State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 11
(1/1/2016 – 12/31/2016)

Quarterly Report for the period
January 1, 2016 – March 31, 2016

Submitted Via PMDA Portal on May 31, 2016

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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).

As of January 30, 2015, the Global Commitment (GC) waiver was amended to include authority for the former Choices for Care 1115 waiver. In addition, the State received section 1115 authority to provide full Medicaid State Plan benefits to pregnant women who are determined presumptively eligible.

The initial Global Commitment to Health (GC) and Choices for Care (CFC) demonstrations were approved in September 2005, effective October 1, 2005. The GC demonstration was extended for three years, effective January 1, 2011, and again for three years effective October 2, 2013. The CFC demonstration was extended for 5 years effective October 1, 2010. The following amendments have been made to the GC demonstration:

- 2007: a component of the Catamount Health 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 federal poverty level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State.

- 2009: the state extended Catamount Health 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.

- 2012: CMS provided authority for the State to eliminate the $75 inpatient admission copay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid State Plan.

- 2013: CMS approved the extension of the GC demonstration which included sun-setting the authorities for most of the 1115 Expansion Populations because they would be eligible for Marketplace coverage beginning January 1, 2014. The renewal also added the New Adult Group to the demonstration effective January 1, 2014. Finally, the renewal also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.

- 2015: As of January 30, 2015, the GC demonstration was amended to include authority for the former Choices for Care demonstration. In addition, the State received section 1115 authority to provide full Medicaid State Plan benefits to pregnant women who are determined presumptively eligible.

As the Single State Agency under the Global Commitment to Health Waiver, AHS designates DVHA

as a Managed Care Entity (MCE) that must meet rules for traditional Medicaid MCEs. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services).
One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the first quarterly report for waiver year 11, covering the period from January 1, 2016 through March 31, 2016 (QE0316).***

II. Enrollment Information and Counts

Key updates from QE0316:

- There were no enrollment fluctuations greater than 5% this quarter.

Table 1 presents point-in-time enrollment information and counts for Demonstration Populations for the Global Commitment to Health Waiver during the second quarter of federal fiscal year (FFY) 2016. 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 April 4, 2016. 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 QE0316 would be in Section VII: Member Month Reporting. During this quarter, there were no substantial enrollment fluctuations >5% seen in any of the Demonstration Populations.

Table 1. Enrollment Information and Counts for Demonstration Populations*, QE0316

Demonstration Population	Current Enrollees Last Day of Qtr March 31, 2016	Previously Reported Enrollees Last Day of Qtr December 31, 2015	Percent Variance 12/31/2015 to 3/31/2016	Variance by Enrollee Count 12/31/2015 to 3/31/2016
Demonstration Population 1:	36,311	37,538	-3.27%	(1,227)
Demonstration Population 2:	84,759	84,772	-0.02%	(13)
Demonstration Population 3:	63,072	60,317	4.57%	2,755
Demonstration Population 4:	2,839	2,819	0.71%	20
Demonstration Population 5:	955	929	2.80%	26
Demonstration Population 6:	841	873	-3.67%	(32)
Demonstration Population 7:	7,506	7,397	1.47%	109
Demonstration Population 8:	4,270	4,213	1.35%	57
	198,858	195,737	1.59%	

* Demonstration Population counts are person counts, not member months.

III. Outreach Activities

i. Member Relations

Key updates from QE0316:

- Long Acting-Reversible Contraceptives (LARC) provided in hospital, post-partum settings
- Interrupted Psychiatric Stays
- Payment Error Rate Measurement (PERM)
- The Medicaid and Exchange Advisory Board (MEAB)

The Provider and Member Relations (PMR) Unit is responsible for member relations, outreach and communication, including the GreenMountainCare.org member website. The PMR Unit ensures an adequate network of providers, enrolls providers, manages the provider network, and has responsibility for the Medicaid Non-Emergency Medical Transportation (NEMT) Program.

Long Acting-Reversible Contraceptives Provided in Hospital, Post-Partum Settings(LARC)

Vermont unintended pregnancy rate is 47%. Through the Vermont Department of Health, Long Acting-Reversible Contraceptives (LARC) utilization is being promoted as an efficient means to eliminate unplanned pregnancy. Women facing an unplanned pregnancy are at greater risk for a number of social, economic and health problems.

The DVHA has implemented a pricing policy that establishes an add-on payment of $200 when an inpatient claim is billed for a childbirth delivery and a LARC is also administered. This change is anticipated to improve the untilization of LARC in the immediate postpartum period. This change is effective with a discharge date of 1/1/2016 or after, when a LARC is provided in an inpatient hospital setting, postpartum.

Interrupted Psychiatric Stays

In order to align psychiatric billing requirements and reimbursement with the current Medicare Policy 190.7 Vermont Medicaid has made the following changes for effective date of service 1/1/2016.
An interrupted stay occurs when an individual is discharged or transferred to a medical floor from an inpatient psychiatric facility and readmitted to the same or another inpatient psychiatric facility before midnight on the third consecutive day following the discharge from the original inpatient psychiatric facility.

For an interrupted stay where a patient is discharged and readmitted to the same facility, providers must indicate an interrupted stay to a medical floor in the same facility by using Occurrence Span Code 74 with the days the individual was on the medical floor. Interrupted stays will be considered continuous for the purposes of applying the variable per diem adjustment. The interrupted stay is treated as one stay and one discharge for the purposes of payment. Facilities are expected to hold claims for 3 days to ensure a readmission does not occur. Stays are considered continuous for the purpose of applying the variable per diem adjustment and is considered one continuous stay for payment.

Payment Error Rate Measurement (PERM)

The Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate

Measurement (PERM) program in response to the Improper Payment Information Act, 2002 [IPIA, Public Law 107–300,] enacted November 26, 2002. This act required federal agencies to review annually programs they oversee that are susceptible to significant erroneous payments, to estimate the amount of improper payments, to report those estimates to Congress and to submit a report of the actions the federal agency is taking to reduce erroneous expenditures. The Improper Payments Elimination and Recovery Act of 2010 (IPERA) enhances the IPIA of 2002 and aims to further reduce improper payments

The 2016 PERM cycle is Vermont's next review of provider payments which will occur between October 2015 through the fall of 2017. The 2016 PERM cycle will review payments to providers during federal fiscal year 2016 (October 2015 - September 2016). Providers, selected in the sample, will be required to submit medical records and associated documentation with the claims. CNI Advantage, LLC will be contacting these providers directly. DVHA will provide assistive guidance and support during this process as well as issue ongoing PERM notices and direct communications to PERM selected providers.

The Medicaid and Exchange Advisory Board (MEAB) held meetings on January 25, 2016, February 22, 2016 and March 28, 2016. Agendas and minutes are publicly posted at: http://info.healthconnect.vermont.gov/advisory_board/meeting_materials.

IV. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE0316:

- Vermont Health Connect contacted more than 26,000 MAGI Medicaid households with cases in the State's legacy ACCESS to renew their coverage into the VHC system.
- The State's System Integrator completed development work with upgrades to support the renewal of 54,000 MAGI Medicaid households with cases already in the VHC system.
- More than 153,000 1095 tax forms, including the new 1095-B form for Medicaid enrollees, were processed and mailed ahead of deadline.
- A February study by the State Health Access Data Assistance Center reported that Vermont is first in the nation in terms of insuring children. It also showed that Vermont made major gains, especially in terms of insuring low-income and middle-income children, in the first year of Vermont Health Connect.

Medicaid renewals were a major focus during QE0316. The biggest project was verifying and transitioning more than 26,000 MAGI Medicaid households from the State's legacy system (ACCESS) to Medicaid or qualified health plans in the Vermont Health Connect (VHC) system. This population was divided into three groups. The first 9,000 households received initial notices in January, while the second and third groups received initial notices in February and March. The outreach plan included two additional mailed reminders plus a phone call before closure. The closures were set to take place in the following quarter.

Optum, the State's System Integrator (SI), deployed a system upgrade in early March to support the ability to process redeterminations and verifications for MAGI Medicaid members whose cases are already in the VHC system (approximately 54,000 households). This was the last in a year-long series

of system upgrades, which also included the automation of the change of circumstance (COC) process in May 2015 and the qualified health plan (QHP) renewal process in October 2015. Business processes and outreach materials were developed in QE0316 to support these "VHC Medicaid renewals," which were scheduled to be contacted at a rate of 9,000 households per month starting in April.

In addition, monthly redeterminations for Medicaid for the Aged, Blind and Disabled (MABD) beneficiaries – which had restarted in November – continued at a rate of 1,000 households per month throughout the quarter.

With the completion of major system development work, Vermont Health Connect and Optum turned their focus to improving the system's performance with a focus on integration, reconciliation, and the Medicaid renewal process. By performing root cause analysis and defect remediation, this initiative aimed to deliver an improved customer experience by fixing current errors and significantly reducing their reoccurrence.

Vermont Health Connect met its mailing targets for tax forms, sending 1095-A forms to QHP customers by the last week of January and the new 1095-B forms to Medicaid enrollees in February – more than a month ahead of the March 31 deadline. Together, more than 153,000 1095 forms were mailed this winter, up from 34,000 in 2015. Corrected notices were also processed and mailed as needed.

Maximus continues to manage the VHC Customer Support Center (call center), currently utilizing 89 customer service representatives (monthly average for the quarter). The call center serves Vermonters enrolled in both public and private health insurance coverage, providing Level 1 call center support, which includes phone applications, payment, basic coverage questions, and change of circumstance requests. Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to the State's Health Access Eligibility & Enrollment Unit for resolution and log service requests, which are escalated to the appropriate resolver group. The Customer Support Center managed incoming call volume, receiving more than 120,000 calls over the quarter, with an abandon rate of 14.6% and answering more than half (52.6%) of calls within 30 seconds.

Throughout QE0316, the system continued to operate as expected. The average page load time for the quarter was under 1.8 seconds and minimal downtime resulted in availability of approximately 99.9%.

Vermont Health Connect's 202 Assisters (53 Navigators, 70 Certified Application Counselors, and 79 Brokers) were very active in QE0316. The early winter focus was on helping uninsured Vermonters beat the January 31 open enrollment deadline and avoid the increased federal Shared Responsibility Provision fee. Navigators alone had 1,755 consultations in January. In February and March, the focus switched to helping Vermonters with Medicaid renewals, particularly new Vermonters and others with accessibility challenges. Navigators had 1,553 and 1,487 consultations in February and March.

Health insurance literacy was a major focus of outreach work in QE0316. Vermont Health Connect also engaged health care providers, libraries, state offices, and legislators in helping Vermonters understand the importance of signing up during open enrollment, responding to Medicaid renewal notices, and comparing options for qualified health plans. Vermont Health Connect's website continued to be a key source of information for current and prospective customers alike, receiving more than 180,000 visits in the quarter. The Plan Comparison Tool, which helps customers estimate total costs of coverage based on family members' age, health, and income, was used in more than

15,000 sessions during the quarter – the majority of which took place in January, prior to the end of open enrollment.

A February study by the State Health Access Data Assistance Center pointed to the results of outreach by Vermont Health Connect and its partners. The study reported that Vermont is first in the nation in terms of insuring children. It also showed that Vermont made major gains, especially in terms of insuring low-income and middle-income children, in the first year of Vermont Health Connect. Vermont's uninsured rate for low-income children dropped from 5.7% in 2013 to 1.5% in 2014. Vermont's uninsured rate for middle-income children dropped from 2.0% in 2013 to 0.2% in 2014.

ii. Choices for Care

Key updates from QE0316:

- Vermont budget and home delivered meals bill proposed.
- DAIL continues work on HCBS federal regulations alignment work.
- MFP Grant approved.

Vermont Legislation

The Department of Disabilities, Aging and Independent Living submitted its annual budget for SFY2017. The budget included a request to convert $1.2 million (gross) in one-time Moderate Needs funding into the base allocation for services. This would assure continuity of services for Moderate Needs services into the next fiscal year. The Vermont budget will be finalized during the next reporting period. The Department budget testimony can be found at: http://dail.vermont.gov/dail-statutes/legislative-testimony-2016/sfy17-dail-budget-testimony-final2.

Vermont stakeholders also proposed a bill (H.730) to add home delivered meals as a Choices for Care service option for people living in the community. Proponents of the bill believe that this would enhance food security for vulnerable people, support sustainability of home delivered meals in Vermont and is in line with Vermont's State Plan on Aging objective to *"Improve food security of older Vermonters and Vermonters with Disabilities."* Though there was no resolution to the bill during this reporting period, the state is reviewing the topic further.

HCBS Regulations

During this reporting period, the State continued communications with CMS to clarify Vermont's plan to assess and strengthen alignment with the federal HCBS regulations. The State initiated the Choices for Care work plan and a resource table for Case Management, Adult Day, Adult Family Care and Enhanced Residential Care home providers. Next steps involve sitting down with stakeholders to review affected standards and initiating a provider self-assessment.

A full copy of the Systemic Self-Assessment Report and Choices for Care Work Plan being submitted to CMS may be found at: http://ddas.vt.gov/ddas-projects/cfc-hcbs-final-aligment-report-12-18-15 and http://ddas.vt.gov/ddas-projects/final-cfc-work-plan-12-18-15.

Money Follows the Person

Vermont's MFP program provides supports to Choices for Care participants who wish to transition

from nursing facility living back to the community living. During this reporting period, the State submitted its final $13 million proposed budget to CMS for approval through 2020. Unexpectedly, the CMS office was not able to support the proposed budget and initially responded with a dramatically reduced $5 million grant approval. Fortunately, after further negotiations, CMS was able to return with a final grant approval of $8 million. Though with reduced funding Vermont may need to shorten the duration of the MFP grant by a year or two, it will allow for better planning within the scope of the sustainability plan. Vermont will submit a final MFP budget and plan to CMS during the next reporting period.

Department Relocation

Effective March 1, 2016, the Department of Disabilities, Aging and Independent Living relocated its central office back to Waterbury, Vermont more than three years after being displaced due to the Hurricane Irene flooding. The new address is 280 State Drive, HC2 South, Waterbury, VT 05676-2070. The new main phone number is (802) 241-0294.

iii. Global Commitment Register

Key updates from QE0316:

- Since the Global Commitment Register (GCR) launched in November 2015, 16 final GCR policies have been publicly posted.

With the addition of a Global Commitment Register (GCR) in November 2015, the AHS has created a formal and comprehensive approach to documentation of Medicaid policy. Changes to policy and practices require engagement with internal and external stakeholders. Some changes require a federally mandated public notice process, and others do not. Regardless of the change, Vermont values engaging with stakeholders as an essential part of any policy change, and has fully integrated stakeholder engagement into the change process via the GCR.

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 250 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.

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

V. Expenditure Containment Initiatives

i. Medicaid Shared Savings Program

Key updates from QE0316:

- As of March, 79,670 Medicaid beneficiaries are attributed to two accountable care organizations (ACOs) through the Vermont Medicaid Shared Savings Program (VMSSP).
- Submitted VMSSP Year 3 SPA to CMS on March 30, 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.

Beneficiary attribution in the VMSSP continues to increase as new providers are added to participating ACO entities, with 907 providers participating in the program and 79,670 total beneficiaries attributed—50,772 lives in OneCare Vermont (OCVT) and 28,898 lives in Community Health Accountable Care (CHAC).

DVHA submitted a SPA to CMS for Year 3 of the VMSSP on March 30, 2016.

DVHA continues to work with OCVT on standard contract language sections of the VMSSP Contract Amendment Agreement, and expects to sign an amendment in the beginning of Q2.

In Performance Year 3, VMSSP staff will continue to engage in implementation activities and will also work closely with the analytics team to study the outcomes of the first and second program years.

ii. Vermont Chronic Care Initiative (VCCI)

Key updates from QE0316:

- The VCCI completed the first full quarter of business operation in the new eQH Enterprise Medicaid Management Information Systems/Care Management (MMIS/CM).
- The VCCI collaborated in development of the care management section of the Medicaid 'next generation' ACO RFP, to be released in April, 2016.
- The VCCI continues collaboration with both Medicaid ACO's for direct referral of identified high risk members in common.

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 care management strategies. The VCCI uses a holistic approach of evaluating and supporting improvement in medical and behavioral health, as well as socioeconomic issues that are often barriers to sustained health improvement. The top 5% of VCCI-eligible Medicaid members account for approximately 39% of Medicaid costs. Excluded populations include dually eligible individuals, those receiving other waiver services and/or CMS-reimbursed case management. The new vendor, eQH, has instituted a new predictive modeling and risk stratification process based on the Johns Hopkins ACG. This new model will enhance VCCI's ability to identify eligible members based on both past and anticipated future utilization, risks and costs, and intervene earlier in order to track the clinical and financial improvements, using the eQHealth Suite.

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. By targeting predicted high-cost members, resources can be allocated to areas representing the greatest opportunities for 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 has only generated an abridged list of eligible members, while we continue to work on the stratification requirements and related eligibility rules. Concurrently, the goal is to establish ACO affiliated member/provider profiles to eliminate redundancies and to track results – both clinical and financial.

The VCCI continues its collaboration with ACO partners and the Blueprint for Health, to enhance the number of hospitals providing secure File Transfer Protocol (FTP) data feeds for its focused efforts on transitions in care and prevention of 30-day hospital readmissions. The VCCI has access to hospital data on inpatient and ED admissions through data sharing from partner hospitals. While the VCCI now receives electronic data from 6 partner hospitals, the goal is to have electronic census data from all hospitals in FFY 2016. The VCCI has updated and standardized a template with eQH for the new data elements and to assure all hospitals are sharing the same data for upload into eQSuite and consideration of acuity and utilization patterns (predictive risk). The enhanced capability of the eQHealth system will enable direct referrals to VCCI case managers based on this point in time data, and allow case managers to intervene upon discharge to lessen the risk of readmission.

The VCCI has supplemented its embedded model with a nurse 'liaison role' to each hospital given space constraints at provider and hospital sites. All 14 hospitals have a designated VCCI staff 'liaison' assigned who meets with hospital case managers to support the reduction of Ambulatory Care Sensitive (ACS) ED utilization as well as support transitions from inpatient to outpatient care to avoid 30-day readmission rates. Liaisons also meet with several large Medicaid practices to support referrals and communication on high risk – a common metric among VCCI, Blueprint and ACO partners. VCCI leadership meets regularly with ACO partners to strengthen ties and further develop referral and reporting processes; however, this continues to prove to be a significant challenge to the ACO and their provider networks, given the current 'excel' spread sheet process for each practice to sort through in order to identify members for referral. There continues to be a push-back to Medicaid/VCCI staff relative direct referrals from most communities, although several are proactively working with us and see the benefit of this partnership, given resource constraints as well as common goals (clinical and financial). We anticipate more proactive work effort in the next quarter as we have elicited our internal ACO unit support to help engage partners based on our contract(s).

Enhanced service coordination continues to be a common goal of the VCCI, ACO's and the Green Mountain Care Board (GMCB) who provide leadership in the Community Learning Collaborative

relative care 'coordination' to minimize redundant efforts. A 'single, shared care plan' remains the long term vision; and the MMIS Care Management system offers this opportunity as part of the 'future state' for AHS Departments. Specifically, the Enterprise Medicaid Management Information Systems/Care Management Solution will support the work of the Learning Collaboratives and ACO partners, by providing a provider and consumer portal in SFY 2017 for a single shared are plan, thus maximizing the CMS investments to the State via ACA funding.

Medicaid Obstetric and Maternal Supports (MOMS) Care Management Services
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. Since this change in structure and staff, the initiative had been able to move forward at an accelerated rate, developing and administering a training curriculum for VCCI and community partner staff to help facilitate a common approach to care management for Medicaid members who are pregnant. The MOMs resource was receiving significant attention as evidenced by the increase in referrals. Unfortunately, the VCCI lost its single lead nurse for this effort in late December 2015, and was unable to successfully recruit for this expertise in the quarter ending 3/31/16. We will continue our recruitment efforts as this position 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. As we grow this resource, we also anticipated that case management will be tracked at a more detailed level in the new eQH Care Management system.

Enterprise Care Management vendor transition:
The VCCI was the initial DVHA unit to go live in the new enterprise care management system with eQHealth (eQH) late in CY 2015. The VCCI was heavily engaged in planning and development of system design including data migration, development of eligibility rules, workflow mapping, assessments and related alerts in the new system. These efforts led to the VCCI staff assisting with UAT for system functionality and successful Go-Live in December 2015. During the first quarter, the VCCI and MMIS project team were challenged by technical issues (bugs, defects; data transfer) and supplemental functionality released, such that staff have been unable to build back up to their normal case load level of 25 or greater cases/FTE. This coupled with staff engaged in training, and additional UAT; as well as the decline in overall VCCI FTE's with the sun setting of our former vendor, guarantees a decline in overall caseload for the remaining SFY. The VCCI was not able to secure additional state FTEs to replace the vendor staff, due to State budget constraints. However, the DVHA did request supplemental VCCI FTE's in the 2016 legislative session and we remain optimistic these FTE's will be approved.

With the continued support of the Organizational Change Management (OCM) team at the state and with eQH, we continue to develop and expand on training materials and guides for the team, supplemented by phone feedback sessions, webinars, 1:1 coaching, and group meetings to support staff in transition and adoption of the new system in day to day work.

The DVHA's Clinical Operations Unit and the Quality Improvement Units are expected to utilize the system in the next quarter after policies are updated and system features available for their extended support of VCCI referrals. Roles and permissions are being updated accordingly with both units using the system for direct referral of hospitalized members in need of transnational care and related support.

iii. Blueprint for Health

Key updates from QE0316:

- The governance model guiding the local Unified Community Collaboratives has been adopted by the developing Vermont Care Organization business plan in preparation for an All Payer Waiver framework.
- Blueprint made the first performance payments to practices in this quarter.
- The Blueprint Clinical Registry was successfully migrated to the Vermont Information Technology Leaders (VITL) hosted environment and feeds of clinical messages are successfully populating the registry.
- Enrollment in the Hub and Spoke Health Home for opioid addiction continued to grow in the quarter; the total enrollment at the end of March was 5,499.

Unified Community Collaboratives

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 project 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. Each Administrative Entity has contributed 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 have merged local activities with Accountable Care Organization (ACO) workgroups into Unified Community Collaboratives (UCCs). Their leadership teams include the area's Blueprint Project Manager, representatives of 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, and strategies, including the configuration of the Blueprint CHT. The ultimate goal of these UCCs is to prepare each health service area (HSA) to function as an Accountable Health Community, 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.

The three ACOs in Vermont have developed an MOU to explore formation of a single entity Vermont Care Organization and the governance model in development mirrors the Unified Community Collaborative structure.

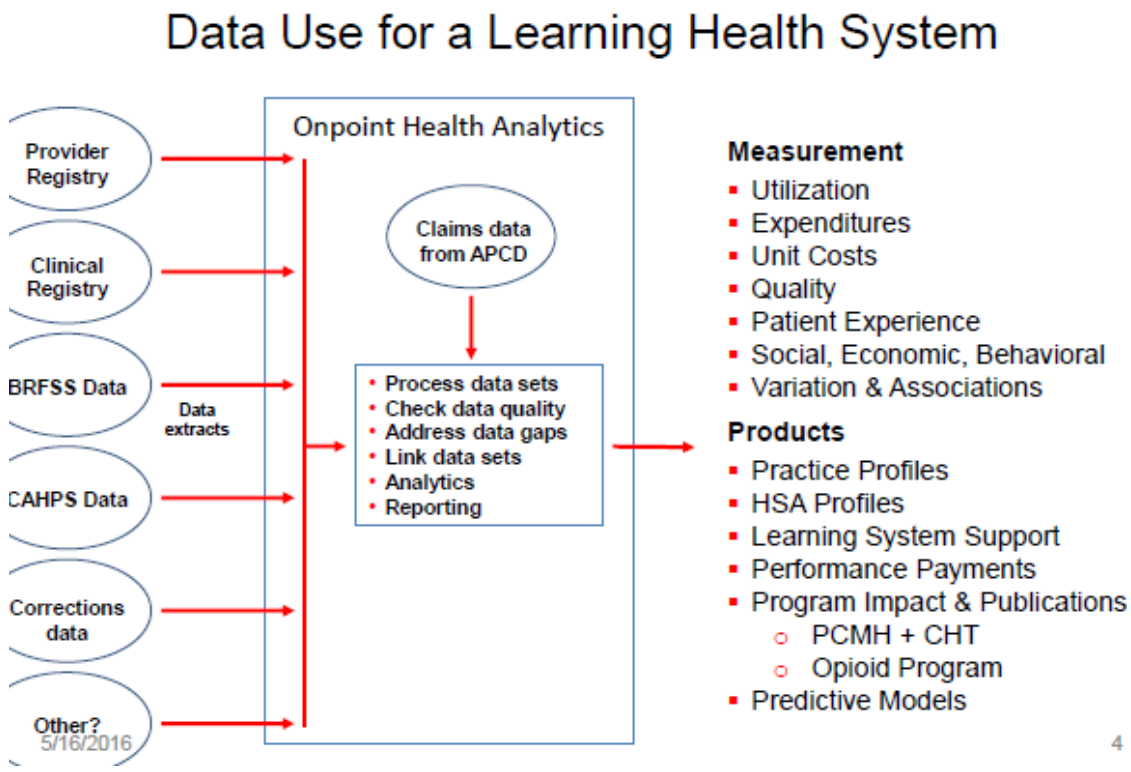
Patient Centered Medical Homes

The number of Blueprint for Health program practices is the same as the previous quarter. The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. The number of Blueprint PCMH practices (MAPCP and non-MAPCP) as of the end of the quarter was 124.

The Blueprint Infrastructure for Data Analytics & Reporting to Support a Learning Health System

In the first quarter of 2016, the Blueprint team fully assessed the functionality of the Clinical Registry and built new interfaces to improve capture of clinical messaging from the Information Exchange. The Blueprint Clinical Registry aggregates clinical data from electronic health records for the purposes of data analysis, evaluation, and quality improvement initiatives. The Blueprint also supports a Provider Registry in which detailed information on participating primary care practices is compiled and regularly updated. The analytics contractor, Onpoint Health Data, holds the contract with the Green Mountain Care board to manage Vermont's All Payer Claims Data base (VHCURES). The Blueprint also contracts with Onpoint Health Data to receive the Medicare data set as part of the MAPCP and to create an analytic data set from the raw claims that includes provider and practice linking. The Blueprint for Health, in collaboration with the ACO partners, completed reporting on the CAHPS survey to all practices. The following schematic illustrates the interplay between the data sources (EMRs, Clinical Registry, and Provider Registry etc.), the analytics work, and the measure results and reports. This infrastructure supports the Blueprint payments, evaluation, and learning health system activities.

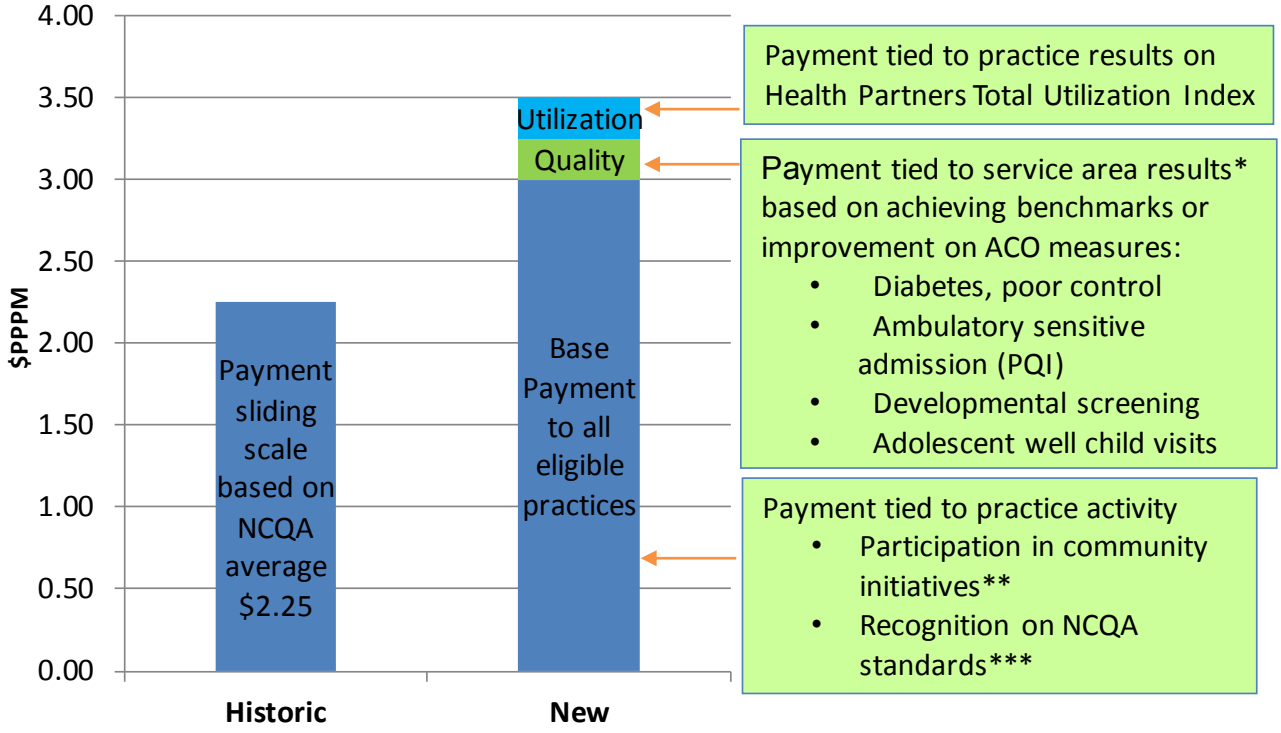
Figure 1. Data Use for a Learning Health System



New Payments

In the first quarter of 2016 Medicaid and Vermont's commercial insurers implemented the changes to the patient-centered medical home payments previously agreed and also paid the first performance payments to eligible practices. The figure below summarizes the changes to the payments. The Medicaid payments for Community Health Teams were adjusted to reflect market share beginning in July 2015.

Figure 2. Comparison of former and current medical home payments



The combined base payments for meeting the NCQA standards and new quality and utilization paytments resulted in the following average PMPM figures.

Table 2. Summary of Performance and Base Payments

Statewide Average PMPM – Utilization	$0.11
Statewide Average PMPM – Quality	$0.10
Combined Statewide Average PMPM	$0.21
Performance + Base Payment	$3.21

Hub and Spoke Program

Enrollment continues to grow in the Hub and Spoke Health Home. Promisingly, we are also seeing an increase in the number of MDs prescribing buprenorphine, especially in the University of Vermont Medical Center Family Medicine group. Also encouraging is the increasing number of MDs prescribing to 10 or more Medicaid beneficiaries by more than 65% between January 2013 and March 2016 from 44 to 73. Spoke staff are deployed in 79 different practice settings statewide (these include primary care, OB-GYN, psychiatry, pain clinics, and specialty addictions programs). The Division of Alcohol and Drug and Abuse issued a new request for proposals for a sixth Hub program located in Northwestern Vermont in this quarter. Finally, the Hub programs began to dispense Vivitrol in this quarter, although the uptake is somewhat limited at 4 patients.

The enrollment detail tables follows.

Table 3. Hub Implementation as of March 28, 2015

Program	Region	Start Date	# Clients	# Buprenorphine	# Methadone
Chittenden Center	Chittenden, Franklin, Grand Isle & Addison	1/13	924	265	654
BAART Central Vermont	Washington, Lamoille, Orange	7/13	380	151	229
Habit OPCO / Retreat	Windsor, Windham	7/13	581	183	398
West Ridge	Rutland, Bennington	11/13	418	123	295
BAART NEK	Essex, Orleans, Caledonia	1/14	612	146	466
STATEWIDE			**2915**	**868**	**2042**

Table 4. Spoke Patients, Providers & Staffing: March 2016

Region	Total # MD prescribing pts	# MD prescribing to ≥ 10 pts	Staff FTE Available Funding	Staff FTE Hired	Medicaid Beneficiaries
Bennington	11	7	5.5	5.6	259
St. Albans	16	11	8.0	3.6	383
Rutland	13	6	6.0	4.1	274
Chittenden	38	17	11.0	10.6	528
Brattleboro	12	6	3.5	3.29	153
Springfield	2	2	2.0	1.5	77
Windsor	8	4	3.5	3.0	175
Randolph	6	3	2.0	1.8	83
Barre	15	8	6.5	4.5	317
Lamoille	7	3	3.5	2.6	155
Newport & St Johnsbury	8	3	2.0	2.0	98
Addison	5	3	1.5	1.5	75
Upper Valley	3	0	.5	0	7
Total	140*	73	55.5	44.09	2,584

Table Notes: Beneficiary count based on pharmacy claims Jan – Mar, 2016; an additional **178** Medicaid beneficiaries are served by **31** out-of- state providers. Staff hired based on Blueprint portal report 3-31-16. *4 providers prescribe in more than one region.

iv. Behavioral Health

- **Key updates from QE0316:**
- Applied Behavior Analysis (ABA) authorizations are ongoing and the ABA Clinical Practice Guidelines have been forwarded to the Managed Care Medical Committee for Approval
- Hybrid Chart Reviews are in process for two HEDIS measures

The DVHA Behavioral Health Team offers a comprehensive approach for behavioral health care coordination. The Team is responsible for concurrent review and authorization of inpatient psychiatric and detox services for Medicaid primary members as well as the utilization management activities for substance abuse residential services for Medicaid primary and uninsured Vermonters. The Team works closely with staff at the inpatient and residential facilities and, when appropriate, the Team collaborates directly with and supports collaboration between facility staff and staff from VCCI, DCF, DMH and ADAP to ensure timely and appropriate transitions of care. The Team also manages the Team Care Program (lock-in) for Medicaid members.

The Applied Behavior Analysis (ABA) benefit was implemented July 1, 2015 and at the time of this report, there continue to be providers in the process of enrolling, representing both designated agencies and a number of private providers. The Autism Specialist has begun the process of the 6 month review for the authorizations that were received and completed in July 2015 and has continued to receive new requests for authorization for Medicaid members. The Autism Specialist continues to provide regular and extensive technical assistance via phone to individual providers and groups with regard to the prior authorization process and other questions about additional enrollments, claims and coverage. The draft Applied Behavior Analysis Clinical Practice Guideline was reviewed by external partners and has been forwarded to the Managed Care Medical Committee (MCMC) for review. The MCMC has recommended the guidelines be adopted and will forward that recommendation and expect to have the Guidelines posted during the next Quarter.

During this quarter, staff continued to solidify and improve the processes for enhanced collaboration with the VCCI. The Behavioral Health Team have received initial training in the use of the new Care Management system which will be used by the Behavioral Health Team to communicate more effectively and efficiently with VCCI staff regarding current VCCI clients who are admitted for psychiatric or substance abuse related care and to make referrals for VCCI services for members who may be eligible but have not yet received services. The team expects to receive additional training in the next Quarter and to begin using the Care Management system as a part of their workflow.

The Behavioral Health Team, in collaboration with the Clinical Operations Unit and the Quality Team has begun the HEDIS hybrid medical record review (MRR) on the controlling high blood pressure (CBP) and adult BMI assessment (ABA) measures. By January of 2016 the new MRR Managers developed a work plan for the MRR. The kickoff meeting with the abstractors and over-readers was held on 1/4/16. Trainings were completed by the end of January. The Inter-rater reliability testing was completed by mid-February. The retrieval letter was approved to go out in the beginning of March. Abstractions began in mid-March and the Behavioral Health Team is working primarily on the ABA Measure, although the Autism Specialist has received training in abstracting both measures.

v. Mental Health System of Care

Key updates from QE0316:

- Global Commitment helps to sustain Mental Health Block Grant-funded programs
- Electronic Health Record development and implementation phase is underway at the state's psychiatric hospital

Mental Health Block Grant (MHBG)

Administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), the mental health block grant allocation to Vermont was increased in the two-year funding cycle that began October 1, 2015, and ends September 30, 2017. This is the first increase in a number of years during which the block grant for community mental health services has decreased under a federal formula. The Department of Mental Health (DMH) has made few if any changes in the distribution of the block grant as the recipient programs and services rely on this revenue source. In the absence of new funding, there has been no real opportunity to direct block grant funds to new initiatives without shifting resources away from existing block grant-funded programs until now. What changed in the second year of the previous funding cycle was growing recognition by behavioral health organizations across the country of the benefits of early intervention to care for young people experiencing a first episode psychosis. SAMHSA addressed this need by a 5% set-aside mandate of the mental health block grant to states. This year, states are required to use 10% of their MHBG on first episode psychosis programming. Congress approved an increase in the MHBG program overall that resulted in Vermont's eligibility for $78,291 uncommitted new dollars in addition to the higher mandatory set-aside for first episode psychosis. The Department of Mental Health brought this information to the Mental Health Block Grant Planning Council, an advisory body whose composition and responsibility are defined in the federal block grant statute. After giving consideration to the expressed interests and priorities of the Planning Council, DMH is developing plans to use the new funds for the Vermont Support Line and for Suicide Prevention. For these program expansions and for long-running recipient programs of the Mental Health Block Grant, the expenditure of state revenues, organizational and community resources, and Global Commitment together form an implementation support structure that makes program sustainability possible.

Mental Health and Health Care Integration

Organizational and staffing changes made to position the Department of Mental Health to seek its place in the great, complex environment of health care reform in Vermont reached a new level in the last quarter. For the first time, DMH sought to make its case to the Green Mountain Care Board that integration was not only essential in moving toward an all-payer system, but also to improving Vermonters' health and lowering health care costs. DMH leadership engaged the Board on the meaning of integration with mental health services as well as better linkages between primary care providers, specialty care, hospitals and other medical services. How to integrate and reimburse those services remains a topic of discussion between DMH, mental health advocates, and the Green Mountain Care Board.

Mental health, physical health and substance abuse services delivered in a coordinated way is a statutory expectation in the most recent legislation defining the Department of Mental Health's role and authority. Previously operating as a division of mental health within the Vermont Department of Health, DMH was re-established in 2007 with an expanded statutory mandate to "…centralize and more efficiently establish the general policy and execute the programs and services of the state concerning mental health, and to integrate and coordinate those programs and services with the

programs and services of other departments of the state, its political subdivisions, and private agencies, so as to provide a flexible comprehensive service to all citizens of the state in mental health and related problems." Act No.15 of 2007 restored a commissioner of mental health, delineating new areas of responsibility to ensure the coordination of mental health, physical health, and substance abuse services provided by the public and private health care delivery systems.

This re-establishment supports DMH's goal to broaden its role to include all Vermonters and to fulfill the statutorily mandated integration and coordination with other health care programs and services. As the framework for Vermont's health care reform evolved, it presented the challenge and the opportunity for DMH to focus on bringing together all of health care—physical health and mental health—within the developing systems of health reform. Research studies support the thinking that mental health has a profound impact on a person's physical health and other social determinants and, conversely, those impact mental health as well. DMH is continuing to lead the discussion regarding the role of health promotion, prevention, early intervention, and evidence-based treatment in health care reform as it relates to mental health and its integration with physical health.

DMH advocates for a range of integrated services to include:

- Strengthened collaboration among primary care practices, designated agencies, and independent mental health services providers
- Co-location between mental health providers and medical providers
- Full integration with shared systems and facilities

This range of integration would facilitate providing the right care at the right time for Vermonters, an important goal of healthcare reform.

Integration of Public Funding for Mental Health Care Services

The Department of Mental Health (DMH) and the Department of Vermont Health Access (DVHA) continue their joint planning process as directed by Act No. 58 of 2015, the budget enacted by the Vermont General Assembly for SFY 2016. Integration of mental and physical health within the State's overall health reform framework, i.e., an integrated health care system, is the goal enunciated in Act 58 and a broadly shared principle. Preliminary to constructing an implementation plan for a unified service and financial allocation for publicly funded mental health services is examination of the current mental health delivery system and the financial, data, quality, policy and oversight functions performed by the Department of Mental Health in fulfillment of its statutory charge to address the mental health needs of all Vermonters. The needs and the activities of this delivery system must be delineated and considered in the effort to integrate Medicaid programs across the Agency of Human Services (AHS) enterprise. Principles to guide the DMH/DVHA planning process must be established. Near and long term initiatives must be identified and sequenced. Action steps required to support meaningful integration across all AHS publically funded mental and physical health services must be supported with the resources necessary to engage in the planning contemplated by Act 58 viewed in the full context of Medicaid programs and services.

Vermont Psychiatric Care Hospital

STATUS OF ELECTRONIC HEALTH RECORD

Development and implementation of an Electronic Health Record (EHR) solution entered a new phase in this quarter. With a vendor[1] under contract, the staff at the Vermont Psychiatric Care Hospital

[1] Computer Programs and Systems, Inc.(CPSI)signed a 5-year contract with the State of Vermont to provide a web-based, contractor-supported electronic medical records system for VPCH. The contracted system will integrate physical,

(VPCH) is involved in planning, training, and working out systems to meeting the needs of hospital patients, providers, and programs at VPCH. For the January through March reporting period, the implementation schedule for the Electronic Health Record remained on track for a fall implementation. In February, the vendor held on-site meetings at VPCH to meet with key staff to gather facility requirements in order to begin configuring the system. The vendor did a walk through to assess equipment and technical requirements to support the system. It will provide VPCH with a map of the facility and the network topology. At these on-site meetings there were opportunities for VPCH staff to ask questions about the system and for the vendor to learn of any differences in the ways that VPCH staff provide patient care that may require modification to the vendor's off-the-shelf system. The vendor's team gathered conversion data, did an interface review, evaluated policies and procedures, evaluated staff responsibilities, and did an IT assessment.

During March the vendor worked on the configurations of VPCH's system based on the requirements gathered in February during the on-site meetings. During this time, VPCH staff gathered the data elements required to populate the system's modules: financial information for billing and insurance, ancillary services, rooms, beds, and specific data needed to populate the patient electronic health record. Also in March, several VPCH staff members traveled to Mobile, Alabama, to attend vendor's training workshops. The week's training consisted of an Electronic Forms Workshop, a System Orientation Seminar, and an Inpatient Physician Administrators workshop.

Reaching this stage of planning for an Electronic Health Record is a significant advancement in bringing the provision of psychiatric inpatient hospital care to a new level of accountability and quality for this component of this system of care.

vi. Pharmacy and 340B Drug Discount Program

Key updates from QE0316:

- The Drug Utilization Review Board held 2 meetings on January 19th and February 23rd. Five new drugs and eleven therapeutic classes were reviewed, two drug utilization review studies were evaluated, and seven safety alerts were presented.
- DVHA sent two provider communications out on the topics of Advair Diskus and 2016 PDL changes.

Pharmacy Benefit Management Program

DVHA's Pharmacy Unit manages the pharmacy benefits for all of Vermont's publicly-funded pharmacy benefit programs. Our goal is to provide the highest quality prescription drug benefits in the most cost effective manner possible. We accomplish this by providing broad coverage of prescription and over-the-counter pharmaceuticals, controlling pharmacy expenditures through managing cost, brand and generic utilization, and reducing state administrative costs. The State of Vermont utilizes the pharmacy benefit management company, Goold Health Systems (GHS), to provide an array of operational, clinical and programmatic support in addition to managing a call center in South Burlington, Vermont, for pharmacies and prescribers. The Pharmacy Unit also has responsibility for overseeing the contract with Goold Health Systems (GHS) as well. The Pharmacy unit manages over $185 million in gross drug spend, and routinely analyzes national and DVHA drug trends, reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy for DVHA members, and managing drug utilization and cost.

behavioral, dietary, billing and lab functions into a single system. This is an "off-the-shelf" system to be tailored to the needs of VPCH.

Pharmacy Operations

- Pharmacy claims processing-enforcing coverage rules for various program.
- Pharmacy provider assistance-DVHA, GHS Technical and Clinical Call Centers.
- Liaison to Coordination of Benefits Unit/PDP/Eligibility/Maximus to resolve issues. Vermont Department of Health (VDH)-Vaccine Program, Substance Abuse Program, Department of Mental Health (DMH) management of antipsychotics.
  - Works with (Vermont Medication Assistance Program) VMAP, Children with Special Health Needs (CSHN) to assist in the management of the programs.

Clinical

- Manages drug utilization and cost
  - Federal, State, Supplemental rebate programs
  - Preferred Drug list
  - DUR/P&T Board activities
    - therapeutic class reviews, prior authorization criteria reviews and step-therapy protocols
  - Specialty Pharmacy
- Manages second reconsiderations, appeals, fair hearings with the Policy Unit
- Works with Program Integrity Unit on drug utilization issues

Initiatives to be Implemented

- Provider Portal
- Electronic Prior Authorization (EPA) (SFY16)
- Electronic Medical Record (EMR) PA (SFY16)
- Medication Therapy Management Program (MTM) (SFY16)

Drug Utilization Review Board (DURB)

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

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

Additionally, per State statute requiring the DVHA Commissioner establish a pharmacy best practice and cost control program, the DURB was designated as the entity to provide clinical guidance on the development of a Preferred Drug List for Medicaid beneficiaries. The DURB typically includes 10-12 members, who are appointed to two-year terms with the option to extend to a 4 year term. 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 Q2 FFY 2016, 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 January 19th and February 23rd DUR meetings:

Full New Drug Reviews

Rexulti, Entresto, Kalydeco, Praluent Injection, Repatha Injection were reviewed for placement on the preferred drug list.

Therapeutic Drug Class Reviews

Acne, Antibiotics, GI, Antibiotics, Misc., Antibiotics, Cephalosporins, Antibiotics, Fluoroquinolones, Tetracyclines, Ophthalmic Antibiotics, Ophthalmics, Glaucoma Agents, Ophthalmic Anti-Inflammatories & Miscellaneous Agents, Ophthalmic Allergic Conjunctivitis and Iron Chelating Agents were reviewed for placement on the preferred drug list.

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
- **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
- 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**
- **UMass Memorial Medical Center**
- **University of Vermont Medical Center and affiliated with UVMMC Outpatient Pharmacies**

vii. Integrating Family Services (IFS) Initiative

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 the waiver. Several such projects have emerged in the children's and EPSDT (early periodic screening diagnostic and treatment) service area.

Specifically, children's Medicaid services are administered across the Intergovernmental Agreement (IGA) partners, and work continues to enhance integration. Programs historically evolved separate and distinct 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 Global Commitment and other changes at the federal level, these siloed structures no longer need to exist. The waiver has allowed for one overarching regulatory structure and one universal EPSDT continuum. This allows for efficient and effective coordination with other federal mandates such as Title V, IDEA parts B and C, Title IV-E, and Federal early childhood programs.

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 is in its fifth state fiscal year, and the second pilot region in Franklin and Grand Isle counties celebrated its second anniversary on April 1, 2016. The initial pilot included consolidation of over 30 state and federal funding streams into one unified whole through one master grant agreement; the second pilot also includes consolidation of several state and federal funding streams. 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. There is a comprehensive effort occurring to move the master grants towards being more integrated in regards to performance measures and alignment of language. These master grants are over 100 pages long and have performance measures listed throughout. There is a significant amount of work the Agency is embarking on with our partners to make these grants more effective and stream-lined.

There is a comprehensive effort occurring to move the Designated Agency Master Grants towards being more integrated in regards to performance measures and alignment of language. These master grants are over 100 pages long and have performance measures listed throughout. There is a significant amount of work the Agency is embarking on to make these grants more effective and stream-lined.

Addison County's aggregate annual budget is approximately $4 million with $3 million being Global Commitment covered services. In Franklin/Grand Isle Counties, the Global Commitment covered services are near $5,400,000. The early successes of these 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, having a positive impact on 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 financial model supporting this agreement includes a monthly case rate established for the reimbursement of all Medicaid-covered sub-specialty services. Case rates are based on agreed upon annual allocations for covered services divided by the minimum Medicaid caseload expectation. The same member month rates will be paid for minimal service packages as for intensive service packages. The goal of the funding model is to ensure that beneficiaries get a package of EPSDT and outreach services commensurate with their functional needs within an overall annual aggregate reimbursement cap. Case rates are not based on any one group of services being 'loaded' into a claim; they are global aggregate budget/minimum caseload. Annually, providers and the State will reconcile actual financial experience to the grant.

With the continued interest in moving IFS statewide, there has been great efforts made through five work groups to reach clarity about the IFS financing model, data and outcomes to be collected, prevention and promotion efforts and how the state in IFS regions has consistent supports and services available to families so that regardless of where they reside in the state they have access to similar service provision. These work groups are made up of state and community partners to ensure multiple perspectives are present at the table and will have completed the work plan goals outlined for them in June 2016.

Continued outreach is occurring across the state to educate regions about the IFS approach and support them in their efforts to move forward. At this time, there are several regions working on the Steps to Readiness required to become an IFS region. It appears there will be multiple regions ready to move forward with IFS in either January 2017 or in SFY2018.

IFS is showing promising results in its pilot regions, and those results are largely due to the payment and service delivery system reforms IFS makes possible. IFS is working within the larger payment reform occurring in Vermont to ensure the current successes can expand under the Medicaid Pathway.

Additionally, IFS continues to work on statewide health care reform and aligning approaches to achieve an integrated behavioral and physical health system. Some examples of how IFS is working to align approaches are:

- IFS is engaged in a statewide effort to look more effectively at how Vermont can increase the number of children and youth in family settings as opposed to residential treatment.
- IFS has created a teaming pilot in two regions in Vermont to look at how agency departments can team to support families who have complex needs and therefore are accessing services through a number of the agencies departments (child welfare, economic services, corrections, substance abuse, early childhood).

- Due to positions in the Agency of Education and the Agency of Human Services being eliminated, IFS is partnering with the Disabilities Division to bring together state and community leaders to strategize about how to ensure focus and services occur for children with autism diagnoses in Vermont.

viii. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE0316:

- DVHA is seeking 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 has drafted a Request for Proposals (RFP) including a proposed Scope of Work for ACOs that would participate in such an arrangement.
- 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.

The Department of Vermont Health Access (DVHA) is seeking 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(s) 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.

In this quarter, DVHA has drafted a Request for Proposals (RFP) including a proposed Scope of Work for ACOs that would participate in such an arrangement. The RFP will be posted and bids will be solicited in the upcoming quarter. Any Apparently Successful Bidders identified as a result of the procurement process will also be subject to a readiness review prior to the effective date of the agreement so that DVHA may ensure an ACO's ability to assume the roles and responsibilities outlined in the RFP. DVHA has also engaged an independent actuarial firm which, at a later point in the procurement process, will develop and certify per member per month (PMPM) capitation rates for inclusion in a contract for the services described above.

DVHA plans to sign an agreement with one or more ACOs to achieve enhanced integration of health care services, with the potential to integrate 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.

VI. Financial/Budget Neutrality Development/Issues

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 optional one-year extensions. AHS will kick-off the FFY17 Global Commitment per member per month rate setting process next quarter.

During this quarter, CMS Regional Office conducted a review of eligibility for VIII Group, also known as the Childless New Adult population. Vermont is entitled to receive enhanced FFP for this group of beneficiaries. The initial review found that six of the thirty individuals sampled may not have been eligible for the VIII Group. AHS and DVHA are in the process of further researching whether or not these six individuals met the eligibility criteria.

AHS experienced challenges with the QE0316 CMS-64 submission when it came to entering negative amounts for current quarter 100% ACA EPCP claims (this enhanced Match expired QE1214). MBES does not allow for entry of negative amounts in the current quarter Waiver forms. Therefore, AHS entered the amounts as a line 10B prior quarter adjustment.

Also on the QE0316 CMS-64 submission, AHS reported CRT-DSHP costs for the initial time on its own Waiver form. These costs represent expenditures under the demonstration payments through a state funded program for CRT services, as defined by Vermont rule and policy, provided to individuals with severe and persistent mental illness who have incomes above 133 percent of the FPL and up to and including 185 percent of FPL, who are not Medicaid enrolled.

VII. Member Month Reporting

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.

Table 5. Number of Recipients, Change from Previous Quarter

	Q1 FFY 2016			Q2 FFY 2016		
Demonstration Population	**October 31, 2015**	**November 30, 2015**	**December 31, 2015**	**January 31, 2016**	**February 29, 2016**	**March 31, 2016**
Demonstration Population 1	37,946	37,896	37,538	37,059	36,672	36,311
Demonstration Population 2	84,551	84,698	84,772	85,027	85,234	84,759
Demonstration Population 3	59,343	59,809	60,317	62,306	63,045	63,072
Demonstration Population 4	2,950	2,887	2,819	2,958	2,905	2,839
Demonstration Population 5	942	930	929	965	964	955
Demonstration Population 6	893	889	873	851	847	841
Demonstration Population 7	7,346	7,376	7,397	7,379	7,530	7,506
Demonstration Population 8	4,195	4,196	4,213	4,216	4,282	4,270
	198,166	198,681	198,858	200,761	201,479	200,553

VIII. Consumer Issues

AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular program. The complaints received by Member Services are based on reports provided to DVHA (see Attachment 3). Member Services works to resolve the issues raised by beneficiaries, and their data helps DVHA look for any significant trends. The reports are seen by several management staff at DVHA and staff asks for additional information on complaints that may appear to need follow-up to ensure that the issue is addressed.

The second mechanism to assess trends in beneficiary issues is the Managed Care Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations across the MCE. The database into which they enter information helps them track the timeframes for responding to the grievances and appeals, as well as assists DVHA and AHS in monitoring compliance and assessing if there are trends that may benefit from a performance improvement project.

The third mechanism to track consumer issues is the Office of the Health Care Advocate (HCA) report which is a comprehensive report of all contacts with beneficiaries (see Attachment 5). These include inquiries, requests for information, and requests for assistance. The HCA's role is to assist individuals to navigate health care insurance systems, and help to resolve eligibility and coverage problems.

IX. Quality Improvement

Key updates from QE0316:

- The MCE Quality Committee recommended changes to our *Global Commitment to Health* Core Performance Measure set.
- The Quality Unit and the Department of Health began a quality improvement collaboration focused on the Medicaid population via a shared grant funded position.
- Members of the Quality Unit and the Vermont Department of Health's Alcohol and Drug Abuse Program (ADAP) engaged appropriate committees in order to further research and plan for our next formal PIP.

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

Quality Committee Updates:
The MCE Quality Committee met monthly during the quarter. Last quarter, the Committee established a set of Quality measure selection criteria that we used during this quarter to review the current *Global Commitment to Health* Core Measure set. The following changes were recommended:

- Eliminate Anti-Depressant Medication Management (AMM) – we are sun setting the measure for this year
- Eliminate Use of Appropriate Medications for People with Asthma (ASM) – retired by NCQA and Replace with Medication Management for People with Asthma (MMA).
- Add Ambulatory Care ER Visits (AMB)

Additionally, we recommended that the MCE work towards disaggregating measures on the GC Core Measure list when possible by target populations that receive GC funding. We feel this will better represent the breadth of Medicaid services delivered and monitored under the Global Commitment to Health waiver. In the following quarter, this Committee will continue to work with the data analysts across these programs to determine data reliability and completeness for various target populations.

The AHS Performance Accountability Committee (PAC) met monthly during the quarter. The group conducted a self-assessment of its performance and effectiveness during the beginning of the quarter. This process included a collective, introspective, and comprehensive reflection by committee members. Areas of consideration included, but were not limited to the following: goals, support, meeting time/location, attendance, and membership. Feeback obtained was used to identify strengths and challenges, flag areas for improvement, and plan for further action as appropriate. In addition, the group addressed Goal Five of the AHS Strategic Plan: *Ensure Accountability for Performance and Outcomes for the People we Serve*. . The first strategy associated with this goal is the development of performance management organizational competencies. The group agreed to use it's time to identify organizational competencies that are aligned with the AHS Performane Framework. This work is expected to continue through the next few quarters. Also during this quarter, HCBS systemic assessments and work plans were finalized and shared with stakeholder groups. The AHS QIM continued to work with PHPG to finalize the Choices for Care systemic assessment. Next steps include developing provider self-assessment and consumer survey validation tools.

Comprehensive Quality Strategy/State Transistion Plan:
During this quarter, all systemic assessments and work plans were completed and shared with stakeholders. Any feedback obtained from stakeholders will be taken into account before the documents are finalized. In addition, the HCBS Implementation Work Group began planning for the provider self-assessment and validation activities. As a first step, members of the group reviewed CMS resource material as well as provider self-assessment and consumer survey tools from other states. In addition, the group reviewed existing State quality oversight and monitoring activities that could be used to support the validation process. The group supported a mixed methods approach to validation. The group expects to select appropriate provider self-assessment and validation tools during the next quarter. Future issues for the group to address include the following: methodology to educate/train providers and consumers and finalize a process to review results and follow up on action items.

MCE Investment Review:
During this quarter, it was decided that the AHS Integrated Operations and Policy Team (IOPT) would take on the responsibility of evaluating the performance of current MCE investments. As a first step, an evaluaton/scoring tool was developed to help guide the process. The tool contains the key or critifcal questions that can be used to guide the presentor – as well as scoring criteria to be used by the team. The tool was reviewed by the AHS PAC and a final version distributed to Departments. The goal is to review all Department investments over the next couple of quarters.

Healthcare Effectiveness Data and Information Set (HEDIS) Hybrid Medical Record Review:

In 2016, DVHA will complete a HEDIS hybrid medical record review (MRR) on the controlling high blood pressure (CBP) and adult BMI assessment (ABA) measures. By January of 2016 the new MRR Managers developed a work plan for the MRR. The kickoff meeting with the abstractors and over-readers was held on 1/4/16. Trainings were completed by the end of January. The Inter-rater reliability testing was completed by mid-February. The retrieval letter was approved to go out in the beginning of March. Abstractions began in mid-March. The retrieval rate by the end of March was about 45% complete with 651 records retrieved.

Grant Funded Quality Improvement Projects:

The Adult Medicaid Quality (AMQ) Grant came to a close February 28, 2016. The last activity under the grant was a mailing sent out under the Breast Cancer Screening (BCS) Performance Improvement Project (PIP). DVHA & VDH partnered in sending a cancer screening mailing to 46,000 Medicaid beneficiaries as an extension of the beneficiary intervention of the PIP.

DVHA and VDH were interested in continuing the partnership, and found funds to continue supporting the AMQ Grant Program Manager position in leading cancer screening quality improvement projects (QIPs). The following QIPs are currently in progress:

- **Provider mailing:** To complement the public brochure sent to Medicaid beneficiaries in February 2016, a cover letter from Dr. Chen (the VDH Commissioner) and copies of the public and provider cancer screening brochures are being sent to 5,100 Medicaid providers in April 2016.

- **Gap-in-care lists:** DVHA has committed to continuing to work with the All Payer Joint Project through 2016. Medicaid, MVP & BCBSVT are sending similarly formatted quarterly gap-in-care (GIC) reports to 29 Blueprint practices. The reports show the entire panel of female Medicaid beneficiaries ages 50-64 served at the practice and whether or not they have received a mammogram in the last 2 years.

- **Ladies First Direct Mail** to all female Medicaid primary beneficiaries ages 40-64 statewide
    - Women ages 40-49: Send a 1 time mailing with recommendation to talk to their PCP on when to get a mammogram based on their risk factors in October 2016
    - Women ages 50-64 who have had a screening mammogram in the last two years: Send a reminder letter to get a f/up mammogram over 12 months beginning in May 2016
    - No mailing will be sent to women ages 50-64 who have had a diagnostic mammogram in the last 2 years; these women should receive individualized follow-up from their PCP or mammogram facility.
    - Women ages 50-64 who have not had a screening or diagnostic mammogram in the last 2 years: Send a one-time mailing with educational materials urging them to get a mammogram in October 2016

- **Ladies First In-person outreach to Medicaid beneficiaries:** The Grant Program Manager & the Ladies First Outreach Specialist are meeting with all of the Ladies First clinic champions to discuss their community outreach efforts. The results of this research will be shared back with

the champions to generate idea sharing and discussion. If there are new outreach efforts that could be developed, assistance in developing & implementing new interventions will be provided.

- **Wise Woman Enrollment Project:** Several months ago, VDH received permission from CDC to offer enrollment in the Ladies First & Wise Woman programs to Medicaid beneficiaries (previously not allowed). Once enrolled in Ladies First, if a woman has received a mammogram & a pap test, she is offered enrollment into one of the Wise Woman lifestyle programs (Weight Watchers, Curves Plus) after receiving a cardiovascular screen from her PCP. Ladies First and Medicaid are currently working on moving the dual enrollment issue through the Policy, Budget & Reimbursement (PBR) process. Once approval is obtained, the program will be rolled out to female Medicaid beneficiaries 30-64 using a planned, strategic approach.

Formal (Validated) Performance Improvement Project:

DVHA continues to lead an AHS-wide Performance Improvement Project (PIP) on Follow-up After Hospitalization (FUH) for Mental Illness, the study indicator for which is the HEDIS measure of the same name (FUH HEDIS). During this quarter, follow-up appointment scheduling reports were again prepared and distributed to the designated hospitals and will continue to be distributed on a quarterly basis. During this reporting period, members of the FUH PIP implementation team continued to work with the Medicaid ACO's to explore a new system intervention. We hoped to identify the individuals in the FUH denominator who are also attributed to ACO's, and outreach the appropriate providers within the ACO network to help support the individual and facility in scheduling follow-up care with a mental health practitioner. Through meeting with the ACO representatives, however, it became clear that the timing wasn't right for this sort of additional intervention. Although interested, both ACO's had other initiatives already underway that were focused on this population – one with DVHA's own Vermont Chronic Care Initiative, the other a joint effort with the Vermont Blueprint for Health's community health teams.

However, also during this quarter, the DVHA QI Administrator was approached by the project coordinator for the Vermont Program for Quality in Healthcare (VPQHC) who had recently been asked to manage a joint payer project between Vermont Blue Cross Blue Shield and MVP focused on improving their FUH HEDIS rates. The DVHA Quality Unit agreed to join this effort. During the QE0316, the QI Administrator shared some of our FUH project information and data and future joint payer meetings are planned for subsequent quarters. This may become an unexpected, yet welcome, avenue to sustain and build upon the work of our PIP.

Future Formal Performance Improvement Projects:

The DVHA Quality Unit staff continue to engage appropriate committees within the Agency, such as the Managed Care Medical Committee, the MCE Quality Committee and the Performance Accountability Committee in conversation about the need to thoughtfully research and plan for future performance improvement projects. Both PIPs that fall within the AMQ Grant ended in December 2016, and the MCE's formal PIP cycle (Follow-Up After Hospitalization for Mental Illness) ends in June 2016. Conversations will continue and data based decisions will be made in the coming months related to new improvement projects.

During the QE0316, the topic of substance use disorders has risen to the top as a potential focus area

for our next MCE 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 have formed a team to explore inter-Agency support and interest in this project topic. A presentation was delivered to the Agency's Substance Abuse Treatment Committee (SATC) and was met with enthusiasm. We were encouraged to also reach out to the Agency's Screening, Brief Intervention, Referral to Treatment (SBIRT) work group to explore how our project could dovetail with work already underway. An April 2016 meeting is planned.

Consumer Assessment of Healthcare Providers and Systems Survey:

In 2015, DVHA participated in a national experience of care survey effort for the adult Medicaid population, which was coordinated by the National Opinion Research Center at the University of Chicago (NORC). Results of the 2015 adults CAHPS survey are expected to be released to states soon. During this reporting period, the DHVA Quality Unit staff continued to work with the Blueprint for Health to finalize contract amendment details for CAHPS survey coordination. It was determined that efficiencies and cost savings could be created by using the Blueprint vendor to field a children's Medicaid health plan survey in 2016. We hope to field that survey during the QE0616.

X. Compliance

Key updates from QE0316:

- 2016 EQRO audit preparation is progressing
- Reviewing new Managed Care rules
- New network standards policy is in draft form

The Managed Care Compliance program is responsible for ensuring that managed care operations are in compliance with all governing policies, regulations, agreements and statutes. This is accomplished through audits and corrective actions coordinated by the Managed Care Compliance Committee. This work is coordinated across AHS through Intergovernmental Agreements (IGAs) with the departments involved in managed care programs.

External Quality Review (EQR):

During this quarter, the AHS QIM worked with the EQRO to develop timelines for each of the required annual external quality review activities. All timelines included the following elements: start date, completion date, task, and responsible party. Key tasks of the Performance Improvement Validation timeline include the following: feedback/comments on PIP documents, review/revise PIP validation tool, provide feedback on draft report, and review final report. The MCE is scheduled to receive the review documents during the next quarter. Key tasks of the Performance Measure Validation timeline included the following: identify measures for validation, review and provide feedback on documentation request letter and attachments, develop schedule of on-site visit, review and provide feedback on draft performance measure validation report. The MCE is scheduled to receive the review documents during the next quarter. Key tasks of the Compliance Review timeline included the following: finalize the scope of the review, review supporting documents and data collection tool, plan on-site visit, and review draft report. The MCE is scheduled to receive the compliance review documents during the next quarter. During this quarter, we continued our preparation for the upcoming EQRO audit by completing our preliminary review of prior-year

recommendations and by meeting with all staff who will participate in this year's review. We have also begun sorting through the documents we expect to submit to the auditors.

Also during this quarter, DVHA staff worked with AHS and the External Quality Review Organization (EQRO) to review and verify the timeline for this year's validation activities. In addition, the staff continued their preparation for the upcoming EQRO audit by completing the preliminary review of prior-year recommendations and by meeting with all staff who will participate in this year's review. Finally during this quarter, DVHA staff began sorting through the documents they expect to submit to the reviewers.

The 2016 EQRO Compliance review will focus on the following Access standards:

I. Availability of services: This standard includes a review of the adequacy of DVHA's 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 DVHA's network, including appointment wait times, access to after-hours assistance and the processes for monitoring and correcting issues related to this standard.
III. Cultural Competence: In this standard, DVHA will need to demonstrate how services and messages are delivered with regard to 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 used to authorize services that require prior approval. DVHA will also demonstrate that the services covered are appropriate in amount, duration, and scope, and that DVHA does not arbitrarily deny covered services without a sound clinical reason for doing so. This standard requires a review of the written procedures for coverage and authorizations and a demonstration of DVHA's coordination with clinicians to ensure that only qualified personnel are making clinical decisions. Finally, this standard requires that DVHA demonstrate adherence to statutory processes around providing timely notices to members about coverage decisions (and their rights to appeal decisions).
VI. Emergency and Post-Stabilization 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.

This is, perhaps, the most complicated and involved year in our three-year EQRO cycle.

Finally, during this quarter, a new external quality review contract was developed and initiated. The term of the new contract runs from February 15, 2016 through February 14, 2018.

New Managed Care Rules Under Review
DVHA's compliance team is in the process of reviewing the final Medicaid Managed Care rules changes. We are working in concert with the AHS Policy Unit and other DVHA units to ensure that DVHA understands and complies with all relevant changes.

New Network Standards Policy has been drafted
The DVHA Compliance Team, Provider and Member Relations Unit, DVHA Data Unit and the AHS Policy Unit collaborated to build a new draft policy around network adequacy. This new policy is designed to comply with new managed care requirements, focuses more on data and reporting and clarifies our network adequacy expectations for many specific provider types. Overall, this policy will help DVHA to continue to ensure that we have a robust network of providers ready to provide covered services to all of our enrolled members.

XI. Demonstration Evaluation

During the previous quarter, a draft evaluation plan was submitted to CMS. The new plan takes key evaluation elements from the previous Global Commitment to Health waiver as well as the previous Choices for Care waiver. In addition, an interim evaluation report was submitted. This document is informed by the aforementioned draft evaluation plan. No feedback on either document has been received to date. Finally, the AHS QIM attended the Vermont's SIM grant evaluation kick off meeting. Topics covered during the meeting included but were not limited to the following: evaluation scope, conceptual framework, and timeline. In addition, the contractor provided an over view of the methods to be used during the evaluation (e.g., site visits, consumer focus groups, and provider surveys). As this evaluation proceeds, it will be important to understand where it intersects with and how it informs Vermont Medicaid health reform/system level reform efforts.

XII. Reported Purposes for Capitated Revenue Expenditures

Provided that DVHA's contractual obligation to the populations covered under the Demonstration is met, any revenue from capitation payments related to the beneficiaries covered under this Demonstration may be used for the following purposes:

- Reduce the rate of uninsured and/or underinsured in Vermont;
- Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
- Provide public health approaches to improve the health outcomes, health status and the quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Attachment 6 is a summary of Managed Care Entity Investments, with applicable category identified, for SFY 2015.

XIII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook

Attachment 2: Enrollment and Expenditures Report

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of the Health Care Advocate Report

Attachment 6: State Fiscal Year 2015 Managed Care Entity Investments

XIV. State Contact(s)

Fiscal:	Sarah Clark, CFO	
	VT Agency of Human Services	802-505-0285 (P)
	280 State Drive	802-241-0450 (F)
	Waterbury, VT 05671-1000	sarah.clark@vermont.gov
Policy/Program:	Selina Hickman, Director of Health Care Operations, Compliance & Improvement	
	VT Agency of Human Services	802-585-9934 (P)
	280 State Drive, Center Building	802-241-0452 (F)
	Waterbury, VT 05671-1000	selina.hickman@vermont.gov
Managed Care Entity:	Steven M. Costantino, Commissioner	
	Department of VT Health Access	802-241-0147 (P)
	280 State Drive, NOB 1 South	802-879-5962 (F)
	Waterbury, VT 05671-1010	steven.costantino@vermont.gov

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ATTACHMENTS

Global Commitment Expenditure Tracking

Attachment 1

QE	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY**9a**	PQA: WY**9b**	PQA: WY10	PQA: WY11	Net Program PQA	Net Program Expenditures as reported on 64	Excess New Adult Expenditures as reported on 64 per STC 55e	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	$ 814,587	$ (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		
Cumulative																		**$ 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		
Cumulative																		**$ 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		
Cumulative																		**$ 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		
Cumulative																		**$ 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	$ 243,508,248						$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		
Cumulative																		**$ 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		
Cumulative																		**$ 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		
Cumulative																		**$ 7,841,950,966**	**$ 8,450,684,486**	**$ 608,733,520**
1213	$ 319,939,651								$ 3,652,767					$ 3,652,767	$ 323,592,418					
WY**9a** SUM	$ 319,939,651	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,652,767					$ 3,652,767	$ 319,921,780		**$ 1,214,631**	$ 321,136,411		
Cumulative																		**$ 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					
WY**9b** SUM	$ 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		
Cumulative																		**$ 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 SUM	$ 1,336,350,389	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (526,911)	$ 9,076,850		$ 8,549,939	$ 1,343,667,762		**$ -**	$ 1,343,667,762		
Cumulative																		**$ 10,620,338,964**	**$ 11,969,357,946**	**$ 1,349,018,982**
0316	$ 370,951,068											$ (1,759,477)		$ (1,759,477)	$ 369,191,591					
0616														$ -	$ -					
0916														$ -	$ -					
1216														$ -	$ -					
WY11 SUM	$ 370,951,068	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,759,477)	$ -	$ (1,759,477)	$ 370,951,068		**$ -**	$ 370,951,068		
Cumulative																		**$ 10,991,290,032**	**$ 13,752,420,439**	**$ 2,761,130,407**
	$ 10,733,112,494	$ 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	$ 7,317,373	$ -		**$ 10,937,928,149**	$ -	$ 53,361,884			

VERMONT

State of Vermont
Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
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Agency of Human Services

Medicaid Program Enrollment and Expenditures Report

Q2 SFY 2016

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

April 12, 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, March 15, 2016

	SFY '16 Appropriated			SFY '16 Actuals thru December 31, 2015			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	15,680	$ 113,165,353	$ 601.43	16,678	$ 53,132,397	$ 530.96	46.95%
ABD Dual	17,978	$ 50,051,552	$ 232.01	18,849	$ 27,203,783	$ 240.54	54.35%
General Adult	15,966	$ 90,450,192	$ 472.09	20,108	$ 47,712,378	$ 395.47	52.75%
New Adult	48,985	$ 193,377,396	$ 328.97	59,040	$ 126,938,322	$ 358.34	65.64%
Exchange Premium Assistance #	18,368	$ 8,541,105	$ 38.75	15,646	$ 2,313,602	$ 24.65	27.09%
Exchange Cost Sharing #	6,034	$ 1,522,615	$ 21.03	5,117	$ 538,822	$ 17.55	35.39%
ABD Child	3,727	$ 38,392,328	$ 858.33	3,279	$ 14,657,900	$ 745.04	38.18%
General Child	57,594	$ 132,798,298	$ 192.15	63,106	$ 75,380,432	$ 199.08	56.76%
Underinsured Child	981	$ 1,137,209	$ 96.59	810	$ 574,183	$ 118.22	50.49%
SCHIP	4,417	$ 7,417,112	$ 139.93	4,462	$ 3,440,777	$ 128.52	46.39%
Pharmacy Only	12,709	$ 6,396,479	$ 41.94	11,575	$ (924,665)	$ (13.31)	-14.46%
Choices for Care	4,222	$ 207,145,319	$ 4,533.64	3,859	$ 105,207,454	$ 4,544.40	50.79%
Total Medicaid Claims Paid	206,663	$ 850,394,957	$ 342.91	222,528	$ 456,210,078	$ 341.69	53.65%

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, March 15, 2016

	SFY '16 Appropriated			SFY '16 Actuals thru December 31, 2015			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	15,680	$ 191,779,487	$ 1,019.23	16,678	$ 90,956,930	$ 908.94	47.43%
ABD Dual	17,978	$ 204,746,363	$ 949.08	18,849	$ 101,203,425	$ 894.86	49.43%
General Adult	15,966	$ 99,955,443	$ 521.71	20,108	$ 52,845,082	$ 438.01	52.87%
New Adult	48,985	$ 213,533,274	$ 363.26	59,040	$ 139,046,910	$ 392.52	65.12%
Exchange Premium Assistance #	18,368	$ 8,541,105	$ 38.75	15,646	$ 2,313,602	$ 24.65	27.09%
Exchange Cost Sharing #	6,034	$ 1,522,615	$ 21.03	5,117	$ 538,822	$ 17.55	35.39%
ABD Child	3,727	$ 91,730,054	$ 2,050.80	3,279	$ 33,832,400	$ 1,719.65	36.88%
General Child	57,594	$ 249,488,277	$ 360.98	63,106	$ 124,186,917	$ 327.99	49.78%
Underinsured Child	981	$ 2,744,907	$ 233.13	810	$ 983,728	$ 202.54	35.84%
SCHIP	4,417	$ 8,720,602	$ 164.52	4,462	$ 4,023,640	$ 150.29	46.14%
Pharmacy Only	12,709	$ 6,396,479	$ 41.94	11,575	$ (828,649)	$ (11.93)	-12.95%
Choices for Care	4,222	$ 207,145,319	$ 4,149.76	3,859	$ 106,429,286	$ 4,597.18	51.38%
Total Medicaid Claims Paid	206,663	$ 1,286,303,925	$ 518.68	222,528	$ 655,556,349	$ 490.99	50.96%

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, March 15, 2016

	SFY '16 Appropriated			SFY '16 Actuals thru December 31, 2015			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	15,680	$ 199,103,799	$ 1,019.23	16,678	$ 91,254,905	$ 911.92	45.83%
ABD Dual	17,978	$ 219,158,951	$ 949.08	18,849	$ 101,263,057	$ 895.39	46.21%
General Adult	15,966	$ 100,841,028	$ 521.71	20,108	$ 52,887,636	$ 438.36	52.45%
New Adult	48,985	$ 215,411,154	$ 363.26	59,040	$ 139,057,365	$ 392.55	64.55%
Exchange Premium Assistance #	18,368	$ 8,541,105	$ 38.75	15,646	$ 2,313,602	$ 24.65	27.09%
Exchange Cost Sharing #	6,034	$ 1,522,615	$ 21.03	5,117	$ 538,822	$ 17.55	35.39%
ABD Child	3,727	$ 96,699,417	$ 2,050.80	3,279	$ 37,077,870	$ 1,884.61	38.34%
General Child	57,594	$ 260,360,035	$ 360.98	63,106	$ 130,113,234	$ 343.64	49.97%
Underinsured Child	981	$ 2,894,111	$ 233.13	810	$ 1,065,005	$ 219.27	36.80%
SCHIP	4,417	$ 9,869,164	$ 164.52	4,462	$ 4,289,285	$ 160.21	43.46%
Pharmacy Only	12,709	$ 6,391,227	$ 41.94	11,575	$ 771,694	$ 11.11	12.07%
Choices for Care	4,222	$ 207,150,597	$ 4,149.76	3,859	$ 106,429,748	$ 4,597.20	51.38%
Total Medicaid Claims Paid	206,663	$ 1,327,943,202	$ 535.47	222,528	$ 667,086,478	$ 499.63	50.23%

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.

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
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Questions, Complaints and Concerns Received by Health Access Member Services
January 1, 2016 – March 31, 2016

January 4 – January 8

- Nothing to report.

January 11 – January 15

- Legacy Renewals: Customer Service Representatives (CSR)'s assisted in completing the application process or advised of other application channels.

January 19 – January 22

- VPharm Premiums: CSR's reviewed account and advised amount due.

January 25 – January 30

- Legacy Medicaid Renewals: CSR's review account to determine if a new application is needed and either assist with the application or request renewal.

January 31 – February 5

- Legacy Medicaid Renewals: CSR's review account to determine if a new application is needed and either assist with the application or advised how to proceed. If changes reported CSR's captured the information and had customer rescreened.
- PDP Invoices for VPharm Customers: CSR's reviewed account to confirm if customer was on a no-cost plan; if yes, CSR's advised to inform PDP that VT SPAP is paying, or, if not, reviewed the amount due.

February 8 – February 12

- Legacy Medicaid Renewals: CSR's review account to determine if a new application is needed and either assist with the application or advised how to proceed. If changes reported CSR's captured the information and had customer rescreened.
- PDP Invoices for VPharm Customers: CSR's reviewed account to confirm if customer was on a no-cost plan; if yes, CSR's advised to inform PDP that VT SPAP is paying and escalated request to OR to L3, or, if not, reviewed the amount due.

February 15 – February 19

- Legacy Medicaid Renewals: CSR's reviewed account to determine if a new application is needed and advised of application channels.
- PDP Invoices for VPharm Customers: CSR's reviewed account and if customer has been on program for less than four months advised to wait the necessary time, or is

customer has been on program for over four months followed the appropriate protocol.

February 22 – February 26

- Legacy Medicaid Renewals: CSR's reviewed account to determine if a new application is needed and advised of application channels, or updated a previously submitted application.

February 29 – March 4

- LMR Closure Letters: CSR's reviewed account to determine if a new application was received and either advised of status or advised of application channels and timeframes.
- MSP Closures: CSR's reviewed account to determine if still income eligible and, if so, submitted a accretion request and sent an imbursement form if necessary.
- PDP Closure Letters: CSR's reviewed HP to confirm payments were being made to the new PDP and escalated an SR if needed.

March 7 – March 11

- LMR Closure Letters: CSR's reviewed account to determine if a new application was received and either advised of status or advised of application channels and timeframes.
- Renewal Application: CSR's reviewed account to determine if a new application is needed and advised of application channels, or updated a previously submitted application.

March 14 – March 18

- LMR Closure Letters: CSR's reviewed account to determine if a new application was received and either advised of status or advised of application channels and timeframes.
- Renewal Application: CSR's reviewed account to determine if a new application is needed and advised of application channels, or updated a previously submitted application.
- VPharm Customers receiving Large PDP Bills: CSR's advised HPE shows payments and to contact PDP, or escalated a L3 SR if PDP unwilling to assist.

March 21 – March 25

- PDP Issues: CSR's researched account in ACCESS and HP to confirm PDP is being paid and advised of the 3 to 4 month waiting period.

March 28 – April 1

- Legacy Medicaid Renewal Applications: CSR's reviewed reference and assisted in completing the application process or advised of other application channels.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
January 1, 2016 – March 31, 2016

The MCE 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 MCE 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 MCE database. This report is based on data compiled on January 16, 2016, from the centralized database for grievances and appeals that were filed from January 1, 2016 through March 31, 2016.

Grievances: A grievance is an expression of dissatisfaction about any matter that is not an action taken by the MCE.

During this quarter, there were 23 grievances filed with the MCE; fourteen 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 three days. Of the grievances filed, 65% were filed by beneficiaries and 35% were filed by a representative of the beneficiary. Of the 23 grievances filed, DMH had 43%, DVHA had 35%, DAIL had 13% and VDH had 9%. There were no grievances filed for the DCF during this quarter.

There were no Grievance Reviews filed this quarter.

Appeals: Medicaid rule 7110.1 defines actions that an MCE 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 MCE 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.

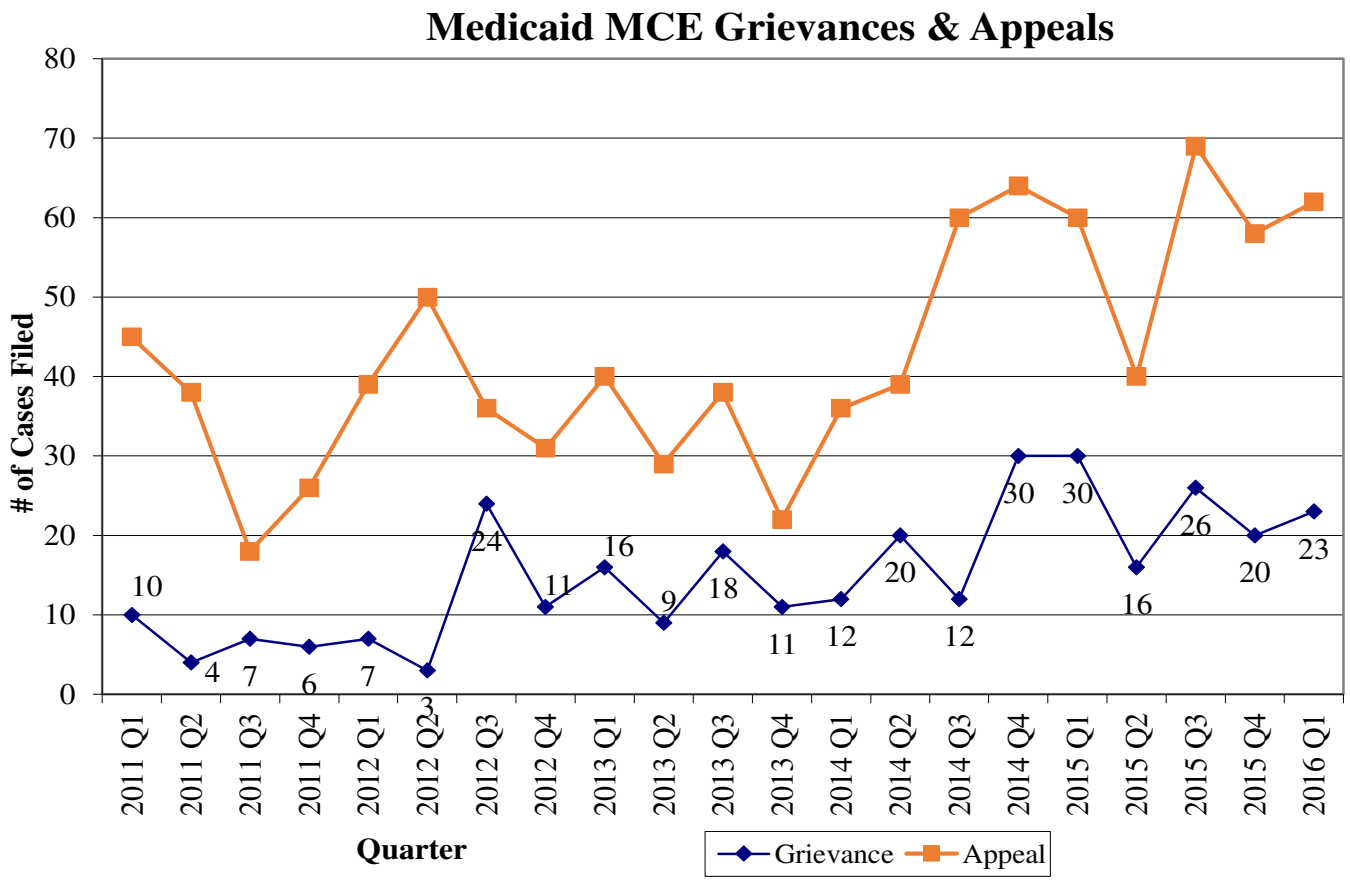
During this quarter, there were 62 appeals filed with the MCE; 34 requested an expedited decision with fifteen of them meeting criteria. Of these 62 appeals, 46 were resolved (74% of filed appeals), 16 were still pending (26%), and none were withdrawn. In twenty-five cases (54% of those resolved), the original decision was upheld by the person hearing the appeal, twelve cases (26%) were reversed, seven cases (15%) were approved by the department and 2 cases (4%) had a modified decision.

Of the 62 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 80% were resolved within 30 days. The average number of days it took to resolve these cases was 20 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days.

Of the 62 appeals filed, 28 were filed by beneficiaries (45%), 31 were filed by a representative of the beneficiary (50%) and 3 were filed by the provider (5%). Of the 62 appeals filed, DVHA had 87%, DAIL had 11%, and DMH had 2%.

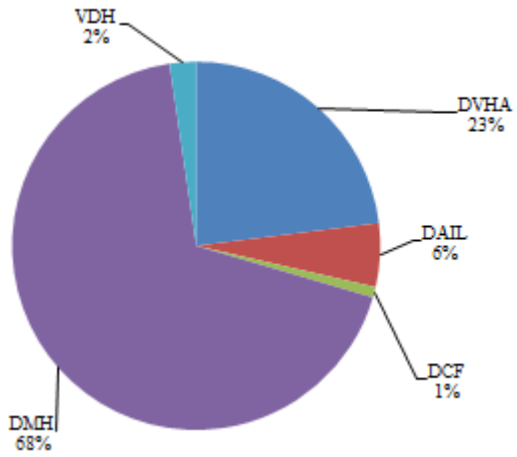
Due to the increase in appeals filed in the past year the compliance committee will review in order to determine the cause and if any remedial action is required.

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 seven fair hearings filed this quarter.

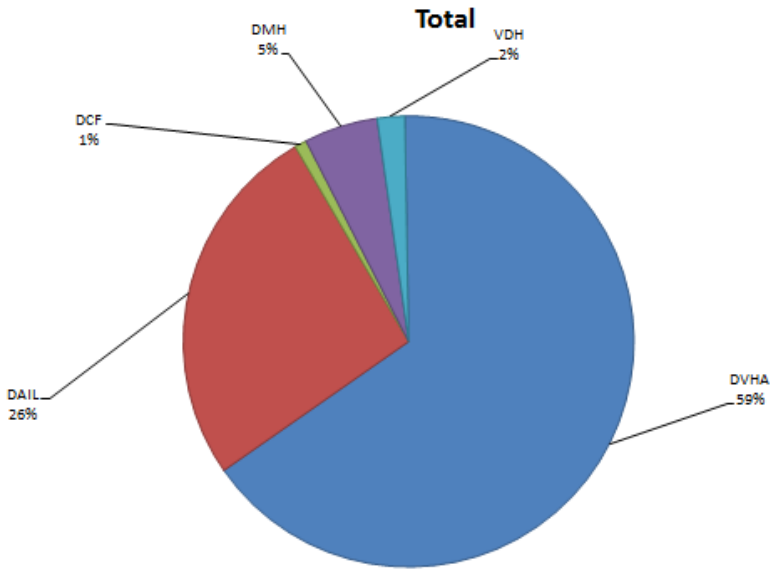


MCE Grievance & Appeals by Department
From January 1, 2008 through March 31, 2016

Grievances



Appeals



Attachment 5

VERMONT LEGAL AID, INC.

OFFICE OF THE HEALTH CARE ADVOCATE

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BURLINGTON, VERMONT 05402
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QUARTERLY REPORT
January 1, 2016 – March 31, 2016
to the
Agency of Administration
submitted by
Trinka Kerr, Chief Health Care Advocate
April 21, 2016

NARRATIVE

I. Executive Summary

The Office of the Health Care Advocate (HCA) provides consumer assistance to individual Vermonters on questions and problems related to health insurance and health care. We also 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.

The full quarterly report for January 1, 2016 - March 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**: 1,338 calls (compared to 1,033 last quarter)
    - **Department of Vermont Health Access (DVHA) beneficiaries**: 354 calls or **26%** of total calls (compared to 288 and 28% last quarter)
    - **Commercial plan beneficiaries**: 435 calls or **33%** (281 and 27%)
    - **Uninsured Vermonters**: 150 calls or **11%** (146 and 14%)
    - **Vermont Health Connect (VHC)**: 737 calls or **55%** (461 and 46%; the VHC data report draws from the All Calls data set)
    - **Two Reportable Activities (Summary & Detail):** 225 activities, 47 documents (141 and 46)

Highlights

- Total call volume was 30% higher than last quarter (1,338 versus 1,033), but slightly lower (2%) than the same quarter last year (1,367). The first quarter of the calendar year usually has the highest call volume of the year because most health care plans end on December 31st and new plans years begin January 1, and this turnover related to renewals can trigger problems.
- Vermont Health Connect (VHC) call volume was 60% higher than last quarter (737 versus 461). Again, this was mostly due to problems with renewals and the start of the plan year. Volume was just slightly higher than the same quarter last year (706).
- VHC change of circumstance calls increased by 68% over the previous quarter, but were 25% lower than the same quarter last year.
- Calls about problems with VHC billing and premium processing more than doubled, and were the number one reason Vermonters called the HCA. The trend line for this issue appears to be going in the wrong direction.
- VHC and Medicaid complaints resulting from mistakes made by the Health Access Eligibility Unit almost doubled over the previous quarter, increasing from 28 to 58. Most of the errors were made in 2015.
- Calls regarding tax form 1095-A were just slightly up over last year (90 compared to 86). Some consumers who had difficulties enrolling in coverage with VHC last year are now facing tax penalties for not having coverage. Tax preparers also reported seeing consumers in this situation. VHC must enroll and effectuate coverage more promptly this year. The tax penalty for going uninsured in 2016 will be even higher.
- The Green Mountain Care Board followed our recommendation to reduce the contribution to surplus in a large group filing. This modification resulted in rates that were 2.5% lower than the rates originally requested.
- In the legislature the HCA advocated for numerous bills with provisions beneficial to consumers, including: improving access to dental care through licensing of mid-level dental providers (S.20); streamlining rules governing insurers including additional reporting of consumer complaints (S.255); and requiring regulation of Vermont's Accountable Care Organizations by the GMCB and creating consumer protections for patients attributed to ACOs (H.812).
- The number of people who used our website to find information and guidance on health care issues continued a pattern of strong growth with 40% more pageviews this quarter, compared with the same period in 2015.
- The number of people seeking information from our website about dental services increased significantly (128%), as it has the past four quarters, and our Vermont Dental

Clinics Chart rose to the third most frequently downloaded of all PDFs downloaded from the Vermont Law Help website.

- We conducted outreach through three published articles, provided information at two events, and gave three presentations to audiences ranging from mental health staff to tax professionals and lawyers to an advisory board for seniors. Additionally, we worked to lower the reading grade level and improve the readability score of 11 State communications to consumers regarding VHC and other health-related issues.

II. Individual Consumer Assistance

The HCA provides assistance to consumers through our statewide helpline (**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 which provides this help to any Vermont resident free of charge, regardless of income.

The HCA received 1,338 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:

- **19.36%** (259) about **Access to Care**;
- **12.41%** (166) about **Billing/Coverage**;
- **1.87%** (25) about **Buying Insurance;**
- **11.51%** (154) about **Consumer Education**;
- **30.49%** (408) about **Eligibility** for state and federal programs; and
- **24.36%** (326) 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 408 of our cases had eligibility for state health care programs as the primary issue, there were actually a total of 1,142 cases that had some eligibility issue. This is because it is possible to have multiple types of issues in a single case.

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. Sometimes it is difficult to determine which issue is the "primary" issue 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 breakouts of the issue numbers in the individual data reports for a more detailed

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

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.

A. The HCA's overall call volume was 30% higher than last quarter, but about the same as the same quarter last year.

Total call volume was 30% higher than last quarter (1,338 versus 1,033), but slightly lower (2%) than the same quarter last year (1,367). The first quarter of the calendar year usually has the highest call volume of the year because most health care plans end on December 31st and new plans years begin January 1, and this turnover can trigger problems. (This was true even before VHC began.) In 2014 we received 1,184 calls for this quarter; in 2013 (pre-VHC) we received 835. This year's call volume for the first calendar quarter is thus 60% higher than the year before the launch of VHC.

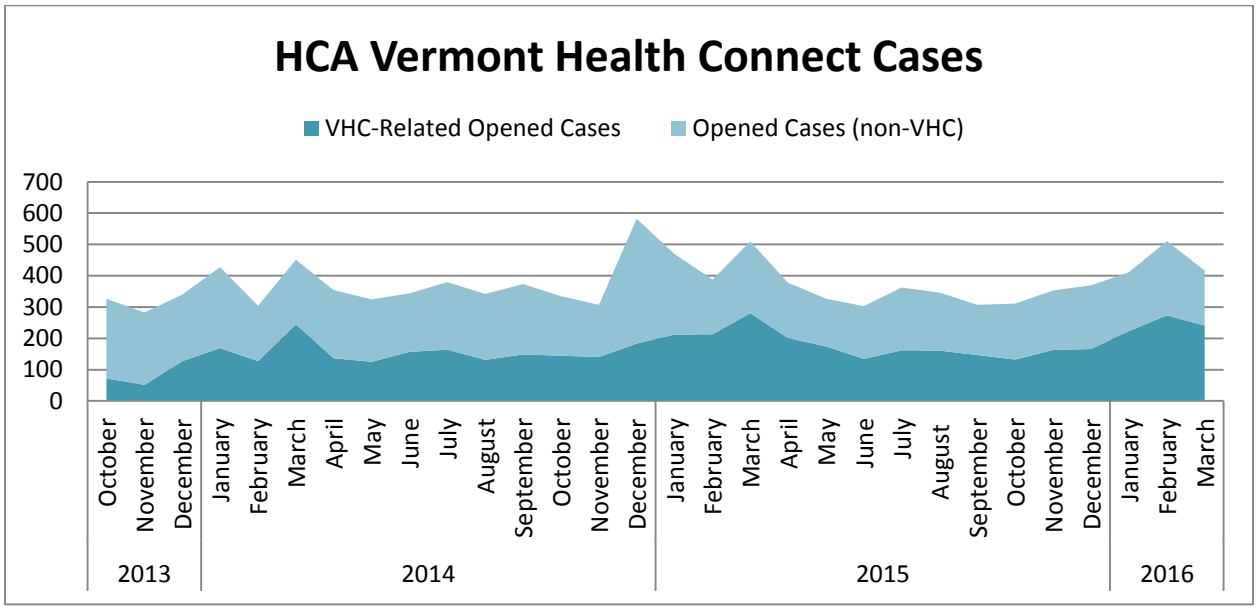
All Cases (2006-2016)											
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
January	313	280	309	240	218	329	282	289	428	470	411
February	209	172	232	255	228	246	233	283	304	388	511
March	192	219	229	256	250	281	262	263	451	509	416
April	192	190	235	213	222	249	252	253	354	378	-
May	235	195	207	213	205	253	242	228	324	327	-
June	236	254	245	276	250	286	223	240	344	303	-
July	183	211	205	225	271	239	255	271	381	362	-
August	216	250	152	173	234	276	263	224	342	346	-
September	181	167	147	218	310	323	251	256	374	307	-
October	225	229	237	216	300	254	341	327	335	311	-
November	216	195	192	170	300	251	274	283	306	353	-
December	185	198	214	161	289	222	227	340	583	369	-
Total	2583	2560	2604	2616	3077	3209	3105	3257	4526	4423	1338

B. Vermont Health Connect call volume was 60% higher than last quarter, and 4% higher than the same quarter last year.

VVHC call volume was 60% higher than last quarter (737 versus 461). This was mainly due to renewals and plan turnover. It was just slightly higher (4%) than the same quarter last year (706). In 2014 we received 541 VHC calls in this quarter. VHC did not exist in this quarter in 2013.

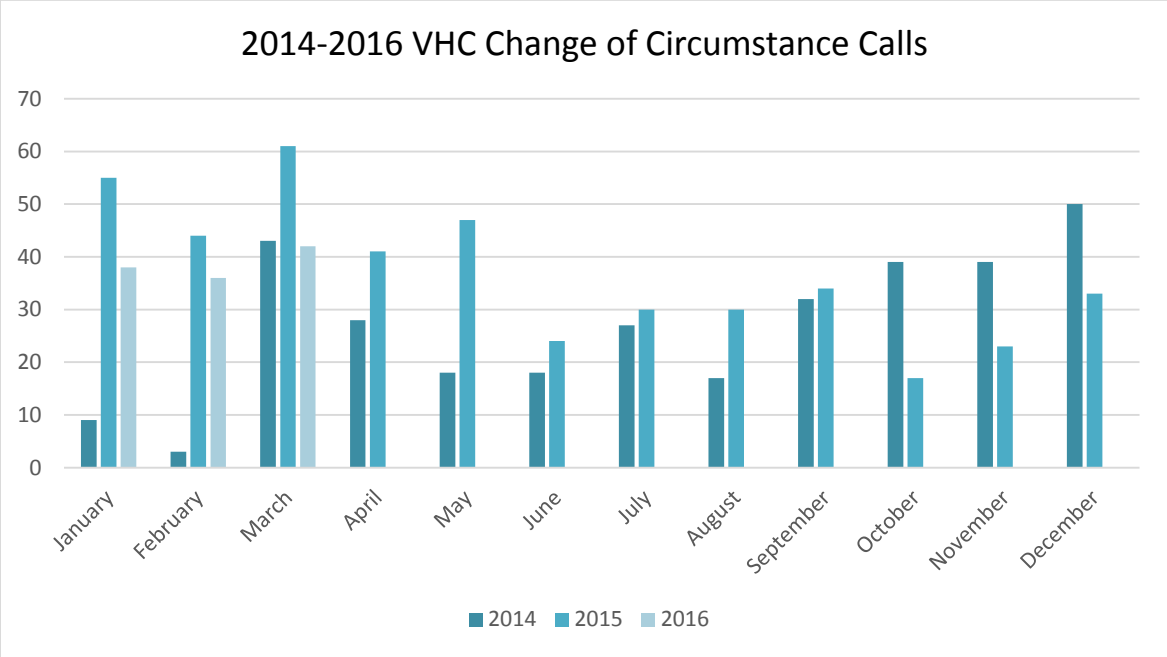
Although VHC continues to improve its functionality and performance, many Vermonters are still having serious problems. Call volume has not decreased as hoped or expected. VHC-related call volume had been trending downward at the end of 2015, but that trend appears to have reversed. We are also disheartened by the number of very complex problems we are still seeing. This quarter, of the 650 VHC calls we resolved with VHC, 38% of them were complex, and 80% of our total complex cases involved VHC.

The HCA works with VHC staff to resolve problems and escalate cases in which Vermonters need immediate access to care. We have weekly meetings with VHC staff to resolve the more complex cases. When we first started these meetings last summer, our list of cases to be resolved was usually 40-50 each week. This quarter the complex cases increased dramatically to 70-80 cases. Although VHC staff work incredibly hard to resolve these cases, many still take weeks to resolve. (Access to care cases are resolved much more quickly.)



C. Vermont Health Connect change of circumstance calls increased by 68%, but were 25% lower than last year's first quarter.

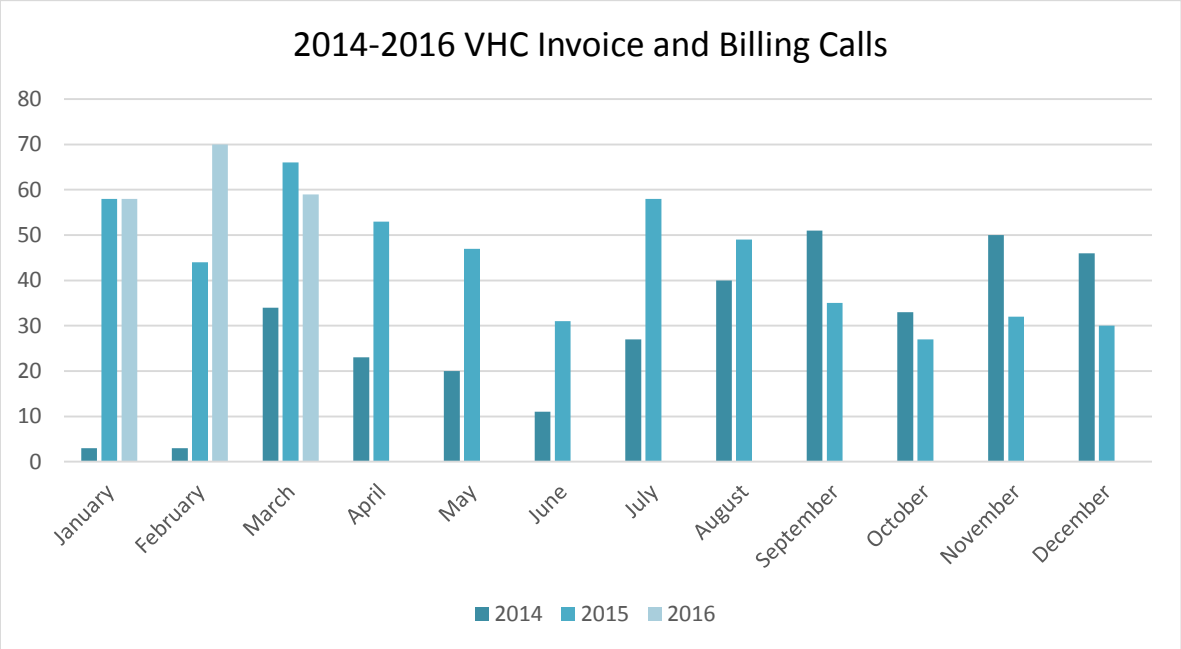
Change of Circumstance calls this quarter increased by more than 68% over last quarter: 38 in January, 36 in February, and 42 in March. COCs had been declining in 2015: 155 in Q1, 109 in Q2, 94 in Q3, and 69 in Q 4 (when primary and secondary issues are counted). The low was 17 calls in October. This quarter these calls shot up to 116 calls. However, it should also be noted that the COC calls this quarter were 25% lower than the same quarter last year, in which we received 155.



D. Vermont Health Connect billing and payment problems more than doubled over the previous quarter, and were the number one reason people called the HCA.

Many consumers who purchased Qualified Health Plans (QHP) from VHC continued to have billing and payment problems. This is the number one complaint about VHC and the number one complaint overall. The problems include: invoices showing the wrong amount due or lack of credit for consumer payments; delays in processing payments, especially payments made by check; delays in applying premiums to the correct account, causing delays in getting active coverage; not receiving invoices, and lost payments. In some cases, the premium problems caused a consumer's coverage to incorrectly be closed because they were not credited for payments they had actually made. Many were related to 2015 COC difficulties and problems with renewals.

This quarter we received 187 calls involving invoices, payment and premium processing, compared to 90 last quarter, and 141 for the quarter before that. In February we received a record high number of complaints on this issue: 70. Problems related to billing and payment appear to be trending in the wrong direction.



E. Health Access Eligibility Unit mistakes almost doubled.

VHC and Medicaid complaints resulting from mistakes made by HAEU almost doubled over the previous quarter, increasing from 28 to 58. Examples of mistakes we saw were: COCs that were not completed—or completed inaccurately, mistakes in renewals, mistakes in closures, premium tax credit amount mistakes, and incorrect advice. The increase may be partly the result of renewals, and some mistakes were brought to light because it was tax season. Some of the mistakes were not actually made this quarter but in previous quarters, and surfaced now as people got their tax forms. We had one case where the mistake was made in 2014. Some human errors were compounded by technology issues.

F. Problems with tax Form 1095-A increased just slightly this year.

We received 90 calls this quarter about problems with 1095-As, compared to 86 for the same quarter last year. Many of the calls involved consumers seeking a 1095-A that accurately reflected both the premiums that they paid and the APTC they received for 2015. Some also called because they had not received a -A and wanted to file their taxes. The HCA helped consumers avoid or minimize a tax penalty by resolving 2015 coverage issues. The HCA's tax attorney provided the HCA advocates with technical assistance on 27 cases.

See more about the HCA's work on tax issues in the **Affordable Care Act Tax-related Activities** section below.

G. The top issues generating calls

The listed issues in this section include <u>both primary and secondary issues</u>, so some of these may overlap.

All Calls 1,338 (compared to 1,033 last quarter)

1. VHC Invoice/Billing Problem affecting eligibility 187 (compared to 90 last quarter)
2. VHC Renewals 137 (45)
3. VHC complaints 127 calls (66)
4. MAGI Medicaid eligibility 120 (82)
5. VHC Change of Circumstance 116 (69)
6. VHC Premium Tax Credit eligibility 115 (67)
7. Complaints about providers 108 (93)
8. DVHA/VHC Premium billing 93 (53)
9. 1095-A problems 90 (8)
10. Access to Prescription Drugs 82 (72)
11. Information/applying for DVHA programs 61 (40)
12. Termination of insurance 62 (68)

13. HAEU Mistake 58 (28)
14. Consumer Education on IRS Reconciliation 57 (0)
15. Special Enrollment Periods (eligibility) 52 (29)
16. Consumer Education about ACA tax issues 51 (23)
17. VHC Website/Technology 51 (17)
18. Affordability issue affecting access to care 48 (53)
19. Medicaid eligibility (non-MAGI) 43 (34)
20. Buy-in Programs/MSPs 42 (27)
21. Disenrollment at consumer request 42 (39)
22. Buying QHPs through VHC 37 (38)

Vermont Health Connect Calls 737 (compared to 461 last quarter)

1. VHC Invoice/Payment/Billing problem 185 (89)
2. VHC Renewals 136 (46)
3. Premium Tax Credit Eligibility 114 (65)
4. Change of Circumstance 113 (67)
5. MAGI Medicaid eligibility 108 (73)
6. DVHA/VHC Premium billing 92 (52)
7. 1095-A problems 89 (8)
8. Consumer Education on IRS Reconciliation 56 (18)
9. HAEU Mistake 56 (25)
10. Termination of insurance 54 (62)
11. VHC Website/Technology 50 (17)

DVHA Beneficiary Calls 354 (compared to 288 last quarter)

1. Complaints about Providers 50 (39)
2. MAGI Medicaid eligibility 47 (26)
3. Information/applying for DVHA programs 29 (24)
4. Access to Prescription Drugs 27 (27)
5. Transportation 26 (17)
6. Medicaid eligibility (non-MAGI) 25 (16)
7. Choosing/Changing Providers 21 (18)
8. Change of Circumstance 17 (9)
9. Affordability affecting access to care 16 (10)
10. Copayments 14 (1)
11. Consumer education about Fair Hearings 14 (12)

H. Hotline call volume by type of insurance:

The HCA received 1,338 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, VPharm, or both Medicaid and Medicare aka “dual eligibles”) insured **26%** (354 calls), compared to 28% (286) last quarter;

- **Medicare**[2] **beneficiaries** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka "dual eligibles," Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **15%** (207), compared to 20% (211) last quarter;
- **Commercial plan beneficiaries** (employer sponsored insurance, small group plans, or individual plans) insured **30%** (395), compared to 27% (282) last quarter; and
- **Uninsured** callers made up **11%** (150) of the calls, compared to 14% (145) last quarter.
- In the remainder of calls insurance status was either unknown or not relevant.

I. Dispositions of closed cases

All Calls

We closed 1,262 cases this quarter, compared to 945 last quarter.

- 38% (358 cases) were resolved by brief analysis and advice;
- 25% (315) were resolved by brief analysis and referral;
- 24% (308) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 13% (164) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- 1 case was resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.

- Appeals: The HCA assisted 27 individuals with appeals: 4 commercial plan appeals, 22 Fair Hearings, 0 VHC expedited internal hearings, 1 DVHA internal MCO appeals and 0 Medicare appeals. Most of our cases involving VHC and DVHA problems are resolved without using the formal appeals process.

DVHA Beneficiary Calls

We closed 354 DVHA cases this quarter, compared to 266 last quarter.

- 35% (123 cases) were resolved by brief analysis and advice;
- 33% (118) were resolved by brief analysis and referral;
- 13% (45) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 13% (45) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- No DVHA cases were resolved in the initial call.

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

- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.

- Appeals: 9 cases involved appeals on behalf of individuals who were on a DVHA program when they called us: 8 Fair Hearings and 1 internal MCO appeal.

Commercial Plan Beneficiary Calls
We closed 386 cases involving individuals on commercial plans, compared to 245 last quarter.

- 23% (87 cases) were resolved by brief analysis and advice;
- 10% (38) were resolved by brief analysis and referral;
- 45% (174) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 16% (63) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information;
- No calls from a commercial plan beneficiary were resolved in the initial call.
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

- Appeals: 19 cases involved appeals for individuals on commercial plan: one External Review, one Level 1 internal appeal, two Level 2 internal appeals, 15 Fair Hearings, and 0 Expedited Fair Hearings.

J. Case outcomes

All Calls
The HCA helped 48 people get enrolled in insurance plans and prevented 15 insurance terminations or reductions. We obtained coverage for services for 2 people. We got 11 claims paid, written off or reimbursed. We estimated VHC insurance program eligibility for 3 more. We provided other billing assistance to 28 individuals. We provided 165 individuals with advice and education. Three people were not eligible for the benefit they sought and two were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 79 more people, many of whom we expected to be approved for medical services and state insurance.

We encourage clients to call us back if they are subsequently denied insurance or a medical service after our assessment and advice, or do not have their issue resolved as expected.

In total, this quarter the **HCA saved individual consumers $98,358.97** in cases opened this quarter**.**

K. Case Examples

Here are five case summaries which illustrate the types of problems we helped Vermonters resolve this quarter:

1. Mr. A called the HCA because he had been diagnosed with a life-threatening condition, and his doctors had told him that the best treatment was a new prescription medication. Mr. A, however, did not have a Medicare Part D plan to cover prescription drugs. In the past, he had paid out of pocket for his prescriptions. This medication cost tens of thousands of dollars, however, and Mr. A could not afford it without insurance coverage. After finding out about treatment plan, Mr. A had tried to sign up for a Part D plan. Each year, Medicare has an Open Enrollment period when you can sign up for or change your Part D plan. Mr. A had missed Open Enrollment by one day. When the advocate investigated the situation, she found that during the Medicare Part D open enrollment, Mr. A had been incapacitated by his illness, and that had limited his ability to sign up during the OEP. The HCA advocate requested a Special Enrollment Period from Medicare, so Mr. A could sign up for a Part D plan. Medicare granted the Special Enrollment Period, and Mr. A was able to sign up for a Part D plan that covered his needed medication and start his treatment.

2. Ms. B was due to deliver her baby any day when she called the HCA. She had a Qualified Health Plan (QHP) through VHC, but her plan left her with high out of pocket costs. When she first got pregnant, she had asked VHC whether she was eligible for Dr. Dynasaur for Pregnant women. The Dr. D would help cover some of the expenses not covered by her QHP. At that time, she was told that as a family of three, she was over the income guidelines for the program and not eligible. That was a mistake. When she called the HCA, the advocate told her that she was actually eligible for the program. Under the eligibility rules for Dr. D for pregnant women, the pregnant woman is counted as herself and the baby she is expected to deliver is counted as another member of the household. For Ms. B, this meant she had a family of four. When the family was counted correctly, Ms. B was found eligible for Dr. D. The HCA requested that her case be rushed, and she was able to get active coverage before she delivered her baby.

3. Ms. C called the HCA in a panic. She was a cancer survivor and needed to fill her medication. She had multiple appointments scheduled for the month. There was a problem with the renewal of her QHP with VHC for 2016. This meant that she did not have active coverage. When VHC was finally able to do the renewal, there was another problem. Ms. C was eligible for Advance Premium Tax Credit (APTC), which helped reduce her monthly premium by several hundred dollars. The VHC system, however, showed incorrectly that she was not eligible for APTC, and that she would need to pay

the full price of the plan. She could not afford to pay full price for the plan. The HCA advocate escalated the case to get the mistake fixed, and the APTC applied to Ms. C's case. This meant Ms. C was able to pay her premium to start her coverage—and was able to get her prescriptions in time.

4. Mr. D called because he needed transportation to his appointment with his substance abuse counselor. When he called to set up a ride, he was told that he did not have Medicaid coverage, and therefore, was no longer eligible for transportation. Mr. D was confused because he had just submitted an application for Medicaid and believed that he was eligible. The HCA advocate investigated and found that Mr. D had submitted an application for VHC Medicaid. Mr. D, however, had Medicare. This meant that he was eligible for a different type of Medicaid called Medicaid for Aged, Blind and Disabled (MABD). MABD and VHC Medicaid require different applications. After he was put onto VHC Medicaid, VHC had discovered the mistake and taken him off. But no one had taken the next step to put him back onto MABD Medicaid. The advocate intervened and asked that Mr. D's Medicaid be restored. It was restored the same day, and Mr. D was given time to submit the correct application. He was also able to get a ride to his appointment.

5. Ms. E called the HCA because she received a closure notice from VHC. The notice said that she was above the resource limit for Medicaid for Aged Blind and Disabled (MABD), and that her Medicaid was going to close. When the HCA advocate investigated, she found that Ms. E was over-resourced for Medicaid, and was not eligible for that program. The advocate also found that Ms. E was eligible for a Medicare Saving Plan (MSP). The MSP pays for the Part B premium, and the program has no resource limits. The advocate found that Ms. E should have been on an MSP since she had submitted her Medicaid application over a year prior because she had asked to be screened for an MSP on that application. The state put her on the MSP back to the date of her application, and Ms. E was refunded over a thousand dollars in Part B premiums.

III. Consumer Protection Activities

A. Rate Reviews

The HCA monitors all insurance carrier requests to the Green Mountain Care Board for changes in premium rates, which are usually rate increases. Six rate review cases were filed during the quarter. The HCA entered Notices of Appearance in five but did not appear in one case setting potential rates for an MVP plan that has no members. We submitted a memorandum in one and are waiting for a report from the actuary for the Green Mountain Care Board and a solvency analysis from the Department of Financial Regulation in the other new cases.

The first case considered during the quarter was the 2016 Large Group Manual Rate Filing by CIGNA Health and Life Insurance Company (Cigna). Cigna requested rates which would produce an average annual rate change of -1.1% and ranged from -3.9% to 1.1%. The filing impacts 15 policyholders with 2,586 covered lives. The HCA requested that the Board reduce the requested 3.5% contribution to surplus to 1%. The Board issued a decision modifying the requested rate with a 1% contribution to surplus. This modification resulted in an approximate -3.5% average annual rate decrease resulting in rates that were 2.5% lower than the rates originally requested.

The HCA has also been involved during the quarter in administrative and judicial review of the Board's December 2015 decision disapproving the rate request for five plans offered by the Agriservices Association, an association for farmers. Agriservices uses MVP's large group Minimum Premium Plan (MPP) funding arrangement for grandfathered plans with a contract renewing with a December 1, 2015 effective date. The average annual increase requested in the filing was 26.9%. The HCA asked the Board to disapprove the requested rates and the Board's December 2015 decision disapproved the increase. In January 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 administrative rate review case to the Vermont Supreme Court. The insurer has filed its brief and the HCA is preparing its brief asking the Supreme Court to uphold the Board decision denying the requested rate increase.

B. Certificate of Need

The HCA has continued to monitor Certificate of Need (CON) processes before the Board. In the last quarter, we tracked University of Vermont Medical Center's compliance with the Board's terms for its Inpatient Bed Project; the Board's Decision in Copley Hospital's Surgical Suite Construction Project; and the ongoing interrogatories for Green Mountain Surgery Center's Ambulatory Surgical Center application.

C. Other Green Mountain Care Board Activities

In the last quarter, we submitted three sets of formal comments to the Board. The first addressed the Board's proposal to lift the moratorium on the VCHURES data, which would allow non-state entities to access the information. In the comments, we supported the lifting of the moratorium, but we urged the Board to only allow data releases to non-state entities when the data will be used to improve healthcare quality, affordability, and/or access to Vermonters; we asked the Board to post data requests and provide a public comment period of at least ten days before issuing a decision on a request; and we recommended that the Board require any entity that is granted access to VCHURES data to agree that the entity cannot claim

confidentiality or intellectual property rights over its research results against the state of Vermont. The Council plans to adopt all three recommendations.

During the quarter the Board developed its guidance for hospitals to use in the next budget review cycle for the 2017 fiscal year, which begins in October 2016. The HCA submitted comments to the Board suggesting some changes to the proposed guidance and met with the Board's Director of Health System Finances to discuss the comments.

The Board also began the process of analyzing and reviewing the hospitals' actual budget amounts compared to their approved budgets for fiscal year 2015 which ended in September 2015. The Board heard presentations from the University of Vermont Medical Center and Central Vermont Medical Center (part of the same hospital network) and from Rutland Regional Medical Center about the facilities' proposed use of excess net patient revenue for 2015. The HCA submitted comments supporting UVMMC and CVMC's proposal to spend money on investments in community resources and on reducing commercial rates.

The HCA attended the GMCB's weekly public meetings (13), Advisory Committee meeting, and Data Governance meetings (3). This quarter we also attended an additional GMCB meeting about hospital budget targets, and met with GMCB staff twice.

D. All-Payer Model

In the last quarter, the staff of the GMCB facilitated meetings of stakeholders to discuss and outline the governance structure, provider payment policies, and related parameters for an all-payer model and single Accountable Care Organization for Vermont. In order to monitor for consumer protection concerns, the HCA participated in various aspects of the planning process for the proposed new ACO. This included joining the provisional board for the new ACO in late March, of which we attended four meetings. We participated in conference calls regarding the proposed business plan (8), reviewed drafts of the plan, and submitted six sets of formal comments. The HCA also continued to participate in meetings of the ACO Payment Subgroup (2) and the ACO Rostering Subgroup (4), and successfully advocated for edits to the draft rostering agreement which make it much more readable for consumers. Finally, the HCA helped organize three informational meetings for consumer groups to learn more about the proposed All-Payer Model.

E. Vermont Health Care Innovation Project

The HCA continues to participate in the Vermont Health Care Innovation Project (VHCIP), which is funded by a federal State Innovation Model (SIM) grant. The Chief Health Care Advocate is a member of the VHCIP Steering Committee, which met one time this quarter. 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. Additionally, we continue to monitor the activities of the VHCIP Core Team. This quarter we attended three Core Team meetings as an interested party.

F. Affordable Care Act Tax-related Activities

During this quarter the HCA continued its tax-related assistance, advocacy, and outreach efforts. In 2016 consumers began to receive two new tax forms relating to health care: Form 1095-B from Medicaid and other providers of health insurance, and Form 1095-C from large employers. The HCA engaged in significant consumer education regarding these new tax forms. We regularly updated Vermont tax preparers on VHC policies related to tax forms and tax issues. We also engaged with VHC when potential problems related to the tax forms surfaced. For example, when consumers reported receiving Forms 1095-B with no information about the sender, we alerted VHC to verify that VHC's forms were being generated correctly. The HCA participated in weekly VHC stakeholder calls during the tax season.

VHC's 2016 open enrollment period ended on January 31, 2016. Throughout the quarter we assisted consumers with renewal and enrollment problems. Many consumers had errors in their 2015 coverage that affected their 2016 benefits or enrollment. Consumer calls related to forms 1095-A brought many 2015 account problems to light. Some consumers discovered that their payments had been lost or misapplied when Form 1095-A unexpectedly showed unpaid months of coverage. Also, we saw many cases in which the consumer received excess APTC after it should have been terminated according to the regulations. The HCA helped many consumers get account changes made and, where appropriate, get amended tax forms from VHC.

In this quarter the HCA continued to employ a half-time tax attorney, who also staffs the Low Income Taxpayer Clinic at VLA. This allowed the HCA to stay up to date on tax law developments and support our staff to effectively field calls related to the ACA and VHC. The tax attorney consulted with HCA advocates when particularly difficult IRS-related issues arose in individual HCA cases. Technical assistance on tax issues remains an important part of the HCA's work in this area. During this quarter the tax attorney advised the HCA on 27 technical assistance questions. She also responded to 82 technical assistance questions from assisters, VHC personnel, Vermont tax preparers, and legal services attorneys in other states. Many technical assistance consultations involved IRS safe harbor rules for mistakes in APTC eligibility determinations, including overlapping coverage situations.

We continued to encounter consumers who reported difficulty enrolling in coverage with VHC last year and now face a tax penalty as a result of not having coverage. Tax preparers also

reported seeing consumers in this situation. We are concerned that these reports persist in VHC's third year. The tax penalty is significantly higher for 2015 than it was for 2014, and in 2016 it will be higher still. We advised consumers and tax preparers to seek Congressional help in these situations, since the federal agency with responsibility for hardship exemptions (HHS) does not recognize a hardship for penalties caused by marketplace error.

The HCA also engaged in outreach and education activities, detailed below in the Outreach and Education section. In addition to those activities, the HCA's tax attorney assisted the Open Door Clinic in Middlebury in developing a flowchart of Affordable Care Act issues for guestworkers. We plan to continue collaborating with assister organizations on educational materials in the future.

G. Other Activities

Administrative Advocacy

VHC Escalation Path
This quarter, the HCA worked extensively with VHC to develop an efficient escalation path for HCA cases, so they can be resolved more quickly. We communicated with VHC multiples times a day, and met at least once per week to discuss the most complex cases. With the new escalation path, we anticipate decreasing the number of cases on the list more rapidly in the future.

HBEE Rule
The HCA submitted formal comments to AHS on emergency amendments to Part Seven of the Health Benefits Eligibility and Enrollment rule, and on proposed amendments to other parts of the HBEE rule.

Health Care Administrative Rules (HCAR)
In March VLA and the HCA submitted formal comments on the first round of proposed Health Care Administrative Rules (HCAR), prior to formal rulemaking. We asked for clarification regarding informed consent for sterilizations, opposed the content of a rule on Medicaid Non-Covered Services, Experimental and Investigational Services, including arguing that the definitions of "services" and "experimental or investigational" be completely rewritten with input from medical professionals and other stakeholders.

Health Information Technology Plan
In February, the HCA submitted formal comments on Vermont's 2016 draft Health Information Technology Plan. Our comments focused on concerns with the costs, preparation, and other resources needed to implement the ambitious plan; the value the state will receive for the costs of health information technology; the need for experts within state government on health

information confidentiality and privacy; and the need for effective provider quality measurements. In addition, we urged VITL and the state to focus on efforts to gain patient consent for the Vermont Health Information Exchange (VHIE). Finally, we asked the state to prioritize the use of technology for care coordination.

Rule 09-03 Work Group

This quarter the HCA continued to be actively involved in this work group which was set up in Act 54 of the 2015 legislative session. The work group met twice during the quarter. The group's purpose is 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 currently in Rule 09-03. The rule contains 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 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 reports showing how many complaints are filed about violations of the consumer protection standards in Rule 09-03. The work group agreed with most of our suggestions but DFR did not want to provide the reports about consumer complaints. We agreed that the legislature should determine whether the reports would be required. The Administration presented proposed language for statutory changes to implement the work group's proposals in S.255, and the HCA has testified about this bill. The HCA also met with MVP and the Vermont Medical Society about network adequacy in relation to Rule 09-03.

2017 Qualified Health Plan 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 2017. The group met twice during the quarter. Recommendations for the 2017 QHPs were presented to the Green Mountain Care Board during the quarter.

2018 Qualified Health Plan (QHP) Work Group

The 2017 QHP Work Group recommended beginning a process to discuss the effect that the maximum out of pocket expense limit set forth in Vermont statutes has on plan design especially at the silver and bronze plan levels. A work group of stakeholders, including the HCA, was convened to discuss this issue and how the state might address it for 2018 plans. The group met four times during the quarter.

Medicaid and Exchange Advisory Board

The Chief Health Care Advocate is an active participant in Vermont's Medicaid and Exchange Advisory Board (MEAB). This quarter the MEAB met three times.

Legislative Activities

This quarter the HCA actively advocated for a number of legislative initiatives, and monitored the activities of the legislative committees that took up issues related to health care and health reform.

H.812: The HCA advocated for H.812, which would require the Green Mountain Care Board to regulate Accountable Care Organizations and would provide protections for patients attributed to ACOs, including grievance and appeals processes. Currently the state is not required to regulate ACOs. H.812 passed out of the House Health Care Committee with a vote of 11-0 and passed the House with a vote of 139-2. The bill was referred to the Senate Health and Welfare Committee.

S.20: The HCA continued to advocate for S.20, which would create a mid-level dental provider (Dental Therapist) in Vermont in order to improve access to dental care, particularly for children, seniors, and Medicaid beneficiaries. Access to dental care is a significant issue about which the HCA receives numerous consumer assistance calls and web page views. This quarter the bill, which passed the Senate in 2015, was taken up in the House Human Services Committee.

S.62: The HCA continued to advocate for S.62 which would allow, in limited circumstances, a surrogate to provide or withhold consent on a patient's behalf for a do-not-resuscitate order or clinician order for life-sustaining treatment. During this quarter the bill, which passed the Senate in 2015, resided in the House Committee on Human Services.

S.216: The HCA supported language recommended by the Administration that would allow the Green Mountain Care Board to permit some bronze plans on Vermont Health Connect in 2018 to use a prescription out of pocket maximum amount that is higher than the maximum amount allowed under current Vermont law. This would enable plan designs to lower cost sharing for other medical costs. There is concern from the actuary who works with DVHA that without adjustments to the pharmacy out of pocket maximum it may be impossible to design bronze plans that meet federal standards. The proposal for plan design changes would be developed by a stakeholder work group.

S. 245: The HCA supported the proposal in S. 245 to require hospitals to notify patients of provider acquisitions, including disclosure of any new charges resulting from hospital affiliations.

S.255: The HCA advocated for provisions in S.255 that would maintain regulatory protections for consumers in commercial health care plans and would require the Department of Financial

Regulation to file reports showing how many complaints are filed about violations of these consumer protection standards. During this quarter the bill passed the Senate with a favorable report from the Senate Health and Welfare Committee and was referred to the House Health Care Committee.

The HCA's legislative advocacy this quarter included testifying before the House Health Care Committee 17 times, testifying before the House Human Services Committee, testifying before a joint meeting of the House Health Care and Human Services Committees, testifying before the House Ways and Means committee two times, testifying before the House Government Operations Committee, and testifying before the Senate Finance Committee two times. We submitted two sets of formal comments to the House Health Care Committee on H.812, submitted formal comments to the Senate Health and Welfare Committee on H.812, and submitted formal comments to the Senate Health and Welfare Committee on consumer protections in Rule 09-03. Additionally, we regularly met with legislators and collaborated with state agencies and other advocates on legislative initiatives. The Chief Health Care Advocate gave a presentation on H. 812 at Vermont Legal Aid's Legislative Breakfast.

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:

- AARP
- American Civil Liberties Union
- Bi-State Primary
- Community Catalyst
- Community Health Accountable Care
- Community of Vermont Elders
- Department of Vermont Health Access
- Families USA
- Health*first*
- Open Door Clinic
- SHIP
- Vermont Family Network
- Vermont Medical Society
- Vermont Oral Health Care for All Coalition
- Vermont Low Income Advocacy Council
- Vermont Public Interest Research Group
- Voices for Vermont's Children

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 show:

- The total number of health pageviews increased by 40% in the reporting quarter ending March 31, 2016 (9,148 pageviews), compared with the same quarter in 2015 (6,518 pageviews).
- The number of people seeking help finding dental services increased significantly (128%), as it has **the past four quarters**. (435 pageviews this quarter, compared with 191 in the same period last year). The number of pageviews this quarter (435) is 58% higher than last quarter (276).
- This quarter, like the previous three quarters, we saw a large increase in the number of people seeking information about Medicaid income limits (2,639 pageviews this quarter, compared with 1,404 in the same quarter in 2015, an increase of 126%). 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 (1,040), an increase of 12% over last year's 930. 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.
- Seven of the 20 health topics with the largest number of pageviews focused on Medicaid or long-term care Medicaid (Choices for Care), while ACA-related tax topics for consumers occupied four of the top slots.
- Other popular topics included:
    - Health Insurance, Taxes and You (476 pageviews, +33%)
    - Medical Marijuana Registry – Patient Form (318 pageviews, +3,433%)
    - Federally Qualified Health Centers (FQHCs) (155 pageviews, +210%)
- While the number is still relatively low at 34, it is significant to note that the number of people seeking information about medical debt rose 183% over the number seeking the information during the same period last year.

PDF Downloads
Forty-eight out of 90 or 53% of the **unique PDFs** downloaded from the Vermont Law Help website were on health care topics. Of those health-related PDFs:

- 19 were created for consumers. The top consumer-focused downloads were the same as last quarter, although the Vermont dental clinics chart took the top spot this quarter:
    - Vermont dental clinics chart
    - Advance directive, short and long forms
    - Blue Cross Blue Shield of VT Annual Report 2014
    - Vermont Medicaid Coverage Exception Request – 10 Standards and Provider Request Form
- 21 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
    - Tax Issues for Health Assisters Form 8965 example
- 8 covered topics related to health policy. The top policy-focused downloads, which were the same as last year's, were:
    - Consumer Principles for Vermont's All-Payer Model
    - Vermont ACO Shared Savings Program Quality Measures

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

B. Education

During this quarter, the HCA provided education materials and presentations and maintained a strong social media presence on Facebook, reaching out directly to consumers as well as to individuals and organizations who serve populations that may benefit from the information and education provided. Materials we developed have also been shared directly with health and tax advocates in Vermont and nationwide and posted to our website.

Education/Outreach
Justice Quarterly (January 13)
The HCA published an article, Medicaid Reviews: Beneficiaries Must Respond or Risk Losing Coverage, in the winter issue of Vermont Legal Aid's quarterly newsletter. The article briefly explained the review process and the consequences of not responding. The newsletter was distributed to 347 subscribers.

Tax Notes (January 29)
The HCA's tax attorney was quoted extensively in an article, Up to a Million Face ACA Reporting Cutoff, Risk Losing Coverage, explaining to tax professionals that thousands of taxpayers, who didn't include the required 8962 when they filed their 2014 returns were at risk of not being eligible for premium subsidies. The article was available to Tax Notes Subscribers.

Cultural Awareness Day (February 17)
The University of Vermont College of Medicine's Department of Family Medicine sponsored a conference, Coming to the USA: A Focus on Healthcare Challenges, attended by approximately 250 medical students, along with some medical professionals and community members. The goal was to raise awareness about the issues and barriers that New Americans may face. The HCA staffed a table where they engaged in conversations, handed out approximately 100 brochures and answered questions.

Social Work Outreach (February 24)
The HCA distributed 33 brochures to students in the Biosociopolitical Issues in Social Work class at the University of Vermont.

Allocation of Premium Tax Credits Rules Summary (March 2016)
The HCA tax attorney created a short reference document, *Allocation of Premium Tax Credits Rules Summary,* that we posted to the Vermont Law Help website. In addition, it was distributed to the 30 subscribers to the Low Income Taxpayer Clinic listserv, as well as to other tax preparers who contacted VLA with allocation questions.

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:

- Revisited the Grace Period one-pager and graphic to address confusion in the latest versions and to increase readability.
- Suggested extensive revisions to various web-based and print communications from Vermont Health Connect related to the ACA and taxes, including:
    - Form 1095 FAQs for Tax Preparers and Vermont Health Connect Customers
    - Health Insurance 101 for Tax Filing: 2016
    - 3 Tips for Filing Taxes if You have Medicaid or a VHC Plan
- Suggested extensive plain language revisions to several critical consumer notices:
    - Verification notice for renewing Medicaid/Dr. Dynasaur enrollees
    - Termination notice for noncompliance with verification request
    - Notice of APTC amount change
- Suggested plain language revisions to ADA notice used by DVHA
- Suggested revisions to VHC's 1095-A call script that alerted people to the fact that they may need to file for an income tax filing extension
- Suggested plain language revisions to VHC's "right to appeal" handout
- Suggested extensive revisions to a primary care enrollment agreement prepared by the Vermont Health Care Innovation Project Rostering Workgroup

Presentations

During this quarter, the HCA provided education directly to approximately 37 individuals, many of whom serve populations that are likely to benefit from the information and education provided.

Washington County Mental Health (February 18)
The HCA presented about the HCA and what we do in addition to discussing the upcoming Medicaid reviews, then answered questions. About 11 WCMH staff members attended. We distributed HCA brochures at the presentation, and WCMH requested additional brochures.

Low Income Taxpayer Clinic Network (March 1)
The HCA tax attorney gave a presentation to the Low Income Taxpayer Clinic Network on the ACA-related problems identified in the 2015 National Taxpayer Advocate annual report to Congress. There were 14 legal services lawyers, 1 tax professor, and 1 law student in attendance.

Senior Solutions Advisory Council (March 23)
The HCA presented information about the All Payer Waiver and H.812 (an act relating to implementing an all-payer model and oversight of accountable care organizations) to approximately 10 members of the Senior Solutions Advisory Council via conference call. The Council is composed of representatives from towns in Windham and Windsor County who are interested in elder and caregiver issues.

MCO Investment Expenditures

Department	Criteria	Investment Description	SFY11 Actuals	SFY12 Actuals	SFY13 Actuals	SFY14 Actuals	SFY15 Actuals
DOE	2	School Health Services	$ 4,478,124	$ 11,027,579	$ 9,741,252	$ 10,454,116	$ 10,029,809
AOA	4	Blueprint Director	$ -	$ -	$ -	$ -	
AOA			$ -	$ -	$ -	$ -	$ 639,239
GMCB	4	Green Mountain Care Board	$ -	$ 789,437	$ 1,450,717	$ 2,360,462	$ 2,517,516
DFR	2	Health Care Administration	$ 1,898,342	$ 1,897,997	$ 659,544	$ 165,946	
DII	4	Vermont Information Technology Leaders	$ -	$ -	$ -	$ -	
VVH	2	Vermont Veterans Home	$ 1,410,956	$ 1,410,956	$ 1,410,956	$ 410,986	$ 410,986
VSC	2	Health Professional Training	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 409,461
UVM	2	Vermont Physician Training	$ 4,006,156	$ 4,006,156	$ 4,006,156	$ 4,006,156	$ 4,046,217
VAAFM	3	Agriculture Public Health Initiatives	$ -	$ 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
AHSCO	4	2-1-1 Grant	$ 415,000	$ 415,000	$ 415,000	$ 499,792	$ 499,667
VDH	2	Emergency Medical Services	$ 333,488	$ 274,417	$ 378,168	$ 498,338	$ 480,027
VDH	2	AIDS Services/HIV Case Management	$ -	$ -	$ -		$ -
VDH	2	TB Medical Services	$ 36,284	$ 39,173	$ 34,046	$ 59,872	$ 28,571
VDH	3	Epidemiology	$ 315,135	$ 329,380	$ 766,053	$ 623,363	$ 872,449
VDH	3	Health Research and Statistics	$ 289,420	$ 439,742	$ 497,700	$ 576,920	$ 715,513
VDH	2	Health Laboratory	$ 1,912,034	$ 1,293,671	$ 2,885,451	$ 2,494,516	$ 3,405,659
VDH	4	Tobacco Cessation: Community Coalitions	$ 94,089	$ 371,646	$ 498,275	$ 632,848	$ 702,544
VDH	3	Statewide Tobacco Cessation	$ 507,543	$ 450,804	$ 487,214	$ 1,073,244	$ 1,148,535
VDH	2	Family Planning	$ 275,803	$ 420,823	$ 1,574,550	$ 1,556,025	$ 1,390,410
VDH	4	Physician/Dentist Loan Repayment Program	$ 900,000	$ 970,000	$ 970,105	$ 1,040,000	$ 900,000
VDH	2	Renal Disease	$ 13,689	$ 1,752	$ 28,500	$ 3,375	$ 10,125
VDH	2	Newborn Screening	$ -	$ -	$ -	$ -	$ -
VDH	2	WIC Coverage	$ 36,959	$ -	$ 77,743	$ 317,775	$ 1,824,848
VDH	4	Vermont Blueprint for Health	$ 752,375	$ 454,813	$ 875,851	$ 713,216	$ 703,123
VDH	4	Area Health Education Centers (AHEC)	$ 500,000	$ 540,094	$ 496,176	$ 547,500	$ 543,995
VDH	4	Community Clinics	$ 640,000	$ 600,000	$ 640,000	$ 688,000	$ -
VDH	4	FQHC Lookalike	$ 87,900	$ 102,545	$ 382,800	$ 160,200	$ 97,000
VDH	4	Patient Safety - Adverse Events	$ 16,829	$ 25,081	$ 42,169	$ 38,731	$ 34,988
VDH	4	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	$ 290,661	$ 318,806	$ 345,930	$ 326,184	$ 395,229
VDH	2	Substance Abuse Treatment	$ 1,693,198	$ 2,928,773	$ 2,435,796	$ 2,363,671	$ 2,913,591
VDH	4	Recovery Centers	$ 648,350	$ 771,100	$ 864,526	$ 1,009,176	$ 1,299,604
VDH	2	Immunization	$ -	$ 23,903	$ 457,757	$ 165,770	$ 253,245
VDH	2	DMH Investment Cost in CAP	$ 752	$ 140	$ -	$ -	$ -
VDH	4	Poison Control	$ 115,710	$ 213,150	$ 152,250	$ 152,433	$ 105,586
VDH	4	Challenges for Change: VDH	$ -	$ 309,645	$ 353,625	$ 288,691	$ 426,000
VDH	3	Fluoride Treatment	$ -	$ 43,483	$ 75,081	$ 59,362	$ 55,209
VDH	4	CHIP Vaccines	$ -	$ 196,868	$ 482,454	$ 707,788	$ 557,784
VDH	4	Healthy Homes and Lead Poisoning Prevention Program	$ -	$ -	$ 101,127	$ 479,936	$ 421,302
DMH	2	Special Payments for Treatment Plan Services	$ 134,791	$ 132,021	$ 180,773	$ 168,492	$ 152,047
DMH	2	MH Outpatient Services for Adults	$ 522,595	$ 974,854	$ 1,454,379	$ 2,661,510	$ 3,074,989
DMH	2	Mental Health Elder Care	$ -	$ -	$ -	$ -	
DMH	4	Mental Health Consumer Support Programs	$ 582,397	$ 67,285	$ 1,649,340	$ 2,178,825	$ 1,132,931
DMH	2	Mental Health CRT Community Support Services	$ 1,935,344	$ 1,886,140	$ 6,047,450	$ 11,331,235	$ 282,071
DMH	2	Mental Health Children's Community Services	$ 1,775,120	$ 2,785,090	$ 3,088,773	$ 3,377,546	$ 3,706,864
DMH	2	Emergency Mental Health for Children and Adults	$ 2,309,810	$ 4,395,885	$ 8,719,824	$ 6,662,850	$ 4,148,197
DMH	2	Respite Services for Youth with SED and their Families	$ 543,635	$ 541,707	$ 823,819	$ 749,943	$ 931,962
DMH	2	CRT Staff Secure Transportation	$ -	$ -	$ -	$ -	
DMH	2	Recovery Housing	$ 512,307	$ 562,921	$ 874,194	$ 985,098	$ 463,708
DMH	2	Transportation - Children in Involuntary Care	$ -	$ -	$ -	$ -	
DMH	2	Vermont State Hospital Records	$ -	$ -	$ -	$ -	
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
DMH	2	Acute Psychiatric Inpatient Services	$ -	$ 12,603,067	$ 5,268,556	$ 3,011,307	$ 2,423,577
DMH	2	Institution for Mental Disease Services: DMH	$ -	$ -	$ 10,443,654	$ 7,194,964	$ 25,371,245
DVHA	4	Vermont Information Technology Leaders/HIT/HIE/HCR	$ 646,220	$ 1,425,017	$ 1,517,044	$ 1,549,214	$ 2,915,149
DVHA	4	Vermont Blueprint for Health	$ 2,616,211	$ 1,841,690	$ 2,002,798	$ 2,490,206	$ 1,987,056
DVHA	1	Buy-In	$ 50,605	$ 24,000	$ 17,878	$ 17,728	$ 27,169
DVHA	1	Vscript Expanded	$ -	$ -	$ -	$ -	$ -
DVHA	1	HIV Drug Coverage	$ 39,176	$ 37,452	$ 39,881	$ 26,540	$ 10,072
DVHA	1	Civil Union	$ 999,084	$ 1,215,109	$ 1,112,119	$ 760,819	$ (50,085)
DVHA	1	Vpharm	$ -	$ -	$ -	$ -	$ -
DVHA	4	Hospital Safety Net Services	$ -	$ -	$ -	$ -	$ -
DVHA	2	Patient Safety Net Services	$ 36,112	$ 73,487	$ 2,394	$ 363,489	$ 335,420
DVHA	2	Institution for Mental Disease Services: DVHA	$ -	$ -	$ 6,214,805	$ 6,948,129	$ 7,792,709
DVHA	2	Family Supports	$ -	$ -	$ 4,015,491	$ 3,723,521	$ 2,982,388
DCF	2	Family Infant Toddler Program	$ 624	$ -	$ -	$ -	
DCF	2	Medical Services	$ 64,496	$ 47,720	$ 37,164	$ 33,514	$ 32,299
DCF	2	Residential Care for Youth/Substitute Care	$ 7,853,100	$ 9,629,269	$ 10,131,790	$ 11,137,225	$ 10,405,184
DCF	2	AABD Admin	$ -	$ -	$ -	$ -	
DCF	2	AABD	$ -	$ -	$ -	$ -	
DCF	2	Aid to the Aged, Blind and Disabled CCL Level III	$ 2,661,246	$ 2,563,226	$ 2,621,786	$ 2,611,499	$ 2,864,727
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level III	$ 136,466	$ 137,833	$ 124,731	$ 89,159	$ 77,196
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level IV	$ 265,812	$ 273,662	$ 269,121	$ 183,025	$ 160,963
DCF	2	Essential Person Program	$ 736,479	$ 775,278	$ 783,860	$ 801,658	$ 707,316
DCF	2	GA Medical Expenses	$ 492,079	$ 352,451	$ 275,187	$ 253,939	$ 211,973
DCF	2	CUPS/Early Childhood Mental Health	$ 112,619	$ 165,016	$ 45,491	$ -	
DCF	2	VCRHYP/Vermont Coalition for Runaway and Homeless Youth Program	$ -	$ -	$ -	$ -	
DCF	2	HBKF/Healthy Babies, Kids & Families	$ -	$ -	$ -	$ -	
DCF	1	Catamount Administrative Services	$ -	$ -	$ -	$ -	
DCF	2	Children's Integrated Services Early Intervention				$ 200,484	
DCF	2	Therapeutic Child Care	$ 570,493	$ 596,406	$ 557,599	$ 543,196	$ 605,419
DCF	2	Lund Home	$ 196,159	$ 354,528	$ 181,243	$ 237,387	$ 405,034
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
DCF	3	Prevent Child Abuse Vermont: Nurturing Parent	$ -	$ 107,184	$ 186,916	$ 54,231	$ 195,124
DCF	4	Challenges for Change: DCF	$ 50,622	$ 196,378	$ 197,426	$ 207,286	$ 189,378
DCF	2	Strengthening Families	$ -	$ 465,343	$ 429,154	$ 399,841	$ 370,003
DCF	2	Lamoille Valley Community Justice Project	$ -	$ 162,000	$ 216,000	$ 402,685	$ 83,315
DCF	3	Building Bright Futures	$ -	$ -	$ 398,201	$ 594,070	$ 514,225
DDAIL	2	Elder Coping with MMA	$ -	$ -	$ -	$ -	
DDAIL	2	Mobility Training/Other Svcs.-Elderly Visually Impaired	$ 245,000	$ 245,000	$ 245,000	$ 245,000	$ 245,000
DDAIL	2	DS Special Payments for Medical Services	$ 757,070	$ 1,498,083	$ 1,299,613	$ 1,277,148	$ 385,896
DDAIL	2	Flexible Family/Respite Funding	$ 1,103,748	$ 1,103,749	$ 1,088,889	$ 2,868,218	$ 1,400,997
DDAIL	4	Quality Review of Home Health Agencies	$ 103,598	$ 128,399	$ 84,139	$ 51,697	$ 44,682
DDAIL	4	Support and Services at Home (SASH)	$ -	$ 773,192	$ 773,192	$ 1,013,671	$ 1,026,155
DDAIL	4	HomeSharing	$ -	$ -	$ 310,000	$ 317,312	$ 327,163
DDAIL	4	Self-Neglect Initiative	$ -	$ -	$ 150,000	$ 200,000	$ 265,000
DDAIL	2	Seriously Functionally Impaired: DAIL	$ -	$ -	$ 1,270,247	$ 859,371	$ 333,331
DOC	2	Intensive Substance Abuse Program (ISAP)	$ 591,000	$ 458,485	$ 400,910	$ 547,550	$ 58,280
DOC	2	Intensive Sexual Abuse Program	$ 70,002	$ 60,585	$ 69,311	$ 19,322	$ 15,532
DOC	2	Intensive Domestic Violence Program	$ 174,000	$ 164,218	$ 86,814	$ 64,970	$ 169,043
DOC	2	Women's Health Program (Tapestry)	$ -	$ -	$ -	$ -	$ -
DOC	2	Community Rehabilitative Care	$ 2,221,448	$ 2,242,871	$ 2,500,085	$ 2,388,327	$ 2,539,161
DOC	2	Return House	$ -	$ -	$ 399,999	$ 399,999	$ 343,592
DOC	2	Northern Lights	$ 40,000	$ -	$ 393,750	$ 335,587	$ 354,909
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
DOC	2	Pathways to Housing	$ -	$ -	$ 802,488	$ 830,936	$ 830,336
			$ 56,275,877	$ 89,836,470	$ 123,669,882	$ 127,103,459	$ 128,924,888

Investment Criteria #	Rationale
1	Reduce the rate of uninsured and/or underinsured in Vermont
2	Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries
3	Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured, and Medicaid-eligible individuals in Vermont
4	Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Attachment 6 - MCE Investments SFY15

Last Updated: September 4, 2015