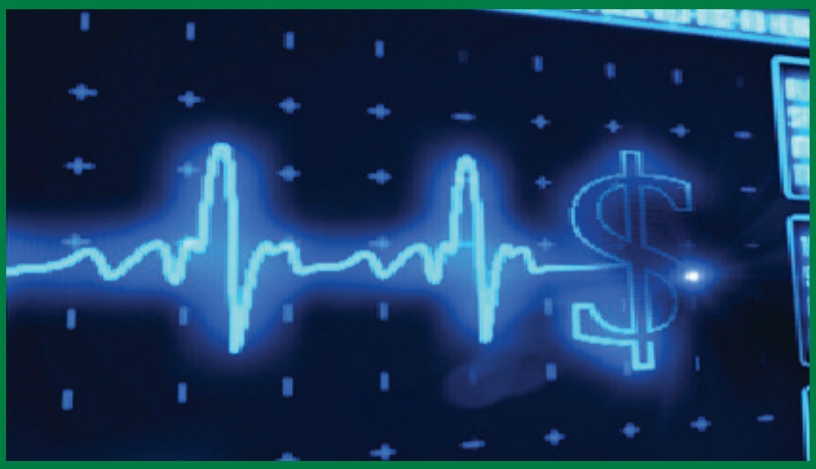
VERMONT

# Department of Vermont Health Access
# SFY 2020 Budget Presentation



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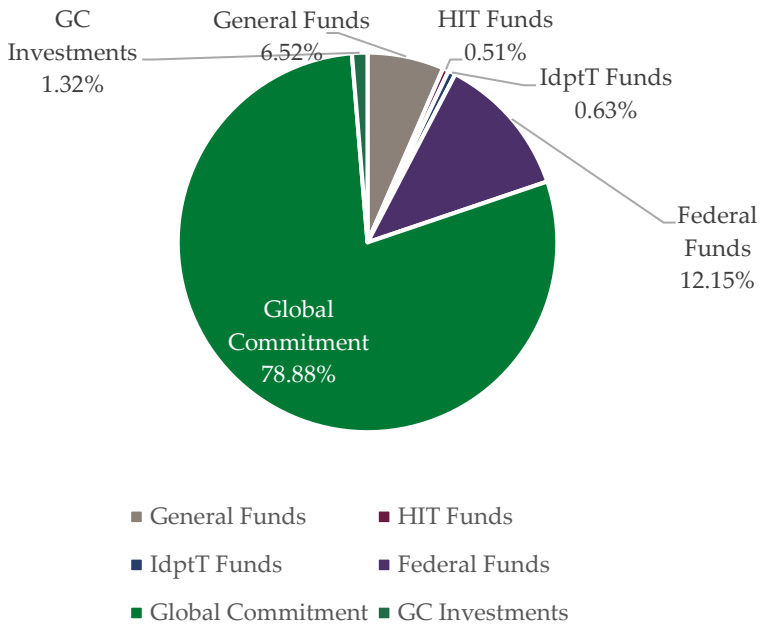
# AGENCY OF HUMAN SERVICES, DEPARTMENT OF VERMONT HEALTH ACCESS FY 2020 GOVERNOR'S RECOMMEND BUDGET

## MISSION

Improve the health and well-being of Vermonters by providing access to quality healthcare cost effectively.




## FY 2020 SUMMARY & HIGHLIGHTS

DVHA is comprised of 379 positions: 16 Exempt and 363 Classified.

This proposal represents an 1.43% increase in general funds.

DVHA continues to focus on three priorities; adoption of value-based payments, management of information technology projects, and operational performance improvement.

We invite you to review Chapter 1 of our Annual Report for a full list of DVHA Accomplishments in the last year.

In Chapter 9, we provide readers with an overview of specific items that we are focused on in the coming year.

### DVHA Budget Recommendation Changes from As Passed

| Changes | Program | Administration | Total DVHA | State Funds Estimate* |
|---|---|---|---|---|
| **SFY 2019 As Passed** | **$1,014,205,305** | **$163,194,019** | **$1,177,399,324** | **$520,286,600** |
| 2020 Changes | $14,078,471 | $8,630,369 | $22,708,840 | $9,379,624 |
| **SFY 2020 Recommendation** | **$1,028,283,776** | **$171,824,388** | **$1,200,108,164** | **$529,666,224** |

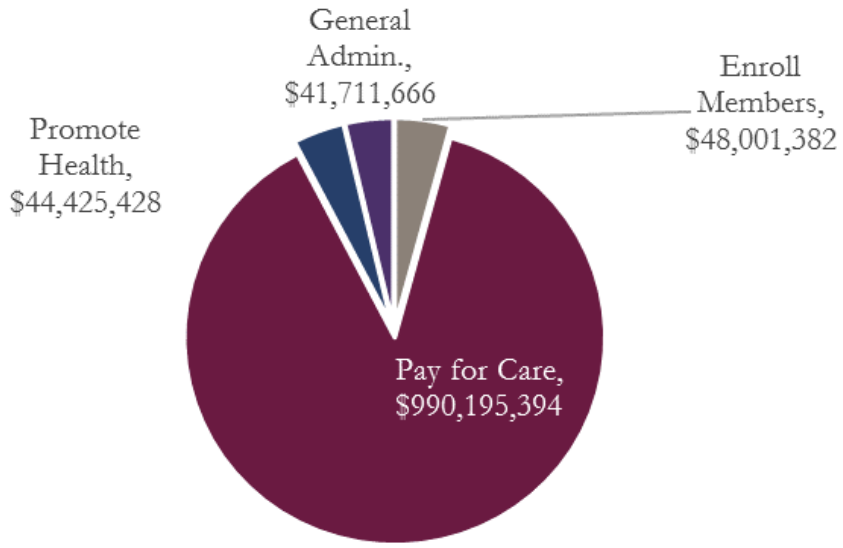
* This estimate converts Global Commitment which is handled at AHS Central Office using a blended Federal Medical Assistance Percentage (FMAP) which may not fully reflect the actual mix of caseload for the New Adults.

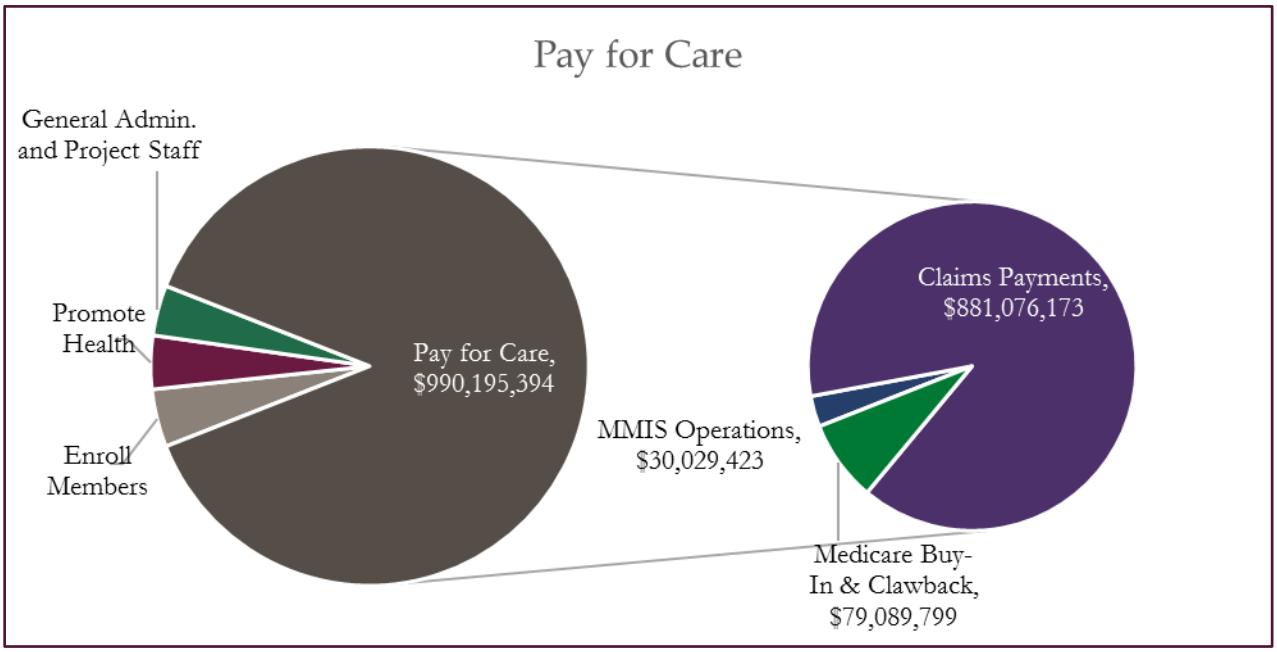
## SFY 2018 Spend

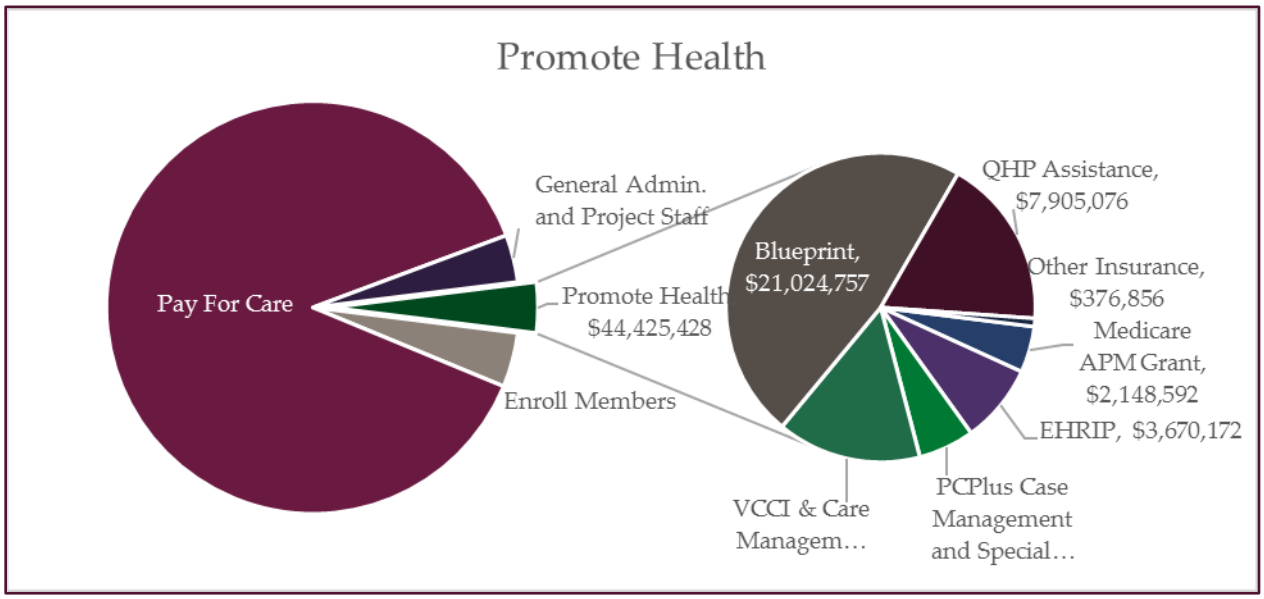
The work of DVHA revolves around three core responsibilities:

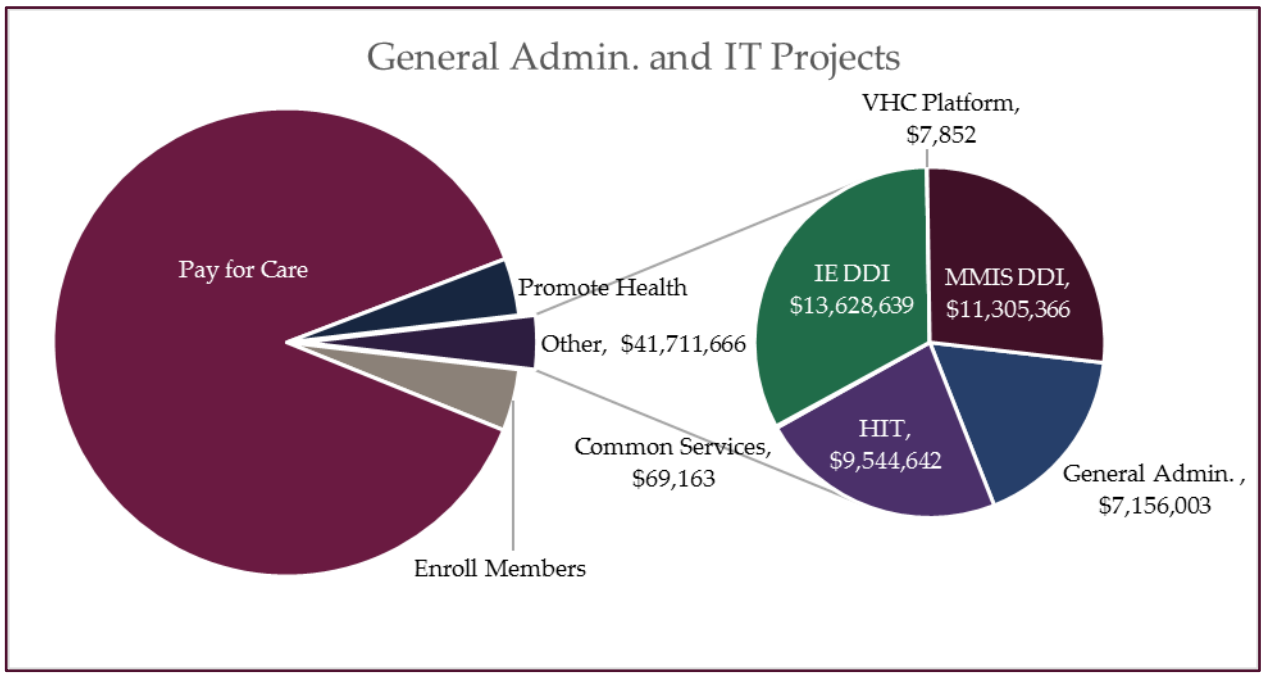
- Assisting Vermonters in need to enroll as members in appropriate programs.
- Paying for care. This work consists of building and collaborating with a robust network of healthcare providers, pharmacies, and others.
- Improving health outcomes. We recognize that simply signing people up will not achieve optimal outcomes at the most efficient cost, so we strategically invest in programs that improve health.

The charts below reflect DVHA's SFY 2018 of $1,124,333,871 spend as it falls into our priority categories.




Promote Health
Pay For Care
General Admin. and Project Staff
Promote Health $44,425,428
Enroll Members
Blueprint, $21,024,757
QHP Assistance, $7,905,076
Other Insurance, $376,856
Medicare APM Grant, $2,148,592
EHRIP, $3,670,172
PCPlus Case Management and Special…
VCCI & Care Managem…


General Admin. and IT Projects
Pay for Care
Promote Health
Other, $41,711,666
Enroll Members
VHC Platform, $7,852
IE DDI $13,628,639
MMIS DDI, $11,305,366
HIT, $9,544,642
General Admin., $7,156,003
Common Services, $69,163

.

## Budget Summary Administration

| | GF | SF | State Health Care Res | IdptT | FF | VT Health Connect (Portion Funded By SHCRF) | Medicaid GCF | Invmnt GCF | Total |
|---|---|---|---|---|---|---|---|---|---|
| **DVHA Administration - As Passed FY19** | **26,674,061** | **3,522,585** | | **7,246,989** | **118,955,295** | | | **6,795,089** | **163,194,019** |
| **Total after FY19 other changes** | **26,674,061** | **3,522,585** | **0** | **7,246,989** | **118,955,295** | **0** | **0** | **6,795,089** | **163,194,019** |
| **FY19 after other changes** | | | | | | | | | |
| **Personal Services:** | | | | | | | | | |
| 1. Salary | (38,370) | (8,029) | | | 682,384 | (157,101) | | (64,759) | **414,125** |
| 2. Retirement Increases | 12,960 | 85 | | 173 | 32,465 | 700 | | 1,054 | **47,437** |
| 3.Other Fringe Increases | 11,762 | 80 | | 164 | 30,555 | 658 | | 992 | **44,211** |
| 4. Eliminate 6 Positions | (300,000) | | | | (300,000) | | | | **(600,000)** |
| 5. Transfer Change Management Staff and Admin from AHS to DVHA (AHS net-neutral) | | | | 43,422 | 390,792 | | | | **434,214** |
| 6. Transfer Rate Setting from AHS to DVHA (AHS Net Neutral) Salary Fringe | 436,834 | | | | 436,834 | | | | **873,668** |
| 6. Transfer Rate Setting from AHS to DVHA (AHS Net Neutral) Contracts | 21,500 | | | | 21,500 | | | | **43,000** |
| 7. Wex Premium Processing for SFY 2020 (renegotiated contract) | 948,300 | | | | 948,300 | | | | **1,896,600** |
| 8. E&E M&O Contract Increase | 690,812 | | | | 2,122,177 | 168,261 | | | **2,981,250** |
| 9. MMIS M&O Contract Increases (non-certified modules) | 490,201 | | | | 490,201 | | | | **980,402** |
| 10. Reduction of SFY2019 OneCare Vermont Accountable Care Organization Quality and Health Management Measurement Improvement Investment | | | | | | | | (1,875,000) | **(1,875,000)** |
| 11. VHC swap | | | | 12,518 | | (12,518) | | | **0** |
| 12. Final Phasedown of HIT Investments | | 643,180 | | | | | | (643,180) | **0** |
| 13. HIT Fair Share FMAP change impact | | 1,925,242 | | | (1,925,242) | | | | **0** |
| | | | | | | | | | **0** |
| **Operating Expenses:** | | | | | | | | | **0** |
| 6. Transfer Rate Setting from AHS to DVHA (AHS Net Neutral) | 48,372 | | | | 48,372 | | | | **96,744** |
| 14. ADS true-up from AHSCO (AHS net-neutral) | 186,473 | 12,965 | | 239,336 | 2,776,120 | | | | **3,214,894** |
| 15. Internal Service Fund Increases | 39,412 | | | | 39,412 | | | | **78,824** |
| | | | | | | | | | |
| **Grants:** | | | | | | | | | **0** |
| | | | | | | | | | |
| **FY20 Changes** | **2,548,256** | **2,573,523** | **0** | **295,613** | **5,793,870** | **0** | **0** | **(2,580,893)** | **8,630,369** |
| **FY20 Gov Recommended** | **29,222,317** | **6,096,108** | **0** | **7,542,602** | **124,749,165** | **0** | **0** | **4,214,196** | **171,824,388** |
| **FY20 Legislative Changes** | | | | | | | | | |
| **FY20 Subtotal of Legislative Changes** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **FY20 As Passed - Dept ID 3410010000** | **29,222,317** | **6,096,108** | **0** | **7,542,602** | **124,749,165** | **0** | **0** | **4,214,196** | **171,824,388** |

## Budget Summary Program

| | GF | SF | State Health Care Res | IdptT | FF | VT Health Connect (Portion Funded By SHCRF) | Medicaid GCF | Invmnt GCF | Total |
|---|---|---|---|---|---|---|---|---|---|
| DVHA Global Commitment - As Passed FY19 | | | | | | | 730,388,202 | | 730,388,202 |
| Total after FY19 other changes | 0 | 0 | 0 | 0 | 0 | 0 | 730,388,202 | 0 | 730,388,202 |
| FY19 after other changes | | | | | | | | | |
| Grants: | | | | | | | | | |
| 16. Medicaid Consensus October 2018 | | | | | | | 4,075,981 | | 4,075,981 |
| 16. Medicaid Consensus December 2018 | | | | | | | 1,206,717 | | 1,206,717 |
| 17. Buy In | | | | | | | 2,741,069 | | 2,741,069 |
| 18. Transfer from DMH to support ABA Payment Model (AHS Net Neutral) | | | | | | | 1,394,200 | | 1,394,200 |
| 19. CIS from DCF (AHS Net Neutral) | | | | | | | 262,508 | | 262,508 |
| 19. Transfer to DCF for services moved into CIS bundle (AHS Net Neutral) | | | | | | | (203,709) | | (203,709) |
| 18. Tranfer to DMH to support DA Payment Reform (AHS Net Neutral) | | | | | | | (5,480,209) | | (5,480,209) |
| 20. ASFCME - Collective Bargaining Agreement - Year 1 (BAA item) | | | | | | | 229,826 | | 229,826 |
| 20. ASFCME - Collective Bargaining Agreement - Year 2 | | | | | | | 240,041 | | 240,041 |
| 20. Other Insurance - Commercial Policy WC reduction | | | | | | | (106,011) | | (106,011) |
| | | | | | | | | | 0 |
| FY20 Changes | 0 | 0 | 0 | 0 | 0 | 0 | 4,360,413 | 0 | 4,360,413 |
| FY20 Gov Recommended | 0 | 0 | 0 | 0 | 0 | 0 | 734,748,615 | 0 | 734,748,615 |
| FY20 Legislative Changes | | | | | | | | | |
| FY20 Subtotal of Legislative Changes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| FY20 As Passed - Dept ID 3410015000 | 0 | 0 | 0 | 0 | 0 | 0 | 734,748,615 | 0 | 734,748,615 |
| | | | | | | | | | |
| DVHA - Med Prog - LTC Waiver-As Passed FY19 | | | | | | | 204,515,915 | | 204,515,915 |
| Total after FY19 other changes | 0 | 0 | 0 | 0 | 0 | 0 | 204,515,915 | 0 | 204,515,915 |
| FY19 after other changes | | | | | | | | | |
| Traditional: | | | | | | | | | 0 |
| 21. Statutory Nursing Home rebase and inflationary rate increase (from Ratesetting) | | | | | | | 5,831,086 | | 5,831,086 |
| 22. Nursing Home Medicaid Bed Day decrease in utilization - 23,759 days @ $210 per day | | | | | | | (4,989,295) | | (4,989,295) |
| 23. Home and Community Based caseload pressure 56 x $31,958 | | | | | | | 1,789,648 | | 1,789,648 |
| 24. ASFCME - Collective Bargaining Agreement - Year 1 (BAA item) | | | | | | | 533,145 | | 533,145 |
| 25. ASFCME - Collective Bargaining Agreement - Year 2 | | | | | | | 556,841 | | 556,841 |
| 26. VVH rate increase - statewide budget neutral | | | | | | | 3,779,395 | | 3,779,395 |
| 27. Other Insurance - Commercial Policy WC reduction | | | | | | | (128,206) | | (128,206) |
| | | | | | | | | | 0 |
| FY20 Changes | 0 | 0 | 0 | 0 | 0 | 0 | 7,372,614 | 0 | 7,372,614 |
| FY20 Gov Recommended | 0 | 0 | 0 | 0 | 0 | 0 | 211,888,529 | 0 | 211,888,529 |
| FY20 Legislative Changes | | | | | | | | | |
| FY20 Subtotal of Legislative Changes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| FY20 As Passed - Dept ID 3410016000 | 0 | 0 | 0 | 0 | 0 | 0 | 211,888,529 | 0 | 211,888,529 |

| | GF | SF | State Health Care Res | IdptT | FF | VT Health Connect (Portion Funded By SHCRF) | Medicaid GCF | Invmnt GCF | Total |
|---|---|---|---|---|---|---|---|---|---|
| **DVHA - Medicaid Program - State Only - As Passed FY19** | **39,074,163** | | | | | | | **8,881,777** | **47,955,940** |
| **Total after FY19 other changes** | **39,074,163** | **0** | **0** | **0** | **0** | **0** | **0** | **8,881,777** | **47,955,940** |
| **FY19 after other changes** | | | | | | | | | |
| **Grants:** | | | | | | | | | |
| 16. Medicaid Consensus October 2018 | 285,820 | | | | | | | 2,737,350 | **3,023,170** |
| 16. Medicaid Consensus December 2018 | (6,104) | | | | | | | | **(6,104)** |
| 17. Buy In | | | | | | | | (13,489) | **(13,489)** |
| 28. Clawback | (1,747,959) | | | | | | | | **(1,747,959)** |
| | | | | | | | | | **0** |
| **FY20 Changes** | **(1,468,243)** | **0** | **0** | **0** | **0** | **0** | **0** | **2,723,861** | **1,255,618** |
| **FY20 Gov Recommended** | **37,605,920** | **0** | **0** | **0** | **0** | **0** | **0** | **11,605,638** | **49,211,558** |
| **FY20 Legislative Changes** | | | | | | | | | |
| **FY20 Subtotal of Legislative Changes** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **FY20 As Passed - Dept ID 3410017000** | **37,605,920** | **0** | **0** | **0** | **0** | **0** | **0** | **11,605,638** | **49,211,558** |
| | | | | | | | | | |
| **DVHA - Medicaid Matched NON Waiver Expenses - As Passed FY19** | **11,400,406** | | | | **19,944,842** | | | | **31,345,248** |
| **Total after FY19 other changes** | **11,400,406** | **0** | **0** | **0** | **19,944,842** | **0** | **0** | **0** | **31,345,248** |
| **FY19 after other changes** | | | | | | | | | |
| **Grants:** | | | | | | | | | |
| 16. Medicaid Consensus October 2018 | 33,256 | | | | 152,323 | | | | **185,579** |
| 16. Medicaid Consensus December 2018 | 11,427 | | | | 52,342 | | | | **63,769** |
| 17. Buy In | | | | | 952,319 | | | | **952,319** |
| 18. Transfer to DMH to support DA Payment Reform (AHS Net Neutral) | (20,042) | | | | (91,799) | | | | **(111,841)** |
| | | | | | | | | | **0** |
| **FY20 Changes** | **24,641** | **0** | **0** | **0** | **1,065,185** | **0** | **0** | **0** | **1,089,826** |
| **FY20 Gov Recommended** | **11,425,047** | **0** | **0** | **0** | **21,010,027** | **0** | **0** | **0** | **32,435,074** |
| **FY20 Legislative Changes** | | | | | | | | | |
| **FY20 Subtotal of Legislative Changes** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **FY20 As Passed - Dept ID 3410018000** | **11,425,047** | **0** | **0** | **0** | **21,010,027** | **0** | **0** | **0** | **32,435,074** |

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## Budget Considerations Administration

Salary and Fringe

DVHA is comprised of 379 positions. The three items below provide the annual increases related to these positions for Payact, retirement, and other fringe benefits.

| | |
|---|---|
| 1. Payact | $414,125 gross *($233,373) state* |
| 2. Retirement Increases | $47,437 gross *$14,403 state* |
| 3. Fringe Increases | $44,211 gross *$13,122state* |
| 4. Elimination of 6 Positions | ($600,000)gross *($300,000) state* |

DVHA shall assess its operations for efficiencies, considering both combining and/or modifying job functions to eliminate positions thru attrition and/or vacancies.

5. Change Management & IE Admin Transfer — $434,214 gross *$43,422 state*

This AHS transfer is net-neutral. DVHA received four change management and admin positions from AHS. These positions support the two major CMS funded technology projects managed by DVHA – MMIS and IE&E. Moving these positions allows for alignment between budgeting and oversight. This request annualizes the ask in Budget Adjustment.

6. Rate Setting Unit Transfer — $1,013,412 gross *$506,706 state*

This AHS transfer is net-neutral. DVHA received eight positions transferred from AHS. The Agency of Human Services (AHS) needs the capacity to take a professional and systematic approach to setting rates and making Medicaid payments across the full continuum of health care providers and services. Medicaid Rate Setting currently exists in at least three places – DVHA's Payment Reform unit, DVHA's Reimbursement unit, and the Division of Rate Setting. The merger of the three division/units in which Medicaid rates are set would improve the odds of success in pursuing the twin goals of creating more value-based payments and creating an integrated health system. Additionally, this transfer should be beneficial for staff over the long-term. Rate setting is highly specialized, and DVHA envisions opportunities for increased professional development, cross-training, collaboration, and a career ladder for rate setting professionals. Also, the move unites the setting of nursing home rates with that spending in DVHA's budget, linking authority and accountability. This transfer includes salary and fringe, contracts, and operating expenses. This request annualizes the ask in Budget Adjustment.

7. Premium Processing Contract — $1,896,600 gross *$948,300 state*

This line item is an extension of the SFY 2019 BAA request and is one-time funding to support DVHA's plan to transition the responsibility for qualified health plan premium billing from Vermont Health Connect to insurance carriers. WEX is the State's current Maintenance and Operations (M&O) premium processing vendor for Vermont Heath Connect. The State is working collaboratively with carriers to craft a plan to transition successfully. The current target for this transition is calendar

year/plan year 2021. The decision to continue contracting with WEX in the interim will be both operationally and financially advantageous to the State. It ensures stability as the State plans for the larger premium billing transition and avoids gaps in services. In addition, the State, through renegotiation, will save money through reduced Per Member Per Month (PMPM) pricing and a reduced fixed monthly cost.

- 2018 and 2019 PMPM $3.17
- 2020 PMPM $2.50
- 2018 Base Services Fee $222,000 per month
- 2019 Base Services Fee $200,000 per month
- 2020 Base Services Fee $180,000 per month

### 8. E& E Maintenance and Operation Contracts

$2,981,250 gross *$859,073 state*

DVHA engages with Optum Health and other vendors to perform hosting and enhanced Maintenance and Operations (M&O) services. This request annualizes the value previously asked for during budget adjustment. As IE matures, it is anticipated that we will see decreased reliance on singular vendors.

### 9. MMIS Maintenance and Operation Contracts

$980,402 gross *$490,201 state*

DVHA contracts with DXC to operate our Medicaid Management Information System and provide fiscal agent services. This request annualizes the Provider Management Module enhancement previously asked for during budget adjustment. In addition, this adds $171,594 for a six month increase to the operating costs associated with the Electronic Visit Verification (EVV) system and the negotiated annual increase to the base contract. Section 12006 of the 21st Century CURES Act requires states to implement an EVV system for (1) Personal Care Services (PCS) by January 1, 2020 and (2) Home Health Care Services (HHCS) by January 1, 2023. The EVVS enables home care workers to digitally record information about the visit—specific care or services rendered—and to report changes in patient condition for follow-up. EVV work will be both less expensive than anticipated and begin later than anticipated.

### 10. Delivery System Reform (DSR) Investment Reduction to Base Budget

($1,875,000) gross *($937,500) state*

Vermont's ACO program runs on a calendar year to align with federal ACO programs. Each year, DVHA negotiates a set price for the care of members attributed to the ACO. The contract makes some of this price dependent on quality benchmarks and places the ACO at financial risk if overspending occurs. Also, each year thus far, DVHA has funded a limited number of DSR investments within the ACO contract, which are designed to accelerate the progress of reform as permitted by Vermont's Global Commitment to Health 1115 Medicaid Waiver. Thus far, investments included in the budget have focused on technology tools. Given the temporary nature of these investments, DVHA proposes removing the investment funding from its base budget and addressing them, if at all, on an ad hoc basis at the conclusion of the annual contracting process and, if needed, in a future Budget Adjustment Act.

### 11. VHC Swap

$0 gross *$0 state*

This item swaps SHCRF funding, $12,518, for the VHC, with an interdepartmental transfer (IDT).

### 12. Final Phasedown of the HIT Investment

$0 gross *$346,481 state*

The 2017 Global Commitment to Health Waiver renewal required the State to begin to phase down Investments to ensure that they are time-limited. DVHA began this process in January 2018, as required, and replaced 50% of the HIT Investments with HIT funds for calendar year 2018. This final phasedown replaces the final 50% of HIT Investments with HIT funds effective January 2019.

### 13. HIT Fair Share FMAP Change

$0 gross *$1,925,242 state*

Health Information Technology match rates are reduced when the technology is used by non-Medicaid populations. This Fair Share calculation is required by CMS and is based on the proportion of insurer coverage as compared to Medicaid coverage in Vermont. The HIT Fair Share FMAP calculation changed from ~78% federal to ~65% federal effective 10/1/2018, effectively making the HIT Fair Share contracts within the HIT fund more expensive for the State. This request annualizes the ask in Budget Adjustment.

### 14. ADS True-up from AHSCO (AHS net-neutral)

$3,214,894 gross *$438,774 state*

There is a transition of ADS technical staff for the Enterprise Project Management Office (EPMO)for healthcare project and operations (IE, MMIS, E&E Operations, & HIE) from AHS to DVHA. This transfer moves the spending authority to support that transition. This request annualizes the ask in Budget Adjustment.

### 15. Internal Service Fund Increase

$78,824 gross *$39,412 state*

DVHA receives allocations from Department of Buildings and General Services (BGS) to cover our share of VISION system and fee-for-space, Agency of Digital Services (ADS) costs, and Department of Human Resources (DHR) costs. Departments are notified annually of increases or decreases and the department's relative share to incorporate into the budget request. The amount above reflects the net change to the DVHA operations budget for these costs.

## Budget Considerations Program

### 16. Medicaid Caseload & Utilization Changes

$8,549,112 gross *$4,024,047 state*

By statute, Vermont uses a consensus process to forecast Medicaid caseload and spending. This program spending is based on projected enrollment, utilization of services, and the price of those services. The consensus forecast proceeded in two steps this year. The forecast group made enrollment adjustments in October 2018 and PMPM cost adjustments in December 2018. These two adjustments are shown as two distinct rows in the ups/downs document. Generally, as compared to SFY 2018 actuals, caseload is down and utilization and price pressures are up, increasing our PMPM.

Overall, program costs are changing due to multiple factors:

- Declining enrollment: 0.91% reduction in Adults as compared to SFY 2018 actuals and 0.34% reduction in children.
- Changes to MEG enrollment: Individuals that were previously ABD with a higher PMPM are now classified as New or General Adults.
- Increases to utilization of healthcare services: 1.4% increase in utilization per member as compared to SFY 2018. This increase in utilization is offsetting the decline in enrollment.
- Hepatitis C utilization
- Brattleboro Retreat Rate Increase: $3.5M rate increase
- Non-Emergency Transportation increase: $2.175M rate increase
- Professionalize DME fee schedule
- Reset VPharm Rebate expectations ongoing: $3M less in State Only rebates per year
- Federally mandated increases for FQHCs/RHCs $2.2M more in reimbursements for SFY 2019.

### 17. Buy-In Adjustment

$3,679,899 gross *$1,258,233 state*

The federal government allows for states to use Medicaid dollars to "buy-in" to Medicare on behalf of dually eligible beneficiaries who would otherwise be fully covered by Medicaid programs. Caseload and member month costs vary from year to year. This change incorporates a rate increase and trend in member months. DVHA experienced an increase to Buy-In enrollment as a result of progress correcting and updating the eligibility files exchanged between CMS and DVHA.

The Medicare Buy-in Programs help people with a low income pay their Medicare premium. There are three distinct Buy-in programs and each has different eligibility requirements:

- *Qualified Medicare Beneficiary* (QMB)– Individuals who qualify for QMB are eligible to have Medicaid pay for Medicare Premiums for Parts A and B, Medicare deductibles, and Medicare coinsurance within the prescribed limits.

- *Special Low-Income Medicare Beneficiary* (SLMB)-Individuals who are eligible for SLMB are eligible to have Medicaid pay Medicare directly for Medicare premiums for Part B.

- *Qualified Individuals* (QI-1)-Individuals who are eligible for QI1 are eligible to have Medicaid pay Medicare directly for Medicare premiums for Part B. The income limits are higher than SLMB and payment is only guaranteed through the end of the year the application was made. This is the only Medicaid benefit.

This request is an annualization of the Budget Adjustment request.

### 18. DMH Interdepartmental Transfer ($4,197,850) gross *($1,904,918) state*

DVHA is engaged in a variety of payment reform projects. This transfer supports two initiatives, DA Payment Reform and Applied Behavior Analysis Payment Reform. Overall, payment reform is intended to pursue the twin goals of making more value- based payments and creating a more integrated system of care across the care continuum. Both items are an annualization of the Budget Adjustment request.

The Applied Behavioral Analysis (ABA) Payment Reform project seeks to create bundled payments that incentivize appropriate clinical treatment and accessibility to services for autism supports. It is scheduled for implementation in January 2019. This transfer effectively reverses the previous transfers from DVHA to DMH that included ABA services in NCSS's IFS case rate.

ABA Transfer from DMH: $1,394,200 gross

In addition to the ABA payment report project, DVHA and DMH have implemented a payment reform project for Designated Agencies in January 2019. This is in the form of a prospective alternative payment and effectively combines DVHA and DMH spending for similar services.

Designated Agency Transfer to DMH: ($5,592,050) gross

### 19. DCF Interdepartmental Transfer $58,799 gross *$27,124 state*

This item relates to a transfer into DVHA from DCF and a transfer to DCF from DVHA. These items are an annualization of items previously requested in Budget Adjustment.

DCF eliminated two contracts because the autism and deaf child services they were covering are Medicaid eligible and can be direct billed by the provider. $262,508 gross

Washington County Youth Services Bureau will be a bundled CIS provider effective 01/01/2019. DVHA is transferring fund for formerly direct billed services to DCF. **($203,710)** gross

### 20. Collective Bargaining Agreement Changes $363,856 gross *$167,847 state*

In 2013 the Vermont Legislature passed Act 48, authorizing collective bargaining agreements (CBA) between independent direct support providers and the State of Vermont. The DVHA funded Children's personal care attendant providers are included in the CBA. The amounts referenced above are for CY Year 1 & 2 increases as determined by the agreement.

- ASFCME – Collective Bargaining Agreement Yr. 1 $229,826 gross
- ASFCME – Collective Bargaining Agreement Yr. 2 $240,041 gross
- Commercial Policy Worker's Compensation Reduction ($106,011) gross

**Choices for Care Changes Decision Items** $7,372,614 gross *$3,400,987 state*

DVHA reimburses providers for the Choices for Care (CFC) services, but DAIL is responsible for managing the long-term care component. DAIL is implementing the following changes and DVHA defers to DAIL for an explanation of each of the changes:

21. Statutory Nursing Home rebase and inflationary rate increase (from Rate Setting)
22. Nursing Home Medicaid Bed Day decrease in utilization - 23,759 days @ $210 per day
23. Home and Community Based caseload pressure 56 x $31,958
24. ASFCME - Collective Bargaining Agreement - Year 1 (BAA item)
25. ASFCME - Collective Bargaining Agreement - Year 2
26. VVH rate increase - statewide budget neutral
27. Other Insurance - Commercial Policy WC reduction

28. "Clawback" Enrollment Decrease ($1,747,959) gross *($1,747,959) state*

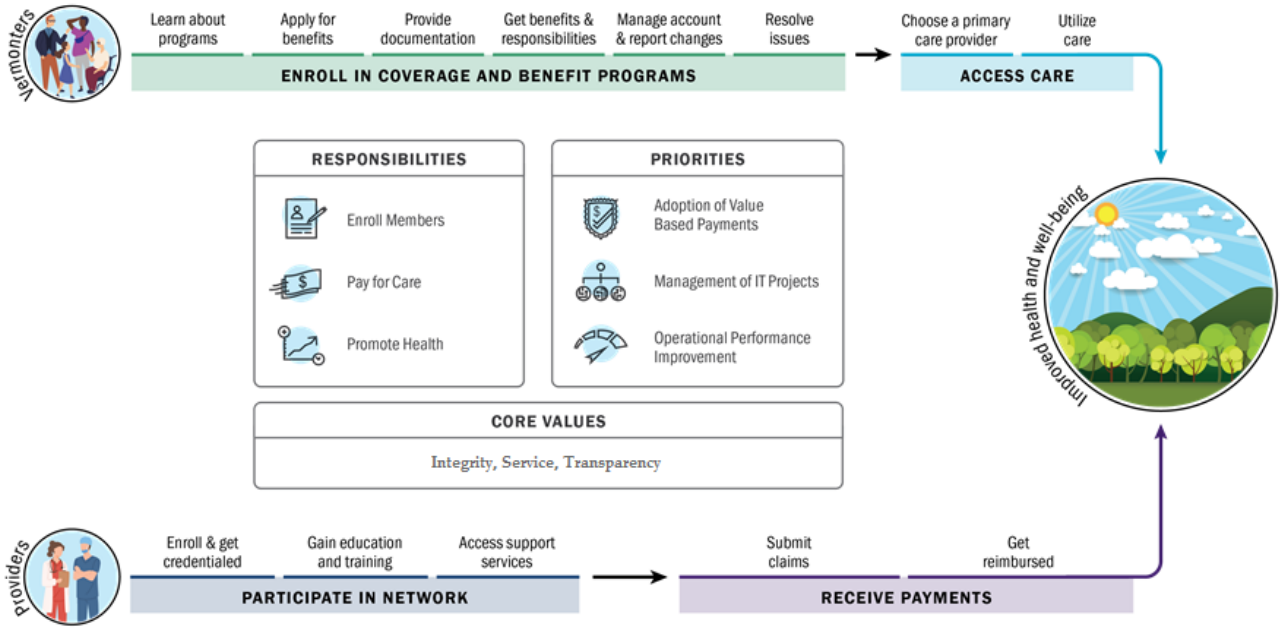
The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), which established the Medicare Part D prescription drug program, eliminated Medicaid prescription drug coverage for people dually eligible for Medicare and Medicaid (duals), and required all duals to receive their drug coverage through a Medicare Part D plan. This reduced state costs; however, MMA also required states to reimburse the federal government for costs associated with the transfer of prescription drug coverage for this population from state Medicaid programs to Medicare.

Since the implementation of the Affordable Care Act, DVHA has seen a marked decline in the number of VPharm Enrollees. Part D members who have high prescription drug expenses currently must pay more once the total cost of their medicines reaches a certain threshold. That's due to an aspect of Part D called the coverage gap, also known as the "donut hole".

The donut hole has been narrowing each year since the Affordable Care Act (ACA) was passed in 2010. Beginning in 2019, Part D enrollees will pay 25 percent of the cost of all their prescription drugs from the time they enter the gap until they reach catastrophic coverage. The narrowing of the donut hole, results in fewer members needing the wrapped benefit of VPharm. DVHA's Clawback enrollment has dropped 7% from a high of 21,347 (Oct 2015) to a current (June 2018) 19,825.
This item is an annualization of the Budget Adjustment request.

## DVHA COMMISSIONER'S MESSAGE

**<u>Our Mission:</u> Improve the health and well-being of Vermonters by providing access to quality healthcare cost effectively.**




### Story Behind the Mission

When we say our mission is "to improve the health and well-being of Vermonters by providing access to quality healthcare cost effectively," we are really saying that we are striving to do multiple things. First, we are saying *what* we're trying to do: to improve the health and well-being of Vermonters. Second, we're saying *how* we're trying to do it: by providing access to quality healthcare. But that's not all. We're *committing* to meeting our first two mission objectives cost-effectively. In other words, we are conscious that we are accountable to both our members and to taxpayers.

To achieve this mission, our work revolves around three core responsibilities:

- Assisting Vermonters in need to enroll as members in appropriate programs. Follow the "Vermonters" path in the diagram above and read on to Chapter 2 to see this process described in greater detail.
- Paying for care. Follow the "Providers" path in the diagram above and read on to Chapter 3 and 4 to hear about our work building and collaborating with a robust network of healthcare providers, pharmacies, and others.
- Improving health outcomes. We recognize that simply signing people up will not achieve optimal outcomes at the most efficient cost, so we strategically invest in

programs that improve health. Read on to Chapter 5 to hear about our commitment to quality and improvement.

### Our Priorities

Our commitment to continual improvement is not limited to health outcomes. When we look for opportunities to improve internally – in the way we carry out our responsibilities – three priorities emerge *adoption of value-based payments, management of information technology projects*, *and operational performance improvement*. If we successfully execute these priorities, we will be well positioned to deliver on the triple aim of improving patient experience of care, improving population health, and reducing per capita cost growth.

Our department has 20 functional units, each works on one or more of our responsibilities and contributes to one or more of our priorities. The graphic at the start of Chapter 9 maps which units work on which priorities, while the Scorecard in Appendix C tracks their key performance indicators.

### Our Values

Our department commits to executing our responsibilities and priorities while adhering to three core values:

| | |
|---|---|
| Transparency | We trust that we will achieve our collective goals most efficiently if we communicate the good, the bad, and the ugly with our partners and stakeholders. |
| Integrity | In the words of psychologist Brené Brown, we commit to "choosing courage over comfort…. choosing what is right over what is fun, fast, or easy…. choosing to practice [our] values rather than simply professing them." |
| Service | Everything we do is funded by taxpayers to serve Vermonters. Therefore, we must ensure that our processes and policies are person-centered. We aim to model, drive, and support the integration of person-centered principles throughout our organizational culture. |

These values guide all our work, including the development of this annual report and budget request. We strive to empower policymakers with more predictable Medicaid forecasting and continually reach for better health outcomes for Vermonters. We seek to determine what drives success in our business and measure performance in these functions over time.

We appreciate that you are taking the time to read our annual report and we welcome your participation in the dialogue.

## Accomplishments

DVHA strives to fulfill its responsibilities to members and taxpayers while making progress on its three priorities: adoption of value-based payments, management of information technology projects, and operational performance improvement. This section offers highlights of some of the past year's accomplishments.

### Adoption of Value-based Payments

DVHA has continued to advance value-based payments, successfully completing and evaluating the first full year of the Accountable Care Organization (ACO) program and initiating the second year; expanding payment reforms out across an array of services; and, through the Medicaid Pathways Work, developing an outline of payment reform processes to help guide future reforms.

#### Refined and Continued Medicaid Pathways Work

Section 12 of Act 113 of 2016 requires the Secretary of the Agency of Human Services to embark upon a multi-year process of payment and delivery system reform for Medicaid providers aligned with the Vermont All-Payer ACO Model and other existing payment and delivery system reform initiatives. DVHA published the Medicaid Pathways report on 1/1/19, which attempts to demystify payment and delivery system reform by describing the process and daily work that occurs within AHS and with our stakeholders. Specifically, the report consisted of two basic elements. First, a description of the payment reform process, which is typically facilitated by the Payment Reform team at DVHA. Second, the report provides an update on completed and in-progress payment reform activities, using the enumerated statutory criteria:

- Medicaid payments to affected providers;
- changes to reimbursement methodology and the services impacted;
- efforts to integrate affected providers into the APM and with other payment and delivery system reform initiatives;
- changes to quality measure collection and identifying alignment efforts and analyses, if any; and
- the interrelationship of results-based accountability initiatives with the quality measures referenced above.

The following payment and delivery system reform initiatives were either completed or in-progress in 2018:

- Vermont Medicaid Next Generation (VMNG) ACO program
- Applied Behavior Analysis (ABA)
- Children's and Adult's Mental Health
- Residential Substance Use Disorder (SUD) Program
- Developmental Disabilities Services
- Pediatric Palliative Care

The report serves as an excellent primer on reform, and some of these programs are described in greater length below.

## Completed the First Full Year of the Vermont Medicaid Next Generation (VMNG) ACO Program

The calendar year 2017 was the first full year of the VMNG ACO program. DVHA reported five distinct results:

1. DVHA and One Care launched the program successfully.
2. The program is growing.
3. The ACO program spent less than expected on healthcare in 2017.
4. The ACO met most of its quality targets. Specifically, the ACO's quality score was 85% on 10 pre-selected measures. Notably, OneCare's performance exceeded the national 75th percentile on measures relating to diabetes control and engagement with alcohol and drug dependence treatment. Examining quality trends over time will be important to understand the impact of changing provider payment on quality of care.
5. DVHA is seeing more use of primary care among ACO-attributed Medicaid members. Based on preliminary analyses of utilization, the cohort of attributed members has had higher utilization of primary care office visits than the cohort of members who are eligible for attribution but not attributed. As further information about utilization becomes available, DVHA will conduct more robust analyses to determine whether differences between cohorts are statistically significant, and to understand the impact of the program on utilization patterns over time.

## Nearly Tripled the Number of Members Covered by Value-Based Payments Rather than Fee-for-service

Additional providers and communities have joined the ACO network to participate in the VMNG program for the 2019 performance year. The table below depicts program growth from 2017 – 2019, a key milestone for provider-led health reform.

| | 2017 Performance Year | 2018 Performance Year | 2019 Performance Year |
|---|---|---|---|
| Hospital Service Areas | 4 | 10 | 13 |
| Provider Entities | Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs | Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs | Hospitals, FQHCs, Independent Practices, Home Health Providers, SNFs, DAs, SSAs |
| Unique Medicaid Providers | ~2,000 | ~3,400 | ~4,300 |
| Attributed Medicaid Members | ~29,000 | ~42,000 | ~79,000 |

## Partnered on Mental Health Payment Reform

The Department of Mental Health (DMH) and DVHA are collaborating on a payment reform project that transitioned Vermont Medicaid payments to all Designated Agencies (DA) and Pathways Vermont (a Specialized Services Agency or SSA), from traditional reimbursement mechanisms (a combination of program-specific budgets and fee for service) to a monthly case rate. Although the

scope of services is narrow, the new payment model relies heavily on prior experience through the Integrating Family Services (IFS) pilot and expands the case rate approach to child and adult populations statewide. Each child and adult case rate are unique to the individual agency's child and adult population, comprised of their mental health allocation from DMH and their historical DVHA fee for service expenditure. Under the new model, agencies are paid a fixed amount prospectively at the beginning of each month and are expected to meet established caseload targets by delivering at least one qualifying service to an individual in each month. Value-based payments are made through a separate quality payment. During each measurement year, DMH will withhold a percentage of the approved adult and child case rate allocations for these payments. The value-based payment model uses three types of performance metrics to assess the quality and value of services: monitoring; reporting; and performance. The payment change went into effect for all mental health services delivered on or after January 1, 2019, for Medicaid beneficiaries receiving treatment at all Vermont DAs and one SSA (Pathways).

### Reformed Residential Substance Use Disorder Payments

The Vermont Department of Health (VDH) and DVHA are collaborating on a payment reform project transitioning Vermont Medicaid payment to residential substance use disorder (SUD) treatment providers from a per diem rate to an episodic payment. An episodic payment was selected as it would: provide a framework to pay for outcomes rather than discrete services; incentivize innovation and cost-containment through increased provider flexibility; and ensure financial stability through the delivery of more predictable payments. The change went into effect for all episodes of care beginning on/after January 1, 2019, for Medicaid beneficiaries at all residential treatment providers in Vermont (Valley Vista: Vergennes, Valley Vista: Bradford, and Serenity House). VDH and DVHA will begin work on the second phase of this payment reform, implementing the value-based component, at the end of January 2019.

### Launched Developmental Disabilities Services Payment Reform

The Department of Disabilities, Aging and Independent Living (DAIL) and DVHA are working in partnership on a payment reform project to transition from the current Developmental Disabilities Services (DDS) home- and community-based services (HCBS) daily rates to a new form of payment for individuals with intellectual and developmental disabilities.

AHS has initiated this project to meet several objectives:

- Comply with the State's APM Agreement with the federal Centers for Medicare & Medicaid Services, which obligates the Agency of Human Services to develop a plan to coordinate payment and delivery of Medicaid Home and Community-based Services with the State's delivery reform efforts for healthcare;
- Increase the transparency and accountability of developmental disabilities services, consistent with recommendations in the 2014 State Auditor's Report;
- Improve the validity and reliability of needs assessments;
- Improve equity and consistency in funding of individual services;

- Increase flexibility in addressing individual needs, services and outcomes, within the limits of available funding; and
- Support a sustainable provider network.

Representatives from the State, provider network, consumers, family members, and other stakeholders have begun work on the project scope and planning. This tentatively scheduled for January 1, 2020.

### Improved Payment Model for Applied Behavior Analysis Services

DVHA partnered with providers to identify barriers to service provision of applied behavioral analysis. Based on stakeholder feedback it was determined that providers needed more flexibility in administering their programs. Therefore, a new payment model was designed, which offers more flexibility, tailored to specific member needs. The team also developed new clinical guidelines to ensure providers have guidance in best practices for service delivery. Additionally, DVHA onboarded two agencies, with multiple ABA practitioners, to further expand the network of providers allowing for an increase in services for our members.

### Gained Federal Approval for Alternative Payments

CMS approved all eight of Vermont Medicaid's Alternative Payment Methodologies through at least CY 2020, marking the first time any of these methodologies were approved beyond a single calendar year. The following programs operate under Alternative Payment Methodologies that requires prospective CMS approval every calendar year: Children's Integrated Services; Integrating Family Services; OneCare Accountable Care Organization; Blueprint Women's Health Initiative; Blueprint Community Health Teams; Blueprint Patient-Centered Medical Homes; Dental Incentive; and Mental Health.

### Clarified Roles and Responsibilities of Program Integrity (PI) in Payment Reform Initiatives

The roles of and mechanism Program Integrity unit uses to detect fraud, waste and abuse were established based on standard fee for service payment models. The Payment Reform and Program Integrity units continue to work to define how PI works in prospective payment, episodic payment and bundled payment constructs wherein providers have more flexibility in how and what services are delivered, and payment is not linked to a specific service

## Management of Information Technology Projects

DVHA and the Agency of Human Services (AHS) continue to collaborate with the Agency of Digital Services (ADS) to overhaul the way the State implements and manages information technology projects. Major focal points from the past year include Integrated Eligibility and Enrollment and the Medicaid Management Information System (described in greater detail in Chapter 9) initiatives to meet federal requirements and advance financial integrity, efforts to efficiently deliver care that improves the health of Vermonters and achieving Health Information Exchange goals including developing the Health Information Exchange Plan.

### Implemented Payer Initiated Eligibility Matching

DVHA's Coordination of Benefits (COB) ensures that Medicaid is always the payer of last resort, recovering funds from other insurers when appropriate. COB launched a Payer Initiated Eligibility

electronic data matching process with Blue Cross Blue Shield of Vermont to better identify and collect payment from liable third parties. This effort resulted in COB billing an additional $3.2M in SFY 2019. COB will continue to roll out data matching with additional insurance carriers and explore options to automate the data matching results in the future.

### Achieved Federal Compliance with Social Security Removal Initiative

The federal government changed Medicare ID's from Social Security Numbers to a unique ID. DVHA completed this federally mandated process which allows for continued data matching with Medicare and the ability to accept claims directly for Medicare.

### Implementing the Provider Management Module

DVHA continually seeks opportunities to reduce provider administrative burden. Enrolling providers into DVHA's network was taking over 120 days, affecting provider payments. DVHA prioritized the creation of a new Provider Management Module to enroll providers in less than 30 days. The procurement was successful, and the new module will launch by April 1st, 2019.

### Launched the Clinical Imaging Project

This project converted 166,000 active Medicaid member Prior Authorization (PA) requests from paper to electronic images retrievable through OnBase Document Control an electronic document manager. In addition, an operational plan was developed to handle new PA requests. The project launched July 15th and went live November 19th, 2018.

### Used Statewide Data to Inform Blueprint for Health Programming

In 2018, the Blueprint began reporting on all Vermonters, not just those in Blueprint practices. This change supports a better understanding of the health of Vermonters and the care they access.

### Significant Improvements were made within the Health Information Exchange (HIE) Program

- DVHA established the Health Information Exchange (HIE) Steering Committee, with representatives from across the continuum of care. The Committee focused on supporting the State in developing a statewide Health Information Exchange Plan. In 2019, the HIE Steering Committee will oversee execution of the Plan and update the Plan for the 2020 calendar year.
- DVHA, with support from the HIE Steering Committee, developed a state-wide strategic Health Information Exchange Plan. The State is obligated to create a Health Information Exchange plan each year; however, a plan had not been approved since 2010. The Green Mountain Care Board approved the Plan in late November 2018.
- DVHA and VITL, the operator of the State's Health Information Exchange, completed all legislative obligations outlined in Act 187 of 2018. This included consistent reporting on progress made to address the recommendations from the HIE Evaluation of 2017, procuring a third-party evaluation (which concluded that work is on track), and procuring a contingency plan to be used if VITL could not address known issues.

### Implemented Interface to Prescribe Medication Securely and Efficiently

Surescripts is a service that supports standard electronic prescription transactions to allow clinicians to securely and easily e-prescribe. DVHA worked with its Provider Benefit Manager, Change Healthcare, to establish a connection with Surescripts to provide electronic health records (EHR) for Medicaid members. Providers who e-prescribe now have access to Vermont Medicaid data to assist them in managing prescriptions for Medicaid members more efficiently. The initiative enables providers to access members' outpatient pharmacy claims history, Medicaid eligibility status, and the status of prescribed drugs on the Medicaid Preferred Drug List. Surescripts currently processes approximately 240,000 EHR transaction requests monthly for DVHA members.

### Launched a Pharmacy Benefits Program Provider Portal

In 2018, DVHA launched the eWEBS Pharmacy Benefits Provider Portal developed by Change Healthcare designed for use by registered prescribers and pharmacies to simplify access to member and drug information securely. Prescribers are guided through preferred and non-preferred drug selections, and potential step therapy, dose limits or other coverage restrictions, giving them the ability to make informed drug choices. Additionally, prescribers and pharmacists can look-up member demographic information, eligibility, current and historical pharmacy claims, pharmacy location and telephone number, the Preferred Drug List (PDL), PA criteria and diagnosis code definitions. Most importantly, providers can electronically submit Prior Authorization (PA) requests, track the progress of a request, and view PA determination results.

## Improve Operational Performance

DVHA is committed to continual improvement. The Department's core values of transparency, integrity, and service call upon all staff to identify opportunities within their sphere of influence to improve the way DVHA serves Medicaid members and Vermont taxpayers. In addition to striving for business efficiencies, DVHA has implemented results-based accountability (RBA) principles and tools to provide structure to the organization's commitment. Along with other departments in the Agency of Human Services, DVHA uses Clear Impact Scorecard, RBA-based strategy management and collaboration support software that facilitates data charting, project management, and public communication of results.

Each of DVHA's units now tracks performance metrics with an emphasis on the core responsibilities of enrolling members, paying for care, and promoting health. The results can be seen across all three areas of responsibility as well as in general operations.

### Enroll Members

#### ✓ Met Federal Requirements on Asset Verification

The federal Social Security Act requires states to implement an asset verification system. Under a mitigation plan between the Centers for Medicare and Medicaid Services (CMS) and DVHA, Vermont agreed to implement an electronic asset verification system (eAVS) by December 31, 2017. The system was approved for deployment on December 29, 2017 and used throughout 2018 to verify assets of Vermonters who were applying to relevant programs, specifically Choices for Care and Medicaid for the Aged, Blind, and Disabled.

### ✓ Designed and Piloted Self-Service Document Uploader

To make it easier for Vermonters to submit pay stubs and other personal documents to verify their eligibility for benefits the Integrated Eligibility and Enrollment (IE&E) program designed a technical solution that utilizes mobile and online technology to submit documents. The tool also eases staff burden by automating the classification of documents. This solution will improve the efficiency of the eligibility determination process and result in better customer experience for Vermonters. A fall 2018 pilot found that the tool enabled 55% of pilot users to submit documents on the same day of their request, compared to 11% of non-pilot users. IE&E also found that the average time from document request to submission was nearly cut in half, from nine days to five. The program aims to roll out the Uploader statewide in fall 2019.

### ✓ Automatically Renewed Nearly All Qualified Health Plan Members

The first step in the renewal effort involves determining eligibility for the coming year's state and federal subsidies and enrolling members in new comparable versions of their health and/or dental plans. In October 2018, this step was operated with a single, clean, automated run that took care of 99.3% of eligible cases, up from 97.8% the prior year and 91.5% two years prior. The small number of remaining cases were processed by staff the following day. This meant that they could log onto their online accounts on the first day of Open Enrollment, see their benefits and net premiums for the coming year, and select a new plan if they wanted to do so.

### ✓ Minimized Errors between Insurance Carriers and Exchange

DVHA set a goal of integrating enrollment files across its insurance carrier partners' systems with no more than a 1.5% error rate and achieved this goal in all 12 months of 2018. Ten months had error rates less than 1.0%. DVHA and its partners also acted quickly to resolve errors that did arise. DVHA's goal was to ensure that no more than one-twentieth of one percent of cases sat in error status for more than ten days. With more than 31,000 subscriber cases across the three carriers, that equated to an inventory of 15 or fewer errors open more than ten days. DVHA met this new target in 11 out of 12 months in 2018, finishing seven months with zero cases in error status for more than ten days.

### ✓ Use of Plan Comparison Tool Increased 62%.

Due to complex policy changes that led to shifts in qualified health plan premiums and subsidies, DVHA strongly encouraged members to comparison shop rather than electing to be automatically renewed into their previous health plan. Vermonters heeded the call, using the online Plan Comparison Tool more than 38,000 times between October 15th and December 15th, a 62% increase over the previous year. They also spent more time researching options, staying on the site 22% longer.

### ✓ Promptly Answered Escalated Calls

When members call with questions about eligibility or other issues that cannot be addressed by DVHA's contracted call center, the calls are transferred to DVHA's Eligibility and Enrollment Unit. DVHA set a goal of answering 90% of these escalated calls within five minutes. As of spring 2017, the team had never responded to more than 68% of these escalated calls within that timeframe. In 2018, they exceeded the target in all twelve months, never falling short of 94%.

### ✓ Processed 98% of Vermont Health Connect Member Requests within Ten Days

Vermonters deserve to have their requests addressed promptly. During the first few years of Vermont's health insurance marketplace, many requests took several weeks or months to complete. For 2018, DVHA set a target to complete 95% of requests within ten days and met this goal for members managed in the Vermont Health Connect system. In fact, in the last quarter of 2018, 98% of requests were completed within ten days – an especially impressive accomplishment given that the remaining two percent include requests that are not allowed to be processed immediately (such as post-partum cases).

### ✓ Executed Monthly Reconciliation of Health Insurance Marketplace Systems

Multiple enrollment systems (Vermont Health Connect, payment processing vendor WEX, and the three insurance carriers) create the risk of discrepancies Medicaid and qualified health plan members across systems. In 2018, DVHA set a target of addressing 100% of potential discrepancies each month and, starting in February, met the goal every month with Blue Cross Blue Shield of Vermont (BCBSVT) and Northeast Delta Dental (NEDD). In June 2018, MVP Healthcare completed the system work needed to support the monthly reconciliation process that DVHA was already operating with BCBSVT and NEDD and operationalized it in the fall.

### ✓ Executed Monthly Reconciliation of Medicaid Systems.

Multiple enrollment systems (Vermont Health Connect and the State's legacy ACCESS system) create the risk of discrepancies across systems, especially during months with large renewal caseloads. In 2018, DVHA honed its Medicaid reconciliation process. The reconciliation team cut the number of Medicaid cases with open discrepancies from more than 8,000 in April 2018 to fewer than 2,000 in July 2018, then consistently worked new discrepancies for the rest of the year. As of December 2018, there were fewer than 2,000 discrepancies and fewer than 150 that had been open for two months.

### ✓ Maintained In-Person Assistance across Vermont

DVHA ended 2018 with 279 DVHA-trained and certified Assisters working in hospitals, clinics, and community-based organizations in all of Vermont's 14 counties to help Vermonters enroll in health coverage through Vermont's health insurance marketplace. In addition, each of Vermont's five Area Agencies on Aging offices has certified State Health Insurance Program (SHIP) staff who provide counseling to Medicare beneficiaries and those about to become eligible for Medicare, and to help Vermonters over 60 years old apply for Choices for Care and Green Mountain Care programs. These partners' outreach efforts, along with other stakeholders and individuals, helped drive the state's uninsured rate to the lowest level ever seen in the Vermont Household Health Insurance Survey.

## Pay for Care

### ✓ Conducted Training with Hospitals on Medicaid Eligibility

In 2018, Provider Member Relations (PMR) conducted training seminars to four Hospitals on Presumptive Eligibility (PE). As of January 1, 2018, Vermont Medicaid enrolled hospitals can immediately determine Medicaid Eligibility for certain individuals who are likely to be eligible for traditional Medicaid based on preliminary information. Eligibility under PE is short-term but allows immediate access to coverage for eligible individuals and ensures the hospital will be reimbursed for services provided, just as if the individual was enrolled in traditional Medicaid.

✓ **Implemented Change in Scope Process for Health Centers**

DVHA continued its commitment to professionalize reimbursement fee schedules generally and improve health center reimbursement specifically. DVHA, in collaboration with Bi-State Primary Care and health centers, implemented the federally mandated change of scope process that adjusts rates due to a change in the type, intensity, duration and /or amount of services.

✓ **Better Aligned Health Center Reimbursements with Health Care Reform**

DVHA continued to align health center rates with reform by phasing down site-specific alternative payment models. DVHA collaborated with health centers, considered their feedback, and implemented a three-year phase down to give health centers more time to adjust to changing reimbursement rates.

✓ **Modified Durable Medical Equipment (DME) Fee Schedule Based on Provider Feedback**

In early 2018, DVHA changed the DME fee schedule for the first time in decades. DVHA partnered with DME providers and their representatives to address serious concerns that arose during implementation. This included further analysis of Medicare, New England states, and New York state reimbursement rates that led to creating a Provisional Access to Care Adjustment (PACA) designed to raise certain rates to ensure access to services.

✓ **Optimized Reimbursement Arrangements Based on Provider Feedback**

DVHA continues to incorporate the helpful feedback of healthcare providers in improving its fee schedules and payment arrangements. Examples include: (1) created a uniform and enough reimbursement for Long Acting Reversible Contraceptive for both inpatient and outpatient providers, (2) eliminated burdensome administrative process related to certain 340B program claims, and (3) ensured full and proper payment by only applying the Nurse Practitioner/Physician's Assistant reduction to their services rather than the full claim.

✓ **Gained Federal Approval to Improve Substance Use Disorder (SUD) Treatments**

The Centers for Medicare and Medicaid Services (CMS) approved an amendment to Vermont's Global Commitment to Health 1115 Demonstration waiver that authorizes the State to receive federal Medicaid funding for treatment services offered in residential and inpatient facilities provided to Medicaid enrollees to treat addictions to opioids and other substances. The approval of this amendment allows Medicaid to pay for inpatient and residential treatment for addiction in institutions for mental disease (IMDs), which is not permitted currently under federal law and removes the mandatory sunset of Vermont's current financial arrangement. Absent this amendment approval, Vermont would be required to phase down federal Medicaid participation for substance use disorders (SUD) treatment in a residential or inpatient setting, beginning in 2021 and phase out completely at the end of 2025.

✓ **Continue to Support Providers through Electronic Health Record Payments**

Vermont successfully executes the Medicaid Promoting Interoperability Program (formerly the Electronic Health Record Incentive Payment Program), connecting Vermont's provider community with incentive payments to offset the cost of Electronic Health Record (EHR) systems. As of 2018, the program has distributed $54.4 million in 100% federal dollars to eligible professionals and hospitals. Every hospital in Vermont has an EHR system and has taken advantage of the program.

**Promote Health**

✓ **Continued the Blueprint for Health's Statewide Reach**

Almost all of Vermont's primary care practices participate in the Blueprint for Health at the end of 2018, including 137 of Vermont's estimated 149 primary care practices. These Patient-Centered Medical Homes provide evidence-based care consistent with national standards focused on care access, team-based care, patient/population health management, care management and support, care coordination and care transitions, and performance measurement and quality improvement.

✓ **Continued to Work on a Common Model of Care**

In 2018 the Blueprint for Health worked with Community Health Team Leaders and staff to implement a common community-based care model adopted by both the Blueprint and OneCare Vermont.

✓ **Grew the Women's Health Initiative**

Participation in the Women's Health Initiative continued to grow adding three new women's health specialty practices and four new Patient-Centered Medical Homes between the third quarter of 2017 and the third quarter of 2018.

✓ **Expanded Hub & Spoke**

The Hub & Spoke program continued to add new medication-assisted treatment (MAT) prescribers in Spokes in 2018, expanding local capacity for opioid use disorder treatment.

✓ **Promoted Chronic Disease Management via the Blueprint for Health**

The Self-Management Programs had 1011 graduates in 2018. The participants learned skills to manage their chronic conditions including diabetes, chronic pain, and more.

✓ **Aligned the Vermont Chronic Care Initiative (VCCI) with Health Care Reform**

Developed a new way to identify and engage patients that reflects the presence of both the ACO and VCCI in Medicaid's network. First, VCCI allied its risk stratification with the ACO's risk methodology. Next, VCCI focused on new Medicaid members to engage members, reflecting the fact the ACO does not add members after the first of the year. Preliminary results are promising. Recent reports show that we were able to help half of the members that needed help finding a PCP get one. Third, creating a needs-based methodology that allows medical practices to identify high-risk people including duals. Despite these changes, analysis by eQHealth continues to demonstrate a decrease in health care utilization.

✓ **Provide Options for Children with Autism Spectrum Disorder to Get Services in Vermont**

DVHA collaborated with two hospitals, addressing their concerns and resulting providing acute mental health stabilization services for children with Autism Spectrum disorder (a service that is not available in Vermont). Both the new providers offer extensive aftercare planning and training for families in the what to do once their child is released from the hospital. Additionally, one of the providers offers inpatient stabilization services for children without a diagnosis of ASD. Previously there was only one hospital in Vermont providing mental health stabilization for children.

✓ **Collaborated Across AHS to Reduce Mental Health Stabilization Wait Times**

DVHA worked with the Department of Mental Health and Department of Children and Families to facilitate more rapid placement for individuals awaiting mental health stabilization services. In addition, this cross-agency planning team conducted weekly meetings to jointly review cases with the

Brattleboro Retreat to Address disposition challenges. In the coming year, the team will track progress toward their goals of 1) reducing the number of days individuals wait in hospital emergency rooms for placement, and 2) ensuring individuals who are inpatient can transition back into the community at the appropriate time, potentially reducing the total number of inpatient days and improving access for services to others.

### ✓ Updated Lock-In Program to Serve Members and Taxpayers Better

This year, the Lock-in program shifted from simply a mechanism to prevent fraud, waste, and abuse to providing wrap-around supports for recovery. The program, which implemented Team Care, now aims to do more than impose federally mandated restrictions. Vermont's Team Care is ***a care-management program*** for members who may need additional support to focus their healthcare services in a way that could be most beneficial to them. The program intends to identify and help to address unmet healthcare and substance use disorder treatment needs, support access to well-coordinated primary and specialty care, and prevent misuse and abuse of regulated medications. Clear criteria were established and adopted for members enrolling in Team Care and a protocol for disenrollment once stabilization is achieved. For members in recovery from addictions, the Team Care Program may be a valuable tool in supporting those members' recovery efforts. Each member's case is now evaluated on a case-by-case basis. Members needs are assessed, and referrals are made to the Vermont Chronic Care Initiative to support individuals in accessing services necessary supports for stabilization and recovery.

### ✓ Improved Access to Substance Use Disorder (SUD) treatments

DVHA modified the PA criteria for Suboxone Film for the Spokes by eliminating prior authorization for doses 16mg or lower to improve access to treatment and lower provider burden for PA submissions. This resulted in an average reduction of 2500 PA's per month, overall a 17% reduction in PA volume. In addition, DVHA aligned Hub and Spoke coverage by adding Buprenorphine/Naloxone tablets, and buprenorphine depot injection (Sublocade®) to the available collection of resources for all authorized prescribers in the Hubs and aligned the PA criteria between Hubs and Spokes for those drugs.

### ✓ Improved Access to Hepatitis C Treatments

In January 2018, DVHA removed the requirement that patients must have a certain level of liver disease (by determining a patient's liver fibrosis score) to be eligible for Direct Acting Antiviral (DAA) drugs. In addition, the requirement for six months of sobriety was removed. These changes opened the door for broader access to treatment for Hepatitis C infected patients. For most patients, DAA's represent a cure for Hepatitis C. These drugs are a focus of pharmacy medication management services to facilitate adherence and follow up to enable the best clinical outcomes. The average number of patients treated per month increased from 33 in 2017 to 63 through September of 2018.

### ✓ Expanded Prenatal and Post-Partum Coverage for New Mothers

DVHA made the following changes to Vermont's Medicaid program to ensure Medicaid mothers had access to the same breastfeeding and parenting services and benefits afforded to Vermont women with commercial coverage, specifically:

- Medicaid expanded its coverage of electric breast pumps to include personal use double electric breast pumps for new mothers who anticipate being separated from their infant on a

regular basis. Previously, Medicaid coverage was limited to hospital grade electric breast pump rentals when medically necessary.

- Medicaid expanded its coverage of lactation services to include in-home lactation consulting services. Previously, Medicaid coverage was limited to lactation services provided only in an office setting.
- Medicaid increased reimbursement for childbirth education classes to address access issues Medicaid parents were experiencing.

## Improve Operations

### ✓ Expanded Use of Key Performance Indicator Scorecards

DVHA continued to refine each unit's performance measures to quantify the culture of continual improvement and track progress over time. Units report goals and monthly metrics related to key performance indicators, share the information in public scorecards, and increasingly use data to assess performance and make business decisions. Scorecards can be found in Appendix C.

### ✓ Streamlined Administration

DVHA created an Administrative Services Unit to streamline and improve operations. First steps focused on documenting business processes and identifying best practices to support program staff and management efficiency. The unit has implemented these practices along with organizational development efforts, activities to improve DVHA's culture, and launched a new DVHA intranet to improve communication across the department.

### ✓ Fostered Business Cohesion through Co-location

DVHA brought three large units to the Waterbury State Office Complex, Program Integrity, Oversight and Monitoring, and the Division of Rate Setting. More units are set to move from Williston to Waterbury in February. DVHA will continue to seek opportunities to move staff to Waterbury and those within the Waterbury State Office Complex closer to DVHA's main office space.

### ✓ Created Structure to Align Authority and Accountability

Understanding that clear lines of authority and accountability are necessary to promote performance and innovation, DVHA developed a Change Management Operations Structure. Three Change Management positions were transferred to DVHA to continue their work in Integrated Eligibility project and Medicaid Management Information System, and DVHA developed an organizational structure and identified roles and responsibilities.

### ✓ Promoted Additional Transparency and Performance in Claims Processing with DXC

DXC and DVHA developed a service level dashboard that is reported on monthly. There are currently 45 SLAs that are monitored and reported on monthly. Examples of service levels measured are the following: (1) notify the state within two business days of the discovery of overpayment, duplicates, or incorrect payments. (2) Adjudicate 90% of clean claims within 90 days of receipt, excluding drug claims. (3) Maintain 1% or less error rate on all reference file updates applied. DXC is meeting more than 90% of these SLAs.

### ✓ Promoted Transparency and Performance in Transportation Services

In 2018, Provider Member Relations (PMR) worked with the Vermont Public Transit Authority (VPTA) to come into compliance with the reporting guidelines of the contract for Nonemergency

Transportation Services (NEMT). PMR collaborated with VPTA and its members, conducting "Road Shows" with the VPTA subcontractors to outline expectations of working with DVHA and the requirements of reports needed. Over the last six months of 2018, VPTA has shown vast improvement in meeting the expectation of DVHA and servicing our members.

### ✓ Designed New Timely Filing Guidelines

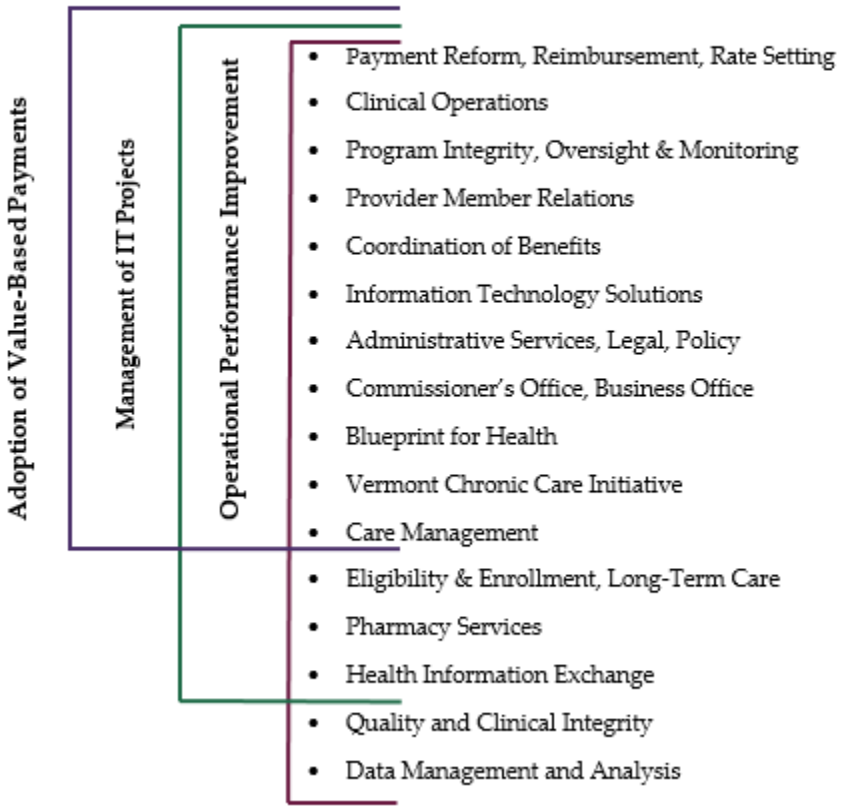
The Reimbursement Unit, in partnership with other units, created new guidelines to assure compliance with federal timely filing requirements. Developed an internal review process to identify claims outside the filing limits that couldn't be paid with Medicaid funds. Worked with DXC to ensure this could be implemented and identified within their system. Caught up outstanding timely filing reconsideration packets and completed the review of timely filing reconsideration requests within our metric of 80 % completed within 15 business days of receipt. The change in timing filing requirements will be rolled out to providers in early 2019.

### ✓ Reduced Administrative Burden for Mental Health Inpatient Stabilization

When a member is experiencing a mental health crisis, it can often be difficult for a provider to get a full clinical assessment and generate a plan of that that anticipates an appropriate length of stay within 24 hours of admission, the requirement for prior authorization. Recognizing this challenge and the potential role it plays in determining the length of inpatient stays, DVHA piloted with Brattleboro Retreat an automatic authorization for mental health inpatient stays of five days for all members meeting the acute level of care criteria. The new process focuses on helping the provider and member determine a length of treatment that will most benefit the member's health and allows time to assess and formulate an individualized plan of care and discharge plan for each member admitted. As a result of the pilot, data indicate that the average number of days for an inpatient psychiatric stay for adults dropped from seven in 2017 to six in July of 2018, for child psychiatric admits it dropped from 16 to 13, and for detoxification admissions, it dropped from five to four.

# DVHA Priorities

## Organizational Priorities by Unit




## Adoption of Value-Based Payments

The Payment Reform Unit seeks to transition Vermont Medicaid's healthcare revenue model from fee-for-service payments to value-based payments. In support of this goal, the Payment Reform Unit partners with internal and external stakeholders in taking incremental steps toward the integrated healthcare system envisioned by the Vermont All-Payer Accountable Care Organization (ACO) Model agreement with CMS. The Payment Reform Unit also works with providers and provider organizations in testing models, ensuring the models encourage higher quality of care, and are supported by robust monitoring and evaluation plans.

The Payment Reform Unit is available as a resource to DVHA and to other departments within AHS in the consideration of potential payment reform options. The unit is also responsible for the implementation and oversight of the Vermont Medicaid Next Generation (VMNG) ACO program, a financial model designed to support and empower the clinical and operational capabilities of the ACO provider network in support of the Triple Aim of better care, better health and lower costs.

During the next year, the Medicaid Payment Reform team will continue to oversee the implementation, evaluation, and evolution of the VMNG program; and will provide support to department and agency leadership in the consideration of and planning for any additional value-based

payment reform models to support continued advancement toward an integrated healthcare system in Vermont.

### Accountable Care

In 2017, DVHA began to test a voluntary pilot program, the VMNG ACO program, which prioritizes paying for the quality of care for each Vermonter rather than the quantity of services delivered. The model is focused on prevention, empowering primary care providers, and coordinating care. It does so through ACOs, which are provider-led and -governed organizations, with a substantial regional clinical leadership role, that have agreed to assume accountability for the quality, cost, and experience of care. The goal of the pilot is to improve health while moderating healthcare costs; which are a barrier to affordability. The VMNG ACO program pursues this goal by taking the next step in transitioning the healthcare revenue model from Fee-for-Service payments to Value-Based payments. One ACO, OneCare Vermont, is currently working with the State to participate in this model. In its first year (2017), OneCare's Medicaid pilot included four hospital communities made up of approximately 2,000 providers and around 29,000 attributed Medicaid members. In calendar year 2018, ten communities participated, including more than 5,000 unique providers and approximately 42,000 attributed Medicaid members. In calendar year 2019, thirteen communities are participating, and the number of attributed Medicaid members is approximately 79,000.

In OneCare Vermont's 2018 Medicaid pilot there were ten hospital communities with approximately 5,000 providers and 42,000 Medicaid members.

Through the VMNG, DVHA (through DXC Technologies) pays OneCare a monthly fixed prospective payment (FPP) for services provided by hospitals (and hospital-owned practices) participating with the ACO. This is a monthly, per member payment made in advance of the services being performed. Medicaid fee-for-service payments continue for all other non-hospital providers in the ACO, for all providers who are not a part of the ACO, and for all services that are not included in the fixed prospective payment. As OneCare providers are still required to submit claims for all services, zero-paid "shadow claims" are used to calculate the cost of services delivered (according to the Medicaid fee-for-service fee schedule) that were covered by the prospective payment from DVHA to OneCare. In addition, OneCare 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 (104% in 2019); if the ACO spends less than its target, it may retain savings to 97% of the target (96% in 2019). This arrangement provides an incentive to use resources efficiently. Because the ACO is responsible for both the cost and quality of care for each attributed member, OneCare will also withhold some of the payment to providers up front—0.5% in 2017, 1.5% in 2018, and 2% in 2019 —to support a quality incentive program. The providers in the ACO can earn this money back through high quality performance on targeted quality measures. This type of payment incentive is provided to encourage high quality care and is expected to grow over time.

In September of 2018, DVHA published the results of the 2017 performance year.[10] The 2017 program results indicate enough, incremental progress that warrants cautious optimism and a continued commitment to the program. A summary of these results is presented below.

**Result 1: DVHA and One Care launched the program successfully.**

- In 2016, DVHA issued a Request for Proposals (RFP) for a new ACO program based on Medicare's "Next Generation" ACO Program. OneCare Vermont was selected as the Apparently Successful Bidder.
- DVHA conducted a readiness review before the launch of the 2017 program year. OneCare Vermont satisfied most requirements before January 1, 2017 and completed all outstanding Readiness Review items prior to the end of the first quarter of 2017.
- DVHA worked with DXC Technologies to change Medicaid payment systems to make fixed prospective payments to OneCare Vermont.
- Processes for ongoing data exchange between DVHA and OneCare have been implemented and are regularly evaluated for potential improvements.
- DVHA and OneCare prepare and maintain an operational timeline to ensure contractually required data sharing and reporting occurs promptly.
- OneCare and DVHA have established a forum for convening operational teams on a weekly basis, and for convening subject matter experts monthly. These forums have allowed the teams to identify, discuss, and resolve multiple operational challenges, and have resulted in several process improvements to date.
- DVHA and OneCare have worked together to monitor and report on program performance on a quarterly basis.

[10] https://legislature.vermont.gov/assets/Legislative-Reports/VMNG-2017-Report-FINAL-09-20-18.pdf

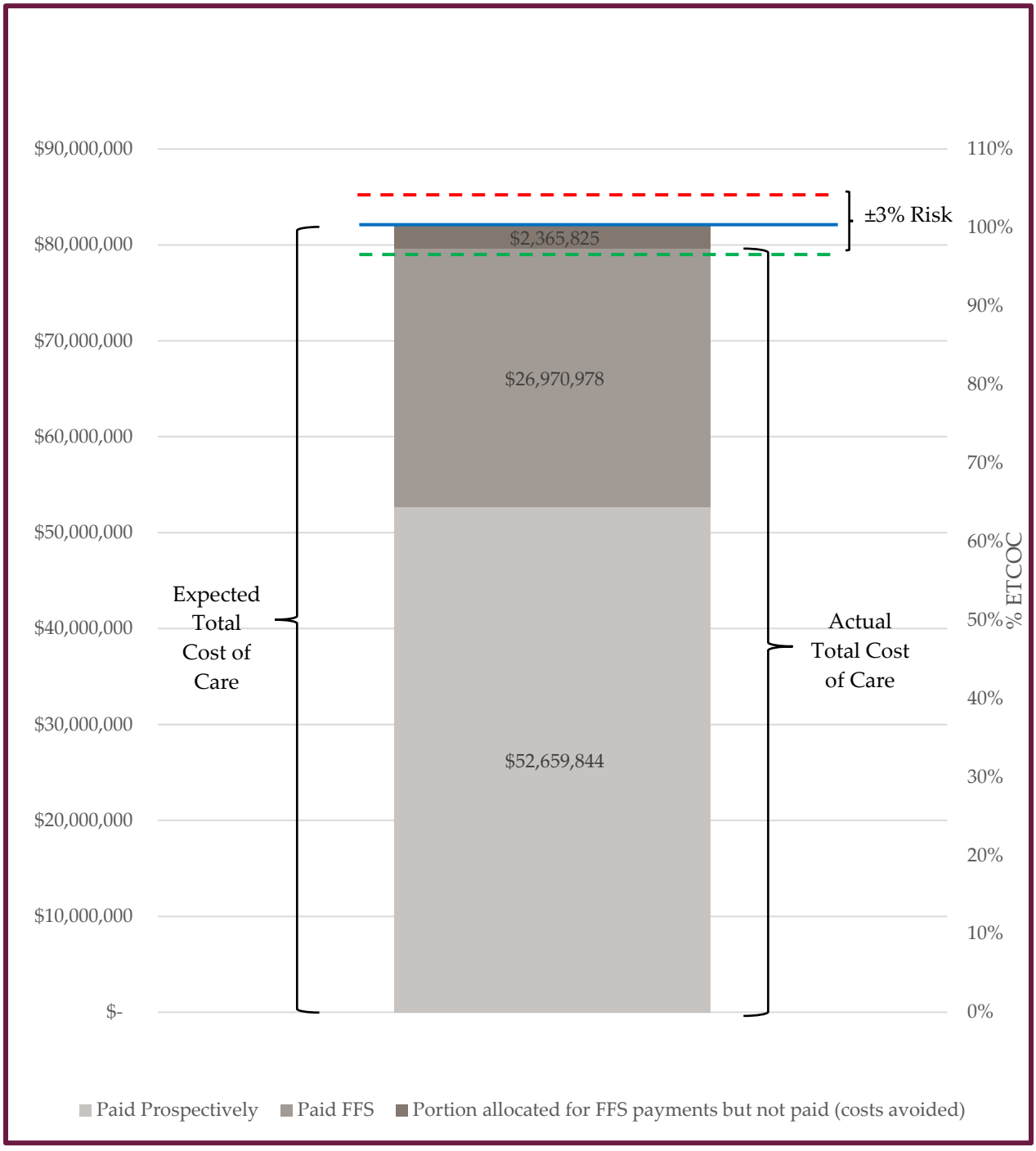
**Result 2: The program is growing.**

Additional providers and communities have joined the ACO network to participate in the program for the 2018 performance year, and more are expected to do so for the 2019 performance year.

**Result 3: The ACO program spent less than expected on health care in 2017.**

DVHA and the ACO agreed on the price of health care upfront, and the ACO spent approximately $2.4 million less than the expected price (see chart below). Financial performance was within the ±3% risk corridor, which means that OneCare Vermont and its members are entitled to save those dollars.

## 2017 VMNG Financial Performance within Expected Total Cost of Care



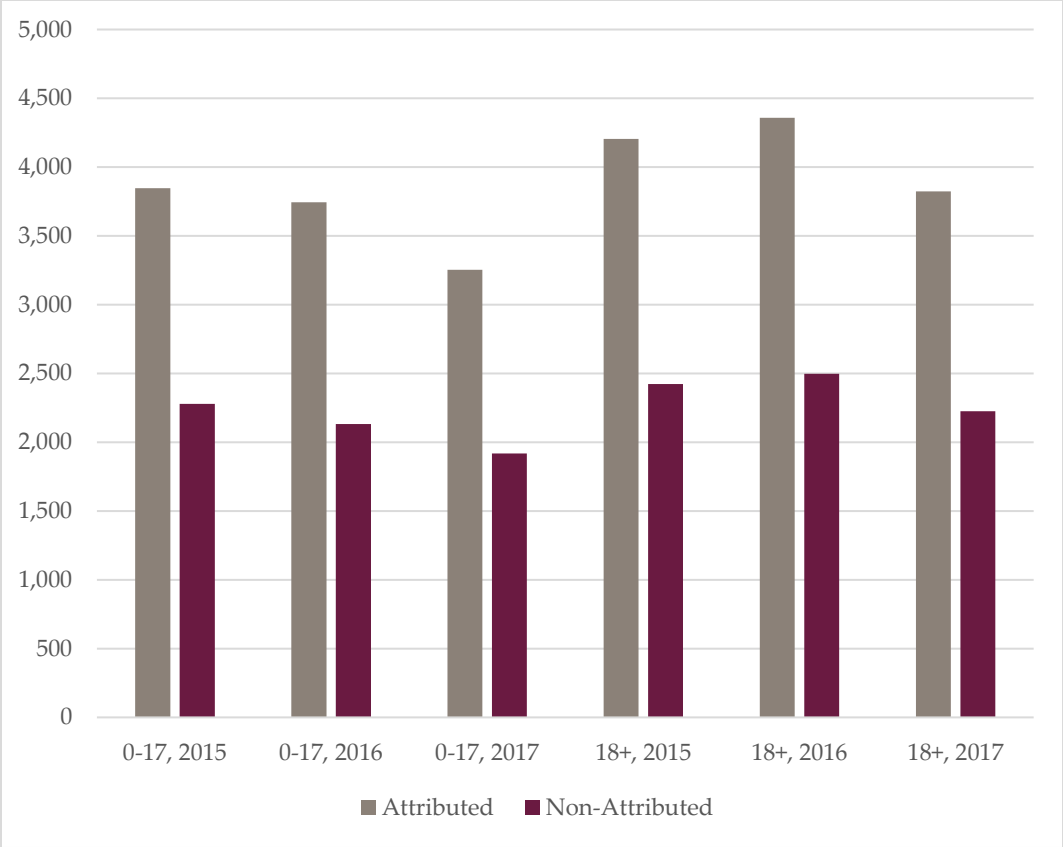

**Result 4: The ACO met most of its quality targets.**

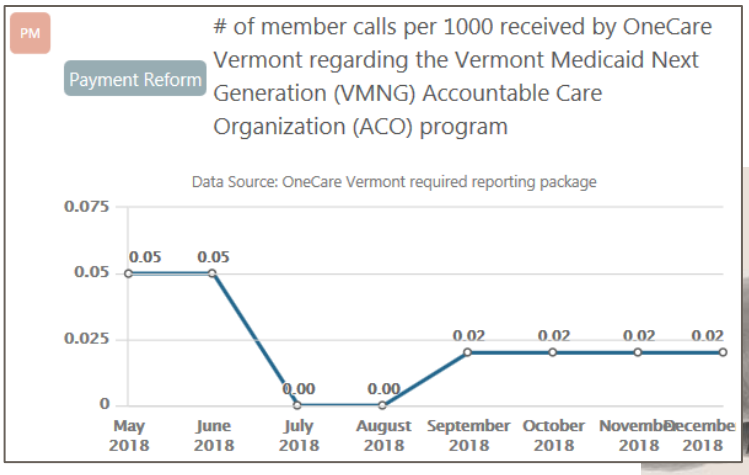
The ACO's quality score was 85% on ten pre-selected measures. Notably, OneCare's performance exceeded the national 75th percentile on measures relating to diabetes control and engagement with alcohol and drug dependence treatment. Examining quality trends over time will be important to understand the impact of changing provider payment on quality of care.

**Result 5: DVHA is seeing more use of primary care among ACO-attributed Medicaid members.**

Based on preliminary analyses of utilization, the cohort of attributed members has had higher utilization of primary care office-visits than the cohort of members who are eligible for attribution but not attributed (see chart below). As further information about utilization becomes available, DVHA will conduct more robust analyses to determine whether differences between cohorts are statistically significant, and to understand the impact of the program on utilization patterns over time.

### Primary Care Visits Per 1,000 Member Years by Age and Year



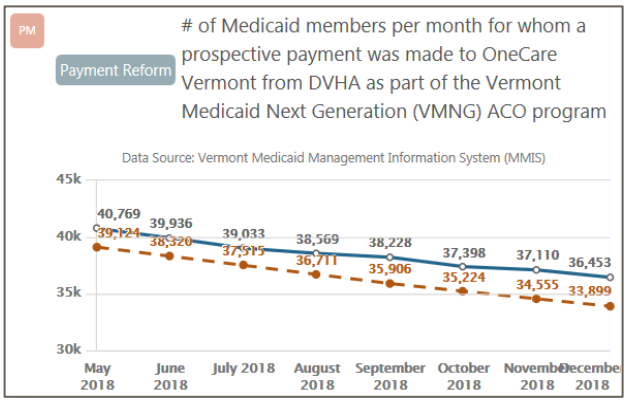



The 2017 and 2018 pilot years have served as a valuable learning experience

both internally at DVHA, and externally in its partnership with OneCare. Though the Payment Reform Unit is the designated contract monitor for the ACO program, coordination across the department in several functional areas is crucial to the program's success. Subject matter experts throughout DVHA review required reports from the ACO which monitor its quality improvement, clinical, financial, provider/member communications, and care management data, to ensure alignment with the department's goals of high-quality care for its members. Externally, DVHA and OneCare have developed a collaborative partnership in support of program implementation and oversight. Regular meetings between DVHA and OneCare operational teams have ensured that a continuous feedback mechanism is in place, giving staff the ability to make operational adjustments as needed. As a result, VMNG program operations have become further streamlined over the course of the year. Ongoing coordination between DVHA and OneCare will be required to maintain and optimize operations in a second performance year.

As the program continues into a third performance year, more data will be available to support meaningful evaluation of both quality and financial performance. DVHA will continue to analyze the financial, clinical, and quality performance of the program to evaluate its efficacy and to determine whether the ACO program generally, and the fixed prospective payments to hospitals specifically, are contributing to an overall moderation in DVHA healthcare spending.

The table below shows monthly changes in attribution of Medicaid members in the 2018 VMNG Program. Attributed Medicaid members are defined as number of individuals for whom a monthly prospective payment was made.



### Medicaid Members Attributed to OneCare for the 2018 VMNG Program

| *Attributed Medicaid Members** | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of 42,342 | 100% | 99.20% | 98.12% | 97.23% | 96.29% | 94.32% | 92.19% | 91.09% | 90.28% | 88.32% | 87.64% | 86.09% |
| Total | 42,342 | 42,005 | 41,545 | 41,169 | 40,769 | 39,936 | 39,033 | 38,569 | 38,228 | 37,398 | 37,110 | 36,453 |
| Aged, Blind, Disabled | 2,757 | 2,705 | 2,686 | 2,632 | 2,613 | 2,607 | 2,587 | 2,578 | 2,571 | 2,562 | 2,547 | 2,560 |
| General Adult | 18,097 | 18,006 | 17,769 | 17,609 | 17,422 | 16,929 | 16,431 | 16,168 | 15,972 | 15,411 | 15,286 | 14,900 |
| General Child | 21,488 | 21,294 | 21,090 | 20,928 | 20,734 | 20,400 | 20,015 | 19,823 | 19,685 | 19,425 | 19,277 | 18,993 |

Attribution of Medicaid members to the ACO occurs prospectively, at the start of the program year. In this way, the ACO is aware of the full population for which it is accountable at the program's outset and can use that information to identify and engage members most effectively. Although no members can be added during a program year, some of the prospectively attributed members may become ineligible for attribution during the program year. Members may become ineligible for attribution due to:

- Becoming ineligible for Medicaid coverage[11]
- Switching to a limited Medicaid benefits package (e.g. pharmacy-only benefits)
- Gaining additional sources of insurance coverage (e.g. commercial or Medicare)
- Death

[11]If a member has lost Medicaid coverage but later becomes eligible for Medicaid again during the performance year, they may also become eligible for attribution again at the time.

### Cross-Agency Payment Reform Projects

During the term of the Vermont All-Payer ACO Model agreement, the State will evolve and expand ACO-based reform and develop payment reform projects that impact other Medicaid-covered services (including, but not limited to, mental health services, substance use disorder treatment services, and long-term services and supports) through partnerships between departments within AHS. The State will place emphasis on program evolution or development that ensures State compliance with the provisions of the All-Payer ACO Model related to achieving scale targets and on planning for the expansion of value-based payment arrangements to include providers and suppliers of additional Medicaid services beyond 2020.

In addition to the Vermont All-Payer ACO Model agreement, Vermont's Global Commitment to Health 1115 Waiver further supports the development of alternative payments for Medicaid providers and services. One of Vermont's key strategies for improving the health status of all Vermonters through implementation of the waiver is "promoting delivery system reform through value-based payment models and alignment across public payers."[12] Within the last year, the Payment Reform unit has begun working with several departments within AHS to contemplate new payment reform projects that would align with Vermont's All-Payer ACO Model agreement and would advance implementation of Vermont's Global Commitment to Health waiver. Models under consideration for future implementation are described in the below table.

[12]http://dvha.vermont.gov/global-commitment-to-health/vt-1115-extension-waivers-exp-author-stcs-techncial-corrections-no-track-changes06212017.pdf

| Project | Model Under Discussion | Potential Impact |
|---|---|---|
| **Applied Behavior Analysis [Department of Vermont Health Access]** | -Prospective monthly bundled payment<br>-Flexibility in payment levels based on total hours in an individual's care plan<br>-Adoption of standardized assessment (begin measurement of progress toward outcomes)<br>-DVHA staff conducting site visits & record review | -Moves away from fee-for-service reimbursement<br>-Gives providers payment predictability and flexibility in service delivery<br>-Establishes monitoring framework that could be used to pay for outcomes in future |
| **Children's and Adult Mental Health [Department of Mental Health]** | -Monthly per person case rate<br>-Based on average monthly case load, not attribution of fixed population<br>-Introduction of quality performance incentive payments (pay for reporting, pay for performance) | -Consolidation of historically program-specific funding streams paid to designated mental health agencies for adult mental health services<br>-Gives providers payment predictability and flexibility in service delivery<br>-Develops a multi-year framework for paying providers based on quality |
| **Residential Substance Use Disorder Programs [Division of Alcohol and Drug Abuse Programs]** | -Bundled payment per residential stay<br>-Variation in payment based on primary SUD diagnosis on admission<br>-Introduction of quality performance measures<br>-ADAP staff conducting site visits & record review | -Moves away from fee-for-service (per diem) reimbursement<br>-Gives providers payment predictability and flexibility in service delivery<br>-Develops a multi-year framework for paying providers based on quality |
| **Developmental Disability Services [Department of Disabilities, Aging, and Independent Living]** | -Payment model options under discussion; to be informed by rate study currently in process | -Develops a revised service delivery and payment model for disability services that is based on data, easy to understand, and transparent regarding the services for which payments are made<br>-Ensures accountability between DAIL and providers without destabilizing the developmental disabilities system of care |
| **Pediatric Palliative Care [Vermont Department of Health]** | -Payment model options under discussion | -Moves away from fee-for-service reimbursement<br>-Gives providers payment predictability and flexibility in service delivery<br>-Establishes monitoring framework that could be used to pay for outcomes in future |

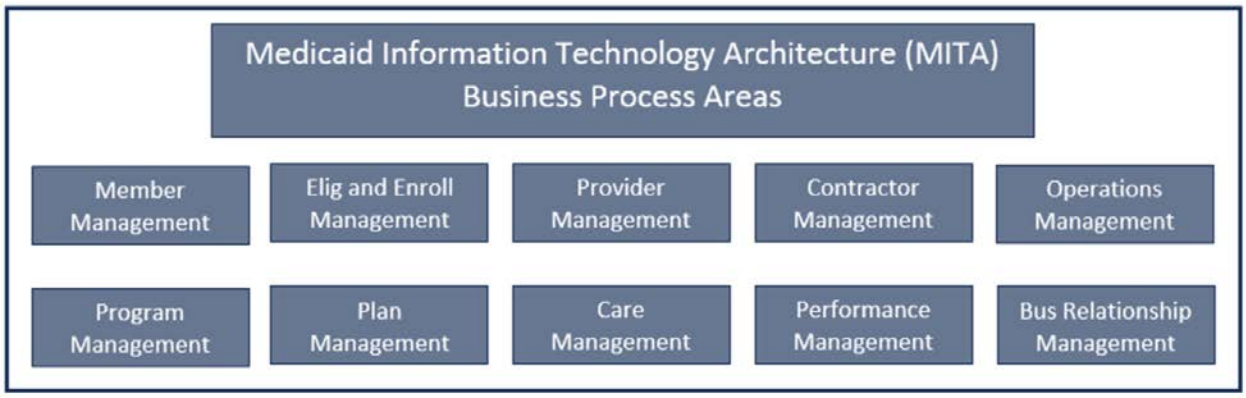
## Management of IT Projects

### MMIS Program

The Medicaid Management Information System (MMIS Program) is one of several programs in the Agency of Human Services (AHS) Information Technology (IT) Portfolio involved with upgrading the State's technological infrastructure for Medicaid and other benefit programs. The MMIS Program consists of projects to respond to Federal and State mandates and Agency goals and to modernize Vermont's Medicaid systems that deliver health care provider solutions and payment capabilities.

Vermont's MMIS Program is leveraging innovative technologies to help AHS administer the Medicaid program and serve Vermonters in the most time efficient, secure and integrated manner. Projects are executed using IT Project Management best practices and are evaluated for alignment with scope, schedule and budget. The Centers for Medicare and Medicaid Services (CMS), Vermont's Federal

Medicaid partner, has established a Medicaid Information Technology Architecture (MITA) framework of Business Process Areas with capabilities and services that support business needs. All these areas are potential opportunities for IT system improvements.




The enhanced MMIS will efficiently and securely share appropriate data with Vermont agencies, providers, and other stakeholders involved in a member's case and care. Guiding principles are to:

- Align with the Triple Aim
  - Improve patient experience of care (including quality and satisfaction)
  - Improve the health of populations
  - Reduce the per capita cost of health care
- Improve the customer service experience for health and human services providers and all Vermonters
- Improve the efficiency and effectiveness of Medicaid operations

Early significant initiatives in transforming Vermont's MMIS include:

- The PBM System was completed and has been certified by CMS, which allows DVHA to receive enhanced funding for Maintenance & Operations expenses. This system provides drug claims adjudication, call center operations, utilization management, drug utilization review, benefit design, clinical support, rebate management, reporting and analytics for over 180,000 Medicaid beneficiaries who have pharmacy benefits.
- The Care Management (CM) System is operational for the Vermont Chronic Care Initiative (VCCI) and will be seeking CMS certification in early 2019. This system evaluates the Vermont Medicaid population to identify members most in need of intensive case management and care coordination services. It provides automated support to VCCI staff in all aspects of providing care management services to the most vulnerable Medicaid members.
- The Provider Management Module (PMM) is in the design and development phase, with implementation planned for the first half of 2019. This system will replace the current manually intensive provider eligibility determination, credentialing, and enrollment processes by automating steps in the business process and allowing providers to enter enrollment information online.

- Electronic Visit Verification (EVV) is being developed in response to a CMS mandate, first for Personal Care Services and then for Home Health Care Services. This system will enable home care workers to digitally record information about their visits, including the specific care or services rendered, and to electronically report changes in a patient's condition for follow-up.
- Payer Initiated Eligibility (PIE) is being executed to support sharing eligibility and coverage data that enables identification and collection of payments from liable third parties. The new system will create efficiencies in ensuring Medicaid is the payer of last resort.
- The Electronic Imaging project is underway to digitize large volumes of paper records, beginning with DVHA's Clinical Operations Unit, which is almost complete. Records for the Program Integrity Unit and the Coordination of Benefits Unit will be digitized during the next phases.

MMIS System enhancements are being developed to support Vermont's Payment and Delivery System (PADS) reform initiatives. Enhancements and replacement of additional MMIS modules are being explored and prioritized. Potential projects on the horizon likely will focus on MMIS Operations Management (OM), System Integration (SI), Coordination of Benefits (COB) and Program Integrity (PI). The MMIS Program currently is establishing a Maintenance & Operations (M&O) Unit that will be responsible for successfully transitioning IT projects from design, development and implementation (DDI) to M&O, providing support to the business units that manage the systems, and monitoring vendor compliance during operations.

## MMIS Maintenance & Operations

The Medicaid Management Information System (MMIS) Maintenance & Operations (M&O) Unit is being formed to provide support and oversight for MMIS IT modules that are transitioning or have transitioned from system design, development, and implementation into ongoing operations. The team's primary objectives are to develop consistent internal M&O practices and procedures, create a standardized operational compliance structure for MMIS vendors, and support the business units that rely on these systems to provide services to Vermonters.

While the MMIS M&O team is still being developed, it already is engaged with active modules and vendors. Work is underway to identify consistent practices that will help ensure the successful transition of projects to M&O. Best practices for developing service level requirements are being determined and opportunities for applying the same service level requirements and vendor compliance standards across modules are being identified. Ultimately, the unit will recommend best practice performance standards to include in future MMIS module procurements and vendor contracts. The M&O Unit also will serve as a central point for staff access to information about MMIS system operations.

Introducing consistent operational best practices across MMIS modules will help address one of DVHA's key focus areas: to improve management of Information Technology projects. Monitoring MMIS vendors for compliance and service standards helps protect the significant State and Federal investments made in developing these IT systems and ensures the appropriate spend of tax dollars to maintain them. These systems are key tools for providing Vermonters with continued access to excellent healthcare services and supports, as well as supporting staff, providers, and other stakeholders in efficiently and effectively serving Vermonters.

MMIS Compliance work previously initiated within the Program Integrity Unit will now be performed through the MMIS M&O Unit. The M&O team will ensure the State receives the appropriate financial credit when vendors fail to meet a Service Level Requirement (SLR) and will follow up with the vendors to ensure improvements are in place to prevent future failures. The team will work with vendors to identify and address root causes for ongoing performance challenges and develop process improvements for state requested MMIS changes. These activities ensure that Vermont Medicaid receives quality customer service from its MMIS vendors and prevents unnecessary spending on system changes or solutions that may be accomplished in a more efficient or less costly manner.

### Challenges

As additional MMIS modules are enhanced or replaced and the number of MMIS vendors increases, inconsistent operational practices create unnecessary complexity and inefficiencies in managing vendor performance and conducting compliance oversight. Divergent performance standards and operating expectations contribute to siloed and disconnected MMIS components. Implementing consistent best practices across MMIS operations will contribute to achieving the goal of building an integrated and interoperable MMIS modular system. The transition by active modules toward greater consistency will require changes to existing business processes and therefore may be more gradual than for new modules; consistent operational expectations and standards for new modules ultimately will begin at the procurement stage.

Scorecard measures will be developed concurrent with developing the MMIS M&O Unit and therefore have not yet been identified.

## Integrated Eligibility & Enrollment Projects

The Integrated Eligibility & Enrollment (IE&E Program) is a central program in the Agency of Human Services (AHS) Information Technology (IT) Portfolio involved with upgrading the State's technological infrastructure for member enrollment in both Medicaid and other healthcare benefit programs as well as the State's economic services administered by the Department of Children and Families.

The program envisions a world in which eligible Vermonters have a simple and easy way to apply for, access, and maintain healthcare and financial benefits, without coverage gaps. To achieve this vision, the State must deliver services efficiently and sustainably, using innovative ways of working and modern technology.

### The Challenge

Enrolling members is one of DVHA's three central responsibilities, yet the current enrollment system and processes are problematic for Vermonters, staff, and the State.

Vermonters who apply for benefits also must submit the same information multiple times and deal with different call centers. They can see that there is little to no coordination across programs. The result is wasted time and missed opportunities. They don't always understand what information they need to provide and can't submit personal documentation easily. They face lengthy approval timelines, complex instructions, and have no way to apply for all benefits at once.

State staff also face challenges as they deliver these services. Staff processes tend to be very manual and labor intensive. Staff must memorize complex rules and processes. They also waste time dealing with multiple systems that don't talk to each other.

Finally, the State bears financial risk due to the current systems. First and foremost, the federal government, through the Centers for Medicare and Medicaid Services (CMS), and Vermont have identified areas where the State is out of compliance along with a mitigation plan to bring the State into compliance. Failure to meet CMS's mitigation plan could result in financial penalties and impact Medicaid funding.

In addition, lack of quality data makes it difficult to ensure that the right people are in the right programs, a situation that could lead to extra expense. Hard-to-maintain systems are also expensive to update, vendor-lock reduces the State's negotiating power, and the size and scale of IT contracts make them unlikely to succeed.

### Goals

*The IE&E Program aims to improve the customer experience in the following ways:*

- Provide a united application, determination, and enrollment experience that allows the customer to engage with the State through the channel of their choosing
- Facilitate a simple, user-friendly experience that allows the customer to maintain continuous benefits, services, or health coverage, especially during critical life transitions
- Ensure accurate and timely determination and notification of eligibility
- Deliver clear and concise information throughout the eligibility and enrollment process through the customer's chosen method and language

*An integrated IE&E technology system will also ensure:*

- Staff can serve Vermonters efficiently and effectively by maximizing focus on case management and customer service.
- Vermont can meet federal and state mandates and requirements.
- Improved data integrity and robust access to data for analysis, reporting and modeling.
- Financial integrity in the administration of benefit programs.

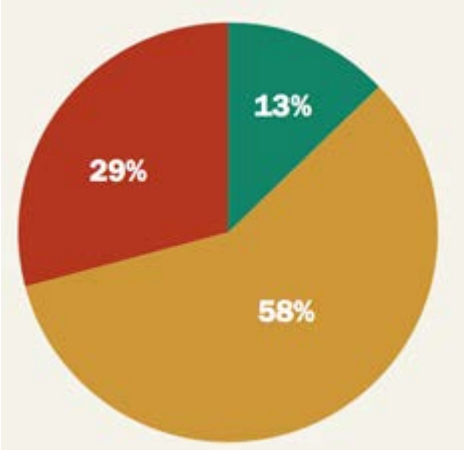
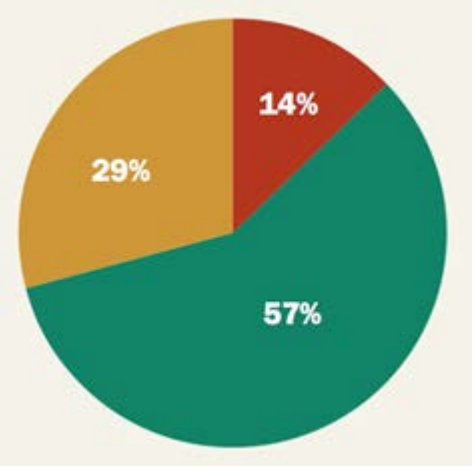
### The IE&E Program Approach

The IE&E Program is committed to putting the needs of the user first. This means taking the time to engage the Vermonters who use services, letting program staff lead, and ensuring that developers understand the problems that need to be solved before building a solution.

The IE&E Program also commits to taking smaller financial risks by breaking up large technology projects into small, manageable chunks that deliver clear value to the end user. This approach allows the IE&E Program to find the best vendor to fill a specific need without getting locked into big, ongoing contracts.

The table below provides evidence for the success of this approach by comparing large government projects versus smaller government projects.

**Smaller IT Projects Have a Much Higher Success Rate**

| Large Government Projects | Small Government Projects |
|---|---|
|  |  |



Source: The Standish Group's CHAOS database. Large is defined as labor cost >5 million euros or $6 million. Small is defined as labor costs less than $1 million (or euros). Successful (green) projects are on time, on budget, and on target. Challenged (yellow) projects are late, over budget, and/or have an unsatisfactory target. Failed (red) projects were either canceled before completion or not used after implementation.

Finally, the IE&E Program utilizes an Agile development methodology, which enables us to be nimbler as we make decisions and to course-correct as we go, resulting in a greater opportunity to achieve our desired outcomes. This incremental approach to delivering value to users, with their needs driving decisions, is a bottom-up instead of top-down mindset.

### New Ways of Working

"New ways of working" does not just refer to updating systems built long ago. It means that we are rethinking every aspect of our work and looking for opportunities to improve. This includes product management, risk mitigation, staffing, procurement, development methods, technology choices, oversight response, design, user engagement, vendor management, and more.

The IE&E Program has already benefited from these new ways of working efforts in terms of meeting delivery schedule, budgets, and quality of results. The Agency of Human Services and Agency of Digital Services seek to share these lessons throughout the rest of their work, and the rest of state government, wherever possible.

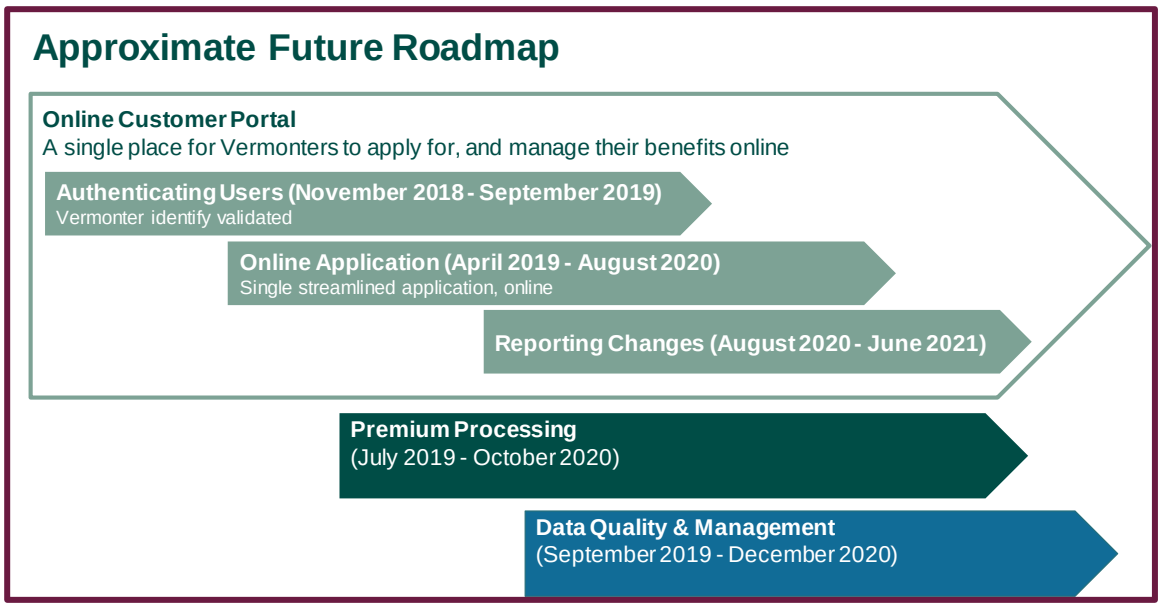
### Technical Principles

The IE&E Program follows nine technical principles:

- Build using Agile and iterative practices to deliver value frequently and incrementally

- Default to Open
- Default to Cloud
- Default to open standards and formats to maximize extensibility and interoperability
- Own and manage our data and business rules
- Choose emergent architecture over 'big up-front design'
- Favor small components and loosely-coupled parts
- Automate testing and deployments
- Value experimentation and innovation

## Product Roadmap

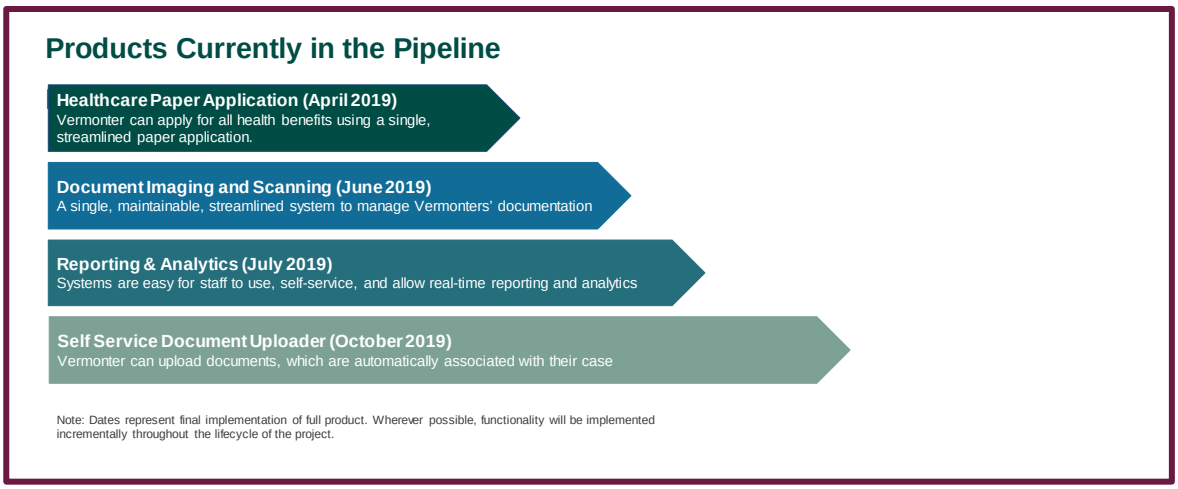



The IE&E Program's delivery plan uses each individual product development to move the program forward in achieving its high-level goals while also providing incremental benefits. The products are developed, tested, and launched with a focus on value proposition, key stakeholders, program promises, and key performance indicators (KPIs).

It is important to understand that the State's roadmap will evolve over time as new information/experience is gained and the marketplace evolves. The products evolve as the users provide feedback and the long-range roadmap evolves as new technologies and other opportunities unfold and the needs of members and staff are clarified.

## Products Currently in the Pipeline

The IE&E Program currently has four products in development and scheduled for release in late SFY 2019 and early SFY 2020.




## Healthcare Paper Application

- Problem: Healthcare paper applications contain essential information needed for staff to process health benefit eligibility determinations decisions. Currently, paper application forms are out of compliance with the Federal mandate to have a single application for all MAGI and non-MAGI healthcare programs. Additionally, the forms do not comply with plain language requirements, making it harder for applicants to complete the application correctly, often leading to requests for additional information which in turn causes processing delays.

- Vision: A newly designed paper application, branded with Vermont logo and colors, that is easy for applicants to complete, enables full healthcare screening for both MAGI and non-MAGI based eligibility determinations, collects information needed for efficient and accurate eligibility decisions, and reduces data entry and processing time for staff.

## Document Imaging and Scanning

- Problem: Currently, Vermont eligibility and enrollment staff utilize two enterprise content management (ECM) systems for scanning, indexing, workflow and viewing Vermonters' documentation and notices. This leads to operational inefficiencies, unnecessary maintenance & operations costs, and difficulty coordinating enrollee documentation across programs.

- Vision: To utilize one system to scan, index, manage workflow, and view Vermonters' documentation and notices. By utilizing only one system, ECM will create a streamlined experience and process for staff that is user-friendly and more efficient for the State to maintain. Training, documentation, and processes will be easier and faster resulting in less waste and improved quality.

## Reporting and Analytics

- Problem: The current reporting system used by Vermont Health Connect (VHC) is expensive, complicated, and does not perform to our standards. It requires outside contractor expertise to support and is manually intensive and time consuming for State staff to maintain. It also

means that VHC data is housed separately from the rest of IE&E Program data, which is in Microsoft SQL Server.

- Vision: To align data storage and reporting for MAGI health coverage programs with the other in-scope benefit programs for IE&E, by migrating the data from the OBIEE data warehouse to Microsoft SQL Server. The new system will be easier for staff to use, enable self-service, and allow for real-time reporting and analytics. It will also be more affordable and enable in-house State of Vermont expertise to sustain support and maintenance of the solution.

### Self Service Document Uploader

- Problem: Vermonters find satisfying verification requirements to be a challenging, time-consuming, and frustrating experience. For staff, verifying Vermonters' income (and other requirements) routinely involves delays, stressful conversations, and duplicative work. Mail and paper slow the entire process from initial notification, to mailing documents, to scanning and indexing. Internal staff wait for Vermonters' submission of required documentation such as pay stubs, employment forms, or attestations to process applications or changes, which lengthens the eligibility determination process.

- Vision: To make it easier for Vermonters to submit- and staff to process- manual verification documentation. We will implement a technical solution which allows Vermonters to utilize mobile and online technology to submit verification documents and to automate the classification of these documents. This solution will improve the efficiency of the eligibility determination process and result in a better customer experience for Vermonters.

## Operational Performance Improvement

### Results-based Accountability

DVHA's third priority, operational performance improvement, relates to every unit and every staff member. In addition to striving for business efficiencies, DVHA has implemented results-based accountability (RBA) principles and tools to provide structure to the organization's commitment. Along with other departments in the Agency of Human Services, DVHA uses Clear Impact Scorecard, an RBA-based strategy management and collaboration support software that facilitates data charting, project management, and public communication of results.

Each of DVHA's units identified key performance indicators (KPI) with an emphasis on their aspect of DVHA's work to enroll members, pay for care, and promote health. Over the last year, DVHA continued to refine each unit's goals and metrics to chart progress over time and find opportunities for improvement. Units report goals and monthly metrics related to KPIs, share the information in public scorecards, and increasingly use data to assess performance and make business decisions. Scorecards can be found in Appendix C of the DVHA Annual Report.