Medicaid & Exchange Advisory Board
Meeting Minutes
November 26, 2018
10am-12pm

Board Members Present:

Arnoff, Susan (phone) Barnard, Jessa; Draper, Lisa (phone); Fay, Michelle (phone); Fisher, Mike; Green, Devon; Hackett, Dale (phone); Kervick, Drew (phone); Konstantin, Gladys Mooney; Lang, Kelly; Lavoie, Joan; Maguire, Erin; Maheras, Georgia (phone); Maynes, Lisa; Murphy, Kirsten; Tessler, Julie; Van Woert, Kay; Vaughan, Amy

Board Members Absent:
Heintz, Rebecca; Henault, Sharon

Other Interested Parties Present: Barnier, Kelly (Maximus), Howe, Toby (MMR)

Staff Present: Department of Vermont Health Access (DVHA): Deputy Commissioner Michael Costa, Etiane George (phone), Scott Strenio, Amy Coonradt and Zachary Goss. Vermont Department of Health (VDH): Nathaniel Waite.

HANDOUTS

- 11/26/18 Agenda
- "The Prior Authorization Waiver in the VMNG ACO Program – past, present, and future" PowerPoint presentation

*all are posted to the VHC website

CONVENE
Mike Fisher and Julie Tessler chaired the meeting.

Welcome/Introductions/Approval of Minutes
Board members and meeting attendees introduced themselves around the room. A quorum was present. June August and September meeting minutes are posted to the VHC website and will be distributed following the meeting.

Commissioner's Office Report – DVHA Deputy Commissioner Michael Costa

1. Vermont Health Connect is in its busy season
    a. Call volumes are very high
    b. Wait times are a little high
        i. Plan to address wait times:
            1. Callbacks have been instituted and customers have a generally positive response
            2. Will be adding an additional team at call center on December 1st.
    c. Deadline for customers to be "in cue" is December 15th (hard deadline).

2. Legislative Session, Governor's Budget and New ACO program year

a. Focus on execution of current programs and focus on a budget that works towards the DVHA Commissioner's three priorities: Continuous Improvement, Health IT and Value Based Payments.
b. Budget still under discussion, but focus remains on incremental improvement on existing programs.

3. Discussion of silver plan outreach efforts and customer reception/understanding of plans. Parties are monitoring customer needs and response.

4. Medicaid Technical Bill
    a. Would like to continue to do this annually
    b. This will be reviewed with stakeholders individually and with the MEAB

5. Consensus forecast
    a. Best estimate of Medicaid enrollment and utilization
    b. Trends:
        i. Gradual and slow decline in Medicaid membership
        ii. Medicaid spending about "flat"
        iii. Big implications for Medicaid waiver (what VT spends on a member by members basis really matters)
    c. SOV has trust in "big number", approximately one billion dollars. Indications are that this figure will remain the same, and AHS/Legislature are looking closely to examine the details.
    d. Not captured in consensus forecast is "price" [which should also be considered].

6. OneCare contract
    a. Focus on Value Based Payments
    b. Should not cost State more to get into Value Based Payment. Should be revenue neutral.
    c. Cap for ACO is "what we would have paid". As more people enter program, there is more risk for inaccurate estimations because actuary could have greater financial consequence if off target.
    d. With Fee For Service about the same price and the risk of overspending being transferred in part to ACO and ACO members, SOV has confidence in staying within consensus forecast.
    e. DVHA committed to incremental improvement on ACO.
    f. Handling discrepancies in the way we pay providers
        i. Michael Costa personal theory:
            1. ACO is tool: using to service integrated care in the future. This results in resource allocation problem.
            2. Provider led reform will be "better and more durable" if this reform happens collectively and is not a DVHA/State mandate
            3. If things change, they would happen slowly
        ii. Out of State patients are not attributed to OneCare, unless they have separate ACO programs, for example: Adirondacks or New Hampshire. At certain point in time Green

Mountain Care board will likely have to consider out of state people in payments on global budgets.

7. Medicaid Eligibility
    a. Different Medicaid eligibility groups
    b. CMS refined agreement with States
        i. Past waiver: do not exceed total
        ii. Future waiver: do not exceed certain amount for each member
    c. Vermont must ensure that members are in the correct group
    d. There is no cap on spending per individual. Spending for each member is based on averages.

Health Information Exchange (HIE) Strategic Plan Update

1. Job of HIE: try to connect providers to more information to enable them to provide better care to Vermonters. This has been a federal priority for a long time (for example subsidizing electronic medical records)
    a. HIE (n): "VITAL" serves as the health information exchange [platform] for Vermont
    b. HIE (v): How providers and people connect using information
2. Vermont has been working on this for 12 years with mixed results
    a. Unable to figure out most efficacious way to use electronic medical record
    b. State struggled to make meaningful investments in HIE
    c. 2017 HIE program in difficult shape with efforts to get program "back on track"
    d. Week of 11/19/18 Green Mountain Care board approved HIE 2019 Annual Report. The report is submitted annually, but this was the first approval since 2010.
    e. Report answers questions of:
        i. What does Vermont want?
        ii. What is good for providers?
        iii. What is good for Vermonters?
    f. Consent policy within the report
        i. Healthcare data goes into VITAL and can only be used if consumers grant their consent
        ii. VITAL struggled getting a sufficient number of people into database
        iii. Third party study found that some states have "opt-in" consent policy (ex. Vermont) and those states struggle to enroll people in HIE and some have an "opt-out" policy who have better luck getting people enrolled. Some states don't have any policy beyond HIPPA.
        iv. Policy question of "What should Vermont's consent policy be? Particularly if you think that the present opt-in policy is an obstacle to having HIE data that's ubiquitous."
        v. Administration is thinking about if the consent policy needs to change. It seems like States with opt-out or no consent policy, can use more records and those with an opt-in policy. Administration plans to bring this question to legislature and consider what we are getting and what we are missing by having the current opt-in policy. DVHA would like to publish memo that makes policy trade offs very clear. State puts significant

resources into HIE program and we are not certain that if we maintain an opt-in consent policy that we will get to a point where we'll have use of all records. Therefore, is this the best use of time and money from the States perspective?

vi. Currently, it seems that management of consent policy [within each provider organization] is uneven.
vii. Out of 625K Vermonters, 217K have opted in
viii. Focus has shifted from "the more people in" [the better] to "what are people going to do with it". This relates in part to connectivity requirements. Level of connectivity yields ability to which data can be used.
ix. Success does not equal connecting everyone to everything all the time. As the broader HIE market develops, Vermont should set up an "eco-system" to take advantage of technology advancements. Vermont will simultaneously try to enroll as many Vermonters as possible with a useable longitudinal health record and will take on discrete projects to reduce provider administrative burden.
x. The State has not exhausted efforts to address "unevenness" in opt-in policy administration among statewide providers. To achieve the goal of ubiquitous health information records, subsequent cost-benefit must be considered in continuing to pursue improving opt-in protocols vs. a change in policy.
xi. Question of "What protections does a state level policy give you that are not already protected by HIPPA?"
xii. Approximately 95% opt in who are asked.
xiii. Progress can be made with opt in. Since 2017 rates have gone from 19% to 37%. This currently does not seem to be the fastest way to get Vermonters enrolled in the HIE program.

ACO Prior Authorization-Amy Coonradt (Director of Operations for ACO programs), Michael Costa (DVHA Deputy Commissioner), Scott Strenio (Medicaid Medical Director)

1. **Prior Authorization Waiver**

Please see PowerPoint "The Prior Authorization Waiver in the VMNG ACO Program – past, present, and future".

MEAB Retreat Review
Materials will be distributed following meeting.

Public Comment
There was no public comment.

Adjournment
The meeting was adjourned at 12:00 PM.

Future Meeting Topics:

1. DVHA Legislative Agenda
2. DVHA Budget
3. Process MEAB retreat
4. Decision to wait until there are more HIE developments to discuss further.

January meeting may take more than 2hrs. Possibility of 3-hour January meeting to accommodate topics.

Next Meetings
January 28, 2019
Time: 9:30AM – 12:30PM (*tentative)*
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