State of Vermont
Agency of Human Services

Global Commitment to Health
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Section 1115
Demonstration Year: 13
(1/1/2018 – 12/31/2018)

Quarterly Report for the period
April 1, 2018 – June 30, 2018

Submitted Via PMDA Portal on August 29, 2018

Table of Contents

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.

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 13, covering the period from April 1, 2018 through June 30, 2018 (QE0618).***

II. Outreach/Innovative Activities

i. Provider and Member Relations

Key updates from QE0618:

- Durable Medical Equipment (DME) Access
- Green Mountain Care Member Services
- Primary Care Timely Access Survey

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.

<u>Durable Medical Equipment (DME) Access</u>

On April 30, the Department of Vermont Health Access (DVHA) received a letter from Keene Medical Products (KMP), a DME supplier within the GMC provider network, which stated that as of May 1, 2018, KMP would be limiting the scope of their services that were provided to Vermont Medicaid members. The letter stated that KMP would only provide services related to Respiratory Ventilation, Home Oximentry, and Home Oxygen Therapy.

Upon receiving the letter, DVHA established a workgroup to communicate with KMP about their needs as well as ensure members continued to have access to DME. This workgroup consisted of a Deputy Commissioner and the PMR and Reimbursement Units. The PMR Unit contacted over 200 enrolled DME Providers within the Vermont Medicaid network to assess their respective capacity and to ensure that Medicaid members had adequate access to DME suppliers.

The PMR Unit fielded 649 member calls and discussed the issue of KMP limiting DME services. The PMR Unit compiled a list of DME providers who could accept new customers based on their DME specialty and helped members connect with a new provider should they require their services.

Conversations continued with KMP to better understand their needs and an agreement was reached on May 25, 2018 which would see KMPs continued full participation and service delivery. During the week of June 4, 2018, letters were mailed to all affected members explaining the updated status of KMP, and telephone outreach was performed by GMC Member Services informing members that Keene was once again a full-service provider of DME equipment and supplies for Vermont Medicaid.

To date, the vast majority of affected members are satisfied with the outcome, although some have decided to switch to another DME provider. Discussions continue on a quarterly basis between DVHA and the HOMES Group (a group of area DME Providers which includes KMP) to ensure that all parties respective needs are heard and addressed within a timely and transparent forum.

Green Mountain Care (GMC) Member Services

The GMC Customer Support Call Center (CSCS) ensures that members have access to information regarding their healthcare. The call center is open Monday through Friday from 8:00AM until 5:00PM.

The PMR Unit receives weekly reporting from the GMC CSCS which focuses on the topics of call rate and statistics, customer support center issues, mailing statistics, and both positive and negative customer feedback.

The reporting period beginning April 1, 2018 and ending June 30, 2018 saw an increased awareness of limited reporting detail related to customer support center issues and negative customer feedback. The PMR Unit raised the issue within DVHA and the GMC CSCS to address the need for better reporting in order to properly track, identify and resolve recurring issues and topics as reported by GMC members.

The lack of unique and specific reporting detail has diminished the ability of the PMR Unit to properly track trending topics, target specific need, and proactively engage with the GMC member population. The PMR Unit is dedicated to increasing first call resolution and continues to drive the need for detailed reporting that better serves GMC members while improving efficiencies.

Primary Care Timely Access Survey

The PMR Unit conducted its annual survey of Primary Care Providers (PCP) timely access standards in accordance with 42 CFR §438.206. The PMR unit, in collaboration with DVHA's Data Unit, sampled PCPs who had a patient roster of at least 25 unique individuals and who had treated those individuals for a minimum of two years. From this sample, an 80% random sample was surveyed. The total number of surveys mailed to providers was 353, and the surveys were mailed on June 1, 2018. PCPs had the choice to either complete the paper survey and return it via fax or access the survey via Survey Monkey. PCPs were instructed to complete the survey no later than June 15, 2018. Survey participation is not required but is used as a tool to gauge PCP availability, after hours answering service and/or instruction, waiting room time, appointment scheduling time, and access to emergency/urgent care when primary care is not available.

The PMR Unit received 69 total responses, demonstrating a 19.5% return rate. 100% demonstrated that PCPs were operating within the timely access standards cited within 42 CFR §438.206. The survey will again be used as proof during audits (most specifically, the External Quality Review Organization audit (EQRO)) to demonstrate that DVHA monitors timely access standards within a

primary care setting. This data is also shared with DVHAs Quality Improvement (QI) Unit.

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE0618:

- The Customer Support Center received fewer than 79,000 calls in QE0618, down 16% from the previous year when there were more than 93,000 calls in the quarter. The lower volume was largely attributed to improved operational performance with fewer problems.
- Vermont Health Connect was supported throughout the state by 277 Assisters in QE0618, up from 231 in QE0317. The Certified Application Counselor program was responsible for most of the growth, increasing by 71% over the last 12 months by training and certifying staff in hospitals, health centers, and other community organizations.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised nearly half (46%) of all applications in QE0618, compared to just over a third (37%) in QE0617. More than 40% more customers made recurring payments in QE0618 than did so the previous year, which in turn was more than double the year before that.

Enrollment

As of QE0618, more than 215,000 Vermonters (more than one-third of the state's population) were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 137,407 in Medicaid for Children and Adults (MCA) and 78,249 in qualified health plans (QHP), with the latter divided between 27,123 enrolled with VHC, 6,382 direct-enrolled with their insurance carrier as individuals, and 44,744 enrolled with their small business employer.

Member Experience

Vermont contracted with UMass Medical School's Center for Health Policy and Research to conduct a survey of Vermont's health insurance marketplace members regarding their experience during the most recent enrollment period. The mixed mode survey used email, mail, and phone to engage a sample of 3,500 members and achieved a response rate of over 41% (46% for qualified health plan members and 33% for Medicaid for Children and Adults members) before closing in late April.

Preliminary data shows significant improvement in members' perception of the marketplace generally, as well as of its website and Customer Support Center specifically, since the survey was last conducted in 2015. MCA members continue to have a more favorable view than QHP members, although the gap has narrowed as most of the improvement compared to the 2015 study was within the QHP cohort. The survey results also show that the marketplace has more room for improvement, especially in terms of working with partners to promote health insurance literacy and helping members understand health insurance terms and subsidies. The full report will be delivered in summer 2018.

Medicaid Renewals

Redeterminations for Medicaid for Children and Adults (MCA) continued on their normal cycle during

QE0618. The ex parte process for the batch run in June had a passive renewal success rate of 46%, up from the previous month's rate of 43%. These success rates are on par with what has been expected since the entire population has to be checked for MAGI income and immigration status. This means that just over half of the member households that are coming up for renewal on September 1 will need to actively respond to a renewal notice or reminder. As of the last Monday in the quarter, DVHA-HAEEU had 488 open applications, 19 of which were older than 45 days.

Customer Support Center

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

The Customer Support Center received fewer than 79,000 calls in QE0618, down more than 16% from the previous year when there were more than 93,000 calls in the quarter. The lower volume was largely attributed to improved operational performance with fewer problems.

Maximus answered 84% of calls within 24 seconds in QE0618, steady with the previous year, and easily surpassed the contracted 75% target during each of the three months.

Even with the low call volume and strong performance metrics, Maximus began to hire new staff in June and ended QE0618 with 75 customer service representatives, up from the 68 on board at the start of the quarter. Hiring was conducted earlier this year for two reasons: first to ensure that performance metrics don't dip in the summer as they have the last two years, second to ensure that new staff are fully trained and gain experience well in advance of the next Open Enrollment.

Maximus 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 a decrease in not only the volume of calls but also in the proportion of calls that have to be escalated. Only 8% of QE0618 calls had to be transferred to DVHA-HAEEU staff, down from 9% in QE0617. Just as importantly, DVHA promptly answered the calls that were transferred. Ninety-seven percent of transferred calls were answered in five minutes 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. DVHA-HAEEU met this goal ahead of schedule and has continued to improve. In QE0316, fewer than 60% of VHC requests were completed within ten days. In QE0618, 97% of VHC requests were completed within ten days.

System Performance

The system continued to operate as expected throughout QE0618, achieving 100% availability outside of scheduled maintenance in each of the three months. The average page load time was less than one second in each of the three months -- well within the two-second target.

In-Person Assistance

Vermont Health Connect was supported throughout the state by 277 Assisters (3 Navigators, 193 Certified Application Counselors or CACs, and 81 Brokers) in QE0618, up from 231 in QE0317. The CAC program was responsible for most of the growth, increasing by 71% over the last 12 months by training and certifying staff in hospitals, health centers, and other community organizations. Other CACs work for a Department of Corrections contractor and focus on helping connect justice-involved individuals with coverage. Overall, Navigators and CACs largely focused on helping Vermonters with Medicaid renewals, particularly new Vermonters who speak English as a second language and others with accessibility challenges.

Outreach

Health insurance literacy was also an outreach focus throughout QE0618. 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 155,000 visits in the quarter – a 25% increase 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 10,000 sessions during the quarter, up 8% over the previous year.

Self-Service

During QE0618, 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 QE0618, compared to just over a third (37%) in QE0617. More than 40% more customers made recurring payments in QE0618 than did so the previous year, which in turn was more than double the year before that (an average of more than 5,700 recurring payments per month in QE0618, 4,000 in QE0617, and 1,600 in QE0616).

ii. Choices for Care and Traumatic Brain Injury Programs

Key updates from QE0618:

- National Core Indicators first cycle complete.
- Wait Lists
- TBI Federal State Partnership Grant Award

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

DAIL's Adult Services Division (ASD) completed its first cycle using the National Core Indicators for Aging and Disabilities (NCI-AD), joining DAIL's Developmental Disabilities Services Division in their continued use of the National Core Indicators for Developmental Disabilities (NCI-DD).

A total of 428 NCI-AD face-to-face interviews were completed by contractor Vital Research. Of the completed interviews, 406 (95%) were from the Choices for Care (CFC) program, and 22 (5%) were from the Traumatic Brain Injury (TBI) program. The project goal was to survey 354 CFC participants, and 71 TBI participants, for a total of 425. Agencies that had eligible TBI participants completed Background Information (BI) for only 54 participants, and four agencies did not respond to VR's multiple outreach attempts to discuss the project and data collection process. VR was approved to complete additional CFC interviews to ensure the overall target of 425 was met. Of the total surveys conducted, 353 (82%) were participant surveys and 75 (18%) were proxy surveys. Table 1 presents the interviews completed by program with response and refusal rates.

Upon completion of the NCI project cycle, interviewers were offered individual exit interviews to discuss their experiences with outreach and conducting surveys. They provided feedback about the helpfulness of call sheets and working with the various VT agencies; everyone noted that these two features of the project contributed to their successful outreach efforts. Interviewers also shared input about survey questions that seem either problematic or helpful for the participants. Several of the Interviewers noted that participants with traumatic brain injury (TBI) or dementia may have had problems understanding some of the longer questions. Overall, the interviewers reported that survey participants were appreciative of the opportunity to give feedback. Interviewers also reported barriers they faced and shared their best practice methods to resolve those issues. A summary report of the Field Interviewer Exit Interview was submitted to DAIL on June 29, 2018.

The NCI-AD survey includes questions related to the federal HCBS regulations regarding setting and community participation. Data will be available to Vermont by January 2019.

Budget & Legislation

Vermont's State Fiscal Year 2019 budget (July 1, 2018 – June 30, 2019) was finalized June 25th, 2018 and included:

- A 2% rate increase for Choices for Care home-based, Adult Family Care, and Enhanced Residential Care services.
- A TBI program appropriation increase from $5,641,336 to $6,005,225.

Act 172 was signed on May 25, 2018 establishing an Older Vermonters Act working group that will develop recommendations for an Older Vermonters Act aligned with the federal Older Americans Act, the Vermont State Plan on Aging, and the Choices for Care program. The working group will address the value of older Vermonters to the fabric of the State's communities, as well as the service and support needs that older Vermonters may have. A final report is due December 2019.

Collective Bargaining Agreement (CBA)

The State of Vermont and the American Federation of State, County and Municipal Employees (AFSCME) negotiated a new contract that raised the minimum wage for self-directed Independent Direct Support Workers to $11.30/hour and $172/day for daily respite (used by TBI, DS and Adult Family Care) effective 7/1/19.

TBI Federal State Partnership Grant Award

Vermont is proud to have been chosen by the federal Administration for Community Living (ACL) as

one of 24 recipients of a three-year cooperative agreement under two new funding opportunities for ACL's Traumatic Brain Injury (TBI) State Partnership Program. The goal of this grant opportunity is to work with the Brain Injury Association, Department of Corrections and Vermont Department of Health to create and strengthen a system of services and supports that maximizes the independence, well-being, and health of people with traumatic brain injuries across the lifespan, their family members, and their support networks. Vermont will receive approximately $150,000 per year for three years (2018-2022). More information about the grant opportunity and Vermont's objectives can be found on the Adult Services Division news web page.

Wait Lists

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

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

As of June 30, 2018, there were six people waiting for admission to the TBI program due to funding availability. With the increased appropriation July 1, 2018, DAIL may be able to enroll some of these people.

iii. Developmental Disabilities Services Division

Key updates from QE0618:

- Developing new payment model
- HCBS rule implementation
- Waitlist

New Payment Model in Development

The Developmental Disabilities Services Division (DDSD) and DVHA have initiated a project to explore a new payment model for Developmental Disabilities home and community-based services (HCBS). The program has grown significantly over the years from several hundred to several thousand participants. Overall, the goal of this payment reform project is to create a transparent, effective, and administrable payment model for Developmental Disabilities Services that aligns with the broader payment reform and health care reform goals of AHS.

DVHA has engaged a Medicaid reimbursement consultant firm to assist the State in completing a provider rate study. The rate study will collect detailed information from providers regarding actual costs to deliver the defined categories of service under HCBS. The information gathered will be utilized in developing the new payment model. In addition to the provider rate study, the project is

examining alternative assessment tools, resource allocation methods and options for more efficiently capturing encounter data for these services.

HCBS Rule Implementation

DDSD continues to work on implementing the HCBS rules to ensure compliance with all requirements by 2022. The Division is currently in the process of completing site visits to validate survey information submitted by providers. In addition, DDSD is developing policy guidance for providers to ensure compliance with the rules.

Wait List

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

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

As of 6/30/18, there were no individuals who met a HCBS funding priority who were waiting for services that helps address the need related to the funding priority. The full set of waiting list data is collated on an annual basis. This information will be provided in the 2018 Annual GC Report.

iv. Global Commitment Register

Key updates from QE0618:

- 39 policies were posted to the GCR in Q2 2018.
- Since the Global Commitment Register (GCR) launched in November 2015, 138 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 39 policies were posted to the GCR this past quarter. This includes 23 proposed changes, 15 final changes, and one clarification. Changes to rates and/or rate methodologies accounted for more than half of the changes.

AHS also issued public notice through the GCR of CMS approval of an amendment request to the Global Commitment for Health 1115 Demonstration waiver. Theamendment seeks to ensure the continued availability of treatment supports that effectively prevent and treat opioid use disorder (OUD) and other substance use disorders (SUD), and promote a comprehensive and integrated continuum of mental and physical health, OUD/SUD treatment, and long-term services and supports for all Vermonters. Specifically, Vermont sought a waiver of all restrictions on payments to Institutions for Mental Disease (IMDs) for individuals ages 21 to 64. The effective date of this change is 7/1/18.

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

IV. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE0618:

- 206 new, unique members were enrolled this quarter.
- A contract for an interface with VITL has been completed. The June 2018 goal for data to be sent into the eQ Suite has been delayed. In the interim, 2 VCCI case managers have been granted access to VITL and are able to easily access the system.
- VCCI exploring pathways for alignment with current healthcare reform activity.
- An annualized cost savings report was delivered by eQ Health, VCCI's Care Management Vendor and is being reviewed.
- Clinical reports continue to be designed and developed by the eQ Vendor.

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

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

For the past 10 years, The VCCI has used a holistic model of evaluating and supporting improvement in medical and behavioral health, as well as identification of socioeconomic issues that are barriers to sustained health improvement. Each member enrollment begins with a General Survey which assesses preventive screenings; behavioral health risk; current health status; status of housing/transportation/financial security/need for interpretative services and initial goals. Individualized plans of care are developed in collaboration with member and primary care provider and implemented throughout enrollment. VCCI case managers work with a multitude of partners/agencies in a team based, member centered approach to help support optimal health/health improvement. VCCI case managers strive to meet with members in their own environments; which may range from their home, homeless camps, shelter, or in the park-and-ride where the member is currently living in their car. Meeting the members literally where they are at, lends demonstration of member's real experience in ability/challenges in managing their health.

The top 5% of VCCI-eligible Medicaid members account for approximately 39% of Medicaid costs and a disproportionate number of hospital admissions and readmissions. The new AHS Enterprise MMIS/care management vendor utilizes the Johns Hopkins evidence based predictive modeling and risk stratification software to support population selection and related eligibility for services. This new model has enhanced VCCI's ability to identify members based on both past cost profiles and anticipated future utilization, risks and costs, and intervene earlier in order to track the clinical and financial improvements. Excluded populations currently include those attributed to the ACO, dually eligible individuals, those receiving other waiver services and CMS-reimbursed clinical case management.

This quarter, DVHA began to assess and explore how VCCI could align more with healthcare reform activities with DVHA and the system of care of the state. As there is an increase in hospitals and providers that are signing onto the ACO, the VCCI eligible population continues to decline as those that are attributed are not eligible for VCCI services. Since 2017, our VCCI eligible population has declined by ~49,000 members. DVHA has begun to explore how the VCCI could support the system of care and are assessing outreach to those members who are new to Medicaid; looking at the goals of 1) orienting the member to the system of care to include navigation of services to health-related needs such as housing, food security and 2) onboarding members ahead of their ACO attribution. Over the upcoming quarter, staff will be able to assess the data; begin to explore evidenced-based screening tools currently being used; design workflows and collaborate with community and state partners as the program moves forward.

Prevention of inpatient readmissions is a priority of the VCCI and to help support members in their transition from an inpatient stay back out into their communities. Staff receive census data from selected hospitals and refer these members to field based case managers for enrollment into the VCCI

program. This population is at great risk for readmission due to poor follow up from facility services, as well as medication adherence issues. By intervening early, readmission could be avoided, and medical follow-up ensured. The VCCI also has two staff embedded part time in high volume Medicaid practices to provide onsite, immediate case management to members the Provider practice has identified as needing complex case management.

The VCCI Data Analyst will be pulling and analyzing emergency department and inpatient data for the next quarterly report.

Quarter 2 Enrollment/Performance

- Enrollment of 206 new, unique members into VCCI; >41% as members with recent inpatient stay: 30% identified as predicted to be high cost/high risk; 20 % as medium risk.
- 2100 visits with members who were currently receiving case management services (not exclusive to the 206 new enrollments)
- 35/71 members with an identified homelessness/unstable housing issue had this resolved this quarter.
- 25/28 members with an identified lack of PCP issue had this resolved this quarter.

ii. Blueprint for Health

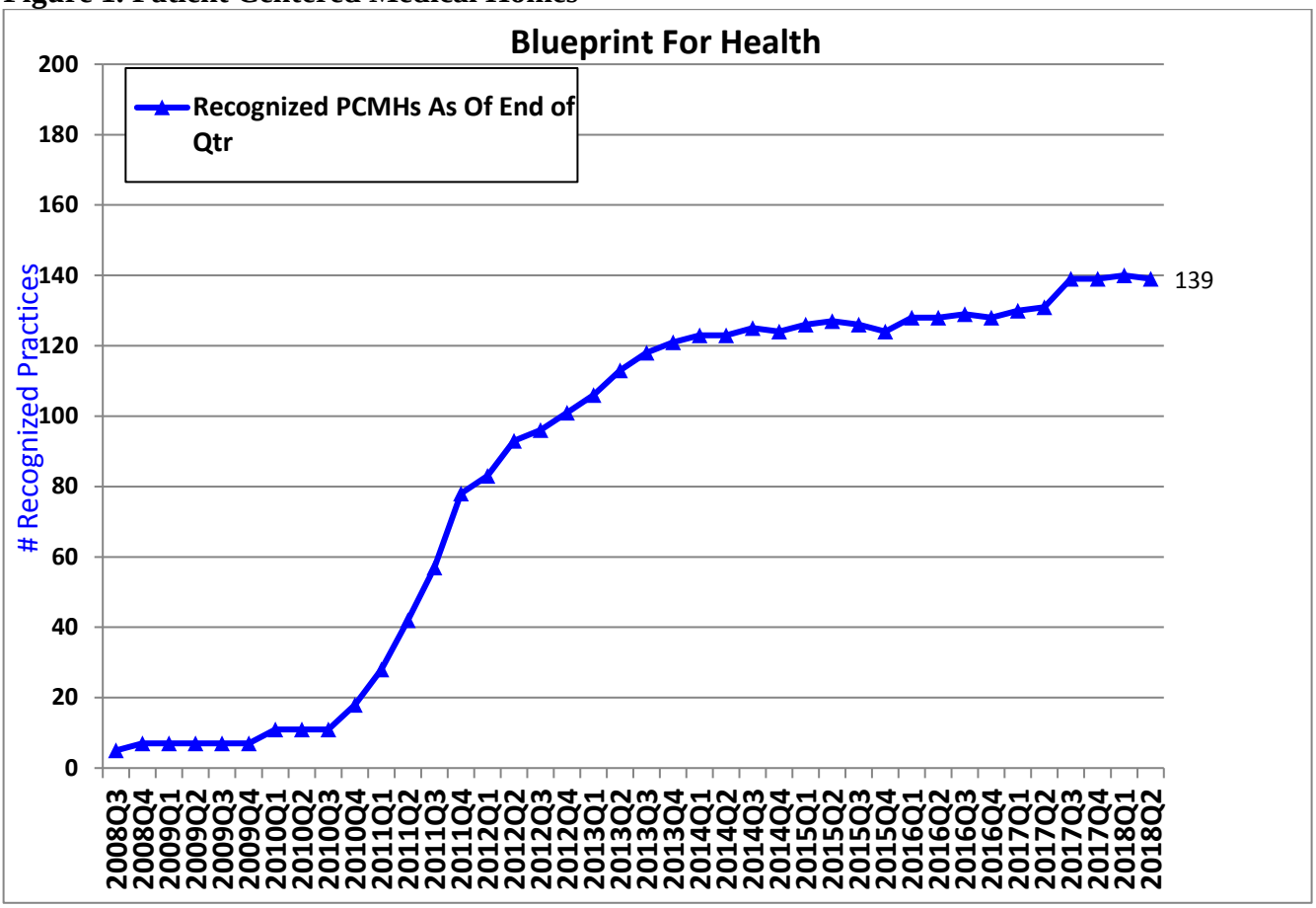
Key updates from QE0618:

- One practice closed and left the Blueprint for Health program effective 6/1/2018, bringing the total number of Patient-Centered Medical Homes in Vermont down to 139.
- Increased access to medicated assisted treatment for patients with opioid use disorder: 3,639 clients were enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of June 2018, and 2,866 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of June 2018.
- Increased access to enhanced health and psychosocial screening along with comprehensive family planning services: the Women's Health Initiative has 35 participating practices.

Patient Centered Medical Homes

In the past quarter, the Blueprint for Health program has had a net decrease of one NCQA-recognized primary care practice. One practice closed and left the Blueprint as Patient-Centered Medical Homes on 6/1/2018: Chester Family Practice. The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. The number of Blueprint PCMH practices as of the end of the quarter was 139.

Figure 1. Patient Centered Medical Homes



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

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

i. 01/2013 - 12/2013
ii. 07/2013 - 06/2014
iii. 01/2014 - 12/2014
iv. 07/2014 - 06/2015
v. 01/2015 – 12/2015
vi. 07/2015 – 06/2016
vii. 01/2016 – 12/2016
viii. 07/2016 – 06/2017

Practice and HSA profiles for the data period 07/2016 – 06/2017 were produced and distributed in June 2018. The information in those profiles give practices an overview of total utilization and expenditures as compared to peers and the rest of the state. Vermont HSA data profiles, including the latest ones for the data period 07/2016 – 06/2017, are posted at http://blueprintforhealth.vermont.gov/community-health-profiles.

Hub & Spoke Program

Vermont's Hub and Spoke program represents the collaborative efforts of the Blueprint for Health, Department of Vermont Health Access, Division of Alcohol and Drug Abuse Programs, Vermont Department of Health, Hub and Spoke staff, community providers, and community leaders to create a coordinated, comprehensive approach to addressing the factors that contribute to the complexity of opioid use disorder and to enhance access to evidence-based treatment for opioid use disorder. The Hub and Spoke model integrates programs providing higher intensity treatment in regional Opioid Treatment Program (OTP or "Hub") settings with community-based general medical practice settings providing Office-Based Opioid Treatment (OBOT or "Spoke").

Quarterly Highlights

- Increased access to medication assisted treatment for Vermont residents with opioid use disorder: 3,639 clients were enrolled in Regional Opioid Treatment Programs (OTPs/Hubs) as of June 2018 and 2,866 Medicaid beneficiaries were receiving medication assisted treatment in Office-Based Opioid Treatment (OBOTs/Spokes) settings as of June 2018.

- Medication Assisted Treatment (MAT) for opioid use disorder is being offered across the State of Vermont by more than 85 different practices and by 224 medical doctors, nurse practitioners and physician assistants who work with 57.20 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 2018).

- A collaborative team, comprised of the Department of Vermont Health Access - Blueprint for Health, Vermont Department of Health – Division of Alcohol and Drug Abuse Programs and University of Vermont Medical Center -- Addiction Treatment Program staff, was convened for the design and delivery of learning sessions intended to enhance best practice adoption by providers and practice teams; learning sessions in the second quarter focused on complex clinical presentations, including psychosocial factors and the complexities of diversion, provider self-care, countertransference, and the impact on patient care, recommendations for improving oral health in patients receiving medication assisted treatment, comparative effectiveness of medications for provision of medication assisted treatment, core elements of providing patient-centered care, from the patient perspective (panel discussion), provision of interventions to support tobacco cessation, and suicide risk assessment in the primary care setting.

Figure 2. MAT-SPOKE Implementation January 2013 – June 2018: Spoke Staffing and Medicaid Beneficiaries

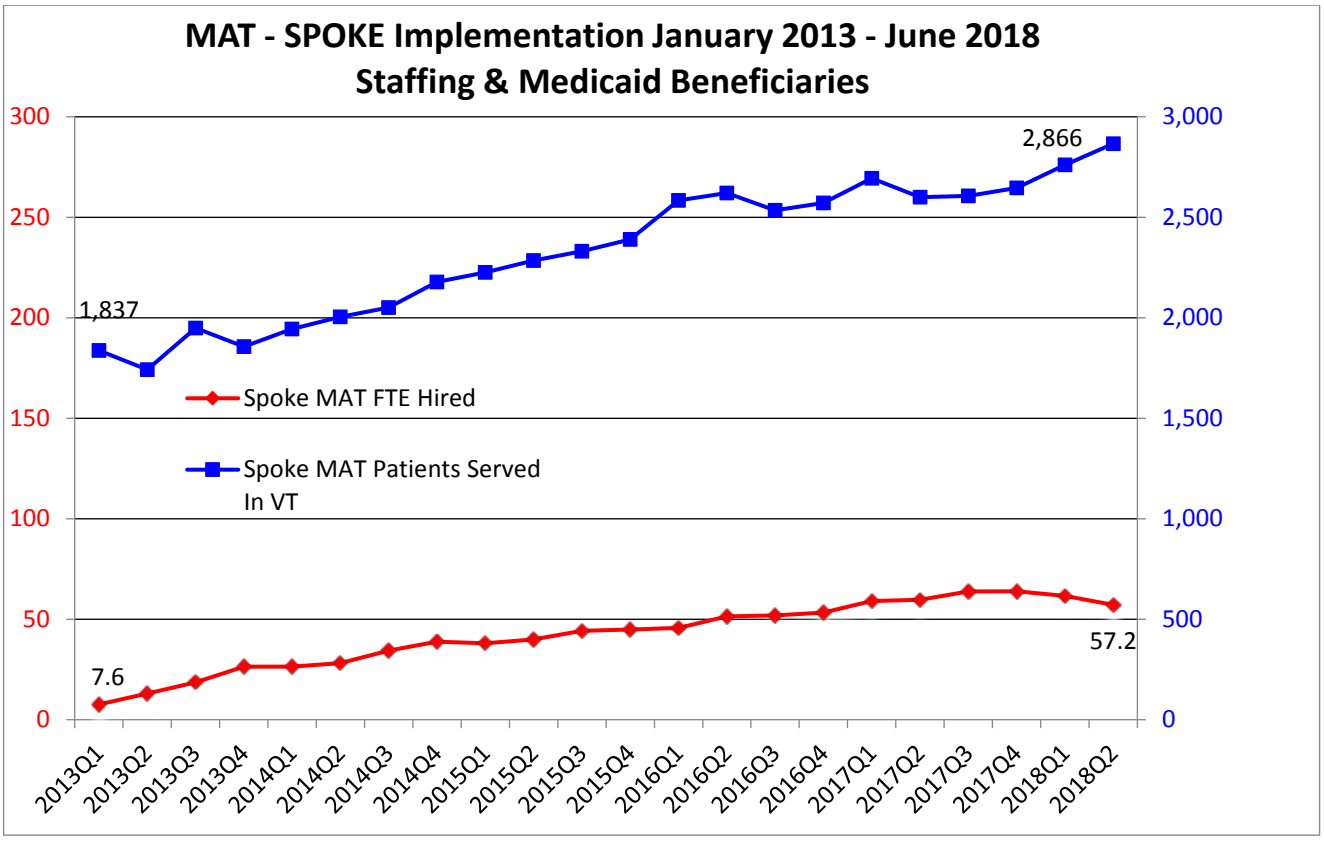


Figure 3. MAT-SPOKE Implementation Jan 2013 – June 2018

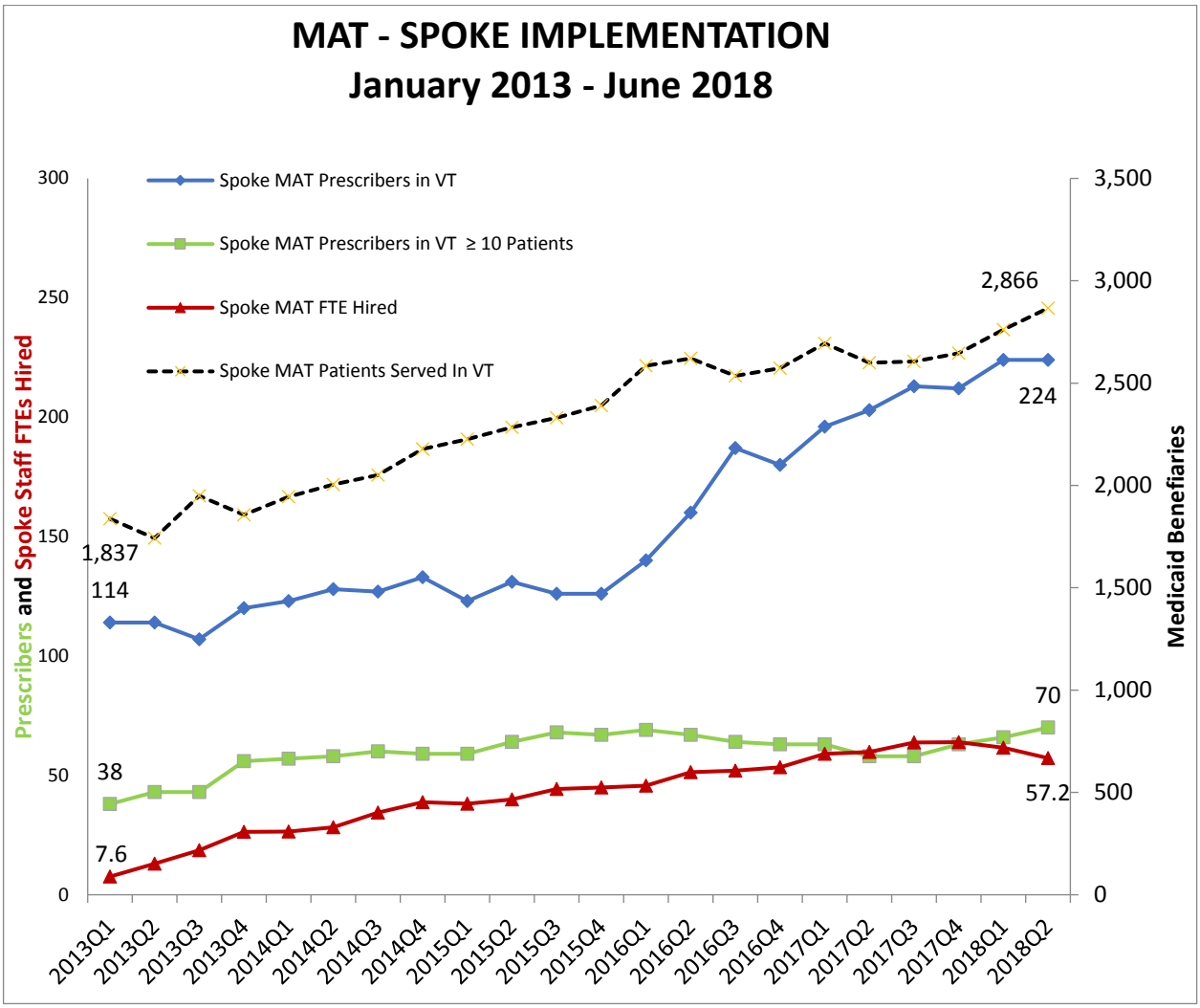


Table Notes: The number of MAT Prescribers in Vermont serving more than 10 Patients has been corrected from previous reports because the numbers were not de-duplicated counts.

The table below shows the caseload of regional Hub programs, the number of clients receiving methadone, buprenorphine, 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 2018).

Table 1. Hub Implementation as of June 2018

Region	# Clients	# Buprenorphine	# Methadone	# Vivitrol	# Receiving Treatment but Not Yet Dosed	# Waiting
Chittenden, Addison	978	293	685	0	0	0
Franklin, Grand Isle	350	157	193	0	0	0
Washington, Lamoille, Orange	491	169	322	0	0	0
Windsor, Windham	655	150	502	0	0	0
Rutland, Bennington	407	87	302	1	17	0
Essex, Orleans, Caledonia	758	199	558	1	0	0
Total	3639	1055	2565	2	17	0

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

Table 2. Spoke Implementation as of June 2018

Region	Total # Providers prescribing patients	# Providers prescribing to ≥ 10 pts	Staff FTE Hired	Medicaid Beneficiaries
Bennington	11	5	5.2	264
St. Albans	22	8	8.6	445
Rutland	19	7	5.15	355
Chittenden	79	16	14.5	589
Brattleboro	11	4	3.5	136
Springfield	6	2	1.55	50
Windsor	11	5	3	227
Randolph	5	4	1.7	119
Barre	19	6	6.45	280
Lamoille	16	6	3.8	170
Newport & St. Johnsbury	11	2	2	99
Addison	11	4	1.25	113
Upper Valley	3	1	0.5	19
Total	**224***	**70**	**57.20**	**2,866**

Table Notes: Beneficiary count based on pharmacy claims for Buprenorphine and Vivitrol, April – June 2018; an additional 271 Medicaid beneficiaries are served by 30 out-of-state providers. Staff hired based on Blueprint portal report 7-20-18. *5 providers prescribe in more than one region.

Women's Health Initiative

The Women's Health Initiative (WHI) launched January 1, 2017 and participation was open to women's health specialty practices, including obstetrics, gynecology, midwifery, and family planning providers; eligibility for participation in the WHI was expanded to Patient Centered Medical Home (PCMH) primary care practices on October 1, 2017. The Blueprint for Health was supported by DVHA to develop the WHI and Blueprint staff worked collaboratively with the Vermont Department of Health and a broad array of content experts and community stakeholders to finalize the design of the WHI. The WHI was designed to increase access to preventative services and reduce the risk for unintended pregnancy in order to improve health outcomes for women, infants, children, and families. Strategies implemented under the WHI were identified from the literature as effective strategies for improving health outcomes and addressing risks for unintended pregnancies.

The Blueprint for Health continues to work collaboratively with the Vermont Department of Health and community organizations, providers, and practices to support Vermont women, children, and families to have healthier lives through the implementation of strategies designed to increase the rate of intentional pregnancies and improve systematic early identification of, and provision of effective interventions for, depression and substance use disorders and non-medical health-related social needs (interpersonal violence, food insecurity, and housing instability).

Vermont's Women's Health Initiative has focused on increasing access to comprehensive family planning counseling, increasing access to long acting reversible contraceptives for same-day insertions (when chosen by the patient and clinically appropriate), and improving systematic psychosocial screening, brief intervention, brief treatment, referral to more intensive treatment and/or support services as appropriate for domains that have been demonstrated to negatively impact health, but that can be addressed through strengthened partnerships between women's health and primary care practices and community organizations.

Women's Health Initiative-participating women's health specialty practices are supported by licensed mental health clinicians (typically a licensed, clinical social worker), funded through the WHI; the licensed mental health clinician is embedded into the women's health specialty practice for provision of screening, brief intervention, brief treatment, referral to more intensive treatment and services, and follow-up services; Women's Health Initiative-participating Patient-Centered Medical Home primary care practices are supported by their area Community Health Team.

Quarterly Highlights

- The WHI is approaching statewide coverage, as all but one Health Service Area that has a specialized women's health practice is now participating in the WHI. Continued expansion of the WHI is expected among Planned Parenthood of Northern New England women's health practices and within Blueprint Patient-Centered Medical Homes (PCMHs).

- The WHI now includes 35 participating practices (20 women's health and 15 primary care) across the State of Vermont.

- Learning collaboratives and clinical training sessions continued to be offered throughout the second quarter to enhance skills for provision of patient-centered, team-based care, insertions and removals of long acting reversible contraceptives, and addressing non-medical health-related social needs.

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

Figure 4. Women's Health Initiative-participating Practices

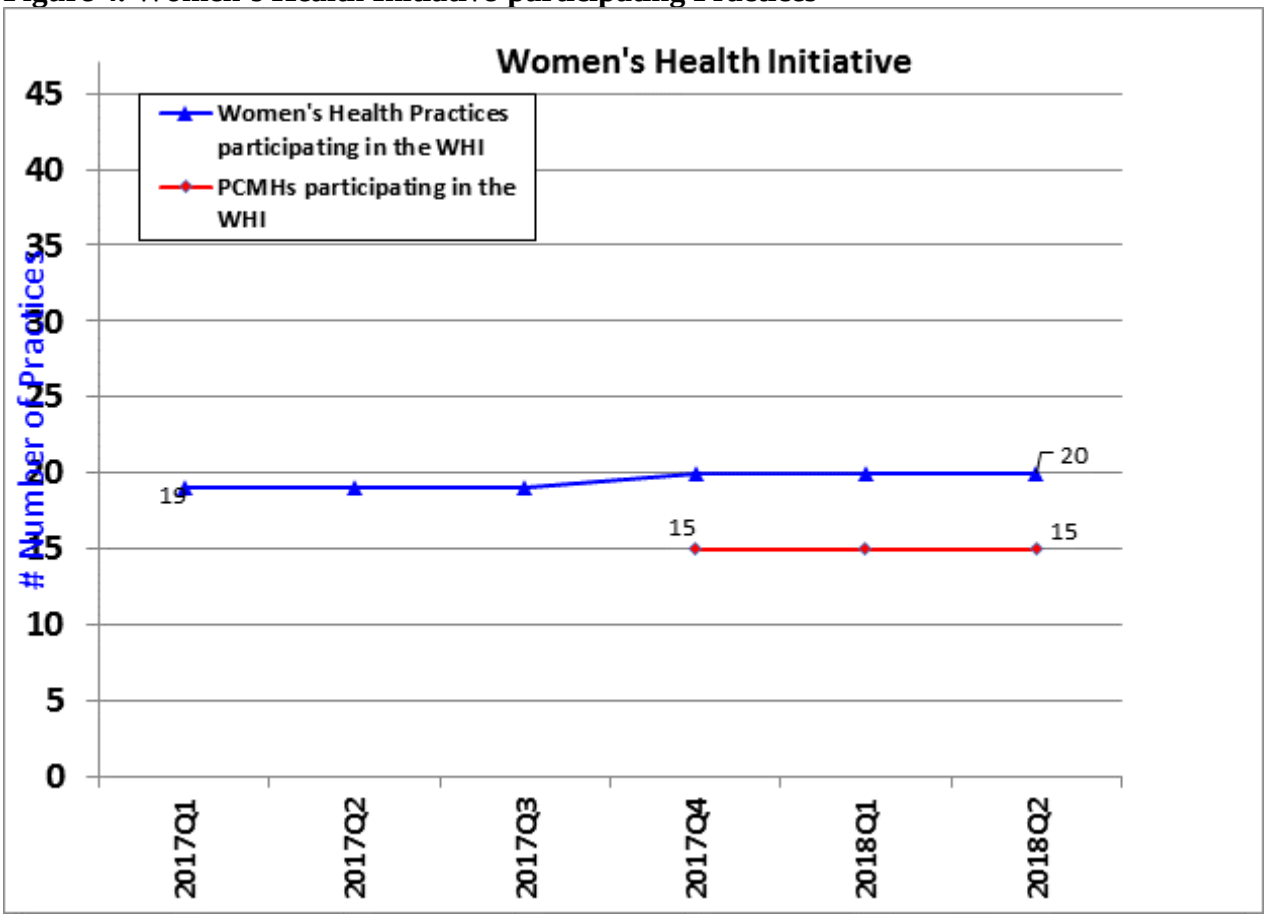


Figure 5. WHI Implementation January 2017 – June 2018 Staffing & Patients

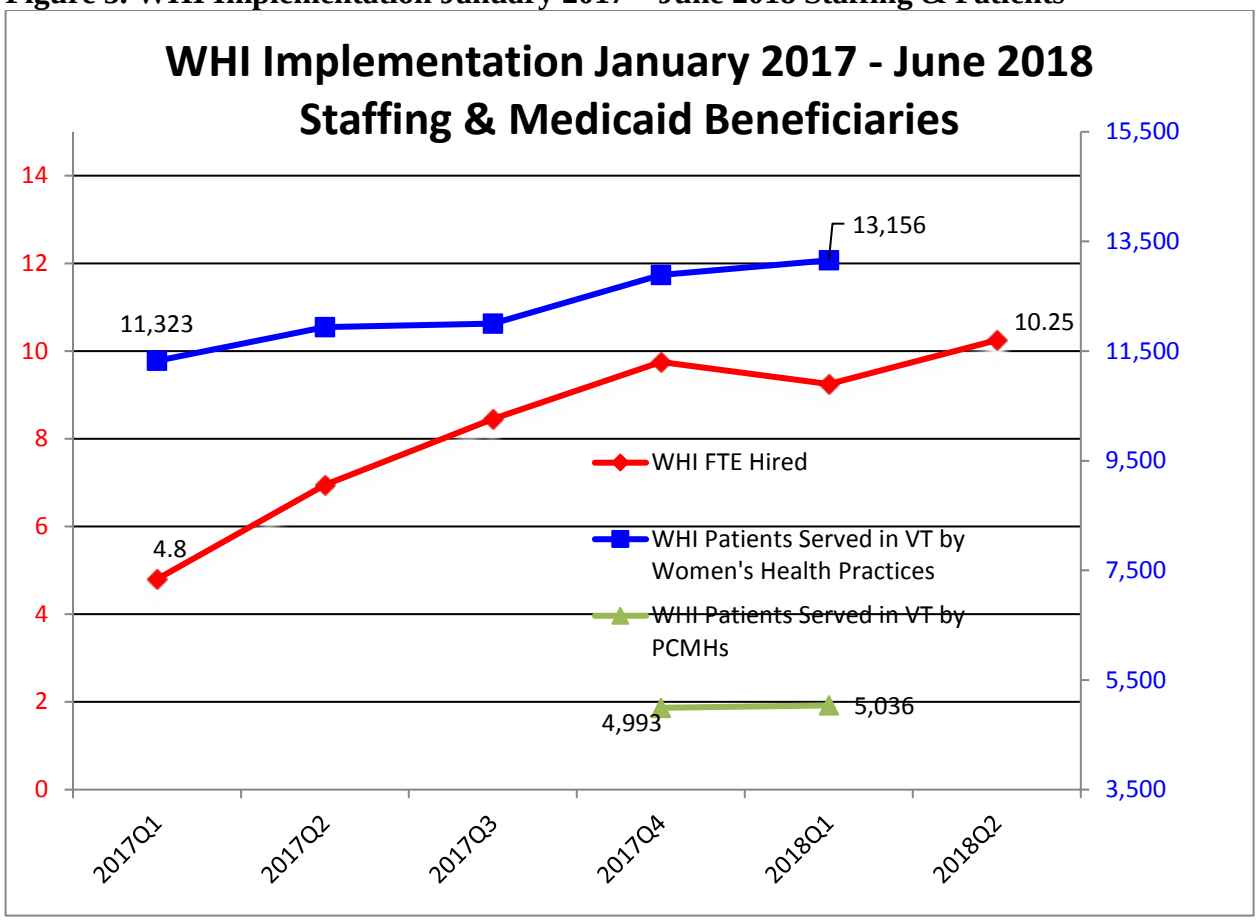


Table 3. WHI Implementation as of June 2018

Region	Total # Women's Health WHI Practices	Total # PCMH WHI Practices	Staff FTE Hired	*Medicaid Beneficiaries – Women's Health Practices	*Medicaid Beneficiaries - PCMHs
Barre	1	1	1	988	508
Bennington	1	1	0.5	1,003	57
Brattleboro	1	0	1	480	0
Burlington	5	5	2	3,830	1,806
Middlebury	2	0	0.5	1,023	0
Morrisville	1	2	0.5	565	464
Newport	0	0	0	0	0
Randolph	3	0	0.5	567	0
Rutland	2	1	1.5	1,885	214
St. Albans	2	0	1	1,348	0
St. Johnsbury	1	2	0.75	982	662
Springfield	1	3	1	485	1,325
Upper Valley	0	0	0	0	0
Windsor	0	0	0	0	0
Total	20	15	10.25	13,156	5,036

Table Note: *Numbers are from March 2018

iii. Behavioral Health

Key updates from QE0618:

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

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric, detoxification, and substance abuse residential services for Medicaid primary beneficiaries. The team maintains a high level of inter rater reliability through clinical supervision and testing. The team has developed a system to ensure internal consistency and educate providers on documentation requirements. The team consists of master's level clinicians called Behavioral Health Concurrent Care Managers. The care managers engage with discharge planners at inpatient and residential facilities to ensure timely and appropriate discharge plans. Care managers collaborate with other departments to support coordination of care and assist in mitigating barriers to discharge. Through collaboration with Vermont Chronic Care Initiative (VCCI) partners, a referral process for VCCI services has been established. The referrals support continuity of care for new enrollees and members already receiving VCCI services. The referral process has been expanded to include members discharging from substance use disorder treatment. Ongoing monitoring of issues has allowed for an improved process. A protocol has been developed and is supervised.

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

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

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

departments to provide substance abuse services to Vermont Medicaid beneficiaries. Team members also participated in the SFI Interagency Team, Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF, and more) and the State Interagency Team.

The Unit also manages the Applied Behavior Analysis (ABA) benefit. The Autism Specialist, a member of the Behavioral Health Team, has worked collaboratively with the Policy Unit and sister departments to evaluate and improve the program. DVHA is currently working on development of a new payment model that would continue to support members and providers, as well as attract new ABA providers to serve members. The Autism Specialist participates in the Autism Workgroup, which happens on a bi-monthly basis and includes community partners, including several ABA providers across the State. This meeting gives ABA providers the opportunity to ask questions and allows them to provide feedback directly to the Autism Specialist. Ongoing collaboration with sister departments has allowed for coordination of services and increasing supports to Medicaid members. DVHA also continues to identify and onboard providers specializing in services for children with autism. The team is currently exploring telemedicine opportunities for communities without access to services.

iv. Mental Health System of Care

Key updates from QE0618:

- Requirements of the Vermont State Legislature: 2018 legislative session
- Mental Health Delivery System and Payment Reform
- Through the Integrating Family Services structure, leadership is being provided in several areas that cut across multiple agency departments, such as:
    - Turning the curve on the number of children and youth in residential settings
    - Coordinating autism services and supports
    - Implementing the Child and Adolescent Needs and Strengths (CANS
    - Supporting the statewide functioning of the Children's System of Care for people under 22 years of age.

<u>Requirements of the Vermont State Legislature: 2018 Legislative Session</u>

During this quarter, the Vermont State Legislature passed legislation regarding the Mental Health System of Care:

1. $5.5M in general fund dollars for renovation and fit-up of an additional 12 level-1 beds at the Brattleboro Retreat, to be completed by December 2019.
2. Collaboration with the University of Vermont Health Network to identify the type and number of additional inpatient psychiatric beds needed in Vermont.
3. Proposal to be submitted by the University of Vermont Health Network on or before 1/15/19 regarding expansion of inpatient psychiatric bed capacity at the Central Vermont Medical Center campus and the impact to the Mental Health system of care.
4. $4.3M rate increase in SFY'19 to Designated Agencies (Mental Health Clinics), with up to 20% of the funds available to be directed through value-based incentive payments focusing on quality and outcomes. The remaining funds are allocated to the base rates for providers. Of these funds, up to 50% may be targeted for direct services that are provided by master's level clinicians and other staff with high levels of credentials and experience.
5. Creation of a time-limited Study Committee (from 8/1/18 to 12/1/18) to examine the strengths and weaknesses of Vermont's orders of non-hospitalization.

6. 3-year data collection initiative including counts of voluntary and involuntary individuals, lengths of stay and involuntary procedures.
7. Requirements that rates of payment to Designated Agencies be based on ongoing reviews of finances, service delivery, and quality that consider changes in operating costs, caseload, programs and practices, labor markets, and the fiscal health of the agency.
8. An evaluation of the overarching structure for the delivery of mental health services due 1/15/2019, to include a common, long-term vision of full integration of mental health services within a comprehensive and holistic health care system.

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

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

Delivery System and Payment Reform Implementation

In addition to activities focused on inpatient and institutional level of care, DMH has been partnering with DVHA to develop delivery system and payment reforms for community-based providers of mental health services (i.e. "designated agencies"). Over the last quarter, DMH has continued to hold weekly planning meetings with stakeholders regarding payment reform and has moved from exploration of key concepts, values, and components toward final specifications for implementation of two new value-based payment models for both child and adult mental health services paid for through DMH, including outpatient services paid for through DVHA. The payment model was submitted to CMS for review and approval on 3/30/18 and will be resubmitted for a revised implementation date of 1/1/2019. The payment models are two "bundled" or "episodic" case rates, one for children and one for adults, that are billed retrospectively, after a qualifying service has been rendered, and which payment then covers all additional services for the member in the month, regardless of quantity or complexity. Additionally, the payment model for these mental health services includes a value-based payment based on reporting for a set of measures that describe progress in terms of "how much", "how well" and "is anyone better off".

Integrating Family Services (IFS) Initiative

Integrating Family Services efforts began in 2008 with a position created in the Agency of Human Services Secretary's Office in 2010. From the beginning, the intent of integrating services for children and their families revolved around providing services, supports and treatment earlier to prevent more intense needs, to achieve better outcomes, and spend funding more efficiently.

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.

As described in the prior section, the Department of Mental Health is working with the DVHA Payment Reform team and in coordination with the Director of Health Care Reform to develop new payment models for reforming child and adult mental health reimbursement that builds upon experiences and methods pioneered through the Integrating Family Services pilots. As AHS' payment reform efforts progress, there is focus on moving the IFS regions into alignment not only in the payment model but also with value-based purchasing. Starting 1/1/19, a subset of mental health related performance measures for the IFS regions will have incentives tied to them in exact alignment with statewide implementation, however, IFS regions continue to have additional requirements for performance measurement in accordance with the broader scope of services included in those regions.

As well, both regions have been utilizing the Child and Adolescent Needs and Strengths (CANS) to look at the needs and strengths of children they are serving. The agencies are using this progress monitoring tool to track progress over time. They are showing that through supports and services children/youth are increasing in their strengths and decreasing needs. The caveat to this is that for children involved in the child welfare system it is taking longer to see positive results; not surprising given the fact that these children experience high levels of trauma, exposure to substances, and/or abuse and neglect. As well, data from both regions indicates that upon the first two years of implementing IFS due to the flexibility in their funding the agencies were able to serve more children and families.

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

v. Pharmacy Program

Key updates from QE0618:

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

Pharmacy Benefit Management Program

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

for DVHA members while managing drug utilization and cost.

Pharmacy Operations

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

Clinical

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

Bulletins and Advisories/Communications

The following communications went out in April to pharmacies and providers:

- Important Changes to Coverage for Concerta® and Actavis (Labeler 00591) Authorized Generic:

    - "Effective 4/27/18, brand name CONCERTA® (methylphenidate HCl) extended-release tablets will be moving to a preferred status on the Department of Vermont Health Access (DVHA) Preferred Drug List (PDL). With the 12/31/17 expiration of the Actavis authorized generic distribution agreement with Janssen, there will be no authorized generic on the market once product in the supply chain has been exhausted. Pharmacies may continue dispensing the authorized generic if they have product in stock. All other generics will remain non-preferred".

- Vermont Medicaid Eprescribing Services now available through Surescripts:

    - "On 4/20/2018, Vermont Medicaid, through its PBM, Change Healthcare, established a connection with **Surescripts** to provide data for Medicaid members. Surescripts supports standard electronic prescription transactions to allow clinicians to securely e-prescribe within their existing workflow. Providers who use electronic prescribing now have access to Vermont Medicaid data to assist them in managing prescriptions for Medicaid members more efficiently. Information that DVHA has made available through prescribers' electronic health record software vendors includes:

- Member's outpatient pharmacy claims history
- Member's Medicaid eligibility/enrollment status
- The preferred status of prescribed drugs on the Medicaid Preferred Drug list
- Indication of a prior authorization requirement for a prescribed drug"

Drug Utilization Review Board

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

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

Additionally, per State statute requiring the DVHA Commissioner establish a pharmacy best practice and cost control program, the DURB was designated as the entity to provide clinical guidance on the development of a Preferred Drug List for Medicaid beneficiaries. The DURB typically includes 10-12 members, who are appointed to two - year terms with the option to extend to a four - year term. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians and at least one-third of its members are licensed and actively practicing pharmacists, in addition to one member at large who is currently a nurse practitioner. Board members are recommended by the DVHA Commissioner and approved by the Governor.

Drug Utilization Review Board meetings occur eight times per year. In QE0618, the DURB held 3 meetings. Information on the DURB and its activities in 2018 is available: http://dvha.vermont.gov/advisory-boards.

Drug Utilization Review Board Meetings

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

340B Drug Discount Program

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

vi. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE0618:

- DVHA continued financial reconciliation activities for the 2017 performance year, in order to determine financial and quality performance. Results will be available in Q3 2018.
- DVHA submitted its first quarterly report to the Vermont legislature for the 2018 performance year.
- DVHA and OneCare entered into contract negotiations for the 2019 performance year.
- Future program implementation will continue to be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

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

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

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

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

DVHA began conducting financial reconciliation activities for its 2017 performance year in Q1 2018 and continued reconciliation work into Q2 2018. Reconciliation activities will determine the ACO's

spend as compared to their financial target and quality performance for the 2017 performance year. Reconciliation activities will continue into Q3 of 2018, and final results will be available later in Q3 2018.

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

DVHA submitted its first 2018 quarterly report to the Vermont legislature on the VMNG program on June 15, 2018. Legislation requires that DVHA report to the legislature on implementation activities and program performance, including data on financial performance, quality performance, operational timeline adherence, utilization monitoring, changes to provider network or size of attributed population, and statistics on member complaints, grievances, and appeals. DVHA's most recent submission to the Vermont legislature can be found here: https://legislature.vermont.gov/assets/Legislative-Reports/ACT-124-VMNG-Report-to-Legislature-June-15-2018.pdf

V. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12 of the legislative budget for Global Commitment on the first business day of every month during the June 2018 quarter. This payment served as the proxy by which to draw down Federal funds for Global Commitment (GC). The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments and admin; please note admin is now claimed outside of GC neutrality) for the given quarter. After each quarterly submission, AHS reconciles what was claimed on the CMS-64 versus the monthly payments made to DVHA.

During QE0618, CMS Regional Office conducted a review of eligibility for VIII Group, also known as the Childless New Adult population. Vermont is entitled to receive enhanced FFP for this group of beneficiaries. It had been one year since the last CMS review and no errors were found.

AHS submitted and certified the CMS64 report for QE0618 on July 30, 2018 as is normal. There were minimal prior quarter adjusting entries needed for program during this period.

In regards to Budget Neutrality, member months are subject to revision over the course of a twelve month period due to a beneficiary's change in enrollment status. It was determined that the enrollment count for CY2017 needed to be updated as it did not reflect all twelve months of revisions in the member months. This update was completed in QE0618.

During this quarter, AHS received and responded to CY2018 round 2 and round 3 rate setting questions, as well as ACO round 1 questions from the CMS Office of the Actuary. In addition, AHS completed and submitted to CMS amended CY2018 PMPM rates to include residential SUD IMD treatment costs. Furthermore, CMS approved Vermont's request to amend the VT Global Commitment to Health 1115 waiver to include SUD IMD costs. The approval is effective from July 1, 2018 through December 31, 2021. A new set of STCs were negotiated with CMS incorporating the SUD IMD amendment. The approval authorizes Vermont to receive FFP for its continuum of services to treat addictions to opioids and other substances, including services provided to Medicaid enrollees with a substance use disorder who are short-term residents in residential and inpatient treatment facilities that meet the definition of an IMD.

In QE0618, AHS continued to work with its actuarial consultant, Milliman, Inc., on the 2019 PMPM rates and it is expected that draft PMPM rate information will be available for review by AHS in mid-August.

Finally, the Medical Loss Ratio (MLR) work per STC#23c is set to begin next quarter (QE0918) with DVHA.

VI. Member Month Reporting

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

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

The table below contains Member Month Reporting for CY2018 including QE0618.

Table 4. Member Month Reporting – Calendar Year 2018

Demonstration Population	**Medicaid Eligibility Group**	**Total CY 2018**
1, 4*, 5*	ABD - Non-Medicare - Adult	**42,264**
1	ABD - Non-Medicare - Child	**13,135**
1, 4*, 5*	ABD - Dual	**127,418**
2	ANFC - Non-Medicare - Adult	**76,482**
2	ANFC - Non-Medicare - Child	**362,170**
	Medicaid Expansion	
7	Global RX	**40,158**
8	Global RX	**23,462**
6	Moderate Needs	**1,542**
	New Adults	
3	New Adult with out child	**239,885**
3	New Adult with child	**110,784**
	Total All	**1,037,300**
*** Long Term Care Group**	**Total CY 2017**	
4 only	ABD Long Term Care Highest Need	**17,090**
5 only	ABD Long Term Care High Need	**6,772**

PMPM Capitated Rates

The PMPM rates as set for 01/01/18 – 12/31/18 are listed below.

Table 5. PMPM Capitated Rates QE0618

01/01/18-12/31/18

Medicaid Eligibility Group		
ABD Adult	$	1,543.54
ABD Child	$	2,634.96
ABD - Dual	$	1,655.26
non-ABD Adult	$	518.79
non-ABD Child	$	442.36
GlobalRx	$	88.19
New Adult	$	444.91
Moderates	$	461.55

Investments totaled $36,403,421 for QE0618. This number is subject to change due to prior quarter adjustments for QE0618 that may occur in future periods.

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 QE0618:

- The Quality Unit continued to lead a formal CMS PIP project focused on improving substance use disorder treatment.
- The DVHA Quality Unit staff continued work on two new QI projects.
- The clinical staff within the Quality Unit completed medical record abstraction for one HEDIS hybrid measure.

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

Managed Care Entity (MCE) Quality Committee

The MCE Quality Committee consists of representatives from all Departments within the Agency of Human Services that serve the Medicaid population. The committee continues to structure its work around the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care. During this time period, the Quality Committee followed the Annual Work Plan by reviewing the topic of quality and appropriateness of care. The Department of Mental Health's committee representative provided a brief overview of their current efforts towards developing a value-based payment model with the Designated Agencies. The Committee also prepared for the annual performance measurement review by discussing the development of an "MCE Scorecard" for the special health care needs populations that could supplement the already established Global Commitment Core Measure Set.

Managed Care Medical Committee (MCMC)

The Managed Care Medical Committee worked throughout the quarter on finalizing changes to two Clinical Practice Guidelines. The Medication Assisted Treatment Guidelines were posted and public comments were included. The Developmental Surveillance and Screening Guidelines are posted for comment. The Diabetes guidelines are being revised. The process for monitoring ACO reports has been reassigned to a smaller group of subject matter experts. The MCMC is collaborating with external partners on establishing documentation standards. The new workplan is being developed.

Formal CMS Performance Improvement Project (PIP)

The topic of substance use disorder treatment was chosen as the formal CMS PIP in July 2016. Work on that project continued throughout QE0618. The PIP team surveyed a representative sample of state-wide substance use disorder treatment providers to identify access issues for members seeking treatment. The surveys were completed by direct phone outreach in early June and the PIP team began results analysis in mid-June to determine next steps and possible new interventions.

Also during this timeframe, the DVHA QI Administrator and staff from contracted EQRO, HSAG, discussed the impact that the significant changes to the 2018 IET HEDIS measure specifications would have on the ability to evaluate the year-to-year PIP results (the study measure is the HEDIS IET Initiation rate). It was decided to make the CY 2017 results the "new baseline" for this project in order to have comparable results in the years to come. The annual PIP summary will be submitted to HSAG for validation with this change in place.

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.

Quality Unit staff also participated in additional collaborative QI initiatives across the Agency of Human Services including the joint payer quality improvement project aimed at increasing follow-up care after hospitalization for mental illness and the collaboration with Vermont Department of Health, the Vermont Children's Health Improvement Program (VCHIP) and the DVHA Data Unit on a joint payer quality improvement project aimed at increasing adolescent well care visits.

Quality Measure Reporting

- Health Home Measure Set – The FFY '17 Health Home Measure Set reporting deadline was 4/30/18. During QE0318 the Blueprint team requested an extension to July 1, which was granted. The extension was requested because DVHA was researching questions that CMS had about the FFY 2014 – 2016 reports. Those issues needed to be resolved prior to reporting for an additional year. These measures are run by the Blueprint and Onpoint; the Quality Unit helps to act as a bridge between the CMS reporting system and program staff. During QE0618, the FFY 2014-2016 Seeking More Information (SMI) requests were completed within CMS' reporting system, MACPro, and the Blueprint team requested an additional extension to 8/31/18 for the FFY 2017 health home measure reporting.

- Healthcare Effectiveness Data & Information Set (HEDIS) Measure Production

    - HEDIS Administrative Measures - during QE0618 DVHA's Quality and Data Units continued to work with the NCQA certified vendor to run the annual HEDIS administrative measures. The Product Summary and rates were delivered to DVHA during QE0618. The performance measure validation audit is scheduled for the next quarter. If no issues are identified, DVHA will make public the HEDIS measures that are part of the Global Commitment Core Measure Set.

    - The Quality Unit also completed and had validated a medical record review for 1 hybrid HEDIS measure during QE0618. The team is developing a plan to include more hybrid measures in coming years.

Results Based Accountability (RBA)/Process Improvement

The Quality Unit is leading 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, and other performance budgeting scorecards. Additional scorecards that were actively maintained or newly created during QE0618 include the following: Applied Behavior Analysis (ABA) benefit, the Adult and Child Medicaid Quality Core Measure Sets, GC Investments, Payment Reform Models, DVHA Standard Operating Procedures (SOPs), and an overall DVHA performance

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

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

AHS Performance Accountability Committee

During this quarter, the AHS Performance Accountability Committee (PAC) discussed the new Data Governance Initiation (DGI) project currently underway at AHS. In addition to a brief overview of the project, the group received an overview of the Data Governance Council (DGC), Data Governance Operations (DGO), and an overview of their roles/responsibilities and accomplishments. During the next quarter, the group will continue to discuss how they can best support the DGI project and the DGO and their current work in progress.

The group also continued to discuss Investment Reporting. The group reviewed the monitoring and evaluation performance data elements, frequency of reporting (including schedule), reporting format, and the selection and reporting process. The group recommended that this reporting be aligned with the reporting requirements associated with the waiver payment models. To facilitate this outcome, the group compared/contrasted data elements for both initiatives and developed a common template for reporting performance. As a final step, payment model performance reporting dates were added to the investment schedule and distributed to all applicable staff.

Finally, during this quarter, the group discussed the Community Profiles Project. The purpose of the project is to increase access to data about the health and well-being of community-wide populations in Vermont. The data is for the use of local communities to understand local conditions and work together to improve quality of life. During this quarter, the group was presented with an overview of the project and the newly developed profiles. As a follow up, the group discussed how they can best support the Community Profiles Project and their current work in progress.

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

During this quarter, the AHS QIM met with DVHA to discuss the monitoring and evaluation requirements associated with their two new Delivery System Reform (DSR) investments:

- OneCare Vermont Accountable Care Organization (ACO) Quality and Health Management Measurement Improvement Investment
- OneCare Vermont ACO Advanced Community Care Coordination

Specifically, the following elements were discussed: definition of monitoring and evaluation data, frequency and format of reports, as well as, the reporting process. Evaluative data will include the following: investment description, performance measures and results, and an interpretation of the results. Monitoring and evaluation of these investments will be conducted following a periodic schedule. 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, DCF highlighted the performance of one of its investments. The Clear Impact Scorecard for this DCF investment is included in this report as Attachment 7.

Payment Models & Performance Monitoring

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

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

During this most recent quarter, DVHA highlighted the performance of its Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) payment model. The Clear Impact Scorecard for this DVHA payment model is included in this report as Attachment 8.

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

During this quarter, the HCBS Implementation Team continued to work on implementing the site-specific setting assessments. The team reviewed individual program response rates and suggested next steps. Next steps include item specific analysis by quality improvement staff to determine level of compliance with the new regulations and any necessary corrective action. Also, during this quarter, the AHS QIM attended the June DAIL Advisory Board Meeting to share the following: an update on implementation plan (site-specific settings assessments and validation activities); a review of next steps in the process (public comment and CMS submission); and an update on conflict free case management geographic exception request (pending outcome).

IX. Demonstration Evaluation

During this quarter, the draft Interim Evaluation Report was posted to the CMS Portal. The interim evaluation includes an assessment of the impact of providing Medicaid payment for Institutes for Mental Disease (IMD) services on the research questions included in the final evaluation design including the outcomes of interest listed above in STC 72 for the four (4) year period preceding the start of this demonstration. The Interim Evaluation Report includes the same core components as identified in STC 76 for the Summative Evaluation Report and follows the CMS approved evaluation design. The interim evaluation will inform the state's IMD phase-down plan which is due December 31, 2018.

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). Upon approval of the demonstration, the State began to arrange for an independent party to conduct an

evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. During the next quarter, the evaluation contract with the current independent party, Pacific Health Policy Group (PHPG), will be modified to include the OUD/SUD amendment evaluation requirements.

X. Compliance

Key updates from QE0618:

- EQRO audit preparation
- Choices For Care Audit
- New AHS/DVHA Inter-Governmental Agreement (IGA)

EQRO Audit Preparation and Document Submission

During this quarter, the AHS QIM continued to work with the EQRO, HSAG, to prepare for this year's activities. Activities related to Performance Improvement Projects (PIPs) included the following: developed/reviewed draft/final PIP templates, prepared/reviewed the PIP submission letter and supporting documents, and reviewed IET measure specification changes. Activities related to performance measures included the following: discussed the applicability of exclusion records for the ABA hybrid measure, developed/reviewed the medical record numerator positives and exclusions case listings template, and reviewed the final PMV MRRV results. Activities related to compliance included the following: developed/reviewed pre-onsite documents, drafted compliance review tool and forms, provided feedback on the tool and forms, and scheduled on-site compliance review date, and developed/reviewed onsite agenda. Also during this quarter, the Medicaid Compliance Officer completed the document submission process for the upcoming EQRO compliance audit and met with subject area experts to prepare for the compliance audit. As part of the process, previous corrective actions were reviewed to ensure that progress was made on deficiencies identified in previous audits. The EQRO will initiate performance measure validation, compliance review, and performance improvement project validation activities during the next quarter.

Compliance Committee

During this quarter, the Compliance Committee continued to develop work plans for compliance requirements in the AHS/DVHA IGA. In addition, the group reviewed the Compliance Plan. During the next quarter, the Compliance Officer will meet with representatives of the Compliance Committee to prepare for updates to the Compliance Plan and to review progress on new monitoring requirements that are required in the AHS-DVHA IGA.

Choices for Care (CFC) audit

The State Auditor's Office is conducting a review of the personal care services delivered through the CFC program to ensure that all payments are accurate and authorized. The Compliance Officer has been involved with interviews and document collection in anticipation of a final audit report next quarter. The final report is expected to identify several areas where programs can be improved to detect and address potential fraud, waste and abuse.

New Intra-Governmental Agreement (IGA) between AHS and DVHA:

During this quarter, the AHS QIM began drafting a new agreement between AHS and DVHA. This new IGA contains updated language to reflect new statutory citations and new Global Commitment waiver requirements. During the next quarter, a draft version of this agreement will be finalized and distributed to appropriate AHS/DVHA staff for review and approval. The final document will be submitted to CMS for review and approval one AHS receives CMS approval on its submitted 2018 IGA.

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 QE0618.

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: QE0618 Investments
Attachment 7: Investment Scorecard: Prevent Child Abuse Vermont – Nurturing Parent Program
Attachment 8: Payment Model Scorecard: VT Medicaid Next Generation Accountable Care Organization

XIII. State Contact(s)

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

Date Submitted to CMS: August 29, 2018

ATTACHMENTS

Attachment 1 - Budget Neutrality

Budget Neutrality New Adult **New Adult (w/ and w/o Child) Medical Costs Only**	**DY 12 – PMPM**				**DY 13 – PMPM**	
	QE 0317	**QE 0617**	**QE 0917**	**QE 1217**	**QE 0318**	**QE 0618**
(A) New Adult Group PMPM Projection	$518.26	$518.26	$518.26	$518.26	$540.03	$540.03
(B-1) eligible member months w/ Child	55,223	57,077	56,790	55,645	55,561	55,223
(B-2) eligible member months w/o Child	124,999	124,981	121,335	119,200	120,730	119,155
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 28,619,871.98	$ 29,580,726.02	$ 29,431,985.40	$ 28,838,577.70	$ 30,004,606.83	$ 29,822,076.69
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 64,781,981.74	$ 64,772,653.06	$ 62,883,077.10	$ 61,776,592.00	$ 65,197,821.90	$ 64,347,274.65
(D-1) New Adult FMAP w/ Child	54.46%	54.46%	54.46%	53.47%	53.47%	53.47%
(D-2) New Adult FMAP w/o Child	86.89%	86.89%	86.89%	86.69%	89.95%	89.95%
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 15,586,382.28	$ 16,109,663.39	$ 16,028,659.25	$ 15,419,987.50	$ 16,043,463.27	$ 15,945,864.41
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 56,289,063.93	$ 56,280,958.24	$ 54,639,105.69	$ 53,554,127.60	$ 58,645,440.80	$ 57,880,373.55
Subtotal Federal Share Supplemental Cap 1	$ 71,875,446.21	$ 72,390,621.63	$ 70,667,764.94	$ 68,974,115.10	$ 74,688,904.07	$ 73,826,237.95
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
Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget	$ 9,058,780.94	$ 10,560,230.30	$ 16,024,695.67	$ 17,815,262.58	$ 12,505,858.63	$ 10,070,087.19

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
Aug 3, 2018

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 DAN - DEC 2019	DY 15 JAN - DEC 2020	DY 16 JAN - DEC 2021	Total
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 142,981,230	$ 66,165,983	$ -	$ -	$ -	$ 209,147,213
ABD - Non-Medicare - Child	$ 85,347,172	$ 40,279,791	$ -	$ -	$ -	$ 125,626,963
ABD - Dual	$ 663,846,624	$ 343,498,541	$ -	$ -	$ -	$ 1,007,345,165
ANFC - Non-Medicare - Adult	$ 101,741,789	$ 51,682,712	$ -	$ -		$ 153,424,501
ANFC - Non-Medicare - Child	$ 392,619,614	$ 203,564,892	$ -	$ -	$ -	$ 596,184,506
Total Expenditures Without Waiver	**$ 1,386,536,429**	**$ 705,191,918**	**$ -**	**$ -**	**$ -**	**$ 2,091,728,347**
With Waiver						
ABD Non Medicare Adult	$ 162,605,120	$ 82,969,555	$ -	$ -	$ -	$ 245,574,675
ABD - Non-Medicare - Child	$ 66,594,520	$ 32,690,844	$ -	$ -	$ -	$ 99,285,364
ABD - Dual	$ 445,853,945	$ 232,585,914	$ -	$ -	$ -	$ 678,439,859
ANFC - Non-Medicare - Adult	$ 84,041,960	$ 44,332,194	$ -	$ -	$ -	$ 128,374,154
ANFC - Non-Medicare - Child	$ 305,549,938	$ 177,340,752	$ -	$ -	$ -	$ 482,890,690
Premium Offsets	$ (655,991)	$ (414,969)	$ -	$ -	$ -	$ (1,070,960)
Moderate Needs Group	$ 1,488,408	$ 738,330	$ -	$ -	$ -	$ 2,226,738
Marketplace Subsidy	$ 6,355,286	$ 3,300,326	$ -	$ -	$ -	$ 9,655,611
VT Global Rx	$ 13,824,516	$ 8,467,259	$ -	$ -	$ -	$ 22,291,775
VT Global Expansion VHAP	$ 414,824	$ 365,460	$ -	$ -	$ -	$ 780,285
CRT DSHP	$ 10,331,787	$ 5,837,735	$ -	$ -	$ -	$ 16,169,522
Investments	$ 142,453,076	$ 70,747,970	$ -	$ -	$ -	$ 213,201,046
Total Expenditures With Waiver	**$ 1,238,857,388**	**$ 658,961,371**	**$ -**	**$ -**	**$ -**	**$ 1,897,818,759**
Supplemental Test: New Adult (Gross)						
Limit	$ 370,685,465	$ 189,371,780	$ -	$ -	$ -	$ 560,057,245
With Waiver Expenditures	$ 295,626,448	$ 156,769,525	$ -	$ -	$ -	$ 452,395,973
Surplus (Deficit)	*$ 75,059,017*	*$ 32,602,255*	*$ -*	*$ -*	*$ -*	*$ 107,661,272*
Waiver Savings Summary						
Annual Savings	$ 147,679,041	$ 46,230,547	$ -	$ -	$ -	$ 193,909,588
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 44,303,712	$ 11,557,637	$ -	$ -	$ -	$ 55,861,349
Total Savings	$ 44,303,712	$ 11,557,637	$ -	$ -	$ -	$ 55,861,349
Cumulative Savings	***$ 44,303,712***	***$ 55,861,349***	***$ 55,861,349***	***$ 55,861,349***	***$ 55,861,349***	***$ 55,861,349***

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

State of Vermont
Department of Vermont Health Access
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http://dvha.vermont.gov

[Phone] 802-879-5900

Agency of Human Services

Medicaid Program Enrollment and Expenditures Report

Q3 SFY 2018

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

Al Gobeille, Secretary
Vermont Agency of Human Services

Cory Gustafson, Commissioner
Department of Vermont Health Access

June 1, 2018

Key Terms

Caseload – Average monthly member enrollment

MEG – Medicaid Eligibility Group

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

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

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

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

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

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

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

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

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

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

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

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

PMPM – Per Member Per Month

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS and AoE Medicaid Expenditures

All AHS and AoE YTD '18

	SFY '18 BAA			SFY '18 Actuals thru March 31, 2018			% of Expenses to
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	Budget Line Item
ABD Adult and Acute CFC	7,218	$ 182,809,143	$ 2,110.45	6,893	$ 122,954,651	$ 1,981.99	67.26%
ABD Dual	17,645	$ 226,912,702	$ 1,071.65	17,581	$ 164,259,669	$ 1,038.09	72.39%
General Adult	12,984	$ 89,522,326	$ 574.55	12,648	$ 61,288,998	$ 538.40	68.46%
New Adult	59,604	$ 299,940,774	$ 419.35	58,508	$ 214,193,409	$ 406.77	71.41%
Vermont Premium Assistance	19,023	$ 6,649,761	$ 29.13	18,290	$ 4,805,765	$ 29.20	72.27%
Vermont Cost Sharing	6,483	$ 2,640,929	$ 33.95	6,113	$ 1,150,352	$ 20.91	43.56%
ABD Child	2,439	$ 75,635,614	$ 2,583.94	2,255	$ 43,686,132	$ 2,152.13	57.76%
General Child	60,360	$ 303,696,157	$ 419.29	59,778	$ 227,112,195	$ 422.14	74.78%
Underinsured Child	831	$ 2,600,955	$ 260.73	608	$ 1,005,672	$ 183.85	38.67%
CHIP	4,817	$ 12,036,223	$ 208.23	4,707	$ 9,096,651	$ 214.72	75.58%
Pharmacy Only	11,182	$ 4,678,042	$ 34.86	10,776	$ 2,112,947	$ 21.79	45.17%
Traditional Choices for Care	4,350	$ 197,420,739	$ 3,782.01	4,201	$ 146,443,423	$ 3,873.55	74.18%
Total Medicaid Claims Paid	206,937	$ 1,404,543,364	$ 565.61	202,357	$ 998,451,545	$ 548.23	71.09%

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS Medicaid Expenditures

All AHS YTD '18

	SFY '18 BAA			SFY '18 Actuals thru March 31, 2018			% of Expenses to
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	Budget Line Item
ABD Adult and Acute CFC	7,218	$ 181,795,706	$ 2,098.75	6,893	$ 122,243,443	$ 1,970.52	67.24%
ABD Dual	17,645	$ 227,793,652	$ 1,075.81	17,581	$ 164,141,387	$ 1,037.34	72.06%
General Adult	12,984	$ 89,437,576	$ 574.00	12,648	$ 61,172,479	$ 537.38	68.40%
New Adult	59,604	$ 300,005,922	$ 419.44	58,508	$ 214,123,248	$ 406.64	71.37%
Vermont Premium Assistance	19,023	$ 6,649,761	$ 29.13	18,290	$ 4,805,765	$ 29.20	72.27%
Vermont Cost Sharing	6,483	$ 2,640,929	$ 33.95	6,113	$ 1,150,352	$ 20.91	43.56%
ABD Child	2,439	$ 58,963,567	$ 2,014.38	2,255	$ 34,636,477	$ 1,706.31	58.74%
General Child	60,360	$ 270,213,215	$ 373.06	59,778	$ 205,709,734	$ 382.36	76.13%
Underinsured Child	831	$ 2,148,032	$ 215.33	608	$ 756,229	$ 138.25	35.21%
CHIP	4,817	$ 10,293,794	$ 178.08	4,707	$ 7,936,918	$ 187.35	77.10%
Pharmacy Only	11,182	$ 4,678,042	$ 34.86	10,776	$ 2,112,947	$ 21.79	45.17%
Traditional Choices for Care	4,350	$ 197,420,739	$ 3,782.01	4,201	$ 146,443,423	$ 3,873.55	74.18%
Total Medicaid Claims Paid	206,937	$ 1,352,040,935	$ 544.46	202,357	$ 965,574,082	$ 530.18	71.42%

The Department of Vermont Health Access

Caseload and Expenditure Report ~ DVHA Only Medicaid Expenditures

DVHA YTD '18

	SFY '18 BAA			SFY '18 Actuals thru March 31, 2018			% of Expenses to
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	Budget Line Item
ABD Adult and Acute CFC	7,218	$ 93,646,370	$ 1,081.11	6,893	$ 60,281,447	$ 971.72	64.37%
ABD Dual	17,645	$ 54,637,311	$ 258.04	17,581	$ 39,263,455	$ 248.14	71.86%
General Adult	12,984	$ 76,353,006	$ 490.03	12,648	$ 52,208,849	$ 458.64	68.38%
New Adult	59,604	$ 268,599,342	$ 375.53	58,508	$ 192,156,839	$ 364.92	71.54%
Vermont Premium Assistance	19,023	$ 6,649,761	$ 29.13	18,290	$ 4,805,765	$ 29.20	72.27%
Vermont Cost Sharing	6,483	$ 2,640,929	$ 33.95	6,113	$ 1,150,352	$ 20.91	43.56%
ABD Child	2,439	$ 24,090,018	$ 822.99	2,255	$ 14,730,393	$ 725.67	61.15%
General Child	60,360	$ 153,061,657	$ 211.32	59,778	$ 113,307,395	$ 210.61	74.03%
Underinsured Child	831	$ 1,171,707	$ 117.46	608	$ 383,055	$ 70.03	32.69%
CHIP	4,817	$ 8,314,607	$ 143.84	4,707	$ 6,210,495	$ 146.59	74.69%
Pharmacy Only	11,182	$ 4,678,042	$ 34.86	10,776	$ 2,112,947	$ 21.79	45.17%
Traditional Choices for Care	4,350	$ 197,420,739	$ 3,782.01	4,201	$ 146,443,423	$ 3,873.55	74.18%
Total Medicaid Claims Paid	206,937	$ 891,263,489	$ 358.91	202,357	$ 633,396,097	$ 347.79	71.07%

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Questions, Complaints and Concerns Received by Health Access Member Services
April 1, 2018 – June 30, 2018

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

April 2 – April 6

- Requesting that feedback be submitted as she thinks that the information necessary to submit a claim should be readily available on the Vermont Health Connect website. CSR apologized for her frustrations, discussed the claims process with her, referred to her provider and offered to document her feedback.
- Caller wanted to document a complaint about the share program driver who was going to make her walk home after he brought her to her destination. She also wanted to complain about a Dr. who injured her in February and induced a seizure which required her to need an ambulance to the hospital and she does not believe Medicaid should be responsible for this. CSR apologized for her frustrations, offered provider complaint and to document her feedback.
- Caller wanted to submit feedback regarding MSP eligibility. He went from Vpharm 1/MSP to just Vpharm 1. He feels that taking the MSP away from customers causes financial hardships and should be looked into. CSR apologized for his frustrations, discussed the income guidelines and offered to document his feedback.
- Caller doesn't feel like he should have to call in and let us know about his appointments before he gets on the bus. He has memory loss and can't remember all the information to do this. CSR apologized for his frustrations, discussed the rules of the Medicaid Bus Program, referred him to resources that could help him with this and offered to document his feedback.
- Caller wanted it noted that she had to miss a medical appointment because her address was updated in the CRM/ACCESS but not HPE so the transportation broker denied transportation initially. She did not want it marked on her record that she was a no call/no

show for a registered appointment. Supervisor apologized for her frustrations, discussed that it sometimes can take some time for information to migrate to the provider billing system (HPE) and offered to document her feedback.
- Caller wanted to submit feedback that she feels the information in the Medicaid Handbook is outdated and that it needs to be overhauled. CSR apologized for her frustrations and offered to document her feedback.

April 9 – April 13
- VPharm/VPharm Review/Reinstatements

April 16 – April 20
- Caller wanted to submit feedback about the Prior Authorization process. She feels it is too difficult for customers to get the information they need to understand the PA process, whether it be denials or approvals. She feels they shouldn't have to go through the doctor to get this information. CSR apologized for her frustrations, discussed the information we have about the PA process and offered to document her feedback.

April 23 – April 27
- VPharm/VPharm Review/Reinstatements
- Caller wanted to document feedback regarding the amount of time (more than two weeks) it is taking for a prior authorization to go through for a request for an MRI following a back injury. She feels we should be able to look further into this for her instead of referring her back to her provider. CSR apologized for her frustrations, explained the process and let her know that she would need to contact her provider for more info. Also, offered to document her feedback.
- Caller wants to document feedback about being locked in to a pharmacy. He feels we should know that he feels trapped in where he is allowed to pick up his prescriptions. He feels like he is being forced to jump through hoops in order to follow the rules to get his prescriptions. He feels it is completely inconvenient to have to call every time he needs to go to a pharmacy if it is not the pharmacy that he is locked in to. He feels this is having to go out of your way especially if you are someone that does not fully understand the process. It can be confusing. CSR apologized for his frustrations, went over the lock in process with him and offered to document his feedback.
- Caller wanted to document feedback about a prescription that Medicaid would not cover. He states he is allergic to a fragrance that is in a certain medication he needs and Medicaid won't cover the one that doesn't have that specific ingredient and wants to know why. CSR apologized for his frustrations, advised him to have his provider submit a PA, offered GAC. He wanted to document negative feedback.

April 30 – May 4
- Caller wanted to submit negative feedback about his RX not being covered. He states he filed a Fair Hearing and feels that the process is ineffective and he has not been updated on his appeal for 2 weeks. He states he needs a prescription refilled that he can't afford and it's not okay to not have an update. He does not think customers should be limited to specific pharmacies covering certain prescriptions. CSR apologized for his frustrations and offered to document feedback.

State of Vermont *Agency of Human Services*
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May 7 – May 11

- Customer wanted to report negative feedback about her DME not being covered under Keene Medical because of cut backs on reimbursement from Medicaid. She feels this is unfair and the state shouldn't be able to do that. CSR apologized for the inconvenience, assisted customer in finding another DME supplier and offered to document her feedback.
- Caller wanted to submit negative feedback regarding Keene Medical no longer covering Medical Supplies she needs. She has called all Medical suppliers in her area and was told this issue is affecting over 4000 people. She reports she can only use certain products and cannot afford to pay out of pocket and DME providers she has talked to will not ship and she has limited transportation. She does not know what she can do for these much needed supplies. She does not think that this is fair. CSR apologized for her frustrations and offered to document her feedback.
- Caller wanted to document negative feedback regarding Keene Medical no longer covering her daughter's medical supplies. She states she received a letter that said as of 6/1 they will no longer accept Medicaid, but as of 5/11 they will not bill for her supplies. She feels this is unfair because there are no other alternatives or options we can provide her. She states she cannot take care of her daughter without the supplies. CSR apologized for her frustrations and tried to assist in finding another DME supplier. Also, offered to document her feedback.

May 14 – May 18

- No issues to report.

May 21 – May 25

- VPharm/VPharm Review/Reinstatements

May 28 – June 1

- VPharm/VPharm Review/Reinstatements
- Caller wanted to submit feedback regarding transportation. He wanted to be brought to his appointment and then for the ride back he wanted to be brought to work. He was advised they could bring him to his appointment and back home. He doesn't feel it's fair that he can't be brought to work. He was advised that isn't how the program works and he does not agree. He was advised it's against the policy to bring someone to another destination since it could be extra mileage. He does not feel this is fair. CSR apologized for his frustrations, explained that is how the program works and offered to document his feedback.
- Caller wanted to submit feedback regarding lack of notice. She states she did not receive a notice saying that her son’s Dr. Dynasaur coverage was going to end at the end of the

month in which he turned 19. She feels this is not fair and should have been notified. CSR apologized for her frustration, discussed why he wasn't eligible for Dr. D and went through QHP options. Also, offered to document her feedback.

June 4 – June 8

- No issues to report

June 11 – June 15

- Caller wanted to submit feedback about VT Notices that are sent out. He recently renewed his Vpharm and got a notice stating that it was going to continue but feels that the Notices Of Decision notice was unclear. He thinks it should state that he is eligible right at the top, not in a box on the 2nd page. CSR apologized for his confusion, went over the notice with him and offered to document his feedback.
- Caller wanted to submit feedback regarding the transportation benefit reimbursement for mileage. She states she only received 18 cents a mile to bring her child back and forth to the clinic and due to all the gas being used she is unable to afford her bills. She states she is trying to take care of her child but is being refused transportation because she has a car in her household. She doesn't think it's fair to do this to a family that is trying to care for their dying child. CSR apologized for her frustrations, discussed the transportation benefit and offered to document her feedback.
- Caller wanted to submit feedback about a provider. She states her daughter was told by their pediatrician's office that they were not going to provide her with any services. This office also denied prescriptions for the caller's son. This office advised caller that she needs to find a new provider for her children and the caller doesn't feel that it's right for the administration to deny her children coverage. Caller also wanted to add that her son is on medication and that he needs this medication and can't go without it. Dr. who both children see at this practice advised caller that he will continue to see both children, that Dr. wasn't aware of the administrative denying coverage for her two children. CSR apologized for this experience, offered a complaint form, but customer wanted to submit feedback.

June 18 – June 22

- No issues to report.

June 25 – June 29

- VPharm/VPharm Review/Reinstatements
- Caller believes that the Dr. Dynasaur as a secondary insurance should cover all further costs that a primary would cover, IE if a dental insurance covered 185 of a 202 service, and medicaid would normally only pay 95 for it, she believes that medicaid should pay out the remaining amount, as opposed to considering the amount paid. CSR apologized for any confusion, explained how Medicaid will reimburse, and offered to document the feedback.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
April 1, 2018 – June 30, 2018

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data compiled on July 23, 2018, from the centralized database that were filed from April 1, 2018 through June 30, 2018.

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

During this quarter, there were 10 grievances filed; three were addressed during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was four days. Of the grievances filed, 80% were filed by beneficiaries and 20% were filed by a representative of the beneficiary. Of the 10 grievances filed, DMH had 50%, DAIL had 40% and DVHA had 10%. There were no grievances filed for VDH or DCF during this quarter.

Grievances were filed for service categories case management, community support, mental health, long-term care and transportation.

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.

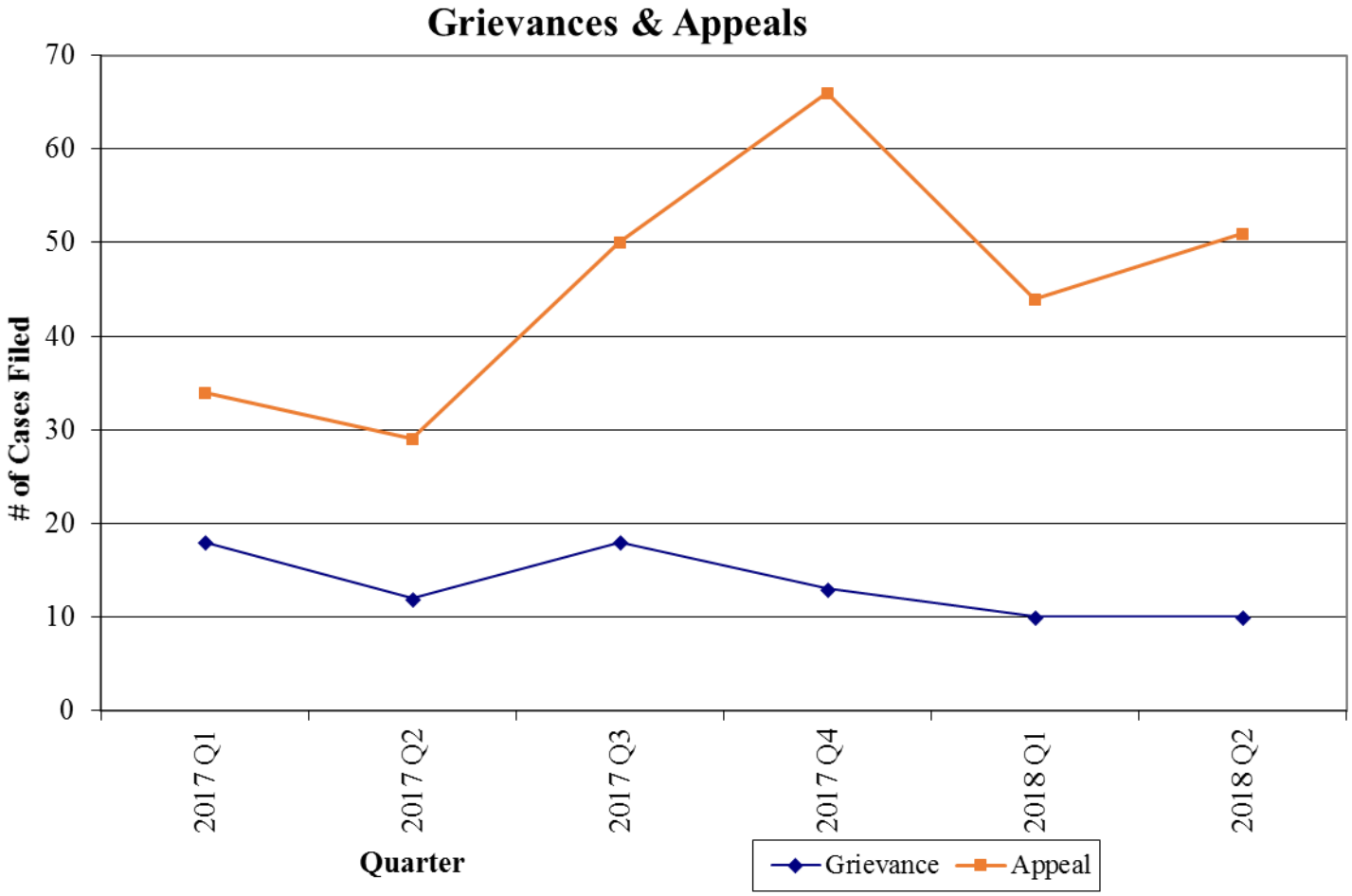
During this quarter, there were 51 appeals filed. Of these 51 appeals, 32 were resolved (63%), 14 were still pending (27%), 4 were withdrawn (8%) and one was filed too late (2%).

Of the 32 appeals that were resolved this quarter, 81% were resolved within the statutory time frame of 30 days. Six appeals were resolved after the 30-day timeframe, of these six appeals, two were extended at the request of the beneficiary. The average number of days it took to resolve these cases was 29 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

Of the 51 appeals filed, DVHA had 23 appeals filed (45%), DAIL had 25 (49%), VDH had 1 (2%) and DMH had 2 (4%).

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

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



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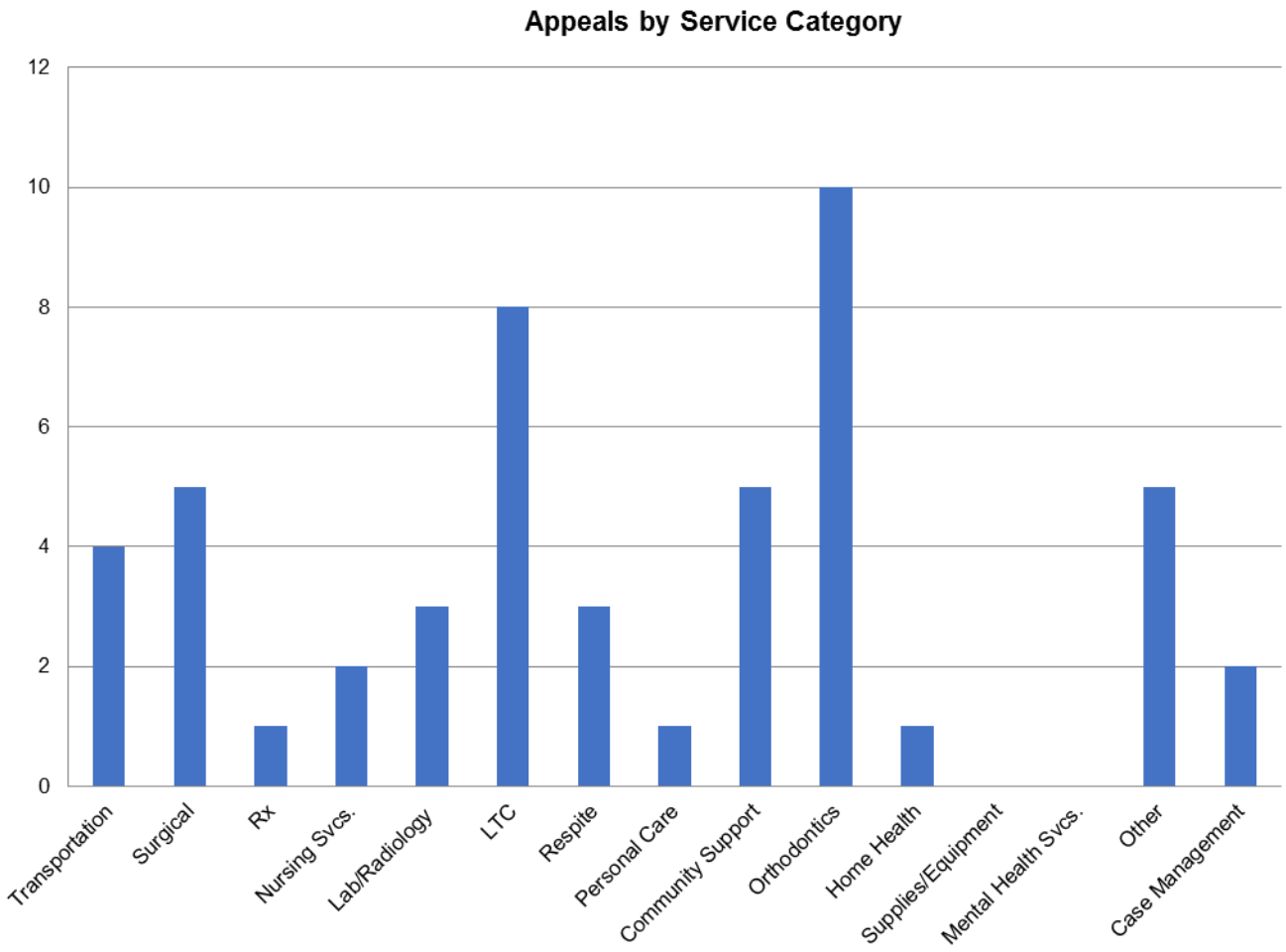
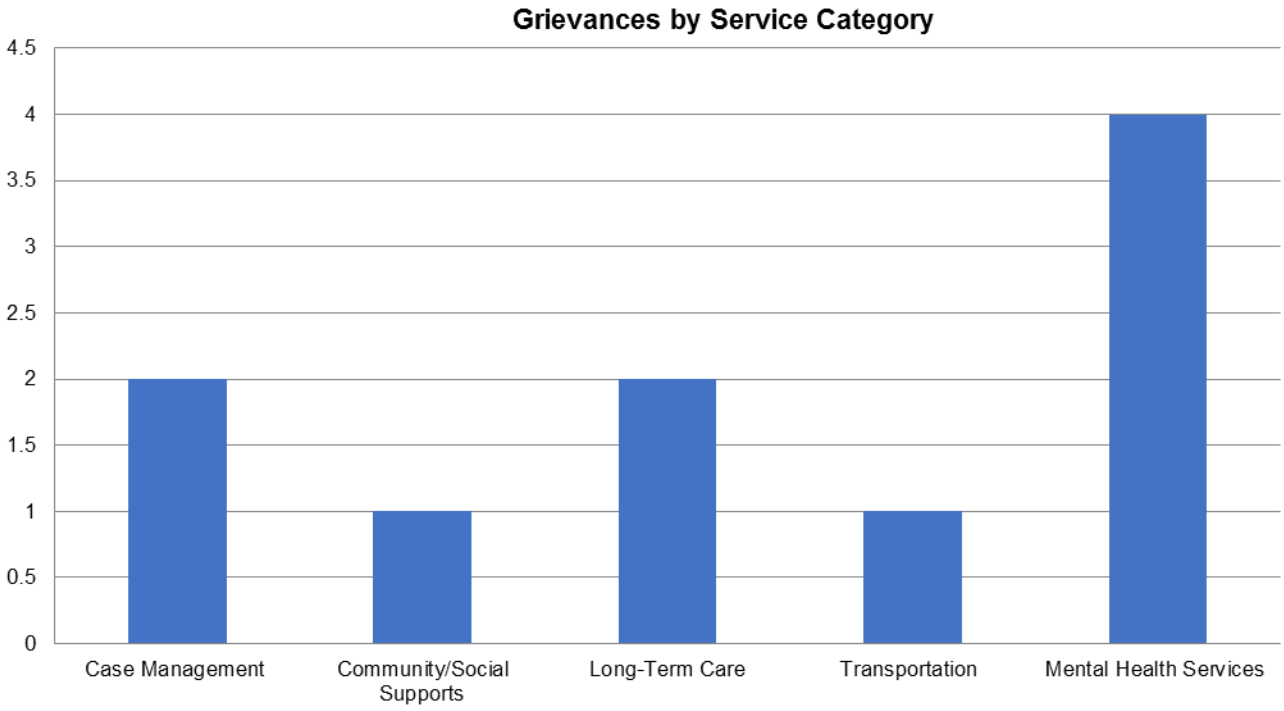
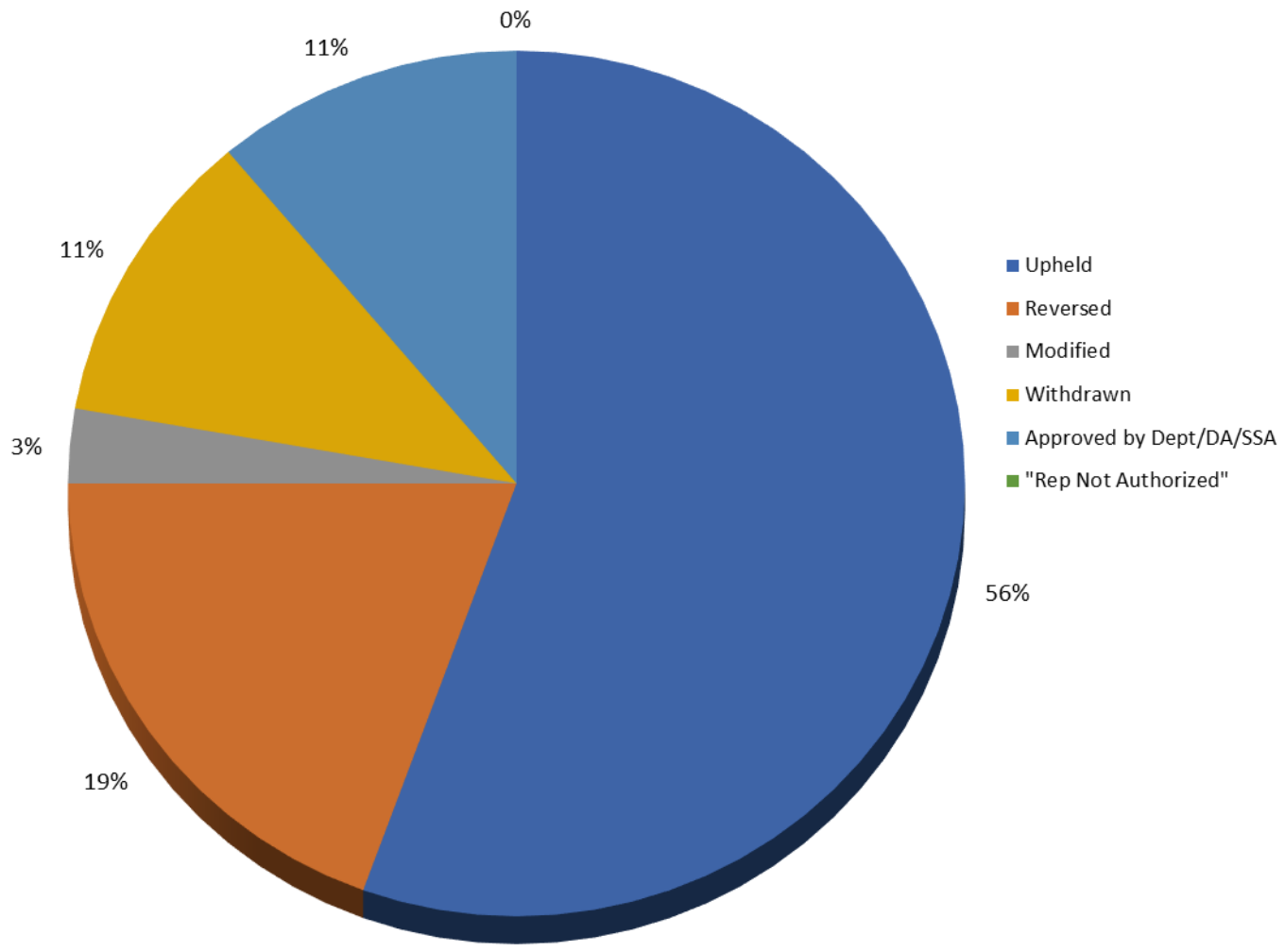

Appeals by Service Category
12
10
8
6
4
2
0
Transportation
Surgical
Rx
Nursing Svcs.
Lab/Radiology
LTC
Respite
Personal Care
Community Support
Orthodontics
Home Health
Supplies/Equipment
Mental Health Svcs.
Other
Case Management


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

MCO Appeal Resolutions
4/1/2018 thru 6/30/2018



Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

April 1, 2018-June 30, 2018

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

July 15, 2018

TABLE OF CONTENTS

Introduction

The Office of the Health Care Advocate (HCA) advocates for all Vermonters through both individual consumer assistance and systemic advocacy on health care issues. We work to increase access to high quality, affordable health care for all Vermonters through individual advocacy and representing the public before the Green Mountain Care Board, state agencies, and the state legislature.

This quarter, the HCA saw an uptick in the number of calls from consumers with complaints about their providers (136 vs. 81). The HCA works to educate consumers about their rights with providers. It also works to support and strengthen Vermont's provider network, so consumers are able to find providers that meet their needs. We also saw an increase in consumers calling about transitions between providers and continuity of care issues (46 vs. 25). The HCA continues to be concerned about the wait times to see specialists and the lack of available primary care providers.

This quarter HCA outreach focused on particularly vulnerable and underserved Vermonters. We do direct work such as going to legal clinics and meeting directly with providers, as well as indirect work such as making notices more clear and understandable to all Vermonters.

The HCA is also working with other stakeholders to prepare for 2019 Open Enrollment. The HCA is committed to helping consumers understand how the changes to the premium pricing will impact their households.

Ava's Story

Ava called because she needed to pick up a prescription, and when she went to the pharmacy she found out that her Medicaid had been closed. The HCA advocate investigated and found two problems. First Ava's Medicaid had been closed, and VHC had not sent the required closure notice telling her that Medicaid was closing and giving her appeal rights. When VHC closes a beneficiary's Medicaid, it is required to send a notice that explains the closure and appeal rights. The advocate was able to get VHC to reinstate the Medicaid immediately because of the failure to send the closure notice, and Ava picked up her prescriptions. Second, VHC had incorrectly found that Ava was over-income for Medicaid. When the advocate reviewed the income information, he found that some of the income being counted by VHC was non-taxable income that Ava earned as a caretaker. Since this income was non-taxable, it should not have been included in the income to screen for Medicaid eligibility. When the income was calculated correctly, Ava was found eligible for Medicaid once again.

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

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

Individual Consumer Assistance

Case Examples

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

Eleanor's Story

Eleanor had lost her job and her health insurance. She called Vermont Health Connect (VHC) to find out about signing up for a plan. When she spoke to VHC, they told her that she qualified for a Special Enrollment Period (SEP) because she has lost her employer insurance, and that she had until the end of the next month to sign up for a plan. Eleanor later called back to sign up, and she was told she had missed her SEP and would need to wait until Open Enrollment to sign up. Eleanor was confused because she had called within the time frame that VHC had given her in the first call. When the HCA advocate investigated, she found that during the first call VHC had told Eleanor the wrong date. It had mistakenly told her that she had more time left in her SEP than she really did. Because Eleanor had relied on this incorrect advice, the advocate asked for a new SEP for Eleanor. VHC granted it, and Eleanor was able to sign up for a plan that suited her health care needs.

Arnold's Story

Arnold had surgery scheduled, and called the HCA because the prior authorization had not been approved, and the provider was threatening to cancel the surgery. Arnold was on Medicaid, and the surgery required a prior authorization under the Medicaid coverage rules. When the HCA advocate looked into the case, he found that although Arnold was on Medicaid, he was also an attributed member of OneCare. OneCare is a state-wide Accountable Care Organization (ACO). The ACO is supposed to improve efficiency, costs, and health outcomes for its members. OneCare members do not need prior authorization for certain medical procedures and services, including the surgery that Arnold had scheduled. This meant that Arnold could go forward with the surgery without getting approval from Medicaid. The HCA made sure Arnold's provider understood that he did not need a prior authorization, and the surgery went forward as scheduled.

Charlotte's Story

Charlotte was at the Kinney Drugs pharmacy to pick up a prescription that normally cost $2. This time the pharmacist was telling her that the price was $70. She had paid for it using her money for groceries and other bills, but could not afford it. The HCA has a partnership with Kinney Drugs to assist in cases just like Charlotte's, and the pharmacist made an emergency referral. The HCA advocate talked to Charlotte and the pharmacist and found out that Charlotte had VPharm coverage. VPharm helps pay the Part D premium, reduces out-of-pocket costs, and keeps co-payments between $1 and $2. The HCA advocate first made sure Charlotte's VPharm was active. It was, so this meant that the $70 copayment had to be an error. He reached out to VHC and asked them to intervene to correct the co-payment problem. VHC was able to do this immediately. When

the pharmacist ran the prescription again, the copayment was now $2. Charlotte was able to get a refund for the $68.

Alice's Story

Alice called the HCA because her children's coverage on Dr. Dynasaur had closed. VHC had determined that the family was over-income for the program. Alice had also just lost her job and her insurance. She did not think that her family could afford a family plan on VHC. Dr. Dynasaur has a low monthly premium, and no deductible or cost-sharing, so a family plan would mean a higher premium and more out-of-pocket costs. When the HCA advocate studied Alice's income, he found that the family was right under the Dr. Dynasaur income limits. Alice's family had made some contributions to an IRA that should not have been counted in the taxable income for the Dr. Dynasaur eligibility calculation. Also, this took place in April, which was the month that VHC updated its income guidelines for Medicaid and started using the 2018 FPL (Federal Poverty Level) guidelines. The updated FPL guidelines changed the income limits slightly. When the contributions were properly calculated and the 2018 FPLs applied, the family was still eligible for Dr. Dynasaur. This meant that the children could stay enrolled on the $60 per month Dr. Dynasaur coverage, and Alice and her partner were also able to enroll in a plan for couples.

Elijah's Story

Elijah called the HCA because VHC had told him that he had missed his Special Enrollment Period (SEP) and would need to wait until Open Enrollment to sign up for a VHC plan. Elijah had been on an employer sponsored insurance (ESI) plan, but he left that job for a new one that did not offer insurance coverage. He called VHC to apply, but did not pick a plan during that conversation. When he called back to enroll in a plan, VHC told him that he had missed his SEP. When the HCA advocate reviewed Elijah's case, he found that VHC had failed to send him an eligibility notice for his Medicaid, federal premium tax subsidies, or cost-sharing assistance. VHC is required to send eligibility notices when you apply for Medicaid or PTC. The notices also would have told Elijah of the 60 day limit for the SEP. The advocate asked for an SEP because of the failure to send the notice, and VHC granted it. Elijah was able to select a plan and enroll.

Gretel's Story

Gretel went to the pharmacy to pick up her prescription, and she was told by the pharmacist that she did not have a Part D plan. Medicare Part D covers prescriptions. She could not afford to pay for her prescriptions out of pocket. When the HCA advocate looked into the case, she found that Gretel had just enrolled in Medicare. She was also on Medicaid for Aged Blind and Disabled (MABD) and enrolled on a Medicare Savings Program (MSP) to help pay for her Medicare cost-sharing. The only piece that she was missing was a Part D plan to cover her prescriptions. The advocate found that she was, indeed, signed up for a Part D plan, but it was not starting until the first day of the following month. In the meantime, Gretel could not afford her prescriptions. In this situation, the advocate realized that Gretel would qualify for a program called LI NET. This program is designed to eliminate coverage gaps for low income individuals. Because Gretel was on MABD and on a Medicare Savings Program, she was be eligible for this program. The advocate spoke with the pharmacist and explained that LI NET program could be billed for Gretel's prescriptions until her Part

D plan started. The pharmacist was able to successful bill LI NET for Gretel's medications, and so she was able to pick up her prescriptions that day.

Avery's Story

Avery called the HCA because she needed some help getting to her medical appointments. She was on Medicaid which meant that she was eligible for Medicaid transportation to get to her appointments. When she requested a ride to the appointment, Medicaid told her would need to take the bus since she lived on the bus-line and that was the least-expensive mode of transportation. Medicaid transportation rules require beneficiaries to use the least-expensive mode of transportation available that suits the needs of the rider. Riding the bus, however, was very difficult for Avery. When she was a child, she had fallen from over 20 feet. The fall had left her with severe vertigo. Riding on buses aggravated her vertigo and also made her nauseated. She had tried using the bus to get to an appointment, and it had made her ill. The HCA advocate worked with Avery to get a letter from her doctor describing her medical condition. The advocate requested that Medicaid allow Avery to ride in a car to her appointments due to her medical condition. With the letter, Medicaid approved the request, and Avery was able to schedule a ride for her next appointment.

Overview

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

The HCA received 967 calls[1] this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller's primary issue, were as follows:

- **27.09%** (262) about **Access to Care**
- **13.86%** (134) about **Billing/Coverage**
- **1.14%** (11) about **Buying Insurance**
- **10.55%** (102) about **Consumer Education**
- **26.06%** (252) about **Eligibility** for state and federal programs
- **21.30%** (206) 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 252 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, a total of 542 cases had eligibility listed as a secondary concern.

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

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 1 - June 30, 2018 includes:

- This narrative, which contains sections on **Individual Consumer Assistance**, **Consumer Protection Activities** and **Outreach and Education**
- Seven data reports, including three based on the caller's insurance status:
  - **All calls/all coverages**: 967calls (compared to 1047 last quarter)
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 355 calls (319 calls last quarter)
  - **Commercial plan beneficiaries**: 165 calls (222 calls last quarter)
  - **Uninsured Vermonters**: 92 calls (100 calls last quarter)
  - **Vermont Health Connect (VHC)**: 242calls (325 calls last quarter)
  - **Reportable Activities (Summary & Detail)**: 94 activities and 14 documents (121 activities, 11 documents)

Priorities

A. The HCA advocates participated in the COTS legal clinic with the goal of reaching vulnerable and underserved consumers.

The advocates educated consumers about both state and federal health care programs and about how the HCA could help them. They also talked to specific consumers about their eligibility for health care programs. Specifically, they advised multiple consumers how to apply for Medicaid and advised them on their eligibility for the program. The HCA also handed out brochures and cards, and plans on participating in clinics in the future.

B. The HCA organized a meeting with area healthcare providers to discuss improving access to transgender health care services.

The HCA, along with Vermont Legal Aid attorneys and nine providers, met to discuss current Medicaid coverage criteria, and the barriers presented by the criteria. This group plans on meeting with AHS to discuss how the current coverage criteria could be changed to expand access of medically-necessary coverage. The group discussed consumer and provider experiences with commercial insurance coverage for these services, and plans on working to increase access to these health care services for all Vermont consumers.

C. The HCA participated in the Adverse Childhood Experiences Pilot Project.

HCA advocates and attorneys met with a local pediatrician who has teamed with the Family Center of Washington County for a pilot project to address adverse childhood experiences (ACES). ACEs are traumatic childhood experiences. Children who experience an increased number of ACEs have been shown to suffer from chronic health conditions and other health problems at a greater rate. The project funds two social workers in the pediatrician's office. The pediatrician uses a questionnaire to identify patients who may be at risk for ACES. The social workers then coordinates help for the families to try to reduce the ACE risk factors. The pilot project is seeing encouraging results but needs additional funding to continue. The HCA discussed some potential funding mechanisms and helped connect the project with some local organizations that may be able to further facilitate funding.

D. The HCA participated in Rural Pride.

This event was organized by the National Center for Lesbian Rights and Green Mountain Crossroads. The HCA advocate presented information on rural LGBTQ health care concerns for an audience of

30. The advocate also outlined the services that the HCA offers—and how it can help Vermonters with healthcare problems and questions.

E. Overall call volume decreased somewhat, but is still higher than the call volume in the same quarter of 2017.

The total call volume decreased by 7.6%. (967 this quarter vs. 1047 last quarter). In 2017, the HCA had 861 calls in the second quarter compared to 967 in 2018. About 12% of those calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We saved consumers $45,408.64 this quarter.

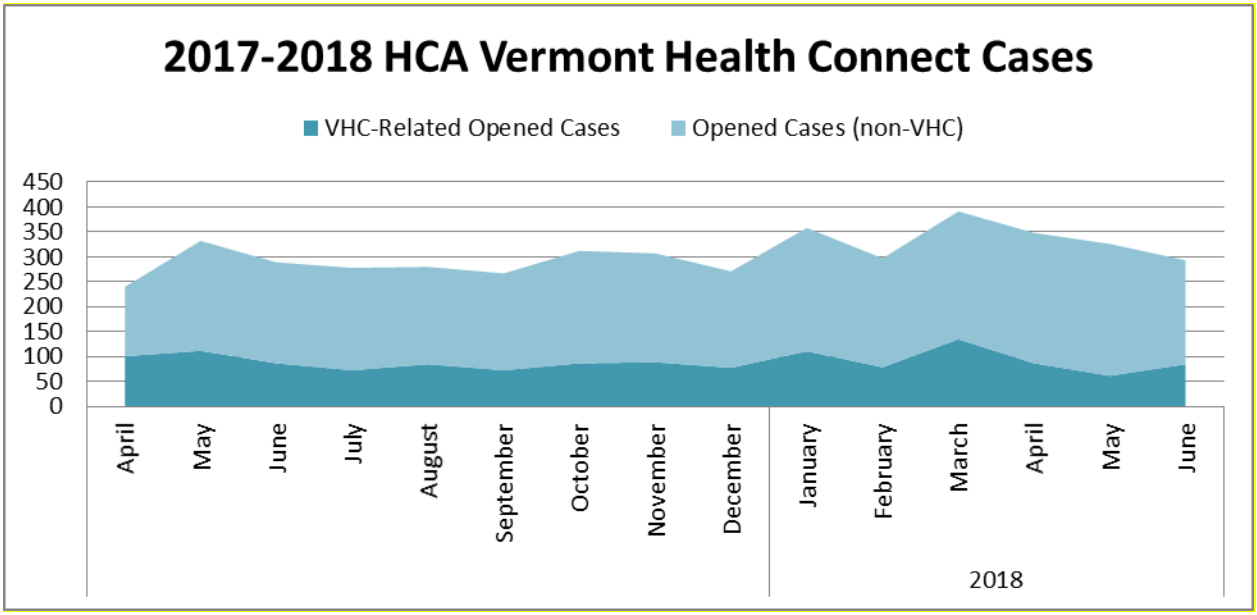
	All Calls (2008-2018)										
	2008	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
January	309	240	218	329	282	289	428	470	411	340	358
February	232	255	228	246	233	283	304	388	511	330	297
March	229	256	250	281	262	263	451	509	416	308	391
April	235	213	222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

F. Calls concerning Vermont Health Connect decreased significantly.

The volume of calls concerning Vermont Health Connect decreased by 26%, compared to the previous quarter (242 v. 325). With the ending of tax season, we saw an expected decrease in our tax-related calls (ACA Tax issues, 30 vs. 43 calls; and 1095-A &B issues, 17 vs. 46 calls). Consumers, however, continue to call in significant numbers about eligibility for Special Enrollment Periods and Termination of insurance (40 vs. 37 for SEPS; and 41 vs. 48 for Termination). The HCA will continue to focus our consumer education and outreach efforts on making sure that consumers enroll in QHPs that they can afford and that best meet their medical needs. This quarter, 96 VHC cases required complex interventions that took more than two hours of an advocate's time to resolve, and 60 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 69 escalated cases (69 vs. 83 last quarter). Of the 69 escalated cases, 62 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 get significant numbers of consumers calling with questions about Medicare Savings Programs (61 vs. 65), MABD (73 vs. 68), and VPharm eligibility (56 vs. 40).



G. Medicaid eligibility calls represented 25% of all our cases (240 calls/967 total calls). Consumers need assistance with all types of Medicaid.

Medicaid eligibility was again the top issue generating calls. We had 102 calls about eligibility for MAGI (expanded) Medicaid, 73 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), 25 about Medicaid Spenddowns, and 17 about Medicaid for Working Disabled. We also had 23 calls specifically about the Medicaid renewal process. MAGI Medicaid and MABD Medicaid have different eligibility and income rules, and HCA advocates assess and advise on eligibility for both programs. Consumers frequently have questions about what counts as income, who should be counted in their household, what expenses can be used to meet a Spenddown, how to complete renewal paperwork, and whether their eligibility decision is correct.

H. The top issues generating calls

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

All Calls 967 (compared to 1047 last quarter)

1. Complaints about providers 136 (81)
2. MAGI Medicaid eligibility 102 (115)
3. Information/applying for DVHA programs 81 (77)
4. Premium Tax Credit eligibility 79 (63)
5. Medicaid eligibility (non-MAGI) 73 (68)
6. Information about VHC 64 (58)

7. Buy-in programs/Medicare Savings Programs 61 (65)
8. Access to Prescription Drugs/Pharmacy 60 (44)
9. Special Enrollment Periods eligibility 59 (54)
10. Information about Medicare 58 (52)
11. Termination of insurance 56 (58)
12. VPharm eligibility 56 (40)
13. DME, Supplies 53 (15)
14. Transition/Continuity of Care 46 (25)
15. Fair hearing appeals 43 (50)

Vermont Health Connect Calls 242 (compared to 325 last quarter)

1. MAGI Medicaid eligibility 90 (97)
2. Premium Tax Credit eligibility 78 (57)
3. Information about VHC 58 (53)
4. Termination of insurance 41 (48)
5. Special Enrollment Periods 40 (37)
6. Grace Periods – VHC 39 (40)
7. IRS Reconciliation 31 (25)
8. ACA Tax issues 30 (43)
9. Fair hearing appeals 30 (39)
10. Change of Circumstance 27 (32)

DVHA Beneficiary Calls 355 (compared to 319 last quarter)

1. Complaints about providers 68 (24)
2. DME, Supplies 47 (11)
3. MAGI Medicaid eligibility 44 (44)
4. Medicaid eligibility (non-MAGI) 41 (29)
5. Transition/Continuity of Care 38 (2)
6. Information/applying for DVHA programs 32 (23)
7. Provider Directory Problems 29 (not counted as separate issue previously)
8. Network Adequacy 27 (2)
9. Choosing/Changing Providers 24 (11)
10. Access to prescription drugs/pharmacy 19 (28)

Commercial Plan Beneficiary Calls 165 (compared to 222 last quarter)

1. Premium Tax Credit eligibility 39 (35)
2. Information about VHC 20 (17)
3. Eligibility for Special Enrollment Periods 17 (14)
4. Insurance Coverage/Contract Questions 18 (13)
5. ACA Tax issues 17 (23)
6. Eligibility for VHC grace periods 16 (18)
7. IRS Reconciliation 17 (17)
8. 1095-A & 1095-B problems 15 (25)
9. MAGI Medicaid eligibility 13 (27)
10. Change of Circumstance 13 (13)

The HCA received 967 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"): 36.7% (355 calls), compared to 30.5 % (319 calls) last quarter
- **Medicare**[2] **beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 28.7% (278 calls), compared to 28.01% (293 calls), last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans 17.1% (165 calls) , compared to 21.1% (222 calls) last quarter
- **Uninsured:** 9.51% (92 calls), compared to 9.56% (100 calls last quarter)

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 1029 cases this quarter, compared to 981 last quarter:

- 32% (327 cases) were resolved by brief analysis and advice
- 32% (327) were resolved by brief analysis and referral
- 22% (228) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time
- 9% (97) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases (50), clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 27 individuals with appeals: 14 Fair Hearings, 3 Commercial Insurance – Internal 1st Level appeals, 2 Commercial Insurance – Internal 2nd Level appeals, 1 Commercial External Appeal, 1 Medicare Part A, B, or C appeal, 2 Medicare Part D appeals, and 4 Medicaid MCO Internal appeals.

DVHA Beneficiary Calls

We closed 363 DVHA cases this quarter, compared to 301 last quarter:

- 32% (117 cases) were resolved by brief analysis and/or referral
- 31% (113) were resolved by brief analysis and/or advice
- 19% (70) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 13% (46) 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 (17) clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 7 DVHA beneficiaries with appeals: 1 Fair Hearing, 2 Medicare Part D appeals, and 4 Medicaid MCO Internal appeals.

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

Commercial Plan Beneficiary Calls

We closed 201 cases involving individuals on commercial plans, compared to 214 last quarter:

- 32% (64 cases) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 30% (61) were resolved by brief analysis and/or advice
- 22% (44) were resolved by brief analysis and/or referral
- 13% (26) 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 (6) clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 23 commercial plan beneficiaries with appeals: 14 Fair Hearings, 3 Commercial Insurance – Internal 1st Level appeals, 2 Commercial Insurance – Internal 2nd Level appeals, 1 Commercial External Appeal, 1 Medicare Part A, B, or C appeal, and 2 Medicare Part D appeals.

B. All Calls Case Outcomes

The HCA helped 87 people with applications for or enrollment in insurance plans and prevented 21 insurance terminations or reductions. We obtained coverage for services for 20 people. We got 24 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 56 more. We provided other billing assistance to 20 individuals. We provided 593 individuals with advice and education. Fourteen people were not eligible for the benefit they sought, and nineteen were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 170 more people.

Consumer Protection Activities

A. Rate Review

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

Five filings related to premium price increases were decided during the quarter covering April 1 through June 30, 2018. Additionally, there are two proposed premium price increases pending at the end of the quarter.

Two decided filings were submitted by Blue Cross Blue Shield of Vermont (BCBSVT) and The Vermont Health Plan (TVHP), a subsidiary of BCBSVT: the BCBSVT Large Group Filing and the TVHP Large Group Filing. BCBSVT and TVHP proposed an average premium price increase of 11.2 percent. Approximately 14,200 Vermonters who obtain coverage through their employers were impacted by the proposed premium price increases. The HCA appeared on behalf of Vermonters in these matters and filed questions to the carriers, post-hearing memoranda, and various motions. The Board reduced BCBSVT's and TVHP's proposed price increases by 12.5 percent to an average increase of 9.8 percent. These premium price reductions translate into approximately $1M of savings for Vermonters.

The other three proposed premium price increases were filed by MVP Health Care, Inc. (MVP). Two of these proposed premium price increases were dealt with jointly, namely, the MVP Large Group HMO 3Q/4Q 2018 and the MVP Large Group Point of Service Rider. This premium price increase affected approximately 2,200 Vermonters who obtain health insurance coverage through their employer. The HCA appeared on behalf of Vermonters in this matter and filed questions to the carrier, and a post-hearing memorandum. The Board reduced MVP's proposed premium price increase to 2.32 percent. This premium price reduction translates into approximately $162,000 of savings for Vermonters.

The final decided filing was related to MVP's small group grand 3Q/4Q 2018 book of business. This premium price increase affected approximately 1,300 Vermonters. The HCA appeared on behalf of Vermonters in this matter and filed questions to the carrier, and a post-hearing memorandum. The Board reduced MVP's premium price increase to 0.8 percent. This premium price reduction translates into approximately $103,000 of savings for Vermonters.

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 represent approximately $41M in additional premiums that Vermonters may have to pay. These two proposed price increases will impact approximately 77,700 Vermont members. The HCA appeared on behalf of Vermonters in these matters and has filed questions to the carriers and 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.

Lastly, as we noted last quarter, the HCA devoted substantial effort to modify the rate review process to allow the HCA to better represent the interests of Vermonters. In response to HCA advocacy, the Board has, for the first time, required health insurers to answer questions related to affordability, access to care, quality of care, and other relevant public policy questions related to how proposed premium price increases impact Vermonters. The HCA is hopeful that its efforts will continue to result in meaningful changes to the rate review process although we have laid the groundwork for a possible statutory solution next legislative session should that be necessary.

B. Hospital Budget Review

The HCA participates in the Board's annual hospital budget review process. This quarter, the Chief Health Care Advocate and HCA staff met with executives at three Vermont hospitals to open channels of communication, share information about the role of the HCA outside the hospital budget review process, and learn about the hospitals' successes and challenges. These first three meetings were with Porter Medical Center, Northeastern Vermont Regional Hospital, and Northwestern Medical Center. Additionally, this quarter the HCA met with leadership at the Vermont Association of Hospitals and Health Systems to discuss the hospital budget review process.

We will begin our review of the hospitals' proposed 2019 budgets and their answers to our first set of written questions (submitted with the Board's budget guidance in March) when the proposed hospital budgets are submitted to the Board in July.

C. Oversight of Accountable Care Organizations

This quarter, the HCA worked with the Board and OneCare Vermont to develop a proposed measure set for the 2019 Medicare ACO program. HCA staff met with the Board and OneCare twice to review measures proposals and develop a recommendation. The group developed a consensus set of 15 measures which were submitted to the Centers for Medicare and Medicaid Services (CMS) by Board staff. CMS accepted 13 of the 15 measures and these are expected to form the core Medicare measure set for 2019. At the Board meeting where the measure set was discussed, the HCA gave an oral comment supporting the consensus measure set and asking the Board and OneCare to implement a point-of-care measure of the patient experience of shared decision-making. Additionally, this quarter the HCA submitted formal comments to the Board outlining concerns about affordability and how patient cost-sharing will interact with ACO goals. In these comments we reiterated our suggestion that the Board and the ACO monitor the patient experience of shared decision-making, including affordability of recommended care, via a point-of-care measure. The HCA continues to have concerns that the ACO quality measures will not be sufficient to assess the model and how it is affecting patients' care experiences.

D. Other Green Mountain Care Board Activities

The HCA continues to participate in several stakeholder groups organized by the Green Mountain Care Board in addition to attending weekly Green Mountain Care Board meetings and periodic Green Mountain Care Board Advisory Board meetings. The Federal Issues Work Group was organized to discuss state issues that could arise as a result of changes made by the federal government. The group is looking at a variety of issues including loss of federal cost sharing funds and changes in federal rules related to short term and association health insurance plans. All of these issues have the potential to increase the cost of health insurance for Vermonters. The HCA actively participates in this group, representing consumers' interests.

In the last quarter, the HCA provided the Board with a report examining demographic change in Vermont by health service area, motivated by a desire to assist the Board with its efforts towards data-driven, responsive policy making. Unlike past demographic data presented to the Board by third parties, the HCA highlighted the complexity of demographic change on health care system function including the potential of demographic change to indicate increased health risks and how the geography of demographic change leads to the need for context-sensitive regulation.

In the last quarter, the HCA also monitored the Board's upcoming Hospital Budget review and Accountable Care Organization Budget review. As a part of this, the HCA asked the Board and OneCare to implement a point-of-care patient experience measure assessing shared decision-making. The HCA also met with Board staff members to discuss ways the Board can better integrate its regulatory processes for rate review, hospital budget review, certificate of need, and accountable care organization budget review.

E. Other Activities

Administrative Advocacy

✧ Access to Screening Mammography

This quarter the HCA continued to advocate for the implementation of Act 25 of 2013, which requires first-dollar coverage of screening mammography including additional views. The law has now been amended, and starting in 2019, ultrasound screening will also be covered with no cost-sharing. The HCA will continue to follow this issue to ensure that law is fully implemented.

✧ Access to Treatment for Hepatitis C Virus

This quarter, the HCA continued to advocate for increased access to hepatitis C virus (HCV) treatment. In the previous quarter we had submitted a request to the Vermont Department of Corrections (VTDOC) for basic information about treatment for patients with HCV in the correctional system in 2017 and early 2018. We received a response to this request in April with some limited data and VTDOC's health care contractor (Centurion)'s treatment protocol. We were told that in 2017, 258 people with HCV spent time in custody of VTDOC, that the total cost of treatment was just over $330,000, and that information about the number of people treated did not exist. We were later told that this information was inaccurate.

In early June we received more information from VTDOC. In this communication they told us that the information provided to us in April was not correct. They informed us that 1 person was treated for HCV in 2017 and that rather than the over $330,000 figure that was previously cited, Centurion spent $47,250 on antiviral medication during that year. Of particular note, we were informed that in 2017 Centurion was paid $2,719,719 for pharmaceuticals. In that same year Centurion spent only $1,785,926 on pharmaceuticals. Similarly, the state paid Centurion $2,113,726 for off-site services for 2017, of which Centurion spent only $883,203.

We submitted an additional request for information to VTDOC and AHS in June asking for explanations as to why only one person was treated for HCV, and where the remaining dollars paid by the state to Centurion for pharmaceuticals and off-site services went. As of quarter-end, we are still awaiting a response.

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

✧ University of Vermont Medical Center Mental Health Program Quality Committee

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

✧ Vermont Health Connect Escalation Path

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

✧ **Comments on Vermont Health Connect Notices**

At VHC's request, the HCA commented on 4 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).

Legislative Activities

The 2018 Legislative session finally came to a close during this quarter. The HCA put considerable time and effort into legislative advocacy during this session. With the close of the session, a review of the legislative year is in order here. A significant theme of this work has been in response to actions or potential actions from the Federal Government that would have a negative impact on the stability of Vermont's health insurance marketplace.

- **S.19** – An act relating to allowing silver-level nonqualified health benefit plans to be offered outside the Vermont Health benefit Exchange. The HCA joined with other advocates to successfully change the organization of Vermont's marketplace to allow the costs of the Federal Cost Sharing Reduction subsidies to be loaded on to the silver-level premiums inside the exchange. This change will draw down significantly more Federal Premium Tax credits for low income Vermonters to more than offset the loss of the Federal CSR monies.

- **H.696** – An act relating to establishing a State individual mandate. This bill creates a state Individual mandate that will be implemented for the 2020 plan year. The bill also includes intent language that the individual mandate will be enforced by a financial penalty or other enforcement mechanism that will be enacted during the 2019 legislative session. An individual mandate working group is established that includes the HCA and is tasked with developing a proposal for legislative action by November 1, 2018. The HCA as well as the Department of Health Access are also directed to engage in outreach efforts for the 2019 open enrollment period.

- **H.892** – An act relating to regulation of short-term, limited-duration health insurance coverage and association health plans. This bill clarified that short-term, limited-duration health insurance coverage plans cannot be longer than 3 months and cannot be renewed in Vermont. It also requires the Department of Financial Regulation to engage in rulemaking to regulate Association Health Plans.

- **H.912** - An act relating to the health care regulatory duties of the Green Mountain Care Board. This was passed by the House and has not been acted upon by Senate Health and Welfare as of the close of the quarter. The HCA engaged significantly and successfully on the CON portion of this bill as well as other incidental sections including the creation of a workgroup to focus on the regulation of freestanding health care facilities. H.912 was also the context in which we engaged in an important conversation about the HCA's ability to ask relevant questions in the Rate Review process. While this advocacy did not result in an update of the statutes, it did result in a memorandum from the Chair of Senate Health and Welfare calling on the GMCB and the HCA to

improve the process to assure that the HCA is able to access the information it requests of carriers while not unjustifiably increasing the administrative burdens of the insurers.

- **S.262** - An act relating to miscellaneous changes to the Medicaid program and the Department of Vermont Health Access. S.262 passed the Senate and has not seen final action in the House Health Care committee as of the close of the quarter. The HCA and VLA advocated for some important changes to this bill with a focus on appropriate notice to applicants that DVHA is using electronic asset verification to review Medicaid eligibility, developing a system to give beneficiaries appropriate assistance asking for a fair hearing after an internal appeal, as well as a minor update to the factors that can lead to a secretary reversal of a HSB decision.

- **H.404** - An act relating to Medicaid reimbursement for long-acting reversible contraceptives. This bill requires Medicaid to reimburse health care providers for the full cost of long acting reversible contraception devices. The HCA supported this bill in each stage of action.

- **H.639** - An act relating to banning cost-sharing for all breast imaging services. This act requires health insurance coverage for screening by ultrasound without cost-sharing requirements for patients whose screening mammograms were inconclusive or who have dense breast tissue, or both. It also directed the Department of Financial Regulation to issue a bulletin by October 1, 2018, providing clarification to health insurers regarding the coding structure for screening mammograms and ultrasounds and for call-back screenings, including clarifying that call-back mammograms and ultrasounds for patients whose screening mammograms were inconclusive or who have dense breast tissue, or both, must be covered without cost-sharing. The HCA worked on this issue for many months from both an individual advocacy perspective as well as advocating for correcting this problem with insurers and providers and ultimately in the legislative context.

- **H.914** - An act relating to reporting requirements for the second year of the Vermont Medicaid Next Generation ACO Pilot Project. This act requires the Department of Vermont Health Access to provide written updates to the legislative committees of jurisdiction, the Green Mountain Care Board, the Medicaid and Exchange Advisory Committee, and the Office of the Health Care Advocate. The HCA generally supported this bill. We testified about specific areas of concern.

- **S.53** - An act relating to a universal, publicly-financed primary care system. S.53 has passed the Senate and was voted out of the House Health Care Committee. It did not make it out of the House Appropriations committee before the end of the session. The HCA testified in favor of this bill in both the Senate and the House.

- **S.175** - An act relating to the wholesale importation of prescription drugs into Vermont. This act directs the Agency of Human Services, in consultation with interested stakeholders and appropriate federal officials, to design a program for wholesale importation of prescription drugs into Vermont from Canada that complies with federal requirements. The HCA supported this bill and tracked it though the process.

- **S.1** (Special Session) - An act relating to co-payment limits for chiropractic care and physical therapy. This act establishes limits on the amount of the co-payment requirement that certain health benefit plans can impose for chiropractic care and physical therapy services. For plan year 2019 only, the act limits the amount of the co-payment requirement that silver- and bronze-level plans offered through the Vermont Health Benefit Exchange (Exchange), and reflective silver plans offered outside the Exchange, may impose for chiropractic services to the amount of the copayment requirement for primary care services under the plan. Beginning in plan year 2020, the act limits the amount of the co-payment requirement that silver and bronze-level Exchange plans and reflective silver plans may impose for chiropractic care and physical therapy services to between 125 and 150 percent of the co-payment requirement for primary care services under the plan. The HCA did not support this bill.

Collaboration with Other Organizations

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

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Community Catalyst
- Families USA
- IRS Taxpayer Advocate Service
- Ladies First
- MVP Health Care
- OneCare Vermont
- Planned Parenthood of Northern New England
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Care Partners
- Vermont CARES
- Vermont Coalition of Clinics for the Uninsured
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Medical Society
- Vermont Program for Quality in Health Care
- VNAs of Vermont
- Voices for Vermont's Children

Outreach and Education

A. Increasing Reach and Education through the Website

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

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

Popular Web Pages

- The total number of **health pageviews increased by 6%** in the reporting quarter ending June 30, 2018 (11,080 pageviews), compared with the same quarter in 2017 (10,406 pageviews).

- The **top-20 health pages** on our website this quarter with change over last year:
  - *Income Limits – Medicaid* – 2,936 pageviews (7% ↑)
  - *Health* – section home page – 1,422 (24% ↑)
  - *Services Covered by Medicaid* – 457 (84% ↑)
  - *Resource Limits – Medicaid* – 450 (23% ↑)
  - *Dental Services* – 442 (2% ↑)
  - *Vermont Choices for Care* – 379 (38% ↓)
  - *Buying Prescription Drugs* – 296 (317% ↑)
  - *HCA Online Help Request Form* – 229 (12% ↑)
  - *Medicaid* – 205 (125% ↑)
  - *Advance Directive Forms* – 178 (249% ↑)
  - *Federally Qualified Health Centers* – 175 (11% ↑)
  - *Long-term Care* – 171 (20% ↑)
  - *Medical Decisions – Advance Directives* – 159 (29% ↑)
  - *Medicare Savings / Buy-In Programs* – 159 (1% ↑)
  - *Choices for Care Resource Limits* – 148 (33% ↓)
  - *Choices for Care Income Limits* – 142 (28% ↓)
  - *Choices for Care Requirements* (new page)– 123 (100% ↑)
  - *Medicaid and Medicare dual eligible* – 120 (3% ↓)
  - *Health Insurance, Taxes and You* – 120 (48% ↓)
  - *Medicaid Transportation* – 112 (38% ↑)

- Besides the pages listed above, other **spikes in interest** in our pages included:
  - *Health home page* – 1,422 (24% ↑)
  - *Long-Term Care Help* (new page) – 89 (100% ↑)
  - *Green Mountain Care* – 93 (86% ↑)
  - *ACA Assisters* – 59 (211% ↑)
  - *Moving from VHC to Medicare* – 57 (73% ↑)

- And we saw a 56% **decrease** in pageviews of our medical marijuana registry pages.

Popular PDF Downloads

21 out of 70, or 30% **of the unique PDFs downloaded** from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:

- 14 PDFs were created for consumers. The top five consumer-focused PDF downloads were:
  - *Advance Directive, short form* (122 downloads)
  - *Advance Directive, long form* (106 downloads)
  - *Vermont Dental Clinics Chart* (95 downloads)
  - *Vermont Medicaid Coverage Exception Request Form* (25 downloads)
  - *BCBSVT 2016 Annual Report* (19 downloads)
  - The advance directive forms were accessed much more often this year as compared to the same period last year (228 downloads versus 131 last year).
- 5 PDFS were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused download was:
  - *PTC Rule Allocation Summary* (23 downloads)
- 2 PDFs covered topics related to health policy. The top policy-focused download was:
  - *VT ACO Shared Savings Program Quality Measures* (5 downloads)

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

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

New Online Help Tool Adds to Our Reach

Last year we added a new Health section to the online help tool on our website. It is found at *https://vtlawhelp.org/triage/vt_triage* and it can be accessed from most pages of our website. The website visitor answers a few questions to find specific health care information they need. The new feature addresses some of the most popular questions that are posed to the HCA. In addition to our deep collection of health-related web pages, the online help tool adds a new way to access helpful information — at all hours of the day and night. The website user can also call us or fill in our online form to get personal help from an advocate.

Website visitors used this new tool to access health care information **145 times** during this quarter. That's a **10% decrease** over the previous quarter (January – March).

Of the **36** 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.
- Dental Services - I need help with dentures.
- Long-Term Care - I want to go over my long-term care options (nursing homes, in-home care and more).
- Long-Term Care - How do I know if I can get Choices for Care Long-Term Care Medicaid?

B. Other Outreach and Educational Activities

Are You Leaving Money on the table? (April 9, 2018)

Mike Fisher, the Chief Health Care Advocate, appeared on WDEV Radio to educate Vermonters about the opportunities for tax credits and promote the HCA's Tax Time PTC Reminder fact sheet.

Meeting with Health Care Providers (April 9, 2018)

HCA advocates and attorneys met with health care providers to discuss Medicaid coverage rules for transgender patients.

Rural Pride (April 27, 2018)

An HCA advocate did a presentation on rural LGBTQ health concerns to an audience of 30.

Meeting with the Pride Center (June 11, 2018)

HCA advocates met with the Pride Center to explain how cases can be referred to the HCA, and how the HCA can help Vermonters with their health care questions and problems.

Training on the revised Medicaid rules regarding internal appeals, grievances, notices and State fair hearings. (June 19, 2018)

HCA presented a training on the revised Medicaid rules for Vermont Legal Aid attorneys.

COTS Legal Clinic (June 19, 2018)

HCA advocates participated in the Legal Clinic and advised Vermonters on state and federal health care programs.

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:

- Authorization form for spouse of MABD/LTC applicant
- Asset Verification on 202 Med application
- OneCare Patient Fact sheet
- OneCare Notice for Medicare beneficiaries

Office of the Health Care Advocate

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

http://www.vtlegalaid.org/health

CY 2018 Investment Expenditures

Department	STC #	Investment Description	QE 0318	QE 0618	CY 2018 Total
AHSCO	41	Investments (STC-79) - 2-1-1 Grant (41)	113,250	113,250	**226,500**
AHSCO	54	Investments (STC-79) - Designated Agency Underinsured Services (54)	1,664,645	1,664,704	**3,329,349**
AOE	11	Non-state plan Related Education Fund Investments	-	-	**-**
DCF	55	Investments (STC-79) - Medical Services (55)	17,267	15,717	**32,984**
DCF	1	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)	2,208,458	3,442,083	**5,650,541**
DCF	56	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	-	128,702	**128,702**
DCF	57	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	-	-	**-**
DCF	58	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	-	-	**-**
DCF	59	Investments (STC-79) - Essential Person Program (59)	226,081	224,058	**450,139**
DCF	60	Investments (STC-79) - GA Medical Expenses (60)	54,512	72,062	**126,574**
DCF	61	Investments (STC-79) - Therapeutic Child Care (61)	500,417	383,222	**883,639**
DCF	2	Investments (STC-79) - Lund Home (2)	555,306	730,209	**1,285,515**
DCF	33	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)	-	-	**-**
DCF	34	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	25,646	25,646	**51,291**
DCF	9	Investments (STC-79) - Challenges for Change: DCF (9)	64,015	49,463	**113,478**
DCF	26	Investments (STC-79) - Strengthening Families (26)	215,717	218,243	**433,960**
DCF	62	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	54,750	54,750	**109,500**
DCF	35	Investments (STC-79) - Building Bright Futures (35)	117,644	151,378	**269,022**
DDAIL	63	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	95,581	73,530	**169,111**
DDAIL	64	Investments (STC-79) - DS Special Payments for Medical Services (64)	515,509	918,088	**1,433,597**
DDAIL	27	Investments (STC-79) - Flexible Family/Respite Funding (27)	614,914	214,622	**829,536**
DDAIL	42	Investments (STC-79) - Quality Review of Home Health Agencies (42)	-	-	**-**
DDAIL	43	Investments (STC-79) - Support and Services at Home (SASH) (43)	13,291	355,197	**368,488**
DDAIL	77	Investments (STC-79) - HomeSharing (77)	82,404	83,492	**165,896**
DDAIL	78	Investments (STC-79) - Self-Neglect Initiative (78)	140,884	-	**140,884**
DDAIL	65	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)	17,807	16,942	**34,749**
DMH	28	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	28,098	50,950	**79,047**
DMH	66	Investments (STC-79) - MH Outpatient Services for Adults (66)	858,990	495,927	**1,354,917**
DMH	79	Investments (STC-79) - Mental Health Consumer Support Programs (79)	116,533	107,824	**224,357**
DMH	16	Investments (STC-79) - Mental Health CRT Community Support Services (16)	509,282	(2,066,805)	**(1,557,523)**
DMH	12	Investments (STC-79) - Mental Health Children's Community Services (12)	1,147,730	1,109,389	**2,257,120**
DMH	29	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,330,483	1,538,487	**3,868,970**
DMH	67	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	302,856	204,850	**507,705**
DMH	22	Investments (STC-79) - Emergency Support Fund (22)	256,829	166,513	**423,342**
DMH	3	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH	6,250,829	4,926,448	**11,177,277**
DMH	3	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR	954,387	2,814,303	**3,768,690**
DMH	68	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	2,475	59,116	**61,592**
DMH	13	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	122,391	2,093,206	**2,215,597**
DOC	4	Return House	117,001	131,406	**248,407**
DOC	5	Northern Lights	98,438	98,438	**196,876**
DOC	6	Pathways to Housing	227,728	324,156	**551,884**
DOC	14	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	193,405	89,806	**283,211**
DOC	15	Northeast Kingdom Community Action	-	-	**-**
DOC	69	Intensive Substance Abuse Program (ISAP)	-	-	**-**
DOC	70	Intensive Domestic Violence Program	-	-	**-**
DOC	71	Community Rehabilitative Care	638,456	1,459,823	**2,098,279**
DOC	80	Intensive Sexual Abuse Program	2,615	2,825	**5,440**
DVHA	8	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)	467,851	574,092	**1,041,943**
DVHA	51	Investments (STC-79) - Vermont Blueprint for Health (51)	869,072	1,037,825	**1,906,897**
DVHA	52	Investments (STC-79) - Buy-In (52)	9,916	8,308	**18,224**
DVHA	53	Investments (STC-79) - HIV Drug Coverage (53)	668	668	**1,335**
DVHA	18	Investments (STC-79) - Patient Safety Net Services (18)	70,560	46,939	**117,500**
DVHA	7	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	1,695,275	2,134,424	**3,829,699**
DVHA	72	Investments (STC-79) - Family Supports (72)	-	-	**-**
DVHA	81	DSR Investment (STC-83) – One Care VT ACO Quality & Health Management (81)	-	614,250	**614,250**
DVHA	82	DSR Investment (STC-83) – One Care VT ACO Advanced Community Care Coordination (82)	-	1,173,125	**1,173,125**
GMCB	45	Green Mountain Care Board	384,321	762,208	**1,146,529**
UVM	10	Vermont Physician Training	1,011,554	1,011,554	**2,023,108**
VAAFM	36	Agriculture Public Health Initiatives	-	-	**-**
VDH	19	Investments (STC-79) - Emergency Medical Services (19)	178,201	218,001	**396,201**
VDH	74	Investments (STC-79) - TB Medical Services (74)	37,827	35,054	**72,881**

Department	STC #	Investment Description	QE 0318	QE 0618	CY 2018 Total
VDH	40	Investments (STC-79) - Epidemiology (40)	291,293	250,729	**542,022**
VDH	39	Investments (STC-79) - Health Research and Statistics (39)	427,372	415,032	**842,404**
VDH	31	Investments (STC-79) - Health Laboratory (31)	869,855	637,355	**1,507,210**
VDH	50	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	253,040	428,115	**681,154**
VDH	76	Investments (STC-79) - Statewide Tobacco Cessation (76)	-	-	**-**
VDH	75	Investments (STC-79) - Family Planning (75)	352,008	271,546	**623,554**
VDH	25	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	466,555	250,556	**717,111**
VDH	73	Investments (STC-79) - Renal Disease (73)	-	-	**-**
VDH	37	Investments (STC-79) - WIC Coverage (37)	1,091,956	1,060,146	**2,152,102**
VDH	21	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	375,000	18,800	**393,800**
VDH	47	Investments (STC-79) - Patient Safety - Adverse Events (47)	12,000	12,657	**24,657**
VDH	30	Investments (STC-79) - Substance Use Disorder Treatment (30)	2,433,133	1,834,748	**4,267,881**
VDH	17	Investments (STC-79) - Recovery Centers (17)	371,652	371,652	**743,304**
VDH	46	Investments (STC-79) - Enhanced Immunization (46)	30,984	24,573	**55,557**
VDH	48	Investments (STC-79) - Poison Control (48)	84,756	-	**84,756**
VDH	23	Investments (STC-79) - Public Inebriate Services, C for C (23)	297,954	223,858	**521,812**
VDH	38	Investments (STC-79) - Fluoride Treatment (38)	13,573	13,417	**26,990**
VDH	24	Investments (STC-79) - Medicaid Vaccines (24)	-	-	**-**
VDH	49	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	51,032	82,519	**133,550**
VDH	44	Investments (STC-79) - VT Blueprint for Health (44)	535,790	349,253	**885,043**
VSC	32	Health Professional Training	204,730	-	**204,730**
VVH	20	Vermont Veterans Home	-	-	**-**
			34,344,549	**36,403,421**	**70,747,970**

Prevent Child Abuse - Nurturing Parent

What We Do

Prevent Child Abuse Vermont (PCAVT) delivers approximately 50 Nurturing Parenting Programs which use an evidenced-based curricula to help families improve their parenting skills. A number of different curricula are used including a Nurturing Father's Program, Nurturing Program for Families in Recovery from Substance Use, Nurturing Parent Program for Teenage Parents, and other specializations such as the age of children, children with special learning needs, foster and adoptive parents and incarcerated parents. The groups run anywhere from 9 weeks up to 18 weeks. PCAVT also offers 13 Circle of Parents Support Groups throughout the state that provide on-going support and information to parents. Both of these programs are offered in community-based settings and in correctional facilities. Both programs provide free childcare and/or playgroups for children.

Performance Measures	Time Period	Actual Value	Target Value	Current Trend	Baseline % Change
PM FSD Number of parenting groups completed	2018	57	–	↗ 1	2% ↑
PM FSD Percent of participants completing program	2018	70	–	→ 1	-3% ↓
PM FSD Percent change in AAPI pre- and post-test score results for participants completing program	2018	15%	–	↘ 1	-12% ↓

Prevent Child Abuse - Nurturing Parent Program

The Nurturing Parent Program is one of DCF's MCO Investments

O InvestmentGoal Provide public health approaches and other innovative programs to improve health outcomes, health status and quality of life for uninsured, under-insured, and Medicaid-eligible individuals in Vermont

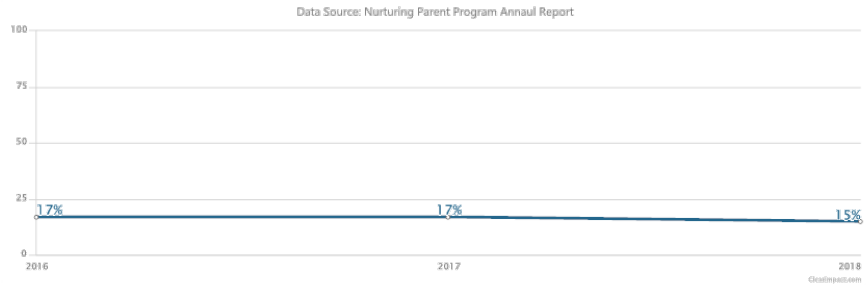
	Time Period	Actual Value	Current Trend	Baseline % Change

P FSD Prevent Child Abuse - Nurturing Parent

	Time Period	Actual Value	Current Trend	Baseline % Change

PM FSD Percent change in AAPI pre- and post-test score results for participants completing program

Time Period	Actual Value	Current Trend	Baseline % Change
2018	15%	↘ 1	-12% ↓
2017	17%	→ 1	0% →
2016	17%	→ 0	0% →



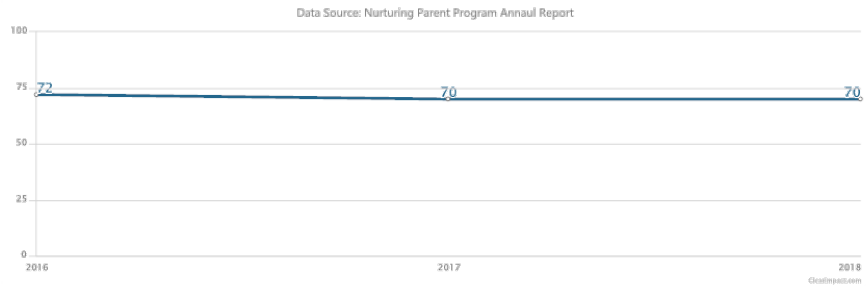
Story Behind the Curve

Participants completing the Nurturing Parenting program are evaluated through the Adult Adolescent Parenting Inventory-2 (AAPI-2) which measures their likelihood for child abuse and neglect in five constructs that are commonly found in abusive parenting. The constructs are: inappropriate expectations of children, lack of empathy, belief in corporal punishment, parent-child role reversal and oppressing children's power and independence. Low scores indicate high risk for abusive parenting and high scores indicate positive, nurturing attitudes and a low risk of abuse. The % change in participants' scores from the pre-test to the post-test are tracked. An increase of of 5% or more is considered by social science research standards to be statistically significant.

In state fiscal year 2018, the average post-test score increased by 15% over the average pre-test score. This is slightly lower from previous years.

PM FSD Percent of participants completing program

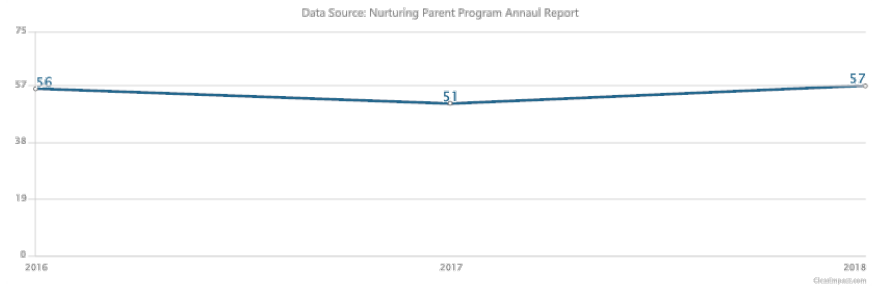
Time Period	Actual Value	Current Trend	Baseline % Change
2018	70	→ 1	-3% ↓
2017	70	↘ 1	-3% ↓
2016	72	→ 0	0% →



Story Behind the Curve

In state fiscal year 2018, 348 participants started the Nurturing Parenting program and 244 completed the program for a 70% completion rate. After each session, Group Faciliators collect evaluation forms from participants that provide a wealth of data and help staff get a sense of how the groups are going allowing for adjustments that may be indicated. Participants have had many positive comments about the program, the group leaders and fellow participants who they also learn from. They especially like spending time in discussion exploring and practicing parenting techniques with other group members. They find this extremely valuable. We believe both the curriculi and this evaluation process has led to a high completion rate of 70% though we continually strive to improve that percentage.

PM FSD Number of parenting groups completed



2018	57	↗ 1	2% ↑
2017	51	↘ 1	-9% ↓
2016	56	→ 0	0% →

Story Behind the Curve

In state fiscal year 2018, 41 Nurturing Parenting programs were completed serving 348 adults and 725 children. An additional 16 Circle of Parents Support groups were completed serving 389 parents and care givers and 568 children, for a total of 57 parenting groups. Nine of these programs were Nuturing Programs for families dealing with substance use recovery.

P
DVHA ACO

Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO)

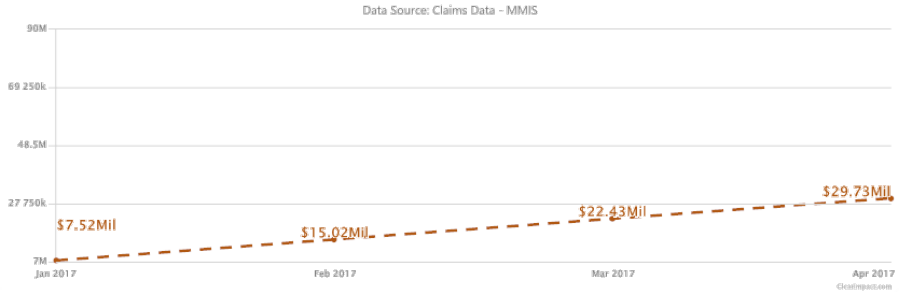
What We Do

The Vermont Medicaid Next Generation (VMNG) ACO program is a pilot program for a risk-bearing ACO to receive a prospective payment and to 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 (MEG). Performance monitoring on the ACO's defined measure set occurs at least annually.

Performance Measures

Time Period | Actual Value

PM DVHA Expected & Actual Total Cost of Care for Medicaid enrollees aligned with an ACO



Notes on Methodology

The Accountable Care Organization's (ACO's) expected total cost of care (ETCOC) is derived based on actuarial projections of the cost of care in 2017 for the population of prospectively attributed Medicaid members, using 2015 claims for the attributed members as a baseline and trending it forward to 2017.

The ACO's actual total cost of care (ATCOC) 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.

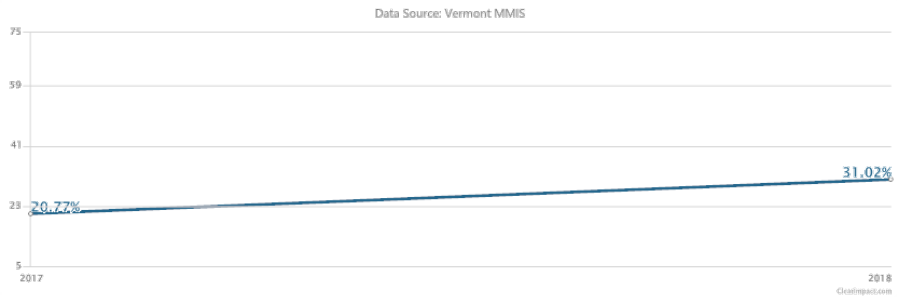
- Please note that dollar amounts shown above are cumulative for the 2017 performance year
- The red line shows the cumulative ETCOC [please note that data is currently undergoing internal evaluation and may be adjusted during the financial reconciliation and validation process for the 2017 performance year]
- The blue line shows the cumulative ATCOC [please note that 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.]

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.

PM DVHA Percent of Medicaid enrollees aligned with ACO

2018	31.02%
2017	20.77%



Notes on Methodology

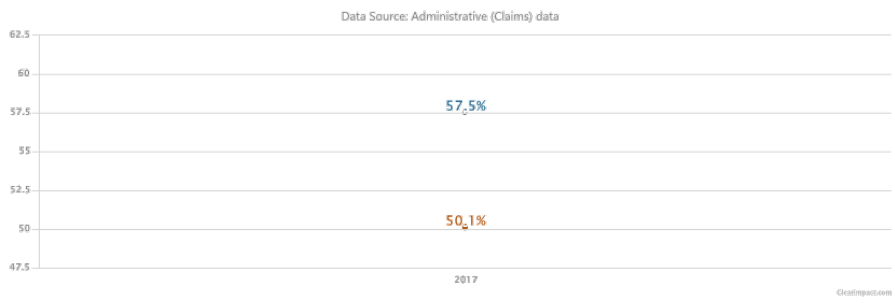
Attribution is prospective and set at the beginning of a performance year. Attribution is based on a member's relationship with a primary care provider in the ACO's network, qualifying utilization in a baseline period, Medicaid eligibility at the beginning of the performance year, and a lack of other 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).

Story Behind the Curve

This measure demonstrates the percentage of the 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).

As seen here, Medicaid attribution to the ACO increased significantly between 2017 and 2018 as the ACO expanded its provider network in Vermont from 4 hospital service areas to 10. Attribution is projected to grow year-over-year as the ACO continues to grow its provider network in the state.

PM DVHA Adolescent Well Care Visits (HEDIS® AWC) **2017** **57.5%**



Notes on Methodology

The red target data point above represents the CY 2016 50th percentile for National Medicaid All Lines of Business (ALOB). The blue data point represents the ACO's actual performance for CY 2017.

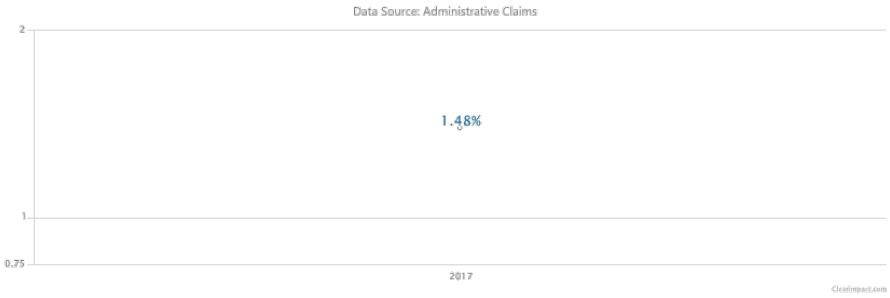
Story Behind the Curve

This measure looks at the use of regular check-ups by adolescents. 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.

Action Plan

This measure is also part of a performance improvement project at the ACO level focusing on increasing utilization of adolescent well care visits among ACO attributed members.

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



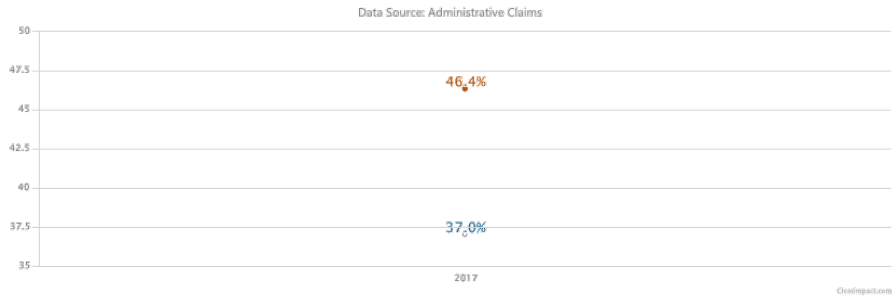
Notes on Methodology

The blue data point above represents the ACO's actual performance for CY 2017. No corresponding benchmarks were available for this measure for CY 2017.

Story Behind the Curve

Rate of risk-standardized acute, unplanned hospital admissions among Medicaid members with multiple chronic conditions (MCCs) who are assigned to the Accountable Care Organization (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.

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



Notes on Methodology

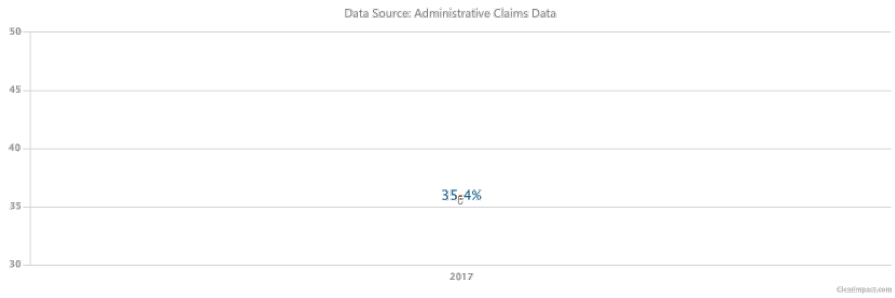
The red target data point above represents the CY 2016 50th percentile for National Medicaid All Lines of Business (ALOB). The blue data point represents the ACO's actual performance for CY 2017.

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**, or within 30 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 therapy 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.

PM DVHA Initiation of Alcohol & Other Drug Abuse or Dependence Treatment (HEDIS® IET-Total) **2017** **35.4%**



Notes on Methodology

The red target data point above represents the CY 2016 50th percentile for National Medicaid All Lines of Business (ALOB). The blue data point represents the ACO's actual performance for CY 2017.

Story Behind the Curve

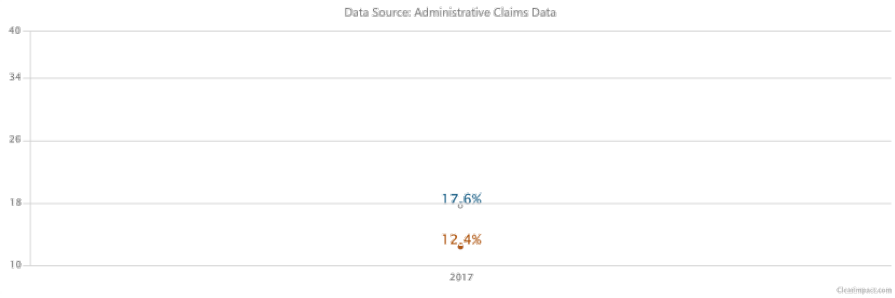
This measure assesses the degree to which the ACO initiates (starts) treatment for members identified with a need for alcohol and other drug dependence (AOD) services.

1. **Initiation – the % of Medicaid beneficiaries 13 years of age & older diagnosed with AOD dependence who start treatment through an inpatient AOD admission or an outpatient service for AOD abuse or dependence within 14 days.**

Action Plan

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

PM DVHA Engagement of Alcohol & Other Drug Abuse or Dependence Treatment (HEDIS® IET-TOTAL) **2017** **17.6%**



Notes on Methodology

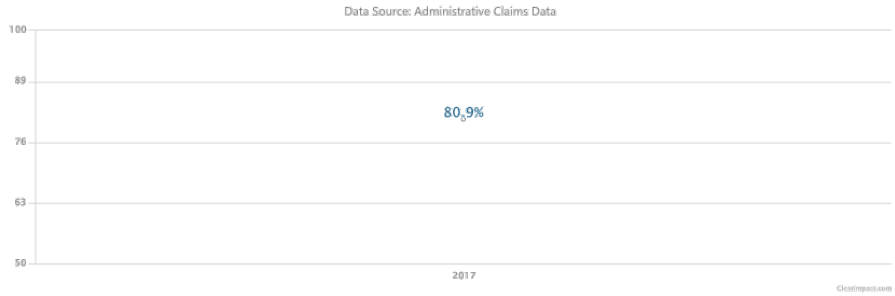
The red target data point above represents the CY 2016 50th percentile for National Medicaid All Lines of Business (ALOB). The blue data point represents the ACO's actual performance for CY 2017.

Story Behind the Curve

This measure assesses the degree to which the ACO engages (continues) members identified with a need for alcohol and other drug dependence (AOD) services in treatment.

- **Engagement – the % of Medicaid beneficiaries diagnosed with AOD dependence who initiate treatment within 14 days of diagnosis and then received <u>two (2) additional AOD services within 34 days</u> after the start of AOD treatment.**

PM DVHA Follow Up After ED Visit for Mental Illness - within 30 days (HEDIS® FUM) **2017** **80.9%**



Notes on Methodology

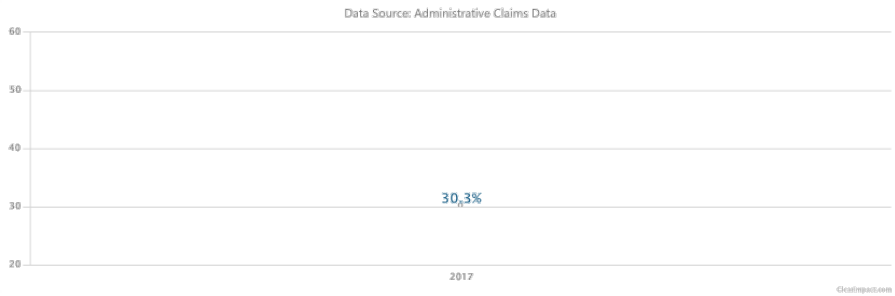
The blue data point above represents the ACO's actual performance for CY 2017. No corresponding benchmarks were available for this measure for CY 2017.

Story Behind the Curve

FUM:

This measure looks at the percentage of emergency department (ED) visits for ACO-attributed members 18 years of age and older with a principal diagnosis of mental illness, who had a follow up visit for mental illness. The 30 day follow-up visit rate is reported here.

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



Notes on Methodology

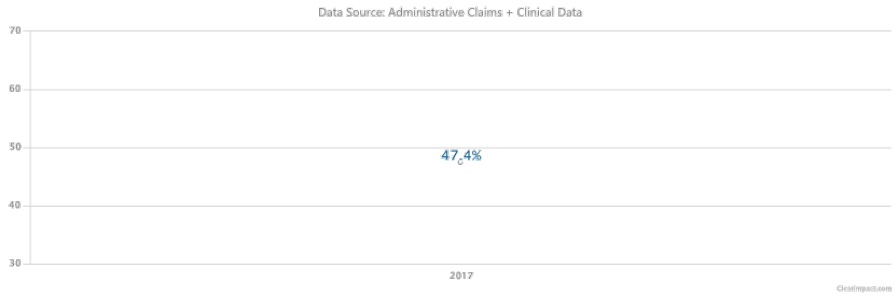
The blue data point above represents the ACO's actual performance for CY 2017. No corresponding benchmarks were available for this measure for CY 2017.

Story Behind the Curve

FUA:

This measure looks at the percentage of emergency department (ED) visits for Vermont Medicaid members attributed to the ACO 18 years of age and older with a principal diagnosis of alcohol or other drug dependence, who had a follow up visit for alcohol or other substance abuse or dependence treatment. The 30 day follow-up visit rate is reported here.

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



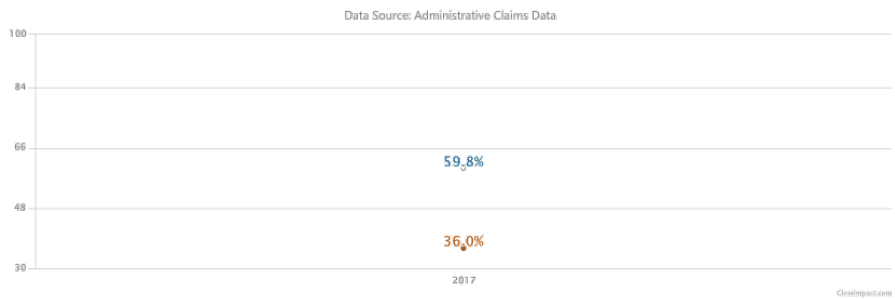
Notes on Methodology

The blue data point above represents the ACO's actual performance for CY 2017. No corresponding benchmarks were available for this measure for CY 2017.

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.

PM DVHA Developmental Screening in the First 3 Years of Life (NQF #1448) **2017** **59.8%**



Notes on Methodology

The red target data point above represents the CY 2016 50th percentile for National Medicaid All Lines of Business (ALOB). The blue data point represents the ACO's actual performance for CY 2017.

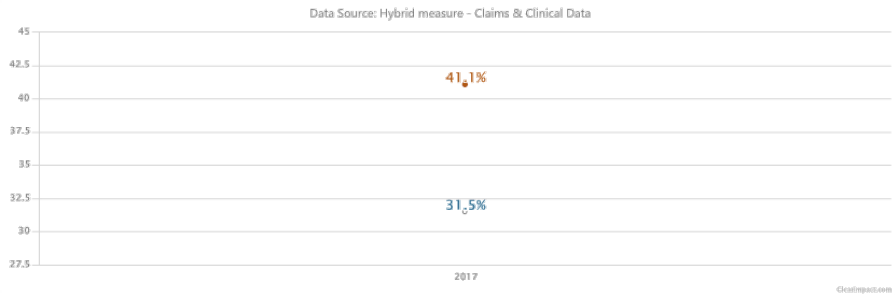
Story Behind the Curve

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.

Action Plan

This measure is part of a Performance Improvement Project at the ACO level focusing on improving the rates of developmental screening in attributed children in the target age range of the measure.

PM DVHA Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%) (NQF #0059) **2017** **31.5%**



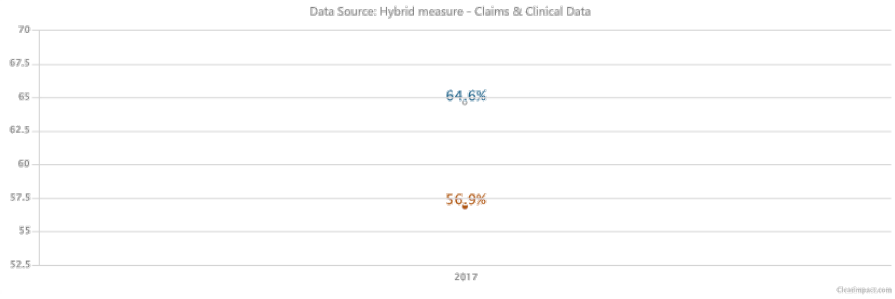
Notes on Methodology

The red target data point above represents the CY 2016 50th percentile for National Medicaid All Lines of Business (ALOB). The blue data point represents the ACO's actual performance for CY 2017.

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) 2017 64.6%



Notes on Methodology

The red target data point above represents the CY 2016 50th percentile for National Medicaid All Lines of Business (ALOB). The blue data point represents the ACO's actual performance for CY 2017.

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. Control is demonstrated by the following criteria:

- Medicaid members 18-59 years of age whose blood pressure was <140/90 mm Hg.
- Medicaid members 60-85 years of age with a diagnosis of diabetes whose blood pressure was <140/90 mm Hg.
- Medicaid members 60-85 years of age without a diagnosis of diabetes whose blood pressure was <150/90 mm Hg.

The specifications of this measure are consistent with current clinical guidelines, such as those of the USPSTF and the Joint National Committee. Treatment to improve hypertension includes dietary and lifestyle changes, as well as appropriate use of medications.

Action Plan

This measure is part of a Performance Improvement Project at the ACO level focusing on improving blood pressure control among attributed lives.
