordance with provisions outlined in 42CFR§460.104.	Equivalent provision for PIHP's.
25	Plans-of-Care	PACE must have a process whereby interdisciplinary team members will implement, coordinate, and monitor the effectiveness of the plan of care, whether services are furnished by PACE employees or contractors. The process must address how the interdisciplinary team members will document and update the plan of care in the participant's medical record and will bring the participant or caregiver into the planning process.	At the state's discretion, it may require PIHP's to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring,. The treatment plan must be developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee.
26	Women's Health and other Provider Access Requirements	Must permit female participants to choose a qualified specialist for women's health services from the PACE Organization's provider network to furnish routine or preventive women's health services	Equivalent women's health provisions for PIHP's. In addition, plan must provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee. Also, PIHP must have a mechanism in place to allow enrollees to directly access a specialist.

Program Area		PACE Requirements	PIHP Requirements
Participant Rights			
27	Bill of Rights	PACE must adopt the CMS-approved participant Bill of Rights.	PIHP must have written policies regarding enrollee rights as specified in 42CFR438.100. The two sets of rights are similar in scope.
28	Explanation of Rights	PACE must have policies and procedures for informing participants of their rights and ensuring they understand those rights, educating staff and promoting participant rights.	Equivalent requirement for PIHP's. States typically require plans to develop handbooks that address enrollee rights, as well as procedures for accessing services etc.
29	Restraints	PACE must have policies and procedures regarding the usage of chemical or physical restraints.	Enrollees must be advised of their rights to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
Grievances & Appeals			
30	Grievances	PACE organization must have a formal written process to evaluate and resolve medical and non-medical grievances (complaints) by participants, their family members, or representatives.	Addressed below. Note that CMS defines grievances for PIHP's to mean both complaints and the overall grievance & appeal system.

Program Area		PACE Requirements	PIHP Requirements
31	Appeals	<p>PACE organization must have a formal written appeals process, with specified timeframes for response, to address non-coverage or nonpayment of a service. The process must be in compliance with provisions of 42CFR460.122 including, but not limited to:</p> <ul style="list-style-type: none"> (1) Timely preparation and processing of a written denial of coverage or payment. (2) Appointment of an appropriately credentialed and impartial third party who was not involved in the original action and who does not have a stake in the outcome of the appeal to review the participant's appeal. (3) Responses to, and resolution of, appeals as expeditiously as the participant's health condition requires, but no later than 30 calendar days after the organization receives an appeal. (4) Continuation of disputed services until issuance of the final determination if participant requests continuation with the understanding that he or she may be liable for the costs of the contested services. (5) Expedited (72-hour) appeals process for situations in which the participant believes that his or her life, health, or ability to regain maximum function would be seriously jeopardized, absent provision of the service in dispute. 72-hour provision can be extended to 14 days under certain circumstances. 	<p>PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the state's fair hearing system. The process must be in compliance with provisions of 42CFR438.408-413, which are equivalent to PACE provisions, though with different timeframes for resolution:</p> <ul style="list-style-type: none"> (1) Disposition of grievances must be within timeframe established by the state that may not exceed 90 days (2) Disposition of standard appeals must be within 45 days (3) Expedited appeals must be resolved within 3 working days. 3 day provision can be extended to 14 days under certain circumstances.
32	Grievance & Appeals Data	Grievance and appeal data must be collected, aggregated, analyzed and trended and included in the QAPI program	The state must require PIHP's to maintain records of grievances and appeals and must review the information as part of the state quality strategy.

Program Area	PACE Requirements	PIHP Requirements
Quality Assessment & Performance Improvement (QAPI)		
33	<p>PACE organization must develop, implement, maintain, and evaluate an effective, data-driven quality assessment and performance improvement program.</p> <p>PACE must have a QAPI, based on clinical practice guidelines and professional practice standards, that describes the methodology the PACE Organization will use to demonstrate improved performance with regard to the following:</p> <ol style="list-style-type: none"> (1). Utilization of PACE services, such as decreased inpatient hospitalizations and emergency room visits. (2). Caregiver and participant satisfaction. (3). Outcome measures that are derived from data collected during assessments, including data on the following: physiological well being, functional status, cognitive ability, social/behavioral functioning, and quality of life of participants. (4). Effectiveness and safety of staff-provided and contracted services, including the following: competency of clinical staff, promptness of service delivery, achievement of treatment goals and measurable outcomes. (5). Non-clinical areas, such as grievances and appeals, transportation services, meals, life safety, and environmental issues. 	<p>The state must have a written strategy for assessing and improving the quality of managed care services offered by all PIHP's. The state must obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final.</p> <p>The PIHP must have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. As part of this plan, at a minimum, the PIHP must:</p> <ol style="list-style-type: none"> (1) Conduct performance improvement projects designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. (2) Submit performance measurement data (3) Have in effect mechanisms to detect both underutilization and overutilization of services. (4) Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. <p>The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's quality assessment and performance improvement program.</p>

Program Area		PACE Requirements	PIHP Requirements
34	Performance Measurement	PACE must ensure that all data used for outcome measures are collected timely and are accurate and complete. Organization must also ensure it meets or exceeds minimum levels of performance, established by CMS and the state, on standardized quality measures which are specified in the PACE program agreement.	PIHP must report the status and results of each project to the state as requested. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
35	Internal QAPI Activities	Organization must: <ul style="list-style-type: none"> (1). Use a set of outcome measures to identify areas of exemplary or problematic performance. (2). Take actions targeted at maintaining or improving care. (3). Incorporate actions resulting in performance improvement into standards of practice for the delivery of care; periodically tracks performance to ensure improvements are sustained over time. (4). Set priorities for performance improvement, and give priority to improvement activities that affect clinical outcomes. (5). Immediately correct any identified problem that directly or potentially threatens the health and safety of a PACE participant. 	Addressed above.

Program Area		PACE Requirements	PIHP Requirements
36	State External Quality Review	No Requirement	<p>The State must review, at least annually, the impact and effectiveness of each PIHP's quality assessment and performance improvement program.</p> <p>In addition, the state's external quality review organization's activities must include: validation of PIHP performance improvement projects required by the state; validation of PIHP performance measures reported during the preceding 12 months; and a review, conducted within the previous 3-year period, to determine the PIHP's compliance with standards for the conduct of performance improvement projects and calculation of performance measures respectively.</p>
37	Committees with Community Input	<p>Organization must establish one or more committees, with community input, to do the following:</p> <ul style="list-style-type: none"> (1) Evaluate data collected pertaining to quality outcome measures. (2) Address the implementation of, and results from, the quality assessment and performance improvement plan. (3) Provide input related to ethical decision making, including end-of-life issues and implementation of the Patient Self-Determination Act. 	No equivalent federal requirement. However, states often mandate establishment of such committees.

Program Area		PACE Requirements	PIHP Requirements
38	Health Information	Organization must establish and maintain a health information system that collects, analyzes, integrates, and reports data necessary to measure the organization's performance, including outcomes of care furnished to participants.	<p>PIHP must collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system. This typically requires submission of data on 100 percent of claims and encounters to the state MMIS.</p> <p>The PIHP also must ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate.</p> <p>The PIHP further must maintain a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.</p>

Program Area		PACE Requirements	PIHP Requirements
Enrollment and Disenrollment			
39	Eligibility Criteria	<p>To be eligible to enroll in PACE, an individual must meet the following requirements:</p> <ul style="list-style-type: none"> (1) Be 55 years of age or older. (2) Be determined by the State administering agency to need the level of care required under the State Medicaid plan for coverage of nursing facility services, which indicates that the individual's health status is comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. (3) Reside in the service area of the PACE organization. (4) Meet any additional program specific eligibility conditions imposed under the PACE program agreement. 	<p>Eligible and excluded populations are defined by the state. The state can restrict enrollment to specific aid categories and age cohorts, such as dual eligibles, certified as nursing home eligible and under age 55.</p>
40	Enrollment Process – Clinical Assessment	<p>As part of the enrollment process, the State administering agency must assess the potential participant, including any individual who is not eligible for Medicaid, to ensure that he or she needs the level of care required under the State Medicaid plan for coverage of nursing facility services, which indicates that the individual's health status is comparable to the health status of individuals who have participated in the PACE demonstration waiver programs.</p> <p>PACE staff must assess the potential participant to ensure that he or she can be cared for appropriately in a community setting and that he or she meets all requirements for PACE eligibility specified in 42CFR460.152.</p> <p>(See also related requirement #22)</p>	<p>The state must implement mechanisms to identify persons with special health care needs to the PIHP, as those persons are defined by the state. These identification mechanisms must be specified in the state's quality improvement strategy and may use state staff, the state's enrollment broker, or the PIHP. (A PIHP serving long term care recipients would be deemed to have an enrollment consisting entirely of persons with special health care needs.)</p>

Program Area		PACE Requirements	PIHP Requirements
Oversight, Data Collection, Record Maintenance and Reporting			
41	Trial Period Reviews	During the trial period, CMS, in cooperation with the State administering agency, conducts comprehensive annual reviews of the operations of a PACE organization to ensure compliance with program requirements.	No specific requirement for annual reviews, other than external quality review activities addressed above. However, states typically do perform such reviews on all managed care plans, at least once per contract cycle (may be less than annual).
42	Post Trial Period Reviews	At the conclusion of the trial period, CMS, in cooperation with the State administering agency, continues to conduct reviews of a PACE organization at least every two years.	See above.
43	Access to Data	Organization must allow CMS and the state administering agency access to data and records including, but not limited to, the following: (1) Participant health outcomes data. (2) Financial books and records. (3) Medical records. (4) Personnel records.	Risk contracts must provide that the state agency and CMS may inspect and audit any financial records of the entity or its subcontractors.
44	Safeguarding and Retention of Records	Organization must establish written policies and implement procedures to safeguard all data, books, and records against loss, destruction, unauthorized use, or inappropriate alteration. Organization must retain records for the longest of the following periods: (i) The period of time specified in State law. (ii) Six years from the last entry date. (iii) For medical records of disenrolled participants, 6 years after the date of disenrollment.	No requirement beyond what is specified in state law.

Appendix II – Model 3 Implementation Tasks and Timeline

Reader Note: This appendix presents a high-level summary of the tasks associated with implementing *MyCare* model 3 (PIHP First). The narrative portion is followed by a twelve-month implementation schedule with estimated start and completion months for each task.

1. **Define PIHP Benefits and Network/Operational Requirements** – The implementation process should begin with the defining of PIHP contractual responsibilities. These include the benefits/services for which it will be capitated, the provider types which must be included in the plan's network and other operational requirements, such as: key staff; enrollment and disenrollment procedures; member services; access standards; care management; utilization review; coordination with Medicare; quality improvement; corporate compliance; grievance and appeals; claims processing; reserve requirements; reporting requirements and performance standards. The standards should be aligned as much as possible with those currently in place for PACE Vermont. They also must conform to Rule 10 requirements for PIHP's, as specified by BISHCA.
2. **Draft PIHP Contract** – Once the PIHP's core responsibilities have been defined, a full model contract will be drafted. The contract will conform to CMS requirements for PIHP's, as outlined in Appendix I.
3. **Provide Infrastructure Development Grant Funds to Prospective PIHPs** – The state has federal funds available that could be distributed to organizations interested in becoming PIHPs, to be used in developing the necessary infrastructure to meet PIHP contractual requirements. Concurrent with publication of PIHP contract specifications, the state can release a Request for Application (RFA) for infrastructure development funds to prospective PIHPs. RFA respondents will be required to submit a plan detailing how grant funds will be used in the development of their PIHP infrastructure, and funds will be released upon approval of the plans.
4. **Develop PIHP Capitation Rates** – The state has existing capitation rates for the Medicaid portion of PACE Vermont. These rates can serve as a starting point for development of PIHP rates, but may have to be adjusted to account for differences in Medicaid benefits, enrolled populations (the PIHP will include adults under age 55), treatment of Medicare cost sharing dollars and any risk/profit sharing arrangements the state chooses to adopt. The rates also must be actuarially certified.
5. **Secure CMS Approval** - The model contract and proposed capitation rates must be submitted to CMS for review and approval. CMS also may require submission of a State Plan Amendment or waiver amendment.

6. **Draft Submission Requirements for Contractors** – Although the state will not be undertaking a competitive procurement, it should require interested contractors to submit information demonstrating conformance with contract requirements. This information should include: provider contracts; policies and procedures; member enrollment and education materials; quality improvement plan; information on key staff; demonstration of claims payment and information system/reporting capacity; and pro forma financial information.
7. **Evaluate Potential Contractor Submissions** – The submitted materials will undergo a desk audit to verify compliance with program operational and financial standards. Any identified issues will be addressed prior to contract execution. The state also will define the contractor’s service area based on the network information submitted.
8. **Execute Contracts** – Once the contractor has demonstrated compliance with program requirements, the contract will be executed. However, enrollment will not commence until the contractor has undergone an on-site readiness review.
9. **Conduct Pre-Operational Readiness Review** – The state will go on-site to verify the contractor has adequate trained staff and capacity to commence operations. Network providers also will be contacted to verify their readiness.
10. **Develop Enrollment Process** – Enrollment and disenrollment policies and procedures will be developed, and enrollment staff trained on these procedures.
11. **Develop Outreach/Enrollment Materials** – The state will develop written materials and web pages devoted to informing potential enrollees about the PIHP option. State workers and enrollment contractor staff also will receive training on the program.
12. **Update Medicaid Management Information System** – The Medicaid Management Information System must be updated to include new enrollment and payment codes for the program.

Implementation Timeline

Task	Start	Finish	Month													
			1	2	3	4	5	6	7	8	9	10	11	12		
1. Define PIHP benefits and network/operational requirements	Month 1	Month 2	█	█												
2. Draft PIHP contract	Month 2	Month 3		█	█											
3. Provide infrastructure development grant funds	Month 2	Month 6		█	█	█	█	█								
4. Develop PIHP capitation rates	Month 2	Month 6		█	█	█	█	█								
5. Secure CMS approval	Month 6	Month 10						█	█	█	█	█				
6. Draft submission requirements for potential contractor(s)	Month 4	Month 6				█	█	█								
7. Evaluate potential contractor submissions	Month 7	Month 8								█	█					
8. Execute contract(s)	Month 9	Month 9										█				
9. Conduct pre-enrollment contractor readiness review	Month 10	Month 10											█			
10. Develop enrollment process	Month 5	Month 8					█	█	█	█						
11. Develop outreach/enrollment materials for potential enrollees	Month 9	Month 12										█	█	█	█	
12. Update the Medicaid Management Information System	Month 7	Month 11									█	█	█	█		
<i>Commence Enrollment</i>	Month 12	Ongoing														█