



## Summative Evaluation for MyCare Vermont: Vermont's Real Choice Systems Change Grant

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## Table of Contents

### Introduction

Report Purpose.....	1
Background: Integrated Care And Funding Initiatives In Vermont .....	1
Development of MyCare Vermont Project.....	3

### MyCare Vermont Project Description

Project Goals.....	5
Expected Outcomes .....	5
Projected Outcomes .....	5
Project Management .....	6
Project Activities.....	9

### Evaluation Methodology

Questions.....	12
Sources of Information and Data Collection Strategies.....	12

### Results

Project Management .....	14
Objective 1: Develop Model Integrated Care Organization .....	17
Objective 2: Develop Interdisciplinary Team and Single Plan of Care.....	25
Objective 3: Develop a Reimbursement System for Integrated Care Organization .....	29
Objective 4: Develop a System to Improve Services and Supports Provided By Integrated Care Organizations.....	33
Objective 5: Ensure Available Services and Sufficient Workers To Meet Consumers Need and Preferences.....	35
Objective 6: Build Quality Management Systems.....	36

### Stakeholder Interview Results

Project Goals, Development, Management .....	38
Stakeholder Involvement .....	42
Proposed Model .....	46
Potential Provider.....	48
Lessons Learned.....	52
Support for MyCare Model.....	55

### Lessons Learned and Guidance For The Future

Project Feasibility .....	58
Project Planning Process.....	60
Model Elements .....	63

<b>Conclusion</b> .....	64
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Appendix A: Project Timeline.....	65
Appendix B: Interview Questions.....	67

Table of Contents, Cont....

Appendix C: Summary of Interviewees.....	69
Appendix D: Document Content Analysis Questions .....	71
Appendix E: New Planning Grants and Initiatives Related To The Health and Long Term Care Integration Project.....	72

## Executive Summary

### MyCare Project Overview

In September 2004 the federal Centers for Medicaid and Medicare (CMS) awarded Vermont a Real Choices Systems Change grant. The grant was designed to create a system to integrate health and long-term care services and Medicaid and Medicare funding streams for frail elders and adults with disabilities. The project came to be known as MyCare Vermont.

This report presents a summative evaluation of the grant project, with the purpose of identifying lessons that emerge from Vermont's MyCare project experience. The evaluation examines the MyCare project goals; activities and processes intended to achieve those goals; and, the degree to which goals were achieved. It explores the experiences of the many stakeholders involved in the project and their views on project strengths, weaknesses, accomplishments and challenges. The report concludes with lessons learned and resulting recommendations for future efforts within Vermont or other rural states.

Project Goal: The MyCare Vermont Project had one overarching goal: *To create a system change by planning, designing, and implementing systems that integrate funding streams, and integrate acute/primary and long-term care service delivery as an option for frail, chronically ill, and physically disabled adults.*

In order to achieve that goal, MyCare Vermont was designed to culminate with an organization ready to pilot test a new model of integrated care. Over a three year period, numerous stakeholders were engaged in designing key elements of the integrated model; four organizations explored the feasibility of implementing the model; and, two organizations proposed implementation plans. While the planning effort resulted in detailed definitions of and practice guidelines for person centered care, integrated care planning, and centralized comprehensive patient records, in the end, none of the potential organizations were deemed ready to develop an acceptable implementation proposal.

Project Objectives: In order to achieve the overall goal of an integrated model, the project was designed to address six specific objectives as follows:

1. Develop a model integrated care organization
2. Develop a system to improve access to services by using an interdisciplinary team and a single care plan
3. Develop a reimbursement system for integrated care organizations
4. Develop a system to improve services and supports provided by integrated care organizations
5. Ensure that services are available that match consumers' needs and preferences, and sufficient workers are available to provide services
6. Build quality management systems

Project Management: The grant was written by and awarded to the Vermont Office of Health Access (OVHA). In the spring of 2005, several months after the grant award (fall 2004), the Vermont Agency of Human Services (AHS) determined that the grant project should be managed by the Vermont Department of Disabilities, Aging and Independent Living (DAIL). The Project Director met bi-weekly with DAIL's Project Management Team that included the DAIL Commissioner and Deputy Commissioners.

Stakeholder Participation: The project sought to involve stakeholders in designing the integrated model at three different levels. A Core Planning Team (CPT) was created to oversee development of the project, including assessing needed infrastructure and capacity to develop an integrated model. Members of the CPT were chosen for their expertise in finance, information systems, quality management, service delivery, marketing/public relations, and medical care. The CPT met for a full-day every other week from January 2006 through June 2007.

In addition, a Community Advisory Committee (CAC) was organized to involve a broad base of stakeholders. The stated objectives of the CAC were:

- Identify and educate potential service providers
- Advise the CPT in development of the system reform to ensure that the reform meets the unique needs of the community and consumers
- Create community allies

The CAC met sixteen times through the course of the project. CAC members included consumers, consumer advocates, health care providers, long-term care providers, other non-profit service providers, government agencies, and local and state officials.

Community Feedback Partners (CFP): A formative evaluation process was used to solicit representative feedback from potential providers throughout Vermont including:

- Vermont Association of Adult Day Services (VAADS)
- Vermont Association of Professional Care Providers (VAPCP)
- Area Agencies on Aging (five agency directors responded collectively)
- Community Geriatric Group, Department of Community and Family Medicine, Dartmouth Medical School
- Community-based Long Term Care Coalitions (eight groups)

Feedback was solicited four times from the CFP on a range of discrete issues. Responses were recorded and sent onto the Project Director who shared this with the other stakeholder groups.

## Evaluation Methodology

The charge for this evaluation was two-fold:

- Identify lessons learned from the Real Choices, MyCare Vermont project
- Provide guidance on what changes are needed to bring about conditions favorable for implementing an integrated care system for elders and disabled persons in Vermont.

Sources of Information and Data Collection Strategies: The evaluation used two primary sources of information: project documentation and interviews with participants. Project documentation, including meeting minutes and reports, provided an outline of what occurred throughout the project and a description of final decisions reflected in program requirements.

In order to understand the varied view points and observations of the multiple parties engaged in this project, structured interviews were held with Core Planning Team, Community Advisory Committee, and Community Feedback Partner members, Project Management Team members, the Project Director, OVHA staff and leadership, project consultants, Technical Assistance (TA) providers, potential bidders, and actual bidders

### **What's Needed to Successfully Implement the MyCare Model**

The lessons and guidance that emerged from the evaluation findings suggest changes needed to bring about conditions favorable for implementing an integrated care system for elders and people with disabilities in Vermont. These address the following four areas:

- Project Leadership
- Project Feasibility
- Project Planning Process
- Project Model Design and Elements

Project Leadership: The summary of stakeholder interviews, described in the full report, details a strong sentiment that to move MyCare Vermont from conception to implementation requires a visible commitment to and engagement of top level state leadership. Specifically:

- Top agency leadership should be fully aware and actively supportive of large-scale policy proposals and grant applications. In advance of submitting the proposal to CMS, cross agency discussions and agreement regarding where the project will live and be managed are needed to maximize the use of the time allotted under the grant timelines.
- In preparing grant proposals, leadership from all agencies involved, in this case OVHA and DAIL, should partner to articulate a common vision for the project, including the appropriate financing and service delivery models. Consensus among top level leaders and project management is essential for strategic planning and project implementation.
- DAIL leadership should build and engage in pro-active strategies with other agencies, with the Vermont legislature and with the Vermont congressional delegation to gain CMS

approval and/or waivers to implement the significant system change needed for integrated financing and service delivery. Changes involving Medicare, in particular, require strategic approaches to work within existing federal rules and regulations involving top level decision-makers.

- Top level leaders should provide ongoing, clear guidance and active involvement with project management and stakeholders so that those implementing the project effectively use their time to craft meaningful, realistic recommendations that will be supported.

Project Feasibility: The Real Choices grant that was funded was ambitious in its scope. Its success required that many conditions and factors align in just the right way so that an integrated system of service funding and delivery could be executed without undue financial risk to service providers. Information regarding costs was required as were plausible estimates about the size of the target population. Waivers from CMS to implement any of the proposed models were also needed. Additionally a range of resources needed to implement the model had to be available. In essence, the feasibility of the MyCare Vermont model had to be addressed. The evaluation activities have yielded the following suggestions.

- Feasibility assessments should be conducted at different stages to guide decision making, address assumptions, address needed systems development and create incentives, interest and assurances regarding risk management for potential providers.
  - As part of the development of grant applications for integrated systems, an assessment should be conducted to determine the readiness and availability of needed human resources to engage in planning, and needed services to realistically implement the model. What other initiatives are demanding these resources? What other initiatives may be serving the same consumer populations? Specifically, what service and needs gaps will the proposed project fill? How ready and willing are stakeholders to address the problem at this time?
  - As part of the development of the grant application an assessment should be made of the commitment and interest of key leaders to pursue this objective.
  - Once the grant is funded the project should begin by determining what stakeholders, policies, regulations and resources will be needed to implement a Person Centered, integrated approach for elders and persons with disabilities.
  - Early in the project data should be gathered and analyzed to determine the cost and scope of Medicare services that will be demanded and utilized.
  - Early in the project data should be gathered and analyzed to assess the population size required for providers to manage risk.

- Once the above assessments are carried out, key assumptions should be considered and critiqued. For example:
  - Should the model consider making enrollment mandatory versus voluntary?
  - Is there any scenario in which out-of-state and/or for profit provider organizations would be invited to apply? This would require that Vermont be willing to research and identify specific provider organizations with a proven track record that meet clear standards for service delivery.
- Leadership efforts should focus on encouraging and creating incentives for existing Vermont provider organizations to partner within geographic regions in order to implement the MyCare Vermont model and manage financial risk. Future RFPs should require and fund one collaborative bid per region.
- Leadership should consider how and if the state can assume and/or share risk in order for a home-grown model to survive

Project Planning Process: Stakeholder interviews and the document review indicate opportunities for improving the planning and design process to yield maximum benefit and increase the chances of implementing the MyCare Vermont model. This assumes that the feasibility issues noted in the full report are addressed in order to enhance provider interest in implementing the MyCare Vermont model.

- The development of grant objectives and activities should be influenced by engaging input and feedback of key stakeholders – including but not limited to top leadership, potential providers and consumers.
- Project time should be portioned up front and closely monitored to insure that sufficient time is set aside for potential providers to engage in business planning leading to the implementation of a pilot program.
- Project management should devise an alternative, more streamlined method for gaining stakeholder advice. Stakeholder groups should be small enough to function effectively and efficiently, and be proportionally representative of varied groups. One strategy might be to use the existing DAIL Advisory Group to fulfill the advisory feedback role. If a working group is needed, such as the CPT, membership should be expanded to include representation from the medical professions, the insurance and for profit sectors to yield a more balanced, appealing and manageable design.
- Clear, open and consistent lines of communication on all aspects of the project must exist between the Project Director and the Project Management Team. Potential changes in group roles and responsibilities, structure and membership should be jointly considered in terms of potential consequences and impacts on expected project outcomes.

- Advisory stakeholders, many of whom are potential providers should receive clear feedback from project management about how and why their ideas were considered and incorporated or not into the project.
- Clear expectations on consultant roles and responsibilities should be developed and adhered to as part of the project management. The Project Management Team should be actively engaged in supervising the Project Director in all aspects of his/her responsibilities including interaction with contractual consultants.

### Model Elements

- Engage in activities that will create clear and common understandings of the model elements among potential providers and consumers for the purpose of building buy-in and support for implementation.
- Assess existing Long Term Care (LTC) service system elements and system strengths in relation to the proposed MyCare model elements.
  - Identify which elements of the model actually exist, where they are in practice and how effective they are.
  - Identify which elements of the model do not presently exist or where there are gaps, determine reasons why the gaps exist, and identify strategies for addressing gaps.
- Seriously consider if and how differentiated approaches to serving elders and persons with disabilities should be developed. Engage a broader range of consumers and providers that currently serve the two populations in order to adjust elements of the model, if indicated, appropriately.
- Create directives that articulate clear outcomes that providers should be achieving, while allowing them the flexibility and creativity needed to implement the model elements within specific regions and settings. In other words, the MyCare Vermont model should be prescriptive about the participant outcomes expected from implementation of the model, but allow individual provider organizations (including their ICT's with the participant) to determine the best way to implement elements of the model.

## **Conclusion**

While the MyCare Vermont project did not accomplish the critical goal of identifying an organization and establishing a pilot project, several project goals were, in fact, accomplished. Perhaps most important to the stakeholders involved, the project crafted a detailed definition of Person Centered Care and established a set of specific practices for providing Interdisciplinary Care through a team and person centered care planning.

Stakeholders invested enormous time and energy in the MyCare Vermont planning process. Any future effort which draws upon this type of stakeholder investment must carefully consider how to honor input and prudently use this critical Vermont resource.

In the end, it is important to note that the majority of persons involved in and interviewed about the MyCare Vermont effort would support implementation of the model.

## **Introduction**

In September 2004 the federal Centers for Medicaid and Medicare (CMS) awarded Vermont a Real Choices Systems Change grant. The grant was designed to create a system to integrate health and long-term care services and Medicaid and Medicare funding streams for frail elders and adults with disabilities. The project came to be known as MyCare Vermont. The project's activities were designed to culminate in an organization ready to pilot test a new model of integrated care. Over a three year period, numerous stakeholders were engaged in designing key elements of the integrated model; four organizations explored the feasibility of implementing the model; and, two organizations proposed implementation plans. While the planning effort resulted in detailed definitions of and practice guidelines for person centered care, integrated care planning, and centralized comprehensive patient records, in the end, none of the potential organizations were deemed ready to develop an acceptable implementation proposal.

### **Report Purpose**

This report presents a summative evaluation of the grant project, with the purpose of identifying lessons that emerge from Vermont's MyCare project experience. The evaluation examines the MyCare project goals; activities and processes intended to achieve those goals; and, the degree to which goals were achieved. It explores the experiences of the many stakeholders involved in the project and their views on project strengths, weaknesses, accomplishments and challenges. The report concludes with lessons learned and resulting recommendations for future efforts within Vermont or other rural states.

The evaluation was conducted by Flint Springs Associates' senior partners, Joy Livingston and Donna Reback, under contract with the Vermont Department of Disabilities, Aging and Independent Living (DAIL).

### **Background: Integrated Care and Funding Initiatives in Vermont**

Vermont state government has launched a number of initiatives over the past years to promote integration of services and supports. In 2004, the Agency of Human Services (AHS) began an extensive reorganization of departments and divisions with the goal of improving coordination of multiple services received by individuals and families. The Office of Vermont Health Access (OVHA), now a free-standing division within AHS, formerly a division of another department, serves as the state Medicaid Office and therefore plays a key role integrating funding streams. The Department of Disabilities, Aging and Independent Living (DAIL), comprised of the former Department of Aging and Disabilities and the Division of Developmental Disabilities, is responsible for long term care and supports for persons with disabilities and older adults. Recent integration initiatives under the leadership of OVHA and DAIL have included:

- Choices for Care Long Term Care Waiver: In October, 2003 DAIL submitted an application for an 1115 Long-Term Care Waiver to CMS; the waiver was launched in October 2005. The MyCare Vermont grant was awarded in 2004; however it took some time for work to begin in earnest. Choices for Care is designed to equalize entitlement to both nursing home care, and home and community based care for adults with disabilities and elders. Under the existing federal Medicaid system, individuals are entitled to a

nursing home bed, but have to wait for a “slot” to receive home and community based services. Choices for Care allows individuals who can maintain themselves in the community the same entitlement to community based service options as to nursing home care. In July 2006, Choices for Care expanded to include PACE as an option (see below) and a “cash and counseling” option entitled Flexible Choices. This option allows assessed needs to be converted to a cash value for services. The consumer, with assistances from a counselor, may then budget that cash value as they see fit, within broad guidelines, to meet their care needs and support their staying at home. Choices for Care, the Flexible Choices option, along with consumer/surrogate directed options for direct care all contribute to DAIL’s efforts to maximize flexibility and choice for consumers to live in their preferred setting.

- Global Commitment to Health: In October 2005, Vermont implemented another 1115 Waiver granted by CMS. This waiver, Global Commitment, converts OVHA to a public Managed Care Organization (MCO). AHS pays the MCO a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Choices for Care Long-Term Care Waiver, managed separately through DAIL). In October 2007, CMS approved an Amendment to the Global Commitment which allows Vermont to implement the Catamount Health Premium Subsidy Program. The Catamount Plan is a new health insurance product which serves a broader range of uninsured Vermonters than the existing Vermont Health Access Plan (VHAP). VHAP, implemented in 1995 under an 1115 waiver, provides health care coverage to uninsured adults with household incomes below 185% of the federal poverty level. VHAP also includes a prescription drug benefit for low-income Medicare beneficiaries who do not otherwise qualify for Medicaid. Global Commitment, along with VHAP, enables flexible use of Medicaid resources. For example, the state can use flexible payment mechanisms such as case rates, capitation and combined funding streams rather than fee-for-service to pay for services not traditionally reimbursed through Medicaid.
- Vermont Blueprint for Health: This statewide planning initiative, under Vermont Department of Health leadership in collaboration with OVHA, DAIL, the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), and the Governor’s Office, seeks to provide Vermonters who have chronic conditions with the information, tools and support they need to successfully manage their health. Initially launched in 2003 by the Governor, the legislature appropriated funds to support the project in 2006. Project activities include advocacy for public policies that support healthy lifestyles and effective health care; self-management tools for individuals; improved health care information systems (including the Chronic Care Information System to give medical professionals information for evidence-based care); and, coordinated approaches by health system organizations including insurers, state government, and health-care organizations.
- Care Coordination Program: Under OVHA leadership, this program provides intensive case management to Medicaid beneficiaries with chronic conditions and highest utilization of services. Persons are selected for the program based on claims data and in collaboration with their primary care provider. Regional Care Coordination teams, including a Registered Nurse and social worker, work with the beneficiary, their

providers, community based organizations, and state entities to develop and implement a care plan. Primary care providers are reimbursed with an enhanced capitated monthly rate to serve as the “medical home.” In addition, OVHA reimburses providers on a fee-for-service basis for initial care planning and discharge meetings.

- Vermont Independence Project (VIP): Prior to the MyCare Vermont grant application, OVHA and DAIL collaborated on a private foundation sponsored effort to explore integration of care and funding. The funding allowed Vermont to link Medicare and Medicaid claims data, showing that 43% of Vermont’s Medicaid budget is spent on 10% of the Medicaid population. This population is often “dual eligible,” that is, entitled to both Medicaid and Medicare, and often in need of long-term care and/or living with chronic health conditions. In response to this finding, the Vermont Independence Project established the Care Partner Program to provide a team approach by co-locating Area Agency on Aging (AAA) case managers in primary health care practices. Physicians referred patients to the case managers who then met with individuals in the physician’s office or the patient’s home. Once grant funding ended, two physicians and AAAs continued the program due to its success in coordinating services for elders and adults with disabilities.
- Program for All Inclusive Care for the Elderly (PACE): Following the success of the VIP project, OVHA and DAIL worked with local long term care coalitions and hospitals to bring the PACE model to Vermont. The PACE model includes a primary care provider office within an Adult Day Center. PACE has an interdisciplinary team that closely monitors and manages the care for dual eligibles who participate in PACE. In 2004, the Vermont legislature appropriated \$100,000 for PACE start-up funds. Initially, the goal was for PACE to open its doors in Chittenden County in August 2004. PACE is funded primarily by capitated Medicare and Medicaid payments. However, establishing the private non-profit status and program took considerably longer than planned. PACE Vermont opened its first site in Chittenden County in April 2007. A second site, in Rutland County, opened in February 2008.

### **Development of MyCare Vermont Project**

Several factors contributed to the development of the grant proposal that led to the MyCare Vermont project. OVHA staff members at the time, Joan Haslett and Brendan Hogan, observed that programs serving Vermont’s elders and adults with disabilities did not address both health and long-term care needs. For example, there is no clear mechanism in the Choices for Care for coordination between acute/primary care and long-term care. In addition, feedback from consumers and providers identified this lack of integration as problematic for a number of reasons, including: delays in services needed immediately, failure to approve necessary services; poor follow-through with approved services; poor communications across systems; lack of coordination between health care and community support providers; and, failures to honor consumer choice.

Through their work at OVHA, Joan Haslett and Brendan Hogan had opportunities to attend national conferences and learned about other states’ efforts to address these common consumer and provider frustrations. They were involved in the development of PACE in Vermont.

Specifically they wrote and OVHA received several PACE planning grants from the John A. Hartford Foundation beginning in 2002. They also learned about alternative approaches that could integrate funding streams, provide coordination across medical and long term care, and operate without the limitations of a center-based program for adults 55 years and older that PACE requires. In addition, they observed the positive outcomes of the VIP program that coordinated social supports and medical care, and continued positive outcomes as a result of flexibility allowed by Vermont's 1115 waiver programs.

Based on these observations and knowledge, Haslett and Hogan developed a grant proposal to design a pilot that would integrate funding and types of care (health and long-term) to provide elders and persons with disabilities with comprehensive and coordinated care and supports. The target population for the pilot was individuals with complex medical needs, mainly people who use multiple providers in both health and long-term support systems. In addition, the project was designed to strengthen the role of the consumer in planning and evaluating care.

## **MyCare Vermont Project Description**

The following description of the MyCare Project is based on the original grant proposal to establish an integrated care model in Vermont. Integration was sought in both funding streams (i.e., Medicare and Medicaid) and services (i.e., medical care, long term care, and social services).

### **Project Goals**

The MyCare Vermont Project had one overarching goal: *To create a system change by planning, designing, and implementing systems that integrate funding streams, and integrate acute/primary and long-term care service delivery as an option for frail, chronically ill, and physically disabled adults.*

### **Expected Outcomes**

As a result of achieving the project goal, the following outcomes were expected:

- Projected cost of total care for consumers served under the integrated model will be budget neutral, predictable and controllable.
- The system will promote integrated funding, increased service flexibility, eliminate cost shifting, improve communication and responsiveness, and increase payment flexibility.
- A provider will commit to begin pilot implementation of the integrated model.

### **Project Objectives**

In order to achieve the overall goal of an integrated model, the project was designed to address six specific objectives as follows:

1. Develop a model integrated care organization
2. Develop a system to improve access to services by using an interdisciplinary team and a single care plan
3. Develop a reimbursement system for integrated care organizations
4. Develop a system to improve services and supports provided by integrated care organizations
5. Ensure that services are available that match consumers' needs and preferences, and sufficient workers are available to provide services
6. Build quality management systems

Activities to address each objective were outlined in the original grant, and again identified in semi-annual reports to CMS. These activities are outlined below in the description of Project Activities.

## **Project Management**

Lead Agency: When the grant was written and awarded, the lead agency was OVHA. However, several months after the grant award (fall 2004), in the spring of 2005, AHS determined that the grant project should be managed by DAIL.

Project Management Team: This group was responsible for overseeing the grant. It met twice a month to review recommendations from stakeholders and make policy decisions based on those recommendations. Members included the DAIL Commissioner, DAIL Deputy Commissioners, the Director of the Division of Disability and Aging Services, the Director of the Community Development Unit, the Medicaid Waiver Manager, and the Director of the Information and Data Unit, as well as the Real Choices Project Director. While there was no formal written record of these meetings, what we know and report about their work came from our interviews with team members.

Project Staff: Joan Haslett, the grant co-author, was also the Project Director. When the project moved from OVHA to DAIL, Haslett also moved from OVHA to DAIL. This shift required a change in position, and was not accomplished until May, 2005. Cecile Sherburn served as the project administrative assistant. In addition, Haslett worked with a management team at DAIL which included an OVHA representative. The project called on consultants for key assistance: Scott Whitman, Pacific Health Policy Group, provided assistance with financial analyses; Bailit Health Purchasing provided facilitators and formative evaluators to assist with stakeholder involvement (described below); and Lex Frieden was assigned by CMS as the Technical Assistance provider to the Vermont project.

Stakeholder Participation – Core Planning Team: The project sought to involve stakeholders in designing the integrated model. A Core Planning Team (CPT) was created to oversee development of the project, including assessing needed infrastructure and capacity to develop an integrated model. Specific activities of the CPT were to include:

- Develop care delivery and administration policies and procedures
- Define target populations
- Define how reform will add to rather than detract from what is currently available
- Develop data and reporting requirements
- Define information systems
- Establish reimbursement rates
- Build protocols for care management teams
- Identify provider networks
- Secure contracts with service providers
- Develop how quality will be monitored
- Build awareness in community

Members of the CPT were to bring expertise in finance, information systems, quality management, service delivery, marketing/public relations, and medical care. The management consultants, Bailit Health Purchasing, were selected, and then tasked with assisting the Project Director in recruiting CPT members. CPT members were expected to participate in day long

meetings every other week for at least one year of planning. They were paid for their time. The CPT membership initially included:

- Area Agency on Aging Case Management Supervisor
- Geriatrician and PACE Vermont Medical Director
- Vermont Center for Independent Living (VCIL) Executive Director and an individual with a disability
- Visiting Nurses Association Supervisor
- Pacific Health Policy Group consultant
- OVHA representative
- Consumer representative (added after second meeting due to community input)
- DAIL staff primarily the Project Director and Administrative Assistant

The CPT began to meet in January 2006. The physician and VNA supervisor both worked for agencies that expressed interest in bidding for grant funds to implement the developing model. In January 2007, due to concerns about conflicts of interest, these two members were replaced by another physician and home health representative. At about the same time, OVHA representation changed hands as well.

Meetings of the CPT were facilitated by Bailit consultants; Ginny Felice from January through June 2006, and Marge Houy from August 2006 through the last CPT meeting in June 2007. Cecile Sherburn recorded minutes that were reviewed and revised by the CPT at its regular meetings. Minutes indicate that CPT members all attended meetings on a regular basis; there were few absences.

Stakeholder Involvement – Community Advisory Committee: The Community Advisory Committee (CAC) was organized to involve a broad base of stakeholders. As written in the grant proposal, the stated objectives of the CAC were:

- Identify and educate potential service providers
- Advise the CPT in development of the system reform to ensure that the reform meets the unique needs of the community and consumers
- Create community allies

In addition to these objectives, the CAC provided input to DAIL in the selection of Bailit Health Purchasing as the consulting firm to provide facilitation and formative evaluation services. The CAC also insisted on the inclusion of a non-professional consumer member for the CPT, which led to the selection of an additional consumer member after the first two CPT meetings. This consumer representative was selected from the CAC.

The original plan was for the CAC to meet quarterly; however, at the first CAC meeting members requested more frequent meetings so they could provide timely input on proposals developed in the CPT. The CAC began meeting before the CPT's first meeting and continued for more than a year after the last CPT meeting. The CAC provided input on the selection of the consultants responsible for convening the CPT. The first CAC meeting was held in September 2005, with another in October 2005. During 2006, there were six meetings, five meetings in

2007, and three in 2008. The final CAC meeting was held in June 2008; however, members asked to be reconvened to review results of the summative evaluation after the grant expired. Cecile Sherburn recorded minutes for each meeting.

CAC members were to include consumers, consumer advocates, health care providers, long-term care providers, other non-profit service providers, government agencies, and local and state officials. Appointed members, and those who attended most meetings, included:

- Consumers (11 appointed, including 6 who were also advocates with organizations such as Vermont Center for Independent Living, PACE Vermont, and the Community of Vermont Elders (COVE); of the 11 appointed, 7 regularly attended meetings)
- Advocates (7 appointed who were not also consumers; 3 advocates attended meetings regularly, representing Vermont Legal Aid and Vermont Center for Independent Living (VCIL), and the Vermont Association of Professional Care Providers, (VAPCP) (1)).
- Health care providers (6 appointed, 5 regularly attended representing hospitals (3), physicians (1), and nursing homes and residential care facilities (Vermont Health Care Association) (1))
- Long-term care providers (10 appointed, 7 regularly attended, representing home health agencies (3), AAAs (2) and Adult Day Centers (2).
- Government agencies and officials (1 representative of VA appointed, attended 4 meetings; 1 state legislator appointed, attended one meeting)

Stakeholder Involvement – Community Feedback Partners: A formative evaluation process was used to solicit feedback from stakeholders throughout Vermont. Bailit Health Purchasing contracted with Vermont consultant, Erica Garfin, to conduct this Community Feedback Partner (CFP) process. Twelve groups served as partners, including:

- Vermont Association of Adult Day Services (VAADS)
- Vermont Association of Professional Care Providers (VAPCP)
- Area Agencies on Aging (five agency directors responded collectively)
- Community Geriatric Group, Department of Community and Family Medicine, Dartmouth Medical School
- Community-based Long Term Care Coalitions (eight groups)

Four times throughout the project, the CFPs received concept papers describing CPT recommendations for the project model. The groups also received a structured questionnaire to use in providing feedback about the recommendations. Each CFP was asked to meet and discuss the recommendations, and then complete one summary questionnaire. Erica Garfin would then summarize responses from the CFPs and present the summary to the CAC. The CAC would review the input and report back to the CPT.

In practice, seven or eight of the CFPs responded in each feedback cycle. While three CFPs report meeting to discuss recommendations, four reported that the recommendations were circulated by email and individual members completed the structured questionnaire. CFP coordinators for these groups then summarized responses, often reporting all responses without one consensus opinion.

CFP input was gathered as follows:

- May 2006 – target populations, hopes/concerns for project
- July 2006 – Interdisciplinary Care Team composition and responsibility; centralized comprehensive records; covered services
- December 2006 – Person Centered Care definition; name for project
- June 2007 – Quality Management and Workforce Initiatives

In addition, from April through June 2007, Joan Haslett met with four CFPs to answer questions about and discuss the proposed model.

### **Project Activities**

The project activities included significant planning efforts, as well as several forms of education and technical assistance to support planning; see Appendix A for a timeline of activities and related events. The CPT met bi-weekly from January 2006 through June 2007 to develop recommendations for many aspects of the integration model. The CAC met to review and respond to CPT recommendations; and CFPs provided input on the developing recommendations at four separate junctures. Technical assistance was provided to the CPT and CAC through a variety of presentations on Medicaid and models used in other states.

In addition, DAIL hosted an initial two-day kick-off conference in September 2005; an educational seminar on emerging models for potential providers in December 2006; four educational seminars during summer 2007 for providers interested in developing implementation proposals; and a conference on Person Centered Care in May 2008.

At the suggestion of the CPT, DAIL decided to issue a Planning RFP to potential providers in November 2006. Successful bidders received funds to explore the feasibility of implementing the emerging model and developing a business plan for such implementation. Responses to the initial bid only came from Chittenden County providers, so the RFP was re-issued with active solicitation of bids from underserved areas of the state, specifically the Northeast Kingdom and Southern Vermont. Two additional bids were received, and granted, both from the Northeast Kingdom. DAIL then developed an implementation RFP that was issued in November 2007. This RFP solicited proposals for start-up of a pilot project designed to implement the MyCare Vermont model as designed through the planning process.

In addition to the two RFPs, several documents were produced through the project detailing the emerging model. These included:

- *MyCare Dual Eligibles and Medicaid-Only Populations* (September 2006)
- *MyCare Overview* (November 2006)
- *Options for Structuring MyCare Vermont Integrated Care Model* (September 2007)
- *Recommendations for MyCare Vermont* (November 2007)
- *Preliminary Draft Model Contract* (April 2008)

All of these project activities were designed to achieve specific milestones for each objective, as described in the grant:

*Objective 1: Develop a model integrated care organization to serve frail, vulnerable and chronically ill elders and physically disabled adults.*

1. Define target population – financial and clinical eligibility
2. Develop policies and procedures for administration, care delivery, enrollment, service provider licensure, and legislative changes, risk-based entity licensure.
3. Solicit and select provider organization(s); synthesize information and create business plan for feasibility of creating integrated care organization to serve subset of dual eligible population.

*Objective 2: Develop a system to improve access to services through integrated care organizations by using an interdisciplinary team and a single care plan.*

1. Define core interdisciplinary team members, including consumer and/or family members or other representative appointed by the consumer.
2. Define relationship of primary care provider to the team
3. Define the role of the consumer in planning and evaluating care
4. Define services to be provided by the team and contracted for by the team
5. Develop operation structure to promote collaboration and care integration, and a single care plan to be used by all team members.

*Objective 3: Develop a reimbursement system for integrated care organizations.*

1. Identify and analyze information needed to develop reimbursement system, including Medicaid spending on the target populations; services currently reimbursed by Medicaid in Vermont.
2. Analyze cost shifting from other insurance sources.
3. Research current regulations from CMS for 1115/222 Medicaid/Medicare waiver or Medicare Specialty Needs Plan (SNP), or Part C Medicare Advantage (MA) Plan.
4. Develop Medicaid Capitation Rate.
5. Develop application to CMS for integration of funding and seek approval from CMS as needed/

*Objective 4: Develop a system to improve services and supports provided by integrated care organizations.*

1. Research procedures for creative service delivery approaches, flexible payment rules, and methods to involve consumers in identifying treatment goals.

*Objective 5: Ensure that services are available that match consumer's needs and preferences, and sufficient workers are available to provide services.*

1. Develop policies, procedures, and incentives for team communication and collaboration to allow team members and consumers to make timely decisions regarding service allocation.
2. Develop procedures to nurture and support an effective and highly collaborative interdisciplinary team to increase worker retention and job satisfaction.
3. Develop flexible payment mechanisms that can be used to create incentives for workers to provide needed services.

*Objective 6: Build quality management systems.*

1. Determine what is important to Vermont consumers; review published research on consumer preferences; and interview Vermont and national consumer advocacy groups to determine their priorities on consumer preferences.
2. Develop a definition of consumer-centeredness that is incorporated into every aspect of the program, and design systems to solicit on-going participation from consumers in both planning and evaluation of care and quality services.
3. Develop quality assurance systems, policies and procedures, and develop a guide to be used for initial program development.

As described below, the evaluation methodology involved examining CPT, CAC, and CFP minutes, as well as interviewing the range of stakeholders, to examine how and the degree to which each of these outlined milestones was implemented.

## **Evaluation Methodology**

### **Questions**

The charge for this evaluation was two-fold:

- Identify lessons learned from the Real Choices, MyCare Vermont project
- Provide guidance on what changes are needed to bring about conditions favorable for implementing an integrated care system for elders and disabled persons in Vermont.

In order to address these issues, detailed questions (see Appendix B) were developed to explore issues relative to:

- Project goals, development and management
- Stakeholder involvement
- Proposed model
- Potential provider organizations
- Lessons learned

### **Sources of Information and Data Collection Strategies**

The evaluation used two primary sources of information: project documentation and interviews with participants. Project documentation provided an outline of what occurred throughout the project and description of final decisions reflected in program requirements. The project also involved a wide range of stakeholders and state government participants. Each person came to the project with a different point of view and held different perspectives on the project's goals, activities and accomplishments. As it was important to understand these varied view points, the evaluation conducted structured interviews to gather individuals' observations about the project.

Interviews were requested and held with CPT, CAC, and CFP members, DAIL and OVHA staff and leaders, consultants, TA providers, potential bidders, and actual bidders. Interview questions were selected from the detailed set of questions (as outlined in Appendix B) depending on the interviewee.

Specifically, interviews were conducted with:

- 9 CPT members
- 17 CAC members
- 15 CFP members, representing eight different groups
- 6 DAIL staff
- 2 DAIL Commissioners who served during the project
- OVHA Director
- 4 potential bidders
- 2 organizations that bid on the implementation grant (three persons interviewed)
- 6 consultants

See Appendix C for a complete list of individuals interviewed. Interviews were transcribed and then analyzed using content analysis strategies.

In addition, content analysis was used to evaluate extensive project documentation. This analysis addressed a separate set of questions developed after reviewing interview responses (see Appendix D). These results were then summarized by the six project objectives. Documents reviewed included:

- All CPT meeting minutes and supporting documents
- All CAC meeting minutes and supporting documents
- MyCare Community Feedback Partners Reports (prepared by Erica Garfin)
- MyCare Process Reports (prepared by Bailit Health Purchasing)
- MyCare Project Reports (prepared by Bailit Health Purchasing)
- Options for Structuring the MyCare Vermont Integrated Care Model (prepared by The Pacific Health Policy Group)
- Recommendations for MyCare Vermont (prepared by Joan Haslett)
- Requests for Proposal (Business Planning and Implementation) and proposals submitted for each RFP
- Preliminary Draft Model Contract for MyCare Vermont Integrated Long Term Care Program
- Semi-annual Systems Change Grant Reports to CMS (prepared by Joan Haslett)
- Supporting documents for September 2005 kick-off conference, December 2006 educational seminar, four summer 2007 educational seminars, and May 2008 conference on person-centered care

## Results

### Documentation Review

#### Project Management

CPT Mission and Guiding Principles: The first item of business for the CPT was to draft a statement of Mission and Guiding Principles to guide the work of the CPT. The CPT developed language at its first and second meetings in January and February 2006; then revised and finalized language in April 2006 based on input from the CAC gathered at their February and April meetings. In May 2006, the CAC provided additional feedback on the statement, encouraging future documents to refer to *Vermonters* rather than *consumers* whenever possible, and to mention families. CFP input was not sought on the Mission, however, in June 2006 CFPs were asked to identify hopes and concerns for the project. Several CFP members had difficulty understanding what the project was designed to accomplish. The CFP hopes and concerns were presented to the CAC in June 2006; however, no further discussion of this list is recorded.

Final language for the Mission and Guiding Principles follows:

#### Mission Statement

Design a new integrated health care option that will offer Vermont consumers an alternative to the usual fragmented health care delivery system. This new option will use a person-centered interdisciplinary team approach and a flexible, single plan of care that preserves consumer choice and direction. Choosing this option will offer consumers improved access, service satisfaction, quality assurance and responsiveness. Projected costs for this new option will be budget neutral, predictable and controllable.

#### Definitions:

Integrated health care option: This program will be a partnership between the consumer, the provider organization and State and Federal government and will integrate long-term care and acute care services. Payments from both Medicare and Medicaid are made to an organization (yet to be defined); the organization will be responsible for providing, at a minimum, all services covered by Medicare and Medicaid.

Consumers: Adults with disabilities and elderly Vermonters who are eligible for both Medicare and Medicaid (“dual eligibles”), or are eligible for Medicaid only.

Health care: Preventive, primary, acute and long term care services.

Person-centered: Defining this term is a future task of the group. For the moment the best description identified by the group is the Wisconsin Partnership client's description that "I'm the boss!"

#### Guiding Principles

Client-centered Care: Consumers will be treated with dignity and respect and be active partners in their care. Services should be timely and delivered where and when they are needed. The consumer (and family) will work with an interdisciplinary team to develop a mutually acceptable plan of care.

Coordinated Care: All the people involved with a consumer's care will communicate with each other, balancing the sharing of appropriate information with the consumer's right to privacy. As a result, transitions across care settings (for example from home health to hospital, or hospital to home) will be smooth and coordinated.

Quality of Care: The integrated health care option will ensure quality of care by utilizing best practice standards. Quality of services will be routinely monitored and assessed.

Caregiver Support: The essential role of informal caregivers will be acknowledged and supported.

Integrated Funding: Funding streams for acute and long term care will be integrated to allow more flexibility to purchase services that will enable consumers to live in the least restrictive setting for as long as possible and desired.

Project Name: In May 2006, the CPT began to brainstorm a name for the project. At the joint August 2006 CAC and CPT meeting, the name *MyCare Vermont: A Resource for Independence through Integrated Health Care* was selected. Although by September 2006 DAIL staff informed the CPT that the decision about a name had been made, CFP input was solicited in November 2006 and presented to the CAC in January 2007. The CFP responses were neutral to positive.

Roles and Decision Making Responsibility: DAIL staff also worked with the CPT and CAC to clarify roles and decision making responsibility. The three stakeholder groups were seen as advisory, with final decisions to be made by DAIL. At its February meeting, the CAC requested more frequent meetings so that it might take a more active role reviewing and commenting on the developing model. In April 2006, the Project Director provided a flow chart to clarify that the CPT would be responsible for developing recommendations that would then be shared with the CAC for their input. Some recommendations would then go to the CFPs for input that would come back to the CAC. Input from the CAC and CFPs would then be shared with the CPT which might use this input to further refine recommendations. This process of review might be repeated until a final proposal was submitted to the DAIL Commissioner. The Commissioner was responsible for final decisions. Indeed, at a CPT meeting in October 2006, several concerns were raised about a document under development. The CPT was told that the Project Director would "take concerns and suggestions under advisement."

A contract with Bailit Health Purchasing outlined their role to provide both substantive expertise as well as meeting facilitation services. However, throughout the project, Director Haslett did not always agree with and or utilize Bailit's substantive expertise.

Stakeholders involved in the process are outlined above in the membership of the CPT, CAC, and CFPs. However, it is important to note that throughout the project, both the CPT and CAC discussed the need for additional stakeholders to be involved in the process. The first issue raised in this regard was consumer representation on the CPT. The CAC wanted to include a non-professional consumer in addition to the Executive Director of VCIL who is also a person with a disability. There was a discussion about this at the CAC October 2005 meeting, and then an Interactive Television (ITV) meeting in January 2006 to reach consensus. It was decided that a consumer member of the CAC would also serve on the CPT. The second consumer was added to the CPT in February 2006.

In addition, the CPT went through a significant change in membership in early 2007 when two members were asked to step down from the group in anticipation of potential conflict of interest should their organizations want to submit proposals. Staffing changes at OVHA led to their representative changing. A new member orientation was held in March 2007. Interviewees often noted that this change in CPT membership considerably slowed down the planning process. The conflict of interest issue responsible for the primary membership change was based on the fact that these CPT members were employed by organizations that expressed interest in bidding on the project. Interestingly, in October 2006, there was a discussion at the CPT about adding new members to include potential providers. As of January 2007, the Project Director determined that CPT meetings were confidential so as to ensure no bidder had an unfair advantage. Meeting minutes were no longer published on the MyCare Vermont website. CAC meeting minutes continued to be published so that, as expressed by the Project Director, no organization would have an unfair advantage. DAIL Management Team members noted in interviews that the CPT meetings, as well as the CAC meetings, were public and therefore incorrectly determined to be confidential.

Additional discussion of stakeholder involvement included the following:

- At their first meeting, CPT members noted that an insurer was not represented in the group. DAIL staff noted that an insurer was invited to participate in the CAC, however no insurance representative accepted or served on the CAC.
- In March 2006, CPT members noted that it might be helpful to have more involvement from nursing homes. Mary Shriver, Executive Director of the Vermont Health Care Association, representing Vermont's nursing homes and residential care facilities, did serve on the CAC and regularly attended meetings.
- In April 2006, the CAC heard that Commissioner Flood intended to "assemble a group of physicians to provide feedback" on the developing model. Again, in February 2007, the CPT was told that a group of physicians would be convened. While DAIL did attempt to convene a group, physicians did not express interest, therefore no such group was convened. In May 2008, Susan Wehry, a geriatric psychiatrist under contract to DAIL, presented a "physician's response to MyCare Vermont" at a CAC meeting.
- In order to gather more professional association and organization input, the CPT and CAC were informed, at their joint August 2006 meeting, that DAIL would publish a White Paper describing the project and host a September forum for discussion. The September forum was not held. According to meeting minutes Commissioner Flood determined that sufficient stakeholder input had been received through the CAC process. Interviews with DAIL staff indicate that this decision was made by the DAIL Project Management Team as a whole. A December 2006 educational seminar was held to inform potential providers about the developing model.

Relationship to Other Integration Initiatives: In February 2006 CPT members expressed concerns that "people are feeling inundated with new initiatives from DAIL, and that we need to articulate how this initiative ties in with the others and how it differs from PACE. In response, Joan Haslett produced a document to explain the various initiatives related to MyCare. This

document provided an organizational chart and narrative description (see Appendix E) and was reviewed by the CPT in March and April, subsequently refined by Haslett and posted on the MyCare website. This document was then reviewed with CAC members in April 2006. Concerns about “initiative overload” were expressed by CFPs, particularly in January 2007, and by potential providers during a December 2006 educational seminar. While there was no evidence of specific efforts to integrate efforts across initiatives, there were attempts to provide CPT and CAC members with more detailed information about related initiatives. Specific presentations included a Department of Health presentation on Blueprint for Health to CPT and CAC (August 2006) and an OVHA presentation on its RFP for Care Coordination to CPT (November 2006).

### **Objective 1: Develop Model Integrated Care Organization**

Define target population: The grant had defined the target population as “frail and chronically ill elders and adults with physical disabilities,” a subset of the dual eligible population (that is eligible for both Medicaid and Medicare). However, the CPT, CAC, and CFPs were all engaged in a process to more clearly define the populations to be served by the new model.

The CPT began this process with a review of Medicaid demographic and claims data, information provided by Technical Assistance advisors from several states using integrated models, and a review of the pros and cons of several possible populations at its early 2006 meetings. By April 2006, the CPT developed a document outlining four possible target populations, along with pros and cons for inclusion of each group. The groups included:

1. Elders and persons with disabilities living in the community who are either “dual eligible” or eligible for Medicaid only Long-Term Care (LTC)
2. Elders and persons with disabilities living in institutions who are either “dual eligible” or eligible for Medicaid only Long-Term Care (LTC)
3. Elders and persons with disabilities who live in the community and are “dual eligible” but not eligible for LTC Medicaid or Developmental Services, TBI or CRT Waiver services – also termed “community well”
4. Elders and persons with disabilities who are “dual eligible” or Medicaid eligible (not including LTC Medicaid) and have chronic illnesses or risk factors for chronic illnesses – a subset of “community well”

The CPT initially recommended excluding the group of individuals living in institutions and including the other three groups in the target population. The CAC reviewed the CPT’s recommendations at the April 2006 meeting, after discussing Medicaid financial and clinical eligibility criteria at the February 2006 meeting. The CAC urged the CPT to include persons living in nursing home; Theresa Wood, the DDAS Deputy Commissioner, noted that the nursing home population was already included in the CFC (Medicaid LTC) population. In May, the CPT responded to the CAC input and agreed to recommend inclusion of all four groups. CFP input was received by the CAC in June 2006, also urging inclusion of the nursing home population.

The CAC reported back to the CPT noting that increased target population size would improve financial viability of the model by spreading risk.

In August and September 2006, the CPT reviewed Medicaid only data for persons who were “dual eligible” but not receiving long-term care services, often termed the “community well.” Inclusion of this population, it was noted, would spread the cost and risk to improve financial viability of the model.

At a joint CPT and CAC meeting in October 2006, Commissioner Flood proposed that the target population exclude “community well” persons while also noting that there is a need for a critical mass of consumers and providers for the model to be financially viable. Commissioner Flood noted that the minimum number of persons needed for enrollment to be financially viable had to be determined as well as when it might be possible for MyCare to include the “community well” population. The CPT reviewed population profile data at a February 2007 meeting, however data were available for Medicaid only; Medicare cost and utilization data were not available. Several stakeholders noted during interviews that lack of Medicare data was a significant concern.

The CAC received feedback from attendees of the December 2006 educational seminar that many providers were concerned that the target population would be too small for financial viability. At the June 2007 CAC meeting, members again asked that the target population include all LTC eligible populations; the Project Director noted that “we don’t want to take on too much at least at the outset.”

The November 2006 RFP language defined the target population as “clinically eligible for LTC” while there were still discussions as to whether or not to include “community well.” The Draft Model Contract, completed in April 2008 defines the target population as “Choices for Care (LTC Medicaid Waiver) eligible in the highest/high needs group and able to live in the community,” thus not including either the “community well” or persons living in nursing homes. In this instance, DAIL did not agree to accept the CAC’s recommendation.

Develop policies and procedures: The project was designed to address administrative, care delivery, and enrollment policies and procedures; and to develop needed legislative changes, service provider licensure, and risk based entity licensure. In practice, the primary issues addressed through the planning efforts were as follows:

- Administrative policy: The one aspect of administration that planning addressed was development and use of a centralized comprehensive record to facilitate integrated care planning and delivery. The CPT received TA on records at its April 2006 meeting, discussed possible requirements at the May meeting, and in June 2006 recommended that the model should not require electronic records as this may not be feasible for many providers. In July 2006, the CFPs enthusiastically supported centralized records, and in August 2006 the CAC received that input and agreed. The CPT discussed needed elements to be included in the record in September 2006, and in May 2007 recommended that if a community-based physician were a member of the team, than an electronic record should be required. The Draft Model Contract (April 2008) requires that the

provider “establish and maintain a centralized electronic medical record for each participant...” Minimum requirements for the record are detailed.

In addition, the June 2007 CPT discussion noted that the organization implementing MyCare would need information systems to accommodate the needs of the program (e.g., comprehensive centralized record and financial tracking). Project Director Joan Haslett recommended that DAIL’s information system, the Social Assistance Management System (SAMS) would serve the purpose and organizations should be required to use SAMS. CPT members were concerned that SAMS would not do well tracking financial data, and were hesitant to require use of SAMS. The CPT noted that the selected organization, in order to manage financial risk, should use an automated financial system, which could generate regular reports to provide the organization with a “heads up” before getting into fiscal trouble.

Project Director Haslett pursued the potential use of SAMS as the vehicle for a comprehensive centralized record, developing a proposal for needed revisions to SAMS to allow this use. The proposal required AHS approval to be implemented and did not receive that approval. AHS planned to acquire an electronic health record system for the State mental health hospital and saw the MyCare proposed revisions as a similar effort to develop a medical record. Factors beyond the above also contributed to the decision to not move forward on this front. The effort to use SAMS for MyCare was not pursued further.

- Care Delivery: During the first six months of 2006, the CPT gathered information and discussed program requirements including a decision making process for provision of “flexible services,” defined as alternative services to meet individual’s needs outside of the defined services. The CAC had recommended use of decision standards or criteria for flexible services in April 2006. By June 2006, the document *Services and Integrated Care Team* had been completed, providing definitions of integrated care, detailing members of the Integrated Care Team (ICT), responsibilities of the ICT, and required services, including flexible services and a decision method based on Wisconsin’s Resource Allocation Decision (RAD) tool. The CAC reviewed the RAD in March 2007. The CAC reviewed the document in June and asked the CPT about tracking utilization; the CPT responded that this was a procedure the contractor would be responsible for developing. In August 2006, the CFPs input on the recommendations was received by a joint meeting of the CAC and CPT. The CFPs expressed confusion about many of the required care delivery recommendations and were concerned about the relationship of the ICT with existing teams and the feasibility of team members participating at the required frequent meetings. In January 2007, the CAC began to discuss how to include consumer/surrogate directed care and community-based physicians in the delivery of services; the CAC cautioned against requirements that couldn’t be met in rural settings. In March and June 2007, the CPT also discussed consumer/surrogate directed care and suggested that DAIL give management of this service to the contractor implementing MyCare. This suggestion seems to have been incorporated in Draft Model Contract language.

- Enrollment: Beyond discussions of target populations, there were only three recorded discussions of enrollment policies and procedures, and both addressed the question of voluntary or mandatory enrollment in the MyCare model. Two CPT meetings included this discussion. It was raised at the first CPT meeting at which time the CPT recommended that enrollment be voluntary. Again, in April 2006, the CPT noted that “mandatory enrollment of seniors won’t work in Vermont.” It was noted at a March 2007 CPT meeting that once a person enrolled in MyCare s/he would not be eligible for other Choices for Care (CFC) options. No further discussions of enrollment policies or procedures are recorded. However, the Draft Model Contract, issued in April 2008, does discuss enrollment and disenrollment processes on the state’s part for making a Medicaid eligible participant a member of the provider’s plan. The contract also describes required provider enrollment procedures, and contains instructions for “Initial Assessments and Enrollment,” including the requirement for an enrollment conference once the initial Individual Care Plan has been developed, and includes a sample enrollment agreement.
- Legislative changes: In an April 2007 CPT discussion, it was noted that federal PACE requirements limited services to persons over age 55. Project Director Haslett commented that she would ask the Commissioner to approach Vermont’s congressional delegation to ask CMS for a demonstration project waiving the age limit. In interviews, Haslett reported that she and the Commissioner met with Vermont’s congressional representatives. Haslett believed the meeting was to discuss expanding the age group PACE could serve; however, the Commissioner also discussed changes that would allow the state to directly manage Medicare payments (see discussion below on state as provider). Interviews with DAIL Management Team members indicated that DAIL pursued a change in State law that would facilitate implementation of the PIHP model. Specifically, Vermont passed legislation that provided the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) with discretion in two areas. BISHCA was given authority to waive Certificate of Need (CON) requirements as well as Rule 10 requirements.

Select provider organization: The grant proposed soliciting and selecting one or more provider organizations to assist in developing an integrated care organization. It also proposed to synthesize the data gathered to create a business plan outlining the feasibility of creating an integrated care organization. Work on this aspect of the project occurred at two levels: within the stakeholder advisory groups (CPT, CAC) and the DAIL staff and leadership.

Within DAIL there were different views on the ideal model and provider entity. Joan Haslett, co-author of the grant proposal and Project Director, envisioned developing a “PACE without walls” that could be expanded to serve persons under age 55. She saw this as a viable method to integrate Medicaid and Medicare funding, and services, since the supporting PACE legislation provided regulations to support such integration. Joan reported that she felt it possible to work with CMS to secure the needed demonstration project waiver to allow Vermont to offer PACE without a center and for persons under age 55.

Commissioner Flood, on the other hand, strongly believed that the best model would be for the state to serve as a Managed Care Organization (MCO) responsible for administering Medicare as well as Medicaid funding for the project population. In an interview, the Commissioner said that

he believed Vermont's Choices for Care program "works so well because we manage it, all the savings accrue to our budget." As the MCO, the state would implement the MyCare model either through directly providing services (e.g., the Inter-disciplinary Care Team (ICT)) or through contracts for specific services. The primary vehicles for integration at the outset of the project were Special Needs Plan (SNPs) and PACE. Commissioner Flood was interested in the state serving as the SNP and expressed at stakeholder meetings strong support for a "home-grown" model relying on Vermont non-profit organizations to provide direct services.

It is not clear from meeting minutes what specific directions the CPT and CAC were given on provider organizations and models early in the process. The CPT received TA presentations on various models of integrated care, including types of organizational approaches, during an April 2006 meeting. Discussion of potential provider organizations began in August 2006. At this joint CPT and CAC meeting, there was a brainstorming discussion about the potential entity to implement the model under development. CPT and CAC members suggested building on existing systems by soliciting involvement from Vermont private non-profit organizations able to accept the risks of a capitated system. The stakeholders expressed support for the state serving as the entity and felt it was not appropriate to mandate that specific providers be involved. Earlier at a June 2006 CAC meeting, consultant Michael Bailit, had noted "there is not yet enough data on the integrated services model to compare services between non-profits and for profits." At the September 2006 meeting, CPT members said that an out-of-state organization would be acceptable if it had a local Vermont presence.

At the joint CPT and CAC meeting in August 2006, stakeholders were presented with a white paper that was to be used to gather professional organization and association input and possibly engage potential providers. A meeting to discuss the White Paper with professionals was to be held in September 2006. The meeting was cancelled by Commissioner Flood, who explained at the October joint meeting, that he "wanted to consider federal financing options, and the role of Vermont providers, before going out to stakeholders." In addition, the Commissioner felt that adequate representation of stakeholders was present in the CAC.

Meanwhile, at a joint meeting of the CPT and CAC in October 2006, information was presented on the possible models that an organization could use to implement integrated care. The two primary models presented as viable options were a PACE "without walls" serving adults over age 55 in a non-centered based approach and a Special Needs Plan (SNP) serving adults under age 55. Both models allowed for capitation of Medicaid and Medicare funds. As described below, DAIL, under Commissioner Flood's leadership, had been pursuing the option of the state serving as a Managed Care Organization (MCO) or the SNP. At the joint CAC/CPT meeting, Commissioner Flood reported that it was clear from CMS that state government could not receive Medicare capitation and could not function as a SNP. During this discussion Project Director Haslett provided further explanation of the SNP structures. The Commissioner outlined his vision of creating PACE programs statewide for persons 55 and older, and his intentions to ask CMS to waive PACE requirements that the program be center-based, and create a statewide SNP to serve younger adults with disabilities. Commissioner Flood expressed the hope that a PACE program would be willing to add a SNP line of business, thus serving both populations. CAC and CPT members raised a number of questions about the SNP and PACE models. The group was asked to provide input on the type of community organization that might be able to jointly contract with Medicaid and Medicare, and failing that determine how to create a new

organization. In addition, Commissioner Flood wanted to “determine the minimum enrollment that will be needed for a SNP to be viable.” At this October meeting, the CAC and CPT members recommended that DAIL reach out to insurers such as Blue Cross/Blue Shield or MVP to encourage them to create a SNP. The Project Director noted that the state could not select an entity without an RFP process.

Back at the September 2006 meeting, the CPT recommended that DAIL fund Vermont organizations to conduct feasibility studies to determine if they might be able to implement the developing MyCare Vermont model. The CPT suggested a RFI (Request for Information) rather than an RFP (Request for Proposal) since organizations might not be able to determine if the model was actually feasible. The CPT also suggested issuing one grant for each region to encourage organizations to work together.

By the October meeting, Project Director Haslett presented the CPT and CAC with a draft Planning RFP to provide potential organizations with funds to develop a business plan exploring the feasibility of implementing the MyCare Vermont model. The RFP language was reviewed by the CAC and CPT, with final decisions made by DAIL. The CPT recommended that the RFP not require potential providers to contract with specific organizations such as the Area Agencies on Aging (AAAs), and the RFP did not make this a requirement.

The Planning RFP was issued in November 2006. In December, the project held an educational seminar for potential RFP bidders. The seminar provided information on the SNP and PACE models, business planning and financial solvency for integrated care. Potential providers at the seminar raised questions about the fate of the SNP model since the authorizing legislation would sunset in 2008. Other concerns were also raised: initiative overload, interrelated programs being implemented in silos, and too few potential participants to make MyCare financially viable.

In January, 2007, three Planning Proposals were received, all from the Chittenden County area. DAIL decided to reissue the Planning RFP to the Northeast Kingdom and Southern Vermont. In March 2007, the CPT reviewed the Chittenden County Planning Proposals and submitted recommendations to DAIL. Three bids were accepted from Vermont Managed Care (VMC, affiliated with Fletcher Allen Health Care), PACE Vermont (to serve people age 55 and older), and Vermont Assembly of Home Health Agencies in conjunction with PACE VT (to serve younger persons with disabilities). VMC decided to decline the offered contract choosing not to pursue the business plan. Interviews revealed that VMC’s proposal was predicated on partnering with PACE-VT and an out-of-state, for-profit provider, Enhanced Care, Inc (ECI). PACE was unwilling to partner with a for-profit. VMC’s leadership felt ECI was experienced and equipped to manage the financial risk within the MyCare Vermont service delivery model. Without ECI’s inclusion on the team, VMC decided it would be too risky to proceed and thus withdrew.

By June 2007, DAIL notified the CAC that two Planning Proposals had been accepted from the Northeast Kingdom, one from the Area Agency on Aging for Northeastern Vermont and another from a consortium headed by the Orleans-Essex Visiting Nurses Association and Hospice. Over the course of the summer of 2007, the MyCare Vermont project sponsored four educational seminars to assist the contractors in developing their business plans.

In July 2007, Patrick Flood was promoted to Deputy Secretary of AHS and Joan Senecal was appointed DAIL Commissioner. In August 2007, Brendan Hogan, formally of OVHA, was appointed DAIL's Deputy Commissioner.

In September 2007, Pacific Health Policy Group provided the MyCare Vermont project with a report exploring *Options for Structuring the MyCare Vermont Integrated Care Model*. Up to this point, it appears that the project was looking for entities to operate a Special Need Plan (SNP) and PACE models, possibly out of one organization. The report notes that "Vermont has received conflicting signals" from CMS with regard to a state-operated SNP. At about the same time, DAIL staff learned that CMS was putting a moratorium on funding SNPs. These factors combined, the report recommends use of a Pre-Paid Inpatient Health Plan (PIHP) model for persons under age 55. The PIHP model is often termed "pre-PACE" as it involves capitation of Medicaid services only, not Medicare.

By September 2007 the CPT was no longer meeting. As a result the CPT didn't have a chance to provide input regarding selection of the PIHP model. However, the CAC learned about PIHP at its November 2007 meeting. In a presentation about the PIHP model, Brendan Hogan also provided context for previous uses of PIHP in Vermont, specifically with Vermont's Community Rehabilitation and Treatment (CRT) payments. The state pays local community mental health agencies Medicaid capitation payments that cover all mental health care for CRT clients with severe and persistent mental illness.

At the December 2007 CAC meeting, all four business plan contractors made presentations. CAC concerns raised following these presentations included: lack of sufficient number of potential enrollees, how to address the needs of younger adults with disabilities in a center-based program, and DAIL's long range capitation plans.

While the business planning was underway, the project was developing a second RFP to solicit organizations interested in developing a pilot implementation of the MyCare Vermont model. The CPT began to discuss development of the Implementation RFP at a December 2006 meeting; at the January 2007 CAC meeting the Project Director said the Implementation RFP could not be limited to non-profit bidders and that final decisions on the RFP language would be made by DAIL. The CPT reviewed Implementation RFP language at its meetings in February and March, 2007. The CAC was informed in June 2007 that the goal was to issue an Implementation RFP in the fall. Indeed, in November 2007, the Implementation RFP was issued. The Implementation Planning RFP asked for organizations to develop a pilot using the PHIP and/or PACE model. Any organization was eligible to respond to the RFP, however, the four contractors who had developed business plans were in the best position to do so as the RFP required a business plan. The CAC members, when presented with the RFP raised concerns with the possible gap between grant funds and start-up costs.

In January 2008, two implementation bids were received, both from organizations in the Northeast Kingdom: Northeastern Vermont Area Agency on Aging and Northeast Kingdom Partners (Orleans Essex Visiting Nurses Association and Hospice, Caledonia Home Health and Hospice, North Country Hospital and Health Systems, and Northeast Regional Vermont Hospital). Interviews revealed that PACE-VT decided to not bid on the implementation RFP because of timing. The project was just opening a center in Chittenden County and was about to

launch a center in Rutland; PACE leaders felt that taking on implementation of yet another project would overwhelm its ability to meet its current obligation.

The proposals were reviewed by a team of DAIL staff and each found to have strengths and significant weaknesses. The NEVAAA proposal was stronger on social support and supportive services, while the Partners proposal was strong on home health providers and partnering with hospitals. Neither proposal ultimately addressed who would take on the financial risk. Both parties were unclear about the potential size of the participant market. The Partners' proposal was strongest in understanding the financing and concept of budget neutrality while the NEVAAA proposal demonstrated strength in grasping person-centered services and the value of flexible supportive services. DAIL asked the organizations to develop a single proposal, building on strengths to address weaknesses, but the organizations were not able to come to consensus on a single proposal.

### **Was Objective 1 met?**

- Define target population: Accomplished. Stakeholders defined the target population more broadly than did DAIL.
- Develop policies and procedures:
  - Administrative procedures: Somewhat accomplished – The primary focus among stakeholders was a comprehensive centralized record; the elements were defined but the mechanism was not, nor was there agreement between stakeholders and DAIL on whether to require use of electronic records. Other administrative procedures outlined in the Draft Model Contract were developed by the Project Director.
  - Care delivery policies: Accomplished – Significant stakeholder discussion of care delivery policies including ICT membership and roles, flexible funding decision methods, and scope of services.
  - Enrollment policies: Accomplished – Primarily by the Project Director as outlined in Draft Model Contract. Decision for voluntary enrollment never fully debated.
  - Legislative changes: Federal – Not accomplished – There was never clear consensus on needed changes or development of a strategy to effect changes. State – Accomplished – Vermont passed legislation that provided the Commissioner of BISHCA with discretion to waive Certificate of Need (CON) requirements as well as Rule 10 requirements.
  - Licensure: Not accomplished – An organization to implement the model was not selected so issues of licensure were not addressed.
- Select provider organization: Not accomplished – Although two provider organizations submitted proposals, the DAIL management team felt that neither was adequate and therefore did not select a contractor.

## **Objective 2: Develop Interdisciplinary Team and Single Plan of Care**

This objective aimed to improve access to services through integrated care organizations that would use an interdisciplinary team and a single care plan.

Define Interdisciplinary Team Members: All three advisory groups spent considerable time addressing this specific project task. The CPT began by receiving TA on various models at meetings in April and May 2006. By the end of May 2006, the CPT had proposed the following: the team would be called the Interdisciplinary Care Team (ICT); and, the ICT would be composed of a primary care provider (PCP), a social worker or case manager, and a Registered Nurse (RN). The CPT didn't want to require that a physician serve on the ICT, but agreed that a Nurse Practitioner (NP) or Physician's Assistant (PA) could fulfill the role. By May 2007, the CPT and CAC agreed that the PCP could be a physician (primary provider or specialist) or NP. The Draft Model Contract requires that the ICT include a PCP "who may be a primary care physician, Nurse Practitioner, or specialist." The nurse may be a NP or RN. This reflects CAC input in June 2007, noting that while it may be preferable to have a NP on the ICT, the short supply of NPs makes it more realistic to include RNs on the team.

The ICT member that received the most discussion was the case manager or social worker. To many stakeholders, the professional qualification of this "non-medical" social services coordinator would tip the model toward a more or less medical bent. If the model required involvement of a Master's level Social Worker (MSW), then many felt this would "medicalize" the model. In May 2006, the CPT could not reach consensus on whether this "non-medical" social services coordinator ought to be a Licensed Clinical Social Worker (LCSW). At this point the CPT recommended that the organization implementing the model decide. CFP input from July 2006 and CAC input received in August 2006 indicated that the stakeholders did not want to require that the ICT include a social worker. Indeed, at the joint CAC/CPT August 2006 meeting, Commissioner Flood noted that he didn't think the ICT needed a MSW. The CAC recommended requiring an Area Agency on Aging (AAA) case manager. The CPT agreed and revised its recommendation to be that the social services coordinator be a State-Certified Case Manager whose function was case management not counseling. At the same time, the CPT recommended that the organization implementing the model not be required to contract with AAAs for case management. November 2006 minutes note that the question of whether or not the ICT must use a local case manager was on hold until the Commissioner determined what the AAA role would be in the model. In January 2007, the case management position was still under discussion within DAIL. By May 2007, the CPT recommended that the organization implementing the model be required to contract with an agency providing State-Certified Case Management (CCM), but it was still not resolved as to whether the ICT would include a CCM or MSW. At the June 2007 CAC meeting, however, Joan Haslett advocated for including an MSW on the ICT so that all participants had access to mental health screening. In the end, the Draft Model Contract published in April 2008 specifies that the ICT must include a "Masters-Level Social Worker, thus reflecting a decision made by the Project Director that went against stakeholder advice.

In addition to membership, the advisory groups also considered the roles and responsibilities of the ICT. Over several meetings, the CPT developed a *Services and Integrated Care Team*

document outlining program requirements for ICT membership and functions which was the culmination of about six months worth of discussions. The document was presented to the CAC in June 2006. Based on input from both the CAC, and then from the CFP (July 2006), the CPT continued to revise the ICT program requirements through its last meeting in June 2007. Primary issues of discussion were frequency of ICT meetings (several comments from CFP and CAC members suggested more flexibility and less prescription on the number of meetings, noting that daily meetings would not be financially and practically feasible); relationships between the ICT and other existing teams; and involvement of additional members (e.g., physician specialists, caregivers, direct care workers). In November 2007, *Recommendations for MyCare Vermont* was published which provided a final review of ICT program requirements. The CAC and CPT reviewed this document and provided continued input through spring of 2007. Particular concerns were frequency of ICT meetings, distinguishing the ICT from other Interdisciplinary Teams used by home health, PACE and medical providers; and, continued discussion of ICT membership, particularly the case manager or social worker. The final set of program requirements are set out in the Draft Model Contract which, among many other things, requires the ICT to hold daily morning meetings to provide Participant updates, contrary to stakeholder advice.

Relationship of Primary Care Provider to ICT: All three stakeholder groups wanted MyCare Participants to have the option of keeping their present PCP when enrolling in the program. This meant that the MyCare provider would have to contract with PCPs in addition to directly employing the PCP included on the ICT. Discussions about PCP involvement in the ICT began early in the project and were held at some length at the joint CAC/CPT meeting in August 2006. At that time, members noted that reimbursement rates would have to be adequate to involve community-based physicians or other PCPs in the ICT. In April 2007, the CPT discussed the challenge of involving community-based physicians given low reimbursement rates and suggested exploring relationships with partners such as Federally Qualified Health Centers (FQHC), the University of Vermont (UVM) and Dartmouth Hitchcock Medical Center. At the June 2007 CAC meeting the Project Director shared a document outlining program requirements for community-based physicians to be included in the ICT. Physicians would be required to have web-access, use an electronic patient record, and participate in daily ICT meetings by conference call or in person. The provider organization would be required to develop an adequate reimbursement schedule for community-based physicians. All of these requirements, save participation in daily meetings, are included in the Draft Model Contract. Based on CPT input, rather than requiring the community-based PCP to participate in daily ICT meetings, the Draft Model Contract requires the ICT to include a NP (who may serve in lieu of the RN) and is responsible for regularly updating the community-based PCP.

Consumer role in Planning and Evaluating Care: Consumers' roles and participation were discussed at great length throughout the planning process. Objective 6 on Quality Management included specific attention to developing a clear understanding of consumer-centered care, and resulted in a definition of Person-Centered Care. In this section, the focus will be on the consumer's or participant's role in the ICT and care planning.

As the ICT membership was articulated, from the start, participants were identified as key members. Discussions focused on language that clearly indicated the participant was an equal member of the team; including the use of the term participant rather than consumer. Concern

was also expressed throughout the process that not all participants would want to be fully involved in ICT meetings and discussions. This point was made by the CFPs in their July 2006 input on the ICT.

At an October 2006 CPT meeting, the issue of individual differences in desired level of involvement in the ICT was again discussed. At a November 2006 meeting, the CPT thought it useful to develop a strategy for monitoring participant involvement in the team. In developing person-centered care guidelines, December 2006, the CPT included discussion of the degree to which participants engage in the ICT process. In January 2007, the CPT decided to use the word *participant* rather than consumer to emphasize equal membership in the ICT. Again emphasizing this point, the CPT recommended in May 2007 that program requirement language not just single out participants as needing education on needs and options.

The Draft Model Contract includes several references to participant involvement, including “decisions shall be made jointly by all ICT members, including the Participant and/or family/caregiver designee.” The contract states that “participant participation is considered satisfactory when the individual is participating to the degree he or she desires and at his or her comfort level.”

Define services provided: The planning groups were asked to assist in defining services to be provided beyond those traditionally covered by Medicaid and Medicare. In April 2006, the CPT began to brainstorm a “wish list” of such services to be included in “flexible services.” In the summer of 2006, the CAC and CFPs were able to respond to a written document, *Services and Integrated Care Team*, outlining a proposed scope of services. The CPT had recommended both “flexible services” and “extra services”; both were services not traditionally covered by Medicaid and Medicare. Flexible services were individualized and extra services were program-based and available more broadly to all enrollees (e.g., expanded dental benefits). Input from the CFP indicated confusion with the intended scope of services, including the concept of “extra services.” Both terms are defined specifically in the Draft Model Contract.

Specific services provided to MyCare participants should be identified in the Integrated Care Plan. The CPT outlined elements of the plan in May 2006, and continued to discuss elements of care planning at meetings through 2006 and into 2007. In September, the CPT suggested that the terms be changed from *care coordination* to *individualized care using an interdisciplinary team* to avoid confusion with an OVHA care coordination project. In February 2007, the CPT recommended that care plans include attainable, measureable goals, and in May suggested standards for plans including clearly defined purpose and required elements. The Draft Model Contract requires use of an *Individualized Care Plan* with clearly defined elements. There are guidelines for care planning as well, in conjunction with descriptions of Person-Centered Care.

In March 2007, Commissioner Flood asked the CPT to include consumer/surrogate directed care such as offered through the Choices for Care (CFC) waiver program as part of the MyCare scope of services. The CPT discussed this issue in March and June 2007, as did the CAC in June 2007. At the last CPT meeting in June 2007, members were asked to figure out how to include consumer/surrogate directed services in the model. The CPT recommended that the state transfer its responsibility for oversight of consumer/surrogate directed care to the ICT. The Draft Model

Contract requires that participants have the option of consumer/surrogate directed care, and outlines the provider's responsibility for oversight.

Joan Haslett expressed an interest in the reasons why consumers select consumer/surrogate care at a March 2007 CPT meeting. She then contracted with a research team to survey consumers and their family members. Results of the survey were presented to the CAC at its June 2008 meeting.

Additional service issues addressed by the CPT were related to the specific needs of adults with disabilities. At March and June 2007 meetings, CPT members discussed inclusion of interpreter services and then outlined specific services to include for adults with disabilities.

Develop Operational Structures and a Single Care Plan: The grant proposal included activities toward developing operational structures that promote collaboration and integration, as well as a single care plan to be used by all ICT members. The Bi-Annual report to CMS from the Project Director in May 2008 notes that these activities will not occur because a provider entity was not selected.

### **Was Objective 2 met?**

- Define Interdisciplinary Care Team members: Accomplished – Though team members were defined, the Project Director's final decision to require inclusion of an MSW was counter to the stakeholder recommendation to require a Certified Case Manager. In addition, required ICT meetings defined by DAIL were more frequent than stakeholders recommended.
- Relationship of primary care provider to ICT: Accomplished – Provisions were outlined for keeping the PCP engaged without having to attend daily meetings.
- Consumer role in planning and evaluating care: Accomplished – The Draft Model Contract states that “participant participation is considered satisfactory when the individual is participating to the degree he or she desires and at his or her comfort level.”
- Define services provided: Accomplished – Services beyond those traditionally covered by Medicaid and Medicare were defined and included; specific services provided were to be identified in the Individualized Care Plan.
- Develop operational structures and single care plan: Not accomplished – Did not occur because a provider entity was not selected.

### **Objective 3: Develop a Reimbursement System for Integrated Care Organization**

Research Medicaid Spending, Services Reimbursed by Medicaid, and Cost Shifting from other Insurance Sources: The CPT first received data on Medicaid expenditures for the dual eligible population, based on FY 04 paid claims data, at a March 2006 meeting. These data provided information on spending and type of reimbursed services. Responding to requests for further clarification, the data report was revised by its author, Scott Wittman, and reviewed again at the April 2006 CPT meetings. During the discussion of the Medicaid data, CPT members requested data for Medicare recipients. The CPT was told such data were not available.

The CAC was introduced to regulations regarding Medicaid financial and clinical eligibility at their February 2006 meeting. In April 2006, when reviewing the CPT's outline of potential target populations, the Medicaid demographic and claims data reported by Pacific Health Policy Group was presented to the CAC.

In August, 2006, at a joint meeting of the CPT and CAC, paid claims data were presented for persons receiving LTC services either through home and community based care or nursing home with Medicaid-only coverage. This sub-set represented about 5% of the target population. Minutes do not indicate that these data were discussed.

In March, 2007, the CPT recommended that the Implementation RFP include an appendix providing data on the CFC experience regarding High versus Highest Needs groups to indicate to bidders how large the waiting list has been in prior years. According to the meeting minutes, the Medicaid data used by the project included both the Highest and High Needs groups but since "the two tiers are not tied to claims data we do not know how much the High Needs Group is actually costing".

In November 2007, DAIL produced the *MyCare Vermont Data Book*, which was presented to the CAC and made available to potential Implementation RFP bidders. The *Data Book* provides Medicaid claims data through CFC in FY 2005, sorted by type of service, service setting, dual or Medicaid-only eligibility, and several demographic characteristics. These data were to assist potential organizations to develop proposals and to serve as the baseline for determining actual capitation rates. In response to a CAC question, DAIL staff noted that Medicare costs should be tracked by providers so they know true costs before full capitation with both Medicaid and Medicare occurs.

Minutes do not indicate any detailed discussion of cost shifting at either CPT or CAC meetings. In discussions of the Medicaid data, occasional questions or comments were made about possible cost shifting from Medicare to Medicaid; however, there were not specific data presented or detailed conversations. At the joint August 2006 joint CAC and CPT meeting, Commissioner Flood noted that he wanted to involve Medicare in the model to prevent cost shifting and allow savings to be re-directed to fund services. In May 2007, there was a question asked at a CPT meeting about the financial responsibility of a MyCare provider when other financing sources are available. The group noted that the ICT was responsible for tapping other sources of funding.

Financial Review for Rate Setting and Develop Capitation Rate: The CPT had several discussions that touched on rate setting and capitation, but did not get into any details. For example, during a March 2006 meeting, the CPT reviewed a chart provided by Joan Haslett that outlined the current fee-for-service model, and briefly discussed the differences in an integrated model. In April, 2006, the CPT noted that when setting capitation rates, it would be important to allow for changes in individuals' conditions and circumstances. In May, 2006, the CPT was discussing whether or not to "carve out" unpredictable, high cost services from capitation rates in order to reduce risk for providers. At that time, the CPT received information about models in which the state shared risk. By August, 2006, the CPT and CAC agree that the model must use a capitation system to successfully achieve integration. Input received from the CFP at that point, however, noted confusion about financing and concerns about adequate funding for the developing model. During the August 2006 meeting, the CAC and CPT recommended that DAIL include more information about capitation in the white paper that was to be released to potential providers, including information on responsibility for assuming risk.

In September 2006, the CPT again reiterated the need for a capitation system, reviewed a published article on risk adjustment of Medicare capitation payments, and discussed possible risk sharing models. In October, 2006, the CPT notes that the current reimbursement system presents a barrier to implementing person-centered care. Also, at the October meeting the CPT received a presentation on the Massachusetts model of state risk sharing.

Confusion about capitation, though, remained. In January 2007, the CFP report to the CPT indicated that members of the CFPs did not understand prospective capitated payment. The CPT concluded that there was a need for more community education on financial restructuring and "people need to understand the financial restructuring and reorganization of service delivery will actually make their lives easier." At their March 2007 meeting in a discussion of decision making for flexible services, CAC members also asked for more information on how capitated payments work.

In the final months of the project, Pacific Health Policy Group developed a methodology for determining a capitation rate to be used once a provider organization was identified.

Research Current CMS Regulations and Seek CMS Approval for Integration of Funding:

Meeting minutes indicate that the CPT received TA presentations on various state models early in the planning process, April 2006. However, discussion of CMS waivers (1115/222), Special Needs Plans (SNP) and Medicare Advantage Plans did not occur until the summer of 2006. Prior to that time, discussions were going on within DAIL, as described above, exploring the option of the state serving as the MCO.

The first recorded discussion of possible structures for integration under CMS rules was held at the joint CAC/CPT meeting in August 2006. At this meeting, Commissioner Flood reported that CMS would not allow the state to serve as the MCO. He proposed a two tier method to serve two key target populations: PACE for persons over 55 and a SNP for adults with disabilities. In September 2006, the CPT discussed Medicare options including 222 Wavier, SNP and PACE; and discussed Medicaid options including Global Commitment for "community well" dual eligible and CFC for long-term care eligible populations. Although the CPT knew CMS was

unlikely to approve of the state as a SNP, members asked that written documents include the option of the state serving as the SNP.

CPT and CAC met jointly in October 2006, at which time CAC members expressed continued confusion on the SNP and PACE models. The CAC received further training on SNPs, as a subset of Medicare Advantage products, at its January 2007 meeting.

In December 2006, DAIL hosted an educational seminar for potential bidders to provide information on the SNP and PACE regulations and financing structures. In January 2007, the CPT received feedback from the educational seminar attendees who raised concerns about the future of SNPs, noting that the authorizing legislation would sunset in 2008. Consultant Marge Houy noted that there were too many existing SNPs for the legislation to end; the question was whether there would be available federal funding. She said there were basically two models available for capitation: SNP and PACE.

In March 2007, at a CPT meeting, Joan Haslett noted that the MyCare Vermont model would eventually operate under the CFC 1115 Waiver; she expected to have conversations with CMS about implementing MyCare under that waiver. The discussion included a note that the Implementation RFP should clearly state that MyCare participants would no longer be eligible for other CFC options.

The CPT again reviewed requirements for SNPs and PACE models in April and May 2007. In May, the CPT discussed changes that would be needed in PACE federal regulations in order to serve younger adults with disabilities.

At some point following these winter and spring discussions, DAIL staff determined that CMS would no longer be approving implementation of a SNP model, and determined that the best option was the PIHP. This revised approach was presented to the CAC in November 2007, at the same time as the Implementation RFP was issued. CAC members learned that the MyCare model would focus on Medicaid capitation and operate as an option under the CFC program. Members raised concerns about capital needed to bridge the gap between grant funds and start-up costs.

### **Was Objective 3 met?**

- Research Medicaid spending, services reimbursed by Medicaid and cost shifting: Somewhat Accomplished – Medicaid data was available and reviewed by stakeholders, however there were virtually no discussions of how to address cost shifting.
- Financial review for rate setting and developing capitation rate: Somewhat accomplished – A methodology for determining rates is in place, to be applied when a provider organization is selected.
- Research current CMS regulations and seek CMS approval for integration of funding: Somewhat accomplished – Pacific Policy Health Group produced a report outlining possible financing models that could be pursued with CMS. However the state did not

determine a specific model for which to request CMS approval, in part because a potential provider was not selected.

#### **Objective 4: Develop a System to Improve Services and Supports Provided by Integrated Care Organizations**

Develop Guidelines for Creative Solutions for Care: During the first six months of planning, the CPT, with CAC input, developed an approach to providing services beyond those traditionally covered by Medicaid and Medicare. Services which offered creative solutions to individual needs were termed “flexible services” (although, this term seemed to shift between “creative” and “flexible”, finally “flexible” is the term in the Draft Model Contract). As described in the Draft Model Contract, reflecting CPT and CAC input, “flexible services” “shall mean alternative, resourceful ways to meet the Participant’s need that are outside the Medicaid benefit package. These services shall be Participant-specific, culturally appropriate, and fiscally and professionally sound.” The CPT and CAC reviewed a model tool from Wisconsin to guide the decision-making process for determining appropriate and necessary flexible services. This Resource Allocation Decision (RAD) tool was reviewed by the CPT in April 2006, discussed again in May 2006, and then reviewed and discussed by the CAC in March and June 2007; stakeholders were consistently positive in review of the RAD. The Draft Model Contract holds the contractor responsible for developing a decision methodology the ICT can use to determine whether or not to offer flexible services; the RAD is offered as a model.

In addition to flexible services, the CPT, with CAC support, defined “extra services” that an organization could provide as part of MyCare. Extra services, as outlined in the Draft Model Contract, include any service offered to all participants that is not part of existing Medicaid benefits, such as expanded dental care. CFP input from July 2006 suggested confusion on the concept of extra services.

Develop Flexible Payment Rules: Although this was a specific activity outlined in the grant proposal, it did not appear separately in reports to CMS and was not directly addressed in CPT or CAC discussions.

Develop Methods to Involve Consumers in Identifying Treatment Goals: As discussed above in the development of the ICT, the CPT, CAC, and CFPs paid careful attention to the consumer’s role in the ICT and treatment planning process. The CPT discussed the consumer’s role in the ICT throughout 2006 meetings. In fall 2006, as the CPT began to define consumer-centered care, discussions also focused on the degree to which different participants might wish to be involved in their ICT and treatment planning. In November 2006 the CPT recommended developing a method to monitor participant involvement. The draft Person Centered Care Program Requirements (reviewed and revised through January 2007), provide guidelines for assessing consumer involvement and satisfaction with involvement in the ICT. In January 2007, the CPT recommended using the term *participant* to emphasize equal status as a member of the ICT. The CAC continued to review CPT recommendations on participant involvement, suggesting refinements to further insure the equal status of participants. The Draft Model Contract includes much of the language developed by the CPT and CAC.

**Was Objective 4 met?**

- Develop guidelines for creative solutions for care: Accomplished – Guidelines defined flexible services and noted that these shall be participant specific, culturally appropriate, and, fiscally and professional sound.
- Develop flexible payment rules: Not accomplished – There were no documented discussions of this issue.
- Develop methods to involve consumers in identifying treatment goals: Accomplished – The draft Person Centered Care Program Requirements provided guidelines for assessing consumer involvement and satisfaction with the ICT.

## **Objective 5: Ensure Available Services and Sufficient Workers to Meet Consumers' Need and Preferences**

Develop Team Communication and Collaboration for Timely Decisions and Best Practices: CPT and CAC discussions focused on ICT meetings and centralized records (described above under Objective 2) were to address communication and collaboration. The frequency and required participation in team meetings was designed to ensure communication; and, there were concerns often expressed by CAC and CFP members that such requirements were burdensome and unwieldy. Quality assurance strategies (discussed below under Objective 6) were to address implementation of best practices and timely decision making.

In June 2007, at their last meeting, CPT members began to discuss strategies for promoting collaboration and care integration through organizational requirements, specifically key personnel. The CPT members identified key staff to be required (Executive Director, Chief Medical Officer, and Chief Financial Officer) and outlined a set of desirable attributes for each of these key staff members. The Draft Model Contract includes these required staff positions.

Develop Procedures to Nurture and Support an Effective ICT to Increase Worker Retention and Job Satisfaction: Discussion of workforce issues began in a January 2007 CPT meeting. At this meeting, Susan Gordon, Executive Director of the Vermont Association of Professional Care Providers (VAPCP) presented information about a recently completed project, Better Jobs/Better Care, promoting workplace culture change to improve recruitment and retention of direct care workers. In addition, CPT members learned about the Gold Star program employed by Vermont's nursing homes to promote similar culture change efforts, as well as models used in other states. In February 2007, the CPT discussed how to include a culture change "workforce initiative" in the MyCare model, noting that the amount of resources organizations would be able to commit to culture change would be impacted by the numbers of enrollees and financial viability of the effort. In March 2007, Joan Haslett presented a draft of workforce initiative program requirements to the CPT for review. In the same month, the proposed requirements were presented to the CAC; members provided mixed reviews, some felt positively about the requirements, though perhaps unwieldy, others felt the requirements were "micromanaging" the potential contractor. CFP feedback was gathered in June 2007 about familiarity with the Better Jobs/Better Care and Gold Star projects in Vermont. CFP members were somewhat familiar with both initiatives and had mixed reviews on their effectiveness.

The language in the Draft Model Contract requiring a workforce initiative to promote staff retention and high quality performance is relatively the same as the draft presented to stakeholders.

### **Was Objective 5 met?**

- Develop team communication and collaboration: Accomplished – Although there was disagreement between stakeholders and DAIL on the required number of ICT meetings.
- Develop procedures to nurture and support worker retention: Accomplished – The Draft Model Contract requires a workforce initiative to promote staff retention and quality performance.

## **Objective 6: Build Quality Management Systems**

Determine What is Important to Vermont Consumers: The first task assigned to CPT members was to review several Vermont studies and reports outlining consumer preferences and satisfaction with services. The CPT members were asked to identify key messages and discussed these at their second meeting in February 2006. The resulting list of observations informed further planning discussions.

Define Consumer Centeredness and Systems to Solicit On-going Consumer Participation: A good deal of planning time and discussion in fall 2006 and winter 2007 focused on developing and refining a definition for Person-Centered Care (PCC). At an October 2006 CPT meeting, DAIL's Division of Disability and Aging Services presented information about their approach to person-centered care planning. The CPT also received information at that meeting about patient-oriented care.

The CPT first defined PCC in October 2006, and continued to discuss and revise at meetings in November 2006 and January 2007. The CAC reviewed the definition and provided suggestions for revisions in October 2006, January and March 2007. CFP input was received in November 2006, emphasizing the need for quality assurance and quality improvement standards, while minimizing bureaucracy.

The definition of PCC included a set of values and principles underlying PCC and described how person-centered planning should be conducted to develop an Individual Care Plan. Measurement of the provision of PCC, which the CPT outlined, is included in the Draft Model Contract. Although CPT members suggested using the term "biopsychosocial model" to describe the PCC guidelines, the Draft Model Contract does not use that term.

Develop Quality Assurance Mechanisms: In August 2006, the CFP input included recommendations that planning create quality standards for contracted services under the integration model. In January 2007, the CPT began to discuss quality oversight. In February 2007, the CPT heard presentations on quality and value based purchasing, existing DAIL quality management systems; and discussed performance measures, strategies to monitor quality without duplicating DAIL systems, and addressing the capacity limitation of small organizations to perform quality management activities. Joan Haslett presented the CAC and CPT with a draft document outlining quality management program requirements in March 2007. CPT members did not discuss the draft during meetings, and were asked to email suggestions to Joan. The CAC discussed the draft in March 2007 and expressed concern that there were too many data requirements. The CFPs felt the proposed quality management strategy required too many committees and was too burdensome for providers. The CFPs suggested collapsing the required three committees into one committee. The Draft Model Contract continues to require three committees and did not substantially change from draft language presented to the CAC and CPT.

### **Was Objective 6 met?**

- Determine what is important to Vermont consumers: Accomplished – CPT members reviewed Vermont studies and reports outlining consumer preferences and satisfaction with services.

- Define consumer centeredness and systems to solicit ongoing consumer participation: Accomplished – The Draft Model Contract reflects the CPT recommended definition of Person Centered Care and emphasizes the need for quality assurance and quality improvement standards.
- Develop quality assurance mechanisms: Accomplished – While the Draft Model Contract clearly outlines quality assurance standards and mechanisms, these were developed by the Project Director and not fully supported by stakeholders.

## Stakeholder Interview Results

A content analysis of responses to the interviews was conducted. The following section discusses key findings which emerged from the analysis. Because persons interviewed frequently gave more than one response to an interview question, the findings reported reflect the number and proportion of *responses* provided per question. Responses are attributed to and categorized by stakeholder group. Interview questions can be found in Appendix B.

### Project Goals, Development, Management

What were your roles and responsibilities in this project? Members of the DAIL project management team, CPT and CAC, consultants and TA providers were asked this question. The majority of responses indicated an accurate and clear sense of their advisory role (see Table 1). However, no one on the CAC specifically articulated the three stated objectives, which were:

- Identify and educate potential service providers
- Advise the CPT in development of the system reform to ensure that the reform meets the unique needs of the community and consumers
- Create community allies

In addition, none of the CPT members identified building awareness in the community as part of their responsibilities. This was one of the CPT roles articulated in grant materials.

Among CAC members, consumers primarily reported that they were there to design or provide advice on the design of the model. Providers on the CAC reported they were there to represent the interests of their constituencies. Nearly a quarter of the 18 responses from CAC members indicate confusion or a lack of clarity about what they were supposed to do. The document review corroborates that CAC members struggled with their roles, particularly in regard to the degree of influence they wanted to have over the model design. As a result, the CAC successfully lobbied for change on a number of issues including having more meetings and opportunities to provide feedback to the CPT, and having a second consumer seated on the CPT.

**Table 1: Project Goals, Development, Management: Perceived Roles and Responsibilities**

Perceived Roles and Responsibilities	Interview Groups				Total	
	State Staff (n*=9)	CPT (n=9)	CAC (n=17)	Consultants (n=6)	Frequency	Percent
Design model		7	2		9	23%
Represent constituencies		3	5		8	21%
Provide professional TA				7	7	18%
Provide advice			5		5	13%
Unclear/confused			4		4	10%
Facilitate group process/meetings				3	3	8%
Provide “token” advice			2		2	5%
Provide project direction	1				1	3%
Total Number of Responses	1	10	18	10	39	100%

\* In all the following tables, n = the number of individuals interviewed. Note that each individual may have provided multiple responses. Therefore the total number of responses will not necessarily equal the number of persons interviewed.

What did you believe the grant was trying to accomplish? Responses to this question, which are not mutually exclusive, revealed a range of themes of innovations around and/or improvements to services and funding for elders and populations with disabilities (see Table 2). A third of responses specifically identified the implementation of a person-centered, integrated care model as the goal of the project, most of these responses from the CAC. The goal of integrating Medicare and Medicaid funding streams was represented by 12% of responses, primarily from the CPT, the CFPs and consultants. What also stands out as interesting is 12% of responses, primarily state staff, CPT and CFP members, identified the project’s goal to expand PACE-VT. These results indicate the presence of confusion about project goals.

**Table 2: Project Goals, Development, Management: Perceived Grant Goals**

Grant goals	Interview Groups					Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	CFP (n=15)	Consultants (n=6)	Frequency	Percent
Implement new model, PCC/ICT		2	18	2		22	37%
Address Elders/Disabled		3	2		4	9	15%
Expand PACE	3	1		3		7	12%
Integrate M/M funding streams		3		2	2	7	12%
Change/Improve Care	3					3	5%
Get grant funds			2			2	3%
Develop state HMO			1		1	2	3%
Unclear		1	1			2	3%
Other	1	2	2			5	8%
<b>Total</b>	<b>7</b>	<b>12</b>	<b>26</b>	<b>7</b>	<b>7</b>	<b>59</b>	<b>100%</b>

Why did it take about a year from grant award to initiation of grant activities? What happened in that first year? Given the length of the grant period (three year funding, received a one year no-cost extension), the evaluation was interested in understanding why it took nearly a year after the award for grant activity to begin and how that might have impacted the outcomes. This question reveals that while routine bureaucratic processes to gain state approval normally drain some upfront time in the life of a grant, much of the delay was related to negotiations and changes occurring at agency and departmental leadership levels (see Table 3). The document review confirms that it took about six months for the AHS leadership to determine the grant should be housed at DAIL, even though it was awarded to OVHA. Changes in AHS leadership occurring during that time may have further contributed to the delay. One response alluded to the fact that the grant was written without upfront strong commitment from leadership; the DAIL leadership team noted that the time available to write the grant proposal was limited making it difficult to gain commitments. In essence, when the award, which was substantial, was made, it apparently came as a surprise and ignited new attention and interest from leadership regarding where it would be housed and managed.

Throughout the interviews, and as indicated below in Table 20 regarding lessons learned, stakeholders frequently said there wasn't enough time in the project. Aside from normal bureaucratic issues, the decision on where the grant would live dug into available time that could have been allocated to the grant activities.

**Table 3: Project Goals, Development, Management: Time for Project to Start**

Reason Behind Long Time to Start Project Activity	Interview Groups		Total	
	State Staff (n=9)	Consultants (n=6)	Frequency	Percent
Negotiation between agencies	7	1	8	53%
Bureaucratic grant process	4		4	27%
AHS administration and leadership changes	2		2	13%
Not prepared - didn't think VT would get the grant	1		1	7%
Total	14	1	15	100%

How much did CMS rules, regulations, parameters affect the process? Responses from a majority of stakeholders asked this question indicate that the moratorium on SNP's and the PACE age eligibility requirements posed barriers to implementing the model as intended (see Table 4). Recognizing that, it is significant that a fifth of responses, coming from state staff, CAC members and consultants alike, claim that Vermont has a history of effectively advocating for waivers and changes in regulations needed to implement innovations in long term and health care services. These responses reflect the opinion that Vermont could have, but did not, proactively develop and pursue a strategic approach to gaining needed CMS waivers and/or approvals to implement an integrated care model and funding stream for frail elders and adults with disabilities. Finally, one respondent noted that the grant provided insufficient time to develop and implement a strategic approach to getting needed waivers.

**Table 4: Project Goals, Development, Management: CMS Regulations**

Impact of CMS regulations	Interview Groups				Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	Consultants (n=6)	Frequency	Percent
Prohibited state assuming risk	5	3	8	2	18	55%
Posed no barriers	2		3	2	7	21%
Don't know		1	4		5	15%
Took time from project	1	1			2	6%
Not enough time to develop strategic approach	1				1	3%
Total	9	5	15	4	33	100%

## Stakeholder Involvement

What brought stakeholders to the table initially? Given the involvement of so many stakeholders, with diverse responsibilities and perspectives, the evaluation sought to understand why people would participate. Not surprisingly, as shown in Table 5, interest in the elements of the model, developing, designing and impacting the model ranked high (45% of responses, combined). More than a fifth of responses identified participation being driven by the desire to represent and protect the interests of stakeholders’ constituencies another correlate to monitoring and impacting the model design. Both providers and consumers on the CAC said they wanted to be involved on behalf of the organizations and consumers they represented.

Consultants and state staff pointed out that DAIL’s commitment to convening and involving stakeholders in policy and project planning initiative played a role in stakeholder participation.

**Table 5: Stakeholder Involvement: What Brought Stakeholders to the Table?**

Brought stakeholders to the Table	Interview Groups					Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	CFP (n=15)	Consultants (n=6)	Frequency	Percent
Design model	3	3	4	2	4	16	27%
Constituency self-interest		2	11			13	22%
Proposed elements of model		4			7	11	18%
Feedback requested				6		6	10%
Pay/stipends	3	2				5	8%
DAIL commitment to involving stakeholders	1				4	5	8%
Expand PACE			1	1		2	3%
Expand options			2			2	3%
<b>Total</b>	<b>7</b>	<b>11</b>	<b>18</b>	<b>9</b>	<b>15</b>	<b>60</b>	<b>100%</b>

What contributed to stakeholder buy-in, agreement and disagreement for the project and proposed model? The vast majority of comments indicated that there was support for elements of the model; interviewees often reflected that this was “a good idea” (see Table 6). Buy-in and support of the model was less evident when the focus turned from conceptual design to concrete implementation. When conversations turned to implementation issues, several issues emerged that interfered with buy-in and support. Providers were concerned about the model’s feasibility; differed with consumers on what key concepts like person-centered care and integrated care team would actually look like in practice; and, feared the model as designed would compete with their current way of doing business and cut into their consumer and funding bases.

In the course of discussing this question, several individuals noted that over time members of the CPT, CAC and CFP began to lose interest and stopped coming regularly to meetings and providing feedback. Disillusionment began to creep in as stakeholders believed that the model was unrealistic and in the end would not be implemented.

**Table 6: Stakeholder Involvement: Issues Contributing to or Inhibiting Buy-In**

Issues Impacting Buy-In	Interview Groups					Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	CFP (n=15)	Consultants (n=6)	Frequency	Percent
CPT and CAC agree on model elements	3		11	3	3	20	61%
Mixed views on feasibility of model		1		3	1	5	15%
Philosophical differences between consumers & providers	1		2		1	4	12%
Provider fear of model's impact	1		2		1	4	12%
Total	5	1	15	6	6	33	100%

Thinking about how meetings were conducted, to what extent did the meeting process contribute to or detract from the groups' effectiveness? Tables 7 and 8 demonstrate a two-to-one (37 to 18 total responses) overall positive response to the CPT and CAC meeting processes. High marks came for the way meetings were facilitated, the quality of information provided to members, and the attention to participant input. Less than a quarter of responses (from state staff, CPT and CAC members) indicated unhappiness with the consultant facilitation services. Four responses, across all stakeholder groups acknowledged the negative impact that inconsistent attendance and new members coming on late in the process had by requiring time to bring people up to date and slowing down decision making.

**Table 7: Stakeholder Involvement: Positive Views on Meeting Process**

Meeting process: Positive Responses	Interview Groups			Total	
	CPT (n=9)	CAC (n=17)	Consultants (n=6)	Frequency	Percent
Meetings well run & facilitated	7	11	4	22	59%
Quality information provided	5	1		6	16%
CPT worked toward consensus	3	1		4	11%
Good participant input			3	3	8%
Praise for DAIL staff		2		2	5%
Total	15	15	7	37	100%

**Table 8: Stakeholder Involvement: Negative Views on Meeting Process**

Meeting process: Negative Responses	Interview Groups				Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	Consultants (n=6)	Frequency	Percent
Poor facilitation, conflict management	2	1	3		6	35%
Inconsistent attendance & new members slowed progress	1	1	1	1	4	24%
Engaged in unrealistic dreaming, waste of time	1	1	1		3	18%
Absence of needed leadership and direction	1	1			2	12%
CAC too large			2		2	12%
Total	5	4	7	1	17	100%

To what extent did stakeholder input influence the project? Tables 9 and 10 report opinions regarding the degree to which stakeholder input was seen as influential. One third of responses to this question indicate beliefs that stakeholder input did influence the project to some extent. These perceptions varied by stakeholder group. Of the positive responses, nearly half (13) indicate CPT input was very influential, as it pertained to designing the MyCare Vermont model. Fewer responses indicated that the CAC was influential, and one suggested CFP influence.

Of the 74 total responses reflected in Tables 9 and 10, 62% indicated stakeholder input was not influential. Eighteen (39%) of negative responses, coming from all groups except state staff, said that decisions about the model elements, funding mechanisms and so forth, were predetermined. Note that interviews with 15 CFP members yielded 14 responses, all negative responses to the question of influence. CFP responses noted that over time, this led to waning participation in the feedback process. The importance of this should not be lost – CFP members represented the potential MyCare Vermont provider community across the state, and this was another lost opportunity to engage their support and buy-in for the project. Equally impressive is the fact that consultants felt overwhelmingly that input from the CAC, CFP and from themselves as a group had little or no influence.

This is a significant finding, given the time and resources invested in convening, educating, gathering feedback from and reimbursing stakeholders – and invested in contracting with professional consultants to facilitate the CPT and CAC meetings. It leaves open the questions of how effective the planning process was, and how grant resources might have been invested differently to yield a different project outcome.

**Table 9: Stakeholder Involvement: Positive Comments on Influence**

Stakeholder Influence: Positive Comments	Interview Groups					Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	CFP (n=15)	Consultants (n=6)	Frequency	Percent
CPT was influential	3	5	1		4	13	46%
CAC was useful		1	5			6	21%
CPT/CAC influenced each other			4			4	14%
CAC reasonably influential			1		3	4	14%
CFP provided reality check	1					1	4%
Total	4	6	11	0	7	28	100%

**Table 10: Stakeholder Involvement: Negative Comments on Influence**

Stakeholder Influence: Negative Comments	Interview Groups					Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	CFP (n=15)	Consultants (n=6)	Frequency	Percent
Decisions pre-determined		1	9	6	2	18	39%
CAC not influential	1	1			7	9	20%
CFP input not influential				4	2	6	13%
Consultant input not used					3	3	7%
Absence of key groups					3	3	7%
Don't know, nothing happened		3				3	7%
Waste of time		2				2	4%
State's hands tied, not able to respond to input				2		2	4%
Total	1	7	9	12	17	46	100%

## Proposed Model

Questions in this section of the interview explored how well the different stakeholder groups understood the service elements and funding structures being proposed in the model.

What proposals in the model represent new ideas, principles, and structures? What elements of the model are operative in existing programs? Responses showed a near even split on whether the individual elements of the model (Person-Centered Care, Interdisciplinary Care Team, Comprehensive Centralized Record, etc.) were new or present in Vermont’s existing long term care and health programs (see Table 11). The divide indicates, as was heard in interviews, that different individuals, programs and organizations may use these terms and that they carry different meanings. All CPT responses indicated that the model presents new elements or elements that do not currently exist as defined in the model. However, the other stakeholder groups generated from a few to a majority of responses indicating that the elements already exist in some form. State staff tended to agree that the model presented new elements while CAC members more often reported the model elements already exist in some fashion.

**Table 11: Proposed Model: Views on Model Elements**

Model Elements	Interview Groups					Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	CFP (n=15)	Consultants (n=6)	Frequency	Percent
Elements already exist in some way	3		10	5	3	21	41%
New or don't currently exist as outlined in model	8	9	3	4	2	26	51%
Elements desirable			2			2	4%
Not sure if new			2			2	4%
Total	11	9	17	9	5	51	100%

What was your understanding of how budget neutrality would be operationalized? This question generated responses that went beyond the information initially desired. To begin with, more than half the responses indicate that stakeholders had a general understanding of what budget neutrality would actually accomplish (see Table 12). Variations on the theme of “no additional costs” came through in the interviews. However, several respondents felt compelled to comment on the actual feasibility of MyCare Vermont model’s ability to attain budget neutrality. This is where potential providers added their concerns to those of state staff, CPT and CAC members; concerns that the assumptions around the target population (dual eligible, high need) and local implementation would make it impossible to achieve budget neutrality.

**Table 12: Proposed Model: Views on Budget Neutrality**

Budget Neutrality	Interview Groups					Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	Potential Providers (n= 7)	Consultants (n=6)	Frequency	Percent
Define as no higher costs	3	5	12		1	21	55%
Not feasible	1	6	2	2		11	29%
Don't know how to define			6			6	16%
Total	4	11	20	2	1	38	100%

How well did stakeholders and potential providers understand the differences, benefits and challenges of each model (PACE, PIHP, SNP)? It appears from the responses to this question that nearly half of the stakeholders, primarily members of the CAC, did not understand the funding models (see Table 13); one consultant agreed that stakeholders did not have a good understanding of the models. The majority of comments from CPT members indicate that this group had at least a basic understanding of models. Potential providers made one comment that indicated confusion and two that indicated understanding. Despite substantial educational efforts on the part of the project, potential providers lacked sufficient understanding of financing required to successfully manage risk while implementing the service delivery aspects of the model.

**Table 13: Proposed Model: Understanding Funding Models**

Stakeholder Understanding of Funding Models	Interview Groups					Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	Potential Providers (n= 7)	Consultants (n=6)	Frequency	Percent
Confused, not enough time to understand		2	8	1	1	12	46%
Basic understanding	1	1	2	1		5	19%
Differed among participants		1	4			5	19%
Very good understanding		2				2	8%
Explained well by TA providers		1		1		2	8%
Total	1	7	14	3	1	26	100%

## Potential Provider

To what extent did providers understand and agree with the following elements of the MyCare VT model?

- i. *Person-centered care (PCC)*
- ii. *Interdisciplinary Care Team (ICT)*
- iii. *Quality management requirements (QM)*
- iv. *Comprehensive patient record (CPR)*
- v. *Budget neutrality and capacity to manage financial requirements for a fully capitated health care model (BN)*
- vi. *Positive Workplace culture requirements (PWC)*

State staff on the proposal review team and potential providers who bid, or considered submitting proposals, were asked this question. The interviews yielded the following observations (see Table 14). First, while 44% of responses said that aspects of the model were already in practice; conversations with interviewees made it clear that the individual elements were not consistently implemented in the manner intended by the MyCare model. In particular, the understanding of Person-Centered Care varied significantly as did the Interdisciplinary Care Team and quality management requirements. Again, the interviews revealed that different stakeholders and providers held different ideas about what the model elements meant. The findings summarized in this table are similar to those presented in Table 11 (Views on Model Elements) indicating varied levels of understanding about elements in the MyCare Vermont model.

Beyond responses to the intended question, one third of the responses indicated that concerns about about the challenges inherent in trying to implement the model. Again, most of these came from providers indicating the need for the project to have engaged early on and meaningfully with providers around these concerns.

**Table 14: State Staff and Potential Providers' Views on Model Elements**

View on Model Elements	Model Elements						Total	
	PCC	ICT	QM	CCR	BN	PWC	Frequency	Percent
Current practice	6	4	3	3		1	17	44%
Not current practice	1	1		1			3	8%
Unclear what "it" is	1		1			4	6	15%
Challenging to implement		2	2	2	4	2	12	31%
Viable to implement					1		1	3%
Total	8	7	6	6	5	7	39	100%

What access to information and resources did bidders receive prior to the planning RFP and business plan RFP to help them understand issues well enough to develop viable proposals?

Potential providers and state staff were asked to assess the quality and accessibility of information made available to bidders. There was solid satisfaction with the project's commitment to and delivery of information about the model and project requirements. Furthermore, those providers who received a planning grant used a portion of their funds to hire consultants with expertise in funding models, rate setting and service delivery models.

What happened between thoughtful, extensive planning and inability to get an organization to implement the model? Why did business plan proposals only come from NEK? What happened in other areas of the state? After multiple efforts to recruit providers to submit proposals, the document review reveals that implementation proposals came from two entities, both located in the Northeast Kingdom. The evaluation asked state staff, CPT and CAC members, consultants, and organizations that submitted or were interested in submitting proposals for their thoughts on why proposals were absent from other parts of the state.

Table 15 reveals a majority opinion across all respondent categories that the financial risk associated with implementing the model was the biggest factor. Responses noted that the home-grown model advocated by the project would be hampered by an inadequate infrastructure (electronic medical records, telemedicine) and a paucity of regional resources (transportation for participants, specialist providers, nurse practitioners) needed to ensure its financial sustainability.

The remaining responses identify a range of issues that, as a whole created, a challenging scenario for successful implementation. Throughout the interviews, project timing was mentioned in relation to the range of other Vermont long term care projects that were in early stages. PACE was most commonly mentioned as a project that was being watched and that needed time to demonstrate its own viability. Many of Vermont's long-term care and medical providers were fully engaged in implementing other new initiatives and/or managing their regular business, not leaving sufficient time and resources to learn about and undertake a new venture.

Additional reasons that kept providers from submitting proposals were cited. For example, the current culture in which providers operate in Vermont does not encourage partnering – yet many recognized that in order to manage risk, regional proposals would require local partnering.

The funding structures and mechanisms required to implement MyCare Vermont were complicated and it was noted that small non-profit providers did not have the needed level of sophistication and understanding about funding.

Finally, throughout interviews a perception emerged that the project's failure to get a pilot site up and running was due, in part to a lack of interest in and commitment from top level leadership. However, interviews with Project Management Team members revealed that the DAIL Commissioner and Deputy Commissioners, with other managers, participated in the bi-weekly team meetings to discuss, oversee and make decisions about the project. In essence, stakeholders were not getting information about the extent and nature of leadership's involvement in and impact on the project.

**Table 15: Potential Providers: Why No Proposals from Other Regions in VT**

Explanations for Why No Bids from Rest of VT	Interview Groups					Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	Potential Provider (n= 7)	Consultants (n=6)	Frequency	Percent
Risk/feasibility	7	8	13	6	3	37	44%
Timing not good	1	1	6	1	2	11	13%
Don't know		2	5		3	10	12%
Lack of needed leadership	1		7			8	9%
Unwillingness of providers to partner		1	2	3	1	7	8%
Providers didn't understand funding	1	1	3			5	6%
Not enough time to implement		2		2		4	5%
Model too prescriptive		1		1		2	2%
Other - CMS wouldn't fund any of the proposals			1			1	1%
<b>Total</b>	<b>10</b>	<b>16</b>	<b>37</b>	<b>13</b>	<b>9</b>	<b>85</b>	<b>100%</b>

What happened with the Northeast Kingdom? More than two-third of responses, and a majority of responses within each of the stakeholder groups asked this question, identify the unwillingness of the two organizations to partner as critical to the decision to not fund a pilot site. Interview responses concur with information from the document review in acknowledging that the two proposals had complementary strengths and weaknesses. As a result, on their own, each organization's proposal did not adequately address quality implementation of the model elements or management of financial risk. While the documents and interviews concur that state staff made efforts to broker a partnership, a quarter of responses indicate that the state did not want to implement MyCare Vermont and therefore did not make concerted efforts to broker a deal between the two providers. In contrast, Project Management Team members clearly expressed their desire to implement the model through a local provider who had the resources and competencies to pilot MyCare and manage the financial risk.

In thinking about ways to have improved the state's chance of receiving an acceptable plan, two provider comments noted that the state should have accepted one Business Plan proposal per region, as the CPT had originally suggested, and subsequently required a single Implementation Proposal per region in the hopes of generating partnerships among providers.

**Table 16: Potential Providers: Why NEK Not Funded**

Explanations for Why NEK Not Funded	Interview Groups				Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	Potential Providers (n= 7)	Frequency	Percent
Neither proposal adequate on own and organizations unwilling to partner	6	2	2	4	14	67%
State didn't want to move forward	1		1	3	5	24%
State should have required one proposal				2	2	10%
Total	7	2	3	9	21	100%

## Lessons Learned

The interview results summarized in Tables 17 through 20 and the findings from the review of project documents underlie the recommendations for future action described in the section on Lessons Learned and Guidance for the Future. The reader is encouraged to review the table summaries in concert with reading the narrative.

**Table 17: Lessons Learned: Project leadership**

Project Leadership	Interview Groups						Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	CFP (n=15)	Consultants (n=6)	Potential Providers (n=7)	Frequency	Percent
Commitment of leaders, presence and collaboration required	6	11	7	2			26	59%
Pro-active, strategic approach to gain CMS approvals/policies	7	3	5	1	2		18	41%
Total	13	14	12	3	2	0	44	100%

**Table 18: Lessons Learned: Project Feasibility**

Project Feasibility	Interview Groups						Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	CFP (n=15)	Consultants (n=6)	Potential Providers (n=7)	Frequency	Percent
Timing not good - Give PACE time to work, too many other initiatives	4	2	6	4	1	2	19	17%
Home-grown model too risky – consider out of state providers/insurers	1		7	2	5	2	17	15%
Encourage provider partnering vs. competition	3	1	6		4	2	16	14%
Upfront assess feasibility/effectiveness of current programs before going after grant			10	1	4		15	13%
Upfront engage/build buy-in from providers and other stakeholders	2	4	1	6	1	1	15	13%
Larger target population and range of needs needed – voluntary enrollment challenging	2	4	1	2	1	2	12	10%
State must share/assume risk	1	2		3	1	2	9	8%
Better understanding needed of current use/cost of services	1		1		7		9	8%
Necessary infrastructure/system changes required – rural resources, use of technologies	1	2					3	3%
<b>Total</b>	<b>15</b>	<b>15</b>	<b>32</b>	<b>18</b>	<b>24</b>	<b>11</b>	<b>115</b>	<b>100%</b>

**Table 19: Lessons learned: Model Design**

Project Model Design	Interview Groups						Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	CFP (n=15)	Consultants (n=6)	Potential Providers (n=7)	Frequency	Percent
Less prescriptive service delivery model	1	4				2	7	50%
Integrate model elements into existing programs, build on existing strengths			1	2		2	5	36%
Differentiate approaches to two different populations			1	1			2	14%
<b>Total</b>	<b>1</b>	<b>4</b>	<b>2</b>	<b>3</b>	<b>0</b>	<b>4</b>	<b>14</b>	<b>100%</b>

**Table 20: Lessons Learned: Project Planning Process**

Project Planning Process	Interview Groups						Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	CFP (n=15)	Consultants (n=6)	Potential Providers (n=7)	Frequency	Percent
Planning process too long	4	3	5		2	4	18	64%
Attend to CFP recommendations				1	1	1	3	11%
Smaller advisory group			3				3	11%
Use expertise/advice of consultants					2		2	7%
Collaborative discussions were valuable	1			1			2	7%
<b>Total</b>	<b>5</b>	<b>3</b>	<b>8</b>	<b>2</b>	<b>5</b>	<b>5</b>	<b>28</b>	<b>100%</b>

## Support for MyCare Model

Would you support future efforts to implement model? The final interview question sought to assess the level of support stakeholders would have for future efforts to implement the MyCare Vermont model. More than 90% of responses indicate strong support for the model (see Table 21). CFP and Potential Providers qualified their support with the following caveats:

- a range of conditions are in place, including sufficient resources, to manage risk and deliver services ;
- evidence exists that the PACE model is viable;
- the timing is correct;
- implementation of the MyCare Vermont model does not damage the existing system of care and service delivery that works;
- needed skills sets and services are in place to implement an interdisciplinary model.

**Table 21: Stakeholder Support for Future Implementation of MyCare Model**

Support Model in the Future	Interview Groups					Total	
	State Staff (n=9)	CPT (n=9)	CAC (n=17)	CFP (n=15)	Potential Providers (n=7)	Frequency	Percent
Yes	1	6	11			18	53%
Yes with caveats				5	7	12	35%
No				2		2	6%
Not Sure				1	1	2	6%
<b>Total</b>	<b>1</b>	<b>6</b>	<b>11</b>	<b>8</b>	<b>8</b>	<b>34</b>	<b>100%</b>

## Lessons Learned and Guidance for the Future

The charge for this evaluation was two-fold:

- Identify lessons learned from the Real Choices, MyCare Vermont project
- Provide guidance on what is needed to implement an integrated care system for elders and persons with disabilities in Vermont.

Our review of documents and stakeholder interviews, summarized in previous sections, provide observations and guidance for any future efforts to successfully implement the MyCare Vermont model. These address four categories:

- Project Leadership
- Project Feasibility
- Project Planning Process
- Project Model Design and Elements

### Project Leadership

As the summary of stakeholder interviews suggest, concerns, observations and suggestions abound regarding the perception that to move MyCare Vermont from conception to implementation requires a visible commitment to and engagement of top level state leadership.

### Observations

- Top level leadership was not fully engaged in initiating and pursuing an integrated system of care prior to the award of the Real Choices grant. A successful grant proposal to CMS was written by two experienced employees at the Office of Vermont Health Access (OVHA). While the grant amount was substantial and one of two awarded across the country, it appears that top leadership did not initiate the notion of Vermont pursuing this money. This means it was not likely top level leaders had an opportunity to consider and plan strategies to address the demands that would be placed on Vermont by receiving this award, including required time, human resources, strategic planning and political advocacy needed to implement the project goals.
- The grant was awarded to the original agency, OVHA. Once funded, an unanticipated discussion ensued between OVHA and DAIL regarding where the grant should be housed. The time that was required for AHS to reach the decision that DAIL would house and manage the project dug into months that ultimately could have been better used on project planning and implementation.
- There were differences of opinion between the Project Director and the Project Management Team regarding how and when a decision was made about which model to pursue. The Project Manager, co-author of the grant, envisioned the project expanding the PACE model by serving a wider consumer population (including persons under 55

years old) and providing services throughout rural regions of the state in “non-centered” settings. The Project Management Team initially wanted Vermont to become the Managed Care Organization directly responsible for administering both Medicare and Medicaid funds. Either approach would have required CMS waivers and approval and a strategic route to get them but apparently agreement between the management team and the Project Director was not reached in time to pursue a particular model. Noting Vermont’s successful history of innovation in other LTC initiatives, several stakeholders opined that if determined and pro-actively strategic, Vermont would have had a strong chance of gaining needed approvals and/or waivers from CMS to advance the goals of the project.

- Several factors contributed to the perception held by many stakeholders that DAIL did not provide clear guidance and strong leadership to the project. Specifically,
  - DAIL leadership was not regularly present during deliberations at stakeholder meetings. While leadership was not expected to be at CPT meetings, the Project Management Team wanted the DAIL Commissioner or Deputy Commissioner present at every CAC meeting. Persons in one or both of these leadership roles was present in 8 of the 14 CAC meetings for which attendance was recorded, Moreover, there were notable time lags in such attendance: such leaders did not attend CAC meetings during the first 7 months of the project, nor during nearly a full year mid-way in the project.
  - Stakeholders were not aware that the Commissioner and Deputy Commissioner participated in bi-weekly meetings to discuss the project. No evidence indicates that DAIL leadership’s active involvement in these meetings was communicated to CAC or CPT members.
  - Several final decisions, as reflected in the Draft Model Contract, ran counter to recommendations which the CPT and CAC spent significant time debating and developing. For example, stakeholders recommended a broad target population including community well and nursing home residents; DAIL decided to focus on a more limited population (i.e., persons eligible for CFC highest or high needs groups living in the community). Stakeholders felt that DAIL leadership, at best, did not provide clear explanations for decisions and did not provide up front guidance and direction on parameters to recommendations. Many stakeholders felt it would have been helpful to understand DAIL’s positions on issues up front, so that their meeting time could have been better utilized working on ideas that leadership supported. Ultimately feelings ranging from disappointment to cynicism were reflected in interviews. People stated that the project was “pie-in-the-sky”, “a waste of two years”, “unrealistic”, lacking commitment and therefore would not be put into practice.
- Re-organization of the Agency of Human Services (AHS). In addition to the above factors, the leadership and structure of AHS changed during the grant period more than once. Priorities shifted with agency leadership, possibly impacting the degree of attention and importance given to the MyCare project. In addition, the Commissioner of

DAIL was replaced two-thirds of the way through the project, again introducing new vision and direction to the project.

### What's needed for future efforts to successfully implement the MyCare Vermont model?

- Top agency leadership should be fully aware and actively supportive of large-scale policy proposals and grant applications. In advance of submitting the proposal to CMS, cross agency discussions and agreement regarding where the project will live and be managed are needed to maximize the use of the time allotted under the grant timelines.
- In preparing grant proposals, leadership from all agencies involved, in this case OVHA and DAIL, should partner to articulate a common vision for the project, including the appropriate financing and service delivery models. Consensus among top level leaders and project management is essential for strategic planning and project implementation.
- DAIL leadership should build and engage in pro-active strategies with other agencies, with the Vermont legislature and with the Vermont congressional delegation to gain CMS approval and/or waivers to implement the significant system change needed for integrated financing and service delivery. Changes involving Medicare, in particular, require strategic approaches to work within existing federal rules and regulations involving top level decision-makers.
- Top level leaders should provide ongoing, clear guidance and active involvement with project management and stakeholders so that those implementing the project effectively use their time to craft meaningful, realistic recommendations that will be supported.

### **Project Feasibility**

The Real Choices grant that was funded was ambitious in its scope. Its success required that many conditions and factors align in just the right way so that an integrated system of service funding and delivery could be executed without undue financial risk to service providers. Information regarding costs was required as were plausible estimates about the size of the target population. Waivers from CMS to implement any of the proposed models were also needed. Additionally a range of resources needed to implement the model had to be available. In essence, the feasibility of the MyCare Vermont model had to be addressed. The evaluation activities have yielded the following observations and suggestions.

### Observations

- Poor timing - At the time that MyCare Vermont was being developed several other long term care initiatives were underway. PACE VT was still young and not yet operational; Choices for Care and Global Commitment had just been initiated; the Blueprint for Health was also in early stages of development. Many of the same parties were engaged in these multiple efforts. Some described this as “initiative overload”, others felt the range of programs created competition for Vermont’s scarce human and fiscal resources thus leaving MyCare Vermont with limited available resources to plan and execute a new initiative.

- Vermont’s demographics and rural character (small population translating into small consumer demand, scarcity of resources including primary care physicians, specialist providers, lack of transportation systems, etc.) challenge our ability to provide integrated services and manage the risk of a capitated financing system.
- Stakeholders and DAIL disagreed on target population criteria. Stakeholders believed that the target population was too narrow to enable providers to manage financial risk.
- Vermont’s information systems’ capacity is unable to generate the critical data needed to assess feasibility, including data to determine actual demand for services, whether enrollment numbers would be adequate to address risks, utilization and cost of Medicare services.
- The Planning and Implementation RFPs did not require that provider organizations partner at regional levels, as recommended by the CPT.
- Key project assumptions – that this would be a voluntary enrollment, “home-grown” in-state effort, with services provided by not-for-profit – limited the potential range of eligible provider organizations and methods to manage financial risk.
- The existing service provider structure in Vermont is basically competitive. State funding structures for provider organizations do not naturally promote partnering across service provider organizations.

What’s needed for future efforts to successfully implement the MyCare Vermont model?

- Feasibility assessments should be conducted at different stages to guide decision making, address assumptions, address needed systems development and create incentives, interest and assurances regarding risk management for potential providers.
  - As part of the development of grant applications for integrated systems, an assessment should be conducted to determine the readiness and availability of needed human resources to engage in planning, and needed services to realistically implement the model. What other initiatives are demanding these resources? What other initiatives may be serving the same consumer populations? Specifically, what service and needs gaps will the proposed project fill? How ready and willing are stakeholders to address the problem at this time?
  - As part of the development of the grant application an assessment should be made of the commitment and interest of key leaders to pursue this objective.
  - Once the grant is funded the project should begin by determining what stakeholders, policies, regulations and resources will be needed to implement a Person Centered, integrated approach for elders and persons with disabilities.

- Early in the project data should be gathered and analyzed to determine the cost and scope of Medicare services that will be demanded and utilized.
- Early in the project data should be gathered and analyzed to assess the population size required for providers to manage risk.
- Once the above assessments are carried out, key assumptions should be considered and critiqued. For example:
  - Should the model consider making enrollment mandatory versus voluntary?
  - Is there any scenario in which out-of-state and/or for profit provider organizations would be invited to apply? This would require that Vermont be willing to research and identify specific provider organizations with a proven track record that meet clear standards for service delivery.
- Leadership efforts should focus on encouraging and creating incentives for existing Vermont provider organizations to partner within geographic regions in order to implement the MyCare Vermont model and manage financial risk. Future RFPs should require and fund one collaborative bid per region.
- Leadership should consider how and if the state can assume and/or share risk in order for a home-grown model to survive

## **Project Planning Process**

Stakeholder interviews and the document review indicate opportunities for improving the planning and design process to yield maximum benefit and increase the chances of implementing the MyCare Vermont model. This assumes that the feasibility issues noted above are addressed in order to enhance provider interest in implementing the MyCare Vermont model.

## Observations

- The grant was written by two people. Although the proposal was based on the work of several other processes that had gathered stakeholder input, there is no evidence that specific feedback was gathered from potential providers and consumers to craft this proposal to CMS. As is often the case, sufficient time may not have existed between the RFP announcement date and proposal submission date to fully analyze the viability of the project. Thus the objectives and grant activities outlined in the proposal did not reflect or ensure the presence of support and buy-in from key stakeholders whose interest and participation were needed to successfully implement an integrated model.
- While the project sought to engage stakeholders in multiple ways, the existence of three input groups may have proved too unwieldy and slowed down the planning process. The time and resources required to manage and coordinate the activities of the three forums occupied a significant proportion of the grant's life, and less than a year remained for

interested, potential providers to engage in business and implementation planning. Furthermore, the document review showed that issues raised in one stakeholder forum were not always accessible to, or considered, or responded to by another forum. Interview results indicated that stakeholders had different perceptions about their roles and responsibilities. For example, although the articulated role of the CAC was “advisory”, many members viewed their role and input as requiring a greater amount of meeting time and response from the CPT. The manner in which input was gathered from the different CFPs around the state was inconsistent and over time, participation waned and attitudes towards the project ranged from indifference to cynicism.

- Essential stakeholders were not adequately represented in the planning process. Stakeholder interviews noted the absence or under-representation of individual primary care physicians, the medical profession as an entity, hospitals and insurers. The project manager did invite the Vermont Medical Association and the Hospital Association to participate on the CAC. There were no insurers present in the CAC. The Project Management Team felt this was not necessary because the focus was on developing a dual eligible capitated program. However, several stakeholders wanted insurers present for their expertise on finance related issues, and not as potential providers. Interviewees felt that: 1) there was over representation of consumers with disabilities on the CAC; 2) that the individual consumers who participated on the CAC and CPT are often present in other projects and viewed as “professional consumers”; and, 3) the absence of the medical profession and insurers did not allow the model design to take into account the concerns and challenges that medical providers and insurers might anticipate, thus contributing to the low level of interest in and responses to the planning and implementation RFPs.
- Continuity in the deliberation, planning and decision making process was disrupted as a result of changes in CPT membership. In January 2007, after the CPT had been meeting every two weeks for a year, the Project Director, concerned with potential conflict of interest, determined that two members should resign because they represented provider organizations that might bid on the business and implementation RFP’s. New members were recruited to fill their slots. However, inserting new members at an advanced stage of the project significantly slowed the decision making process as new members had to become educated on issues that had been vetted previously in the bi-weekly, day-long meetings. Additionally, membership changes in any group affect its dynamics as time is required to develop respect for each others’ perspectives and build trust that allows diverse groups to engage in meaningful decision making. The Project Management Team was not consulted on this decision and a question remains as to whether it would have been necessary had the Project Director discussed this with management team members. Given that so many potential providers were engaged in all stages of the planning process, concerns with conflict of interest may have been a moot point.
- Significant project time and resources were invested in defining a set of prescriptive requirements that providers would be required to implement in delivering services to individual consumers. Conversely, little attention was given to developing the financing and organizational infra-structure needed to give potential providers guidance for implementing the MyCare Vermont model in a risk-averse manner.

- The majority of stakeholders reported they did not feel their input was influential – to the contrary many believed that decisions about the model elements, funding mechanisms, and enrollment requirements among others, were pre-determined by the project management. Also, both the document review and interviews revealed that some decisions made by the stakeholder groups after extensive conversation were subsequently reversed or changed by the Project Director. For example, stakeholders recommended that the ICT case manager did not need to be a Licensed Clinical Social Worker (LCSW), but the Project Director reversed that in the Draft Model Contract which requires an LCSW be a member of the ICT.
- The contract with Bailit Health Purchasing outlined that they were to facilitate CPT and CAC meetings, and provide their expertise on substantive issues. The Project Director relied on Bailit’s facilitation skills but chose not to engage their expertise in discussions with stakeholders and the formulation of recommendations. As a result, the consultant declined to renegotiate its contract, leaving the facilitation of the remaining project meetings to the Project Director. Furthermore, the Project Management Team was unaware of the conditions that led to Bailit’s withdrawal while assuming that the project was benefiting from both their facilitation and substantive expertise. It is unclear how this situation may have impacted the final program design decisions that emerged.

What’s needed for future efforts to successfully implement the MyCare Vermont model?

- The development of grant objectives and activities should be influenced by engaging input and feedback of key stakeholders – including but not limited to top leadership, potential providers and consumers.
- Project time should be portioned up front and closely monitored to insure that sufficient time is set aside for potential providers to engage in business planning leading to the implementation of a pilot program.
- Project management should devise an alternative, more streamlined method for gaining stakeholder advice. Stakeholder groups should be small enough to function effectively and efficiently, and be proportionally representative of varied groups. One strategy might be to use the existing DAIL Advisory Group to fulfill the advisory feedback role. If a working group is needed, such as the CPT, membership should be expanded to include representation from the medical professions, the insurance and for profit sectors to yield a more balanced, appealing and manageable design.
- Clear, open and consistent lines of communication on all aspects of the project must exist between the Project Director and the Project Management Team. Potential changes in group roles and responsibilities, structure and membership should be jointly considered in terms of potential consequences and impacts on expected project outcomes.
- Advisory stakeholders, many of whom are potential providers should receive clear feedback from project management about how and why their ideas were considered and incorporated or not into the project.

- Clear expectations on consultant roles and responsibilities should be developed and adhered to as part of the project management.. The Project Management Team should be actively engaged in supervising the Project Director in all aspects of his/her responsibilities including interaction with contractual consultants.

## **Model Elements**

### Observations

- Wide variation and different points of view existed among and between the stakeholders and potential providers regarding the following:
  - whether the proposed model elements were new innovations or currently in practice
  - whether the program implementation requirements for providers were reasonable or overly prescriptive
  - whether implementation of certain model elements was or was not feasible (ICT, electronic comprehensive centralize record, etc)
  - whether it was appropriate to serve different populations with the same approach, especially as it pertained to PCC, ICT and centered-based service provision
- DAIL and stakeholders felt it important that MyCare build on existing strengths and system services. However no assessment process was engaged in to determine the extent to which the proposed model elements were already in practice in Vermont.
- Many stakeholders highly valued the extensive conversations regarding model elements, especially around PCC.
- The vast majority of stakeholders interviewed would support the implementation of this model in the future given the correct timing and conditions that address risk management.

### What's needed for future efforts to successfully implement the MyCare Vermont model?

- Engage in activities that will create clear and common understandings of the model elements among potential providers and consumers for the purpose of building buy-in and support for implementation.
- Assess existing LTC service system elements and system strengths in relation to the proposed MyCare model elements.
  - Identify which elements of the model actually exist, where they are in practice and how effective they are.
  - Identify which elements of the model do not presently exist or where there are gaps, determine reasons why the gaps exist, and identify strategies for addressing gaps.

- Seriously consider if and how differentiated approaches to serving elders and persons with disabilities should be developed. Engage a broader range of consumers and providers that currently serve the two populations in order to adjust elements of the model, if indicated, appropriately.
- Create directives that articulate clear outcomes that providers should be achieving, while allowing them the flexibility and creativity needed to implement the model elements within specific regions and settings. In other words, the MyCare Vermont model should be prescriptive about the participant outcomes expected from implementation of the model, but allow individual provider organizations (including their ICT's with the participant) to determine the best way to implement elements of the model.

### **Conclusion**

While the MyCare Vermont project did not accomplish the critical goal of identifying an organization and establishing a pilot project, several project goals were, in fact, accomplished. Perhaps most important to the stakeholders involved, the project crafted a detailed definition of Person Centered Care and established a set of specific practices for providing Interdisciplinary Care through a team and person centered care planning.

Stakeholders invested enormous time and energy in the MyCare Vermont planning process. However, the multiple channels for gathering stakeholder input interfered with effective communication between stakeholders, management and leadership. This meant that stakeholders often did not understand how and why decisions were made; and, the Project Management Team at times, was not aware of recommendations and concerns of stakeholders. Any future effort which draws upon this type of stakeholder investment must carefully consider how to honor input and prudently use this critical Vermont resource.

In the end, it is important to note that most everyone involved in the MyCare Vermont effort would support implementation of the model.

**Appendix A  
Project Time Line**

**MyCare Project Timeline**

<b>Date</b>	<b>Activity</b>
<b>2004</b>	
Fall	CMS Health and LTC Integration Project grant awarded to OVHA
<b>2005</b>	
Winter	AHS moves grant administration from OVHA to DAIL  Mike Smith replaces Charles Smith as AHS Secretary
Spring	Joan Haslett (Project Director) moves to DAIL
Summer	DAIL issues RFP for project managerial support
Fall	Project kick-off two day conference: <i>Health and Long Term Care Integration</i> CAC begins to meet and DAIL selects Bailit DAIL launches CFC (1115 Waiver) OVHA launches Global Commitment (1115 Waiver) Cynthia LaWare replaces Mike Smith as AHS Secretary Legislature endorses Blueprint for Health
<b>2006</b>	
Winter	CPT begins to meet – discusses Mission, target populations, services wish list CAC reviews Mission
Spring	CPT finalizes Mission & Guiding Principles; decides model must be voluntary; outlines covered services CAC revises Mission & Guiding Principles; provides CPT input on target populations, covered services
Summer	CPT recommends covered services, Interdisciplinary Care Team (ICT) composition (Primary care provider (PCP), RN, Certified Case Manager (CCM), not SW) and responsibilities, centralized comprehensive record; responds to CAC input CAC receives CFP input on target populations, ICT, record, and services; recommends including NH population, provides input on covered services, ICT CAC/CPT joint meeting select name MyCare Vermont
Fall	CPT recommends Business Plan RFP; reviews <i>MyCare Vermont Overview</i> ; using CAC input develops Person-Centered Care (PCC) definition and revises ICT (including recommendation not to require entity to contract with AAA for CCM) CAC receives CFP input on name, PCC definition Commissioner Flood presents to CAC/CPT joint meeting: state cannot serve as entity, proposes using PACE and SNP models DAIL issues Planning RFP, releases <i>MyCare Overview</i> Educational Seminar: SNPs, PACE, Business Plan and Financial Solvency for integrated care

<b>Date</b>	<b>Activity</b>
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<b>2007</b>	
Winter	<p>CPT revises PCC definition, based on CAC input; revises Interdisciplinary Care Planning (ICP) program requirements; change in membership due to conflict of interest concerns; begins to work on addressing consumer/surrogate directed (C/SD) care, quality management, and workforce initiatives; issue of CCM on ICT remains unresolved (decision not yet made by DAIL)</p> <p>CAC receives CFP input on PCC definition and MyCare name; provides input on ITC and PCC, quality management, workforce initiative, and Resource Allocation Decision (RAD) tool</p> <p>Bids received for Planning RFP limited to Chittenden county, RFP re-issued for NEK and southern VT; additional bids received from NEK</p>
Spring	<p>CPT discusses community-based physicians, PACE/SNP options, ICT/PCC, services for disabled adults, C/SD care, needed organizational structure to implement MyCare model</p> <p>PACE VT opens Colchester site (incorporated December 2003)</p>
Summer	<p>CPT last meeting discuss C/SD care, ICT, personnel requirements for entity, information systems</p> <p>CAC receive CFP input on quality management and workforce initiatives; reviews RAD tool, contractor accountability, C/SD care, community-based physicians</p> <p>Educational seminars held for Business Planning</p> <p>Joan Senecal becomes Commissioner of DAIL; Patrick Flood becomes Deputy Secretary of AHS; Brendan Hogan new Deputy Commissioner of DAIL</p>
Fall	<p>Original end of grant, receive no-cost extension</p> <p><i>Options for Structuring MyCare Vermont Integrated Care Model</i> completed by Pacific Health Policy Group</p> <p><i>Recommendations for MyCare Vermont</i> published</p> <p>CAC receive information on PIHP model, implementation RFP, Business Plan presentations</p> <p>Implementation RFP issues</p> <p>First Preliminary Draft Model Contract posted on website</p> <p><i>MyCare Vermont Data Book</i> published</p>
<b>2008</b>	
Winter	<p>Implementation proposals received, reviewed, rejected</p> <p>CAC informed of RFP results</p> <p>PACE VT opens Rutland site</p>
Spring	<p>Susan Wehry attends CAC meeting to present physician's response to MyCare Preliminary Draft Model Contract completed</p> <p>Conference: Real People, Real Choices: Person-Centered Care and You</p>
Summer	<p>Final CAC meeting to review C/SD survey results, conference feedback</p>

**Appendix B**  
**Interview Questions**

<b>1. Project goals, development and management:</b>	<b>Who to Ask</b>
b. What was your role, responsibilities in this project	All
c. How did the idea emerge that identified the need for integration (of Medicaid/Medicare and of health, social and long term care)?	DAIL
d. What did you believe the grant was trying to accomplish?	All
e. Once grant was funded, what happened? i. Why did it take about a year from grant award to initiation of grant activities? What happened in that first year? ii. Describe the leadership roles and their influence on this project	DAIL
f. What was the relationship between MyCare and other LTC and healthcare initiatives? (probes: how project fits into agenda, structure of AHS, OVHA, DAIL)	DAIL, CAC, CPT
g. How much did CMS rules and regs/parameters affect the process?	DAIL Consultants CAC, CPT

<b>2. Stakeholder involvement</b>	<b>Who to Ask</b>
a. What brought stakeholders to the table initially?	Consultants CPT, CAC, CFP
b. What contributed to stakeholder buy-in for the project and proposed model? Where and how did consensus emerge? What led to shifts over time? Who were project supporters/detractors and why?	DAIL Consultants CPT, CAC, CFP
c. Thinking about how meetings were conducted, to what extent did the meeting process contribute to or detract from the groups' effectiveness?	CPT, CAC, CFP, DAIL, Consultants
d. How useful and influential did you feel that stakeholder input was on the project?	DAIL CPT, CAC, CFP, Consultants
e. What might have been different if the CPT continued to meet? Would it have been useful?	DAIL, CPT

<b>3. Proposed model</b>	<b>Who to Ask</b>
a. What proposals in the model represent new ideas, principles, and structures? What elements of the model are operative in existing programs? Person Centered Care, Integrated Care Team, comprehensive patient record, workforce culture, quality management	All
b. What was your understanding of how budget neutrality would be operationalized	DAIL, Bidders CPT, CAC, consultants
c. How well did stakeholders and potential providers understand the differences, benefits and challenges of each model (PACE, PIHP, SNP)?	DAIL, CPT, CAC, Bidders
d. How/why was the choice made to include the PIHP and PACE models in the RPF?	DAIL, TA providers
e. Why didn't AHS approve the proposed upgrades to SAMS? Who was involved in the decision?	DAIL

<b>4. Potential provider organizations</b>	<b>Who to Ask</b>
a. To what extent did providers understand and agree with: <ul style="list-style-type: none"> <li>i. Person-centered care</li> <li>ii. Quality management requirements (including staff resources, clinical practice guidelines, and annual quality goals)</li> <li>iii. Comprehensive patient record</li> <li>iv. Budget neutrality and capacity to manage financial requirements for a fully capitated health care model (budget, contracting, etc.)</li> <li>v. Workplace culture requirements</li> </ul>	Bidders DAIL
b. What access to information and resources did bidders receive prior to the planning RFP and business plan RFP to help them understand issues well enough to develop viable proposals? How did bidders judge the process of engaging them in developing proposals?	DAIL Bidders
c. Why did business plan proposals only come from NEK? What happened in other areas of the state?	DAIL Consultants, CPT CAC, Bidders, Potential bidders
d. What happened between thoughtful, extensive planning and inability to get an organization to implement the model? What were the underlying issues? What happened with NEK?	DAIL, CPT, CAC, Bidders, Potential Bidders

<b>Lessons Learned</b>	<b>Who to Ask</b>
a. What did we learn from this project that will be helpful for future efforts in Vermont? For other states, particularly rural states?	All
b. With hindsight, what could have been done differently?	All
c. What needs to change for an integrated model to work in Vermont?	All
d. Looking toward the future, is this a model you would support? Be interested in implementing?	All

## **Appendix C**

### **Summary of Interviewees**

The list below identifies the several categories of participation and/or affiliation of persons interviewed. Several persons participated in more than one capacity and in our individual interview with them were asked questions related to their different roles; these individuals are noted with an asterisk (\*).

#### *DAIL Project Management Team – group interview*

- DAIL Commissioner
- DAIL Deputy Commissioner
- Director, Division of Disability and Aging Services
- Medicaid Waiver Manager

#### *DAIL Project Management Team – individual interviews*

- Former DAIL Commissioner, Current AHS Deputy Secretary
- DAIL Deputy Commissioner
- Director of the Community Development Unit/DDAS
- CMS Real Choices Project Manager

#### *Core Planning Team (CPT) – individual interviews*

- Vermont Center for Independent Living (VCIL)
- Champlain Valley Agency on Aging
- Consumer
- DAIL Administrative Assistant
- PACE VT
- OVHA (1 current and 1 former staff member)
- Physician, St. Albans
- Registered Nurse

#### *Community Advisory Committee (CAC) – individual interviews*

- 5 Consumers (including Consumer Representative on Core Planning Team)
- \*The Gathering Place; and the Vermont Association of Adult Day Services (VAADS)
- \*PACE Vermont
- Vermont Assembly of Home Health Agencies, Inc.
- \*Addison County Home Health and Hospice
- The Meeting Place (Adult Day provider)
- Elder Care at Fletcher Allen & Champlain Long Term Care Coalition
- Vermont Legal Aid/State Long-term Care Ombudsman
- Vermont Center for Independent Living
- Dartmouth Hitchcock Medical Center (2 staff members, including a physician)
- Vermont Health Care Association
- \*Central Vermont Council on Aging

#### *Community Feedback Partners – individual interviews*

- \*The Gathering Place; and the Vermont Association of Adult Day Services (VAADS)

Rutland Area Visiting Nurse Association and Hospice, Rutland Long Term Care Coalition

\*PACE Vermont

\*Addison County Home Health and Hospice

Vermont Association of Professional Care Providers

\*Eldercare at FAHC, PACE Board, and Chittenden County Long Term Care Coalition

Council on Aging for Southeastern Vermont, Windham County Long Term Care Coalition

\*Vermont Center for Independent Living

\*Lamoille Home Health Agency

\*Franklin Home Health Agency, Franklin/Grand Isle Long Term Care Coalition

Physician

\*Central Vermont Council on Aging, part of both AAA and Lamoille County Long Term Care Coalition feedback partners

*Community Feedback Partners – group interview – Bennington*

Southwestern Vermont Council on Aging

Southwestern Vermont Council on Aging

Visiting Nurse Association and Hospice of Southwestern Vermont Health Care

*Bidders and Potential Provider Organizations – individual interviews*

Vermont Managed Care

Consultant, PACE-VT

Vermont Managed Care

Northeast Kingdom Area Agency on Aging

\*Lamoille Home Health Agency

\*Franklin Home Health Agency

PACE-VT

*Bidders and Potential Provider Organizations – group interview*

Caledonia Home Health

Orleans-Essex VNA

*Consultants – individual interviews*

Bailit Health Purchasing, CAC Facilitator

Bailit Health Purchasing, CPT Facilitator (2 persons who served in this role)

CMS TA Provider

Community Feedback Partners Facilitator

Pacific Health Policy Group, CPT consultant

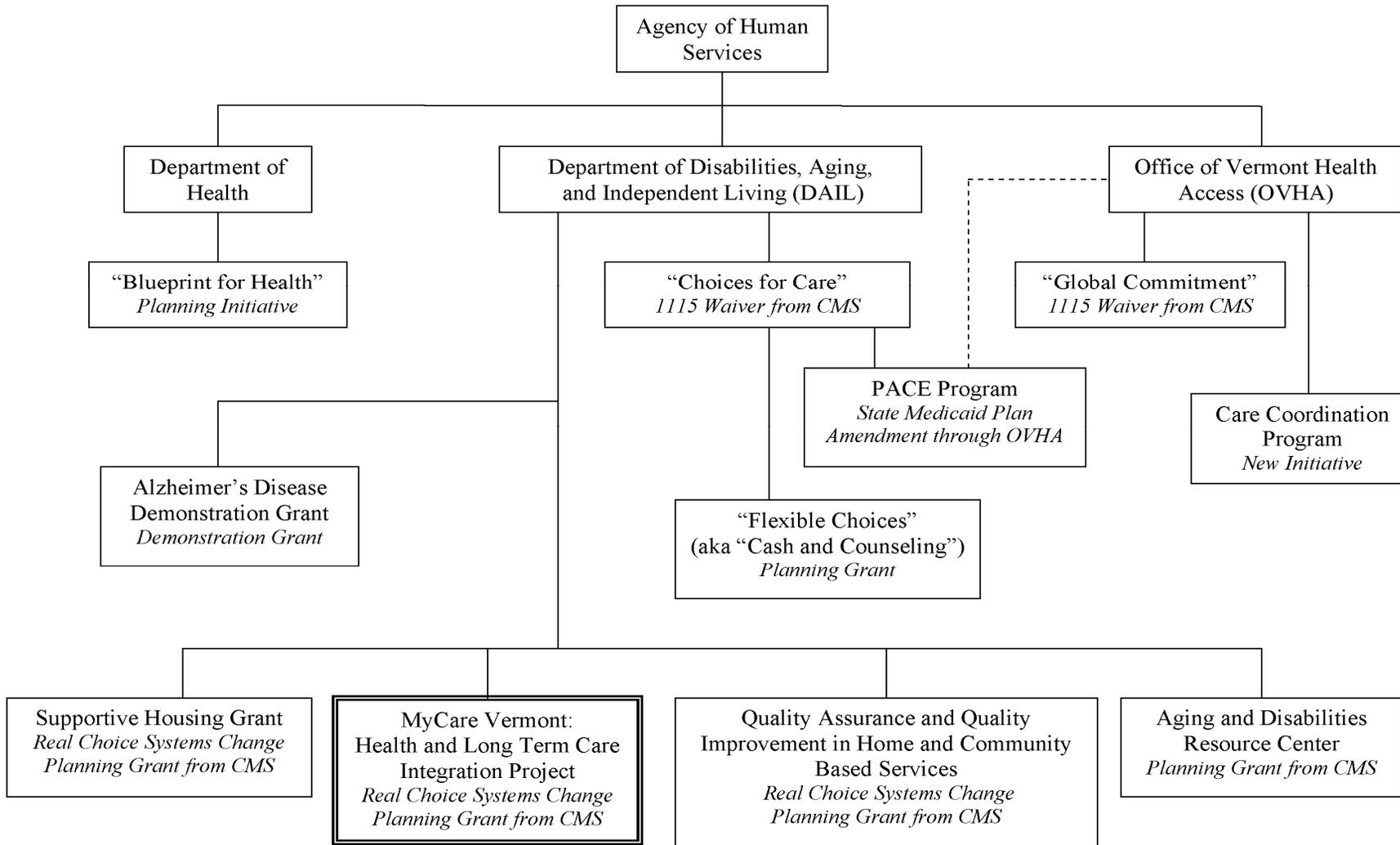
*Other – individual interview*

Director, OVHA

## **Appendix D**

### **Document Content Analysis Questions**

1. Who served on each group: CPT, CAC, CFP? Attendance at meetings (regularly present, there occasionally)? Consumer representatives (any new players)? Industry representatives (potential provider organizations)? Which CFP groups seemed to provide most input (review Erica's reports)?
2. What were roles and responsibilities of groups as articulated in written materials, meeting minutes? Indication of participants' understanding/agreement?
3. Were goals of meetings clearly articulated, understood, met? Was content of meeting discussion consistent with meeting goals, roles of group?
4. What were articulated goals of project by varied stakeholders/participants (DAIL, CPT, CAC, etc)? Financial integration, service integration, cost savings, etc.?
5. Any evidence of CPT/CAC/CFP participants' understanding of issues/decisions under discussion? Areas with most/least understanding? Areas of agreement/disagreement? Evidence of participants' buy-in/consensus on model elements?
6. Was focus of discussion on financing mechanism and/or service delivery?
7. Outline the decision making process as documented in minutes and reports. How was CPT, CAC and CFP input used in development of model, decisions?
8. How were decisions made about:
  - a. Home-grown model vs out of state provider/non-profit vs for-profit
  - b. Focus on dual eligibles
  - c. Voluntary enrollment
  - d. State as entity
9. To what extent did groups discuss CMS rules as part of decision making? How did CMS moratorium on SNPs impact discussions?
10. To what extent did each group discuss challenges presented by:
  - a. Using voluntary system
  - b. Working with small populations
  - c. Building trust among providers and between consumers and providers
  - d. Financial risk for providers
  - e. Focus on home-grown, in-state, non-profit provider
11. Access to information and resources for bidders prior to planning and business plan RFPs – evidence of understanding of requirements? Data on current services, costs?
12. Leadership evidenced by DAIL and OVHA management/leaders?



**New Planning Grants and Initiatives  
Related to the  
Health and Long Term Care Integration Project  
MyCare Vermont**

**Descriptions**

**DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING (DAIL):**

Choices for Care – 1115 Waiver from the federal Center for Medicare and Medicaid Services (CMS)

- Individuals can receive long term care services only.
- Medicaid Individuals eligible for Long-Term Care Medicaid (Elderly and younger physically disabled)
- Provides long-term care services (PCA, adult day, case management, emergency response, home modifications), Nursing Home, ERC.
- Responsible for managing budget neutrality for all the acute and primary care for this population
- *Fee-for-service*

PACE Program (Program for All-inclusive Care for the Elderly):

- Individuals can receive acute, primary and long term care services in one package
- Must be 55 years or older
- Must be eligible for Long Term Care Medicaid
- Is a State Medicaid Plan Amendment through OVHA, administered through DAIL
- *Capitated payment Medicaid and Medicare*

Flexible Choices (formerly “Cash and Counseling”)

- Individuals receive a “cash” benefit (through vouchers) to purchase and manage their long term care services only
- Self-directed care that provides flexibility for individuals to purchase non-traditional long-term care services
- *Capitated payment determined individually–Cash value of PCA services*

*Demonstration Grant:*

Alzheimer’s Disease Demonstration Grant to States

- Grant has four parts: two programs and two training components
- Dementia Respite Program: to prevent caregiver burnout and prevent or delay nursing home placements by providing respite care to family caregivers so they may remain in their roles.
- Caregiver Bridges: to establish links between primary care practices and other community providers, in order to improve and expand services for people with dementia and their family caregivers.
- Two training components: 1. Increase capacity of case managers, eldercare clinicians and other community providers to address the physiological and psychological needs of family caregivers; 2. Training for support teams of individuals with developmental

disabilities and dementia.

- *Funding is a mix of state general funds and federal grant funds.*

#### *Real Choice Systems Change Planning Grants*

##### *from CMS: Supportive Housing Grant*

- A planning grant to figure out how individuals can receive supportive services in congregate housing settings so they can “age in place.”
- *Funding is from a federal Real Choice Systems Change grant.*

##### **MyCare Vermont: Health and Long Term Care Integration Project**

- Develop a model that integrates funding streams and integrates acute/primary and long-term care service delivery as a choice for elderly who are frail, at-risk or chronically ill and adults with physical disabilities for individuals who are Medicaid eligible.
- *Once operational, new provider entity will receive a capitated payment*

##### Quality Assurance and Quality Improvement in Home and Community Based Services

- A grant to develop quality assurance (QA) and quality improvement (QI) systems for programs for individuals receiving waiver services from the department, to ensure waiver services are adequate, appropriate and of high quality.
- The goal is to have a consistent system of QA and QI across waiver services and supports.
- *Funded through a grant from CMS.*

#### *Planning Grant from CMS:*

##### Aging and Disability Resource Center (ADRC) Grant

- Establishes highly-visible and trusted places in the community where people can go for comprehensive information, referral and assistance, short-term case management, and eligibility screening and determination.
- Designs a streamlined eligibility process for Medicaid and Medicaid LTC for one-stop shopping.
- Serves older adults, people with physical or developmental disabilities, and/or traumatic brain injury.
- *Funded through grants from CMS and the Administration on Aging*

## **DEPARTMENT OF HEALTH:**

### Blueprint for Health

- A project targeted at all Vermonters to enhance cooperation between providers, patients, the community, and insurers
- Supports health care providers to deliver world class care through the provision of improved information technologies and training in chronic care issues
- Optimizes treatment options for people with chronic disease by creating information networks that allow them to tap into community resources, classes, and activities to improve quality of life
- *Funding from legislative appropriation*

## **OFFICE OF VERMONT HEALTH ACCESS (OVHA):**

### Global Commitment - 1115 Waiver from CMS

- Serves Medicaid population with the exception of Individuals eligible for Choices for Care Medicaid Waiver (Elderly and younger physically disabled)
- Provides program flexibility
- Responsible for budget neutrality for populations served
- *Currently fee-for-service*

### Care Coordination Program

- Regionally-based program RN/Medical Social Worker Teams will work in collaboration with PCP.
- Targets most expensive cases, no clinical eligibility
- *Fee-for Service: reimbursement is enhanced bill for care plans and time spent in monthly care conferences*

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