Medicaid & Exchange Advisory Board
Meeting Minutes
March 27, 2017

Board Members Present: Paul Bakeman, Kay Van Woert, Michelle Fay (phone), Dale Hackett (phone), Donna Sutton Fay, Bram Kleppner, Lisa Maynes, Kelly Lang (BCBS representing Rebecca Heintz), Gladys Konstantin, and Amy Vaughan (phone).
Board Members Absent: Julie Tessler, Lila Richardson, Rebecca Heintz, Joan Lavoie, Vaughn Collins, , Erin McIntyre, Laura Pelosi, Nate Waite, Sharon Winn, Clifton Long, Christina Colombe (phone), Sharon Henault (phone) and Mike Fisher (Healthcare Advocate)
Other Interested Parties Present: Susan Gretkowski (MVP, phone). Kelly Barnier (Maximus), Paul Harrington (VT Medical Society)
Staff Present: Department of Vermont Health Access (DVHA): Commissioner Cory Gustafson, Aaron French, Deputy Commissioner Michael Costa, Deputy Commissioner Lori Collins, Carrie Hathaway, Amy Simons, Molly Waldstein and Stacy Gibson-Grandfield. AHS Policy: Ashley Berliner

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.

Cory Gustafson introduced Molly Waldstein to the group. Molly is auditing the MEAB process to see how we might be able to bring improvements to it.

Approval of Minutes:

November 21, 2016 Minutes – Approved
January 23, 2017 Minutes – Discussion
- Shorter minutes – capture main points in general
- Page 12, 1st paragraph – Revisions provided by Kay Van Woert to be updated in the official minutes –Revised as follows: first sentence stands, replace remainder of the paragraph as follows: "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"
- Revised minutes Approved

February 27, 2017 Minutes - Approved

Women's Health Initiative – Michael Costa, Jenny Samuelson

Women's Health Initiative

- Overview of the Initiative
- What does it mean to integrate with AHS

What problem are we trying solve?

- In VT approximately 50% of pregnancies are unintended
- One of the barriers to unintended pregnancies are barriers to contraception, specifically use of contraception in a consistent way
- Long Acting Reversible Contraception has been recognized as a way that is both safe and easiest for women to prevent unintended pregnancies
- Why we are looking at unintended pregnancies and Long Acting Reversible Contraception?
    - About 41% of pregnancies that are unintended are women that are already using a form of birth control but are not using it the way it is intended to be used due to the following issues:
        - Accessing birth control pills
        - Or are not using them every single day as prescribed
    - 54% of those who have unintended pregnancies are not using contraception
        - Some because they don't have access to contraception
        - Some are not choosing to use it
- 95% of unintended pregnancies due to not using contraception or not using them properly – presents an opportunity to have more intended pregnancies and if you have more intended pregnancies you have fewer Medicaid beneficiaries.
- If we want to innovate, how do we actually do that?
    - Leveraging Blueprint to align Medicaid's reimbursements with innovation.
        - Women's Health Initiative
        - Act 120 mandate to create a value based payment for LARCs
            - PPNNE issue – DVHA had to fix the rates for Planned Parenthood
            - Aligning efforts going forward
        - Can we make the connections?
            - Create a process and center for Innovation - align innovation at AHS between AHS Central Office, Blueprint, and across the departments

Create an Integrated Health System

- How do things really change in practice and how do we pay for those things
- Women's Health Initiative is one piece of how things can change

Healthier Women, Children, and Families

- In Vermont, 50% of all pregnancies are unintended – hasn't changed in 50 years; higher among Medicaid beneficiaries; results in about 6,000 pregnancies per year
- Unintended in this case means mis-timed or unwanted; unintentional meaning they really didn't want it or it was planned in the future
    - Interrupts education
    - Interrupts economics
    - Makes it more difficult to raise a family with those consequences

- Original research indicated unintended pregnancies occurring in the 25-35 year range; unintended pregnancy rates coincide with abortion rates (combination of PRAMS, vital statistics data and Medicaid data)
- Refer to slide 5 of the hand out for more data; additional data to be provided by Jenny Samuelson
- Women who have an unintended pregnancy have children who are more likely to have an unintended pregnancy.
- Women's Health Initiative also has goal to identify some of the risk factors for pregnancy – Women are more likely to become unintentionally pregnant:
    - if they've experienced trauma
    - if they've used substances, have a substance abuse disorder
    - if they have mental health issues
    - housing insecurity and food insecurity
- Having an unintentional pregnancy puts you at higher risk for:
    - Having a mental health disorder
    - Housing insecurity
    - Food insecurity
- Goal is to break this cycle through earlier intervention; also focusing on psycho social screening for those risk factors

What the Women's Health Initiative is composed of
Coalition effort across the Agency and our community partners

Many women receive majority of their health care at OB-GYN, women's health clinics and nurse midwives
In these settings, this initiative will allow for:

- Enhanced health and psychosocial screening
- Comprehensive family planning counseling
- Timely access to long-acting reversible contraception (LARC)

By offering:

- New staff (supplemental CHT social workers)
- Practice support (learning collaboratives & practice facilitators)
- Payments (for practices participating in the initiative)

Both a community effort and a Women's health practice effort

- Form a coalition of diverse organizations including medical practices
- Identify and include organizations working with youth and women at risk
- Incorporate family planning counseling and screening for primary care into existing services of community organizations where relevant
    - Community organizations act as navigators for their clients
    - Create referral pathways between community organizations and health care providers that ensures immediate follow-up
- Update knowledge of providers and community on LARC
- Leverage social networks for community education

Practices and Communities Started on January 1

- The initiative is dependent on participation of both women's health practices and community organizations

- 14 practices started January 1, 2017 including hospital owned, independent, FQHC, and Planned Parenthood of Northern New England. Practices who are interested will join quarterly in 2017.
- January 1, 2017 represent 9 Health Service Areas (geographic regions)
    - Barre
    - Bennington
    - Burlington
    - Middlebury
    - Morrisville
    - Newport
    - Rutland
    - St. Albans
    - St. Johnsbury
- Practices:
    - Gynecology, maternal fetal medicine, obstetric, reproductive health, or family planning medical practice, specializing in providing women's preventive services as defined by the American Congress of Obstetricians and Gynecologists.
    - Mixed specialty medical practice with board certified obstetric or gynecology providers whose primary scope of services is women's preventive services as defined by the American Congress of Obstetricians and Gynecologists.
- Providers:
    - Physicians (MD, DO)
    - Advance Practice Registered Nurses (NP, CNM, APRN)
    - Physician Assistants

Practices, Screening and Referrals

- Psychosocial screening
  Within the first 3 months:
    - Depression
    - Current intimate partner violence and adverse childhood experience
    - Substance abuse

  Within the first 18 months
    - Access to primary care/patient centered medical home (PCMH)
    - Food insecurity
    - Housing stability
- Onsite availability of the full spectrum of LARC within 1 month
- Efficacy-based, comprehensive family planning counseling within the first 3 months
- Same-day insertion within 6 months
- Agreements with community based organizations to see patients within 1 week at which time they will provide same-day availability for full spectrum of birth control options within first year at least 3 agreements
- Agreement with PCMHs to accept patients who are identified without a primary care provider within first year at least 3 agreements

Payments

- Through the payments mental health clinicians through the Blueprint Community Health Teams will be available in Women's Health Practices for follow-up, brief intervention and referral.
- Long Acting Reversible Contraception will be available on-site.
- Three forms of payment:
  - WHI Practice Per Person Per Month - an ongoing payment to support enhanced care and screening
  - WHI CHT Payment – supports 1 FTE mental health clinician per every 1200 attributed beneficiary for brief intervention and referral
  - WHI Capacity Payment – on-time initial funding to help practices cover the costs of initially implementing the program including stocking LARC
- Family practice clinics already get a PMPM payment, of these 3 payments they don't get the capacity payment to purchase the stocking devices. Each of these devices cost between $700-$800, many of them don't keep them on hand
- Payments are currently separate from the Next Gen ACO payments; clinics in the Next Gen ACO are getting payments separately
- Applied for funding under the Medicaid 1115 waiver for this program
- Payments to women's health providers (PCMH not eligible)
- Payment tied to implementing screening and referrals
- Medicaid payments only to start, but other insurers/payers invited to join
- Use a 24-month lookback period for the claims-based attribution
- De-duplicated by WHI practices with patients attributed to the practice that has provided the majority of services during the 24 month look back, with attribution going toward the most recent provider if there is the same number of visits to two or more providers

Practice PMPM & CHT Payments

Practices
- Year 1 - $1.25 PMPM payment for the population of Medicaid-enrolled reproductive-age women (age 15 to 44)
- Year 2 – Up to $1.50
  $1 base and $0.50 performance component – currently working with the practices and across AHS to determine what the performance measures will be (example: rate of pregnancy between ages 15-19)

CHT
- CHT mental health clinicians will be available in practices for brief intervention and follow-up
- $5.42 PMPM
- Funding goes directly to the CHT entity, the CHT contract with the social workers from the DAs.
- Doing two learning collaboratives – one for communities and one for the practices themselves (example: 10 best practices for contraception and on how to create a referral). Also plan to do ongoing skills building with community based providers.

Affordable Care Act - Repeal – Cory Gustafson, Michael Costa

Activities across the Agency to assess potential changes to the ACA and possible impacts:
- A lot of unknown answers around impacts to Vermont, more questions than answers
- Rough estimates

  - Range of $182-275/300 Million = net impact to VT Medicaid Program
  - GC waiver impacts – Investments are changing – assumption that investments wouldn't get approved ($75 Million hit)
  - Per Capita Cap – look at PMPM in 2016
    - PMPM in 2016 lower than what it is today – waiver on re-determinations
      - More people on Medicaid enrollment file than we had in previous years
      - Redeterminations began last year and are ongoing. Healthier people are coming off the rolls.
      - PMPM in 2016 not a good moment in time to look at this
- American Health Care Act – bill was pulled from Congress – no vote on it now
- Still need to think about what ways the changes to the ACA might be executed by the Republican Controlled Congress and White House.
  - What kind of activities can the Administration do to achieve some of its goals without passing legislation (i.e. weakening the ACA) – it's anyone's guess
  - CMS Administrator – pledged to be more enabling entity
    - Giving more flexibility to States' to do what's best for their population
    - Could provide opportunities to the States
- First big opportunity for Leadership team to work across Departments to solve for the problem.
- While Bill has gone away not certain the idea has gone away, so we will continue to assess risks and look for opportunities to work with the Federal government to make our Medicaid Program better.
- One of the challenging parts is that Health Care Reform is a 3 part deal
  - Reconciliation
  - Regulation
  - Legislation – changes to the ACA – highest bar to clear to get done.
  - These work together closely, not knowing about all 3 makes it hard to understand changes and impacts to Vermont.
- Health Care Advocate can make request for comments on proposed rules available to the group.
- Request for a list of those things most vulnerable for being impacted by de-funding – DVHA to take that back and consider how to accommodate request – concerned about putting together a list without understanding plans.
- State Budget proposal to cut $200K from Navigator program – Within Facilities – effective way to get people onto Medicaid or QHP
  - Commissioner Gustafson has a 5 Point plan that he can share with the MEAB.
  - Rules are changing, use Navigators to get people in, transition aligning to a different area – provide awareness of what coverage is available when people come into facilities.
  - Federal Gov't gave us a certain cap that we were not able to spend down to because we didn't have the General Funds associated. We have GC agreement until 2021. In most recent renewal, they pushed down the cap.
  - AHCA does contain legislation that could limit CMS' ability to offer us waivers

- Difference between capacity and cash
  - There are many ways the federal government can eliminate funding without touching the cap

Budget Update – Carrie Hathaway, Lisa Schilling

Governor's proposed budget – currently in the House and will then go to the Senate for review. Proposed budget has already changed since it was first presented. We know there are changes being made to the AHS budget, but don't have the details yet from the Legislature.

Carrie presented companion PowerPoint (dvha-SFY2018-Overview) document to the Budget Book

Slide #4 - Looking at what DVHA does

- Large part of administrative budget is allocated to projects.
- Projects are not just technology work being done. We spend on Technology efforts under Claims Services and Health Access & Eligibility (reference slide #4).
- Projects are a big part of the admin spend.
- Continue to wrestle with what's the sustainable spend we need to make sure our programs are working the best they can and we're utilizing technology in ways that are good for our members and affordable for our taxpayers.

Slide #5 – Connecting DVHA with AHS

- Demonstrates that DVHA is not the only Medicaid Department.
- Where DVHA spends $1 Billion in Medicaid funds, the overall AHS spend is $1.5 Billion.

Next few slides map out the different eligibility groups by population percentages. Remember that different groups have different match rates.

Slide 7 – Connecting AHS to Services Provided

- Medicaid spend on pharmaceuticals is very different than the commercial spend.
- Still have to deal with high costs of new drugs.
- Overall, we spent $208 Million dollars in SFY 2016 on Pharmacy, come down to total offsets where most of that is Pharmacy rebates (approximately $111 Million of the $125 Million total offsets on slide 7). Take that $111 Million away from the $208 Million.
- Medicaid spends just under $100 Million on Pharmacy as opposed to Blue Cross whose numbers are probably double that amount.
- We are getting into discussions now about how to handle the pharmaceutical spend in the Legislature.

Slide 9 – DVHA Budget Ask for SFY 2017

Slide 10 – Caseload & Utilization

- Able to cover the 53rd week in SFY 16 so we didn't have to ask for any extra in our base.
- Even though our caseload is dropping due to the re-determinations our PMPMs increased disproportionately.
- When folks fall off it tends to be the healthier people, whereas when people come on the program new they are actually costing more and those who stay in have a higher PMPM.

Slide 12 – Demonstrates 80/20 rule

- 80% of the costs are born by the fewer number of people.
- The Green bars on the bottom are the number of people, the Green line is the total spend for those people. When you aggregate the bars you see the total number of people with the total spend.

Slide 13 – Additional changes made to the Program budget.

- Decision was made by the Administration to move $20 Million out of the DVHA budget to put into a Caseload Utilization Reserve Fund based on spend patterns that were seen at the time the budget was built. It's not actually a reduction in the budget, it just looks like it in DVHA's budget.
- Buy-In Adjustment is where we purchase Medicare coverage for our enrollees, this just represents a change in the rates of reimbursement for Medicare as well as the enrollment factor.
- Clawback is a State only general fund program from when Medicare Part D was implemented. Where Medicare used to cover pharmacy benefits we then have to transfer that State General Fund that used to cover the Medicaid Pharmacy benefit back to the Federal Government.
- Disproportionate share reductions – we pay hospitals roughly $37 Million to help cover for uncompensated care. Reduction under the ACA for the uninsured the Administration proposed a 10% reduction to the DISH program.
- Change in Federal Match – every time the federal match percentage changes in distribution to our populations we have to make an adjustment.

Slide 14 – Administrative Considerations

- We have a $5.5 Million increase ask for personal services.
- The predominance of this ask has to do with an expectation that we would be able to eliminate 52 Health Access Eligibility & Enrollment employees due to the system enhancements, reality is that we are not going to be able to see an elimination or reduction in those positions.
- Pay Act and fringe increase is for our staff.
- Operating is dollars that get allocated for other departments such as fee for space or DII. It's a cost that we have to send on to our sister departments.

Slide 15 – Grants and Contracts

- $6 Million reduction.
- Biggest line item is a decrease in project contracts.

Slide 16 – Depiction of the overall DVHA budget.

- Of the $189 Million, $91 Million is for project, 10% or less of that $91 Million is General funded, it's heavily federally funded.

Slide 17 – Breaks down Administrative budget dollars down to individual units.

- Vermont Health Connect & Health Access Eligibility and Enrollment
    - Have a lot of people power (104 employees) trying to overcome our technology limitations, $21 Million is the spend on technology.
    - Vermont Health Connect is the name but what's really going on there is eligibility and enrollment across Medicaid and across the commercially insured population related to qualified health plans.
    - Repealing the ACA doesn't necessarily mean we eliminate that expenditure. We need that functionality, or some functionality like it that works even better than what we have now.

Request DVHA to come back next month with a budget update. Also ask for updates from other Departments as well for next meeting.

EPSTD Recommendation – Kay Van Woert, Susan Coburn

Substantial underpayments are a bad idea and in particular special concern this particular budget cycle with impacts to CIS and the long-term care workforce. Underpayment is leading to barriers in services.

Resolution states:

Substantial underpayment of providers is detrimental to the healthcare system and a barrier to children receiving needed EPSTD services to which they are entitled. Provider reimbursement should be high enough to allow for beneficiaries to access all covered services. Medicaid reimbursement rates for CIS providers must be adequate to ensure recruitment and retention of providers. Medicaid funding for early intervention services must provide for the scope and duration of the services medically necessary, not to be limited by the availability of funding in any given service area. In light of historic underfunding and continued flat funding of Vermont Medicaid direct care programs and providers special and immediate planning focus should be given to development of a reimbursement approach to the direct care giving workforce to ensure a viable system of community based care. To ensure the availability of consumer directed services, care workers under the direct control of consumers should be reimbursed at a wage that will allow the consumer to hire them.

Kay Van Woert moves to adopt this resolution and forward it to all policy makers, all Departments, AHS Policy Unit and the Legislature and all appropriate committees. Seconded.

Approved unanimously.

Other Business

Aaron French announced his resignation from DVHA. He will be working for a Federally Qualified Health Care Center overseeing quality and compliance at that health center. The MEAB thanks Aaron for his service. Scott Strenio will be returning to DVHA as Chief Medical Officer. DVHA will be working with the MEAB Chairs to determine how to fill Aaron's role on the MEAB.

Adjournment
The meeting was adjourned at 12:05PM.

Topics for Regular Update:

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

Future Meeting Topics:

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

Next Meeting
April 24, 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