

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 13
(1/1/2018 – 12/31/2018)

Quarterly Report for the period
July 1, 2018 – September 30, 2018

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I. Background and Introduction

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

The initial Global Commitment to Health (GC) and Choices for Care (CFC) demonstrations were approved in September 2005, effective October 1, 2005. The GC demonstration was extended for three years, effective January 1, 2011, and again for three years effective October 2, 2013. The GC demonstration was again renewed for five years effective January 1, 2017. The CFC demonstration was extended for 5 years effective October 1, 2010. The following amendments have been made to the GC demonstration:

- 2007: a component of the Catamount Health 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 federal poverty level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State.
- 2009: the state extended Catamount Health 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.
- 2012: CMS provided authority for the State to eliminate the \$75 inpatient admission copay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid State Plan.
- 2013: CMS approved the extension of the GC demonstration which included sun-setting the authorities for most of the 1115 Expansion Populations because they would be eligible for Marketplace coverage beginning January 1, 2014. The renewal also added the New Adult Group to the demonstration effective January 1, 2014. Finally, the renewal also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.
- 2015: As of January 30, 2015, the GC demonstration was amended to include authority for the former Choices for Care demonstration. In addition, the State received section 1115 authority to provide full Medicaid State Plan benefits to pregnant women who are determined presumptively eligible.
- 2016: On October 24, 2016 Vermont received approval for a five-year extension of the Global Commitment to Health 1115 waiver, effective from January 1, 2017 through December 31, 2021.
- 2018: 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).

As Vermont's Medicaid Single State Agency and under the Terms and Conditions of the Global Commitment to Health Waiver, AHS has entered into an Inter-Governmental Agreement (IGA) with the Department of Vermont Health Access (DVHA). The AHS/DVHA IGA functions similarly to a Medicaid Managed Care contract in that it delineates program requirements and responsibilities between AHS and DVHA and according to federal Medicaid Managed Care requirements found at 42 CFR §438. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services).

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the third quarterly report for waiver year 13, covering the period from July 1, 2018 through September 30, 2018 (QE0918).***

II. Outreach/Innovative Activities

i. Provider and Member Relations

Key updates from QE0918:

- DVHA changed its methodology and rates paid to suppliers of Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) effective after July 1, 2018 for Medicare categories of service listed below. Out-of-State Medical Services and Non-Emergency Medical Transportation
- MMIS Provider Management Module

The Provider and Member Relations (PMR) Unit ensures members 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 Title 42 Code of Federal Regulations (CFR) §455.410 and §455.450 requiring that all participating providers be screened upon initial enrollment and revalidation of enrollment.

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

Fee-for-Service Payments for Durable Medical Equipment (DME), Prosthetics/Orthotics, and Supplies Reimbursement Update

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 Medicare categories of service listed below. These changes were made in an effort to improve access to medical equipment for Vermont Medicaid beneficiaries and in response to public comments received.

Out-of-State Medical Services and Non-Emergency Medical Transportation

Due to the recent trend of rising costs and increased volume of requests related to travel for out-of-

state medical appointments, the DVHA PMR unit met with both the DVHA Clinical and Reimbursement units to develop new strategies and policies to better address these issues.

The current process allows VT Medicaid members to access care and services at participating out of state facilities when those services or level of care is not available within the existing in-state network. Federal regulation (42 CFR §440.170) indicates that DVHA must assist these members when they travel to access such care, with such assistance coming in the form of mileage reimbursements, lodging assistance, and payments for meal expenses. As the number of requests increased, the costs associated with these requests followed suit. Per the current NEMT (Non-Emergency Medical Transportation) contract with VPTA (the Vermont Public Transportation Association), any per trip total costs that exceed \$1,000 are paid directly to the provider, rather than captured in the contracted per member/per week payment methodology. As the out-of-state requests increased, so did the number of payments of over-\$1,000 claims, payments which went above and beyond the current contract totals.

The three DVHA units involved now work together in a more coordinated effort to monitor these out-of-state approvals and ensure that the cost and medical necessity are appropriate. The Clinical Unit maintains more contact with the PMR Unit, as greater advance notice allows the NEMT contractor to better establish more affordable, medically appropriate lodging. The Reimbursement Unit monitors any trends in out-of-state placements and advises other units if any costly placements occur.

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 a high priority legislative initiative aimed to reduce the timeframe to enroll Medicaid Providers, passed in 2018 as [Act 116](#). Implementation is planned by 3/1/2019 and a reduction in the timeframe for provider enrollment is anticipated to go from an average of 120 days to below 45 days.

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE0918:

- The Customer Support Center received just over 84,000 calls in QE0918. Volume has been lower in every month of 2018 to date compared to 2017, but the gap has narrowed as open enrollment approaches.
- Vermont Health Connect was supported throughout the state by 277 Assistants in QE0918, up from 232 in QE0917. The Certified Application Counselor program was responsible for most of the growth, increasing by 70% over the last 12 months by training and certifying staff in hospitals, health centers, and other community organizations.
- Increasing numbers of customers are using self-service functions, especially recurring payments. More than a third (37%) additional customers made recurring payments in QE0918 than did so the previous year, which in turn was more than double the year before that. Automatic recurring payments ensure that members' premiums are paid on time, helping them to avoid going into grace period – and ultimately losing coverage – due to late payments.

Enrollment

As of QE0918, more than 210,000 Vermonters (over one-third of the state's population) were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 133,000 in Medicaid for Children and Adults (MCA) and 77,000 in qualified health plans (QHP), with the latter divided between 26,000 enrolled with VHC, 6,000 direct-enrolled with their insurance carrier as individuals, and 45,000 enrolled with their small business employer.

Medicaid Renewals

Redeterminations for Medicaid for Children and Adults (MCA) continued on their normal cycle during QE0918. The ex parte process for the three batch runs during the quarter had a passive renewal success rate of 42%. This success rate is on par with what has been expected since the entire population has to be checked for MAGI income and immigration status. This means that just over half of the member households that are coming up for renewal in QE1218 will need to actively respond to a renewal notice or reminder.

Customer Support Center

DVHA continues to contract with Maximus to staff and manage the VHC Customer Support Center. The Customer Support Center serves Vermonters enrolled in both public and private health insurance coverage by providing support with phone applications, payment, basic coverage questions, and change of circumstance requests.

The Customer Support Center received just over 84,000 calls in QE0918, down slightly from the previous year when there were more than 85,000 calls in the quarter. The call volume has been lower in every month of 2018 to date compared to 2017, but the gap has narrowed as QHP open enrollment approaches..

Maximus answered 81% of calls within 24 seconds in QE0918, a significant improvement over the previous year (64%), and easily surpassed the contracted 75% target during each of the three months. In addition, the 2% abandoned rate exceeded the 5% target in each of the three months.

Maximus continued to hire new staff in advance of open enrollment and ended QE0918 with 85 customer service representatives, up from the 75 on board at the start of the quarter. Hiring was conducted earlier this year for two reasons: first to ensure that performance metrics don't dip in the summer as they have the last two years, second to ensure that new staff are fully trained and gain experience well in advance of the next Open Enrollment. Maximus did encounter a high attrition rate among the new hires, losing 19 staff in September alone, but still managed to add net capacity.

Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group.

An increase in new staff is typically accompanied by an increase in the proportion of calls that have to be escalated, however the 8% of QE0918 calls had to be transferred to DVHA-HAEEU staff was steady from the previous quarter (though up from 6% in QE0917). Importantly, DVHA promptly

answered the calls that were transferred. Ninety-seven percent of transferred calls were answered in five minutes in QE0918, up from 93% in QE0917.

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days by October 2016 and 85% by June 2017. DVHA-HAEEU met this goal ahead of schedule and has continued to improve. In QE0316, fewer than 60% of VHC requests were completed within ten days. In QE0918, 95% of VHC requests were completed within ten days.

System Performance

The system continued to operate as expected throughout most of QE0918, achieving 100% availability outside of scheduled maintenance in July and September and 99.45% in August. The average page load time was less than 1.1 seconds in each of the three months -- well within the two-second target.

In-Person Assistance

Vermont Health Connect was supported throughout the state by 277 Assisters (3 Navigators, 193 Certified Application Counselors or CACs, and 81 Brokers) in QE0918, up from 232 in QE0917. The CAC program was responsible for most of the growth, increasing by 70% over the last 12 months by training and certifying staff in hospitals, health centers, and other community organizations. Other CACs work for a Department of Corrections contractor and focus on helping connect justice-involved individuals with coverage. Overall, Navigators and CACs largely focused on helping Vermonters with Medicaid renewals, particularly new Vermonters who speak English as a second language and others with accessibility challenges.

DVHA held an Assister conference in Montpelier in September to help Assisters network with fellow Assisters and DVHA staff, to review policies and procedures, and prepare for open enrollment.

Outreach

Health insurance literacy was also an outreach focus throughout QE0918. DVHA-HAEEU engaged health care providers, libraries, state offices, and legislators in helping Vermonters understand the importance of responding to Medicaid renewal notices and comparing options for qualified health plans. Vermont Health Connect's website continued to be a key source of information for current and prospective customers alike, with more than 56,000 visits to the site's Help Center – steady from the previous year. The Plan Comparison Tool, which helps customers estimate total costs of coverage based on family members' age, health, and income, was used in more than 10,000 sessions during the quarter, up 12% over the previous year.

Self-Service

During QE0918, DVHA-HAEEU continued to promote self-service options for customers to pay their bills, report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through monthly recurring payments

rather than one-time payments. Self-serve applications comprised nearly half (46%) of all applications in QE0918, up slightly from QE0917 (45%). More than a third (37%) additional customers made recurring payments in QE0918 than did so the previous year, which in turn was more than double the year before that (an average of nearly 6,000 recurring payments per month in QE0918, 4,400 in QE0917, and 2,300 in QE0916). Automatic recurring payments ensure that members' premiums are paid on time, helping them to avoid going into grace period – and ultimately losing coverage – due to late payments.

ii. *Choices for Care and Traumatic Brain Injury Programs*

Key updates from QE0918:

- Implemented 2% rate increase & increased TBI program appropriation.
- Wait Lists

Rate and Appropriation Increases

Effective July 1, 2018, Vermont has:

- Implemented a 2% Medicaid rate increase for Choices for Care home-based, Adult Family Care, and Enhanced Residential Care services,
- Increased the Traumatic Brain Injury Program appropriation from \$5,641,336 to \$6,005,225, and
- Increased the minimum wage for Independent Direct Support workers to \$11.30/hour and \$172/day (daily respite).

Wait Lists

Choices for Care does not have a wait list for people applying for High/Highest (nursing home level of care) and are clinically and financially eligible for services.

Choices for Care Moderate Needs Group (MNG) services are not an entitlement and instead are limited by funding which is allocated to providers and managed at the local level. This requires that providers establish a wait list when funds are spent in their region. As of September 30, 2018, providers report approximately 800 people are waiting for help to pay for homemaker services statewide and approximately 17 people are waiting for help to pay for Adult Day services. Though total funding for MNG services was increased to eliminate the wait list in SFY2015, it is important to note that eligibility for Moderate Needs is quite broad which creates an opportunity for a very large number of Vermonters to be eligible. Therefore, the State is working with stakeholders to explore opportunities for modifying the Moderate Needs wait list criteria to prioritize people with greatest need versus chronological application.

As of September 30, 2018, the TBI program was working to enroll all TBI program applicants, resulting in no wait list.

iii. *Developmental Disabilities Services Division*

Key updates from QE0918:

- Developing new payment model
- HCBS rule 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. 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.

DVHA has engaged a Medicaid reimbursement consultant firm to assist the State in completing a provider rate study. The rate study will collect 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.

HCBS Rule Implementation

DDSD continues to work on implementing the HCBS rules to ensure compliance with all requirements by 2022. The Division is currently in the process of completing site visits to validate survey information submitted by providers. Most of the site visits have been completed. It is anticipated that most 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.

Wait List

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

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

As of 9/30/18, 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. The full set of waiting list data is collated on an annual basis. This information will be provided in the 2018 Annual GC Report.

iv. *Global Commitment Register*

Key updates from QE0918:

- 28 policies were posted to the GCR in Q3 2018.
- Since the Global Commitment Register (GCR) launched in November 2015, 157 final GCR policies have been publicly posted.

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.

A combined total of 28 policies were posted to the GCR this past quarter. This includes 8 proposed changes and 20 final changes. Changes to rates and/or rate methodologies accounted for nearly half of the changes, clinical coverage changes and guidelines accounted for nearly half, and there were a few administrative rule and State Plan Amendment notices.

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

v. *Opioid Use Disorder/Substance Use Disorder Program*

Key updates from QE0918:

- This is the first quarterly report for the OUD/SUD Program, which went into effect on July 1, 2018.
- Reporting on metrics for this program will not be available until the first quarter report of 2019 (QE0319).
- Recovery Supports in the Emergency Room project launched this quarter.

Executive Summary

During the first quarter of the demonstration the State of Vermont continued to have all ASAM levels of care available and no ongoing waitlist in regard to access to Medication Assisted Treatment. The Vermont Department of Health’s Division of Alcohol and Drug Abuse Programs (ADAP) continued the finalization of the scoring tool to determine the Preferred Providers’ compliance and certification status and as the final stage, 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 also 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 biweekly or more often 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 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 worked to identify the methods to capture the data elements for the Regional Managers’ site visits.

ADAP staff worked diligently to meet the established timelines of the RFP for the Centralized Intake and Call Center. Once the independent review is the complete, the contract can begin to be executed.

Vermont’s Director of Drug Prevention Policy and the Vermont Opioid Coordination Council continued their work to develop strategies for the Council’s list of 22 recommendations to the Governor. Several workgroups were established to develop the strategies. These included workgroups in prevention, treatment, and recovery/recovery housing.

Also, during this first quarter, Vermont launched the Recovery Supports in the Emergency Room project. Two areas launched on July 1, 2018 and the third area launched on August 1, 2018. As of September 27th, 162 individuals were seen in the emergency rooms. Vermont continues to work on expanding the program, with the plan to add 6 additional sites in 2019.

Assessment of Need and Qualification for SUD Services

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.			
<i>[Add rows as needed]</i>			

<input checked="" type="checkbox"/> 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.
<input checked="" type="checkbox"/> 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.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Milestone 1 Implementation Update			

<p>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:</p> <p>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)?</p> <p>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?</p> <p>Summary: There are no planned changes to access to SUD treatment or the SUD benefit coverage.</p>			
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.
<input checked="" type="checkbox"/> 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			
<input checked="" type="checkbox"/> The state is not reporting any metrics related to this reporting topic.			
Milestone 2 Implementation Update			
<p>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:</p> <p>a. Planned activities to improve providers’ use of evidence-based, SUD-specific placement criteria?</p> <p>b. Implementation of a utilization management approach to ensure:</p> <ol style="list-style-type: none"> 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? <p>Summary: As of August 1, 2018, the revised version of the Substance Use Disorder Treatment Standards has been implemented. The ADAP Compliance Assessment Tool has also been updated to reflect the revised version of the Substance Use Disorder Treatment Standards. As of October 3, 2018, the Compliance Assessment Tool will have been utilized with seven substance use disorder treatment providers.</p> <p>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</p>			

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.

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	In progress
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	Not 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	Not Completed
Implement the Compliance Assessment Tool with seven providers	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)	January 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Not Completed

Vermont also 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 implementation of the value-based

portion of the new model will be implemented in 2020. During the first quarter of the demonstration the Vermont team completed the model to the providers. Feedback from the providers is due in October 2018. Vermont has updated the timeline:

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	11/1/18	Payment Reform Team, ADAP Director of Clinical Services, VDH Business Office
Residential providers to provide feedback	10/1/18	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	11/15/18	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	10/15/18	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			
<input checked="" type="checkbox"/> The state is not reporting any metrics related to this reporting topic.			
Milestone 3 Implementation Update			
<p>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:</p> <ol style="list-style-type: none"> Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards? State review process for residential treatment providers' compliance with qualifications standards? Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site? <p>Summary: As of August 1, 2018, the revised version of the Substance Use Disorder Treatment Standards has been implemented. The ADAP Compliance Assessment Tool has also been updated to reflect the revised version of the Substance Use Disorder Treatment Standards. As of October 3, 2018, the Compliance Assessment Tool will have been utilized with seven substance use disorder treatment providers.</p> <p>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.</p> <p>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.</p>			
<p>Are there any other anticipated program changes that may 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.</p>			
<input type="checkbox"/> 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.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Milestone 4 Implementation Update			
<p>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?</p> <p>Summary: 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 implementation of the value-based portion of the new model will be implemented in 2020. During the first quarter of the demonstration the Vermont team completed the model to the providers. Feedback from the providers is due in October 2018. Vermont has updated the timeline – please see Table 2 under Milestone 2 Summary above.</p>			
Are there any other anticipated program changes that may impact metrics related to provider capacity at critical levels of care, including for medication assisted treatment (MAT) for OUD? If so, please describe these changes.			
<input type="checkbox"/> 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.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Milestone 5 Implementation Update			
<p>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:</p> <p>a. Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD?</p> <p>b. Expansion of coverage for and access to naloxone?</p>			
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.			
<input type="checkbox"/> 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.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Milestone 6 Implementation Update			
<p>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?</p> <p>Summary: As of August 31, 2018, Vermont has implemented the Peer Recovery Coaches in the Emergency Department Program in three regions of the state. A total of 162 individuals have been seen by recovery coaches. Vermont plans to expand to 6 additional regions by the end of 2019.</p> <p>Vermont continues with the plan to develop a new scoring tool for compliance and certification of the Preferred Providers. The new certification standards were approved on January 1, 2018. ADAP’s Clinical Unit and Quality Unit certified one of the four residential providers using the new tool. ADAP met the milestones of finalizing the standards by May 1, 2018 and updating the tool by May 15, 2018 to include all ASAM criteria. The ADAP Quality Unit completed the annual review of the Valley Vista Vergennes residential program by June 30, 2018.</p> <p>Vermont also 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 implementation of the value-based portion of the new model will be implemented in 2020. During the first quarter of the demonstration the Vermont team completed the model to the providers. Feedback from the providers is due in October 2018. Vermont has updated the timeline – see Table 2 under Milestone 2 Summary above.</p>			
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.			
<input type="checkbox"/> 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	Related	Summary
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	Year (DY) and quarter first reported	metric (if any)	
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.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Implementation Update			
<p>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:</p> <ol style="list-style-type: none"> How health IT is being used to slow down the rate of growth of individuals identified with SUD? How health IT is being used to treat effectively individuals identified with SUD? How health IT is being used to effectively monitor “recovery” supports and services for individuals identified with SUD? 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? Other aspects of the state’s health IT implementation milestones? The timeline for achieving health IT implementation milestones? Planned activities to increase use and functionality of the state’s prescription drug monitoring program? 			
<p>Summary:</p> <ul style="list-style-type: none"> <i>ADAP to work with vendor to complete contract deliverables and develop the linkage to RxCheck hub by 10/31/18:</i> Vermont’s current vendor, Appriss reported that they have connected Florida with RxCheck. Further information is being gathered. VT is on the implementation list, but timing is limited by vendor. Although Vermont has a requirement and funding in the contract to connect to RxCheck for interstate data sharing, Appriss indicates that because Vermont wants to use it for connecting to health systems/EHRs it is outside the scope of the contract. This continues to be worked on. <i>ADAP to negotiate data sharing with FL after 7/1/18 when FL Statue allows for sharing. By year end, connect a total of at least three new states:</i> FL is only connecting through RxCheck so before Vermont can connect with them, will need to connect to RxCheck. <i>VDH will explore feasibility of integrating the VT MPI with the vendor system through discussions with the vendor. If deemed possible, determine timing, cost, and process. Discussions to begin by 12/31/18:</i> Appriss is testing an improved patient matching algorithm and VT is in queue to have the new static consolidated identifier applied to VPMS. <i>VDH is promoting the availability of technical assistance at the prescriber level. Promotion has been integrated into the March 2018 implementation of prescriber insight reports and the impact of implementation of the insight reports is being evaluated:</i> Vermont will be issuing the fourth round of prescriber insight reports 10/15/18. <i>VDH is conducting an impact evaluation of the 7/1/17 pain prescribing rule change. Planned completion is expected by 12/31/18.</i> 			

- VDH began user acceptance testing of the clinical alerts 2/2018 and has a target implementation date of 7/1/18. Clinical alerts were implemented 9/27/18. A formal survey on impact of insight reports and clinical alerts will be sent to prescribers at the end of October.
- VDH is currently working with the VPMS vendor on threshold reporting. Threshold reporting is available through clinical alerts as of 9/27/18.

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.

IV. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

- Key updates from QE0918:**
- Assessment of current VCCI case management services and how to improve unit alignment with state healthcare reform.
 - VCCI piloting outreach to beneficiaries new to Medicaid; includes screening with goals of facilitation to primary care and other community resources.
 - VCCI exploring enhancing eligible population; to include dually insured.
 - The VITL interface work has completed and data is being stored within eQ Suite. Development is ongoing for displaying the data in the User Interface and completion is targeted for middle November 2018 for testing. All VCCI staff have been trained in accessing VITL access in order to view patient information to better inform the case management plan.
 - Clinical reports continue to be designed and developed by the eQ Vendor.

The VCCI is a statewide Medicaid case management service for Medicaid members, historically providing 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 VCCI eligible members accounted for ~39% of Medicaid expenditures. The emergence of the Accountable Care Organizations (ACO) and a subsequent increase in the number of attributed lives to the ACO prompted the necessary review of how and who VCCI would deliver case management services to; ACO attributed lives are not eligible to receive VCCI services.

This past quarter, VCCI continued efforts focused on how to better align with state healthcare reform efforts, including the ACO, capitalizing on the skill and experience of a seasoned case management team. 2019 will bring more hospitals and providers into the ACO which will in turn, decrease the VCCI eligible population. The VCCI goal of supporting statewide health care reform, coupled with feedback from community partners and leaders, led to the VCCI exploring and piloting the following strategies toward enhancement of population.

As of October 1, 2018, VCCI will proactively conduct outreach to all new to Medicaid members using a verbal, telephonic screening tool to stratify them into risk levels and screen for access to primary care, health conditions and social determinants of health. The goals are to 1) orient the member to the system of care to include navigation of services to health-related needs such as housing and food security and 2) onboard members ahead of their ACO attribution to facilitate access to primary care, and connection to community supports and resources. If members need intensive case management services, they will be offered enrollment into VCCI.

Concurrent with the piloting of outreach to new to Medicaid members, VCCI is creating a training for the VCCI case management team on the complex care model, also adopted by the ACO. The complex care model includes eco-mapping of member relationships; member identification of goals; shared care plan development and care team conferences. Through this effort, members new to Medicaid and who will likely be attributed to ACO in the future will have received delivery of services using the same model – regardless of agency or entity.

VCCI efforts toward implementation of pilot outreach efforts included review of data on new to Medicaid enrollees, inventory and review of current tools, communication with experts in motivational interviewing and complex care model delivery, development of outreach screening tool to include screening questions re: healthcare and healthcare related issues such as, cycling 4 PDSA outreach rounds, refining data collection tool, full team training on providing brief intervention via phone. This effort also included DVHA leadership discussion with ACO leadership on the proposal to help onboard new to Medicaid members ahead of future ACO attribution.

Outreach and collaboration with local and state partners has included:

- Vermont Health Connect- Population Identification, Phone Numbers
- Blueprint for Health – Team Trainings; Primary Care Access, Direct Registration to Self-Management Programs (SMP) in communities
- Quality Improvement Unit- Project of Adult Access to Preventive/Ambulatory Care
- Bi State- Primary Care Access and Barriers

VCCI is also exploring lifting the eligibility criteria of members needing to be predicted to be high cost/high risk to potentially receive case management services. Community feedback offered to the department cited this specific criterion as a barrier, with providers feeling that their clinical judgment in identification of members needing VCCI case management services should be ample reason to start the referral process.

Similarly, community feedback cited eligibility requirement of Medicaid as the sole insurance as limiting, citing the need for specialized VCCI services for other populations. The VCCI is looking into including those members who are dually insured as part of the population enhancement.

ii. *Blueprint for Health*

Key updates from QE0918:

- The majority of Vermont’s primary care practices are now Blueprint-participating Patient Centered Medical Homes, as evidenced by the fact that 137 of Vermont’s estimated 149 primary care practices are Blueprint-participating practices;
- Vermont continues to demonstrate increased access to medication assisted treatment for Vermonters with opioid use disorder, as evidenced by the 3,637 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of August 2018 and the 2,887 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of September 2018;
- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 36 practices to participate in the Women’s Health Initiative as of September 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. Patient Centered Medical Homes provide care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The Patient Centered Medical Home model changes the way a patient experiences care by promoting care that is provided when and where the patient needs it, and in a way that the patient understands it. Patient Centered Medical Homes 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 give primary care providers the confidence to work alongside patients to identify the cause of health problems, including those that may have a psychosocial component, and connect patients with effective interventions upon identification, manage chronic conditions, or simply provide 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 the remaining primary care practices in each region that have not begun the process of transforming their practice into Patient Centered Medical Homes, indicating 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-Patient Centered Medical Home recognition, and then 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:

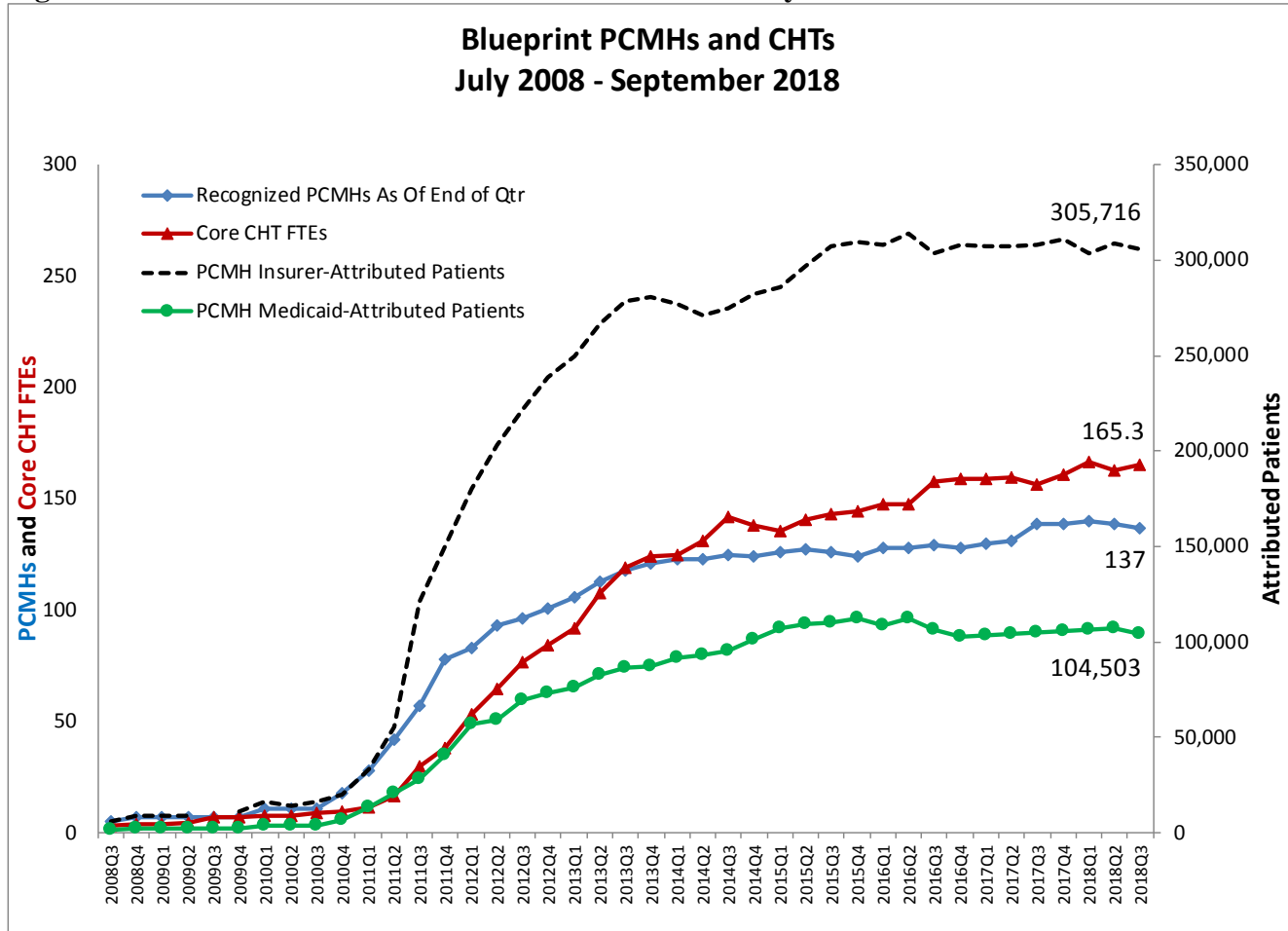
- focusing quality improvement activities on All Payer Model agreement and Accountable Care Organization quality measures;
- integration of the care model;
- implementation of new initiatives (e.g. Spoke program, Women’s Health Initiative, improving opioid prescribing patterns);
- prevention and management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

Blueprint-participating Patient Centered Medical Homes currently serve 305,716 Insurer-attributed patients (identified and attributed as a current active patient if the patient has had a majority of their primary care visits in the primary care practice within the 24 months prior to the date the attribution process is conducted), 104,503 Medicaid-attributed patients, and are supported by 165.30 full-time equivalents of Community Health Team staff.

Quarterly Highlights

At the end of the 3rd quarter of 2018, 137 Vermont practices were operating as Patient Centered Medical Homes, 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 1. Patient Centered Medical Homes and Community Health Teams



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. Practice Health Profiles and Community Health Profiles have been distributed to practices and healthcare organizations for the following data time periods:

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

- vii. 01/2016 – 12/2016
- 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, including the latest ones for the data period 07/2016 – 06/2017, are posted at <http://blueprintforhealth.vermont.gov/community-health-profiles>. The next set of profiles are expected to be distributed in the final quarter of 2018.

Hub & Spoke Program

Medication assisted treatment (MAT) for opioid use disorder (OUD) 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 assisted treatment for opioid use disorder in two settings – regional, specialty Opioid Treatment Programs (OTPs, Hubs), which provide higher intensity treatment and office-based opioid treatment (OBOT) 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 recent evaluation of Vermont’s Hub and Spoke system. The State Plan Amendment for the Vermont Medicaid Program, approved by the Centers for Medicare and Medicaid Services, 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.

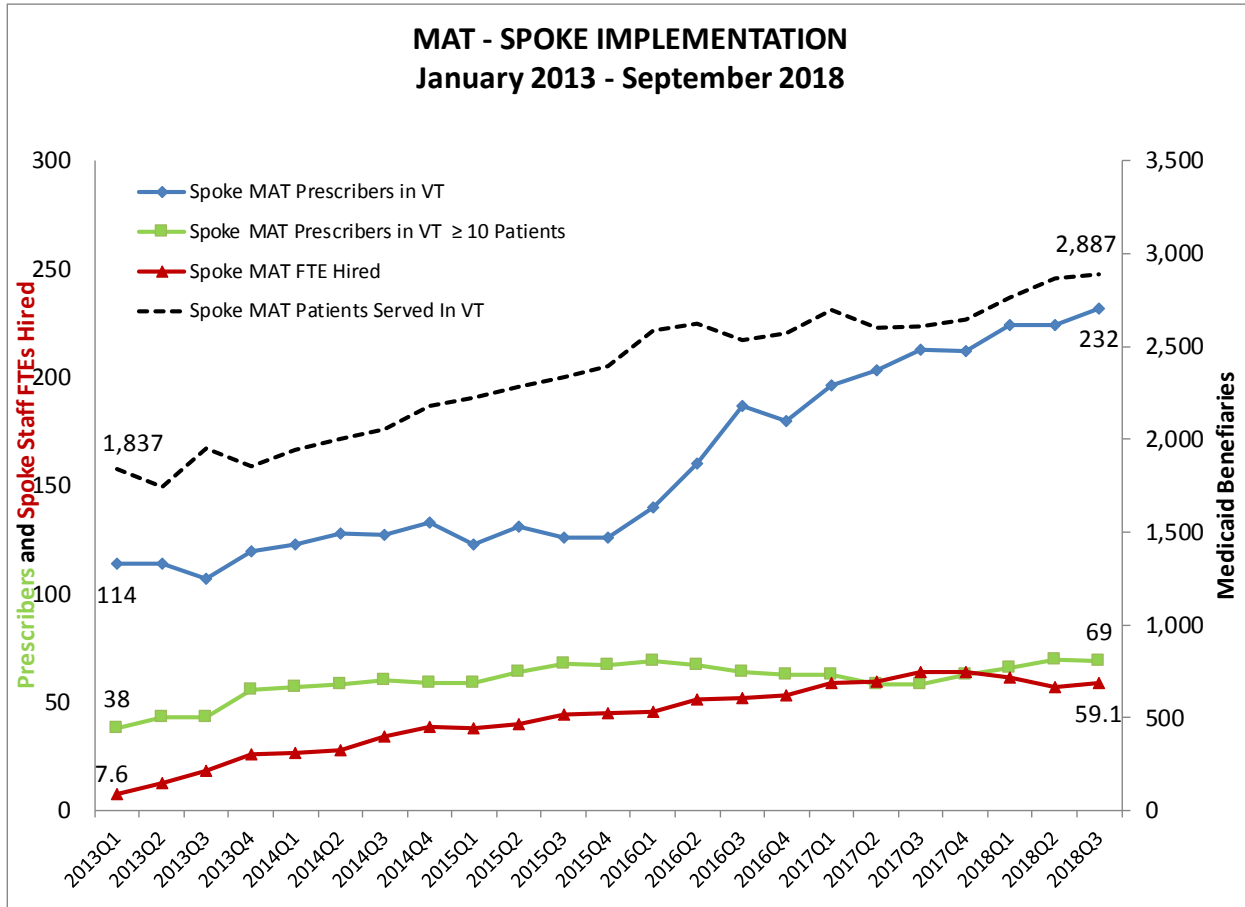
The Blueprint, in partnership with the Division of Alcohol and Drug Abuse Programs (Department of Health), continues to offer learning sessions with expert-led, and peer-supported, training in best practices for providing team- and evidence-based medication assisted treatment for opioid use disorder. 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 3rd quarter of 2018, capacity for receiving medication assisted treatment in Spoke settings continued to increase, as evidenced by 2,887 Vermonters with Medicaid insurance receiving medication assisted treatment for opioid use disorder from 232 prescribers and 59.1 full-time equivalent Spoke staff, working as teams, across more than 86 different Spoke settings (as of

September 2018).

Quarterly Highlights

- Vermont continues to demonstrate increased access to medication assisted treatment for Vermonters with opioid use disorder, as evidenced by the 3,637 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of August 2018 and the 2,887 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of September 2018.
- Medication Assisted Treatment (MAT) for opioid use disorder is being offered across the State of Vermont by more than 86 different practices and by 232 medical doctors, nurse practitioners and physician assistants who work with 59.1 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 September 2018).
- A collaborative team, comprised of the Department of Vermont Health Access - Blueprint for Health and the Vermont Department of Health – Division of Alcohol and Drug Abuse Programs staff and clinical content experts, was convened for the design and delivery of learning sessions intended to enhance best practice adoption by providers and practice teams. The planning team will offer two learning sessions in the fourth quarter of 2018; the learning sessions are open to MAT teams, with CMEs and CEUs offered. The learning sessions will be dedicated to enhancing best practices for comprehensive transitional care and prevention in practice, focusing on strategies to improve seamless transitions from one treatment setting to another, that improve patient and provider satisfaction and patient outcomes, and strategies that support patient-oriented wellness and recovery.

Figure 2. MAT-SPOKE Implementation Jan 2013 – September 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 (August 2018).

Table 3. Hub Implementation by Region as of August 2018



Hub Census and Waitlist: August 2018

Region	# Clients	# Buprenorphine	# Methadone	# Vivitrol	# Receiving Treatment but Not Yet Dosed	# Waiting
Chittenden, Addison	979	282	697	0	0	0
Franklin, Grand Isle	352	144	207	1	0	0
Washington, Lamoille, Orange	483	161	322	0	0	0
Windsor, Windham	634	130	503	0	1	0
Rutland, Bennington	422	99	301	0	22	0
Essex, Orleans, Caledonia	767	208	558	0	1	0
Total	3637	1024	2588	1	24	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 4. Spoke Implementation by Region as of September 2018



Spoke Patients, Providers & Staffing: September 2018

Region	Total # Providers prescribing patients	# Providers prescribing to ≥ 10 pts	Staff FTE Hired	Medicaid Beneficiaries
Bennington	11	5	4.8	247
St. Albans	24	10	10.1	428
Rutland	20	8	5.55	343
Chittenden	85	16	15.25	624
Brattleboro	13	5	3.19	135
Springfield	9	2	1.55	47
Windsor	10	5	3	258
Randolph	5	4	1.7	120
Barre	23	5	6.45	308
Lamoille	12	6	3.8	131
Newport & St. Johnsbury	11	2	2	104
Addison	11	4	1.25	122
Upper Valley	4	1	0.5	20
Total	232*	69*	59.14	2,887

Table Notes: Beneficiary count based on pharmacy claims for Buprenorphine and Vivitrol, July – September, 2018; an additional **306** Medicaid beneficiaries are served by **41** out-of-state providers. Staff hired based on Blueprint portal report 10/3/18. *6 providers prescribe in more than one region.

Women's Health Initiative

Like the Hub & Spoke program, the Women's Health Initiative 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 Women's Health Initiative 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 Women's Health Initiative-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 Women's Health Initiative 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 Women's Health Initiative have developed coalitions that include the participating medical practices and community organizations in order to develop bidirectional referrals 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 36 practices to participate in the Women's Health Initiative as of September 2018.
- The Women's Health Initiative now includes 36 participating practices (20 women's health and 16 primary care) across the State of Vermont.
- The Women's Health Initiative (WHI) is approaching statewide coverage, as all but one 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 Patient-Centered Medical Homes (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 Women’s Health Initiative; the WHI profiles will be used to guide future program improvement initiatives.

Figure 3. Women’s Health Initiative: Practices, Patients, and CHT Staffing

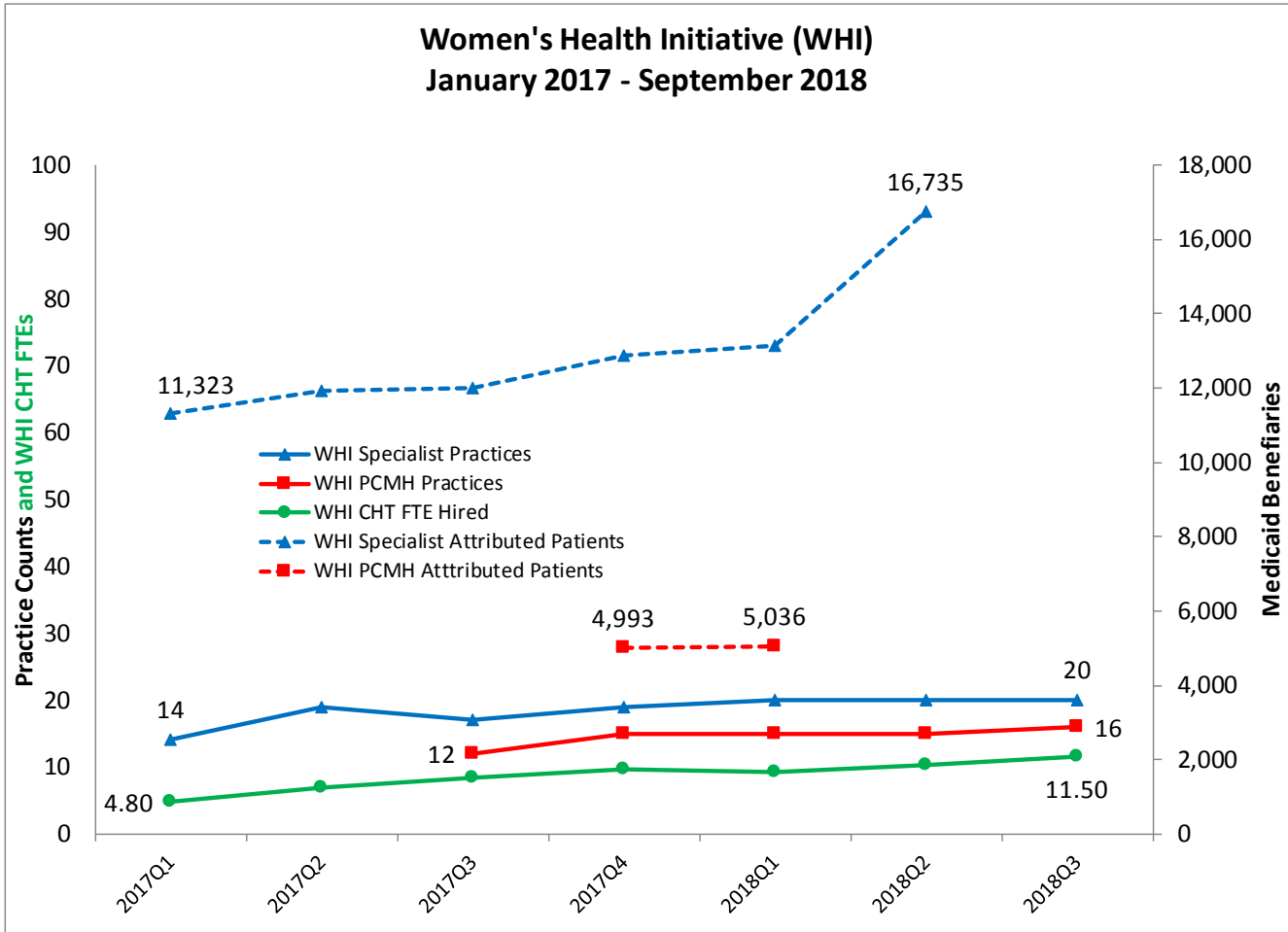


Table 5. Women’s Health Implementation by Region

Region	WHI Specialist Practices as of September 2018	WHI PCMH Practices as of September 2018	WHI CHT Staff FTE Hired as of September 2018	WHI Specialist Attributed Medicaid Beneficiaries as of June 2018	WHI PCMH Attributed Medicaid Beneficiaries as of March 2018
Barre	1	1	1	1,451	508
Bennington	1	1	0.5	1,045	57
Brattleboro	1	0	1	530	0
Burlington	5	6	3	6,222	1,806
Middlebury	2	0	0.75	1,130	0
Morrisville	1	2	0.5	578	464
Newport	0	0	0	0	0
Randolph	3	0	0.5	599	0
Rutland	2	1	1.5	2,356	214
Springfield	1	3	1	518	1,325
St. Albans	2	0	1	1362	0
St. Johnsbury	1	2	0.75	944	662
Upper Valley	0	0	0	0	0
Windsor	0	0	0	0	0
Total	20	16	11.50	16,735	5,036

iii. Behavioral Health

Key updates from QE0918:

- Pilot Project Analysis and Extension
- Team Care program revisions
- Applied Behavior Analysis

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric, detoxification, and substance abuse residential services for Medicaid primary beneficiaries. The team maintains a high level of inter-rater reliability through clinical supervision and testing. The team has developed a system to ensure internal consistency and educate providers on documentation requirements. The team consists of master’s level clinicians called Behavioral Health Concurrent Care Managers. The care managers engage with discharge planners at inpatient and residential facilities to ensure timely and appropriate discharge plans. Care managers collaborate with

other departments to support coordination of care and assist in mitigating barriers to discharge. Through collaboration with Vermont Chronic Care Initiative (VCCI) partners, a referral process for VCCI services has been established. The referrals support continuity of care for new enrollees and members already receiving VCCI services. The referral process has been expanded to include members discharging from substance use disorder treatment. Ongoing monitoring of issues has allowed for an improved process

In recognition of the inherent challenges in providing strong clinical documentation to justify admission and continued stay within 24 hours of admission, DVHA has engaged in a pilot project in which there is automatic initial authorization of 5 days for all members meeting the acute level of care criteria at the Brattleboro Retreat. This practice allows time for the assessment and formulation of an individualized plan of care and discharge plan for each member admitted. Qualitative reviews on a large sample of pilot project authorizations were conducted to ensure appropriate utilization. The reviews found that the admissions would have been authorized under the previous system. There continues to be a decline in the average lengths of stay. This decrease allows for an increase in access and may be attributable to a stronger focus on discharge planning upon admission. The project was extended through July 1, 2019. Close monitoring and quarterly qualitative reviews will continue. The team is also evaluating whether members attributed to the Accountable Care Organization have similar average lengths of stay.

The Behavioral Health Team also manages the Team Care program (the lock-in program). The team completed a complete review of clinical documentation and data to support ongoing member inclusion in the program. Members no longer requiring inclusion were notified of disenrollment. The team also conducted a complete review of Team Care protocol. Standards (objective and subjective) for inclusion and disenrollment were defined and are being operationalized by the team. A Standard Operating Procedure was developed, and staff have been trained on the new procedure. The practice of referring Team Care program members to VCCI when appropriate has been incorporated in the protocol. New methods for identification of potential members are being explored as there have been minimal referrals this quarter. The lack of referrals may demonstrate success of the Vermont Prescription Monitoring System (VPMS) and new opiate rules associated with VPMS. The team is also developing a method to more accurately assess cost savings attributable to inclusion in the Team Care program.

The Unit also manages the Applied Behavior Analysis (ABA) benefit. The Autism Specialist, a member of the Behavioral Health Team, has worked collaboratively with the Policy Unit and sister departments to evaluate and improve the program. DVHA is currently working on development of a new payment model that would continue to support members and providers, as well as attract new ABA providers to serve members. A new model has been established and stakeholders engaged. Quality Review procedures have been revised. The Clinical Guidelines are being updated and the benefit has been rewritten. The revisions were posted for public comment on 11/15/18. 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. Ongoing collaboration with sister departments has allowed for coordination of services and increasing supports to Medicaid members. DVHA also continues to identify and onboard providers specializing in services for children with autism. The team is currently exploring telemedicine opportunities for communities without access to services.

iv. *Mental Health System of Care*

Key updates from QE0918:

- Implementation of Vermont State Legislative requirements
- IMD Phase Down
- Home and Community Based Services- Site Self-Assessments and Validation
- Delivery System and Payment Reform
- Integrating Family Services updates

Requirements of the Vermont State Legislature: 2018 Legislative Session

During this quarter, the Department of Mental Health implemented requirements of the 2018 legislative session regarding the Mental Health System of Care:

1. Development and planning with the Brattleboro Retreat for renovation and fit-up of an additional 12 level-1 beds, to be completed by December 2019.
2. Collaboration with the University of Vermont Health Network to identify the type and number of additional inpatient psychiatric beds needed in Vermont.
3. \$4.3M rate increase in SFY' 19 to Designated Agencies (Mental Health Clinics), with up to 20% of the funds available to be directed through value-based incentive payments focusing on quality and outcomes starting January 1, 2019.
4. Facilitation of a time-limited Study Committee (from 8/1/18 to 12/1/18) to examine the strengths and weaknesses of Vermont's orders of non-hospitalization.
5. Initiation of a 3-year data collection initiative including counts of voluntary and involuntary individuals, lengths of stay and involuntary procedures.
6. An evaluation of the overarching structure for the delivery of mental health services due 1/15/2019, to include a common, long-term vision of full integration of mental health services within a comprehensive and holistic health care system.

Initial planning regarding CMS's requirement to phase down federal financial participation (FFP) for Institutions of Mental Disease (IMD)

During this quarter, DMH continued to participate in AHS planning for the phase down of FFP for IMDs, working toward the required submission of a phase-down plan to CMS by 12/31/2018. AHS is working with the goal to minimize impact to beneficiary access to appropriate levels care, with a focus on parity and sustaining FFP. The State is also working on increasing access to inpatient psychiatric levels of care and is significantly concerned that phase down of FFP for psychiatric IMD will create additional capacity crises.

Home and Community Based Services

The DMH Child, Youth, and Family Unit completed the first phase of HCBS site self-assessments for all (39) child/youth mental health settings providing HCBS through Medicaid (aka Enhanced Family Treatment) across Vermont. The validation tool was finalized, and a stratified random sampling of settings were selected for DMH to conduct validation activities to validate the self-assessments and assure that the settings are compliant. In September 2018, DMH Children's Mental Health Care Managers began to conduct on-site reviews using the validation tool. In addition to direct observation of the setting, the validation reviews include a resident and parent/guardian interview component. Nearly half of the validation reviews were conducted this period. Results of the self-assessments and

validation activities will be summarized, any discrepancies between the validation and self-assessment will be addressed, and recommendations for any remediation will be made in the next reporting quarter.

The DMH Adult Unit completed the first phase of HCBS site self-assessments for all (77) adult mental health residential settings providing HCBS through Medicaid across Vermont. The validation tool was finalized in June 2018. A random sampling of settings in all 11 provider agencies that offer these residential services were selected for on-site surveys to validate the self-assessments and determine whether the settings are compliant. In addition to direct observation of the setting, the validation reviews include a resident interview component. In June 2018 through September 2018, DMH Adult Unit staff completed on-site reviews using the validation tool. The goal was a 15% sample size, which was exceeded. A total of 55 residents were interviewed. Results of the self-assessments and validation activities will be summarized, any discrepancies between the validation and self-assessment will be addressed, and recommendations for any remediation will be made in the next reporting quarter.

Delivery System and Payment Reform Implementation

In addition to the above activities, DMH has been partnering with DVHA to develop delivery system and payment reforms for community-based providers of mental health services (i.e. “designated agencies”). Over the last quarter, DMH has continued to hold weekly planning meetings with stakeholders regarding payment reform and has moved from final specifications toward operational planning for implementation of two new value-based payment models for both child and adult mental health services paid for through DMH, including outpatient services paid for through DVHA. The payment model was submitted to CMS for review and approval on 3/30/18 and was resubmitted for a revised implementation date of 1/1/2019 on 9/25/18. The payment models are two “bundled” or “episodic” case rates, one for children and one for adults, that are paid prospectively and then annually reconciled to actual caseload. The case rate is earned when a qualifying service has been rendered, and the payment then covers all additional services for the member in the month, regardless of quantity or complexity. Additionally, the payment model for these mental health services includes a value-based payment based on reporting for a set of measures that describe progress in terms of “how much”, “how well” and “is anyone better off”.

Integrating Family Services (IFS) Initiative

Integrating Family Services efforts began in 2008 with the intent of integrating services for children and their families to provide services, supports and treatment earlier to prevent more intense needs, to achieve better outcomes, and spend funding more efficiently.

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.

The Department of Mental Health continues to work closely with the DVHA Payment Reform team to develop new payment models for reforming child and adult mental health reimbursement that builds upon experiences and methods pioneered through the Integrating Family Services pilots. As AHS'

payment reform efforts progress, there is focus on moving the IFS regions into alignment not only in the payment model but also with value-based purchasing. Starting 1/1/19, a subset of mental health related performance measures for the IFS regions will have incentives tied to them in alignment with statewide implementation, however, IFS regions continue to 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 is awaiting a response as of the writing of this report.

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 the Department of Mental Health) recently attended the annual National CANS conference and presented on the implementation of CANS in Vermont and shared data.

The flexibility allowed by utilizing a case rate has allowed both regions to determine the need in their community and put their resources in those areas. This has meant serving more young children who have entered DCF custody, supporting higher numbers of adolescents using substances, supporting children on the autism spectrum, and providing more population-health prevention and promotion activities.

v. *Pharmacy Program*

Key updates from QE0618:

- The Drug Utilization Review Board (DURB) held three meetings in April, May, and June.
- Bulletins and Advisories

Pharmacy Benefit Management Program

The DVHA's Pharmacy Unit manages the pharmacy benefits for all of Vermont's publicly-funded pharmacy benefit programs. The Pharmacy Unit's goal is to provide the highest quality prescription drug benefits in the most cost-effective manner possible. This is accomplished by providing broad coverage of prescription and over-the-counter pharmaceuticals, controlling pharmacy expenditures through managing cost, brand and generic utilization, and reducing state administrative costs. The State of Vermont utilizes the pharmacy benefit management company, Change Healthcare (CHC), to provide an array of operational, clinical, and programmatic support in addition to managing a call center in South Burlington, Vermont, for pharmacies and prescribers. The Pharmacy Unit is also responsible for overseeing the contract with CHC. The Pharmacy Unit manages over \$185 million in gross drug spend, and routinely analyzes national and DVHA drug trends, reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy for DVHA members while managing drug utilization and cost.

Pharmacy Operations

- Pharmacy claims processing - enforcing coverage rules for various program.
- Pharmacy provider assistance - DVHA, Change Healthcare Technical and Clinical Call Centers.
- Liaison to Coordination of Benefits Unit/Part D Plan Team/Eligibility/Maximus to resolve issues. Vermont Department of Health (VDH)-Vaccine Program, Substance Abuse Program, Department of Mental Health (DMH) management of antipsychotics.
 - Works with Vermont Medication Assistance Program (VMAP) and Children with Special Health Needs (CSHN) to assist in the management of the programs.

Clinical

- Manages drug utilization and cost
 - Federal, State, Supplemental rebate programs
 - Preferred Drug list
 - Drug Utilization Review/Pharmaceutical & Therapeutics Board activities
 - therapeutic class reviews, prior authorization criteria reviews and step-therapy protocols
 - Specialty Pharmacy
- Manages exception requests, second reconsiderations, appeals and fair hearings with the Policy Unit
- Works with Program Integrity Unit on drug utilization issues

Bulletins and Advisories/Communications

The following communications went out in July, August and September to pharmacies and providers:

- [Important Changes to Coverage for Adderall and Generic Amphetamine/Dextroamphetamine ER capsules:](#)

Effective 8/24/18, brand name Adderall XR® will be moving to a non-preferred status on the Department of Vermont Health Access (DVHA) Preferred Drug List (PDL). Generic formulations of amphetamine/dextroamphetamine extended-release capsules now have a lower net cost to Vermont Medicaid compared to the brand name. BOTH brand and generic will be preferred from 7/6/18-8/24/18 to allow providers and patients ample time to transition and use up current inventory. Prescribers will not be required to change the way new prescriptions are written nor re-write currently valid prescriptions for Adderall XR as generic substitution is permitted under current policy. After 8/24/18, any prescriptions for brand Adderall XR specifying “Dispense As Written” will require Prior Authorization.

- [Point of Sale \(POS\) Blackout Period Wednesday July 11th, 2018](#)

Due to the need to perform system maintenance, the Department of Vermont Health Access POS system will be unavailable for approximately 6 hours starting at 8:00PM on Wednesday, July 11, 2018. Pharmacy claims will not be adjudicated during this time. We apologize for any inconvenience this may cause.

Providers may verify member eligibility using the Green Mountain Eligibility Verification System (EVS) by calling: toll-free in Vermont (800) 925-1706; local and out-of-state (802) 878-7871, then press #1.

You can also check eligibility on-line using the VTMEDICAID Web Services Portal at

<https://www.vtmedicaid.com/secure/logon.do>

- **[Important Changes to Administration Fee for Influenza Vaccine](#)**

Effective 8/31/2018, the pharmacy administration fee for influenza vaccine will be changing from \$20.35 to \$16.71. This adjustment is being made to align with changes to the physician fee schedule (CPT code 90471) for adult vaccinations. Pharmacies will continue to be reimbursed for the ingredient cost of the vaccine as well as the administration fee. The same administration fee will be paid for both In-State and Out-of-State pharmacies. Through the pharmacy point-of-sale (POS) system, the pharmacy must submit the code “MA” in the Professional Service Code field in order to receive full reimbursement. The Advisory Committee on Immunization Practices (ACIP) and The Centers for Disease Control and Prevention (CDC) have not published their official recommendations for the 2018/19 season, therefore the list of covered vaccines has not been finalized. Information on these vaccines will be sent in a future communication. For questions, please contact the Change Healthcare Pharmacy Help Desk at 1-844-679-5362. Vermont providers can also send inquiries via email to **PBA_VTHelpdesk@changehealthcare.com**.

- **[Notice of Potential Labeler Terminations](#)**

As you may know, federal law requires that Medicaid programs only reimburse drugs from manufacturers and labelers who have signed a rebate agreement with the federal government. Due to revisions to the National Drug Rebate Agreement (NDRA) by the Centers for Medicare & Medicaid Services (CMS), existing drug manufacturers are required to complete a new NDRA before September 30, 2018 if they want continued Medicaid coverage of their products. Some manufacturers have decided not to continue Medicaid participation, while others may be late in submitting their agreements. **This may cause some drug claims to now deny, that previously paid.**

This communication is intended to inform pharmacies of certain manufacturer products that will no longer be covered by Vermont Medicaid after 9/30/18. Below is a list of manufacturers from whom CMS does not yet have a rebate agreement on file. Please make note of this and adjust your inventory levels accordingly. The great majority are generic products available from multiple sources and should have minimal impact on Medicaid members.

As of 9/25/18, the following manufacturers have not returned a complete updated NDRA form to CMS:

00064 HEALTHPOINT, LTD.
10158 GSK CONSUMER HEALTHCARE HOLDINGS (US)LL
15821 FOCUS LABORATORIES, INC.
41616 SUN PHARMA GLOBAL, INC.
49158 THAMES PHARMACEUTICALS, INC.
50192 NAUTILUS NEUROSCIENCES, INC.
50844 LNK INTERNATIONAL, INC.
55607 HEALTH SCIENCE FUNDING, LLC
57278 ROCKWELL MEDICAL, INC.
57881 GALENA BIOPHARMA, INC.
59075 ELAN PHARMACEUTICALS, INC./ATHENA NEURO
61364 BIOCSL, INC.

69036 SALLUS LABORATORIES, LLC
69150 BIOMES PHARMACEUTICALS, LLC
69158 GLENVIEW PHARMA, INC
70147 GLENDALE INC.
70688 KASTLE THERAPEUTICS, INC.
70882 CAMBRIDGE THERAPEUTIC TECHNOLOGIES, LLC
71399 AKRON PHARMA INC.

The following manufacturers have confirmed they are not renewing and will terminate on 10/1/18:

00062 ORTHO MCNEIL PHARMACEUTICALS
11701 COLOPLAST CORPORATION
15749 AMERICAN ANTIBIOTICS, INC.
43595 ANGELINI PHARMA, INC.
44946 SANCILIO & COMPANY, INC.
46026 GLOUCESTER PHARMACEUTICAL INC.
50816 NEW AMERICAN THERAPEUTICS
55390 BEDFORD LABORATORIES
58487 NEW HAVEN PHARMACEUTICALS, INC.
62250 BELCHER PHARMACEUTICALS, LLC
62794 MYLAN BERTEK PHARMACEUTICALS, INC.
67467 OCTAPHARMA PHARMAZEUTIKAGM
68405 PHYSICIAN THERAPEUTICS LLC
68453 VICTORY PHARMA, INC
68669 VISTAKON PHARMACEUTICAL LLC
69171 MERRIMACK PHARMACEUTICALS, INC.
75989 ACTON PHARMACEUTICALS
68209 OCTAPHARMA A.B.
00300 TAP PHARMACEUTICALS INC
00149 WARNER CHILCOTT PHARMACEUTICALS INC.
46987 ACTAVIS KADIAN LLC
00535 FOREST LABORATORIES

- **[Influenza \(Flu\) 2019/2019 Season provider notification](#)**

The 2018/19 Influenza (Flu) season is now underway. DVHA-enrolled pharmacies may be reimbursed for injectable influenza vaccinations administered by pharmacists to adults 19 years and older who are enrolled in Vermont's publicly funded programs. Pharmacists must be certified to administer vaccines in the State of Vermont and must be in compliance with all Vermont laws governing vaccine administration. Failure to comply with all Vermont immunization regulations will subject these claims to recoupment. Children age 6 months through 18 years presenting for flu vaccination at pharmacies should be referred to their health care provider for State-supplied vaccines.

Covered Vaccines:

- ✓ Afluria® (Trivalent, Quadrivalent)
- ✓ Fluarix® (Quadrivalent)
- ✓ FluLaval® (Quadrivalent)

√ Fluzone® (Quadrivalent, Intradermal)

Pharmacies are reimbursed for the ingredient cost of the vaccine as well as the administration fee. No dispensing fee is paid for these claims. Reimbursement will be based on either a written prescription or a non-patient specific written protocol based on a collaborative practice agreement per state law. These orders must be kept on file at the pharmacy. Through the pharmacy POS system, the pharmacy must submit the code “MA” in the Professional Service Code field for the influenza vaccine claim in order to receive full reimbursement. Please note there will be NO beneficiary copay for influenza vaccine.

Required NCPDP Fields

NCPDP Field Number	NCPDP Field Description	Required Code
44Ø-E5	Professional Service Code	MA
4Ø7-D7	Product/Service ID	NDC for Flu Vaccine

Drug Utilization Review Board

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

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

Additionally, per State statute requiring the DVHA Commissioner establish a pharmacy best practice and cost control program, the DURB was designated as the entity to provide clinical guidance on the development of a Preferred Drug List for Medicaid beneficiaries. The DURB typically includes 10-12 members, who are appointed to two - year terms with the option to extend to a four - year term. 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.

Drug Utilization Review Board meetings occur eight times per year. In QE0918, the DURB held 3 meetings. Information on the DURB and its activities in 2018 is available: <http://dvha.vermont.gov/advisory-boards>.

Drug Utilization Review Board Meetings

Twenty-three new drugs and eighteen therapeutic classes were reviewed at the DURB meetings held this quarter; five RetroDur reviews and six safety alerts were also presented.

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. *All Payer Model: Vermont Medicaid Next Generation Program*

Key updates from QE0918:

- DVHA completed financial reconciliation activities for the 2017 performance year and notified stakeholders of final 2017 program results for financial and quality performance.
- DVHA submitted its second quarterly report to the Vermont legislature for the 2018 performance year.
- DVHA and OneCare continued contract negotiations for the 2019 performance year.
- Future program implementation will continue to be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

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

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

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

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

attributed lives for the 2018 performance year increased from approximately 29,000 lives to 42,342 lives.

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 less during the program year than its expected total cost of care and will retain those funds. 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/VMNG-2017-Report-FINAL-09-20-18.pdf>

DVHA entered into contract negotiations with OneCare for the 2019 performance year in mid-Q2 of 2018, and negotiations are ongoing as of the end of Q3 2018. Potential program changes for 2019 focus on refinement of the VMNG attribution methodology; other programmatic changes will be minimal. Negotiations are expected to continue into Q4 of 2018.

DVHA submitted its second 2018 quarterly report to the Vermont legislature on the VMNG program on September 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 member complaints, grievances, and appeals. DVHA's most recent submission to the Vermont legislature can be found here: <https://legislature.vermont.gov/assets/Legislative-Reports/ACT-124-VMNG-Report-to-Legislature-September-15-2018.pdf>

V. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12 of the legislative budget for Global Commitment on the first business day of every month during the September 2018 quarter. This payment served as the proxy by which to draw down Federal funds for Global Commitment (GC). 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 reconciles what was claimed on the CMS-64 versus the monthly payments made to DVHA.

AHS submitted and certified the CMS64 report for QE0918 on October 30, 2018, as is normal. There were minimal prior quarter adjusting entries needed for program during this period. This marked the first quarter in which AHS had expenditure authority for Residential and Inpatient Treatment for Individuals with Substance Use Disorder. Expenses for SUD IMD services were reported on the CMS64. The budget neutrality workbook was modified to accommodate the SUD IMD supplemental test. Individuals whom receive SUD IMD services in a given month are counted as a member month under the SUD IMD test, and not counted as a member month under the comprehensive waiver demonstration to avoid duplication of member month reporting. The CY 2018 PMPM rates were adjusted and re-certified to reflect the SUD IMD allowable expenditures. The CY 2019 per member per month (PMPM) rates were also finalized by the contracted actuary, Milliman. These rates will be reflected in the CY 2019 Intergovernmental Agreement between AHS and DVHA. These rates were developed in accordance with STCs #24-25.

AHS continues to actively monitor Investment spending. The total Investment spending for QE0918 was \$35,537,175. CY 2018 marks the first year in which Investment spending must be phased down, in particular for the HIT Investment. Per recent discussions with CMS, AHS will be submitting a draft template for Investment Claiming protocol approval.

I. 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 CY2018 including QE0918 and reflects the unduplicated count of member months for SUD IMD stays.

Table 6. Member Month Reporting – Calendar Year 2018

Demonstration Population	Medicaid Eligibility Group	Total CY 2018
1, 4*, 5*	ABD - Non-Medicare - Adult	62,789
	SUD - IMD - ABD	51
1	ABD - Non-Medicare - Child	19,246
1, 4*, 5*	ABD - Dual	191,758
	SUD - IMD - ABD Dual	54
2	ANFC - Non-Medicare - Adult	112,033
	SUD - IMD - ANFC	127
2	ANFC - Non-Medicare - Child	542,700
	Medicaid Expansion	
7	Global RX	59,935
8	Global RX	35,242
6	Moderate Needs	2,262
	New Adults	
3	New Adult without child	356,862
	SUD - IMD New Adult w/o child	502
3	New Adult with child	166,616
	SUD - IMD New Adult with child	73
	Total	1,550,250
	Total CY 2018	
* Long Term Care Group		
4 only	ABD Long Term Care Highest Need	25,811
5 only	ABD Long Term Care High Need	10,311

PMPM Capitated Rates

The original PMPM rates as set for 01/01/18 – 12/31/18 are listed below. The rates were modified effective 07/01/18 to reflect the addition of SUD IMD costs in the amended rate certification.

Table 7. PMPM Capitated Rates QE0918

		<u>01/01/18-06/30/18</u>	
Medicaid Eligibility Group			
ABD Adult	\$		1,543.54
ABD Child	\$		2,634.96
ABD - Dual	\$		1,655.26
non-ABD Adult	\$		518.79
non-ABD Child	\$		442.36
GlobalRx	\$		88.19
New Adult	\$		444.91
Moderates	\$		461.55
		<u>07/01/18-12/31/18</u>	
Medicaid Eligibility Group			
ABD Adult	\$		1,549.16
ABD Child	\$		2,634.96
ABD - Dual	\$		1,657.20
non-ABD Adult	\$		524.56
non-ABD Child	\$		442.36
GlobalRx	\$		88.19
New Adult	\$		455.68
Moderates	\$		461.55

II. Consumer Issues

AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular program. The complaints received by Member Services are reported to DVHA (see Attachment 3). Member Services works to resolve the issues raised by beneficiaries, and the reports are seen by several management staff at DVHA.

The second mechanism to assess trends in beneficiary issues is the Managed Care Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations across the MCE. The database into which they enter information helps them track the timeframes for responding to the grievances and appeals, as well as assists DVHA and AHS in monitoring compliance and assessing if there are trends that may benefit from a performance improvement project.

The third mechanism to track consumer issues is the Office of the Health Care Advocate (HCA) report which is a comprehensive report of all contacts with beneficiaries (see Attachment 5). These include inquiries, requests for information, and requests for assistance. The HCA's role is to advocate for all Vermonters by providing individual consumer assistance and consumer advocacy on issues related to health insurance and health care.

III. Quality Improvement

Key updates from QE0918:

- The Quality Unit continued to lead a formal CMS PIP project focused on improving substance use disorder treatment.
- The DVHA Quality Unit staff continued work on two new QI projects.
- DVHA's Quality Assessment & Performance Improvement (QAPI) program was assessed during the annual Managed Care Compliance Audit in July 2018. All standards were met and there were no findings. DVHA's formal Performance Improvement Project (PIP)'s annual report received an overall validation status of *Met*.

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

Managed Care Entity (MCE) Quality Committee

The MCE Quality Committee consists of representatives from all Departments within the Agency of Human Services that serve the Medicaid population. The committee continues to structure its work around the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care. During this time period, the Quality Committee followed the Annual Work Plan by beginning its annual analysis of the quality measures within the Global Commitment Core Measure Set. The committee will finish its analysis at the November meeting and create a short list of any measures that it feels need more attention.

External Quality Review (EQR) Activities

During the QE0918 the Quality Unit prepared for and participated in the Performance Measure Validation Audit and the Managed Care Compliance Audit. The Quality Assessment and Performance Improvement (QAPI) program was one of the elements under review for the compliance audit. All standards were met and there were no findings. The Quality Unit also submitted its annual Performance Improvement Project (PIP) Summary report to the EQRO during this time period. Due to significant changes to the specifications of the study measure (IET-Initiation), the Unit re-set the baseline measurement year to CY 2017. All PIP elements were scored as *Met* – and the PIP received an overall validation status of *Met*.

Managed Care Medical Committee (MCMC)

The Managed Care Medical Committee worked throughout the quarter on finalizing changes to two Clinical Practice Guidelines. The Developmental Surveillance and Screening Guidelines were posted for comment. The Diabetes guidelines have been revised and will be posted for comment in the upcoming quarter. The process for monitoring ACO reports has been reassigned to a smaller group of subject matter experts. The MCMC is collaborating with external partners on establishing documentation standards. The new workplan has been developed. A new procedure for ensuring clinical review of new policies is being developed through the compliance committee. The MCMC is the identified body to perform initial review.

Formal CMS Performance Improvement Project (PIP)

The topic of substance use disorder treatment was chosen as the formal CMS PIP in July 2016. Work on that project continued throughout QE0918. In June the PIP team surveyed a representative sample of state-wide substance use disorder treatment providers to identify access issues for members seeking treatment. After survey analysis the team decided to pursue a telehealth-related intervention. Targeted communications about telehealth (its potential impact on providers' business and efficiency, its convenience for customers, and the fact that it can be reimbursed through Medicaid) were developed starting in July and implementation began in August. The first "banner" on providers' remittance advice was released at the end of August and weekly banners followed for approximately the next 6 weeks. During the month of September, the PIP team also planned for and developed:

- A provider advisory newsletter article,
- a telemedicine brochure to be used during provider/association outreach visits,
- targeted emails to SUD treatment providers,
- a presentation to DVHA's Clinical Utilization Review Board (CURB),
- and the build out of a section on the DVHA website to hold these telemedicine resources and links for providers.

All of those modes of communication were prepared in September or are on track for implementation in October and November.

Other Collaborative Quality Improvement Projects

The Quality Unit is leading informal PIPs on two topic areas: chlamydia screening and adults' access to preventive/ambulatory health services. These topics were selected after annual review of program performance by the MCE Quality Committee, Managed Care Medical Committee and the Clinical Utilization Review Board (CURB). Project charters and work plans have been developed and meetings are ongoing.

The chlamydia project team reviewed possible interventions starting in September and has landed on designing a modified learning collaborative through the Blueprint's Women's Health Initiative. The adults' access to preventive/ambulatory services team is collecting additional baseline data through the Vermont Chronic Care Initiative (VCCI). VCCI has recently taken on a new task of screening all new to Medicaid members. Their screening tool includes questions related to access time for PCP appointments. Data collection was ongoing during QE0918. Initial data will be presented to the project team during QE1218.

Quality Unit staff also participated in additional collaborative QI initiatives across the Agency of

Human Services including a collaboration with the Vermont Department of Health, the Vermont Children's Health Improvement Program (VCHIP) and the DVHA Data Unit on a joint payer quality improvement project aimed at increasing adolescent well care visits. During this time period, the Quality Unit sent gap in care reports to the 2nd cohort of practices participating in that project.

Quality Measure Reporting

- CMS' Adult and Child Quality Measure Core Sets – The Quality Unit is working with DVHA's Deputy Commissioner on a larger vision for quality measure production that will enable DVHA to reach full reporting capacity on these measure sets by the year 2024. The Unit also recently started internal conversations about the capabilities of the Vermont Clinical Registry to meet some of these reporting needs. A question was submitted to the MAC Quality TA team about whether other states use a clinical registry as the data source for any measures within these Core sets. The FFY 2018 Adult and Child Core Set measure reporting deadline is January 11, 2019. The Quality Unit will start working with the Data Unit during QE1218 to prepare data points for the reporting deadline.
- Healthcare Effectiveness Data & Information Set (HEDIS) measure production – During QE0918 the Quality Unit worked with the Business Office, Payment Reform Unit and Data Unit to extend and amend the contract with Verscend Technologies, the HEDIS measure production vendor. The Quality Unit has requested that Verscend perform medical record retrieval for three measures and abstraction for one measure. The Quality Unit clinicians will abstract for two measures. This contract includes the option for hybrid measure production and last year was amended to include an ACO product line.
- Customer Satisfaction Measures– CAHPS Survey – Quality Unit staff worked with the vendor, Data Stat, to prepare for the annual adult and child CAHPS experience of care surveys. Vermont Medicaid uses the Health Plan version of the CAHPS surveys. Survey materials were reviewed and approved, and the member sample securely transmitted to the vendor during QE9018. These surveys will be conducted starting in October through mid-December, with a final report from the vendor to DVHA in January 2019.
- Health Home Measure Set –These measures are run by the Blueprint and Onpoint; the Quality Unit helps to act as a bridge between the CMS reporting system and program staff. During QE0618, the FFY 2014-2016 Seeking More Information (SMI) requests were completed within CMS' reporting system, MACPro, and the Blueprint team requested an extension to 8/31/18 for the FFY 2017 health home measure reporting. During the QE0918, the Blueprint submitted the FFY 2017 measure set reporting by their extension deadline. The FFY 2018 Health Home measure reporting deadline is January 11, 2019.

Results Based Accountability (RBA)/Process Improvement

The Quality Unit continues to lead the Results Based Accountability (RBA) scorecard development effort at DVHA. 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 scorecard, and other performance budgeting scorecards. Additional scorecards that were actively maintained or newly created during QE0918 include the following: Applied Behavior Analysis (ABA) benefit, the Adult and Child Medicaid Quality Core Measure Sets, GC Investments, Payment Reform Models, DVHA Standard Operating Procedures (SOPs), and an overall DVHA

performance accountability scorecard - which includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services.

Quality Unit staff also attended additional LEAN/RBA internal training sessions during 2017. The trainings are centered around process improvement and contribute to the Governor's initiative called PIVOT, or Program to Improve Vermont Outcomes Together. Quality Unit staff attended advanced internal training sessions during QE0618 and are now part of the Agency's Improvement Network.

AHS Performance Accountability Committee

During this quarter, the AHS Performance Accountability Committee (PAC) continued to discuss how they can best support the new Data Governance Initiation (DGI) project currently underway at AHS. In addition, the group also reviewed the use of evidence-based practices used across the Agency. During the meeting, members highlighted evidence-based programs in their respective work areas. Moving forward, the group will need to determine the best way to message their work in this arena to internal/external stakeholders.

Global Commitment (GC) and Delivery System Reform (DSR) Investment Review

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

Payment Models & Performance Monitoring

During this quarter, the AHS QIM reviewed the CMS quality criteria and framework questions of the DMH preprint associated with DMH's proposed monthly case rate payment to mental health clinics. Language was suggested to ensure that the payment arrangement advances at least one of the goals/objectives of the Comprehensive Quality Strategy (CQS) and that there was a corresponding evaluation plan which measures the degree to which the payment arrangement advanced the CQS goals/objectives. In addition, to the aforementioned items, the AHS QIM reviewed the performance measures identified in Table 17a of the preprint. During the next quarter, the AHS QIM will continue to support the DMH preprint submission.

AHS Departments are required to monitor and evaluate the performance of their payment models on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of GC and DSR investment performance information contained in a web browser-based software application (Clear Impact Scorecard).

During this most recent quarter, DVHA highlighted the performance of its Blueprint for Health payment models.. The Clear Impact Scorecard for this DVHA payment model is included in this report as Attachment 8.

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

During this quarter, the HCBS Implementation Team continued to work on implementing the site-specific setting assessments. The team continues to review individual program response rates and suggested next steps. Next steps include item specific analysis by quality improvement staff to determine level of compliance with the new regulations and any necessary corrective action. Also, during this quarter, the AHS QIM attended the first of a series of CMS-sponsored Statewide

Transition Plan training modules. The title of the training was *The Process for Final Approval: Site-Specific Assessment and Validation*. This webinar addressed key components of the Site-Specific Assessment process, including strategies for identifying all home and community-based settings, assessment methodologies and validation strategies. In addition, it covered criteria for reporting state's compliance with the settings rule and the aggregation of results by setting type in each category (comply; does not comply but can with modifications; cannot comply; are presumed to have the qualities of an institution but for which the state will submit evidence for the application of heightened scrutiny). Information obtained during this webinar will be used to finalize Vermont's CQS/STP.

VI. Demonstration Evaluation

During the previous quarter, the draft Interim Evaluation Report was posted to the CMS Portal. The interim evaluation includes an assessment of the impact of providing Medicaid payment for Institutes for Mental Disease (IMD) services on the research questions included in the final evaluation design including the outcomes of interest listed above in STC 72 for the four (4) year period preceding the start of this demonstration. The Interim Evaluation Report includes the same core components as identified in STC 76 for the Summative Evaluation Report and follows the CMS approved evaluation design. The interim evaluation will inform the state's IMD phase-down plan which is due December 31, 2018. During this quarter, the State did not receive any feedback from CMS on its draft Interim Evaluation Report.

In June 2018, the Global Commitment to Health demonstration was amended to include Opioid Use Disorder (OUD/SUD) and recovery services through covering Medication Assisted Treatment (MAT). During this quarter, the AHS QIM initiated discussions with the current demonstration evaluator, PHPG, to explore the feasibility of amending the current contract to accommodate the SUD demonstration deliverables identified in the new STCs. As a first step, the evaluator reviewed the new demonstration STCs as well as CMS guidance for states with SUD demonstrations. It was determined that the current evaluator could adequately address the SUD demonstration requirements. During the next quarter, the AHS QIM will modify the existing contract to include the SUD demonstration requirements.

IV. Compliance

Key updates from QE0918:

- EQRO Compliance Audit
- Compliance Committee
- Electronic Visit Verification

EQRO Compliance Audit

During this quarter, the EQRO, HSAG, visited Vermont to conduct an on-site review of compliance activities. These annual audits follow a three-year cycle of standards. This year's standards were related to Measurement and Improvement and included the following:

- Practice Guidelines
- Quality Assessment and Performance Improvement Program

- Health Information Systems

Subject matter experts and managers from several units and departments represented their programs and provided answers and documents to the reviewers. During the review, the auditors discussed some potential required corrective actions as well as some recommendations to make Vermont's programs stronger. During the onsite review exit interview, AHS learned that there were no anticipated required actions for this audit. An analysis of the final audit report will be provided in next quarter's report.

Also, during this quarter, the EQRO visited Vermont to conduct Performance Measure Validation (PMV) activities. 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. A report documenting the result of the PMV activities is due next quarter.

EQRO Performance Improvement Project Validation activities are described in the Quality Improvement Section of this report.

Compliance Committee

During this quarter, the Compliance Officer drafted improvements to the Medicaid Compliance Plan and Code of Conduct. These items will be reviewed with the Compliance Committee in the Fall.

Electronic Visit Verification

In response to section 12006 of the 21st Century Cures Act, Vermont is implementing an electronic visit verification system (EVV) to electronically verify personal care service visits in home and community settings. During this quarter, an advance planning document was submitted to CMS for enhanced funding and DVHA began contract amendment discussions with its fiscal agent and fiscal employment agent. Vermont is proposing an open EVV solution that will interface with existing solutions already in use in this state while providing tools for providers who do not yet have an EVV solution. The implementation deadline for this project is 1/1/2020.

V. Reported Purposes for Capitated Revenue Expenditures

Provided that DVHA's contractual obligation to the populations covered under the Demonstration is met, any revenue from capitation payments related to the beneficiaries covered under this Demonstration may be used for the following purposes:

- Reduce the rate of uninsured and/or underinsured in Vermont;
- Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
- Provide public health approaches and other innovative programs to improve the health outcomes, health status and the quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and

- Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system and promote transformation to value-based and integrated models of care.

Attachment 6 is a summary of Investments, with applicable category identified, for QE0918.

VI. Enclosures/Attachments

- Attachment 1: Budget Neutrality Workbook
- Attachment 2: Enrollment and Expenditures Report
- Attachment 3: Complaints Received by Health Access Member Services
- Attachment 4: Medicaid Grievance and Appeal Reports
- Attachment 5: Office of the Health Care Advocate Report
- Attachment 6: QE0918 Investments
- Attachment 7: Investment Scorecard: Department of Corrections
- Attachment 8: Payment Model Scorecards: Blueprint for Health (3 Programs)

VII. State Contact(s)

Fiscal:	Sarah Clark, CFO VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-505-0285 (P) 802-241-0450 (F) sarah.clark@vermont.gov
Policy/Program:	Ashley Berliner, Director of Health Care Policy & Planning VT Agency of Human Services 280 State Drive, Center Building Waterbury, VT 05671-1000	802-578-9305 (P) 802-241-0958 (F) ashley.berliner@vermont.gov
Managed Care Entity:	Cory Gustafson, Commissioner Department of VT Health Access 280 State Drive, NOB 1 South Waterbury, VT 05671-1010	802-241-0147 (P) 802-879-5962 (F) cory.gustafson@vermont.gov

Date Submitted to CMS: November 29, 2018

ATTACHMENTS

Attachment 1 - Budget Neutrality

State of Vermont Global Commitment to Health
 Budget Neutrality PMPM Projection vs 64 Actuals Summary
 Nov 13, 2018

ELIGIBILITY GROUP	DY 12	DY 13	DY 14	DY 15	DY 16	Total
	JAN - DEC 2017	JAN - DEC 2018	DAN - DEC 2019	JAN - DEC 2020	JAN - DEC 2021	
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	\$ 142,861,965	\$ 98,298,691	\$ -	\$ -	\$ -	\$ 241,160,656
ABD - Non-Medicare - Child	\$ 85,359,001	\$ 59,019,784	\$ -	\$ -	\$ -	\$ 144,378,784
ABD - Dual	\$ 664,145,584	\$ 516,948,887	\$ -	\$ -	\$ -	\$ 1,181,094,470
ANFC - Non-Medicare - Adult	\$ 101,757,894	\$ 75,706,300	\$ -	\$ -	\$ -	\$ 177,464,193
ANFC - Non-Medicare - Child	\$ 392,668,513	\$ 305,035,389	\$ -	\$ -	\$ -	\$ 697,703,902
Total Expenditures Without Waiver	\$ 1,386,792,955	\$ 1,055,009,050	\$ -	\$ -	\$ -	\$ 2,441,802,005
With Waiver						
ABD Non Medicare Adult	\$ 162,605,120	\$ 123,744,738	\$ -	\$ -	\$ -	\$ 286,349,858
ABD - Non-Medicare - Child	\$ 66,594,520	\$ 45,316,392	\$ -	\$ -	\$ -	\$ 111,910,912
ABD - Dual	\$ 445,853,945	\$ 348,054,229	\$ -	\$ -	\$ -	\$ 793,908,174
ANFC - Non-Medicare - Adult	\$ 84,041,960	\$ 65,227,051	\$ -	\$ -	\$ -	\$ 149,269,010
ANFC - Non-Medicare - Child	\$ 305,549,938	\$ 249,556,760	\$ -	\$ -	\$ -	\$ 555,106,698
Premium Offsets	\$ (655,991)	\$ (590,746)	\$ -	\$ -	\$ -	\$ (1,246,736)
Moderate Needs Group	\$ 1,488,408	\$ 1,044,762	\$ -	\$ -	\$ -	\$ 2,533,169
Marketplace Subsidy	\$ 6,355,286	\$ 4,807,731	\$ -	\$ -	\$ -	\$ 11,163,017
VT Global Rx	\$ 13,824,516	\$ 11,907,281	\$ -	\$ -	\$ -	\$ 25,731,797
VT Global Expansion VHAP	\$ 414,824	\$ 630,035	\$ -	\$ -	\$ -	\$ 1,044,859
CRT DSHP	\$ 10,331,787	\$ 7,512,284	\$ -	\$ -	\$ -	\$ 17,844,071
Investments	\$ 142,453,076	\$ 106,285,145	\$ -	\$ -	\$ -	\$ 248,738,222
Total Expenditures With Waiver	\$ 1,238,857,388	\$ 963,495,662	\$ -	\$ -	\$ -	\$ 2,202,353,049
Supplemental Test: New Adult (Gross)						
Limit New Adult	\$ 370,687,020	\$ 282,693,824	\$ -	\$ -	\$ -	\$ 653,380,844
Without Waiver SUD - IMD New Adult Expenditures		\$ 1,718,169	\$ -	\$ -	\$ -	\$ 1,718,169
With Waiver New Adult Expenditures	\$ 295,626,448	\$ 235,006,805	\$ -	\$ -	\$ -	\$ 530,633,253
With Waiver SUD - IMD New Adult Expenditures		\$ 1,406,733	\$ -	\$ -	\$ -	\$ 1,406,733
<i>Surplus (Deficit)</i>	<i>\$ 75,060,572</i>	<i>\$ 47,998,455</i>	<i>\$ -</i>	<i>\$ -</i>	<i>\$ -</i>	<i>\$ 123,059,027</i>
Supplemental Test: IMD SUD (Gross)						
SUD - IMD ABD - Non-Medicare - Adult		\$ 175,256	\$ -	\$ -	\$ -	\$ 175,256
SUD - IMD ABD - Dual		\$ 148,497	\$ -	\$ -	\$ -	\$ 148,497
SUD - IMD ANFC - Non-Medicare - Adult		\$ 362,250	\$ -	\$ -	\$ -	\$ 362,250
Limit SUD IMD Without Waiver		\$ 686,003	\$ -	\$ -	\$ -	\$ 686,003
SUD - IMD ABD Non Medicare Adult		\$ 134,869	\$ -	\$ -	\$ -	\$ 134,869
SUD - IMD ABD - Dual		\$ 103,479	\$ -	\$ -	\$ -	\$ 103,479
SUD - IMD ANFC - Non-Medicare - Adult		\$ 282,218	\$ -	\$ -	\$ -	\$ 282,218
Limit SUD IMD With Waiver		\$ 520,566	\$ -	\$ -	\$ -	\$ 520,566
<i>Surplus (Deficit)</i>		<i>\$ 165,437</i>	<i>\$ -</i>	<i>\$ -</i>	<i>\$ -</i>	<i>\$ 165,437</i>
Waiver Savings Summary						
Annual Savings	\$ 147,935,567	\$ 91,513,389	\$ -	\$ -	\$ -	\$ 239,448,956
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	\$ 44,380,670	\$ 22,878,347	\$ -	\$ -	\$ -	\$ 67,259,017
Total Savings	\$ 44,380,670	\$ 22,878,347	\$ -	\$ -	\$ -	\$ 67,259,017
Cumulative Savings	\$ 44,380,670	\$ 67,259,017	\$ 67,259,017	\$ 67,259,017	\$ 67,259,017	\$ 67,259,017

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
(A) New Adult Group PMPM Projection	\$518.26	\$518.26	\$518.26	\$518.26	\$540.03	\$540.03	\$540.03
(B-1) eligible member months w/ Child	55,223	57,077	56,789	55,635	55,548	55,355	55,713
(B-2) eligible member months w/o Child	124,999	124,981	121,338	119,211	120,821	119,677	116,364
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	\$ 28,619,871.98	\$ 29,580,726.02	\$ 29,431,467.14	\$ 28,833,395.10	\$ 29,997,586.44	\$ 29,893,360.65	\$ 30,086,691.39
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	\$ 64,781,981.74	\$ 64,772,653.06	\$ 62,884,631.88	\$ 61,782,292.86	\$ 65,246,964.63	\$ 64,629,170.31	\$ 62,840,050.92
(D-1) New Adult FMAP w/ Child	54.46%	54.46%	54.46%	53.47%	53.47%	53.47%	53.47%
(D-2) New Adult FMAP w/o Child	86.89%	86.89%	86.89%	86.69%	89.95%	89.95%	89.95%
(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	\$ 15,417,216.36	\$ 16,039,709.47	\$ 15,983,979.94	\$ 16,087,353.89
(E-2 = C-2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	\$ 56,289,063.93	\$ 56,280,958.24	\$ 54,640,456.64	\$ 53,559,069.68	\$ 58,689,644.68	\$ 58,133,938.69	\$ 56,524,625.80
Subtotal Federal Share Supplemental Cap 1	\$ 71,875,446.21	\$ 72,390,621.63	\$ 70,668,833.64	\$ 68,976,286.04	\$ 74,729,354.15	\$ 74,117,918.63	\$ 72,611,979.69
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

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	\$ 17,817,433.52	\$ 12,546,308.71	\$ 10,361,767.87	\$ 9,945,643.21



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

[Phone] 802-879-5900

Agency of Human Services

Medicaid Program Enrollment and Expenditures Report

Q4 SFY 2018

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

Al Gobeille, Secretary
Vermont Agency of Human Services

Cory Gustafson, Commissioner
Department of Vermont Health Access

August 31, 2018



Key Terms

Caseload – Average monthly member enrollment

MEG – Medicaid Eligibility Group

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

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

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

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

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

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

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

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

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

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

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

PMPM – Per Member Per Month

The Department of Vermont Health Access
Caseload and Expenditure Report ~ All AHS and AoE Medicaid Expenditures
All AHS and AoE YTD '18

	SFY '18 BAA			SFY '18 Actuals thru June 30, 2018			% of Expenses to Budget Line Item
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	
ABD Adult and Acute CFC	7,218	\$ 182,809,143	\$ 2,110.45	6,799	\$ 167,609,124	\$ 2,054.41	91.69%
ABD Dual	17,645	\$ 226,912,702	\$ 1,071.65	17,659	\$ 222,809,638	\$ 1,051.44	98.19%
General Adult	12,984	\$ 89,522,326	\$ 574.55	12,664	\$ 83,434,709	\$ 549.01	93.20%
New Adult	59,604	\$ 299,940,774	\$ 419.35	58,535	\$ 293,727,200	\$ 418.16	97.93%
Vermont Premium Assistance	19,023	\$ 6,649,761	\$ 29.13	18,275	\$ 6,334,440	\$ 28.88	95.26%
Vermont Cost Sharing	6,483	\$ 2,640,929	\$ 33.95	6,141	\$ 1,570,896	\$ 21.32	59.48%
ABD Child	2,439	\$ 75,635,614	\$ 2,583.94	2,241	\$ 60,785,052	\$ 2,259.92	80.37%
General Child	60,360	\$ 303,696,157	\$ 419.29	59,821	\$ 318,447,021	\$ 443.61	104.86%
Underinsured Child	831	\$ 2,600,955	\$ 260.73	601	\$ 1,398,663	\$ 193.83	53.77%
CHIP	4,817	\$ 12,036,223	\$ 208.23	4,667	\$ 12,511,519	\$ 223.41	103.95%
Pharmacy Only	11,182	\$ 4,678,042	\$ 34.86	10,717	\$ 4,588,899	\$ 35.68	98.09%
Traditional Choices for Care	4,350	\$ 197,420,739	\$ 3,782.01	4,232	\$ 196,563,497	\$ 3,870.35	99.57%
Total Medicaid Claims Paid	206,937	\$ 1,404,543,364	\$ 565.61	202,353	\$ 1,370,386,458	\$ 564.35	97.57%

The Department of Vermont Health Access
Caseload and Expenditure Report ~ DVHA Only Medicaid Expenditures
DVHA YTD '18

	SFY '18 BAA			SFY '18 Actuals thru June 30, 2018			% of Expenses to Budget Line Item
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	
ABD Adult and Acute CFC	7,218	\$ 93,646,370	\$ 1,081.11	6,799	\$ 83,331,998	\$ 1,021.41	88.99%
ABD Dual	17,645	\$ 54,637,311	\$ 258.04	17,659	\$ 53,612,503	\$ 253.00	98.12%
General Adult	12,984	\$ 76,353,006	\$ 490.03	12,664	\$ 71,486,396	\$ 470.39	93.63%
New Adult	59,604	\$ 268,599,342	\$ 375.53	58,535	\$ 264,090,016	\$ 375.97	98.32%
Vermont Premium Assistance	19,023	\$ 6,649,761	\$ 29.13	18,275	\$ 6,334,440	\$ 28.88	95.26%
Vermont Cost Sharing	6,483	\$ 2,640,929	\$ 33.95	6,141	\$ 1,570,896	\$ 21.32	59.48%
ABD Child	2,439	\$ 24,090,018	\$ 822.99	2,241	\$ 20,174,102	\$ 750.05	83.74%
General Child	60,360	\$ 153,061,657	\$ 211.32	59,821	\$ 156,825,223	\$ 218.47	102.46%
Underinsured Child	831	\$ 1,171,707	\$ 117.46	601	\$ 515,180	\$ 71.39	43.97%
CHIP	4,817	\$ 8,314,607	\$ 143.84	4,667	\$ 8,323,354	\$ 148.63	100.11%
Pharmacy Only	11,182	\$ 4,678,042	\$ 34.86	10,717	\$ 4,588,899	\$ 35.68	98.09%
Traditional Choices for Care	4,350	\$ 197,420,739	\$ 3,782.01	4,232	\$ 196,563,497	\$ 3,870.35	99.57%
Total Medicaid Claims Paid	206,937	\$ 891,263,489	\$ 358.91	202,353	\$ 868,043,548	\$ 357.48	97.39%



State of Vermont

Department of Vermont Health Access

280 State Drive, NOB 1 South

Waterbury, VT 05671-1010

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Agency of Human Services

**Questions, Complaints, and Concerns Received by Health Access Member Services
July 1, 2018 – September 30, 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.

July 2 – July 6

- No issues to report

July 9 – July 13

- VPharm/VPharm Review/Reinstatements

July 16 – July 20

- No issues to report

July 23 – July 27

- VPharm/VPharm Review/Reinstatements

July 30 – August 3

- Caller called in twice same day and now wants to submit negative feedback regarding the dental providers in the Brattleboro area. She states she called the CSC earlier and was given some names and numbers of dentists in her area and they either are not accepting new Medicaid patients or are out of business. She declined us helping her find a dental provider in a different town and was referred to the vtmedicaid.com website. CSR apologized for her frustrations and offered to help her find a different dentist, she declined. Also offered to document her feedback.

August 6 – August 10

- Caller wanted to submit feedback because she feels that it is not fair that we closed her Medicaid before sending out a notice of decision. She feels that there should be a



minimum of 30 days notification to allow time for finding another health insurance option. CSR apologized for her frustrations, discussed her eligibility and her options, offered to document her feedback.

August 13 – August 17

- No issues to report.

August 20 – August 24

- No issues to report.

September 3 – September 7

- Caller wanted to submit negative feedback as she feels Medicaid should provide monthly statements to customers who are on Medicaid. She was not happy that this wasn't an option we offered and feels we should be able to provide a monthly statement of benefits. CSR apologized for her frustration, explained we unfortunately can't provide what she is asking for and offered to document her feedback.
- Caller wanted to submit negative feedback regarding her provider's office, Central Vermont Medical Center, billing office in Berlin 844-321-4001. Customer has talked to staff in that office and they are informing the customer that Medicaid needs to call them regarding dates of service that have not been paid for. Dates of service are March 27, 2018. Hospital is refusing to call providers service for customer regarding coverage at that time. Customer has called Medicaid to ensure that the hospital needs to call Providers service for the next step of things.

September 10 – September 14

- No issues to report.

September 17 – September 21

- VPharm/VPharm Review/Reinstatements

September 24 – September 28

- Caller would like to submit feedback about covered services and the process of getting things covered. She has severe allergies and is a CPAP user. When she has to submit this PA and is denied this medication, she gets sick and then ends up having to go to the doctor, get steroids, and many other things. She is annoyed that she has no predictability. She gets 4 allergy injections per week. When she does not have the Nasonex, it prevents her from being able to live her life and work. She has tried many other medications and is frustrated that she has to submit PAs all of the time. She has been struggling for years with this. Her allergens prevent her from using her CPAP machine, so she can only use it when she has a clear nose. When we demand that she tries new medications, it causes her to end up needing to take steroids or Afrin, and it is not advisable. She can occasionally use her CPAP machine when she uses OTC Flonase and Afrin. She does not need to be put through hell by her health insurance

company. She is happy to try new medications when she is stable. She is not trying to be demanding to have us go to heaven and earth to pay for her medications, but she would just like us to work with her. She needs support. She would like to never again go through calling her doctor's office for a week and calling us. When her allergies aren't treated, she doesn't sleep, and then she is no closer to rejoining to workforce. There are things that she needs to do in her life and this cannot be done unless she has the appropriate medication.

1. She is wondering if the state would be willing to create a system where the same questions asked on every PA can be recorded, as the information is the same on every past PA so she does not need to spend a week without the RX.

2. If she needs some predictability about a when a PA is going to expire, she is happy to try alternatives, but needs to do this from a position of strength. It does not make sense for her to start a trial when her condition has deteriorated. This is out of a sense of safety. She needs some notice about when her PA will end. She is a certified WRAP (Wellness Recovery Action Plan) facilitator. She is very much a citizen of the health care system. She has a daily maintenance plan and works very hard to maintain her wellness.

3. Be transparent. She wants to see statements about what her healthcare is costing. She wants to be a good steward of resources, but she cannot unless she sees the price tags. State how much her medications cost and what medications may work and cost less. "If you are willing to try these when your condition is stable, please conduct a trial."

Essentially, she just wants a heads up. She does not want to be monkeying around with PAs (for example when she has an infection or when and has been out of her medication for a week). These are not the times to be withholding a medication that works and to demand that she conduct a trial.

If the state has any other questions or wants more feedback about their system, she is happy to help.

I went over the options for appeal and advised that she speak with her doctor's office to have them call provider services to let them know how this is affecting her and to get the PA approved. CSR apologized for her frustrations, went over the PA process and offered to document her feedback.



**Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
July 1, 2018 – September 30, 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 October 15, 2018, from the centralized database that were filed from July 1, 2018 through September 30, 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 7 grievances filed; two 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 7 grievances filed, DMH had 100%. There were no grievances filed for DAIL, 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 46 appeals filed. Of these 46 appeals, 38 were resolved (83%), 5 were still pending (11%), and 3 were withdrawn (6%).

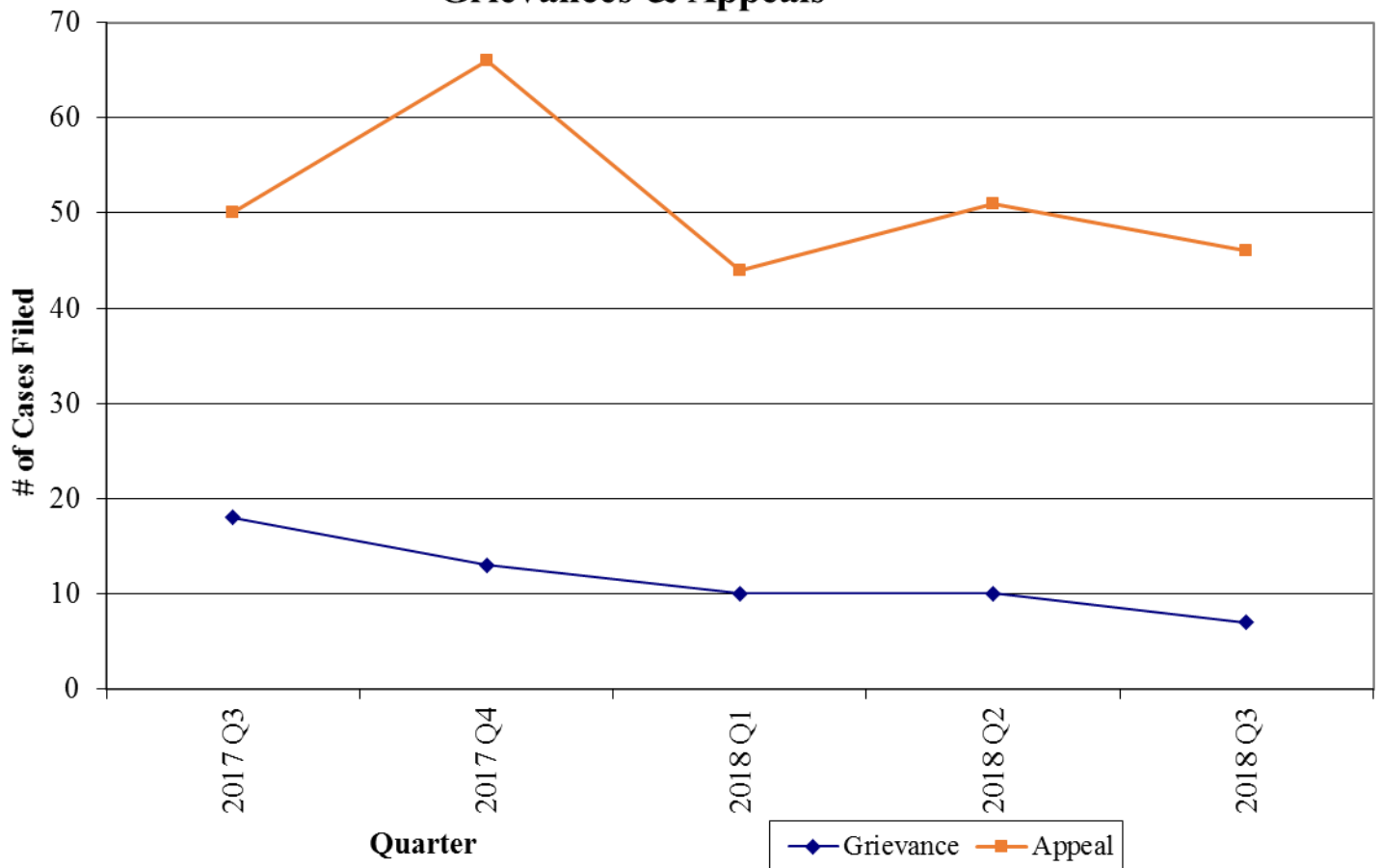
Of the 38 appeals that were resolved this quarter, 76% were resolved within the statutory time frame of 30 days. Nine appeals were resolved after the 30-day timeframe, of these nine appeals, three were extended at the request of the beneficiary. The average number of days it took to resolve these cases was 29 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

Of the 46 appeals filed, DVHA had 25 appeals filed (55%), DAIL had 19 (41%), VDH had 1 (2%) and DMH had 1 (2%).

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

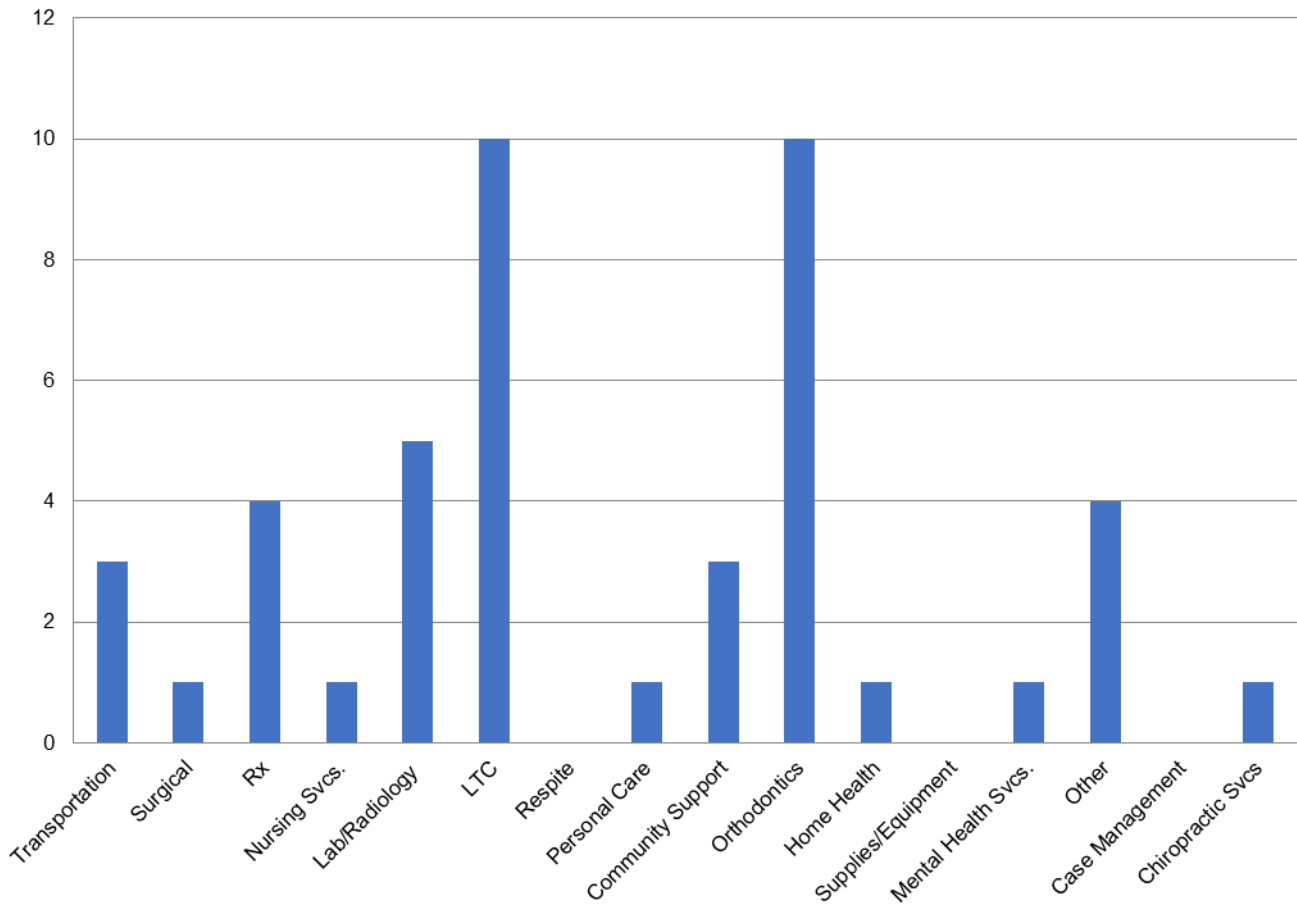
Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There were three fair hearings filed this quarter.

Grievances & Appeals

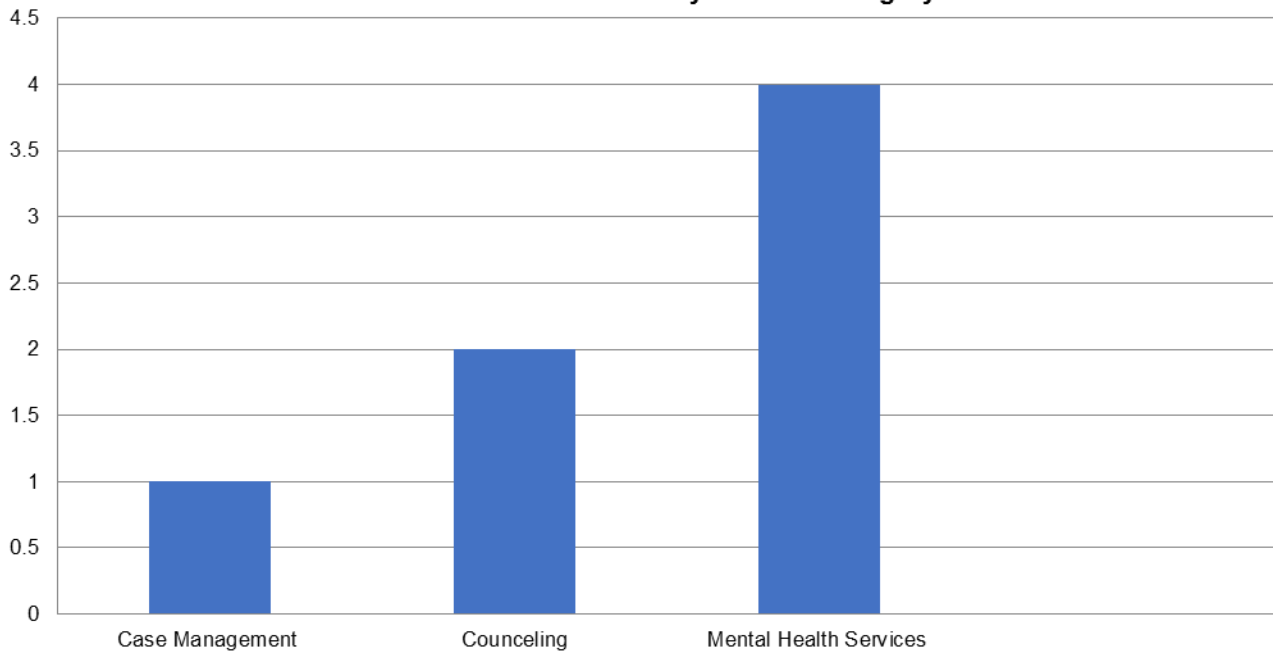


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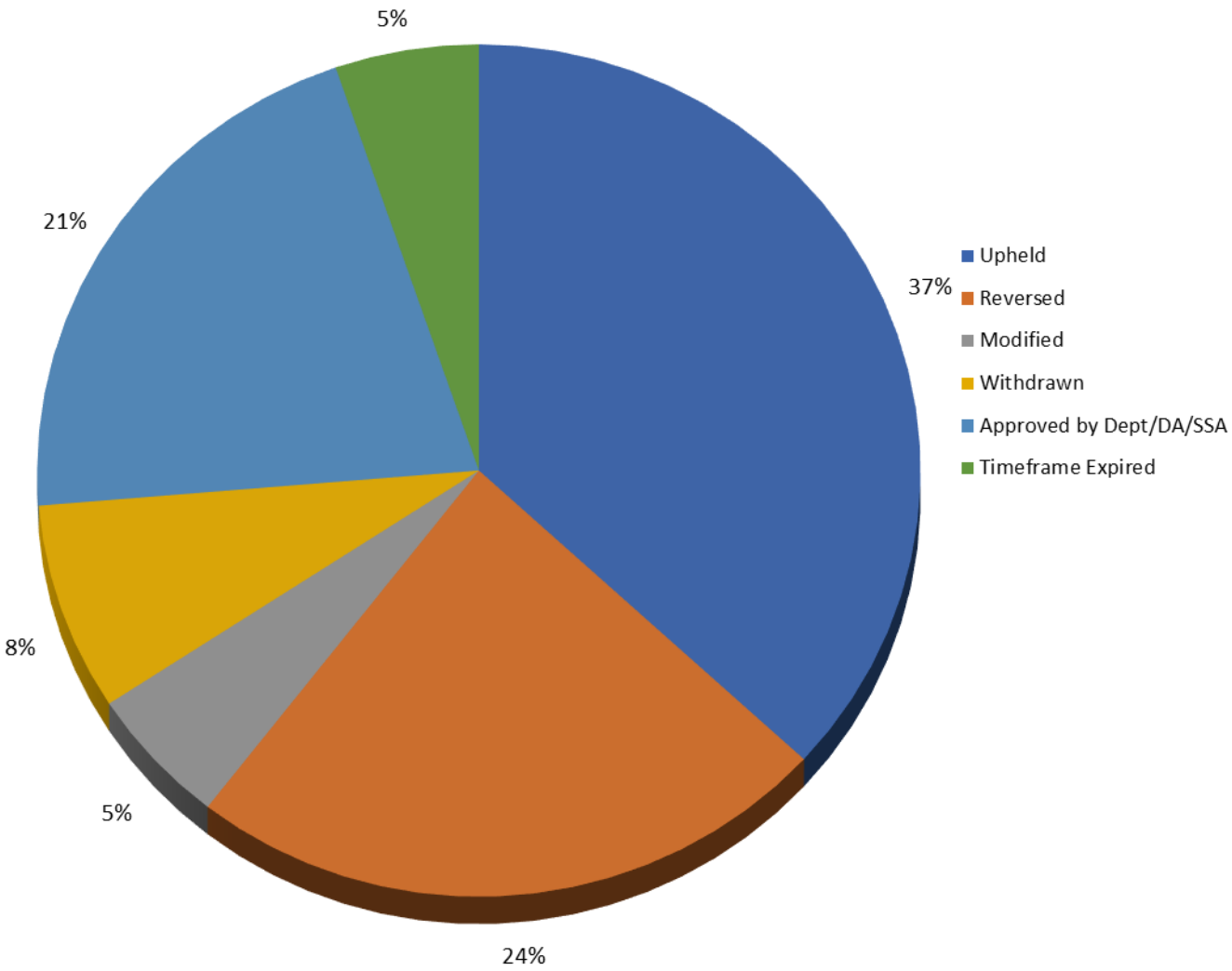
Appeals by Service Category



Grievances by Service Category



MCO Appeal Resolutions 7/1/2018 thru 9/30/2018



Vermont Legal Aid
Office of the Health Care Advocate

Quarterly Report
July 1, 2018- September 30, 2018
to the
Agency of Administration
submitted by
Michael Fisher, Chief Health Care Advocate
Office of the Health Care Advocate

October 19, 2018

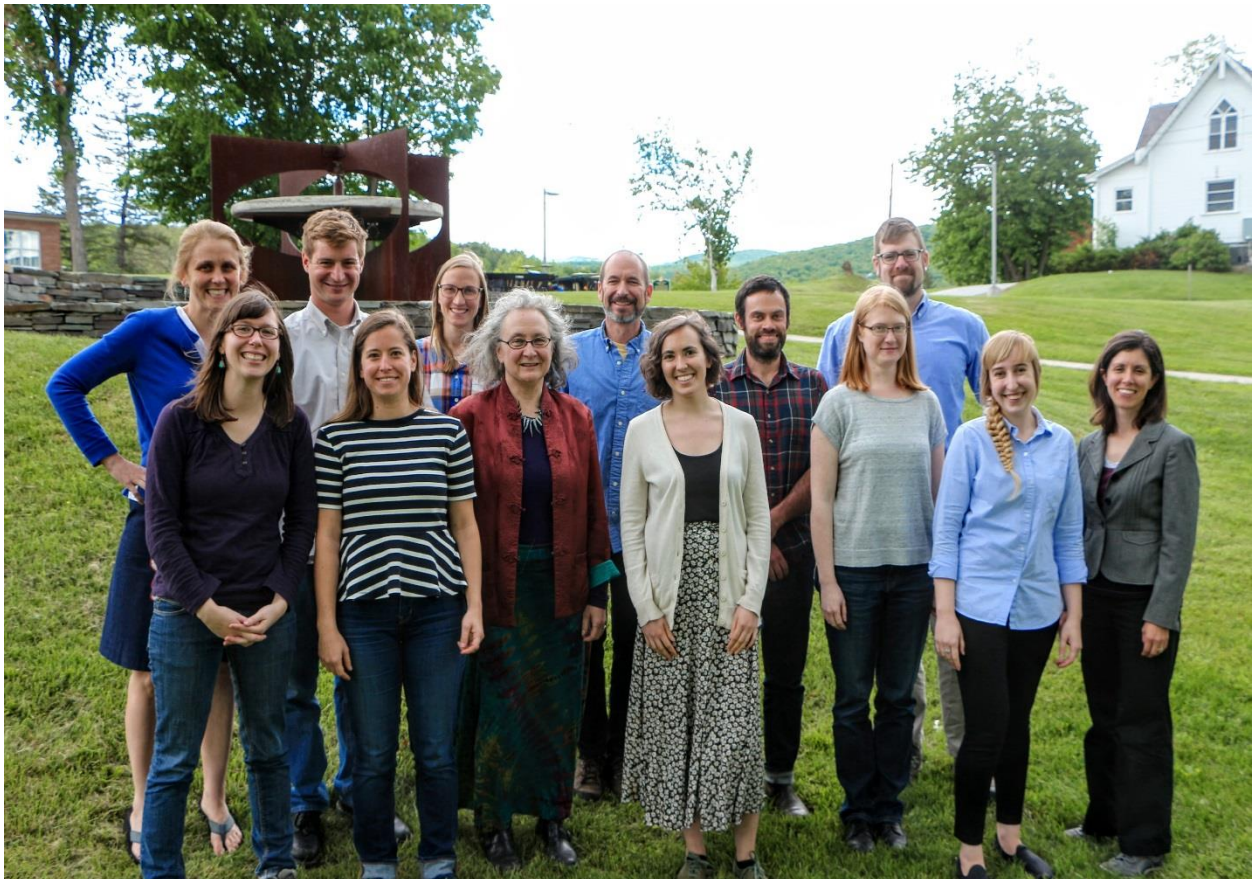


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Introduction

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 developing coherent and understandable messaging for consumers about 2019 Open Enrollment. The HCA is helping consumers understand how the changes to the premium pricing will impact their households. 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 can buy gold plans for about the same monthly premium. Consumers who are not eligible for APTC can enroll in Reflective Silver plans directly with the carriers. The HCA wants to make sure that consumers understand both the opportunities and risks presented by silver-loading.

The HCA also sounded the alarm about risks to Vermont's marketplace stability due to segmentation caused by Association Health Plans. The HCA is concerned that the introduction of these plans in 2019 will undermine the marketplace and drive premium prices up. The HCA continues to work toward ensuring all Vermonters are able to access affordable, quality health care coverage.

The HCA is committed to helping Vermonters navigate the health care system. Today's uncertainty makes the role of the HCA even more essential.

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

Elise's Story:

Elise called the HCA because she needed to sign up for Medicare Part B. She was already on Medicare A that covers hospital care. But she was not on Medicare Part B that covers out-patient care. She had not enrolled in Part B when she was first eligible because she did not think that she could afford to pay the monthly Medicare Part B premium. Now she needed the coverage. She still could not afford the premium, and she was now going to owe the late enrollment penalty for failing to enroll in Part B during her initial enrollment period. She was also outside the regular enrollment period for Medicare which meant that she would have to wait for months to get on Part B. The HCA advocate investigated and found that Elise was eligible for a Medicare Savings Program (MSP). With this program, the State of Vermont would pay for her Part B premiums. Her late enrollment penalty would also be waived. It also meant she could enroll immediately, instead of waiting for the regular enrollment period. The advocate helped her complete the application for the MSP. Elise was approved for the program and enrolled in Part B. This meant that Elise was able to make an appointment to see her physician.

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 839 calls¹ 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:

- **25.60%** (215) about **Access to Care**
- **13.33%** (112) about **Billing/Coverage**
- **1.55%** (13) about **Buying Insurance**
- **9.76%** (82) about **Consumer Education**
- **27.74%** (233) about **Eligibility** for state and federal programs
- **21.90%** (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 233 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, a total of 405 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 July 1 - September 30, 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**: 839 calls (compared to 968 last quarter)

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

- **Department of Vermont Health Access (DVHA) beneficiaries:** 297 calls (355 calls last quarter)
- **Commercial Plan Beneficiaries:** 151 calls (165 calls last quarter)
- **Uninsured Vermonters:** 79 calls (90 calls last quarter)
- **Vermont Health Connect (VHC):** 170 calls (243 calls last quarter)
- **Reportable Activities (Summary & Detail):** 88 activities and 8 documents (94 activities, 14 documents)

Individual Consumer Assistance

Case Examples

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

Lauren's Story:

When Lauren was making an appointment to see her doctor, she found that her VHC insurance coverage had been cancelled. She was confused because she had been paying her premiums on time and did not understand why her coverage was closed. When the advocate researched the case, she found that Lauren had actually been slightly late on one premium payment, and that had put her into a grace period. Once she was in a grace period, it meant that Lauren had to catch up and pay everything that she owed by the end of the grace period. Lauren did not do this, so her coverage was closed. Lauren, however, had not known she was in a grace period. She had not received the required grace period notices telling her that she was behind and in danger of losing her coverage. When the advocate looked at the grace period notices, she found that they were being sent to the wrong address. VHC was using one address and the insurance carrier was using a different, incorrect address. This meant that Lauren never received the grace period notices as required under the eligibility rules, and so she was not aware that she was even in a grace period. The advocate pointed out the error in the address, and VHC agreed to reinstate. Lauren's coverage was reinstated, and her address was corrected going forward.

Elliot's Story

When Elliot went to pick up his asthma inhaler, the pharmacist told him that it would cost him over \$400. He could not afford this cost, and did not understand why the price had increased so much. The last time he had filled the prescription, the cost was less than \$5. The HCA advocate discovered that Elliot had been on Medicaid for Children and Adults (MCA), but it had just terminated. Because Elliot was on Medicare, it meant that he was not eligible for MCA Medicaid. He had been on MCA in error. He actually needed to be on a different type of Medicaid called Medicaid for the Aged, Blind and Disabled (MABD). Because he was on Medicare, he also needed to sign up for a Medicare Part D prescription drug plan. First, the HCA advocate helped get Elliot's MABD Medicaid active. Once he was found eligible for MABD Medicaid, it also meant that he was deemed eligible for a

program called “Extra Help.” Extra Help will pay for Part D premiums, and it reduces copayments. Elliot then signed up for a Part D plan. Because he was now on “Extra Help,” his copayment for the inhaler was about \$3 instead of \$400.

Samantha’s Story

Samantha was scheduled for surgery, and needed to pick up medication before the surgery. When she went to pick up the medication, she could not afford it because the copayment was several hundred dollars. This was much more than she had paid for any of her previous prescriptions. She could not get the surgery if she did not take her prescription first. First, the advocate investigated whether Samantha was on VPharm. VPharm is a state of Vermont program that reduces Medicare Part D prescription drug costs. If a person is enrolled in VPharm, their prescription copayments are limited to \$1 to \$2. Samantha, however, was not enrolled in VPharm. Instead, she had been on a program called “Extra Help.” Extra Help also reduces Medicare Part D copayments, but because Samantha’s income had increased, she had lost her eligibility for that program. She did not understand that the program had ended for her until she went to get her prescription. The advocate realized that Samantha would still be eligible for VPharm, and he helped her apply and expedited the application. Samantha’s application was processed, her premium was received in time, and her VPharm was activated. That meant she was able to pick up the prescription and go forward with the surgery as scheduled.

Anna’s Story

Anna called the HCA because she needed to pick up a prescription and discovered that her Medicaid was closed. Anna had been on Medicare and Medicaid for the Aged Blind and Disabled (MABD). Since Medicare was her primary insurance, her Medicare Part D plan covered her prescriptions. But Anna was on a specific prescription that her Part D plan did not cover. Because it was excluded from her Part D plan, Medicaid covered that prescription. When her Medicaid had closed, it meant that she could not afford the price of the prescription out of pocket. The HCA advocate researched Anna’s Medicaid and found the Medicaid application was pending. VHC needed to verify her income and resources before granting the Medicaid. The HCA advocate helped Anna verify her resources by faxing VHC the necessary information, and he requested that the application be expedited. Within a day, VHC had approved the application for MABD. This meant that Anna was able to pick up her prescription.

Hayden’s Story

Hayden called the HCA because he was anticipating getting a settlement from a lawsuit. He was fearful that the settlement of about \$10,000 would make him ineligible for Medicaid. Hayden was on Medicaid for the Aged, Blind and Disabled (MABD). This type of Medicaid has a \$2,000 resource limit, which means that if you have more than that amount of money in a bank account, you will be found ineligible and lose your Medicaid coverage. Hayden could maintain his Medicaid eligibility by “spending down” the settlement money, which means that he would have to spend all of the money beyond the \$2,000. However, he wanted to save the money for future use. During their conversations, the HCA advocate found that Hayden had been disabled before the age of 26. This made him eligible for a new type of account called a STABLE account. A federal law called the ABLE Act made it possible for disabled individuals to save money while staying on public benefits

programs. In Vermont, a person who qualifies can open what is called a “STABLE” account, and save up \$14,000 a year. To find out more about Stable Accounts, see <https://www.vermontable.com/stable-account>. This money can later be used for education, housing, training, and basic living expenses. Hayden was able to set up a STABLE account and deposit the settlement money into that account so that he could save that money for future expenses and stay on Medicaid.

Allison’s Story

Allison called the HCA because her Medicaid had closed and she was unsure why. When the advocate looked into why she was closed, he asked for a copy of the Medicaid closure notice. He found that Allison’s notice did not explain why her Medicaid was closing or give a closure date. VHC is required to give advance notice when it closes a beneficiary’s Medicaid coverage and explain the basis for its decision. When the advocate talked to VHC, they said that they had closed Allison’s coverage because she had not done her yearly renewal to verify her Medicaid eligibility. VHC, however, agreed that their closure notice was not adequate and reinstated Alison’s Medicaid coverage. The advocate then helped Allison complete and submit the Medicaid application which meant that her Medicaid stayed active and Allison had no further breaks in coverage.

Linda’s Story

Over the summer, Linda had gotten a raise at work that pushed her over the Medicaid income limit. She called Vermont Health Connect to report her new income, and her MCA Medicaid closed because she was over-income. Because her Medicaid had closed, that she had a 60-day Special Enrollment Period (SEP) to enroll in a VHC plan. Linda did not apply immediately to get on her VHC plan because she was worried about affording the monthly premium. Unfortunately for her, Linda’s chronic health condition suddenly flared up. This meant that she needed her prescription immediately, but did not have any coverage. The HCA advocate explained that Linda was still within her 60-day SEP period. She was also eligible for an Advance Premium Tax Credit (APTC) to help pay for the monthly premium and cost-sharing reductions to help reduce her out of pocket costs. Linda was able to apply and enroll in a VHC plan. For help with the immediate prescription needs, the HCA referred Linda to the Health Assistance Program at the University of Vermont. They assisted Linda in getting her prescription filled until her VHC insurance was activated.

Priorities

A. The HCA participated in a working group to develop clear communication about 2019 Open Enrollment and silver-loading.

The HCA worked with other stakeholders to develop coherent messaging for the 2019 Open Enrollment. In particular, stakeholders worked on developing clear and understandable communication for all segments of the market. The HCA wants to reach consumers whose eligibility for increased APTC this year gives them an opportunity to buy a gold plan for about the same cost as the silver plan. We also focused on reaching consumers who were not APTC eligible, and who would benefit by directly enrolling in Reflective Silver plans with the carriers. Overall, the HCA is working toward creating a coherent, consistent, and accessible message for all Vermonters.

B. The HCA added a new outreach, communications, and education coordinator to help reach more Vermonters.

The HCA added a new Outreach and Education Coordinator to our team. The coordinator will work on further expanding the HCA's outreach throughout the state. The coordinator will focus on making sure consumers know how to access the HCA and also on helping consumers understand both state and federal health care programs. The new coordinator, Amelia Schlossberg, had been an HCA hotline advocate since 2015. She also previously worked at Vermont Health Connect. She is additionally going to focus on developing even closer relationships with our community partners, so they are aware of exactly how the HCA can help consumers. The HCA will also continue to work on developing clear and accessible explanations of complex health care issues on our website.

C. The HCA continued its participation in the COTS clinic in an effort to reach underserved populations.

The HCA is working on developing a closer relationship with the Committee on Temporary Shelter (COTS), so we can identify Vermonters who need our assistance. At the clinic, the HCA advocates educated consumers about both state and federal health care programs and about how the HCA could help them. They also talked to individual consumers about their eligibility for health care programs. Specifically, they advised multiple consumers how to apply for Medicaid. We are also working on increasing our referrals from COTS. The HCA handed out brochures and cards, and plans to have ongoing participation in the clinic.

D. Overall call volume decreased but was similar to call volume during the same quarter in 2017.

The total call volume decreased by 13% (839 this quarter vs. 967 last quarter). Call volume this quarter is very similar to call volume in the same quarter in 2017. In 2017, the HCA had 825 calls in the third quarter compared to 840 in 2018. About 11% of those calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We saved consumers \$66,933.20 this quarter.

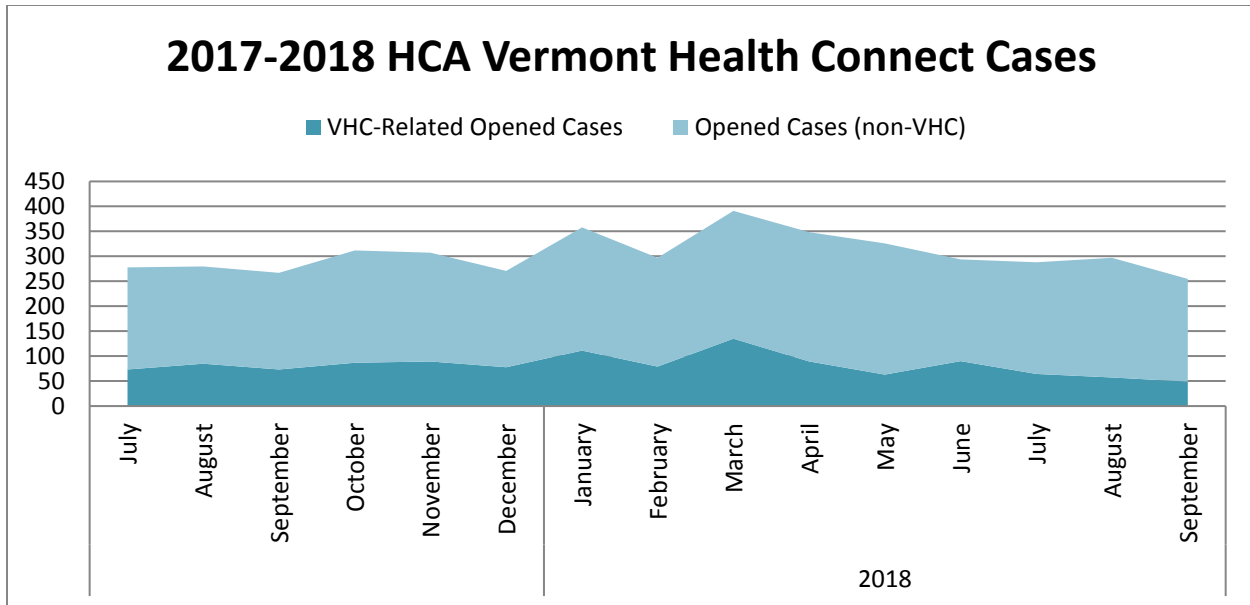
	All Calls (2008-2018)										
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
January	309	240	218	329	282	289	428	470	411	340	358
February	232	255	228	246	233	283	304	388	511	330	297
March	229	256	250	281	262	263	451	509	416	308	391
April	235	213	222	249	252	253	354	378	333	240	348
May	207	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	-
November	192	170	300	251	274	283	306	353	287	307	-
December	214	161	289	222	227	340	583	369	284	271	-
Total	2604	2616	3077	3209	3105	3257	4526	4423	4237	3554	2854

E. Calls concerning Vermont Health Connect decreased for the third quarter in a row.

The volume of calls concerning Vermont Health Connect decreased this quarter (170 vs. 243). The top two VHC issues were eligibility for MAGI Medicaid (85) and eligibility for Premium Tax Credits (60). This quarter, 76 VHC cases required complex interventions that took more than two hours of an advocate's time to resolve, and another 25 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 39 escalated cases (39 vs. 69 last quarter). Of the 39 escalated cases, 33 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 (39), MABD (61) and VPharm eligibility (19).



F. Medicaid eligibility calls represented 29% of all our cases (241 cases/839 total cases). Consumers need assistance with all types of Medicaid.

Medicaid eligibility was again the top issue generating calls. We had 143 calls about eligibility for Medicaid for Children and Adults (MCA) Medicaid, 61 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), 12 about Medicaid Spenddowns, and 10 about Medicaid for Working Disabled. We also had 15 calls specifically about the Medicaid renewal process. 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 839 (compared to 968 last quarter)

1. MAGI Medicaid eligibility 143 (102)
2. Complaints about providers 81 (136)
3. Information about VHC 67 (64)
4. Premium Tax Credit eligibility 62 (79)
5. Medicaid eligibility (non-MAGI) 61 (73)
6. Not health related 61 (40)
7. Change of Circumstance eligibility 58 (34)
8. Access to Prescription Drugs/Pharmacy 57 (60)
9. Special Enrollment Periods eligibility 51 (59)

10. Information/applying for DVHA programs 46 (81)
11. Hospital billing 43 (37)
12. Buy-in programs/Medicare Savings Programs 39 (61)
13. Termination of insurance 39 (56)
14. Fair hearing appeal 35 (43)
15. Information about Medicare 29 (58)

Vermont Health Connect Calls 170 (compared to 243 last quarter)

1. MAGI Medicaid eligibility 85 (90)
2. Premium Tax Credit eligibility 60 (78)
3. Information about VHC 44 (61)
4. Change of Circumstance eligibility 37 (27)
5. Special Enrollment Periods 34 (40)
6. Grace Periods – VHC 23 (29)
7. Termination of insurance 20 (41)
8. Fair hearing appeals 19 (30)
9. Buying QHPs through VHC 18 (18)
10. Affordability affecting access to care 15 (3)
11. Information regarding the ACA 15 (8)

DVHA Beneficiary Calls 297 (compared to 355 last quarter)

1. MAGI Medicaid eligibility 58 (44)
2. Complaints about providers 30 (68)
3. Medicaid eligibility (non-MAGI) 36 (41)
4. Hospital Billing 21 (11)
5. Change of Circumstance eligibility 21 (14)
6. Buy In Programs/MSPs eligibility 19 (16)
7. Information regarding the ACA 19 (4)
8. Information/applying for DVHA programs 18 (32)
9. PA Denial 17 (10)
10. Access to Prescription Drugs/Pharmacy 17 (19)

Commercial Plan Beneficiary Calls 151 (compared to 165 last quarter)

1. Premium Tax Credit eligibility 33 (39)
2. MAGI Medicaid eligibility 30 (15)
3. Information about VHC 25 (20)
4. Change of Circumstance 22 (13)
5. Eligibility for Special Enrollment Periods 13 (17)
6. Claim Denials 13 (7)
7. Hospital Billing 13 (12)
8. Access to Prescription Drugs/Pharmacy 10 (8)
9. Information regarding the ACA 10 (1)
10. IRS Reconciliation issues 10 (17)

The HCA received 839 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”): 35.4% (297 calls), compared to 36.7 % (355 calls) last quarter
- **Medicare² 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): 25.5% (214 calls), compared to 28.7% (278 calls), last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans 15.6% (151 calls) , compared to 17.1% (165 calls) last quarter
- **Uninsured**: 9.41% (79 calls), compared to 9.51% (92 calls last quarter)

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 839 cases this quarter, compared to 1029 last quarter:

- 38% (320 cases) were resolved by brief analysis and advice
- 30% (254) were resolved by brief analysis and referral
- 20% (171) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate’s time
- 7% (60) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases, 34 clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 40 individuals with appeals: 34 Fair Hearings, 2 Commercial Insurance – Internal 1stLevel 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 2 Medicaid MCO Internal appeals.

DVHA Beneficiary Calls

We closed 299 DVHA cases this quarter, compared to 363 last quarter:

- 39% (117) were resolved by brief analysis and/or advice
- 23% (68) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate’s time
- 21% (63 cases) were resolved by brief analysis and/or referral
- 13% (38) 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, 13 clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 13 DVHA beneficiaries with appeals: 11 Fair Hearing, 0 Medicare Part D appeals, and 2 Medicaid MCO Internal appeals.

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

Commercial Plan Beneficiary Calls

We closed 142 cases involving individuals on commercial plans, compared to 214 last quarter:

- 42% (60) were resolved by brief analysis and/or advice
- 25% (35) were resolved by brief analysis and/or referral
- 23% (32 cases) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 7% (10) 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 29 commercial plan beneficiaries with appeals: 25 Fair Hearings, 2 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 59 people with applications for or enrollment in insurance plans and prevented 13 insurance terminations or reductions. We obtained coverage for services for 24 people. We got 22 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 70 more. We provided other billing assistance to 13 individuals. We provided 458 individuals with advice and education. Fourteen people were not eligible for the benefit they sought, and nineteen were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 145 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.

Two filings related to premium price increases were decided during the quarter covering July 2018 through September 2018. Additionally, two rate filings were pending at the end of the quarter.

Both decided filings were for products offered on Vermont Health Connect. Due to the number of Vermonters impacted by these two proposed premium price increases, the HCA contracted with an independent actuary to support the HCA's analysis of the filings and retained Mr. Jay Angoff to assist the HCA with its advocacy before the Board. Mr. Angoff has deep expertise in health insurance rate filings from, among other experiences, his service as the Missouri Insurance Commissioner and the director of the Affordable Care Act implementation with the U.S. Department of Health and Human Services.

Blue Cross Blue Shield of Vermont (BCBSVT) submitted one of the decided filings, the BCBSVT 2019 Vermont Health Connect 2019 filing. As subsequently amended by BCBSVT, this filing proposed an

average premium price increase of 9.6 percent. Approximately 70,200 Vermonters are covered by products affected by this filing. The HCA appeared on behalf of Vermonters in this matter, filed questions for the carrier, filed an expert witness report, appeared at the hearing, filed a post-hearing memorandum, and filed various motions with the Board related to this matter. The Board reduced BCBSVT's proposed price increase from 9.6 percent to an average of 6.6 percent. This premium price reduction translates into, not accounting for increased federal subsidy amounts, approximately \$13 million of savings for Vermonters.

MVP Health Plan, Inc. (MVP) submitted the other filing decided this quarter, the MVP 2019 Vermont Health Connect filing. MVP proposed increasing the premium price paid by Vermonters for these products by 10.9 percent. Approximately 16,360 Vermonters are covered by products affected by this filing. The HCA appeared on behalf of Vermonters in this matter, filed questions for the carrier, filed an expert witness report, appeared at the hearing, filed a post-hearing memorandum, and filed various motions with the Board related to this matter. The Board reduced MVP's proposed price increase from 10.9 percent to an average of 5.8 percent. This premium price reduction translates into, not accounting for increased federal subsidy amounts, approximately \$7.3M of savings for Vermonters.

There are two pending filings related to proposed premium price increases by MVP, the Q1/Q2 2019 Large Group HMO filing and the Q1/Q2 2019 Large Group POS Riders filing. As these two filings are associated with MVP's large group HMO product, the Board has decided to treat them in one proceeding. MVP proposes to increase the premium paid by Vermonters for these products by 13.7 percent. There are approximately 2,171 Vermont members enrolled in plans affected by these proposed premium price increases. The HCA has entered appearances on behalf of Vermonters in these matters, has filed questions to the carrier, and has filed various motions with the Board related to this matter. We intend to file all appropriate memoranda and other documents to represent the interests of Vermonters in these matters.

B. Hospital Budget Review

The HCA participates in the Board's annual hospital budget review process, which took place this quarter. The HCA received and reviewed the fourteen hospital budgets submitted to the Board in July. These submissions included answers to our first set of written questions which were included in the Board's hospital budget guidance issued in March. After reviewing the materials, we submitted a set of follow-up questions for the hospitals to be discussed during the hearings. HCA staff participated in each hospital budget hearing and asked questions of each hospital. We focused our questions on affordability, negotiations between hospitals and insurers, harm reduction, and patient financial assistance. Following the hearings, we submitted written comments outlining our concerns about the budgets. In our comments we asked the Board not to approve a rate increase for UVM Medical Center, and to consider affordability when setting commercial rate increases for other hospitals. We highlighted the gap between eligibility for hospitals' financial assistance policies and being able to afford care, and asked the hospitals to implement sliding scale and other consumer-friendly policies rather than using aggressive collections practices. We noted the connection between the cost shift and affordability issues for the commercially insured, and the implications for Vermont's all-payer model. We asked the Board to advocate for Medicaid rate increases, and asked the hospitals to work harder to lower costs for consumers. Finally, we asked hospitals to invest more in harm reduction services to better serve their patients and communities.

HCA staff attended three public meetings at which the Board deliberated and then voted on each hospital's budget. The Board approved a lower rate increase for UVM Medical Center than the hospital had requested, but did not accept the HCA's recommendation to forego a rate increase entirely.

C. Oversight of Accountable Care Organizations

The HCA continues to work with the Board and OneCare Vermont to develop a measure set and quality improvement methodology for the 2019 Medicare ACO program. This quarter, HCA staff met with the Board and OneCare three times to discuss quality measures and methodology and to develop a recommendation. We submitted two sets of comments and edits to the Board outlining our suggestions to the proposed quality methodology. While the HCA is encouraged that the Board has made improvements to these proposals, we remain concerned about OneCare's accountability to patients and the state for quality of care and we continue to advocate for increased oversight and accountability.

Next quarter, the Board will begin its review of OneCare's proposed 2019 budget. In September, the HCA met with Board staff to discuss the review process and our role. We also met with DVHA staff to discuss the Medicaid ACO program.

D. Other Green Mountain Care Board Activities

The HCA continues to attend the weekly Green Mountain Care Board meetings. This quarter, the Chief also held annual meetings with individual members of the Board for the purpose of maintaining good communications and understanding the perspectives of the Green Mountain Care Board members.

E. 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.

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

The HCA continues to advocate for increased access to hepatitis C virus (HCV) treatment. This 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 records from VDH and we anticipate receiving the remainder of the records next quarter.

In late September, the Joint Legislative Justice Oversight Committee met to discuss the DOC health care contract with Centurion, a private prison health care provider. The HCA's Chief Health Care Advocate and Policy Analyst testified at the hearing and provided the committee with the information we had received to date about the state and Centurion's treatment of Vermonters with HCV in corrections.

The HCA continues to actively participate in the Vermont Department of Health Hepatitis C Task Force, and our Policy Analyst is a member of the Task Force Steering Committee. We attended one meeting of the Task Force and one meeting of the Steering Committee this quarter.

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

The HCA continues to participate in the UVMHC 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.

✧ **U.S. Census Comments**

In August, the HCA submitted comments to the Department of Commerce on its proposal to add a citizenship question to the 2020 census. Here is a short summary of our comments: We are concerned that this change would increase fear of persecution in immigrant communities. Further, immigrant communities may refrain from responding to the census if such a question is included. We know the collection of accurate, objective data about our nation's people, housing, economy, and communities is vitally important. The federal government uses census-derived data to direct at least \$800 billion annually in federal assistance to states, localities, and families. We strongly oppose the addition of a citizenship question to the 2020 Census.

✧ **Global Commitment Register Comments**

The HCA regularly comments on Global Commitment rule and policy changes. This quarter we commented on a proposed change to Medicaid coverage of electric breast pumps. We asked DVHA to expand access to breast pumps beyond what had been proposed.

✧ **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 9 notices, in an effort to make them more readable and consumer-friendly. See **Promoting Plain Language in Health Communications** below.

❖ **Medicaid and Exchange Advisory Board**

This quarter, the Chief Health Care Advocate 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.

Legislative Activities

The summer months of this quarter, particularly in an election year, saw few formal legislative activities. This quarter, the HCA monitored the legislature's off-session activities. We attended one meeting of the Health Reform Oversight Committee, one meeting of the Joint Fiscal Committee, one meeting of the Justice Oversight Committee, and one meeting 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. Due to the fact that the Legislature's Health Reform Oversight Committee only managed to meet one time and that meeting was called to organize itself during this quarter, our advocacy activities included many more informal communications. The Chief Advocate testified before LCAR this quarter about the Department of Financial Regulation's emergency rule allowing fully insured Association Health Plans to be rated in the large group. The HCA did not object to the emergency rule but did express its strong opposition to the upcoming proposed rule to continue this practice. By allowing healthier small groups to pull their risk out of the individual/small group risk pool, that pool of risk will see a predictable spiraling of cost 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

- Planned Parenthood of Northern New England
- 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 Health Connect
- Vermont Medical Society
- Vermont Program for Quality in Health Care

Outreach and Education

A. Increasing Reach and Education through the Website

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

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

Popular Web Pages

- The total number of **health pageviews increased by 7%** in the reporting quarter ending September 30, 2018 (11,534 pageviews), compared with the same quarter in 2017 (10,736 pageviews).
- The **top-20 health pages** on our website this quarter with change over last year:
 - *Income Limits – Medicaid* – 3,200 pageviews (15% ↑)
 - *Health* – section home page – 1,505 (12% ↑)
 - *Services Covered by Medicaid* – 449 (39% ↑)
 - *Vermont Choices for Care* – 444 (4% ↓)
 - *Resource Limits – Medicaid* – 422 (4% ↑)
 - *Dental Services* – 411 (7% ↓)
 - *Buying Prescription Drugs* – 245 (195% ↑)
 - *Medicaid* – 225 (84% ↑)
 - *Medicare Savings / Buy-In Programs* – 199 (5% ↑)
 - *HCA Online Help Request Form* – 193 (17% ↑)
 - *Advance Directive Forms* – 189 (56% ↑)
 - *Choices for Care Income Limits* – 177 (1% ↓)
 - *Medicaid and Medicare dual eligible* – 173 (27% ↑)
 - *Long-term Care* – 168 (2% ↑)
 - *Choices for Care Resource Limits* – 160 (6% ↓)

- *Federally Qualified Health Centers* – 144 (20% ↓)
 - *Choices for Care Requirements* (new page) – 141 (100% ↑)
 - *Medicaid Transportation* – 136 (97% ↑)
 - *Health Insurance, Taxes and You* – 135 (31% ↓)
 - *Medical Decisions – Advance Directives* – 128 (7% ↑)
- Besides the pages listed above, other **spikes in interest** in our pages included:
 - *Green Mountain Care* – 114 (68% ↑)
 - *Dr. Dynasaur* – 107 (214% ↑)
 - *Long-Term Care Help* (new page) – 100 (39% ↑)
 - *Complaints About Providers* – 52 (136% ↑)
 - *Medicare Supplemental Plans* – 37 (640% ↑)

Popular PDF Downloads

28 out of 84 or 33% of the unique PDFs downloaded from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:

- 20 PDFs were created for consumers. The top five consumer-focused PDF downloads were:
 - *Advance Directive, short form* (162 downloads)
 - *Advance Directive, long form* (89 downloads)
 - *Vermont Dental Clinics Chart* (90 downloads)
 - *Vermont Medicaid Coverage Exception Request Form* (32 downloads)
 - *BCBSVT 2016 Annual Report* (15 downloads)
 - The advance directive forms were accessed more often this year as compared to the same period last year (251 downloads versus 217 last year).
- 4 PDFs were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused download was:
 - *PTC Rule Allocation Summary* (5 downloads)
- 3 PDFs covered topics related to health policy. The top policy-focused download was:
 - *VT ACO Shared Savings Program Quality Measures* (2 downloads)

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

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

Online Help Tool Adds to Our Reach

Last year we added a new Health section to the online help tool on our website. It is found at https://vtlawhelp.org/triage/vt_triage and can be accessed from most pages of our website. 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 **144 times** during this quarter. That's the **same amount of usage** as the previous quarter (April – June 2018).

Of the **43** 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).
- Dental Services - I need help with dentures.
- Long-Term Care - How do I know if I can get Choices for Care Long-Term Care Medicaid?
- Long-Term Care - Medicaid won't pay for me to stay at a nursing home.

B. Other Outreach and Educational Activities

COTS Clinic, July 17, 2018

HCA advocates attended and gave advice on eligibility for state and federal health care programs and shared information about the HCA.

Lavender Law Conference, August 8-10, 2018

HCA advocate attended and shared information about the HCA.

Pride Festival, September 8, 2018

HCA advocates attended the Festival and provided information about the HCA and its services, and handed out brochures.

Meeting with the Pride Center, September 21, 2018

HCA advocates met with the new director of Health and Wellness and new Transgender Program Coordinator.

UVM Pediatric Fair, September 26, 2018

HCA advocates attended the Pediatric Fair and provided information about the HCA services.

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:

- Draft to Non-APTC Household, Silver Reflective Plans
- SSA Macros: when to refer to SSA
- Comments on 202 Med application, VHC application, LTC application
- VHC October Stuffer
- Comments on Revised Health Care Application
- VHC invoice stuffer
- VHC notice stuffer, draft#1 and draft #2

- Open Enrollment Poster
- VHC cost-sharing reduction brochures

Office of the Health Care Advocate

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

<http://www.vtlegalaid.org/health>

Attachment 6 - GC Investments

CY 2018 Investment Expenditures

Department	STC #	Final Receiver Suffix	Investment Description	QE 0318	QE 0618	QE 0918	CY 2018 Total
AHSCO	41	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,250	113,250	113,084	339,584
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	55	9402	Investments (STC-79) - Medical Services (55)	17,267	15,717	17,672	50,655
DCF	1	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)	2,208,458	3,442,083	2,286,340	7,936,881
DCF	56	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	-	128,702	1,383,634	1,512,336
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	671,276
DCF	60	9409	Investments (STC-79) - GA Medical Expenses (60)	54,512	72,062	89,289	215,863
DCF	61	9411	Investments (STC-79) - Therapeutic Child Care (61)	500,417	383,222	(242,070)	641,568
DCF	2	9412	Investments (STC-79) - Lund Home (2)	555,306	730,209	169,704	1,455,219
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	101,700
DCF	9	9415	Investments (STC-79) - Challenges for Change: DCF (9)	64,015	49,463	68,552	182,030
DCF	26	9416	Investments (STC-79) - Strengthening Families (26)	215,717	218,243	255,663	689,623
DCF	62	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	54,750	54,750	-	109,500
DCF	35	9418	Investments (STC-79) - Building Bright Futures (35)	117,644	151,378	107,033	376,055
DDAIL	63	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	95,581	73,530	76,691	245,802
DDAIL	64	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	515,509	918,088	93,428	1,527,025
DDAIL	27	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	614,914	214,622	-	829,536
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	707,897
DDAIL	77	9607	Investments (STC-79) - HomeSharing (77)	82,404	83,492	18,403	184,298
DDAIL	78	9608	Investments (STC-79) - Self-Neglect Initiative (78)	140,884	-	-	140,884
DDAIL	65	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)	17,807	16,942	12,134	46,883
DMH	28	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	28,098	50,950	25,561	104,608
DMH	66	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	858,990	495,927	313,066	1,667,983
DMH	79	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	116,533	107,824	73,910	298,267
DMH	16	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	509,282	(2,066,805)	7,015,077	5,457,554
DMH	12	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	1,147,730	1,109,389	980,464	3,237,584
DMH	29	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,330,483	1,538,487	-	3,868,970
DMH	67	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	302,856	204,850	-	507,705
DMH	22	9510	Investments (STC-79) - Emergency Support Fund (22)	256,829	166,513	-	423,342
DMH	3	9511	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - VPCH	6,250,829	4,926,448	6,512,245	17,689,522
DMH	3	9512	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - BR	954,387	2,814,303	1,285,646	5,054,336
DMH	68	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	2,475	59,116	17,590	79,182
DMH	13	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	122,391	2,093,206	122,579	2,338,176
DOC	4	n/a	Return House	117,001	131,406	127,898	376,305
DOC	5	n/a	Northern Lights	98,438	98,438	98,438	295,314
DOC	6	n/a	Pathways to Housing	227,728	324,156	302,736	854,620
DOC	14	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	193,405	89,806	193,405	476,616
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	-	2,098,279
DOC	80	n/a	Intensive Sexual Abuse Program	2,615	2,825	2,615	8,055
DVHA	8	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)	467,851	574,092	537,130	1,579,073
DVHA	51	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	869,072	1,037,825	592,139	2,499,036
DVHA	52	9103	Investments (STC-79) - Buy-In (52)	9,916	8,308	10,854	29,078
DVHA	53	9104	Investments (STC-79) - HIV Drug Coverage (53)	668	668	668	2,003
DVHA	18	9106	Investments (STC-79) - Patient Safety Net Services (18)	70,560	46,939	2,992	120,492
DVHA	7	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	1,695,275	2,134,424	1,994,880	5,824,579
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
DVHA	82	9110	DSR Investment (STC-83) - One Care VT ACO Advanced Community Care Coordination (82)	-	1,173,125	923,126	2,096,251
GMCB	45	n/a	Green Mountain Care Board	384,321	762,208	409,212	1,555,741
UVM	10	n/a	Vermont Physician Training	1,011,554	1,011,554	844,804	2,867,912
VAAF	36	n/a	Agriculture Public Health Initiatives	-	-	-	-
VDH	19	9201	Investments (STC-79) - Emergency Medical Services (19)	178,201	218,001	212,618	608,819
VDH	74	9203	Investments (STC-79) - TB Medical Services (74)	37,827	35,054	33,414	106,295
VDH	40	9204	Investments (STC-79) - Epidemiology (40)	291,293	250,729	268,903	810,925

Attachment 6 - GC Investments

Department	STC #	Final Receiver Suffix	Investment Description	QE 0318	QE 0618	QE 0918	CY 2018 Total
VDH	39	9205	Investments (STC-79) - Health Research and Statistics (39)	427,372	415,032	356,259	1,198,663
VDH	31	9206	Investments (STC-79) - Health Laboratory (31)	869,855	637,355	1,029,074	2,536,284
VDH	50	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	253,040	428,115	181,877	863,031
VDH	76	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)	-	-	-	-
VDH	75	9209	Investments (STC-79) - Family Planning (75)	352,008	271,546	355,593	979,147
VDH	25	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	466,555	250,556	50,000	767,111
VDH	73	9211	Investments (STC-79) - Renal Disease (73)	-	-	-	-
VDH	37	9213	Investments (STC-79) - WIC Coverage (37)	1,091,956	1,060,146	929,109	3,081,211
VDH	21	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	375,000	18,800	268,800	662,600
VDH	47	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	12,000	12,657	12,850	37,506
VDH	30	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	2,433,133	1,834,748	510,577	4,778,458
VDH	17	9220	Investments (STC-79) - Recovery Centers (17)	371,652	371,652	301,902	1,045,206
VDH	46	9221	Investments (STC-79) - Enhanced Immunization (46)	30,984	24,573	65,396	120,953
VDH	48	9222	Investments (STC-79) - Poison Control (48)	84,756	-	28,252	113,008
VDH	23	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	297,954	223,858	418,075	939,887
VDH	38	9224	Investments (STC-79) - Fluoride Treatment (38)	13,573	13,417	17,921	44,910
VDH	24	9225	Investments (STC-79) - Medicaid Vaccines (24)	-	-	-	-
VDH	49	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	51,032	82,519	91,723	225,274
VDH	44	9228	Investments (STC-79) - VT Blueprint for Health (44)	535,790	349,253	341,117	1,226,160
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	106,285,145

Transitional Housing (MCO Investments)

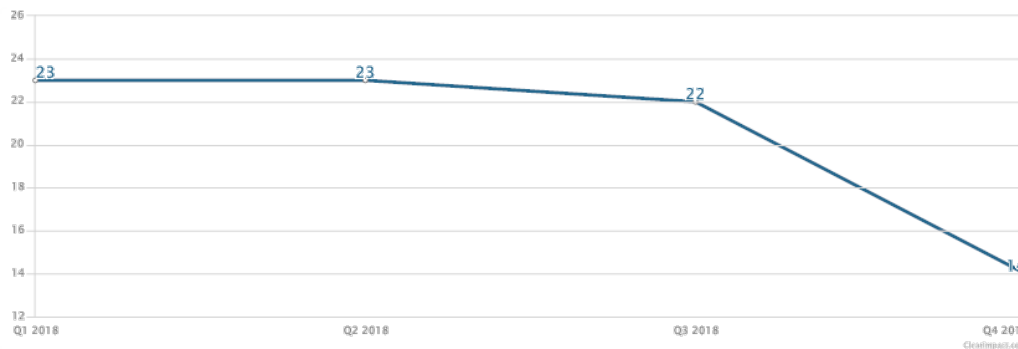
O	Provide public health approaches to improve the health outcomes and the quality of life for Medicaid -eligible individuals in Vermont.	Time Period	Actual Value
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P	GCI Transitional Housing Services	Time Period	Actual Value
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What We Do

Transitional housing programs are an integral component of offender reentry. The goal of the programs is to move residents recently releases from incarceration into stable living situation within one year. Succesful reentry depends on multiple factors falling into place at the same time. With the support of transitional housing, participants can live in the community, look for work, engage in education, or other programs that will support their long term stability.

PM	GCI Number of Individuals Served	Q4 2018	14
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Q3 2018	22
Q2 2018	23
Q1 2018	23

Story Behind the Curve

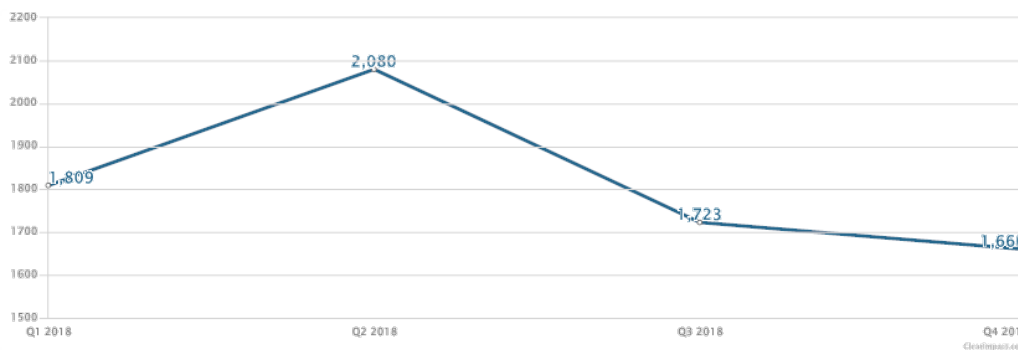
Individual served can fluctuate over the year depending on the circumstance of people in the program and the circumstance of people scheduled for release. 143 people were served FY18 which is over the target of 99.

Partners

What Works

Action Plan

PM	HW Bed Days Utilized	Q4 2018	1,660
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Q3 2018	1,723
Q2 2018	2,080
Q1 2018	1,809

Story Behind the Curve

Bed utilization fluctuates over each quarter depending on the circumstance of the individuals in the program. The bed days for FY18 totaled 7,272. The target was 10,585

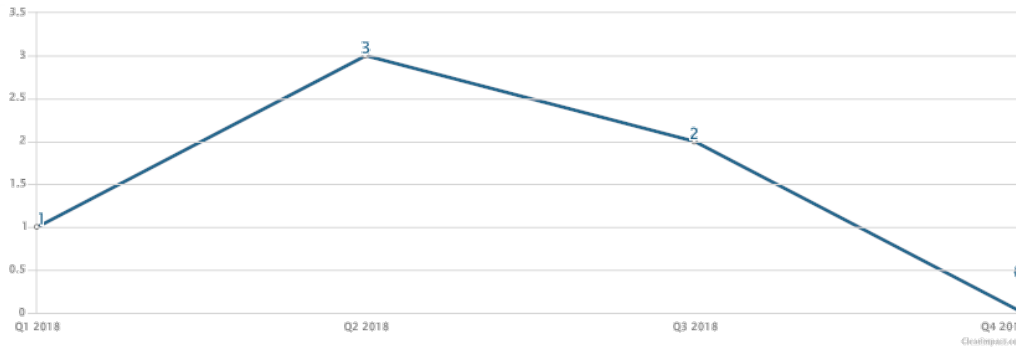
Partners

What Works

Action Plan

PM **HM** Individuals Housed (Search and Retention Services)

Q4 2018	0
Q3 2018	2
Q2 2018	3
Q1 2018	1



Story Behind the Curve

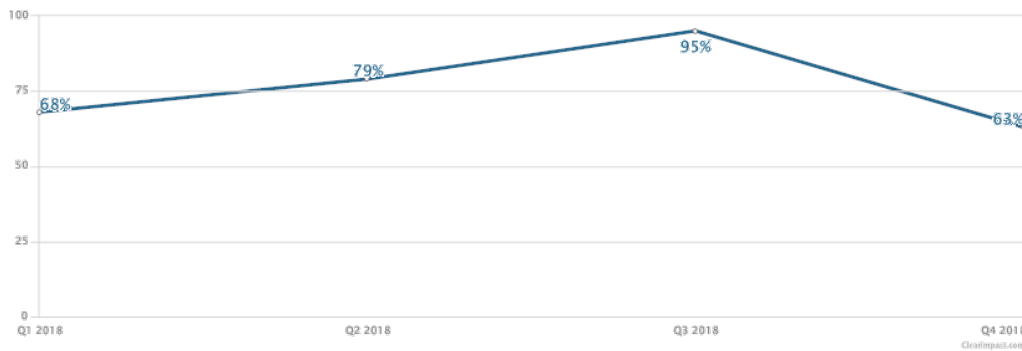
Partners

What Works

Action Plan

PM **HW** Percent of Beds Utilized

Q4 2018	63%
Q3 2018	95%
Q2 2018	79%
Q1 2018	68%



Story Behind the Curve

Overall utilization for FY18 was 69%. The target was 80%.

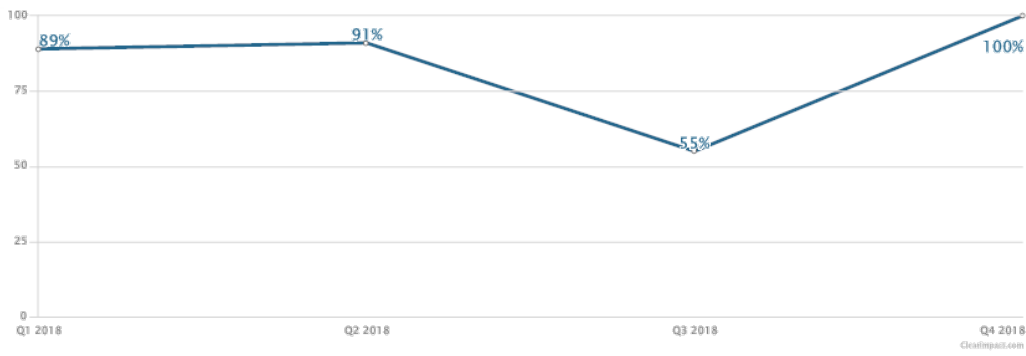
Partners

What Works

Action Plan

PM **HW** Percent of Referrals Accepted

Q4 2018	100%
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Q3 2018	55%
Q2 2018	91%
Q1 2018	89%

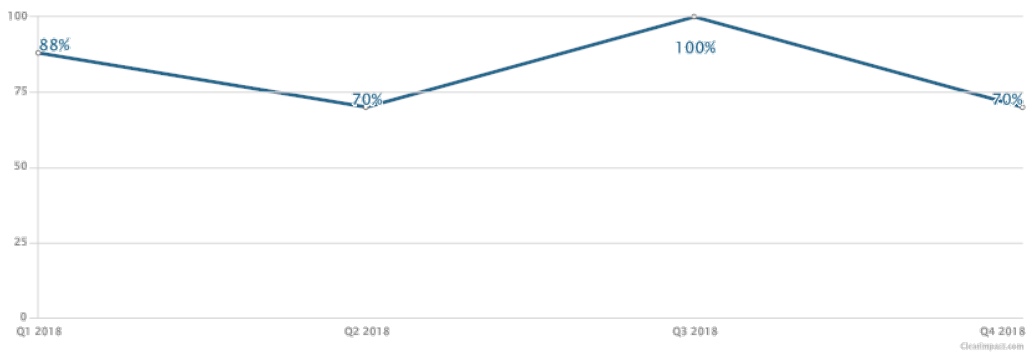
Story Behind the Curve

Partners

What Works

Action Plan

PM BO Percent of participants employed, enrolled in an educational/training program, or receiving benefits at exit



Q4 2018	70%
Q3 2018	100%
Q2 2018	70%
Q1 2018	88%

Story Behind the Curve

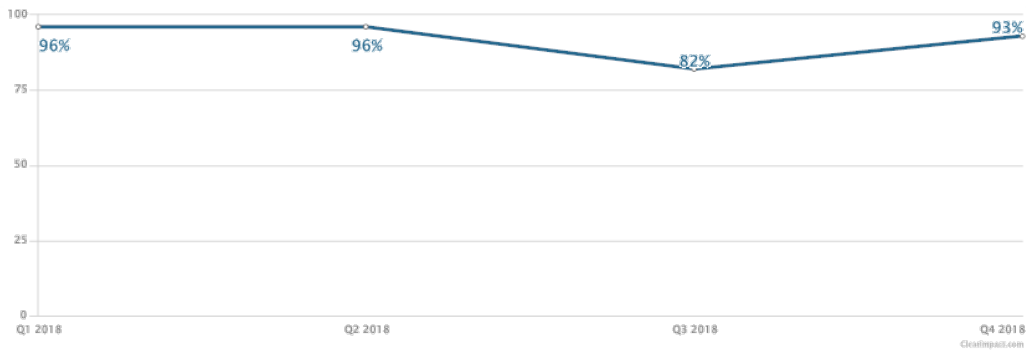
Partners

What Works

Action Plan

PM BO Percent of offender remaining crime free while in program

Q4 2018	93%
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Q3 2018	82%
Q2 2018	96%
Q1 2018	96%

Story Behind the Curve

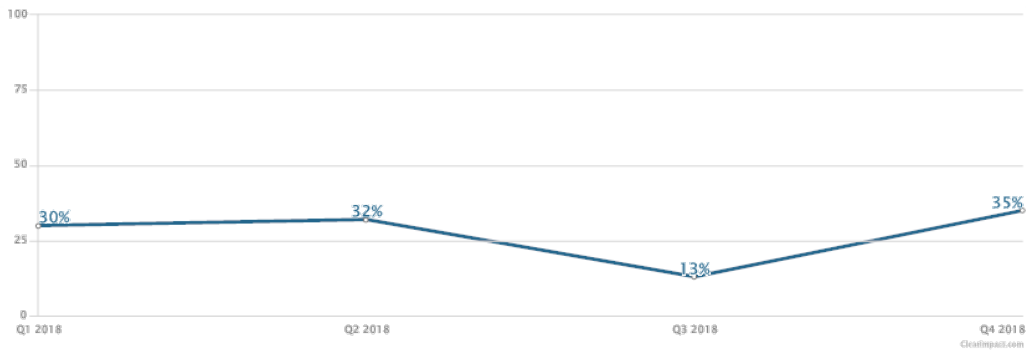
A significant factor in reentry is to remain crime free. In FY18, 95% of program participants remained crime free while in the program. The target for the year was 60%.

Partners

What Works

Action Plan

PM **BO** Percent of participants who exited to permanent housing



Q4 2018	35%
Q3 2018	13%
Q2 2018	32%
Q1 2018	30%

Story Behind the Curve

Partners

What Works

Action Plan

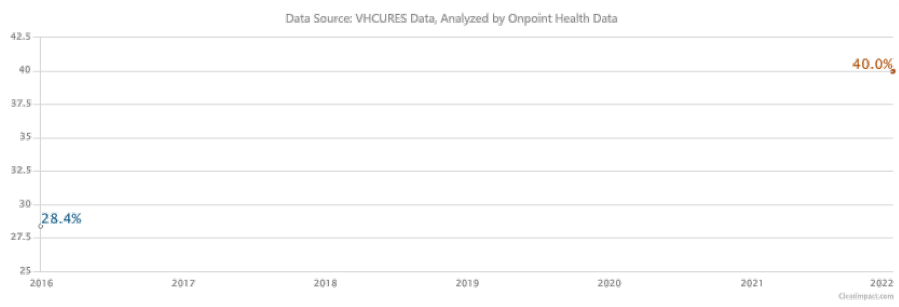
What We Do

The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Women's Health Initiative, Accountable Communities for Health, the Hub & Spoke system of care, Support and Services at Home (SASH), Self-Management and Healthier Living workshops, and a series of learning collaboratives for communities and teams. Blueprint interventions have been shown to maintain or improve health outcomes while controlling growth in health care costs. Of note, the first three have payment models authorized under Vermont's Global Commitment to Health 1115 waiver.

Community Health Teams partner with patient-centered medical homes, hospital systems, health care and social service organizations to supplement the services available in primary care, support coordinated care, and promote prevention and wellness. A per patient per month payment is made to regional entities accountable for managing ongoing Community Health Team operations, including hiring and management of staffing, in order to meet identified community health priorities while offering services that are available for patients to access with minimal barriers (no eligibility requirements, prior authorizations, referrals or co-pays). Measures used to evaluate the overall impact of the Community Health Teams are representative of the provision of coordinated care in each region (follow-up after discharge from the emergency department for mental health or substance use disorders and patient experience of coordinated care composite).

Performance Measures Time Period Actual Value

PM **CHT** Follow-up After Discharge from Emergency Department Visit for Alcohol & Other Drug Dependence **2016** **28.4%**



Notes on Methodology

The red dot on the graph above represents the target value the State aims to achieve by the year 2022 for this measure as outlined in the Vermont All-Payer ACO model Agreement. The white dot represents the actual data value for 2016.

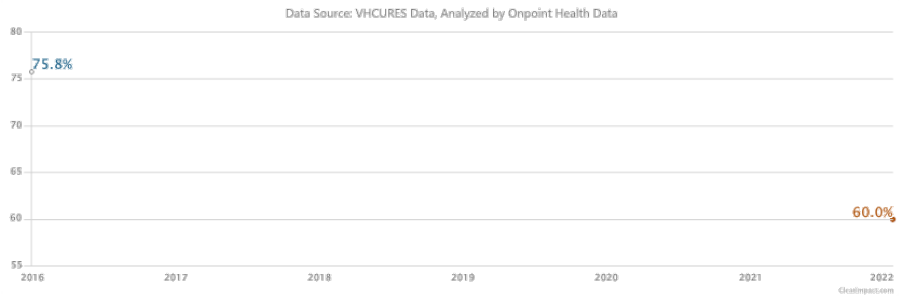
This measure shows the percent of ED visits for members, age 18 years and older, with a principal diagnosis of substance use disorder who had a follow-up visit for substance use disorder within 30 days of the ED visit. (NQF #2605)

Partners

1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. Green Mountain Care Board
5. OneCareVermont

Story Behind the Curve

In support of people with substance use disorders, Vermont has committed to expanding access to treatment and services that can address factors contributing to these disorders, in much the same way that other chronic conditions are managed. This effort requires coordination and partnership among social, medical, and mental health providers. Community Health Teams play a critical role in this coordination and navigating individuals to the most appropriate level of treatment and support services. Following up with individuals who have an Emergency Department visit due to substance use is an important point of contact and an opportunity to engage a person in treatment if needed. Measuring whether this contact is made is one way to monitor the Community Health Team's engagement in the health care system. The above data point shows the statewide average for Medicaid members attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. As of 2016, the rate of follow-up among this population is substantially below the target in the Vermont All-Payer ACO Model Agreement. Community Health Teams in collaboration with practices, OneCare Vermont, and community-based services are currently working on strategies to address improving these rates.



Notes on Methodology

The red dot on the graph above represents the target value the State aims to achieve by the year 2022 for this measure as outlined in the Vermont All-Payer ACO model Agreement. The white dot represents the State's actual value for 2016.

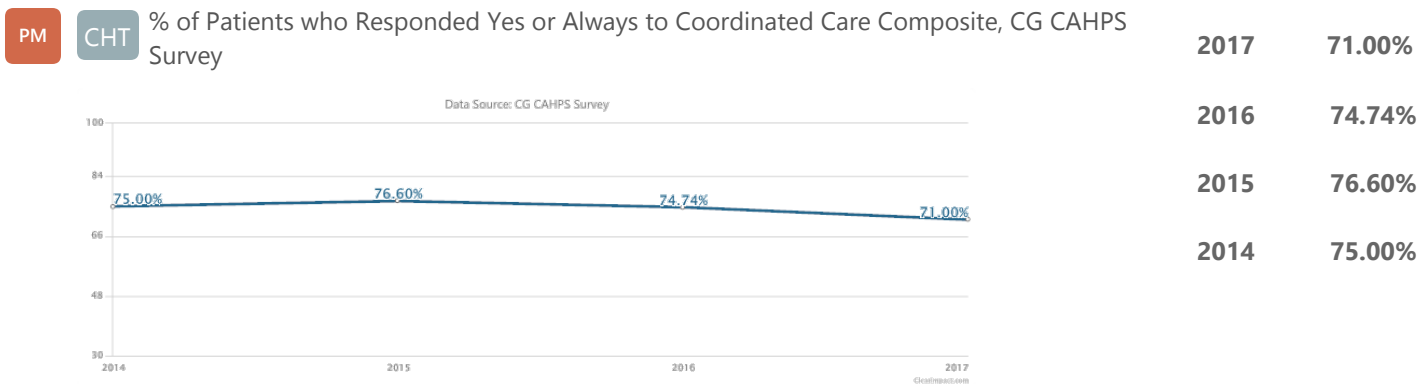
This measure shows the percent of ED visits for members, age 18 years and older, with a principal diagnosis of mental illness who had a follow-up visit for mental health within 30 days of the ED visit. (NQF #2605)

Partners

1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. Green Mountain Care Board
5. OneCareVermont

Story Behind the Curve

While the Vermont rate of follow-up to an Emergency Department visit with a primary diagnosis of mental health condition is higher among its Blueprint-attributed Medicaid population than the All-Payer ACO Model Agreement target, the state continues to work on improving how people with mental health conditions move through the system and receive the services they need. To do so requires coordination and partnership among social, medical, and mental health providers. Community Health Teams play a critical role in this coordination and navigating individuals to the most appropriate level of treatment and support services. Following up with individuals who have an Emergency Department visit due to mental health is an important point of contact and an opportunity to engage a person in treatment if needed. Measuring whether this contact is made is one way to monitor the Community Health Team’s engagement in the health care system. The above data points show the statewide average for Medicaid members attributed to patient-centered medical homes, which coordinate with community health teams. While the Community Health Team payments are not dependent on performance measurement, the Blueprint for Health closely follows this measure to identify service areas that that may benefit from additional assistance to improve this measure.



Notes on Methodology

The Department of Vermont Health Access annually administers CG CAHPS survey with PCMH supplemental questions to patients of patient-centered medical homes. All practices are offered the option to participate, and typically more than 75% do. Of note, almost all primary care practices in the state are recognized as patient-centered medical homes. This measure represents responses from patients covered by all major payers, including Medicare and commercial, and is therefore not Medicaid specific.

Partners

1. Patients
2. Patient-Centered Medical Homes
3. DVHA Payment Reform Unit
4. Green Mountain Care Board
5. OneCare Vermont

Story Behind the Curve

How patients experience their care is a core element in assessing the quality of their care. As the state of Vermont works to increase integration and coordination across medical and community services, supported by Community Health Teams, to improve health outcomes and reduce unnecessary or duplicative care, the state needs to understand whether patients are seeing the results of these efforts in their own experience. Over the last few years, more than 70% of respondents reported that their primary care provider was up-to-date on and discussed with them the care received from specialists, prescription medicines they were taking, and/or tests they had received. However, more work can be done to improve this measure. Shifting this trend involves continual improvement in person-to-person communication, practice workflows, and information technology. While the community health team payments are not dependent on performance measurement, the Blueprint for Health closely follows this measure to identify service areas that that may benefit from additional assistance to improve this measure.

Actions

Name	Assigned To	Status	Due Date	Progress
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What We Do

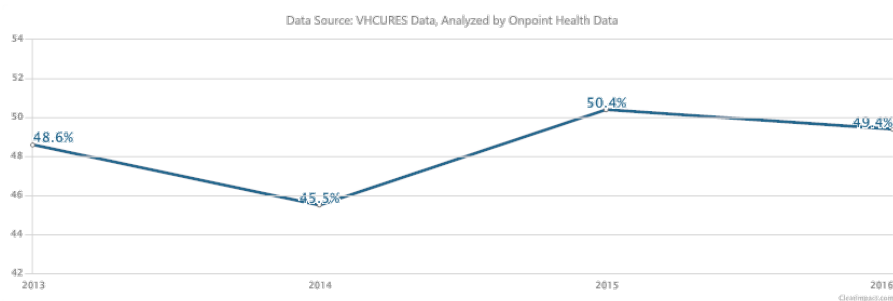
The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Women's Health Initiative, Accountable Communities for Health, the Hub & Spoke system of care, Support and Services at Home (SASH), Self-Management and Healthier Living workshops, and a series of learning collaboratives for communities and teams. Blueprint interventions have been shown to maintain or improve health outcomes while controlling growth in health care costs. Of note, the first three have payment models authorized under Vermont's Global Commitment to Health 1115 waiver.

The Women's Health Initiative includes 3 types of payments designed to incentivize Women's Health practices, and patient-centered medical homes providing women's health services, to provide high quality, integrated, and well-coordinated preventative care for women aged 15-44. Participating practices implement enhanced psychosocial screening and evidence-based interventions for depression, substance use disorder, interpersonal violence, housing instability, and food insecurity are provided by Women's Health Initiative-funded licensed mental health clinicians. Participating practices also offer comprehensive family planning services and increase access to long acting reversible contraceptives when chosen by the patient and clinically appropriate (by removing barriers that frequently prevent patients from being able to access these devices). As a result, measures that are indicative of access to care and preventative care were chosen to evaluate the overall impact of the Women's Health Initiative.

Performance Measures

PM **WHI** % of Chlamydia Screening in Women

Time Period Actual Value



2016	49.4%
2015	50.4%
2014	45.5%
2013	48.6%

Notes on Methodology

This measure shows the percentage of female members, ages 16 to 24, identified as sexually active and who had at least one test for chlamydia in the measurement year. This measure is derived from claims data.

Partners

1. DVHA Quality Unit
 2. VT Department of Health
 3. Planned Parenthood of Northern New England
-

Story Behind the Curve

The rate of chlamydia screening rate in Women 16-24 years old has not changed significantly from 2013-2016. In 2018 and 2019, the Blueprint for Health will be working with DVHA's Quality Unit, the Vermont Department of Health, and Planned Parenthood of Northern England to identify strategies to improve chlamydia screening rates in Women's Health Initiative participating practices. The state is currently using this measure to monitor rates of preventive services. However, it is under consideration for a performance payment measure, which will involve identifying benchmarks in the future should it be chosen.



Adults' Access to Preventive/Ambulatory Health Services

Notes on Methodology

This measure will show the percentage of Medicaid members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

Partners

1. DVHA Quality Unit
 2. VT Department of Health
 3. Planned Parenthood of Northern New England
-

Story Behind the Curve

This measure is still in development. We are currently collecting data for calendar year 2017.

Actions

Name	Assigned To	Status	Due Date	Progress
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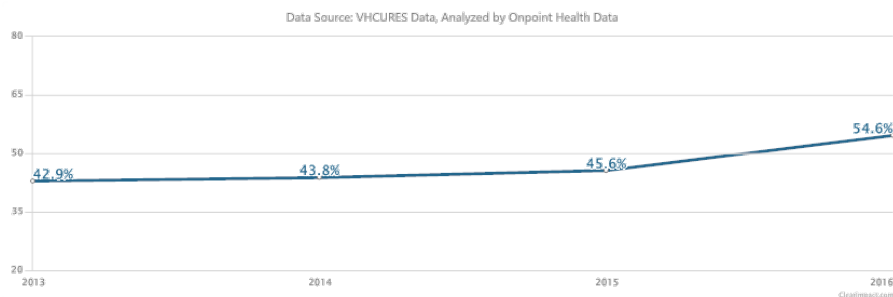
What We Do

The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Women's Health Initiative, Accountable Communities for Health, the Hub & Spoke system of care, Support and Services at Home (SASH), Self-Management and Healthier Living workshops, and a series of learning collaboratives for communities and teams. Blueprint interventions have been shown to maintain or improve health outcomes while controlling growth in health care costs. Of note, the first three have payment models authorized under Vermont's Global Commitment to Health 1115 waiver.

The Patient-Centered Medical Home model utilizes a per patient per month base payment to incentivize primary care practices to be recognized as patient-centered medical homes by the National Committee for Quality Assurance (NCQA). This payment also includes performance-based payments for quality and utilization. The quality payment is determined based on the results of four measures that were selected to be representative of outcomes across the lifespan (developmental screenings that occur within the first three years of life, adolescent well-care visits, and the management of 2 chronic conditions: hypertension and diabetes).

Performance Measures

	Time Period	Actual Value
PM PCMH Developmental Screening in the First Three Years of Life	2016	54.6%
	2015	45.6%
	2014	43.8%
	2013	42.9%



Notes on Methodology

This is a claim-based measure using data from VHCURES that calculates the number of children who turned 1, 2, or 3 years of age in the measurement period who were screened for the risk of developmental, behavioral, and social delays using a standardized screening tool. This is limited to those children with health coverage and attributed to a patient-centered medical home. (NQF #1448)

Partners

1. Patient Centered Medical Homes
 2. Community Health Teams
 3. Vermont Department of Health
 4. Vermont Child Health Improvement Program
 5. Early education and child care professionals
-

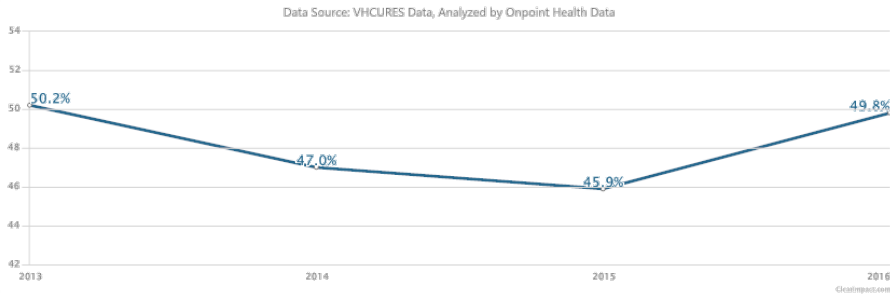
Story Behind the Curve

The Developmental Screening measure was chosen for its potential to positively impact young children at a developmentally critical time. The screenings provide opportunities for early identification and interventions that support improved development and health. Statewide organizations such as the Vermont Department of Health, the Vermont Child Health Improvement Program (VCHIP), and the Blueprint for Health have supported efforts to use data for quality improvement initiatives and increase communication and coordination around child well-being. Currently, each pediatric-service patient-centered medical home receives their practice-level results in semi-annual profiles provided by the Blueprint for Health. At the community level, Brattleboro, Burlington, Middlebury, Windsor, and St. Johnsbury have all supported strategies intended to support family wellness, with many practices prioritizing improving on the Developmental Screening measure.

While this payment model supports all patients in the medical home, regardless of payer, the above data points show the statewide average for Medicaid members attributed to a patient-centered medical home to demonstrate how Medicaid enrollees are faring. The above data indicate that the efforts employed around the state are having a positive impact.

The goal is for a region to perform above the statewide average and demonstrate improvement between measurement periods, or have outcomes in the 90th percentile relative to other regions. HEDIS does not benchmark this measure.

2016	49.8%
2015	45.9%
2014	47.0%
2013	50.2%



Notes on Methodology

This is a claim-based measure using data from VHCURES that calculates adolescents and young adults 12-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. (HEDIS measure.)

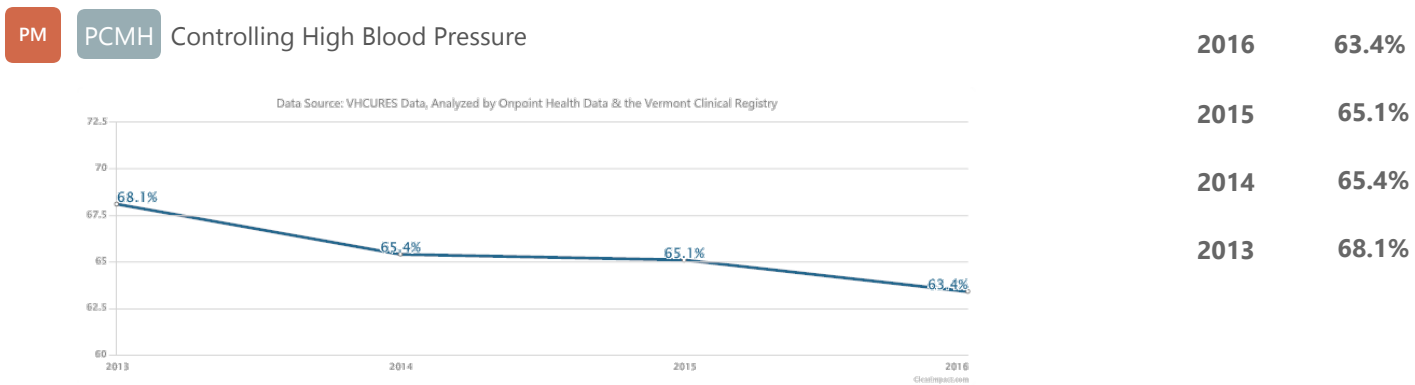
Partners

1. Patient Centered Medical Homes
2. Community Health Teams
3. Vermont Child Health Improvement Program
4. OneCare Vermont
5. School nurses

Story Behind the Curve

Adolescent well-care visits provide an important opportunity to establish lifelong healthy behaviors, identify risk factors (e.g., sexual activity, substance use, depression, etc.), and intervene at an early stage if concerns are raised. However, the percent of adolescents who receive this care frequently drops off except for students participating in sports. Corresponding with the implementation of this measure, several regions, including Barre, Bennington, Burlington, Randolph, St. Albans, and Middlebury, have developed initiatives specifically to increase the number of adolescents receiving well-care. For example, Middlebury improved its follow-up process for reaching patients overdue for their visit by better tracking them, developing outreach material and processes, and implementing a policy of scheduling the next adolescent well-care visit when the patient is in the office for any reason. While this payment model supports all patients in the medical home, regardless of payer, the above data points show the statewide average for Medicaid members attributed to a patient-centered medical home to demonstrate how Medicaid enrollees are faring. The most recent data point suggest that these efforts are having an impact; however these rates remain below the national 50th percentile benchmark of 50.12%, indicating that practices and communities need to continue efforts to improve upon this measure.

The goal is for a region to perform above the statewide average and demonstrate improvement between measurement periods, or have outcomes in the HEDIS 90th Percentile.



This is a hybrid measure using claims data from VHCURES linked to clinical data from the Vermont Clinical Registry (VCR). The measure includes members age 18-85 years, who were identified in claims as having hypertension and who could be linked with a valid blood pressure reading in the VCR. Those members whose last recorded systolic blood pressure was less than 140 mm/Hg diastolic blood pressure was less than 90 mm/Hg were considered to have their hypertension in control. Of note, future measurement for this measure will adhere to the updated guidelines going forward. (NQF #0018)

Partners

1. VT Department of Health
 2. OneCare Vermont
 3. SASH
 4. New England QIN-QIO
 5. Vermont Program for Quality in Health Care
-

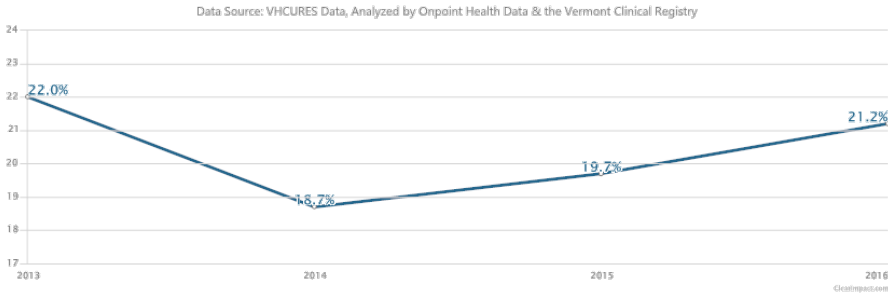
Storv Behind the Curve

Hypertension is a risk factor for much morbidity, including heart disease and stroke, which are leading causes of death in the United States. However, guideline-based medical treatment and increases in healthy behaviors can improve the management of this condition. To achieve better outcomes in this measure, many health service areas have identified hypertension as a regional priority and are working to align medical care with community-based initiatives. For example, the Blueprint for Health, in conjunction with the Vermont Department of Health, OneCare Vermont, SASH, the New England QIN-QIO, and the Vermont Program for Quality in Health Care, launched a 6-month long peer-learning project to support practices implement strategies to improve blood pressure control. Six practices participated in the learning collaborative. These practices implemented strategies that led to improved blood pressure control amongst their patients with hypertension. One practice improved by 13 percentage points. The strategies included panel management, staff training on measuring blood pressure accurately, patient education and self-management planning, home blood pressure monitoring, and motivational interviewing.

While these types of interventions and this payment model support all patients in the medical home, regardless of payer, the above data points show the statewide average for Medicaid members attributed to a patient-centered medical home to demonstrate how Medicaid enrollees are faring. The above data points indicate that overall more work at the practice and communities level needs to be done. The success seen in individual practices shows that improvements in this measure are possible and provides potential options for other practices and regions to follow. Additionally, this measure requires clinical information derived from electronic medical record systems. The measure results are dependent on populating the Vermont Clinical Registry, which is currently limited to those systems that can send machine readable data in standard formats through the Health Information Exchange. Therefore additional work on connectivity and flow of data is also necessary to improve completeness in reporting this measure.

The goal is for a region to perform above the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions.

2016	21.2%
2015	19.7%
2014	18.7%
2013	22.0%



Notes on Methodology

This is a hybrid measure using claims data from VHCURES linked to clinical data from the Vermont Clinical Registry (VCR). The measure includes members age 18 to 75 years identified in claims as having diabetes and who could be linked with valid HbA1c measurement data in the VCR. If the HbA1c glycosylation was greater than nine percent, that member was considered “in poor control”. Increasing rates indicate that the population with diabetes needs additional interventions or is in worse health. (NQF #0059)

Partners

1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. OneCareVermont

Story Behind the Curve

Diabetes affects over 6% of the Vermont population and is a leading cause of death due to chronic conditions. Additionally, those with diabetes or pre-diabetes often go undiagnosed. However, guideline-based early detection, treatment, and self-management can help individuals with diabetes improve control of the disease and improve long-term health outcomes and quality of life. Many regional communities have identified diabetes management as a priority and have implemented initiatives to foster improvements in this area. For example, the Morrisville service area, has been working on follow-up appointment processes and referrals to self-management services for patients with diabetes. The outreach includes identifying those overdue for regular appointments with their primary care provider, emphasizing the importance of regular appointments, training staff to review physician-recommended follow-up, and scheduling the next appointment prior to patients leaving the office. Subsequently, the region saw an improvement in the rate of patients with diabetes who were overdue for an appointment.

The above data points show the statewide average for Medicaid members attributed to a patient-centered medical home to demonstrate how these Medicaid enrollees are faring. The above trend line indicates the rate has improved since 2013; however, the 2015/16 increase indicates more work can be done. Morrisville’s efforts could provide an example for other regions to follow. Additionally, this measure requires clinical information derived from electronic medical record systems. The measure results are dependent on populating the Vermont Clinical Registry, which is currently limited to those systems that can send machine-readable data in standard formats through the Health Information Exchange. Therefore additional work on connectivity and flow of data is also necessary to improve completeness in reporting this measure.

The goal is for a region to perform above the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions. HEDIS does not benchmark this measure.

Actions

Name	Assigned To	Status	Due Date	Progress