State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Annual Report
For Demonstration Year 2017
January 1, 2017 to December 31, 2017

Submitted via PMDA portal on March 29, 2018

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I. Background and Introduction

The Global Commitment to Health is a Demonstration Waiver authorized pursuant to Section 1115(a) by the Centers for Medicare and Medicaid Services (CMS), within the Department of Health and Human Services (HHS).

Vermont is a national leader in making affordable health care coverage available to low-income children and adults. Vermont was among the first states to expand coverage for children and pregnant women, through the 1989 implementation of the state-funded Dr. Dynasaur program. In 1992, Dr. Dynasaur became part of the state-federal Medicaid program.

When the federal government introduced the state Children's Health Insurance Program (CHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300 percent of the Federal Poverty Level (FPL).

In 1995, Vermont implemented an 1115(a) waiver program, the Vermont Health Access Plan (VHAP); the primary goal was to expand access to comprehensive health care coverage for uninsured adults with household incomes below 150 percent (later raised to 185 percent) of FPL, through enrollment in managed care. VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both waiver populations pay a modest premium on a sliding scale based on household income.

Implemented October 1, 2005, the Global Commitment converted the (then Office) Department of Vermont Health Access (DVHA), the state's Medicaid organization, to a public Managed Care Entity (MCE). The Agency of Human Services (AHS) paid the MCE a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately).

The Global Commitment provides Vermont with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g., case rates, capitation, combined funding streams) rather than fee-for-service, to pay for services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatric consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). The managed care model also requires interdepartmental collaboration and reinforces consistency across programs.

An extension effective January 1, 2011 was granted and included modifications based on the following amendments: 2006 - inclusion of Catamount Health to fill gaps in coverage for Vermonters by providing a health services delivery model for uninsured individuals; 2007 - a component of the Catamount program was added enabling the State to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the FPL, and who do not have access to cost effective employer-sponsored insurance, as determined by the State; 2009 - CMS processed an amendment allowing the State to extend coverage to Vermonters at or below 300 percent of the FPL; 2011 - inclusion of a palliative care program for children who are at or below 300 percent of the FPL, and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

In 2011, DAIL was awarded a five year $17.9 million "Money Follows the Person" (MFP) grant from CMS to help people living in nursing facilities overcome barriers to moving to their preferred community-based setting.

In 2012, CMS processed a cost-sharing amendment providing the authority for the State to eliminate the $75 inpatient co-pay and to implement nominal co-pays for the Vermont Health Access Plan (VHAP).

In 2013, CMS approved Vermont's Waiver Renewal for the period from October 2, 2013-December 31, 2016. AHS and DVHA have been working closely with Vermont's Medicaid Fiscal Agent to support all ACA reporting requirements, including identification of those services reimbursed at a different Federal match rate and in support of the revised MEG bucketing effective with the latest STC package.

In 2013, the State based Exchange, Vermont Health Connect (VHC), went live. CMS approved Vermont's correspondence, dated November 19, 2013, which requested authorization for expenditure authority for the period from January 1, 2014-April 30, 2014, to ensure temporary coverage for individuals previously eligible and enrolled as of December 31, 2013, in coverage through VHAP, Catamount Premium Assistance, and pharmacy assistance under Medicaid demonstration project authority during the transition to VHC.

In 2015, Vermont consolidated the Choices for Care 1115 waiver with Vermont's Global Commitment to Health 1115 waiver. Choices for Care offers a broad system of long-term services and supports across all settings for adult Vermonters with physical disabilities and needs related to aging.

On October 24th, 2016 Vermont received approval for a five-year extension of the Global Commitment to Health 1115 waiver, 1/1/2017-12/31/2021.

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit an annual report. This is the report for the twelfth waiver year, demonstration year 2017, which ended on December 31, 2017. This report encompasses fourth quarter updates for this demonstration year (10/1/17 – 12/31/17).

II. Highlights and Accomplishments

- As of December 2017, over **212,000** Vermonters were covered by a Vermont Health Connect health plan, either a qualified health plan (QHP) or Medicaid for Children and Adults (MCA). QHP enrollment included 32,508 as individuals (26,550 enrolled through VHC and 5,958 direct-enrolled through an insurance carrier) and 45,524 direct-enrolled through a small business employer, as reported by Vermont Health Connect's carrier partners. MCA enrollment (including CHIP) included 69,708 adults and 64,327 children (December 2017 enrollment as evaluated January 2018).

- In 2017, AHS submitted its Comprehensive Quality Strategy (CQS) and State Transition Plan (STP) to CMS for review after receiving public comment. The document included more detail about the phases of HCBS implementation. CMS sent a letter of initial approval for the CQS/STP to bring settings into compliance with federal HCBS regulations.

- 2017 marked the first year of the Women's Health Initiative, a new services initiative to reduce Vermont's rate of unintended pregnancies. The Women's Health Initiative has grown from 15 to 20 women's health clinics and from 13 to 15 participating Patient Centered Medical Homes.

- The AHS Performance Accountability Committee (PAC) created an Investment scorecard template for all departments to use going forward in order to communicate the performance of programs/services that use GC investment funding.

- The Developmental Disability Services Division completed revisions of 2 major documents in 2017 – the Developmental Disability Services Regulations and the Vermont State System of Care Plan. Both were effective 10/1/17. Together these documents outline how Medicaid funds are used for individuals with developmental disabilities and their families. New language was added to both documents to ensure compliance with the new Home and Community Based Services rules.

- The Brain Injury Association of Vermont received 165 responses to its state needs assessment survey and is evaluating these responses now with the goal of using them to help share the development of TBI services in VT for the next 5 years.

- Enrollment in the Hub and Spoke Health Home for opioid addiction continued to grow throughout the year; the total enrollment at the end of December was 5,850.

- In 2017, DVHA implemented the nation's first Medicaid Next Generation Accountable Care Organization program. The Vermont Medicaid Next Generation (VMNG) ACO pilot included four risk-bearing hospital communities and had approximately 29,000 attributed lives. In 2018, these numbers are expanding to ten hospital service areas and 42,000 attributed lives.

- The Agency of Human Services identified seven existing non-fee-for-service payment models to submit for approval to CMS prior to implementation according to STC 24i. These payment models will be discussed in 2018 progress reports.

- Strategic alliance work between Vermont Chronic Care Initiative (VCCI) and Blueprint has begun, including discussions to expand the population served by VCCI.

- The Global Commitment Register (GCR) listserv expanded to include approximately 95 additional interested parties. 2017 was the second full year the GCR was operational, and it has been a successful tool for public notice and documentation of Medicaid policy.

III. Project Status

i. Enrollment Information and Member Month Reporting

The State of Vermont certifies the accuracy of the member month reporting. The enrollment report is produced as of the 15th of every month. The member months are subject to revision over the course of a twelve month period due to a beneficiary's change in enrollment status.

GC quarterly reports prior to 2017 provided an enrollment count by Demonstration Population only. Medicaid Eligibility Groups have been added for the new Budget Neutrality (see Attachment 1). To maintain continuity, the table below crosswalks the count from Medicaid Eligibility Group to Demonstration Population. Both counts use the same unduplicated enrollment count information.

The table below contains Member Month Reporting for CY2017 including QE1217.

Table 1. Member Month Reporting – Calendar Year 2017

Demonstration Population	Medicaid Eligibility Group	Total CY 2017
1, 4*, 5*	ABD - Non-Medicare - Adult	**94,916**
1	ABD - Non-Medicare - Child	**28,849**
1, 4*, 5*	ABD - Dual	**254,347**
2	ANFC - Non-Medicare - Adult	**157,619**
2	ANFC - Non-Medicare - Child	**728,864**
	Medicaid Expansion	
7	Global RX	**84,129**
8	Global RX	**47,613**
6	Moderate Needs	**2,998**
	New Adults	
3	New Adult without child	**488,855**
3	New Adult with child	**224,310**
	Total All	**2,112,500**
*** Long Term Care Group**	**Total CY 2017**	
4 only	ABD Long Term Care Highest Need	**34,785**
5 only	ABD Long Term Care High Need	**13,146**

ii. Global Commitment to Health Post Award Forum

A post award forum for the latest Global Commitment to Health 1115 waiver renewal was held from 10:00 – 11:00am on Monday, February 27, 2017. This forum was conducted in accordance with item 43 under the Special Terms & Conditions (STCs) of the GC Demonstration waiver. Public comments were accepted at this forum and via email through March 3, 2017. Here is a summary of the public comments received:

- Comments in support of Vermont's Medicaid Program:
  Most commenters initiated remarks with words of praise for Vermont's Waiver and Medicaid program. Comments ranged from praise for Choices for Care and Moderate needs program, support for the overall goals of the Waiver to pride in the overall breadth of accomplishments of the Vermont Medicaid program.

- Comments regarding rates, workforce and access:
  Several commenters noted that reimbursement levels are too low, leading to difficulties with workforce development and turnover, directly impacting access and capacity to provide services. One commenter connected workforce issues to flat funding and expressed the need to explore additional opportunities for federal match. Another commenter connected inefficient processes and lack of case management with poor access to services. Several comments on rates and budget concluded with concerns regarding sustainability of programming.

- Comments regarding performance measurement:

Several commenters noted that although Vermont compares well against other states' Medicaid programs, higher standards exist and national averages should not necessarily be the benchmark for performance. Concerns were noted regarding measurements of access including shortages of certain provider types and the need to drill down further into sub-populations that might not have the same great access or outcomes as the program average. One commenter noted that consumers receiving HCBS might be reluctant to share negative opinions about their caregivers through consumer satisfaction surveys.

- Comments regarding care coordination:
  One commenter noted the need to coordinate and improve care coordination efforts across programs. Another commenter noted that more case management would improve access to care.

The 2018 post award forum was held on February 26, 2018. Further information will be included in the first quarter report for 2018 as well as the 2018 Annual Report pursuant to 42 CFR 431.420(c) and item 43 under the STCs of this Global Commitment waiver.

iii. Vermont Health Connect

Key updates:

- New system functionality in 2017 increased the number of Medicaid members who can be passively renewed through automatic verification of eligibility criteria.
- Vermont Health Connect's fifth open enrollment period launched successfully on November 1, 2017 and closed on December 15, 2017.
- By end of 2017, as with end of 2016, over 212,000 Vermonters were covered by either a qualified health plan (QHP) or Medicaid for Children and Adults (MCA).

The State of Vermont launched Vermont Health Connect (VHC), a state-based health benefits exchange for individuals and small businesses in Vermont, in October 2013. As of December 2017, over 212,000 Vermonters were covered by a Vermont Health Connect health plan, either a qualified health plan (QHP) or Medicaid for Children and Adults (MCA). QHP enrollment included 32,508 as individuals (26,550 enrolled through VHC and 5,958 direct-enrolled through an insurance carrier) and 45,524 direct-enrolled through a small business employer, as reported by Vermont Health Connect's carrier partners. MCA enrollment (including CHIP) included 69,708 adults and 64,327 children (December 2017 enrollment as evaluated January 2018).

Vermont Health Connect's small business enrollment held steady from 2016, closing out 2017 with 172 more covered lives than December 2016. Vermont's small business exchange utilizes direct enrollment with its carrier partners to enroll small businesses with 100 employees or fewer into qualified health plans.

This steady enrollment indicates that Vermont is likely maintaining its low uninsured rate. The 2014 Vermont Household Health Insurance Survey (VHHIS) estimated that Vermont's uninsured rate dropped from 6.8% to 3.7% after the launch of the health insurance marketplace. This rate – one of the lowest in the nation – meant that roughly 23,000 Vermonters lacked insurance. A September 2017 U.S. Census Bureau report estimated that the number of uninsured Vermonters held at 23,000 in 2016.

Medicaid Renewals

Redeterminations for Medicaid for Children and Adults continued on a normal annual cycle in 2017. New system functionality deployed in 2017 increased the number of members who can be passively renewed through automatic verification of eligibility criteria. For DVHA staff, the result is greater efficiency and a more manageable workload. For members, the result is less need for members to take action, fewer gaps in coverage and improved customer service.

DVHA is not able to renew members if they have been shown by the automated sources of information to no longer qualify for Medicaid, have been asked to verify information and that request is still pending review, or have not authorized DVHA to automatically renew their coverage. When members cannot be automatically renewed, DVHA mails notices encouraging them to complete their renewal online, by phone, or with an Assister.

Redeterminations for Medicaid for the Aged, Blind and Disabled (MABD) beneficiaries also continued on a normal annual cycle in 2017 and was bolstered by the launch of Asset Verification System (AVS) functionality at the end of the year.

QHP Open Enrollment and Renewals

In July 2017, DVHA kicked off a series of preparatory meetings for 2018 Open Enrollment with its carrier partners to prepare for system testing, business, and transactional planning activities. QHP renewals presented major challenges for Vermont Health Connect in past years, including the 2016 Open Enrollment, which was the first year with automated renewal functionality and was complicated by a significant contractor going out of business at the start of Open Enrollment. In contrast, both last year and this year DVHA and its partners successfully completed three major steps on, or ahead of, schedule to ensure a successful renewal effort.

The first step in the renewal effort involved determining eligibility for 2018 state and federal subsidies and enrolling members in 2018 versions of their health and/or dental plans. The step was operated with a single, clean automated run which took care of 97.8% eligible cases, up from 91.5% the previous year and about 80% the year before that. Remaining cases were processed the next day using the staff renewal form, allowing staff to return to business as usual with two days and enabling all members to have updated accounts and 2018 information prior to the start of Open Enrollment.

The second step involved sending these files to payment processor Wex Health and the insurance carriers to ensure appropriate billing and effectuation. The initial integration run was completed with 99% accuracy in mid-November. The State and its partners collaborated to clean up and re-send the remaining cases well in advance of the new year.

The third step consisted of a year-end business process that allows changes to be made on cases, if necessary, in 2018. This process ran with nearly a 100% success rate, meaning virtually all cases were ready to accept change requests starting on January 1st.

Altogether, performance on these three steps have made 2018 even smoother than 2017, which in turn was markedly different than the rocky 2016 -- when the renewal process was not complete until the end of March. State staff now face manageable workloads, decreasing the utilization of overtime, and are confident that they will be able to tackle any challenges that do arise.

The experience for callers to Vermont Health Connect's Customer Support Center was strong during the newly compressed Open Enrollment period as well. In anticipation of heavy volumes as the December 15

deadline approached, customer support implemented a new triage process that allowed callers to decide whether to request a callback or stay on the line during times of high volume. DVHA credits this process with the fact that there were minimal customer complaints even though the Customer Support Center fell short of its target of answering 75% of calls in 24 seconds (actuals were 73% for November, 65% for December). Notably, the proportion of callers who responded to a survey saying that they were satisfied with their overall service on the call was 96.0% in November and 96.3% in December.

The customer experience was also improved by a decrease in escalations. Only 6% of November-December 2017 calls had to be transferred to DVHA's Eligibility and Enrollment staff, down from 8% in November-December 2016. Just as importantly, DVHA promptly answered the calls that were transferred; 92% of those November-December 2017 transfers were answered in five minutes, up from 46% in November-December 2016.

Outreach & Education

Vermont continues to prioritize engagement and collaboration with key partners and stakeholders to ensure the successful design, development, and implementation of Vermont Health Connect. DVHA uses advisory meetings, public forums, media inquiries, and other interactions to educate Vermonters about DVHA's vision for health care reform and the role of the Exchange in that vision. DVHA also values the input of Vermonters in the process of building the Exchange, soliciting input through formal structures and information interactions.

An important priority for VHC is providing effective consumer assistance to individuals and small businesses. Vermont has developed goals for the consumer experience within the Marketplace for both individuals and small businesses. The mission of Vermont Health Connect is to provide all Vermonters with the knowledge and tools needed to easily compare and choose a quality, affordable, and comprehensive health plan. VHC has identified five functions that it feels are critical in providing the level of consumer support required by the ACA.

1. Having a call center with a toll-free hotline to assist all Vermonters seeking health insurance;
2. Developing a broad network of Navigators and in-person assister personnel;
3. Promote health insurance literacy;
4. Working closely with agents and brokers; and
5. Working closely with the Office of the Health Care Advocate.

DVHA continued to work with assisters throughout 2017 to ensure adequate training and prepare this group to assist with 2018 open enrollment and Medicaid redeterminations. More than 160 Certified Application Counselors (CACs) and Navigators provided free assistance throughout the state; this is the most in-person Assisters Vermont has ever had, up more than 50% from two years earlier. In addition, nearly 80 registered brokers were trained and available to help.

DVHA's Outreach & Education Campaign for 2018 open enrollment focused on health insurance literacy, helping customers understand the total cost of insurance, and ensuring that Vermonters are aware of the increased fee for not having health insurance. Vermont Health Connect partnered with pharmacies, agricultural organizations, and other stakeholders to promote to participate in events aimed at helping customers and potential customers better understand health insurance terms, financial help, and how to interact with the Vermont Health Connect system.

The online Plan Comparison Tool was a core piece of DVHA's health insurance literacy effort, helping Vermonters better understand their subsidies and assess how various plan designs and out-of-pocket costs

could impact their total health care costs. The tool was created by the non-profit Consumers' Checkbook and was named the nation's best plan selection tool by Robert Wood Johnson. The tool was used in more than 60,000 sessions in 2017.

Finally, DVHA worked closely with the Health Care Advocate and other partners to resolve problem cases promptly. The volume of problems in 2017 was down and the speed with which they were resolved was up. There were fewer than 20 open cases for the last 40 weeks of the year.

Plan Management

In 2017, DVHA elected to continue with its benchmark plan selection that has been in place for Vermont since 2014. As in previous years, Vermont Health Connect determined that the basic configuration of benefits should be continued into 2018 to maintain market stability. Within the established annual certification cycle, Vermont Health Connect presented and received formal approval from the Green Mountain Care Board (GMCB) for minimal changes to enrollee cost-share amounts in order to remain within required actuarial values (AVs) for all 2018 standard plans. Four new bronze-level plans were approved to be offered beginning in the 2018 coverage year: one standard plan and one non-standard plan offered by each of Vermont's two issuers.

IV. Findings

i. *External Quality Review*

Key updates:

- DVHA received a compliance score of 90% during this year's EQRO Audit.
- DVHA received an overall PIP validation score of Met – with 100% of all applicable evaluation elements receiving a score of Met.
- All DVHA performance measures reported to AHS were determined to be reliable and valid.

During this year, the AHS QIM worked with the EQRO to develop timelines for each of the required annual external quality review activities (i.e., performance improvement project validation, performance measure validation, and compliance review). All timelines included the following elements: start date, completion date, task, and responsible party. Also, during this year, the AHS QIM worked with EQRO staff to develop material to be used during the activities. Once all documents were finalized, the EQRO initiated the Compliance Review, Performance Measure Validation, and Performance Improvement Project Validation activities. The following sections provide a brief overview of the EQRO activities that took place this year.

Monitoring Compliance with Standards

This year's onsite compliance review took place during July and focused on the following standards:

- Selecting individual practitioners and organizational providers.
- Credentialing and recredentialing individual practitioners and organizational providers.
- Ensuring that beneficiaries receive all required information and that the information is available and provided at a level and in a language and format that make it easy for beneficiaries to

understand.

- Informing beneficiaries about their rights and ensuring that their rights are protected.
- Protecting the confidentiality of beneficiary information.
- Receiving and responding to beneficiary grievances/complaints.
- Receiving and responding to beneficiary appeals and requests for State fair hearings.
- Ensuring that subcontracts and written delegation agreements include all required provisions and conducting all required activities associated with delegating one or more of DVHA's administrative functions to another entity.

The audit revealed several areas requiring improvements to DVHA processes and documents. DVHA also received several helpful recommendations for process improvements from the auditors. DVHA has already begun working with the responsible departments/units to complete corrective action plans. The work includes the following improvements:

1. DVHA must make several improvements to its provider selection, credentialing and re-credentialing processes to come into compliance with federal law. These improvements were already in development during the audit, but they were not completed prior to the close of the audit. DVHA anticipates full compliance by Spring 2018.
2. DVHA must ensure that written information included in the member handbook describes the beneficiary's right to terminate enrollment in the Medicaid program.
3. DVHA must make several changes to the grievance and appeals processes, including the creation of a unified procedure manual and better monitoring for timeline adherence. DVHA will also need to update some notice language to be clearer on processes and resources available to members.
4. DVHA must add language to departmental Intra-Governmental Agreements to better clarify roles and monitoring processes. These improvements were partially implemented prior to the end of the audit period.

Performance Improvement Project Validation

The performance improvement documents were reviewed by the EQRO contractor via an off-site desk review. For this year's 2017–2018 validation, DVHA submitted a new PIP topic: *Initiation of Alcohol and Other Drug Dependence Treatment* and completed the first eight steps of the PIP Summary Form with the reporting of baseline data. The PIP topic addresses the initiation of alcohol and other drug dependence treatment for adolescent and adult beneficiaries with a new alcohol or other drug dependence diagnosis. This PIP topic represents a key area of focus for improvement by DVHA. Members receiving the appropriate care and services in the recommended time frames is essential to the recovery process.

The EQRO's validation evaluated the technical methods of the PIP (i.e., the study design and data analysis and implementation). The PIP received an overall *Not Met* validation status upon initial review. Following technical assistance provided by the EQRO, DVHA resubmitted the PIP for a final validation and improved the percentage scores of evaluation elements and critical elements that were *Met*. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

The strong performance on this PIP suggests a thorough application of the Design stage (Steps I through VI). A sound study design created the foundation for DVHA to progress to subsequent PIP stages—collecting baseline data and implementing a system-level intervention that has the potential to impact study indicator outcomes.

Performance Measure Validation

The EQRO visited Vermont to conduct Performance Measure Validation (PMV) activities during the month of July. The validation activities were conducted as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 1, 2012.* Information was collected using several methods, including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site activities are described as follows: opening session, evaluation of system compliance, overview of data integration and control procedures, and closing conference.

The EQRO identified overall strengths and areas for improvement for DVHA. In addition, the EQRO evaluated DVHA's data systems for the processing of each type of data used for reporting the required performance measures. Identified strengths were as follows: DVHA continued to use an external, NCQA approved, certified software vendor to produce the HEDIS measures under review, DVHA staff utilized trending mechanisms to monitor claims submissions which ensured data completeness prior to rate production, DVHA also refreshed administrative data frequently to ensure the most recent claim information was available for measure calculation, DVHA continues to partner with DXC (formerly Hewlett Packard Enterprise) to manage its core systems, and DVHA staff continued to review performance measures to identify areas for improvement and to identify mechanisms for improving outcomes for its beneficiaries. Areas for improvement were as follows: DVHA may benefit from using supplemental data for some measures, DVHA should explore all external sources available, including data from health information exchanges, to enhance the administrative rates, DVHA should continue the process of monitoring and trending claims submissions throughout the year, and DVHA should continue to work with laboratory vendors to ensure appropriate capture of laboratory claims and results.

During the most recent quarter, the AHS QIM reviewed/approved the Performance Improvement Project (PIP), Compliance, and Performance Measure (PM) validation reports, agreed to the format of the annual technical report, provided feedback and approval regarding the EQR Technical Report timeline and report template. In addition, the AHS QIM provided feedback regarding follow-up on prior year's recommendations, discussed 2018 PMV medical record review activities and measure information with the EQRO medical record review team, and confirmed 2018 PMV audit measures. Also, during this most recent quarter, a new agreement was developed and signed by the Secretary of AHS and the Commissioner of DVHA. The document assigns certain responsibilities related to the Global Commitment to Health waiver. This new IGA contains updated language to reflect new statutory citations, new Global Commitment waiver requirements, and new language between the Agency of Human Services and DVHA. The new AHS DVHA IGA also contains language describing the coordination of services provided by Medicaid (Title XIX) and Maternal and Child Health (Title V). In addition, Section 3.4: Oversight and Performance Evaluation of the new IGA identifies procedures for monitoring that need to be in place before December 31, 2017. Toward the end of the most recent quarter, the updated document was sent to CMS for review/approval. In addition, the end date of the current EQRO contract was extended from February 14, 2018 to February 14, 2020.

ii. Quality Assurance and Performance Improvement Activities

Key updates:

- The Quality Unit continued to lead a formal CMS PIP project focused on improving substance use disorder treatment.
- The DVHA Quality Unit secured the staffing and training necessary to take on additional QI project work. The DVHA Quality Unit staff were integral in helping to develop a set of quality metrics for use with the new Accountable Care Organization (ACO) program. The Quality Unit met all CMS Quality Measure Set reporting deadlines in 2017, including for the Health Home, Medicaid Adult and Child quality measures.

The DVHA Quality Improvement (QI) and Clinical Integrity Unit monitors, evaluates and improves the quality of care to Vermont Medicaid beneficiaries by improving internal processes, identifying performance improvement projects and performing utilization management. Efforts are aligned across the Agency of Human Services as well as with community providers. The unit is responsible for instilling the principles of quality throughout DVHA; helping everyone in the organization to achieve excellence. The Unit's goal is to develop a culture of continuous quality improvement throughout DVHA.

MCE Quality Committee

The MCE Quality Committee remained active throughout 2017 and consists of representatives from all Departments within the Agency of Human Services that serve the Medicaid population. The committee continues to structure its work around the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care. During this time period, the Quality Committee reviewed the *Global Commitment to Health* (GC) Core Measure Set results. This analysis led to the recommendation that the MCE further explore two topic areas that indicated room for improvement: chlamydia screening and adults' access to preventive/ambulatory health services. The committee also tasked a sub-group to explore the addition of a social determinant of health measure to the GC Core Measure Set.

Additionally, the committee discussed the annual Child and Adult CAHPS surveys, and ultimately combined contracting efforts with Vermont's Blueprint for Health program. An annual report and discussion of the MCE's grievances and appeals also occurred during Q4 CY 2017. In the future, the committee decided to also incorporate the customer service complaint log and the annual Legal Aid report into the analysis.

Managed Care Medical Committee (MCMC)

The Managed Care Medical Committee worked throughout the year to review Clinical Practice Guidelines. There were major revisions to the Medication Assisted Treatment Guidelines. The MCMC also worked with the Quality committee to identify potential quality improvement efforts. The MCMC solidified the process for addressing quality of care concerns. A process was developed to ensure appropriate review of ACO reports.

Formal CMS Performance Improvement Projects (PIPs)

Starting in July 2016, the topic of substance use disorder treatment was chosen as the MCE's **formal CMS PIP**. Work on that project continued throughout 2017. The combined Blueprint for Health/Medicaid ACO QI Project Leads team was identified as a key stakeholder group. Members of the PIP project's steering committee presented data and evidence-based intervention ideas to that team over

the course of the year. Through those exchanges, a data gap in the HEDIS IET measure was recognized. The SUD treatment services provided by Community Health Team staff are not included in the HEDIS rates since they are paid for through a separate funding mechanism without claims. The PIP steering committee has proposed a process for submitting “zero pay” claims for the provision of those services. A pilot community to test the CHT service tracking process will be identified after administrative, credentialing and operational hurdles are addressed.

Additionally, the PIP team is developing an SUD treatment provider access survey, which the team hopes to deliver via phone calls. With the data gathered, the team plans to provide community level provider lists, as well as targeted referral flow information and support during CY 2018.

The MCE’s Quality Unit was also charged with leading **informal PIPs** on the two topic areas identified by the Quality Committee (see above): chlamydia screening and adults’ access to preventive/ambulatory health services. During 2017, the Quality Unit secured the staffing and training necessary to take on this additional work. Project leads within the unit were identified, and initial evidence-based research was completed. As 2018 begins, project teams are being assembled and additional baseline data collected.

<u>Other Collaborative Quality Improvement Projects</u>

The Quality Unit staff participated in additional collaborative QI initiatives across the Agency of Human Services. Project underway in 2017 included:

- The QI Administrator continued to participate on a joint payer quality improvement project aimed at increasing follow-up care after hospitalization for mental illness. The Quality Unit has connected with the Policy Unit to explore the status of coverage for behavioral health telemedicine visits, which could have a big impact on this and other performance measures. This work group hosted a full day meeting in September for insurer and hospital clinical case managers entitled “Improving the Quality and Continuity of Care for Vermonters Hospitalized with Mental Illness”. Barriers to follow-up care and ideas for improvement were discussed. Next steps with volunteer pilot sites are ongoing.
- The QI Administrator continued to participate with Vermont Dept. of Health, the Vermont Children’s Health Improvement Program (VCHIP) and the DVHA Data Unit on a joint payer quality improvement project aimed at increasing adolescent well care visits. Four (4) additional practices were recruited to participate in Cohort 2 of this project during 2017, which includes targeted gap-in-care reports and a variety of other youth-centered interventions.

<u>Quality Measure Reporting</u>

- CMS Medicaid Quality Core Sets - Quality Unit staff collaborated with the Blueprint for Health and submitted the Health Home Core measure sets for FFY 2014 – FFY 2016 by the deadline of 7/31/17.

- The Quality Unit and the Data Unit also submitted the Adult and Child Quality Core Set reports by 12/31/17.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit’s QI Administrator coordinated the 2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children’s and Adults Medicaid 5.0H survey. The Quality Unit collaborated with the Vermont Blueprint for Health and consolidated work under one vendor, also used for the Patient Centered Medical Home (PCMH) survey. The contracted vendor, DataStat,

Inc., distributed and collated the surveys according to AHRQ and NCQA protocols. The results are the surveys were delivered to the DVHA in January 2018 and will be presented by the QI Administrator to the MCE Quality Committee and DVHA's Senior Leadership Team in March 2018. The DVHA QI Administrator also updated the Experience of Care scorecards for both adults and children which is posted on the DVHA public website here: http://dvha.vermont.gov/experience-of-care/view.

- HEDIS Hybrid Medical Record Review (MRR) - in 2017 the funding that DVHA had received through its Medicaid Quality Grant had ended and DVHA was not able to build any hybrid measure production costs into its budget. The Quality Unit pursued this as the 2018 budget was developed and was able to secure funding for the record retrieval for one hybrid measure – Adult BMI Assessment. The QI Administrator worked with the DVHA Data unit in 2017 to add this work to the HEDIS vendor agreement. The vendor, Verscend Technologies, Inc., will perform the record retrieval, while DVHA clinical staff will perform the record abstraction during CY 2018.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are being developed at DVHA for both internal and external performance management purposes. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff. The DVHA Quality Unit staff received training and has used this tool to create a Global Commitment Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. New scorecards actively under development in 2017 are related to the Applied Behavior Analysis (ABA) benefit, the Adult and Child Medicaid Quality Core Measure Sets, GC Investments and an overall DVHA performance accountability scorecard - which includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services.

Quality Unit staff also attended additional LEAN/RBA internal training sessions during 2017. The trainings are centered around process improvement and contribute to the Governor's initiative called PIVOT, or Program to Improve Vermont Outcomes Together.

Vermont Next Generation Medicaid ACO

In 2016, the DVHA Quality Unit staff were integral in the development of a set of metrics to measure the cost and quality of care provided to the Medicaid population by the newly contracted Accountable Care Organization. Additionally, the Quality Unit staff advised on a quality reporting matrix to be used for monitoring and oversight. The DVHA Quality Unit participated in internal DVHA readiness review preparation and in 2017 attended regular operational meetings.

Starting in 2017, the Quality Unit staff received, reviewed and approved quarterly VMNG ACO quality management reports. No areas of concern were identified. The Quality staff from DVHA and the VMNG ACO met regularly during 2017 with a focus on quality measurement and ongoing QI efforts. A supportive relationship is developing between the two Quality Teams.

AHS Performance Accountability Committee

During this year, the AHS Performance Accountability Committee (PAC) continued to focus on advancing organizational competencies associated with monitoring and evaluating performance. Specifically, the group reviewed sub-competencies, evidence of achieving the competency, and deliverables associated with monitoring performance. The committee also discussed the utility and feasibility of implementing a staff survey or questionnaire designed to assess the extent to which AHS

supports organizational competencies characteristic of high performing organizations that are associated with monitoring performance.

Also, this quarter, the PAC reviewed a draft GC Investment scorecard to be used to communicate the performance of programs/services that use GC investment funding. Group discussions centered around the use of the Clear Impact Scorecard that is currently in use in a majority of the AHS departments and how it might be modified to address the GC investment reporting needs. The group finalized the scorecard template after piloting a draft version. The new template will be used by all departments going forward.

The group also continued to discuss an Executive Order from Vermont's new governor, Phil Scott, creating the Program to Improve Vermont Outcomes Together (PIVOT). In addition to discussing the deliverables and timelines associated with the program, the group began to craft recommended roles/responsibilities that they might play with program implementation. To date, much of the conversation has focused on how the group might leverage monitoring performance competencies to support PIVOT activities.

During the final quarter in 2017, the AHS Performance Accountability Committee continued to discuss the utility and feasibility of an Organizational Competency Assessment. The purpose of the assessment would be to establish some baseline measurement in the various AHS Departments and Divisions. While a clear majority of the group supported the utility of such an assessment – they were unable to establish a plan to prioritize the resources needed to implement such an assessment. Finally, during the final quarter of this year, the group discussed the GC Evaluation Plan. Specifically, the group discussed how best to capture the performance measures being generated in the various AHS Departments. The group suggested that those developing measures to support the GC Evaluation Plan should consider using the Clear Impact Scorecard. This tool is currently begin used in the Medicaid program with GC Investments and expanding its use to Evaluation measures would support a move from measuring performance to managing it. The group will continue to discuss/debate the strengths/challenges associated with the tool and form a recommendation in the coming year.

Global Commitment (GC) Investment Review

In 2017, individual AHS department meetings were initiated with group discussions and decisions focusing on the monitoring and evaluation requirements in the new Special Terms and Conditions (STCs). Beginning this year, each department is required to submit financial monitoring data to AHS and evaluative data that highlights the performance of a subset of their investments. During the year, criteria was finalized and communicated. It was agreed that evaluative data will appear in Clear Impact GC Investment Scorecards and will include the following: investment description (i.e, the goal of the investment, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the investment is achieving its desired goal), results (performance measure rates for most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). A schedule of evaluative reporting was published with the Vermont Department of Health agreeing to provided investment monitoring and evaluation data for the during mid-year GC CMS Quarterly report. Monitoring and Evaluation of investments will continue following a periodic schedule. All Departments will highlight the performance of at least one of their investments in the Quarterly/Annual report.

During this most recent quarter, DVHA highlighted the performance of one of its investments – the Blueprint for Health. The Clear Impact Scorecard for this DVHA investment is included in this report as Attachment 7.

Comprehensive Quality Strategy (CQS)/State Transition Plan (STP)

During this year, Vermont submitted their CQS/STP to CMS for review. Also, during this year, the CQS/STP was posted for public comment. The document included the following: changes to the format to help consumers more readily navigate the strategy; an introductory section was added to orient the reader to the new HCBS regulations and the role that the CQS plays in meeting the State Transition Plan requirements; and more detail was added to the phases of HCBS implementation to clarify the use of systemic and site-specific assessments, remediation activities, monitoring and oversight methodology. In addition, text was added to the Heightened Scrutiny and Relocation of Beneficiaries Sections. Finally, a link to all assessments and work plans was included in the CQS. A public hearing was also held during the first half of the year. While no individuals from the community attended the most recent public hearing – AHS did receive three pieces of written feedback during the public comment period. After the close of the public comment period, a summary of feedback with state responses was developed. The state also received feedback from CMS during this time. The CQS/STP was subsequently modified to consider the stakeholder and consumer feedback obtained during the public notice process, the CMS feedback, as well as those generated because of a recent Demonstration Evaluation Plan review and Alternative Payment Model applications. The updated CQS/STP was resubmitted to CMS towards that end of the year.

Also, during this year, the Home and Community Based Services (HCBS) Implementation Team continued to work on applying the site-specific setting assessments to all applicable providers. The Department of Disabilities, Aging, and Independent Living (DAIL) and the Department of Mental Health (DMH) program surveys along with introductory messages were created and sent to all program directors responsible for each of the specific settings that provide home and community-based services. Reminder emails and phone follow up was conducted to enhance response rates. The team will continue to monitor program response rates and adjust their actions accordingly.

During the most recent quarter, AHS received a letter from CMS informing them that they had received initial approval of its CQS/STP to bring settings into compliance with the federal home and community-based services (HCBS) regulations found at 42 CFR Section 441.301(cXaX5) and Section aa|.110(a)(1)(2).

Global Commitment (GC) Evaluation Activities

During this year, a draft evaluation design and tentative evaluation budget was submitted to CMS for review/approval. The document included details for the following: study populations, suggest hypotheses to be tested, and recommend measures that need to be collected/reported. While the draft design included a section specific to the assessment of the impact of providing Medicaid reimbursement for IMD services for beneficiaries in need of acute mental health or substance use disorder treatment, it also included a section that addresses whether the evaluators find the demonstration to be budget neutral, what impact the demonstration has on health outcomes, as well as any policy implications. The budget included total estimated costs for each year of the demonstration, as well as an annual breakdown of estimated staff, contractual, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation.

During this year, a Global Commitment to Health Evaluation Request for Proposals (RFP) was developed and posted. In addition to outlining the scope of work and deliverables, the document provided potential bidders with information re: general requirements, the content and format of responses, as well as submission instructions. Links to the draft evaluation design discussed above were included in the RFP. Also, during this year, a bidder's conference was held to ensure potential bidders had sufficient

information to help them submit a proposal that responds to the needs of the state. Interested parties were asked to submit questions ahead of the bidder's conference. The state responded to some questions and took additional questions during the bidder's conference. All questions and responses will be posted on the state website for all to see – even those that did not attend the bidder's conference.

Also, during this year, AHS executed a contract with an independent vendor and subsequently worked with them to modify the draft evaluation design. An evaluation kickoff meeting was held, and the following items were reviewed: overview of demonstration evaluation, alignment between Payment Initiatives, GC Investments, Comprehensive Quality Strategy, and Evaluation, timelines, tasks, and the content of Interim Report #1. The group used the remainder of the meeting time to review potential measures and data availability. To facilitate this work, the groups walked through worksheets targeted to specific evaluation focus areas including IMD, ACO, and Vermont Blueprint for Health. The remainder of the meeting was spent in small group breakout discussions.

During this most recent quarter, AHS received feedback from CMS re: the draft Evaluation Plan. In addition, the AHS QIM worked with various AHS Departments to identify and finalize data for IMD and non-IMD aspects of the evaluation. This work included the development of a GC Evaluation Measures Workbook with change log. This spreadsheet includes a general measures tab, IMD measures tab, and a Rapid Cycle tab. All tabs include columns for data collection information – including but not limited to the following: data source, frequency, description, measure steward, benchmark, rate/result, and baseline. In addition, any changes in policy or program operations from the previous GC reporting period (e.g., eligibility criteria, service limitations or enhancements, covered benefits, new service locations/geography, significant network changes, etc.,) and measure specification modifications (e.g., any changes in specs from the previous GC reporting period) are documented as well. Finally, during this most recent quarter, the Evaluation plan was edited to consider the CMS recommendation(s) received on October 13, 2017 and submitted to CMS for review/approval.

iii. Provider and Member Relations

Key updates:

- Non-Emergency Medical Transportation
- Dental Services
- Provider Enrollment
- Access to Care

The Provider and Member Relations (PMR) Unit ensures members have access to appropriate health care for their medical, dental, and mental health needs. The Unit monitors the adequacy of the Green Mountain Care (GMC) network of providers and is responsible for implementation of the enrollment, screening and revalidation of providers in accordance with Title 42 Code of Federal Regulations (CFR) §455.410 and §455.450 requiring that all participating providers be screened upon initial enrollment and revalidation of enrollment.

<u>Non-Emergency Medical Transportation</u>

The Non-Emergency Medical Transportation (NEMT) program ensures that Medicaid members who do not have access to transportation are able to get rides to and from medical appointments and daily dosing for opioid addiction treatment. Vermont works with Vermont Public Transit Authority (VPTA), under a contract that was effective January 1, 2017. This contract included a 6-month transition period to allow for the creation of a call center and other new infrastructure. The transition period ended on June

30, 2017. As of July 1st, 2017, DVHA works with only one transportation provider, VPTA, as of July 1, 2017 has 7 subcontracted Brokers to provide these services through a network of eight subcontractors.

Following unanticipated financial constraints, Southeast Vermont Transit, the VPTA sub-contractor for Medicaid Transportation in Windham and southern Windsor Counties, determined they would no longer provide demand response transit service in their jurisdiction effective January 14, 2018. Vermont Medicaid was notified of this decision on October 20, 2017. In response, DVHA and VPTA worked collaboratively to ensure members received need rides. VPTA created a centralized call center and a new diverse transportation network, called "Shared Transportation Services". This new program will continue to serve all eligible Medicaid beneficiaries in Windham and southern Windsor Counties with no disruption in service. The call center phones are staffed Monday through Friday, 7:45AM-4:30PM. Return ride requests will also be routed through the call center. As with any transition there were adjustments and some changes in service delivery. The goal was to create more transit options, along with cost effective efficiencies, and to strive to continually operate in a safe and timely manner. Although nearly 500 beneficiaries were affected by Southeast Vermont Transit's service decision, there was ultimately no disruption in Medicaid transportation services.

Dental Services

Vermont continues to struggle with the lack of dentists practicing in the state, many dentists reaching retirement age, and the lack of dentists that participate with Vermont Medicaid. Nearly 25% of Vermont Medicaid beneficiaries receive dental care in a given year. To assist the Department of Vermont Health Access (DVHA) begin enrolling independently billing Dental Hygienists as Vermont Medicaid providers. To enroll, a Dental Hygienist must meet all licensing requirements set forth by the State of Vermont. To date, three Dental Hygienists have been enrolled. DVHA continues to collaborate with Vermont Dental Society and the Department of Health in order to initiate policies to address the lack of dentists in Vermont.

Provider Enrollment

On average, Vermont Medicaid receives about 400 provider enrollment applications per month and it takes 120 days before the enrollment process is completed. In December 2017 the decision was granted to start a project to allow provides to enroll online and reduce the turnaround time for enrollment. The Provider Management Module (PMM) is a project under the Medicaid Management Information System (MMIS) program and is part of the overall MMIS Road Map as presented to the Centers for Medicare and Medicaid Services (CMS). The MMIS program is focused on enhancing business processes and leveraging technology to help the Agency of Human Services (AHS) achieve its goal of administering the Medicaid program and serving Vermonters efficiently and effectively. The MMIS program consists of many projects that address federal mandates and take the appropriate steps to modernize Vermont's Medicaid systems which deliver health care provider solutions and payment capabilities along with the associated quality and monitoring services. The goal for the PMM project is to "go-live" no later than 2/1/2019 and reduce the provider enrollment timeframe from an average of 120 days to below 30 days.

Access to Care Plan Review

Following the initial release in October 2016 of the DVHA Network Standards, the DVHA Data Unit has compared the baseline figures presented there with more recent data. Based on claims, the analysis estimates travel times needed to traverse Vermont's highway network from Medicaid recipients' homes to each of their provider's practice locations. This summary is one such review of the Access Plan based on those quantifiable measures. These are completed every half year. The most recent review was completed in October 2017. The next scheduled review is for April 2018.

The below summary is a comparison between 2015 medical claims and the July 2016-June 2017 period most recently available. This is in accordance with DVHA's commitment to run this data twice yearly. All relevant claims during calendar year 2016 were selected based on providers' specialties. Valid location data was chosen based on the Vermont Medicaid recipients' postal address.

Findings from latest Access Plan Review:

- Statewide, travel times have increased since 2015 for the Cardiology and Urology specialties.
- Statewide, the pediatric travel time has increased slightly.
- Travel time to ophthalmology or optometry has decreased across the state.
- For those specialties with increases, there is a corresponding decline of 3 to 5 percent in travel distribution for under 30 minutes (Pediatric) and under 60 minutes (Cardiology and Urology).
- All other specialty or primary care changed only slightly or hardly at all compared to 2015.

Travel time and distance from claims data
Access Plan Review - STATEWIDE COMPARISON 2015 vs July 2016-June 2017

Vermont Medicaid Recipients - All Counties Combined

Primary Care	Year	Average (mean)		Median		Distribution		Change from 2015	
		Time	Distance	Time	Distance	Time % below 30 minutes	Distance % below 30 miles	Time	Distance
Primary Care	2015	25.9	18	17.9	10	68%	82%	≈	≈
	Jul'16~Jun'17	25.8	18	18.0	10	68%	82%		
Pediatric	2015	22.7	15	15.3	9	72%	86%	+	+
	Jul'16~Jun'17	25.0	17	17.5	9	69%	83%		

Specialty Care	Year	Average (mean)		Median		Distribution		Change from 2015	
		Time	Distance	Time	Distance	Time under 60 minutes	Distance under 60 miles	Time	Distance
Cardiology	2015	41.2	31	32.8	23	73%	83%	+	+
	Jul'16~Jun'17	46.3	36	38.7	36	68%	80%		
Affected counties: All ++ except Essex, Franklin, Grand Isle and Orange									
Urology	2015	35.6	26	27.9	18	78%	88%	+	+
	Jul'16~Jun'17	40.8	31	31.6	23	75%	84%		
Affected counties: Addison, Chittenden, Rutland and Windham ++									
Behavioral, Mental Health & Substance Abuse	2015	27.0	19	16.4	9	85%	93%	≈	≈
	Jul'16~Jun'17	26.7	19	15.3	9	86%	93%		
Obstetrics	2015	29.9	20	21.5	13	86%	93%	–	≈
	Jul'16~Jun'17	27.8	19	21.3	13	88%	95%		
Dental	2015	24.1	15	17.7	10	91%	97%	≈	≈
	Jul'16~Jun'17	23.3	15	18.3	9	91%	97%		
Ophthalmology, Optometry	2015	33.2	23	23.5	15	81%	91%	–	–
	Jul'16~Jun'17	25.9	17	20.9	12	90%	96%		
Affected counties: All - or --. Most change in Franklin, Grand Isle, Orleans and Rutland									
Advanced Imaging	2015	28.1	19	20.2	12	86%	93%	≈	≈
	Jul'16~Jun'17	27.7	19	19.8	11	87%	93%		

revised
10/23/2017

V. Cost Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates:

- The AHS MMIS Enterprise Care Management System has been live for the VCCI for 2 years. The Vendor, eQ Health, presented a preliminary Cost Savings report for Calendar Year 2016. The cumulative total medical costs twelve months before and after enrollment periods show estimated annualized savings compared to a control group. This report will be recalculated to allow for a more complete claims adjudication period. The expected delivery of the final report is May 2018.
- Emergency Department utilization decreased post-VCCI enrollment for the 3rd and 4th quarter of CY 2016.
- VCCI continues to work with the Vendor to design reports on clinical, financial and performance metrics to be delivered in June 2018.
- A contract for an interface with VITL has been completed. The goal is for data to be sent into the eQ Suite in June, 2018.
- VCCI and Blueprint working together on improved integration and collaboration in providing case management and care coordination services to Vermont's most vulnerable people.

The goal of the VCCI is to improve health outcomes of Medicaid beneficiaries by addressing the increasing prevalence of chronic illness through various support and comprehensive case management strategies. The Case Management Society of America defines case management as: a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

The VCCI is a component of DVHA's health care reform goals and its supporting strategic plan. The VCCI employs 20 licensed field-based Case Managers and 2 non-licensed professional staff operating in a decentralized model statewide, so resources are available where members need them. The VCCI is designed to identify and assist high risk/high cost, medically complex Medicaid members with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower members to eventually self-manage their chronic conditions. A significant effort is placed on facilitating and supporting Medicaid member identification, access and use of a Medical Home for receipt of primary care.

The VCCI uses a holistic model of evaluating and supporting improvement in medical and behavioral health, as well as identification of socioeconomic issues that are barriers to sustained health improvement. The top 5% of VCCI-eligible Medicaid members account for approximately 39% of Medicaid costs and a disproportionate number of hospital admissions and readmissions. The new AHS Enterprise MMIS/care management vendor utilizes the Johns Hopkins evidence based predictive modeling and risk stratification software to support population selection and related eligibility for services. This new model will enhance VCCI's ability to identify members based on both past cost profiles and anticipated future utilization, risks and costs, and intervene earlier in order to track the clinical and financial improvements. Excluded populations currently include dually eligible individuals, those receiving other waiver services and CMS-

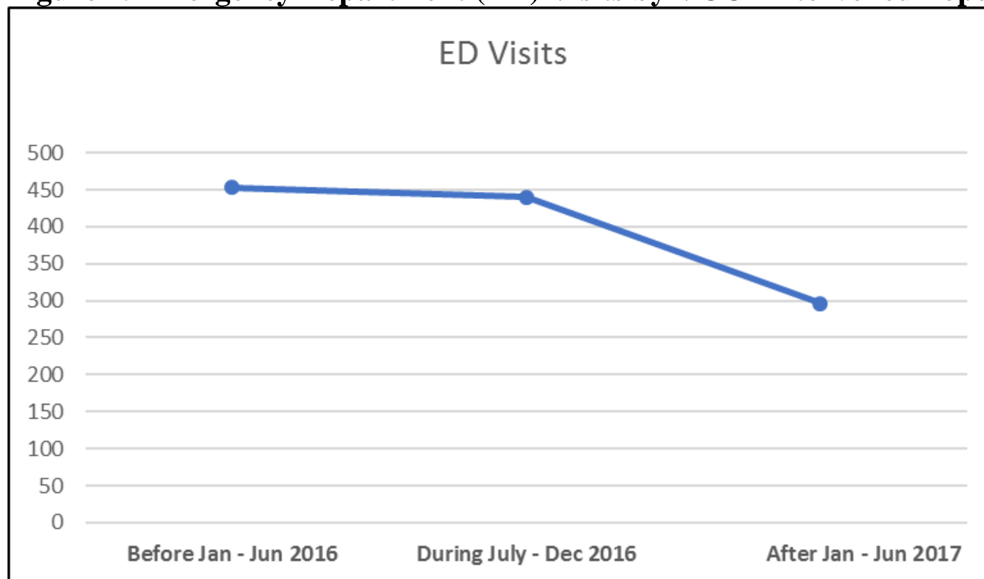
reimbursed clinical case management. There is an effort underway to identify opportunities to expand the population that VCCI serves.

The VCCI deploys Case Manager to hospitals to serve as liaisons to the VCCI Field staff/programs. The focus of this work is to identify members early in order to facilitate safe transitions of care to include medication reconciliation and medical/behavioral health appointment follow up toward reductions in 30-day readmission rates. VCCI also has embedded staff in high volume Medicaid medical homes to provide "on site" case management to the Medicaid population of that practice.

This past quarter, the development of program reports around clinical, cost, and performance was a priority of the VCCI. The preliminary cost savings report showed an annualized cost savings for 2016 - the first full year the system was operational. This report was done comparing total costs and total utilization amongst a control group (non-VCCI intervened) and Members that were enrolled in the program for more than 1 month. The report showed that the VCCI Case Management services provided to members had a positive financial impact. The average medical costs for the Intervened group in the pre-enrollment period were found to be statistically greater than the post-enrollment period. A comparison of the utilization trends among the intervened group and the control group also showed a positive impact of the program on patient outcomes as an annualized savings. Further analysis also showed the VCCI eligible population migrating toward lesser morbidity and total cost. This report will be recalculated to allow for a full 14 months of claims processing with an expected delivery of May 2018.

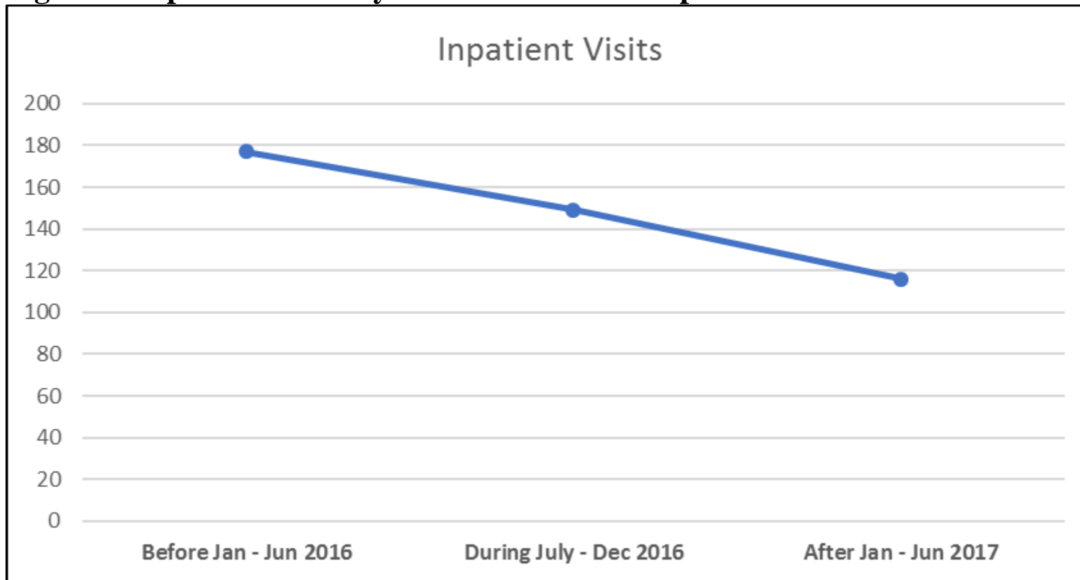
Preliminary reports pulled by the VCCI Data Analyst demonstrated a reduction in ED utilization on the VCCI intervened population. The report reviewed utilization 6 months prior to VCCI intervention, during VCCI intervention and 6 months post-intervention. The final data showed a significant decrease in the number of inpatient visits from 177-116; and a decrease in the inpatient visit per thousand from 600 to 393. The number of ED visits also dropped from 453-296; and ED visit per thousand went from 1,536 to 1,003.

Figure 1. Emergency Department (ED) Visits by VCCI Intervened Population



Time Frame	ED Visits	ED Visits/1000
Before Jan - Jun 2016	453	1,536
During July - Dec 2016	440	1,492
After Jan - Jun 2017	296	1,003

Figure 2. Inpatient Visits by VCCI Intervened Population



Time Frame	IP Visits	IP Visits/1000
Before Jan - Jun 2016	177	600
During July - Dec 2016	149	505
After Jan - Jun 2017	116	393

The AHS Enterprise Care Management solution, eQ Health, has been operational for 2 years. There is continued design, development and implementation (DDI) being done. This DDI phase will finish in June of 2018. Work has begun on pursuing CMS certification of the system, with a CMS site visit and evaluation anticipated for the end of Calendar year 2018.

DVHA's Clinical Operations Unit and the Quality Improvement Units have been utilizing eQ Health for direct referrals to VCCI Case Managers to eliminate the need for manual workarounds. This has enhanced the volume of warm transfers of complex members to the VCCI for managing care transitions and related decline in hospital readmission rates.

The VCCI Management team and Data team continue to work with the technical team toward receipt of biomedical and immunization data feeds from the HIE into the care Management eQ Suite. This data resource for 100% of Medicaid members will enhance the clinical staff's ability to effectively identify need and manage care based on member's treatment of chronic conditions and management of the condition toward evidence-based treatment and care goals. It is anticipated that this will be operationalized in June, 2018. This data will also assist DVHA in evaluating the ACO.

Strategic alignment of work between DVHA, VCCI, and DVHA Blueprint for Health has begun. Ongoing discussions are exploring a VCCI population expansion, potential identification of shared tools, closer collaboration with the NCQA certified advanced practice medical homes and local Community Health Teams. The goal of this alignment is to reduce redundancies, enhance communication/collaboration among the teams, and support development of a single, shared plan of care.

MOMS (Medicaid Obstetrical and Maternal supports) for Pregnant Women

The VCCI initially launched the service line for pregnancy case management in October 2013 and which has steadily evolved based on staff and partner input. The primary focus is on women with a history of mental health and substance use/abuse and related management of these conditions during pregnancy in an effort to improve birth outcomes and limit NICU and/or inpatient stays for both baby and mother. The MOMs program has integrated with the Blueprint for Health Women's Health Initiative and the programs have begun to integrate at the local community level in sharing resources and collaborating on cases, as well as referrals to VCCI field case managers.

ii. Behavioral Health Services

Key updates:
- Paper review transition
- Applied Behavior Analysis
- Pilot Project
- Team Care program revitalized
- Telehealth

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric, detoxification, and substance abuse residential services for Medicaid primary beneficiaries. In 2017, the team completed the transition to paper reviews for all providers. This practice ensures member confidentiality and improved interrater reliability. As a result of the transition to paper, the clinical documentation to support authorization requests has improved significantly. The team has developed a system to ensure internal consistency and educate providers on documentation requirements. Team members work closely with discharge planners at inpatient and residential facilities to ensure timely and appropriate discharge plans. DVHA collaborates with other Departments to support coordination of care. The Team has worked with VCCI staff to develop a referral process for VCCI services and to ensure continuity of care for members already enrolled with VCCI admitted to inpatient or residential care facilities. In recognition of the inherent challenges in providing strong clinical documentation to justify admission and continued stay within 24 hours of admission, DVHA has engaged in a pilot project in which there is automatic initial authorization of 5 days for all members meeting the acute level of care criteria at the Brattleboro Retreat. This practice allows time for the assessment and formulation of an individualized plan of care and discharge plan for each member admitted. The team is closely monitoring trends to ensure appropriate utilization.

The Behavioral HealthTeam also manages the Team Care program (formally the lock-in program). Clinical review of all available data allowed for an accurate assessment of current enrollees' need to remain in the program. Standards for inclusion and removal are being operationalized by the Team. Team Care program members are also referred to VCCI when appropriate. Outreach with providers and pharmacies is planned for the upcoming year. There have been no referrals for inclusion in the program. The lack of referrals may demonstrate success of the Vermont Prescription Monitoring System (VPMS) and new opiate rules associated with VPMS.

Behavioral Health Team members continued involvement in the AHS Substance Abuse Treatment Coordination Workgroup. This workgroup strives to standardize substance abuse screening and referral processes throughout the Agency of Human Services. Team members also participate in monthly meetings with the VDH's Alcohol and Drug Abuse Prevention Division to coordinate efforts between the two departments to provide substance abuse services to Vermont Medicaid beneficiaries. Team members

also participated in the SFI Interagency Team, and the Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF, and more).

Following the initiation of the Applied Behavior Analysis (ABA) benefit in July 2015 the Autism Specialist, a member of the Behavioral Health Team, has worked collaboratively over the past two years with the Policy Unit and sister Departments to evaluate and improve the program. The Autism Specialist surveyed consumers to gain feedback of the effectiveness of ABA treatment for the members receiving the service. Additionally, the Autism Specialist has elicited feedback from providers in an effort to strengthen and improve the prior authorization process. As a result, there was an approved rate increase in Spring of 2016. The intention of the rate increase was to attract new providers and to help current providers sustain their practices and continue to provide treatment. Over the past two years there has been an increase in the number of members receiving ABA services, as well as an increase in enrollment of ABA providers (BCBAs). There continues to be ongoing discussions at the DVHA regarding alternative payment options for ABA that would continue to support members and providers, as well as attract new ABA providers to serve members. The Autism Specialist participates in the Autism Workgroup, which happens on a bi-monthly basis and includes community partners, including several ABA providers across the State. This meeting gives ABA providers the opportunity to ask questions and allows them to provide feedback directly to the Autism Specialist. The Autism Specialist has conducted site visits with several ABA agencies over the past 6 months. This has allowed the Autism Specialist to connect and foster relationships with the providers and to see first-hand the treatment that is being provided to Medicaid members. Future visits are being scheduled, and it is a goal for this to become a regular practice to further quality assurance at the DVHA. Providers have been open and welcoming to this process and thus far the Autism Specialist has seen impressive facilities, documentation, and work being done. The Applied Behavior Analysis Clinical Practice Guideline have been completed and are available to providers. Currently, the Autism Specialist is conducting research for expansion of the benefit beyond a Autism Spectrum Disorder (ASD) diagnosis as there have been increasing requests of authorizations for children who do not have an ASD diagnosis, yet who could benefit from ABA services. The Autism Specialist will continue to gather data, although there is limited research done at this time of the effectiveness beyond ASD.

iii. Mental Health System of Care

Key updates:

- Report on reforming Vermont's Mental Health System submitted to the Vermont State Legislature (Act 82, Sections 3 & 4).
- The Department of Mental Health initiated payment reform for its Child and Adult Mental Health programming.

The Department of Mental Health is responsible for mental health services provided under state funding to special-needs populations including children with serious emotional disturbances (SED) and adults with severe and persistent mental illnesses (SPMI). Funding is provided through the Vermont Agency of Human Services (AHS) Master Grants to ten Designated Agencies and two Specialized Service Agencies. These agencies are located across the state of Vermont for the provision of

- Community Rehabilitation and Treatment (CRT) services for adults with severe and persistent mental illness;
- Adult Outpatient for adults who are experiencing emotional or behavioral distress severe enough to disrupt their lives but who do not have long-term disabling conditions;
- Emergency Services for anyone, regardless of age, in a mental-health crisis; and

- Children, Youth, and Family Services, including children who have a serious emotional disturbance and their families.

The Department also contracts with several peer and family-run organizations to provide additional support and education for peers and family members who are seeking supplemental or alternative supports outside of the Designated Agencies in their catchment area. Peer and family-run organizations also help educate individuals and families to advocate for their needs within the Designated Agencies and across multiple service provider organizations.

Inpatient care is provided through a decentralized system which includes one state-run psychiatric care hospital and five Designated Hospitals located across the state.

Community services support hospital diversion through expanded crisis services and increased residential treatment using the least restrictive setting that is appropriate for the level of care required. In many cases, treatment can be provided closer to individuals' homes.

Enhancements of the Mental Health System of Care through the Department of Mental Health:

Hospital Services

- 45 Level 1 beds and a total of 199 adult psychiatric inpatient beds across the system of care
- 25 bed psychiatric hospital that is CMS certified and TJC accredited
- Operational capacity for Level 1 inpatient care at Rutland Regional Medical Center and Brattleboro Retreat
- Emergency Involuntary Procedure Rulemaking process completed with Legislative Committee on Administrative Rules (LCAR)
- Designation of the White River Junction Veterans Administration Medical Center to provide involuntary inpatient care

Community Services

- Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop
- Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs
- Increased capacity to provide mobile crisis responses to those needing screening and intervention in the community
- Increased and additional training for Team Two collaboration between law enforcement and mental health responders
- Additional availability of soft-restraints for law enforcement transports for mental health hospitalizations
- Resources to assist individuals in finding and keeping stable housing
- Expansion of warmline hours

Residential and Transitional Services

- Soteria, a five-bed, peer supported alternative residential program opened in Chittenden County
- Maintaining full occupancy at the secure residential recovery program, the Middlesex Therapeutic Community Residence, serving 7 individuals
- Continued planning for permanent replacement capacity for the Secure Residential Program

Performance and Reporting

- Along with AHS, DMH has adopted the Results-Based Accountability (RBA) framework for assessing performance of providers via grants and contracts

- Creation of a “Vermont Psychiatric Care Hospital Outcomes” scorecard to meet legislative reporting requirements
- Creation of a “DMH Scorecard” using the RBA scorecard reporting tool
- Migration of the “DMH Snapshot” and the “DMH continued reporting” report to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting
- Participation in development of the Agency of Human Services Community profiles

Regulation and Guidance

- Revision of the Designated Hospital Manual and Standards to better reflect the scope of review and designation and creation of a designation protocol to efficiently manage the process
- Creation of involuntary transportation manual to consolidate the expectations of the department into a single document
- Revision of the emergency services standards

Payment Reform

DMH continues to work on payment reform, building off the Medicaid Pathways work and aligning necessary changes in the provider system with the All-Payer Model. The Department is working toward a FY 2019 timeline to have several—if not all—children’s mental health programs in a model similar to Integrating Family Services. Work is underway on a similar initiative for adult mental health services. The goal of this work is to move toward a simple, but accountable system that reduces the complexities of payment and shifts the focus of the providers and the department on outcomes and quality. DMH is committed to reforming the system to better serve Vermont’s population and continue to move towards full integration.

iv. Blueprint for Health

Key updates:

- The number of Blueprint primary care practices overall increased by eleven over the year with eleven primary care practices joining the Blueprint. There were no practices that closed or left the Blueprint over the year.
- Practice and HSA level profiles for time periods 7/1/15 – 6/30/16 (Rolling Year 2016) and 1/1/16 – 12/31/16 (Calendar Year 2016) were released.
- 2017 marked the first year of the Women’s Health Initiative, a new services initiative to reduce Vermont’s rate of unintended pregnancies. The Women’s Health Initiative has grown from 15 to 20 women’s health clinics and from 13 to 15 participating Patient Centered Medical Homes.
- Enrollment in the Hub and Spoke Health Home for opioid addiction continued to grow throughout the year; the total enrollment at the end of December was 5,850.

The Blueprint combines state-level strategic direction with local organization and ownership of care delivery. The state’s 14 Health Service Areas (HSAs) each have an Administrative Entity, such as a hospital or Federally Qualified Health Center (FQHC), that leads the Blueprint locally. Their work includes local program management, staffing of Community Health Teams (CHTs), and financial management. The Blueprint’s Transformation Network includes Project Managers, hired by the Administrative Entities, who lead implementation and engage community partners at the local level. Each Administrative Entity contributes their own financial and human resources, beyond the scope of their Blueprint grants, demonstrating their commitment to the Blueprint’s sustainability and success.

The Administrative Entities in each HSA work to include local partners in guiding Blueprint implementation. In 2015, local Blueprint work groups (originally known as Integrated Health Services advisory groups) merged with Accountable Care Organization (ACO) work groups (known as Regional Clinical Performance Committees). These combined groups are now known as Community Collaboratives (CCs).

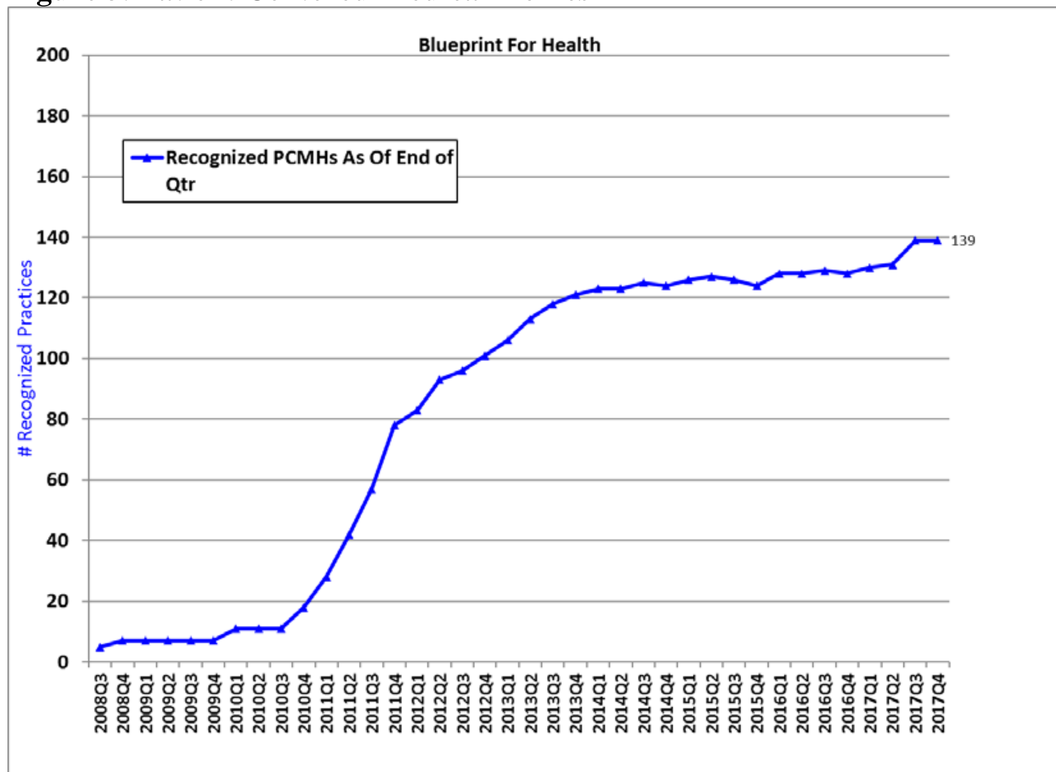
Staffed by the Blueprint Project Manager with clinical leadership supported by the ACOs, the CC leadership teams include representatives from ACOs present in that community, local primary care leaders (including a pediatric provider), the hospital, home health or the Visiting Nurse Association, Area Agency on Aging, Designated (mental health) Agency, Designated Regional Housing Organization, and others. They meet to identify local priorities, goals, strategies, and quality or process improvement projects, including the design and staffing of the area's Blueprint CHT.

The long-term goal of these CCs is to prepare each HSA to function as an Accountable Community for Health (ACH), responsible for the wellness of the whole population and its health care budget. This model supports the complete integration of high-quality medical care, mental health and substance abuse services, social services, and prevention.

Patient Centered Medical Homes

In the past quarter, the Blueprint for Health program has had a net increase of eleven NCQA-recognized primary care practices with eleven primary care practices joining the Blueprint. The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. The number of Blueprint PCMH practices as of the end of the quarter was 139.

Figure 3. Patient Centered Medical Homes



Healthcare data profiles of practices and Hospital Service Areas (HSAs)

Practice-level and HSA-level profiles of all-payer healthcare outcomes data, for adult and pediatric patient populations, combine claims, clinical, and survey information, and continue to be produced by Onpoint for the Blueprint roughly every 6 months. Practice profiles and HSA profiles have been distributed to practices and healthcare organizations for the following data time periods:

i. 01/2013 - 12/2013
ii. 07/2013 - 06/2014
iii. 01/2014 - 12/2014
iv. 07/2014 - 06/2015
v. 01/2015 – 12/2015
vi. 07/2015 – 06/2016
vii. 01/2016 – 12/2016

Practice and HSA profiles for the data period 07/2015 – 06/2016 were produced and distributed in June 2017. Practice and HSA profiles for the data period 01/2016 – 12/2016 were produced and distributed in December 2017. The information in those profiles give practices an overview of total utilization and expenditures as compared to peers and the rest of the state. Vermont HSA data profiles, including the latest ones for the data period 01/2016 – 12/2016, are posted at http://blueprintforhealth.vermont.gov/community-health-profiles.

Blueprint Outcomes for 2017

Methodology: Constructing Test Groups and Comparison Groups

The Blueprint Evaluation uses data from Vermont's all payer claims database, Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), for calendar year 2008 through calendar year 2016. The evaluation compares results for people who received the plurality of their care at a Patient-Centered Medical Home (this is the test group) with results for people who received the plurality of their care at a non-Patient-Centered Medical Home (this is the comparison group).

People who receive care in Patient-Centered Medical Homes also have access to Community Health Team services, so while the evaluation calls the test group "PCMH patients," it should be kept in mind that they benefit from the larger Blueprint approach to coordinated primary and preventative care.

The Blueprint has grown to include 139 Patient-Centered Medical Homes over the nine years it has been in operation. The evaluation design accounts for the different dates when participating practices became recognized Patient-Centered Medical Homes by assigning a "program stage" to each practice. The programmatic stages are:

- **Pre-year**: the year prior to starting work with the program
- **Implementation year**: the year the practice started to prepare for NCQA scoring as a PCMH and received CHT staffing
- **NCQA Scoring Year**: the year the practice was independently scored against NCQA Standards
- **Post-Years 1 through 5**: the years the practice operated as a recognized PCMH

Non-Patient-Centered Medical Home primary care practices do not have comparable stages, so the evaluation randomly assigns patients attributed to non-PCMH practices to programmatic years. Comparison group patients are randomized to programmatic stage in a manner that mirrors the distribution of Patient-Centered Medical Home patients by programmatic stage and calendar year.

Methodology: Risk-Adjustment

Having constructed the test and comparison groups, the evaluation uses a regression-based risk-adjustment procedure to control for observed differences in health status between members of the Patient-Centered Medical Home group and the comparison group. Risk-adjustments are made for the following factors:

- demographics (e.g. age and gender groups)
- health status (3M™ Clinical Risk Groups (CRG))
- select chronic conditions identified by the Blueprint program (i.e., asthma, attention deficit disorder, chronic obstructive pulmonary disorder, congestive heart failure, coronary heart disease, depression, diabetes, and hypertension)
- maternity
- Medicaid and Medicare coverage
- length of enrollment
- Medicare-specific adjustors including disability and end-stage renal disease (ESRD).

Adjusted expenditures and utilization rates were calculated for all individuals in the evaluation (in both test and comparison groups) for every year. These adjusted rates serve as the basis for the outcome measures discussed here.

Methodology: Analysis Methods

To describe how Patient-Centered Medical Home participants differed from the comparison group, adjusted rates are shown graphically, and statistical tests are used to identify the mean difference in the adjusted outcome measures by programmatic year. These approaches are useful, but additional investigation is required to document the impact of Patient-Centered Medical Home maturation over time.

The evaluation uses a difference-in-difference model, a common statistical technique used in observational studies, to better understand the impact of Patient-Centered Medical Home maturation. Difference-in-difference uses a regression-based framework to estimate the averted expenditures and averted health care utilization associated with Blueprint participation in each programmatic year. The difference-in-difference model compares the change in an outcome from the pre-period and the post-period for the test group vs. the comparison group. It then calculates the probability that the observed change could be due to chance.

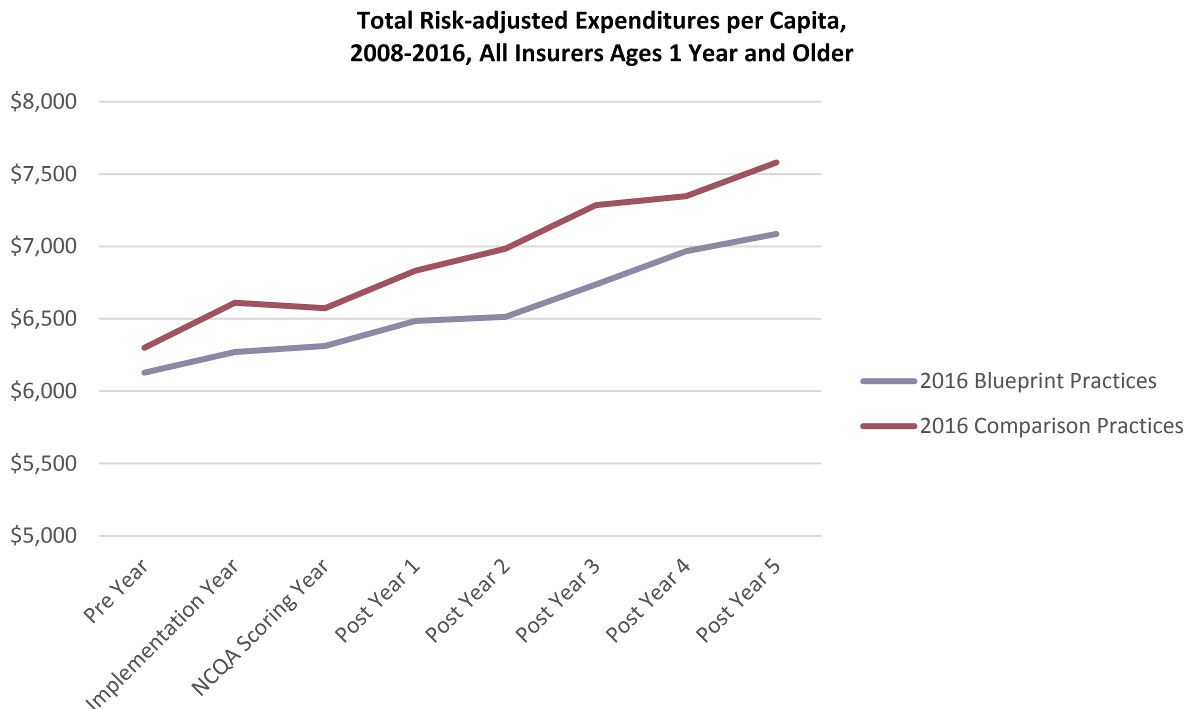
As discussed above, the Blueprint is an ongoing program in a dynamic environment. Individuals transition across practices, providers join and leave practices, Vermonters leave the state and new Vermonters arrive, new practices transform into Patient-Centered Medical Homes, and practices advance through the programmatic stages. This means that the mix of patients and practices in each programmatic year is changing in every iteration of the evaluation. Thus, while results from previous years are an important benchmark, it is almost assured that the findings here will differ slightly from those presented in prior periods.

Results: All Payer Expenditures

One of the most consistent findings of the Blueprint's Patient-Centered Medical Home evaluations has been lower average risk-adjusted expenditures for patients of Blueprint Patient-Centered Medical Homes relative to the comparison group. The total risk-adjusted expenditures include Medicare, Medicaid, and Commercial insurers. Figure 2 shows that total risk-adjusted expenditures were significantly and meaningfully lower for people attributed to a Blueprint Patient-Centered Medical Home. In post-year 5, individuals attributed to a Blueprint Patient-Centered Medical Home had mean risk-adjusted total

expenditures of $7,086, which was $494 lower than the mean for individuals in the comparison group (p<0.0001). Difference-in-difference results indicate that the rate of growth in risk-adjusted total expenditures across the eight-year window was $322 lower for a typical patient attributed to a Blueprint Patient-Centered Medical Home (p<0.0001) than the typical patient in the comparison group.

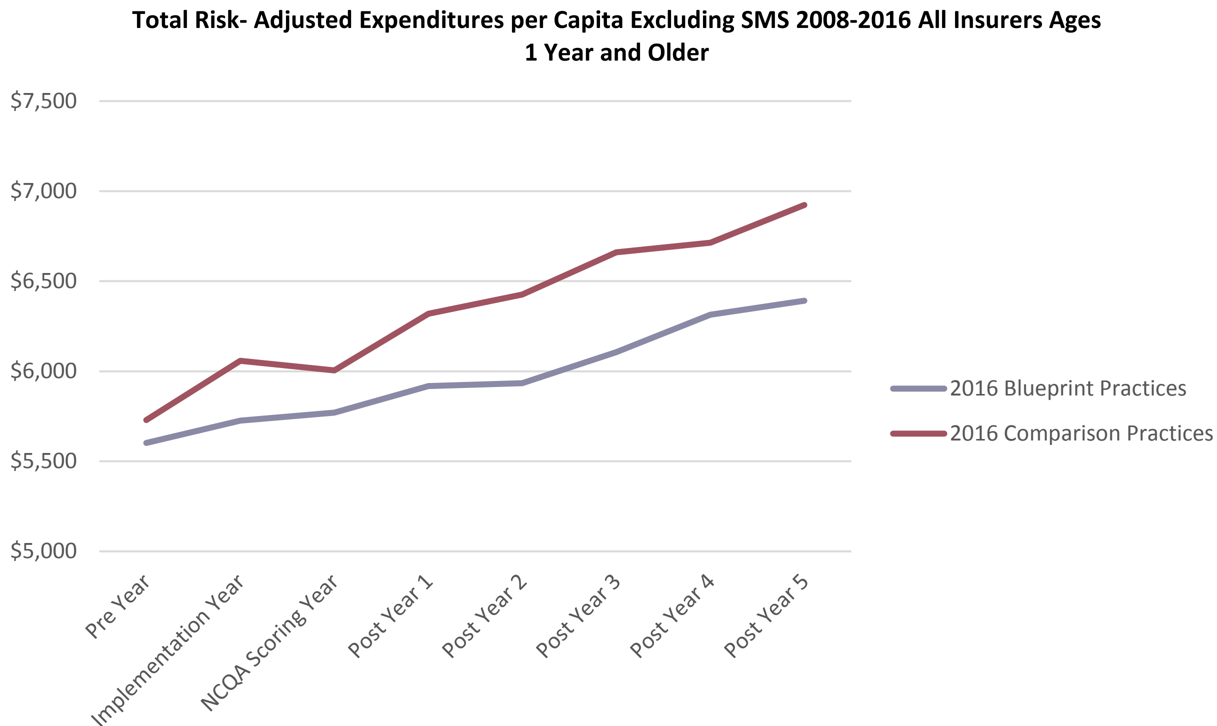
Figure 4: Comparing Total Risk-Adjusted Expenditures for Blueprint Patient Centered Medical Patients and Comparison Group



Results: Health Care Expenditures Only

To provide a more focused comparison of just health care expenditures (without non-medical support services) the Blueprint evaluates expenditures excluding Special Medicaid Services. Figure 3 shows total risk-adjusted expenditures, excluding Special Medicaid Services, by programmatic year. As with total risk-adjusted expenditures, patients attributed to a Blueprint Patient-Centered Medical Home had uniformly lower risk-adjusted total expenditures. In the pre-year, the typical Patient-Centered Medical Home patient had risk-adjusted total expenditures excluding Special Medicaid Services that were $127 lower (P<0.0001) than the typical individual in the comparison group. By post-year five, the typical Blueprint Patient-Centered Medical Home-attributed patient had total risk-adjusted expenditures that were $532 lower than the typical patient in the comparison group (p<0.0001). The difference-in-difference estimate finds that PCMH-attributed patients save an average of $404 in averted, risk-adjusted total expenditures excluding Special Medicaid Services by post-year five. This even larger savings reinforces the idea that the Blueprint reduces health care spending, and that it does so in part by connecting people with other resources that support wellness.

Figure 5: Comparing Total Risk-Adjusted Expenditures Excluding Special Medicaid Services

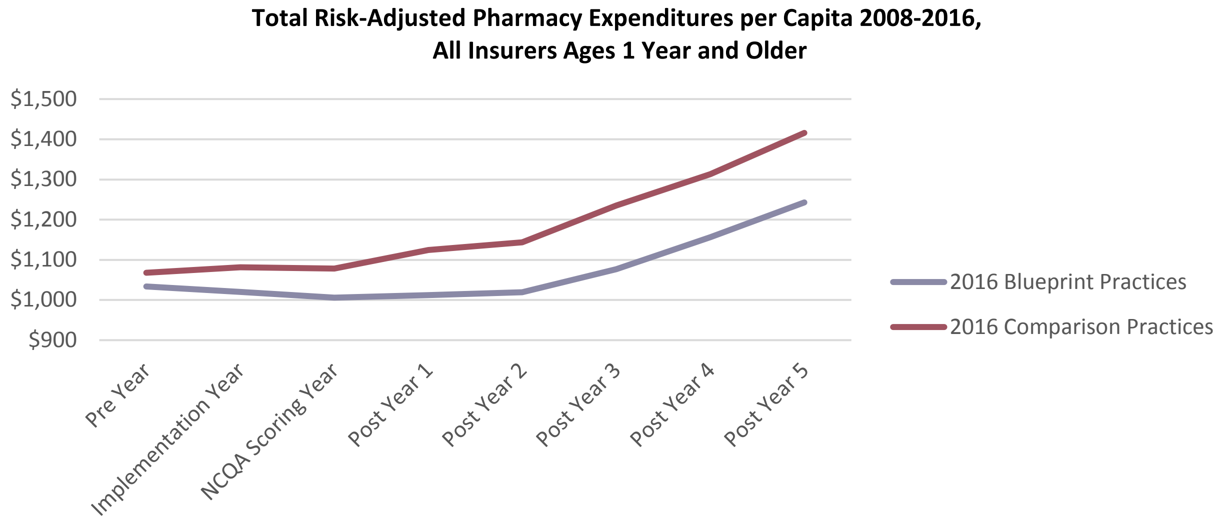


Results: Drivers of Slower Expenditure Growth

One important driver of the slower growth in expenditures observed for Blueprint test group patients was materially lower risk-adjusted pharmacy expenditures, as shown in Figure 3. At every programmatic year, the average risk-adjusted pharmacy spend for Blueprint Patient-Centered Medical Home patients was significantly lower than the average risk-adjusted pharmacy expenditure for those in the comparison group. By post-year five, the typical Blueprint Patient-Centered Medical Home patient has an annual risk-adjusted pharmacy expenditure $173 lower than the typical individual in the comparison group. Based on point estimates in post-year five, 35% of the difference in total risk-adjusted expenditures can be explained by differences in pharmacy expenditures.

Not only was there a level difference in adjusted pharmacy expenditures, but the Difference-in-Difference estimate indicates that the growth in pharmacy expenditures was significantly lower for Blueprint Patient-Centered Medical Home patients ($p<0.0001$). This finding of significant averted costs through reduced pharmacy expenditure has been found in previous iterations of this analysis and has been found in the academic literature.

Figure 6: Comparison of Total Risk-Adjusted Pharmacy Expenditures

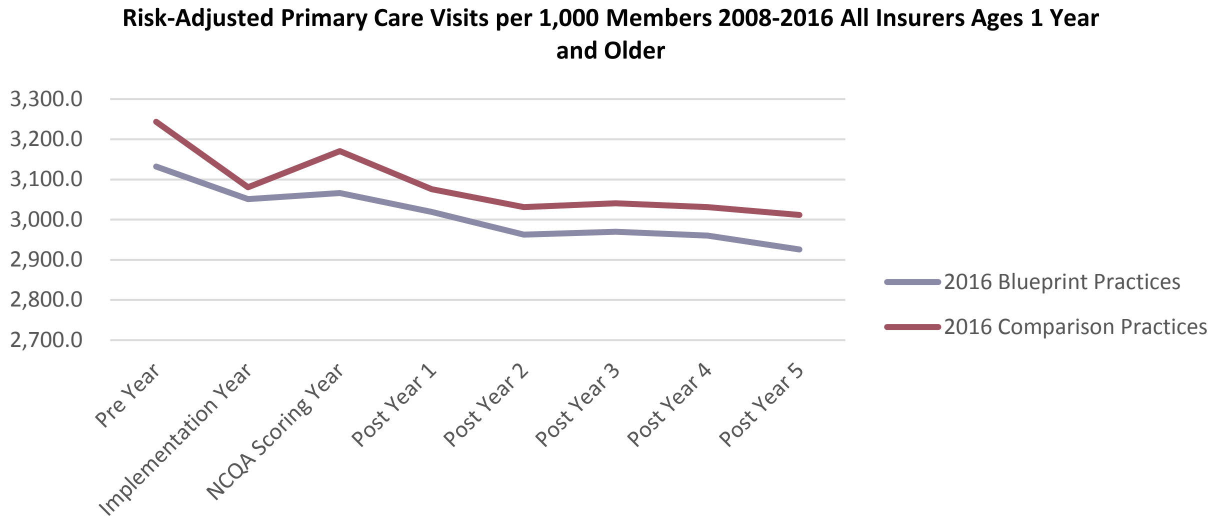


Although not shown graphically, Blueprint PCMH participation was also associated with moderately slower growth in risk-adjusted outpatient emergency department expenditures. Difference-in-Difference estimates indicate that by post year 5, receiving care in a Blueprint Patient-Centered Medical Home was associated with a $14 reduction in the growth of risk-adjusted outpatient emergency department expenditures ($p<0.0001$). Difference-in-difference estimates find no statistically significant averted risk-adjusted inpatient expenditures associated with receiving primary care in a Blueprint Patient-Centered Medical Home.

There is clear evidence of level differences in risk-adjusted expenditures between people who receive their primary care in a Blueprint Patient-Centered Medical Home versus the comparison group. There is also clear evidence, based on Difference-in-Difference estimates, that receiving primary care at a Blueprint Patient-Centered Medical Home is associated with slower growth in risk-adjusted expenditures over time. However, the evidence for an effect of the Patient-Centered Medical Home initiative on utilization is considerably weaker. Difference-in-difference estimates indicate no significant change in the growth/reduction of risk-adjusted inpatient discharges, risk-adjusted outpatient emergency department visits, risk-adjusted medical specialist visits, or risk-adjusted surgical specialist visits.

Figure 5 shows the one utilization measure considered in this evaluation for which there is marginal statistical evidence of an effect of the Patient-Centered Medical Home initiative. That measure is primary care visits, and the trend is towards fewer visits per capita. In every year from the pre-intervention year through the fifth year after NCQA scoring, patients attributed to a Blueprint Patient-Centered Medical Home have significantly lower risk-adjusted rates of primary care visits (p-values<0.0001 for every programmatic year). Difference-in-Difference estimates indicate marginal statistical evidence ($p=0.063$) that the risk-adjusted rate of primary care visits declined less for Patient-Centered Medical Home-attributed patients than for the comparison group between the pre-intervention year and post-year 5. In the context of the focus on primary and preventative care, a general decline in primary care visits was unanticipated.

Figure 7: Comparison of Risk-Adjusted Primary Care Visits per Capita

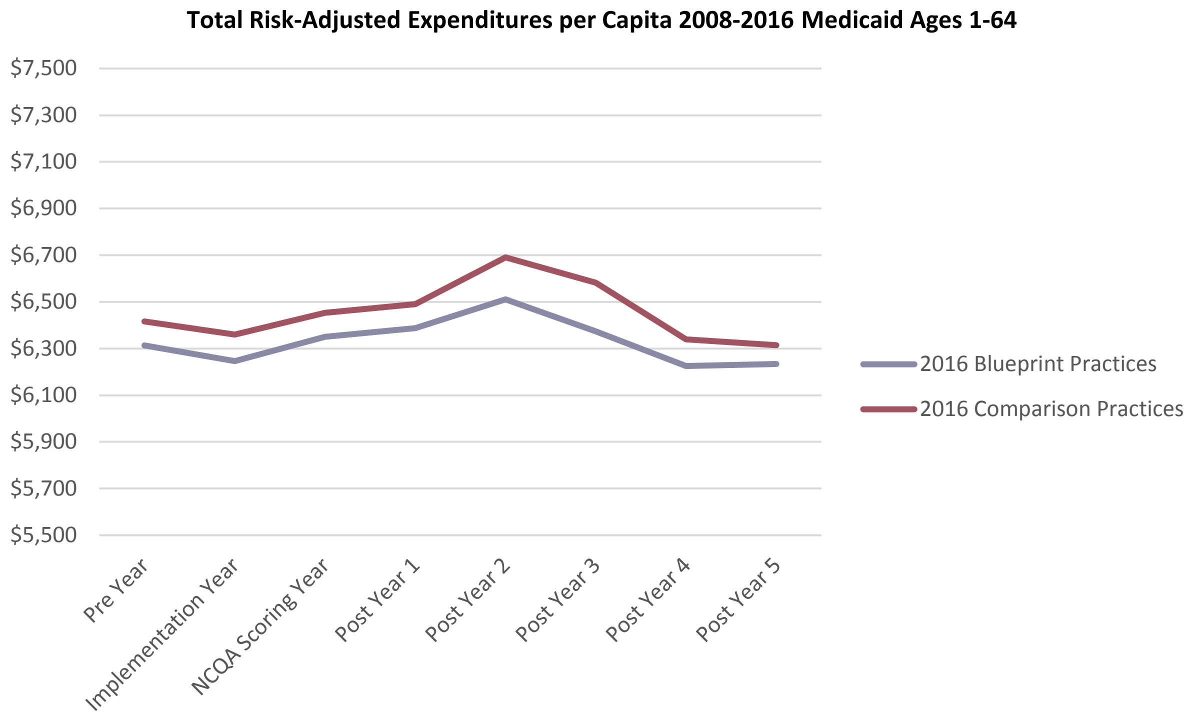


Results: Medicaid Expenditures

Bending the cost curve for all patients of Blueprint Patient-Centered Medical Homes, regardless of payer, is the key finding of this evaluation. However, there is one specific population of patients that are likely of special interest to state-level policymakers – those whose healthcare is financed by the state-federal partnership Medicaid program. The following analysis subsets the Medicaid population and examines the impact of the Blueprint Patient-Centered Medical Home initiative on the healthcare utilization and expenditure for this specific payor.

Shown in Figure 6, when considering only the Medicaid population, results indicate little difference in total per capita risk-adjusted expenditures between those attributed to a Blueprint Patient-Centered Medical Home and those in the comparison group. Only in two programmatic years (post year 2 and post year 3) is there a statistically significant difference in mean risk-adjusted total expenditures between the two groups (p-value=0.0074 and 0.0012, respectively). Not surprisingly, Difference-in-Difference analysis finds no significant difference between Blueprint Patient-Centered Medical Home patients and the comparison group in the rate of change in risk-adjusted total per capita expenditures.

Figure 8: Total Risk-Adjusted Medicaid Expenditures per Capita



However, when Special Medicaid Services are removed, receiving care in a Blueprint Patient-Centered Medical Home is associated with significant reductions in total per capita expenditures for Medicaid beneficiaries. Figure 7 shows that Medicaid beneficiaries attributed to a Blueprint Patient-Centered Medical Home had significantly lower total risk-adjusted per capita expenditures, excluding Special Medical Services, in every programmatic year. Not only was there clear evidence of a level reduction, but Difference-in-Difference estimates indicate that total risk-adjusted expenditures between the pre-year and post-year five, excluding Special Medicaid Services, grew more slowly for those attributed to a Blueprint Patient-Centered Medical Home than for those in the comparison group by $134 (p=0.014).

Also of note is the magnitude of the risk-adjusted per capita Special Medicaid Services expenditures. In post-year five, the typical Medicaid patient attributed to a Blueprint Patient-Centered Medical Home would incur $2,244 in risk-adjusted Special Medicaid Services expenditures. For context, this is over a third (36%) of expected total risk-adjusted expenditures for Medicaid Blueprint Patient-Centered Medical Home patients.

As Vermont considers how to shift investments from high-acuity, high-cost health care to wellness, prevention, and chronic care management, it is worth examining the example of the Vermont Medicaid program and its provision of Special Medicaid Services.

Results: Spending on Special Medicaid Services

Services funded exclusively by Medicaid – referred to below as Special Medicaid Services (SMS) – include transportation, home and community-based services, case management, dental, residential treatment, day treatment, mental health facilities, and school-based services. Special Medicaid Services may be thought of as services that help Medicaid recipients meet their social, economic, and rehabilitation needs and potentially avoid more costly or institutional care. For instance, transportation to primary care visits helps patients get the care they need to manage their chronic conditions, which may prevent costly hospitalization. Likewise, rehabilitation services can help prevent hospital re-admission following an

inpatient stay. While Special Medicaid Services contribute to the overall cost of care, the higher spending in the Blueprint group for SMS may indicate that Patient-Centered Medical Homes and Community Health Teams are more successful in connecting Medicaid beneficiaries to community-based supports than primary care as usual. Higher spending on Special Medicaid Services may also delay or prevent larger expenditures for higher acuity care.

One consistent finding of this evaluation over time is a higher level of risk-adjusted Special Medicaid expenditures for those Medicaid patients attributed to a Blueprint Patient-Centered Medical Home. Consistent with this, in every programmatic year after the pre-year, Medicaid patients attributed to a Blueprint Patient-Centered Medical Home had significantly greater risk-adjusted Special Medicaid Services expenditures (p-values<=0.031 for level differences in all years). Trends in adjusted Special Medicaid Services expenditures across programmatic years are shown in Figure 8.

Not only are risk-adjusted Special Medicaid Services expenditures for Medicaid patients in Blueprint Patient-Centered Medical Home higher in most programmatic years, but these expenditures for Blueprint Patient-Centered Medical Home-attributed patients declined at a slower rate across the programmatic period than those in the comparison year. Difference-in-Difference estimates indicate that risk-adjusted Special Medicaid Services expenditures declined more slowly across the programmatic window by $173 (p=0.014).

Figure 9: Risk-Adjusted Medicaid Expenditures per Capita excluding Special Medicaid Services

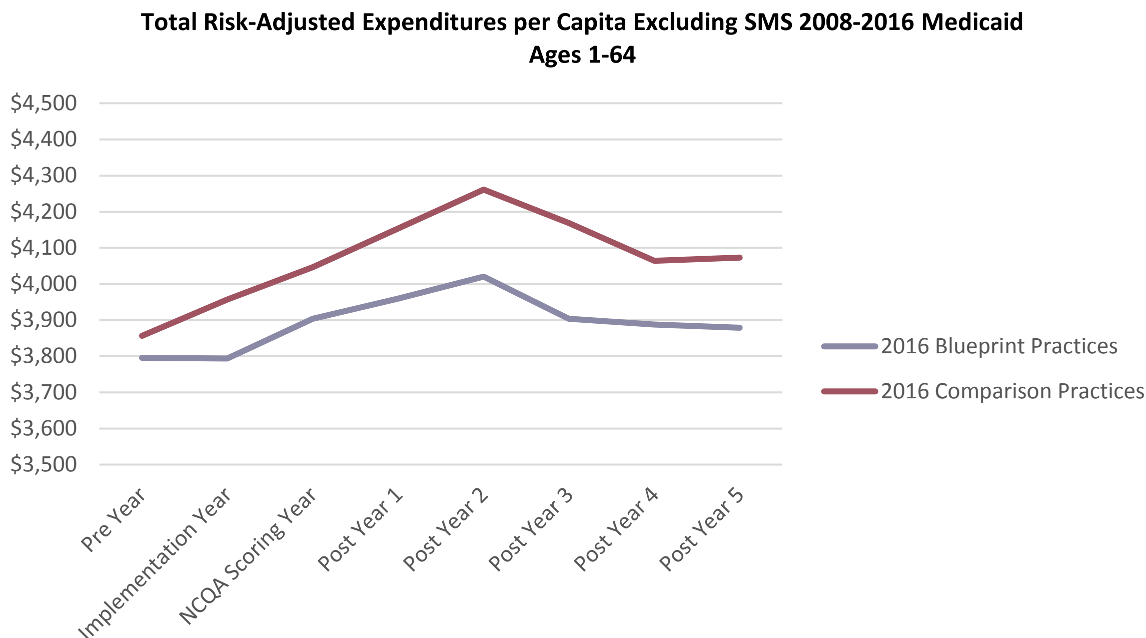
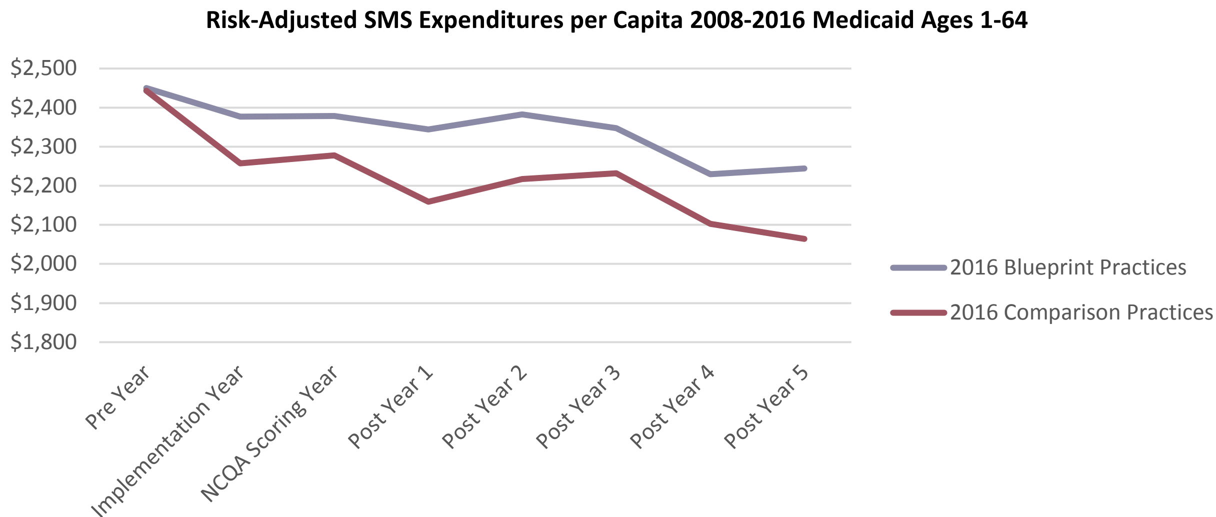


Figure 10: Risk-Adjusted Special Medicaid Services Expenditures per Capita



Higher rates of risk-adjusted Special Medicaid Services expenditures for Medicaid patients receiving care in Blueprint Patient-Centered Medical Homes have been found in this analysis since 2014. The reason for this difference is beyond the scope of this quantitative evaluation, but the Blueprint team and its partners have considered possible explanations for the phenomena. The strongest hypothesis is that Patient-Centered Medical Homes, working with Community Health Teams (which do not bill for their own services), may be better than non-Patient-Centered Medical Homes at engaging community partners to meet the needs of patients, including needs that have traditionally been considered beyond the purview of the health care system. Some of these community partners bill for Special Medicaid Services, resulting in an increase in Special Medicaid Services expenditures for patients of Patient-Centered Medical Homes. Insofar as it can be posited that a dollar spent on Special Medicaid Services averts more than a dollar in traditional healthcare spending, increased Special Medicaid Services expenditures may be socially beneficial and may ultimately reduce costs.

Hub & Spoke Program

Vermont's Hub and Spoke program represents the collaborative efforts of the Blueprint for Health, Department of Vermont Health Access, Vermont Department of Health, Hub and Spoke staff, community providers, and community leaders to create a coordinated, comprehensive approach to addressing the factors that contribute to the complexity of opioid use disorder. The Hub and Spoke model integrates programs providing higher intensity treatment in regional opioid treatment program settings ("Hubs") with programs offering lower intensity treatment in general medical settings (office-based opioid treatment programs, called "Spokes"). Vermont's approach to treating opioid use disorder has garnered national attention for its expanded treatment access, including from the Director of the Office of National Drug Control Policy, Richard Baum, who visited Vermont in July and stated that, "Vermont has made more progress on that challenge [of expanding treatment capacity] than any other state in the country." Increased access to medication assisted treatment for Vermont residents with opioid use disorder is evidenced by the 3,304 clients enrolled in regional Opioid Treatment Programs (OTPs, "Hubs") and the 2,646 Medicaid beneficiaries who were served by Office-Based Opioid Treatment (OBOT, "Spokes") programs as of December 2017.

The observed expanded access to medication assisted treatment has been possible through the committed network of 212 prescribers (i.e. medical doctors, nurse practitioners, physician assistants) across the State

of Vermont, who are supported by 63.90 FTE (as of December 2017) licensed, registered nurses and licensed, Master's-prepared mental health / substance use disorder clinicians (Spoke staff), and work as a team to offer office-based opioid treatment to Vermont residents in the communities in which they live. Treatment capacity was further enhanced by the opening of another regional Opioid Treatment Program ("Hub") in Northwestern Vermont (St. Albans, VT) in July 2017, whereby the increased access within that region of the State improved treatment capacity in surrounding areas as well. As a result, the Chittenden Opioid Treatment Program (Chittenden "Hub") waitlist has remained at 0 (as of December 2017) and Vermont's Governor Scott indicated, in a press release in September 2017, that the hard work and partnerships between state, local and community partners were essential for improving the waitlist and facilitating appropriate connections to care.

In addition to expanding treatment access, the Program continues to focus on continuing education opportunities for Hub and Spoke staff as best practices continue to emerge. A collaborative team, comprised of Blueprint, Vermont Department of Health and UVM staff, convened to plan the 2017-2018 learning collaborative series and develop learning sessions designed to enhance the knowledge of the entire medication assisted treatment community. The October and December learning sessions emphasized the importance of recognizing substance use disorder as a chronic condition and avoiding language that can be stigmatizing, compared the likelihood of relapse to other chronic medical conditions, incorporated imaging studies illustrating the time associated with recovering brain functioning, and described the relationship established in the literature between a patient's continuous use of buprenorphine over 12 months and the associated lower risk of emergency department visits and all-cause hospitalizations. Presentations provided strategies for reducing opioid-related fatalities, included a review of literature detailing death rates for the general population in comparison to those with opioid use disorder that were receiving no treatment, withdrawal-based treatment or receiving medication assisted treatment and the importance of connection with community-based organizations that distribute naloxone and support recovery. Topics specifically requested by Hub and Spoke staff, such as the appropriate use of urine drug testing as a therapeutic tool to support individuals remaining in treatment and care coordination across levels of care and for pregnant residents, were also covered.

The Blueprint for Health continues to work collaboratively with the Division of Alcohol and Drug Abuse Programs of the Vermont Department of Health on developing ongoing initiatives based upon provider, staff and community feedback, including the Initiation and Engagement in Treatment and Opioid Prescribing projects, in order to provide an interagency, coordinated and data-driven approach to addressing the opioid crisis in the State of Vermont. Community and State partners continue to work with the Opioid Coordination Council to identify strategies that will appropriately address the Council's recently released recommendations for comprehensive system improvements and create a multi-generational approach to address the impacts of opioid use disorder.

Figure 11. MAT-SPOKE Implementation January 2013 – December 2017 Staffing

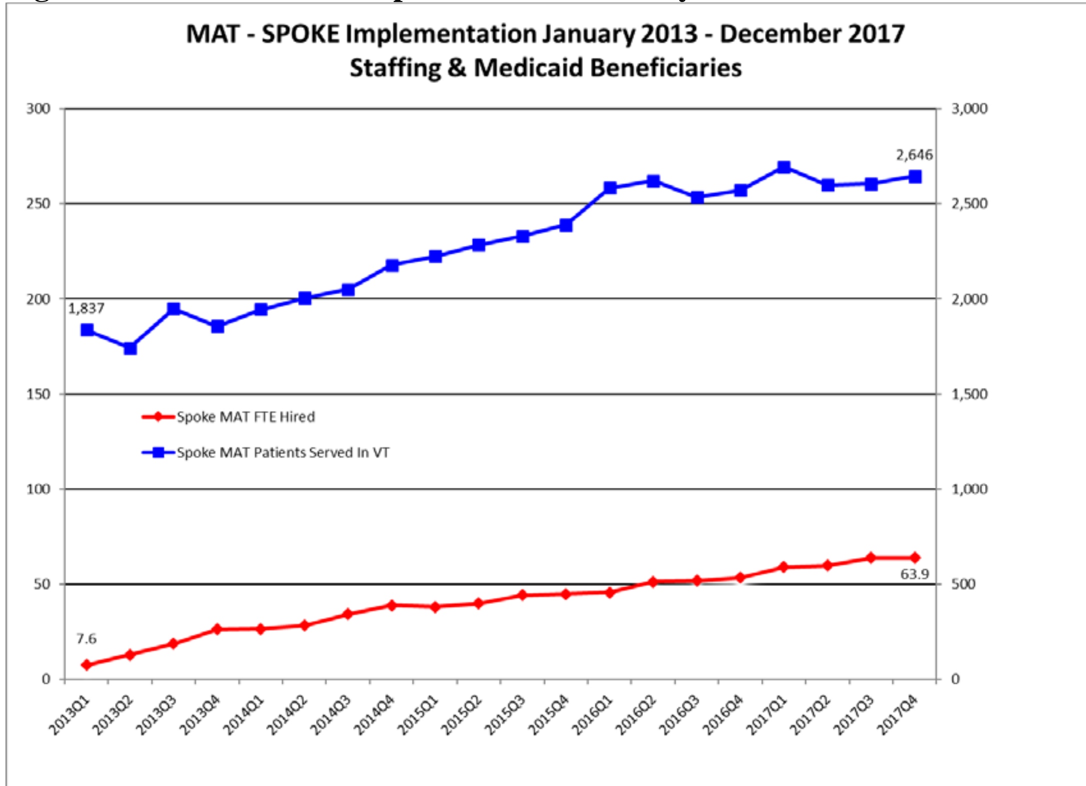


Figure 12. MAT-SPOKE MDs Prescribing Buprenorphine January 2013 – December 2017

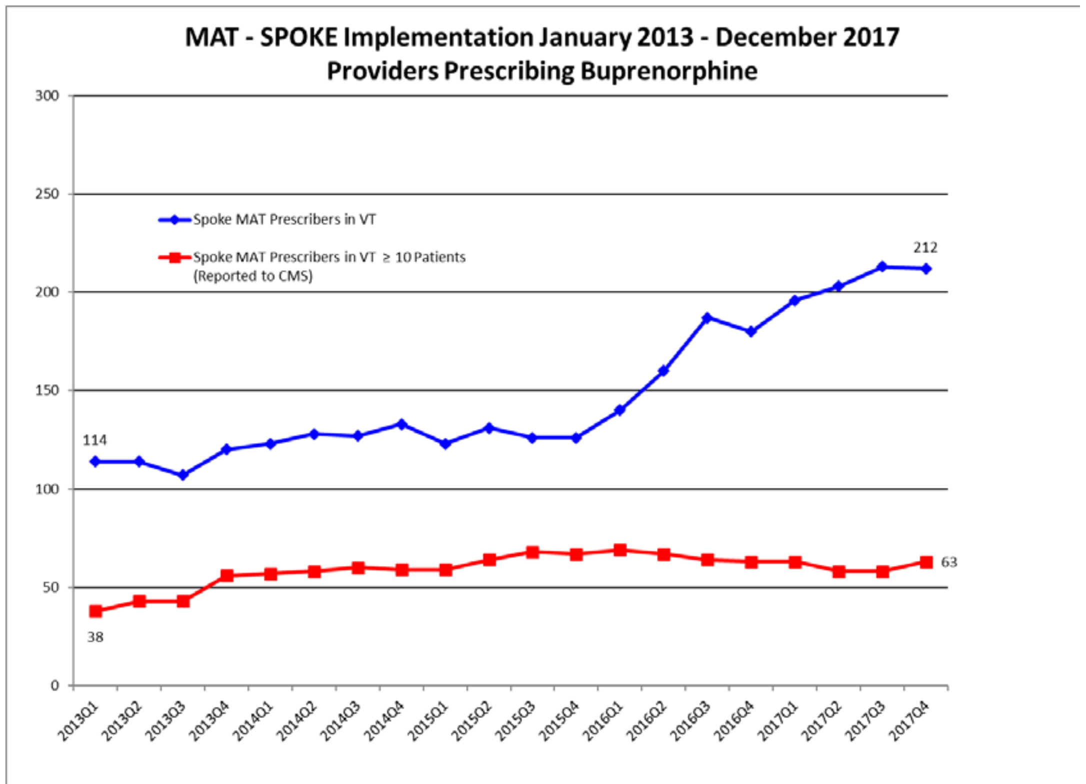
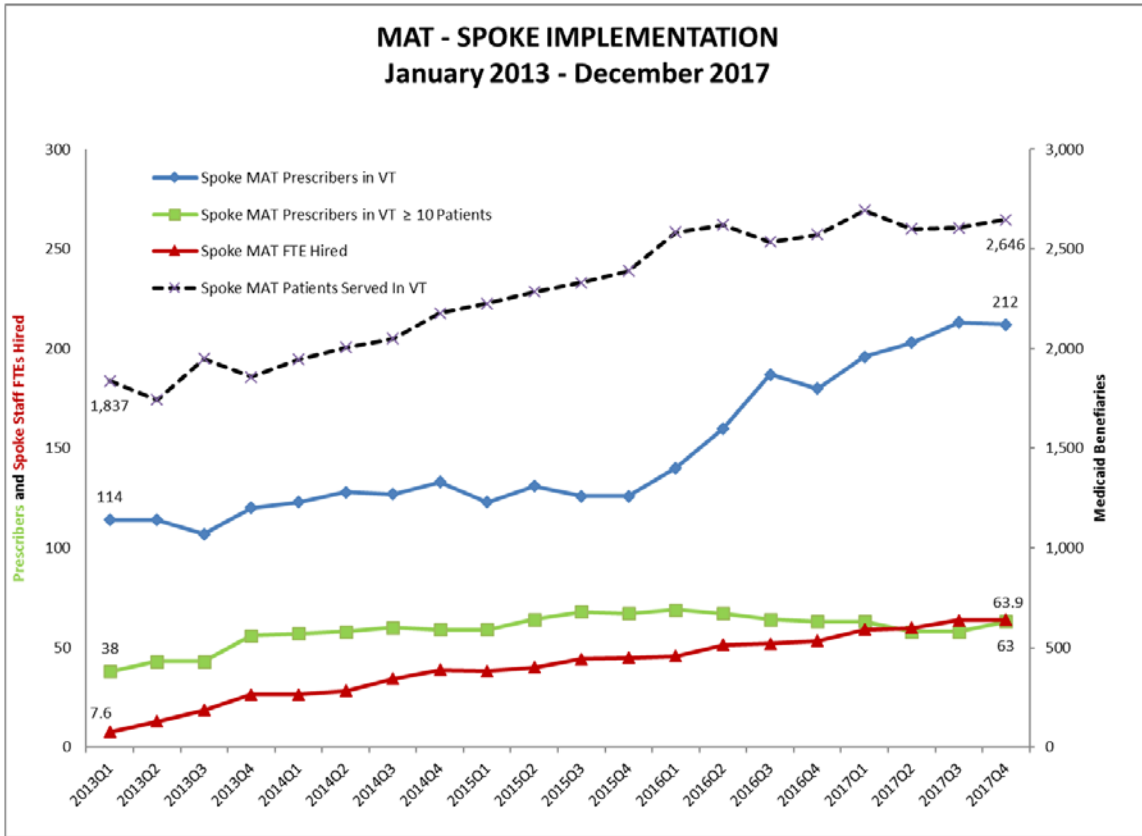


Figure 13. MAT-SPOKE Implementation Jan 2013 – December 2017



Note: The numbers for the Spoke MAT Prescribers in Vermont serving more than 10 Patients has been corrected from previous reports because the numbers were not de-duplicated counts.

The table below shows the caseload of Hub programs and also the number of clients receiving methadone or buprenorphine.

Table 2. Hub Implementation as of December 31, 2017

Region	# Clients	# Buprenorphine	# Methadone	# Vivitrol	# Receiving Treatment but Not Yet Dosed	# Waiting
Chittenden, Addison	998	320	664	0	14	0
Franklin, Grand Ilse	245	85	160	0	0	26
Washington, Lamoille, Orange	472	171	301	0	0	0
Windsor, Windham	437	144	290	0	3	0
Rutland, Bennington	406	90	303	5	8	32
Essex, Orleans, Caledonia	746	205	539	2	0	0
Total	3304	1015	2257	7	25	58

Table Notes: The Franklin/Grand Isle location opened in July 2017. Some clients are transferring from the Chittenden/Addison Hub to the Franklin/Grand Isle Hub.

The table below shows the number of Medicaid beneficiaries receiving treatment in the "Spokes" and the full-time-equivalent staff of nurses and licensed clinicians.

Table 3. Spoke Implementation as of December 31, 2017

Region	Total # providers prescribing pts	# providers prescribing to ≥ 10 pts	Staff FTE Hired	Medicaid Beneficiaries
Bennington	11	4	5.2	230
St. Albans	16	9	9.1	404
Rutland	20	8	5.15	327
Chittenden	82	14	15.3	516
Brattleboro	12	5	3.5	132
Springfield	4	2	1.55	50
Windsor	10	5	4	205
Randolph	7	4	3.1	108
Barre	19	6	6.45	248
Lamoille	14	5	4.8	228
Newport & St Johnsbury	11	2	2	96
Addison	7	3	2.25	86
Upper Valley	3	0	1.5	16
Total	212*	63*	63.9	2,646

Table Notes: Beneficiary count based on pharmacy claims October – December, 2017; an additional **276** Medicaid beneficiaries are served by **35** out-of- state providers. Staff hired based on Blueprint portal report 1/24/18. *4 providers prescribe in more than one region.

Women’s Health Initiative

The Women’s Health Initiative launched January 1, 2017 to women’s health practices, including obstetrics, gynecology, midwifery, and family planning providers, and expanded eligibility to Patient Centered Medical Home (PCMH) primary care practices on October 1, 2017. The Blueprint was supported by DVHA to develop this initiative and worked collaboratively with the Vermont Department of Health and a broad group of content experts and community stakeholders to design interventions aimed at helping women be well, avoid unintended pregnancies, and build thriving families. The Women’s Health Initiative now includes 35 participating practices (20 women’s health and 15 primary care) across the State of Vermont. In the past year, the Women’s Health Initiative has had a net increase of 5 women’s health clinics and 2 participating Patient Centered Medical Homes. Six women’s health practices and three PCMHs joined the Women’s Health Initiative in 2017. Two women’s health practices and one PCMH dropped out of the Women’s Health Initiative on 9/30/2017 and 7/31/2017, respectively. The Women’s Health Initiative is approaching a saturation point in the state whereby all but one Health Service Area that has a specialized women’s health practice is represented in the Women’s Health Initiative. The Women’s Health Initiative is continuing to expand among Planned Parenthood of Northern New England women’s health practices and Blueprint PCMHs.

At each participating practice, practice staff develop and implement policies and procedures and design workflows that include provision of preconception counseling and contraceptive counseling (depending on the person’s response to the One Key Question) to support healthy pregnancies and avoid unintended pregnancies, access to long acting reversible contraceptives for same-day insertions, when clinically appropriate and chosen by the person as the preferred method of contraception, and implementation of psychosocial screening for the early identification of factors well-established in the literature to impact health and health care utilization, such as depression, substance use, interpersonal violence, housing instability and food insecurity. Once identified, interventions involve critical clinical-community linkages for appropriately addressing the identified conditions, requiring continuous development of local referral relationships. Each women’s health practice is supported by a licensed, Master’s-prepared mental health clinician (typically a licensed, clinical social worker), funded through the Women’s Health Initiative, who is embedded into the practice for screening, brief intervention, brief treatment, referral to more intensive treatment and services, and follow-up; Patient-Centered Medical Home primary care practices are supported by their area Community Health Team.

The Blueprint for Health provides a tested model for driving change: a combination of developing new ideas through a collaborative design process, rapid implementation across practices and communities, and research and evaluation that informs new initiatives and iterative improvements. Each of these elements – design, implementation, and research – is critical to the success of the interventions the Blueprint supports. The Blueprint, in collaboration with an analytics contractor, Onpoint Health Data, is currently working to develop data profiles that will provide valuable information regarding demographic and health status information, health service utilization, expenditures and outcome measures for the Women’s Health Initiative that will inform the determination of quality improvement priorities.

Figure 14. Women's Health Initiative Practices

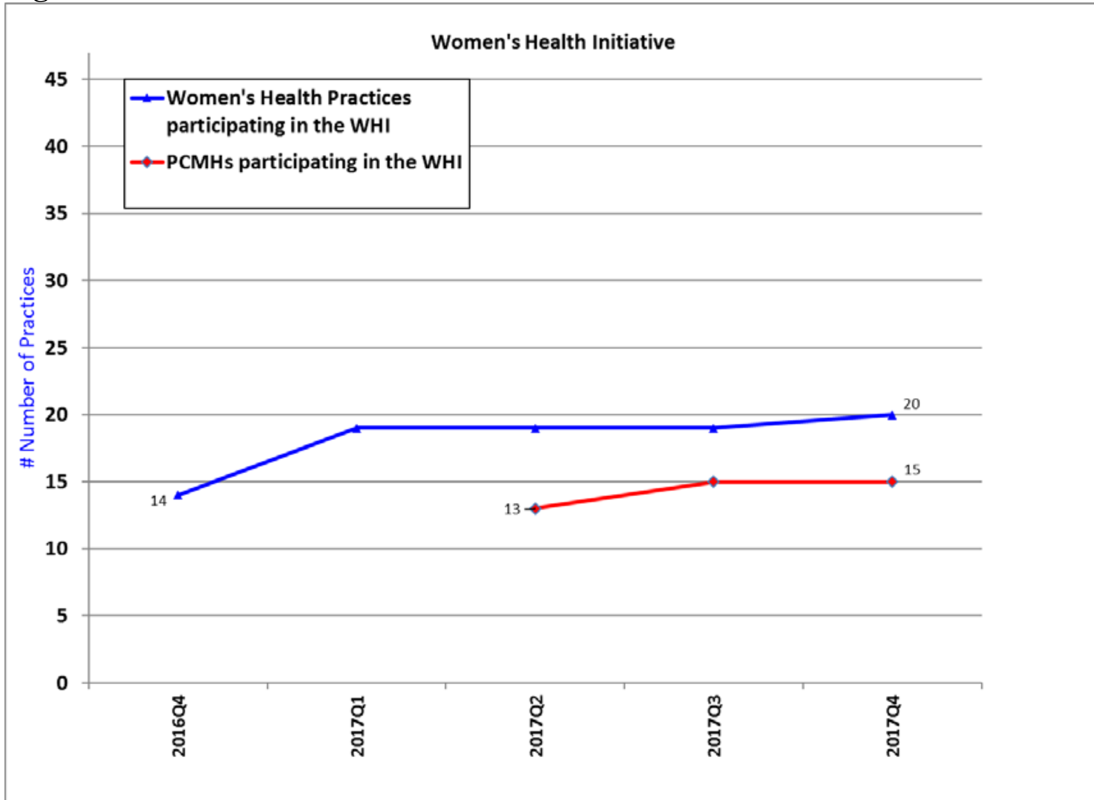


Figure 15. WHI Implementation January 2017 – December 2017 Staffing & Patients

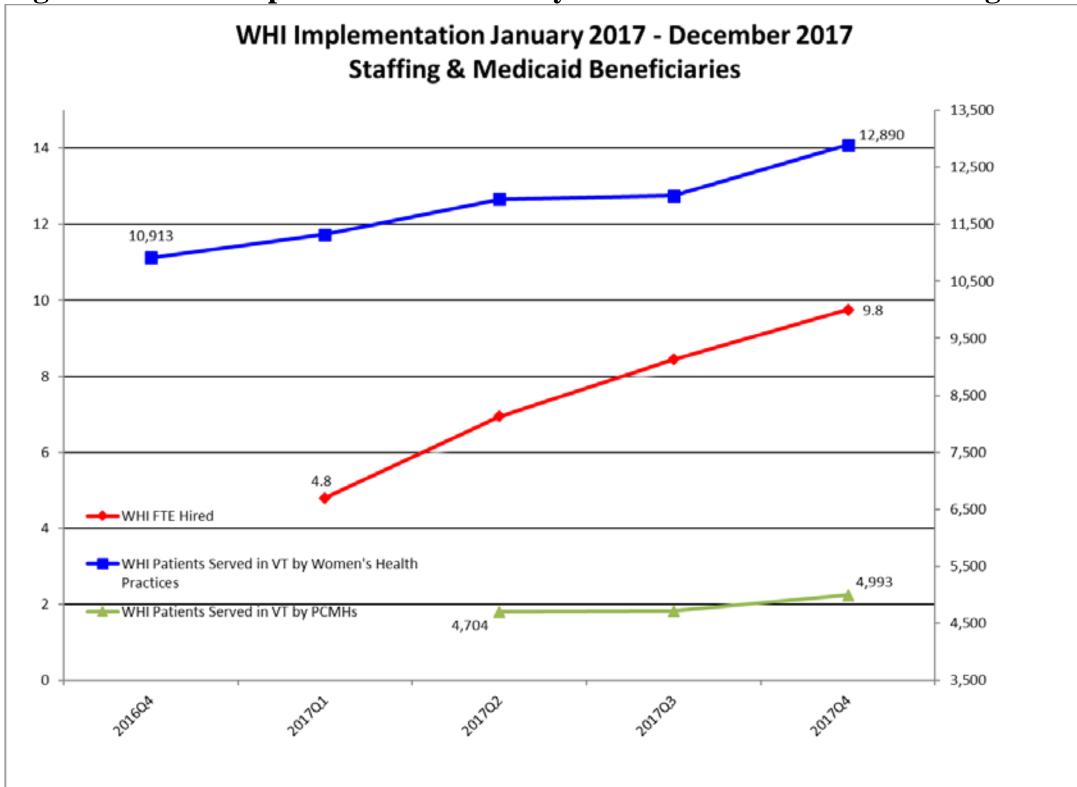


Table 4. WHI Implementation as of December 31, 2017

Region	Total # Women's Health WHI Practices	Total # PCMH WHI Practices	Staff FTE Hired	Medicaid Beneficiaries – Women's Health Practices	Medicaid Beneficiaries - PCMHs
Barre	1	1	1	980	463
Bennington	1	1	0.5	989	62
Brattleboro	1	0	1	451	0
Burlington	5	5	1	3,660	1,834
Middlebury	2	0	0.5	1,040	0
Morrisville	1	2	1	558	463
Newport	0	0	0	0	0
Randolph	3	0	0.5	548	0
Rutland	2	1	1.5	1,794	203
St. Albans	2	0	1	1,392	0
St. Johnsbury	1	2	0.75	1,000	652
Springfield	1	3	1	478	1,316
Upper Valley	0	0	0	0	0
Windsor	0	0	0	0	0
Total	20	15	9.75	12,890	4,993

v. Pharmacy Program

Key updates:

- Pharmacy Reimbursement Changes for SFY 2017
- Specialty Pharmacy
- Changes to Coverage of Hepatitis C Agents
- CMS Certification
- Changes to Maximum Days' Supply and Maximum Dosage for Initial Opioid Prescriptions
- Naloxone Prior Authorization Changes
- 340B Drug Discount Program

The DVHA Pharmacy Unit is responsible for managing the pharmacy benefits for members enrolled in Vermont's publicly funded health care programs. Functions include:

- processing pharmacy claims
- making drug coverage determinations
- assisting with drug appeals and exception requests
- overseeing federal, state and supplemental drug rebate programs and the state's manufacturer fee program
- resolving drug-related pharmacy and medical provider issues
- overseeing and managing the Drug Utilization Review Board (DURB) and managing the Preferred Drug List (PDL)
- assuring compliance with state and federal pharmacy and pharmacy-benefits regulations

In addition, the pharmacy unit manages drug spend and routinely analyzes national and DVHA-specific drug trends and drug utilization. The pharmacy unit strives to deliver high-quality customer service, optimal drug therapy for DVHA members and successful management of drug utilization and costs.

Change Healthcare (CHC), DVHA's contracted Prescription Benefit Manager (PBM) since 1/1/15, provides many clinical and operational support services in addition to managing a provider call center in South Burlington, Vermont.

Key drug spend statistics for SFY17 include the following:

- Total GC Drug Spend: $193,945,218
    - $39 million or 20.5% of this spend was on specialty drugs
- Total number of GC paid prescriptions: 2,110,704
    - Brand Drugs on PDL: 79% Preferred and 21% Non-Preferred
    - Generic Drugs on PDL: 92% preferred and 8% Non-Preferred
- The average cost per prescription paid for all drugs was $92.
- The average cost per prescription for specialty drugs was $7,097.

Pharmacy Reimbursement Changes for SFY 2017

In SFY 2017, State Medicaid agencies were directed by the federal Centers for Medicare and Medicaid Services (CMS) to adopt fee-for-service pharmacy payment policies designed to reimburse pharmacies for

the actual acquisition cost of drugs plus a reasonable professional dispensing fee. The professional dispensing fee would be based on the actual cost to the pharmacy of dispensing drugs to Medicaid members.

As part of this directive, beginning in September 2016, DVHA invited all Medicaid-enrolled pharmacies to participate in a pharmacy cost-of-dispensing survey. DVHA partnered with the New England States Consortium Systems Organization (NESCO) and the accounting firm of Myers and Stauffer LC, a reputable firm with extensive experience in pharmacy costs and reimbursement.

Based on the results of this survey, dispensing fees were increased:

- The professional dispensing fee for retail community pharmacies, institutional and long-term care pharmacies was increased to $11.13.
- The professional dispensing fee for specialty drugs dispensed by specialty pharmacies was increased to $17.03.

The dispensing fee was adjusted accordingly from $4.75 (in-state) and $2.50 (out-of-state) on April 1, 2017.

In addition, the Department of Vermont Health Access (DHVA) conducted extensive analysis to determine the ingredient-cost benchmarks needed to more accurately reflect actual pharmacy acquisition cost for ingredient-cost reimbursement.

DVHA now uses a “lower-of” methodology utilizing the benchmark of National Average Drug Acquisition Cost (NADAC) in place of its previous methodology. The NADAC is based on CMS’ monthly surveys of retail pharmacies to determine average acquisition cost for covered outpatient drugs.

This additional federal pricing source is updated by DVHA each month upon being published by CMS. Beginning on April 1, 2017, CHC implemented the first of the monthly updated NADAC prices and incorporated those into the “lower-of logic” when calculating the reimbursement, which is consistent with pharmacy pricing reimbursement policy.

Payment of covered outpatient drugs dispensed by an enrolled pharmacy includes the reimbursement for Actual Acquisition Cost (AAC) of the drug plus a professional dispensing fee.

AAC is defined as the lower of:

a. The National Drug Average Acquisition Cost (NADAC);
b. The Wholesale Acquisition Cost (WAC) + 0%;
c. The State Maximum Allowable Cost (SMAC);
d. The Federal Upper Limit (FUL)
e. AWP-19%;
f. Submitted Ingredient Cost;
g. The provider’s Usual and Customary (U&C) charges; or
h. The Gross Amount Due (GAD)

Based on extensive analysis of DVHA’s claims, this change was expected to be largely cost-neutral to total drug reimbursement, creating an overall reduction of one-half of one percent (0.5%) in reimbursement to all pharmacies.

Specialty Pharmacy

During most of SFY 2017, Vermont Medicaid utilized the services of BriovaRx®, a full-service specialty pharmacy located in South Portland, Maine, that partnered with the pharmacy benefits manager, Change Healthcare. Some examples of specialty drugs managed by BriovaRx® include drugs used to treat Multiple Sclerosis; Hepatitis C; Cancer; Rheumatoid, Psoriatic and Juvenile Arthritis; Psoriasis; Crohn's Disease; Ankylosing Spondylitis; growth hormone deficiencies and Ulcerative Colitis. Dispensing of identified specialty medications was limited to this pharmacy for Medicaid beneficiaries (when Medicaid was the primary insurer) until April 30, 2017.

Effective May 1st, 2017, DVHA expanded the number of pharmacies that can dispense specialty medications. A list of enrolled Specialty pharmacies can be found on the DVHA website at: http://dvha.vermont.gov/for-providers/2dvha-enrolled-specialty-pharmacies.pdf . The list of specialty medications is updated quarterly and can be found on the DVHA website at http://dvha.vermont.gov/for-providers/specialtydrugweblist-20170421.pdf.

A specialty drug must meet a minimum of two (2) of the following requirements:

- The cost of the medication exceeds $5,000 per month.
- The medication is used in the treatment of a complex, chronic condition. This may include but is not limited to drugs that require administration, infusion or injection by a health care professional.
- The manufacturer or FDA requires exclusive, restricted or limited distribution. This includes medications which have REMS requirements requiring training, certifications or ongoing monitoring for the drug to be distributed.
- The medication requires specialized handling, storage or inventory reporting requirements.

Changes to Coverage for Hepatitis C Agents

Effective 1/1/18, DVHA changed its clinical criteria for approval of direct-acting antiviral agents used in the treatment of Hepatitis C. Previously, members were required to have a documented Metavir fibrosis score of F2, F3 or F4 to qualify for treatment with these drugs. Approval will now be considered in individuals with **ANY** Metavir fibrosis score, including F0 and F1. Direct-acting antivirals will continue to require prior authorization to ensure the patient meets clinical criteria and that the most cost-effective, clinically appropriate regimen is utilized. Preferred agents are Epclusa®, Mavyret®, and Zepatier®. Clinical documentation supporting the use of a non-preferred agent or regimen must be submitted with the prior authorization.

Non-preferred agents include but are not limited to: Daklinza® (daclatasvir), Epclusa® (sofosbuvir/velpatasvir), Harvoni® (ledipasvir/sofosbuvir), Mavyret® (glecaprevir/pibrentasvir), Sovaldi® (sofosbuvir), Technivie® (ombitasvir, paritaprevir, ritonavir), Viekira XR® (ombitasvir, paritaprevir, ritonavir, dasabuvir), Vosevi® (sofosbuvir/velpatasvir/voxilaprevir), and Zepatier® (elbasvir/grazoprevir). These changes resulted from review of AASLD and IDSA guidelines and DURB recommendations.

Due to the complexity and variety of treatment options and potential for drug interactions, the requirement remains that the prescriber is or has consulted with a gastroenterologist, hepatologist, infectious disease specialist or other Hepatitis specialist. Consultation must be within the past year and include documentation regarding the requested regimen.

The changes described above are incorporated into the prior authorization request form for Hepatitis C agents and the DVHA preferred drug list (PDL), both of which are available on the DVHA provider website http://dvha.vermont.gov/for-providers/.

CMS Certification of PBMS Solution

DVHA's current pharmacy benefit management system (PBMS) with Change Healthcare (CHC) went live on January 1, 2015. The solution supports Vermont's drug benefit programs in the following areas: claims processing platform and operational support; e-prescribing support; drug benefit management; drug utilization review activities; preferred drug list (PDL) management; drug prior authorization programs (manual and automated PA); Drug Utilization Review Board (DURB) coordination; federal, state, and supplemental rebate management; analysis and reporting; a provider portal on a secure, web-based application offering more timely transactional features for prior authorizations (PA) and reporting; a pharmacy and provider call center staffed by Vermont pharmacists and pharmacy technicians and a high-cost/high-risk drug management program.

The CMS certification effort evaluated the solution and associated documentation to ensure adherence to federal regulations and industry standards. By achieving certification, DVHA can claim 75% federal financial participation (FFP) for maintenance and operations (M&O) costs. While the formal certification approval letter is still pending, CMS summarized the review as thorough, informative and successful.

CMS' final certification of the PBM model is anticipated to be received during the first quarter of 2018.

Changes to Maximum Days' Supply and Maximum Dosage for Initial Opioid Prescriptions

Effective July 5, 2017, initial opioid prescriptions for patients 18 years and older are limited to 50 Morphine Milligram Equivalents (MME) per day and a maximum of 7 days' supply. Patients 17 years of age and younger are limited to 24 MME per day and a maximum of 3 days' supply. If there is a documented clinical need to support exceeding these limits, a prior authorization is required. Approval for prescriptions exceeding initial days' supply limits are assessed on a patient-by-patient basis after relevant clinical information supporting the request is provided by the prescriber.

Pursuant to Sections 14(e) and 11(e) of Act 75 (2013) and Sections 2(e) and 2a of Act 173 (2016), the "opioid rule" provides legal requirements for the appropriate use of opioids in treating pain to minimize opportunities for misuse, abuse and diversion, and to optimize prevention of addiction and overdose. The purpose of this statute is to provide prescribers with the framework for prescribing opioids in the smallest dose for the shortest possible length of time.

The prescription limits apply only to the first prescription filled in an outpatient setting for a given course of treatment and do not apply to renewals or refills. The limits do not apply to long-acting opioids as they are intended for opioid-tolerant patients and are not indicated for acute pain.

The amount of daily morphine milligram equivalents (MMEs) is frequently used to gauge the abuse and overdose potential of opioids and is part of the calculation to determine Vermont Medicaid prescription limits. The MME conversion factor uses relevant prescription data to calculate the daily MME. The strength per Unit x (Number of Units/Day Supply) x MME conversion factor = MME/Day. DVHA will use the MME conversion factors provided by the Centers for Disease Control (CDC). More detailed information can be found on their website at https://www.cdc.gov/drugoverdose/media/index.html.

Naloxone Availability

The Vermont Department of Health (VDH) developed a statewide opioid antagonist pilot program that emphasizes access to opioid antagonists to and for the benefit of individuals with a history of opioid use. Along with the pilot program a policy was generated for "Standing Order for Distribution of Naloxone Prescription for Overdose Prevention," which allows Naloxone Hydrochloride (Narcan ®) to be covered without a prescription. This policy can be found at http://www.vtpharmacists.com/resources/RESP_Naloxone_standingorder.pdf

This policy is in accordance with a Standing Order issued pursuant to 18 V.S.A. § 4240 (c) (1) ensures that residents of the State of Vermont who are at risk of opioid-related overdose along with other persons such as family members and friends who can assist an at-risk individual without a prescription. The statue can be found at http://legislature.vermont.gov/statutes/section/18/084/04240.

In support of this program and the standing order, two Naloxone products are widely available and preferred on the DVHA's PDL without any prior authorization requirement for Medicaid members. This includes Narcan® (naloxone hcl) Nasal Spray with a quantity limit of 4 single-use sprays every 28 days, and Naloxone HCL Prefilled luer-lock needleless syringe plus an intranasal mucosal atomizing device.

340B Drug Discount Program

The 340B Drug Pricing Program resulted from enactment of the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is a federal program managed by the Health Resources and Services Administration (HRSA), Office of Pharmacy Affairs. Section 340B requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics and hospitals (termed "covered entities") at a significantly reduced price. The 340B price is a "ceiling price," meaning it is the highest price that the covered entity would have to pay for select outpatient and over-the-counter drugs and the minimum savings that the manufacturer must provide to covered entities. The 340B ceiling price is at least as low as the price that state Medicaid agencies currently pay for select drugs. Participation in the program results in significant savings to covered entities, estimated to be 20% to 50% on the cost of outpatient drug purchases by 340B covered entities. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reach more eligible patients and provide more comprehensive services.

Only federally designated covered entities are eligible to purchase at 340B pricing, and only patients of record of those covered entities may have prescriptions filled by a 340B pharmacy.
Because of federal laws prohibiting "duplicate discounts" on 340 B eligible claims, covered entities are responsible for properly identifying claims as 340B eligible. Vermont has strict controls in place to prohibit the billing of federal, state, and supplemental rebates on 340B eligible claims. In Vermont, the following entities participate in the DVHA's Medicaid 340B Program.

- Planned Parenthood of Northern New England's Vermont clinics
- Vermont's FQHCs, operating 41 health center sites statewide
- Berkshire Medical Center
- Brattleboro Memorial Hospital
- Central Vermont Medical Center
- Community Health Pharmacy
- Community Health Center of Burlington

- Copley Professional Services Group DBA Community Health Services of Lamoille Valley and affiliated with Community Health Pharmacy
- Indian Stream Health Center (New Hampshire)
- Northeast Washington County Community Health and affiliated with Community Health Pharmacy
- Northern Counties Healthcare and affiliated with Community Health Pharmacy
- Notch Pharmacy
- Richford Health Center, Inc.
- Southwestern Vermont Medical Center
- Springfield Hospital
- The Health Center (Plainfield)
- UMass Memorial Medical Center
- University of Vermont Medical Center and UVMMC Outpatient Pharmacies

vi. Integrating Family Services (IFS) Initiative

Key updates:

- AHS shifted the internal structure of the Integrating Family Services initiative to more closely align it with work being done at the Commissioner level to works towards integration and collaboration both at the agency level and in communities.
- IFS and interagency work continues to provide support and leadership regarding several efforts that cut across multiple agency departments such as:
  - turning the curve on the number of children and youth in residential settings
  - coordinating autism services and supports
  - implementing the Child and Adolescent Needs and Strengths (CANS) to have a common tool for progress monitoring to know if children and families are better off due to these efforts.
  - assessing the functioning of early childhood supports and funding streams (known as Children's Integrated Services)
  - supporting the statewide functioning of the Children's System of Care
- CMS approved the IFS case rate for calendar year 2017.

Integrating Family Services efforts began in 2008 with a position created in the Agency of Human Services Secretary's Office in 2010. From the beginning, the intent of integrating services for children and their families revolved around providing services, supports and treatment earlier to prevent more intense needs, to achieve better outcomes and spend funding more efficiently. AHS was able to test the model in two regions while several other important reform efforts began to take shape such as Accountable Care Organizations, the All Payer Model, the State Innovation grant and other important health care and human services reform efforts.

The initial IFS implementation site in Addison County began on July 1, 2012, and the second pilot region in Franklin/Grand Isle counties began on April 1, 2014. These pilots included consolidation of over 30 state and federal funding streams into one unified whole through one AHS Master Grant agreement. The State created an annual aggregate spending cap for two providers in Addison County (the designated agency and the parent child center) and one in Franklin/Grand Isle (this provider is both the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children and families.

During the summer and fall of 2017, it became clear the lessons learned through IFS needed to shift from "testing a model" to the way business is done, including more attention on how AHS operates internally so community partners can achieve positive outcomes for children and their families.

Therefore, as of September 2017, the following shifts occurred within AHS:

- The efforts of IFS were absorbed into the departments and continue; however, the unique identification of an "IFS effort" will end.
- IFS Collaborative Leadership efforts in communities is continuing with an increased focus on Local Interagency Teams and Children's Integrated Services teams as the forums to work together on the children's system of care.
- Regular meetings with the Commissioners of DCF, DAIL and DMH as the "executive managers" of children and family services began to ensure a cohesive child and family system of care.

The Agency of Human Services continues to be committed to maintaining the gains made in the IFS regions and within AHS and would like to improve the current model. The existing IFS grants will continue to be managed through the Department of Mental Health budget.

An analysis occurred of IFS Lessons Learned from these two pilots which is informing larger payment reform efforts in the state. The areas analyzed included:

- Financing and Payment Reform
- Collaborative Leadership
- Accountability and Oversight
- State and Local Service Delivery

The following themes emerged from this analysis:

- IFS has created a decrease in administrative burden allowing for more time to serve children, youth and families
- The child and family level of need drives the intensity and type of service
- Needs are addressed earlier, helping reduce the need for more intensive and costly services
- A unified local network/continuum for direct services was created
- There is greater flexibility to determine how much funding to direct to services/supports
- Eliminated funding silos and provides the opportunity to provide more health promotion activities
- Stronger community leadership teams exist in each region to assess community needs, gaps, collective resources and population health
- Both IFS regions have created a cross-departmental "Utilization Review" team to discuss the need for increased support or stepdown from residential care for children and youth

Through the IFS grants and larger payment reform work, AHS will continue to act on opportunities to improve quality and access to care, within existing budgets, using managed care flexibilities and payment reforms available under 42 CFR § 438 and the GC waiver. This includes such items as: integration of administrative structures for programs serving the same or similar populations; opportunities to increase access to services by decreasing administrative burdens on providers; reviewing pre-GC waiver operations to determine if separate administrative and Medicaid reimbursement structures can be streamlined under GC.

Each IFS grantee reports on performance measures on an annual basis to show much, how well and is

anyone better off. These measures were determined after a year-long stakeholder workgroup and were first utilized in the FY16 IFS grants. In both regions for the first year after implementation, there was the ability to increase services for children with the funding allocation due to a decrease in administrative burden and streamlined documentation after the onset of IFS. As well, both regions have been utilizing the CANS to look at the needs and strengths of children they are serving and they are using the tool to track progress over time. They are showing that through supports and services children/youth are increasing in their strengths and decreasing needs. The caveat to this is that for children involved in the child welfare system it is taking longer to see positive results; not surprising given the fact that these children experience high levels of trauma, exposure to substances, and/or abuse and neglect. As well, data from both regions indicates that upon the first two years of implementing IFS due to the flexibility in their funding the agencies were able to serve more children and families. The flexibility allowed by utilizing a case rate has allowed both regions to determine the need in their community and put their resources in those areas. This has meant serving more young children who have entered DCF custody, supporting higher numbers of adolescents using substances and supporting children on the autism spectrum.

vii. Vermont Medicaid Shared Savings Program (VMSSP)

Key updates:

- As of December 2016, 67,515 beneficiaries were attributed to two Accountable Care Organizations (ACOs) through 1,007 providers participating in the VMSSP.
- Shared savings were not achieved by either ACO in Performance Year 3 of the program; both ACOs maintained high quality measure scores.

The Vermont Medicaid Shared Savings Program (VMSSP) was a three-year program to test if the accountable care organization (ACO) models in Vermont could meet the Triple Aim goals of improving health and quality while also reducing cost. In a shared savings program, the provider network allows the State to track total costs and quality of care for the patients it serves in exchange for the opportunity to share in any savings achieved through better care management. This program was supported by a State Innovation Model (SIM) testing grant and overseen by the Green Mountain Care Board (GMCB) and AHS.

Contracts were signed between Vermont Medicaid and the two participating ACOs in February 2014. The ACOs varied in terms of geographic spread and patient mix—*OneCare Vermont* was statewide, included both the University of Vermont Medical Center and Dartmouth Hitchcock Medical Center and had a larger presence in Vermont's urban areas, while *Community Health Accountable Care* was FQHC-based and included more rural practice sites.

Performance Results, 2014-2016:

For Performance Year 1 (CY 2014), both ACOs met financial and quality targets and were able to each receive a portion of shared savings. Program savings for the year totaled $14.6 million dollars, and DVHA distributed a total of $6.6 million dollars in savings, with each ACO receiving approximately $3.3 million. Both ACOs scored well on quality measurement.

Performance Year 2 (CY 2015) results saw mixed results for the ACOs participating in the program, with CHAC demonstrating savings (a program total of $2.4 million, with shared savings incentive payments totaling $452,459 from DVHA to CHAC), while OneCare Vermont did not garner shared savings in 2015 and thus received no payout. Both ACOs demonstrated a high level of performance on a number of

clinical and claims-based quality measures, with maintenance of scores for most measures from CY 2014 (Performance Year 1) to CY2015 and demonstrated significant improvement in some areas.

Performance Year 3 (CY 2016) was the final year of the Shared Savings Program for both ACOs. Financial results were positive for CHAC, but it did not reach the 2% minimum savings rate threshold, and therefore did not qualify to receive shared savings in CY 2016. OneCare Vermont did not meet its financial targets in CY 2016 and did not qualify to receive shared savings. Both ACOs demonstrated a high level of performance in quality measurement.

Beneficiary Attribution, 2014-2016:

Beneficiary attribution in the VMSSP increased from 2014 to 2015, from 47,000 lives to 78,000 lives attributed by the end of 2015. Attribution decreased slightly in 2016, with a final attribution count for 2016 of 67,500 beneficiaries, through a total of 1,007 providers. The lower attribution count at the end of 2016 was due to changes in network composition for both ACOs and Medicaid eligibility redetermination occurring throughout 2016.

viii. Choices for Care

Key updates:

- Implemented a plan for Choices for Care online training tools.
- State audit initiated for self-directed personal care.
- Finalized a contract for National Core Indicators – Aging and Disabilities.
- Wait List

Choices for Care online training tools

In response to a survey of case management providers that indicated a need for more Choices for Care training, the Adult Services Division created a plan to launch narrated PowerPoint modules. This allows ASD to create low-cost, low-tech, easy-to-use, easy-to-maintain, on-demand training tools for providers. The first training module, Choices for Care Overview, is now available on the ASD website training page in video and printable PDF format. Future modules will be created to focus on different Choices for Care topic-specific information. Once the Choices for Care training modules are complete, ASD will expand to other program topics.

State Audit

In August 2017, DAIL was notified that the Office of the Vermont State Auditor was commencing an audit of the self-directed personal care services offered under the Choices for Care program. The auditors review compliance with program standards including the contract for Fiscal Employer Agent payroll services. It is expected that the audit will continue through February of 2018.

National Core Indicators for Aging and Disabilities (NCI-AD)

The Department of Disabilities, Aging & Independent Living (DAIL) finalized a contract with the National Association of States United on Aging & Disabilities (NASUAD) to begin participation in the National Core Indicators for Aging & Disabilities (NCI-AD). NCI-AD is a consumer experience survey that collects valid and reliable person-reported data about the impact of Vermont's long-term services and

supports on quality of life and outcomes for older adults and individuals with physical disabilities. The results of this survey will allow DAIL to evaluate the effectiveness of Vermont's programs and to compare results to similar programs across the nation.

DAIL has contracted with Vital Research to conduct the surveys as a separate, unbiased entity. Participants for the survey will be randomly selected from the Choices for Care program (including Traditional Home-Based Care, Flexible Choices and Adult Family Care) and from the Traumatic Brain Injury Program. DAIL plans to add NCI-AD for individuals receiving services through Nursing Homes and Enhanced Residential Care in 2019.
The survey process includes:
1. Vital Research works with DAIL to select a random sample of participants (January 2018)
2. Vital Research collects presurvey/background information from the agencies (January/February 2018)
3. Vital Research sends notification letters to the participants (February 2018)
4. Vital Research performs outreach to participants to ask if they are willing to participate and to schedule the interview (February/March 2018)
5. Vital Research conducts the interviews at the person's home or location of choice (February-May 2018)
6. Vital Research submits the information to the NCI-AD program for analysis (May 2018)
7. NCI-AD provides results to Vermont (January 2019)

Choices for Care Wait List

Choices for Care does not have a wait list for people applying for High/Highest and are clinically and financially eligible for services.

Moderate Needs Group (MNG) services are not an entitlement and instead are limited by funding which is allocated to providers and managed at the local level. This requires that providers establish a wait list when funds are spent in their region. Currently, home health providers report that approximately 800 people are waiting for help to pay for homemaker services statewide and zero people are waiting for help to pay for Adult Day services. Though total funding for MNG services was increased to eliminate the wait list in SFY2015, it is important to note that eligibly for Moderate Needs is quite broad which creates an opportunity for a very large number of Vermonters to be eligible. Therefore, it is expected that unless the eligibility criteria were to be modified, wait lists for the limited Moderate Needs funding will continue for the foreseeable future.

ix. Traumatic Brain Injury (TBI) Program

Key updates:
- State-wide needs assessment survey responses received.
- Wait list.

Brain Injury Association of Vermont (BIAVT) receives responses to state needs assessment.

As reported in the last quarterly report, in August 2017 the Brain Injury Association of Vermont (BIAVT) launched its state needs assessment survey. Approximately 165 people responded, including survivors, family/friends and providers. Responses will be evaluated and used to help shape the development of TBI services in Vermont over the next five years.

The following organizations collaborated with the BIAVT in the development of the survey:

- Vermont Department of Disabilities, Aging and Independent Living
- Vermont TBI Advisory Board
- Disability Rights Vermont

Wait List

There is one person who has applied and is waiting for services due to the lack of available appropriations. DAIL is working hard to find alternative services options for people waiting for TBI services. For some people, this may include participation in the Choices for Care program.

x. Developmental Disabilities Services Division

Key updates:

- HCBS rules implementation
- Updated Regulations and System of Care Plan
- DDS Medicaid Manual updated
- Workforce investment
- Continued positive outcomes for Supported Employment
- Waitlist

HCBS rules implementation

Vermont has completed a provider self-assessment survey for developmental services in relation to milestones outlined in Vermont's Comprehensive Quality Strategy (CQS). The CQS is being used to demonstrate the state's compliance with the new HCBS rules - analogous to Statewide Transition Plans being developed by other states. The division Quality Service Review team has started to conduct follow up validation visits. Based on the findings, a variety of improvement plans will be identified. These activities will serve to bring the system to full compliance with Home and Community-Based Settings rules by the due date of March 2023.

Updated Regulations and System of Care Plan

The Developmental Disabilities Services Division (DDSD) completed revisions of two major guiding documents for provision of Developmental Disability Services, the *Regulations Implementing the Developmental Disabilities Act of 1996* and the *Vermont State System of Care Plan for Developmental Disabilities Services.* Both have an effective date of October 1, 2017. This was the culmination of over a year-long process gathering input and public comment from major stakeholders. The *Regulations* were updated in response to legislation that required certain categories of the *System of Care Plan* to be adopted by the rulemaking process, including identifying the priority programs, the criteria for receiving services or funding, types of services provided and the process for evaluating the success of programs. Together these documents outline how Medicaid funds are used for individuals with developmental disabilities and their families. New language was added to both documents to ensure compliance with the new Home and Community-based rules. These documents are available at: http://humanservices.vermont.gov/on-line-rules/health-care-administrative-rules-hcar/final-clean.ddact-regulations-10-01-2017.pdf and http://ddsd.vermont.gov/ds-vt-socp.

Updated Medicaid Manual for Developmental Disabilities Services

DDSD also updated its *Medicaid Manual for Developmental Disabilities Services* in November 2017. The Medicaid Manual includes guidance for provider agencies regarding billing for services, descriptions of qualified providers and documentation requirements. It was updated to reflect changes in the revised *Regulations* and *System of Care Plan,* as well as other technical updates to be consistent with current procedures. The manual is available at:

http://ddsd.vermont.gov/sites/ddsd/files/documents/dds-medicaid-procedures.pdf

Increased Funding for Direct Support Staff

The Vermont legislature provided increased funding to require Developmental Disabilities Service provider agencies to increase wages for direct support staff to $15 per hour. This was in response to difficulties hiring sufficient numbers of workers to provide essential care and support. The state will monitor the staff turnover and vacancy rate to determine whether increased wages had any affect on alleviating the worker shortage and improving access to authorized services.

Supported Employment

Vermont continues to have very positive outcomes in supporting individuals with developmental disabilities to work. According to the 2016 *StateData: The National Report on Employment Services and Outcomes,* 38% of people receiving services in the state were employed in community-based jobs compared to the national average of 19%. Vermont ranked #1 in the country for the number of people with developmental disabilities employed per 100,000 of population: 194 vs the US average of 35. DDSD has worked closely with Vocational Rehabilitation, the Agency of Education and the University of Vermont for many years to support integrated employment.

Wait List

DDSD collects information from service providers on individuals who request funding for Home and Community-Based Services (HCBS) and other services including Targeted Case Management (TCM), Family Managed Respite (FMR), Flexible Family Funding (FFF) or Post-Secondary Education Initiative (PSEI). The information is gathered the State from providers to determine individuals with developmental disabilities (DD) who are waiting for DD services but are not currently eligible. HCBS funding priorities are the method by which Vermont prioritizes who will receive caseload funding allocated annually by the legislature. Individuals are placed on the waiting list if they meet the following criteria:

1. HCBS Applicants: Individuals with DD who are clinically and financially eligible but who do not meet a funding priority for HCBS and have been denied services in whole or in part.
2. Individuals who are clinically and financially eligible for TCM, FMR, FFF or PSEI, but for whom there are insufficient funds.

There were no individuals who met a home and community-based services funding priority who were waiting for services that helps address the need related to the funding priority. As of 6/30/17, there were 238 people who requested HCBS services but were denied because they did not meet a funding priority. 5 people were waiting for FMR and 20 were waiting for FFF. There was no one waiting for TCM or PSEI. The waiting list is monitored by providers to determine if people have a change in circumstance that makes them eligible to receive HCBS. The waiting list is also reviewed when additional funds become available for other programs.

xi. All-Payer Model: Vermont Medicaid Next Generation Program

Key updates:

- Quarterly reporting to the legislature began in Q2 and continued through Q4; the program submitted its latest report on December 15, 2017.
- Received Global Commitment Payment Model approval from CMS for the Medicaid Next Generation ACO Model for the 2018 performance year in Q3.
- DVHA and OneCare executed a contract extension to the program for a 2018 performance year.
- Future program implementation will continue to be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

In 2016, the Department of Vermont Health Access (DVHA) sought to establish service agreements with one (or more) Accountable Care Organization(s) (ACOs) for participation in a population-based payment model that is based on the Centers for Medicare and Medicaid Services (CMS) *Next Generation* ACO Model. As an evolution of the *Vermont Medicaid Shared Savings Program* (VMSSP), this new program offering creates a structure for provider organizations and other suppliers to join together under an ACO to voluntarily contract with DVHA to assume accountability for the cost and quality of care for Vermont's Medicaid beneficiaries, and for ACOs to distribute payments to their contracted network providers for any covered services rendered on behalf of Vermont Medicaid beneficiaries using alternatives to fee-for-service reimbursement. The goal of this agreement is to improve the quality and value of the care provided to the citizens served by the State of Vermont's public health care programs.

DVHA and OneCare entered into an agreement for the 2017 performance year as a pilot year with four possible one-year extensions to the program. Four risk-bearing hospital communities participated in the *Vermont Medicaid Next Generation* (VMNG) model for the pilot year: the University of Vermont Medicaid Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital, with additional participation from FQHCs, independent practices, home health providers, Designated Agencies, and skilled nursing agencies in the four communities.

DVHA issues a prospective Per-Member-Per-Month (PMPM) payment to the ACO; the ACO distributes payments to providers participating in the program per contractual arrangements between the ACO and providers. The ACO is paid for each attributed member according to their Medicaid Eligibility Group, and the ACO is accountable for the cost and quality of care of each attributed member. Payments for services not included in the ACO contract continue to be paid fee-for-service, as are payments made to Medicaid providers not participating in the ACO's network.

DVHA began submitting quarterly reports to the Vermont legislature on the VMNG program in June, 2017, and submitted its latest quarterly report to the legislature on December 15, 2017. Legislation requires that DVHA report to the legislature on implementation activities and program performance, including data on financial performance, quality performance, operational timeline adherence, utilization monitoring, changes to provider network or size of attributed population, and statistics on member complaints, grievances, and appeals. While information on performance and utilization is helpful to understand how patterns generally compare for members who are attributed to OneCare and members who are not attributed to OneCare, caution should be exercised when using the information presented in this report to evaluate 2017 program performance. Claims lag continues to cause a delay in data availability and analysis, even as the program finished the final quarter of 2017. As such,

DVHA will not have complete information on what services were provided to the attributed population during the reporting period until mid-2018. The full report can be found here: https://legislature.vermont.gov/assets/Legislative-Reports/DVHA-ACT-25-VMNG-Report-to-Legislature-Dec-15-2017.pdf

DVHA and OneCare executed a contract amendment to extend the VMNG program into a 2018 performance year. Minimal programmatic changes were made, as the focus for the 2018 year will be on growing the model and expanding the number of participating providers and attributed members, while maintaining alignment across payer programs as part of Vermont's All-Payer ACO Model. The number of risk-bearing hospital communities will increase from four to ten for the 2018 performance year, with continued participation from other providers within the communities. The number of attributed lives for the 2018 performance year will increase from approximately 29,000 lives to 42,342 lives.

DVHA and OneCare continue discussions of potential modifications for future program years, while remaining focused on aligning programs across payers in support of broader All Payer Model efforts.

xii. Global Commitment Register

Key updates:
- Since the Global Commitment Register (GCR) launched in November 2015, 99 final GCR policies have been publicly posted.
- The GCR listserv expanded from about 350 to 445 interested parties.

The GCR is a database of policy changes to and clarifications of existing Medicaid policy under Vermont's 1115 Global Commitment to Health waiver. It is based on the Federal Register, and can be used as both a public notice and documentation tool for Medicaid policy. Like the Federal Register, the GCR can be used to publish proposed policy, including information on public comment submissions, final policy, notices, and policy clarifications. The GCR is available on the DVHA website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

The GCR listserv is a group of about 445 interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. A policy change in the GCR could be a change made under the authority of the waiver, a proposed waiver amendment or extension, an administrative rule change or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not clearly answered in current policy.

Health care policy stakeholders are notified via email every time a proposed or final policy is posted to the GCR; an email is also sent when policy clarifications are posted. Stakeholders have an opportunity to provide comments on proposed GCR policies before the policies are made final. Comments received are posted in the GCR online. The GCR emails are also distributed to members of the Medicaid and Exchange Advisory Board.

Many policies were posted to the GCR in 2017. Of the 34 final policies issued, approximately 40 percent were notices of administrative rulemaking. Two State Plan Amendments (SPAs) were announced for public comment through the GCR in 2017. Other final policies included reimbursement/rate changes,

coding corrections, waiver documents and public forums, and changes to covered services. There were 9 policy clarifications issued through the GCR and six of them were announcements of approved SPAs.

The GCR can be found here: http://dvha.vermont.gov/global-commitment-to-health/global-commitment-register.

VI. Utilization Management

Utilization Management is a systematic evaluation of the necessity, appropriateness, and efficiency of managed care model services. These activities are designed to influence providers' resource utilization and clinical practice decisions in a manner consistent with established criteria or guidelines to maximize appropriate care and minimize or eliminate inappropriate care. The DVHA must have a mechanism to detect both under/over-utilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

i. Clinical Utilization Review Board

The Clinical Utilization Review Board (CURB) was established by Act 146 Sec. C34, 33 V.S.A. Chapter 19, Subchapter 6 during the 2010 legislative session. DVHA was tasked to create the CURB to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations to DVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the state's Medicaid programs.

The CURB is comprised of 10 members with diverse medical experience, appointed by the Governor upon recommendation of the DVHA Commissioner. The CURB solicits additional input as needed from individuals with expertise in areas of relevance to the CURB's deliberations. The Medical Director of DVHA serves as the State's liaison to the CURB.

The CURB has the following duties and responsibilities:

1) Identify and recommend to the Commissioner opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's medical programs by:
   a) Examining high-cost and high-use services identified through the programs' current medical claims data;
   b) Reviewing existing utilization controls to identify areas in which improved utilization review might be indicated, including use of elective, nonemergency, out-of-state outpatient and hospital services;
   c) Reviewing medical literature on current best practices and areas in which services lack sufficient evidence to support their effectiveness;
   d) Conferring with commissioners, directors, and councils within the Agency of Human Services and the Department of Financial Regulation, as appropriate, to identify specific opportunities for exploration and to solicit recommendations;
   e) Identifying appropriate but underutilized services and recommending new services for addition to Medicaid coverage;
   f) Determining whether it would be clinically and fiscally appropriate for the DVHA to contract with facilities that specialize in certain treatments and have been recognized by the medical community as having good clinical outcomes and low morbidity and mortality rates, such as transplant centers and pediatric oncology centers; and

g) Considering the possible administrative burdens or benefits of potential recommendations on providers, including examining the feasibility of exempting from prior authorization requirements those health care professionals whose prior authorization requests are routinely granted.

2) Recommend to the Commissioner the most appropriate mechanisms to implement the recommended evidence-based clinical practice guidelines. Such mechanisms may include prior authorization, prepayment, post service claim review, and frequency limits.

ii. Drug Utilization Review Board

The DUR Board was authorized by Congress under Section 4401, 1927(g) of the Omnibus Reconciliation Act of 1990. This act mandated that the Vermont AHS develop a drug use review program for covered outpatient drugs, effective January 1, 1993. The Act required the establishment of a DUR Board to:

1) Review and approve drug use criteria and standards for both retrospective and prospective drug use reviews (DURs)
2) Apply these criteria and standards in the application of DUR activities
3) Review and report the results of DURs, and
4) Recommend and evaluate educational intervention programs.

Additionally, the Vermont Legislature enacted the Pharmacy Best Practices and Cost Control Program from the 2002 Appropriations Act, H. 485, which mandated that:

"The commissioner of prevention, assistance, transition, and health access [now the Department of Vermont Health Access] shall establish a pharmacy best practices and cost control program designed to reduce the cost of providing prescription drugs, while maintaining high quality in prescription drug therapies. The program shall include a preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives, utilization review procedures, including a prior authorization review process, and any other cost containment activity adopted by rule by the commissioner, designed to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies."

Implementation of this pharmaceutical initiative required that either the DUR Board or a Pharmacy and Therapeutics Committee be established that would provide guidance on the development of a Preferred Drug List for Medicaid patients. The DVHA elected to utilize the already established DUR Board to obtain current clinical advice on the use of pharmaceuticals. Meetings of the DUR Board occur monthly or bimonthly depending upon the numbers of drugs and issues to be reviewed.

The DUR Board typically includes 10-12 members who are appointed to two-year terms with an option for a two-year extension. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians and at least one-third of its members are licensed and actively practicing pharmacists, in addition to one member at large who is currently a nurse practitioner. Board members are recommended by the DVHA Commissioner and approved by the Governor.

Meetings of the DURB occur eight times per year. In Q4 2017, the DURB held two meetings. Information on the DURB and its activities in 2017 is available here: http://dvha.vermont.gov/advisory-boards.

DUR Board Decisions

Updates from October 24th and December 5th DUR Board meetings:

Full New Drug Reviews

Airduo, Seebri, Ocrevus, Synjardy XR, Austedo, Ingrezza, Kevzara, Mavyret, Vosevi, Arymo ER, Morphabond, Benlysta, Brineura, Zinplava, Tymlos, Siliq, Tremfya, and Xatmep were reviewed for placement on the preferred drug list.

Therapeutic Drug Class Reviews

Multiple Scleorsis, Cytokine and CAM agents, Alzheimer's agents, topical Analgesics, Anticoagulants, Antiparkinson's agents, Cytokine Cam Antagonist, Gaucher Disease and NSAID's were reviewed for placement on the preferred drug list.

Newly-Developed/Revised Clinical Coverage Criteria and/or Preferred Products

ADHS long-acting stimulants, antidiabetic/Peptide Hormones, Antidepressants/SNRI's, Antipsychotics/Long-acting injectables GI/Antiemetics, IBS and ulcerative colitis, long-acting revisable contraceptives, ophthalmic/dry eye syndrome, prenatal vitamins, chemical dependency and urinary antispasmodics.

RetroDUR/DUR topics included:

Introduction of use of Fluoroquinolones and Overuse Long-Acting Stimulants

iii. Appropriateness of Services

DVHA delegates to its IGA partners who provide care to the four identified special health care needs populations, the responsibility to develop mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. DMH monitors the quality and appropriateness of care for enrollees in the Community, Rehabilitation and Treatment (CRT) Program through the biennial Minimum Standards Review and for children identified with severe emotional disturbance through Program Reviews. The Department of Disability, Aging and Independent Living (DAIL) monitors the quality and appropriateness of care to enrollees in the Developmental Services Program and the Traumatic Brain Injury Program through Quality Service Reviews. (For further descriptions of the delegated activities see the individual departments' quality plans.)

iv. Program Integrity Unit

Key updates:

- Realignment of compliance and integrity functions to all be within the Program Integrity Unit.
- Creation of the DVHA Fiscal Compliance unit to conduct sub-recipient monitoring of Federal and State funds.
- Creation of an MMIS Compliance Unit to ensure appropriate processing and adjudication of Vermont Medicaid claims.
- Creation of the Healthcare Quality Control Unit to comply with CMS Payment Error Rate Measurement requirements for accurate beneficiary eligibility and enrollment determinations.
- Relocation of the DVHA Compliance Officer to the Program Integrity Unit for the broad oversight of compliance.
- Facilitated seven state and federal audits of DVHA programs from Federal and State regulators.
- Received more than 90 new Provider fraud allegations and over 130 new Beneficiary fraud allegations.

The Program Integrity (PI) Unit is responsible for ensuring compliance, proper oversight, efficient care and appropriate use of Federal and State funds with minimal waste. PI works to promote efficiency, accountability, compliance and integrity within the Medicaid Program.

The PI unit has grown in the past year with efforts to ensure better accountability, and quality control of the Medicaid Program. The Provider Audit & Compliance Unit (PACU), Beneficiary Fraud Investigative Unit (BFIU), and Oversight & Monitoring (O/M) are the three units that historically made up the Program Integrity unit. Four additional functional units were added in an effort to create the ultimate DVHA compliance structure.in the VT Medicaid program: HealthCare Quality Control, DVHA Fiscal Compliance, MMIS Compliance, and the addition of DVHA's Compliance Officer.

Effective program integrity ensures:

- Accurate beneficiary enrollment and eligibility determinations
- Accurate and compliant provider enrollment
- Compliance with Federal & State Medicaid Policies and regulations
- Services provided to beneficiaries are medically necessary and appropriate
- Provider payment & reimbursement is made in accordance with State/Federal policies
- Subrecipient monitoring of Federal and State funds
- Accuracy of claim processing in the Medicaid Management Information System
- Transparent and appropriate responses to external audits
- Timely response to corrective action requests
- Clear documentation of policies and procedures

The PI unit works in partnership with many Federal and State partners such as, the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), the Medicaid Fraud & Residential Abuse Unit (MFRAU) of the Attorneys General (AG) Office, State's Attorney's Office, Medical Practice and Licensing Boards, Drug Enforcement Administration (DEA) and other Law Enforcement Offices. Additionally, there is always communication with Federal and State Regulators, AHS Departments, State Fiscal Agents, providers, beneficiaries, and more.

The Medicaid Management Information System (MMIS) is an integral component of the Program Integrity utilization review activities. The MMIS maintains Medicaid claims data, beneficiary eligibility

and demographics, and provider enrollment information which allows for additional review and scrutiny of the Medicaid eligibility, enrollment and claims data.

PI staff examine beneficiary eligibility, provider enrollment and claims data to verify appropriate determinations in pre-& post payment reviews. Staff utilize data mining techniques and have developed a variety of algorithms to detect aberrant utilization. Medicaid policies, guidelines and claims data are utilized in the development of these algorithms. Reports generated from these reviews could result in supporting existing PI investigations or the creation of new.

PI staff also utilize the Enhanced Vermont Ad Hoc (EVAH) system. The EVAH system is a Business Objects application that enables the auditors and analysts to mine data and create varied and comprehensive ad hoc reports from the MMIS. Business Objects is an invaluable tool to advance investigations that enables staff to focus on individual elements within each case.

Data gleaned from Business Objects allows for analysis of claim information submitted by providers. The data can be reported and analyzed using any of the claim details to compare individuals, evaluate adherence to policy, etc. This is the primary method used in detecting under/over-utilization on a global scale.

PACU – Provider Audit & Compliance Unit

The PACU initiates work to prevent, detect and investigate fraud, waste and abuse by healthcare providers and seeks to recover incorrect payments. Reviews are conducted to ensure that services were provided, medically necessary, properly coded, billed and paid in accordance with federal and state Medicaid rules, regulations, provider agreements and relevant statutes. Cases of suspected provider fraud are referred to MFRAU.

The PACU employs several methods to identify fraud, waste and abuse, such as:

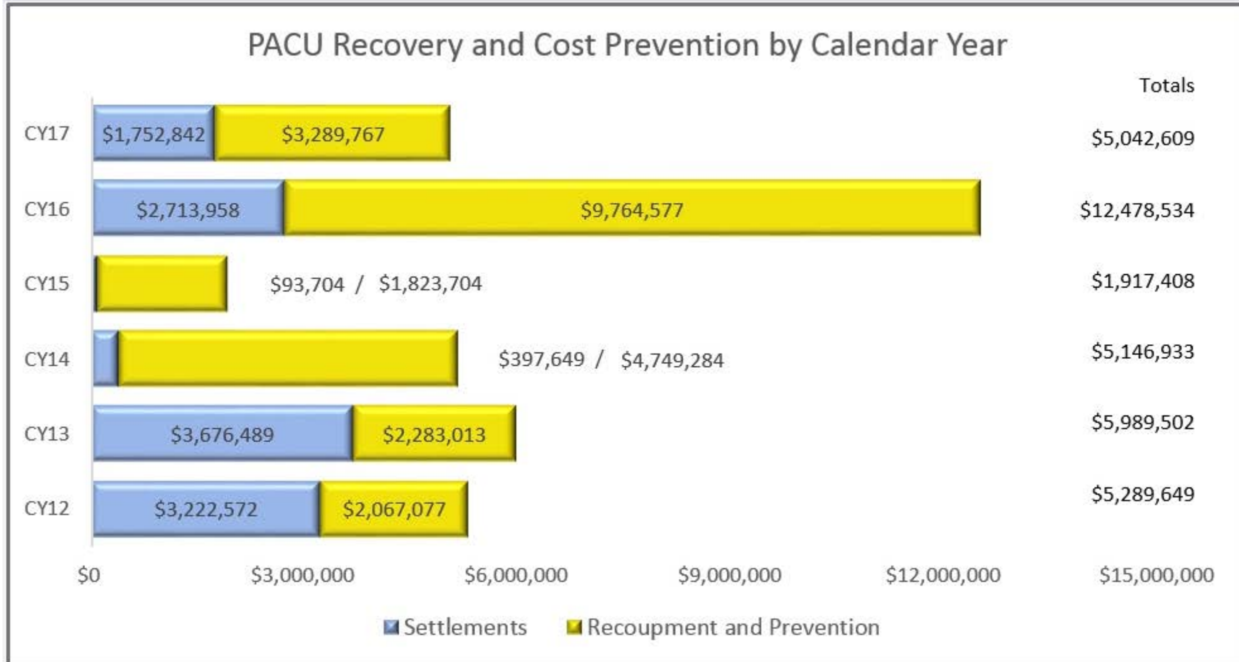
- Referrals from providers, pharmacies, national alerts, the public, etc.
- Pre-& Post-payment reviews
- Data mining activities
- Recipient verification
- Desk and on-site reviews

The PACU analyzes claims data to detect aberrant billing practices, identify potential findings and perform preliminary and full investigations. The Medicaid Integrity Contractors (MIC) and the Investigations & Audits Group (IAG) staff of CMS help to support the PACU in audit, oversight, and antifraud, waste and abuse efforts.

Outcomes:
The PACU's focus is the integrity of the program. When overpayments are made, the PACU seeks to recover funds to ensure that Medicaid dollars are appropriately spent. Money recovered because of fraud, waste and abuse, can be reinvested back into the Medicaid program. Efforts are made to provide additional education to providers and to implement system limitations to prevent future incorrect or overpayments. Analyses of risks and vulnerabilities are also conducted periodically to seek opportunities to prevent future overpayments. Program Recommendations are shared with the Agency of Human Services Departments and units to provide suggestions for change to lessen future risks. When these actions are taken, incorrect spending is prevented.

PACU efforts for CY17 recoveries and cost prevention totaled $5,042,609.08. Much of the PI Unit's success continues to be the result of the ongoing support and ability to receive enhanced training to PI staff through the Medicaid Integrity Institute (MII). CMS, the Department of Justice (DOJ) and MII staff continue to recognize Vermont Program Integrity employees as national leaders and strong authorities on fraud, waste and abuse and have recruited them to conduct training for other State's Program Integrity employees.

Figure 16. Program Integrity PACU Recovery and Cost Prevention, by Calendar Year



Beneficiary Fraud Investigative Unit (BFIU)

The BFIU is responsible for investigating, detecting and preventing beneficiary healthcare eligibility and enrollment fraud in the Medicaid programs. All other non-healthcare fraud investigations of State-funded assistance programs remain the responsibility of the Department for Children and Families (DCF). The BFIU and DCF Fraud unit work collaboratively to ensure all aspects of Vermont assistance programs are considered and evaluated as a collective.

The BFIU works with the Health Access Enrollment & Eligibility Unit (HAEEU), as well as other State and Federal partners to ensure Vermonters are receiving appropriate eligibility determinations based on their applications, and that income thresholds, residency and other means of determining coverage are proper.

Outcomes:
The BFIU team is new and establishing many internal policies and procedures to be the foundation for the success of this team. In late CY17, BFIU put significant efforts toward defining and strengthening the work performed for the review and analysis of the Public Assistance Reporting Information System (PARIS) matches to reduce the number of beneficiaries who are enrolled in more than one State Medicaid program simultaneously. The roll-out of a new review process is underway and expected to have great results in CY18.

Oversight & Monitoring (O&M)

DVHA Oversight & Monitoring (O&M) was established to ensure the effectiveness and efficiency of departmental control environments, operational processes, financial and performance reporting; in alignment with federal and state laws and regulations; and the strategic direction of DVHA and Agency Leadership. This unit is the key liaison for DVHA Federal, State and Independent examinations to ensure consistent, timely and professional response; and presentation of requested material.

O&M proactively evaluates units for audit readiness and provides consultation regarding auditor/regulator communications, proper response, follow up, escalation and reporting.
Additionally, O&M acts as an intermediary and advocate for DVHA setting a basis of understanding and expectation for Regulators, Examiners, Auditors, Independent Auditors and State Senior Leadership.

Outcomes:
In calendar year 2017 the Oversight and Monitoring (O&M) unit made significant strides in coordinating DVHA participation in State, Federal, and independent audits and examinations, seeking to ensure that information shared is consistent, accurate, and timely. Specifically, O&M:

- Facilitated seven state and federal audits of DVHA programs, including KPMG CAFR, KPMG DVHA A133 Single Audit, PERM, PERM Pilot Round 5, Berry Dunn Financial and Programmatic Audits, CMS Targeted Provider Review, CMS Terminated Provider Review.
- KPMG DVHA A133 Single Audit reduction of 5 repeat findings to 2.
- Reduction of PERM findings by detail analysis and understanding of errors/exceptions and presentation/representation of supporting documentation resulting in material reduction of errors and next review sample size.
- PERM Pilot Round 5 case analysis and preparation/approval of CAPs. Worked to bring CMS/CCIIO areas in line with mitigation plans and appreciation of accomplishments in closing several mitigation issues.
- Provided ongoing tracking and monitoring and follow-up of mitigation plans and other open Corrective Action Plans.
- Supported AHS & DVHA staff with documentation standards for better Standard Operating Procedures and policies.

The goal of the O&M group is to facilitate open communication, through a single voice, to ensure all expectations of auditors and regulators are met, and that there are no repeat findings. Collectively, this transparency will promote further success of the program.

Healthcare Quality Control Unit (HCQC)

In CY17, DVHA enhanced its healthcare quality control program and relocated DVHA's internal Healthcare Quality Control Unit (HCQC) under the DVHA Program Integrity Unit giving it focus and independence from eligibility & enrollment operations. Monthly case reviews (post completion) are conducted by for MAGI-based and Non-MAGI-based health care programs. Results of this review are shared with the Health Access Eligibility & Enrollment Unit (HAEEU) weekly for review and corrective action. The HAEEU formally implemented a front-end internal Quality Assurance unit in early 2018 to complement the work conducted by HCQC. The PI HCQC and HAEEU QA units work closely to validate findings and ensure corrective actions.
The efforts of this collaboration are expected to decrease errors and findings and include any necessary change to business processes and staff training.

Outcomes:

- Developed, implemented and established Healthcare Quality Control Unit including identification of federal and state regulations, establishment of policies, procedures and standard operating procedures.
- Hired and trained new staff for the execution of expected deliverables for the Federal Payment Error Rate Measurement (PERM) audit.
- Established the sampling methodology for case reviews.
- Created a Corrective Action Process (CAP) with a tracking process.

In CY18, HCQC will be monitoring the effectiveness of its quality control program through dashboard reporting. This reporting will include details to support the number and types of eligibility cases reviewed, along with outcomes of correct or incorrect eligibility determinations, etc.

<u>Medicaid Management Information System Compliance</u>

Medicaid Management Information System Compliance (MC) was new to the Program Integrity Unit in CY17. MC was developed to ensure compliance between the MMIS changes and State and Federal policies. In addition, MC has the following key functions:

- Monitor MMIS Fiscal Agent Service Level Agreements (SLAs) and Service Level Credits (SLCs)
- Identify and resolve discrepancies between MMIS and Medicaid policies
- Facilitate System requests for edit and audit changes

In addition, MMIS Compliance collaborates with DVHA's Fiscal Agent to address process improvements for state requested MMIS changes. The primary goals of this unit are to ensure that Vermont Medicaid is receiving quality customer service from the MMIS Fiscal Agent and to prevent unnecessary spending on system changes or solutions that may be accomplished in another, less costly, manner.

Outcomes:
During CY17, MC worked with stakeholders from DVHA's Fiscal Agent, DXC Technologies, and the State of Vermont to ensure that the new contract SLAs and their reporting was meeting the needs of the Medicaid program. MC also spearheaded a process improvement project which allows State of Vermont sponsors the opportunity to participate in DXC testing when system changes are implemented to the MMIS. MC collaborated with DXC to bring about process improvements to the State Request Log (S-log) process so that the approvals for many changes are funneled through more reviews prior to final approval, thus allowing for unintended consequences to be mitigated.

<u>DVHA Fiscal Compliance Unit</u>

The DVHA Fiscal Compliance Unit (DFCU) is one of the newest units to join the Program Integrity unit. It is responsible for ensuring the fiscal integrity of DVHA and its subrecipients/grantees through proactive, preventative strategies. The primary objective of the unit is to minimize the risk to DVHA's current financial assets by ensuring its compliance, and that of its subrecipients and grantees, to all applicable fiscal/financial regulations. The DFCU uses a risk-based strategy to actively examine the financial records of the Department and its subrecipients noting any compliance exceptions, regulation at risk, cause of the exception, party accountable and the financial exposure to DVHA.

DFCU acts as a resource to DVHA programs by providing training and engaging with managers early on in the process to prevent non-compliance. The unit provides DVHA leadership with reports showing the

results of each review. Through the work of this unit, weaknesses with subrecipient contracts and/or agreements can be reduced and prevented.

DVHA Medicaid Compliance

The Medicaid Compliance Officer (CO) collaborates with Medicaid programs across the Agency of Human Services to ensure compliance with state and federal Medicaid requirements. The CO maintains formal agreements with partner departments, conducts internal risk assessments, reviews and consults on projects and manages a compliance committee. When non-compliant programs or procedures are discovered, the CO manages a corrective action process.
The Compliance Officer works closely with the various units within DVHA to maintain continuity between compliance, clinical and quality improvement activities such as:

- Support compliance with all state and federal Medicaid requirements
- Manage DVHA Inter-Governmental Agreements (IGA's) with other AHS Departments
- Identify and correct Medicaid compliance issues

Each year, the Compliance Officer coordinates a compliance audit, which is conducted by an External Quality Review Organization (EQRO), designated by CMS. This audit covers a broad range of compliance issues and is conducted on a three-year cycle of topics. The CO is responsible for managing any required corrective actions or recommendations listed in the final audit report.

v. *Inpatient, Outpatient, and Emergency Department Utilization*

Methods
Utilization statistics for inpatient, outpatient, and emergency department services provided under Global Commitment during FFY 2015-17 were compiled by the DVHA's Data Unit in February 2018 using paid claims data. The scope of analysis included institutional services provided under the Medicaid program between 10/1/2014 and 9/30/2017, excluding crossover claims.[1] The following areas of utilization were the focus of this analysis:

- Total Inpatient Utilization
    - Inpatient Medicine
        - Inpatient Medicine – Alcohol and Substance Abuse Services
        - Inpatient Medicine – Psychiatric Services
        - Inpatient Medicine – All Other Services
    - Inpatient Surgery
- Total Outpatient Utilization
    - Emergency Department Utilization

Measures consisted of discharge counts and institutional length-of-stay, in days, for inpatient services, and visit counts for outpatient services. The results were broken out by age category.

Findings
The following table (Table 5) presents discharge counts and average length-of-stay by age for inpatient services provided in FFY 2015-17.

[1] Crossover claims or claims for which the State of Vermont was the payer of last resort and paid the remainder of cost for services covered by Medicare.

Table 5. Inpatient Utilization by Fiscal Year and Age Group

Total Inpatient:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
<1	12,142	12,024	10,882	3,082	2,996	2,879	3.9	4.0	3.8
1-9	3,162	2,276	2,355	433	459	399	7.3	5.0	5.9
10-19	8,833	8,621	8,091	1,151	1,173	1,053	7.7	7.3	7.7
20-44	28,852	27,602	29,171	6,290	6,122	6,022	4.6	4.5	4.8
45-64	20,353	20,982	21,785	3,724	3,850	3,782	5.5	5.4	5.8
65+	631	1,303	1,050	107	96	139	5.9	13.6	7.6
Overall	**73,973**	**72,808**	**73,334**	**14,787**	**14,696**	**14,274**	**5.0**	**5.0**	**5.1**

A) Inpatient Medical (Alcohol/Substance + Mental Health + Other Medical):

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
<1	11,748	11,834	10,671	3,057	2,968	2,848	3.8	4.0	3.7
1-9	2,731	1,895	1,972	358	371	341	7.6	5.1	5.8
10-19	8,080	7,785	7,273	994	991	892	8.1	7.9	8.2
20-44	23,181	21,048	23,705	5,031	4,677	4,794	4.6	4.5	4.9
45-64	14,724	14,385	14,934	2,760	2,719	2,705	5.3	5.3	5.5
65+	537	1,059	883	91	78	116	5.9	13.6	7.6
Overall	**61,001**	**58,006**	**59,438**	**12,291**	**11,804**	**11,696**	**5.0**	**4.9**	**5.1**

A1) Alcohol/Substance Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
<1	-	-	4	-	-	1	-	-	4.0
1-9	-	-	-	-	-	-	-	-	-
10-19	63	48	120	15	7	7	4.2	6.9	17.1
20-44	3,255	1,613	1,724	726	382	399	4.5	4.2	4.3
45-64	1,311	1,356	1,290	276	296	262	4.8	4.6	4.9
65+	-	24	-	-	1	-	-	24.0	-
Overall	**4,629**	**3,041**	**3,138**	**1,017**	**686**	**669**	**4.6**	**4.4**	**4.7**

A2) Mental Health Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
<1	-	-	5	-	-	2	-	-	2.5
1-9	768	667	951	33	32	56	23.3	20.8	17.0
10-19	6,253	5,923	5,525	507	461	423	12.3	12.8	13.1
20-44	9,076	9,471	11,553	906	1,011	1,185	10.0	9.4	9.7
45-64	3,296	3,695	4,115	369	352	352	8.9	10.5	11.7
65+	20	378	120	1	5	4	20.0	75.6	30.0
Overall	**19,413**	**20,134**	**22,269**	**1,816**	**1,861**	**2,022**	**10.7**	**10.8**	**11.0**

A3) Other Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
<1	11,748	11,834	10,662	3,057	2,968	2,845	3.8	4.0	3.7

Age	2015	2016	2017	2015	2016	2017	2015	2016	2017
1-9	1,963	1,228	1,021	325	339	285	6.0	3.6	3.6
10-19	1,764	1,814	1,628	472	523	462	3.7	3.5	3.5
20-44	10,850	9,964	10,428	3,399	3,284	3,210	3.2	3.0	3.2
45-64	10,117	9,334	9,529	2,115	2,071	2,091	4.8	4.5	4.6
65+	517	657	763	90	72	112	5.7	9.1	6.8
Overall	**36,959**	**34,831**	**34,031**	**9,458**	**9,257**	**9,005**	**3.9**	**3.8**	**3.8**

B) Inpatient Surgery:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**	**2015**	**2016**	**2017**
<1	394	190	211	25	28	31	15.8	6.8	6.8
1-9	431	381	383	75	88	58	5.7	4.3	6.6
10-19	753	836	818	157	182	161	4.8	4.6	5.1
20-44	5,671	6,554	5,466	1,259	1,445	1,228	4.5	4.5	4.5
45-64	5,629	6,597	6,851	964	1,131	1,077	5.8	5.8	6.4
65+	94	244	167	16	18	23	5.9	13.6	7.3
Overall	**12,972**	**14,802**	**13,896**	**2,496**	**2,892**	**2,578**	**5.2**	**5.1**	**5.4**

The following table (Table 6) presents visit counts by age for outpatient services provided in FFY2015-17, first for all outpatient clinic services, emergency department services, other outpatient services, and then the combination of ED and other outpatient.

Table 6. Outpatient Utilization by Fiscal Year and Age Group

FFY15					EXCLUDING Clinic	
	Age	***Clinic****	**ED**	**Other**	**ED & Other**	**%ED**
	<1	*7,942*	2,939	3,065	6,004	49%
	1-9	*29,391*	14,727	17,479	32,206	46%
	10-19	*25,692*	16,157	27,745	43,902	37%
	20-44	*64,913*	44,390	102,540	146,930	30%
	45-64	*46,621*	15,479	88,217	103,696	15%
	65+	*656*	177	1,279	1,456	12%
	Overall	***175,215***	**93,869**	**240,325**	**334,194**	**28%**
FFY16					EXCLUDING Clinic	
	Age	***Clinic****	**ED**	**Other**	**ED & Other**	**%ED**
	<1	*8,371*	2,714	2,766	5,480	50%
	1-9	*32,250*	14,227	17,666	31,893	45%
	10-19	*27,759*	16,024	28,169	44,193	36%
	20-44	*67,853*	43,614	103,854	147,468	30%
	45-64	*52,175*	16,136	89,756	105,892	15%
	65+	*546*	172	1,247	1,419	12%
	Overall	***188,954***	**92,887**	**243,458**	**336,345**	**28%**
FFY17					EXCLUDING Clinic	
	Age	***Clinic****	**ED**	**Other**	**ED & Other**	**%ED**
	<1	0	2,447	3,044	5,491	45%
	1-9	0	13,774	19,248	33,022	42%
	10-19	0	15,128	31,296	46,424	33%
	20-44	0	37,621	106,020	143,641	26%
	45-64	0	15,136	90,974	106,110	14%

65+	0	173	1,378	1,551	11%
Overall	0	**84,279**	**251,960**	**336,239**	**25%**

*Outpatient clinic visits (provider-based billing) based on Medicare reimbursement practices ended on 6/30/2016.

Discussion

In FFY2017, Global Commitment, Medicaid, paid for 14,274 inpatient stays and 336,239 outpatient visits for Vermonters. The total number of inpatient visits were slightly decreased over the three years. 82% of inpatient discharges were for medicine and 18% were for surgery. The total number of outpatient visits has decreased by 36% but this decrease was due to provider-based billing where hospital owned practices bill for separate professional fees and outpatient clinic facility fees. DVHA has since ended provider-based billing on June 30, 2016.

Alcohol/substance-abuse stays were somewhat longer duration, surgeries were moderately longer, and psychiatric stays were much longer than other inpatient medical stays. Psychiatric medical services constituted 14% of the total inpatient stays and medical treatment for alcohol and substance abuse were 5% of the total inpatient stays. Total bed days were stable for alcohol/substance abuse during FFY16 to FFY17 however there had been a 34% decrease from FFY15 to FFY16. Average length of stay alcohol/substance abuse stayed around 4.5 days. Inpatient psychiatric medical discharges continued to increase during each year and the average length of stay increased slightly to 11 days. Inpatient surgery bed days increased 14% between FFY15 and FFY16 and then decreased 11% in FFY17.

Among outpatient visits, emergency department visits constituted roughly 25% of the emergency and other outpatient visits. Outpatient clinic facility visits were treated separately in this report due to fluctuations in billing practices. “Provider-based billing” was adopted by each hospital at different dates starting in the fall of 2014 and was an effort to conform to existing Medicare hospital owned department (including outpatient departments outside the traditional hospital campus) billing practices. “Provider-based billing” involves the hospital billing Medicaid separate facility and professional service claims. Hospital outpatient clinic facility visits were zero in FFY17 since billing ended.

VII. Policy and Administrative Difficulties

Fiscal & Operational Management:

For all CY2017, AHS paid DVHA 1/12 of the legislative budget for Global Commitment on the first business day of every month during the year. This payment serves as the proxy by which to draw down Federal funds for Global Commitment. The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments, and admin; please note admin is now claimed outside of GC neutrality) for the given quarter. After each quarterly submission, AHS reconciled what was claimed on the CMS-64 versus the monthly payments made to DVHA.

Regarding Budget Neutrality, one issue to be noted is that the ABD Dual MEG is combined with the ABD MEG on the CMS-64 but needs to be categorized separately for budget neutrality per STC#62. There is no form to report the ABD-Dual MEG separately on the CMS-64; however, because it is subject to budget neutrality, it requires AHS to manually move this cost in the “With Waiver” section to ABD-Dual on the budget neutrality spreadsheet. This adjustment is being done QE1217 and will not impact the cumulative total expenditures for the year. The Budget Neutrality spreadsheet is tied quarterly to the CMS-64 Schedule C Expenditure Report.

It should also be noted that per STC#40, the State stayed below the CY2017 funding limit of $6.5M for state funded marketplace subsidies with a cumulative total of $6.3M. Also, the State's CY2017 annual investment expenditures of $142.5M complied with the STC#81 annual limit.

Although delayed, AHS filed the CMS-64.11 & CMS-64.11A reports beginning QE0917. Part of the issue with filing these reports has been deciphering what constitutes a health care related tax given that the information provided in the health care manual is relatively generic. AHS continues to file the reports quarterly based on the following provider taxes: Ambulance, Home Health, Hospital, Intermediate Care Facility (ICF), Nursing Home, and Pharmacy.

The CMS-64 report was filed as normal for QE1217. Some prior quarter adjusting (PQA) entries were necessary this quarter primarily due to Financial Balancing Report (FBR) updates made by DXC moving cost from GC Program to Investment. Other miscellaneous PQA entries were also done related to updated cost allocation information and finalized data.

Since Vermont reached four consecutive quarters of 3 or less errors in the June quarter, CMS has not performed the VIII Group 30-sample review since QE0317 so there were no prior quarter adjustments related to this for QE1217 on the CMS-64 report.

AHS submitted the calendar year 2018 PMPM Medicaid rates during the QE1217 quarter.

Finally, AHS will be working with DVHA in the coming months to calculate the 2017 Medical Loss Ratio (MLR) per STC#23c.

VIII. Capitated Revenue Spending

The PMPM rates as set for 04/01/17 – 12/31/17 are listed below.

Table 7. PMPM Capitated Rates QE1217

Medicaid Eligibility Group		04/01/17-12/31/17
ABD Adult	$	1,620.46
ABD Child	$	2,642.56
ABD - Dual	$	1,959.12
non-ABD Adult	$	587.93
non-ABD Child	$	428.33
GlobalRx	$	85.13
New Adult	$	507.66
Moderates	$	458.29

Investments totaled $36,430,334 for QE1217 and $142,500.000 for CY2017.

Attachments

Budget Neutrality New Adult
New Adult (w/ and w/o Child) Medical Costs Only

	DY 12 – PMPM			
	QE 0317	**QE 0617**	**QE 0917**	**QE 1217**
(A) New Adult Group PMPM Projection	$518.26	$518.26	$518.26	$518.26
(B-1) eligible member months w/ Child	55,221	57,032	56,699	55,358
(B-2) eligible member months w/o Child	124,997	124,845	120,933	118,080
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 28,618,835.46	$ 29,557,404.32	$ 29,384,823.74	$ 28,689,837.08
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 64,780,945.22	$ 64,702,169.70	$ 62,674,736.58	$ 61,196,140.80
(D-1) New Adult FMAP w/ Child	54.46%	54.46%	54.46%	53.47%
(D-2) New Adult FMAP w/o Child	86.89%	86.89%	86.89%	86.69%
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 15,585,817.79	$ 16,096,962.39	$ 16,002,975.01	$ 15,340,455.89
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 56,288,163.30	$ 56,219,715.25	$ 54,458,078.61	$ 53,050,934.46
Subtotal Federal Share Supplemental Cap 1	$ 71,873,981.09	$ 72,316,677.65	$ 70,461,053.62	$ 68,391,390.35
Total FFP reported for New Adult Group	$ 62,816,665.28	$ 61,830,391.33	$ 54,643,069.28	$ 51,158,852.52
Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget neutrality	$ 9,057,315.82	$ 10,486,286.31	$ 15,817,984.35	$ 17,232,537.82

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
February 1, 2018

ELIGIBILITY GROUP	DY 12	DY 13	DY 14	DY 15	DY 16	Total
	JAN - DEC 2017	JAN - DEC 2018	DAN - DEC 2019	JAN - DEC 2020	JAN - DEC 2021	
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 143,293,736	$ -	$ -	$ -	$ -	$ 143,293,736
ABD - Non-Medicare - Child	$ 85,311,686	$ -	$ -	$ -	$ -	$ 85,311,686
ABD - Dual	$ 661,213,179	$ -	$ -	$ -	$ -	$ 661,213,179
ANFC - Non-Medicare - Adult	$ 101,535,007	$ -	$ -	$ -		$ 101,535,007
ANFC - Non-Medicare - Child	$ 391,655,070	$ -	$ -	$ -	$ -	$ 391,655,070
Total Expenditures Without Waiver	**$ 1,383,008,678**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,383,008,678**
With Waiver						
ABD Non Medicare Adult	$ 162,605,926	$ -	$ -	$ -	$ -	$ 162,605,926
ABD - Non-Medicare - Child	$ 66,594,520	$ -	$ -	$ -	$ -	$ 66,594,520
ABD - Dual	$ 445,853,945	$ -	$ -	$ -	$ -	$ 445,853,945
ANFC - Non-Medicare - Adult	$ 84,041,960	$ -	$ -	$ -	$ -	$ 84,041,960
ANFC - Non-Medicare - Child	$ 305,549,938	$ -	$ -	$ -	$ -	$ 305,549,938
Premium Offsets	$ (655,991)	$ -	$ -	$ -	$ -	$ (655,991)
Moderate Needs Group	$ 1,487,602	$ -	$ -	$ -	$ -	$ 1,487,602
Marketplace Subsidy	$ 6,355,286	$ -	$ -	$ -	$ -	$ 6,355,286
VT Global Rx	$ 13,824,516	$ -	$ -	$ -	$ -	$ 13,824,516
VT Global Expansion VHAP	$ 414,824	$ -	$ -	$ -	$ -	$ 414,824
CRT DSHP	$ 10,331,787	$ -	$ -	$ -	$ -	$ 10,331,787
Investments	$ 142,500,000	$ -	$ -	$ -	$ -	$ 142,500,000
Total Expenditures With Waiver	**$ 1,238,904,312**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,238,904,312**
Supplemental Test: New Adult (Gross)						
Limit	$ 369,604,893	$ -	$ -	$ -	$ -	$ 369,604,893
With Waiver Expenditures	$ 295,626,448	$ -	$ -	$ -	$ -	$ 295,626,448
Surplus (Deficit)	*$ 73,978,445*	*$ -*	*$ -*	*$ -*	*$ -*	*$ 73,978,445*
Waiver Savings Summary						
Annual Savings	$ 144,104,366	$ -	$ -	$ -	$ -	$ 144,104,366
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 43,231,310	$ -	$ -	$ -	$ -	$ 43,231,310
Total Savings	$ 43,231,310	$ -	$ -	$ -	$ -	$ 43,231,310
Cumulative Savings	***$ 43,231,310***	***$ 43,231,310***	***$ 43,231,310***	***$ 43,231,310***	***$ 43,231,310***	***$ 43,231,310***

New Adult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality New Adult tab (STC#64)
See CY2017 Investments tab
See EG MM CY 2017 Tab for Member Month Reporting

State of Vermont
Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
http://dvha.vermont.gov

[Phone] 802-879-5900

Agency of Human Services

Medicaid Program Enrollment and Expenditures Report

Q2 SFY 2018

Quarterly Report to the General Assembly
Pursuant to 33 V.S.A. § 1901f

Al Gobeille, Secretary
Vermont Agency of Human Services

Cory Gustafson, Commissioner
Department of Vermont Health Access

March 1, 2018

Key Terms

Caseload – Average monthly member enrollment

MEG – Medicaid Eligibility Group

ABD Adult and Acute CFC – Beneficiaries age 19 or older; categorized as aged, blind, disabled, and/or medically needy

ABD Dual – Beneficiaries eligible for both Medicare and Medicaid; categorized as aged, blind, disabled, and/or medically needy

General Adult – Beneficiaries age 19 or older; pregnant women or parents/caretaker relatives of minor children receiving cash assistance and those receiving transitional Medicaid after the receipt of cash assistance

New Adult - Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL

Vermont Premium Assistance - Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL

Vermont Cost Sharing - Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL

ABD Child – Beneficiaries under age 19; categorized as blind, disabled, and/or medically needy

General Child – Beneficiaries under age 19, and below the protected income level, categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E)

Underinsured Child – Beneficiaries under age 19 or under with household income 237-312% FPL with other (primary) insurance

CHIP – Children's Health Insurance Program – Beneficiaries under age 19 with household income 237-312% FPL with no other insurance

Pharmacy Only – Assistance to help pay for prescription medicines based on income, disability status, and age

Traditional Choices for Care - Vermont's Long Term Care Medicaid Program; for Vermonters in nursing homes, home-based settings, and/or enhanced residential care (ERC)

PMPM – Per Member Per Month

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS and AoE Medicaid Expenditures

All AHS and AoE YTD '18

	SFY '18 As Passed Rescission			SFY '18 Actuals thru December 31, 2017			% of Expenses to Budget Line Item
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	
ABD Adult and Acute CFC	7,243	$ 183,995,423	$ 2,116.99	7,001	$ 78,850,020	$ 1,877.07	42.85%
ABD Dual	17,645	$ 228,189,169	$ 1,077.68	17,551	$ 107,020,944	$ 1,016.28	46.90%
General Adult	14,343	$ 93,350,816	$ 542.37	12,526	$ 38,829,629	$ 516.65	41.60%
New Adult	59,604	$ 301,442,712	$ 421.45	58,223	$ 136,649,503	$ 391.16	45.33%
Vermont Premium Assistance	19,381	$ 6,649,761	$ 28.59	18,022	$ 3,134,000	$ 28.98	47.13%
Vermont Cost Sharing	6,483	$ 2,640,929	$ 33.95	5,977	$ 750,476	$ 20.93	28.42%
ABD Child	2,221	$ 76,042,202	$ 2,853.69	2,289	$ 27,850,113	$ 2,027.53	36.62%
General Child	60,360	$ 305,499,555	$ 421.78	59,592	$ 140,527,474	$ 393.03	46.00%
Underinsured Child	831	$ 2,614,573	$ 262.10	629	$ 665,037	$ 176.22	25.44%
CHIP	5,020	$ 12,342,233	$ 204.87	4,668	$ 5,819,407	$ 207.76	47.15%
Pharmacy Only	11,333	$ 4,686,531	$ 34.46	10,838	$ 1,433,424	$ 22.04	30.59%
Traditional Choices for Care	4,350	$ 196,483,201	$ 3,763.93	4,208	$ 97,905,592	$ 3,877.76	49.83%
Total Medicaid Claims Paid	208,814	$ 1,413,937,105	$ 564.27	201,525	$ 639,673,077	$ 529.03	45.24%

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS Medicaid Expenditures

All AHS YTD '18

	SFY '18 As Passed Rescission			SFY '18 Actuals thru December 31, 2017			% of Expenses to
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	Budget Line Item
ABD Adult and Acute CFC	7,243	$ 183,031,444	$ 2,105.89	7,001	$ 78,421,452	$ 1,866.87	42.85%
ABD Dual	17,645	$ 229,183,523	$ 1,082.37	17,551	$ 106,948,716	$ 1,015.59	46.67%
General Adult	14,343	$ 93,273,779	$ 541.92	12,526	$ 38,750,344	$ 515.60	41.54%
New Adult	59,604	$ 301,527,893	$ 421.57	58,223	$ 136,617,514	$ 391.07	45.31%
Vermont Premium Assistance	19,381	$ 6,649,761	$ 28.59	18,022	$ 3,134,000	$ 28.98	47.13%
Vermont Cost Sharing	6,483	$ 2,640,929	$ 33.95	5,977	$ 750,476	$ 20.93	28.42%
ABD Child	2,221	$ 59,297,638	$ 2,225.30	2,289	$ 23,151,103	$ 1,685.43	39.04%
General Child	60,360	$ 271,900,475	$ 375.39	59,592	$ 129,403,497	$ 361.92	47.59%
Underinsured Child	831	$ 2,159,698	$ 216.50	629	$ 507,096	$ 134.37	23.48%
CHIP	5,020	$ 10,599,804	$ 175.95	4,668	$ 5,189,472	$ 185.27	48.96%
Pharmacy Only	11,333	$ 4,686,531	$ 34.46	10,838	$ 1,433,424	$ 22.04	30.59%
Traditional Choices for Care	4,350	$ 196,483,201	$ 3,763.93	4,208	$ 97,905,592	$ 3,877.76	49.83%
Total Medicaid Claims Paid	208,814	$ 1,361,434,676	$ 543.32	201,525	$ 622,450,144	$ 514.78	45.72%

The Department of Vermont Health Access

Caseload and Expenditure Report ~ DVHA Only Medicaid Expenditures

DVHA YTD '18

	SFY '18 As Passed Rescission					SFY '18 Actuals thru December 31, 2017					
	Caseload		Budget		PMPM	Caseload		Expenses		PMPM	% of Expenses to Budget Line Item
ABD Adult and Acute CFC	7,243	$	94,328,051	$	1,085.30	7,001	$	38,166,896	$	908.58	40.46%
ABD Dual	17,645	$	54,938,819	$	259.46	17,551	$	25,205,275	$	239.35	45.88%
General Adult	14,343	$	80,106,967	$	465.42	12,526	$	32,863,987	$	437.28	41.03%
New Adult	59,604	$	269,923,909	$	377.38	58,223	$	122,347,753	$	350.23	45.33%
Vermont Premium Assistance	19,381	$	6,649,761	$	28.59	18,022	$	3,134,000	$	28.98	47.13%
Vermont Cost Sharing	6,483	$	2,640,929	$	33.95	5,977	$	750,476	$	20.93	28.42%
ABD Child	2,221	$	24,204,894	$	908.35	2,289	$	10,278,480	$	748.29	42.46%
General Child	60,360	$	154,012,569	$	212.63	59,592	$	71,568,110	$	200.16	46.47%
Underinsured Child	831	$	1,177,236	$	118.01	629	$	247,711	$	65.64	21.04%
CHIP	5,020	$	8,620,617	$	143.10	4,668	$	4,125,727	$	147.29	47.86%
Pharmacy Only	11,333	$	4,686,531	$	34.46	10,838	$	1,433,424	$	22.04	30.59%
Traditional Choices for Care	4,350	$	196,483,201	$	3,763.93	4,208	$	97,905,592	$	3,877.76	49.83%
Total Medicaid Claims Paid	208,814	$	897,773,485	$	358.28	201,525	$	408,264,887	$	337.65	45.48%

State of Vermont
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston VT 05495-2807
dvha.vermont.gov

[Phone] 802-879-5900
[Fax] 802-879-5651

Agency of Human Services

Questions, Complaints and Concerns Received by Health Access Member Services
October 1, 2017 – December 31, 2017

October 2 – October 6
- No issues to report

October 9 – October 13
- No issues to report

October 16 – October 20
- VPharm/VPharm Review/Reinstatements

October 23 – October 27
- No issues to report

October 30 – November 3
- VPharm/VPharm Review/Reinstatements

November 6 – November 10
- No issues to report

November 13 – November 17
- No issues to report

November 20 – November 24
- No issues to report

November 27 – December 2
- No issues to report

December 4 – December 9
- No issues to report

December 11 – December 15
- No issues to report

December 18 – December 22
- No issues to report

December 25 – December 29

- No issues to report

YEAR END SUMMARY

Green Mountain Care Customer Service continued to provide members with timely and accurate information. Member Services receives a wide variety of questions on a daily basis and is able to access the information necessary to resolve the member's question internally or contact the appropriate subject matter expert (e.g. state eligibility representative, DVHA Provider and Member Relations Unit, etc.) for resolution. Some topics addressed by Provider and Member Relations Staff, in cooperation with Maximus Call Center staff, include:

- Non-Emergency Medical Transportation benefits
- Out-of-Network Emergency Services Billing

Green Mountain Care Customer Service Representatives (CSRs) saw a high volume of calls related to the following topics throughout 2017:

- Prescription Drug Plan (PDP) invoicing
- VPharm Closure notices

Customer service representatives monitored the volume of these call topics and built appropriate processes to ensure resolution. DVHA continues to monitor weekly reports to ensure that all member questions or complaints are understood, addressed and resolved in a timely and accurate manner.

DVHA and Maximus staff continue to strive for first call resolution whenever possible and hope to achieve greater member satisfaction and success throughout 2018.

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
October 1, 2017 – December 31, 2017

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data compiled on January 5, 2018, from the centralized database that were filed from October 1, 2017 through December 31, 2017.

Grievances: A grievance is an expression of dissatisfaction about any matter that is not an action taken by the Medicaid Managed Care Model.

During this quarter, there were 13 grievances filed; ten were addressed during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was four days. Of the grievances filed, 85% were filed by beneficiaries and 15% were filed by a representative of the beneficiary. Of the 13 grievances filed, DMH had 78%, DAIL had 23% and DVHA had 8%. There were no grievances filed for VDH or DCF during this quarter.

Grievances were filed for service categories case management, community support, employment, mental health, psychiatric and transportation.

There were no Grievance Reviews filed this quarter.

Appeals: Medicaid rule 7110.1 defines actions that Managed Care Model makes that are subject to an internal appeal. These actions are:

1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered service;
4. failure to provide a clinically indicated, covered service, when the Managed Care provider is a DA/SSA;
5. failure to act in a timely manner when required by state rule;
6. denial of a beneficiary's request to obtain covered services outside the network.

During this quarter, there were 66 appeals filed; 11 requested an expedited decision with six of them meeting criteria. Of these 66 appeals, 47 were resolved (71% of filed appeals), 15 were still pending (23%), and 4 were withdrawn (6%).

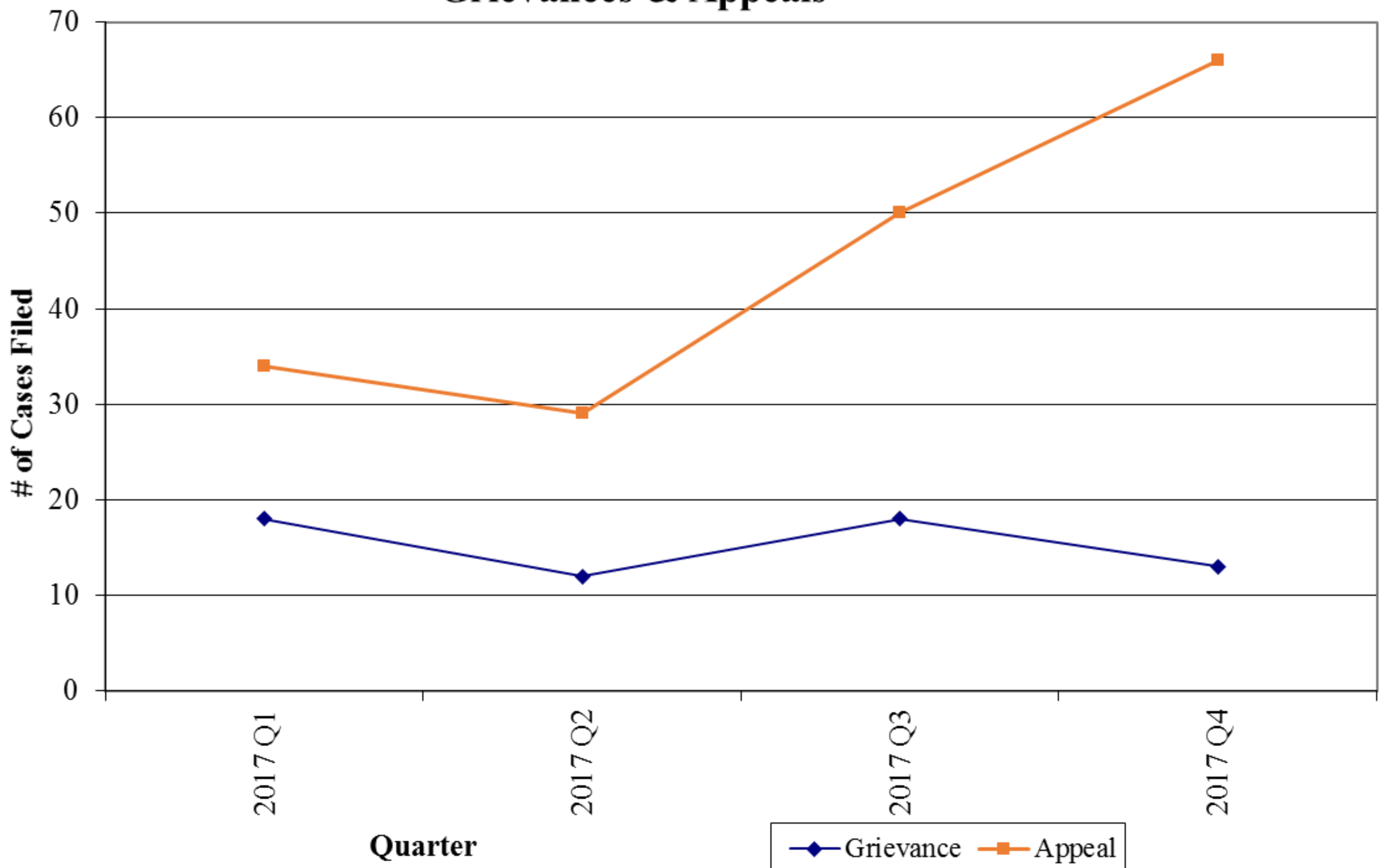
Of the 47 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 76% were resolved within 30 days. The average number of days it took to resolve these cases was 29 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

Of the 66 appeals filed, DVHA had 23 appeals filed (35%), and DAIL had 38 (57%) and VDH had 5 (8%) and DMH had none.

The appeals filed were for service categories; long term care, respite, personal care, orthodontics, home health, nursing, prescriptions, transportation, surgical, community supports, supplies/equipment and mental health.

There was an increase in appeals filed in this quarter due to increased trainings with DAIL and VDH.

Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were four fair hearings filed this quarter.



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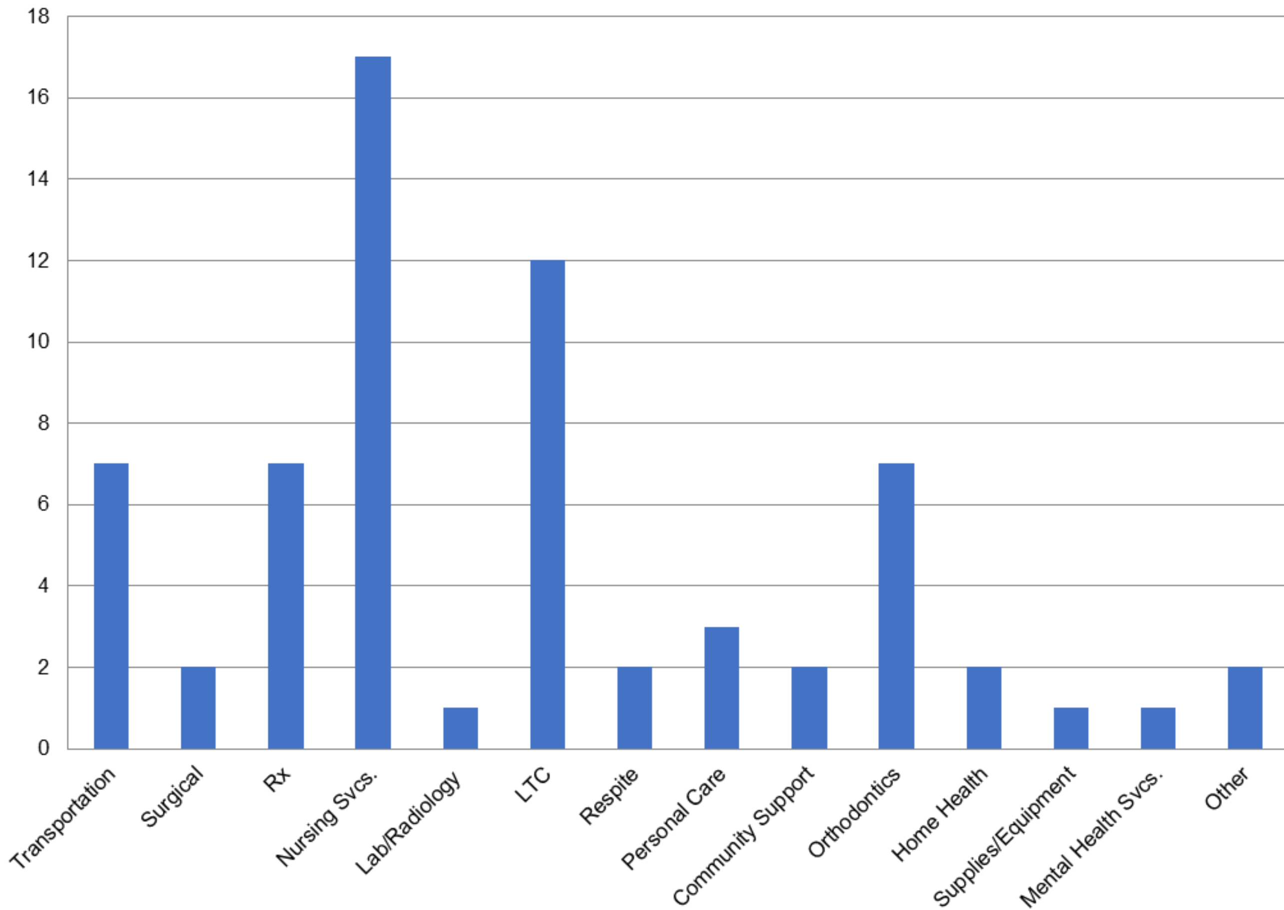
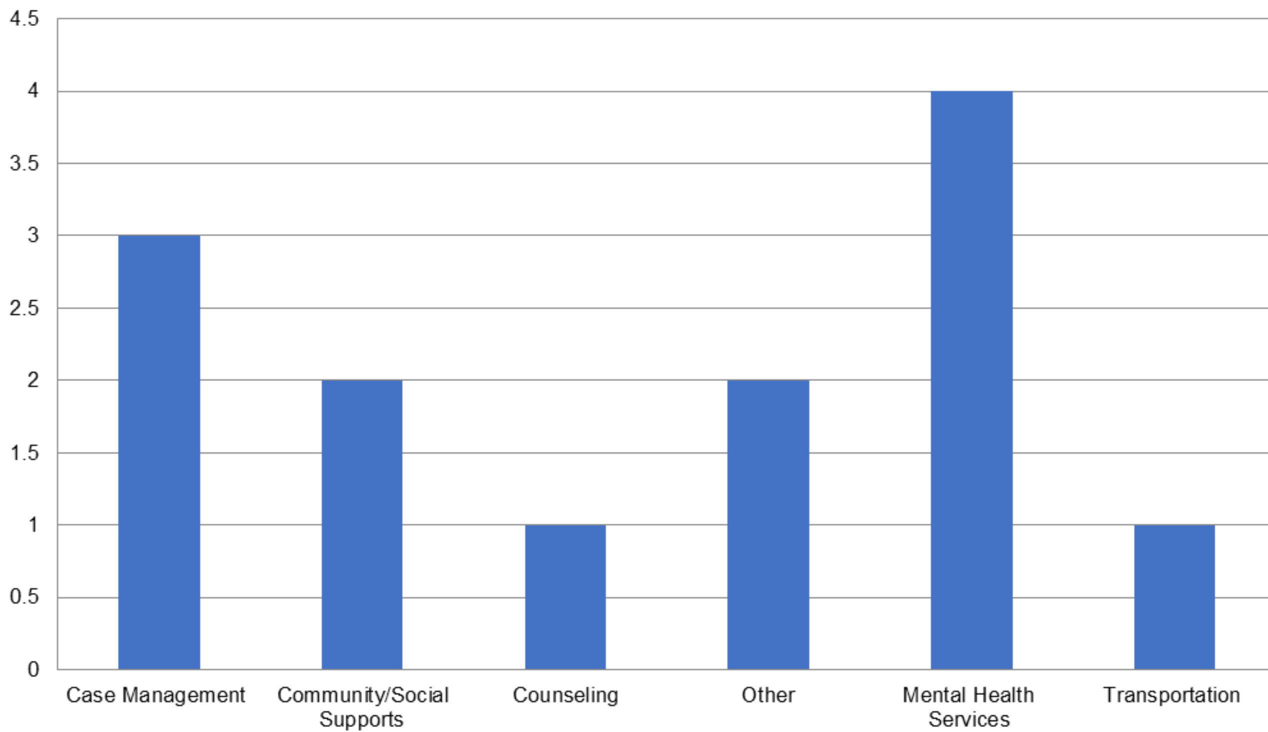
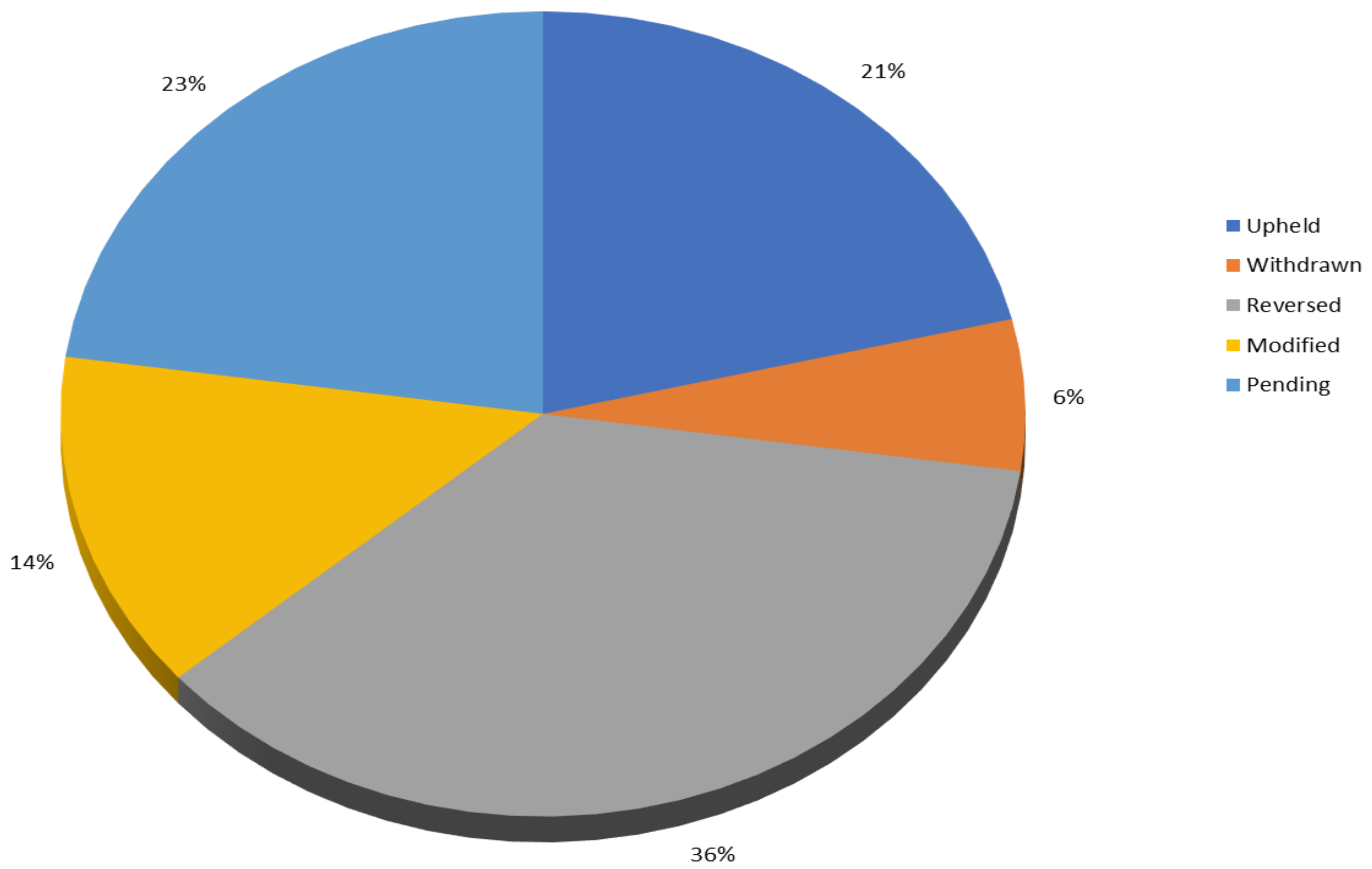

Appeals by Service Category
18
16
14
12
10
8
6
4
2
0
Transportation
Surgical
Rx
Nursing Svcs.
Lab/Radiology
LTC
Respite
Personal Care
Community Support
Orthodontics
Home Health
Supplies/Equipment
Mental Health Svcs.
Other


Grievances by Service Category
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Case Management
Community/Social Supports
Counseling
Other
Mental Health Services
Transportation

MCO Appeal Resolutions
10/1/2017 thru 12/31/2017



Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

October 1, 2017- December 31, 2017

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

January 22, 2018

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Introduction

The Office of the Health Care Advocate (HCA) advocates for all Vermonters by doing both individual consumer assistance and systemic advocacy on health care issues. We work to increase access to high quality, affordable health care for all Vermonters when we represent the public before Green Mountain Care Board, state agencies, and the state legislature. Helping Vermonters navigate a shortened Open Enrollment Period was a central task for the HCA this past quarter. The HCA engaged in outreach and education to help Vermonters understand the shorter enrollment period. The HCA also worked with VHC and other stakeholders during Open Enrollment to share information and developments. We saw a 10% increase in our overall VHC calls, and particular increases in calls about Medicaid Eligibility, Premium Tax Credit Eligibility, Information about VHC, and Change of Circumstances.

The HCA is pleased to announce a new partnership with Kinney Drugs to provide advocacy for customers who encounter a problem getting their medication at the drugstore. We have worked to develop this partnership over several months. We created training materials for pharmacy staff and a direct referral system between the pharmacist and the HCA.

The HCA has also been responding to President Trump's decision to stop making cost-sharing reduction payments. The HCA is working with other stakeholders to protect consumers from cost increases and also stabilize the individual market.

The HCA is committed to helping Vermonters navigate the health care system during this confusing and anxious time. Our goal remains the same: to increase access to affordable, high quality health care for all Vermonters. Today's uncertainty makes the role of the HCA even more essential.

The HCA supports Vermonters through individual advocacy as well as at the legislative and administrative policy level. Our priorities are informed by our daily work with Vermonters struggling with a health care system that often does not meet their needs, such as Newman's experience described in the case narrative at right. We work to control unnecessary costs and make the health care system sustainable, and to ensure that Vermont consumers are heard by providers and policy-makers.

Newman's Story

Newman called the HCA because he had lost his insurance and needed medication. He had a plan on Vermont Health Connect (VHC), and had been receiving Premium Tax Credit (PTC) which helped lower the monthly payment. VHC had terminated his PTC. When he lost the PTC, the premium went up to $500 month. When the HCA advocate investigated, the advocate discovered that VHC had sent Newman some requests for income information. Newman did not recall getting any notices. The advocate also realized VHC had not followed its own verification rules. Under VHC rules, it must try to electronically verify income with the federal government before requesting this information from the beneficiary. If VHC had done this, it would have been able to verify Newman's income. Newman's only income was from Social Security. Since VHC did not attempt to electronically verify the income first, the advocate asked for the plan and PTC to be reinstated. VHC agreed that it violated its own rules, and it should have electronically verified the income with Social Security. It reinstated Newman's VHC plan and his PTC. With the PTC in place again, Newman's monthly premium was under $100 a month, an amount which he could afford to pay. He paid his premium and was able to pick up his medication.

Individual Consumer Assistance

Case Examples

These case summaries illustrate the types of problems we helped Vermonters resolve this quarter:

Anna's Story

When Anna went to the pharmacy to pick up her asthma medication, she discovered that her Medicaid was not active. She had been on Medicaid for years, and did not understand what had happened. She also needed her asthma inhaler daily—and could not afford to pay for it out of pocket. When Anna had called the state of Vermont, she was told that she was on Medicaid. The pharmacy, however, kept telling her that she did not have any coverage. Anna called the HCA for help. The advocate discovered that although Anna had been approved for Medicaid coverage, it was not yet active in the pharmacy system. This made it look like she did not have any coverage. The advocate was able to get the pharmacy coverage activated, and Anna picked up her medication later that afternoon.

Brennan's Story

Brennan called the HCA because he did not understand why his Vermont Health Connect premium bill had increased by about $30 a month. The advocate investigated and found that VHC had calculated his premium based on Brennan's new income. He had gotten a raise at the start of the year, and reported it to VHC. Because his income had increased, that meant he qualified for less premium tax credit (PTC), and the amount that he would have to pay each month had increased. That explained the increase in his monthly premium. The advocate confirmed that VHC had correctly calculated how much PTC Brennan was eligible for at his new pay rate. The advocate, however, also studied Brennan's paychecks, and realized that although it said that his pay rate had increased, he was still receiving the same gross amount as he had before the raise. He had not actually received his raise even though he had reported it to VHC, and his health care premium had increased because of it. After learning about this from the advocate, Brennan went to his Human Resources office, and they corrected the problem and also gave him a check for the back pay that he should have received. When Brennan started receiving his correct amount of income, it made it easier for him to pay the increased health care premium.

Caroline's Story

Caroline was in the hospital when she first found out that her Medicaid had ended. When the advocate did some research, she found that Caroline had been on both Medicaid and a Medicare Savings Program (MSP). The MSP paid for her Medicare Part B premium and covered her Medicare cost-sharing. She had been closed from both programs for 'failure to review.' The state had requested that Caroline do a new application to verify her eligibility, and she had not done this. Caroline did not remember receiving any notices. The advocates asked VHC about the notices, and it produced the verification request and the closure notices for both Medicaid and the MSP. When the advocate closely studied the closure notices, she found that they did not list a reason for a

closure. Under VHC's eligibility rules, all notices must include the reason why the program is being closed. Because the notices were not adequate, the advocate was able to have Caroline's Medicaid and MSP reinstated back to the month that they were closed. This meant that the bills related to her hospital stay could be covered. The advocate also helped Caroline file a new application, so that VHC would be able to review her eligibility going forward.

Sky's Story

Sky called the HCA because her spouse had recently retired and enrolled in retiree insurance. The cost of the retiree insurance was reasonable for her spouse, about $100 per month. But adding Sky to the retiree insurance would increase the cost to nearly $900 a month. She had applied on VHC, but had been told that she was not eligible for PTC because of her spouse's retiree coverage. This meant that she would have to pay the full cost for a VHC plan, over $500 per month. She could not afford that price. HCA advocate realized that VHC had made an error. If you are enrolled in retiree insurance, you are not eligible for PTC. Sky, however, was not enrolled in her spouse's retiree coverage. The advocate contacted VHC and argued that Sky was eligible for PTC. VHC agreed, and found her eligible for PTC, which made her monthly premium about $200.

Ruby's Story

Ruby called the HCA because she had applied for Medicaid and had been turned down. She did not understand why and wanted to appeal the decision. After talking to Ruby, the advocate learned that Ruby had a green card and had been in the United States for two years. The advocate explained that because Ruby had only been in the United States for two years, she was not eligible for Medicaid yet. She was subject to what is called the 'five year bar.' This meant that Ruby would not be eligible for certain public benefit programs, including Medicaid, until she has been in the United States for five years. Ruby had very little income, and did not understand how she would be able to afford to get insurance. She also had some pressing medical needs. Although she was not eligible for Medicaid because of the 'five year bar,' she is eligible for PTC. The HCA advocate explained that the 'five year bar' does not apply PTC. You need to show that you are in the United States lawfully, and Ruby is here lawfully. The advocate assisted with the application, and Ruby was found eligible for PTC. With the PTC, Ruby only pays about $10 per month. Once she was able to sign up for coverage, Ruby was able to schedule an appointment with her provider.

Marina's Story

Marina called the HCA because her Medicaid application had been denied. She needed to get a prescription filled and could not afford to do that without coverage. Marina had adopted her grandchildren, and she received an adoption subsidy for both children. The children had coverage under Dr. Dynasuar, but Marina did not have anything. When she applied for Medicaid on VHC, VHC had included the adoption subsidies in her monthly income total, which made her ineligible for Medicaid. The HCA advocate quickly realize that the adoption subsidies, however, should not be included in the calculation. They are not taxable income, and should have been excluded from the income calculation. Once the subsidies were removed, Marina was found eligible for Medicaid and was able to pick up her prescription.

Overview

The HCA provides assistance to consumers through our statewide hotline (**1-800-917-7787**) and through the Online Help Request feature on our website, Vermont Law Help (*www.vtlawhelp.org/health)*. We have a team of advocates located in Vermont Legal Aid's Burlington office that provides this help to any Vermont resident free of charge, regardless of income.

The HCA received 890 calls[1] this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller's primary issue, were as follows:

- **19.55%** (174) about **Access to Care**
- **13.26%** (118) about **Billing/Coverage**
- **1.91%** (17) about **Buying Insurance**
  13.71% (122) about **Consumer Education**
- **29.78%** (265) about **Eligibility** for state and federal programs
- **21.80%** (194) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved a particular issue. For example, although 218 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, a total of 359 cases had eligibility listed as a secondary concern.

In each section of this Narrative, we indicate whether we are referring to data based on just primary issues, or primary and secondary issues combined. Determining which issue is the "primary" issue is sometimes difficult when there are multiple causes for a caller's problem. This has proven to be particularly true for Vermont Health Connect (VHC) cases. See the breakdowns of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues in addition to the "primary" reason for their call.

The most accurate information about eligibility for state programs is in the All Calls data report because callers who had questions about Vermont Health Connect and Medicaid programs fell into all three insurance status categories.

The full quarterly report for October 1- December 31, 2017 includes:

- This narrative, which contains sections on **Individual Consumer Assistance**, **Consumer Protection Activities** and **Outreach and Education**
- Seven data reports, including three based on the caller's insurance status:
  - **All calls/all coverages**: 890 calls (compared to 825 last quarter)

[1] The term "call" includes cases we get through the intake system on our website.

- **Department of Vermont Health Access (DVHA) beneficiaries**: 259 calls (242 calls last quarter)
- **Commercial plan beneficiaries**: 209 calls (167 calls last quarter)
- **Uninsured Vermonters**: 77 calls (74 calls last quarter)
- **Vermont Health Connect (VHC)**: 254 calls (231 calls last quarter)
- **Reportable Activities (Summary & Detail)**: 83 activities and 20 documents

Priorities

A. The HCA focused on educating consumers about a shorter Open Enrollment Period.

Because Open Enrollment was shorter this year, consumers had less time to make decisions about their 2018 coverage. The HCA was concerned that consumers would not realize that their premiums may have increased, and would be left on more expensive plans. The HCA did outreach through social media, released press releases, gave interviews, and continually updated VLA's website. During Open Enrollment, the HCA met with stakeholders on a weekly basis to assess how Open Enrollment was going and stay updated on new developments.

B. The HCA launched a partnership Kinney Drugstores

The HCA advocates had noticed that many consumers first discover that they have an insurance problem when they go to the pharmacy to pick up a prescription. We also realized that pharmacists were on the front-line helping consumers. We wanted to collaborate—so we could reach these consumers more quickly, and also help the pharmacists do their jobs. We developed a substantive training about how the HCA can help consumers, a referral process so pharmacists could quickly refer their customers, and also provided pharmacies with HCA materials. We have already started getting referrals from the drugstores, and we are planning on expanding this project to other area pharmacies in the future.

C. The HCA collaborated with other stakeholders to respond to the federal government's decision to stop funding cost-sharing reductions.

After the federal government decided to stop funding the Cost Sharing Reduction (CSR) payments in 2017, the HCA immediately started working with other stakeholders to develop a strategy to protect consumers from cost increases and also support and stabilize the individual market for the future. The HCA is participating in a stakeholder group addressing the CSR issue, and also had multiple attorneys participate in the 2019 Qualified Health Plan (QHP) plan design process.

D. Access to Treatment for Hepatitis C Virus

This quarter, the HCA actively worked to improve Vermonter's access to hepatitis C treatment. This project included advocacy before state boards as well as participation in the Vermont Department of Health Hepatitis C Task Force. We are pleased that Vermont has moved forward with improvements to access to treatment for this illness. The HCA will continue to work on making sure Vermonters are aware of their treatment options and will continue to oppose any barriers to effective treatments.

E. Overall call volume increased this quarter due to Open Enrollment

The total call volume increased by 8% (890 this quarter vs. 825). Nearly 10% of those calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We saved consumers $46,327 this quarter.

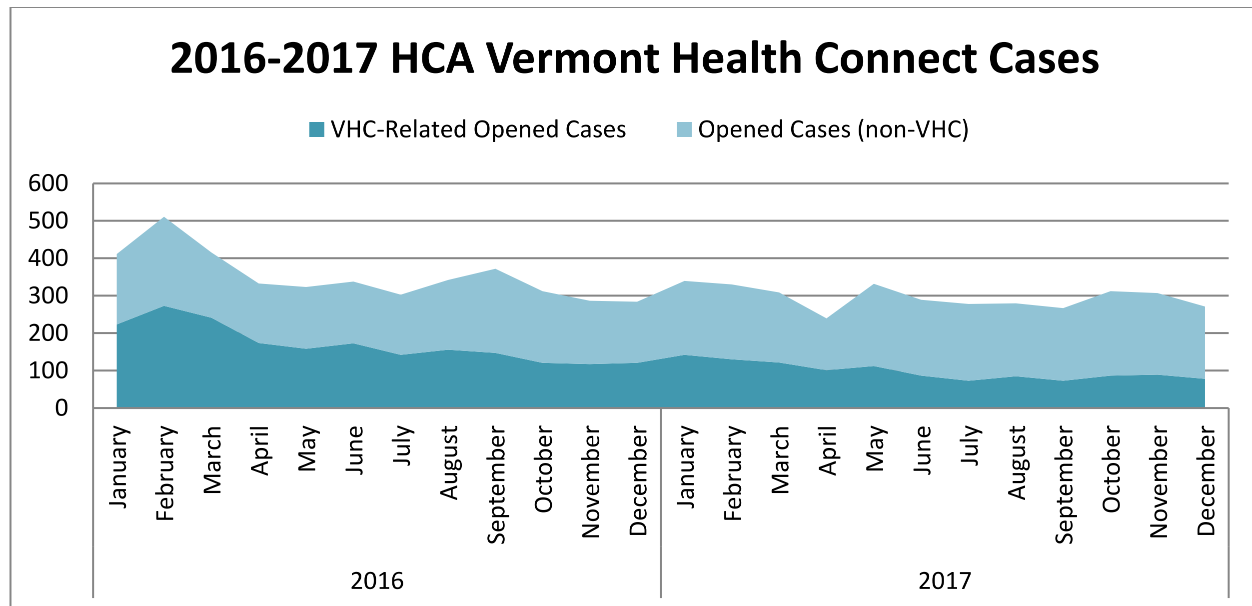
	All Calls (2007-2017)										
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
January	280	309	240	218	329	282	289	428	470	411	340
February	172	232	255	228	246	233	283	304	388	511	330
March	219	229	256	250	281	262	263	451	509	416	308
April	190	235	213	222	249	252	253	354	378	333	240
May	195	207	213	205	253	242	228	324	327	325	332
June	254	245	276	250	286	223	240	344	303	339	289
July	211	205	225	271	239	255	271	381	362	304	278
August	250	152	173	234	276	263	224	342	346	343	280
September	167	147	218	310	323	251	256	374	307	372	267
October	229	237	216	300	254	341	327	335	311	312	312
November	195	192	170	300	251	274	283	306	353	287	307
December	198	214	161	289	222	227	340	583	369	284	271
Total	2560	2604	2616	3077	3209	3105	3257	4526	4423	4237	3554

F. Calls concerning Vermont Health Connect increased due to Open Enrollment.

The volume of calls concerning Vermont Health Connect increased by 10%, compared to the previous quarter (254 vs. 231). We saw a particular jump in calls about Premium Tax Credit (PTC) eligibility (67 vs. 34). Consumers had questions about how much PTC they would be eligible for in 2018 when they were considering whether to stay on the same plan or switch. During Open Enrollment, the HCA did a lot of consumer education about VHC and Medicaid. We also saw a jump in cases from consumers asking for information about VHC (50 vs. 35 last quarter), and we talked to 60 people about applying for State of Vermont health care programs. This quarter, 73 VHC cases required complex interventions that took more than two hours of an advocate's time to resolve, and 37 required a direct intervention to resolve the case.

The HCA continues to resolve its cases by working directly with Tier 3 Health Access Eligibility Unit (HAEU) workers, who are trained to resolve all aspects of complex cases. In addition, the HCA meets with VHC each week to discuss cases as needed, and has regular email contact with Tier 3. This quarter we had significant increase in our escalated cases (73 vs. 44 last quarter). Of the 73 escalated cases, 50 were resolved within the quarter.

Tier 3 also now works on resolving Green Mountain Care cases (VPharm, Medicaid for Aged Blind and Disabled (MABD), Medicare Saving Programs, and Medicaid Spenddowns). This quarter we had a jump in cases for consumers having issues with either Medicare Savings Programs (52 vs. 40) and MABD (63 vs. 45).



G. Medicaid eligibility calls represented 21% of all our cases (188 calls/ 890 total calls). Consumers need assistance with all types of Medicaid.

Medicaid eligibility was again the top issue generating calls. We had 97 calls about eligibility for MAGI (expanded) Medicaid, 63 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), and 28 about Medicaid Spenddowns. MAGI Medicaid and MABD Medicaid have different eligibility and income rules, and HCA advocates assess and advise on eligibility for both programs. Consumers frequently have questions about what counts as income, who should be counted in their household, what expenses can be used to meet a Spenddown, how to complete renewal paperwork, and whether their eligibility decision is correct.

H. The top issues generating calls

The listed issues in this section include both primary and secondary issues, so some of these may overlap.

All Calls 890 (compared to 825 last quarter)

1. MAGI Medicaid eligibility 97 (77)
2. Complaints about providers 80 (87)
3. Premium Tax Credit eligibility 70 (34)
4. Medicaid eligibility (non-MAGI) 63 (45)
5. Information/applying for DVHA programs 60 (60)
6. Buy-in programs/Medicare Savings Programs 52 (40)
7. Consumer education about Medicare 51 (31)
8. Information about VHC 50 (35)
9. Access to prescription drugs/pharmacy 44 (41)

10. Other: Not health related 41 (35)
11. Change of Circumstance 39 (22)
12. Fair hearing appeals 36 (39)
13. Eligibility for VHC grace periods 29 (35)
14. Confusing notice 29 (27)
15. Termination of insurance 28 (36)
16. Medicaid spend down (eligibility) 28 (34)
17. VPharm eligibility 27 (28)
18. Mammography billing/coverage 27 (11)
19. Provider billing problems 26 (22)
20. Hospital billing 25 (31)
21. Nursing home complaint 25 (24)
22. Special enrollment periods (eligibility) 23 (33)
23. VHC invoice/billing problem affecting eligibility 22 (37)
24. Buying QHPs through VHC 21 (8)

Vermont Health Connect Calls 254 (compared to 231 last quarter)

1. MAGI Medicaid eligibility 84 (66)
2. Premium Tax Credit eligibility 67 (34)
3. Information about VHC 47 (34)
4. Change of Circumstance 33 (20)
5. Eligibility for VHC grace periods 29 (35)
6. Fair hearing appeals 24 (26)
7. VHC invoice/payment/billing problem affecting eligibility 22 (37)
8. Buying QHPs through VHC 20 (6)
9. Termination of insurance 19 (28)
10. VHC complaints 17 (16)
1.

DVHA Beneficiary Calls 259 (compared to 241 last quarter)

1. MAGI Medicaid eligibility 36 (36)
2. Medicaid eligibility (non-MAGI) 33 (17)
3. Complaints about providers 25 (26)
4. Access to prescription drugs/pharmacy 21 (13)
5. Buy-in programs/Medicare Savings Programs 19 (11)
6. Information/applying for DVHA programs 17 (19)
7. Provider billing problems 17 (8)
8. Access to specialty care 14 (11)
9. Access to transportation 13 (10)
10. Medicaid/VHAP Managed Care Billing 13 (17)
11. Fair hearing appeals 12 (10)
12. Consumer education about Medicare 11 (6)
13. VPharm eligibility 11 (4)

Commercial Plan Beneficiary Calls 209 (compared to 166 last quarter)

1. Premium Tax Credit eligibility 48 (18)
2. MAGI Medicaid eligibility 26 (11)
3. Information about VHC 25 (16)
4. Change of circumstance 19 (9)
5. Eligibility for VHC grace periods 18 (17)
6. Mammography 16 (9)
7. VHC invoice/payment/billing problem related to eligibility 14 (22)
8. DVHA/VHC premium billing 13 (7)
9. VHC renewals 13 (2)
10. Consumer education about Medicare 13 (13)
11. IRS reconciliation 12 (5)
12. Hospital billing 11 (9)

The HCA received 890 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as "dual eligible"): 29.1% (259 calls), compared to 29.2% (241 calls) last quarter
- **Medicare[2] beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 28.7% (255 calls), compared to 26% (218 calls) last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans): 23.5% (209 calls), compared to 20% (166 calls) last quarter
- **Uninsured:** 8.7% (77 calls), compared to 9% (74 calls) last quarter

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 885 cases this quarter, compared to 808 last quarter:

- 35% (312 cases) were resolved by brief analysis and referral
- 29% (261) were resolved by brief analysis and advice
- 18% (160) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time
- 9% (78) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.

[2] Because Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with the figures for those categories.

- In the remaining cases (74), clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 24 individuals with appeals: 21 Fair Hearings, 1 Commercial Insurance – Internal 2nd Level appeal, 1 Medicare Part D appeal, and 1 Medicaid MCO Internal appeal.

DVHA Beneficiary Calls

We closed 257 DVHA cases this quarter, compared to 250 last quarter:

- 38% (98 cases) were resolved by brief analysis and/or referral
- 25% (64) were resolved by brief analysis and/or advice
- 20% (51) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 12% (31) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 7 DVHA beneficiaries with appeals: 5 Fair Hearings, 1 Medicare Part D appeal, and 1 Medicaid MCO Internal appeal.

Commercial Plan Beneficiary Calls

We closed 199 cases involving individuals on commercial plans, compared to 153 last quarter:

- 38% (76 cases) were resolved by brief analysis and/or advice
- 25% (50) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 20% (40) were resolved by brief analysis and/or referral
- 11% (22) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 19 commercial plan beneficiaries with appeals: 17 Fair Hearings, 1 Commercial Insurance – Internal 2nd Level appeal, and 1 Medicare Part D appeal.

B. Case Outcomes

The HCA helped 48 people get enrolled in insurance plans and prevented 21 insurance terminations or reductions. We obtained coverage for services for 21 people. We got 20 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 37 more. We provided other billing assistance to 16 individuals. We provided 477 individuals with advice and education. One person was not eligible for the benefit they sought, and nine were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 164 more people.

Consumer Protection Activities

A. Certificate of Need

The HCA participates in Certificate of Need (CON) processes as an "interested party" to ensure that approved health care investments are in the best interests of Vermonters. In January 2017, the HCA intervened in the University of Vermont Medical Center's (UVMMC) CON for a replacement electronic health record system (EHR). UVMMC proposed to migrate four of its hospital to a unified health record system purchased from the Epic Systems Corporation. The proposed project has a total cost of ownership of approximately 150 million dollars over six years. In November 2017, the HCA appeared at the hearing before the Green Mountain Care Board (Board) on the matter. Subsequent to the hearing, the HCA filed a post-hearing memorandum for the Board's consideration. In the post-hearing memorandum and at the hearing, while acknowledging the potential benefits of EHRs, the HCA raised several examples of substantial cost-overruns in Epic EHR implementations by top-tier hospital and health systems and an increased potential for the provision of inappropriate care. In light of these and other concerns, the HCA asked the Board to make any approval of UVMMC's CON subject to enhanced reporting requirements and other process and procedural safeguards to protect Vermont consumers. The Board approved UVMMC's CON subject to conditions to ensure that the EHR promotes quality and engaged care and that UVMMC uses metrics to evaluate the impact of the EHR on the health network.

B. Other Green Mountain Care Board Activities

During the last quarter, the HCA participated in several stakeholder groups organized by the Green Mountain Care Board in addition to attending weekly Green Mountain Care Board meetings, a Green Mountain Care Board advisory committee meeting, and periodic meetings with Board staff and/or individual Board members. One stakeholder group was organized to discuss potential changes to state statutes that impact the Green Mountain Care Board's work. As a part of this work, the Board proposed changes to the Certificate of Need Statute. The HCA participated in these meetings and submitted written comments on the proposed rule changes. These written comments asked for any CON statute changes to provide details on the process for expedited review including the role an interested party would play in an expedited process, and we proposed that the window for requesting interested party status should be changed. The HCA is concerned that the current lack of transparency on expedited review processes impedes advocates', the public's, and other potential stakeholders' abilities to participate in the process in an effective way. Further, the current statute requires that if anyone wants to apply for interested party status but misses the initial application window, they must wait until the application is closed to apply for the status. Allowing potential applicants a longer period to apply for interested party status during the regular review period would help to avoid complicating the review process at the end.

In the last quarter, we also attended a meeting of Green Mountain Care Board staff and hospital Chief Financial Officers convened to discuss potential changes to the Board's Hospital Budget Review process. We separately met with the Board's Director of Health Systems Finance to discuss the FY 2019 Budget Review. We agreed that the HCA would submit requests for information to be added to the Board's 2019 Hospital Budget Guidance. This should allow the HCA to obtain some information we would like to review sooner and in a more efficient manner than is possible during the July and August budget review period.

As a part of our comments on the ACO budget process last quarter, we asked the Board to form a stakeholder group to develop standard forms and metrics for its regulatory processes that would allow for comparison of documentation across review processes. For example, it would be helpful

to be able to easily compare care coordination programs, utilization trends, provider payment increases, and cost factors currently outside the control of state-level actors (e.g, pharmaceuticals) across the Board's reviews. Standard forms and metrics would allow the Board, the HCA, other stakeholders, and the public to compare the information reported by each entity and more easily identify duplication, inconsistencies, points of consensus, and areas of concern.

In addition, we participated in a stakeholder group discussing state reactions to federal changes that negatively impact the state. The first topic the group addressed was the loss of Cost Sharing Reduction funding from the federal government. The HCA extensively researched the issue and agree with the group's consensus that the best option for Vermonters is to add the cost of the lost funding to subsidized silver plans. This allows the costs to be absorbed by increased federal premium tax credit funds. The HCA also participated in a Billback stakeholder group, which discussed ways to improve fairness in the distribution of Billback fees among health care entities.

Finally, the HCA presented before the Green Mountain Care Board at a weekly meeting last quarter. We provided the Board and the public with information on our hotline that works to improve Vermonters' access to health care. We also previewed an affordability analysis that our office has been working on. The analysis takes into account costs of living for various income levels and whether there is enough money left over for the costs of premiums and cost sharing for health insurance exchange plans. The analysis shows significant affordability issues in Vermont's individual health insurance market.

C. Rate Review

The HCA monitors all commercial insurance carrier requests to the Green Mountain Care Board (Board) for changes to premium rates. These are usually requests for rate increases.

One new rate filing was submitted during the quarter covering October 2017 through December 2017. The HCA filed a Notice of Appearances in this case. Additionally, two rate filings were pending at the beginning of the quarter that affected Vermont consumers and in which the HCA appeared. One additional filing was pending at the start of the quarter; however, no individuals were enrolled in the offered plan.

The two pending rate filings that affected Vermonters involved premium rates for the 2018 plans that MVP will offer for grandfathered small groups and 1st and 2nd quarter large group PPOs. These two rate filings affected approximately 3,700 members. The grandfathered small group filing affected approximately 1,700 members and the 1st and 2nd quarter large group PPO filing affected approximately 2,000 members.

The HCA submitted memoranda in both of these filings. The HCA did not object to the proposed rate due to recent and emerging federal funding and regulatory changes that introduced substantial uncertainty into the Vermont health insurance market. However, the HCA expressed its concern that rate growth for both books of business outpaced Vermont's economic growth, indicative of a general trend towards decreasing health care affordability.

The new rate filing filed during this quarter is CIGNA's Vermont Large Major Medical Filing. CIGNA proposes a 6.2% average annual rate change to its manual rating formula and the rate will affect approximately 498 Vermonters. HCA will file a memorandum in this matter in February 2018.

D. Accountable Care Organization Budget Review

This quarter, the Board completed its first Accountable Care Organization (ACO) Budget Review. Act 113 of 2016 requires the Board to review ACO budgets starting in 2018 (for fiscal year 2019), so the Board used this year as a test year and reviewed the ACOs' fiscal year 2018 budgets. During the quarter, one of Vermont's two ACOs (Community Health Accountable Care (CHAC)) withdrew its budget submission. The Board completed its review of the remaining ACO (OneCare Vermont)'s budget and approved the budget with conditions. The HCA continued to actively participate in the Board's review of OneCare's budget. This quarter, we received and reviewed OneCare's second budget submission. We submitted written questions to OneCare and received written answers to our questions. We participated in OneCare's November 2 budget review hearing and asked questions of OneCare's executives. Prior to the hearing, we submitted an additional document asking OneCare to explain the flow of money in various scenarios. In late November we met with OneCare and Board staff via telephone to discuss these scenarios. We had an additional phone call with the Board and OneCare staff to clarify OneCare's risk model and attended a OneCare Governing Board meeting at which the budget was discussed.

In late December we submitted written comments to the Board asking the Board not to approve OneCare's budget unless OneCare agreed to additional transparency, accountability, and consumer protection measures. Specifically, we outlined concerns about the lack of executed contracts for Board review, the lack of tools to adequately monitor utilization, quality, and access, the lack of sufficient quality, access and experience metrics, and the lack of sufficient grievance and appeal processes. We also asked the Board to ensure that OneCare sufficiently invests in community-based services, and to encourage OneCare to invest in programs aimed at improving care, reducing costs, and addressing social determinants of health for vulnerable and high-cost populations.

In its budget order, the Board approved OneCare's budget and applied conditions. The conditions require OneCare to submit its payer contracts to the Board upon execution and to consult with the HCA to establish a grievance and appeals process consistent with Rule 5.000, among others.

E. Accountable Care Organization Rule

This quarter, the Green Mountain Care Board's proposed Rule 5.000 Oversight of Accountable Care Organizations went before the Legislative Committee on Administrative Rules (LCAR) for a second time. Prior to the first hearing before LCAR (in the previous quarter), we submitted written comments asking for annual enrollee notification of attribution, whistleblower protections, and information regarding care management mechanisms. We also asked for a requirement for referral to the Attorney General (AG) for anticompetitive behavior along with clarification that individual Board members and staff could report potential anticompetitive behavior to the AG's office without Board consensus. Early this quarter we worked with the Board, at LCAR's request, to try to address these concerns. The Board discussed this topic at one of its regular public meetings and agreed to some of our suggested changes including improved patient notice language, stronger whistleblower protections, and referral to the AG for anticompetitive behavior. LCAR approved the rule at its October 12 meeting.

F. Affordable Care Act Tax-related Activities

Tax-related calls from consumers declined this quarter, but tax issues are still regularly encountered in our VHC cases.

The HCA continued to employ a half-time tax attorney, who also staffs the Low-Income Taxpayer Clinic at VLA. This arrangement has allowed the HCA to stay up to date on tax law developments, and enables our staff to effectively field calls related to the ACA and VHC. This quarter saw several federal changes

affecting, or appearing to affect, the Vermont healthcare landscape. The HCA's tax attorney analyzed multiple federal changes this quarter, including the cessation of federal cost-sharing subsidy reimbursements to insurance companies, and changes made in the Tax Cuts and Jobs Act.

As in prior quarters, the HCA's tax attorney consulted with HCA advocates when particularly difficult IRS-related issues arose in HCA cases. During this quarter, the tax attorney advised the HCA on 15 technical assistance questions. She also responded to 30 technical assistance questions from Vermont tax preparers and legal aid attorneys. Question topics included shared responsibility exemptions, difficulties encountered in premium tax credit audits, and collection options for excess premium tax credits. The most common issues for consultation were premium tax credit audits and other post-filing correspondence from the IRS.

In December, the HCA's tax attorney met with the IRS Office of Chief Counsel's Healthcare Counsel to discuss emerging issues including how tax privacy restrictions affect consumers' ability to find out why their VHC premium subsidies are ending. This is an issue we will continue to monitor.

The HCA continued to engage in tax-related outreach and educational activities this quarter. They are detailed below in the **Outreach and Education** section.

G. Other Activities

Administrative Advocacy

✧ **Access to Screening Mammography**

This quarter the HCA continued to advocate for implementation of Act 25 of 2013, which requires first-dollar coverage of screening mammography including additional views. We believe that hundreds of women have been and continue to be charged cost-sharing and deductibles for call-back mammograms that should be fully covered under Vermont law. This law had an implementation date of over three and a half years ago, and yet it continues to not be followed. We are actively pursuing full implementation, which would save many Vermont women hundreds of dollars each year and reduce the financial barriers that make it harder for Vermonters to access these preventative cancer screenings. This quarter we wrote an op-ed that was printed in a number of media outlets to raise awareness about this issue. Our office received a number of calls in response to our outreach on this issue.

✧ **Access to Treatment for Hepatitis C Virus**

This quarter the HCA wrote another letter to DVHA's Drug Utilization Review Board (DURB) asking the DURB to remove all remaining restrictions on access to hepatitis C treatment for Medicaid beneficiaries. The DURB reviewed the criteria at its October meeting and voted to remove the liver damage (fibrosis) requirement, opening up treatment to Medicaid beneficiaries with hepatitis C regardless of their disease stage. We testified before the DURB in support of this change and advocated for DVHA to implement the DURB's recommendation immediately. In early December, DVHA issued a letter to providers indicating that it would implement the DURB's recommended change as of 1/1/18.

Additionally, the HCA continues to actively participate in the Vermont Department of Health Hepatitis C Task Force. We attended one meeting of the task force this quarter and met with the VDH Hepatitis Coordinator to discuss task force priorities.

✧ Family and Medical Leave Insurance (FaMLI) Coalition

The HCA continued to participate in the FaMLI Coalition this quarter, advocating for paid family and medical leave for all Vermonters. We attended one meeting of the coalition this quarter and conducted outreach for coalition events.

✧ Health Care Administrative Rules (HCAR)

In 2016, the Department of Vermont Health Access (DVHA) began a multi-year revision of Medicaid rules. Eventually all Medicaid rules will be amended and adopted under the title of Health Care Administrative Rules (HCAR). HCA supports the HCAR project and has committed significant resources to leading VLA's review of all HCAR rules, both in draft form and when officially proposed.

The HCAR process continued this quarter. We submitted formal public comments on DVHA's proposed rule describing non-covered services. The comments were a joint effort with the Senior Citizens Law Project (SCLP) of VLA. The non-covered services rule is an important rule for Medicaid providers and beneficiaries, because it delineates the coverage limits of Medicaid. The proposed rule adopted several positive changes which we had advocated in our informal comments this past July. However, we still have substantial concerns about how this proposed rule would impact Medicaid beneficiaries' ability to access appropriate and necessary care. We again urged DVHA to consult with a variety of medical professionals before publishing a final proposed rule.

✧ Health Benefits Eligibility and Enrollment Rule

During this quarter, AHS issued a final proposed rule incorporating several of the comments HCA had made in the prior quarter. In November, Chief Advocate Michael Fisher testified before the Legislative Committee on Administrative Rules (LCAR) to explain the HCA's position on the special enrollment period for pregnant women. The HCA disagrees with DVHA's interpretation of the special enrollment period for pregnancy, which was created by the Vermont legislature in 2016. Pregnant women should be permitted to change health plans because of the overriding public interest in maternal and child health. We believe that the statutory language could be read to apply to current VHC enrollees as well as uninsured individuals, and that DVHA should interpret the statute in that way for public policy reasons. As DVHA did not agree, we expect to raise the issue before the legislature in 2018.

✧ Vermont Health Connect Escalation Path

The HCA and VHC continue to collaborate to resolve complex VHC issues. The VHC escalation path now also works to resolve issues regarding Medicaid for Aged, Blind and Disabled (MABD), Medicare Savings Programs, Medicaid Spenddowns and V-Pharm. We communicate with VHC multiple times a day and meet as needed to discuss the most difficult cases.

✧ Comments on Vermont Health Connect Notices

At VHC's request, the HCA commented on 10 notices, in an effort to make them more readable and consumer-friendly. See **Promoting Plain Language in Health Communications** below.

✧ Medicaid and Exchange Advisory Board

This quarter, the Chief Health Care Advocate continue to co-chair and actively participate in Vermont's Medicaid and Exchange Advisory Board (MEAB). The Chief attended and chaired three meetings of the MEAB during the quarter, and presented on the work of the HCA at one meeting of the MEAB.

✧ **Comments on Essential Health Benefits**

The HCA endorsed a Families USA letter to the federal Department of Health and Human Services (HHS) regarding the importance of strong federal standards for Essential Health Benefits.

✧ **Comments on HHS Proposed Notice of Benefit and Payment Parameters for 2019**

The HCA commented in opposition to several proposed changes that would relax federal ACA standards or harm consumers. For example, we strongly support maintaining the current requirement that exchanges directly notify enrollees who will lose subsidies for failure to reconcile premium tax credits. The HCA also commented in support of some provisions of the Proposed Notice, including changes that would make it easier for consumers to end their coverage.

✧ **Comments on HHS Draft Strategic Plan**

The HCA submitted comments on HHS's draft strategic plan for fiscal years 2018 through 2022. Among other comments, we raised concerns regarding access to reproductive health care, and we objected to statements within the strategic plan that promote the religious belief that life begins at conception.

Legislative Activities

There were no official legislative meetings this quarter. The HCA hosted a legislator access to care roundtable meeting at the Burlington office. We also continued to engage legislative leaders during the quarter to keep them up to date on the issues that the HCA was working on. In addition, the HCA partnered with a number of legislators this quarter in providing services to constituents with health care questions and concerns. The Chief Health Care Advocate traveled to member's home communities in the southern part of the state to discuss local access to care issues and educate legislators about the work of the HCA.

Collaboration with Other Organizations

The HCA regularly collaborates with other organizations to advance consumer-oriented policy objectives and to conduct outreach and education. We worked with the following organizations this quarter:

- Advocates for Basic Legal Equality (ABLE) Ohio
- AIDS Project of Southern Vermont
- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Families USA
- HIV/HCV Resource Center
- Howard Center Safe Recovery
- IRS Office of Chief Counsel
- IRS Taxpayer Advocate Service
- Ladies First
- Let's Grow Kids
- MVP Health Care
- National Health Law Program
- OneCare Vermont
- Planned Parenthood of Northern New England
- Public Assets Institute

- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Care Partners
- Vermont CARES
- Vermont Coalition of Clinics for the Uninsured
- Vermont Department of Health
- Vermont Health Connect
- Vermont Medical Society
- Vermont Prisoners' Rights Office
- Vermont Program for Quality in Health Care
- Professor James Maule, Villanova Law School
- VNAs of Vermont
- Voices for Vermont's Children

Outreach and Education

A. Increasing Reach and Education through the Website

Vermont Law Help is a statewide website maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section (*https://vtlawhelp.org/health*) with more than 250 pages of consumer-focused health information maintained by the HCA.

HCA advocates work diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

Popular Web Pages

The total number of **health pageviews increased by 23%** in the reporting quarter ending December 31, 2017 (11,687 pageviews), compared with the same quarter in 2016 (9,490 pageviews). This is noteworthy because the total number of pageviews for the entire Vermont Law Help website increased by only about 11%.

The top-20 health pages on our website this quarter with change over last year:

- *Income Limits – Medicaid* – 3,198 pageviews (1% ↓)
- *Health* – section home page – 1,295 (33% ↑)
- *Vermont Choices for Care* – 429 (34% ↑)
- *Resource Limits – Medicaid* – 414 (209% ↑)
- *Dental Services* – 381 (20% ↓)
- *Services Covered by Medicaid* – 372 (17% ↑)
- *Long-term Care* – 218 (69% ↑)
- *HCA Online Help Request Form* – 209 (99% ↑)
- *Health Insurance, Taxes and You* – 205 (26% ↓)
- *Choices for Care Resource Limits* – 195 (47% ↑)
- *Medical Marijuana Registry Patient Form* – 192 (63% ↑)
- *Medicaid* – 179 (17% ↑)
- *Choices for Care Income Limits* – 171 (2% ↓)
- *Medicaid and Medicare dual eligible* – 168 (4% ↑)
- *Advance Directives and Living Wills* – 157 (8% ↑)

- *Medicare Savings / Buy-In Programs* – 155 (72% ↑)
- *Federally Qualified Health Centers* – 148 (29% ↑)
- *Long-term Care Help* (new page) – 144 (100% ↑)
- *Vermont Health Connect – main page* – 143 (138% ↑)
- *Advance Directive Forms* – 137 (73% ↑)

Besides the pages listed above, other spikes in interest in our pages included:

- *Prescription Assistance – State Pharmacy Programs* (up from 38 pageviews last year to 132 pageviews this year)
- *Medicaid Transportation* (up from 37 to 120)
- *Choices for Care Requirements* (new page up from 0 to 99)
- *HCA Policy Papers* (new page up from 0 to 85)
- *Cost-Sharing Reductions* (up from 17 to 70)
- *Premium Tax Credits* (up from 20 to 69)
- *Ladies First Health Program* (up from 10 to 43)

Popular PDF Downloads

31 out of 80 (39%) of the unique PDFs downloaded from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:

- 17 were created for consumers. The top five consumer-focused PDF downloads were:
    - *Vermont Dental Clinics Chart* (117 downloads)
    - *Advance Directive, short form* (112 downloads)
    - *Advance Directive, long form* (73 downloads)
    - *Vermont Medicaid Coverage Exception Request Form* (19 downloads)
    - *Simple 5-Step Guide to Getting DME through Medicaid* (16 downloads)
    - The advance directive forms were accessed more often this year as compared to the same period last year (185 downloads versus 54 last year).
- 5 were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused download was:
    - *PTC Rule Allocation Summary* (5 downloads)
- 10 covered topics related to health policy. The top policy-focused download was:
    - *HCA Press Release: Medicaid Review Board Lifts Liver Damage Restriction on Life Saving Cures for Vermonters with Hepatitis C* (13 downloads)

Our *Vermont Dental Clinics Chart* is the **fifth most downloaded of all PDFs** downloaded from the entire Vermont Law Help website.

The *Advance Directive Short Form* is the **sixth most downloaded of all PDFs** downloaded from the entire Vermont Law Help website.

New Online Help Tool Adds to Our Reach

In 2017 we added a new Health section to the online help tool on our website. It is found at *https://vtlawhelp.org/triage/vt_triage* and can be accessed from most pages of our website. Our first Health topic was posted in June and a final section was added in October.

The website visitor answers a few questions to find specific health care information they need. The new feature addresses some of the most popular questions that are posed to the HCA. In addition to our

deep collection of health-related web pages, the online help tool adds a new way to access helpful information — at all hours of the day and night. The website user can also call us or fill in our online form to get personal help from an advocate.

Website visitors used this new tool to access health care information **136 times** during this quarter, signifying a 91% increase over the previous quarter.

Of the 52 health care topics that were accessed, the top topics were:

- Dental Services - I need help finding a low-cost dentist and paying for dental care.
- Long-Term Care - I want to go over my long-term care options (nursing homes, in-home care, and more).
- VHC - I want to apply for Vermont Health Connect for myself or my children.
- Complaints - I want to file a complaint against a doctor.
- Advance Directives - I need help with an advance directive or living will.

B. Other Outreach and Educational Activities

Op Ed: Mammograms are Free in Vermont (October 3, 2017)

Chief Health Care Advocate Michael Fisher published an opinion piece in the Burlington Free Press to spread the word about changes to Vermont law that require no-cost mammography screenings and follow-up screenings. The HCA was concerned that the law had not been implemented in the years since its passage. The news item generated several calls to the HCA from consumers with mammogram bills.

Mauled Again (October 11, 2017)

The HCA's tax attorney analyzed the regulations governing liability for advance premium tax credit payments when a young adult dependent erroneously enrolls himself in subsidized coverage.

Outreach to Agricultural Guestworkers (October 21, 2017)

HCA staff visited three orchards in Windham County to distribute outreach materials and answer health care and health insurance questions from agricultural workers with H-2A visas. Topics discussed included Vermont Health Connect enrollment, health insurance subsidies, how to get emergency medical care, and the penalty for going without insurance. We met with 31 workers in total.

Vermont Edition (October 27, 2017)

Chief Health Care Advocate Michael Fisher and Sean Sheehan from Vermont Health Connect appeared on Vermont Edition, *A Checkup on VHC*. The program addressed VHC's functionality ahead of open enrollment, and discussed the range of policies and financial assistance available.

VPR News (October 27, 2017)

Chief Health Care Advocate Michael Fisher appeared on a VPR News segment, *Vermont Health Connect Has Solved Many of Its Problems as New Enrollment Begins*.

University of Vermont Tax School (November 8 & 15, 2017)

The HCA's tax attorney spoke to attendees at both sessions of the UVM Tax School about VHC open enrollment and the subsidies available to taxpayers. She explained that the federal decision to stop cost-sharing subsidy reimbursements for insurers did not affect Vermont health insurance options for 2018. About 350 tax professionals (enrolled agents, CPAs, attorneys, and un-credentialed preparers) attended.

VPR News (December 6, 2017)

Chief Advocate Michael Fisher appeared on a VPR News segment, *Chief Health Care Advocate Says Families Struggling to Meet Basic Needs.*

Annual Low-Income Taxpayer Clinic Grantee Conference (December 6, 2017)

The HCA's tax attorney was featured on a panel that presented "Affordable Care Act: Hot Topics and Developments" to about 75 attendees. Attendees were largely directors and staff attorneys from Low-Income Taxpayer Clinics (LITC) and staff from the IRS Taxpayer Advocate Service (TAS). The presentation was a collaboration with the IRS Taxpayer Advocate Service and the IRS Office of Chief Counsel.

VPR News (December 11, 2017)

Chief Advocate Michael Fisher appeared on a VPR News segment, *State Officials: Enrollment For The Affordable Care Act Ends Friday, Act Now.*

VPR News (December 22, 2017)

Chief Advocate Michael Fisher appeared on a VPR News segment, *State Health Care Board Gives Green Light To Major Payment Reform Plan.*

Kinney Drugs Referral Program (December 2017)

The HCA and Kinney Drugs developed referral procedures and a referral form so that consumers at the pharmacy will have easy access to an HCA advocate in case of problems with healthcare or health insurance. HCA staff met with Kinney Drugs representatives to explain HCA services and the problems that HCA can help consumers resolve.

C. Promoting Plain Language in Health Communications

During this quarter, the HCA provided feedback and revisions to promote the use of plain language and increase consumers' accessibility to and understanding of important communications from the state and other health organizations regulated by the state. The HCA made plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:

- Bronze Plan design brochure
- BCCTP steps notice
- BCCTP brochure
- VHC catastrophic brochure
- VHC Silver CSR plans brochure
- Dr. Dynasaur premium increase notice
- Healthy Vermonters outreach
- Comments on voice and text messages for VHC customers
- Comments on notice to QHP subscribers with out of state addresses
- Comments of EE202-MM, verification notice of Indian status

Office of the Health Care Advocate

Vermont Legal Aid
264 North Winooski Avenue
Burlington, Vermont 05401
800.917.7787

http://www.vtlegalaid.org/health

Attachment 6

CY 2017 Investment Expenditures

Department	Criteria	STC #	Final Receiver	Final Receiver Suffix	Investment Description	QE 0317	QE 0617	QE 0917	QE 1217	CY 2017 Total
AHSCO	4	41	99999	9091	Investments (STC-79) - 2-1-1 Grant (41	113,250	113,250	113,250	113,250	**453,000**
AHSCO	2	54	99999	9090	Investments (STC-79) - Designated Agency Underinsured Services (54	1,289,600	1,908,765	1,664,645	1,664,665	**6,527,675**
AOE		11	n/a	n/a	Non-state plan Related Education Fund Investments	-	-			**-**
DCF	2	1	99999	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1	2,302,666	3,750,502	2,317,786	1,048,771	**9,419,725**
DCF	2	2	99999	9412	Investments (STC-79) - Lund Home (2	563,548	1,205,069	226,781	837,554	**2,832,952**
DCF	2	9	99999	9415	Investments (STC-79) - Challenges for Change: DCF (9	64,031	15,000	12,864	76,146	**168,041**
DCF	2	26	99999	9416	Investments (STC-79) - Strengthening Families (26	140,360	124,483	212,199	275,163	**752,205**
DCF	2	33	99999	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33	-	-			**-**
DCF	2	34	99999	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34	28,742	27,605	25,646	25,646	**107,638**
DCF	2	35	99999	9418	Investments (STC-79) - Building Bright Futures (35	215,963	153,681	116,014	158,574	**644,232**
DCF	2	55	99999	9402	Investments (STC-79) - Medical Services (55	18,232	34,104	14,989	23,410	**90,734**
DCF	2	56	99999	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56	-	198,036	1,613,493	1,066,953	**2,878,482**
DCF	2	57	99999	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57	-	-	13,425	30,104	**43,529**
DCF	2	58	99999	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58	-	-	34,175	71,419	**105,594**
DCF	2	59	99999	9408	Investments (STC-79) - Essential Person Program (59	247,955	245,989	254,083	237,837	**985,864**
DCF	2	60	99999	9409	Investments (STC-79) - GA Medical Expenses (60	57,275	61,464	48,476	61,593	**228,808**
DCF	2	61	99999	9411	Investments (STC-79) - Therapeutic Child Care (61	183,832	171,688	190,092	205,765	**751,377**
DCF	1	62	99999	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62	54,000	54,000	54,750	54,750	**217,500**
DDAIL	2	27	99999	9604	Investments (STC-79) - Flexible Family/Respite Funding (27	669,264	231,127	17,233	744,142	**1,661,766**
DDAIL	2	42	99999	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42	1,838	-	-		**1,838**
DDAIL	4	43	99999	9606	Investments (STC-79) - Support and Services at Home (SASH) (43	323,108	337,902	329,760	339,172	**1,329,942**
DDAIL	2	63	99999	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63	-	141,010	72,998	26,560	**240,568**
DDAIL	2	64	99999	9603	Investments (STC-79) - DS Special Payments for Medical Services (64	144,167	620,425	17,384	396,346	**1,178,321**
DDAIL	4	65	99999	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65	16,964	22,350	23,251	15,785	**78,350**
DDAIL	4	77	99999	9607	Investments (STC-79) - HomeSharing (77	163,230	-	99,891	82,319	**345,440**
DDAIL	4	78	99999	9608	Investments (STC-79) - Self-Neglect Initiative (78	139,535	-	139,818		**279,353**
DMH	2	3	99999	9511	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH	6,122,077	4,901,581	6,342,378	4,582,343	**21,948,378**
DMH	2	3	99999	9512	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR	2,851,306	1,935,511	(484,400)	359,926	**4,662,343**
DMH	2	12	99999	9506	Investments (STC-79) - Mental Health Children's Community Services (12	1,100,031	1,110,338	835,385	1,618,762	**4,664,517**
DMH	2	13	99999	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13	513,189	1,009,161	830,521	90,330	**2,443,202**
DMH	4	16	99999	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16	(2,421,435)	72,606	8,268,643	1,844,025	**7,763,839**
DMH	2	22	99999	9510	Investments (STC-79) - Emergency Support Fund (22	253,660	168,692	102,893	494,228	**1,019,474**
DMH	2	28	99999	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28	30,434	37,281	24,058	41,697	**133,469**
DMH	2	29	99999	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29	6,062,573	421,086	260,430	5,145,291	**11,889,380**
DMH	2	66	99999	9502	Investments (STC-79) - MH Outpatient Services for Adults (66	759,746	487,738	620,290	921,018	**2,788,792**
DMH	2	67	99999	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67	302,581	201,030	153,548	551,848	**1,209,008**
DMH	2	68	99999	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68	77,594	(57,791)	23,198	24,925	**67,926**
DMH	2	79	99999	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79	141,556	111,938	53,321	118,323	**425,138**
DOC	2	4	n/a	n/a	Return House	108,512	130,579	81,336	127,396	**447,823**
DOC	2	5	n/a	n/a	Northern Lights	97,223	96,231	118,869	98,438	**410,761**
DOC	2	6	n/a	n/a	Pathways to Housing	259,443	203,973	168,065	217,915	**849,395**
DOC		14	n/a	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change	198,983	182,616	87,724	89,806	**559,128**
DOC	4	15	n/a	n/a	Northeast Kingdom Community Action	46,405	48,975	45,293	-	**140,673**
DOC	2	69	n/a	n/a	Intensive Substance Abuse Program (ISAP	-	-	-		**-**
DOC	2	70	n/a	n/a	Intensive Domestic Violence Program	-	-	-		**-**
DOC	2	71	n/a	n/a	Community Rehabilitative Care	-	1,365,476	-	741,757	**2,107,233**
DOC	2	80	n/a	n/a	Intensive Sexual Abuse Program	2,130	2,835	2,680	2,675	**10,320**
DVHA	1	7	99999	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7	1,763,069	2,251,854	1,891,110	2,177,152	**8,083,185**
DVHA	4	8	99999	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8	968,032	1,758,683	153,283	935,818	**3,815,816**
DVHA	1	18	99999	9106	Investments (STC-79) - Patient Safety Net Services (18	206,199	171,891	194,940	(283,390)	**289,640**
DVHA	4	51	99999	9102	Investments (STC-79) - Vermont Blueprint for Health (51	511,845	971,586	709,701	669,621	**2,862,753**
DVHA	1	52	99999	9103	Investments (STC-79) - Buy-In (52	5,762	10,720	5,762	6,700	**28,944**
DVHA	1	53	99999	9104	Investments (STC-79) - HIV Drug Coverage (53	1,422	1,607	1,628	1,122	**5,779**
DVHA	1	72	99999	9108	Investments (STC-79) - Family Supports (72	-	-	6,362	-	**6,362**
GMCB	4	45	n/a	n/a	Green Mountain Care Board	609,467	796,535	413,119	360,494	**2,179,615**
UVM	4	10	n/a	n/a	Vermont Physician Training	1,011,555	1,011,552	1,011,555	1,011,554	**4,046,216**
VAAFM	3	36	n/a	n/a	Agriculture Public Health Initiatives	5,335	46,167	-	-	**51,502**
VDH	3	17	99999	9220	Investments (STC-79) - Recovery Centers (17	430,500	380,500	343,178	400,152	**1,554,330**
VDH	2	19	99999	9201	Investments (STC-79) - Emergency Medical Services (19	160,328	127,062	191,619	173,089	**652,097**
VDH	3	21	99999	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21	266,000	-		162,300	**428,300**
VDH	4	23	99999	9223	Investments (STC-79) - Public Inebriate Services, C for C (23	594,748	353,986	125,975	171,240	**1,245,949**
VDH	4	24	99999	9225	Investments (STC-79) - Medicaid Vaccines (24	-	-			**-**
VDH	3	25	99999	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25	432,000	68,111		50,000	**550,111**
VDH	3	30	99999	9219	Investments (STC-79) - Substance Use Disorder Treatment (30	2,192,838	1,754,278	2,082,135	2,108,511	**8,137,762**
VDH	2	31	99999	9206	Investments (STC-79) - Health Laboratory (31	875,545	743,581	868,545	847,850	**3,335,520**
VDH	2	37	99999	9213	Investments (STC-79) - WIC Coverage (37	493,350	409,352	979,866	734,668	**2,617,237**
VDH	4	38	99999	9224	Investments (STC-79) - Fluoride Treatment (38	22,103	14,661	15,788	14,478	**67,030**
VDH	2	39	99999	9205	Investments (STC-79) - Health Research and Statistics (39	351,753	317,081	382,953	344,080	**1,395,866**
VDH	2	40	99999	9204	Investments (STC-79) - Epidemiology (40	221,654	198,470	318,271	279,474	**1,017,869**
VDH	4	44	99999	9228	Investments (STC-79) - VT Blueprint for Health (44	379,115	176,411	279,550	295,424	**1,130,499**
VDH	4	46	99999	9221	Investments (STC-79) - Enhanced Immunization (46	48,051	80,762	51,389	58,547	**238,749**
VDH	3	47	99999	9217	Investments (STC-79) - Patient Safety - Adverse Events (47	1,264	20,893	12,000		**34,157**
VDH	4	48	99999	9222	Investments (STC-79) - Poison Control (48	26,873	80,618			**107,491**
VDH	4	49	99999	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49	71,195	70,509	57,618	63,731	**263,053**
VDH	4	50	99999	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50	-	-	229,376	440,928	**670,304**
VDH	2	73	99999	9211	Investments (STC-79) - Renal Disease (73	-	6,750			**6,750**
VDH	2	74	99999	9203	Investments (STC-79) - TB Medical Services (74	41,645	40,557	39,611	19,013	**140,826**
VDH	2	75	99999	9209	Investments (STC-79) - Family Planning (75	378,879	378,576	375,990	350,167	**1,483,612**
VDH	2	76	99999	9208	Investments (STC-79) - Statewide Tobacco Cessation (76	158,405	99,102			**257,507**
VSC	2	32	n/a	n/a	Health Professional Training	204,730	-	204,731		**409,461**
VVH	2	20	n/a	n/a	Vermont Veterans Home	110,986	-		410,986	**521,972**
						35,788,216	**34,188,159**	**36,093,291**	**36,430,334**	**142,500,000**

P BP Blueprint for Health

Attachment 7 - Investment Scorecard

Budget Information

SFY 2017 Costs: $2,456,161

What We Do

The Vermont Blueprint for Health is a state-led, nationally-recognized initiative that helps health care providers meet the medical and social needs of people in their communities. The Blueprint's aim is constant: better care, better health, and better control of health care costs.

The Blueprint encourages initiatives to support and improve health care delivery. It promotes innovative initiatives aimed at improving health outcomes, increasing preventive health approaches, addressing quality of life concerns, and increasing access to quality care through patient-centered medical homes and community health teams.

Who We Serve

The Blueprint for Health serves all Vermonters.

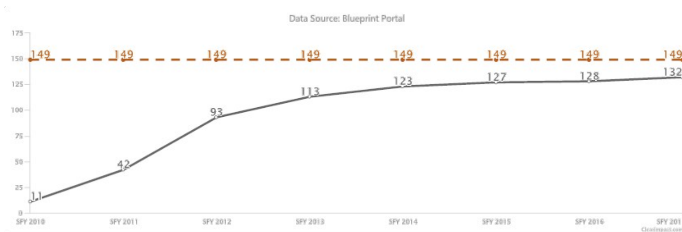
How We Impact

Investment Objective:

Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Performance Measures

PM BP # of primary care practices participating in the Blueprint



Time Period	Actual Value	Target Value	Current Trend	Baseline % Change
SFY 2017	132	149	↗ 7	1100% ↑
SFY 2016	128	149	↗ 6	1064% ↑
SFY 2015	127	149	↗ 5	1055% ↑
SFY 2014	123	149	↗ 4	1018% ↑
SFY 2013	113	149	↗ 3	927% ↑
SFY 2012	93	149	↗ 2	745% ↑
SFY 2011	42	149	↗ 1	282% ↑
SFY 2010	11	149	→ 0	0% →

Notes on Methodology

- The number of participating practices per quarter is generated from data stored in the Blueprint portal (https://blueprintforhealthport...). The Blueprint Data Analyst manages information stored in the Blueprint portal.
- The goal figure for this measure was obtained by identifying all primary care practices in the AHEC survey database and immunization registry database, validating these primary care practices with our Blueprint project managers, and eliminating from the count practices with 1 FTE or less of a provider.

Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers

Story Behind the Curve

These are practices who meet the NCQA standard of a patient-centered medical home (PCMH) and participate in Blueprint initiatives. This measure is fundamental in assessing the reach of the Blueprint program. As larger numbers of practices are qualified as PCMHs and supported by Blueprint payments, increasing numbers of Vermonters should have access to high quality primary care.

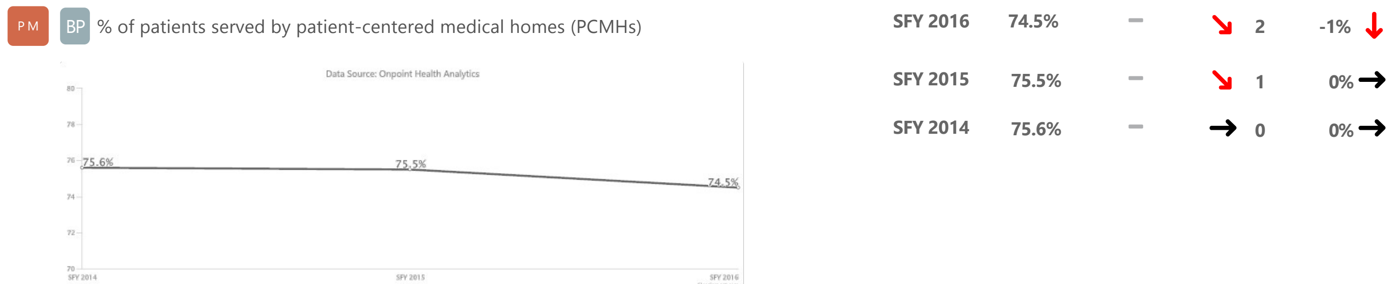
The trend line above clearly highlights the rapid increase in practice participation in the Blueprint as NCQA-recognized Patient-Centered Medical Homes (PCMHs) in 2011. This rapid increase is the result of a coordinated effort by the Blueprint team to comply with the enactment of Act 128 in May 2010 by the Vermont General Assembly. The Act mandated the statewide expansion of the Blueprint, including practice recognition as PCMHs. Evidence of this expansion required a minimum of two primary care practices in each health service area (HSA) becoming PCMHs by July 2011. The Act additionally required the involvement of all willing primary care providers in Vermont by October 2013 (full statewide spread). A significant achievement in 2010 that paved the way towards compliance with Act 128 was the Blueprint's successful application for the Centers for Medicare & Medicaid Services' Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration Project. In mid-July, Medicare joined all other major insurers in Vermont in contributing to the financial payments to PCMHs.

Since the mandate that all willing primary care providers in Vermont be involved as a PCMH in the Blueprint by October 2013, Blueprint practice facilitators have continued to engage providers across the State to encourage and inspire participation. Practice facilitators, highly skilled and intensively trained clinical and process coaches, work with primary care practices throughout the state and guide them as they make quality improvement changes on the path towards becoming PCMHs. When practices achieve NCQA certification as a PCMH with the assistance of the Blueprint practice facilitators, they demonstrate adherence with important characteristics of high quality healthcare and well-coordinated health services. The practices find the NCQA PCMH standards and Blueprint program as value-adds to their practice, as since the inception of the Blueprint program, only one PCMH has dropped out of the Blueprint (pending an upcoming move out of state).

The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. Program expansion is continuing due to the outreach efforts of the Blueprint practice facilitators, who are making a coordinated effort to reach primary care practices in their communities that have not participated in the Blueprint as a patient-centered medical home in the past. Generally, the practices that are continuing to join the Blueprint are independent and naturopathic practices.

Last updated: 08/31/17

Author: Blueprint for Health



Notes on Methodology

- The percentage of Blueprint patients from the population of VHCURES members with a primary care visit is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint updates this percentage every six months, accounting for the next 6 month time period.
- The trend line for this measure should increase as additional practices join the Blueprint.

Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes (PCMHs)
- Onpoint Health Analytics

Story Behind the Curve

This is a measure of the percentage of Vermonters who receive their primary care from a Blueprint PCMH from the population of VHCURES members with a primary care visit. This is an access to care measure.

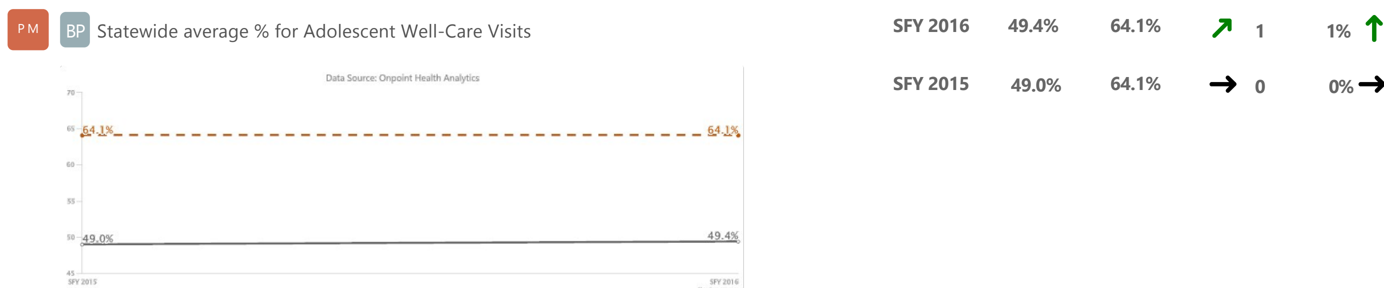
PCMHs provide top-quality primary care centered on several key evidence-based standards. By increasing the percentage of

Vermonters who receive their primary care through PCMHs, we are increasing access to high quality care and the opportunity for improved health outcomes.

The trend line above, while moving towards the right direction, suggests an opportunity for improvement. Data points from 2013 to 2014 clearly highlight the effects of the rapid increase in practice participation in the Blueprint as NCQA-recognized Patient-Centered Medical Homes (PCMHs) in due to the mandate that all willing primary care providers in Vermont by involved as a PCMH in the Blueprint by October 2013. Data points in 2015 show a decrease in the percentage of the Blueprint patients from the population of VHCURES members with a primary care visit due to either improvements in the accuracy of attributing individuals to PCMHs at Onpoint Health Analytics or access to care issues. The recent increase in the percentage in the latest study time period can be attributed to a continued engagement of providers across the State by Blueprint practice facilitators to encourage and inspire participation in the Blueprint.

Last updated: 08/31/17

Author: Blueprint for Health



PM BP Statewide average % for Adolescent Well-Care Visits

SFY 2016	49.4%	64.1%	↗	1	1% ↑
SFY 2015	49.0%	64.1%	→	0	0% →

Notes on Methodology

- The statewide average percentage of the Adolescent Well-Child Visit performance measure is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint updates this measure every six months, accounting for the next 6 month time period. The statewide average percentage of the Adolescent Well-Child Visit performance measure is listed in every Health Service Area Pediatric profile, which can be found here (http://blueprintforhealth.verm...).
- The statewide average percentage of the Adolescent Well-Child Visit performance measure is a claim-based measure pertaining only to a subset of the Vermont population - insured patients who received the majority of their primary care from a Blueprint practice. This measure is not a Vermont population-level estimate.
- The goal figure for this measure represents the weighted average of the HEDIS national Medicaid 90th percentile benchmark for 2016 and the HEDIS national Commercial 90th percentile benchmark for 2016.

Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes
- Onpoint Health Analytics

Story Behind the Curve

The Adolescent Well Care (AWC) measure is the first of the four key indicators of quality health care. This measure assesses the statewide average percentage of members, ages 12–21 years, who had at least one well-care visit with a primary care practitioner or OB/GYN during the measurement year.

The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above, while moving towards the right direction, suggests an opportunity for improvement. The Blueprint implemented the pay for performance model on this measure in July 2015. This measure was chosen for payment because it reflected a priority of each of the provider networks (ACOs) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concerns involving complex medical and social determinants, and it could be improved through better coordination, outreach, and transitions between medical and non-medical providers. Since the implementation of the pay for performance model, a number of Health Service Areas have developed quality improvement policies on this measure, including Barre, Bennington, Burlington, Randolph, St. Albans, and Middlebury.

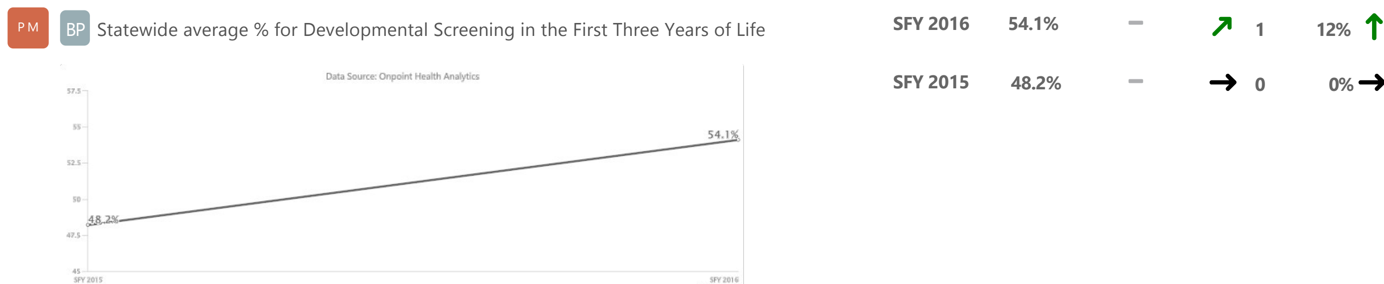
Middlebury in particular has been working on follow-up processes for patients that are overdue for adolescent well child visits (2016, 2017). Practice staff have been developing reports for the number of active 11-23 year old patients who have not had an adolescent well child visit in the past year, developing outreach materials and outreach processes for those patients that have not had a visit in the past year, and implemented a policy of ensuring that the next adolescent well child visit is scheduled when the patient visits the office for any reason. In addition, a reminder is sent to patients when the adolescent well child visit nears to avoid increased cancelations. Within the last year, there was an improvement in the rate of patients who had an adolescent well child visit.

Last updated: 08/31/17

Author: Blueprint for Health

PM BP Statewide average % for Developmental Screening in the First Three Years of Life

SFY 2016	54.1%	—	↗ 1	12% ↑
SFY 2015	48.2%	—	→ 0	0% →



Notes on Methodology

- The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint updates this measure every six months, accounting for the next 6 month time period. The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure is listed in every Health Service Area Pediatric profile, which can be found here (http://blueprintforhealth.verm...).
- The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure is a claim-based measure pertaining only to a subset of the Vermont population - insured patients who received the majority of their primary care from a Blueprint practice. This measure is not a Vermont population-level estimate.
- Since HEDIS does not produce national benchmarks on this measure, the goal has been identified as the Blueprint's metric of improvement in the Blueprint performance payment methodology, which is an increase of 5% change each study period. The Blueprint performance payment methodology can be found here (http://blueprintforhealth.verm...)

Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes (PCMHs)
- Onpoint Health Analytics
- Vermont Department of Health
- Vermont Child Health Improvement Program

Story Behind the Curve

The Developmental Screening in the First Three Years of life (DEV) measure is the second of the four key indicators of quality health care. This measure assesses the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.

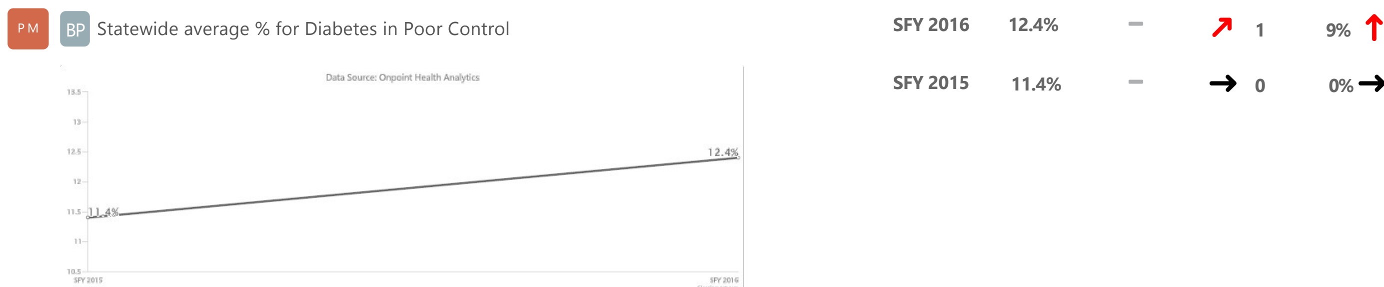
The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above shows that there has been significant improvement on this measure due to the coordinated efforts of internal and external partners. The Blueprint implemented the pay for performance model on this measure in July 2015. This measure was chosen for payment because it reflected a priority of each of the provider networks (ACOs) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concerns involving complex medical and social determinants, and it could be improved through better coordination, outreach, and transitions between medical and non-medical providers. Following this measure's implementation as a payment measure in July 2015, practices showed renewed interest in developmental screening with almost fifty practices participating in the University of Vermont College of Medicine's Child Health Advances Measured in Practice (CHAMP) initiative funded by the Vermont Department of Health (VDH). The Blueprint worked collaboratively with VCHIP to provide

each practice with their practice-level results for this measure in Fall 2016 (rather than Health Service Area results), and is happy to announce that practice-level results for this measure will be reported on all Blueprint practice profiles starting with Calendar Year 2016 data, set to be released in November 2017.

Last updated: 08/31/17

Author: Blueprint for Health



Notes on Methodology

- The statewide average percentage of the Diabetes in Poor Control performance measure is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint links claims in the APCD to clinical records stored by Capitol Health Associates in the Clinical Registry. Onpoint updates this measure every six months, accounting for the next 6 month time period. The statewide average percentage of the Diabetes in Poor Control performance measure is listed in every Health Service Area Adult profile, which can be found here (http://blueprintforhealth.verm...). The statewide average percentage of the Diabetes in Poor Control performance measure relies on data from the Clinical Registry and therefore is influenced when practices interrupt their data feed to the Clinical Registry. The outcomes described here are estimated using data only from individuals for whom claims data could be linked with valid Clinical Registry data. This non-random sampling variability is not accounted for in the measure.
- It is important to note that the weighted average of the HEDIS national Medicaid 90th percentile benchmark for 2016 and the HEDIS national Commercial 90th percentile benchmark for 2016 is **28%**. Given that Vermont is performing significantly better than the national 90th percentile benchmark, the Blueprint has elected to not include a goal for this measure.

Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Home
- Onpoint Health Analytics

Story Behind the Curve

The Diabetes in Poor Control (i.e., Hemoglobin A1c>9%) measure is the third of 4 key indicators of quality health care. This measure assesses the percentage of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded hemoglobin A1c test in the Clinical Registry was in poor control (>9%). This is a mixed methods measure relying both on claims and clinical data.

The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above suggests an opportunity for improvement given that the data is not moving in the right direction. The Blueprint implemented the pay for performance model on this measure in July 2015. This measure was chosen for payment because it reflected a priority of each of the provider networks (ACOs) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concerns involving complex medical and social determinants, and it could be improved through better coordination, outreach, and transitions between medical and non-medical providers. Since the implementation of the pay for performance model, a number of Health Service Areas have developed quality improvement policies on this measure, most notably, Morrisville.

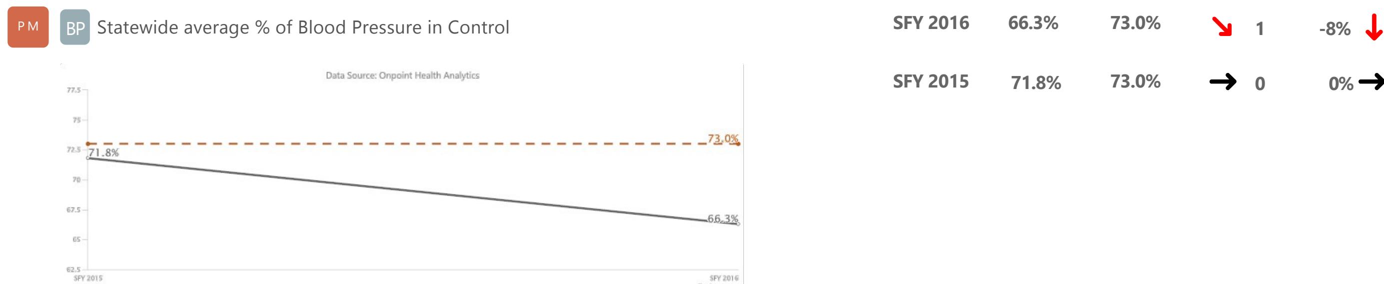
Morrisville has been working on follow-up appointment processes and referrals to self-management services for patients with diabetes (2016, 2017). With regard to quality improvement work directed towards diabetes, practice staff conducted outreach to patients that were overdue for follow-up appointments, reminded patients of the importance of regular appointments with their PCP, and new staff members were trained on how to review physician follow-up recommendations and complete appropriate scheduling for patients for the next visit prior to the patients leaving the office. An improvement in the rate of patients with diabetes who were

overdue for an appointment was observed. In addition, the care coordinator nurse was provided with a list of patients with diabetes who were determined to have an A1C greater than 9%, chart review was completed to determine current status of self-management activities, and depending on patient needs, assistance and referrals were completed. There was an improvement in the rate of patients who are engaged with a form of self-management within the last year.

Last updated: 08/31/17

Author: Blueprint for Health

PM BP Statewide average % of Blood Pressure in Control



SFY 2016	66.3%	73.0%	↘	1	-8% ↓
SFY 2015	71.8%	73.0%	→	0	0% →

Notes on Methodology

- The statewide average % for the Blood Pressure in Control performance measure is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint links claims in the APCD to clinical records stored by Capitol Health Associates in the Clinical Registry. Onpoint updates this measure every six months, accounting for the next 6 month time period. The statewide average percentage of the Hypertension in Control performance measure is listed in every Health Service Area Adult profile, which can be found here (http://blueprintforhealth.verm...). The statewide average percentage of the Hypertension in Control performance measure relies on data from the Clinical Registry and therefore is influenced when practices interrupt their data feed to the Clinical Registry. The outcomes described here are estimated using data only from individuals for whom claims data could be linked with valid Clinical Registry data. This non-random sampling variability is not accounted for in the measure.
- The goal figure for this measure represents a weighted average of the HEDIS national Medicaid 90th percentile benchmark for 2016 and the HEDIS national Commercial 90th percentile benchmark for 2016.

Partners

- The local Blueprint Transformation Network, which includes: Practice Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes
- Onpoint Health Analytics
- Vermont Department of Health
- OneCare Vermont
- Support And Services at Home
- New England Quality Innovation Network-Quality Improvement Organization
- Community Health Accountable Care, LLC
- Vermont Program for Quality in Health Care, Inc.

Story Behind the Curve

The Blood Pressure in Control measure is the fourth of 4 key indicators of quality health care. This measure assesses the percentage of continuously enrolled members with hypertension, ages 18-85 years, whose last recorded systolic blood pressure was less than 140 mm/Hg and whose last recorded diastolic blood pressure was less than 90 mm/Hg.

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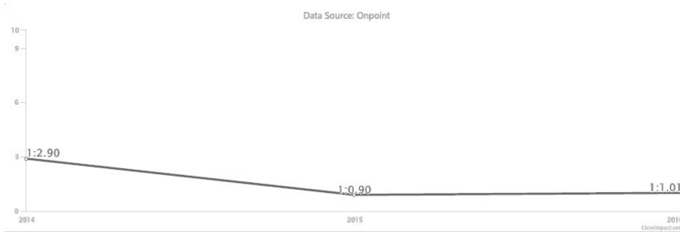
learning community to support practices in implementing key strategies to improve blood pressure control in patients with hypertension. In the peer-learning community, we have bought together expert faculty to provide a dynamic learning environment and provided practices the opportunity to learn from peers and have quality improvement coaching support.

Last updated: 08/31/17

Author: Blueprint for Health

PM BP Blueprint Return on Investment (ROI) - Medicaid without Special Medicaid Services (SMS)

Time Period	Actual Value	Target Value	Current Trend	Baseline % Change
2016	1:1.01	-	↗ 1	-65% ↓
2015	1:0.90	-	↘ 1	-69% ↓
2014	1:2.90	-	→ 0	0% →



Story Behind the Curve

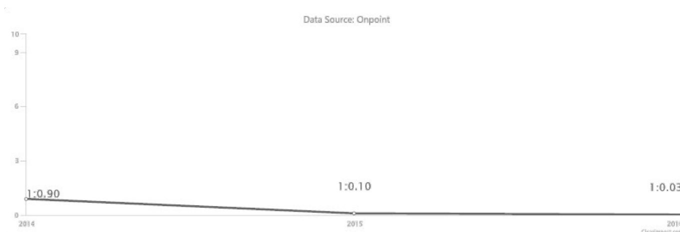
This performance measure is important because it measures how well the program is doing; it measures quality of program effort.

In general, return on investment (ROI) is the benefit (return) of an investment divided by the cost of an investment, and then expressed as a percentage or a ratio. In this case, the benefit of our investment is a reduction in healthcare expenditures. The cost of the investment is the total amount of money invested by the federal government through the Global Commitment to Health Section 1115 waiver and by the State through the General Fund.

The Blueprint's ROI calculation takes in to consideration payments to medical home and Community Health Teams and the program budget. Overall, return on investment (ROI) in the Blueprint across all payers is strongly positive, except for Medicaid when including Special Medicaid Services (SMS), which cover social supports for better health - like transportation to appointments (see Medicaid with SMS performance measure). When these other services are included, the reduction in expenditures does not fully offset investments. This indicates a better balance in utilization of medical and social services, and greater investment in prevention versus treatment.

PM BP Blueprint Return on Investment (ROI) with Special Medicaid Services (SMS)

Time Period	Actual Value	Target Value	Current Trend	Baseline % Change
2016	1:0.03	-	↘ 2	-97% ↓
2015	1:0.10	-	↘ 1	-89% ↓
2014	1:0.90	-	→ 0	0% →



Story Behind the Curve

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In general, return on investment (ROI) is the benefit (return) of an investment divided by the cost of an investment, and then expressed as a percentage or a ratio. In this case, the benefit of our investment is a reduction in healthcare expenditures. The cost of the investment is the total amount of money invested by the federal government through the Global Commitment to Health Section 1115 waiver and by the State through the General Fund.

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Our Work Helps Turn These Indicators

Time Period	Actual Value	Target Value	Current Trend	Baseline % Change

VAHS InvestmentGoal Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system

Actions

Name	Assigned To	Status	Due Date	Progress