Attachment 1a - DLTSS Work Group Meeting Agenda 6-19-14

VT Health Care Innovation Project

"Disability and Long Term Services and Supports" Work Group Meeting Agenda

Thursday, June 19th 2014; 10:00 AM to 12:30 PM

AHS Training Room, 208 Hurricane Lane, Williston, VT

Call-In Number: 1-877-273-4202; Passcode 8155970; Moderator PIN 5124343

Item	Time Frame	Topic	Relevant Attachments	Action
1	10:00 – 10:10	**Welcome; Introductions; Approval of Minutes** Deborah Lisi-Baker and Judy Peterson	• Attachment 1a: Meeting Agenda • Attachment 1b: Minutes from May 2 meeting • Attachment 1c: Minutes from May 22 meeting	
2	10:10 – 10:45	**DLTSS Medicaid Expenditure Overview Discussion and Final Draft** Scott Wittman, PHPG, Susan Besio, PHPG	• Attachment 2a: Medicaid Expenditure Analysis Final June 6, 2014 • Attachment 2b: Medicaid Expenditure Analysis - DLTSS WG Member Questions Responses 6-9-14	
3	10:45-11:00	**Recommendations for Criteria for Second Round of Provider Grant Program** Georgia Maheras	• Attachment 3: VHCIP Round Two Grant Award Background	
4	11:00 – 11:35	**DLTSS Quality and Performance Measures** • Update on Recommendations to the QPM Work Group • Process and Methodology for defining and analyzing the DLTSS Population • Plan for presentation of AHS Survey Results to DLTSS Work Group Deborah Lisi-Baker, Judy Peterson, Pat Jones, Scott Wittman, PHPG, Susan Besio, PHPG	• Attachment 4a: Year 2 Reporting and Payment Measures 2014-05-14 (QPM WG document; includes DLTSS recommendations) • Attachment 4b: Two Options to Identify DLTSS Population for ACO Performance Measures Analyses 6-9-14 • Attachment 4c: AHS Survey Results Plan	

5	11:35 – 12:20	**Provider Training – Define Issues, Goals and Next Steps** Deborah Lisi-Baker and Judy Peterson	• Attachment 5: Provider Training Discussion document	
6	12:20 – 12:30	**Public Comment/Updates/Next Steps** Deborah Lisi-Baker and Judy Peterson	Next Meeting: July 24th 10:00 am - 12:30 pm, Williston	

Attachment 1b - DLTSS Work Group Minutes 5-02-14

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Date of meeting: May 2, 2014, 10-12 pm; 4th Floor Pavilion, Montpelier, VT

Attendees: Deborah Lisi-Baker and Judy Peterson, Co-Chairs; Susan Besio, PHPG; Georgia Maheras, AoA; Anya Wallack, Core Team Chair; Pat Jones, GMCB; Sam Liss, Statewide Independent Living Council; Jackie Majoros, VT Legal Aid; Dion LaShay, Consumer Representative; Joyce Gallimore, CHAC; Vicki Loner, OneCare; Alysia Chapman, Bob Bick, Howard Center; Joy Chilton, Central VT HHH; Erin Flynn, Kara Suter, Amy Coonradt, Alicia Cooper, DVHA; Amy Cooper, Accountable Care Coalition of the Green Mountains; Dale Hackett, Consumer Advocate; Julia Shaw, Trinka Kerr, HCA; Carol Maroni, Community Health Services of Lamoille County; Marybeth McCaffrey, Jen Woodard, DAIL; Kirsten Murphy, Julie Wasserman, AHS; Ed Paquin, Disability Rights VT; Julie Tessler, Marlys Waller, VT Council of Dev. and MH Services; Jason Williams, FAHC; Jessica Mendizabal, George Sales, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions	Judy Peterson called the meeting to order at 10:07 am. Deb Lisi-Baker explained that this second meeting was meant to help the group with the following: • Have a better sense of ACOs and Shared Savings Programs; Explain how these relate to broader health care reform; • Describe how they may benefit/affect the DLTSS population; • Create a better understanding of how the DLTSS population is currently included in any of the Shared Savings Programs and each ACO; • Create a better understanding of how the DLTSS population may be included in any of the Shared Savings Programs and each ACO in the future.	

Agenda Item	Discussion	Next Steps
	Susan Besio, Julie Wasserman and other work group members compiled the information presented in the meeting and summarized the group's questions.	
2. Shared Savings Programs (SSPs) and Accountable Care Organizations (ACOs) in Vermont	**<u>Overview of Shared Savings Programs (SSPs) and Accountable Care Organizations (ACOs) in Vermont</u>** Susan Besio presented attachment 2 and the following points were discussed: • There is a distinction between ACOs and SSPs. SSPs are payer programs which lay out specific requirements and ACOs are comprised of providers that come together to respond to those requirements. The definition of an SSP in the handout is incorrect, in that an SSP is the program created by the payer. For the Medicaid SSP, the contract is the agreement between the ACO and Medicaid. For the Commercial SSP, the agreement is between the ACO and the Commercial payer. Each ACO also has provider agreements with providers who sign up to participate in the ACO. • There are three types of SSPs operating in Vermont, based on payer: 1. Medicare: The Medicare SSP was created by CMS and the state has no say in how it is operated. ACOs in each state reach agreement with CMS regarding their participation in the program. 2. Medicaid: This SSP was designed based on the input of a work group of public and private sector stakeholders in Vermont, and was also vetted by the VHCIP Steering Committee and Core Team. The program is administered by DVHA. 3. Commercial (private payer) SSP: In many states, these programs are created solely by commercial carriers. Vermont is unique in that the Green Mountain Care Board was instrumental in bringing the private carriers and potential accountable care organizations, along with other stakeholders from the public and private sectors, together to develop the program parameters. • The Medicaid and Commercial SSPs were developed by Vermont stakeholders; the VHCIP (SIM) proposal included plans to develop both Medicaid and Commercial SSPs as one approach to achieving the health care reform goals of the state. • Because both the Medicaid and Commercial SSPs were designed concurrently by Vermont stakeholders, great efforts were made to align the design and administration of the two programs in order to allow ease of participation on the part of ACOs. • Because the Medicare SSP is a relationship between CMS and ACOs and is administered by CMS, the State has no control over this program. CMS has an established design for what	**The handout will be corrected and redistributed.** **Please contact Susan with any changes or updates to the document since networks are changing etc. sbesio@phpg.com.**

Agenda Item	Discussion	Next Steps
	quality and performance measures will be used in this program, and how they will be used to determine shared savings. Therefore, the DLTSS work group will not have the opportunity to make recommendations on quality measures for the Medicare SSP, but it will be able to make recommendations regarding the Medicaid and Commercial SSPs. • There are 4 ACOs operating in Vermont: o OneCare Vermont is participating in all three of the shared saving programs; their networks and other aspects look different for each shared savings program. o Health*first* is an association of independent provider practices. They've created two ACOs for participation in SSPs: o Accountable Care Coalition of the Green Mountains (ACCGM), the ACO for the Medicare SSP, and o VT Collaborative Physicians, the ACO for the Commercial SSP. Health*first* has not created an ACO to participate in the Medicaid SSP at this time. For Medicare, they are collaborating with Collaborative Health Systems for administrative functions. o Community Health Accountable Care (CHAC) is participating in all three of the shared savings programs; their networks and other aspects look different for each shared savings program. • Each payer develops virtually the same contract terms and conditions for their agreements with ACOs (i.e. all ACOs in the Medicaid SSP have virtually the same contract terms and conditions). • The Commercial contracts may not be made public because they are contracts between private organizations, but the programmatic standards are publicly available and will be posted in a new, easier to understand format on the VHCIP website in a few weeks. • Regarding Risk Profile (page 7): o Each of the SSPs has defined parameters regarding how ACOs can share in program savings. o "Upside risk" means that ACOs have to meet savings targets to share in an SSP savings, but they do not have to pay something back if they don't meet the savings targets. o "Downside risk" means the ACO may have to pay something back if they don't meet the savings targets. Depending on the SSP, there are different rules about the inclusion of downside risk at different times in each program. o Under current rules, the Medicare SSP has upside risk for three years and if ACOs	

Agenda Item	Discussion	Next Steps
	decide to participate after that they would have to bear some downside risk. o Currently the Medicaid SSP does not include downside risk for the three years of the program. This is partially because this is a new program and the State wanted to wait until the programs were more established. Furthermore, stakeholders in the VHCIP felt strongly that downside risk should not be included in the first three years of the Medicaid SSP. While the State doesn't anticipate changing this parameter in the three years, it plans to track expenditures and evaluate what would have been the impact if ACOs had accepted downside risk. This will help facilitate discussions regarding downside risk after the existing three year contract. o Vermont Commercial SSP includes upside risk for the first two years and strategies for including downside risk in year three are currently under review. The current Commercial SSP contracts are for three years. o The current Commercial and Medicaid SSP contracts are for three years, and there is not a penalty if an ACO ceases to participate after the first three years of an SSP. o If a provider within an ACO performs poorly, how are their attributed beneficiaries protected from the downside risk? ▪ Because the participation agreement is between a provider and an ACO, not a beneficiary and an ACO, beneficiaries are not exposed to financial risk. Furthermore, beneficiaries will have freedom of choice with regard to what provider they see consistent with their health plan benefit. For example, individual beneficiaries have a choice of provider and can move to another provider who is not participating in the ACO if the beneficiary does not like their provider. ▪ Because downside risk is not included in either the commercial or Medicaid SSPs in the current performance year, the Medicare SSP is the only example of a SSP that has potential downside risk. ▪ Another key component of beneficiary protection is quality and performance measurement thresholds. For example, if an ACO does not meet key performance metrics, then the amount of shared savings they receive will be affected. ▪ Finally, for both the Medicare and Medicaid shared savings programs (Medicare already complete, Medicaid in process) beneficiary notification letters will be sent out to all attributed beneficiaries letting them know that their provider is participating in an ACO. Because the participation	**Georgia will provide answer: In which SSP are people attributed who are enrolled in both Medicare and**

Agenda Item	Discussion	Next Steps
	agreements are between the providers and the ACO (not the beneficiaries and the ACO), beneficiaries don't need to indicate if they would like to participate in the program or not. However, if a beneficiary does not want their health plan to share their claims data with an ACO, they may choose to opt out of claims data sharing by completing a form enclosed in the beneficiary notification, or calling a number. ▪ The rules and regulations of the Medicare program are described in the federal registry (i.e., regulations). There also is an appeal process in place for the Medicare SSP, and the existing Medicaid grievance and appeals process applies in the case of the Medicaid SSP. Beneficiary protection is a top priority. • Regarding Cost Calculations (page 7): o **Key concept:** the service reimbursement mechanisms don't change in any of these programs. Medicare, Medicaid and Commercial are still paying all of the providers based on fee for service or other payment methods (e.g., DRGs for inpatient hospital stays). o Under the SSP arrangements the payer looks at past service claims for a set period of time (varies amongst the three SSPs) known as the "look back period" for the ACO attributed population and calculates their annual total cost of care and trend over time. If the ACOs actual expenditures in a performance year is below that expected expenditure trend by a certain percentage, the ACO will get a certain percentage of the savings. The process is based on predicting what those lives would have cost and then calculating what they actually cost, which is an accounting procedure, not a change in reimbursement methodology. o If money is saved, the ACO and the payer share it. o Cost calculations- the services that are included in the total cost of care are explained at the top of page 10 of the SSP-ACO Table. o No beneficiary can be attributed to more than one ACO in each SSP, since a beneficiary's cost of care must be attributed to only one ACO to determine potential savings. o There is about a six month lag between the end of the payer fiscal year and the determination of ACO savings: i.e. OneCare should know whether it has qualified for Year One MSSP savings sometime this summer. o The GMCB has the authority to monitor and regulate payment reforms. This	**Commercial insurance?**

Agenda Item	Discussion	Next Steps
	statutory authority will exist after the SIM grant ends. • One of the general concepts of the ACO model is to allow providers to work together to improve care delivery and increase the quality of care. If this leads to a decrease in the cost of care based on more efficient delivery, then savings are created. One of the ways ACOs do this, with participating providers, is to set care protocols around how services are provided. An important discussion with the DLTSS Work Group is how to have a consumer voice in those conversations. • Participants versus Affiliates: o The SSPs use the term "Participants" for providers in the ACO network that have attributed lives. All three SSP programs are very specific about the kinds of providers (PCP, FQHC) that are qualified to have attributed lives; Medicare's SSP is the narrowest in scope regarding these qualified providers. o Affiliate Participants are providers who don't have lives attributed to them but are also part of the ACO network. o Any Participant or Affiliate provider can sign an agreement with any or all of the three SSPs, although in the Medicare SSP the provider must have a Medicare billing number and CMS must approve shared savings arrangements with Affiliates. The shared savings formulas are still being determined by each ACO, but will most likely be different depending on the SSP. • Medicare SSP: o There are three Vermont ACOs that have contracts with CMS. They each had different start times, but the first year was treated in some cases as an 18 month performance period to get everybody on the same cycle. o About two-thirds of the State's PCPs are participating in the Medicare ACO's. o About half of all Medicare enrollees in Vermont are attributed to a Vermont Medicare ACO, which includes those dually eligible for Medicare and Medicaid. Note that the dual eligible population includes both low income seniors and individuals under 65 who have SSI (disability). The Medicare SSP also excludes anyone with a Medicare Advantage Plan which is about 7% (see ACO Table footnote 5). • Medicaid SSP: o Healthfirst is not participating. One Care and CHAC are participating. o CHAC has 9 FQHC's in the Medicaid SSP, but only 5 FQHCs in the Medicare SSP. o About 84% of PCP's are affiliated with an ACO in their service to Medicaid beneficiaries.	

Agenda Item	Discussion	Next Steps
	o Based on the most current provider rosters, attribution numbers for the two ACOs participating in the Medicaid SSP are as follows: ▪ OneCare Vermont: 27,000 attributed lives; or 28% of all attributable lives Community Health Accountable Care: 20,000 lives; or 21% of all attributable lives Combined, the two ACOs cover 49%, or roughly ½ of all attributable Medicaid beneficiaries. • Commercial SSP's: o There are two insurance carriers participating: BCBS and MVP. o Only those beneficiaries with an exchange plan (where purchased through an employer or individually at VT Health Connect) are eligible for attribution in a commercial carrier's SSP, per the Affordable Care Act. Roughly 70,000 individuals are eligible. About 43% of those who could be attributed to a commercial SSP are so attributed. The document has several footnotes that provide more details and clarification. Page 7 of the ACO Table details information about some of the SSP rules and how each program will work. These parameters are the same for all ACOs that participate in the particular SSP. • Performance Measures o In order to be eligible for savings, ACOs must first meet a quality performance threshold based on national performance benchmarks. If the threshold is met, the ACO's overall quality score determines the percentage of shared savings the ACO is eligible to receive. The higher the quality score for the ACO, the higher percentage of savings an ACO is eligible to receive. o In the Medicaid and Commercial SSPs, the Core Set of quality measures for year one of the program includes measures classified as Payment and measures classified as Reporting. ACOs performance on Payment measures will affect their quality score. ACOs performance on reporting measures will not affect their quality score; they are required to report these measures, but will not be penalized if they do not. In Year One, the Reporting measures can be met with either reported information *or* a plan to include reporting in subsequent years. o The Quality and Performance Measures Work Group is currently reviewing recommendations from other work groups regarding changes to performance measures for year two of the commercial and Medicaid SSPs.	

Agenda Item	Discussion	Next Steps
	o CMS makes ACO data regarding performance measures for the Medicare SSP publically available. VT has not made a plan yet for whether or how to share data on ACO performance measures for the Medicaid and Commercial SSPs.	
3. Public Comment/Updates/ Next Steps	No further comments were made. Public comments can also be emailed to staff and Co-Chairs. **Next Steps:** • This topic will be on the agenda as needed going forward but participants must review the material ahead of time or there will not be enough time to discuss. • An edited version of the ACO Table will be sent out to the group and Sam Liss's questions (that were emailed to Georgia) will be addressed in the next iteration. • Participants should contact Susan (sbesio@phpg.com) with any feedback on the document. Please distinguish between whether you have: a question; a correction in language or data; or a suggested change for clarity. **Next meeting:** Thursday, May 22nd, 2014 10:00 AM – 12:30 PM, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

Attachment 1c - DLTSS Work Group Minutes 5-22-14

VT Health Care Innovation Project
DLTSS Work Group Meeting Minutes

Date of meeting: Thursday May 22, 2014, 10 am – 12:30 pm, DVHA, 312 Hurricane Lane, Williston, VT

Attendees: Deborah Lisi-Baker and Judy Peterson, Co-Chairs; Georgia Maheras, AoA; Anya Wallack, Core Team Chair; Joy Chilton, CVHHH; Melissa Miles, Bi-State; Carol Maroni; Community Health Services of Lamoille County; Susan Besio, PHPG; John Barbour, CVAAA; Marie Zura, Howard Center; Molly Dugan, Cathedral Square; Dale Hackett, Consumer; Trinka Kerr, HCA; Rachel Seelig, VT Legal Aid; Ed Paquin, Disability Rights Vermont; Dion LaShay, Consumer; Sam Liss, Statewide Independent Living Council; Marybeth McCaffrey, DAIL; Madeline Mongan, VMS; Barbara Prine, VT Legal Aid; Jackie Majoros, LTC Ombudsman; Julie Tessler, VT Council of Developmental and Mental Health Services; Julie Wasserman, AHS; Jason Williams, FAHC; Brendan Hogan, Bailit Health Purchasing; Erin Flynn, Alicia Cooper, Amy Coonradt, Kara Suter, DVHA; Jeanne Hutchins, UVM Center on Aging; Pat Jones, GMCB; Norm Ward, OneCare; Nelson LaMothe, Jessica Mendizabal, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome and Introductions, and approval of the minutes.	Judy Peterson called the meeting to order at 10:05 am. Ed Paquin moved to approve the minutes from the April meeting and Carol Maroni seconded the motion. Carol noted she was left off the meeting attendance list but did attend. The motion passed pending the change.	**The minutes will be updated and posted to the website.**
2. DLTSS Quality and Performance Measures Recommendations to the QPM Work Group	Deborah Lisi-Baker thanked the group for their work on this project thus far. Julie Wasserman handed out the "Summary of Votes Needed" to determine DLTSSS Work Group recommendations to the Quality and Performance Measures Work Group. (This document was also distributed the morning of the meeting via email). The group reviewed the Performance Measures Reference Document (attachment 2b): • The payment measures are considered when calculating shared savings.	

Agenda Item	Discussion	Next Steps
	• Monitoring and Evaluation measures: are reported at the plan or state level, not obtained from ACOs and are not considered for calculating shared savings. • Reporting measures are required, but there is no penalty for not reporting. They are not considered for calculating shared savings. • Definition of the DLTSS population: the group will need to vote on a definition. Two potential definitions are 1) Individuals receiving specialized services, and 2) Individuals enrolled in Medicaid based on disability aide codes. (See the top of page 2 of the Reference document, attachment 2b). o Staff and Co-Chairs are proposing to use definition #2 because it is a broader view and captures those with needs who don't qualify for specialized waiver programs. o How do we account for those over 65? They do have a disability aid code associated with them. o Marybeth McCaffrey noted that the Medicaid system requires us to assign a category which describes the basis for their eligibility. There are over 200 aid categories and at least half are related to being aged, blind or disabled. Age is a disability aid code. o Susan Besio will do additional research to find out if the codes capture substance abuse and mental health populations**.** o Scott Whitman will attend the next meeting to discuss the DLTSS Medicaid Expenditure analysis and respond to questions on how those who need services are captured if they are not receiving services (such as income eligible families with a child with disabilities). o For people 65 years old and older, acute care is paid for by Medicare so those expenditures are not represented in the DLTSS Medicaid Expenditure analysis. o The DLTSS Work Group expressed concern about performance measurement for the dually eligible. Kara Suter commented that those who are dually eligible are not included in the Medicaid SSP. The Medicaid disability aide codes are: BD Child, ABD Adult, General Child and General Adult. o For the DLTSS sub population analyses, one option is for the state of VT to hire a contractor. • Measures recommended to the Quality and Performance Work Group will have to go through a multi-tiered approval process: QPM Work Group, Steering Committee, Core	**The group agreed to table the definition discussion until the next meeting. Participants should send additional comments via email.**

Agenda Item	Discussion	Next Steps
	Team and the GMCB. The QPM Work Group staff would communicate back at a future DLTSS work group meeting if certain recommended measures are not approved. • Attachment 2a-ACO All Measures: the final three columns were added to address DLTSS related information. • Dale asked if there was a code that reflects what the person is going to be treated for. This does not capture social determinants, and people might still be left out. o Julie responded that this list of measures is for all people attributed to a Medicaid ACO. There are measures that cover social determinants in this list. **Core- 8 Developmental Screening as a Payment measure for Commercial insurers**: Currently this measure is in the Medicaid ACO payment measure set and cannot easily be collected via claims in the Commercial population. The question is should this be added for the Commercial ACOs. The Population Health work group recommended that it be included. o This was recommended because there was interest in including it last year by GMCB and because people felt that it was an important measure. Developmental screening is a critical tool in assuring children receive needed services. Marybeth expressed support for making this motion. Ed Paquin and Sam Liss seconded. This measure would require the Commercial insurers to do a chart review; however, if providers began using the CPT code for this measure, it could potentially be claims based. Medicaid does reimburse for this and it's a nationally recognized CPT code. Marybeth moved to approve the recommendation and Jason Williams seconded. Madeline Mongan asked that the Commercial plans explore the possibility of turning on the reporting code for screenings so that it can be collected from claims. This is not conditional, just a recommendation. Jason stated he doesn't question the importance of doing the screening, but doesn't want to force another system to do something, noting we need a more effective way to measure it. It was pointed out that there are standard screening tools providers routinely use to measure developmental milestones in childhood.	

Agenda Item	Discussion	Next Steps
	Ed asked if the group has clearly stated that the purpose of these measures is to have an efficient way to spot check that an ACO is doing what needs to be done; and that we can't have measures that drill so deeply that we don't have the resources to perform the check. Carol Maroni noted she works with quality measures and they have to structure data to be able to mine it. The "how" should not stop us from collecting it. Georgia offered an amendment along with the motion to suggest the Commercial payers utilize the known CPT code to minimize administrative burden. The motion passed unanimously initially. Dale Hackett redacted his vote and changed it to "nay", for lack of information. The motion passed. **Core-12 Rate of Hospitalization for Ambulatory Care Sensitive Conditions:** CMS and DVHA recommend this measure be moved from reporting to payment. Good ambulatory (outpatient) care keeps people out of the hospital. The DLTSS recommendation concurs and also recommends a sub-analysis of the DLTSS population. Ed Paquin moved to approve the recommendation and Marybeth McCaffrey seconded. The motion passed unanimously. **Core 15, 16, 17, 19, 20:** relate to conditions or diseases whose impact may be more significant for the DLTSS population. The recommendation is to promote these measures from reporting to payment. John Barbour moved to approve the recommendation and Jackie Majoros seconded. Joy Chilton asked whether the diabetes related Core 16 & 17 measures are duplicative and will add to administrative burden, noting there is a cost to collect the data. Pat responded that the first measure is a composite of things going well for those with diabetes, and includes good	

Agenda Item	Discussion	Next Steps
	control measures. The second is more indicative of when things are not going well. The national group who developed both of these measures felt both were needed and complementary. These are not fully claims based measures and are currently in the reporting measure set. Carol Maroni noted that for the blood pressure measure there are new American Heart Association guidelines we need to be aware of. Deborah noted the DLTSS recommendations will go to the QPM staff to make adjustments and the group needs a timely way to give them input. Kara commented that these are not a standardized way to measure care management. These are performance measures and individual organizations may want to measure their care management differently. The motion passed unanimously. **Core-28 Coordination of Care Composite and Core-29 Specialist Composite:** Both of these "Patient Experience Measures" are important to the DLTSS population for measuring coordination of care and quality of care. The DLTSS recommendation is to add additional questions (re: case management services, and integration of acute care with DLTSS) to these existing Core measures. Ed moved to approve the recommendation and Julie Tessler seconded. The motion passed unanimously. The **LTSS Rebalancing Measure** is a new measure recommendation which aligns with Vermont's 10-15 year DAIL initiative of shifting public dollars from institutional care to home and community-based services. . Brendan noted that DAIL's rebalancing efforts are calculated via Medicaid claims, specifically for the Choices for Care waiver. This data has been collected for over 10 years at both the state and county level. The rebalancing concept also relates to DS, MH and the State hospital.	

Agenda Item	Discussion	Next Steps
	Pat noted that to put forward a new measure it's important to have clear specifications. She asked if this is Medicaid specific and if it is meant to be Monitoring and Evaluation on a statewide basis or ACO-specific. Julie responded that it is currently collected statewide. Marybeth commented that the nuances of the details should be left for future discussions in the interest of time. The proposal is to recommend the measure, which is as inclusive as possible, and work out the details later. Ed Paquin moved to adopt the recommendation for the new measure and that it be Reporting in Year two and move to Payment for Year 3. Monitoring and Evaluation is at the state level, reporting is at the ACO level. He changed Reporting to Monitoring and Evaluating in Year two. Julie Tessler noted that sometimes we send people out of state to get institutional-type care so we need to keep looking at this in the future. Julie Tessler seconded the motion. Jakie Majoros stated that there needs to be a connection between the statewide level and the ACO level and wants to understand how to make it an ACO specific measure. Because it is a claims based measure, we may be able to monitor it by ACO. Pat responded that if it's a fully claims based measure, attributed Medicaid beneficiaries could be flagged and we may be able to get some ACO-specific data. Pat hasn't seen the specification but if it can be done, it could be a Reporting measure. Ed changed his amendment to the motion back to the original language, understanding that we'll have to hear back from the QPM group on whether or not it's viable. The motion passed unanimously. **M&E-14 Avoidable ED Visits:** Recommended to be moved from Monitoring and Evaluation to Payment. Julie stated this measure is a predictor of whether the system is working well. Avoidable ED visits result in *unnecessary* hospitalizations, readmissions, and nursing home stays which contribute to higher health care costs. (M&E 19 is straight inpatient utilization without	

Agenda Item	Discussion	Next Steps
	regard for condition, outpatient care, etc.) Carol stated sometimes patients choose to go to ER because they want to be seen quickly and don't have to worry about ER costs personally. We also need to teach the population to wait and know that PCPs have same day appointment openings. She stated Monitoring and Evaluation is a good place for this measure. Ed Paquin moved to approve the original recommendation as proposed. John Barbour seconded the motion. Pat stated she it would be necessary to determine an appropriate benchmark if this measure were to be used for Payment. **Overall Measures-Include a DLTSS sub-population analysis for all measures selected for endorsement by the DLTSS Work Group:** A discussion of the specific definition of the DLTSS Sub-group will occur in the future.. Rachel Seelig moved to approve the recommendation and Jackie Majoros seconded. **Regarding a possible RFP for analysis of the DLTSS sub-population: Georgia, staff and Co-Chairs will work on a more detailed proposal for the DLTSS Work Group over the next several months.** Dale Hackett abstained from voting and the motion passed. **Core 36, 39, 40, 45 - Recommendation from the Population Health Work Group to promote these measures from Pending to Reporting in Year 2.** Ed Paquin moved to approve the recommendation and Rachel Seelig seconded. Madeline asked why these measures are pending. Alicia responded that all the reasons why the measures are pending (e.g. lack of data or specifications, burdensome, etc) will be considered by QPM. Madeline Mongan and Dale Hackett abstained from voting and the motion passed.	

Agenda Item	Discussion	Next Steps
6. Public Comment/Updates/ Next Steps	**Next Steps:** • Continue the discussion on the definition of the DLTSS sub-population. • Discuss a plan for presentation of AHS survey results for the DLTSS Work Group. • Discuss how the HIE group's ACTT proposal partners can explore strategies for measuring the additional DLTSS measures listed in the Performance Measures Reference Document. Staff thanked the group for going through the process and all offered special thanks to the phone participants. **Next meeting:** Thursday June 19, 2014 10:00 AM – 12:30 PM, AHS Training Room, 208 Hurricane Lane, Williston.	

Attachment 2a - Medicaid Expenditure Analysis

State of Vermont
Disability & Long Term Services and Supports (DLTSS) Medicaid Expenditures
Calendar Year 2012

April 24, 2014

Finalized June 6, 2014

Prepared by the Pacific Health Policy Group
for the VHCIP DLTSS Work Group

Introduction

- Purpose of Discussion
  - Review role of Medicaid related to funding of both "traditional" health services as well as specialized programs and services (Slides 4 through 10)
  - Review Medicaid expenditures on behalf of individuals receiving specialized services versus all other Medicaid program participants (Slides 11 & 12)
  - Review Medicaid expenditures on the basis of eligibility (Slides 13 & 14)

- *Data Notes*
  - *Dates of service between 1/1/12 and 12/31/12*
  - *Includes individuals eligible for full Medicaid benefits*
  - *Pharmacy includes rebate factor of 44%*
  - *Claims only; excludes:*
    - *Managed care investments*
    - *Medicare Buy-in*
    - *Other Payments made outside the claims system (e.g., PACE capitation payments)*
  - *For Planning Only – Data have not been validated against secondary sources*

Role of the Vermont Medicaid Program

The Vermont Medicaid program essentially has two roles. The Medicaid program's policies related to both service coverage and eligibility reflect these two roles. Medicaid provides coverage for:

"*Traditional Services*"

Like commercial health insurance policies, the Vermont Medicaid program provides coverage for traditional services, such as hospital, physician, pharmacy, and dental services

"*Specialized Programs and Services*"

The Vermont Medicaid program is the primary funding source for several specialized health programs, including long-term care, Developmental Services, and the public mental health and substance abuse treatment systems; these programs receive limited financial support outside of the Vermont Medicaid program. Medicaid also is an important financial resource for supporting public care systems, including Department for Children and Families (DCF) and school-based health services.

Expenditure Summary by Program

In recognition of the Medicaid program's two roles, services were categorized as follows:

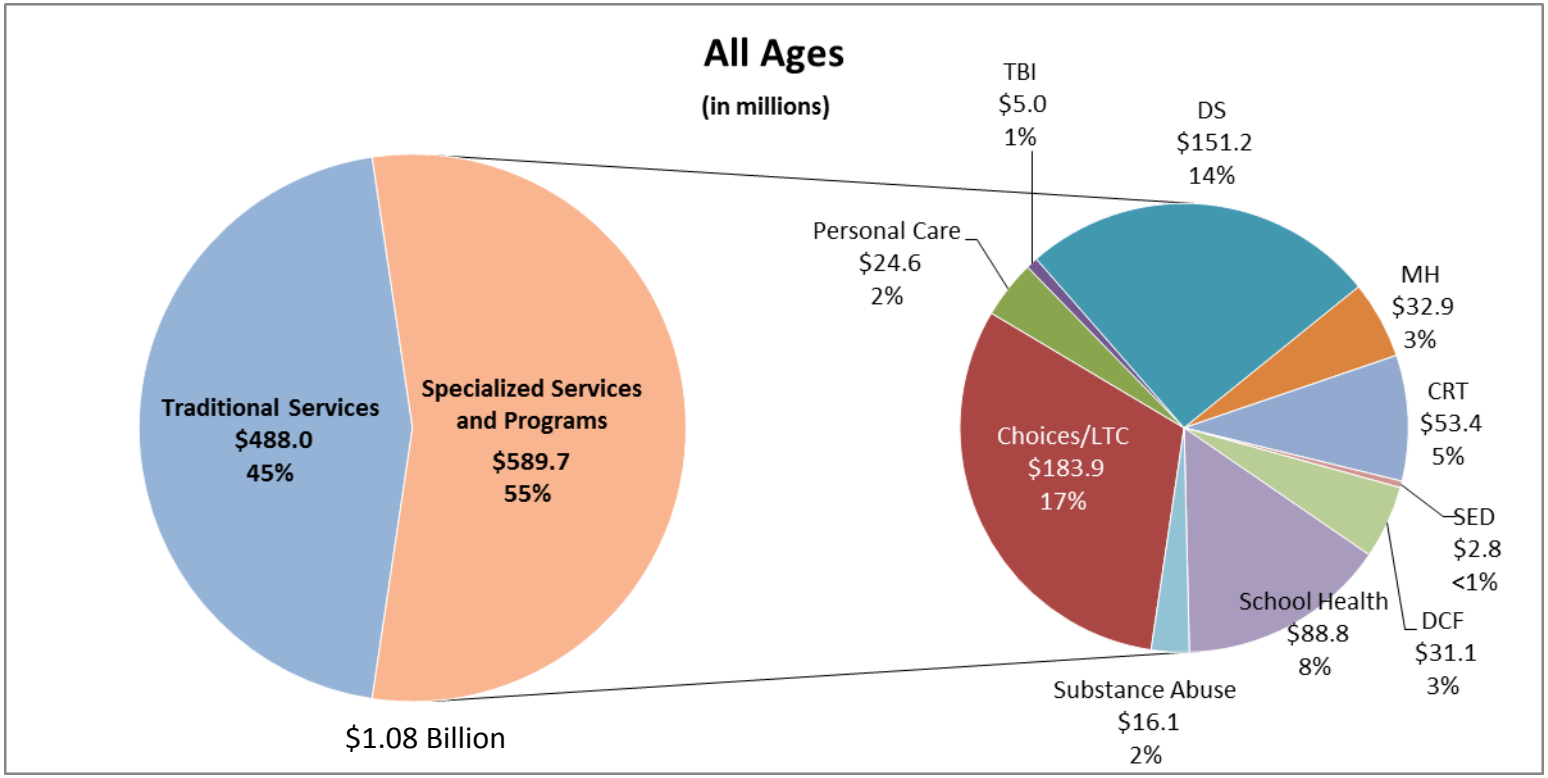
Traditional

- Ambulance
- Dental
- Durable Medical Equipment
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)
- Home Health
- Hospice
- Independent Lab
- Inpatient Hospital
- Medical Supplies
- Other
- Other Practitioner
- Outpatient Hospital
- Pharmacy
- Physician
- Prosthetic/Orthotic
- Therapy Services
- Transportation

Specialized Services and Programs

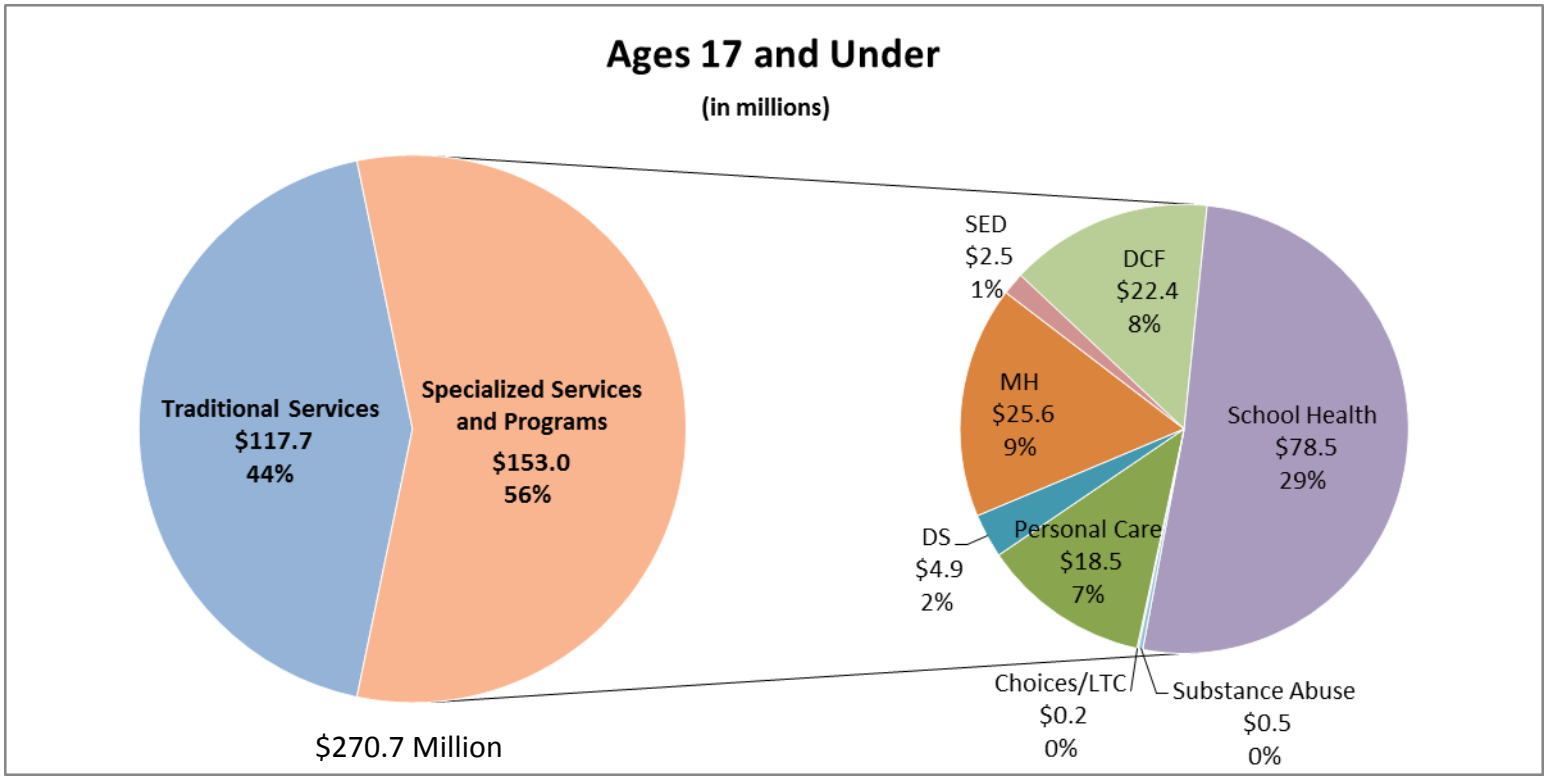
- Choices for Care/Long-Term Care
  Assistive Community Care, Choices for Care Home and Community Based Services (HCBS), Nursing Home
- Personal Care
- Traumatic Brain Injury (TBI) Program
- Developmental Services
  Developmental Services, Intermediate Care Facility/Intellectual Disabilities (ICF/ID)
- Mental Health Treatment
  Community Rehabilitation Treatment, Day Treatment, Day Treatment/Private Non-Medical Institution (PNMI), Children and Adolescents with Serious Emotional Disturbances (SED), Mental Health Facility, Targeted Case Management
- Department for Children and Families - Case Management
- School Health
  Department of Health, School-Based Health Services (DOE), Success Beyond Six
- Substance Abuse Treatment

Medicaid Expenditure Summary by Program: All Ages



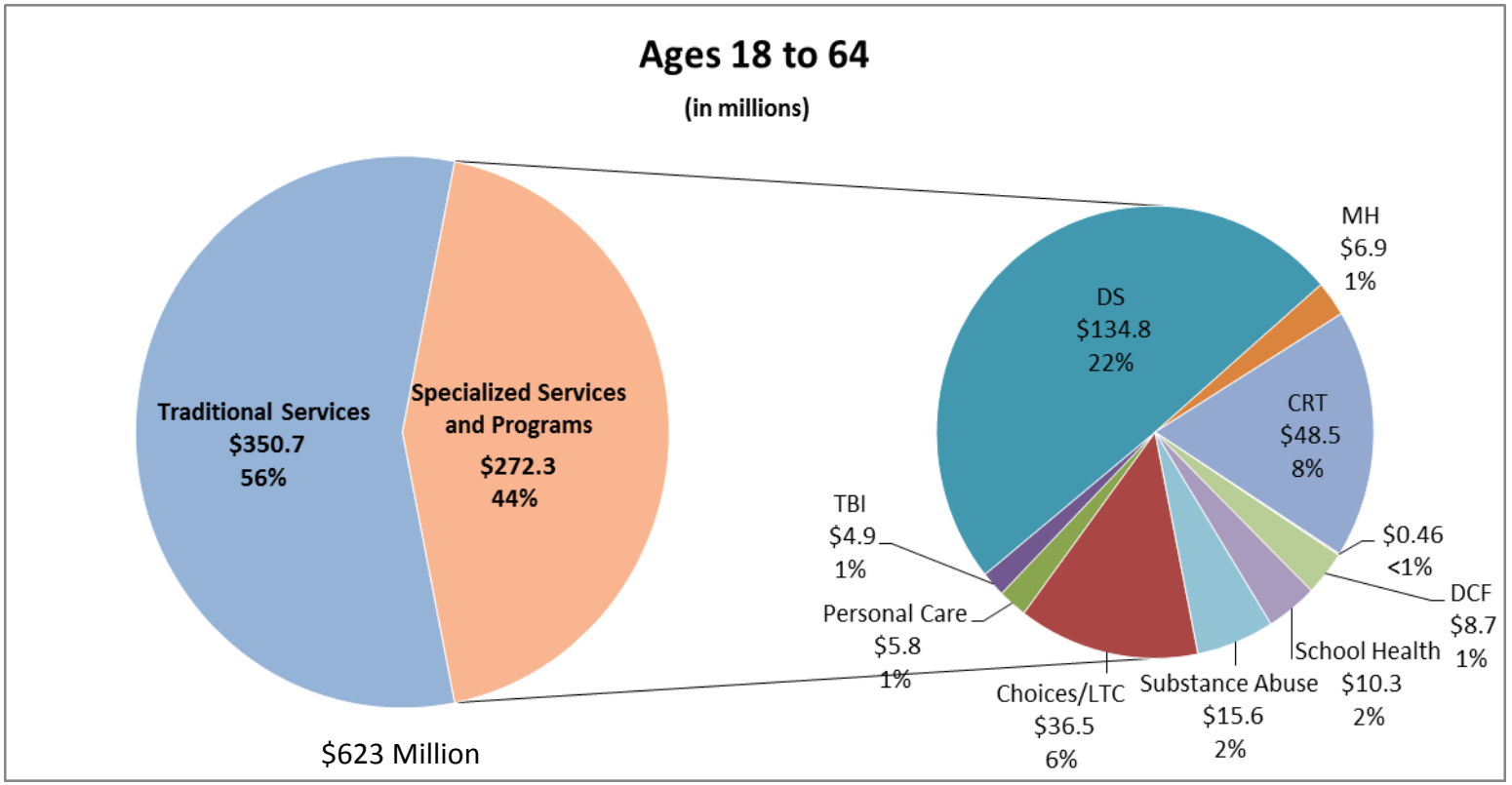
The Vermont Medicaid program spends approximately $488 million **(45%)** for coverage of traditional services and approximately $590 million **(55%)** to support specialized services and programs

Medicaid Expenditure Summary by Program: Ages 17 and Under



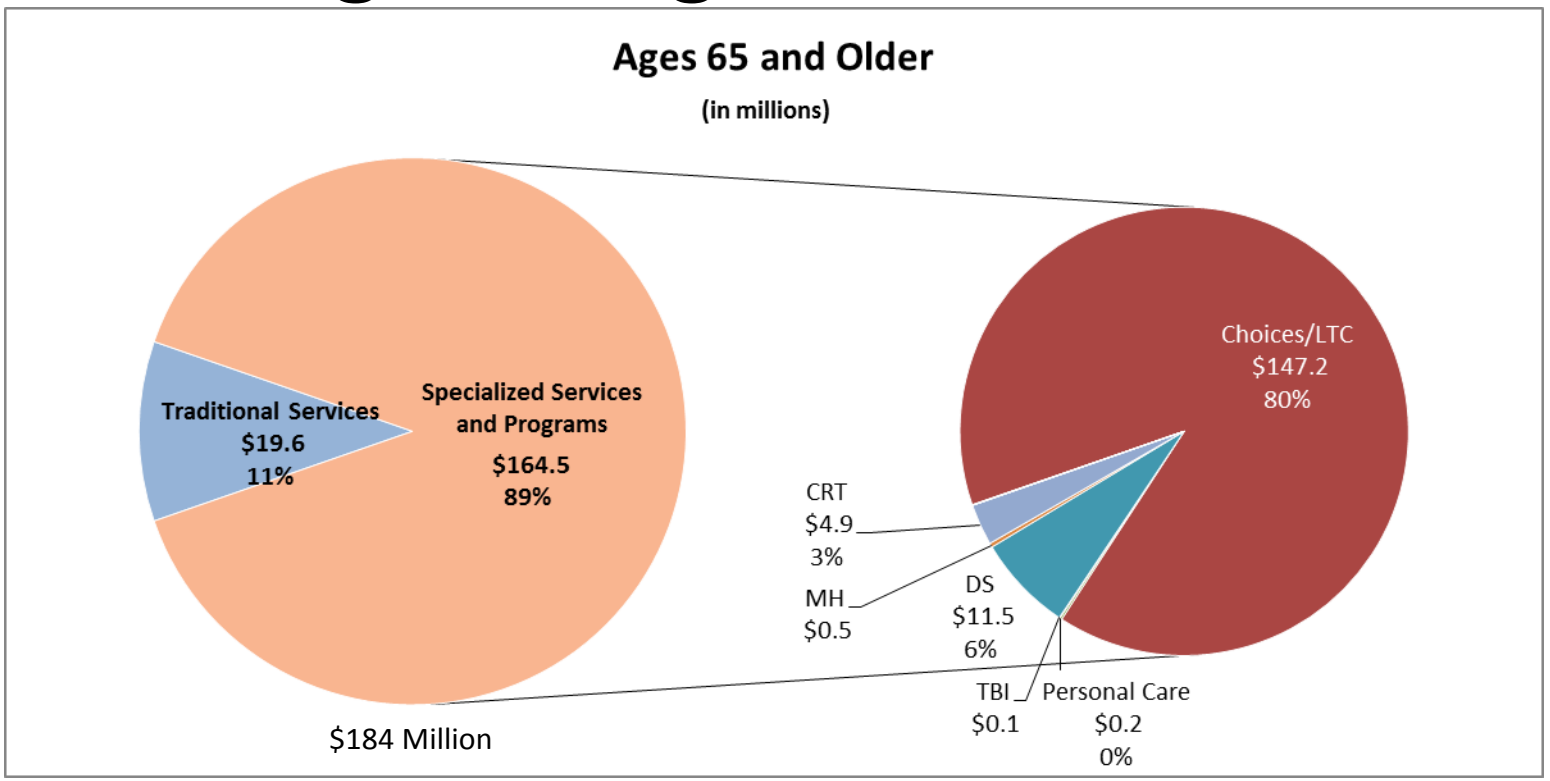
Specialized services for children and adolescents represent more than one-half of total program spending on behalf of children

Medicaid Expenditure Summary by Program: Ages 18 to 64



Developmental Services funding on behalf of adults between the ages of 18 and 64 accounts for approximately one-half of specialized service expenditures for this age group and approximately 90 percent of total Developmental Services spending on behalf of all ages (see Slide 10)

Medicaid Expenditure Summary by Program: Ages 65 and Over



Most Vermonters who are 65 years and older have Medicare coverage for traditional services. For individuals who are dually eligible, Medicaid provides financial assistance to meet Medicare cost sharing obligations and provides coverage for some services not covered by Medicare. Long term care represents eighty percent of total Medicaid expenditures on behalf of individuals ages 65 and older. *(Note: Figures do not include Medicaid payments for Medicare premiums)*

Medicaid Expenditure Detail: Traditional Services

($ millions)

Traditional Services	Age Range			
	Less than 18	18 to 64	65 and Older	Total Paid
Ambulance	$ 0.5	$ 2.7	$ 0.7	$ 3.9
Dental	$ 12.2	$ 7.1	$ 0.4	$ 19.6
Durable Medical Equipment	$ 1.5	$ 5.1	$ 1.2	$ 7.8
FQHC/RHC	$ 7.2	$ 16.0	$ 0.7	$ 23.9
Home Health	$ 1.8	$ 4.2	$ 1.3	$ 7.3
Hospice	$ 0.0	$ 0.3	$ 0.5	$ 0.8
Independent Lab	$ 0.3	$ 5.0	$ 0.0	$ 5.3
Inpatient Hospital	$ 26.8	$ 90.4	$ 3.0	$ 120.2
Medical Supplies	$ 0.2	$ 0.5	$ 0.1	$ 0.8
Other	$ 0.1	$ 1.3	$ 0.3	$ 1.7
Other Practitioner	$ 9.9	$ 16.3	$ 0.5	$ 26.7
Outpatient Hospital	$ 15.8	$ 78.8	$ 5.3	$ 99.9
Pharmacy	$ 16.3	$ 59.1	$ 0.6	$ 76.0
Physician	$ 22.8	$ 56.5	$ 2.8	$ 82.1
Prosthetic/Orthotic	$ 1.3	$ 1.5	$ 0.0	$ 2.9
Therapy Services	$ 0.7	$ 2.2	$ 0.2	$ 3.1
Transportation	$ 0.3	$ 3.9	$ 2.1	$ 6.2
Total	**$ 117.7**	**$ 350.7**	**$ 19.6**	**$ 488.0**

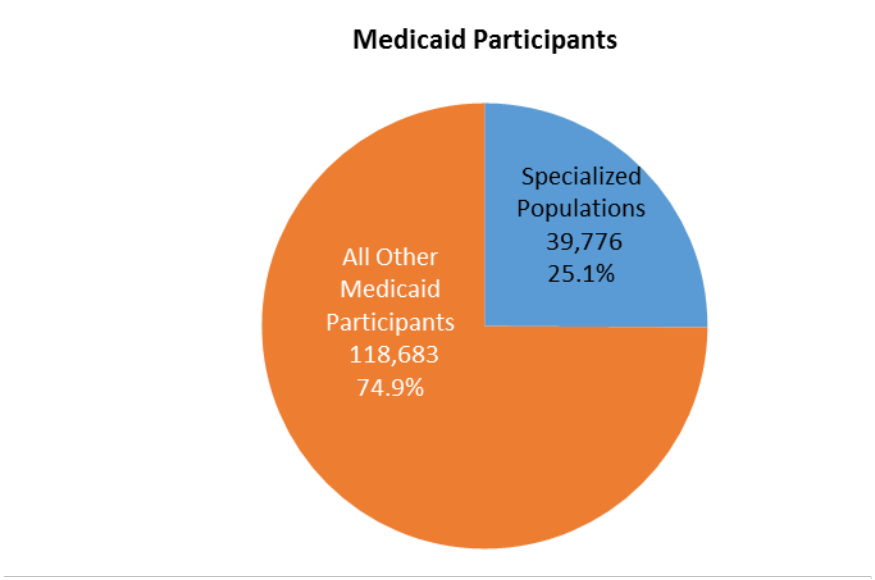
Coverage of traditional services on behalf of non-elderly (ages 18 to 64) adults accounts for approximately 70 percent of Medicaid spending for traditional services. Payments for inpatient and outpatient hospital services total approximately $220 million for all age groups, approximately 45 percent of total spending for traditional services.

Expenditure Detail: Specialized Services and Programs

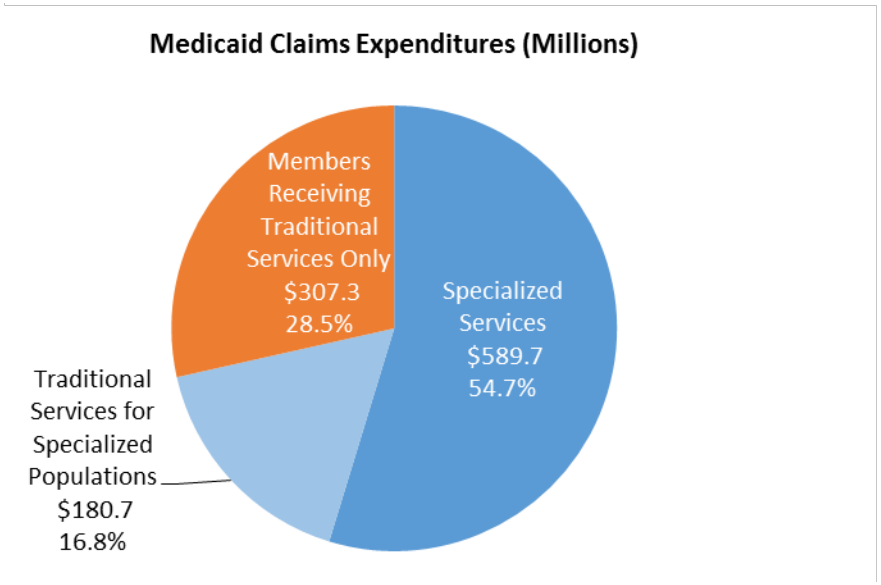
($ millions)

Specialized Services and Programs	Age Range			
	Less than 18	18 to 64	65 and Older	Total Paid
Choices for Care/Long Term Care				
Assistive Community Care	$ -	$ 4.9	$ 10.6	$ 15.4
Choices for Care HCBS	$ -	$ 17.8	$ 33.7	$ 51.5
Nursing Home	$ 0.2	$ 13.7	$ 103.0	$ 116.9
Subtotal	*$ 0.2*	*$ 36.5*	*$ 147.2*	*$ 183.9*
Personal Care Services	$ 18.5	$ 5.8	$ 0.2	$ 24.6
Traumatic Brain Injury (TBI) Program	$ -	$ 4.9	$ 0.1	$ 5.0
Developmental Services				
Developmental Services HCBS	$ 4.9	$ 133.6	$ 11.4	$ 149.9
ICF/ID (DS)	$ -	$ 1.2	$ 0.1	$ 1.3
Subtotal	*$ 4.9*	*$ 134.8*	*$ 11.5*	*$ 151.2*
Mental Health Treatment				
Community Rehabilitation and Treatment (CRT)	$ -	$ 48.5	$ 4.9	$ 53.4
Day Treatment/Private Non-Medical Institution	$ 9.7	$ 1.5	$ 0.2	$ 11.4
HCBS SED Children and Adolescents	$ 2.5	$ 0.3	$ -	$ 2.8
Mental Health Facility	$ 11.8	$ 4.8	$ 0.2	$ 16.8
Targeted Case Management -MH	$ 4.1	$ 0.6	$ 0.0	$ 4.7
Subtotal	*$ 28.0*	*$ 55.7*	*$ 5.4*	*$ 89.1*
Department for Children and Families	$ 22.4	$ 8.7	$ 0.0	$ 31.1
School Health				
Department of Health	$ 1.0	$ 0.1	$ -	$ 1.1
School-Based Health Services (DOE)	$ 35.1	$ 5.1	$ -	$ 40.2
Success Beyond Six	$ 42.4	$ 5.1	$ -	$ 47.5
Subtotal	*$ 78.5*	*$ 10.3*	*$ -*	*$ 88.8*
Substance Abuse Treatment	$ 0.5	$ 15.6	$ 0.0	$ 16.1
Total	**$ 153.0**	**$ 272.3**	**$ 164.5**	**$ 589.7**

Expenditure and Enrollment Summary: Individuals Receiving Specialized Services v. All Other Medicaid Program Participants



158,459 Service Recipients



$1.08 Billion

Individuals receiving specialized services represent approximately 25 percent of total Medicaid participants receiving services, but coverage of services to meet their DLTSS and traditional medical needs comprises more than 70 percent of the Medicaid budget

Medicaid Expenditures: Individuals Receiving Specialized Services v. All Other Medicaid Participants

$ millions

Program	Program Participants	Percent of Total	Traditional Services		Specialized Services		All Services	
			Expenditures	Percent of Total	Expenditures	Percent of Total	Expenditures	Percent of Total
Primary Specialized Programs								
Choices for Care/LTC	6,673	4.2%	$ 31.2	6.4%	$ 184.7	31.3%	215.9	20.0%
Personal Care	1,555	1.0%	$ 10.4	2.1%	$ 22.3	3.8%	32.7	3.0%
Traumatic Brain Injury	71	0.0%	$ 0.4	0.1%	$ 5.0	0.8%	5.4	0.5%
Developmental Services	2,952	1.9%	$ 11.8	2.4%	$ 155.8	26.4%	167.6	15.6%
MH Treatment	3,799	2.4%	$ 15.3	3.1%	$ 27.1	4.6%	42.4	3.9%
CRT	2,215	1.4%	$ 17.4	3.6%	$ 55.5	9.4%	72.9	6.8%
SED	95	0.1%	$ 0.7	0.1%	$ 2.8	0.5%	3.5	0.3%
Substance Abuse Treatment	5,186	3.3%	$ 32.7	6.7%	$ 15.9	2.7%	48.6	4.5%
Subtotal	*22,546*	*14.2%*	*$ 120.0*	*24.6%*	*$ 469.1*	*79.5%*	*589.0*	*54.7%*
Other Specialized Programs								
DCF Case Management	6,791	4.3%	$ 32.9	6.7%	$ 29.6	5.0%	62.6	5.8%
Department of Health	164	0.1%	$ 1.3	0.3%	$ 0.5	0.1%	1.8	0.2%
School-Based Health Services	7,141	4.5%	$ 15.6	3.2%	$ 37.6	6.4%	53.1	4.9%
Success Beyond Six	3,134	2.0%	$ 10.9	2.2%	$ 53.0	9.0%	63.9	5.9%
Subtotal	*17,230*	*10.9%*	*$ 60.7*	*12.4%*	*$ 120.7*	*20.5%*	*181.4*	*16.8%*
Subtotal: All Specialized Programs	***39,776***	***25.1%***	***$ 180.7***	***37.0%***	***$ 589.7***	***100.0%***	***770.4***	***71.5%***
All Other Medicaid Participants	***118,683***	***74.9%***	***$ 307.3***	***63.0%***	***$ -***	***0.0%***	***307.3***	***28.5%***
Total	**158,459**	**100.0%**	**$ 488.0**	**100.0%**	**$ 589.7**	**100.0%**	**1,077.8**	**100.0%**

Summary of Expenditures: Basis for Eligibility

- Medicaid eligibility rules reflect the important role of Medicaid in meeting the coverage needs of individuals with specialized needs
- Eligibility rules extend coverage to individuals with specialized needs and extensive health care needs
- Individuals enrolled on the basis of their medical needs represent approximately one-fourth of all Medicaid program participants
- Expenditures on behalf of individuals eligible due to medical needs represent 58 percent of total program expenditures *(Detail provided on next slide)*

Expenditures by Basis of Eligibility and Age *($ millions)*

Service Description	Non-Disability Related Aid Codes				Disability Related Aid Codes				Total: All Participants	Percentage of Expenditures: Disability-Related Aid Codes
Age:	Less than 18	18 to 64	65 and Older	Total	Less than 18	18 to 64	65 and Older	Total		
Program Recipients	58,429	57,500	3,512	**119,441**	4,326	28,056	6,636	**39,018**	**158,459**	
Percentage of Total	*37%*	*36%*	*2%*	***75%***	*3%*	*18%*	*4%*	***25%***		
Traditional Services										
Ambulance	$ 0.4	$ 1.1	$ 0.2	$ 1.8	$ 0.1	$ 1.5	$ 0.5	$ 2.1	$ 3.9	*54%*
Dental	$ 11.2	$ 3.5	$ 0.2	$ 14.9	$ 1.0	$ 3.6	$ 0.2	$ 4.7	$ 19.6	*24%*
Durable Medical Equipment	$ 0.6	$ 1.5	$ 0.4	$ 2.5	$ 0.9	$ 3.6	$ 0.8	$ 5.3	$ 7.8	*68%*
FQHC/RHC	$ 6.7	$ 10.9	$ 0.3	$ 17.9	$ 0.5	$ 5.1	$ 0.4	$ 5.9	$ 23.9	*25%*
Home Health	$ 1.2	$ 1.0	$ 0.3	$ 2.5	$ 0.6	$ 3.2	$ 0.9	$ 4.8	$ 7.3	*66%*
Hospice	$ 0.0	$ 0.1	$ 0.0	$ 0.1	$ -	$ 0.2	$ 0.5	$ 0.7	$ 0.8	*89%*
Independent Lab	$ 0.2	$ 3.9	$ 0.0	$ 4.1	$ 0.0	$ 1.1	$ 0.0	$ 1.1	$ 5.3	*21%*
Inpatient Hospital	$ 22.3	$ 59.7	$ 1.3	$ 83.3	$ 4.5	$ 30.7	$ 1.7	$ 36.9	$ 120.2	*31%*
Medical Supplies	$ 0.1	$ 0.2	$ 0.0	$ 0.3	$ 0.1	$ 0.3	$ 0.0	$ 0.5	$ 0.8	*58%*
Other	$ 0.1	$ 0.4	$ 0.1	$ 0.5	$ 0.0	$ 0.9	$ 0.2	$ 1.2	$ 1.7	*68%*
Other Practitioner	$ 7.1	$ 9.5	$ 0.1	$ 16.7	$ 2.8	$ 6.8	$ 0.4	$ 10.0	$ 26.7	*37%*
Outpatient Hospital	$ 14.1	$ 50.7	$ 2.4	$ 67.2	$ 1.7	$ 28.1	$ 2.9	$ 32.7	$ 99.9	*33%*
Pharmacy	$ 11.4	$ 36.1	$ 0.1	$ 47.6	$ 4.9	$ 23.0	$ 0.5	$ 28.4	$ 76.0	*37%*
Physician	$ 20.5	$ 38.9	$ 1.2	$ 60.6	$ 2.3	$ 17.6	$ 1.6	$ 21.5	$ 82.1	*26%*
Prosthetic/Orthotic	$ 0.4	$ 0.7	$ 0.0	$ 1.2	$ 0.9	$ 0.9	$ 0.0	$ 1.8	$ 2.9	*61%*
Therapy Services	$ 0.5	$ 1.6	$ 0.1	$ 2.2	$ 0.2	$ 0.6	$ 0.1	$ 0.9	$ 3.1	*29%*
Transportation	$ 0.2	$ 0.5	$ 0.5	$ 1.3	$ 0.1	$ 3.3	$ 1.5	$ 4.9	$ 6.2	*79%*
Subtotal: Traditional Services	***$ 97.1***	***$ 220.3***	***$ 7.3***	***$ 324.7***	***$ 20.6***	***$ 130.4***	***$ 12.3***	***$ 163.4***	***$ 488.0***	***33%***
Specialized Services										
Assistive Community Care	$ -	$ 0.4	$ 3.0	$ 3.4	$ -	$ 4.5	$ 7.5	$ 12.1	$ 15.4	*78%*
Choices for Care HCBS	$ -	$ 0.0	$ 4.2	$ 4.3	$ -	$ 17.8	$ 29.5	$ 47.3	$ 51.5	*92%*
Nursing Home	$ -	$ 0.2	$ 3.4	$ 3.6	$ 0.2	$ 13.5	$ 99.6	$ 113.3	$ 116.9	*97%*
Personal Care Services	$ 4.8	$ 0.4	$ 0.1	$ 5.3	$ 13.8	$ 5.4	$ 0.1	$ 19.3	$ 24.6	*79%*
Traumatic Brain Injury (TBI)	$ -	$ -	$ -	$ -	$ -	$ 4.9	$ 0.1	$ 5.0	$ 5.0	*100%*
Developmental Services HCBS	$ 0.8	$ 0.5	$ 1.5	$ 2.8	$ 4.1	$ 133.1	$ 9.9	$ 147.0	$ 149.9	*98%*
ICF/ID (DS)	$ -	$ -	$ -	$ -	$ -	$ 1.2	$ 0.1	$ 1.3	$ 1.3	*100%*
CRT	$ -	$ 3.1	$ 1.4	$ 4.5	$ -	$ 45.4	$ 3.5	$ 48.9	$ 53.4	*92%*
Day Treatment/Private Non-Medical Inst (PNMI)	$ 6.6	$ 1.2	$ 0.1	$ 7.9	$ 3.1	$ 0.3	$ 0.1	$ 3.5	$ 11.4	*31%*
HCBS SED Children and Adolescents	$ 1.7	$ 0.1	$ -	$ 1.8	$ 0.8	$ 0.2	$ -	$ 1.0	$ 2.8	*36%*
Mental Health Facility	$ 7.8	$ 1.6	$ 0.1	$ 9.4	$ 4.0	$ 3.2	$ 0.1	$ 7.4	$ 16.8	*44%*
Targeted Case Management -MH	$ 2.9	$ 0.2	$ 0.0	$ 3.1	$ 1.2	$ 0.3	$ 0.0	$ 1.6	$ 4.7	*34%*
DCF - Case Management	$ 18.9	$ 5.4	$ 0.0	$ 24.2	$ 3.5	$ 3.3	$ 0.0	$ 6.9	$ 31.1	*22%*
Department of Health	$ 0.5	$ 0.0	$ -	$ 0.5	$ 0.5	$ 0.1	$ -	$ 0.5	$ 1.1	*49%*
School-Based Health Services (DOE)	$ 18.3	$ 1.0	$ -	$ 19.4	$ 16.8	$ 4.0	$ -	$ 20.8	$ 40.2	*52%*
Day Trmt - Success Beyond Six	$ 24.9	$ 1.7	$ -	$ 26.6	$ 17.6	$ 3.4	$ -	$ 20.9	$ 47.5	*44%*
Substance Abuse Treatment	$ 0.4	$ 11.5	$ 0.0	$ 11.9	$ 0.1	$ 4.1	$ 0.0	$ 4.2	$ 16.1	*26%*
Subtotal: Specialized Services	***$ 87.5***	***$ 27.4***	***$ 13.9***	***$ 128.7***	***$ 65.5***	***$ 244.9***	***$ 150.6***	***$ 461.0***	***$ 589.7***	***78%***
Total	**$ 184.6**	**$ 247.6**	**$ 21.2**	**$ 453.4**	**$ 86.1**	**$ 375.4**	**$ 162.9**	**$ 624.4**	**$ 1,077.8**	**58%**

Attachment 2b - Medicaid Expenditure Analysis - DLTSS WG Member Questions Responses

Responses to DLTSS Work Group Member Comments and Questions regarding the DLTSS Medicaid Expenditure Analysis presented on April 24, 2014

Prepared by the Pacific Health Policy Group (PHPG)

June 9, 2014

This document provides responses to questions raised by the Disability and Long-Term Services and Supports (DLTSS) Work Group members and other interested stakeholders regarding a presentation provided at the April 24, 2014 DLTSS Work Group meeting on Medicaid Expenditure Analysis performed by PHPG. The primary purpose of this analysis was to identify expenditures in Vermont's Medicaid program that are related to enrollees with DLTSS needs. The analysis examined the DLTSS expenditures utilizing two approaches: 1) expenditures related to the Medicaid specialized services and programs for specific populations who have DLTSS needs, and 2) expenditures for Medicaid enrollees who were determined Medicaid-eligible due to a DLTSS-related aid category. As such, this document is divided into two sections to reflect questions related to each approach, beginning with a descriptive overview to provide context for the approach.

Analyses Comparing Traditional versus Specialized Services (Slides 3 - 12):

Overview of Traditional versus Specialized Services: *Medicaid is a federal government program to help provide health care coverage to people who have low income and few assets (other than the home they live in). Among those covered by Medicaid are people over 65 and those with disabilities. Each state runs its own version of Medicaid, with slightly different rules and coverage.*

Coverage under the Vermont Medicaid program includes:

- *Medical benefits that are typical of other comprehensive health insurance plans offered by commercial insurers and by Medicare. Medicaid also pays Medicare premiums, deductibles, and co-payments for people who are enrolled in both programs.*
- *Specialized services and programs designed to support Medicaid enrollees with unique needs; these programs receive limited financial support outside of the Vermont Medicaid program.*
    - *Comprehensive specialized programs that serve individuals with disability and long-term services and support needs, including long-term care provided in-home and in nursing facilities, developmental services and the public mental health and substance abuse treatment systems. Income and asset eligibility rules for these long-term, at-home care programs are usually quite a bit looser than for regular Medicaid medical coverage.*
    - *Financial support for public care systems for children, such as case management for children in custody of the Department for Children and Families (DCF); Department of Health nurses within schools; school-based health services related to a student's Individualized Educational Program (administered by the VT Department of Education); and Success Beyond Six, in which school districts or supervisory unions contract with their region's community mental health center to provide mental health services to Medicaid eligible students, consultation to teachers, and early intervention and prevention supports to whole classrooms or groups of students.*

Specific Questions and Responses related to Analyses Comparing Traditional versus Specialized Services (Slides 3 - 12):

1. Slide 4: Nursing home expenditures are not listed as a "traditional" Medicaid covered item, but instead are listed as a subset of Choices for Care. Prior to CFC start in 2006, they would have been listed as a traditional service. The cost of nursing home care is almost two thirds of the whole Choices for Care Program and for people 65 and over it is 70% ($103 million out of a total CFC cost for this age group of $147.2 million) – these are the numbers on p. 10.

   Response: It is correct that nursing home services are classified as Medicaid State Plan services. However, in these analyses, we are comparing the utilization and costs of traditional services covered by Medicaid that also would be covered by commercial health insurance policies (e.g., hospital, physician, pharmacy, and dental service) versus those specialized services that are only covered by Medicaid due to a person's disability or long-term care need. As such, nursing home services were included as a specialized service because commercial plans only have limited coverage for nursing home stays when there is a medical need for skilled nursing care (like changing sterile dressings). Further evidence that this is the appropriate classification for nursing home services can be found on page 14 where the data show that 97% of the Medicaid expenditures for nursing home services were for individuals enrolled due to disability-related aid codes and thus, most likely were not for time-limited skilled nursing care.

2. Slides 4 - 9: Home health is listed in traditional even though some home health services are LTSS – how was the decision made to put it in traditional rather than specialized services programs? Was it based on the preponderance and/or type of claims?

   Response: As stated above, the intent of this analysis is to distinguish between traditional services covered by Medicaid that also would be covered by commercial health insurance policies (e.g., hospital, physician, pharmacy, and dental service) versus those specialized services that are only covered by Medicaid due to a person's disability or long-term care need. As noted in the comment, home health services are a hybrid between the two; home health agencies provide medical physician-ordered services which are covered by commercial insurers (as well as Medicare and Medicaid), while home health agencies also provide long term supports and services (LTSS) that are only covered by Medicaid i.e., for enrollees in the Specialized Services and Programs). We included home health expenditures in the traditional services category because they are services that are broadly available to Vermont Medicaid enrollees.

3. Slides 5 – 8: Most of the acute care for people over age 65 is paid for by Medicare so those expenses are not represented in the Medicaid Expenditure Analysis. → Susan Besio agreed to review the Duals Eligibles Project data to determine how much was spent by Medicare for dual eligibles.

   Response: Agreed. As noted on Slide 8 "Most Vermonters who are 65 years and older have Medicare coverage for traditional services." The traditional service expenditures represented in these slides (regardless of age) does not reflect Medicare expenditures for traditional services (i.e., Part A and B) for dual eligibles, which would be in addition to the Medicaid expenditures. In Calendar Year 2010, Medicare expenditures for dual eligibles in VT were $190 million.

Service Category	CY 2010 Payments
Diagnostic Testing	$15,775,103
DME-Supplies	$7,130,420
Home Health-Care	$9,789,119

Service Category	CY 2010 Payments
Hospice	$2,713,082
Inpatient Hospital	$72,460,357
Mental Health-SA Clinic	$458,739
Miscellaneous	$2,141
Nursing Home	$25,605,577
Non-Physician Practitioner	$3,405,518
Outpatient Hospital	$15,762,797
Physician	$23,023,401
Pharmacy	$8,856,044
Transport	$5,655,406
Total	**$190,637,703**

4. Slide 10: Since all these costs are for 2012, I assume they reflect costs associated with PACE which would have been operational in Rutland and Burlington areas for the whole year. If these costs are included, I guess they are in the Choices for Care HCBS line for 2012 and would be in 2013 claims for one quarter of the year and then disappear afterwards?

   Response: The analysis only includes expenditures made through Vermont's claims system; PACE capitation payments were made outside the claims system and therefore are not included in the data.

5. Slide 12: What is the difference between MH treatment and CRT (i.e., what services are included in MH Treatment)?

   Response: CRT participants include individuals for whom a CRT case rate payment was made to a Designated Agency (Category of Service 09-16). Individuals receiving MH treatment include persons for whom a mental health clinic (DA) claim was paid (primarily Categories of Service 07-01 and 09-01).

   Does MH Treatment include non-DA providers in the community? If not, are these providers included in Other Practitioners under traditional services?

   Response: The category "MH Treatment" only includes services provided by the Designated Agencies. Mental health services provided by other providers (e.g., Psychiatrists, psychologists, and other providers who bill for behavioral health services) are included under traditional services in the "Other Practitioners" category.

6. Slides 4, 10, 12 and 14: Does the School-based Health Services category within specialized programs include EPSDT or are the EPSDT services included in traditional services?

   Response: Early and periodic screening, diagnostic and treatment services (EPSDT) is a broad spectrum of services required under the Medicaid program for all Medicaid eligible individuals under age 21. EPSDT services include: Screening (unclothed exam, immunizations, lab tests, & anticipatory guidance), Vision, Dental, Hearing and Other Necessary Health care (i.e., diagnostic services, treatment, and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by screening services).

The School-based Health Services Program provides Medicaid reimbursement for services provided in accordance with an Individual Education Plan (IEP). Such services could include: Case management; Developmental & assistive therapy; Mental health counseling (if not provided by a mental health agency); Rehabilitative nursing services; Occupational therapy; Physical therapy; Speech, language & hearing services; and Personal care. These are the only types of services that are included in the Special Services and Program expenditures for the School-based Health Services Program. Expenditures related to all other services received by these enrollees would be included in the traditional services category.

7. Slides 4, 9 and 14: Are vision benefits listed under traditional benefits (acknowledging that coverage for children is much better than coverage for adults)?

   Response: Optometrist and Optician services are included under "Other Practitioner" services.

Analyses using Disability-related Eligibility Codes (Slides 13 and 14):

Overview of Medicaid Eligibility: *Medicaid is a cost-sharing program between the federal and state governments to provide health care services to eligible low-income Americans.*

General Eligibility Criteria: *As a result of the Affordable Care Act (ACA), states must provide Medicaid coverage for nearly all Americans under age 65 whose income is at or below 133% of the Federal Poverty Level (FPL). However, low income is only one test for Medicaid eligibility. For some eligibility groups, assets and resources are also tested against established thresholds. For other groups, eligibility is based on non-financial criteria standards for other programs. In addition, all individuals eligible for Medicaid must meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.*

Specific Eligibility Groups: *In order to participate in Medicaid, federal law requires states to cover certain population groups (**mandatory eligibility groups**) and gives them the flexibility to cover other population groups (**optional eligibility groups**). Within each of these two groups, individuals or families qualify because they are determined to be either "**categorically needy**" or "**medically needy**." States can also apply to the Centers for Medicare & Medicaid Services (CMS) for waivers to provide Medicaid to **expansion populations** beyond what traditionally can be covered under the Medicaid State Plan.*

Categorically needy *is defined as individuals who receive federally-assisted income maintenance payments [e.g., Temporary Assistance for Needy Families (TANF); Supplemental Security Income (SSI) cash assistance for people with limited income and resources who are disabled, blind, or age 65 or older, and blind or disabled children; State supplemental cash assistance; children receiving Title IV-E foster care or adoption payments], and individuals eligible for but not receiving these payments. It also includes individuals such as caretakers who take care of a child under age 18; pregnant women; children under age 6 whose family income is at or below 133% of the FPL; individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard; individuals receiving HCBS who would only be eligible for Medicaid under the State Plan if they were in a medical institution; and individuals who were previously covered under a separate 1915(c) Demonstration (i.e., TBI, Children's SED, and the DS Programs).*

Medically Needy *is defined as individuals who would be eligible as Categorically Needy except that their income and/or assets are too high, but they cannot afford to pay their medical bills. These people are allowed to spend down their excess income to the Medically Needy Income Level (MNIL) by incurring medical expenses. The entire Medically Needy section is optional. However, when a state elects to provide coverage to the Medically Needy, the federal government mandates coverage of some population groups (i.e., certain children*

under age 18 and pregnant women who, except for income and resources, would be eligible as categorically needy). There are 7 Medically Needy Eligible populations in Vermont, which include medically needy aged, blind, and/or disabled persons; certain relatives of children deprived of parental support and care; certain other financially eligible children up to age 21, and medically needy pregnant women.

***Expansion Populations** in Vermont include the following: Underinsured children with income between 237% and including 312% FPL, Children's Health Insurance Program (CHIP), Medicare beneficiaries who are 65 years and older or have a disability with income at or below 150% FPL (VPharm program), and Medicare beneficiaries who are 65 years and older or have a disability with income above 150% and at or below 225% FPL, and CHIP.*

As of January 1, 2014 Vermont has 55 population categories under which a person may become eligible for the Medicaid program, comprised of 32 Mandatory Categorically Eligible populations, 12 Optional Categorically Eligible populations in Vermont, 7 Medically Needy populations, and 4 Expansion Populations. Following are the more general descriptions typically utilized to define Vermont's Medicaid eligibility categories.

Vermont Medicaid for Adults

Aged, Blind, or Disabled (ABD) and/or Medically Needy Adults
The general eligibility requirements for the ABD and/or Medically Needy Adults are: age 18 and older; categorized as ABD but ineligible for Medicare; generally includes SSI cash assistance recipients, working disabled, hospice patients, Breast and Cervical Cancer Treatment (BCCT) participants, or Medicaid/Qualified Medicare Beneficiaries (QMB); and medically needy. Medically needy adults may be ABD or the parents/caretaker relatives of minor children.

Dual Eligibles
Dual Eligibles are eligible for both Medicare and Medicaid. Medicare eligibility is either due to being at least 65 years of age or categorized as blind, or disabled, and below the protected income level (PIL).

Choices for Care Demonstration
The Choices for Care section 1115 Medicaid Demonstration is managed by the Department of Disabilities, Aging, and Independent Living (DAIL), in conjunction with the Department of Vermont Health Access (DVHA) and the Department for Children and Families (DCF). The purpose of this waiver is to equalize the entitlement to both home and community based services and nursing home services for all eligible participants. The general eligibility requirements for the waiver are: Vermonters in nursing homes, home-based settings under home and community based services (HCBS) waiver programs, and enhanced residential care (ERC).

General Adults
The general eligibility requirements for General Adults are: parents/caretaker relatives of minor children including cash assistance recipients and those receiving transitional Medicaid after the receipt of cash assistance.

Prescription Assistance Pharmacy-Only Programs
VPharm assists Vermonters enrolled in Medicare Part D with paying for prescription medicines. There is a monthly premium based on income and co-pays based on the cost of the prescription. Those eligible include people age 65 and older, and Vermonters of all ages with disabilities who have household incomes up to 225% FPL.

Vermont Medicaid for Children

Blind or Disabled (BD) and/or Medically Needy Children
The general eligibility requirements for BD and/or Medically Needy Children are: under age 18 or under age 22 who are regularly attending school; categorized as blind or disabled; generally includes SSI cash assistance recipients; hospice patients; those eligible under "Katie Beckett" rules; and medically needy Vermonters. Medically needy children may or may not be blind or disabled.

General Children
The general eligibility requirements for General Children are: under age 21 and categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E).

Underinsured Children
The general eligibility requirements for Underinsured Children are: up to age 18 and up to 312% FPL. This program was designed as part of the original 1115 Waiver to Title XIX of the Social Security Act to provide health care coverage for children who would otherwise be underinsured.

Children's Health Insurance Program (CHIP)
The general eligibility requirements for the Children's Health Insurance Program (CHIP) are: up to age 18, uninsured, and up to 312% Federal Poverty Limit (FPL), and eligible under the CHIP eligibility rules in Title XXI of the Social Security Act.

Eligibility Aid Codes

As of January 1, 2014 Vermont has 195 aid codes aligned with the above population categories that are used to determine an applicant's eligibility for the Medicaid program. The Medicaid Expenditure Analysis was conducted using Calendar Year 2012 claims data (i.e., before the ACA altered eligibility categories). Attached is a Table of the Vermont Medicaid eligibility aid codes for CY12, separately listing the codes considered to be disability-related aid codes and those considered to be non-disability aid codes for purposes of this Expenditure Analysis.

Specific Questions and Responses regarding Analyses using Disability-related Eligibility Codes (Slides 13 and 14):

8. Are eligibility codes ever updated when a person's situation changes?

   Response: In certain circumstances, a person's eligibility code can change due to a change in his or her health status; for example, a person may be enrolled as a general adult but then qualify for SSI and be enrolled in the ABD category. However, an individual who already is eligible for Medicaid may retain the same eligibility code even if they begin to receive specialized services or because their situation changes.

9. Are people on CFC considered to be in the group of people with disability-related aid codes even if they are 65 or older? If I am already Medicaid eligible with a non-disability aid code and the next month I am enrolled in Choices for Care, do I acquire a disability-related code?

   Response: No. However, approximately 80 percent of Choices for Care participants have aid codes that are specific to nursing home and HCBS eligibility.

10. Are people over 65 included in the disability-related aid codes even if they don't have a disability?

    Response: No. The methodology used for this analysis did not include SSI-Aged aid categories in the definition of disability-related aid codes.

11. Under Dr. Dynasaur, all children in the family become eligible for Medicaid due to the family income. If one child has a disability, would they be captured in the disability-related aid code group?

    Response: No; children enrolled in Vermont Medicaid due to family incomes less than 300% of the federal poverty level would be enrolled with a non-disability related aid code, including a child with disabilities.

12. What about people who do not become eligible for Medicaid through SSI, but then become sick or are waiting for a disability-determination?

    Response: SSI stands for Supplemental Security Income. The federal Social Security Program, which administers the SSI program, pays monthly benefits to people with limited income and resources who are disabled, blind, or age 65 or older; blind or disabled children may also get SSI. In most states including Vermont, if you are an SSI beneficiary you are automatically eligible for Medicaid.

    SSI eligibility codes are included in the disability-related aid categories if the basis of the determination is disability-related (and not age). If someone who is already enrolled in Medicaid becomes eligible for SSI, their eligibility code would change.

13. Are Substance Abuse and Mental Health outpatient populations included in the disability-related aid codes?

    Response: It depends. Based on the data presented on Slide 14, the majority of mental health services are provided to individuals with disability-related aid codes. However, only about 25 percent of substance abuse treatment services were provided to individuals with disability-related aid codes.

Disability-Related Aid Codes for Vermont Medicaid 2012	
Aid Code	**Description** [1]
A4	Cash Assistance-SSI/AABD- Blind Adult
A6	Cash Assistance-SSI/AABD-Disabled Adult
A9	Cash Assistance-SSI/AABD-Blind/Disabled Child
AB	Cash Assistance-SSI/AABD-Blind Adult
AD	Cash Assistance-SSI/AABD-Disabled Adult
AZ	Cash Assistance-SSI/AABD-Blind/Disabled Child
B4	Medicaid Pickle Eligibles
B6	Medicaid Working Disabled
BB	Medicaid Pickle Eligibles
BD	Medicaid Working Disabled
H3	Hospice-Aged
H4	Hospice-Blind Adult
H5	Hospice-Child
H6	Hospice-Disabled Adult
H8	Hospice-Parent/Caretaker Relative
H9	Hospice/Blind/Disabled Child
HA	Hospice-Aged
HB	Hospice-Blind Adult
HC	Hospice-Child
HD	Hospice-Disabled Adult
HR	Hospice-Parent/Caretaker Relative
HZ	Hospice/Blind/Disabled Child
ID	Medicaid SLMB-Disabled Adult
J3	Medically Needy- Selected VHAP managed Care instead of Spend-Down-Aged
J4	Medically Needy- Selected VHAP managed Care instead of Spend-Down-Blind Adult
J5	Medically Needy- Selected VHAP managed Care instead of Spend-Down-Child
J6	Medically Needy- Selected VHAP managed Care instead of Spend-Down-Disabled Adult
J7	Medically Needy- Selected VHAP managed Care instead of Spend-Down-Pregnant
J8	Medically Needy- Selected VHAP managed Care instead of Spend-Down-Parent/Caretaker Relative
K5	Katie Beckett Child
K9	Special Needs Adoption
KC	Katie Beckett Child
KZ	Special Needs Adoption
L3	Nursing Home-Income less than the Institutional Income Level-Aged
L4	Nursing Home-Income less than the Institutional Income Level-Blind Adult
L5	Nursing Home-Income less than the Institutional Income Level-Child
L6	Nursing Home-Income less than the Institutional Income Level-Disabled Adult
L8	Nursing Home-Income less than the Institutional Income Level-Parent/Caretaker Relative
L9	Nursing Home-Income less than the Institutional Income Level-Blind/Disabled Adult
LA	Nursing Home-Income less than the Institutional Income Level-Aged
LB	Nursing Home-Income less than the Institutional Income Level-Blind Adult
LC	Nursing Home-Income less than the Institutional Income Level-Child
LD	Nursing Home-Income less than the Institutional Income Level-Disabled Adult
LR	Nursing Home-Income less than the Institutional Income Level-Parent/Caretaker Relative
LZ	Nursing Home-Income less than the Institutional Income Level-Blind/Disabled Adult

[1] Some descriptions are listed twice due to the fact that individuals receive an initial eligibility aid code and move to the corresponding "managed care" aid code once they have chosen a Primary Care Physician and are enrolled in the Global Commitment Demonstration.

Disability-Related Aid Codes for Vermont Medicaid 2012	
Aid Code	**Description** [1]
M3	Medically Needy-Over SSI/AABD Maximum-Under PIL-Aged
M4	Medically Needy-Over SSI/AABD Maximum-Under PIL-Blind Adult
M5	Medically Needy-Over ANFC Maximum-Under PIL-Child
M6	Medically Needy-Over SSI/AABD Maximum-Under PIL-Disabled Adult
M7	Medically Needy-Over ANFC Maximum-Under PIL-Pregnant
M8	Medically Needy-Over ANFC Maximum-Under PIL-Parent/Caretaker Relative
MA	Medically Needy-Over SSI/AABD Maximum-Under PIL-Aged
MB	Medically Needy-Over SSI/AABD Maximum-Under PIL-Blind Adult
MC	Medically Needy-Over ANFC Maximum-Under PIL-Child
MD	Medically Needy-Over SSI/AABD Maximum-Under PIL-Disabled Adult
MP	Medically Needy-Over ANFC Maximum-Under PIL-Pregnant
MR	Medically Needy-Over ANFC Maximum-Under PIL-Parent/Caretaker Relative
NA	Medically Needy-Spend-down met with health ins prem and/or noncovered expenses-Aged
NB	Medically Needy-Spend-down met with health ins prem and/or noncovered expenses-Blind Adult
NC	Medically Needy-Spend-down met with health ins prem and/or noncovered expenses-Child
ND	Medically Needy-Spend-down met with health ins prem and/or noncovered expenses-Disabled Adult
NP	Medically Needy-Spend-down met with health ins prem and/or noncovered expenses-Pregnant
NR	Medically Needy-Spend-down met with health ins prem and/or noncovered expenses-Parent/Caretaker Relative
P3	Medically Needy-Spend-Down-Aged
P4	Medically Needy-Spend-Down-Blind Adult
P5	Medically Needy-Spend-Down-Child
P6	Medically Needy-Spend-Down-Disabled Adult
P7	Medically Needy-Spend-Down-Pregnant
P8	Medically Needy-Spend-Down-Parent/Caretaker Relative
PA	Medically Needy-Spend-Down-Aged
PB	Medically Needy-Spend-Down-Blind Adult
PC	Medically Needy-Spend-Down-Child
PD	Medically Needy-Spend-Down-Disabled Adult
PP	Medically Needy-Spend-Down-Pregnant
PR	Medically Needy-Spend-Down-Parent/Caretaker Relative
Q6	Medicaid/QMB-Disabled
QD	Medicaid/QMB-Disabled
W3	Home/Community Based Waiver-Aged
W4	Home/Community Based Waiver-Blind Adult
W6	Home/Community Based Waiver-Disabled Adult
W9	Home/Community Based Waiver-Blind/Disabled Child
WA	Home/Community Based Waiver-Aged
WB	Home/Community Based Waiver-Blind Adult
WD	Home/Community Based Waiver-Disabled Adult
WZ	Home/Community Based Waiver-Blind/Disabled Child
X6	Eligible for cash assistance but not receiving-Blind Adult
XD	Eligible for cash assistance but not receiving-Blind Adult

Non-Disability Related Codes for Vermont Medicaid 2012	
Aid Code	**Description**[2]
A3	Cash Assistance-SSI/AABD- Aged
A5	Cash Assistance-ANFC-Child
A8	Cash Assistance-ANFC-Parent/Caretaker Relative
AA	Cash Assistance-SSI/AABD- Aged
AC	Cash Assistance-ANFC-Child
AR	Cash Assistance-ANFC-Parent/Caretaker Relative
B3	Non Cash Assistance-Misc Eligibility Conditions-Aged
B5	Non Cash Assistance-Misc Eligibility Conditions-Child
B7	Non Cash Assistance-Misc Eligibility Conditions-Pregnant
B8	Non Cash Assistance-Misc Eligibility Conditions-Parent/caretaker Relative
BA	Non Cash Assistance-Misc Eligibility Conditions-Aged
BC	Non Cash Assistance-Misc Eligibility Conditions-Child
BG	Breast or Cervical Cancer Treatment Group-Medicaid
BH	Breast or Cervical Cancer Treatment Group-Medicaid
BP	Non Cash Assistance-Misc Eligibility Conditions-Pregnant
BR	Non Cash Assistance-Misc Eligibility Conditions-Parent/caretaker Relative
C0	Medicaid/Dr. Dynasaur Child
C2	Underinsured Expanded Dr. Dynasaur Child-300% FPL (Title XXI-SCHIP)
C3	Underinsured Expanded Medicaid Dr. Dynasaur Child-300% FPL (Medicaid 1115 Waiver)
C4	Medicaid/Dr. Dynasaur Child
C5	Committed Child-IV-E Eligible
C6	Underinsured Expanded Dr. Dynasaur Child-300% FPL (Title XXI-SCHIP)
C7	Committed Child-Child Placement Agency
C8	Committed Child-Refugee Resettlement Program Participant
C9	Underinsured Expanded Dr. Dynasaur Child-300% FPL (Medicaid 1115 Waiver)
CC	Committed Child-IV-E Eligible
CG	Underinsured Expanded Dr. Dynasaur Child-300% FPL (Title XXI-SCHIP) (member of Fed Rec Amer Native Tribe)
CP	Committed Child-Child Placement Agency
CR	Committed Child-Refugee Resettlement Program Participant
D5	Transitional Medicaid-ANFC ended due to Increased Child Support-Child
D8	Transitional Medicaid-ANFC ended due to Increased Child Support-Parent/Caretaker Relative
DC	Transitional Medicaid-ANFC ended due to Increased Child Support-Child
DR	Transitional Medicaid-ANFC ended due to Increased Child Support-Parent/Caretaker Relative
E5	ANFC ended-pending medicaid determination-Child (converted to AC/A5 for EDS)
E8	ANFC ended-pending medicaid determination-Parent/Caretaker Relative (converted to AR/A8 for EDS)
EA	Federal Essential Person/SSI/AABD-Aged (obsolete with ACCESS derived cat codes)
EC	ANFC ended-pending medicaid determination-Child (converted to AC/A5 for EDS)
ER	ANFC ended-pending medicaid determination-Parent/Caretaker Relative (converted to AR/A8 for EDS)
F5	Committed Child-Non IV-E Eligible
FC	Committed Child-Non IV-E Eligible
G5	Transitional Medicaid-Non-ANFC coverage due to increased Earnings-Child
G8	Transitional Medicaid-Non-ANFC coverage due to increased Earnings-Parent/Caretaker Relative
GA	General Assistance
GC	Transitional Medicaid-Non-ANFC coverage due to increased Earnings-Child
GE	General Assistance-Emergency Assistance Eligible

[2] Some descriptions are listed twice due to the fact that individuals receive an initial eligibility aid code and move to the corresponding "managed care" aid code once they have chosen a Primary Care Physician and are enrolled in the Global Commitment Demonstration.

Non-Disability Related Codes for Vermont Medicaid 2012	
Aid Code	**Description**[2]
GR	Transitional Medicaid-Non-ANFC coverage due to increased Earnings-Parent/Caretaker Relative
HT	HIV/AIDS Drug Coverage Only
HV	HIV/AIDS Insurance Premium Coverage only
I5	Transitional Medicaid-Non-ANFC coverage due to increased Child Support-Child
I8	Transitional Medicaid-Non-ANFC coverage due to increased Child Support-Parent/Caretaker Relative
IA	Medicaid SLMB-Aged
IC	Transitional Medicaid-Non-ANFC coverage due to increased Child Support-Child
IR	Transitional Medicaid-Non-ANFC coverage due to increased Child Support-Parent/Caretaker Relative
MH	Mental Health only
O5	Older Child - 100% FPL
OC	Older Child - 100% FPL
P1	Dr. Dynasaur Pregnant
P2	Dr. Dynasaur Pregnant
PQ	Pure QMB-Medicare premiums, deductibles, and copay
PS	Pure SLMB-Medicare Part B premiums
Q3	Medicaid/QMB-Aged
QA	Medicaid/QMB-Aged
R1	Refugee Resettlement Program
RR	Refugee Resettlement Program
S5	Infants at 185% FPL
S7	Pregnant Women at 185% FPL
SC	Infants at 185% FPL
SP	Pregnant Women at 185% FPL
T5	Transitional Medicaid-Non-ANFC ended due to increased Earnings-Child
T8	Transitional Medicaid-Non-ANFC ended due to increased Earnings-Parent/Caretaker Relative
TC	Transitional Medicaid-Non-ANFC ended due to increased Earnings-Child
TR	Transitional Medicaid-Non-ANFC ended due to increased Earnings-Parent/Caretaker Relative
TV	HIV/AIDS drugs and insurance premiums only
U1	VHAP-Uninsured-25% FPL
U2	VHAP-Uninsured-50% FPL
U3	VHAP-Uninsured-100% FPL
U4	VHAP-Uninsured-125% FPL
U5	VHAP-Uninsured-150% FPL
U6	VHAP-Uninsured with children in the household-185% FPL
UA	VHAP-Uninsured-25% FPL
UB	VHAP-Uninsured-50% FPL
UC	VHAP-Uninsured-100% FPL
UD	VHAP-Uninsured-125% FPL
UE	VHAP-Uninsured-150% FPL
UF	VHAP-Uninsured with children in the household-185% FPL
V1	VHAP Pharmacy-100% FPL
V2	VHAP Pharmacy-125% FPL
V3	VHAP Pharmacy-150% FPL
V4	VHAP Pharmacy/QMB/QDWI-100% FPL
V5	VHAP Pharmacy/QMB/QDWI-125% FPL
V6	VHAP Pharmacy/SLMB/QDWI-150% FPL
V7	Vscript/QMB/SLMB-Aged
V8	Vscript/QMB/SLMB-Disabled

Non-Disability Related Codes for Vermont Medicaid 2012	
Aid Code	**Description**[2]
VA	Vscript-Aged-175% FPL
VB	Vscript-Aged-200% FPL
VC	Vscript-Aged-225% FPL
VP	Health Vermonters
VS	Vscript-Disabled Adult-175% FPL
VT	Vscript-Disabled Adult-200% FPL
VU	Vscript-Disabled Adult-225% FPL
X3	Eligible for cash assistance but not receiving-Aged
X5	Eligible for cash assistance but not receiving-Child
X8	Eligible for cash assistance but not receiving-Parent/Caretaker Relative
XA	Eligible for cash assistance but not receiving-Aged
XC	Eligible for cash assistance but not receiving-Child
XR	Eligible for cash assistance but not receiving-Parent/Caretaker Relative
Y5	Younger Child at 133% FPL
YC	Younger Child at 133% FPL
Z9	Correctional Facility Residents-Inpatient Coverage
ZA	Employer-Sponsored Insurance
ZB	Employer-Sponsored Insurance
ZC	Employer-Sponsored Insurance
V1	VHAP Pharmacy-100% FPL
V2	VHAP Pharmacy-125% FPL
V3	VHAP Pharmacy-150% FPL
V4	VHAP Pharmacy/QMB/QDWI-100% FPL
V5	VHAP Pharmacy/QMB/QDWI-125% FPL
V6	VHAP Pharmacy/SLMB/QDWI-150% FPL
V7	Vscript/QMB/SLMB-Aged
V8	Vscript/QMB/SLMB-Disabled
VA	Vscript-Aged-175% FPL
VB	Vscript-Aged-200% FPL
VC	Vscript-Aged-225% FPL
VP	Health Vermonters
VS	Vscript-Disabled Adult-175% FPL
VT	Vscript-Disabled Adult-200% FPL
VU	Vscript-Disabled Adult-225% FPL
X3	Eligible for cash assistance but not receiving-Aged
X5	Eligible for cash assistance but not receiving-Child
X8	Eligible for cash assistance but not receiving-Parent/Caretaker Relative
XA	Eligible for cash assistance but not receiving-Aged
XC	Eligible for cash assistance but not receiving-Child
XR	Eligible for cash assistance but not receiving-Parent/Caretaker Relative
Y5	Younger Child at 133% FPL
YC	Younger Child at 133% FPL
Z9	Correctional Facility Residents-Inpatient Coverage
ZA	Employer-Sponsored Insurance
ZB	Employer-Sponsored Insurance
ZC	Employer-Sponsored Insurance

Attachment 3 - VHCIP Round Two Grant Award Background

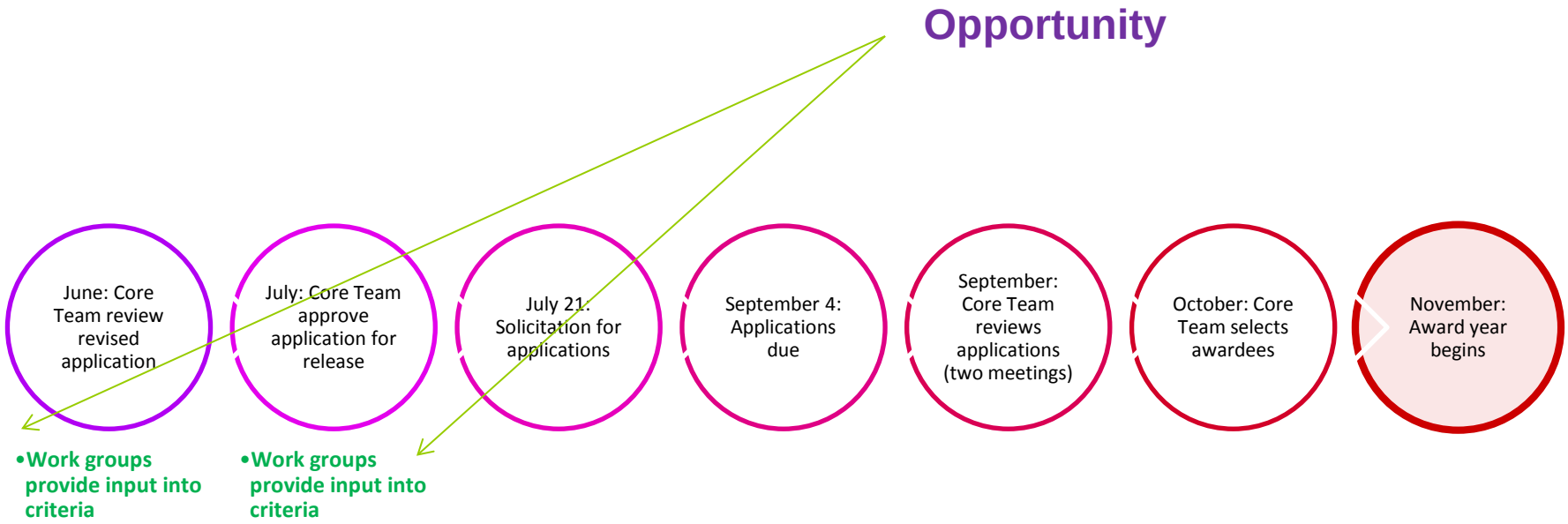
VHCIP Round Two Grant Award Background for the DLTSS Work Group

June 19, 2014

Georgia Maheras, JD

Project Director

Timeline


Opportunity
June: Core Team review revised application
July: Core Team approve application for release
July 21: Solicitation for applications
September 4: Applications due
September: Core Team reviews applications (two meetings)
October: Core Team selects awardees
November: Award year begins
•Work groups provide input into criteria
•Work groups provide input into criteria

Request:

The Core Team requested that the DLTSS Work Group:

- Provide feedback on criteria used in Round One of the provider grant program, and
- Recommend additional criteria for the next round of grant funding that will help achieve VHCIP goals.

Grant Program Goals

- Grant Program is intended to foster health care innovation throughout Vermont.

- To maximize the impact of non-governmental entity involvement in this health care reform effort.

Grant Program Criteria

- Activities that directly enhance provider capacity to test one or more of the three alternative payment models approved in Vermont's SIM grant application.
- Infrastructure development that is consistent with development of a statewide high-performing health care system, including:
  - Development and implementation of innovative technology that supports advances in sharing clinical or other critical service information across different types of provider organizations;
  - Development and implementation of innovative systems for sharing clinical or other core services across different types of provider organizations;
  - Development of management systems to track costs and/or quality across different types of providers in innovative ways.

Preference for:

- Support from and equitable involvement of multiple provider organization types that can demonstrate the grant will enhance integration across the organizations;
- A scope of impact that spans multiple sectors of the continuum of health care service delivery (for example, prevention, primary care, specialty care, mental health and long term services and supports);
- Innovation, as shown by evidence that the intervention proposed represents best practices in the field;
- An intent to leverage and/or adapt technology, tools, or models tested in other States to meet the needs of Vermont's health system;
- Consistency with the Green Mountain Care Board's specifications for Payment and Delivery System Reform pilots.

Awardee Summaries:

Grantee
Rutland Area Visiting Nurse Association & Hospice in Collaboration with Rutland Regional Medical Center, Community Health Centers of the Rutland Region and the Rutland Community Health Team
Project Description
This project will support design and implementation of a supportive care program for seriously ill patients with congestive heart failure and /or chronic lung disease. The program will improve communication between the multiple providers and organizations involved in the care of these patients and advance a patient-centered model for care planning and shared decision-making. The project is expected to reduce use of hospital and emergency department care, improve patient quality of life and save money.

Grantee
Northeastern Vermont Regional Hospital in Collaboration with Northern Counties Health Care, Rural Edge Affordable Housing, the Support and Services at Home (SASH) Program, the Northeastern Vermont Area Agency on Aging and Northeast Kingdom Community Services
Project Description
This project will provide flexible funding for goods and services not normally covered by insurance, enabling an integrated multi-disciplinary community care team to better care for clients who are at risk for poor outcomes and high costs of medical care.

Awardee Summaries:

Grantee
White River Family Practice in Collaboration with the Geisel School of Medicine at Dartmouth College
Project Description
This project will continue work at one of the most innovative primary care practices in the state to manage patient care using data systems, team-based care protocols and tools shown to improve patient self-management of their health. The focus will be on patients with chronic conditions who often have high emergency room use and high rates of hospital readmission.

Grantee
InvestEAP in Collaboration with the Burlington Community Health Center and Northern Counties Health Care
Project Description
InvestEAP, Vermont's public/private employee assistance program, and two federally-qualified health centers, will partner to demonstrate the impact of integrating an innovative stress prevention and early intervention program with traditional primary care delivery. The project embodies the core belief that early intervention aimed at the social determinants of health and the root causes of stress will improve health outcomes and reduce medical expenditures.

Awardee Summaries:

Grantee
The Vermont Medical Society Education and Research Foundation in Collaboration with Vermont's "Hospitalist" Physicians and the Fletcher Allen Health Care Department of Pathology and Laboratory Medicine
Project Description
This project will support an effort to decrease waste and potential harm in the hospital setting based on evidence behind the national "Choosing Wisely" campaign that estimates 30 percent of U.S. health care spending is avoidable and potentially harmful. Physicians from Vermont hospitals and Dartmouth-Hitchcock Medical Center will work together to reduce unnecessary lab testing, and in doing so will create a statewide provider network to lead additional waste reduction and care improvement efforts.

Grantee
Bi-State Primary Care in Collaboration with all Participating Providers and Affiliates of Community Health Accountable Care
Project Description
Seven Federally Qualified Health Centers and Bi-State have formed a primary care centric Accountable Care Organization, Community Health Accountable Care (CHAC), to participate in Shared Savings Programs with all payers. This capacity grant will allow CHAC to further develop their ACO infrastructure to manage patient care. Their specific focus will be to integrate with other community providers, including Behavioral Health Network of VT, the VT Assembly of Home Health and Hospice, Area Agencies on Aging and the Support and Services at Home program.

Awardee Summaries:

Grantee
HealthFirst in Collaboration with all Participating Providers and Affiliates of their ACOs: Accountable Care Coalition of the Green Mountains and Vermont Collaborative Physicians
Project Description
HealthFirst is an Independent Practice Association that includes 120 physicians in 58 independent practices in Vermont. HealthFirst has formed ACOs to participate in both the Medicare and commercial shared savings programs. This capacity grant will allow HealthFirst to further develop their ACO infrastructure to manage patient care. Their specific focus will be increasing coordination between physical and mental health providers and increasing communication between primary care and specialty physicians.

Grantee
The Vermont Program for Quality in Health Care in Collaboration with the Vermont Association of Hospitals and Health Systems, all Vermont hospitals and the Vermont chapter of the American College of Surgeons
Project Description
This grant will provide partial funding for a statewide surgical quality improvement program. The program will gather clinical data to feed into a national database maintained by the American College of Surgeons, allowing Vermont surgeons to benchmark their practices and outcomes against peers nationally and target improvement efforts. The program is expected to improve surgical outcomes, enhance patient safety and reduce costs from surgical complications.

Attachment 4a - Year 2 Reporting and Payment Measures

VT Quality and Performance Measures Work Group
Review of Changes in Measures Proposed for Year 2 Reporting and Payment
May 27, 2014

Additional Measures Proposed for 2015 Reporting:

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-8	Developmental Screening in the First Three Years of Life (*currently in Medicaid measure set; proposed for commercial measure set*)	NQF #1448; NCQA (not HEDIS); and CHIPRA	Yes		Medicaid can use claims data, but provider coding for commercial payers is not currently reliable, so the commercial measure could require data from clinical records.	CMS has analyzed data from five states (AL, IL, NC, OR, TN) that reported the measure for FFY12 consistently using prescribed specifications. CMS reports that 12 states reported in FFY13, and 18 intend to do so in FFY14. Best practice is in IL, which reported rates of 77%, 81%, 65% in Years 1-3; the five-state median was 33%, 40%, 28%.	• Vermont Legal Aid • Population Health WG • DLTSS Work Group
Core-30	Cervical Cancer Screening	NQF #0032; NCQA (HEDIS)	Yes	Changes in HEDIS specifications for 2014: • Added steps to allow for two appropriate screening methods of cervical cancer screening: cervical cytology performed every three years in women 21–64 years of age and cervical cytology/HPV co-testing performed every five years in women 30–64 years of age.	For HEDIS purposes in 2014, both commercial and Medicaid plans could use the hybrid method which requires data from clinical records.	HEDIS benchmark available (for HEDIS 2015; no benchmark for 2014). Historical Performance HEDIS 2013 (PPO) • BCBSVT: 72%; CIGNA: 71%; MVP: 71% • National 90th percentile: 78%; **Regional 90th percentile: 82%** • National Average: 74%; Regional Average: 78%	• Population Health WG
Core-34	Prenatal and Postpartum Care	NQF #1517; NCQA (HEDIS)	Yes		HEDIS rates are collected using the hybrid method, using claims data and clinical records.	Timeliness of Prenatal Care Historical Performance HEDIS 2013 (PPO): • BCBSVT: 94%; CIGNA: 74%; MVP: 95% • National 90th percentile: 96%; **Regional 90th percentile: 96%** • National Average: 81%; Regional	• Population Health WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
						Average: 82% Postpartum Care Historical Performance (PPO): • BCBSVT: 83%; CIGNA: N/A; MVP: 84% • National 90th percentile: 86%; **Regional 90th percentile: 90%** • National Average: 70%; Regional Average: 70%	
Core-35/ MSSP-14	Influenza Immunization	NQF #0041; MSSP	Yes		Requires clinical data or patient survey to capture immunizations that were given outside of the PCP's office (e.g., in pharmacies, at public health events)	Medicare MSSP benchmarks available from CMS.	• Population Health WG • DTLSS WG
Core-36/ MSSP-17	Tobacco Use Assessment and Tobacco Cessation Intervention	NQF #0028; MSSP	Yes		Clinical records	CMS set benchmarks for MSSP shared savings distribution. For this measure, the benchmarks equate to the rates for 2014 and 2015 reporting years. For example, the 50th percentile is 50%, and the 90th percentile is 90%. This measure is in use in other states and HRSA and CDC publish benchmarks, so additional benchmarking feasible if there is interest in adoption.	• Population Health WG • DLTSS WG
Core 37	Transition Record Transmittal to Health Care Professional	NQF #0648/#2036 (paired measure – see below)	Yes		Clinical records	None identified	• DTLSS WG
Core-39/ MSSP-28	Hypertension (HTN): Controlling High Blood Pressure	NQF #0018; MSSP	Yes	Guideline change: In December 2013, the eighth Joint National Committee (JNC 8) released updated guidance for treatment of	Clinical records	HEDIS benchmark currently available, but with measure likely to change, there is a possibility that there won't be a benchmark for 2015.	• Population Health WG • DLTSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
				hypertension: • Set the BP treatment goal for patients 60 and older to <150/90 mm Hg. • Keep the BP treatment goal for patients 18–59 at <140/90 mm Hg. <u>Changes in HEDIS Specifications for 2015</u>: Proposed changes to HEDIS specifications in 2015 to align with the JNC 8 guidelines. The measure will be based on one sample for a total rate reflecting age-related BP thresholds. The total rate will be used for reporting and comparison across organizations.		Historical Performance HEDIS 2013 (PPO) • BCBSVT: 61%; CIGNA PPO: 62%; MVP PPO: 67% • National 90th percentile: 65%; **Regional 90th percentile: 78%** • National Average: 57%; Regional Average: 63%	
Core-40/ MSSP-21	Screening for High Blood Pressure and Follow-up Plan Documented	Not NQF-endorsed; MSSP	Yes		Clinical records	CMS set benchmarks for MSSP shared savings distribution. For this measure, the benchmarks equate to the rates for 2014 and 2015 reporting years. For example, the 50th percentile is 50%, and the 90th percentile is 90%. However, this measure is in use by other states so it may be possible to identify benchmarks.	• Population Health WG • DLTSS WG
Core-44	Percentage of Patients with Self-Management Plans	Not NQF-endorsed	No. Need to develop measure specs based on the NCQA standard, or borrow from a state that uses this measure.		Clinical records	This measure is used by some PCMH programs in other states. Benchmarks could be obtained from those states.	• Population Health WG • DLTSS WG (*see Core-44 ALT)*

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-44 (ALT*)	Transition Record with Specified Elements Received by Discharged Patients	NQF #0647/ #2036 (paired measure - see above)	Yes		Clinical records	None identified	• DTLSS WG
Core-45	Screening, Brief Intervention, and Referral to Treatment	Not NQF-endorsed	No, but a form of the measure is in use by Oregon Medicaid		Could potentially use claims or data from clinical records. If claims-based, could involve provider adoption of new codes.	None available, but a form of the measure is in by Oregon Medicaid, so benchmark rates could be available if the same measure was adopted.	• Population Health WG • DLTSS WG • Howard Center
New Measure	LTSS Rebalancing *(proposed for Medicaid measure set)*	Not NQF-endorsed	DAIL has specifications		DAIL collects statewide and county data from claims; potential to collect at ACO level.	None available	• DLTSS WG
New Measures	3 to 5 custom questions for Patient Experience Survey regarding DLTSS services and case management	Not NQF-endorsed	Questions have been developed; would require NCQA approval to add to PCMH CAHPS Survey		Could add to PCMH CAHPS Patient Experience Survey; might increase expense of survey.	None available	• DLTSS WG

Additional Measures Proposed for 2015 Payment:

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
Core-10 MSSP-9	Ambulatory Care-Sensitive Condition Admissions: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	NQF# 0275; AHRQ PQI #05; Year 1 Vermont SSP Reporting	Yes		Claims	National PQI Benchmarks (for Medicare population) available at www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx	• CMS • DVHA

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
		Measure					
Core-12	Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite	Not NQF-endorsed; AHRQ PQI #92; Year 1 Vermont SSP Reporting Measure	Yes		Claims	National PQI Benchmarks (for Medicare population) available at www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx	• CMS • DVHA • DLTSS WG
Core-15	Pediatric Weight Assessment and Counseling	NQF #0024; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	HEDIS benchmarks available from NCQA. This measure has three components: • BMI Percentile • Counseling for Nutrition • Counseling for Physical Activity BMI Percentile Historical Performance HEDIS 2012 (PPO) • CIGNA PPO:63% • National 90th percentile: 65%; **Regional 90th percentile: 87%** National Average: 25%; Regional Average: 42% Counseling for Nutrition Historical Performance HEDIS 2012 (PPO) • CIGNA PPO: 73% • National 90th percentile: 69%; **Regional 90th percentile: 90%** National Average: 28%; Regional Average: 45% Counseling for Physical Activity Historical Performance HEDIS 2012 (PPO) • CIGNA PPO:72% • National 90th percentile: 65%; **Regional**	• DLTSS WG

#	Measure Name	Use by Other Programs	Do Specs Exist?	Guideline Changes	Source of Data	Benchmarks (Indicates Improvement Opportunity)	Proposed By
						90th percentile: 86% National Avg.: 26%; Regional Avg.: 42%	
Core-16 MSSP-22-26	Diabetes Composite (D5): Hemoglobin A1c control (<8%), LDL control (<100), Blood Pressure <140/90, Tobacco non-use, Aspirin use	NQF #0729; MSSP; Year 1 Vermont SSP Reporting Measure	Yes. Measure steward (MCM) has changed specs for 2014 and 2015.	Change to national LDL control guideline has impacted this measure.	Clinical records	Available from Minnesota Community Measurement for Minnesota provider performance	• DLTSS WG
Core-17 MSSP-27	Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%)	NQF #0059; MSSP; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	HEDIS benchmarks available from NCQA. Historical Performance HEDIS 2012 (PPO): (Lower rate is better) • BCBSVT: 41% • National 90th percentile: 22%; **Regional 90th percentile: 18%** National Average: 28%; Regional Average: 34%	• DLTSS WG
Core-19 MSSP-18	Depression Screening and Follow-up	NQF #0418; MSSP; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	Measure in use in some other states; we would have to review how it is implemented in the other states to see if benchmarks are available	• DLTSS WG
Core-20 MSSP-16	Adult Weight Screening and Follow-up	NQF #0421; MSSP; Year 1 Vermont SSP Reporting Measure	Yes		Clinical records	In use by HRSA so benchmark data may be available.	• DLTSS WG
M&E-14	Avoidable ED Visits (NYU Algorithm)	Not NQF-endorsed; Year 1 Vermont SSP Monitoring and Evaluation Measure	Yes		Claims	Measure used in other states and in research, so it may be possible to identify benchmarks	• DLTSS WG

Attachment 4b - Two Options to Identify the DLTSS population for ACO Performance Measures Analyses

Two Options to Identify the DLTSS Population for Analysis of ACO Performance Measures

Prepared by the Pacific Health Policy Group - June 9, 2014

	Options	
	Utilization of Specialized Services and Programs	**Disability-related Aid Codes**

Methodology Overview	Identify Individuals who receive services in VT Medicaid's Specialized Services and Programs:
	• Choices for Care (CfC)/Long-Term Care
	  - Assistive Community Care, Choices for Care Home and Community Based Services (HCBS), Nursing Home
	• Personal Care
	• Traumatic Brain Injury (TBI) Program
	• Developmental Services (DS)
	  - Developmental Services, Intermediate Care Facility/Intellectual Disabilities (ICF/ID)
	• Mental Health Treatment
	  - Community Rehabilitation Treatment (CRT), Day Treatment, Day Treatment/Private Non-Medical Institution (PNMI), Children and Adolescents with Serious Emotional Disturbances (SED), Mental Health Facility, Targeted Case Management
	• Department for Children and Families (DCF)- Case Management
	• School Health
	  - Department of Health School Nurses, Department of Education School-Based Health Services for IEPs, Success Beyond Six
	• Substance Abuse Treatment
		Identify individuals who are enrolled in Medicaid based on a disability-related aid code, which include:
		• SSI/ABD- Blind or Disabled Adults
		• SSI/ABD- Blind or Disabled Children
		• Medicaid Working Disabled
		• Hospice
		• Medically Needy
		• Katie Beckett
		• Nursing Home
		• Medicaid/QMB-Disabled
		• Home/Community Based Waiver
		• Eligible for cash assistance but not receiving- Blind Adult

# of enrollees (CY12)	39,776 (25% of all Medicaid enrollees)	39,018 (25% of all Medicaid enrollees)
Total expenditures for defined population (CY12)	$770.4 million (71.5% of total Medicaid expenditures)	$624.4 million (58% of total Medicaid expenditures)

	Options	
	Utilization of Specialized Services and Programs	**Disability-related Aid Codes**
Pros of Utilizing Option	↑ The analyses would include all individuals enrolled in the CFC, TBI, DS, CRT, and SED programs. ↑ The analyses would include individuals with substance abuse and/or mental health outpatient treatment needs. ↑ The analyses would focus on individuals with clearly identified DLTSS needs (since these programs have stringent clinical eligibility criteria). ↑ The analyses would include a broad range of children who have DLTSS needs (due to the DCF and School Health programs).	↑ The analyses would include individuals (mainly adults) with a broad range of DLTSS needs, regardless of participation in Specialized Services and programs. ↑ Relatively simple methodology to identify individuals with disability-related aid codes.
Cons of Utilizing Option	↓ The analyses would exclude adults who do not meet the eligibility criteria for these Specialized Services and Programs but who do have functional limitations or complex needs that would benefit from more comprehensive supports. ↓ Currently dual eligibles are excluded from attribution to ACOs in the Medicaid Shared Savings program. Approximately 10,000 of the individuals served in the Specialized Services and Programs are dually eligible for Medicaid and Medicare. As a result, utilization of this methodology would decrease the number of individuals in the DLTSS sub-population analysis regarding ACO performance. ↓ Very complex methodology required to identify individuals receiving Specialized Services and Supports.	↓ The analyses would exclude many children with DLTSS needs, since a large majority of children enrolled in Medicaid are not enrolled due to a DLTSS-related aid code. ↓ The analyses would not include all individuals enrolled in the CFC, TBI, DS, CRT, and SED programs because some do not have a disability-related aid codes. ↓ The analyses would exclude individuals with substance abuse and/or mental health outpatient treatment needs unless they are Medicaid eligible due to blindness or disability. ↓ Currently dual eligibles are excluded from attribution to ACOs in the Medicaid Shared Savings program. Approximately 17,500 individuals who have a disability-related aid code are dually eligible for Medicaid and Medicare. As a result, utilization of this methodology would decrease the number of individuals in the DLTSS sub-population analysis regarding ACO performance.

Attachment 4c - AHS Survey Results Plan

DLTSS Work Group
Draft Plan for Presentation of AHS Survey Results
June 19, 2014

A proposal regarding the use of existing AHS survey data to inform work undertaken by the DLTSS Work Group and the VHCIP.

There are currently six AHS surveys that provide information which can inform DLTSS Work Group activities – see table below. These surveys are targeted at specific populations and address quality of life, quality of care, and issues of individual preference.

Recommendation: Present the results of each of these surveys in a common format to the DLTSS Work Group over the coming year so that this information is more transparent and can be used as a baseline for DLTSS Work Group monitoring over time. The rationale is that the results of these surveys are currently shared with small audiences and DLTSS Work Group review may lead to a broader shared understanding of the survey elements and findings. This information may also be helpful for informing DLTSS Work Group decisions.

Program	Survey	Description
DMH: Community Rehabilitation and Treatment (CRT)	CRT Client Satisfaction Survey	Target population: consumers served by CRT programs in Vermont, part of a larger effort to monitor CRT program performance from the perspective of service recipients.
DAIL	Vermont Long Term Care (LTC) Consumer Survey	Target population: consumers receiving the following long-term care programs/services regarding their satisfaction with services and quality of life: • Choices for Care (CFC) Case Management • Personal Care Services • Homemaker Services • Adult Day Services • Attendant Services Program • Traumatic Brain Injury Program • Home-Delivered Meals Program

DAIL: Choices for Care (CFC)	CFC Home & Community-based Services (HCBS) Consumer Survey *(part of Vermont LTC Consumer Survey)*	Target population: consumers of the long-term services system regarding specific HCBS services. Several specific questions are included to more fully measure outcomes around choice, personal goals and maintaining health.
	'MyInnerView' Nursing Facility and RCH Resident Satisfaction Survey *(part of Vermont Health Care Association Resident Satisfaction Survey)*	Target population: residents in nursing facilities, assisted living facilities, and ERCs to evaluate information dissemination, access, experience with care and quality of life. *(Results are used in the CFC Independent Evaluation)*
DAIL: Developmental Disability Services	DDS Client Satisfaction Survey	Target population: consumers served by DDS to identify what people feel is important to their quality of life and how the program can provide the best support possible.
DVHA	CAHPS Managed Care Survey	Target population: enrollees covered by the Global Commitment to Health 1115 Demonstration Waiver to assess satisfaction with areas such as access to information about benefits and rights, and access to providers.

Attachment 5 - Provider Training Discussion

DLTSS Work Group
Provider Training Discussion
Define Issues, Goals and Next Steps
June 19, 2014

1. What is the overarching goal of conducting provider training specific to the needs of the DLTSS population?

2. What specific opportunities exist for training providers?
    a. Do these opportunities vary by provider type?

3. What processes could be used to develop provider training?
    a. How will the training curriculum be developed?
    b. Which organizations and entities need to be involved in these activities?
    c. How will consumer input and sensitivity to the needs of DLTSS populations be assured?
    d. How will we assure provider participation and buy-in?
    e. How could these activities be financially supported?

4. What processes could be used to deliver provider training?
    a. How will training methods be tailored to specific audiences?
    b. Which entities and organizations need to be involved in these activities?
    c. How could these activities be financially supported?

5. How will the effectiveness of provider trainings be measured?