

*State of Vermont*  
*Agency of Human Services*

**Global Commitment to Health**  
**11-W-00194/1**

**Section 1115**  
**Demonstration Year: 15**  
**(1/1/2019 – 12/31/2019)**

**Quarterly Report for the period**  
**April 1, 2019 – June 30, 2019**

**Submitted Via PMDA Portal on August 29, 2019**

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## **I. Background and Introduction**

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

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 second quarterly report for waiver year 15, covering the period from April 1, 2019 through June 30, 2019 (QE0619).***

## II. Outreach/Innovative Activities

### i. Provider and Member Relations

#### **Key updates from QE0619:**

- Adult Dental Cap Increase
- MMIS Provider Management Module (PMM)

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.

#### The Provider Management Module (PMM)

The Provider Management Module (PMM) went live on May 1, 2019. This has been a year-long endeavor starting with the signing of Act 166 by Governor Scott on May 1, 2018 mandating enrollment of Medicaid providers in 60 days or less.

The Provider Management Module has now been live for almost 45 days. In that time, over 550 providers have been approved to participate with Vermont Medicaid. As of June 12th, 433 providers are pending enrollment with the average turnaround time to enroll being around 15 days. The provider community has commented on how easy and fast the module is to enroll. We want to take this opportunity to thank each and every staff member who contributed to the success of this IT project – congratulations and well done!

#### Adult Dental Cap Increase

The Provider and Member Relations Unit is working with the Dental Provider Community in order to create awareness regarding the Adult Dental Cap on services increase from \$510 to \$1,000. This increase will go into effect on January 1, 2020. Preventive services will be covered outside of the annual cap without copayment. Changes are pursuant to Vermont General Assembly Act 72 enacted June 18, 2019.

### III. Operational/Policy Developments/Issues

#### i. Vermont Health Connect

##### **Key updates from QE0619:**

- The Customer Support Center received more than 83,880 calls in QE0619, up 6.40% from the previous year when there were less than 79,000 calls in the quarter. The higher volume is attributed to predictable seasonal call variation.
- Vermont Health Connect provided in-person supportive enrollment assistance throughout the state through the Assister Program. As of the end of June 2019, there were 242 Assisters (159 Certified Application Counselors, 2 Navigators, and 81 Brokers), down from 277 at the end of QE0618. The largest decline was in the CAC category, where the program experienced a loss of 41 CACs in the first two quarters of 2019. This decline was attributed to several factors, including the lack of available replacement CACs for when one leaves, the loss of funding outside of the State, and an overall loss of interest in continuing to provide the service. Work continues on program and process improvement, refocusing on CAC training and quality assurance.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised nearly half (46%) of all applications in QE0619. This metric has stayed consistent from QE0618 to QE0619. In addition, 59% of customers made recurring payments in QE0619. This is a 4% growth from the previous year.

#### Enrollment

As of QE0619, more than 195,000 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 122,508 in Medicaid for Children and Adults (MCA) and 73,783 in qualified health plans (QHP), and with the latter divided between 25,856 enrolled with VHC, 7,249 direct-enrolled with their insurance carrier as individuals, and 40,678 enrolled with their small business employer.

#### Member Experience

In preparing for this year's open enrollment, the State is leveraging the information received from the survey that was conducted on Vermont's health insurance marketplace members regarding their experience during last year's open enrollment. The information collected helped to drive the overall communication plan centered on education of the plans, options, and channels for help. This open enrollment, there are five key points the State is ensuring each Vermonter has clear, concise, and direct information on:

- Mandate requirement

- Increased financial help
- Plan comparison tool
- Direct enrollment for Vermonters with no financial assistance
- Ability to self-serve online or to call the call centers

### Medicaid Renewals

Redeterminations for Medicaid for Children and Adults (MCA) continued on their normal cycle during QE0619. The passive renewal success rate for the quarter averaged 32%, a decrease from the monthly averages over the last year. The Zero Authorization logic that identifies if members can be submitted to the Hub for verification has a defect which caused the decrease in the passive renewal success rate. The solution has been identified and the fix will be released into production in August 2019.

Pre-populated renewal applications were sent to the remainder of the population, requiring an active response. As of the last day of the quarter, DVHA-HAEEU had 62 open applications, one of which is older than 45 days.

### 1095 Tax Forms

2018 1095B corrections started to be mailed on 3/11/19. As of 7/17/19, a total of 2,860 corrected 1095B's have been mailed.

### Customer Support Center

Maximus continues to manage the VHC Customer Support Center (call 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 more than 83,880 calls in QE0619, up 6.40% from the previous year when there were less than 79,000 calls in the quarter. The higher volume is attributed to predictable seasonal call variation.

Maximus answered 87% of calls within 24 seconds in April 2019, 86% in May 2019, and 84% in June 2019. With increased staffing and lower call volumes, Maximus met the target in QE0619.

Even with the low call volume and strong performance metrics, Maximus began to hire new staff in June and ended QE0619 with 94 customer service representatives. Hiring was conducted earlier this year for two reasons: first to ensure that performance metrics do not dip in the summer, second to ensure that new staff are fully trained and gain experience well in advance of the next open enrollment.

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. This year has seen an increase in the volume of calls with a slight decrease in the proportion of calls that were escalated. 7.18% of QE0619 calls were transferred to DVHA-HAEEU staff, down from 7.92% in QE0319 which was down from 8% over QE0618. Just as importantly, DVHA promptly answered the calls that were transferred; 96.77% of transferred calls were answered in five minutes in QE0619, compared to 97% in QE0618.

## 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. In QE0316, fewer than 60% of VHC requests were completed within ten days. In QE0317, more than 90% of requests were completed within ten days. In QE0318 and again in QE0319, more than 95% of VHC requests were completed within ten days. In the most recent quarter (QE0619), more than 98% of the VHC requests were completed within the same ten-day time period.

## System Performance

The system continued to operate as expected throughout QE0619, achieving 100% availability outside of scheduled maintenance in each of the three months. The average page load time for the quarter was just over one second (1.42) in each of the three months -- well within the two-second target.

## In-Person Assistance

Vermont Health Connect provided in-person supportive enrollment assistance throughout the state through the Assister Program. As of the end of June 2019, there were 242 Assisters (159 Certified Application Counselors, 2 Navigators, and 81 Brokers), down from 277 at the end of QE0618. The largest decline was in the CAC category, where the program experienced a loss of 41 CACs in the first two quarters of 2019. This decline was due to various reasons including the lack of available replacement CACs for when one leaves, the loss of funding outside of the State, and an overall loss of interest in continuing to provide the service. Work continues on program and process improvement, refocusing on CAC training and quality assurance.

## Outreach

Health insurance literacy was also an outreach focus throughout QE0619. 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, receiving more than 126,000 visits in the quarter – a 19% decrease over 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 12,473 sessions during the quarter.

## Self-Service

During QE0619, 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 QE0619, which is identical to QE0618. More than 6,700 customers made recurring payments per

month in QE0619. Overall, 36% of total payments made per month are recurring payments and 60% of all electronic payments in QE0619 were recurring payments.

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

**Key updates from QE0619:**

- Adult Day Center Closes due to Federal HCBS Regulations
- Conflict Free Case Management System Evaluation in Full Swing

Rate Increases

The Vermont Legislature approved a 2% increase for all Choices for Care home-based (High, Highest & Moderate Needs), Adult Family Care, Enhanced Residential Care and Traumatic Brain Injury (TBI) services effective July 1, 2019.

New Minimum Wage

DAIL implemented new minimum wage requirements found in the State's Collective Bargaining Agreement, for Independent Direct Support Workers. The minimum wage went from \$11.30 an hour to \$11.55 an hour for all employees of self-managed hourly services, and from \$172 per day to \$176.48 per day for daily respite. Using the minimum wages as a starting point, employers are allowed to set their own wages for their employees within their state-approved individualized budget.

Choices for Care Regulations

DAIL is revising the 2009 Choices for Care state regulations into the Health Care Administrative Rules (HCAR) format to modernize the text and better align with Medicaid rules. Included in the proposed new regulations is an increase in the maximum amount of Moderate Needs Case Management services from 12 to 24 hours per calendar year, and a proposed change in how the Moderate Needs wait list is managed from chronological to priority-based. AHS has communicated with CMS about the proposed wait list process change and is planning to submit a new Attachment F after working through the process details with stakeholders this fall.

New Housing Inspection Database

Vermont launched a new housing inspection database for all shared living providers served by Choices for Care, TBI and Developmental Services program. The new database allows the state to better monitor housing inspection data for safety and accessibility and provides a platform for providers to plan and coordinate inspections with their home providers. It is expected that this new process will improve compliance with the state's housing inspection protocol and lead to better outcomes for home providers and consumers.

Wait Lists

- There is currently no wait list for the High Needs Group.
- There continues to be provider wait lists for Moderate Needs Group, estimated at almost 800 people statewide. Because the eligibility criteria for Moderate Needs services is so broad, Vermont does not expect to eliminate the wait list in the near future. However, the state is



planning to revise the wait list procedures from chronological to priority-based in order to serve applicants with the greatest needs first.

- There is currently no wait list for the TBI program.

iii. *Developmental Disabilities Services Division*

**Key updates from QE0619:**

- New payment model in development
- 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. The State has engaged stakeholders including recipients, families, advocacy organizations, and providers to participate in workgroups for the development and implementation of the new payment model.

A provider rate study has been completed and the state is in the process of collecting public comment on the recommended rates. Final recommended rates will be determined after the public input has been analyzed. The information from the rate study 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. An RFP for a standardized assessment tool has been posted and the state is considering the one bid it received. Changes are being made to prepare MMIS to accept encounter claims to document service delivery. Providers are preparing their systems to be able to report the encounter data. Ongoing work will be required regarding changes to the payment methodology, including seeking any needed CMS approval.

HCBS Rule Implementation

DDSD continues to work on implementing the HCBS rules to ensure compliance with all requirements. Currently the state is working on addressing the issue of conflict of interest in case management. DVHA is working with departments who operate HCBS programs, including DDSD, to analyze HCBS case management across the state and is seeking stakeholder input on how to address any potential conflict of interest in each of the programs. During quarters 2 and 3, the State will develop proposals, seek additional stakeholder input on those proposals, and plan for implementation.

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 by the State from providers to determine individuals with developmental disabilities (DD) who are waiting for DD services but are not currently eligible. HCBS funding priorities are the method

by which Vermont prioritizes who will receive caseload funding allocated annually by the legislature. Individuals are placed on the waiting list if they meet the following criteria:

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

As of 6/30/19, 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 2019 Annual GC Report.

iv. *Global Commitment Register*

**Key updates from QE0619:**

- 20 policies were posted to the GCR in Q2 2019.
- Since the Global Commitment Register (GCR) launched in November 2015, 182 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 20 policies were posted to the GCR this past quarter. This includes 14 proposed changes and 6 final changes. Changes to rates and/or rate methodologies accounted for over half of the changes. Other changes include clinical coverage changes, administrative rulemaking notices, State Plan Amendment notices, and updated 2019 financial eligibility standards for MAGI-based Medicaid.

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

v. *Substance Use Disorder Program (SUD Demonstration Monitoring Report)*

**1. Title Page for Vermont’s SUD Components of the Global Commitment to Health Demonstration**

State	Vermont
Demonstration Name	Global Commitment to Health 1115 Demonstration
Approval Date	July 1, 2018
Approval Period	July 1, 2018 – December 31, 2021
SUD (or if broader demonstration, then SUD Related) Demonstration Goals and Objectives	<i>Enter summary of the SUD (or if broader demonstration, then SUD related) demonstration goals and objectives as summarized in the STCs and/or demonstration fact sheet.</i>

**2. Executive Summary**

During the second quarter of 2019 the State of Vermont continued to have all ASAM levels of care available and no ongoing waitlist to access Medication Assisted Treatment. The Vermont Department of Health’s Division of Alcohol and Drug Abuse Programs (ADAP) continues using the scoring tool to determine the Preferred Providers’ compliance and certification status.

ADAP continues to develop the value-based payment model for residential programs, to align with its All Payer Model Agreement with CMS, for implementation in 2020.

ADAP executed a contract for the Centralized Intake and Resource Center (CIRC) with Health Resources in Action (HRiA). The major components are: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to centrally manage appointments with ADAP’s Preferred Provider Network.

The Substance Misuse Prevention Oversight and Advisory Council replaces Vermont’s Opioid Coordination Council. The new Council encompasses all substances of misuse including tobacco. Working committees have been formed that include a focus on intervention, treatment, recovery and families.

Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018 at three sites. Currently, there are six sites up and running. 1,090 individuals were seen in the EDs from July 1, 2018 – June 30, 2019. Four additional sites are in the planning stage (with one Recovery Center serving 2 hospitals).

The plan for the SUD Mid-Point Assessment was determined. An internal team has been established and is executing the plan.

**3. Narrative Information on Implementation, by Reporting Topic**

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
<b>1.2 Assessment of Need and Qualification for SUD Services</b>			
<b>1.2.1 Metric Trends</b>			
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.			
<b>1.2.2 Implementation Update</b>			
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 updates 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
<b>2.2 Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)</b>			
<b>2.2.1 Metric Trends</b>			
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.			
<b>2.2.2 Implementation Update</b>			
<p><b>Prompts:</b> 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>			
<b>Summary:</b> There are no planned changes to access to SUD treatment or the SUD benefit coverage.			
Are there any other anticipated program changes that may impact metrics related to access to critical levels of care for OUD and other SUDs? If so, please describe these changes.			There are no anticipated program changes.
<input checked="" type="checkbox"/> The state has no implementation updates 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
<b>3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)</b>			
<b>3.2.1 Metric Trends</b>			

The state is not reporting any metrics related to this reporting topic.

### 3.2.2 Implementation Update

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

- a. Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria?
- b. Implementation of a utilization management approach to ensure:
  - i. Beneficiaries have access to SUD services at the appropriate level of care?
  - ii. Interventions are appropriate for the diagnosis and level of care?
  - iii. Use of independent process for reviewing placement in residential treatment settings?

**Summary:** The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 23 substance use disorder treatment providers.

The application for the recertification moved to an online survey process in March 2018. This online survey makes the utilization of the Compliance Assessment Tool for the different ASAM Levels of Care more efficient. The providers completing the survey will indicate their level of care and will submit documents based on the level of care indicated. This survey has undergone additional changes to ensure that documentation is as thorough as possible and is now available for new programs as well.

#### Milestone 2 - Table 1

Action	Revised Completion Date	Responsible	Status
Finalize Substance Use Disorder Treatment Standards	August 1, 2018	Director of Quality Management and Compliance	Completed
Update Compliance Assessment Tool with revised Substance Use Disorder Treatment Standards and all residential ASAM criteria	August 15, 2018	Director of Quality Management and Compliance	Completed
Updated online recertification survey to reflect new revision of Substance Use Disorder Treatment Standards	October 31, 2018	Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Vergennes)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Bradford)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Implement the Compliance Assessment Tool	October 3, 2018	Director of Clinical Services; Director of	Completed

		Quality Management and Compliance	
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	Completed
Use of the Compliance Assessment Tool to certify ASAM Level 3.2-WM Level of Care Provider (Act 1/Bridge)	March 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Completed

Vermont continues to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The value-based portion of the new model is anticipated to be implemented in 2020. Milestone 2 – Table 2 (below) will be updated in the third quarter report of 2019.

**Milestone 2 – Table 2**

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

Are there any other anticipated program			
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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.			
<input type="checkbox"/> The state has no implementation updates 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
<b>4.2 Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)</b>			
<b>4.2.1 Metric Trends</b>			
<input checked="" type="checkbox"/> The state is not reporting any metrics related to this reporting topic.			
<b>4.2.2 Implementation Update</b>			
<p><b>Prompts:</b> 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"> <li>Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards?</li> <li>State review process for residential treatment providers’ compliance with qualifications standards?</li> <li>Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site?</li> </ol> <p><b>Summary:</b> The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 23 substance use disorder treatment providers.</p> <p>The application for the recertification moved to an online survey process in March 2018. 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. This survey has undergone additional changes to ensure that documentation is as thorough as possible and is now available for new programs as well.</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>			
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.			
<input type="checkbox"/> The state has no implementation updates 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
<b>5.2 Sufficient Provider Capacity at Critical Levels of Care including Medication Assisted Treatment for OUD (Milestone 4)</b>			
<b>5.2.1 Metric Trends</b>			
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.			
<b>5.2.2 Implementation Update</b>			
<p><b>Prompts:</b> 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><b>Summary:</b> Vermont continues to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The value-based portion of the new model is anticipated to be implemented in 2020.</p> <p>ADAP executed a contract for the Centralized Intake and Resource Center (CIRC) with Health Resources in Action (HRiA). The major components are: 1) a call center staffed by certified Screening &amp; Intake Specialists and licensed clinicians, 2) a website with information related to</p>			

SUD and a self-screen tool, and 3) an appointment board to centrally manage appointments with ADAP's Preferred Provider Network.			
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 updates 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
<b>6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)</b>			
<b>6.2.1 Metric Trends</b>			
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.			
<b>6.2.2 Implementation Update</b>			
<p><b>Prompts:</b> 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"> <li>Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD?</li> <li>Expansion of coverage for and access to naloxone?</li> </ol> <p><b>Summary:</b> The are no planned changes to the prescribing guidelines and other interventions.</p>			
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 checked="" type="checkbox"/> The state has no implementation updates 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
<b>7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)</b>			
<b>7.2.1 Metric Trends</b>			
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.			
<b>7.2.2 Implementation Update</b>			
<p><b>Prompts:</b> 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><b>Summary:</b> Vermont launched the Recovery Coaches in the Emergency Department Program at six sites with four more sites in the planning stage. A total of 1090 individuals have been seen by recovery coaches.</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 updates to report for this reporting topic.			

**SUD Health Information Technology (Health IT)**

*This reporting topic focuses on SUD health IT to assess the state’s progress on the health IT portion of the implementation plan.*

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
<b>8.2 SUD Health Information Technology (Health IT)</b>			
<b>8.2.1 Metric Trends</b>			
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.			
<b>11.2.2 Implementation Update</b>			
<p><b>Prompts:</b> 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"> <li>How health IT is being used to slow down the rate of growth of individuals identified with SUD?</li> <li>How health IT is being used to treat effectively individuals identified with SUD?</li> <li>How health IT is being used to effectively monitor “recovery” supports and services for individuals identified with SUD?</li> <li>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?</li> <li>Other aspects of the state’s health IT implementation milestones?</li> <li>The timeline for achieving health IT implementation milestones?</li> <li>Planned activities to increase use and functionality of the state’s prescription drug monitoring program?</li> </ol> <p><b>Summary:</b></p> <ul style="list-style-type: none"> <li>Vermont has a requirement and funding in the current contract with Appriss to connect VPMS to RxCheck for interstate data sharing. RxCheck is developing functionality for direct integration with EHRs and other health systems. Appriss indicates that because Vermont plans to use RxCheck for connecting to health systems/EHRs it is outside the scope of the Appriss contract; this continues to be worked on.</li> <li>Funding through the Center for Disease Control and Prevention, and the Bureau for Justice Administration requires the connection to RxCheck. The requirements to update and revise the MOU for the connection to RxCheck is in process.</li> <li>The current contract for the VPMS will be put out to bid later this year. The request for proposal (RFP) will include high priorities such as improved access and support for providers, integration and data management, and increased reporting functionality.</li> </ul>			

- VPMS, Dr. First and Appriss are testing and verifying Appriss’s Gateway integration tool to enable direct population of VPMS data into Dr. First’s prescription ordering section, eliminating the need for providers to navigate between systems. This project has been put on hold until the fall to accommodate updates made to the Dr. First platform.
- VPMS staff are engaged with the NESCSO State HIT Learning Community. This group works to create a shared understanding of Federal legislation, the current state of PDMP activities, and identifies opportunities for multi-state alignment.
- VPMS staff participated in interviews for the development of statewide data integration opportunities. These interviews were with the contractor tasked with developing the health IT infrastructure plans for the HIE Steering Committee and will be compiled with other data systems needs and requirements for integration.
- VDH promoted the availability of technical assistance at the prescriber level. Promotion was integrated into the implementation of prescriber insight reports; the impact of implementation of the insight reports is being evaluated. Insight reports include metrics for providers about the prescriptions dispensed that they prescribed and comparisons with other providers within their specialty. Vermont continues to offer prescriber reports on a quarterly basis.
- VDH is conducting an impact evaluation of the 7/1/17 pain prescribing rule change; evaluation plan in place 12/2018. The goals are: assess the impact of the new prescribing rules on prescribing patterns, determine if new prescribing rules affect awareness/usage of VPMS and evaluate impact of stricter prescribing rules on future prescription opioid misuse. VDH continues to monitor trends to look for sustained change over time.
- The Centralized Intake and Resource Center (CIRC) will encompass a call center, public-facing informational website, and a web-based appointment board that will be leveraged to support waitlist management and interim services provision. The contract with Health Resources in Action (HRiA) has been executed.

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

Other SUD-Related Metrics

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
<b>9.2 Other SUD-Related Metrics</b>			
<b>9.2.1 Metric Trends</b>			
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.			
<b>9.2.2 Implementation Update</b>			
Are there any other anticipated program changes that may impact the other SUD-related metrics? If so, please describe these changes.			
<input checked="" type="checkbox"/> The state has no implementation updates to report for this reporting topic.			

Budget Neutrality

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
<b>10.2 Budget Neutrality</b>			
<b>10.2.1 Current status and analysis</b>			
Discuss the current status of budget neutrality and provide an analysis of the budget neutrality to date. If the SUD component is part of a comprehensive demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality as a whole.			Updates on Budget Neutrality can be found in Section V. <i>Financial/Budget Neutrality Development/Issues</i> of this report.
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
<b>10.2.2 Implementation Update</b>			
Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no implementation updates to report for this reporting topic.			

SUD-Related Demonstration Operations and Policy

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
<b>11.1 SUD-Related Demonstration Operations and Policy</b>			
<b>11.1.1 Considerations</b>			
<p>Highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.</p>			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no related considerations to report for this reporting topic.			
<b>11.1.2 Implementation Update</b>			
<p>Compared to the demonstration design and operational details outlined in STCs and 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"> <li>a. How the delivery system operates under the demonstration (e.g.</li> </ol>			

through the managed care system or fee for service)? b. Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes)? c. Partners involved in service delivery?			
Has the state experienced any significant challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers)? Has the state noted any performance issues with contracted entities?			
What other initiatives is the state working on related to SUD or OUD? How do these initiatives relate to the SUD demonstration? How are they similar to or different from the SUD demonstration?			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no implementation updates to report for this reporting topic.			

SUD Demonstration Evaluation Update

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
<b>12.1 SUD Demonstration Evaluation Update</b>			
<b>12.1.1 Narrative Information</b>			
Provide updates on SUD evaluation work and timeline. The appropriate content will			Updates on the SUD evaluation work, deliverables, and timeline can be found in Sections VIII. <i>Quality Improvement</i> and



depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			IX. <i>Demonstration Evaluation</i> of this report.
Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
<b>10.2.2 Implementation Update</b>			
Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no SUD demonstration evaluation update to report for this reporting topic.			

Other Demonstration Reporting

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
<b>13.1 Other Demonstration Reporting</b>			
<b>13.1.1 General Reporting Requirements</b>			
Have there been any changes in the state's implementation of the demonstration that might necessitate a change to approved STCs, implementation			

plan, or monitoring protocol?			
Does the state foresee the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes?			
Compared to the details outlined in the STCs and the monitoring protocol, has the state formally requested any changes or does the state expect to formally request any changes to: <ul style="list-style-type: none"> <li>a. The schedule for completing and submitting monitoring reports?</li> <li>b. The content or completeness of submitted reports? Future reports?</li> </ul>			Updates on the Monitoring Protocol work, deliverables, and timeline can be found in Section X. <i>Compliance</i> of this report.
Has the state identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation?			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no updates on general reporting requirements to report for this reporting topic.			
<b>13.1.2 Post Award Public Forum</b>			
If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was			

held and in the annual report.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> There was not a post-award public forum held during this reporting period and this is not an annual report, so the state has no post award public forum update to report for this reporting topic.			

Notable State Achievements and/or Innovations

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
<b>14.1 Notable State Achievements and/or Innovations</b>			
<b>14.1 Narrative Information</b>			
Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no notable achievements or innovations to report for this reporting topic.			

**IV. Expenditure Containment Initiatives**

i. *Vermont Chronic Care Initiative (VCCI)*

**Key updates from QE0619:**

- Strategic planning continues with DVHA Payment Reform Team and ACO for continued alignment of service delivery to Vermont.
- Geographic Attribution Methodology pilot continues in one HSA; three VCCI staff with access to Vermont ACO Care Navigator as communication platform.
- System acceptance of the AHS MMIS Enterprise Care Management system; CMS certification is in process.
- Admissions | Discharge | Transfer messaging from VHIE functional in care management system.
- VITL Informed Consent – VCCI actively signing members on in anticipation of change to opt in as default for consent.
- VITL Single Sign On (SSO) was deployed to the Care Management system.
- VCCI partnership with Vermont Department of Corrections on coordination of treatment upon member’s release, to include population receiving (Hepatitis C+) HCV treatment.

The VCCI is a statewide Medicaid case management service for Medicaid beneficiaries. VCCI is comprised of licensed, field-based case managers and two non-licensed professional staff who operate in a decentralized VCCI model statewide, providing case management resources at the community level. Facilitation of access to clinically appropriate health care information and services; coordination of the efficient delivery of health care by attempting to remove barriers, bridge gaps, and avoid duplication of services; and education and empowering beneficiaries to eventually self-manage their chronic conditions are longstanding goals. Historically, VCCI has provided intensive, short term case management services to those who were predicted to be high cost/high risk. This was premised on reports highlighting that the top 5% of Medicaid beneficiaries accounted for ~39% of Medicaid expenditures.

The emergence of the Accountable Care Organization (ACO) and a subsequent increase in the number of attributed lives to the Vermont Next Generation Medicaid ACO prompted the review of who VCCI would deliver case management services to and how best to deliver these services, as ACO attributed beneficiaries are not eligible to receive VCCI services. At the end of 4<sup>th</sup> quarter 2018, VCCI had implemented state-wide the enhancements to population served, and to the model of service delivery. The VCCI program shifted from a model of serving only high-risk beneficiaries, to include at-risk population and members new to the health plan. The at-risk population may include beneficiaries identified by their healthcare and social service community providers, as in need and potentially able to benefit from VCCI case management services - due to healthcare needs as well as challenges with social determinants of health such as housing, food security, and transportation issues. Outreach to beneficiaries new to Medicaid continues with initial screen of members and their access to primary care, current health conditions, risky behaviors, and social determinants of health.

Current revision to new to Medicaid screening includes edit of question about PCP wait times to ask specific wait times for preventive care/wellness appointment, and the addition of dental care access questions. The goals are to 1) orient the beneficiary to the system of care, including navigation of services for health-related needs such as housing/food security and facilitating connections to local domestic violence resources, and 2) onboard beneficiaries ahead of their anticipated ACO attribution to facilitate access to primary care and connect to community resources, including self-management programs. Beneficiaries’ responses to screening questions coupled with the clinical judgment of VCCI case managers allows stratification into 1 of 4 risk levels – mirroring the ACO’s framework.

**Table 1. Q2 CY data on new to Medicaid beneficiaries screened & establishment of primary care home**

% of New to Medicaid members who accepted help with PCP establishment and who successfully established care with practice/medical home	SFY19
	Q4
Measure	7/15/2019
# of "New to Medicaid" members who already had a PCP they saw regularly (of those screened)	289
# who didn't have a PCP and declined help	21
# who didn't have a PCP and accepted help	51
# of members who successfully established care	11
% of members who successfully established care	21.57%

Total number of members screened was 356, with 289 reporting they had PCP established. As a program, the VCCI are indicating successful establishment when actual appointment is scheduled. Identified barriers to timely PCP establishment include: 1) Primary care offices' requirement for former medical records prior to scheduling new patient appointment, and 2) practices not accepting any new members due to shortage of providers. VCCI has been working with DVHA leadership, community health teams and Bi-State Primary Care Association to begin to learn processes, establish and share best practices and subsequent collaboration to create solutions.

In continued efforts to align with the healthcare reform and the ACO, the VCCI has been meeting with DVHA leadership and colleagues to include Payment Reform and the Blueprint; and the ACO. Initial work is focused on assessing opportunities for alignment in service delivery of the Care Model. Pilot effort is underway in one health service area to assess non-ACO members for collaborative and strategic member outreach. Pilot team includes Payment Reform, Blueprint, ACO, health service area leaders, and community team members. The population cohort is analyzed and broken down into different buckets, including those without any claims that demonstrate connectedness to community and those with claims but without any E & M codes. This past quarter, VCCI focused on 1) testing the current NTM outreach screening tool on a cohort of members not new to Medicaid, but without any evidence of claims 2) continued facilitation to community services including primary and dental care 3) use of complex care model in high risk members and 4) ability to see + use of Vermont's ACO Care Navigator platform as communication tool.

It has been determined that the current NTM screening tool is appropriate to use for outreach to members that are not new to the health plan and who do not have claims to show access to primary care. In instances when members did have primary care establishment and the claims did not show up in claims due to the report run dates, our team continued with the screening to assess access to dental care, hospital utilization, depression screening, presence of inter partner violence, and risky behaviors. For beneficiaries successfully outreached, and those screened as high risk | complex, VCCI continues to lead the way with implementation of the complex care model, using patient engagement tools, supporting member identification of a lead care coordinator and the development of a shared care plan. A new development this past quarter was that three VCCI staff were granted access and receiving initial training in Care Navigator, Vermont's ACO communication platform. Staff have just begun to utilize this tool and expect to leverage this as common communication platform on high risk members in this service area. This pilot was built upon the current foundation of the strong local partnerships and communication that exist in this service area as well as community team readiness.

The VCCI approaches case management from the lens that a holistic model of service delivery to encompass both health and health related issues, helps to support likelihood of sustained health improvement and overall quality of life. Assessment of the presence of social determinants of health occurs early in VCCI's outreach and work, followed by appropriate referrals and navigation to services. In addition to the experience out in the field, VCCI case managers easily navigate the web of various state services available to Vermonters. To that end, VCCI has started to receive a report highlighting Vermonters who are impending loss of health coverage. VCCI then reviews members who are enrolled with VCCI, alerts the assigned field-based case manager, who then helps to facilitate action steps needed to ensure continued coverage. It is the goal that the VCCI team would be a supplemental resource to help support complex members in avoiding loss of health care coverage. It is expected that VCCI will receive monthly reports and will easily continue to incorporate this into their daily workflow.

This quarter, the VCCI continued to work with the Agency of Human Services Field Directors on practical ways to address some of the barriers that members encounter when attempting to access General or Emergency Assistance (GA | EA) benefits. When members are inpatient in a hospital, it is hard for them to attend the face to face interview required to maintain a benefit, that may help support their housing +/- help pay the copays necessary on required Rx. The VCCI and AHS GA teams were able to brainstorm and have proposed solution eliminating the requirement of face to face interviews, for certain cohorts and will test this in the upcoming quarter.

This past year marks the 3<sup>rd</sup> year that the VCCI team has been functional in the eQHealthCare Management system. System acceptance was achieved, and CMS certification is in process. All VCCI staff have been trained in VITL access (external to eQHealth care management system) in order to view patient information, as appropriate, to help better inform the case management plan and will have subsequent training as needed. VITL interface allows users to utilize data that was previously viewed in other systems such as provider or facility systems. Users have the ability to see facility visits, Continuing Care Documents, and labs. This past quarter, Admissions | Discharges | Transfers (ADT) messaging from the Vermont Health Information Exchange (VHIE) became functional with alerts to VCCI case managers on assigned cases that were in the hospital. This allows for point in time collaboration to occur with hospital case managers, and for timely follow up of a hospital stay. During the next quarter, VCCI will work with departmental colleagues to assess if practical for their receipt of ADT messaging on population. The statewide VCCI also launched obtaining informed consent to VITL, with their assigned members in order to help support information exchange.

A collaborative team of the VCCI, DOC, and DVHA's Chief Medical Officer continued initial conversations started in the first quarter on how best to coordinate treatment for inmates being released from correctional facility- specifically those with HCV treatment initiated. Current workflows continue to be developed that help to gain efficiencies in information sharing; and in the utilization of already paid for Rx. The referral process to VCCI has been started with next quarter work to focus on ongoing development of workflow, data collection and measurement of success.

ii. *Blueprint for Health*

**Key updates from QE0619:**

- 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 primary care practices are Blueprint-participating practices, out of an estimated 169 total primary care practices operating in the state, of which an estimated 148 employ more than one provider;
- Vermont continues to demonstrate increased access to medication assisted treatment for Vermonters with opioid use disorder, as evidenced by the 3,157 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of December 2018 and the 3,064 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of March 2019;
- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 38 practices to participate in the Women's Health Initiative as of March 2019.

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 313,172 insurer-attributed patients, of which 100,778 are Medicaid enrollees. Attribution to a practice is determined by the practice at which the patient has received the majority of their primary care within the 24 months prior to the date the attribution process is conducted. These practices and patients are supported by 160 full-time equivalents of Community Health Team staff.

### Quarterly Highlights

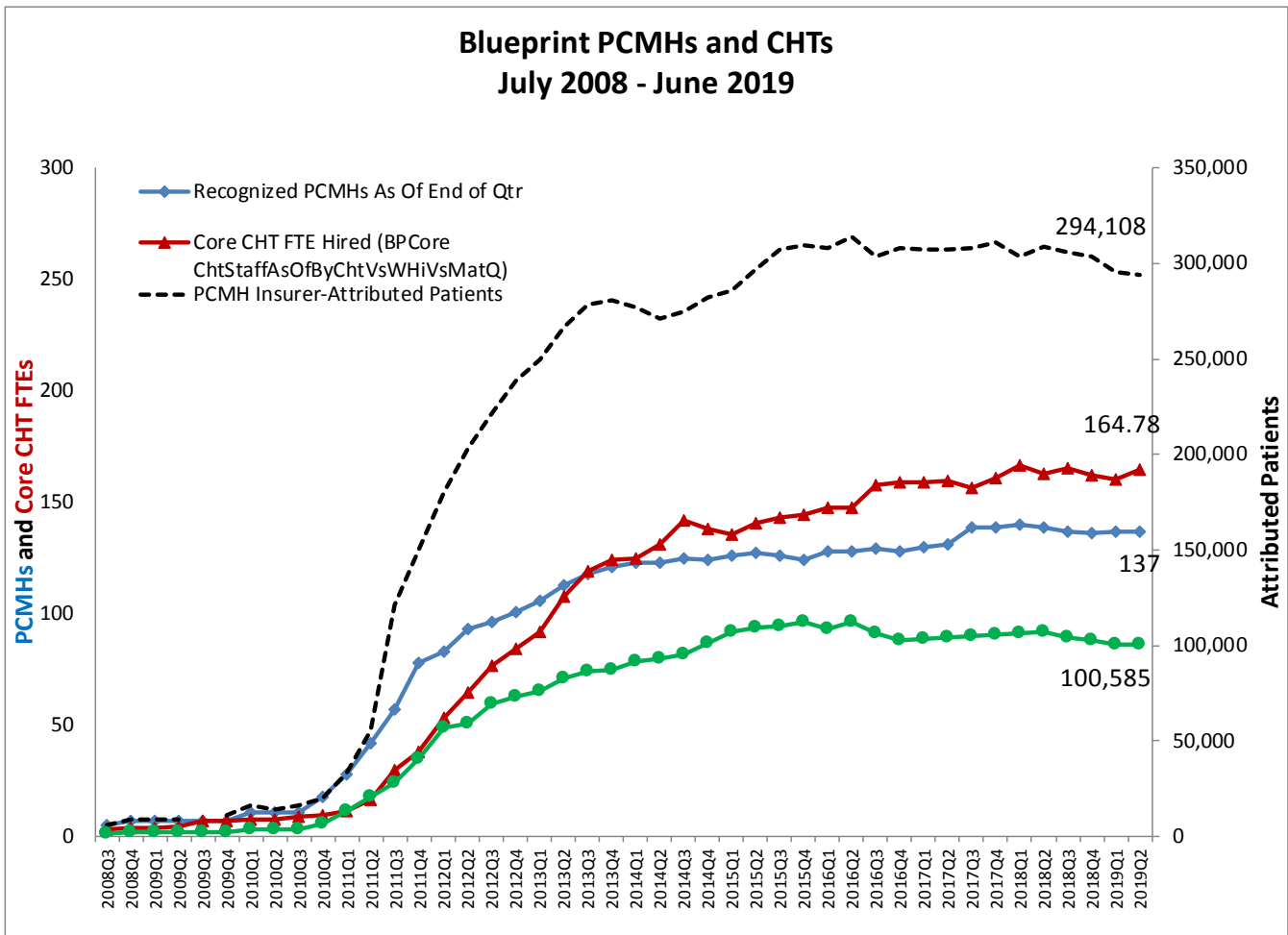
At the end of the 2nd quarter of 2019, 137 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 169 total primary care practices operating in the state, of which an estimated 148 employ more than one provider.

During the first two quarters of 2019, new and renewing practices went through the 2017 NCQA Patient-Centered Medical Home recognition process. This new recognition process has been greatly streamlined and is composed of three tracks based on a practice’s history as a Patient-Centered Medical Home. Once practices have reached the sustaining renewal track after the first year of initiation or engagement, the documentation and evidence required for recognition each year has been consolidated from more than 60 criteria requiring evidence down to 15 to 20. Due to the change in reporting timeline the cost for renewal has also decreased and for many practices will be less than it would have been for the 3-year cycle.

This means that practices can shift their focus to improving patient outcomes for measures the practices have chosen based on the practice’s needs rather than focus on time-consuming documentation of evidence for a broad set of generic activities required for all practices. For most practices this has also reduced the preparation time for renewal from an intense 6-8 months down to 2-3 months of simple data gathering.

### **Figure 1. Patient-Centered Medical Homes (PCMH) and Community Health Teams (CHT)**





### Practice Health Profiles and Community Health Profiles

The Blueprint for Health supports data-driven population health improvement by producing profiles that describe the health status and health care utilization, expenditures, and outcomes of individuals in each community (health service area) and patients in each Patient-Centered Medical Home. In 2018, production of these profiles shifted from semi-annual to annual. Both practice-level and community-level profiles use all-payer administrative data, clinical outcomes, and survey information for adult and pediatric populations. Practice Health Profiles help practices identify ways that they can better serve their patients and track the success of quality improvement initiatives. Community Health Profiles 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. As mentioned in the last report, significant changes were made in how data is reported back to the communities. These changes include:

- Reporting on outcomes for all Vermont residents with claims in the Vermont All Payer Claims Database (VHCURES) that reside within a specified health service area instead of those patients attributed to a practice within that health service area. This shift captures a more representative “whole population” sample;
- Breaking out reporting on individuals attributed to a Blueprint for Health Patient-Centered Medical Home, those receiving the majority of their primary care from another practice, which could include specialists or out-of-state practice, and those with no record of a primary care

visit within the last two years meaning no attribution to primary care.

This transition to a more complete representation of a hospital service area's population better meets the needs of those using these profiles and has allowed them to be of use in Vermont's hospital budget approval process and Health Resource Allocation Plan, both responsibilities of the state's health care regulatory body, the Green Mountain Care Board. Onpoint Health Data continues to produce these profiles. 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
- ix. 01/2017 – 12/2017

Practice Health and Community Health Profiles for the data period 01/2018 – 12/2018 are anticipated to be produced and distributed in October 2019. The currently available Community Health Profiles, including the most recent period 01/2017 – 12/2017, are posted at <http://blueprintforhealth.vermont.gov/community-health-profiles>.

The Blueprint for Health Central Office team has actively been working with stakeholders to redesign the practice level profiles with intent to offer these new products at the next distribution of profiles.

### Hub & Spoke Program

Medication-assisted treatment for opioid use disorder is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a “whole patient” approach to the treatment of opioid use disorder. The Hub and Spoke system of care in Vermont provides medication-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, Spokes) in community-based medical practice settings. 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 & 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 2nd quarter of 2019, capacity for receiving medication-assisted treatment in Spoke settings continued to increase, as evidenced by 3,057 Vermonters with Medicaid insurance receiving medication-assisted treatment for opioid use disorder from 273 prescribers and 70.7 full-time equivalent Spoke staff, working as teams, across more than 85<sup>1</sup> different Spoke settings (as of June 2019).

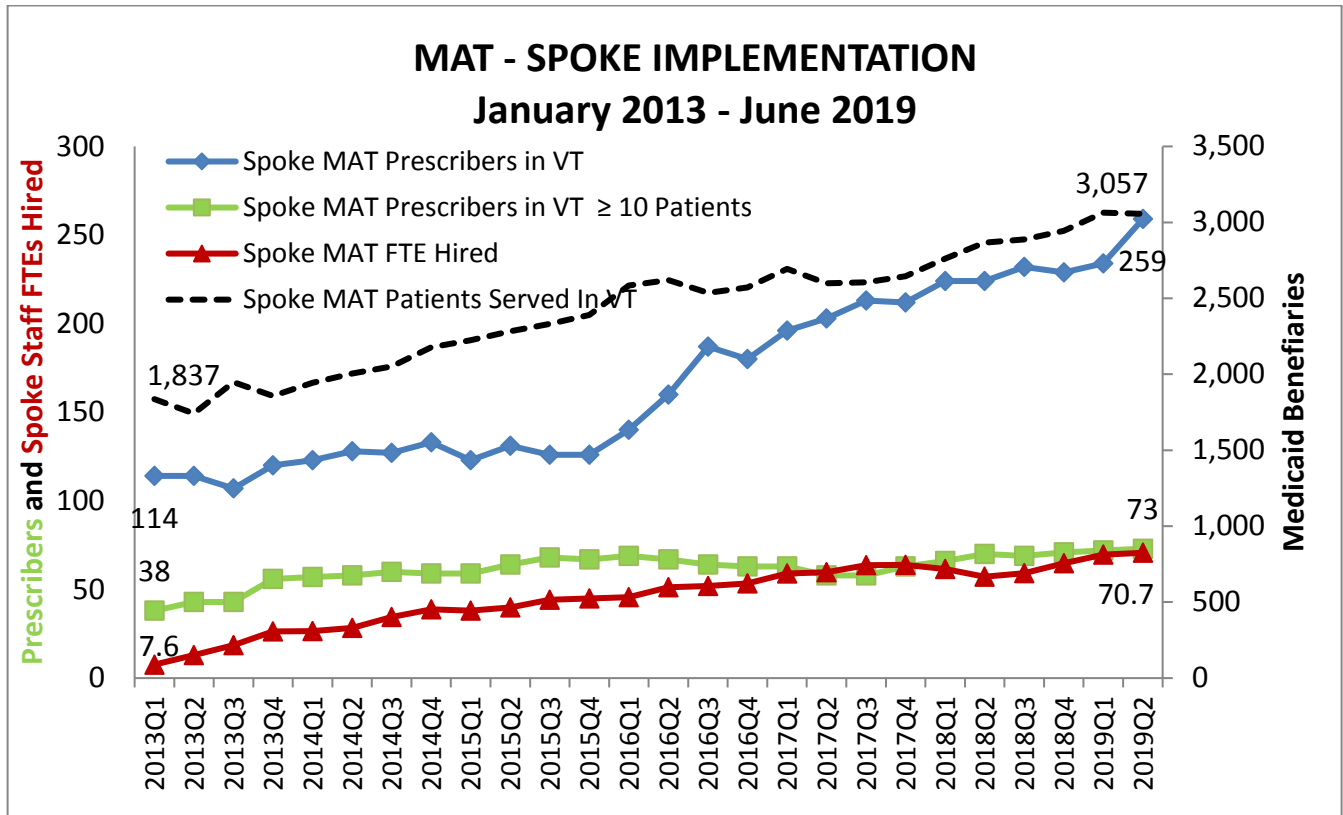
### Quarterly Highlights

- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid use disorder, as evidenced by the 3,774 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of June 2019 and the 3,057 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of June 2019.
- Medication-assisted treatment for opioid use disorder is being offered across the State of Vermont by more than 86 different practices and by 273 medical doctors, nurse practitioners and physician assistants who work with 70.7 FTE licensed, registered nurses and licensed, Master’s-prepared, mental health / substance use disorder clinicians as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder (as of June 2019).
- A learning session this quarter concluded a series of four gatherings that brought together Spoke teams from around the state to learn about practice innovations and best practices in opioid use disorder treatment. These sessions were planned collaboratively by the Department of Vermont Health Access – Blueprint for Health and the Vermont Department of Health – Division of Alcohol and Drug Abuse Programs along with clinical content experts. The two most recent meetings took place in March 2019 and May 2019. The March session featured effective management of co-occurring mental health and substance use disorders. The May 29<sup>th</sup> session focused on treating polysubstance use and clinically appropriate drug testing in patients receiving medicated-assisted treatment.

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<sup>1</sup> Number of Spoke settings is defined as the number of unique zip codes where there is at least one active Spoke provider.

Figure 2. MAT-SPOKE Implementation January 2013 – June 2019



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 (June 2019).

**Table 2. Hub Implementation by Region as of June 2019**



Hub Census and Waitlist: June 2019

Region	# Clients	# Buprenorphine	# Methadone	# Vivitrol	# Receiving Treatment but Not Yet Dosed	# Waiting
Chittenden, Addison	1002	260	742	0	0	0
Franklin, Grand Isle	413	177	235	1	0	0
Washington, Lamoille, Orange	480	138	342	0	0	0
Windsor, Windham	637	98	535	0	4	0
Rutland, Bennington	410	104	294	0	12	0
Essex, Orleans, Caledonia	832	235	593	2	2	0
<b>Total</b>	<b>3774</b>	<b>1012</b>	<b>2741</b>	<b>3</b>	<b>18</b>	<b>0</b>

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

Vermont Department of Health

Source: Alcohol and Drug Abuse Treatment Programs

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.

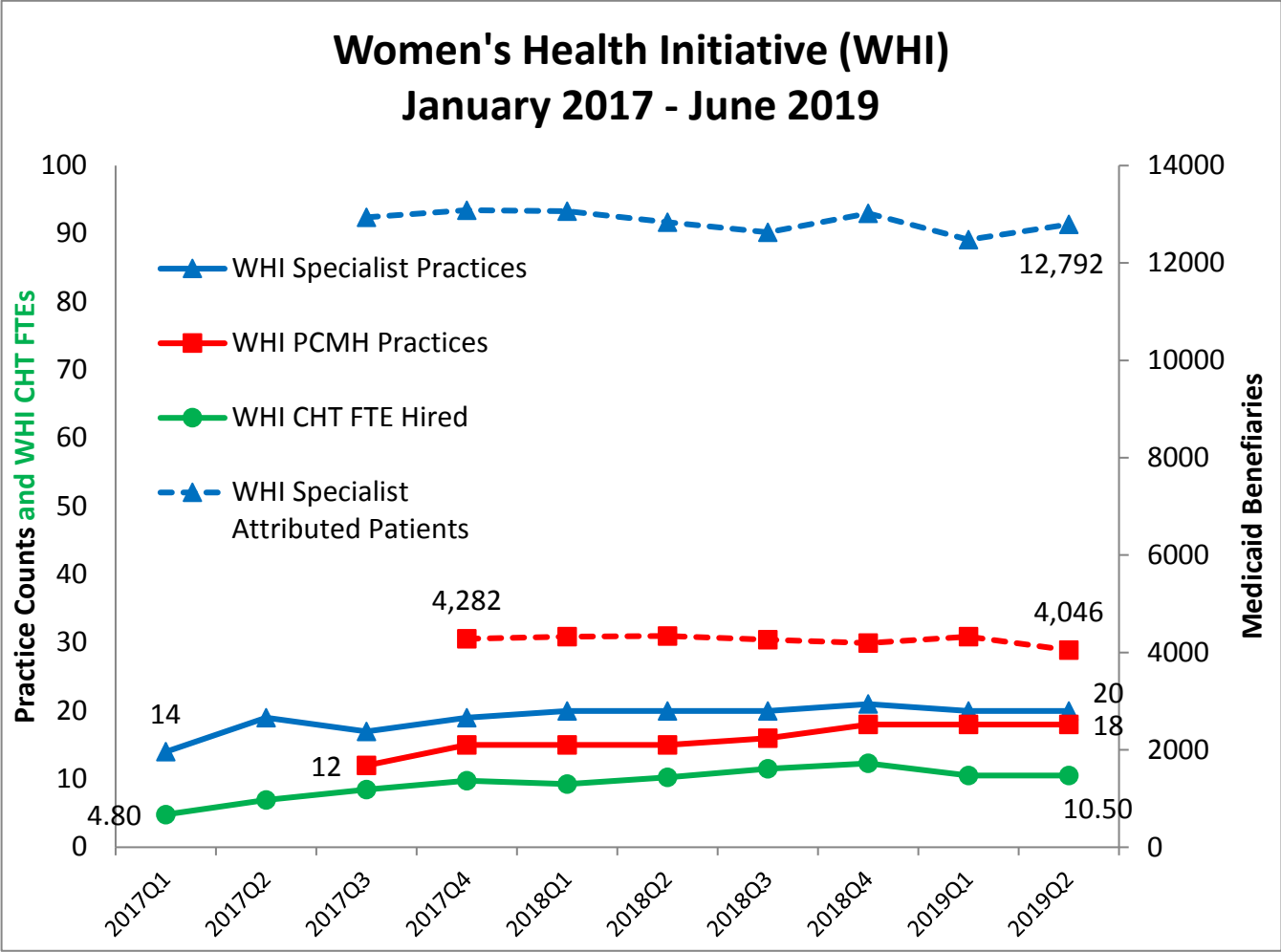
The payments associated with participating in the Women's Health Initiative support women's health and primary care practices in designing workflows that support the enhanced psychosocial screening, comprehensive family planning counseling, and same-day LARC insertion and support the provision of effective 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 38 practices (20 women's health and 18 primary care) to participate in the Women's Health Initiative as of June 2019.
- The Women's Health Initiative (WHI) is approaching statewide coverage, as all but two Hospital Service Areas 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.

In May the Blueprint for Health, in collaboration with an analytics contractor, Onpoint Health Data, released 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 Community Health Team (CHT) Staffing**



**Table 3. Women’s Health Implementation by Region**

Health Service Area / Team	WHI Specialist Practices as of June 2019	WHI PCMH Practices as of June 2019	WHI CHT Staff FTE Hired as of June 2019	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of June 2019	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of June 2019
Barre	1	1	1.00	1390	574
Bennington	1	2	0.50	1020	275
Brattleboro	1	0	1.00	580	0
Burlington	3	6	3.00	6103	3937
Middlebury	1	0	0.75	1185	0
Morrisville	1	2	0.50	611	490
Newport	0	0	0.00	0	0
Randolph	2	0	0.50	511	0
Rutland	1	1	1.50	1861	198
Springfield	1	4	1.00	513	1,536
St. Albans	1	0	0.00	1292	0
St. Johnsbury	1	2	0.75	818	688
Windsor*	0	0	0.00	0	0
Planned Parenthood (Statewide)	6	0	N/A	4,775	0
<b>Total</b>	<b>20</b>	<b>18</b>	<b>10.50</b>	<b>13,020</b>	<b>7648</b>

\*The Windsor Health Service Area does not have women’s health specialty practices.

\*\*Quarterly attributed patient counts at the HSA level have a small amount of overlap due to patients moving across HSAs in different months. The statewide quarterly total is deduplicated.



iii. Behavioral Health

**Key updates from QE0619:**

- Pilot Project Analysis and Extension
- Team Care program revisions
- Applied Behavior Analysis
- Administrative Authorization Pilot Review
- Onboarding providers

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric, eating disorder, and detoxification 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.

In recognition of the inherent challenges in providing strong clinical documentation to justify admission and continued stay within 24 hours of admission, DVHA is in year three of 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 are conducted to ensure appropriate utilization. The reviews have 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. There has also been a significant decrease in contested authorization decisions. The pilot project was extended through December 31<sup>st</sup>, 2020. Close monitoring and quarterly qualitative reviews continue with similar results. The team is also evaluating whether members attributed to the Accountable Care Organization have similar average lengths of stay.

In an effort to reduce the number of members waiting in emergency departments for placement, staff from the quality unit joined colleagues from other departments to develop a system for identifying and supporting transition. A practice has been developed to support high needs members in accessing care and other proposals are being explored. A follow up meeting is scheduled on August 26<sup>th</sup>, 2019 to work towards finalizing the process.

The Behavioral Health Team also manages the Team Care program (the lock-in program). The annual review has begun of clinical documentation and data to support ongoing member inclusion in the program. The team also identifies members who may no longer need the structure of the program and can potentially be disenrolled. The team 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. Claims data is being queried and generating potential new referrals which are being reviewed by the team for program appropriateness. There have been minimal referrals this quarter which may demonstrate the 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 unit collaborated with Payment Reform Unit, Policy Unit and AHS sister departments to explore opportunities for changing the current payment method for Applied Behavior Analysis. A tiered rate was developed with a roll out date of 7/1/19. Providers successfully received their first prospective payment in June/July services. The goal of this payment reform project was to increase utilization and access to services; in July, 27 new members began receiving ABA services. Unit has developed an external provider guidance document as well as a data collection processes and procedure, and have developed a site visit score sheet, a scoring analysis and data plan. Site visits to ABA facilities will begin in January 2020. The QICI 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 Unit has been actively working to onboard new Vermont Medicaid providers and have been working to build upon existing relationships with current providers. Over the past year, the Unit Director and Manager have visited facilities, including Spring Harbor in Portland, Maine. This facility has an inpatient psychiatric unit that specializes with children and adolescents diagnosed with Autism Spectrum Disorder. The provider enrolled with Vermont Medicaid, a protocol for admissions was established, and rates were set. The Unit also visited Champlain Valley Physicians Hospital (CVPH) in Plattsburg, New York. This facility has an inpatient psychiatric unit for children and adolescents. CVPH was already enrolled as a Vermont Medicaid provider, but was being underutilized. The Unit worked to establish a relationship, identify barriers, remove the identified barriers and establish a protocol which included clarification around transportation and education services. The Unit is identifying other facilities/providers to onboard and plan to visit these sites within the next year.

#### *iv. Mental Health System of Care*

##### **Key updates from QE0619:**

- Implementation of Vermont State Legislative requirements
- Delivery System and Payment Reform
- Integrating Family Services updates

#### System Overview

The Department of Mental Health (DMH) is responsible for mental health services provided under state funding to special-needs populations including children with serious emotional disturbances (SED) and adults with severe and persistent mental illnesses (SPMI). Funding is provided through the

Vermont Agency of Human Services (AHS) Master Grants to ten Designated Agencies and two Specialized Service Agencies. These agencies are located across the state of Vermont for the provision of:

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

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

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

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

## **Updates**

### Residential Capacity

In the second quarter of the calendar year, the Vermont State Legislature approved a bill that formalizes plans for replacement of the temporary, secure residential treatment facility in Middlesex, Vermont with a permanent, 16-bed, state-run, physically secure, residential facility with increased clinical capacity. The intended outcome is to improve flow and inpatient bed availability in the system of care.

Funds to support the planning and development of the larger, permanent facility are included in the Fiscal Year 2020 Capital Bill of the Vermont Legislature. Specifications include a better permanent facility design and footprint for a next generation, physically secure residential facility, ideally located somewhere in Central Vermont.

### Inpatient Capacity

This second quarter continued renovations at the Brattleboro Retreat that will support 12 new inpatient level-1 beds, which are expected to come online in the first half of calendar year 2020. There are currently a total of 201 adult psychiatric inpatient beds across the system of care, of which 45 beds are level 1.

### Stakeholder Engagement

During the second quarter the Department of Mental Health initiated a robust stakeholder engagement process. The process is set to occur over the summer of 2019, with the first session completed during QE0619 on June 18<sup>th</sup> in Rutland, Vermont. The process will inform the creation of a 10-year vision for the mental health system of care spanning children, youth, families and adults, accompanied by clear action steps for achievement. The Department intends to use the 2019 engagement process to inform a shared vision, shared commitment, and shared accountability for the long-term vision of an integrated, holistic health care system. The process is meant to consider implementation of current system changes resulting from healthcare reform, planned changes in inpatient capacity and other commitments of the Department of Mental Health, the Agency of Human Services, and the many partners, providers and payers who are responsible for the State's mental health system of care. The resulting vision will be used to create a framework for implementation strategies and a process to achieve a comprehensive continuum of integrated care.

### Payment Reform

As part of the State's efforts to develop health care payment reform models that align with Vermont's All-Payer ACO Model agreement and advance implementation of Vermont's Global Commitment to Health waiver, DMH has worked with other departments in the AHS and with stakeholders to design and implement a payment model for children's and adult mental health services provided by Designated and Specialized Services Agencies (Mental Health Clinics). DMH successfully executed all Agreements necessary for implementation on January 1, 2019 and has spent the first and second quarter of the calendar year providing technical support to providers and monitoring for potential implementation issues.

During the second quarter, the Department began work with the mental health clinic providers and the state's MMIS vendor to perform an in-depth validation of prior months caseload reports to ensure that final year end counts will be well understood and able to be reconciled, if necessary, for providers that do not hit the required annual caseload targets.

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

At the end of the second quarter, the Department continued to report on achievement of value-based payments for process measures related to standardized and timely submission of service data for January dates of service.

**Table 4. Value Based Payment Scoring 2019**

Value Based Payment Scoring 2019												
Agency	Jan-19			Feb-19			Mar-19			Apr-19		
	Timely	% Complete	Met 20% Target	Timely	% Complete	Met 30% Target	Timely	% Complete	Met 40% Target	Timely	% Complete	Met 50% Target
1	Yes	99%	Yes	Yes	100%	Yes	Yes	100%	Yes	Yes	100%	Yes
2	Yes	53%	Yes	Yes	95%	Yes	Yes	88%	Yes	Yes	85%	Yes
3	Yes	98%	Yes	Yes	96%	Yes	Yes	100%	Yes	Yes	97%	Yes
4	Yes	66%	Yes	Yes	95%	Yes	Yes	91%	Yes	Yes	92%	Yes
5	Yes	86%	Yes	Yes	85%	Yes	Yes	93%	Yes	Yes	87%	Yes
6	Yes	100%	Yes	Yes	100%	Yes	Yes	100%	Yes	Yes	39%	No
7	Yes	100%	Yes	Yes	92%	Yes	Yes	91%	Yes	Yes	88%	Yes
8	Yes	94%	Yes	Yes	91%	Yes	Yes	74%	Yes	Yes	89%	Yes
9	Yes	100%	Yes	Yes	98%	Yes	Yes	98%	Yes	Yes	99%	Yes
10	Yes	92%	Yes	Yes	93%	Yes	Yes	94%	Yes	Yes	93%	Yes

**Table 5. 2019 Consumer Satisfaction Surveys**

**2019 Consumer Satisfaction Surveys:**

Consumer Satisfaction Surveys			
Agency	Timely	Complete	CAHPS Points Earned (out of 8 possible)
1	Yes	Yes	8
2	Yes	Yes	8
3	Yes	Yes	8
4	Yes	Yes	8
5	Yes	Yes	8
6	Yes	Yes	8
7	Yes	Yes	8
8	Yes	Yes	8
9	Yes	Yes	8
10	Yes	Yes	8

Integrating Family Services

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

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

As part of quality oversight, this spring the Addison site had an integrated quality chart review; the

Franklin/Grand Isle review will occur in September. This review occurs every two years and includes an interagency team from AHS doing a minimum standards chart review across all funding streams that are included in the IFS case rates in addition to mental health funds-this includes the Department of Health, Child Development Division, Family Services Division, and Developmental Services. This process results in a report being issued that focuses on their strengths and areas that need improvement or corrective action. The results and subsequent report issued for Addison was encouraging as they had improvements that were implemented from feedback that occurred on their last review with only a few areas identified needing a quality improvement plan.

Both IFS regions continue to utilize 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. The data in both regions is being used to launch population health efforts to do more prevention and promotion work-a key goal of having the flexibility within bundled payments.

v. *Pharmacy Program*

**Key updates from QE0619:**

- The Drug Utilization Review Board (DURB) held three meetings this quarter.
- 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 were sent to pharmacies and providers:

### **Important Changes to Coverage for Brand and Generic Formulations of Retin-A® (tretinoin) and Differin® (adapalene)\*\***

Dear Medicaid Provider,

**Effective 4/26/19**, generic formulations of Tretinoin cream and gel (all strengths) will be moving to non-preferred status on the Department of Vermont Health Access (DVHA) Preferred Drug List (PDL). Brand name Retin-A® cream and gel will be moving to preferred status as it now has a lower net cost to Vermont Medicaid compared to generics. Prescribers will not be required to change the way new prescriptions are written nor re-write currently valid prescriptions. If the patient is unable to switch to brand Retin-A®, use of generic will require Prior Authorization. Retin-A Micro® and generic Tretinoin microsphere will remain non-preferred. Additionally, brand name Differin® (cream, gel and lotion) will be moving to preferred status. Generic Adapalene products will remain non-preferred and will require Prior Authorization.

We continually monitor the net costs of these medications and periodically adjust the PDL if new or more cost-effective products become available.

### **Important Changes to Sildenafil Coverage**

Dear Provider,

On July 1, 2006 phosphodiesterase-5 (PDE-5) inhibitors became a non-covered benefit for all Vermont Pharmacy Programs for the treatment of erectile dysfunction (ED). The change was resultant from changes set into effect January 1, 2006 and as detailed in Section 1903 (i)(21)(K) of the Social Security Act, precluding Medicaid Federal Funding for outpatient drugs used for the treatment of sexual or erectile dysfunction. Sildenafil 20mg remained available for coverage via prior-authorization (PA) for the treatment of Pulmonary Arterial Hypertension (PAH). Due to low cost, however, the PA requirement was removed 1/1/17.

The Drug Utilization Review (DUR) Board is composed of practicing Vermont pharmacists and physicians who are responsible for reviewing and advising the Department of Vermont Health Access (DVHA) about drug utilization for Vermont Medicaid enrollees. A recent retrospective drug utilization review focused on Vermont Medicaid enrollees taking sildenafil in calendar year 2016 and 2017. It revealed a dramatic increase in the use of sildenafil. Additionally, it revealed that a significant percentage of members taking Sildenafil after it became preferred in 2017 did not have a diagnosis of

PAH. This suggests that it is being used to treat ED which Medicaid policy does not cover. In response to these data findings, the DUR Board has recommended moving sildenafil back to a non-preferred status on the Preferred Drug List (PDL). **Effective 4/26/19**, Sildenafil will require prior authorization to verify a diagnosis of PAH. It will not be a covered benefit when used for any other indication or diagnosis.

### **340B Claims Submission at Point of Sale (POS) for Pharmacies enrolled in the Vermont Medicaid 340B Program**

Dear Medicaid Provider,

**Effective 4/11/2019**, the Department of Vermont Health Access will be accepting 340B designated claims at Point-of-Sale (POS) for any pharmacy enrolled in the Medicaid 340B program. Please note, DVHA is not requiring pharmacies to submit their 340B Acquisition Cost through the POS at this time, but we encourage all pharmacies enrolled in the Medicaid 340B program to submit at POS whenever possible to reduce the burden of manual reconciliation.

Currently, 340B claims are billed through POS with no indicator showing the claim is 340B eligible. To reconcile payment, each provider receives a monthly 340B utilization file of all claims. The provider indicates, by claim, what drugs are eligible for 340B pricing, the acquisition cost for each drug on the Date of Service and returns the file to DXC within 30 calendar days of receipt of the file. DXC calculates the refund due from the provider based on the 340B acquisition cost as compared to the Medicaid paid amount.

Providers who choose to identify 340B claims at the POS should submit those claims with the Submission Clarification Code “20” and Basis of Cost “8”. The “lower of” logic will apply when calculating the price of the claim using current pricing methodology. Claims should pay utilizing the pharmacy’s 340B Acquisition Cost plus a dispensing fee of \$11.13 retail and \$17.03 for specialty drugs.

**\*\*Providers may choose to continue with the manual reconciliation process currently in place. Please note that DVHA policy does not allow contract pharmacies to enroll in the Vermont Medicaid 340B Program.**

### **Pharmacy Newsletter**

#### **IN THIS ISSUE**

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FDA Safety Alerts

### **IMPORTANT HUB (OTP) CHANGES FOR BUPRENORPHINE PRODUCTS\*\*\***

#### **NEW PA LIMIT FOR SUBOXONE FILM**

Effective 5/1/19, the dose limit for **Suboxone Film** requiring prior authorization has been raised from **16mg to 24mg**. Patients on a dose of 24mg or less will NOT require prior authorization. If the patient requires a dose exceeding 24mg per day, a prior authorization will still be required. Documentation to support using a dose greater than the FDA recommended maximum will need to accompany the



request, and these will be routed to a DVHA Medical Director for review. Providers are reminded that Suboxone when prescribed for opioid dependency (its only FDA approved indication) is designed to be dosed once daily. Daily doses should be made up of the fewest number of dosage units possible. Films should never be divided as the child protection is then lost for the remainder of the dose.

### **BUPRENORPHINE/NALOXONE TABLETS ADDED**

Effective 1/1/19, Buprenorphine/Naloxone combination tablets have been added as a covered product by Vermont Medicaid for use in the HUB setting. This change resulted from provider feedback and is part of an effort to better align clinical criteria for both HUB and SPOKE sites of service. Use of buprenorphine/naloxone tablets requires prior authorization, and approval will be granted if the following criteria are met: FDA MedWatch form has been submitted documenting a provider-observed reaction to Suboxone films severe enough to require discontinuation; and documentation of measures tried to mitigate/manage symptoms.

The following Buprenorphine/Naloxone SL Tab NDC's are now approved for use in the HUBS.

1. **J0572 (2mg Tabs):** 00054-0188-13, 00228-3154-73, 00406-1923-03, 50268-0144-11, 50268-0144-15, 50383-0294-93, 62756-0969-83, and 65162-0416-03
2. **J0574 (8mg Tabs):** 00054-0189-13, 00228-3155-67, 00228-3155-73, 00406-1924-03, 00406-8020-03, 50268-0145-11, 50268-0145-15, 50383-0287-93, 62756-0970-83, and 65162-0415-03

**HUB facilities have until 6/01/2019 to order and stock Buprenorphine/naloxone tablets.** After that time, Buprenorphine mono tablets will only be approved if one of the following criteria are met:

- Patient is pregnant and copy of positive pregnancy test has been submitted (duration of PA will be one 1 month post anticipated delivery date).
- Patient is breastfeeding an opioid dependent baby and history from the neonatologist or pediatrician has been submitted.
- MedWatch form has been submitted documenting a provider-observed reaction to Suboxone films AND buprenorphine/naloxone combination tablets severe enough to require discontinuation. Documentation of measures tried to mitigate/manage symptoms is also required.

### **Point of Sale (POS) Blackout Period**

Due to the need to perform system maintenance, the Department of Vermont Health Access POS system will be unavailable for approximately 8 hours starting at 8:00 PM on Wednesday, June 12, 2019. 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>

DVHA would like to thank all Medicaid pharmacy providers for their patience during this process. If you have any questions regarding this issue, please call the POS Helpdesk at 1-844-679-5362

## Vermont Medicaid Co-pay Clarification

Dear Medicaid Provider,

The DVHA would like to clarify that medications covered by Medicaid **cannot be denied for a Medicaid beneficiary who does not pay their co-pays.** Although members are expected to make co-payments, if the member states they are unable to make a payment, Medicaid providers may not deny services. Per section 1916 (c) of the Social Security Act, “no provider participating under the State [Medicaid] plan may deny care of services to an individual eligible for [Medicaid] on account of such individuals inability to pay (the copayment).

Additionally, the DVHA Pharmacy Provider manual states, “A pharmacy may not refuse to dispense a prescription to a Medicaid beneficiary who does not provide the copayment. However, the beneficiary will still owe the pharmacy any copayment that is not paid.” There is no rule that a pharmacy needs to “waive” a co-pay. The pharmacy can continue to request payment. <http://dvha.vermont.gov/providers/dvha-pharmacy-provider-manual.pdf>

## 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 seven times per year. In QE0619, the DURB held 3 meetings. The DURB is scheduled to hold 1 meeting next quarter. Information on the DURB and its activities in 2019 is available at this link: <http://dvha.vermont.gov/advisory-boards>.

## Drug Utilization Review Board Meetings

Twenty-three new drugs and 17 therapeutic classes were reviewed at the DURB meetings held this quarter; six RetroDur reviews and four safety alerts was also presented.

**Key updates from QE0619:**

- DVHA continued financial reconciliation activities for the 2018 performance year, in order to determine financial and quality performance. Results will be available at the end of Q3 2019.
- DVHA and OneCare entered into contract negotiations for the 2020 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 2019 performance year. A notable adjustment to the VMNG program for 2019 was to the methodology by which members are attributed to the model, to more accurately reflect relationships between members and providers. Additionally, a pilot geographic attribution methodology was put into place for one VMNG-participating Health Service Area (HSA), through which all Medicaid members are attributed to the ACO based on their residence in that HSA. This pilot will be studied throughout 2019 to assess whether expanding a geographic approach to attributing members to the program is feasible to expand to other HSAs in the state. Other programmatic changes were minimal, as the primary focus for the 2019 year continues to be on growing the model and expanding the number of participating providers and attributed members, while maintaining alignment across payer programs as part of Vermont's All-Payer ACO Model. The number of risk-bearing hospital communities increased from ten to thirteen

for the 2019 performance year, with continued participation from other providers within the communities. The number of attributed lives for the 2019 performance year increased from approximately 42,000 lives to approximately 79,000 lives.

DVHA began conducting financial reconciliation activities for its 2018 performance year in Q1 2019 and continued reconciliation work into Q2 2019. Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2018 performance year. Reconciliation activities will continue through June, 2019, and final results will be available by the end of Q3 2019.

DVHA entered into contract negotiations with OneCare for the 2020 performance year in mid-Q2 of 2019. The main potential changes to the program for the 2020 performance year focus on the development of a more inclusive attribution methodology that builds on its 2019 geographic attribution pilot. Other anticipated programmatic changes are minor. Negotiations are expected to continue into Q4 of 2019.

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

## **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 June 2019 quarter. This payment served as the proxy by which to draw down Federal funds for Global Commitment (GC). After each quarterly submission, AHS reconciles the amount claimed on the CMS-64 versus the monthly payments made to DVHA.

The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments and admin) for the given quarter. AHS submitted and certified the CMS64 report for QE0619 on July 30, 2019, as is normal. There were minimal prior quarter adjusting entries needed for program during this period. As a result of the Program Integrity Audit, an overpayment of FFP was identified and a correction adjustment of (\$8,681) was entered on the CMS 64 Summary line 9C1.

AHS and DVHA have discovered a discrepancy in the assignment of Medicaid Eligibility Group (MEG) for some of our members. There are approximately 450 members that have been erroneously counted in the ABD member month count, while their costs have been reported in the non-ABD group for the CMS64. AHS will be adjusting the member month count for these members beginning next quarter so they are properly accounted for in the non-ABD group. Although this will have budget neutrality implications, AHS does not anticipate it will be significant.

AHS has observed that expenditures for the SUD IMD group are currently exceeding the supplemental SUD IMD budget neutrality test. AHS believes there is a discrepancy in the member month count and are working to identify the issue.

DVHA and AHS have completed the CY2017 medical loss ratio (MLR) calculation and will be submitting to the CMS Regional Office for review.

AHS continues to actively monitor Investment spending. The total Investment spending for QE0619 was \$31,342,074. There was no spending for Delivery System Reform Investments. While reconciling

to the MBES Schedule C, AHS noticed that Investment spending for CY2018 exceeded the annual cap by \$84,046. AHS will enter a prior quarter adjustment in QE0919 to reduce the Investment claim for CY2018 by that amount. CY2019 marks the first year in which room & board and physician training program Investments must be phased down by 33%. The HIT and non-State plan related Education fund Investments have already been fully phased-down.

## VI. Member Month Reporting

The State of Vermont certifies the accuracy of the member month reporting. The enrollment report is produced as of the 15<sup>th</sup> 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.

The table below contains Member Month Reporting for QE0619 of CY2019 and includes the unduplicated count of member months for SUD IMD stays. CY2018 and CY 2017 member months are also reported in the tables below.

**Table 6. Member Month Reporting – Calendar Year 2019, QE0619, *subject to revision***

Demonstration Population	Medicaid Eligibility Group	Total CY 2019
1, 4*, 5*	ABD - Non-Medicare - Adult	41,292
	SUD - IMD - ABD	66
1	ABD - Non-Medicare - Child	12,729
1, 4*, 5*	ABD - Dual	128,033
	SUD - IMD - ABD Dual	56
2	ANFC - Non-Medicare - Adult	54,803
	SUD - IMD - ANFC	94
2	ANFC - Non-Medicare - Child	353,496
	<b>Medicaid Expansion</b>	
7	Global RX	39,023
8	Global RX	22,559
6	Moderate Needs	1,028
	<b>New Adults</b>	
3	New Adult with out child	217,278
	SUD - IMD New Adult w/o child	534
3	New Adult with child	116,388
	SUD - IMD New Adult with child	105
	<b>Total</b>	<b>987,484</b>
	<b>Total CY 2019</b>	
<b>* Long Term Care Group</b>		
4 only	ABD Long Term Care Highest Need	17,271
5 only	ABD Long Term Care High Need	7,441

Demonstration Population	Medicaid Eligibility Group	Total CY 2018
1, 4*, 5*	ABD - Non-Medicare - Adult	83,173
	SUD - IMD - ABD	78
1	ABD - Non-Medicare - Child	25,571
1, 4*, 5*	ABD - Dual	257,226
	SUD - IMD - ABD Dual	78
2	ANFC - Non-Medicare - Adult	143,568
	SUD - IMD - ANFC	187
2	ANFC - Non-Medicare - Child	723,162
	<b>Medicaid Expansion</b>	
7	Global RX	79,493
8	Global RX	46,795
6	Moderate Needs	2,321
	<b>New Adults</b>	
3	New Adult with out child	471,902
	SUD - IMD New Adult w/o child	791
3	New Adult with child	223,928
	SUD - IMD New Adult with child	114
	<b>Total</b>	<b>2,058,387</b>
<b>* Long Term Care Group</b>	<b>Total CY 2018</b>	
4 only	ABD Long Term Care Highest Need	34,853
5 only	ABD Long Term Care High Need	14,062

Demonstration Population	Medicaid Eligibility Group	Total CY 2017
1, 4*, 5*	ABD - Non-Medicare - Adult	94,629
1	ABD - Non-Medicare - Child	28,865
1, 4*, 5*	ABD - Dual	255,478
2	ANFC - Non-Medicare - Adult	157,964
2	ANFC - Non-Medicare - Child	730,744
	<b>Medicaid Expansion</b>	
7	Global RX	84,049
8	Global RX	47,561
6	Moderate Needs	2,960
	<b>New Adults</b>	
3	New Adult with out child	490,537
3	New Adult with child	224,721
	<b>Total</b>	<b>2,117,508</b>
<b>* Long Term Care Group</b>	<b>Total CY 2017</b>	
4 only	ABD Long Term Care Highest Need	35,052
5 only	ABD Long Term Care High Need	13,202

**Table 7. PMPM Capitated Rates CY 2019**

	<b>DY 14 PMPM CY2019</b>
<b>Medicaid Eligibility Group</b>	
ABD - Non-Medicare - Adult	\$1,623.47
SUD - IMD ABD	\$3,553.24
ABD - Non-Medicare - Child	\$3,180.06
ABD - Dual	\$2,795.58
SUD - IMD Dual	\$2,799.44
ANFC - Non-Medicare - Adult	\$ 708.86
SUD - IMD ANFC	\$2,852.36
ANFC - Non-Medicare - Child	\$ 587.93
New Adult Group	\$ 562.71
SUD - IMD - New Adult	\$3,006.05

	<i>includes SUD</i>
	<b><u>1/1/2019-12/31/2019</u></b>
<b>Medicaid Eligibility Group</b>	
ABD Adult	\$ 2,115.84
ABD Child	\$ 2,668.98
ABD - Dual	\$ 1,787.87
non-ABD Adult	\$ 590.64
non-ABD Child	\$ 464.71
GlobalRx	\$ 103.91
New Adult	\$ 463.29
Moderates	\$ 512.98

## VII. 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.

## VIII. Quality Improvement

### **Key updates from QE0619:**

- The Quality Unit continued to lead a formal CMS PIP project focused on improving substance use disorder treatment.
- The DVHA Quality Unit staff continued to lead two QI projects.
- The Quality Unit clinicians received medical record review (MRR) training, performed inter-rater reliability (IRR) testing, and completed chart abstraction for two national HEDIS hybrid measures.

The DVHA Quality Improvement (QI) and Clinical Integrity Unit monitors, evaluates and improves the quality of care to Vermont Medicaid beneficiaries by improving internal processes, identifying performance improvement projects and performing utilization management. Efforts are aligned across the Agency of Human Services as well as with community providers. The unit is responsible for instilling the principles of quality throughout DVHA; 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 containing the cost of health care. During this most recent quarter the committee met once. In May the committee discussed the addition of questions to the 2019 CAHPS experience of care survey tools. Another discussion centered around the quality and appropriateness of care managed care standard. Representatives from DAIL and DMH presented to the Committee on the special health care needs populations their Departments manage, including their quality review processes. It was an informative discussion that laid the groundwork for more meaningful assessment of this standard by the committee in the future.

### Medicaid ACO Monitoring and Operations

Quality Unit staff participate in two workgroups that are responsible for monitoring the Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO). A group of staff from around the Department who receive and review the required ACO reporting meet on a monthly basis. DVHA's Quality Improvement Administrator reviews the Quality Management report submitted by OneCare each quarter. The group believes that a coordinated internal review increases the opportunity to identify gaps/areas of concern.

The DVHA Quality Unit also meets quarterly with the OneCare VT Quality team for a more targeted quality management review, often with a focus on coordinating quality improvement efforts. During the most recent reporting period our teams met in May to review a set of grant projects - the VMNG Value Based Incentive Fund Quality Improvement Projects.



## Formal CMS Performance Improvement Project (PIP)

The Quality Unit continues to coordinate VT Medicaid's formal CMS Performance Improvement Project (PIP) – the topic of which is substance use treatment initiation. The cross-departmental PIP team is focused on a multi-pronged telehealth-related intervention. Targeted communications about telehealth continue to be dispersed via provider banners and newsletter articles. Telehealth resources continued to be added to the provider section of the VT Medicaid website during the QE0619. Additionally, DVHA's Quality Improvement Administrator prepared the annual PIP Summary report for submission to the EQRO in early July.

The CY 2018 HEDIS IET study rate (the HEDIS IET Initiation measure) became available during QE0619. Vermont achieved statistically significant improvement with an increase from 44.2% in CY 2017 to 46.7% in CY 2018. Interim indicator data on telehealth use is also being collected to monitor progress. Data points include: # of telehealth episodes of care, # of unduplicated providers billing for telehealth and # of unduplicated members receiving telehealth services. There was an increase in all metrics from the baseline of Q2 SFY 18. The Quality Unit is also starting to sort these episodes of care by HEDIS diagnosis code value sets for mental health and substance use disorder. Data continues to show that SUD treatment providers are using telehealth in comparatively small numbers and continued focus here could be meaningful.

## 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.

During the most recent quarter the chlamydia project team designed a modified learning collaborative through the Blueprint's Women's Health Initiative. The collaborative will include 8 monthly webinars, running from April-September 2019. The adults' access to preventive/ambulatory services team circulated a banner release related to medical record transfers (an activity that can increase the wait time for appointment scheduling) and wrapped up their work with a provider advisory article on that topic in June.

## 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. During QE0619 the Quality Unit explored ways to maximize the use of available resources, including the potential use of the Vermont Clinical Registry and contracted ACO-attributed hybrid measure rates. A team from DVHA's Health Information Exchange (HIE), Vermont Chronic Care Initiative (VCCI), the Quality Unit, Senior Management Team, and the Data Unit is exploring the potential to use current systems for hybrid measure production.
- Healthcare Effectiveness Data & Information Set (HEDIS) measure production – During QE0619 the Quality Unit continued to work with the contracted HEDIS vendor, Cotiviti, on both administrative and hybrid measure runs. Cotiviti performed medical record retrieval for

three hybrid measures and abstraction for one measure. The Quality Unit clinicians abstracted the remaining two hybrid measures. The Quality Assurance Manager coordinated the internal hybrid measure production process. During the most recent quarter clinicians received training, performed the IRR, and completed chart abstraction on 6/14/19.

- Customer Satisfaction Measures– CAHPS Survey – DVHA’s Quality Improvement Administrator works with our vendor, Data Stat, to prepare for the annual adult and child CAHPS experience of care surveys, as well as upload our results to the national CAHPS database. The most recent surveys were conducted from mid-October through mid-December 2018 and the results were uploaded to the national AHRQ CAHPS database during the most recent reporting period. Additionally, during QE0619 the Quality Committee considered adding survey questions to our 2019 surveys, potentially focused on smoking, mental health and/or medication reconciliation. Potential new questions were discussed at the May 17<sup>th</sup> Quality Committee meeting.

### 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 QE0619 include the following: DVHA Strategic Priorities, , GC/Delivery System Related Investments, Payment Reform Models, 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 are also actively engaged in the Agency’s Improvement Network. This is a group of staff trained in process improvement, facilitation and tools that can be deployed to help on improvement projects around the Agency.

### AHS Performance Accountability Committee

During this quarter, the AHS Performance Accountability Committee (PAC) reviewed the accomplishments of the Data Governance Council (DGC), Data Governance Operations (DGO), and the Data Governance Workgroup. Specifically, the committee discussed the progress that the DGW has made re: the implementation of the Roles and Responsibilities policy. To date, a spreadsheet has been developed to capture the data sets that exist in each of the AHS Departments as well as a tracker tool to capture the roles and responsibilities of staff supporting the data set. During the next quarter, the group will discuss communications and trainings necessary to facilitate the implementation of AHS Data Governance. Also this quarter, the group reviewed the process for GC Investment & Payment Model performance reporting. The group agreed that performance monitoring would be 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). An account with permissions to view all scorecards would be created to satisfy the comprehensive internal annual review requirement. Finally, the group received an overview of the Comprehensive Quality Strategy. The group is tasked with reviewing the document and making any necessary edits before the document is posted for public comment in the fall. Specifically, the following sections were discussed: quality strategy priority areas, quality management structure, AHS performance framework, national performance measures, population specific measures, and improvements. The group will suggest edits and review a final

version of the document before it is posted for public comment.

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

AHS Departments are required to monitor and evaluate the performance of their GC and DSR investment supported activities 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, DOC and DCF each highlighted the performance of one of its investments. The Clear Impact Scorecard for this investment is included in this report as Attachment 7a and Attachment 7b.

### Payment Models & Performance Monitoring

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 performance information contained in a web browser-based software application (Clear Impact Scorecard).

During this most recent quarter, DVHA highlighted the performance of its VMNG ACO payment model. The Clear Impact Scorecard for this 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 reviewed the following upcoming State Transition Plan Milestones: completion of site-specific assessments, completion of validation activities, modifying STP to incorporate results of site-specific assessments and validation activities, and submitting final STP to CMS for review and approval. Each program shared the status of their assessment and validation activities. It is anticipated that both of these activities will be completed on time. The group also discussed the chart that identifies that number of sites falling into categories of compliance (a) fully compliant with the settings criteria, (b) could come into full compliance with modifications, (c) cannot comply with the federal settings criteria, or (d) are presumptively institutional in nature. The group reviewed potential formats for reporting this information and agreed to use a standardized template when adding this information to the updated STP. In addition, the group discussed the public comment process associated with updating the STP. It is anticipated that the STP will be posted for public comment September 9, 2019. The public comment period would run for 30 days – ending on October 7, 2019. The group will discuss the additional details associated with the public comment process (e.g., MEAB, public hearing, process for written comment, etc.) during the next quarter.

## **IX. Demonstration Evaluation**

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). As per the amended STCs, the State is required to modify their current Evaluation Design to

accommodate the evaluation requirements associated with the SUD amendment. Last quarter, the State submitted its updated Evaluation Design. During this quarter, the State received feedback from CMS re: its modified Evaluation Design. Overall, CMS found that Vermont's draft design was moderately responsive to the requirements specified in the STCs and the Evaluation Design TA document. In addition, CMS identified places where Vermont should make revisions or provide clarification in order to fulfill the requirements specified in the aforementioned documents. Specifically, CMS asked the following: reorganize table with evaluation goals, questions, and hypotheses, provide more detail re: planned design and analyses, and provide a description of the planned cost analysis. The AHS QIM met with the evaluation team to review the feedback and consider appropriate responses. At the end of the quarter, the group had put together a document containing state responses. This document was forwarded to CMS. During the next quarter, the State will modify the evaluation design to accommodate the CMS feedback. Within 60 days of receiving the feedback, it will be posted to the CMS PMDA site for CMS review/approval.

## X. Compliance

### **Key updates from QE0619:**

- EQRO Compliance Audit Preparation
- Compliance Committee
- Electronic Visit Verification

During this quarter, the DVHA Medicaid Compliance Officer completed the document submission requests for each of this year's EQRO Compliance Audit standards. This year's review is scheduled for July and will include the Clinical Operations Unit, Vermont Chronic Care Initiative unit, Provider and Member Relations unit, Health Access Eligibility & Enrollment unit and two other AHS departments. All relevant units have been prepared for this audit and are scheduled for interviews next month.

As part of the process, previous corrective actions were reviewed to ensure that progress was made on deficiencies identified in previous audits. In addition to the compliance review, the EQRO will initiate performance measure validation and performance improvement project validation activities during the next quarter.

### Compliance Committee

The Compliance Committee reviewed the annual work plan for mid-year adjustments. Additional adjustments will be made this fall after we receive our EQRO audit findings. .

### Electronic Visit Verification

In response to section 12006 of the 21<sup>st</sup> Century Cures Act, Vermont is implementing an electronic visit verification system (EVV) to electronically verify personal care service visits in home and community settings. Since the last report, the following milestones for this project were met this quarter:

- Our workbook of business requirements and a workflow process model were approved
- We continued our engagement with Home Health Agencies (HHAs) to prepare them for the interfaces they will need to build to move EVV data into our data aggregator. The data

aggregator will allow us to analyze data from the myriad EVV systems used by HHAs.

- We created a communications work stream to formalize our outreach and support efforts
- We solved several interoperability issues between our new EVV solution and existing payroll and claims-processing processes. Several additional interoperability issues were identified that will delay implementation
- Due to these interoperability issues (and other issues), we decided to request a one-year extension for this project. We expect to send our extension request during Q3 2019.

#### Intra-Governmental Agreement (IGA) between AHS and DVHA

During this quarter, the AHS QIM received feedback from CMS on the 2018 Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) IGA. The feedback was reviewed internally, responses were developed, and an updated version of the IGA was submitted to CMS. Approval of the 2018 IGA is anticipated during the next quarter. All requested changes to the 2018 agreement were incorporated into the 2019 version. After approving the 2018 IGA, CMS plans to provide feedback to the 2019 version of the agreement.

#### SUD Monitoring Protocol & Metrics Workbook

During this quarter, the AHS QIM received feedback from CMS on Vermont's SUD Monitoring Protocol and its associated Metrics Workbook. Feedback was provided in the following categories: compliance with STCs and alignment with 1115 SUD monitoring protocol guidance. Examples of STC feedback included the following: review of identified goals and targets for metrics while alignment with 1115 SUD monitoring protocol guidance feedback included addressing deviations from CMS technical specifications for metrics. This feedback was reviewed by the SUD Monitoring Protocol Implementation team and responses were prepared. Toward the end of the quarter, a revised protocol and workbook was resubmitted to CMS for review and approval.

### **XI. 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 QE0619.

## **XII. 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: QE0619 Investments
- Attachment 7a: Investment Scorecard: Department of Corrections
- Attachment 7b: Investment Scorecard: Department for Children and Families
- Attachment 8: Payment Model Scorecard: Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO)

## **XIII. 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) <a href="mailto:sarah.clark@vermont.gov">sarah.clark@vermont.gov</a>
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) <a href="mailto:ashley.berliner@vermont.gov">ashley.berliner@vermont.gov</a>
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) <a href="mailto:cory.gustafson@vermont.gov">cory.gustafson@vermont.gov</a>

**Date Submitted to CMS: August 29, 2019**

## **ATTACHMENTS**

# Attachment 1 - Budget Neutrality

State of Vermont Global Commitment to Health  
 Budget Neutrality PMPM Projection vs 64 Actuals Summary  
 Aug 1, 2019

ELIGIBILITY GROUP	DY 12	DY 13	DY 14	DY 15	DY 16	Total
	JAN - DEC 2017	JAN - DEC 2018	JAN - DEC 2019	JAN - DEC 2020	JAN - DEC 2021	
<b>Without Waiver (Caseload x pmpms)</b>						
ABD - Non-Medicare - Adult	\$ 142,860,455	\$ 130,210,658	\$ 67,036,323	\$ -	\$ -	\$ 340,107,437
ABD - Non-Medicare - Child	\$ 85,359,001	\$ 78,416,029	\$ 40,478,984	\$ -	\$ -	\$ 204,254,013
ABD - Dual	\$ 664,153,383	\$ 693,440,140	\$ 357,926,494	\$ -	\$ -	\$ 1,715,520,017
ANFC - Non-Medicare - Adult	\$ 101,757,250	\$ 97,016,076	\$ 38,847,655	\$ -	\$ -	\$ 237,620,980
ANFC - Non-Medicare - Child	\$ 392,665,288	\$ 406,467,665	\$ 207,830,903	\$ -	\$ -	\$ 1,006,963,857
<b>Total Expenditures Without Waiver</b>	<b>\$ 1,386,795,376</b>	<b>\$ 1,405,550,568</b>	<b>\$ 712,120,359</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 3,504,466,304</b>
<b>With Waiver</b>						
ABD Non Medicare Adult	\$ 162,602,154	\$ 162,728,372	\$ 87,983,264	\$ -	\$ -	\$ 413,313,790
ABD - Non-Medicare - Child	\$ 66,593,208	\$ 60,077,015	\$ 32,351,980	\$ -	\$ -	\$ 159,022,203
ABD - Dual	\$ 445,847,909	\$ 461,739,496	\$ 245,554,477	\$ -	\$ -	\$ 1,153,141,882
ANFC - Non-Medicare - Adult	\$ 84,040,228	\$ 83,558,956	\$ 36,012,323	\$ -	\$ -	\$ 203,611,507
ANFC - Non-Medicare - Child	\$ 305,543,574	\$ 335,706,591	\$ 187,453,362	\$ -	\$ -	\$ 828,703,528
Premium Offsets	\$ (655,991)	\$ (772,935)	\$ (393,552)	\$ -	\$ -	\$ (1,822,478)
Moderate Needs Group	\$ 1,488,408	\$ 1,378,915	\$ 625,017	\$ -	\$ -	\$ 3,492,340
Marketplace Subsidy	\$ 6,355,286	\$ 6,242,717	\$ 3,105,475	\$ -	\$ -	\$ 15,703,478
VT Global Rx	\$ 13,824,166	\$ 15,300,919	\$ 5,808,607	\$ -	\$ -	\$ 34,933,692
VT Global Expansion VHAP	\$ 414,824	\$ 716,198	\$ 795,304	\$ -	\$ -	\$ 1,926,326
CRT DSHP	\$ 10,331,787	\$ 9,240,772	\$ 5,212,174	\$ -	\$ -	\$ 24,784,733
Investments	\$ 142,332,671	\$ 148,578,762	\$ 57,765,094	\$ -	\$ -	\$ 348,676,528
<b>Total Expenditures With Waiver</b>	<b>\$ 1,238,718,223</b>	<b>\$ 1,284,495,781</b>	<b>\$ 662,273,525</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 3,185,487,529</b>
<b>Supplemental Test: New Adult (Gross)</b>						
Limit New Adult	\$ 370,689,611	\$ 375,769,075	\$ 187,757,195	\$ -	\$ -	\$ 934,215,881
Without Waiver SUD - IMD New Adult Expenditures	\$ -	\$ 2,704,249	\$ 1,920,866	\$ -	\$ -	\$ 4,625,115
With Waiver New Adult Expenditures	\$ 295,620,340	\$ 312,104,578	\$ 168,692,352	\$ -	\$ -	\$ 776,417,269
With Waiver SUD - IMD New Adult Expenditures	\$ -	\$ 2,826,119	\$ 2,507,720	\$ -	\$ -	\$ 5,333,838
<i>Surplus (Deficit)</i>	<i>\$ 75,069,271</i>	<i>\$ 63,542,627</i>	<i>\$ 18,477,989</i>	<i>\$ -</i>	<i>\$ -</i>	<i>\$ 157,089,888</i>
<b>Supplemental Test: IMD SUD (Gross)</b>						
SUD - IMD ABD - Non-Medicare - Adult	\$ -	\$ 268,039	\$ 234,514	\$ -	\$ -	\$ 502,553
SUD - IMD ABD - Dual	\$ -	\$ 214,495	\$ 156,769	\$ -	\$ -	\$ 371,264
SUD - IMD ANFC - Non-Medicare - Adult	\$ -	\$ 533,391	\$ 268,122	\$ -	\$ -	\$ 801,513
<b>Limit SUD IMD Without Waiver</b>		<b>\$ 1,015,926</b>	<b>\$ 659,404</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 1,675,330</b>
SUD - IMD ABD Non Medicare Adult	\$ -	\$ 249,820	\$ 289,184	\$ -	\$ -	\$ 539,005
SUD - IMD ABD - Dual	\$ -	\$ 199,224	\$ 235,610	\$ -	\$ -	\$ 434,834
SUD - IMD ANFC - Non-Medicare - Adult	\$ -	\$ 540,841	\$ 365,358	\$ -	\$ -	\$ 906,199
<b>Limit SUD IMD With Waiver</b>		<b>\$ 989,886</b>	<b>\$ 890,151</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 1,880,038</b>
<i>Surplus (Deficit)</i>		<i>\$ 26,040</i>	<i>\$ (230,747)</i>	<i>\$ -</i>	<i>\$ -</i>	<i>\$ (204,707)</i>
<b>Waiver Savings Summary</b>						
Annual Savings	\$ 148,077,153	\$ 121,054,788	\$ 49,846,834	\$ -	\$ -	\$ 318,978,775
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	\$ 44,423,146	\$ 30,263,697	\$ 12,461,709	\$ -	\$ -	\$ 87,148,551
Total Savings	\$ 44,423,146	\$ 30,263,697	\$ 12,461,709	\$ -	\$ -	\$ 87,148,551
<b>Cumulative Savings</b>	<b>\$ 44,423,146</b>	<b>\$ 74,686,843</b>	<b>\$ 87,148,551</b>	<b>\$ 87,148,551</b>	<b>\$ 87,148,551</b>	<b>\$ 87,148,551</b>

11%                      9%                      7%

New Adult Waiver Savings Not Included in Waiver Savings Summary  
 See Budget Neutrality New Adult tab (STC#64)  
 See CY2019 Investments tab  
 See EG MM CY 2019 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				DY 14 – PMPM			
	QE 0317	QE 0617	QE 0917	QE 1217	QE 0318	QE 0618	QE 0918	QE 1218	QE 0319	QE 0619	QE 0919	QE 1219
(A) New Adult Group PMPM Projection	\$518.26	\$518.26	\$518.26	\$518.26	\$540.03	\$540.03	\$540.03	\$540.03	\$562.71	\$562.71		
(B-1) eligible member months w/ Child	55,223	57,077	56,789	55,632	55,583	55,408	55,889	57,048	58,000	58,388		
(B-2) eligible member months w/o Child	124,999	124,981	121,338	119,219	120,870	119,755	116,895	114,382	110,690	106,588		
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	\$ 28,619,871.98	\$ 29,580,726.02	\$ 29,431,467.14	\$ 28,831,840.32	\$ 30,016,487.49	\$ 29,921,982.24	\$ 30,181,736.67	\$ 30,807,631.44	\$ 32,637,180.00	\$ 32,855,511.48		
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	\$ 64,781,981.74	\$ 64,772,653.06	\$ 62,884,631.88	\$ 61,786,438.94	\$ 65,273,426.10	\$ 64,671,292.65	\$ 63,126,806.85	\$ 61,769,711.46	\$ 62,286,369.90	\$ 59,978,133.48		
(D-1) New Adult FMAP w/ Child	54.46%	54.46%	54.46%	53.47%	53.47%	53.47%	53.47%	53.89%	53.89%	53.89%		
(D-2) New Adult FMAP w/o Child	86.89%	86.89%	86.89%	86.69%	89.95%	89.95%	89.95%	89.99%	93.00%	93.00%		
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	\$ 15,586,382.28	\$ 16,109,663.39	\$ 16,028,377.00	\$ 15,416,385.02	\$ 16,049,815.86	\$ 15,999,283.90	\$ 16,138,174.60	\$ 16,602,232.58	\$ 17,588,176.30	\$ 17,705,835.14		
(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	\$ 53,562,663.92	\$ 58,713,446.78	\$ 58,171,827.74	\$ 56,782,562.76	\$ 55,586,563.34	\$ 57,926,324.01	\$ 55,779,664.14		
Subtotal Federal Share Supplemental Cap 1	\$ 71,875,446.21	\$ 72,390,621.63	\$ 70,668,833.64	\$ 68,979,048.94	\$ 74,763,262.64	\$ 74,171,111.64	\$ 72,920,737.36	\$ 72,188,795.93	\$ 75,514,500.31	\$ 73,485,499.27		
Total FFP reported for New Adult Group	\$ 62,816,665.28	\$ 61,830,391.33	\$ 54,643,069.28	\$ 51,158,852.52	\$ 62,183,045.44	\$ 63,756,150.76	\$ 62,666,336.47	\$ 61,269,677.13	\$ 67,854,834.87	\$ 68,588,592.26		
<b>Supplemental Budget Neutrality Test 1</b>												
over/(under) - report any negative # under main GC budget neutrality	\$ 9,058,780.94	\$ 10,560,230.30	\$ 16,025,764.37	\$ 17,820,196.41	\$ 12,580,217.20	\$ 10,414,960.88	\$ 10,254,400.88	\$ 10,919,118.80	\$ 7,659,665.44	\$ 4,896,907.02		



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**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**

### **Q3 SFY 2019**

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**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

June 1, 2019



## Key Terms

**Caseload** – Average monthly member enrollment

**MEG** – Medicaid Eligibility Group

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**PMPM** – Per Member Per Month

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

Medicaid Eligibility Group	SFY'19 BAA			SFY'19 Actuals Thru March 31, 2019			% of Expenses to Budget Line Item
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	
ABD Adult	6,250	\$ 146,702,165	\$ 1,956.03	6,489	\$ 105,595,983	\$ 1,808.09	71.98%
ABD Dual	17,742	\$ 242,706,736	\$ 1,139.98	17,622	\$ 165,652,545	\$ 1,044.49	68.25%
General Adult	12,958	\$ 88,656,569	\$ 570.15	10,594	\$ 57,079,910	\$ 598.68	64.38%
New Adult Childless	39,248	\$ 227,769,694	\$ 483.61	37,952	\$ 172,323,110	\$ 504.51	75.66%
New Adult w/Child	18,813	\$ 87,998,161	\$ 389.79	18,954	\$ 69,477,985	\$ 407.29	78.95%
BD Child	2,166	\$ 64,844,308	\$ 2,494.78	2,067	\$ 42,241,342	\$ 2,270.19	65.14%
General Child	59,811	\$ 332,852,007	\$ 463.76	58,846	\$ 240,620,573	\$ 454.34	72.29%
Underinsured Child	584	\$ 1,469,272	\$ 209.66	557	\$ 1,019,212	\$ 203.31	69.37%
CHIP	4,697	\$ 12,551,135	\$ 222.68	4,508	\$ 9,215,748	\$ 227.12	73.43%
Sunsetted Programs	-	\$ -		-	\$ 884,846		
Vermont Premium Assistance	19,085	\$ 6,614,098	\$ 28.88	17,163	\$ 4,588,094	\$ 29.70	69.37%
Vermont Cost Sharing	5,309	\$ 1,520,434	\$ 23.87	5,239	\$ 1,180,416	\$ 25.03	77.64%
Pharmacy Only	10,497	\$ 11,278,883	\$ 89.54	10,441	\$ 7,457,165	\$ 79.36	66.12%
Choices for Care - Traditional	4,390	\$ 209,074,560	\$ 3,968.77	4,284	\$ 151,089,078	\$ 3,918.79	72.27%
Choices for Care - Acute	4,390	\$ 31,288,498	\$ 593.94	4,284	\$ 25,092,835	\$ 650.83	80.20%
<b>Total Medicaid</b>	<b>196,241</b>	<b>\$ 1,465,326,521</b>	<b>\$ 622.25</b>	<b>189,477</b>	<b>\$ 1,053,518,841</b>	<b>\$ 617.79</b>	<b>71.90%</b>

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

Medicaid Eligibility Group	SFY'19 BAA			SFY'19 Actuals Thru March 31, 2019			% of Expenses to Budget Line Item
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	
ABD Adult	6,250	\$ 146,644,178	\$ 1,955.26	6,489	\$ 104,734,173	\$ 1,793.33	71.42%
ABD Dual	17,742	\$ 245,148,578	\$ 1,151.45	17,622	\$ 165,542,381	\$ 1,043.80	67.53%
General Adult	12,958	\$ 88,621,911	\$ 569.93	10,594	\$ 56,899,380	\$ 596.79	64.20%
New Adult Childless	39,248	\$ 228,050,283	\$ 484.21	37,952	\$ 172,272,633	\$ 504.36	75.54%
New Adult w/Child	18,813	\$ 88,060,301	\$ 390.07	18,954	\$ 69,476,942	\$ 407.28	78.90%
BD Child	2,166	\$ 49,597,023	\$ 1,908.16	2,067	\$ 32,558,601	\$ 1,749.80	65.65%
General Child	59,811	\$ 296,053,250	\$ 412.48	58,846	\$ 215,712,547	\$ 407.30	72.86%
Underinsured Child	584	\$ 1,078,976	\$ 153.96	557	\$ 803,531	\$ 160.29	74.47%
CHIP	4,697	\$ 10,740,115	\$ 190.55	4,508	\$ 8,103,877	\$ 199.72	75.45%
Sunsetted Programs	-	\$ -		-	\$ 884,846		
Vermont Premium Assistance	19,085	\$ 6,614,098	\$ 28.88	17,163	\$ 4,588,094	\$ 29.70	69.37%
Vermont Cost Sharing	5,309	\$ 1,520,434	\$ 23.87	5,239	\$ 1,180,416	\$ 25.03	77.64%
Pharmacy Only	10,497	\$ 11,278,883	\$ 89.54	10,441	\$ 7,457,165	\$ 79.36	66.12%
Choices for Care - Traditional	4,390	\$ 209,074,560	\$ 3,968.77	4,284	\$ 151,089,078	\$ 3,918.79	72.27%
Choices for Care - Acute	4,390	\$ 32,083,931	\$ 609.03	4,284	\$ 25,092,835	\$ 650.83	78.21%
<b>Total Medicaid</b>	<b>196,241</b>	<b>\$ 1,414,566,521</b>	<b>\$ 600.69</b>	<b>189,477</b>	<b>\$ 1,016,396,499</b>	<b>\$ 596.02</b>	<b>71.85%</b>

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

Medicaid Eligibility Group	SFY'19 BAA			SFY'19 Actuals Thru March 31, 2019			% of Expenses to Budget Line Item
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	
ABD Adult	6,250	\$ 57,191,818	\$ 762.56	6,489	\$ 45,774,347	\$ 783.78	80.04%
ABD Dual	17,742	\$ 57,507,834	\$ 270.11	17,622	\$ 42,496,299	\$ 267.95	73.90%
General Adult	12,958	\$ 75,554,021	\$ 485.89	10,594	\$ 48,749,849	\$ 511.31	64.52%
New Adult Childless	39,248	\$ 202,267,933	\$ 429.47	37,952	\$ 153,909,121	\$ 450.60	76.09%
New Adult w/Child	18,813	\$ 81,007,952	\$ 358.83	18,954	\$ 64,671,411	\$ 379.11	79.83%
BD Child	2,166	\$ 20,395,140	\$ 784.67	2,067	\$ 15,471,913	\$ 831.51	75.86%
General Child	59,811	\$ 155,918,142	\$ 217.24	58,846	\$ 122,783,803	\$ 231.84	78.75%
Underinsured Child	584	\$ 502,278	\$ 71.67	557	\$ 358,640	\$ 71.54	71.40%
CHIP	4,697	\$ 8,362,970	\$ 148.37	4,508	\$ 6,812,246	\$ 167.89	81.46%
Sunsetted Programs	-	\$ -		-	\$ 884,846		
Vermont Premium Assistance	19,085	\$ 6,614,098	\$ 28.88	17,163	\$ 4,588,094	\$ 29.70	69.37%
Vermont Cost Sharing	5,309	\$ 1,520,434	\$ 23.87	5,239	\$ 1,180,416	\$ 25.03	77.64%
Pharmacy Only	10,497	\$ 11,278,883	\$ 89.54	10,441	\$ 7,457,165	\$ 79.36	66.12%
Choices for Care - Traditional	4,390	\$ 209,074,560	\$ 3,968.77	4,284	\$ 151,089,078	\$ 3,918.79	72.27%
Choices for Care - Acute	4,390	\$ 28,306,765	\$ 537.33	4,284	\$ 23,373,425	\$ 606.24	82.57%
<b>Total Medicaid</b>	<b>196,241</b>	<b>\$ 915,502,828</b>	<b>\$ 388.77</b>	<b>189,477</b>	<b>\$ 689,600,652</b>	<b>\$ 404.39</b>	<b>75.32%</b>

## **Questions, Complaints and Concerns Received by Health Access Member Services April 1, 2019 – June 30, 2019**

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.

### **April 2019**

- Caller wanted to submit negative feedback about the lack of mental health providers that accept Medicaid. States son needs a mental health provider and wishes that there was a way to get it covered without needing to be a Medicaid provider since it seems like there are so few providers in that field that accept Medicaid. Recommends we outreach for recruitment or some other way to do a workaround for payment would be good for people who can't find a provider. CSR apologized for frustrations, assisted in trying to find a provider that accepts Medicaid and offered to document feedback.
- Caller wanted to report negative feedback. They are on GMC programs and do not appreciate how much time and energy they spend trying to send verification documents. They expressed how much stress this process has caused and that she has spent a lot of money on sending in documents that were later found not needed. They also did not like getting notices that did not have any signature from those that sent them. CSR apologized for frustration, explained the process of sending in documents and offered to document her feedback.
- Caller wanted to document negative feedback about a dentist. Caller reports daughter had a dental appointment with Dr. X. Reports that when they got to office for 11:50 appointment they were told daughter (age 17) could not be seen because her dental benefits were exhausted last June. Caller also states that Dr. X said he did not have time even if they paid cash. CSR apologized for her frustration, mailed her a complaint form and also assisted her by giving her names of other dentists near her. Also offered to document her feedback.

### **May 2019**



- Caller wishes to express displeasure of lack of dentists who are Medicaid providers in area of the state - White River Jct. Caller feels there should be more options. CSR apologized for frustrations, looked up some dentists in surrounding areas and gave caller the info.

### **June 2019**

- Caller wanted to submit negative feedback regarding children's dr. d dental benefits/providers. She called to say she is looking for a dentist for her children on the Dr Dynasaur program and used the Medicaid web page to find a dentist. She was very disappointed because every dentist she called was no longer accepting the insurance and said they could not afford to. The reduced rates were too much for their business to absorb so had to discontinue accepting patients. Caller said she was extremely frustrated and has yet to find a dentist and said we should update our web page. CSR apologized for her frustrations, offered to assist in finding another dentist. Also offered to document her feedback.
- Caller's complaint/feedback is that he would like a list of DME for diabetic supplies that Medicaid is currently contracted with that covers the cost of DME; and, the frustration is that is not available. Without the list he does not know where to go to fill the prescriptions. The provider list online does not sort for diabetic DME. He wished there was an easier way to find specific DME suppliers that had the supplies that he needs. CSR apologized for his frustrations and tried to assist in finding DME suppliers. Also offered to document his feedback.
- Caller wanted to submit feedback regarding her DME Supplier. She is calling about a Durable Medical Equipment (DME) Supplier in Rutland, VT. She states they changed the way she can refill supplies. There is no way to contact the DME provider directly. CSR apologized for her frustration, explained the process and offered to document her feedback.
- Caller wanted to submit negative feedback about the PA process and getting services or products covered. She states that she has a hard time getting her medical needs covered and feels the process for getting a PA or certain service covered takes too long. She feels it should be changed so she can get the medical attention she needs. CSR apologized for her frustrations, explained the process to her and offered to document her feedback.
- Caller wanted to submit negative feedback about the process of getting medications early when she needs to go out of town. She wanted to stress her dissatisfaction with the process as she is going out of the country due to a family emergency and she is not going on vacation, so it shouldn't be this difficult. She takes several medications and has to wait until the day before she leaves to fill the medication due to our policy. She wants the state to know that this is a huge inconvenience and feels there should be an emergency travel override instead of only a vacation over ride. She feels we should give people more time to get their prescriptions as she takes a certain medication that needs to be mailed out and kept at a certain temp and to have it filled the day before does not work for her due to this. CSR apologized for her frustrations and offered to document here feedback.
- Caller wanted to submit negative feedback about RX PA process. He states he contacted his doctor today and is very upset that he has not been able to get his RX refill yet. He states that not being able to get medication right away is like asking him to hold his breath for 3 days and that lack of medication is causing problems in his school & life.



States he was not informed on last PA approval as to when it would expire. Reports his doctor is "on the Ball" and it is not like his doctor to miss something like this. Says he is advocating for himself and that medication is not controlled substance. Therefore he feels that approval should not take any time and that he is holding State accountable for the delay. Reports he is in pain and does not have funds to pay out of pocket. Explained that customer support cannot process PA that MD Office needs to speak with Goold. CSR apologized for his frustrations, explained the process and offered to document his feedback.

- Caller wanted to submit negative feedback about receiving out of state care. He would like for Vermont Health Connect to have a list of Out of State providers that will accept Vermont Medicaid. He had to go to the emergency room for an emergency situation and does not think it is fair for the majority of the responsibility to be on the customer. CSR apologized for his frustrations and advised him of the VT MEDICAID website and offered to document his feedback.
- Caller wanted to submit negative feedback about our VT Medicaid website. He states his doctor is leaving the practice he goes to and needs to update his PCP. He feels that the Medicaid provider look up website is outdated and couldn't find assistance getting a new PCP. CSR apologized for his frustration, offered to assist him in finding a new PCP and offered to document his feedback.





**Grievance and Appeal Quarterly Report  
Medicaid Managed Care Model  
All Departments Combined Data  
April 1, 2019 – June 30, 2019**

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 July 19, 2019 from the centralized database that were filed from April 1, 2019 through June 30, 2019.

**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 21 grievances filed; twelve 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 three days. Of the grievances filed, 100% were filed by beneficiaries. Of the 21 grievances filed, DMH had 76%, DAIL had 19% and DVHA had 5%. There were no grievances filed for 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 41 appeals filed. Of these 41 appeals, 15 were resolved (37%), 24 were still pending (58%), and 2 were withdrawn (5%).

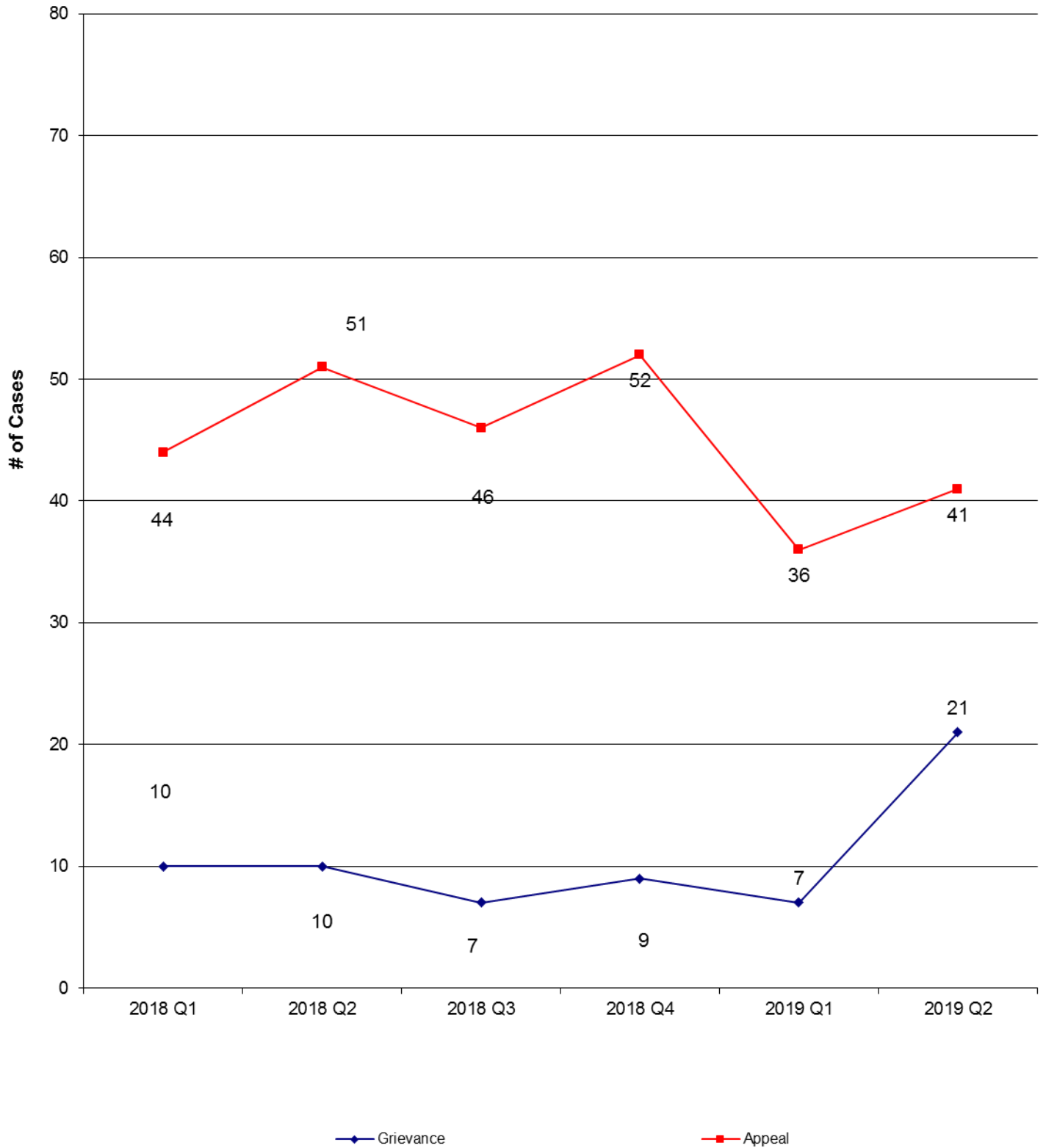
Of the 15 appeals that were resolved this quarter, 95% were resolved within the statutory time frame of 30 days. One appeal was resolved after the 30-day timeframe, this appeal was extended at the request of the beneficiary. The average number of days it took to resolve these cases was 25 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

Of the 41 appeals filed, DVHA had 22 appeals filed (54%), DAIL had 15 (37%), DCF had 2 (5%), VDH had 1 (2%) and DMH had 1 (2%).

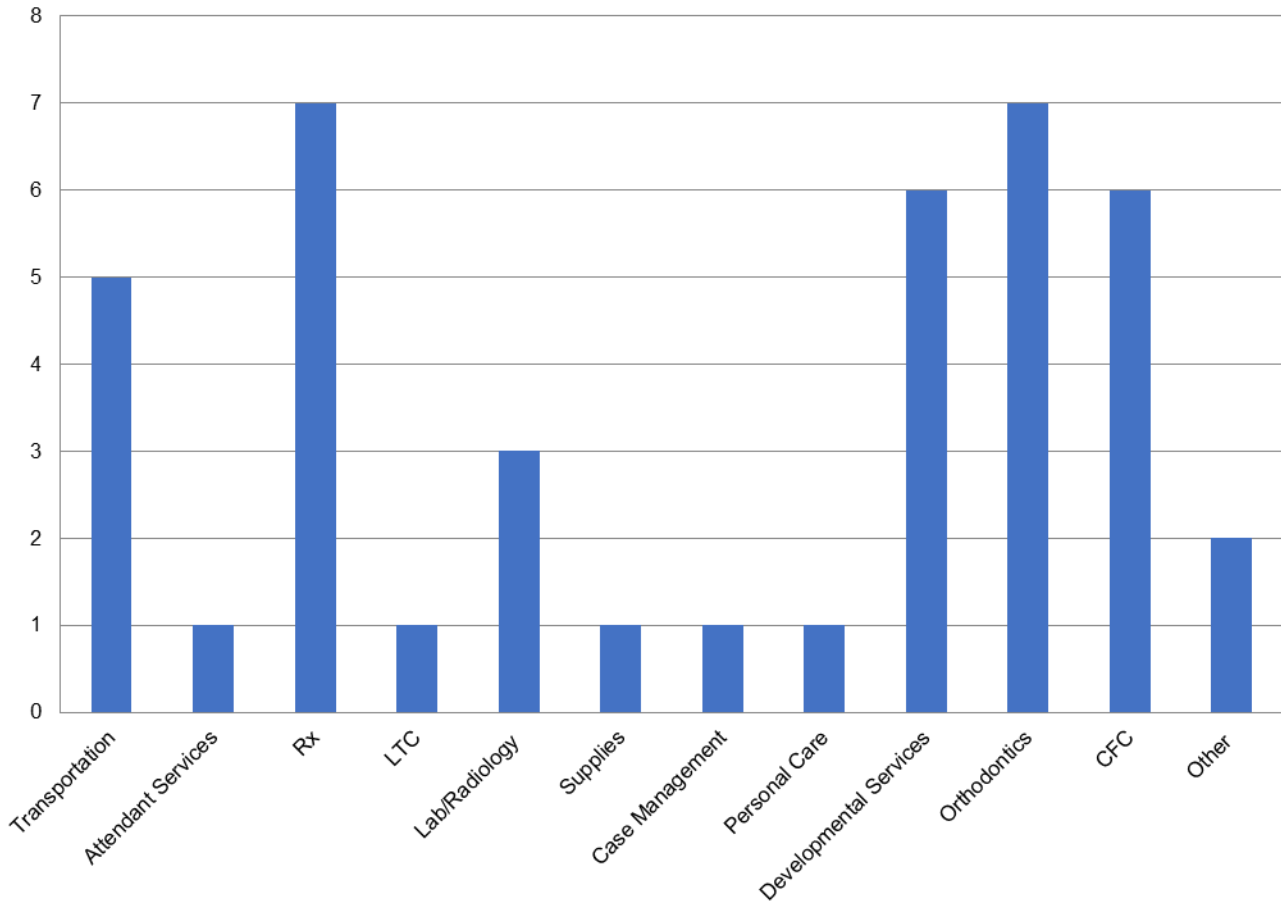
The appeals filed were for service categories; choices for care, personal care, orthodontics, home health, radiology, transportation, attendant services, long term care, supplies, community supports, prescriptions, community/social supports and case management.

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

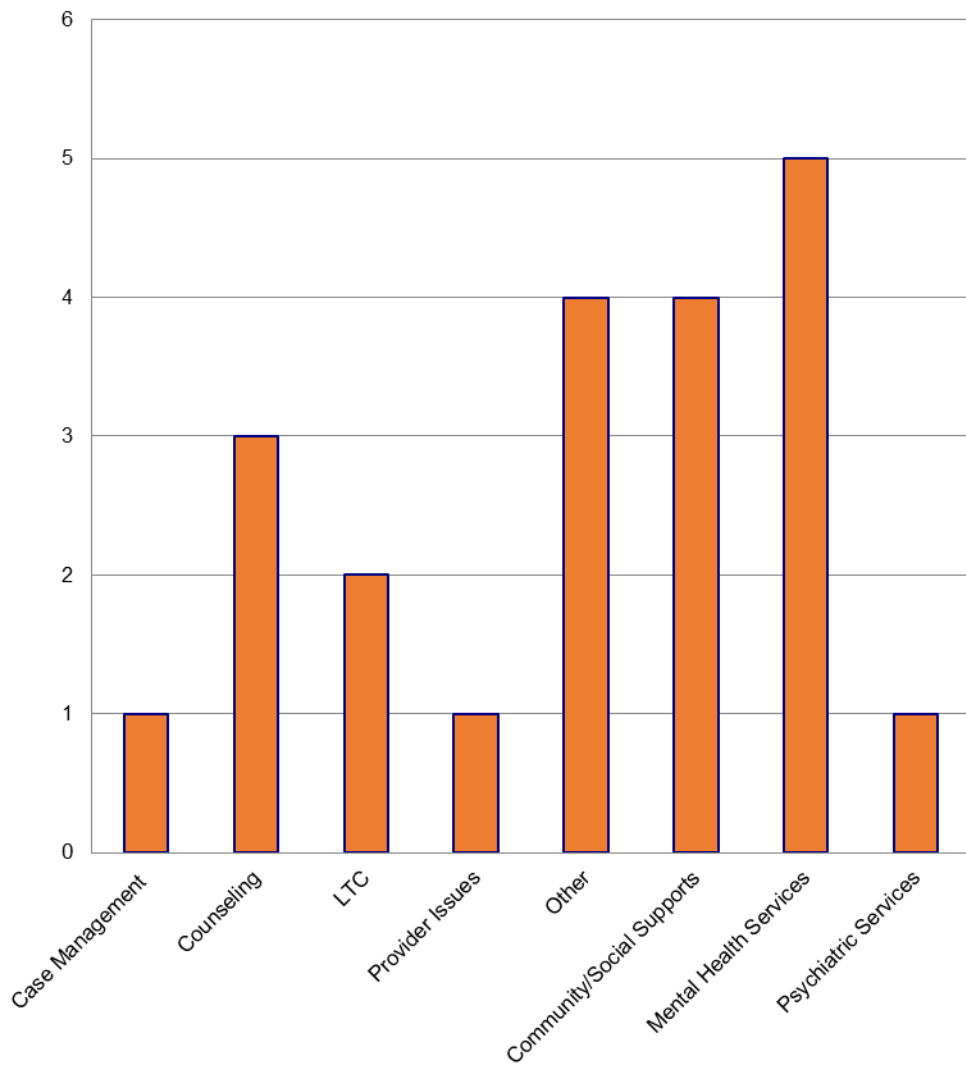
# Grievances and Appeals January 1, 2018– June 30, 2019



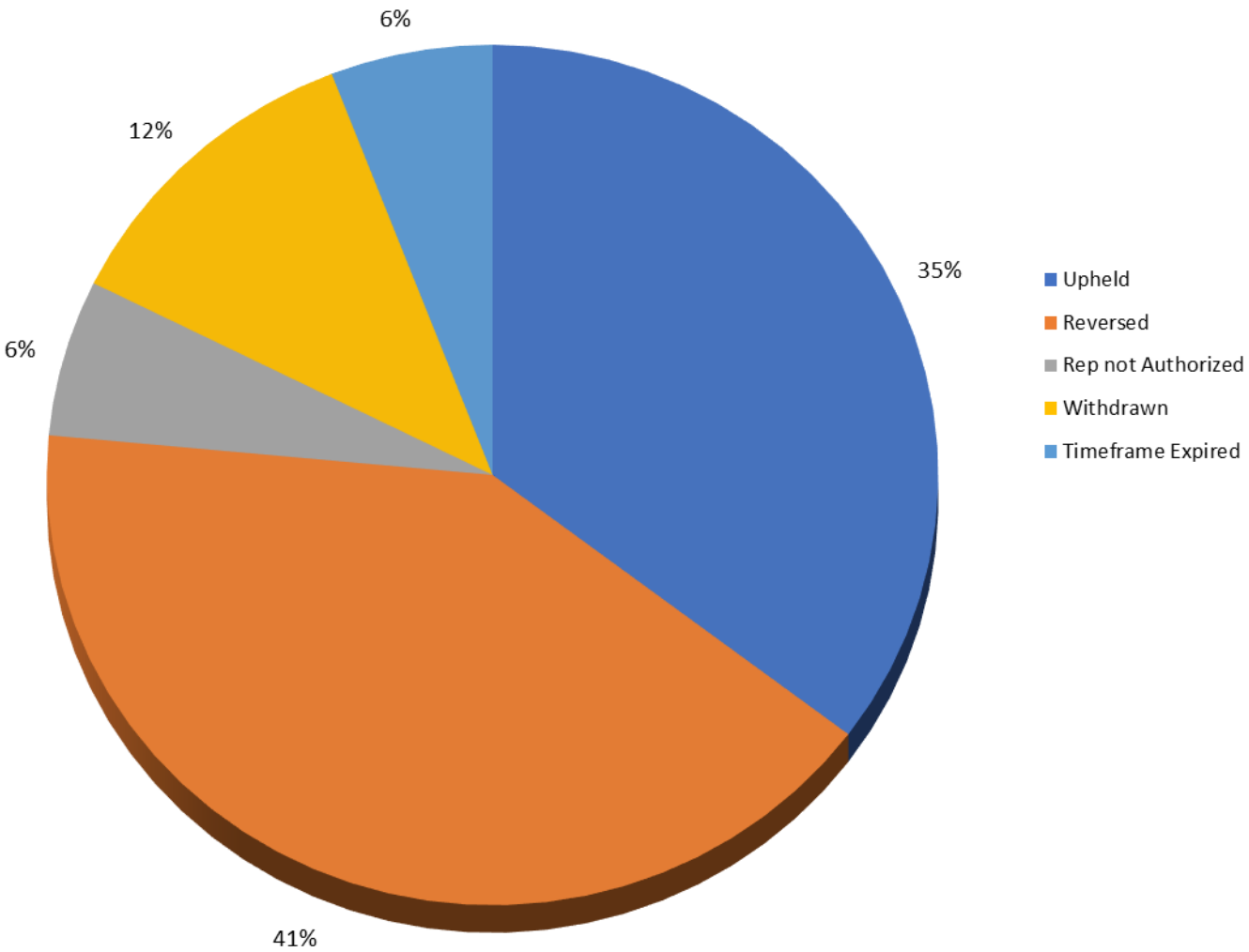
### Appeals by Service Category



### Grievance by Service Catagory



# Appeal Resolutions 4/1/2019 thru 6/30/2019



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Vermont Legal Aid  
**Office of the Health Care Advocate**

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Quarterly Report  
April 1, 2019- June 30, 2019  
to the  
Agency of Administration  
submitted by  
Michael Fisher, Chief Health Care Advocate  
Office of the Health Care Advocate

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July 22, 2019





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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 helpline advocates focused on helping Vermonters navigate the end of tax filing season by answering questions about IRS reconciliation and the shared responsibility penalty. There was a significant drop in the number of Vermonters calling with 1095-A problems. The 1095-A is a tax form generated by Vermont Health Connect (VHC) that shows the household's insurance coverage for the year. We had 10 cases in 2019 about issues with 1095 tax form. This number is a drop from the two previous years (18 in 2018, 31 in 2017) and reflects that VHC is now producing much more accurate and timely notices.

The HCA also completed its pilot project, Vermont Health Connect, on the new integrated application for Health Care programs. During the process, HCA helped 11 households get onto insurance using the new application. It also provided substantive feedback on making the new application easier to understand for all applicants. The HCA expects to continue to provide feedback on the new application as it is introduced to consumers.

The HCA also continued to work with VHC on making VHC notices more understandable and readable for all Vermonters. We focus on using plain language whenever possible, and explaining legal rules and rights in a straightforward manner, while avoiding legal jargon. It is especially important that Vermonters understand their appeal rights which are explained with these notices. We had 49 cases this quarter where we advised Vermonters appealing a decision by the state of Vermont.

The HCA represents Vermonters through individual, administrative, and legislative advocacy. Our policy priorities reflect our daily work with Vermonters struggling with a health care system that often does not meet their needs. We work to control unnecessary costs and make the health care system sustainable, and to ensure that Vermont consumers are heard by providers and policy-makers.

### Cooper's Story

Cooper had recently enrolled on Medicare, but he was having trouble affording the premiums. His only income was from Social Security, and paying the \$135.50 monthly premium for Medicare Part B was creating a hardship. When the HCA advocate researched his case, she found that Cooper had filled out a health care application with the State of Vermont. The state, however, had failed to screen him for a Medicare Savings Program (MSP). Medicare Saving Programs pay for Part B premiums, and, in some cases, Medicare cost-sharing for eligible Vermonters. Cooper was eligible for an MSP that paid both his Part B premium and all of his Medicare cost-sharing. Being on the MSP meant that the state would pay the \$135.50 Part B premium, and Cooper would have more monthly income. The HCA advocate also discovered that Cooper was not enrolled on a Medicare Part D plan to cover his prescription drugs. Because Cooper was eligible for MSP, it also meant that he was deemed eligible for a program called "Extra Help." Extra Help is a Federal program that helps pay for Part D premiums and keep the Part D copayments low. Being eligible for "Extra Help" meant that Cooper had a special enrollment period to enroll in a Part D plan. With the MSP and "Extra Help," Cooper now had assistance paying for his Part B and Part D premiums as well as his Medicare cost-sharing.

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## 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 (<https://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 835 calls<sup>1</sup> this quarter. We divided these calls into broad 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:

- **24.79%** (207) about **Access to Care**
- **10.18 %** (85) about **Billing/Coverage**
- **1.92%** (16) about **Buying Insurance**
- **11.14%** (93) about **Complaints**
- **9.70%** (81) about **Consumer Education**
- **29.46%** (246) about **Eligibility** for state and federal programs
- **9.58%** (80) 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 246 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 436 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 April - June, 2019, 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:** 835 calls (compared to 1018 calls last quarter)
  - **Department of Vermont Health Access (DVHA) beneficiaries:** 307 calls (329 calls last quarter)

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

- **Commercial Plan Beneficiaries:** 170 calls (237 calls last quarter)
- **Uninsured Vermonters:** 64 calls (77 calls last quarter)
- **Vermont Health Connect (VHC):** 188 calls (259 calls last quarter)
- **Reportable Activities (Summary & Detail):** 105 activities and 17 documents (135 activities, 12 documents)

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## Individual Consumer Assistance

### Case Examples

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

#### **Robin's Story:**

Robin called the HCA helpline because she was uninsured and needed to fill a prescription for a chronic condition. She had been on Medicaid, but that had closed at the start of the year when she was found to be over-income for the program. After her Medicaid closed, Robin had a two-month Special Enrollment Period (SEP) to enroll in a Vermont Health Connect (VHC) plan. She did not understand that she needed to enroll within the 60-day period. By the time she called the HCA, she had missed her SEP to enroll in a VHC plan. She had also had an unexpected trip to the hospital, and was worried about how she was going to pay for it. When the HCA advocate studied Robin's income, she found that Robin was very close to the Medicaid eligibility cut off. The HCA advocate recommended that Robin make a small monthly contribution to a traditional IRA to reduce her monthly taxable income. Medicaid eligibility is based on a person's "Modified Adjusted Gross Income" (MAGI). Contributing to the IRA lowered Robin's MAGI just enough to make her eligible for Medicaid again. The advocate then helped expedite the application and get the coverage activated, so Robin could get her prescriptions.

#### **Anthony's Story:**

Anthony's grandmother called the HCA when she found out that Anthony's Medicaid for the Aged Blind and Disabled (MABD) had been closed. The notice from the State of Vermont said that he was now over income for the program. Anthony was eligible for Medicaid because he was in the special eligibility category called "Disabled Adult Child." He had been disabled before age 22, and he was receiving Social Security benefits based on his parent's work record. When his parent died, those benefits had increased, and his Medicaid had been closed for being over income. However, the advocate pointed out that this was an error and that under the eligibility rules for this category of Medicaid, the benefits based on his parent's record should have not have been counted when determining Medicaid eligibility. The State of Vermont agreed that it had been a mistake to count those benefits and close Anthony's Medicaid, and his coverage was reinstated.

#### **Megan's Story:**

Megan called the HCA because she got a bill from her Medicare Part D plan charging her for two prescriptions from the month before. When the HCA advocate investigated, she found that Megan was on VPharm. VPharm is a State of Vermont pharmacy program that reduces Medicare Part D out-of-pocket prescription costs. If you are enrolled on VPharm 1, like Megan, your prescription copayments are \$1 to \$2. When the advocate checked, she found that VPharm had covered over ten prescriptions for that month. Since the Part D plan had been paid by VPharm, it should not have been billing Megan directly, so Megan was not responsible for those bills. The advocate contacted the State of Vermont which confirmed that Megan should not be charged for those prescriptions because VPharm had already paid. The State of Vermont reached out to Megan's Part D plan and told it stop billing Megan. The Part D plan stopped billing Megan, and she was able to continue to fill her prescriptions.

**Caitlin's story:**

Caitlin called the HCA because she was about to turn 26 and would no longer be able to stay on her parents' health insurance. Under the Affordable Care Act, young adults can stay on their parents' insurance until age 26. Caitlin was on several regular prescriptions and did not want to have a break in coverage when she aged off her parents' plan. The HCA advocate helped Caitlin apply, using VHC's new integrated health care application. With the integrated application, Vermonters can apply for multiple health care programs in one place. (See *Priorities* for more about the new application and the Pilot Project.) Caitlin was able to complete the application in less than 30 minutes and was found eligible for a Qualified Health Plan (QHP) on VHC. She was also eligible for an APTC (Advance Premium Tax Credit) to help lower her monthly premium. Caitlin was able to enroll in a plan on VHC and did not have any lapses in insurance coverage.

**Nathan's Story:**

Nathan's surgery was scheduled for the spring. He had been on Medicaid, Medicaid had granted a prior authorization approving the out-of-state surgery, and all of his plans were in place to go forward with the surgery. He called the HCA because his Medicaid had closed. This would mean that he did not have insurance and would not be able to have the surgery. When the advocate investigated, she found that the family had been over-income for Medicaid because Nathan had been working some extra shifts for one month. But the extra shifts had ended. She helped Nathan calculate his income for the current month, and found that the family was once again eligible. She helped him apply and expedited the application. Nathan's Medicaid was reinstated, and he was able to go forward with the surgery.

**Shannon's Story:**

Shannon was enrolled on a plan on Vermont Health Connect (VHC), and called the HCA because she needed VHC to issue a refund so that she could pay her rent. She was entitled to a significant amount of Advance Premium Tax Credit (APTC) to help lower her monthly premiums. With the APTC, Shannon's premium was less than \$10 per month. However, when she paid her monthly premium, she was mistakenly charged the full cost of the plan, about \$500. There had been an error and her APTC had not been applied to that month, so she had been charged for the whole cost of the plan. Shannon needed that money to pay her rent and food. The HCA advocate worked immediately to get the APTC applied to that month and requested an expedited refund. The refund was issued within a week of the request, and Shannon was able to use it to pay her rent.

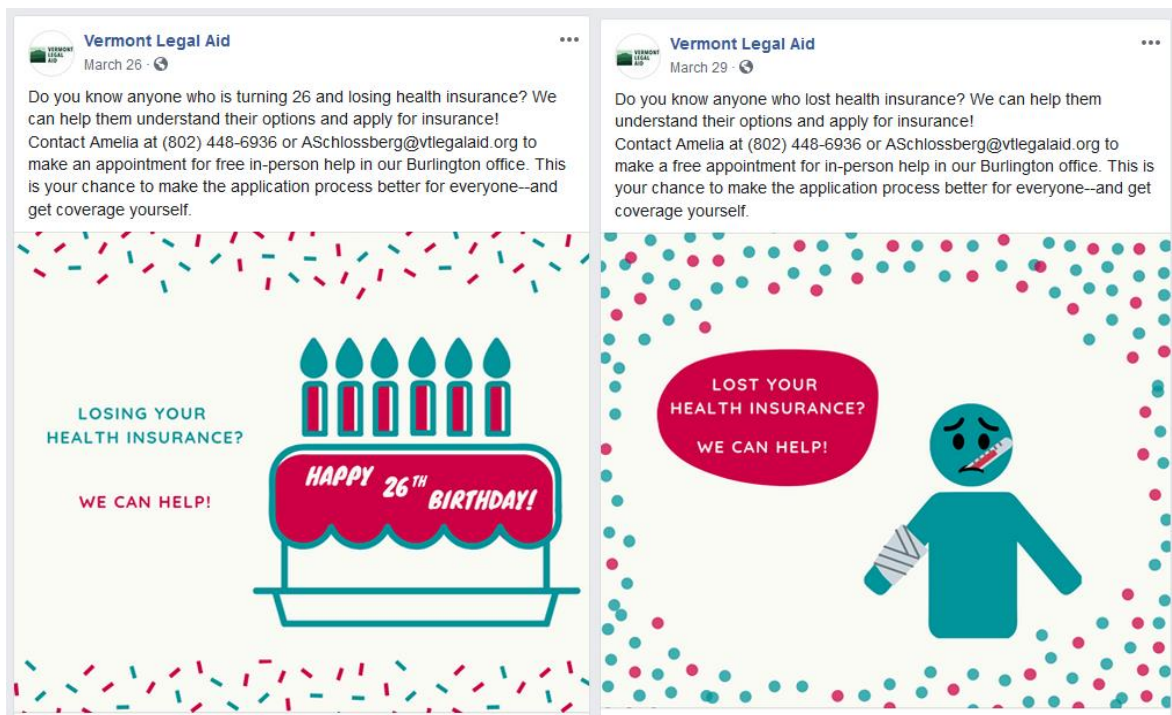
**Abigail's Story:**

Abigail had been on Medicaid for Aged, Blind and Disabled (MABD). Her Medicaid had closed, however, when she got a part-time job. The income from the job pushed her slightly over the eligibility cut-off for MABD. She called the HCA, wondering whether she should quit the job, so she could maintain her Medicaid coverage. The HCA advocate realized that Abigail was eligible for Medicaid for the Working Disabled, which has a significantly-higher income limit. This meant that Abigail could keep her job, and also stay on Medicaid. The advocate helped Abigail get screened for the program by providing pay checks and other verification to the State of the Vermont. Abigail was approved for the Medicaid for the Working Disabled, and her coverage was activated—and she also kept her job.

## Priorities

### A. The HCA finished its pilot project with VHC on the new Health Care Application.

The HCA partnered with VHC to provide an evaluation of the new streamlined paper application for Health Care programs. The HCA helped get 11 households onto healthcare using the new application. During the project, the HCA used social media to find Vermonters who did not have insurance and were interested in applying on VHC. The HCA advocates were able to see how Vermonters understood and experienced the application, and what areas were confusing or problematic. The HCA also provided its own assessment of the application, and submitted comments to improve its clarity. The new, integrated application allows Vermonters to apply for multiple health care programs with one application, including both Medicaid for Children and Adults, and Medicaid for the Aged, Blind and Disabled. As the new application is being introduced statewide, the experience from the pilot project will help the HCA advocates assist other Vermonters.



### B. The HCA presented a training on state health care programs at Vermont Legal Aid's annual training.

The HCA did a presentation on state and federal health care programs for Vermont Legal Aid and Legal Services Vermont attorneys and paralegals. Besides giving an overview of eligibility rules for state health care programs, the presenters also discussed how Vermonters can be referred to the HCA and how we can help on these cases. The HCA plans to do a follow-up training, specifically for attorneys in the Senior Citizens Law Project at Vermont Legal Aid who have questions about Medicare Savings Programs.

**C. The HCA is participating in the Rural Health Services Task Force.**

The HCA is participating in the task force on rural health, with the goal of making health care more accessible and sustainable to Vermonters who live in rural areas. Every quarter, the HCA has cases from Vermonters who have transportation barriers to getting the care that they need. We had 11 Medicaid transportation cases this past quarter. We also get many calls from consumers who want to change providers, and are limited in their selection because of their rural location.

**D. The HCA kicked off a consumer engagement strategy for the small group and individual 2020 insurance rate review.**

The HCA began by developing and distributing an accessible, plain language public comment tool, along with graphics for posters and online outreach. The HCA also began a social media campaign, engaged the press with messaging on the importance of consumer engagement, and met health care policy staff at local non-profit organizations.

**E. Overall call volume decreased by 18%, but was similar to call volume for the second and third quarters of 2018.**

The total call volume decreased by 18% (835 this quarter vs 1018 last quarter). About 12% of those calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We also helped 50 households estimate their eligibility for insurance programs. We saved consumers \$12,468.05 this quarter.

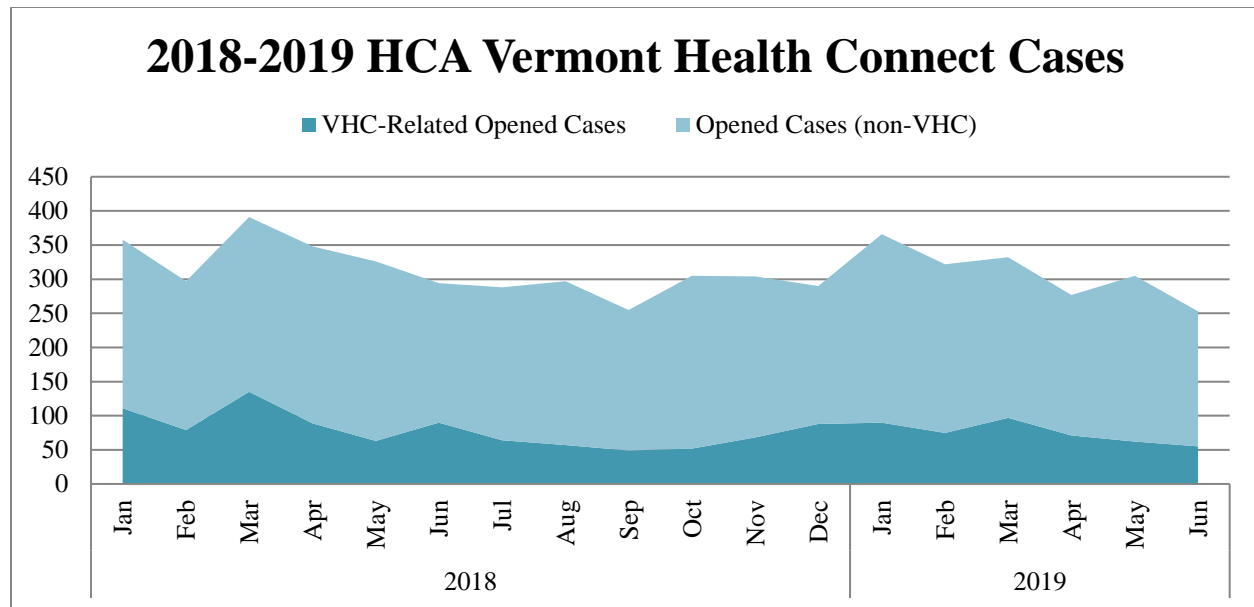
**F. Calls concerning Vermont Health Connect decreased by 27% this quarter.**

The volume of calls concerning Vermont Health Connect decreased this quarter (188 vs. 259). The top two VHC issues were Eligibility for Medicaid - MAGI (78), and Eligibility for Special Enrollment Periods (64). This quarter, 62 VHC cases required complex interventions that took more than two hours of an advocate's time to resolve, and another 35 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 41 escalated cases (37 last quarter). Of the 41 escalated cases, 30 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 (57), MABD (60), Medicaid Spend Downs (22) and VPharm eligibility (420).





**E. Medicaid eligibility calls represented 32% of all our cases (268 cases/835 total cases). Consumers need assistance with all types of Medicaid.**

Medicaid eligibility was again the top issue generating calls. We had 125 calls about eligibility for Medicaid for Children and Adults (MCA) Medicaid, 60 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), 21 about Medicaid Spend Downs, and 17 about Medicaid for Working Disabled, and 5 about Katie Beckett Medicaid. We also had 39 calls about Long Term Care Medicaid. MAGI Medicaid and MABD Medicaid have different eligibility and income rules, and HCA advocates assess and advise on eligibility for both programs. Consumers frequently have questions about what counts as income, who should be counted in their household, what expenses can be used to meet a Spend Down, how to complete renewal paperwork, and whether their eligibility decision is correct.

**F. 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 835 (compared to 1017 last quarter)**

1. MAGI Medicaid eligibility 125 (125)
2. Termination of Insurance 87 (70)
3. Eligibility for Special Enrollment Periods 77 (56)
4. Complaints about providers 76 (92)
5. Information/applying for DVHA programs 74 (79)
6. Information about Medicare 69 (80)
7. Premium Tax Credit eligibility 62 (83)
8. Medicaid eligibility (non-MAGI) 57 (74)
9. Affordability affecting access to care 59 (126)
10. Buy-in programs/Medicare Savings Programs 57 (70)
11. Not health related 54 (60)
12. Access to Prescription Drugs/Pharmacy 47 (88)

13. Nursing Home & Home Health access 42 (42)
14. Fair Hearing - Eligibility 38 (20)
15. Premiums billing 34 (10)

**Vermont Health Connect Calls 188 (compared to 259 last quarter)**

1. MAGI Medicaid eligibility 78 (91)
2. Eligibility for Special Enrollment Periods 64 (45)
3. Termination of Insurance 62 (37)
4. Premium Tax Credit eligibility 58 (79)
5. Fair Hearing – Eligibility 30 (12)
6. Information about Grace Periods 30 (18)
7. Buying QHPs through VHC 27 (31)
8. Complaints about VHC – Invoices or Payment 26 (33)
9. Information about DVHA 24 (38)
10. IRS Reconciliation 19 (26)
11. Premiums billing 19 (7)

**DVHA Beneficiary Calls 307 (compared to 329 last quarter)**

1. MAGI Medicaid eligibility 63 (59)
2. Medicaid eligibility (non-MAGI) 35 (36)
3. Information about DVHA 34 (28)
4. Complaints about providers 27 (29)
5. Buy In Programs/MSPs eligibility 23 (26)
6. Access to Prescription Drugs/Pharmacy 21 (34)
7. Information about Medicare 20 (12)
8. Not health related 19 (13)
9. Termination of Insurance 18 (21)
10. Eligibility for Long Term Care Medicaid & Choices for Care 17 (12)
11. Access to transportation 16 (15)
12. Eligibility for Special Enrollment Periods 16 (6)

**Commercial Plan Beneficiary Calls 170 (compared to 237 last quarter)**

1. Termination of Insurance 32 (20)
2. Premium Tax Credit eligibility 30 (49)
3. Eligibility for Special Enrollment Periods 32 (24)
4. MAGI Medicaid eligibility 22 (21)
5. Premiums billing 22 (5)
6. Affordability affecting access to care 20 (27)
7. Complaints about VHC - Invoices or Payment 20 (28)
8. Fair Hearing – Eligibility 17 (8)
9. Buying QHP through VHC 16 (20)
10. Information about Grace Periods 16 (12)
11. Coverage & Contract Questions 13 (13)
12. Information about DVHA 13 (12)

The HCA received 835 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”): 36.8% (307 calls), compared to 32.2 % (329 calls) last quarter
- **Medicare<sup>2</sup> beneficiaries** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as “dual eligible,” Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 32.2% (269 calls), compared to 30.8% (313 calls), last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans 20.4% (170 calls) , compared to 23.2% (237 calls) last quarter
- **Uninsured:** 7.66% (64 calls), compared to 7.56% (77 calls last quarter)

## Case Results

### A. Dispositions of Closed Cases

#### All Calls

We closed 816 cases this quarter, compared to 986 last quarter:

- 38% (308 cases) were resolved by brief analysis and advice
- 27% (222) were resolved by brief analysis and referral
- 20% (161) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate’s time
- 10% (81) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases, 44 clients withdrew, resolved the issue on their own, or had some other outcome.

**Appeals:** The HCA assisted worked on 63 cases related to appeals: 41 Fair Hearings; 8 Commercial Insurance appeals; 4 Medicare Part A, B, or C appeal; 2 Medicare Part D appeals; 5 Medicaid MCO Internal appeals; and 3 Medicaid Eligibility Internal appeals.

#### DVHA Beneficiary Calls

We closed 300 DVHA cases this quarter, compared to 321 last quarter:

- 36% (108 cases) were resolved by brief analysis and/or advice
- 23% (68) were resolved by brief analysis and/or referral
- 22% (66) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate’s time
- 13% (40) 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, 18 clients resolved the issue on their own, or had some other outcome.

<sup>2</sup> 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 172 cases involving individuals on commercial plans, compared to 222 last quarter:

- 39% (67 cases) were resolved by brief analysis and/or advice
- 26% (45) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 15% (26) were resolved by brief analysis and/or referral
- 14% (25) 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, 9 clients withdrew, resolved the issue on their own, or had some other outcome.

**B. All Calls Case Outcomes**

The HCA helped 413 people with advice and education about health insurance questions about problems. We got 57 households onto insurance. We assisted 8 people with applications for or enrollment in insurance plans and prevented 17 insurance terminations or reductions. We obtained coverage for services for 21 people. We got 9 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 50 more. We provided other billing assistance to 27 individuals. We obtained other access or eligibility outcomes for 78 additional people.

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## Consumer Protection Activities

### A. Rate Review

The HCA analyzes all commercial insurance carrier requests to the Green Mountain Care Board (Board) to change premium prices. Insurers typically request to increase the premium prices that Vermonters must pay.

The Board decided three filings the quarter covering April 1, 2019 through June 30, 2019. Additionally, there are two proposed premium price increases pending at the end of this quarter.

Cigna Health and Life Insurance Company (CHLIC) submitted one of the filings decided by the Board this quarter, namely, the CHLIC large group filing. Approximately 794 Vermonters who obtain coverage through their employers were impacted by CHLIC's proposed premium change. The HCA appeared on behalf of Vermonters and filed a memorandum in lieu of hearing in this matter. The HCA advocated that CHLIC's proposed premium change be reduced by one-and-a-half points due to an excessive profit margin. The Board agreed with this recommendation, and reduced CHLIC's proposed premium change by one-and-a-half points.

Blue Cross Blue Shield of Vermont (BCBSVT) submitted two of the filings decided by the Board this quarter, namely, the consolidated BCBSVT and The Vermont Health Plan (TVHP) large group filing, and the BCBSVT association health plan (AHP) filing. Approximately 14,700 Vermonters who obtain coverage through their employers were impacted by the consolidated BCBSVT and TVHP large group filing. The HCA appeared on behalf of Vermonters, filed questions to the carrier, and submitted a memorandum in lieu of hearing in this matter. The Board reduced BCBSVT's and TVHP's proposed average approximately one point.

Regarding the decided BCBSVT association health plan filing, we are not able to estimate the number of Vermonters affected by the filing as the filing was for a relatively new product. The AHP filing was an unusually complicated and controversial case. In the past, federal rules regarding AHPs have limited their existence. In 2018, the Trump Administration released a rule to make it easier for small groups and individuals to purchase health insurance from an association instead of through the state's health insurance marketplace. The HCA has fought to keep Vermont from implementing the Trump AHP rule, because the cheaper AHP plans create higher prices for Vermont's remaining small group and individual health insurance plan members.

As a result of the Trump AHP rule, BCBSVT began selling AHP plans for 2019 coverage and filed a rate request with the Board in February 2019 for the 2020 plan year. However, in late March of 2019, a federal court declared that the Trump AHP rule was unlawful, stating that it relied on a tortured reading of the Affordable Care Act and that it undermined the market structure that Congress carefully crafted. After significant research, including speaking with national experts on the subject, the HCA filed a motion for summary rate rejection with the Board, asking them to reject BCBSVT's 2020 AHP filing on the basis that it is for an illegal product following the federal court decision. The Board rejected the HCA's motion, but asked the parties to brief the issue as a part of their memos in lieu of hearing. The HCA re-asserted this argument in its memo in lieu submitted in late May. In June 2019, the Department of Financial Regulations issued a statement that it will not allow insurers to sell AHPs formed under the Trump rule in 2020 due to the federal court ruling. The Board then issued a decision, rejecting BCBSVT's AHP filing.

There are two pending filings related to premium price increases for individual and small group health insurance plans. These two proposed premium price increases were filed by BCBSVT and MVP and these two proposed price increases will impact approximately 75,000 Vermont members. These two filings

request a 15.6 percent (BCBSVT) and a 9.4 percent (MVP) increase. The HCA appeared on behalf of Vermonters in these matters, submitted questions to the carriers, and filed various motions. We intend to file all appropriate memoranda and other documents to represent the interests of Vermonters in these matters. Additionally, we intend to represent Vermonters at the public hearings related to these two premium price increases and devote substantial resources to outreach regarding these filings.

### **B. Hospital Budget Review**

The HCA participates in the Board's annual hospital budget review process. This quarter, the HCA attended the Board's enforcement hearings and deliberations for the FY2018 budget year. The Board considered enforcement action for hospitals' who exceeded their FY2018 budget by 2.0% or more (one hospital: Mount Ascutney) and for hospitals who fell below their FY2018 budget by 2.5% or more (five hospitals: Copley, Northwestern, North Country, Springfield, and Gifford). The Board voted not to take any enforcement action against any of the hospitals.

### **C. Oversight of Accountable Care Organizations**

The HCA participates in the Board's annual ACO budget review process. This quarter, the Board developed its ACO budget guidance for the 2020 budget year. The HCA reviewed the Board's draft guidance and provided written feedback to Board staff. We subsequently met with Board staff to review our concerns. Board staff incorporated some of our suggestions into the draft they presented to the Green Mountain Care Board for approval. The HCA submitted formal comments to the Board outlining our remaining concerns. We asked for clear information on the community initiatives funded or otherwise supported by OneCare, and for year-over-year quality information. We also asked questions of Board staff and made general suggestions for the ACO budget process, including improved transparency. The Board partially incorporated our suggestion about community initiatives into its approved budget guidance, but did not ask for year-over-year quality information. The HCA will request this information in our questions to the ACO. By the end of the quarter, the HCA had not received a response from the Board to our written questions.

### **D. Certificate of Need Applications**

This quarter, the HCA participated in two Certificate of Need (CON) review proceedings before the Green Mountain Care Board.

#### *GMCB 001-19con University of Vermont Medical Center Adult Primary Care Facility Replacement Project*

The HCA submitted comments supporting the project and noting that our helpline hears from a significant number of Vermonters who have trouble finding a primary care provider in Chittenden County. We also asked the Board to require UVMHC Essex Family Care practitioners to certify that they will accept patients without regard to payer type, insurance status, or their ability to pay for services.

#### *GMCB-010-15con Green Mountain Surgery Center Multi-Specialized Ambulatory Surgical Center*

In 2017, the Board approved a Certificate of Need (CON) for this project. The CON required the GMSC to submit regular updates on the project. The CON also required the GMSC to appear before the Board to prove that it had satisfied several conditions prior to commencing operations. The HCA participated in this hearing which took place on April 17. Following the hearing we submitted a request for policy modifications including that the GMSC bring its financial assistance policy into line with those of the University of Vermont Medical Center (UVMHC) and Northwestern Medical Center, and that the GMSC

work with the HCA to ensure that its financial assistance policy, eligibility information, and application are clear, complete, and readable for consumers. The Board issued a Statement of Decision and Order on June 4<sup>th</sup>.

### **E. Other Green Mountain Care Board Activities**

The HCA continues to attend the weekly Green Mountain Care Board meetings. This quarter we also participated in the Board's Rate Review 101 presentation. The HCA attended two meetings of the Board's Data Governance Council and one meeting of the Board's Advisory Group. We also met and communicated with Board staff about various topics including the ACO budget review process and bad debt and free care.

### **F. Other Activities**

#### **Administrative Advocacy**

##### **❖ Comments on Proposed Change to Federal Poverty Level Calculation**

This quarter, the HCA submitted comments to the Office of Management and Budget (OMB) on its notice regarding differences among various consumer price indexes (CPIs) and their influence on the estimation of the Official Poverty Measure. OMB's notice proposed lowering the poverty line by applying a smaller cost-of-living adjustment each year, using either the chained CPI or the Personal Consumption Expenditures Price Index in place of the Consumer Price Index for All Urban Consumers. The HCA's comments strongly opposed this proposal, noting that the official poverty measure is already too low, that there are other significant problems with the poverty line, that low-income households experience higher inflation, and that in-depth analysis is needed before making any changes to the poverty threshold.

##### **❖ Access to Treatment for Hepatitis C Virus**

The HCA continues to advocate for increased access to hepatitis C virus (HCV) treatment. This quarter the Chief Health Care Advocate testified at the Joint Legislative Justice Oversight Committee about our ongoing concerns with HCV treatment practices at the Department of Corrections (DOC). These concerns include length of stay restrictions for treatment eligibility that exclude large numbers of people in custody, and significant delays in treatment access for people eligible under DOC's current guidelines.

##### **❖ 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.

##### **❖ Vermont Health Information Exchange Consent Policy**

The HCA advocated for meaningful informed consent for patient participation Vermont's Health Information Exchange. The HCA commented about this issue at a Green Mountain Care Board meeting this quarter. Given that the legislature has decided to move to an opt out consent policy, the HCA is engaged with state partners to assure that there is a robust outreach and communications plan to ensure that Vermonters understand how and why their health information will be shared. We

participated in a preliminary meeting with DVHA regarding the stakeholder input process for the change from an opt-in consent policy to opt-out.

#### ❖ **Vermont Crisis Standards of Care Work Group**

The HCA participated in two meetings of this workgroup in this quarter, in order to review and provide feedback on the state's Crisis Standards of Care plan.

#### ❖ **Hospital-Associated Infections Advisory Committee**

The HCA provided a health care consumer perspective during the June meeting, regarding surveillance of antimicrobial resistance and WHONET.

#### ❖ **Global Commitment Register Comments**

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

#### ❖ **Vermont Health Connect Escalation Path**

The HCA and VHC continue to collaborate to resolve complex VHC issues. The VHC escalation path now also works to resolve issues regarding Medicaid for Aged, Blind and Disabled (MABD), Medicare Savings Programs, Medicaid Spend Downs 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 5 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 focused on the Medicaid budget in DVHA as well as other key parts of the Agency including DAIL, DCF, and DMH. We also focused on the administration's legislative agenda as well as general functioning of open enrollment and health care IT projects. The Chief attended and co-chaired two meetings of the MEAB this quarter.

#### ❖ **Gender Affirming Surgery**

The HCA continues to advocate for increased access to medically necessary gender affirming surgery for gender dysphoria. Last quarter, the Chief Health Care Advocate submitted comments during the informal rulemaking comment period. This quarter, the HCA continued coordinating outreach to transgender and non-binary consumers, as well as local and regional stakeholder organizations on the topic of gender affirming treatment for gender dysphoria in preparation for DVHA's July 2019 public hearing. In our comments and outreach, the HCA's priorities are ensuring that Medicaid is accurately determining medical necessity while decreasing onerous barriers to access to care for Vermonters with gender dysphoria.



## Legislative Activities

The HCA was active in the State House this quarter with a number of legislative projects. We represented the consumer perspective in various legislative discussions including open enrollment, silver loading, transparency in medical billing, abortion access, HIE consent policy, and various other issues discussed in the Legislature this year.

The most significant legislative project this this year for the HCA was to protect consumers from federal efforts to undermine the Affordable Care Act.

*Association Health Plans (H. 524):* The HCA took a lead role in pushing back on the Trump Administration push to divide our community rated risk pool. The legislature chose to limit association health plans beginning in 2020, allowing existing AHPs to enroll current (2019) employer members (dependent on the results of a federal court case), but prohibiting existing AHPs from enrolling new employer members and prohibiting the formation of new AHPs. This bill ensures that there will not be a growing AHP marketplace that would further destabilize Vermont's individual and small group insurance risk pool.

*Affordable Care Act Consumer Protections (H. 524):* The legislature codified in state law a number of important consumer protections from the ACA, including guaranteed issue, the ban on preexisting condition exclusions, annual limits on cost sharing, the ban on annual and lifetime limits, no cost sharing for preventive services, and a requirement to allow for coverage of dependents up to age 26. Adding these provisions to state law will help protect Vermonters from potential changes at the federal level.

*Other Health Care Bills:* The legislature passed a number of other health care-related bills this session, which the HCA tracked and engaged in as-needed. These included abortion legislation (H. 57 and Proposal 5) and bills on integration of social services with Vermont's all-payer model (S. 7), informed health care decision-making (S. 31), regulation of health reimbursement accounts and other tax-advantaged accounts for health spending (S. 41), licensure of ambulatory surgery centers (S. 73), structural changes to Vermont Health Connect premiums if there are changes at the federal level (S. 89/Act 19), increasing the Medicaid dental cap (H. 542/originally S. 95), and restoring the Vermont tax deduction for medical expenses (H. 541).

*Health Care Stakeholder Work Groups:* The legislature created a number of stakeholder work groups related to health care policy that the HCA will engage in. These include a health insurance affordability report (H. 524) a health insurance market study (H. 524), a rural health services task force (H. 528), a price transparency report (S. 31), implementation of an opt-out consent policy for the Vermont Health Information Exchange (S. 31), a primary care spending report (Act 107), and a dental access and reimbursement work group.

## 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:

- Altarum Health Care Value Hub
- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Burlington School District
- Community Catalyst
- Dartmouth College Pathways to Medicine Scholars Program
- Families USA

- IRS Taxpayer Advocate Service
- Ladies First
- MVP Health Care
- National Center for Transgender Equality
- NHeLP, National Health Law Program
- OneCare Vermont
- Out in the Open (formerly Green Mountain Crossroads)
- Outright Vermont
- Pride Center of Vermont
- Planned Parenthood of Northern New England
- Rights and Democracy Vermont
- SHIP, State Health Insurance Assistance Program
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Businesses for Social Responsibility
- Vermont Care Partners
- Vermont CARES
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Developmental Disabilities Council
- Vermont Health Connect
- Vermont Medical Society
- Vermont Program for Quality in Health Care
- Vermont Workers' Center

## Outreach and Education

### Quarterly report – website stats – April - June 2019

Note: Office pageviews of the health web pages are included in the numbers here. The **only** numbers where office traffic is **excluded** are the Online Help Tool numbers.

### A. Increasing Reach and Education through the Website

VTLawHelp.org is a statewide website maintained by Vermont Legal Aid and Legal Services Vermont. The site includes a substantial Health section (<https://vtlawhelp.org/health>) with more than 200 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 6%** in the reporting quarter ending June 30, 2019 (11,745 pageviews), compared with the same quarter in 2018 (11,080 pageviews).
- The **top-20 health pages** on our website this quarter with change over last year:
  - *Income Limits – Medicaid* – 2,652 pageviews (10% ↓)
  - *Health* – section home page – 1,885 (33% ↑)
  - *Dental Services* – 453 (3% ↑)
  - *Choices for Care* – 415 (10% ↑)
  - *Services Covered by Medicaid* – 353 (23% ↓)
  - *Resource Limits – Medicaid* – 309 (31% ↓)
  - *HCA Help Request Form* – 305 pageviews (33% ↑) and 67 online requests (33% ↑)
  - *Medicare Savings / Buy-In Programs* – 271 (70% ↑)
  - *Medicaid* – 248 (21% ↑)
  - *Buying Prescription Drugs* – 209 (30% ↓)
  - *Health Insurance, Taxes and You* – 168 (40% ↑)
  - *Advance Directive Forms* – 159 (11% ↓)
  - *Medicaid and Medicare Dual Eligible* – 148 (23% ↑)
  - *Health Insurance* – 147 (41% ↑)
  - *Federally Qualified Health Centers* – 142 (19% ↓)
  - *Choices for Care Income Limits* – 138 (3% ↓)
  - *Choices for Care Resource Limits* – 136 (8% ↓)
  - *Long-term Care* – 134 (22% ↓)
  - *Medical Decisions: Advance Directives* – 133 (16% ↓)
  - *Prescription Help – State Pharmacy Programs* – 129 (54% ↑)
- In addition to the pages listed above, such as *Medicare Savings / Buy-In Programs* (70% ↑), other **spikes in interest** in our pages included:
  - *Supplemental Medicare Plans* – 121 (1000% ↑)
  - *Complaints* – 113 (82% ↑)

- *Dr. Dynasaur* – 123 (52% ↑)
- *Form 1095-A* – 86 (69% ↑)
- *Vermont Health Connect main page* – 91 (67% ↑)
- *Resources for Vermonters Who Don't Have Insurance* – 86 (54% ↑)
- *Medicaid/Green Mountain Care* – 120 (29% ↑)

### **Popular Downloads**

29 different health care-related PDF, Word or other files were downloaded from the VTLawHelp.org website. Of those unique health-related PDF titles:

- The top five consumer-focused PDF downloads were:
  - *Advance Directive, short form* (111 downloads)
  - *Vermont Dental Clinics Chart* (106 downloads)
  - *Advance Directive, long form* (71 downloads)
  - *Vermont Medicaid Coverage Exception Standards & Form* (27 downloads)
  - *Fair Hearing Flyer* (15 downloads)
- The top advocate-focused PDF download was:
  - *PTC Rule Allocation Summary* (20 downloads)
- The top policy-focused PDF download was:
  - *VT ACO Shared Savings Program Quality Measures* (5 downloads)

The *Advance Directive Short Form* is the **third most downloaded of all PDFs** downloaded from the entire VTLawHelp.org website. The *Long Form* is the **sixth most downloaded**. The *Vermont Dental Clinics Chart* is the **fourth most downloaded**.

### **Online Help Tool Adds to Our Reach**

Health is one of the topics in the online help tool on our website. It can be accessed from most pages of our website [https://vtlawhelp.org/triage/vt\\_triage](https://vtlawhelp.org/triage/vt_triage). The website visitor answers a few questions to find specific health care information they need. The tool 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 tool to access health care information **156 times** during this quarter. That's slightly up from the same quarter last year as well as the previous quarter (January – March 2018).

Of the **41** 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 – How do I know if I can get Choices for Care Long-Term Care Medicaid?
- Medicaid – I want to apply for Medicaid or Dr. Dynasaur for myself or for my children.
- Complaints – I want to file a complaint against a doctor or hospital.
- Long-Term Care – I want to go over my long-term care options (nursing homes, in-home care and more).

## B. Other Outreach and Educational Activities

- **Planned Parenthood of Northern New England Meeting, April 4, 2019.** The HCA met with the Senior Operations Manager to discuss the HCA HelpLine services, policy advocacy, and introduce the health care application pilot program. After the meeting, Planned Parenthood's Burlington office distributed HCA business cards to uninsured Vermonters needing help with a Medicaid application
- **Community Health Centers of Burlington Meeting, April 4, 2019.** The HCA met with the Patient Support Services department to discuss trends in patient health insurance issues and how the HCA can be a resource to patients and navigators at CHCB. The HCA also introduced the health care application pilot program and established a streamlined referral process for Medicaid application support.
- **Bi-State Member Meeting, April 9, 2019.** The HCA gave a 55-minute presentation to nine Bi-State members and staff from across the state. Along with sharing information on HelpLine services, the HCA updated Bi-State on our policy advocacy.
- **Community Wellness Fair, April 16, 2019.** The HCA tabled at the fair and distributed information about health care legal services. HCA reached 12 families, parents of young children, and high schoolers.
- **Dartmouth College Pathways to Medicine, April 27, 2019.** The HCA presented on Vermont's health care system, the HCA's HelpLine, policy advocacy, and how to resolve health insurance issues to 25 pre-med students. The HCA also distributed brochures and business cards.
- **Multicultural Youth Leadership Conference Resource Fair, May 5, 2019.** The HCA participated in an outreach event at Champlain College for attendees of the conference. HCA advocates educated attendees about HelpLine services, distributed business cards, and met with representatives from 20 other non-profit organizations in health and human services.
- **Policy in Plain English Podcast, May 28, 2019.** The HCA supervising attorney and health care communications coordinator appeared on-air for a Bi-State podcast episode about editing notices for accessibility and plain English.
- **Parent University Class, May 30, 2019.** The HCA presented to 15 adult learners with interpreters in several languages. Attendees learned how to access health care advocate services, discussed language accessibility concerns of state health care programs, and received HCA outreach materials.
- **Vermont Coalition of Clinics for the Uninsured, June 7, 2019.** The HCA presented on the HCA HelpLine, health care policy advocacy, and health care access issues to eight board members of the VCCU, each representing one of the clinics for uninsured Vermonters.
- **Parent University Graduation, June 19, 2019.** The HCA tabled at the graduation of students in Parent University, distributing business cards and information about health insurance advocacy to 20 families and community members who attended in support of the graduates. The HCA also distributed a set of HCA outreach materials to each of the 25 student graduates.
- **Social Media Outreach.** The HCA published 12 posts on Facebook, with a total of 5,817 views. The HCA published 18 posts on Twitter.



### 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:

- EE1167 for individuals who need to submit a new 202 Med
- Residency Notice (#1)
- RE 001, request for authorization
- GMC Uploader Macro
- Residency MNT Notice (#2)

**Office of the Health Care Advocate**

Vermont Legal Aid  
264 North Winooski Avenue  
Burlington, Vermont 05401  
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<https://vtlawhelp.org/health>

**CY 2019 Investment Expenditures**

Depart ment	STC #	Receiver Suffix	Investment Description	QE 0319	QE 0619	QE 0919	QE 1219	CY 2019 Total
AHSCC	41	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,067	113,067			226,134
AHSCC	54	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	3,309,488	1,615,107			4,924,595
AOE	11	n/a	Non-state plan Related Education Fund Investments					-
DCF	55	9402	Investments (STC-79) - Medical Services (55)	23,713	16,960			40,673
DCF	1	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)	2,232,488	2,163,050			4,395,538
DCF	56	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	1,047,295	697,313			1,744,608
DCF	57	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	27,795	18,726			46,521
DCF	58	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	68,004	44,134			112,138
DCF	59	9408	Investments (STC-79) - Essential Person Program (59)	209,725	209,216			418,941
DCF	60	9409	Investments (STC-79) - GA Medical Expenses (60)	70,191	83,423			153,614
DCF	61	9411	Investments (STC-79) - Therapeutic Child Care (61)	285,108	303,798			588,906
DCF	2	9412	Investments (STC-79) - Lund Home (2)	366,961	697,058			1,064,019
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)	44,660	101,852			146,512
DCF	9	9415	Investments (STC-79) - Challenges for Change: DCF (9)	48,807	20,545			69,352
DCF	26	9416	Investments (STC-79) - Strengthening Families (26)	308,531	272,857			581,388
DCF	62	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	68,790	65,921			134,711
DCF	35	9418	Investments (STC-79) - Building Bright Futures (35)	206,047	148,849			354,896
DDAIL	63	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	120,100	66,080			186,180
DDAIL	64	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	353,476	856,447			1,209,923
DDAIL	27	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	289,997	193,985			483,982
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)	232,386	282,202			514,588
DDAIL	77	9607	Investments (STC-79) - HomeSharing (77)	86,397	86,312			172,709
DDAIL	78	9608	Investments (STC-79) - Self-Neglect Initiative (78)	110,761	69,406			180,167
DDAIL	65	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)	16,175	17,153			33,328
DMH	28	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	38,771	33,410			72,181
DMH	66	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	665,517	645,037			1,310,554
DMH	79	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	130,269	111,612			241,881
DMH	16	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	(5,624,184)	(834,225)			(6,458,409)
DMH	12	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	1,096,710	662,760			1,759,470
DMH	29	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,723,842	1,595,744			4,319,586
DMH	67	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	465,823	158,672			624,495
DMH	22	9510	Investments (STC-79) - Emergency Support Fund (22)	287,906	75,706			363,612
DMH	3	9511	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - VPCH	5,513,064	4,779,527			10,292,591
DMH	3	9512	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - BR	1,390,537	2,610,673			4,001,210
DMH	68	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	11,939	41,947			53,886
DMH	13	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	43,293	436,132			479,425
DOC	4	n/a	Return House	117,936	135,666			253,602
DOC	5	n/a	Northern Lights	98,438	98,438			196,876
DOC	6	n/a	Pathways to Housing - Transitional Housing	278,587	383,103			661,690
DOC	14	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	130,237	62,365			192,602
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	-	1,364,230			1,364,230
DOC	80	n/a	Intensive Sexual Abuse Program	2,500	2,720			5,220
DVHA	8	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)	-	-			-
DVHA	51	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	770,216	823,697			1,593,913
DVHA	52	9103	Investments (STC-79) - Buy-In (52)	14,170	10,699			24,869
DVHA	53	9104	Investments (STC-79) - HIV Drug Coverage (53)	682	682			1,364
DVHA	18	9106	Investments (STC-79) - Patient Safety Net Services (18)	-	-			-
DVHA	7	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	2,306,138	2,716,620			5,022,758
DVHA	72	9108	Investments (STC-79) - Family Supports (72)	-	-			-
DVHA	81	9109	DSR Investment (STC-83) - One Care VT ACO Quality & Health Management (81)	-	-			-
DVHA	82	9110	DSR Investment (STC-83) - One Care VT ACO Advanced Community Care Coordination (82)	-	-			-
MVCB	45	n/a	Green Mountain Care Board	437,029	717,531			1,154,560
UVM	10	n/a	Vermont Physician Training	844,804	844,805			1,689,609
VAAF	36	n/a	Agriculture Public Health Initiatives	-	-			-
VDH	19	9201	Investments (STC-79) - Emergency Medical Services (19)	123,846	116,394			240,240
VDH	74	9203	Investments (STC-79) - TB Medical Services (74)	10,095	15,236			25,331
VDH	40	9204	Investments (STC-79) - Epidemiology (40)	174,421	322,332			496,753
VDH	39	9205	Investments (STC-79) - Health Research and Statistics (39)	270,241	304,300			574,541
VDH	31	9206	Investments (STC-79) - Health Laboratory (31)	810,186	959,944			1,770,130
VDH	50	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	210,907	818,988			1,029,895
VDH	76	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)	-	-			-
VDH	75	9209	Investments (STC-79) - Family Planning (75)	406,196	400,950			807,146
VDH	25	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	18,722	-			18,722
VDH	73	9211	Investments (STC-79) - Renal Disease (73)	-	-			-
VDH	37	9213	Investments (STC-79) - WIC Coverage (37)	808,915	1,054,030			1,862,945
VDH	21	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	268,800	-			268,800
VDH	47	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	12,065	15,299			27,364
VDH	30	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	473,797	512,894			986,691
VDH	17	9220	Investments (STC-79) - Recovery Centers (17)	310,887	327,846			638,733
VDH	46	9221	Investments (STC-79) - Enhanced Immunization (46)	90,214	21,081			111,295
VDH	48	9222	Investments (STC-79) - Poison Control (48)	26,246	28,252			54,498
VDH	23	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	279,443	475,636			755,079
VDH	38	9224	Investments (STC-79) - Fluoride Treatment (38)	14,144	15,440			29,584
VDH	24	9225	Investments (STC-79) - Medicaid Vaccines (24)	-	-			-
VDH	49	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	58,791	48,459			107,250
VDH	44	9228	Investments (STC-79) - VT Blueprint for Health (44)	466,192	283,982			750,174
VSC	32	n/a	Health Professional Training	204,730	-			204,730
VVH	20	n/a	Vermont Veterans Home	-	-			-
				26,423,019	31,342,075	-	-	57,765,094



# Transitional Housing

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

Most Recent Period  
Current Actual Value

**P** **GCI** Transitional Housing Services

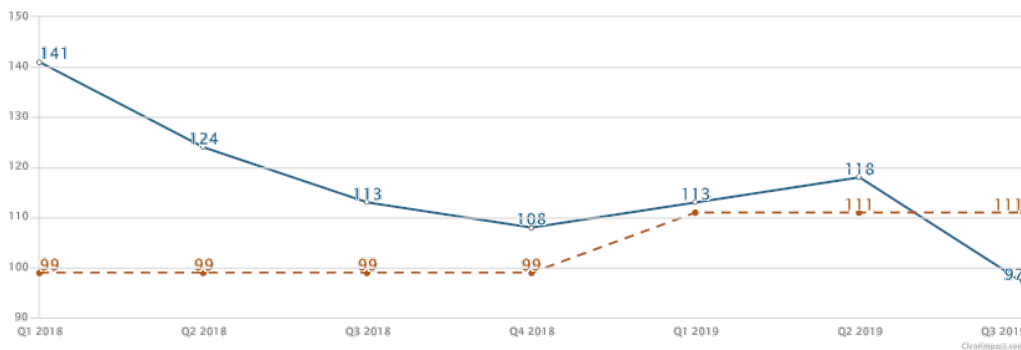
Most Recent Period  
Current Actual Value

What We Do

Transitional housing programs are an integral component in an offender's reentry process. The goal of the program is to move residents recently released from incarceration into stable living situations within one year. With the support of transitional housing, participants can live in the community, find employment opportunities, engage in education, or participate in other programs that will support their long term stability in the community. In this way, transitional housing helps encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system. Up to 100% of these services transitional housing provides are eligible for MCO Investment funding.

**PM** **GCI** Number of Individuals Served

Q3 2019	97
Q2 2019	118
Q1 2019	113
Q4 2018	108
Q3 2018	113
Q2 2018	124
Q1 2018	141

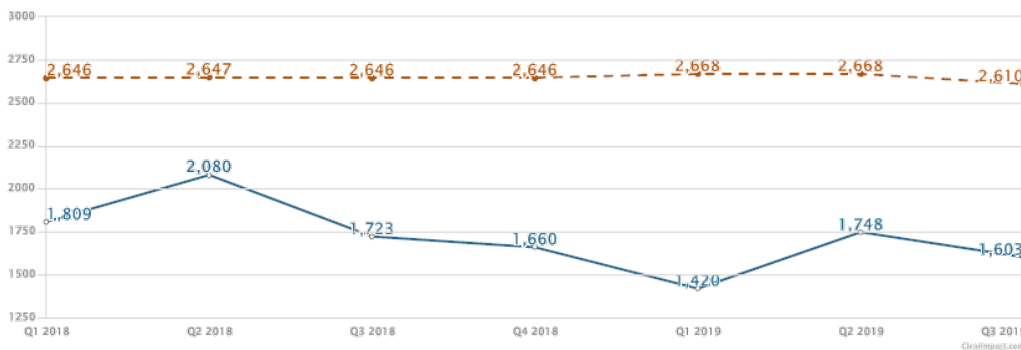


## Story Behind the Curve

The number of individuals served can fluctuate over time depending on the circumstance of people in the program and the circumstance of people scheduled for release. The quarterly target (FY 19) for number of people served is 111; the actual number of people served has been consistently above our target, with the exception of FY19 Q3. The decrease in the number of people served between FY19 Q2 and FY19 Q3 is due to a program closure. The decrease in the number of people served between FY18 and FY19 is due to program closures, limited clinical staff, and updated data reporting techniques.

**PM** **HW** Bed Days Utilized

Q3 2019	1,603
Q2 2019	1,748
Q1 2019	1,420
Q4 2018	1,660
Q3 2018	1,723
Q2 2018	2,080
Q1 2018	1,809

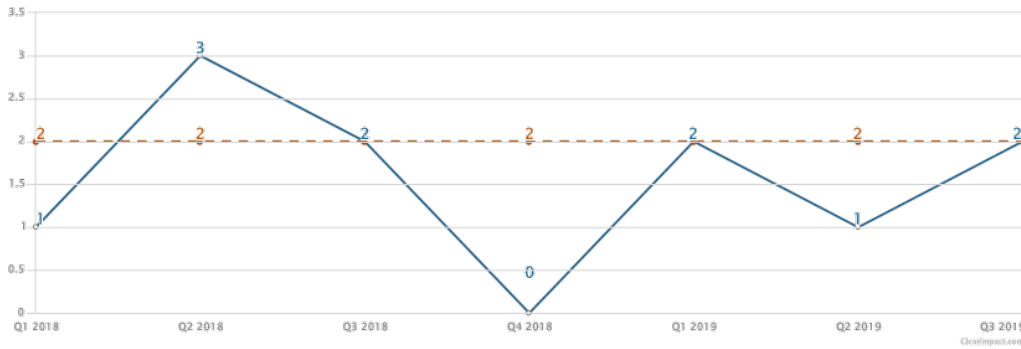


## Story Behind the Curve

Bed utilization fluctuates each quarter because of the variability in individuals' circumstances. The bed days for FY18 totaled 7,272, which was 69% of our annual target (10, 585). The quarterly target for FY19 (Q3) is 2,610. While we are below our annual targets, every quarter we are meeting at minimum 60% of our target bed days utilized.

PM HM Individuals Housed (Search and Retention Services)

Q3 2019	2
Q2 2019	1
Q1 2019	2
Q4 2018	0
Q3 2018	2
Q2 2018	3
Q1 2018	1

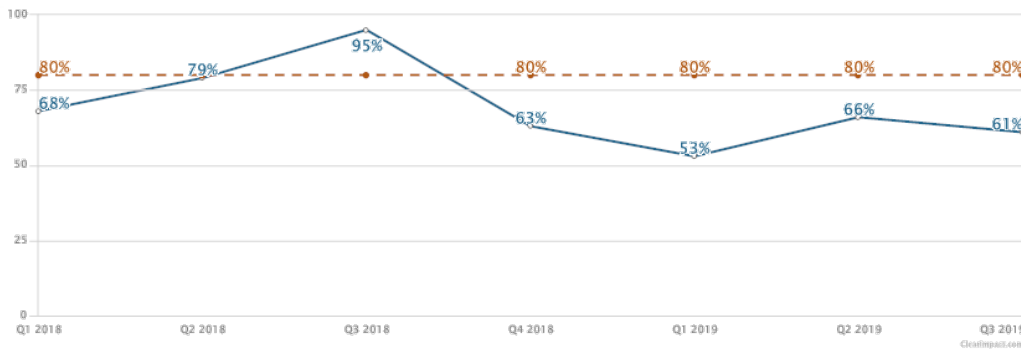


### Story Behind the Curve

The number of individuals housed (search and retention services) fluctuates each quarter because of variability in individuals' circumstances. We have met or exceeded our quarterly target of housing 2 individuals (search and retention services) every quarter except FY18 Q4 and FY19 Q2 (67% of the time).

PM HW Percent of Beds Utilized

Q3 2019	61%
Q2 2019	66%
Q1 2019	53%
Q4 2018	63%
Q3 2018	95%
Q2 2018	79%
Q1 2018	68%

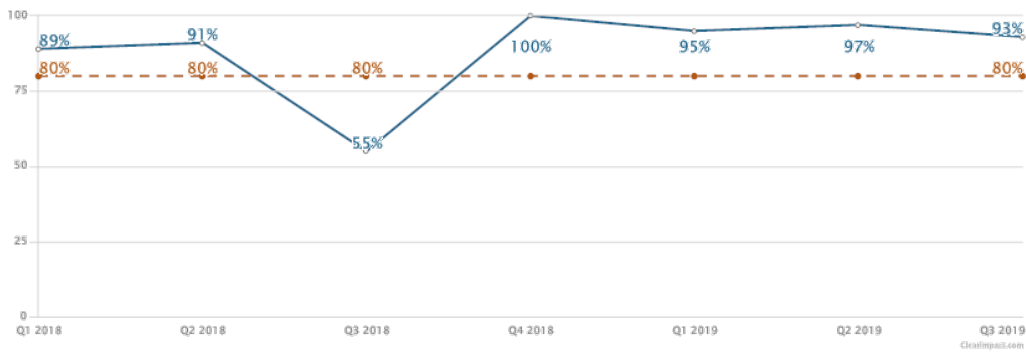


### Story Behind the Curve

Overall utilization for FY18 was 69%. The target for FY19 is 80%; currently we are below our quarterly target for bed utilization by 19%.

PM HW Percent of Referrals Accepted

Q3 2019	93%
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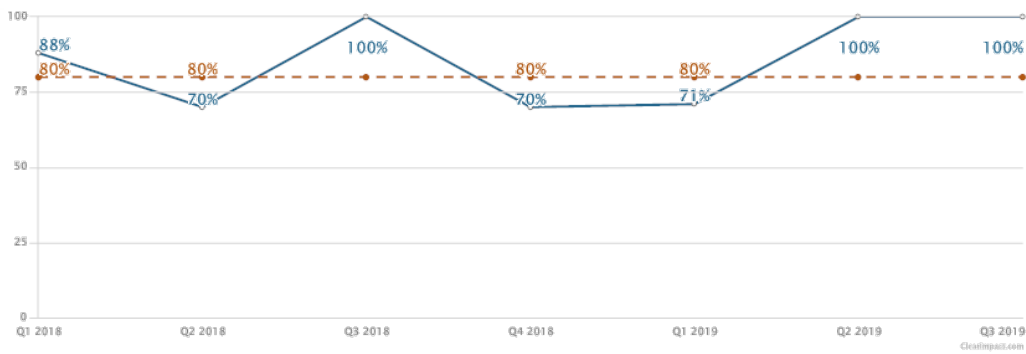
Q2 2019	97%
Q1 2019	95%
Q4 2018	100%
Q3 2018	55%
Q2 2018	91%
Q1 2018	89%

## Story Behind the Curve

Overall percent of referrals accepted for FY18 was above target, at 84%. In FY19, we have been consistently above our quarterly target (80%); currently, we are above our quarterly target for percent of referrals accepted by 13%.

PM

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



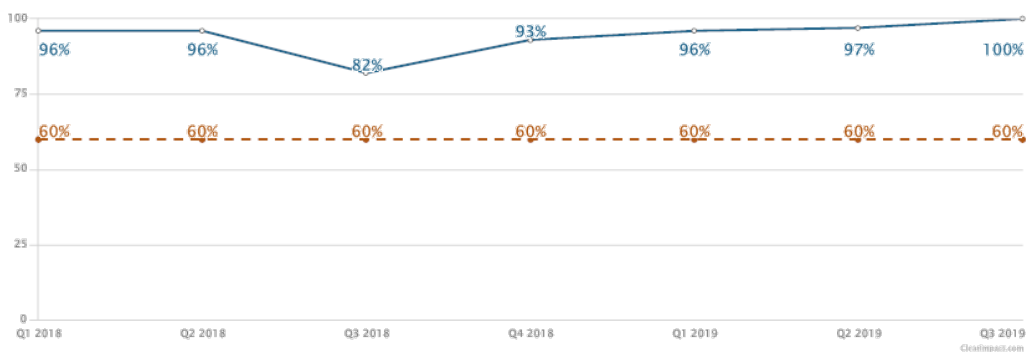
Q3 2019	100%
Q2 2019	100%
Q1 2019	71%
Q4 2018	70%
Q3 2018	100%
Q2 2018	70%
Q1 2018	88%

## Story Behind the Curve

Overall the percent of participants employed, enrolled in an educational/training program, or receiving benefits at exit for FY18 was 75, only 5% below our annual target%. The target for FY19 is 80%. While we were below our target in FY19 Q1, in Q2 and Q3, we were above our quarterly target for by 20%.

PM

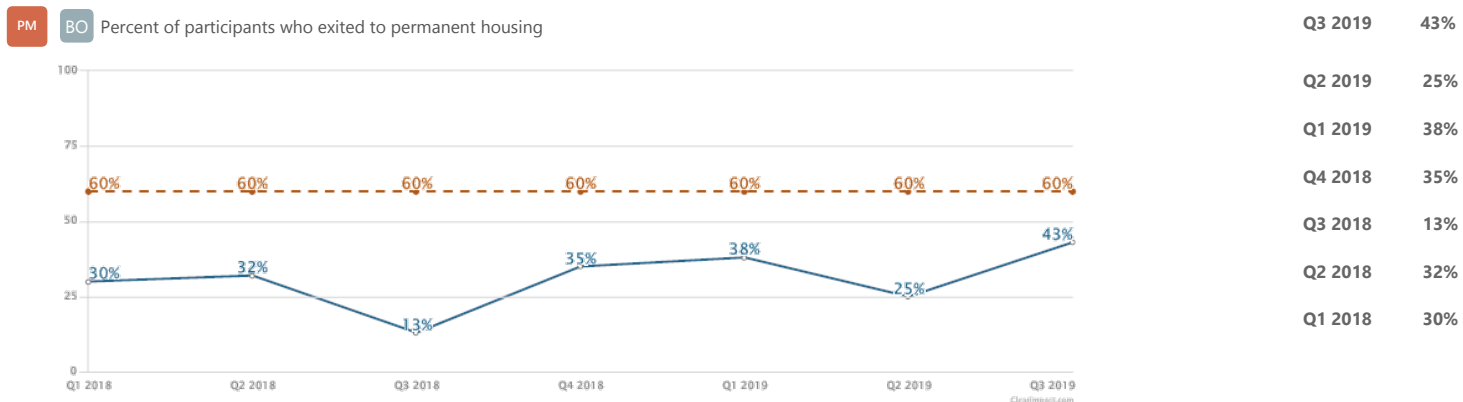
BO Percent of offender remaining crime free while in program



Q3 2019	100%
Q2 2019	97%
Q1 2019	96%
Q4 2018	93%
Q3 2018	82%
Q2 2018	96%
Q1 2018	96%

## Story Behind the Curve

Remaining crime free is significantly associated with successful reentry. In FY18, 95% of program participants remained crime free while in the program (well above our 60% annual target). We have been consistently above our FY19 quarterly target (60%); most recently, 100% of individuals in our programs have remained crime free (FY19 Q3).



## Story Behind the Curve

The percentage of people who exit transitional housing to permanent housing variables across time due to the high variable nature of individuals' circumstances. In FY18, 29% of program participants remained crime free while in the program (below our 60% annual target). While we continue to be below our quarterly target (60%) in FY19, in Q3 43% of individuals exited to permanent housing, which is the highest proportion to date.

What We Do

The Resilience Beyond Incarceration (RBI) Program provides intensive, health-focused case management services to ensure children served establish medical and dental homes and attend well child visits through enrollment in available health insurance programs. Case management services also address other behavioral and mental health issues of the families and children enrolled in program.

Who We Serve

Children of incarcerated and formerly incarcerated parents.

How We Impact

The services provided mitigate the negative impact of incarceration on children by engaging parents in building protective factors that strengthen family and community connections.



Performance Measures		Most Recent Period	Current Actual Value
PM	FSD Number of families served by program	2019	25
PM	FSD Percent of families engaged in health promotion activities	2019	91%
PM	FSD Percent of parents that improve their cumulative self-sufficiency scores across 11 domains	2019	55%

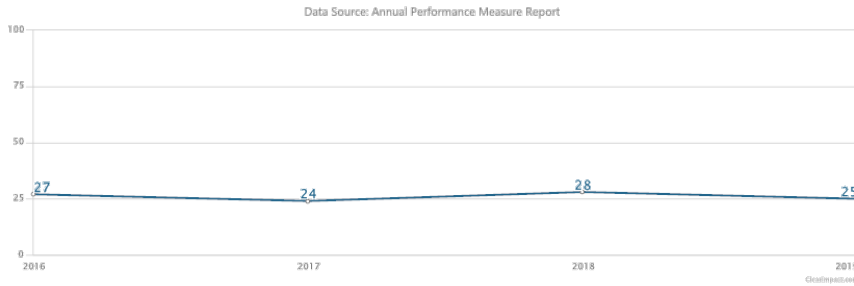
# Lamoille Valley Community Justice Project

**P** **FSD** Lamoille Valley Community Justice Project

Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
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**PM** **FSD** Number of families served by program

2019	25	↘ 1	-7% ↓
2018	28	↗ 1	4% ↑
2017	24	↘ 1	-11% ↓
2016	27	→ 0	0% →



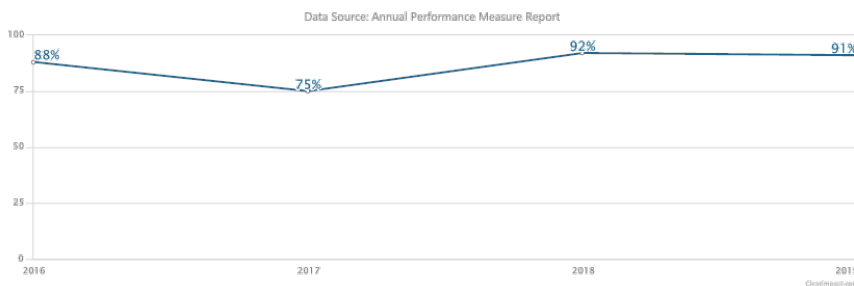
## Story Behind the Curve

The Resilience Beyond Incarceration (RBI) Program serves families for anywhere from 6-18 months and provides intensive case management services using trauma-informed approaches, and evidence-informed methods that align with the Strengthening Families Framework. RBI focuses on developing protective factors to prevent adverse childhood experiences (ACEs) and build resilience in children served.

The program serve between 25 - 30 families per year, and between 50 - 60 children each year. The number of families and children served has remain stable each year. The number of families and children served is driven by the budgetary limitations of having a level-funded budget each year.

**PM** **FSD** Percent of families engaged in health promotion activities

2019	91%	↘ 1	3% ↑
2018	92%	↗ 1	5% ↑
2017	75%	↘ 1	-15% ↓
2016	88%	→ 0	0% →

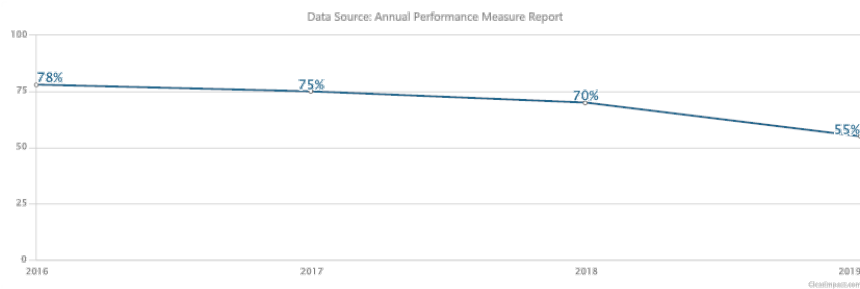


## Story Behind the Curve

The program supports parents to engage in health promotion and/or safety education activities including but not limited to smoking cessation, yoga, swimming, walking, mindfulness and acupuncture. It also works with the VT Chronic Care Initiative to address chronic health issues and other programs such as the Women, Infant and Children program (WIC) for nutrition education.

For the last two years, RBI has been able to engage over 90% of the families served in health promotion activities.

2019	55%	↘ 3	-29%	↓
2018	70%	↘ 2	-10%	↓
2017	75%	↘ 1	-4%	↓
2016	78%	→ 0	0%	→



## Story Behind the Curve

Families are scored on a self-sufficiency matrix (SSM) on the following domains: safety, physical health, mental health, parenting skills, community connections, financial stability, legal, housing, transportation, education/vocation and substance use disorders. Baseline scores are established upon enrollment to program and are measured each quarter.

Due to the small number of families served, this trend line can fluctuate. In 2019, the program served two high risk families who experienced a decreased in SSM scores due to declining mental health and housing instability issues.

## Attachment 8 - Payment Model Scorecard: VMNG ACO

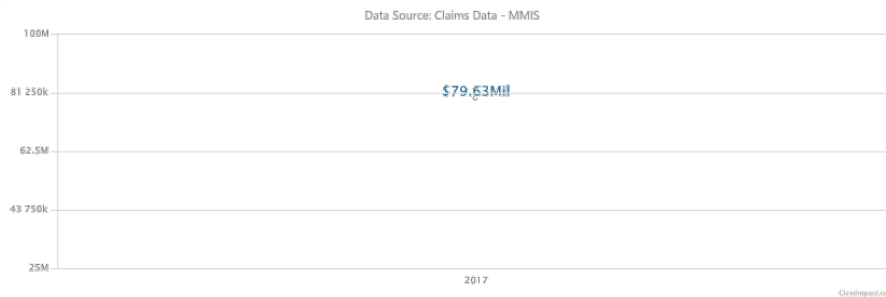
### What We Do

The Vermont Medicaid Next Generation (VMNG) ACO program is a pilot program for a risk-bearing ACO to receive prospective payment and assume accountability for the costs and quality of care for prospectively-attributed Medicaid members. The VMNG model is structured similarly to the Medicare Next Generation ACO Model, but has been modified to address the needs of the Medicaid population in Vermont. Medicaid issues a prospective All-Inclusive Population Based Payment (AIPBP) to the ACO on a Per-Member-Per-Month basis according to a member's Medicaid Eligibility Group. Performance monitoring on the ACO's defined measure set occurs at least annually.

### Performance Measures

Most Recent Period  
Current Actual Value

**PM** **DVHA** Expected and Actual Total Cost of Care for Medicaid enrollees aligned with an ACO **2017** **\$79.63Mil**



#### Notes on Methodology

The expected total cost of care (ETCOC) for ACO(s) in the VMNG program is derived based on actuarial projections of the cost of care in the calendar year for the population of prospectively attributed Medicaid members, using claims history for the two years prior to the calendar year for the attributed members as a baseline and trending it forward to the performance year.



The actual total cost of care (ATCOC) for the ACO is the sum of the Fixed Prospective Payment (FPP) paid to the ACO and the total actual Fee-For-Service expenditures paid by DVHA on behalf of the ACO to its providers for services not covered by the FPP.

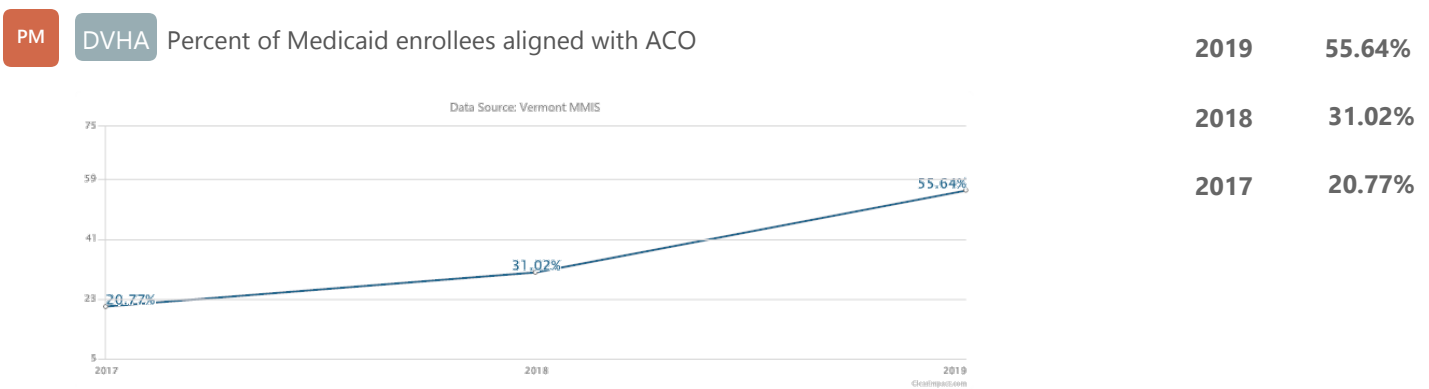
[Please note that final 2018 financial data is currently undergoing internal evaluation and is not publicly available at this time. It is Vermont’s intent to report on this data when available.]

- The red dot above shows the ETCOC
- The blue dot above shows the ATCOC

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### Story Behind the Curve

The ACO has agreed to a risk-based spending target for the full attributed population during the performance year. If the ACO exceeds its spending target for the Performance Year, it is liable for expenses up to 103% of the target; if the ACO spends less than its target, it may retain savings to 97% of the target. This arrangement provides an incentive to use resources efficiently. If the ETCOC and ATCOC are equal, then the ACO’s actual spending is on consistent with its projected spending for the performance year, and a minimal amount of financial reconciliation will occur between the ACO and DVHA during the final financial reconciliation. If the ETCOC is greater than the ATCOC, the ACO’s spending has been less than the financial target, and the ACO would be eligible to retain a portion of the dollars saved relative to the target. Conversely, if the ATCOC is higher than the ETCOC, the ACO’s spending has exceeded its financial target, and the ACO would be liable for a portion of the dollars spent in excess of the target.



Notes on Methodology

Attribution is prospective and set at the beginning of a performance year. Attribution is based on a member's relationship with a primary care provider in the ACO's network, qualifying utilization in a baseline period, Medicaid eligibility at the beginning of the performance year, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible).

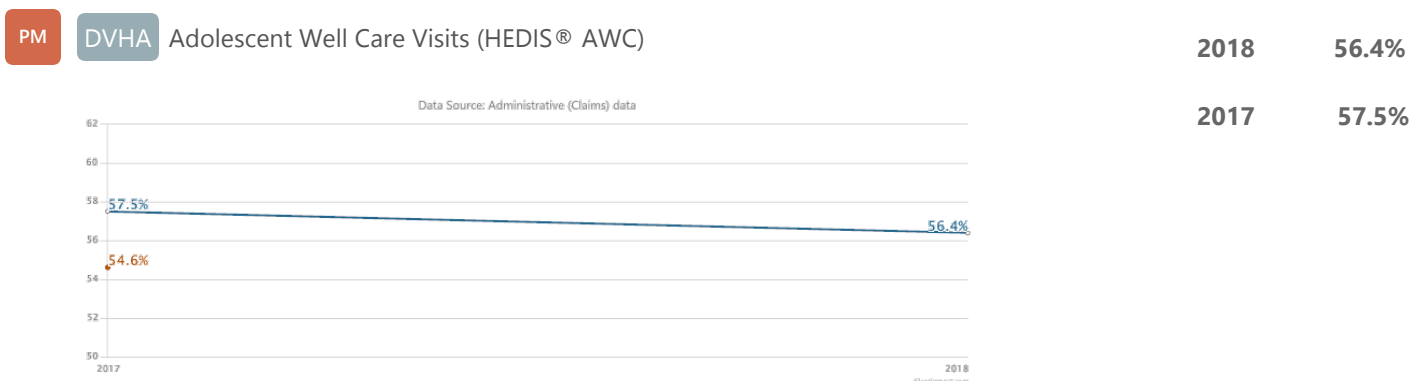
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#### Story Behind the Curve

This measure demonstrates the percentage of the attributable Medicaid population that has been assigned to the VMNG program on an annual basis. Attribution is prospective and set at the beginning of a performance year. Attribution is based on a member's relationship with a primary care provider in the ACO's network, qualifying utilization in a baseline period, Medicaid eligibility at the beginning of the performance year, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible).

Attribution is projected to grow year-over-year as the ACO continues to grow its provider network in the state.

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#### Notes on Methodology

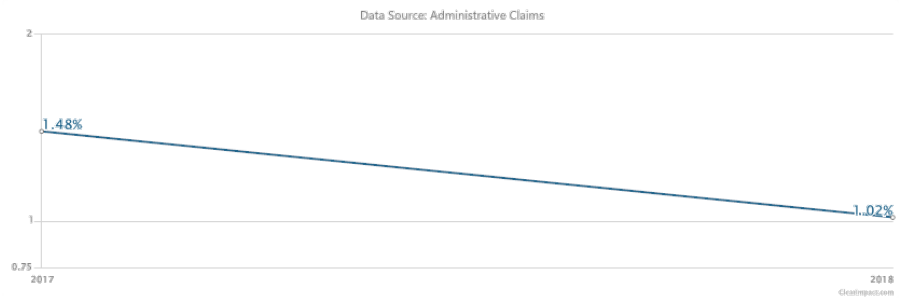
The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual performance for CY 2017 and CY 2018.

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#### Story Behind the Curve

This measure looks at whether adolescents receive regular check-ups. It reports the percentage of adolescents 12-21 years of age attributed to the ACO who had one or more well-care visits with a primary care provider or OB/GYN during the measurement year. Adolescents benefit from an annual preventive health care visit that addresses the physical, emotional and social aspects of their health.

PM	DVHA	All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (NQF #2888)	2018	1.02%
			2017	1.48%



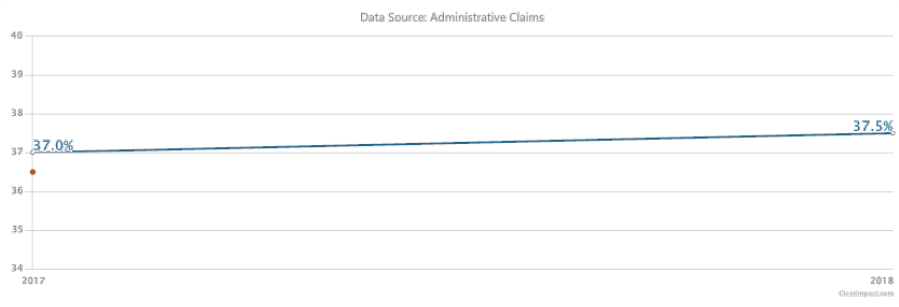
Notes on Methodology

The trend line above represents the ACO's actual performance for CY 2017 and CY 2018. No corresponding benchmarks were available for this measure for this time period.

Story Behind the Curve

Rate of risk-standardized acute, unplanned hospital admissions among Medicaid members with multiple chronic conditions (MCCs) who are attributed to the ACO. Chronic conditions for this measure include acute myocardial infarction, Alzheimer's disease and related disorders or senile dementia, atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease (COPD) and asthma, depression, heart failure, stroke and transient ischemic attack. For this measure, a lower rate is better.

PM	DVHA	Follow Up After Hospitalization for Mental Illness - within 7 days (HEDIS® FUH)	2018	37.5%
			2017	37.0%



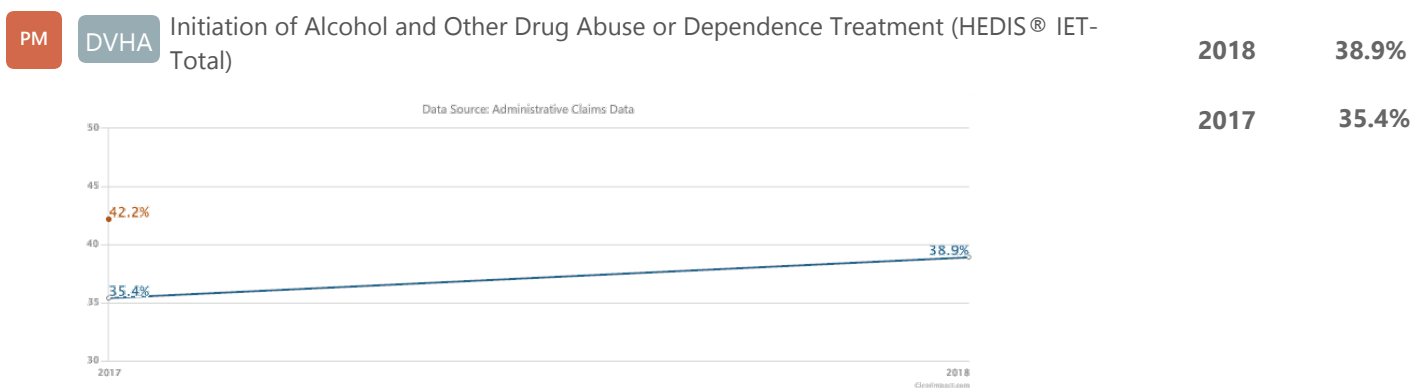
Notes on Methodology

The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual performance for CY 2017 and CY 2018.

Story Behind the Curve

This measure looks at continuity of care for mental illness. It measures the percentage of Medicaid beneficiaries 6 years of age and older who are attributed to the ACO and who were hospitalized for selected mental disorders and then seen on an outpatient basis by a mental health provider **within 7 days** after their discharge from the hospital. The specifications for this measure are consistent with guidelines of the National Institute of Mental Health and the Centers for Mental Health Services.

It is important to provide regular follow-up treatment to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care.



#### Notes on Methodology

The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual performance for CY 2017 and CY 2018.

#### Story Behind the Curve

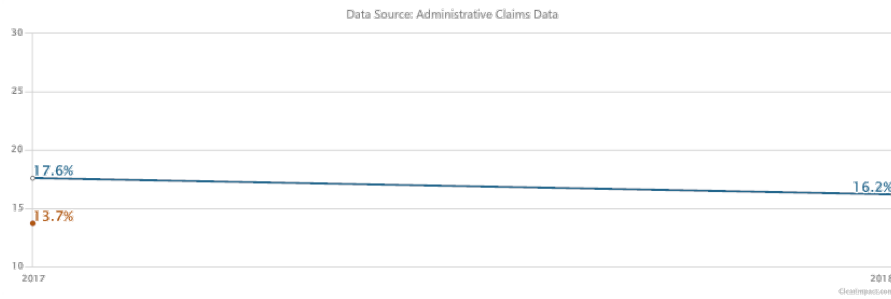
This measure assesses the percentage of ACO-attributed Medicaid beneficiaries 13 years of age and older who are diagnosed with alcohol and other drug dependence (AOD) and who start treatment through an inpatient AOD admission or an outpatient service for AOD within 14 days.

#### Action Plan

Quality Improvement staff from the ACO are participating in a DVHA-led performance improvement project focused on SUD treatment initiation.

**PM** DVHA Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS® IET-TOTAL) **2018 16.2%**

**2017 17.6%**



Notes on Methodology

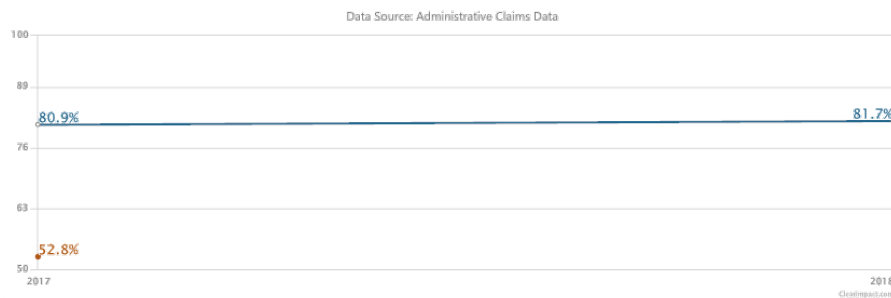
The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual performance for CY 2017 and CY 2018.

Story Behind the Curve

This measure assesses the percentage of ACO-attributed Medicaid beneficiaries 10 years of age and older who are diagnosed with alcohol and other drug dependence (AOD) and who initiated AOD treatment within 14 days of diagnosis and then received two (2) additional AOD services within 34 days after the start of AOD treatment.

**PM** DVHA Follow Up After ED Visit for Mental Illness - within 30 days (HEDIS® FUM) **2018 81.7%**

**2017 80.9%**



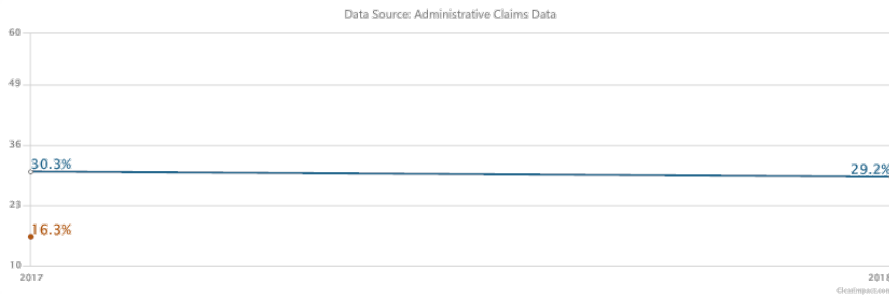
Notes on Methodology

The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual performance for CY 2017 and CY 2018.

Story Behind the Curve

This measure looks at the percentage of ACO-attributed Medicaid beneficiaries 18 years of age and older with emergency department visits with a principal diagnosis of mental illness, who had a follow up visit for mental health treatment within 30 days.

PM	DVHA	Follow Up After ED Visit for Alcohol or Other Drug Dependence - within 30 days (HEDIS® FUA)	2018	29.2%
			2017	30.3%



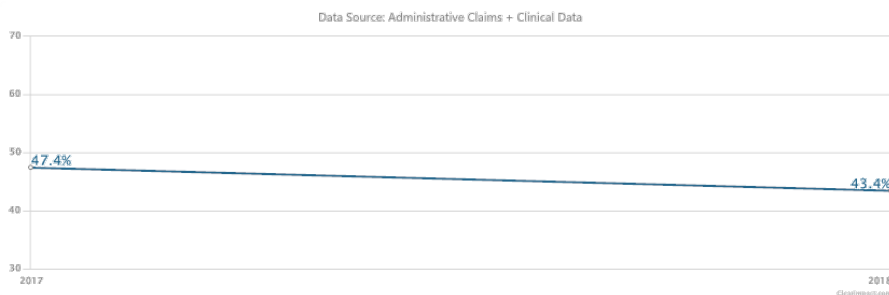
Notes on Methodology

The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual performance for CY 2017 and CY 2018.

Story Behind the Curve

This measure looks at the percentage of ACO-attributed Medicaid beneficiaries 18 years of age and older with emergency department visits with a principal diagnosis of alcohol or other drug dependence, who had a follow up visit for alcohol or other drug dependence treatment within 30 days.

PM	DVHA	Screening for Clinical Depression and Follow-Up Plan (HEDIS® DSF)	2018	43.4%
			2017	47.4%



Notes on Methodology

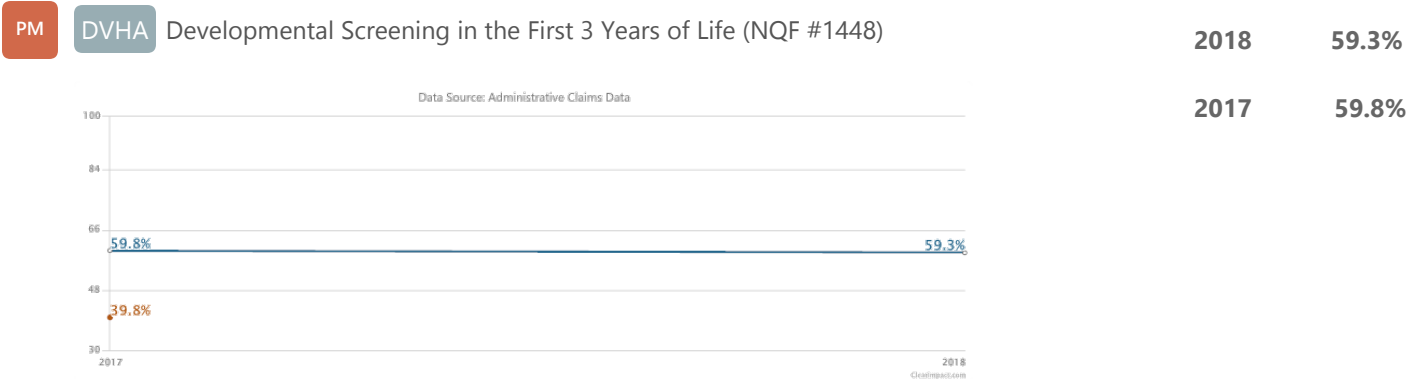
The blue trend line above represents the ACO's actual performance for CY 2017 and CY 2018. No corresponding benchmarks were available for this measure.

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#### Story Behind the Curve

This measure looks at the percentage of ACO-attributed Medicaid members age 18 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

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#### Notes on Methodology

The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual performance for CY 2017 and CY 2018.

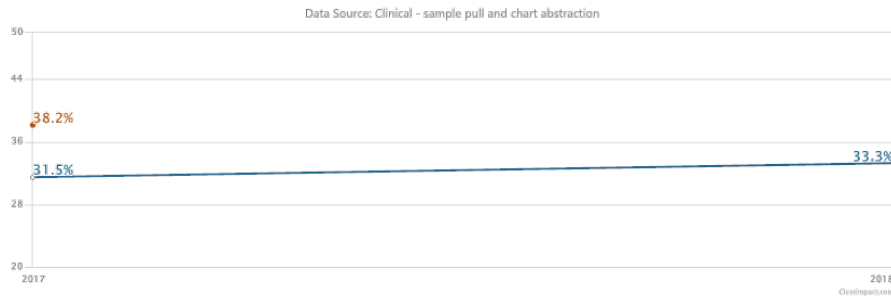
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#### Story Behind the Curve

This measure shows the percentage of ACO-attributed children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. This is a composite measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened in the 12 months preceding or on their first, second or third birthday.

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PM	DVHA	Diabetes Mellitus: Hemoglobin A1c Poor Control (greater than 9%) (NQF #0059)	2018	33.3%
			2017	31.5%



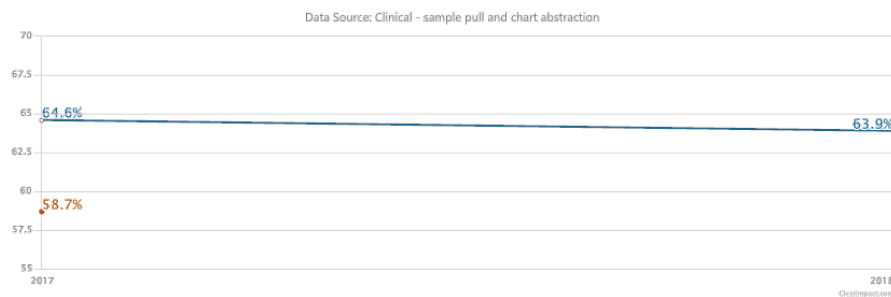
#### Notes on Methodology

The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual performance for CY 2017 and CY 2018.

#### Story Behind the Curve

This measure looks at the percentage of ACO-attributed Medicaid members ages 18-75 with diabetes who had hemoglobin A1c > 9.0% (poor control) during the measurement period. For this measure, a lower rate is better.

PM	DVHA	Hypertension: Controlling High Blood Pressure (HEDIS® CBP)	2018	63.9%
			2017	64.6%



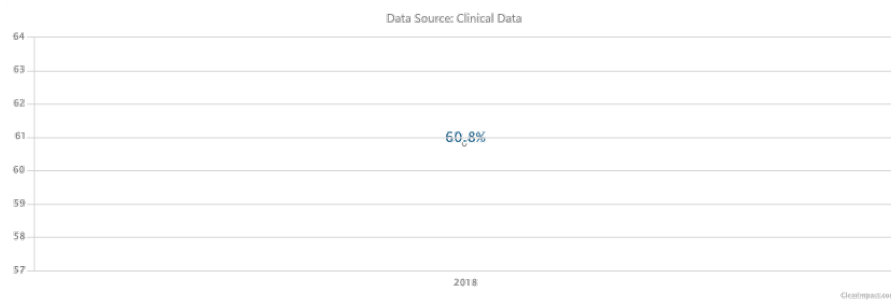
#### Notes on Methodology

The red target data point above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The blue trend line represents the ACO's actual performance for CY 2017 and CY 2018.

#### Story Behind the Curve

This intermediate-outcome measure looks at whether blood pressure was controlled among ACO-attributed adults 18-85 years of age who were diagnosed with hypertension.





#### Notes on Methodology

There is currently no benchmark for this measure. The blue dot above represents the ACO's actual performance for CY 2018.

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#### Story Behind the Curve

This measure looks at ACO-attributed Medicaid beneficiaries 18 years and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling when screening was positive.

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