

Response to Questions for MyCare RFP

Issued November 16, 2007

Written Questions submitted before December 4, 2007 Conference

Question 1) Can the State give us the numbers of persons in 2005 and 2006 that the tables relate to -- especially for tables 16 and 17?

Response: The data is built upon the number of member months, which is already in the Data Book. The Data Book that has been released can be found at: <http://www.ddas.vermont.gov/ddas-projects/hltcip/hltcip-default>. Additional information on the number of unique individuals included in each month is presented in Attachment A.

Question 2) Can the State also give us a range of lowest cost person to highest cost person and the median in addition to the mean which is represented in the tables?

Response: This information is provided in Attachment B.

Question 3) Has there been a decision re what the ratio of nursing home to community based care costs will be?? --especially for persons 18-64 (and are we talking about 18 or 21 as the lower age limit??)

Response: 18 is the lower age limit (not 21). The ratio of nursing home cost to Home and Community Based Service and rate categories, e.g. age, will be determined by the independent actuary, hired by the State.

Question 4) Page number 3 of the Program Agreement #3 states that the provider must agree to use an electronic centralized health record -- it is also referenced later on page 16 -- can you be more specific regarding the costs, linkages and comprehensiveness required (will this include progress notes or will it provide a base for recording assessments only)?

Response: The State is planning on expanding the existing Social Assistance Management System (SAMS) to accommodate this requirement. The SAMS database is an off the shelf software product from Synergy Software (now Harmony, Inc.) of Essex Junction, Vermont. DAIL/DDAS uses SAMS to manage Choices for Care (CFC) and some other programs. It is accessible on the Internet through a secure website called Agingnetwork.com. This website is hosted by Synergy (now Harmony, Inc.) and meets all HIPAA requirements for security. The CFC database in SAMS includes client demographics, enrollments and approved care plans. SAMS action fields can be used to send client-specific messages to other SAMS users. In addition, the OMNIA Assessment is a component of the SAMS database and has the capacity for recording assessments. The State and the MyCare Organization will determine the data context of the form. No system modification is needed.

The Core Planning Team, after extensive research, agreed on the following data elements to be included in a centralized record. Some capacity already exists in SAMS, some will require modifications. The following list identifies data elements to be included in a centralized electronic record for Participants in MyCare.

Data Elements:

1. Participant identifying information, including communication and service accommodations in response to the Participant's disability, and spiritual preference, if any.
2. Documentation of contacts with Participant, family members and persons giving informal support, if any.
3. Participant's goals.
4. A list of Participant's strengths and problems.
5. A summary of the Participant's medical and social history prior to joining MyCare Vermont.
6. Prescribed medications, including dosages and any known drug contraindications that are Participant-specific, and any discontinued medications and the rationale for the discontinuation.
7. Documentation of each service provided, including the date of service, the name of both the authorizing provider and the servicing provider (if different), and how they may be contacted.
8. Multidisciplinary assessments, including diagnoses, prognoses, reassessments, plans of care, and treatment and progress notes, signed and dated by the appropriate provider.
9. Laboratory results, radiology reports and reports from specialists.
10. Documentation about the services being received by the Participant from community agencies that are not part of the Provider Network.
11. Physician orders.
12. Disenrollment agreement, if applicable.
13. Participant's individual advance directives and health care proxy, recorded and maintained in a prominent place.
14. Plan for emergency conditions and Urgent Care, including identifying information about any emergency contact persons.

15. Emergency code list.
16. Allergies and special dietary needs.
17. Activities of Daily Living (ADLs) deficits, if any.
18. HIPAA consent forms regarding who may access Participant's record.

The current SAMS database meets all functional and business process and data needs except for the following new areas needed for data capture:

1. Prescription Medications: (area to hold prescription meds, dosages, etc. and linked to client)
2. Allergies and special dietary needs (area to hold allergies linked to client)
3. Lab reports, x-rays etc. (area to hold images linked to client):
4. Emergency Codes: (area to hold emergency codes linked to client):

The State is responsible for funding the necessary modification to SAMS. The MyCare Organization will need to purchase a subscription fee to the Agingnetwork.com and SAMS license. Below is a table outlining the charges for the subscription and license. Please note all fees are on a yearly basis:

Number of Users	Agingnetwork Subscription Fee	SAMS License Fee	Total
One	\$330	\$200	\$ 530
Two	\$330 x 2	\$200	\$ 860
Three	\$330 x 3	\$200 x 2	\$1390
Four	\$330 x 4	\$200 x 2	\$1720
Five	\$330 x 5	\$200 x 3	\$ 2250
Six	\$330 x 6	\$200 x 3	\$ 2580

If laptops are needed to do assessments while not connected to the Agingnetwork, an additional subscription fee of \$200 per laptop per year would be added.

Question 5) Pages 13 and 14 discuss the Interdisciplinary Care Team (ICT) -- will it be permissible to contract for those positions (NP, MD, MSW/Case manager) from the primary care physician's (PCP) practice?

Response: Yes, the MyCare Organization can contract for positions; the issue is not how people are paid but how they will function as a team. Bidders should be thinking of how this is tied to their business models, and do what makes sense from a business perspective on how the Interdisciplinary Care Team members are reimbursed.

Question 6) On page 24 relating to the required services, Dental is listed and includes dentures. Will this cost be reflected in the capitation since I understand that the coverage from Medicaid is limited?

Response: Dental benefits are a State Plan service with funding limits. There is an appeal process that beneficiaries can utilize to request additional benefits. All dental services funded by Medicaid will be included in the capitation rate. At a minimum, the MyCare organization will be required to fund the same level of Dental benefits as those provided by the State Medicaid program; however, the Organization is encouraged to provide additional medically necessary dental benefits.

Question 7) On page 24 relating to transportation, Escort services are mentioned -- we assume they will be required [to be paid for?] as needed, right? Are Escort services paid through Personal Care through OVHA or under the Waiver? How much does this cost?

Response: The reference to escort services in the draft agreement was in error. In the current Choices for Care Waiver, if an individual needs to be accompanied because of physical, mental or development capacity, this service is provided with personal care or companion hours. The MyCare Organization would be expected to provide personal care or companion hours to meet this need. There is not enough detail in the claims data to identify this item as a separate expense; however the cost of this service is included in the capitation rate.

Question 8) On page 25 [regarding the requirement for translation services] -- is there a history of costs of translation services?

Response: The MyCare Organization will be responsible for the cost of any translation services needed to deliver care. This might include translation for physician visits, personal care services, etc. Translation services are addressed as a rate setting component for administrative costs for the MyCare Organizations. Since translation services are a component of administrative costs, claims history is not available. The State is responsible for providing translation services for individuals during the application process for Choices for Care and Medicaid long-term care. Additional information concerning the State's policy addressing translation services can be found at: <http://humanservices.vermont.gov/policy-legislation/policies/>. Translation services include ASL interpreters for the Deaf and Hard of Hearing population and materials must be available in alternative formats as requested.

Question 9) Page 30 relating to preventive services -- is there a list of required preventive services?

Response: There are two ways the MyCare Organization is responsible for achieving this: 1) the organization is responsible for informing Participants of community resources, and 2) the Team, as part of care plan development, shall assess the individual and develop an individualized care plan that includes prevention activities. At a minimum the Participant will be assessed for tobacco abuse, nutrition, lack of physical activity, excessive alcohol consumption, drug abuse and reduction in range of motion/fall risk.

All prevention programs shall be tailored to the Participant's condition and needs. As a Participant's condition changes over time the prevention program should be modified to reflect changing needs. Please refer to the MyCare Recommendations document, page 22 for additional information.

The definition of medically necessary care (draft Agreement on page 30) includes prevention services as defined in Rule 10 of the Vermont Division of Health Care Administration. The State does not require the use of a specific set of guidelines; however the MyCare Organization as part of the Organization's Quality Improvement plan shall demonstrate that the best practices they have chosen are effective. The MyCare Organization shall consult the Vermont Department of Health's Blueprint Initiative as a reference for best practices in Vermont for clinical guidelines for chronic care and prevention services. Information can be found at: <http://healthvermont.gov/>.

Question 10) Pages 31-33 regarding Consumer/surrogate directed services -- can you describe who is responsible for certification now and how that is reimbursed?

Response: Case Managers from the Area Agencies on Aging or Home Health Agencies are responsible for the certification process. Reimbursement is through fee-for-service Medicaid. The cost of this certification process is included in the calculation of the rate.

Question 11) Pages 47-48 regarding third party payers. Please clarify what data will be required when the Participant utilizes another payer source such as Medicare.

Response: This requirement relates to capitated services the MyCare Organization is providing. If the Participant has other insurance that includes coverage for any of the capitated services, the MyCare Organization is responsible for billing the other insurance. The MyCare Organization is required to report to the State all Participants with third party insurance and payments they receive from this third party insurance. This will not change the capitation payment the Organization receives from the State. This will help the MyCare Organization maximize resources.

Question 12) If a Participant goes to a specialist who bills Medicare, what data will we be required to collect and what if the Participant goes to a specialist without our knowledge?

Response: The MyCare Organization will be required to develop and implement policies and procedures to coordinate all the services provided to a Participant, including the services that are not the fiscal responsibility of the Organization. The Organization shall:

1. Report fiscal and utilization information for all services covered by the capitation payment to the State.
2. Report utilization information for services not covered by the capitation payment to the State.

A sample fiscal report can be found Attachment C. Utilization reporting will be developed through the SAMS database referred to in question 4. It is anticipated that the State will work with the Organization to develop the utilization reports (encounter data).

In addition, the Organization is responsible for providing education to the Participant that is outlined on page 51 of the draft Agreement. The Participant Handbook shall include an explanation of the importance of coordinating Medicare, Medicaid and other third party payers. The goal is to achieve Medicaid and Medicare capitation, so the MyCare Organization needs to develop policies and procedures to reach this outcome.

Additional Questions from Bidders asked at December 4, 2007 Conference

Question 13) The Options for Structuring the MyCare Vermont Integrated Care Model, on page 7 stated the potential savings for PACE is low. A national consultant, Jade Gong, felt that the estimate of possible savings is not accurate. Please comment.

Response: The PACE rate reflects a mix of nursing home and community based services in direct proportion to their size within the long-term care program and is currently discounted at 10%. Since 90% of PACE participants remain in the community and have significantly lower costs than participants in nursing homes, the PACE capitation methodology is beneficial to the PACE Organization.

Question 14) When the CRT waiver case rates were established the State involved the providers in establishing the rates; also the risk was passed on to the Department of Mental Health. Will a PIHP operate the same way?

Response: The CRT managed care structure is not the same as the MyCare managed care structure. Under CRT the Department of Mental Health is the PIHP. The MyCare Organization is the PIHP.

Question 15) We are currently doing our financial proforma based on what we think the rates will be (in the Data Book); will the actual rates be much different?

Response: Pacific Health Policy Group (PHPG) has been involved with this project from the outset. PHPG will work with the actuary to build the data set and the actuary will independently set the rates. Since the data are ready (except for some minor adjustments) the capitation rate for the PIHP should be set within the next two to three months, and the process should be wrapped up by spring 2008. The State does not anticipate much change in the final rate. The data referred to are in the Data Book that has been released and can be found at <http://www.ddas.vermont.gov/ddas-projects/hltcip/hltcip-default>.

Question 16) Can the State also give us a range of lowest cost person to highest cost person and the median in addition to the mean which is represented in the tables?

Response: See response to question 2.

Question 17) Are the costs of consumer/surrogate directed certification in the Data Book?

Response: Yes, costs for consumer and surrogate directed services can be found on page 39 of the Data Book and in Attachment D. See the answer to question 10.

Question 18) Will providers bill MyCare Vermont for crossover claims? How will this be done?

Response: The State has not yet determined how the cross-over claims will be processed. During the development phase the State will work with potential MyCare Organizations to finalize this issue.

Question 19) The Draft Provider Agreement (page 28) states: “Provide or provide coverage of counseling or referral services as deemed medically necessary; however, the Provider is not required to do so if the Provider objects to the service on moral or religious grounds.” What does this mean?

Response: CMS allows managed care organizations to elect to not cover certain services on religious or moral grounds. Any MyCare Organization electing not to cover services based on religious or moral grounds would need to inform the State during the contract negotiation process.

Question 20) What is a “Positive Work Culture”?

Response: A detailed explanation of a positive workforce culture can be found in the MyCare Recommendations document on page 59. The goal is to improve the retention and recruitment of the workforce. The basic concept requires the MyCare Organization to conduct a staff assessment, develop a plan to address workforce issues identified in the staff assessment, and implement the plan. As an example, workforce improvement initiatives have been implemented in some nursing homes and home health agencies in Vermont. This effort is known as the Gold Star program. Information on the Gold Star program is in Attachment E.

Question 21) Timing and available funding and the two-year startup period – need time to raise other dollars to support the first two years of actual operations. Is it true we cannot use grant dollars except maybe for marketing?

Response: Grant funds can be used to support the development of infrastructure and operational capacity for a MyCare Organization. Grant funds cannot be used for direct services. Payments will be made in accordance with the schedule outlined in the RFP.

Question 22) A main concern was expressed about the number of different programs one small population is trying to support. Since capitation is a new shift (in the way DAIL does business), the providers need to know how will the State help them. If MyCare competes with the existing waiver program/CFC, how can enrollment be achieved with PACE and CFC and the new 24-hour in-home program?

Response: The State’s core principles include: person-centered; respect; choice; living well; contributing to the community; flexibility; effective and efficient; and collaboration. To respond to the needs of consumers and to be consistent with the core principles, the

State recognizes the importance of consumer choice and will continue to offer several options to meet these needs. The State acknowledges this presents a challenge, however Organizations should address these challenges as part of their business plan and SWOT analysis that is required in response to this RFP. The State firmly believes in the value of MyCare; however, it will be the responsibility of the Organization to effectively market that value to the consumer.

Question 23) Another concern: there's a clear choice between PACE and CFC (Choices for Care), but MyCare Vermont is not differentiated from CFC clearly enough to attract market share. It (MyCare model) is certainly more cumbersome for providers and possibly for families.

Response: This model has worked successfully in Pennsylvania. Initially in Pennsylvania PACE organizations were PIHP (or pre-PACE) before they became PACE organizations. The State has had several discussions with staff from Pennsylvania to understand how this model works. Staff from Pennsylvania believe the model of organizations becoming PIHPs and transitioning to PACE is responsible for the successful development of PACE in their state. Pennsylvania surveyed the first four organizations that started as pre-PACE and 3 of the 4 organizations said if they had to do it over, they would start as pre-PACE (PIHP). Below is a list of advantages and disadvantages identified by the state of Pennsylvania for using the pre-PACE model for providers.

Advantages:

- Organizations can build census.
- Organizations can start to serve and receive income for participants while waiting for CMS review and approval.
- Organizations are not at full risk when operation begins.
- Organizations do not have to become a Part D Provider.
- Contract and rates only need approval from regional CMS office.

Disadvantages:

- Pre-PACE organizations operating for more than one year are subject to External Quality Review Organization (EQRO) requirements. In Pennsylvania they piggy-back on the existing contract. This is not applicable if the organization is pre-PACE for less than a year.
- Organizations do not have the advantage of Medicare savings.

Differences for Participants and Families:

Participants will have freedom of choice of Medicare providers; however the PIHP model should not be more cumbersome. It will be the responsibility of the MyCare Organization to develop policies and procedures so coordination of care and flexible services are an advantage to Participants and their families. In addition, if the MyCare Organization has been successful in developing the team approach to care, the transition should be transparent when the conversion from a PIHP to full Medicare and Medicaid capitation is implemented by the Organization.

Additional Resources for PIHP:

<http://www.ahrq.gov/research/nov07/1107RA7.htm>

Three rural case studies: <http://pace.techriver.net/website/download.asp?id=586>

Contact Information for pre-PACE providers:

<http://www.npaonline.org/website/download.asp?id=1740>

Question 24) How will cost share items be dealt with?

Response: The State has not yet determined how cost share items will be addressed. During the development phase the State will work with potential MyCare Organizations to finalize this issue.