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Date: March 1, 2019

Re: Public comments received for GCR 18-124: Vermont Medicaid Next Generation ACO Program

Comment:
A letter with comments from the Vermont Legal Aid Office of the Health Care Advocate can be found below.

Response:
The Department of Vermont Health Access (DVHA) appreciates the Health Care Advocate's comments on GCR 18-124. DVHA agrees with the Advocate's statement that quality and access must be prioritized in Vermont's ACO programs and other health reform efforts, and also agrees that transparency, accountability, and consumer protection mechanisms need to be sufficient to ensure to the success of these programs. DVHA will continue to work with the Health Care Advocate to address these concerns as the program evolves.

DVHA acknowledges the comment suggesting that the proposed policy "singles out services for transgender individuals for different prior authorization requirements" and "is discriminatory by holding gender-affirming surgeries to a different standard than other medically necessary care, including the very same surgeries for non-transgender patients." No changes are being made as a result of this comment. The policy is not discriminatory. Gender-affirming surgeries need to be part of a comprehensive treatment plan. DVHA is responsible for ensuring that the specific clinical guidelines provided by DVHA are adhered to. Maintaining prior authorization guarantees that all Medicaid recipients diagnosed with Gender Dysphoria, within or outside of the Next Generation ACO, receive medically necessary care subject to those same clinical guidelines – thereby also ensuring comparability. Prior authorization also guarantees consent requirements for minors, provided in Vermont law and the draft proposed rule, are followed. This decision is in parity with the Department's approach to other services or durable medical equipment requests where improper coverage is more likely because of the technical nature of the clinical coverage policy and may result in irreversible harm to individual patients, irrespective of the underlying diagnosis.

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January 28, 2019

To: Medicaid Policy Unit

Re: GCR Proposed Policy 18-124: Vermont Medicaid Next Generation ACO Program

Thank you for the opportunity to comment on GCR Proposed Policy 18-124: Vermont Medicaid Next Generation ACO Program. The Office of the Health Care Advocate (HCA) has serious concerns about discrimination against transgender individuals codified in this proposed policy change. The remainder of our comments echo many of the concerns stated in our previous comments on this program and on OneCare Vermont's budget proposals, focusing on the following areas: attribution, measurement and accountability, grievance and appeals, and case management.

Throughout the development of Vermont's ACO programs, the HCA has maintained that payment reform may benefit Vermonters if quality and access are prioritized, and if there is sufficient transparency, accountability, and consumer protection to ensure that patients are not harmed and that any quality or access issues are identified and addressed in a timely manner. As Vermont substantially expands its Medicaid ACO program, we are concerned that the transparency, accountability, and consumer protection practices in place remain insufficient to keep Vermonters informed and protected, to counterbalance some of the potentially harmful incentives inherent in acceptance of financial risk by providers, and to ensure success of the model. We once again ask DVHA to require additional consumer protections in the Medicaid ACO model and to ensure that OneCare Vermont is held to a high level of accountability to Vermont Medicaid beneficiaries and to the state.

Prior Authorization

We object to the way the contract, as written, singles out services for transgender individuals for different prior authorization requirements than the vast majority of other covered services. Under the contract, most procedures no longer require a prior authorization. The contract, however, lists 67 surgical procedures where prior authorization is neither waived nor required for all VMNG Attributed Patients. For these 67 surgical procedures, whether a prior authorization is required depends on whether the code is billed in conjunction with a diagnosis code indicating that the patient is transgender.[1]

Although Section 8.8 (Member Care & Safety) of the contract states that this is "a subset of services that [DVHA] has identified as having the potential to cause imminent harm if prescribed, fitted, or used incorrectly", many complex and potentially risky medically necessary surgical procedures

[1]Provided by DVHA: 302.5 Trans-sexualism; 302.51 Trans-sexualism with asexual history; 302.52 Trans-sexualism with homosexual history; 302.53 Trans-sexualism with heterosexual history; 302.6 Gender identity disorder in children; 302.85 Gender identity disorder in adolescents or adults; F64.0 Transsexualism; F64.1 Gender identity disorder in adolescence and adulthood; F64.2 Gender identity disorder of childhood; F64.8 Other gender identity disorders; F64.9 Gender identity disorder, unspecified; Z87.890 Personal history of sex reassignment

included in these Covered Procedures, such as gastric bypass, brain surgeries, and heart transplant, do not require a prior authorization. The 67 surgical procedures solely comprise surgeries that are necessary as part of medical transition for transgender Vermonters. Furthermore, the same codes do not require prior authorization when provided to patients who are not transgender. Research does not support the claim that medical transition surgeries for transgender patients should be singled out for additional clinical review on the basis of safety.

Transgender Medicaid patients have a right to equal access to medically necessary care. The proposed policy, which requires prior authorization for gender-affirming surgeries but does not require prior authorization for equivalent surgeries, is discriminatory and violates the law. Vermont's Public Accommodations Act prohibits policies that withhold from individuals the benefits of government services based on the individual's gender identity. 9 V.S.A. Sec 4502. In addition, Vermont Department of Financial Regulation Insurance Bulletin No. 174 interprets Act 41 to prohibit discrimination on the basis of gender identity. This contract is discriminatory by holding gender-affirming surgeries to a different standard than other medically-necessary care, including the very same surgeries for non-transgender patients.

We ask DVHA to waive the prior authorization requirement for these procedures, and to stop singling out transgender patients for additional scrutiny.

Attribution

We continue to have concerns about the exclusion of vulnerable and potentially high-cost populations, including individuals dually eligible for Medicaid and Medicare ("duals") and newborns, from Vermont's Medicaid ACO program. Focus on patients who make frequent contact with the health care system and can benefit greatly from intervention is essential to improving system-wide health and cost outcomes. Investment in and focus on high-cost and high-need populations requires collaboration with and investment in community-based services and interventions to address social determinants of health. Such investments have the potential to greatly affect long-term health outcomes, quality of life, and cost. We ask DVHA to seriously consider including these populations to ensure that OneCare is sufficiently investing in community-based services and interventions and to strongly encourage OneCare to invest in programs aimed at improving care, reducing costs, and addressing social determinants of health for vulnerable and potentially high-cost populations including duals and newborns.

Measurement and Accountability

The HCA continues to advocate for a robust set of quality measures, and for all quality measures to be tied to payment in a meaningful way. If the overall goal of the program is to improve quality of care and contain the growth of healthcare costs, the only way to measure the success of the program is to comprehensively measure quality. A comprehensive measure set would cover diverse populations including adult, maternity, and pediatric; healthy and chronically ill; and physically and developmentally disabled. A comprehensive measure set would also cover a wide range of process, outcome, and experience measures to ensure that patients' health status and experience of care are not adversely affected by changes in provider payment methodologies. It is vitally important that we measure quality in the context of new payment methodologies with potential incentives to provide less care to Vermonters. We again strongly encourage DVHA to require additional quality measurement in 2019 to ensure that the quality measures cover the attributed population in a logical and systematic way.

We are disappointed that the Patient Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers & Systems (CAHPS) measure remains a reporting measure for 2019. We would like to see this measure, and all the remaining reporting measures, tied to payment. Additionally, we continue to advocate for implementation of a pilot of a point-of-care measure such as CollaboRATE™ to further assess patients' experiences of care under this model. As OneCare assumes financial risk for a larger population of Medicaid beneficiaries, it is increasingly essential for DVHA and policy makers to learn about the ways in which patients are experiencing the model. A point-of-care measure would give DVHA, OneCare, and health care providers insight into how patients are experiencing their interactions with providers participating in the model. We encourage DVHA to solicit feedback from attributed beneficiaries in other ways as well, such as via focus groups, member meetings, and/or other consumer engagement activities.

Grievance and Appeals

We maintain our position that patients must have, and be aware of, an avenue to report and appeal under-treatment, provider denials of service, and any other ACO issues they may encounter. Under a model in which provider organizations bear financial risk, providers have a financial incentive to provide fewer services. In some circumstances, providers may deny medically necessary services to patients in order to meet the financial goals of the model. We continue to believe that patients must have clear processes for filing appeals and grievances related to provider denials of service. We continue to advocate for robust grievance and appeals processes for beneficiaries attributed to the Medicaid ACO program. Such processes must consider the risk-bearing model and resulting changes to the kinds of grievances and appeals that are likely to occur. Whereas in a fee-for-service system the provider generally advocates on behalf of the beneficiary in the case of an appeal, in a risk model the provider and patient may no longer be on the same side.

Patients must also be informed about any appeal and grievance avenues to which they have access. Currently, to our knowledge patients are not informed that they can file grievances and appeals with the ACO. Grievances that are filed elsewhere (e.g., hospital patient complaint departments) by ACO-attributed patients are not reported as ACO complaints. We are concerned about how OneCare is categorizing calls it receives from consumers and whether or not complaints are being accurately counted.

We continue to advocate for grievances and appeals to be filed with, or reported in detail to, an independent entity. It is essential that reported issues be tracked and analyzed in a timely manner so that any patterns of under treatment or barriers to access that may emerge or worsen can be identified and addressed as quickly as possible. DVHA and OneCare must have a systematic way of handling grievances from both patients and providers, resolving disagreements between patients and providers, resolving disagreements between providers and OneCare, and documenting all of the above. Since it is impossible in many instances to determine which issues are caused directly or indirectly by the ACO, any complaint by an attributed member must be handled and documented as an ACO grievance.

Case Management

We understand that OneCare is now responsible for meeting the case management needs of its attributed Medicaid members, and that these members are no longer eligible to receive Vermont Chronic Care Initiative case management services through DVHA. We are concerned about gaps in

services for these patients, particularly for patients who find themselves without a primary care provider and without a community health team relationship. We ask DVHA to ensure that these patients receive needed case management services either through VCCI or another avenue.

Thank you for considering our comments. If you have any questions, please contact Julia Shaw.

Sincerely,

s\ Julia Shaw
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s\ Barbara Prine
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