State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 10
(1/1/2015 – 12/31/2015)

Quarterly Report for the period
January 1, 2015 – March 31, 2015

Submitted Via Email on May 29, 2015

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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).

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

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

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

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

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

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

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

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

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

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.

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. ***This is the first quarterly report for waiver year 10, covering the period from January 1, 2015 through March 31, 2015 (QE0315).***

i. Global Commitment to Health Waiver: Renewal

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

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

Independent, The Bennington Banner, Newport Daily Express, The Islander, Herald of Randolph, and the News and Citizen. This distribution list represents all geographic regions of the state.

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

The State posted a comprehensive description of the draft waiver request on February 13, 2013 on the above-cited websites. The document included: program description, goals and objectives; a description of the beneficiary groups that will be impacted by the demonstration; the proposed health delivery system and benefit and cost-sharing requirements impacted by the demonstration; estimated increases or decreases in enrollment and in expenditures; the hypothesis and evaluation parameters of the proposal; and the specific waiver and expenditure authorities it is seeking. In addition to the draft posted for public comment, an Executive Summary and the PowerPoint presentation used during each public hearing was also posted to the same state websites noted above.

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

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

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

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

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

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

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

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

II. Enrollment Information and Counts

Key updates from QE0315:

- With the consolidated waiver effective January 30, 2015, this is the first quarterly reporting for enrollment counts of the revised Demonstration Populations.

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

With the consolidated waiver effective January 30, 2015, this is the first quarterly reporting for enrollment counts of the revised Demonstration Populations. Since this is the first quarterly reporting for these populations, the percent variance from last quarter has not been calculated. The percent variance between quarters will be calculated in the QE0615 report.

Table 1. Enrollment Information and Counts for Demonstration Populations*, QE0315

Demonstration Population	Current Enrollees Last Day of Qtr
	March 31, 2015
Demonstration Population 1:	36,732
Demonstration Population 2:	81,010
Demonstration Population 3:	56,047
Demonstration Population 4:	2,905
Demonstration Population 5:	877
Demonstration Population 6:	918
Demonstration Population 7:	7,608
Demonstration Population 8:	4,344
	190,441

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

III. Outreach Activities

i. Member Relations

Key updates from QE0315:

- A banner was published to remind providers to update their account information, which will provide current information for beneficiaries in the web-based provider look-up.
- Member Health Care Program Handbooks were reviewed and revised.
- The annual Green Mountain Care Member Newsletter is being drafted in preparation for communicating legislated changes to benefits.
- Contracts are drafted for the extension of 8 contracts with transportation brokers for SFY 2016.
- The Medicaid and Exchange Advisory Board met three times in this quarter.

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

A banner was published reminding providers to update their provider account information (demographics, group affiliation, and contact information). These updates feed into the provider look-up search feature on the Vermont Medicaid website, enabling beneficiaries to locate providers and determine their availability. Banners are published twice annually to outreach to providers about the importance in making their information current.

Member Handbooks were reviewed and an insert was prepared in January and put into each existing Health Care Programs Handbook to ensure correct information is mailed to new Medicaid members. An additional review of the Pharmacy Program and Enrollment Handbooks is scheduled for May to further address clarifications that will assist members in understanding their Medicaid coverage and benefits. The revised handbooks are scheduled for publication and distribution in June.

The annual Green Mountain Care Member Newsletter is currently being planned to communicate any legislated changes to health care benefits for SFY 2016, along with helpful health and preventative care information.

Contracts with eight transportation providers for non-emergency medical transportation are in the drafting process. The extended contracts will begin on July 1 for SFY 2016.

The Medicaid and Exchange Advisory Board (MEAB) held meetings on January 26, February 23 and March 23. Agendas and minutes are publicly posted at: http://info.healthconnect.vermont.gov/advisory_board/meeting_materials.

IV. Operational/Policy Developments/Issues

In January 2015, Hal Cohen took over as the Secretary of AHS, replacing Dr. Harry Chen who was the Interim Secretary. Dr. Chen has transitioned back to his previous role as Commissioner of VDH. Additionally, in February 2015, Steven M. Costantino replaced Mark Larson as the DVHA Commissioner.

i. Vermont Health Connect

Key updates from QE0315:

- During the 2015 open enrollment period, more than 14,000 individuals who were new to the Vermont Health Connect (VHC) system—meaning that they neither had VHC coverage in 2014 nor were they listed as being in the household of a customer—enrolled in a health plan with a coverage effective date starting in QE0315.
- New enrollments are coming in ahead of projections, indicating that Vermont is likely to lower its 3.7% uninsured rate even further.
- In early March, VHC implemented its plan to transition 26,000 households from the State's legacy ACCESS system to VHC to receive their MAGI Medicaid eligibility determination.
- The Customer Support Center managed incoming call volume, receiving more than 120,000 calls over the quarter, achieving an abandon rate of 1.8% and answering four out of five calls (80%) in less than 30 seconds.

Vermont Health Connect's second open enrollment period for qualified health plans (QHPs) kicked off on November 15, 2014 and closed on February 15, 2015. Vermonters who were new to the Marketplace signed up for 2015 health coverage, while existing QHP customers requested changes or auto-renewed for 2015 coverage. In addition to renewing customers, more than 14,000 individuals who were new to the Vermont Health Connect system—meaning that they neither had VHC coverage in 2014 nor were they listed as being in the household of a customer—enrolled in a health plan with a coverage effective date starting in QE0315. These new enrollments put Vermont Health Connect on pace to beat actuarial projections for the year and further reduce Vermont's 3.7% uninsured rate, which already had been cut nearly in half from 2012 to 2014. Nearly three out of five (56%) of these new enrollees qualified for Medicaid or Dr. Dynasaur.

In early March, Vermont Health Connect began implementing its plan to transition 26,000 households from the State's legacy ACCESS system to VHC to receive their MAGI Medicaid eligibility determination. The plan began with a pilot of highest income households, as they are the most likely to no longer be eligible for Medicaid. The pilot involved small numbers of renewals, scheduled over a three-month period of time to allow VHC to assess the success of its renewal strategy. Once the strategy is refined and Vermont Health Connect understands which method of outreach is most successful, the monthly renewal cadence will increase to allow for the legacy system transition to be completed by March 2016.

VHC continued to utilize Optum agents to augment manual processes throughout QE0315, though at a much smaller scale than in 2014. After using as many as 170 Optum agents in October and November to process both the backlog of Change of Circumstance (CoC) requests and VHC renewals, the State decided to reduce its pool of contract resources to 30 highly trained Optum agents beginning December 31. The main reason for this decision was the complexity of the remaining manual work. These agents continued to process remaining renewals and CoCs throughout QE0315 and will continue to do so until May 15, 2015.

In QE0315, the State executed a contract with Optum for systems integrator (SI) delivery and deployment for FFY2015. The first major deployment is scheduled for May 31 and will include renewal functionality and automated processing of CoCs.

Maximus continues to manage the VHC Customer Support Center (call center), currently utilizing 82 customer service representatives. The call center serves Vermonters enrolled in both public and private health insurance coverage, providing Level 1 call center support, which includes phone applications, payment, and basic coverage questions. Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. They transfer calls to the State's Health Access Eligibility Unit for resolution and log service requests, which are escalated to the appropriate resolver group. Throughout QE0315, the system's performance continued to be stable and operated as expected. The Customer Support Center managed incoming call volume, receiving more than 120,000 calls over the quarter, achieving an abandon rate of 1.8% and answering four out of five calls (80%) in less than 30 seconds.

ii. Choices for Care

Effective January 30, 2015, Vermont consolidated the Choices for Care 1115 waiver with Vermont's Global Commitment to Health 1115 waiver. This section represents the first quarterly report for Choices for Care.

Program Summary:
Choices for Care offers a broad system of long-term services and supports across all settings for adult Vermonters with physical disabilities and needs related to aging. People who meet the Highest or High Needs clinical level of care (nursing home level of care), and meet Vermont's financial criteria for long-term care Medicaid may choose to receive services in one of the following settings:

1. Home-Based Options

- *"Traditional" Home-Based*– A case manager helps coordinate a person-centered plan with the participant that may include personal care, adult day services, personal emergency response and some assistive devices/home modification funds. Care may be provided through a local certified home health agency or if eligible, participants may hire their own caregivers through the consumer or surrogate directed option. The participant chooses either their local Area Agency on Aging or Designated Home Health Agency to provide case management services.

- *Flexible Choices*– If eligible, a consultant agency (Transition II) helps the participant create an allowance and budget for services that is managed by the participant or an eligible surrogate. The participant or surrogate acts as the employer and works within their budget to choose and arrange for services in their home.

2. Adult Family Care (AFC) Option

AFC is a residential option for participants to receive their care and services in an unlicensed, private family home-provider setting. Services are managed through an Authorized Agency who is paid a daily tier rate for the home provider and other long-term services and supports. Homes must pass a safety and accessibility inspection and agree to a signed contract with the Authorized Agency.

3. Enhanced Residential Care (ERC) Option

This option provides 24-hour care and supervision in approved Vermont licensed Level III Residential Care Homes or Assisted Living Residences. Services include personal care, housekeeping, meals, activities, nursing oversight and medication management. For individuals in the ERC option, the home may also bill Medicaid for Assistive Community Care Services (ACCS) payments as well. The individual pays for room and board. More information or a list of ERC providers may be found online at http://www.dail.state.vt.us/lp/.

4. Nursing Home Option

This option provides 24-hour nursing care, supervision, therapies, personal care, meals, nutrition services, activities and social services provided by nursing facilities that are both Medicare certified and Vermont licensed. More information or a list of nursing homes may be found online at http://www.dail.state.vt.us/lp/.

In addition to the services offered to people who meet Highest/High Needs clinical standards (nursing home level of care), Choices for Care also provides limited funding for people with Moderate Needs. To be eligible, people must meet a modest clinical eligibility standard and a non-Medicaid financial eligibility test with an adjusted income of up to 300% of Vermont's Supplemental Security Income (SSI) rate. Eligible participants may receive homemaker services, adult day services, and flexible funds in addition to case management services.

Choices for Care participants who are eligible for Vermont Medicaid also maintain their full range of State Plan health care benefits.

Money Follows the Person Grant:
In 2011, DAIL was awarded a five year $17.9 million "Money Follows the Person" (MFP) grant from CMS to help people living in nursing facilities overcome barriers to moving to their preferred community-based setting. The program provides participants the assistance of a Transition Coordinator and up to $2,500 to address barriers to transition. Since 2012, MFP and its partners have helped 162 people transition to the community while 60 people completed a full 365 days of living in a community setting. In September 2013, with the help of the MFP grant, Choices for Care (CFC) implemented a new service called Adult Family Care (AFC). It is a wonderful new option that provides long-term services and supports in private homes around the state. Additionally, the MFP enhanced federal match for CFC community-based services has helped fund growth in Vermont's long-term services and supports system, such as increased wages for self-directed independent direct support workers.

For more information on Vermont's Money Follows the Person Grant, go to:
http://www.ddas.vermont.gov/ddas-projects/mfp/mfp

Consumer Survey Report:
Each year, Vermont contracts with an independent entity to complete a long-term services and supports consumer survey, focusing on quality of services and quality of life. In February 2015, Thoroughbred Research Group published the 2014 Vermont Long-Term Services and Supports HCBS Consumer Survey Report.

In summary, *"The results of the survey suggest that the large majority of consumers are satisfied with DAIL programs, satisfied with the services they receive, and consider the quality of these services to be excellent or good. The survey results are a clear indication that DAIL is in large part fulfilling its goal 'to make Vermont the best state in which to grow old or to live with a disability ~ with dignity, respect and independence.' This high level of satisfaction continues a trend observed…since 2008. …the survey results did not identify any major systemic problems with the programs and services provided by DAIL. DAIL is providing the services needed by the vast majority of its consumers in a manner that is effective, appropriate and that clients appreciate."*

- 91% of people rate the services as excellent or good.
- 93% of people rate the value of the services as excellent or good.
- 90% of people rate the reliability of the people that help them as excellent or good.

Survey results are used by Vermont to inform program improvement efforts. The complete report can be seen at: *http://www.ddas.vermont.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/cfc-evaluation-rpts-consumer-surveys.*

Policy Brief:
Through the management of Vermont's Money Follows the Person (MFP) grant, the MFP team has observed a relatively high number of people returning to the nursing facility after transition. This prompted Vermont to work with the University of Massachusetts Medical School (UMMS) independent evaluation team to develop a policy brief regarding factors leading to readmissions to nursing facilities. In March 2015, the policy brief was published: *Vermont Choices for Care: Personal and Systemic Factors Leading to Nursing Facility Readmission.*

Through document research and interviews with participants, family and case managers, UMMS identified the following factors:

1. Pre-disposing person factors
    a. history of falls/accidents
    b. mental health and substance abuse concerns
    c. behavioral and cognitive concerns
    d. obesity
    e. longstanding disability
2. Enabling environmental factors
    a. transition communication and coordination
    b. influence of physicians in nursing facility admissions
    c. enhanced residential care options
3. Perceived services needs factors
    a. eligibility and assessment process
    b. sufficiency and appropriateness of services
    c. need for additional service hours
    d. need for two-person assist
    e. case management needs
    f. need for worker training
    g. medication management needs
    h. availability of caregiver education and support

To better identify and address these personal and systemic factors, UMMS made recommendations in four areas: 1) improve the CFC assessment, care planning and case management processes; 2) enhance information and referral; 3) ensure appropriateness and sufficiency of services, and 4) enhance capacity of settings. These recommendations will be incorporated into Vermont's program improvement efforts.

The full policy brief can be found at: http://ddas.vt.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/umass-policy-brief-factors-leading-to-nursing-facility-readmission-march-2015

Nursing Facility Companion Aide Pilot:
In March 2015, Vermont implemented a Companion Aide Pilot Project to provide assistance to nursing facilities in advancing culture change with a focus on person-centered dementia care. The goal of the pilot is to provide an enhanced Medicaid rate to five interested and eligible facilities that are committed to person-centered dementia care through dedicated 'Companion Aide' staff. A Companion Aide is a trained licensed nursing assistant (LNA) who will champion person-centered dementia care with the goal of improving the lives of people with dementia, as evidenced by positive changes such as a reduction of the use of psychotropic drugs, incidence of resident-to-resident altercations, and improved staff satisfaction.

The following 5 facilities were chosen to participate in the pilot using pre-determined criteria:

- Brookside in White River Junction, VT
- Derby Green in Derby, VT
- Helen Porter in Middlebury, VT
- Mayo in Northfield, VT
- Mountain View in Rutland, VT

These nursing facilities are committed to furthering culture change with a focus on person-centered

dementia care. The facilities will collect data and complete the Artifacts of Culture Change Tool, Care Practice and Environment sections (Developed by CMS and Edu-Catering, LLP) to help evaluate the success of this enhancement to dementia care. The facility's enhanced rate for the Companion Aides are contingent on the Companion Aides meeting the requirements and training outlined in the job description. Companion Aides must also be part of an overall facility-wide effort to improve the lives of residents with various forms of dementia.

The pilot is projected to run from March 1, 2015 through the end of the current Demonstration period—December 31, 2016. The State expects to continue funding the pilot into the next Global Commitment reauthorization through June 30, 2017. Participating nursing facilities are currently in the process of hiring additional staff and training Companion Aides. A full description of the pilot may be found in Attachment H of the Global Commitment waiver: http://dvha.vermont.gov/administration/vt-1115-companion-aide-pilot-attachment-h-approval-02272015.pdf.

V. Expenditure Containment Initiatives

i. Medicaid Shared Savings Program

Key updates from QE0315:

- As of April, 48,000 Medicaid beneficiaries are attributed to two Accountable Care Organizations (ACOs) through the Vermont Medicaid Shared Savings Program (VMSSP).
- Work continues with other state programs and initiatives, including Vermont's Blueprint for Health and the Vermont Chronic Care Initiative (VCCI), to strengthen care management collaboration for the Medicaid population.
- Developed care management standards as guidelines for ACOs.
- Updated Year 2 quality measures and Gate & Ladder calculation.
- Continued research into cost categories to be included in VMSSP Total Cost of Care for Performance Year 3.

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. Vermont Medicaid is currently working toward an approval from CMS for a State Plan Amendment for the VMSSP.

Beneficiary attribution in the VMSSP continues to increase as new providers are added to participating ACO entities, with over 880 providers participating in the program, resulting in 48,000 total beneficiaries attributed—approximately 29,000 lives in OneCare Vermont (OCVT) and 19,000 lives in Community Health Accountable Care (CHAC).

The Care Models and Care Management working group of the Vermont Health Care Innovation Project (VHCIP), comprised of public and private stakeholders, developed a set of care management standards as guidelines for ACOs to operate and integrate with other health care entities to promote better health for the people of Vermont.

Over the course of the three-year program, the VMSSP seeks to expand the scope of accountability in

care to go beyond traditional medical services. This expansion aims to include pharmacy, non-emergency transportation, long term care services and supports, mental health and substance abuse services, and other social services that are commonly sought by Medicaid beneficiaries. The ACOs did not elect to take on optional cost categories (including pharmacy and non-emergency medical transportation) for Year 2 of the VMSSP. VMSSP staff continue to research and analyze the potential impacts of including additional cost categories into the Year 3 Total Cost of Care (TCOC) for the ACOs. Inclusion of additional cost categories chosen by VMSSP staff for Year 3 is mandatory. VMSSP staff will notify the ACOs of selected additional cost categories no later than October 1, 2015.

In Year 2 the VMSSP is building on the momentum in Year 1 to continue to strengthen the relationship between the ACOs and existing statewide initiatives, such as the Blueprint for Health and the Vermont Chronic Care Initiative (VCCI). The ACOs have been engaging with the Blueprint for Health on the use of performance measures in Blueprint-ACO Unified Community Collaboratives and on the use of ACO quality results in these Collaboratives. Additionally, clinical leadership at DVHA has been working with the ACOs and VCCI to strategize around further coordination of care, including the development of targeted reporting tools.

In the coming year, VMSSP staff will continue to focus on the expansion of the quality measure set for Year 3 and will also work closely with the analytics team to study the outcomes of the first year.

ii. Vermont Chronic Care Initiative (VCCI)

Key updates from QE0315:

- The VCCI documented net savings over anticipated expense in SFY 2014 of $30.5 million with a concurrent reduction in inpatient admissions of 31%, readmissions of 30% and emergency department utilization reduction of 15%, as compared to SFY 2013.
- The Enterprise Medicaid Management Information Systems/Care Management contracting process was concluded; the contract has been submitted to CMS for approval.
- The DVHA/APS contract extension to support continuity of VCCI business operations, pending the successful on-boarding of the enterprise CM vendor, was concluded. Final contract approval is anticipated by 4/1/15 for an extension through calendar year 2015.
- The VCCI field staff will become voting members of the ACO locally sponsored 'regional clinical planning committees' (RCPCs). Initial meetings to set priorities and coordinate referrals have been initiated in several hospital service areas (HSAs); and with ACO partners.
- The VCCI is scheduled to launch the newly restructured pregnancy case management service—renamed Medicaid Obstetrical and Maternal Supports (MOMS)—in early May after staff and partner trainings that are scheduled throughout April 2015.

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

The VCCI uses a holistic approach of evaluating and supporting improvement in medical and

behavioral health, as well as socioeconomic issues that are often barriers to sustained health improvement. Medicaid members who are eligible for the VCCI (super-utilizers) account for the top 5% of service utilization and approximately 39% of Medicaid costs. 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. The VCCI's SFY 2014 final report validates its approach, demonstrating a reduction of 30% in hospital admissions, a 31% reduction in 30-day readmissions and a 15% reduction in Emergency Department (ED) usage among members in the top 5% as compared to SFY 2013. These reductions in utilization, along with related improvement in evidence based chronic disease management, resulted in a net savings of $30.5 million over anticipated expenses in SFY 2014.

The VCCI is also continuing its collaboration with ACO partners to enhance the number of participating hospitals providing 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 (via secure file transfer protocol). While the VCCI currently receives electronic data from 5 partner hospitals, the goal is to have electronic census data from all hospitals in FFY 2015. While some hospitals have not supported these strategies in the past, the advent of Medicaid ACOs may help facilitate new relationships based on common goals and financial incentives. The VCCI has requested that its ACO partners facilitate this with member hospitals.

The VCCI had expanded the embedded staffing model with licensed staff in high volume Medicaid primary care sites and hospitals that experience high rates of ambulatory care sensitive (ACS) ED visits and inpatient admissions/readmissions. The VCCI supplemented its embedded model with a nurse 'liaison role' 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 ACS ED utilization and 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/high cost members. These efforts have facilitated more robust communication, referral and support of mutual goals of the VCCI with practices and Medicaid ACO partners.

The VCCI believes that the embedded approach offers several advantages and that the liaison role will garner similar benefits.

1. The embedded approach fosters strong provider relationships and direct referral for high-risk populations.
2. It encourages 'real time' case findings at the point-of-service within primary care physician (PCP) and hospital sites to assist in reducing hospital readmission rates in high-risk populations.
3. The embedded staffing model also provides an opportunity for enhanced coordination and care transitions with hospital partners and primary care sites, as well as with home health agencies that may be delivering skilled nursing care post-discharge.

This enhanced service coordination is a goal of the VHCIP Care Management and Care Models (CMCM) workgroup, which has launched an integrated care management learning collaborative in 3 pilot locations—Rutland, Burlington and St. Johnsbury—in which the VCCI participates along with other community service providers. The pilot was launched in the last quarter and is expected to run for one year. New communities will be brought on in a progressive fashion, concurrent with the pilot under way.

Due to their Medicaid knowledge and case management experience, VCCI nurse case managers have been hired by partners of the VCCI, and at a higher pay scale than provided by the State. DVHA and AHS are currently assessing a market factor adjustment for nursing positions to support both recruitment and retention. This is targeted for completion prior to QE0615 and would be implemented in QE0915, pending budget approval.

High Risk Pregnancy Care Management (MOMS program)
The VCCI launched its initial pilot program for pregnancy case management services in October 2013. While strides were made, the clinical team recommended that 2 registered nurses (RNs) were not indicated as a centralized resource, and a better model to support clinical and quality goals could be achieved via one nurse case management expert functioning as a liaison with other state and community partners and as an expert consultant to the VCCI field staff receiving referrals for at risk pregnant women. Subsequently, one high risk pregnancy position was converted into a field-based nurse case manager. Since this change, the initiative has been able to move forward at an accelerated rate, including changing the name to Medicaid Obstetrical and Maternal Supports (MOMS); developing a curriculum for VCCI and community partner staff; developing logos, brochures and action plans for each trimester; and performing early outreach to multiple AHS sister departments, community service providers, hospitals, high risk obstetric clinics, substance use/abuse treatment providers and other stakeholder groups. The focus of the MOMS program is supported by data on Medicaid members with mental health and substance use/abuse and those at risk for premature delivery.

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

In 2011, the VCCI implemented a combination of individual- and population-based strategies for disease management, with a primary focus on the super-utilizers. That same year, DVHA's contract with APS Healthcare was 100% risk-based with a guaranteed 2:1 return on investment (ROI). In SFY 2014 the VCCI delivered a net ROI of $30.5 million over anticipated cost for those members in the top 5%. This represents a consistent improvement each year, with a savings of $25.5 million in SFY 2013 and $11.5 million in SFY 2012.

To assure continuity of the VCCI business operations during the Medicaid Management Information Systems (MMIS)/Care Management (CM) procurement and on-boarding process, DVHA has further extended its contract with APS Healthcare through December 31, 2015. This will help facilitate the transition to the new enterprise level CM vendor once that contract is approved by CMS and fully executed. The VCCI is working proactively with APS Healthcare to facilitate a smooth transition of

the historic data to the new vendor in a timely fashion and format that supports data consumption by the new system. A formal transition plan and related discussions have been ongoing between APS and DVHA staff throughout the last quarter.

One Provider Health Registry (PHR) was developed and released this quarter, and a subsequent PHR on Heart Failure is scheduled for dissemination in early May.

Activities supported by APS this quarter include:

- Collaboration on the data transition plan required to support data migration to the new CM vendor and prevent interruption of VCCI services to Medicaid members.
- Outreach and program education by the VCCI pharmacist to high volume Medicaid pharmacies serving the VCCI population
- Conducted a member mailing on the benefits of physical activity and exercise on health.
- Average VCCI caseload (DVHA/APS): 586; unique members: 611, over 25% of VCCI's annual goal of 2000 members.

iii. Blueprint for Health

Key updates from QE0315:

- The Blueprint for Health and Vermont's three ACOs have developed a joint plan to combine quality improvement and coordination of care efforts at the local level in a Unified Community Collaborative.
- The Chittenden Center Hub program became formally recognized by the National Committee for Quality Assurance as a Patient-Centered Specialty Practice program.
- A series of four webinars for the entire Hub and Spoke provider network was completed.
- The Administration's proposed 2016 budget includes an increase to the Medicaid payments for community health teams and patient-centered medical homes.

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

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

[1] 18 VSA Chapter 13.

Current Operations:
As of March 31, 2015, there are 129 primary care practices operating in Vermont as patient centered medical homes (PCMHs) supported by multi-disciplinary community health teams (CHTs). In this program, each practice is scored against the National Committee for Quality Assurance (NCQA) PCMH recognition program standards for high quality patient centered care.

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

Medical homes and CHT staff are intended to strengthen network interactions with a larger array of medical and non-medical providers in their community and to help people link more seamlessly with the services they need. The implementation and expansion of the model has been supported with a locally organized transformation infrastructure including program managers, CHT leaders, practice facilitators, multi-stakeholder workgroups, and shared learning forums.

Key design principles of the model include: local leadership and organization; consistent statewide quality standards (NCQA PCMH) and measurement of performance against those standards; close coordination between primary care, CHT staff, and community based services; and an emphasis on prevention, improved control of established health problems, and healthier lifestyles.
The Blueprint for Health and Vermont's three Accountable Care Organizations—OneCare Vermont, Community Health Accountable Care, and Healthfirst—have developed a proposal for delivery system reforms to combine quality improvement and coordination of care efforts at the local level in a Unified Community Collaborative. Currently an array of meetings focused on quality and coordination are taking place in communities across Vermont. Most areas have Blueprint integrated health services workgroups as well as workgroups for participants in the provider network shared savings programs (ACOs). The Blueprint meetings are oriented towards coordination of community health team operations and services across providers in the community while the ACO meetings are oriented towards attaining the goals of the participating provider network. The same providers may be participating in mutlitple meetings with overlapping but distinct work on coordination of services and quality. The joint plan to coalesce quality and coordination activities is described in the document 'Proposal for Delivery Reforms: Integrating Vermont ACO and Blueprint Activities and Phase II Payment Reforms – March 22, 2015'. This plan has been presented to the Legislature and is forming the basis of ongoing work in the communities. The plan also proposes the next phase of payment reforms for primary care and community health team operations. The proposed payment reforms include increasing the base payment for medical home and community health team operations, and also include a pay for performance component based on reduced total utilization and improved health services area outcomes. The three ACOs and the Blueprint are agreeing on four key HEDIS measures to drive the pay for performance component.

Hub and Spoke Initiative:

As part of the Blueprint, the Hub and Spoke Initiative creates a framework for integrating treatment services for opioid addiction. This Initiative represents AHS and DVHA's efforts—referred to as the Alliance for Opioid Addiction—to collaborate with community providers to create a coordinated, systemic response to the complex issues of opioid addiction in Vermont. The Hub and Spoke Initiative is focused on beneficiaries receiving Medication-Assisted Treatment (MAT) for opioid addiction. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders. The two primary medications used to treat opioid dependence are methadone and buprenorphine. Buprenorphine is typically prescribed by specially licensed physicians in a medical office setting, and methadone is

provided only in specialty opioid treatment programs. Both of these treatment regimens are associated with substantial service fragmentation as providers are not well integrated into the larger health care and mental health care systems.

As part of the Initiative, five regional Hubs were established, which were built upon the existing methadone opioid treatment programs. These Hubs serve as the regional consultants and subject matter experts on opioid dependence and treatment. Hubs are replacing episodic care based exclusively on addiction illness with comprehensive health care and continuity of services. Hubs also provide buprenorphine treatment to a subset of clinically complex patients (Table 2). The programmatic enhancement of allowing Hubs to also dispense buprenorphine continues to be important with about 30% of the caseload (833 individuals) receiving dispensed buprenorphine as of March 26, 2015.

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

The program has established statewide operations, and caseloads continue to expand. This Health Home initiative now serves 4,931 Medicaid beneficiaries in Hub and Spoke programs combined as of March 31, 2015. The following tables present the caseloads of regional Hub and Spoke staffing as of March 2015. Spoke staffing is scaled at 1 registered nurse and 1 licensed clinician for every 100 patients receiving MAT.

Table 2. Hub Caseload: March 26, 2015

Region (Counties in Vermont)	Start Date (Month/Year)	Total Number of Clients (Buprenorphine and Methadone)	Number of Clients Receiving Buprenorphine	Number of Clients Receiving Methadone
Chittenden, Franklin, Grand Isle & Addison	1/2013	912	264	648
Washington, Lamoille, Orange	7/2013	334	148	186
Windsor, Windham	7/2013	543	139	404
Rutland, Bennington	11/2013	426	164	262
Essex, Orleans, Caledonia	1/2014	491	118	373
Total		**2706**	**833**	**1873**

Table 3. Spoke Beneficiaries, Providers, & Staffing: March 31, 2015

Region	Providers Serving 10 or more Medicaid Beneficiaries	Staff FTE Funding	Staff FTE Hired	Medicaid Beneficiaries
Bennington	8	4.5	2.4	229
St. Albans	6	7.0	4.9	376
Rutland	5	5.0	3.4	245
Chittenden	14	8.0	7.5	400
Brattleboro	6	4.0	3.5	176
Springfield	1	1.5	1.5	52
Windsor	3	2.5	2.0	121
Randolph	3	2.0	1.4	95
Barre	8	5.5	5.5	254
Lamoille	3	3.0	3.6	137
Newport & St Johnsbury	3	2.0	2.0	86
Addison	2	1.5*	1.5	49
Upper Valley	1	0	.5	7
Total	**62**	**47**	**39**	**2,132**

*staffing enhanced for planned program expansion

Improving the quality of care provided to this population and disseminating best practices among the prescribing practices remains a key focus of this program. The ongoing series of Learning Collaboratives for Spoke practices continues this quarter. Twenty-seven practices are sending teams to the in-person events, are reporting on common measures and sharing quality improvement initiatives. Additionally, a series of four webinars for the entire Hub and Spoke provider network was completed. The Spoke staff and practices are actively using a web-based platform (Basecamp) to share information, post documents, and develop discussions on topics of interest to the community.

The Chittenden Center Hub program became formally recognized by the National Committee for Quality Assurance as a Patient-Centered Specialty Practice program. This addictions treatment program is one of the first in the nation to be recognized under these specialty standards.

iv. Behavioral Health

Key updates from QE0315:

- Met with substance abuse residential facilities in anticipation of utilization review duties transferring from VDH to DVHA.
- Implemented the McKesson InterQual ® Care Enhance Review Manager behavioral health clinical criteria product.

The DVHA Behavioral Health Team offers a comprehensive approach for behavioral health care coordination. The Team is responsible for concurrent review and authorization of inpatient psychiatric

and detox services for Medicaid primary beneficiaries. The Team works closely with staff at the inpatient facilities to ensure timely and appropriate discharge plans. It also manages the Team Care Program (lock-in) for Medicaid beneficiaries. A dedicated phone line for Team Care beneficiaries became available as of January 2, 2015.

During this quarter, the Autism Specialist, in collaboration with Agency partners, began developing the proposed benefit design for applied behavioral analysis (ABA) services. Staff researched and designed a benefit based on best practices and is comparable to benefit designs of third party insurers. Work continued on the development of outcome measures for these services, developing a provider manual, researching best practices in anticipation of the development of a clinical practice guideline for ABA services, and creating ABA tools within an electronic record-keeping system. Staff continued to work with the AHS Medicaid Policy Unit on the upcoming State Plan Amendment submission and began working with DVHA Quality and AHS staff to develop a scorecard in anticipation of the start of the ABA benefit.

The Behavioral Health staff continues to collaborate with DMH in performing concurrent review and authorization for all inpatient psychiatric and detoxification services. During this quarter staff began an enhanced collaboration with the Vermont Chronic Care Initiative. The Team and the VCCI worked to develop a method by which the utilization review staff are able to alert the VCCI staff when beneficiaries with whom the VCCI is working, or who could benefit from VCCI services, are admitted to inpatient psychiatric floors. The utilization review team also shared admission data with the VCCI data analyst to mine for beneficiaries who are appropriate for VCCI services.

The Behavioral Health Team was trained and transitioned to using the Care Enhance Review Manager solution as the platform for the behavioral health clinical criteria products. This solution and the clinical criteria products were again offered to sister Department staff that perform utilization review duties. The DMH Children and Families Unit (CAFU) reached out to DVHA, and as a result the DVHA Behavioral Health Team has assumed the responsibility for authorizing residential treatment for Eating Disorders for children and adolescents. The DVHA and CAFU staff will continue to work closely regarding the needs of these beneficiaries.

Additionally, the Team has worked this quarter collaboratively with VDH's Alcohol and Drug Abuse Program (ADAP) to transition the utilization review responsibilities for substance abuse residential programs from ADAP to DVHA. DVHA staff traveled to each of the residential facilities in February 2015 to discuss the change, and DVHA began authorizing these services starting with admissions on April 1, 2015.

The Behavioral Health Team, in collaboration with the Clinical Operations Unit and the Quality Team were trained this quarter to perform medical record reviews and for three hybrid HEDIS measures chosen by DVHA. Training occurred early in March 2015, and the Team began reviewing records at the end of that same month.

v. Pharmacy and 340B Drug Discount Program

Key updates from QE1214:

- Vermont has realized $139,835.99 net cost savings for this reporting period through Medicaid participation of a relatively small number of eligible covered entities.
- UMass Medical Center now participates in the 340B program as well as Medicaid's 340B initiative.

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

Only federally designated covered entities are eligible to purchase at 340B pricing, and only patients of record of those covered entities may have prescriptions filled by a 340B pharmacy.

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

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

DVHA expanded its 340B program to encourage enrollment of both existing and newly eligible entities within Vermont and to encourage covered entities to include Medicaid in their 340B programs. In 2012, the DVHA received federal approval for a Medicaid pricing 340B methodology. To encourage participation in the Vermont Medicaid 340B program, providers receive an incentive payment (described below). The methodology for the 340B incentive payment is the lesser of 10% of the total Medicaid savings or $3 per claim for non-compound drugs and $30 per claim for compound drugs. Claims are paid at the regular rates, and a monthly true-up process calculates the 340B acquisition cost, dispensing fees, savings, and what is owed back to the State with payments due 30 days after the invoices are mailed.

DVHA continues to encourage Medicaid enrollment with the goal of enrolling all eligible and HRSA-enrolled covered entities in Vermont.

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

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

340B Reimbursement and Calculation of Incentive Payment:
DVHA identified the following goals in establishing its proposed 340B reimbursement methodology:

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

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

Because of federal laws prohibiting "duplicate discounts" on Medicaid drug pricing related to the

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

For the reporting period, Vermont has realized $139,835.99 net cost savings through Medicaid participation of a relatively small number of eligible covered entities.

v. Mental Health System of Care

Key updates from QE0315:

- The Vermont Psychiatric Care Hospital is operating at full capacity of 25 beds.
- Soteria-Vermont has completed renovations and hosted an open house.

The Department of Mental Health (DMH) is continuing its Post-Irene work to build capacity within the inpatient and outpatient systems; expand quality and evaluation activities; and improve transitions of care. During this quarter, fourteen Level I beds at the Brattleboro Retreat and seven Level I beds at Rutland Regional Medical Center were fully operational, and, for the first time, the Vermont Psychiatric Care Hospital (VPCH) operated at full capacity of 25 beds. Soteria-Vermont (see below) completed its building renovations and hosted an open house, and the program expects to receive final licensing and begin accepting admissions in early April. With the completion of this final milestone, all of the psychiatric beds conceptualized and funded[2] through Act 79 of 2012 will be operational.

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

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

Chart 1: Psychiatric Beds in the System of Care

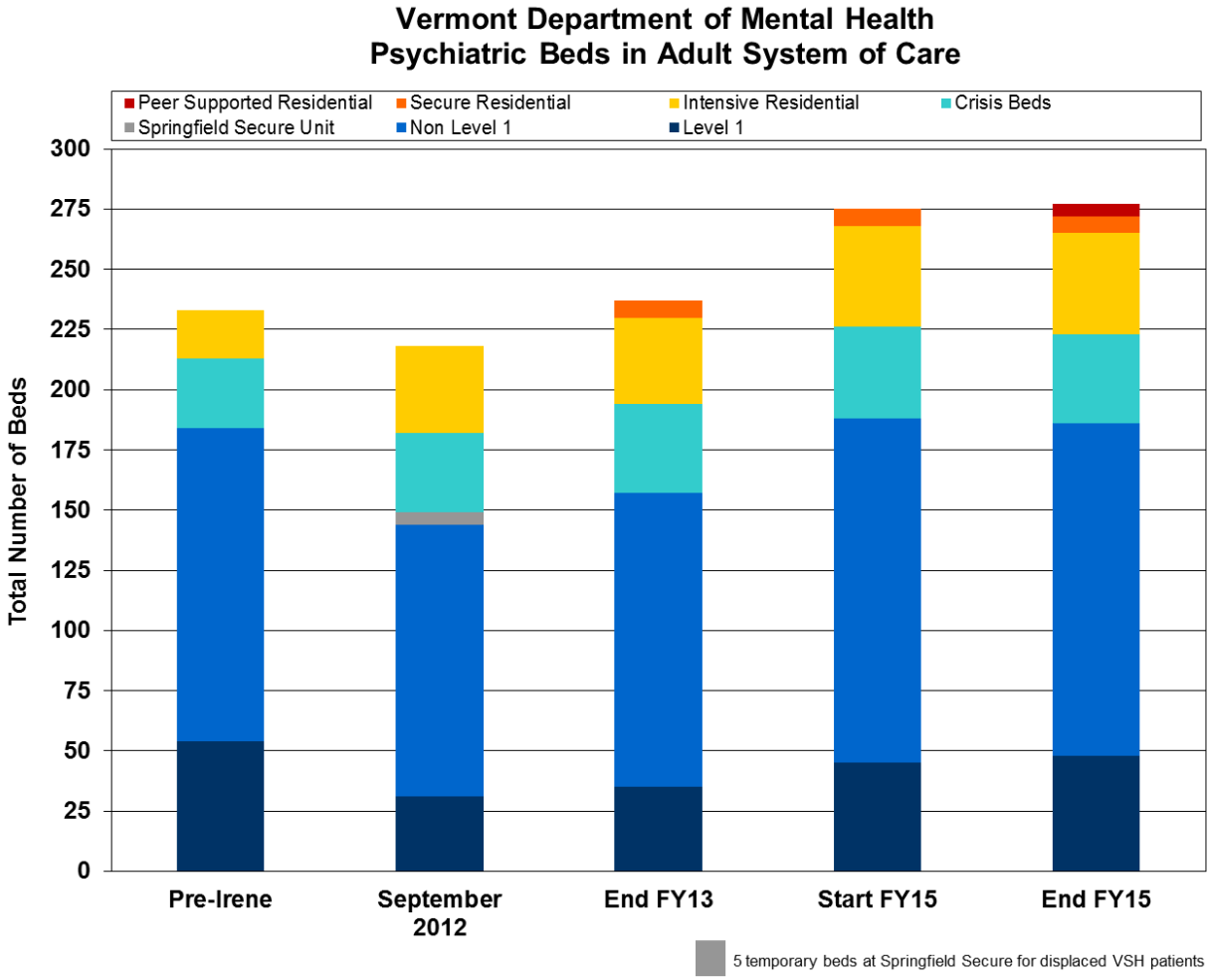

Chart 1 shows the changes in available psychiatric placements since August 2011. The total number of inpatient beds in the system at the start of SFY 2015 was 275. These include inpatient psychiatric treatment beds, residential treatment programs, crisis beds and peer-supported placements for transition.

Soteria-Vermont will be the last of the facilities conceptualized in Act 79 (and funded by the legislature) to open. The building has been renovated to accommodate a five-bed residence located in Burlington's Old North End. Soteria will offer a supportive environment for individuals going through an early experience of psychosis; will practice a cautious and limited use of psychoactive medications; and will provide a safe, flexible, empowering, home-like environment. During this quarter, Soteria-Vermont finalized its obligations for policies and procedures, accessible design, staffing, licensing, and received a Certificate of Occupancy from the City of Burlington. The program expects to be licensed by the Division of Licensing and Protection by early April. The core staff for the program have been hired and provided with extensive training and orientation with the expectation that the program will begin accepting admissions in the first week of April. Soteria has also completed purchasing of furniture and household goods, office equipment and a house vehicle. An open house was held at the end of this quarter in anticipation of the opening of the program.

At this time, demand for inpatient care still exceeds current capacity with some frequency. This is disruptive to the emergency care setting and not a standard that the Department regards as adequate for

individuals requiring inpatient care. To address this ongoing issue, DMH is continuing to monitor the functioning of the clinical resource management system to "coordinate the movement of individuals to appropriate services throughout the continuum of care and to perform ongoing evaluations and improvements of the mental health system," as written in Act 79. This system encompasses the following functions:

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

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

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

Integrated Family Services (IFS) Initiative:

AHS continues to act on opportunities to improve quality and access to care, within existing budgets, using managed care flexibilities and payment reforms available under 42 CFR 438 and the GC waiver. This includes such items as: integration of administrative structures for programs serving the same or similar populations; opportunities to increase access to services by decreasing administrative burdens on providers; reviewing pre-GC waiver operations to determine if separate administrative and Medicaid reimbursement structures can be streamlined under the waiver. Several such projects have emerged in the Children's and EPSDT 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 early periodic screening diagnostic and treatment (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 all AHS children, youth and family services together in an integrated and consistent continuum for families. The premise being that giving families early support, education and intervention will produce more favorable health outcomes at a lower cost than the current practice of 'waiting until circumstances are bad enough' to access funding which often 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.

Annual Aggregate Budgets and PMPM for Medicaid Children's Mental Health and Family Support Services:
The initial IFS implementation site in Addison County is in its fourth state fiscal year, and the second pilot region in Franklin and Grand Isle counties just celebrated its one year anniversary, having commenced on April 1, 2014. The initial pilot included consolidation of over 30 state and federal funding streams into one unified whole through one master grant agreement; the second pilot also includes consolidation of several state and federal funding streams. The State has created an annual aggregate spending cap for two providers in Addison and one in Franklin/Grand Isle (this provider houses the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children and families.

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, at the same time as the balance of the State has experienced a near doubling of that number.
- Increased ability to provide the right services to children and their families more immediately.
- Increased ability to provide services in a child's natural setting.
- Increased ability to work with a variety of providers and bring resources together to support families.
- Reduction in separate and conflicting paperwork having a positive impact on the number of hours clinicians can spend on direct services.
- A more immediate response to families who ask for help who, prior to this pilot, were 'not sick enough' to meet funding criteria.
- Unified local efforts to offer a single onsite response to families combining multiple state and

federal programs that would otherwise be offered at differing times and places.
- Initial numbers indicate an ability to serve more children and families with the same amount of resources.

The financial model supporting this agreement includes a monthly PMPM rate established for the reimbursement of all Medicaid-covered sub-specialty services. Member month rates are based on agreed upon annual allocations for covered services divided by the minimum Medicaid caseload expectation. The same member month rates will be paid for minimal service packages as for intensive service packages. The goal of the funding model is to ensure that beneficiaries get a package of early periodic screening diagnostic and treatment and outreach services commensurate with their functional needs within an overall annual aggregate reimbursement cap. PMPM and 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.

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

VI. Financial/Budget Neutrality Development/Issues

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

In March 2015, AHS entered into a contract extension with the actuarial firm, Milliman, in order to receive certified PMPM rates for FFY 2016. AHS will begin to transfer enrollment and claims data to Milliman in QE0615.

The GC and Choices for Care 1115 Waivers were officially combined on January 30, 2015. For ease of reporting, CMS agreed that CMS-64 quarterly reporting could begin effective January 1, 2015. Per the STCs, AHS reported actual expenses according to the revised Demonstration Populations. In addition, AHS continued to report Choices for Care by appropriate service category lines within the ABD and Moderate Needs populations.

The State's eligibility system has faced some difficulty with accurate beneficiary coding post-ACA implementation; AHS and DVHA are currently working through issues with the Eligibility Services unit to ensure enrollees are bucketed in the proper Medicaid Eligibility Groups (MEGs). The State is working to institute a permanent automated solution.

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 4. Number of Recipients, by Month

Demonstration Population	1/31/2015	2/28/2015	3/31/2015	Total for Quarter Ending 3/31/2015
Demonstration Population 1	36,638	36,744	36,732	110,114
Demonstration Population 2	79,924	80,564	81,010	241,498
Demonstration Population 3	53,723	55,375	56,047	165,145
Demonstration Population 4	3,015	2,971	2,905	8,891
Demonstration Population 5	893	876	877	2,646
Demonstration Population 6	879	913	918	2,710
Demonstration Population 7	7,578	7,570	7,608	22,756
Demonstration Population 8	4,332	4,306	4,344	12,982

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 ask for additional information on complaints that may appear to need follow-up to ensure that the issue is addressed.

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

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

IX. Quality Improvement

Key updates from QE0315:

- Utilizing resources from the Adult Medicaid Quality (AMQ) Grant, DVHA continued to develop staff capacity to produce performance measure data for monitoring and improving access and the quality of care in Medicaid.
- Performance Improvement Projects under the AMQ grant entered into a second cycle: Year 2 interventions were launched for the Breast Cancer Screening Performance Improvement Project in January 2015. Planning began for a second round of interventions (to be launched in spring/summer 2015) for the Initiation and Engagement of Alcohol and Other Drug Treatment Performance Improvement Project.
- Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) contract and survey materials were finalized.

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 in QE0315. During this period, the Committee reviewed CY 2014 summary reports for DVHA's grievances and appeals, the Agency of Human Service's confidentiality breaches and DVHA's Experience of Care survey results. The Committee produced process improvement recommendations for these activities and continued to discuss standard frameworks that will allow for easier data presentation and analysis by all members of this cross-departmental work group.

The AHS Performance Accountability Committee (PAC) also met monthly during the quarter. A majority of the time was spent developing a draft Global Commitment to Health (GC) waiver driver diagram and a Comprehensive Quality Strategy (CQS) outline and timeline. The GC driver diagram is a tool used to display the components of Vermont's improvement efforts in its Medicaid Program (via the waiver), as well as, to communicate the waiver's theory of change. The driver diagram displays the goals of the waiver, identifies their drivers, shows how the drivers are connected, and ultimately provides the basis for how Vermont will measure its performance relative to the goals. The Vermont CQS Outline serves as a blueprint or road map for Vermont and its public MCE in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. During the next quarter, both documents will be shared with internal and external stakeholders before being sent to CMS for review.

MCE Investment Review:
As part of an agency-wide process improvement project, a joint AHS-DVHA work group was tasked with an in-depth analysis of the current Global Commitment investment expenditures. Moving beyond measuring and reporting data—to managing performance toward improving results—is an AHS-wide priority and was one of the drivers to initiate this review. This work group set review criteria, created a tracking spreadsheet, and conducted a prioritized first set of investment reviews during QE1214. During the current reporting period, a summary of Phase I findings was produced and distributed by

the AHS Quality Improvement Manager and Phase II of the investment reviews began. Key recommendations from Phase I of the review included the following: enhance investment objectives by incorporating SMART criteria, continue to review performance measure data, continue to prioritize data collection and the development of a quality management system for measuring, monitoring, and improving the activities funded by investment dollars. The work group will continue to review those investments not covered during Phase I during the next two quarters.

Healthcare Effectiveness Data and Information Set (HEDIS) Hybrid Medical Record Review:
DVHA staff continues to develop the capacity to complete an internal HEDIS hybrid medical record review (MRR). A core committee worked closely with vendors Verisk and HSAG to develop internal policies and procedures for the MRR. DVHA has contracted with Verisk to do the record retrieval and will DVHA will complete the record abstraction using Verisk software. Abstractors were trained in early March 2015 and began the MRR in mid-March. The MRR will run for 16 weeks; the target end date is June 30, 2015. The hybrid HEDIS measures will be validated by HSAG in July 2015.

Formal (Validated) Performance Improvement Project:
DVHA continues to lead an AHS-wide Performance Improvement Project (PIP) on Follow-up After Hospitalization (FUH) for Mental Illness, the study indicator for which is the HEDIS measure of the same name (FUH HEDIS). During this quarter, follow-up appointment scheduling reports were again prepared and distributed to the designated hospitals and will continue to be distributed on a quarterly basis. Members of the FUH implementation team also attended the designated hospital in-person meeting in January 2015. The hospitals spoke of changes they had made to their systems based on the appointment scheduling data reports and their knowledge of this project. Barriers to follow-up appointment scheduling were also discussed. Preliminary calendar year 2014 FUH measure results were also shared with the implementation team by the DVHA Data Unit during this time period. Due to lack of movement in the overall FUH measure rates and feedback from our designated hospital partners, the FUH PIP implementation team revisited our root cause analysis diagram and began discussing an additional intervention for Year 2 of the project.

Adult Medicaid Quality (AMQ) Grant Performance Improvement Projects:

- Breast Cancer Screening (BCS) PIP:
  The goal of this project is to increase the overall HEDIS rate of female Medicaid beneficiaries ages 50-74 receiving a mammogram. The BCS interventions involve a two-prong approach aimed at both providers (gap in care lists) and beneficiaries (educational materials and grocery store gift card incentive). The DVHA Quality Unit requested and received a no-cost extension for the AMQ Grant. Therefore, the BCS PIP team extended the project for a second year. Year 2 interventions were implemented and will run on the same schedule as Year 1.

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) PIP:
  The goal of this project is to increase the statewide IET HEDIS 18+ initiation and engagement rates. Currently, Vermont Medicaid encourages PCPs to refer beneficiaries with a diagnosis of alcohol abuse or dependence to the preferred provider network (organizations funded through and overseen by ADAP).This project expanded the substance abuse provider network in Addison, Bennington and Rutland Counties to include clinicians who are Licensed Alcohol and Drug Counselors (LADCs) and licensed mental health clinicians.

  The IET project's interventions also involve a two-prong approach in those three counties aimed at primary care providers (provide them with an expanded list of substance abuse

clinicians in their area) and substance abuse clinicians (enroll in a pay for performance reimbursement model). The AMQ grant no-cost extension allowed the IET PIP team in QE0315 to begin planning for a second round of project interventions.

Consumer Assessment of Healthcare Providers and Systems Survey:
The DVHA Quality Unit finalized the contracting process for the continuation of the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. DVHA is working with WBA Research, Inc., a NCQA-certified vendor, in CY 2015 and focusing the CAHPS survey efforts on children. The Children's Chronic Conditions (CCC) supplemental question set was added to the survey for the first time during this reporting period. Surveys will be fielded in May, with a final summary report due from WBA Research to DVHA in August 2015. Additionally, DVHA is participating in a national experience of care survey effort for the adult Medicaid population. This is being coordinated by the National Opinion Research Center at the University of Chicago.

Quality Measure Set Reporting:
The Quality Unit continues to work with representatives from within DVHA, as well as outside of DVHA with partner AHS Departments, to coordinate quality measure core set reporting. DVHA continues to increase the number of measures reported for CMS' Adult and Children's Core Quality Measure sets—both measure sets were reported out on in a timely manner by DHVA in December 2014 and January 2015. The QI Administrator also participates on the Health Home Measure work group and the Vermont Health Care Innovation Project (VHCIP) Quality and Performance Measures work group.

AHS Quality Improvement Manager:
During this quarter, the AHS Quality Improvement Manager (QIM) worked with the External Quality Review Organization (EQRO) to develop documents for each of the required annual external quality review activities. In addition to developing letters, tools, and reference documents, timelines were developed for each activity. All timelines included the following elements: start date, completion date, task, and responsible party. Key tasks of the Performance Improvement Validation timeline include the following: feedback and comments on PIP documents, review and revise the PIP validation tool, provide feedback on the draft report, and review the final report. Key tasks of the Performance Measure Validation timeline include the following: identify measures for validation, review and provide feedback on documentation request letter and attachments, develop schedule of on-site visit, and review and provide feedback on draft performance measure validation report. Key tasks of the Compliance Review timeline include the following: finalize the scope of the review, review supporting documents and the data collection tool, plan on-site visit, and review the draft report. The MCE is scheduled to receive all review documents during the next quarter. Finally, during this quarter, the AHS QIM worked with the EQRO to produce a final version of the EQRO Annual Technical Report. This report was reviewed by the AHS PAC. Findings and recommendations contained in the report were used by the group to re-evaluate the Comprehensive Quality Strategy (CQS).

X. Compliance

Key updates from QE0315:

- DVHA is preparing for its next EQRO cycle.
- The Compliance Committee membership and purpose have been updated.
- IGA monitoring plan updates are being drafted.

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.

EQRO Preparation:
DVHA recently received the new review tool and document requests for this year's EQRO audit. DVHA is preparing the required documents and responses. The onsite review is scheduled for July 15, 2015.

The audit will focus on the following standards:

I. Practice Guidelines
II. Quality Assessment and Performance Improvement (QAPI) Program
III. Health Information Systems

Compliance Committee Updates:
DVHA and AHS are working collaboratively to streamline and coordinate the way compliance issues are addressed across the Agency. To that end, DVHA, AHS and partnering departments have expanded the purpose of the Managed Care Compliance Committee to include compliance issues that exist outside the managed care world. The Compliance Committee contributes to improving the delivery of services, consumer outcomes, and the overall health and well-being of those served by AHS. The group will address Agency-wide & MCE-specific adherence to program integrity and Global Commitment to Health (GC) Medicaid waiver regulatory guidelines. The recommendations made by this group will directly impact the MCE Compliance Plan. The following shall be the responsibilities and common recurring activities of the Compliance Committee in carrying out its purpose:

- Identify best practices and tools for conducting Program Integrity & Regulatory Compliance audits.
- Establish, maintain, and further develop the GC Compliance Plan.

These activities are set forth as a guide with the understanding that the group may diverge from this list as appropriate given the circumstances. This updated focus will allow the team to more thoroughly explore and address compliance needs across the Agency, which will provide for a stronger managed care system.

IGA Monitoring Plans:
DVHA and its IGA partners are developing new IGA monitoring tools designed to better track the progress made toward improvements in compliance with managed care requirements.

XI. Demonstration Evaluation

During this quarter, the consolidation of Vermont's 1115 Medicaid waivers became official. As a result, the QIM spent time identifying key evaluation elements from the previous Choices for Care 1115 waiver and modifying them to fit the current Global Commitment to Health waiver. The AHS QIM will continue to work with staff at the Pacific Health Policy Group (PHPG) to modify the plan as needed. Also during this quarter, the AHS QIM continued to meet with members of Vermont's SIM

grant to develop its evaluation plan. While Medicaid is only one of the participating payers, it was thought that there might be some efficiencies realized by leveraging the GC waiver evaluation efforts with those of the SIM grant.

XII. Reported Purposes for Capitated Revenue Expenditures

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

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

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

XIII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook

Attachment 2: Enrollment and Expenditures Report

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of the Health Care Advocate Report

Attachment 6: State Fiscal Year 2014 Managed Care Entity Investments

XIV. State Contact(s)

Fiscal:	Sarah Clark, CFO	
	VT Agency of Human Services	802-871-3005 (P)
	208 Hurricane Lane	802-871-3001 (F)
	Williston, VT 05495	sarah.clark@state.vt.us
Policy/Program:	Selina Hickman, Director of Medicaid Policy	
	VT Agency of Human Services	802-585-9934 (P)
	208 Hurricane Lane	802-871-3001 (F)
	Williston, VT 05495	selina.hickman@state.vt.us
Managed Care Entity:	Steven M. Costantino, Commissioner	
	Department of VT Health Access	802-879-5901 (P)
	312 Hurricane Lane, Suite 201	802-879-5952 (F)
	Williston, VT 05495	steven.costantino@state.vt.us

Date Submitted to CMS: May 29, 2015

ATTACHMENTS

Attachment 1

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY**9a**	PQA: WY**9b**	PQA: WY10	PQA: WY11	Net Program PQA	Net Program Expenditures as reported on 64	Excess New Adult Expenditures as reported on 64 per STC 55e	non-MCO Admin Expenses	Total columns J:K for Budget Neutrality calculation - **Includes** New Adult	Cumulative Waiver Cap - **Excluding** New Adult per 10/2/13 STCs	Variance to Cap under/(over)
1205	$ 178,493,793														$ 178,493,793					
0306	$ 189,414,365	$ 14,472,838												$ 14,472,838	$ 203,887,203					
0606	$ 209,647,618	$ (14,172,165)												$ (14,172,165)	$ 195,475,453					
0906	$ 194,437,742	$ 133,350												$ 133,350	$ 194,571,092					
WY1 SUM	$ 771,993,518	$ 434,023												$ 434,023	**$ 782,159,845**		**$ 4,620,302**	**$ 786,780,147**	**$ 841,266,663**	**$ 54,486,516**
1206	$ 203,444,640	$ 8,903												$ 8,903	$ 203,453,543					
0307	$ 203,804,330	$ 8,894,097												$ 8,894,097	$ 212,698,427					
0607	$ 186,458,403	$ 814,587	$ (68,408)											$ 746,179	$ 187,204,582					
0907	$ 225,219,267	$ -	$ -											$ -	$ 225,219,267					
WY2 SUM	$ 818,926,640	$ 9,717,587	$ (68,408)											$ 9,649,179	**$ 802,884,359**		**$ 6,464,439**	$ 809,348,797		
Cumulative																		**$ 1,596,128,945**	**$ 1,684,861,317**	**$ 88,732,372**
1207	$ 213,871,059	$ -	$ 1,010,348											$ 1,010,348	$ 214,881,406					
0308	$ 162,921,830	$ -	$ -											$ -	$ 162,921,830					
0608	$ 196,466,768	$ 14,717	$ -	$ 40,276,433										$ 40,291,150	$ 236,757,918					
0908	$ 228,593,470	$ -	$ -	$ -										$ -	$ 228,593,470					
WY3 SUM	$ 801,853,126	$ 14,717	$ 1,010,348	$ 40,276,433										$ 41,301,498	**$ 881,729,256**		**$ 6,457,896**	$ 888,187,152		
Cumulative																		**$ 2,484,316,097**	**$ 2,604,109,308**	**$ 119,793,211**
1208	$ 228,768,784		$ -	$ -										$ -	$ 228,768,784					
0309	$ 225,691,930		$ (16,984,221)	$ 38,998,635	$ (4,144,041)									$ 17,870,373	$ 243,562,303					
0609	$ 204,169,638		$ -	$ 686,851	$ 5,522,763									$ 6,209,614	$ 210,379,252					
0909	$ 235,585,153		$ -	$ 30,199	$ 34,064,109									$ 34,094,308	$ 269,679,461					
WY4 SUM	$ 894,215,505	$ -	$ (16,984,221)	$ 39,715,685	$ 35,442,831									$ 58,174,295	**$ 935,368,819**		**$ 5,495,618**	$ 940,864,437		
Cumulative																		**$ 3,425,180,534**	**$ 3,606,430,571**	**$ 181,250,037**
1209	$ 241,939,196				$ 5,192,468									$ 5,192,468	$ 247,131,664					
0310	$ 246,257,198				$ 531,141	$ 4,400,166								$ 4,931,306	$ 251,188,504					
0610	$ 253,045,787				$ 248,301	$ 5,260,537								$ 5,508,838	$ 258,554,625					
0910	$ 252,294,668			$ (115,989)	$ (261,426)	$ 3,348,303								$ 2,970,888	$ 255,265,556					
WY5 SUM	$ 993,536,849	$ -	$ -	$ (115,989)	$ 5,710,484	$ 13,009,006								$ 18,603,501	**$ 1,012,990,839**		**$ 5,939,459**	$ 1,018,930,298		
Cumulative																		**$ 4,444,110,832**	**$ 4,700,022,174**	**$ 255,911,342**
1210	$ 262,106,988				$ -	$ 6,444,984								$ 6,444,984	$ 268,551,972					
0311	$ 257,140,611													$ -	$ 257,140,611					
0611	$ 277,708,043						$ (121,416)							$ (121,416)	$ 277,586,627					
0911	$ 243,508,248						$5,528,143							$ 5,528,143	$ 249,036,391					
WY6 SUM	$ 1,040,463,890	$ -	$ -	$ -	$ -	$ 6,444,984	$5,406,727							$ 11,851,711	**$ 1,045,342,616**		**$ 6,071,553**	$ 1,051,414,168		
Cumulative																		**$ 5,495,525,000**	**$ 5,865,213,737**	**$ 369,688,737**
1211	$ 253,147,037						$ (531,744)							$ (531,744)	$ 252,615,293					
0312	$ 267,978,672						$ 3,742	$ 49,079						$ 52,821	$ 268,031,493					
0612	$ 302,958,610							$ 6,393,928						$ 6,393,928	$ 309,352,538					
0912	$ 262,406,131							$ 7,750,994						$ 7,750,994	$ 270,157,125					
WY7 SUM	$ 1,086,490,450	$ -	$ -	$ -	$ -	$ -	$ (528,002)	$ 14,194,000						$ 13,665,998	**$ 1,134,526,550**		**$ 5,751,066**	$ 1,140,277,616		
Cumulative																		**$ 6,635,802,617**	**$ 7,113,290,903**	**$ 477,488,286**
1212	$ 282,701,072							$ 3,036,447						$ 3,036,447	$ 285,737,519					
0313	$ 285,985,057							$ 991,340						$ 991,340	$ 286,976,397					
0613	$ 336,946,361							29,814,314	$ (125,679)					$ 29,688,635	$ 366,634,996					
0913	$ 286,067,548								$ 2,162,772					$ 2,162,772	$ 288,230,320					
WY8 SUM	$ 1,191,700,038	$ -	$ -	$ -	$ -	$ -	$ -	$ 33,842,100	$ 2,037,093					$ 35,879,193	**$ 1,199,887,555**		**$ 6,260,794**	$ 1,206,148,349		
Cumulative																		**$ 7,841,950,966**	**$ 8,450,684,486**	**$ 608,733,520**
1213	$ 319,939,651								$ 3,652,767					$ 3,652,767	$ 323,592,418					
WY**9a** SUM	$ 319,939,651	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,652,767					$ 3,652,767	$ 319,921,780		**$ 1,214,631**	$ 321,136,411		
Cumulative																		**$ 8,163,087,376**	**$ 8,955,886,798**	**$ 792,799,422**
0314	$ 288,542,475								$ 2,159,834					$ 2,159,834	$ 290,702,309					
0614	$ 288,845,927													$ -	$ 288,845,927					
0914	$ 242,449,803								$ 337,823	$ (17,871)	$ 1,743,008			$ 2,062,960	$ 244,512,763					
1214	$ 286,853,166										$ 867,215			$ 867,215	$ 287,720,381					
WY**9b** SUM	$ 1,106,691,370	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,497,657	$ (17,871)	$ 2,610,223			$ 5,090,009	$ 1,109,301,593		**$ 5,086,126**	$ 1,114,387,719		
Cumulative																		**$ 9,277,475,096**	**$ 10,290,338,883**	**$ 1,012,863,787**
0315	$ 321,140,737													$ -	$ 321,140,737					
0615														$ -	$ -					
0915														$ -	$ -					
1215														$ -	$ -					
WY10 SUM	$ 321,140,737	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ 321,140,737		$ -	$ 321,140,737		
Cumulative																		**$ 9,598,615,833**	**$ 11,969,357,946**	**$ 2,370,742,113**
0316														$ -	$ -					
0616														$ -	$ -					
0916														$ -	$ -					
1216														$ -	$ -					
WY11 SUM	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -		
Cumulative																		**$ 9,598,615,833**	**$ 13,752,420,439**	**$ 4,153,804,606**
	$ 9,346,951,774	$ 10,166,327	$ (16,042,281)	$ 79,876,130	$ 41,153,315	$ 19,453,990	$4,878,725	$ 48,036,100	$ 8,187,517	$ (17,871)	$ 2,610,223	$ -	$ -		**$ 9,545,253,949**	$ -	$ 53,361,884			

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Glossary of Terms

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

VERMONT

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Caseload and Expenditure Report ~ All AHS Medicaid Spend
All AHS YTD '15
Thursday, April 30, 2015

	SFY '15 BAA			SFY '15 Actuals thru March 31, 2015			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	15,378	$ 193,276,892	$ 1,047.35	15,765	$ 136,123,431	$ 959.42	70.43%
ABD Dual	17,682	$ 201,843,736	$ 951.26	17,949	$ 155,177,615	$ 960.62	76.88%
General Adult	15,504	$ 97,628,847	$ 524.74	17,001	$ 72,522,780	$ 473.98	74.28%
New Adult	48,500	$ 209,264,433	$ 359.56	51,670	$ 176,486,682	$ 379.52	84.34%
Exchange Premium Assistance #	18,007	$ 7,974,888	$ 36.91	16,021	$ 4,273,039	$ 29.63	53.58%
Exchange Cost Sharing #	5,859	$ 1,372,578	$ 19.52	4,924	$ 772,776	$ 17.44	56.30%
ABD Child	3,713	$ 94,079,724	$ 2,111.29	3,678	$ 63,232,275	$ 1,910.17	67.21%
General Child	58,301	$ 240,111,188	$ 343.21	60,301	$ 191,489,902	$ 352.84	79.75%
Underinsured Child *	1,082	$ 2,731,816	$ 210.34	947	$ 4,307,282	$ 505.25	157.67%
SCHIP	4,273	$ 9,918,936	$ 193.43	4,432	$ 6,251,578	$ 156.73	63.03%
Pharmacy Only	12,684	$ 6,571,233	$ 43.17	12,079	$ 3,201,430	$ 29.45	48.72%
Choices for Care	4,177	$ 208,784,793	$ 4,165.02	4,172	$ 156,158,988	$ 4,159.25	74.79%
Total Medicaid Claims Paid	205,162	$ 1,273,559,065	$ 517.30	208,937	$ 969,484,507	$ 515.56	76.12%

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.

* Underinsured Child/SCHIP expenditure adjustment will be made in June quarter, to align with enrollment adjustment made in March quarter

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State of Vermont
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Agency of Human Services
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Caseload and Expenditure Report ~ DVHA Only Medicaid Spend

DVHA YTD '15

Thursday, April 30, 2015

	SFY '15 BAA			SFY '15 Actuals thru March 31, 2015			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	15,378	$ 111,329,467	$ 603.29	15,765	$ 76,104,719	$ 536.40	68.36%
ABD Dual	17,682	$ 49,095,602	$ 231.38	17,949	$ 38,696,903	$ 239.55	78.82%
General Adult	15,504	$ 87,534,771	$ 470.48	17,001	$ 65,076,067	$ 425.31	74.34%
New Adult	48,500	$ 191,135,130	$ 328.41	51,670	$ 159,912,397	$ 343.88	83.66%
Exchange Premium Assistance #	18,007	$ 7,974,888	$ 36.91	16,021	$ 4,273,039	$ 29.63	53.58%
Exchange Cost Sharing #	5,859	$ 1,372,578	$ 19.52	4,924	$ 772,776	$ 17.44	56.30%
ABD Child	3,713	$ 39,229,677	$ 880.37	3,678	$ 23,425,316	$ 707.65	59.71%
General Child	58,301	$ 133,584,397	$ 190.94	60,301	$ 105,328,708	$ 194.08	78.85%
Underinsured Child *	1,082	$ 1,274,160	$ 98.10	947	$ 2,868,582	$ 336.49	225.14%
SCHIP	4,273	$ 7,165,946	$ 139.74	4,432	$ 4,530,946	$ 113.59	63.23%
Pharmacy Only	12,684	$ 6,571,233	$ 43.17	12,079	$ 3,201,430	$ 29.45	48.72%
Choices for Care	4,177	$ 208,784,793	$ 4,165.02	4,172	$ 156,158,988	$ 4,159.25	74.79%
Total Medicaid Claims Paid	205,162	$ 845,052,643	$ 343.25	208,937	$ 639,828,066	$ 340.25	75.71%

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.

* Underinsured Child/SCHIP expenditure adjustment will be made in June quarter, to align with enrollment adjustment made in March quarter

Attachment 3

State of Vermont *Agency of Human Services*
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Questions, Complaints and Concerns Received by Health Access Member Services
January 5, 2015 – April 4, 2015

January 5 – January 10

- New PDP: CSR's followed the Taking Changes reference in KB.
- DSS issues: CSR's instructed callers to first contact Gould directly, and if issue persisted sent email to DSS to have to problem investigated.

January 12 – January 17

- DSS issues (e.g. TLP's or Pharmacy home not showing up): CSR's instructed callersto first contact Gould directly, and if issue persisted sent email to DSS to have toproblem investigated.

January 19 – January 24

- Invoices from new PDP's: CSR's referenced HP to verify if bill was paid and advised that it will be processed in 3 to 4 months.
- PC Plus Enrollment: CSR's assisted callers with enrolling in their PCP of choice.
- DSS issues: CSR's instructed callers to first contact Gould directly, and if issue persisted sent email to DSS to have to problem investigated.

January 26 – January 31

- PDP Billing issue: CSR's reviewed PDP billing issues protocol.
- VPharm Closure notices: CSR's advised when the payment was due and provided mailing address to send in a check.
- TPL Closure notices: CSR's referenced the appropriate protocol in the KB.
- POI Request: CSR's referenced the appropriate protocol in the KB.

February 2 – February 7

- PDP Billing issue: CSR's advised there is a 3-4 month period for systems to align once a PDP is changed

- VPharm invoices not received: CSR's verified if the invoice was mailed out and provided information how to mail in payments without the coupon.

February 9 – February 14

- PDP Billing issue: CSR's advised there is a 3-4 month period for systems to align once a PDP is changed
- VPharm invoices not received: CSR's verified if the invoice was mailed out and provided information how to mail in payments without the coupon.

February 15 – February 21

- PDP Billing issue: CSR's advised there is a 3-4 month period for systems to align once a PDP is changed

February 23 – February 28

- PDP Billing issue: CSR's advised there is a 3-4 month period for systems to align once a PDP is changed

March 2 – March 7

- New PDP: CSR's reviewed account and escalated an SR with information.
- Rx Issues: CSR's reviewed account and escalated the issues to the Goold Health Services.

March 9 – March 14

- PC Plus Enrollment: CSR's assisted callers with enrolling in their PCP of choice

March 16 – March 21

- PC Plus Enrollment: CSR's assisted callers with enrolling in their PCP of choice.
- VPharm Payment Confirmations: CSR's verified whether payment had been received as customer had received a closures notice and advised accordingly.
- New PDP: CSR's reviewed account and escalated an SR with information.
- Renewal Application CSR's reviewed account and assisted completing an application if needed.

March 23 – March 28

- Legacy Medicaid clients transitioning to VHC Renewals: CSR's either assisted with the application, mailed a paper application, or advised how to complete an application online.

March 30 – April 4

- Legacy Medicaid clients transitioning to VHC: CSR's assisted with the application,

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mailed a paper application, or advised how to complete an application online.

- PDP bills still received after transitioning to VPharm: CSR's followed the KB reference and advised accordingly.

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Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
January 1, 2015 – March 31, 2015

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

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

During this quarter, there were 30 grievances filed with the MCE; with sixteen of them being addressed during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was two days. Of the grievances filed, 73% were filed by beneficiaries, and 27% were filed by a representative of the beneficiary. Of the 30 grievances filed, DVHA had 57%, and DMH had 43%.

There were no Grievance Reviews filed this quarter.

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

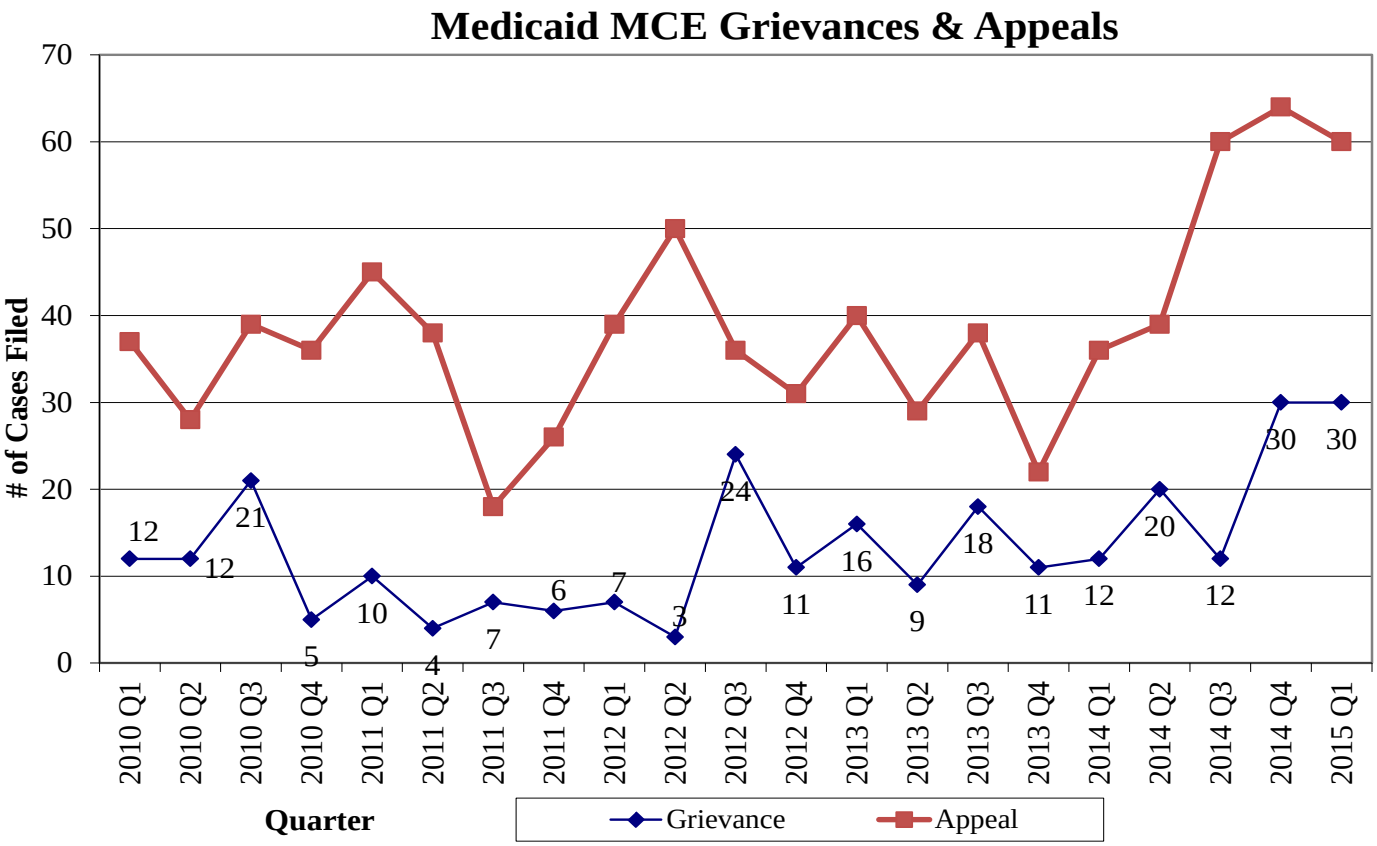
1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered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

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

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

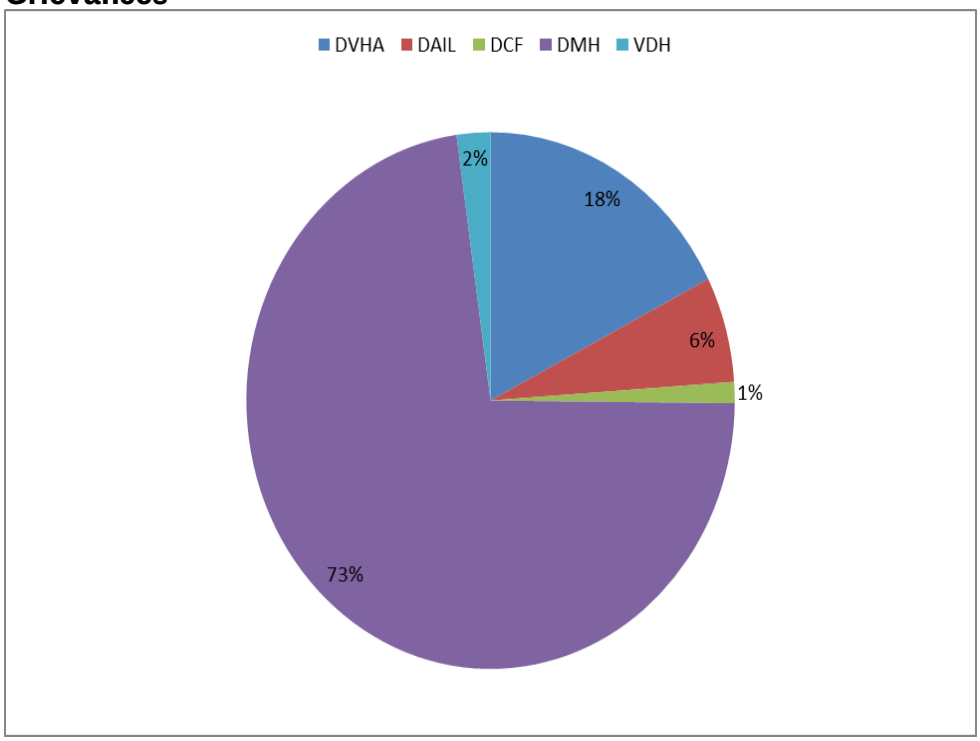
Of the 64 appeals filed, 36 were filed by beneficiaries (56%), 27 were filed by a representative of the beneficiary (42%), and 1 (2%) was filed by the provider. Of the 64 appeals filed, DVHA had 88%, DAIL had 9%, and DMH had 3%.

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

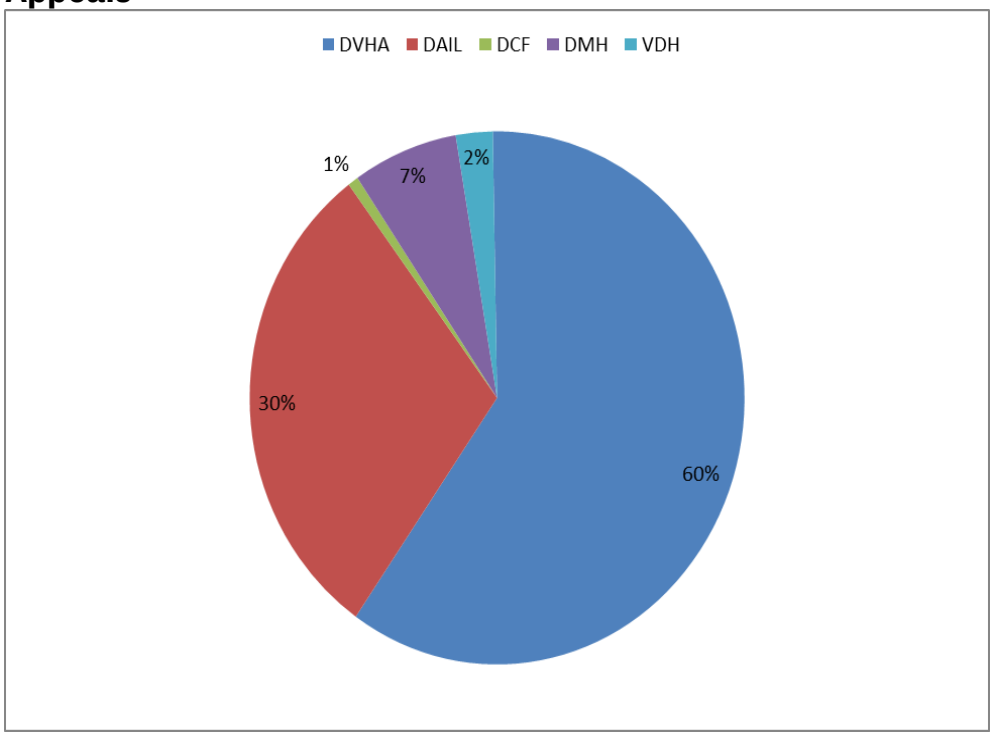


MCE Grievance & Appeals by Department
From January 1, 2010 through March 31, 2015

Grievances



Appeals



Attachment 5

VERMONT LEGAL AID, INC.

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OFFICES:
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QUARTERLY REPORT
January 1, 2015 – March 31, 2015
to the
Agency of Administration
submitted by
Trinka Kerr, Chief Health Care Advocate
April 20, 2015
NARRATIVE

I. Introduction

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

The full quarterly report for January 1, 2015 - March 31, 2015 includes:

- This Narrative, which contains sections on **Individual Consumer Assistance, Consumer Protection Activities** and **Outreach and Education**
- Six data reports, including three based on the caller's insurance status:
  - **All calls/all coverages**: 1,367 calls
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 414 calls or **30%** of total calls
  - **Commercial plan beneficiaries**: 491 calls or **36%**
  - **Uninsured Vermonters**: 149 calls or **11%**
  - **Vermont Health Connect**: 706 calls or **52%** (this data report draws from the All Calls data set above)
  - **Reportable Activities (Summary & Detail):** 241 activities, 46 documents

II. Individual Consumer Assistance

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

The HCA received 1,367 calls[1] this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category based on the caller's primary issue were as follows:

- **18.37%** (273) about **Access to Care**;
- **13.80%** (210) about **Billing/Coverage**;
- **1.14%** (27) about **Buying Insurance;**
- **14.12%** (216) about **Consumer Education**;
- **34.53%** (381) about **Eligibility** for state programs and Medicare; and
- **18.04%** (260) 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 381 of our cases had eligibility for state health care programs as the primary issue, there were actually a total of 1,325 cases that had some eligibility issue. This is because it is possible to have multiple types of issues in a single case.

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

See our recommendations to the state at the end of this section on page 12.

A. The HCA's call volume again hit record high levels.

The HCA again broke its record for the most cases in a single quarter. Last quarter was the previous record holder at 1,224. This quarter we received 1,367, which is a 12% increase. This was directly attributable to a huge increase in Vermont Health Connect calls. More than half of our calls involved issues with VHC. Two other interesting statistics jump out for this quarter:

- The number of callers on commercial plans exceeded the number of callers on DVHA programs for the first time ever.

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

- The number of complex cases increased 43% over last quarter. (A complex case is one that takes more than two hours of an advocate's time to resolve.)

All Cases (2005-2015)											
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
January	178	313	280	309	240	218	329	282	289	428	470
February	160	209	172	232	255	228	246	233	283	304	388
March	188	192	219	229	256	250	281	262	263	451	509
April	173	192	190	235	213	222	249	252	253	354	n/a
May	200	235	195	207	213	205	253	242	228	324	n/a
June	191	236	254	245	276	250	286	223	240	344	n/a
July	190	183	211	205	225	271	239	255	271	381	n/a
August	214	216	250	152	173	234	276	263	224	342	n/a
September	172	181	167	147	218	310	323	251	256	374	n/a
October	191	225	229	237	216	300	254	341	327	335	n/a
November	168	216	195	192	170	300	251	274	283	306	n/a
December	175	185	198	214	161	289	222	227	340	583	n/a
Total	**2200**	**2583**	**2560**	**2604**	**2616**	**3077**	**3209**	**3105**	**3257**	**4526**	**1367**

B. Vermont Health Connect problems continued and increased 51%.

VHC has been plagued with operational problems since it was launched in October 2013, and many of its backend functions are being done manually. As a result, we heard about a tangled web of VHC problems that left consumers without coverage, in financial difficulty, and generally angry. We received 706 calls related to VHC compared to 469 last quarter, a 51% increase. There were a lot of different types of issues involving VHC, but the most problematic areas were: invoice, billing and payment; renewals for 2015 coverage; the implementation of changes in circumstances; and tax-related issues. Of the 706 VHC cases, 131 or 19% involved access to care issues. The HCA worked with VHC to expedite the resolution of access cases.

Here are some examples of the problems we saw:

- Invoice and premium payment problems continued. Renewal delays created uncertainty for consumers because some did not receive invoices for the first three months of 2015. When they received an invoice, they had a short amount of time to pay for several months of coverage all at once. Some consumers tried to pay without an invoice, and had the 2015 payment applied incorrectly to their 2014 account.

- New mistakes occurred during the renewal process, such as miscalculations in income made by counting seasonal income as annual income. Because of these errors, consumers did not

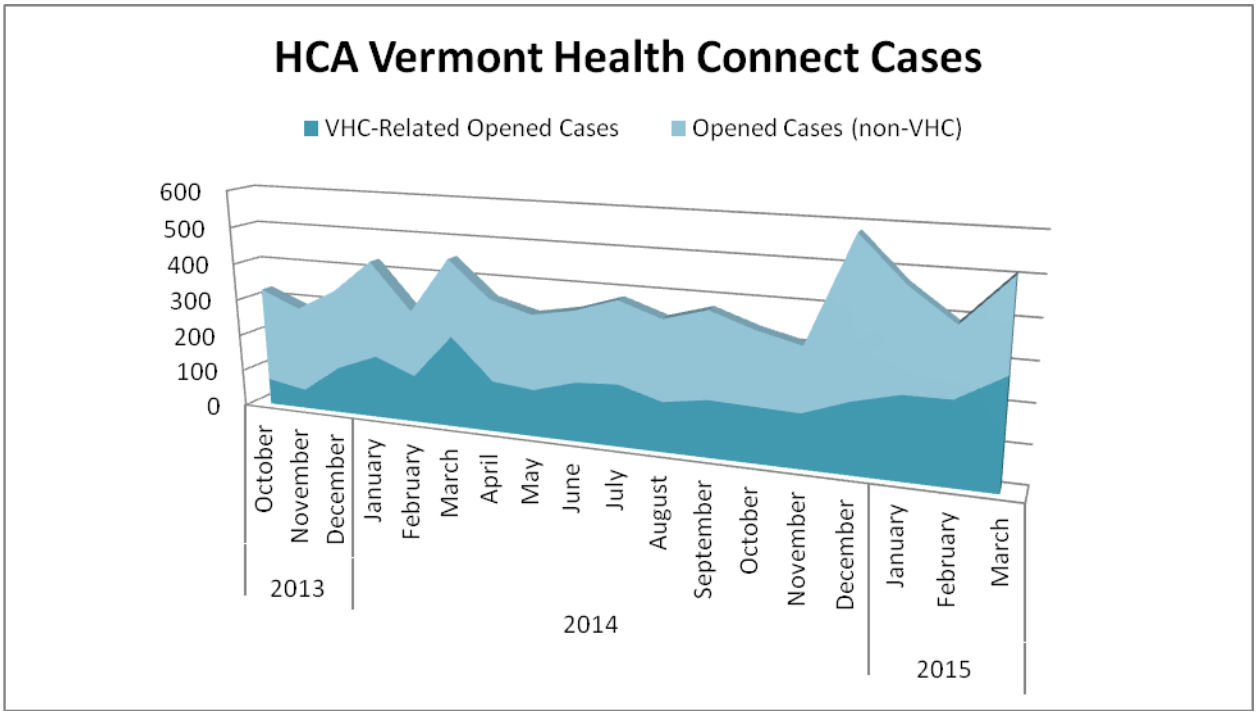
receive enough Advance Premium Tax Credits to help pay for their monthly premiums. Without APTC, they started 2015 unable to pay their premiums.

- Consumers landed in limbo because of delays in the renewal process. We worked with consumers who were left hanging without coverage because of the delays in the renewal process. Some had requested a different plan for 2015. When VHC did not process that change it meant the consumer was renewed onto a plan they no longer wanted or could not afford.

- Changes of Circumstances requested in 2014 that had not been completed caused problems in coverage and payment.

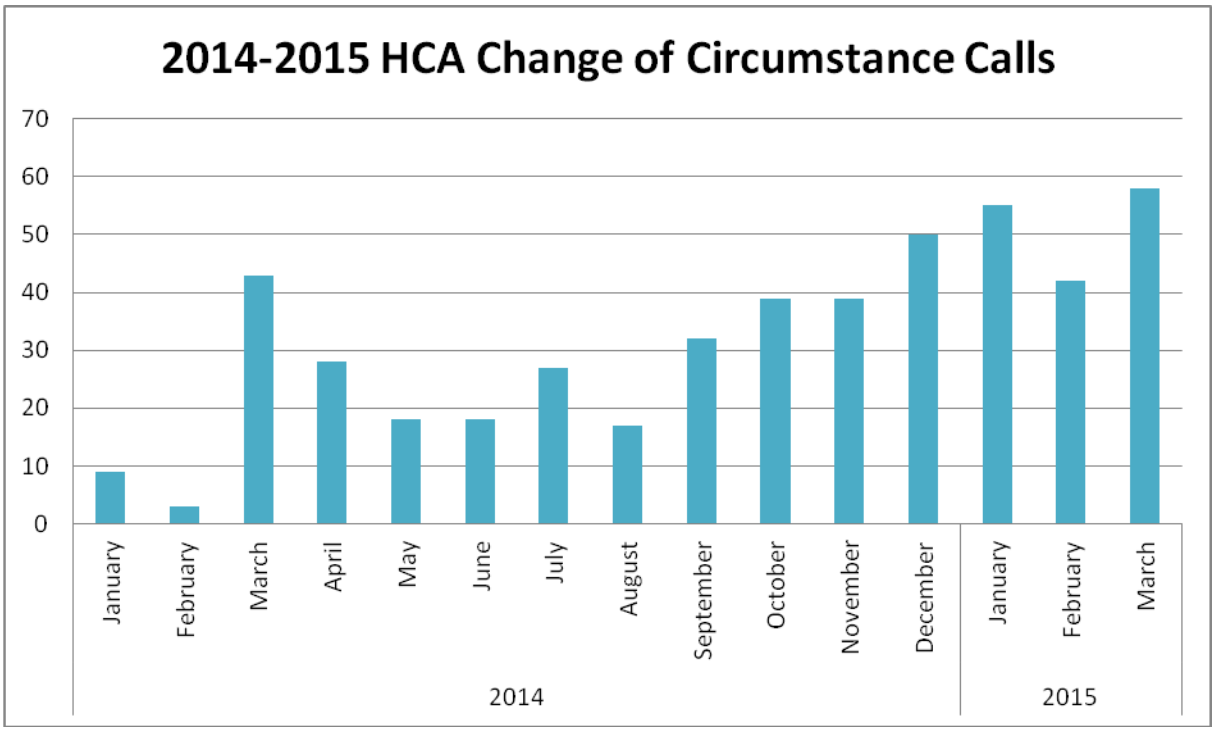
- Consumers whose coverage was terminated in error in 2014 and not reinstated in time for 2015, had trouble getting active coverage at the start of the new year.

- 2014 mistakes in the calculation of Advance Premium Tax Credits. When some consumers did their 2014 taxes they discovered they had received too much APTC in 2014 and owed money to the IRS because of the overpayment. The APTC overpayment was frequently caused because the consumer earned more in 2014 than anticipated. Other times it was caused by a VHC mistake in its APTC calculations, or because VHC had not been able to process a reported change in income in a timely manner. Also, many consumers who owed money on their taxes were still receiving too much APTC for 2015. This meant that this issue had to be resolved very quickly, or they would owe money again next year.



C. Complaints related to Vermont Health Connect's lack of Change of Circumstance functionality continued, and increased by 27%.

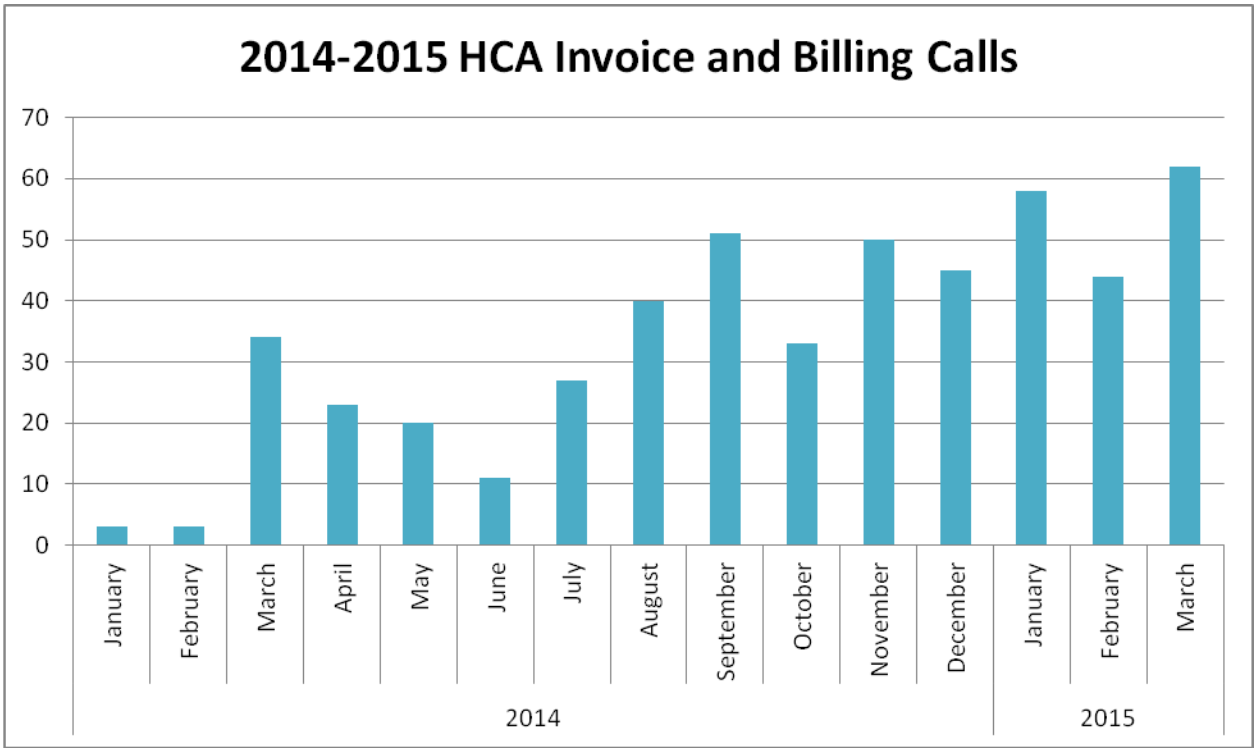
COC cases increased 27% over the previous quarter. The HCA had 155 cases involving COC problems, when we counted both primary and secondary issues. This is up from 122 last quarter, and 75 the previous quarter. This is a known, ongoing problem that has been mentioned in previous reports. We know that VHC is working on it.



D. Vermont Health Connect invoice, billing and premium payment problems increased 34%.

Many consumers who purchased Qualified Health Plan (QHP) from VHC had problems getting the coverage they bought because of invoicing and billing problems. The problems include non-receipt of invoices, multiple invoices in one month, delays in processing, and delays in actually getting correct coverage. Some people reported that they had made payments for months which did not seem to be recorded anywhere. Many of these cases involved problems from 2014 that were not completely resolved.

This quarter we received 164 calls involving invoices, billing and premium processing, compared to 125 last quarter when primary and secondary issues are counted, an increase of 34%.



E. About 27% of the Vermont Health Connect calls were related to tax issues generated by the Affordable Care Act.

For the first time, Americans' health insurance status over the course of the previous year had serious tax consequences. Of the 706 VHC calls, 192 or 27% had primary issues involving the 2014 tax consequences of the Affordable Care Act. However, that is only 14% of All Calls, which was not as bad as we expected. When we count both primary and secondary issues, 85 calls involved Form 1095-A, 101 calls involved APTC reconciliation, and 59 involved the penalty (Individual Shared Responsibility Payment) for going uninsured for three months or longer. Two individuals were referred to the HCA's tax attorney for direct representation. HCA advocates provided a significant amount of consumer education to Vermonters who did not understand the ACA's tax consequences.[2]

[2] See also our many other tax-related activities that were not related to individual consumers in the Outreach and Education section beginning on page 18.

F. The top issues generating calls

The listed issues in this section include both primary and secondary issues.

All Calls 1,367 (compared to 1,225 last quarter)

1. VHC complaints 204 calls (compared to 163 last quarter)
2. Information about VHC 197 (168)
3. VHC Invoice/billing Problem 164 (125)
4. VHC Renewals 160 (46)
5. VHC Change of Circumstance 155 (122)
6. VHC Premium Tax Credit eligibility 137 (93)
7. Information about DVHA programs 122 (127)
8. Affordability issue that created an access problem 117 (87)
9. DVHA/VHC Premium billing 103 (68)
10. MAGI Medicaid eligibility 101 (108)
11. Complaints about providers 96 (101)
12. Access to Prescription Drugs 87 (92)
13. Form 1095-A 86 (new code)
14. IRS Reconciliation consumer education 82 (new code)
15. Medicare consumer education 79 (236)

Vermont Health Connect Calls 706 (compared to 469 last quarter)

1. VHC complaints 202 (162)
2. Information about VHC 196 (163)
3. VHC Invoice/Payment/Billing problem 164 (125)
4. VHC Renewals 160 (46)
5. Change of Circumstance 155 (122)
6. Premium Tax Credit Eligibility 136 (91)
7. DVHA/VHC Premium billing 101
8. MAGI Medicaid eligibility 94 (103)
9. Form 1095-A 86 (new code)
10. IRS Reconciliation consumer education 82 (new code)

DVHA Beneficiary Calls 414 (compared to 501 last quarter)

1. Information about DVHA programs 58 (60)
2. Complaints about Providers 57 (61)
3. Affordability 44 (28)
4. Access to Prescription Drugs 42 (47)
5. Problem with Medicaid PBM 42 (new code)
6. Medicaid Billing 41 (33)
7. MAGI Medicaid eligibility 39 (43)
8. Medicare consumer education 23 (146)
9. VHC complaints 22 (27)
10. Information about VHC 21 (33)

Commercial Plan Beneficiary Calls 491 (compared to 308 last quarter)

1. VHC complaints 129 (80)
2. QHP Renewals 123 (33)
3. VHC invoice/payment problem 119 (81)
4. Information about 108 (78)
5. Change of Circumstance 102 (79)
6. Premium Tax Credit eligibility 81 (52)
7. DVHA/VHC premiums billing 78 (42)
8. IRS Reconciliation consumer education 66 (new code)
9. Form 1095-A 62 (new code)
10. VHC website/technology problem 53 (39)

G. Hotline call volume by type of insurance:

The HCA received 1,367 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, VPharm, or both Medicaid and Medicare aka "dual eligibles") insured **30%** (414 calls), compared to 41% (502) last quarter;
- **Medicare**[3] **beneficiaries** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka "dual eligibles," Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **19%** (264), compared to 31% (380) last quarter;
- **Commercial plan beneficiaries** (employer sponsored insurance, small group plans, or individual plans) insured **36%** (491), compared to 25% (308) last quarter; and
- **Uninsured** callers made up **11%** (149) of the calls, compared to 10% (126) last quarter.
- In the remainder of calls insurance status was either unknown or not relevant.

H. Dispositions of closed cases

All Calls

We closed 1,340 cases this quarter, compared to 1,155 last quarter.

- 27% (366 cases) were resolved by brief analysis and advice;
- 29% (390) were resolved by brief analysis and referral;
- 26% (344) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time;

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

- 14% (191) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- Just 1 case was resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 29 cases involved help with appeals: 5 commercial plan appeals, 22 Fair Hearings, 1 DVHA internal MCO appeals and 1 Medicare appeal. Most of our cases involving VHC and DVHA problems are resolved without using the formal appeals process.

DVHA Beneficiary Calls

We closed 395 DVHA cases this quarter, compared to 500 last quarter.

- 31% (122 cases) were resolved by brief analysis and advice;
- 30% (119) were resolved by brief analysis and referral;
- 21% (81) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 16% (65) 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 in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 23 cases involved appeals: 22 Fair Hearings, no Expedited Fair Hearings, and 1 internal MCO appeal.

Commercial Plan Beneficiary Calls

We closed 488 cases involving individuals on commercial plans, compared to 253 last quarter.

- 25% (124 cases) were resolved by brief analysis and advice;
- 19% (94) were resolved by brief analysis and referral;
- 35% (172) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time (this measure increased by 20% over last quarter);
- 17% (83) 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: 5 cases involved appeals.

I. Case outcomes

All Calls
The HCA helped 116 people get enrolled in insurance plans and prevented 6 insurance terminations or reductions. We obtained coverage for services for 59 people. We got 44 claims paid, written off or reimbursed. We helped 7 people complete applications and estimated VHC insurance program eligibility for 20 more. We provided other billing assistance to 57 individuals. We obtained hospital patient assistance for 2 people. We provided 717 individuals with advice and education. We obtained other access or eligibility outcomes for 135 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 $219,054** in cases opened this quarter**.** So far in SFY 2015, we have saved Vermonters **$518,776.76.**

J. Case examples

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

1. 90 year old woman denied premium subsidies. Ms. A called the HCA because she could not afford her monthly premiums, which were 20 percent of her monthly income. Although she was 90 years old, she was not eligible for Medicare or Medicaid. She had purchased insurance on VHC, and been found ineligible for any subsidies, so she was struggling to make the monthly payments. The advocate reviewed her case with VHC. To qualify for federal subsidies, a VHC applicant must agree to file federal taxes. Ms. A's income was so low that it did not meet the tax filing threshold, and she had originally told VHC that she did not plan to file a return (because she hadn't had to do so in years past). Because of this, VHC denied her application for subsidies. When she explained to VHC that she would file a tax return now that she understood its importance, VHC told her it was too late. The HCA advocate intervened and VHC approved Ms. A for APTC, which reduced the cost of her monthly premium by almost 80 percent.

2. Two cent payment error caused a series of problems. When Mr. B went to file his 2014 tax return, he discovered he had not yet received a necessary form, Form 1095-A, from VHC. He called the HCA. His advocate helped him get the form. However, when she reviewed it, she saw that it said that Mr. B had only paid his premiums through November 2014. Mr. B did not understand this because he had sent in twelve premium payments to VHC, and was sure he was paid through December. The advocate studied the payment history, and discovered that one of the premium payments was too low by

two cents. This had caused VHC records to show that Mr. B was not completely paid up for the whole year. The advocate directed Mr. B to send in the payment for two cents. When VHC received the payment, however, it applied it to 2015 coverage instead of 2014 coverage. This meant that it still looked like Mr. B had not paid all his premiums for 2014. The advocate got VHC to move the two cent payment to 2014. Once the payment was correctly applied, VHC sent him a corrected 1095-A that showed that he had made all his premium payments, and Mr. B was able to file his return.

3. Investigation into one VHC mistake leads to the discovery of another. Ms. C contacted the HCA when her medical providers threatened to send her bills to collections because they had not been paid. With much difficulty, Ms. C had paid her Qualified Health Plan premiums for over six months. When the HCA advocate investigated why the bills were not being paid, she learned that Ms. C's QHP had never been activated. The advocate also figured out that VHC had made a mistake in calculating Ms. C's income. When the income was calculated correctly, Ms. C and her family were eligible for Medicaid. The advocate requested that VHC put the family on Medicaid retroactive to the original application, which it did. This meant that Ms. C's providers could be paid by submitting the outstanding bills to Medicaid. She also received a $1,600 refund for the premiums she had paid for the QHP coverage she never had.

4. There can be multiple barriers to transportation to medical care. Mr. D, who was 89 years old, needed transportation to a medical appointment. He had requested a ride from Medicaid, but Medicaid had denied the request because it said that Mr. D could get a ride from his son. Mr. D called the HCA for help. His advocate investigated and learned that the son's car was inoperable. She got a report from a mechanic to show that the car was not in working order. She then helped Mr. D submit a new transportation request to Medicaid with this evidence. Mr. D then faced a new obstacle: the driver wanted to pick him up at the end of his driveway because it was mud season. The driveway was nearly a half mile long, a distance that the elderly Mr. D could not walk. So, the advocate requested that the Medicaid driver pick Mr. D up at his house. The advocate provided evidence that the driveway was passable, despite it being mud season. Medicaid approved the ride, and specified that Mr. D had to be picked up at his house. Mr. C was able to make it to his appointment.

5. Insurance carrier denied coverage for treatment of a serious illness. Mr. E needed treatment for a life-threatening condition, which his insurance carrier denied. The insurer said the treatment was experimental and unproven for this particular condition.

Mr. E's providers believed this treatment was Mr. E's best, possibly only, hope. After Mr. E lost his first level internal appeal, he contacted the HCA. The HCA advocate helped Mr. E with a second level internal appeal. After he lost that one, too, the advocate helped him file for external review. The advocate provided guidance on what evidence should be submitted, and how, to the independent review organization. The IRO decided that the treatment had been studied and shown to be effective for Mr. E's condition, and as a result the insurance carrier must cover it. The cost of this treatment was approximately $175,000.

K. Recommendations to Vermont Health Connect

This has been a very difficult period for many people dealing with VHC. As evidenced by this report, the problems we are seeing are increasing, and not yet diminishing. We do, however, appreciate all the efforts that VHC has made to ease the problems for consumers while waiting for the exchange's functionality to be improved, which we all hope will happen by the end of May. VHC has continued to work with us and set up systems to resolve our clients' problems. Our first two recommendations are repeats of earlier recommendations because the problems remain. We realize that VHC is well aware of these issues, so we're not detailing the problems here.

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

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

3. *Keep working to improve quality control on manual operations.*

We continue to see VHC errors compounded by other errors.

4. *Reinstate high level stakeholder consumer experience meetings to keep everyone up to date on VHC's efforts and to elicit specific suggestions for improved customer service.*

We have not had a regular monthly meeting with VHC leadership, the carriers, navigators and the HCA since February. As we approach the long hoped-for deployment of change of circumstance functionality and more complete reconciliation of payments between VHC and the carriers, it would be beneficial to all if we could have regular discussions about what is happening and what to expect. And, if the changes do not happened as planned at the end of May, it will be even more important for all the stakeholders to know what is going on in order to help consumers. Open and ongoing communication among the stakeholders is a critical factor in the resolution of consumer problems.

III. Consumer protection activities

A. Rate review work

Five new rate review cases were filed with the Green Mountain Care Board in this quarter. The HCA entered Notices of Appearance in all five of these cases. None of the cases was ready for hearing during the quarter.

The Department of Vermont Health Access and the Board have developed a schedule for the rate review hearings for plans offered on Vermont Health Connect in 2016. The carriers are expected to file their requests for rates on May 15, 2015, and the Board will issue a decision by August 13, 2015. The HCA will work with Donna Novak of NovaRest, Inc. as its independent actuary to review the filings, propose questions for the carriers, and present testimony at the hearings which are currently scheduled for the end of July.

B. Certificate of Need Applications

The HCA continues to monitor the Green Mountain Care Board's Certificate of Need (CON) examinations. This quarter, we participated in several CON processes as an interested party. In January, we submitted questions to the Board for Northwestern Medical Center regarding its inpatient bed renovation CON application (GMCB-022-14con). Our questions focused largely on the benefits it expects to gain from the renovations and whether its plans will efficiently utilize available space. Also in January, we received a call from a Vermont citizen regarding Copley Hospital's surgical suite renovation project which is currently under CON review (GMCB-015-13con). The citizen expressed concern about the fact that Copley recently dismissed the last of its general surgeons in favor of using locum tenens physicians. We subsequently submitted an additional question to the Board for Copley Hospital asking the hospital to explain its rationale behind this staffing change.

In February, we provided written and oral testimony for the Attuned Eating and Living Centers CON hearing (GMCB- 013-14con). Our testimony outlined our concerns with the project which included the lack of evidence demonstrating the effectiveness of the proposed treatment model, the lack of evidence on the cost-effectiveness of the proposed project, the adverse impact the project could have on existing health care facilities in Vermont, and the lack of significant benefit to Vermont residents likely to arise from the project.

In March, the HCA participated in a meeting with the University of Vermont Medical Center (UVMC) and the Board's hearing officer to discuss UVMC's proposed inpatient bed renovation CON project (GMCB 21-14con). We also provided information to a Vermont consumer assistance organization on how to apply for "interested party" status as a part of the CON

review process. We also reviewed the updated report on the Soteria mental health treatment program CON (GMCB-005-13con).

C. Other Green Mountain Care Board activities

The HCA is active in the Board's regulatory responsibilities beyond our regular rate review and CON work. This quarter, the HCA monitored proposed legislative changes to the Board's duties. In addition, we submitted two sets of formal public comments to the Board, one on the state's proposed changes to the Vermont health insurance exchange's qualified health plan designs and a second on our office's position on the administration's health policy proposal. Further, in the last quarter we met with the Board's chair, attended weekly Board meetings, met with the Board's staff to discuss current health care legislation proposals and other consumer protection priorities, attended the Board's Advisory Committee meeting, and attended the Board's monthly Data Governance Committee meetings. We also attended two extra board meetings on hospitals budgets, one comparing the previous year's approved hospital budgets to the actual numbers, and one discussing the upcoming hospital budget review and Board guidance to hospitals.

D. Vermont Health Care Innovation Project

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

- Participated in 1 meeting as a member of the VHCIP Steering Committee
- Participated, along with representatives from other projects of Vermont Legal Aid, as "active members" in six of the seven VHCIP work groups:
    - Payment Models Work Group
    - Quality and Performance Measures Work Group
    - Population Health Work Group
    - Care Models and Care Management Work Group
    - Disability and Long Term Services and Supports Work Group
    - Health Information Exchange/Health Information Technology Work Group
- Attended 10 VHCIP work group meetings
- Attended 3 meetings of the VHCIP Core Team as an interested party
- Gave a formal interview to provide the HCA's perspective on Vermont's Health Information Technology Plan in preparation for an upcoming rewrite of the plan

E. Affordable Care Act Tax-related Activities

The federal Affordable Care Act made tax law newly important to effective health advocacy. It imported tax concepts into Medicaid, created a new federal tax credit to subsidize private health insurance purchased through health benefit exchanges, and created a tax penalty for failure to have insurance coverage. In October 2014, the HCA partnered with the Low Income

Taxpayer Project at Vermont Legal Aid to engage in education, outreach, and advocacy relating to the Affordable Care Act. This partnership continued during the reporting period.

During this quarter, the HCA continued to employ a half-time tax attorney, who also staffs the Low Income Taxpayer Project at VLA. This allowed the HCA to stay up to date on legal developments and educate our staff to effectively field calls related to the ACA and Vermont Health Connect. In addition, the tax attorney consulted with HCA advocates when particularly difficult tax issues arose in HCA cases.

Through the tax attorney alone, the HCA answered more than 100 tax-related questions from VHC, tax preparers, health assisters, advocates in other states, Congressional caseworkers, and from Vermont consumers. This quarter, many of the questions involved Form 1095-A, the Premium Tax Credit eligibility rules, or the Individual Shared Responsibility Payment. A significant number of consumers did not understand how Advance Premium Tax Credits (APTC) worked when they applied last year. Some consumers and assisters erroneously believed that there were exemptions from the reconciliation process, particularly for errors made by VHC. To address consumers' confusion and misunderstanding of the tax implications of the Affordable Care Act, the HCA engaged in a significant number of outreach and education activities. They are detailed below in the Outreach and Education section.

We alerted the IRS Taxpayer Advocate Service to hardships facing Vermonters due to APTC reconciliation. In particular, we reported that VHC's lack of functionality in 2014 caused many consumers to receive excess APTC through no fault of their own. We suggested that IRS should compromise the resulting tax debt if the consumer was not at fault and cannot afford to repay the debt.

HCA also had meetings and other communications with VHC regarding substantive issues that arose such as APTC overlap with non-QHP health insurance coverage. The HCA's tax attorney presented at three VHC cross training events for health and tax assisters. We provided case examples and scenarios to VHC for use in trainings. We commented on VHC outreach and educational materials. We also commented on proposed revisions to DCF's Health Benefits Eligibility and Enrollment Rule, which implements the Affordable Care Act in Vermont.

F. Other Activities

Policy Paper on Health Literacy and Plain Language

This quarter we completed policy paper entitled Health Literacy and Plain Language. All of the HCA's policy papers are available on the Health Care Policy page on our website: http://www.vtlawhelp.org/health-care-policy.

Other Boards, Task Forces, and Work Groups
The HCA participated in:

- 3 Medicaid and Exchange Advisory Board (MEAB) meetings

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

Legislative Activities

This quarter the HCA actively advocated for the following legislative initiatives:

- An act relating to notification of individuals placed in hospital observation status
- An act relating to establishing and regulating dental therapists
- An act relating to surrogate decision making for do-not-resuscitate orders and clinician orders for life-sustaining treatment
- An act relating to supporting health care initiatives and establishing payroll and sugar-sweetened beverage taxes

Additionally, HCA staff consistently monitored the activities of legislative committees that took up issues related to health care and health reform.

This quarter, HCA staff:

- Testified before legislative committees 10 times
- Submitted 5 sets of written comments/testimony
- Met informally with legislators about legislative initiatives
- Regularly met and collaborated with other advocates on legislative initiatives, including participation in the Surrogate Decision Making working group and the Oral Health Care for All legislative team
- Conducted an educational presentation for the House Ways & Means Committee, explaining the Advance Premium Tax Credit reconciliation process and the tax issues that VHC consumers may encounter during the filing season.
- Attended:
    - 1 meeting of the Health Reform Oversight Committee
    - 3 meetings of the General Assembly
    - 1 meeting of the House Committee on Appropriations
    - 1 joint meeting of the House Committees on Appropriations and Health Care
    - 42 meetings of the House Committee on Health Care
    - 2 meetings of the House Committee on Human Services
    - 19 meetings of the House Committee on Ways and Means
    - 1 meeting of the Senate Committee on Appropriations
    - 20 meetings of the Senate Committee on Finance
    - 5 meetings of the Senate Committee on Government Operations
    - 10 meetings of the Senate Committee on Health and Welfare
    - 2 joint meetings of the Senate Committee on Health and Welfare and the House Committee on Health Care

Administrative Advocacy

This quarter, the HCA:

- Submitted formal comments on VHC regulations
- Submitted 4 sets of formal comments on VHC notices
- Submitted 7 sets of complaints and suggestions about VHC operations
- Participated in weekly 1095-A check-in phone calls
- Attended a 1095-A press round table
- Met and corresponded with SHIP and DVHA about improving the VPharm annual notice
- Signed on to a letter to congress in support of funding for CHIP with First Focus and numerous other organizations
- Corresponded with DVHA about work products related to the MEAB Improving Access work group

Collaboration with other organizations

The HCA worked with the following organizations this quarter:

- AARP Vermont
- American Cancer Society of Vermont
- American Heart Association Vermont Chapter
- American Civil Liberties Union (ACLU)
- Alliance for a Healthier Vermont
- Bi-State Primary Care Association
- Community Catalyst
- Community of Vermont Elders
- Disability Rights Vermont
- Families USA
- Iowa Legal Aid
- Main Street Alliance
- National Health Law Program
- Peoples Health and Wellness Clinic
- Planned Parenthood of Northern New England
- Springfield Area Public Access Television
- University of Vermont Medical Center
- Valley Health Connections
- Vermont Association of Hospitals and Health Systems
- Vermont Oral Health Care for All Coalition
- Vermont Campaign for Health Care Security
- Vermont Dental Hygienists' Association
- Vermont Health Connect
- Vermont Low Income Advocacy Council (VLIAC)
- Vermont National Education Association (NEA)
- Vermont Public Interest Research Group
- Vermont Technical College

- Voices for Vermont's Children

Trainings

- Vermont Health Information Technology Plan webinar
- National Consumer Law Center webinar: Medical debt – Overview of New IRS Regulations and Industry Best Practices
- Community Catalyst webinar: Meaningful Engagement in Community Health Needs Assessments
- Community Catalyst webinar: Final IRS Rules for Tax-Exempt Hospitals

IV. Outreach and education

A. Website

Vermont Law Help is a statewide website maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section (www.vtlawhelp.org/health) with more than 150 pages of consumer-focused health information maintained by the HCA. Since the launch of Vermont Health Connect, we have worked diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

Google Analytics statistics show that:

- The total number of health pageviews increased by 131% in the reporting quarter ending March 31, 2015 (6,320 pageviews), compared with the same quarter in 2014 (2,732 pageviews).
- The number of people seeking information about dental services increased by 961%. (191 pageviews this quarter, compared with 18 in the same period last year)
- A significant part of the overall increase in the number of health pageviews can be attributed to new pages that did not exist last year. Many of these pages were developed as part of the education and outreach effort to better inform consumers about the tax implications of the Affordable Care Act, as described in Section III.E. of this report. These pages include:
    - Health Insurance, Taxes and You (359 pageviews)
    - ACA for Assisters (217 pageviews)
    - Several news items that we posted to keep the information readily visible to site visitors.
- There was a sharp uptick in the number of people seeking information about Medicaid income limits (1,404 pageviews this quarter, compared with 89 in the same quarter in 2014, an increase of 2,280%). Since the number of Vermont Law Help visitors to other pages providing information about Medicaid showed much more modest gains, we believe that search engines are delivering this page as a top source of information about Medicaid income limits.

24 Out of 50 PDF Downloads Were on Health Care Topics
Health-related PDFs accounted for 336 out of 1,140 PDFs that were downloaded from the Vermont Law Help website during this quarter. The majority of these were related to the Affordable Care Act, shown in italics below.

- *Premium Tax Credit - Marriage, Separation and Divorce 12-8-14.pdf (61)*
- *Form 1095-A FINAL 1-27-15.pdf (40)*
- *Low-Income Taxpayers and the Affordable Care Act Nov-2014.pdf (32)*
- *Tax Issues for Health Assisters Form 8965 example.pdf (29)*
- *MAGI 2.0 (it's complicated) 12-8-14 Final.pdf (21)*
- Advance Directive Short Form.pdf (17)
- *No Health Insurance (flyer) FINAL 1-21-15.pdf (15)*
- *APTC Reconciliation (flyer) FINAL 1-21-15.pdf (14)*
- *Tax Issues for Health Assisters 1095-A example John.pdf (14)*
- Catamount or VHAP to Medicaid.pdf (10)
- *Tax Issues for Health Assisters 1-27-15.pdf (10)*
- *Affordable Care Act - 2014 Tax Returns and Beyond.pdf (9)*
- *APTC Reconciliation Examples (Updated).pdf (9)*
- *HCA Tax Training (PowerPoint) 10-22-14.pdf (9)*
- *Tax Issues for Health Assisters Hardship Exemption Application.pdf (7)*
- *Tax Issues for Health Assisters ISRP Form 8965 instructions.pdf (7)*
- Vermont Dental Clinics Chart - 2013.pdf (6)
- Advance Directive For Health Care Long Form.pdf (5)
- *The Health Care Assister Guide to Tax Rules.pdf (5)*
- Vermont Medicaid Coverage Exception Request - 10 Standards and Provider Request Form.pdf (4)
- *ACA and Federal Income Tax Filing Requirements 2-24-15 (slide deck).pdf (3)*
- *Form 8965 example 2-24-15 presentation.pdf (3)*
- HCA Comments to GMCB on Hospital Budget Review 09.03.14.pdf (3)
- Health Literacy and Plain Language Jan 2015 posted 1-21-15.pdf (3)

B. Education

During this quarter, the HCA provided education materials, presentations, and public services announcements both directly to consumers and to individuals and organizations who serve populations that may benefit from the information and education provided.

Flyers, Letter Templates, Other Printed Material
In January, we created three flyers to inform consumers about important new tax implications of health care reform. The first flyer encouraged those who did not have insurance to apply during open enrollment and provided a clear chart showing the steep increases in penalties for not having health insurance in 2015. The second flyer explained IRS Form 1095-A and what

consumers should do if they don't receive a form or if it has incorrect information. The third flyer explained why consumers who received APTCs should file a tax return and what would happen if they were paid too much or too little APTC. Electronic versions of the flyers were emailed to more than 150 partners and assisters; almost 500 print copies of each flyer were distributed to organizations and partners for redistribution to consumers; and the flyers were available to download and print from our website.

In February the American Bar Association (ABA) published the 6th edition of its manual, Effectively Representing Your Client Before the IRS, which includes a chapter on the Affordable Care Act co-authored by the HCA tax attorney. It builds on the policy paper that HCA originally published on our public website in January 2014. The chapter outlines the main components of the ACA that are relevant to low-income taxpayers and provides practice tips and information about important ACA tax issues such as Individual Shared Responsibility Payments and Premium Tax Credits. A free copy of the manual was furnished by the ABA to the 132 Low Income Taxpayer Clinics nationwide, giving more than 1,300 advocates access to the information to use when assisting clients.

We developed template advice letters for clients on issues including how individuals having to repay Advance Premium Tax Credits can claim IRS penalty relief. The materials we developed for advocates have been shared with health and tax advocates in Vermont and nationwide.

In collaboration with the Champlain Valley Agency on Aging, the HCA created a handout to inform seniors and people with disabilities about Moving from Vermont Health Connect to Medicare. (January)

The HCA created a VPharm fact sheet to accompany notices the state sends to VPharm recipients. The fact sheet explains about eligibility and costs of VPharm, as well as benefits. (February)

This quarter the HCA also provided brochures to Planned Parenthood of Northern New England (January) and Champlain Valley Office of Economic Opportunity (February).

Public Service Announcements

We collaborated with Valley Health Connections to record two Public Service Announcements (PSAs) on Springfield Area Public Access Television to help the public prepare for the tax filing season. The first PSA explained what everyone needs to know about health insurance and taxes. It focused on the individual shared responsibility provision. The second PSA was aimed and individuals who had a QHP through VHC. It explained the APTC reconciliation process. Both PSAs were posted to a statewide network of 26 public access stations.

We collaborated with VHC staff in several outreach and educational efforts this quarter. The HCA had two tax outreach planning meetings with VHC outreach staff, and was in frequent communication with VHC regarding tax outreach events and materials.

Presentations
During this quarter, the HCA provided education to more than 400 individuals who serve populations that may benefit from the information and education provided.

VocRehab Vermont (January 8)
The HCA presented via teleconference to inform 9 VocRehab Vermont staff members about what the HCA advocacy team does and the kinds of cases that VocRehab Vermont can refer to us for help. We also provided HCA brochures for staff use and distribution to clients. With more than 120 staff members statewide, VocRehab Vermont services over 8,000 clients with disabilities each year.

VHC Cross Training Events for Tax and Health Assisters (January 12, 13, and 14)
The HCA presented at three VHC events designed to prepare health and tax assisters to help consumers with ACA issues during the tax filing season. Topics included basic tax season information for health assisters, resource and referral information, and VHC procedures. There were 19 total attendees.

VHC Webinar for Health Assisters (January 27)
The HCA presented a webinar on tax filing season issues to 24 health assisters. The webinar was organized by VHC and posted to the VHC assister website. The presentation covered basic IRS procedures, 1095-A issues, tax filing resources for consumers, and referral information.

Low Income Taxpayer Clinics (LITC) Networking Group (February 3)
The HCA presented ACA Filing Season Issues to 15 tax attorneys at other legal services organizations around the country at a meeting of the Low Income Taxpayer Clinics (LITC) networking group. The presentation discussed ACA tax issues likely to surface this filing season, and gave examples of cases already received by the HCA.

Bi-State Primary Care Association Navigator Peer to Peer Meeting (February 18)
The HCA co-authored an advanced presentation on Taxable Income and MAGI with an assister from the Bi-State Primary Care Association. The webinar was presented by the Bi-State assister to approximately 20 other health assisters. HCA's tax expert participated in the webinar to answer tax questions from attendees, and recruited an experienced Enrolled Agent to answer questions as well. The presentation covered advanced topics and frequently asked questions regarding taxable income, household income, and MAGI, and provided links to helpful resources.

University of Vermont Social Work Class (February 18)
The HCA presented about the HCA to the UVM class, Biosociopolitical Issues in Social Work, to 31 students, many of whom have field placements doing social work with various local agencies. We also provided HCA brochures for staff use and distribution to clients.

National Health Law Program (NHeLP) Webinar (February 24)
The HCA's tax expert presented The ACA and Federal Income Tax Filing Requirements to 176 legal services health law attorneys nationwide in a webinar sponsored by the National Health Law Program. The presentation emphasized ACA issues that consumers will encounter during the tax filing season. Topics included tax filing mechanics related to the Premium Tax Credit and the ACA penalty, IRS assessment and collection issues, IRS and HHS procedures, tax help available for consumers, and advocacy areas. The presentation was recorded and posted on the NHeLP and VT Law Help public websites.

Vermont Workers' Center (February 25)
The HCA met with a staff member from Vermont Workers' Center on February 25 to inform about what the HCA does and the kinds of cases the VWC can refer to HCA. We also provided HCA brochures for staff use and distribution to clients.

Attachment 6

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

SFY14 Final MCO Investments

8/27/14

MCO Investment Expenditures

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