State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Annual Report
For Demonstration Year 2018
January 1, 2018 to December 31, 2018

Submitted via PMDA portal on March 28, 2019

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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.

As of July 1, 2018, the Global Commitment to Health demonstration was amended to include authority for Vermont to receive federal Medicaid funding for Substance Use Disorder treatment services provided to Medicaid enrollees in Institutions for Mental Disease (IMDs).

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 2018, which ended on December 31, 2018. This report encompasses fourth quarter updates for this demonstration year (10/1/18 – 12/31/18).

II.   Highlights and Accomplishments

- As of December 2018, nearly 208,000 Vermonters were covered by a Vermont Health Connect health plan, either a qualified health plan (QHP) or Medicaid for Children and Adults (MCA), down about 4,000 from the prior year. The declining enrollment was accompanied by a strong economy and low jobless rate, as well as by an increasing proportion of Vermonters turning 65 and enrolling in Medicare.

- In 2018, the following payment and delivery system reform initiatives were either completed or in-progress: Vermont Medicaid Next Generation ACO program; Applied Behavior Analysis (ABA); Children's and Adult's Mental Health; Residential Substance Use Disorder (SUD) Program; Developmental Disabilities Services; Pediatric Palliative Care.

- DVHA launched the eWEBS Pharmacy Benefits Provider Portal developed by Change Healthcare in 2018. This portal is designed for use by registered prescribers and pharmacies to simplify access to beneficiary and drug information securely. Among other things, this portal allows providers to electronically submit Prior Authorization (PA) requests, track the progress of a request, and view PA determination results.

- Work continued in 2018 to define how Program Integrity, which was established based on standard fee for service payment models, works in prospective, episodic, and bundled payment constructs wherein providers have more flexibility in how and what services are delivered, and payment is not linked to a specific service.

- The Developmental Disability Services Division is working to establish a value-based payment methodology for developmental disability home and community-based services. The Division is working closely with providers, beneficiaries, and families to create a new payment model aimed at efficiency, economy, quality, transparency, accountability, and sufficient access to care.

- In 2018, DVHA prioritized the creation of a new Provider Management Module to reduce provider administrative burden and bring the time it takes to enroll providers into Vermont Medicaid's network down from over 120 days to less than 45 days. The procurement was successful, and the new module will launch by April 1, 2019.

- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid use disorder, as evidenced by 3,750 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of December 2018 and 2,944 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of December 2018.

- 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. The program grew to 10 hospital communities and 42,000 attributed lives in 2018. In 2019, these numbers are expanding to thirteen hospital service areas and 79,000 attributed lives.

- The Agency of Human Services received approval from CMS for all eight of Vermont Medicaid's Alternative Payment Methodologies through at least CY2020, marking the first time any of these methodologies were approved beyond a single calendar year.

- The Vermont Chronic Care Initiative (VCCI) changed its eligibility process to incorporate screening and stratification for social determinants of health, proactively conduct outreach to new Medicaid beneficiaries using a telephonic screening tool to connect them with appropriate care management programs and providers and accept provider referrals that include beneficiaries for whom Medicaid is the secondary payer.

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	94,629
1	ABD - Non-Medicare - Child	28,865
1, 4*, 5*	ABD - Dual	255,478
2	ANFC - Non-Medicare - Adult	157,964
2	ANFC - Non-Medicare - Child	730,744
	Medicaid Expansion	
7	Global RX	84,049
8	Global RX	47,561
6	Moderate Needs	2,960
	New Adults	
3	New Adult without child	490,537
3	New Adult with child	224,721
	Total All	**2,117,508**
* Long Term Care Group	**Total CY 2017**	
4 only	ABD Long Term Care Highest Need	35,052
5 only	ABD Long Term Care High Need	13,202

The table below contains Member Month Reporting for CY2018 including QE1218.

Table 2. Member Month Reporting – Calendar Year 2018

Demonstration Population	Medicaid Eligibility Group	Total CY 2018
1, 4*, 5*	ABD - Non-Medicare - Adult	83,356
	SUD – IMD - ABD	77
1	ABD - Non-Medicare - Child	25,413
1, 4*, 5*	ABD – Dual	256,263
	SUD – IMD – ABD Dual	78
2	ANFC - Non-Medicare - Adult	143,558
	SUD – IMD - ANFC	187
2	ANFC - Non-Medicare - Child	722,239
	Medicaid Expansion	
7	Global RX	79,575
8	Global RX	46,863
6	Moderate Needs	2,660
	New Adults	
3	New Adult without child	471,388

	SUD – IMD New Adult w/o child	**791**
3	New Adult with child	**223,874**
	SUD – IMD New Adult with child	**115**
	Total All	**2,056,437**
* Long Term Care Group	**Total CY 2018**	
4 only	ABD Long Term Care Highest Need	**34,607**
5 only	ABD Long Term Care High Need	**13,986**

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 10:00am – 12:00pm on Monday, February 26, 2018. This forum was conducted in accordance with Special Terms & Condition 44 of the Global Commitment to Health 1115 Demonstration waiver. Public comments were solicited, but it was primarily a discussion about how the proposed substance use disorder (SUD) demonstration amendment submitted by the State relates to the existing 1115 demonstration waiver. There were no substantive comments on the current 1115 Global Commitment Demonstration.

The 2019 post award forum was held on February 25, 2019. Further information will be included in the first quarter report for 2019 as well as the 2019 Annual Report pursuant to 42 CFR 431.420(c) and item 44 under the STCs of this Global Commitment waiver.

iii.   Vermont Health Connect

Key updates:
- By end of 2018, nearly 208,000 Vermonters were covered by either a qualified health plan (QHP) or Medicaid for Children and Adults (MCA), down about 4,000 from the prior year. The declining enrollment was accompanied by a strong economy and low jobless rate, as well as by an increasing proportion of Vermonters turning 65 and enrolling in Medicare.
- Vermont Health Connect's sixth open enrollment period launched successfully on November 1, 2018. In October 2018, 99.3% of eligible QHP renewals were handled through a single, clean automated process (up from 97.8% the prior year and 91.5% two years prior).
- Vermonters used the online Plan Comparison Tool more than 38,000 times between October 15th and December 15th, a 62% increase over the previous year.

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. Data show that the exchange has combined with other efforts in the state to increase Vermont's health coverage and improve health access.

The Vermont Household Health Insurance Survey (VHHIS), published in December 2018, reported that Vermont cut its uninsured rate by more than half from 2012 to 2018, resulting in a 3.2% rate or fewer than 20,000 uninsured Vermonters. This result marks the lowest rate and lowest number of uninsured Vermonters of any VHHIS since it was first fielded in 2000.

As of December 2018, nearly 208,000 Vermonters were covered by a VHC health plan, either a qualified health plan (QHP) or Medicaid for Children and Adults (MCA). QHP enrollment included 31,922 as individuals (25,739 enrolled through VHC and 6,183 direct-enrolled through an insurance carrier) and

44,670 direct-enrolled through a small business employer, as reported by VHC's carrier partners. MCA enrollment (including CHIP) included 67,237 adults and 63,886 children (December 2018 enrollment as evaluated in January 2019), a drop of nearly 2,500 adults and 500 children relative to the prior year. The declining enrollment was accompanied by a strong economy and low jobless rate, as well as by an increasing proportion of Vermonters turning 65 and enrolling in Medicare.

In seeking to protect the most vulnerable, Vermont has been particularly successful when it comes to engaging and enrolling the lowest income Vermonters. The 2018 VHHIS shows that the lowest income Vermonters (under 139% of federal poverty level) were at least as likely to have coverage as any other income group. In 2008, one in eight (13%) of the lowest income Vermonters were uninsured; in 2018, one in 50 (2%) were uninsured. From 2014 to 2018, the uninsured rate for this group fell more than the rate for any income group, an achievement that stands out even more considering the State resumed annual Medicaid redeterminations in 2016 and has done a better job in ensuring Vermonters do not continue to receive Medicaid when they become ineligible. In fact, the number of Vermonters who were uninsured because they "lost eligibility/not eligible for state health insurance" increased from 4,900 in 2014 to 6,700 in 2018, while the number who said they were uninsured for any other reason (i.e., affordability, job loss, employer stopped offering insurance) all fell over the same period.

Of those uninsured Vermonters who reported the length of time they haven't had insurance, more than half said they had coverage at some point in the last twelve months and nearly two-thirds said within the last two years. Recent reports from the U.S. Census, National Center for Health Statistics, and the State Health Access Data Assistance Center (SHADAC) have also highlighted Vermont for having one of the lowest overall uninsured rates in the country as well as the lowest childhood uninsured rate in the nation.

Medicaid Renewals

Annual Medicaid redeterminations are an important piece of DVHA's work to ensure that beneficiaries maintain eligibility for the programs in which they are enrolled. Redeterminations for Medicaid for Children and Adults (MCA) continued their normal cycle throughout 2018. The auto-renewal process, known as "ex parte," consistently confirmed the continuing eligibility of more than 40% of renewing beneficiaries each month. As a result, fewer than 60% of beneficiaries were required to fill out a renewal application and provide documentation.

QHP Renewals

DVHA kicked off a series of meetings with its insurance carrier partners and the Health Care Advocate in early summer 2018 to prepare for the coming Open Enrollment system. The meetings focused on testing, business, and transactional planning activities. QHP renewals presented major challenges for the marketplace in its early years. The last three years have gone increasingly well as 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 involves determining eligibility for the coming year's state and federal subsidies and enrolling beneficiaries in new comparable versions of their health and/or dental plans. In October 2018, this step was operated with a single, clean, automated run that took care of 99.3% of eligible cases, up from 97.8% the prior year and 91.5% two years prior. The 0.7% failure rate meant that only 312 cases needed to be renewed by staff the following day; allowing all beneficiaries to have updated accounts and 2019 information before the start of Open Enrollment. This meant that they could log onto their online accounts on the first day of Open Enrollment, see their benefits and net premiums for the coming year, select a new plan if they wanted to do so. This year, due to changes in premiums and subsidies, DVHA strongly encourage beneficiaries to comparison shop rather than simply accepting their auto-renewal plan. Beneficiaries also had the option to call the Customer Support Center or meet with an

In-Person Assister and go through the same steps if they did not want or were unable to use the online option.

The second step involves sending these files to the payment and premium processor, Wex Health, and the insurance carriers to ensure appropriate billing and effectuation. In November 2018, this initial integration run was completed with 99% accuracy. DVHA and its partners collaborated to clean up and re-send the remaining cases well in advance of the new year.

The third step consists of a year-end business process that allows changes to be made on cases if the beneficiary reports changes in household or income information. In SFY 2018 this process ran with nearly a 100% success rate and all cases were ready to accept change requests in early January.

Altogether, performance on these three steps made the 2019 QHP renewal experience markedly different than the early years of the marketplace and left DVHA staff both optimistic and well-positioned to tackle other challenges.

Applying Online

Two years ago, DVHA set a goal for a continual 10% year-over-year increase in the adoption of self-service functionalities. Since that time, the actual growth in online applications has far exceeded the goal. The percentage of Vermonters applying for coverage online has more than tripled over the last two years, increasing from 16% of VHC applications in June 2016 to 51% in June 2018. The online option has the potential for improved customer experience as Vermonters can log in at their convenience. The increased automation can also allow state staff to spend less time processing applications and more time delivering on other priorities for Vermonters.

Change Requests

During the first few years of Vermont's health insurance marketplace, many beneficiary change requests took several weeks or months to complete. For 2018, DVHA set a target to complete 95% of requests within ten days and met this goal for beneficiaries managed in the Vermont Health Connect system. In fact, in the last quarter of 2018, 98% of requests were completed within ten days – an especially impressive accomplishment given that the remaining two percent include requests that are not allowed to be processed immediately (such as post-partum cases).

Integration and Reconciliation

DVHA set a goal of integrating enrollment files across its insurance carrier partners' systems with no more than a 1.5% error rate and achieved this goal in all 12 months of 2018. Ten months had error rates less than 1.0%. DVHA and its partners also acted quickly to resolve errors that did arise. DVHA's goal was to ensure that no more than one-twentieth of one percent of cases sat in error status for more than ten days. With more than 31,000 subscriber cases across the three carriers, that equated to an inventory of 15 or fewer errors open more than ten days. DVHA met this new target in 11 out of 12 months in 2018, finishing seven months with zero cases in error status for more than ten days.

DVHA also executed monthly reconciliation of the marketplace's enrollment systems in 2018. Multiple enrollment systems (Vermont Health Connect, payment processing vendor WEX, and the three insurance carriers) create the risk of discrepancies Medicaid and QHP members across systems. In 2018, DVHA set a target of addressing 100% of potential discrepancies each month and, starting in February, met the goal every month with Blue Cross Blue Shield of Vermont (BCBSVT) and Northeast Delta Dental (NEDD). In

June 2018, MVP Healthcare completed the system work needed to support the monthly reconciliation process that DVHA was already operating with BCBSVT and NEDD and operationalized it in the fall.

DVHA also honed its Medicaid reconciliation process in 2018. The reconciliation team cut the number of Medicaid cases with open discrepancies from more than 8,000 in April 2018 to fewer than 2,000 in July 2018, then consistently worked new discrepancies for the rest of the year. As of December 2018, there were fewer than 2,000 discrepancies and fewer than 150 that had been open for two months.

Customer Support Center

Callers to VHC's contracted Customer Support Center experienced prompt service throughout the first three quarters of calendar year 2018. Call volume for each of the first nine months was down from the corresponding month in 2017, likely due to both downward enrollment trends as well as improved operational performance. This low volume combined with ample spring and summer staffing levels at call center contractor Maximus to result in short wait times for callers. More than four out of five calls were answered within 24 seconds nearly every month. Maximus met its contracted service level agreements and earned a bonus during every month from February through October.

This experience changed in November 2018 as Maximus struggled to retain the staff needed to meet staffing level targets and was unable to hire enough new staff to keep up with attrition. Combined with DVHA's success in encouraging members to comparison shop and Open Enrollment's call volumes, the result was long waits and missed service levels in November and December. Per the contract, Maximus paid a penalty both months.

On the positive side, there was a decrease in the percentage of calls that Maximus needed to escalate to DVHA. Maximus only transferred 5% of December 2018 calls to DVHA's Eligibility and Enrollment staff, down from 6% in both the prior month (November 2018) and prior year (December 2017). This figure would have been even lower if its transfers were limited to calls that Maximus was unable to resolve. Instead DVHA took additional calls during high volume times in order to alleviate Vermonters' wait times.

DVHA worked closely with Maximus management to monitor performance and adopt a mitigation plan which included opening a satellite support center in Virginia and committing to maintain it until they can hire enough Vermont staff to meet contracted service level agreements.

DVHA's Tier 2 call center team maintained prompt service on escalated calls throughout 2018. In early 2017, DVHA set a goal of answering 90% of these escalated calls within five minutes. As of spring 2017, the team had never responded to more than 68% of these escalated calls within that timeframe. In 2018, they exceeded the target in all twelve months, never falling short of 94%.

In-person Assisters

DVHA continued to work with In-person Assisters throughout 2018 to ensure adequate training and prepare this group to assist with open enrollment and Medicaid redeterminations. DVHA ended 2018 with 279 DVHA-trained and certified Assisters working in hospitals, clinics, and community-based organizations in all of Vermont's 14 counties to help Vermonters enroll in health coverage through Vermont's health insurance marketplace.

Outreach & Education

DVHA uses advisory meetings, community and online events, media inquiries, social media, and other collaborative engagements with partners and stakeholders to educate Vermonters about the opportunities to apply for health benefits, how to compare plans, and how to get the most out of their health coverage. DVHA also values the input of Vermonters in the process of building its eligibility and enrollment systems, soliciting input through formal structures and informal interactions.

DVHA's educational work in advance of open enrollment focused on health insurance literacy and helping customers understand the total cost of insurance. VHC 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 VHC 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.

Due to significant shifts in QHP premiums and subsidies, DVHA strongly encouraged members to the Plan Comparison Tool and other resources to actively comparison shop in fall 2018 rather than electing to be automatically renewed into their previous health plan. Vermonters heeded the call, using the online Plan Comparison Tool more than 38,000 times between October 15th and December 15th, a 62% increase over the previous year. They also spent more time researching options, staying on the site 22% longer.

Future Development

To make it easier for Vermonters to submit pay stubs and other personal documents to verify their eligibility for marketplace benefits, along with other health care and economic services, the State's Integrated Eligibility & Enrollment (IE&E) Program designed a technical solution that utilizes mobile and online technology to submit documents. The tool also eases staff burden by automating the classification of documents. This solution will improve the efficiency of the eligibility determination process and result in better customer experience for Vermonters. A fall 2018 pilot found that the tool enabled 55% of pilot users to submit documents on the same day of their request, compared to 11% of non-pilot users. IE&E also found that the average time from document request to submission was nearly cut in half, from nine days to five. The Program aims to roll out the Uploader statewide in fall 2019.

IV.   Findings

i.   *External Quality Review*

> **Key updates:**
> - DVHA received a compliance score of 100% 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 Quality Improvement Manager (QIM) worked with the External Quality Review Organization (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. In addition to timelines, letters, tools, and reference documents were also developed for each activity. Once all documents were finalized and distributed, the EQRO initiated the Compliance Review, Performance Measure Validation, and Performance Improvement Project Validation activities. In addition, technical assistance calls with the EQRO and face-to-face meetings with DVHA were held to clarify elements contained in the PIP data collection tool, prepare for the Performance Measure Validation on-site review, and clarify the requirements for this year's compliance on-site review. As with all previous years, the three activities were conducted on time and in accordance with the work plans. Once the activities were completed, final reports were produced and shared with DVHA and AHS.

The following sections provide a brief overview of the EQRO activities that took place this year.

Monitoring Compliance with Standards

During this year, the onsite compliance review took place during July and focused on DVHA's compliance with the Managed Care performance requirements described in 42 CFR 438, as well as state-specific requirements contained in the AHS/DVHA Intergovernmental Agreement (IGA). This year's performance audit focused on the following standards:

- Practice Guidelines
- Quality Assessment and Improvement (QAPI) Program
- Health Information Systems

The audit resulted in a compliance score for these standards of 100%, an improvement from the previous score of 97% during the last cycle to cover these standards. While DVHA had no areas requiring corrective action, the auditors did make several recommendations to strengthen programs. DVHA is considering these recommendations and will implement every recommendation that can be reasonably implemented given current technology and human resources.

Performance Improvement Project Validation

The performance improvement documents were reviewed by the EQRO contractor via an off-site desk review. For this year's 2018–2019 validation, DVHA submitted an ongoing PIP topic: *Initiation of Alcohol and Other Drug Dependence Treatment.* DVHA continued the PIP this year; however, it modified the methodology and results to align with the updated HEDIS specifications for the measure. In this year's submission, DVHA submitted a new baseline result due to the change in HEDIS specifications for the measure.

The PIP topic continues to address 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. Beneficiaries receiving the appropriate care and services in the recommended time frames is essential to the recovery process.

DVHA completed the first eight steps of the PIP Summary Form with the reporting of new baseline data. Overall, 100% of all applicable evaluation elements received a score of *Met*. DVHA has demonstrated a thorough application of the Design stage (Steps I through VI), documenting the methodology for the PIP in alignment with the HEDIS specifications. DVHA provided a new baseline result for the PIP that aligns with the updated HEDIS specifications. This will ensure that baseline to remeasurement comparisons are valid. In next year's PIP submission, DVHA should include a first remeasurement result and compare it

to the baseline. DVHA and the EQRO auditor will assess whether a change from baseline to the first remeasurement is statistically significant. Statistically significant improvement from baseline to a subsequent measurement period indicates real improvement in outcomes.

<u>Performance Measure Validation</u>

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 demonstrate a commitment to providing high-quality services to its beneficiaries through various outreach programs; DVHA maintained a strong relationship with its vendor, DXC, to assist in processing claims, enrollment, and data integration services; DVHA also maintained a high level of oversight over DXC to ensure all systems are meeting service level requirements; and DVHA continued to focus on performance measurement improvement through benchmarking rates and systemic areas. Areas for improvement were as follows: DVHA had an acceptable medical record completion rate; however, the EQRO auditor recommends that DVHA strive to improve this rate by at least 5 to 10 percent. Increasing the completion rate by this amount could improve numerator compliance significantly; the EQRO auditor continued to recommend that DVHA work with laboratory (lab) vendors to ensure capture of lab claims and results. This will enhance rates that use lab values for numerator compliance.

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 met all CMS Quality Measure Set reporting deadlines in 2018, including for the Health Home, Medicaid Adult and Child quality measures. The Quality Unit spearheaded the planning for eventual mandatory reporting of various core set measures by exploring hybrid measure production options with the HEDIS vendor and by starting conversations with CMS and other states about reporting through DVHA's clinical registry.

The DVHA Quality Improvement (QI) and Clinical Integrity Unit monitors, evaluates and improves the quality of care to Vermont Medicaid beneficiaries through the use of performance and utilization management frameworks. The Unit makes data-driven decisions about beneficiaries' care and improvement projects through measuring and monitoring efforts. Efforts are aligned across the Agency of Human Services (AHS) as well as with community providers. The unit is responsible for instilling the principles of quality management 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.

PIHP Quality Committee

The Quality Committee remained active throughout 2018 and consists of representatives from all departments within AHS 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 this committee work with the Managed Care Medical Committee in 2019 to update the measure targets.

Additionally, the committee reviewed the annual Child and Adult CAHPS surveys, a grievances and appeals summary, confidentiality procedures, included HIPAA breach tracking and updated the PIHP Quality Management Plan.

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 Applied Behavior Analysis Guidelines and updated Diabetes guidelines were adopted. The group also approved the Developmental Surveillance and Screening Guidelines and Preferred Tool List. The MCMC worked with the Quality committee to identify 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. The team is currently reviewing the charter and defining its purpose.

Formal CMS Performance Improvement Project (PIP)

In 2018 the Quality Unit continued to coordinate VT Medicaid's formal CMS Performance Improvement Project (PIP) – the topic of which is substance use treatment. The Unit is re-setting the baseline year for the PIP since the specifications changed significantly for the study measure (HEDIS IET initiation rate). The team was focused on a multi-pronged telehealth-related intervention during 2018. Targeted communications about telehealth were periodically dispersed via banners in the fall and winter. The team also prepared and implemented:

- A provider advisory article for November 2018,
- a telemedicine handout that is used during provider/association outreach visits,
- presentations to local stakeholder groups, and
- the build out of a section on the DVHA website to hold these telemedicine resources and links.

The team plans to sustain the above activities and add:
- targeted emails to SUD treatment providers,
- a presentation to the Clinical Utilization Review Board (CURB), and
- telehealth information/resources for beneficiaries.

In 2018, data was collected on telehealth use as a way to monitor progress. Data points included: number of telehealth claims, number of unduplicated providers billing for telehealth, and number of unduplicated beneficiaries receiving telehealth services. There was an increase in all metrics from the baseline of Q2 SFY2018.

Informal Quality Improvement Projects

The Quality Unit staff are taking the lead on two informal quality improvement projects. The topics are chlamydia screening (CHL) and adults' access to ambulatory/preventive services (AAP). These topics were selected after annual review of program performance by the Quality Committee, MCMC, and the CURB. Project charters and work plans are complete and project teams are active.

- CHL Screening Quality Improvement Project: The project team includes DVHA Quality Unit, Data Unit & Blueprint staff as well as VDH staff from Maternal and Child Health and Health Surveillance Divisions. During 2018 the team planned a learning collaborative offered through the Blueprint's Women's Health Initiative. The collaborative will include 6 monthly webinars, running from April-September 2019.

- AAP Adults' Access to Ambulatory/Preventative Services Project: The project team includes DVHA Quality Unit, Clinical, Data, Vermont Chronic Care Initiative (VCCI) and Provider & Member Relations (PMR) staff. During 2018 the team performed additional data analysis and planned a banner release related to medical record transfers (an activity that can increase the wait time for appointment scheduling). The team is also investigating the pediatric to adult care transition.

Quality Measure Reporting

- CMS Medicaid Quality Core Sets - The Quality Unit and the Data Unit prepared and submitted the Adult and Child Quality Core Set reports by the deadline of 01/11/2019. The Quality Unit also reached out to CMS during 2018 to learn more about the possibility of reporting core measures through the clinical registry.

- Also during 2018 and early 2019, the Quality Unit staff collaborated with the Blueprint for Health and submitted the Health Home Core measure set.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit's QI Administrator coordinated the 2018 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children's and Adults Medicaid 5.0H 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 2019 and will be presented by the QI Administrator to the PIHP Quality Committee and DVHA's Senior Leadership Team in March 2019. 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 measure production – In 2018, the Quality Unit staff worked with the Business Office, Payment Reform Unit and Data Unit to extend and amend the contract with Verscend/Cotiviti, the HEDIS measure production vendor. In addition to producing administrative (claims based) measures, the Quality Unit began preparing for the HEDIS 2019 season by requested that Cotiviti perform medical record retrieval for three hybrid measures and abstraction for one of those measures. The Quality Unit clinicians will abstract for two measures. The Quality Assurance Manager coordinates the internal hybrid measure production process.

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. Additional scorecards actively under development or maintenance in 2018 were related to the Applied Behavior Analysis (ABA) benefit, the Adult and Child Medicaid Quality Core Measure Sets, Payment Reform Models, Global Commitment/Delivery System Reform 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 maintained their Green Belt status during 2018. Green Belt is the highest level of internal training offered through the State based on LEAN/RBA principles. 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

Throughout 2018 (Year 2 of the DVHA/VMNG ACO contract) 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 2018 with a focus on quality measurement and ongoing QI efforts.

AHS Performance Accountability Committee

During this year, the AHS Performance Accountability Committee (PAC) discussed the Health in All Policies Task Force. The Health in All Policies Task Force is a cabinet-level body established by Executive Order No. 7-15 to identify how agency policies, programs and budgets can improve the health of Vermonters, especially vulnerable populations. Members of the Task Force are looking at the practices within their agencies and working to coordinate across agencies around issues of healthy communities. The Task Force developed a Health and Equity Framework for creating economically and socially vibrant communities that build upon the shared values of equity, access and affordability. The framework identified potential areas of impact and domains for measuring successes. The Task Force is developing a shared Dashboard to demonstrate the successes and track the work of various partners in contributing to health and equity.

Also during this year, the PAC reviewed the current GC Investment and Payment Model scorecards that are used to communicate the performance of programs/services that use GC investment funding as well as payment models. Group discussions centered on the use of the Clear Impact Scorecard and how it might be modified to address the GC investment and payment model reporting needs.

The group also discussed the new Data Governance Initiative being undertaken at AHS. During the first quarter, the group attended a presentation to orient themselves to the Data Governance activities to date. Topics covered were purpose, timeline, activities, and scope. The group reviewed the DG Manual and DGC Charter. The group also recommended how performance measures could be used to assess the performance of the initiative as well as the implementation of individual policies. 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 DG activities.

During this year, the group also discussed community profiles. The Community Profiles tool is a way to visualize and track important indicators that serve to represent the well-being of all Vermonters across the state. The new Community Profiles project consists of three profiles highlighting important areas of

community well-being which the Agency of Human Services is trying to improve. Each profile contains different population-level indicators showing how Vermonters overall, and members of smaller populations within specific geographic areas, are doing regarding economic opportunity, equitable access, and resilient communities. Each profile is available for viewing at 3 different levels of sub-geography: County, AHS District Office (DO), and Hospital Service Area (HSA). You can compare trends over time, by geography, and in relation to state averages.

Finally, during 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

During this year, each department submitted financial monitoring data to AHS and evaluative data that highlights the performance of a subset of their investments following an agreed upon schedule. Evaluative data was reported using a Clear Impact GC Investment Scorecards and included the following data elements: 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). Monitoring and evaluation of investments will continue following a periodic schedule. All departments will continue to highlight the performance of at least one of their investments in the quarterly/annual progress reports.

During this most recent quarter, DVHA highlighted the performance of two of its investments related to the Medicaid ACO. 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 an updated milestone template to CMS for review. The new version was created using the Proposed VT HCBS Milestone Template that was created by CMS and the May 9, 2018 version of Vermont's STP. The updated document was accepted, and corresponding changes were made to Vermont's HCBS Milestone section of the HCBS STP website. Also, during this year, the HCBS Implementation team continued to work on completing the site-specific assessment (including validation activities). The Department of Disabilities, Aging, and Independent Living (DAIL) and the Department of Mental Health (DMH) continued to send surveys and messages to all program directors responsible for each of the specific settings that provide home and community-based services. Reminder emails and phone follow up continued to be conducted in order to enhance response rates. The team will continue to monitor program response rates and adjust their actions accordingly. The group anticipates this work being finished by Q3 2019. Once this work is done, aggregate results for all setting will be incorporated into the final version of the STP and released for public comment.

Also, during this year, members of the implementation team attended CMS training for settings implementation. The training series assists state representatives with developing and implementing the Statewide Transition Plan (STP) necessary to achieve final approval of the plan. The series comprises

modules covering specific elements of the plan required for final approval. These modules address the following key topics: site-specific assessments and validation, remediation, resolution of beneficiary concerns, ongoing monitoring, and heightened scrutiny. Each module reviews key components a state should address in the STP for each element, includes strategies employed by a variety of states, and concludes with a series of review questions and tools a state can voluntarily use to manage strategy development and achieve final STP approval. The team has been able to leverage learning obtained from the trainings to support the development of the CQS/STP as well as implement the HCBS setting regulations.

Global Commitment (GC) Evaluation Activities (*including SUD*)

During this year, the AHS QIM continued to work with an independent evaluator to conduct the evaluation activities outlined in the evaluation design. To facilitate the process, a schedule was developed with the input of the various AHS departments.

In June of this past year, CMS approved an amendment to Vermont's Global Commitment to Health 1115 Demonstration waiver that authorizes the State to receive federal Medicaid funding for treatment services offered at inpatient facilities provided to Medicaid enrollees to treat addictions to opioids and other substances. In order to respond to the evaluation requirements of the SUD waiver, the GC evaluation contract was amended to extend the end date of the contract to October 31, 2022 to accommodate post-implementation evaluation requirements and adds payment provisions and their associated dollar amounts for years 3 – 5 of the waiver evaluations; including post-implementation reporting to CMS. To comply with the new waiver Standard Terms and Conditions (STC #71) Vermont needed to amend the existing Global Commitment (GC) waiver evaluation design/plan to incorporate the new SUD components/requirements. Near the end of this past year, an updated GC evaluation design was submitted to CMS.

SUD Monitoring Protocol

During this year, the State worked with CMS to develop a SUD Monitoring Plan Protocol and Metrics Workbook. At a minimum, the SUD Monitoring Plan Protocol will include reporting relevant to each of the program implementation areas listed in STC 42. The protocol will also describe the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. In addition, the SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 49 of the demonstration. In addition, for each performance measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

As part of the Monitoring Report Template, a SUD Metrics Workbook was created. The name, description, and detail for all Vermont SUD metrics can be found in the Monitoring tab of the SUD Metrics Workbook, which is posted on the Department of Vermont Health Access website at this address: http://dvha.vermont.gov/global-commitment-to-health/global-commitment-to-health-1115-waiver-2018-documents
Vermont plans to report all twenty-four CMS required metrics as well as three state-identified Health IT metrics.

Vermont plans to report the narrative information requested in the SUD Monitoring Report Template as part of the comprehensive Global Commitment to Health 1115 demonstration quarterly and annual

reports. The SUD-related metrics workbook will be submitted along with future quarterly and annual progress reports, but as a separate file.

iii.   Provider and Member Relations

Key updates:
- MMIS Provider Management Module project continues, with a planned implementation date of 3/29/2019.
- Primary Care Timely Access Survey
- Durable Medical Equipment (DME)

The Provider and Member Relations (PMR) Unit ensures beneficiaries have access to appropriate health care for their medical, dental, and mental health needs. The PMR 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 42 CFR §455.410 and §455.450 requiring that all participating providers be screened upon initial enrollment and revalidation of enrollment.

The PMR Unit also collaborates with GMC's Customer Support Center to better address and assess GMC member issues and needs.

MMIS Provider Management Module

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 PMM project is also a high priority legislative initiative aimed to reduce the timeframe to enroll Medicaid providers, passed in 2018 as Act 116. Implementation is planned by 3/29/2019 and a reduction in the timeframe for provider enrollment is anticipated to go from an average of 120 days to below 45 days.

The Provider Management Module from DXC allows providers to register themselves through a web portal and maintain their information. It also supports the State of Vermont Provider Management organization with an automated workflow for certifying and re-certifying the provider enrollment status.

Primary Care Timely Access Survey

The PMR Unit conducted its annual survey of Primary Care Providers (PCPs) timely access standards in accordance with 42 CFR §438.206. The PMR Unit, in collaboration with DVHA's Data Unit, sampled PCPs who had a patient roster of at least 25 unique individuals and who had treated those individuals for a minimum of two years. From this sample, an 80% random sample was surveyed. The total number of surveys mailed to providers was 353, and the surveys were mailed on June 1, 2018.

PCPs had the choice to either complete the paper survey and return it via fax or access the survey via Survey Monkey. PCPs were instructed to complete the survey no later than June 15, 2018. Survey participation is not required but is used as a tool to gauge PCP availability, after hours answering service and/or instruction, waiting room time, appointment scheduling time, and access to emergency/urgent care when primary care is not available.

The PMR Unit received 69 total responses, demonstrating a 19.5% return rate. 100% demonstrated that PCPs were operating within the timely access standards cited within 42 CFR §438.206. The survey will

again be used as proof during audits (most specifically, the External Quality Review Organization audit (EQRO)) to demonstrate that DVHA monitors timely access standards within a primary care setting. This data is also shared with DVHAs Quality Improvement (QI) Unit.

<u>Fee-for-Service Payments for Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Reimbursement Update</u>

The Department of Vermont Health Access (DVHA) changed the methodology and rates paid to suppliers of Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) for dates of service on or after July 1, 2018 for certain Medicare categories of service. These changes were made in an effort to improve access to medical equipment for Vermont Medicaid beneficiaries and in response to public comments received in GCR 17-091. These rates are provisional until the January 1, 2019 fee schedule update. Further information can be found in the public notice for this change, GCR 18-075.

V.   Cost Containment Initiatives

 i.   *Vermont Chronic Care Initiative (VCCI)*

Key updates:
- Alignment of VCCI with state health care reform and ACO.
- Population enhancement to include needs-based eligibility; dually insured and new to Medicaid.
- VCCI and OneCare Vermont collaboration on transitions of 2019 ACO attribute cases.
- Full VCCI Team trained in complex care model delivery of services.
- Hospital service utilization for members enrolled during 2017 demonstrates decrease one-year post enrollment of inpatient, emergency department, and on 30-day readmissions.
- The AHS MMIS Enterprise Care Management System has been live for the VCCI for 3 years. The focus this past year was on system acceptance toward CMS certification.
- A contract for an interface with Vermont Information Technology Leaders (VITL) has been completed.

The VCCI is a statewide Medicaid case management service for Medicaid beneficiaries. VCCI is comprised of licensed, field-based case managers and 2 non-licensed professional staff who operate in a decentralized VCCI model statewide, providing case management resources at the community level. Facilitation of access to clinically appropriate health care information and services; coordination of the efficient delivery of health care by attempting to remove barriers, bridge gaps, and avoid duplication of services; and education and empowering beneficiaries to eventually self-manage their chronic conditions are longstanding goals. Historically, VCCI has provided intensive, short term case management services to those who were predicted to be high cost/high risk. This was premised on reports highlighting that the top 5% of Medicaid beneficiaries accounted for ~39% of Medicaid expenditures. The emergence of the Accountable Care Organization (ACO) and a subsequent increase in the number of attributed lives to the Vermont Next Generation Medicaid ACO prompted the review of how and who VCCI would deliver case management services to, as ACO attributed beneficiaries are not eligible to receive VCCI services.

As part of an effort toward improved alignment with health reform and the system of care, VCCI implemented the following strategies:

1) Enhancement of the VCCI eligible population to include beneficiaries new to Medicaid, with case managers completing telephonic outreach, completing a screening tool that screens for access to primary care, health conditions and risky behaviors, and social determinants of health. The goals are to 1) orient the beneficiary to the system of care, including navigating services for health-related needs such as housing/food security and facilitating connections to local domestic violence resources, and 2) onboard beneficiaries ahead of their anticipated ACO attribution to facilitate access to primary care and connect to community resources, including self-management programs. Beneficiaries' responses to screening questions coupled with the clinical judgment of VCCI case managers allows stratification into 1 of 4 risk levels – mirroring the ACO's framework.

Figure 1. VCCI Screening & Stratification Diagram
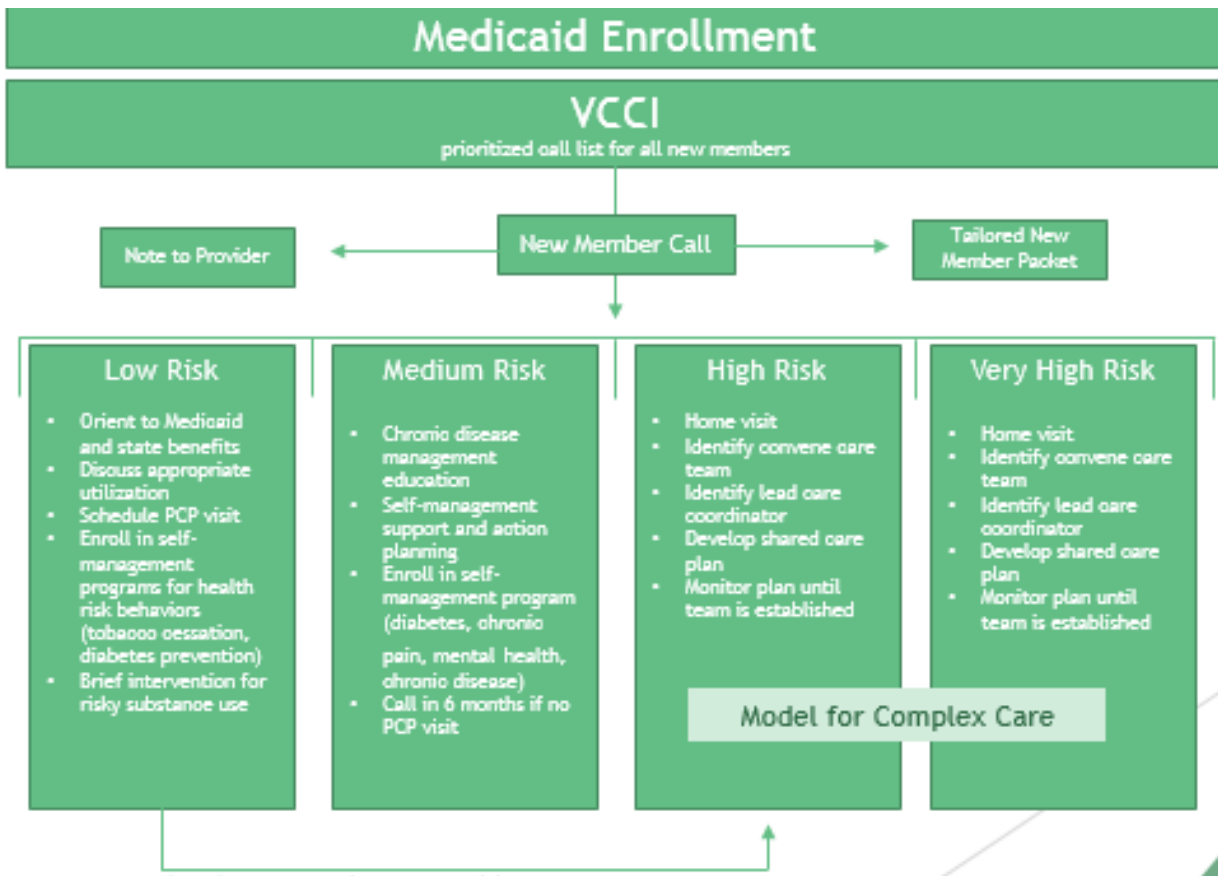
Other enhancements to the VCCI eligible population include supplementing the traditional population with needs-based referrals from health care and community partners who have identified beneficiaries in need of complex care management, including dually insured individuals.

2) VCCI underwent formal adoption of the complex care model and subsequent training of all VCCI field case managers. Tools and processes include the identification of a lead care coordinator, development of care teams, and the facilitation of shared care plans utilizing the same shared plan template as ACO partners. This is in tandem with local community teams who are also adopting this model of care and have been or will be trained in the service delivery approach.

In the fall of 2018, the DVHA Payment Reform unit was able to provide VCCI with a preliminary list of 2019 ACO attributed beneficiaries so that the case management team could ensure appropriate coordination with community care teams ahead of the 'transfer' of the case from VCCI to community prior to January 2019. The information shared included the developed shared care plan and the beneficiary identified lead care coordinator or recommendations on potential for lead care coordinator if

needed. VCCI field case managers worked with their community partners on this process with the goal of ensuring continuity of care for beneficiaries.

The VCCI approaches case management from the lens that a holistic model of service delivery to encompass both health and health related issues helps to support likelihood of sustained health improvement and overall quality of life. Assessment of the presence of social determinants of health occurs early in VCCI's outreach and work, followed by appropriate referrals and navigation to services. In addition to the experience out in the field, VCCI case managers easily navigate the web of various state services available to Vermonters. Over this upcoming year, VCCI will work with community partners to transfer this knowledge and provide support as needed so that navigational assistance for beneficiaries will be seamless.

Available data demonstrated continued reduction in hospital service utilization among beneficiaries referred to VCCI with recent data showing sustained change.

Figure 2. Change in Utilization 1 Year Before & After VCCI Enrollment/Referral

VCCI Referred 2017
% Change in Utilization 1 Yr Before and After Enrollment/Referral

Not Enrolled, 29 % Increase
Not Enrolled, 8 % Increase
Not Enrolled, 8 % Increase
Enrolled, 33 % Decrease
Enrolled, 19 % Decrease
Enrolled, 30 % Decrease

Inpatient Hospitilizations   ED Visits   30 Day Readmissions

Data Source: EQ-Health Solutions: VCCI Cost Savings Summary 12/03/2018
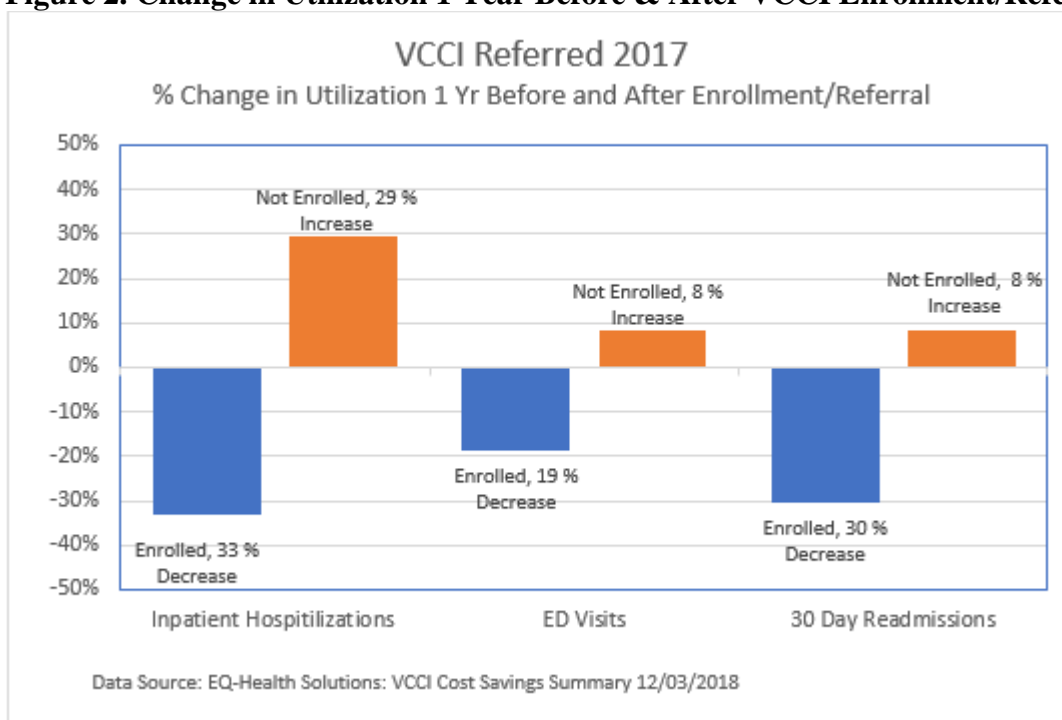
This past year marks the 3rd year that the VCCI team has been functional in the eQHealth care management system. Efforts this quarter have focused on system acceptance work and certification and review of the Maintenance and Operations manual. Work has been slowed down due to System Acceptance Schedule and ongoing discussion on fixes needed for deployment into the production environment. Certification Evidence Packages (CEP) were created by eQHealth and reviewed by the VCCI Program Consultant and Functional lead.

eQHealth supported the VCCI's program evolution and population enhancement by way of:
- Loading new letters specific to the New to Medicaid project
- Reconfiguring eligibility rules to allow dually insured cohort

Continued development and design include but is not limited to: ongoing development of the user interface for the VITL data; ADT messaging through VITL; and continued work on the single sign-on for VITL within the eQ Suite with initial testing beginning this quarter and anticipated to continue through

beginning of next quarter. There has been some delay due to vendor resource limitations, as well as the ADT messaging coming over with missing data. All VCCI staff have been trained in VITL access (outside of eQHealth) in order to view patient information, as appropriate, to help better inform the case management plan and will have subsequent training in 2019. Initial development of gap-in-care functionality with initial testing occurred. Through testing, it was learned that not all the gap-in-care data elements/codes match the codes that DVHA uses. Once implemented, the gap-in-care feature will help to support population health data and analysis.

ii.   *Behavioral Health Services*

Key updates:
- Applied Behavior Analysis
- Pilot Project
- Team Care program revitalized

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric and detoxification services for Medicaid primary beneficiaries. Team members work closely with discharge planners at inpatient facilities to ensure timely and appropriate discharge plans. DVHA collaborates with other departments to support coordination of care. In 2018, the team worked with VCCI staff to develop a referral process for VCCI services and to ensure continuity of care for beneficiaries 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 beneficiaries 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 beneficiary admitted. The team is closely monitoring trends to ensure appropriate utilization.

The Behavioral Health Team also manages the Team Care 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 have been operationalized by the team. A new procedure for inclusion, screening tool, and manual have been developed. Team Care program beneficiaries are also referred to VCCI when appropriate. Outreach with providers and pharmacies is ongoing. There have been minimal referrals to 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). Team members are active in ensuring that beneficiaries with multi-department involvement are getting appropriate services delivered in the most efficient manner. This is accomplished through participation in state interagency team meetings, weekly case review, and development of protocols for cross departmental service delivery.

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 surveys consumers to gain feedback of the effectiveness of ABA treatment for the beneficiaries receiving the service. Additionally, the Autism Specialist 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 beneficiaries receiving ABA services, as well as an increase in enrollment of ABA providers (BCBAs). There continues to be ongoing discussions at DVHA regarding alternative payment options for ABA that would continue to support beneficiaries and providers, as well as attract new ABA providers to serve beneficiaries. A new tiered payment model has been developed and the team is providing education and guidance to providers and beneficiaries. 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 beneficiaries. Future visits are being scheduled, and it is a goal for this to become a regular practice to further quality assurance at 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 Guidelines have been revised and are available to providers. Currently, the Autism Specialist is conducting research for expansion of the benefit beyond diagnosis of Autism Spectrum Disorder (ASD) exclusively, 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](#)- Evaluation of the Overarching Structure for the Delivery of Mental Health Services
- The Department of Mental Health implements payment reform for its Child and Adult Mental Health programming.
- Integrating Family Services Updates

The Department of Mental Health (DMH) 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.

DMH 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 DMH:

Hospital Services
- There are a total of 201 adult psychiatric inpatient beds across the system of care, of which 45 beds are level 1.
- The Designation of White River Junction VA Medical Center added 10 adult inpatient beds to the system of care at last report. As of December 2018, the VA Medical Center increased to 12 psychiatric inpatient beds and continues to allocate two to three beds for involuntary care for Veterans.
- Act 190 (2018) provided $5.5 million dollars for the development of 12 inpatient Level I beds at the Brattleboro Retreat. A construction agreement was completed between the Retreat and DMH of Buildings and General Services (BGS) in December 2018. This additional inpatient bed capacity is currently anticipated to come online in early 2020.

Adult inpatient bed occupancy has decreased slightly in 2018 but is not suggesting a decreasing need for inpatient capacity given the small percentage fluctuation. During FY 2018, involuntary inpatient lengths of stays was relatively unchanged. Readmission rates were also unchanged, a trend that remains below the national readmission rate trends. Additionally, more adults were being referred to involuntary inpatient care than in previous years.

DMH also compares the utilization of its system of care to national benchmarks. The following two charts provide information on Vermont utilization as compared to national benchmarks. Data from these two charts are calculated by the Substance Abuse and Mental Health Services Administration's (SAMSHA) Uniform Reporting System (URS), which generates the National Outcomes Measures (NOMs). FY 2017 is the most recent data available.

Figure 3. State Hospital Utilization per 1,000 people (in Vermont and the United States)
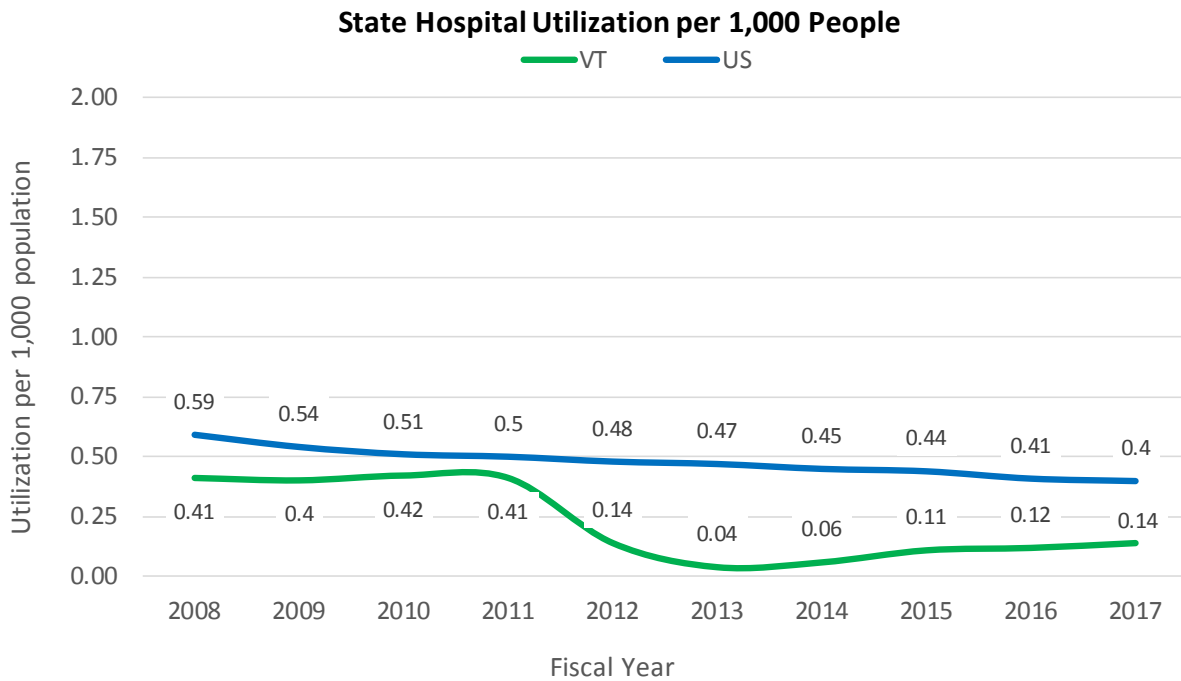
State Hospital Utilization per 1,000 People

Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2017.

The national rate of state hospital utilization continues to decline year-over-year. Vermont Psychiatric Care Hospital opened in FY 2015 with 25 beds and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents the closure of Vermont State Hospital due to flooding from Tropical Storm Irene in August 2011. The Vermont hospital utilization data is showing a slowly progressing upward trend since 2012. Vermont is one of a handful of states that only has one state hospital. Nationally, the number of state hospital beds and residents at the end of the year has been steadily decreasing.

Figure 4. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)
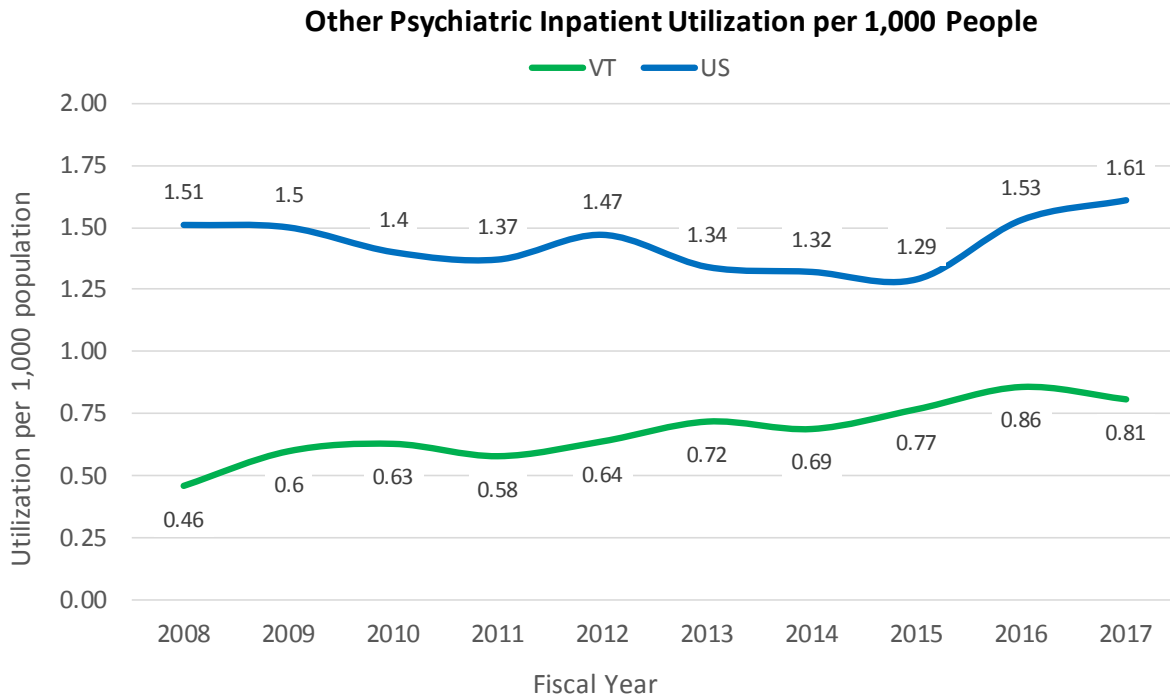
Other Psychiatric Inpatient Utilization per 1,000 People

Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2017.

Other involuntary psychiatric hospital unit admissions, such as those at Designated Hospitals, are included in chart above. The national rate of psychiatric hospital utilization since 2008 has generally declined year-over year through 2016 while Vermont's rate of utilization has increased. However, in both 2017 and 2018 there have been substantial increases in national utilization of psychiatric hospital beds. Vermont experienced a slight decline in 2017. Inpatient utilization is still below the national averages while rates of community services utilization in Vermont continues to be markedly higher than national averages (*Community Utilization per 1,000 Populations*).

Figure 5. Adult Inpatient Utilization and Bed Closures

Adult Inpatient Bed Utilization
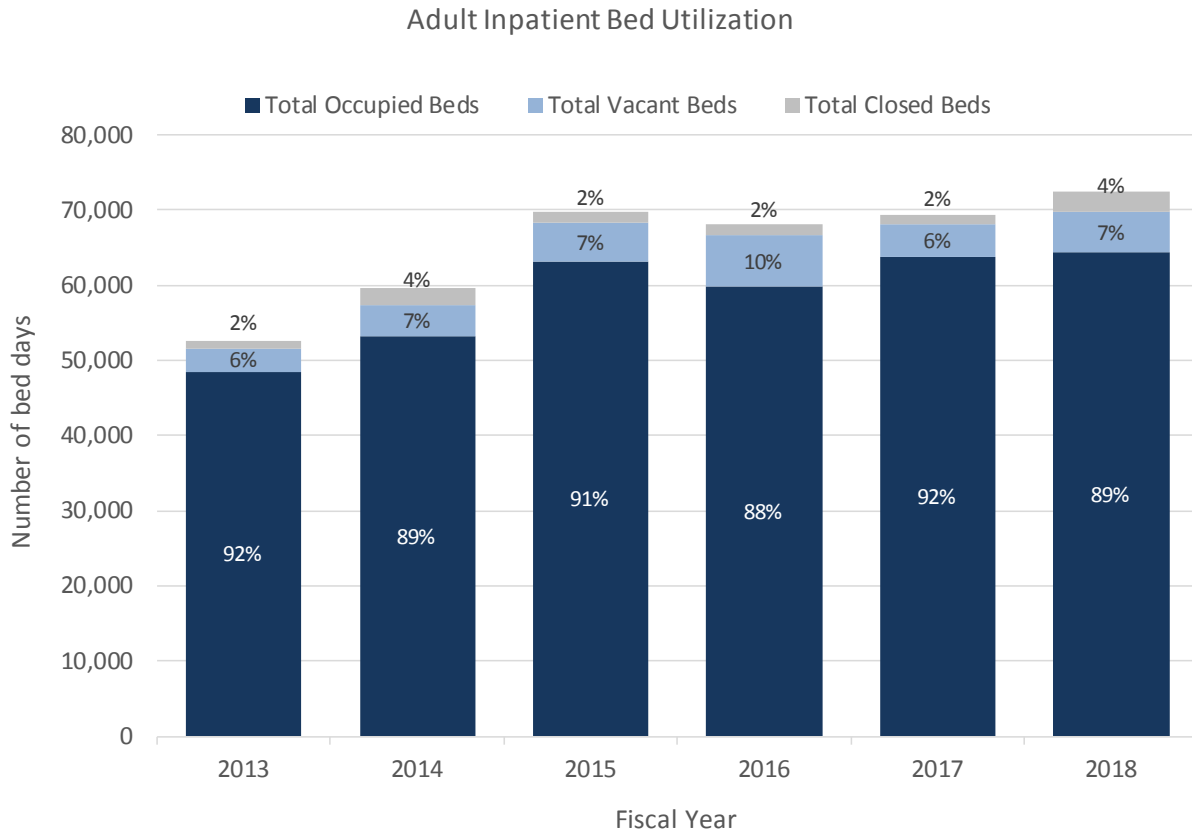
This chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2018. The total bed day availability across the system has remained relatively constant in 2018 with only two additional beds added at the Write River Junction VA Medical Center. On average and in the most recent three years, approximately 2% of all available bed days were closed during each fiscal year. In 2018, bed day closures rose to approximately 4% throughout the system which may be due to room repairs, staffing, unit acuity, patient safety and care, or other causes. DMH, in concert with the Designated Hospitals, works to maintain the maximum compliment of beds and utilization of these beds through the bed board system.

Community Services

This past year, Act 11 (2018) provided an increase of $4.3 million to DA workforce targeting direct care staff and supporting DA recruitment and retention efforts to maintain a professional workforce. The payment reform initiative beginning 1/1/2019 has also been an effort to reduce barriers to access and promote more "needs" driven service delivery that can be more responsive to individuals seeking mental health services. The new payment reform methodology, more flexible service delivery, and value-based incentive payment framework focused on quality and outcomes supports a more streamlined approach to adult program access and the service capacity available in each DA catchment area.

Figure 6. Designated Agency Volume by Program

DA Utilization by Primary Program
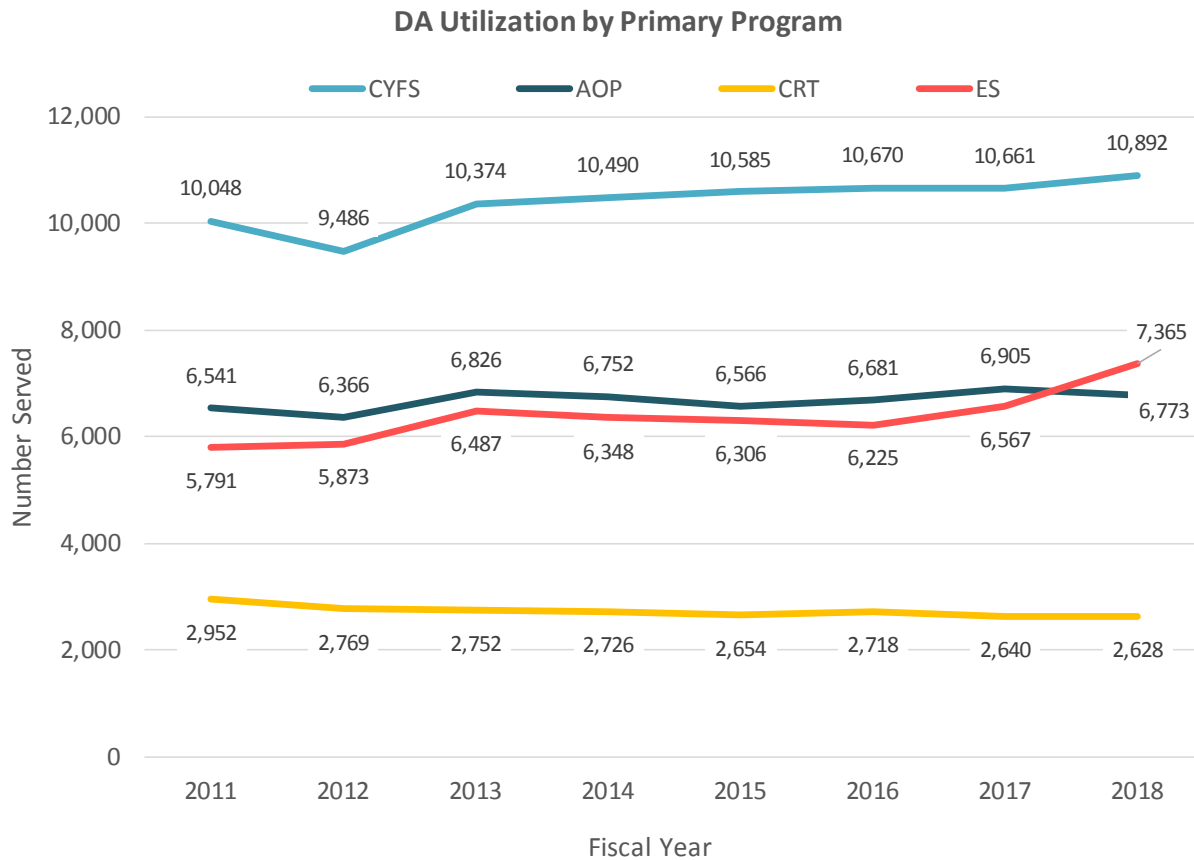
The highest number of persons served by a program offered by the Designated Agencies (DAs) continues to be in services for children, youth, and families. This program also reflects a slow upward trend over the most recent six fiscal years. The lowest numbers of persons served by a Designated Agency program continue to be those in the Community Rehabilitation and Treatment (CRT) programs. Adult Outpatient programs reveal a relatively stable trend over time. Between 2016 - 2018, Emergency Services programs have seen a slowly advancing upward trend for persons served by that program suggesting of a system that continues to be stressed in meeting urgent community mental health service demands. There is likely correlation between ongoing wait times for individuals in hospital emergency departments and the role of Emergency Services programs, which includes screening and follow-up for those awaiting inpatient hospitalization.

Figure 7. Community Utilization per 1,000 Populations
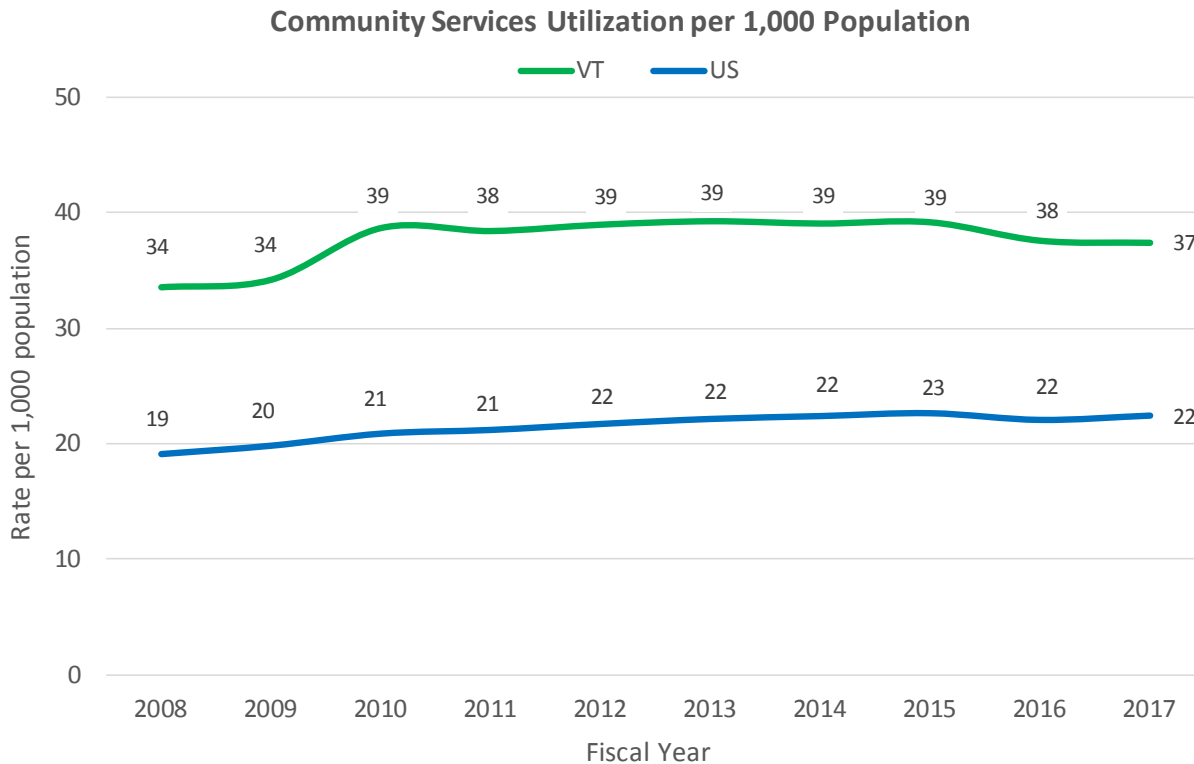
Community Services Utilization per 1,000 Population

Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2017.

The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national figure. These data show that Vermont has a strong and fairly consistent record of service delivery in community-based programs. While the progress appears to be static, data indicates that significantly higher rates of service are being provided to fewer numbers of clients who may otherwise have needed hospital levels of care.

The system of care is established on the principle that the intensity of services an individual requires will change over time. Individuals receive community-based treatment appropriate to their needs and move to higher or lower levels of care only as necessary to support them. For many who have a chronic illness this is more challenging, as they continuously require higher level of service needs within the system. For others, they enter and exit intermittently depending on their individual needs. The system must have the flexibility to meet the needs of the individuals and provide the necessary services.

Residential and Transitional Services

- DMH and other AHS agencies continue to work together to identify and develop permanent replacement capacity for the Secure Residential Recovery Program. The planning considerations of this collaborative work was outlined in the Act 84 AHS Major Facilities Report submitted in January 2018 to the Vermont House Committees on Appropriations, Corrections and Institutions, Health Care, and Human Services, and the Senate Committees on Appropriations, Health and Welfare and Institutions. To date, no funding has been allocated for either replacement or expansion of service capacity.

Figure 8. Intensive Residential Bed Utilization

Utilization of Intensive Residential Beds

Chart: Percent Occupancy (y-axis) vs. Fiscal Year (x-axis). Line labeled "Intensive Residentials." Data points: 2013: 93%, 2014: 91%, 2015: 93%, 2016: 86%, 2017: 87%, 2018: 91%.
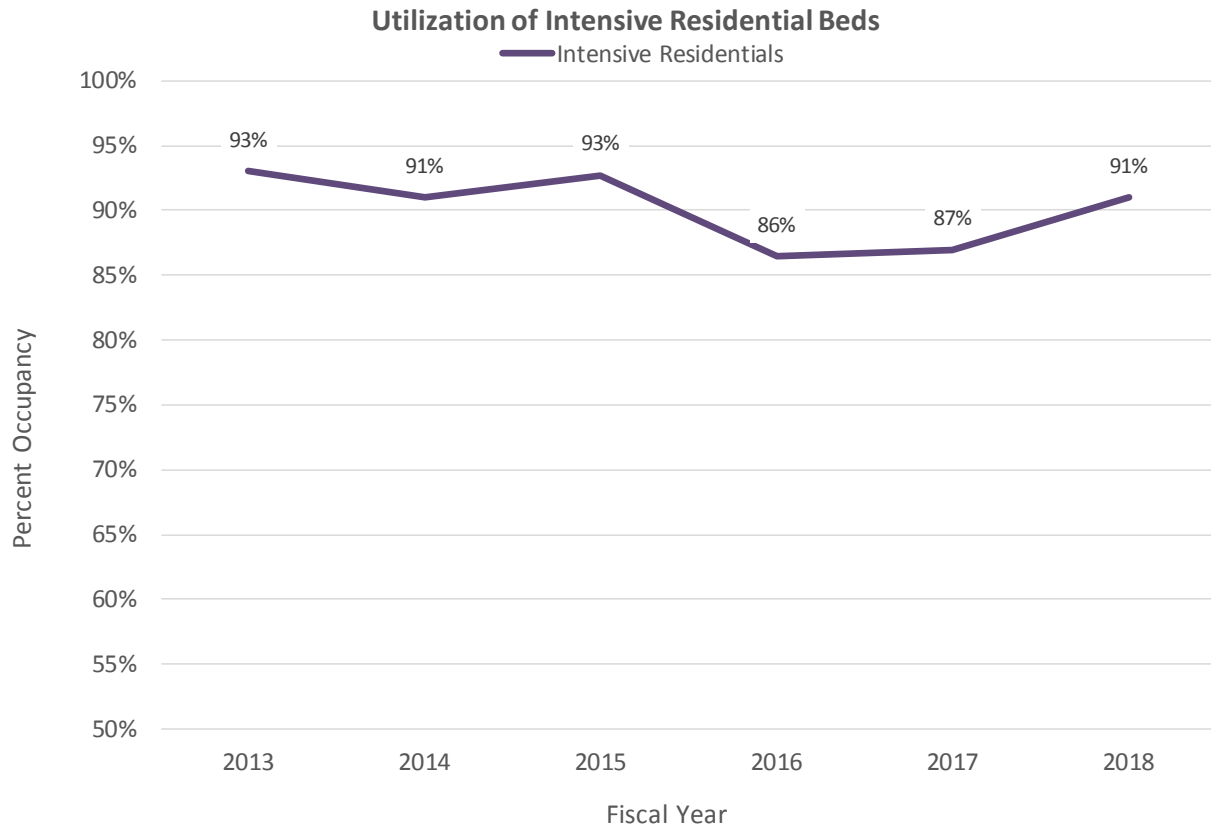
The Intensive Residential Recovery Programs (IRRs) are continuing to meet a key need for a significant number of individuals who are ready to leave higher levels of care, but who still require intensive supervision and support before taking steps toward independent living. The chart above illustrates the utilization of beds in these programs. FY 16 – FY 18 reflects a slow upward trend in utilization of IRR beds. There are seven programs in operation in Vermont. Soteria House opened in spring 2015, adding 5 beds. Maplewood opened in spring 2014, adding 4 beds for those needing a higher level of community care. Second Spring Westford and Middlesex Therapeutic Community Residence (MTCR) opened in February 2013. The programs provide both transitional and longer term supports, averaging residential program lengths of stay within a 12-18 month time frame for residents.

Performance and Reporting

- DMH has implemented the Results-Based Accountability (RBA) framework for assessing performance of providers via grants and contracts and in 2018 completed planning to implement a value-based payment model for a large portion of mental health programming through DMH.
- RBA examples:
    - "VPCH Outcomes" scorecard to meet legislative reporting requirements
    - "DMH Scorecard" using the RBA scorecard reporting tool

Regulation and Guidance

- 2018 updates to: Critical Incident Reporting Guidelines for Designated and Specialized Services Agencies, ECT informed Consent Package, ECT Standards to be Monitored 2018-2019, Minimum Standards Adult Mental Health Guidelines, Minimum Standards, Corrective Action Plan Guidelines, Out of Home Placement Procedural Guidelines, Restraints Use Policy for Involuntary Transport.

- Revision and consolidation of the DMH Fee-for-Service Medicaid, the CRT Provider, and the Enhanced Family Treatment Manuals into a comprehensive, coordinated and policy aligned service provider reference manual for Payment Reform.

Payment Reform

As part of the State's efforts to develop health care payment reform models that align with Vermont's All-Payer ACO Model agreement and advance implementation of Vermont's Global Commitment to Health waiver, DMH has worked with other departments in the AHS and with stakeholders to design and implement a payment model for children's and adult mental health services provided by Designated and Specialized Services Agencies (Mental Health Clinics). DMH concluded design and implementation planning for mental health payment reform in December of 2018 and successfully executed all Agreements necessary for implementation on January 1, 2019. The total annualized value of the payment model is just under $100M statewide.

This alternative payment model is intended to improve the predictability of payments to providers of mental health services, and to increase their flexibility to meet the needs of the Vermonters they serve. The new model places additional focus on quality—at first by providing an incentive for providers to report complete, accurate, and timely information, and in the future by linking a portion of payments to providers' performance on certain quality measures. The new payment model shares many characteristics of other value-based payment models that the State is implementing or considering for future implementation; such alignment should contribute to both State and provider readiness for an increasingly integrated health care delivery system over time and should aid the State in developing a strategy for inclusion of additional services in All-Payer financial targets in future.

Integrating Family Services

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.

Beginning on January 1, 2019, the IFS sites became aligned with larger payment reform efforts occurring across AHS including having incentives tied to them in alignment with statewide implementation. At the same time, IFS regions have additional requirements for performance measurement in accordance with the broader scope of services included in those regions. Vermont submitted a multiyear payment model for consideration to CMS in September 2018 and received approval in late December.

Both IFS regions have been utilizing the Child and Adolescent Needs and Strengths (CANS) to look at the needs and strengths of children they are serving. The agencies are using this progress monitoring 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—this data also follows national trends in data analysis for this subset of the population. A team of three (one from a Designated Agency and two from DMH) recently attended the annual National CANS conference and presented on the implementation of CANS in Vermont and shared data.

iv.   Blueprint for Health

Key updates:
- The majority of Vermont's primary care practices are Blueprint-participating Patient-Centered Medical Homes, as evidenced by the fact that 136 of Vermont's estimated 149 primary care practices are Blueprint-participating practices. In CY2018, there was a net decrease of 3 practices participating in the Blueprint due to practice closures and mergers.
- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid use disorder, as evidenced by a total enrollment of 6,694 individuals, with 3,750 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of December 2018 and 2,944 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of December 2018.
- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 39 practices to participate in the Women's Health Initiative as of December 2018.

Patient-Centered Medical Home Program

The Blueprint uses national standards to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for Quality Assurance (NCQA)-certified Patient-Centered Medical Homes (PCMHs). PCMHs provide care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The PCMH model changes the way a patient experiences care by striving to provide care when and where the patient needs it and in a way that the patient understands it. PCMHs in Vermont are supported by multi-disciplinary teams of dedicated health professionals in each health service area of the state who provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, and coordinated care. The support and services of the Community Health Team enhance a primary care provider's ability to work with patients to identify underlying causes of health problems, including those that with a psychosocial component. They also support connecting patients with effective interventions, improving management of chronic conditions, or providing additional opportunities to support improved well-being.

Blueprint Program Managers, who are local leaders in each community, are responsible for contacting all primary care practices within their health service area to encourage, engage, and support practice participation in the Blueprint for Health and learning health system activities. Annually, Program Managers report on any remaining primary care practices in each region that have not begun the process of transforming their practice into PCMHs, including the rationale provided by each practice contact. Importantly, Blueprint Program Managers report very few practices in each health service area remaining who are not currently engaged with the Blueprint for Health program. Beyond the support of regional Program Managers, the Blueprint further supports each participating practice with a quality improvement coach, called a Quality Improvement Facilitator. Quality Improvement Facilitators bring Blueprint-generated all-payer data about practice performance (Blueprint Practice Profiles, Blueprint Community Health Profiles) and their own training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement). Quality Improvement Facilitators initially help launch patient-centered practices and secure NCQA-PCMH recognition. Subsequently, they return regularly to help with quality improvement efforts related to panel management

and outreach, care coordination, promotion of individual health and wellness, chronic condition management, and ongoing practice transformation in alignment with State-led health care reform priorities, including:

- quality improvement activities around the All-Payer Accountable Care Organization Model agreement and Accountable Care Organization quality measures;
- integration of the care model;
- implementation of new initiatives (e.g. Spoke program, Women's Health Initiative, improving opioid prescribing patterns);
- prevention and management of chronic conditions (e.g. for diabetes and hypertension through connections with learning collaboratives, self-management programs, health coaches, registered dieticians, and care management).

As of the end of CY2018, Blueprint-participating PCMHs served 303,777 payer-attributed patients (identified and attributed as a current active patient if the patient has had the majority of their primary care visits in the primary care practice within the 24 months prior to the date the attribution process is conducted), including a subset of 102,858 Medicaid-attributed patients. These individuals had access to care by 162.4 full-time equivalents of Community Health Team staff.

Quarterly Highlights

- At the end of the 4th quarter of 2018, 136 Vermont practices were operating as PCMHs, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure. The Blueprint estimates that there are about 149 total primary care practices currently in the State of Vermont that employ more than one provider operating in the state.

Figure 9. Patient Centered Medical Homes and Community Health Teams

Blueprint PCMHs and CHTs
July 2008 - December 2018

Legend:
- Recognized PCMHs As Of End of Qtr
- Core CHT FTEs
- PCMH Insurer-Attributed Patients
- PCMH Medicaid-Attributed Patients

Data labels: 303,777; 162.4; 136; 102,858

Y-axis (left): PCMHs and Core CHT FTEs (0–300)
Y-axis (right): Attributed Patients (0–350,000)
X-axis: 2008Q3 through 2018Q4
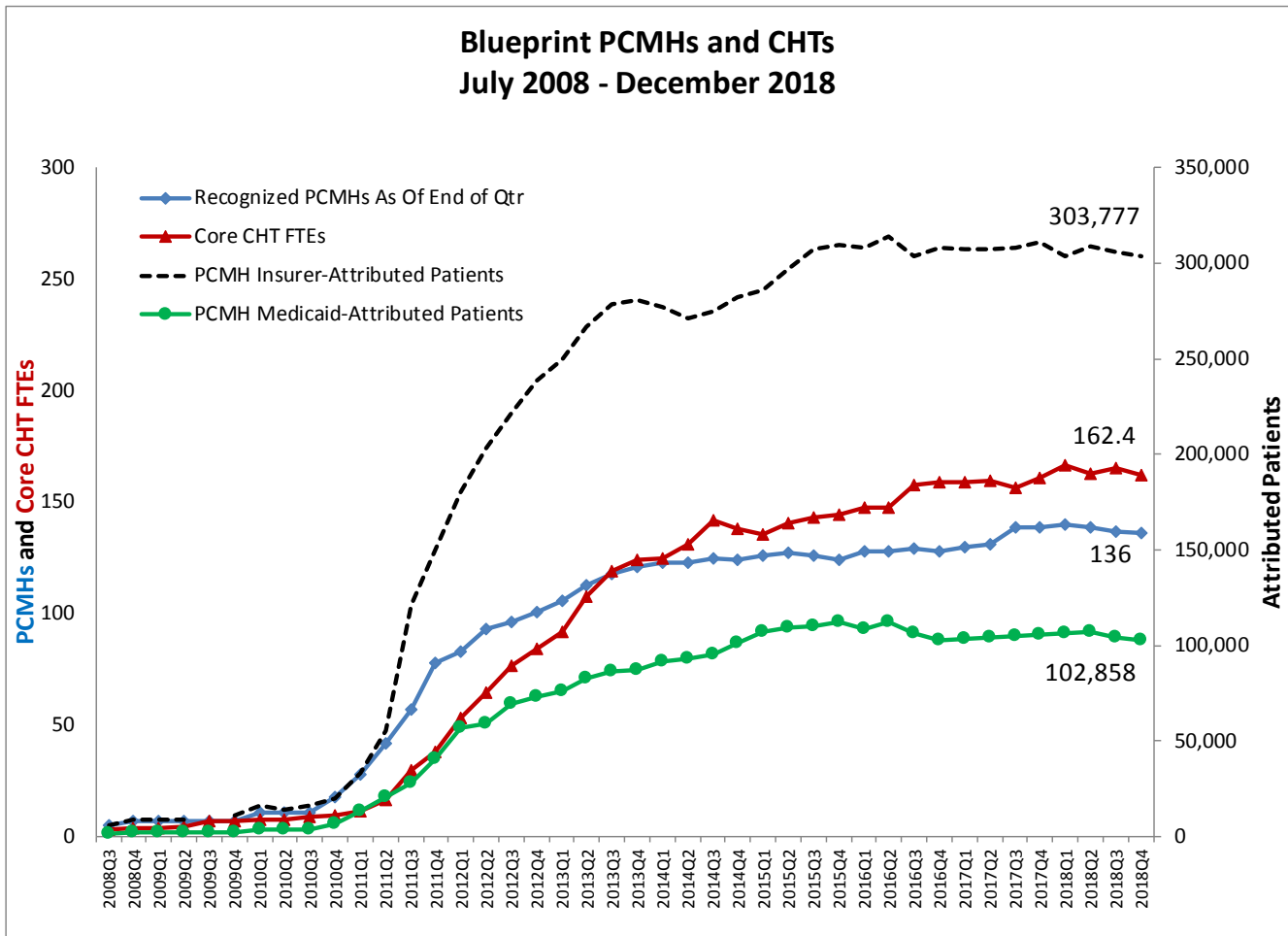
Patient-Centered Medical Home Practice Health Profiles and Community Health Profiles

The Blueprint for Health supports data-driven population health improvement by producing biannual profiles that describe the health status, health care utilization, health care expenditures, and health care outcomes of the patients in each Blueprint practice and community. Practice-level and community-level (by Hospital Service Area) 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 Health Data for the Blueprint roughly every 6 months. Practice Health Profiles help practices identify ways that they can better serve their patients and to track the success of quality improvement initiatives. Community Health Profiles, organized by hospital-service area level data, are used by the regional Accountable Communities for Health (Community Collaboratives) and other local workgroups to inform and complement Community Health Needs Assessments and other community data products. By the end of CY 2018, Practice Health Profiles and Community Health Profiles had 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
viii.   07/2016 – 06/2017

Practice Health and Community Health Profiles for the data period 07/2016 – 06/2017 were produced and distributed in June 2018. The information in the most recent set of profiles gives practices the most up-to-date overview of total utilization and expenditures as compared to peers and the rest of the state. The Community Health Profiles are posted at http://blueprintforhealth.vermont.gov/community-health-profiles. The next set of profiles are expected to be distributed in the first quarter of 2019.

Blueprint Patient-Centered Medical Home Outcomes for 2017
Methodology: Shifting from a Program to a System Perspective

Previous reports focused on outcomes for Vermonters attributed to Blueprint for Health PCMHs relative to a comparison group of those receiving primary care in another setting. This evaluation expands its focus to the health service expenditures, utilization, and quality indicators of all Vermonters, regardless of primary care attribution, enrolled with a health plan reporting to the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all-payer claims database. While it does look at subpopulations grouped by primary care attribution, these groups are meant to provide context rather than statistical comparisons. Many factors contributed to this decision.

First, as the Blueprint program has matured, almost all primary care practices in the state have transformed to a PCMH. While almost 100,000 Vermonters continue to receive care in non-PCMH settings, these could include out-of-state practices or specialty practices providing primary care services. Therefore, this group has become less meaningful as a comparison group for statistical models used in previous evaluations.

Second, since the Blueprint was expanded statewide, the state has also pursued additional approaches to health care reform, including establishing the Green Mountain Care Board, pursuing ACO-based reform (initially through shared savings), using Vermont's State Innovation Model grant to support additional payment models, delivery system reforms, and health information technology improvements, developing the Hub and Spoke Program, and launching the Women's Health Initiative. These reforms do not impact Vermont's health care system in isolation making it difficult to attribute any outcome to any one initiative.

Finally, the state signed an agreement with the Centers for Medicare and Medicaid Services (CMS), the Vermont All-Payer ACO Model Agreement, in which the state aims to control total cost of care and improve quality through an ACO model. Several targets were established in that agreement:

- Limiting the annual growth in health care costs to 3.5% or less for included services;
- Increasing access to primary care;
- Decreasing deaths due to suicide and drug overdoses; and
- Reducing morbidity and limiting the increase in prevalence of three chronic illnesses (COPD, diabetes).

The Blueprint has therefore shifted its evaluation to understand the trends in expenditures and utilization of health services across the full population and select sub-populations, including those attributed to a PCMH. It also seeks to align its focus with the priorities set in the All-Payer ACO Model Agreement. The following evaluation includes a descriptive analysis of crude and risk-adjusted rates for expenditures, utilizations, and quality measures, and shows differences across different populations. It does not provide a return on investment calculation because the comparison group by which that information was derived is no longer appropriate for that purpose.

Evaluation Populations:
The populations the Blueprint annual evaluation reviewed were:
1. **Full Population**: all individuals age one and older enrolled in a health plan in VHCURES;
2. Primary care-attributed groups
    a. **Blueprint PCMH**: Vermonters receiving most of their care in a Patient-Centered Medical Home;
    b. **Other Primary Care**: Vermonters receiving most of their primary care in a setting other than a Blueprint Patient-Centered Medical Home;
    c. **No Primary Care**: Vermonters who did not have a primary care visit.

The below table shows the characteristics of each of these populations and how they changed from 2011, the year the Blueprint had significant expansion. The below tables shows that those attributed to PCMHs had a slightly younger, though statistically significant, average than the those receiving primary care in other settings. This group also had a higher proportion of Medicaid enrollees, but lower proportions of commercially insured and Medicare beneficiaries.

In addition to the characteristics shown in Table 1, the Blueprint reviewed health status based on the 3M™ Clinical Risk Groups, which fell into the following categories: Healthy, Acute or Minor Chronic Conditions, Moderate Chronic Conditions, Significant Chronic Conditions, and Cancer or Catastrophic Chronic Conditions. By grouping the populations in this way, this evaluation found that the overall population with data in VHCURES saw an increase in the more severe health risk categories and a decline in lower risk categories over time, consistent with Vermont's aging demographics. It also found that the Blueprint PMCH group tended to have a sicker population than the Other Primary Care group across all years, with the exception of the Cancer or Catastrophic risk group. This finding may indicate people with cancer or catastrophic conditions receive primary care from their specialty care providers.

Table 3. Population Characteristics and Changes Over Time

Demographics	Full Pop	BP PCMH	Other PC	No PC
2011 Total Number	391,659	167,848	180,469	43,342
2017 Total Number	426,527	289,095	96,424	41,008
% Change	8.9%	72.2%	(46.6%)	(5.4%)
2011 Ave Age	41	43	40	40
2017 Ave Age	43	43	45	40
% Change	4.9%	0.0%	12.5%	0.0%
2011 % Female	52.8%	54.5%	54.7%	37.8%
2017 % Female	52.7%	54.2%	54.7%	38.0%
% Difference	(0.1%)	(0.3%)	(0.0%)	0.2%
2011 % Medicaid	28.5%	29.1%	28.8%	24.5%
2017 % Medicaid	31.2%	32.8%	26.8%	30.3%
% Difference	2.8%	3.7%	(2.0%)	5.8%
2011 % Medicare	23.9%	26.1%	23.5%	17.0%
2017 % Medicare	28.2%	28.5%	31.3%	18.7%
% Difference	4.4%	2.5%	7.8%	1.7%
2011 % Commercial	47.7%	44.8%	47.7%	58.5%
2017 % Commercial	40.6%	38.6%	41.9%	51.0%
% Difference	(7.1%)	(6.2%)	(5.8%)	(7.5%)

Methodology: Risk-Adjustment

Much of the analysis looked at crude rates; however, where risk adjustments were applied to sub-populations, the models adjusted 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).

Results: All-Payer Expenditures

Based on the below figures and table, the Blueprint PCMH group had lower total expenditures and growth in expenditures despite having a higher proportion of beneficiaries in the sicker clinical risk groups, and higher prevalence of COPD, diabetes, and hypertension than the Other Primary Care Group.

Findings:
- The Blueprint PCMH group had lower growth in inpatient costs compared to both the Other Primary Care group and the No Primary Care group.
- The Blueprint PCMH group had the highest annual growth (4.5%) in Special Medicaid Services, indicating that the care received within the Patient-Centered Medical Home setting and from Community Health Teams increased connections between individuals and community- and team-based care to address social, economic, and behavioral risk factors.
- When total expenditures for each primary care group are adjusted for age, sex, health status, payer, etc. the trends are maintained, and the differences are statistically significant.

Figure 10. Total Expenditures by Category for Primary Care Attribution Groups

A. Total PMPY Expenditures by Primary Care Attribution, Unadjusted

B. Total PMPY Expenditures by Primary Care Attribution, Adjusted
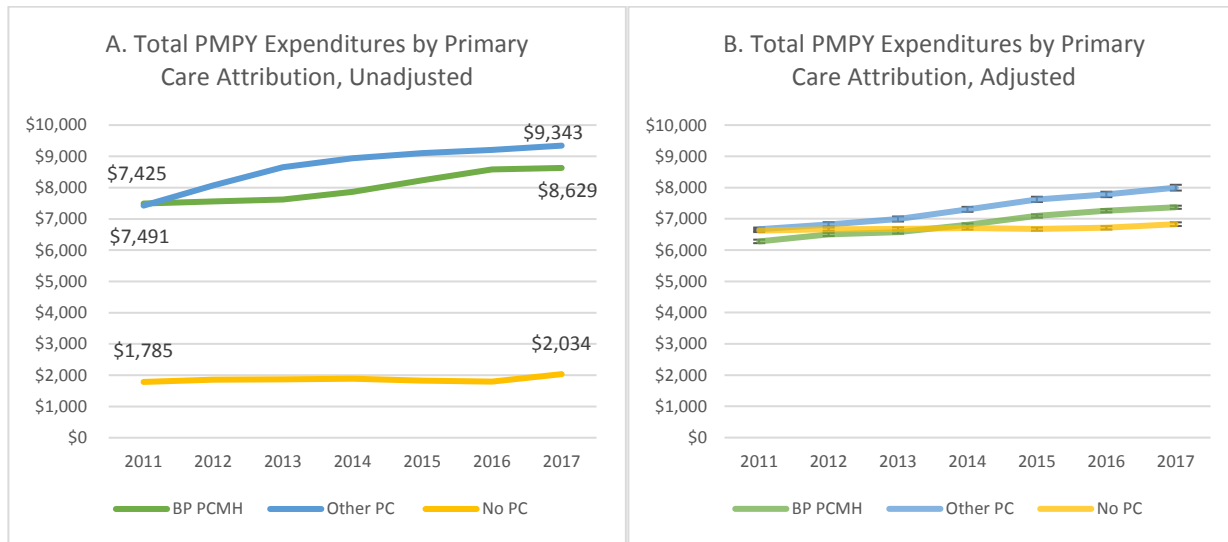
Table 4. Total Expenditures by Category for Primary Care Attribution Groups, Unadjusted

Category	BP PCMH			Other Primary Care			No Primary Care		
	2017 PMPY	2011-2017 % Change	Annual Growth	2017 PMPY	2011-2017 % Change	Annual Growth	2017 PMPY	2011-2017 % Change	Annual Growth
*Inpatient**	$1,791	2.7%	0.44%	$2,113	17.7%	2.75%	$420	7.1%	1.16%
*Outpatient**	$2,158	13.3%	2.10%	$2,636	44.5%	6.33%	$446	0.9%	0.15%
Professional	$1,678	6.3%	1.02%	$1,825	12.9%	2.05%	$417	17.1%	2.67%
*Pharmacy***	$1,547	26.7%	4.02%	$1,782	53.5%	7.40%	$338	39.7%	5.73%
Other	$261	(8.7%)	(1.51%)	$291	7.0%	1.13%	$37	(30.2%)	(5.81%)
SMS	$966	33.2%	4.9%	$622	(17.7%)	(3.2%)	$361	20.3%	3.13%
Blueprint	$96	131.5%	15. 2%	$0	—	—	$0	—	—
ACO Capitated	$132	—	—	$74	—	—	$15	—	—
Total	$8,629	15.2%	2.39%	$9,343	25.8%	3.90%	$2,034	13.9%	2.20%

*Facility claims; ** Total claims reported in claims; does not include pharmaceutical manufacturer rebates

Results: All-Payer Utilization

Total Resource Use

The approach this evaluation used to assess utilization was the Total Care Relative Resource Value™ (TCRRV) or Total Resource Use developed by HealthPartners. This method assesses health care utilization across four categories[1] of services based on a standardized measure of relative economic resources consumed, rather than by counting the number or rate of individual procedures or services. It

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[1] TCRRV categories:
- Inpatient: facility claims for inpatient stays e.g. for knee replacement surgery, vaginal delivery, pneumonia, skilling nursing facility
- Outpatient: facility claims outpatient procedures e.g., knee arthroscopy, colonoscopy, MRI, mammogram, emergency department visit
- Professional: professional provider claims for procedures or services, e.g., knee arthroscopy, colonoscopy, MRI, mammogram, office visits, behavioral health therapy
- Pharmacy: medications to treat diabetes, asthma, depression, high blood pressure, high cholesterol, pain, cancer, infections, gastrointestinal conditions. Does not include medications dispensed in a medical setting.

does do by assigning a standardized relative cost to various procedures or services to eliminate the distortion caused by variation in pricing across providers, regions, and payers. For example, a surgery uses more resources than a primary care visit; therefore, an individual with one surgical procedure and one primary care visit will have a higher resource score than someone with three primary care visits. The below analysis reviews the Total Resource Use over time, stratified by its four categories to assess trends in utilization.

Figures 11- a, b, c, d. Total Resource Use, by Primary Care Attribution Groups, Unadjusted

a.

Total Resource Use, BP PCMH Group

2011-2017 Percent Change, Total: +9%
+6%
+35%
-3%
+8%

b.

Total Resource Use, Other PC Group

2011-2017 Percent Change, Total: +26%
+23%
+37%
+24%
+22%

c.

Total Resource Use, No PC Group

2011-2017 Percent Change
Total: +8%
Pharmacy: +14%
Professional: +40%
Outpatient: -4%
Inpatient: -5%

d.

Total TCRRVs, Primary Care Atribution, Risk Adjusted

6516
7874
6116
6919
5956
6282
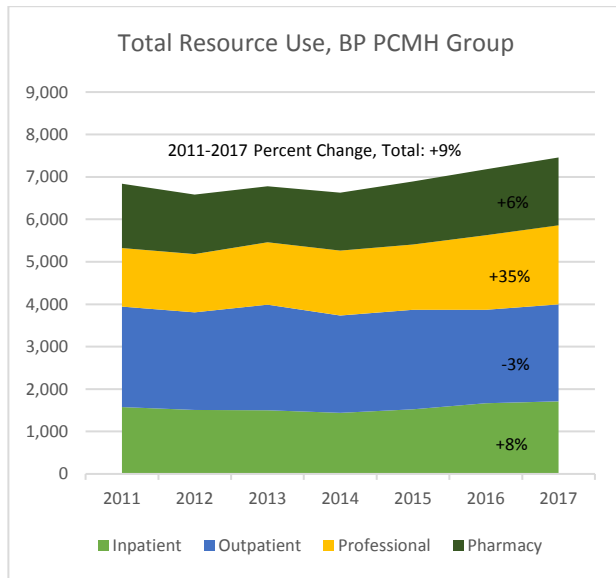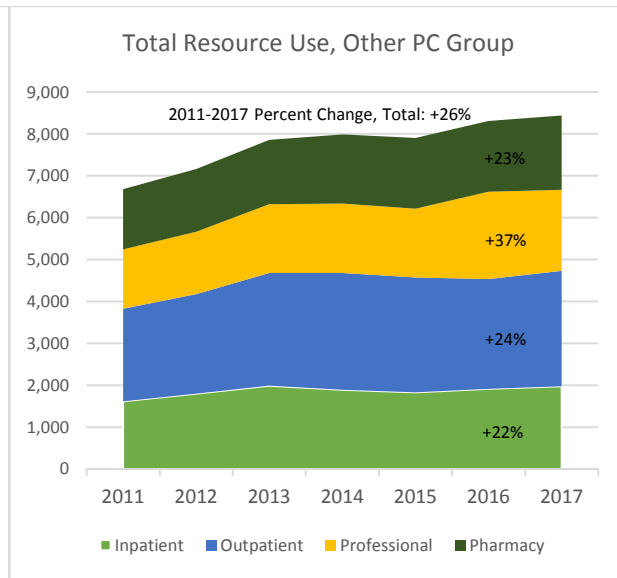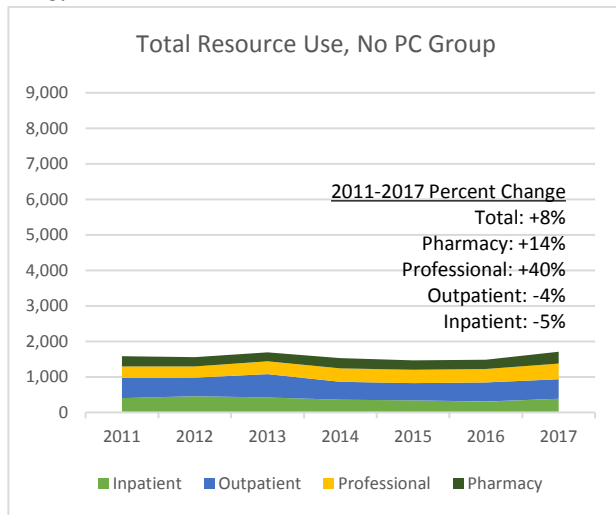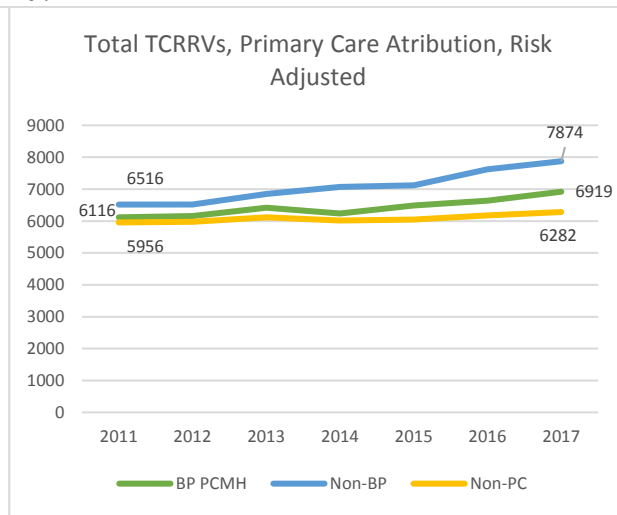
Findings:

- Overall Total Resource Use grew by 15% between 2011 and 2017.
- Increases in use of professional services and pharmacy drive the increase in Total Resource Use.
- The Blueprint PCMH group had lower Total Resource Use and lower growth than the Other Primary Care group (9% growth versus 26% growth), despite the Blueprint PCMH group having higher

disease burden (see health status and chronic condition prevalence), which indicates care from community health teams and Patient-Centered Medical Homes in associated with limiting resource intensive utilization.

- When adjusted for age, sex, payer, and health status, the trend holds, indicating that the lower resource use by the Blueprint PCMH group is not simply due to healthier demographics.

Potentially Avoidable Emergency Department Visits and Inpatient Discharges

Beyond monitoring overall utilization, the Blueprint reviewed data to identify areas where improvements to health care delivery could potentially reduce unnecessary utilization of services, such as emergency department (ED) visits and inpatient discharges. The below table shows rates of ED visits, potentially avoidable ED visits, inpatient discharges, inpatient discharges for ambulatory care sensitive conditions (ACSC), and inpatient readmissions within 30 days. The specifications for the measure on potentially avoidable ED visits can be found of the Blueprint website here.[2] The measure on ACSCs was chosen because these are conditions that can be well managed on an outpatient basis with guideline-based care. Therefore, rates of ACSC inpatient admissions may indicate opportunities to prevent unnecessary utilization.

Table 5. Emergency Department and Inpatient Utilization and Potentially Avoidable Utilization

	ED Visits / 1,000 Member Years				Inpatient Discharge / 1,000 Member Years				Inpatient
	2017 Visit Rate	2011-2017 % Chng	2017 P.A. Visit	% ED Visit P.A.	2017 Dischg. Rate	2011-2017 % Chng	2017 ACSC	% IP ACSC	2017 % 30-Day Readmit
Blueprint PCMH	405	(8.0%)	68	16.8%	103	1.0%	11	10.7%	11.9%
Other Primary Care	382	(2.6%)	62	16.2%	112	15.5%	11	9.8%	12.7%
No Primary Care	135	(15.6%)	22	16.3%	26	(13.3%)	1	3.8%	6.5%

ED = Emergency Department; P.A. = Potentially Avoidable; IP = Inpatient; ACSC = Ambulatory Care Sensitive Conditions

Findings:

- Overall, emergency visits not resulting in an inpatient admission have declined for the full population, due primarily to declines in potentially avoidable ED visits.

- While the Blueprint PCMH group had higher rates of ED visits, its rate declined more over time relative to the Other Primary Care.

- Inpatient rates for the full population increased due to both ACSCs and other causes, with the Blueprint PCMH group showing both lower growth and a 2017 rate; the Other Primary Care group had the biggest increase.

- All-cause inpatient readmission within 30 days of discharge was between 6% and 12.7% in 2017 across the primary care categories. Except for the No Primary Care group, these proportions represent an increase from 2011.

Hub & Spoke Program

Medication-assisted treatment for opioid use disorder is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole patient" approach to the treatment of opioid use disorder. The Hub and Spoke system of care in Vermont provides medication-

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[2] Full link: https://blueprintforhealth.vermont.gov/sites/bfh/files/documents/Onpoint%20-%20Supporting%20Documentation%20for%20Blueprint%20HSA%20Profiles%20%2820180711%29.pdf

assisted treatment for opioid use disorder in two settings – regional, specialty Opioid Treatment Programs (Hubs), which provide higher intensity treatment, and office-based opioid treatment in community-based medical practice settings (Spokes). The Blueprint administers the Spoke part of the Hub & Spoke system of care. Peer-reviewed literature has established medication-assisted treatment as an evidence-based, effective approach to the treatment of opioid use disorder, based upon notable, published outcomes such as decreased opioid use, decreased opioid-related overdose deaths, decreased criminal activity, decreased infectious disease transmission and increased social functioning and retention in treatment.

Many of these outcomes were supported by the evaluation of Vermont's Hub and Spoke system. The State Plan Amendment for the Vermont Medicaid Program, approved by the CMS, established a Health Home for Vermonters with Opioid Use Disorder. As of July 1, 2013, Medicaid beneficiaries receiving medication-assisted treatment for opioid use disorder in a Hub or Spoke setting were eligible to receive enhanced services, such as comprehensive care management, care coordination, comprehensive transitional care, health promotion, individual and family support, and referral to community and social support services. The Health Home functions to enhance Hub programming and embeds essential support staff (1 registered nurse and 1 licensed mental health clinician per every 100 Medicaid patients receiving medication-assisted treatment) into Spoke practices for a patient-centered, team- and evidenced-based approach to the treatment of opioid use disorder and the provision of Health Home services. Based upon the "significant impact" demonstrated by the Hub and Spoke system, Vermont is working towards gaining all-payer participation in the Opioid Use Disorder Health Home model. BlueCross BlueShield of Vermont has launched pilot participation in two communities to date – Burlington and Bennington; MVP is currently designing their pilot for participation, having recently consulted with the Executive Director of the Blueprint for Health regarding the specifics of local Spoke program implementation.

The Blueprint, in partnership with the Division of Alcohol and Drug Abuse Programs (Department of Health), continues to offer learning sessions with expert-led, and peer-supported, training in best practices for providing team- and evidence-based medication-assisted treatment for opioid use disorder. For many physicians, nurse practitioners, and physician assistants, access to specialized staffing and ongoing training opportunities provide the support and confidence the providers need to accept the challenge of treating opioid use disorder in community-based medical practice settings (Spokes). For patients, the Spoke staff become a critical part of their care team, working together week-by-week and month-by-month towards long-term recovery and improved health and well-being. At the end of the 4th quarter of 2018, capacity for receiving medication assisted treatment in Spoke settings continued to increase, as evidenced by 2,944 Vermonters with Medicaid insurance receiving medication assisted treatment for opioid use disorder from 229 prescribers and 64.7 full-time equivalent Spoke staff, working as teams, across more than 90 different Spoke settings (as of December 2018).

Quarterly Highlights

- Vermont continues to demonstrate increased access to medication assisted treatment for Vermonters with opioid use disorder, as evidenced by a total enrollment of 6,694 individuals, with 3,750 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of December 2018 and 2,944 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of December 2018.

- Medication-assisted treatment for opioid use disorder is being offered across the State of Vermont by more than 90 different practices and by 229 medical doctors, nurse practitioners and physician assistants who work with 64.7 FTE licensed, registered nurses and licensed, Master's-prepared, mental health / substance use disorder clinicians as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder (as of December 2018).

- A collaborative team, comprised of the DVHA - Blueprint for Health and the Vermont Department of Health – Division of Alcohol and Drug Abuse Programs staff and clinical content experts, convened to design and deliver learning sessions intended to enhance best practice adoption by providers and practice teams. Two learning sessions with CMEs and CEUs available were offered in the fourth quarter of 2018 and were open to medication-assisted treatment teams. The learning sessions focused on enhancing best practices for comprehensive transitional care and prevention, including strategies to improve seamless transitions from one treatment setting to another, to improve patient and provider satisfaction and patient outcomes, to support effective provision of team-based care (including coordination with key community partners), and to support patient-oriented wellness and recovery approaches. The learning session evaluations were overwhelmingly positive, indicating that the learning objectives had not only been met and that teams believed these sessions would improve their clinical practice.

Figure 12. MAT-SPOKE Implementation Jan 2013 – December 2018
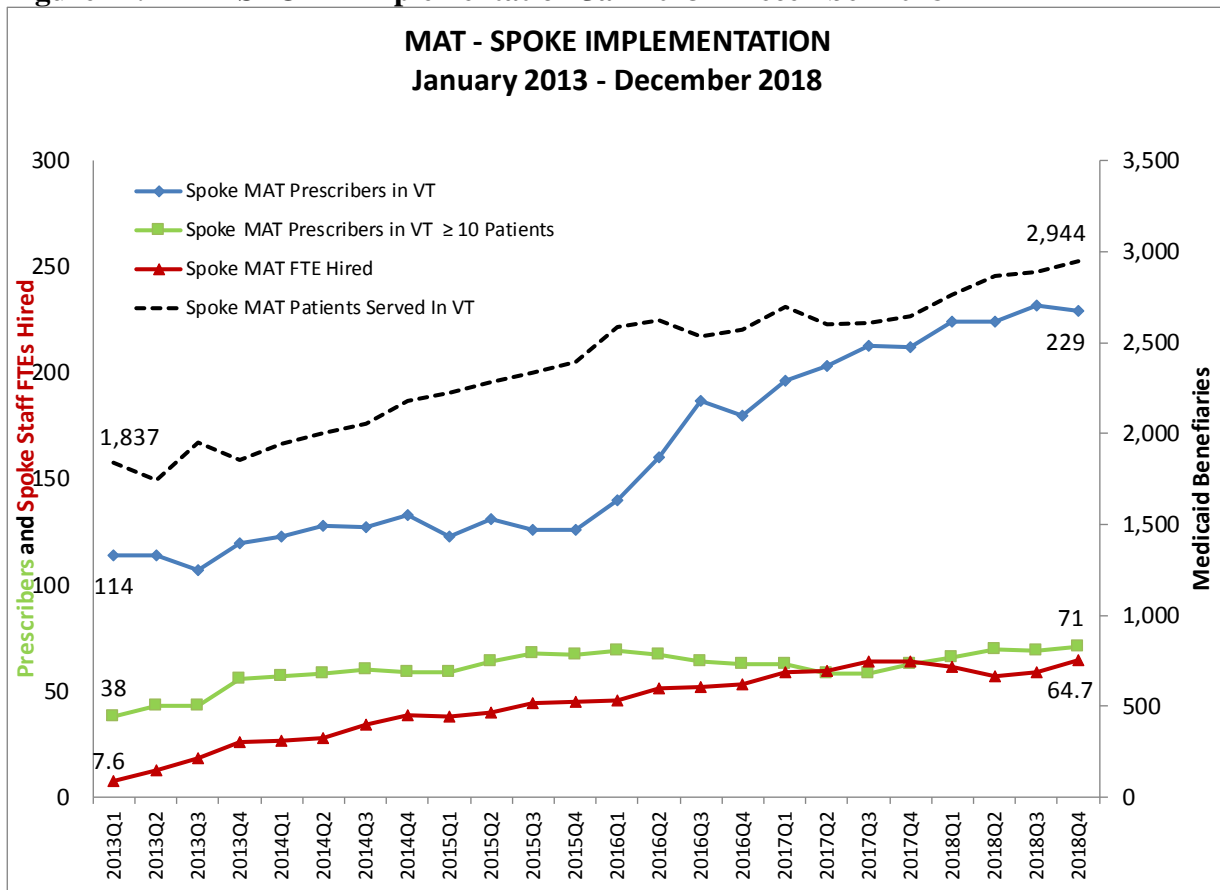
The table below shows the caseload of regional Hub programs, the number of clients receiving buprenorphine, methadone, or Vivitrol, and indicates that there continues to be no waitlist at any of the regional Hub settings as of the most recent report (December 2018).

Table 6. Hub Implementation by Region as of December 2018

VERMONT
VT Department of Health

VERMONT
Department of VT Health Access

Hub Census and Waitlist: December 2018

Region	# Clients	# Buprenorphine	# Methadone	# Vivitrol	# Receiving Treatment but Not Yet Dosed	# Waiting
Chittenden, Addison	1006	284	722	0	0	0
Franklin, Grand Isle	395	170	224	1	0	0
Washington, Lamoille, Orange	495	168	327	0	0	0
Windsor, Windham	637	120	515	0	2	0
Rutland, Bennington	420	104	302	0	14	0
Essex, Orleans, Caledonia	797	223	571	1	2	0
Total	3750	1069	2661	2	18	0

Note: The Franklin/Grand Isle location opened in July 2017. Some clients are transferring from the Chittenden/Addison hub to the FGI hub.

The table below shows the number of Medicaid beneficiaries receiving medication assisted treatment in Spoke settings, the number of providers prescribing medication assisted treatment for opioid use disorder, the number of providers prescribing to 10 or more patients, and the full-time-equivalents for hired Spoke staff (licensed, registered nurses and licensed mental health clinicians) by region and statewide.

Table 7. Spoke Implementation by Region as of December 2018

VERMONT
Agency of Human Services

Spoke Patients, Providers & Staffing: December 2018

Region	Total # Providers prescribing patients	# Providers prescribing to ≥ 10 pts	Staff FTE Hired	Medicaid Beneficiaries
Bennington	9	5	5.6	263
St. Albans	25	13	10.1	412
Rutland	19	9	8.8	353
Chittenden	83	15	15.85	630
Brattleboro	12	4	3.19	137
Springfield	9	2	1.55	48
Windsor	15	6	4.5	325
Randolph	5	3	2.7	106
Barre	20	5	4.75	258
Lamoille	12	7	3.2	177
Newport & St. Johnsbury	11	2	2	107
Addison	13	4	2.5	126
Total	**229***	**71**	**64.74**	**2,944**

Table Notes: Beneficiary count based on pharmacy claims for Buprenorphine and Vivitrol, October – December, 2018; an additional **307** Medicaid beneficiaries are served by **44** out-of-state providers. Staff hired based on Blueprint portal report 1/23/19. *4 providers prescribe in more than one region.

Women's Health Initiative

Like the Hub & Spoke program, the Women's Health Initiative (WHI) began as a challenge from state leadership to improve the health of women and families by addressing the high percentage of unintended pregnancies. Initially, the Initiative was a design project for the Blueprint, in partnership with the Vermont Department of Health and other policy makers, providers, and experts, and subsequently developed into a statewide intervention that now helps Vermonters with accessing evidence-based care.

The WHI offers participating providers and practices new training, staffing, payments, and community connections. With these supports, practices can now offer women enhanced preventative care, screenings and follow-up to address health and social risks, comprehensive family planning counseling, and timely access to the most effective forms of contraception, including Long Acting Reversible Contraceptives (LARC), when chosen by the patient and clinically appropriate. Women who visit WHI-participating women's health practices (OB-GYN offices, midwifery practices, and family planning clinics) and primary care practices engage in enhanced psychosocial screening for mental health and substance use disorders, interpersonal violence, and access to housing and food.

Women identified as at-risk are immediately connected to a licensed mental health clinician for brief intervention, counseling, and referral to more intensive treatment as needed. The clinicians connect women with their local network of health, social, economic and community services. Women also engage in comprehensive family planning counseling at participating practices and community-based organizations. Women who wish to become pregnant receive pre-conception counseling and services to support the healthiest pregnancies possible. For those women who indicate they do not want to have a baby in the coming year, they have access to the full spectrum of contraception options, including immediate access to LARC.

The payments associated with participating in the WHI support women's health and primary care practices in designing workflows that support the enhanced psychosocial screening, comprehensive family planning counseling, and same-day LARC insertion and support the provision of effective interventions by licensed mental health clinicians. A key aspect of the initiative is the focus on improving clinical-community linkages, which involves collaboration between participating practices and community-based organizations in order to successfully address health care and non-medical health related social needs. Communities that have practices participating in the WHI have developed coalitions that include the participating medical practices and community organizations in order to develop bidirectional referral pathways that support Vermonters with accessing necessary services more efficiently.

Quarterly Highlights

- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 39 practices (21 women's health and 18 primary care) to participate in the WHI as of December 2018.

- The WHI is approaching statewide coverage, as all but one eligible Hospital Service Area have a specialized women's health practice now participating in the WHI. Furthermore, continued expansion of the WHI is expected among Planned Parenthood of Northern New England women's health practices and within Blueprint PCMHs.

- The Blueprint for Health, in collaboration with an analytics contractor, Onpoint Health Data, is developing data profiles that will provide valuable information regarding demographic and health status information, and outcome measures for the WHI; the WHI profiles will be used to guide future program improvement initiatives.

Figure 13. Women's Health Initiative: Practices, Patients, and CHT Staffing

Women's Health Initiative (WHI)
January 2017 - December 2018

- WHI Specialist Practices
- WHI PCMH Practices
- WHI CHT FTE Hired
- WHI Specialist Attributed Patients
- WHI PCMH Atttributed Patients

11,323 ... 13,020

4,282 ... 4,195

14 ... 21

12 ... 18

4.80 ... 12.30
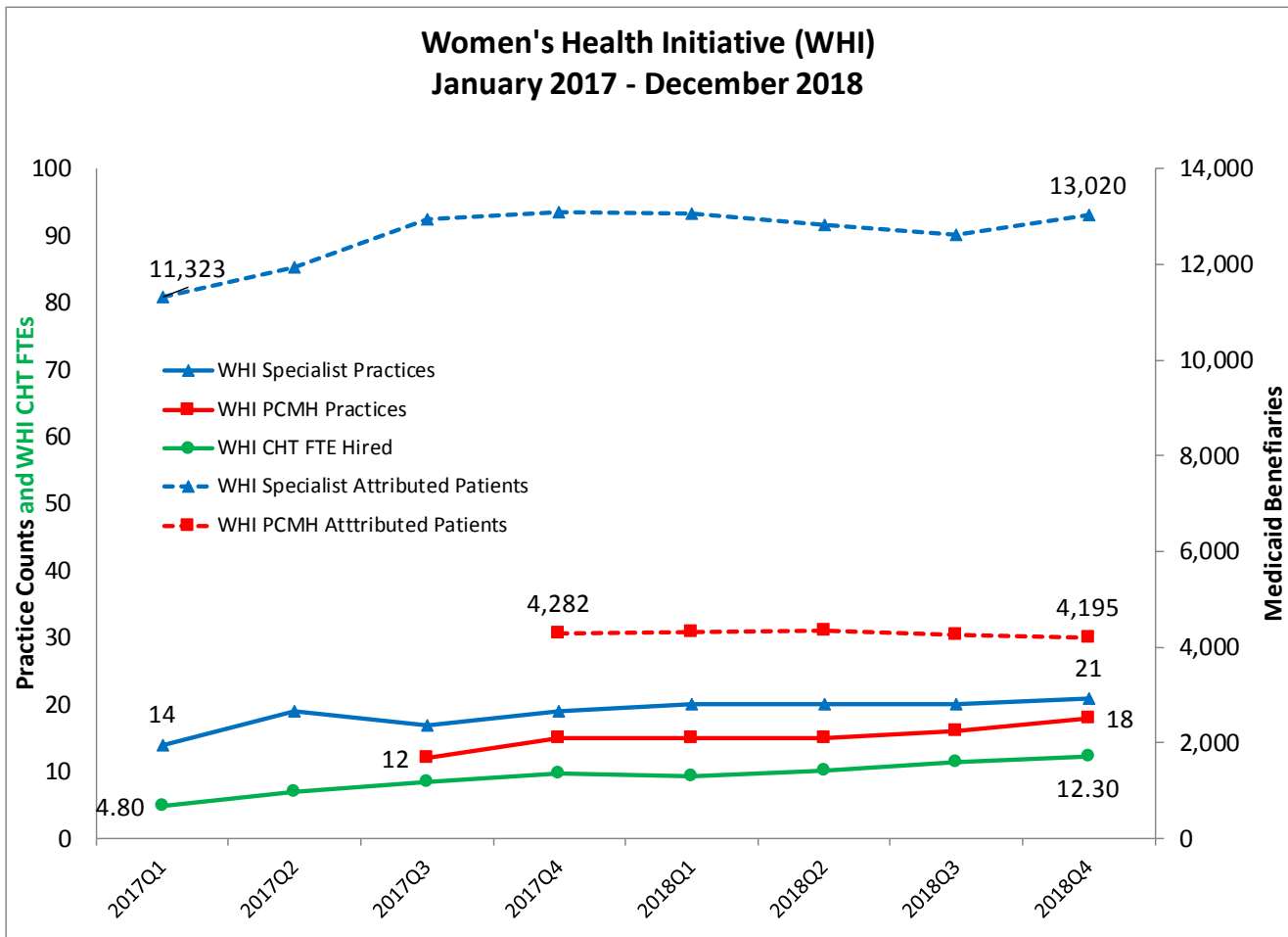
Please note that this graph has been revised from earlier versions to display WHI patient attributions calculated by Medicaid for practice payment purposes, based on claims data.

Table 8. Women's Health Implementation by Region

Health Service Area / Team	WHI Specialist Practices as of December 2018	WHI PCMH Practices as of December 2018	WHI CHT Staff FTE Hired as of December 2018	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of December 2018	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of December 2018
Barre	1	1	1.00	800	(With Burlington)
Bennington	1	2	0.50	906	52
Brattleboro	1	0	1.00	365	0
Burlington	3	6	3.00	2,230	1,657
Middlebury	1	0	0.75	388	0
Morrisville	1	2	1.30	536	446
Newport	0	0	0.00	0	0
Randolph	3	0	0.50	538	0
Rutland	1	1	1.50	1,185	174
Springfield	1	4	1.00	427	1,278
St. Albans	1	0	1.00	1,057	0
St. Johnsbury	1	2	0.75	662	593
Windsor*	0	0	0.00	0	0
Planned Parenthood (Statewide)	6	0	N/A	4,236	0
Total	21	18	12.30	13,020	4,195

*The Windsor Health Service Area does not have women's health specialty practices.
**Quarterly attributed patient counts at the HSA level have a small amount of overlap due to patients moving across HSAs in different months. The statewide quarterly total is deduplicated.

v.   Pharmacy Program

Key updates:
- Pharmacy Key Drug Spend Statistics for SFY2018
  - Overall drug spend, changes to coverage of Hepatitis C agents, opioids and drugs used to treat Opioid Use Disorder
- Auto prior authorization and e-prescribing updates
- Pharmacy Program Provider Portal
- Update to CMS Certification
- Pharmacy Care Management (PCM) Program

The DVHA Pharmacy Unit is responsible for managing the pharmacy benefits for beneficiaries 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 beneficiaries and successful management of drug utilization and costs.

Change Healthcare (CHC), DVHA's contracted Prescription Benefit Manager (PBM) since January 1, 2015, provides many clinical and operational support services, in addition to managing a provider call center in South Burlington, Vermont.

Key Drug Spend Statistics for State Fiscal Year 2018 (SFY18):

- Total GC Drug Spend for SFY18 was $196.5 million. This represents an increase in gross expenditures of approximately $2.6 million (or 1.4%) from SFY17.

- In SFY18, specialty drugs represented 24.2% of DVHA's overall drug spend, compared to SFY17 when specialty drug spend represented 20.2% of DVHA's drug spend.

- Total number of GC paid prescription claims in SFY18 was 2,064,317.

- Of branded drugs on the Preferred Drug list in SFY18, 79% of DVHA's utilization was for preferred drugs and 21% of utilization was for non-preferred drugs.

- The average cost per prescription for specialty drugs in SFY18 was $7,004 which represents a decrease of $172 from SFY17.

Changes to Coverage for Hepatitis C Agents

Hepatitis C Direct-Acting Antiviral (DAA) drugs are highly effective and offer high cure rates for patients with Hepatitis C Virus (HCV). DAA total amount paid increased by 17.46% between SFY2017 and SFY18, while at the same time claim count increased 65.15%. This is due primarily to competition and the introduction of drugs with lower wholesale acquisition cost (WAC).

DVHA will continue to see a significant financial impact as a result of these drugs as more beneficiaries continue to be treated for HCV. There are two DAA drugs on the DVHA's top-10 list by gross spend, Epclusa® and Harvoni®, the latter of which is being replaced by Mavyret® toward the middle of SFY18/into SFY19. Mavyret® is notable in that it can be used for all genotypes. Many patients can be treated with an eight-week course of therapy (with a lower cost of treatment) versus 12 weeks for some other DAA agents.

In January 2018, the "Fibrosis Score = 2 or more" requirement was removed from prior authorization criteria for DAA drugs. This opened the door for broader access to treatment for Hepatitis C-infected patients. DAA drugs represent the highest cost per prescription of any drug on DVHA's top-10 list by gross spend. These drugs are a focus of Pharmacy Care management (PCM) services, which are designed to facilitate adherence and follow up, and to enable the best clinical outcomes for beneficiaries.

Opioids and Drugs Used to Treat Opioid Use Disorder

Opioid partial agonists, which include Suboxone®, are DVHA's top drugs in terms of both spend and utilization. In SFY18, the number of claims for all buprenorphine-containing drugs increased by 8.26% and the utilization of Suboxone® increased by 10.59%, supporting the trend toward more patients with opiate-use disorder accessing treatment. Vermont is recognizing and treating opioid addiction as a chronic medical condition. This has expanded access for those who seek treatment and, in some counties, greatly decreased wait times for those patients. The Hub and Spoke program continues to be a valuable resource for improved access and treatment.

Table 9. Top Therapeutic Drug Classes by Gross Spend

Current Rank	Previous Rank	Drug Name	2017 Gross Paid	2018 Gross Paid	2017 Claim Count	2018 Claim Count	Total Amount Paid Change	Claim Count Paid
1	1	Opioid Partial Agonist	$12,038,870.18	$14,060,281.05	115,966	125,547	16.79%	8.26%
2	5	Hepatitis Agents	$10,163,836.97	$11,938,034.43	528	872	17.46%	65.15%
3	2	Insulin	$11,902,281.44	$11,838,769.70	15,554	15,508	-0.53%	-0.30%
4	4	Amphetamines	$11,211,854.03	$11,646,725.94	53,916	55,248	3.88%	2.47%
5	3	Stimulants – Misc.	$11,215,354.46	$10,560,261.27	49,171	49,860	-5.84%	1.40%
6	6	Sympathomimetics	$9,955,629.22	$10,192,620.08	66,520	65,739	2.38%	-1.17%
7	8	Anti-TNF-Alpha-Monoclonal Antibodies	$6,500,330.73	$9,174,851.15	1,375	1,737	41.14%	26.33%
8	7	Anticonvulsants-Misc.	$6,504,560.05	$7,102,910.87	67,974	68,918	9.20%	1.39%
9	9	Antiretrovirals	$4,881,763.74	$5,140,765.56	2,580	2,627	5.31%	1.82%

10	10	Cystic Fibrosis	$4,474,383.02	$4,735,130.36	568	561	5.83%	- 1.23%

Table 10. Top <u>Drugs</u> by Utilization

Current Rank	Previous Rank	Drug Name	2017 GROSS PAID	2018 GROSS PAID	2017 Rx Count	2018 Rx Count	GROSS PAID CHANGE	CLAIM COUNT CHANGE
1	1	Suboxone	$11,194,619.81	$13,299,665.84	98,204	108,600	18.80%	10.59%
2	2	Proair HFA	$2,818,110.06	$3,044,148.42	39,523	39,291	8.02%	-0.59%
3	3	Methylphenidate HCL	$5,728,086.69	$5,356,793.96	36,413	35,820	-6.48%	-1.63%
4	4	Gabapentin	$457,227.50	$531,295.78	30,132	30,834	16.20%	2.33%
5	5	Sertraline HCL	$290,370.22	$352,269.24	29,307	29,279	21.32%	-0.10%
6	6	Fluoxetine HCL	$244,960.75	$292,410.18	25,486	25,506	19.37%	0.08%
7	7	Vyvanse	$5,904,769.94	$6,597,801.73	23,624	25,007	11.74%	5.85%
8	9	Amoxicillin	$223,374.82	$286,588.67	22,600	23,627	28.30%	4.54%
9	8	Omeprazole	$275,942.24	$313,122.65	22,845	21,876	13.47%	-4.24%
10	10	Clonazepam	$144,919.23	$205,579.95	21,721	19,107	41.86%	-12.03%

While increased utilization of drugs used to treat Opioid Use Disorder (e.g. opioid partial agonists) was observed, opioid prescription utilization decreased by 30% and the number of beneficiaries using opiates decline by 36%. There continues to be a significant focus on initiatives to address the opioid crisis. Vermont has put into place better prescribing practices and rules limiting the quantities of opioids that can be prescribed. For example, 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. Educational initiatives and awareness around treating chronic pain differently – without the use of opioids – is also a contributing factor to the decline.

Naloxone for Opioid Overdose

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.healthvermont.gov/sites/default/files/documents/pdf/RESP_Naloxone_standingorder.pdf

This policy is in accordance with a standing order issued pursuant to 18 V.S.A. § 4240(c)(1), which 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, can access naloxone 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, several naloxone products are widely available and preferred on the DVHA's PDL without any prior authorization requirement for Medicaid beneficiaries. 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 used with an intranasal mucosal atomizing device. The following chart depicts DVHA's utilization of all naloxone products for CY2018.

Table 11. Utilization of All Naloxone Products – CY2018

PRODUCT DESCRIPTION	DOSAGE FORM	CLAIM COUNT	DISTINCT MEMBER COUNT	TOTAL AMOUNT PAID
NALOXONE INJ 0.4MG/ML	Solution Cartridge	2	2	$ 35.52
NALOXONE INJ 1MG/ML	Solution Prefilled Syringe	5	5	$ 308.79
NARCAN SPR	Liquid	805	798	$ 100,351.49
	TOTALS	812	777	$ 100,695.80

Auto Prior Authorization

To reduce provider administrative burden, DVHA implemented an automated drug prior authorization (PA) program that has eliminated a substantial number of manual prior authorizations that would have had to be completed by provider staff. For a growing number of drugs, the pharmacy claims processing system checks the beneficiary's record for the required medical diagnosis on the claim's date of service. The system can also automatically calculate the daily dose of a medication based on the patient's medication history and the quantity and days' supply submitted. These "auto-PA" edits were implemented in response to feedback received from providers and have had a positive impact on both providers and patients. DVHA will continue to monitor manual and automated PA volume and implement additional automated edits over the next few years. The goal is to reduce provider burden while assuring clinical and financial integrity of pharmacy programs.

E-Prescribing

Through its PBM, Change Healthcare, DVHA has established a connection with Surescripts to provide data for Medicaid beneficiaries. Surescripts supports standard electronic prescription transactions to allow clinicians to securely e-prescribe within their existing workflow system. Providers who use electronic prescribing now have access to Vermont Medicaid data to assist them in managing prescriptions for Medicaid beneficiaries more efficiently. DVHA has made available the beneficiary's outpatient pharmacy claims history, Medicaid eligibility status, and the status of prescribed drugs on the Medicaid Preferred Drug List (PDL). Surescripts currently processes approximately 240,000 EHR transaction requests monthly for DVHA beneficiaries.

Pharmacy Program Provider Portal

In 2018, DVHA launched the eWEBS Pharmacy Benefits Provider Portal developed by Change Healthcare and designed for use by registered prescribers and pharmacies to simplify access to beneficiary and drug information in a secure way. Prescribers are guided through preferred and non-preferred drug selections, and potential step therapy, dose limits, or other coverage restrictions, giving them the ability to make informed drug choices. Additionally, prescribers and pharmacists can look up beneficiary demographic information, eligibility, current and historic pharmacy claims, pharmacy location and telephone number, the PDL, PA criteria, and diagnosis code definitions. Most importantly, providers can electronically submit PA requests, track the progress of a request, and view PA determination results.

Pharmacy Care Management Program

In late SFY 2017, DVHA, in collaboration with Change Healthcare, implemented the Pharmacy Care Management (PCM) Program. The goal of the program was to mitigate the impact of high-cost specialty drugs on pharmaceutical expenditures while ensuring that the full value of these medications in improving patient outcomes and reducing medical expenditures can be realized. Achieving this goal would require focus, attentive oversight and management of both the drugs and the patients receiving them to ensure that patients are not only prescribed the optimal drug for their specific condition, but that they are taking the drug as prescribed and are receiving the appropriate monitoring, testing, and follow-up care.

The PCM Program documented savings of nearly $700,000 for DVHA during SFY18. The PCM program enrolled 711 total beneficiaries on 101 unique medications. PCM interventions may not always result in direct cost avoidance but are in place to encourage adherence and thus improve beneficiary outcomes and avoid unnecessary medical costs. The program continues to grow, identifying new beneficiaries and including more specialty medications as they are marketed and utilization increases.

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: a 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. DVHA received its final CMS certification on March 28, 2018. By achieving certification, DVHA can claim 75% federal financial participation (FFP) for maintenance and operations (M&O) costs.

340B Drug Discount Program

Effective April 1, 2018, the 340B program State Plan Amendment (SPA) was approved by the Center for Medicare and Medicaid Services (CMS). DVHA filed Medicaid SPA 18-0001 to update its payment methodology for drugs acquired through the 340B drug pricing program. Incorporating the 340B payment methodology in the State Plan is required by the Center for Medicare and Medicaid Services (CMS) based on the Covered Outpatient Drug Final Rule (81 FR 5170). The public comment period ended on April 9, 2018. No comments were received.

vi.   Choices for Care & Traumatic Brain Injury Programs

Key updates:
- Finalized consumer validation surveys for HCBS federal regulations.
- Initiated stakeholder feedback for an improved quality plan for Adult Family Care & Traumatic Brain Injury (TBI) services.
- 27% of TBI rehab participants returned to work.

Consumer Validation Surveys

The Adult Services Division (ASD) finalized an in-person consumer validation survey for 15% of all Adult Family Care, Adult Day and TBI shared living participants for each provider of services. The survey covered the same topic areas that were asked in the Provider Self-Assessment survey that was previously completed by each provider. Questions included physical environment characteristics, community integration, and privacy, dignity and respect.

Data from both surveys will be analyzed early 2019 to identify next steps in the work plan for HCBS regulatory alignment.

Adult Family Care (AFC) & Traumatic Brain Injury Program Quality Plan

The ASD drafted an improved quality plan for AFC and TBI shared living services that aligns with HCBS federal regulations and program standards. The plan was presented to providers during a training in November 2018 for feedback. A revised draft will be distributed for additional stakeholder input early 2019, prior to implementation.

TBI Program Employment Rate

One goal of the TBI program is to help participants return to work by focusing on person-centered goals, life skills aide services and connections to Vocational Rehabilitation services. In SFY2018, 27% of participants were able to return to work, exceeding the State's 25% target.

Wait Lists
- There continues to be provider wait lists for Moderate Needs Group, estimated at over 800 people statewide.
- There is currently no wait list for the TBI program.

2018 Year End Summary

1. DAIL's ASD completed its first cycle using the National Core Indicators for Aging and Disabilities (NCI-AD), joining DAIL's Developmental Disabilities Services Division in their continued use of the National Core Indicators for Developmental Disabilities (NCI-DD).
2. A 2% rate increase was approved by the Vermont legislature and implemented for Choices for Care home-based, Adult Family Care, and Enhanced Residential Care services.
3. The State increased the TBI Program appropriation from $5,641,336 to $6,005,225.
4. Act 172 was signed on May 25, 2018 establishing an Older Vermonters Act working group that will develop recommendations for an Older Vermonters Act aligned with the federal Older Americans Act, the Vermont State Plan on Aging, and the Choices for Care program.
5. Vermont is proud to have been chosen by the federal Administration for Community Living (ACL) as a recipient of a three-year cooperative agreement. The goal of this grant opportunity is to work with the Brain Injury Association, Department of Corrections and Vermont Department of Health to create and strengthen a system of services and supports that maximizes the independence, well-being, and health of people with traumatic brain injuries across the lifespan, their family members, and their support networks. Vermont will receive approximately $150,000 per year for three years (2018-2022). More information about the grant opportunity and Vermont's objectives can be found on the Adult Services Division news web page.

6. The State of Vermont and the American Federation of State, County and Municipal Employees (AFSCME) negotiated a new Collective Bargaining Agreement that raised the minimum wage for self-directed Independent Direct Support Workers to $11.30/hour and $172/day for daily respite (used by TBI, DS and Adult Family Care) effective 7/1/19.
7. The ASD drafted an improved quality plan for Adult Family Care and TBI shared living services.
8. The Department of Disabilities, Aging & Independent Living published its annual report, which includes a section about the Choices for Care and TBI program. The full annual report can be found on the Department's website at this link: https://dail.vermont.gov/sites/dail/files/documents/2018_Full_Annual.pdf

vii. *Developmental Disabilities Services Division*

Key updates:
- New payment model in development
- HCBS rules implementation
- Waitlist

New Payment Model in Development

The Developmental Disabilities Services Division (DDSD) and DVHA have initiated a project to explore a new payment model for Developmental Disabilities home and community-based services (HCBS). The program has grown significantly over the years from several hundred to several thousand participants. This has provided the impetus for modernization to allow for more efficient oversight of the program. Overall, the goal of this payment reform project is to create a transparent, effective, and administrable payment model for Developmental Disabilities Services that aligns with the broader payment reform and health care reform goals of AHS. The State has engaged stakeholders including recipients, families, advocacy organizations, and providers to participate in workgroups for the development and implementation of the new payment model.

DVHA has engaged a Medicaid reimbursement consultant firm to assist the State in completing a provider rate study. The rate study has collected detailed information from providers regarding actual costs to deliver the defined categories of service under HCBS. The providers have submitted their information to the consultant firm who is currently analyzing the data. The information gathered will be utilized in developing the new payment model. In addition to the provider rate study, the project is examining alternative assessment tools, resource allocation methods and options for more efficiently capturing encounter data for these services. The goal is to have a new payment model implemented by January 1, 2020, although adjustments to that date may be necessary. Ongoing work will be required, including seeking any needed CMS approval.

HCBS Rules Implementation

DDSD continues to work on implementing the HCBS rules to ensure compliance with all requirements by 2022. The Division has currently completed site visits to validate survey information submitted by providers. Providers are mostly in compliance with the setting requirements with minor changes being required. It is anticipated that all providers will be able to comply with the setting requirements and none will need to transition recipients to other settings. In addition, DDSD is developing policy guidance for providers to ensure compliance with the rules. The DDSD Quality Management Unit has incorporated

oversight of HCBS rule requirements into their overall quality review process to ensure ongoing compliance with the rules.

<u>Wait List</u>

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 by 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 HCBS funding priority who were waiting for services that helps address the need related to the funding priority. As of 6/30/18, there were 258 people who requested HCBS services but were denied because they did not meet a funding priority. 41 people were waiting for FMR and 49 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.

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

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Key updates:
- Continued quarterly reporting to the legislature from Q2 through Q4; the program submitted its latest report on December 15, 2018.
- Completed financial reconciliation activities for the 2017 performance year and notified stakeholders of final 2017 program results for financial and quality performance.
- Received Global Commitment Payment Model approval from CMS for the Medicaid Next Generation ACO Model for the 2019 and 2020 performance years in Q4.
- Executed a contract extension with OneCare for a 2019 performance year of the program.
- Continue to support Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model through future program planning and implementation.

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 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 executed a contract amendment to extend the VMNG program into a 2019 performance year in Q4. Refinements were made to the VMNG's attribution methodology to better reflect relationships between ACO-participating primary care providers and Medicaid beneficiaries. Other programmatic adjustments were minimal, to ensure continued alignment across payer programs as part of the Vermont All Payer ACO Model. The number of risk-bearing hospital communities will increase from ten to thirteen for the 2019 performance year, with continued participation from other providers within the communities. The number of attributed lives for the 2019 performance year will increase from approximately 42,342 lives to 79,140 lives.

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 beneficiary according to their Medicaid Eligibility Group, and the ACO is accountable for the cost and quality of care of each attributed beneficiary. 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, 2018. 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 beneficiary complaints, grievances, and appeals. While information on performance and utilization is helpful to understand how patterns generally compare for beneficiaries who are attributed to OneCare and beneficiaries who are not attributed to OneCare, caution should be exercised when using the information presented in this report to evaluate 2018 program performance. Claims lag continues to cause a delay in data availability and analysis, even as the program finished the final quarter of 2018. As such, DVHA will not have complete information on what services were provided to the attributed population during the reporting period until mid-2019. The full report can be found here: https://legislature.vermont.gov/assets/Legislative-Reports/VMNG-Report-to-Legislature-December-15-2018-FINAL.pdf

DVHA completed financial reconciliation activities for its 2017 performance year in mid-September 2018. Results were released on September 20, 2018. OneCare spent $2.4 million (or approximately 2.89%) less than its expected total cost of care during the program year and will retain those funds per the agreed-up risk corridor of 3% (upside and downside) of the expected total cost of care for the program's financial performance. OneCare demonstrated a quality score of 85% on 10 payment measures from its measure set, and some measures presented a good opportunity for improvement in future years. Further information regarding the VMNG's 2017 performance can be found here: https://legislature.vermont.gov/assets/Legislative-Reports/VMNG2017-Report-FINAL-09-20-18.pdf

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.

ix. *Substance Use Disorder Program*

Key updates:
- The SUD Program went into effect on July 1, 2018.
- Reporting on metrics will not be available until the first quarter report of 2019 (QE0319).
- Recovery Coaches in the Emergency Room Program launched in three communities.
- Revised versions of the Substance Use Disorder Treatment Standards and Compliance Assessment Tool were implemented.
- Reimbursement methodology change to residential treatment providers from a per diem payment to an "episodic payment", effective January 1, 2019. Vermont is planning to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS.
- A State Plan Amendment to update SUD coverage to align with the waiver was posted for public comment at the end of December and will be submitted to CMS shortly.

<u>Executive Summary</u>

During 2018 the State of Vermont continued to have all ASAM levels of care available and no ongoing waitlist to access to Medication Assisted Treatment. The Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP) finalized the scoring tool to determine the Preferred Providers' compliance and certification status and began implementing the tool. ADAP staff met with the Vermont Association of Addiction Treatment Professionals as part of the finalization process and elicited feedback from Preferred Providers of all ASAM levels of care.

ADAP continued to develop the value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The Vermont Medicaid payment reform team, ADAP clinical team, Health Department business office staff, and the Medicaid Policy Director met as needed to develop the financial modeling and the criteria for the differential case rate. The team researched models and coding. The team prepared a presentation of their recommendations for the State leadership. The ADAP Regional Managers provided oversight of and technical assistance to the Preferred Providers, including addressing clinically appropriate utilization of residential level of care. The ADAP Director of Clinical Services and the ADAP Director of Quality and Compliance identified the methods to capture the data elements for the Regional Managers' site visits.

ADAP met the established timelines of the RFP for the Centralized Intake and Call Center. The independent review was completed. The contract between the vendor and the State has been negotiated and received State approvals. The contract will process for execution in 2019.

Vermont's Director of Drug Prevention Policy and the Vermont Opioid Coordination Council produced their "Strategic Actions and Progress Report" (December 2018) available at: http://www.healthvermont.gov/sites/default/files/documents/pdf/OCC-Progress-Report-20181212.pdf. Several workgroups were established to develop the strategies. These included workgroups in prevention, treatment, and recovery/recovery housing.

Vermont launched the Recovery Coaches in the Emergency Room Program on July 1, 2018 at three sites. As of November 30th, 317 individuals were seen in the emergency rooms; up from 162 individuals seen at the end of September. Vermont plans to add up to six additional sites in 2019.

<u>Assessment of Need and Qualification for SUD Services</u>

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Implementation Update			
Compared to the demonstration design details outlined in the STCs and implementation plan, have there been any changes or does the state expect to make any changes to: A) the target population(s) of the demonstration? B) the clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration?			There are no planned changes to the target population or clinical criteria.
Are there any other anticipated program changes that may impact metrics related to assessment of need and qualification for SUD services? If so, please describe these changes.			There are no anticipated program changes.
☒ The state has no implementation update to report for this reporting topic.			

Milestone 1: Access to Critical Levels of Care for OUD and other SUDs

This reporting topic focuses on access to critical levels of care for OUD and other SUDs to assess the state's progress towards meeting Milestone 1.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 1 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)? SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs? **Summary**: There are no planned changes to access to SUD treatment or the SUD benefit coverage.			
Are there any other anticipated program changes that may impact metrics related to access to critical levels of care for OUD and other SUDs? If so, please describe these changes.			There are no anticipated program changes.
☒ The state has no implementation update to report for this reporting topic.			

Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

This reporting topic focuses on use of evidence-based, SUD-specific patient placement criteria to assess the state's progress towards meeting Milestone 2.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary

Milestone 2 Metric Trends
☒ The state is not reporting any metrics related to this reporting topic.
Milestone 2 Implementation Update

Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to:
a.   Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria?
b.   Implementation of a utilization management approach to ensure:
     i.   Beneficiaries have access to SUD services at the appropriate level of care?
    ii.   Interventions are appropriate for the diagnosis and level of care?
   iii.   Use of independent process for reviewing placement in residential treatment settings?

Summary: The revised version of the Substance Use Disorder Treatment Standards has been implemented. The Compliance Assessment Tool has also been updated and implemented to reflect the revised version of the Substance Use Disorder Treatment Standards. During 2018, the Compliance Assessment Tool will have been utilized with nine substance use disorder treatment providers.

An additional action item that was not reflected in the original implementation plan was the modification to ADAP's recertification survey. In order to ensure that documentation is collected consistently, thoroughly, and accurately, the application for the recertification has moved to an online survey process. This online survey makes the utilization of the Compliance Assessment Tool for the different ASAM Levels of Care more efficient. The providers completing the survey will indicate their level of care and will submit documents based on the level of care indicated.

Milestone 2 - Table 1

Action	Revised Completion Date	Responsible	Status
Finalize Substance Use Disorder Treatment Standards	August 1, 2018	Director of Quality Management and Compliance	Completed
Update Compliance Assessment Tool with revised Substance Use Disorder Treatment Standards and all residential ASAM criteria	August 15, 2018	Director of Quality Management and Compliance	Completed
Updated online recertification survey to reflect new revision of Substance Use Disorder Treatment Standards	October 31, 2018	Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Vergennes)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Bradford)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed

Implement the Compliance Assessment Tool	October 3, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use of the Compliance Assessment Tool to certify ASAM Level 3.3 Level of Care Provider (Recovery House)	March 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Not Completed
Use of the Compliance Assessment Tool to certify ASAM Level 3.2-WM Level of Care Provider (Act 1/Bridge)	March 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Not Completed

Vermont continues with the plan to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The Vermont team communicated with providers regarding the model and providers offered feedback. The implementation of the value-based portion of the new model is planned for implementation in 2020. Milestone 2 – Table 2 (below) will be updated in the first quarter report of 2019 (QE0319).

Milestone 2 – Table 2

Action	Date	Responsible
Develop the criteria for the differential case rate	Completed	ADAP Director of Clinical Services
Model the methodology using the identified criteria for the Vermont team to review	Completed	Payment Reform Team
Work with financial colleagues to finalize budget and rate decisions for the model	Completed	Payment Reform Team, ADAP Director of Clinical Services, VDH Business Office
Residential providers to provide feedback	Completed	ADAP Director of Clinical Services
Work with the Medicaid fiscal agent to identify and complete the necessary system's changes required for the Medicaid billing system	Completed	ADAP Director of Clinical Services, Payment Reform Team, DXC (Fiscal Agent)
Work with the residential providers to provide technical assistance and education around the necessary billing changes	Completed	ADAP Clinical Team
Regional Managers will partner with the compliance and quality team to determine the appropriate frequency with which the Regional Managers will perform the between audit chart reviews	Completed	ADAP Clinical Team and ADAP Quality Team

Are there any other anticipated program changes that may impact metrics related to the use of evidence-based, SUD-specific patient placement criteria (if the state is reporting such metrics)? If so, please describe these changes.			

☐ The state has no implementation update to report for this reporting topic.

Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

This reporting topic focuses on the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities to assess the state's progress towards meeting Milestone 3.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 3 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
Milestone 3 Implementation Update			

Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to:
a. Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards?
b. State review process for residential treatment providers' compliance with qualifications standards?
c. Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site?

Summary: The revised version of the Substance Use Disorder Treatment Standards has been implemented. The ADAP Compliance Assessment Tool has also been updated and implemented to reflect the revised version of the Substance Use Disorder Treatment Standards. The Compliance Assessment Tool will have been utilized with nine substance use disorder treatment providers.

An additional action item that was not reflected in the original implementation plan was the modification to ADAP's recertification survey. In order to ensure that documentation is collected consistently, thoroughly, and accurately, the application for the recertification has moved to an online survey process. This online survey will also make the utilization of the Compliance Assessment Tool for the different ASAM Levels of Care be more efficient. The providers completing the survey will indicate their level of care and will submit documents based on the level of care indicated. Please see Table 1 under Milestone 2 Summary above for further details.

There are no anticipated changes to the residential treatment provider qualifications, the state review process or the availability of medication assisted treatment at the residential facilities.

Are there any other anticipated program changes that may			

Prompts			
impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities (if the state is reporting such metrics)? If so, please describe these changes.			

☐ The state has no implementation update to report for this reporting topic.

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

This reporting topic focuses on provider capacity at critical levels of care including for medication assisted treatment (MAT) for OUD to assess the state's progress towards meeting Milestone 4.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 4 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 4 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care? **Summary**: Vermont continues to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The implementation of the value-based portion of the new model will be implemented in 2020. Please see Table 2 under Milestone 2 Summary above.			
Are there any other anticipated program changes that may impact metrics related to provider capacity at critical levels of care, including for			

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
medication assisted treatment (MAT) for OUD? If so, please describe these changes.			

☐ The state has no implementation update to report for this reporting topic.

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

This reporting topic focuses on the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD to assess the state's progress towards meeting Milestone 5.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 5 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			

☒ The state has no metrics trends to report for this reporting topic.

Milestone 5 Implementation Update			

Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to:
a. Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD?
b. Expansion of coverage for and access to naloxone?

Summary: The are no planned changes to the prescribing guidelines and other interventions.

Are there any other anticipated program changes that may impact metrics related to the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD? If so, please describe these changes.			

☒ The state has no implementation update to report for this reporting topic.

Milestone 6: Improved Care Coordination and Transitions between Levels of Care

This reporting topic focuses on care coordination and transitions between levels of care to assess the state's progress towards meeting Milestone 6.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 6 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 6 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports? **Summary**: Vermont implemented the Peer Recovery Coaches in the Emergency Department Program in three communities. A total of 317 individuals have been seen by recovery coaches.			
Are there any other anticipated program changes that may impact metrics related to care coordination and transitions between levels of care? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

SUD Health Information Technology (Health IT)
This reporting topic focuses on SUD health IT to assess the state's progress on the health IT portion of the implementation plan.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Metric Trends			
Discuss any relevant trends that the data shows related to			

assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			

☒ The state has no metrics trends to report for this reporting topic.

Implementation Update

Prompts: Compared to the demonstration design and operational details outlined in STCs and implementation plan, have there been any changes or does the state expect to make any changes to:

a. How health IT is being used to slow down the rate of growth of individuals identified with SUD?
b. How health IT is being used to treat effectively individuals identified with SUD?
c. How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD?
d. Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels?
e. Other aspects of the state's health IT implementation milestones?
f. The timeline for achieving health IT implementation milestones?
g. Planned activities to increase use and functionality of the state's prescription drug monitoring program?

Summary:

- Vermont's current vendor, Appriss reported that they have connected Florida with RxCheck. Although Vermont has a requirement and funding in the contract to connect to RxCheck for interstate data sharing, Appriss indicates that because Vermont plans to use it for connecting to health systems/EHRs it is outside the scope of the contract; this continues to be worked on. FL is only connecting through RxCheck so Vermont will need to connect with RxCheck before connecting with FL.
- Through prioritization of provider requests, VPMS identified Delaware as a key state and connected in 12/2018.
- VPMS was upgraded to Appriss's improved patient matching algorithm in 11/2018.
- VDH promoted the availability of technical assistance at the prescriber level. Promotion was integrated into the implementation of prescriber insight reports; the impact of implementation of the insight reports is being evaluated. Insight reports include metrics for providers about the prescriptions dispensed that they prescribed and comparisons with other providers within their specialty. Vermont issued the fourth round of prescriber insight reports in 10/2018. By the end of 2018, a total of 7,902 reports were sent to providers.
- VDH is conducting an impact evaluation of the 7/1/17 pain prescribing rule change; evaluation plan in place 12/2018. VDH continues to monitor trends to look for sustained change over time.
- Clinical alerts and threshold reporting were implemented in 2018. Clinical alerts highlight potentially dangerous prescription histories on patient reports. Threshold reporting provides a measure of potential misuse or diversion of prescriptions.
- A formal survey on impact of insight reports and clinical alerts was sent to prescribers at the end of 10/2018.
- The central intake and resource center will encompass a call center, public-facing informational website, and a web-based appointment board that will be leveraged to support Vermont's waitlist management and interim services provision. It will support consumers and professionals in accessing timely care for substance use disorder, improve integration of services, improve coordination of care, and increase the rate of retention of individuals in

treatment. A vendor was selected, an IT Project Manager has been onboarded, and a final draft contract has received approval to proceed to execution in 2019.			
Are there any other anticipated program changes that may impact metrics related to SUD Health IT (if the state is reporting such metrics)? If so, please describe these changes.			

☐ The state has no implementation update to report for this reporting topic.

x. *Global Commitment Register*

Key updates:
- Since the Global Commitment Register (GCR) launched in November 2015, 154 final GCR policies have been publicly posted.
- The GCR listserv expanded to approximately 450 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 450 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 2018. Of the 55 final policies issued, approximately 7 percent were notices of administrative rulemaking and 9 percent were State Plan Amendments (SPAs). Other final policies included reimbursement/rate changes, coding corrections, waiver amendment and public forums, and changes to covered services. There were 5 policy clarifications issued through the GCR in 2018, including an announcement of updated Federal Poverty Levels for MAGI-based Medicaid.

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. 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:

- Review and approve drug use criteria and standards for both retrospective and prospective drug use reviews (DURs)
- Apply these criteria and standards in the application of DUR activities
- Review and report the results of DURs, and
- 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 2018, the DURB held two meetings. Information on the DURB and its activities in 2018 is available here: http://dvha.vermont.gov/advisory-boards.

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. *Vermont Integrity Program*

Key updates:
- DVHA's Program Integrity Unit underwent reorganization in 2018, resulting in two units now supporting Vermont's overall Integrity Program – Oversight & Monitoring Unit and Program Integrity Unit.
- Corrective action plans were put in place and actively pursued to ensure a reduction in repeat findings. The result was a reduction from 3 to 1 repeat findings reduction for SFY 2017 Single audit.
- Facilitated six state and federal audits of DVHA programs from Federal and State regulators.
- All DVHA units have been a part of the Standard Operating Procedure (SOP) project this year. The SOP project was needed to standardize how each department documents the risks and controls in each area and to provide leadership, regulators, examiners, and auditors with documentation to support the assessment that DVHA has a strong control environment. Being able to document a strong control environment (that stands up to audit testing) results in reduced testing and findings.

Program Integrity Unit

The Program Integrity Unit (PIU) is responsible for ensuring provider and beneficiary compliance with federal and state Medicaid regulations and has the responsibility to monitor, detect, prevent, and investigate inappropriate use of resources, fraud, waste and abuse.

The PIU works with providers, beneficiaries, federal and state partners such as the Centers for Medicare & Medicaid (CMS), Office of Inspector General (OIG), Medicaid Fraud & Residential Abuse Unit (MFRAU), fiscal agents, contractors, and many other various partners to ensure that federal and state regulatory requirements are met, and that compliance and integrity are fundamental in all aspects of the Vermont Medicaid program.

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.

PIU 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 investigations.

The Provider Audit & Compliance Unit (PACU)

The PACU works to establish and maintain the integrity of the Medicaid program by engaging in activities to prevent, detect and investigate Medicaid provider fraud, waste and abuse. PACU receives referrals from a variety of sources and uses data mining and analytics to investigate allegations of fraud, waste and abuse. PACU works with Vermont Medicaid providers and partners to identify payment

integrity issues and will provide education to providers when deficiencies and incorrect billing practices are identified. PACU works with providers to develop the appropriate resolution and recovers overpayments. Cases with credible allegations of fraud are referred to MFRAU. In addition, PACU assists other Medicaid program units to facilitate changes in policies, procedures, and program logic to ensure the integrity of the programs.

Beneficiary Fraud Investigative Unit (BFIU)

The responsibility of the BFIU is to investigate, detect and prevent beneficiary healthcare eligibility and enrollment fraud in the Vermont Medicaid Program. All other non-healthcare programs remain the responsibility of the Department for Children and Families (DCF). The BFIU team works with DCF to evaluate and investigate allegations received. 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 correct.

Outcomes

The Vermont PIU is regularly regarded by CMS, as well as other federal and state partners, as a leading and strong unit. The PIU takes pride in ensuring the appropriate use and spending of Medicaid federal and state dollars, which further allows for more flexibility in the budget to consider increased coverage options, increased budgetary appropriations, and potential increased rates.

In SFY 2018, the PACU worked more than 300 provider fraud, waste and abuse allegation cases. Of these cases, PACU successfully settled, recovered and cost-avoided a collective $4,433,183. Case settlements and recoveries totaled $4,221,551 and the unit projected a cost avoidance savings of $211,632.

In SFY 2018, the BFIU successfully cost-avoided and settled a collective $560,124. The cost avoidance amount of $544,809 was achieved by working the Public Assistance Reporting Information System (PARIS) Interstate Match Report. This report identifies beneficiaries that are active in two or more state Medicaid programs. BFIU was able to identify, investigate and determine the beneficiaries correct state Medicaid Program. BFIU also recouped $15,315 in a case settlement.

Oversight & Monitoring Unit
The Oversight & Monitoring Unit (OMU) is responsible for ensuring compliance, proper oversight, and appropriate use of Federal and State funds with minimal waste. OMU works to promote efficiency, accountability, compliance, and integrity within the DVHA Healthcare Program.

OMU includes Healthcare Program Oversight & Monitoring (O&M), HealthCare Quality Control (HCQC), and Promoting Interoperability/EHR Incentive Program (HIT Auditor).

Effective oversight & monitoring ensures:
- Compliance with Federal & State Medicaid Policies and regulations
- Transparent and appropriate responses to external audits
- Timely response to corrective action requests
- Clear documentation of policies and procedures (SOPs)
- Mitigation of potential fraud, waste and abuse

OMU works in partnership with the Program Integrity Unit, 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.

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 AHS 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 by establishing a basis of understanding and expectation for regulators, examiners, auditors, independent auditors and State senior leadership.

Outcomes

In calendar year 2018 the 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 six state and federal audits of DVHA programs, including KPMG CAFR, KPMG DVHA A133 Single Audit, PERM, Berry Dunn Financial and Programmatic Audits, and CMS Targeted Desk Reviews.
- KPMG DVHA A133 Single Audit reduction of 2 repeat findings to 1.
- Provided ongoing tracking and monitoring and follow-up of mitigation plans and other open Corrective Action Plans.
- Supported AHS and 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)

HCQC was established to enhance DVHA's healthcare quality control program by performing independent monthly case reviews (post completion) for MAGI-based, VPharm, and Non-MAGI-based health care programs. Results of their reviews are shared with the Health Access Eligibility & Enrollment Unit (HAEEU), Long-Term Care (LTC), and Coordination of Benefits (COB) units. The HAEEU formally implemented a front-end internal Quality Assurance unit in early 2018 to complement the work conducted by HCQC.

Outcomes
- For FY 2018, 742 cases were reviewed.
- To date for FY 2019, 429 cases have been reviewed.
- Streamlined the Difference Resolution process to mirror the CMS DR process.

Promoting Interoperability Program (HIT Auditor)

The EHR Incentive Program (rebranded this year to the Promoting Interoperability Program (PIP)), was established by the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act (ARRA). The program is designed to support providers during the period of health information technology transition and includes the requirement that States develop financial oversight and monitoring of expenditures for the Medicaid EHR Incentive Program/PIP. The post-payment audit function of the program was transitioned under the Oversight & Monitoring Unit this year.

Outcomes
- Audits are performed following an Audit Plan, annually approved by CMS, to accommodate rule changes.
- Approximately ten percent of individual providers and fifty percent of hospitals are selected for audit each program year.
- This year, fifty individual and two hospital audits have been completed, with one individual failing audit. The incentive money is scheduled to be returned.

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

Methods
Utilization statistics for inpatient, outpatient, and emergency department services provided under Global Commitment during FFY 2016-18 were compiled by the DVHA's Data Unit in February 2019 using paid claims data. The scope of analysis included institutional services provided under the Medicaid program between 10/1/2015 and 9/30/2018, excluding crossover claims.[3] 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 2016-18.

Table 12. Inpatient Utilization by Fiscal Year and Age Group

Total Inpatient:									
	Sum LOS Days			**Discharges**			**Average LOS Days**		
Age	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**	**2016**	**2016**	**2018**

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[3] 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.

Age	Sum LOS Days 2016	2017	2018	Discharges 2016	2017	2018	Average LOS Days 2016	2017	2018
<1	12,024	10,882	10,658	2,996	2,879	2,794	4.0	3.8	3.8
1-9	2,276	2,355	2,606	459	399	461	5.0	5.9	5.7
10-19	8,621	8,091	8,979	1,173	1,053	1,194	7.3	7.7	7.5
20-44	27,602	29,171	31,704	6,122	6,022	6,184	4.5	4.8	5.1
45-64	20,982	21,785	23,809	3,850	3,782	3,934	5.4	5.8	6.1
65+	1,303	1,050	590	96	139	85	13.6	7.6	6.9
Overall	**72,808**	**73,334**	**78,346**	**14,696**	**14,274**	**14,652**	**5.0**	**5.1**	**5.3**

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

Age	Sum LOS Days 2016	2017	2018	Discharges 2016	2017	2018	Average LOS Days 2016	2017	2018
<1	11,834	10,671	10,549	2,968	2,848	2,774	4.0	3.7	3.8
1-9	1,895	1,972	2,216	371	341	384	5.1	5.8	5.8
10-19	7,785	7,273	8,020	991	892	1,010	7.9	8.2	7.9
20-44	21,048	23,705	25,398	4,677	4,794	4,919	4.5	4.9	5.2
45-64	14,385	14,934	17,315	2,719	2,705	2,882	5.3	5.5	6.0
65+	1,059	883	526	78	116	74	13.6	7.6	7.1
Overall	**58,006**	**59,438**	**64,024**	**11,804**	**11,696**	**12,043**	**4.9**	**5.1**	**5.3**

A1) Alcohol/Substance Inpatient Medical:

Age	Sum LOS Days 2016	2017	2018	Discharges 2016	2017	2018	Average LOS Days 2016	2017	2018
<1	-	4	-	-	1	-	-	4.0	-
1-9	-	-	-	-	-	-	-	-	-
10-19	48	120	63	7	7	13	6.9	17.1	4.8
20-44	1,613	1,724	1,558	382	399	401	4.2	4.3	3.9
45-64	1,356	1,290	1,955	296	262	367	4.6	4.9	5.3
65+	24	-	4	1	-	1	24.0	-	4.0
Overall	**3,041**	**3,138**	**3,580**	**686**	**669**	**782**	**4.4**	**4.7**	**4.6**

A2) Mental Health Inpatient Medical:

Age	Sum LOS Days 2016	2017	2018	Discharges 2016	2017	2018	Average LOS Days 2016	2017	2018
<1	-	5	-	-	2	-	-	2.5	-
1-9	667	951	1,239	32	56	74	20.8	17.0	16.7
10-19	5,923	5,525	6,261	461	423	572	12.8	13.1	10.9
20-44	9,471	11,553	13,200	1,011	1,185	1,261	9.4	9.7	10.5
45-64	3,695	4,115	4,965	352	352	429	10.5	11.7	11.6
65+	378	120	149	5	4	6	75.6	30.0	24.8
Overall	**20,134**	**22,269**	**25,814**	**1,861**	**2,022**	**2,342**	**10.8**	**11.0**	**11.0**

A3) Other Inpatient Medical:

Age	Sum LOS Days 2016	2017	2018	Discharges 2016	2017	2018	Average LOS Days 2016	2017	2018
<1	11,834	10,662	10,549	2,968	2,845	2,774	4.0	3.7	3.8
1-9	1,228	1,021	977	339	285	310	3.6	3.6	3.2
10-19	1,814	1,628	1,696	523	462	425	3.5	3.5	4.0
20-44	9,964	10,428	10,640	3,284	3,210	3,257	3.0	3.2	3.3
45-64	9,334	9,529	10,395	2,071	2,091	2,086	4.5	4.6	5.0
65+	657	763	373	72	112	67	9.1	6.8	5.6

Overall	34,831	34,031	34,630		9,257	9,005	8,919		3.8	3.8	3.9

B) Inpatient Surgery:

	Sum LOS Days			Discharges			Average LOS Days		
Age	2016	2017	2018	2016	2017	2018	2016	2017	2018
<1	190	211	109	28	31	20	6.8	6.8	5.5
1-9	381	383	390	88	58	77	4.3	6.6	5.1
10-19	836	818	959	182	161	184	4.6	5.1	5.2
20-44	6,554	5,466	6,306	1,445	1,228	1,265	4.5	4.5	5.0
45-64	6,597	6,851	6,494	1,131	1,077	1,052	5.8	6.4	6.2
65+	244	167	64	18	23	11	13.6	7.3	5.8
Overall	14,802	13,896	14,322	2,892	2,578	2,609	5.1	5.4	5.5

The following table (Table 6) presents visit counts by age for outpatient services provided in FFY2016-18, first for all outpatient clinic services, emergency department services, other outpatient services, and then the combination of ED and other outpatient.

Table 13. Outpatient Utilization by Fiscal Year and Age Group

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%
FFY18				EXCLUDING Clinic	
Age	Clinic*	ED	Other	ED & Other	%ED
<1	0	2,473	2,958	5,431	46%
1-9	0	13,764	19,581	33,345	41%
10-19	0	15,181	32,037	47,218	32%
20-44	0	36,322	104,607	140,929	26%
45-64	0	15,572	88,145	103,717	15%
65+	0	162	1,303	1,465	11%
Overall	0	83,474	248,631	332,105	25%

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

Discussion

In FFY2018, Global Commitment, Medicaid, paid for 14,652 inpatient stays and 332,105 outpatient visits for Vermonters. The total number of inpatient visits increased 7.6% from FFY16 through FFY18. Eighty-two percent of inpatient discharges were for medicine and 18% were for surgery. Outpatient visits have decreased largely due to an end to provider-based billing where hospital owned practices bill for separate professional fees and outpatient clinic facility fees that stopped on June 30, 2016.

Alcohol/substance-abuse inpatient stays were somewhat longer duration, inpatient surgeries were moderately longer, and psychiatric stays were much longer duration than other inpatient medical stays. Psychiatric inpatient medical services constituted 16% of the total inpatient stays (up from 14% during FFY17) and medical treatment for alcohol and substance abuse were 5% of the total inpatient stays. Total bed days increased for both psychiatric and alcohol/substance abuse stays during FFY16 to FFY18. Average length of stay alcohol/substance abuse was about the same duration with an average of 4.6 days in FFY18 and inpatient psychiatric medical average length of stay was about 11 days.

Among outpatient visits, emergency department visits constituted roughly 25% of the emergency and other outpatient visits throughout the three-year period. Outpatient clinic facility visits were treated separately in this report due to fluctuations in billing practices and were zero in FFY17/FFY18 since outpatient clinic billing has ended.

VII. Policy and Administrative Difficulties

Fiscal & Operational Management:
For all CY2018, 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.

The tracking of Budget Neutrality was updated in QE0918 to reflect the approval of claiming federal financial participation (FFP) for SUD services delivered in an IMD. The Supplemental Budget Neutrality Test for SUD Expenditures shows that SUD IMD expenses for ABD Adult, ABD Dual and non-ABD Adult have not exceeded the without waiver limits. The SUD IMD expenses for the New Adult MEG have slightly exceeded the without waiver limit by $118,883 gross; however, there is ample headroom in the non-SUD IMD New Adult budget neutrality to accommodate this overage. The overall Budget Neutrality is in a favorable position.

It should also be noted that per STC#41, the State stayed below the CY2018 funding limit of $7.1M for state funded marketplace subsidies with a cumulative total of $6.2M. Also, the State's CY2018 annual investment expenditures of $148.5M complied with the STC#84 annual limit.

AHS submitted the calendar year 2019 PMPM Medicaid rates during the QE1218 quarter.

AHS continues to work with DVHA on calculating the 2017 Medical Loss Ratio (MLR) per STC#24b. This is the first time that DVHA must comply with this requirement. There is no standard template for a State-based managed care-like model and AHS sought technical assistance from the CMS Regional Office with the development of the calculation. AHS and DVHA are close to having this task complete.

VIII. Capitated Revenue Spending

The PMPM rates as set for 1/1/18-12/31/18 are listed below. The rates effective 7/1/18 reflect the addition of SUD IMD allowable expenses.

Table 14. PMPM Capitated Rates

	Monthly Capitation Rate 1/1/18-6/30/18	Monthly Capitation Rate 7/1/18-12/31/18
ABD Adult	$1,543.54	$1,549.16
ABD Child	$2,634.96	$2,634.96
ABD Dual	$1,655.26	$1,657.20
Global Rx	$88.19	$88.19
LTC Moderate	$461.55	$461.55
New Adult	$444.91	$455.68
Non-ABD Adult	$518.79	$524.56
Non-ABD Child	$442.36	$442.36

Attachments

Attachment 1 - Budget Neutrality

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY 16 JAN - DEC 2021	Total
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 142,860,455	$ 130,497,152	$ -	$ -	$ -	$ 273,357,607
ABD - Non-Medicare - Child	$ 85,359,001	$ 77,931,506	$ -	$ -	$ -	$ 163,290,507
ABD - Dual	$ 664,153,383	$ 690,844,046	$ -	$ -	$ -	$ 1,354,997,429
ANFC - Non-Medicare - Adult	$ 101,757,250	$ 97,009,319	$ -	$ -	$ -	$ 198,766,568
ANFC - Non-Medicare - Child	$ 392,665,288	$ 405,948,875	$ -	$ -	$ -	$ 798,614,163
Total Expenditures Without Waiver	**$ 1,386,795,376**	**$ 1,402,230,897**	**$ -**	**$ -**	**$ -**	**$ 2,789,026,274**
With Waiver						
ABD Non Medicare Adult	$ 162,605,120	$ 162,733,910	$ -	$ -	$ -	$ 325,339,030
ABD - Non-Medicare - Child	$ 66,594,520	$ 60,079,345	$ -	$ -	$ -	$ 126,673,865
ABD - Dual	$ 445,853,945	$ 461,750,677	$ -	$ -	$ -	$ 907,604,622
ANFC - Non-Medicare - Adult	$ 84,041,960	$ 83,562,231	$ -	$ -	$ -	$ 167,604,191
ANFC - Non-Medicare - Child	$ 305,549,938	$ 335,719,387	$ -	$ -	$ -	$ 641,269,325
Premium Offsets	$ (655,991)	$ (772,935)	$ -	$ -	$ -	$ (1,428,926)
Moderate Needs Group	$ 1,488,408	$ 1,378,915	$ -	$ -	$ -	$ 2,867,323
Marketplace Subsidy	$ 6,355,286	$ 6,242,717	$ -	$ -	$ -	$ 12,598,003
VT Global Rx	$ 13,824,516	$ 15,301,533	$ -	$ -	$ -	$ 29,126,049
VT Global Expansion VHAP	$ 414,824	$ 716,198	$ -	$ -	$ -	$ 1,131,023
CRT DSHP	$ 10,331,787	$ 9,240,772	$ -	$ -	$ -	$ 19,572,559
Investments	$ 142,332,671	$ 148,463,641	$ -	$ -	$ -	$ 290,796,312
Total Expenditures With Waiver	**$ 1,238,736,983**	**$ 1,284,416,393**	**$ -**	**$ -**	**$ -**	**$ 2,523,153,376**
Supplemental Test: New Adult (Gross)						
Limit New Adult	$ 370,689,611	$ 375,462,338	$ -	$ -	$ -	$ 746,151,949
Without Waiver SUD - IMD New Adult Expenditures		$ 2,707,237	$ -	$ -	$ -	$ 2,707,237
With Waiver New Adult Expenditures	$ 295,626,448	$ 312,118,542	$ -	$ -	$ -	$ 607,744,990
With Waiver SUD - IMD New Adult Expenditures		$ 2,826,120	$ -	$ -	$ -	$ 2,826,120
Surplus (Deficit)	*$ 75,063,163*	*$ 63,224,913*	*$ -*	*$ -*	*$ -*	*$ 138,288,076*
Supplemental Test: IMD SUD (Gross)						
SUD - IMD ABD - Non-Medicare - Adult		$ 264,603	$ -	$ -	$ -	$ 264,603
SUD - IMD ABD - Dual		$ 214,495	$ -	$ -	$ -	$ 214,495
SUD - IMD ANFC - Non-Medicare - Adult		$ 533,391	$ -	$ -	$ -	$ 533,391
Limit SUD IMD Without Waiver		**$ 1,012,489**	**$ -**	**$ -**	**$ -**	**$ 1,012,489**
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ -	$ -	$ -	$ 249,820
SUD - IMD ABD - Dual		$ 199,224	$ -	$ -	$ -	$ 199,224
SUD - IMD ANFC - Non-Medicare - Adult		$ 540,841	$ -	$ -	$ -	$ 540,841
Limit SUD IMD With Waiver		**$ 989,886**	**$ -**	**$ -**	**$ -**	**$ 989,886**
Surplus (Deficit)		*$ 22,603*	*$ -*	*$ -*	*$ -*	*$ 22,603*
Waiver Savings Summary						
Annual Savings	$ 148,058,394	$ 117,814,504	$ -	$ -	$ -	$ 265,872,897
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 44,417,518	$ 29,453,626	$ -	$ -	$ -	$ 73,871,144
Total Savings	$ 44,417,518	$ 29,453,626	$ -	$ -	$ -	$ 73,871,144
Cumulative Savings	*$ 44,417,518*	*$ 73,871,144*	*$ 73,871,144*	*$ 73,871,144*	*$ 73,871,144*	*$ 73,871,144*

11%   8%

New Adult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality New Adult tab (STC#64)
See CY2018 Investments tab
See EG MM CY 2018 Tab for Member Month Reporting

Budget Neutrality New Adult

New Adult (w/ and w/o Child) Medical Costs Only	DY 12 – PMPM				DY 13 – PMPM			
	QE 0317	QE 0617	QE 0917	QE 1217	QE 0318	QE 0618	QE 0918	QE 1218
(A) New Adult Group PMPM Projection	$518.26	$518.26	$518.26	$518.26	$540.03	$540.03	$540.03	$540.03
(B-1) eligible member months w/ Child	55,223	57,077	56,789	55,632	55,583	55,412	55,917	56,962
(B-2) eligible member months w/o Child	124,999	124,981	121,338	119,219	120,870	119,745	116,825	113,948
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 28,619,871.98	$ 29,580,726.02	$ 29,431,467.14	$ 28,831,840.32	$ 30,016,487.49	$ 29,924,142.36	$ 30,196,857.51	$ 30,761,188.86
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 64,781,981.74	$ 64,772,653.06	$ 62,884,631.88	$ 61,786,438.94	$ 65,273,426.10	$ 64,665,892.35	$63,089,004.75	$61,535,338.44
(D-1) New Adult FMAP w/ Child	54.46%	54.46%	54.46%	53.47%	53.47%	53.47%	53.47%	53.89%
(D-2) New Adult FMAP w/o Child	86.89%	86.89%	86.89%	86.69%	89.95%	89.95%	89.95%	89.99%
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 15,586,382.28	$ 16,109,663.39	$ 16,028,377.00	$ 15,416,385.02	$ 16,049,815.86	$ 16,000,438.92	$ 16,146,259.71	$ 16,577,204.68
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 56,289,063.93	$ 56,280,958.24	$ 54,640,456.64	$ 53,562,663.92	$ 58,713,446.78	$ 58,166,970.17	$ 56,748,559.77	$ 55,375,651.06
Subtotal Federal Share Supplemental Cap 1	$ 71,875,446.21	$ 72,390,621.63	$ 70,668,833.64	$ 68,979,048.94	$ 74,763,262.64	$ 74,167,409.09	$ 72,894,819.48	$ 71,952,855.74
Total FFP reported for New Adult Group	$ 62,816,665.28	$ 61,830,391.33	$ 54,643,069.28	$ 51,158,852.52	$ 62,183,045.44	$ 63,756,150.76	$ 62,666,336.47	$ 61,269,677.13
Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget neutrality	$ 9,058,780.94	$ 10,560,230.30	$ 16,025,764.37	$ 17,820,196.41	$ 12,580,217.20	$ 10,411,258.33	$10,228,483.01	$10,683,178.61

VERMONT

State of Vermont
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280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
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Agency of Human Services

Medicaid Program Enrollment and Expenditures Report

Q2 SFY 2019

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, 2019

Key Terms

Caseload – Average monthly member enrollment

MEG – Medicaid Eligibility Group

ABD Adult – 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 Childless - Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL who do not have dependent children

New Adult w/Child - Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL who have dependent children

BD 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

Sunsetted Programs - Expenditures still being incurred for programs no longer active such as VHAP, VHAP ESI, and Catamount.

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

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

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

Choices for Care - Acute - Long Term Care Medicaid for Vermonters who would otherwise qualify for Choices for Care - Traditional, but who are currently receiving a lower level of care

PMPM – Per Member Per Month

The Department of Vermont Health Access
Caseload and Expenditure Report
All AHS and AOE YTD SFY'19

Medicaid Eligibility Group	SFY'19 BAA Caseload	SFY'19 BAA Budget	SFY'19 BAA PMPM	SFY'19 Actuals Thru December 31, 2018 Caseload	SFY'19 Actuals Thru December 31, 2018 Expenses	SFY'19 Actuals Thru December 31, 2018 PMPM	% of Expenses to Budget Line Item
ABD Adult	6,250	$ 146,702,165	$ 1,956.03	6,500	$ 68,366,231	$ 1,753.03	46.60%
ABD Dual	17,742	$ 242,706,736	$ 1,139.98	17,562	$ 108,289,577	$ 1,027.68	44.62%
General Adult	12,958	$ 88,656,569	$ 570.15	11,141	$ 39,837,399	$ 595.97	44.93%
New Adult Childless	39,248	$ 227,769,694	$ 483.61	38,413	$ 113,533,213	$ 492.61	49.85%
New Adult w/Child	18,813	$ 87,998,161	$ 389.79	18,767	$ 44,763,261	$ 397.53	50.87%
BD Child	2,166	$ 64,844,308	$ 2,494.78	2,040	$ 27,459,057	$ 2,243.75	42.35%
General Child	59,811	$ 332,852,007	$ 463.76	59,103	$ 158,112,965	$ 445.87	47.50%
Underinsured Child	584	$ 1,469,272	$ 209.66	535	$ 676,044	$ 210.54	46.01%
CHIP	4,697	$ 12,551,135	$ 222.68	4,425	$ 5,493,445	$ 206.91	43.77%
Sunsetted Programs	-	$ -		-	$ 351,857		
Vermont Premium Assistance	19,085	$ 6,614,098	$ 28.88	17,072	$ 3,016,111	$ 29.45	45.60%
Vermont Cost Sharing	5,309	$ 1,520,434	$ 23.87	5,856	$ 850,461	$ 24.21	55.94%
Pharmacy Only	10,497	$ 11,278,883	$ 89.54	10,521	$ 3,912,702	$ 61.98	34.69%
Choices for Care - Traditional	4,390	$ 209,074,560	$ 3,968.77	4,281	$ 100,929,650	$ 3,929.06	48.27%
Choices for Care - Acute	4,390	$ 31,288,498	$ 593.94	4,281	$ 16,533,448	$ 643.63	52.84%
Total Medicaid	196,241	$ 1,465,326,521	$ 622.25	190,360	$ 692,125,421	$ 605.98	47.23%

The Department of Vermont Health Access
Caseload and Expenditure Report
All AHS YTD SFY'19

Medicaid Eligibility Group	SFY'19 BAA			SFY'19 Actuals Thru December 31, 2018			% of Expenses to Budget Line Item
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	
ABD Adult	6,250	$ 146,644,178	$ 1,955.26	6,500	$ 67,877,738	$ 1,740.50	46.29%
ABD Dual	17,742	$ 245,148,578	$ 1,151.45	17,562	$ 108,223,462	$ 1,027.05	44.15%
General Adult	12,958	$ 88,621,911	$ 569.93	11,141	$ 39,735,970	$ 594.45	44.84%
New Adult Childless	39,248	$ 228,050,283	$ 484.21	38,413	$ 113,508,186	$ 492.50	49.77%
New Adult w/Child	18,813	$ 88,060,301	$ 390.07	18,767	$ 44,762,950	$ 397.53	50.83%
BD Child	2,166	$ 49,597,023	$ 1,908.16	2,040	$ 22,055,111	$ 1,802.18	44.47%
General Child	59,811	$ 296,053,250	$ 412.48	59,103	$ 144,448,472	$ 407.34	48.79%
Underinsured Child	584	$ 1,078,976	$ 153.96	535	$ 563,151	$ 175.38	52.19%
CHIP	4,697	$ 10,740,115	$ 190.55	4,425	$ 4,865,313	$ 183.25	45.30%
Sunsetted Programs	-	$ -		-	$ 351,857		
Vermont Premium Assistance	19,085	$ 6,614,098	$ 28.88	17,072	$ 3,016,111	$ 29.45	45.60%
Vermont Cost Sharing	5,309	$ 1,520,434	$ 23.87	5,856	$ 850,461	$ 24.21	55.94%
Pharmacy Only	10,497	$ 11,278,883	$ 89.54	10,521	$ 3,912,702	$ 61.98	34.69%
Choices for Care - Traditional	4,390	$ 209,074,560	$ 3,968.77	4,281	$ 100,929,650	$ 3,929.06	48.27%
Choices for Care - Acute	4,390	$ 32,083,931	$ 609.03	4,281	$ 16,533,448	$ 643.63	51.53%
Total Medicaid	196,241	$ 1,414,566,521	$ 600.69	190,360	$ 671,634,583	$ 588.04	47.48%

The Department of Vermont Health Access
Caseload and Expenditure Report
DVHA Only YTD SFY'19

Medicaid Eligibility Group	SFY'19 BAA			SFY'19 Actuals Thru December 31, 2018			% of Expenses to Budget Line Item
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	
ABD Adult	6,250	$ 57,191,818	$ 762.56	6,500	$ 29,416,179	$ 754.28	51.43%
ABD Dual	17,742	$ 57,507,834	$ 270.11	17,562	$ 28,054,130	$ 266.24	48.78%
General Adult	12,958	$ 75,554,021	$ 485.89	11,141	$ 33,966,723	$ 508.14	44.96%
New Adult Childless	39,248	$ 202,267,933	$ 429.47	38,413	$ 101,136,541	$ 438.82	50.00%
New Adult w/Child	18,813	$ 81,007,952	$ 358.83	18,767	$ 41,545,815	$ 368.96	51.29%
BD Child	2,166	$ 20,395,140	$ 784.67	2,040	$ 10,412,258	$ 850.81	51.05%
General Child	59,811	$ 155,918,142	$ 217.24	59,103	$ 79,476,311	$ 224.12	50.97%
Underinsured Child	584	$ 502,278	$ 71.67	535	$ 224,488	$ 69.91	44.69%
CHIP	4,697	$ 8,362,970	$ 148.37	4,425	$ 3,986,651	$ 150.16	47.67%
Sunsetted Programs	-	$ -		-	$ 351,857		
Vermont Premium Assistance	19,085	$ 6,614,098	$ 28.88	17,072	$ 3,016,111	$ 29.45	45.60%
Vermont Cost Sharing	5,309	$ 1,520,434	$ 23.87	5,856	$ 850,461	$ 24.21	55.94%
Pharmacy Only	10,497	$ 11,278,883	$ 89.54	10,521	$ 3,912,702	$ 61.98	34.69%
Choices for Care - Traditional	4,390	$ 209,074,560	$ 3,968.77	4,281	$ 100,929,650	$ 3,929.06	48.27%
Choices for Care - Acute	4,390	$ 28,306,765	$ 537.33	4,281	$ 15,398,844	$ 599.46	54.40%
Total Medicaid	196,241	$ 915,502,828	$ 388.77	190,360	$ 452,678,721	$ 396.34	49.45%

VERMONT

Questions, Complaints and Concerns Received by Health Access Member Services
October 1, 2018 – December 31, 2018

The following information represents the weekly documentation of Green Mountain Care Member Questions, Complaints, and Concerns as reported to Green Mountain Care Member Services (1-800-250-8427) per quarter. Calls are addressed per guidelines (policy, scripts, multi-tier resolver groups) developed by the Department of Vermont Health Access and in collaboration with Maximus. The nature of each call is assessed by the customer service representative (CSR) and the appropriate action (appeal rights, fair hearings, policy explanation, etc.) is then applied. If the call requires an action or advice that is beyond the scope of information available to the CSR, the member is then afforded a warm transfer to the appropriate subject matter expert within DVHA (e.g. Provider and Member Relations, Health Access Eligibility & Enrollment Unit, etc.). Each documented question, complaint, or concern is captured in order to ensure that the member's needs are met and that proper resolution is guaranteed.

October 1 – October 5
- VPharm/VPharm Review/Reinstatements

October 8 – October 12
- VPharm/VPharm Review/Reinstatements
- Caller wanted to document feedback about the VTMedicaid website. She thinks the vtmedicaid list should be updated as she said she was given 7 dentists who accept medicaid from this website, but when she called them none of them claimed to accept Medicaid. CSR apologized for her frustrations and offered to document her feedback.

October 15 – October 19
- VPharm/VPharm Review/Reinstatements
- Caller wanted to submit negative feedback about how long it has taken for him to get his prescriptions. He states it has been such a hassle every time he goes to the pharmacy because the ghost TPL shows up and they have to call GHS to get an override. He does not feel it should be such a process for him to pick up his RX. CSR apologized for his frustrations and offered to document his feedback.

October 22 – October 26
- Nothing to report

October 29 – November 2
- Caller called because she was a patient at a crisis mental health center and while she was instructed to do duties that the staff should have been doing. She thinks that Medicaid

will be billed for work that other people should have been doing. She thinks that Medicaid is being billed for services and medications that are not needed. She is requesting that Medicaid go into some of these facilities (mental health and nursing homes) and make sure what Medicaid is paying for is what is actually being done or used and that no fraud is being committed. CSR apologized for her frustration and offered to document her feedback. Also offered the provider fraud contact info.

November 5 – November 9
- Nothing to report.

November 12 – November 16
- Caller stated that she called to update her income and during that session she also was asked about her citizenship and she needed to provide proof of citizenship. Caller stated that she relayed to the individual that she did not find it necessary for her to provide that information since it was just to update her income. Caller also relayed to her that her citizenship was addressed in the beginning when she first applied to Vermont Health Connect. The individual did relay to her that this question was a part of the normal questioning to process the income change. CSR apologized for any frustration, offered assistance, and to document the feedback

November 19 – November 23
- Nothing to report

November 26 – November 30
- Caller wanted to submit feedback about our communication. He states he has a speech impediment and sometimes having a verbal conversation is very difficult for him to carry on. He had an excellent idea for communication. He feels we should have a virtual forum for customers who have a difficult time speaking. CSR apologized for his frustrations and offered to document and pass along his suggestion.

December 3 – December 7
- Caller wanted to submit feedback about his Medicaid provider. He is upset because he states that his current PCP is not being professional. Caller states that there is some sort of communication breakdown, between the PCP, Specialists that caller sees, along with himself and his family. Also, caller has concerns with cardiology department, because that specialist did not respond back to him in a timely manner as they were supposed to do. The PCP and the cardiologist both seemed short with caller, and his family, and not giving him the attention that he needs for his healthcare. CSR apologized for his frustrations and offered to send him the provider complaint form. Sent him the form, but he also wanted his feedback documented.

December 10 – December 15
- Caller was calling regarding a letter they had received as part of a PA that was submitted on their behalf by their doctor and wanted to submit negative feedback about this process. Caller feels that the letter was not clear that they (the customers) did not have to take any action on what was missing for the approval of the PA, that their doctor would be sent the

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same letter and that they (himself and his pregnant wife) did not need to rush up to the hospital to get any information they could so they could respond to the request in the PA. When I explained about how the PAs are submitted and processed, he made a point to say that he feels it was a serious flaw in the letters to not actually tell the customer if it was something they needed to do something about or not. Caller strongly feels that the notices being more clear and concise would have alleviated their stress and lack of knowing how to handle the letter. CSR apologized to Caller that the forms were not more direct and clear with what was expected (if anything) as a result of receiving that letter. She also discussed the process with him and helped him understand. She also offered to document his feedback.

December 17 – December 21
- Nothing to report.

December 24 – December 28
- Nothing to report.

VERMONT

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
October 1, 2018 – December 31, 2018

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 15, 2019 from the centralized database that were filed from October 1, 2018 through December 31, 2018.

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 9 grievances filed; five were addressed and one was withdrawn 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, 100% were filed by beneficiaries. Of the 9 grievances filed, DMH had 88% and DAIL had 11%. There were no grievances filed for DVHA, VDH or DCF during this quarter.

Grievances were filed for service categories case management, counseling services, and mental health services.

There were no Grievance Reviews filed this quarter.

Appeals: Health Care Administrative Rule 8.100 defines adverse benefit determinations that the 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 52 appeals filed. Of these 52 appeals, 35 were resolved (67%), 15 were still pending (29%), and 2 were withdrawn (4%). The higher number of pending appeals this quarter was due to a change in the coordinator for DAIL. There were some issues around the resolution of cases that has now been resolved.

Of the 35 appeals that were resolved this quarter, 94% were resolved within the statutory time frame of 30 days. Two appeals were resolved after the 30-day timeframe, of these two appeals, one was extended at the request of the beneficiary. The average number of days it took to resolve these cases was 25 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

Of the 52 appeals filed, DVHA had 22 appeals filed (42%), DAIL had 23 (44%), VDH had 4 (8%) and DMH had 3 (6%).

The appeals filed were for service categories; long term care, personal care, orthodontics, home health, nursing, radiology, transportation, surgical, community supports, imaging, outpatient hospital services, prescriptions, respite and case management.

Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There were two fair hearings filed this quarter.

2018 Summary:

Grievances: There were 37 Grievances filed in 2018. Of those 37 grievances filed, DAIL had 14%, DMH had 75%, DVHA had 3% and VDH had 8%.

The top service categories for grievances filed were for mental health and case management.

Appeals: There were 200 appeals filed in 2018. Of those appeals filed, DAIL had 46%, DMH had 4%, DVHA had 45%, and VDH had 5%.

The top reasons for appeal were, orthodontic services, transportation services, community/social supports, imaging, long-term care and personal care services.

Grievances & Appeals
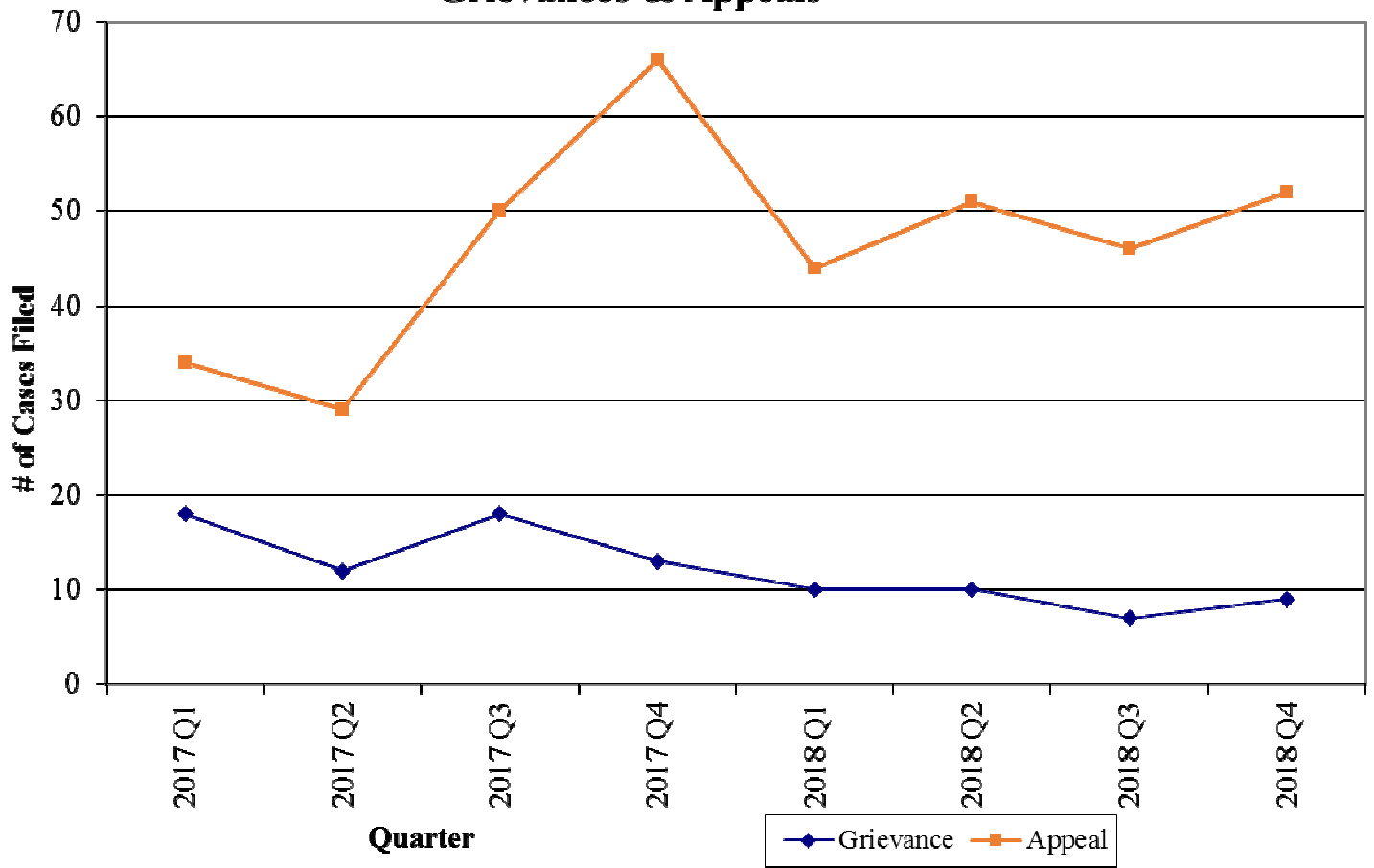
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Appeals by Service Category
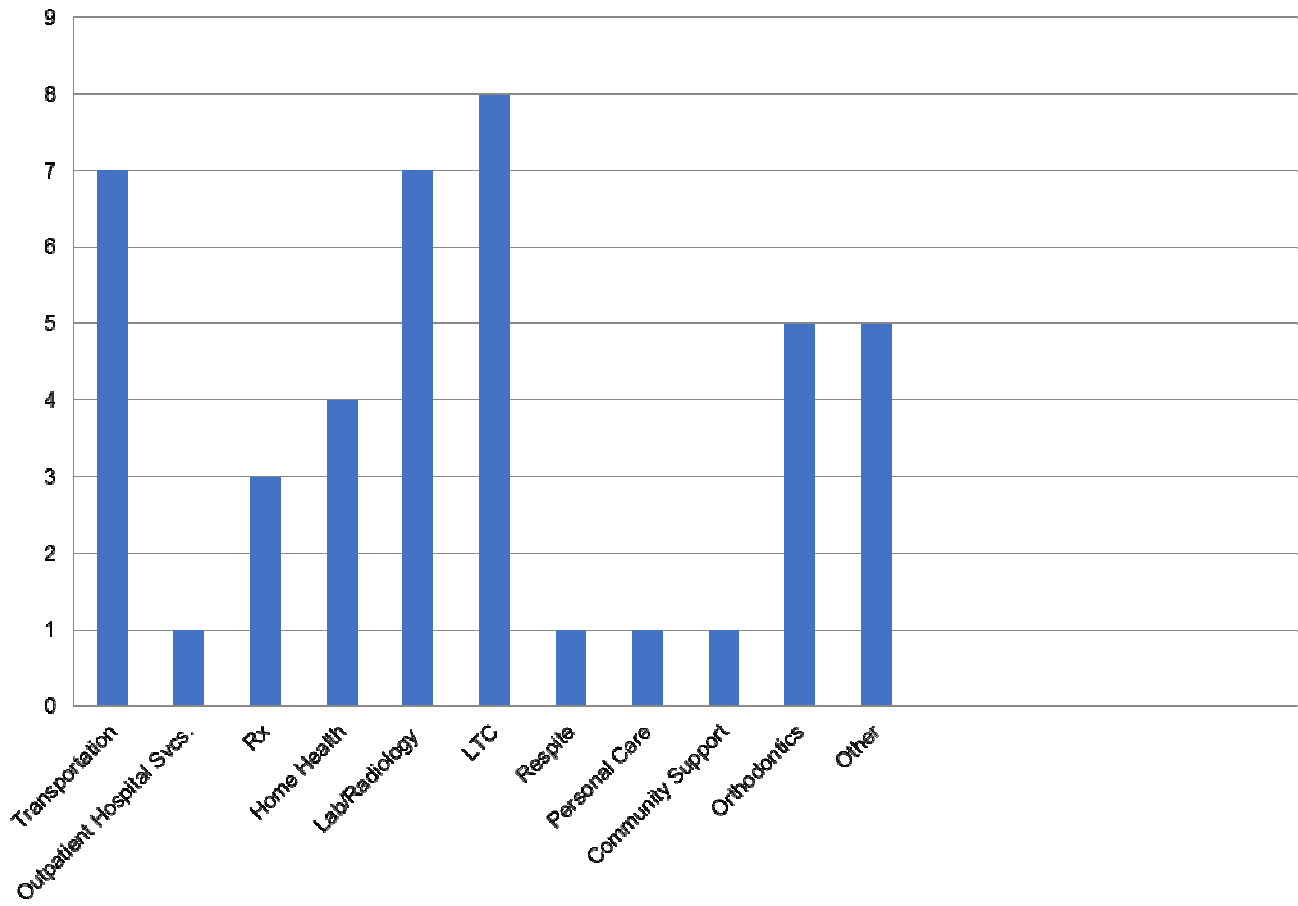
Grievance by Service Catagory
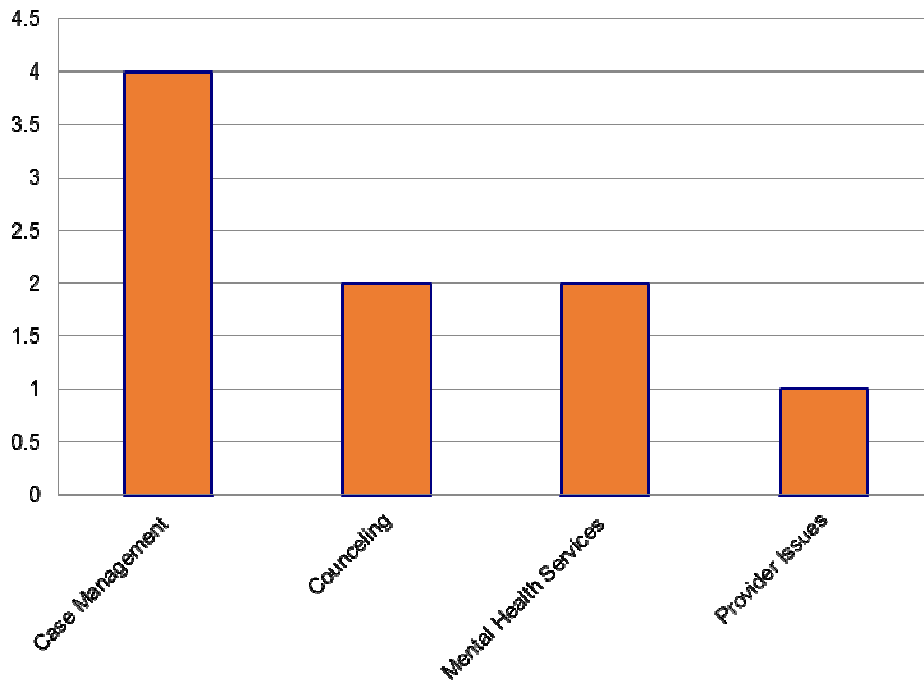
MCO Appeal Resolutions
10/1/2018 thru 12/31/2018

5%

21%

37%

8%

5%

24%

- Upheld
- Reversed
- Modified
- Withdrawn
- Approved by Dept/DA/SSA
- Timeframe Expired
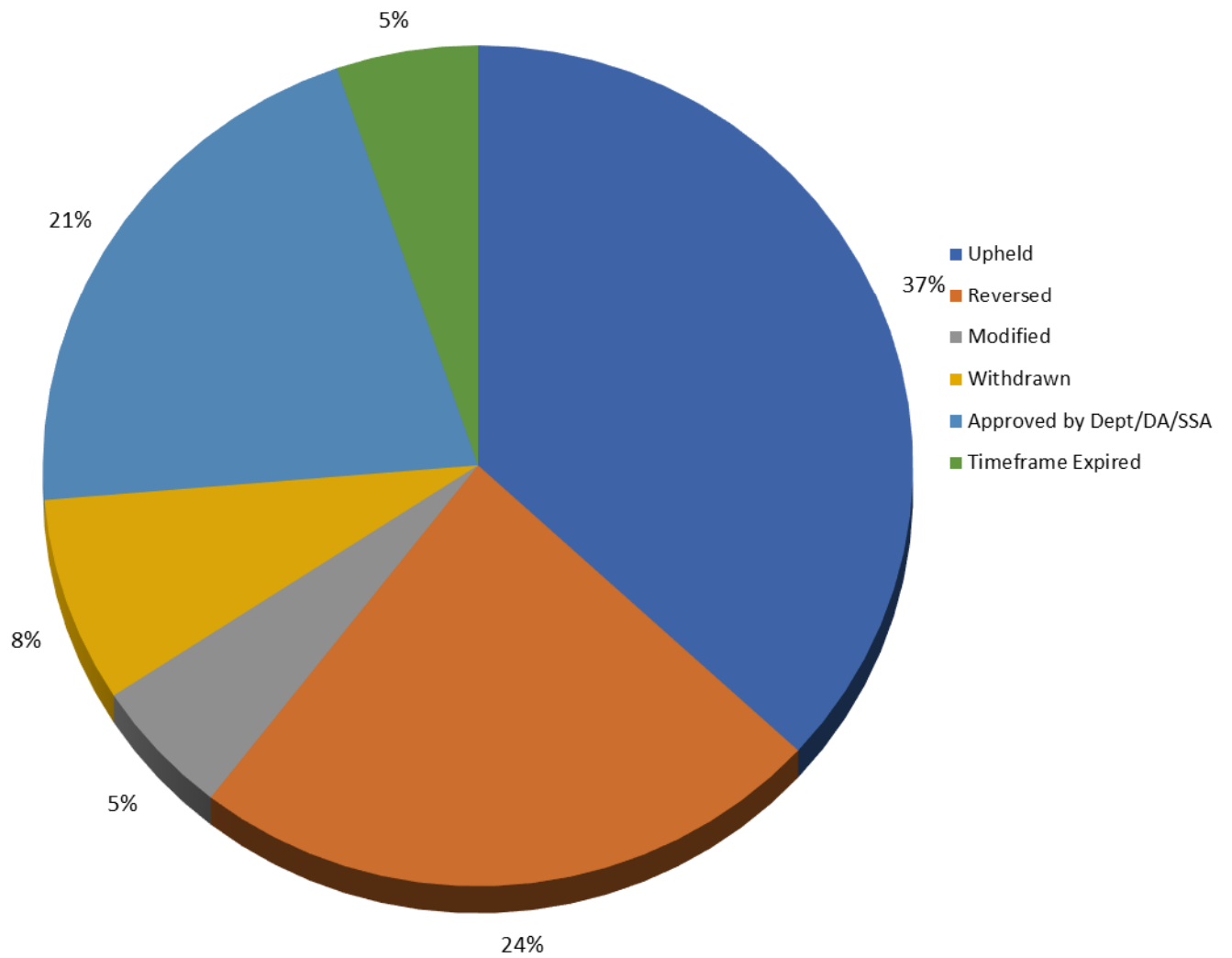
Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

October 1, 2018- December 31, 2018

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

January 18, 2019

TABLE OF CONTENTS

Introduction

The Office of the Health Care Advocate (HCA) advocates for all Vermonters through 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 through individual advocacy and representing the public before the Green Mountain Care Board, state agencies, and the state legislature.

This quarter, the HCA focused on helping consumers navigate Open Enrollment and find the plan that best met their health care needs. In 2019, households eligible for Advance Premium Tax Credit (APTC) will be getting, on average, $100 more in APTC per month. With this increased APTC, consumers on silver plans could buy gold plans for about the same monthly premium, such as Ronald's story described in the case narrative at the right.

The HCA helpline advocates spent considerable time educating consumers about silver-loading as well, and trying to help them understand the system. We had a significant increase in our cases related to Buying Insurance (54 vs. 13 last quarter) and Consumer Education (104 vs. 80 last quarter). This quarter, 200 of our cases were complex interventions, meaning that advocate spent two or more hours helping the consumer, which represented a 17% increase in complex cases from last quarter.

The HCA is working on a proposal to maximize the AV (actuarial value) for silver plans in 2020. With a maximized AV, consumers will be eligible for more APTC and be able to enroll in plans with lower out-of-pocket costs. We also remain concerned about the impact of Association Health Plans (AHPs) on the marketplace and believe that AHPs plan pose a risk to the stability of the marketplace. The HCA continues to work toward ensuring that all Vermonters are able to access affordable, quality health care coverage.

> **Ronald's Story:**
>
> Ronald called the HCA because both he and his son did not have health care coverage. Ronald had not enrolled on a VHC plan in 2018 because he did not think that he could afford it. His son had been on Dr. Dynasaur (Dr. D), but it had closed earlier in the year and Ronald had been unsure why. That meant both had no insurance for most of the year. Since it was the Open Enrollment Period, Ronald had a chance to enroll in a qualified health plan (QHP) on Vermont Health Connect (VHC) for 2019. When the HCA advocate reviewed Ronald's information, she found that he was eligible for several hundred dollars a month in Advance Premium Tax Credit (APTC). In 2019, the price of silver exchange plans on VHC had increased, in a strategy called "silver-loading." The increase in premium for silver plans meant that APTC-eligible households like Ronald's were eligible for more APTC. With the additional APTC, Ronald was able to enroll in a gold plan on VHC which would have lower out-of-pocket costs than the silver plans. The advocate also reviewed Ronald's son's eligibility for Dr. D and found that he was still eligible for that program and helped to expedite the application. Ronald's son was able to get onto Dr. D the month that he was found eligible, and Ronald's coverage started on January 1 of 2019.

The HCA represents Vermonters through individual, administrative and legislative advocacy. Our policy priorities reflect our daily work with Vermonters struggling with a health care system that often does not meet their needs. 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.

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 894 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:

- **25.84%** (231) about **Access to Care**
- **10.85%** (97) about **Billing/Coverage**
- **6.04%** (54) about **Buying Insurance**
- **11.63%** (104) about **Consumer Education**
- **23.83%** (213) about **Eligibility** for state and federal programs
- **20.58%** (184) 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 213 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 61 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, 2018 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**: 894 calls (compared to 840 last quarter)

  - **Department of Vermont Health Access (DVHA) beneficiaries**: 284 calls (297 calls last quarter)

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

- ○ **Commercial Plan Beneficiaries**: 161 calls (150 calls last quarter)

- ○ **Uninsured Vermonters**: 84 calls (80 calls last quarter)

- ○ **Vermont Health Connect (VHC)**: 208 calls (171 calls last quarter)

- ○ **Reportable Activities (Summary & Detail)**: 51 activities and 10 documents (88 activities, 8 documents)

Individual Consumer Assistance

Case Examples

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

Mason's Story:

Mason's mother called the HCA because Mason needed braces for his teeth, but Medicaid had told her that he did not meet the coverage requirements for braces. Mason was on Dr. Dynasaur (Dr. D). The family could not afford to pay for braces out of pocket. The family had appealed Medicaid's decision to deny coverage by asking for an internal appeal. The HCA advocate reviewed the Medicaid coverage criteria — and Mason's dental records, and recommended that the family talk with the orthodontist again to get a more up-to-date assessment of his teeth. The advocate also found out that Mason was getting therapy to help him with social adjustment issues at school. The therapist believed that braces were key to Mason's mental well-being and would help him stay engaged and focused at school. On the advice of the HCA, the family was able to get an additional letter from the therapist detailing how braces were vital to Mason's mental health and to submit new, more-detailed information from the orthodontist. When Medicaid reviewed the additional information, it approved the braces and Mason's mother was able to schedule his appointment to get the braces on his teeth.

Olivia's Story:

Olivia called the HCA when she found out that a pay raise she earned at work was going to make her son ineligible for Dr. Dynasaur (Dr. D). She called the HCA because she wanted to know if she needed to sign her son up on her employer insurance — her employer's open enrollment for signing up for coverage was ending the next day. However, the employer insurance was going to cost more for the monthly premium and have significantly more out-of-pocket costs than the Dr. D coverage. Olivia was paying $60 per month for Dr. D, and it had no deductible or copayments.   She was considering turning down the pay raise to stay on Dr. D. When she talked to the HCA advocate, the advocate advised that Olivia could reduce her taxable income by increasing her 401(k) contributions. By reducing her taxable income, Olivia's son would stay within the eligibility requirements for Dr. D. In addition, this would mean that Olivia could accept the raise and save more money for her retirement, and that her son would continue to have affordable and accessible coverage.

William's Story:

William called the HCA because he wanted to make sure that he did not lose his eligibility for Medicaid for the Working Disabled (MWD). William worked part-time, and he owned his home. He needed to sell his home and move in with his family across the state, but did not want to lose his eligibility for MWD. The HCA advocate reviewed the eligibility rules with William. Medicaid for the Working Disabled has different income and resource rules than Medicaid for the Aged, Blind and Disabled (MABD).   The resource limit for an individual on Medicaid for Working Disabled is $10,000, while the limit for MABD is $2000. The expected proceeds from the house sale were less than $10,000, so this meant that William would stay eligible. The HCA advocate also helped William understand how he could do a resource spend down, in case he ever got above the resource limit for MWD. After learning this information, William felt comfortable going forward with the sale of his house and his move.

Liza's Story:

Liza called the HCA because she needed to pick up her daughter's asthma inhaler. She had taken her daughter to the pediatrician the day before and found out the Dr. Dynasaur (Dr. D) coverage was not active. This meant that she could not pick up the inhaler at the pharmacy. Liza had done the application for Dr. D two months before calling the HCA. She had received a letter saying that her daughter was eligible and enrolled on Dr. D, so she was confused about what was happening. When the advocate called VHC, she found that Liza's daughter had been approved for Dr. D, but coverage would not begin until the next month. The advocate pointed out the error. Liza had done the application and the income verification two months prior. Under the eligibility rules, this meant that Medicaid coverage should start the month that she was found eligible. VHC agreed that Dr. D should be active, and they activated the coverage immediately. Liza was able to pick up her daughter's inhaler that afternoon.

Polly's Story:

Polly called the HCA because she was losing her Medicaid coverage. When the HCA advocate investigated, she found that Polly had been on MAGI Medicaid on Vermont Health Connect (VHC). Her Medicaid was closing, however, because she had turned 65 and thus had become eligible for Medicare. Once a person becomes eligible for Medicare, they are no longer eligible for MAGI Medicaid. Instead, they must apply for Medicaid for Aged Blind and Disabled (MABD), which has lower income limits than MAGI Medicaid. Polly's situation was even more complicated because she had dis-enrolled from Medicare Part B when she first became eligible for Medicare. She did not think that she could afford it. She also did not realize that she would not be able to stay on MAGI Medicaid. Polly needed to get back on Medicare Part B, and under the normal Medicare enrollment rules, the Part B would not start until July, and she needed coverage sooner than that. The advocate found that Polly was eligible for the Medicare Savings Program (MSP). The MSP can pay for Medicare premiums and cost-sharing. Also, if a person is found eligible, the State of Vermont will help enroll them, and they will not have to follow the normal Medicare enrollment timeline. Polly was found eligible for an MSP, and was enrolled in Part B. The MSP will pay her Part B premium. She was not eligible for MABD because she was above the income limit for that program, but she

was found eligible for VPharm, a state pharmacy program, which will help reduce her out-of-pocket Medicare Part D costs.

Clara and Minna's Story:

Minna called the HCA because her Vermont Health Connect (VHC) plan had been closed. She had no insurance and needed to go to the doctor. She had been enrolled in a VHC plan with her spouse, Clara. During the year, Clara had turned 65 and become eligible for Medicare. Instead of enrolling on Medicare Part B, Clara had stayed on the VHC plan and continued to receive an Advance Premium Tax Credit (APTC) to help pay for it. This was the couple's first problem of many. Once Clara had become eligible for Medicare, she was no longer eligible for APTC. The fact that she had not actually enrolled in Part B did not matter—she was not eligible for APTC. The household received too much APTC for the months that Clara was both on the VHC plan *and* eligible for Medicare. First, the HCA advised the couple that they would be required to pay back the excess APTC amount when they filed taxes. Next, the HCA advocate dealt with Minna's issues. She found that VHC had failed to send a closure notice before closing the couple plan, and asked for Minna to be enrolled in an individual plan. Minna was not *yet* eligible for Medicare, and this meant she was *still* eligible for APTC to help pay for an individual plan. Next, the advocate worked on Clara's issues. Because Clara had failed to enroll in Part B during her initial enrollment period (IEP), she would normally have to wait until the General Enrollment Period (GEP) to enroll. The GEP for Medicare runs from January to March, but the coverage does not start until July, so Clara would experience a gap in coverage. However, Social Security has a limited-time equitable relief program for people like Clara — people who were enrolled in a QHP on exchanges and missed their initial enrollment period for Medicare due to a confusion or mistake. The advocate helped Clara apply so she would not have to wait for her Part B coverage to start. This meant that both Clara and Minna would have coverage going forward. (See CMS fact sheet to find out more about equitable relief: *http://medicarerights.org/pdf/100118-cms-factsheet-marketplace-relief.pdf*)

Julian's Story:

Julian called the HCA after he had gone to a medical appointment and discovered that his Medicaid was not active. When the HCA advocate did some research, she found that Julian's Medicaid had been closed because of non-renewal. In the VHC system, it looked like he had not done the annual review paperwork that is required to check if a beneficiary is still eligible for Medicaid. But when the advocate looked further, she found that the paperwork had been sent to Julian's mother's address, and that Julian was listed in his mother's Medicaid household. In general, Medicaid households are based on your tax household, so if a child qualifies as a dependent of a parent, then that child will be in the parent's Medicaid household. Julian, however, was no longer a tax dependent. He had moved out of his mother's household to live with his girlfriend and had his own job. He planned on filing taxes on his own. The advocate helped to get Julian in his own Medicaid household, complete the Medicaid application, and get his current coverage activated.

Priorities

A. The HCA focused on outreach and consumer education about 2019 Open Enrollment.

The HCA worked with other stakeholders to develop coherent messaging for the 2019 Open Enrollment, and this quarter it focused on reaching consumers directly and via the HCA website to educate them about "silver loading" and Open Enrollment. We also produced materials about Open Enrollment for our community partners and participated in the Guen Gifford Advocacy Training. At the training, we presented information about state and federal health care programs and answered questions about Vermont Health Connect and Open Enrollment. The HCA also recorded two television Open Enrollment messages. These Open Enrollment messages were aired on Channel 17 for a week each, starting 11/16 and 12/7, and shared with 3,358 viewers on Facebook. Three additional Open Enrollment HCA Facebook posts reached an additional 6,489 people and were shared 89 times.

B.   The HCA participated in Vermont's annual conference for the American Nurses Association.

This year's conference focused on Advocacy, and the HCA advocate discussed how nurses and providers can advocate for patients by helping with prior authorizations, appeals, and insurance enrollment. We also explained how the HCA works for consumers and how the HCA can advise on appeals, insurance denials, and enrollment problems. The advocate gave information on how to refer cases to the HCA. Other guests for the day includes the Deputy Director of VT Network Against Domestic Violence and Sexual Violence, Governor Scott, and Gubernatorial candidate Christine Hallquist, and a panel on end-of-life and hospice care.

C.   The HCA is participating in 2020 QHP Benefits planning and working to maximize benefits for consumers.

During the last quarter, the HCA participated in a work group to plan the benefit packages for qualified health plans offered on Vermont Health Connect in 2020. We proposed that the group approve plans that maximized the AV (actuarial value) of silver plans on the exchange. With a maximized AV level, consumers will be eligible for more APTC. This would give them the ability to enroll in plans with more generous cost-sharing and lower out-of-pocket costs. It also means that all silver exchange plans would have more generous cost-sharing which would make it easier for consumers to access healthcare. A recent analysis showed that a silver plan with a $4,800 deductible could be reduced to a $2,800 deductible if the AV level of the plan was maximized. The HCA plans to continue participating in this work group through the next quarter.

D. Overall call volume increased by 6% and was similar to the call volume in the same quarter in 2017.

The total call volume increased by 6% (894 this quarter vs. 840 last quarter). Call volume this quarter is very similar to call volume in the same quarter in 2017. In 2017, the HCA had 890 calls in the third quarter compared to 894 in 2018. About 12% of those calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We saved consumers $60,132.90 this quarter.

	All Calls (2008-2018)										
	2008	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
January	309	240	218	329	282	289	428	470	411	340	358
February	232	255	228	246	233	283	304	388	511	330	297
March	229	256	250	281	262	263	451	509	416	308	391
April	235	213	222	249	252	253	354	378	333	240	348
May	207	213	205	253	242	228	324	327	325	332	326
June	245	276	250	286	223	240	344	303	339	289	294
July	205	225	271	239	255	271	381	362	304	278	288
August	152	173	234	276	263	224	342	346	343	280	297
September	147	218	310	323	251	256	374	307	372	267	255
October	237	216	300	254	341	327	335	311	312	312	305
November	192	170	300	251	274	283	306	353	287	307	304
December	214	161	289	222	227	340	583	369	284	271	290
Total	2604	2616	3077	3209	3105	3257	4526	4423	4237	3554	3753

E. Calls concerning Vermont Health Connect increased by 22% this quarter.

The volume of calls concerning Vermont Health Connect increased this quarter (208 vs. 171). The top two VHC issues were eligibility for Premium Tax Credits (83) and eligibility for Medicaid - MAGI (78). This quarter, 55 VHC cases required complex interventions that took more than two hours of an advocate's time to resolve, and another 26 cases 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 as needed to discuss cases and has regular email contact with Tier 3. This quarter we had 46 escalated cases (46 vs. 39 last quarter). Of the 46 escalated cases, 42 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 continued to receive significant numbers of consumers calling with questions about Medicare Savings Programs (56), MABD (78) and VPharm eligibility (38).

2017-2018 HCA Vermont Health Connect Cases

■ VHC-Related Opened Cases   ■ Opened Cases (non-VHC)
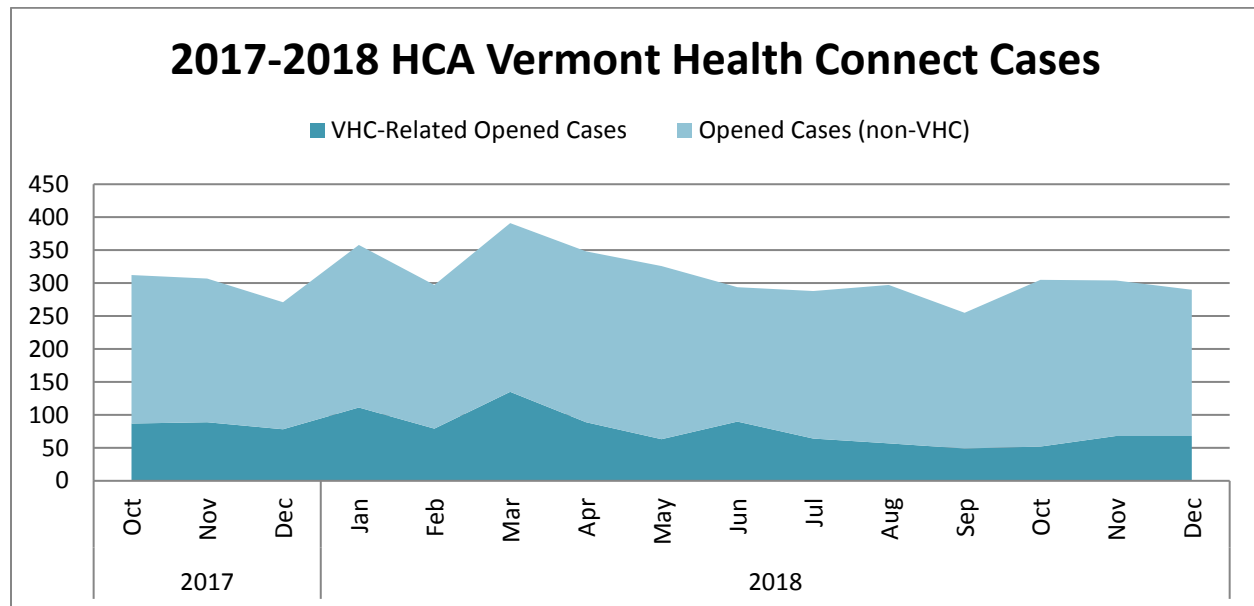
F. Medicaid eligibility calls represented 29% of all our cases (260 cases/894 total cases). Consumers need assistance with all types of Medicaid.

Medicaid eligibility was again the top issue generating calls. We had 116 calls about eligibility for Medicaid for Children and Adults (MCA) Medicaid, 78 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), 16 about Medicaid Spenddowns, and 13 about Medicaid for Working Disabled. We also had 19 calls specifically about the Medicaid renewal process, and 15 calls about Long Term Care Medicaid. 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.

G. 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 894 (compared to 840 last quarter)

1. MAGI Medicaid eligibility 116 (143)
2. Information about VHC 98 (67)
3. Premium Tax Credit eligibility 91 (62)
4. Affordability affecting access to care 86 (45)
5. Medicaid eligibility (non-MAGI) 78 (61)
6. Complaints about providers 74 (81)
7. Access to Prescription Drugs/Pharmacy 61 (57)

8. Buying QHP through VHC 59 (22)
9. Buy-in programs/Medicare Savings Programs 56 (39)
10. Information about Medicare 53 (29)
11. Information/applying for DVHA programs 50 (46)
12. Not health related 50 (61)
13. Change of Circumstance eligibility 44 (58)
14. Special Enrollment Periods eligibility 43 (51)
15. VPharm Eligibility 43 (19)

Vermont Health Connect Calls 208 (compared to 171 last quarter)

1. Premium Tax Credit eligibility 83 (60)
2. MAGI Medicaid eligibility 78 (85)
3. Information about VHC 76 (44)
4. Buying QHPs through VHC 52 (18)
5. Special Enrollment Periods 35 (34)
6. Affordability affecting access to care 25 (15)
7. Change of Circumstance eligibility 20 (37)
8. Information regarding the ACA 19 (15)
9. IRS Reconciliation 15 (16)
10. Information regarding ACA Tax issues 14 (3)
11. VHC Renewal Eligibility 14 (2)

DVHA Beneficiary Calls 284 (compared to 297 last quarter)

1. MAGI Medicaid eligibility 53 (58)
2. Medicaid eligibility (non-MAGI) 44 (36)
3. Affordability affecting access to care 29 (10)
4. Access to Prescription Drugs/Pharmacy 21 (17)
5. Buy In Programs/MSPs eligibility 21 (19)
6. Information about VHC 21 (19)
7. Choices for Care Eligibility 20 (6)
8. Complaints about providers 19 (30)
9. PA Criteria 18 (12)
10. Balance billing 18 (18)

Commercial Plan Beneficiary Calls 161 (compared to 150 last quarter)

1. Premium Tax Credit eligibility 53 (33)
2. Information about VHC 40 (25)
3. Buying QHP through VHC 27 (8)
4. MAGI Medicaid eligibility 18 (30)
5. Eligibility for Special Enrollment Periods 18 (13)
6. VHC Renewal Eligibility 15 (1)
7. Affordability affecting access to care 13 (8)
8. Change of Circumstance 12 (22)
9. Claim Denials 12 (13)
10. Changing Plan 11 (1)

11. IRS Reconciliation issues 11 (10)

The HCA received 894 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"): 31.8% (284 calls), compared to 35.4 % (297 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): 32.6% (291 calls), compared to 25.5% (214 calls), last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans 18.0% (161 calls) , compared to 15.6% (151 calls) last quarter
- **Uninsured:** 9.40% (84 calls), compared to 9.41% (79 calls last quarter)

Case Results

A. Dispositions of Closed Cases

All Calls
We closed 915 cases this quarter, compared to 839 last quarter:
- 40% (367 cases) were resolved by brief analysis and advice
- 25% (230) were resolved by brief analysis and referral
- 22% (200) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time
- 7% (65) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases, 53 clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 26 individuals with appeals: 17 Fair Hearings, 0 Commercial Insurance – Internal 1st Level appeals, 1 Commercial Insurance – Internal 2nd Level appeal, 0 Commercial External Appeal, 1 Medicare Part A, B, or C appeal, 0 Medicare Part D appeals, and 7 Medicaid MCO Internal appeals.

DVHA Beneficiary Calls
We closed 300 DVHA cases this quarter, compared to 299 last quarter:
- 43% (130 cases) were resolved by brief analysis and/or advice
- 24% (73) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 17% (51) were resolved by brief analysis and/or referral
- 12% (36) 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, 10 clients resolved the issue on their own, or had some other outcome.

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

Appeals: The HCA assisted 11 DVHA beneficiaries with appeals: 5 Fair Hearing, 0 Medicare Part D appeals, and 6 Medicaid MCO Internal appeals.

Commercial Plan Beneficiary Calls

We closed 151 cases involving individuals on commercial plans, compared to 142 last quarter:

- 43% (65 cases) were resolved by brief analysis and/or advice
- 28% (43) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 17% (26) were resolved by brief analysis and/or referral
- 8% (12) 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, 5 clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 14 commercial plan beneficiaries with appeals: 12 Fair Hearings, 0 Commercial Insurance – Internal 1st Level appeals, 1 Commercial Insurance – Internal 2nd Level appeal, 0 Commercial External Appeal, 1 Medicare Part A, B, or C appeal, and 0 Medicare Part D appeals.

B.   All Calls Case Outcomes

The HCA helped 536 people with advice and education about health insurance questions about problems. We got 63 households onto insurance.   We assisted 11 people with applications for or enrollment in insurance plans and prevented 19 insurance terminations or reductions. We obtained coverage for services for 26 people. We got 22 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 58 more. We provided other billing assistance to 13 individuals. We obtained other access or eligibility outcomes for 63 additional people.

Consumer Protection Activities

A.   Rate Review

The HCA monitors all commercial insurance carrier requests to the Green Mountain Care Board (Board) for changes to premium prices. These requests are typically requests to increase the premiums that Vermonters must pay for commercial health insurance.

One filing related to premium price increases was decided during the quarter covering October 2018 through December 2018. No rate filings were pending at the end of the quarter.

MVP Health Plan, Inc. (MVP) submitted the single filing decided this quarter, the MVP 2019 Large Group HMO and Large Group POS Riders. Approximately 2,171 people are covered by products affected by this filing. MVP proposed increasing the average annual premium price paid by Vermonters for these products by 13.7 percent. The HCA appeared on behalf of Vermonters in this matter, filed questions for the carrier, file a response to an objection by the carrier to the questions asked, and filed a memorandum in lieu of hearing. The Board reduced MVP's proposed price increase from 13.7 percent to an average of 11.5 percent. This premium price reduction translates into approximately $250,000 of savings for Vermonters.

B. Hospital Budget Review

The HCA participates in the Board's annual hospital budget review process, which took place last quarter. This quarter the Board convened a work group of hospital Chief Financial Officers, Board Staff, the Hospital Association, and the HCA to provide input prior to the Board's fiscal year 2020 hospital budget review process. The HCA participated in 2 meetings of this work group in December.

C. Oversight of Accountable Care Organizations

The HCA participates in the Board's annual ACO budget review process which took place this quarter. The Board reviewed the budget of OneCare Vermont, the state's only ACO. The HCA reviewed OneCare's budget materials, submitted a set of written questions to OneCare, participated in OneCare's budget hearing before the Board, and submitted two sets of formal comments after the hearing. Our first set of comments expressed our concerns about Oversight & System Alignment, Affordability, Transparency, Accountability, and Care Management. Our second set of comments asked the Board to curb cost growth and promote affordability by pursuing provider rate setting for the Vermont Health Connect population.

This quarter the HCA also continued to work with Board staff and OneCare to develop a proposed Medicare ACO measure set. The HCA attended two meetings on this topic and submitted feedback to Board staff.

D. Certificate of Need Applications

The HCA entered an appearance in two new certificate of need applications in the past quarter. One application was from Springfield hospital and contained a plan to replace their electronic medical record system. The second application was for a new substance use disorder treatment center in Bennington, Vermont. We are currently reviewing the applications.

E. Other Green Mountain Care Board Activities

The HCA continues to attend the weekly Green Mountain Care Board meetings. The HCA submitted written and verbal comments to the Board on the 2018-2019 Health Information Exchange (HIE) Strategic plan. Our comments addressed our concerns about lack of consumer representation on the HIE Steering Committee and the permanent HIE governing Board. We also participated in a meeting of the Board's Data Governance Council where we advocated for policies around use and release of VHCURES data to ensure that the data is only released to parties whose work will benefit Vermont and Vermonters.

F. Other Activities

Administrative Advocacy

✧ **Individual Mandate Working Group**

The HCA was named in the statute forming this group. Its purpose was to consider pros and cons and potential structure for a Vermont individual mandate penalty to replace the federal penalty that was removed by congress in the 2017 Tax Cuts and Jobs Act. The removal of the federal penalty resulted in a premium increase of $7.9 million in 2019 rates.

This work group met seven times but the background work requirement was significant as subgroups worked their way through various issues including MEC, exemptions, affordability, and modeling various enforcement options. As of the end of the quarter, there were a few key issues where there were no opportunities for consensus in this group. The HCA was only willing to support the concept of a financial penalty with a larger affordability exemption, the carriers were in support of an enforcement mechanism that was more in line with the ACA with a few key differences to make it work going forward, the administration supported outreach and education approaches, and the GMCB had not considered the proposal by the end of the quarter.

✧ **Freestanding Health Care Facility Working Group**

The HCA participated in the meetings of the Freestanding Health Care Facilities Working group this past quarter. These meetings focused on questions of which freestanding health care facilities deserved the focus of this group, how to regulate those facilities without creating duplication and undo regulation, and how freestanding health care facilities should participate in the payment and delivery reform efforts. This working group developed recommendations that will be presented to the committees of jurisdiction this legislative session.

✧ **Chronic Pain Working Group**

The HCA participated in the Chronic Pain Working Group created by Act 7 of the 2018 Special Session. This new working group joined with efforts already in progress within state government to address these issues. The Executive Summary of the report produced by this group states that, "The working group recommends that the State address this aspect of the opioid crisis initially through fundamental changes to the delivery system instead of ad hoc changes to commercial insurance coverage, focusing on collaboration and integration instead of encouraging use of discrete modalities. Specifically, the working group recommends the continued pursuit of pilot programs in integrated pain management. This way, the State can learn through the pilots what is feasible and scalable to larger portions of the market and population. In the near term, the goal is to implement pilots in a way that does not require insurance plan design changes or new provider payment structures on a broad scale. In the longer term, the pilots will provide valuable data to inform insurance coverage of a new treatment and payment models that address chronic pain."

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

The HCA continues to advocate for increased access to hepatitis C virus (HCV) treatment. Last quarter, we partnered with the ACLU of Vermont and submitted public records requests to the Vermont

Department of Corrections (DOC), the Department of Vermont Health Access (DVHA), the Vermont Department of Health (VDH) and the Agency of Human Services Central Office. We asked for information about the state's treatment of people with HCV within the correctional system. During the quarter we received and reviewed many of the requested records.

In December we submitted a memo to the Joint Legislative Justice Oversight Committee reiterating our concerns about HCV treatment access in DOC. We also provided oral testimony at JLJOC's hearing on the topic. Later in the month we met with the Secretary of the Agency of Human Services and outlined concerns about discrepancies between DOC's testimony and information we received from DOC's consulting infectious disease specialist at UVMMC. After the meeting we sent a letter to Secretary Gobeille clearly outlining our ongoing questions and concerns. We expect a response to this letter next quarter.

✧ **University of Vermont Medical Center Mental Health Program Quality Committee**

The HCA continues to participate in the UVMMC Mental Health Program Quality Committee (PQC). The PQC meets monthly and discusses mental health quality, programs, infrastructure, and planning. This quarter we attended two meetings of the PQC.

✧ **Global Commitment Register Comments**

The HCA continues to monitor Global Commitment rule and policy changes. This quarter we reviewed several proposed rule and policy changes.

✧ **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 1 notice, 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 continued to co-chair and actively participate in Vermont's Medicaid and Exchange Advisory Board (MEAB). The MEAB had a significant focus during this quarter on its internal functioning and the way it interacts with state government. This focus led to the recognition that the MEAB needed to take the time to review its statutory responsibilities and consider updating its operational manual.

✧ **Federal Issues Work Group: Silver Stacking Contingency Planning**

The HCA continues to participate in the Federal Issues Work group, a group of health care stakeholders that was convened to address issues caused by policy changes at the federal level. During the last quarter, the group met to discuss possible options to fund cost sharing reductions if federal guidance prohibits insurers from adding the cost to on-exchange silver plan premiums. The group has reviewed proposals for changes to the health insurance exchange marketplace and possible state statutory

changes that may be necessary to address this issue. The federal government has significantly delayed releasing its guidance on this issue, so the group has so far been unable to make any final decisions.

Legislative Activities

This quarter the HCA continued to monitor the legislature's off-session activities. We attended one meeting of the Health Reform Oversight Committee, one meeting of the Joint Legislative Justice Oversight Committee, and two meetings of the Legislative Committee on Administrative Rules (LCAR). In addition, the HCA engaged in multiple activities to bring our ongoing concerns to both current legislators and prospective legislators. The Chief Advocate testified before HROC and before LCAR twice this quarter expressing the HCA's opposition to the Department of Financial Regulation's proposed rule allowing fully-insured Association Health Plans to be rated in the large group. The rule would allow healthier small groups to pull their risk out of the individual/small group risk pool, resulting in a predictable spiraling of costs in that pool and a corresponding increase in the number of Vermonters priced out of the health insurance marketplace.

The HCA also testified before the Joint Legislative Justice Oversight Committee about our findings regarding the treatment of individuals in corrections custody who have hepatitis C. For more information about this advocacy, see *Access to Treatment for Hepatitis C Virus*, above.

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:

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Community Catalyst
- Families USA
- IRS Taxpayer Advocate Service
- Ladies First
- MVP Health Care
- OneCare Vermont
- Outright Vermont
- Pride Center of Vermont
- Planned Parenthood of Northern New England
- SHIP, State Health Insurance Assistance Program
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Care Partners
- Vermont CARES
- Vermont Defender General's Prisoners' Rights Office
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Developmental Disabilities Council
- Vermont Health Connect
- Vermont Medical Society
- Vermont Program for Quality in Health Care

Outreach and Education

A. Increasing Reach and Education through the Website

VTLawHelp.org is a statewide website maintained by Vermont Legal Aid and Legal Services 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.

*Office pageviews of the health web pages are included in the numbers here. The **only** numbers where office traffic is **excluded** are the triage numbers.*

Popular Web Pages

- The total number of **health pageviews increased by 7%** in the reporting quarter ending December 31, 2018 (12,463 pageviews), compared with the same quarter in 2017 (11,687 pageviews).

- The **top-20 health pages** on our website this quarter with change over last year:
    - *Income Limits – Medicaid* – 3,369 pageviews (5% ↑)
    - *Health* – section home page – 1,855 (43% ↑)
    - *Services Covered by Medicaid* – 482 (30% ↑)
    - *Resource Limits – Medicaid* – 426 (3% ↑)
    - *Dental Services* – 407 (7% ↑)
    - *Choices for Care* – 326 (24% ↓)
    - *Health Insurance, Taxes and You* – 254 (24% ↑)
    - *Medicaid* – 239 (34% ↑)
    - *HCA Online Help Request Form* – 237 (13% ↑)
    - *Vermont Health Connect* – 214 (50% ↑)
    - *Federally Qualified Health Centers* – 191 (29% ↑)
    - *Medicare Savings / Buy-In Programs* – 177 (14% ↑)
    - *Advance Directive Forms* – 174 (27% ↑)
    - *Medicaid and Medicare dual eligible* – 161 (4% ↓)
    - *Long-term Care* – 156 (28% ↓)
    - *Choices for Care Income Limits* – 146 (15% ↓)
    - *Dr. Dynasaur* – 137 (145% ↑)
    - *Supplemental Plans Medicare* – 135 (1500% ↑)
    - *Medical Decisions – Advance Directives* – 130 (17% ↓)
    - *Choices for Care Resource Limits* – 124 (36% ↓)

- Besides the pages listed above, other **spikes in interest** in our pages included:
  - *Resources for Uninsured Vermonters* – 75 (295% ↑)
  - *Complaints About Providers* – 54 (184% ↑)
  - *VHC Coverage for Individuals & Families* – 68 (135% ↑)
  - *Apply for Choice for Care* – 88 (132% ↑)
  - *VHC Coverage for Small Employers* – 56 (87% ↑)

Popular PDF Downloads

23 out of 77, or 30% **of the unique PDFs downloaded** from the VTLawHelp.org website were on health care topics. Of those unique health-related PDF titles:

- The top five consumer-focused PDF downloads were:
  - *Advance Directive, short form* (100 downloads)
  - *Advance Directive, long form* (68 downloads)
  - *Vermont Dental Clinics Chart* (91 downloads)
  - *Vermont Medicaid Coverage Exception Standards & Form* (27 downloads)
  - *5-Step Guide to Getting DME from Medicaid* (14 downloads)
- The top advocate-focused PDF download was:
  - *PTC Rule Allocation Summary* (5 downloads)
- The top policy-focused PDF download was:
  - *VT ACO Shared Savings Program Quality Measures* (3 downloads)

The *Advance Directive Short Form* is the **fourth most downloaded of all PDFs** downloaded from the entire VTLawHelp.org website. The *Long Form* is the **eighth most downloaded**.

The *Vermont Dental Clinics Chart* is the **ninth most downloaded of all PDFs** downloaded from the entire website.

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 it can be accessed from most pages of our website. 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 **151 times** during this quarter. That's slightly up from 144 in the previous quarter (July – September 2018).

Of the **42** health care topics that were accessed using this tool, 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 VHC for myself or my children.
- Complaints – I want to file a complaint against a doctor or hospital.

- Dr. Dynasaur – I want to apply for Medicaid or Dr. Dynasaur for myself or for my children.

B. Other Outreach and Educational Activities

- **National Legal Aid & Defender Association Conference, November 1, 2018**. HCA presented on best practices for LGBTQ clients.
- **American Nurses of Vermont on November 2, 2018**. HCA presented on the HCA and how to advocate for consumers.
- **Guen Gifford Advocacy Training on November 30, 2019**. HCA advocates presented on state health care programs and answered questions about Open Enrollment.
- **Translating Identity Conference, University of Vermont on November 3, 2018**.   HCA presented on Open Enrollment, and answered questions about Medicaid, Medicare and private insurance coverage.
- **NHelp (National Health Law Program) Conference, December 2-4 2018**, HCA advocates and attorneys attended the national conference on health care issues.

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:

- Medicaid Verification, EE513

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Office of the Health Care Advocate

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

http://www.vtlegalaid.org/health

</div>

Attachment 6 - GC Investments

CY 2018 Investment Expenditures

Department	STC #	Receiver Suffix	Investment Description	QE 0318	QE 0618	QE 0918	QE 1218	CY 2018 Total
AHSCO	41	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,250	113,250	113,084	113,067	452,651
AHSCO	54	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	1,664,645	1,664,704	1,664,665	-	4,994,014
AOE	11	n/a	Non-state plan Related Education Fund Investments	-				-
DCF	1	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)	2,208,458	3,442,083	2,286,340	1,214,781	9,151,661
DCF	2	9412	Investments (STC-79) - Lund Home (2)	555,306	730,209	169,704	732,951	2,188,170
DCF	9	9415	Investments (STC-79) - Challenges for Change: DCF (9)	64,015	49,463	68,552	70,193	252,224
DCF	26	9416	Investments (STC-79) - Strengthening Families (26)	215,717	218,243	255,663	216,977	906,600
DCF	33	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)	-	-	-	-	-
DCF	34	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	25,646	25,646	50,409	55,450	157,150
DCF	35	9418	Investments (STC-79) - Building Bright Futures (35)	117,644	151,378	107,033	147,944	523,999
DCF	55	9402	Investments (STC-79) - Medical Services (55)	17,267	15,717	17,672	11,542	62,197
DCF	56	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	-	128,702	1,383,634	(1,383,634)	128,702
DCF	57	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	-	-	37,531	(37,531)	-
DCF	58	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	-	-	94,993	(94,993)	-
DCF	59	9408	Investments (STC-79) - Essential Person Program (59)	226,081	224,058	221,137	219,447	890,722
DCF	60	9409	Investments (STC-79) - GA Medical Expenses (60)	54,512	72,062	89,289	73,072	288,935
DCF	61	9411	Investments (STC-79) - Therapeutic Child Care (61)	500,417	383,222	(242,070)	204,158	845,726
DCF	62	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	54,750	54,750	-	38,506	148,006
DDAIL	27	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	614,914	214,622	-	678,171	1,507,707
DDAIL	42	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)	-	-	-		-
DDAIL	43	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)	13,291	355,197	339,410	186,674	894,571
DDAIL	63	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	95,581	73,530	76,691	59,122	304,924
DDAIL	64	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	515,509	918,088	93,428	592,216	2,119,241
DDAIL	65	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)	17,807	16,942	12,134	22,884	69,767
DDAIL	77	9607	Investments (STC-79) - HomeSharing (77)	82,404	83,492	18,403	111,352	295,650
DDAIL	78	9608	Investments (STC-79) - Self-Neglect Initiative (78)	140,884	-	-	28,241	169,125
DMH	3	9511	Investments (STC-79) - Institution for Mental Disease Servceis: DMH (3) - VPCH	6,250,829	4,926,448	6,512,245	5,154,570	22,844,092
DMH	3	9512	Investments (STC-79) - Institution for Mental Disease Servceis: DMH (3) - BR	954,387	2,814,303	1,285,646	2,621,430	7,675,766
DMH	12	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	1,147,730	1,109,389	980,464	1,372,596	4,610,180
DMH	13	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	122,391	2,093,206	122,579	893,541	3,231,717
DMH	16	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	509,282	(2,066,805)	7,015,077	7,321,168	12,778,722
DMH	22	9510	Investments (STC-79) - Emergency Support Fund (22)	256,829	166,513	-	536,669	960,011
DMH	28	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	28,098	50,950	25,561	41,307	145,915
DMH	29	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,330,483	1,538,487	-	4,949,826	8,818,795
DMH	66	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	858,990	495,927	313,066	1,185,902	2,853,885
DMH	67	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	302,856	204,850	-	607,370	1,115,076
DMH	68	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	2,475	59,116	17,590	(48,063)	31,119
DMH	79	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	116,533	107,824	73,910	162,684	460,951
DOC	4	n/a	Return House	117,001	131,406	127,898	108,806	485,111
DOC	5	n/a	Northern Lights	98,438	98,438	98,438	98,438	393,752
DOC	6	n/a	Pathways to Housing	227,728	324,156	302,736	178,989	1,033,609
DOC	14	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	193,405	89,806	193,405	146,878	623,493
DOC	15	n/a	Northeast Kingdom Community Action	-	-	-	-	-
DOC	69	n/a	Intensive Substance Abuse Program (ISAP)	-	-	-	-	-
DOC	70	n/a	Intensive Domestic Violence Program	-	-	-	-	-
DOC	71	n/a	Community Rehabilitative Care	638,456	1,459,823	-	1,452,717	3,550,996
DOC	80	n/a	Intensive Sexual Abuse Program	2,615	2,825	2,615	2,675	10,730
DVHA	7	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	1,695,275	2,134,424	1,994,880	2,653,122	8,477,700
DVHA	8	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)	467,851	574,092	537,130	388,000	1,967,073
DVHA	18	9106	Investments (STC-79) - Patient Safety Net Services (18)	70,560	46,939	2,992	11,639	132,130
DVHA	51	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	869,072	1,037,825	592,139	730,670	3,229,706
DVHA	52	9103	Investments (STC-79) - Buy-In (52)	9,916	8,308	10,854	13,859	42,937
DVHA	53	9104	Investments (STC-79) - HIV Drug Coverage (53)	668	668	668	672	2,675
DVHA	72	9108	Investments (STC-79) - Family Supports (72)	-	-	-		-
DVHA	81	9109	DSR Investment (STC-83) – One Care VT ACO Quality & Health Management (81)	-	614,250	614,250	1,228,500	2,457,000
DVHA	82	9110	DSR Investment (STC-83) – One Care VT ACO Advanced Community Care Coordination (82)	-	1,173,125	923,126	1,846,252	3,942,503
GMCB	45	n/a	Green Mountain Care Board	384,321	762,208	409,212	502,428	2,058,169
UVM	10	n/a	Vermont Physician Training	1,011,554	1,011,554	844,804	844,804	3,712,716
VAAFM	36	n/a	Agriculture Public Health Initiatives	-	-	-	-	-
VDH	17	9220	Investments (STC-79) - Recovery Centers (17)	371,652	371,652	301,902	495,876	1,541,082
VDH	19	9201	Investments (STC-79) - Emergency Medical Services (19)	178,201	218,001	212,618	119,017	727,836
VDH	21	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	375,000	18,800	268,800	-	662,600
VDH	23	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	297,954	223,858	418,075	133,240	1,073,127
VDH	24	9225	Investments (STC-79) - Medicaid Vaccines (24)	-	-	-	-	-
VDH	25	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	466,555	250,556	50,000	-	767,111
VDH	30	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	2,433,133	1,834,748	510,577	126,209	4,904,668
VDH	31	9206	Investments (STC-79) - Health Laboratory (31)	869,855	637,355	1,029,074	687,631	3,223,915
VDH	37	9213	Investments (STC-79) - WIC Coverage (37)	1,091,956	1,060,146	929,109	646,830	3,728,042
VDH	38	9224	Investments (STC-79) - Fluoride Treatment (38)	13,573	13,417	17,921	18,459	63,370
VDH	39	9205	Investments (STC-79) - Health Research and Statistics (39)	427,372	415,032	356,259	243,254	1,441,917
VDH	40	9204	Investments (STC-79) - Epidemiology (40)	291,293	250,729	268,903	185,791	996,717
VDH	44	9228	Investments (STC-79) - VT Blueprint for Health (44)	535,790	349,253	341,117	287,756	1,513,916
VDH	46	9221	Investments (STC-79) - Enhanced Immunization (46)	30,984	24,573	65,396	101,851	222,803
VDH	47	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	12,000	12,657	12,850	738	38,244
VDH	48	9222	Investments (STC-79) - Poison Control (48)	84,756	-	28,252	28,252	141,260
VDH	49	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	51,032	82,519	91,723	64,844	290,118
VDH	50	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	253,040	428,115	181,877	404,306	1,267,337
VDH	73	9211	Investments (STC-79) - Renal Disease (73)	-	-	-	-	-
VDH	74	9203	Investments (STC-79) - TB Medical Services (74)	37,827	35,054	33,414	4,251	110,546
VDH	75	9209	Investments (STC-79) - Family Planning (75)	352,008	271,546	355,593	362,153	1,341,300
VDH	76	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)	-	-	-	-	-
VSC	32	n/a	Health Professional Training	204,730	-	204,731	-	409,461
VVH	20	n/a	Vermont Veterans Home	-	-	-	-	-
				34,344,549	36,403,421	35,537,175	42,178,496	148,463,641

P **OneCare Vermont ACO Quality/Health Management Measurement (QHMM) and Advanced Community Care Coordination (ACCC) DSR Investments**

`DVHA` `Investment`

Budget Information

Calendar Year 2018 combined investment costs: $7,442,503

What We Do

The Vermont All-Payer Accountable Care Organization (ACO) Model is the Centers for Medicare & Medicaid Services' (CMS) new test of an alternative payment model in which the most significant payers throughout the entire state – Medicare, Medicaid, and commercial health care payers – incentivize health care value and quality, with a focus on health outcomes, under the same payment structure for the majority of providers throughout the state's care delivery system and transform health care for the entire state and its population. The overarching objective is to establish an integrated care delivery system that is person-centered, efficient, and equitable though the implementation of a community-based care coordination model.

Specifically, the OneCare Vermont ACO Quality/Health Management Measurement and Advanced Community Care Coordination Investments support the OneCare Vermont ACO in:

- Creating and distributing new tools, and further developing existing tools to enhance OneCare's existing population health management analytics and care coordination platform by adding new analytic applications and system functionality, along with providing technical assistance and deployment support to ACO providers throughout the OneCare network; and

- Implementing a team-based approach to care coordination designed to strengthen relationships between primary care and the continuum of care providers to support the physical, mental, and social wellbeing of Medicaid members attributed to OneCare Vermont. By building upon the foundation of Patient Centered Medical Homes and Community Health Teams established through Vermont's multi-payer Blueprint for Health initiative, this community-based care coordination model will further organize and refine existing care management and care coordination activities by improving integration and collaboration across local care teams, thus increasing effectiveness and efficiency while eliminating duplication of efforts over time.

Who We Serve

All Vermonters participating in ACO based reform.

How We Impact

Investment Objective:

Support implementation of Vermont's All Payer Accountable Care Organization (ACO) model.

Performance Measures	Most Recent Period	Current Actual Value
PM **DVHA** ACCC: % of communities participating in community-based care coordination model, including regular participation in "Care Coordination Core Team"	**2018**	**71%**

Data Source: OneCare 2018 Network Roster
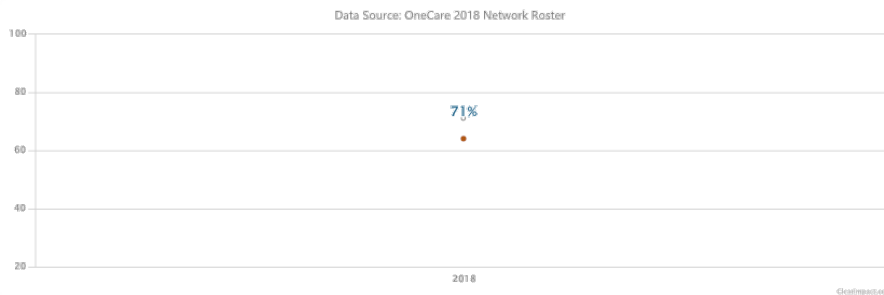
Notes on Methodology

The red dot on the graph above represents the target for CY 2018, while the white dot represents OneCare's actual value for CY 2018.

Vermont has 14 Health Service Areas (HSA's). The CY 2018 data point represents 10 HSA's.

Partners

OneCare Vermont ACO

Story Behind the Curve

All communities participating in OneCare's ACO risk contracts actively engage in OneCare's community-based care coordination model to further integrate their local care delivery infrastructure. In 2018, 10 of the 14 health service areas participated in the Vermont Medicaid Next Generation ACO program: Berlin, Bennington, Brattleboro, Burlington, Lebanon (NH), Middlebury, Newport, St. Albans, Springfield, and Windsor. ACO/provider agreements are typically executed on an annual basis, therefore this measure is reported as a single annual data point.

DVHA ACCC: # care team members/leaders trained in care coordination skills/core competencies, including Care Navigator

Q4 2018	692
Q3 2018	636
Q2 2018	550
Q1 2018	431
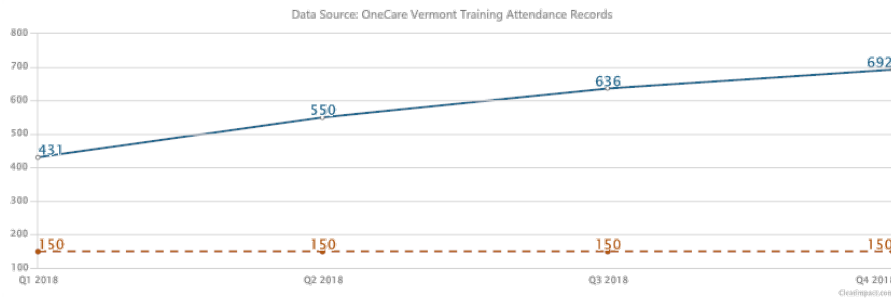
Data Source: OneCare Vermont Training Attendance Records

Notes on Methodology

The red dashed line in the graph above represents the target for CY 2018, while the blue solid line represents OneCare's actual cumulative quarterly values.

A break out is provided here:

Quarter	Quarterly Data	Year to date (cumulative)
1	431	431
2	119	550
3	86	636
4	56	692

Partners

- OneCare Vermont Regional Care Coordination Core Teams
- Blueprint for Health

Story Behind the Curve

Statewide care coordination skills trainings began in November 2017 with strong attendance and momentum. Between January 1 and March 31, 2018 OneCare hosted 10 Core Skills trainings, 4 Care Conferences trainings, and 7 Leader/Staff trainings in various HSAs: Williston, Bennington, St Albans, Burlington, Springfield, Windsor, Brattleboro, and Lebanon NH. Training attendees were from all 10 OneCare-participating health service areas (HSAs), as well as Randolph and Rutland, demonstrating widespread engagement in gaining skills, completing gap analyses and implementing workforce development principles to advance the care coordination model.

The Care Coordination program continued to make great strides in Q2 to reach wide audiences and refine workflows at various levels and aspects of the care coordination model. Participants continued to focus on improving communication and collaboration across their communities and organizations – one of the hallmarks of the community-based care coordination model. Between April 1 and June 30, 2018 OneCare hosted one Core Skills trainings, one Care Conferences trainings, two Leader/Staff trainings, and one Senior Leader training in various HSAs: Bennington, Burlington, Brattleboro, and Lebanon NH. In addition to scheduling existing trainings, a new training was developed based on community interest and needs– titled, "Putting Care Coordination Tools into Action."

In Q3, the Care Coordination program continued to reach a diverse audience of individuals and organizations across the continuum of care, with training attendees representing participating OneCare organizations, as well as organizations not currently participating with the ACO. Participants continue to be focused on improving communication and collaboration across their communities and organizations. Between July 1 and September 30, 2018, OneCare hosted three Care Coordination Core Skills trainings and one Care Conferences trainings in the Burlington and Middlebury health service areas.

In Q4, OneCare hosted 7 Care Coordination Core Skills trainings, and 1 Care Conference Training in various locations state-wide. Participants represented a wide range of Health Service Areas as well as organization types including Skilled Nursing Facilities, Designated Agencies, VCCI, Hospital primary care, specialty and care management depts., Area Agency on Aging, and Specialty practices including Oncology. Participants continue to grow their skills with particular focus on communication and collaboration across their communities and organizations.

PM DVHA ACCC: Total amount of advanced community care coordination payments made to eligible ACO participants

Data Source: OneCare Vermont Financial Reports

Q4 2018	$2.73Mil
Q3 2018	$2.06Mil
Q2 2018	$1.34Mil
Q1 2018	$639,465

Notes on Methodology
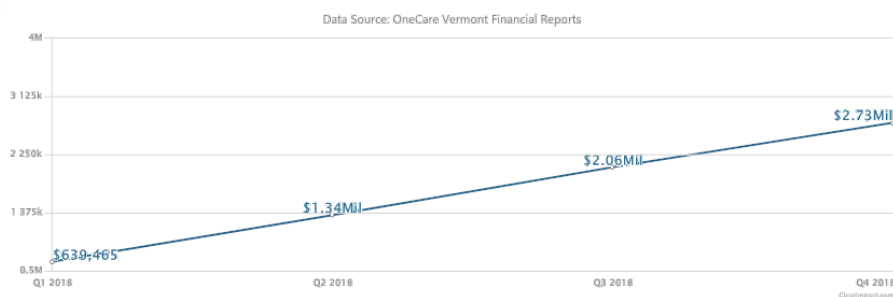
Notes on Methodology

The quarterly data points in the graph above are cumulative. A break-out table is provided here:

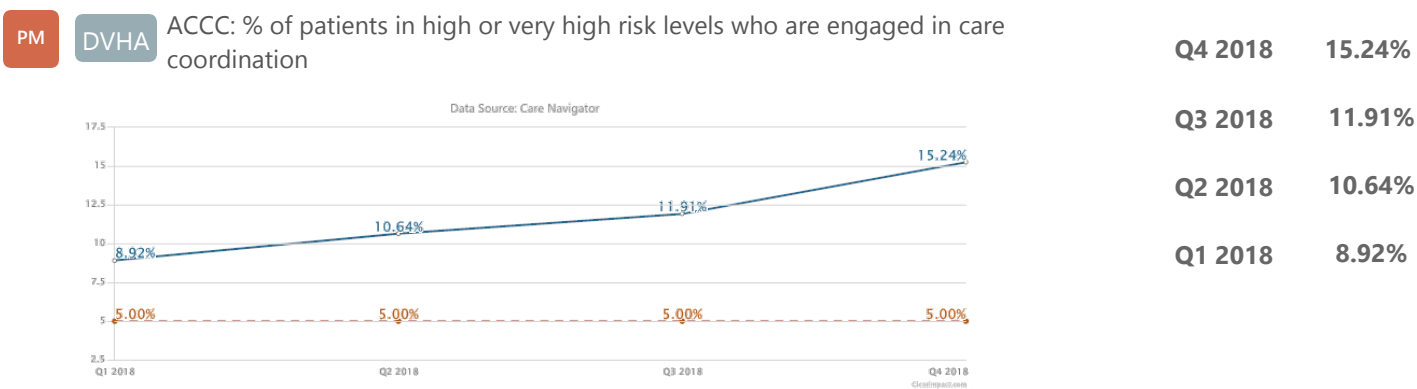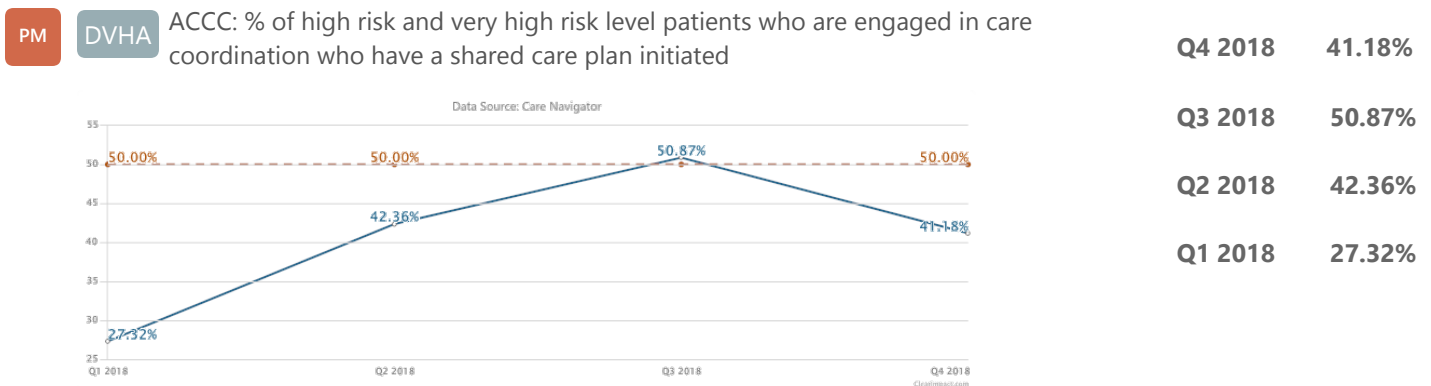| Quarter	Data Point	Year to Date (Cumulative)
1	$639,465	$639,465
2	$698,800	$1,338,265
3	$733,964	$2,059,729
4	$656,620	$2,728,849

Partners

Participating continuum of care team members including:

- Designated Mental Health Agencies
- Home Health Agencies
- Area Agencies on Aging
- Primary Care Providers

Story Behind the Curve

Key strategies behind OneCare's community-based care coordination model include utilizing population segmentation approaches to identify and outreach patients to engage them in preventive care, chronic disease management, and complex care coordination as indicated by their risk score and clinical judgment regarding the person's physical, mental, and social needs. For all participants this means utilizing effective team-based care strategies, conducting panel management, promoting preventive/wellness care, and outreaching to members to engage them in their healthcare. For high and very high risk patients engaged in complex care coordination this includes identifying care team members, facilitating the identification of a patient-directed lead care coordinator, and creating and supporting attainment of a person-centered shared care plan. Documentation of care coordination activities occurs in Care Navigator, a software platform designed to promote care team collaboration and communication in support of person-centered care. In order to facilitate team-based care, patient activation and engagement in care coordination, OneCare provides annual and per member per month payments to primary care and identified continuum of care providers (i.e. Home Health, Area Agencies on Aging and Designated Mental Health Agencies) to resource these activities. These payments are designed to compensate care team members and organizations for time spent engaging in activities of team-based and cross-community care coordination, the core premise of the care coordination model being tested in Vermont's All Payer ACO Model.

PM	DVHA	ACCC: % of patients in high or very high risk levels who are engaged in care coordination		

Data Source: Care Navigator

Q4 2018	15.24%
Q3 2018	11.91%
Q2 2018	10.64%
Q1 2018	8.92%

Notes on Methodology

The red dotted line in the graph above represents the target percentage (5%) set for CY 2018. The blue solid line represents OneCare's actual quarterly values.

A break-out table is provided here:

Quarter	Full population (for reference)	H and VH risk	Denominator (Total H and VH Risk)	%
1	812	604	6,768	8.92%
2	995	720	6,768	10.64%
3	1140	806	6,768	11.91%
4	1346	1,032	6,768	15.24%

Partners

Participating continuum of care team members including:

- Designated Mental Health Agencies

- Home Health Agencies

- Area Agencies on Aging

- Primary Care Providers

Story Behind the Curve

Engaged status indicates that a patient has been identified as needing review for care coordination by a care coordinator. It is the first step in the care management process. This field allows care coordinators to indicate that they have engaged directly with the patient to begin assessing needs and establishing a team within the tool. Status can be updated to indicate that care coordination has completed or is not needed once assessment is complete.

PM DVHA ACCC: % of high risk and very high risk level patients who are engaged in care coordination who have a shared care plan initiated

Data Source: Care Navigator

Q4 2018	41.18%
Q3 2018	50.87%
Q2 2018	42.36%
Q1 2018	27.32%

Notes on Methodology

The red dotted line in the graph above represents the target percentage for CY 2018. The blue solid line represents OneCare's actual quarterly data values.

A break-out table is provided here:

| Quarter	Full Population (for reference)	H and VH Risk	H and VH Risk Engaged Patients	%
1	225	165	604	27.32%
2	428	305	720	42.36%
3	610	410	806	50.87%
4	678	425	1,032	41.18%

Partners

Participating continuum of care team members including:

- Designated Mental Health Agencies,

- Home Health Agencies

- Area Agencies on Aging

- Primary Care Providers

Story Behind the Curve

A shared care plan is considered initiated when the first goal is added. All the patients with Shared Care Plans initiated have at least one goal. The shared care plan is the core of the care coordination model. The creation of goals and tasks assigned to the patient or the care team guide how care is coordinated for the patient. The initiation of this shared care plan starts the process toward becoming fully care managed under the model.

PM DVHA ACCC: % of high and very high risk level patients who have a shared care plan with completed tasks and goals   **Q4 2018**   **23.29%**
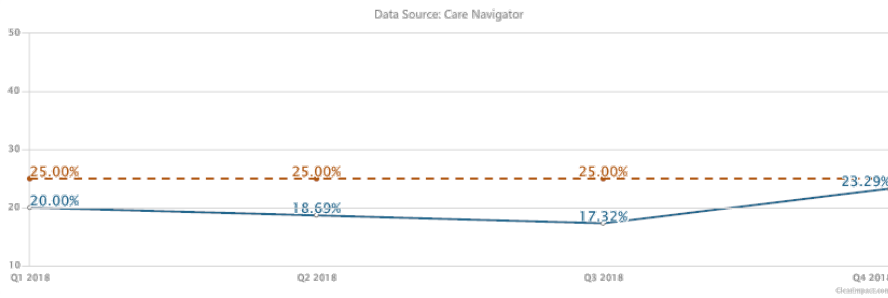
Notes on Methodology

The red dotted line in the graph above represents the target percentage for CY 2018. The blue solid line represents OneCare's actual quarterly data values.

A more detailed data break-out is provided here:

H and VH Risk Patients with Completed Goals Tasks (Goal 25% of those with SCP Created)				
Quarter	Full Population Completed Tasks/Goals (for reference)	H and VH Risk Completed Tasks/Goals	H and VH Risk with Shared Care Plans Initiated	%
1	37	33	165	20%
2	69	57	305	18.69%
3	96	71	410	17.32%
4	118	99	425	23.29%

Partners

Participating continuum of care team members including:

- Designated Mental Health Agencies
- Home Health Agencies
- Area Agencies on Aging
- Primary Care Providers

Story Behind the Curve

Early on in the care coordination process, initial member engagement in shared care planning and goal creation are critical first steps towards a successful relationship with a lead care coordinator. With time goals and tasks are completed in the shared care plan, indicating that the needs of the patient are being met. These are great milestones toward impacting the care of the patient. The denominator for this measure is the total number of patients with shared care plans. As more members have shared care plans the percentage goes down even though the raw numbers show continued growth in engagement and completed goals.

| PM | DVHA | QHMM: % of health service areas who received data literacy training and technical support | **2018** | **100%** |

Data Source: OneCare Vermont Training Attendance Records
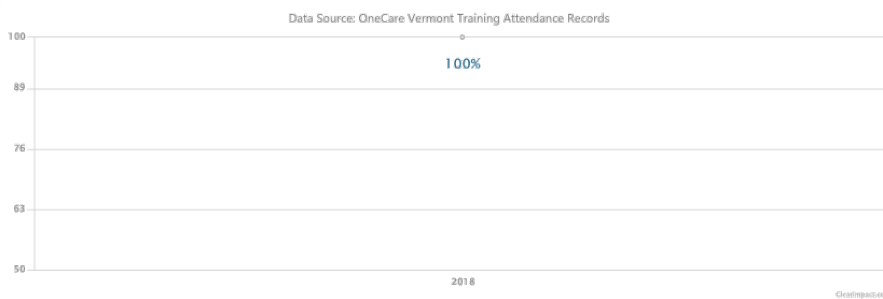
Notes on Methodology

This performance measure is reported on an annual basis. The data point above represents ten (10) health service areas that received data literacy training and technical support, which is 100% of our current health service areas.


Partners

OneCare Vermont ACO

Story Behind the Curve

OneCare Provides Data Literacy trainings to all Health Service Areas. The goal of these trainings is to provide insight into available data and tools from the ACO. We spend time reviewing reports and self-service tools, answering questions and collaborating with participants.

Q4 2018	**20**
Q3 2018	**15**
Q2 2018	**6**
Q1 2018	**1**

Data Source: 2018 VMNG Quarterly Contract Deliverables
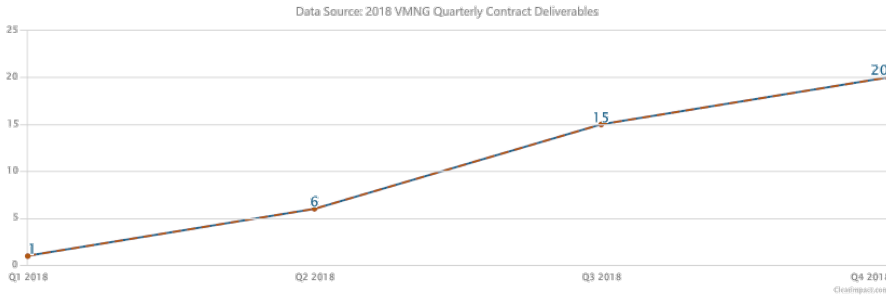
Notes on Methodology

The red dashed line in the graph above represents the quarterly CY 2018 target values, while the blue solid line represents OneCare's quarterly actual cumulative values. All targets were met through Q4 2018.

A more detailed data break-out is provided here:

Quarter	Quarterly Actual (Cumulative)	Quarterly Target (Cumulative)
1	1	1
2	6	6
3	15	15
4	20	20

Partners

OneCare Vermont

Story Behind the Curve

The quality and health management measurement improvement investments are directed at various capabilities and functionalities within OneCare Vermont's operations. Following is a list of VMNG contract deliverables supported by the health management measurement improvement investments:

- Integrate data from all payers for 2018 risk-based programs into OneCare's analytics platform and Care Navigator

- Create and deploy 2018 ACO Quality Measure Scorecard for all payers

- Provide analysis and reporting to support independent primary care practice payment reform pilot

- Enhance analysis and reporting to support financial and risk management priorities, to include out-of-network utilization, regional practice, and provider variation analysis, and integrated payment and performance reporting for risk-bearing hospitals and communities

- Develop self-service analytic application or reports to support Care Coordination Programs

- Integrate event notification from out-of-state facilities into Care Navigator

- Enhance analytic application to support Data Quality Improvement work for data received from the Vermont Health Information Exchange (VHIE)

- Develop and design project aimed at integrating Patient Experience data into platform

- Enhance analysis and reporting to support Mental Health providers and programs

- Deploy Pediatric Shared Care Plan functionality

- Develop and deploy at least one (1) additional automated workflow for end users

- Deploy desktop application to multiple participants

- Deploy end user satisfaction surveys

- Enhance mobile application functionality or access

- Enhance patient resource library content or access

- Enhanced analysis and reporting to support financial and risk management priorities, to include analytics to support a new pharmacy risk model

- Analysis and reporting to support 2018 Medicare and Medicaid Benefit Enhancement waiver implementation

- Analysis and reporting to support 2018 OneCare Clinical and Quality Advisory Board priorities

- Plan for the collection and incorporation of Social Determinants of Health data into the OneCare analytics platform

- Up to 50 ad hoc reports to support the OneCare network and demonstration that technical assistance and deployment support was provided to ACO providers throughout the OneCare network.

What We Do

CMS GC Investment Goal: Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont

Background on IFS: 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.

Who We Serve

IFS offers families an expanded array of service domains, including: mental and behavioral health, developmental disabilities, and substance use. Services include the following Medicaid State Plan and Demonstration services: Section 1115 Demonstration Services: specialized mental health services for children under 22 with a severe emotional disturbance; specialized developmental disability services for individuals under 18. State Plan Services: mental health clinic services including mental health outpatient therapy, targeted case management, specialized rehabilitation services (early childhood development and mental health), intensive family-based services, extended nursing visits for pregnant and postpartum women.

The Integrating Family Services (IFS) bundled payment model supports Medicaid services for pregnant women and children birth through age 21 across service domains, including: mental and behavioral health, developmental disabilities, and substance use. Services reach across the continuum of prevention, diagnosis, and treatment.

The bundled rate allows IFS providers to bill once a month for Medicaid services after a single unit of service. That single payment supports services regardless of how frequently or intensively services occurred in a month for an individual. The bundled rate further supports IFS delivery of service in the most natural setting for the child and family, including in the home, and allows the provider to focus on the plan of care and supporting individuals in meeting goals. A unique case rate is established for each provider. The provider case rate represents reimbursement for specific Medicaid-covered services to the target population (pregnant women and children age 0 through 21 years). The specific Medicaid services within each IFS provider's case rate differ, based on the array of services provided by that provider.

How We Impact

Goals of IFS: The goals of IFS are: a) to improve the delivery of services and ultimately the health and well-being of pregnant/postpartum women, infants, children and young adults and b) advance maternal and child health and safety, family stability, and optimal healthy development through the transition to adulthood. This is achieved by:

- Providing flexible funding that allows service providers to meet family needs as they become known.

- Bringing children's, youth and family services together in an integrated and seamless continuum.

- Offering families supports and services based on need rather than program eligibility criteria.

- Shifting the focus from counting clients and service units to measuring the impact of those services.

IFS propels individuals, organizations and systems at the state and community level to work together more collaboratively, use resources more flexibly, and make supports and services more family-friendly so children, youth and families are better off as a result of their interaction with AHS and its community partners.

Performance Measures	Most Recent Period	Current Actual Value
PM **CMS** % of clients seen within 5 days of their first call requesting services.	**2018**	**48%**

Data Source: NCSS and CSAC
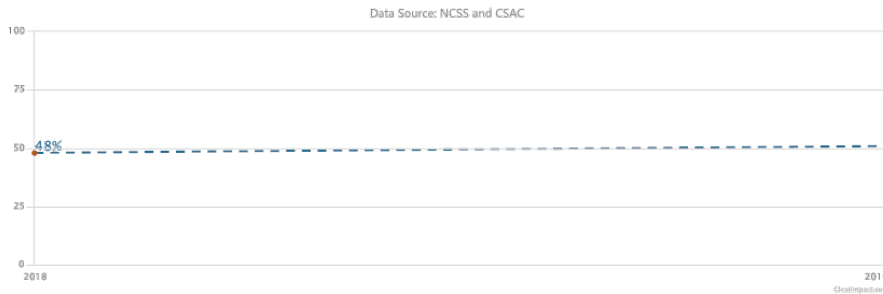
Story Behind the Curve

This measure is used to monitor from an access perspective. When a family calls requesting services, IFS regions are looking to provide them supports and services as quickly as possible. Important to note is that while we are looking for quick access, families are also being asked when they would like services which may impact the timeline for services beginning.

Special Note related to NCSS data: We believe this percent is much higher than what was able to be tracked in the agency data system. There are several reasons for this hypothesis 1) the data collection for this performance measure began on January 1, 2018 so it is still a newer category for staff to enter 2) due to this, there is an effort being made to remind staff to enter the data point and to ensure the data point remains in the system without being changed at a later date 3) this region went from having one centralized cost center within IFS to multiple cost centers which means more data can be parsed out, but that the agency is still in a transition period which is impacting the data quality.

Partners

NCSS and CSAC

Action Plan

IFS grantees will demonstrate a 2% decrease in the average wait time (in days) between first call requesting services and first appointment offered.


Notes on Methodology

This is an averge of CSAC and NCSS' baseline data for 2018. CSAC reported 75% and NCSS 20%.

Numerator: Time in days between first call requesting services and appointment offered.

Denominator: Total number of inactive clients requesting services.

These are the baseline measures. Future reporting sets will begin using the CY data as agreed upon for start on January 1, 2019. Previous to January 1, 2019 IFS has been operating on a CMS approved fiscal year.

| PM | CMS | % of eligible clients with a CANS administered | **2018** | **64%** |

Data Source: NCSS and CSAC
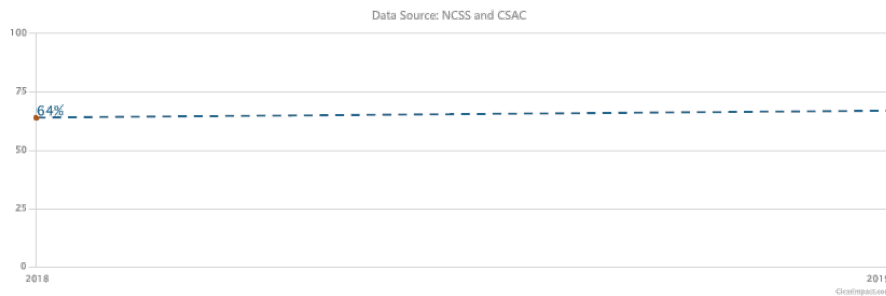
Story Behind the Curve

There has been a tremendous increase in a small amount of time by both IFS regions in how many children are receiving CANS administration which is a direct result of the significant time and resources both regions have invested in using this tool.

Partners

NCSS and CSAC.

Action Plan

IFS grantees will demonstrate a 2% increase of children who have the CANS administered per the eligibility guidelines in the IFS Procedures Manual


Notes on Methodology

This is an average of NCSS and CSAC's data. CSAC reported 62% and NCSS reported 67% for baseline 2018 data.

Numerator: All children who have a plan of care completed within 45 days

Denominator: All children eligible for a plan of care

These are the baseline measures. Future reporting sets will begin using the CY data as agreed upon for start on January 1, 2019. Previous to January 1, 2019 IFS has been operating on a CMS approved fiscal year.

PM CMS % of clients who have a plan of care completed within 45 days of referral   **2018**   **29%**

Data Source: NCSS and CSAC
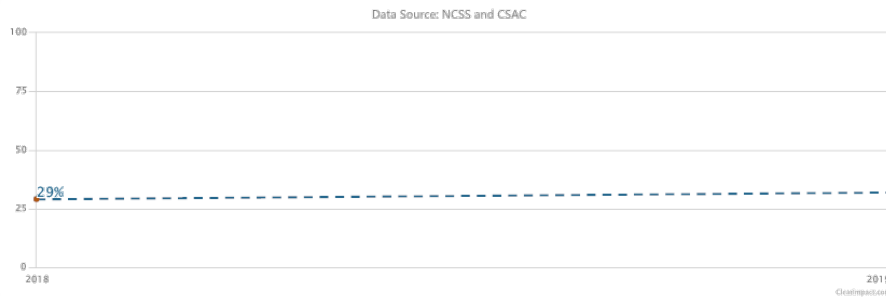
Story Behind the Curve

This measurement is a Medicaid standard which indicates access to care.

Access to care data is being focused on across all the designated agency systems and having operationalized definitions of referral date is being worked on. The definition clarity will be established for 2020. Through the process of payment reform it became clear that across the system this was an area to work on and the engagement from both the state and DA system has been strong.

We suspect there are clients in the denominator who did not follow through with care which could explain why this percentage is so low. We will continue to monitor this data point closely.

Partners

NCSS and CSAC

Action Plan

IFS grantees will demonstrate a 2% increase in the percent of clients that have a plan completed within 45 days of referral during the measurement period.

Notes on Methodology

This is an average of NCSS and CSAC's data. NCSS reported 28% and CSAC 31% for 2018 baseline data.

Numerator: All children who have a plan of care completed within 45 days

Denominator: All children eligible for a plan of care

These are the baseline measures. Future reporting sets will begin using the CY data as agreed upon for start on January 1, 2019. Previous to January 1, 2019 IFS has been operating on a CMS approved fiscal year.