State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 12
(1/1/2017 – 12/31/2017)

Quarterly Report for the period
January 1, 2017 – March 31, 2017

Submitted Via PMDA Portal on May 30, 2017

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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).

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 GC demonstration was again renewed for five years effective January 1, 2017. 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.

- 2016: On October 24, 2016 Vermont received approval for a five-year extension

of the Global Commitment to Health 1115 waiver, effective from January 1, 2017 through December 31, 2021.

As Vermont's Medicaid Single State Agency and under the Terms and Conditions of the Global Commitment to Health Waiver, AHS has entered into an Inter-governmental Agreement (IGA) with the Department of Vermont Health Access (DVHA). The AHS/DVHA IGA functions similarly to a Medicaid Managed Care contract in that it delineates program requirements and responsibilities between AHS and DVHA and according to federal Medicaid Managed Care requirements found at 42 CFR 438. 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 12, covering the period from January 1, 2017 through March 31, 2017 (QE0317).***

II. Enrollment Information and Counts

Prior to 2017, Vermont provided an enrollment count by demonstration population in this section. Due to changes to Budget Neutrality under the new waiver agreement effective January 1, 2017, enrollment information and a description of the unduplicated enrollment count by both demonstration population and eligibility group can be found in Section VII. Member Month Reporting.

III. Outreach/Innovative Activities

i. Provider and Member Relations

Key updates from QE0317:

- Access to Care Plan 6-month review occurred in April 2017.

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

The Department of Vermont Health Access (DVHA) has completed the 6-month review on the Access to Care Plan. Following the initial release in October 2016 of the DVHA Network Standards, the DVHA Data Unit has compared the baseline figures presented there with more recent data. Based on claims, the analysis estimates travel times needed from Medicaid recipients' homes to each of their provider's practice locations.

Methods:

- Select any relevant claims during calendar year 2016 based on a provider's specialty;
- Choose valid location data based on the Vermont Medicaid recipients' postal addresses;
- Assign a travel route between representative origin (home zip code) and destination points (practice location zip code, including out-of-state);
- Compare times and distances to the 2015 calendar year Access Plan results.

The Statewide comparison is found on the left side of the attached data sheet:

- 2016 closely adheres to the patterns found in the 2015 travel times and distances.
- Statewide in 2016, all primary care and specialty care average drive times and distances fall within the accepted parameters outlined in the Access Plan.
- In terms of travel times, several groups had slight increases, including Primary Care, Pediatric, Cardiology, and Urology. Respectively, these increased 0.4, 2.0, 1.1 and 2.1 minutes above the 2015 average travel times. Travel to pharmacy providers was up slightly in 2016.
- Average travel times were lower than 2015 value for the remainder of specialties.
- Travel distribution indicators -- distance under 30 minutes/miles (Primary Care) or 60 minutes/miles (Specialty Care) -- were nearly all within a couple percentage point of the 2015 value. The exception is Optometry/Ophthalmology which showed an increase in accessibility.

The County comparison is found on the right side of the data sheet below:

- Red highlights were added to the 2016 county mean travel time figures to emphasize that the value is greater than the standard and the figure increased.
- Seven of Vermont's 14 counties exceed the standard for travel time in 2016, the same number as in 2015.
- For primary care, Addison, Essex, Franklin, Grand Isle, Orange, Orleans and Rutland counties had average travel times over 30 minutes. In 2015, Caledonia and Lamoille average travel time exceeded 30 minutes, but not in 2016.
- Pediatric care is a subset of the primary care category. There are some spikes in 2016 travel times, compared to Pediatric statistics for 2015. These occur in Addison and Rutland counties.
- Travel is lengthy from Caledonia, Essex, and Lamoille county to see a Cardiologist (over 60 minutes). However, only Essex County is higher in that measure since 2015 (77 minutes).
- All other specialist travel times/distances are within the standard for all counties.

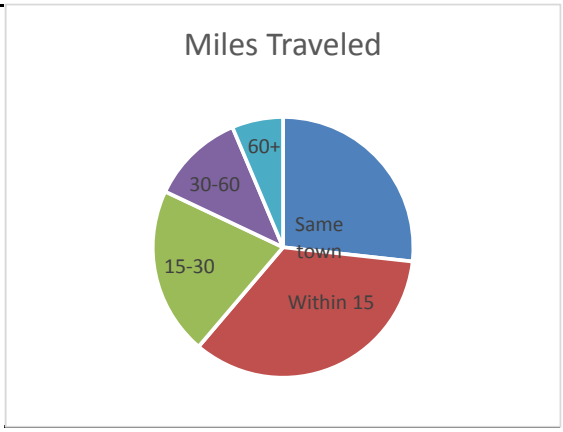
The report defines Vermont Medicaid's standards for access to care to certain categories of providers, such as primary care, hospitals, and various specialty services. The plan is reviewed bi-annually for compliance. After analysis of the recent access report and review of providers who have left Medicaid's network, DVHA is actively soliciting enrollment of dental providers as well as DME providers to supply diabetic supplies.

STANDARD	*Primary Care - travel distance for a member to access a Primary Care Provider should generally not exceed 30 miles. Primary care includes general practice, family practice, internal medicine, pediatric medicine, geriatric medicine, nurse practitioner, preventive medicine, certified clinical nurse specialist, naturopathic physicians, and cost based clinics.*

PRIMARY CARE services

CY 2016 Medicaid Recipients

County of Residence	Roadway distance (miles) for PRIMARY CARE services: Mean	Recipients	trips over 30 miles	30+ mi % CY2015
ADDISON	20.2	5%	19.1%	18.0%
BENNINGTON	13.5	7%	12.6%	12.5%
CALEDONIA	22.3	6%	23.8%	25.9%
CHITTENDEN	10.0	20%	5.9%	6.0%
ESSEX	33.3	1%	31.6%	31.7%
FRANKLIN	21.2	9%	24.7%	23.3%
GRAND ISLE	30.1	1%	35.1%	36.8%
LAMOILLE	18.2	4%	25.0%	25.8%
ORANGE	21.2	4%	23.6%	25.4%
ORLEANS	26.1	6%	23.7%	23.0%
RUTLAND	20.2	11%	22.8%	20.4%
WASHINGTON	17.4	8%	19.2%	15.9%
WINDHAM	17.8	7%	14.4%	16.2%
WINDSOR	18.9	8%	20.9%	21.3%
Statewide	17.9	100%	18.0%	17.6%



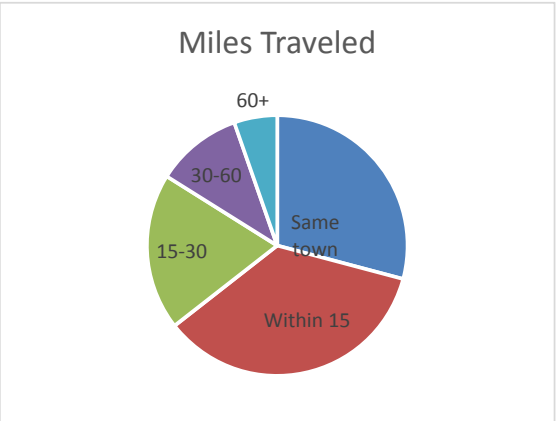
Travel Distribution Summary (miles)

Same town	Within 15	15-30	30-60	60+
27%	34%	21%	12%	6%

PEDIATRIC services

CY 2016 Medicaid Recipients

County of Residence	Roadway distance (miles) for PEDIATRIC services: Mean	Recipients	trips over 30 miles	30+ mi % CY2015
ADDISON	29.5	5%	23.3%	17.1%
BENNINGTON	12.3	10%	10.1%	8.6%
CALEDONIA	21.1	6%	19.0%	17.6%
CHITTENDEN	7.8	22%	2.3%	2.5%
ESSEX	26.9	1%	29.0%	25.8%
FRANKLIN	15.4	9%	12.4%	13.9%
GRAND ISLE	30.9	1%	41.0%	29.8%
LAMOILLE	21.5	2%	34.5%	40.6%
ORANGE	16.8	5%	17.9%	19.2%
ORLEANS	26.4	4%	23.2%	24.2%
RUTLAND	25.8	10%	34.5%	23.0%
WASHINGTON	16.9	8%	21.0%	18.0%
WINDHAM	15.6	8%	12.9%	12.8%
WINDSOR	18.2	8%	20.8%	18.7%
Statewide	16.8	100%	16.1%	14.5%



Travel Distribution Summary (miles)

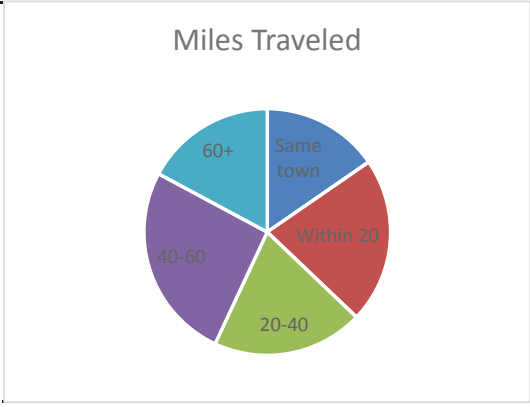
Same town	Within 15	15-30	30-60	60+
29%	35%	19%	11%	5%

STANDARD	*Specialty Care - travel distance from a specialist should generally not exceed 60 miles. Specialty care includes cardiology, urology, behavioral health, mental health, substance abuse specialists, obstetrics, and home health services*

Cardiology

CY 2016 Medicaid Recipients

County of Residence	Roadway distance (miles) for CARDIOLOGY services			60+ mi % CY 2015
	Mean	Recipients	Trips over 60+ miles	
ADDISON	31.1	5%	6.2%	6.0%
BENNINGTON	21.3	8%	12.1%	10.5%
CALEDONIA	58.5	5%	46.6%	46.6%
CHITTENDEN	13.2	21%	3.8%	3.1%
ESSEX	60.7	1%	50.8%	45.8%
FRANKLIN	38.1	9%	9.7%	18.7%
GRAND ISLE	33.7	1%	5.0%	19.2%
LAMOILLE	47.5	3%	5.5%	7.0%
ORANGE	34.8	4%	4.5%	5.2%
ORLEANS	45.1	5%	42.0%	50.7%
RUTLAND	37.9	15%	33.9%	28.3%
WASHINGTON	33.6	7%	15.7%	14.2%
WINDHAM	35.5	7%	32.3%	30.9%
WINDSOR	33.5	8%	3.9%	3.5%
Statewide	32.0	100%	17.2%	16.9%



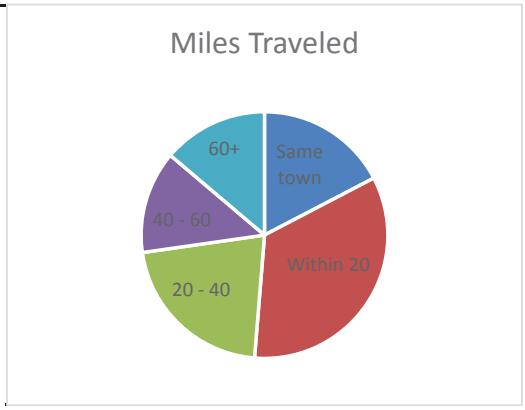
Travel Distribution Summary (miles)

Same town	Within 20	20-40	40-60	60+
15%	22%	20%	26%	17%

UROLOGY services

CY 2016 Medicaid Recipients

County of Residence	Roadway distance (miles) for UROLOGY services			60+ mi % CY 2015
	Mean	Recipients	trips over 60+ miles	
ADDISON	22.8	5%	3.3%	1.4%
BENNINGTON	25.2	7%	16.7%	13.1%
CALEDONIA	33.6	8%	25.9%	48.7%
CHITTENDEN	10.0	16%	1.1%	0.8%
ESSEX	62.1	1%	65.7%	72.6%
FRANKLIN	23.9	7%	0.0%	1.7%
GRAND ISLE	31.0	1%	2.7%	4.9%
LAMOILLE	46.4	3%	3.4%	1.6%
ORANGE	32.6	6%	5.1%	5.5%
ORLEANS	80.3	4%	83.7%	91.1%
RUTLAND	30.1	14%	20.7%	13.0%
WASHINGTON	24.9	10%	8.4%	15.2%
WINDHAM	25.1	9%	19.6%	14.3%
WINDSOR	25.2	8%	2.0%	3.1%
Statewide	27.8	100%	13.8%	11.6%



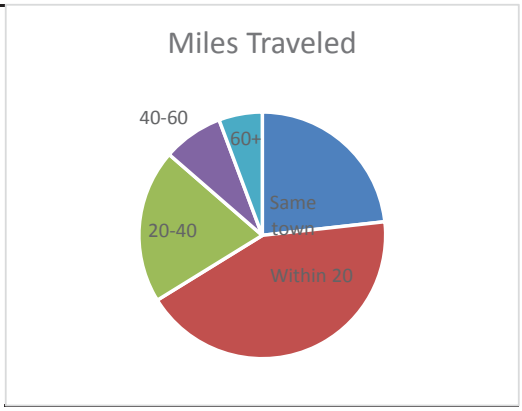
Travel Distribution Summary (miles)

Same town	Within 20	20 - 40	40 - 60	60+
17%	34%	21%	13%	14%

OBSTETRIC services

CY 2016 Medicaid Recipients

County of Residence	Roadway distance (miles) for OBSTETRIC services: Mean	Recipients	trips over 60+ miles	60+ mi % CY 2015
ADDISON	20.4	4%	2.3%	2.7%
BENNINGTON	15.0	9%	7.0%	18.2%
CALEDONIA	20.8	7%	8.4%	7.4%
CHITTENDEN	12.5	18%	2.9%	2.5%
ESSEX	30.6	1%	15.9%	19.5%
FRANKLIN	19.8	7%	1.8%	2.9%
GRAND ISLE	29.1	1%	3.0%	1.6%
LAMOILLE	17.7	9%	3.1%	1.1%
ORANGE	18.5	6%	3.8%	6.0%
ORLEANS	25.0	7%	14.0%	9.7%
RUTLAND	22.0	11%	9.5%	12.6%
WASHINGTON	22.9	8%	4.2%	3.3%
WINDHAM	18.8	7%	7.5%	9.2%
WINDSOR	25.0	7%	4.4%	8.9%
Statewide	19.2	100%	5.7%	6.9%



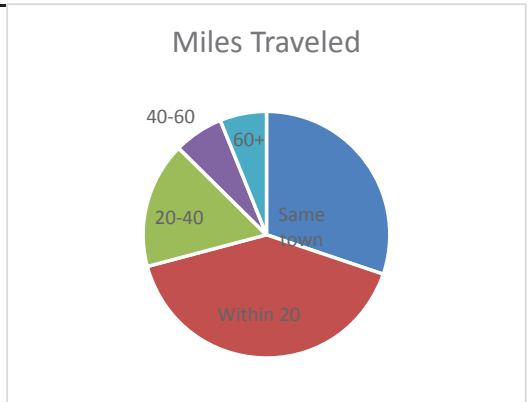
Travel Distribution Summary (miles)

Same town	Within 20	20-40	40-60	60+
23%	43%	20%	8%	6%

BEHAVIORAL, MENTAL HEALTH & SUBSTANCE ABUSE services

CY 2016 Medicaid Recipients

County of Residence	Roadway distance (miles) for BEHAVIORAL, MENTAL HEALTH & SUBSTANCE ABUSE services: Mean	Recipients	trips over 60+ miles	60+ mi % CY 2015
ADDISON	20.6	3%	5.8%	8.4%
BENNINGTON	13.8	11%	3.3%	4.8%
CALEDONIA	27.5	4%	5.2%	6.5%
CHITTENDEN	11.9	22%	3.0%	3.5%
ESSEX	41.0	1%	28.9%	23.9%
FRANKLIN	22.6	8%	11.3%	3.8%
GRAND ISLE	33.3	1%	6.6%	4.2%
LAMOILLE	19.2	6%	1.3%	1.6%
ORANGE	23.5	4%	13.5%	20.0%
ORLEANS	22.6	4%	10.7%	9.2%
RUTLAND	16.5	9%	8.6%	12.8%
WASHINGTON	11.2	13%	2.1%	5.8%
WINDHAM	18.1	7%	7.2%	9.0%
WINDSOR	29.0	7%	12.1%	14.7%
Statewide	17.6	100%	6.1%	7.2%



Travel Distribution Summary (miles)

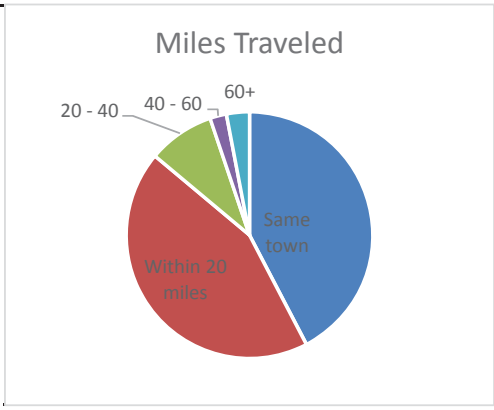
Same town	Within 20	20-40	40-60	60+
30%	41%	17%	7%	6%

STANDARD	*Pharmacy, Laboratory, Dental, Ophthalmology/Optometry and Advanced Imaging services - should be located so that members do not generally need to travel more than 60 miles to access their services*

Pharmacy

CY 2016 Medicaid Recipients

County of Residence	Roadway distance to Pharmacy Mean	Recipients	trips over 60+ miles	60+ mi % CY 2015
ADDISON	11.4	5%	2.1%	1.7%
BENNINGTON	7.9	8%	2.2%	1.8%
CALEDONIA	13.0	6%	4.9%	3.7%
CHITTENDEN	7.1	20%	2.1%	1.5%
ESSEX	23.9	1%	7.2%	5.3%
FRANKLIN	10.8	9%	1.9%	1.8%
GRAND ISLE	25.4	1%	2.2%	1.5%
LAMOILLE	13.0	4%	1.5%	1.3%
ORANGE	15.7	4%	3.4%	2.7%
ORLEANS	17.0	6%	5.8%	4.0%
RUTLAND	10.6	11%	3.3%	3.0%
WASHINGTON	11.8	8%	3.3%	2.4%
WINDHAM	11.5	6%	3.8%	3.6%
WINDSOR	11.9	9%	2.9%	3.3%
Statewide	11.2	100%	3.0%	2.5%



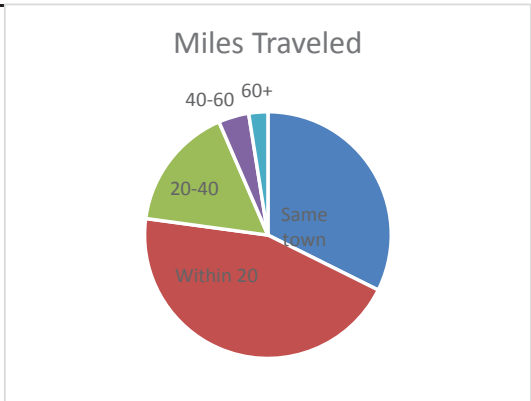
Travel Distribution Summary (miles)

Same town	Within 20 r	20 - 40	40 - 60	60+
42%	44%	9%	2%	3%

DENTAL services

CY 2016 Medicaid Recipients

County of Residence	Roadway distance (miles) for DENTAL services Mean	Recipients	Trips over 60+ miles	60+ mi % CY 2015
ADDISON	11.4	10%	0.6%	1.3%
BENNINGTON	10.0	9%	1.7%	1.6%
CALEDONIA	28.3	2%	8.8%	5.6%
CHITTENDEN	10.2	14%	1.5%	0.7%
ESSEX	38.7	1%	11.8%	6.1%
FRANKLIN	16.0	6%	2.7%	2.8%
GRAND ISLE	19.0	2%	1.4%	3.0%
LAMOILLE	29.0	2%	1.5%	0.8%
ORANGE	14.9	5%	3.6%	5.6%
ORLEANS	11.1	11%	2.8%	6.8%
RUTLAND	10.8	19%	1.4%	4.2%
WASHINGTON	18.1	5%	4.7%	3.0%
WINDHAM	13.0	8%	5.3%	3.4%
WINDSOR	23.2	6%	2.7%	4.3%
Statewide	13.8	100%	2.5%	3.0%



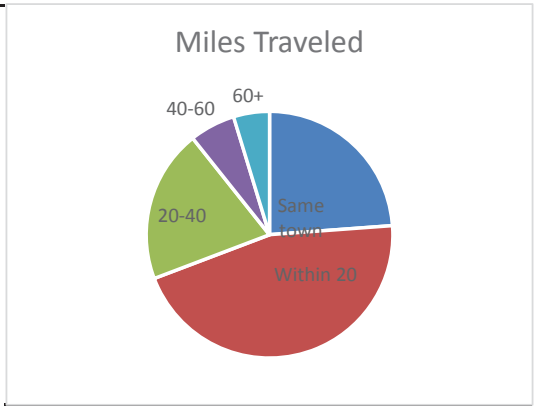
Travel Distribution Summary (miles)

Same town	Within 20	20-40	40-60	60+
32%	45%	16%	4%	3%

OPHTHALMOLOGY - OPTOMETRY services

CY 2016 Medicaid Recipients

County of Residence	Roadway distance (miles) for OPHTHALMOLOGY - OPTOMETRY services: Mean	Recipients	Trips over 60+ miles	60+ mi % CY 2015
ADDISON	13.2	4%	1.6%	3.0%
BENNINGTON	16.9	4%	4.1%	10.3%
CALEDONIA	20.1	10%	3.4%	11.3%
CHITTENDEN	12.2	15%	2.2%	1.8%
ESSEX	30.2	2%	7.2%	19.7%
FRANKLIN	15.9	9%	2.3%	2.1%
GRAND ISLE	26.2	1%	1.2%	22.8%
LAMOILLE	35.0	6%	25.0%	12.6%
ORANGE	20.1	6%	0.7%	3.0%
ORLEANS	17.7	11%	6.6%	29.2%
RUTLAND	14.7	8%	2.6%	20.6%
WASHINGTON	16.3	9%	2.1%	4.5%
WINDHAM	18.3	8%	7.0%	10.4%
WINDSOR	15.3	7%	2.4%	3.3%
Statewide	17.9	100%	4.7%	9.0%



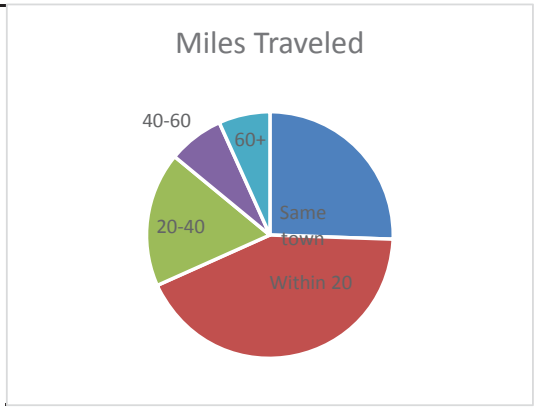
Travel Distribution Summary (miles)

Same town	Within 20	20-40	40-60	60+
24%	45%	20%	6%	5%

ADVANCED IMAGING services

CY 2016 Medicaid Recipients

County of Residence	Roadway distance (miles) for ADVANCED IMAGING services: Mean	Recipients	Trips over 60+ miles	60+ mi % CY 2015
ADDISON	19.7	5%	4.1%	3.5%
BENNINGTON	14.8	8%	5.7%	6.6%
CALEDONIA	24.4	6%	13.7%	10.6%
CHITTENDEN	10.7	19%	2.4%	3.0%
ESSEX	38.8	1%	25.6%	18.1%
FRANKLIN	20.9	10%	3.8%	4.3%
GRAND ISLE	30.2	1%	3.6%	5.3%
LAMOILLE	21.2	4%	1.9%	3.4%
ORANGE	24.7	4%	7.2%	14.4%
ORLEANS	27.4	7%	17.2%	13.5%
RUTLAND	17.6	12%	7.8%	7.5%
WASHINGTON	21.3	8%	7.7%	5.3%
WINDHAM	19.9	7%	9.5%	10.1%
WINDSOR	19.8	8%	4.0%	4.0%
Statewide	19.1	100%	6.7%	6.9%



Travel Distribution Summary (miles)

Same town	Within 20	20-40	40-60	60+
26%	43%	18%	7%	7%

ii. Global Commitment to Health Post Award Forum

A post award forum for the latest Global Commitment to Health 1115 waiver renewal was held from 10:00 – 11:00am on Monday, February 27, 2017. This forum was conducted in accordance with item 43 under the Special Terms & Conditions (STCs) of the GC Demonstration waiver. Public comments were accepted at this forum and via email through March 3, 2017. Here is a summary of the public comments received:

- Comments in support of Vermont's Medicaid Program:
  Most commenters initiated remarks with words of praise for Vermont's Waiver and Medicaid program. Comments ranged from praise for Choices for Care and Moderate needs program, support for the overall goals of the Waiver to pride in the overall breadth of accomplishments of the Vermont Medicaid program.

- Comments regarding rates, workforce and access:
  Several commenters noted that reimbursement levels are too low, leading to difficulties with workforce development and turnover, directly impacting access and capacity to provide services. One commenter connected workforce issues to flat funding and expressed the need to explore additional opportunities for federal match. Another commenter connected inefficient processes and lack of case management with poor access to services. Several comments on rates and budget concluded with concerns regarding sustainability of programming.

- Comments regarding performance measurement:
  Several commenters noted that although Vermont compares well against other states' Medicaid programs, higher standards exist and national averages should not necessarily be the benchmark for performance. Concerns were noted regarding measurements of access including shortages of certain provider types and the need to drill down further into sub-populations that might not have the same great access or outcomes as the program average. One commenter noted that consumers receiving HCBS might be reluctant to share negative opinions about their caregivers through consumer satisfaction surveys.

- Comments regarding care coordination:
  One commenter noted the need to coordinate and improve care coordination efforts across programs. Another commenter noted that more case management would improve access to care.

IV. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE0317:

- With nearly 30,000 individuals enrolled in a qualified health plan (QHP) through Vermont Health Connect, more than 5,000 directly enrolled with insurance carriers, more than 45,000 enrolled in a SHOP small business plan, more Vermonters were covered by a QHP at the end of QE0317 than ever before.
- Redeterminations for Medicaid for Children and Adults (MCA) and Medicaid for the Aged, Blind and Disabled (MABD) both continued on a normal annual cycle; staff kept up with the processing work and maintained a manageable queue of open applications.
- Operational metrics related to customer support, integration, work processing, and escalated cases, all of which had improved dramatically over the course of 2016, stayed strong throughout the quarter.
- In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of customer requests within ten business days by October 2016 and 85% by June 2017; this goal was met ahead of schedule as more than 90% of requests were completed within ten days during QE0317.
- Increasing numbers of customers are using self-service functions, including both online accounts and the options of paying premiums through monthly recurring payments rather than one-time payments; nearly 50% more Vermonters logged into their online account in January 2017 than did so in January 2016.

On January 31, 2017, Vermont Health Connect completed its most successful Open Enrollment to date. As of the end of Open Enrollment, 31,736 individuals had selected a 2017 qualified health plan (QHP) through Vermont Health Connect and 29,234 individuals had effectuated into a plan. More than three-quarters (76%) qualified for financial help. In addition to those who enrolled through Vermont Health Connect, more than 5,000 unsubsidized individuals chose to enroll in a QHP directly with an insurance carrier and more than 45,000 enrolled through their small business employer. Altogether more Vermonters were covered by a QHP at the end of QE0317 than ever before.

Enrollment data suggests that Vermont continues to make progress in enrolling "young invincibles." Young adults aged 26-34 comprised more than 23% of new enrollments, compared to less than 13% of re-enrollments.

Operationally, open enrollment and renewal work was successful in 2017 due to the success of the automated renewal run and integration efforts in fall 2016. The initial integration run was completed with 99% accuracy in mid-November. The State and its partners collaborated to clean up and re-send the remaining cases well in advance of the new year.

On January 1, 2017, the State and its partners ran the year-end business process that allows changes to be made on cases, when necessary, in 2017. This process ran with a 100% success rate, meaning all cases were ready to accept change requests starting the first day of the year.

Altogether, performance on these operational steps made the 2017 QHP renewal experience markedly different than 2016 -- when the renewal process was not complete until the end of March – and left state staff both optimistic and better positioned to serve customers.

Redeterminations for Medicaid for Children and Adults (MCA), which had re-started in January 2016, completed their first annual cycle during QE0317, with the final group being closed or renewed as of February 1, 2017. DVHA-HAEEU then continued on a normal annual cycle and kept up with work, ending QE0317 with 180 open applications, six of which was older than 45 days. Five of the six open applications were waiting on the applicant to provide required information.

Redeterminations for Medicaid for the Aged, Blind and Disabled (MABD) beneficiaries, which had re-started in late 2015 and completed its first annual cycle in October 2016, then continued onto a normal annual cycle. DVHA-HAEEU kept up with work, ending QE0317 with fewer than 400 open applications, one of which was older than 45 days.

DVHA-HAEEU mailed two versions of IRS Form 1095 during QE0317. 1095A serves as proof of coverage and subsidy for QHP members to use when filing taxes. Roughly 25,000 initial forms were mailed to QHP members in January. Corrected forms are sent throughout the winter and spring due to reconciliation efforts or when members pay overdue 2016 bills. 1095-related service requests decreased from the previous year and DVHA-HAEEU successfully handled incoming volume. Throughout February and March, year-over-year inventory was down over 90 percent from the same time the previous year. As of late March 2016, there were 301 open 1095A requests. As of late March 2017, there were 13.

1095B is an informational form that shows months of coverage for Medicaid members. Over 125,000 were mailed in February in advance of the deadline.

Maximus continues to manage the VHC Customer Support Center (call center), currently utilizing 115 customer service representatives (as of the end of QE0317). 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 DVHA-HAEEU 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 130,000 calls over the quarter, with an abandon rate of 4% and answering more than three-quarters (76%) of calls within 24 seconds.

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of customer requests within ten business days by October 2016 and 85% by June 2017. In QE0316, fewer than 60% of requests were completed within ten days. In QE0317, more than 90% of requests were completed within ten days.

Throughout QE0317, the system continued to operate as expected. The average page load time

for the quarter was about 1.7 seconds and was within the two-second target in each of the three months -- and minimal downtime resulted in availability of more than 99.9%.

Vermont Health Connect was supported throughout the state by 229 Assisters (40 Navigators, 112 Certified Application Counselors or CACs, and 77 Brokers) in QE0317. The CAC program continued to grow, increasing by 26 over the last six months, by training and certifying staff in hospitals, health centers, and other community organizations. Other CACs work for a Department of Corrections contractor and focus on helping connect justice-involved individuals with coverage. Overall, Navigators and CACs largely focused on helping Vermonters with Medicaid renewals, particularly new Vermonters with limited English proficiency and others with accessibility challenges. Navigators alone had more than 6,600 consultations in the quarter.

Health insurance literacy was also an outreach focus throughout QE0317. DVHA-HAEEU engaged health care providers, libraries, state offices, and legislators in helping Vermonters understand the importance of 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 195,000 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 nearly 15,000 sessions during the quarter – more than 8,000 sessions during the last month of Open Enrollment and more than 3,000 sessions in each of the next two months – approximately the same traffic as the first quarter of the previous year.

During QE0317, DVHA-HAEEU also promoted self-service options for customers to pay their bills, report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts and the options of paying premiums through monthly recurring payments rather than one-time payments. Nearly 50% more customers logged into their online account in January 2017 than did so in January 2016 (9,411 in Jan. 2017 vs 6,520 in Jan. 2016). More than three times as many customers made recurring payments in QE0317 than did so in QE0316 (an average of more than 3,200 recurring payments per month in QE0317 compared to fewer than 1,000 in QE0316).

ii. Choices for Care

Key updates from QE0317:

- CFC operationalized SFY16 Year End Savings Reinvestments.
- HCBS provider self-assessment tool created.
- No wait list for high/highest; provider wait lists for Moderate Needs only.

SFY16 Reinvestments

In February 2017, the Department of Disabilities, Aging and Independent Living (DAIL) received legislative approval to reinvest approximately $800,000 gross in Choices for Care SFY16 year-end savings. DAIL operationalized these reinvestments by authorizing approximately $481,000 in one-time adjustments for Moderate Needs services provided in SFY17, and approximately $321,000 towards a rate increase to Enhanced Residential Care services effective May 1, 2017. Reinvestments were based on elements presented in DAIL's annual "Adequacy of Choices for Care Provider System" report to the legislature and stakeholder feedback. The adequacy report can be found here: http://legislature.vermont.gov/assets/Legislative-Reports/CFC-Adequacy-Report-9.6.16-v3.pdf

HCBS Federal Regulations

During this reporting period, Vermont continued work to finalize an online provider self-assessment survey for implementation in April. The survey will require that Choices for Care case management, adult day and adult family care providers answer specific questions related to their practices and whether they are in line with the new regulations. The same survey will be used to assess the Traumatic Brain Injury and Developmental Services provider systems. Survey results will help Vermont better understand how provider operations align with the new federal rules and what changes are necessary to comply with the new HCBS Rules by March 2019. For more information on the Choices for Care HCBS work plan, go to: http://asd.vermont.gov/special-projects/federal-hcbs.

Wait List

Choices for Care does not have a wait list for people applying for High/Highest and are clinically and financially eligible for services.

Moderate Needs Group (MNG) services are not an entitlement and instead are limited by funding which is allocated to providers and managed at the local level. This requires that providers establish a wait list when funds are spent in their region. Currently, home health providers report that approximately 700 people are waiting for help to pay for homemaker services statewide and approximately three people are waiting for help to pay for Adult Day services. Though total funding for MNG services was increased to eliminate the wait list in SFY2015, it is important to note that eligibly for Moderate Needs is quite broad, which creates an opportunity for a very large number of Vermonters to be eligible. Therefore, it is expected that unless the eligibility criteria is modified, wait lists for the limited Moderate Needs funding will continue for the foreseeable future.

iii. Developmental Disabilities Services Division

Key updates from QE0317:

- SFY 16 Reinvestments
- HCBS provider self-assessment tool created.
- Wait List

SFY16 Reinvestments

DDSD collects performance measure data on programs funded through investments throughout the year but only reports full fiscal year data (July 1 – June 30) after the end of the State Fiscal Year.

HCBS Provider Self-Assessment

Vermont continued work to finalize an online provider self-assessment survey for implementation in April. Based on work with a HCBS Transition Advisory Committee the division designed a paper version of the survey form for application in rural areas and offered a dedicated staff person to assist with the collection of information and data entry into a web based survey. The survey will require that Developmental Services providers answer questions designed to assess the degree to which current practice varies from the new rule requirements. This information will provide a basis for follow up validation visits and completion of our system to full compliance by the due date of March, 2022.

Wait List

DDSD collects information from service providers on individuals who request funding for Home and Community-Based Services (HCBS). The information is a reporting spreadsheet created by the State and used by Designated and Specialized Services Agencies and the Supportive Intermediary Service Organization (Supportive ISO) to collect information on individuals with developmental disabilities (DD) who are waiting for DD services. HCBS funding priorities are the method by which Vermont prioritizes who will receive the new caseload funding allocated annually by the legislature (managed by the State though the Equity Fund and Public Safety Fund) and existing funding (managed internally by the Agencies and Supportive ISO, and the State through Returned Caseload Fund). When these reports are created they include three categories:

1. New Applicants: Individuals with DD who are clinically and financially eligible but who do not meet a funding priority for HCBS and have been denied services in whole or in part.
2. Individuals Receiving Services: Individuals with DD currently receiving HCBS services whose requests for additional services is denied in whole or in part because the change in their circumstance does not result in meeting a funding priority.
3. Individuals who are clinically and financially eligible for Targeted Case Management (TCM), Family Managed Respite (FMR), Flexible Family Funding (FFF) or Post-Secondary Education Initiative (PSEI), but for whom there are insufficient funds.

Vermont has always been able to fund services to individuals whose needs meet a funding priority. Therefore, no one has ever been on a waiting list for HCBS who meets a funding priority. No one who was eligible for HCBS was waiting for services between 1/1/17 – 3/31/17.

iv. Traumatic Brain Injury (TBI) Program

Key updates from QE0317:

- HCBS provider self-assessment tool created.
- No wait list for TBI services.

HCBS Federal Regulations

As with Choices for Care and DDSD, Vermont continued work to finalize an online provider self-assessment survey for implementation in April. The survey will require that TBI providers answer specific questions related to their practices and whether they are in line with the new regulations. Survey results will help Vermont better understand how provider operations align with the new federal rules and what changes are necessary to comply with the new HCBS Rules by March 2019. For more information on the TBI HCBS work plan, go to: http://asd.vermont.gov/special-projects/federal-hcbs.

Wait List

There is currently no wait list for TBI services in Vermont.

v. Global Commitment Register

Key updates from QE0317:

- Since the Global Commitment Register (GCR) launched in November 2015, 72 final GCR policies have been publicly posted.

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

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

Health care policy stakeholders are notified via email every time a proposed or final policy is

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

A combined total of 21 policies were posted to the GCR this past quarter. This includes proposed and final changes, as well as one clarification. Administrative rulemaking accounted for about half of the changes, with the remainder largely being changes to rates and State Plan Amendments.

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

V. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE0317:

- The VCCI continues to work with the MMIS enterprise Care Management team on system bugs/defects, end user training, user acceptance testing UAT), data integrity and reporting; as well as new features to enhance case management performance.
- CMS certification requirements will be initiated in quarter 2 CY 2017.
- The VCCI leadership is working with DVHA legal counsel, MMIS care management technical colleagues, the MMIS care management vendor and Vermont Health Information Exchange (VHIE) to facilitate biomedical data transfers from the VHIE on Medicaid members, into the enterprise care management solution. The goal is to enhance identification of case management needs, clinical monitoring and evaluation, including for next generation ACO attributed members.
- The DVHA next generation ACO contract with Vermont Care Organization precludes ACO attributed members from receiving VCCI case management services. As a result, 67 active VCCI members were transitioned to the ACO by March 31, 2017; and new eligibility rules are in development.

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

The VCCI is a component of DVHA's health care reform goals and its supporting strategic plan. The VCCI employs 27 licensed and non-licensed professional staff operating in a decentralized model statewide, so resources are available where members need them. The VCCI is designed to

identify and assist high risk/high cost, medically complex Medicaid members with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower members to eventually self-manage their chronic conditions. A significant effort is placed on facilitating and supporting Medicaid member identification, access and use of a Medical Home for receipt of primary care.

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

The VCCI's strategy of embedding staff in high-volume hospital sites to support population engagement at the point-of-need in areas of high service utilization and prior to claim adjudication continues, and supports direct referral at the point of need. By targeting high risk/cost members, resources can be allocated to areas representing the greatest opportunities for member engagement, clinical improvement and cost savings.

The model of embedding staff in high volume provider practice sites is under review as necessitated by the decline in eligible practice site members, concurrent with the launch of the next generation ACO in 2017. ACO attributed members are no longer VCCI eligible.

As a result of the ACO launch, VCCI will update eligibility criteria with exclusion of ACO attributed members in their pilot communities. The VCCI target population will expand to include members in the top 10%, and with high anticipated future cost, based on predictive analytics.

The VCCI continue to strive for strategic alignment with other important State health care reform efforts, such as the DVHA Blueprint for Health, their NCQA certified advance practice medical homes and local Community Health Teams (CHTs) funded by pubic and commercial payers. The VCCI staff function as extensions of the local CHT and support coordinated care planning with local partners.The VCCI generally supports the highest risk population and performs home visiting, while the carrier funded CHT's have historically focused on less acute Medicaid members, often seen in the PCP office site. In pilot communities, the ACO, via PCP and CHT staff, will be accountable for case management of all Medicaid members attributed, including high and very high risk.

The vision of enhanced local coordination and a single plan of care remains a component of the long-term state vision toward an all payer model. The AHS Enterprise MMIS Care Management system supports this opportunity as part of the 'future state'. Specifically, the next release is

intended to have both provider and consumer portals, and is anticipated to accept biomedical data from the VHIE as well as case management data from the Medicaid next generation contracted ACO, This will leverage and maximizing the CMS investments to the State via MMIS for monitoring, evaluation and reporting of clinical and financial outcomes on Medicaid members.

MOMS (Medicaid Obstetrical and Maternal supports) for Pregnant Women

The VCCI initially launched the service line for pregnancy case management in October 2013 as a pilot and which had steadily evolved based on staff and partner input. The position has been vacant for the first quarter of calendar 2017 and is under recruitment. There was a refocusing to a single centralized resource/expert available to the field staff as well as community and statewide partners. The MOMs case manager also has a case load of pregnant women. Since this change in structure the initiative had been able to move forward on a more accelerated rate. VCCI staff are trained on the MOMs services and supports and accept local at risk MOMs candidates on their case load. The primary focus is on women with a history of mental health and substance use/abuse and related management of these conditions during pregnancy in an effort to improve birth outcomes and limit NICU and/or inpatient stays for both baby and mother. The MCH staff liaison and case manager, is an important resource to the statewide VCCI team as well as to our partners supporting at risk pregnant women and women of child bearing years. The expansion of pregnancy case management assessment tools is anticipated in the new eQH system in 2017 as part of Release 3. The vacant position is anticipated for hire in the second quarter of calendar 2017. A challenge in hiring remains as the starting state nursing salaries for experienced nurses- despite a 35% market factor added in 2016 - remains under other community case management positions for experienced staff. Elimination of a 'hire into range' for nurse case managers prevents consideration of 'experience' in any new hire offer.

Enterprise Care Management System

The VCCI was the initial DVHA unit to go live in the new enterprise care management system with our vendor partner, eQHealth (eQH) on 12/31/15. The VCCI was engaged in planning and development of system configuration, including eligibility rules, workflow mapping, survey tools and related system alerts on gaps in care. The VCCI staff continue to support User Acceptance Testing (UAT) of system features as well as bugs/defects identified and resolved by the vendor; as well as testing initiated for Release 2, scheduled for June 2017. Thus, the VCCI overall caseload remains below goal. The UAT part time efforts by roughly 6 clinical staff, coupled with system training time and the reduction of nurse FTE's in 2016 due to the sunset of our previous vendor all contribute to the decline in the overall VCCI case load. In CY 2017, VCCI case load rates were adversely impacted further by the required transition of eligible members to the next generation ACO; and the need to develop new eligibility rules in the data system for an expanded target population.

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

of documentation standards outlined in our workflow are monitored by monthly audits with a staff goal of 90% accuracy. At the end of quarter one, staff were trending toward 90% average on audits.

Tickets for system bugs and defects remain and there is a SOV/MMIS QA team addressing these with the vendor for resolution. The business will have a more 'hands on' approach going forward as the vendor backlog on fixes has adversely impacted end user efficiency due to workarounds. Backlog grooming sessions will also be initiated to address and prioritize resolution of fixes for both bugs and defects in various category levels. New Service Level Agreements (SLAs) will be in place.

The VCCI clinical SME who is also a regional manager, will reduce hours to 20% MMIS effort, effective quarter two, in order to support clinical field operations. Another MMIS/VCCI staff who is a 'super user' will be 100% allocated to a SME role. Focus will be on assuring end user needs are being addressed and communicated, training documents reviewed, edited and streamlined for VCCI workflow; and related staff training and monitoring of adherence via audits, and impending system reports are in place. Additionally, this resource will also be responsible for working on new functionality for R2 and related test cases, testing and related supports to operationalize (i.e. portals for consumer/providers) in partnership with the VCCI Director and AHS leadership to assure HIPAA privacy and security standards and policy development and/or alignment.

System training documents and policies have been updated to include direct referral within the enterprise system by the internal DVHA's Clinical Operations Unit and the Quality Improvement Units. Both units have been trained and have initiated utilization of this feature with direct referral to the VCCI field staff for members that are transitioning from hospital settings for mental health and/or substance use abuse admissions; or other long term hospital stays (13 days or greater) to reduce 30 day hospital admission rates. This internal system referral process eliminated the manual workaround for referrals between units.

The VCCI management team and analyst initiated work with the Care Management technical team toward receipt of biomedical and immunization data feeds from the HIE into the care management suite. This data resource for 100% of Medicaid members will enhance the clinical staff ability to effectively identify need and manage care based on member treatment and management to evidence based care goals. Trending is anticipated at the member, provider, and hospital service area level, as well as by ACO attribution. The HIE vendor has been difficult to communicate with to date, and the DVHA senior management and legal counsel have subsequently been engaged in these efforts, toward contracted interface development, which was anticipated for completion by 6/30/17.

Meetings with the CMS certification team to review requirements and related check lists, artifacts and operational criteria will be in Q2 of calendar year 2017.

ii. Blueprint for Health

Key updates from QE0317:

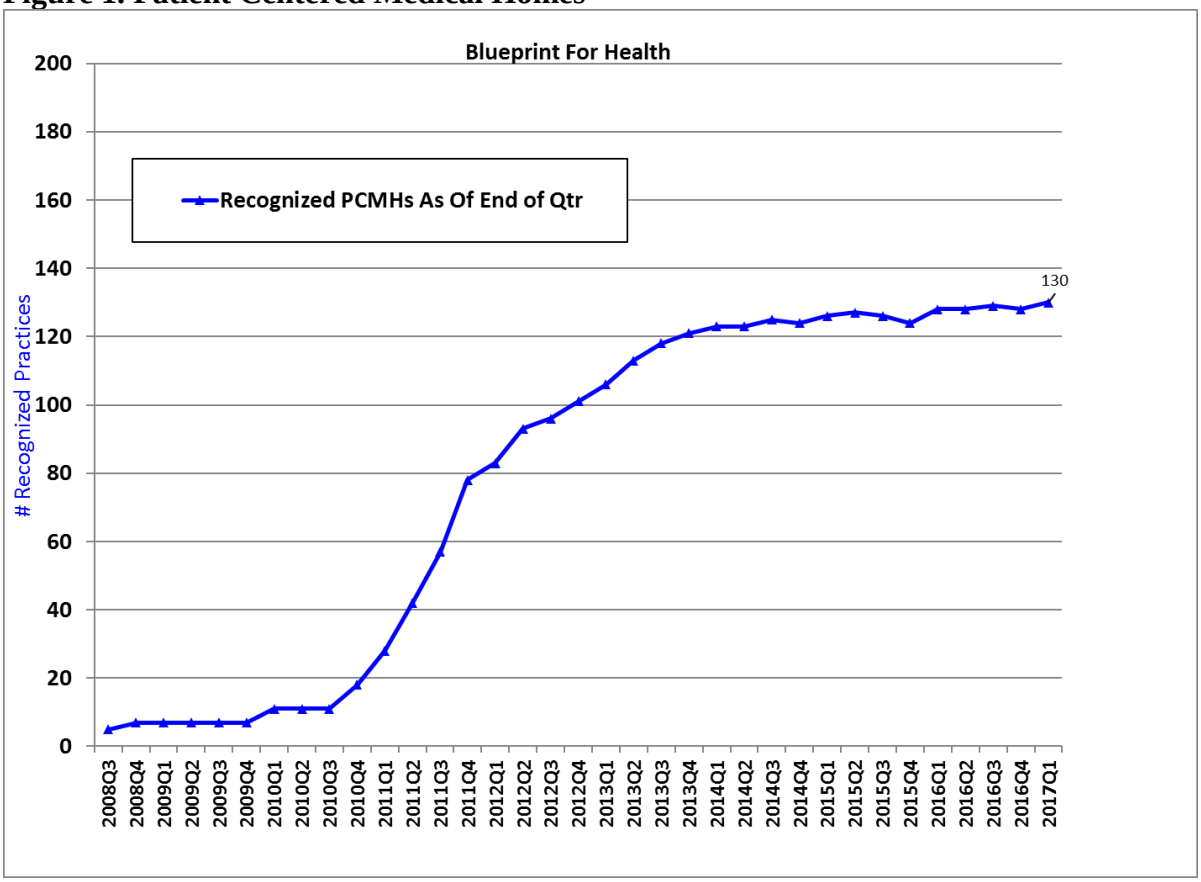
- Beth Tanzman was appointed the Executive Director of the Blueprint for Health program from her prior appointment as the Interim Executive Director.
- Increased access to treatment for patients with opioid use disorder: 3,271 clients enrolled in Regional Opioid Treatment Programs (OTPs) and 2,694 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT) programs as of March 2017.

Patient Centered Medical Homes

In the past quarter, the Blueprint for Health program has had a net increase of one NCQA-recognized primary care practice. One new practice qualified and joined the Blueprint within the quarter and one additional practice qualified as of 8/1/2016 but did not report their qualification to the Blueprint until 4/21/2017. This practice retroactively joined the Blueprint as of 8/1/2016. 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 as of the end of the quarter was 130.

Beth Tanzman was appointed the Executive Director of the Blueprint for Health program from her prior appointment as the Interim Executive Director. Two new employees, Mara Donohue and Nissa Walke, have joined the Blueprint for Health team as Assistant Directors.

Figure 1. Patient Centered Medical Homes



Hub & Spoke Program

The "Hubs" are regional specialty addictions treatment programs. The “Spokes” are counselors, nurses and social workers who provide support for patients in the primary care setting, and are members of the local Community Health Teams. The Hub & Spoke model has increased access to treatment for patients with opioid use disorder: 3,271 clients enrolled in Regional Opioid Treatment Programs (OTPs) and 2,694 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT) programs as of March 2017. Medication assisted treatment is being offered across more than 80 different practices and by 196 medical doctors and 56.65 FTE registered nurses and Master’s-prepared, licensed mental health / substance use disorder clinicians working as a team to offer Office-Based Opioid Treatment (as of March 2017). The Opioid Treatment Program (OTP) development in Northwestern Vermont continues and is nearing completion; the community has reacted in a positive and supportive manner throughout the program development process.

Learning collaboratives were convened throughout January, February and March for providers and practice teams that are new to Office-Based Opioid Treatment (OBOT), for advanced providers and practice teams to address best practices and emerging topics, such as complex care considerations associated with medication assisted treatment patients, and regionally (Chittenden) to identify and improve transition issues, including referral and consultation, between the Opioid Treatment Program (OTP) and Office-Based Opioid Treatment (OBOT)

practices. The Blueprint for Health, in collaboration with an analytics contractor, Onpoint Health Data, worked throughout January, February and March to develop data profiles that provide valuable information regarding demographic and health status information, health service utilization, and expenditures for Medicaid beneficiaries served by Opioid Treatment Programs (OTPs, "Hubs") and Office-Based Opioid Treatment (OBOT, "Spokes").

The Blueprint for Health continues to work collaboratively with the Division of Alcohol and Drug Abuse Programs of the Vermont Department of Health on many initiatives, including the Initiation and Engagement in Treatment and Opioid Prescribing Project, in order to provide an interagency, comprehensive and data-driven approach to addressing the opioid crisis in the State of Vermont. The Vermont Department of Health commissioned a qualitative research study to conduct detailed interviews with medication assisted treatment participants to assess the patient experience of care and that study is currently in-process.

Community and State partners continue to work within the Chittenden County Opioid Alliance to develop a system of care for substance use disorder that is timely, coordinated and comprehensive. As part of this project, the City of Burlington's Police Department now has an "Opioid Dashboard" that includes a "CommStat" section whereby the number of accidental opioid overdose fatalities in Chittenden County and the Number of Burlington Police Department Calls for Service (related to retail theft) are now tracked and linked to from the City of Burlington Police Department public website.

Figure 2. MAT-SPOKE Implementation January 2013 – March 2017 Staffing

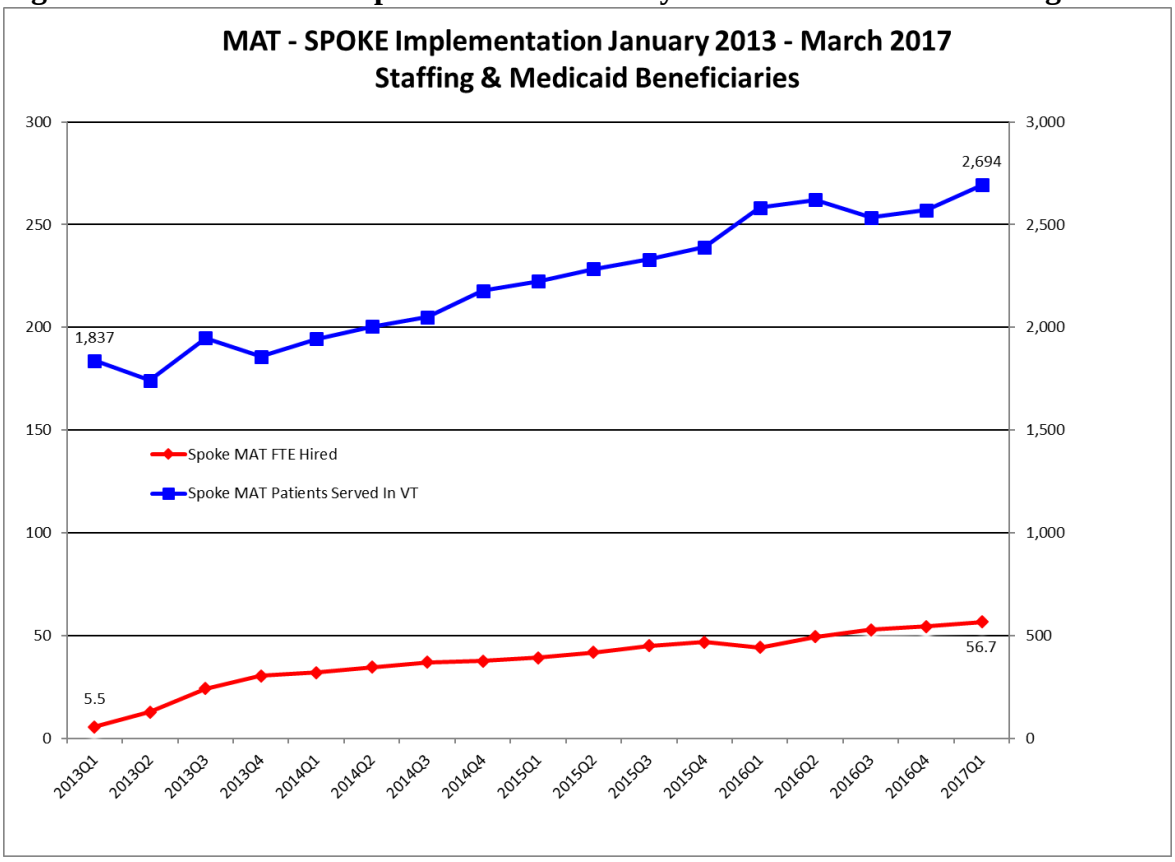


Figure 3. MAT-SPOKE MDs Prescribing Buprenorphine Jan 2013 – Mar 2017

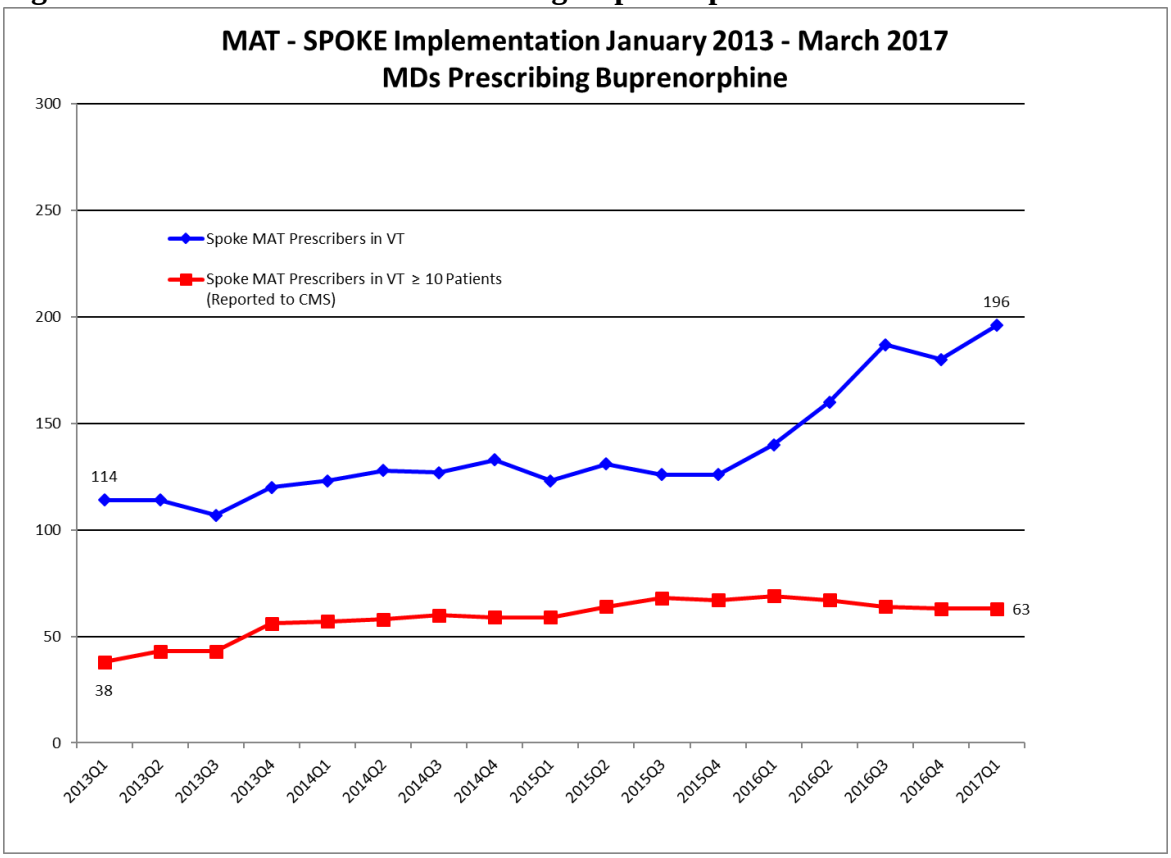
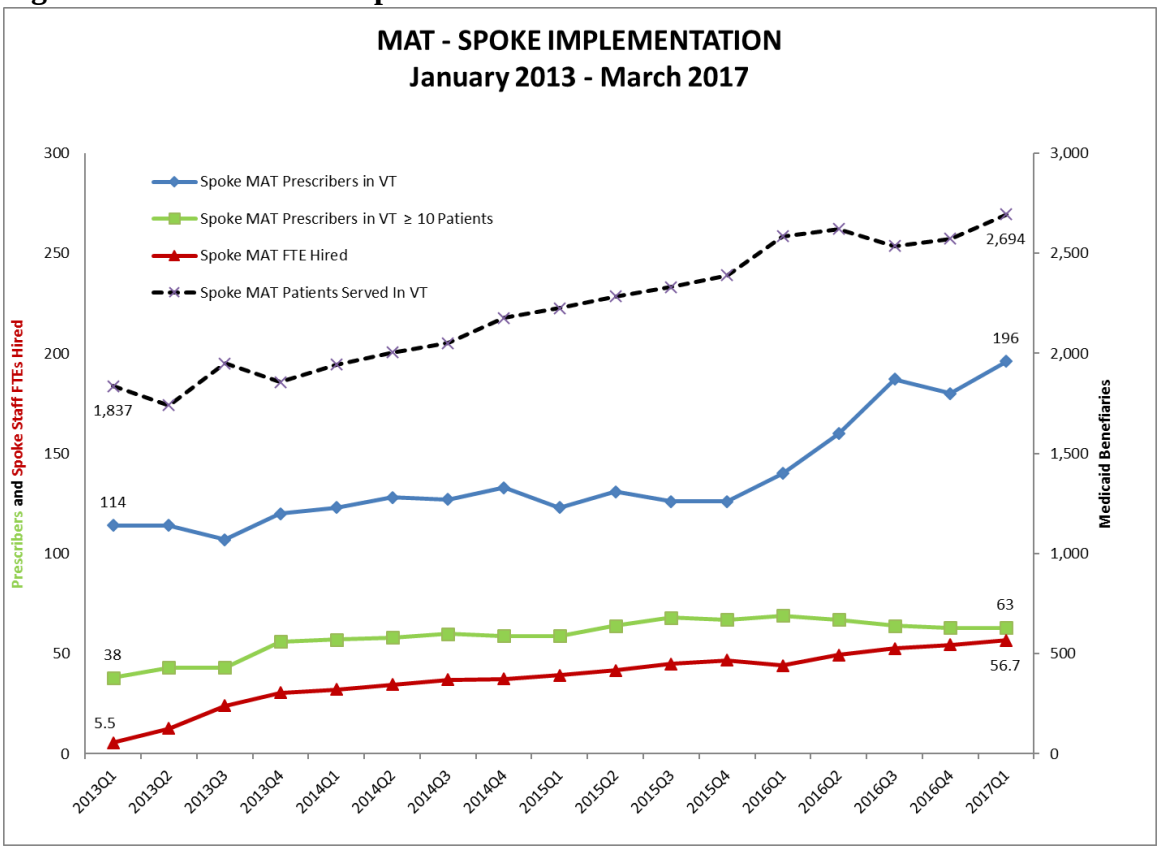


Figure 4. MAT-SPOKE Implementation Jan 2013 – March 2017



Note: The numbers for the Spoke MAT Prescribers in Vermont serving more than 10 Patients has been corrected from previous reports because the numbers were not de-duplicated counts.

The table below shows the caseload of Hub programs and also the number of clients receiving methadone or buprenorphine.

Table 1. Hub Implementation as of March 31, 2017

Region	# Clients	# Buprenorphine	# Methadone	# Vivitrol	# Receiving Treatment but Not Yet Dosed
Chittenden, Franklin, Grand Isle & Addison	976	290	685	0	1
Washington, Lamoille, Orange	457	189	268	0	0
Windsor, Windham	622	163	459	0	0
Rutland, Bennington	439	96	312	6	25
Essex, Orleans, Caledonia	777	207	564	6	0
Total	3271	945	2288	12	26

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

Table 2. Spoke Implementation as of March 31, 2017

Region	Total # MD prescribing pts	# MD prescribing to ≥ 10 pts	Staff FTE Hired	Medicaid Beneficiaries
Bennington	10	4	4.6	239
St. Albans	13	8	8.1	402
Rutland	16	8	5.1	282
Chittenden	78	15	11.85	573
Brattleboro	13	6	3.7	150
Springfield	3	2	1.5	73
Windsor	8	4	4	229
Randolph	7	3	2.1	97
Barre	19	8	5.5	263
Lamoille	12	5	4.7	217
Newport & St Johnsbury	15	3	2	97
Addison	4	2	2	60
Upper Valley	4	0	1.5	12
Total	196*	63*	56.65	2,694

iii. Behavioral Health

Key updates from QE0317:

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

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric, detoxification, and substance abuse residential services for Medicaid primary beneficiaries. In 2016, the team moved to paper reviews for psychiatric and detoxification services to ensure member confidentiality and improve interrater reliability. This practice has been expanded to include substance abuse residential facilities. As a result, the clinical documentation to support authorization requests has improved significantly. There has been a sharp decline in requests for reconsideration. Review of the data suggests a very low discrepancy rate. The team has developed a system to ensure internal consistency and educate providers on documentation requirements. Team members work closely with discharge planners at inpatient and residential facilities to ensure timely and appropriate discharge plans. The unit has been expanding collaboration efforts with sister Departments supporting coordination of

care. A protocol has been developed for referral to VCCI for services and to ensure continuity of care for members already enrolled with VCCI admitted to inpatient or residential care facilities.

The Team Care program (formally the lock-in program) is also managed by the Unit. A thorough clinical review of all available data allowed for an accurate assessment of current enrollees' need to remain in the program. Those members no longer requiring oversight have been disenrolled from the program. Standards for inclusion in and removal from Team Care are being developed/manualized. A process for referring Team Care program members to VCCI has been implemented. Outreach with providers and pharmacies is planned for the upcoming year.

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

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

iv. Mental Health System of Care

Key updates from QE0317:

- Vermont Psychiatric Care Hospital is in transition to a new executive for the hospital.
- Level 1 units at Brattleboro Retreat and Rutland Regional Medical Center have developed their own culture within the inpatient psychiatric hospital system.
- State legislative committees of jurisdiction devoted resources to formulate legislation to conduct a thorough study of the mental health system of care.
- The State is experiencing prolonged impact of the nationwide opiate crisis.

The Department of Mental Health (DMH), Designated Hospitals (DHs), Designated Agencies (DAs), and Agency of Human Services (AHS) partners form the mental health system of care.

Each has a vital role in meeting the mental health needs of Vermont's population.

The Department provides inpatient psychiatric treatment at the highest level of acuity using a decentralized system that includes a 25-bed state-operated hospital, a 14-bed privately operated hospital, and a 6-bed private unit integrated with physical health care in a general hospital. These three facilities are spread out geographically to comprise the dispersed system of inpatient psychiatric care to meet the needs of acutely ill psychiatric patients. Psychiatric units also are hosted by five Designated Hospitals located across the state. Still, there is an occurrence of waiting for extended periods of time in emergency departments until an appropriate placement in a psychiatric unit becomes available. Working collaboratively with community providers, crisis teams, hospitals, and peers, the department's clinical care managers work daily to reduce wait times and ensure that people seeking treatment are given priority and placed according to their clinical needs. Significant progress has been made this quarter in terms of data collection, reporting, and analysis to reduce wait times.

Community services, already strong and effective, continue to be enhanced and to support hospital diversion through expanded crisis services and increased residential treatment using the least restrictive setting that is appropriate for the level of care required. In many cases, treatment can be provided fairly close to individuals' homes despite Vermont being a rural state. This is due to the core of our mental health system – the ten designated agencies that formed and grew beginning in the 1960's. In more recent years, two specialized service agencies have been added, strengthening the community system of care. They all receive funding through the Global Commitment, their own development initiatives, insurance, municipalities, and state investments. Neither enhanced family treatment (EFT) nor community rehabilitation and treatment (CRT), two HCBS-like programs under the Global Commitment waiver, operate with wait lists.

The Vermont Psychiatric Care Hospital (VPCH) has operated for two and a half years, attaining Centers for Medicare and Medicaid Services (CMS) certification and The Joint Commission (TJC) accreditation. The Level 1 units at the Brattleboro Retreat and the Rutland Regional Medical Center were completed prior to VPCH and have the equivalent status as Level I units with the capacity to treat the highest level of acuity inpatient psychiatric care. Vermont developed all three facilities after Tropical Storm Irene forced closure of the former Vermont State Hospital. The investment required and rapid replacement of the antiquated institution is a major achievement for the State.

Local hospital emergency departments in collaboration with the Designated Agencies throughout the state provide screening, stabilization, and limited treatment until admission to a psychiatric inpatient bed can be facilitated. Many of the patients who come to hospitals have not been a client of a Designated Agency so their needs must be assessed in the emergency departments. As part of "decentralizing high intensity inpatient mental health care,"[1] the Department works to improve the quality of treatment services afforded to patients who are involuntarily hospitalized in Vermont, most of whom are served by the Designated Hospitals.

Under Act No.79 of 2012, the Department continues its work to strengthen Vermont's existing

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

mental health care system. This work has included the development of enhanced community services, including emergency/crisis responses, residential services and support, housing, and inpatient treatment capacity. In the past few years, specific enhancements by category include:

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

- Community Services
    - Community Rehabilitation and Treatment (CRT) and peer programs provide community support, outreach, and crisis response.
    - Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs.
    - Mobile crisis responses for screening and intervention in the community.
    - Team Two collaboration between law enforcement and mental health responders.
    - Soft-restraints for law enforcement transports for mental health hospitalizations.
    - Assist individuals in finding and keeping stable housing.

- Residential and Transitional Services
    - Soteria, a five-bed, peer supported alternative residential program in Vermont's urban Chittenden County (Burlington).
    - The Middlesex Therapeutic Community Residence, a secure (locked) residential recovery program that serves 7 individuals remains fully occupied.
    - Critical need for a permanent facility to replace the Middlesex Therapeutic Community Residence and to determine the population(s) that required a secure residential program.

- Performance and Reporting
    - Consistent with mandatory adoption of Results-Based Accountability throughout the Agency of Human Services (AHS), DMH adopted the RBA framework for assessing performance of providers via grants and contracts
    - Created a "VPCH Outcomes" scorecard to meet legislative reporting requirements
    - Created a "DMH Scorecard" using the RBA scorecard reporting tool

- Migrated the "DMH Snapshot" and the "DMH continued reporting" report to the RBA scorecard reporting tool

- Regulation and Guidance

  - Revision of the Designated Hospital Manual and Standards to better reflect the scope of review; created a designation protocol to manage the process
  - Created an involuntary transportation manual to consolidate expectations of the department based on Act No. 180 2006 (ADJ) Session [2] into a single document.

The Department monitors the functioning of the clinical resource management system to "coordinate the movement of individuals to appropriate services throughout the continuum of care and to perform ongoing evaluations and improvements of the mental health system" as written in Act 79.

> The Care Management team currently is comprised of four care managers with the specific focus of supporting the movement of consumers through the different systemic levels of care. The lead for admissions work focuses on collaborating with DA screeners and ED staff as well as the inpatient admissions staff to facilitate and triage an admission for someone who is on involuntary status and waiting for placement. She is also available to support folks who are voluntary as needed. Two of the care managers meet weekly with the hospital inpatient units to assist in facilitating discharges to the next appropriate level of care. They work in collaboration with several state and community partners to problem solve and provide clinical consultation with a primary focus on those individuals who have been admitted through an emergency examination. They have a bird's eye view on available resources and potential resources and can "cue" up potential next admissions to decrease discharge wait times. They are typically managing a combined caseload of approximately 65 individuals on a weekly basis. Rounding out the team is a care manager who works in collaboration with Designated Agencies and the DMH legal unit to support the work our partners are providing to those folks who are under the care and custody of the Commissioner and reside in the community. She also works directly with Department of Corrections staff to support reentry efforts for individuals who have been designated SFI (Severe Functional Impairment) in corrections.
>
> This current care management structure has evolved as we meet the needs of the state system of care to provide direct DMH support to Designated Agencies and other community partners for individuals who are accessing all the levels of mental health care the state offers.

In general, the care management system encompasses these functions:

- Departmental clinical care managers help crisis services clinicians in the field, Designated Agency case managers, and Designated Hospital social workers link individuals with the appropriate level of care and services act as a bridging team for aftercare and discharge planning from hospital inpatient care to community services

[2] Transportation of individuals in the custody of the Commissioner of mental health [Section 3 – 18 V.S.A. §7511]

- Departmental clinical care managers support Designated Agencies and monitor care to individuals on Orders of Non-Hospitalization (ONH)
- An electronic bed board to track available bed space is updated regularly to enable close to real time access to information for individuals needing inpatient treatment, residential treatment or crisis bed services
- Patient transport services are coordinated through Admissions and Central Office
- Supervision by law enforcement for individuals in emergency departments on emergency examination status who are awaiting admission to a Designated Hospital is by the Department
- Review and coordination of intensive residential care bed placement within a no-refusal system
- Access by individuals to a mental health patient representative
- Periodic review of individuals' clinical progress.

v. Pharmacy and 340B Drug Discount Program

Key updates from QE0317:

- The Drug Utilization Review Board held meetings on January 17 and February 21, 2017. Fifteen new drugs and fourteen therapeutic classes were reviewed, five reviews of Newly-Developed/Revised Clinical Coverage Criteria, four RetroDUR reviews and six safety alerts were presented.
- DVHA sent six provider communications out on topics of Preferred Drug List Changes, Preferred Diabetic Supply List Changes, Contraceptive Day's Supply Changes, Hepatitis C Criteria Changes, New Pharmacy Pricing Rules and Point-of-Sale Blackout Period.

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, Change Healthcare (CH), 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 is responsible for overseeing the contract with Change Healthcare (CH) 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 while managing drug utilization and cost.

Pharmacy Operations

- Pharmacy claims processing-enforcing coverage rules for various program.

- Pharmacy provider assistance-DVHA, CH 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

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 four - 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 QE0317, the DURB held 2 meetings. Information on the DURB and its activities in 2017 is available: http://dvha.vermont.gov/advisory-boards.

340B Drug Discount Program

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

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

To encourage participation in the Vermont Medicaid 340B program, DVHA offers a "shared savings" program whereby covered entities receive a share of the total savings generated for the state by the 340b program. DVHA identified the following goals in establishing its proposed 340B reimbursement methodology:

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

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

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

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

vi. Integrating Family Services (IFS) Initiative

Key updates from QE0317:

- The following IFS frameworks have been finalized:
  - Collaborative Leadership and Decision-Making**:**
    - Share responsibility with the IFS grantees/contractors and state district offices to improve IFS population indicators and apply a Results-Based Accountability™ framework
    - Share performance data: Annually review performance data of state district offices and community grantees/contractors to increase collaborative problem solving and shared decision making; and specifically to promote: a) maximizing the impact of IFS grants and improving outcomes, b) developing collaborative and integrated strategies to support each other's performance, and c) celebrating both collective and organization-level achievements
  - Service Delivery
  - Accountability and Oversight (see below for outcome metrics)
- Several regions are consolidating regional teams so they have a strong IFS Core Team which will be responsible for implementing the Collaborative Leadership Framework.

IFS is aligning its payment reform efforts with the larger healthcare reform to ensure coordination across the state.

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

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

The IFS Initiative seeks to bring state government and local communities together to ensure

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

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

Successes of the two pilots include:

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

As well, IFS continues to provide support and leadership regarding several efforts that cut across multiple agency departments such as:

- enhanced teaming for families with complex needs,
- turning the curve on the number of children and youth in residential settings,
- coordinating autism services and supports,
- coordinating and supporting Act 264,
- having a common tool for progress monitoring to know if children and families are better off due to our efforts.

IFS Accountability and Oversight Framework (Outcome Metrics)

Population-Level Outcomes and Indicators

1. Vermont statute Act 186 (2014) establishes outcomes and indicators that are intended to align programs and strategies across the state toward the same ends.
2. Population indicators will be available to IFS regions through an AHS Scorecard. This information will be used by IFS Regional Core Teams to inform how they target supports and services to best meet the needs of children, youth and families in their communities
3. An entire community, not just IFS grantees, is responsible for the IFS population-level indicators, bending the curve on population indicators. However, IFS grantees' performance measures will positively impact the health and well-being of the whole population.

Act 186 Outcomes	1. Pregnant women and young children thrive/Children are ready for school	2. Families are safe, stable, nurturing and supported	3. Youth choose healthy behaviors/Youth successfully transition to adulthood	4. Communities are safe and supportive
Population Indicators	a. % of children who are ready for kindergarten in all five domains of healthy development	a. Rate of child abuse and neglect b. Number of Vermont families with one or more children who are experiencing homelessness	a. % of high school seniors who have a plan following high school b. % of adolescents in grades 9-12 who drank alcohol before age 13 c. Number of youth (12-21) who have adolescent well-care visits with a PCP or Ob/Gyn	a. Rate of children living below the 200% poverty rate b. % of infants and toddlers likely to need care who do not have access to a high quality, regulated child care program

Performance Measures for IFS Grantees

These performance measures were embedded in the FY17 IFS grants and data will be available in the fall 2017.

How Much?	How Well?	Is Anyone Better Off?
1. Number of children served by fiscal quarter 2. Number of children served by age 3. Number of hours of service 4. % of services provided to child/youth with Medicaid	5. % of children with a plan developed collaboratively with families 6. Satisfaction measure from family perspective 7. % of children with a plan completed within 90 days of referral 8. % of children (Prenatal to 6) that received initial contact within 5 calendar days 9. % of children (Prenatal to 6) that had a transition plan (30 or 90 days before transition) upon discharge 10. % of children/youth receiving non-emergency service within 7 days of emergency service 11. % of children/youth living at home or close to home in a family-like setting	12. % of children/youth that have shown improvement on the CANS or an approved assessment tool 13. % of children whose CANS score shows improvement in the family domain *OR* % of families who show improvement on an approved assessment tool
14. Report any novel, innovative and successful initiatives taken in any arena (such as: quality, teaming, services, system, fiscal, or data sharing) in your region.		

vii. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE0317:

- On February 1, 2017 DVHA executed a contract with OneCare Vermont as a risk-bearing Accountable Care Organization (ACO) for participation in a population-based payment model that is based on the Centers for Medicare and Medicaid Services (CMS) *Next Generation* ACO Model.2017 is the pilot year of implementation for the Vermont Medicaid Next Generation ACO program; approximately 29,000 Vermont Medicaid beneficiaries are attributed through this model in four risk-bearing communities.
- Readiness review activities were conducted in late 2016 and concluded in early 2017 with 100% completion.
- Future program implementation will be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

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

DVHA and OneCare entered into an agreement for the 2017 performance year as a pilot year with four possible one-year extensions to the program. Four risk-bearing hospital communities are participating in the *Vermont Medicaid Next Generation* (VMNG) model for the pilot year: the University of Vermont Medicaid Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital, with additional participation from FQHCs/independent practices, home health providers, Designated Agencies, and skilled nursing agencies in the four communities.

DVHA issues a prospective Per-Member-Per-Month (PMPM) payment to the ACO; the ACO distributes payments to providers participating in the program per contractual arrangements between the ACO and providers. The ACO is paid for each attributed member according to their Medicaid Eligibility Group, and the ACO is accountable for the cost and quality of care of each attributed member. Payments for services not included in the ACO contract continue to be paid fee-for-service, as are payments made to Medicaid providers not participating in the ACO's network .

DHVA conducted a readiness review in November and December of 2016 of OneCare's operational preparedness for the 2017 program year. The review consisted of a desk review and on-site review of a total of 174 readiness items, which covered the breadth of OneCare's functional areas. Subject matter experts from DVHA participated in the review and deemed the readiness requirements sufficiently met for a 2017 start date. Several lower priority items remained partially

met at the beginning of 2017, but all requirements were completed as of March 31, 2017. DVHA's operational readiness was also a focus in the first months of 2017, with processes being established and tested to support ongoing Q1 activities implementation and monitoring of the VMNG program.

DVHA While 2017 is a pilot year, there is the potential to integrate additional providers and additional Medicaid-covered services in future program years. Program implementation will continue to support and align with Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

VI. Financial/Budget Neutrality Development/Issues

AHS paid DVHA 1/12 of the legislative budget for Global Commitment on the first business day of every month during the March 2017 quarter. This payment served as the proxy by which to draw down Federal funds for Global Commitment. The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments and admin; please note admin is now claimed outside of GC neutrality) for the given quarter. After each quarterly submission, we reconciled what was claimed on the CMS-64 versus what we made for payments to DVHA.

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

In respect to the new STCs, AHS is having difficulty interpreting STC #65. Part of this language was in the previous version of the GC waiver STCs, however it only applied to the New Adult Group. It is unclear if STC #65 applies to the entire demonstration and how it should be calculated.

Upon further review of the Hub and Spoke adjustments made in the previous quarter, it was determined that more information is needed to be sure the source data tied to the Financial Balancing Reports (FBR) provided by DXC Technology (formerly HPE). Entries were made this quarter to zero the adjustments from the previous quarter while further research is being done by DVHA.

In the previous 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 three of the thirty individuals sampled were not eligible for the VIII Group. This resulted in a disallowance of $3,503 in FFP. AHS entered this as a Prior Quarter Adjustment on the QE0317 CMS-64 report. CMS will continue the VIII Group sample review for QE 0317.

Work has begun this quarter with our actuarial contractor Milliman to develop the 2018 PMPM rates.

VII. Member Month Reporting

The State of Vermont certifies the accuracy of the member month reporting. The enrollment report is produced as of the 15th of every month. The member months are subject to revision over the course of a twelve month period due to a beneficiary's change in enrollment status.

GC quarterly reports prior to 2017 provided an enrollment count by Demonstration Population only. Medicaid Eligibility Groups have been added for the new Budget Neutrality (see Attachment 1). To maintain continuity, the table below crosswalks the count from Medicaid Eligibility Group to Demonstration Population. Both counts use the same unduplicated enrollment count information.

The table below contains Member Month Reporting for QE0317. Please note that although the New Adult Budget Neutrality is calculated, it is not included in the waiver saving summary in Attachment 1. Please further note the Medicaid Expansion counts in this table are not used to calculate the waiver saving summary. Finally, please note that the long-term care (LTC) population in the table below is a subset of two Medicaid Eligibility Groups.

Table 3. Member Month Reporting – Calendar Year 2017

Member Month Reporting					
Demonstration Population	**Medicaid Eligibility Group**	**Total CY 2017**	**2017 01**	**2017 02**	**2017 03**
1, 4*, 5*	ABD - Non-Medicare - Adult	**25,036**	8,453	8,374	8,209
1	ABD - Non-Medicare - Child	**6,865**	2,318	2,281	2,266
1, 4*, 5*	ABD - Dual	**63,068**	21,092	21,019	20,957
2	ANFC - Non-Medicare - Adult	**42,676**	14,319	14,227	14,130
2	ANFC - Non-Medicare - Child	**182,131**	60,638	60,856	60,637
	Medicaid Expansion				
7	Global RX	**21,548**	7,194	7,200	7,154
8	Global RX	**12,197**	4,128	4,052	4,017
6	Moderate Needs	**750**	247	248	255
	New Adults				
3	New Adult with out child	**123,608**	40,956	41,347	41,305
3	New Adult with child	**54,616**	18,003	18,246	18,367
	Total	**532,495**	**177,348**	**177,850**	**177,297**
*** Long Term Care Group**		**Total CY 2017**	**2017 01**	**2017 02**	**2017 03**
4 only	ABD Long Term Care Highest Need	**8,776**	2,963	2,933	2,880
5 only	ABD Long Term Care High Need	**3,235**	1,091	1,074	1,070

PMPM Capitated Rates

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

Table 4. PMPM Capitated Rates QE0317

Medicaid Eligibility Group		10/1/15-03/31/17
ABD Adult	$	1,534.86
ABD Child	$	3,038.82
ABD - Dual	$	2,480.59
non-ABD Adult	$	736.04
non-ABD Child	$	488.80
GlobalRx	$	78.76
New Adult	$	513.91
Moderates	$	686.79

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 QE0317:

- The MCE's formal CMS PIP topic that focused on improving substance use disorder treatment is making progress with engaged community champions and intervention efforts underway.
- The DVHA Quality Unit hired a full time Quality Assurance Manager.
- The MCE Quality Committee requested TA so that we can take on a new role in understanding and using rapid cycle evaluation.

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 the Agency of Human Services and community providers. The unit is responsible for instilling the principles of quality throughout DVHA and helping everyone in the organization to achieve excellence. The Unit's goal is to develop a culture of continuous quality improvement throughout DVHA.

MCE Quality Committee

The MCE Quality Committee remained very active during Q1 CY2017 and consists of representatives from all Departments within the Agency of Human Services that serve the Medicaid population. The committee continues to structure its work around the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care. During this time period, the Quality Committee discussed their experience of care survey strategy and collaboration with the Blueprint for Health and ACO. The committee made a decision to oversample at least one of the special populations this year for use in comparison to the overall Medicaid population. The Committee also discussed involvement in moving toward rapid cycle evaluation of payment reform models. The committee will continue exploration in the coming months. CMS has been contacted regarding potential TA for the committee.

Formal CMS Performance Improvement Project (PIP)

The CMS reporting cycle for the AHS-wide PIP on Follow-Up After Hospitalization for Mental Illness (FUH) came to a close in June 2016.

The topic of substance use disorders rose to the top as the focus area for the next formal PIP. A small group of staff from the DVHA Quality Unit and the Vermont Department of Health's Alcohol and Drug Abuse Programs (ADAP) division formed a team and confirmed inter-Agency support and interest in this project topic during the 2nd half of 2016. This group of ADAP and DVHA staff performed a root cause analysis and prioritized barriers.

Community champions were identified through multiple stakeholder meetings for collaboration. Starting in January 2017, the PIP team began presenting monthly project work to the Blueprint/Accountable Care Organization (ACO) All Field Team meeting. This group consists of Blueprint and ACO QI project managers as well as Community Health Team leads. Associate Directors within the Blueprint connected the work of this PIP and the use of the HEDIS IET measures as the study measure to other measure sets and initiatives ongoing within the State that the Blueprint is

involved in – the All Payer Model quality measures, as well as the Women's Health Initiative. The BP/ACO project managers were engaged in this topic and requested additional data that will help them move forward with QI efforts within their communities. In February and March, the PIP team provided this group with additional county-level data, including index event location break outs. The PIP team hosted a conference call that was widely attended where they discussed promising interventions both local and outside the state. The team shared best practices by different community leads reporting out on improvements they are trying in their own area. Conversations have begun with the DVHA Data Unit to create an interim measure – likely number of people who received new treatment services by county. The PIP team hopes to provide this data to the All Field Team on a monthly basis to gauge progress.

Quality Measure Reporting

- CMS Medicaid Quality Core Sets - During Q1 CY2017, the Quality Unit reported the Adult and Child Quality Core Measure Sets to CMS via the MACPro reporting platform.

- HEDIS - During this time frame the Quality Unit also executed a contract with a vendor to produce the nationally recognized HEDIS performance measures. This year's scope of work includes administrative measure production only.

- VT Medicaid Global Commitment Core Measure Set – the MCE Quality Committee regularly reviews the GC Core Measure set, made of high priority measures that indicate conditions of health that are important to AHS and the population we serve. Time was spent during CY 2016 discussing how this core set could better represent the breadth of services provided under the GC waiver. It was decided to disaggregate at least one measure on the core set in 2017 in order to report rates for special populations as well as the general Medicaid population. Final data preparations were done for this work during Q1 2017 for the ED visit measure.

- Experience of Care Measures – the Quality Unit worked with the Blueprint for Health and the Quality Committee during Q1 CY2017 to review bids and contract with a vendor for the CAHPS Health Plan 5.0 survey to be fielded later this year. The Quality Unit reports out on CAHPS survey results using a scorecard tool on the public-facing website.

- Quality Unit staff continued to collaborate with the Blueprint for Health on the eventual reporting of the Health Home Core measure set to CMS.

Collaborative Quality Improvement Projects

During this reporting time period the Quality Unit was able to convert a limited service grant funded position into a full time permanent position focused on data analysis and project management. With the additional capacity of the Quality Assurance Manager position, the unit is better able to lead and participate in additional collaborative QI initiatives across the Agency. Current projects include:

- The QI Administrator continues to participate on a joint payer quality improvement project aimed at increasing follow-up care after hospitalization for mental illness. The Quality Unit has connected with the Policy Unit to explore the status of coverage for behavioral health telemedicine visits, which could have a big impact on this and other performance measures. Metric = HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) measure.

- The QI Administrator continues to participate with VDH and the Data Unit on a joint payer quality improvement project aimed at increasing adolescent well care visits. Metric = HEDIS Adolescent Well Care Visit (AWC) measure.
- The Quality Assurance Manager continues to collaborate with the VDH All Payer Joint Project. Medicaid, MVP & BCBSVT have been sending similarly formatted quarterly gap-in-care reports to 29 Blueprint practices since 2015. The reports show the entire panel of female Medicaid beneficiaries ages 50-64 served at the practice and whether they have received a mammogram in the last 2 years. An evaluation of the project is being planned and will be completed by September 2017. Metric = HEDIS Breast Cancer Screening (BCS) measure.
- The DVHA Quality Unit and the Vermont Department of Health's Health Promotion and Disease Prevention (HPDP) division created a partnership during 2016. A shared Grant Manager position funded through the Ladies First Breast and Cervical Cancer Screening Program was created in July 2016 and has led multiple cancer screening quality improvement projects (QIPs):
  - Cancer screening brochures were sent to Medicaid beneficiaries and Medicaid providers.
  - Mammogram gap-in-care reports are sent quarterly to 29 Blueprint for Health practices. This was a joint payer project, including MVP and BCBS along with Medicaid. Reports were sent in January 2017. An evaluation of this project is being planned for July 2017.
  - Ongoing monthly mammogram reminder letters to female Medicaid beneficiaries state-wide..
  - Ladies First in-person outreach by clinic "champions" to Medicaid beneficiaries focused on breast cancer screening.
  - Ladies First two-step screening reminder project for cardiovascular, breast and cervical cancer screening. The first step is a postcard reminder, followed by a motivational follow-up call from a clinic champion.

Results of these QIPs are currently being evaluated.

Results Based Accountability (RBA) Scorecards:

Results Based Accountability (RBA) scorecards are being developed for both internal and external performance management purposes. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff for the past few years. The DVHA Quality Unit staff received training and has used this tool to create a GC Core Measure scorecard, as well as Experience of Care and certain other performance budgeting scorecards. New scorecards actively under development are related to the Applied Behavior Analysis (ABA) benefit and an overall DVHA performance accountability scorecard, which will include key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services.

Vermont Medicaid *Next Generation* ACO Model

In 2016, the DVHA Quality Unit staff were integral in the development of a set of metrics with which to measure the cost and quality of care provided to the Medicaid population by the newly contracted Accountable Care Organization. Additionally, the Quality Unit staff advised on a quality reporting matrix to be used for monitoring and oversight. The DVHA Quality Unit participated in internal DVHA readiness review preparation and have joined monthly operations meetings starting early in 2017. In the coming months, Quality Unit staff, as subject matter experts will review the ACO's quarterly quality management reports.

AHS Performance Accountability Committee

During this quarter, the AHS Performance Accountability Committee (PAC) continued to focus on advancing organizational competencies associated with monitoring and evaluating performance. Members of the group reviewed monitoring and oversight requirements for state grants and contracts (Bulletins 5.0 and 3.5 respectively) to ensure alignment.

Also during this quarter, the group discussed an Executive Order from Vermont's new governor, Phil Scott, creating the Program to Improve Vermont Outcomes Together (PIVOT). This program provides a framework and set of tools for agencies and departments to understand *why* and *what we do* so that we can strategically and continuously improve *how we do it* to achieve better outcomes. There are three key elements of PIVOT:

1. Inventory of Service Domains, Programs, and Activities (SPA)
2. Strategic Planning
3. Continuous Improvement Activities

In addition to discussing the deliverables and timelines associated with the program, the group began to craft recommended roles/responsibilities that they might play with program implementation.

MCO Investment Review

As per STC #88 of the GC to Health Waiver, Vermont needs to include in their quarterly and annual reports to CMS any "monitoring and evaluation" activities conducted by AHS departments relative to their approved investments. During this quarter, the AHS QIM initiated discussions with finance, program, and quality staff across the Agency re: how best to modify the current process of reviewing MCO investments. In the past, Departments have been responsible for the financial and performance monitoring of their investments. Beginning last year, each Department was required to report investment financial and performance data to the cross-agency Integrated Operations and Policy Team (IOPT). Feedback on the process was obtained and will be used when modifying the process for the coming year. In addition to clarifying investment monitoring and evaluation expectations going forward, it is expected that the new process will be implemented that allows outcomes of the regular Department reviews to be captured in the quarterly and annual reports to CMS. Investments totaled $32,778,291 for QE0317.

Comprehensive Quality Strategy/State Transition Plan:

During this quarter, the Comprehensive Quality Strategy (CQS) was posted for public comment. The document included the following: changes to the format to help consumers more readily navigate the strategy; an introductory section was added to orient the reader to the new HCBS regulations and the role that the CQS plays in meeting the State Transition Plan requirements; more detail was added to the phases of HCBS implementation to clarify the use of systemic and site-specific assessments, remediation activities, monitoring and oversight methodology. In addition, text was added to the Heightened Scrutiny and Relocation of Beneficiaries Sections. Finally, a link to all assessments and work plans were included in the CQS. After the public comment period closes, a summary of feedback with state responses will be developed. The CQS will be modified to consider the stakeholder and consumer feedback obtained and submitted to CMS during the next quarter.

During this quarter, the HCBS Implementation Team continued to work on implementing the site-

specific setting assessments developed in the previous quarter. Specific introductory messages for the surveys were created by the Choices for Care, Developmental Disabilities Services, Traumatic Brain Injury, and Community Rehabilitation and Rehabilitation programs. These messages were sent, along with the survey tool to all program directors responsible for each of the specific settings that provide home and community based services (HCBS). The survey shall remain open for 6 weeks. The state plans to use a combination of reminder emails and phone follow up as a way to enhance response rates. All survey data will be collected centrally using SurveyGizmo and distributed to each program manager for follow up.

X. Compliance

Key updates from QE0317:

- Network Monitoring review with Compliance Committee
- Utilization Management Plan Updates
- Compliance staff participated in the procurement of the new All Payer contract recently signed by DVHA.

Network Monitoring review with Compliance Committee

The Compliance Committee received and reviewed a set of reports focused on our provider network. The committee compared the reports to Vermont's network adequacy standards and determined that the network is adequately meeting the standard overall and that the network is sufficient to handle all of our members' covered services. Due to an increase in travel times for one region, we will be monitoring pediatric primary care in Rutland County to ensure that members in this region can find a pediatrician. This monitoring has been shared with the local District Health Office in that county.

Utilization Plan Updates:

DVHA's Utilization Management Plan has been completely vetted by clinical and management staff. The final step in the approval process is for one last review with the Managed Care Medical Committee. This updated plan more accurately reflects the titles and scopes of various covered services categories/programs and better represents our current best practices around utilization management.

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. 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. 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 all review documents during the next quarter. During this quarter, staff also

continued their preparation for the upcoming EQRO audit by completing a preliminary review of prior-year recommendations and by meeting with other staff that will participate in this year's review. Finally, during this quarter, staff began sorting through the documents expected to be submitted to the EQRO as part of the review activities.

XI. Demonstration Evaluation

During this quarter, a draft evaluation design and tentative evaluation budget was submitted to CMS. The document included details for the following: study populations, suggest hypotheses to be tested, and recommend measures that need to be collected/reported. While the draft design includes a section specific to the assessment of the impact of providing Medicaid reimbursement for IMD services for beneficiaries in need of acute mental health or substance use disorder treatment, it also includes a section that addresses whether the evaluators find the demonstration to be budget neutral, what impact the demonstration has on health outcomes, as well as any policy implications. The budget includes total estimated costs for each year of the demonstration, as well as an annual breakdown of estimated staff, contractual, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. The state expects to receive CMS comments to the draft evaluation plan during the next quarter. The State will work with the successful bidder to incorporate any CMS feedback into a final evaluation design and adjust the budget if necessary.

During this quarter, a Global Commitment to Health Evaluation Request for Proposals (RFP) was developed and posted. In addition to outlining the scope of work and deliverables, the document provided potential bidders with information re: general requirements, the content and format of responses, as well as submission instructions. Links to the draft evaluation design discussed above were included in the RFP. Also during this quarter, a bidder's conference was held to ensure potential bidders had sufficient information to help them submit a proposal that responds to the needs of the state. Interested parties were asked to submit questions ahead of the bidder's conference. The state responded to some questions and took additional questions during the bidder's conference. All questions and responses will be posted on the state website for all to see – even those that did not attend the bidder's conference. Responses to the RFP are due next quarter.

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 and other innovative programs 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 and promote transformation to value-based and integrated models of care.

Attachment 6 is a summary of Investments, with applicable category identified, forQE0317.

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: QE0317 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:	Cory Gustafson, Commissioner	
	Department of VT Health Access	802-241-0147 (P)
	280 State Drive, NOB 1 South	802-879-5962 (F)
	Waterbury, VT 05671-1010	cory.gustafson@vermont.gov

Date Submitted to CMS: May 30, 2017

ATTACHMENTS

Attachment 1 - Budget Neutrality

Budget Neutrality New Adult
New Adult (w/ and w/o Child) Medical Costs Only

	DY 12 – PMPM			
	QE0317	**QE0617**	**QE0917**	**QE1217**
(A) New Adult Group PMPM Projection	$518.26	$518.26	$518.26	$518.26
(B-1) eligible member months w/ Child	54,616			
(B-2) eligible member months w/o Child	123,608			
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 28,305,288.16			
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 64,061,082.08			
(D-1) New Adult FMAP w/ Child	54.46%			
(D-2) New Adult FMAP w/o Child	86.89%			
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 15,415,059.93			
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 55,662,674.22			
Subtotal Federal Share Supplemental Cap 1	$ 71,077,734.15			
Total FFP reported for New Adult Group	$62,816,665.28			

Supplemental Budget Neutrality Test 1	
over/(under) - report any negative # under main GC budget neutrality	$ 8,261,068.88

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
May 16, 2017

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 DAN - DEC 2019	DY 15 JAN - DEC 2020	DY 16 JAN - DEC 2021	Total
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 37,796,599	$ -	$ -	$ -	$ -	$ 37,796,599
ABD - Non-Medicare - Child	$ 20,301,041	$ -	$ -	$ -	$ -	$ 20,301,041
ABD - Dual	$ 163,954,726	$ -	$ -	$ -	$ -	$ 163,954,726
ANFC - Non-Medicare - Adult	$ 27,491,026	$ -	$ -	$ -	$ -	$ 27,491,026
ANFC - Non-Medicare - Child	$ 97,868,093	$ -	$ -	$ -	$ -	$ 97,868,093
Total Expenditures Without Waiver	**$ 347,411,484**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 347,411,484**
With Waiver						
ABD Non Medicare Adult	$ 98,812,291	$ -	$ -	$ -	$ -	$ 98,812,291
ABD - Non-Medicare - Child	$ 18,848,026	$ -	$ -	$ -	$ -	$ 18,848,026
ABD - Dual	$ 62,317,327	$ -	$ -	$ -	$ -	$ 62,317,327
ANFC - Non-Medicare - Adult	$ 23,192,490	$ -	$ -	$ -	$ -	$ 23,192,490
ANFC - Non-Medicare - Child	$ 79,722,818	$ -	$ -	$ -	$ -	$ 79,722,818
Premium Offsets	$ (191,375)	$ -	$ -	$ -	$ -	$ (191,375)
Moderate Needs Group	$ 287,385	$ -	$ -	$ -	$ -	$ 287,385
Marketplace Subsidy	$ 1,761,600	$ -	$ -	$ -	$ -	$ 1,761,600
VT Global Rx	$ 2,456,668	$ -	$ -	$ -	$ -	$ 2,456,668
VT Global Expansion VHAP	$ 130,973	$ -	$ -	$ -	$ -	$ 130,973
CRT DSHP	$ 2,629,104	$ -	$ -	$ -	$ -	$ 2,629,104
Investments	$ 32,778,291	$ -	$ -	$ -	$ -	$ 32,778,291
Total Expenditures With Waiver	**$ 322,745,597**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 322,745,597**
Supplemental Test: New Adult (Gross)						
Limit	$ 92,366,370	$ -	$ -	$ -	$ -	$ 92,366,370
With Waiver Expenditures	$ 80,271,189	$ -	$ -	$ -	$ -	$ 80,271,189
Surplus (Deficit)	*$ 12,095,181*	*$ -*	*$ -*	*$ -*	*$ -*	*$ 12,095,181*
Waiver Savings Summary						
Annual Savings	$ 24,665,887	$ -	$ -	$ -	$ -	$ 24,665,887
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 7,399,766	$ -	$ -	$ -	$ -	$ 7,399,766
Total Savings	$ 7,399,766	$ -	$ -	$ -	$ -	$ 7,399,766
Cumulative Savings	***$ 7,399,766***	***$ 7,399,766***	***$ 7,399,766***	***$ 7,399,766***	***$ 7,399,766***	***$ 7,399,766***

New Adult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality New Adult tab (STC#64)
See CY2017 Investments tab
See EG MM CY 2017 Tab for Member Month Reporting

Attachment 2

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

[Phone] 802-879-5900

Agency of Human Services

Medicaid Program Enrollment and Expenditures Report

Q2 SFY 2017

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

Al Gobeille, Secretary
Vermont Agency of Human Services

Cory Gustafson, Commissioner
Department of Vermont Health Access

March 1, 2017

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 '17

Thursday, February 09, 2017

	SFY '17 Appropriated			SFY '17 Actuals thru December 31, 2016			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	17,229	$ 105,981,420	$ 512.62	9,514	$ 33,751,054	$ 591.24	31.85%
ABD Dual	19,153	$ 55,272,017	$ 240.48	17,456	$ 25,091,395	$ 239.57	45.40%
General Adult	22,041	$ 100,815,869	$ 381.17	16,129	$ 38,061,667	$ 393.30	37.75%
New Adult	59,021	$ 231,146,862	$ 326.36	58,632	$ 118,434,201	$ 336.66	51.24%
Exchange Premium Assistance #	17,588	$ 5,954,932	$ 28.21	17,212	$ 2,812,961	$ 27.24	47.24%
Exchange Cost Sharing #	5,646	$ 1,232,289	$ 18.19	5,590	$ 589,893	$ 17.59	47.87%
ABD Child	3,417	$ 28,773,934	$ 701.72	2,528	$ 10,834,824	$ 714.27	37.65%
General Child	64,846	$ 149,777,097	$ 192.48	59,030	$ 72,327,794	$ 204.21	48.29%
Underinsured Child	820	$ 1,207,158	$ 122.66	826	$ 514,594	$ 103.85	42.63%
SCHIP	4,874	$ 8,400,371	$ 143.61	5,102	$ 3,480,435	$ 113.70	41.43%
Pharmacy Only	11,026	$ 5,020,813	$ 37.95	11,721	$ 967,965	$ 13.76	19.28%
Choices for Care	4,623	$ 209,154,497	$ 3,827.62	4,284	$ 108,702,006	$ 4,229.49	51.97%
Total Medicaid Claims Paid	230,285	$ 902,737,259	$ 326.67	208,023	$ 415,576,147	$ 332.96	46.04%

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 '17

Thursday, February 09, 2017

	SFY '17 Appropriated			SFY '17 Actuals thru December 31, 2016			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	17,229	$ 186,733,502	$ 903.20	9,514	$ 73,919,286	$ 1,294.90	39.59%
ABD Dual	19,153	$ 250,558,121	$ 1,090.14	17,456	$ 107,076,166	$ 1,022.35	42.74%
General Adult	22,041	$ 108,093,038	$ 408.68	16,129	$ 44,292,292	$ 457.68	40.98%
New Adult	59,021	$ 284,259,970	$ 401.36	58,632	$ 133,733,218	$ 380.15	47.05%
Exchange Premium Assistance #	17,588	$ 5,954,932	$ 28.21	17,212	$ 2,812,961	$ 27.24	47.24%
Exchange Cost Sharing #	5,646	$ 1,232,289	$ 18.19	5,590	$ 589,893	$ 17.59	47.87%
ABD Child	3,417	$ 68,246,490	$ 1,664.35	2,528	$ 27,183,686	$ 1,792.06	39.83%
General Child	64,846	$ 264,057,892	$ 339.34	59,030	$ 120,539,043	$ 340.34	45.65%
Underinsured Child	820	$ 1,958,507	$ 199.01	826	$ 1,059,092	$ 213.74	54.08%
SCHIP	4,874	$ 9,766,690	$ 166.97	5,102	$ 4,367,055	$ 142.66	44.71%
Pharmacy Only	11,026	$ 5,020,813	$ 37.95	11,721	$ 967,965	$ 13.76	19.28%
Choices for Care	4,623	$ 221,379,182	$ 3,990.23	4,284	$ 109,783,037	$ 4,271.55	49.59%
Total Medicaid Claims Paid	230,285	$ 1,407,261,426	$ 509.25	208,023	$ 626,330,756	$ 501.81	44.51%

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 '17

Thursday, February 09, 2017

	SFY '17 Appropriated			SFY '17 Actuals thru December 31, 2016			% of Approp.
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	Spent to Date
ABD Adult	17,229	$ 186,952,635	$ 904.26	9,514	$ 74,418,917	$ 1,303.65	39.81%
ABD Dual	19,153	$ 249,193,065	$ 1,084.20	17,456	$ 107,120,856	$ 1,022.78	42.99%
General Adult	22,041	$ 107,618,669	$ 406.89	16,129	$ 44,349,277	$ 458.27	41.21%
New Adult	59,021	$ 282,483,139	$ 398.85	58,632	$ 133,752,307	$ 380.20	47.35%
Exchange Premium Assistance #	17,588	$ 5,954,932	$ 28.21	17,212	$ 2,812,961	$ 27.24	47.24%
Exchange Cost Sharing #	5,646	$ 1,232,289	$ 18.19	5,590	$ 589,893	$ 17.59	47.87%
ABD Child	3,417	$ 84,204,841	$ 2,053.53	2,528	$ 32,552,149	$ 2,145.97	38.66%
General Child	64,846	$ 292,987,771	$ 376.52	59,030	$ 131,209,694	$ 370.46	44.78%
Underinsured Child	820	$ 2,380,002	$ 241.83	826	$ 1,193,356	$ 240.84	50.14%
SCHIP	4,874	$ 11,130,462	$ 190.29	5,102	$ 4,886,410	$ 159.63	43.90%
Pharmacy Only	11,026	$ 5,020,813	$ 37.95	11,721	$ 967,965	$ 13.76	19.28%
Choices for Care	4,623	$ 219,966,581	$ 3,964.77	4,284	$ 109,784,586	$ 4,271.61	49.91%
Total Medicaid Claims Paid	230,285	$ 1,449,125,199	$ 524.39	208,023	$ 643,645,434	$ 515.68	44.42%

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.

VERMONT

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

Questions, Complaints and Concerns Received by Health Access Member Services
January 1, 2017 – March 31, 2017

January 2 – January 6

- No issues to report.

January 9 – January 13

- VPharm Status: CSR reviews case to see if there is a reason the VPharm should have closed (non-payment, non-review) and advises customer. If case was closed in error, CSR follows process re: non-payment reinstatements if for nonpayment error. If for non-review when review sent, verifies no outstanding requests not answered & escalates to HAEU if all done properly but still closed.

January 16 – January 20

- VPharm Status: CSR reviews case to see if there is a reason the VPharm should have closed (non-payment, non-review) and advises customer. If case was closed in error, CSR follows process re: non-payment reinstatements if for nonpayment error. If for non-review when review sent, verifies no outstanding requests not answered & escalates to HAEU if all done properly but still closed.

January 23 – January 27

- VPharm Status: CSR reviews case to see if there is a reason the VPharm should have closed (non-payment, non-review) and advises customer. If case was closed in error, CSR follows process re: non-payment reinstatements if for nonpayment error. If for non-review when review sent, verifies no outstanding requests not answered & escalates to HAEU if all done properly but still closed.

January 30 – February 3

- No issues to report

February 6 – February 10

- VPharm Review/Reinstatements: CSR reviews case to see if there is a reason the VPharm should have closed (non-payment, non-review) and explains the closure or escalates as necessary.

February 13 – February 17

- VPharm Review/Reinstatements: CSR reviews case to see if there is a reason the VPharm should have closed (non-payment, non-review) and explains the closure or escalates as necessary.

February 20 – February 24

- VPharm Review/Reinstatements: CSR reviews case to see if there is a reason the VPharm should have closed (non-payment, non-review) and explains the closure or escalates as necessary.

February 27 – March 3

- VPharm Review/Reinstatements: CSR reviews case to see if there is a reason the VPharm should have closed (non-payment, non-review) and explains the closure or escalates as necessary.

March 6 – March 10

- VPharm Review/Reinstatements: CSR reviews case to see if there is a reason the VPharm should have closed (non-payment, non-review) and explains the closure or escalates as necessary.

March 13 – March 17

- No issues to report

March 20 – March 24

- No issues to report

March 27 – March 31

- VPharm Reviews/Reinstatements

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
January 1, 2017 – March 31, 2017

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data compiled on April 21, 2017, from the centralized database that were filed from January 1, 2017 through March 31, 2017.

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

During this quarter, there were 18 grievances filed; ten were addressed during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was four days. Of the grievances filed, 78% were filed by beneficiaries, 5% were filed by a representative of the beneficiary and 17% were filed by another source. Of the 18 grievances filed, DMH had 83%, and DVHA had 17%. There were no grievances filed for DAIL, VDH or DCF during this quarter.

There were no Grievance Reviews filed this quarter.

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

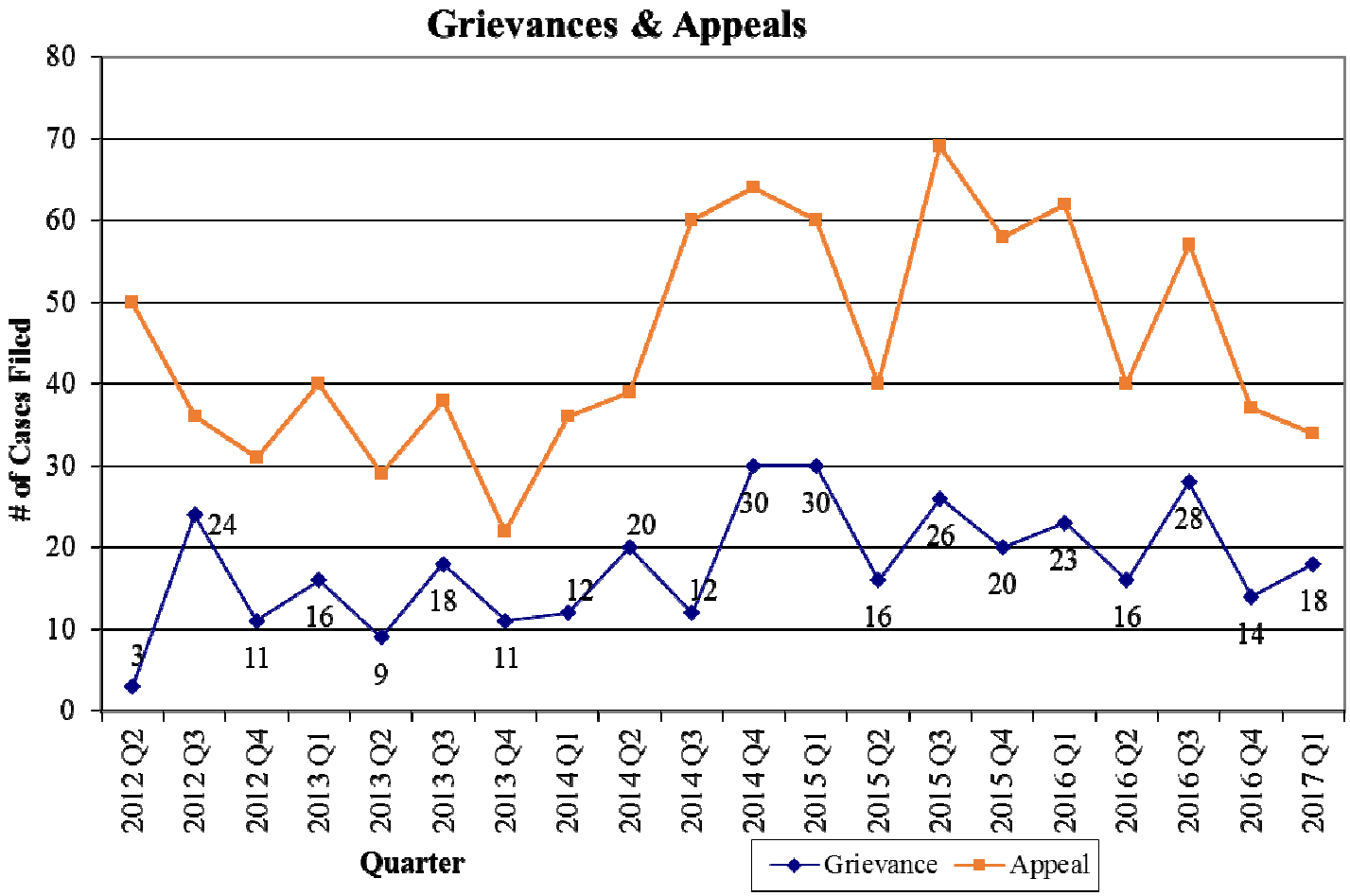
1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered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

During this quarter, there were 34 appeals filed; 11 requested an expedited decision with seven of them meeting criteria. Of these 34 appeals, 23 were resolved (68% of filed appeals), 10 were still pending (29%), and one was withdrawn (3%).

Of the 23 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 82% were resolved within 30 days. The average number of days it took to resolve these cases was 29 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

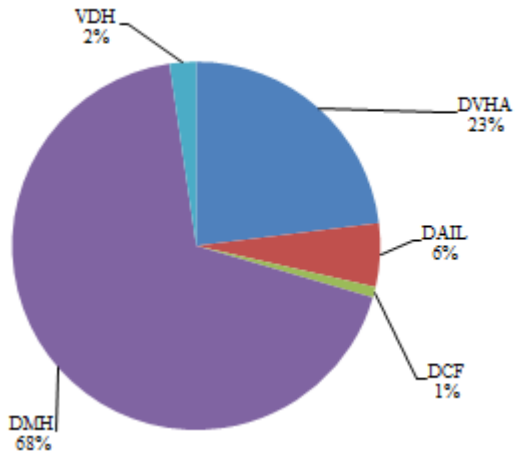
Of the 34 appeals filed, 12 were filed by beneficiaries (38%), and 21 were filed by a representative of the beneficiary (62%). Of the 34 appeals filed, DVHA had sixteen appeals filed (47%), DAIL had seventeen (50%), DMH had one (3%), DMH and VDH had none.

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

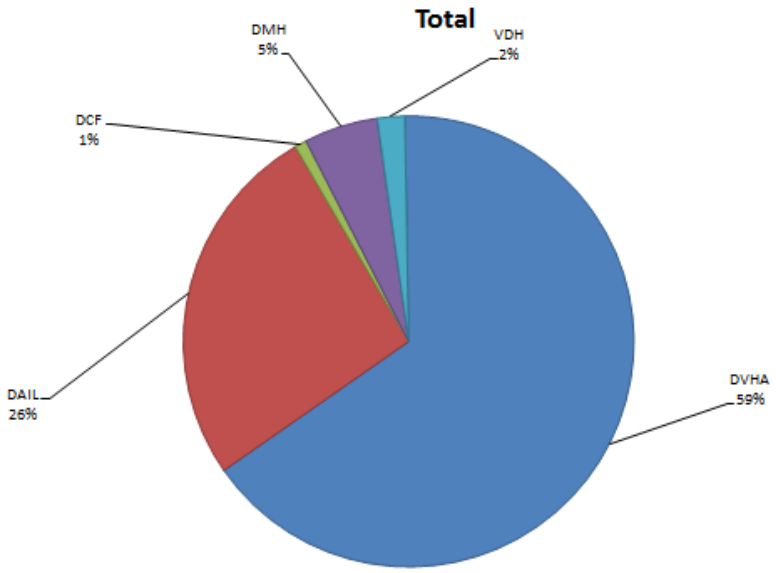


Grievance & Appeals by Department
From January 1, 2008 through March 31, 2017

Grievances



Appeals



Attachment 5

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

January 1, 2017-March 31, 2017

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

April 21, 2017

Vermont Legal Aid

Working for Justice

CONTENTS

Introduction

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

Helping Vermonters navigate Vermont Health Connect (VHC) has been a significant task for the HCA over the last 3 and a half years. This report shows continued improvement at VHC. VHC calls, however, still represent 40% of the calls to the HCA, and the number of consumer calls for help at the HCA has not returned to pre-VHC levels.

During this time period, the HCA has also seen increased usage of our website, particularly the Medicaid eligibility pages. It is clear to us that there are many Vermonters who have real struggles with access to care, but who do not know about our services. We continually assess how to best reach more Vermonters.

This continues to be a precarious time for consumers, health care providers, and carriers given the ongoing discussions at the federal level of possible repeal of the ACA, changes to Medicaid funding, and administrative changes that could have a real impact on Vermonters. We regularly receive calls from Vermonters who express anxiety about how these possible changes will affect their families' access to care. Today's uncertainty has an impact on Vermont consumers and makes the role of the HCA even more essential.

Lisa's Story

Lisa called the HCA in a panic. She was on Medicaid, but VHC had withdrawn the full cost of a Qualified Health Plan (QHP), over $500, from her bank account. The withdrawal amounted to over half of her monthly income and overdrew her checking account. She was left without enough money to pay for rent or food.

Lisa had been enrolled in a QHP with Premium Tax Credit (PTC), paying about $30 a month for her premium. When she transitioned to Medicaid, her QHP was supposed to close but that did not happen. Lisa had been paying for her QHP with automatic withdrawal from her bank account. Because her QHP was still active and she was no longer eligible for PTC due to her Medicaid coverage, VHC withdrew the full premium payment for the QHP.

Lisa was told that it would take 4 to 6 weeks to get her payment refunded. She could not afford to wait that long. The HCA spent over 8 hours investigating Lisa's case and advocating on her behalf. Ultimately, we were able to help Lisa get her QHP closed and expedite the refund.

A key strength of the HCA is our continued support for Vermonters through individual advocacy as well as at the legislative and administrative policy level. We are able to provide policy makers with feedback informed by our daily work with Vermonters facing challenges accessing the care they need such as Lisa's experience described in the case narrative above. We work to control unnecessary costs and make the health care system sustainable, and to ensure that Vermont consumers are heard by providers and policy-makers.

The full quarterly report for January 1 – March 31, 2017 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**: 978 calls (compared to 883 last quarter)
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 274 calls (269 calls last quarter)
  - **Commercial plan beneficiaries**: 223 calls (178 calls last quarter)
  - **Uninsured Vermonters**: 110 calls (127 calls last quarter)
  - **Vermont Health Connect (VHC)**: 393 calls (360 calls last quarter)
  - **Reportable Activities (Summary & Detail)**: 106 activities and 17 documents (75 activities, 15 documents

Individual Consumer Assistance

Overview

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

The HCA received 978 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:

- **21.78 %** (213) about **Access to Care**
- **11.96%** (117) about **Billing/Coverage**
- **3.17%** (31) about **Buying Insurance**
- **11.86%** (116) about **Consumer Education**
- **28.73%** (281) about **Eligibility** for state and federal programs
- **22.49%** (220) 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

[1] The term "call" includes cases we get through the intake system on our website.

281 of our cases had as the primary issue eligibility for state and federal healthcare programs, a total of 486 cases had eligibility listed as a secondary concern.

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

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

Highlights

- Total hotline call volume increased (978 this quarter vs. 883 last quarter).
- The HCA advised on 31 appeals this quarter. Of the 31 appeals, 22 were fair hearings.
- The HCA saved consumers $46,785.61 this quarter.
- The HCA successfully advocated for implementation of Medicaid's new, less-restrictive coverage criteria for hepatitis C. Medicaid's Drug Utilization Review Board (DURB) voted in December to recommend covering treatment for patients with less severe liver disease, and for patients regardless of their substance use history, and DVHA accepted the DURB's recommendations. This quarter, DVHA implemented the new criteria, allowing more Vermonters to access curative treatments for hepatitis C.
- The HCA assembled a stakeholder group of representatives from payers, provider organizations and consumer groups as well as representatives from the Scott Administration, to facilitate better communication for the purpose of understanding each organization's positions on prospective policies on both the State and Federal level. This group has been meeting weekly during the second half of the legislative session.
- The HCA continued to promote the use of plain language in VHC notices, so the information is more accessible and understandable to consumers. The HCA provided comments on plain language and content on 10 different VHC notices.
- The total number of health pageviews increased by 27% in the reporting quarter ending March 31, 2017 (11,839 pageviews), compared with the same quarter in 2016 (9,322 pageviews). This is especially noteworthy because traffic to the Vermont Law Help website as a whole was nearly even when compared with the same period last year.
- The ***Health home page*** again had the second largest number of pageviews (1,182), slightly higher than last year's 1,040. 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.
- In this quarter, as in the previous six quarters, we saw a large increase in the number of people seeking information about ***Medicaid Income Limits*** (3,960 pageviews this quarter, compared with 2,639 in the same quarter in 2016 – an increase of 50%). The consistently high numbers indicate that search engines are delivering this page as a high-ranking source of information about Medicaid income limits, and are indicative also of the increasing age of Vermont's population.

Case Examples

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

Anne recently immigrated to the United States and was living with her son. She suddenly became ill and had to go the Emergency Room. She had almost no monthly income and no way to pay her bills. When she applied with Vermont Health Connect (VHC), she was told she was not eligible for Medicaid. VHC also told her that she was not eligible for a Premium Tax Credit (PTC) to help reduce the cost of her insurance coverage. This would mean that she would need to pay the full cost of a plan by herself—which would be nearly $500 a month for a silver plan. She could not afford to do this, so she called the HCA for help. VHC had been correct when they told Anne that she was not eligible for Medicaid. A rule called the "five year bar" generally means that qualified lawful immigrants like Anne are not eligible to get Medicaid for a five-year waiting period. VHC had been wrong, however, when they told her she was not eligible for PTC. The HCA advocate showed that the "five year bar" did not apply to Anne's eligibility for PTC. This meant that Anne was eligible to get PTC to help reduce her monthly costs. The HCA asked VHC to screen her again for PTC. VHC found her eligible, and the final cost of her plan was less than $25 per month.

When Charlie received his health insurance bill for January 2017, it was over a thousand dollars, almost double what he had been paying. Charlie could not afford to pay the bill, and his family was in danger of losing health insurance for non-payment. The HCA discovered that VHC had removed Charlie's subsidies because IRS data showed he had not filed his 2015 taxes. (People with subsidized health insurance must file their taxes to keep getting subsidies.) HCA determined the information that the IRS sent to VHC had not been accurate. Charlie had filed his taxes well before the deadline. Charlie's case was not unusual. A recent Treasury Department study of the 2016 open enrollment period found that the IRS provided erroneous data about tax filing in 25% of the cases reviewed. (*See* https://www.treasury.gov/tigta/auditreports/2017reports/201743022fr.pdf) This erroneous data can delay or prevent an individual from getting the subsidies that they are eligible for. The HCA advocate showed VHC that Charlie had filed his taxes in time, and was able to get his subsidies reinstated for January.

Denise was at the pharmacy to pick a prescription for her son's ear infection, and she was told by the pharmacist that Dr. Dynasaur (Dr. D) was not active. She could not afford to pay for the medication. When the HCA advocate investigated, he found that Dr. D had been closed for several months because Denise had not completed the renewal application. The advocate discovered, though, that Denise had tried to complete the application. The first time she had tried to do it on the phone, her call had been cut off. She had completed the application on a second try, but that application had not been processed yet. The HCA was able to get the application processed quickly and Dr. D re-activated. In the meantime, Denise was able to tell the pharmacist that Dr. D was being activated, and the pharmacy gave her a partial fill of the prescription. This meant that Denise's son was able to get his medication right away.

Frank called the HCA because he did not have any insurance. He had been on a Qualified Health Plan (QHP) with VHC, but his income had dropped. Because he was unable to pay the premiums, his coverage had closed. When Frank tried to apply for Medicaid he was told he would be eligible. But he did not receive any documentation confirming that he was insured. When the HCA called to

check on the application, it discovered that VHC was erroneously counting income from a job that Frank no longer had. The HCA was able to correct the error, and get Frank's application expedited. He was found eligible for Medicaid back to January when he had originally applied. While Frank was uninsured, he had been paying for prescription and medical costs out of pocket. Now that he had Medicaid he was able to ask providers to re-bill Medicaid and get that money reimbursed.

Gerry called the HCA because she had received a notice saying her V-Pharm was closing at the end of the month. She would not be able to afford her medication without it. When the advocate looked into it, she found that Gerry had already paid for the next month's V-Pharm. However, she had been delayed in sending in her renewal paperwork and had missed the deadline. Gerry lived by herself and had difficulty doing paperwork on her own; she had needed someone to assist her with the paperwork, but had not been able to get help before the deadline. The HCA explained the circumstances to the State of Vermont, which agreed to extend Gerry's V-Pharm by one month. This gave her time to complete the application so she was able to afford her medication.

Victor called the HCA because he needed to get bloodwork but had no insurance coverage. He had received a transplant and needed medication and monitoring to make sure that he was healthy. The HCA advocate researched the problem and found that Victor had been on Medicaid until his income went over the Medicaid limit. Victor had met with a navigator and had completed a VHC application for a Qualified Health Plan (QHP), doing everything except the last step of enrolling in a plan. At that point, however, the navigator stopped answering Victor's calls, and failed to call VHC to enroll him in the plan that they had selected. The HCA advocate argued that Victor was eligible for a special enrollment period because of the navigator's error. VHC granted the special enrollment period. The HCA was able to help get Victor on a QHP with a Premium Tax Credit (PTC), which meant that Victor did not have any interruption in his medical care.

Beth discovered that she did not have any health care coverage when she received a large bill from her provider. By that time her coverage had been closed for months, and she had missed her chance to enroll in her employer's plan. The HCA reviewed Beth's history and found that Beth's Medicaid had been closed without any advance notice. VHC is required to send Medicaid beneficiaries a notice before they close their Medicaid. Because of the lack of notice, the HCA advocate argued that VHC needed to reinstate the Medicaid. VHC agreed and reinstated Beth's Medicaid coverage. Beth was able to ask her provider to re-bill Medicaid for that time period. This meant she would not owe the large bill to her provider. When VHC reviewed Beth's eligibility again and found that she was over-income for Medicaid, they sent a proper and timely notice. Beth was able to take that notice to her employer and enroll in her employer's plan.

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Priorities

A. The HCA's overall call volume increased this quarter.

Total call volume was higher than last quarter (978 vs. 883). Our call volume is usually high from January to March because most healthcare plans end on December 31, with a new plan year starting on January 1. The renewal process can trigger problems. We also had calls related to VHC's open enrollment period which ended on January 31 as well as a jump in calls related to tax issues.

	All Calls (2007-2017)										
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
January	280	309	240	218	329	282	289	428	470	411	340
February	172	232	255	228	246	233	283	304	388	511	330
March	219	229	256	250	281	262	263	451	509	416	308
April	190	235	213	222	249	252	253	354	378	333	-
May	195	207	213	205	253	242	228	324	327	325	-
June	254	245	276	250	286	223	240	344	303	339	-
July	211	205	225	271	239	255	271	381	362	304	-
August	250	152	173	234	276	263	224	342	346	343	-
September	167	147	218	310	323	251	256	374	307	372	-
October	229	237	216	300	254	341	327	335	311	312	-
November	195	192	170	300	251	274	283	306	353	287	-
December	198	214	161	289	222	227	340	583	369	284	-
Total	2560	2604	2616	3077	3209	3105	3257	4526	4423	4237	978

B. Vermont Health Connect call volume increased 9% compared with last quarter. The increase was likely due to the Open Enrollment Period which ended on January 31, 2017.

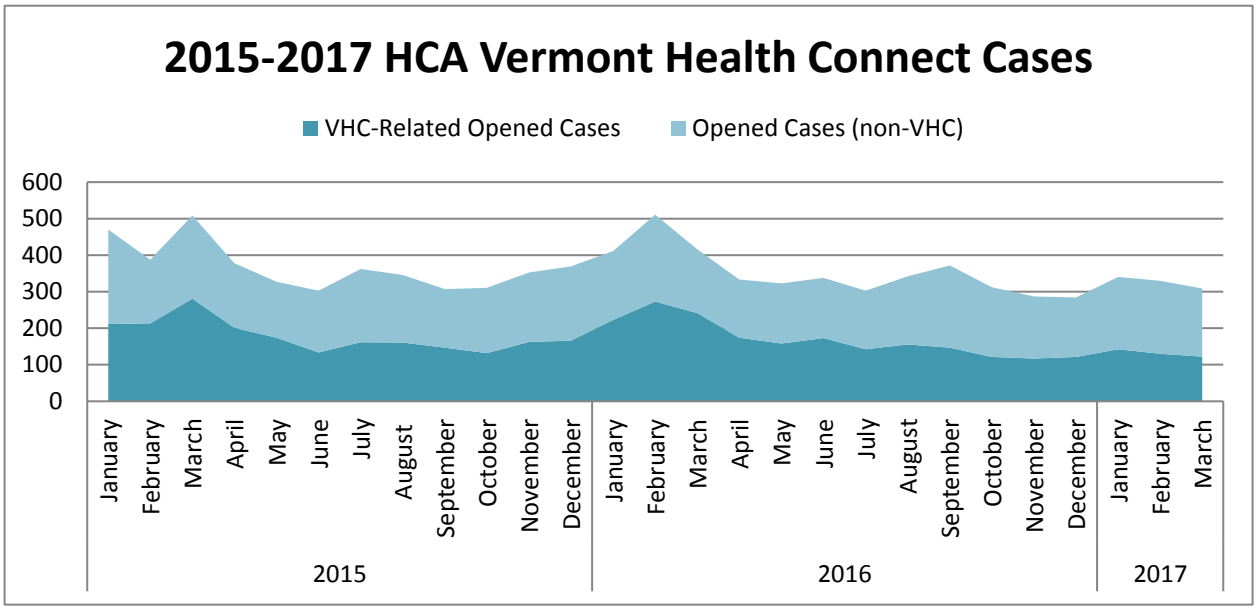
VHC call volume increased 9% this quarter compared to the previous quarter (393 vs. 360). With Open Enrollment closing at the end of January, consumers were calling about eligibility and plan selection. The HCA also had an increase of tax calls this quarter, as consumers started to file their taxes. The call volume for the quarter, however, represented a 46% decrease from the same quarter last year (393 vs. 737). This decrease in VHC cases reflects that VHC is functioning better and more consistently.

Even though VHC call numbers dropped from 2016, consumers are still having difficulties. The HCA had 64 calls this quarter about VHC complaints, and 50 calls about mistakes made by the VHC eligibility unit. Overall 29% of our VHC cases this quarter involved a mistake or complaint (114 calls about a mistake or complaint vs. 393 total VHC calls).

VHC cases still represent 40% of all HCA calls. Of all VHC cases, 30% required complex interventions that took more than two hours of an advocate's time to resolve (116 complex interventions out of 393 total VHC cases). We remain concerned about consumers who are trying to navigate VHC to resolve problems on their own.

The HCA continues to resolve its cases by working directly with a Tier 3 Health Access Eligibility Unit (HAEU) worker, who is trained to resolve all aspects of complex cases. In addition, the HCA meets with

VHC each week to discuss cases as needed, and has regular email contact with Tier 3. During the first quarter of 2016, before the escalation path was launched, the HCA was carrying 75-80 complex cases per week. That number gradually decreased to 40-50 per week, and now, because the new escalation process allows complex cases to be resolved more quickly and efficiently, the HCA generally carries fewer than 20 unresolved complex cases per week. This quarter, the HCA escalated 52 complex cases, and 44 were resolved within the quarter.



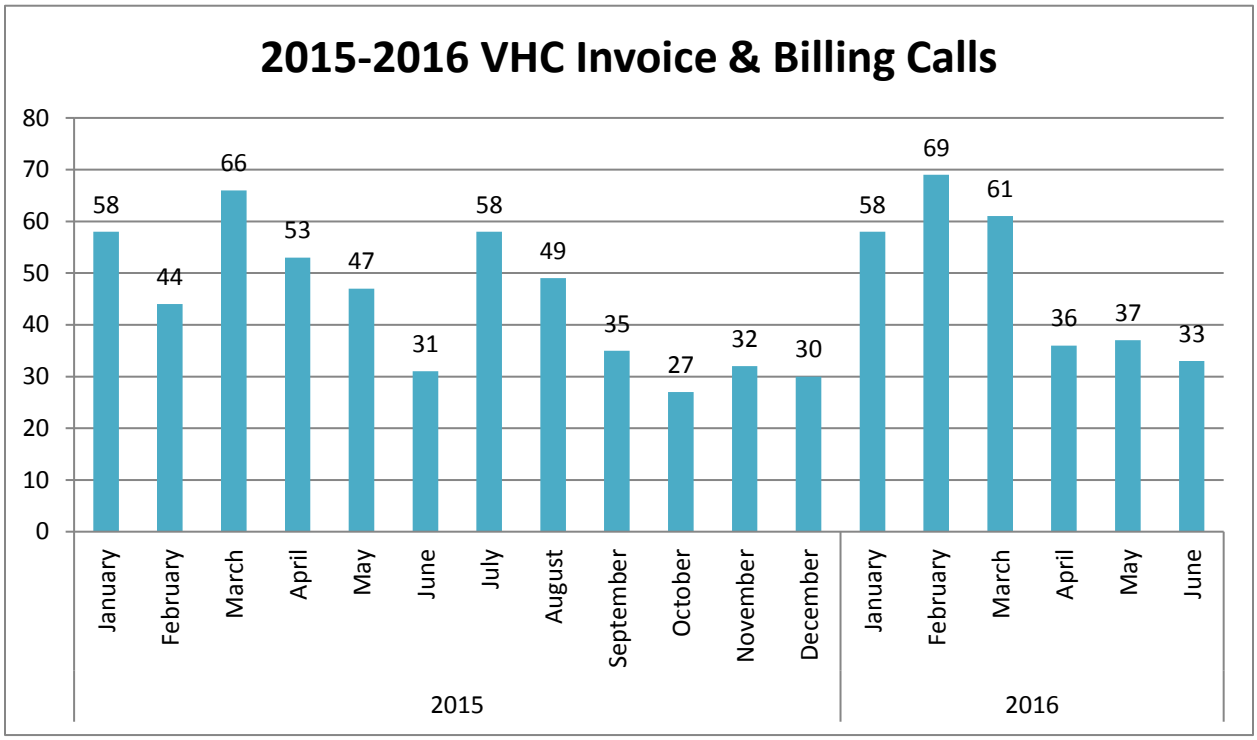
C. With the start of tax season, calls about tax issues increased. Tax calls represented 36% of all VHC calls (142 out of 393 total VHC calls).

The HCA advises consumers on multiple tax issues related to the Affordable Care Act. These calls are complex and represent a significant portion of our VHC calls. We had 33 calls about general tax questions related to the Affordable Care Act, and 41 calls specifically about reconciliation (74 calls this quarter vs. 52 last quarter). Reconciliation is the process by which consumers must figure their actual Premium Tax Credit (PTC). If too much PTC was received from VHC, consumers must pay the IRS some or all of the excess they received.

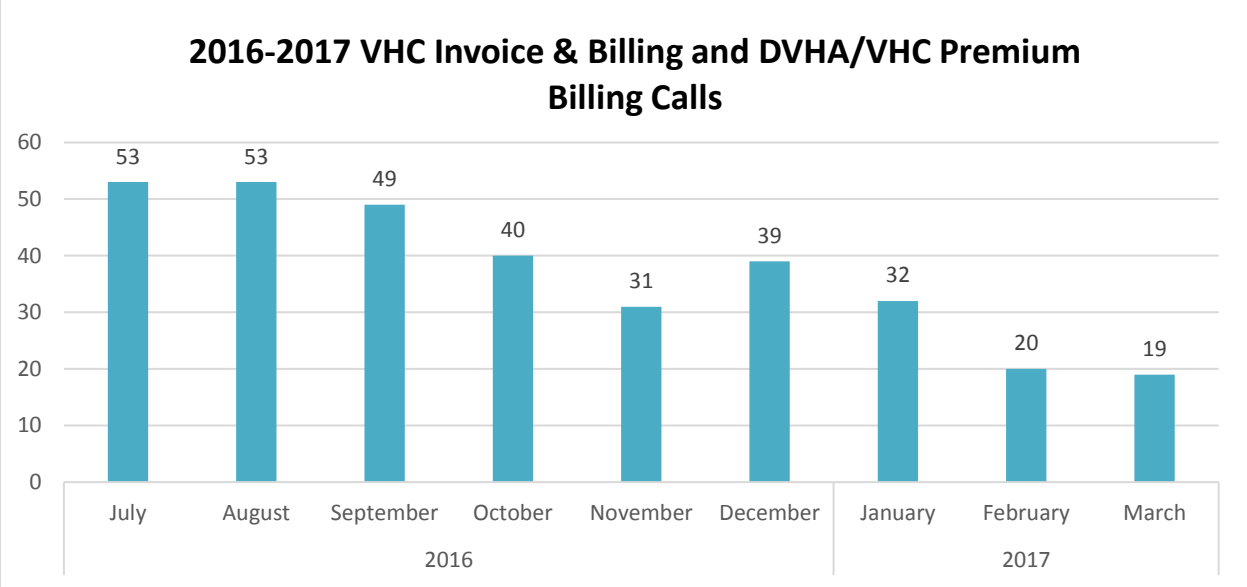
The HCA received 30 calls about the Individual Shared Responsibility Payment (ISRP), which consumers may have to pay for not having healthcare coverage (30 this quarter vs. 23 last quarter). In addition, we started to see more calls concerning Form 1095-A problems (38 this quarter vs. 11 last quarter). 1095-A is the tax form that documents the months a consumer had private insurance through VHC, and the advance PTC they received. If the form is not accurate, it can unfairly increase a consumer's tax liability.

D. Vermont Health Connect invoice and premium cases decreased by 40%.

VHC continued to improve its ability to generate accurate and timely invoices and resolve billing problems. This quarter the HCA received 71 calls about billing issues (35 about DVHA/VHC premium issues, and 36 about VHC invoice/billing problems affecting eligibility). Last quarter the HCA received 117 calls about billing issues (52 about DVHA/VHC premium issues, and 65 about VHC invoice/billing problems affecting eligibility). When we combine these two billing issue categories, billing is the fourth most common issue this quarter.[2] This shows significant improvement in an area which has been particularly frustrating for consumers for the past three years.



[2] In 2016, the HCA revised how we code VHC billing cases. Now cases with general VHC billing problems are recorded as DVHA/VHC premium issues. If the billing problem directly impacts eligibility, it is recorded under VHC invoice/billing problems affecting eligibility. This change resulted in a drop in the number of cases coded for VHC invoice/billing problems affecting eligibility and an increase in the cases coded for general VHC billing problems. Both codes represent VHC billing problems. As a result, the historical data can no longer be represented in separate charts.



E. Calls about Premium Tax Credit (PTC) eligibility stayed about the same.

The HCA received 94 calls from consumers concerning their eligibility for the Premium Tax Credit (PTC), compared to 95 last quarter. These cases represent 24% of our total VHC cases. With the Open Enrollment Period still ongoing, consumers were reviewing plan selections and reporting changes impacting eligibility for PTC. These calls are relatively complex because the HCA advises consumers regarding their eligibility for PTC, which can involve multiple issues and calculations. If consumers are eligible, the HCA also calculates how much PTC they should be receiving. If consumers receive more PTC then they are eligible for, they may have to pay some or all of it back when they file their taxes. This process is called reconciliation. The HCA received 41 calls involving reconciliation this quarter.

F. Consumers need assistance with all types of Medicaid eligibility. Medicaid eligibility calls represented 20% of all our cases. (203 calls/ 978 total calls).

For the second quarter in a row, Medicaid eligibility was the top issue of all calls. We had 126 calls about eligibility for MAGI (expanded) Medicaid, 44 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), and 30 about Medicaid Spenddowns. MAGI Medicaid and MABD Medicaid have different eligibility and income rules, and HCA advocates assess and advise on eligibility for both programs. Consumers frequently have questions about what counts as income; who should be counted in their household; what expenses can be used to meet a Spenddown; how to complete renewal paperwork, and whether their eligibility decision is correct.

G. The top issues generating calls

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

All Calls 978 (compared to 883 last quarter)

1. MAGI Medicaid eligibility 126 (130)
2. Complaints about providers 103 (75)
3. VHC Premium Tax Credit eligibility 94 (95)
4. VHC Change of Circumstance 64 (54)
5. VHC complaints 64 (59)
6. Access to prescription drugs 55 (56)
7. HAEU mistake 50 (43)
8. Medicaid eligibility (non-MAGI) 44 (44)
9. Other: Not health related 41 (24)
10. Information/applying for DVHA programs 41 (59)
11. Consumer education about IRS reconciliation 41 (39)
12. Buy-in programs/Medicare Savings Programs 40 (55)
13. Termination of insurance 38 (58)
14. 1095-A problems 38 (11)
15. Affordability affecting access to care 37 (38)
16. VHC invoice/billing problem affecting eligibility 36 (65)
17. Special enrollment periods (eligibility) 36 (32)
18. Fair hearing appeals 36 (26)
19. DVHA/VHC premium billing 35 (52)
20. Information about VHC 34 (33)
21. VPharm eligibility 33 (42)
22. ACA Tax issues 33 (13)
23. Consumer education about Medicare 30 (36)
24. Consumer education about IRS penalty 30 (23)
25. Medicaid spend down (eligibility) 30 (31)
26. Buying QHPs through Vermont Health Connect 26 (15)
27. Hospital billing 25 (20)
28. Provider billing problems 24 (23)
29. Access to transportation 23 (11)

Vermont Health Connect Calls 393 (compared to 359 last quarter)

1. MAGI Medicaid eligibility 120 (121)
2. Premium Tax Credit eligibility 92 (94)
3. VHC complaints 64 (59)

4. Change of Circumstance 61 (52)
5. HAEU mistake 44 (39)
6. Consumer education about IRS reconciliation 39 (39)
7. 1095-A problems 38 (11)
8. VHC invoice/payment/billing problem affecting eligibility 36 (65)
9. Information about VHC 32 (32)
10. DVHA/VHC premium billing 28 (48)

DVHA Beneficiary Calls 274 (compared to 269 last quarter)

1. MAGI Medicaid eligibility 44 (58)
2. Complaints about providers 41 (27)
3. Information/applying for DVHA programs 21 (29)
4. Access to transportation 19 (9)
5. Change of Circumstance 18 (15)
6. Pain management (access to care) 17 (3)
7. Medicaid eligibility (non-MAGI) 16 (20)
8. VHC Premium Tax Credit eligibility 14 (16)
9. Medicaid balance billing 13 (4)
10. Access to dental care 12 (10)
11. Medicaid/VHAP Managed Care Billing 12 (14)

Commercial Plan Beneficiary Calls 223 (compared to 178 last quarter)

1. Premium Tax Credit 50 (51)
2. Change of Circumstance 32 (22)
3. 1095-A problems 27 (3)
4. VHC complaints 27 (24)
5. MAGI Medicaid eligibility 27 (19)
6. VHC invoice/payment/billing problem related to eligibility 26 (36)
7. HAEU mistake 22 (14)
8. DVHA/VHC premium billing 20 (30)
9. Consumer education about IRS reconciliation 16 (26)
10. Access to prescription drugs 12 (6)
11. Consumer education about Medicare 11 (4)
12. Cost sharing too high 10 (5)
13. ACA Tax issues 10 (7)
14. Information about VHC 10 (11)

H. The top issues generating calls

The HCA received 978 total calls this quarter. Callers had the following insurance statuses:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as “dual eligible”): 28% (274 calls), compared to 30% (265 calls) last quarter

- **Medicare[3] beneficiaries** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 22% (217 calls), compared to 30% (316 calls) last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans): 23% (223 calls), compared to 18% (159 calls) last quarter
- **Uninsured:** 11% (110 calls), compared to 14% (124) of calls last quarter

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 981 cases this quarter, compared to 913 last quarter:

- 32% (311 cases) were resolved by brief analysis and advice
- 22% (213) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time
- 25% (245) were resolved by brief analysis and referral
- 13% (128) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases (84), clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 31 individuals with appeals: 22 Fair Hearings, 3 Medicaid MCO Internal appeals, 1 Commercial Insurance – Internal 2nd Level appeals, 2 Commercial Insurance – Internal 1st Level appeals, 1 Commercial Insurance – External appeals, 1 Medicare Part D Appeal, and 1 Medicare Part A, B, or C Appeal.

DVHA Beneficiary Calls

We closed 266 DVHA cases this quarter, compared to 274 last quarter:

- 33% (89 cases) were resolved by brief analysis and/or advice
- 19% (50) were resolved by brief analysis and/or referral
- 23% (61) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 20% (52) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 7 DVHA beneficiaries with appeals: 4 Fair Hearings and 3 Medicaid MCO Internal appeals

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

Commercial Plan Beneficiary Calls

We closed 218 cases involving individuals on commercial plans, compared to 284 last quarter:

- 34% (74 cases) were resolved by brief analysis and/or advice
- 15% (33) were resolved by brief analysis and/or referral
- 30% (65) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 17% (38) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 24 commercial plan beneficiaries with appeals: 1 Commercial Insurance – External appeals, 2 Commercial Insurance – Internal 1st Level appeals, 1 Commercial Insurance – Internal 2nd Level appeals, 18 Fair Hearings, 1 Medicaid Part D appeal, and 1 Medicaid Part A, B, or C appeal.

B. All Calls Case Outcomes

The HCA helped 89 people get enrolled in insurance plans and prevented 16 insurance terminations or reductions. We obtained coverage for services for 24 people. We got 11 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 35 more. We provided other billing assistance to 12 individuals. We provided 583 individuals with advice and education. One person was not eligible for the benefit they sought, and four were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 84 more people.

Consumer Protection Activities

A. Rate Reviews

The HCA monitors all commercial insurance carrier requests to the Green Mountain Care Board for changes in premium rates. These are usually requests for rate increases.

Five new cases were filed during the quarter, and the HCA has entered appearances in all of these cases. They involve rates for MVP's small group grandfathered plans, MVP's large group PPO plans, Blue Cross and Blue Shield of Vermont (BCBSVT)'s large group manual rates, The Vermont Health Plan (TVHP)'s large group manual rates and MVP's Large Group HMO plans. The Board's independent actuary and the HCA have been reviewing the rate filings during the quarter.

The BCBSVT and TVHP filings will affect 15,908 members (8,159 subscribers) in 67 groups. Because of the impact of these filings on many Vermonters, the HCA has worked with an independent actuary to review the filings. The HCA submitted suggested questions for BCBSVT and TVHP at the end of the quarter.

One rate review case was decided during the quarter. The case involves Cigna's manual rating formula for its large employer groups. The proposed rates in this filing will affect approximately 1,940

Vermonters. The HCA argued that the requested Contribution to Surplus should be reduced from 3.5% to 1%. The Board reduced the contribution to 2%.

B. Certificate of Need

The HCA participates in Certificate of Need processes as an "interested party" to ensure that approved projects are in the public's best interest. In January, the HCA submitted a notice of intervention and began reviewing Brattleboro Memorial Hospital's proposal to construct a four-story building to house medical offices and cardiac rehabilitation, and to replace the hospital's operating room suite and boilers. We also submitted a notice of intervention in the University of Vermont Medical Center's application to replace its electronic medical records at a cost of $112.4 million. In addition, the HCA entered the final phase of the Board's two-year review of the Green Mountain Surgery Center's proposal to create a for-profit ambulatory surgery center which will charge lower rates than local hospitals charge for the same services. The HCA spent the last quarter assessing the positives and negatives of the proposed project from a consumer's perspective and preparing to question witnesses at the hearing. The hearing for this matter took place in April.

C. Other Green Mountain Care Board Activities

In the past quarter, Mike Fisher met with the Green Mountain Care Board to introduce himself and discuss our role in their work. In addition, HCA staff attended nine weekly Board meetings.

Qualified Health Plan Benefits

The HCA again participated in regular stakeholder calls with the Department of Vermont Health Access (DVHA) to develop benefit designs for next year's Qualified Health Plans. At the end of the process, the proposed benefit designs were submitted to the Green Mountain Care Board for approval. We submitted comments to the Board at that time, urging the Board to support a new bronze plan option that would provide some first dollar coverage for office visits beyond preventative care. We also stressed that DVHA needs to improve its outreach and education to the significant number of Vermonters who are income eligible for cost sharing reductions but have purchased plans that do not qualify for the reductions.

Hospital Budget Review

The HCA continues to participate in the Green Mountain Care Board's Hospital Budget Review process. In the last quarter, we attended three Green Mountain Care Board meetings related to the hospital budget review process. We submitted formal comments on the Board's proposed Fiscal Year 2018 Hospital Budget Guidance. In our comments we suggested that the Board break out the 0.4% net patient revenue growth allowable for new health care reform investments and that the Board clearly define "health care reform investment." We supported the use of a dashboard of metrics in the budget review process, and advocated for inclusion of quality and access measures, payer mix, health care reform investments, bad debt, and charity care in the dashboard. We strongly supported the inclusion of pricing information in the budget review process to improve hospital price transparency. Additionally, we asked the Board to formalize its budget review hearings with standardized presentations from the hospitals. Finally, we opposed the Board waiving the hospital budget review hearing for any hospital because the hearings are essential to ensure a transparent budget review process.

Accountable Care Organization Rule

Last quarter, the Board continued to hold bi-weekly meetings with a stakeholder group including the HCA to develop the Accountable Care Organization Rules required by Act 113 of 2016. The HCA attended five stakeholder meetings during that time and submitted two sets of comments with suggestions for changes to the draft rule to enhance consumer protections. These changes increased requirements for care quality in addition to cost savings, strengthened Board oversight on issues strongly related to consumer protection, improved rule clarity, and enhanced transparency of ACO work.

D. All-Payer Model

During the last quarter the Department of Vermont Health Access entered into a contract with OneCare Vermont, the state's largest Accountable Care Organization, to manage the care of approximately 30,000 Medicaid beneficiaries. This contract was announced by Governor Scott as a "pilot" for the All-Payer Model. This quarter the HCA reviewed the contract, met with DVHA staff members, and asked questions of DHVA about the contract. We continue to advocate for robust consumer protections in the All-Payer Model, and in any pilot or other contract that involves providers taking on financial risk for Vermonters' health care. We detail our consumer protection concerns about the APM in our paper: *Consumer Principles for Vermont's All-Payer Model*.

E. Vermont Health Care Innovation Project (SIM Grant)

This quarter the HCA continued to participate in the Vermont Health Care Innovation Project (VHCIP), which is funded by a federal State Innovation Model (SIM) grant. The VHCIP is in its final stages and the work groups, in which we had been active participants, have concluded their activities. During this quarter we continued to monitor the activities of the VHCIP Core Team and attended one Core Team meeting as an interested party. The HCA is a participant in the VHCIP Self-Evaluation Committee and attended one meeting of the committee this quarter. Additionally, this quarter the HCA completed an evaluation interview with the federal State Innovation Model evaluator, RTI International.

F. Affordable Care Act Tax-related Activities

During this quarter the HCA continued tax-related assistance, advocacy, and outreach efforts. We continued to participate in a stakeholder workgroup on QHP renewals and open enrollment issues, to ensure that consumers experienced as smooth a transition as possible from 2016 to 2017 plans. In general VHC improved its renewal and enrollment operations over last year; however, the HCA did get calls from consumers who either (1) had an erroneous non-filer indicator from the IRS which endangered their subsidies, or (2) did not realize they needed to file their 2015 tax return to continue receiving PTC from VHC. Because the warning notice does not explicitly tell consumers that they have a non-filer indicator on their account, some consumers did not realize there was a problem until they received their bill for January 2017. Some consumers were not able to fix the issue by December 15, which is the deadline to make changes affecting January premiums. In January, the HCA helped several consumers demonstrate to VHC that they had filed their 2015 taxes, and helped others obtain copies of their 2015 Form 1095-A so that they could file in time to receive PTC for February. The HCA successfully advocated for consumers to receive January PTC if the non-filer indicator on their account was wrong.

The HCA has consistently advocated for tax forms to be more accessible to consumers. We are pleased that consumers can now download 1095 forms from their online account.

As in prior quarters, we commented on notices to consumers affecting their eligibility for tax credits. The HCA also continued to receive and escalate cases with VHC involving APTC reconciliation and forms

1095-A. As described above under Priorities, a significant portion of our VHC calls this quarter were tax-related.

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

As in prior quarters, the HCA's tax attorney consulted with HCA advocates when particularly difficult IRS-related issues arose in HCA cases. During this quarter, the tax attorney advised the HCA on 13 technical assistance questions. She also responded to 58 technical assistance questions from nonprofit tax assisters, Vermont tax preparers, and legal services attorneys in other states. During tax season the most common technical assistance questions involved the complex IRS rules on how to reconcile advance payments of the Premium Tax Credit (PTC). The tax attorney also answered questions on a wide variety of ACA topics including unusual types of income, tax filing status, Form 1095 errors, IRS procedures, shared responsibility payment exemptions, and coverage overlaps.

As described below under **Administrative Advocacy**, the HCA submitted formal comments to the federal Department of Health and Human Services (HHS) regarding its proposed Market Stabilization rule. The HCA objected to a proposed change in actuarial value methodology for silver plans, which has the potential to reduce PTC (and thus increase the cost of coverage) for a significant number of consumers nationwide.

The HCA also engaged in tax-related outreach and education activities this quarter, particularly in the wake of the January 20, 2017 Executive Order directing federal agencies to "minimize the economic burden" of the ACA. We updated our website to include information about the Executive Order and its impact on the ACA's Shared Responsibility Provision. Further information is below in the **Outreach and Education** section.

G. Other Activities

Administrative Advocacy

✧ Access to Treatment for Hepatitis C Virus

This quarter the HCA successfully advocated for implementation of Medicaid's new, less-restrictive coverage criteria for hepatitis C. Medicaid's Drug Utilization Review Board (DURB) voted in December to recommend covering treatment for patients with less severe liver disease, and for patients regardless of their substance use history, and DVHA accepted the DURB's recommendations. This quarter the HCA met with the DVHA Commissioner and communicated with DVHA staff and health care providers to ensure that the policy change was fully implemented. DVHA implemented the new criteria during the quarter, allowing more Vermonters to access curative treatments for hepatitis C.

✧ Controlled Substance and Pain Management Advisory Council

Act 173 of 2016 created this council to advise the Commissioner of Health on matters related to the Vermont Prescription Monitoring System, the appropriate use of controlled substances in treating pain, and preventing prescription drug abuse, misuse, and diversion. This quarter the HCA reviewed the Department of Health's draft Rule for Medication-Assisted Treatment for Opioid Dependence. The rule would expand capacity for the treatment of opioid dependence by allowing advanced practice registered nurses and physician's assistants to prescribe buprenorphine to individuals requiring and seeking treatment for opioid dependence. The rule would also increase the number of patients a provider may treat.

✧ Health Care Administrative Rules (HCAR)

The Department of Vermont Health Access (DVHA) has begun a multi-year revision of Medicaid rules. Eventually all Medicaid rules will be amended and adopted under the title of Health Care Administrative Rules (HCAR). In January, the HCA submitted formal comments on three proposed HCAR Rules describing coverage for dental and orthodontic services. We asked for changes to the proposed rules that would clarify providers' responsibility to explain the patient's financial responsibility for non-covered services and would use the existing definition of the clinical criteria for coverage of orthodontic services. During the quarter, DVHA made changes to address our concerns in the final proposed version of the regulations. These rules were pending at the Legislative Committee on Administrative Rules (LCAR) at the end of the quarter.

DVHA also proposed new HCAR rules covering augmentative communication devices. The Disability Law Project (DLP) of Vermont Legal Aid and other advocates commented extensively on these regulations because they made substantive changes in coverage criteria for the devices. The HCA endorsed the DLP comments. As a result of the large number of public comments, DVHA rewrote the rule and held a new public comment period during the quarter. The DLP and HCA agree with the new version of the rule.

✧ 2018 Qualified Health Plan (QHP) Work Group

The HCA participated in this stakeholder group which was convened by DVHA to help develop any recommended changes to benefit design for Qualified Health Plans (QHPs) offered on Vermont Health Connect in 2018. The legislature set up a process to discuss the effect that the maximum out-of-pocket expense limit for prescription drugs in Vermont law has on plan design, especially at the bronze plan metal level. The work group also reviewed other plan design changes. We attended one meeting of the group during the quarter. DVHA's recommendations for plan design changes were presented to the Green Mountain Care Board at the end of January.

✧ Vermont Health Connect Escalation Path

The HCA and VHC continued to collaborate on improving the State's escalation path for HCA cases involving complex VHC issues. We communicate with VHC multiple times a day and meet as needed to discuss the most difficult cases. **HHS Market Stabilization Rule**

The HCA submitted formal comments in response to a Notice of Proposed Rulemaking by the federal Department of Health and Human Services (HHS). HCA raised concerns with several proposals that could reduce enrollment of healthy consumers and cause hardships for consumers who experience a loss of income or other challenging situations. HCA strongly objected to any continuous coverage requirement for exchange coverage as contrary to the plain language of the Affordable Care Act. HCA requested that HHS recognize state flexibility in several areas, to allow Vermont to tailor its rules and procedures to the issues facing our exchange.

✧ Comments on Vermont Health Connect Notices

At VHC's request, the HCA commented on 10 notices, in an effort to make them more readable and consumer-friendly. See **Promoting Plain Language in Health Communications** below.

✧ Medicaid and Exchange Advisory Board

This quarter, the new Chief Health Care Advocate was appointed to Vermont's Medicaid and Exchange Advisory Board (MEAB) and continued the HCA's active participation on this board. The Chief attended 3 meetings of the MEAB during the quarter.

Legislative Activities

This quarter included the first three months of the 2017 session of the Vermont Legislature. During the quarter, the HCA advocated for legislation that would benefit health care consumers and monitored the activity of legislative committees that took up issues related to health care. We worked on legislation to improve Accountable Care Organization transparency to the public as well as reporting on ACO activities to the Legislature. The HCA also responded to legislative requests for comment on a number of other issues.

Our new Chief Health Care Advocate testified numerous times before legislative committees this quarter, including 7 times before the Senate Committee on Health and Welfare and 5 times before the House Committee on Health Care.

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:

- American Civil Liberties Union of Vermont (ACLU-VT)
- Bi-State Primary Care Association
- Blue Cross Blue Shield of Vermont
- Community Catalyst
- MVP Health Care
- National Association of Enrolled Agents
- OneCare Vermont
- Prisoners' Rights Office
- South Royalton Legal Clinic
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems (VAHHS)
- Vermont CARES
- Vermont Health Connect
- Villanova University Tax Clinic (Procedurally Taxing)
- Voices for Vermont's Children
- Women's Freedom Center

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Outreach and Education

A. Website

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

Google Analytics Statistics

- The total number of health pageviews increased by 27% in the reporting quarter ending March 31, 2017 (11,839 pageviews), compared with the same quarter in 2016 (9,322 pageviews). This is noteworthy because the total number of pageviews for the entire Vermont Law Help website was nearly even when compared with the same period last year.
- The number of people who visited our ***Services Covered by Medicaid*** page increased by 221% this quarter, with 350 pageviews compared to last year's 109. Last quarter that page had 129 pageviews.
- This quarter, like the previous six quarters, we saw a large increase in the number of people seeking information about ***Medicaid Income Limits*** (3,960 pageviews this quarter, compared with 2,639 in the same quarter in 2016 – an increase of 50%). 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 number of people seeking help finding ***Dental Services*** increased (16%) compared with the previous year. (504 pageviews this quarter, compared with 435 in the same period last year.)
- The ***Health home page*** again had the second largest number of pageviews (1,182), slightly higher than last year's 1,040. 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.
- The number of people looking for information about ***Prescription Drugs, Prescription Assistance and Medicare Part D*** jumped significantly. All these topics together earned 302 pageviews this quarter compared to 145 pageviews in 2016. This is a 300% increase.
- 11 of the 25 health pages with the largest number of pageviews focused on ***Medicaid or long-term care Medicaid (Choices for Care)***. There is almost no information about MCA Medicaid or Dr. Dynasaur available on the state websites, but there is clearly a need for information on these topics.
- There were spikes in interest in our pages on the ***Ladies First Health Program*** (up from 9 to 83 pageviews), ***Dr. Dynasaur*** (up from 24 to 77 pageviews) and the health care ***Complaints*** page (up from 62 to 111).
- We saw decreases in traffic over last year on the following pages: ***Health Insurance, Taxes and You*** (down from 476 to 396), ***Medical Marijuana Registry Patient Form*** (down from 318 to 172), ***Tax Form 1095-B and C*** (down from 197 to 78), and ***VHC Appeals*** (down from 29 to 14).
- The top-12 health pages on our website this quarter with change over last year:
    - Income Limits – Medicaid – 3,960 pageviews (50% ↑)
    - Health section home page – 1,182 (14% ↑)
    - Dental Services – 504 (16% ↑)
    - Vermont Choices for Care – 405 (65% ↑)
    - Health Insurance Taxes and You – 396 (17% ↓)
    - Services Covered by Medicaid – 350 (221% ↑)
    - Medicaid – 229 (70% ↑)
    - Resource Limits – Medicaid – 208 (48% ↑)
    - Medicaid and Medicare Dual Eligible – 172 (20% ↓)
    - Medical Marijuana Registry Patient Form – 172 (46% ↓)
    - Choices for Care Income Limits – 162 (22% ↑)

PDF Downloads

- 43 out of 101 or **43% of the unique PDFs downloaded** from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:

- 23 were created for consumers. The top five consumer-focused PDF downloads were:
  - *Vermont Dental Clinics Chart* (135 downloads)
  - *Advance Directive, short form* (51 downloads)
  - *Blue Cross Blue Shield of VT Annual Report 2014* (24 downloads)
  - *Vermont Medicaid Coverage Exception Request - 10 Standards and Provider Request Form* (23 downloads)
  - *Advance Directive, long form* (13 downloads)
- 15 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:
  - *PTC rule allocation summary* (12 downloads)
  - *2015 Affordability Exemption Charts handout (from September ACA Refresher presentation)* (4 downloads)
  - *Low-Income Taxpayers and the Affordable Care Act – November 2014* (3 downloads)
- 5 covered topics related to health policy. The top policy-focused downloads were:
  - *Vermont ACO Shared Savings Program Quality Measures* (12 downloads)
  - *Consumer Principles for Vermont's All-Payer Model Nov 2015* (2 downloads)

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

The *Advance Directive, short form* is the **fifth most downloaded of all PDFs** downloaded from the Vermont Law Help website.

B. Education/Outreach

Immigrants' Rights Forum (March 28, 2017)

An HCA attorney attended an immigrants' rights forum presented by the Women's Freedom Center and the South Royalton Legal Clinic at the School for International Training in Brattleboro. HCA brochures were offered to 36 attendees, and the attorney announced that the HCA is available to consult with consumers of all immigration statuses who have healthcare or health insurance questions.

Procedurally Taxing (February 2, 2017)

The HCA's tax attorney analyzed the January 20, 2017 Executive Order which directed federal agencies to reduce the economic burden of the Affordable Care Act. The analysis explains the effect of the Order on the Shared Responsibility Provision and Premium Tax Credit, and discusses tax preparers' ethical obligation to prepare a complete and correct tax return. Procedurally Taxing is a blog run by Villanova University Law School professors, which has an audience of hundreds of tax professionals.

National Association of Enrolled Agents E@lert Newsletter (February 3, 2017)

The National Association of Enrolled Agents included the HCA tax attorney's article on the Executive Order in its electronic newsletter, which is sent to thousands of tax professionals nationwide.

C. Promoting Plain Language in Health Communications

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

- Provided extensive plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:
  - Notice on SHIP (State Health Insurance Assistance Program) assistance sent on 1-6-17
  - EE509-MNT Applying for Retro Medicaid sent on 1-17-17
  - EE510-MNT –Grant of Retro Medicaid sent on 1-17-17
  - EE511-MNT –Denial of Retro Medicaid sent on 1-17-17
  - EE714-Spend Down Request sent on 2-3-17
  - EE715 Spend Down Request Denial sent on 2-3-17
  - SYS712 Dr. D Premium Change Notice sent on 2-3-17
  - ADM-600-MM Direct Enrollment Notice sent on 3-6-2017
  - Automatic Medicaid Renewal Notice sent on 3-16-2017
  - Self-Service blurb sent on 3-21-17

Office of the Health Care Advocate

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Attachment 6

CY 2017 Investment Expenditures

Department	STC #	Investment Description	QE 0317
AHSCO	41	2-1-1 Grant	113,250
AHSCO	54	Designated Agency Underinsured Services	1,289,600
AOE	11	Non-state plan Related Education Fund Investments	-
DCF	1	Residential Care for Youth/Substitute Care	2,302,666
DCF	2	Lund Home	563,548
DCF	9	Challenges for Change: DCF	64,031
DCF	26	Strengthening Families	140,360
DCF	33	Prevent Child Abuse Vermont: Shaken Baby	-
DCF	34	Prevent Child Abuse Vermont: Nurturing Parent	28,742
DCF	35	Building Bright Futures	215,963
DCF	55	Medical Services	18,232
DCF	56	Aid to the Aged, Blind and Disabled CCL Level III	-
DCF	57	Aid to the Aged, Blind and Disabled Res Care Level III	-
DCF	58	Aid to the Aged, Blind and Disabled Res Care Level IV	-
DCF	59	Essential Person Program	247,955
DCF	60	GA Medical Expenses	57,275
DCF	61	Therapeutic Child Care	183,832
DCF	62	Lamoille Valley Community Justice Project	54,000
DDAIL	27	Flexible Family/Respite Funding	668,431
DDAIL	42	Quality Review of Home Health Agencies	1,768
DDAIL	43	Support and Services at Home (SASH)	320,709
DDAIL	63	Mobility Training/Other Svcs.-Elderly Visually Impaired	-
DDAIL	64	DS Special Payments for Medical Services	143,988
DDAIL	65	Seriously Functionally Impaired: DAIL	16,943
DDAIL	77	HomeSharing	162,018
DDAIL	78	Self-Neglect Initiative	138,499
DMH	3	Institution for Mental Disease Servcies: DMH - VPCH	5,771,260
DMH	3	Institution for Mental Disease Servcies: DMH - BR	613,029
DMH	12	Mental Health Children's Community Services	1,097,702
DMH	13	Acute Psychiatric Inpatient Services	501,066
DMH	16	Mental Health CRT Community Support Services	(2462,689)
DMH	22	Emergency Support Fund	253,299
DMH	28	Special Payments for Treatment Plan Services	30,423
DMH	29	Emergency Mental Health for Children and Adults	6,052,211
DMH	66	MH Outpatient Services for Adults	758,456
DMH	67	Respite Services for Youth with SED and their Families	302,241
DMH	68	Seriously Functionally Impaired: DMH	77,578
DMH	79	Mental Health Consumer Support Programs	141,257
DOC	4	Return House	108,512
DOC	5	Northern Lights	97,223
DOC	6	Pathways to Housing	-
DOC	14	St. Albans and United Counseling Service Transitional Housing (Challenges for Chang	458,426
DOC	15	Northeast Kingdom Community Action	46,405
DOC	69	Intensive Substance Abuse Program (ISAP)	-
DOC	70	Intensive Domestic Violence Program	-
DOC	71	Community Rehabilitative Care	-
DOC	80	Intensive Sexual Abuse Program	2,130
DVHA	7	Institution for Mental Disease Services: DVHA	1,763,069
DVHA	8	Vermont Information Technology Leaders/HIT/HIE/HCR	968,032
DVHA	18	Patient Safety Net Services	206,199
DVHA	51	Vermont Blueprint for Health	507,608
DVHA	52	Buy-In	5,762
DVHA	53	HIV Drug Coverage	1,422
DVHA	72	Family Supports	-

Department	STC #	Investment Description	QE 0317
GMCB	45	Green Mountain Care Board	609,467
UVM	10	Vermont Physician Training	1,011,555
VAAFM	36	Agriculture Public Health Initiatives	5,335
VDH	17	Recovery Centers	430,500
VDH	19	Emergency Medical Services	157,292
VDH	21	Area Health Education Centers (AHEC)	266,000
VDH	23	Public Inebriate Services, C for C	594,748
VDH	24	Medicaid Vaccines	-
VDH	25	Physician/Dentist Loan Repayment Program	432,000
VDH	30	Substance Use Disorder Treatment	1,918,079
VDH	31	Health Laboratory	854,053
VDH	37	WIC Coverage	478,297
VDH	38	Fluoride Treatment	21,715
VDH	39	Health Research and Statistics	341,202
VDH	40	Epidemiology	214,776
VDH	44	VT Blueprint for Health	372,571
VDH	46	Enhanced Immunization	47,498
VDH	47	Patient Safety - Adverse Events	1,221
VDH	48	Poison Control	26,873
VDH	49	Healthy Homes and Lead Poisoning Prevention Program	68,973
VDH	50	Tobacco Cessation: Community Coalitions	-
VDH	73	Renal Disease	-
VDH	74	TB Medical Services	40,705
VDH	75	Family Planning	378,879
VDH	76	Statewide Tobacco Cessation	158,405
VSC	32	Health Professional Training	204,730
VVH	20	Vermont Veterans Home	110,986
			32,778,291