

*State of Vermont*  
*Agency of Human Services*

**Global Commitment to Health**  
**11-W-00194/1**

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

**Quarterly Report for the period**  
**April 1, 2016 – June 30, 2016**

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## **I. Background and Introduction**

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

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

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

- 2007: a component of the Catamount Health program was added, enabling the state to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the federal poverty level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State.
- 2009: the state extended Catamount Health coverage to Vermonters at or below 300 percent of the FPL.
- 2011: inclusion of a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.
- 2012: CMS provided authority for the State to eliminate the \$75 inpatient admission copay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid State Plan.
- 2013: CMS approved the extension of the GC demonstration which included sun-setting the authorities for most of the 1115 Expansion Populations because they would be eligible for Marketplace coverage beginning January 1, 2014. The renewal also added the New Adult Group to the demonstration effective January 1, 2014. Finally, the renewal also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.
- 2015: As of January 30, 2015, the GC demonstration was amended to include authority for the former Choices for Care demonstration. In addition, the State received section 1115 authority to provide full Medicaid State Plan benefits to pregnant women who are determined presumptively eligible.

As the Single State Agency under the Global Commitment to Health Waiver, AHS designates DVHA as a Managed Care Entity (MCE) that must meet rules for traditional Medicaid MCEs. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services).

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. *This is the second quarterly report for waiver year 11, covering the period from April 1, 2016 through June 30, 2016 (QE0616).*

## II. Enrollment Information and Counts

### Key updates from QE0616:

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

Table 1 presents point-in-time enrollment information and counts for Demonstration Populations for the Global Commitment to Health Waiver during the third quarter of federal fiscal year (FFY) 2016. Due to the nature of the Medicaid program, beneficiaries may become retroactively eligible and may move between eligibility groups within a given quarter or after the end of a quarter. Additionally, since the Global Commitment to Health Waiver involves most of the State’s Medicaid program, Medicaid eligibility and enrollment in Global Commitment are synonymous.

Table 1 is populated based on reports run the Monday after the last day of the quarter, in this case on June 4, 2016. Results yielding 5% fluctuation from quarter to quarter are considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting 5% fluctuation between quarters are reviewed by staff from DVHA and AHS to provide further detail and explanation of the changes in enrollment. The explanation of any substantial fluctuations observed in Demonstration Populations during QE0616 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\*, QE0616**

Demonstration Population	Current Enrollees	Previously Reported Enrollees	Percent Variance 3/31/2016 to 6/30/2016	Variance by Enrollee Count 3/31/2016 to 6/30/2016
	Last Day of Qtr June 30, 2016	Last Day of Qtr March 31, 2016		
Demonstration Population 1:	36,311	37,538	-3.27%	(1,227)
Demonstration Population 2:	84,759	84,772	-0.02%	(13)
Demonstration Population 3:	63,072	60,317	4.57%	2,755
Demonstration Population 4:	2,839	2,819	0.71%	20
Demonstration Population 5:	955	929	2.80%	26
Demonstration Population 6:	841	873	-3.67%	(32)
Demonstration Population 7:	7,506	7,397	1.47%	109
Demonstration Population 8:	4,270	4,213	1.35%	57
	198,858	195,737	1.59%	

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

### III. Outreach Activities

#### i. Member Relations

##### **Key updates from QE0616:**

- Dental Hygienists
- Non Emergency Transportation System request for proposal
- Payment Error Rate Measurement (PERM)
- The Medicaid and Exchange Advisory Board (MEAB)

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

##### **Dental Hygienists**

As of July 1<sup>st</sup>, 2016 The Department of Vermont Health Access (DVHA) is actively enrolling licensed dental hygienists to the network of Medicaid providers so that they can bill Medicaid directly. DVHA received approval from the Center for Medicare and Medicaid Services (CMS) for Vermont Medicaid State Plan Amendment (SPA) #15-0023 to enroll Dental hygienists. Dental hygienists will be allowed to practice in public health settings to increase access to dental services for beneficiaries who may not be able to access conventional settings (e.g. nursing homes). The hygienists will have to have a collaborative agreement with a Vermont licensed dentist provider.

##### **Non-Emergency Medical Transportation System Request for Proposal**

Effective June 1<sup>st</sup>, 2016, The Department of Vermont Health Access (hereinafter called DVHA) issue a Request for Proposal seeking to establish service agreements with one or more companies to Implement and Operate a Medicaid Non-Emergency Medical Transportation System in Vermont. DVHA is looking to procure a Contractor(s) to provide for, arrange, and facilitate reimbursement of transportation for eligible Vermont Medicaid beneficiaries who have no other means to get too Medicaid-billable, non-emergency appointments. Proposal are due to DVHA as of September 1, 2016 at 2:00 pm.

##### **The selected vendor for transportation coordination must:**

- Demonstrate that any service delivery program introduced will not compromise any State of Vermont policy, including the coordinated delivery of transportation services to the Elderly and Disabled program;
- Continuously prove through scheduled reporting that there is no degradation of service to eligible individuals since the onset of the contracted period;
- Demonstrate through reporting that the State's public transportation system remains viable and financially stable;
- Have a documented successful history of brokering NEMT services to Medicaid members, a documented successful history of working with public entities, and a documented successful history of working with other providers to develop and provide transportation services;
- Not be a direct provider of transportation services, but have a network of contracted transportation providers sufficient to provide statewide NEMT services;

- Possess or demonstrate the ability to obtain an agreement with the Department of Vermont Health Access for operation and reimbursement to their contracted providers;
- Possess or demonstrate the ability to meet the insurance, background check, and other requirements listed in this document;
- Demonstrate ability to comply with all data privacy requirements.

***Payment Error Rate Measurement (PERM)***

The FY2016 Centers for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement (PERM) audit is underway. The audit is derived from the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). The IPIA directs Federal agencies to annually review its programs and report any improper payments to Congress. Because the Department of Vermont Health Access (Vermont Medicaid) is identified as a federal program, our participation is both active and required. Providers selected for the sample are required to submit medical record and associated documents on specific claims. CMS auditor A+ Government Solutions will be sending direct notification to those selected. At this time about 350 providers have been sampled and additional providers will be sampled in October 2016.

**Medicaid and Exchange Advisory Board (MEAB)**

The Medicaid and Exchange Advisory Board (MEAB) held meetings on April 25, 2016, June 27, 2016, and July 25, 2016. Agendas and minutes are publicly posted at: [http://info.healthconnect.vermont.gov/advisory\\_board/meeting\\_materials](http://info.healthconnect.vermont.gov/advisory_board/meeting_materials).

**IV. Operational/Policy Developments/Issues**

*i. Vermont Health Connect*

**Key updates from QE0616:**

- Vermont Health Connect completed outreach to the more than 26,000 MAGI Medicaid households with cases in the State’s legacy ACCESS to renew their coverage into the VHC system and began the review process for MAGI Medicaid households with cases already in the VHC system.
- With the completion of system development work, VHC and Optum focused on identifying and remediating defects and making process improvements within a stable system. Escalated cases were cut 80 percent from March levels. Integration errors were also cut by 80 percent.
- Vermont Health Connect added 29 new Certified Application Counselors (CACs) in QE0616, bringing the total number of Assisters to 234.
- The National Center for Health Statistics used U.S. Census Bureau data to estimate that Vermont’s low uninsured rate was driven even lower in 2015, down to 2.7%.

Medicaid renewals were a major focus during QE0616. The project involved first contacting more than 26,000 MAGI Medicaid households from the State’s legacy system (ACCESS) to help them transition to Medicaid or qualified health plans in the Vermont Health Connect (VHC) system, then proceeding with redeterminations and verifications for MAGI Medicaid members whose cases are already in the VHC system (approximately 54,000 households). The effort continued at a pace of 9,000 households

per month and consisted of an initial notice, a reminder notice a few weeks later, and a closure notice the following month.

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

Vermont Health Connect and Optum deployed its final system upgrade just before the start of QE0616, in March, to enable the processing of Medicaid renewals. With the completion of major system development work, the teams no longer had to manage continual cycles of major code changes. Instead they could focus on identifying and remediating defects and making process improvements within a stable system. This effort came to be known as the Maintenance and Operations (M&O) Surge. The M&O Surge began in March and is scheduled to wind up in July.

The results of the M&O Surge were clearly visible by the end of QE0616. Escalated cases were down 80 percent from March levels. Integration errors were also down 80 percent. Customer requests were being processed in an increasingly timely manner. The Level 1 Customer Support Center was resolving more phone calls themselves without having to transfer. All of this happened at a time that, with Medicaid renewals, the Customer Support Center and Health Access Eligibility and Enrollment Unit were experiencing the highest call volumes of the year --even higher than during QHP open enrollment.

Maximus continues to manage the VHC Customer Support Center (call center), currently utilizing 87 customer service representatives (monthly average for the quarter). The call center serves Vermonters enrolled in both public and private health insurance coverage, providing Level 1 call center support, which includes phone applications, payment, basic coverage questions, and change of circumstance requests. Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to the State's Health Access Eligibility & Enrollment Unit for resolution and log service requests, which are escalated to the appropriate resolver group. The Customer Support Center managed incoming call volume, receiving approximately 130,000 calls over the quarter, with an abandon rate of 11.80% and answering more than half (55.42%) of calls within 30 seconds.

Throughout QE0616, the system continued to operate as expected. The average page load time for the quarter was under 1.4 seconds and minimal downtime resulted in availability of more than 99.9%.

Vermont Health Connect added 29 new Certified Application Counselors (CACs) in QE0616, bringing the total number of Assisters to 234 (54 Navigators, 99 CACs, and 80 Brokers). Many of these new CACs work for a Department of Corrections contractor and focus on helping connect justice-involved individuals with coverage. Overall, Navigators and CACs largely focused on helping Vermonters with Medicaid renewals, particularly new Vermonters who speak English as a second language and others with accessibility challenges. Navigators alone had more than 3,700 consultations in the quarter.

Health insurance literacy was a major focus of outreach work in QE0616. Vermont Health Connect also engaged health care providers, libraries, state offices, and legislators in helping Vermonters understand the importance of responding to Medicaid renewal notices and comparing options for qualified health plans. Vermont Health Connect's website continued to be a key source of information for current and prospective customers alike, receiving more than 175,000 visits in the quarter. The Plan Comparison Tool, which helps customers estimate total costs of coverage based on family

members' age, health, and income, was used in more than 10,000 sessions during the quarter.

During QE0616, the National Center for Health Statistics used U.S. Census Bureau data to estimate that Vermont's low uninsured rate was driven even lower in 2015, down to 2.7%. This followed late 2015 reports from the Census Bureau that Vermont had passed Hawaii and Washington, D.C. to attain one of the two lowest uninsured rates in the nation.

Vermont attributes its enrollment success to an integrated approach to QHP and Medicaid enrollment that ensures that Vermonters don't fall through the cracks or face multiple applications, a commitment to state programs to reduce the cost of health insurance, and a strong consumer assistance program that offers telephone support and online tools while collaborating with community partners and stakeholders across the state.

ii. *Choices for Care*

**Key updates from QE0616:**

- Vermont Choices for Care State Fiscal Year 2017 budget approved.
- DAIL continues work on HCBS federal regulations alignment work.
- MFP reduced budget submitted.

*Vermont Legislation*

The Department of Disabilities, Aging and Independent Living (DAIL) received legislative approval for its annual budget for State Fiscal Year (SFY) 2017 beginning July 1, 2016. The budget included a request to convert \$1.2 million (gross) in one-time Moderate Needs funding (SFY16) into the base allocation for services. This will help assure continuity of services for Moderate Needs services into the next fiscal year. However, variations in spending trends and wait lists by provider continue to create unique fiscal needs around the state for Moderate Needs services. Fortunately, Vermont is able to offer a mid-year provider allocation adjustment in the event that spending trends support an adjustment. This encourages full maximization of available funds, while reducing wait lists and minimizing surpluses and deficits between Moderate Needs providers.

The SFY17 budget also included a small rate increase for certain HCBS services (estimated September implementation) and a new minimum wage of \$11.04/hour for self-directed services as negotiated within the Independent Director Support Workers union (AFSCME) Collective Bargaining Agreement in July 2016.

Finally, though funding is not currently appropriated, the Big Bill (Act 172) offered language to support adding home delivered meals as a new Choices for Care reimbursable service should State general funds be identified as match for this purpose.

The Department budget can be found at:

[http://www.leg.state.vt.us/jfo/appropriations/fy\\_2017/Department%20Budgets/DAIL%20-%20FY2017%20Budget.pdf](http://www.leg.state.vt.us/jfo/appropriations/fy_2017/Department%20Budgets/DAIL%20-%20FY2017%20Budget.pdf) and Act 172 (Vermont budget act) can be found at

<http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT172/ACT172%20As%20Enacted.pdf>.



## *HCBS Regulations*

During this reporting period, the State held six meetings with three Choices for Care provider stakeholder groups (Case Management, Adult Day and Adult Family Care) to review federal HCBS regulations and to strengthen language within current standards as described in the Vermont Systemic Self-Assessment alignment report <http://ddas.vt.gov/ddas-projects/cfc-hcbs-final-alignmnet-report-12-18-15> and Choices for Care work plan. <http://ddas.vt.gov/ddas-projects/final-cfc-work-plan-12-18-15>. The State continues to finalize a provider self-assessment tool and that will be administered in the next reporting period and will be used to identify strengths and areas for improvement for each HCBS provider. This will be followed by a consumer survey to verify accuracy of the provider self-assessments.

## *Money Follows the Person*

During this reporting period, Vermont submitted its MFP budget to CMS which reflected the unexpected reduction in funding from an anticipated \$13m to \$8m. The reduced budget required that Vermont remove one MFP grant funded position from the MFP budget and reduce the projected timeframe for funding other MFP positions and enhanced federal match. The State continues to strategize with CMS to find the best balance within the budget to maximize important services to Vermonters.

### *iii. Global Commitment Register*

#### **Key updates from QE0616:**

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

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

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

The GCR listserv is a group of about 250 interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. A policy change in the GCR could be a change made under the authority of the waiver, a proposed waiver amendment or extension, an administrative rule change or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not clearly answered in current policy.

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

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

## V. Expenditure Containment Initiatives

### i. *Medicaid Shared Savings Program*

#### **Key updates from QE0616:**

- As of June, 79,086 Medicaid beneficiaries are attributed to two accountable care organizations (ACOs) through the Vermont Medicaid Shared Savings Program (VMSSP).
- Received VMSSP Year 3 SPA approval from CMS on June 20, 2016.
- Contract amendment between DVHA and OCVT successfully executed on April 7, 2016.

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

Beneficiary attribution in the VMSSP remains stable, with 1015 providers participating in the program and 79,086 total beneficiaries attributed—45,648 lives in OneCare Vermont (OCVT) and 33,438 lives in Community Health Accountable Care (CHAC).

DVHA received SPA approval for Year 3 of the VMSSP from CMS on June 30, 2016.

DVHA successfully executed a contract amendment with OCVT on April 7, 2016. This amendment sought to update program standards and standard state contract language..

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

ii. *Vermont Chronic Care Initiative (VCCI)*

**Key updates from QE0616:**

- The VCCI completed the second quarter of business operation in the new eQH Enterprise Medicaid Management Information System/Care Management (MMIS/CM).
- The VCCI continued collaboration with our AHS Enterprise Partners and our vendor, eQ Health for completion of Release 1 requirements, scheduled for deployment in late August, 2016.

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

The VCCI's strategy of embedding staff in high-volume hospitals and primary care sites continues to support population engagement at the point-of-need in areas of high service utilization. By targeting predicted high-cost members, resources can be allocated to areas representing the greatest opportunities for clinical improvement and cost savings. Due to migration to the new system and related identification of a new cohort of high risk members, the VCCI has generated an abridged list of eligible members, while we continue to work on the stratification requirements and related eligibility rules. Concurrently, the goal is to establish ACO affiliated member/provider profiles to eliminate redundancies and to track results – both clinical and financial – of our Medicaid contracted ACO's.

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

The VCCI has supplemented its embedded model with a nurse 'liaison role' to each hospital given space constraints at provider and hospital sites. All 14 hospitals have a designated VCCI staff 'liaison' assigned who meets with hospital case managers to support the reduction of Ambulatory Care Sensitive (ACS) ED utilization by assuring member access to a Medical Home, as well as support transitions from inpatient to outpatient care to avoid 30-day readmission rates. Liaisons also meet with several large Medicaid practices to support referrals and communication on high risk members – a

common metric among VCCI, Blueprint and ACO partners. VCCI leadership meets with ACO partners to strengthen ties and further develop referral and reporting processes; however, this continues to prove to be a significant challenge to the ACO and their provider networks, given the current 'excel' spread sheet process for each practice to sort through in order to identify members for referral. There continues to be a push-back to Medicaid/VCCI staff relative direct referrals from most communities, although several are proactively working with us and see the benefit of this partnership, given resource constraints as well as common goals (clinical and financial). We anticipate more proactive work effort in the next quarter as we have elicited our internal ACO unit support to help engage partners based on our contract(s); as well as the anticipated 'next generation' ACO award based on the RFP released in April, 2016.

Enhanced service coordination continues to be a common goal of the VCCI, ACO's and the Green Mountain Care Board (GMCB) who provide leadership in the Community Learning Collaborative relative care coordination to minimize redundant efforts. A 'single, shared care plan' remains the long term vision; and the MMIS Care Management system offers this opportunity as part of the 'future state' for AHS Departments. Specifically, the Enterprise Medicaid Management Information Systems/Care Management Solution will support the work of the Learning Collaboratives and ACO partners, by providing a provider and consumer portal in SFY 2017 for a single shared care plan, thus maximizing the CMS investments to the State via ACA funding.

#### *Medicaid Obstetric and Maternal Supports (MOMS) Care Management Services*

The VCCI initially launched the service line for pregnancy case management in October 2013 and which has steadily evolved based on staff and partner input. There is a centralized resource/expert available to the field staff as well as community and statewide partners. Since this change in structure and staff, the initiative had been able to move forward at an accelerated rate, developing and administering a training curriculum for VCCI and community partner staff to help facilitate a common approach to care management for Medicaid members who are pregnant. The MOMs resource was receiving significant attention as evidenced by the increase in referrals. Unfortunately, the VCCI lost its single lead nurse for this effort in late December 2015, and was unable to successfully recruit for this expertise until June, 2016. This position is an important resource to the statewide VCCI team as well as to our partners supporting at risk pregnant women and women of child bearing years. As we mature our new case manager in this role, we also anticipated the expansion of pregnancy case management in the new eQH system.

#### *Enterprise Care Management vendor transition:*

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

In the last 3 month of system utilization, the vendor has continued to work with the state to address system defects and bugs with progression in resolution of both. As of QE 6/31/16 the State and VCCI continue our joint efforts with eQH toward User Acceptance Testing (UAT), Staging testing and deployment of fixes into the production environment; as well as planning of impending functionality in Release 1 (final) in late August, 2016.

With the continued support of the Organizational Change Management (OCM) team at the state and with eQH, we are continuing to develop and expand on training materials and guides for the team, supplemented by phone feedback sessions, webinars, 1:1 coaching, and group meetings to support staff in transition and adoption of the new system in day to day work. As we are still below case load goals, we also set up PDSA cycles with individual and team goals to support end user adoption. A time study is under consideration to determine the supplemental training needs and monitor successful adoption of training materials.

The DVHA's Clinical Operations Unit and the Quality Improvement Units are expected to utilize the system in the when the Release 1 is completed and allows for direct referrals within the system between units.

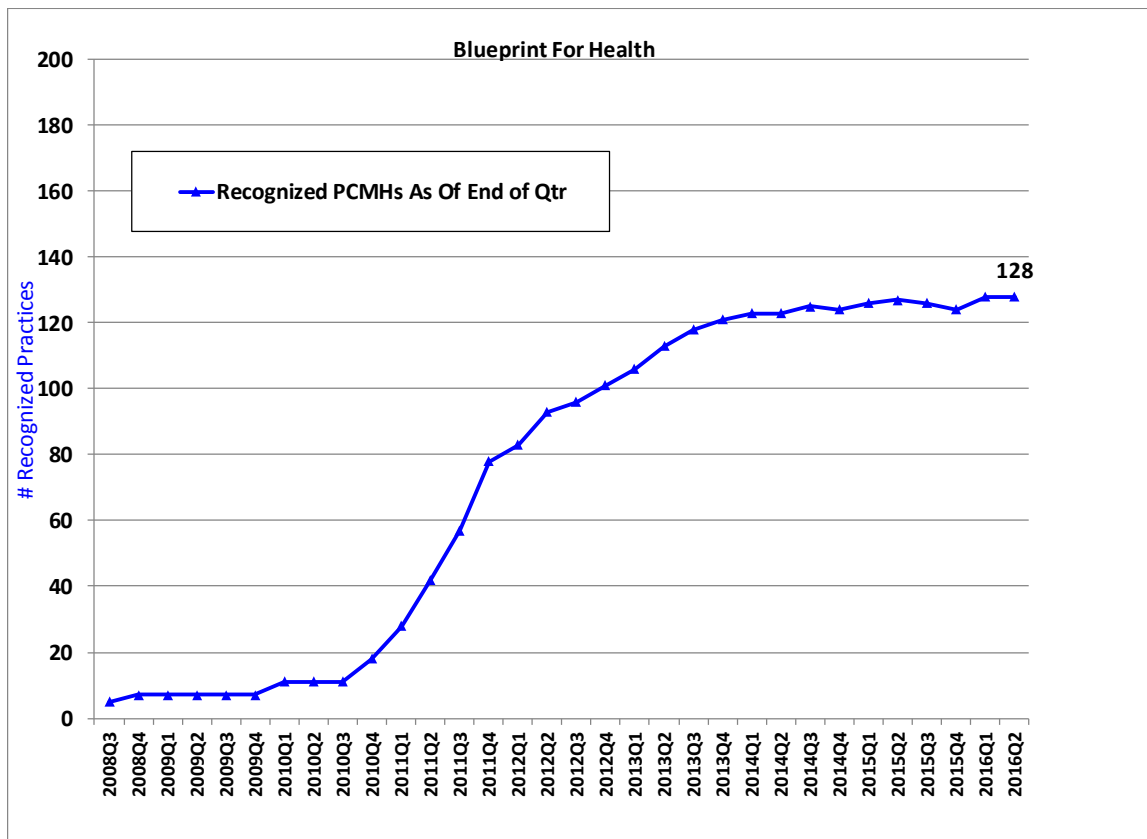
iii. *Blueprint for Health*

**Key updates from QE0616:**

- The number of Blueprint primary care practices and providers remained stable in the quarter.
- The data extracts from Clinical Registry were successfully linked to claims.
- Practice and HSA level data profiles for the time period 7/1/15 – 6/30/16 were released.
- The Blueprint in partnership with the Vermont Department of Health launched a new services initiative to reduce Vermont's rate of unintended pregnancies.
- A one year care coordination learning collaborative has been launched.
- Enrollment in the Hub and Spoke Health Home for opioid addiction continued to grow in the quarter; the total enrollment at the end of June was 5,499.
- The Department of Health issued a Request for Proposals for a new Hub program in Northwestern Vermont.

*Patient Centered Medical Homes*

In the past quarter, the Blueprint for Health program has had no net change in the number of NCQA-recognized primary care practices. One practice underwent a buy-out and conversion to FQHC ownership at the end of the quarter, one practice closed, and one new practice qualified and joined the Blueprint. The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. The number of Blueprint PCMH practices (MAPCP and non-MAPCP) as of the end of the quarter was 128.



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

In the first quarter of 2016, the Blueprint team fully assessed the functionality of the Clinical Registry and built new interfaces to improve capture of clinical messaging from the Information Exchange. The Blueprint Clinical Registry aggregates clinical data from electronic health records for the purposes of data analysis, evaluation, and quality improvement initiatives. The Blueprint also supports a Provider Registry in which detailed information on participating primary care practices is compiled and regularly updated. The analytics contractor, Onpoint Health Data, holds the contract with the Green Mountain Care board to manage Vermont’s All Payer Claims Data base (VHCURES). The Blueprint also contracts with Onpoint Health Data to receive the Medicare data set as part of the MAPCP and to create an analytic data set from the raw claims that includes provider and practice linking.

In the second quarter of 2016, the Blueprint completed reconstitution of the Blueprint Clinical Registry (adapting the former DocSite application from Covisint), newly hosted by Vermont Information Technology Leaders (VITL), the state’s Health Information Exchange (HIE) provider. Go-Live for the reconstituted registry took place at the end of June, 2016. An extract of archived clinical registry data through the first quarter of 2016 was successfully produced from the Blueprint Clinical Registry and delivered to the State’s analytic contractor in May, 2016.

The Blueprint continues to utilize its web-based portal for collecting provider, practice, and CHT information related to attribution, payment, and general program analysis.

*Healthcare data profiles of practices and Hospital Service Areas (HSAs):* Practice-level and HSA-level profiles of all-payer healthcare outcomes data, for adult and pediatric patient populations, combine claims, clinical, and survey information, and are now being produced by Onpoint for the Blueprint roughly every 6 months. Practice profiles and HSA profiles have been distributed to practices and healthcare organizations for the following data time periods:

- i. 01/2013 - 12/2013.
- ii. 07/2013 - 06/2014.
- iii. 01/2014 - 12/2014.
- iv. 07/2014 - 06/2015

Practice profiles for the data period 07/2014 – 06/2015 were produced and distributed in May, 2016. The information in those profiles give practices an overview of total utilization and expenditures as compared to peers and the rest of the state. Vermont HSA data profiles, including the latest ones for the data period 07/2014 – 06/2015, are posted at [http://blueprintforhealth.vermont.gov/reports\\_and\\_analytics/hospital\\_service\\_area\\_profiles](http://blueprintforhealth.vermont.gov/reports_and_analytics/hospital_service_area_profiles)

### *New Services Initiative*

In this quarter the Blueprint for Health completed a detailed cost and return on investment model to reduce unintended pregnancies in Vermont. Drawing heavily on the experience of Colorado and the St. Louis MO area, a plan for targeted new payments to ob-gyn providers, and modest services enhancements was developed and supported by the Secretary of the Agency of Human Services and the Commissioner of the Department of Vermont Health Access. A summary of the initiative follows.

## **Women’s Health Initiative**

VERMONT BLUEPRINT FOR HEALTH | MAY 2016

### **Program Overview**

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

### **What: Women will experience enhanced screening, connections, options**

Women who visit women’s health providers – OB-GYN offices, midwifery practices, and Planned Parenthood – will engage in enhanced health and psychosocial screening to assess mental health, substance abuse, trauma, partner violence, and access to food and housing.

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

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

## **WHY: Healthier women, children, and families**

Women's health providers help women live healthy lives, and a few key supports can make them even more effective in providing preventive care, identifying health and social risks, connecting women to community supports, and helping ensure more pregnancies are intentional.

Currently in Vermont, half of all pregnancies are unintended. Unintended pregnancies are associated with increased risk of poor health outcomes for mothers and babies and long-term negative consequences for the health and wellbeing of the children and adults those babies become.

The Healthy Vermonters 2020 goal for pregnancy intention is 65%.

## **How: multi-disciplinary expert direction, community implementation**

The Blueprint is convening a Steering Committee of experts in women's health, including providers, health and social services leaders, pharmacists and insurers. This group will refine the initiative design and help launch interventions in their communities and practices. The Steering Committee will meet in June, July, August and September. They will also help populate workgroups to plan curriculum, payment, and evaluation.

Another workgroup will address LARC accessibility. They will determine how to provide an initial supply of LARC devices, so they will be available at practices for same day insertion. They will also work with insurers, drug companies, and pharmacies to ensure providers are adequately reimbursed for comprehensive contraceptive counseling, LARC insertion and removal, and restocking.

With the Steering Committee and project team's support, area administrative entities (Blueprint grantees), Blueprint Project Managers, and Community Health Teams will recruit practices to participate in the Women's Health Initiative and recruit, hire, and train the social workers who will offer screening follow-up to at-risk women.

Quality Improvement Practice Facilitators will work with participating practices to design practice workflows to support enhanced screening, comprehensive contraceptive counseling, and same-day LARC insertion. Practice Facilitators will also help practices integrate the social worker into their practice. This work will range from the basics such as finding space to more complex tasks such as referral tracking.

A per-patient, per-month payment will support women's health care providers participating in this initiative. The payment model will be designed by the Steering Committee's Payment Workgroup. A statewide Learning Collaborative will offer provider and team training in the screening model, LARC insertion, and more.

## **When: Initiative Launches to Vermont Women in January 2017**

Planning for the Women's Health Initiative is underway, and the first Steering Committee Meeting is scheduled for June 14, 2016. Planning will continue through the summer and fall.

Learning Collaboratives begin in October 2016.

Communities will begin recruiting staff late in 2016.

Practices will be staffed with social workers, supported by Practice Facilitators, and have LARC on-hand in January 2017. Providers will be ready to provide full health and psychosocial screening and



comprehensive contraceptive counseling, knowing they have the resources available to provide timely, supportive follow-up that will help their patients live healthy lives.

### *Care Coordination Learning Collaborative*

The Blueprint is working with the Care Models and Care Management (CMCM) Workgroup, a subgroup of the Vermont Health Care Innovation Project (VHCIP), utilizing State Innovation Model (SIM) grant funds to pilot a year-long Health Care Reform learning collaborative in communities all over the state of Vermont, focusing on integrated communities care management to test interventions based on promising models. The goals are to reduce growth in health care costs, improve care and improve the health of the population. The initial focus is at-risk populations, ultimately moving on to the broader population.

### *Hub and Spoke Program*

The first publication of the initiative was accepted in the Journal of Substance Abuse Treatment in this quarter. The study examines the services utilization and total cost of care for a matched comparison sample of Medicaid beneficiaries with opioid addiction who receive Medication Assisted Treatment (MAT) and those who receive care as usual. Considered a baseline study in that it predates the services enhancements referred to as the Hub and Spoke, the findings make a good case for investments in MAT.

#### Impact of Medication-Assisted Treatment for Opioid Addiction on Medicaid Expenditures and Health Services Utilization Rates in Vermont

Mohlman Mary Kate, Tanzman Beth, Finison Karl, Pinette Melanie, and Jones Craig. Journal of Substance Abuse Treatment. August 2016, vol. 67: 9-14.

The Vermont Department of Health received proposals in response to an RFP to create a new Hub program in Northwestern Vermont. Contract negotiations with the apparently successful bidder were underway at the close of this quarter.

“Hub and Spoke”: Populations served under Vermont’s Medication Assisted Treatment (MAT) program for opiate addicted individuals continued to grow in 2016-Q2. The "Hubs" are regional specialty addictions treatment programs. The “Spokes” are counselors, nurses and social workers who provide support for patients in the primary care setting, and are members of the local Community Health Teams.

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

## Hub Implementation as of June 30, 2016

Program	Region	Start Date	# Clients	# Buprenorphine	# Methadone	# Vivitrol
Chittenden Center	Chittenden, Franklin, Grand Isle & Addison	1/1/2013	956	277	669	0
BAART Central Vermont	Washington, Lamoille, Orange	7/1/2013	471	218	253	0
Habit OPCO/Retreat	Windsor, Windham	7/1/2013	711	181	525	0
West Ridge	Rutland, Bennington	11/6/2013	362	89	273	0
BAART NEK	Essex, Orleans, Caledonia	1/1/2014	671	168	500	3
Statewide		Total	3,171	933	2,220	3

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

## Spoke Implementation as of June 30, 2016

Region	Total # MD prescribing pts	# MD prescribing to ≥ 10 pts	Staff FTE Available Funding	Staff FTE Hired	Medicaid Beneficiaries
Bennington	10	5	5.0	5.6	238
St. Albans	15	12	8.0	5.4	385
Rutland	13	7	6.0	4.25	300
Chittenden	53	18	10.5	11.6	514
Brattleboro	11	6	3.0	2.57	144
Springfield	3	2	2.0	1.5	77
Windsor	7	4	4.0	3.0	206
Randolph	5	4	2.0	1.8	107
Barre	20	6	6.0	5.5	301
Lamoille	9	3	3.5	3.6	157
Newport & St Johnsbury	10	2	2.0	2.0	97
Addison	4	3	2.0	1.5	87
Upper Valley	4	0	.5	1.0	8
Total	160*	72	54.50	49.32	2,621

Table Notes: Beneficiary count based on pharmacy claims April - June, 2016; an additional **177** Medicaid beneficiaries are served by **29** out-of-state providers. Staff hired based on Blueprint portal report 7/1/16.

\*4 providers prescribe in more than one region.

iv. Behavioral Health

**Key updates from QE0616:**

- Applied Behavior Analysis (ABA) authorizations are ongoing, additional ABA providers are continuing to enroll with the Vermont Medicaid program
- Hybrid Chart Reviews are completed for two HEDIS measures

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

The Applied Behavior Analysis (ABA) benefit was implemented July 1, 2015 and there continue to be providers submitting applications to become enrolled as Vermont Medicaid providers, representing both designated agency staff and private providers. At the time of this report, there were a total of 48 enrolled providers with a specialty of behavioral analyst. The Autism Specialist is continuing to review clinical documentation and provide initial and 6 month review authorization decisions for applied behavior analysis services for Vermont Medicaid members. At the time of this report, the Autism Specialist was managing over 60 active cases.. The Autism Specialist continues to provide regular and extensive technical assistance via phone to individual providers and groups with regard to the prior authorization process and other questions about additional enrollments, claims and coverage. In addition, the Autism Specialist, Director of Quality Improvement and Clinical Integrity and the Director of Provider and Member Relations made site visits to several ABA private provider organizations during this quarter to provide support regarding billing and to elicit feedback from providers on the Medicaid process. The Applied Behavior Analysis Clinical Practice Guideline was reviewed and recommended for adoption in the previous quarter and the bythe Guidelines have been posted to the DVHA website..

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

The Behavioral Health Team, in collaboration with the Clinical Operations Unit and the Quality Team completed the chart reviews for the HEDIS hybrid medical record review (MRR) on the controlling high blood pressure (CBP) and adult BMI assessment (ABA) measures.

In early 2016, the Department of Vermont Health Access (DVHA) developed and then issued a Request for Proposals (RFP) for one or more Accountable Care Organizations (ACOs) to participate in a new population-based payment model. Based on CMS' *Next Generation* ACO Model, the new

payment model would pay an ACO a prospective, all-inclusive population-based payment (AIPBP) for providing an array of services to its assigned beneficiary population. The model would hold the ACO accountable for both the cost and quality of health care provided, as measured by a set of quality metrics as well as clinical and utilization management requirements that the DVHA Quality Unit Behavioral Health Team staff were integral in helping to develop. Additionally, as contract negotiations continue with the chosen bidder, the Quality Unit Behavioral Health Team staff are currently advising on a reporting matrix to be used for monitoring and oversight.

v. *Mental Health System of Care*

**Key updates from QE0616:**

- Social determinants of health are prioritized in Vermont's healthcare reform arena
- Network design architecture, pharmacy connections, physician records conversion, and new IT hardware installations for VPCH's Electronic Health Record

Healthcare Reform and the Mental Health System of Care

Vermont continues to push at the boundaries of the known healthcare world, working on payment and practice reform from a number of angles. From the mental health perspective, healthcare reform presents both opportunities and challenges. The conversation often focuses on the integration of mental health in healthcare reform, sidelining the broad range of mental health promotion, mental illness prevention and treatment activities common across Vermont's mental health system of care. An exclusive focus on any one area of mental health risks neglect of the essential, foundational services that support thousands of Vermonters annually. The Department of Mental Health (DMH) seeks ways to promote mental health, prevent mental illness, and support mental health treatment and recovery within the healthcare reform arena.

Other players, including the Vermont Council of Developmental and Mental Health Services, the trade association that represents 16 community-based agencies providing a range of mental health and developmental services, ask how do we ensure the resources will be there to meet people's needs? The agencies' revenues come primarily from state and federal funding streams, which have failed to keep up with the cost of inflation. As a result, staff wages are well below those of state employees and staff turnover has reached 27%. Long waiting lists for individuals seeking services are concerning to policy makers, providers, and consumers.

The community system advocates payment reform to increase flexibility in funding and to work more effectively with their partners. Agency leaders are not clear on the meaning of integration, questioning what is meant by integration. What are we integrating? Is the focus of integration solely on the delivery of services within the medical system or is integration about closer collaboration among all community services providers, including medical providers?

This quarter, the 2015-2016 state legislative biennium came to a close, resulting in new statutory language to ensure that flexibility was part of the various healthcare reform bills considered by the health-related legislative committees of jurisdiction. As a result, Act 113<sup>1</sup>, signed into law this spring, has a far greater focus on community services than it had at the beginning of the session.

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<sup>1</sup> <http://legislature.vermont.gov/bill/status/2016/H.812>

The community mental health system worked hard to ensure that the omnibus health bill, H.812, would identify and support the community based and social components of the health care system. Lawmakers incorporated community based and social components into the resulting Act No. 113 of 2016 (H.812) in response to this educational dialogue.

*Social components* refer to the social determinants of health: poverty, early childhood adversity, unemployment, housing status, affordable and accessible healthy food, access to transportation, access and ability (including time) to recreate, and more. A major goal of Act 113 is to see the healthcare reform engines in the state – the Green Mountain Care Board and the accountable care organizations – broaden their focus from the traditional medical measures of disease (blood pressure, blood cholesterol, weight, etc.) to preventing the root causes – poor social conditions in other words -- of so much disease.

Overall, the community-based agencies and their community partners continue to advocate for a focus on strengthening the community services that exist in order to support people in the ways that are the most helpful and cost effective. Agency leaders are working to make sure that community services and the social determinants of health are pressed forward as Vermont’s healthcare reform structure evolves. What makes the difference is for people to stay at home and not enter higher levels of care.

#### Integration of Public Funding for Mental Health Care Services

The Department of Mental Health (DMH) and the Department of Vermont Health Access (DVHA) continue their joint planning process as directed by Act No. 58 of 2015, the budget enacted by the Vermont General Assembly for SFY 2016. Integration of mental and physical health within the State’s overall health reform framework, i.e., an integrated health care system, is the goal enunciated in Act 58 and a broadly shared principle. Preliminary to constructing an implementation plan for a unified service and financial allocation for publicly funded mental health services is examination of the current mental health delivery system and the financial, data, quality, policy and oversight functions performed by the Department of Mental Health in fulfillment of its statutory charge to address the mental health needs of all Vermonters.

#### Vermont Psychiatric Care Hospital

#### STATUS OF ELECTRONIC HEALTH RECORD

Staff at the Vermont Psychiatric Care Hospital (VPCH) continued this quarter to be actively involved in the implementation of the Electronic Health Record (EHR).

Architecture and design planning is underway and will continue outlining the integration and interoperability of the components of the EHR. The Medical Director, doctors, and nursing staff worked to fine tune the conversion of physician documents.

Continued dialog between DII, AHS IT, CPSI, Pipeline and CareFusion<sup>2</sup> has resulted in the development of a draft network design architecture outlining connectivity, interfaces, VLAN’s, and VPN’s. Work continues and the final design is expected to be completed soon.

On June 1<sup>st</sup> the test and pre-production system went live. Staff continue to work to fine tune data

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<sup>2</sup>

Pipeline: remote pharmacy provider (provides afterhours and weekend remote pharmacy services)

CareFusion: also known as Pyxis – medication management and dispensing solution

elements, screens, and electronic forms. Also in June, several data lines were installed to accommodate the pharmacy connections needs and to stand up the CareFusion server and console. This hardware is currently hosted by Copley Hospital, but in late June DMH amended its current contract with Copley to lay the ground work to move the current pharmacy solution off of Copley's network to one hosted by the State. This migration will allow the CareFusion (Pyxis) system to interface with VPCH's new EHR on go-live.

VPCH purchased and received IT hardware to accommodate the Electronic Health Record. This includes several printers, thermal label printers, and 17 touchscreen-convertible laptops. The EHR project steering committee will begin working to complete a deployment plan that will outline locations of hardware, the applications that need to be installed, etc. Currently, VPCH has four test systems configured with the EHR application successfully connected to the vendor hosted HIS test and pre-production environments.

<sup>1</sup> The Division of Alcohol and Drug Abuse Programs (ADAP), a division of the Vermont Department of Health, administers the SABG.

<sup>2</sup> <http://legislature.vermont.gov/bill/status/2016/H.812>

<sup>3</sup> Pipeline: remote pharmacy provider (provides afterhours and weekend remote pharmacy services)CareFusion: also known as Pyxis – medication management and dispensing solution

vi. *Pharmacy and 340B Drug Discount Program*

**Key updates from QE0616:**

- The Drug Utilization Review Board held 2 meetings on April 5th and May 17<sup>th</sup>. Ten new drugs and eleven therapeutic classes were reviewed, one review of Newly-Developed/Revised Clinical Coverage Criteria, 4 RetroDUR reviews and six safety alerts were presented.
- DVHA sent two provider communications out on the topics of a Federal Upper Limit (FUL) Update and 2016 Preferred Drug List changes.

**Pharmacy Benefit Management Program**

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

## Pharmacy Operations

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

## Clinical

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

## Initiatives to be Implemented

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

## ***Drug Utilization Review Board (DURB)***

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

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

Additionally, per State statute requiring the DVHA Commissioner establish a pharmacy best practice and cost control program, the DURB was designated as the entity to provide clinical guidance on the development of a Preferred Drug List for Medicaid beneficiaries. The DURB typically includes 10-12

members, who are appointed to two-year terms with the option to extend to a 4 year term. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians and at least one-third of its members are licensed and actively practicing pharmacists, in addition to one member at large who is currently a nurse practitioner. Board members are recommended by the DVHA Commissioner and approved by the Governor.

Meetings of the DURB occur eight times per year. In Q3 FFY 2016, the DURB held 2 meetings. Information on the DURB and its activities in 2016 is available: <http://dvha.vermont.gov/advisory-boards>.

### **DUR Board Decisions**

Updates from April 5th and May 17th DUR meetings:

#### **Full New Drug Reviews**

Aristada Injection, Narcan NS, Synjardy tabs, Zecuity transdermal, Durlaza caps, Nucala Injection, Prestalia tabs, Tresiba Insulin, Varubi tabs and Vivlodex caps were reviewed for placement on the preferred drug list.

#### **Therapeutic Drug Class Reviews**

Androgenic Agents, Antibiotics Topical, Hemophilia Factors, Prenatal Vitamins, Steroids Topical, Antibiotics Vaginal, Bone Resorption Agents, Cytokine & CAM Antagonists, Growth Hormones, Hereditary Angioedema and Multiple Sclerosis Agents were reviewed for placement on the preferred drug list.

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

##### **SSRI's**

Fluoxetine tabs, Escitalopram tabs, Luvox CR.

### ***340B Drug Discount Program***

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

Only federally designated covered entities are eligible to purchase at 340B pricing, and only patients



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

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

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

More details about the program can be found on the 340B link at [www.vtmedicaid.com](http://www.vtmedicaid.com).

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

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

- **Richford Health Center, Inc. (Notch) and affiliated with Notch Pharmacy & Community Health Pharmacy**
- Rutland Regional Medical Center
- **Southwestern Vermont Medical Center**
- **Springfield Hospital**
- **UMass Memorial Medical Center**
- **University of Vermont Medical Center and affiliated with UVMHC Outpatient Pharmacies**

vii. *Integrating Family Services (IFS) Initiative*

**Key updates from QE0616:**

- IFS is showing promising results in its pilot regions, and those results are largely due to the payment and service delivery system reforms IFS makes possible. IFS is working within the larger payment reform occurring in Vermont to ensure the current successes expand under the Medicaid Pathway
- Additionally, IFS continues to work on statewide health care reform and aligning approaches to achieve an integrated behavioral and physical health system.

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

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

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

based reimbursement projects, capitated annual budgets, and flexible choices for self-managed services. This integration is an ongoing process that is evolving into a very positive direction for children and families.

The initial IFS implementation site in Addison County is in its fifth state fiscal year, and the second pilot region in Franklin and Grand Isle counties celebrated its second anniversary on April 1, 2016. The initial pilot included consolidation of over 30 state and federal funding streams into one unified whole through one master grant agreement; the second pilot also includes consolidation of several state and federal funding streams. The State has created an annual aggregate spending cap for two providers in Addison and one in Franklin/Grand Isle (this provider houses the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children and families. A comprehensive effort continues to move the master grants towards being more integrated in regards to performance measures and alignment of language continues making significant progress to ensure the grants more effective and stream-lined.

Addison County's aggregate annual budget is approximately \$4 million with \$3 million being Global Commitment covered services. In Franklin/Grand Isle Counties, the Global Commitment covered services are near \$5,400,000. The early successes of these two pilots include:

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

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

With the continued interest in moving IFS statewide, great efforts were made through five work groups which accomplished the following during FY16:

1. Accountability and Oversight: Finalized population indicators and performance measures which will ensure quality and consistent data in all IFS regions. This data will allow regional and state leaders to track and adjust service delivery as needed.
2. Leadership and Governance: A governance framework which focused on two, primary goals: a) clarifying the roles and responsibilities of each component of the IFS infrastructure—on the state level and in the regions; and b) improving communication pathways between and among community stakeholders and state partners.
3. State and Local Service Delivery: The creation of a service delivery framework that puts into practice a common language about how we think about the intersection of service delivery; accountability; core supports and services; and prevention and promotion. As well, a regional, outcomes-reporting tool was developed that will be used by Regional Core Teams to look at how outcome data is impacted by service delivery.
4. The creation of a set of guiding questions for each IFS region to grapple with—and intended to help Regional Core Teams look for opportunities to improve how they're promoting the Strengthening Families protective factors in their work.

These work groups are made up of state and community partners to ensure multiple perspectives are present at the table and will have completed the work plan goals outlined for them in June 2016.

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

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

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

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

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

**Key updates from QE0616:**

- DVHA is seeking to establish service agreements with one (or more) Accountable Care Organization(s) (ACOs) for participation in a population-based payment model that is based on the Centers for Medicare and Medicaid Services (CMS) *Next Generation ACO Model*.
- DVHA released a Request for Proposals (RFP) including a proposed Scope of Work for ACOs that would participate in such an arrangement.
- DVHA received bids in response to the RFP. Future program implementation will be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

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

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

DVHA plans to sign an agreement with one or more ACOs to achieve enhanced integration of health care services, with the potential to integrate additional Medicaid-covered services in future program years. Program implementation will be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

## **VI. Financial/Budget Neutrality Development/Issues**

AHS kicked-off the FFY17 Global Commitment per member per month rate setting process in April 2016. Our contracted actuarial consultant, Milliman Inc., has been given historical claims and eligibility data for the purposes of setting per member per month rates for the following Medicaid Eligibility Groups (MEGs):

- Aged Blind Disabled Non-Medicare Adult
- Blind Disabled Non-Medicare Child
- Aged Blind Disabled Dual (Medicaid and Medicare)
- Non-Aged Blind Disabled Adult (General Adult)
- Non-Blind Disabled Child (General Child)
- New Adult Medical Only
- Moderate Needs
- Global Rx

In the previous quarter, CMS Regional Office conducted a review of eligibility for VIII Group, also known as the Childless New Adult population. Vermont is entitled to receive enhanced FFP for this group of beneficiaries. The initial review found that six of the thirty individuals sampled may not have been eligible for the VIII Group. AHS and DVHA conducted further research on eligibility criteria and found that four individuals did not meet the VIII Group criteria. This resulted in a disallowance of \$5,959 in FFP for the QE1215 GC claim.

AHS continued to experience challenges with the QE0616 CMS-64 submission when it came to entering negative amounts for current quarter 100% ACA EPCP claims (this enhanced Match expired QE1214). MBES does not allow for entry of negative amounts in the current quarter Waiver forms. Therefore, AHS entered the amounts as a line 10B prior quarter adjustment.

As reported last quarter, the QE0316 CMS-64 submission included CRT-DSHP costs that were reported for the initial time on its own Waiver form. For the QE0616 CMS-64 submission, CRT-DSHP costs for prior quarters (QE0915-1215) were reported in addition to current quarter costs. These costs represent expenditures under the demonstration payments through a state funded program for CRT services, as defined by Vermont rule and policy, provided to individuals with severe and persistent mental illness who have incomes above 133 percent of the FPL and up to and including 185 percent of FPL, who are not Medicaid enrolled.

## **VII. Member Month Reporting**

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

summed across quarters. All payments are adjusted at the end of the year to reconcile expected population movement between eligibility groups.

**Table 5. Number of Recipients, Change from Previous Quarter**

Demonstration Population	Q2 FFY 2016			Q3 FFY 2016		
	January 31, 2016	February 29, 2016	March 31, 2016	April 30, 2016	May 31, 2016	June 30, 2016
Demonstration Population 1	37,059	36,672	36,311	35,428	33,831	32,887
Demonstration Population 2	85,027	85,234	84,759	85,567	84,214	82,228
Demonstration Population 3	62,306	63,045	63,072	64,960	63,428	60,838
Demonstration Population 4	2,958	2,905	2,839	2,965	2,909	2,865
Demonstration Population 5	965	964	955	1,015	1,011	1,003
Demonstration Population 6	851	847	841	832	823	819
Demonstration Population 7	7,379	7,530	7,506	7,435	7,477	7,552
Demonstration Population 8	4,216	4,282	4,270	4,259	4,240	4,263

### VIII. Consumer Issues

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

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

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

## IX. Quality Improvement

### Key updates from QE0616:

- The MCE Quality Committee began work on Experience of Care Survey Criteria.
- The Quality Unit and the Department of Health continued the work of a new quality improvement collaboration focused on the Medicaid population via a shared grant funded position.
- The DVHA QI Administrator submitted the 2016-2017 Follow-Up After Hospitalization for Mental Illness PIP Summary to our EQRO for validation.

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

### *Quality Committee Updates:*

The MCE Quality Committee met monthly during the quarter. Last quarter, the Committee recommended that the MCE work towards disaggregating measures on the *Global Commitment to Health* Core Measure list when possible by target populations that receive GC funding. We feel this will better represent the breadth of Medicaid services delivered and monitored under the Global Commitment to Health waiver. In QE0616, Committee members met with the data analysts across these programs to determine data reliability and completeness for these various target populations. We also researched our ability to access Medicare data and found that in the short-term we do not have access to this data, but when the State does receive approval for this, our own Data Unit would access this data themselves; not rely on another data analytics vendor.

Also during QE0616 the MCE Quality Committee began anew a conversation about our beneficiaries' experience of care. In the past, discussions about how to provide oversight to this key element of our quality program has resulted in comparisons of particular surveys and/or discussion of the merits of particular survey questions. We decided to bring the conversation up to a higher level and mirror the work we had accomplished recently with our *Global Commitment to Health* performance measures. In June we began work on a set of recommended experience of care survey criteria. The hope is that we will identify any current survey gaps and the criteria set can be used to guide further action. Discussing the criteria set and providing information about each of our Department's current survey practices and tools has also proven to be a good way to learn about what others across the Agency are doing related to customer satisfaction/experience of care.

The AHS Performance Accountability Committee (PAC) met monthly during the quarter. During this quarter the AHS PAC focused its attention on two key topics: evaluating MCO Investments and identifying AHS organizational Performance Management Competencies. Specific to the former, the group reviewed and recommended an evaluation tool and process. The group also recommended the following four key assessment instrument items to guide the review process: obligation, alternative funding, impact on other programs, and interpreting results. Regarding the latter, the group discussed organizational competencies related to identifying outcomes and goals, monitoring performance, measuring performance, improving performance, and teaching performance. In addition to the



competencies, the group discussed the development of a self-assessment/survey, a communication plan, and also began formulating an implementation plan.

*Comprehensive Quality Strategy/State Transition Plan:*

During this quarter, the AHS HCBS Implementation Team met monthly to continue Vermont's Comprehensive Quality Strategy/State Transition Plan efforts. The primary focus of the group this quarter was the provider self-assessment and validation activities. In addition to discussions re: structure, format, and content of the tools, the group considered topics such as the following: data collection methodology, training/educational material, data analysis, and State initialed follow up. The group recommended that the State should with a contractor to develop an on-line survey for providers and consumers. While the consumer validation survey would be administered face-to-face, it should use the same online interface. The group will work with stakeholders and consumers to pilot both tools during the upcoming quarters. After a discussion with CMS, the State recommended that any tools developed should be informed by those used by the state of Tennessee. Also during this quarter, members of the implementation team continue to update stakeholders and consumers of the State's efforts. In addition, the Developmental Services, Choices for Care, and Traumatic Brain Injury systemic assessments and work plans were shared with stakeholders. Finally, all remaining systemic assessments and the work plans for the two outstanding DAIL programs were submitted to CMS during this quarter. .

*MCE Investment Review:*

During this quarter, the AHS Integrated Operations and Policy Team (IOPT) used the newly developed evaluation tool and process to review MCO investments housed in the Department of Health and the Department of Children and Family Services. While all investments were assessed by the departments, the IOPT prioritized certain investments for the meeting presentations.

The DVHA will establish an evaluation/scoring team for their investments that consist of Quality Unit staff, the Business Manager and the Deputy Commissioner of Health Care Services and Operations. Using the revised scoring tool, each investment will be reviewed and subject matter experts will be brought in where necessary in order to determine scores. The DVHA is due to present our investments to the IOPT in August 2016. Other departments presenting at IOPT next quarter include the Department of Mental Health and the Department of Disabilities, Aging and Independent Living.

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

The DVHA has completed the 2016 HEDIS hybrid medical record review (MRR) on the controlling high blood pressure (CBP) and adult BMI assessment (ABA) measures. The MRR began in January of 2016. All participating staff members completed training in January. Inter-rater reliability testing was completed in February. The retrieval process began in March. Abstractions began in March and were completed by June 30, 2016. The Inter rater reliability scores remained above 90% for all abstractors throughout the review. There were no issues identified in the MRR Validation Final Report.

*Grant Funded Quality Improvement Projects:*

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

beneficiaries as an extension of the beneficiary intervention of the PIP.

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

- **Provider mailing:** To complement the public brochure sent to Medicaid beneficiaries in February 2016, a cover letter from Dr. Chen (the VDH Commissioner) and copies of the public and provider cancer screening brochures was sent to 5,100 Medicaid providers in April 2016.
- **Gap-in-care lists:** DVHA has committed to continuing to work with the All Payer Joint Project through 2016. Medicaid, MVP & BCBSVT are sending similarly formatted quarterly gap-in-care (GIC) reports to 29 Blueprint practices. The reports show the entire panel of female Medicaid beneficiaries ages 50-64 served at the practice and whether or not they have received a mammogram in the last 2 years. The lists were sent out mid-January and mid-April.
- **Ladies First Direct Mail** to all female Medicaid primary beneficiaries ages 40-64 statewide
  - Women ages 40-49: Send a 1 time mailing with recommendation to talk to their PCP on when to get a mammogram based on their risk factors in October 2016
  - Women ages 50-64 who have had a screening mammogram in the last two years: Send a reminder letter to get a f/up mammogram over 12 months beginning in May 2016. Letters were sent in May and June.
  - No mailing will be sent to women ages 50-64 who have had a diagnostic mammogram in the last 2 years; these women should receive individualized follow-up from their PCP or mammogram facility.
  - Women ages 50-64 who have not had a screening or diagnostic mammogram in the last 2 years: Send a one-time mailing with educational materials urging them to get a mammogram in October 2016
- **Ladies First In-person outreach to Medicaid beneficiaries:** The Grant Program Manager & the Ladies First Outreach Specialist spoke with each of the Ladies First clinic champions in May and discussed their community outreach efforts. Their efforts, ideas, and suggestions were developed into a power point presentation and shared back to the group in a conference call on June 6<sup>th</sup>. The champions were interested in hearing what each other has been/would like to do. There has been additional networking post-call as champions move their outreach efforts forward.
- **Ladies First Two-Step Screening Reminder Project:** Ladies First is implementing an ongoing two-step screening reminder project in July 2016 in an effort to increase the cardiovascular, breast & cervical cancer screening rates of its members. The first step is a reminder card based on the due date of the cardiovascular screen, and will also include the member's mammogram & pap test due date (as applicable). The second step is a motivational follow up call from a Clinic Champion to the member if the member isn't current on all three screens 60 days after the reminder card is sent.

**Wise Woman Enrollment Project:** In the spring of 2015, the Centers for Disease Control (CDC) granted VDH permission to enroll female Medicaid beneficiaries between the ages of 30 – 64 in the Ladies First (LF) program. If the beneficiary meets eligibility requirements, LF may pay for approved lifestyle programs (LSP) including Weight Watchers and Curves Complete or memberships to fitness

programs (FP).

LF began enrolling Medicaid beneficiaries on a trial basis during the summer of 2015. Medicaid beneficiaries who enrolled in Ladies First were informed that if they were up-to-date with their breast, cervical and cardiovascular risk factor screening they would then be eligible for Ladies First's expanding member benefits and programming, including its weight management and fitness options.

When the Grant Program Manager position began working with VDH in January 2016, a team was assembled to design and implement a strategy to roll out the offer of enrolling in the Ladies First program to female Medicaid beneficiaries ages 30-64.

*Formal (Validated) Performance Improvement Project:*

The CMS reporting cycle for our AHS-wide Performance Improvement Project (PIP) on Follow-up After Hospitalization (FUH) for Mental Illness came to a close during QE0616. During this quarter, follow-up appointment scheduling reports were again prepared and distributed to the designated hospitals. The DVHA QI Administrator also submitted the 2016-2017 PIP Summary for validation to our vendor, Health Services Advisory Group (HSAG), on 6/29/16. Also during this quarter, the DVHA QI Administrator continued to work with the project coordinator for the Vermont Program for Quality in Healthcare (VPQHC) who has recently been asked to manage a joint payer project between Vermont Blue Cross Blue Shield and MVP focused on improving their FUH HEDIS rates. The DVHA Quality Unit agreed to join this effort. During the QE0616, the project team set a date for our first meeting, which is set for August 12, 2016. Again, this may become an unexpected, yet welcome, avenue to sustain and build upon the work of our PIP.

*Future Formal Performance Improvement Project(s):*

As our FUH PIP winds to a formal close, the topic of substance use disorders has risen to the top as a potential focus area for our next MCE formal PIP. A small group of staff from the DVHA Quality Unit and the Vermont Department of Health's Alcohol and Drug Abuse Programs (ADAP) division have formed a team to explore inter-Agency support and interest in this project topic. A presentation was delivered to the Agency's Substance Abuse Treatment Committee (SATC) during QE0316 and was met with enthusiasm. We were encouraged to also reach out to the Agency's Screening, Brief Intervention, Referral to Treatment (SBIRT) work group to explore how our project could dovetail with work already underway. We joined their meeting on May 24, 2016 and were again encouraged by the feedback we received from that group. They felt it was a worthwhile topic area and recommended a few intervention points that we could consider. Members of our team also met with the Assistant Director to the Vermont Blueprint for Health during QE0616. We discussed the data that they collect by Hospital Service Area as well as recommendations on how to approach practice level/regional initiatives. This team continues to meet to refine our topic area and eventual implementation team membership.

*Consumer Assessment of Healthcare Providers and Systems Survey:*

In 2015, DVHA participated in a national experience of care survey effort for the adult Medicaid population, which was coordinated by the National Opinion Research Center at the University of Chicago (NORC). Results of the 2015 adults CAHPS survey are expected to be released to states soon. During this reporting period, the DVHA Quality Unit staff finalized contract amendment details and

began working with a new CAHPS survey vendor. The Children's Medicaid health plan survey materials and sample frame were provided to the vendor during QE0616, and the survey was fielded during this quarter as well. The survey process will be complete and a summary report due to the DVHA during the next reporting period.

*All Payer Model:*

In early 2016, the Department of Vermont Health Access (DVHA) developed and then issued a Request for Proposals (RFP) for one or more Accountable Care Organizations (ACOs) to participate in a new population-based payment model. Based on CMS' *Next Generation ACO Model*, the new payment model would pay an ACO a prospective, all-inclusive population-based payment (AIPBP) for providing an array of services to its assigned beneficiary population. The model would hold the ACO accountable for both the cost and quality of health care provided, as measured by a set of quality metrics that the DVHA Quality Unit staff were integral in helping to develop. Additionally, as contract negotiations continue with the chosen bidder, the Quality Unit staff are currently advising on a quality reporting matrix to be used for monitoring and oversight.

## **X. Compliance**

### **Key updates from QE0616:**

- 2016 EQRO audit preparation
- New network maps and charts have been developed

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

*External Quality Review (EQR):*

During this quarter, review documents were sent by the EQRO to DVHA for all three EQRO required activities: Performance Improvement Project (PIP) Validation; Review of Compliance with Standards; and Validation of Performance Measures. The AHS Quality Improvement Manager (QIM) participated in a technical assistance call with the EQRO and face-to-face meetings with DVHA to clarify elements contained in the PIP data collection tool. The PIP validation tool was completed by DVHA and submitted to the EQRO at the end of this quarter. Feedback and scoring is expected to take place during next quarter. Also during this quarter, the AHS QIM participated in technical assistance calls with the EQRO and DVHA to prepare for the Performance Measure Validation on-site review. During these calls, it was decided that both administrative and hybrid measures would again be validated by the EQRO this year. The scope of the review was finalized and initial rates were sent to the EQRO along with requested documentation. The on-site review is scheduled for early next quarter. Finally, the AHS QIM participated in a number of calls/meetings to clarify the requirements for this year's compliance on-site review. During the quarter, all review documents were posted by the EQRO and completed/reposted by DVHA. These documents included policies, manuals, notices and samples of prior authorizations and treatment plans from all departments involved in delivering Medicaid Managed Care services. Each department was briefed and their processes were evaluated to ensure compliance with the required standards. DVHA also conducted an internal practice audit in

preparation for this year's EQRO review. This practice session helped us to identify a few additional documents and processes that will better demonstrate our compliance with the standards listed above. The 2016 EQRO Compliance review is scheduled for July 26-27, 2016 and will focus on the following Access standards:

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

#### *New Network Maps and Charts Developed*

The DVHA Data unit and Provider and Member Relations unit worked in collaboration with the AHS Policy unit to develop a series of new maps, charts and data elements. These new tools are broken down by geographical area and provider type and will give us a more comprehensive process for evaluating and tracking our provider network over time.

## **XI. Demonstration Evaluation**

During this quarter, the AHS Quality Improvement Manager continued to plan activities outlined in the new Global Commitment to Health evaluation plan. The new plan takes key evaluation elements

from the previous Global Commitment to Health waiver as well as the previous Choices for Care waiver. In the past, Pacific Health Policy Group (PHPG) has assisted with the waiver evaluation. The PHPG contract is due to expire later this year – so a decision will need to be made re: contractor support for this activity. In addition to waiver evaluation activities, the AHS QIM continues to support VHCIP evaluation activities as a member of the Evaluation Steering Committee. As this evaluation proceeds, it will be important to understand where it intersects with and how it informs Vermont Medicaid health reform/system level reform efforts.

**XII. Reported Purposes for Capitated Revenue Expenditures**

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

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

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

**XIII. Enclosures/Attachments**

Attachment 1: Budget Neutrality Workbook

Attachment 2: Enrollment and Expenditures Report

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of the Health Care Advocate Report

Attachment 6: State Fiscal Year 2015 Managed Care Entity Investments

**XIV. State Contact(s)**

Fiscal:	Sarah Clark, CFO VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-505-0285 (P) 802-241-0450 (F) <a href="mailto:sarah.clark@vermont.gov">sarah.clark@vermont.gov</a>
Policy/Program:	Selina Hickman, Director of Health Care Operations, Compliance & Improvement VT Agency of Human Services 280 State Drive, Center Building Waterbury, VT 05671-1000	802-585-9934 (P) 802-241-0452 (F) <a href="mailto:selina.hickman@vermont.gov">selina.hickman@vermont.gov</a>

Managed Care Entity: Steven M. Costantino, Commissioner  
Department of VT Health Access  
280 State Drive, NOB 1 South  
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802-241-0147 (P)  
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**Date Submitted to CMS: August 31, 2016**

## **ATTACHMENTS**







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**State of Vermont**

**Department of Vermont Health Access**

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Waterbury, VT 05671-1010

<http://dvha.vermont.gov>

[Phone] 802-879-5900

*Agency of Human Services*

## **Medicaid Program Enrollment and Expenditures Report**

### **Q4 SFY 2016**

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

**Hal Cohen, Secretary**  
Vermont Agency of Human Services

**Steven M. Costantino, Commissioner**  
Department of Vermont Health Access

August 31, 2016



## Glossary of Terms

**PMPM** – Per Member Per Month

**MEG** – Medicaid Eligibility Group

**ABD Adult** – Beneficiaries age 19 or older; categorized as aged, blind, disabled, and/or medically needy

**ABD Child** – Beneficiaries under age 19; categorized as blind, disabled, and/or medically needy

**ABD Dual** – Beneficiaries eligible for both Medicare and Medicaid; categorized as blind, disabled, and/or medically needy

**General Adult** – Beneficiaries age 19 or older; pregnant women or parents/caretaker relatives of minor children receiving cash assistance and those receiving transitional Medicaid after the receipt of cash assistance

**General Child** – Beneficiaries under age 19, and below the protected income level, categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E)

**New Adult** - Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL

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

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

**Underinsured Child** – Beneficiaries under age 19 or under with household income 237-312% FPL with other insurance

**CHIP** – Beneficiaries under age 19 with household income 237-312% FPL with no other insurance

**Pharmacy Only** – Assistance to help pay for prescription medicines based on income, disability status, and age

**Choices for Care** - Vermont's Long Term Care Medicaid Program; for Vermonters in nursing homes, home-based settings, and/or enhanced residential

**The Department of Vermont Health Access**  
**Caseload and Expenditure Report ~ DVHA Only Medicaid Spend**

DVHA YTD '16

Monday, August 8, 2016

	SFY '16 Appropriated			SFY '16 Actuals thru June 30, 2016			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	16,508	\$ 106,452,055	\$ 601.43	15,758	\$ 99,308,972	\$ 525.18	93.29%
ABD Dual	18,772	\$ 55,064,900	\$ 232.01	18,611	\$ 55,523,042	\$ 248.61	100.83%
General Adult	20,228	\$ 101,044,865	\$ 472.09	20,315	\$ 92,641,465	\$ 380.01	91.68%
New Adult	58,292	\$ 239,445,492	\$ 328.97	61,292	\$ 248,721,362	\$ 338.16	103.87%
Exchange Premium Assistance #	17,244	\$ 5,838,169	\$ 38.75	14,893	\$ 5,266,242	\$ 29.47	90.20%
Exchange Cost Sharing #	5,481	\$ 1,196,397	\$ 21.03	4,976	\$ 1,186,720	\$ 19.88	99.19%
ABD Child	3,503	\$ 30,763,473	\$ 858.33	3,242	\$ 27,174,573	\$ 698.56	88.33%
General Child	62,462	\$ 150,882,900	\$ 192.15	63,093	\$ 151,736,910	\$ 200.41	100.57%
Underinsured Child	865	\$ 1,289,560	\$ 96.59	819	\$ 1,186,527	\$ 120.70	92.01%
SCHIP	4,463	\$ 7,471,592	\$ 139.93	4,482	\$ 7,025,792	\$ 130.62	94.03%
Pharmacy Only	11,761	\$ 5,221,382	\$ 41.94	11,612	\$ 702,094	\$ 5.04	13.45%
Choices for Care	4,516	\$ 208,569,796	\$ 4,533.64	4,218	\$ 213,115,112	\$ 4,210.93	102.18%
<b>Total Medicaid Claims Paid</b>	<b>224,094</b>	<b>\$ 913,240,581</b>	<b>\$ 339.60</b>	<b>223,310</b>	<b>\$ 903,794,834</b>	<b>\$ 337.27</b>	<b>98.97%</b>

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

**The Department of Vermont Health Access**  
**Caseload and Expenditure Report ~ All AHS Medicaid Spend**  
**All AHS YTD '16**  
Monday, August 8, 2016

	SFY '16 Appropriated			SFY '16 Actuals thru June 30, 2016			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	16,508	\$ 187,113,755	\$ 991.76	15,758	\$ 181,583,629	\$ 960.27	97.04%
ABD Dual	18,772	\$ 213,788,855	\$ 978.08	18,611	\$ 218,379,458	\$ 977.81	102.15%
General Adult	20,228	\$ 110,797,688	\$ 585.99	20,315	\$ 104,967,060	\$ 430.57	94.74%
New Adult	58,292	\$ 260,126,345	\$ 435.04	61,292	\$ 276,420,440	\$ 375.82	106.26%
Exchange Premium Assistance #	17,244	\$ 5,838,169	\$ 38.75	14,893	\$ 5,266,242	\$ 29.47	90.20%
Exchange Cost Sharing #	5,481	\$ 1,196,397	\$ 21.03	4,976	\$ 1,186,720	\$ 19.88	99.19%
ABD Child	3,503	\$ 85,490,421	\$ 1,847.90	3,242	\$ 66,364,338	\$ 1,705.98	77.63%
General Child	62,462	\$ 270,612,159	\$ 385.33	63,093	\$ 256,775,510	\$ 339.15	94.89%
Underinsured Child	865	\$ 2,932,720	\$ 954.97	819	\$ 1,904,494	\$ 193.74	64.94%
SCHIP	4,463	\$ 9,049,198	\$ 182.28	4,482	\$ 8,392,111	\$ 156.03	92.74%
Pharmacy Only	11,761	\$ 5,221,382	\$ 41.94	11,612	\$ 1,405,028	\$ 10.08	26.91%
Choices for Care	4,516	\$ 211,558,241	\$ 4,151.24	4,218	\$ 215,667,896	\$ 4,261.37	101.94%
<b>Total Medicaid Claims Paid</b>	<b>224,094</b>	<b>\$ 1,363,725,329</b>	<b>\$ 507.12</b>	<b>223,310</b>	<b>\$ 1,338,505,934</b>	<b>\$ 499.49</b>	<b>98.15%</b>

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

**The Department of Vermont Health Access**  
**Caseload and Expenditure Report ~ All AHS and AoE Medicaid Spend**  
**All AHS and AoE YTD '16**  
Monday, August 8, 2016

	SFY '16 Appropriated			SFY '16 Actuals thru June 30, 2016			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	16,508	\$ 194,437,118	\$ 991.76	15,758	\$ 182,970,086	\$ 967.60	94.10%
ABD Dual	18,772	\$ 228,199,574	\$ 978.08	18,611	\$ 218,616,055	\$ 978.87	95.80%
General Adult	20,228	\$ 111,683,157	\$ 585.99	20,315	\$ 105,181,219	\$ 431.45	94.18%
New Adult	58,292	\$ 262,003,982	\$ 435.04	61,292	\$ 276,465,556	\$ 375.88	105.52%
Exchange Premium Assistance #	17,244	\$ 5,838,169	\$ 38.75	14,893	\$ 5,266,242	\$ 29.47	90.20%
Exchange Cost Sharing #	5,481	\$ 1,196,397	\$ 21.03	4,976	\$ 1,186,720	\$ 19.88	99.19%
ABD Child	3,503	\$ 90,459,139	\$ 1,847.90	3,242	\$ 82,411,072	\$ 2,118.48	91.10%
General Child	62,462	\$ 281,482,507	\$ 385.33	63,093	\$ 286,746,415	\$ 378.73	101.87%
Underinsured Child	865	\$ 3,081,904	\$ 954.97	819	\$ 2,329,302	\$ 236.96	75.58%
SCHIP	4,463	\$ 10,197,759	\$ 182.28	4,482	\$ 9,755,883	\$ 181.38	95.67%
Pharmacy Only	11,761	\$ 5,221,382	\$ 41.94	11,612	\$ 3,005,371	\$ 21.57	57.56%
Choices for Care	4,516	\$ 211,563,519	\$ 4,151.24	4,218	\$ 215,674,825	\$ 4,261.51	101.94%
<b>Total Medicaid Claims Paid</b>	<b>224,094</b>	<b>\$ 1,405,364,607</b>	<b>\$ 522.61</b>	<b>223,310</b>	<b>\$ 1,389,801,754</b>	<b>\$ 518.64</b>	<b>98.89%</b>

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

**Questions, Complaints and Concerns Received by Health Access Member Services**  
**April 1, 2016 – June 30, 2016**

**April 4 – April 8**

- Legacy Medicaid Renewal Applications: CSR's reviewed reference and either advised of current status process or advised of application channels.

**April 11 – April 15**

- PCP Enrollment: CSR's assisted in finding a PCP or entering current PCP.

**April 18 – April 22**

- No issues to report.

**April 25 – April 29**

- No issues to report.

**May 2 – May 6**

- VPharm Billing Issues: CSR's escalated the call per reference.

**May 9 – May 13**

- No issues to report.

**May 16 – May 20**

- MSP: CSR's reviewed account to confirm customer was on MSP and, if financial hardship was reported, confirmed if MSP agreement form was in Onbase and assisted accordingly.

**May 23 – May 27**

- VPharm Closure Notices: CSR's determined when the payment was mailed and advised that if it was received before June 1 coverage will not be disrupted

**May 31 – June 3**

- MSP premiums taken from SS checks: CSR's verified the MSP form is on file and escalated to HAEU if financial hardship.

**June 6 – June 10**

- No issues to report



**June 13 – June 17**

- VPharm Renewal Notice: CSR's advised the notice was just to inform customer of upcoming changes and advised new renewal date.

**June 20 – June 24**

- VPharm Renewal Notice: CSR's advised the notice was just to inform customer of upcoming changes and advised new renewal date.
- PCP Enrollment: CSR's assisted in finding a PCP or entering current PCP.

**June 27 – July 1**

- No issues to report.





**Grievance and Appeal Quarterly Report  
Medicaid Managed Care Model  
All Departments Combined Data  
April 1, 2016 – June 30, 2016**

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data compiled on August 2, 2016, from the centralized database that were filed from April 1, 2016 through June 30, 2016.

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

During this quarter, there were 16 grievances filed; eight were addressed during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 72% were filed by beneficiaries, 21% were filed by a representative of the beneficiary and 7% were filed by another source. Of the 16 grievances filed, DMH had 79%, DAIL had 14% and DVHA had 7%. There were no grievances filed for the DCF or VDH during this quarter.

There were no Grievance Reviews filed this quarter.

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

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

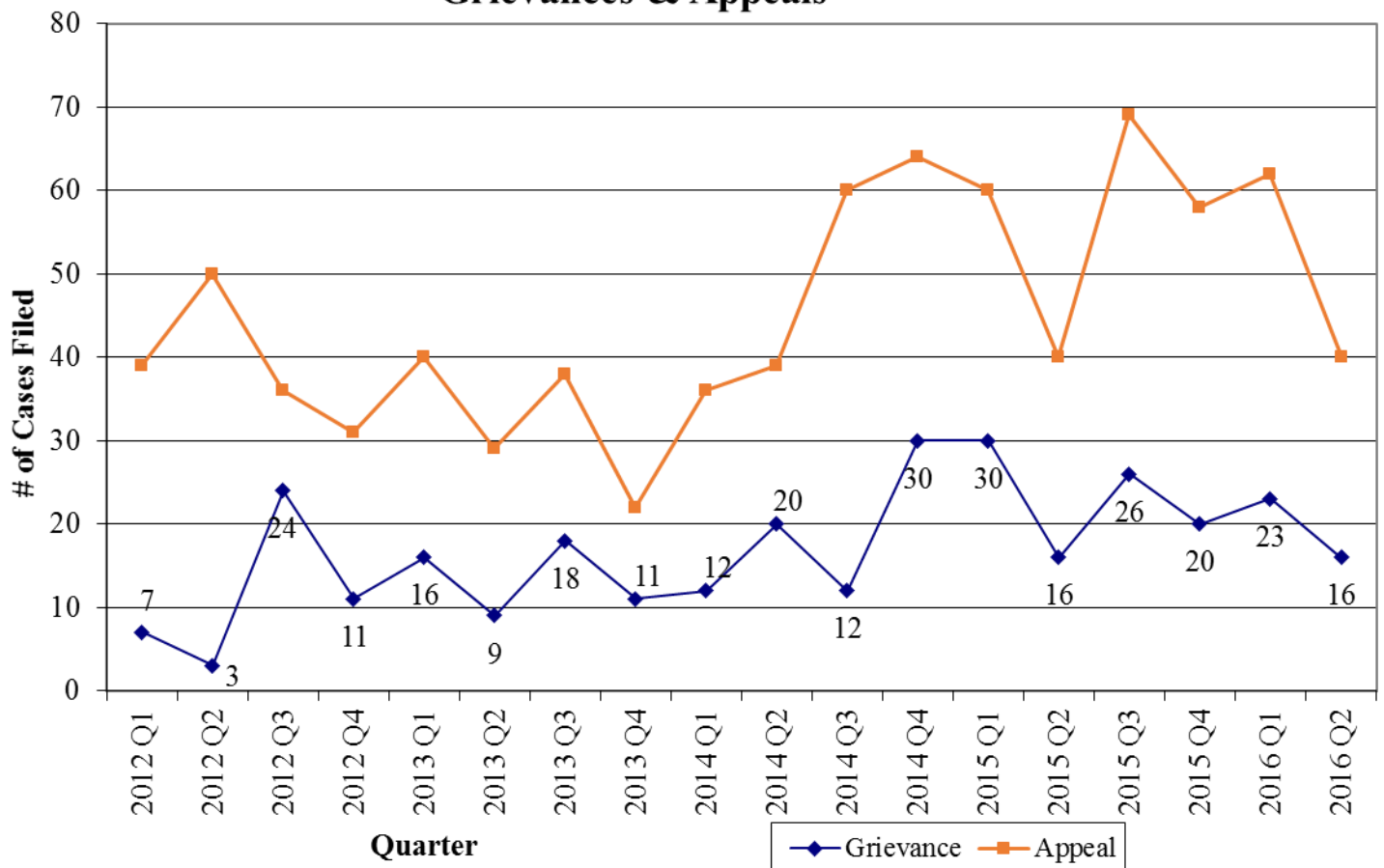
During this quarter, there were 40 appeals filed; 13 requested an expedited decision with eight of them meeting criteria. Of these 40 appeals, 26 were resolved (65% of filed appeals), 12 were still pending (30%), and 1 was filed too late (5%). In nine cases (35% of those resolved), the original decision was upheld by the person hearing the appeal, ten cases (38% of those resolved) were reversed, one had a modified approval (4%), and six were approved by the applicable department/DA/SSA before the appeal meeting (23% of those resolved).

Of the 26 appeals that were resolved this quarter, 96% were resolved within the statutory time frame of 45 days, with one (4%) being extended by the beneficiary; 92% were resolved within 30 days. The average number of days it took to resolve these cases was 12 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days.

Of the 40 appeals filed, 22 were filed by beneficiaries (55%), 14 were filed by a representative of the beneficiary (35%) and 4 were filed by the provider (10%). Of the 40 appeals filed, DVHA had 73%, DAIL had 22%, and VDH had 5%.

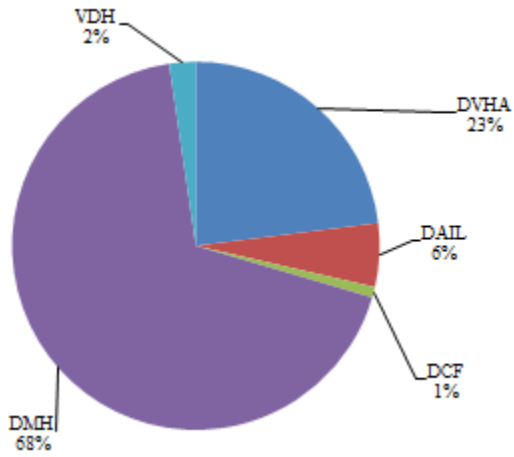
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were four fair hearings filed this quarter.

### Grievances & Appeals

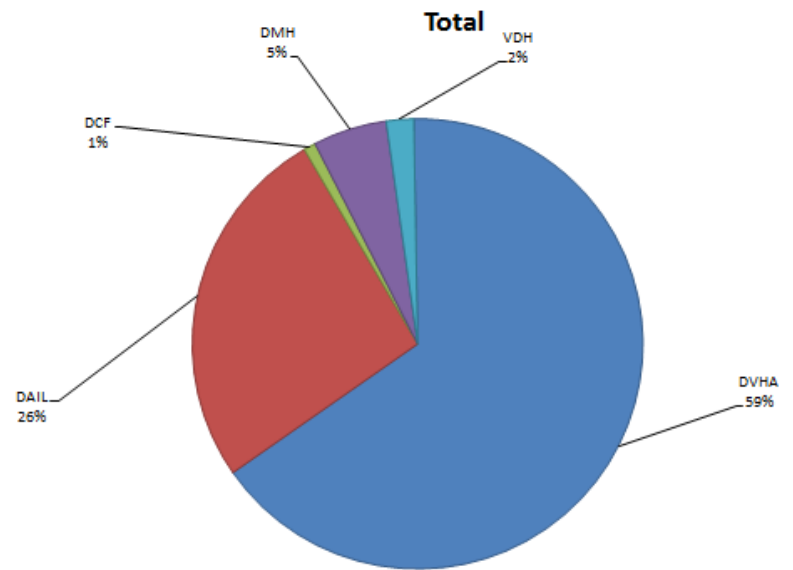


## Grievance & Appeals by Department From January 1, 2008 through June 30, 2016

### Grievances



### Appeals



Vermont Legal Aid

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**Office of the Health Care Advocate**

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Quarterly Report

April 1, 2016 – June 30, 2016

to the

Agency of Administration

submitted by

Trinka Kerr, Chief Health Care Advocate

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July 19, 2016



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## 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. We also engage in a wide variety of consumer protection activities on behalf of the public, including before the Green Mountain Care Board, other state agencies and the state legislature.

The full quarterly report for April 1, 2016 – June 30, 2016 includes:

- This narrative, which contains sections on **Individual Consumer Assistance, Consumer Protection Activities** and **Outreach and Education**
- Seven data reports, including three based on the caller's insurance status:
  - **All calls/all coverages:** 994 calls (compared to 1,338 last quarter)
  - **Department of Vermont Health Access (DVHA) beneficiaries:** 234 calls or **24%** of total calls (compared to 354 and 26% last quarter)
  - **Commercial plan beneficiaries:** 292 calls or **29%** (437 and 33%)
  - **Uninsured Vermonters:** 108 calls or **11%** (149 and 11%)
  - **Vermont Health Connect (VHC):** 505 calls or **51%** (737 and 55%; the VHC data report draws from the All Calls data set)
  - **Two Reportable Activities (Summary & Detail):** 174 activities, 49 documents (225 and 47)

## Highlights

- ✦ Total hotline call volume decreased 26% from last quarter and was similar to the same quarter in 2015. (The third quarter of the state fiscal year, January – March, typically has the highest call volume of the year.)
- ✦ Vermont Health Connect (VHC) calls were down 31% from last quarter, and very close to the level for the same period last year.
- ✦ Although VHC continues to improve functionality and performance, many Vermonters are still having serious problems. About half of all calls involved VHC, and about half of those took more than two hours of an advocate's time to resolve.
- ✦ We are able to resolve many difficult VHC cases much more quickly. Our weekly list of complex cases dropped from an average of 75 cases to about 30.
- ✦ Call volume related to VHC change of circumstance problems decreased by 39% from last quarter and was 58% lower than the same period last year.
- ✦ Calls about problems with VHC billing and premium processing decreased by 43% from last quarter's all-time high, but were the second most common reason Vermonters called the HCA.
- ✦ We continued to get calls related to tax problems as the tax season ended: 49 calls about Form 1095-A, compared to 90 last quarter, and 33 during the same quarter last year.
- ✦ We received just 26 calls related to Medicaid reviews, which is a surprisingly low number considering that thousands of Medicaid beneficiaries have been reviewed each month since January. Of those, 12 were correct terminations, 7 were incorrect terminations, and 7 were requests for information about the review process.
- ✦ The HCA assisted with 60% more appeals this quarter, an increase from 27 to 44. Of the 44, 37 involved VHC Fair Hearings requested by individuals on commercial plans.

- ✦ The HCA submitted a brief and argued on behalf of consumers in the first Vermont Supreme Court appeal from a Green Mountain Care Board rate review case. The HCA supported the Board's denial of a large rate increase requested by MVP. The Solicitor General, representing the Board, also briefed and argued the case. The Court's decision is pending.
- ✦ The HCA began analyzing the requested rate increases filed for the 2017 Vermont Health Connect plans. Blue Cross Blue Shield of Vermont requested an average rate increase of 8.2%, and MVP requested an average increase of 8.8%. The hearings are on July 20 and 21.
- ✦ The HCA filed a complaint with the Office for Civil Rights regarding a HIPAA violation by Vermont Information Technology Leaders (VITL). We also immediately notified VITL and met with its leadership and counsel about its plans to prevent further privacy breaches.
- ✦ In another Vermont Supreme Court case this quarter, the HCA asked to appear as a friend of the court, *amicus curiae*, in a Vermont Health Connect appeal. The Human Services Board granted Advanced Premium Tax Credits (APTC) to the spouse of an individual receiving Medicaid because he was a former foster child, and VHC appealed the decision. The spouse seeking APTC was unrepresented. The Court granted the HCA's motion to submit an *amicus* brief.
- ✦ The HCA submitted formal comments on four sets of proposed state regulations.
- ✦ The 2016 legislative session wrapped up at the beginning of this quarter. There were about twenty health care bills, and the HCA actively worked on a number of them. Two of particular significance were Act 113, which requires the Green Mountain Care Board to regulate Accountable Care Organizations (ACOs) and includes protections for patients attributed to ACOs, and Act 161 which creates a new mid-level dental provider, dental therapists, to expand access to dental care in the state.
- ✦ The number of people who used our website to find information and guidance on health care issues continued a pattern of strong growth with 52% more pageviews this quarter, compared with the same period in 2015.
- ✦ The number of people seeking information from our website about *dental services* increased significantly (189%) compared with the same period last year. This is the fifth quarter that the number of dental services pageviews has increased significantly over the previous year. Further, the number of dental services pageviews increased 48% over the previous quarter. Our Vermont Dental Clinics Chart was again the third most frequently downloaded of all PDFs downloaded from the Vermont Law Help website and the top health PDF download.
- ✦ The HCA played a central role in planning, moderating and presenting a full-day program at this year's Vermont Legal Services Staff College focused on gaining a better understanding of addiction, increasing awareness of resources for and obstacles to treatment and prevention in Vermont, and the impact addiction has had on the ability to effectively provide civil legal services to clients. Approximately 70 lawyers, paralegal advocates and other staff members who serve people across the state attended.

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## Individual Consumer Assistance

### Overview

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

The HCA received 994 calls<sup>1</sup> 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:

- **17.81%** (177) about **Access to Care**
- **14.69%** (146) about **Billing/Coverage**
- **1.51%** (15) about **Buying Insurance**
- **11.87%** (118) about **Consumer Education**
- **28.67%** (285) about **Eligibility** for state and federal programs
- **25.45%** (253) 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 285 of our cases had eligibility for state health care programs as the primary issue, there were actually a total of 773 cases that had some eligibility issue.

In each section of this Narrative we indicate whether we are referring to data based on just primary issues, or primary and secondary issues combined. 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.

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<sup>1</sup> The term "call" includes cases we get through our website.

## Top Problem Areas

### A. The HCA's overall call volume was 26% lower than last quarter, very close to the volume during the same quarter last year, and 38% higher than pre-VHC volume.

Total call volume was 26% lower than last quarter (994 versus 1,338), but about the same when compared with the same quarter last year (1,008). Our call volume is usually highest in January through March because most health care plans end on December 31, the new plan years begin January 1, and the renewal process can trigger problems. This was true even before the launch of VHC. In 2014 we received 1,022 calls for this quarter (April – June); in 2013 (pre-VHC) we received 721. This year's call volume for the fourth quarter is 38% higher than for the year before VHC began.

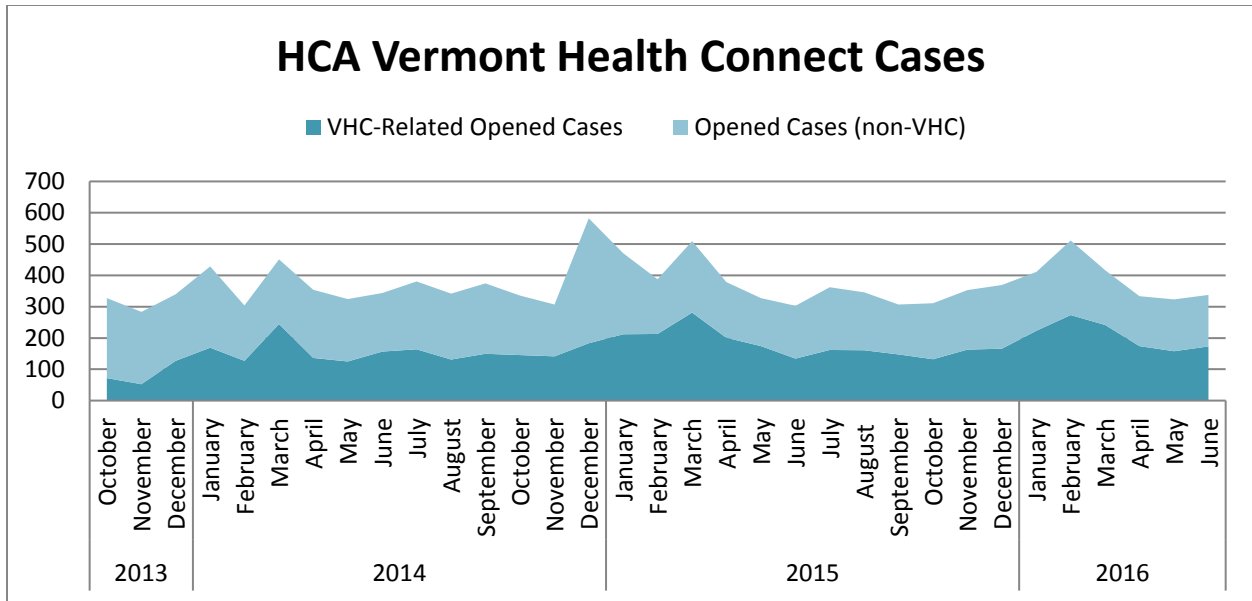
All Cases (2006-2016)											
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
January	313	280	309	240	218	329	282	289	428	470	411
February	209	172	232	255	228	246	233	283	304	388	511
March	192	219	229	256	250	281	262	263	451	509	416
April	192	190	235	213	222	249	252	253	354	378	333
May	235	195	207	213	205	253	242	228	324	327	325
June	236	254	245	276	250	286	223	240	344	303	339
July	183	211	205	225	271	239	255	271	381	362	-
August	216	250	152	173	234	276	263	224	342	346	-
September	181	167	147	218	310	323	251	256	374	307	-
October	225	229	237	216	300	254	341	327	335	311	-
November	216	195	192	170	300	251	274	283	306	353	-
December	185	198	214	161	289	222	227	340	583	369	-
<b>Total</b>	<b>2583</b>	<b>2560</b>	<b>2604</b>	<b>2616</b>	<b>3077</b>	<b>3209</b>	<b>3105</b>	<b>3257</b>	<b>4526</b>	<b>4423</b>	<b>2335</b>

### B. Vermont Health Connect call volume dropped 31% from last quarter and was similar to the call volume during the same quarter last year.

VHC call volume was 31% lower than last quarter (505 versus 737). This was very close to the volume of calls in the same quarter last year (509 calls), and much better than in 2014, when we received 1,022 VHC calls in this quarter. VHC did not exist in the second quarter of 2013.

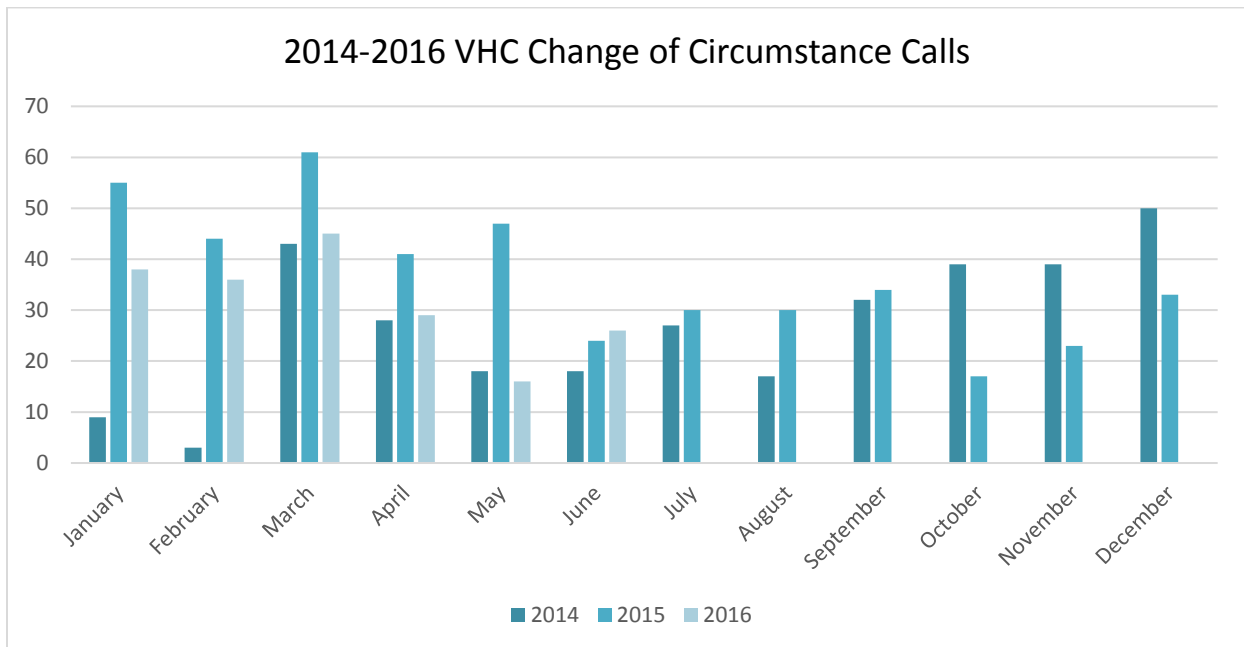
Although VHC continues to improve its functionality and performance, many Vermonters are still having serious problems. VHC-related calls constitute half of our call volume, and about half of the VHC calls this quarter were complex calls, i.e. taking up more than two hours of an advocate's time to resolve. Last quarter, only 38% of the VHC-related calls were complex.

The HCA works with VHC staff to resolve problems and escalate cases in which Vermonters need immediate access to care. We have weekly meetings with VHC staff to resolve the more complex cases. When we first started these meetings last summer, we usually had a list of 40-50 cases to be resolved each week. Last quarter the number of complex cases increased dramatically to 70-80 cases per week, but this quarter they have dropped to around 30 cases per week -- a welcome improvement. VHC is resolving the complex cases more quickly, and we are hopeful that, with continued technical improvements, the tide of difficulties is finally turning.



**C. Vermont Health Connect change of circumstance calls decreased by 39% from last quarter, and were 58% lower than last fiscal year’s fourth quarter.**

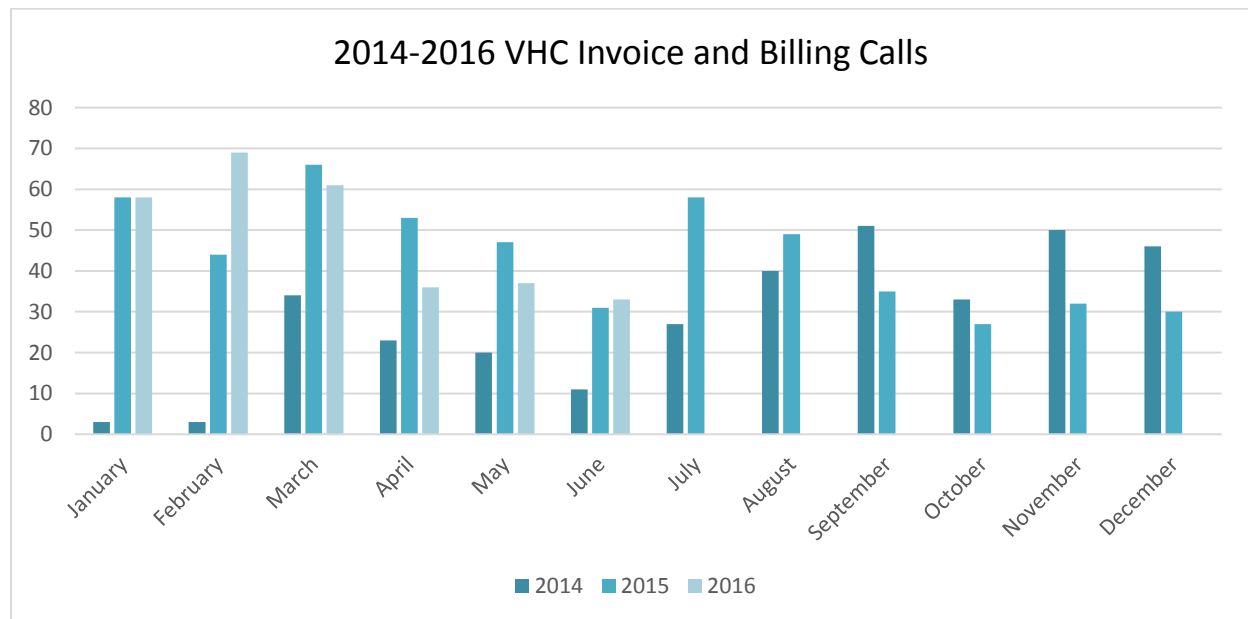
After declining throughout calendar year 2015 (155 in Q1, 109 in Q2, 94 in Q3, 69 in Q4 - the low was 17 calls in October), the number of Change of Circumstance calls jumped last quarter to 116 (when primary and secondary issues are counted) then fell again to 71 calls this quarter: 29 in April, 16 in May, and 26 in June. COC calls were 58% lower than the same quarter last year. In general, VHC has been able to process the 2016 COCs much more quickly, so we are getting far fewer calls from consumers who have had long delays in processing a COC.



**D. Vermont Health Connect invoice and billing problems decreased 43% from the previous quarter’s all-time high, but were the second most common reason people called the HCA.**

Many consumers who purchased Qualified Health Plans (QHPs) from VHC had billing and payment problems this quarter, but overall the billing and payment issue seems to be getting a bit better. Last quarter it was the most common complaint made to the HCA; this quarter, it was the second most common complaint. The problems include: invoices showing the wrong amount due or lack of credit for consumer payments; delays in processing payments, especially payments made by check; delays in applying premiums to the correct account, causing delays in getting active coverage; not receiving invoices; and lost payments. In some cases, payment problems caused consumers’ coverage to incorrectly be terminated because they were not credited for payments they had actually made. Many billing and payment problems were related to 2015 COCs that were not processed correctly or in a timely manner and problems with renewals. We also heard from consumers for whom VHC had fixed the underlying eligibility problem but the consumer was still receiving incorrect invoices, as well as from consumers who had closed their QHPs but continued to receive invoices.

This quarter we received 106 calls involving invoices, payment and premium processing, compared to the record high of 187 last quarter. Invoicing problems were also down 20% from the same quarter last year, when we received 132 such calls.



**E. Calls about tax Form 1095-A issues increased over the same quarter last year.**

This quarter included just the last two weeks of the 2015 tax season. The HCA received 49 calls about problems with 1095-As, compared to 90 calls last quarter, and 33 for the same quarter last year. Many of the calls involved consumers seeking a 1095-A which accurately reflected both the premiums that they paid and the APTC they received for 2015. Some also called because they had not received a 1095-A and wanted to file their taxes. The HCA helped consumers avoid or minimize a tax penalty by resolving 2015 coverage issues. The HCA’s tax attorney provided the HCA advocates with technical assistance on 14 cases, and accepted one HCA case referral to the Low-Income Taxpayer Clinic.

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

#### F. We received 26 calls related to Medicaid reviews.

The HCA started receiving more calls about Medicaid terminations this quarter. Of the 26 calls about the reviews which began in January, 12 were correct terminations, 7 were incorrect terminations, and 7 were for information about the review process. This was an unexpectedly low volume of calls on this issue, in light of the thousands of individuals who received review notices.

#### G. The top issues generating calls.

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

##### All Calls 994 (compared to 1,338 last quarter)

1. MAGI Medicaid eligibility 115 (120)
2. VHC invoice/billing problem affecting eligibility 106 (187)
3. VHC complaints 83 (127)
4. Complaints about providers 82 (108)
5. VHC Premium Tax Credit eligibility 82 (115)
6. DVHA/VHC premium billing 75 (93)
7. VHC Change of Circumstance 71 (116)
8. Access to prescription drugs 58 (82)
9. Termination of insurance 56 (62)
10. Consumer education about Fair Hearings 50 (36)
11. 1095-A problems 49 (90)
12. Information/applying for DVHA programs 48 (61)
13. Consumer education on IRS reconciliation 41 (57)
14. Medicaid eligibility (non-MAGI) 39 (43)
15. Affordability issue affecting access to care 37 (48)
16. Buy-in programs/Medicare Savings Programs 34 (42)
17. HAEU mistake 34 (58)
18. Grace periods-VHC 33 (36)
19. Information about VHC 32 (34)
20. Special Enrollment Periods (eligibility) 30 (52)
21. Consumer education about Medicare 30 (22)
22. VHC renewals 27 (137)
23. Medicaid spend down eligibility 26 (16)
24. Disenrollment at consumer request 26 (42)
25. Consumer education about ACA tax issues 23 (51)
26. Consumer education about IRS penalty/ISRP 23 (27)

##### Vermont Health Connect Calls 505 (compared to 737 last quarter)

1. MAGI Medicaid eligibility 107 (108)
2. VHC invoice/payment/billing problem affecting eligibility 105 (185)
3. VHC complaints 83 (129)
4. Premium Tax Credit eligibility 79 (114)
5. DVHA/VHC premium billing 75 (92)

6. Change of Circumstance 67 (113)
7. 1095-A problems 49 (89)
8. Termination of insurance 47 (54)
9. Consumer education about Fair Hearings 44 (26)
10. Consumer education on IRS reconciliation 39 (56)
11. Grace periods-VHC 33 (36)
12. HAEU mistake 32 (56)

#### **DVHA Beneficiary Calls 234 (compared to 354 last quarter)**

1. MAGI Medicaid eligibility 51 (47)
2. Complaints about providers 34 (50)
3. Access to prescription drugs 30 (27)
4. Information/applying for DVHA programs 23 (29)
5. Eligibility for Premium Tax Credit 19 (15)
6. Medicaid eligibility (non-MAGI) 16 (25)
7. Affordability affecting access to care 13 (16)
8. VHC Complaints 12 (8)
9. Consumer education about Medicare 11 (4)
10. Transportation 10 (26)
11. Choosing/changing providers 10 (21)
12. Buy-In programs/Medicare Savings Programs 10 (19)
13. Change of Circumstance 10 (17)

#### **Commercial Plan Beneficiary Calls 292 (compared to 437 last quarter)**

1. VHC invoice/payment/billing problem affecting eligibility 72 (81)
2. DVHA/VHC premium billing 53 (67)
3. Change of Circumstance 45 (80)
4. Premium Tax Credit 45 (72)
5. VHC complaints 36 (78)
6. 1095-A problems 28 (57)
7. Consumer education about IRS reconciliation 23 (36)
8. MAGI Medicaid eligibility 20 (32)
9. HAEU mistake 19 (40)
10. Consumer education about Fair Hearings 17 (11)
11. Disenrollment at consumer request 14 (30)
12. Termination of insurance 13 (22)
13. VHC renewals 13 (97)

#### **H. Hotline Call Volume by Type of Insurance:**

The HCA received 994 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as “dual eligibles”): **24%** (234 calls), compared to 26% (354) last quarter

- **Medicare<sup>2</sup> beneficiaries** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as “dual eligibles,” Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): **14%** (144), compared to 15% (207) last quarter
- **Commercial plan beneficiaries** (employer sponsored insurance, small group plans, or individual plans): **29%** (292), compared to 30% (395) last quarter
- **Uninsured: 11%** (108) of the calls, compared to 11% (150) last quarter
- In the remainder of calls, insurance status was either unknown or not relevant.

## Recommendations

1. Keep improving Vermont Health Connect functionality and integration. It is getting better, but some consumer problems remain difficult to resolve. Failure to promptly make expected changes and have them show up in real time across all data systems can cause access to care problems and tax consequences the following year.
2. Each part of the system (carriers, premium processor and VHC) should have the same, accurate information about consumers, their coverage and their payment history.
3. Investigate allowing the carriers to directly handle VHC billing as well as dunning. We still see many problems related to billing and dunning. Only one other state has an outside vendor managing premium processing.
4. To speed up the processing of checks, consider requiring premium payments to be sent directly to WEX Health, the premium processor, rather than to the Vermont address for forwarding to WEX Health.
5. Continue to support and train VHC navigators and assisters.
6. Improve the system for automatically screening for eligibility for other Medicaid programs when Medicaid for Children and Adults (MCA) is terminated or denied.
7. Improve the system for all transitions such as QHP to Medicare, MCA to Medicare, and QHP to Medicaid. Transition changes should be completed in a timely manner to avoid gaps in coverage. Some progress has been made on this issue, but more is needed.

## Case Results

### A. Dispositions of Closed Cases

#### All Calls

We closed 1,048 cases this quarter, compared to 1,262 last quarter:

- 24% (249 cases) were resolved by brief analysis and advice
- 23% (239) were resolved by brief analysis and referral
- 30% (313) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate’s time
- 12% (121) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.

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<sup>2</sup> Because Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with the figures for those categories.

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

Appeals: The HCA assisted 44 individuals with appeals: 4 commercial plan appeals, 38 Fair Hearings, 1 VHC expedited internal hearing, 0 DVHA internal MCO appeals and 1 Medicare Part D appeal. Most of our cases involving VHC and DVHA are resolved without using the formal appeals process.

### **DVHA Beneficiary Calls**

We closed 225 DVHA cases this quarter, compared to 354 last quarter:

- 27% (60 cases) were resolved by brief analysis and advice
- 31% (69) were resolved by brief analysis and referral
- 21% (48) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 12% (27) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information
- No DVHA cases were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: One case involved a Fair Hearing for an individual on a DVHA program.

### **Commercial Plan Beneficiary Calls**

We closed 345 cases involving individuals on commercial plans, compared to 386 last quarter:

- 20% (68 cases) were resolved by brief analysis and advice
- 12% (40) were resolved by brief analysis and referral
- 48% (165) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 15% (52) 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: 42 cases involved appeals for individuals on commercial plans: two External Reviews, one Level 1 internal appeal, one Level 2 internal appeal, 37 Fair Hearings, and one VHC Expedited Fair Hearing.

## **B. All Calls Case Outcomes**

The HCA helped 94 people get enrolled in insurance plans and prevented 22 insurance terminations or reductions. We obtained coverage for services for 14 people. We got 26 claims paid, written off or reimbursed. We estimated VHC insurance program eligibility for 18 more. We provided other billing assistance to 52 individuals. We provided 502 individuals with advice and education. Three people were not eligible for the benefit they sought and three were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 127 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 **\$52,363.48** in cases opened this quarter, and **\$166,865.88** in 2016 year to date.

### C. Case Examples

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

1. Ms. A called the HCA because VHC was sending her incorrect bills and as a result her health coverage was about to be terminated. When she applied for benefits, VHC told her she qualified for several hundred dollars of Advanced Premium Tax Credit (APTC) per month. However, when she received her first VHC invoice, the APTC had not been applied. This meant she was billed for the full cost of the plan. She could not afford to pay that amount and immediately fell behind on her payments. When the HCA advocate investigated, she found that the income VHC had used to calculate Ms. A's eligibility was incorrect. She notified VHC of the error and pointed out that Ms. A was, in fact, eligible for Medicaid. VHC closed her Qualified Health Plan (QHP) and moved her onto Medicaid.
2. Ms. B called the HCA the day of a scheduled surgery because her doctor was threatening to cancel the procedure because Medicaid had failed to approve a prior authorization (PA). The provider had submitted the PA request a week earlier. The HCA advocate immediately contacted DVHA and demonstrated that the requirements for the PA had been met. DVHA approved the PA just in time, and the surgery went forward as scheduled.
3. Mr. C received a closure notice in the mail from the State saying that his Medicare Savings Program (MSP) was being terminated for failure to complete a review. Mr. C was on an MSP that paid his Medicare Part A and B premiums and cost-sharing. Without the MSP, Mr. C could not afford to stay on Medicare. He had high medical needs and multiple appointments already scheduled. When the HCA advocate investigated, she found that Mr. C had sent in his review application and VHC actually had a copy of it. She found that Mr. C remained eligible for the MSP. The advocate contacted the State, and Mr. C's MSP was reinstated without interruption.
4. Ms. D had struggled for a year to get her children's Dr. Dynasaur coverage straightened out. She had re-applied early in the year and the children had been found eligible. However, when she took her children to the pediatrician, she was told that they did not have active coverage. She called VHC many times and was repeatedly told that the problem had been fixed. But the problem persisted and the pediatrician was impatient to be paid. The HCA advocate investigated and found that a misspelling in Ms. D's name was causing the problem. Once the spelling was corrected, the Dr. Dynasaur coverage was activated and the pediatrician paid.
5. Ms. E wanted to close her VHC plan because she planned to move out of state. She called VHC and requested that it close her plan the following week. VHC told her it was too late to close the coverage by the end of the next week, but it could be closed at end of the following month. Ms. E paid her premium for the final month of coverage, and believed her plan had been closed. Later, however, when her 1095-A tax form arrived it showed that her coverage had not been closed. Rather, her coverage had continued for all of 2015 and the form said she had received five months of APTC, despite the fact that Ms. E had not paid premiums for the final five months of the year. This resulted in a large tax bill. The HCA advocate found a record of Ms. E's call to VHC cancelling the coverage. The advocate then requested that Ms. E's plan be closed as of the correct date. She also

requested a new Form 1095-A reflecting the correct payments and closure date. Once Ms. E received the form, she filed an amended tax return to have her tax bill reduced.

6. Mr. F's monthly invoice from VHC was more than triple what he had been paying the year before. His income had not changed and he did not understand why the bill was so high. He called VHC but made no progress resolving the problem. He could not afford to pay the premiums and he had fallen behind in the payments. He called the HCA when he was in the second month of his grace period. At that point his carrier was not paying his medical claims. He could not afford to pay out of pocket for his prescriptions and needed to get his blood pressure medication. When the HCA advocate investigated, she found that VHC made an error in his APTC calculation. He was entitled to a much greater amount of APTC, which reduced his monthly bill by nearly \$300. With the correct APTC, Mr. F could afford his plan and was able to catch up on his payments, keep his coverage and pick up his medications.

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## Consumer Protection Activities

### A. Rate Reviews

The HCA reviews all insurance carrier requests submitted to the Green Mountain Care Board (Board) for changes in premium rates, and appears on behalf of Vermont consumers in most cases. This quarter we participated in a Vermont Supreme Court appeal of a rate review case, two new and significant rate review cases and four of five pending cases.

MVP appealed a December 2015 Board decision which disapproved MVP's rate request for five plans offered by the Agriservices Association. Agriservices, an association for farmers, uses MVP's large group Minimum Premium Plan funding arrangement for grandfathered plans. MVP requested a very large average annual rate increase of 26.9%. The HCA asked the Board to disapprove the requested rates and the Board did so. In January, MVP asked the Board to reconsider its decision. The HCA opposed this request and the Board refused to change its initial decision. MVP then appealed the Board's decision to the Vermont Supreme Court. MVP claimed that the criteria used by the Board in denying the rate increase were unconstitutionally vague or in the alternative that the Board's findings of fact and conclusions were not consistent with the standards in the rate review statute. The insurer filed its brief in March 2016. In April 2016, the HCA filed its brief asking the Supreme Court to find the statute constitutional and to uphold the Board decision. The Solicitor General also filed a brief on behalf of the Board asking the Supreme Court to affirm the Board's decision. MVP, the HCA and the Solicitor General all participated in oral argument in front of the Supreme Court on June 21, 2016. The Supreme Court is now considering all the arguments presented in the case.

Two significant new rate review cases requests were filed on May 11, 2016 for the 2017 products to be offered on the Vermont health benefits exchange, Vermont Health Connect. Blue Cross Blue Shield of Vermont (BCBSVT) requested an average 8.2% increase for its 2017 plans, which have 70,423 members. MVP requested an average increase of 8.8% for its plans with 6,614 members. During the quarter, the Board's actuary, the firm of Lewis and Ellis (L & E), began to review the filings and to request additional information from the insurers. The HCA and its independent actuary also analyzed the two filings and suggested questions for L & E to pose to the insurers. The HCA's actuary will file expert reports in the two cases on July 13, 2016. Hearings will be held on July 20 and July 21, 2016, and the Board will issue its decisions no later than August 9, 2016.

The Board decided two related cases filed by BCBSVT during the quarter, and the HCA submitted memoranda arguing for rate reductions. These cases were factor filings for BCBSVT's Large Group Rating Program and for the Large Group Rating Program of the Vermont Health Plan, a for-profit subsidiary of BCBSVT. The HCA argued that the requested contribution to reserves should be decreased from 2% to 1.3% for BCBSVT and from 2% to 0% for TVHP. However, the Board approved the filings without any modification.

The Board also decided three cases involving rates proposed by MVP. The first was a Third and Fourth Quarter filing for grandfathered small group EPO/PPO products. The HCA asked the Board to reduce the requested Contribution to Surplus by 1%, and the Board agreed with this rate reduction. The HCA and the Board also agreed on changes recommended by the Board's actuary in the calculations of medical and pharmacy trend that offset each other and did not result in a rate change.

The second MVP case was the Third and Fourth Quarter Large Group EPO/PPO filing in which MVP requested a rate decrease. The HCA argued and the Board agreed that the rate change should be decreased even further based on changes in the medical trend and pharmacy trend and on actual experience. However, the Board did not agree with the HCA that a larger reduction based on experience and on a lower contribution to surplus should be made. The final decision resulted in an average annual rate change of -12.3% for members renewing in the third quarter and -13.3% for those renewing in the fourth quarter instead of the -8.6% and -9.6% rate changes originally requested.

The HCA did not enter an appearance in the third MVP filing for the insurer's Large Group HMO filing because this filing did not affect any covered lives in Vermont and because the rate filing recommended rate decreases.

## **B. Certificates of Need**

The HCA monitors Certificate of Need (CON) proceedings before the Board for potential consumer protection issues. In the last quarter, we reviewed two new CON submissions: The University of Vermont Medical Center's (UVMC) replacement of its Da Vinci Robotic Surgery system and Option Care Inc.'s home infusion nursing system proposal which is pending jurisdiction determination. We also tracked UVMC's compliance with the Board's terms for its Inpatient Bed Project and the ongoing interrogatories for Green Mountain Surgery Center's Ambulatory Surgical Center application. We submitted questions last year to the applicant for the Ambulatory Surgical Center, and we are evaluating whether to submit an additional set. The only CON hearing during this quarter was Genesis Healthcare, Inc.'s proposed purchase of five Vermont nursing homes. Vermont Legal Aid's Long Term Care Ombudsman appeared as an interested party to this proceeding, as permitted by statute. She consulted with the HCA in preparation for the hearing.

## **C. Other Green Mountain Care Board Activities**

The HCA submitted two sets of comments to the Board this quarter. One was a formal letter to the Board in reaction to draft Accountable Care Organization (ACO) standards presented by the Board's staff at its June 9, 2016 meeting. These standards related to the Board's new responsibility to regulate Accountable Care Organizations. The letter pressed the Board to incorporate all of the quality standards required by Act 113 into any new standards for ACOs. Our second set of comments provided feedback to the Board on ways the HCA might want to access and use VHCURES data in the future to inform our work.

We attended the the Board's weekly public meetings (9), and monthly Data Governance meetings (3). We met with one of the Board's policy analysts to discuss hospital acquisitions of physician practices.

HCA staff also met with University of Vermont Health Network's chief financial officers, The University of Vermont Medical Center, and Central Vermont Medical Center to discuss the hospitals' upcoming budget and current projects.

#### **D. All-Payer Model**

Since earlier this year, the staff of the Green Mountain Care Board has facilitated meetings of stakeholders to discuss and outline the governance structure, provider payment policies, and related parameters for a possible all-payer model (APM) and single Accountable Care Organization to implement the APM. The HCA has been monitoring the planning process for the proposed APM and unified ACO for potential consumer protection concerns.

During the last quarter, we attended thirteen meetings related to the creation of a unified ACO, one meeting of the ACO Payment Subgroup, and two meetings of the ACO Rostering Subgroup. We also continued to push for more edits to the draft patient roosting agreement to make it more readable for consumers.

#### **E. Vermont Health Care Innovation Project (SIM Grant)**

The HCA continues to participate in the Vermont Health Care Innovation Project (VHCIP), which is funded by a federal State Innovation Model (SIM) grant. The Chief Health Care Advocate is a member of the VHCIP Steering Committee, which met twice this quarter. The HCA participated, along with representatives from other projects of Vermont Legal Aid, as "active members" in five of the six VHCIP work groups: Payment Model Design and Implementation, Practice Transformation, Health Data Infrastructure, Disability and Long Term Services and Supports, and Population Health. This quarter we participated in five VHCIP work group meetings. We continued to monitor the activities of the VHCIP Core Team and attended two Core Team meetings as an interested party. The HCA is also a participant in the VHCIP Self-Evaluation Committee and attended two meetings of the Committee this quarter.

The HCA submitted a set of questions to DVHA and the Payment Model Design and Implementation work group regarding the Year One results of the Medicaid Shared Savings Program. The HCA also met with Green Mountain Care Board staff to discuss a potential change to a payment measure on hospitalization for ambulatory-care-sensitive conditions for the state's Commercial Shared Savings Program. We advocated for the proposed change when it was discussed by the Core Team, but the Core Team did not vote on the change during the quarter.

Additionally, we attended the VHCIP Provider Grant Outcomes Congress organized by the Vermont Medical Society Education and Research Foundation.

#### **F. Affordable Care Act Tax-Related Activities**

During this quarter the HCA continued tax-related assistance, advocacy, and outreach efforts. We contacted VHC whenever potential problems related to the APTC tax reconciliation process surfaced. For example, we alerted VHC when the call center repeatedly gave out incorrect information about the availability of Form 1095-A amendments after April 15. The HCA participated in weekly VHC stakeholder calls about the tax forms through the middle of May.

We continued to hear from consumers whose VHC billing and enrollment problems caused them potential or actual tax problems. Some consumers discovered that their payments had been lost or misapplied when Form 1095-A unexpectedly showed unpaid months of coverage. In other cases, consumers received excess APTCs after they should have been terminated under the regulations. The HCA helped many consumers get account changes made and, where appropriate, get amended tax

forms from VHC. We advocated with VHC and the insurance carriers for a uniform application of the grace period and termination rules and received assurances that the system has improved. This should reduce the number of reconciliation-related problems in the next tax season. However, significant improvements to the VHC billing system are still needed to ensure that consumers can file accurate tax returns in a timely manner.

In this quarter the HCA continued to employ a half-time tax attorney, who also staffs the Low-Income Taxpayer Clinic at VLA. This allowed the HCA to stay up to date on tax law developments and support our staff to effectively field calls related to the ACA and VHC. Significant federal guidance and regulations impacting VHC and Vermont consumers were released this spring by HHS and IRS. The tax attorney also consulted with HCA advocates when particularly difficult IRS-related issues arose in individual HCA cases. Technical assistance on tax issues remains an important part of the HCA's work in this area. Technical assistance numbers were lower this quarter, reflecting both the end of the tax filing season on April 15 and the increased experience of the HCA's hotline advocates in resolving tax-related questions. During this quarter the tax attorney advised the HCA on 14 technical assistance questions. She also responded to 71 technical assistance questions from assisters, Vermont tax preparers, and legal services attorneys in other states. This quarter saw a rise in technical assistance consultations on IRS procedures and consumer rights before the IRS. IRS safe harbor rules for incorrect APTC determinations and Modified Adjusted Gross Income were also frequent technical assistance topics.

The HCA referred one case to VLA's Low-Income Taxpayer Clinic for representation this quarter. The consumer's employer had inflated her taxable wages in an apparent attempt to avoid a tax penalty from the IRS.

In May the HCA learned of a pending appeal before the Vermont Supreme Court on an important question of first impression, involving eligibility for premium subsidies through VHC. The Vermont Supreme Court must interpret federal tax law to decide whether contingent eligibility for employer-sponsored insurance denies an employee's spouse access to APTC. In this case, *In Re J.H.*, the employer will only permit the consumer to enroll in its health plan if her husband (the employee) also enrolls. Because the consumer's husband has Medicaid coverage as a former foster child, he did not enroll in his employer plan. The consumer then sought to purchase a subsidized plan through VHC. The Human Services Board ordered VHC to enroll the consumer with subsidies, and the State appealed to the Supreme Court. The consumer in the case is self-represented.

Because low- and moderate-income consumers generally cannot afford to purchase an unsubsidized VHC plan, the *J.H.* case will decide whether this consumer and others like her have practical access to affordable health insurance. To ensure that consumers' voices are represented as this legal question is decided, the HCA filed a motion with the Vermont Supreme Court asking for permission to submit a legal argument as *amicus curiae*, friend of the court. The motion was granted in June.

The HCA also engaged in outreach and education activities, detailed below in the **Outreach and Education** section.

## G. Other Activities

### Litigation

#### ✧ In Re: J.H.

As described above under **Affordable Care Act Tax-Related Activities**, the HCA filed a motion to participate as *amicus curiae* in a Vermont Supreme Court appeal involving eligibility for QHP subsidies under federal tax law. The motion was granted by the Court.

✦ **In Re: MVP Health Insurance Company 2015 Agriservices GMCB Rate Filing**

As described above under **Rate Reviews**, the HCA participated on behalf of Vermont consumers in the first Vermont Supreme Court appeal of a rate review decision by the Green Mountain Care Board. The Court's decision is pending.

## **Administrative Advocacy**

✦ **Vermont Information Technology Leaders (VITL) HIPAA Violation**

The HCA filed a complaint with the Office for Civil Rights (OCR) regarding a HIPAA violation by Vermont Information Technology Leaders (VITL). At a meeting with HCA staff, Green Mountain Care Board staff and other stakeholders, VITL staff shared the protected health information (PHI) of a number of Vermonters during a demonstration of a new product. The PHI was visible to people who were present at the meeting as well as to those attending via WebEx. The HCA brought the breach to the attention of those in the meeting, sent VITL a letter about the violation, met with VITL leadership and filed an OCR complaint. VITL told the HCA that it has reported the data breach to the relevant medical practice, assigned a new staff member to the role of Privacy and Security Officer and conducted training of its staff regarding HIPAA. The HCA provided feedback to VITL's counsel on the draft privacy training presentation.

✦ **Health Benefit Eligibility and Enrollment (HBEE) Rules**

In May the HCA and VLA once again submitted formal comments on new proposed amendments to the HBEE rules. After the comment period closed, AHS made additional changes to the final proposed rule to reflect new legislation and federal rulemaking. The HCA met with AHS and health insurance issuers to discuss the changes. The HCA raised concerns over implementation of the new Special Enrollment Period (SEP) for pregnant women recently created by the legislature effective July 1, 2016, which was not one of the additions to the rule proposed by AHS.

The HCA attended LCAR's review of the rule and afterward met with AHS staff to discuss ongoing operational and rules issues. These include a potential ambiguity in the rule on application of payments and the implementation of the SEP for pregnant women. The HCA followed up to ensure that legislative intent was implemented despite the postponement of rulemaking on that issue. AHS committed to working with the HCA and other stakeholders on proposed rule language over the next several months.

✦ **Health Care Administrative Rules (HCAR)**

In the last quarter VLA and the HCA submitted formal comments on the first round of proposed HCAR regulations, prior to formal rulemaking. We also raised general questions and concerns regarding the HCAR process. As a result, AHS made revisions to its proposed rule on sterilizations and did not move forward with formal rulemaking on a Medicaid non-covered services rule. AHS agreed that additional stakeholder engagement is warranted on the HCAR process generally. The HCA will participate in stakeholder input opportunities related to HCAR as they arise.

The HCA continues to monitor HCAR rulemaking as proposed changes are periodically released.

✦ **VPharm Rules**

VPharm is Vermont's State Pharmacy Assistance Program which wraps Medicare Part D prescription drug coverage. The HCA submitted formal comments, supporting SHIP's comments and requesting that the new monthly VPharm reviews be suspended for the period October to December, to prevent confusion during the annual open enrollment period for Medicare Part D.

#### ✧ **Qualified Health Plan (QHP) Rule**

In May the HCA submitted formal comments on a pre-rulemaking draft of DVHA's QHP certification and direct enrollment rule, *Standards for Issuers Participating in the Vermont Health Benefits Exchange*. The HCA's comments emphasized the need for the rule to be written in plain language so that it will be accessible to consumers and assisters as well as health insurance issuers. The HCA also advocated limiting consumer and issuer liability for mistakes made by VHC and creating a formal guidance system so that sub-regulatory guidance is accessible to consumers and the public.

After submitting comments, the HCA attended a follow-up stakeholder meeting with DVHA and AHS to discuss the rule. DVHA accepted several changes suggested in the HCA's comments. The HCA will continue to advocate for consumers as the rule moves into the formal rulemaking process this summer. In addition, the HCA will participate in two workgroups that were formed to discuss retroactive account changes and billing and enrollment.

#### ✧ **2018 Qualified Health Plan (QHP) Work Group**

The HCA is participating in this stakeholder group which was convened by DVHA to help develop any recommended changes to benefit design for QHPs offered on Vermont Health Connect in 2018. The legislature set up a process to discuss the effect that the maximum out of pocket expense limit for prescription drugs in Vermont law has on plan design, especially at the bronze plan metal level. The new federal standards being developed for 2018 plans may make it impossible for the state to develop plan designs for bronze plans that meet both the federal rules and the state limit for prescription spending. The stakeholder group had its first meeting this quarter.

#### ✧ **Rule 09-03 Work Group**

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

The HCA advocated for provisions in the statute and rule that would maintain regulatory protections for consumers in commercial health care plans, would improve the reports insurers provide about denied claims and would require DFR to file quarterly reports showing how many complaints are filed about violations of the consumer protection standards in Rule 09-03. The Administration presented proposed language for statutory changes to implement the work group's proposals in S.255, and the HCA testified about this bill. DFR and the HCA negotiated a compromise section requiring annual reports about the complaints DFR receives about violations of the rule, aggregated for all insurers. After S.255 passed during the legislative session, the work group met to discuss the rule before the Administration begins the formal rule-making process under the Administrative Procedures Act.

#### ❖ **Vermont Health Connect Escalation Path**

The HCA and VHC continued to collaborate on improving the State's escalation path for HCA cases involving complex VHC issues. We communicated with VHC multiple times a day and met at least once a week to discuss the most difficult cases. With the latest version of our escalation path, we anticipate resolving cases more quickly and efficiently.

#### ❖ **Comments on Vermont Health Connect Notices**

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

#### ❖ **Vermont Health Connect Consumer Experience Work Group**

The HCA participated in one meeting of this stakeholder work group, which was convened by Blue Cross Blue Shield of Vermont to discuss ways to improve the consumer experience for Vermonters using VHC.

#### ❖ **Medicaid and Exchange Advisory Board**

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

#### ❖ **42 C.F.R. Part 2 Advisory Group**

We continued to participate in the 42 C.F.R. Part 2 advisory group started by DVHA. This group is working on ways the Vermont Health Information Exchange (VHIE) can protect patient privacy in compliance with federal rules on substance abuse information in medical records without excluding these patients' records from the Exchange. The group met once this quarter.

#### ❖ **Universal Primary Care Study**

The HCA reviewed the Administration's draft literature review related to the Universal Primary Care proposal and provided feedback.

#### ❖ **Vermont Hepatitis Task Force**

The HCA is participating in this task force convened by the Vermont Department of Health to work on issues related to Hepatitis C in Vermont. The task force had its first meeting this quarter.

### **Legislative Activities**

This quarter included the last five weeks of the legislative session. The HCA continued to advocate for a number of legislative initiatives related to health care and health care reform.

#### ❖ **H.812 / Act 113 of 2016**

The HCA advocated for H.812, now Act 113 of 2016, which requires the Green Mountain Care Board to regulate Accountable Care Organizations and provides protections for patients attributed to ACOs, including grievance and appeals processes. Previously the state was not required to regulate ACOs.

#### ❖ **S.20 / Act 161 of 2016**

The HCA continued to advocate for S.20, now Act 161 of 2016, which creates a mid-level dental provider (Dental Therapist) in Vermont in order to improve access to dental care, particularly for children,



seniors, and Medicaid beneficiaries. Access to dental care is a significant issue about which the HCA receives numerous consumer assistance calls and web page views.

✧ **S.62 / Act 136 of 2016**

The HCA continued to advocate for S.62, now Act 136 of 2016, which allows, in limited circumstances, a surrogate to provide or withhold consent on a patient's behalf for a do-not-resuscitate order or clinician order for life-sustaining treatment.

✧ **S.216 / Act 165 of 2016**

The HCA supported language recommended by the Administration which allows the Green Mountain Care Board to permit some bronze plans on Vermont Health Connect in 2018 to use a prescription out of pocket maximum amount that is higher than the maximum amount previously allowed under Vermont law. This will enable plan designs to lower cost sharing for other medical costs. There was concern from the actuary who works with DVHA that without adjustments to the pharmacy out of pocket maximum it may become impossible to design bronze plans to meet federal standards. The proposal for plan design changes will be developed by a stakeholder work group (see **2018 Qualified Health Plan (QHP) Work Group**). The HCA also supported other sections of the bill related to increasing drug cost transparency.

✧ **S. 245 / Act 143 of 2016**

The HCA supported the provision in S. 245, now Act 143 of 2016, to require hospitals to notify patients of provider acquisitions, including disclosure of any new charges resulting from hospital affiliations.

✧ **S.255 / Act 152 of 2016**

The HCA advocated for the provisions in S.255, now Act 152 of 2016, that maintain regulatory protections for consumers in commercial health care plans and require the Department of Financial Regulation to file reports showing how many complaints are filed about violations of these consumer protection standards.

✧ **Other Legislative Advocacy**

The HCA's legislative advocacy this quarter included testifying before the House Health Care Committee (9 times), the House Judiciary Committee, the Senate Appropriations Committee, the Senate Finance Committee (3 times), and the Senate Health and Welfare Committee.

We submitted formal comments to the House Judiciary Committee on the proposed private right of action for HIPAA violations and to the House Government Operations Committee on the need for dental therapists in Vermont. Additionally, we regularly met with legislators and collaborated with state agencies and other advocates on legislative initiatives.

The Chief Health Care Advocate testified on new Health Benefits Eligibility and Enrollment (HBEE) regulations before the Legislative Committee on Administrative Rules.

### **Collaboration with Other Organizations**

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

- American Cancer Society of Vermont
- American Civil Liberties Union (ACLU)

- Association of Africans Living in Vermont (AALV)
- Bi-State Primary Care Association
- Center on Budget and Policy Priorities
- Community Health Accountable Care
- Community Catalyst
- Consumers Union
- Dartmouth-Hitchcock Medical Center
- Families USA
- IRS Office of Chief Counsel
- National Health Law Program (NHeLP)
- National Immigration Law Center
- National Viral Hepatitis Roundtable
- Oklahoma Indian Legal Services
- OneCare Vermont
- State Health Insurance Assistance Program (SHIP)
- Vermont Health Connect
- Vermont Medical Society
- Vermont Oral Health Care for All Coalition
- Vermont Public Interest Research Group
- Voices for Civil Justice
- The University of Vermont Medical Center

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## Outreach and Education

### A. Website

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

### Google Analytics Statistics

- The total number of health pageviews increased by 52% in the reporting quarter ending June 30, 2016 (8,125 pageviews), compared with the same quarter in 2015 (5,346 pageviews). This is particularly noteworthy because the total number of pageviews for the entire Vermont Law Help website was only slightly higher (5%) compared with the same period last year.
- The number of people seeking help finding *dental services* increased significantly (189%), as it has **the past five quarters**. (552 pageviews this quarter, compared with 191 in the same period last year). The number of pageviews this quarter (552) is 27% higher than last quarter (435).
- This quarter, like the previous four quarters, we saw a large increase in the number of people seeking information about *Medicaid income limits* (2,722 pageviews this quarter, compared with 1,365 in the same quarter in 2015, an increase of 99%). The consistently high numbers indicate that search engines are delivering this page as a high-ranking source of information about Medicaid income limits, as well as the increasing age of Vermont's population.

- The *health home page* again had the second largest number of pageviews (895), an increase of 13% over last year's 790. The home page tells consumers how we can help them and provides several ways to contact us including an online form that can be filled out and submitted 24/7.
- Eight of the 20 health topics with the largest number of pageviews focused on Medicaid or long-term care Medicaid (Choices for Care), while ACA-related tax topics for consumers occupied two of the top 20 slots.
- Other popular topics included:
  - *Health Insurance, Taxes and You* (275 pageviews, +118%)
  - *Medical Marijuana Registry – Patient Form* (237 pageviews, +1,085%)
  - *Federally Qualified Health Centers (FQHCs)* (147 pageviews, +141%)
- While the numbers are small, these pages showed a significant increase in the number of page views compared with the same period last quarter:
  - *Medical Debt* (39 pageviews, +160%)
  - *BCBSVT 2014 Annual Report* (37, +236%)
  - *Medical Marijuana Registry Caregiver Form* (29, +625%)
  - *How to Get Durable Medical Equipment (DME) through Medicaid* (25, +257%)
  - *Vermont Health Connect Appeals* (18, +800%) [private insurance appeals pageviews decreased slightly]
  - *Ladies First Health Program* (16, +1,500%)

## PDF Downloads

Fifty-seven out of 98 or 58% of the **unique PDFs** downloaded from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:

- 26 were created for consumers. The top five consumer-focused PDF downloads were the same as last quarter:
  - *Vermont Dental Clinics Chart* (152 downloads)
  - *Advance directive, short form* (60 downloads)
  - *Blue Cross Blue Shield of VT Annual Report 2014* (22 downloads)
  - *Vermont Medicaid Coverage Exception Request – 10 Standards and Provider Request Form* (17 downloads)
  - *Advance directive, long form* (16 downloads)
- 20 were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused downloads were:
  - *PTC Allocation Rules Summary (updated 4-18-16)* (9 downloads)
  - *Premium Tax Credit – Marriage, Separation and Divorce 12-8-14* (5 downloads)
- 11 covered topics related to health policy. The top policy-focused downloads were:
  - *Consumer Principles for Vermont's All-Payer Model* (12 downloads)
  - *Vermont ACO Shared Savings Program Quality Measures* (6 downloads)

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

## B. Education

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

### Education/Outreach

#### Presentations

During this quarter, the HCA provided education directly to approximately 183 individuals, many of whom serve populations that are likely to benefit from the information and education provided.

##### *Vermont Legal Services Staff College (June 3, 2016)*

The HCA played a central role in planning, moderating and presenting a full-day program at this year's statewide Legal Services Staff College focused on gaining a better understanding of addiction, increasing awareness of resources for and obstacles to treatment and prevention in Vermont, and the impact addiction has had on the ability to effectively provide civil legal services to clients. Approximately 70 lawyers, paralegal advocates and other staff members who serve people across the state attended.

##### *Vermont Legal Services Staff College (June 3, 2016)*

Providing written communications in plain language is essential to ensuring that clients understand both their rights and their responsibilities. The HCA led a workshop, Using Plain Language to Improve Readability (and Understanding), that showed participants how to use tools that measure a document's reading ease and grade level and strategies for writing and designing documents that are easier to read. The presenters provided a plain language checklist to guide both writing and layout of documents to increase readability. Approximately 12 people, including some HCA staff members, attended.

##### *Consumers Union Webinar (May 20, 2016)*

The HCA was one of four presenters for a "Spotlight on Vermont" webinar offered by Consumers Union's Health Care Value Hub. The Hub supports and connects consumer advocates across the U.S., providing comprehensive fact-based information to help them advocate for change. The webinar outlined Vermont's long history of pursuing innovative policies that promote better value in health care. There were 51 participants in addition to the four presenters and two Consumers Union staff members.

##### *American Bar Association Tax Section (May 6, 2016)*

The HCA's tax attorney presented Litigating Affordable Care Act Cases, along with panelists from the National Immigration Law Center, the IRS' Office of Chief Counsel, and the IRS' Office of the Associate Chief Council. The presentation was sponsored by the ABA Tax Section Diversity Committee. The panelists discussed issues related to the Affordable Care Act (ACA) raised in pending Tax Court cases, including deficiency cases involving the premium tax credit. The panel also addressed issues affecting immigrants who seek to enroll in a health plan and provide strategies to avoid disqualification from enrollment or access to the premium tax credit. Approximately 15 IRS and legal services attorneys attended.

##### *American Bar Association Tax Section (May 5, 2016)*

The HCA's tax attorney and a policy analyst from the Center on Budget and Policy Priorities (CBPP) presented *Addressing ACA problems in Non-Tax Fora* as part of the Low-Income Taxpayers Representation Workshop sponsored by the ABA Tax Section's Pro Bono & Tax Clinics Committee. The panel was moderated by an attorney from Oklahoma Indian Legal Services. The presentation focused on tax-related appeals before the federal Health Insurance Marketplace. It was a collaboration with CBPP and Oklahoma Indian Legal Services. There were about 35 attendees, including legal services and IRS Taxpayer Advocate Service attorneys.

### **Promoting Plain Language in Health Communications**

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

- Suggested revisions to VHC's on-hold message about a Medicaid renewal notice error
- Suggested extensive revisions to VHC call script
- Provided extensive plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:
  - EE600-VLMM VHC change request follow-up letters 6-24-16
  - EE701-MM Transitioning MCA Population 6-13-16 Magi Pop
  - EE711-MM Transitioning MCA Population 6-13-16 Non Magi Pop
  - SYS709-MM Dr. D Premium Change Notice VLA 6 2 16
  - ADM708-MM VPharm Annual Review Change Notice 6 2 16
  - VHC Right to Appeal
- Suggested additional extensive revisions to a primary care enrollment agreement prepared by the Vermont Health Care Innovation Project Rostering Workgroup
- Reviewed final version, suggested minor changes to these consumer notices:
  - APTC Correction Notice
  - EMP005 Employee Eligibility for APTC DRAFT

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## **Office of the Health Care Advocate**

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

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

MCO Investment Expenditures

Department	Criteria	Investment Description	SFY11 Actuals	SFY12 Actuals	SFY13 Actuals	SFY14 Actuals	SFY15 Actuals	Investment Criteria #	Rationale
DOE	2	School Health Services	\$ 4,478,124	\$ 11,027,579	\$ 9,741,252	\$ 10,454,116	\$ 10,029,809		
AOA	4	Blueprint Director	\$ -	\$ -	\$ -	\$ -	\$ -	1	Reduce the rate of uninsured and/or underinsured in Vermont
AOA			\$ -	\$ -	\$ -	\$ -	\$ 639,239		
GMCB	4	Green Mountain Care Board	\$ -	\$ 789,437	\$ 1,450,717	\$ 2,360,462	\$ 2,517,516	2	Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries
DHR	2	Health Care Administration	\$ 1,898,342	\$ 1,897,997	\$ -	\$ -	\$ -		
DVI	4	Vermont Information Technology Leaders	\$ -	\$ -	\$ -	\$ -	\$ -	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
VVH	2	Vermont Veterans Home	\$ 1,410,956	\$ 1,410,956	\$ 1,410,956	\$ 410,986	\$ 410,986		
VSC	2	Health Professional Training	\$ 405,407	\$ 405,407	\$ 405,407	\$ 405,407	\$ 409,461	4	Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.
UVM	2	Vermont Physician Training	\$ 4,006,156	\$ 4,006,156	\$ 4,006,156	\$ 4,006,156	\$ 4,046,217		
VAAF	3	Agriculture Public Health Initiatives	\$ -	\$ 90,278	\$ 90,278	\$ 90,278	\$ 90,278		
AHSCO	2	Designated Agency Underinsured Services	\$ 2,510,099	\$ 5,401,947	\$ 6,232,517	\$ 7,184,084	\$ 6,894,205		
AHSCO	4	2-1-1 Grant	\$ 415,000	\$ 415,000	\$ 415,000	\$ 499,792	\$ 499,667		
VDH	2	Emergency Medical Services	\$ 333,488	\$ 274,417	\$ 378,168	\$ 498,338	\$ 480,027		
VDH	2	AIDS Services/HIV Case Management	\$ -	\$ -	\$ -	\$ -	\$ -		
VDH	2	TB Medical Services	\$ 36,284	\$ 39,173	\$ 34,046	\$ 59,872	\$ 28,571		
VDH	3	Epidemiology	\$ 315,135	\$ 329,380	\$ 766,053	\$ 623,363	\$ 872,449		
VDH	3	Health Research and Statistics	\$ 289,420	\$ 439,742	\$ 497,700	\$ 576,920	\$ 715,513		
VDH	2	Health Laboratory	\$ 1,912,034	\$ 1,293,671	\$ 2,885,451	\$ 2,494,516	\$ 3,405,659		
VDH	4	Tobacco Cessation: Community Coalitions	\$ 94,089	\$ 371,646	\$ 498,275	\$ 632,848	\$ 702,544		
VDH	3	Statewide Tobacco Cessation	\$ 507,543	\$ 450,804	\$ 487,214	\$ 1,073,244	\$ 1,148,535		
VDH	2	Family Planning	\$ 275,803	\$ 420,823	\$ 1,574,550	\$ 1,556,025	\$ 1,390,410		
VDH	4	Physician/Dentist Loan Repayment Program	\$ 900,000	\$ 970,000	\$ 970,105	\$ 1,040,000	\$ 900,000		
VDH	2	Renal Disease	\$ 13,689	\$ 1,752	\$ 28,500	\$ 3,375	\$ 10,125		
VDH	2	Newborn Screening	\$ -	\$ -	\$ -	\$ -	\$ -		
VDH	2	WIC Coverage	\$ 36,959	\$ -	\$ 77,743	\$ 317,775	\$ 1,824,848		
VDH	4	Vermont Blueprint for Health	\$ 752,375	\$ 454,813	\$ 875,851	\$ 713,216	\$ 703,123		
VDH	4	Area Health Education Centers (AHEC)	\$ 500,000	\$ 540,094	\$ 496,176	\$ 547,500	\$ 543,995		
VDH	4	Community Clinics	\$ 640,000	\$ 600,000	\$ 640,000	\$ 688,000	\$ -		
VDH	4	FOHC Lookalike	\$ 87,900	\$ 102,545	\$ 382,800	\$ 160,200	\$ 97,000		
VDH	4	Patient Safety - Adverse Events	\$ 16,829	\$ 25,081	\$ 42,169	\$ 38,731	\$ 34,988		
VDH	4	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	\$ 290,661	\$ 318,806	\$ 345,930	\$ 326,184	\$ 396,229		
VDH	2	Substance Abuse Treatment	\$ 1,693,198	\$ 2,928,773	\$ 2,435,796	\$ 2,363,671	\$ 2,913,591		
VDH	4	Recovery Centers	\$ 648,530	\$ 771,100	\$ 864,526	\$ 1,009,176	\$ 1,299,604		
VDH	2	Immunization	\$ -	\$ 23,903	\$ 457,757	\$ 165,770	\$ 253,245		
VDH	2	DMH Investment Cost in CAP	\$ 752	\$ 140	\$ -	\$ -	\$ -		
VDH	4	Poison Control	\$ 115,710	\$ 213,150	\$ 152,250	\$ 152,433	\$ 105,586		
VDH	4	Challenges for Change: VDH	\$ -	\$ 309,645	\$ 353,625	\$ 288,691	\$ 426,000		
VDH	3	Fluoride Treatment	\$ -	\$ 43,483	\$ 75,081	\$ 59,362	\$ 55,209		
VDH	4	CHIP Vaccines	\$ -	\$ 196,868	\$ 482,454	\$ 707,788	\$ 557,784		
VDH	4	Healthy Homes and Lead Poisoning Prevention Program	\$ -	\$ -	\$ 101,127	\$ 479,936	\$ 421,302		
DMH	2	Special Payments for Treatment Plan Services	\$ 134,791	\$ 132,021	\$ 180,773	\$ 168,492	\$ 152,047		
DMH	2	MH Outpatient Services for Adults	\$ 522,595	\$ 974,854	\$ 1,454,379	\$ 2,661,510	\$ 3,074,989		
DMH	2	Mental Health Elder Care	\$ -	\$ -	\$ -	\$ -	\$ -		
DMH	4	Mental Health Consumer Support Programs	\$ 582,397	\$ 67,285	\$ 1,649,340	\$ 2,178,825	\$ 1,132,931		
DMH	2	Mental Health CRI Community Support Services	\$ 1,935,344	\$ 1,886,140	\$ 6,047,450	\$ 11,331,235	\$ 282,071		
DMH	2	Mental Health Children's Community Services	\$ 1,775,120	\$ 2,785,090	\$ 3,088,773	\$ 3,377,546	\$ 3,706,864		
DMH	2	Emergency Mental Health for Children and Adults	\$ 2,309,810	\$ 4,395,885	\$ 8,719,824	\$ 6,662,850	\$ 4,148,197		
DMH	2	Respite Services for Youth with SED and their Families	\$ 543,635	\$ 541,707	\$ 823,819	\$ 749,943	\$ 931,962		
DMH	2	CRT Staff Secure Transportation	\$ -	\$ -	\$ -	\$ -	\$ -		
DMH	2	Recovery Housing	\$ 512,307	\$ 562,921	\$ 874,194	\$ 985,098	\$ 463,708		
DMH	2	Transportation - Children in Involuntary Care	\$ -	\$ -	\$ -	\$ -	\$ -		
DMH	2	Vermont State Hospital Records	\$ -	\$ -	\$ -	\$ -	\$ -		
DMH	4	Challenges for Change: DMH	\$ 229,512	\$ 945,051	\$ 819,069	\$ -	\$ -		
DMH	2	Seriously Functionally Impaired: DMH	\$ 68,713	\$ 160,560	\$ 1,151,615	\$ 721,727	\$ 392,593		
DMH	2	Acute Psychiatric Inpatient Services	\$ -	\$ 12,603,067	\$ 5,268,556	\$ 3,011,307	\$ 2,423,577		
DMH	2	Institution for Mental Disease Services: DMH	\$ -	\$ -	\$ 10,443,654	\$ 7,194,964	\$ 25,371,245		
DVHA	4	Vermont Information Technology Leaders/HIT/HIE/HCR	\$ 646,220	\$ 1,425,017	\$ 1,517,044	\$ 1,549,214	\$ 2,915,149		
DVHA	4	Vermont Blueprint for Health	\$ 2,616,211	\$ 1,841,690	\$ 2,002,798	\$ 2,490,206	\$ 1,987,056		
DVHA	1	Buy In	\$ 50,605	\$ 24,000	\$ 17,878	\$ 17,728	\$ 27,169		
DVHA	1	Visiting Expanded	\$ -	\$ -	\$ -	\$ -	\$ -		
DVHA	1	HIV Drug Coverage	\$ 39,176	\$ 37,452	\$ 39,881	\$ 26,540	\$ 10,072		
DVHA	1	Civil Union	\$ 999,084	\$ 1,215,109	\$ 1,112,119	\$ 760,819	\$ (50,085)		
DVHA	1	Vtgham	\$ -	\$ -	\$ -	\$ -	\$ -		
DVHA	4	Hospital Safety Net Services	\$ -	\$ -	\$ -	\$ -	\$ -		
DVHA	2	Patient Safety Net Services	\$ 36,112	\$ 73,487	\$ 2,394	\$ 363,489	\$ 335,420		
DVHA	2	Institution for Mental Disease Services: DVHA	\$ -	\$ -	\$ 6,214,805	\$ 6,948,129	\$ 7,792,709		
DVHA	2	Family Supports	\$ -	\$ -	\$ 4,015,491	\$ 3,723,521	\$ 2,982,388		
DCF	2	Family Infant Toddler Program	\$ 624	\$ -	\$ -	\$ -	\$ -		
DCF	2	Medical Services	\$ 64,496	\$ 47,720	\$ 37,164	\$ 33,514	\$ 32,299		
DCF	2	Residential Care for Youth/Substitute Care	\$ 7,853,100	\$ 9,629,269	\$ 10,131,790	\$ 11,137,225	\$ 10,405,184		
DCF	2	AABD Admin	\$ -	\$ -	\$ -	\$ -	\$ -		
DCF	2	AABD	\$ -	\$ -	\$ -	\$ -	\$ -		
DCF	2	Aid to the Aged, Blind and Disabled CCL Level III	\$ 2,661,246	\$ 2,563,226	\$ 2,621,786	\$ 2,611,499	\$ 2,864,727		
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level III	\$ 136,466	\$ 137,833	\$ 124,731	\$ 89,159	\$ 77,196		
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level IV	\$ 265,812	\$ 273,662	\$ 269,121	\$ 183,025	\$ 160,963		
DCF	2	Essential Person Program	\$ 736,479	\$ 775,278	\$ 783,860	\$ 801,658	\$ 707,316		
DCF	2	GA Medical Expenses	\$ 492,079	\$ 352,451	\$ 275,187	\$ 253,939	\$ 219,973		
DCF	2	CUPS/Early Childhood Mental Health	\$ 112,619	\$ 165,016	\$ 45,491	\$ -	\$ -		
DCF	2	VCRHYP/Vermont Coalition for Runaway and Homeless Youth Program	\$ -	\$ -	\$ -	\$ -	\$ -		
DCF	2	HBKF/Healthy Babies, Kids & Families	\$ -	\$ -	\$ -	\$ -	\$ -		
DCF	1	Catamount Administrative Services	\$ -	\$ -	\$ -	\$ -	\$ -		
DCF	2	Children's Integrated Services Early Intervention	\$ -	\$ -	\$ -	\$ 200,484	\$ -		
DCF	2	Therapeutic Child Care	\$ 570,493	\$ 596,406	\$ 557,599	\$ 543,196	\$ 605,419		
DCF	2	Lund Home	\$ 196,159	\$ 354,528	\$ 181,243	\$ 237,387	\$ 405,034		
DCF	2	GA Community Action	\$ 199,762	\$ 338,275	\$ 420,359	\$ 25,181	\$ -		
DCF	3	Prevent Child Abuse Vermont: Shaken Baby	\$ 44,119	\$ 74,250	\$ 86,969	\$ 111,094	\$ 54,125		
DCF	3	Prevent Child Abuse Vermont: Nurturing Parent	\$ -	\$ 107,184	\$ 186,916	\$ 54,231	\$ 195,124		
DCF	4	Challenges for Change: DCF	\$ 50,622	\$ 196,378	\$ 197,426	\$ 207,286	\$ 189,378		
DCF	2	Strengthening Families	\$ -	\$ 465,343	\$ 429,154	\$ 399,841	\$ 370,003		
DCF	2	Lamoille Valley Community Justice Project	\$ -	\$ 162,000	\$ 216,000	\$ 402,685	\$ 83,315		
DCF	3	Building Bright Futures	\$ -	\$ -	\$ 398,201	\$ 594,070	\$ 514,225		
DDAIL	2	Elder Coping with MMA	\$ -	\$ -	\$ -	\$ -	\$ -		
DDAIL	2	Mobility Training/Other Svcs.-Elderly Visually Impaired	\$ 245,000	\$ 245,000	\$ 245,000	\$ 245,000	\$ 245,000		
DDAIL	2	DS Special Payments for Medical Services	\$ 757,070	\$ 1,498,083	\$ 1,299,613	\$ 1,271,148	\$ 385,896		
DDAIL	2	Flexible Family/Respite Funding	\$ 1,103,748	\$ 1,103,749	\$ 1,088,889	\$ 2,868,218	\$ 1,400,997		
DDAIL	4	Quality Review of Home Health Agencies	\$ 103,598	\$ 128,399	\$ 84,139	\$ 51,697	\$ 44,682		
DDAIL	4	Support and Services at Home (SASH)	\$ -	\$ 773,192	\$ 773,192	\$ 1,013,671	\$ 1,026,155		
DDAIL	4	HomeSharing	\$ -	\$ -	\$ 310,000	\$ 317,312	\$ 327,163		
DDAIL	4	Self-Neglect Initiative	\$ -	\$ -	\$ 150,000	\$ 200,000	\$ 265,000		
DDAIL	2	Seriously Functionally Impaired: DAIL	\$ -	\$ -	\$ 1,270,247	\$ 859,371	\$ 333,331		
DOC	2	Intensive Substance Abuse Program (ISAP)	\$ 591,000	\$ 458,485	\$ 400,910	\$ 547,550	\$ 58,280		
DOC	2	Intensive Sexual Abuse Program	\$ 70,002	\$ 60,585	\$ 69,311	\$ 19,322	\$ 15,532		
DOC	2	Intensive Domestic Violence Program	\$ 174,000	\$ 164,218	\$ 86,814	\$ 64,970	\$ 169,043		
DOC	2	Women's Health Program (Tapestry)	\$ -	\$ -	\$ -	\$ -	\$ -		
DOC	2	Community Rehabilitative Care	\$ 2,221,448	\$ 2,242,871	\$ 2,500,085	\$ 2,388,327	\$ 2,539,161		
DOC	2	Return Home	\$ -	\$ -	\$ 399,999	\$ 399,999	\$ 343,592		
DOC	2	Northern Lights	\$ 40,000	\$ -	\$ 393,750	\$ 335,587	\$ 354,909		
DOC	4	Challenges for Change: DOC	\$ -	\$ 687,166	\$ 524,594	\$ 433,910	\$ 539,727		
DOC	4	Northeast Kingdom Community Action	\$ -	\$ -	\$ 548,825	\$ 287,662	\$ 267,025		
DOC	2	Pathways to Housing	\$ -	\$ -	\$ 802,488	\$ 830,936	\$ 830,338		
			\$ 56,275,877	\$ 89,836,470	\$ 123,669,882	\$ 127,103,459	\$ 128,924,888		

Attachment 6 - MCE Investments SFY15