State of Vermont
Agency of Human Services

Global Commitment to Health
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Section 1115
Demonstration Year: 9b
(1/1/2014 – 12/31/2014)

Quarterly Report for the period
October 1, 2014 – December 31, 2014

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Table of Contents

I. Background and Introduction ... 3
II. Enrollment Information and Counts ... 6
III. Outreach Activities ... 6
IV. Operational/Policy Developments/Issues ... 7
V. Expenditure Containment Initiatives ... 9
VI. Financial/Budget Neutrality Development/Issues ... 23
VII. Member Month Reporting ... 24
VIII. Consumer Issues ... 25
IX. Quality Improvement ... 26
X. Compliance ... 29
XI. Demonstration Evaluation ... 30
XII. Reported Purposes for Capitated Revenue Expenditures ... 30
XIII. Enclosures/Attachments ... 31
XIV. State Contact(s) ... 31

I. Background and Introduction

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

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

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

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

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

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

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

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

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

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

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 fourth quarterly report for waiver year 9b, covering the period from October 1, 2014 through December 31, 2014 (QE1214).***

i. *Global Commitment to Health Waiver: Renewal*

The Global Commitment Waiver renewal process was started in February 2013 with the commencement of the public process conducted pursuant to 42 CFR 431.408: the public comment period was from February 14 through March 22, 2013. On February 13, the draft *Global Commitment to Health* Waiver Renewal Request, the public notice, and executive summary of the draft, were posted online. Materials were available on the following websites: DVHA, the Agency of Human Services, the Agency of Administration Health Care Reform home pages. Also, the draft was distributed simultaneously to the Medicaid and Exchange Advisory Board, the committees of jurisdiction in the Vermont legislature, the DAIL Advisory Board, Department of Children and Families (DCF) District Offices, Dual Eligible Demonstration Stakeholders, DMH, VDH and other external stakeholders as well as internal management teams from across AHS.

On February 14, 2013, a public notice was published in the Burlington Free Press noticing the availability of the draft renewal request, two public hearing dates, the online website, and the deadline for submission of written comments with contact information. Additionally, all district offices of the Department for Children and Families' Economic Services Division, the division responsible for health care eligibility had notice posted and proposal copies available, if requested. The Burlington Free Press is the state's newspaper with the largest statewide distribution and paid subscriptions. Between February 16-20, additional public notices were published in Vermont's other newspapers of record, including the Valley News, The Caledonian Record, St. Albans Messenger, Addison Independent, The Bennington Banner, Newport Daily Express, The Islander, Herald of Randolph, and the News and Citizen. This distribution list represents all geographic regions of the state.

On March 1, 2013, a public notice and link to the renewal documents was included on the banner page for Vermont's Medicaid provider network.

The State posted a comprehensive description of the draft waiver request on February 13, 2013 on the

above-cited websites. The document included: program description, goals and objectives; a description of the beneficiary groups that will be impacted by the demonstration; the proposed health delivery system and benefit and cost-sharing requirements impacted by the demonstration; estimated increases or decreases in enrollment and in expenditures; the hypothesis and evaluation parameters of the proposal; and the specific waiver and expenditure authorities it is seeking. In addition to the draft posted for public comment, an Executive Summary and the PowerPoint presentation used during each public hearing was also posted to the same state websites noted above.

The State convened to two public hearing on the Global Commitment to Health 1115 Waiver renewal request.

On February 19, 2013, a public hearing was held using videoconferencing at Vermont Interactive Television (VIT) sites in Bennington, Brattleboro, Johnson, Lyndonville, Middlebury, Newport, Randolph Center, Rutland, Springfield, St. Albans, White River Junction, Montpelier, and originating in Williston.

On March 11, 2013, a public hearing was held during the Medicaid and Exchange Advisory Board meeting in Winooski, with teleconferencing available for individuals who could not attend in person.

On March 14, 2013, an informational presentation (with a question/answer period), was given at the Department of Disabilities, Aging, and Independent Living (DAIL) Advisory Board meeting in Berlin, Vermont.

The comment period concluded on March 23, 2013; the AHS compiled and considered the comments and questions received, made changes to the waiver renewal document as appropriate, generated responses to the comments/questions and made the document publicly available.

The AHS submitted its waiver renewal request to the HHS Secretary on April 23, 2013: the request packet included the transmittal letter, public notice, renewal request including budget neutrality documents, interim evaluation plan, and a summary of the Choices for Care Waiver. On May 17, 2013, AHS submitted an updated waiver renewal request with the evaluation plan.

AHS received CMS approval of its Waiver renewal request effective as of October 2, 2013. The approval allows Vermont to sustain and improve its ability to provide coverage, affordability, and access to health care by making changes that conform to the new coverage opportunities created under the Affordable Care Act, such as adoption of the new adult group in the Medicaid State Plan, and the authority to provide hospice care concurrently with curative therapy for adults.

CMS and AHS continue to collaborate on review of Vermont's requests related to use of modified adjusted gross income (MAGI) for MAGI exempt beneficiaries.

AHS and CMS came to successful resolution regarding Vermont's waiver consolidation request, to move the Choices for Care demonstration under the Global Commitment 1115 waiver, with a final effective date of January 30, 2015. AHS notes that CHIP consolidation remains an outstanding issue that will require focus during renewal discussions for 1/1/2017.

II. Enrollment Information and Counts

Key updates from QE1214:

- No enrollment fluctuations >5% seen in any of the Demonstration Populations.

Table 1 presents point-in-time enrollment information and counts for Demonstration Populations for the Global Commitment to Health Waiver during the first quarter of federal fiscal year (FFY) 2015. Due to the nature of the Medicaid program, beneficiaries may become retroactively eligible and may move between eligibility groups within a given quarter or after the end of a quarter. Additionally, since the Global Commitment to Health Waiver involves most of the State's Medicaid program, Medicaid eligibility and enrollment in Global Commitment are synonymous, with the exceptions of the Choices for Care Waiver and the Children's Health Insurance Program (CHIP).

Table 1 is populated based on reports run the Monday after the last day of the quarter, in this case on January 5, 2015. Results yielding ≤5% fluctuation from quarter to quarter are considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting >5% fluctuation between quarters are reviewed by staff from DVHA and AHS to provide further detail and explanation of the changes in enrollment. The explanation of any substantial fluctuations observed in Demonstration Populations during QE1214 would be in Section VII: Member Month Reporting. During this quarter, there were no substantial enrollment fluctuations >5% seen in any of the Demonstration Populations.

Table 1. Enrollment Information and Counts for Demonstration Populations*, QE1214

Demonstration Population	Current Enrollees Last Day of Qtr 12/31/2014	Previously Reported Enrollees Last Day of Qtr 9/30/2014	Percent Variance 9/30/2014 to 12/31/2014	Variance by Enrollee Count 9/30/2014 to 12/31/2014
Demonstration Population 1:	95,490	96,272	-0.81%	(782)
Demonstration Population 2:	54,255	54,779	-0.96%	(524)
Demonstration Population 3:	11,187	11,289	-0.90%	(102)
Demonstration Population 4:	N/A	N/A	N/A	-
Demonstration Population 5:	2,080	2,145	-3.03%	(65)
Demonstration Population 6:	0	0	0.00%	0
Demonstration Population 7:	0	0	0.00%	0
Demonstration Population 8:	9,752	9,707	0.46%	45
Demonstration Population 9:	2,466	2,453	0.53%	13
Demonstration Population 10:	N/A	N/A	N/A	-
Demonstration Population 11:	0	0	0.00%	0
	175,230	176,645	-0.80%	

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

III. Outreach Activities

i. Member Relations

Key updates from QE1214:

- A banner reminding providers of waiting time standards and access to care requirements was published.
- Member handbooks are currently under review.
- The annual Green Mountain Care Member Newsletter is being drafted and will include plan renewal information.
- The Medicaid and Exchange Advisory Board met three times this quarter.

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

A banner reminding primary care providers of case management, waiting time standards and access to care requirements was published on November 28. The banner includes information on the following:

- Requirements for 24-hour/seven days-per-week coverage that will assure practitioner availability in person or by phone.
- Requirements of office-visiting hours at least four days per week for at least twenty-five hours per week.
- Appointment waiting time standards as set out in the Medicaid Rule, including immediate access to emergency care.
- Standard waiting times for non-emergent care.

Member handbooks are currently under review to address clarifications that will assist members in understanding their Medicaid coverage and benefits.

The publication of the Green Mountain Care Member Newsletter, scheduled for Spring 2015, is planned to communicate health care renewal update information for all members, along with health and preventative care information.

The Medicaid and Exchange Advosory Board (MEAB) held meetings on October 20, November 10 and December 8. Agendas and minutes are publicly posted at http://gmcboard.vermont.gov/meetings.

IV. Operational/Policy Developments/Issues

In December 2014, the DVHA Policy Unit transitioned to AHS Central Office in order to more effectively serve as a resource for all Medicaid policy issues throughout all Agency departments.

i. Vermont Health Connect

Key updates from QE1214:

- During calendar year (CY) 2014, more than 115,000 Vermonters used Vermont Health Connect to enroll into coverage for at least part of the year. The Household Health Insurance Survey announced this month that Vermont's uninsured rate was cut nearly in half over the past two years. The 3.7% rate puts Vermont second in the nation in health insurance coverage.
- Due to issues with successfully transitioning Medicaid renewals from the State's legacy ACCESS system to the Marketplace, VHC has temporarily halted these renewals. Vermont has submitted a renewals and verification plan to CMS and is working with federal partners to finalize the approach. 2015 verifications are targeted to begin in January, and Medicaid renewals will begin in April.
- VHC opened for 2015 enrollment on November 15, and is continuing to process renewals.
- New enrollments are coming in ahead of projections.

Vermont Health Connect's second open enrollment period for qualified health plans (QHPs) kicked off on November 15, 2014 and will close on Sunday, February 15, 2015. Vermonters who are new to the Marketplace began signing up for 2015 health coverage, while existing QHP customers requested changes or auto-renewed for 2015 coverage. As of December 31, a total of 23,356 renewing individuals have been checked out into 2015 health plans. In addition, 6,881 individuals who were new to VHC checked out a plan. Nearly three out of five (58%) of these new applicants qualified for Medicaid or Dr. Dynasaur.

VHC's expected renewal pool is limited to the 38,704 individuals who are either enrolled in QHPs or else are members of a mixed household (households with both QHP and Medicaid members). The State received permission from CMS to delay renewals for Medicaid-only households until automated Change of Circumstance (CoC) functionality is delivered in April. Vermonters who are eligible for Medicaid or Dr. Dynasaur and those who experience a qualifying event—such as having a baby, getting married or losing their prior insurance—continued to be enrolled in 2014 coverage through November and December.

Customer Service Representatives continued to receive calls from Vermonters who qualify to be covered for the final weeks of 2014 and provided guidance on next steps to ensure that they recieved this coverage as promptly as possible. Due to continued functional constraints, Vermont Health Connect worked with insurance carriers to facilitate direct enrollment for these individuals. VHC maintains responsibility for determining eligibility for benefits and financial help and remains the system of record for individual and family customers.

VHC continued to utilize Optum agents to augment manual processes throughout QE1214. The State ramped up to a high of 170 Optum agents in October and November to process both the backlog of Change of Circumstance requests and VHC renewals. Due to the complexity of the remaining manual work, the State decided to reduce its pool of contract resources to 30 highly trained Optum agents beginning December 31st. These agents will continue to process remaining renewals, as well as assist the State in keeping the 2015 CoC backlog at manageable levels. The State continues to pursue a contract with Optum for systems integrator (SI) delivery and deployment for FFY 2015. This first major deployment is scheduled for April 30 and will include renewal functionality and automated processing of CoCs.

Maximus continues to manage the VHC Customer Support Center (call center), currently utilizing 90 customer service representatives. 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, and basic coverage questions. Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. They transfer calls to the State's Health Access Eligibility Unit for resolution and log service requests, which are escalated to the appropriate resolver group. Throughout QE1214, the system's performance continued to be stable and operated as expected. The Customer Support Center managed incoming call volume, receiving more than 106,000 calls over the quarter and answering more than nine out of ten calls (93%) in less than 30 seconds.

V. Expenditure Containment Initiatives

i. Medicaid Shared Savings Program

Key updates from QE1214:

- As of November, 47,000 Medicaid beneficiaries are attributed to two Accountable Care Organizations (ACOs) through the Vermont Medicaid Shared Savings Program (VMSSP).
- Selected additional quality measures to be included in the VMSSP in year two.
- Selected additional cost categories to be included as optional in the VMSSP Total Cost of Care (TCOC) in exchange for enhanced sharing rate; ACOs to decide on optional track by December 31, 2014.

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

Contracts were signed between Vermont Medicaid and the two participating ACOs in February 2014 with a retrospective year-one performance period starting on January 1, 2014. Eligible Medicaid beneficiaries are attributed to one of two ACOs in Vermont, OneCare Vermont (OCVT) and Community Health Accountable Care (CHAC), based on their relationship with their primary care provider (PCP). The ACOs vary in terms of geographic spread and patient mix—OCVT is statewide, includes both the University of Vermont Medical Center and Dartmouth Hitchcock Medical Center and has a larger presence in Vermont's urban areas, while CHAC is FQHC-based (Federally Qualified Health Center) and includes more rural practice sites.

In its first year, the VMSSP began ramping up its implementation activities, including:

- Notifying beneficiaries of their providers' participation in the shared savings program and providing them with the opportunity to opt out of having their claims data shared between DVHA and the ACOs; beneficiaries had the option of calling the ACO's call center, the Department of Vermont Health Access's dedicated call center line, or the Office of the Health Care Advocate for assistance related to the notifications.

- Notifying all newly attributed beneficiaries through a quarterly mailing process.
- Sharing claims data with OCVT and CHAC on a monthly basis, beginning in August 2014 and October 2014 respectively.

Beneficiary attribution in the VMSSP continues to increase as new providers are added to participating ACO entities, with over 880 providers participating in the program, resulting in 47,000 total beneficiaries attributed—approximately 27,000 lives in OCVT and 20,000 lives in CHAC.

In the VMSSP program, performance on quality measures plays a role in determining the final shared savings rate and amount. Quality measure selection is done through a multi-stakeholder process under the SIM grant, known as the Vermont Health Care Innovation Project (VHCIP). A key milestone in year-one is that the stakeholders recommended and voted to pass new measures for year-two of the VMSSP program. The additional measures set will include two payment measures, one additional measure each for reporting and monitoring/evaluation, as well as some reclassification of measures between the monitoring/evaluation and reporting categories.

Over the course of the three-year program, the VMSSP seeks to expand the scope of accountability in care to go beyond traditional medical services. This expansion aims to include pharmacy, non-emergency transportation, long term care services and supports, mental health and substance abuse services, and other social services that are commonly sought by Medicaid beneficiaries. In year-two of the VMSSP, there is an optional track where the ACOs that elect to take on Total Cost of Care (TCOC) expansion in year-two of VMSSP would receive an increase in shared savings percentage—from 50% to 60%. DVHA selected pharmacy and non-emergency medical transportation as the two additional services to be included in the year-two TCOC. ACOs were notified of this option, and the deadline for participating in this track is 12/31/14.

In the coming year, VMSSP staff will be focusing on the expansion of the quality measure set and TCOC for year-three, and will also work closely with the analytics team to study the outcomes of the first year.

ii. Vermont Chronic Care Initiative (VCCI)

Key updates from QE1214:

- The Enterprise Medicaid Management Information Systems/Care Management review process concluded with a successful vendor selection.
- DVHA, VCCI and IT leaders met with APS Healthcare to review and discuss the DVHA-APS data transition plan requirements to support successful on-boarding of the new MMIS Care Management vendor and to ensure continuity of VCCI business operations.
- VCCI and OneCare Vermont, co-presented to joint staff on the Medicaid ACO contract and opportunities for collaboration to ensure integration and referral requirements for high cost/risk members, without service redundancy. A leadership meeting to vet recommendations into year-two ACO contracts is scheduled for early QE0315.
- DVHA leadership initiated bi-weekly meetings between the VCCI and the Blueprint for Health to ensure collaboration administratively and locally toward integrated models of care. This will include VCCI participation on local 'Regional Clinical Planning Committees' and data driven intervention strategies with internal and contracted partners (i.e. ACOs).

The goal of the VCCI is to improve health outcomes of Medicaid beneficiaries by addressing the

increasing prevalence of chronic illness through various support and care management strategies. Specifically, the program is designed to identify and assist Medicaid members with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care to this population by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower this population to eventually self-manage their chronic conditions.

The VCCI uses a holistic approach of evaluating and supporting improvement in medical and behavioral health, as well as socioeconomic issues that are often barriers to sustained health improvement. Medicaid members that are eligible for the VCCI account for the top 5% of service utilization, or are on a trajectory to become 'super-utilizers' of services. The VCCI's strategy of embedding staff in high-volume hospitals and primary care sites continues to support population engagement at the point-of-need in areas of high service utilization. By targeting predicted high-cost members, resources can be allocated to areas representing the greatest opportunities for clinical improvement and cost savings.

The VCCI had expanded the embedded staffing model with licensed staff in high volume Medicaid primary care sites and hospitals that experience high rates of ambulatory care sensitive (ACS) Emergency Department (ED) visits and inpatient admissions/readmissions. The VCCI remains embedded in 6 primary care practice sites and 2 hospitals, and it is continuing to collaborate with hospital partners to expand on-site staffing. The VCCI will continue collaborating with provider/hospital network partners to enhance the number of participating hospitals providing File Transfer Protocol (FTP) data feeds.

The VCCI supplemented its embedded model with a nurse 'liaison' model, given space constraints at provider and hospital sites. All 14 hospitals have a designated VCCI staff 'liaison' assigned who will meet regularly with hospital case managers to support the reduction of ACS ED utilization and support transitions from inpatient to outpatient care to avoid 30-day readmission rates. Liaisons will also meet with large Medicaid practices to support referrals and communication on high risk/high cost members. These efforts will facilitate communication and support mutual goals of the VCCI and Medicaid ACO partners.

The VCCI believes that the embedded approach offers several advantages, and it hopes that the liaison role may garner similar benefits. First, it fosters strong provider relationships and direct referral for high-risk populations. Second, it encourages 'real time' case findings at the point-of-service within PCP and hospital sites to assist in reducing hospital readmission rates in high-risk populations. The VCCI has access to hospital data on inpatient and ED admissions through data sharing from partner hospitals (via secure FTP site transfers). While the VCCI currently receives electronic data from 5 partner hospitals, the goal is to have electronic census data from all hospitals in FFY 2015. While some hospitals have not supported these strategies in the past, the advent of Medicaid ACOs may help facilitate new relationships based on common goals and financial incentives. Third, the embedded staffing model provides an opportunity for enhanced coordination and care transitions with hospital partners and primary care sites, as well as with home health agencies that may be delivering skilled nursing care post-discharge. This enhanced service coordination is a goal of the VHCIP Care Management and Care Models (CMCM) workgroup, which is launching an integrated care management learning collaborative in 3 pilot locations—Rutland, Burlington and St. Johnsbury—starting in QE0315.

Due to their Medicaid knowledge and case management experience, VCCI nurse care managers have

been frequently hired by partners of the VCCI, and at a higher pay scale than provided by the State. The VCCI is continuing to work with senior DVHA leadership, and an AHS leadership team is currently assessing a market factor adjustment for nursing positions to support both recruitment and retention. This is targeted for completion prior to QE0615 and would be implemented in QE0915.

The VCCI remains strategically aligned with the Blueprint for Health, which is further described in *Section V.iii*.

High Risk Pregnancy Care Management (Pregnancy Care Connection):
The VCCI launched its initial pilot program for the High Risk Pregnancy (HRP) Case Management service in October 2013. While strides were made, the clinical team recommended that 2 registered nurses (RNs) were not indicated as a centralized resource, and a better model to support clinical and quality goals could be achieved via one HRP expert functioning as a liaison with other state and community partners and as an expert consultant to the VCCI field staff receiving high risk pregnancy referrals. Subsequently, one high risk pregnancy position was converted into a field based nurse case manager. In QE1214 the VCCI successfully recruited and hired a high risk pregnancy nurse with experience in labor and delivery as well as neonatal intensive care. This combination of knowledge and skill makes this candidate a unique member of the team as she understands both the risks as well as results of these risks on the newborn. This skilled paractitioner is scheduled to join the VCCI in QE0315. Data supports the opportunity to positively impact pregnancy outcomes for high risk women, particularly those with mental health and substance use/abuse diagnoses.

APS Contract:
APS Healthcare provides several services to support the VCCI, including supplemental professional staffing and data analytics. APS Healthcare delivers enhanced information technology and sophisticated decision-support tools to assist case management staff in doing outreach to the most costly and complex beneficiaries. Additionally, APS Healthcare provides supplemental population-based reports on gaps in care to PCPs, which support ACO providers and case managers working with patients who are considered high utilizers and/or at risk to become so.

In 2011, the VCCI implemented a combination of individual- and population-based strategies for disease management, with a primary focus on the top 5% of beneficiaries accounting for the highest service utilization. That same year, DVHA's contract with APS Healthcare was 100% risk-based with a guaranteed 2:1 return on investment (ROI). In state fiscal year (SFY) 2012, the VCCI delivered a net $11.5 million ROI, which included both the APS and DVHA staff efforts. In SFY 2013, the VCCI significantly exceeded its 2012 results, with a $23.5 million net savings over anticipated expense for this population. Consistent with these results, the VCCI demonstrated a 17% reduction in ACS ED usage, a 37 % reduction in ACS hospitalizations, and a 34% reduction in 30-day readmission rates among the top 5% of members. SFY 2013 was the first year that it was feasible to conduct a comparative analysis on the top 5% of members. Results for SFY 2014—the last year of a fully risk based contract with APS—are pending the 6 month claim run out and will be available in the QE0315 report.

To assure continuity of the VCCI business operations during the Medicaid Management Information Systems (MMIS)/Care Management (CM) procurement process, the DVHA extended its contract with APS Healthcare through June 30, 2015. This was to allow for a thoughtful procurement, contracting and onboarding process. APS did not submit a bid in response to the MMIS/CM request for proposals (RFP). A formal transition plan and related discussions on data requirements has been initiated between APS and DVHA staff. Challenges with APS staffing continue, given the impending

termination of the contract. The data reporting specialist assigned to the VCCI since contract inception tendered her resignation, as did the full time data analyst.

There were no Provider Health Registries (PHRs) developed/released this quarter; however a coronary artery disease (CAD) PHR is scheduled for dissemination in early QE0315 due to several APS data challenges limiting capacity to deliver this tool in QE1214.

Activities supported by APS in QE1214 include:

- Collaboration on the 'data transition' plan required to support data migration to the new CM vendor and prevent interruption of VCCI services to Medicaid members.
- A flu vaccine mailing was completed and disseminated.
- A 'healthy eating during the holidays' mailing was sent to high risk members with CAD, diabetes, congestive heart failure and chronic obstructive pulmonary disease.
- A targeted pharmacy mailing to support improvement in medication adherence.
- Average VCCI caseload (DVHA/APS): 732; unique members: 443, or roughly 25% of VCCI's annual goal of 2000 members.

iii. Blueprint for Health

The Blueprint for Health is described in statute as "*a program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.*[1]"

The Blueprint program works with practices, hospitals, health centers, and other stakeholders to implement a statewide health service model in Vermont. The model includes advanced primary care in the form of patient centered medical homes (PCMHs), multi-disciplinary support services in the form of community health teams (CHTs), a network of self-management support programs, comparative reporting from statewide data systems, and activities focused on continuous improvement (Learning Health System). The program is intended to ensure that all citizens have access to high quality primary care and preventive health services and to establish a foundation for a high value health system in Vermont.

Current Operations:
As of December 2014, there are 124 primary care practices are operating in Vermont as patient centered medical homes (PCMHs) supported by multi-disciplinary community health teams (CHTs). In this program, each practice is scored against the National Committee for Quality Assurance Patient Centered Medical Home (NCQA PCMH) recognition program standards for high quality patient centered care.

Community health teams provide medical home patients with more direct and unhindered access to diverse staff such as nurse coordinators, social workers, counselors, dieticians, health educators, and others.

Medical homes and CHT staff are intended to strengthen network interactions with a larger array of medical and non-medical providers in their community and to help people link more seamlessly with the services they need. The implementation and expansion of the model has been supported with a

[1] 18 VSA Chapter 13.

locally organized transformation infrastructure including program managers, CHT leaders, practice facilitators, multi-stakeholder workgroups, and shared learning forums.

Key design principles of the model include: local leadership and organization; consistent statewide quality standards (NCQA PCMH) and measurement of performance against those standards; close coordination between primary care, CHT staff, and community based services; and an emphasis on prevention, improved control of established health problems, and healthier lifestyles.

Hub and Spoke Initiative:

Key updates from QE1214:

- The Hub and Spoke program has established statewide operations, and caseload expansion has begun to slow; serving 2,542 Vermonters as of December 30, 2014.
- The programmatic enhancement of allowing Hubs to also dispense buprenorphine continues to be important with 823 Hub patients receiving buprenorphine as of the end of calendar year 2014.
- The Chittenden Center Hub program formally submitted an application to the National Committee for Quality Assurance for recognition under the Patient-Centered Specialty Practice program.
- A new series of Learning Collaboratives for Spoke practices began this quarter. Twenty-seven practices are sending teams to the in-person events, are reporting on common measures and sharing quality improvement initiatives.
- A series of four webinars for the entire Hub and Spoke provider network has begun, with the first topic, management of Hepatitis C, completed.
- The Spoke staff and practices are actively using a web-based platform (Basecamp) to share information, post documents, and develop discussions on topics of interest to the community.

As part of the Blueprint, the Hub and Spoke Initiative creates a framework for integrating treatment services for opioid addiction. This Initiative represents AHS and DVHA's efforts, referred to as the Alliance for Opioid Addiction, to collaborate with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont. The Hub and Spoke Initiative is focused on beneficiaries receiving Medication-Assisted Treatment (MAT) for opioid addiction. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders. The two primary medications used to treat opioid dependence are methadone and buprenorphine. Buprenorphine is typically prescribed by specially licensed physicians in a medical office setting, and methadone is provided only in specialty opioid treatment programs. Both of these treatment regimens are associated with substantial service fragmentation as providers are not well integrated into the larger health care and mental health care systems.

As part of the Initiative, five regional Hubs were established, which build upon the existing methadone opioid treatment programs, and provide buprenorphine treatment to a subset of clinically complex patients (Table 2). These Hubs serve as the regional consultants and subject matter experts on opioid dependence and treatment. Hubs are replacing episodic care based exclusively on addiction illness with comprehensive health care and continuity of services.

In addition to Hubs, Spoke staff is embedded directly in the prescribing practices to allow more direct

access for patients to mental health and addiction services, promote continuity of care and support the provision of multidisciplinary team care. Spoke staff provide service free of cost to patients receiving MAT. Spokes include a physician prescribing buprenorphine in office-based opioid treatment and the collaborating health and addictions professionals who monitor adherence to treatment; coordinate access to recovery supports and community services; and provide counseling, contingency management, care coordination and case management services. Registered nurses and licensed addictions/mental health clinicians, who are part of the Blueprint CHTs, also provide support to the Spoke providers and their patients receiving MAT.

For updates from QE1214, please see the above "Key Updates." Blueprint practice facilitators continue to work extensively with Hub and Spoke providers on common measurement, practice-level quality improvement, and implementation of evidence-based care. In addition, the practice facilitators are working with the Hub programs on preparing to meet the NCQA Patient-Centered Specialty Practice standards. This will further align these specialty addictions programs with the PCMH primary care providers.

Spoke staffing is scaled at 1 registered nurse and 1 licensed clinician for every 100 patients receiving MAT. The following tables present the caseloads of regional Hubs and Spoke staffing as of December 2014.

Table 2. Hub Caseload: December 30, 2014

Region (Counties in Vermont)	Start Date (Month/Year)	Total Number of Clients (Buprenorphine and Methadone)	Number of Clients Receiving Buprenorphine	Number of Clients Receiving Methadone
Chittenden, Franklin, Grand Isle & Addison	1/2013	945	287	658
Washington, Lamoille, Orange	7/2013	275	116	159
Windsor, Windham	7/2013	455	145	310
Rutland, Bennington	11/2013	399	157	242
Essex, Orleans, Caledonia	1/2014	468	118	350
Total		**2542**	**823**	**1719**

Table 3. Spoke Staffing: December 2014

Region	Providers Serving 10 or more Medicaid Beneficiaries	Staff FTE Funding	Staff FTE Hired	Medicaid Beneficiaries
Bennington	6	4.5	2.4	207
St. Albans	6	6.5	4.8	307
Rutland	5	5.0	3.1	242

Chittenden	14	8.0	8.2	392
Brattleboro	9	4.5	4.5	217
Springfield	1	1.5	1.5	56
Windsor	3	2.5	2.0	112
Randolph	3	2.0	1.8	100
Barre	7	5.5*	4.5	238
Lamoille	4	3.0	3.6	131
Newport & St Johnsbury	3	2.0	1.0	93
Addison	1	1.5*	1.5	30
Upper Valley	1	0	.5	7
Total	**62**	**47**	**39**	**2,132**

iv. Behavioral Health

Key updates from QE1214:

- Established clinical criteria for authorization of applied behavioral analysis services.
- Authorization of opioid replacement therapy was transitioned to Goold Health Systems.

The DVHA behavioral health team offers a comprehensive approach for behavioral health care coordination. The team is responsible for concurrent review and authorization of inpatient psychiatric and detox services for Medicaid primary beneficiaries. The team works closely with discharge planners at the inpatient facilities to ensure timely and appropriate discharge plans. The team authorizes payment for opioid treatment medications and coordinates its MAT efforts with the Hub and Spoke Initiative, the VCCI, and the Pharmacy Unit to provide beneficiary oversight and outreach. The team also manages the Team Care Program (lock-in) for Medicaid beneficiaries.

During this quarter, the new Autism Specialist developed the utilization process for authorization of applied behavioral analysis (ABA) services. Staff researched and chose a clinical criteria set for authorizations. Work continued on the development of outcome measures for these services, developing a provider manual, researching best practices, and creating ABA tools within the electronic record-keeping system. Staff worked with the AHS Medicaid Policy Unit on the upcoming State Plan Amendment submission.

The behavioral health staff continued to collaborate with the Department of Mental Health in performing concurrent review and authorization for all inpatient psychiatric and detoxification services. Staff throughout the unit were provided an orientation to the Team Care program as part of the transition of this responsibility to all staff. In the next quarter, the Team Care program components (i.e. criteria, documentation process, etc.) will be reviewed and updated. A dedicated phone line for Team Care beneficiaries will be available by January 2015.

Team members continued to facilitate authorization of opioid replacement medications, while transitioning this responsibility to Goold Health Systems is slated to begin January 1, 2015. Team members also continue to work closely with the Vermont Department of Health's Alcohol and Drug Abuse Program (ADAP) around the Hub and Spoke system of care. Working with ADAP, team

members developed policies regarding lab services in the Hubs and have drafted criteria for authorization of buprenorphine over 16mg.

v. Pharmacy and 340B Drug Discount Program

Key updates from QE1214:

- Vermont has realized $465,290.82 net cost savings for this reporting period and year-to-date net cost savings of $1,096,054.10 through Medicaid participation of a relatively small number of eligible covered entities.

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 estimated to be 20% to 50% on the cost of outpatient drug purchases for 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.

Covered entities can utilize contract pharmacy services under a “ship to-bill to” arrangement where the covered entity retains legal title of the drugs purchased under 340B and has their drugs shipped to the contract pharmacy. The covered entity retains legal title to all drugs purchased under 340B and must pay for all 340B drugs. The contract pharmacy is subject to audits to identify and prevent diversion and/or duplicate discounts (accessing the 340B discount and Medicaid rebate on the same drug).

Vermont has made substantial progress in expanding 340B availability since 2005. This expansion was aided by federal approval of the statewide 340B network infrastructure, which is operated by five federally qualified health centers (FQHCs) in Vermont. In 2010, DVHA aggressively pursued enrollment of 340B covered entities made newly eligible by the ACA and as a result of the Challenges for Change legislation passed in Vermont. As of October 2011, all but two Vermont hospitals and some of their owned practices were eligible for participation in 340B as covered entities.

DVHA expanded its 340B program to encourage enrollment of both existing and newly eligible entities within Vermont and to encourage covered entities to include Medicaid in their 340B programs. In 2012, the DVHA received federal approval for a Medicaid pricing 340B methodology. To encourage participation in the Vermont Medicaid 340B program, providers receive an incentive payment (described below). The methodology for the 340B incentive payment is the lesser of 10% of the total Medicaid savings or $3 per claim for non-compound drugs and $30 per claim for compound drugs. Claims are paid at the regular rates, and a

monthly true-up process calculates the 340B acquisition cost, dispensing fees, savings, and what is owed back to the State with payments due 30 days after the invoices are mailed. DVHA continues to encourage Medicaid enrollment with the goal of enrolling all eligible and HRSA-enrolled covered entities in Vermont.

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

- Vermont Department of Health, for the AIDS Medication Assistance Program, Sexually-Transmitted Disease Drugs Programs, and Tuberculosis Program; all of these programs are specifically allowed under federal law.
- **Planned Parenthood of Northern New England's Vermont clinics**
- **Vermont's FQHCs**, operating 41 health center sites statewide
- **Brattleboro Memorial Hospital**
- **Central Vermont Medical Center**
- Copley Hospital
- **University of Vermont Medical Center and its outpatient pharmacies**
- Gifford Hospital
- Grace Cottage Hospital
- **Indian Stream Health Center (New Hampshire)**
- North Country Hospital
- Northeastern Vermont Regional Hospital
- Notch Pharmacy
- Porter Hospital
- Rutland Regional Medical Center
- **Springfield Hospital**

340B Reimbursement and Calculation of Incentive Payment:
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.

Vermont researched available resources regarding pharmacy dispensing costs, which included consultation with local pharmacists. Vermont determined that a reasonable estimate of pharmacy dispensing costs falls in the range of $12.00 to $15.00 per prescription. DVHA also determined that pharmacies' additional costs associated with 340B program management would equal $3.00 per prescription. Therefore, Vermont determined that a reasonable 340B dispensing fee would range from $15.00 to $18.00 per prescription. Vermont's proposed reimbursement methodology established a flat rate payment at the low end of this range ($15.00) and presents the opportunity, subject to demonstrated Medicaid program savings, for entities to share in Medicaid savings.

Because of federal laws prohibiting “duplicate discounts” on Medicaid drug pricing related to the interaction of 340B and manufacturer rebate programs, Medicaid participation in 340B has been limited both in Vermont and nationally. Vermont put in place an innovative, first in the nation, methodology to maximize Medicaid participation in 340B pricing for Medicaid beneficiaries served by eligible prescribers at 340B-enrolled covered entities. Using the Global Commitment authority, the DVHA provides incentive payments to providers for their 340B participation that recognizes the additional administrative burden of the program. Because of the beneficial 340B pricing, both Vermont and CMS benefit from higher rates of 340B covered entity-employed prescribers and Medicaid beneficiary participation in the program.

For the reporting period, Vermont has realized $465,290.82 net cost savings and year-to-date net cost savings of $1,096,054.10 through Medicaid participation of a relatively small number of eligible covered entities.

v. Mental Health System of Care

The Department of Mental Health (DMH) is continuing its Post-Irene work to build capacity within the inpatient and outpatient systems; expand quality and evaluation activities; and improve transitions of care. During this quarter, fourteen Level I beds at the Brattleboro Retreat and 7 Level I beds at Rutland Regional Medical Center were fully operational, and the Vermont Psychiatric Care Hospital (VPCH) operated at close to full capacity. DMH expects VPCH to be operating at its full capacity of 25 beds in the next quarter. DMH also anticipates that Soteria-Vermont (see below) will be begin accepting admissions in the next quarter. With the completion of these two final milestones, all of the psychiatric beds conceptualized and funded[2] through Act 79 will be operational.

An overview of psychiatric beds in the system of care Pre-Irene and projected through the end of SFY 2015 was outlined in the 2015 Department of Mental Health (DMH) Act 79 report and follows below.

Chart One: Psychiatric Beds in the System of Care (below)

[2] Act 79 authorized an additional 15 intensive residential recovery beds in northwestern Vermont, but there was not adaquete funding in the state budget to develop these beds.

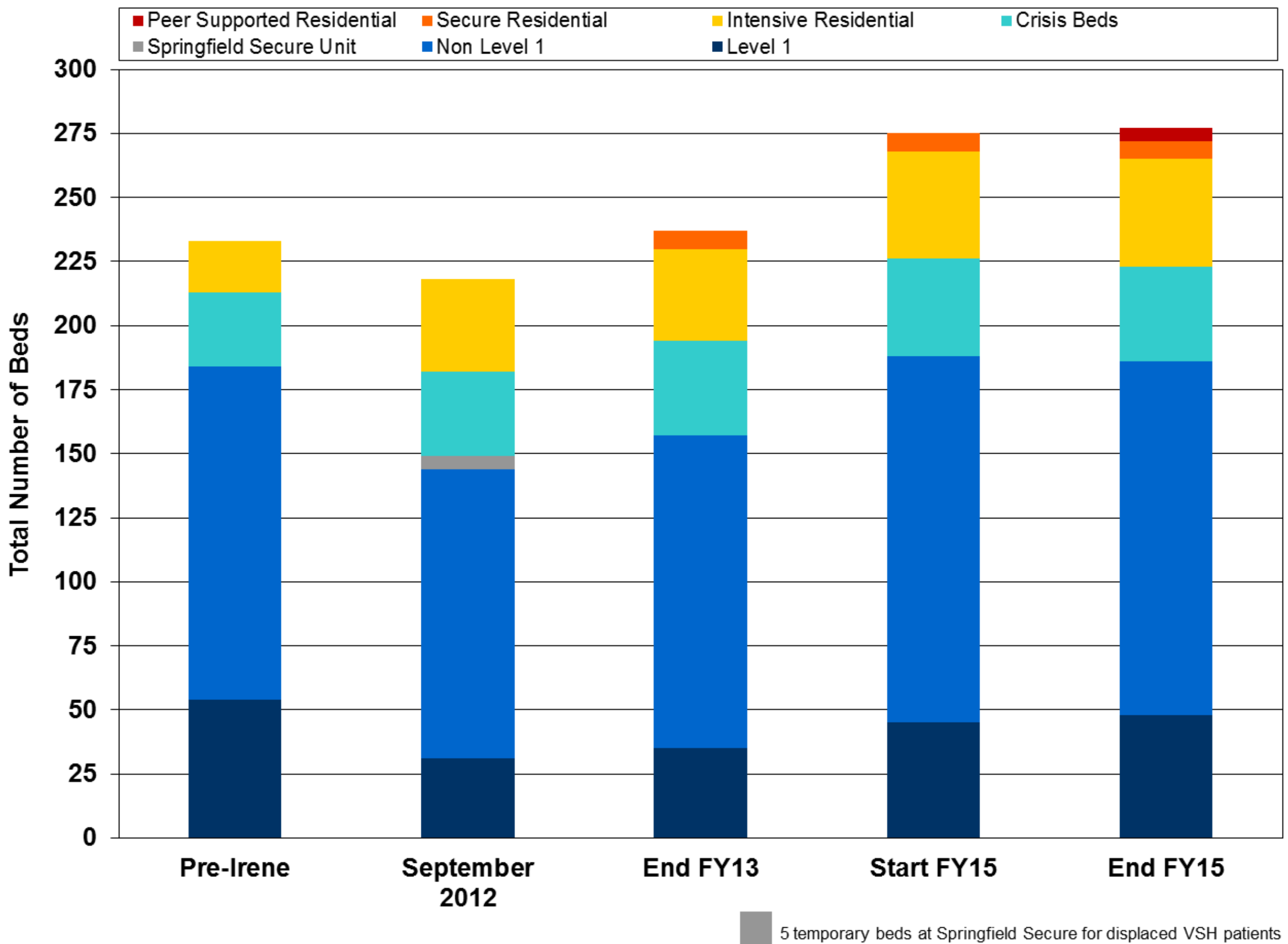

Chart 1 shows the changes in available psychiatric placements since August 2011. The total number of inpatient beds in the system at the start of SFY 2015 was 275. These include inpatient psychiatric treatment beds, residential treatment programs, crisis beds and peer–supported placements for transition.

Soteria-Vermont will be the last of the facilities conceptualized in Act 79 (and funded by the legislature) to open. The building is currently being renovated to accommodate a five-bed residence located in Burlington's Old North End. Soteria will offer a supportive environment for individuals going through an early experience of psychosis, will practice a cautious and limited use of psychoactive medications, and will provide a safe, flexible, empowering, home-like environment. Soteria-Vermont development is coming down the home stretch in terms of meeting its obligations for policies and procedures, accessible design, staffing, licensing, and a Certificate of Occupancy from the City of Burlington. Job postings have begun, and Soteria is purchasing furniture and household goods, office equipment and a house vehicle. An Open House will be planned for March of 2015.

At this time, demand for inpatient care still exceeds current capacity with some frequency. This is disruptive to the emergency care setting and not a standard that the department regards as adequate for individuals requiring inpatient care. To address this ongoing issue, DMH is continuing to monitor the functioning of the clinical resource management system to "coordinate the movement of individuals to

appropriate services throughout the continuum of care and to perform ongoing evaluations and improvements of the mental health system," as written in Act 79. This system encompasses the following functions:

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

With improvements to these care management and transition planning functions, in addition to VPCH and Soteria-VT becoming fully operational, the Department expects that pressure will be alleviated in the numbers of patients waiting for admission and the lengths of time they may spend in Emergency Departments or the Department of Corrections.

Community System Development:
Act 79 authorized significant investments in a more robust publicly funded mental health services system for Vermont. SFY 2014 and 2015 funding supported the implementation of service expansion in several support and services areas that will offer a stronger continuum of care for the public mental health system. Each new initiative carries reporting requirements to inform the Department of Mental Health (DMH) regarding overall contribution to the system of care and impacts to persons served. A full report of Act 79 funded initiatives and early outcomes was submitted to the Vermont Legislature on January 15, 2015. The report provides an overview of the significant program development areas and preliminary data collection and outcomes findings and can be found at: http://mentalhealth.vermont.gov/sites/dmh/files/report/legislative/2015-ACT79_Final_1-15-15.pdf.

Vermont's enhancement of community services was also highlighted this quarter at the Department of Mental Health's fall conference entitled *Challenges, Opportunities, and Future Directions of Vermont's Adult Mental Health System.* The conference featured 17 workshops focused on many different programs, services and innovations that have been implemented following Tropical Storm Irene, representing an investment in enhanced community and inpatient programming. As expressed by Commissioner Paul Dupre during his opening remarks, the conference demonstrated how much the system of care has changed over the last three years and the importance of how these new and enhanced programs need to work together to actively reduce and prevent the need for hospitalization. Vermont no longer has a large, centralized state hospital and we must change the way we do business to ensure this new capacity fully achieves the vision that was laid out in Act 79.

Integrated Family Services (IFS) Initiative:

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

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

The IFS Initiative seeks to bring all AHS children, youth and family services together in an integrated and consistent continuum of services for families. The premise being that giving families early support, education and intervention will produce more favorable health outcomes at a lower cost than the current practice of *waiting until circumstances are bad enough* to access funding which often result in treatment programs that are out of home or out of state. Several efforts are underway and include: performance based reimbursement projects, capitated annual budgets and flexible choices for self-managed services. Each of these is described in brief below. This integration is an ongoing process that is evolving into a very positive direction for children and families.

Annual Aggregate Budgets and PMPM for Medicaid Children's MH and Family Support Services:
The initial IFS pilot, in Addison County has finished the second full state fiscal year and we have started the second pilot region in Franklin/Grand Isle counties on April 1, 2014. The initial pilot included consolidation of over 30 state and federal funding streams into one unified whole through one master grant agreement; the second pilot also includes consolidation of several state and federal funding streams. The state has created an annual aggregate spending cap for two providers in Addison and one in Franklin/Grand Isle (this provider houses the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children (prenatal to 22) and families. For Addison, the aggregate annual budget for this pilot is approximately $4M with $3M being Global Commitment covered services, and in Franklin/Grand Isle the Global Commitment covered services are near $5.4M. The pilot successes are:

- Increased ability to provide the right services to children and their families more immediately.
- Increased ability to provide services in a child's natural setting.
- Increased ability to work with a variety of providers and bring resources together to support families.

- Reduction in separate and conflicting paperwork having a positive impact on the number of hours clinicians can spend on direct services.
- A more immediate response to families who ask for help who, prior to this pilot, were "not sick enough" to meet funding criteria.
- Unified local efforts to offer a single onsite response to families combining multiple state and federal programs that would otherwise be offered at differing times and places.
- Initial numbers indicate an ability to serve more children and families with the same amount of resources.

The financial model supporting this agreement includes a monthly PMPM rate established for the reimbursement of all Medicaid-covered sub-specialty services. Member month rates are based on agreed upon annual allocations for covered services divided by the minimum Medicaid caseload expectation. The same member month rates will be paid for minimal service packages as for intensive service packages. The goal of the funding model is to ensure that beneficiaries get a package of early periodic screening diagnostic and treatment and outreach services commensurate with their functional needs within an overall annual aggregate reimbursement cap. PMPM/Case rates are not based on any one group of services being "loaded" into a claim; they are global aggregate budget/minimum caseload. Annually, providers and the state will reconcile actual financial experience to the grant.

This shift continues to be addressed both programmatically and financially. There is a review of the method used to establish the PMPM to see if there is a more effective method.

The interest in moving statewide continues. Changes in leadership at the AHS Secretary's office and in IFS has led to a series of strategic planning activities over the past several months designed to establish clearer and broadly agreed upon population level indicators and service performance measures which grantee program accountability. IFS staff have attended meetings in four additional communities to talk about the vision for IFS and the process for communities to move toward integrated funding. Clear expansion criteria are in development and comprehensive governance agreement terms are also being refined. Additionally, IFS continues to work on statewide healthcare reform and aligning approaches to achieve an integrated behavioral health and physical health system.

VI. Financial/Budget Neutrality Development/Issues

Effective with the January 1, 2011 waiver renewal, AHS began paying DVHA a monthly PMPM estimate using the existing rates on file, in accordance with the new Special Terms and Conditions. This monthly payment reflects the State's monthly need for Federal funds based on estimated Global Commitment expenditures for the month. Beginning with the QE0311 filing, AHS has reconciled the Federal claims from the estimated monthly PMPM payments to the underlying actual Global Commitment expenditures incurred via the usual reconciliation draw process on a quarterly basis.

In mid-October 2014, a group comprised of representatives from AHS, DVHA, State of Vermont Finance & Management, and the Legislative Joint Fiscal Committee, met to forecast GC enrollment for the remainder of SFY 2015 and the upcoming SFY 2016 budget cycle. These forecasts are essential to building both the SFY appropriations request, as well as the quarterly CMS-37 estimates.

In early October 2014, AHS received a final draft report of the PMPM rate development from contracted actuarial firm, Milliman. For FFY 2015, Milliman developed two sets of rates: one set to be used as if there were no changes to the GC Waiver, and another set to be used if the GC and Choices

for Care Waivers were combined. Per the STCs, a copy of this actuarial report was sent to CMS in November 2014.

Throughout this quarter, AHS and CMS were involved in negotiations to combine the GC and Choices for Care Waiver. As part of this negotiation, AHS was asked to answer a set of Standard Funding Questions. AHS continues to work with CMS on providing detailed answers to these questions.

AHS has worked with DVHA and CMS throughout QE1214 to ensure all the new reporting requirements per the October 2, 2013 STCs are met. The State's eligibility system has faced some difficulty with accurate beneficiary coding post-ACA implementation; AHS and DVHA are currently working through issues with the Eligibility Services unit to ensure enrollees are properly bucketed in the proper MEGs. The State is working to institute a permanent automated solution.

VII. Member Month Reporting

Key updates from QE1214:

- Minor fluctuations in enrollment led to an overall decrease in enrollment of 0.80%.

Demonstration Populations are not synonymous with Medicaid Eligibility Group (MEG) reporting in Table 5. The numbers presented in the following table may represent duplicated population counts. For example, an individual in Demonstration Population 4, which is home and community-based services, and Demonstration Population 10 may in fact be in MEG 1 or 2.

This report is run the first Monday following the close of the month for all persons eligible as of the 15th day of the preceding month. Data reported in Table 4 are not used in Budget Neutrality Calculations or Capitation Payments, as information will change at the end of the quarter. The information in this table cannot be summed across quarters. All payments are adjusted at the end of the year to reconcile expected population movement between eligibility groups. The monthly totals for each of the last four quarters are reflected in Table 4.

Table 4. Number of Recipients, by Month

	QE0314			QE0614			QE0914			QE1214		
Demonstration Population	**Jan. 2014**	**Feb. 2014**	**March 2014**	**April 2014**	**May 2014**	**June 2014**	**July 2014**	**August 2014**	**Sept. 2014**	**Oct. 2014**	**Nov. 2014**	**Dec. 2014**
Demonstration Population 1	86,074	87,603	89,867	95,507	92,966	95,001	94,779	95,436	96,272	96,985	97,466	95,490
Demonstration Population 2	45,826	46,190	46,617	48,661	47,914	51,961	53,001	53,984	54,779	55,698	56,358	54,255
Demonstration Population 3	13,485	13,627	13,780	12,280	11,466	11,718	11,682	11,169	11,289	11,502	11,567	11,187
Demonstration Population 4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 5	1,103	1,155	1,208	1,639	1,716	1,990	2,017	2,074	2,145	2,187	2,212	2,080
Demonstration Population 6	2,175	1,857	1,585	0	0	0	0	0	0	0	0	0
Demonstration Population 7	2,379	2,021	1,743	11	1	1	2	2	0	2	0	0
Demonstration Population 8	10,168	10,203	10,130	9,963	10,027	9,894	9,832	9,797	9,707	9,755	9,677	9,752
Demonstration Population 9	2,607	2,588	2,581	2,546	2,557	2,496	2,471	2,470	2,453	2,475	2,432	2,466
Demonstration	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Population 10												
Demonstration Population 11	9,759	8,327	7,178	6	0	0	0	0	0	0	0	0
	173,576	173,571	174,689	170,613	166,647	173,061	173,784	174,932	176,645	178,604	179,712	175,230

Table 5. Enrollment Information and Counts for Demonstration Populations*, QE1214

Demonstration Population	Current Enrollees Last Day of Qtr 12/31/2014	Previously Reported Enrollees Last Day of Qtr 9/30/2014	Percent Variance 9/30/2014 to 12/31/2014	Variance by Enrollee Count 9/30/2014 to 12/31/2014
Demonstration Population 1:	95,490	96,272	-0.81%	(782)
Demonstration Population 2:	54,255	54,779	-0.96%	(524)
Demonstration Population 3:	11,187	11,289	-0.90%	(102)
Demonstration Population 4:	N/A	N/A	N/A	-
Demonstration Population 5:	2,080	2,145	-3.03%	(65)
Demonstration Population 6:	0	0	0.00%	0
Demonstration Population 7:	0	0	0.00%	0
Demonstration Population 8:	9,752	9,707	0.46%	45
Demonstration Population 9:	2,466	2,453	0.53%	13
Demonstration Population 10:	N/A	N/A	N/A	-
Demonstration Population 11:	0	0	0.00%	0
	175,230	176,645	-0.80%	

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

After several quarters with enrollment fluctuations, this quarter had no fluctuations greater than 5%. In QE1215, minor fluctuations in enrollment led to an overall decrease in enrollment of 0.80%.

VIII. Consumer Issues

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

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

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

IX. Quality Improvement

Key updates from QE1214:

- The *Follow-up After Hospitalization for Mental Illness* Performance Improvement Project's interim study indicators was distributed to the designated hospitals.
- DVHA Quality Improvement (QI) staff attended Results Based Accountability software training in October 2014 and plan to develop—in conjunction with DVHA Senior Leadership—both internal- and external-facing performance outcome scorecards.
- DVHA QI staff attended the CMS-sponsored National Quality Conference in Baltimore, Maryland.

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

Quality Committee Updates:
The MCE Quality Committee is made up of representatives from the DVHA and its IGA Partners under the Global Commitment to Health Waiver. This Committee met monthly in QE1215. During this period, the Committee reviewed the scope of work, reviewed and approved the Committee Charter and updated the annual work plan. The Committee is also working towards agreement on standard report formatting for Committee members to use for future presentations. This will include a summary or pre-analysis findings, which will enable the Committee to focus on improvement recommendations moving forward.

MCE Investment Review:
As part of an agency-wide process improvement project - a joint AHS-DVHA work group was tasked with an in-depth analysis of the current Global Commitment to Health investment expenditures earlier this year. Moving beyond measuring and reporting data, to managing performance toward improving results, is an AHS-wide priority and was one of the drivers to initiate this review. The review hopes to answer the following questions: are existing AHS MCO Investment expenditures realizing optimal outcomes?; are appropriate performance measures in place?; is the service performing to expectations?; can existing MCO Investment appropriations be realigned to better meet one of the four allowable criteria?; and are there any existing MCO Investments that could become programmatic or administrative claims instead? This work group set review criteria, created a tracking spreadsheet, and conducted a prioritized first set of investment reviews. A summary of Phase I findings is due during QE0315.

Formal (Validated) Performance Improvement Project:
DVHA continues to lead an AHS-wide Performance Improvement Project (PIP) on Follow-up After Hospitalization (FUH) for Mental Illness, the study indicator for which is the Healthcare Effectiveness Data and Information Set (HEDIS) measure of the same name (FUH HEDIS). During this quarter, follow-up appointment scheduling reports were prepared and distributed to the designated hospitals and will again be distributed in January 2015. Members of the FUH implementation team will also

attend the designated hospital in-person meeting in January 2015 to discuss best practices and barriers experienced thus far with the project. Data Unit representatives from DVHA and the Department of Mental Health have been working together to prepare preliminary calendar year 2014 FUH measure results for the implementation team to review in mid-January 2015.

Consumer Assessment of Healthcare Providers and Systems Survey:
The DVHA Quality Unit's QI Administrator coordinated the RFP process for the continuation of the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Vendor proposals were reviewed and scored, and a new contract was drawn up during QE1214. DVHA is planning to work with a NCQA-certified vendor in CY 2015 and focus the CAHPS survey efforts on children. The plan is to incorporate the children's chronic conditions supplemental question set for the first time in 2015. Additionally, DVHA is participating in a national experience of care survey effort for the adult Medicaid population. This is being coordinated by the National Opinion Research Center at the University of Chicago.

Quality Measure Core Set Reporting:
The DVHA QI Administrator met with representatives from DVHA's Policy and Data units to coordinate the annual quality measure core set reporting for both adults and children. DVHA continues to increase the number of measures reported for both measure sets and is prepared to meet the CMS reporting deadlines of December 31, 2014 and January 31, 2015 for children and adults, respectively.

National Quality Conference:
The DVHA QI staff attended the CMS-sponsored National Quality Conference in Baltimore, MD in December 2014 as Adult Medicaid Quality and CHIPRA Grant representatives. The staff prepared storyboard presentations of the Breast Cancer Screening PIP and the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment PIP.

AHS Performance Accountability Committee:
DVHA's Quality Unit Director continued to represent Vermont Medicaid's *Global Commitment for Health* activities at the monthly AHS-lead Performance Accountability Committee (PAC) meetings. During this quarter, the committee continued to clarify its roles and responsibilities relative to the Medicaid Program and the additional programs and services provided or supported by the Agency of Human Services. In addition to changes in the community structure and operations, specific deliverables were identified to assist the group in assessing its performance. It was agreed that this group will focus on establishing, maintaining, and further developing an AHS-wide Performance/Quality Management framework by focusing on business processes related to measuring, monitoring, and improving population and program performance.

AHS Quality Improvement Manager:
During this quarter, the AHS Quality Improvement Manager (QIM) worked with the External Quality Review Organization (EQRO) to produce a final report of the Performance Improvement Project (PIP) validation activity. The PIP validation evaluated the technical methods of the PIP (i.e., the study design and implementation/evaluation). The *Follow-up After Hospitalization for Mental Illness* PIP received a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements in the Study Design and Implementation and Evaluation stages. DVHA elected not to resubmit the PIP for a second validation because the original submission had 100 percent of evaluation elements receive a *Met* score. The performance of this PIP suggests a thorough application of the PIP design. DVHA's documentation provided evidence that they appropriately conducted the data collection activities of the Implementation stage. These activities ensured that the study properly

defined and collected the necessary data to produce accurate study indicator rates. Additionally, DVHA documented appropriate improvement strategies targeted to overcome identified barriers.

During this quarter, the AHS QIM worked with the External Quality Review Organization (EQRO) to produce a final report of the Performance Measure Validation (PMV) activity. DVHA staff demonstrated their commitment to performance measure reporting in many ways again this year. DVHA enjoyed a high degree of electronic claims data and automated processes, enhancing the validity of data, while the payment structure facilitated data completeness. DVHA's HEDIS team collaborates well with the common goal of obtaining complete and accurate data. Starting last year, DVHA's quality team began reviewing performance measure rates in detail in an effort to identify mechanisms for improving the quality of care and outcomes for members. The EQRO recommended that DVHA continue this review practice and enhance it to identify rates that fall below the national 10th percentiles.

During this quarter, the AHS QIM also worked with the EQRO to produce a final report of the Compliance with Standards review activity. DVHA staff members were diligent, detailed and exemplary in the manner and detail with which they identified and provided to the EQRO for its office-based desk review of documentation (and during the on-site review) key DVHA documents that demonstrated their actions and performance in complying with the set of standards and associated requirements. It was clear from the review of DVHA's documentation, organizational structure, and staff responses during the interviews that DVHA staff members were passionate about providing quality, accessible, timely care and services to members and regularly went well beyond the minimum required to ensure that they took care of the members and adequately responded to their needs, while complying with the applicable CMS and AHS requirements related to this year's compliance review activity. It was also clear that, during the year, AHS and DVHA initiated numerous new, or enhanced existing projects and programs, designed to both improve member care and access to quality, accessible, and timely services. The EQRO also determined during its review that DVHA had strengthened its organizational structure; management and administrative processes; and the quality, frequency and level of detail and meaningful information in its written documents, including Operating Principles (i.e., policies and procedures), reports related to numerous activities, and IGAs with partner delegates. In addition, DVHA staff was actively engaged with AHS on its expansion and redesign activities. It was also evident that DVHA had enhanced oversight of its partner delegates and contractors/vendors. During the interviews, the EQRO reviewers found DVHA staff members to be open and candid about both the accomplishments and outcomes achieved that they were proud of and those where they recognized and were either already beginning to implement or planned to implement continued improvements.

Finally, during this quarter, the AHS QIM worked with the EQRO to develop the Annual Technical Report. This document combines the results of all three external quality review activities and identifies strengths and challenges associated with the three activities as well as making recommendations to improve the timeliness, access, and quality of services provided by the MCE. With each successive EQR contract year, it was found that for the three activities the EQRO conducted, DVHA continues to follow up on prior year EQRO recommendations and initiate numerous additional improvement efforts. DVHA, in consultation with AHS, continues to regularly conduct self-assessments and, as applicable, modifies its internal organizational structure and key positions to more effectively align staff skills, competencies, and strengths with the work required and unique challenges associated with each operating unit within the organization. DVHA's continuous quality improvement focus and activities, along with the steady improvements made across the years, continue to be substantive and

led to demonstrated performance improvements, notable strengths, and commendable and impressive outcomes across multiple areas and performance indicators.

X. Compliance

Key updates from QE1214:

- DVHA's final EQRO audit report was released; the overall compliance score improved to 92% during this year's cycle.
- DVHA implemented a corrective action plan to address the EQRO required actions. All corrections will be complete by March 2015.
- The Compliance Committee will expand to include all AHS Managed Care Compliance issues. The committee will be co-chaired by leaders from AHS and DVHA.

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

EQRO Audit Results:
In October 2015, DVHA received the final report of the EQRO compliance audit. The EQRO reviewed DVHA's performance related to 93 elements across the eight standards. Of the 93 requirements, DVHA obtained a score of *Met* for 79 of the requirements and a score of *Partially Met* for 14 elements. As a result, DVHA obtained a total percentage of compliance score of 92 percent across the applicable elements. With scores at or above 90 percent in seven of the eight standard areas reviewed, DVHA demonstrated numerous performance strengths in meeting the federal structure and operations regulations and AHS contract requirements. Four of the seven standards indicated significant areas of strength, with scores of 100 percent. For the only standard area with a score below 90 percent—Beneficiary Information—DVHA scored *Partially Met* on eight of the 20 evaluation elements and, therefore, has targeted opportunities for improvement in those areas. DVHA's performance represented improvement compared to its overall performance for the EQRO's 2010–2011 review of the same standards. For that review, DVHA scored 90 percent across the eight standard areas as compared to 92 percent this year. All but one standard area either maintained the previous high performance or improved. The score for only one standard declined from the previous review—Beneficiary Information.

The audit focused on the following standards:

I. Provider Selection
II. Credentialing and Re-credentialing of providers
III. Beneficiary Information
IV. Beneficiary Rights
V. Confidentiality
VI. Grievance System—Beneficiary Grievances
VII. Grievance System—Beneficiary Appeals and State Fair Hearings
VIII. Subcontractual Relationships and Delegation

In their final report, the auditors noted that:

"*It was clear from the review of DVHA's documentation, organizational structure, and staff responses*

during the interviews that DVHA staff members were passionate about providing quality, accessible, timely care and services to members and regularly went well beyond the minimum required to ensure that they took care of the members and adequately responded to their needs, while complying with the applicable CMS and AHS requirements related to this year's compliance review activity. It was also clear that, during the year, AHS and DVHA initiated numerous new, or enhanced existing projects and programs, designed to both improve member care and access to quality, accessible, and timely services."

The audit identified several areas requiring corrective action, including:

- The Member Handbook needs to do a better job of describing confidentiality practices.
- DVHA needs to inform members that they can choose to disenroll from Medicaid/Dr. Dynasaur if they no longer want coverage.
- The Member Handbook should inform members about the appeal rights given to providers.
- Members should be informed that post-emergency stabilization services are covered, even if the hospital providing the care is not already an enrolled Vermont Medicaid provider.
- The Provider Manual needs to include information about the provider's obligation to assist during a member's appeal or fair hearing.
- DVHA needs to more consistently define the term "action" as it relates to appeals and fair hearings.
- One of DVHA's IGA partners will need to more carefully adhere to notice and decision timelines for appeals.
- DVHA and AHS need to better define what is meant by "reconsideration" and make sure this definition complies with the grievance and appeals requirements.

DVHA has a corrective action plan in place and it is anticipated that all of these corrections will be completed by March 2015.

Compliance Committee Expansion:
DVHA's Compliance Committee will expand to include all AHS Managed Care Compliance needs. This expansion will allow the State to more efficiently handle compliance issues with a broader focus across the Agency. The meetings will be chaired by leaders from AHS and DVHA.

XI. Demonstration Evaluation

During this quarter, the AHS QIM reviewed the status of the Global Commitment evaluation plan results and provided an update on its results. Highlights included the following: increased average enrollment, decrease in Vermont's uninsured rate, and improvement on numerous HEDIS and CHAPS quality measures. In anticipation of the Global Commitment and Choices for Care waiver consolidation, the AHS QIM also reviewed the status of the Choices for Care evaluation plan and provided an update on its results. Highlights included the following: increased ability to serve participants in the community, elimination of waiting lists for high needs group participants, decrease in the number of applicants waiting for eligibility and financial determination, as well as improvement on numerous consumer satisfaction measures. In addition to improved beneficiary experience, cost control initiatives under both waivers have proven very successful. Also during this quarter, the AHS QIM continued to be involved in the Vermont SIM grant evaluation design and planning.

XII. Reported Purposes for Capitated Revenue Expenditures

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

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

Attachment 6 is a summary of Managed Care Entity Investments, with applicable category identified, for SFY 2014.

XIII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook

Attachment 2: Enrollment and Expenditures Report

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of the Health Care Advocate Report

Attachment 6: State Fiscal Year 2014 Managed Care Entity Investments

XIV. State Contact(s)

Fiscal:	Sarah Clark, CFO	
	VT Agency of Human Services	802-871-3005 (P)
	208 Hurricane Lane	802-871-3001 (F)
	Williston, VT 05495	sarah.clark@state.vt.us
Policy/Program:	Monica Light, Director	
	AHS Health Care Operations, Compliance, and Improvement	
	VT Agency of Human Services	802-871-3254 (P)
	208 Hurricane Lane	802-871-3001 (F)
	Williston, VT 05495	monica.light@state.vt.us
Managed Care Entity:	Steven M. Costantino, Commissioner	
	Department of VT Health Access	802-879-5901 (P)
	312 Hurricane Lane, Suite 201	802-879-5952 (F)
	Williston, VT 05495	steven.costantino@state.vt.us

Date Submitted to CMS: February 27, 2015

ATTACHMENTS

Global Commitment Expenditure Tracking

Attachment 1

QE	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY**9a**	PQA: WY**9b**	PQA: WY10	PQA: WY11	Net Program PQA	Net Program Expenditures as reported on 64	Excess New Adult Expenditures as reported on 64 per STC 55e	non-MCO Admin Expenses	Total columns J:K for Budget Neutrality calculation - **Includes** New Adult	Cumulative Waiver Cap - **Excluding** New Adult per 10/2/13 STCs	Variance to Cap under/(over)
1205	$ 178,493,793														$ 178,493,793					
0306	$ 189,414,365	$ 14,472,838												$ 14,472,838	$ 203,887,203					
0606	$ 209,647,618	$ (14,172,165)												$ (14,172,165)	$ 195,475,453					
0906	$ 194,437,742	$ 133,350												$ 133,350	$ 194,571,092					
WY1 SUM	$ 771,993,518	$ 434,023												$ 434,023	**$ 782,159,845**		**$ 4,620,302**	**$ 786,780,147**	**$ 841,266,663**	**$ 54,486,516**
1206	$ 203,444,640	$ 8,903												$ 8,903	$ 203,453,543					
0307	$ 203,804,330	$ 8,894,097												$ 8,894,097	$ 212,698,427					
0607	$ 186,458,403	$ 814,587	$ (68,408)											$ 746,179	$ 187,204,582					
0907	$ 225,219,267	$ -	$ -											$ -	$ 225,219,267					
WY2 SUM	$ 818,926,640	$ 9,717,587	$ (68,408)											$ 9,649,179	**$ 802,884,359**		**$ 6,464,439**	$ 809,348,797		
Cumulative																		**$ 1,596,128,945**	**$ 1,684,861,317**	**$ 88,732,372**
1207	$ 213,871,059	$ -	$ 1,010,348											$ 1,010,348	$ 214,881,406					
0308	$ 162,921,830	$ -	$ -											$ -	$ 162,921,830					
0608	$ 196,466,768	$ 14,717	$ -	$ 40,276,433										$ 40,291,150	$ 236,757,918					
0908	$ 228,593,470	$ -	$ -	$ -										$ -	$ 228,593,470					
WY3 SUM	$ 801,853,126	$ 14,717	$ 1,010,348	$ 40,276,433										$ 41,301,498	**$ 881,729,256**		**$ 6,457,896**	$ 888,187,152		
Cumulative																		**$ 2,484,316,097**	**$ 2,604,109,308**	**$ 119,793,211**
1208	$ 228,768,784		$ -	$ -										$ -	$ 228,768,784					
0309	$ 225,691,930		$ (16,984,221)	$ 38,998,635	$ (4,144,041)									$ 17,870,373	$ 243,562,303					
0609	$ 204,169,638		$ -	$ 686,851	$ 5,522,763									$ 6,209,614	$ 210,379,252					
0909	$ 235,585,153		$ -	$ 30,199	$ 34,064,109									$ 34,094,308	$ 269,679,461					
WY4 SUM	$ 894,215,505	$ -	$ (16,984,221)	$ 39,715,685	$ 35,442,831									$ 58,174,295	**$ 935,368,819**		**$ 5,495,618**	$ 940,864,437		
Cumulative																		**$ 3,425,180,534**	**$ 3,606,430,571**	**$ 181,250,037**
1209	$ 241,939,196				$ 5,192,468									$ 5,192,468	$ 247,131,664					
0310	$ 246,257,198				$ 531,141	$ 4,400,166								$ 4,931,306	$ 251,188,504					
0610	$ 253,045,787				$ 248,301	$ 5,260,537								$ 5,508,838	$ 258,554,625					
0910	$ 252,294,668			$ (115,989)	$ (261,426)	$ 3,348,303								$ 2,970,888	$ 255,265,556					
WY5 SUM	$ 993,536,849	$ -	$ -	$ (115,989)	$ 5,710,484	$ 13,009,006								$ 18,603,501	**$ 1,012,990,839**		**$ 5,939,459**	$ 1,018,930,298		
Cumulative																		**$ 4,444,110,832**	**$ 4,700,022,174**	**$ 255,911,342**
1210	$ 262,106,988				$ -	$ 6,444,984								$ 6,444,984	$ 268,551,972					
0311	$ 257,140,611													$ -	$ 257,140,611					
0611	$ 277,708,043						$ (121,416)							$ (121,416)	$ 277,586,627					
0911	$ 243,508,248						$5,528,143							$ 5,528,143	$ 249,036,391					
WY6 SUM	$ 1,040,463,890	$ -	$ -	$ -	$ -	$ 6,444,984	$5,406,727							$ 11,851,711	**$ 1,045,342,616**		**$ 6,071,553**	$ 1,051,414,168		
Cumulative																		**$ 5,495,525,000**	**$ 5,865,213,737**	**$ 369,688,737**
1211	$ 253,147,037						$ (531,744)							$ (531,744)	$ 252,615,293					
0312	$ 267,978,672						$ 3,742	$ 49,079						$ 52,821	$ 268,031,493					
0612	$ 302,958,610							$ 6,393,928						$ 6,393,928	$ 309,352,538					
0912	$ 262,406,131							$ 7,750,994						$ 7,750,994	$ 270,157,125					
WY7 SUM	$ 1,086,490,450	$ -	$ -	$ -	$ -	$ -	$ (528,002)	$ 14,194,000						$ 13,665,998	**$ 1,134,526,550**		**$ 5,751,066**	$ 1,140,277,616		
Cumulative																		**$ 6,635,802,617**	**$ 7,113,290,903**	**$ 477,488,286**
1212	$ 282,701,072							$ 3,036,447						$ 3,036,447	$ 285,737,519					
0313	$ 285,985,057							$ 991,340						$ 991,340	$ 286,976,397					
0613	$ 336,946,361							29,814,314	$ (125,679)					$ 29,688,635	$ 366,634,996					
0913	$ 286,067,548								$ 2,162,772					$ 2,162,772	$ 288,230,320					
WY8 SUM	$ 1,191,700,038	$ -	$ -	$ -	$ -	$ -	$ -	$ 33,842,100	$ 2,037,093					$ 35,879,193	**$ 1,199,887,555**		**$ 6,260,794**	$ 1,206,148,349		
Cumulative																		**$ 7,841,950,966**	**$ 8,450,684,486**	**$ 608,733,520**
1213	$ 319,939,651								$ 3,652,767					$ 3,652,767	$ 323,592,418					
WY**9a** SUM	$ 319,939,651	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,652,767					$ 3,652,767	$ 319,921,780		**$ 1,214,631**	$ 321,136,411		
Cumulative																		**$ 8,163,087,376**	**$ 8,955,886,798**	**$ 792,799,422**
0314	$ 288,542,475								$ 2,159,834					$ 2,159,834	$ 290,702,309					
0614	$ 288,845,927													$ -	$ 288,845,927					
0914	$ 242,449,803								$ 337,823	$ (17,871)	$ 1,743,008			$ 2,062,960	$ 244,512,763					
1214	$ 286,853,166										$ 867,215			$ 867,215	$ 287,720,381					
WY**9b** SUM	$ 1,106,691,370	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,497,657	$ (17,871)	$ 2,610,223			$ 5,090,009	$ 1,109,301,593		**$ 5,086,126**	$ 1,114,387,719		
Cumulative																		**$ 9,277,475,096**	**$ 10,290,338,883**	**$ 1,012,863,787**
0315														$ -	$ -					
0615														$ -	$ -					
0915														$ -	$ -					
1215														$ -	$ -					
WY10 SUM	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -		**$ -**	$ -		
Cumulative																		**$ 9,277,475,096**	**$ 11,706,456,093**	**$ 2,428,980,997**
0316														$ -	$ -					
0616														$ -	$ -					
0916														$ -	$ -					
1216														$ -	$ -					
WY11 SUM	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		**$ -**	$ -		
Cumulative																		**$ 9,277,475,096**	**$ 13,209,265,211**	**$ 3,931,790,115**
	$ 9,025,811,037	$ 10,166,327	$ (16,042,281)	$ 79,876,130	$ 41,153,315	$ 19,453,990	$4,878,725	$ 48,036,100	$ 8,187,517	$ (17,871)	$ 2,610,223	$ -	$ -		**$ 9,224,113,212**	$ -	$ 53,361,884			

VERMONT

Attachment 2

State of Vermont
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston VT 05495-2807
dvha.vermont.gov

Agency of Human Services
[Phone] 802-879-5900
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Glossary of Terms

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

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The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS Medicaid Spend

All AHS YTD '15

Wednesday, February 11, 2015

	SFY '15 BAA			SFY '15 Actuals thru Dec. 31, 2014			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	15,378	$ 193,276,892	$ 1,047.35	15,631	$ 90,313,432	$ 962.95	46.73%
ABD Dual	17,682	$ 201,843,736	$ 951.26	17,730	$ 97,252,505	$ 914.20	48.18%
General Adult	15,504	$ 97,628,847	$ 524.74	16,457	$ 48,524,656	$ 491.42	49.70%
New Adult	48,500	$ 209,264,433	$ 359.56	49,897	$ 116,259,589	$ 388.34	55.56%
Sunsetted Program*					$ (601,563)		
Exchange Premium Assistance #	18,007	$ 7,974,888	$ 36.91	16,985	$ 2,920,871	$ 28.66	36.63%
Exchange Cost Sharing #	5,859	$ 1,372,578	$ 19.52	5,145	$ 511,812	$ 16.58	37.29%
ABD Child	3,713	$ 94,079,724	$ 2,111.29	3,760	$ 41,472,504	$ 1,838.40	44.08%
General Child	58,301	$ 240,111,188	$ 343.21	59,618	$ 128,284,871	$ 358.63	53.43%
Underinsured Child	1,082	$ 2,731,816	$ 210.34	2,179	$ 3,098,828	$ 237.08	113.43%
SCHIP	4,273	$ 9,918,936	$ 193.43	3,134	$ 4,675,219	$ 248.64	47.13%
Pharmacy Only	12,684	$ 6,585,623	$ 43.27	12,173	$ 1,823,110	$ 24.96	27.68%
Choices for Care	4,177	$ 208,784,793	$ 4,165.02	4,133	$ 105,248,954	$ 4,244.42	50.41%
Total Medicaid	205,162	$ 1,273,573,454	$ 517.30	206,842	$ 639,784,790	$ 515.52	50.24%

* - Sunsetted Programs defined as VHAP, VHAP ESI, Catamount and ESIA Medicaid Eligible Groups

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

State of Vermont
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dvha.vermont.gov

Agency of Human Services
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The Department of Vermont Health Access

Caseload and Expenditure Report ~ DVHA Only Medicaid Spend

DVHA YTD '15

Wednesday, February 11, 2015

	SFY '15 BAA			SFY '15 Actuals thru Dec. 31, 2014			% of Approp.
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	Spent to Date
ABD Adult	15,378	$ 112,692,767	$ 610.67	15,631	$ 52,195,786	$ 556.53	46.32%
ABD Dual	17,682	$ 49,371,309	$ 232.68	17,730	$ 25,355,647	$ 238.35	51.36%
General Adult	15,504	$ 88,847,459	$ 477.54	16,457	$ 43,860,888	$ 444.19	49.37%
New Adult	48,500	$ 193,856,692	$ 333.09	49,897	$ 106,155,125	$ 354.58	54.76%
Sunsetted Programs*					$ (609,777)		
Exchange Premium Assistance #	18,007	$ 7,974,888	$ 36.91	16,985	$ 2,920,871	$ 28.66	36.63%
Exchange Cost Sharing #	5,859	$ 1,372,578	$ 19.52	5,145	$ 511,812	$ 16.58	37.29%
ABD Child	3,713	$ 39,330,836	$ 882.64	3,760	$ 15,484,202	$ 686.39	39.37%
General Child	58,301	$ 134,490,705	$ 192.24	59,618	$ 72,186,682	$ 201.80	53.67%
Underinsured Child	1,082	$ 1,279,046	$ 98.48	2,179	$ 2,087,758	$ 159.72	163.23%
SCHIP	4,273	$ 7,165,946	$ 139.74	3,134	$ 3,595,597	$ 191.22	50.18%
Pharmacy Only	12,684	$ 6,585,623	$ 43.27	12,173	$ 1,823,110	$ 24.96	27.68%
Choices for Care	4,177	$ 208,784,793	$ 4,165.02	4,133	$ 105,248,954	$ 4,244.42	50.41%
Total Medicaid	205,162	$ 851,752,643	$ 345.97	206,842	$ 430,816,656	$ 347.14	50.58%

* - Sunsetted Programs defined as VHAP, VHAP ESI, Catamount and ESIA Medicaid Eligible Groups

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

Attachment 3

State of Vermont
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Agency of Human Services

Questions, Complaints and Concerns Received by Health Access Member Services
September 29, 2014 – January 3, 2015

<u>September 29 – October 4</u>

- Active OVHAD claims in RxClaims billing system prior to Medicare becoming active causing inability to pick up prescriptions: CSR's created a SR and supervisors forwarded it to Catamaran to correct dates.
- PC Plus Enrollment: CSR's assisted callers with enrolling in their PCP of choice.
- TPL Closures: CSR's submitted TPL closures or transferred to SSU is necessary.

<u>October 6 – October 11</u>

- Active OVHAD claims in RxClaims billing system prior to Medicare becoming active causing inability to pick up prescriptions: CSR's created a SR and supervisors forwarded it to Catamaran to correct dates.
- VPharm bills not received: CSR's advised when payment was due and UID, and reprinted bill if requested.

<u>October 13 – October 18</u>

- PCP Enrollment: CSR's assisted callers with enrolling in their PCP of choice.
- PDP Reports: CSR's escalated an SR to level 3.

<u>October 20 – October 25</u>

- LIS applications: CSR's updated the ACCESS or referred the caller to SSA/AOC for further assistance.
- New PDP Reports: CRS's followed references to make the change or referred the caller AOA for further assistance.
- Late Premium Notices for VPharm: CSR's advised is payment received or provided the mailing address for it to be received by 11/3.

<u>October 27 – November 1</u>

- No issues to report this week.

November 3 – November 8

- Medicare Part D billing information in system early: CSR's notified Supervisors to email Catamaran to resolve the issue.

November 10 – November 15

- Medicare Part D billing information in system early: CSR's notified Supervisors to email Catamaran to resolve the issue

November 17 – November 22

- PDP changes: CSR's escalated the call per the Taking Calls reference.
- RxClaims discrepancy: MPSOVAD Segments are still showing early in RxClaims. CSR's called the Supervisor queues to have an email sent to Catamaran.

November 24 – November 29

- VPharm Payments: CSR's advised callers that they have until December 1 to make a payment and provided a mailing address
- RxClaims discrepancy: MPSOVAD Segments are showing early in RxClaims. CSR's alerted a Supervisor to have an email sent to Catamaran.

December 1 – December 6

- MSP Notice stating beneficiary is no longer eligible: CSR's reviewed account to see if there had been a change that would make the caller no longer eligible, and if no change was made transferred to HAEU.
- RxClaims discrepancy: MPSOVAD Segments are showing early in RxClaims. CSR's alerted a Supervisor to have an email sent to Catamaran.

December 8 – December 13

- New PDP or changes to existing plan: CSR's escalated the information to the DVHA PDP team.
- MSP closure notices: CSR's reviewed account and advised if the notice was incorrect or why they were no longer eligible.
- Medicare Part D billing information in system early: CSR's notified Supervisors to email Catamaran to resolve the issue.

December 15 – December 20

- Medicare Part D billing information in system early: CSR's notified Supervisors to email Catamaran to resolve the issue.

December 22 – December 27

State of Vermont *Agency of Human Services*
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dvha.vermont.gov

- Medicare Part D billing information in system early: CSR's notified Supervisors to email Catamaran to resolve the issue.

December 29 – January 3

- Medicare Part D billing information in system early: CSR's notified Supervisors to email Catamaran to resolve the issue.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
October 1, 2014 – December 31, 2014

The MCE is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCE are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCE database. This report is based on data compiled on January 15, 2015 from the centralized database for grievances and appeals that were filed from October 1, 2014 through December 31, 2014.

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

During this quarter, there were 30 grievances filed with the MCE; with sixteen of them being 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 two days. Of the grievances filed, 73% were filed by beneficiaries, and 27% were filed by a representative of the beneficiary. Of the 30 grievances filed, DVHA had 57%, and DMH had 43%.

There were no Grievance Reviews filed this quarter.

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

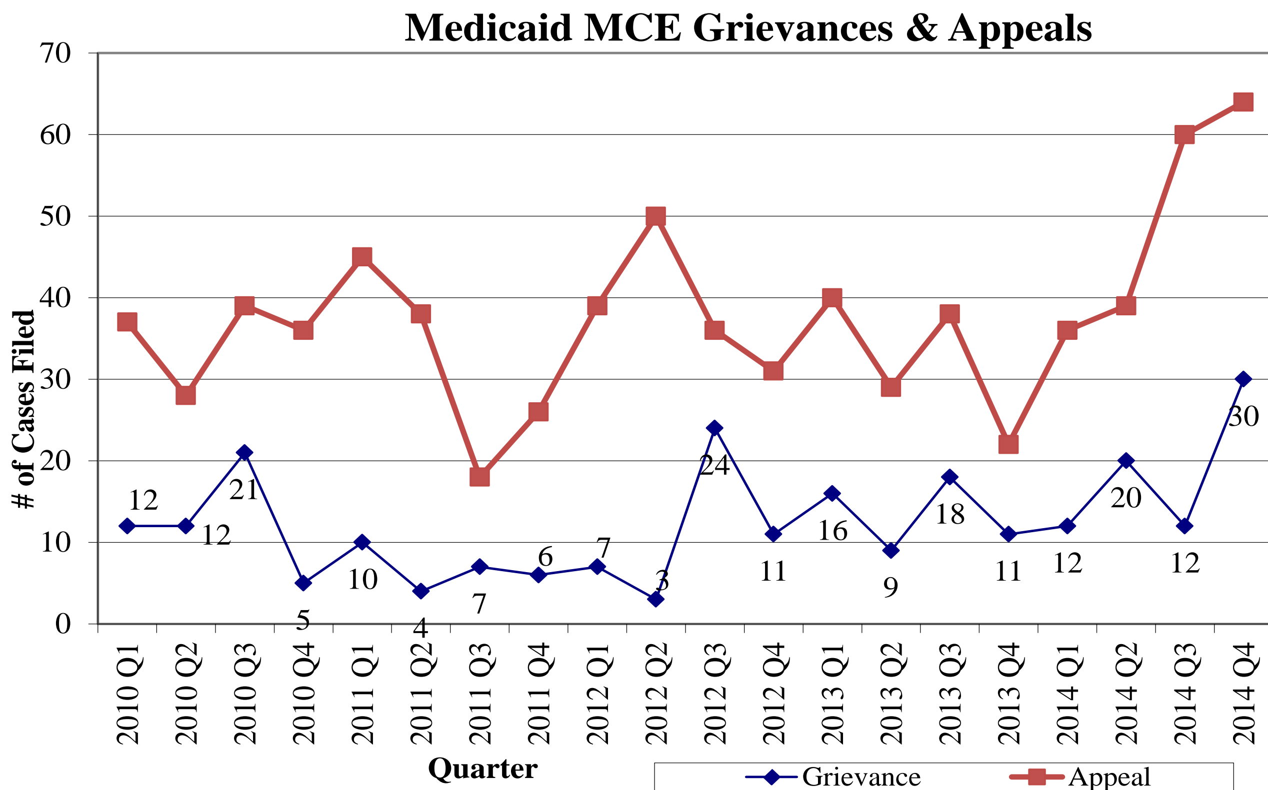
1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered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

During this quarter, there were 64 appeals filed with the MCE; 25 requested an expedited decision, with 18 of them meeting the criteria. Of these 64 appeals, 55 were resolved (86% of filed appeals), and 9 were still pending (16%). In fourteen cases (33% of those resolved), the original decision was upheld by the person hearing the appeal, in eighteen cases (25%) the original decision was reversed, and in twenty three cases the decision was approved by the department (42%).

Of the 55 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 64% were resolved within 30 days. The average number of days it took to resolve these cases was 23 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days, with none of them being late.

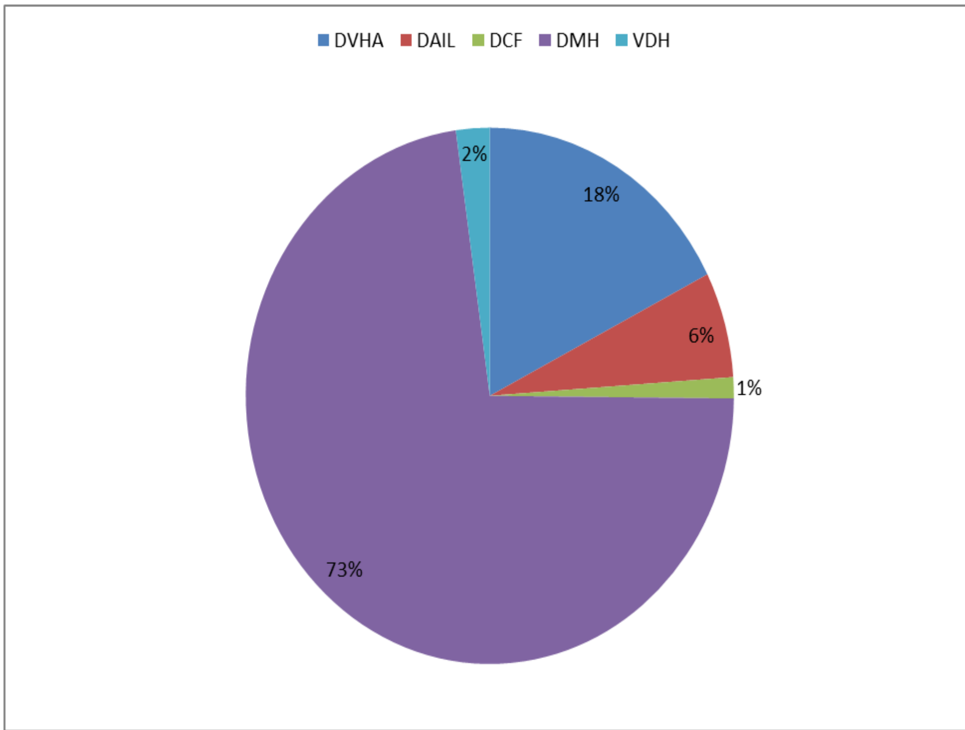
Of the 64 appeals filed, 36 were filed by beneficiaries (56%), 27 were filed by a representative of the beneficiary (42%), and 1 (2%) was filed by the provider. Of the 64 appeals filed, DVHA had 88%, DAIL had 9%, and DMH had 3%.

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

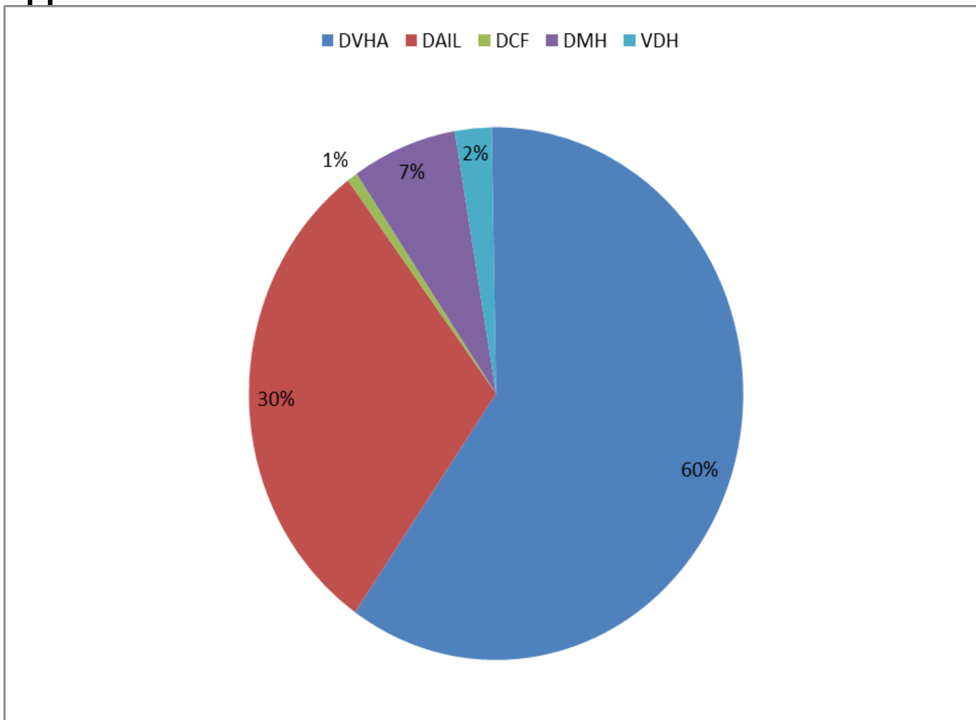


MCE Grievance & Appeals by Department
From January 1, 2010 through December 31, 2014

Grievances



Appeals



Attachment 5

VERMONT LEGAL AID, INC.

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OFFICES:
MONTPELIER
SPRINGFIELD

QUARTERLY REPORT
October 1, 2014 – December 31, 2014
to the
Agency of Administration
submitted by
Trinka Kerr, Chief Health Care Advocate
January 21, 2015
NARRATIVE

I. Introduction

The Office of the Health Care Advocate (HCA) provides consumer assistance to individual Vermonters on questions and problems related to health insurance and health care. The HCA also engages in consumer protection activities on behalf of the public before the Green Mountain Care Board, other state agencies and the state legislature.

The full quarterly report for October 1, 2014-December 31, 2014 includes:

- This Narrative which contains sections on **Individual Consumer Assistance, Consumer Protection Activities** and **Outreach and Education**
- Six data reports, including three based on the caller's insurance status:
  - **All calls/all coverages**: 1,225 calls
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 502 calls or **41%** of total calls
  - **Commercial plan beneficiaries**: 309 calls or **25%**
  - **Uninsured Vermonters**: 126 calls or **10%**
  - **Vermont Health Connect**: 470 calls or **38%** (this data report draws from the All Calls data set above)
  - **Reportable Activities (Summary & Detail):** 129 activities, 54 documents

II. Individual Consumer Assistance

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

The HCA received 1,225 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:

- **18.37%** (225) about **Access to Care**;
- **13.80%** (169) about **Billing/Coverage**;
- **1.14%** (14) about **Buying Insurance**;
- **14.12%** (173) about **Consumer Education**;
- **34.53%** (423) about **Eligibility** for state programs and Medicare; and
- **18.04%** (221) 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 423 of our cases had eligibility for state health care programs as the primary issue, there were actually a total of 1,394 eligibility issues raised. This is because it is possible to have multiple specific eligibility issues in a single case.

In each section of this Narrative we indicate whether we are referring to data based on just primary issues, or primary and secondary issues combined. Sometimes it is difficult to determine which issue is the "primary" issue when there are multiple causes for a caller's problem. This has proven to be particularly true for Vermont Health Connect (VHC) cases. [See the breakouts of the issue numbers in the individual data reports for a more detailed 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.

Our recommendations to the state are at the end of this section, beginning on page 10.

A. The HCA's call volume again hit record high levels: calendar year 2014 had 39% more calls than 2013.

The HCA received 4,527 calls this past year, compared to 3,257 in 2013, a 39% increase, and the most ever by far. Call volume was 12% higher this quarter over last quarter, and 29% higher than the same quarter in 2013. It was the highest quarterly call volume we have ever had; the previous record was 1,184 in the first quarter of 2014.

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

In December we received 583 calls, the most we have ever received in one month. Before VHC launched, our call volume usually ran at 200-300 calls per month, and we rarely hit 300. Since December 2013, we have received at least 300 calls every month, and twice we received more than 400 calls in a month. There were two main reasons for the spike in calls in December. The first is that DVHA sent out a new annual notice to VPharm beneficiaries that confused many recipients. The second is that VHC continues to lack the technical capability necessary to operate properly, causing major problems for many Vermonters.

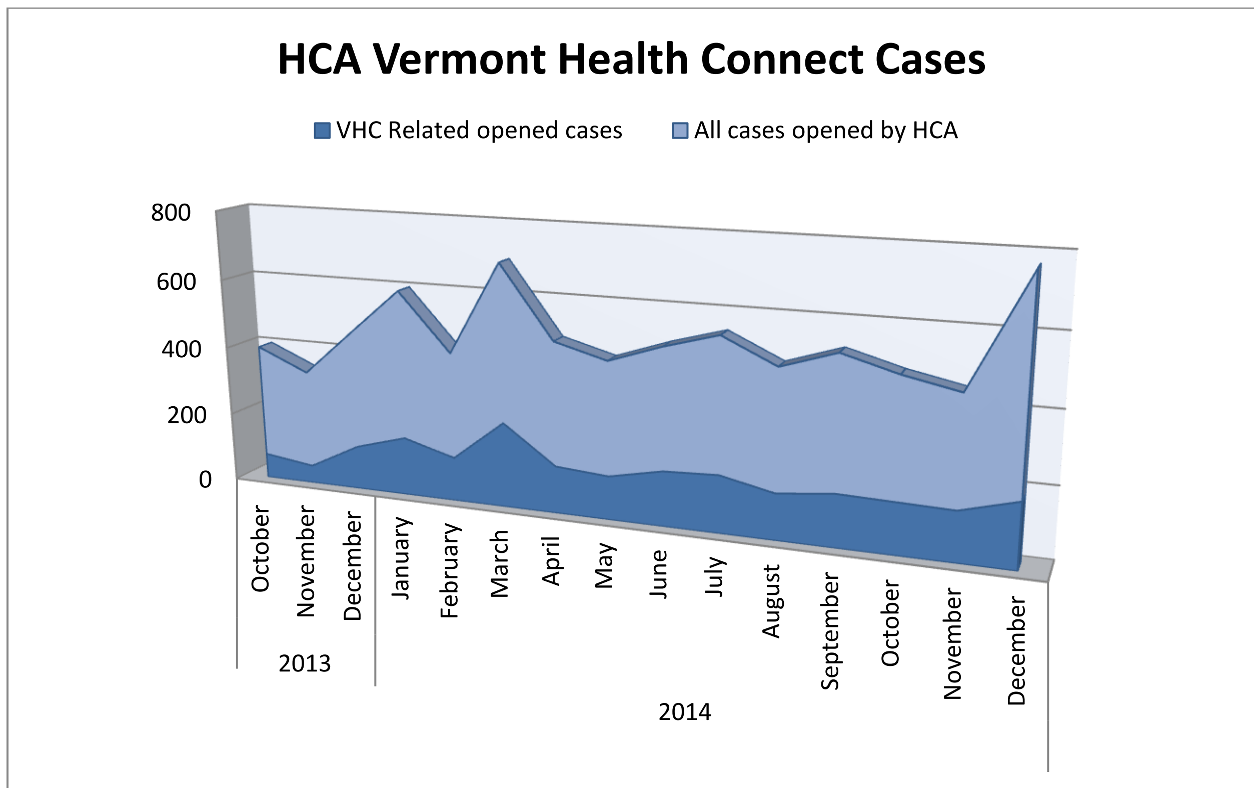
Calls by month and year:

All Cases (2004-2014)											
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
January	252	178	313	280	309	240	218	329	282	289	428
February	188	160	209	172	232	255	228	246	233	283	304
March	257	188	192	219	229	256	250	281	262	263	451
April	203	173	192	190	235	213	222	249	252	253	354
May	210	200	235	195	207	213	205	253	242	228	324
June	176	191	236	254	245	276	250	286	223	240	344
July	208	190	183	211	205	225	271	239	255	271	381
August	236	214	216	250	152	173	234	276	263	224	342
September	191	172	181	167	147	218	310	323	251	256	374
October	172	191	225	229	237	216	300	254	341	327	335
November	146	168	216	195	192	170	300	251	274	283	306
December	170	175	185	198	214	161	289	222	227	340	583
Total	**2409**	**2200**	**2583**	**2560**	**2604**	**2616**	**3077**	**3209**	**3105**	**3257**	**4526**

B. Problems with Vermont Health Connect continued, and increased slightly over the previous two quarters.

VHC has been plagued with operational problems since it was launched in October 2013. This quarter we received 470 calls related to VHC, compared to 444 last quarter (a 6% increase), and 418 for the quarter before that. There were a lot of different types of issues involving VHC, but the most problematic areas were billing and the lack of computer functionality to make changes in the system ("Change of Circumstance" functionality). Invoice/Payment/Billing problems were the most frequent VHC complaint at 125 calls, followed by 122 calls related to the lack of Change of Circumstance (COC) functionality (when primary and secondary issues are counted). There can be some overlap between these two types of cases. That is, many people had problems with both COCs and billing.

This chart shows the proportion of VHC cases in our caseload this over the past year.



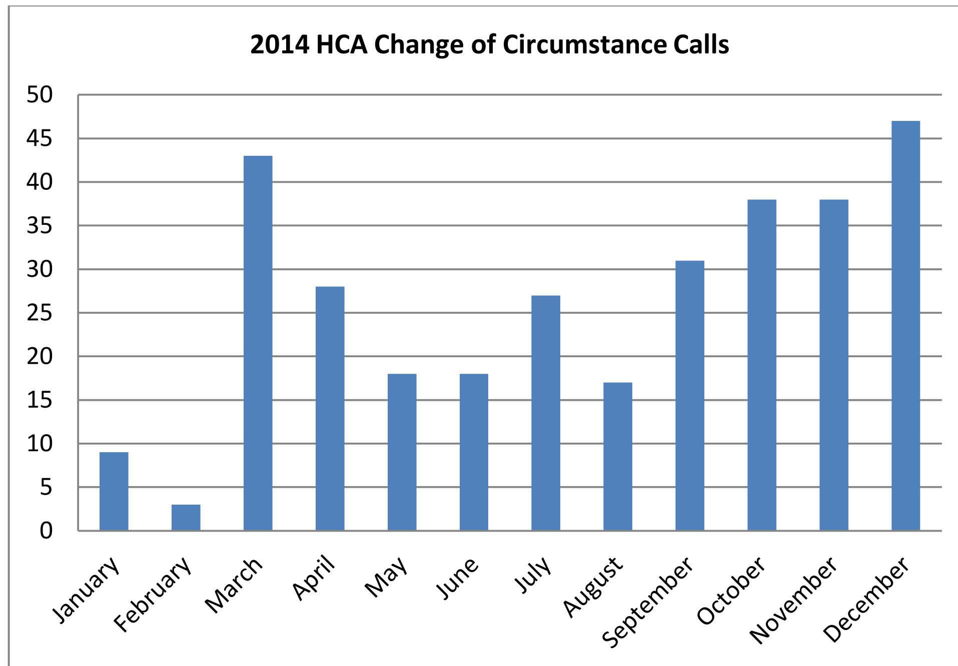
C. Complaints related to Vermont Health Connect's lack of Change of Circumstance functionality increased by 63%.

The HCA had 122 cases involving Change of Circumstance problems, when we counted both primary and secondary issues. This is up from 75 last quarter, and 64 the previous quarter.

Fifteen of our clients with a COC problem this quarter also had an access to care issue, caused by the delay in changing their coverage. VHC has designated the need for care as a high priority. Despite that triage level, in some cases Vermonters have gone without needed care for days and even weeks.

VHC's inability to make corrections in its system easily because its computer system lacks that functionality has been increasingly identified as the source of clients' coverage problems. Without COC functionality, VHC has been forced to make changes manually, a process that is cumbersome, time consuming, and prone to human error. Although state employees have been making a valiant effort to make requested changes as quickly as possible, many Vermonters have gone without coverage, or been unable to drop unwanted coverage, get correct invoices, get on the plan they wanted, or add or subtract a dependent. In some cases these problems have lasted for <u>months</u>. As a result of lengthy waits for corrections to be made, many of our clients are extremely frustrated and angry, something we rarely saw in the past.

We understand that VHC will not be able to deploy the COC functionality until April 2015. Since VHC has been unable to resolve all 2014 COCs, and new requests for COCs continue to come in, it is going to be a difficult few months. In the meantime, we expect many Vermonters who had COC problems in 2014 to also have tax issues[2] and problems with their 2015 coverage.



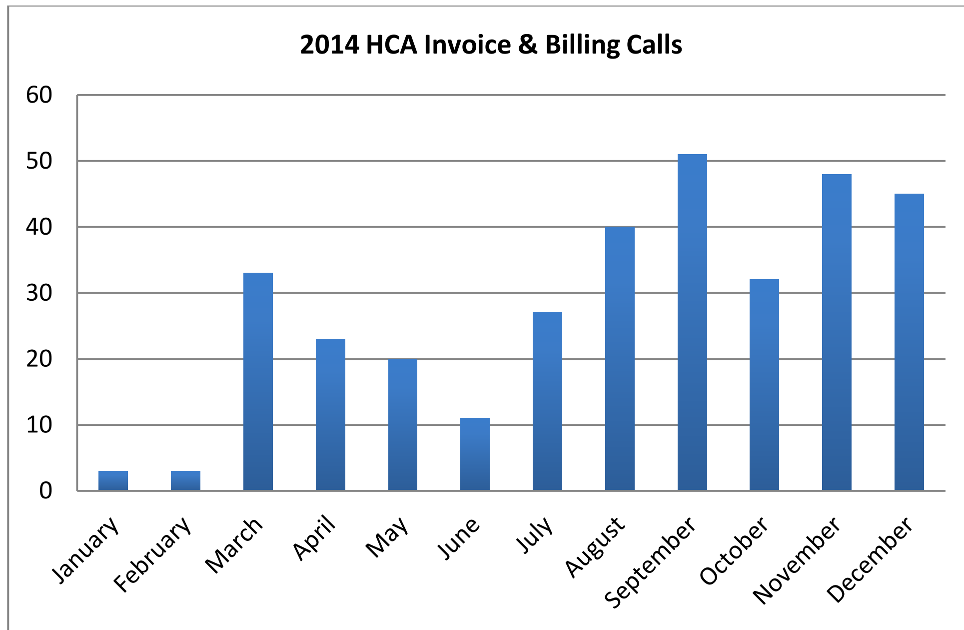
D. Vermont Health Connect billing and premium processing continue to be major problems.

Some consumers who purchased a Qualified Health Plan (QHP) from VHC continued to have problems getting the coverage they bought. The problems include non-receipt of invoices, multiple invoices in one month, delays in processing, and sometimes longer delays in actually getting correct coverage. Some people reported that they had made payments for months which did not seem to be recorded anywhere. Frequently these problems resulted in individuals going without coverage for months. In many cases they were deferring or going without care or medications because their insurance had not been activated. It is small consolation for people to get retroactive coverage when things are finally fixed if they went

[2] VHC is required by the Affordable Care Act to give people who purchased Qualified Health Plans tax forms indicating the months they had coverage and any Advance Premium Tax Credits (APTC) the tax household received. For the first time, the IRS will look at tax filers' health insurance status for the year and determine each individual's entitlement to a Premium Tax Credit based on his or her income. The IRS will reconcile any APTC with the income reported, causing some individuals to owe more or less in taxes than they expected.

without care while waiting for their coverage to be activated. Many do not want to pay for retroactive coverage that they were unable to use.

This quarter we received 125 calls involving invoices, billing and premium processing, compared to 117 last quarter when primary and secondary issues are counted, an increase of 6%. Eighteen of our premium processing cases also involved access to care issues, and eight involved debt collection issues connected to VHC billing problems. We created a new code for VHC Debt Collection this quarter, as it is an emerging problem.



E. Calls involving Premium Tax Credits increased.

Calls in which we addressed questions and concerns about Advance Premium Tax Credits increased from 73 to 91, when both primary and secondary issues are counted. After VHC sends out the new 1095-A tax forms at the end of January to all QHP beneficiaries, we expect to see an even greater increase in calls involving the implications of the tax credit.

F. The new annual notice about VPharm caused confusion.

Right before Thanksgiving DVHA sent out a notice to over 12,000 VPharm[3] beneficiaries telling them about the benefits of that program and suggesting that some beneficiaries might not actually need it. This notice was required by the state legislature, and this was the first year it was sent out. The HCA's phone number was the number given on the form for questions. As a result, we received 207 calls from mostly elderly VPharm beneficiaries during this quarter, 168 of whom found the notice confusing. For comparison, in the same six weeks in 2013 we received 12 calls from VPharm beneficiaries.

[3] VPharm is essentially a state wrap around the federal Medicare Part D prescription drug benefit.

As a result of this onslaught of calls, we have since worked with DVHA and the State Health Insurance assistance Program (SHIP)[4] to improve the notice and the process for 2015. DVHA will change the contact number for questions on the notice to the SHIP's phone number and the HCA, DVHA and SHIP will rewrite the notice to make it more understandable. Also, the notice will go out at a different time of year, before the Medicare Part D Open Enrollment Period, so that SHIP staff will have the time to do appropriate counseling.

G. The top issues generating calls

The listed issues in this section include both primary and secondary issues. Calls can have more than one secondary issue.

All Calls 1,225 (compared to 1,096 last quarter)

1. Medicare consumer education 236 (compared to 67 last quarter)[5]
2. Notice-confusing 202 (33)
3. VPharm eligibility 197 (25)
4. VHC complaints 163 (198)
5. Information about VHC 168 (185)
6. Information about DVHA programs 127 (138)
7. VHC Invoice/billing Problem 125 (117)
8. Change of Circumstance 122 (76)
9. MAGI Medicaid eligibility 108 (92)
10. Complaints about providers 101 (146)
11. Premium Tax Credit eligibility 93 (73)
12. Access to Prescription Drugs 92 (101)
13. Affordability issue that created an access problem 87 (57)
14. DVHA/VHC Premium billing 68 (12)
15. VHC website/technology problem 66 (127)

Vermont Health Connect Calls 470 (compared to 444 last quarter)

1. Information about VHC 163 (181)
2. VHC complaints 162 (197)
3. VHC Invoice/Payment/Billing problem 125 (117)
4. Change of Circumstance 122 (76)
5. MAGI Medicaid eligibility 103 (82)
6. Premium Tax Credit eligibility 91 (71)
7. Information about applying for DVHA programs 72 (71)
8. VHC website/technology problem 65 (109)
9. Buying QHPs through VHC 49 (67)
10. VHC Renewals 46 (a new code)

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[4] SHIP provides Medicare beneficiaries with counseling and assistance with Medicare Part D.

[5] This big increase, along with the big increases in the next two issues on this list, was a result of the VPharm annual notice.

DVHA Beneficiary Calls 502 (compared to 403 last quarter)

1. Medicare consumer education 146 (24)
2. VPharm eligibility 139 (9)
3. Notices-confusing 138 (10)
4. Complaints about Providers 61 (84)
5. Information about DVHA programs 60 (56)
6. Access to Prescription Drugs 47 (41)
7. MAGI Medicaid eligibility 43 (25)
8. Medicaid Billing 33 (37)
9. Information about VHC 33 (21)
10. Affordability 28 (23)
11. VHC complaints 27 (28)

Commercial Plan Beneficiary Calls 309 (compared to 264 last quarter)

1. VHC invoice/payment problem 81 (69)
2. VHC complaints 80 (92)
3. Change of Circumstance 79 (44)
4. Information about VHC 78 (99)
5. Premium Tax Credit eligibility 52 (40)
6. DVHA/VHC premiums billing 42 (6)
7. VHC website/technology problem 39 (57)
8. QHP Renewals 33 (new code)
9. Affordability that created an access problem 26 (20)
10. MAGI Medicaid 23 (29)

H. Hotline call volume by type of insurance:

The HCA received 1,225 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, VPharm, or both Medicaid and Medicare aka "dual eligibles") insured **41%** (502 calls), compared to 37% (403) last quarter;
- **Medicare**[6] **beneficiaries** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka "dual eligibles," Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **31%** (380[7]), compared to 19% (209) last quarter;
- **Commercial plan beneficiaries** (employer sponsored insurance, small group plans, or individual plans) insured **25%** (309), compared to 24% (264) last quarter; and
- **Uninsured** callers made up **10%** (126) of the calls, compared to 14% (152) last quarter.

[6] Because Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with those figures.
[7] This big increase is a result of the VPharm annual notice.

- In the remainder of calls insurance status was either unknown or not relevant.

I. Dispositions of closed cases

All Calls

We closed 1,155 cases this quarter, compared to 1,086 last quarter.

- 33% (378 cases) were resolved by brief analysis and advice;
- 27% (309) were resolved by brief analysis and referral;
- 21% (240) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 14% (167) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- Just 1 case was resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 26 cases involved help with appeals: 3 commercial plan appeals, 17 Fair Hearings, 1 Expedited Fair Hearing, 4 DVHA internal MCO appeals and 1 Medicare appeal. Most of our cases involving VHC and DVHA problems are resolved without using the formal appeals process.

DVHA Beneficiary Calls

We closed 500 DVHA cases this quarter, compared to 407 last quarter.

- 36% (180 cases) were resolved by brief analysis and advice;
- 28% (138) were resolved by brief analysis and referral;
- 16% (80) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 16% (82) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- Just 1 DVHA beneficiary call was resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 22 cases involved appeals: 17 Fair Hearings, 1 Expedited Fair Hearing, and 4 internal MCO appeals.

Commercial Plan Beneficiary Calls

We closed 253 cases involving individuals on commercial plans, compared to 253 last quarter.

- 32% (80 cases) were resolved by brief analysis and advice;
- 15% (39) were resolved by brief analysis and referral;
- 31% (78) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time (this measure increased by 20% over last quarter);

- 19% (48) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information;
- No calls from commercial plan beneficiaries were resolved in the initial call.
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 3 cases involved appeals.

J. Case outcomes

All Calls

The HCA helped 93 people get enrolled in insurance plans and prevented 11 insurance terminations or reductions. We obtained coverage for services for 43 people. We got 32 claims paid, written off or reimbursed. We helped 6 people complete applications and estimated VHC insurance program eligibility for 11 more. We provided other billing assistance to 41 individuals. We obtained hospital patient assistance for 2 people. We provided 676 individuals with advice and education. We obtained other access or eligibility outcomes for 72 more people, many of whom we expected to be approved for medical services and state insurance.

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

In total, this quarter the **HCA saved individual consumers $46,439.34** in cases opened this quarter**.** The amount of individual savings in calendar year 2014 was **$374,140.54.** In 2013 we saved consumers $187,214.96.

K. Case examples

Here are a few examples of the problems we helped Vermonters resolve this quarter:

1. VHC loses premium check and terminates insurance. Mr. A suddenly found himself without insurance. His family had a plan through VHC, and he had paid the premiums on time each month. All of his checks had been cashed by VHC. Nevertheless, he received a notice saying that his insurance had been cancelled for non-payment. He had no idea what was going on, and was worried because his family needed continuing medical care. He called the HCA for help. The HCA advocate investigated and found that even though Mr. A's premium checks had been cashed by VHC, one check had not been applied to his account. It apparently had been lost, causing Mr. A's account to be closed for non-payment. The advocate contacted VHC and requested an immediate reinstatement because Mr. A could prove he had sent the check and that it had been cashed by VHC. VHC reinstated Mr. A's coverage, and eventually found the check and applied it to his account.

2. Despite premium payment, VHC cancels coverage. When Mr. B went to the pharmacy to pick up a prescription, he was told that he did not have any active insurance. Mr. B was shocked. He had been on a plan through VHC, and he had been paying for his plan every month. He had a chronic medical condition and needed daily medication. He called VHC and was told that his plan had been closed for non-payment. He had not received any notices warning him that the coverage was going to be closed. Mr. B requested that VHC reinstate his coverage, but VHC initially denied that request. He then asked for a fair hearing to contest VHC's decision and called the HCA. His HCA advocate helped him prepare for the hearing. Mr. B argued that his plan should be reinstated because he had been paying his monthly premiums all along and had received no notices that he was in a grace period or that his plan was about to be closed. VHC changed its position and reinstated Mr. B's coverage.

3. Hospital bill threatens housing. Ms. C called the HCA because she had just paid a $1900 hospital bill, and was distressed that as a result she could not pay her mortgage. Ms. C was in her 80's and afraid she was going to lose her home, where she had lived her entire life. Her HCA advocate got a copy of the hospital bill, and discovered that Ms. C had both Medicare and Medicaid. The hospital had billed both, and Medicaid had paid on the claim. It was unclear why Ms. C had been billed at all since it was illegal for the hospital to balance bill Ms. C. The advocate called the hospital which immediately agreed to refund the $1900 payment. Ms. C was greatly relieved that she would be able to keep living in the home where she was born, and sent the HCA an incredibly sweet thank you note.

4. Uninsured individual can't pay hospital bill and is unaware of programs to make health care more affordable. Mr. D was uninsured and unable to pay a hospital bill. In the past when he'd had hospital bills, the hospital had given him patient financial assistance. However, the hospital now said it was not going to give him patient financial assistance again unless he applied for some coverage. Mr. D, however, did not think he could afford insurance and did not know what to do. He called the HCA. The HCA advocate learned that when Mr. D had turned 65, he had not signed up for Medicare because of the costs. The HCA advocate determined that Mr. D was probably eligible for multiple programs that would help with these costs. First, the advocate helped him apply for a Medicare Savings Program through the state. This program would help him enroll in Medicare immediately, cover cost-sharing, and also cover the late penalties he would have had to pay because he failed to enroll in Medicare when he turned 65. Next, the advocate helped him sign up for a Medicare Part D plan that would cover his drug costs. Finally, she helped him get onto Medicaid. When Mr. D's case was finished, he had Medicare Parts A, B and D, as well as Medicaid. As a result, he will no longer need patient financial assistance and has minimal out-of-pocket costs.

5. Use of wrong Medicaid application causes coverage denial and delayed medical care. Ms. E had a chronic health condition and was very low income but had been denied Medicaid. She had just moved to Vermont and needed to see a doctor quickly. She

believed she was eligible for Medicaid, so she did not understand what was happening. She called the HCA. Her HCA advocate discovered that Ms. E had applied for the wrong type of Medicaid and had used the wrong application. Ms. E had applied for Medicaid for the Aged, Blind, and Disabled (MABD). She was not eligible for MABD because she was under 65 and not disabled. Ms. E, however, was eligible for Medicaid for Children and Adults (MCA) through Vermont Health Connect. The advocate explained this to Ms. E, helped her apply using the correct Medicaid application, and asked VHC to rush processing it due to medical need. VHC found Ms. E eligible for MCA, she had active coverage within the week and was able to get the care she needed.

L. Recommendations

1. *Improve the Vermont Health Connect invoice and payment system.*

Internal processes must be improved so that checks are not lost, payment is attributed to the correct account, payments are transferred correctly and promptly to the carriers, and all payments are correctly recorded. We have heard about so many problems with the billing system that it is difficult to catalogue them all: lack of invoices, confusing invoices, the inability to process some payments, etc. It is unacceptable that some people are paying as they are supposed to, yet still have their coverage terminated. It is also unacceptable that coverage cannot be promptly terminated when the beneficiary requests closure. Failure to do this for individuals who are getting Advanced Premium Tax Credits may result in incorrect income tax liability.

2. *Make the Vermont Health Connect change of circumstance functionality operational as soon as possible.*

This goes without saying at this point, but we have to raise the issue again since it is such a huge problem. We know the expectation is that COC functionality will be deployed in April. The sooner the better. Lack of this functionality has created major problems and hardship for many people.

3. *Develop a system so that individuals who are denied one form of Medicaid are automatically screened for other programs.*

Vermonters applying for Medicaid cannot be expected to know there are now different types of Medicaid with different applications. There must be a system whereby a denial for one program automatically sends the applicant to the other for screening.

4. *Remind all state staff to involve stakeholders in the development of consumer communications, to write them in plain language, and to strive for a reading level of eighth grade or lower.*

If these guidelines had been followed, the problems arising from the VPharm annual notice described on page 5 would not have happened. Also, it is especially important to include any stakeholder whose phone number is going to be on the notice.

III. Consumer protection activities

A. Rate review work

No new rate review cases were filed with the Green Mountain Care Board in this quarter. However, we filed memoranda in six of the pending cases filed during the previous quarter. There were also no contested hearings this quarter.

One rate review proceeding of note was the 2015 MVP Agriservices filing. It covered an "association" plan that offered insurance for 1,371 farmers and dairymen and MVP requested a 16% increase. It appeared that MVP had filed as a large group plan when it should have been a small group or individual plan. The HCA was concerned that the group size categorization might prevent current policyholders from having the option to receive subsidies on the exchange (Vermont Health Connect) under Affordable Care Act rules. We therefore raised this issue with the Board. After researching the federal and state laws on association plans, submitting a supplemental brief on the issue, and participating in extra meetings on the filing with the hearing officer and MVP, we were able to ensure that Agriservices policyholders have the option to access subsidies on the exchange. The HCA also argued that the contribution to surplus should be reduced from 2% to 0%, and the Board reduced it to 1%. The Agriservices plan will not continue in 2016.

We also argued for lower rates in five additional MVP filings. In all of these cases, the HCA argued that MVP's requested pharmacy trend should be lowered and that the requested contribution to surplus should be reduced from 2% to 1%. The Board made these changes which were consistent with the September 2014 decision in the MVP Exchange filing.

Finally, in December the HCA attended a general hearing on the topic of rate review held by the Board.

B. Certificate of Need Applications

The HCA continues to monitor all Certificate of Need activities before the Green Mountain Care Board.

In October, the HCA submitted proposed questions for the applicant for the Green Mountain at Fox Run application for creation of an outpatient binge eating disorder treatment program (GMCB-013-14con). After reviewing this application, we had significant consumer protection concerns. We focused our questions to the applicant on issues regarding access to care for low-income individuals and peer-reviewed evidence on the likely treatment success rate, cost

efficacy, and adequacy of medical staff coverage for the proposed program design. The Board incorporated eight out of our nine questions in their subsequent request for information to the applicant.

Later in October, we submitted a notice of intervention for the University of Vermont Medical Center's (UVMC) application for replacement of inpatient beds (GMCB-021-14con), a 187 million dollar project. UVMC's earlier application for a South Burlington property acquisition (GMCB-015-14con) was put on hold pending the outcome of this new application. In December, we submitted questions to the applicant. We requested additional explanation and evidence on how the project would result in improved and cost-effective patient care and how the hospital will fully utilize the new space resulting from the project. The Board incorporated nine of our twelve proposed questions in its following request for information from the applicant.

C. Other Green Mountain Care Board activities

As Vermont increases its efforts to control health care spending by changing payment and delivery systems, the HCA will increase its advocacy to maintain or improve the quality of care that Vermonters receive. The Board and providers in the state have already been actively engaged in various payment reform initiatives, and the HCA has been pressing for more accountability.

This quarter the HCA submitted two sets of formal comments to the Board on the Vermont Accountable Care Organization Shared Savings Program Quality Measures. In the first set of comments we argued for increased quality measurement in year two of the program. In the second set of comments we argued against a proposed hiatus on measures for year three of the commercial shared savings program. As these measures are designed to track quality of care status as payment reform initiatives are implemented, our office is stressing that insufficient quality measurement threatens consumers.

The HCA attended three days of vendor demonstrations for the Board's VHCURES 2.0 procurement. We subsequently submitted formal comments on consumer protection priorities for the vendor selection process, based on potential vendor treatment of the VCHURES data.

We also attended weekly Board meetings to monitor the Board's activities, and had monthly meetings with the Board's staff to discuss consumer protection priorities. We met with the Board's newest member, Jessica Holmes, to introduce her to our office. We attended the Board's Advisory Committee meeting in October which focused on Health Care Quality and Performance Measures. And finally, we attended monthly meetings of the Board's Data Governance Program Committee which was newly formed to manage data resources at the Board. Our office is monitoring the patient information privacy and security aspects of this project.

D. Vermont Health Care Innovation Project

The HCA continues to participate in the Vermont Health Care Innovation Project (VHCIP), which is funded by Vermont's State Innovation Model (SIM) grant. This quarter we:

- Participated in 2 meetings as a member of the VHCIP Steering Committee
- Participated, along with representatives from other projects of Vermont Legal Aid, as "active members" in six of the seven VHCIP work groups including the Payment Models Work Group, the Quality and Performance Measures Work Group, the Population Health Work Group, the Care Models and Care Management Work Group, the Disability and Long Term Services and Supports Work Group, and the Health Information Exchange/Health Information Technology Work Group
- Attended 13 VHCIP work group meetings
- Attended 3 meetings of the VHCIP Core Team as an interested party
- Submitted comments to the Care Models and Care Management Work Group about proposed Accountable Care Organization Care Model Standards
- Submitted comments to DVHA and the Payment Models Work Group regarding changes to the Medicaid Shared Savings Program gate and ladder methodology for year two of the program
- Attended the Vermont Health Care Workforce Symposium
- Met with two Accountable Care Organizations (Community Health Accountable Care and Accountable Care Coalition of the Green Mountains) regarding consumer engagement
- Attended the 'Frail Elders Proposal' webinar

E. Affordable Care Act Tax-related Activities

The federal Affordable Care Act made tax law newly important to effective health advocacy. It imported tax concepts into Medicaid, created a new federal tax credit to subsidize private health insurance purchased through health benefit exchanges, and created a tax penalty for failure to have insurance coverage. The HCA responded by partnering with the Low Income Taxpayer Project at Vermont Legal Aid to engage in education, outreach, and advocacy relating to the Affordable Care Act.

During this quarter, the HCA employed a half-time tax attorney, who also staffs the Low Income Taxpayer Project at VLA. This allowed the HCA to stay up to date on legal developments and educate its staff so they can better field calls related to the ACA and Vermont Health Connect. We trained HCA staff in IRS procedures and rules.

The HCA answered many tax-related questions from VHC, tax preparers, health assisters, and from individual callers. We developed template advice letters for clients on issues including reconciliation of Advanced Premium Tax Credits. The materials we developed for advocates have been shared with health and tax advocates in Vermont and nationwide.

We made several educational presentations for other advocacy groups, and we developed materials and presentations to help advocates. During the quarter we updated and re-distributed educational materials we produced earlier, including the white paper *Low Income Taxpayers and the Affordable Care Act*, and a presentation entitled *Health Care Reform for Guest Workers in Vermont*. The presentation materials were shared with several Vermont assisters and VHC staff, and are posted to our public website.

We collaborated with VHC staff in several outreach and educational efforts this quarter. The HCA had two tax outreach planning meetings with VHC outreach staff, and was in frequent communication with VHC regarding tax outreach events and materials. HCA co-authored a presentation with VHC that was used at a training for tax preparers given by AHS Special Counsel for Health Reform Devon Green on November 20, 2014. We developed multiple presentations to be used in January 2015. We provided case examples and scenarios to VHC for use in trainings. We commented on VHC outreach materials.

See also descriptions of the presentations that the HCA's tax attorney gave at national conferences in the Outreach and Education section below.

F. Other Activities

Plain Language Materials

The HCA continues to advocate for the use of plain language in materials intended for health care consumers. This quarter we conducted additional research on health literacy and plain language, drafted a policy paper that will be released next quarter, and continued to encourage state agencies and health care provider organizations to use plain language in their health care communications. For example, we worked with the University of Vermont Medical Center to improve the readability of their draft notices to inform patients of their status as an inpatient or an outpatient under observation.

Policy Paper on Affordable Care Act Taxes and Penalties

This quarter the HCA's tax attorney updated her policy paper entitled 'Low Income Taxpayers and the Affordable Care Act. The paper outlines recently implemented components of the ACA that are relevant to low-income taxpayers and provides information about important ACA tax issues such as Individual Shared Responsibility Payments and Premium Tax Credits. The paper was originally completed in January 2014.

Other Boards, Task Forces, and Work Groups

The HCA participated in:

- 2 Medicaid and Exchange Advisory Board (MEAB) meetings
- 2 Governor's Consumer Advisory Council meetings

- 2 MEAB Improving Access Work Group meetings (a subgroup of the MEAB which works on improving access to Medicaid services, which the Chief Health Care Advocate Chairs)
- 2 MEAB VHC Individuals and Families Work Group meetings
- 2 VHC Consumer Experience Work Group meetings
- 3 VHC Customer Support meetings with Maximus, VHC, DVHA and HAEU
- 1 Vermont Oral Health Care for All Coalition meeting

Legislative Activities

HCA staff:

- Testified before legislative committees 2 times
- Attended 2 additional legislative hearings on health care
- Submitted a letter to Republican legislative leadership regarding reasons why Vermont should not move to the federal health insurance exchange

Administrative Advocacy

The HCA:

- Commented on VHC notices 5 times
- Submitted multiple complaints and suggestions about VHC operations
- Submitted questions to VHC regarding open enrollment period processes
- Submitted comments to the MEAB Improving Access Work Group
- Submitted comments on proposed IRS Premium Tax Credit regulations
- Submitted comments to the Taxpayer Advocate Service on its Shared Responsibility Payment estimator
- Signed on to a letter from First Focus to Congress regarding CHIP renewal
- Submitted comments to Visiting Nurse and Hospice for VT and NH
- Submitted comments to VHC on ACA tax outreach and education materials
- Met and corresponded with DVHA about notices of decision for prior authorizations
- Met and corresponded with DVHA about Medicaid exceptions
- Met and corresponded with DVHA and SHIP about the VPharm annual notice
- Met and corresponded with SHIP/CVAA about VHC and Medicare
- Met and corresponded with VHC about ACA tax outreach and education
- Met with VHC about Optum
- Met with VHC about complaints and suggestions
- Met and corresponded with VHC about tax outreach and education issues
- Met with Congressional delegation staff about potential consumer problems related to upcoming ACA tax issues

Collaboration with other organizations

The HCA worked with the following organizations this quarter:

- American Civil Liberties Union (ACLU)
- Blue Cross Blue Shield of Vermont
- Center on Budget and Policy Priorities

- Community of Vermont Elders
- Consumers Union
- Disability Rights Vermont
- Families USA
- Iowa Legal Aid
- National Health Law Program
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Oral Health Care for All Coalition
- Vermont Campaign for Health Care Security
- Vermont Developmental Disabilities Council
- Vermont Health Connect
- Vermont Interfaith Action
- Vermont Medical Society
- Vermont Public Interest Research Group
- Vermont Workers' Center
- Voices for Vermont's Children

Trainings

- National Academy for State Health Policy Annual Conference, Innovations Ripe for the Picking, October 6-8, 2014
- Community Catalyst Learning Community Conference Call, Introducing New Resources for Community Benefit, October 9, 2014
- Consumers Union Conference Call, National Issues with Rate Review, October 14, 2014
- Center on Budget and Policy Priorities Webinar, Income and Household Composition for Premium Tax Credits and Medicaid, October 16, 2014
- National Academy for State Health Policy Webinar, Identifying Value in Multi-Payer Payment Reform: The Nuts and Bolts of Quality Measurement, October 16, 2014
- Center on Budget and Policy Priorities Webinar, Premium Tax Credit Reconciliation and the Marketplace Renewal Process, October 23, 2014
- Ohio Poverty Law Center and the Committee on Regional Training Webinar, The ACA and Family Law Cases: First Do No Harm, Then Do Good Things, November 7, 2014
- 2 Webinars with Mark Painter, Claims Edits, October 29, 2014 and December 10, 2014
- Centers for Disease Control and Prevention online training, Health Literacy for Public Health Professionals – Part 1, November, 2014

IV. Outreach and education

A. Website

Vermont Law Help is a statewide website maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section (www.vtlawhelp.org/health) with more

than 150 pages of consumer-focused information maintained by the HCA. Since the launch of Vermont Health Connect, we have worked diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

We have improved our method of collecting health care site data through Google Analytics. Analysis of this data shows that the dramatic increases in the total number of pageviews that we have seen over the past two years as we worked to improve the health contents and design have leveled off somewhat. The statistics show that:

- The total number of health pageviews increased by 13% in the reporting quarter ending December 31, 2014 (3,649 pageviews), compared with the same quarter in 2013 (3,225 pageviews).
- Fewer Vermonters sought out information about Vermont Health Connect this quarter compared to the same quarter in 2013 (191 total pageviews in 2014 compared with 633 pageviews in 2013, a decrease of 70%).
- There was a sharp uptick in the number of people seeking information about Medicaid (1,163 pageviews this quarter compared with 450 in the same quarter in 2013, an increase of 158%). Vermont Law Help visitors to the Medicaid section were primarily seeking information about Medicaid income limits, which accounted for 65% or 767 of total Medicaid pageviews.
- Pageviews of our Medicare information increased by 117% to 280 this year, compared with 129 in the same quarter last year. The Long Term Care/Choices for Care information drew 300 pageviews, a 110% increase over last year's 143.

14 of Vermont Law Help's Top 30 PDF Downloads Were on Health Care Topics

Health-related PDFs accounted for 300 out of 940 PDFs that were downloaded from the Vermont Law Help website during this quarter. The majority of these were high-level presentations and papers related to the Affordable Care Act or policy white papers covering other health care reform issues.

High-Level Health Care Presentations and Papers and Health Care Policy Papers

- Low-Income Taxpayers and the ACA for Non-Tax Lawyers, updated Nov-23-2014.pdf (103 downloads)
- Affordable Care Act - 2014 Tax Returns and Beyond.pdf (50 downloads)
- HCA Tax Training PowerPoint 10-22-14.pdf (48 downloads)
- The Health Care Assister Guide to Tax Rules.pdf (27 downloads)
- US Health Reform for H-2A workers in VT updated 9-9-2014 v3.pdf (12 downloads)
- The Limits of Cost Sharing.pdf (9 downloads)
- Protected Health Information - What Vermonters Should Know.pdf (7 downloads)
- Accountable Care Organizations - What is the Evidence.pdf (6 downloads)
- FAQ - Taxes and Vermont Health Connect.pdf (4 downloads)

Other Health-Related PDF Downloads

- Advance Directive for Health Care Long Form.pdf (10 downloads)
- Catamount or VHAP to Medicaid.pdf (8 downloads)

- May 31 2014 Health Fair flyer.pdf (7 downloads)
- Vermont Dental Clinics Chart - 2013.pdf (5 downloads)
- Vermont Medicaid Coverage Exception Request - 10 Standards and Provider Request Form.pdf (4 downloads)

B. Education

During this quarter, the HCA provided education to approximately 430 individuals who serve populations that may benefit from the information and education provided.

Low Income Taxpayer Clinics (LITC) Networking Group (October 7, 2014)
The HCA presented an ACA update to 16 tax attorneys at other legal services organizations around the country at a meeting of the Low Income Taxpayer Clinics (LITC) networking group.

Justice Quarterly (October 24, 2014)
The HCA authored two articles in VLA's newsletter, Justice Quarterly. The newsletter is sent electronically to over 100 advocates, social service organizations, and interested parties in Vermont. One article reminded readers about the upcoming Open Enrollment Period at Vermont Health Connect. A second article, jointly submitted by HCA and the VLITP, flagged tax season issues related to the ACA.

VHC Discussion Forum (October 24, 2014)
An HCA advocate participated as a panelist discussing VHC and Medicaid including open enrollment, APTC, rates and answering questions from the audience and other panelists at South Burlington High School, and distributed about 24 HCA brochures.

Beneficiary Engagement Committee of Community Health Accountable Care (CHAC) (December 4, 2014)
Presented to 8 people from provider organizations attending the Beneficiary Engagement Committee (BEC) of Community Health Accountable Care (CHAC) about what the HCA does and what we could do to support consumer representatives on CHAC's governing board and BEC, and distributed 25 brochures.

National Health Law Program (NHeLP) Conference (December 8, 2014)
The HCA's tax expert presented an advanced session on MAGI Medicaid and Premium Tax Credit eligibility rules with a co-presenter from NHeLP to 44 health law attorneys at this national conference in Washington, DC. The presentation covered more complex rules and situations under the Modified Adjusted Gross Income rules, including when married individuals are considered unmarried for tax filing purposes, head of household filing status, and how to count the Social Security income of dependents.

Low Income Taxpayer Representation Workshop (December 8, 2014)
The HCA's tax attorney gave an educational presentation on Premium Tax Credit rules and advocacy issues involving marriage, separation, and divorce, together with a co-presenter from

a national organization, the Center on Budget and Policy Priorities. This presentation was at a workshop sponsored by the Pro Bono and Tax Clinics Committee of the American Bar Association, and took place in Washington, DC. About 56 LITC advocates and tax attorneys attended.

Low Income Taxpayer Clinic Presentation (December 11, 2014)
The HCA's tax attorney gave a third presentation in Washington that same week. She sat on a panel with three other presenters at a training conference for the 2015 recipients of IRS Taxpayer Advocate Service Low Income Taxpayer Clinic (LITC) Grants. Over 200 advocates from all over the country attended this presentation. Topics included Premium Tax Credits, the ACA penalty, IRS assessment and collection issues, advocacy areas, and potential filing season pitfalls.

Attachment 6

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

SFY14 Final MCO Investments

8/27/14

MCO Investment Expenditures

Criteria	Department	Investment Description
2	DOE	School Health Services
4	GMCB	Green Mountain Care Board
2	BISHCA	Health Care Administration
2	VVH	Vermont Veterans Home
2	VSC	Health Professional Training
2	UVM	Vermont Physician Training
3	VAAFM	Agriculture Public Health Initiatives
2	AHSCO	Designated Agency Underinsured Services
4	AHSCO	2-1-1 Grant
2	VDH	Emergency Medical Services
2	VDH	TB Medical Services
3	VDH	Epidemiology
3	VDH	Health Research and Statistics
2	VDH	Health Laboratory
4	VDH	Tobacco Cessation: Community Coalitions
3	VDH	Statewide Tobacco Cessation
2	VDH	Family Planning
4	VDH	Physician/Dentist Loan Repayment Program
2	VDH	Renal Disease
2	VDH	WIC Coverage
4	VDH	Vermont Blueprint for Health
4	VDH	Area Health Education Centers (AHEC)
4	VDH	Community Clinics
4	VDH	FQHC Lookalike
4	VDH	Patient Safety - Adverse Events
4	VDH	Coalition of Health Activity Movement Prevention Program (CHAMPPS)
2	VDH	Substance Abuse Treatment
4	VDH	Recovery Centers
2	VDH	Immunization
4	VDH	Poison Control
4	VDH	Challenges for Change: VDH
3	VDH	Fluoride Treatment
4	VDH	CHIP Vaccines
4	VDH	Healthy Homes and Lead Poisoning Prevention Program
2	DMH	Special Payments for Treatment Plan Services
2	DMH	MH Outpatient Services for Adults
4	DMH	Mental Health Consumer Support Programs
2	DMH	Mental Health CRT Community Support Services
2	DMH	Mental Health Children's Community Services
2	DMH	Emergency Mental Health for Children and Adults
2	DMH	Respite Services for Youth with SED and their Families
2	DMH	Recovery Housing
2	DMH	Seriously Functionally Impaired: DMH
2	DMH	Acute Psychiatric Inpatient Services
2	DMH	Institution for Mental Disease Services: DMH
4	DVHA	Vermont Information Technology Leaders/HIT/HIE/HCR
4	DVHA	Vermont Blueprint for Health
1	DVHA	Buy-In
1	DVHA	HIV Drug Coverage
1	DVHA	Civil Union
2	DVHA	Patient Safety Net Services
2	DVHA	Institution for Mental Disease Services: DVHA
2	DVHA	Family Supports
2	DCF	Medical Services
2	DCF	Residential Care for Youth/Substitute Care
2	DCF	Aid to the Aged, Blind and Disabled CCL Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level IV
2	DCF	Essential Person Program
2	DCF	GA Medical Expenses
2	DCF	Therapeutic Child Care
2	DCF	Lund Home
2	DCF	GA Community Action
3	DCF	Prevent Child Abuse Vermont: Shaken Baby
3	DCF	Prevent Child Abuse Vermont: Nurturing Parent
4	DCF	Challenges for Change: DCF
2	DCF	Strengthening Families
2	DCF	Lamoille Valley Community Justice Project
3	DCF	Building Bright Futures
2	DCF	Children's Integrated Services Early Intervention
2	DDAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired
2	DDAIL	DS Special Payments for Medical Services
2	DDAIL	Flexible Family/Respite Funding
4	DDAIL	Quality Review of Home Health Agencies
4	DDAIL	Support and Services at Home (SASH)
4	DDAIL	HomeSharing
4	DDAIL	Self-Neglect Initiative
2	DDAIL	Seriously Functionally Impaired: DAIL
2	DOC	Intensive Substance Abuse Program (ISAP)
2	DOC	Intensive Sexual Abuse Program
2	DOC	Intensive Domestic Violence Program
2	DOC	Community Rehabilitative Care
2	DOC	Return House
2	DOC	Northern Lights
4	DOC	Challenges for Change: DOC
4	DOC	Northeast Kingdom Community Action
2	DOC	Pathways to Housing