Medicaid and Exchange Advisory Committee

January 27th, 2020

1.	10:00	**Call to order** • **Roll Call** • **Establish quorum**	Zack Goss, Health Care Training and Communication Manager (DVHA)
2.	10:05	**Chairperson selection**	Zack Goss, Health Care Training and Communication Manager (DVHA)
3.	10:10	**Approve Previous Minutes**	Co-Chairs
4.	10:15	**FY '21 DVHA Budget**	Cory Gustafson, Commissioner (DVHA) Lisa Schilling, Financial Director (DVHA)
5.	10:35	**Vermont Medicaid Next Generation**	Alicia Cooper, Director of Payment Reform, Reimbursement, and Rate Setting (DVHA)
6.	11:00	**Hi-Tech**	Jenney Samuelson, Deputy Commissioner (DVHA)
7.	11:15	**Premium Processing Project Planning**	Dan Fay, HAEEU Deputy Director (DVHA) Addie Strumolo, Deputy Commissioner (DVHA)
8.	11:40	**HBEE Rule Update**	Addie Strumolo, Deputy Commissioner (DVHA)
9.	11:50	**Commissioner's Update—New DVHA website**	Cory Gustafson, Commissioner (DVHA) Deidra Jarvis, Provider Relations Specialist (DVHA) Suellen Bottiggi, Provider and Member Service Director (DVHA)
10.	11:55	**Public comment**	
11.	12:00	**Adjourn**	Co-Chairs

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Upcoming MEAB draft Agendas

February	March	April
• St. Johnsbury Attribution Study • Integrated Enrollment and Eligibility and MMIS • 2020 Open Enrollment • Commissioner's update	• DAIL Budget • Medicaid Reimbursement • EPSDT • Commissioner's update	• DCF Budget • Legislative report • DVHA priorities • Commissioner's update

Chairperson Selection

Zack Goss, Healthcare Training and Communication Manager, DVHA

Summary

- Two thirds of the voting members have submitted votes
- One member has withdrawn their nomination
- Vote results are very close

Option 1

Members who have not yet voted to cast votes within the next 48 hours and determine outcome

Option 2

Conduct a new vote for all members with updated nominee list (to be completed ASAP)

Fiscal Year 2021 Department of Vermont Health Access Budget

Cory Gustafson, Commissioner, DVHA
Lisa Schilling, Financial Director, DVHA

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Vermont Medicaid Next Generation ACO Program: 2018 Performance

Alicia Cooper, Director of Payment Reform, Reimbursement and Rate Setting, DVHA

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The VMNG program is reinforced by DVHA's priorities

01	02	03
Value-Based Payments	Information Technology Projects	Performance

- Medicaid as predictable and reliable payer partner
- A focus on continual, incremental programmatic and performance improvements
- Opportunities to align with other payer programs; opportunities to be an innovative leader

VMNG ACO Contract Term

- The original contract was a one-year agreement (2017) with four optional one-year extensions.
- DVHA and OneCare triggered one-year extensions for each 2018, 2019, and 2020. The parties will have the option of one additional one-year extension thereafter.
- Rates are renegotiated annually and reconciliation may occur more frequently.

2018 VMNG Program Performance

2018 Results Report ▶

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Result 1: DVHA and OneCare made incremental program improvements

- DVHA and OneCare continued program operations and identified opportunities for incremental improvement.
  - Expansion of prior authorization waiver to all providers in the Vermont Medicaid network.
  - Further decreasing administrative burden for providers; relying on their clinical expertise when caring for patients.

Result 2: The program continues to grow

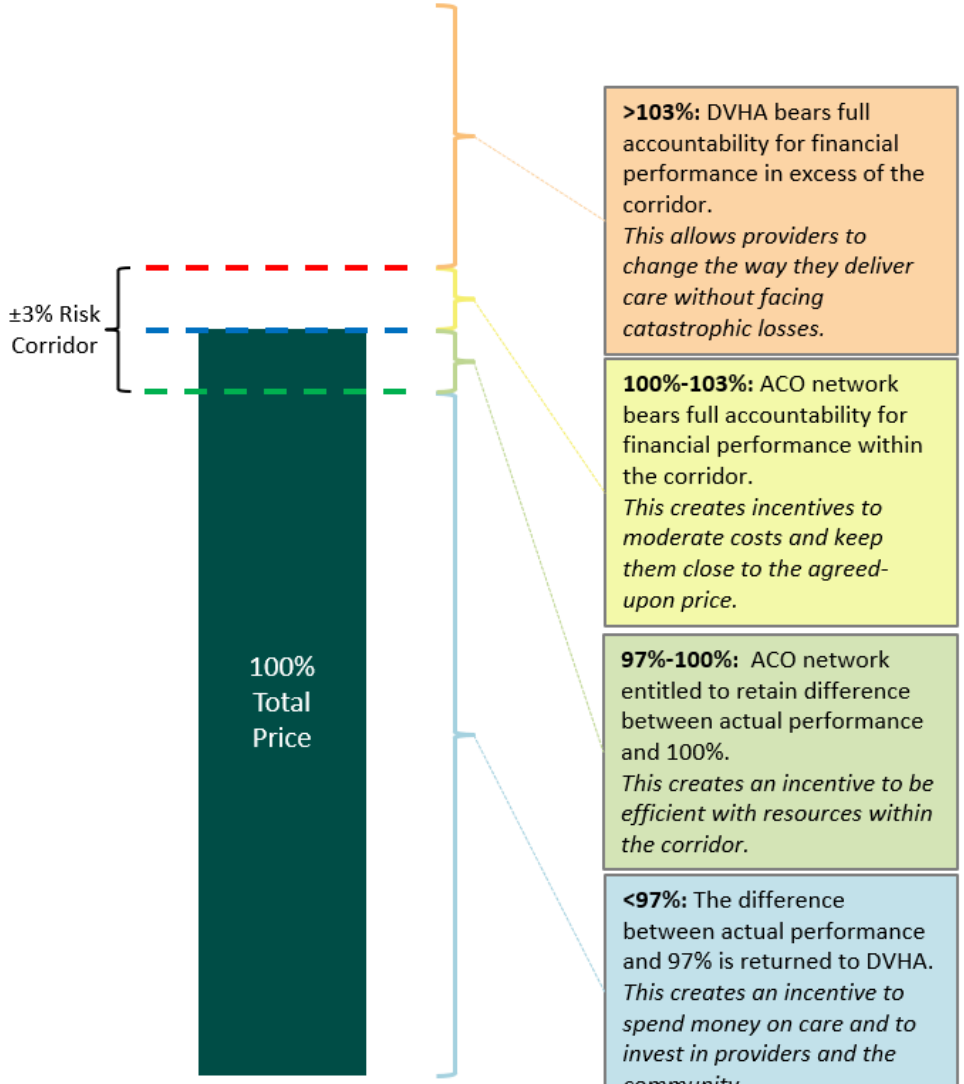
- Additional providers and communities have joined the ACO network to participate in the program for the 2019 and 2020 performance years.
- In 2020, DVHA and OneCare are testing a new attribution methodology, which further increases the number of Vermonters connected to the All-Payer ACO Model.

	2017 Performance Year	2018 Performance Year	2019 Performance Year	2020 Performance Year
Health Service Areas	4	10	13	14
Provider Entities	Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs			
Unique Medicaid Providers	~2,000	~3,400	~4,300	~5,000
Attributed Medicaid Members	~29,000	~42,000	~79,000	~114,000 *(~86,000 + ~28,000)*

Result 3: ACO providers and Medicaid shared financial accountability for health care in 2018

- DVHA and the ACO agreed on the price of health care upfront, and the ACO provided approximately $1.5 million in care above the expected price. Financial performance was within the ±3% risk corridor, which means that OneCare Vermont and its members paid this amount to DVHA.

DVHA and OneCare set an agreed-upon price for each VMNG contract year



>103%: DVHA bears full accountability for financial performance in excess of the corridor.
This allows providers to change the way they deliver care without facing catastrophic losses.

100%-103%: ACO network bears full accountability for financial performance within the corridor.
This creates incentives to moderate costs and keep them close to the agreed-upon price.

97%-100%: ACO network entitled to retain difference between actual performance and 100%.
This creates an incentive to be efficient with resources within the corridor.

<97%: The difference between actual performance and 97% is returned to DVHA.
This creates an incentive to spend money on care and to invest in providers and the community.

Vermont Medicaid Next Generation ACO Program: 2017 & 2018 Financial Performance

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Result 4: The ACO met most of its quality targets

- The ACO's quality score was 85% on 10 pre-selected measures.
- OneCare's performance exceeded the national 75th percentile on measures relating to developmental screening in the first three years of life and 30-day follow-up after discharge from Emergency Departments for mental health, alcohol, and other drug abuse or dependence.
- Examining quality results over time will be important in order to understand the effect of changing provider payment on quality of care.

Overview of VMNG Quality Performance, 2018

Measure Description	NQF #	Numerator	Denominator	Rate	Quality Compass 2018 Benchmarks (CY 2017) National Medicaid Percentiles				Points awarded
					25th	50th	75th	90th	
30 Day Follow-Up after Discharge from the ED for Alcohol and Other Drug Dependence	2605	72	247	29.15%	10.07	16.26	24.48	32.15	2
30 Day Follow-Up after Discharge from the ED for Mental Health	2605	282	345	81.74%	45.58	52.79	66.25	74.47	2
Adolescent Well Care Visits	N/A	4903	8693	56.40%	45.74	54.57	61.99	66.80	1.5
All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions*	CMS ACO #38	11	1078	1.02%	N/A	N/A	N/A	N/A	2
Developmental Screening in the First 3 Years of Life‡	1448	1861	3140	59.27%	17.80	39.80	53.90	N/A	2
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)*	0059	122	366	33.33%	46.96	38.20	33.09	29.68	1.5
Hypertension: Controlling High Blood Pressure	0018	223	349	63.90%	49.27	58.68	65.75	71.04	1.5
Initiation of Alcohol and Other Drug Dependence Treatment	0004	494	1271	38.87%	38.62	42.22	46.40	50.20	1
Engagement of Alcohol and Other Drug Dependence Treatment	0004	206	1271	16.21%	9.11	13.69	17.74	21.40	1.5
Screening for Clinical Depression and Follow-Up Plan	418	142	327	43.43%	N/A	N/A	N/A	N/A	2
								Total Points Earned	**17**

** denotes measures for which a lower rate indicates higher performance*
‡ denotes measure with multi-state benchmarks: 26 states reporting (FFY 2016)

Key: Performance Compared to National Benchmarks
Equal to and below 25th percentile (0 points)
Above 25th percentile (1 point)
Above 50th percentile (1.5 points)
Above 75th percentile (2 points)
Above 90th percentile (2 points)

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Result 5: The ACO expanded implementation of the Advanced Community Care Coordination (A3C) model to all participating communities

- OneCare distributed approximately $2.7 million in A3C payments to 65 community partner organizations (including primary care practices, Designated Mental Health Agencies, Area Agencies on Aging, and Visiting Nurse Associations).
- Key performance indicators showed incremental increases in care team activity in OneCare's care coordination software, Care Navigator.
- OneCare trained nearly 700 community care team members in care coordination skills and core competencies, including the use of Care Navigator.
- Care Coordination Core Teams were active in all ten participating communities, tasked with expanding upon best practices, sharing learnings, and implementing team-based care quality improvement projects using Care Navigator.

Hi-Tech

Jenney Samuelson, Deputy Commissioner, DVHA

Premium Processing Project Planning

Dan Fay, Health Access Enrollment and Eligibility Deputy Director, DVHA

Addie Strumolo, Deputy Commissioner, DVHA

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Introduction to Premium Processing

The goal of the Premium Processing project is to streamline the financial transactions and processes associated with the administration of health coverage and financial benefit programs as a part of the overall IE&E roadmap. The State will first transition responsibility for Qualified Health Plan premium processing to insurance carriers for coverage starting 1/1/2021. The resulting product will ensure that:

- Customers will understand what they need to pay, by when, and how it will impact their coverage
- Customers will know who to call when there is a problem
- Staff will understand the premium payment process and their role in it
- Improved data quality and a simplified user interface will ensure that staff can understand and trust the information they are seeing and communicate next steps to the customer
- Vermont will be in compliance with State rules and legislative direction regarding premium processing
- It will reduce the operating expenses associated with its health insurance exchange

Reason for presenting to the MEAC

- Overview of premium processing changes to internal and external stakeholders
- Impacts to Vermonters
- Awareness of project timeline

Customer Experience Survey Results

The study was conducted through phone and online administration with a total of 792 responses received.

High Satisfaction Areas:

- Nearly 70% of respondents said it was somewhat or very easy to make their payments.
- Over 70% of respondents somewhat or strongly agree that their invoices are accurate.
- Nearly 70% of respondents somewhat or strongly agree that their invoices are easy to understand.
- Over 65% of respondents felt very or somewhat respected by the VHC customer service representative.

Low Satisfaction Areas:

- Nearly 30% of respondents described themselves as very or somewhat dissatisfied with Vermont Health Connect's overall customer service.
- Over 30% of respondents felt VHC was very or somewhat ineffective in resolving their billing issue.
- Over 30% of respondents made four calls or more to resolve their billing issue.

Premium Processing : policy update

Guiding principles for regulatory approach to transition:

- Remove State from the middle of the QHP billing transactions
- Ease administrative burden on Customers, Issuers, and State
- Allow for transitional flexibility to improve customer experience

Premium Processing : policy update cont'd

Milestones:

- Confirmation of federal (CMS) regulatory involvement
- Research of other state exchange billing practices
- Eligibility and enrollment rule revisions
- Legislative codification of change (33 VSA 1805)
- Customer complaint process mapping
- Issuer contract planning

Health Benefits Eligibility and Enrollment (HBEE) Rule Update

Addie Strumolo, Deputy Commissioner, DVHA

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Health Benefits Eligibility and Enrollment (HBEE) Rule

Introduction:

- HBEE is an eight-part rule that establishes eligibility and enrollment requirements for Medicaid/Dr. Dynasaur as well as Qualified Health Plan (QHP) insurance coverage.
- Updates are made regularly to implement changes in federal and state law.

Health Benefits Eligibility and Enrollment (HBEE) Rule

- **HBEE Part 1** - General Provisions and Definitions
- HBEE Part 2 - Eligibility Standards
- HBEE Part 3 - Nonfinancial Eligibility Requirements
- HBEE Part 4 - Special Rules for Medicaid Coverage of Long-Term Care Services
- **HBEE Part 5** - Financial Methodologies
- HBEE Part 6 - Small Employer Health-Benefits Program Rules
- **HBEE Part 7** - Eligibility-and-Enrollment Procedures
- **HBEE Part 8** - State Fair Hearings and Expedited Eligibility Appeals

Health Benefits Eligibility and Enrollment (HBEE) Rule

Part 1 Proposed Revisions:

- 2.02(c). Remove detail about EPSDT that is now in AHS's Health Care Administrative Rules (HCAR)
- 5.03(f)(4). Remove duty of a Navigator to provide information about and facilitate the establishment of cafeteria or premium-only plans *to implement a legislative change*

Health Benefits Eligibility and Enrollment (HBEE) Rule

Part 5 Proposed Revision:

- 28.03(d)(1). Reference recent federal law creating an exception, for MAGI-based Medicaid eligibility purposes, to the treatment of lump sums as income only in the month received

Health Benefits Eligibility and Enrollment (HBEE) Rule

Part 7 Proposed Revisions:

- 55.02(d). Restate the verification procedure around enrollment in an eligible employer-sponsored plan when determining eligibility for the advance payment of tax credits (APTC) and cost-sharing reduction (CSR) *to reflect current practice*
- 64.00, 68.01, 69.00, 71.00. Remove rules governing AHS's QHP premium processing and clarify premium rules as they relate to Medicaid *to implement legislative initiative*

Health Benefits Eligibility and Enrollment (HBEE) Rule

Part 7 Proposed Revisions (continued):

- 71.03(d)(6). Clarify the applicability of this QHP special enrollment period to enrollees in reflective plans (QHP-like plans offered off the exchange) *to implement existing guidance and align with federal law*
- 71.03(d)(13). Expand the triggering event that allows for a QHP special enrollment period for individuals who provide verification following termination of their enrollment for failure to verify *to more closely align with federal regulation*

Health Benefits Eligibility and Enrollment (HBEE) Rule

Part 7 Proposed Revisions (continued):

- 75.02. Restate the renewal procedures for QHP enrollment *to reflect current practice and codify DVHA's annual publication of QHP renewal procedures*
- 76.00. Reference federal QHP grace period rules

Health Benefits Eligibility and Enrollment (HBEE) Rule

Part 7 Proposed Revisions (continued):

- 77.00(b)(3)(ii). Restate, as permissive, AHS's employer reporting of an individual's QHP termination *to reflect current practice on the federal and state level*
- 77.00(f). Clarify proration methodology for premium assistance, remove rules governing AHS's QHP premium processing

Health Benefits Eligibility and Enrollment (HBEE) Rule

Part 8 Proposed Revision:

- 80.03 Clarify premium rules as they relate to Medicaid

Commissioner's Update—New DVHA Website

Cory Gustafson, Commissioner, DVHA
Deidra Jarvis, Provider Relations Specialist, DVHA
Suellen Bottiggi, Provider and Member Service Director, DVHA

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Public Comment