State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Annual Report
For Demonstration Year 2016
January 1, 2016 to December 31, 2016

Submitted via PMDA portal on March 27, 2017

Table of Contents

I. Background and Introduction 3
II. Highlights and Accomplishments 4
III. Project Status 5
IV. Findings 11
V. Cost Containment Initiatives 20
VI. Utilization Management 49
VII. Policy and Administrative Difficulties 59
VIII. Capitated Revenue Spending 59

Attachments

Attachment 1: Budget Neutrality

Attachment 2: Enrollment & Expenditures Report (Q4)

Attachment 3: Complaints from Member Services (Q4)

Attachment 4: Grievances & Appeals Report (Q4)

Attachment 5: Health Care Advocate Report (Q4)

Attachment 6: SFY 2016 Investments

I. Background and Introduction

The Global Commitment to Health is a Demonstration Waiver authorized pursuant to Section 1115(a) by the Centers for Medicare and Medicaid Services (CMS), within the Department of Health and Human Services (HHS).

Vermont is a national leader in making affordable health care coverage available to low-income children and adults. Vermont was among the first states to expand coverage for children and pregnant women, through the 1989 implementation of the state-funded Dr. Dynasaur program. In 1992, Dr. Dynasaur became part of the state-federal Medicaid program.

When the federal government introduced the state Children's Health Insurance Program (CHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300 percent of the Federal Poverty Level (FPL).

In 1995, Vermont implemented an 1115(a) waiver program, the Vermont Health Access Plan (VHAP); the primary goal was to expand access to comprehensive health care coverage for uninsured adults with household incomes below 150 percent (later raised to 185 percent) of FPL, through enrollment in managed care. VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both waiver populations pay a modest premium on a sliding scale based on household income.

Implemented October 1, 2005, the Global Commitment converted the (then Office) Department of Vermont Health Access (DVHA), the state's Medicaid organization, to a public Managed Care Entity (MCE). The Agency of Human Services (AHS) paid the MCE a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately).

The Global Commitment provides Vermont with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g., case rates, capitation, combined funding streams) rather than fee-for-service, to pay for services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatric consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). The managed care model also requires interdepartmental collaboration and reinforces consistency across programs.

An extension effective January 1, 2011 was granted and included modifications based on the following amendments: 2006 - inclusion of Catamount Health to fill gaps in coverage for Vermonters by providing a health services delivery model for uninsured individuals; 2007 - a component of the Catamount program was added enabling the State to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the FPL, and who do not have access to cost effective employer-sponsored insurance, as determined by the State; 2009 - CMS processed an amendment allowing the State to extend coverage to Vermonters at or below 300 percent of the FPL; 2011 - inclusion of a palliative care program for children who are at or below 300 percent of the FPL, and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

In 2011, DAIL was awarded a five year $17.9 million "Money Follows the Person" (MFP) grant from CMS to help people living in nursing facilities overcome barriers to moving to their preferred community-based setting.

In 2012, CMS processed a cost-sharing amendment providing the authority for the State to eliminate the $75 inpatient co-pay and to implement nominal co-pays for the Vermont Health Access Plan (VHAP).

In 2013, CMS approved Vermont's Waiver Renewal for the period from October 2, 2013-December 31, 2016. AHS and DVHA have been working closely with Vermont's Medicaid Fiscal Agent HP to support all ACA reporting requirements, including identification of those services reimbursed at a different Federal match rate and in support of the revised MEG bucketing effective with the latest STC package.

In 2013, the State based Exchange, Vermont Health Connect (VHC), went live. CMS approved Vermont's correspondence, dated November 19, 2013, which requested authorization for expenditure authority for the period from January 1, 2014-April 30, 2014, to ensure temporary coverage for individuals previously eligible and enrolled as of December 31, 2013, in coverage through VHAP, Catamount Premium Assistance, and pharmacy assistance under Medicaid demonstration project authority during the transition to VHC.

In 2015, Vermont consolidated the Choices for Care 1115 waiver with Vermont's Global Commitment to Health 1115 waiver. Choices for Care offers a broad system of long-term services and supports across all settings for adult Vermonters with physical disabilities and needs related to aging.

On October 24th, 2016 Vermont received approval for a five-year extension of the Global Commitment to Health 1115 waiver, 1/1/2017-12/31/2021.

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit an annual report. This is the report for the eleventh waiver year, demonstration year 2016, which ended on December 31, 2016. This report encompasses fourth quarter updates for this demonstration year (10/1/16 – 12/31/16).

II. Highlights and Accomplishments

- Vermont received federal approval to extend the Global Commitment to Health waiver for five years from 1/1/2017-12/31/2021. This extension allows the demonstration to further promote delivery system and payment reform and introduces a new Accountable Care Organization (ACO) payment and care delivery model to Medicaid in Vermont in concert with a new All-Payer ACO initiative under the Center for Medicare and Medicaid Innovation. Several improvements were made to the Global Commitment to Health demonstration in order to further transparency and to promote program integrity.
- External Quality Review - the DVHA with its IGA partners was found to be 97% in compliance with the external quality review standards.

- In 2016, the DVHA began implementing changes required by the new Medicaid Managed Care rules.

- AHS developed a set of quality metrics for use with the new Accountable Care Organization (ACO) program.

- In early 2016, the DVHA issued a Request for Proposals for one or more ACOs to participate in a new population-based payment model. Contract negotiations were ongoing throughout CY 2016, and the contract is effective January 1, 2017. 2017 will be the pilot year of implementation and approximately 29,000 Vermont Medicaid beneficiaries will be attributed through this model.

- The DVHA completed the Access to Care Plan, a report that defines Vermont Medicaid's standards for access to care to certain types of health care providers and facilities.

- The Blueprint for Health, in partnership with the Vermont Department of Health, implemented the Women's Health Initiative – a new services initiative aimed at reducing Vermont's rate of unintended pregnancies.

- The number of Blueprint primary care practices increased and enrollment in the Hub and Spoke Health Home for opioid addiction continued to grow throughout the year.

- The Vermont Medicaid Shared Savings Program (VMSSP) realized shared savings of approximately $2.4 million in the second program year, with $452,459 distributed to the participating Accountable Care Organizations.

- In November 2016, a new Adult Services Division website was launched with improved access to information for both consumers and providers.

- The Global Commitment Register (GCR) listserv expanded to include approximately 100 additional interested parties. 2016 was the first full year the GCR was operational, and it has been a successful tool for public notice and documentation of Medicaid policy.

III. Project Status

i. Enrollment Information and Member Month Reporting

Table 1 presents point-in-time enrollment information and counts for Demonstration Populations for the Global Commitment to Health Waiver during the first quarter of federal fiscal year (FFY) 2017. Due to the nature of the Medicaid program, beneficiaries may become retroactively eligible and may move between eligibility groups within a given quarter or after the end of a quarter. Additionally, since the Global Commitment to Health Waiver involves most of the State's Medicaid program, Medicaid eligibility and enrollment in Global Commitment are synonymous.

Table 1 is populated based on reports run the Monday after the last day of the quarter, in this case on January 3, 2017. Results yielding ≤5% fluctuation from quarter to quarter are considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting >5% fluctuation between quarters are reviewed by staff from DVHA and AHS to provide further detail and explanation of the changes in enrollment. The explanation of any substantial fluctuations observed in Demonstration Populations during QE1216 are below. During this quarter, there were no substantial enrollment fluctuations >5% seen in any of the Demonstration Populations, apart from Population 1.

Table 1. Enrollment Information and Counts for Demonstration Populations*, QE1216

Demonstration Population	Current Enrollees Last Day of Qtr	Previously Reported Enrollees Last Day of Qtr	Percent Variance 9/30/2016 to 12/31/2016	Variance by Enrollee Count 9/30/2016 to 12/31/2016
	December 31, 2016	September 30, 2016		
Demonstration Population 1:	27,233	28,747	-5.27%	(1,514)
Demonstration Population 2:	74,287	74,899	-0.82%	(612)
Demonstration Population 3:	57,764	57,523	0.42%	241
Demonstration Population 4:	2,882	2,877	0.17%	5
Demonstration Population 5:	1,050	1,019	3.04%	31
Demonstration Population 6:	770	797	-3.39%	(27)
Demonstration Population 7:	7,404	7,698	-3.82%	(294)
Demonstration Population 8:	4,152	4,235	-1.96%	(83)
	175,542	177,795	-1.27%	

Demonstration Populations are not synonymous with MEG reporting. The numbers presented in the following table avoid duplication of population counts. To achieve this, Demonstration Populations 1, 2, and 3 may be reduced compared to their corresponding MEGs in order to draw counts for Demonstration Populations 4, 5, and 6. For example, individuals qualifying for inclusion in Demonstration Population 6 (via the appropriate placement level) may elsewhere be reported as MEG 1, 2 or 3. Data reported in Table 4 are not used in Budget Neutrality Calculations or Capitation Payments, as information will change at the end of the quarter. The information in this table cannot be summed across quarters. All payments are adjusted at the end of the year to reconcile expected population movement between eligibility groups.

During this quarter, there was a moderate drop in enrollment with fluctuation of -5.27% in Demonstration Population 1. This decrease was primarily due to the fact that Vermont completed Medicaid renewals this year after a multiple year hold. The increase in time between renewals led to a larger discrepancy between the information that was in the case management system and current household circumstances for individuals being redetermined. The population is expected to stabilize over time as individuals are redetermined on a yearly basis. Addditionally, individuals renewing coverage through Vermont Health Connect for the first time were learning to navigate a new process. Vermont expects timely response rates to rise over time as individuals become comfortable with the new processes for redetermination. This in turn, will increase the population that is enrolled at any given time.

Table 2. Number of Recipients, Change from All Quarters Demonstration Year 2016

	Q2 FFY 2016			Q3 FFY 2016		
Demonstration Population	**1/31/16**	**2/29/16**	**3/31/16**	**4/30/16**	**5/31/16**	**6/30/16**
Demonstration Population 1	37,059	36,672	36,311	35,428	33,831	32,887
Demonstration Population 2	85,027	85,234	84,759	85,567	84,214	82,228
Demonstration Population 3	62,306	63,045	63,072	64,960	63,428	60,838
Demonstration Population 4	2,958	2,905	2,839	2,965	2,909	2,865

Demonstration Population 5	965	964	955	1,015	1,011	1,003
Demonstration Population 6	851	847	841	832	823	819
Demonstration Population 7	7,379	7,530	7,506	7,435	7,477	7,552
Demonstration Population 8	4,216	4,282	4,270	4,259	4,240	4,263
	200,761	201,479	200,553	202,461	197,933	192,455

	Q4 FFY 2016			**Q1 FFY 2017**		
Demonstration Population	**7/31/16**	**8/31/16**	**9/30/16**	**10/31/16**	**11/30/16**	**12/31/16**
Demonstration Population 1	30,581	29,567	28,747	28,102	27,561	27,233
Demonstration Population 2	80,045	77,715	74,899	75,379	74,614	74,287
Demonstration Population 3	60,998	59,805	57,523	57,969	57,952	57,764
Demonstration Population 4	2,985	2,934	2,877	2,988	2,937	2,882
Demonstration Population 5	1,034	1,028	1,019	1,072	1,068	1,050
Demonstration Population 6	821	820	797	787	781	770
Demonstration Population 7	7,557	7,543	7,698	7,623	7,480	7,404
Demonstration Population 8	4,224	4,207	4,235	4,171	4,178	4,152
	188,245	183,619	177,795	178,091	176,571	175,542

ii. Vermont Health Connect

Key updates:

- Major system development completed in late winter, followed by defect resolution throughout spring, and a major improvement in operational performance by summer.
- Multiple reports pointed to Vermont's national leadership in terms of health access and affordability.
- By end of year, over 212,000 Vermonters were covered by a Vermont Health Connect health plan, either a qualified health plan (QHP) or Medicaid for Children and Adults (MCA).
- Vermont Health Connect's fourth open enrollment period launched successfully on November 1, 2016 and will close on January 31, 2017.

The State of Vermont launched Vermont Health Connect (VHC), a state-based health benefits exchange for individuals and small businesses in Vermont, in October 2013. As of December 2016, over 212,000 Vermonters were covered by a Vermont Health Connect health plan, either a qualified health plan (QHP) or Medicaid for Children and Adults (MCA). QHP enrollment included 32,908 as individuals (27,978 enrolled through VHC and 4,930 direct-enrolled through an insurance carrier) and 45,352 direct-enrolled

through a small business employer, as reported by Vermont Health Connect's carrier partners. MCA enrollment (including CHIP) included 70,076 adults and 63,763 children.

Vermont Health Connect's small business enrollment experienced an increase from 2015, largely due to the fact that the State expanded availability of qualified health plans to small businesses from 50 employees or fewer to 100 employees or fewer for 2016.

For some Vermonters, Vermont Health Connect serves as safety net to temporarily find health insurance and avoid gaps in coverage during times of transition. This churn is demonstrated by the fact that 40,814 different individuals had Individual-QHP coverage at some point in 2016.

Three national studies that came out in 2016 speak to Vermont's success in enrolling its citizens and improving health access.

First, the State Health Access Data Assistance Center reported a steep drop in uninsured children nationally, even steeper in VT. The report said Vermont had the lowest childhood uninsured rate in the nation, and that the state had made major gains, especially in terms of insuring low-income and middle-income children. According to the data in the report, a family's income no longer determines whether a child is covered in Vermont, as low, middle, and high-income children all have less than a two percent uninsured rate.

Second, the National Center for Health Statistics estimates that Vermont's uninsured rate fell to 2.7% in 2015. According to their data, Vermont's overall uninsured rate is second in the nation (after Massachusetts), and its 18-64 year-old uninsured rate was cut by more than half from 2014 to 2015.

Finally, in December, the Commonwealth Fund released a report that pointed to widespread improvements in health access across the nation. The report said that the uninsured rate for working-age adults has fallen in every state since the Affordable Care Act's coverage provisions took effect, and that significantly fewer people are going without care because of costs. The report also said that Vermont leads the nation in terms of health access and affordability. Vermont's ranking on this metric has steadily improved over the last several years, climbing from twelfth in 2009, to fourth in 2014, to second in 2015, before taking over the top spot in 2016. The report also showed that Vermont had the smallest access gap between rich and poor individuals of any state.

According to 2016 VHC enrollment data, Vermont is continuing to chip away at the last 2.7% uninsured and reaching the challenging "young invincible" demographic. At the time of 2014 Vermont Household Health Insurance Survey, 25-34 year olds were more than twice as likely as any other age group to be uninsured. This group is now enrolling through VHC at a much higher rate. More than one in five (21%) new VHC QHP enrollees are in the 26-34 age group, compared to just 12% of the renewing population.

Technology-wise, Vermont Health Connect and Optum deployed its final system upgrade in March to enable the processing of Medicaid renewals. With the completion of major system development work, the teams no longer had to manage continual cycles of major code changes. Instead they could focus on identifying and remediating defects and making process improvements within a stable system. This effort came to be known as the Maintenance and Operations (M&O) Surge. The M&O Surge began in March and continued into the summer.

The results of the M&O Surge were clearly visible by late spring. Escalated cases fell 80 percent from March levels. Integration errors were also cut 80 percent. Customer requests were being processed in an increasingly timely manner. The Level 1 Customer Support Center were able to resolve more phone calls themselves without having to transfer.

Medicaid Renewals

Medicaid renewals were a major focus in 2016. Redeterminations for Medicaid for Children and Adults began in January 2016, focusing initially on verifying and transitioning 9,000 MAGI Medicaid households per month from the State's legacy system (ACCESS) to Medicaid. Then starting in April, VHC began renewing Medicaid members who were already in the VHC system. All members were contacted in 2016, with the final group set to be closed or renewed as of February 1, 2017, then continuing on a normal annual cycle.

Redeterminations for Medicaid for the Aged, Blind and Disabled (MABD) beneficiaries, which had re-started in late 2015, completed their first annual cycle in October 2016, then continued onto a normal annual cycle.

QHP Open Enrollment and Renewals

In July 2016, the State kicked off a series of preparatory meetings for 2017 Open Enrollment with its carrier partners to prepare for system testing, business, and transactional planning activities. QHP renewals presented major challenges for Vermont Health Connect in past years, including the 2016 Open Enrollment, which was the first year with automated renewal functionality and was complicated by a significant contractor going out of business at the start of Open Enrollment. This year, the State of Vermont and its partners successfully completed three major steps on, or ahead of, schedule to ensure a successful 2017 renewal effort.

The first step in the renewal effort involved determining eligibility for 2017 state and federal subsidies and enrolling members in 2017 versions of their health and/or dental plans. The step was operated with a single, clean automated run which took care of 91.5% eligible cases. Remaining cases were processed the same week using the staff renewal form, allowing all members to have updated accounts and 2017 information prior to the start of Open Enrollment.

The second step involved sending these files to payment processor Wex Health and the insurance carriers to ensure appropriate billing and effectuation. The initial integration run was completed with 99% accuracy in mid-November. The State and its partners collaborated to clean up and re-send the remaining cases well in advance of the new year.

The third step consisted of a year-end business process that allows changes to be made on cases, if necessary, in 2017. This process ran with a 100% success rate, meaning all cases were ready to accept change requests starting on January 1st.

Altogether, performance on these three steps made the 2017 QHP renewal experience markedly different than 2016 -- when the renewal process was not complete until the end of March – and left state staff both optimistic and better able to tackle any challenges that do arise.

The experience for callers to Vermont Health Connect's Customer Support Center finished 2016 strong. After difficulty handling call volume related to Medicaid renewals in the summer of 2016, the State worked with its contractor Maximus to ensure adequate staffing through an overflow call center. As a result, the Customer Support Center exceeded performance targets in October, November, and December. With more than 100,000 calls over the first ten weeks of Open Enrollment, more than eight in ten (82%) calls were answered within 24 seconds, and the abandoned rate is 3.3% (performance targets are 75% answered within 24 seconds and a 5.0% abandoned rate). The one-minute average speed of answer was five times better than Vermont's performance in last year's Open Enrollment.

Outreach & Education

Vermont continues to prioritize engagement and collaboration with key partners and stakeholders to ensure the successful design, development, and implementation of Vermont Health Connect. The State uses advisory meetings, public forums, media inquiries, and other interactions to educate Vermonters about the State's vision for health care reform and the role of the Exchange in that vision. The State also values the input of Vermonters in the process of building the Exchange, soliciting input through formal structures and information interactions.

An important priority for VHC is providing effective consumer assistance to individuals and small businesses. Vermont has developed goals for the consumer experience within the Marketplace for both individuals and small businesses. The mission of Vermont Health Connect is to provide all Vermonters with the knowledge and tools needed to easily compare and choose a quality, affordable, and comprehensive health plan. VHC has identified four functions that it feels are critical in providing the level of consumer support required by the ACA.

1. Having a call center with a toll-free hotline to assist all Vermonters seeking health insurance;
2. Developing a broad network of Navigators and in-person assister personnel;
3. Working closely with agents and brokers; and
4. Working closely with the Office of the Health Care Advocate.

The State continued to work with assisters throughout 2016 to ensure adequate training and prepare this group to assist with 2017 open enrollment and Medicaid redeterminations.

The State's Outreach & Education Campaign for 2017 open enrollment focused on health insurance literacy, helping customers understand the total cost of insurance, and ensuring that Vermonters are aware of the increased fee for not having health insurance. Vermont Health Connect partnered with pharmacies, agricultural organizations, and other stakeholders to promote to participate in events aimed at helping customers and potential customers better understand health insurance terms, financial help, and how to interact with the Vermont Health Connect system.

Vermont Health Connect also utilized its online Plan Comparison Tool to help Vermonters better understand their subsidies and assess how various plan designs and out-of-pocket costs could impact their total health care costs. The tool was created by the non-profit Consumers' Checkbook and was named the nation's best plan selection tool by Robert Wood Johnson. The tool was used in more than 60,000 sessions in 2016.

Plan Management

In June 2016, DVHA provided CMS with its benchmark plan selection---continuing with the same plan that has been in place for Vermont since 2014. Vermont Health Connect determined that the basic configuration of benefits should be continued into 2017 for market stability. Vermont Health Connect presented and received approval from the Green Mountain Care Board (GMCB) for minimal changes to enrollee cost-share amounts in order to remain within required actuarial values (AVs) for all 2017 standard plans. In 2016, DVHA continued its work with stakeholders on a comprehensive state rule detailing policies and procedures for recertification of existing QHPs and issuers, as well as the processes for new medical and dental issuers wishing to become certified and submit plans to be offered on Vermont Health Connect. This rule is expected to be completed in 2017.

IV. Findings

i. *External Quality Review*

Key updates:

- DVHA received a compliance score of 97% during this year's EQRO Audit.
- DVHA began implementing changes required by the new Medicaid Managed Care rules.
- Compliance staff participated in the procurement of the new All Payer contract recently signed by DVHA.

During this year, the AHS Quality Improvement Manager (QIM) worked with the External Quality Review Organization (EQRO) to develop documents for each of the required annual external quality review activities. In addition to developing letters, tools, and reference documents – timelines were developed for each activity. Once developed, these documents were shared with DVHA. In addition, technical assistance calls with the EQRO and face-to-face meetings with DVHA were held to clarify elements contained in the PIP data collection tool, prepare for the Performance Measure Validation on-site review, and clarify the requirements for this year's compliance on-site review. As with all previous years, the three activities were conducted on time and in accordance with the work plans. Once the activities were completed, final reports were produced and shared with DVHA and AHS.

Performance Improvement Project Validation

For this year's 2016-2017 validation, DVHA submitted its PIP topic, *Follow Up After Hospitalization for Mental Illness*. The PIP validation evaluated the technical methods of the PIP (i.e., the study design and implementation/evaluation). Based on its technical review, the overall methodological validity was determined. The PIP received an overall *Not Met* validation status. DVHA resubmitted the PIP for a second validation and improved the percentage scores of evaluation elements and critical elements that were *Met*. Overall, 85 percent of all applicable evaluation elements received a score of *Met*. DVHA progressed to reporting second re-measurement data in this year's submission, and the PIP was assessed for statistically significant improvement from the baseline.

DVHA provided all the required documentation for Activities I through VI. It was determined that DVHA designed a methodologically sound study. The technical design of the PIP was sufficient to measure valid study indicator outcomes. DVHA met 89 percent of the requirements for data analysis and interpretation of reported data. It was determined that DVHA accurately documented the data collection methodology and analysis of the results. DVHA completed a causal barrier analysis, prioritized barriers, and implemented an intervention linked to a barrier. In addition, DVHA has a process in place to evaluate the effectiveness of the intervention.

DVHA had an opportunity for improvement related to the timeliness of intervention implementation in the current measurement period. During this year, DVHA reported re-measurement 2 results. The assessment for real improvement determined that although improvement occurred for both study indicators from the first re-measurement, neither study indicator's second re-measurement result demonstrated statistically significant improvement from the baseline. Study Indicator 2's second re-measurement result was lower than the baseline.

While both study indicators demonstrated improvement from the first re-measurement to the second re-measurement, neither study indicator demonstrated statistically significant improvement from the baseline to the second re-measurement. It appears the PIP needs more robust interventions to facilitate

improvement that would be statistically significant from the baseline. DVHA will continue to evaluate interventions, determine if interventions are having the desired impact, and implement additional interventions to address high-priority barriers. If the interventions are not having the desired impact, changes should be made before the measurement year has concluded. During the next year, DVHA will consider conducting small tests of change using a rapid-cycle approach and expend successful changes to a larger scale.

Performance Measure Validation

During the Performance Measure Validation activity, all rates were validated for the set of performance measures selected by AHS for 2016 reporting. The measurement period for all measures was identified by AHS as CY2015. Although most measures were reported using administrate data, DVHA was required to report two measures using both administrative data and medical record review, known as the hybrid method, to ensure that the rates more accurately reflected the services provided to beneficiaries. As with previsions years, all measures were determined to be reliable and valid. It was recommended that DVHA review their practice and enhance it to identify rates that fall below the national 10th percentiles.

Monitoring Compliance with Standards

During this year, the EQRO reviewed DVHA's compliance with the Managed Care performance requirements described in 42 CFR §438, as well as state-specific requirements contained in the AHS/DVHA IGA. This year's performance audit occurred on July 27-28, and focused on the following standards:

I. Availability of services: This standard includes a review of the adequacy of our provider network, the availability of women's health services, direct access to specialists, the use of treatment plans (when appropriate), opportunities for members to seek a second opinion and processes to ensure the delivery of specialized services not available in our network.
II. Furnishing of Services: This standard includes a review of the timeliness of the services delivered by our network, including appointment wait times, access to after-hours assistance and our processes for monitoring and correcting issues related to this standard.
III. Cultural Competence: In this standard, DVHA will need to demonstrate how it delivers services and messages with regard to its members' cultural needs/preferences and the languages they speak/sign and read.
IV. Coordination of Care: This standard relates to the processes DVHA and its network of providers use to ensure that care is coordinated across provider types and with care coordinators and program administrators.
V. Coverage and Authorization of Services: In this standard, DVHA will demonstrate the processes it uses to authorize services that require prior approval. DVHA will also demonstrate that the services covered are appropriate in amount, duration, and scope, and that the department does not arbitrarily deny covered services without a sound clinical reason for doing so. This standard requires a review of written procedures for coverage and authorizations and a demonstration of coordination with clinicians to ensure that only qualified personnel are making clinical decisions. Finally, this standard requires that DVHA demonstrate its adherence to statutory processes around providing timely notices to members about coverage decisions (and their rights to appeal decisions).
VI. Emergency and Poststabilization Services: DVHA will demonstrate its procedures for ensuring that emergency and post-emergency stabilization services are covered and not arbitrarily limited (including instances where an emergency happens out-of-state and care is rendered by a non-network provider).
VII. Enrollment and Disenrollment Requirements: In this standard, the auditors will review

DVHA's practices around enrollment and disenrollment with a focus on the materials and information provided to new enrollees.

DVHA's overall compliance score was 97%, a slight improvement over last year. The auditors score their findings as either "Met", "Partially Met" or "Not Met". DVHA met 75 standards and "partially met" five standards. DVHA did not receive any "not met" scores.

DVHA developed corrective action plans for the findings and has already begun working with the responsible departments/units to get these plans completed. The findings are summarized below:

1. DVHA must modify its network maps to ensure that physical rehabilitative services meet the requirement of being within 60 minutes of each beneficiary.
2. DVHA must modify its network maps to ensure that laboratories meet the requirement of being within 60 minutes of each beneficiary.
3. DVHA also must ensure that its network monitoring maps are sent to AHS quarterly.
4. DVHA must ensure that DCF notices to guardians of children in state custody include:
   • The beneficiary's or provider's right to file an appeal and procedures for doing so.
   • Circumstances under which an expedited resolution is available and how to request one.
   • The beneficiary's right at any time to request a State fair hearing for covered services and how to request that covered services be extended.
   • The beneficiary's right to request external review by AHS/DVHA for covered services (as applicable to Medicaid eligibility) or alternative services.
   • The circumstances under which the beneficiary may be required to pay the cost of these services pending the outcome of a fair hearing or external review by AHS/DVHA.
5. A new requirement added to this year's review involved informing beneficiaries in the Choices for Care Program about systems to prevent, detect and report, investigate, and remediate abuse, neglect, and exploitation.

<u>Changes to Medicaid Managed Care regulations</u>

In response to changes to the Medicaid Managed Care regulations in 42 CFR 438, DVHA began implementing several required programmatic changes. For example, DVHA worked in collaboration with AHS to develop new network standards and monitoring tools. DVHA also created an inventory of new requirements as well as several workgroups to ensure its ability to meet these new requirements. This work will continue throughout calendar-year 2017.

<u>Compliance staff participated in the procurement and implementation of the new All Payer Model (APM) contract.</u>

DVHA compliance staff played a role in the creation of the APM RFP, participated in RFP review and evaluated the contractor's progress during the readiness review phase of this project. This allowed DVHA to focus on building an innovative new payment model that remains in compliance with myriad state and federal requirements. As DVHA moves toward implementation of this new program, compliance staff will continue to monitor compliance with the rules and regulations that govern this important work.

ii. Quality Assurance and Performance Improvement Activities

Key updates:

- The Agency-wide FUH PIP cycle ended in June 2016, and the MCE chose a new formal CMS PIP topic focused on improving substance use disorder treatment.
- The DVHA Quality Unit and the Vermont Department of Health's Ladies First Program shared a Grant Manager position focused on cancer screening projects.
- The DVHA Quality Unit staff were integral in helping to develop a set of quality metrics for use with the new Accountable Care Organization (ACO) program.

The DVHA Quality Improvement (QI) and Clinical Integrity Unit monitors, evaluates and improves the quality of care to our Vermont Medicaid beneficiaries by improving internal processes, identifying performance improvement projects and performing utilization management. Efforts are aligned across the Agency of Human Services as well as with community providers. The unit is responsible for instilling the principles of quality throughout DVHA; helping everyone in the organization to achieve excellence. Our Unit's goal is to develop a culture of continuous quality improvement throughout DVHA.

MCE Quality Committee

The MCE Quality Committee remained very active throughout 2016 and consists of representatives from all Departments within the Agency of Human Services that serve the Medicaid population. The committee continues to structure its work around the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care. During this time period, the Quality Committee reviewed and revised our *Global Commitment to Health* (GC) Core Measure Set, including the decision to disaggregate measures where possible by target populations that receive GC funding. The committee feels this will better represent the breadth of services provided and monitored under the GC waiver. Also during 2016, the Quality Committee developed two tools: a performance measure selection criteria and an experience of care survey criteria. These were shared with other workgroups within the Agency that were working to establish measure sets. The role of the MCE Quality Committee was also discussed as it relates to the implementation and monitoring of a CMS *Next Generation* ACO.

Managed Care Medical Committee (MCMC)

The Managed Care Medical Committee worked throughout the year to finalize and adopt the Clinical Practice Guideline for Applied Behavior Analysis. The MCMC also worked with the Compliance and Quality committees to revise the Managed Care Entity Utilization Management Program document. The MCMC also developed a process for addressing quality of care concerns.

Formal CMS Performance Improvement Projects (PIPs)

The CMS reporting cycle for the AHS-wide PIP on Follow-Up After Hospitalization for Mental Illness (FUH) came to a close in June 2016. The DVHA QI Administrator submitted the 2016-2017 PIP summary to the vendor, Health Services Advisory Group (HSAG), for validation. Overall, the study design, implementation and evaluation elements scored very high. However, AHS was not able to demonstrate statistically significant improvement in its FUH rates over baseline during the PIP cycle. However, AHS learned a lot about its data and systems during this process and the DVHA QI Administrator has continued to work on this measure by participating in a joint payer project lead by the Vermont Program for Quality in Healthcare (VPQHC). This project team meets monthly, has shared state-

wide data and is in the process of identifying a project intervention. The work of the Medicaid FUH PIP has greatly informed this team.

The topic of substance use disorders has risen to the top as a focus area for our next formal PIP. A small group of staff from the DVHA Quality Unit and the Vermont Department of Health's Alcohol and Drug Abuse Programs (ADAP) division formed a team to explore inter-Agency support and interest in this project topic. To that end, the team met with the Agency's Substance Abuse Treatment Committee (SATC), the Agency's Screening, Brief Intervention, Referral to Treatment (SBIRT) work group and with the Assistant Director to the Vermont Blueprint for Health between March – June 2016. All of these groups and individuals felt that the project would dovetail well with work they had started and encouraged the project to move forward.

The contributing factors that make improving substance use disorder treatment difficult are many. A small group of ADAP and DVHA staff performed a root cause analysis and prioritized barriers. The group also met with the SBIRT lead and ER Director for one area hospital, the Central Vermont Medical Center. The group knew from the SBIRT meeting it attended that this hospital has created an ongoing regional partnership meeting that has helped them unearth gaps in care and barriers to care in their region. The PIP team wanted to explore whether there were best practices in play there that could help address any of the barriers identified. An important take-away from the meeting with the CVMC staff was the recommendation that each community identify a champion to lead in their community.

In fact, these regional partnerships have stood out to the team as a best practice and possible intervention for this project. The lead role was a concept worthy of more exploration. The team continued to spread the word of the PIP across the Agency between September – December 2016. The team met with the Agency's Field Service Directors and with an established group of hospital Quality Directors in order to take steps towards the first PIP intervention.

A strong recommendation from these groups was that a one-size fits all project intervention may not work very well for this topic since each community is unique. The Field Service Directors also identified the Blueprint for Health project coordinators as the most evident leads in their communities for any improvement efforts currently underway.

Moving into January 2017, the PIP team presented its project work thus far to the Blueprint/Accountable Care Organization (ACO) All Field Team meeting. Associate Directors within the Blueprint connected the work of this PIP and the use of the HEDIS IET measures as the study measure to other measure sets and initiatives ongoing within the State that the Blueprint is involved in – the All Payer Model quality measures, as well as the Women's Health Initiative. The BP/ACO project managers were engaged in this topic and requested additional data that will help them move forward with QI efforts within their communities.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

The DVHA Quality Unit's QI Administrator coordinated the 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children's Medicaid 5.0H survey. The Quality Unit collaborated with the Vermont Blueprint for Health and consolidated our work under one vendor, also used for the Patient Centered Medical Home (PCMH) survey. The contracted vendor, DataStat, Inc., distributed and collated the Children's Medicaid CAHPS 5.0H survey according to AHRQ and NCQA protocols. An Adult Medicaid 5.0H survey was not fielded in 2016, as DVHA awaited summary results from the 2015 CMS sponsored national survey effort. Results were received from the 2015 adult survey in the summer of 2016, at which time the DVHA QI Administrator updated the Experience of Care scorecards for both adults and children which is posted on our public website.

In 2017, the MCE would like to continue the collaboration that was begun with the Blueprint for Health and explore the various CAHPS survey modules that are available and in use throughout the MCE. Taking into consideration the overlap of our populations, as well as the time needed to analyze and act upon survey results, we'd like to have an inclusive conversation about survey types and frequency that could meet all of our needs and possibly provide some economies of scale.

HEDIS Hybrid Medical Record Review (MRR)

In 2016, the DVHA maintained the internal capacity that was developed the previous year to complete hybrid chart reviews for a limited number of measures. DVHA completed the 2016 HEDIS hybrid medical record review (MRR) on the controlling high blood pressure (CBP) and adult BMI assessment (ABA) measures. The rates were validated by our EQRO in July 2016 and were reported to CMS as part of the Adult Core Set by the DVHA Quality unit in January 2017.

Grant Funded Quality Improvement Projects

The DVHA Quality Unit and the Vermont Department of Health's Health Promotion and Disease Prevention (HPDP) division created a partnership during 2016. A shared Grant Manager position funded through the Ladies First Breast and Cervical Cancer Screening Program lead cancer screening quality improvement projects (QIPs). The following QIP's were in progress during 2016:

- Cancer screening brochures were sent to Medicaid beneficiaries and Medicaid providers.
- Mammogram gap-in-care reports were sent quarterly to 29 Blueprint for Health practices. This was a joint payer project, including MVP and BCBS along with Medicaid.
- Ladies First direct mail to female Medicaid beneficiaries state-wide focused on breast cancer screening.
- Ladies First in-person outreach by clinic "champions" to Medicaid beneficiaries focused on breast cancer screening.
- Ladies First two-step screening reminder project for cardiovascular, breast and cervical cancer screening. The first step is a postcard reminder, followed by a motivational follow-up call from a clinic champion.

Results of these QIPs are currently being evaluated.

Communicating our QAPI Work

In addition to maintaining the Quality Reporting section of the Vermont Medicaid website, the Managed Care Quality Committee began discussing in 2016 other ways to communicate quality-related work. The Committee has shared some of our tools with other workgroups within the Agency of Human Services (AHS), such as the quality performance measure selection criteria and experience of care survey measure criteria. The Secretary of AHS also publishes a monthly newsletter and the Managed Care Quality Committee submitted an article in the fall of 2016 to introduce the concept of Quality at the health plan level. This will become a series of articles to be continued in 2017.

All Payer Model

In early 2016, the DVHA developed and then issued a Request for Proposals (RFP) for one or more Accountable Care Organizations (ACOs) to participate in a new population-based payment model. Based on CMS's *Next Generation* ACO Model, the new payment model would pay an ACO a prospective, all-inclusive population based payment (AIPBP) for providing an array of services to its assigned beneficiary

population. The model would hold the ACO accountable for both the cost and quality of health care provided, as measured by a set of quality metrics that the DVHA Quality Unit staff were integral in helping to develop. Additionally, the Quality Unit staff advised on a quality reporting matrix to be used for monitoring and oversight. Contract negotiations were ongoing throughout CY 2016. The DVHA Quality Unit participated in internal DVHA readiness review preparation and will be joining monthly operations meetings starting early in 2017.

AHS Performance Accountability Committee

During this year, the AHS Performance Accountability Committee (PAC) focused on enhancing the key elements of the AHS Performance Framework. Specific work was done to advance organizational competencies associated with identifying outcomes and goals, measuring performance, monitoring and evaluating performance, improving performance, as well as communicating and teaching performance. In addition to developing the competencies, the group identified examples of each competency to help staff answer the question of what each competency might look like in their work areas. The group later edited the competencies document to include a rating scale that will allow quality management staff to assess the Agencies level of performance in each area.

Also during this year, the PAC began to develop a set of best practices for performance monitoring. As a first step, the group engaged in a root cause analysis-like activity that allowed the group to brainstorm possible causes for a lapse in performance monitoring. With a list of preliminary root causes identified, each member of the group reviewed a couple of grants/contracts that are considered high performers in their work areas. During the review, members identified elements of the contract/grant that contributed to its success. The goal of this activity is to develop a list of best practices for performance monitoring that can be shared with the broader agency.

MCO Investment Review

During this year, AHS continued to improve its monitoring/oversight of MCO Investments. At the start of the first quarter, the Integrated Operations and Planning Team (IOPT) charged each of the AHS Departments with conducting a self-assessment of the performance of their investments against a standard set of criteria. Criteria was developed by the AHS Performance Accountability Committee (PAC) and included key elements such as the use of performance measures, the inclusion of performance targets, regular monitoring and oversight, the use of SMART objectives, and the use of evidenced-based or informed practices. During quarters two and three, each department presented the results of their reviews to the IOPT. At the start of the fourth quarter, all departments were expected to submit score sheets for each of their investments to the Secretary's Office. A total of 73 investments were subject to review (n=73) and 68 assessment tools were completed and submitted by Departments (n=68) for a return rate of 93.2%. Possible investment scores ranged from 14-50. A score in the range of 14-26 was assigned a red designation, a score in the range of 27-39 was considered yellow, and a score in the range of 40-50 was assigned a green designation. 2.9% of investments were scored as Red; 27.9% of investments were scored as Yellow; and 69.2% of investments were scored as Green. Scores ranged from a low of 22 to a high of 47. The average score was 40.0 and the median score was 41.0. Strengths Based on Scores included the following: 79.4% of all investments integrated best available evidence to guide implementation and improve outcomes & 83.4% of investments either met or exceeded performance expectations. Opportunities Based on Scores included the following: 19.1% of written investment objectives were missing a majority of the SMART criteria & growth in spending over time had increased for 26.5% of investments. Strengths Based on Previous Recommendations included the following: 70.6% of investments had identified performance targets & departments regularly collected both Financial & Performance Management Information for 82.4% of investments. Opportunities Based on Previous Recommendations included the following: while a number of investments have been converted –

additional work is required in this area & a plan for monitoring investments needs to added by Departments for all current investments. Next steps include additional analysis; developing conclusions/recommendations, and producing a final report.

Quality Strategy

During this year, an updated Comprehensive Quality Strategy (CQS) was submitted to CMS for review. The document incorporated both CMS and consumer feedback on the version posted for public comment. The edits included the following: changes to the format to help consumers more readily navigate the strategy; an introductory section was added to orient the reader to the new HCBS regulations and the role that the CQS plays in meeting the State Transition Plan requirements; more detail was added to the phases of HCBS implementation to clarify the use of systemic and site-specific assessments, remediation activities, monitoring and oversight methodology. In addition, text was added to the Heightened Scrutiny and Relocation of Beneficiaries Sections. Also during this year, the Systemic Assessments and Remediation/Work Plans were finalized for the remaining special health needs programs (i.e., DS, TBI, CRT, and EFT/SED). All assessments and work plans were shared with stakeholders and consumers and feedback was requested. These documents, along with an updated CQS will be posted for public comment during the first quarter of next year. Vermont hopes to receive Initial Approval of their CQS/STP during the early part of next year.

During this year, the HCBS Implementation Team also began work on Final Approval CQS/STP elements. The team finalized site-specific assessment and consumer survey tools for DAIL programs as well as one for DMH programs. Both versions of the tool contain skip logic so that it can be used by the various DAIL and DMH programs respectively. An implementation plan was also developed for the site-specific assessment. In addition, the team modified the site-specific validation strategy to accommodate a mixed-methods approach. While most DAIL and DMH programs will rely on a Consumer Survey to validate the findings of the site-specific self-assessment – some will rely on data collected during regular quality management/compliance monitoring activities to validate the results. For those programs using a mixed-methods approach, the implementation team conducted a cross-walk to ensure that all site-specific self-assessment questions had analogous consumer survey or quality management/compliance monitoring elements

Evaluation Activities

During this year, timelines were established for the following Demonstration evaluation items: *draft/final evaluation design, Interim Evaluation Report #1 (April 1, 2018), Interim Evaluation Report #2* (December 31, 2020), *Summative Evaluation Report #1* (April 1, 2021), and *Summative Evaluation Report #2* (June 30, 2022). A waiver evaluation group was convened to develop a draft evaluation design. The group contains evaluation staff from VDH/ADAP and DMH as a specific section of the evaluation design must address the impact of providing Medicaid reimbursement for mental health and substance use disorder admissions to facilities classified by CMS as Institutions for Mental Disease (IMD). The group is supported by staff from Pacific Health Policy Group (PHPG). Before developing the design, the group must consider existing or planned Evaluations or Quality Monitoring activities – including a discussion of potential impacts that the SUD Demo might have on the design. During next quarter, the group needs to identify study populations, suggest hypotheses to be tested, and recommend specific measures that need to be collected/reported. A draft evaluation design is due to CMS by the end of February 2017. Next steps include the development of a Demonstration evaluation request for proposal, CMS feedback on the draft evaluation design, posting of the design for public comment, and contracting with an independent entity to conduct the evaluation.

iii. Provider and Member Relations

Key updates:

- Non-Emergency Medical Transportation new contract awarded
- Access to Care
- Provider Screening
- Dental Services

The Provider and Member Relations (PMR) Unit ensures members have access to appropriate health care for their medical, dental and mental health needs. The Unit monitors the adequacy of the Green Mountain Care (GMC) network of providers and is responsible for implementation of the enrollment, screening and revalidation of providers in accordance with Title 42 Code of Federal Regulations (CFR) §§455.410 and §455.450 requiring that all participating providers be screened upon initial enrollment and revalidation of enrollment.

PMR is also responsible for outreach and communication, including Medicaid policy education, provider manuals and newsletters, member handbooks and newsletters, the Green Mountain Care member website, the Department of Vermont Health Access website, and other communications. Additionally, The PMR Non-Emergency Medical Transportation (NEMT) program ensures that Medicaid members who do not have access to transportation are able to get rides to and from medical appointments and daily dosing for opioid addiction treatment. PMR handles contract management and quality review of the 8 transportation brokers who provide transportation services statewide.

A RFP was issued for Non-Emergency Medical Transportation and the contract was awarded to Vermont Public Transportation Authority as January 1, 2017. The new contract will ensure Vermont Medicaid members are afforded the benefit for transportation to medical appointments when no other means are available to them.

The Department of Vermont Health Access (DVHA) completed the Access to Care Plan. The report defines Vermont Medicaid's standards for access to care to certain categories of providers, such as primary care, hospitals, and various specialty services. The plan will be reviewed bi-annually for compliance.

As of September 24, 2016, the DVHA was in full compliance with 42 CFR §455 regarding Provider Enrollment and Screening. All newly enrolling providers must adhere to the screening requirements outlined in 42 CFR §455 as well as existing providers must revalidate every five years under the requirements outlined.

Access to dental providers is a top priority for Provider Member Relations. The DVHA continues to meet with the Vermont Dental Society to strategize how best serve Medicaid members dental needs.

V. Cost Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates:

- The VCCI was the first care management service line to go live in the new AHS, MMIS enterprise Care Management system. Release one was completed in the last quarter of 2016 with new features anticipated in 2017.
- The DVHA Quality Improvement Unit initiated use of the Care Management system in the fall of 2016 to generate electronic referrals to VCCI to support transition in care among members hospitalized for mental health and/or substance abuse treatment, and to improve medical follow up and reduce 30 day readmission rates. The Clinical Operations Unit (COU) will utilize the system for electronic referrals for hospital inpatients in 2017.
- VCCI and MMIS/Care Management technology team initiated work with the Vermont Health Information Exchange (VHIE) to secure biomedical data feeds into the Enterprise Care Management system in 2017, for Medicaid members. This will significantly enhance case management priorities and outcome reporting for all Medicaid member, including the ACO attributed population.
- VCCI teams statewide participated in the State Innovation Model 'Learning Collaboratives' toward unified local care teams to improve service coordination with a lead care manager. Enhanced relationships are supporting improvements in referrals at the point services are needed most.

The goal of the VCCI is to improve health outcomes of Medicaid beneficiaries by addressing the increasing prevalence of chronic illness through various support and comprehensive case management strategies. The Case Management Society of America defines case management as: a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

The VCCI is a component of DVHA's health care reform goals and its supporting strategic plan. The VCCI employs 27 licensed and non-licensed professional staff operating in a decentralized model statewide, so resources are available where members need them. The VCCI is designed to identify and assist high risk/high cost, medically complex Medicaid members with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower members to eventually self-manage their chronic conditions. A significant effort is placed on facilitating and supporting Medicaid member identification, access and use of a Medical Home for receipt of primary care.

The VCCI uses a holistic model of evaluating and supporting improvement in medical and behavioral health, as well as identification of socioeconomic issues that are barriers to sustained health improvement. The top 5% of VCCI-eligible Medicaid members account for approximately 39% of Medicaid costs and a disproportionate number of hospital admissions and readmissions. The new AHS Enterprise MMIS/care management vendor utilizes the Johns Hopkins evidence based predictive modeling and risk stratification software to support population selection and related eligibility for services. This new model will enhance VCCI's ability to identify members based on both past cost profiles (top 5%) and anticipated future utilization, risks and costs, and intervene earlier in order to track the clinical and financial improvements.

Excluded populations currently include dually eligible individuals, those receiving other waiver services and CMS-reimbursed clinical case management.

The VCCI's strategy of embedding staff in high-volume hospitals and primary care sites continues to support population engagement at the point-of-need in areas of high service utilization and prior to claim adjudication. By targeting high risk/cost members, resources can be allocated to areas representing the greatest opportunities for member engagement, clinical improvement and cost savings. Due to migration to the new system and related identification of a new cohort of high risk members, the VCCI generated an abridged target population while work on the stratification requirements and related eligibility rules continues. In 2017, VCCI will further evaluate the eligibility profiles, which will exclude the Medicaid Next Gen ACO attributed cohort from receiving VCCI services. The 2016 goal of ACO affiliated member/provider profiles to eliminate redundancies and to track results – both clinical and financial –was not realized, as very few direct referrals of ACO attributed members from primary care providers were generated. Feedback from both ACO's and providers alike indicated that the manual processes of ACO member identification for services was too labor intensive.

On a positive note in 2016, the VCCI did expand the number of hospital partners providing FTPs census data to the VCCI for targeting engagement of those members at risk including of readmission rates. These data will be uploaded into the new vendor care management system for staff referral and management. The VCCI hospital 'liaison' role - where every hospital has a VCCI nurse collaborating with the hospital discharge planners - continues to require maturation for enhanced identification and referral for care transitions, including medication reconciliation post discharge and medical appointment follow up, toward reduction in 30-day readmission rates.

The VCCI continue to strive for strategic alignment with other important State health care reform efforts, such as the Blueprint for Health, their NCQA certified advance practice medical homes and local Community Health Teams (CHTs) funded by pubic and commercial payers. The VCCI staff function as members of the local CHT, and were members of the SIM funded Learning Collaboratives for care coordination, administered by the Vermont HealthCare Improvement Project (VHCIP). The goal of this collaboration was to support development of a single plan of care and related transition between levels of need (hospital to outpatient; chronic unmanaged, to managed within a medical home); and reduce redundancies while enhancing communication among teams. VCCI supports the highest risk population and performs home visiting, while the CHT's focus is on less acute Medicaid members, often seen in the PCP office site.

The vision of enhanced local coordination and a single plan of care remains a component of the long-term state vision toward an all payer model. The AHS Enterprise MMIS Care Management system supports this opportunity as part of the 'future state'. Specifically, the next release is intended to have both provider and consumer portals, and is anticipated to accept data from the VHIE as well as the Medicaid next generation contracted ACO, scheduled to launch in 2017. This will leverage and maximizing the CMS investments to the State via MMIS.

<u>MOMS (Medicaid Obstetrical and Maternal supports) for Pregnant Women</u>

The VCCI initially launched the service line for pregnancy case management in October 2013 and which has steadily evolved based on staff and partner input. There is a centralized resource/expert available to the field staff as well as community and statewide partners, who also takes a case load of pregnant women. Since this change in structure the initiative had been able to move forward on a more accelerated rate. All VCCI staff are subsequently trained on the MOMs services and supports and accept local at risk MOMs candidates on their case load. The primary focus is on women with a history of mental health and substance use/abuse and related management of these conditions during pregnancy in an effort to improve

birth outcomes and limit NICU and/or inpatient stays for both baby and mother. The MCH staff liaison and case manager, is an important resource to the statewide VCCI team as well as to our partners supporting at risk pregnant women and women of child bearing years. The expansion of pregnancy case management assessment tools is anticipated in the new eQH system in 2017 as part of Release 2.

Enterprise Care Management System

The VCCI was the initial DVHA unit to go live in the new enterprise care management system with eQHealth (eQH) on 12/31/15. The VCCI was engaged in planning and development of system configuration, including eligibility rules, workflow mapping, survey tools and related system alerts on gaps in care. The VCCI staff continue to support UAT of system features as well as bugs/defects identified and resolved by the vendor; as well as testing initiated for Release 2. Thus, the VCCI caseload remains below goal. The UAT part time efforts by roughly 6 clinical staff, coupled with system training time and the reduction of nurse FTE's in 2016 due to the sunset of our previous vendor all contribute to the decline in the overall VCCI case load.

With the continued support of the Organizational Change Management (OCM) team at the state and with eQH, VCCI is continuing to develop and expand on training materials and guides for the team, supplemented by phone sessions, monthly staff meeting agenda items, 'trained trainer' sessions followed by small group hands on training with supplemental practice sessions and materials in the training environment to assure expertise. Knowledge assessment and application of documentation standards outlined in our workflow are monitored by monthly audits with a staff goal of 90% accuracy.

System training documents and policies have been updated to include direct referral within the enterprise system by the internal DVHA's Clinical Operations Unit and the Quality Improvement Units. Both units will utilize the eQH system after R1 final is launched and functionality required is available across teams. This process of direct referral will also eliminate the need for manual workarounds existing between units and will enhance the volume of 'warm transfers' of complex members to the VCCI for managing care transitions and related decline in hospital readmission rates.

The VCCI management team and analyst initiated work with the Care Management technical team toward receipt of biomedical and immunization data feeds from the HIE into the care management suite. This data resource for 100% of Medicaid members will enhance the clinical staff ability to effectively identify need and manage care based on member treatment and management to evidence based care goals. Trending is anticipated at the member, provider, and hospital service area level, as well as by ACO attribution.

ii. Behavioral Health Services

Key updates:

- Paper review process initiated
- Applied Behavior Analysis benefit moves forward
- Substance abuse residential level of care authorization procedure solidified
- Team Care program revitalized

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric, detoxification, and substance abuse residential services for Medicaid primary beneficiaries. In 2016, the team moved to paper reviews to ensure member confidentiality and improve interrater

reliability. As a result, the clinical documentation to support authorization requests has improved significantly. This process also may have contributed to the sharp decline in reconsideration requests. The team has developed a system to ensure internal consistency and educate providers on documentation requirements. Team members work closely with discharge planners at inpatient and residential facilities to ensure timely and appropriate discharge plans. The Team also works with other Departments supporting coordination of care. The Team has worked with VCCI staff to develop a referral process for VCCI services and to ensure continuity of care for members already enrolled with VCCI admitted to inpatient or residential care facilities. The Team hopes to continue to refine this process.

The Team also manages the Team Care program (formally the lock-in program). Clinical review of all available data allowed for an accurate assessment of current enrollees' need to remain in the program. Standards for inclusion and removal are being developed/manualized by the Team. Team Care program members are also referred to VCCI when appropriate. Outreach with providers and pharmacies is planned for the upcoming year.

Behavioral Health Team members continued involvement in the AHS Substance Abuse Treatment Coordination Workgroup. This workgroup strives to standardize substance abuse screening and referral processes throughout the Agency of Human Services. Team members also participate in monthly meetings with the VDH's Alcohol and Drug Abuse Prevention Division to coordinate efforts between the two departments to provide substance abuse services to Vermont Medicaid beneficiaries. Team members also participated in the SFI Interagency Team, the Criminal Justice Capable Workgroup, Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF etc.), and the MAT learning collaborative.

Following the initiation of the Applied Behavior Analysis (ABA) benefit the Autism Specialist, a member of the Behavioral Health Team, worked collaboratively with the AHS Policy Unit and sister Departments throughout the year to evaluate and improve the program. The Autism Specialist surveyed consumers and elicited feedback from providers in an effort to strengthen and improve the prior authorization process. As a result, there was an approved rate increase. It is hoped that the increase will help to attract new providers. The Autism Specialist participates in the Autism Workgroup. The Applied Behavior Analysis Clinical Practice Guideline has been completed and is available to providers. Currently, the Autism Specialist is conducting research for expansion of the benefit.

iii. Mental Health System of Care

Key updates:

- Vermont Psychiatric Care Hospital has attained CMS certification and accreditation from The Joint Commission.
- Level 1 unit at the Brattleboro Retreat and the Rutland Regional Medical Center are fully operational.

The Vermont Department of Mental Health (DMH), with the Designated Hospitals (DHs), Designated Agencies (DAs), and other community and Agency of Human Services (AHS) partners, has continued to work throughout the past year to move the system of care forward within Vermont for people with mental health needs.

The Department has made significant progress since the emergency closing of the Vermont State Hospital in late August 2011 following Tropical Storm Irene. Inpatient care is being provided using a decentralized system which includes one state-run hospital and five Designated Hospitals located across the state.

Community services have been enhanced and support hospital diversion through expanded crisis services and increased residential treatment using the least restrictive setting that is appropriate for the level of care required. In many cases, treatment can be provided closer to individuals' homes.

The Vermont Psychiatric Care Hospital, which opened in July 2014, has been in operation for over two years and has attained Centers for Medicare and Medicaid Services (CMS) certification and The Joint Commission (TJC) accreditation. The Level 1 units at the Brattleboro Retreat and the Rutland Regional Medical Center are fully operational and have remained at capacity throughout the year.

Local hospital emergency departments in collaboration with the Designated Agencies throughout the state provide screening, stabilization, and limited treatment until admission to a psychiatric inpatient bed can be facilitated. As part of "decentralizing high intensity inpatient mental health care,"[1] the Department is also working to preserve the quality of treatment services afforded to patients who experience involuntary hospitalization in Vermont.

Under Act 79, the Department continues its collaborative work to strengthen Vermont's existing mental health care system. This work has included the development of enhanced community services, including emergency/crisis responses, residential services and support, housing, and inpatient treatment capacity. Specific enhancements by category include:

- Hospital Services
    - Operating a new 25 bed psychiatric hospital (July, 2014) that is both CMS certified and TJC accredited.
    - Ongoing operational capacity for Level 1 inpatient care at both Rutland Regional Medical Center and Brattleboro Retreat.
    - 45 Level 1 beds with a total of 188 adult psychiatric inpatient beds across the system of care.
    - Emergency Involuntary Procedure Rule-making process completed with Legislative Committee on Administrative Rules (LCAR).
    - Designation of the Veterans Administration Medical Center at White River Junction to provide involuntary inpatient care (December 2016).

- Community Services
    - Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop.
    - Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs.
    - Increased capacity to provide mobile crisis responses to those needing screening and intervention in the community.
    - Increased and additional training for Team Two collaboration between law enforcement and mental health responders.
    - Additional availability of soft-restraints for law enforcement transports for mental health hospitalizations.
    - Resources to assist individuals in finding and keeping stable housing.

- Residential and Transitional Services

[1] http://legislature.vermont.gov/assets/Documents/2012/Docs/ACTS/ACT079/ACT079%20As%20Enacted.pdf

    - Soteria, a five-bed, peer supported alternative residential program opened in Chittenden County.
    - Maintaining full occupancy at the secure residential recovery program, the Middlesex Therapeutic Community Residence, serving 7 individuals.
    - Continued planning for permanent replacement capacity for the Secure Residential Program.

- Performance and Reporting

    - Along with AHS, DMH has adopted the Results-Based Accountability (RBA) framework for assessing performance of providers via grants and contracts
    - Creation of a "VPCH Outcomes" scorecard to meet legislative reporting requirements
    - Creation of a "DMH Scorecard" using the RBA scorecard reporting tool
    - Migration of the "DMH Snapshot" and the "DMH continued reporting" report to the RBA scorecard reporting tool

- Regulation and Guidance

    - Revision of the Designated Hospital Manual and Standards to better reflect the scope of review and designation and creation of a designation protocol to efficiently manage the process
    - Creation of involuntary transportation manual to consolidate the expectations of the department into a single document.

The Department is continuing to monitor the functioning of the clinical resource management system to "coordinate the movement of individuals to appropriate services throughout the continuum of care and to perform ongoing evaluations and improvements of the mental health system" as written in Act 79. This system encompasses the following functions:

- Departmental clinical care managers provide assistance to crisis services clinicians in the field, Designated Agency case managers, and Designated Hospital social workers to link individuals with the appropriate level of care and services as well as acting as a bridging team for aftercare and discharge planning from hospital inpatient care to community services
- Departmental clinical care managers provide support to Designated Agencies and monitor care to individuals on Orders of Non-Hospitalization (ONH)
- An electronic bed board to track available bed space is updated regularly to enable close to real time access to information for individuals needing inpatient treatment, residential treatment or crisis bed services
- Patient transport services that are least restrictive have been developed and are coordinated through Admissions and Central Office
- Supervision by law enforcement for individuals in emergency departments on emergency examination status who are awaiting admission to a Designated Hospital is coordinated through the Department
- Review and coordination of intensive residential care bed placement within a no-refusal system
- Access by individuals to a mental health patient representative
- Periodic review of individuals' clinical progress.

iv. Blueprint for Health

Key updates:

- The number of Blueprint primary care practices overall increased by four over the year – six primary care practices joined the Blueprint and two practices closed.
- Practice and HSA level profiles for time periods 7/1/14 – 6/30/16 (Rolling Year 2015) and 1/1/15 – 12/31/15 (Calendar Year 2015) were released.
- The Blueprint in partnership with the Vermont Department of Health implemented a new services initiative to reduce Vermont's rate of unintended pregnancies entitled the Women's Health Initiative. 14 practices pledged to join the Women's Health Initiative in the first quarter of 2017.
- Enrollment in the Hub and Spoke Health Home for opioid addiction continued to grow throughout the year; the total enrollment at the end of December was 5,813.
- Community collaboratives, which are local governing bodies, were put in all 14 HSAs as a collaborative effort between Blueprint and the ACOs. Each of these community collaboratives has identified key quality improvement projects in their community. Examples include: reducing emergency room visits and hospitalization, increasing hospice use, implementing cross-organization shared plans of care, and addressing opioid addition.

The Blueprint combines state-level strategic direction with local organization and ownership of care delivery. The state's 14 Health Service Areas (HSAs) each have an Administrative Entity, such as a hospital or Federally Qualified Health Center (FQHC), that leads the Blueprint locally. Their work includes local program management, staffing of Community Health Teams (CHTs), and financial management. The Blueprint's Transformation Network includes Project Managers, hired by the Administrative Entities, who lead implementation and engage community partners at the local level. Each Administrative Entity contributes their own financial and human resources, beyond the scope of their Blueprint grants, demonstrating their commitment to the Blueprint's sustainability and success.

The Administrative Entities in each HSA work to include local partners in guiding Blueprint implementation. In 2015, local Blueprint work groups (originally known as Integrated Health Services advisory groups) merged with Accountable Care Organization (ACO) work groups (known as Regional Clinical Performance Committees). These combined groups are now known as Community Collaboratives (CCs).

Staffed by the Blueprint Project Manager with clinical leadership supported by the ACOs, the CC leadership teams include representatives from ACOs present in that community, local primary care leaders (including a pediatric provider), the hospital, home health or the Visiting Nurse Association, Area Agency on Aging, Designated (mental health) Agency, Designated Regional Housing Organization, and others. They meet to identify local priorities, goals, strategies, and quality or process improvement projects, including the design and staffing of the area's Blueprint CHT.

The long-term goal of these CCs is to prepare each HSA to function as an Accountable Community for Health (ACH), responsible for the wellness of the whole population and its health care budget. This model supports the complete integration of high-quality medical care, mental health and substance abuse services, social services, and prevention.

<u>The Clinical Registry</u>

Blueprint practices across the state have been populating the clinical data registry for over 7 years. The registry, previously referred to as DocSite, was hosted by Covisint. In January 2015, Covisint announced it would no longer support the DocSite product, giving the Blueprint until August of 2015 to find a replacement system. The Blueprint for Health, under direction from the Agency of Administration, was instructed to purchase a perpetual software license for the DocSite software product from Covisint, stand up the Blueprint Clinical Registry at an alternate location, and have it functional by June 30, 2016. The system would thereafter be referred to as the Vermont Statewide Clinical Registry.

The Blueprint entered into an agreement with Capitol Health Associates (CHA) to manage the overall project and continuing operations and maintenance of the Clinical Registry. CHA subcontracted with Vermont Information Technology Leaders (VITL) to host and provide technical support for the Clinical Registry and to work with the Blueprint team to convert the message handling processes from Covisint Connect to VITL Rhapsody. CHA also subcontracted with MDM Technologies to provide advisory and special technical services to support the migration and to stand up the registry at VITL's hosting contractor, Rackspace, and with KeyW Corporation to provide data security services. Following the migration of the system, CHA and MDM have been providing support for practices to connect to the Clinical Registry since June 30, 2016.

The fully functional Clinical Registry includes a client-facing user interface for data entry and reporting for Blueprint programs, including, Community Health Team (CHT), Self-Management Support Programs (SMSP), and Tobacco Cessation (TCC). The system also provides data collection through standard Admission, Discharge and Transfer (ADT) and Continuity of Care Document (CCD) interfaces for 175 sites through the Vermont Health Information Exchange (VHIE), flat file demographic and clinical interfaces for four (4) sites through an FTP site, and flat file pass-through services for nine (9) sites. CHA and its subcontractors completed the Blueprint Clinical Registry migration project on schedule and under budget.

Success criteria for the project included:
- The Blueprint Clinical Registry will be functional and deployed to production environment on or about June 30, 2016.
- The Blueprint Clinical Registry will be fully migrated to Rackspace.
- Functionality of Covisint Connect data messaging system will be documented and tested.
- A plan to migrate data feeds from Covisint Connect to VITL's Rhapsody interface engine will be established.
- Successful completion of functional and user acceptance testing of all end-user data entry activities and reporting.
- Production data feeds from the VHIE successfully pointed to the Blueprint Clinical Registry via Rhapsody.
- Production data feeds from Covisint's FTP site in support of flat file interfaces successfully pointed to the Blueprint Clinical Registry via Rhapsody.
- Readiness to onboard new sites and users to the Blueprint Clinical Registry.

New Payments Finalized

New performance-based payments to PCMHs are effective January 1, 2017 for Medicaid and all commercial insurers. PCMHs will be eligible for up to $0.25 PPPM for performance of the community on healthcare quality measures, and up to $0.25 PPPM for performance of the practice on healthcare utilization measures.

<u>Latest analysis of Calendar Year 2015 data evaluated impact of PCMH activities by programmatic stage</u>

The analysis used a Difference in Differences (DID) methodology, a technique often used to evaluate policies over time. It calculates the final difference between PCMH patients and comparison outcomes minus any initial difference. This is the third year that Blueprint has used this methodology to evaluate the impact of the program. Of note, each year the analysis is run, the mix of practices, and therefore patients, included in each program stage changes as new practices transition to PCMHs.

As in prior years, the results suggest that patients receiving the majority of their care in a Blueprint PCMH have reduced annual medical expenditures and utilization rates. For example, after accounting for the initial difference between the PCMH patients and the comparison group in the Pre-Year, the total expenditures per patient per year (excluding services covered only by Medicaid) was $247 less for PCMH patients relative to patients in the comparison group (P-value: <0.001) by Post-Year 4.

Special Medicaid services are services uniquely funded by Medicaid and targeted at meeting social, economic, and rehabilitative needs (e.g. transportation, home- and community-based services, case management, dental, residential treatment, day treatment, mental health facilities, and school-based services). The analysis of total expenditures for all payers excluded SMS services to allow more comparable comparisons of expenditures across the payers. When broken down to specific expenditure categories, the PCMH patients had significantly less per patient per year inpatient expenditures (DID: $-78; p-value: <0.018) and pharmacy expenditures (DID: $-80; p-value: <0.001).

Figures 1, 2, and3 show the trends for total medical expenditures (excluding SMS), inpatient expenditures, and pharmacy expenditures respectively. While patients attributed to PCMHs continue to demonstrate lower medical expenditures and utilization rates as the PCMHs mature, the analysis also shows greater differences between the comparison and PCMH group in the pre-year expenditures than in previous iterations, which showed no significant difference.

There are a number of potential reasons for the greater difference in pre-program year expenditures between the 2014 and the 2015 trend analysis. First, the patient attribution methodology was adjusted to improve how patients are counted in light of practice mergers, ownership transitions, and closures. Second, changes in data management were made, which included transitioning to ICD-10 coding and improving how person-level records for payments were handled.

The impact of the greater difference in the pre-year between the PCMH and comparison group is a reduction in the DID or overall impact seen in previous analyses. However, what does become apparent in the trend lines is a stabilization of the difference in expenditures between the PCMH group and comparison group beginning in Post-Year 1. Figure 1 shows this stabilization for Total Expenditures excluding SMS. Figure 2 shows the similar trend for Inpatient Expenditures, and Figure 3 shows the trend for Pharmacy Expenditures.

Figure 1. Total expenditures excluding special Medicaid services per capita 2008-2015, all insurers, ages 1 year and older

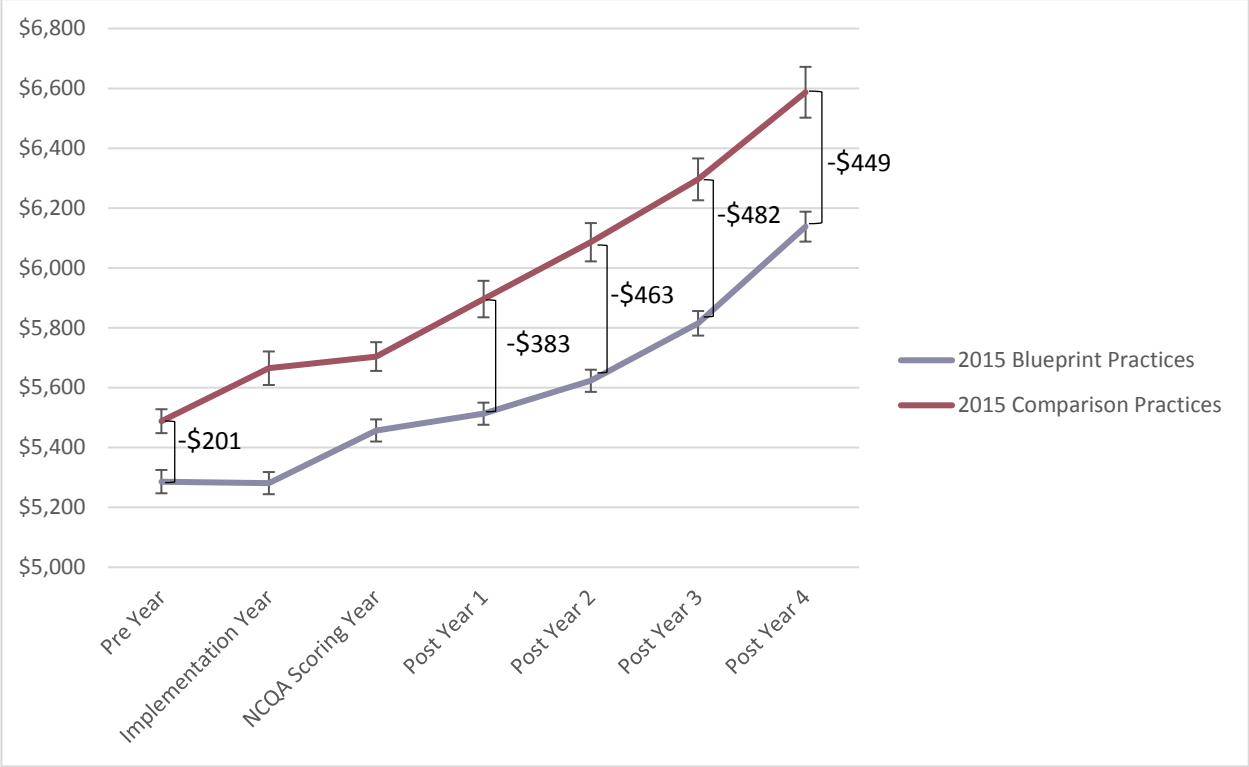


Figure 2. Total inpatient expenditures per capita 2008-2015, all insurers, ages 1 year and older

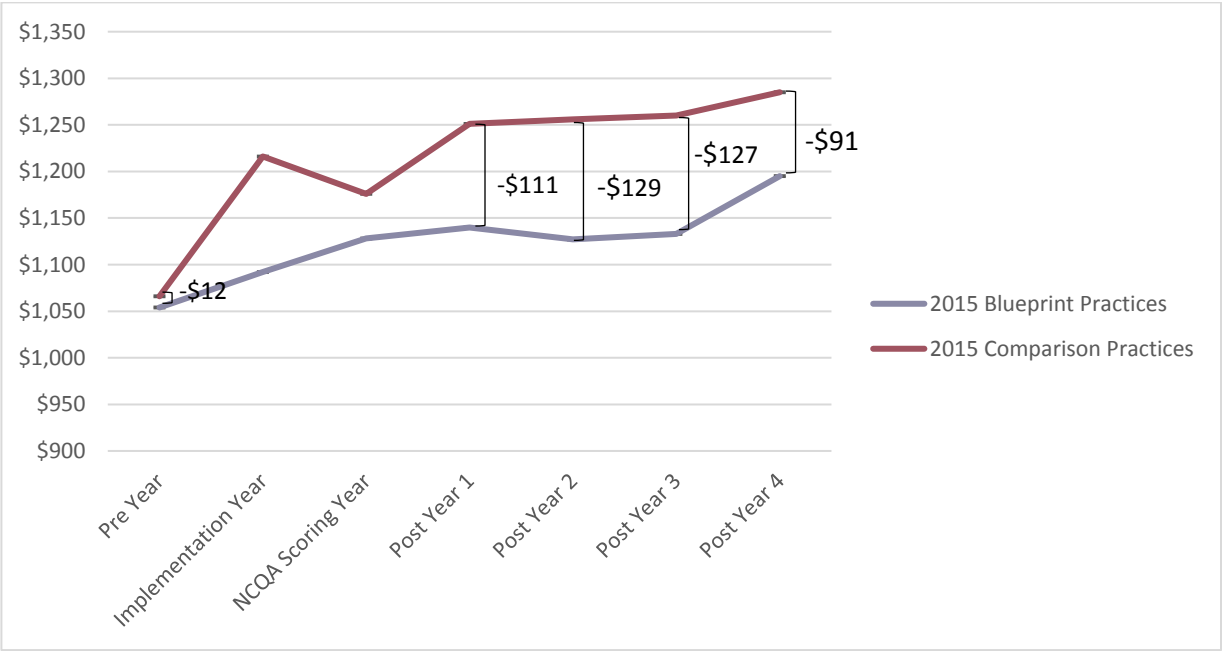
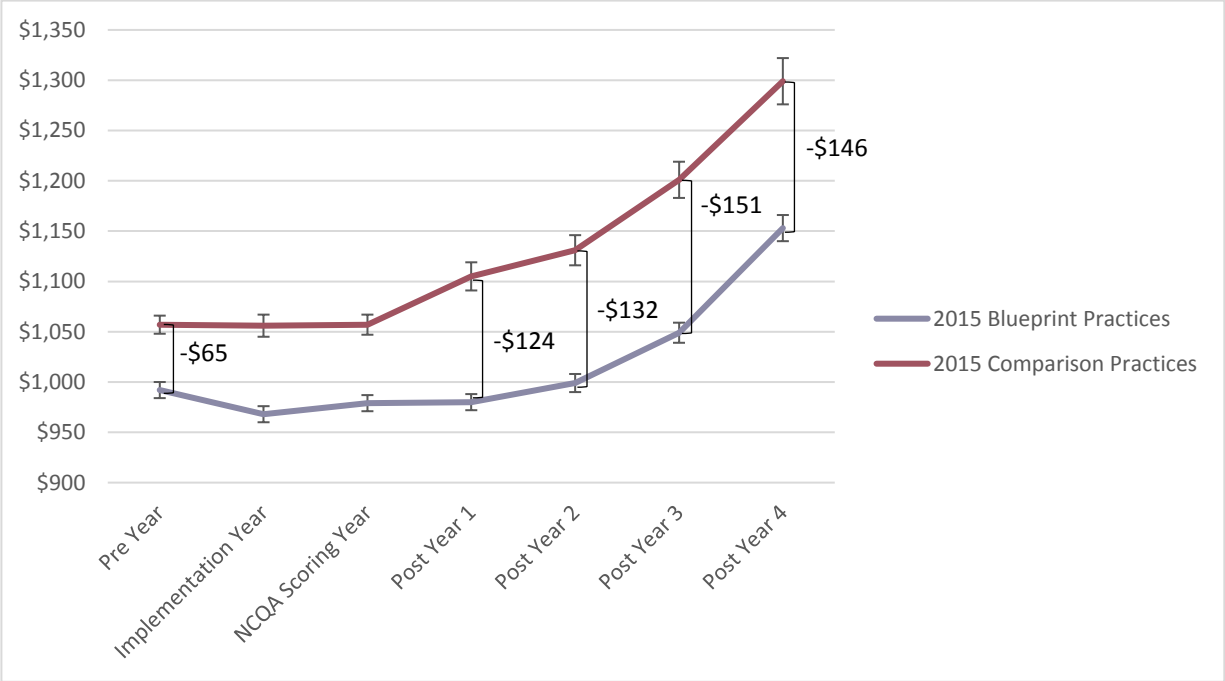


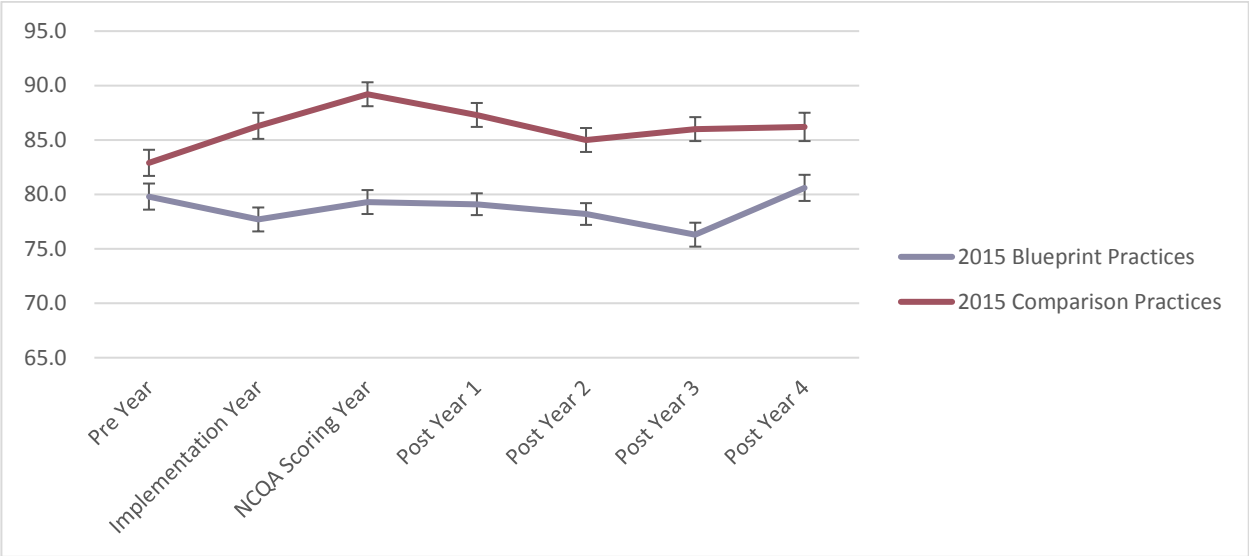
Figure 3. Total pharmacy expenditures per capita 2008-2015, all insurers, ages 1 year and older



Regarding utilization rates, PCMH patients generally had statistically significant lower rates of inpatient discharges per 1,000 for each stage with a weighted average of 7.6 fewer discharges per 1,000 relative to the comparison group (Figure 4). These rates stayed relatively constant through each program stage, which contributed to a DID of 2.4 fewer discharges per 1,000 that was not statistically significant (P-value 0.178). Similar patterns were seen for medical and surgical specialist visits. PCMH patients had a weighted average across all stages of 69.5 fewer medical specialist visits per 1,000, and both the PCMH and comparison groups show upward trends in the latter stages.

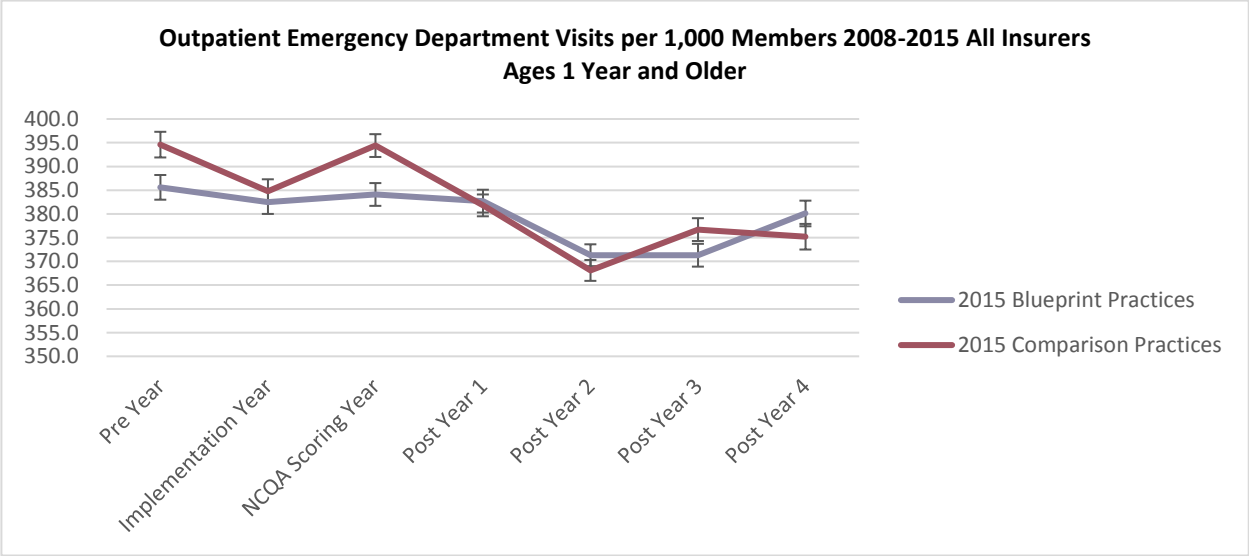
Although lower at each stage, the DID indicated that PCMH patients netted 15.6 more medical specialist visits per 1,000 (P-value 0.073) relative to the comparison group and initial differences. Regarding surgical specialist visits, PCMH patients had an average of 27.4 per 1,000 fewer visits with a decreasing trend across stages. When assessing change from Pre-Year to Post-Year 4 (DID), PCMH patients had a net 14 more visits per 1,000 (P-value 0.076). Figure 4 shows the inpatient trend line to demonstrate the patterns seen in these measures.

Figure 4. Inpatient discharges per 1,000 members 2008-2015, all insurers, ages 1 year and older



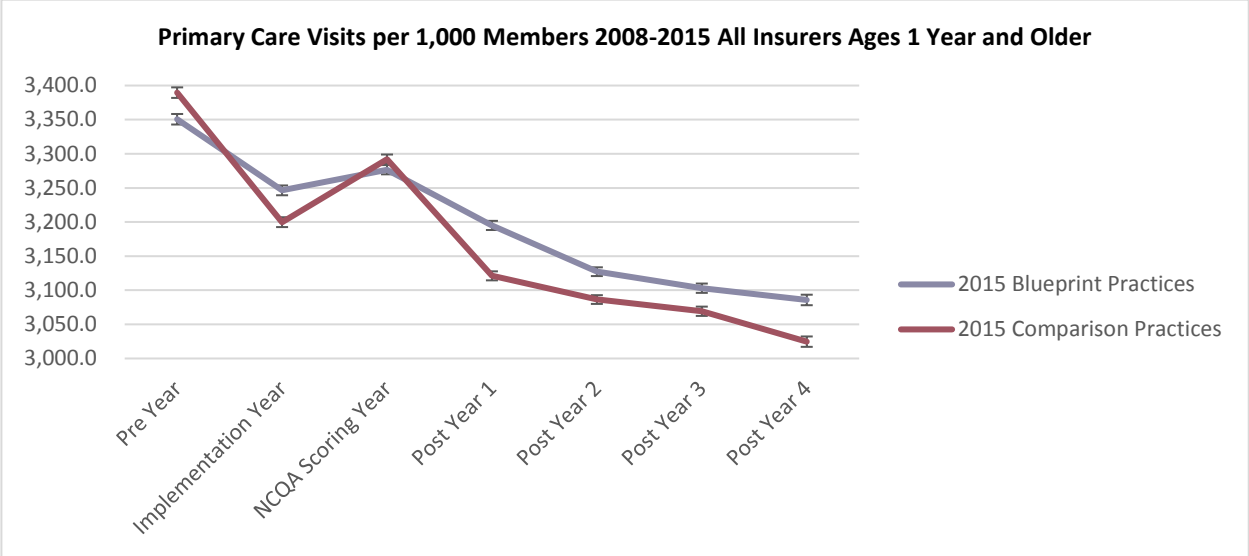
Unlike medical and surgical specialist visit trends, PCMH patients' emergency department (ED) visit rates were not statistically different from comparison patients for most stages (refer to Figure 5). However, DID analysis indicated that PCMH patients had a net increase in their rate relative to the comparison group with 13.9 more outpatient ED visits per 1,000 (P-value 0.002).

Figure 5. Outpatient emergency department visits per 1,000 members 2008-2015, all insurers, ages 1 year and older



PCMH patients showed higher rates of primary care visits relative to the comparison group especially beginning in Post-Year 1. Figure 6 shows this trend. The DID value was 100.1 more primary care visits per 1,000 (P-value 0.001) than the comparison patients. However, the rate of primary care visits for both groups declined for each stage over time. This trend may indicate reduced access to primary care across the state, regardless of PCMH recognition.

Figure 6. Primary care visits per 1,000 members 2008-2015, all insurers, ages 1 year and older



Analysis specific to Medicaid patients attributed to PCMHs indicates they generally have lower traditional health care costs and higher special Medicaid services (SMS) costs than the comparison group. When SMS expenditures are included, there is no statistical difference between the groups as seen by the overlapping confidence intervals in Figure 7. When SMS expenses are removed, medical expenses for the PCMH patients decrease significantly below the comparison group in Post-Years 1, 2, and 3. The significance of the different is lost in Post-Year 4 (Figure 8).

Conversely, in Figure 9, which shows the trend for SMS expenditures, the PCMH group has higher expenditures. However, it should be noted that both groups saw a decrease in expenditures in Post-Year 4. Since this dip was seen in both groups, it is likely due to statewide factors, such as any change to Medicaid policy; however, the specific factors contributing to this trend are not fully understood at this time.

Higher SMS expenditures for the PCMH group were first noted in the 2014 analysis. This trend of lower medical expenses and higher social and economic service expenditures is in line with achieving a better balance of medical and social expenditures, as proposed by Bradley and Taylor in *The American Health Care Paradox: Why Spending More is Getting Us Less*. Further exploration about the impact of differential SMS services on outcomes and quality is needed, which could also provide information on factors influencing the trend lines in Figure 9.

Figure 7. Total expenditures per capita 2008-2015, Medicaid, ages 1-64 years

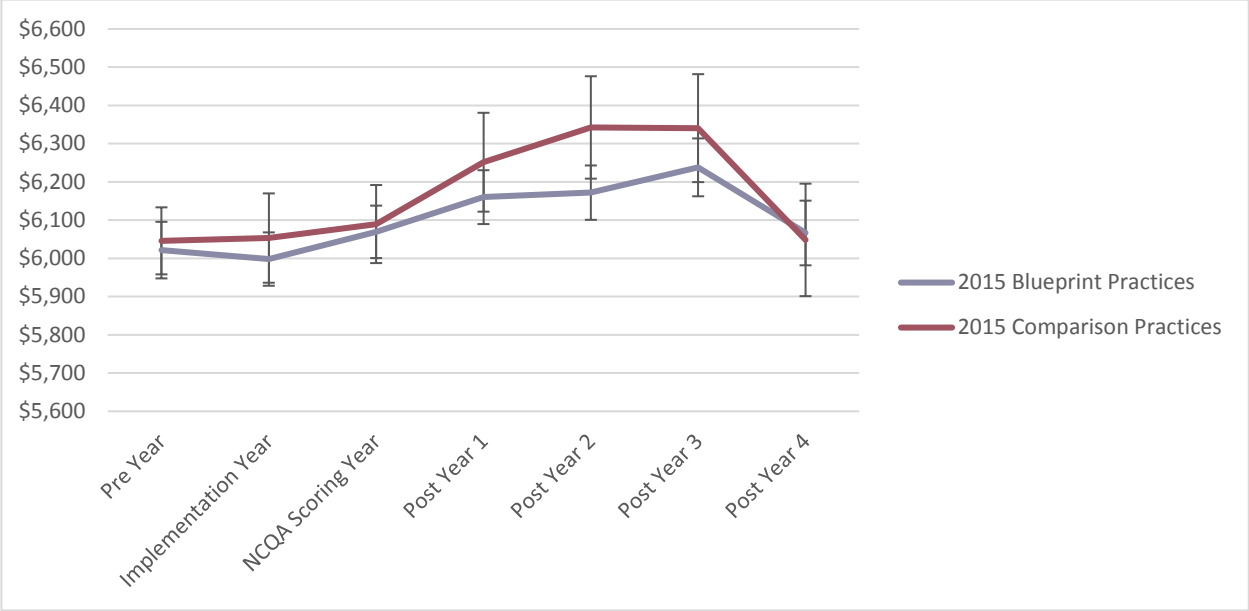


Figure 8. Total expenditures per capita excluding SMS 2008-2015, Medicaid, ages 1-64 years

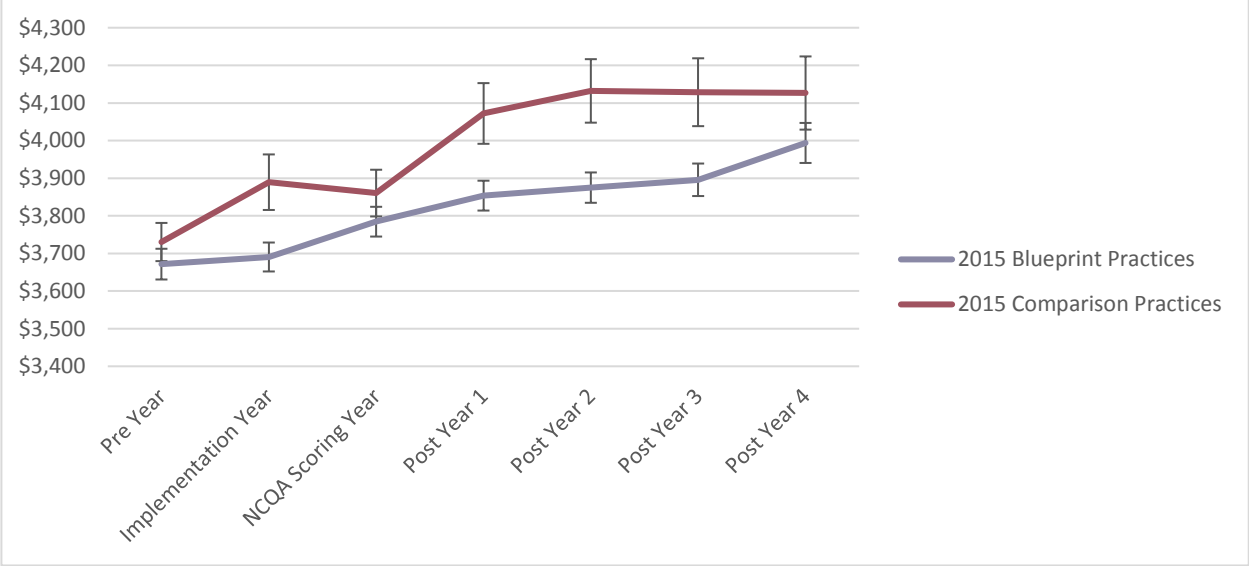
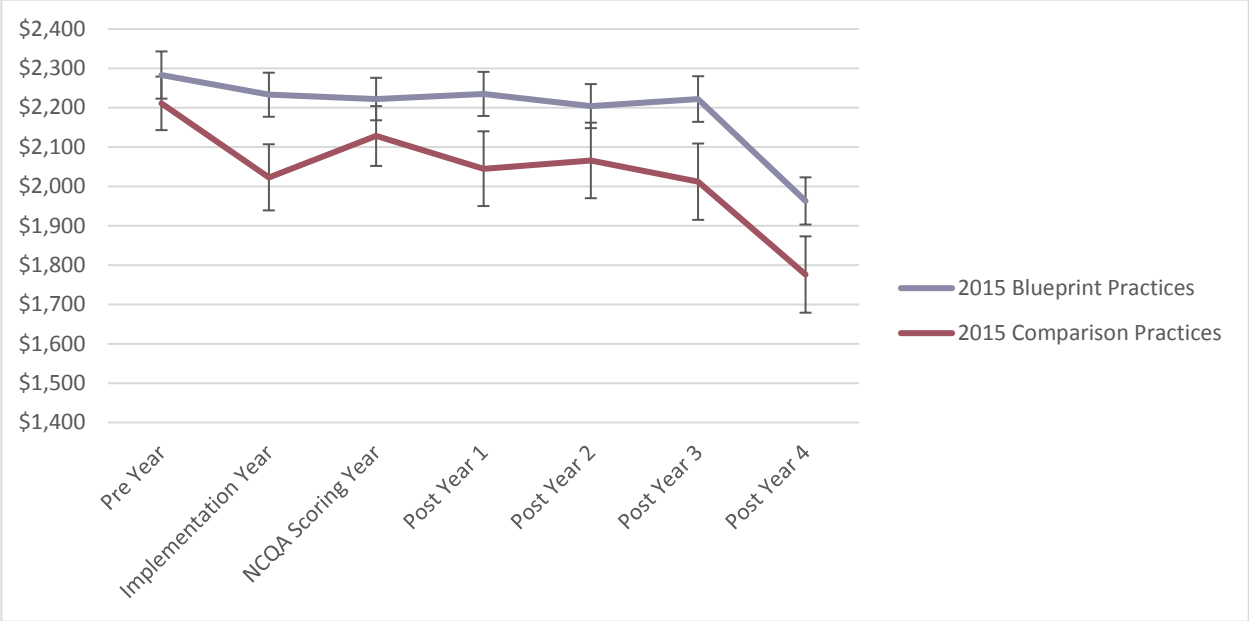


Figure 9. SMS expenditures per capita 2008-2015, Medicaid, Ages 1-64 Years



Hub and Spoke Initiative

As part of the Blueprint, the Hub and Spoke Initiative creates a framework for integrating treatment services for opioid addiction. This initiative represents AHS and DVHA's efforts—referred to as the Alliance for Opioid Addiction—to collaborate with community providers to create a coordinated, systemic response to the complex issues of opioid addiction in Vermont. The Hub and Spoke Initiative is focused on beneficiaries receiving Medication-Assisted Treatment (MAT) for opioid addiction.

This Health Home initiative now serves 5,813 Medicaid beneficiaries in Hub and Spoke programs combined as of December 31, 2016. The following tables present the caseloads of regional Hub and Spoke staffing as of December, 2016. Spoke staffing is scaled at 1 registered nurse and 1 licensed clinician for every 100 patients receiving MAT.

Table 3. Hub Implementation as of December 31, 2016

Program	Region	Start Date	# Clients	# Buprenorphine	# Methadone	# Vivitrol
Chittenden Center	Chittenden, Franklin, Grand Isle & Addison	1/2013	957	281	664	1
BAART Central Vermont	Washington, Lamoille, Orange	7/2013	478	209	269	0
Habit OPCO / Retreat	Windsor, Windham	7/2013	623	167	456	0
West Ridge	Rutland, Bennington	11/2013	414	115	270	4
BAART NEK	Essex, Orleans, Caledonia	1/2014	769	196	567	6
Statewide			3241	968	2226	11

The table below shows the number of Medicaid beneficiaries receiving treatment in the Spokes and the full-time-equivalent staff of nurses and licensed clinicians.

Table 4. Spoke Patients, Providers & Staffing: December 31, 2016

Region	Total # MD prescribing pts	# MD prescribing to ≥ 10 pts	Staff FTE Hired	Medicaid Beneficiaries
Bennington	9	4	5.6	229
St. Albans	15	10	5.6	382
Rutland	12	7	4.9	253
Chittenden	70	16	13.9	596
Brattleboro	10	5	2.57	145
Springfield	4	1	1.5	53
Windsor	6	3	4	161
Randolph	7	5	2.1	145
Barre	19	8	5.5	273
Lamoille	9	3	3.2	151
Newport & St Johnsbury	14	2	2	95
Addison	5	2	2	74
Upper Valley	4	0	1.5	13
Total	180*	63*	54.37	2,572

Table Notes: Beneficiary count based on pharmacy claims October – December, 2016; an additional 167 Medicaid beneficiaries are served by 32 out-of- state providers. Staff hired based on Blueprint portal report 1/17/17. *4 providers prescribe in more than one region.

v. Pharmacy Program

Key updates:

- Improving the management of psychotherapeutic drugs in children continues to be a focus. Recent analysis has demonstrated a significant decline in the prescribing of anti-psychotic medications in children.
- In support of the Governor's substance use treatment goals, DVHA expanded access to Vivitrol (naltrexone) as a treatment tool within Vermont's Hubs and Spokes
- An update on the specialty drugs forecast outlook is provided.
- The Drug Utilization Review Board held two meetings during 4th Q2016. Nine new drugs and thirteen therapeutic classes were reviewed, twenty-eight reviews of Newly-Developed/Revised Clinical Coverage Criteria, three RetroDUR reviews and nine safety alerts were presented.
- Provider communications were issued on topics of the Pharmacy Care Management Program, New Buprenorphine Billing Codes, PDL Changes, and Preferred Diabetic Supply List changes.

The DVHA Pharmacy Unit is responsible for managing all aspects of Vermont's publicly funded pharmacy benefits program. Responsibilities include but are not limited to: processing pharmacy claims; making drug coverage determinations; assisting with drug appeals and exception requests; overseeing federal, state, and supplemental drug rebate programs and the manufacturer fee program; resolving drug-related pharmacy and medical provider issues; overseeing and managing the Drug Utilization Review (DUR) Board; managing the Preferred Drug List (PDL); and assuring compliance with state and federal pharmacy and pharmacy benefits regulations.

Change Healthcare provides many clinical and operation support services in addition to managing a provider call center in South Burlington. The Pharmacy unit manages drug spend, and routinely analyzes national and DVHA-specific drug trends and drug utilization. The Pharmacy unit strives to deliver high-quality customer service, optimal drug therapy for DVHA members, and successful management of drug utilization and costs.

During CY16, the DVHA Pharmacy Unit continued to focus on ensuring that members receive high quality, clinically appropriate, evidence-based medications in the most efficient and cost-effective manner. The key drug spend statistics for CY16 include the following:

- Total GC Drug Spend: $198,234,647
- Total number of GC paid prescriptions: 2,198,521
    - Brand Drugs on PDL: 70% Preferred and 30% Non-Preferred
    - Generic Drugs on PDL: 97% preferred and 3% Non-Preferred
- In CY 2016, DVHA paid 5,300 prescriptions totaling $35,320,554 on specialty drugs.

<u>Psychotherapeutic Drug Management in Children</u>

DVHA's Pharmacy Unit participates in the *Psychiatric Medication Quality Improvement Collaborative(PMQIC)* which is a 3-year technical assistance grant awarded in 2012 with whom Vermont -participates with five other states. The PMQIC is a collaborative interdepartmental project involving the Department of Children and Families, Department of Mental Health, and the DVHA. Vermont's focus has been to develop a monitoring system for psychiatric medications for children in

foster care focusing on anti-psychotic medications since this class of drugs has the most serious potential side effects. All states are looking collectively at children under the age of 6 years old on psychiatric medication by specific classes, same classes and/or anti-psychotic medication. This coupled with other major components of the informed consent process will hypothesize that the utilization for medications would become more appropriate and would decrease inappropriate utilization.

The PMQIC and the Child and Adolescent Psychiatric Medications Trend Monitoring Group have created changes to insure the safe utilization of anti-psychotic medications for children living in foster care. A consultation with a fellow in child and adolescent psychiatry is required before consent for anti-psychotic medication is given in certain scenarios to insure appropriate use occurs. Social workers are now given the option to consult with a fellow in child and adolescent psychiatry if any help is needed to understand medical information received from the child's prescribing health care provider. A survey was supplied to Vermont prescribers to determine how and why antipsychotic medications are utilized in children as well as non-pharmacological treatments that are trialed with or before prescribing the medications.

A recent report created by Change Healthcare documented a significant decrease in the prescribing of psychiatric medications for Vermont Medicaid-insured youth from 2012 to 2016. Both the 6-12 year old and the 13-17 year old age brackets had a drop of approximately 42% in children prescribed at least one psychiatric medication. Antipsychotic utilization decreased dramatically across the youth in foster care as well as those that are not in foster care. ADHD medication usage dropped for all age groups except children in the foster care system under the age of 6, which had an increase. In general, psychiatric medication use has a higher prevalence in children within the foster care system compared to children that are not in foster care. It should be noted that there are other possible reasons for the decrease in prescribing of psychiatric medications, such as the increased number of children enrolled in Medicaid. DVHA and DMH continue to monitor psychotherapeutic drug use in children through the activities of the Adolescent Psychiatric Medications Trend Monitoring Group.

Substance Abuse Treatments and Opioids

DVHA continues its efforts to make substance abuse treatments readily accessible to all Medicaid members seeking treatment. During SFY2016, Vivitrol (naltrexone) was made available to all Opiate Treatment Programs (Hubs) across Vermont as an additional tool for substance use treatment. In addition, Vivitrol is available for outpatient prescriptions for both alcohol and opiate abuse. DVHA continues to make Buprenorphine products widely available as well. In CY 2016, DVHA paid for 115,827 claims for substance use treatment drugs. This was a 13% increase over CY 2015, when DVHA paid 100,589 claims. In CY 2016, DVHA spent $12,124,510 on substance use treatment drugs. This is an 13% increase over CY 2015, when substance use treatment costs were $10,601,027. In CY 2016 DVHA spend and an average cost of $104.75 per prescription for substance use treatment. This is an 1% decrease over CY 2015, when the average cost per prescription was $105.32. Substance use treatment drug utilization and spend continue to increase in Vermont.

An opiate is a narcotic analgesic that is derived directly from the opium poppy (ex. morphine, codeine), while an opioid is a narcotic analgesic that is at least partially synthetic e.g. not found in nature. However, the term "opioid" is typically used interchangeably to describe the entire therapeutic class of "narcotic analgesics" that includes both natural and synthetic opiates such as morphine, oxycodone, fentanyl, hydrocodone, hydromorphone, methadone, and similar products. These are all Schedule II controlled substances, meaning that they are all FDA-approved, have a medical indication (mostly for acute and chronic pain), can be prescribed by certain licensed prescribers, and are more tightly controlled. In CY 2016, DVHA paid for 71,555, opioid prescriptions. This was a 6% decrease over CY 2015, when DVHA paid for 75,710 prescriptions. In CY 2016, DVHA spent $2,972,304 on opioid drugs. This is an 25% decrease over CY 2015, when costs were $3,950,969. In CY 2016, DVHA spend an average cost of

$479.52 per opioid prescription. This is an 20% decrease over CY 2015, when the average cost per prescription was $591.14.

Specialty Drugs Update

Although this category has historically focused on injectable and infused formulations, a significant number of specialty medications in oral dosage forms have entered the market recently. This trend is only expected to continue, especially among oral oncolytics (cancer drugs). Due to the complexities associated with specialty pharmaceuticals, patients receiving these medications require a significant degree of continuous patient education, ongoing monitoring, and medication management by well-qualified and skilled specialty pharmacy staff.

The Pharmacy Unit is expecting to see the biggest increases in net expenditures in the treatment of inflammatory conditions with a 20% to 25% average annual increase, followed by cystic fibrosis, oncology and hemophilia, each with an average annual increase of approximately eighteen percent (18%). Increases in expenditures for the treatment of Human Immunodeficiency Virus (HIV), Multiple Sclerosis (MS) and growth deficiency are projected to increase by 5-10% each year while expenditures for anticoagulants and hepatitis C drugs are projected to decrease slightly. Expenditures for hemophilia are expected to increase as a result of the approval and launch of several new long acting factor products. The impact of these new, costlier factor products will be mitigated by aggressive rebate negotiations and Preferred Drug List (e.g. formulary) management. As more of these extremely expensive drugs reach the market, it will be necessary to monitor patient health outcomes and changes in overall health care costs to truly evaluate a drug's benefit.

Not all of the projected increase in pharmacy expenditures represents "new" cost but, rather a shift in costs from one benefit to another, as more drugs move from physician administered to self-administered oral dosage forms.

340B Drug Discount Program

The 340B Drug Pricing Program resulted from enactment of the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is a federal program managed by the Health Resources and Services Administration (HRSA), Office of Pharmacy Affairs. Section 340B requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics and hospitals (termed "covered entities") at a significantly reduced price. The 340B price is a "ceiling price," meaning it is the highest price that the covered entity would have to pay for select outpatient and over-the-counter drugs and the minimum savings that the manufacturer must provide to covered entities. The 340B ceiling price is at least as low as the price that state Medicaid agencies currently pay for select drugs. Participation in the program results in significant savings to covered entities, estimated to be 20% to 50% on the cost of outpatient drug purchases by 340B covered entities. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reach more eligible patients, and provide more comprehensive services.

Only federally designated covered entities are eligible to purchase at 340B pricing, and only patients of record of those covered entities may have prescriptions filled by a 340B pharmacy.
Because of federal laws prohibiting "duplicate discounts" on 340 B eligible claims, covered entities are responsible for properly identifying claims as 340B eligible. Vermont has strict controls in place to prohibit the billing of Federal, State, and Supplemental rebates on 340B eligible claims.

To encourage participation in the Vermont Medicaid 340B program, DVHA offers a "shared savings" program whereby covered entities receive a share of the total savings generated for the state by the 340b

program. DVHA identified the following goals in establishing its proposed 340B reimbursement methodology:

- Reduce Medicaid program expenditures;
- Encourage broad participation in the 340B program, thereby increasing potential savings to the Medicaid program;
- Acknowledge that 340B pharmacies will be covering their operating costs solely through the dispensing fee, since acquisition cost savings essentially are "passed through" to the Medicaid program; and
- Recognize pharmacies' additional administrative costs related to 340B inventory management and reporting.

More details about the program can be found on the 340B link at www.vtmedicaid.com.

In Vermont, the following entities are eligible to participate in the 340B Program. **Boldfaced** entities participate in Medicaid's 340B initiative (although this is not an exhaustive list):

- Vermont Department of Health, for the AIDS Medication Assistance Program, Sexually-Transmitted Disease Drugs Programs, and Tuberculosis Program; all of these programs are specifically allowed under federal law.
- **Planned Parenthood of Northern New England's Vermont clinics**
- **Vermont's FQHCs**, operating 41 health center sites statewide
- **Berkshire Medical Center**
- **Brattleboro Memorial Hospital**
- **Central Vermont Medical Center**
- **Community Health Center of Burlington**
- **Copley Professional Services Group DBA Community Health Services of Lamoille Valley and affiliated with Community Health Pharmacy**
- Five Town Health Alliance
- Gifford Hospital
- Grace Cottage Hospital
- **Indian Stream Health Center (New Hampshire)**
- North Country Hospital
- Northeastern Vermont Regional Hospital
- **Northeast Washington County Community Health and affiliated with Community Health Pharmacy**
- **Northern Counties Healthcare and affiliated with Community Health Pharmacy**
- Northwestern Medical Center
- **Notch Pharmacy**
- Porter Hospital
- **Richford Health Center, Inc. (Notch) and affiliated with Notch Pharmacy & Community Health Pharmacy**
- Rutland Regional Medical Center
- **Southwestern Vermont Medical Center**
- **Springfield Hospital**

- **The Health Center and affiliated with Community Health Pharmacy**
- **UMass Memorial Medical Center**
- **University of Vermont Medical Center and affiliated with UVMMC Outpatient Pharmacies**

vi. Integrating Family Services (IFS) Initiative

Key updates:

- In May 2016, four year-long statewide work groups ended which resulted in creating frameworks that clarified collaborative leadership, service delivery, data and prevention and promotion. The work of these groups has created a solid foundation for IFS to grow and expand in Vermont.
- Several regions of the state are utilizing the IFS Regional Steps to Readiness to begin IFS in FY2018.
- IFS is aligning its payment reform efforts with the larger healthcare reform to ensure coordination across the state.
- IFS continues to provide support and leadership regarding several efforts that cut across multiple agency departments such as:
  - enhanced teaming for families with complex needs
  - turning the curve on the number of children and youth in residential settings
  - coordinating autism services and supports
  - having a common tool for progress monitoring to know if children and families are better off due to our efforts.

AHS continues to act on opportunities to improve quality and access to care, within existing budgets, using managed care flexibilities and payment reforms available under 42 CFR § 438 and the GC waiver. This includes such items as: integration of administrative structures for programs serving the same or similar populations; opportunities to increase access to services by decreasing administrative burdens on providers; reviewing pre-GC waiver operations to determine if separate administrative and Medicaid reimbursement structures can be streamlined under GC. Several such projects have emerged in the Children's and early periodic screening diagnostic and treatment (EPSDT) service area.

Specifically, children's Medicaid services are administered across the IGA partners so work continues to enhance integration. Programs historically evolved separately from each other with varying Medicaid waivers, procedures and rules for managing sub-specialty populations. These were the best approaches available at the time; however, the artifacts of this history are multiple and fragmented funding streams, policies, and guidelines. Often the same provider and family will be captive to varied and conflicting procedures, reporting and eligibility requirements. With the inception of the Global Commitment and other changes at the federal level these siloed structures no longer need to exist. Global Commitment has allowed for one overarching regulatory structure (42 CFR § 438) and one universal EPSDT continuum. This allows for efficient and effective coordination with other federal mandates such as Title V, IDEA part B and C, Title IV-E, Federal early childhood programs and others.

The IFS Initiative seeks to bring state government and local communities together to ensure holistic and accountable planning, support and service delivery aimed at meeting the needs of Vermont's children, youth and families. The premise being that giving families early support, education and intervention will produce more favorable health outcomes at a lower cost than the current practice of 'waiting until circumstances are bad enough' to access funding which often results in treatment programs that are out of home or out of state. Several efforts are underway and include: performance based reimbursement projects, capitated annual budgets, and flexible choices for self-managed services. This integration is an

ongoing process that is evolving into a very positive direction for children and families.

The initial IFS implementation site in Addison County began on July 1, 2012, and the second pilot region in Franklin/Grand Isle counties began on April 1, 2014. These pilots included consolidation of over 30 state and federal funding streams into one unified whole through one AHS Master Grant agreement. The State has created an annual aggregate spending cap for two providers in Addison and one in Franklin/Grand Isle (this provider houses the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children and families

Early successes of the two pilots include:

- Increased service hours overall, increased number of people served, and simultaneous reduction in requests for children's mental health crisis services.
- Stable trend line for children entering the State's custody in the Addison pilot region while at the same time the State overall has experienced a 30% increase in children coming into DCF custody.
- Increased ability to provide the right services to children and their families more immediately.
- Increased ability to provide services in a child's natural setting.
- Increased ability to work with a variety of providers and bring resources together to support families.
- Reduction in separate and conflicting paperwork, which increases the number of hours clinicians can spend on direct services.
- A more immediate response to families who ask for help.
- Unified local efforts to offer a single onsite response to families combining multiple state and federal programs that would otherwise be offered at differing times and places.
- Initial numbers indicate an ability to serve more children and families with the same amount of resources.
- Increased staff morale at the two Designated Agencies who are IFS grantees.

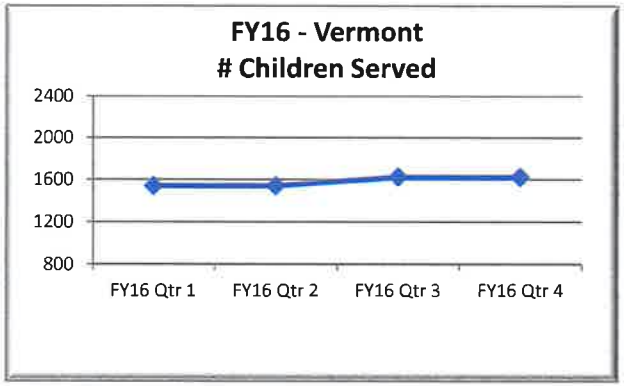
The following 3 pages are the FY16 data points measured by the IFS regions which show the increase in service hours, overall increased family satisfaction, assessments conducted and the measurement of families being served who have Medicaid vs. Are Uninsured or Underinsured.

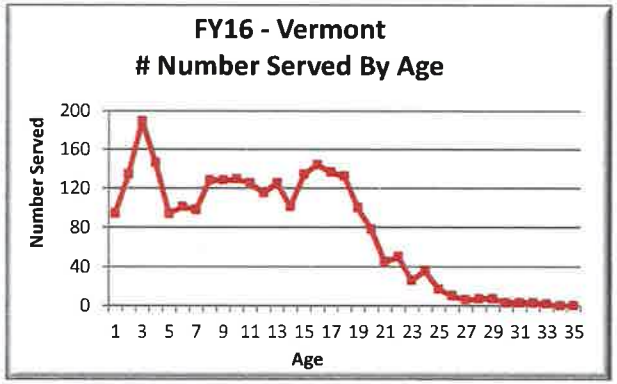
Vermont

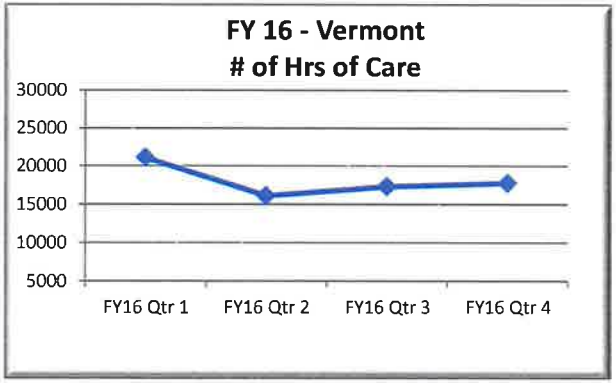
Integrating Family Services Dashboard

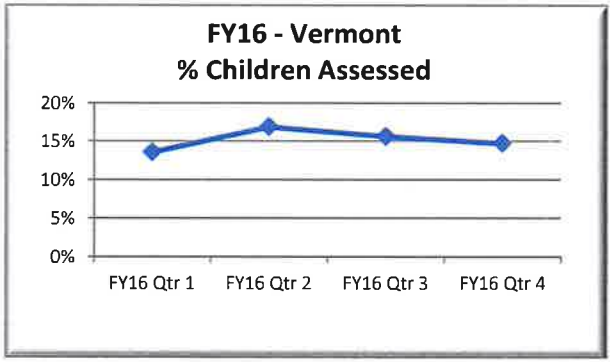
(Aggregated Data from Addison, Franklin & Grand Isle Counties)

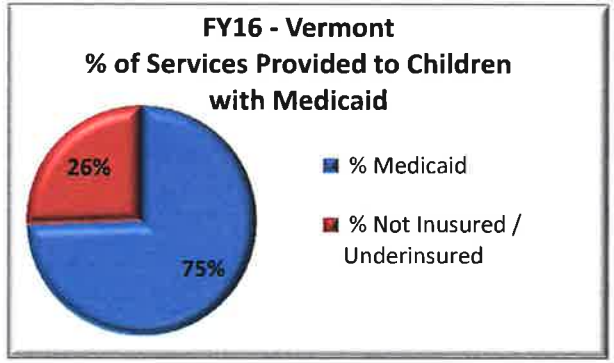
FY16

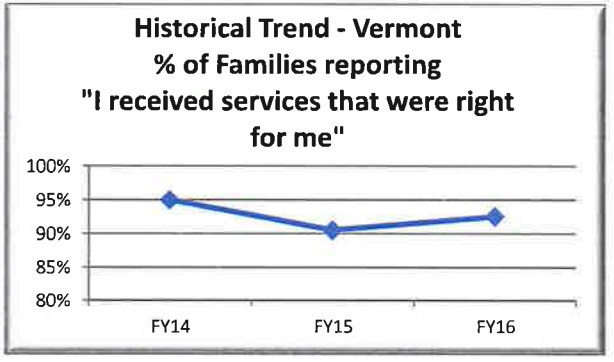


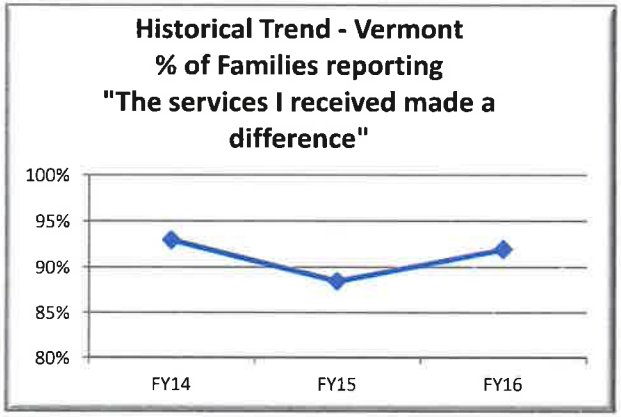


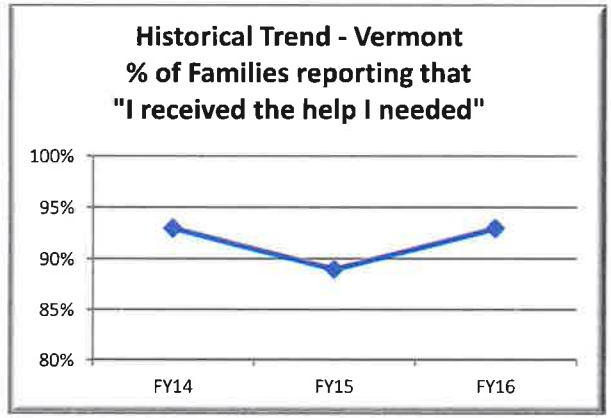


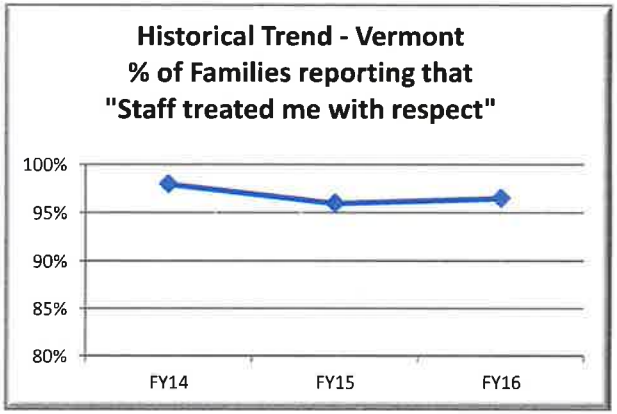




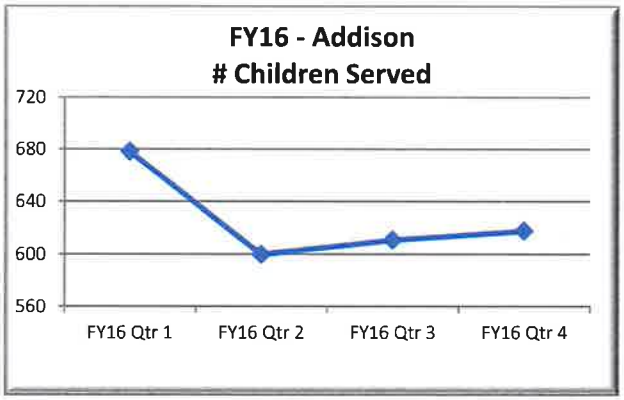


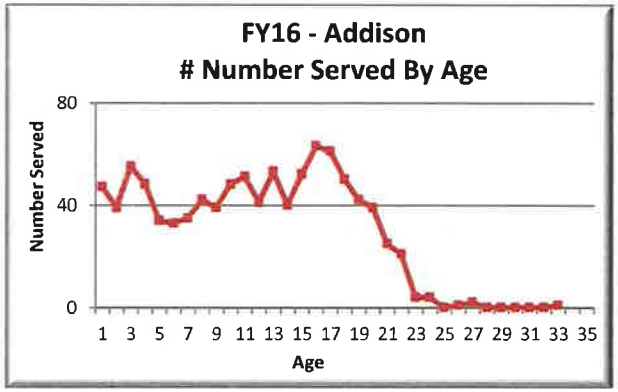


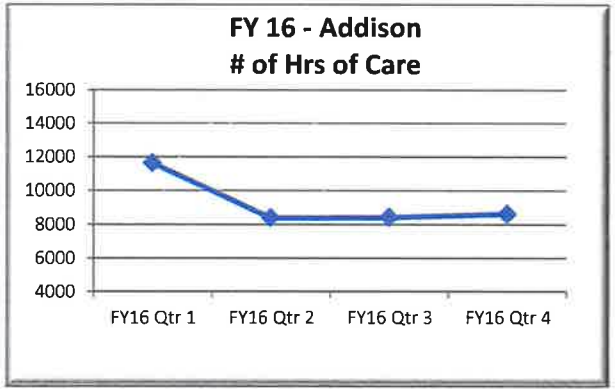


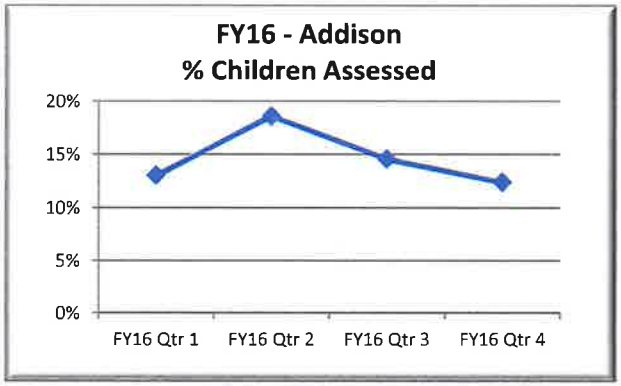


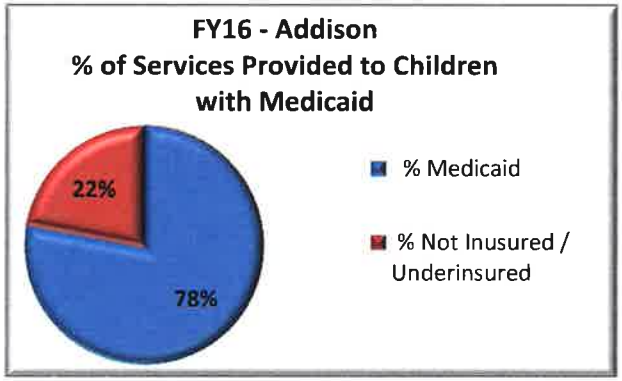
Addison County
Integrating Family Services Dashboard
FY16

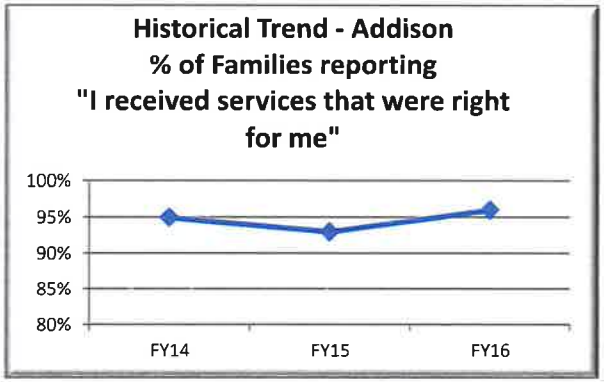


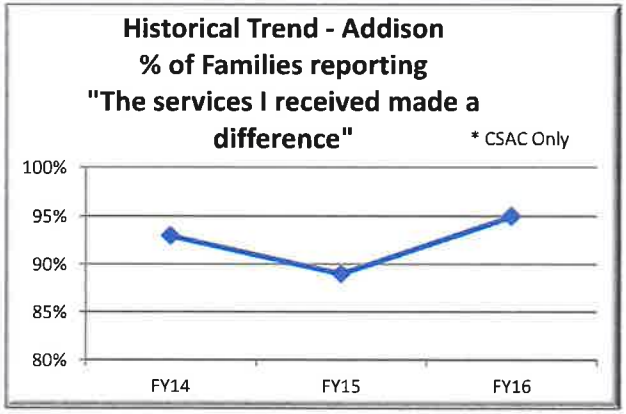


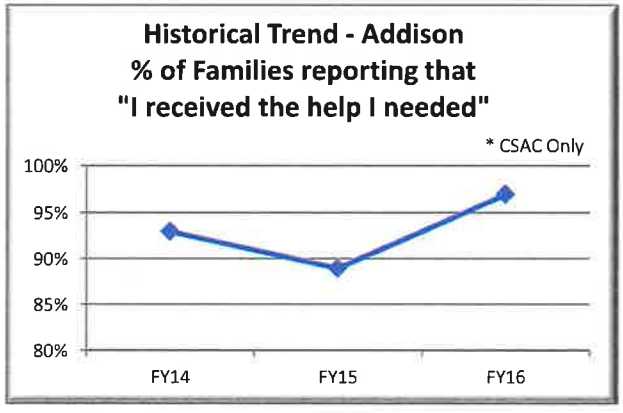


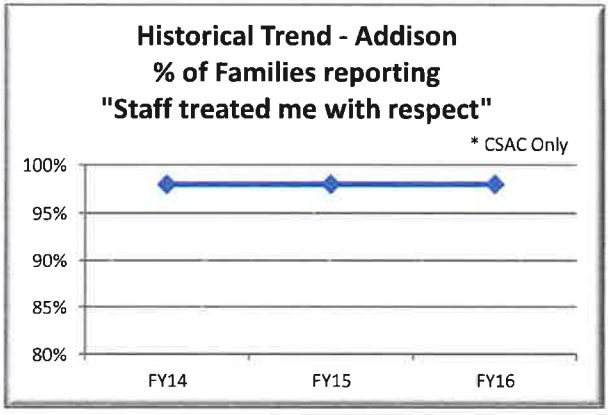




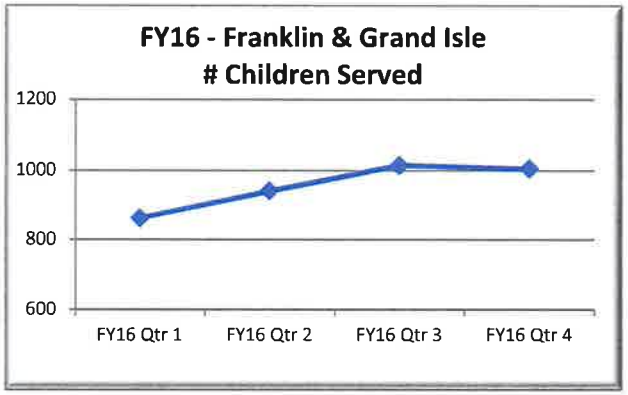


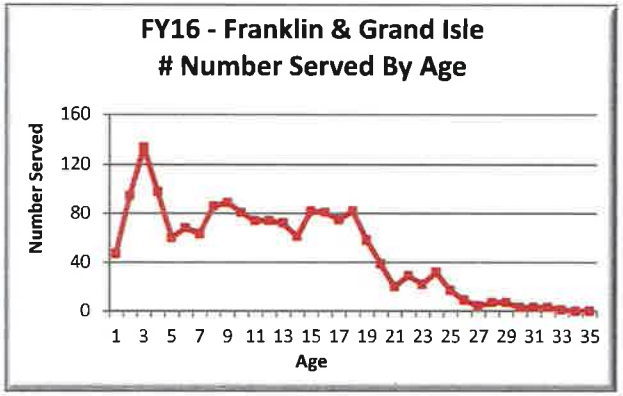


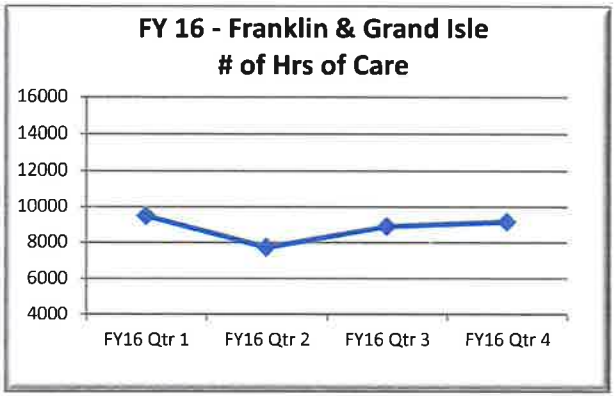


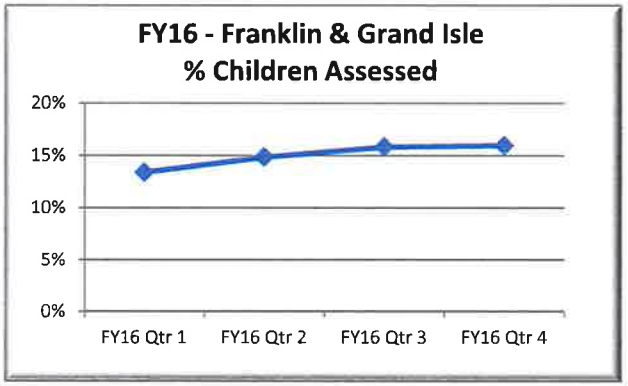


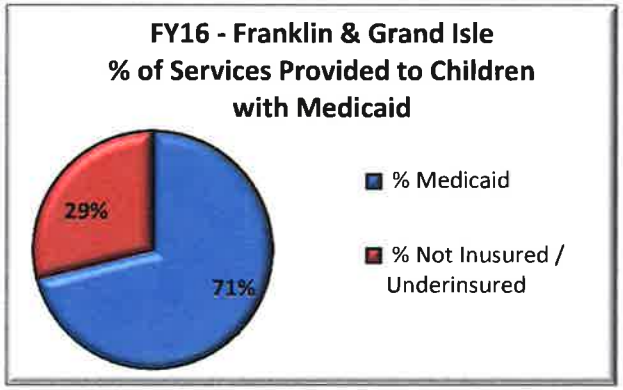
Franklin / Grand Isle Counties
Integrating Family Services Dashboard
FY16

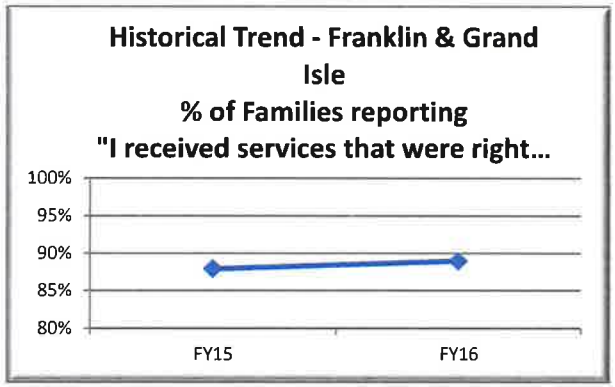


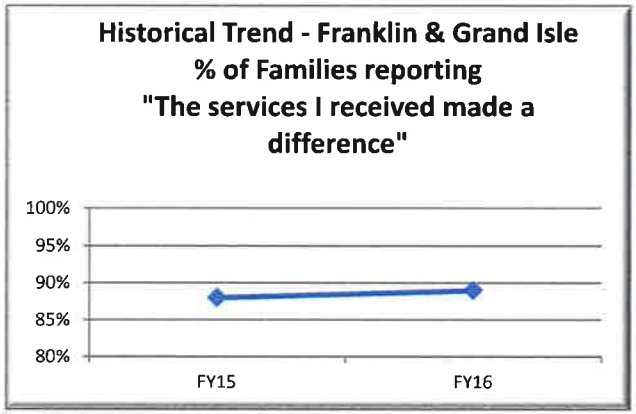


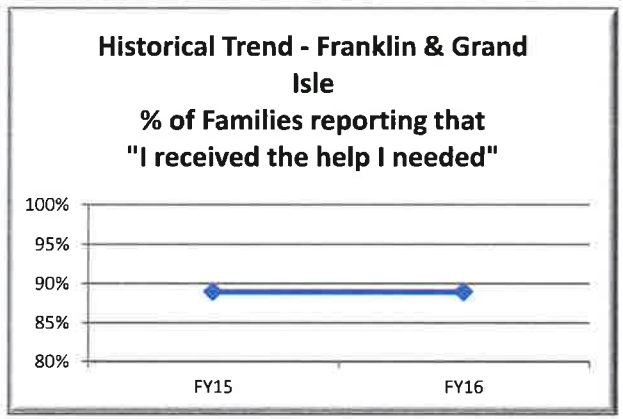












vii. Vermont Medicaid Shared Savings Program (VMSSP)

Key updates:

- CY16 saw the conclusion of the VMSSP's second program year (CY 2015) and the implementation and conclusion of the third program year (CY 2016).
- As of December 2016, 67,515 beneficiaries were attributed to two Accountable Care Organizations (ACOs) through 1,007 providers participating in the VMSSP.
- Shared savings of $2.4million achieved by the VMSSP in the second program year, with $452,459 distributed to the ACOs.
- CMS approved a State Plan Amendment for the VMSSP in June 2016.

The Vermont Medicaid Shared Savings Program (VMSSP) is a three-year program to test if the accountable care organization (ACO) models in Vermont can meet the Triple Aim goals of improving health and quality while also reducing cost. In a shared savings program, the provider network allows the State to track total costs and quality of care for the patients it serves in exchange for the opportunity to share in any savings achieved through better care management. This program is supported by a State Innovation Model (SIM) testing grant and overseen by the Green Mountain Care Board (GMCB) and AHS.

Contracts were signed between Vermont Medicaid and the two participating ACOs in February, 2014. The ACOs vary in terms of geographic spread and patient mix—*OneCare Vermont* is statewide, includes both the University of Vermont Medical Center and Dartmouth Hitchcock Medical Center and has a larger presence in Vermont's urban areas, while *Community Health Accountable Care* is FQHC-based and includes more rural practice sites.

Performance Year 2 (CY 2015) results saw mixed results for the ACOs participating in the program, with CHAC demonstrating savings (a program total of $2.4 million, with shared savings incentive payments totaling $452,459 from DVHA to CHAC), while OneCare Vermont did not garner shared savings in 2015 and thus received no payout. Both ACOs demonstrated a high level of performance on a number of clinical and claims-based quality measures, with maintenance of scores for most measures from CY 2014 (Performance Year 1) to CY2015, and demonstrated significant improvement in some areas.

Due to claim lag, cost and quality results for Performance Year 3 (CY 2016) will not be available until Q3 of CY 2017.

Beneficiary attribution in the VMSSP remained steady through 2015 and 2016, with 1,007 providers participating in the program, and a final attribution count for 2016 of 67,500 beneficiaries—approximately 39,000 lives in *OneCare Vermont* and 28,000 lives in *Community Health Accountable Care*. Beneficiary attribution was slightly lower at the end of 2016 than in 2015 due to changes in network composition for both ACOs.

viii. Choices for Care

Key updates:

- Home Delivered Meals as a Choices for Care service.
- Finalized Case Management and Adult Day Standards with new HCBS Rules.
- Launched new Adult Services Division website.

Home Delivered Meals as a Choices for Care Service

The Agency of Human Services (AHS) was requested by the State Legislature within Act 172, Sec. E.308.1, to determine the amount of existing non-federal dollars currently expended by Area Agencies on Aging to provide home-delivered meals to Choices for Care recipients that could be matched with federal Medicaid dollars without adversely affecting other Choices for Care recipients or individuals receiving home-delivered meals who are not in Choices for Care.

In this quarter, DAIL worked closely with Area Agency on Aging stakeholders within the context of the Older American's Act to thoroughly research the legislative request in preparation for the report. The results of the research and final report submitted February 1, 2017 will appear in the next quarterly report (QE0317).

HCBS Federal Regulations

During this reporting period, work continued to finalize revised standards for Case Management and Adult Day Services in accordance with Vermont's Comprehensive Strategy Systemic Assessment. Documents can be found online at http://asd.vermont.gov/special-projects/federal-hcbs. As of December 30, 2016, the State had not yet received requested guidance from CMS on the topic of conflict of interest and how it relates to Vermont's system of case management.

New Adult Services Division Website Launched

A new website was launched in November 2016 for the Adult Services Division. The website creates improved access to information for both consumers and providers. Get Help Now directs people to relevant resources and program applications. In addition, Special Projects and Initiatives clearly directs people to information such as the status of the Vermont HCBS Systemic Assessment and Work Plan. The new website address is http://asd.vermont.gov/.

Choices for Care FFY16 Annual Summary

- October 2015 DAIL submitted its annual legislative report on the Adequacy of the Choices for Care Provider System. Areas of focus included staffing shortages, Moderate Needs funding and lack of adequate housing & residential care options (especially for people with complex needs). http://asd.vermont.gov/sites/asd/files/documents/Choices_for_Care_Adequacy_Report_2015.pdf
- AHS, together with DAIL, received stakeholder input and finalized the Choices for Care HCBS Regulations systemic report and work plan for submission to CMS.
- HCBS work plan was initiated with stakeholder involvement and included a change in the Case Management and Adult Day Standards.
- A bill was proposed to add home delivered meals as a Choices for Care services. The bill was not approved but instead the legislature requested a report by February 1, 2017 on potential funding for a new service.
- The MFP grant was approved for $8 million, $5 million less than anticipated.
- SFY17 State budget was approved and included the conversion of $1.2 million (gross) in one-time Moderate Needs funding (SFY16) into the base allocation for services. This helped assure continuity of services for Moderate Needs services into the next fiscal year.

- Vermont implemented a 2% rate increase for Choices for Care home-based and Enhanced Residential Care services effective 9/1/2016.
- Approximately $800,000 (gross) was available at the end of SFY16 to "reinvest" back into long-term services and supports. Due to the timing of the state budget process, any reinvestment will be implemented mid-year SFY2017 or the beginning of SFY2018.

ix. All-Payer Model: Vermont Medicaid Next Generation Program

Key updates:

- DVHA sought to establish service agreements with one (or more) Accountable Care Organization(s) (ACOs) for participation in a population-based payment model that is based on the Centers for Medicare and Medicaid Services (CMS) *Next Generation* ACO Model.
- DVHA received and reviewed bids in response to a Request for Proposals (RFP), and engaged in contract negotiations with the Apparently Successful Bidder.
- 2017 will be the pilot year of implementation for the Vermont Medicaid Next Generation ACO program; one ACO (OneCare Vermont) will participate, and approximately 29,000 Vermont Medicaid beneficiaries will be attributed through this model.
- Future program implementation will be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

In 2016, the Department of Vermont Health Access (DVHA) sought to establish service agreements with one (or more) Accountable Care Organization(s) (ACOs) for participation in a population-based payment model that is based on the Centers for Medicare and Medicaid Services (CMS) *Next Generation* ACO Model. As an evolution of the *Vermont Medicaid Shared Savings Program* (VMSSP), this new program offering creates a structure for provider organizations and other suppliers to join together under an ACO to voluntarily contract with DVHA to assume accountability for the cost and quality of care for Vermont's Medicaid beneficiaries, and for ACOs to distribute payments to their contracted network providers for any covered services rendered on behalf of Vermont Medicaid beneficiaries using alternatives to fee-for-service reimbursement. The goal of this agreement is to improve the quality and value of the care provided to the citizens served by the State of Vermont's public health care programs.

DVHA reviewed bids in response to a Request for Proposals that had been issued in April 2016, and identified an Apparently Successful Bidder (OneCare Vermont). DVHA began contract negotiations with OneCare Vermont in July 2016. Simultaneously, DVHA engaged an independent actuarial firm to develop per member per month (PMPM) capitation rates for inclusion in a contract for the services described above. In November and December of 2016, DVHA conducted a readiness review with the OneCare Vermont to ensure the ACO's ability to assume the roles and responsibilities outlined in the contractual agreement.

DVHA and OneCare entered into an agreement for the 2017 performance year to achieve enhanced integration of health care services, with the potential to integrate additional providers and additional Medicaid-covered services in future program years. Program implementation will be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

x. Global Commitment Register

Key updates:

- Since the Global Commitment Register (GCR) launched in November 2015, 67 final GCR policies have been publicly posted.
- The GCR listserv expanded from about 250 to 350 interested parties.

The GCR is a database of policy changes to and clarifications of existing Medicaid policy under Vermont's 1115 Global Commitment to Health waiver. It is based on the Federal Register, and can be used as both a public notice and documentation tool for Medicaid policy. Like the Federal Register, the GCR can be used to publish proposed policy, including information on public comment submissions, final policy, notices, and policy clarifications. The GCR is available on the DVHA website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

The GCR listserv is a group of about 350 interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. A policy change in the GCR could be a change made under the authority of the waiver, a proposed waiver amendment or extension, an administrative rule change or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not clearly answered in current policy.

Health care policy stakeholders are notified via email every time a proposed or final policy is posted to the GCR; an email is also sent when policy clarifications are posted. Stakeholders have an opportunity to provide comments on proposed GCR policies before the policies are made final. Comments received are posted in the GCR online. The GCR emails are also distributed to members of the Medicaid and Exchange Advisory Board.

Many policies were posted to the GCR in 2016. Of the 67 final policies issued, approximately half were reimbursement/rate changes or coding corrections. 15 State Plan Amendments (SPAs) were announced for public comment through the GCR in 2016. Other final policies included notice of administrative rulemaking, waiver requests, changes to covered services, and the Access to Care Plan. There were 9 policy clarifications issued through the GCR and all involved clarification of billing practices.

The GCR can be found here: http://dvha.vermont.gov/global-commitment-to-health/global-commitment-register.

VI. Utilization Management

Utilization Management is a systematic evaluation of the necessity, appropriateness, and efficiency of managed care model services. These activities are designed to influence providers' resource utilization and clinical practice decisions in a manner consistent with established criteria or guidelines to maximize appropriate care and minimize or eliminate inappropriate care. The DVHA must have a mechanism to detect both under/over-utilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

i. Clinical Utilization Review Board

The Clinical Utilization Review Board (CURB) was established by Act 146 Sec. C34, 33 V.S.A. Chapter 19, Subchapter 6 during the 2010 legislative session. DVHA was tasked to create the CURB to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations to DVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the state's Medicaid programs.

The CURB is comprised of 10 members with diverse medical experience, appointed by the Governor upon recommendation of the DVHA Commissioner. The CURB solicits additional input as needed from individuals with expertise in areas of relevance to the CURB's deliberations. The Medical Director of DVHA serves as the State's liaison to the CURB.

The CURB has the following duties and responsibilities:

1) Identify and recommend to the Commissioner opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's medical programs by:
   a) Examining high-cost and high-use services identified through the programs' current medical claims data;
   b) Reviewing existing utilization controls to identify areas in which improved utilization review might be indicated, including use of elective, nonemergency, out-of-state outpatient and hospital services;
   c) Reviewing medical literature on current best practices and areas in which services lack sufficient evidence to support their effectiveness;
   d) Conferring with commissioners, directors, and councils within the Agency of Human Services and the Department of Financial Regulation, as appropriate, to identify specific opportunities for exploration and to solicit recommendations;
   e) Identifying appropriate but underutilized services and recommending new services for addition to Medicaid coverage;
   f) Determining whether it would be clinically and fiscally appropriate for the DVHA to contract with facilities that specialize in certain treatments and have been recognized by the medical community as having good clinical outcomes and low morbidity and mortality rates, such as transplant centers and pediatric oncology centers; and
   g) Considering the possible administrative burdens or benefits of potential recommendations on providers, including examining the feasibility of exempting from prior authorization requirements those health care professionals whose prior authorization requests are routinely granted.

2) Recommend to the Commissioner the most appropriate mechanisms to implement the recommended evidence-based clinical practice guidelines. Such mechanisms may include prior authorization, prepayment, post service claim review, and frequency limits.

ii. Drug Utilization Review Board

The DUR Board was authorized by Congress under Section 4401, 1927(g) of the Omnibus Reconciliation Act of 1990. This act mandated that the Vermont AHS develop a drug use review program for covered outpatient drugs, effective January 1, 1993. The Act required the establishment of a DUR Board to:

1) Review and approve drug use criteria and standards for both retrospective and prospective drug use reviews (DURs)
2) Apply these criteria and standards in the application of DUR activities
3) Review and report the results of DURs, and
4) Recommend and evaluate educational intervention programs.

Additionally, the Vermont Legislature enacted the Pharmacy Best Practices and Cost Control Program from the 2002 Appropriations Act, H. 485, which mandated that:

"The commissioner of prevention, assistance, transition, and health access [now the Department of Vermont Health Access] shall establish a pharmacy best practices and cost control program designed to reduce the cost of providing prescription drugs, while maintaining high quality in prescription drug therapies. The program shall include a preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives, utilization review procedures, including a prior authorization review process, and any other cost containment activity adopted by rule by the commissioner, designed to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies."

Implementation of this pharmaceutical initiative required that either the DUR Board or a Pharmacy and Therapeutics Committee be established that would provide guidance on the development of a Preferred Drug List for Medicaid patients. The DVHA elected to utilize the already established DUR Board to obtain current clinical advice on the use of pharmaceuticals. Meetings of the DUR Board occur monthly or bimonthly depending upon the numbers of drugs and issues to be reviewed.

The DUR Board typically includes 10-12 members who are appointed to two-year terms with an option for a two year extension. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians and at least one-third of its members are licensed and actively practicing pharmacists, in addition to one member at large who is currently a nurse practitioner. Board members are recommended by the DVHA Commissioner and approved by the Governor.

Meetings of the DURB occur eight times per year. In Q1 FFY 2017, the DURB held 2 meetings. Information on the DURB and its activities in 2016 is available: http://dvha.vermont.gov/advisory-boards.

DUR Board Decisions

Updates from October 25th and December 6th DUR meetings:

Full New Drug Reviews

Onzetra Xsail, Zembrace Sym Touch, Otiprio, Sernivo spray, Taltz Injection, Tolak cream, Cinqair Injection, Cholbam Cap and Ocaliva Tablet were reviewed for placement on the preferred drug list.

Therapeutic Drug Class Reviews

Antivirals, Oral, H.Pylori, Bronchodilators, Beta Agonists, Bronchodilators & COPD Agents, Cystic Fibrosis Agents, Glucocorticoids Inhaled, Pulmonary Anti-hypertensives, Phosphodiesterase-5 Inhibitors, Sublingual Allergan Extract Immunotherapy, Antifungals, Oral, Botulinum Toxins, Immunologic Therapies for Asthma and Bile Salts and Biliary Agents were reviewed for placement on the preferred drug list.

Newly-Developed/Revised Clinical Coverage Criteria and/or Preferred Products

-Androgens -Alzheimer's Medications-Anti-Diabetics: Dipeptidyl Peptidase Inhibitors, Anti-Diabetics: SGLT2 Inhibitors, Anti-Diabetics: Peptide Hormone-Growth Hormone-Hemophilia Factors-Multiple Sclerosis Agents-Scabicides/Pediculicides-Bone Resorption Inhibitors-Hepatitis

C Agents-ADHD and Cataplexy Medications: Miscellaneous-Anti-coagulants: Injectable-Anti-hypertensives: ARB/CCB Combo -Anti-hypertensives: ARB-Anti-infective Cephalosporins 3rd Generations-Epinephrine Auto Injector-Gout Agents-Lipotropics; Fibric Acid Derivatives-Opthalmics: Antibiotics, Antihistamines, Topical Corticosteroids, Glaucoma Agents, NSAIDs-Renal Disease: Phosphate Binders-Urinary Antispasmodics-Vaginal Anti-Infectives

RetroDUR/DUR topics included:

Use of Naltrexone in Children: Diabetes: GLP1 Receptor Agonist- Methadone use after Prior Authorization

iii. Appropriateness of Services

DVHA delegates to its IGA partners who provide care to the four identified special health care needs populations, the responsibility to develop mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. DMH monitors the quality and appropriateness of care for enrollees in the Community, Rehabilitation and Treatment (CRT) Program through the biennial Minimum Standards Review and for children identified with severe emotional disturbance through Program Reviews. The Department of Disability, Aging and Independent Living (DAIL) monitors the quality and appropriateness of care to enrollees in the Developmental Services Program and the Traumatic Brain Injury Program through Quality Service Reviews. (For further descriptions of the delegated activities see the individual departments' quality plans.)

iv. Program Integrity Unit

Key updates:

- Facilitated nine State and Federal Audits of DVHA Programs, including Medicaid, Vermont Health Connect, VITL and other programs.
- Received more than 80 new Provider fraud allegation referrals and completed almost 90 referrals.
- Creation of the Beneficiary Healthcare Fraud Unit as part of DVHA to support the Medicaid Program's ongoing efforts to combat Fraud, Waste and Abuse in the Vermont Medicaid program.
- Conducted training for other State Medicaid Program Integrity units at the Medicaid Integrity Institute at the request of CMS, DOJ and the MII.

The Program Integrity (PI) Unit is responsible for ensuring compliance, proper oversight, efficient care and appropriate use of Federal and State funds with minimal waste. PI works to promote economy, efficiency, accountability and integrity within the Medicaid Program. The Medicaid Audit & Compliance Unit (MACU), Oversight & Monitoring (O/M) and Beneficiary Healthcare Fraud Unit (BHFU) are the three units that make up the Program Integrity unit and are responsible for ensuring integrity in the VT Medicaid program.

Effective Program Integrity will ensure:

- Accurate beneficiary determinations
- Accurate and compliant provider enrollment
- Compliance with Federal & State Medicaid Policies and regulations
- Services provided to beneficiaries are medically necessary and appropriate

- Provider payment & reimbursement is made in accordance with State/Federal policies
- Transparent and appropriate responses to external audits
- Timely response to corrective action requests
- Clear documentation of policies and procedures

The PI unit works in partnership with many Federal and State partners such as, the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), the Medicaid Fraud & Residential Abuse Unit (MFRAU) of the Attorneys General (AG) Office, State's Attorney's Office, Medical Practice and Licensing Boards, Drug Enforcement Administration (DEA) and other Law Enforcement Offices. Additionally, there is always communication with Federal and State Regulators, AHS Departments, State Fiscal Agents, providers, beneficiaries, and more.

MACU – Medicaid Audit & Compliance Unit

The MACU initiates work to prevent, detect and investigate fraud, waste and abuse by healthcare providers and seeks to recover incorrect payments. Reviews are conducted to ensure that services were provided, medically necessary, properly coded, billed and paid in accordance with federal and state Medicaid rules, regulations, provider agreements and relevant statutes. Cases of suspected provider fraud are referred to MFRAU.

The MACU employs several methods to identify fraud, waste and abuse, such as:

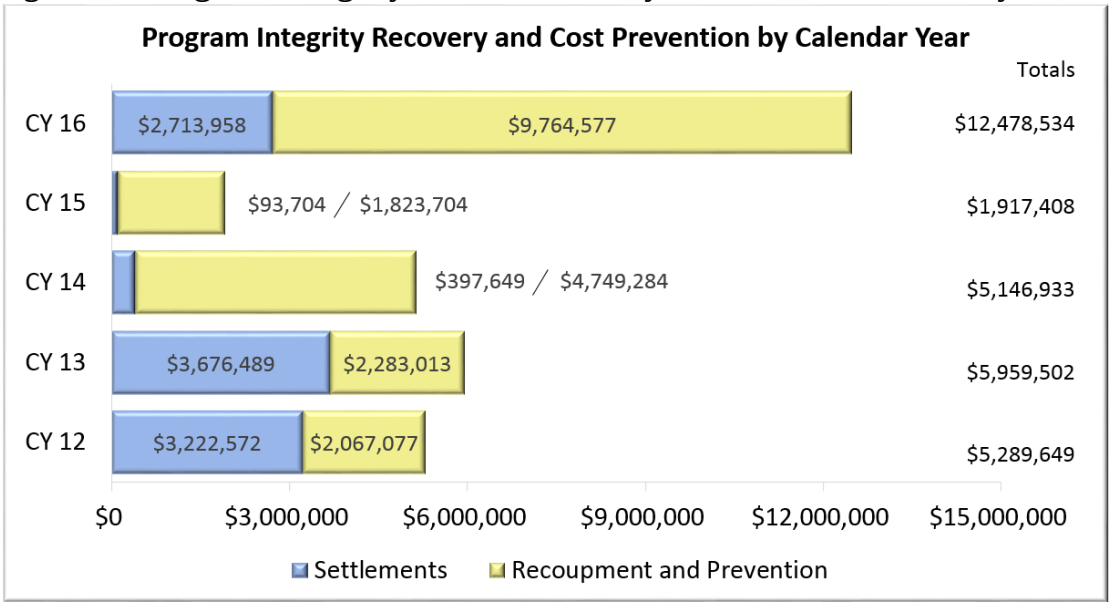
- Referrals from providers, pharmacies, national alerts, the public, etc.
- Pre-& Post-payment reviews
- Data mining activities
- Recipient verification
- Desk and on-site reviews

The MACU analyzes claims data to detect aberrant billing practices, identify potential findings and perform preliminary and full investigations. The Medicaid Integrity Contractors (MIC) and Unified Program Integrity Contractors (UPIC) for CMS support the MACU in audit, oversight, and antifraud, waste and abuse efforts.

Outcomes:
The MACU's focus is the integrity of the program. When overpayments are made, the MACU seeks to recover to ensure that Medicaid dollars are appropriately spent. Money recovered because of fraud, waste and abuse, can be reinvested back into the Medicaid program. Efforts are made to provide additional education to providers and to implement system limitations to prevent future incorrect or overpayments. When these actions are taken, incorrect spending is prevented.

MACU efforts for CY 16 recoveries and cost prevention totaled $12,478,534. The highest producing recoveries and cost-avoidance since the inception of the Program Integrity unit in 2007. Much of the PI Unit's success is due to the ongoing support of and ability to receive enhanced training to PI staff through the Medicaid Integrity Institute (MII). CMS, Department of Justice (DOJ) and MII staff have recognized VT MACU employees as national leaders and strong authorities on fraud, waste and abuse and have recruited them to conduct training for other State's Program Integrity employees.

Figure 10. Program Integrity MACU Recovery and Cost Prevention, by Calendar Year



Oversight & Monitoring (O&M)

In 2015, the PI Unit expanded and formalized an Oversight & Monitoring Unit (O&M Unit) for the Medicaid Program, including the Vermont Health Connect. This follows the strategic direction of DVHA and Agency Leadership to ensure the effectiveness and efficiency of departmental control environments and operational processes in alignment with applicable laws and regulations.

Outcomes:
In calendar year 2016 the Oversight and Monitoring (O&M) unit made significant strides in coordinating DVHA participation in State, Federal, and independent audits and examinations, seeking to ensure that information shared is consistent, accurate, and timely. Specifically, O&M:

- Facilitated nine state and federal audits of DVHA programs, including Medicaid, Vermont Health Connect (VHC), VITL, and other programs.
- Coordinated a federal questionnaire on VHC Eligibility Customer Service.
- Tracked and monitored any open items from previous audits.
- Provided ongoing tracking and monitoring and follow-up of new mitigation plans and other open Corrective Action Plans.
- Supported AHS & DVHA staff with documentation standards for better Standard Operating Procedures and policies.

The goal of the O&M group is to facilitate open communication, through a single voice, to ensure all expectations of auditors and regulators are met, and that there are no repeat findings. Collectively, this transparency will promote further success of the program.

Beneficiary Healthcare Fraud Unit (BHFU)

In July, 2016, the Beneficiary Healthcare Fraud Unit joined the DVHA Program Integrity Unit. The BHFU is responsible for investigating, detecting and preventing beneficiary eligibility healthcare fraud in the Medicaid program. All other non-healthcare fraud investigations of State-funded assistance programs remain the responsibility of the Department for Children and Families (DCF). The DVHA BHFU and the DCF Fraud unit work collaboratively to ensure all aspects of Vermont assistance programs are considered and evaluated as a collective.

The BHFU works with the Health Access Enrollment & Eligibility Unit (HAEEU), as well as other State and Federal partners to ensure Vermonters are receiving appropriate eligibility determinations based on their applications, and that income thresholds, residency and other means of determining coverage are proper.

The BHFU is still in the process of developing the team and is poised to have a successful year.

Medicaid Management Information System

The Medicaid Management Information System (MMIS) is an integral component of the MACU and BHFU utilization review activities. The MMIS maintains Medicaid claims data, beneficiary eligibility and demographics, and provider enrollment information which allows for additional review and scrutiny of the Medicaid eligibility, enrollment and claims data.

Claims Data Analysis and Post Payment Review

MACU and BHFU staff examine beneficiary eligibility, provider enrollment and claims data to verify appropriate determinations in pre-& post payment reviews. Staff utilize data mining techniques and have developed a variety of algorithms to detect aberrant utilization. Medicaid policies, guidelines and claims data are utilized in the development of these algorithms. Reports generated from these reviews could result in supporting existing PI investigations or the creation of new.

Ad Hoc Queries

The PI Units utilizes the Enhanced Vermont Ad Hoc (EVAH) system. The EVAH system is a Business Objects application that enables the PI Units to mine data and create varied and comprehensive ad hoc reports from the MMIS. Business Objects is an invaluable tool employed by the PI Units to advance investigations that enables them to focus on individual elements within each case.

Data gleaned from Business Objects allows the PI Units to compare claims information submitted by providers. The data can be reported and analyzed using any of the claim details to allow the PI units to compare individuals, evaluate adherence to policy, etc. This is the primary method used in detecting under/over-utilization on a global scale.

v. Inpatient, Outpatient, and Emergency Department Utilization

Methods

Utilization statistics for inpatient, outpatient, and emergency department services provided under Global Commitment during FFY2014-16 were compiled by the DVHA's Data Unit in January 2017 using paid claims data. The scope of analysis included institutional services provided under the Medicaid program between 10/1/2013 and 9/30/2016, excluding crossover claims.[2] The following areas of utilization were the focus of this analysis:

- Total Inpatient Utilization
    - Inpatient Medicine
        - Inpatient Medicine – Alcohol and Substance Abuse Services

[2] Crossover claims, or claims for which the State of Vermont was the payer of last resort and paid the remainder of cost for services covered by Medicare.

        - Inpatient Medicine – Psychiatric Services
        - Inpatient Medicine – All Other Services
    - Inpatient Surgery
- Total Outpatient Utilization
    - Emergency Department Utilization

Measures consisted of discharge counts and institutional length-of-stay, in days, for inpatient services, and visit counts for outpatient services. The results were broken out by age category.

Findings

The following table (Table 5) presents discharge counts and average length-of-stay by age for inpatient services provided in FFY 2014-16.

Table 5. Inpatient Utilization by Fiscal Year and Age Group

Total Inpatient:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
<1	12,999	12,142	12,024	3,292	3,082	2,996	3.9	3.9	4.0
1-9	2,471	3,162	2,276	490	433	459	5.0	7.3	5.0
10-19	9,332	8,833	8,621	1,189	1,151	1,173	7.8	7.7	7.3
20-44	31,107	28,852	27,602	6,152	6,290	6,122	5.1	4.6	4.5
45-64	23,176	20,353	20,982	3,416	3,724	3,850	6.8	5.5	5.4
65+	1,238	631	1,303	139	107	96	8.9	5.9	13.6
Overall	**80,323**	**73,973**	**72,808**	**14,678**	**14,787**	**14,696**	**5.5**	**5.0**	**5.0**

A) Inpatient Medical (Alcohol/Substance + Mental Health + Other Medical):

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
<1	12,442	11,748	11,834	3,257	3,057	2,968	3.8	3.8	4.0
1-9	1,938	2,731	1,895	402	358	371	4.8	7.6	5.1
10-19	8,592	8,080	7,785	1,012	994	991	8.5	8.1	7.9
20-44	24,690	23,181	21,048	4,774	5,031	4,677	5.2	4.6	4.5
45-64	16,657	14,724	14,385	2,454	2,760	2,719	6.8	5.3	5.3
65+	1,071	537	1,059	110	91	78	9.7	5.9	13.6
Overall	**65,390**	**61,001**	**58,006**	**12,009**	**12,291**	**11,804**	**5.4**	**5.0**	**4.9**

A1) Alcohol/Substance Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
<1	-	-	-	-	-	-	-	-	-
1-9	-	-	-	-	-	-	-	-	-
10-19	35	63	48	9	15	7	3.9	4.2	6.9
20-44	2,690	3,255	1,613	634	726	382	4.2	4.5	4.2
45-64	1,305	1,311	1,356	264	276	296	4.9	4.8	4.6
65+	-	-	24	-	-	1	-	-	24.0
Overall	**4,030**	**4,629**	**3,041**	**907**	**1,017**	**686**	**4.4**	**4.6**	**4.4**

A2) Mental Health Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
<1	-	-	-	-	-	-	-	-	-
1-9	508	768	667	26	33	32	19.5	23.3	20.8
10-19	6,211	6,253	5,923	448	507	461	13.9	12.3	12.8
20-44	11,640	9,076	9,471	865	906	1,011	13.5	10.0	9.4
45-64	4,810	3,296	3,695	313	369	352	15.4	8.9	10.5
65+	513	20	378	3	1	5	171.0	20.0	75.6
Overall	**23,682**	**19,413**	**20,134**	**1,655**	**1,816**	**1,861**	**14.3**	**10.7**	**10.8**

A3) Other Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
<1	12,442	11,748	11,834	3,257	3,057	2,968	3.8	3.8	4.0
1-9	1,430	1,963	1,228	376	325	339	3.8	6.0	3.6
10-19	2,346	1,764	1,814	555	472	523	4.2	3.7	3.5
20-44	10,360	10,850	9,964	3,275	3,399	3,284	3.2	3.2	3.0
45-64	10,542	10,117	9,334	1,877	2,115	2,071	5.6	4.8	4.5
65+	558	517	657	107	90	72	5.2	5.7	9.1
Overall	**37,678**	**36,959**	**34,831**	**9,447**	**9,458**	**9,257**	**4.0**	**3.9**	**3.8**

B) Inpatient Surgery:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
<1	557	394	190	35	25	28	15.9	15.8	6.8
1-9	533	431	381	88	75	88	6.1	5.7	4.3
10-19	740	753	836	177	157	182	4.2	4.8	4.6
20-44	6,417	5,671	6,554	1,378	1,259	1,445	4.7	4.5	4.5
45-64	6,519	5,629	6,597	962	964	1,131	6.8	5.8	5.8
65+	167	94	244	29	16	18	5.8	5.9	13.6
Overall	**14,933**	**12,972**	**14,802**	**2,669**	**2,496**	**2,892**	**5.6**	**5.2**	**5.1**

The following table (Table 6) presents visit counts by age for outpatient services provided in FFY2014-16, first for all outpatient clinic services, emergency department services, other outpatient services, and then the combination of ED and other outpatient.

Table 6. Outpatient Utilization by Fiscal Year and Age Group

FFY14				EXCLUDING Clinic	
Age	***Clinic****	**ED**	**Other**	**ED & Other**	**%ED**
<1	*1,116*	2,852	3,105	5,957	48%
1-9	*4,165*	14,514	17,902	32,416	45%
10-19	*4,348*	14,529	28,401	42,930	34%
20-44	*16,519*	41,157	104,435	145,592	28%
45-64	*11,161*	13,891	85,246	99,137	14%
65+	*174*	246	1,609	1,855	13%
Overall	***37,483***	**87,189**	**240,698**	**327,887**	**27%**
FFY15				EXCLUDING Clinic	

	Age	*Clinic**	ED	Other	ED & Other	%ED
	<1	*7,942*	2,939	3,065	6,004	49%
	1-9	*29,391*	14,727	17,479	32,206	46%
	10-19	*25,692*	16,157	27,745	43,902	37%
	20-44	*64,913*	44,390	102,540	146,930	30%
	45-64	*46,621*	15,479	88,217	103,696	15%
	65+	*656*	177	1,279	1,456	12%
	Overall	***175,215***	**93,869**	**240,325**	**334,194**	**28%**
FFY16					**EXCLUDING Clinic**	
	Age	***Clinic****	**ED**	**Other**	**ED & Other**	**%ED**
	<1	*8,371*	2,714	2,766	5,480	50%
	1-9	*32,250*	14,227	17,666	31,893	45%
	10-19	*27,759*	16,024	28,169	44,193	36%
	20-44	*67,853*	43,614	103,854	147,468	30%
	45-64	*52,175*	16,136	89,756	105,892	15%
	65+	*546*	172	1,247	1,419	12%
	Overall	***188,954***	**92,887**	**243,458**	**336,345**	**28%**

*Outpatient clinic visits increased due to a DVHA requirement for hospitals to conform to provider-based billing to match Medicare.

Discussion

In FFY2016, Global Commitment, Medicaid, paid for 14,696 inpatient stays and 525,299 outpatient visits for Vermonters. The total number of inpatient visits were nearly constant over the three years FFY2014-16. 80% of inpatient discharges were for medicine and 20% were for surgery. The total number of outpatient visits has increased by 44% but this increase was majorly due to provider-based billing where hospital owned practices bill for separate professional fees and outpatient clinic facility fees. DVHA has since ended provider-based billing on June 30, 2016.

Alcohol/substance-abuse stays were somewhat longer duration, surgeries were moderately longer, and psychiatric stays were much longer than other inpatient medical stays. Psychiatric medical services constituted 13% of the total inpatient stays and medical treatment for alcohol and substance abuse were 5% of the total inpatient stays. Total bed days decreased for alcohol/substance abuse with a 34% decrease from FFY15 to FFY16 and average length of stay being stable at around 4.4 days. Inpatient psychiatric medical was higher in FFY15 and then highest in FFY16. Inpatient surgery bed days both decreased 13% during FFY14 to FFY15 and then increased 14% between FFY15 and FFY16. There has been variability in service volume for inpatient surgical, medical psychiatric and medical alcohol/substance stays.

Among outpatient visits, emergency department visits constituted roughly 28% of the emergency and other outpatient visits. Outpatient clinic facility visits were treated separately in this report due to changes in billing practices largely starting in FFY15. "Provider-based billing" was adopted by each hospital at different dates starting in the fall of 2014 and was an effort to conform to existing Medicare hospital owned department (including outpatient departments outside the traditional hospital campus) billing practices. "Provider-based billing" involves the hospital billing Medicaid separate facility and professional service claims. Hospital outpatient clinic facility visits grew from only six hundred in FFY13 (from a previous report) to over 189 thousand in FFY16.

VII. Policy and Administrative Difficulties

Fiscal & Operational Management:

AHS paid DVHA a prospective PMPM capitation payment on the first business day of every month duringCY2016. This PMPM payment served as the proxy by which to draw down Federal funds for Global Commitment. The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (administrative, program, and MCE Investments) for the given quarter. After each quarterly submission, AHS reconciled what was claimed on the CMS-64 versus what was made for Capitation payments to DVHA.

As of December 2016, the Global Commitment to Health waiver negotiations were completed with an approved waiver extension and a new set of Special Terms and Conditions (STCs). For purposes of the demonstration, DVHA will operate as if it were a non-risk pre-paid inpatient health plan (PIHP) and AHS, as the Single State Agency, will provide oversight of DVHA in that capacity. In the negotiations, it was agreed upon that AHS would continue to use FFY 16 per member per month rates for the period 10/01/2016 – 03/31/2017. And, as outlined in the Waiver extension STCs, new per member per month rates will be established for the period 04/01/2017 – 12/31/2017.

During the Waiver extension negotiations, CMS put forth guidance that the State of Vermont was no longer able to claim enhanced FMAP on the Admin and MCO Investment allocation for the Childless New Adult population. AHS removed this allocation from the Childless New Adult MEG effective 07/01/2016. Another topic that impacted financial reporting were the costs for the Woodside Juvenile Rehabilitation Center. CMS determined that the residents of this facility are considered inmates and therefore, no longer eligible for federal Medicaid reimbursement. This information was not finalized until late October. CMS and AHS agreed that QE0916 would be the last CMS-64 report that could include costs for Woodside.

The contract with Milliman for actuarial services expired March 31, 2016. AHS received four bids for the Actuarial Consultant request for proposal. The winning bid was awarded to Milliman, Inc. The contract will be for two years with two options one-year extensions.

VIII. Capitated Revenue Spending

The PMPM rates as set for FFY16 are listed below. The rates were extended by CMS to be in effect until 3/31/17.

Table 7. **10/1/15-03/31/17**

Medicaid Eligibility Group		
ABD Adult	$	**1,534.86**
ABD Child	$	**3,038.82**
ABD - Dual	$	**2,480.59**
non-ABD Adult	$	**736.04**
non-ABD Child	$	**488.80**
GlobalRx	$	**78.76**
New Adult	$	**513.91**
Moderates	$	**686.79**

Investments made by the MCE for SFY16 totaled $126,882,102. Areas of capitated spending and the associated categories are outlined in Attachment 1.

Attachments

Attachment 1 - Budget Neutrality

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY9a	PQA: WY9b	PQA: WY10	PQA: WY11	Net Program PQA	Net Program Expenditures as reported on 64	New Adult Expenditures as reported	non-MCO Admin Expenses	Total columns J:K for Budget Neutrality calculation - **Includes** New Adult	Cumulative Waiver Cap - **Excluding** New Adult per 10/2/13 STCs	Variance to Cap under/(over)
1205	$ 178,493,793														$ 178,493,793					
0306	$ 189,414,365	$ 14,472,838												$ 14,472,838	$ 203,887,203					
0606	$ 209,647,618	$ (14,172,165)												$ (14,172,165)	$ 195,475,453					
0906	$ 194,437,742	$ 133,350												$ 133,350	$ 194,571,092					
WY1 SUM	$ 771,993,518	$ 434,023												$ 434,023	**$ 782,159,845**		**$ 4,620,302**	**$ 786,780,147**	**$ 841,266,663**	**$ 54,486,516**
1206	$ 203,444,640	$ 8,903												$ 8,903	$ 203,453,543					
0307	$ 203,804,330	$ 8,894,097												$ 8,894,097	$ 212,698,427					
0607	$ 186,458,403	$ 614,587	$ (68,408)											$ 746,179	$ 187,204,582					
0907	$ 225,219,267	$ -	$ -											$ -	$ 225,219,267					
WY2 SUM	$ 818,926,640	$ 9,717,587	$ (68,408)											$ 9,649,179	**$ 802,884,359**		**$ 6,464,439**	$ 809,348,797		
Cumulativ																		**$ 1,596,128,945**	**$ 1,684,861,317**	**$ 88,732,372**
1207	$ 213,871,059	$ -	$ 1,010,348											$ 1,010,348	$ 214,881,406					
0308	$ 162,921,830	$ -	$ -											$ -	$ 162,921,830					
0608	$ 196,466,768	$ 14,717	$ -	$ 40,276,433										$ 40,291,150	$ 236,757,918					
0908	$ 228,593,470	$ -	$ -	$ -										$ -	$ 228,593,470					
WY3 SUM	$ 801,853,126	$ 14,717	$ 1,010,348	$ 40,276,433										$ 41,301,498	**$ 881,729,256**		**$ 6,457,896**	$ 888,187,152		
Cumulativ																		**$ 2,484,316,097**	**$ 2,604,109,308**	**$ 119,793,211**
1208	$ 228,768,784		$ -	$ -										$ -	$ 228,768,784					
0309	$ 225,691,930		$ (16,984,221)	$ 38,998,635	$ (4,144,041)									$ 17,870,373	$ 243,562,303					
0609	$ 204,169,638		$ -	$ 686,851	$ 5,522,763									$ 6,209,614	$ 210,379,252					
0909	$ 235,585,153		$ -	$ 30,199	$ 34,064,109									$ 34,094,308	$ 269,679,461					
WY4 SUM	$ 894,215,505	$ -	$ (16,984,221)	$ 39,715,685	$ 35,442,831									$ 58,174,295	**$ 935,368,819**		**$ 5,495,618**	$ 940,864,437		
Cumulativ																		**$ 3,425,180,534**	**$ 3,606,430,571**	**$ 181,250,037**
1209	$ 241,939,196				$ 5,192,468									$ 5,192,468	$ 247,131,664					
0310	$ 246,257,198				$ 531,141	$ 4,400,166								$ 4,931,306	$ 251,188,504					
0610	$ 253,045,787				$ 248,301	$ 5,260,537								$ 5,508,838	$ 258,554,625					
0910	$ 252,294,668			$ (115,989)	$ (261,426)	$ 3,348,303								$ 2,970,888	$ 255,265,556					
WY5 SUM	$ 993,536,849	$ -	$ -	$ (115,989)	$ 5,710,484	$ 13,009,006								$ 18,603,501	**$ 1,012,990,839**		**$ 5,939,459**	$ 1,018,930,298		
Cumulativ																		**$ 4,444,110,832**	**$ 4,700,022,174**	**$ 255,911,342**
1210	$ 262,106,988				$ -	$ 6,444,984								$ 6,444,984	$ 268,551,972					
0311	$ 257,140,611													$ -	$ 257,140,611					
0611	$ 277,708,043						$ (121,416)							$ (121,416)	$ 277,586,627					
0911	$ 243,508,246						$ 5,528,143							$ 5,528,143	$ 249,036,391					
WY6 SUM	$ 1,040,463,890	$ -	$ -	$ -	$ -	$ 6,444,984	$ 5,406,727							$ 11,851,711	**$ 1,045,342,616**		**$ 6,071,553**	$ 1,051,414,168		
Cumulativ																		**$ 5,495,525,000**	**$ 5,865,213,737**	**$ 369,688,737**
1211	$ 253,147,037						$ (531,744)							$ (531,744)	$ 252,615,293					
0312	$ 267,978,672						$ 3,742	$ 49,079						$ 52,821	$ 268,031,493					
0612	$ 302,958,610							$ 6,393,928						$ 6,393,928	$ 309,352,538					
0912	$ 262,406,131							$ 7,750,994						$ 7,750,994	$ 270,157,125					
WY7 SUM	$ 1,086,490,450	$ -	$ -	$ -	$ -	$ -	$ (528,002)	$ 14,194,000						$ 13,665,998	**$ 1,134,526,550**		**$ 5,751,066**	$ 1,140,277,616		
Cumulativ																		**$ 6,635,802,617**	**$ 7,113,290,903**	**$ 477,488,286**
1212	$ 282,701,072							$ 3,036,447						$ 3,036,447	$ 285,737,519					
0313	$ 285,985,057							$ 991,340						$ 991,340	$ 286,976,397					
0613	$ 336,946,361							29,814,314	$ (125,679)					$ 29,688,635	$ 366,634,996					
0913	$ 286,067,548								$ 2,162,772					$ 2,162,772	$ 288,230,320					
WY8 SUM	$ 1,191,700,038	$ -	$ -	$ -	$ -	$ -	$ -	$ 33,842,100	$ 2,037,093					$ 35,879,193	**$ 1,199,887,555**		**$ 6,260,794**	$ 1,206,148,349		
Cumulativ																		**$ 7,841,950,966**	**$ 8,450,684,486**	**$ 608,733,520**
1213	$ 319,939,651								$ 3,652,767					$ 3,652,767	$ 323,592,418					
WY9a SU	$ 319,939,651	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,652,767					$ 3,652,767	$ 319,921,780		**$ 1,214,631**	$ 321,136,411		
Cumulativ																		**$ 8,163,087,376**	**$ 8,955,886,798**	**$ 792,799,422**
0314	$ 288,542,475								$ 2,159,834					$ 2,159,834	$ 290,702,309					
0614	$ 288,845,927													$ -	$ 288,845,927					
0914	$ 242,449,803								$ 337,823	$ (17,871)	$ 1,466,026			$ 1,785,978	$ 244,235,780					
1214	$ 286,853,166										$ 867,215			$ 867,215	$ 287,720,381					
WY9b SU	$ 1,106,691,370	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,497,657	$ (17,871)	$ 2,333,241			$ 4,813,027	$ 1,108,497,700		**$ 5,086,126**	$ 1,113,583,826		
Cumulativ																		**$ 9,276,671,203**	**$ 10,290,338,883**	**$ 1,013,667,680**
0315	$ 321,140,737													$ -	$ 321,140,737					
0615	$ 357,677,001										$ (526,911)			$ (526,911)	$ 357,150,090					
0915	$ 309,207,552											$ 3,080,254		$ 3,080,254	$ 312,287,806					
1215	$ 348,325,098											$ 5,996,596		$ 5,996,596	$ 354,321,694					
WY10 SU	$ 1,336,350,389	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (526,911)	$ 9,076,850		$ 8,549,939	$ 1,348,857,571		$ -	$ 1,348,857,571		
Cumulativ																		**$ 10,625,528,774**	**$ 11,969,357,946**	**$ 1,343,829,172**
0316	$ 370,951,068											$ (1,759,477)		$ (1,759,477)	$ 369,191,591					
0616	$ 338,344,448											$ 1,209,934	$ (13,427,019)	$ (12,217,085)	$ 326,127,363					
0916	$ 314,847,438											$ 3,979,875	$ (97,502)	$ 3,882,373	$ 318,729,811					
1216	$ 324,018,989												$ 2,231,683	$ 2,231,683	$ 326,250,671					
WY11 SU	$ 1,348,161,943	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,430,332	$ (11,292,839)	$ (7,862,507)	$ 1,336,869,104		$ -	$ 1,336,869,104		
Cumulativ																		**$ 11,962,397,877**	**$ 13,752,420,439**	**$ 1,790,022,562**
	$ 11,710,323,369	$ 10,166,327	$ (16,042,281)	$ 79,876,130	$ 41,153,315	$ 19,453,990	$ 4,878,725	$ 48,036,100	$ 8,187,517	$ (17,871)	$ 1,806,330	$ 12,507,182	$ (11,292,839)		**$ 11,909,035,994**	$ -	$ 53,361,884			

Attachment 2

State of Vermont
Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
http://dvha.vermont.gov

[Phone] 802-879-5900

Agency of Human Services

Medicaid Program Enrollment and Expenditures Report

Q1 SFY 2017

Quarterly Report to the General Assembly
Pursuant to 33 V.S.A. § 1901f

Hal Cohen, Secretary
Vermont Agency of Human Services

Steven M. Costantino, Commissioner
Department of Vermont Health Access

December 1, 2016

Glossary of Terms

PMPM – Per Member Per Month
MEG – Medicaid Eligibility Group
ABD Adult – Beneficiaries age 19 or older; categorized as aged, blind, disabled, and/or medically needy
ABD Child – Beneficiaries under age 19; categorized as blind, disabled, and/or medically needy
ABD Dual – Beneficiaries eligible for both Medicare and Medicaid; categorized as blind, disabled, and/or medically needy
General Adult – Beneficiaries age 19 or older; pregnant women or parents/caretaker relatives of minor children receiving cash assistance and those receiving transitional Medicaid after the receipt of cash assistance
General Child – Beneficiaries under age 19, and below the protected income level, categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E)
New Adult - Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL
Exchange Vermont Premium Assistance - Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL
Exchange Vermont Cost Sharing - Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL
Underinsured Child – Beneficiaries under age 19 or under with household income 237-312% FPL with other insurance
CHIP – Beneficiaries under age 19 with household income 237-312% FPL with no other insurance
Pharmacy Only – Assistance to help pay for prescription medicines based on income, disability status, and age
Choices for Care - Vermont's Long Term Care Medicaid Program; for Vermonters in nursing homes, home-based settings, and/or enhanced residential

The Department of Vermont Health Access

Caseload and Expenditure Report ~ DVHA Only Medicaid Spend

DVHA YTD '16

Tuesday, November 15, 2016

	SFY '17 Appropriated			SFY '17 Actuals thru September 30, 2016			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	17,229	$ 105,981,420	$ 551.69	10,367	$ 18,487,752	$ 594.46	17.44%
ABD Dual	19,153	$ 55,272,017	$ 228.15	17,529	$ 13,178,273	$ 250.60	23.84%
General Adult	22,041	$ 100,815,869	$ 384.07	17,347	$ 20,859,946	$ 400.84	20.69%
New Adult	59,021	$ 231,146,862	$ 331.30	58,496	$ 59,737,645	$ 340.41	25.84%
Exchange Premium Assistance #	17,588	$ 5,954,932	$ 29.47	17,103	$ 1,455,033	$ 28.36	24.43%
Exchange Cost Sharing #	5,646	$ 1,232,289	$ 19.88	5,571	$ 309,608	$ 18.53	25.12%
ABD Child	3,417	$ 28,773,934	$ 698.22	2,613	$ 5,954,956	$ 759.66	20.70%
General Child	64,846	$ 149,777,097	$ 199.75	58,321	$ 34,916,391	$ 199.56	23.31%
Underinsured Child	820	$ 1,207,158	$ 119.66	799	$ 303,065	$ 126.38	25.11%
SCHIP	4,874	$ 8,400,371	$ 130.15	4,841	$ 1,693,275	$ 116.58	20.16%
Pharmacy Only	11,026	$ 5,020,813	$ 16.55	11,802	$ 1,282,863	$ 36.23	25.55%
Choices for Care	4,623	$ 209,154,497	$ 4,228.78	4,216	$ 54,360,177	$ 4,297.59	25.99%
Total Medicaid Claims Paid	230,285	$ 902,737,259	$ 326.67	209,005	$ 212,598,210	$ 339.06	23.55%

Exchange Premium Assistance (VPA) and Cost Sharing (CSR) PMPM's were budgeted based on subscriber count. On average, there are 1.2 individuals per subscriber enrollment for VPA, and 1.14 individuals per subscriber enrollment for CSR. Actual caseload and PMPM is reported as individual count.

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS Medicaid Spend

All AHS YTD '16

Tuesday, November 15, 2016

	SFY '17 Appropriated			SFY '17 Actuals thru September 30, 2016			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	17,229	$ 186,733,502	$ 1,008.75	10,367	$ 37,940,419	$ 1,219.95	20.32%
ABD Dual	19,153	$ 250,558,121	$ 1,001.16	17,529	$ 52,573,749	$ 999.75	20.98%
General Adult	22,041	$ 108,093,038	$ 435.77	17,347	$ 24,130,697	$ 463.69	22.32%
New Adult	59,021	$ 284,259,970	$ 368.19	58,496	$ 67,283,435	$ 383.41	23.67%
Exchange Premium Assistance #	17,588	$ 5,954,932	$ 29.47	17,103	$ 1,455,033	$ 28.36	24.43%
Exchange Cost Sharing #	5,646	$ 1,232,289	$ 19.88	5,571	$ 309,608	$ 18.53	25.12%
ABD Child	3,417	$ 68,246,490	$ 1,705.15	2,613	$ 13,770,976	$ 1,756.73	20.18%
General Child	64,846	$ 264,057,892	$ 338.03	58,321	$ 57,620,679	$ 329.33	21.82%
Underinsured Child	820	$ 1,958,507	$ 192.06	799	$ 605,519	$ 252.51	30.92%
SCHIP	4,874	$ 9,766,690	$ 155.46	4,841	$ 1,998,236	$ 137.58	20.46%
Pharmacy Only	11,026	$ 5,020,813	$ 44.41	11,802	$ 1,348,026	$ 38.07	26.85%
Choices for Care	4,623	$ 221,379,182	$ 4,278.76	4,216	$ 54,926,341	$ 4,342.35	24.81%
Total Medicaid Claims Paid	230,285	$ 1,407,261,426	$ 509.25	209,005	$ 314,021,945	$ 500.82	22.31%

Exchange Premium Assistance (VPA) and Cost Sharing (CSR) PMPM's were budgeted based on subscriber count. On average, there are 1.2 individuals per subscriber enrollment for VPA, and 1.14 individuals per subscriber enrollment for CSR. Actual caseload and PMPM is reported as individual count.

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS and AoE Medicaid Spend

All AHS and AoE YTD '16

Tuesday, November 15, 2016

	SFY '17 Appropriated			SFY '17 Actuals thru September 30, 2016			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	17,229	$ 186,952,635	$ 904.26	10,367	$ 38,141,430	$ 1,226.41	20.40%
ABD Dual	19,153	$ 249,193,065	$ 1,084.20	17,529	$ 52,599,147	$ 1,000.23	21.11%
General Adult	22,041	$ 107,618,669	$ 406.89	17,347	$ 24,147,143	$ 464.00	22.44%
New Adult	59,021	$ 282,483,139	$ 398.85	58,496	$ 67,290,149	$ 383.44	23.82%
Exchange Premium Assistance #	17,588	$ 5,954,932	$ 28.21	17,103	$ 1,455,033	$ 28.36	24.43%
Exchange Cost Sharing #	5,646	$ 1,232,289	$ 18.19	5,571	$ 309,608	$ 18.53	25.12%
ABD Child	3,417	$ 84,204,841	$ 2,053.53	2,613	$ 16,235,419	$ 2,071.11	19.28%
General Child	64,846	$ 292,987,771	$ 376.52	58,321	$ 62,454,331	$ 356.96	21.32%
Underinsured Child	820	$ 2,380,002	$ 241.83	799	$ 661,575	$ 275.89	27.80%
SCHIP	4,874	$ 11,130,462	$ 190.29	4,841	$ 2,252,566	$ 155.09	20.24%
Pharmacy Only	11,026	$ 5,020,813	$ 37.95	11,802	$ 1,348,026	$ 38.07	26.85%
Choices for Care	4,623	$ 219,966,581	$ 3,964.77	4,216	$ 54,926,698	$ 4,342.37	24.97%
Total Medicaid Claims Paid	230,285	$ 1,449,125,199	$ 524.39	209,005	$ 321,880,352	$ 513.35	22.21%

Exchange Premium Assistance (VPA) and Cost Sharing (CSR) PMPM's were budgeted based on subscriber count. On average, there are 1.2 individuals per subscriber enrollment for VPA, and 1.14 individuals per subscriber enrollment for CSR. Actual caseload and PMPM is reported as individual count.

Attachment 3

State of Vermont *Agency of Human Services*
Department of Vermont Health Access [Phone] 802-879-5900
312 Hurricane Lane, Suite 201 [Fax] 802-879-5651
Williston VT 05495-2807
dvha.vermont.gov

Questions, Complaints and Concerns Received by Health Access Member Services
October 1, 2016 – December 31, 2016

October 3 – October 7

- No issues to report

October 10 – October 14

- No issues to report

October 17 – October 21

- No issues to report.

October 24 – October 28

- LIS Notices: CSR's updated ACCESS or advised customer of the steps to apply.
- GMC Reviews: CSR's reviewed Onbase and advised what further action was needed.

Ocotber 31 – November 4

- VPharm invoices not received: CSR's reviewed account and advised the amount due.
- Closure Notices for Non-Review: CSR's reviewed account to see if review was sent in. If not, CSR's advised to submit review to be rescreened. If so, CSR's reviewed account to determine what further information is needed or if the review is processing.

November 7 – November 11

- PDP Open Enrollment: CSR's reviewed notice and, if needed, referred the customer to AOA for further assistance.

November 14 – November 18

- PDP Open Enrollment: CSR's reviewed notice and, if needed, referred the customer to AOA for further assistance.

November 21 – November 25

- PDP Open Enrollment: CSR's reviewed notice and, if needed, referred the customer to AOA for further assistance.

November 28 – December 2

- No issues to report.

December 5 – December 9

- No issues to report

December 12 – December 16

- No issues to report

December 19 – December 23

- VPharm: CSR's reviewed case and followed the PDP Issue Protocol reference.

December 26 – December 30

- No issues to report.

YEAR END SUMMARY

Green Mountain Care Customer Service continued to provide members with timely and accurate information. Member Services receives a wide variety of questions on a daily basis and is able to access the information necessary to resolve the member's question internally or contact the appropriate subject matter expert (e.g. HAEU rep, DVHA Provider and Member Relations Unit, etc.) for resolution.

Green Mountain Care Customer Service Representatives (CSRs) saw a high volume of calls related to the following topics throughout 2016:

- Primary Care Provider (PCP) enrollment (finding a PCP)
- Legacy Medicaid renewals
- Prescription Drug Plan (PDP) invoicing
- VPharm Closure notices

CSRs monitored the volume of the aforementioned call topics and built appropriate resolution processes. DVHA continues to monitor weekly reports to ensure that all member questions or complaints are understood, addressed and resolved in a timely and accurate manner.

2017 will see increased collaboration between DVHA's Provider and Member Relations Unit and Maximus staff to ensure that all Green Mountain Care Member questions or complaints receive the maximum amount of attention required to improve customer satisfaction wherever possible.

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
October 1, 2016 – December 31, 2016

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data compiled on January 10, 2017, from the centralized database that were filed from October 1, 2016 through December 31, 2016.

Grievances: A grievance is an expression of dissatisfaction about any matter that is not an action taken by the Medicaid Managed Care Model.

During this quarter, there were 14 grievances filed; ten were addressed during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was four days. Of the grievances filed, 72% were filed by beneficiaries, 21% were filed by a representative of the beneficiary and 7% were filed by another source. Of the 14 grievances filed, DMH had 71%, DVHA had 22%, and VDH had 7%, There were no grievances filed for DAIL or DCF during this quarter.

There were no Grievance Reviews filed this quarter.

Appeals: Medicaid rule 7110.1 defines actions that Managed Care Model makes that are subject to an internal appeal. These actions are:

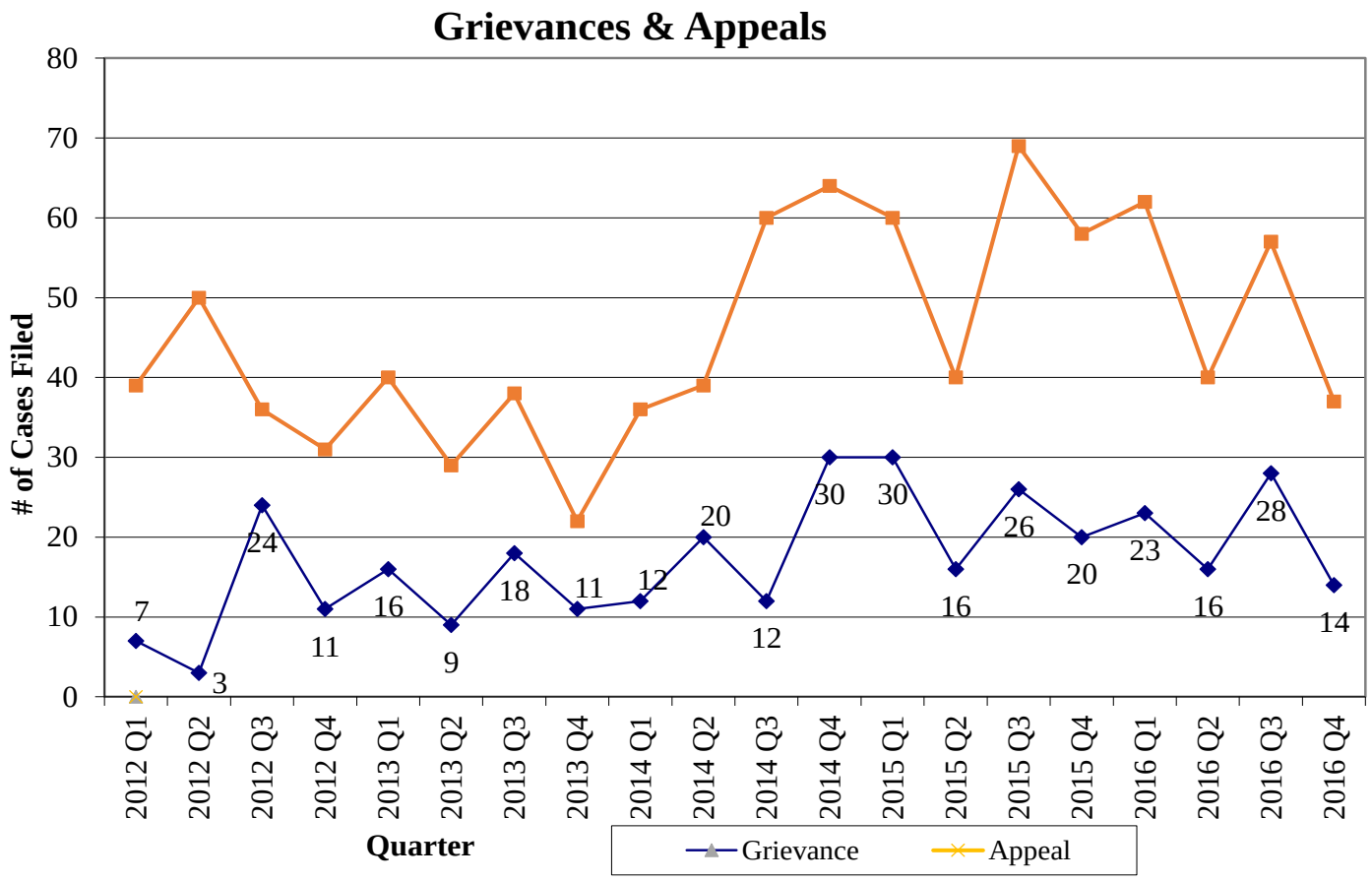
1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered service;
4. failure to provide a clinically indicated, covered service, when the Managed Care provider is a DA/SSA;
5. failure to act in a timely manner when required by state rule;
6. denial of a beneficiary's request to obtain covered services outside the network.

During this quarter, there were 37 appeals filed; 17 requested an expedited decision with seven of them meeting criteria. Of these 37 appeals, 30 were resolved (81% of filed appeals), and 7 were still pending (19%).

Of the 30 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 86% were resolved within 30 days. The average number of days it took to resolve these cases was 22 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days.

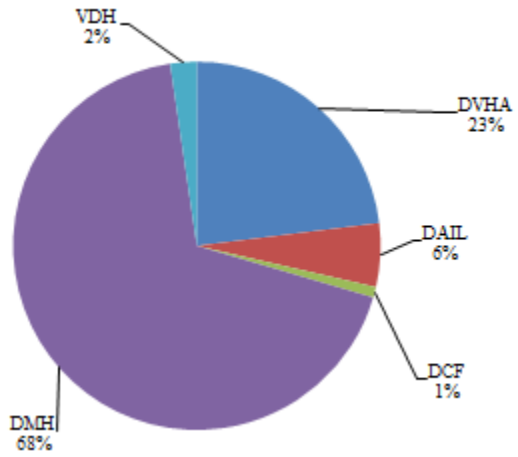
Of the 37 appeals filed, 20 were filed by beneficiaries (54%), and 17 were filed by a representative of the beneficiary (46%). Of the 37 appeals filed, DVHA had twenty-nine appeals filed (78%), DAIL had seven (19%), DMH and VDH had none.

Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were four fair hearings filed this quarter.

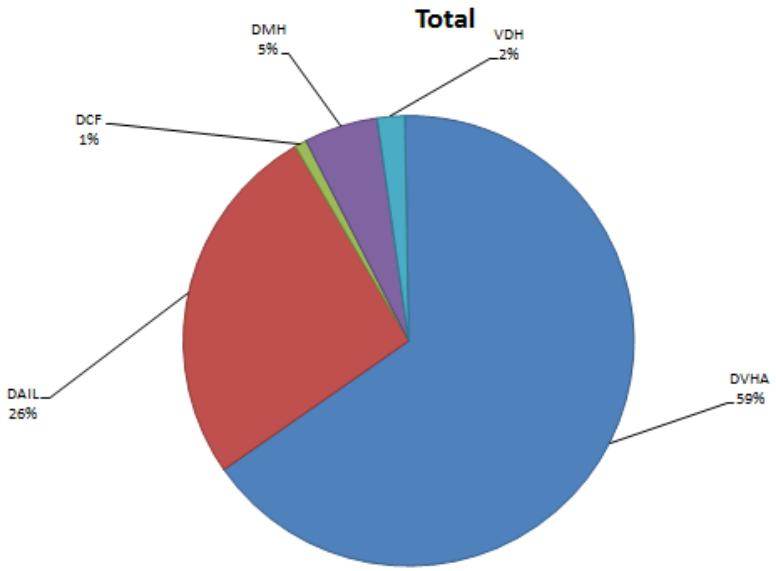


Grievance & Appeals by Department
From January 1, 2008 through December 31, 2016

Grievances



Appeals



Attachment 5

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

October 1, 2016-December 31, 2016

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

January 20, 2017

Vermont Legal Aid

Working for Justice

Table of Contents

Introduction 1

Highlights 1

Individual Consumer Assistance 2

Overview 2

Top Problem Areas 3

A. The HCA's overall call volume was lower than the last quarter, and lower than the call volume during the same quarter in 2015. The call volume was more in line with pre-VHC volume. 3

B. Vermont Health Connect call volume dropped by 20% compared with last quarter. The VHC escalation path is resolving complex cases more quickly and efficiently. 4

C. Vermont Health Connect invoice and premium cases decreased by 26%. 4

D. Vermont Health Connect Change of Circumstance calls decreased. 6

E. Calls about Premium Tax Credit (PTC) eligibility jumped by 22%. 6

F. Calls about V-Pharm and Medicare Savings Program eligibility increased. 7

G. The top issues generating calls 7

Recommendations for Vermont Health Connect 9

Case Results 9

A. Dispositions of Closed Cases 9

B. Case Examples 10

Consumer Protection Activities **13**

A. Rate Reviews 13

B. Certificate of Need 13

C. Other Green Mountain Care Board Activities 14

Hospital Budget Review 14

Accountable Care Organization Rule 14

D. All-Payer Model 14

E. Vermont Health Care Innovation Project (SIM Grant) 15

F. Affordable Care Act Tax-related Activities 15

G. Other Activities 16

Litigation 16

Administrative Advocacy 16

Legislative Activities 18

Collaboration with Other Organizations 18

Outreach and Education **19**

A. Website 19

Google Analytics Statistics 19
PDF Downloads 20
B. Education 20
Education/Outreach 20
Presentations 20
Promoting Plain Language in Health Communications 21

Introduction

The Office of the Health Care Advocate (HCA) provides individual consumer assistance as well as consumer advocacy on behalf of Vermonters on issues related to health insurance and health care. We engage in a wide variety of consumer protection activities on behalf of the public, including before the Green Mountain Care Board, other state agencies and the state legislature to promote improvements in access, quality and affordability.

The current report highlights some of VHC's gradual improvements over 2016. Even with the improvements, many Vermonters are still struggling to access and maintain health care coverage. The HCA gets many calls from consumers unable to navigate the complex health care system.

This is a precarious moment for consumers, health care providers, and carriers given the discussions of possible repeal of the ACA and changes in Medicaid funding. The uncertainty impacts Vermont consumers and makes the role of the HCA even more essential.

The HCA provides frontline support and advocacy for Vermonters who are trying to access affordable high quality health care coverage. We work to control unnecessary costs and make the health care system sustainable. The HCA also ensures that Vermont consumers are heard by policy-makers, providers, state agencies, and in the legislature.

The full quarterly report for October 1 – December 31, 2016 includes:

- This narrative, which contains sections on **Individual Consumer Assistance**, **Consumer Protection Activities** and **Outreach and Education**
- Seven data reports, including three based on the caller's insurance status:
  - **All calls/all coverages**: 883 calls (compared to 1019 last quarter)
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 269 calls (306 calls last quarter)
  - **Commercial plan beneficiaries**: 178 calls (254 calls last quarter)
  - **Uninsured Vermonters**: 126 calls (131 calls last quarter)
  - **Vermont Health Connect (VHC)**: 359 calls (449 calls last quarter)
  - **Two Reportable Activities (Summary & Detail)**: 75 activities and 15 documents (105 activities, 42 documents)

Highlights

- Total hotline call volume decreased (883 this quarter vs. 1018 last quarter).
- Vermont Health Connect calls dropped for the second quarter in a row.
- The Open Enrollment Period for VHC started on November 1. The HCA has been meeting with VHC regularly to address any OEP issues.
- We are resolving complex cases more quickly. The HCA escalated 77 complex cases to VHC this quarter, and 51 were resolved by the end of the quarter.
- The HCA advised on 38 appeals this quarter. Of the 38 appeals, 27 were fair hearings.
- The HCA saved consumers $297,584.82 in 2016.

- In December, the Vermont Supreme Court issued a decision agreeing with the HCA position that a Vermont consumer was eligible for Advanced Premium Tax Credit (APTC). The Human Services Board granted APTC to the spouse of an individual receiving Medicaid because he was a former foster child, and VHC appealed the decision. The spouse seeking APTC was unrepresented. The HCA argued that the consumer was eligible for APTC because her ability to enroll in her husband's employer-sponsored plan was conditioned on his enrolling - and that condition was unmet.
- The HCA successfully advocated for changes to Medicaid's restrictive coverage criteria for hepatitis C. Medicaid's Drug Utilization Review Board (DURB) voted in December to recommend covering treatment for patients with less severe liver disease, and for patients regardless of their substance use history. DVHA has accepted the DURB's recommendations. Once implemented, the changes will allow more Vermonters to access curative treatments for hepatitis C.
- The HCA continued to promote the use of plain language in VHC notices, so the information is more accessible and understandable to consumers.
- The number of people who used our website to find information and guidance on health care issues continued a pattern of strong growth with 48% more page views this quarter, compared with the same period in 2015.
- The number of people seeking information from our website about *dental services* increased significantly (72%) compared with the same period last year. Our Vermont Dental Clinics Chart was again the third most frequently downloaded of all PDFs downloaded from the Vermont Law Help website, and the top health PDF download.
- An increasing number of Vermonters are seeking out information about Medicaid for Children & Adults (MCA) and Dr. Dynasaur on our website. Half of the top 20 health topics focused on Medicaid or long-term care Medicaid (Choices for Care).

Individual Consumer Assistance

Overview

The HCA provides assistance to consumers through our statewide hotline (**1-800-917-7787**) and through the Online Help Request feature on our website, *www.vtlawhelp.org/health*. We have a team of advocates located in Vermont Legal Aid's Burlington office that provides this help to any Vermont resident free of charge, regardless of income.

The HCA received 883 calls[1] this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller's primary issue, were as follows:

- **23.56%** (208) about **Access to Care**
- **15.06%** (133) about **Billing/Coverage**
- **1.81%** (16) about **Buying Insurance**
- **11.10%** (98) about **Consumer Education**
- **30.92%** (278) about **Eligibility** for state and federal programs

[1] The term "call" includes cases we get through our website.

- **17.55%** (155) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved a particular issue. For example, although 273 of our cases had eligibility for state health care programs as the primary issue, a total of 610 cases had some eligibility issue listed as a secondary issue.

In each section of this Narrative, we indicate whether we are referring to data based on just primary issues, or primary and secondary issues combined. Determining which issue is the "primary" issue is sometimes difficult when there are multiple causes for a caller's problem. This has proven to be particularly true for Vermont Health Connect (VHC) cases. See the breakdowns of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues in addition to the "primary" reason for their call.

The most accurate information about eligibility for state programs is in the All Calls data report because callers who had questions about Vermont Health Connect and Medicaid programs fell into all three insurance status categories.

Top Problem Areas

A. The HCA's overall call volume was lower than the last quarter, and lower than the call volume during the same quarter in 2015. The call volume was more in line with pre-VHC volume.

Total call volume was lower than last quarter (883 vs. 1018). It was also lower than the call volume compared to the same quarter last year (883 vs. 1033). Our call volume is usually highest from January to March because most health care plans end on December 31, with a new plan year starting on January 1. The renewal process can trigger problems. The call volume appears to be returning to the pre-VHC call volume (883 this quarter vs. 950 calls for the same quarter in 2013).

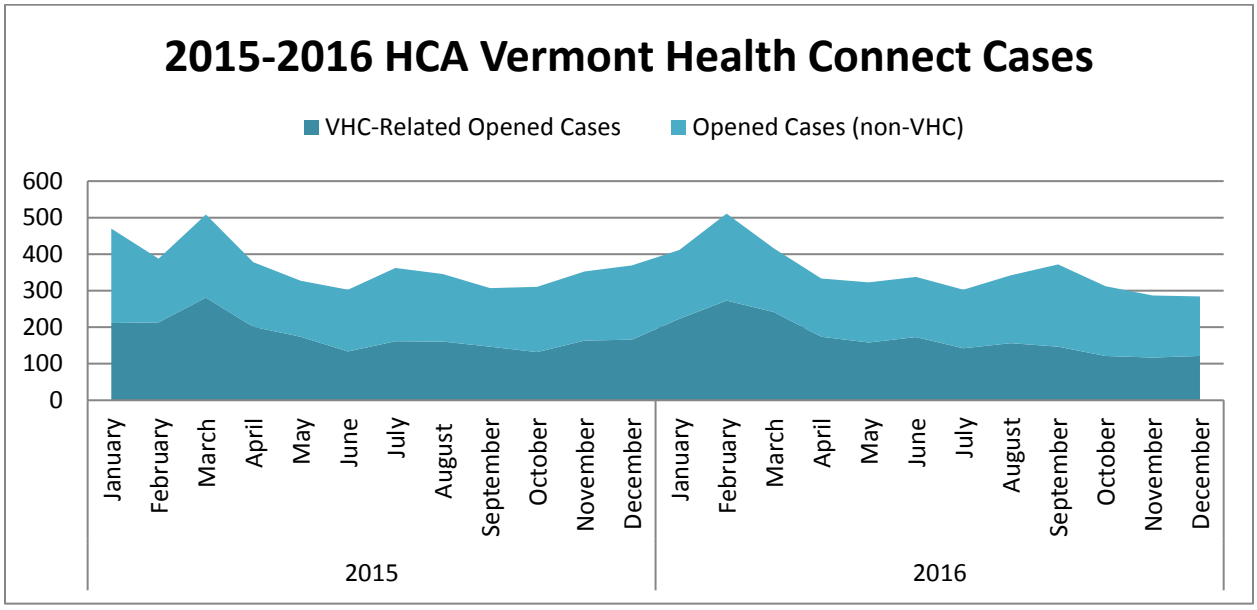
	All Calls (2006-2016)										
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
January	313	280	309	240	218	329	282	289	428	470	411
February	209	172	232	255	228	246	233	283	304	388	511
March	192	219	229	256	250	281	262	263	451	509	416
April	192	190	235	213	222	249	252	253	354	378	333
May	235	195	207	213	205	253	242	228	324	327	325
June	236	254	245	276	250	286	223	240	344	303	339
July	183	211	205	225	271	239	255	271	381	362	304
August	216	250	152	173	234	276	263	224	342	346	343
September	181	167	147	218	310	323	251	256	374	307	372
October	225	229	237	216	300	254	341	327	335	311	312
November	216	195	192	170	300	251	274	283	306	353	287
December	185	198	214	161	289	222	227	340	583	369	284
Total	2583	2560	2604	2616	3077	3209	3105	3257	4526	4423	4237

B. Vermont Health Connect call volume dropped by 20% compared with last quarter. The VHC escalation path is resolving complex cases more quickly and efficiently.

VHC call volume this quarter was 20% lower than last quarter (359 vs. 449), and there was a significant drop (22%) compared with the same quarter last year (359 for 2016 vs. 461 for 2015).

Even though VHC call numbers dropped, consumers are still having significant problems. VHC cases still represented 41% of the HCA's total calls in 2016. Of all VHC cases, 29% required complex interventions that took more than two hours of an advocate's time to resolve (103 complex interventions out of 359 total VHC cases). We also remain concerned about consumers who are trying to navigate VHC to resolve problems on their own.

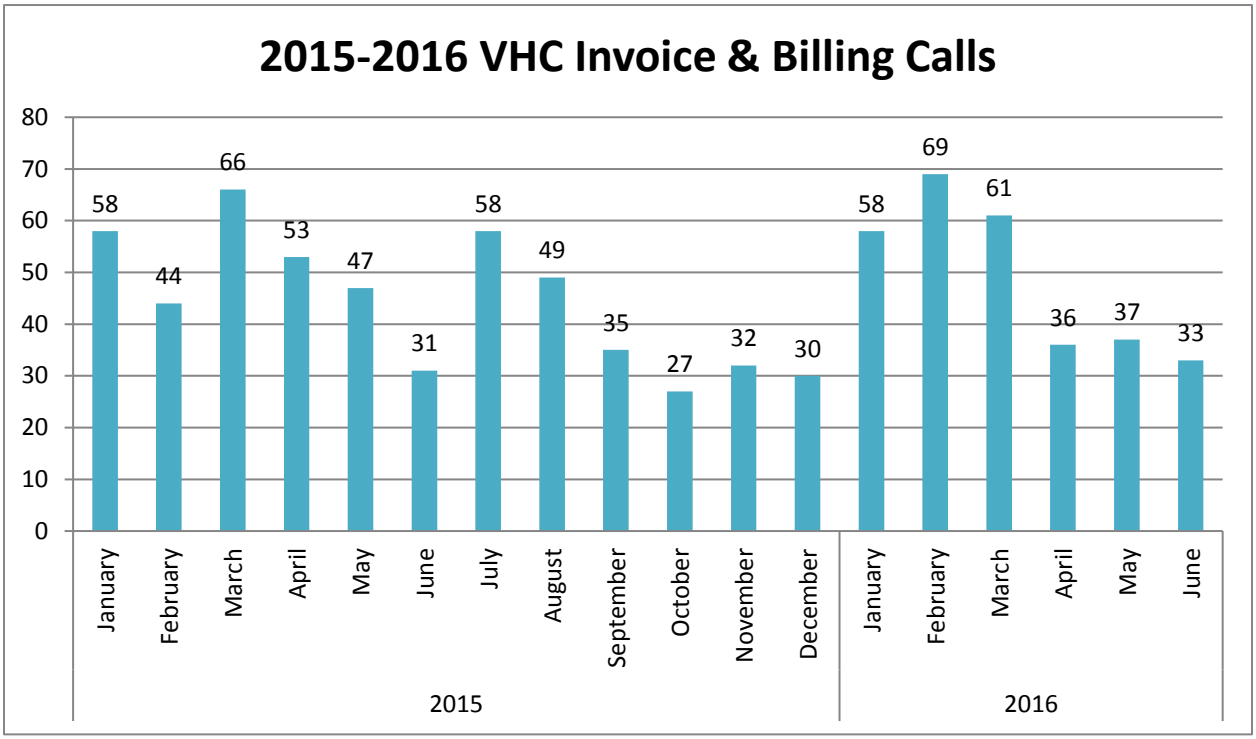
The HCA has been using VHC's new escalation path for about six months now. The process allows the HCA to work directly with a Tier 3 Health Access Eligibility Unit (HAEU) worker, who is trained to resolve all aspects of complex cases. In addition, the HCA meets with VHC each week to discuss cases as needed, and has regular email contact with Tier 3. During the first quarter of 2016, before the new escalation path was launched, the HCA was carrying 75-80 complex cases per week. That number gradually decreased to 40-50 per week, and now, because the new escalation process allows complex cases to be resolved more quickly and efficiently, the HCA generally carries fewer than 20 unresolved complex cases per week. This quarter, the HCA escalated 77 complex cases, and 51 were resolved within the quarter.



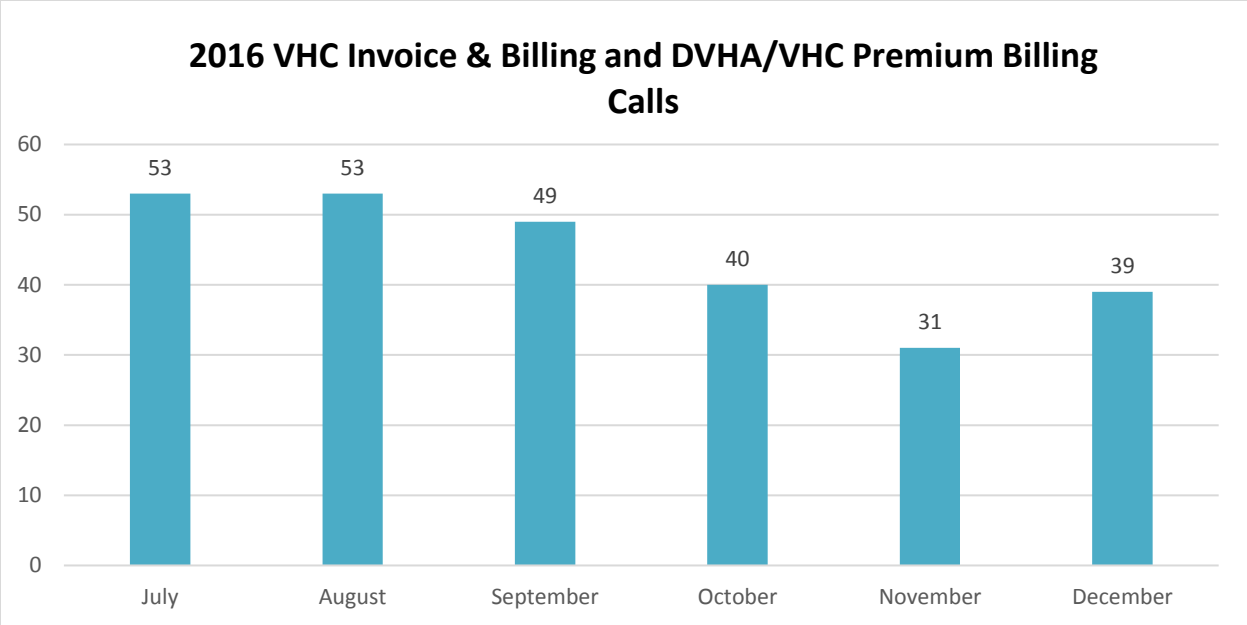
C. Vermont Health Connect invoice and premium cases decreased by 26%.

VHC continued to improve its ability to generate accurate and timely invoices for consumers. The HCA has also seen improvement in VHC's ability to resolve billing problems. This quarter, the HCA received a total of 117 calls about billing issues (52 about DVHC/VHC premium issues and 65 about VHC invoice/billing problems affecting eligibility). Last quarter the HCA received 158 calls about billing issues (99 about DVHA/VHC premiums issues, and 59 about VHC invoice/payment billing problems affecting eligibility). When we combine those two categories of billing issues, billing was

the second most common issue for the quarter.[2] The specific billing problems included inaccurate invoices, payments not applied correctly, and payments not reflected on the invoices**.** The billing problems can easily turn into access to care cases when a mistake in the invoice causes a consumer's coverage to be erroneously cancelled.

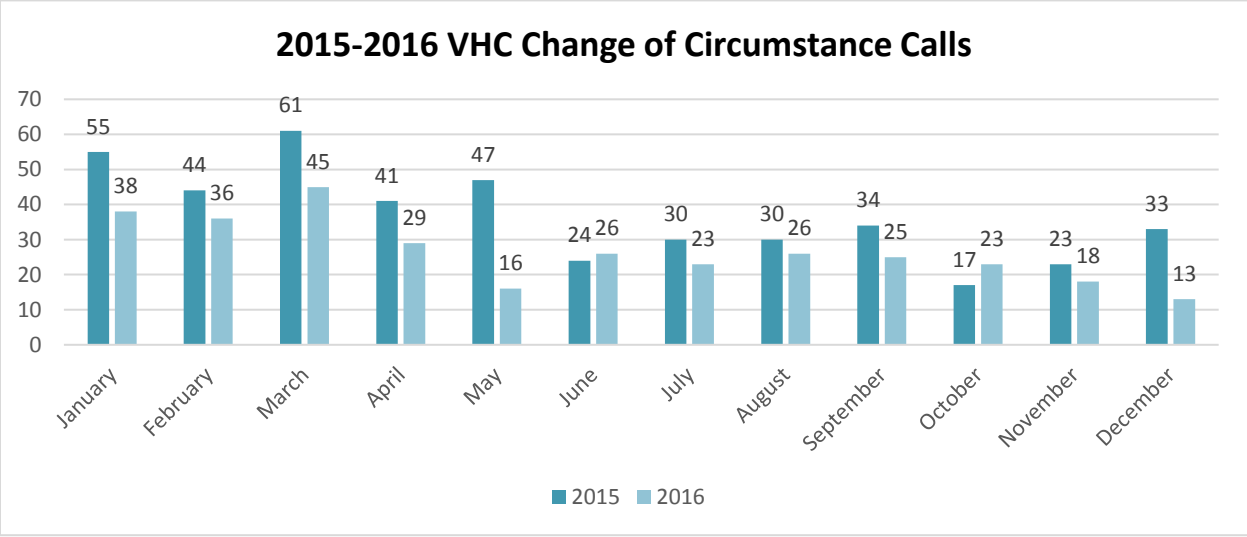


[2] In the third quarter the HCA revised how we code VHC billing cases. Now cases with general VHC billing problems are billed under DVHA/VHC premium issues. If the billing problem directly impacts eligibility, it is billed under VHC invoice/payment issues affecting eligibility. This change resulted in a drop in the number of cases coded for VHC invoice/billing problems affecting eligibility and an increase in the cases coded for general VHC billing problems. Both codes represent VHC billing problems. As a result, the data can no longer be represented in one chart.



D. Vermont Health Connect Change of Circumstance calls decreased.

The HCA received 54 Change of Circumstance calls this quarter, compared with 74 last quarter (in a 27% decrease). VHC has been resolving the Change of Circumstances cases much more quickly, and we are getting fewer calls from consumers complaining about processing delays. As a result, the HCA has had to escalate far fewer Change of Circumstance cases (318 total for 2016 vs. 439 for 2015).



E. Calls about Premium Tax Credit (PTC) eligibility jumped by 22%.

The HCA received 95 calls from consumers related to their eligibility for the Premium Tax Credit (PTC), compared to 78 last quarter. It is unsurprising that there was an increase in calls in this area. With the start of the Open Enrollment Period on November 1, consumers were reviewing plan selection and reporting changes. The changes have the potential of impacting eligibility for PTC. These calls are

relatively complex because the HCA advises consumers regarding their eligibility for PTC. If consumers are eligible, the HCA also calculates how much PTC they should be receiving. If consumers receive more PTC then they are eligible for, they may have to pay some or all of it back when they file their taxes. This process is called reconciliation. The HCA received 39 calls involving reconciliation this quarter.

F. Calls about V-Pharm and Medicare Savings Program eligibility increased.

The HCA had 42 cases involving V-Pharm eligibility compared to 29 last quarter. Open enrollment for Part D plan runs from October 15 to December 7 each year. It makes sense that when consumers were reviewing their Part D plan, they would also have questions about their eligibility for V-Pharm. V-Pharm helps reduce Part D expenses. The HCA had 55 cases about Medicare Saving Program (MSP) eligibility compared to 48 last quarter. The MSPs help reduce out-of-pocket Medicare costs by paying for the Part A and/or the Part B premiums for eligible beneficiaries. The HCA also had 36 cases where we gave advice on Medicare eligibility**.**

G. The top issues generating calls

The issues listed in this section include both primary and secondary issues, so some may overlap.

All Calls 883 (compared to 1018 last quarter)

1. MAGI Medicaid eligibility 130 (126)
2. VHC Premium Tax Credit eligibility 95 (78)
3. Complaints about providers 75 (81)
4. VHC invoice/billing problem affecting eligibility 65 (59)
5. VHC complaints 59 (63)
6. Information/applying for DVHA programs 59 (58)
7. Access to prescription drugs 56 (76)
8. Buy-in programs/Medicare Savings Programs 55 (48)
9. VHC Change of Circumstance 54 (74)
10. DVHA/VHC premium billing 52 (99)
11. Medicaid eligibility (non-MAGI) 44 (52)
12. HAEU mistake 43 (37)
13. VPharm eligibility 42 (29)
14. Consumer education about IRS reconciliation 39 (32)
15. Affordability affecting access to care 38 (25)
16. Consumer education about Medicare 36 (41)
17. Confusing notice related to eligibility 35 (45)
18. Information about VHC 33 (27)
19. Special Enrollment Periods (eligibility) 32 (49)
20. Medicaid spend down (eligibility) 31 (21)
21. VHC renewals (eligibility) 27 (6)

Vermont Health Connect Calls 359 (compared to 442 last quarter)

1. MAGI Medicaid eligibility 121 (116)
2. Premium Tax Credit eligibility 94 (75)

3. VHC invoice/payment/billing problem affecting eligibility 65 (55)
4. VHC complaints 59 (62)
5. Change of Circumstance 52 (65)
6. DVHA/VHC premium billing 48 (94)
7. Termination of insurance 43 (50)
8. HAEU mistake 39 (36)
9. Consumer education about IRS reconciliation 39 (31)
10. Information about VHC 32 (22)
11. VHC renewals (eligibility) 27 (6)

DVHA Beneficiary Calls 269 (compared to 300 last quarter)

1. MAGI Medicaid eligibility 58 (46)
2. Information/applying for DVHA programs 29 (26)
3. Complaints about providers 27 (33)
4. Medicaid eligibility (non-MAGI) 20 (20)
5. Confusing notice 16 (14)
6. VHC Premium Tax Credit eligibility 16 (9)
7. Buy-in programs/Medicare Savings Programs 16 (9)
8. Change of Circumstance 15 (19)
9. Provider billing problems 15 (1)
10. Medicaid/VHAP Managed Care Billing 14 (11)
11. VPharm eligibility 13 (10)
12. Access to dental care 10 (6)
13. Home health 10 (1)
14. PA Denial 10 (7)
15. Transportation 9 (18)
16. Medicaid Renewal/Review 9 (14)
17. Consumer education about Medicare 9 (10)

Commercial Plan Beneficiary Calls 178 (compared to 252 last quarter)

1. Premium Tax Credit 51 (46)
2. VHC invoice/payment/billing problem related to eligibility 36 (48)
3. DVHA/VHC premium billing 30 (69)
4. Consumer education about IRS reconciliation 26 (22)
5. VHC complaints 24 (37)
6. Change of Circumstance 22 (40)
7. VHC renewals (eligibility) 21 (3)
8. MAGI Medicaid eligibility 19 (23)
9. HAEU mistake 14 (13)
10. Grace periods – VHC 12 (28)

H. The top issues generating calls

The HCA received 883 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as "dual eligible"): 30% (265 calls), compared to 31% (316 calls) last quarter
- **Medicare[3] beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 30% (316 calls), compared to 26% (266) last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans): **18%** (159), compared to 22% (220) last quarter
- **Uninsured: 14%** (124) of the calls, compared to 13% (132) last quarter

Recommendations for Vermont Health Connect

1. Continue to work on making all VHC notices more readable, accurate, timely and understandable.
2. Continue to work on the accuracy of advice from both the call center and HAEU (Health Eligibility Access Unit). The call center is the main source of contact with VHC for most consumers.
3. Continue to work on the billing system, so consumers receive timely and accurate invoices.
4. Continue to support and train navigators and assistors and work with other community stakeholders.

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 913 cases this quarter, compared to 1,059 last quarter:

- 28% (256 cases) were resolved by brief analysis and advice
- 27% (249) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time
- 26% (240) were resolved by brief analysis and referral
- 11% (103) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases (65), clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 38 individuals with appeals: 27 Fair Hearings, 2 Medicaid MCO Internal appeals, 2 Commercial Insurance – Internal 2nd Level appeals, 2 Commercial Insurance – Internal 1st Level appeals, 4 Commercial Insurance – External appeals, and 1 Medicare Part A, B, or C Appeal.

[3] Because Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with the figures for those categories.

DVHA Beneficiary Calls

We closed 274 DVHA cases this quarter, compared to 315 last quarter:

- 36% (99 cases) were resolved by brief analysis and/or advice
- 24% (67) of the cases were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 23% (62) were resolved by brief analysis and/or referral
- 13% (35) of the cases were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 5 DVHA beneficiaries with appeals: 3 Fair Hearings and 2 Medicaid MCO Internal appeals

Commercial Plan Beneficiary Calls

We closed 284 cases involving individuals on commercial plans, compared to 345 last quarter:

- 22% (62 cases) were resolved by brief analysis and/or advice
- 14% were resolved by brief analysis and/or referral
- 39% (112) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 19% (55) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 34 commercial plan beneficiaries with appeals: 4 Commercial Insurance – External appeals, 2 Commercial Insurance – Internal 1st Level appeals, 2 Commercial Insurance – Internal 2nd Level appeals, 25 Fair Hearings, and 1 Medicaid Part A, B, or C appeal.

All Calls Case Outcomes

The HCA helped 91 people get enrolled in insurance plans and prevented 14 insurance terminations or reductions. We obtained coverage for services for 20 people. We got 20 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 34 more. We provided other billing assistance to 28 individuals. We provided 499 individuals with advice and education. Four people were not eligible for the benefit they sought, and five were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 82 more people.

B. Case Examples

These case summaries illustrate the types of problems we helped Vermonters resolve this quarter:

Lisa was nearly out of her insulin when she discovered that her Medicaid had closed. She called the State of Vermont and had been told that she would need to re-apply for Medicaid to see if her

family was still eligible. The family would need to have their income verified—this meant that Lisa would need to get pay stubs to prove the family's income. The whole process could take weeks—and by that time Lisa would be out of insulin and unable to pay for it. The HCA advocate investigated why Lisa's Medicaid had closed and found that the State of Vermont had failed to send a termination notice. Before the State of Vermont can close someone's Medicaid, the State needs to give prior notice. It did not send Lisa any notice that her Medicaid was about to close. The HCA advocate pointed out the error—and the State of Vermont reinstated the Medicaid coverage for another month. This gave Lisa enough time to complete a new Medicaid application—and meant that she was able to fill her prescriptions. This quarter, MAGI Medicaid eligibility was the top issue for all calls. The HCA advocates worked on 130 cases about Medicaid eligibility. They advised 27 families on Medicaid renewals, and they prevented 14 families from having their insurance terminated.

Mary called the HCA because her Social Security check had dropped to less than $500 per month. She had received a letter from the Social Security Administration telling her that the State of Vermont would no longer be paying for her Medicare Part B premium. This meant that the Part B premium would be coming out of her monthly Social Security check. Mary did not understand why she was no longer eligible—her household's income had actually decreased. The advocate found that Mary and her husband had both been on a Medicare Savings Program (MSP), which meant that the State of Vermont paid the Medicare Part B premium for them. They had also been on V-Pharm 1, which helped keep their co-payments for prescriptions low. They had re-applied for those programs, but the State of Vermont had found them ineligible. The advocate discovered that the State had made an error in counting the household income. It was counting income from a business that Mary and her husband were no longer operating. Mary and her husband had also received a one-time lump sum payment, and this was being counted as a recurring payment. When their income was counted correctly, both Mary and her husband were found eligible and were put back on the programs to the date of application. The HCA worked on 55 cases on MSP eligibility this quarter, and advised 42 households about V-Pharm eligibility this quarter.

Katherine called the HCA because she could not afford her monthly health insurance premium. She had been on Medicaid earlier in the year, but VHC had reviewed her eligibility and found her ineligible for Medicaid. She was enrolled in a Qualified Health Plan (QHP) on VHC, but it was too expensive for her. Katherine had heart surgery scheduled, and she could not have a lapse in her coverage. When the advocate looked at Katherine's information, she found that VHC was counting her income incorrectly. Katherine was a home care provider, which meant that she cared for a disabled individual who lived in her home. She was receiving a 'difficulty of care' stipend each month for this care. The IRS considers Katherine's stipend to be non-taxable income. This means that VHC should not have included it when it calculated Katherine's eligibility for Medicaid. When the income was properly calculated, Katherine was found eligible for Medicaid. The HCA advocate was able to get the Medicaid reinstated back to the time that it was closed, and Katherine was refunded the premiums she paid for her QHP. The HCA had 43 cases involving eligibility mistakes this quarter, and it saved consumers $61,393 this quarter.

When Paul received his invoice for his QHP on VHC for 2017, the amount was more than double what he had been paying. He could not afford to pay that amount. When the advocate investigated, she found that he been found ineligible for premium tax credits (PTC). The PTC helped reduce his monthly premium by hundreds of dollars a month. VHC said that the reason he was ineligible was that he had failed to file his taxes. If a consumer receives PTC, they need to file taxes and

"reconcile" the amount of PTC that they received during the year. During that process, the IRS checks to see if the consumer received the correct amount of PTC based on their yearly income. If you do not file your taxes and reconcile, you will not be able to get PTC the following year. Paul had filed his taxes. That meant he was eligible for PTC. When VHC did his renewal, however, an error showed he had failed to file taxes and reconcile. The HCA advocate pointed out the error, and VHC restored Paul's subsidies. After his subsidies were restored, his premium was reduced by over $250 dollars per month. The HCA advises consumers all year round on tax issues related to the ACA. This quarter, it advised 39 households about IRS reconciliation. The HCA also worked on 95 cases related to PTC eligibility, which is the second-highest issue generating calls.

Elizabeth called the HCA because she had an appointment with a specialist, but she did not have a way to get to that appointment. She was not able to drive and did not have a car. In the past, she always relied on Medicaid transportation to get to her appointments. When she tried to schedule a ride, however, she was told that she was no longer had Medicaid. She had filled out a new application, and had believed she had been all set. Then, she had received a letter asking her to fill out another application. So she had filled out a second application, but she was still being told that she did not have coverage. The HCA advocate looked into the problem, and found that Elizabeth had completed the wrong Medicaid application the first time she applied. Elizabeth is eligible for Medicaid for the Aged, Blind and Disabled (MABD). This type of Medicaid has a different application than the Medicaid on VHC (Medicaid for Children & Adults). The advocate found out that the State of Vermont did have Elizabeth's second and correct application, but it had not been processed yet. The advocate intervened and asked for that application to be processed immediately. It was processed and Elizabeth was found eligible for MABD. She was able to schedule her ride and get to her appointment. The HCA worked on 44 MABD Medicaid eligibility cases this quarter. It also intervened and advised on 9 Medicaid transportation cases.

John needed to pick up his heart medication, but when he went to the pharmacy he found out that he was no longer on Medicaid. He could not afford to pay for his medication. When he called the State of Vermont, he found that his Medicaid had been closed because he had not filled out his Medicaid renewal. The State of Vermont had sent him renewal paperwork, but it had been sent to an old address. The mail had not been forwarded, and John never received it. John was now homeless, unemployed and had no income. The HCA advocate intervened and argued that John should be reinstated because of the error in sending the renewal paperwork. VHC reinstated the coverage the same day. This meant that John was able to pick up his heart medication. He also had time to fill out a new Medicaid application. The HCA worked on 56 cases this quarter where consumers encountered problems getting their prescription drugs.

Back to Table of Contents

Consumer Protection Activities

A. Rate Reviews

The HCA monitors all commercial insurance carrier requests to the Green Mountain Care Board for changes in premium rates. These are usually requests for rate increases. One new rate review case was filed at the end of the quarter by Cigna. It covers the insurer's manual rating formula for large employer groups. The Board and the HCA will review this filing in the next quarter.

The HCA participated in two pending MVP rate review cases during the quarter. The first shows the premium rate development for MVP's large group EPO/PPO products for the first and second quarters of 2017 including high deductible health plans and non-high deductible plans. The proposed rates in this filing will affect approximately 2,234 Vermonters. The HCA argued that the Contribution to Surplus should be reduced from 2% to 1% but the Board approved the filing without modification. The second MVP filing included proposed quarterly rate increases for MVP's small group grandfathered EPO/PPO product portfolio. This is a closed block of business. As of June 2016, 1,933 members were enrolled in the plans affected by this rate filing. The proposed filing would result in a 9% annual rate increases for first quarter 2017 group renewals, and a 10.5% increases for second quarter group renewals. The HCA asked the Board to eliminate the Contribution to Surplus for the filing but the Board approved the request as filed.

The HCA also continued its work as a party in the Vermont Supreme Court's review of the Board's December 2015 decision disapproving the rate request for five plans offered by the Agriservices Association. Agriservices, an association for farmers, used MVP's large group Minimum Premium Plan funding arrangement for grandfathered plans with a contract renewing with a December 1, 2015 effective date. MVP requested a very large average annual rate increase of 26.9%. The HCA asked the Board to disapprove the requested rates and the Board's December 2015 decision disapproved the increase. In January 2016, MVP asked the Board to reconsider its decision. The HCA opposed this request and the Board refused to change its initial decision. MVP then appealed the Board's decision to the Vermont Supreme Court. MVP claimed that the criteria used by the Board in denying the rate increase were unconstitutionally vague or in the alternative that the Board's findings of fact and conclusions were not consistent with the standards in the rate review statute. The HCA asked the Supreme Court to find the statute constitutional and uphold the Board decision, and the Solicitor General also asked the Court to affirm the Board's decision. The Supreme Court issued its decision on September 23, 2016. It found the rate review statute constitutional but agreed with MVP's argument that the Board's conclusions of law were not supported by specific findings of fact that related to the statutory criteria. The Court sent the case back to the Board for new findings.

MVP and the HCA both submitted proposed findings of fact and conclusions of law for the Agriservices case in October. The Board issued its Amended Order and Decision in November. The Board again disapproved the requested rate increase in the new Order. MVP and Agriservices decided not to continue to offer the Agriservices products in 2017, so there was no new filing during 2016.

B. Certificate of Need

In October, the HCA submitted a notice of intervention in response to Manchester Emergency Center's proposal to open a new emergency/urgent care facility. The medical center withdrew the application in December.

During the last quarter, the HCA continued to participate in the Board's ongoing review of Green Mountain Surgery Center's proposal to create an ambulatory surgery center. When the Board asked the

center to submit information on project investors, the center asked that the information be kept confidential from the interested parties in the matter. The center argued that the information could be used to retaliate against the physician investors because the interested parties in this matter included the Vermont Association of Hospitals and Health Systems and Northwestern Medical Center, both of which potentially employ some of the investing physicians. The Board granted the confidentiality request. The HCA successfully argued that it should be exempt from this ruling because of the HCA's important role protecting the interests of Vermont consumers and because the HCA does not pose a threat of retaliation against the physician investors. The Board agreed with the HCA and ruled that the HCA will continue to be given access to all documents in the matter.

C. Other Green Mountain Care Board Activities

In the past quarter, the HCA attended eight weekly Board meetings and one advisory committee meeting.

Hospital Budget Review

The HCA took advantage of a new opportunity in 2016 to protect consumer interests through an expanded role in the Green Mountain Care Board's Hospital Budget Review process. This new role developed from changes to Act 152, which gave the HCA the right to pose written questions to Green Mountain Care Board staff and to the hospitals regarding the hospitals' budget submissions, and to ask questions and provide testimony at the Hospital Budget hearings, in addition to providing written comments after the hearings. In our role, we focused on the hospitals' community benefit activities, health care reform work to lower costs and improve quality, services related to substance abuse and mental health support, and justifications for their requested budget increases. In the last quarter, we attended one Green Mountain Care Board hospital budget hearing on Copley Hospital's proposed revisions to its FY17 budget. In December, we submitted formal comments to the Board about the Board's draft rule regarding physician transfers and acquisitions. We pointed out that the draft rule was not clear that the rule should only apply to transfers and acquisitions within the Vermont health care system. In response to our comment, the Board changed the language.

Accountable Care Organization Rule

Last quarter the Board convened a stakeholder group to begin working on the Accountable Care Organization Rule required by Act 113 of 2016. The HCA attended the first meeting of the group which occurred in December.

D. All-Payer Model

During the last quarter the Green Mountain Care Board, Agency of Administration, and Agency of Human Services proposed and then signed an all-payer model (APM) agreement for the state, which will be implemented by a unified Accountable Care Organization (ACO). The HCA reviewed the proposed agreement and submitted formal comments to the Administration and the Board. We also submitted a letter of support for the model to Governor Shumlin that expressed agreement with the model's goals to increase quality and lower costs, as well as significant concerns about its implementation. The letter expressed that our support of the APM is contingent on the ways in which important issues of concern to consumers, including robust regulatory structures, are addressed in the model's implementation, as well as on adequate funding of the state's Medicaid program. We detail our consumer protection concerns about the APM in our paper: *Consumer Principles for Vermont's All-Payer Model*.

E. Vermont Health Care Innovation Project (SIM Grant)

This quarter the HCA continued to participate in the Vermont Health Care Innovation Project (VHCIP), which is funded by a federal State Innovation Model (SIM) grant. The prior Chief Health Care Advocate was a member of the VHCIP Steering Committee until her retirement on August 31. The Steering Committee had its final two meetings this quarter which the HCA's policy analyst attended in the Chief's absence. The HCA participated, along with representatives from other projects of Vermont Legal Aid, as "active members" in five of the six VHCIP work groups: Payment Model Design and Implementation, Practice Transformation, Health Data Infrastructure, Disability and Long Term Services and Supports, and Population Health. This quarter we participated in six VHCIP work group meetings, including the final meetings of the Payment Model Design and Implementation work group, the Health Data Infrastructure Work Group, and the Population Health work group.

We continued to monitor the activities of the VHCIP Core Team and attended one Core Team meeting as an interested party. The HCA is a participant in the VHCIP Self-Evaluation Committee and attended one meeting of the committee this quarter. The HCA is a participant in the VHCIP Sustainability Planning Group and attended three meetings of the group this quarter. We also participated in one VHCIP webinar on the Shared Savings Program Year 2 results, and one meeting convened by the VHCIP and the Administration about Delivery System Reform grants.

F. Affordable Care Act Tax-related Activities

During this quarter the HCA continued tax-related assistance, advocacy, and outreach efforts. We participated in a stakeholder workgroup on QHP renewals and open enrollment issues, to ensure that consumers experienced as smooth a transition as possible from 2016 to 2017 plans. We commented on notices to consumers affecting their eligibility for tax credits. The HCA also continued to receive and escalate cases with VHC involving APTC reconciliation and forms 1095-A.

The HCA continued to employ a half-time tax attorney, who also staffs the Low-Income Taxpayer Clinic at VLA. This arrangement has allowed the HCA to stay up to date on tax law developments, and enables our staff to effectively field calls related to the ACA and VHC.

As in prior quarters, the HCA's tax attorney consulted with HCA advocates when particularly difficult IRS-related issues arose in HCA cases. During this quarter, the tax attorney advised the HCA on 9 technical assistance questions and accepted one tax case referred from the HCA. She also responded to 32 technical assistance questions from assisters, Vermont tax preparers, and legal services attorneys in other states. This quarter saw more questions about exemptions from the ACA penalty. We also saw an increase in more complex financial eligibility determinations related to federal taxable income. The HCA continued to get both consumer and technical assistance questions on IRS procedures and consumer rights after a tax return is filed. One consumer was referred to the HCA's tax attorney for assistance with an IRS audit of her Premium Tax Credit.

This quarter the Vermont Supreme Court issued its decision in the *In Re J.H.* case, involving eligibility for premium subsidies through VHC. The HCA participated in the case as *amicus curiae*, friend of the court. The Court decision adopts the HCA's legal argument and allows J.H. to receive premium subsidies, because she cannot enroll in employer-sponsored insurance unless her husband changes his mind and decides to also enroll. The decision interpreting federal regulations rejects an unjust outcome for consumers in J.H.'s situation. The HCA's tax attorney was interviewed about the case for Vermont Public Radio.

The HCA also engaged in significant tax-related outreach and education activities this quarter. These are detailed below in the **Outreach and Education** section.

G. Other Activities

Litigation

✧ In Re: J.H.

As described above under **Affordable Care Act Tax-Related Activities**, the HCA participated as *amicus curiae* in a Vermont Supreme Court appeal involving eligibility for QHP subsidies under federal tax law. The Court's decision was issued this quarter. In it, the Court adopted the HCA's legal reasoning.

Administrative Advocacy

✧ Access to Treatment for Hepatitis C Virus

This quarter the HCA worked with a coalition of organizations to improve access to treatment for Hepatitis C Virus (HCV) for Vermont Medicaid beneficiaries. In October, the HCA sent a letter to DVHA's Drug Utilization Review Board (DURB) on behalf of the coalition requesting that the DURB review and remove Medicaid's restrictive and illegal criteria for accessing curative HCV treatment. Four individual health care providers and the Vermont Medical Society also sent letters supporting our request. Staff members from the HCA, the ACLU, and Vermont CARES testified at the December meeting of the DURB and at that meeting the DURB voted to reduce the level of liver damage required for treatment of HCV, and to stop restricting patients with current or past substance use from accessing treatment. We are continuing to advocate for implementation of these changes at DVHA, and for giving all patients access to treatment for HCV as is recommended by nationally-accepted medical guidelines.

✧ Billing and Enrollment Work Group

The HCA is participating in this stakeholder group, which was convened by VHC to review and recommend changes to VHC's billing and enrollment process and timeline.

✧ Controlled Substance and Pain Management Advisory Council

Act 173 of 2016 created this council to advise the Commissioner of Health on matters related to the Vermont Prescription Monitoring System, the appropriate use of controlled substances in treating pain, and preventing prescription drug abuse, misuse, and diversion. This quarter the HCA attended the public hearing on the proposed rules for opiate prescribing and the Vermont Prescription Monitoring System, submitted comments to the Department of Health on the two proposed rules, and attended the Legislative Committee on Administrative Rules hearings on the rules.

✧ HIT Plan Interim Governance Team

The state's HIT Plan creates an Interim Governance Team responsible for developing recommendations for the Secretary of Administration to provide to the next Administration. The HCA is participating in this group, which includes state employees and stakeholders. We attended two meetings of the governance team this quarter.

✧ Health Care Administrative Rules (HCAR)

In September, VLA's Disability Law Project and the HCA submitted formal comments on proposed Health Care Administrative Rules (HCAR) as part of the Administrative Procedure Act's formal rulemaking process. We asked for changes to the proposed rules for Specialized Services and Programs and for the definition of Early Periodic Screening, Diagnostic and Treatment services, and argued against the

elimination of some non-eyewear aids to vision. During the quarter, the Department of Vermont Health Access (DVHA) made changes to address our concerns in the final proposed version of the regulations.

The HCA also participated in an informal meeting with DVHA and other Vermont Legal Aid attorneys to discuss the HCAR rule-making schedule and process.

✧ 2018 Qualified Health Plan (QHP) Work Group

The HCA is participating in this stakeholder group, which was convened by DVHA to help develop any recommended changes to benefit design for QHPs offered on Vermont Health Connect in 2018. The legislature set up a process to discuss the effect that the maximum out-of-pocket expense limit for prescription drugs in Vermont law has on plan design, especially at the bronze plan metal level. The work group is also reviewing other plan design changes. We attended three meetings of the group during the quarter.

✧ Rule 09-03 Work Group and regulations

The HCA was actively involved in this work group, which was set up in Act 54 of the 2015 legislative session. The group's purpose was to help the Agency of Administration, the Green Mountain Care Board, and the Department of Financial Regulation (DFR) evaluate the necessity of maintaining provisions for regulating commercial insurers that were included in Rule 09-03. The existing rule contained consumer protection and quality requirements for insurers in areas such as the adequacy of provider networks and the way insurers conduct prior authorization reviews for requested services. The group also reviewed reporting requirements for the insurers that provide details about the claims for covered services that are denied.

The HCA advocated for provisions in the statute and rule that would maintain regulatory protections for consumers in commercial health care plans, would improve the reports insurers provide about denied claims, and would require DFR to file quarterly reports showing how many complaints are filed about violations of the consumer protection standards in Rule 09-03. The Administration presented proposed language for statutory changes to implement the work group's proposals in S.255, and the HCA testified about this bill. DFR and the HCA negotiated a compromise section requiring annual reports about the complaints DFR receives about violations of the rule, aggregated for all insurers. After S.255 (Act 152) passed during the 2016 legislative session, the work group met to discuss the rule before the Administration began the formal rule-making process under the Administrative Procedures Act. The formal rule was filed in August. The HCA did not have any issues with the rule as filed. The Legislative Committee on Administrative Rules reviewed and approved the rule in December.

✧ Qualified Health Plan (QHP) Certification Work Group

In May 2016 DVHA developed a draft QHP certification and direct enrollment rule, *Standards for Issuers Participating in the Vermont Health Benefits Exchange*. DVHA began the formal rule making process in July, and the HCA submitted comments on the regulations. During the quarter the HCA attended a meeting with DVHA to discuss remaining issues with the regulations prior to a meeting of the Legislative Committee on Administrative Rules scheduled in November. DVHA decided to withdraw the rule immediately prior to the LCAR meeting. DVHA did not want to include provisions about retroactive account changes and billing and enrollment in the regulations but convened work groups to discuss these issues. The HCA has participated in these work groups.

✧ **Vermont Health Connect Escalation Path**

The HCA and VHC continued to collaborate on improving the State's escalation path for HCA cases involving complex VHC issues. We communicate with VHC multiple times a day and meet as needed to discuss the most difficult cases. With the latest version of our escalation path, we have begun to resolve cases more quickly and efficiently.

✧ **Comments on Vermont Health Connect Notices**

At VHC's request, the HCA commented on five notices, in an effort to make them more readable and consumer-friendly. See **Promoting Plain Language in Health Communications** below.

✧ **Medicaid and Exchange Advisory Board**

The Chief Health Care Advocate was an active participant in Vermont's Medicaid and Exchange Advisory Board (MEAB) until her retirement at the end of August 2016. The HCA attended two meetings of the MEAB in October and November and expects that the new Chief Advocate will be appointed to the MEAB in 2017**.**

Legislative Activities

This quarter, the HCA monitored the activity of joint committees that took up issues related to health care. We attended two meetings of the Health Reform Oversight Committee, one meeting of the Joint Fiscal Committee, and three meetings of the Legislative Committee on Administrative Rules.

Collaboration with Other Organizations

The HCA regularly collaborates with other organizations to advance consumer-oriented policy objectives. We worked with the following organizations this quarter:

- ABA Section of Taxation Pro Bono and Tax Clinics Committee
- AIDS project of Southern Vermont
- American Civil Liberties Union of Vermont (ACLU-VT)
- Arkansas Legal Aid
- Center on Budget and Policy Priorities
- Community Catalyst
- Consumers Union
- HIV/HCV Resource Center
- IRS Office of Chief Counsel
- IRS Stakeholder Partnerships, Education and Communication (SPEC)
- IRS Taxpayer Advocate Service
- National Health Law Program
- National Viral Hepatitis Round Table
- Oklahoma Indian Legal Services
- OneCare Vermont
- Prisoners' Rights Office
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems (VAHHS)

- Vermont CARES
- Vermont Health Connect
- Vermont Medical Society
- Vermont Oral Health Care for All Coalition
- Vermont People With AIDS Coalition
- Vermont Public Interest Research Group (VPIRG)

Back to Table of Contents

Outreach and Education

A. Website

Vermont Law Help is a statewide website maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section (*www.vtlawhelp.org/health*) with more than 200 pages of consumer-focused health information maintained by the HCA. We work diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

Google Analytics Statistics

- The total number of health pageviews increased by 48% in the reporting quarter ending December 31, 2016 (9,299 pageviews), compared with the same quarter in 2015 (6,273 pageviews). This is particularly noteworthy because the total number of pageviews for the entire Vermont Law Help website was only slightly higher (6.1%) compared with the same period last year.
- The number of people seeking help finding ***dental services*** increased significantly (72%) compared with the previous year. (475 pageviews this quarter, compared with 276 in the same period last year.)
- The number of people who visited our ***Services covered by Medicaid*** page increased by 323% this quarter, with 317 pageviews compared to last year's 75. Last quarter that page had 129 pageviews.
- This quarter, like the previous five quarters, we saw a large increase in the number of people seeking information about ***Medicaid income limits*** (3,240 pageviews this quarter, compared with 1,732 in the same quarter in 2015 – an increase of 87%). The consistently high numbers indicate that search engines are delivering this page as a high-ranking source of information about Medicaid income limits, as well as the increasing age of Vermont's population.
- The ***health home page*** again had the second largest number of pageviews (971), slightly higher than last year's 843. The home page tells consumers how we can help them and provides several ways to contact us including an online form that can be filled out and submitted 24/7.
- Half of the 20 health topics with the largest number of pageviews focused on Medicaid or long-term care Medicaid (Choices for Care). There is almost no information about MCA Medicaid or Dr. Dynasaur available on the state websites, but there is clearly a need for information on these topics.
- The number of people looking for information about ***Buying Prescription Drugs*** jumped significantly (175 pageviews, this year compared to 72 pageviews in 2015). This number is 72% higher than last quarter (102 pageviews).
- Other popular topics included:
    - *Vermont Choices for Care* (320 pageviews,)

- *Health Insurance Taxes and you* (276 pageviews)
- *Medicaid and Medicare-(Dual Eligible)* (162 pageviews)
- *Resource Limits-Medicaid* (134 pageviews)

PDF Downloads

- Forty-five out of 120 or 38% of the **unique PDFs** downloaded from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles: 18 were created for consumers. The top five consumer-focused PDF downloads were the same as the last two quarters:
  - *Vermont Dental Clinics Chart* (92 downloads)
  - *Advance directive, short form (38 downloads)*
  - *Free Dental Care Day* (27 downloads)
  - *Blue Cross Blue Shield of VT Annual Report 2014* (21 downloads)
  - *Advance directive, long form* (16 downloads)
- 13 were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused downloads were:
  - *Low-Income Taxpayers and the Affordable Care Act – November 2014* (10 downloads)
  - *PTC rule allocation summary (3 downloads)*
- 7 covered topics related to health policy. The top policy-focused downloads were:
  - *Vermont ACO Shared Savings Program Quality Measures* (14 downloads)
  - *Consumer Principles for Vermont's All-Payer Model (12 downloads)*

Our *Vermont Dental Clinics Chart* continues to be the **third most downloaded of all PDFs** downloaded from the Vermont Law Help website.

B. Education

Education/Outreach

Presentations

Midwest LITC Network (October 6, 2016)

The HCA's tax attorney covered Medical Loss Ratio Rebates, APTC safe harbors, ACA information returns, ACA-related letters from the IRS, and outreach topics in this presentation to 22 low-income tax clinic attorneys from legal services organizations and academic LITC clinics.

Health Care & Rehabilitation Services of Vermont (HRCS) (October 31, 2016)

The HCA presented about the Office of the Health Care Advocate and other health care topics to approximately 18 HRCS staff members. The presenter explained what the HCA is, how we fit into VLA, and who is eligible for our servings (any Vermont resident with a health care issue). The presenter also discussed Vermont Health Connect and open enrollment for 2017, as well as Medicaid reviews. The HRCS staff asked questions about best practices for referring clients, in what situations they should give people our phone number, and other ways clients can access our services (website, email) and took 68 HCA brochures. The HCRS has over 600 staff members serving clients throughout Vermont.

University of Vermont Tax School (November 15, 2016)

In response to a question from an attendee at UVM's Tax School about where to turn for help with ACA tax-related problems, VLA's tax attorney discussed and provided contact information for the HCA

hotline. About 160 tax professionals (enrolled agents, CPAs, attorneys, and un-credentialed preparers) attended the presentation.

University of Vermont Tax School Organizing Committee Meeting (December 6, 2016)

The HCA presented about the Office of the Health Care Advocate, emphasizing the Vermont Health Connect issues the HCA can help with, and explained how to refer consumers to the HCA. Twelve members of the committee were present. Committee members are generally tax professionals in private tax practices.

ABA Tax Section (December 12, 2016)

The HCA tax attorney partnered with the Center on Budget and Policy Priorities to present "Form 1095 Conflicts & Appeals in the Health Insurance Marketplace" to 75 attendees, mostly Low Income Taxpayer Clinic attorneys, at the ABA Tax Section's annual Low-Income Taxpayer Representation Workshop.

Annual Low-Income Taxpayer Clinic Grantee Conference (December 13, 2016)

The HCA's tax attorney was featured on a panel that presented "The Affordable Care Act: Premium Tax Credit and Individual Shared Responsibility Payment" to about 250 attendees [directors and staff attorneys from Low-Income Taxpayer Clinics (LITC) and staff from the Taxpayer Advocate Service (TAS)]. The presentation was a collaboration with the Taxpayer Advocate Service, the Affordable Care Act Office, and the IRS Office of Chief Counsel.

Publications

Justice Quarterly (November 29, 2016)

Three health care articles were published in the Fall issue of VLA's quarterly newsletter, Justice Quarterly. One article informed readers about new ACA requirements for nonprofit hospitals to have a *written financial assistance policy* and make it available to patients when they are admitted or discharged. Another article provided *Vermont Health Connect open enrollment tips*, including to sign up in early December to ensure coverage on January 1. The third briefly explained the *all-payer model agreement* that Vermont entered into with the federal government, including the HCA's plans to monitor the plans as they develop and identify potential consumer protection issues.

The HCA updated our *Fair Hearing Fact Sheet* that tells consumers how to prepare for and what to expect at Fair Hearing appeals of health care decisions.

Promoting Plain Language in Health Communications

During this quarter, the HCA provided feedback and revisions to promote the use of plain language and increase consumers' accessibility to and understanding of important communications from the state and other health organizations regulated by the state. The HCA:

- Provided extensive plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:
    - EE311-MNT closure for Non-Category sent 12-23-16
    - EE508-MM NoD Indian Status sent 12-12-16
    - EE002PEND-MM V3 sent 11-10-16
    - EE503-MM NoD after MAGI verification, approved sent 11-10-16
    - VLAEE504-MM NoD after MAGI + verification approved sent 11-10-16

Office of the Health Care Advocate

Vermont Legal Aid
264 North Winooski Avenue
Burlington, Vermont 05401
800.917.7787

http://www.vtlegalaid.org/health

Attachment 6: SFY 2016 Final Investment Expenditures

MCO Investment Expenditures

Department	Criteria	Investment Description	SFY06 Actuals - 3/4 SFY	SFY07 Actuals	SFY08 Actuals	SFY09 Actuals	SFY10 Actuals	SFY11 Actuals	SFY12 Actuals	SFY13 Actuals	SFY14 Actuals	SFY15 Actuals	SFY16 Actuals
AOE	2	School Health Services	$ 6,397,319	$ 8,956,247	$ 8,956,247	$ 8,956,247	$ 8,956,247	$ 4,478,124	$ 11,027,579	$ 9,741,252	$ 10,454,116	$ 10,029,809	$ 10,472,205
AOA	4	Blueprint Director	$ -	$ -	$ 70,000	$ 68,879	$ 179,284	$ -	$ -	$ -	$ -		
AOA	4	Green Mountain Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 639,239	
GMCB	4	Green Mountain Care Board	$ -	$ -	$ -	$ -	$ -	$ -	$ 789,437	$ 1,450,717	$ 2,360,462	$ 2,517,516	$ 2,188,901
DFR	2	Health Care Administration	$ 983,637	$ 914,629	$ 1,340,728	$ 1,871,651	$ 1,713,959	$ 1,898,342	$ 1,897,997	$ 659,544	$ 165,946		
DII	4	Vermont Information Technology Leaders	$ 266,000	$ 105,000	$ 105,000	$ 339,500	$ -	$ -	$ -	$ -	$ -		
VVH	2	Vermont Veterans Home	$ 747,000	$ 913,047	$ 913,047	$ 881,043	$ 837,225	$ 1,410,956	$ 1,410,956	$ 1,410,956	$ 410,986	$ 410,986	$ 410,986
VSC	2	Health Professional Training	$ 283,154	$ 391,698	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 409,461	$ 629,462
UVM	4	Vermont Physician Training	$ 2,798,070	$ 3,870,682	$ 4,006,152	$ 4,006,156	$ 4,006,152	$ 4,006,156	$ 4,006,156	$ 4,006,156	$ 4,006,156	$ 4,046,217	$ 4,046,217
VAAFM	3	Agriculture Public Health Initiatives	$ -	$ -	$ -	$ -	$ -	$ -	$ 90,278	$ 90,278	$ 90,278	$ 90,278	$ 90,278
AHSCO	2	Designated Agency Underinsured Services	$ -	$ -	$ -	$ -	$ -	$ 2,510,099	$ 5,401,947	$ 6,232,517	$ 7,184,084	$ 6,894,205	$ 5,632,253
AHSCO	4	2-1-1 Grant	$ -	$ -	$ -	$ 415,000	$ 415,000	$ 415,000	$ 415,000	$ 415,000	$ 499,792	$ 499,667	$ 453,000
VDH	2	AIDS Services/HIV Case Management	$ 152,945	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	
VDH	2	Newborn Screening	$ 74,899	$ 166,795	$ 136,577	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
VDH	2	DMH Investment Cost in CAP	$ -	$ -	$ -	$ 64,843	$ -	$ 752	$ 140	$ -	$ -	$ -	
VDH	2	Renal Disease	$ 15,000	$ 7,601	$ 16,115	$ 15,095	$ 2,053	$ 13,689	$ 1,752	$ 28,500	$ 3,375	$ 10,125	$ 13,500
VDH	2	TB Medical Services	$ 27,052	$ 29,129	$ 15,872	$ 28,359	$ 41,313	$ 36,284	$ 39,173	$ 34,046	$ 59,872	$ 28,571	$ 9,738
VDH	4	Immunization	$ -	$ -	$ -	$ 726,264	$ -	$ -	$ 23,903	$ 457,757	$ 165,770	$ 253,245	$ 109,373
VDH	2	Emergency Medical Services	$ 174,482	$ 436,642	$ 626,728	$ 427,056	$ 425,870	$ 333,488	$ 274,417	$ 378,168	$ 498,338	$ 480,027	$ 442,538
VDH	2	Family Planning	$ 365,320	$ 122,961	$ 169,392	$ 300,876	$ 300,876	$ 275,803	$ 420,823	$ 1,574,550	$ 1,556,025	$ 1,390,410	$ 1,193,215
VDH	3	WIC Coverage	$ 161,804	$ 1,165,699	$ 562,446	$ 86,882	$ -	$ 36,959	$ -	$ 77,743	$ 317,775	$ 1,824,848	$ 1,201,498
VDH	2	Substance Abuse Treatment	$ 1,466,732	$ 2,514,963	$ 2,744,787	$ 2,997,668	$ 3,000,335	$ 1,693,198	$ 2,928,773	$ 2,435,796	$ 2,363,671	$ 2,913,591	$ 2,169,074
VDH	2	Health Laboratory	$ 1,369,982	$ 1,908,982	$ 2,012,252	$ 1,522,578	$ 1,875,487	$ 1,912,034	$ 1,293,671	$ 2,885,451	$ 2,494,516	$ 3,405,659	$ 3,294,240
VDH	3	Fluoride Treatment	$ -	$ -	$ -	$ -	$ -	$ -	$ 43,483	$ 75,081	$ 59,362	$ 55,209	$ 75,916
VDH	3	Health Research and Statistics	$ 276,673	$ 403,244	$ 404,431	$ 217,178	$ 254,828	$ 289,420	$ 439,742	$ 497,700	$ 576,920	$ 715,513	$ 1,195,231
VDH	3	Epidemiology	$ 326,708	$ 427,075	$ 416,932	$ 204,646	$ 241,932	$ 315,135	$ 329,380	$ 766,053	$ 623,363	$ 872,449	$ 750,539
VDH	3	Statewide Tobacco Cessation	$ -	$ -	$ -	$ 230,985	$ 484,998	$ 507,543	$ 450,804	$ 487,214	$ 1,073,244	$ 1,148,535	$ 257,507
VDH	4	Community Clinics	$ -	$ -	$ -	$ 640,000	$ 468,154	$ 640,000	$ 600,000	$ 640,000	$ 688,000	$ -	
VDH	4	Patient Safety - Adverse Events	$ -	$ -	$ 190,143	$ 100,509	$ 44,573	$ 16,829	$ 25,081	$ 42,169	$ 38,731	$ 34,988	$ 35,033
VDH	4	FQHC Lookalike	$ -	$ -	$ 30,000	$ 105,650	$ 81,500	$ 87,900	$ 102,545	$ 382,800	$ 160,200	$ 97,000	$ 6,000
VDH	4	Poison Control	$ -	$ -	$ -	$ -	$ 176,340	$ 115,710	$ 213,150	$ 152,250	$ 152,433	$ 105,586	$ 85,586
VDH	4	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	$ -	$ 100,000	$ 291,298	$ 486,466	$ 412,043	$ 290,661	$ 318,806	$ 345,930	$ 326,184	$ 395,229	$ (26,262)
VDH	4	Healthy Homes and Lead Poisoning Prevention Program	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 101,127	$ 479,936	$ 421,302	$ 187,784
VDH	4	Challenges for Change: VDH	$ -	$ -	$ -	$ -	$ -	$ -	$ 309,645	$ 353,625	$ 288,691	$ 426,000	$ 784,155
VDH	4	Area Health Education Centers (AHEC)	$ -	$ 35,000	$ 310,000	$ 565,000	$ 725,000	$ 500,000	$ 540,094	$ 496,176	$ 547,500	$ 543,995	$ 562,000
VDH	4	CHIP Vaccines	$ -	$ -	$ -	$ -	$ -	$ -	$ 196,868	$ 482,454	$ 707,788	$ 557,784	$ 578,183
VDH	4	Tobacco Cessation: Community Coalitions	$ 938,056	$ 1,647,129	$ 1,144,713	$ 1,016,685	$ 535,573	$ 94,089	$ 371,646	$ 498,275	$ 632,848	$ 702,544	
VDH	4	Vermont Blueprint for Health	$ 92,049	$ 1,975,940	$ 753,087	$ 1,395,135	$ 1,417,770	$ 752,375	$ 454,813	$ 875,851	$ 713,216	$ 703,123	$ 757,576
VDH	4	Physician/Dentist Loan Repayment Program	$ 810,716	$ 439,140	$ 930,000	$ 1,516,361	$ 970,000	$ 900,000	$ 970,000	$ 970,105	$ 1,040,000	$ 900,000	$ 770,000
VDH	4	Recovery Centers	$ 171,153	$ 287,374	$ 329,215	$ 713,576	$ 716,000	$ 648,350	$ 771,100	$ 864,526	$ 1,009,176	$ 1,299,604	$ 1,354,104
DMH	2	Special Payments for Treatment Plan Services	$ 101,230	$ 131,309	$ 113,314	$ 164,356	$ 149,068	$ 134,791	$ 132,021	$ 180,773	$ 168,492	$ 152,047	$ 158,316
DMH	2	MH Outpatient Services for Adults	$ 775,899	$ 1,393,395	$ 1,293,044	$ 1,320,521	$ 864,815	$ 522,595	$ 974,854	$ 1,454,379	$ 2,661,510	$ 3,074,989	$ 4,446,379
DMH	2	Mental Health Elder Care	$ 38,563	$ 37,682	$ 38,970	$ -	$ -	$ -	$ -	$ -	$ -		
DMH	4	Mental Health Consumer Support Programs	$ 451,606	$ 546,987	$ 673,160	$ 707,976	$ 802,579	$ 582,397	$ 67,285	$ 1,649,340	$ 2,178,825	$ 1,132,931	$ 470,222
DMH	2	Mental Health CRT Community Support Services	$ 2,318,668	$ 602,186	$ 807,539	$ 1,124,728	$ -	$ 1,935,344	$ 1,886,140	$ 6,047,450	$ 11,331,235	$ 282,071	$ 5,866,297
DMH	2	Mental Health Children's Community Services	$ 1,561,396	$ 3,066,774	$ 3,341,602	$ 3,597,662	$ 2,569,759	$ 1,775,120	$ 2,785,090	$ 3,088,773	$ 3,377,546	$ 3,706,864	$ 4,379,820
DMH	2	Emergency Mental Health for Children and Adults	$ 1,885,014	$ 1,988,548	$ 2,016,348	$ 2,165,648	$ 1,797,605	$ 2,309,810	$ 4,395,885	$ 8,719,824	$ 6,662,850	$ 4,148,197	$ 2,528,751
DMH	2	Respite Services for Youth with SED and their Families	$ 385,581	$ 485,586	$ 502,237	$ 412,920	$ 516,677	$ 543,635	$ 541,707	$ 823,819	$ 749,943	$ 931,962	$ 1,286,154
DMH	2	CRT Staff Secure Transportation	$ -	$ -	$ 52,242	$ -	$ -	$ -	$ -	$ -	$ -		
DMH	2	Recovery Housing	$ -	$ -	$ 235,267	$ -	$ 332,635	$ 512,307	$ 562,921	$ 874,194	$ 985,098	$ 463,708	$ 914,858
DMH	2	Transportation - Children in Involuntary Care	$ 4,768	$ 1,075	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
DMH	2	Vermont State Hospital Records	$ -	$ -	$ -	$ -	$ 19,590	$ -	$ -	$ -	$ -		
DMH	4	Challenges for Change: DMH	$ -	$ -	$ -	$ -	$ -	$ 229,512	$ 945,051	$ 819,069	$ -		
DMH	2	Seriously Functionally Impaired: DMH	$ -	$ -	$ -	$ -	$ -	$ 68,713	$ 160,560	$ 1,151,615	$ 721,727	$ 392,593	$ 246,049
DMH	2	Acute Psychiatric Inpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ 12,603,067	$ 5,268,556	$ 3,011,307	$ 2,423,577	$ 3,145,476
DMH	2	Institution for Mental Disease Services: DMH	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,443,654	$ 7,194,964	$ 25,371,245	$ 22,335,938
DVHA	4	Vermont Information Technology Leaders/HIT/HIE/HCR	$ -	$ -	$ -	$ -	$ 339,500	$ 646,220	$ 1,425,017	$ 1,517,044	$ 1,549,214	$ 2,915,149	$ 1,887,543
DVHA	4	Vermont Blueprint for Health	$ -	$ -	$ -	$ -	$ -	$ 2,616,211	$ 1,841,690	$ 2,002,798	$ 2,490,206	$ 1,987,056	$ 2,594,329
DVHA	1	Buy-In	$ 4,594	$ 314,376	$ 419,951	$ 248,537	$ 200,868	$ 50,605	$ 24,000	$ 17,878	$ 17,728	$ 27,169	$ 29,447
DVHA	1	Vscript Expanded	$ 1,695,246	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
DVHA	1	HIV Drug Coverage	$ 31,172	$ 42,347	$ 44,524	$ 48,711	$ 38,904	$ 39,176	$ 37,452	$ 39,881	$ 26,540	$ 10,072	$ 8,484
DVHA	1	Civil Union	$ 373,175	$ 543,986	$ 671,941	$ 556,811	$ 627,976	$ 999,084	$ 1,215,109	$ 1,112,119	$ 760,819	$ (50,085)	$ (585)
DVHA	1	Vpharm	$ -	$ -	$ -	$ 278,934	$ 210,796	$ -	$ -	$ -	$ -	$ -	
DVHA	4	Hospital Safety Net Services	$ -	$ -	$ 281,973	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
DVHA	2	Patient Safety Net Services	$ -	$ -	$ -	$ -	$ -	$ 36,112	$ 73,487	$ 2,394	$ 363,489	$ 335,420	$ 573,050
DVHA	2	Institution for Mental Disease Services: DVHA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,214,805	$ 6,948,129	$ 7,792,709	$ 7,839,519
DVHA	2	Family Supports	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,015,491	$ 3,723,521	$ 2,982,388	$ 273,177
DCF	2	Family Infant Toddler Program	$ -	$ 199,064	$ 326,424	$ 335,235	$ 81,086	$ 624	$ -	$ -	$ -	$ -	
DCF	2	Medical Services	$ 69,893	$ 91,569	$ 120,494	$ 65,278	$ 45,216	$ 64,496	$ 47,720	$ 37,164	$ 33,514	$ 32,299	$ 55,400
DCF	2	Residential Care for Youth/Substitute Care	$ 9,181,386	$ 10,536,996	$ 10,110,441	$ 9,392,213	$ 8,033,068	$ 7,853,100	$ 9,629,269	$ 10,131,790	$ 11,137,225	$ 10,405,184	$ 10,238,115
DCF	2	AABD Admin	$ 988,557	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ 135,517
DCF	2	AABD	$ 2,415,100	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
DCF	2	Aid to the Aged, Blind and Disabled CCL Level III	$ 96,000	$ 2,617,350	$ 2,615,023	$ 2,591,613	$ 2,827,617	$ 2,661,246	$ 2,563,226	$ 2,621,786	$ 2,611,499	$ 2,864,727	$ 2,753,853
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level III	$ -	$ 143,975	$ 170,117	$ 172,173	$ 137,356	$ 136,466	$ 137,833	$ 124,731	$ 89,159	$ 77,196	$ 80,830
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level IV	$ 210,989	$ 312,815	$ 349,887	$ 366,161	$ 299,488	$ 265,812	$ 273,662	$ 269,121	$ 183,025	$ 160,963	$ 190,066
DCF	2	Essential Person Program	$ 542,382	$ 675,860	$ 614,974	$ 620,052	$ 485,536	$ 736,479	$ 775,278	$ 783,860	$ 801,658	$ 707,316	$ 667,102
DCF	2	GA Medical Expenses	$ 254,154	$ 339,928	$ 298,207	$ 380,000	$ 583,080	$ 492,079	$ 352,451	$ 275,187	$ 253,939	$ 211,973	$ 181,835
DCF	2	CUPS/Early Childhood Mental Health	$ -	$ -	$ 52,825	$ 499,143	$ 166,429	$ 112,619	$ 165,016	$ 45,491	$ -		
DCF	2	VCRHYP/Vermont Coalition for Runaway and Homeless Youth Program	$ -	$ -	$ 1,764,400	$ -	$ -	$ -	$ -	$ -	$ -		
DCF	2	HBKF/Healthy Babies, Kids & Families	$ -	$ -	$ 318,321	$ 63,921	$ -	$ -	$ -	$ -	$ -		
DCF	1	Catamount Administrative Services	$ -	$ -	$ -	$ 339,894	$ -	$ -	$ -	$ -	$ -		
DCF	2	Children's Integrated Services Early Intervention									$ 200,484		$ 371,836
DCF	2	Therapeutic Child Care	$ -	$ -	$ -	$ 978,886	$ 577,259	$ 570,493	$ 596,406	$ 557,599	$ 543,196	$ 605,419	$ 712,884
DCF	2	Lund Home	$ -	$ -	$ -	$ 325,516	$ 175,378	$ 196,159	$ 354,528	$ 181,243	$ 237,387	$ 405,034	$ 261,081
DCF	2	GA Community Action	$ -	$ -	$ -	$ -	$ -	$ 199,762	$ 338,275	$ 420,359	$ 25,181		
DCF	3	Prevent Child Abuse Vermont: Shaken Baby	$ -	$ -	$ -	$ -	$ -	$ 44,119	$ 74,250	$ 86,969	$ 111,094	$ 54,125	$ 54,125
DCF	3	Prevent Child Abuse Vermont: Nurturing Parent	$ -	$ -	$ -	$ -	$ -	$ -	$ 107,184	$ 186,916	$ 54,231	$ 195,124	$ 126,365
DCF	4	Challenges for Change: DCF	$ -	$ -	$ -	$ -	$ -	$ 50,622	$ 196,378	$ 197,426	$ 207,286	$ 189,378	$ 202,488
DCF	2	Strengthening Families	$ -	$ -	$ -	$ -	$ -	$ -	$ 465,343	$ 429,154	$ 399,841	$ 370,003	$ 426,417
DCF	2	Lamoille Valley Community Justice Project	$ -	$ -	$ -	$ -	$ -	$ -	$ 162,000	$ 216,000	$ 402,685	$ 83,315	$ 216,000
DCF	3	Building Bright Futures	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 398,201	$ 594,070	$ 514,225	$ 531,283
DDAIL	2	Elder Coping with MMA	$ 441,234	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
DDAIL	2	Mobility Training/Other Svcs.-Elderly Visually Impaired	$ 187,500	$ 250,000	$ 250,000	$ 250,000	$ 245,000	$ 245,000	$ 245,000	$ 245,000	$ 245,000	$ 245,000	$ 270,171
DDAIL	2	DS Special Payments for Medical Services	$ 394,055	$ 192,111	$ 880,797	$ 522,058	$ 469,770	$ 757,070	$ 1,498,083	$ 1,299,613	$ 1,277,148	$ 385,896	$ 1,904,880
DDAIL	2	Flexible Family/Respite Funding	$ 1,086,291	$ 1,135,213	$ 1,341,698	$ 1,364,896	$ 1,114,898	$ 1,103,748	$ 1,103,749	$ 1,088,889	$ 2,868,218	$ 1,400,997	$ 1,919,377
DDAIL	4	Quality Review of Home Health Agencies	$ -	$ 77,467	$ 186,664	$ 126,306	$ 90,227	$ 103,598	$ 128,399	$ 84,139	$ 51,697	$ 44,682	$ 35,203
DDAIL	4	Support and Services at Home (SASH)	$ -	$ -	$ -	$ -	$ -	$ -	$ 773,192	$ 773,192	$ 1,013,671	$ 1,026,155	$ 1,013,283
DDAIL	4	HomeSharing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 310,000	$ 317,312	$ 327,163	$ 339,966
DDAIL	4	Self-Neglect Initiative	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 150,000	$ 200,000	$ 265,000	$ 276,830
DDAIL	2	Seriously Functionally Impaired: DAIL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,270,247	$ 859,371	$ 333,331	$ 120,997
DOC	2	Intensive Substance Abuse Program (ISAP)	$ 382,230	$ 299,602	$ 310,610	$ 200,000	$ 591,004	$ 591,000	$ 458,485	$ 400,910	$ 547,550	$ 58,280	
DOC	2	Intensive Sexual Abuse Program	$ 72,439	$ 46,078	$ 85,542	$ 88,523	$ 68,350	$ 70,002	$ 60,585	$ 69,311	$ 19,322	$ 15,532	$ 6,375
DOC	2	Intensive Domestic Violence Program	$ 109,692	$ 134,663	$ 230,353	$ 229,166	$ 173,938	$ 174,000	$ 164,218	$ 86,814	$ 64,970	$ 169,043	$ 88,152
DOC	2	Women's Health Program (Tapestry)	$ 460,130	$ 487,344	$ 487,231	$ 527,956	$ -	$ -	$ -	$ -	$ -	$ -	
DOC	2	Community Rehabilitative Care	$ 1,038,114	$ 1,982,456	$ 2,031,408	$ 1,997,499	$ 2,190,924	$ 2,221,448	$ 2,242,871	$ 2,500,085	$ 2,388,327	$ 2,539,161	$ 2,639,580
DOC	2	Return House	$ -	$ -	$ -	$ 51,000	$ -	$ -	$ -	$ 399,999	$ 399,999	$ 343,592	$ 342,084
DOC	2	Northern Lights	$ -	$ -	$ -	$ -	$ 40,000	$ 40,000	$ -	$ 393,750	$ 335,587	$ 354,909	$ 768,289
DOC	4	Challenges for Change: DOC	$ -	$ -	$ -	$ -	$ -	$ -	$ 687,166	$ 524,594	$ 433,910	$ 539,727	
DOC	4	Northeast Kingdom Community Action	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 548,825	$ 287,662	$ 267,025	$ 220,436
DOC	2	Pathways to Housing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 802,488	$ 830,936	$ 830,336	$ 1,018,229
			$ 45,455,809	$ 55,495,719	$ 59,918,097	$ 62,419,988	$ 55,554,314	$ 56,275,877	$ 89,836,470	$ 123,669,882	$ 127,103,459	$ 128,924,888	$ 126,882,102

Last Updated: 9/15/16