Medicaid & Exchange Advisory Board
Meeting Minutes
January 23, 2017

Board Members Present: Donna Sutton Fay, Bram Kleppner, Lisa Maynes, Paul Bakeman, Sharon Henault (phone). Mike Fisher (Healthcare Advocate) Erin McIntyre, Laura Pelosi, Julie Tessler, Amy Vaughan (phone), Kay Van Woert, Rebecca Heintz, Joan Lavoie, Vaughn Collins, Michelle Fay (phone), Dale Hackett (phone), Christina Colombe (phone), Nate Waite
Board Members Absent: Lila Richardson, Sharon Winn, Gladys Konstantin, Jessa Barnard and Clifton Long.
Other Interested Parties Present: Sherry Greifzu (ACHHH), Betty Morse, Bill Lambrukos, and Susan Gretkowski (MVP, phone).
Staff Present: Department of Vermont Health Access (DVHA): Commissioner Cory Gustafson, Deputy Commissioner Lori Collins, i, Deputy Commissioner Michael Costa, Amy Simons Cassandra Gekas, Betty Morse (VDH)

HANDOUTS
- Agenda

*all are posted to the VHC website

CONVENE
Donna Sutton Fay and Bram Kleppner chaired the meeting.

Welcome/Introductions/Approval of Minutes
Board members and meeting attendees introduced themselves around the room. The minutes from the November meeting were not available for review and approval.

Introductions – Cory Gustafson, DVHA Commissioner

Cory Gustafson introduced himself to the group as the new Commissioner of DVHA. Last couple of roles were involved in the healthcare system, through the lens of legislative process and policy, not so much politics. Last job was with Blue Cross Blue Shield of VT as Director of Legislative Government Relations. Prior to that was in a legislative role with VT Association of Hospitals and Healthcare Systems. Looked at healthcare systems from different angles. Provided personal background (competitive former athlete, played hockey, lived in Canada, Germany and the US). Having lived in different places and worked in different areas of healthcare, come with this idea that things can be done differently, always multiple ways that things can get done. Come from a place where team is very important. Sees everyone at this table as part of the team, what's important along with communication is the idea that we are all open to each other's ideas. Commissioner is here to be part of your team. Advisory board has a very important role, it guides the work of DVHA, take that very seriously. This is the Commissioner's first meeting. He needs to meet with Donna and Bram and come to a place that even if we aren't all in perfect agreement that we are going to get the most out of this time (technical issues aside). If better communication is needed, we will do better going forward (i.e. on the agenda). If we communicate better between the Commissioner's office and the Board's Chairs, then I think the agendas will be better going forward. Open and looking forward to relationships with everyone on the board going forward. Mission of DVHA hasn't changed. Looking to best serve all our members benefiting from the programs and the VT taxpayers that fund these programs. The

goals of both groups will collide from time to time and this group has to guide us on how we are going to approach that collision of priorities. Overall the mission doesn't change, it's just how we do our work. Successful teams get where we are going, if we know where we want to get to and we all agree on how we're going to do it the decisions become a lot clearer, the values that we want to hold to make those decisions, integrity, transparency, service, those are some of the values that have been discussed all the way up to the Agency level. Getting us all processing the issues that come before us here with the same sorts of values and goals and perspectives that will help our work be effective.

Commissioner needs to leave at 10:30 for another commitment. Really wants to be present for the MEAB meetings in their entirety going forward. Request related to the EPSTD Update, that it be moved up in the agenda. Not likely to have a long budget update due to timing of Governor's budget address 1/24/17.

Vermont Health Connect – Cassandra Madison (Gekas)

Provided slide deck with VHC update to the group. Updated group on her new last name (Gekas is now Madison). Provided quarterly update. Presentation framed around DVHA's Eligibility and Enrollment unit. VHC is one piece of what we do in serving enrollees in MAGI Medicaid and Qualified Health Plans, we also serve those enrolled in the MABD population as a part of our larger operational unit. Not everyone goes through the actual VHC system.

Status of Health Access and Affordability in Vermont
Presented updates based on some studies that have come out regarding uninsured in Vermont.

National Center for Health Statistics – uninsured rate continues to fall across all age groups and income levels. VT is #2 in nation just behind Massachusetts. VT's 18-64-year-old uninsured rate was cut by more than half from 2014-2015. **Question:** Do you know what the definitions of near poor, poor and not poor are on that first graph is? **Answer:** We can get that for you.

State Health Access Data Assistance Center has VT at #1 in terms of insuring children and really looked at the gains made at insuring lower and middle income children, less than 2% uninsured rate. **Questions:** Do you know how many of 2% are off at any moment, but are cycling on and off but are known at any given moment? **Answer:** No but we need to have a discussion about churn. Everyday working on how to get better data, as we get more people consolidated into one system, tracking that data becomes easier but I don't have that specifically to the uninsured rate but it's a good place for us to focus in terms of data.

Commonwealth Fund – Looked at uninsured rates for working-age adults, placed VT at #1 for health access and affordability. **Can provide you information on how they are defining health access and affordability**. The trend is one that is mirrored in the other two studies – consistent improvement no matter where we are in the rank, we are continuing to improve over the past few years.

Goals and Results
Presented updates on four major goals.

1.) Complete the first annual cycle of Medicaid redeterminations and improve efficiency of future cycles. Included both MABD and MCA renewals. Successfully completed full annual redetermination cycle.
    a. MABD renewals restarted October 2015. First annual cycle completed, now processing normal renewals monthly.
    b. MCA on average are completing 9,000 renewals per month. The population varies a little bit, every time someone responds it puts them on a 12-month schedule from the time they were renewed so the actual population renewed each month can fluctuate between 3,000 to 9,000 per month. Will have completed the full cycle renewal for this population by the end of January 2017. Will do first round of closures for those individuals that were renewed in the last month of that 12-month cycle. **Question:** Do you have #s of how many people lapsed in their renewals? **Answer:** We do, we have data on response rates that we can bring if that's something folks are interested in. This is a place where it can get a little tricky with data. People are considered renewals if they come in during their renewal window. They may not, they may come in 3 months later as a new applicant, as a part of a different household sometimes, so tracking people across the populations is tricky but is something we are working on. We can bring data we have on response rates and how people are coming in and out of the system. **Question:** Does any of that data, do you separate out households where English is not the primary language? **Answer:** We have not looked at it, the application asks what their primary language is so we can pull that data. It's a little tricky because we don't know all the information about the people who are not responding. We can keep a running list of the places of the data you are most interested in diving into in more detail and we can go back and figure out how to pull it or at least get as close to the data we are looking for as possible to the data you are looking for. **Comment:** At least put the problem on your radar so that as you are looking at things to evaluate. Timeliness of notice, language of notice is a barrier for English speaking people so just extrapolate it. Don't think we need the data ourselves. It's more important that you have it as part of your analysis. **Question:** Eligibility and getting insurance aren't the same, is there a way to get information on what happened in the end (renewing, QHP, did nothing). **Answer:** yes, we do have that data, I don't have it with me today but we can track it. Of those folks, eligible for a QHP with subsidy, how many are enrolling in a plan and staying on that coverage. **Question:** 90% of those who came back in are eligible, I'm just curious because I think there are a set of Vermonters who weren't in the practice of having to renew and I wonder how many of them lapsed in coverage. **Answer:** do you mean the waiver from the federal government for renewals for Medicaid? **Question:** Yes, so what do we have to do to help people who are eligible not lapse? **Answer:** Also interested in seeing if response rates increase over time as people get used to renewing again. Presumably, with Medicaid, if folks are income eligible when they have to go to the doctor they are going to reapply because they have medical expenses, it's not clear of the people who never responded, are they used to being on Medicaid, they don't have any medical expenses and they are just going to come back in

when they do or are they not income eligible anymore and they just don't feel they have the money to buy qualified health plans even with the subsidies. Looking at response rate trends over time as people get used to renewing will be a helpful indicator there. Problems people are having with enrollment should get escalated to VHC Operations to be addressed systematically. The cleaner we get with our data and our operating processes it will clean out some of the noise we around the response rate numbers we are seeing. **Question:** How much are you hearing about the affordability of healthcare from consumers who are found they don't qualify for a subsidy and have to absorb the full cost of healthcare? When you look at the full cost of the plan it's not affordable. **Answer:** We hear stories just like you do in the community of folks who are struggling to afford insurance or who have had a troubling customer service experience with Vermont Health Connect which has delayed their coverage. When you look at the data that we just looked at on the uninsured rate, the big picture overall is the trends are going in the right direction, more people are able to afford insurance because of the work that we've done as a State. It's important to keep that in mind in the big picture, not that it discounts any of those individual experiences but according to the big picture we are moving in the right direction. We still have work to do and that's indicated by both of the stories we just heard. **Follow Up Comment:** One point is about affordability then there's the operations of the work that we do at Vermont Health Connect in the Enrollment and Eligibility Unit. We have an operational responsibility to do better. The affordability piece is a longer-term conversation for sure. **Question:** Concern with VHC, situation where Economic Service regulations and how they intertwine with VHC seems lacking. Concerned customers will get frustrated with the process and confusion around two applications and just give up. **Answer:** This discussion is important and we need to keep having it. To the extent, we can do things operationally to make the experience better for the Vermonter we be talking about that, to the extent that there are policies, opportunities we can be taking advantage of at the State or Federal level we should explore that. **Question:** Regarding Member Services and the quality resulting in poor customer service, that is a piece of what people's experience is with VHC. **Answer:** We will look at some of the call center stats. We project call volume quarterly in partnership with Maximus. We've learned a lot over the past 6 months, we've restarted a lot of activities in addition to Open Enrollment, there was recognition that our call center responsiveness dipped pretty significantly at the end of the summer given the volume of calls that we were receiving. We hired up really quickly in preparation for open enrollment and there were some bumps in the road with that. When the Call Center hires a lot of staff all at once a bunch of new people are on the phone. We are working with the Call Center to make sure retention is at the top of the priority list and that the folks that are trained and on the phones, are staying and trying to figure out how we can improve that, while modifying projections as well.

c. We do have some new functionality to automate Medicaid renewals. This is really good news from the consumer/enrollee perspective because for folks, if we are able to verify income and citizenship and immigration status using electronic data sources, those folks are automatically renewed into MCA Medicaid, they

don't have to physically return an application to keep their coverage. We are successfully running the Ex-Parte Medicaid renewal process, which is this automated functionality for a percentage of the population. This past month we hoped to have 43% up for renewal through that process, so less work on the consumer side. Our goal is to get that number up to 70%, reliant on the quality of our electronic data sources but integration electronic Department of Labor data into our eligibility system has been really fruitful. We've been able to drive that percentage up. **Question:** What data sources do you use to confirm income? **Answer:** The federal hub and quarterly wage data. **Question:** From the VT DOL? **Answer:** Yes. **Question:** What about self-employed people? **Answer:** There isn't an electronic data source that we have that can access that information.

2.) Ensure a smooth Qualified Health Plan (QHP) renewal process for 2017.
   a. Step 1, making sure we took total population of people who needed to be renewed into QHP coverage. We pinged the federal hub to verify data, we repopulated their eligibility based on updated federal guidance and mapped them to their 2017 plans. This is the second year that we've had automated functionality for that. Last year we used the automated functionality but there was a population that couldn't be processed through that automatic enrollment functionality, and those folks that fell out last year took us a lot of staff time to renew (into the early months of 2016). Better than the year before but not where we wanted to be. We did a lot of data clean up over the summer this last year, we were able to get over 90% of folks through that automated process. For the 8% of people who fell out of the automated process we, using our internal staff manual renewal process got everyone renewed within a week. Operationally speaking, we were in a much better position this year and were able to get everyone mapped over before open enrollment even started.
   b. Step 2 involved sending the files to our insurance partners and to Wex Health, which is our billing partner. We had a 99% success rate there. The small percentage of cases that errored out when they went over were reviewed and we were able to get all of that data over at the end of November instead of into January/February of this year.

3.) Customer Support Center.
   a. We staffed up pretty significantly going into open enrollment. Call center opened a satellite office in Chicago due to challenges staffing up in Burlington, VT given the unemployment rates. Our call volume was 25% higher than last year due to completing Medicaid renewals as well but performance is better. Based on open enrollment, looking back at how we've done, we've been able to hit our target service levels (average speed of answer and abandoned rates).

4.) Timely Case Resolution.
   a. We spent time thinking about what our initial targets would be around responsiveness to consumer requests. We looked at all of our incoming work and

the places where we should be able to respond to consumer requests quickly. For example, a change of circumstance request. We came up with a goal. It's important that we have a goal. A goal doesn't represent where we want to be necessarily a year from now or two years or three years. We are trying to promote a culture of continuous improvement so that every time we meet a goal we are setting another goal that's more aggressive. This is our starting point based on the fact we were coming out of a place of large operational backlogs. We wanted to get through customer requests within 10 days 85% of the time. The good news here is that we've been exceeding that goal, over 90% for the past 11 weeks. We are in the process of refining that goal, or creating a more aggressive goal. We want to look at aging, of the 10% that aren't meeting that goal, how long are they sitting out there and making sure we put some boundaries on that and also making sure we bring that number into 5 days or something of that nature. **Question:** These are business days, correct? **Answer:** Yes. **Question:** So, that means two weeks from the customer's perspective? **Answer:** Correct. **Follow up comment:** One of the things we've done both at DVHA and at the State is talk a lot about how much better we've gotten and it confuses the issue. We may be at 85% but 15% of the time is the other side of the coin, we aren't doing well, from that team perspective, I'm on a team that's doing things 80% of the time well, what I'm really focused on is that 20%. The confusion has been people experiencing in that box, or in that grouping that the system is not serving them, but publicly the conversation has been about how well VHC is functioning compared to what it was. The way to get to those last pieces is to focus on them, talk about them in a transparent way with Boards like this and with ourselves, within our teams. We are going to focus in on the pieces that we are falling short and incrementally move forward on the goals to improve. As the Commissioner noted we are going to be revising this and continuing we have a goal we are reaching towards.

b. Other places that we are looking at, continuing to figure out how we can get to a place where we are conducting ongoing monthly reconciliation with both Wex Health and our Carrier partners is at the top of our priority list. In addition to making sure we are preventing discrepancies from even making it to the other systems. What additional quality controls we can put in place, focusing on data clean up so that we can prevent some of the downstream issues customers are experiencing. On the top of our minds for the next 3-6 months.
c. 1095 time again this year. You will see some information about that. Just a reminder that 1095As go out to folks who enrolled in qualified health plans, if they received Advanced Premium Tax Credit (APTC) it also details the APTC they received during the months they paid for coverage so that they can use it when they file their taxes. Just about 25,000 of these will be mailed by the end of the month, we've already started mailing our first batch. Our Tier 1 and Tier 2 customer service center staff have been trained, we have a corrections team just like we have the last two years, that will intake customer questions, request for changes and work through those corrections throughout the tax season. In the past years, the main driver we've seen for the need for corrected forms were due to operational backlogs we were experiencing. We're hopeful that now that

we're out of the period of large operational backlogs that it will be easier on customers.

d. 1095B – this is the proof of Medicaid coverage. They aren't as complicated as the 1095A. You do need to report on your taxes the periods you had coverage so the 1095B serves as a reference point. It's not quite the same as a 1095A where there's really detailed information you are going to see on your 1095A and fill out on your tax form, it's really more of a reference document for folks. These were new last year, this is our second year sending them out and we're going to mail to 125,000 Medicaid members. The federal deadline for these is a little bit longer. We're going to mailing them out in February and the deadline that the Feds have set is March 2. **Question:** What's the difference between the two forms that you send out? **Answer:** The value? Because there is a lot fewer people enrolled in Qualified Health Plans. 1095Bs are for Medicaid. 1095As are for Qualified Health Plans.
e. The other big deadline coming up, January 31, is the end of open enrollment. Just a reminder to make sure that folks who are seeking coverage make sure that they apply before the end of the month. They can still get in for the next 10 days or so and would qualify for March 1 coverage. Just a reference to our online tools that we have to help people make decisions. The Plan Comparison Tool has been really popular. The first month or two of open enrollment we had 10,000 visitors. Some of them may have been repeat visitors but clearly families were finding it helpful so we want to keep directing folks to that tool.
f. **Question:** Where is the threshold for the waiver from the penalty, income waiver? Where do you have to be to not have to have health insurance according to the Feds vs what is the income level for Medicaid. Wondering if by definition everybody is now Dr. Dynasaur? **Answer:** I don't think Dr. Dynasaur. I don't remember what it is off hand, if it's 100 or 133. I can find out for you. Do you know that off the top of your head Dana? At what FPL do they start assessing a penalty for not having insurance? I think it's above Medicaid. Yes, but you can get an exemption. Your only options are unaffordable to you as determined by. They're not going to assess a penalty if you qualify for Medicaid. The folks who are below income for Medicaid even if they aren't enrolled in Medicaid are not getting assessed the penalty. We can confirm that figure.

QHP Overview – Dana Houlihan, Plan Management Director, DVHA/VHC

Reviewed two things:

1.) Orient us to what is on the Exchange right now (the spreadsheet you have)
2.) Go over what is being proposed for 2018. A lot of that will remain the same, or similar to what's here with one piece for 2018 that's new and unique.

On the Exchange, right now:

We have 22 medical plans (does not include dental plans). 12 of them (6 from each issuer) are the standard plans (in the left-handed column in dark blue represented as standard and standard deductible plans). That's one set of plans and by Standard we mean across all of the medical

issuers (and in VT we have just MVP and Blue Cross) the benefits are the same. The set of plans to the right where it says blue rewards or MVP those are non-standard or issuer choice plans. Meaning that the issuers designed those benefits and they're approved or certified in a different way. **Question:** Is it not benefits that are different but the cost sharing? **Answer:** All Qualified Health Plans have to offer essential health benefits, the set of things at a higher level that were decided to be just that, essential to be a plan offered on the Exchange. How we structure the plan, what we choose to make less expensive or more expensive in favor of something else is the flexibility we have. **Question:** But for the not-standard plans there are bells and whistles that the Carriers offer that are different, there are only bells and whistles added and nothing subtracted. Correct. **Answer:** They all have to have that base of the essential benefits. **Comment:** And the standard plans just have the base. **Response:** No, being in Vermont we may have some things in addition to… **Comment:** So you could take something away from standard… What people really care about is cost sharing.

On the back of the sheet are the plan designs for the cost sharing reduction plans and the silver level if someone's income qualifies them for a CSR that's going beyond what they might get for premium subsidy, this shows what the same plan, silver plan, of a CSR would look like. This is just for your own information.

We are at the point in qualified health plan certification, it's an annual cycle. We are preparing for a presentation to the Green Mountain Care Board later this week in fact of what will be offered for 2018. We (DVHA) goes before the Board with request to changes for the standard plans only. Not the non-standard plans which are on this sheet. Slide 3 is just explaining what dental benefits are. On slide 4 I'm showing you there are by law thresholds whereby if we (DVHA) proposes a cost share that is above one of these levels the GMCB has to give us approval. If it's any cost share change, for example if we propose a cost share, a co-pay of $10 more that would not require approval, if above $15 it would.

Every year the federal government comes out with what's called the actuarial value calculator. That is a tool at the federal level where each of the Exchanges have to run their plan benefit designs through. That results in these set of numbers for each plan of the actuarial values. For instance, if a plan has an actuarial value of 80%, that means the insurer pays 80%, the individual pays 20%. That's the average cost share. A plan that's platinum at 90% is a richer plan than a bronze plan which averages at 60%. There's a range where the average for example a bronze plan, the average of 60% can be +/- 2% so they need to be in that range of 58-62. What you are seeing on slide 5. We at DVHA lead a stakeholder group comprised of our issuers, others at the State myself, our Outreach and Education team, we have external stakeholders from the healthcare advocates office, from other agencies such as the American Cancer Society and Aids advocates. So we are a very broad based stakeholder group to make some of these hard choices where we're looking at what cost shares we need to change for a new year in order to make that plan fit within the guardrails**,** the actuarial value that we have to get to. Move to slide 6, this shows you by another level, first whether any changes were required (yes/no). For example the 2018 platinum plan did not require changes, our stakeholder group is proposing these changes in green for other reasons, nothing was required. We want to propose these changes that don't require Board approval to keep the actuarial value in the middle and also avoid any premium increase that we're concerned about. This is what you are seeing here. The changes highlighted

in orange do require Board approval. In detail this is what we will be presenting to the Board later this week. **Comments:** Looking at this chart here and wondering about adult with a disability, over the age of 26, which tier do they fall under, see in the fine print, just throw out the comment that the language, not sure if this is what the State uses, but incapacitated dependents is hurtful. That's a legal term, we could change, it might actually go into Federal law. What would you prefer? Individual with disability, individual you have guardianship of. Not all individuals with a disability qualify as an incapacitated dependent and not all incapacitated dependents necessarily have a guardianship relationship. There is specific language related to incapacitated individual related to health insurance. Right, it comes from the law, to qualify for that, it's not enough to be disabled in order to be on your parent's insurance. The legal definition allows them to stay on as a dependent over age 26 so that's a definition that ties to an eligibility process. It's just a description so you don't necessarily have to use the legal term. Not trying to be insensitive but it gets very confusing when you have multiple terms to refer to, so if you were to change it, suggest you change it in the law so that when somebody is trying to navigate the process everybody is using the same term. This looks like generic language, it's not listed as a label, it's in a note that is just trying to inform people and I think that it's misleading depending on what the definition is because parents may not put their kids in an incapacitated… there's just a conflict. We do a lot of work in Vermont to push independence to the greatest extent possible, we do all of these things like self-determination but then you see a term like that and I understand it could be a legal thing but I wonder when I asked the question why it's in conflict with everything else that we're about. It's not a legal note, it's an informational note, right. My point is if you're going to call up and try to understand how to qualify for that treatment and you're using a term that's different, we should all use the same term to refer it back to specific eligibility criteria. Now whether that's the most sensitive way that it could have been expressed, I have no dispute against that but let's have one term that's in statute. Otherwise they call up and use the term and there's time wasted trying to figure out what someone is talking about. Could change the language to state that this is a specific legal criterion, or put it in quotes or something so people don't think it's just a generic term. From the point of view of communicating with people, it seems to me the best thing to have here, even if you have to meet the legal requirement and have it in fine print is to have a description of who that is. I don't think incapacitated dependents tells me who those people are. You don't need a definition here, you need a description that will convey what you are trying to convey to somebody who wants to ask that question. The summary information lives on the VHC information site, so going further up on the site there would be more information on this eligibility, exceptions to that, additions to that, I don't have that for you but it would be addressed elsewhere on the eligibility pages. Here it's just a reference to a legal term. **Comment:** On the subject of these large increases in the deductibles and the net amounts of profits for the silver and bronze… ouch. Absolutely. All of these meta levels have as I said guardrails of the actuarial value that we need to land within and there are a limited number of levers that we can push or pull in order to meet given that range. What you are seeing is that the cost of going to that calculator is trying to lead to less choice in terms of what we can increase or decrease in order to land in the right place.

<u>What's new for 2018</u>

- Maximum out of pocket - $1300 for the prescription max out of pocket; $1300 individual, $2600 family, that's the same across all plans. That's a Vermont law passed

many years ago, and what's happening on the qualified health plans is that that restriction applies all the way across, has become problematic especially in the bronze plans. For 2018 there is additional flexibility from the Legislature to make changes to that maximum out of pocket. We as individuals want a bronze plan for a lower premium because they are the lowest priced plans that restriction in the pharmacy max out of pocket means that the other cost shares in the plan had to rise years ago, especially in the deductible, medical max amount out of pocket. So, for 2018 our stakeholder group is getting flexibility to look at other alternatives and make a suggestion. For 2018 if you look at slide 7 an area that we explored as a stakeholder group was some of the other pressures, the benefit areas that are included in all of our plans, if we took away or increased cost share for some of these things that don't have cost share, what does that mean for this maximum out of pocket. As a stakeholder group, we weren't comfortable touching any of these. **Question:** These categories were suggested by a Legislator? **Answer:** Yes. **Comment:** as things that we could perhaps make less generous and it really didn't have any impact. **Response:** It didn't and politically for many reasons we were uncomfortable doing it plus they wouldn't have the impact we need. **Comment:** the theory is that if someone had high drug needs they could just move into a plan that would work better for that and just have to live with it in the year. Practically very, very, very few people that have these plans hit that max so we're presupposing that everybody's biggest priority is protecting themselves against drug costs and that's not bearing out in the utilization of the benefit package. So why is there a problem with them? Because all of the other levers have to go up so your deductibles and everything are much higher. Well if it's not actually costing anymore because nobody is actually going to use it. No, they're not utilizing the benefit but they are paying for the benefit. The way that the rating rules work with the ACA is that you cannot in fact plan or price or design for plan selection so people in a bronze plan do not get a pricing benefit for the fact that all people in a bronze plan aren't using the RX max out of pocket benefit. That cost is spread across all of the plans. Because we aren't seeing that utilization in those plans and we're going to have to not have bronze plans because they aren't lean enough to meet the federal definition. So the Legislature gave an exemption to that maximum out of pocket prescription drug benefit for one year? That's correct, for 2018, we would need to report back to the Legislature on enrollment trends and so forth. I think one year is very difficult to see an impact to something so the deadline may be revisited but at this point it is for 2018. And it will be a further item for education of the consumer. The flexibility was just given on the bronze plan, that's where the pressure is at. The pharmacy max out of pocket affects all plans but the impact is most acute on the bronze plan. For 2018 the law requires continuation of at least two of the plans with this maximum out of pocket for pharmacy so the two plans that you see, one that has a high deductible health plan will continue and DVHA will be proposing a new bronze plan for 2018 standard plan and that's what you see on slide 9. What we have landed on is what we want to have is a plan that is significantly different than the others. You'll see in the first column for 2017 is the standard plan and the proposed is what we want to ask for approval on, there's an alternative and in the column on the right you'll see a federal deductible plan just for your reference. It does have a high deductible and also the maximum out of pocket for medical is the same but what we've done for that is have more services outside of the deductible. Preventive was always covered outside of the

deductible but for the one we're proposing office visits would be as well and generics will. This is something we felt was important to give. What we are trying to accomplish with those plans is to appeal to those who want a lower premium plan but to have some value of their services ahead of the deductible. All plans include the RX max out of pocket. One of the oddities is that we adopted this maximum out of pocket for drugs only and then the federal government came along and said no were going to impose a maximum out of pocket to all plans for both drugs and medical. We were careful not to add too many bronze plans. **Question:** How resilient are the Vermont plans? **Answer:** We are at the mercy of what happens at the federal level, a lot of wait and see but we need to go forward with our 2018 proposals. Changes after this is approved will be difficult on VHC and the issuers.

EPSDT Updates – Kay Van Woert

Early Periodic Screening Diagnosis and Treatment. Sub workgroup of this group. Stakeholders that include State players, well supported by what used to be in DVHA and is now in the AHS Policy unit, well supported by the Department of Health with participation from lots of non-profits and even consumers to try and compare notes about what's not working. What is a barrier to delivery of EPSDT for kids, a federal requirement to treat any conditions? Just as a historical note for those who are new, EPSDT became a federal requirement for Medicaid benefits because in the 1960's during the Vietnam war, the armed forces were finding that kids were arriving with all kinds of conditions that should have been addressed when they were younger children. It became a recognition of a public health problem at a national level that our kids weren't healthy. Because they weren't properly insured and they weren't getting benefits. EPSDT is a federal requirement for Medicaid to make sure that kids have access to screening, diagnosis and treatment. Lucky in Vermont because our eligibility has been fantastic, we've always done our best to insure as many kids as we could in Medicaid expansion programs and now with our Exchange programs. Our coverage and benefits have also been for the most part more generous than many other states. And yet we still see patterns of children who are not getting these services. 12 pages of Barriers to Access – document distributed to the group. Internal working document, very technical.

Barriers that we've identified have not been eligibility barriers other than the snafus we've talked about in getting enrolled, and it hasn't been coverage and benefits that are theoretically available, the barriers that are in our 12 pages that we've all identified working together are really in making sure that people know they have a provider to go to, know that a service is available and that they even have a provider to go to. It started with Medicaid underpayments to providers, it's gotten even more complicated with health care reform efforts, but at this point, one of the major barriers we're wrestling with, that this group can't do anything about, AHS is doing its best to do something about it, is provider issues. The EPSDT group has brought back to the MEAB some recommended language that has forwarded to policy makers before. We feel it's not getting through, that it's getting lost, and it's the primary barrier. Three statements that you will recognize. Internal procedures are that we warn language and then informally pass it to the next meeting. We were hoping to warn this in December so that it would get to the policy makers in January. Without a December meeting we're a month behind.

The EPSDT group is bringing this recommendation back to the MEAB to pass forward: ***Underpayment of providers is detrimental to the healthcare system and a barrier to children receiving EPSDT services to which they are entitled***. Examples of providers of EPSDT services where low reimbursement has led to access issues and provider shortages include OT, PT, SLP, early intervention, personal care, Hi-Tech nursing, and pediatric practices able and willing to serve a large Medicaid caseload and/or medically complex Medicaid children. On the other hand, reimbursement for ABA was raised as a result of that and has made a significant positive impact on kids accessing those services.

Children's Integrated Services (early intervention) is a program that has been flat funded --there is not enough money in the system right now to give kids with suspected autism, and other delays that need immediate attention, the treatment they need, to save a lot of money later on and have better outcomes. The EPSDT group would like to ask for a presentation from DCF to the MEAB to discuss this (maybe next time). This is a budget thing due to the flat funding and mixing non-Medicaid kids with Medicaid kids. VT Family Network is not a "business" nor are other early intervention programs across the State, and like VNA are not given funding to deliver all the care that kids need and are entitled to. Because of this funding mechanism, we're setting ourselves up for a lot of school and Medicaid expenditures 10-20 years from now.

Our ***direct care workforce*** has also been flat funded and underfunded. It's a problem for kids and an even worse barrier on a numbers level for adults. It continues to be a barrier to families to getting EPSDT entitled services.

Question: Do you know if we are effectively using the EPSDT flexibility to steer Medicaid dollars to provider networks that are out doing developmental screenings for kids in the community? **Answer:** That's an AAP question. On our matrix is a concern that we aren't doing the screening that we should be doing. **Response:** Saying the opposite, that there's a whole lot of screening going on in the community that is right in line with EPSDT directive that we are not taking advantage… I'm wondering if we aren't taking advantage of the Medicaid dollars. **Answer:** Certainly a question, group is meeting in two weeks, will ask members to respond to that. In terms of our barriers our matrix is filled with examples of people not getting financial services. One of the few benefit areas where we really do fail in Vermont is in Case Management. It's medically necessary and as a result of that, we are not getting enough connections to treatment. **One last statement**: We could dock EPSDT Pediatrician payments, some pediatricians see a kiddo and they go and do an ASQ on them, they will stop and do it, most will refer that kiddo to CIS and that doesn't get the EPSDT funding. **Response**: A Pediatrician who works unit one o'clock in the morning doing free case management for kids that are considered at risk, think pediatricians don't always make that connection because they don't have the manpower to make commitment and those that do are doing it as volunteers in the community not as paid, so when I hear dock EPSDT I think we are going to lose more pediatricians. We have pediatricians who don't take kids who are high needs precisely because of this. On one hand you can say they are bad people but on the other hand you can understand why people who have really high medical school debts don't want to be working for $10/hour by the time they are done doing all of this work. It's definitely an issue. We didn't bring in Case Management this time but that paying for physician time to make those connections. **Clarifying statement Question:**

Repeating back what I'm hearing for understanding, you're saying that reimbursements need to be higher for some Pediatricians and are you saying that there might be other alternatives to get the work done. **Clarifying Statement Response**: This isn't one or the other. It's both. Vermont is doing some good things with the local pediatric collaboratives, it's doing some good work but it's voluntary again, it's not paid and it's catch as catch can. **Comment**: If you ask the Child Development Division (CDD) they'll say that VT doesn't use EPSDT to support early child care home visiting, not sure if that's true. **Response:** I think they are making change, CDD is now going back to billing for Medicaid services. They decided this didn't work very well and they are trying to renegotiate, we did have a report on that at our last meeting. Would love to hear this at the Commissioner level, how this is going to work because I agree that presumably we have a viable Medicaid program, we could get some good federal dollars to support stuff that we aren't doing. It's not that we aren't doing it by design, we're not doing it because the system is not set up to do it. **Question:** How do we get information to parents on benefits that are available? **Answer:** This is not part of the language we put in front of you this time, this was more about getting funding for outreach and case management discussion because there's lots of benefits where people aren't making connections. Children with special health needs has been really attempting to become a more inclusive home for kids with special needs. The Maternal and Child Health program within the Department has been doing outreach efforts. Needs to be coordinated at the AHS level. AHS does have an EPSDT initiative to take an inventory of what they are doing, what they aren't doing and how they could do better as an Agency. **Response:** When we started the CIS program there was a theory that we wouldn't include things in that bundled payment that could be billed to Medicaid directly and get an enhanced rate. It's the conundrum of trying to pay providers differently and also be able to draw down the higher match on those services. You have to separate them out. Targeting this conversation when we get into that discussion it's going to be important to understand what is being billed in that bundle, what in our payment system as we know it today would need to be billed fee for service, or be part of some payment reform initiative moving forward? **Response:** The CDD has reopened this recognizing that we've lost some opportunity to get Medicaid funds that we have but it's early in the process. Which is exactly why we were hoping to get the Commissioner in to talk about the whole budget, the whole bundle of funding which is an issue in and of itself, but also to update us on new approach to get Medicaid to pay for what's medically necessary which is what we should be doing. **Comments:** It's a creative type of conversation in which we need to tease out the things that will get us the higher match rate in Medicaid and figure out how to get it out of the bundle if it is or somehow figure out what part of that bundle should be reimbursed at a higher level from the feds. I think what folks are saying is that there may be a missed opportunity to get the EPSDT rate at the federal funding rate which used to be 90/10, it's 50/50 and 75/25. The bottom line is even if the State is recouping, it's not trickling down to the service level of the kids. Understood, it's starting that conversation about what, first and foremost is in that bundle and how are we actually getting funded for that bundle. It's important that it get on the radar at the policy level. It's noble to open this up to all kids so that Medicaid kids are labeled but the bottom line is there isn't enough money to do all of this. We don't have the duration and intensity of services that are medically necessary and that's wrong for the kid and wrong for our future expenditures as well. **Comment:** The technicality of the discussion is challenging even for those of us who work it a lot but one of the things that we've been trying to understand, and can't say that we have it yet, is the new federal parity requirements and how things like bundled payments and capped funding interact with it. If the solution is you have to meet demand to meet mental

health parity, you can bundle it and that can be your payment model, you can't cap it because you have to meet the demands of people who need mental health services just like diabetes, cancer and everything else. Don't know the answer, don't know how to do the research, we've been working on it and aren't sure if we're closer than anyone else but hoping it can stay in the conversation to look at that dynamic and make sure that we fully do meet mental health parity. **Comment:** We're not meeting Part C, we're not meeting EPSDT, we're not meeting mental health and when we say providers, using pediatricians as an example but certainly finding mental health providers for kids is really tough for us so were talking about the entire network of providers, when we can get into a smaller level, this is a more conceptual level. **Comment:** Expect that there isn't going to be more money for Medicaid spending going forward. To the extent there are opportunities to use money that we do have more effectively, that's where the real opportunity lies and there might be more tolerance of a little bit less reporting and following the dollars everywhere that could free up some of those resources and those will be the most effective recommendations, don't make us do this because of this. **Comment:** That certainly is the complaint the providers. **Comment:** There might be a little opportunity there. Opportunity or not, at least for the moment we're not meeting the law. There's lots of reasons politically why it's going here and there and it's not say a Medicaid kid shouldn't have exactly the same services as another kid that isn't a Medicaid kid. It is to say at a minimum we should be meeting the law in terms of what the medical necessity needs are of these kids are. Aside from being the law it's just a good place to invest.

Public Comment Opportunity – Co-Chairs
There was no public comment during the meeting.

Adjournment
The meeting was adjourned at 12:06PM.

Topics for Regular Update:

- Vermont Health Connect Quarterly Update
- Commissioner Updates (Current Topics Discussion)
- GC Waiver (as Necessary)
- Quarterly Advocate Report (Legal Aid)

Draft Topics for January 23 Meeting:

- Vermont Health Connect Quarterly Update
- DVHA Budget
- QHP Overview
- EPSTD Updates

Future Meeting Topics:

- Health Care Reform - All Payer Model updates
- Medicaid Budget updates

Next Meeting
January 23, 2017
Time: 10:00AM - 12:00PM
Site: DVHA, State Office Complex, Waterbury, VT
Please visit the Advisory Board website for up-to-date information:
http://info.healthconnect.vermont.gov/advisory_board/meeting_materials