# *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
## July 1, 2017 – September 30, 2017

**Submitted Via PMDA Portal on November 28, 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 third quarterly report for waiver year 12, covering the period from July 1, 2017 through September 30, 2017 (QE0917).***

## II. Outreach/Innovative Activities

### *i. Provider and Member Relations*

**Key updates from QE0917:**

- Access to Dental Care
- Member newsletter

The Provider and Member Relations (PMR) Unit ensures members have access to appropriate health care for their medical, dental, and mental health needs. The PMR 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.

Member Newsletter

The annual Green Mountain Care member newsletter was sent to 95,747 households in August 2017. The newsletter included articles on staying current with your health coverage, improving individual's health to create healthier communities statewide, and a healthy smile for your young child. The newsletter also included a reminder of privacy practices as well as an article on physical activity and nutrition. A full-page article was published on three key things all members should know about their personal health. Coordination with the Department of Health occurred to publish an article on smoking cessation as well as an article on preventive care. Member newsletter are published by PMR once a year and are posted online here: http://www.greenmountaincare.org/member-information/member-newsletter

Dental Services

DVHA lost an important dental provider in the White River Junction area who served only Vermont Medicaid patients. As of June 30, 2017, this provider retired leaving 572 Medicaid patients without a dental provider. To ensure all members have access to dental service, DVHA continued to work with the Vermont Dental Society and its members this past quarter to solicit providers to take on Medicaid members' care in the White River Junction area. DVHA has also conducted direct outreach to dental providers in the area to expand access to care for Medicaid members. DVHA has successfully notified

all 572 members of providers in their area and the majority have since found dental care. Recruiting new dentists to practice in Vermont is an ongoing collaborative activity.

DVHA recently upgraded and enhanced the Provider Look-Up page on its website to provide a better tool for Medicaid members to locate dentists and dental specialists in the Medicaid network. As part of this upgrade, DVHA conduced outreach to all enrolled dental providers in its network to ensure the most accurate, up-to-date information was listed. The result is an easy and accurate access tool for members seeking both general dentists and specialists. In addition to the upgrade Provider Look-Up page, DVHA continues to provide quarterly updates to the federal dental access program for children – Insure Kids Now. DVHA also continues to monitor data on regional availability of dental care throughout the state.

## III. Operational/Policy Developments/Issues

*i. Vermont Health Connect*

**Key updates from QE0917:**

- Nearly 80,000 Vermonters were enrolled in a qualified health plan (QHP) – more than in the third quarter of any prior year – including nearly 30,000 enrolled through Vermont Health Connect (VHC), 5,000 direct-enrolled with insurance carriers, and more than 45,000 enrolled in a SHOP small business plan.
- ExParte Medicaid Renewals resulted in more than three out of five members being passively renewed, which meant less burden on Vermonters and less processing work for Health Access Eligibility and Enrollment Unit (HAEEU) staff.
- Operational metrics related to customer support, integration, reconciliation, work processing, and escalated cases – all of which had improved dramatically over the previous year – stayed strong throughout the quarter.

As of September 2017 more than 210,000 Vermonters (more than one-third of the population) were enrolled in VHC health plans (approximately 80,000 in Qualified Health Plans and more than 130,000 in Medicaid for Children and Adults) either through the marketplace or directly through an insurance carrier. Enrollment data suggests that Vermont continues to make progress in enrolling "young invincibles." Young adults aged 26-34 comprised 25% of new enrollments, compared to 12% of re-enrollments.

Operationally, the Department of Vermont Health Access's Health Access Eligibility and Enrollment Unit (DVHA-HAEEU) kept up with incoming work, ending QE0917 with some of the shortest work queues in VHC's existence. In the spring of 2016, DVHA-HAEEU had set a goal of completing 75% of customer requests within ten business days by October 2016 and 85% by June 2017. DVHA-HAEEU met this goal ahead of schedule and continued to improve. In QE0916, 84% of requests were completed within ten days. In QE0917, 97% of requests were completed within ten days.

A year ago, the integration of cases across partner systems continued to pose significant challenges for VHC. After work to address defects, the integration team set ambitious goals for 2017 and have met the mark nearly every month. The VHC-Carrier integration error rate was just 1.0% in QE0917, compared to 5.7% in QE0916. Just as importantly, the team maintained a low inventory of open errors by promptly addressing and staying on top of any issues that arose. At the end of QE0917, one VHC-Carrier error had been open for ten days or more, compared to 163 at the end of QE0916.

Similarly, the reconciliation team set ambitious goals for 2017, aiming to conduct monthly reconciliation across the VHC system, BlueCross BlueShield of Vermont's system, and payment processor WEX's system, and address at least 90% of data discrepancies within 30 days. As of the end of QE0917, the reconciliation team had surpassed the goal every month.

Redeterminations for Medicaid for Children and Adults (MCA) and Medicaid for the Aged, Blind and Disabled (MABD), which had completed their first annual cycles in QE0317 and QE0916 respectively, continued on a normal annual cycle. DVHA-HAEEU promptly processed incoming applications, ending QE0917 with 428 open MCA applications (12 of which were older than 45 days) and 329 open MABD (two of which were older than 45 days).

The MCA redetermination effort benefitted from new ExParte functionality that increased the number of MCA members who could be passively renewed in QE0917. More than three out of five (62%) of income-based Medicaid customers were able to be renewed without any action by the member, resulting in less burden on Vermonters and less processing work for DVHA-HAEEU staff. DVHA-HAEEU helped achieve the high success rate by prescreening relevant cases, identifying potential data issues, and working to clean the data in the weeks prior to the renewal.

Maximus continued to manage the VHC Customer Support Center (call center), utilizing 83 customer service representatives as of the end of QE0917. 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 received just over 81,000 calls in the quarter. Even though call volume was down 10,000 from the previous quarter, Maximus had trouble with summer staffing and missed its targets in July and August. DVHA initiated a corrective action plan with Maximus in early August then met weekly throughout the rest of the quarter to monitor progress on hiring, overflow readiness and contingency planning. Maximus then met its targets for September. Over the course of QE0917, the call center had an abandon rate of 5% and answered just over two-thirds (68%) of calls within 24 seconds.

Vermont Health Connect was supported throughout the state by 232 Assisters (15 Navigators, 139 Certified Application Counselors or CACs, and 78 Brokers) in QE0917, giving Vermont the most Assisters it has ever had even as Navigator grants were greatly reduced with the start of the new fiscal year. Most former Navigators converted to being CACs and the Assister program worked with hospitals, health centers, and other community organizations to recruit and train additional CACs. Overall, in QE0917 Navigators and CACs largely focused on helping Vermonters with Medicaid renewals, particularly new Vermonters with limited English proficiency and others with accessibility challenges.

Health insurance literacy was also an outreach focus throughout QE0917. 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 101,000 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 12,000 sessions during the quarter – up more than 20% from the previous quarter.

During QE0917, 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 half (45%) of new applications were made online in QE0917, up from 30% in QE0916, and 80% more customers were signed up for recurring payments at the end of QE0917 than QE0916.

### *ii. Choices for Care*

**Key updates from QE0917:**

- State Fiscal Year 2017 ends with no available savings for reinvestment.
- Workforce crisis continues.
- Vermont improves LTSS Scorecard and wins inaugural Pacesetter award.
- Wait lists status – Moderate Needs continues to rise.

State Fiscal Year 2017 (SFY2017) Year End Budget Summary

The Choices for Care state budget closed SFY2017 just under plan by approximately $1,172,329 gross or approximately ½ of 1% of total budget $193,809,572. Since that is less than the 1% "reserve" required by the Vermont Budget Appropriations Act, there were no year-end savings for "reinvestment" in SFY2018.

For more information on Vermont's Choices for Care legislative budget process, refer to Section E.308 of Vermont Act 172.

Workforce Crisis

During the last year, Vermont has begun to experience a crisis in its caregiving workforce. Though we see it directly through our work with people at home seeking staff for personal care services, hospitals and other healthcare facilities are also expressing the same challenges. Some of the indicators include increased appeals due to reduction in home health services, Money Follows the Person (MFP) participants waiting in facilities due to lack of staff to assure a safe discharge, and a slight reduction in the home and community-based services provided as compared to authorized.

Though there is no magic bullet for this crisis, here are some things that are happening in Vermont:

- In 2016, Vocational Rehabilitation received a $9 million dollar grant called "Linking Learning to Careers" which is focused on helping high school students with disabilities access education and training needed to enter the workforce in their chosen careers. This grant will give Vermont the opportunity to include caregiver/healthcare career pathways for youth as well.
- The Department of Disabilities, Aging & Independent Living (DAIL) has been working with home health agencies to contract with non-medical homecare providers to help fill the gaps.

- Vermont's Money Follows the Person (MFP) team is participating in a multi-state workgroup led by CMS. The goal is to help states work together to create action plans to help address workforce needs.
- Vermont is engaging with an online registry to improve access for people seeking caregivers.
- The Vermont State Unit on Aging is leading a "Reframing Aging" initiative in Vermont intended to drive culture change around how we view older Vermonters, including as an important workforce resource.

Long-Term Services and Supports (LTSS) Scorecard and Pacesetter Award

AARP released its 2017 State Scorecard on Long-Term Services and Supports (LTSS): Picking up the Pace of Change: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers.

Vermont is proud to be ranked 3rd overall in the nation in the delivery of long-term services and supports, showing improvement in Affordability & Access, Choice of Setting & Provider and Support for Family Caregivers. Vermont was also the "most improved" in the area of Access and Affordability. In response to that improvement, Vermont was awarded the SCAN Foundation "Pacesetter Award" on September 21, 2017 at the Waterbury State Office Complex.

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 800 people are waiting for help to pay for homemaker services statewide and zero 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 were to be modified, wait lists for the limited Moderate Needs funding will continue for the foreseeable future.

Moderate Needs Stakeholder Workgroup

DAIL continues the stakeholder workgroup that was initiated in the previous quarter. This workgroup was created following a State initiative to evaluate opportunities for Medicaid payment and service delivery reform in Vermont. The workgroup provides feedback on opportunities for improved management of Moderate Needs services with a focus on improving outcomes for Vermonters. The workgroup will meet through the end of calendar year 2017.

*iii. Developmental Disabilities Services Division*

**Key updates from QE0917:**

- Updated Regulations and System of Care Plan
- Workforce investment
- Continued positive outcomes for Supported Employment

Updated Regulations and System of Care Plan

The Developmental Disabilities Services Division (DDSD) completed revisions of two major guiding documents for provision of Developmental Disability Services, the *Regulations Implementing the Developmental Disabilities Act of 1996* and the *Vermont State System of Care Plan for Developmental Disabilities Services.* Both have an effective date of October 1, 2017. This was the culmination of over a year-long process gathering input and public comment from major stakeholders. The *Regulations* were updated in response to legislation that required certain categories of the *System of Care Plan* to be adopted by the rulemaking process, including identifying the priority programs, the criteria for receiving services or funding, types of services provided and the process for evaluating the success of programs. Together these documents outline how Medicaid funds are used for individuals with developmental disabilities and their families. New language was added to both documents to ensure compliance with the new Home and Community-based rules. These documents are available at: http://humanservices.vermont.gov/on-line-rules/health-care-administrative-rules-hcar/final-clean.ddact-regulations-10-01-2017.pdf and http://ddsd.vermont.gov/ds-vt-socp.

Increased Funding for Direct Support Staff

The Vermont legislature provided increased funding to allow Developmental Disabilities Service provider agencies to increase wages for direct support staff to $14 per hour. This was in response to difficulties hiring sufficient numbers of workers to provide essential care and support. The state will monitor the staff vacancy rate to determine whether increased wages helps alleviate the worker shortage so that people received authorized services.

Supported Employment

Vermont continues to have very positive outcomes in supporting individuals with developmental disabilities to work. According to the 2016 *StateData: The National Report on Employment Services and Outcomes,* 38% of people receiving services in the state were employed in community-based jobs compared to the national average of 19%. DDSD has worked closely with Vocational Rehabilitation, the Agency of Education and the University of Vermont for many years to support integrated employment.

*iv. Traumatic Brain Injury (TBI) Program*

**Key updates from QE0917:**

- Enrollments suddenly increase.
- Brain Injury Association of Vermont (BIAVT) launches needs assessment survey.
- Wait list.

Enrollments

Vermont's TBI program provides specialty rehab services to people with a recent traumatic brain injury in addition to some long-term services for people who need then. Program utilization is based on the frequency of accidents and injuries at a given point in time. Recently, Vermont saw an increase of 10 new enrollments within a short timeframe, bringing enrollments up to 90 people. This increase, in addition to one very high cost complex plan, maximized the current TBI appropriation of $5,641,336. Therefore, to bring new people on to the TBI program, people must either graduate off the program or transition to other programs that can provide adequate long-term services and supports. There are approximately 5 people who have applied and are waiting for services.

Brain Injury Association of Vermont (BIAVT) Launches State Needs Assessment

August 2017 the Brain Injury Association of Vermont (BIAVT) launched its state needs assessment survey. The last survey was conducted in 2010 and was used to create the State TBI Action Plan, instrumental in shaping Vermont's current service structure. Input will be used to help shape the development of TBI services in Vermont over the next five years.

The following organizations collaborated with the BIAVT in the development of the survey:

- Vermont Department of Disabilities, Aging and Independent Living
- Vermont TBI Advisory Board
- Disability Rights Vermont

*v. Global Commitment Register*

**Key updates from QE0917:**

- 15 policies were posted to the GCR in Q3 2017.
- Since the Global Commitment Register (GCR) launched in November 2015, 86 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 375 interested parties who have elected to receive periodic key updates about Vermont health care programs. All members of the Medicaid and Exchange Advisory Board are also on this listserv. GCR updates include 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.

A combined total of 15 policies were posted to the GCR this past quarter. This includes six proposed and six final changes, as well as three clarifications. Changes to rates and/or rate methodologies accounted for more than half of the changes, with the remainder being changes to clinical policies, expansion of telemedicine services, and a State Plan Amendment.

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

## IV. Expenditure Containment Initiatives

### *i. Vermont Chronic Care Initiative (VCCI)*

**Key updates from QE0917:**

- The VCCI team worked with the MMIS Enterprise Care Management team toward the successful deployment of Release 2 functionality this summer.
- The CMS certification 'customized check list' is in development for the VCCI utilization of the Enterprise MMIS/Care Management software system, with completion contingent of release 3 functionality for full system certification slated for mid-calendar year 2018.
- The VCCI leadership and the MMIS care management technical team are working with the MMIS care management vendor and Vermont Health Information Exchange (VHIE) toward provision of biomedical data feeds into the enterprise care management solution. These data will enhance identification of member case management needs, clinical monitoring, and evaluation of case management interventions by VCCI and by the next generation ACO providers and their case management network toward provision of evidence based care and clinical improvement of Medicaid members. The data interface is anticipated in mid CY 2018.
- The DVHA next generation ACO contract with Vermont Care Organization precludes ACO attributed members from receiving VCCI case management services concurrent with ACO management. New VCCI eligibility rules are to be deployed prior to calendar year end and in anticipation of an increase in the ACO attributed member population in CY 2018.
- The VCCI leadership is working with DVHA senior management, the Medicaid Chief Medical Officer and our ACO partners regarding collaboration and leveraging the VCCI expertise as a resource in our Health Care Reform vision in 2018 and beyond.

The VCCI is a component of DVHA's health care reform goals and its supporting strategic plan. 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 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 high cost VCCI-eligible Medicaid members account for a disproportionate number of hospital emergency department and inpatient admissions and readmissions.

The VCCI's strategy of hospital liaisons collaborating and referring members at the point-of-need in areas of high service utilization and prior to claim adjudication continues, and supports referral at the point when patients may be most ready to engage. By targeting high cost members, resources can be allocated to areas representing the greatest opportunities for member engagement, clinical improvement and cost savings.

VCCI updates its eligibility criteria and related rules in response to the Medicaid next generation ACO efforts and related exclusion of VCCI as a resource. The target population change has increased VVCI's eligible cohort; however, it is anticipated that the 2018 attribution may result in a further decline in the VCCI target population. The new VCCI target population now includes members in the top 10%, and with high anticipated future cost, based on predictive analytics.

The VCCI continues to strive for strategic alignment with other important State health care reform efforts, such as the DVHA Blueprint for Health, 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 partnership with Medicaid's Chief Medical Officer, the VCCI is exploring collaborative opportunities with ACO partners to assure continued care management of the most vulnerable and costly members assigned to VCCI.

Enterprise Care Management System

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'. Toward this effort, the MMIS project team and vendor successfully launched release two in July, which included both consume and provider portals. Release 3 efforts are underway with a projected deployment date of first half of CY 2018.

Case management services will be enhanced for all Medicaid members with impending access to biomedical data on Medicaid members via the data interface between the VHIE and the State Enterprise Care Management system. The data interface is expected to enhance clinical and financial reporting capabilities on Medicaid members consistent with DVHA priorities: enhancing information technology, results based accountability (RBA) and performance based payment. This enterprise care management technology will leverage and maximize the CMS investments to the State for evaluation and reporting of clinical and financial outcomes on Medicaid members in areas of investment, which include technology and payment reform via the next generation ACO. The interface is anticipated to be finalized in the first quarter of CY 2018.

The business operating/evaluation 'reports' work effort is underway, concurrent with Release 3 development and deployment cycle. A full time clinical analyst is indicated to develop the required business reports from disparate data models in the Tableau environment, as the system 'base product' reports will not fully meet the business operating needs.

CMS certification

CMS system certification efforts are underway, and the customized check list finalization will be contingent on functionality available in the release 3 deployment. The Reports workstream efforts for business reporting, finalizing of Gap in Care functionality and delivery of these individual and population based system features concurrent with reduction in bugs/defects. Resultantly, the timeline for submission of the certification letter is likely year end with anticipated CMS review 6 months after request for certification review.

*ii. Blueprint for Health*

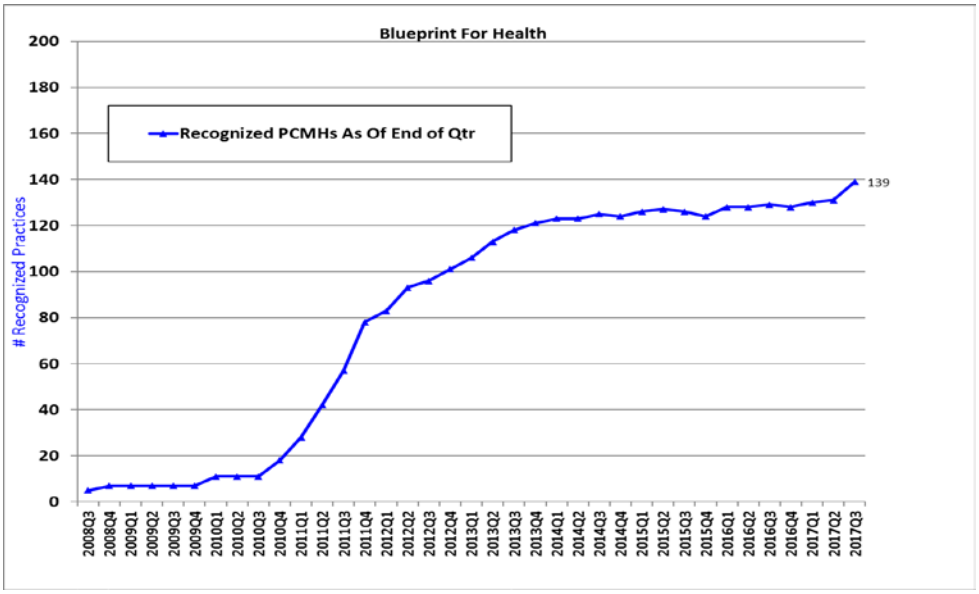
**Key updates from QE0917:**

- Eight new practices joined the Blueprint for Health program as of 10/1/2017, bringing the total number of Patient-Centered Medical Homes in Vermont up to 139.
- The opening of the Opioid Treatment Program in Northwestern Vermont has decreased the waiting list within this region from 189 as of October 2016 to 80 as of October 2017.
- Increased access to treatment for patients with opioid use disorder: 3,148 clients enrolled in Regional Opioid Treatment Programs (OTPs) and 2,606 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT) programs as of September 2017.
- Increased access to enhanced health and psychosocial screening along with comprehensive family planning: 2 new women's health practices enrolled in the WHI and 3 new Blueprint PCMHs enrolled in the WHI as of 10/1/2017, serving a total of 16,719 patients.

Patient Centered Medical Homes

In the past quarter, the Blueprint for Health program has had a net increase of seven NCQA-recognized primary care practices. Two practices qualified and joined the Blueprint as of 9/1/2017 and six practices qualified and joined the Blueprint as of 10/1/2017. One practice that had previously reported a qualifying NCQA submission to join the Blueprint as of 7/1/2017 did not in fact qualify. 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 139.

**Figure 1. Patient Centered Medical Homes**




Healthcare data profiles of practices and Hospital Service Areas (HSAs)

Practice-level and HSA-level profiles of all-payer healthcare outcomes data, for adult and pediatric patient populations, combine claims, clinical, and survey information, and continue to be produced by Onpoint for the Blueprint roughly every 6 months. Practice profiles and HSA profiles have been distributed to practices and healthcare organizations for the following data time periods:

- 01/2013 - 12/2013
- 07/2013 - 06/2014
- 01/2014 - 12/2014
- 07/2014 - 06/2015
- 01/2015 – 12/2015
- 07/2015 – 06/2016

Practice and HSA profiles for the data period 07/2015 – 06/2016 were produced and distributed in June 2017. The information in those profiles give practices an overview of total utilization and expenditures as compared to peers and the rest of the state. Vermont HSA data profiles, including the latest ones for the data period 07/2015 – 06/2016, are posted at http://blueprintforhealth.vermont.gov/reports_and_analytics/hospital_service_area_profiles.

Practice profiles and HSA profiles for the data time period 01/2016 – 12/2016 are expected to be distributed to practices and healthcare organizations in December 2017.

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: 3,148 clients enrolled in Regional Opioid Treatment Programs (OTPs) and 2,606 Medicaid beneficiaries were served by Office-Based Opioid Treatment

(OBOT) programs as of September 2017. Medication assisted treatment is being offered across more than 80 different practices and by 213 medical doctors and 63.15 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 September 2017). The Opioid Treatment Program in Northwestern Vermont (St. Albans, VT) opened and the effect observed has been increasing treatment access within that region of the State and improved treatment capacity within Chittenden County as a result. The Chittenden Hub and Northwestern Vermont Hub waitlists are now at 80 and Vermont's Governor Scott indicated, in a press release in September 2017, that hard work and partnerships between state, local and community partners were essential for improving the waitlist for the OTP and facilitating appropriate connections to care. The Director of the Office of National Drug Control Policy, Richard Baum, visited Vermont in July and stated that, "Vermont has made more progress on that challenge [of expanding treatment capacity] than any other state in the country."

A collaborative team, comprised of Blueprint, Vermont Department of Health and UVM staff, was convened for the planning of the 2017-2018 learning collaborative series in July, August and September for the development of events designed to enhance the entire learning community of providers and practice teams (those new to Office-Based Opioid Treatment (OBOT) and for advanced providers and practice teams) through engagement with best practices and emerging topics.

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, University of Vermont – College of Medicine, and the Blueprint launched the learning series for the facilitation network and interested practices to provide education on topics such as the new rules for prescribing opioids, best practices for treatment of chronic pain (including topics of tapering and opioid-induced hyperalgesia), the Vermont Prescribing Monitoring System (VPMS) and to encourage a practice team-based approach to improving opioid prescribing within the practice environment.

Community and State partners continued to work with the Opioid Coordination Council to identify recommendations for system improvements that will positively impact Vermont's ability to appropriately address the substance use disorder workforce issues it has faced, including reform of the administrative rules to increase efficiency whilst maintaining integrity for substance use disorder professionals (including LADCs).

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

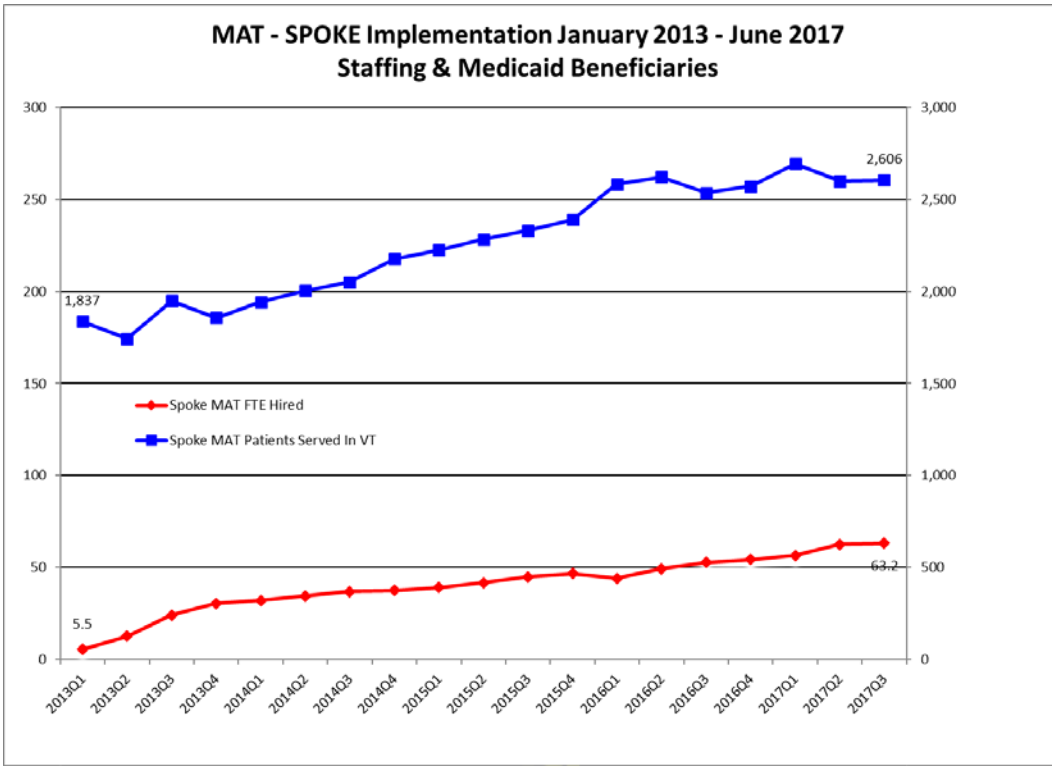



**Figure 3. MAT-SPOKE MDs Prescribing Buprenorphine January 2013 – September 2017**

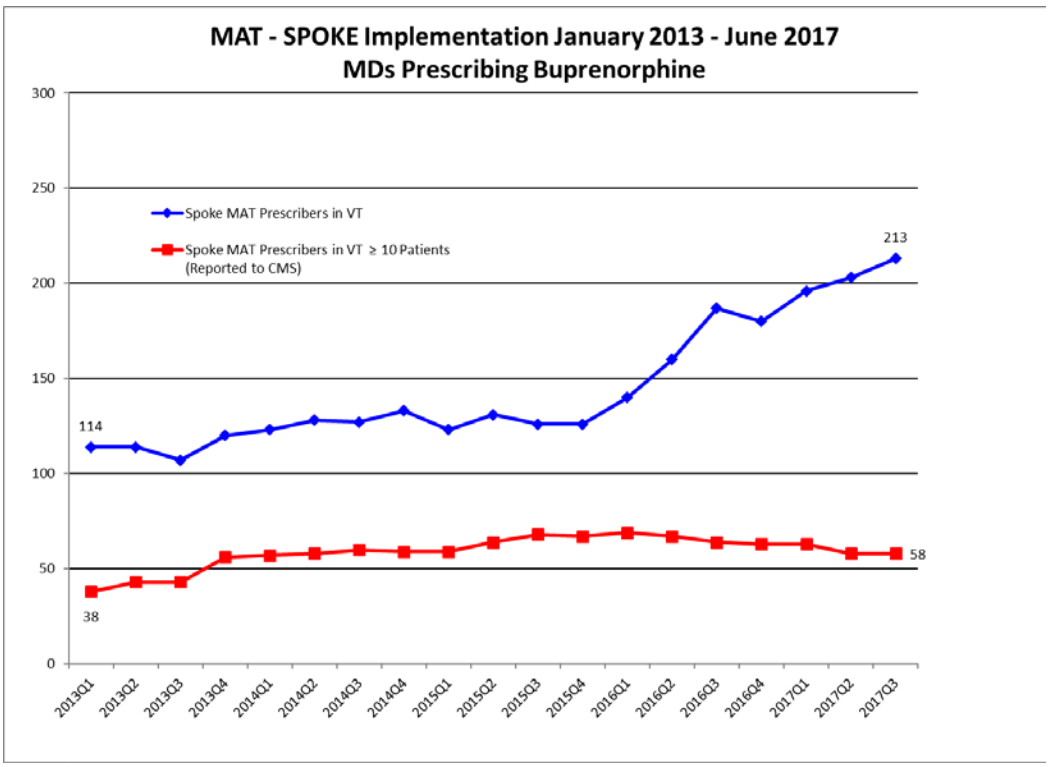
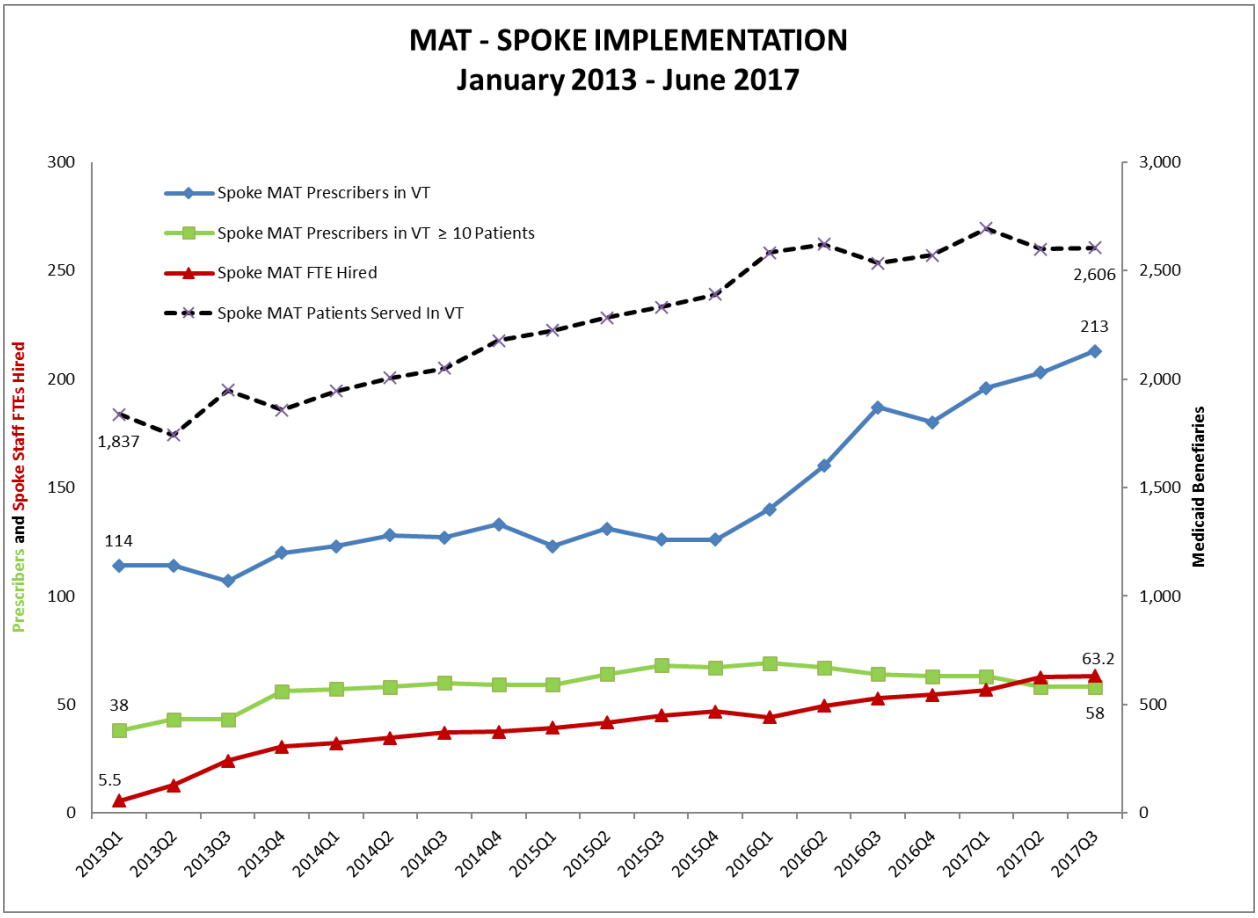


**Figure 4. MAT-SPOKE Implementation Jan 2013 – September 2017**




**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 the number of clients receiving methadone or buprenorphine.

**Table 1. Hub Implementation as of September 30, 2017**

| Region | # Clients | # Buprenorphine | # Methadone | # Vivitrol | # Receiving Treatment but Not Yet Dosed | # Waiting |
|---|---|---|---|---|---|---|
| Chittenden, Addison | 984 | 316 | 654 | 1 | 13 | 59 |
| Franklin, Grand Ilse | 67 | 27 | 40 | 0 | 0 | 21 |
| Washington, Lamoille, Orange | 473 | 183 | 290 | 0 | 0 | 0 |
| Windsor, Windham | 423 | 147 | 285 | 0 | 0 | 0 |
| Rutland, Bennington | 446 | 106 | 315 | 5 | 20 | 25 |
| Essex, Orleans, Caledonia | 746 | 205 | 539 | 2 | 0 | 5 |
| Total | 3148 | 984 | 2123 | 8 | 33 | 110 |

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 September 30, 2017**

| Region | Total # MD prescribing pts | # MD prescribing to ≥ 10 pts | Staff FTE Hired | Medicaid Beneficiaries |
|---|---|---|---|---|
| Bennington | 11 | 4 | 5.2 | 232 |
| St. Albans | 17 | 7 | 9.1 | 395 |
| Rutland | 18 | 7 | 5.2 | 310 |
| Chittenden | 83 | 12 | 14.8 | 505 |
| Brattleboro | 12 | 6 | 3.7 | 134 |
| Springfield | 5 | 2 | 1.55 | 55 |
| Windsor | 10 | 4 | 4 | 204 |
| Randolph | 6 | 4 | 3.1 | 95 |
| Barre | 20 | 6 | 6.2 | 244 |
| Lamoille | 12 | 5 | 4.8 | 243 |
| Newport & St Johnsbury | 14 | 2 | 2 | 91 |
| Addison | 8 | 2 | 2 | 81 |
| Upper Valley | 4 | 0 | 1.5 | 18 |
| Total | 213* | 58* | 63.15 | 2,606 |

**Table Notes**: Beneficiary count based on pharmacy claims July – September 2017; an additional **280** Medicaid beneficiaries are served by **37** out-of- state providers. Staff hired based on Blueprint portal report 10/20/17. *6 providers prescribe in more than one region.

Women's Health Initiative

In the past quarter, the Women's Health Initiative has had a net increase of two Blueprint PCMHs that joined the initiative. Three Blueprint PCMHs and two women's health practices joined the WHI as of 10/1/2017. One Blueprint PCMH and two women's health practices that had previously joined the Blueprint in July, April, and January 2017, dropped out of the WHI as of 9/30/2017.

Through the Women's Health Initiative, women's health specialty providers provide enhanced health and psychosocial screening along with comprehensive family planning counseling and timely access to long acting reversible contraception (LARC). New staff, training, and payments support effective follow-up to provider screenings through brief, in-office intervention and referral to services for mental health, substance abuse, trauma, partner violence, food and housing. The Women's Health Initiative ensures women's health providers have the resources they need to help women be well, avoid unintended pregnancies, and build thriving families.

Women identified as at-risk are immediately connected to a social worker for brief intervention and counseling and referral to more intensive treatment as needed. Each social worker is a member of the Community Health Team and available to connect women with the local network of health, social, economic and community service providers.

Women also receive comprehensive family planning counseling and services. Those who tell their providers they do not want to have a baby in the coming year have immediate and affordable access to LARC and other forms of contraception. Women who wish to become pregnant receive pre-conception counseling and services.

Quality Improvement Practice Facilitators work with participating practices to design practice workflows to support the enhanced screening, comprehensive contraceptive counseling, and same-day LARC insertion. Practice Facilitators also help practices integrate the social worker into their practice. Three payments support women's health care providers participating in this initiative. These three payments are:

- Recurring per member per month (PMPM) payments to WHI practices
- Recurring payments to support WHI Community Health Team (CHT) staff to the CHT administrative entities
- A one-time per member payment (PMP) to assist WHI practices in initiating WHI strategies and specifically provide support to the practices as they design and implement processes to provide evidence-based family planning counseling on the full spectrum of birth control options, stock LARC devices, and offer patients who choose LARC same-day insertion.

Each participating community builds a coalition including the participating women's health practices, primary care practices, and community organizations serving youth and women at risk of unintended pregnancy. Together, they develop referral pathways that get clients quicker access to necessary services.

Extension of the one-time per member payment (PMP) to current Blueprint Patient-Centered Medical Homes was approved in the second quarter of 2017 to be implemented on July 1. Practices who received this payment in July attested to:

1. implementing enhanced screening, comprehensive contraceptive counseling, and same-day insertion for those women who choose LARC as their preferred birth control method;
2. increasing affordable access to LARC and other forms of contraception; and
3. developing referral protocols for at least 3 community-based organizations to see patients within one week of being referred for family planning services.

Extension of the recurring per-member per-month payment (PMPM) to current Blueprint Patient-Centered Medical Homes was approved in the third quarter of 2017 to be implemented on October 1. Practices who received this payment in October attested to:

1. implementing enhanced screening, brief treatment, and referral for depression, intimate partner violence, substance abuse, access to primary to primary care, food insecurity, and housing stability; and
2. incorporating the local Community Health Team into the practice.

The Blueprint for Health continues to work collaboratively with the Vermont Department of Health, community organizations, providers, and practices to support Vermont women to have healthier lives through increasing the number of intentional pregnancies by increasing access to comprehensive family planning counseling, long acting reversible contraceptives for same-day insertions, and psychosocial screening and referral to treatment and services through continued development of local referral relationships with crucial community partners for mental health, substance use disorder, intimate partner violence, food insecurity and housing instability.

The Blueprint for Health, in collaboration with an analytics contractor, Onpoint Health Data, is working to develop data profiles that will provide valuable information regarding demographic and health status information, health service utilization, expenditures and outcome measures for the Women's Health Initiative.

**Figure 5. Women's Health Initiative Practices**

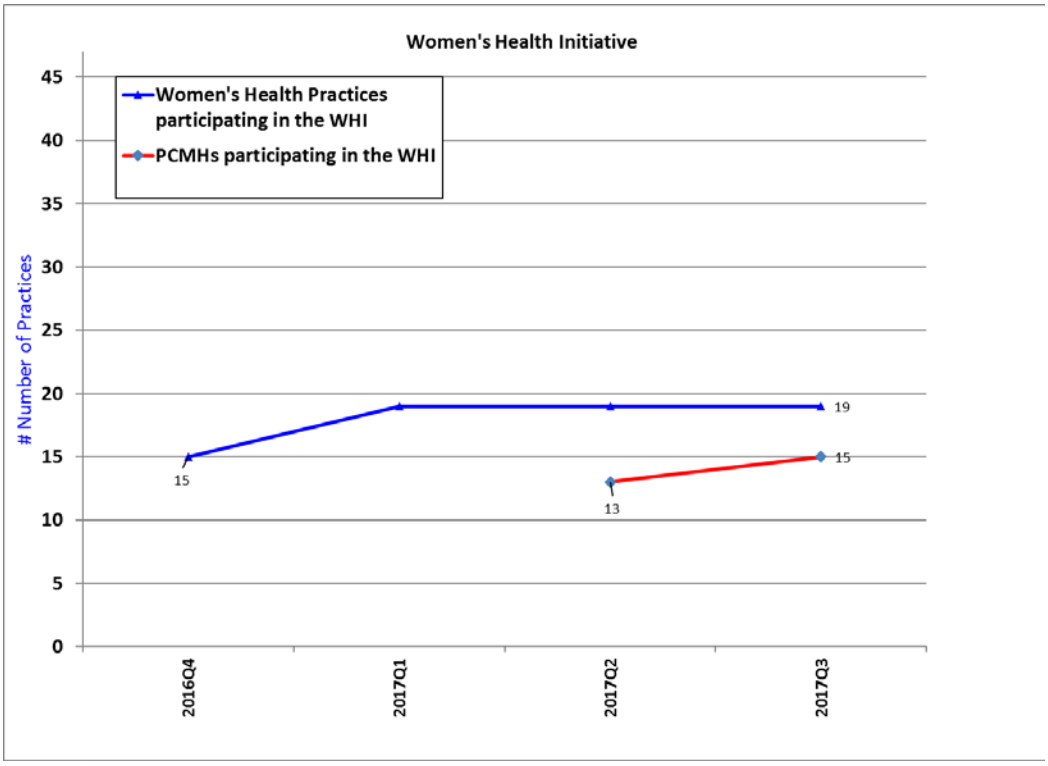



**Figure 6. WHI Implementation January 2017 – September 2017 Staffing & Patients**

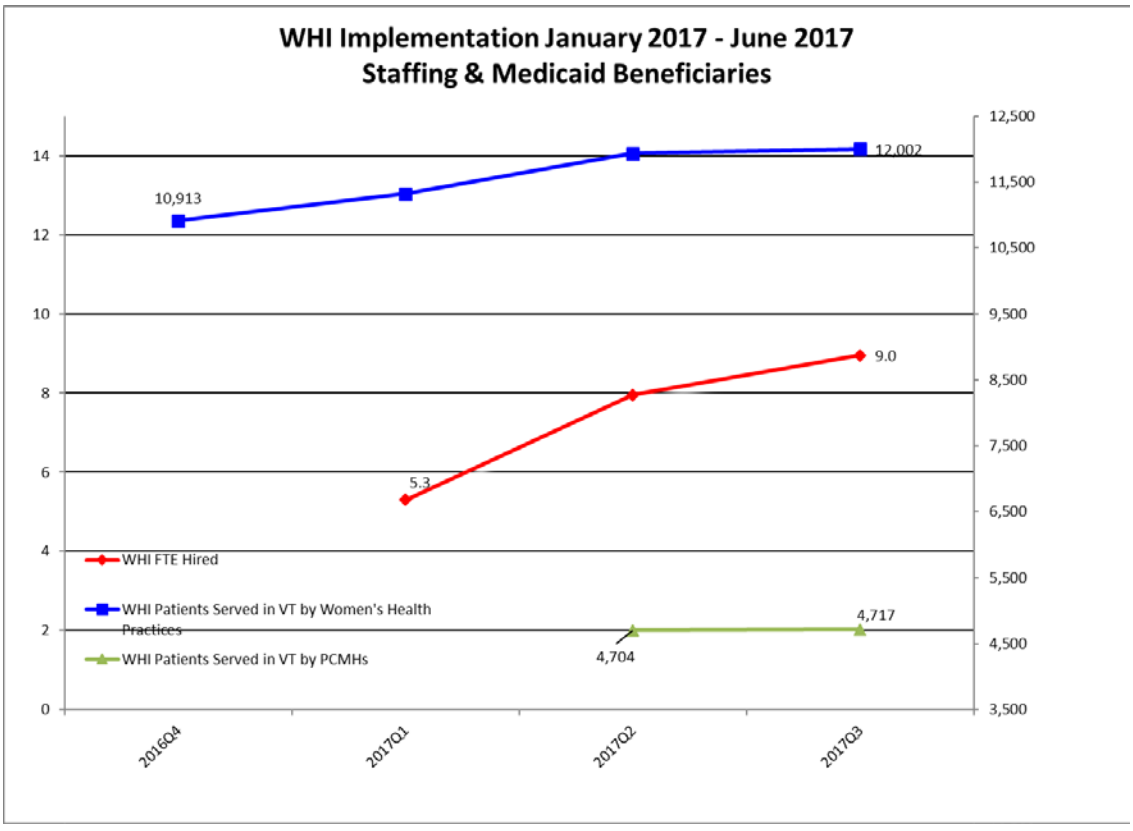


**Table 3. WHI Implementation as of September 30, 2017**

| Region | Total # Women's Health WHI Practices | Total # PCMH WHI Practices | Staff FTE Hired | Medicaid Beneficiaries – Women's Health | Medicaid Beneficiaries - PCMHs |
|---|---|---|---|---|---|
| Barre | 1 | 1 | 0.7 | 1,001 | 415 |
| Bennington | 1 | 1 | 0.5 | 968 | 59 |
| Brattleboro | 1 | 0 | 1 | 412 | 0 |
| Burlington | 4 | 5 | 1 | 2,848 | 1,615 |
| Middlebury | 2 | 0 | 0.5 | 1,037 | 0 |
| Morrisville | 1 | 2 | 0.5 | 532 | 443 |
| Newport | 0 | 0 | 0 | 0 | 0 |
| Randolph | 3 | 0 | 0.5 | 552 | 0 |
| Rutland | 2 | 1 | 1.5 | 1,779 | 193 |
| St. Albans | 2 | 0 | 1 | 1,404 | 0 |
| St. Johnsbury | 1 | 2 | 0.75 | 1,000 | 622 |
| Springfield | 1 | 3 | 1 | 469 | 1,276 |
| Upper Valley | 0 | 0 | 0 | 0 | 0 |
| Windsor | 0 | 0 | 0 | 0 | 0 |
| Total | 19 | 15 | 8.95 | 12,002 | 4,717 |

*iii. Behavioral Health*

**Key updates from QE0917:**

- Applied Behavior Analysis benefit moves forward
- Telepsychiatry protocol established
- Pilot project for inpatient psychiatric care
- Substance abuse residential level of care authorization procedure solidified

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. Training sessions with residential facilities have been provided. 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. Inter-rater reliability testing was completed for the year with a 100 percent success rate. All team members passed the test with the required greater than 85%. The average score was 93%. 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. Weekly status calls with sister departments ensure ongoing communication. The pilot project for administrative authorization for inpatient psychiatric care for children has been in effect for one year. Data has been reviewed. The team evaluated the percentage of admissions requiring administrative authorization, department deficiencies contributing to the need, and costs and practices to mitigate barriers to discharge. The project has been extended.

The Quality Unit also partnered with a provider on a pilot project designed to address inherent challenges in providing strong clinical documentation to justify admission and continued stay within 24 hours of admission. The DVHA will authorize an initial 5 days for assessment, individualized plan of care, and a discharge plan (or summary if discharged within the 5 days.) The Quality unit will closely monitor data to analyze any potential change in utilization.

The protocol that was developed for referral to VCCI to ensure continuity of care for members already enrolled with VCCI that have been admitted to inpatient or residential care facilities has been modified, and the process is running smoothly. A new protocol has been established to allow members access to psychiatric services while inpatient that would not otherwise available.

Behavioral Health Team members continued their 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 (ADAP) 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. The Managed Care Medical Committee is currently modifying Medication Assisted Treatment clinical guidelines.

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 to strengthen and improve the prior authorization process. As a result, there was an approved rate increase. The rate increase does not seem to have enticed new providers. Another survey was conducted. There were billing/coding issues identified and a need for provider education became apparent and was delivered by the Autism

Specialist. Exploration of alternative payment methods continues in an effort to increase the number of members receiving services. The Autism Specialist participates in the Autism Workgroup, which strives toward increasing and improving services for children with autism. The Applied Behavior Analysis Clinical Practice Guideline has been completed and is available to providers.

*iv. Mental Health System of Care*

**Key updates from QE0917:**

- Intensive planning focused on addressing wait times for inpatient beds and improving mental health system of care passed (Act 82).

Addressing Emergency Department Wait Times and Improving the Mental Health System of Care

During this quarter, the Department of Mental Health (DMH) completed the first phase of intensive planning and analysis focused on improving the mental health system of care and, more specifically, addressing the need to reduce the number of people waiting for psychiatric inpatient care in emergency departments, as required by Act 82[1]. Actions completed and findings are described below.

On July 25, 2017 and August 17, 2017, the Department of Mental Health held all day public working meetings to gather input and ideas regarding the analysis required by Act 82 and for producing a corresponding action plan. Participation included, but was not limited to, representatives from the Department of Mental Health Leadership and Staff, the Designated Agencies Leadership and Staff, Hospital Leadership and Medical personnel, Vermont Association of Hospitals and Health Services (VAHHS), Vermont Chapter of the National Alliance of Mental Illness, Vermont Care Partners, Disability Rights Vermont, Vermont Psychiatric Survivors, Consumers and Families, and Legislators[2]. Information presented and discussed during the sessions covered all elements of our system of care, including: data collection, referrals, accessibility and gaps in service, emergency department wait times, demographic trends, gaps in service/staffing, regional care coordination, DMH care coordination, crisis diversion models, previous expansion of services through Act 79, mental health parity, geriatric support, forensic support, and emergency services.

Findings from these planning sessions focused on the growing pressures on the mental health system of care from inpatient to community based have continued to evolve over the last several years. The most recent pressures on inpatient flow and the needs of individuals requiring that level of care and intensive community based plans has been and continues to be a focal point. Some of the key themes continue to be:

- Best engagement strategies and access to care
- Peer supports
- Medicaid funding vs general funds
- Court involvement including voluntary vs. involuntary treatment
- Licensing requirements and restrictions that present as barriers

[1] http://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT082/ACT082%20As%20Enacted.pdf
[2] For more information including PowerPoints from DMH, presentations by participants, meeting notes, written comments and other information please visit: http://mentalhealth.vermont.gov/news/act-82-working-meeting http://mentalhealth.vermont.gov/sites/dmh/files/documents/news/Act82_Working_Meeting_2017-08-17_FINAL.pdf

Several actions and resources continue to be identified as needed components to support intensive levels of care:

1. Increase the capacity of DMH's existing secure residential recovery program to at least 16 beds
2. Examine licensing and rules regarding emergency involuntary procedures
3. Create a forensic unit which could be in a corrections facility, a stand-alone facility, or a new hospital
4. Create additional "Level 1" or Vermont Psychiatric Hospital(VPCH)-type beds, assuring a true "no refusal" system
5. Develop intensive residential programs for treating and maintaining individuals with aggressive behavior
6. Assure crisis beds are fully utilized and explore some alternatives that people are more willing to access.
7. Expand mobile crisis outreach to assure community outreach and appropriately address crisis in community so individuals can be diverted, when appropriate from the ED
8. Continue to explore or build geriatric psychiatric capacity
9. Address the conflicting opinions of involuntary treatment
10. Develop or expand supportive housing that can adequately support people coming out of inpatient or prevent some individuals needing inpatient or crisis services
11. Add resources to assure training in evidence based practices
12. Expand and support peer services
13. Expand mental health treatment court.

For any of the items listed above, DMH will need to develop a budget, identify any law or regulation changes needed, and determine potential location of where the services should be provided.

Next steps from this planning will include:

1. Continue to identify and expand what data is needed from the Vermont's Emergency Departments (ED's), as well as other data elements that will help provide a full picture of current ED, inpatient and other patient flow related issues.
2. Use DMH's existing ED Data subgroup to further understand reasons for referrals to EDs
3. Work with VAHHS to implement prospective collecting of data as it relates to reasons for referral to EDs, need for inpatient and barriers to discharge including gaps in services (and in connect to ED Data subgroup)
4. Work with ED Data subgroup and hospitals to complete current data survey.
5. Use ED subgroup to explore alternatives to ED options, develop budget and identify statute or regulation changes needed
6. Summarize current workforce planning findings and recommendations for final report
7. Work with other facilities report requirements to finalize recommendations on forensic, potentially more inpatient, crisis alternatives, and secure residential
8. Use the current work occurring in Washington County on regional navigation to further develop framework for regional navigation, budget and plan needed to implement state-wide and if that will have any impact or identify changes needed from DMH Care Management Teams
9. Create workgroup to further explore expanding mobile crisis, supportive housing needs and other community based services needed
10. Use work and information from involuntary treatment planning to inform ED and system's improvement planning

11. Continue to develop nursing facilities' options and explore what other options are needed in relation to services for geriatric individuals.

As described in the previous quarterly report, DMH has received proposals from a number of community providers to develop capacity to replace the temporary secure residential recovery program in Middlesex, VT. DMH has chosen to not act on any of these proposals until the Act 82 planning process has been completed and the Vermont legislature has fully reviewed the findings and recommendations.

The analysis and findings from Act 82 will have a significant impact on future planning, development and improvement of the mental health system of care going forward. Results of this planning process will be included in future reports as appropriate.

*v. Integrating Family Services (IFS) Initiative*

**Key updates from QE0917:**

- AHS shifted the internal structure of the Integrating Family Services initiative to more closely align with work being done at the Commissioner level to works towards integration and collaboration both at the agency level and in communities.

Integrating Family Services efforts began in earnest in 2008 with a position created in the Agency of Human Services Secretary's Office in 2010. From the beginning, the intent of integrating services for children and their families revolved around providing services, supports and treatment earlier to ***prevent more intense needs, to achieve better outcomes and spend funding more efficiently***. AHS was able to test the model in two regions while several other important reform efforts began to take shape such as Accountable Care Organizations, an All Payer Model, the State Innovation grant and other important health care and human services reform efforts. During the last several months it has become clear that the lessons learned through IFS need to shift from "testing a model" to the way we do business including more attention on how we operate internally at AHS, so our community partners can achieve positive outcomes for children and their families.

Therefore, as of September 2017, the following shifts occurred within AHS:

- The efforts of IFS were absorbed into the departments and continue; however, the unique identification of an "IFS effort" will end.
- IFS Collaborative Leadership efforts in communities will continue with an increased focus on Local Interagency Teams and Children's Integrated Services teams as the forums to work together on the children's system of care.
- Regular meetings with the Commissioners of DCF, DAIL and DMH as the "executive managers" of children and family services will begin to ensure a cohesive child and family system of care.

AHS continues to be committed to maintaining the gains we have made in the IFS regions and within AHS and would like to improve the current model. The existing IFS grants will continue to be managed through the DMH budget.

Through the IFS grants and larger payment reform work, AHS will continue 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 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. 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 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. A recent analysis occurred of IFS Lessons Learned from these two pilots to inform larger payment reform efforts. The areas analyzed included:

- Financing and Payment Reform
- Collaborative Leadership
- Accountability and Oversight
- State and Local Service Delivery

Each of the IFS grantees are designated agencies and are not allowed to have a waitlist for EPSDT services. Due to an increased need in Franklin County for services for children with autism, the IFS grantee notified AHS in the spring 2017 that they had an increased need for this population and we were able to look at data, service delivery and outcome measures which resulted in an additional allocation from AHS to the IFS grantee. During this fiscal year, the agency will be able to serve an additional 21 children who are in need of services.

The following performance measures were finalized in FY2016 and have been embedded in FY17 grants which means we will have data to analyze by winter 2017. These measures will be utilized as a foundation as we move towards creating more consistent performance measures across the state with those partner agencies providing services to children, youth and families.

# 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<br>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<br>b. % of adolescents in grades 9-12 who drank alcohol before age 13<br>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<br>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<br>2. Number of children served by age<br>3. Number of hours of service<br>4. % of services provided to child/youth with Medicaid | 5. % of children with a plan developed collaboratively with families<br>6. Satisfaction measure from family perspective<br>7. % of children with a plan completed within 90 days of referral<br>8. % of children (Prenatal to 6) that received initial contact within 5 calendar days<br>9. % of children (Prenatal to 6) that had a transition plan (30 or 90 days before transition) upon discharge<br>10. % of children/youth receiving non-emergency service within 7 days of emergency service<br>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<br>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. | | |

*vi. Pharmacy and 340B Drug Discount Program*

**Key updates from QE0917:**

- The Drug Utilization Review Board held a meeting on September 12, 2017. Seven new drugs and six therapeutic classes were reviewed, two RetroDUR reviews and four safety alerts were presented.
- DVHA sent four provider communications out on topics of Point-of-Sale System Black-Out Periods, 2017/2018 Synagis Season Updates, 2017/2018 Influenza Season Updates.

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 (CHC), 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 (CHC) 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, CHC 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
    - Drug Utilization Review/Pharmaceutical & Therapeutics 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 QE0917, the DURB held 1 meeting. 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; 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**
- 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**

### *vii. Vermont Medicaid Shared Savings Program*

**Key updates for QE0917 (CY 2016 final results):**

- CY17 saw the conclusion of the VMSSP's third program year (CY 2016).
- Final ACO financial and quality performance results will be included in the 2017 Global Commitment Annual Report.

The Vermont Medicaid Shared Savings Program (VMSSP) was a three-year program (2014-2016) to test if the accountable care organization (ACO) model in Vermont could help to meet the Triple Aim goals of improving health and quality while also reducing cost. In a shared savings program, the provider network allows the State to track total costs and quality of care for the patients it serves in exchange for the opportunity to share in any savings achieved through better care management. This program was supported by a State Innovation Model (SIM) testing grant and overseen by the Green Mountain Care Board (GMCB) and AHS. Contracts were signed between Vermont Medicaid and the two participating ACOs (OneCare Vermont and Community Health Accountable Care) in February 2014. The program concluded December 31, 2016. Financial and quality performance results from the 2016 performance year (in addition to results from the 2014 and 2015 performance years) will be summarized in the 2017 Global Commitment Annual Report.

### *viii. All Payer Model: Vermont Medicaid Next Generation Program*

**Key updates from QE0917:**

- Quarterly reporting to the legislature began in Q2 and continued in Q3; the program submitted its latest report on September 15, 2017.
- Received Global Commitment Payment Model approval from CMS for the Medicaid Next Generation ACO Model on September 21, 2017.
- DVHA and OneCare continued discussions of potential modifications to the program for a 2018 performance year.
- 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 submitted its second quarterly report on the VMNG program to the Vermont legislature on September 15, 2017. Legislation requires that DVHA report to the legislature on implementation activities and program performance, including data on financial performance, quality performance, operational timeline adherence, utilization monitoring, changes to provider network or size of attributed population, and statistics on member complaints, grievances, and appeals. While information on performance and utilization is helpful to understand how patterns generally compare for members who are attributed to OneCare and members who are not attributed to OneCare, caution should be exercised when using the information presented in this report to evaluate 2017 program performance. Claims lag continues to cause a delay in data availability and analysis, even as the program moves into the final quarter of 2017. As such, DVHA will not have complete information on what services were provided to the attributed population during the reporting period until later in 2017. The full report can be found here: http://legislature.vermont.gov/assets/Legislative-Reports/DVHA-ACT-25-VMNG-ACO-Report-to-Legislature-Sept-15-2017.pdf

Anticipating the launch of OneCare's Medicare Modified Next Generation ACO program in 2018, DVHA began researching whether the benefit enhancements offered under Medicare's Next Generation program are in line with what Vermont Medicaid currently covers under similar services, and exploring possible adjustments to the Medicaid program to ensure better alignment. The state will continue identifying opportunities to align programs across payers in support of its broader efforts to develop an integrated health care delivery system under an All Payer Model.

DVHA and OneCare continue discussions of potential modifications for the CY2018 program year.

## V. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12 of the legislative budget for Global Commitment on the first business day of every month during the September 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.

It should be noted that AHS updated the format of the quarterly Budget Neutrality PMPM Projection vs. 64 Actuals spreadsheet at the start of the new waiver (2017). We are pleased to report that the new format is much easier to update and read from the prior version. It is tied quarterly to the CMS 64 Schedule C Expenditure Report.

Since Vermont reached four consecutive quarters of 3 or less errors, CMS did not perform the VIII Group 30-sample review for QE0617 so there were no prior quarter adjustments related to this for QE0917 on the CMS-64 report.

Our contracted actuarial consultant, Milliman, Inc., provided the rate report and exhibits for calendar year 2018 Medicaid rates for Vermont. The information has been delivered to CMS for review and we will provide additional information to CMS as needed.

## VI. 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 CY2017 including QE0917. 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 4. Member Month Reporting – Calendar Year 2017**

| **Member Month Reporting** | | |
|---|---|---|
| **Demonstration Population** | **Medicaid Eligibility Group** | **Total CY 2017** |
| 1, 4*, 5* | ABD - Non-Medicare - Adult | **73,472** |
| 1 | ABD - Non-Medicare - Child | **22,130** |
| 1, 4*, 5* | ABD - Dual | **190,453** |
| 2 | ANFC - Non-Medicare - Adult | **120,437** |
| 2 | ANFC - Non-Medicare - Child | **547,739** |
| | **Medicaid Expansion** | |
| 7 | Global RX | **63,578** |
| 8 | Global RX | **35,917** |
| 6 | Moderate Needs | **2,222** |
| | **New Adults** | |
| 3 | New Adult without child | **369,542** |
| 3 | New Adult with child | **168,725** |
| | **Total** | **1,594,215** |
| *** Long Term Care Group** | **Total CY 2017** | |
| 4 only | ABD Long Term Care Highest Need | **26,201** |
| 5 only | ABD Long Term Care High Need | **9,792** |

PMPM Capitated Rates

The PMPM rates as set for 04/01/17 – 12/31/17 are listed below.

**Table 5. PMPM Capitated Rates QE0917**

| Medicaid Eligibility Group | | 04-01-17-12/31/17 |
|---|---|---|
| ABD Adult | $ | 1,620.46 |
| ABD Child | $ | 2,642.56 |
| ABD - Dual | $ | 1,959.12 |
| non-ABD Adult | $ | 587.93 |
| non-ABD Child | $ | 428.33 |
| GlobalRx | $ | 85.13 |
| New Adult | $ | 507.66 |
| Moderates | $ | 458.29 |

Investments totaled $35,766,010 for QE0917.

## VII. 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 reported to DVHA (see Attachment 3). Member Services works to resolve the issues raised by beneficiaries, and the reports are seen by several management staff at DVHA.

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 advocate for all Vermonters by providing individual consumer assistance and consumer advocacy on issues related to health insurance and health care.

## VIII. Quality Improvement

**Key updates from QE0917:**

- The MCE's annual formal CMS PIP Summary scored a 100% by the EQRO.
- The Quality Unit continues to build and develop multiple Results Based Accountability (RBA) Scorecards for both internal management and external reporting and communication. The MCE Quality Committee reviewed the Global Commitment Core Performance Measure Set. Recommended informal QI projects resulted.

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 active during QE0917 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 quarter, the Committee continued its annual review of the Global Commitment Core Performance Measure Set, including analysis of the Ambulatory Care ED Visit measure which was broken out for the first time by special health needs sub-populations. The Global Commitment Core Measure Set results for CY 2016 were validated by the EQRO during QE0917. A sub-group of the committee continued to work on developing a social determinant of health measure focused on employment.

The Quality Committee's co-chair presented the Global Commitment Core Measure set scorecard to the Managed Care Medical Committee on September 8, 2017. The MCMC made recommendations for potential improvement projects. These recommendations were presented to the Clinical Utilization Review Board (CURB) meeting on September 20, 2017. After review of the recommendation the Quality Unit plans to engage in two informal quality improvement projects.

The first is Adult Access to Preventative/ Ambulatory Health Services. This measure looks at the percentage of Vermont adults with Medicaid who have had a preventive or ambulatory visit to their physicians. The Quality Unit Integrated Healthcare Director will be the project lead. He has begun research and enrolled in the White Belt training. A team will be identified to join in the project.

The second informal project will be to improve the rate of Chlamydia screenings for women 16-24 years of age. The Quality Assurance Manager will lead this project.

Formal CMS Performance Improvement Project (PIP)

The DVHA Quality Unit continues to partner with the Vermont Department of Health's (VDH) Alcohol and Drug Abuse Program (ADAP), the Blueprint for Health, and the Vermont Medicaid Next Generation ACO on a formal Performance Improvement Project (PIP) focused on initiation and engagement in alcohol and other drug treatment. Quality Unit staff continue to regularly attend the All Field staff meetings (a joint meeting of state-wide Quality Improvement Project Managers) and to work with partners to develop intervention strategies and evaluation measures. The Year One PIP Summary was due to our external quality review organization (EQRO) during QE0917. DVHA's Year One Summary received a score of 100%. Annual Metric = HEDIS Initiation of Alcohol and Other Drug Dependence Treatment (IET) measure.

Quality Measure Reporting

- CMS Medicaid Quality Core Sets - Quality Unit staff collaborated with the Blueprint for Health and submitted our Health Home Core measure sets for FFY 2014 – FFY 2016 by 7/31/17.

Also during QE0917, the Quality Unit and the Data Unit began preparing for the annual end of year Adult and Child Quality Core Set reporting.

- HEDIS - During this time frame DVHA's EQRO validated our HEDIS 2017 measure results. We also continued contract amendment negotiations with our HEDIS vendor. The current 2017 scope of work includes just administrative (claims based) measures. The Quality, Data and Payment Reform units are working together to extend and amend the current contract to include a set of ACO measures, as well as one hybrid measure in 2018.

- 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. During QE0917, the QI Administrator participated in materials review and survey preparation. The survey will be in the field during QE1217, with a summary report due from the vendor to DVHA in January 2018.The Quality Unit reports out on CAHPS survey results using a scorecard tool on the public-facing website.

Collaborative Quality Improvement Projects

The Quality Unit staff 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 substantial impact on this and other performance measures. This work group hosted a full day meeting in September for insurer and hospital clinical case managers entitled "Improving the Quality and Continuity of Care for Vermonters Hospitalized with Mental Illness". Barriers to follow-up care and ideas for improvement were discussed. Next steps with volunteer pilot sites will start during QE1217. 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. Four (4) additional practices are currently being recruited to participate in Cohort 2 of this project. During QE0917 further analysis was performed on the well care visit rates for the practices involved in Cohort 1 compared to the rest of the population. This analysis will continue in QE1217. Metric = HEDIS Adolescent Well Care Visit (AWC) measure.
- The Quality Assurance Manager finished participating on multiple QI projects with the Vermont Department of Health during QE0917. The projects were related to cancer screening and involved a few different types of interventions, including gap-in-care reports to providers and reminder letters for beneficiaries.

Results of these QIPs are currently being evaluated.

Results Based Accountability (RBA) Scorecards

Results Based Accountability (RBA) scorecards are being developed at DVHA 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 Global Commitment 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, the Adult and Child Medicaid Quality Core Measure Sets, MCE Investments and an overall DVHA performance accountability scorecard - which includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services.

Quality Unit staff are registered to take an additional LEAN/RBA internal training series (called Yellow Belt) in January 2018.

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 continue to join monthly operations meetings.

Quality Unit staff received, reviewed and approved the second round of VMNG ACO quality management reports during QE0917. No areas of concern were identified. The Quality staff from DVHA and the VMNG ACO will meet to discuss ongoing QI project planning and collaboration during QE1217.

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. Specifically, the group reviewed sub-competencies, evidence of achieving the competency, and deliverables associated with monitoring performance. Examples include, but were not limited to the following: results are examined, conclusions are drawn and opportunities are identified, activities are considered and action is agreed upon, and implementation plan is initiated and follow up is scheduled. The committee also discussed the utility and feasibility of implementing a staff survey or questionnaire designed to assess the extent to which AHS supports organizational competencies characteristic of high performing organizations that are associated with *monitoring performance*. The group considered issues surrounding the following: sample size and selection process, type of information and how it would be collected, and piloting the survey/questionnaire. During the next quarter, the group will need to prioritize deliverables associated these sub-competencies and determine the role they might play in assessing organizational competencies and implementing a staff survey/questionnaire. Also this quarter, the PAC reviewed a draft GC Investment scorecard to be used to communicate the performance of programs/services that use GC investment funding. The group is looking to establish a standard template that can be used for all GC investments. Group discussions centered around the use of the ClearImpact Scorecard that is currently in use in a majority of the AHS departments and how it might be modified to address the GC investment reporting needs. The group finalized the scorecard

template after piloting a draft version. The new template will be used by all departments going forward.

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, each department will continue to submit financial monitoring data to CMS via this report. In addition, AHS will include with this report evaluative data that highlights the performance of a subset of their investments. Evaluative data appears in the attached ClearImpact GC Investment Scorecards (Attachment 7) and includes the following: investment description (i.e., the goal of the investment, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the investment is achieving its desired goal), results (performance measure rates for most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). This quarter, DAIL and VDH GC Investment scorecards are included as part of this report.

Comprehensive Quality Strategy/State Transition Plan

During this quarter, Vermont submitted their CQS/STP to CMS for review and worked with folks across AHS to incorporate comments submitted as a result of the public notice process, as well as those generated because of a recent Demonstration Evaluation Plan review and Alternative Payment Model applications. By early next quarter, the state also expects to receive CMS feedback on the CQS/STP. All changes will be incorporated in its next CQS/STP submission.

Also during this quarter, the HCBS implementation team continued to review a draft HCBS milestone document from CMS. The group agreed with the milestones offered – but suggested alternative due dates. This document will be shared with CMS during the upcoming quarter – and uploaded to the Liberty system once it is finalized.

Finally, during this quarter, the HCBS Implementation Team continued to work on implementing the site-specific setting assessments developed in the previous quarter. The team reviewed individual program response rates and suggested next steps. The Choices for Care and Traumatic Brain Injury programs sent reminders to providers to complete the survey. Telephonic outreach was conducted by state staff to determine barriers to completing the survey. The group will continue to monitor program response rates and adjust their actions accordingly.

## IX. Compliance

**Key updates from QE0917:**

- EQRO audit on-site review completed

External Quality Review Organization (EQRO) Audit On-site Review Completed

During this quarter, the EQRO visited Vermont to conduct an on-site review of compliance activities. These annual audits follow a three-year cycle of standards. This year's standards included:

- Provider Selection

- Provider Credentialing/re-credentialing
- Information we send to members (notices, handbooks, etc.)
- Member Rights
- Confidentiality
- Member Grievances, Appeals and Fair Hearings
- Subcontractor Relationships and Monitoring

Subject matter experts and managers from several units and departments represented their programs and provided answers and documents to the reviewers. During the review, the auditors discussed some potential required corrective actions as well as some recommendations to make programs stronger.

An analysis of the final audit report will be provided in the 2017 Annual Report.

Also during this quarter, the EQRO visited Vermont to conduct Performance Measure Validation (PMV) activities. The validation activities were conducted as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 1, 2012.* Information was collected using several methods, including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site activities are described as follows: opening session, evaluation of system compliance, overview of data integration and control procedures, and closing conference. A report documenting the result of the PMV activities is due next quarter.

## X. Demonstration Evaluation

During this quarter, AHS executed a contract with an independent vendor and subsequently worked with them to modify the draft evaluation design. An evaluation kickoff meeting was held and the following items were reviewed: overview of demonstration evaluation, alignment between Payment Initiatives, GC Investments, Comprehensive Quality Strategy, and Evaluation, timelines, tasks, and the content of Interim Report #1. The group used the remainder of the meeting time to review potential measures and data availability. To facilitate this work, the groups walked through worksheets targeted to specific evaluation focus areas including IMD, ACO, and Vermont Blueprint for Health. The remainder of the meeting was spent in small group breakout discussions. The groups will continue to complete the data collection plan details for their area of interest through the next quarter.

## XI. 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, for QE0917.

## XII. 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: QE0917 Investments
Attachment 7: Investment Scorecards

## XIII. 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: | Ashley Berliner, Director of Health Care Policy & Planning | |
| | VT Agency of Human Services | 802-578-9305 (P) |
| | 280 State Drive, Center Building | 802-241-0958 (F) |
| | Waterbury, VT 05671-1000 | ashley.berliner@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: November 29, 2017**

**ATTACHMENTS**

# Attachment 1 - Budget Neutrality

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

| | DY 12 – PMPM QE 0317 | QE 0617 | QE 0917 |
|---|---|---|---|
| (A) New Adult Group PMPM Projection | $518.26 | $518.26 | $518.26 |
| (B-1) eligible member months w/ Child | 55,233 | 57,013 | 56,479 |
| (B-2) eligible member months w/o Child | 124,884 | 124,561 | 120,097 |
| (C-1 = (A x B-1) Supplemental Cap 1 w/ Child | $ 28,625,054.58 | $ 29,547,557.38 | $ 29,270,806.54 |
| (C-2 = (A x B-2) Supplemental Cap 1 w/o Child | $ 64,722,381.84 | $ 64,554,983.86 | $ 62,241,471.22 |
| (D-1) New Adult FMAP w/ Child | 54.46% | 54.46% | 54.46% |
| (D-2) New Adult FMAP w/o Child | 86.89% | 86.89% | 86.89% |
| (E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child | $ 15,589,204.72 | $ 16,091,599.75 | $ 15,940,881.24 |
| (E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child | $ 56,237,277.58 | $ 56,091,825.48 | $ 54,081,614.34 |
| Subtotal Federal Share Supplemental Cap 1 | $ 71,826,482.31 | $ 72,183,425.23 | $ 70,022,495.58 |
| Total FFP reported for New Adult Group | $62,816,665.28 | 61,830,391.33 | 54,643,069.28 |
| Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget | $ 9,009,817.03 | $ 10,353,033.89 | $ 15,379,426.31 |

## State of Vermont Global Commitment to Health
## Budget Neutrality PMPM Projection vs 64 Actuals Summary
## November 6, 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 | $ 110,919,944 | $ - | $ - | $ - | $ - | $ 110,919,944 |
| ABD - Non-Medicare - Child | $ 65,442,393 | $ - | $ - | $ - | $ - | $ 65,442,393 |
| ABD - Dual | $ 495,111,141 | $ - | $ - | $ - | $ - | $ 495,111,141 |
| ANFC - Non-Medicare - Adult | $ 77,583,107 | $ - | $ - | $ - | | $ 77,583,107 |
| ANFC - Non-Medicare - Child | $ 294,327,552 | $ - | $ - | $ - | $ - | $ 294,327,552 |
| **Total Expenditures Without Waiver** | **$ 1,043,384,137** | **$ -** | **$ -** | **$ -** | **$ -** | **$ 1,043,384,137** |
| **With Waiver** | | | | | | |
| ABD Non Medicare Adult | $ 278,625,357 | $ - | $ - | $ - | $ - | $ 278,625,357 |
| ABD - Non-Medicare - Child | $ 51,942,039 | $ - | $ - | $ - | $ - | $ 51,942,039 |
| ABD - Dual | $ 180,863,713 | $ - | $ - | $ - | $ - | $ 180,863,713 |
| ANFC - Non-Medicare - Adult | $ 65,565,007 | $ - | $ - | $ - | $ - | $ 65,565,007 |
| ANFC - Non-Medicare - Child | $ 232,820,867 | $ - | $ - | $ - | $ - | $ 232,820,867 |
| Premium Offsets | $ (484,207) | $ - | $ - | $ - | $ - | $ (484,207) |
| Moderate Needs Group | $ 1,035,392 | $ - | $ - | $ - | $ - | $ 1,035,392 |
| Marketplace Subsidy | $ 4,888,047 | $ - | $ - | $ - | $ - | $ 4,888,047 |
| VT Global Rx | $ 9,870,399 | $ - | $ - | $ - | $ - | $ 9,870,399 |
| VT Global Expansion VHAP | $ 256,396 | $ - | $ - | $ - | $ - | $ 256,396 |
| CRT DSHP | $ 7,614,772 | $ - | $ - | $ - | $ - | $ 7,614,772 |
| Investments | $ 104,464,236 | $ - | $ - | $ - | $ - | $ 104,464,236 |
| **Total Expenditures With Waiver** | **$ 937,462,019** | **$ -** | **$ -** | **$ -** | **$ -** | **$ 937,462,019** |
| ***Supplemental Test: New Adult (Gross)*** | | | | | | |
| Limit | $ 278,962,255 | $ - | $ - | $ - | $ - | $ 278,962,255 |
| With Waiver Expenditures | $ 229,696,333 | $ - | $ - | $ - | $ - | $ 229,696,333 |
| *Surplus (Deficit)* | *$ 49,265,922* | *$ -* | *$ -* | *$ -* | *$ -* | *$ 49,265,922* |
| **Waiver Savings Summary** | | | | | | |
| Annual Savings | $ 105,922,118 | $ - | $ - | $ - | $ - | $ 105,922,118 |
| Shared Savings Percentage | 30% | 25% | 25% | 25% | 25% | |
| Shared Annual Savings | $ 31,776,635 | $ - | $ - | $ - | $ - | $ 31,776,635 |
| Total Savings | $ 31,776,635 | $ - | $ - | $ - | $ - | $ 31,776,635 |
| ***Cumulative Savings*** | ***$ 31,776,635*** | ***$ 31,776,635*** | ***$ 31,776,635*** | ***$ 31,776,635*** | ***$ 31,776,635*** | ***$ 31,776,635*** |

*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*

**State of Vermont**
**Department of Vermont Health Access**
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
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[Phone] 802-879-5900

*Agency of Human Services*

# Medicaid Program Enrollment and Expenditures Report

# Q4 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

September 1, 2017

# Key Terms

**Caseload** – Average monthly member enrollment

**MEG** – Medicaid Eligibility Group

**ABD Adult** – Beneficiaries age 19 or older; categorized as aged, blind, disabled, and/or medically needy
**ABD Dual** – Beneficiaries eligible for both Medicare and Medicaid; categorized as aged, 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
**New Adult** - Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL

**Vermont Premium Assistance** - Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL
**Vermont Cost Sharing** - Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL

**ABD Child** – Beneficiaries under age 19; categorized as blind, disabled, and/or medically needy
**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)
**Underinsured Child** – Beneficiaries under age 19 or under with household income 237-312% FPL with other (primary) insurance
**CHIP** – Children's Health Insurance Program – 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 care (ERC)

**PMPM** – Per Member Per Month

# The Department of Vermont Health Access

**Caseload and Expenditure Report ~ All AHS and AoE Medicaid Expenditures**

**All AHS and AoE YTD '17**

| | SFY '17 Appropriated | | | SFY '17 Actuals thru June 30, 2017 | | | |
|---|---|---|---|---|---|---|---|
| | Caseload | Expenses | PMPM | Caseload | Expenses | PMPM | % of Approp. Spent to Date |
| ABD Adult | 8,791 | $ 158,618,312 | $ 1,503.56 | 8,470 | $ 150,586,971 | $ 1,481.66 | 94.94% |
| ABD Dual | 17,758 | $ 229,776,003 | $ 1,078.28 | 17,601 | $ 214,721,288 | $ 1,016.60 | 93.45% |
| General Adult | 15,848 | $ 95,900,502 | $ 504.26 | 15,140 | $ 89,853,697 | $ 494.58 | 93.69% |
| New Adult | 59,021 | $ 285,093,609 | $ 402.53 | 60,102 | $ 293,599,896 | $ 407.09 | 102.98% |
| Vermont Premium Assistance | 15,831 | $ 6,065,475 | $ 31.93 | 17,961 | $ 6,100,378 | $ 28.30 | 100.58% |
| Vermont Cost Sharing | 5,358 | $ 1,232,289 | $ 19.17 | 5,816 | $ 1,355,318 | $ 19.42 | 109.98% |
| ABD Child | 2,490 | $ 83,165,401 | $ 2,783.31 | 2,368 | $ 71,540,812 | $ 2,517.36 | 86.02% |
| General Child | 60,003 | $ 295,934,148 | $ 411.00 | 60,114 | $ 295,676,075 | $ 409.88 | 99.91% |
| Underinsured Child | 833 | $ 2,415,745 | $ 241.72 | 845 | $ 2,440,929 | $ 240.87 | 101.04% |
| CHIP | 5,280 | $ 12,130,576 | $ 191.45 | 5,142 | $ 11,615,325 | $ 188.25 | 95.75% |
| Pharmacy Only | 11,640 | $ 6,266,029 | $ 44.86 | 11,399 | $ 3,155,724 | $ 23.07 | 50.36% |
| Choices for Care | 4,310 | $ 225,786,465 | $ 4,365.92 | 4,290 | $ 225,042,484 | $ 4,371.28 | 99.67% |
| Total Medicaid Claims Paid | 207,163 | $ 1,402,384,554 | $ 564.12 | 209,247 | $ 1,365,875,586 | $ 543.97 | 97.40% |

# The Department of Vermont Health Access

**Caseload and Expenditure Report ~ All AHS Medicaid Expenditures**

**All AHS YTD '17**

| | SFY '17 Appropriated | | | SFY '17 Actuals thru June 30, 2017 | | | |
|---|---|---|---|---|---|---|---|
| | Caseload | Expenses | PMPM | Caseload | Expenses | PMPM | % of Approp. Spent to Date |
| ABD Adult | 8,791 | $ 157,169,654 | $ 1,489.83 | 8,470 | $ 149,149,847 | $ 1,467.52 | 94.90% |
| ABD Dual | 17,758 | $ 229,528,791 | $ 1,077.12 | 17,601 | $ 214,594,895 | $ 1,016.00 | 93.49% |
| General Adult | 15,848 | $ 95,676,736 | $ 503.08 | 15,140 | $ 89,701,744 | $ 493.75 | 93.76% |
| New Adult | 59,021 | $ 285,046,469 | $ 402.47 | 60,102 | $ 293,487,912 | $ 406.93 | 102.96% |
| Vermont Premium Assistance | 15,831 | $ 6,065,475 | $ 31.93 | 17,961 | $ 6,100,378 | $ 28.30 | 100.58% |
| Vermont Cost Sharing | 5,358 | $ 1,232,289 | $ 19.17 | 5,816 | $ 1,355,318 | $ 19.42 | 109.98% |
| ABD Child | 2,490 | $ 66,398,766 | $ 2,222.18 | 2,368 | $ 55,658,763 | $ 1,958.51 | 83.82% |
| General Child | 60,003 | $ 264,618,665 | $ 367.51 | 60,114 | $ 263,519,747 | $ 365.31 | 99.58% |
| Underinsured Child | 833 | $ 1,971,880 | $ 197.31 | 845 | $ 2,009,308 | $ 198.27 | 101.90% |
| CHIP | 5,280 | $ 10,766,803 | $ 169.93 | 5,142 | $ 9,872,896 | $ 160.01 | 91.70% |
| Pharmacy Only | 11,640 | $ 6,266,029 | $ 44.86 | 11,399 | $ 3,155,724 | $ 23.07 | 50.36% |
| Choices for Care | 4,310 | $ 225,779,225 | $ 4,365.78 | 4,290 | $ 225,039,504 | $ 4,371.23 | 99.67% |
| Total Medicaid Claims Paid | 207,163 | $ 1,350,520,781 | $ 543.26 | 209,247 | $ 1,313,832,726 | $ 523.24 | 97.28% |

# The Department of Vermont Health Access

**Caseload and Expenditure Report ~ DVHA Only Medicaid Expenditures**

**DVHA YTD '17**

| | SFY '17 Appropriated | | | SFY '17 Actuals thru June 30, 2017 | | | |
|---|---|---|---|---|---|---|---|
| | Caseload | Expenses | PMPM | Caseload | Expenses | PMPM | % of Approp. Spent to Date |
| ABD Adult | 8,791 | $ 70,363,336 | $ 666.98 | 8,470 | $ 68,865,433 | $ 677.58 | 97.87% |
| ABD Dual | 17,758 | $ 57,665,231 | $ 270.61 | 17,601 | $ 52,597,445 | $ 249.02 | 91.21% |
| General Adult | 15,848 | $ 82,715,184 | $ 434.93 | 15,140 | $ 77,460,396 | $ 426.37 | 93.65% |
| New Adult | 59,021 | $ 255,945,079 | $ 361.38 | 60,102 | $ 264,105,297 | $ 366.19 | 103.19% |
| Vermont Premium Assistance | 15,831 | $ 6,065,475 | $ 31.93 | 17,961 | $ 6,100,378 | $ 28.30 | 100.58% |
| Vermont Cost Sharing | 5,358 | $ 1,232,289 | $ 19.17 | 5,816 | $ 1,355,318 | $ 19.42 | 109.98% |
| ABD Child | 2,490 | $ 24,874,655 | $ 832.49 | 2,368 | $ 23,032,607 | $ 810.47 | 92.59% |
| General Child | 60,003 | $ 153,506,519 | $ 213.19 | 60,114 | $ 153,917,906 | $ 213.37 | 100.27% |
| Underinsured Child | 833 | $ 1,210,126 | $ 121.09 | 845 | $ 1,095,901 | $ 108.14 | 90.56% |
| CHIP | 5,280 | $ 9,400,484 | $ 148.37 | 5,142 | $ 7,893,710 | $ 127.94 | 83.97% |
| Pharmacy Only | 11,640 | $ 6,266,029 | $ 44.86 | 11,399 | $ 3,155,724 | $ 23.07 | 50.36% |
| Choices for Care | 4,310 | $ 223,201,934 | $ 4,315.94 | 4,290 | $ 222,772,830 | $ 4,327.20 | 99.81% |
| Total Medicaid Claims Paid | 207,163 | $ 892,446,342 | $ 359.00 | 209,247 | $ 882,539,930 | $ 351.48 | 98.89% |

**State of Vermont**
**Department of Vermont Health Access**
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*Agency of Human Services*

## Questions, Complaints and Concerns Received by Health Access Member Services
## July 1, 2017 – September 30, 2017

**July 3 – July 7**
- VPharm/VPharm Review/Reinstatements

**July 10 – July 14**
- Nothing to report

**July 17 – July 21**
- VPharm/VPharm Review/Reinstatements

**July 24 – July 28**
- Nothing to report.

**July 31 – August 4**
- Nothing to report.

**August 7 – August 11**
- Nothing to report

**August 14 – August 18**
- Nothing to report.

**August 21 – August 25**
- VPharm/VPharm Review/Reinstatements

**August 28 – September 1**
- VPharm/VPharm Review/Reinstatements

**September 4 – September 8**
- Nothing to report

**September 11 – September 15**
- Nothing to report.

**September 18 – September 22**
- VPharm/VPharm Review/Reinstatements

**September 25 – September 29**

- VPharm/VPharm Review/Reinstatements

VERMONT

Agency of Human Services

# Grievance and Appeal Quarterly Report
# Medicaid Managed Care Model
# All Departments Combined Data
# July 1, 2017 – September 30, 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 October 19, 2017, from the centralized database that were filed from July 1, 2017 through September 30, 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 16 grievances filed; eleven 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, 89% were filed by beneficiaries and 11% were filed by a representative of the beneficiary. Of the 16 grievances filed, DMH had 78%, DAIL had 5% and DVHA had 17%. There were no grievances filed for VDH or DCF during this quarter.

Grievances were filed for service categories case management, community support, employment, long term care, mental health, psychiatric and transportation.

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.

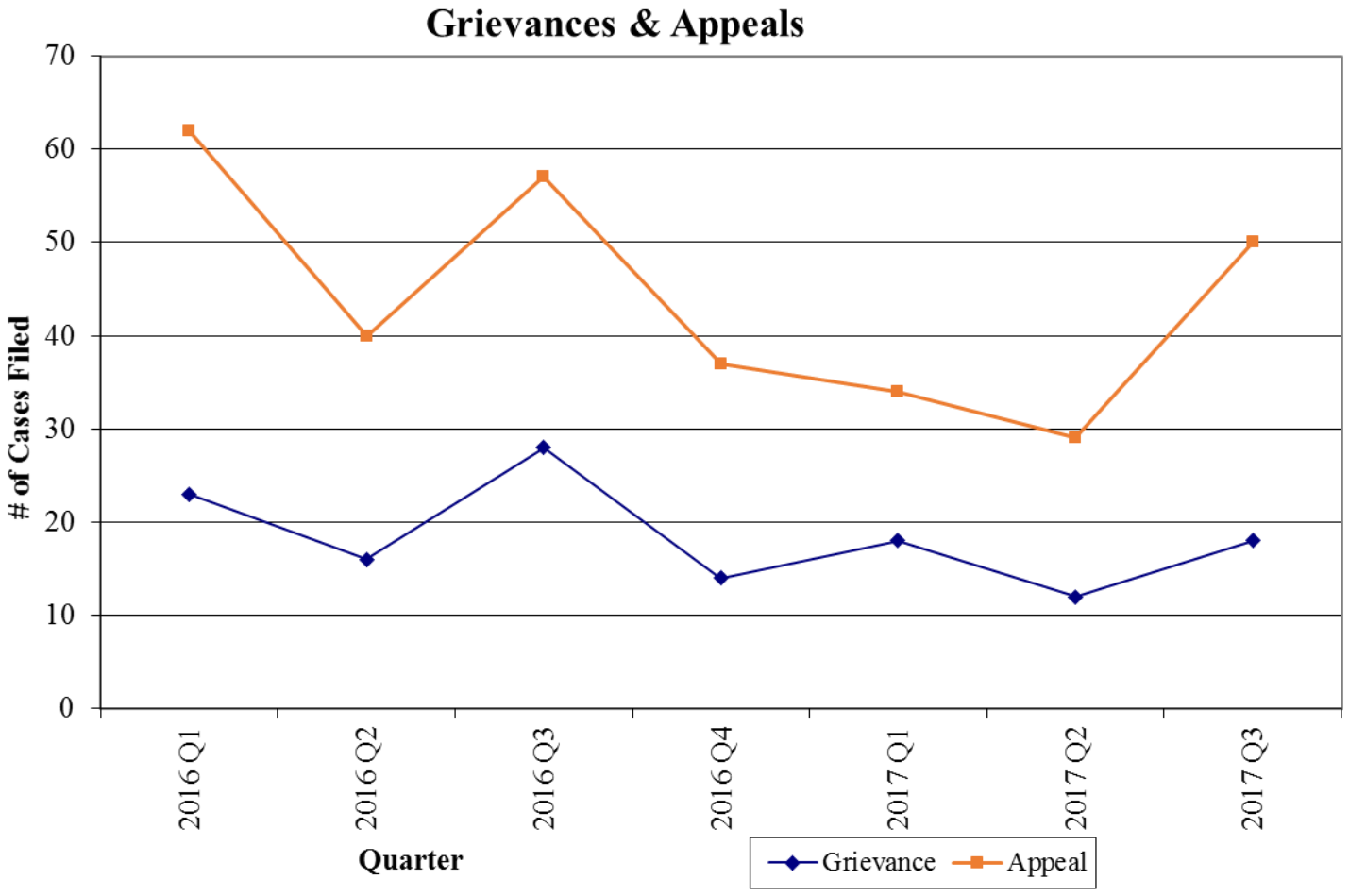
During this quarter, there were 40 appeals filed; 6 requested an expedited decision with one of them meeting criteria. Of these 40 appeals, 23 were resolved (58% of filed appeals), 16 were still pending (40%), and one was withdrawn (2%).

Of the 23 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 76% 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 40 appeals filed, DVHA had 13 appeals filed (26%), and DAIL had 21 (42%), DMH had 1 (2%) and VDH had 5 (10%).

The appeals filed were for service categories; long term care, respite, personal care, orthodontics, home health, nursing, prescriptions, transportation, surgical, community supports, chiropractic, supplies/equipment and mental health.

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.



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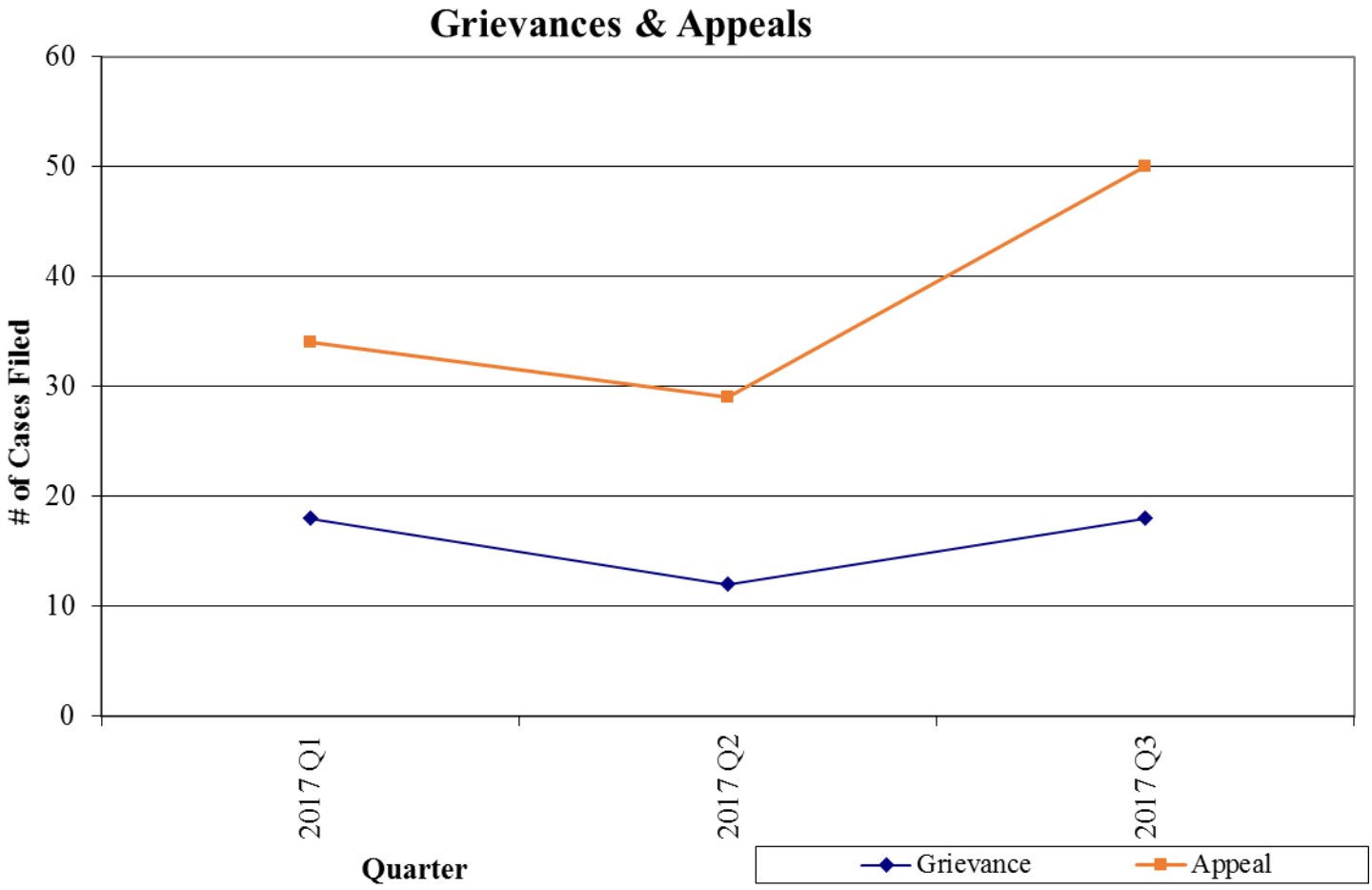
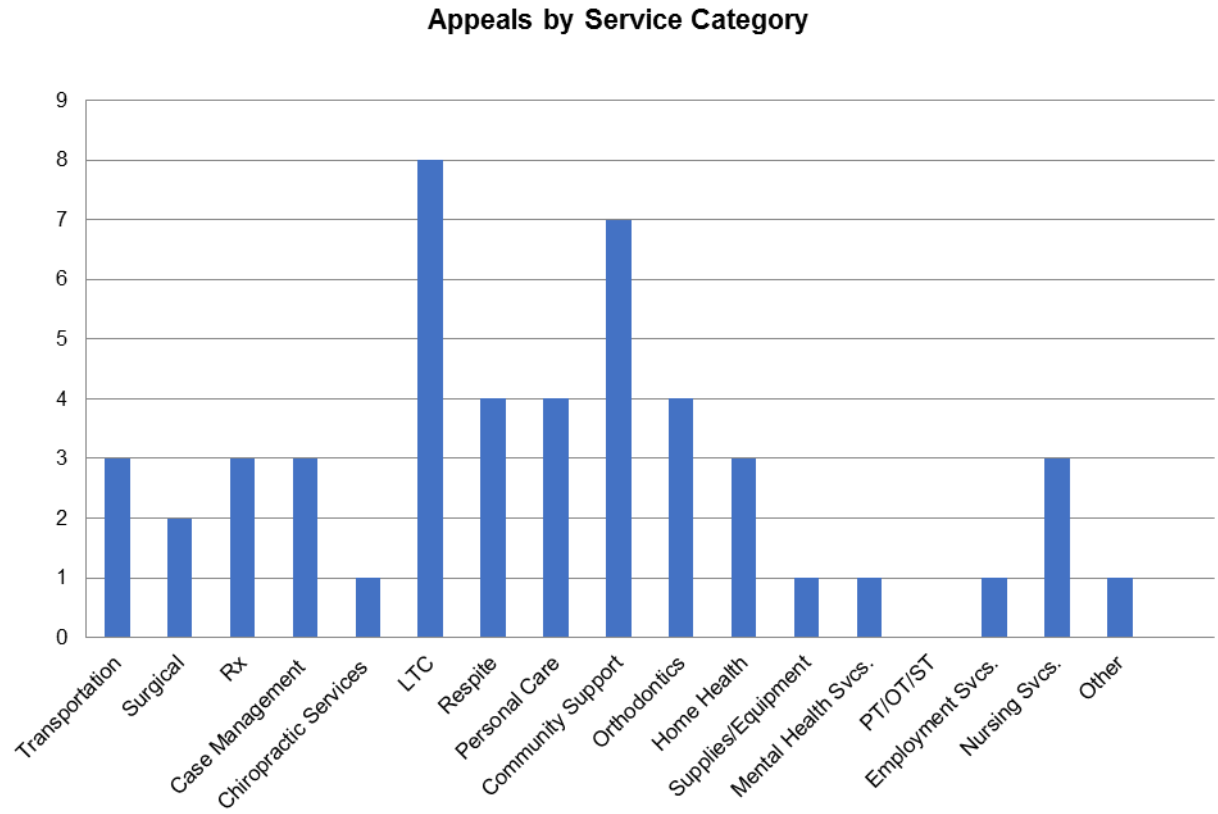
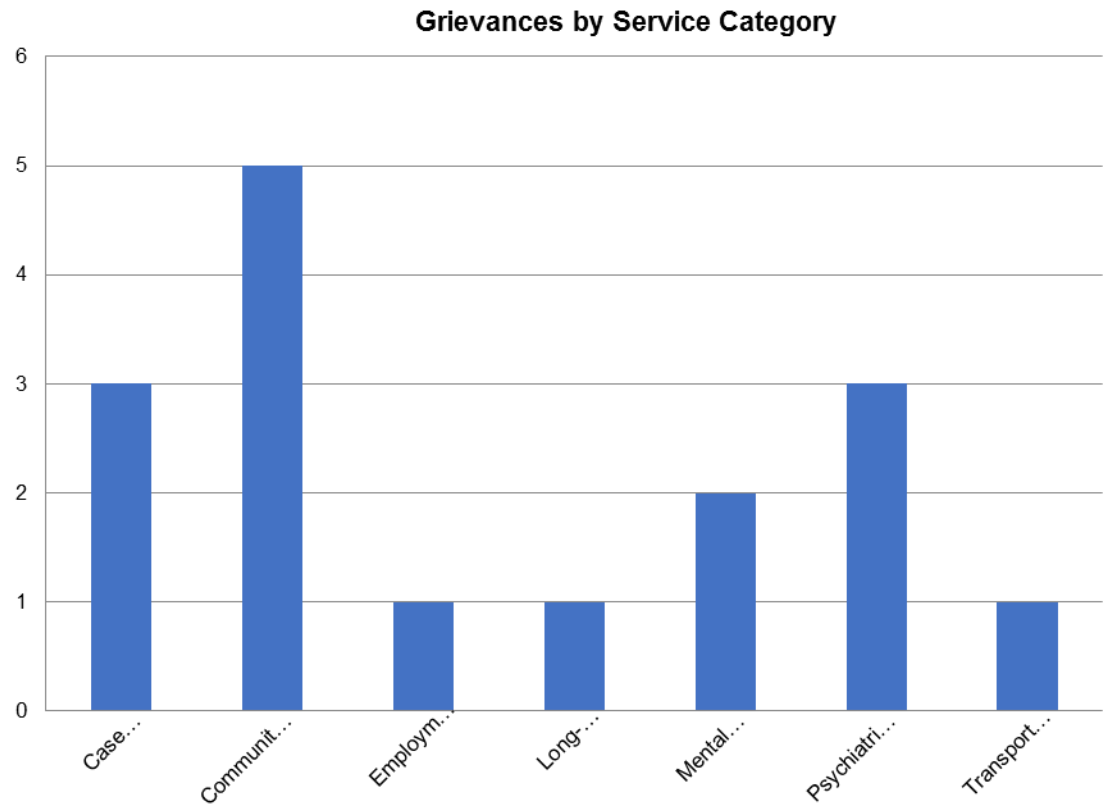
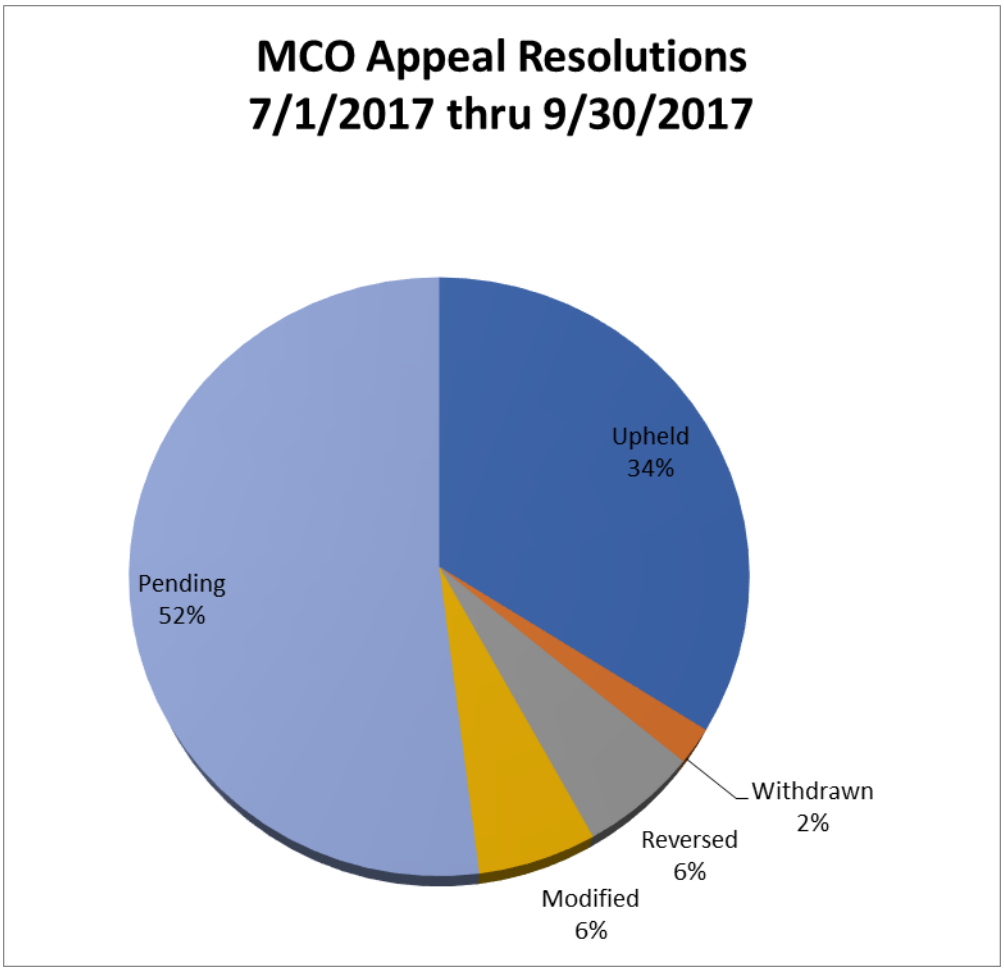

Grievances & Appeals
60
50
40
30
20
10
0
# of Cases Filed
2017 Q1
2017 Q2
2017 Q3
Quarter
Grievance
Appeal


Appeals by Service Category
9
8
7
6
5
4
3
2
1
0
Transportation
Surgical
Rx
Case Management
Chiropractic Services
LTC
Respite
Personal Care
Community Support
Orthodontics
Home Health
Supplies/Equipment
Mental Health Svcs.
PT/OT/ST
Employment Svcs.
Nursing Svcs.
Other


Grievances by Service Category
6
5
4
3
2
1
0
Case...
Communit...
Employm...
Long-...
Mental...
Psychiatri...
Transport...


MCO Appeal Resolutions
7/1/2017 thru 9/30/2017
Upheld
34%
Withdrawn
2%
Reversed
6%
Modified
6%
Pending
52%

**Attachment 5**

Vermont Legal Aid

# Office of the Health Care Advocate

Quarterly Report

July 1, 2017- September 30, 2017

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

October 20, 2017

Vermont Legal Aid

Working for Justice

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# Introduction

The Office of the Health Care Advocate (HCA) advocates for all Vermonters by combining individual consumer assistance and consumer advocacy on issues related to health insurance and health care. We engage in a variety of consumer protection activities on behalf of the public, including appearing 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 4 years. This report shows continued improvement and stabilization at VHC. The number of VHC calls dropped by 23% this quarter. VHC cases also tend to be more complicated and time-consuming. This quarter, 39% of VHC cases were "complex interventions" that took more than two hours of an advocate's time to resolve. With improved VHC functioning, we have been able to offer more in-depth supports for a broader number of cases.

We have continued to work on our website to make it accessible to more Vermonters. This quarter we expanded our new online health care tool. This tool gives consumers a way to get an answer to their specific health questions. 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 also put significant work into the rate review process this quarter, arguing that the proposed insurance rates were too high and that they would result in significant loss of affordability for many Vermonters.

With the recent decision by President Trump to stop making cost-sharing reduction payments, many Vermonters are uncertain and confused. The HCA is committed to helping Vermonters navigate the health care system during this confusing and anxious time. Our goal remains the same: increase access to affordable, high quality health care for all Vermonters. Today's uncertainty makes the role of the HCA even more essential.

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 Annabelle's experience described in the case narrative at right. 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.

## Annabelle's Story

Annabelle called in a panic. She had just gotten a letter from her substance abuse clinic, telling her that she was being dismissed as a patient. There was no other clinic in her area. She was taking methadone and desperately trying to get her life back together. The letter said that she was being dismissed because she had missed her counseling appointments. The advocate talked with her and found that Annabelle had missed appointments because she was overwhelmed: her landlord was trying to evict her; she had temporarily lost custody of her children; she was struggling with depression; the counselor she'd been working with had suddenly left, and so she was trying to adjust to a new counselor. All these factors caused her to miss some appointments. The HCA advocate intervened and asked the clinic to reconsider. He showed that Annabelle had a strong commitment to going to counseling. He also reviewed the clinic notes and he showed that Annabelle had tried to call ahead to cancel and re-schedule some of the missed appointments. In light of this evidence the clinic reconsidered its decision and allowed Annabelle to stay on as a patient.

# Individual Consumer Assistance

## Case Examples

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

**Lucy's Story**

Lucy was in the hospital for about a month, and when she got home she found a letter from the State of Vermont telling her that her Medicaid was ending that week. She was also on a Medicare Savings Program—a program paying for her Medicare Part B premium and Medicare cost-sharing—which was scheduled to close as well. She needed to fill prescriptions, but her income was less than $1000 per month. When the advocate investigated, she found that Lucy's Medicaid and Medicare Savings program were scheduled to close because Lucy had not sent in paperwork confirming her income. The State of Vermont, however, had not sent Lucy an adequate notice explaining why the programs were closing, and did not inform Lucy of her right to appeal the decision. Because of this failure the HCA advocate argued that neither program could be closed without a proper notice. The State of Vermont agreed to reinstate both programs.

**Taylor's Story**

Taylor called the HCA because he lost his job. He was on a Qualified Health Plan (QHP) with Vermont Health Connect (VHC); when he reported his job loss to VHC, he was told he was now eligible for Medicaid. Still, nothing had happened since the phone call. He did not have Medicaid, and even worse, his premium for his QHP had increased. When the advocate researched the issue, he found Taylor had been 'temporarily' approved for Medicaid. But the process for getting him on Medicaid had not been completed. His QHP also not been closed. So instead of being on Medicaid, Taylor was still on the QHP and being charged full price. The HCA advocate intervened to get the QHP closed, and to get the Medicaid activated.

**Abby's Story**

Abby called VHC to make her monthly premium payment but she was told that her plan was closed. She had an appointment scheduled with her doctor, which would be cancelled if her coverage was not active. The HCA advocate investigated and found that Abby had called VHC a couple weeks earlier because she had received a partial payment notice. The notice told her that she had not made her full monthly premium payment. She was confused because she had made the full payment on the invoice. In that call, she was told that the notice was incorrect. She was also given an amount to pay. The HCA advocate found that VHC's advice was incorrect. Abby actually was in a grace period because she was behind on her premium payments. VHC gave her a wrong amount to pay to get caught up. Her invoices also did not reflect what she actually owed. The advocate argued that VHC's errors caused Abby's coverage to be closed. VHC agreed to reinstate the coverage, which meant that Abby was able to keep her appointment with her doctor.

**Phoebe's Story**

Phoebe called the HCA because she received a bill for over $500 for a recent mammogram. This was her first mammogram, and she was surprised by the large bill because she thought that the mammogram would be covered by her insurance. Vermont has a law that requires screening mammography, including additional views, to be covered without cost-sharing. The advocate researched Phoebe's case and found that her mammogram had been coded as diagnostic. This was why Phoebe was getting the bill for it. The advocate intervened with Phoebe's insurance carrier and explained that that the screening mammogram should be covered. The carrier agreed and they covered the mammogram, saving Phoebe more than $500.

**Dexter's Story**

Dexter called the HCA because he did not understand his invoice from VHC. Dexter was first on a VHC plan in 2015. He closed the coverage that year because he could not afford the payments. He did not sign up again until 2017, when he chose a new plan and was told that his monthly payment would be about $400. Dexter started making his monthly payments but his invoice showed a balance due each month. When the HCA advocate looked into it she found that VHC had been incorrectly applying payments from 2017 to his 2015 balance. This made it look like Dexter was behind for 2017. Because Dexter actively signed up for new coverage, VHC should not have been applying payments to 2015. The 2015 balance should not have carried over to the 2017 bill. The advocate was able get Dexter's 2017 payments applied to his 2017 coverage. After the payments were applied correctly Dexter was up to date and current in his payments for 2017. The advocate was also able to investigate the 2015 balance—and found that it should have been much smaller than what VHC was charging Dexter. This meant that he would be able to catch up on that balance also.

**Jerome's Story**

Jerome called because his monthly premium from VHC had almost doubled. He could not afford to pay the premium and did not understand why his premium had jumped so suddenly. The HCA advocate investigated and found that VHC had requested an income verification from Jerome, and Jerome had sent in a copy of a pay stub to verify his income. VHC, however, scanned the pay stub into the wrong record. This made it look like Jerome had not verified his income, so VHC terminated the subsidies that were helping Jerome pay his monthly premium. The advocate got the subsidies reinstated back to when they were terminated, which meant Jerome could afford to pay his premium again.

**Katelyn's Story**

Katelyn called the HCA because her Medicaid had closed and she was unsure why. When the HCA advocate investigated, he found that VHC sent her a notice telling her that Medicaid was closing. The notice, however, did not explain why Medicaid was closing. Under VHC's eligibility rules, closure notices are required to contain an explanation of why the program is being closed. The

advocate argued that the notice was not legally adequate, and asked for VHC to reinstate the coverage. VHC agreed the notice was not adequate and reinstated the coverage.

## 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 825 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:

- **24.85%** (205) about **Access to Care**
- **12.24%** (101) about **Billing/Coverage**
- **1.33%** (11) about **Buying Insurance**
- **10.79%** (89) about **Consumer Education**
- **26.42%** (218) about **Eligibility** for state and federal programs
- **24.36%** (201) 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 218 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, a total of 359 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.

The full quarterly report for July 1- September 30, 2017 includes:

- This narrative, which contains sections on **Individual Consumer Assistance**, **Consumer Protection Activities** and **Outreach and Education**

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

- Seven data reports, including three based on the caller's insurance status:
  - **All calls/all coverages**: 825 calls (compared to 861 last quarter)
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 241 calls (278 calls last quarter)
  - **Commercial plan beneficiaries**: 166 calls (155 calls last quarter)
  - **Uninsured Vermonters**: 74 calls (112 calls last quarter)
  - **Vermont Health Connect (VHC)**: 231 calls (300calls last quarter)
  - **Reportable Activities (Summary & Detail)**: 340 activities and 209 documents (74 activities and 27)

## Priorities

### A. The HCA continued to work on the implementation of Act 25 of 2013.

The HCA has been working to ensure that Act 25 of 2013 has been fully implemented. The statute requires that screening mammography, including additional views, be covered without cost-sharing. We have launched outreach about this issue in local news and the social media. This quarter we had 11 mammography cases and have saved consumers hundreds of dollars. We expect to save more money for consumers when all the current cases are resolved. We also expect to see more cases as consumers learn about this issue.

### B. More consumers are using the HCA's expanded Online Help Tool.


*Explore our Online Tool by clicking the hyperlink in the image above and navigating to our Health tab.*

Last quarter, the HCA developed a new online tool to help consumers get answers to their specific health care questions. The online help tool (accessible by clicking the button that appears on every page of the Vermont Law Help website, pictured at left) adds a new way to access helpful information – at all hours of the day and night.

This quarter the HCA added even more content to the tool, including a section on filing provider complaints. We had a 66% increase in page views. The most popular sections this quarter were about denials of coverage and information about Medicare and how it works.

### C. The HCA participated in outreach efforts to help H-2A farmworkers learn about the ACA and get coverage.

As part of our effort to reach vulnerable populations, HCA advocates participated in outreach to local H-2A farm workers. They visited farms in Chittenden and Addison counties to help educate workers about the Affordable Care Act. They provided education about the requirements under the ACA, answered eligibility questions about signing up for coverage, and provided assistance in signing up for coverage.

### D. The HCA collaborated with SHIP (the State Health Insurance Assistance Program) to conduct outreach about Medicare and Health Savings Accounts (HSA).

As HSAs continue to grow in popularity with consumers, both the HCA and SHIP have encountered Vermonters who have had difficulties when transitioning to Medicare. SHIP is a federally-funded program administered by the Vermont Area Agencies on Aging to assist Medicare beneficiaries with Medicare and other health insurance issues. Once you enroll in Medicare, you can't make deposits in your HSA. Your employer also can't make deposits. The HCA and SHIP have worked with consumers surprised by this rule, and by other issues regarding the transition to Medicare. The HCA produced a four-page educational handout to answer questions and warn consumers about common problems related to HSAs and Medicare. We shared the handout around the state, and have made it available on our website at the following address: *https://vtlawhelp.org/sites/default/files/HSA-and-Medicare-handout-7-13-2017.pdf*.

### E. Overall call volume dropped slightly this quarter.

The total call volume dropped slightly quarter (825 vs. 861). Nearly 11% of those calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We saved consumers $130,863 this quarter. With the Open Enrollment Period for Vermont Health Connect starting November 1, 2018, the HCA anticipates a jump in VHC calls next quarter.

| | 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 | 240 |
| **May** | 195 | 207 | 213 | 205 | 253 | 242 | 228 | 324 | 327 | 325 | 332 |
| **June** | 254 | 245 | 276 | 250 | 286 | 223 | 240 | 344 | 303 | 339 | 289 |
| **July** | 211 | 205 | 225 | 271 | 239 | 255 | 271 | 381 | 362 | 304 | 278 |
| **August** | 250 | 152 | 173 | 234 | 276 | 263 | 224 | 342 | 346 | 343 | 280 |
| **September** | 167 | 147 | 218 | 310 | 323 | 251 | 256 | 374 | 307 | 372 | 267 |
| **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 | 2664 |

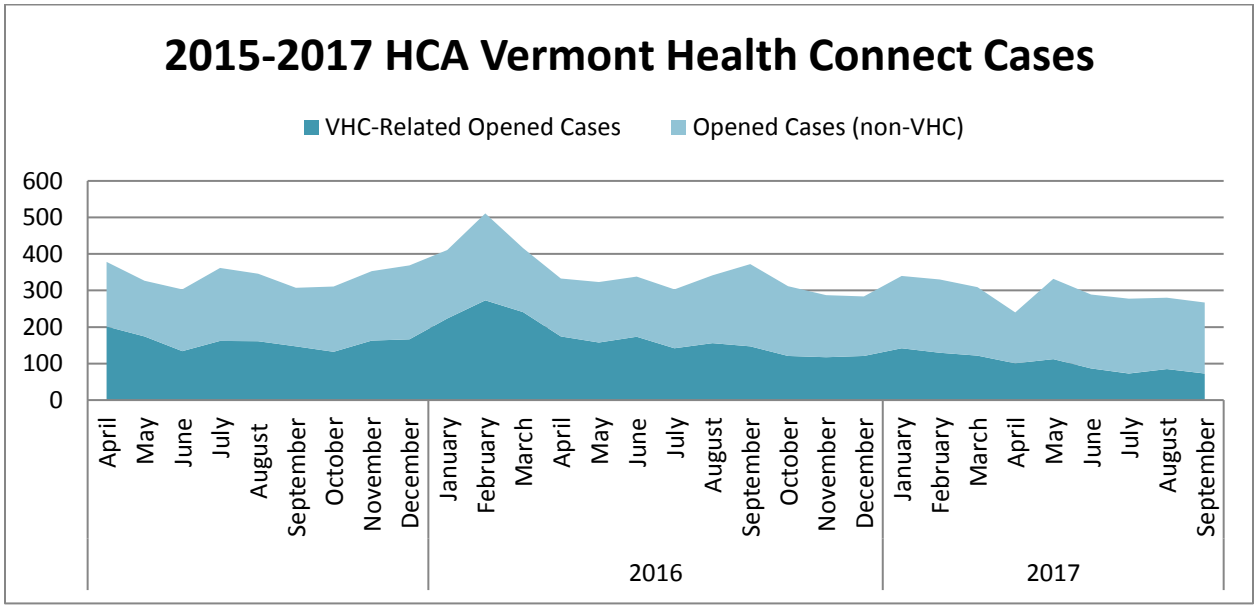
### F. Calls concerning Vermont Health Connect continued to decrease.

The volume of calls concerning Vermont Health Connect decreased by 23%, compared to the previous quarter (231 vs. 300). VHC calls have decreased steadily this year over the past three quarters (394 to 300 to 231). The decrease in VHC cases reflects that VHC is functioning more consistently and resolving problems more quickly. VHC cases now represent 27% of all HCA calls, which is also a drop: in previous quarters, VHC cases made up 30% to 40% of our overall cases. Of all VHC cases this quarter, 90 required

complex interventions that took more than two hours of an advocate's time to resolve, and 38 required a direct intervention to resolve the case. With open enrollment starting on November 1, we expect a jump in Vermont Health Connect calls next quarter.

The HCA continues to resolve its cases by working directly with Tier 3 Health Access Eligibility Unit (HAEU) workers, who are 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. This quarter, the HCA escalated 44 complex cases to Tier 3. (compared to 49 last quarter); 34 were resolved within the quarter.

This quarter, Tier 3 also expanded the types of cases that it resolves. It now works on resolving Green Mountain Care cases (VPharm, Medicaid for Aged Blind and Disabled, Medicare Saving Programs, and Medicaid Spenddowns). We have met regularly to ensure that the escalation process is working and that the cases are being resolved quickly and efficiently.




## G. Medicaid eligibility calls represented 19% of all our cases (156 calls/ 825 total calls). Consumers need assistance with all types of Medicaid.

Medicaid eligibility was again the top issue generating calls. We had 77 calls about eligibility for MAGI (expanded) Medicaid, 45 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), and 34 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.

## 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 825 (compared to 861 last quarter)

1. Complaints about providers 87 (78)
2. MAGI Medicaid eligibility 77 (84)
3. Information/applying for DVHA programs 60 (48)
4. Medicaid eligibility (non-MAGI) 45 (72)
5. Access to prescription drugs/pharmacy 41 (53)
6. Buy-in programs/Medicare Savings Programs 40 (47)
7. Fair hearing appeals 39 (44)
8. VHC invoice/billing problem affecting eligibility 37 (39)
9. Termination of insurance 36 (63)
10. Eligibility for VHC grace periods 35 (43)
11. Information about VHC 35 (31)
12. Other: Not health related 35 (50)
13. Medicaid spend down (eligibility) 34 (29)
14. VHC Premium Tax Credit eligibility 34 (55)
15. Special enrollment periods (eligibility) 33 (40)
16. Affordability affecting access to care 32 (39)
17. Hospital billing 31 (21)
18. Consumer education about Medicare 31 (37)
19. VPharm eligibility 28 (21)
20. Confusing notice 27 (20)
21. Nursing home complaint 24 (18)
22. Provider error/medical malpractice 23 (16)
23. Choosing/changing providers 22 (14)
24. Change of Circumstance 22 (34)
25. Medicaid/VHAP Managed Care billing 22 (13)
26. Provider billing problems 22 (18)
27. Hospital financial assistance 22 (23)
28. Info about HCA 21 (21)
29. HAEU mistake 21 (28)
30. Access to nursing home care 21 (14)

### Vermont Health Connect Calls 231 (compared to 300 last quarter)

1. MAGI Medicaid eligibility 66 (74)
2. VHC invoice/payment/billing problem affecting eligibility 37 (39)
3. Eligibility for VHC grace periods 35 (42)
4. Premium Tax Credit eligibility 34 (55)
5. Information about VHC 34 (28)
6. Termination of insurance 28 (48)

7. Fair hearing appeals 26 (34)
8. VHC special enrollment periods 23 (37)
9. Change of Circumstance 20 (27)
10. HAEU mistake 17 (22)
11. VHC complaints 16 (43)

### DVHA Beneficiary Calls 241 (compared to 278 last quarter)

1. MAGI Medicaid eligibility 36 (36)
2. Complaints about providers 26 (25)
3. Information/applying for DVHA programs 19 (17)
4. Medicaid/VHAP Managed Care Billing 17 (9)
5. Medicaid eligibility (non-MAGI) 17 (35)
6. Access to prescription drugs/pharmacy 13 (21)
7. Choosing/changing providers 12 (10)
8. Buy-in programs/Medicare Savings Programs 11 (20)
9. Confusing notice 11 (4)
10. Access to specialty care 11 (8)
11. PA denial 11 (12)
12. Access to transportation 10 (10)
13. OOS Billing for state programs 10 (8)
14. Fair hearing appeals 10 (12)
15. Change of Circumstance 9 (9)
16. Provider error/medical malpractice 9 (4)
17. Medicaid balance billing 8 (9)
18. Hospital billing 8 (5)
19. Provider billing problems 8 (9)
20. Affordability affecting access to care 8 (10)
21. PA/UR taking too long 8 (7)

### Commercial Plan Beneficiary Calls 166 (compared to 155 last quarter)

1. VHC invoice/payment/billing problem related to eligibility 22 (15)
2. Premium Tax Credit eligibility 18 (27)
3. Eligibility for VHC grace periods 17 (12)
4. Information about VHC 16 (13)
5. Consumer education about Medicare 13 (4)
6. Access to prescription drugs/pharmacy 12 (5)
7. MAGI Medicaid eligibility 11 (18)
8. Insurance coverage/contract questions 10 (5)
9. Hospital billing 9 (7)
10. Provider billing problems 9 (5)
11. Change of Circumstance 9 (17)
12. Mammography 9 (**new category added this quarter**)
13. Complaints about providers 8 (1)
14. Eligibility for special enrollment periods 8 (11)

**15.** Claim denials 8 (6)

The HCA received 825 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as "dual eligible"): 29.2% (241 calls), compared to 32% (278 calls) last quarter
- **Medicare[2] 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): 26% (218 calls), compared to 27% (232 calls) last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans): 20% (166 calls), compared to 18% (155 calls) last quarter
- **Uninsured:** 9% (74 calls), compared to 13% (113 calls) last quarter

## Case Results

### *A.* Dispositions of Closed Cases

**All Calls**

We closed 808 cases this quarter, compared to 898 last quarter:

- 31% (247 cases) were resolved by brief analysis and referral
- 29% (238) were resolved by brief analysis and advice
- 21% (168) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time
- 9% (73) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases (82), clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 26 individuals with appeals: 22 Fair Hearings, 1 Commercial Insurance – Internal 2nd Level appeal, 1 Medicare Part D appeal, and 2 Medicare Part A, B, or C appeals.

**DVHA Beneficiary Calls**

We closed 250 DVHA cases this quarter, compared to 273 last quarter:

- 29% (72 cases) were resolved by brief analysis and/or referral
- 27% (67) were resolved by brief analysis and/or advice
- 24% (60) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 15% (37) 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 5 DVHA beneficiaries with appeals: 4 Fair Hearings and 1 Medicare Part D appeal.

[2] 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 153 cases involving individuals on commercial plans, compared to 189 last quarter:

- 33% (50 cases) were resolved by brief analysis and/or advice
- 26% (40) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 21% (32) were resolved by brief analysis and/or referral
- 13% (20) 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 22 commercial plan beneficiaries with appeals: 18 Fair Hearings, 1 Commercial Insurance – Internal 2nd Level appeal, 1 Medicare Part D appeal, 1 Commercial Insurance – External appeals, and 1 Medicare Part A, B, or C appeal.

### *B.* All Calls Case Outcomes

The HCA helped 55 people get enrolled in insurance plans and prevented 9 insurance terminations or reductions. We obtained coverage for services for 19 people. We got 20 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 22 more. We provided other billing assistance to 10 individuals. We provided 447 individuals with advice and education. Nine people were not eligible for the benefit they sought, and three were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 65 more people.

## Consumer Protection Activities

### Other Green Mountain Care Board Activities

In the last quarter, the HCA attended 7 regular Green Mountain Care Board meetings. Board meeting topics included Certificate of Need proceedings, an All-Payer Model Update, and an update on the Board's pay parity work.

We continued to participate in the Green Mountain Care Board's bi-weekly stakeholder meetings to develop the Board's proposed Rule 5.000: Oversight of Accountable Care Organizations (ACOs) (see below) and to provide feedback on other topics related to ACOs and Vermont's All-Payer Model (APM). We also participated in the first meeting of a new stakeholder group looking at potential changes to the Board's regulatory statutes. This meeting focused on possible changes to the Certificate of Need review process.

### Rate Review

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

Two new rate filings were submitted during the quarter covering July 2017 through September 2017. The HCA filed Notices of Appearances in both of these cases. Additionally, two rate filings were pending at the beginning of the quarter.

The pending rate filings involved premium rates for the 2018 plans that MVP and Blue Cross and Blue Shield of Vermont (BCBSVT) will offer on Vermont Health Connect (VHC). These two rate filings affected approximately 80,000 members. The BCBSVT filing affected approximately 70,000 members and the MVP filing affected approximately 10,000 members.

The HCA worked with an independent actuary to review the two VHC rate filings because of the substantial number of Vermonters impacted. In addition, the HCA engaged in considerable work developing quantitative methods to assess and measure the affordability of health insurance coverage purchased on VHC.

The HCA submitted suggested questions for MVP and BCBSVT at the end of the April through June quarter. During the quarter covering July through September, the HCA's independent actuary submitted an expert actuarial report evaluating the BCBSVT filing. During the quarter, HCA represented the interests of Vermonters and argued for rate reductions at public hearings for the MVP and BCBSVT VHC filings. Also, the HCA's independent actuary testified before the Board and offered scientific justification for reductions to BCBSVT's proposed rate. After the public hearings for both VHC rate review cases, the HCA submitted post-hearing legal memoranda to the Board. BCBSVT moved to strike the use of affordability statistics and public comment from the HCA's post-hearing legal memorandum. The Board denied BCBSVT's motion.

The Board modified the proposed VHC rate filings downwards for both carriers. In the case of the MVP VHC rate filing, the Board reduced the proposed rate by nearly 50% from approximately 6.7% to 3.5%. In the case of the BCBSVT VHC rate filing, the Board reduced the proposed rate by 38% from approximately 12.7% to 9.2%. Neither MVP nor BCBSVT requested reconsideration of the Board's decisions.

The two new rate review cases filed during the quarter covering July 2017 through September 2015 are (1) MVP's Small Group Grandfathered Q1/Q2 2018 Filing and (2) MVP's Large Group PPO Q1/Q2 2018 Filing. MVP's Small Group Grandfathered Q1/Q2 2018 Filing proposes a rate increase of 4.2% and affects 1,711 members. MVP's Large Group PPO Q1/Q2 2018 Filing proposes a rate increase of 5.8% and affects 1,996 members. The HCA will submit two legal memoranda arguing that the proposed rates should be reduced to minimize the hardship imposed on Vermont households. These two memoranda will be filed in October 2017.

## Hospital Budget Review

The HCA participated in the Green Mountain Care Board's 2018 Hospital Budget Review process. In the last quarter, we submitted written questions to each hospital. Our questions focused on each hospital's plans for payment reform participation including financial risk management, financial incentives given to staff to increase revenue, patient centered care, and compliance with federal financial assistance requirements. We attended each hospital's budget hearing before the Green Mountain Care Board and asked each hospital questions following up on their budget presentations and our previous written questions. Further, we questioned Northwestern Medical Center about the fact that they are not in compliance with federal requirements for hospital financial assistance policies. The hospital's representatives stated that they would remedy the situation.

After the hospital budget hearings, we submitted written comments to the Board. As a part of our comments, we 1) asked the Board to deny Brattleboro Memorial Hospital's request to increase its rates

to include reserves for participation in risk based payment models, 2) asked the Board to require all hospitals to certify that they are in compliance with federal financial assistance policy requirements, and 3) asked the Board to require all hospitals to provide the status of the projects included in their 2015 energy efficiency plans. The Board's final 2018 budget orders to the hospitals included these three points.

### Accountable Care Organization Budget Review

This year the Board is reviewing Accountable Care Organization (ACO) Budgets for the first time. Act 113 of 2016 requires the Board to review ACO budgets starting in 2018 (for fiscal year 2019), so the Board is using this year as a trial year and reviewing the ACOs' fiscal year 2018 budgets. The first phase of the ACO budget review process took place this quarter. The HCA has a similar role in the ACO budget review process as in the Board's hospital budget review process. We reviewed the first round of budget documents and submitted written questions to each ACO in early July. The Board held a preliminary hearing in mid-July focused on the ACOs' care model. At the hearings we asked each ACO questions in follow-up to their presentations and to our written questions. Due to the incomplete nature of the ACOs' budget submissions, the Board chose to wait until November to hold a second set of hearings focused on the budgets themselves. We expect to receive updated and complete budget submissions as well as answers to our written questions from the ACOs next quarter.

### Accountable Care Organization Rule

This quarter the Board continued to hold regular meetings with a stakeholder group including the HCA to develop the Rule 5.000: Oversight of Accountable Care Organizations, as required by Act 113 of 2016. We submitted two more sets of written comments on the proposed rule asking for stronger oversight, consumer protections, and transparency. In our first set of comments, sent to the Board's counsel during the stakeholder process, we suggested numerous edits to the text of the rule and asked for stronger consumer protections in many areas of the draft rule. In our second set of comments, sent to the Board during its public comment period on the rule, we asked the Board to require ACOs to notify patients in writing of ACO attribution, to require ACOs to make their care models and mechanisms transparent, to protect whistleblowers, and to have the proposed rule reviewed by an independent entity with expertise in antitrust law.

A number of changes were made to the proposed rule in response to our first set of comments. No changes were made to the proposed rule based on our second set of comments. At the first Legislative Committee on Administrative Rules (LCAR) hearing on the proposed rule, which took place this quarter, LCAR did not approve the rule and asked the Board to work with the HCA to resolve some of our outstanding concerns.

### All-Payer Model

The HCA continued to work with DVHA and OneCare Vermont this quarter on ACO grievance and appeals processes. We met twice with OneCare and DVHA staff to discuss grievance and appeals structures

As noted above, the Board continues to hold its bi-weekly stakeholder meetings on the proposed ACO rule and other topics related to the All-Payer Model. Board staff also gave a presentation on All-Payer Model implementation at one of the Board's regularly scheduled meetings.

## Affordable Care Act Tax-related Activities

Tax-related calls from consumers declined this quarter, but tax issues are still regularly encountered in our VHC cases. This quarter, the HCA had seven cases where it helped consumers get a corrected 1095-A or 1095-B tax forms.

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. Changes to the Treasury regulations were reflected in the HBEE rule revisions which HCA commented on. (See **Administrative Activities**.)

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 18 technical assistance questions. She also responded to 68 technical assistance questions from Vermont tax preparers, and legal aid attorneys. Question topics included amended returns (including how to amend and whether taxpayers have a duty to amend), shared responsibility exemptions, reconciliation of advance premium tax credits, premium tax credit eligibility under federal regulations, and Modified Adjusted Gross Income. The tax attorney also gave advice regarding federal administrative law and the uncertainties created by the Trump Administration regarding the individual shared responsibility provision and ACA subsidies.

The HCA continued tax-related outreach and educational activities, which are detailed below in the **Outreach and Education** section. In particular, the HCA's tax attorney analyzed the first decisions on the premium tax credit to emerge from the U.S. Tax Court.

## Other Activities

## Administrative Advocacy

### ✧ Access to Screening Mammography

This quarter the HCA continued to advocate for implementation of Act 25 of 2013, which requires first-dollar coverage of screening mammography including additional views. We believe that hundreds of women have been and continue to be charged cost-sharing and deductibles for call-back mammograms that should be fully covered under Vermont law. This law had an implementation date of over three and a half years ago, and yet it continues to not be followed. We are actively pursuing full implementation, which would save many Vermont women hundreds of dollars each year and reduce the financial barriers that make it harder for Vermonters to access these preventative cancer screenings.

### ✧ Access to Treatment for Hepatitis C Virus

This quarter the HCA continued to monitor access to treatment for hepatitis C. A new drug was approved by the FDA that will allow cheaper treatment. The HCA plans to continue to advocate for access to treatment for all Vermonters with HCV. This quarter we attended one meeting of the Vermont Department of Health Hepatitis C Task Force.

### ✧ Family and Medical Leave Insurance (FaMLI) Coalition

The HCA began participating in the FaMLI Coalition this quarter, advocating for paid family and medical leave for all Vermonters. We attended one meeting of the coalition this quarter and conducted outreach for coalition events.

### ✧ Health Care Administrative Rules (HCAR)

In 2016, the Department of Vermont Health Access (DVHA) began 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 July, the HCA and representatives of two other Vermont Legal Aid (VLA) projects met informally with DVHA staff to discuss the HCAR project generally and to flag issues of concern. HCA supports the HCAR project and has committed significant resources to leading VLA's review of all HCAR rules, both in draft form and when officially proposed.

In July, the HCA and the Senior Citizens Law Project (SCLP) of VLA submitted joint comments on draft HCAR rules describing non-covered services and supervised billing. In the supervised billing rule, we requested a clarification about billing for out of state emergency services.

The non-covered services rule is an important rule for Medicaid providers and beneficiaries, because it delineates the coverage limits of Medicaid. In July we reviewed a revised draft rule, which addressed many of the problems we had identified in March 2016 comments. However, we are still concerned about certain issues, including that the rule could exclude from coverage some items that Medicaid now pays for, such as services and supports for the elderly and disabled, which are not strictly speaking "medical treatments." We urged DVHA to consult with a variety of medical professionals before publishing a proposed rule.

In September, the HCA led the SCLP, the Disability Law Project, and the Long-Term Care Ombudsman Project in commenting on draft HCAR grievance and appeal rules. The draft rule makes significant changes to Vermont rules and practice, partially in response to a March 2017 federal rule on Medicaid Managed Care. VLA submitted comments raising significant concerns regarding access to the appeals process for disabled and other vulnerable beneficiaries. We then met with DVHA staff regarding our comments. We expect to submit additional formal comments when the rule is officially proposed.

### ✧ Health Benefits Eligibility and Enrollment Rule

The HCA submitted formal comments on proposed revisions to DVHA's Health Benefits Eligibility and Enrollment (HBEE) rule. The proposed rule largely reflects updates in Vermont law and in federal regulations. However, the HCA raised some concerns with the rule. In particular, the HCA disagrees with DVHA's interpretation of the special enrollment period for pregnancy, which was created by the Vermont legislature in 2016. We believe that the language could be read to apply to current VHC enrollees as well as uninsured individuals, and that DVHA should interpret the statute in that way for public policy reasons. Pregnant women should be permitted to change health plans because of the overriding public interest in maternal and child health. We expect to raise this issue before the legislature in the future. Following submission of our comments, the HCA participated in an informal call with DVHA staff. DVHA agreed to address several of VLA's comments in the final proposed rule. At DVHA's invitation, the HCA then submitted proposed language for a new binder payment rule that was requested by another commenter.

### ✧ Request for Information on Reducing Regulatory Burdens

The HCA submitted formal comments in response to a Request for Information from the federal Department of Health and Human Services (HHS). HHS sought comments in four broad areas relating to the regulatory burden of the ACA. The HCA urged HHS to continue the protections in existing regulations, including transparency requirements and standardized benefit options. The HCA advocated strengthening the Marketplaces by continuing cost-sharing reduction payments and by limiting the

availability of limited benefit and short-term plans. Finally, we urged HHS to grant more state flexibility in enrollment periods while maintaining federal minimum standards to protect consumers.

✧ **Hospital Reporting Rule**

This quarter the Vermont Department of Health (VDH) reached out to the HCA for feedback on its draft updated Hospital Reporting Rule. The HCA attended one meeting about the rule and submitted written comments to the VDH.

✧ **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. The VHC escalation path now also works to resolve issues regarding Medicaid for Aged, Blind and Disabled (MABD), Medicare Savings Programs, Medicaid Spenddowns and V-Pharm. We communicate with VHC multiple times a day and meet as needed to discuss the most difficult cases.

✧ **Comments on Vermont Health Connect Notices**

At VHC's request, the HCA commented on 11 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 Chief Health Care Advocate continue to co-chair and actively participate in Vermont's Medicaid and Exchange Advisory Board (MEAB). The Chief attended the one meeting of the MEAB during the quarter as well as numerous organizational meetings to plan for leadership transitions as well as plans for future meeting agendas.

✧ **Secretary of State Administrative Rules Modernization Project**

The HCA met with Deputy Secretary of State Chris Winters to discuss the Secretary of State's administrative rules modernization project. HCA provided comments on the project outline, and explained the variety of ways in which the HCA and other consumer advocates interact with agency rulemaking processes.

## Legislative Activities

There were no official legislative meetings this quarter. The HCA continued to engage legislative leaders during the quarter to keep them up to date on the issues that the HCA was working on. In addition, the HCA partnered with a number of legislators this quarter in providing services to constituents with health care questions and concerns. The Chief Health Care Advocate also participated in forums organized by legislators in their communities.

## Collaboration with Other Organizations

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

- American Civil Liberties Union of Vermont
- Barre Area Veteran's Council: American Legion Post 10, VFW Post 790, BPOE Elks Lodge 1535, 302 Sons Of The Civil War
- Blue Cross Blue Shield of Vermont

- Ladies First, Vermont Department of Health
- MVP Health Care
- OneCare Vermont
- SHIP (State Health Insurance Assistance Program)
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Care Partners
- Vermont CARES
- Vermont Coalition of Clinics for the Uninsured
- Vermont Energy Investment Corporation
- Vermont Health Connect
- Vermont Medical Society
- Vermont Program for Quality in Health Care
- Villanova University Charles Widger School of Law (Procedurally Taxing)
- VNAs of Vermont
- Voices for Vermont's Children

## Outreach and Education

### A. Increasing Reach and Education through the 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 (*https://vtlawhelp.org/health*) with more than 250 pages of consumer-focused health information maintained by the HCA.

This quarter **new online content** was added including health topics in an online help tool. HCA advocates work diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

**Popular Web Pages**

- The total number of **health pageviews increased by 26%** in the reporting quarter ending September 30, 2017 (10,738 pageviews), compared with the same quarter in 2016 (8,519 pageviews). This is noteworthy because the total number of pageviews for the entire Vermont Law Help website increased by only about 5%.

- The **top 20 health pages** on our website this quarter with change over last year were:
  - *Income Limits – Medicaid* – 2,783 pageviews (11% ↓)
  - *Health* – section home page – 1,343 (46% ↑)
  - *Vermont Choices for Care* – 464 (81% ↑)
  - *Dental Services* – 442 (16% ↓)
  - *Medical Marijuana Registry Patient Form* – 432 (168% ↑)
  - *Resource Limits – Medicaid* – 404 (168% ↑)
  - *Services Covered by Medicaid* – 324 (151% ↑)
  - *Health Insurance, Taxes and You* – 195 (30% ↓)
  - *Medicare Savings / Buy-In Programs* – 189 (66% ↑)
  - *Federally Qualified Health Centers* – 181 (57% ↑)
  - *Choices for Care Income Limits* – 178 (66% ↑)

- *Choices for Care Resource Limits* – 171 (51% ↑)
- *HCA Online Help Request Form* – 165 (111% ↑)
- *Long-term Care* – 165 (106% ↑)
- *Medicaid and Medicare dual eligible* – 136 (13% ↓)
- *Medicaid* – 122 (11% ↓)
- *Advance Directive Forms* – 121 (195% ↑)
- *Advance Directives and Living Wills* – 120 (14% ↓)
- *Vermont Health Connect – main page* – 112 (203% ↑)
- *Choices for Care Giving Away Property* – 111 (76% ↑)

- Besides the pages listed above, other **spikes in interest** in our pages included:
  - *Vermont Long-Term Care Ombudsman Project* (a new page – up from 0 last year to 72 pageviews this year)
  - *VHC Price Increases & Enrollment news item* (a new page – up from 0 to 68)
  - *How the Public Can Participate in Insurance Rate Reviews* (up from 2 to 38)
  - *Health Insurance Rate Reviews* (up from 5 to 34)
  - *Ladies First Health Program* (up from 12 to 57 pageviews)
  - *Green Mountain Care Board* (up from 7 to 31)
  - *Prescription Assistance – State Pharmacy Programs* (up from 18 to 61)
  - *How to Get Durable Medical Equipment from Medicaid* (up from 17 to 48)

**Popular PDF Downloads**

- 17 out of 71 or **24% of the unique PDFs downloaded** from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:
- 12 were created for consumers. The top five consumer-focused PDF downloads were:
  - *Vermont Dental Clinics Chart* (225 downloads)
  - *Advance Directive, short form* (131 downloads)
  - *Advance Directive, long form (86 downloads)*
  - *Simple 5-Step Guide to Getting DME through Medicaid* (16 downloads)
  - *Vermont Medicaid Coverage Exception Request Form* (27 downloads)
  - The advance directive forms were accessed more often this year as compared to the same period last year (217 downloads versus 65 last year).
- 4 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* (11 downloads)
  - *Low-Income Taxpayers and the Affordable Care Act – November 2014* (3 downloads)
  - *Hospital Financial Assistance Fact Sheet* (3 downloads)
- 1 covered topics related to health policy. The top policy-focused download was:
  - *Vermont ACO Shared Savings Program Quality Measures* (10 downloads)

Our *Vermont Dental Clinics Chart* is the **fourth most downloaded of all PDFs** downloaded from the Vermont Law Help website.

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

**New Online Help Tool Adds to Our Reach**

In June 2017 we added a new Health section to the online help tool on our website. It is found at *https://vtlawhelp.org/triage/vt_triage* and can be accessed from most pages of our website. Our first Health topic was posted on June 19 and featured both Vermont Health Connect and work-based health insurance information. More sections were added between July and September (Medicare, Medicaid, complaints, finding low-cost care and long-term care), and a final section will be added in October.

Through the online help tool, the website visitor answers a few questions to find the specific health care information they need. The new feature addresses some of the most popular questions that are posed to the HCA. In addition to our extensive collection of health-related web pages, the online help tool adds a new way to access helpful information -- at all hours of the day and night. The website user can also call us or fill in our online form to get personal help from an advocate.

**144 pageviews** of informational health care results were seen by the public in the online help tool from July through September. That is a **66% increase** in pageviews over last quarter. Since we were adding new topics to the triage throughout the summer and fall, we anticipate higher numbers next quarter.

The top-viewed results were:

- Medicare - *I need help signing up for Medicare Parts A & B – hospital and medical coverage*.
- VHC - *I have been denied coverage for a medical procedure, service, drug, or equipment*.
- Medicare - *What is Medicare and what are Parts A, B, C and D?*

## B. Other Outreach and Educational Activities

**Attorney General Health Care Forum (July 9, 2017)**

The Chief patriated on a panel in Burlington's Contois Auditorium organized by the Attorney General about Health Care affordability and access to care.

**Procedurally Taxing on Forbes.com (July 20, 2017)**

The HCA's tax attorney analyzed the first premium tax credit decisions from the U.S. Tax Court, and explained how they illustrate common misunderstandings and pitfalls.

**Procedurally Taxing (July 21, 2017)**

The HCA's article analyzing U.S. Tax Court decisions was posted on the Procedurally Taxing blog after appearing on Forbes.com. Procedurally Taxing is a blog started by Villanova University Law School professors, which has an audience of hundreds of tax professionals.

The Ramble, (July 29, 2017) The HCA advocates handed out HCA material and spoke to consumers at the Ramble, a celebration of the Old North End in Burlington.

**Midwest LITC Network (August 1, 2017)**

The HCA's tax attorney gave a presentation to the Midwest Low-Income Taxpayer Clinic Network about the ACA problems identified in the National Taxpayer Advocate's most recent two reports to Congress.

Press release about Act 25, Access to Screening Mammography (August 11, 2017) The HCA released a press release about the statute and how it has not been fully implemented. It urged consumers to call the HCA with questions.

Outreach to H-2A Visa workers (August 29 and August 31, 2017) HCA advocates visited area farms and spoke to H-2A visa workers about the Affordable Care Act. The advocates answered questions and gave HCA material out.

Annual Financial Wellness Day (September 20, 2017) The HCA participated in the second annual financial wellness day.

**Hartland Health Care Forum (September 11, 2017) and Lamoille Health Forum (September 14, 2017)**

The chief participated on these two panels and presented information about the access to care challenges that impact Vermonters who call the HCA as well as resources available to assist with these challenges.

**Stand Down (September 30, 2017)**

HCA staffed a table at Vermont Stand Down, a daylong service event for veterans. The event was organized by the Barre Area Veteran's Council: American Legion Post 10, VFW Post 790, BPOE Elks Lodge 1535, 302 Sons Of The Civil War. HCA distributed cards and brochures, and spoke with veterans and veteran service providers who had questions about HCA services. Over two dozen service organizations participated in the event.

## 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 made plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:

- Open Enrollment Stuffer
- Open Enrollment Stuffer for September
- Open Enrollment Stuffer for October
- Open Enrollment Poster
- Partial Payment Reinstatement SYS271
- Partial Payment Reinstatement SYS272
- ADM 601
- ADM 602
- ADM 603
- EE201
- Bronze plan flier

**Office of the Health Care Advocate**

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

*http://www.vtlegalaid.org/health*

**Attachment 6**

## CY 2017 Investment Expenditures

| Department | STC # | Investment Description | QE 0317 | QE 0617 | QE 0917 | CY 2017 Total |
|---|---|---|---|---|---|---|
| AHSCO | 41 | Investments (STC-79) - 2-1-1 Grant (41) | 113,250 | 113,250 | - | **226,500** |
| AHSCO | 54 | Investments (STC-79) - Designated Agency Underinsured Services (54) | 1,289,600 | 1,250,906 | 1,664,645 | **4,205,151** |
| AOE | 11 | Non-state plan Related Education Fund Investments | - | - | | **-** |
| DCF | 1 | Investments (STC-79) - Residential Care for Youth/Substitute Care (1) | 2,302,666 | 3,750,502 | 2,317,786 | **8,370,954** |
| DCF | 2 | Investments (STC-79) - Lund Home (2) | 563,548 | 1,205,069 | 226,781 | **1,995,398** |
| DCF | 9 | Investments (STC-79) - Challenges for Change: DCF (9) | 64,031 | 15,000 | 12,864 | **91,895** |
| DCF | 26 | Investments (STC-79) - Strengthening Families (26) | 140,360 | 124,483 | 212,199 | **477,042** |
| DCF | 33 | Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33) | - | - | | **-** |
| DCF | 34 | Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34) | 28,742 | 27,605 | 25,646 | **81,992** |
| DCF | 35 | Investments (STC-79) - Building Bright Futures (35) | 215,963 | 153,681 | 116,014 | **485,658** |
| DCF | 55 | Investments (STC-79) - Medical Services (55) | 18,232 | 34,104 | 14,989 | **67,325** |
| DCF | 56 | Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56) | - | 198,036 | 1,613,493 | **1,811,529** |
| DCF | 57 | Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57 | - | - | 13,425 | **13,425** |
| DCF | 58 | Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58 | - | - | 34,175 | **34,175** |
| DCF | 59 | Investments (STC-79) - Essential Person Program (59) | 247,955 | 245,989 | 254,083 | **748,027** |
| DCF | 60 | Investments (STC-79) - GA Medical Expenses (60) | 57,275 | 61,464 | 48,476 | **167,215** |
| DCF | 61 | Investments (STC-79) - Therapeutic Child Care (61) | 183,832 | 171,688 | 190,092 | **545,612** |
| DCF | 62 | Investments (STC-79) - Lamoille Valley Community Justice Project (62) | 54,000 | 54,000 | 54,750 | **162,750** |
| DDAIL | 27 | Investments (STC-79) - Flexible Family/Respite Funding (27) | 669,264 | 231,127 | 17,233 | **917,624** |
| DDAIL | 42 | Investments (STC-79) - Quality Review of Home Health Agencies (42) | 1,838 | - | - | **1,838** |
| DDAIL | 43 | Investments (STC-79) - Support and Services at Home (SASH) (43) | 323,108 | 337,902 | 329,760 | **990,770** |
| DDAIL | 63 | Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63 | - | 141,010 | 72,998 | **214,008** |
| DDAIL | 64 | Investments (STC-79) - DS Special Payments for Medical Services (64) | 144,167 | 620,425 | 17,384 | **781,976** |
| DDAIL | 65 | Investments (STC-79) - Seriously Functionally Impaired: DAIL (65) | 16,964 | 22,350 | 23,251 | **62,565** |
| DDAIL | 77 | Investments (STC-79) - HomeSharing (77) | 163,230 | - | 99,891 | **263,121** |
| DDAIL | 78 | Investments (STC-79) - Self-Neglect Initiative (78) | 139,535 | - | 139,818 | **279,353** |
| DMH | 3 | Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH | 6,122,077 | 4,901,581 | 6,342,378 | **17,366,035** |
| DMH | 3 | Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR | 2,851,306 | 1,935,511 | (484,400) | **4,302,417** |
| DMH | 12 | Investments (STC-79) - Mental Health Children's Community Services (12) | 1,100,031 | 1,110,338 | 835,385 | **3,045,754** |
| DMH | 13 | Investments (STC-79) - Acute Psychiatric Inpatient Services (13) | 513,189 | 1,009,161 | 830,521 | **2,352,871** |
| DMH | 16 | Investments (STC-79) - Mental Health CRT Community Support Services (16) | (2,421,435) | 72,606 | 8,268,643 | **5,919,814** |
| DMH | 22 | Investments (STC-79) - Emergency Support Fund (22) | 253,660 | 168,692 | 102,893 | **525,246** |
| DMH | 28 | Investments (STC-79) - Special Payments for Treatment Plan Services (28) | 30,434 | 37,281 | 24,058 | **91,773** |
| DMH | 29 | Investments (STC-79) - Emergency Mental Health for Children and Adults (29) | 6,062,573 | 421,086 | 260,430 | **6,744,088** |
| DMH | 66 | Investments (STC-79) - MH Outpatient Services for Adults (66) | 759,746 | 487,738 | 620,290 | **1,867,774** |
| DMH | 67 | Investments (STC-79) - Respite Services for Youth with SED and their Families (6 | 302,581 | 201,030 | 153,548 | **657,160** |
| DMH | 68 | Investments (STC-79) - Seriously Functionally Impaired: DMH (68) | 77,594 | (57,791) | 23,198 | **43,001** |
| DMH | 79 | Investments (STC-79) - Mental Health Consumer Support Programs (79) | 141,556 | 111,938 | 53,321 | **306,815** |
| DOC | 4 | Return House | 108,512 | 130,579 | 81,336 | **320,427** |
| DOC | 5 | Northern Lights | 97,223 | 96,231 | 118,869 | **312,323** |
| DOC | 6 | Pathways to Housing | - | - | - | **-** |
| DOC | 14 | St. Albans and United Counseling Service Transitional Housing (Challenges for Ch | 458,426 | 386,589 | 255,788 | **1,100,803** |
| DOC | 15 | Northeast Kingdom Community Action | 46,405 | 48,975 | 45,293 | **140,673** |
| DOC | 69 | Intensive Substance Abuse Program (ISAP) | - | - | - | **-** |
| DOC | 70 | Intensive Domestic Violence Program | - | - | - | **-** |
| DOC | 71 | Community Rehabilitative Care | - | 1,365,476 | - | **1,365,476** |
| DOC | 80 | Intensive Sexual Abuse Program | 2,130 | 2,835 | 2,680 | **7,645** |
| DVHA | 7 | Investments (STC-79) - Institution for Mental Disease Services: DVHA (7) | 1,763,069 | 2,251,854 | 1,891,110 | **5,906,034** |
| DVHA | 8 | Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8 | 968,032 | 1,758,683 | 148,652 | **2,875,367** |
| DVHA | 18 | Investments (STC-79) - Patient Safety Net Services (18) | 206,199 | 171,891 | 194,940 | **573,030** |
| DVHA | 51 | Investments (STC-79) - Vermont Blueprint for Health (51) | 511,845 | 971,586 | 688,260 | **2,171,691** |
| DVHA | 52 | Investments (STC-79) - Buy-In (52) | 5,762 | 10,720 | 5,762 | **22,244** |
| DVHA | 53 | Investments (STC-79) - HIV Drug Coverage (53) | 1,422 | 1,607 | 1,628 | **4,657** |
| DVHA | 72 | Investments (STC-79) - Family Supports (72) | - | - | 6,362 | **6,362** |
| GMCB | 45 | Green Mountain Care Board | 609,467 | 796,535 | 413,119 | **1,819,121** |
| UVM | 10 | Vermont Physician Training | 1,011,555 | 1,011,552 | 1,011,555 | **3,034,662** |
| VAAFM | 36 | Agriculture Public Health Initiatives | 5,335 | 46,167 | - | **51,502** |
| VDH | 17 | Investments (STC-79) - Recovery Centers (17) | 430,500 | 380,500 | 343,178 | **1,154,178** |
| VDH | 19 | Investments (STC-79) - Emergency Medical Services (19) | 160,328 | 127,062 | 191,619 | **479,008** |
| VDH | 21 | Investments (STC-79) - Area Health Education Centers (AHEC) (21) | 266,000 | - | | **266,000** |
| VDH | 23 | Investments (STC-79) - Public Inebriate Services, C for C (23) | 594,748 | 353,986 | 125,975 | **1,074,709** |
| VDH | 24 | Investments (STC-79) - Medicaid Vaccines (24) | - | - | | **-** |
| VDH | 25 | Investments (STC-79) - Physician/Dentist Loan Repayment Program (25) | 432,000 | 68,111 | | **500,111** |

| Department | STC # | Investment Description | QE 0317 | QE 0617 | QE 0917 | CY 2017 Total |
|---|---|---|---|---|---|---|
| VDH | 30 | Investments (STC-79) - Substance Use Disorder Treatment (30) | 1,918,079 | 1,408,748 | 1,894,177 | **5,221,003** |
| VDH | 31 | Investments (STC-79) - Health Laboratory (31) | 875,545 | 743,581 | 868,545 | **2,487,671** |
| VDH | 37 | Investments (STC-79) - WIC Coverage (37) | 493,350 | 409,352 | 979,866 | **1,882,568** |
| VDH | 38 | Investments (STC-79) - Fluoride Treatment (38) | 22,103 | 14,661 | 15,788 | **52,552** |
| VDH | 39 | Investments (STC-79) - Health Research and Statistics (39) | 351,753 | 317,081 | 382,953 | **1,051,787** |
| VDH | 40 | Investments (STC-79) - Epidemiology (40) | 221,654 | 198,470 | 318,271 | **738,396** |
| VDH | 44 | Investments (STC-79) - VT Blueprint for Health (44) | 379,115 | 176,411 | 279,550 | **835,076** |
| VDH | 46 | Investments (STC-79) - Enhanced Immunization (46) | 48,051 | 80,762 | 51,389 | **180,202** |
| VDH | 47 | Investments (STC-79) - Patient Safety - Adverse Events (47) | 1,264 | 20,893 | 12,000 | **34,157** |
| VDH | 48 | Investments (STC-79) - Poison Control (48) | 26,873 | 80,618 | | **107,491** |
| VDH | 49 | Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program ( | 71,195 | 70,509 | 57,618 | **199,322** |
| VDH | 50 | Investments (STC-79) - Tobacco Cessation: Community Coalitions (50) | - | - | 229,376 | **229,376** |
| VDH | 73 | Investments (STC-79) - Renal Disease (73) | - | 6,750 | | **6,750** |
| VDH | 74 | Investments (STC-79) - TB Medical Services (74) | 41,645 | 40,557 | 39,611 | **121,813** |
| VDH | 75 | Investments (STC-79) - Family Planning (75) | 378,879 | 378,576 | 375,990 | **1,133,445** |
| VDH | 76 | Investments (STC-79) - Statewide Tobacco Cessation (76) | 158,405 | 99,102 | | **257,507** |
| VSC | 32 | Health Professional Training | 204,730 | - | 204,731 | **409,461** |
| VVH | 20 | Vermont Veterans Home | 110,986 | - | | **110,986** |
| | | | | | | |
| | | * QE0317 updated to include PQA adjustments entered QE0917 | **35,513,457** | **33,184,769** | **35,766,010** | **104,464,236** |

# P Family Planning - VDH GC Investment Scorecard

## What We Do

Family Planning services as funded by the State support the following clinical services: gender appropriate clinical exams including – medical and social history, height and weight, urinalysis, pelvic exam, breast exam, testicular exam, screening and treatment for sexually transmitted diseases, identification and treatment/referral for general health conditions, follow up for reproductive health conditions, provision/education around appropriate contraceptive methods, information and referral for fertility related problems, fertility related counseling, pregnancy testing and counseling, client support and education. These services are provided consistent with the most current nationally recognized standards of care.

## Who We Serve

All services are provided on a sliding fee scale. No individuals are denied care because of inability to pay. Community education services are offered that include family planning and reproductive health training programs for educators, health and human service workers and also informational sessions for parents, families and the public.

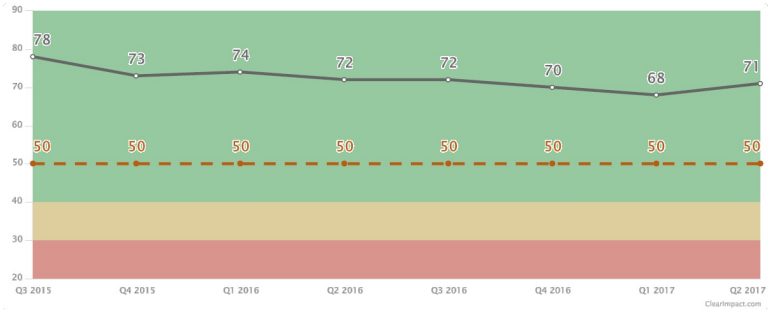
## How We Impact

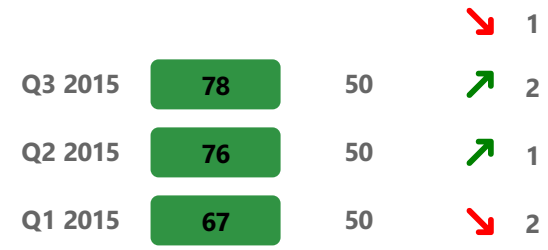
Investment Objective:

Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries

## Performance Measures

| PM | | Time Period | Actual Value | Target Value | Current Trend |
|---|---|---|---|---|---|
| PM | Family Planning – % of low income (Title X) family planning clients that use effective or highly effective birth control methods | Q2 2017 | 71 | 50 | ↗ 1 |
| | | Q1 2017 | 68 | 50 | ↘ 2 |
| | | Q4 2016 | 70 | 50 | ↘ 1 |
| | | Q3 2016 | 72 | 50 | → 1 |
| | | Q2 2016 | 72 | 50 | ↘ 1 |
| | | Q1 2016 | 74 | 50 | ↗ 1 |
| | | Q4 2015 | 73 | 50 | |






Story Behind the Curve

*Last Updated: August, 2017*

*Author: Division of Maternal and Child Health, Vermont Department of Health*

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The Title X Family Planning program was enacted in 1970 as Title X of the Public Health Service Act (Public Law 91-572 Population Research and Voluntary Family Planning Programs). Title X is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. Nationally, Title X-supported clinics provide a number of related preventive health services such as: patient education and counseling; breast and pelvic examinations; breast and cervical cancer screening according to nationally recognized standards of care; sexually transmitted disease (STD) and Human Immunodeficiency Virus (HIV) prevention education, counseling, testing and referral; and pregnancy diagnosis and counseling.

The overarching goal of Vermont's Title X program is to *provide high quality clinical family planning and related preventive health services, education, and counseling to Vermonters who would otherwise not have access, with a special focus on low-income and rural populations.* Specifically, Vermont's Title X program seeks to:

- Reduce unintended pregnancies in Vermont
- Improve access to a broad range of effective contraceptive methods
- Provide access to emergency contraceptive services
- Reduce sexually transmitted diseases
- Promote healthy relationships, healthy sexual behaviors and strengthen community capacity to promote positive reproductive health

There is a focus on providing high-quality comprehensive family planning and related preventive health services to vulnerable populations through a minimum of nine (9) health centers statewide. Starting in 2016, the goal is to reach a minimum of 10,000 patients each year and at least 50% of those patients who report an income will be at less than or equal to 250% Federal Poverty Level.

Ensuring access to and encouraging the use of a broad range of effective contraceptive options is a priority of the Title X program. Highly effective methods are long acting reversible contraception (LARCs), which include intrauterine devices (IUDs) and subdermal implants.

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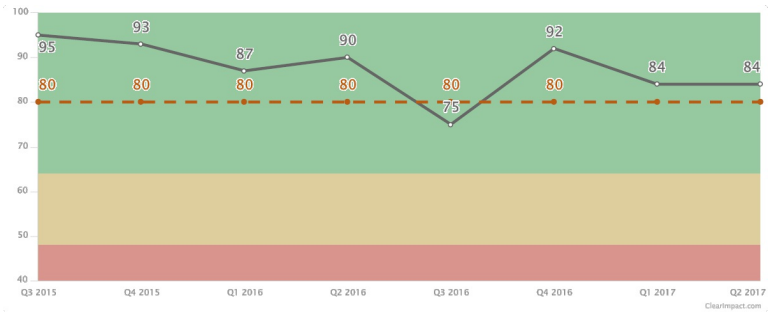
PM

Family Planning

% of youth ages 10-19 completing at least 80% of evidence-based comprehensive sexuality education sessions through VDH-sponsored programs




| | | | |
|---|---|---|---|
| Q2 2017 | 84 | 80 | → 1 |
| Q1 2017 | 84 | 80 | ↘ 1 |
| Q4 2016 | 92 | 80 | ↗ 1 |
| Q3 2016 | 75 | 80 | ↘ 1 |
| Q2 2016 | 90 | 80 | ↗ 1 |
| Q1 2016 | 87 | 80 | ↘ 2 |
| Q4 2015 | 93 | 80 | ↘ 1 |
| Q3 2015 | 95 | 80 | ↗ 2 |
| Q2 2015 | 85 | 80 | ↗ 1 |
| Q1 2015 | 84 | 80 | ↘ 2 |

Story Behind the Curve

*Last Updated: August, 2017*

*Author: Division of Maternal and Child Health, Vermont Department of Health*

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The consequences of adolescent sexual activity remain a troubling issue in the U.S.

The 2015 national Youth Risk Behavior Survey indicates that among U.S. high school students:

- 41% ever had sexual intercourse.
- 4% had sexual intercourse for the first time before age 13 years.
- 11.5% had sexual intercourse with four or more persons during their life.
- 30% had sexual intercourse with at least one person during the 3 months before the survey.
- 57% used a condom during last sexual intercourse.
- 14% did not use any method to prevent pregnancy during last sexual intercourse.
- 18% used birth control pills to prevent pregnancy.

In Vermont, the 2015 Youth Risk Behavior Survey indicates:

- 41% of students reported ever having sex and 42% reported ever having oral sex, both significantly decreased from 43% and 44% in 2013.
- 31% of students reported having sex in the past 3 months, a significant decrease from 33% in 2013.
- 10% reported four or more sexual partners in their lifetime and 3% had sex by age 13, both significantly decreased from 12% and 4% in 2013.
- 10% have been tested for HIV, a significant decrease from 12% in 2013.
- Among sexually active students, the last time they had sex:
- 58% used a condom and 47% used prescription birth control to prevent pregnancy, both significant changes from 62% and 44% in 2013.
- 87% used either prescription birth control or condoms.
- 19% used drugs or alcohol at last sex, a significant decrease from 22% in 2013

Estimates suggest that adolescents and young adults account for half of all new STI cases in the U.S. every year

***What is PREP?***

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act. The Act amended Title V of the Social Security Act to include the Personal Responsibility Education Program (PREP). The Administration on Children and Families (ACF) and the Family and Youth Services Bureau (FYSB) jointly oversee the program.

Through the Personal Responsibility Education Program (PREP), awards are granted to State agencies to educate young people on both abstinence and contraception to prevent pregnancy and sexually transmitted infections, including HIV/AIDS. The program targets youth ages 10-19 who are homeless, in foster care, live in rural areas or in geographic areas with high teen birth rates, or come from racial or ethnic minority groups. The program also supports pregnant youth and mothers under the age of 21.

PREP projects replicate effective, evidence based programs or substantially incorporate elements of projects that have been proven to delay sexual activity, increase condom or contraceptive use for sexually active youth, or reduce pregnancy among youth. Through a systematic review, the Department of Health and Human Services (HHS) selected 31 models that States could use, depending on the needs and age of the target population in each State.

Vermont PREP grantees use the curriculum *Reducing the Risk* by ETR Associates.

In addition to education on abstinence and contraceptive use, PREP projects also offer services to prepare young people for adulthood by implementing activities that address healthy relationships, positive adolescent development, and healthy

life skills. Vermont also requires PREP grantees to include a lesson on consent and a lesson on supporting LGBTQ youth.

States may provide referrals to youth for pregnancy prevention-related health care services and may help enroll eligible youth in public assistance programs like Medicaid, CHIP or any other Federal or State assistance program for which they may be eligible.

Nationally, there is a concerted effort to engage young adolescent males in pregnancy prevention. The PREP program offers an excellent opportunity to bring more young men into conversations about healthy relationships, pregnancy prevention, the prevention of STIs and HIV, as well as broader issues related to positive adolescent development and healthy life skills.

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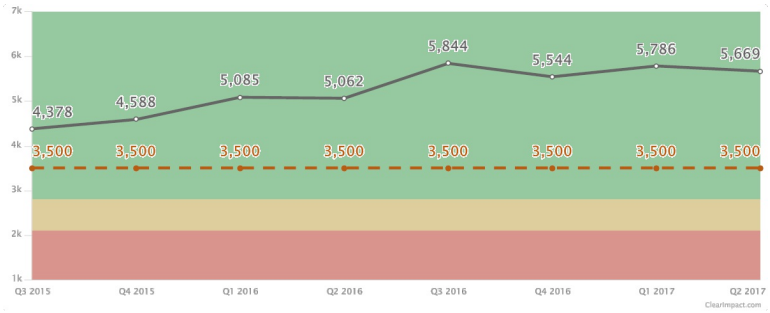
PM

Family Planning

# of individuals receiving free or low-cost family planning services through VDH-sponsored programs




| | | | |
|---|---|---|---|
| Q2 2017 | 5,669 | 3,500 | ↘ 1 |
| Q1 2017 | 5,786 | 3,500 | ↗ 1 |
| Q4 2016 | 5,544 | 3,500 | ↘ 1 |
| Q3 2016 | 5,844 | 3,500 | ↗ 1 |
| Q2 2016 | 5,062 | 3,500 | ↘ 1 |
| Q1 2016 | 5,085 | 3,500 | ↗ 2 |
| Q4 2015 | 4,588 | 3,500 | ↗ 1 |
| Q3 2015 | 4,378 | 3,500 | ↘ 5 |
| Q2 2015 | 4,490 | 3,500 | ↘ 4 |
| Q1 2015 | 4,815 | 3,500 | ↘ 3 |

Story Behind the Curve

*Last Updated: August, 2017*

*Author: Division of Maternal and Child Health, Vermont Department of Health*

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The Title X Family Planning Program was enacted in 1970 as Title X of the Public Health Service Act (Public Law 91-572 Population Research and Voluntary Family Planning Programs). Title X is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. Nationally, Title X-supported clinics provide a number of related preventive health services such as: patient education and counseling; breast and pelvic examinations; breast and cervical cancer screening according to nationally

recognized standards of care; sexually transmitted disease (STD) and Human Immunodeficiency Virus (HIV) prevention education, counseling, testing and referral; and pregnancy diagnosis and counseling.

The overarching goal of Vermont's Title X program is to *provide high quality clinical family planning and related preventive health services, education, and counseling to Vermonters who would otherwise not have access, with a special focus on low-income and rural populations.* Specifically, Vermont's Title X program seeks to:

- Reduce unintended pregnancies in Vermont
- Improve access to a broad range of effective contraceptive methods
- Provide access to emergency contraceptive services
- Reduce sexually transmitted diseases
- Promote healthy relationships, healthy sexual behaviors and strengthen community capacity to promote positive reproductive health

There is a focus on providing high-quality comprehensive family planning and related preventive health services to vulnerable populations through a minimum of ten (10) health centers statewide. Starting in 2016, the goal is to reach at least 10,000 patients each year and at least 50% of those patients who report an income will be at less than or equal to 250% Federal Poverty Level.

| Our Work Helps Turn These Indicators | Time Period | Actual Value | Target Value | Current Trend |
|---|---|---|---|---|
| O GCI Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries | | | | |

# DAIL GC Investment Scorecard

O GCI **Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured, and Medicaid-eligible individuals in Vermont**

| Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|

P DAIL **Vermont Communication Support Project (VCSP)**

| Time Period | Actual Value | Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|

### What We Do

The Vermont Communication Support Project (VCSP) assists people with disabilities who have difficulty understanding court and administrative proceedings and may need assistance in communicating with attorneys, judges and other officials. VCSP assists individuals who, due to their disabilities, might otherwise be unable to follow the content of proceedings or who have difficulty expressing themselves during administrative and court proceedings that include CHINS (children in need of supervision), custody/parental rights (including Termination of Parental Rights), divorce, relief from abuse, child support, and interactions with professionals and attorneys directly related to such proceedings. An initial communication plan is developed for each individual and includes an outline of the tools and strategies that may be implemented as best practice for that person. The VCSP facilitates the use of independently contracted Communication Support Specialists (CSS) in judicial, quasi-judicial, administrative hearings and professional interactions relevant to such hearings. The CSS supports people by assisting them with comprehension, providing opportunities to practice their verbal communication, providing guidance in organizational thought, and reviewing strategies to remain focused on the tasks at hand. This is designed to improve the ability of the individual to communicate effectively and to participate more fully and effectually in the trial or proceeding.

### Who We Serve

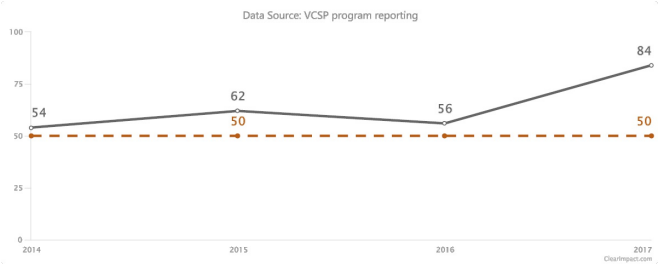
People with disabilities who have difficulty understanding court and administrative proceedings and need assistance in communicating with attorneys, judges and other officials.

### How We Impact

Investment Objective:

Provide public health and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured, and Medicaid-eligible individuals in Vermont.

PM DAIL **Vermont Communication Support Project (VCSP) Number of Cases Worked**




| | | | | |
|---|---|---|---|---|
| 2017 | 84 | 50 | ↗ 1 | 56% ↑ |
| 2016 | 56 | 50 | ↘ 1 | 4% ↑ |
| 2015 | 62 | 50 | ↗ 1 | 15% ↑ |
| 2014 | 54 | 50 | → 0 | 0% → |

### Story Behind the Curve

The increase of number of cases worked over time shows the need for the service provided by the Vermont Communication Support Project. While the project does not have direct control over when and what cases may be referred to the project,

these data show the effectiveness of the ongoing outreach to the courts, Department for Children and Family Services District Offices, AHS Field Services Directors and State Public Defenders, among others.

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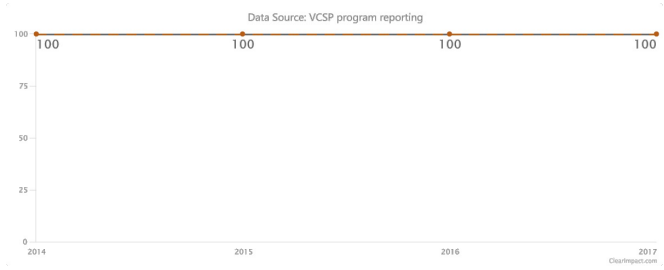
PM DAIL Vermont Communication Support Project (VCSP) New Referral Response Rate




| | | | | |
|---|---|---|---|---|
| 2017 | 100 | 100 | → 3 | 0% → |
| 2016 | 100 | 100 | → 2 | 0% → |
| 2015 | 100 | 100 | → 1 | 0% → |
| 2014 | 100 | 100 | → 0 | 0% → |

Story Behind the Curve

The Vermont Communication Support Project has maintained long standing success in responding to all new referrals that meet the project criteria regardless of the type and geographic location of the referral. The 100% responsiveness to referrals by the project is impressive considering the wide variety of sources of referrals and types of communication needs across recipients of the service. The VCSP strives to provide equal access to the Vermont system of justice and State services for people whose disabilities affect comprehension, verbal expression as well as effective participation and focus. The support and accommodations that were provided assisted the individuals in overcoming barriers and challenges as a result of disability. Of particular importance and the hallmark of the success of the project is the flexibility and attention to each person's individualized needs to get at what works best for each individual in each situation.

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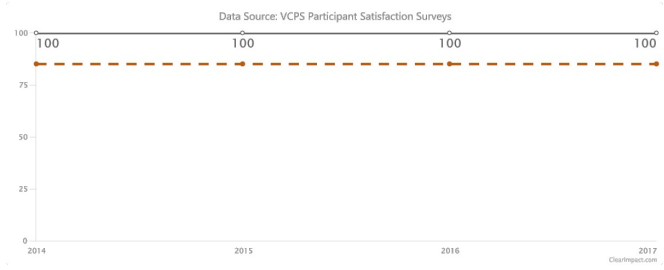
PM DAIL Vermont Communication Support Project (VCSP) Satisfaction Rate




| | | | | |
|---|---|---|---|---|
| 2017 | 100 | 85 | → 3 | 0% → |
| 2016 | 100 | 85 | → 2 | 0% → |
| 2015 | 100 | 85 | → 1 | 0% → |
| 2014 | 100 | 85 | → 0 | 0% → |

Story Behind the Curve

100% of individuals who received communication supports and who responded to the survey indicated satisfaction of services provided by the project. The satisfaction cut across four areas: 1. importance of the service, 2. services made a difference in the person understanding the legal process, 3. services made a difference in the persons ability to communicate, and 4. satisfaction with the Communication

Support Specialist. Users of the services express gratitude for the support that is provided by the communication specialists. While the users recognize the project does not have control over the outcomes of a particular case or hearing, they recognize the benefit from being heard and having a more active and effective role in the process.