State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 13
(1/1/2018 – 12/31/2018)

Quarterly Report for the period
January 1, 2018 – March 31, 2018

Submitted Via PMDA Portal on May 29, 2018

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I. Background and Introduction

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

The initial Global Commitment to Health (GC) and Choices for Care (CFC) demonstrations were approved in September 2005, effective October 1, 2005. The GC demonstration was extended for three years, effective January 1, 2011, and again for three years effective October 2, 2013. The GC demonstration was again renewed for five years effective January 1, 2017. The CFC demonstration was extended for 5 years effective October 1, 2010. The following amendments have been made to the GC demonstration:

- 2007: a component of the Catamount Health program was added, enabling the state to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the federal poverty level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State.

- 2009: the state extended Catamount Health coverage to Vermonters at or below 300 percent of the FPL.

- 2011: inclusion of a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

- 2012: CMS provided authority for the State to eliminate the $75 inpatient admission copay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid State Plan.

- 2013: CMS approved the extension of the GC demonstration which included sun-setting the authorities for most of the 1115 Expansion Populations because they would be eligible for Marketplace coverage beginning January 1, 2014. The renewal also added the New Adult Group to the demonstration effective January 1, 2014. Finally, the renewal also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.

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

- 2016: On October 24, 2016 Vermont received approval for a five-year extension of the Global Commitment to Health 1115 waiver, effective from January 1, 2017 through December 31, 2021.

As Vermont's Medicaid Single State Agency and under the Terms and Conditions of the Global Commitment to Health Waiver, AHS has entered into an Inter-Governmental Agreement (IGA) with

the Department of Vermont Health Access (DVHA). The AHS/DVHA IGA functions similarly to a Medicaid Managed Care contract in that it delineates program requirements and responsibilities between AHS and DVHA and according to federal Medicaid Managed Care requirements found at 42 CFR §438. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services).

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the first quarterly report for waiver year 13, covering the period from January 1, 2018 through March 31, 2018 (QE0318).***

II. Outreach/Innovative Activities

i. Provider and Member Relations

Key updates from QE0318:

- Provider Enrollment

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

Provider Enrollment

In December 2017, the decision was made to start a project to allow provides to enroll online and reduce the turnaround time for enrollment. The Provider Management Module (PMM) is a project under the Medicaid Management Information System (MMIS) program and is part of the overall MMIS Road Map as presented to the Centers for Medicare and Medicaid Services (CMS). Work on the Provider Management Module has started. DVHA is currently in the Planning Phase of the project and is working to create project processes and documentation. The following documents have been completed or are in final drafts:

- IT ABC Form reviewed by the Procurement Advisory Team on 3/1/2018.
- Amendment 2 approved by the PAT on 3/22/2018.
- IAPD Update submitted to CMS on 3/8/2018.
- IT ABC Form approved on 3/9/2018.
- Project Charter-approved.
- Deliverables Management Plan complete.
- SoV Project Management Plan complete.
- Received the CMS approval on 5/4/2018 for the IAPD submitted on 3/8/2018.
- Kickoff Meeting conducted May 8th and 9th.
- The contract amendment has been fully executed.

Next steps are to Start discussions with CMS regarding R1 milestone review, receive the DXC project plan as soon as possible, and begin collaboration with other state agencies in regards to provider screening interface work.

ii. Global Commitment to Health Post Award Forum

A post award forum for the latest Global Commitment to Health 1115 waiver renewal was held from 10:00am – 12:00pm on Monday, February 26, 2018. This forum was conducted in accordance with Special Terms & Condition 43 of the Global Commitment to Health 1115 Demonstration waiver. Public comments were solicited, but it was primarily a discussion about how the proposed substance use disorder (SUD) demonstration amendment submitted by the State relates to the existing 1115 demonstration waiver. There were no substantive comments on the current 1115 Global Commitment Demonstration.

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE0318:

- The Customer Support Center received fewer than 91,000 calls in QE0318, down more than 30% from the previous year when there were more than 130,000 calls in the quarter. The lower volume was attributed in part to an earlier open enrollment period that drove calls in the previous quarter and in part to improved operational performance with fewer problems.
- Vermont Health Connect was supported throughout the state by 266 Assisters in QE0318, up from 229 in QE0317. The Certified Application Counselor (CAC) program was responsible for most of the growth, increasing by 55% over the last 12 months by training and certifying staff in hospitals, health centers, and other community organizations.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised nearly half (45%) of all applications in QE0318, compared to just over a third in the three months after the previous year's open enrollment. In addition, more than 50% more customers made recurring payments in QE0318 than did so the previous year, which in turn was more than triple the year before that.

Enrollment

As of QE0318, more than 215,000 Vermonters (more than one-third of the population) were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 136,514 in Medicaid for Children and Adults (MCA) and 78,913 in qualified health plans (QHP), with the latter divided between 27,799 enrolled with VHC, 6,440 direct-enrolled with their insurance carrier as individuals, and 44,674 enrolled with their small business employer.

QE0318 was less eventful than the first quarter of years past, largely because this year's open enrollment ending on December 15, 2017, six weeks earlier than recent years. Enrollment data shows that the most significant result of the change was that fewer members had a gap in coverage; those who signed up at this year's deadline started coverage on January 1st, rather than the March 1st start tied to

recent years' deadlines. Enrollment data also suggests that Vermont continues to make progress in enrolling "young invincibles." Young adults aged 26-34 comprised 25% of new QHP enrollments, compared to 14% of QHP re-enrollments.

Member Experience

Vermont contracted with UMass Medical School's Center for Health Policy and Research to conduct a survey of Vermont's health insurance marketplace members during QE0318. The mixed mode survey used email, mail, and phone to engage a sample of 3,500 members and achieved a response rate of over 39% (45% for qualified health plan members and 32% for Medicaid for Children and Adults members). The full report will be delivered in early summer. Preliminary data shows significant improvement in members' perception of the marketplace generally, as well as of its website and Customer Support Center specifically, since the survey was last conducted in 2015. MCA members continue to have a more favorable view than QHP members, although the gap has narrowed as most of the improvement compared to the 2015 study was within the QHP cohort.

Medicaid Renewals

Redeterminations for Medicaid for Children and Adults (MCA) continued on their normal cycle during QE0318. The ex parte process for the batch run in March had a passive renewal success rate of 43 percent, steady from the previous month's rate. This success rate is on par with what has been expected since the entire population has to be checked for MAGI income and immigration status. This means that over half of the member households that are coming up for renewal on June 1 needed to be sent a renewal notice and to actively respond. As of the last Monday in the quarter, DVHA-HAEEU had 664 open applications, seven of which were older than 45 days.

1095 Tax Forms

DVHA-HAEEU mailed two versions of IRS Form 1095 during QE0318. 1095A serves as proof of coverage and subsidy for QHP members to use when filing taxes. Nearly 27,000 initial forms were mailed to QHP members in January. Corrected forms are sent throughout the winter and spring due to reconciliation efforts or when members pay overdue 2017 bills. 1095-related service requests decreased from the previous year and DVHA-HAEEU successfully handled incoming volume.

1095B is an informational form that shows months of coverage for Medicaid members. Nearly 117,000 were mailed in January in advance of the deadline. In 2017 the federal deadline was in March and 1095-B forms were mailed in February.

Customer Support Center

Maximus continues to manage the VHC Customer Support Center (call center). The Customer Support Center serves Vermonters enrolled in both public and private health insurance coverage by providing support with phone applications, payment, basic coverage questions, and change of circumstance requests.

The Customer Support Center received fewer than 91,000 calls in QE0318, down more than 30% from the previous year when there were more than 130,000 calls in the quarter. February 2018 was especially quiet, with the lowest volume of any month since the launch of Vermont's health insurance marketplace. The lower volume was attributed in part to the earlier open enrollment period and in part

to improved operational performance with fewer problems.

Lower call volume translated into lower staffing needs. As of the end of QE0318, Maximus had 68 customer service representatives, down 40% from the 115 on staff at the end of QE0317.

Maximus answered 73% of calls within 24 seconds in January 2018, just missing the 75% target, then met the target in both February and March (with 76% and 80% respectively).

Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group.

This year has seen a decrease in not only the volume of calls but also in the proportion of calls that have to be escalated. Only 7% of QE0318 calls had to be transferred to DVHA-HAEEU staff, down from 10% in QE0317. Just as importantly, DVHA promptly answered the calls that were transferred; 97% of transferred calls were answered in five minutes in QE0318, compared to fewer than 60% in QE0317.

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days by October 2016 and 85% by June 2017. In QE0316, fewer than 60% of VHC requests were completed within ten days. In QE0317, more than 90% of requests were completed within ten days. In QE0318, more than 95% of VHC requests were completed within ten days.

System Performance

Throughout most of QE0318, the system continued to operate as expected. There was one hosting incident that resulted in more than a day of downtime in March, or 96.2% availability for the month. The system had 100% availability in January and February. The average page load time for the quarter was less than one second in each of the three months -- well within the two-second target.

In-Person Assistance

Vermont Health Connect was supported throughout the state by 266 Assisters (13 Navigators, 174 Certified Application Counselors or CACs, and 79 Brokers) in QE0318, up from 229 in QE0317. The CAC program was responsible for most of the growth, increasing by 55% over the last 12 months by training and certifying staff in hospitals, health centers, and other community organizations. Other CACs work for a Department of Corrections contractor and focus on helping connect justice-involved individuals with coverage. Overall, Navigators and CACs largely focused on helping Vermonters with Medicaid renewals, particularly new Vermonters for whom English is not their primary language and others with accessibility challenges.

Outreach

Health insurance literacy was also an outreach focus throughout QE0318. DVHA-HAEEU engaged health care providers, libraries, state offices, and legislators in helping Vermonters understand the importance of responding to Medicaid renewal notices and comparing options for qualified health plans. Vermont Health Connect's website continued to be a key source of information for current and

prospective customers alike, receiving more than 155,000 visits in the quarter. The Plan Comparison Tool, which helps customers estimate total costs of coverage based on family members' age, health, and income, was used in more than 12,000 sessions during the quarter. Both of these volumes were down from the previous year, largely because Open Enrollment 2017 extended a month into QE0317 while Open Enrollment 2018 ended prior to the start of QE0318.

Self-Service

During QE0318, DVHA-HAEEU continued to promote self-service options for customers to pay their bills, report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through monthly recurring payments rather than one-time payments. Self-serve applications comprised nearly half (45%) of all applications in QE0318, compared to just over a third in the three months after the previous year's open enrollment. More than 50% more customers made recurring payments in QE0318 than did so the previous year, which in turn was more than triple the year before that (an average of more than 5,200 recurring payments per month in QE0318, 3,200 in QE0317, and fewer than 1,000 in QE0316).

ii. Choices for Care and Traumatic Brain Injury Programs

Key updates from QE0318:

- National Core Indicators implementation is progressing well.
- Program Integrity work identifies improvement opportunity.
- Wait Lists

National Core Indicators for Aging and Disabilities (NCI-AD)

DAIL's Adult Services Division (ASD) is excited to launch the National Core Indicators for Aging and Disabilities (NCI-AD), joining DAIL's Developmental Disabilities Services Division in their continued use of the National Core Indicators for Developmental Disabilities (NCI-DD).
In January 2018, ASD worked with contractor Vital Research to implement the NCI-AD tool for Choices for Care and the Traumatic Brain Injury programs. A Vermont specific NCI website was created by Vital Research to provide citizens and provider agencies information and assistance regarding the NCI process in Vermont.

Choices for Care (CFC) Program Integrity

DVHA identified a Medicaid claims edit (530) that was not consistently preventing Home and Community Based Services (HCBS) Medicaid claims to be paid for people who had a co-occuring nursing facility stay. Action has been taken by DVHA to fix the edit problem and analysis of all overlapping claims from the last two years indicated that only 18 out of 205 (9%) CFC claims errors required Vermont to take action to recoup approximately $10,000.

Wait Lists

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

Choices for Care Moderate Needs Group (MNG) services are not an entitlement and instead are limited by funding which is allocated to providers and managed at the local level. This requires that providers establish a wait list when funds are spent in their region. As of March 31, 2018, providers report that approximately 800 people are waiting for help to pay for homemaker services statewide and eight people are waiting for help to pay for Adult Day services. Though total funding for MNG services was increased to eliminate the wait list in SFY2015, it is important to note that eligibly for Moderate Needs is quite broad which creates an opportunity for a very large number of Vermonters to be eligible. Therefore, it is expected that unless the eligibility criteria were to be modified, wait lists for the limited Moderate Needs funding will continue for the foreseeable future.

As of March 31, 2018, there was one person waiting for admission to the TBI program due to funding availability. DAIL is working hard to find alternative services options for people waiting for TBI services. For some people, this may include participation in the Choices for Care program.

Brain Injury Association of Vermont (BIAVT) receives responses to state needs assessment.

As reported in the last quarterly report, in August 2017 the Brain Injury Association of Vermont (BIAVT) launched its state needs assessment survey. Approximately 165 people responded, including survivors, family/friends and providers. Responses will be evaluated and used to help shape the development of TBI services in Vermont over the next five years.

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

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

iii. Developmental Disabilities Services Division

Key updates from QE0318:

- Developing new payment model
- Waitlist

New Payment Model in Development

The Developmental Disabilities Services Division (DDSD) and DVHA have initiated a project to explore a new payment model for Developmental Disabilities home and community-based services (HCBS). The program has grown significantly over the years from several hundred to several thousand participants. Overall, the goal of this payment reform project is to create a transparent, effective, and administrable payment model for Developmental Disabilities Services that aligns with the broader payment reform and health care reform goals of AHS.

A workgroup including State agency staff, provider agencies, advocacy organizations, families and recipients started meeting bi-weekly in December of 2017 to develop a new payment model. The goal

is to have a new payment model implemented by January 1, 2020. Ongoing work will be required, including seeking any needed CMS approval.

Wait List

DDSD collects information from service providers on individuals who request funding for HCBS and other services including Targeted Case Management (TCM), Family Managed Respite (FMR), Flexible Family Funding (FFF) or Post-Secondary Education Initiative (PSEI). The information is gathered the State from providers to determine individuals with developmental disabilities (DD) who are waiting for DD services but are not currently eligible. HCBS funding priorities are the method by which Vermont prioritizes who will receive caseload funding allocated annually by the legislature. Individuals are placed on the waiting list if they meet the following criteria:

1. HCBS Applicants: Individuals with DD who are clinically and financially eligible but who do not meet a funding priority for HCBS and have been denied services in whole or in part.
2. Individuals who are clinically and financially eligible for TCM, FMR, FFF or PSEI, but for whom there are insufficient funds.

As of 3/30/18, there were no individuals who met a HCBS funding priority who were waiting for services that helps address the need related to the funding priority. The full set of waiting list data is collated on an annual basis and will not be available until after the end of the fiscal year (6/30/18). This information will be provided in the 2018 Annual GC Report.

iv. Global Commitment Register

Key updates from QE0318:

- 15 policies were posted to the GCR in Q1 2018.
- Since the Global Commitment Register (GCR) launched in November 2015, 133 final GCR policies have been publicly posted.

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

The GCR listserv is a group of about 450 interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. A policy change in the GCR could be a change made under the authority of the waiver, a proposed waiver amendment or extension, an administrative rule change or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not clearly answered in current policy.

Health care policy stakeholders are notified via email every time a proposed or final policy is posted to the GCR; an email is also sent when policy clarifications are posted. Stakeholders have an opportunity

to provide comments on proposed GCR policies before the policies are made final. Comments received are posted in the GCR online. The GCR emails are also distributed to members of the Medicaid and Exchange Advisory Board.

A combined total of 24 policies were posted to the GCR this past quarter. This includes 12 proposed changes, 10 final changes, and two clarifications. Changes to rates and/or rate methodologies accounted for more than half of the changes, with the remainder being changes to clinical policies, expansion of covered services such as silver diamine fluoride application for cavities, and notice of the annual Post Award Forum for this waiver.

AHS also issued public notice through the GCR of its plan to submit an amendment request to CMS for the Global Commitment 1115 Demonstration waiver. The proposed amendment request seeks to ensure the continued availability of treatment supports that effectively prevent and treat opioid use disorder (OUD) and other substance use disorders (SUD), and promote a comprehensive and integrated continuum of mental and physical health, OUD/SUD treatment, and long-term services and supports for all Vermonters. Specifically, Vermont is seeking a waiver of all restrictions on payments to Institutions for Mental Disease (IMDs) for individuals ages 21 to 64. The target effective date of this change is 7/1/18.

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

IV. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE0318:

- eQ Health, VCCI care management vendor will deliver a final report on estimated annualized cost savings as compared to the control group in May 2018.
- Report on Inpatient and Emergency Department utilization decreased post-VCCI enrollment for the 3rd and 4th quarter of SFY 2017.
- Enrollment of new members up 25% from prior quarter.
- VCCI has started user acceptance testing on clinical reports. VCCI continues to work with the Vendor to design reports on clinical, financial and performance metrics to be delivered in June 2018.
- A contract for an interface with VITL has been completed. The goal is for data to be sent into the eQ Suite in June 2018.
- VCCI and Blueprint working together on improved integration and alignment in providing case management and care coordination services to Vermont's most vulnerable people.

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

The VCCI is a component of DVHA's health care reform goals and its supporting strategic plan. The VCCI employs 20 licensed field-based case managers and 2 non-licensed professional staff operating in a decentralized model statewide, ensuring resources are available in each local community throughout the state. The VCCI is designed to identify and assist high risk/high cost, medically complex Medicaid members with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower members to eventually self-manage their chronic conditions. A significant effort is placed on facilitating and supporting Medicaid member identification, access and use of a Medical Home for receipt of primary care.

For the past 10 years, The VCCI has used a holistic model of evaluating and supporting improvement in medical and behavioral health, as well as identification of socioeconomic issues that are barriers to sustained health improvement. Each member enrollment begins with a General Survey which assesses preventive screenings; behavioral health risk; current health status; status of housing/transportation/financial security/need for interpretative services and initial goals. Individualized plans of care are developed in collaboration with member and primary care provider and implemented throughout enrollment. VCCI case managers work with a multitude of partners/agencies in a team based, member centered approach to help support optimal health/health improvement. VCCI case managers strive to meet with members in their own environments; which may range from their home, homeless camps, shelter, in the park-and-ride where the member is currently living in their car. Meeting the members literally where they are at, lends demonstration of member's real experience in ability/challenges in managing their health.

The top 5% of VCCI-eligible Medicaid members account for approximately 39% of Medicaid costs and a disproportionate number of hospital admissions and readmissions. The new AHS Enterprise MMIS/care management vendor utilizes the Johns Hopkins evidence based predictive modeling and risk stratification software to support population selection and related eligibility for services. This new model will enhance VCCI's ability to identify members based on both past cost profiles and anticipated future utilization, risks and costs, and intervene earlier in order to track the clinical and financial improvements. Excluded populations currently include dually eligible individuals, those receiving other waiver services and CMS-reimbursed clinical case management. There is an effort underway to assess and identify opportunities to expand the population that VCCI serves.

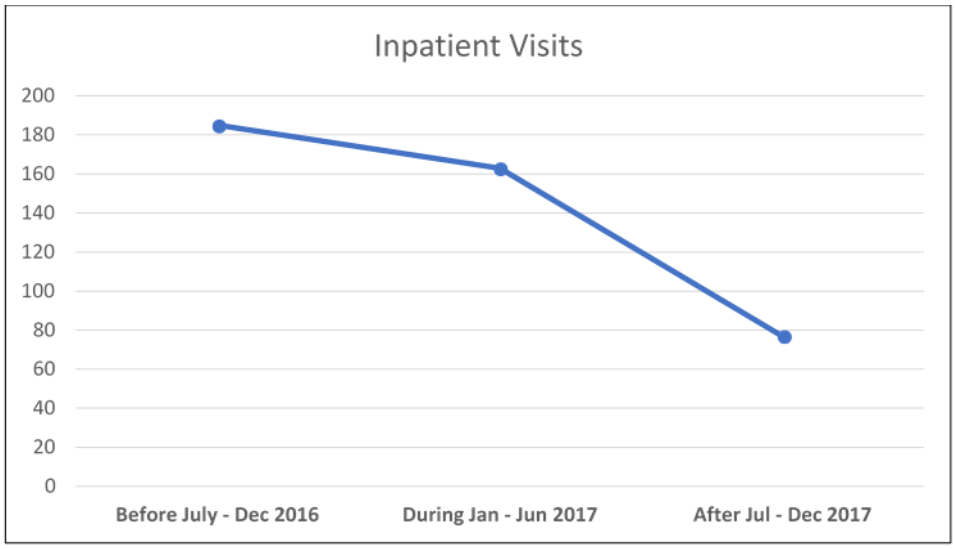
Prevention of inpatient readmissions is a priority of the VCCI and to help support members in their transition from an inpatient stay back out into their communities. The VCCI deploys case managers to hospitals and facilities to serve as liaisons to the VCCI case management services. The focus of this work is to identify members, meet with them when close to discharge, collaborate with hospital case managers – all prior to member discharge. These efforts strive to facilitate safe transitions of care to include medication reconciliation and medical/behavioral health appointment follow up toward reductions in 30-day readmission rates. VCCI also has embedded staff in high volume Medicaid medical homes to provide "on site" case management to the Medicaid population of that practice. In this first quarter of 2018, VCCI embedded a nurse case manager within a primary care office in Central Vermont; this was at the request of the medical home.

This past quarter, the development of program reports around clinical, cost, and performance was a priority of the VCCI. The preliminary cost savings report showed an annualized cost savings for 2016 - the first full year the system was operational. This report was done comparing total costs and total utilization amongst a control group (non-VCCI intervened) and Members that were enrolled in the

program for more than 1 month. The report only analyzed ~40% of enrolled members. The report showed that the VCCI Case Management services provided to members had a positive financial impact. The average medical costs for the intervened group in the pre-enrollment period were found to be statistically greater than the post-enrollment period. A comparison of the utilization trends among the intervened group and the control group also showed a positive impact of the program on patient outcomes as an annualized savings. Further analysis also showed the VCCI eligible population migrating toward lesser morbidity and total cost. This report will be recalculated to allow for a full 14 months of claims processing with an expected delivery of May 2018.

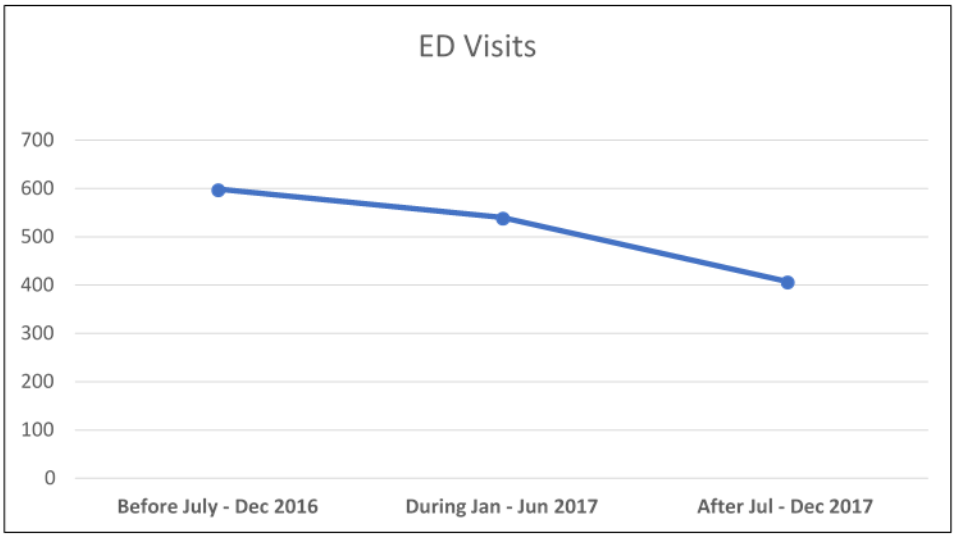
Updated reports pulled by the VCCI Data Analyst demonstrated a continued reduction in both IP and ED utilization on the VCCI intervened population; the trend in decrease has been consistently demonstrated over the past 3 reporting quarters. The report reviewed utilization 6 months prior to VCCI intervention, during VCCI intervention and 6 months post-intervention. This review looked at 312 members that were case managed and then closed between 1/1/2017-6/30/2017. The final data showed a significant decrease in the number of inpatient visits from 185-77; and a decrease in the inpatient visit per thousand from 593 to 247 **(Figure 1).** The number of ED visits also dropped from 599-408; and ED visit per thousand went from 1,920 to 1,308 **(Figure 2).**

Figure 1 . Inpatient Visits by VCCI Intervened Population



Time Frame	IP Visits	IP Visits/1000	Pd + WHP
Before July - Dec 2016	185	593	$1,689,041
During Jan - Jun 2017	163	522	$1,318,706
After Jul - Dec 2017	77	247	$679,211

Figure 2. Emergency Department Visits by VCCI Intervened Population



Time Frame	ED Visits	ED Visits/1000	Pd + WHP
Before July - Dec 2016	599	1,920	$629,509
During Jan - Jun 2017	540	1,731	$539,182
After Jul - Dec 2017	408	1,308	$323,630

Enrollment

For Quarter 1 2018, VCCI enrolled 222 unique members into VCCI; which is a 25% increase from last quarter. The hiring of a FTE RN for Windham County may account for some of the new enrollment count; in addition to the end of the holiday season. Another CM position continues to be under recruitment. VCCI anticipates that when this position is filled, it will help to support ongoing enrollment of vulnerable Medicaid members in need of intensive case management services.

The AHS Enterprise Care Management solution, eQ Health, has been operational for 2 years. There is continued design, development and implementation (DDI) being done. This DDI phase will finish in June of 2018. Work has begun on pursuing CMS certification of the system, with a CMS site visit and evaluation anticipated for the end of Calendar year 2018.

DVHA's Clinical Operations Unit and the Quality Improvement Unit have been utilizing eQ Health for direct referrals to VCCI Case Managers to eliminate the need for manual workarounds and to provide the opportunity for timelier outreach to members post discharge. This has enhanced the volume of warm transfers of complex members to the VCCI for managing care transitions and related decline in hospital readmission rates.

The VCCI management team and data team continue to work with the technical team toward receipt of biomedical and immunization data feeds from the HIE into the Care Management eQ Suite. This data resource for 100% of Medicaid members will enhance the clinical staff's ability to effectively identify need and manage care based on member's treatment of chronic conditions and management of the

condition toward evidence-based treatment and care goals. It is anticipated that this will be operationalized in June 2018. This data will also assist DVHA in evaluating the ACO. Strategic alignment of work between VCCI and the Blueprint for Health has begun. Ongoing discussions include exploring a VCCI population expansion, potential identification of shared tools, closer collaboration with the NCQA certified advanced practice medical homes and local Community Health Teams. Discussion has also included exploring the ability to look at the total cost of care of vulnerable members; recognizing that VCCI case management services may also have the potential to impact costs across the Agency of Human Services departments – Department of Corrections; Department of Children and Families; Department of Mental Health. Early preliminary efforts at seeing what data is available has begun this quarter. The goal of this alignment is to reduce redundancies, enhance communication/collaboration among the teams, and support development of a single, shared plan of care.

ii. Blueprint for Health

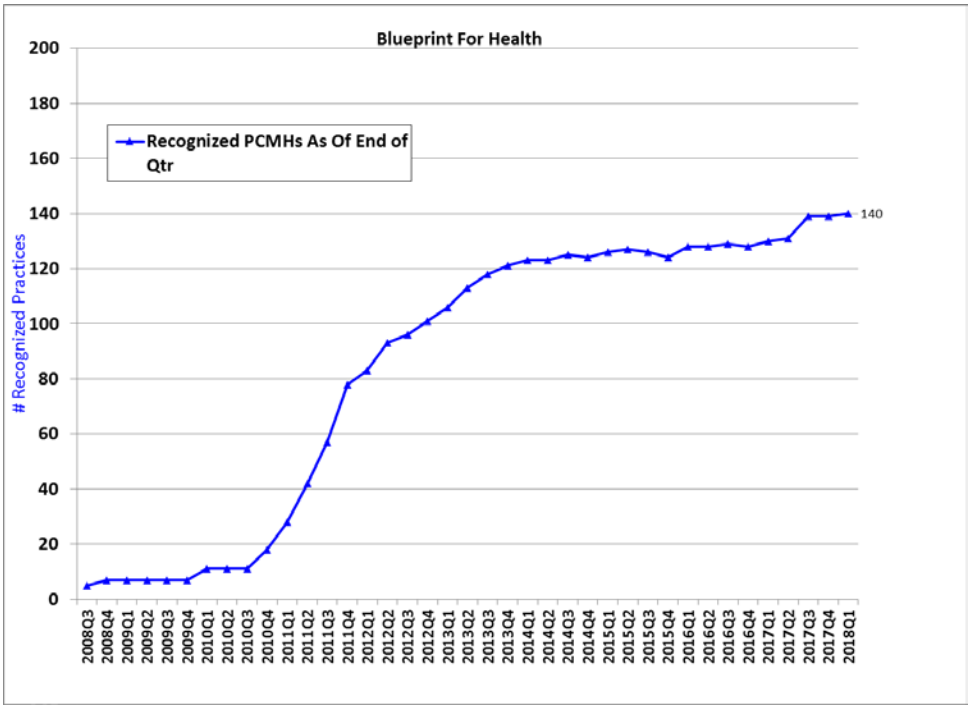
Key updates from QE0318:

- One new practice joined the Blueprint for Health program effective 2/1/2018, bringing the total number of Patient-Centered Medical Homes in Vermont up to 140.
- The opening of the Opioid Treatment Program (Hub) in Northwestern Vermont in July of 2017 has decreased the waiting list within this region from 189 individuals as of October 2016 to 15 individuals as of February 2018.
- Increased access to treatment for patients with opioid use disorder: 3,403 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of February 2018, and 2,761 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of March 2018.
- Increased access to enhanced health and psychosocial screening along with comprehensive family planning: Women's Health Initiative practices served a total of 18,192 patients in 2018-Q1.

<u>Patient Centered Medical Homes</u>

In the past quarter, the Blueprint for Health program has had a net increase of one NCQA-recognized primary care practice. That one practice began engaging with NCQA and joined the Blueprint as Patient-Centered Medical Homes on 2/1/2018: SVMC Pownal Campus. The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. The number of Blueprint PCMH practices as of the end of the quarter was 140.

Figure 3. Patient Centered Medical Homes



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

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

i. 01/2013 - 12/2013

ii. 07/2013 - 06/2014

iii. 01/2014 - 12/2014

iv. 07/2014 - 06/2015

v. 01/2015 – 12/2015

vi. 07/2015 – 06/2016

vii. 01/2016 – 12/2016

Practice and HSA profiles for the data period 01/2016 – 12/2016 were produced and distributed in December 2017. The information in those profiles give practices an overview of total utilization and expenditures as compared to peers and the rest of the state. Vermont HSA data profiles, including the latest ones for the data period 01/2016 – 12/2016, are posted at http://blueprintforhealth.vermont.gov/community-health-profiles.

Hub & Spoke Program

Vermont's Hub and Spoke program represents the collaborative efforts of the Blueprint for Health, Department of Vermont Health Access, Vermont Department of Health, Hub and Spoke staff, community providers, and community leaders to create a coordinated, comprehensive approach to addressing the factors that contribute to the complexity of opioid use disorder. The Hub and Spoke model integrates programs providing higher intensity treatment in regional Opioid Treatment Program (OTP, or "Hub") settings with programs offering lower intensity treatment in general medical settings, in Office-Based Opioid Treatment (OBOT, or "Spoke") programs.

Quarterly Highlights

- Increased access to treatment for Vermont residents with Opioid Use Disorder (OUD): 3,403 clients received treatment at Hubs (Opioid Treatment Programs, as of February 2018) and 2,761 Medicaid beneficiaries were served by Spoke (Office-Based Opioid Treatment) practices as of March 2018.

- Medication Assisted Treatment (MAT) is being offered across more than 80 different practices and by 224 medical doctors, nurse practitioners and physician assistants and 61.60 FTE licensed, registered nurses and Master's-prepared, licensed mental health / substance use disorder clinicians working as a team to offer medication assisted treatment and provide Health Home services for Vermonters with opioid use disorder (as of March 2018).

- A collaborative team, comprised of Blueprint for Health, Vermont Department of Health – Division of Alcohol and Drug Abuse Programs and University of Vermont Medical Center Addiction Treatment Program staff, was convened for the design and delivery of learning sessions intended to enhance best practice adoption by providers and practice teams; learning sessions in the first quarter focused on complex clinical considerations, such as polysubstance use, the perioperative management of pain, and pregnancy in patients receiving medication assisted treatment, and the appropriate use of urine drug testing as a therapeutic tool to support continued, successful engagement in treatment.

- The Blueprint for Health continues to work with the Division of Alcohol and Drug Abuse Programs of the Vermont Department of Health on many initiatives, including the Initiation and Engagement in Treatment performance improvement project, in order to provide an interagency, comprehensive and data-driven approach to addressing the opioid crisis in the State of Vermont. The team has been designing its next project during the first quarter of 2018; the project will focus on assessing access to treatment in preferred provider (for substance use disorder treatment), Spoke, and private practitioner settings across the State to inform selection of quality improvement initiatives for improved initiation and engagement in treatment for Vermonters with substance use disorders.

- The Opioid Coordination Council, created by Governor Scott's Executive Order 02-17, released its recommendations in January of 2018 for system improvements that will positively impact Vermont's ability to appropriately address substance use disorder, including expanding screening, brief intervention, and referral to treatment throughout primary care and emergency department settings, development of non-opioid, non-pharmacologic pain management

therapies and patient education, and strengthening Vermont's network of recovery centers and recovery coaches.

Figure 4. MAT-SPOKE Implementation January 2013 – March 2018 Staffing

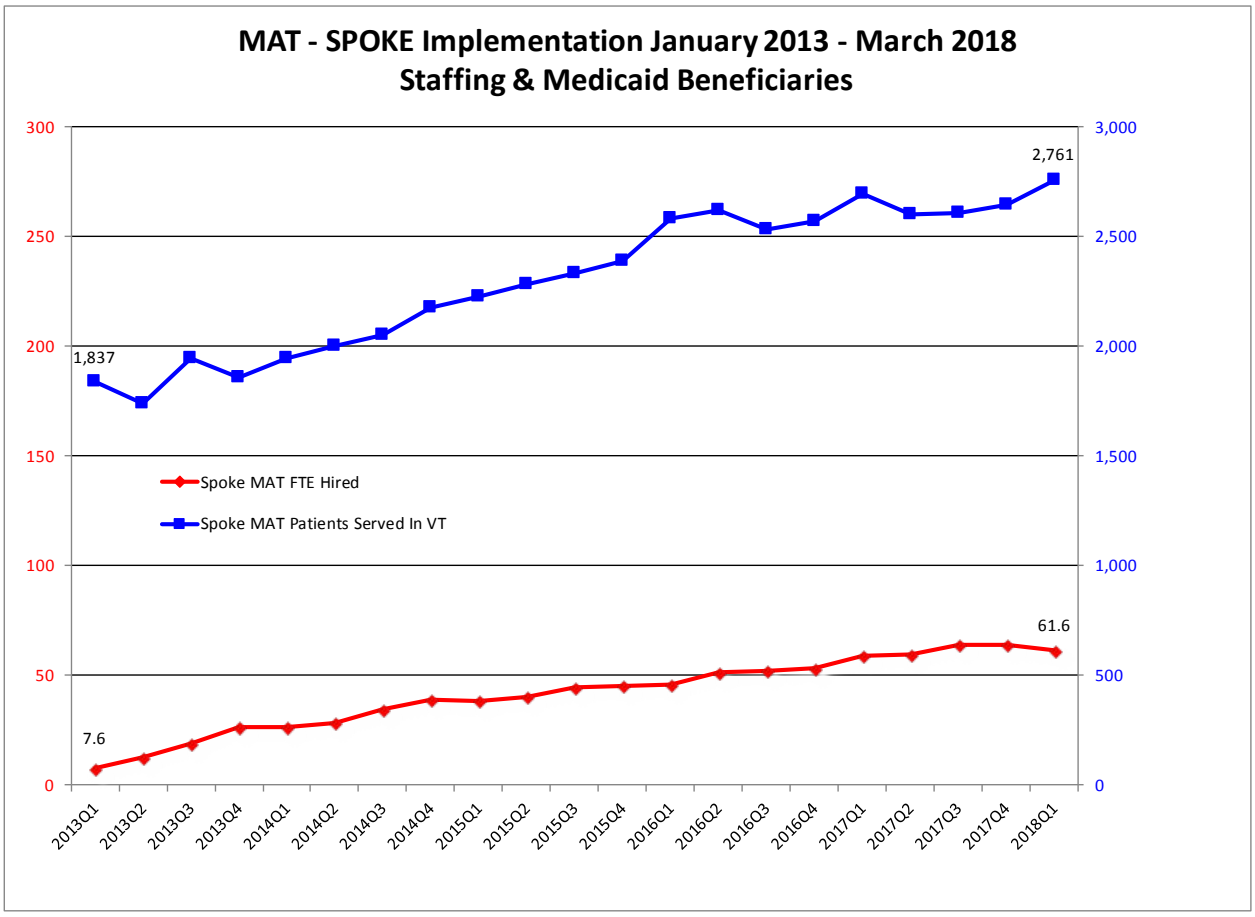


Figure 5. MAT-SPOKE MDs Prescribing Buprenorphine January 2013 – March 2018

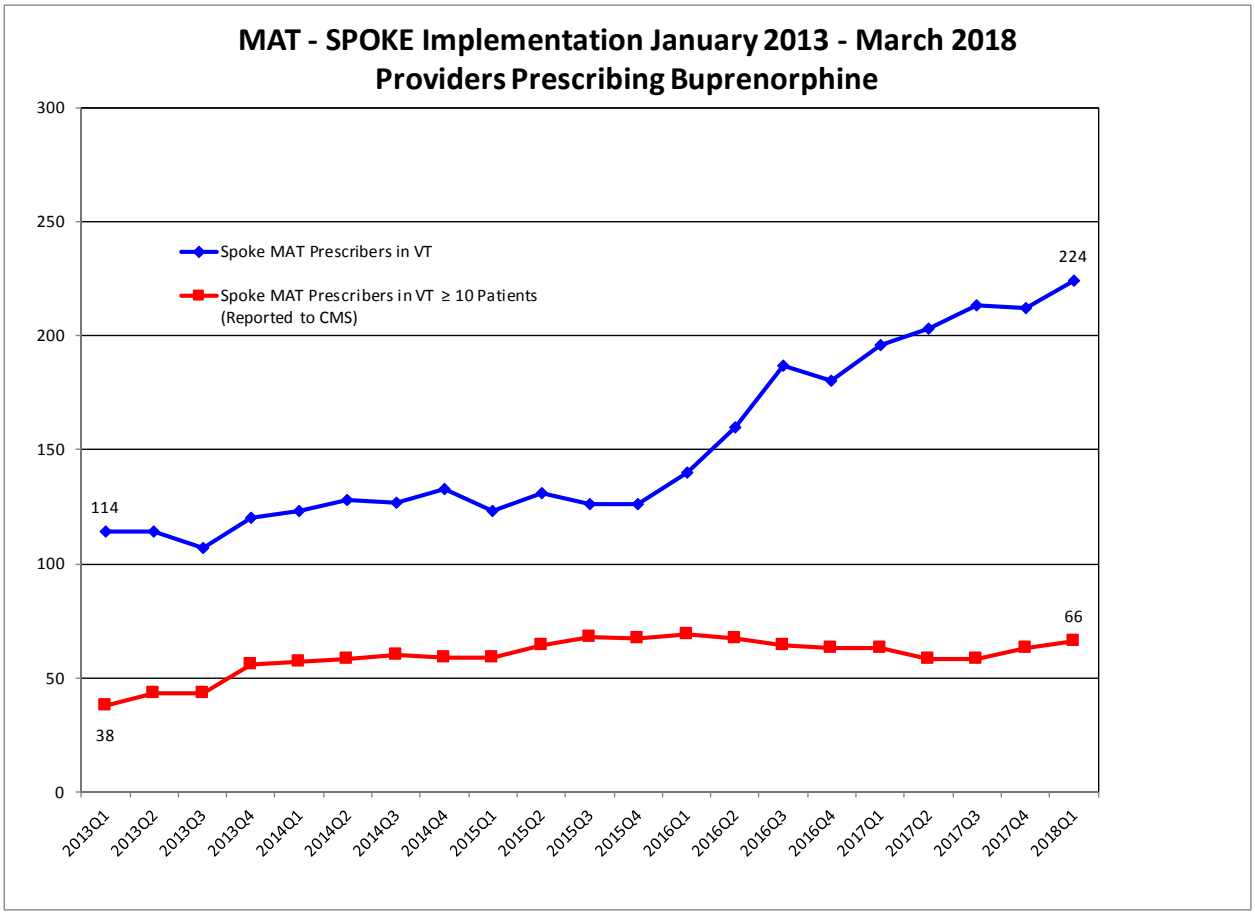
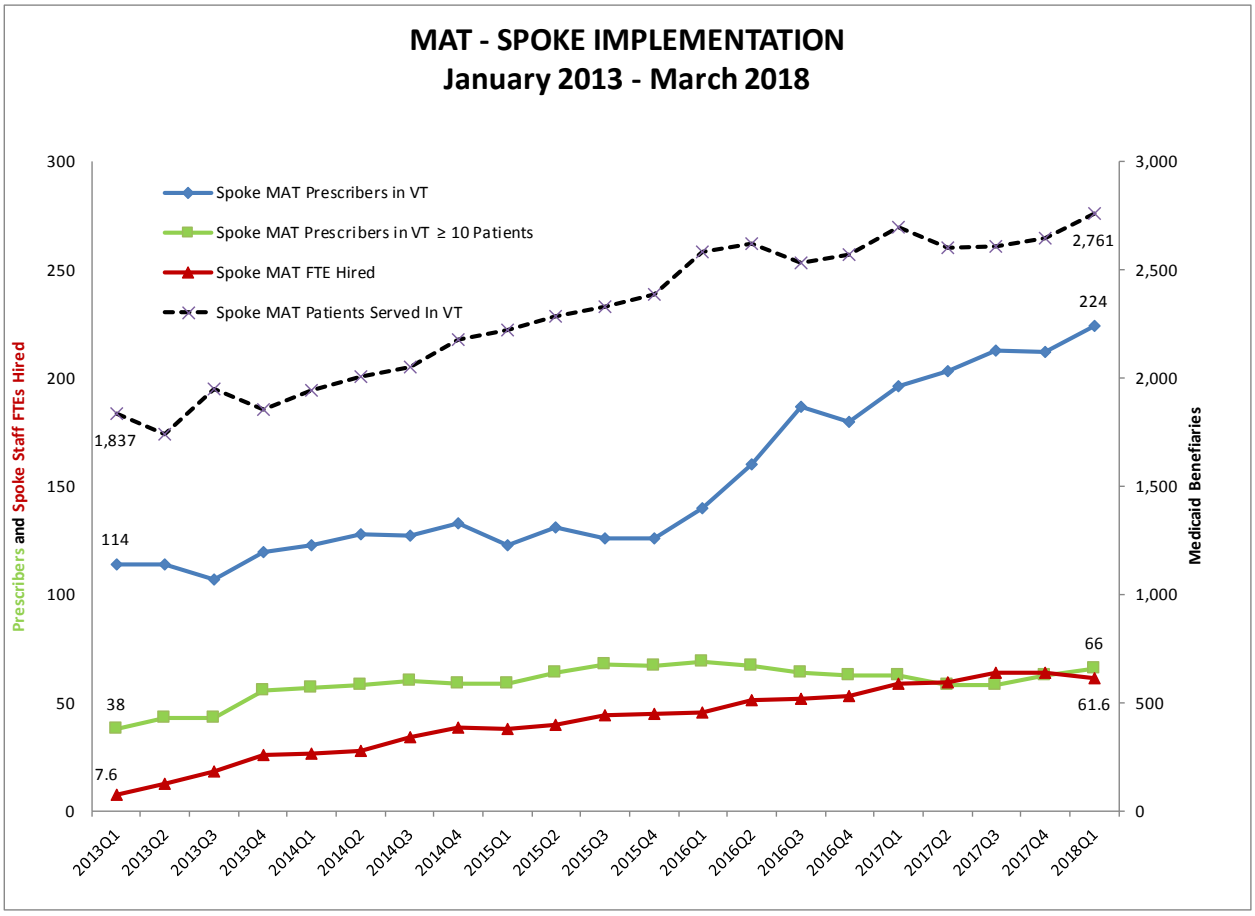


Figure 6. MAT-SPOKE Implementation Jan 2013 – March 2018



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

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

Table 1. Hub Implementation as of February 28, 2018

Region	# Clients	# Buprenorphine	# Methadone	# Vivitrol	# Receiving Treatment but Not Yet Dosed	# Waiting
Chittenden, Addison	1014	320	694	0	0	0
Franklin, Grand Isle	269	94	175	0	0	15
Washington, Lamoille, Orange	510	196	314	0	0	0
Windsor, Windham	430	146	282	0	2	0
Rutland, Bennington	421	95	311	1	14	0
Essex, Orleans, Caledonia	759	203	555	1	0	0
Total	3403	1054	2331	2	16	15

Note: The Franklin/Grand Isle location opened in July 2017. Some clients are transferring from the Chittenden/Addison hub to the Franklin/Grand-Isle hub.

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

Table 2. Spoke Implementation as of September 30, 2017

Region	Total # provider prescribing to pts	# provider prescribing to ≥ 10 pts	Staff FTE Hired	Medicaid Beneficiaries
Bennington	10	4	5.2	253
St. Albans	23	9	9.1	428
Rutland	16	7	5.15	352
Chittenden	80	14	15	545
Brattleboro	15	5	3.5	139
Springfield	7	2	1.55	52
Windsor	10	5	4	217
Randolph	5	4	3.1	111
Barre	18	6	6.45	219
Lamoille	16	5	3.8	215
Newport & St Johnsbury	12	3	2	99
Addison	11	4	2.25	109
Upper Valley	5	2	0.5	22
Total	224*	66*	61.6	2,761

Table Notes: Beneficiary count based on pharmacy claims for Buprenorphine, Naloxone, Bunavail, Butrans, Suboxone, Zubsolv and Vititrol January – March, 2018; an additional **284** Medicaid beneficiaries are served by **38** out-of- state providers. Staff hired based on Blueprint portal report 4/11/18. *4 providers prescribe in more than one region.

Women's Health Initiative

The Women's Health Initiative launched January 1, 2017 to women's health practices, including obstetrics, gynecology, midwifery, and family planning providers, and expanded eligibility to Patient Centered Medical Home (PCMH) primary care practices on October 1, 2017. The Blueprint was supported by the Department of Vermont Health Access to develop this initiative and worked collaboratively with the Vermont Department of Health and a broad group of content experts and community stakeholders to design interventions aimed at helping women be well, avoid unintended pregnancies, and build thriving families.

The Blueprint for Health continues to work collaboratively with the Vermont Department of Health and community organizations, providers, and practices to support Vermont women, children and families to have healthier lives through the implementation of strategies designed to increase the rate of intentional pregnancies and encourage systematic early identification of, and appropriate intervention for, mental health and substance use disorders and health-related social needs (interpersonal violence, food insecurity and housing instability).

Vermont's Women's Health Initiative has focused on increasing access to comprehensive family planning counseling, increasing access to long acting reversible contraceptives for same-day insertions (when chosen by the patient and clinically appropriate), and improving systematic psychosocial screening, brief intervention, brief treatment, referral to more intensive treatment and/or support services as appropriate for domains that have been demonstrated to negatively impact health, but that can be addressed through strengthened partnerships between women's health and primary care practices and community organizations.

Each women's health practice is supported by a licensed, Master's-prepared mental health clinician (typically a licensed, clinical social worker), funded through the Women's Health Initiative, who is embedded into the practice for screening, brief intervention, brief treatment, referral to more intensive treatment and services, and follow-up; Patient-Centered Medical Home primary care practices are supported by their area Community Health Team.

Quarterly Highlights

- The Women's Health Initiative is approaching statewide coverage, as all but one Health Service Area that has a specialized women's health practice is now represented in the Women's Health Initiative. Continued expansion of the Women's Health Initiative is expected among Planned Parenthood of Northern New England women's health practices and Blueprint Patient-Centered Medical Homes (PCMHs), however no new practices joined the Women's Health Initiative within the past quarter.
- The Women's Health Initiative now includes 35 participating practices (20 women's health and 15 primary care) across the State of Vermont.
- Learning sessions were held to further develop crucial clinical-community linkages for early identification and intervention of health-related social needs were held in January (housing instability) and March (food insecurity) of 2018 with 11 community teams from across the State of Vermont participating.

- A skills-based training for providers on Long-Acting Reversible Contraceptive Insertion and Removal (including the FDA-approved Nexplanon training led by MERCK) was completed in January of 2018.

- A 6-month quality improvement Learning Collaborative was designed to support 12 Women's Health Initiative practice teams in improving clinical workflows for increasing access to comprehensive family planning and screening, brief intervention, and navigation of services. The collaborative included 2 webinars that were completed in March of 2018 for assessing and addressing mental health and substance use disorders in the practice setting.

- The Blueprint for Health, in collaboration with an analytics contractor, Onpoint Health Data, is developing data profiles that will provide valuable information regarding demographic and health status information, and outcome measures for the Women's Health Initiative and will be used to guide future program improvement initiatives.

Figure 7. Women's Health Initiative Practices

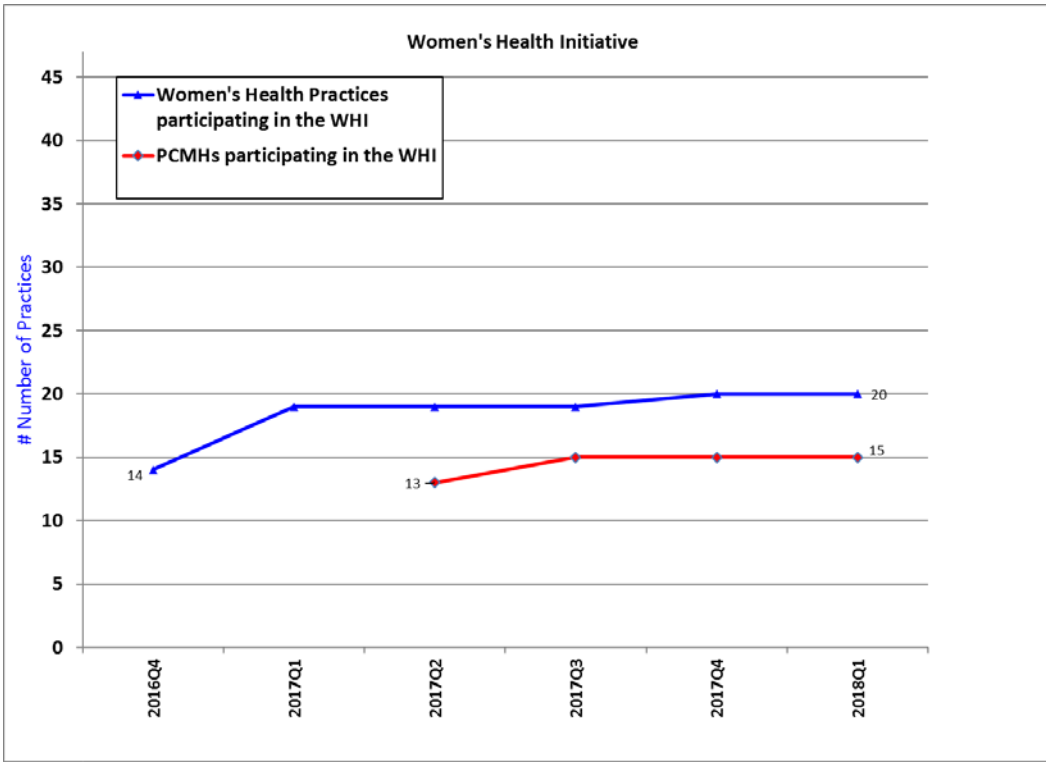


Figure 8. WHI Implementation January 2017 – March 2018 Staffing & Patients

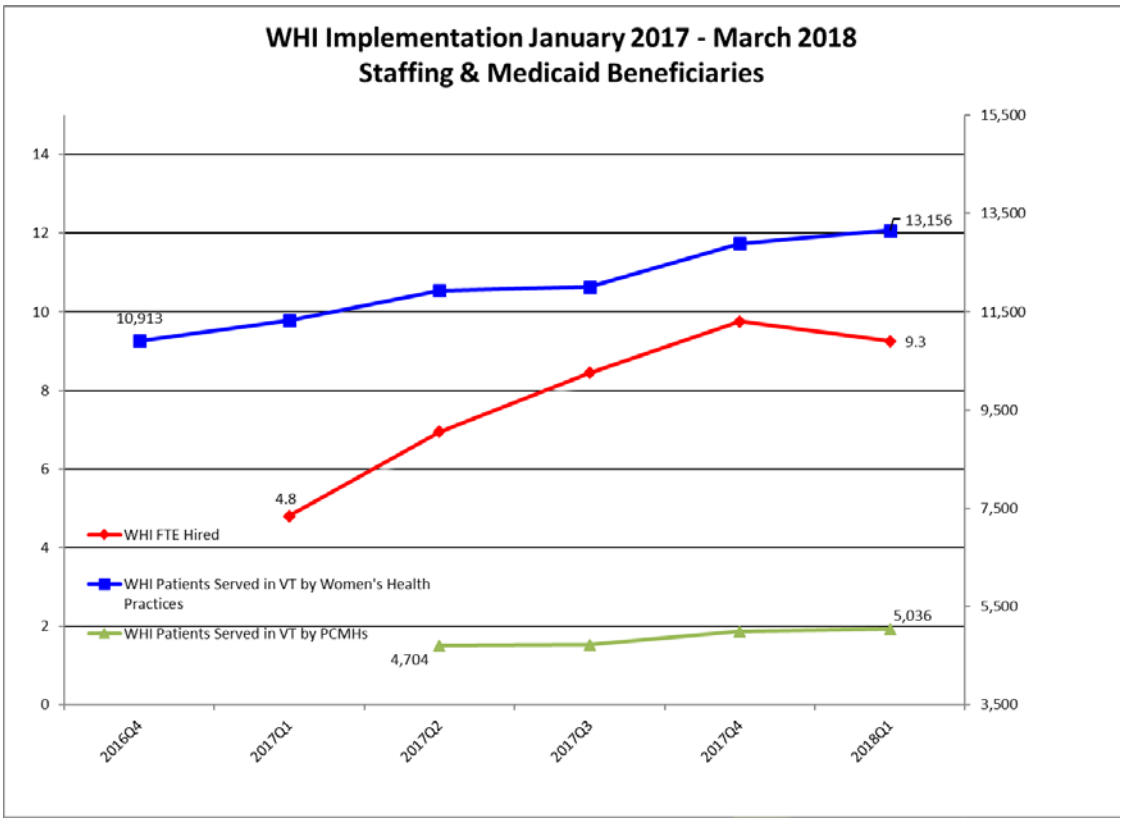


Table 3. WHI Implementation as of March 31, 2018

Region	Total # Women's Health WHI Practices	Total # PCMH WHI Practices	Staff FTE Hired	Medicaid Beneficiaries – Women's Health Practices	Medicaid Beneficiaries - PCMHs
Barre	1	1	1	988	508
Bennington	1	1	0.5	1,003	57
Brattleboro	1	0	1	480	0
Burlington	5	5	1	3,830	1,806
Middlebury	2	0	0.5	1,023	0
Morrisville	1	2	0.5	565	464
Newport	0	0	0	0	0
Randolph	3	0	0.5	567	0
Rutland	2	1	1.5	1,885	214
St. Albans	2	0	1	1,348	0
St. Johnsbury	1	2	0.75	982	662
Springfield	1	3	1	485	1,325
Upper Valley	0	0	0	0	0
Windsor	0	0	0	0	0
Total	20	15	9.25	13,156	5,036

iii. Behavioral Health

Key updates from QE0318:

- Paper review transition
- Applied Behavior Analysis
- Pilot Project
- Team Care program

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric, detoxification, and substance abuse residential services for Medicaid primary beneficiaries. In 2017, the team completed the transition to paper reviews for all providers. This practice ensures member confidentiality and improved interrater reliability. The team has developed a system to ensure internal consistency and educate providers on documentation requirements. Team members also engage with discharge planners at inpatient and residential facilities to ensure timely and appropriate discharge plans. Care managers collaborate with other Departments to support coordination of care and assist in mitigating barriers to discharge. Through collaboration with Vermont Chronic Care Initiative (VCCI) partners, a referral process for VCCI services has been established. The referrals support continuity of care for new enrollees and members already receiving VCCI services. The referral process has been expanded to include members discharging from substance use disorder treatment.

In recognition of the inherent challenges in providing strong clinical documentation to justify admission and continued stay within 24 hours of admission, DVHA has engaged in a pilot project in which there is automatic initial authorization of 5 days for all members meeting the acute level of care criteria at the Brattleboro Retreat. This practice allows time for the assessment and formulation of an individualized plan of care and discharge plan for each member admitted. The team is closely monitoring trends to ensure appropriate utilization. A qualitative review was conducted on a sample of pilot project authorizations. The review found that the admissions would have been authorized under the previous system. There has been a slight decline in the average lengths of stay. This decrease allows for an increase in access and may be attributable to a stronger focus on discharge planning upon admission.

The Behavioral Health Team also manages the Team Care program (the lock-in program). A major review of clinical documentation and data to support ongoing inclusion in the program was completed. Members no longer needing Teamcare were notified of disenrollment. Standards for inclusion and disenrollment are being operationalized by the Team. Team Care program members are also referred to VCCI when appropriate. There have been no new referrals for inclusion in the Teamcare program this quarter. The lack of referrals may demonstrate success of the Vermont Prescription Monitoring System (VPMS) and new opiate rules associated with VPMS.

Behavioral Health Team members participate in the AHS Substance Abuse Treatment Coordination Workgroup. This workgroup strives to standardize substance abuse screening and referral processes throughout the Agency of Human Services. Team members also participate in monthly meetings with the VDH's Alcohol and Drug Abuse Prevention Division to coordinate efforts between the two departments to provide substance abuse services to Vermont Medicaid beneficiaries. Team members also participated in the SFI Interagency Team, Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF, and more) and the State Interagency Team.

The Unit also manages the Applied Behavior Analysis (ABA) benefit. The Autism Specialist, a member of the Behavioral Health Team, has worked collaboratively with the Policy Unit and sister Departments to evaluate and improve the program. DVHA is currently working on development of a new payment model that would continue to support members and providers, as well as attract new ABA providers to serve members. The Autism Specialist participates in the Autism Workgroup, which happens on a bi-monthly basis and includes community partners, including several ABA providers across the State. This meeting gives ABA providers the opportunity to ask questions and allows them to provide feedback directly to the Autism Specialist.

iv. Mental Health System of Care

Key updates from QE0318:

- Planning to decrease emergency department wait times and increase access to inpatient psychiatric level of care.
- Planning initiated for phase down of federal financial participation for Institutions of Mental Disease.
- Mental Health Delivery System and Payment Reform
- Through the Integrating Family Services structure, leadership is being provided in several areas that cut across multiple agency departments, such as:
    - Turning the curve on the number of children and youth in residential settings
    - Coordinating autism services and supports
    - Implementing the Child and Adolescent Needs and Strengths (CANS
    - assessing the functioning of early childhood supports and funding streams (known as Children's Integrated Services)
    - Supporting the statewide functioning of the Children's System of Care

<u>Increasing Psychiatric Inpatient Capacity and Addressing Emergency Department Wait Times</u>

During this quarter, the Department of Mental Health (DMH) discussed planning results from the prior quarter with the Vermont State Legislature that were required through Act 82 of the 2017-2018 legislative session, focused on the Mental Health System of Care and improving wait times for accessing inpatient psychiatric beds. Proposals supported by the Administration included expansion of mobile crisis outreach services and a proposal from the Agency of Human Services that describes a comprehensive, long-term proposal to build facility capacity, part of which supports reduced Emergency Department wait times through diversion to more appropriate facility and/or residential settings such as a new permanent secure residential recovery facility for mental health, a new forensic facility, as well as preliminary planning for sustaining capacity in Institutions of Mental Disease for primary psychiatric diagnoses. The legislature has debated all points in both the House and Senate. The next quarterly report will describe any resultant legislative action.

<u>Initial planning regarding CMSs' requirement to phase down federal financial participation (FFP) for Institutions of Mental Disease (IMD)</u>

During this quarter, AHS engaged in preliminary planning for the phase down of FFP for IMDs, working toward the required submission of a phase-down plan to CMS by 12/31/2018. AHS will be incorporating any legislative determinations into its phase down plan and has initiated preliminary

planning conversations with stakeholders to inventory all possible solutions. AHS is working with the goal to minimize impact to beneficiary access to appropriate levels care, with a focus on parity and sustaining federal financial participation. As noted above, the State is also working on increasing access to inpatient psychiatric levels of care and is significantly concerned that phase down of FFP for psychiatric IMD will precipitate additional crises of capacity.

Delivery System and Payment Reform Implementation

In addition to activities focused on inpatient and institutional level of care, DMH has been partnering with DVHA to develop delivery system and payment reforms for community-based providers of mental health services (i.e. "designated agencies). Over the last quarter, DMH has held weekly planning meetings with stakeholders to explore key concepts, values, and components of mental health reforms and has made considerable progress with development of a new payment model for both child and adult mental health services paid for through DMH, including outpatient services paid for through DVHA. The payment model was submitted to CMS for review and approval on 3/30/18 and describes two "bundled" or "episodic" case rates, one for children and one for adults, that are billed retrospectively, after a qualifying service has been rendered, and which payment then covers all additional services for the member in the month, regardless of quantity or complexity. Additionally, the payment model for these mental health services includes a value-based payment based on reporting for a set of measures that describe progress in terms of "how much", "how well" and "is anyone better off".

Integrating Family Services (IFS) Initiative

As of September 2017, the efforts of Integrating Family Services were structurally shifted into the Department of Mental Health Commissioner's office. The existing IFS grants will continue to be managed through the Department of Mental Health budget.

Integrating Family Services efforts began in 2008 with a position created in the Agency of Human Services Secretary's Office in 2010. From the beginning, the intent of integrating services for children and their families revolved around providing services, supports and treatment earlier to prevent more intense needs, to achieve better outcomes and spend funding more efficiently.

The initial IFS implementation site in Addison County began on July 1, 2012, and the second pilot region in Franklin/Grand Isle counties began on April 1, 2014. These pilots included consolidation of over 30 state and federal funding streams into one unified whole through one AHS Master Grant agreement. The State created an annual aggregate spending cap for two providers in Addison County (the designated agency and the parent child center) and one in Franklin/Grand Isle (this provider is both 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.

Through the IFS grants and larger payment reform work, AHS will continue to act on opportunities to improve quality and access to care, within existing budgets, using managed care flexibilities and payment reforms available under 42 CFR § 438 and the GC waiver. As well, the IFS pilots and lessons learned are informing the larger payment reform efforts underway in the Agency of Human Services.

Each IFS grantee reports on performance measures on an annual basis to show much, how well and is anyone better off. These measures were determined after a year-long stakeholder workgroup and were first utilized in the FY16 IFS grants. In both regions for the first year after implementation, there was

the ability to increase services for children with the funding allocation due to a decrease in administrative burden and streamlined documentation after the onset of IFS.

As well, both regions have been utilizing the Child and Adolescent Needs and Strengths (CANS) to look at the needs and strengths of children they are serving. The agencies are using this progress monitoring tool to track progress over time. They are showing that through supports and services children/youth are increasing in their strengths and decreasing needs. The caveat to this is that for children involved in the child welfare system it is taking longer to see positive results; not surprising given the fact that these children experience high levels of trauma, exposure to substances, and/or abuse and neglect. As well, data from both regions indicates that upon the first two years of implementing IFS due to the flexibility in their funding the agencies were able to serve more children and families.

The flexibility allowed by utilizing a case rate has allowed both regions to determine the need in their community and put their resources in those areas. This has meant serving more young children who have entered DCF custody, supporting higher numbers of adolescents using substances, supporting children on the autism spectrum and providing more population-health prevention and promotion activities.

v. Pharmacy Program

Key updates from QE0318:

- The Drug Utilization Review Board held two meetings on January 16, 2018 and February 20, 2018. Nine new drugs and thirteen therapeutic classes were reviewed, five RetroDUR reviews and two safety alerts were presented.
- Department of Vermont Health Access sent two provider communications on topics of Average Wholesale Price (AWP) Notification – Update Claims Reprocessing and Tamiflu-Influenza Season Update.

Pharmacy Benefit Management Program

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

Pharmacy Operations

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

- Pharmacy provider assistance - DVHA, Change Healthcare Technical and Clinical Call Centers.
- Liaison to Coordination of Benefits Unit/Part D Plan Team/Eligibility/Maximus to resolve issues. Vermont Department of Health (VDH)-Vaccine Program, Substance Abuse Program, Department of Mental Health (DMH) management of antipsychotics.
  - Works with Vermont Medication Assistance Program (VMAP), Children with Special Health Needs (CSHN) to assist in the management of the programs.

Clinical

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

Drug Utilization Review Board

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

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

Additionally, per State statute requiring the DVHA Commissioner establish a pharmacy best practice and cost control program, the DURB was designated as the entity to provide clinical guidance on the development of a Preferred Drug List for Medicaid beneficiaries. The DURB typically includes 10-12 members, who are appointed to two - year terms with the option to extend to a four - year term. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians and at least one-third of its members are licensed and actively practicing pharmacists, in addition to one member at large who is currently a nurse practitioner. Board members are recommended by the DVHA Commissioner and approved by the Governor.

Drug Utilization Review Board meetings occur eight times per year. In QE0318, the DURB held 2 meetings. Information on the DURB and its activities in 2018 is available: http://dvha.vermont.gov/advisory-boards.

340B Drug Discount Program

The 340B Drug Pricing Program resulted from enactment of the Veterans Health Care Act of 1992,

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

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

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

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

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

- Vermont Department of Health, for the AIDS Medication Assistance Program, Sexually-Transmitted Disease Drugs Programs, and Tuberculosis Program; these programs are specifically allowed under federal law.
- **Planned Parenthood of Northern New England's Vermont clinics**
- **Vermont's FQHCs**, operating 41 health center sites statewide
- **Berkshire Medical Center**
- **Brattleboro Memorial Hospital**
- **Central Vermont Medical Center**
- **Community Health Center of Burlington**
- **Copley Professional Services Group DBA Community Health Services of Lamoille Valley and affiliated with Community Health Pharmacy**
- Gifford Hospital
- Grace Cottage Hospital

- **Indian Stream Health Center (New Hampshire)**
- North Country Hospital
- Northeastern Vermont Regional Hospital
- **Northeast Washington County Community Health and affiliated with Community Health Pharmacy**
- **Northern Counties Healthcare and affiliated with Community Health Pharmacy**
- Northwestern Medical Center
- **Notch Pharmacy**
- Porter Hospital
- **Richford Health Center, Inc. (Notch) and affiliated with Notch Pharmacy & Community Health Pharmacy**
- Rutland Regional Medical Center
- **Southwestern Vermont Medical Center**
- **Springfield Hospital**
- **The Health Center and affiliated with Community Health Pharmacy**
- **UMass Memorial Medical Center**
- **University of Vermont Medical Center and affiliated with UVMMC Outpatient Pharmacies**

vi. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE0318:

- DVHA and OneCare executed a contract extension to the program for a 2018 performance year.
- DVHA began conducting financial reconciliation activities for the 2017 performance year, in order to determine financial and quality performance. Results will be available in early Q3 2018.
- Future program implementation will continue to be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

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

DVHA and OneCare entered into an agreement for the 2017 performance year as a pilot year with four possible one-year extensions to the program. Four risk-bearing hospital communities participated in the *Vermont Medicaid Next Generation* (VMNG) model for the pilot year: the University of Vermont Medicaid Center, Central Vermont Medical Center, Northwestern Medical

Center, and Porter Hospital, with additional participation from FQHCs, independent practices, home health providers, Designated Agencies, and skilled nursing agencies in the four communities.

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

DVHA and OneCare executed a contract amendment to extend the VMNG program into a 2018 performance year. Minimal programmatic changes were made, as the focus for the 2018 year is on growing the model and expanding the number of participating providers and attributed members, while maintaining alignment across payer programs as part of Vermont's All-Payer ACO Model. The number of risk-bearing hospital communities increased from four to ten for the 2018 performance year, with continued participation from other providers within the communities. The number of attributed lives for the 2018 performance year increased from approximately 29,000 lives to 42,342 lives.

DVHA began conducting financial reconciliation activities for its 2017 performance year in Q1 2018. Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2017 performance year. Reconciliation activities will continue through June, 2018, and final results will be available in early Q3 2018.

Quarterly reporting to the Vermont legislature on the VMNG program for 2018 will begin with a submission on June 15, 2018 and will continue for the duration of the performance year. DVHA's most recent submission to the Vermont legislature can be found here: https://legislature.vermont.gov/assets/Legislative-Reports/DVHA-ACT-25-VMNG-Report-to-Legislature-Dec-15-2017.pdf

DVHA and OneCare continue discussions of potential modifications for future program years, while remaining focused on aligning programs across payers in support of broader All Payer Model efforts.

V. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12 of the legislative budget for Global Commitment on the first business day of every month during the March 2018 quarter. This payment served as the proxy by which to draw down Federal funds for Global Commitment (GC). The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments and admin; please note admin is now claimed outside of GC neutrality) for the given quarter. After each quarterly submission, AHS reconciles what was claimed on the CMS-64 versus the monthly payments made to DVHA.

Regarding the budget neutrality format, AHS will manually move the ABD-Dual Medicaid Eligibility Group (MEG) cost quarterly this calendar year on the budget neutrality spreadsheet. As previously noted, the ABD Dual MEG is combined with the ABD MEG on the CMS-64 but needs to be categorized separately for budget neutrality per STC#62. There is no form to report the ABD-Dual MEG separately on the CMS-64; however, because it is subject to budget neutrality, it requires

AHS to manually move this cost in the "With Waiver" section to ABD-Dual on the budget neutrality spreadsheet. This adjustment was done for QE0318. The Budget Neutrality spreadsheet is tied quarterly to the CMS-64 Schedule C Expenditure Report.

CMS Regional Office noticed that a prior quarter adjusting (PQA) entry on the QE1217 CMS-64 extended beyond the allowable eight quarter time range. The PQA entry moved cost from GC Program to Investment. After further review, AHS determined that the entry was not necessary given that Program and Investment cost were treated the same during that period by the waiver. The PQA entry was removed from the QE1217 CMS-64 along with a couple other similar entries that were not necessary for the same reason but were within the two-year rule. The QE1217 CMS-64 was then recertified.

During this quarter, AHS received and responded to the CMS CY18 Round 1 Rate Setting questions. In order to align with the recently submitted SUD IMD 1115 Waiver amendment, AHS is preparing to amend the CY18 PMPM rates to include residential SUD IMD treatment costs which were previously excluded from the rate certification. The current waiver allows residential IMD SUD costs to be treated as Investments, so the costs were excluded from the original CY18 rates. In addition, the CY18 PMPM rates will be amended to reflect the inclusion of Woodside PRTF costs.

Finally, the Medical Loss Ratio (MLR) work per STC#23c will begin with DVHA in the coming period.

VI. Member Month Reporting

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

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

The table below contains Member Month Reporting for CY2018 including QE0318.

Table 4. Member Month Reporting – Calendar Year 2018

Demonstration Population	**Medicaid Eligibility Group**	**Total CY 2018**
1, 4*, 5*	ABD - Non-Medicare - Adult	**21,296**
1	ABD - Non-Medicare - Child	**6,586**
1, 4*, 5*	ABD - Dual	**63,331**
2	ANFC - Non-Medicare - Adult	**38,374**
2	ANFC - Non-Medicare - Child	**181,135**
	Medicaid Expansion	
7	Global RX	**20,274**
8	Global RX	**11,676**
6	Moderate Needs	**794**
	New Adults	
3	New Adult with out child	**120,377**

3	New Adult with child	**55,422**
	Total All	**519,265**
*** Long Term Care Group**	**Total CY 2017**	
4 only	ABD Long Term Care Highest Need	**8,404**
5 only	ABD Long Term Care High Need	**3,312**

PMPM Capitated Rates

The PMPM rates as set for 01/01/18 – 12/31/18 are listed below.

Table 5. PMPM Capitated Rates QE0318

	01/01/18-12/31/18
Medicaid Eligibility Group	
ABD Adult	**$ 1,543.54**
ABD Child	**$ 2,634.96**
ABD - Dual	**$ 1,655.26**
non-ABD Adult	**$ 518.79**
non-ABD Child	**$ 442.36**
GlobalRx	**$ 88.19**
New Adult	**$ 444.91**
Moderates	**$ 461.55**

Investments totaled $34,206,221 for QE0318.

VII. Consumer Issues

AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular program. The complaints received by Member Services are reported to DVHA (see Attachment 3). Member Services works to resolve the issues raised by beneficiaries, and the reports are seen by several management staff at DVHA.

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

The third mechanism to track consumer issues is the Office of the Health Care Advocate (HCA) report which is a comprehensive report of all contacts with beneficiaries (see Attachment 5). These include inquiries, requests for information, and requests for assistance. The HCA's role is to advocate for all

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

VIII. Quality Improvement

Key updates from QE0318:

- The Quality Unit continued to lead a formal CMS PIP project focused on improving substance use disorder treatment.
- The DVHA Quality Unit staff started two new QI projects.
- The clinical staff within the Quality Unit performed medical record abstraction for one HEDIS hybrid measure.

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

Managed Care Entity (MCE) Quality Committee

The MCE Quality Committee consists of representatives from all Departments within the Agency of Human Services that serve the Medicaid population. The committee continues to structure its work around the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care. During this time period, the Quality Committee followed the Annual Work Plan by reviewing the AHS Confidentiality Report and Quality Management Plan. The Committee also reviewed the Adult and Child CAHPS survey results. The only action suggested by the committee was to pursue offering the survey in different languages to increase access.

Managed Care Medical Committee (MCMC)

The Managed Care Medical Committee worked throughout the quarter on finalizing changes to two Clinical Practice Guidelines. The Medication Assisted Treatment Guidelines have been posted for comment. The Developmental Surveillance and Screening Guidelines are in the final revision stages. The MCMC has identified other guidelines for revision and a team has been identified for action. The process for monitoring ACO reports has been reassigned to a smaller group of subject matter experts. The team is also collaborating with external partners on establishing documentation standards.

Formal CMS Performance Improvement Project (PIP)

The topic of substance use disorder treatment was chosen as the formal CMS PIP in July 2016. Work on that project continued throughout QE0318. During stakeholder meetings in 2017 a data gap in the HEDIS IET measure (the PIP study measure) was recognized. The SUD treatment services provided by Community Health Team staff are not included in the HEDIS rates since they are paid for through a separate funding mechanism without claims. The PIP steering committee has proposed a process for

submitting “zero pay” claims for the provision of those services, to capture that data. Proposals are being pursued.

Concurrently, the PIP team is pursuing surveying providers to identify access issues for members seeking treatment. The tools are developed, and a team has been identified for execution. Target for completion is May 31, 2018.

Other Collaborative Quality Improvement Projects

The Quality Unit is leading informal PIPs on two topic areas: chlamydia screening and adults’ access to preventive/ambulatory health services. These topics were selected after annual review of program performance by the MCE Quality Committee, Managed Care Medical Committee and the Clinical Utilization Review Board (CURB). Project charters have been developed.

also participated in additional collaborative QI initiatives across the Agency of Human Services including the joint payer quality improvement project aimed at increasing follow-up care after hospitalization for mental illness and the collaboration with Vermont Dept. of Health, the Vermont Children’s Health Improvement Program (VCHIP) and the DVHA Data Unit on a joint payer quality improvement project aimed at increasing adolescent well care visits.

Quality Measure Reporting

Health Home Measure Set – The FFY ’19 Health Home Measure Set reporting deadline has been set by CMS as 4/30/18. During QE0318 the Blueprint team request an extension to July 1, which was granted. The extension was requested because DVHA is still researching questions that CMS had about the FFY 2016 – 2018 reports. Those issues will be resolved prior to reporting for an additional year. These measures are run by the Blueprint and Onpoint; the Quality Unit helps to act as a bridge between the CMS reporting system and program staff.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit’s QI Administrator coordinated the 2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children’s and Adults Medicaid 5.0H survey. The Quality Unit collaborated with the Vermont Blueprint for Health and consolidated work under one vendor, also used for the Patient Centered Medical Home (PCMH) survey. The contracted vendor, DataStat, Inc., distributed and collated the surveys according to AHRQ and NCQA protocols. The results of the surveys were delivered to the DVHA in January 2018 and were presented to the MCE Quality Committee during QE0318. The DVHA QI Administrator also updated the Experience of Care scorecards for both adults and children which is posted on the DVHA public website and can be seen here: https://embed.resultsscorecard.com/Scorecard/Embed/10292

- Healthcare Effectiveness Data & Information Set (HEDIS) Measure Production

    - HEDIS Administrative Measures - during QE0318 DVHA’s Quality and Data Units worked with the NCQA certified vendor to prepare for and run the annual HEDIS administrative measures. The Product Summary and rates will be available during QE0618.

- The Quality Unit is also conducting a medical record review for 1 hybrid measure. The team is developing a plan to include more hybrid measures in coming years.

Results Based Accountability (RBA)/Process Improvement

The Quality Unit is leading the Results Based Accountability (RBA) scorecard development effort at DVHA. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff. The DVHA Quality Unit staff received training and has used this tool to create a Global Commitment Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. Additional scorecards that were actively maintained or newly created during QE0318 include the following: Applied Behavior Analysis (ABA) benefit, the Adult and Child Medicaid Quality Core Measure Sets, GC Investments, Payment Reform Models, DVHA Standard Operating Procedures (SOPs), and an overall DVHA performance accountability scorecard - which includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services.

Quality Unit staff also attended additional LEAN/RBA internal training sessions during 2017. The trainings are centered around process improvement and contribute to the Governor's initiative called PIVOT, or Program to Improve Vermont Outcomes Together. Quality Unit staff will attend advanced internal training sessions during QE0618.

AHS Performance Accountability Committee

During this quarter, the AHS Performance Accountability Committee (PAC) discussed the Health in All Policies approach to improving the health of all people by incorporating health considerations into decision making across sectors and policy areas. A Health in All Policies approach identifies the ways in which decisions in multiple sectors affect health and how better health can support the goals of multiple sectors. The AHS PAC members agreed that decision-makers should consider the health consequences of various policy options during the decision-making process.

Also, this quarter, the group discussed the Global Commitment to Health Medicaid Demonstration Evaluation Design. The group reviewed available data, refined, and revised performance measures. This work lead to the development of a log of changes made to the proposed measure and sampling methods originally presented to evaluators and a summary of final measures, sampling methods, identified benchmarks, data sources, reporting periods and baseline years each of the overall Global Commitment to Health evaluation measures.

In addition, the AHS PAC reviewed the current AHS strategic plan and agreed upon a process to update the plan prior to its expiration date.

Finally, the group discussed the need for AHS-wide Data and Analytics. The group also brainstormed potential roles/responsibilities for the work group. Ideas discussed included but were not limited to the following: reviewing requests, recommending methods, identifying cross-departmental connections, and identifying which data sets may be of value.

Global Commitment (GC) and Delivery System Reform (DSR) Investment Review

In late November of 2017 two new investments were approved by CMS in the ACO delivery system reform category. Investments are scheduled to begin in 2018 and include administrative and infrastructure support for:

- OneCare Vermont ACO Quality Health Management Measurement Improvement investment. This project is designed to assist the ACO in providing technical assistance to network providers in setting quality improvement targets and using a suite of new and enhanced information dissemination tools and reports; and
- OneCare Vermont ACO Advanced Community Care Coordination investment. This project is designed to support an integrated care delivery system that is person-centered, efficient and equitable through the implementation of a community-based care coordination model.

AHS Departments are required to monitor and evaluate the performance of their GC and DSR investment supported activities on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of GC and DSR investment performance information contained in a web browser-based software application (Clear Impact Scorecard).

During this most recent quarter, DMH highlighted the performance of one of its investments – the Vermont Psychiatric Care Hospital (VPCH). The Clear Impact Scorecard for this DMH investment is included in this report as Attachment 7.

Payment Model Performance Monitoring

AHS Departments are required to monitor and evaluate the performance of their payment models on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of GC and DSR investment performance information contained in a web browser-based software application (Clear Impact Scorecard).

The Clear Impact Scorecard for this DVHA payment model is included in this report as Attachment 8.

Comprehensive Quality Strategy (CQS)/State Transition Plan (STP)

During this quarter, the HCBS Implementation Team continued to work on implementing the site-specific setting assessments developed in the previous quarter. Each of the programs continued to support the completion and submission of the self-assessment survey tool. The state continues to use a combination of reminder emails and phone follow up as a way to enhance response rates.

In order to collect consistent information on the implementation of the HCB Settings criteria and Statewide Transition Plan (STP), CMS has identified a standard set of milestones to track across states. Since each state is different, the milestone must align with the Statewide Transition Plan (STP) evidence. During this quarter, the team reviewed the tasks and due dates contained in the draft Vermont milestone document. An updated milestone document will be forwarded to CMS during the next quarter.

Global Commitment (GC) Evaluation Activities

During this quarter, a draft evaluation design and tentative evaluation budget was approved by CMS. The document includes details for the following: study populations, hypotheses to be tested, and recommend measures that need to be collected/reported. The document includes a section specific to the assessment of the impact of providing Medicaid reimbursement for IMD services for beneficiaries in need of acute mental health or substance use disorder treatment as well as sections that addresses whether the evaluators find the demonstration to be budget neutral, what impact the demonstration has on health outcomes, as well as any policy implications.

During this quarter, the AHS QIM worked with the evaluation contractor, PHPG, and state staff to review available data and refine and revised performance measures. This work lead to the development of a log of changes made to the proposed measure and sampling methods originally presented to evaluators and a summary of final measures, sampling methods, identified benchmarks, data sources, reporting periods and baseline years each of the overall Global Commitment to Health evaluation measures.

In addition, the AHS QIM worked with PHPG and state staff to compile an Interim Evaluation Report that included an evaluation of IMD expenditures. This report relies on quantitative study methods to address research questions regarding the impact of the Demonstration on: access to care; quality of care; cost containment; and stable in-home and community alternatives to institutional care. In addition to the overall waiver/demonstration, this report contains an assessment of IMD settings used to assure access to needed psychiatric and substance use disorder treatment services for Medicaid beneficiaries. The study design includes longitudinal analysis to measure change over time and differential statistics to describe the population and findings. Results are compared to national benchmarks, as applicable. Information contained in this Interim Report #1 represents the first of four evaluation reports for the Global Commitment to Health Section 1115 Medicaid Demonstration. Each report will build on data presented in the prior report and form the basis for the final summative report due June 30, 2022, six months following the end of the current extension period. The state expects to submit the Interim Evaluation Report to CMS during the next quarter.

IX. Compliance

Key updates from QE0318:

- EQRO audit on-site review completedThe Medicaid Compliance Plan updated
- ew AHS/DVHA IGA requirements reviewedSeveral IGAs were updated
- Preparation has begun for the 2018 EQRO compliance audit preparation initiated

Compliance Plan

During this quarter, updates to the Medicaid Compliance Plan were implemented, including better integration of several compliance functions, a new code of conduct and improved processes for corrective action and reporting. These changes also include a process for conducting risk assessments to drive the content of Vermont's annual compliance work plan. In addition to the updates to the plan, the Compliance Officer met with the QIM to review the new Medicaid Managed Care requirements in the AHS/DVHA Intergovernmental Agreement (IGA). Changes to the following DVHA sections were discussed: enrollee handbook, languages other than English, subcontractors, covered services, coordination of services, grievances and appeals, fraud and abuse, and records retention. In addition to the changes in the DVHA sections, the group also discussed changes to the following AHS sections:

oversight and performance evaluation. During the next quarter, the compliance officer will involve members of the compliance committee in the discussion. The group will determine what changes need to be made to the Compliance Plan to reflect the new requirements. Work plans will be developed for items that are not fully implemented. Finally, several improvements/additions were made to the agreements between DVHA and partner departments in order to clarify roles, comply with new requirements and improve lines of communication and cooperation.

Compliance Committee

The compliance committee did not meet during this quarter. Rather than engaging the full committee, the compliance officer met with the AHS QIM to review the new AHS and DVHA changes to the AHS/DVHA IGA. The compliance officer will initiate discussions re: the new requirements with the compliance committee starting next quarter.

External Quality Review (EQR)

During this quarter, the AHS QIM worked with the EQRO to develop timelines for each of the required annual external quality review activities. All timelines included the following elements: start date, completion date, task, and responsible party. Key tasks of the Performance Improvement Validation timeline include the following: feedback/comments on PIP documents, review/revise PIP validation tool, provide feedback on draft report, and review final report. Key tasks of the Performance Measure Validation timeline included the following: identify measures for validation, review and provide feedback on documentation request letter and attachments, develop schedule of on-site visit, review and provide feedback on draft performance measure validation report. Key tasks of the Compliance Review timeline included the following: finalize the scope of the review, review supporting documents and data collection tool, plan on-site visit, and review draft report. The MCE is scheduled to receive all review documents during the next quarter.

During this quarter, the Medicaid Compliance Officer also reviewed the 2018 audit standards with subject matter experts and unit directors to ensure that they are prepared for the upcoming document collection process. The topics for this year's audit include: Clinical Practice Guidelines; Quality Assurance/Improvement Activities; and Data Systems (MMIS). To prepare for the upcoming EQRO audit, staff completed a preliminary review of prior-year recommendations. Finally, during this quarter, staff began sorting through the documents expected to be submitted to the EQRO as part of the review activities. The onsite review has been scheduled for early July.

X. Demonstration Evaluation

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

XI. Reported Purposes for Capitated Revenue Expenditures

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

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

Attachment 6 is a summary of Investments, with applicable category identified, for QE0318.

XII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook
Attachment 2: Enrollment and Expenditures Report
Attachment 3: Complaints Received by Health Access Member Services
Attachment 4: Medicaid Grievance and Appeal Reports
Attachment 5: Office of the Health Care Advocate Report
Attachment 6: QE0318 Investments
Attachment 7: Investment Scorecards
Attachment 8: Payment Model Scorecard

XIII. State Contact(s)

Fiscal:	Sarah Clark, CFO	
	VT Agency of Human Services	802-505-0285 (P)
	280 State Drive	802-241-0450 (F)
	Waterbury, VT 05671-1000	sarah.clark@vermont.gov
Policy/Program:	Ashley Berliner, Director of Health Care Policy & Planning	
	VT Agency of Human Services	802-578-9305 (P)
	280 State Drive, Center Building	802-241-0958 (F)
	Waterbury, VT 05671-1000	ashley.berliner@vermont.gov
Managed Care Entity:	Cory Gustafson, Commissioner	
	Department of VT Health Access	802-241-0147 (P)
	280 State Drive, NOB 1 South	802-879-5962 (F)
	Waterbury, VT 05671-1010	cory.gustafson@vermont.gov

Date Submitted to CMS: May 29, 2018

ATTACHMENTS

Budget Neutrality New Adult

New Adult (w/ and w/o Child) Medical Costs Only	**DY 12 – PMPM**				**DY 13 – PMPM**
	QE 0317	**QE 0617**	**QE 0917**	**QE 1217**	**QE 0318**
(A) New Adult Group PMPM Projection	$518.26	$518.26	$518.26	$518.26	$540.03
(B-1) eligible member months w/ Child	55,221	57,032	56,699	55,358	55,422
(B-2) eligible member months w/o Child	124,997	124,845	120,933	118,080	120,377
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 28,618,835.46	$ 29,557,404.32	$ 29,384,823.74	$ 28,689,837.08	$ 29,929,542.66
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 64,780,945.22	$ 64,702,169.70	$ 62,674,736.58	$ 61,196,140.80	$ 65,007,191.31
(D-1) New Adult FMAP w/ Child	54.46%	54.46%	54.46%	53.47%	53.47%
(D-2) New Adult FMAP w/o Child	86.89%	86.89%	86.89%	86.69%	89.95%
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 15,585,817.79	$ 16,096,962.39	$ 16,002,975.01	$ 15,340,455.89	$ 16,003,326.46
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 56,288,163.30	$ 56,219,715.25	$ 54,458,078.61	$ 53,050,934.46	$ 58,473,968.58
Subtotal Federal Share Supplemental Cap 1	$ 71,873,981.09	$ 72,316,677.65	$ 70,461,053.62	$ 68,391,390.35	$ 74,477,295.04
Total FFP reported for New Adult Group	$ 62,816,665.28	$ 61,830,391.33	$ 54,643,069.28	$ 51,158,852.52	$ 62,183,045.44
Neutrality Test 1	$ 9,057,315.82	$ 10,486,286.31	$ 15,817,984.35	$ 17,232,537.82	$ 12,294,249.60

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
May 1, 2018

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 DAN - DEC 2019	DY 15 JAN - DEC 2020	DY 16 JAN - DEC 2021	Total
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 143,293,736	$ 33,339,740	$ -	$ -	$ -	$ 176,633,476
ABD - Non-Medicare - Child	$ 85,311,686	$ 20,196,628	$ -	$ -	$ -	$ 105,508,313
ABD - Dual	$ 661,213,179	$ 170,730,243	$ -	$ -	$ -	$ 831,943,422
ANFC - Non-Medicare - Adult	$ 101,535,007	$ 25,931,231	$ -	$ -		$ 127,466,238
ANFC - Non-Medicare - Child	$ 391,655,070	$ 101,810,549	$ -	$ -	$ -	$ 493,465,620
Total Expenditures Without Waiver	**$ 1,383,008,678**	**$ 352,008,390**	**$ -**	**$ -**	**$ -**	**$ 1,735,017,069**
With Waiver						
ABD Non Medicare Adult	$ 162,605,926	$ 41,404,523	$ -	$ -	$ -	$ 204,010,449
ABD - Non-Medicare - Child	$ 66,594,520	$ 15,741,610	$ -	$ -	$ -	$ 82,336,130
ABD - Dual	$ 445,853,945	$ 114,524,675	$ -	$ -	$ -	$ 560,378,620
ANFC - Non-Medicare - Adult	$ 84,041,960	$ 22,343,947	$ -	$ -	$ -	$ 106,385,906
ANFC - Non-Medicare - Child	$ 305,549,938	$ 86,407,137	$ -	$ -	$ -	$ 391,957,075
Premium Offsets	$ (655,991)	$ (207,689)	$ -	$ -	$ -	$ (863,680)
Moderate Needs Group	$ 1,487,602	$ 394,028	$ -	$ -	$ -	$ 1,881,629
Marketplace Subsidy	$ 6,355,286	$ 1,732,390	$ -	$ -	$ -	$ 8,087,675
VT Global Rx	$ 13,824,516	$ 4,034,049	$ -	$ -	$ -	$ 17,858,565
VT Global Expansion VHAP	$ 414,824	$ 103,602	$ -	$ -	$ -	$ 518,426
CRT DSHP	$ 10,331,787	$ 2,395,141	$ -	$ -	$ -	$ 12,726,928
Investments	$ 142,500,000	$ 34,206,221	$ -	$ -	$ -	$ 176,706,221
Total Expenditures With Waiver	**$ 1,238,904,312**	**$ 323,079,634**	**$ -**	**$ -**	**$ -**	**$ 1,561,983,945**
Supplemental Test: New Adult (Gross)						
Limit	$ 369,604,893	$ 94,936,734	$ -	$ -	$ -	$ 464,541,627
With Waiver Expenditures	$ 295,626,448	$ 77,419,576	$ -	$ -	$ -	$ 373,046,024
Surplus (Deficit)	*$ 73,978,445*	*$ 17,517,158*	*$ -*	*$ -*	*$ -*	*$ 91,495,603*
Waiver Savings Summary						
Annual Savings	$ 144,104,366	$ 28,928,757	$ -	$ -	$ -	$ 173,033,123
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 43,231,310	$ 7,232,189	$ -	$ -	$ -	$ 50,463,499
Total Savings	$ 43,231,310	$ 7,232,189	$ -	$ -	$ -	$ 50,463,499
Cumulative Savings	***$ 43,231,310***	***$ 50,463,499***	***$ 50,463,499***	***$ 50,463,499***	***$ 50,463,499***	***$ 50,463,499***

New Adult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality New Adult tab (STC#64)
See CY2018 Investments tab
See EG MM CY 2018 Tab for Member Month Reporting

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

Medicaid Program Enrollment and Expenditures Report

Q2 SFY 2018

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

Al Gobeille, Secretary
Vermont Agency of Human Services

Cory Gustafson, Commissioner
Department of Vermont Health Access

March 1, 2018

Key Terms

Caseload – Average monthly member enrollment

MEG – Medicaid Eligibility Group

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

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

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

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

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

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

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

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

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

CHIP – Children's Health Insurance Program – Beneficiaries under age 19 with household income 237-312% FPL with no other insurance

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

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

PMPM – Per Member Per Month

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS and AoE Medicaid Expenditures

All AHS and AoE YTD '18

	SFY '18 As Passed Rescission			SFY '18 Actuals thru December 31, 2017			% of Expenses to
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	Budget Line Item
ABD Adult and Acute CFC	7,243	$ 183,995,423	$ 2,116.99	7,001	$ 78,850,020	$ 1,877.07	42.85%
ABD Dual	17,645	$ 228,189,169	$ 1,077.68	17,551	$ 107,020,944	$ 1,016.28	46.90%
General Adult	14,343	$ 93,350,816	$ 542.37	12,526	$ 38,829,629	$ 516.65	41.60%
New Adult	59,604	$ 301,442,712	$ 421.45	58,223	$ 136,649,503	$ 391.16	45.33%
Vermont Premium Assistance	19,381	$ 6,649,761	$ 28.59	18,022	$ 3,134,000	$ 28.98	47.13%
Vermont Cost Sharing	6,483	$ 2,640,929	$ 33.95	5,977	$ 750,476	$ 20.93	28.42%
ABD Child	2,221	$ 76,042,202	$ 2,853.69	2,289	$ 27,850,113	$ 2,027.53	36.62%
General Child	60,360	$ 305,499,555	$ 421.78	59,592	$ 140,527,474	$ 393.03	46.00%
Underinsured Child	831	$ 2,614,573	$ 262.10	629	$ 665,037	$ 176.22	25.44%
CHIP	5,020	$ 12,342,233	$ 204.87	4,668	$ 5,819,407	$ 207.76	47.15%
Pharmacy Only	11,333	$ 4,686,531	$ 34.46	10,838	$ 1,433,424	$ 22.04	30.59%
Traditional Choices for Care	4,350	$ 196,483,201	$ 3,763.93	4,208	$ 97,905,592	$ 3,877.76	49.83%
Total Medicaid Claims Paid	208,814	$ 1,413,937,105	$ 564.27	201,525	$ 639,673,077	$ 529.03	45.24%

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS Medicaid Expenditures

All AHS YTD '18

	SFY '18 As Passed Rescission			SFY '18 Actuals thru December 31, 2017			% of Expenses to
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	Budget Line Item
ABD Adult and Acute CFC	7,243	$ 183,031,444	$ 2,105.89	7,001	$ 78,421,452	$ 1,866.87	42.85%
ABD Dual	17,645	$ 229,183,523	$ 1,082.37	17,551	$ 106,948,716	$ 1,015.59	46.67%
General Adult	14,343	$ 93,273,779	$ 541.92	12,526	$ 38,750,344	$ 515.60	41.54%
New Adult	59,604	$ 301,527,893	$ 421.57	58,223	$ 136,617,514	$ 391.07	45.31%
Vermont Premium Assistance	19,381	$ 6,649,761	$ 28.59	18,022	$ 3,134,000	$ 28.98	47.13%
Vermont Cost Sharing	6,483	$ 2,640,929	$ 33.95	5,977	$ 750,476	$ 20.93	28.42%
ABD Child	2,221	$ 59,297,638	$ 2,225.30	2,289	$ 23,151,103	$ 1,685.43	39.04%
General Child	60,360	$ 271,900,475	$ 375.39	59,592	$ 129,403,497	$ 361.92	47.59%
Underinsured Child	831	$ 2,159,698	$ 216.50	629	$ 507,096	$ 134.37	23.48%
CHIP	5,020	$ 10,599,804	$ 175.95	4,668	$ 5,189,472	$ 185.27	48.96%
Pharmacy Only	11,333	$ 4,686,531	$ 34.46	10,838	$ 1,433,424	$ 22.04	30.59%
Traditional Choices for Care	4,350	$ 196,483,201	$ 3,763.93	4,208	$ 97,905,592	$ 3,877.76	49.83%
Total Medicaid Claims Paid	208,814	$ 1,361,434,676	$ 543.32	201,525	$ 622,450,144	$ 514.78	45.72%

The Department of Vermont Health Access

Caseload and Expenditure Report ~ DVHA Only Medicaid Expenditures

DVHA YTD '18

	SFY '18 As Passed Rescission			SFY '18 Actuals thru December 31, 2017			% of Expenses to
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	Budget Line Item
ABD Adult and Acute CFC	7,243	$ 94,328,051	$ 1,085.30	7,001	$ 38,166,896	$ 908.58	40.46%
ABD Dual	17,645	$ 54,938,819	$ 259.46	17,551	$ 25,205,275	$ 239.35	45.88%
General Adult	14,343	$ 80,106,967	$ 465.42	12,526	$ 32,863,987	$ 437.28	41.03%
New Adult	59,604	$ 269,923,909	$ 377.38	58,223	$ 122,347,753	$ 350.23	45.33%
Vermont Premium Assistance	19,381	$ 6,649,761	$ 28.59	18,022	$ 3,134,000	$ 28.98	47.13%
Vermont Cost Sharing	6,483	$ 2,640,929	$ 33.95	5,977	$ 750,476	$ 20.93	28.42%
ABD Child	2,221	$ 24,204,894	$ 908.35	2,289	$ 10,278,480	$ 748.29	42.46%
General Child	60,360	$ 154,012,569	$ 212.63	59,592	$ 71,568,110	$ 200.16	46.47%
Underinsured Child	831	$ 1,177,236	$ 118.01	629	$ 247,711	$ 65.64	21.04%
CHIP	5,020	$ 8,620,617	$ 143.10	4,668	$ 4,125,727	$ 147.29	47.86%
Pharmacy Only	11,333	$ 4,686,531	$ 34.46	10,838	$ 1,433,424	$ 22.04	30.59%
Traditional Choices for Care	4,350	$ 196,483,201	$ 3,763.93	4,208	$ 97,905,592	$ 3,877.76	49.83%
Total Medicaid Claims Paid	208,814	$ 897,773,485	$ 358.28	201,525	$ 408,264,887	$ 337.65	45.48%

VERMONT

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Questions, Complaints and Concerns Received by Health Access Member Services
January 1, 2018 – March 31, 2018

January 1 – January 5

- No issues to report.

January 8 – January 12

- A few customers called to voice their displeasure with receiving either late notices or notices whose envelopes were unsealed. CSR apologized and documented the customer feedback.

January 22 – January 26

- No issues to report.

January 29 – February 2

- Policy – customer called to express frustration that VT Medicaid does not "follow her son out-of-state for coverage" while attending college in MA. CSR apologized for her frustration, discussed the Medicaid coverage and offered to document her feedback.

February 5 – February 9

- Covered Services - Customer was upset that none of the opticians on the VT Medicaid portal are accepting Dr. D for eyeglasses. He states he called several of them and they either do not accept Dr. D or their phone numbers are non-working numbers. He feels there should be more options out there. CSR apologized for his frustrations, offered to assist him with the website and document his feedback.

February 12 – February 16

- Customer called to complain about the Medicaid bus services in Windsor and Windham county. He states that the transportation provider is consistently late or just doesn't show. He feels that the state should find a new transportation service for both Windsor and Windham counties. Customer states that his doctor let him know that he is not the only one having issues in the area with this transportation provider. CSR apologized for the customers frustrations, went over the transportation covered service and offered to document his feedback.

February 19 – February 23

- No issues to report.

February 26 – March 2

- No issues to report.

March 5 – March 9

- No issues to report.

March 12 – March 16

- VPharm/VPharm Review/Reinstatements

March 19 – March 23

- VPharm/VPharm Review/Reinstatements

March 26 – March 30

- Customer wanted to leave feedback regarding covered services and the way things are denied. She feels the process of notifying customers about PA denials, covered service denials is outdated and very confusing. She feels it should be easier to find these things out, other than waiting for the doctors or to receive a letter in the mail. CSR apologized for her frustrations and let her know that unfortunately the doctors are the ones that would need to follow up with provider services. Also, offered to document her feedback.
- Customer wanted to submit feedback about a concern she has about not being able to get the specific information regarding PA's for medications as she'd like. She feels like she has to jump through hoops by calling different places (doctor's office, pharmacy, the state) to get information. CSR apologized for her frustrations but advised her we have limited information regarding the PA process. She was referred to her provider to gather more information about the status. Also, offered to document her feedback.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
January 1, 2018 – March 31, 2018

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data compiled on January 5, 2018, from the centralized database that were filed from January 1, 2018 through March 31, 2018.

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

During this quarter, there were 10 grievances filed; four were addressed during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was four days. Of the grievances filed, 90% were filed by beneficiaries and 10% were filed by a representative of the beneficiary. Of the 10 grievances filed, DMH had 80%, VDH had 10% and DVHA had 10%. There were no grievances filed for DAIL or DCF during this quarter.

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

There were no Grievance Reviews filed this quarter.

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

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

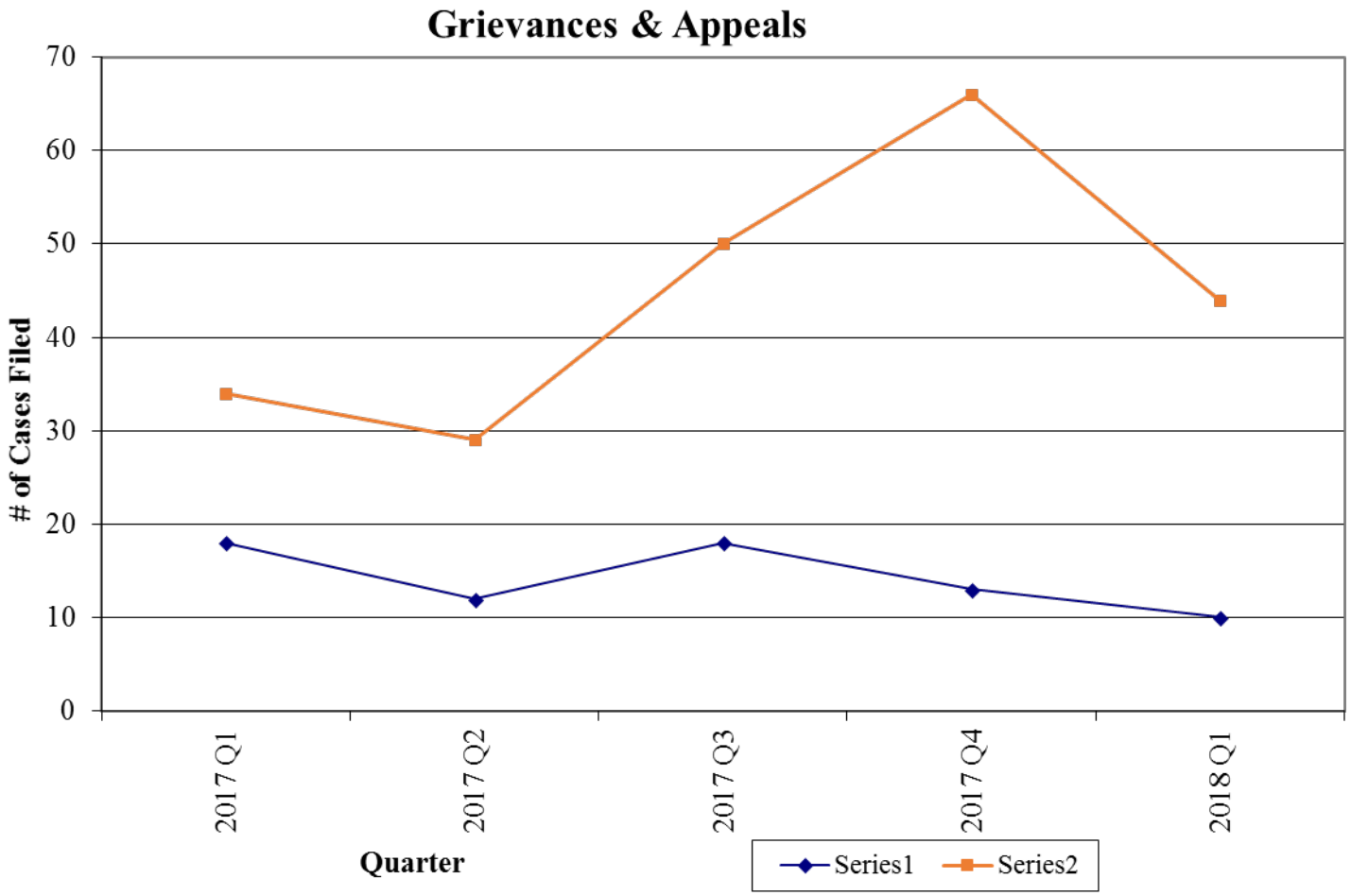
During this quarter, there were 44 appeals filed. Of these 44 appeals, 27 were resolved (63) % of filed appeals), 12 were still pending (28%), 3 were withdrawn (7%) and one was filed too late (2%).

Of the 27 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was 29 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

Of the 44 appeals filed, DVHA had 13 appeals filed (30%), and DAIL had 27 (61%) and VDH had 3 (7%) and DMH had 1 (2%).

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

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



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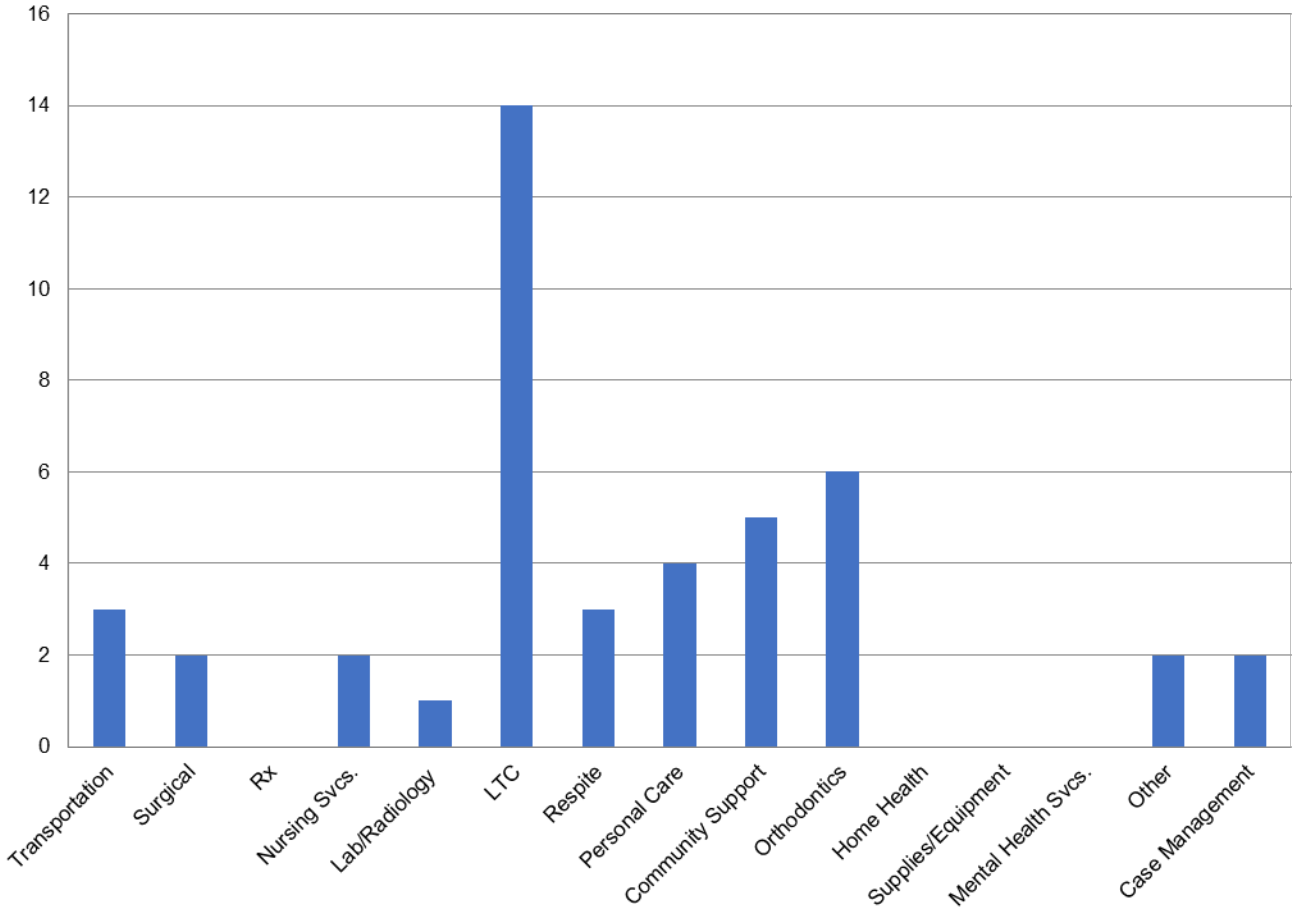
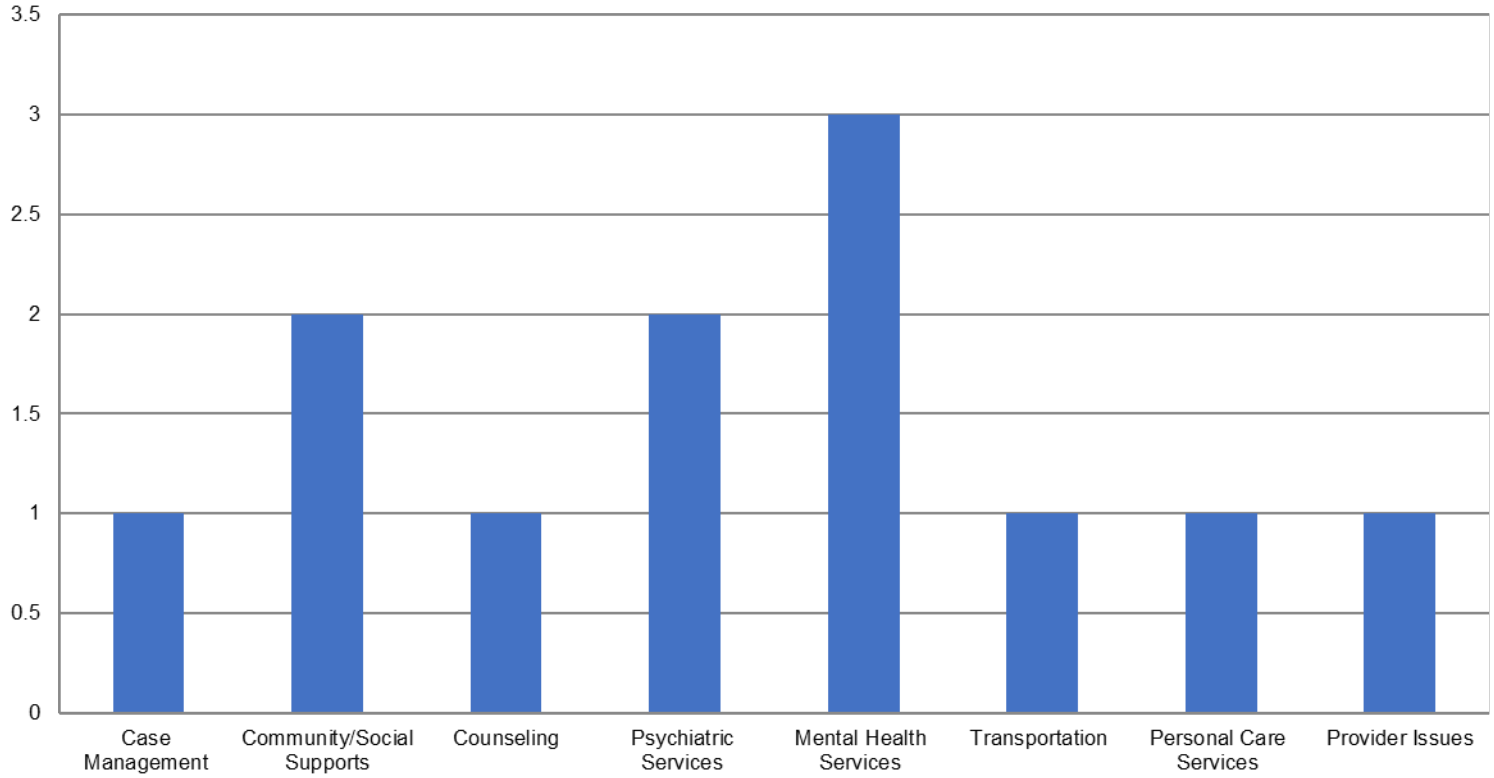
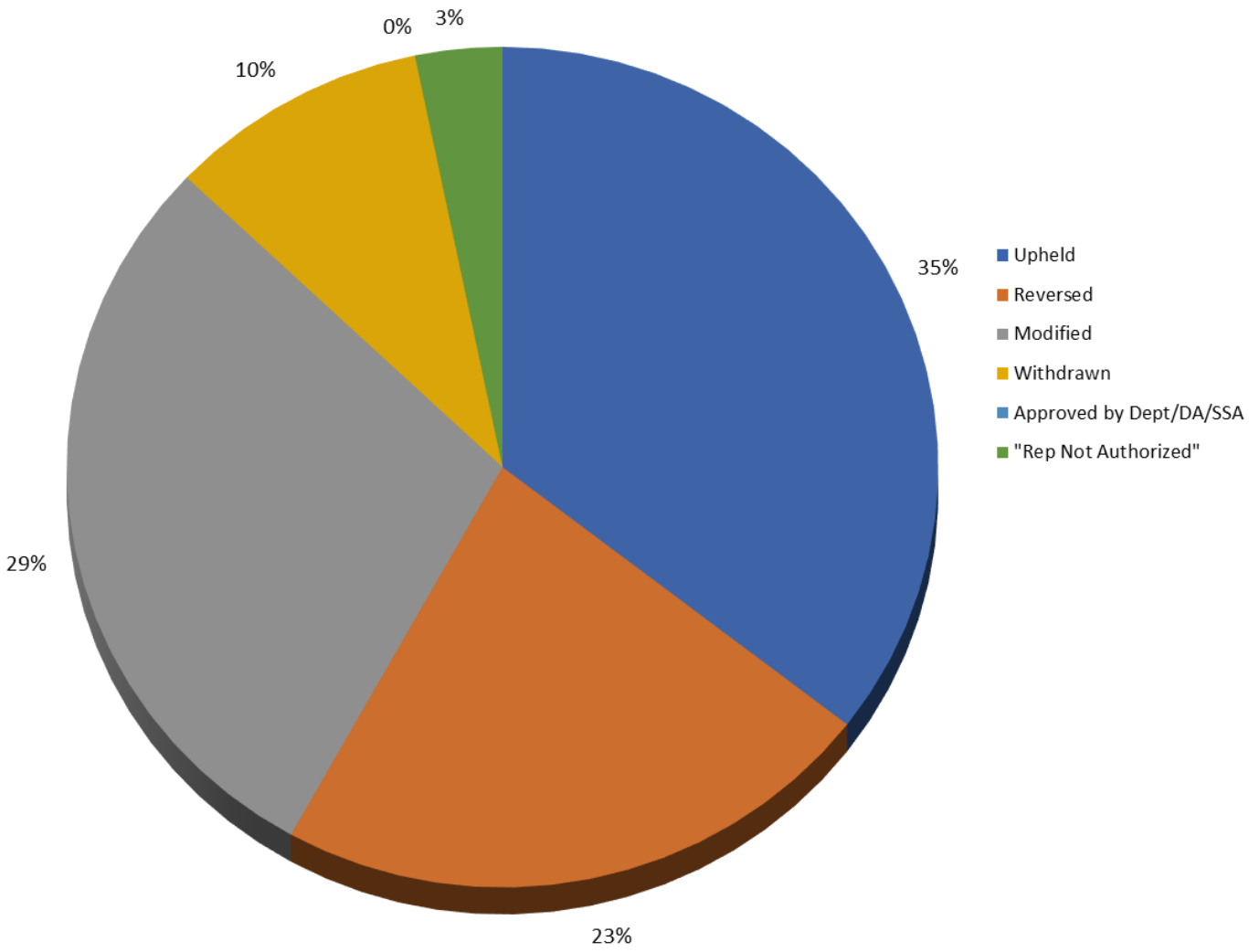
Appeals by Service Category



Grievances by Service Category



MCO Appeal Resolutions
1/1/2018 thru 3/31/2018



Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

January 1, 2018- March 31, 2018

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

April 23, 2018

Vermont Legal Aid
Working for Justice

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Introduction

The Office of the Health Care Advocate (HCA) advocates for all Vermonters through both individual consumer assistance and systemic advocacy on health care issues. We work to increase access to high quality, affordable health care for all Vermonters through individual advocacy and representing the public before Green Mountain Care Board, state agencies, and the state legislature. The HCA saw a significant jump in its calls this quarter (18%). Consumers again had particular issues and questions about Medicaid eligibility (220 cases) and access to prescriptions drugs (90 cases). With the start of tax season, we also saw an increase in our tax related cases (ACA Tax Issues, 48 cases, and 1095-A &B problems, 56 cases).
We continued to work on making notices more transparent and understandable to all consumers, and in particular ensuring that consumers recognize their grace period notices.

Due to new actions from the Federal Government, efforts to maintain stability in the marketplace were an important part of the HCA's advocacy this quarter. The HCA will also be working closely with stakeholders to develop an outreach strategy to help consumers understand changes to the marketplace plans for 2019.

The HCA is committed to helping Vermonters navigate the health care system during this confusing and anxious time. Our goal remains the same: to increase access to affordable, high quality health care for all Vermonters. Today's uncertainty makes the role of the HCA even more essential.

The HCA supports Vermonters through individual advocacy as well as at the legislative and administrative policy levels. Our policy priorities are informed by our daily work with Vermonters struggling with a health care system that often does not meet their needs, such as Tim's experience described in the case narrative at right. We work to control unnecessary costs and make the health care system sustainable, and to ensure that Vermont consumers are heard by providers and policy-makers.

Tim's Story

Tim called the HCA because he could not afford his employer sponsored insurance. He was paying nearly $10,000 a year for coverage for himself and his family. That was the minimum cost for a year without any major health problems. Because his employer plan was considered "affordable," he was not eligible to get APTC to help pay for a plan on VHC. An employer plan is considered affordable if it does not cost more 9.56% of the household income to get an employee only plan. The affordability test does not consider how much it costs to cover your family. This is called the "family glitch." It means that you could be spending much more than 9.56% of your household income to cover your family, but you would still be ineligible for APTC. When the advocate reviewed Tim's household income, he found that if Tim started to contribute about $400 a month to his 401(K), the family would reduce its taxable income and become eligible for Medicaid. Since the family was already paying $10,000 a year for the employer insurance, this cut the costs by more than half. Plus, Medicaid has very limited out of pocket costs while Tim's employer plan had a nearly $2000 deductible and expensive copayments. Tim was also relieved to have affordable coverage, and to start saving more money for retirement.

Individual Consumer Assistance

Case Examples

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

Maddie's Story

Maddie called the HCA because she could not afford the premium for her new health plan on Vermont Health Connect (VHC). She did not want to go without insurance but did not think that she could afford the increased monthly premium. She did not understand why her premium had increased so quickly. When the advocate investigated, she discovered that Maddie was not receiving the correct amount of Advance Premium Tax Credit (APTC) for her current income. The APTC is applied monthly to reduce the premium, and how much you are eligible for depends both on your household size and your income. When the advocate called VHC, she found that it was using incorrect yearly income. VHC had Maddie's income listed as almost $10,000 more than what she was currently earning, and that was reducing the amount of APTC she qualified for. When the income was corrected, Maddie's monthly APTC increased and her premium decreased by about $100 a month. Maddie was able to make the payments and stay on the coverage.

Cora's Story

Cora was desperate when she called the HCA. She had cancelled two doctor's appointments and was not able to pick up four prescriptions because her new health plan on VHC was not active. She has signed up for a new health plan on VHC for January, and sent her payment at the end of December. Because her first payment for the new plan had been sent towards the end of the month, it meant that Cora's coverage was not active on the first day of the month. Cora had called VHC to request that her case be expedited, but her coverage was still not active. When the advocate intervened, she found that Cora's request that her case be expedited had not yet been communicated to the right team at VHC. The advocate submitted another request that the coverage be expedited, and also contacted the carrier which worked to speed up the process. Once the coverage was activated, the advocate contacted the pharmacy, which was able to fill the prescriptions immediately. Cora picked up the prescriptions and was able to re-schedule her doctor's appointments.

Liam's Story

Liam called the HCA because he had Hepatitis C and wanted to get treatment. The new treatment had an excellent chance of curing his disease. When his provider submitted a prior authorization request to Medicaid, it was denied because he had not met the treatment criteria. According to the Medicaid treatment criteria, his disease was not advanced enough for Medicaid to cover the direct-acting antiviral treatment. The HCA helped Liam with an internal appeal with Medicaid. He lost at that stage. He then filed a fair hearing to contest the denial. He also lost at the fair hearing stage. At the same time the HCA also worked to change the treatment criteria, so people like Liam could get curative treatment before the disease did more damage. Ultimately, Medicaid expanded the

treatment criteria for Hepatitis C. This meant that people like Liam could get treatment before they had further liver damage due to the disease. The process had taken more than a year, but Liam was finally able to start treatment.

Art's story

Art had lost his job and his health care coverage. Because he had lost his employer health care coverage, he had a 60 day special enrollment period to apply on VHC. With the help of an assistor at his provider's office, he had applied for a special enrollment period on VHC. He called the HCA, however, because he had never gotten a VHC plan and still needed coverage. The advocate discovered that Art had applied within the 60 day special enrollment period, so he should have been able to sign up for a plan. When the assistor had submitted the application, however, she had not marked that Art had lost his employer coverage. This meant that VHC had denied his request for a special enrollment period. Since he had applied within the 60 day period and the denial was due to an error on the application by the assistor, VHC granted Art another special enrollment period. He was able to sign up for a plan and get active coverage.

Edward's story

Edward had ten prescriptions to pick up, and the pharmacy was telling him that it was going to cost several hundred dollars. Edward thought that he had Medicaid, but when he gave the pharmacy his card, he was told that he had Healthy Vermonters. Healthy Vermonters is another state health care program that gives Vermonters a discount on prescriptions. But if you have Medicaid, your drug copayments are much lower--only $1 to $3. The advocate reviewed Edward's case and found that he had applied for Medicaid, but had used the wrong application. He had applied for Medicaid for the Aged, Blind and Disabled and filled out a paper application. He was actually eligible for Medicaid for Children and Adults. For that type of Medicaid, you can apply online or over the phone with VHC. The advocate helped Edward apply and expedited his application. Once the coverage was active, he was able to pick up all of his prescriptions for about $20 instead of several hundred dollars.

Annette's Story

When Annette turned 65, she had not signed up for Medicare. She did not qualify for free Part A and did not believe she could afford it. She called the HCA to see if there were any affordable health care options for her. The advocate explained that Annette qualified for Medicaid. She also qualified for a Medicare Savings Program (MSP). If she was on an MSP, the State of Vermont would pay for her Medicare Part A & B premiums, and the Medicare cost-sharing. The state could also sign her up outside of the general Medicare enrollment times. That meant she could get on right away instead of waiting about six months for Part B coverage to start. The advocate helped her fill out the application for an MSP and Medicaid. The State approved her for both programs. By being on an MSP and Medicaid, she also qualified for what is called Low Income Subsidy (LIS). This federal program helps pay for Part D prescription drug coverage. It meant that Annette was able to sign up for a Part D plan, and LIS would cover the monthly premium. Now Annette was fully covered on Medicare, with programs to help cover the cost-sharing for Medicare Part A, B, & D.

Eloise's story

Eloise called because she got a notice from the State of Vermont telling her that her Medicaid and her Medicare Savings Program (MSP) were closing because she was now over-income for the programs. Her income had not changed, so Eloise did not understand why the programs were closing. When the advocate looked into the issue, he found that Eloise's husband was on Long Term Care Medicaid. This meant that when the State of Vermont calculated whether Eloise was eligible for Medicaid, it should have excluded her husband's income from the eligibility calculation. When the State found her ineligible, it had erroneously included her husband's Social Security income. The advocate pointed out the error, and the State agreed that it made a mistake. When the income was calculated correctly, Eloise was found eligible for both Medicaid and an MSP.

Shannon's story

Shannon called because both she and her new husband had received closure notices from Medicaid. Both Shannon and her husband had been on Medicaid for the Aged, Blind and Disabled (MABD). They each received monthly disability payments. They had just gotten married and did not realize that when they married, their incomes would count together. When their incomes were combined, they were significantly over-income for Medicaid. For MABD, the income limits for a household of one and household of two are the same. For example, in Chittenden County, the limit for a household of one and a household of two is $1125 a month. The Medicaid coverage was particularly important because both relied on Medicaid transportation to get to their medical appointments. When the advocate researched the situation with them, he realized that they could qualify for another program. The couple had started a small business together. This meant that they could be eligible for Medicaid for the Working Disabled. That program has a higher income and resource limit, and the couple would still be income eligible for that program. The advocate helped submit the application and the necessary documentation about their business, and the State found them eligible for Medicaid for the Working Disabled. This meant that they would be able to get rides to their medical appointments once again.

Overview

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

The HCA received 1046 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:

- **23.42%** (245) about **Access to Care**
- **12.52 %** (131) about **Billing/Coverage**

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

- **0.86% (**9) about **Buying Insurance**
- **13.00%** (136) about **Consumer Education**
- **25.24%** (264) about **Eligibility** for state and federal programs
- **24.95%** (261) 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 264of our cases had eligibility for state and federal healthcare programs listed as the primary issue, a total of 521 cases had eligibility listed as a secondary concern.

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

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

The full quarterly report for January 11- March 31, 2018 includes:

- This narrative, which contains sections on **Individual Consumer Assistance**, **Consumer Protection Activities** and **Outreach and Education**
- Seven data reports, including three based on the caller's insurance status:
  - **All calls/all coverages**: 1046 calls (compared to 890 last quarter)
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 319 calls (257 calls last quarter)
  - **Commercial plan beneficiaries**: 221 calls (212 calls last quarter)
  - **Uninsured Vermonters**: 100 calls (78 calls last quarter)
  - **Vermont Health Connect (VHC)**: 325 calls (254 calls last quarter)
  - **Reportable Activities (Summary & Detail)**: 121 activities and 11 documents

Priorities

A. The HCA worked with VHC and other stakeholders to make sure that grace period notice envelopes are properly marked.

The HCA advocates talked to many consumers who had not realized that they were in a grace period for being behind on their monthly premiums. By the time they called the HCA, they were outside of their grace period and their coverage had been terminated. When the advocates investigated, they found that most of the time the grace period notices had been sent to the consumers. The problem was that consumers did not recognize that they were receiving an important notice. Because some of the grace periods notices were sent in blank envelopes, consumers assumed that they were junk mail and recycled them without opening the notice. By the time they called the HCA, they were often outside their grace period and in danger of being without insurance for the rest of the year. The HCA worked with VHC and stakeholders to ensure that the envelopes were marked with a return address to alert consumes that this was an important notice. This will allow consumers to quickly recognize that they are in a grace period, and give them an opportunity to catch up on their premiums and maintain their coverage.

B. The HCA collaborated with stakeholders to support 'silver loading' QHPs to help stabilize the market and maintain access to affordable healthcare.

After the Federal Government decided to stop funding the Cost Sharing Reduction (CSR) payments in 2017, the HCA immediately started working with other stakeholders to develop a strategy to protect consumers from cost increases and also support and stabilize the individual market for the future. The HCA joined with stakeholders to support changing the marketplace to allow Vermont Health Connect (VHC) to offer "silver-loaded" plans and for the carriers to offer "reflective" silver plans. The VHC "silver-loaded" plans mean that Premium Tax Credit (PTC)-eligible households will be eligible for more PTC to offset the increased cost of plans due to the loss of CSR. Consumers will be able to use the additional PTC to maintain their coverage or purchase a QHP with lower cost-sharing, or a QHP with a lower premium. Households who are not eligible for PTC can purchase "reflective" silver plans directly from the carriers and be protected from premium increases due to the "silver-loading" strategy while maintaining the same level of coverage. The HCA is actively working with other stakeholders to develop an outreach strategy to help consumers understand the changes and find what plan makes the most sense for them.

C. The HCA expanded its partnership with Kinney Drugs.

This quarter the HCA advocacy team visited Kinney drugstores throughout the state to educate pharmacists about how the HCA can help consumers. The HCA is now getting a steady stream of referrals from the drugstores. Most of the referrals are emergency cases where the consumer cannot pick up a prescription because their coverage is not active or because the prescription that they need is not covered by their Medicare Part D plan.

D. Access to Breast Cancer Screening

This quarter, the HCA supported legislation to further reduce the out pocket costs for breast cancer screening. Although Vermont law already waives cost-sharing for screening mammograms, the HCA often spoke with consumers who needed additional ultrasounds because of the screening mammogram. Many were left with large bills from the ultrasound. The bills made them reluctant to do annual screenings. The proposed law will waive cost-sharing for medically necessary breast imaging.

E. Overall call volume increased for the third consecutive quarter.

The total call volume increased by 18% (1045 this quarter vs. 890 last quarter). About 15% of those calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We saved consumers $186,529.15 this quarter.

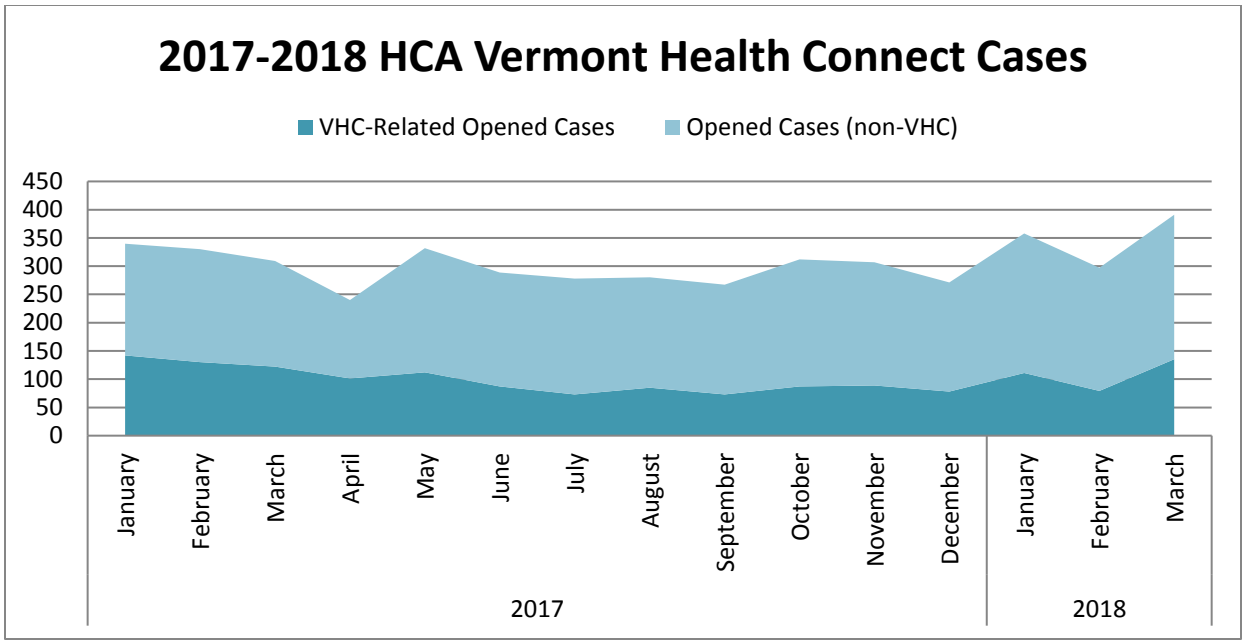
	All Calls (2008-2018)										
	2008	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
January	309	240	218	329	282	289	428	470	411	340	358
February	232	255	228	246	233	283	304	388	511	330	297
March	229	256	250	281	262	263	451	509	416	308	391
April	235	213	222	249	252	253	354	378	333	240	-
May	207	213	205	253	242	228	324	327	325	332	-
June	245	276	250	286	223	240	344	303	339	289	-
July	205	225	271	239	255	271	381	362	304	278	-
August	152	173	234	276	263	224	342	346	343	280	-
September	147	218	310	323	251	256	374	307	372	267	-
October	237	216	300	254	341	327	335	311	312	312	-
November	192	170	300	251	274	283	306	353	287	307	-
December	214	161	289	222	227	340	583	369	284	271	-
Total	2604	2616	3077	3209	3105	3257	4526	4423	4237	3554	1046

F. Calls concerning Vermont Health Connect increased significantly.

The volume of calls concerning Vermont Health Connect increased by 28%, compared to the previous quarter (325 vs. 254). With the opening of tax season, we saw an expected jump in our tax related calls (ACA Tax issues, 43 vs. 13 calls, and 1095-A &B issues, 46 vs. 10 calls). The number of calls related to eligibility for Special Enrollment Periods and the Termination of Insurance both doubled (37 vs. 16 for SEPS and 48 vs. 19 for Termination). With a shorter Open Enrollment this year, some consumers missed their opportunity to switch plans and called to see if they would qualify for a Special Enrollment Period. Another group of consumers were terminated at the start of 2018, and called the HCA for help. This quarter, 94 VHC cases required complex interventions that took more than two hours of an advocate's time to resolve, and 49 required a direct intervention to resolve the case.

The HCA continues to resolve its cases by working directly with Tier 3 Health Access Eligibility Unit (HAEU) workers, who are trained to resolve all aspects of complex cases. In addition, the HCA meets with VHC each week to discuss cases as needed, and has regular email contact with Tier 3. This quarter we had a significant increase in our escalated cases (83 vs. 73 last quarter). Of the 83 escalated cases, 71 were resolved within the quarter.

Tier 3 also now works on resolving Green Mountain Care cases (VPharm, Medicaid for Aged Blind and Disabled (MABD), Medicare Saving Programs, and Medicaid Spenddowns). This quarter we had a jump in cases for consumers having issues with Medicare Savings Programs (65 vs. 52), MABD (68 vs. 43), and VPharm eligibility (40 vs. 29).



G. Medicaid eligibility calls represented 21% of all our cases (220 calls/ 1046 total calls). Consumers need assistance with all types of Medicaid.

Medicaid eligibility was again the top issue generating calls. We had 115 calls about eligibility for MAGI (expanded) Medicaid, 68 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), 24 about Medicaid Spenddowns, and 13 about Medicaid for Working Disabled. MAGI Medicaid and MABD Medicaid have different eligibility and income rules, and HCA advocates assess and advise on eligibility for both programs. Consumers frequently have questions about what counts as income, who should be counted in their household, what expenses can be used to meet a Spenddown, how to complete renewal paperwork, and whether their eligibility decision is correct.

The top issues generating calls

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

All Calls 1046 (compared to 890 last quarter)

1. MAGI Medicaid eligibility 115 (97)
2. Access to prescription drugs/pharmacy 90 (44)
3. Complaints about providers 81 (80)
4. Information/applying for DVHA programs 77 (60)
5. Medicaid eligibility (non-MAGI) 68 (63)
6. Buy-in programs/Medicare Savings Programs 65 (52)
7. Premium Tax Credit eligibility 63 (70)
8. Termination of Insurance 58 (28)
9. Information about VHC 58 (50)

10. 1095-A and 1095-B problems 56 (10)
11. Special Enrollment Periods eligibility 54 (23)
12. Consumer education about Medicare 52 (31)
13. Fair hearing appeals 50 (36)
14. ACA Tax issues 48 (15)
15. VPharm eligibility 40 (27)
16. Eligibility for VHC grace periods 40 (29)

Vermont Health Connect Calls 325 (compared to 254 last quarter)

1. MAGI Medicaid eligibility 97 (84)
2. Premium Tax Credit eligibility 57 (67)
3. 1095-A & 1095-B problems 46 (10)
4. Information about VHC 53 (47)
5. Termination of insurance 48 (19)
6. ACA Tax Issues 43 (13)
7. Eligibility for VHC grace periods 40 (29)
8. Fair hearing appeals 39 (24)
9. Special Enrollment Periods 37 (16)
10. Change of Circumstance 32 (33)
11. VHC invoice/payment/billing problem affecting eligibility 32 (26)

DVHA Beneficiary Calls 319 (compared to 259 last quarter)

1. MAGI Medicaid eligibility 44(36)
2. Medicaid eligibility (non-MAGI) 29 (33)
3. Access to prescription drugs/pharmacy 28 (21)
4. Complaints about providers 24 (25)
5. Buy-in programs/Medicare Savings Programs 22 (19)
6. Information/applying for DVHA programs 23 (17)
7. VPharm eligibility 16 (9)
8. Access to transportation 15 (13)
9. Medicaid/VHAP Managed Care Billing 15 (13)
10. PA Denial 14 (4)

Commercial Plan Beneficiary Calls 221 (compared to 209 last quarter)

1. Premium Tax Credit eligibility 35 (48)
2. Eligibility for VHC grace periods 28 (18)
3. MAGI Medicaid eligibility 27 (26)
4. 1095-A & 1095-B problems 25 (6)
5. ACA Tax issues 23 (8)
6. VHC invoice/payment/billing problem related to eligibility 21 (14)
7. Information about VHC 17 (25)
8. Consumer education about Medicare 17 (13)
9. Change of circumstance 13 (13)
10. DVHA/VHC premium billing 14 (13)
11. Termination of Insurance 14 (4)

12. Fair Hearings 14 (8)

The HCA received 1046 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as "dual eligible"): 30.5% (319 calls), compared to 28.8 % (257 calls) last quarter
- **Medicare**[2] **beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 28.01% (293 calls), compared to 28.7% (255 calls), last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans 21.1% (221 calls), compared to 23.5% (209 calls) last quarter
- **Uninsured:** 9.56% (100 calls), compared to 8.7% (77 calls last quarter)

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 981 cases this quarter, compared to 890 last quarter:

- 35% (340) were resolved by brief analysis and advice
- 27% (269 cases) were resolved by brief analysis and referral
- 24% (237) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time
- 9% (85) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases (49), clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 32 individuals with appeals: 24 Fair Hearings, 1 Commercial Insurance – Internal 1st Level appeal, 1 Commercial External Appeal, 2 Medicare Part D appeal, and 4 Medicaid MCO Internal appeal.

DVHA Beneficiary Calls

We closed 301 DVHA cases this quarter, compared to 257 last quarter:

- 35% (105) were resolved by brief analysis and/or advice
- 26% (80) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 26% (78 cases) were resolved by brief analysis and/or referral
- 9% (29) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information

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

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

Appeals: The HCA assisted 10 DVHA beneficiaries with appeals: 5 Fair Hearings, 2 Medicare Part D appeal, and 3 Medicaid MCO Internal appeal.

Commercial Plan Beneficiary Calls

We closed 214 cases involving individuals on commercial plans, compared to 199 last quarter:

- 35% (74 cases) were resolved by brief analysis and/or advice
- 30% (65) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 17% (36) were resolved by brief analysis and/or referral
- 15% (33) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 24 commercial plan beneficiaries with appeals: 19 Fair Hearings, 1 Commercial Insurance – Internal 1st Level appeal, 1 Commercial Insurance – External appeal, 2 Medicare Part D appeals, and 1 Medicaid MCO Internal appeal.

B. All Calls Case Outcomes

The HCA helped 99 people get enrolled in insurance plans and prevented 20 insurance terminations or reductions. We obtained coverage for services for 31 people. We got 14 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 37 more. We provided other billing assistance to 16 individuals. We provided 538 individuals with advice and education. Twelve people were not eligible for the benefit they sought, and nine were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 106 more people.

Consumer Protection Activities

A. Rate Review

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

One new rate filing was decided during the quarter covering January 2018 through March 2018. The HCA filed a Notice of Appearance and a Memorandum in Lieu of Hearing in the matter. Additionally, five rate filings were pending at the end of the quarter.

The one decided filing involved the premium rates that the Cigna Health and Life Insurance Company (CHILIC) will charge large employer groups in 2018. Roughly 500 Vermont members will be affected by this rate filing. CHILIC proposed an average 6.2 percent increase for its large group book of business. CHILIC's proposed rate was reduced to 2.7 percent.

The five pending rate filings are Blue Cross and Blue Shield of Vermont's 2019 large group filing, The Vermont Health Plan's 2019 large group filing, MVP's 2018 large group HMO 3Q/4Q filing, MVP's 2018 POS large group 3Q/4Q filing, and MVP's 2018 small group 3Q/4Q filing. These five filings collectively

impact approximately 17,800 Vermont members. The HCA has filed Notices of Appearance in all five of these matters and we intend to file all appropriate memoranda and other documents and to represent the interests of Vermonters affected by these filings.

This quarter, the HCA also devoted substantial effort to modify the rate review process to allow the HCA to better represent the interests of Vermonters. We engaged multiple stakeholders in this effort including Green Mountain Care Board staff, Blue Cross and Blue Shield of Vermont staff, MVP staff, and state legislators. The HCA is hopeful that its efforts will result in meaningful changes to the rate review process although we have laid the groundwork for a possible statutory solution next legislative session should that be necessary.

B. Certificate of Need

The HCA participates in Certificate of Need (CON) processes as an "interested party" to ensure that approved health care investments are in the best interests of Vermonters. During the last quarter, the Green Mountain Care Board (Board) asked the legislature to make changes to the state statute governing its certificate of need review process. The HCA testified before the House Health Care Committee and asked for several changes to the Board's proposal: 1) The Board's proposal asked for the statute to allow the Board to index CON thresholds at the rate of medical inflation. The HCA asked the committee to retain the current statutory language, limiting indexing to the rate of general inflation; 2) Currently, facilities such as urgent care centers are excluded from CON review. The HCA asked for a statutory change to bring within the Board's CON jurisdiction freestanding walk-in clinics; 3) The Board's proposal excluded routine replacement of non-medical equipment. The HCA asked for these terms to be clearly defined if this exclusion is added to the statute; 4) The HCA asked for the statute to require more transparency on the process for CON expedited review. Currently, if a CON project goes under expedited review, the Board can follow any process it chooses and does not publicly disclose what the process will be, making it difficult for the public and other stakeholders to participate; 5) The Board proposed removing projects that repair, renovate, or replace infrastructure from CON review. The HCA asked for this type of CON application to continue to be subject to CON review or for the exclusion to be narrowed to those projects that do not involve new construction, is unlikely to significantly increase the cost of medical services to patients, and will not impact the provision of medical services to patients; 6) The Board's proposal removed the option for potential interested parties to apply during the 20 day period following the close of a CON application, leaving just the first 20 days after a CON application is filed for someone to apply for interested party status. The Board argued that the period after the application has closed delayed the process unnecessarily. The HCA opposed this change because the initial 20 day period is too short for many potential applicants to reasonably assess whether they want to intervene. Often CON reviews take more than a year and large amounts of information on the project are not made available until well after the first 20 days. The HCA asked for potential interested parties to be allowed to apply any time within the Board's review of a CON application, ending 5 days after the application closes; and 6) The HCA asked for the statute to require a more robust review of energy efficiency measures to ensure potential energy efficiency financial savings are maximized. The Board and the HCA worked together to modify the Board's proposal and came to a consensus that satisfied most of the HCA's concerns. The bill is currently pending at the legislature.

C. Hospital Budget Review

The HCA participates in the Board's annual hospital budget review process. This quarter, we worked with Board staff to improve our role in the process. We met with Board staff and together determined that asking our standard questions as early in the process as possible would help the summer review period go more smoothly for the Board, the HCA, and the hospitals. We submitted a set of questions to

the Board, and the Board incorporated some of our questions into its own budget guidance. Additionally, the Board voted to include our full set of questions as an attachment to the hospital budget guidance, which was sent out to all hospitals in March. We look forward to receiving the written answers to our questions when the hospitals submit their budget materials in June or July, and anticipate that having these answers earlier in the process will allow us participate more meaningfully in the review process and to use the hearing time more efficiently.

D. Oversight of Accountable Care Organizations

This quarter, the Board and the HCA received the Blue Cross Blue Shield of Vermont 2018 contract with OneCare Vermont (deemed confidential by the Board). Submission of payer contracts is one of the conditions imposed by the Board in its approval of OneCare Vermont's 2018 budget. The HCA also continued to track the Board's ACO certification process and other budget contingencies, including attribution numbers which were released this quarter.

Additionally, this quarter the HCA participated in two meetings convened by the Board related to development of the OneCare Vermont measure set for 2019. We continue to advocate for measures that look at the patient experience and adequately capture quality of care and access. This work is ongoing.

E. Other Green Mountain Care Board Activities

During the last quarter, the HCA participated in several stakeholder groups organized by the Green Mountain Care Board in addition to attending weekly Green Mountain Care Board meetings. The Federal Issues Work Group was organized to discuss state issues that could arise as a result of changes made by the federal government. The HCA has been an active member of this group. The first issue the group worked on was the loss of federal cost sharing reduction funding for health insurance exchange plans. The group agreed on a solution to this issue, which required a statutory change. The HCA and other stakeholders supported the statutory change before the legislature and the bill passed. The group also did some work related to both proposed and final federal rule changes to short-term insurance plans and association health plans, and again supported a bill to address the issues in Vermont. During the current legislative session, the legislature passed a bill that tasked the federal issues working group with addressing whether Vermont would benefit from a state mandate requiring all Vermonters to have health insurance, and if so, how such a mandate should be structured. The bill required the group to include a representative from the HCA.

During this time the HCA also submitted public comments to the Board regarding the Board's approval of 2019 qualified health plan benefits and the Board staff's proposed changes to the Board's Data Governance Council Charter. For the qualified health plan benefits, we asked the Board to increase the benefit richness of silver plans to the maximum allowed by the federal government. This would allow individuals who receive subsidies to have the richest plans possible with no increased premium costs. It also would minimize the financial losses health insurers will experience from paying for cost sharing reductions, because richer plans would require less cost sharing subsidization. Ultimately, the Board decided to consider this argument in future years but did not make the change this year.

Separately, we submitted comments arguing that the Data Governance Council Charter did not include sufficient details to ensure that the Board functioned efficiently. We pointed out that the charter gave very little information about the purpose and powers of the Council as a whole and allows almost all decisions to be dictated by the chair, a position which is automatically held by the director of the Board. It does not require the chair to have any experience or expertise in data governance. We asked the

Board to take its role as a steward for Vermont's health care data seriously and ensure that the Council is well designed. The Board adopted some or our suggestions including requiring the full Council to vote on any changes to Council members, instead of allowing the chair to make these changes unilaterally.

F. Affordable Care Act Tax-related Activities

Due to the tax filing season, our tax-related calls from consumers increased this quarter as detailed above. HCA advocates helped consumers get corrections made to their tax forms including 1095-As from VHC but also 1095-B forms from government plans and private insurance companies. Advocates answered questions about the individual shared responsibility provision and available exemptions, especially in light of the December 2017 tax legislation. VHC was able to correct forms 1095-A much more quickly than in past filing seasons. We are pleased to report that we heard from significantly fewer people this year who needed to file an extension on their taxes because they were waiting for a corrected 1095-A.

The HCA continued to employ a half-time tax attorney, who also staffs the Low-Income Taxpayer Clinic at VLA. This arrangement has allowed the HCA to stay up to date on tax law developments, and enables our staff to effectively field calls related to the ACA and VHC. In this quarter, the HCA's tax attorney spent significant time parsing the December 2017 federal tax legislation (the so-called Tax Cuts and Jobs Act) and advising the HCA policy team on its impact as they pursued administrative and legislative priorities.

Our tax technical assistance also increased with the filing season. As in prior quarters, the HCA's tax attorney consulted with HCA advocates when particularly difficult IRS-related issues arose in HCA cases. During this quarter, the tax attorney advised the HCA on 17 technical assistance questions (vs. 15 last quarter). She also responded to 43 technical assistance questions (vs. 30 last quarter) from Vermont tax preparers and legal aid attorneys. Common question topics included shared responsibility exemptions, advance premium tax credit reconciliation and repayment, and various questions about Modified Adjusted Gross Income (MAGI).

In December, the HCA's tax attorney met with the IRS Office of Chief Counsel's Healthcare Counsel to discuss emerging issues including how tax privacy restrictions affect consumers' ability to find out why their VHC premium subsidies are ending. In late December the federal government changed its position and allowed the Marketplace to explicitly notify consumers that they are scheduled to lose subsidies due to failure to file taxes. This should help consumers avoid confusion and needless delay in fixing the problem.

In January, we learned through a Vermont Department of Taxes legislative presentation that a significant number of very low income Vermonters had paid an individual shared responsibility penalty in prior years. This group of Vermonters very likely should not have owed a penalty. We submitted an informal information request to the IRS Taxpayer Advocate for the State of Vermont. The IRS Taxpayer Advocate investigated and found that the IRS had sent letters to those taxpayers who it identified as likely eligible for an affordability exemption from the individual mandate. We will continue to monitor this issue and encourage government agencies to engage in proactive outreach when they have information suggesting that taxpayers are being harmed by tax filing confusion.

The HCA also engages in tax-related outreach and educational activities. This quarter we developed a fact sheet to educate consumers and tax preparers on ways to reduce MAGI in order to qualify for more affordable health insurance or minimize APTC repayment. This effort is described below in the **Outreach and Education** section.

G. Other Activities

Administrative Advocacy

✧ Access to Screening Mammography

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

✧ Access to Treatment for Hepatitis C Virus

On January 1 Vermont Medicaid implemented new treatment guidelines for Hepatitis C Virus (HCV) based on the Drug Utilization Review Board (DURB) recommendation from October 2017. The new guidelines allow Medicaid beneficiaries with HCV to be treated regardless of their disease stage. This quarter the HCA worked with providers at the University of Vermont Medical Center and submitted a data and information request to DVHA to ensure that the new guidelines are fully implemented. This quarter we also submitted a data and information request to the Vermont Department of Corrections (VTDOC) to determine if people in the custody of VTDOC are receiving comparable HCV care to people in the community.

The HCA continues to actively participate in the Vermont Department of Health Hepatitis C Task Force, and our Policy Analyst is a member of the Task Force Steering Committee. We attended two meetings of the Task Force Steering Committee this quarter.

✧ Health Care Stop Loss Insurance

The Chief Advocate testified before the Legislative Committee on Administrative Rules about the Department of Financial Regulation's proposed modifications to stop loss insurance regulations (H-2009-02), which make it easier for companies to offer self-insured health plans. The HCA submitted written comments in the prior quarter. HCA's LCAR testimony repeated our written concerns that making it easier for small employers to self-insure undermines the State of Vermont's health care reform agenda. Increased self-insurance could hurt the small group market and consumers and places additional health insurance plans beyond the state's regulatory reach. Self-insured plans are not subject to many of the consumer protections of the Affordable Care Act, yet the offer of insurance can disqualify low and moderate-income consumers from subsidized ACA-regulated plans. We remain concerned about DFR's approach to this issue.

✧ Health Care Administrative Rules (HCAR)

The Agency of Human Services (AHS) continued its gradual and systematic revision of Medicaid rules known as the Health Care Administrative Rules (HCAR) project. HCA supports the project and has committed significant resources to leading VLA's review of all HCAR rules, both in draft form and when officially proposed.

This quarter we submitted substantial formal public comments on AHS's proposed HCAR rule on Internal Appeals, Grievances, Notices and State Fair Hearings on Medicaid Services. We raised significant concerns about how federal managed care reforms are implemented in Vermont in light of the unique

nature of Global Commitment. The comments were a joint effort with the Elder Law Project, the Disability Law Project, and the Vermont Ombudsman Project of VLA.

In January we also submitted formal public comments on Medicaid Cost-Sharing and Medicaid Benefit Delivery. These comments were a joint effort with the Elder Law Project and the Vermont Ombudsman Project of VLA.

Some HCAR rules on which we previously commented were finalized this quarter including Non-covered Services, which was substantially improved from the first draft on which we commented in 2017. This quarter we attended the Legislative Committee on Administrative Rules meeting at which this rule was reviewed.

HCA also coordinates VLA's response to HCAR developments on which we do not comment. One set of informal comments was submitted this quarter on Durable Medical Equipment, written by the Disability Law Project of VLA.

✧ **Comments on HHS proposed rule, "Protecting Statutory Conscience Rights in Health Care"**

The HCA submitted comments to the federal Department of Health and Human Services (HHS) in response to its proposed rule permitting increased discrimination in health care. The proposed regulation would exacerbate the challenges that many patients --especially women, LGBTQ people, people of color, immigrants and low-income people --already face in getting the health care they need in a timely manner and at an affordable cost. The rule would expose vulnerable patients to increased discrimination and denials of medically-indicated care by broadening religious health care provider exemptions beyond the existing limited circumstances allowed by law.

✧ **Vermont Health Connect Escalation Path**

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

✧ **Comments on Vermont Health Connect Notices**

At VHC's request, the HCA commented on 4 notices, in an effort to make them more readable and consumer-friendly. See **Promoting Plain Language in Health Communications** below.

✧ **Medicaid and Exchange Advisory Board**

This quarter, the Chief Health Care Advocate continue to co-chair and actively participate in Vermont's Medicaid and Exchange Advisory Board (MEAB).

Legislative Activities

The HCA has put considerable time and effort into focusing on legislative advocacy this quarter. A significant theme of this work has been in response to actions or potential actions from the Federal Government that would have a negative impact on the stability of Vermont's health insurance marketplace.

- **S.19** – Silver loading bill passed both houses and has been signed by the governor. The HCA joined with other advocates to successfully change the organization of Vermont's marketplace

to allow for a silver loading with reflective silver plans to maintain Cost Sharing Supports for lower income Vermont families and focusing those costs on premiums for people who receive Premium Tax Credits.

- Advocated for **H. 696** - Individual mandate bill passed the House and has not been acted upon by Senate Finance committee at the end of the quarter. This bill established a state individual mandate and established a working group to work over the interim to develop strategies to potentially establish penalties or incentives to maintain a high rate of health insurance participation.
- **H.892** – Short Term, Limited Duration health insurance coverage and Association Health Plan regulation bill passed the House and has not been acted upon by Senate Finance at the end of the quarter. This bill establishes that Short Term Limited Duration plans cannot be longer than 3 months and cannot be renewed in Vermont. It also requires the Department of Financial Regulation to engage in rulemaking to regulate Association Health Plans.
- **H.912** - An act relating to the health care regulatory duties of the Green Mountain Care Board. Passed by the House and has not been acted upon by Senate Health and Welfare as of the close of the quarter. The HCA engaged significantly and successfully on the CON portion of this bill as well as other incidental sections including the creation of a workgroup to focus on the regulation of freestanding health care facilities. H.912 was also the context in which we engaged in an important conversation about the HCA's ability to ask relevant questions in the Rate Review process. While this advocacy did not result in an update of the statutes, it did result in a memorandum from the Chair of Senate Health and Welfare calling on the GMCB and the HCA to improve the process to assure that the HCA is able to access the information it requests of carriers while not unjustifiably increasing the administrative burdens of the insurers.
- **S. 262** - An act relating to miscellaneous changes to the Medicaid program and the Department of Vermont Health Access. S. 262 passed the Senate and has not seen final action in the House Health Care committee as of the close of the quarter. The HCA and VLA advocated for some important changes to this bill with a focus on appropriate notice to applicants that DVHA is using electronic asset verification to review Medicaid eligibility, developing a system to give beneficiaries appropriate assistance asking for a fair hearing after an internal appeal, as well as a minor update to the factors that can lead to a secretary reversal of a HSB decision.
- **H. 905** - An act relating to the Green Mountain Care Board's bill back formula. This bill passed the House Health Care Committee and became a part of a larger tax bill in House Ways and Means. The HCA was a member of the stakeholder group that developed this proposal and supported its passage.
- **H. 404** - An act relating to Medicaid reimbursement for long-acting reversible contraceptives was passed by the House and is awaiting final action in Senate Health and Welfare at the end of the quarter. The HCA supported this bill in each stage of action.
- **H. 639** - An act relating to banning cost-sharing for all breast imaging services. This bill passed the House and has not seen substantial action in Senate Finance. This is a bill that the HCA requested legislators introduce this year.
- **H. 914** - An act relating to reporting requirements for the second year of the Vermont Medicaid Next Generation ACO Pilot Project. This bill passed the House and is awaiting final action in Senate Health and Welfare at the end of the quarter. The HCA generally supported this bill. We testified about specific areas of concern.
- **S. 53** - An act relating to a universal, publicly financed primary care system. S.53 has passed the Senate and is awaiting action in House Health Care. The HCA testified in favor of this bill in both the Senate and the House.

- **S. 176** - An act relating to the wholesale importation of prescription drugs into Vermont, bulk purchasing, and the impact of prescription drug costs on health insurance premiums. S.176 passed the Senate and is awaiting action from House Health Care. The HCA supports this bill and tracked it though the process.

Collaboration with Other Organizations

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

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Community Catalyst
- Families USA
- IRS Taxpayer Advocate Service
- Ladies First
- MVP Health Care
- OneCare Vermont
- Planned Parenthood of Northern New England
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Care Partners
- Vermont CARES
- Vermont Coalition of Clinics for the Uninsured
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Medical Society
- Vermont Program for Quality in Health Care
- VNAs of Vermont
- Voices for Vermont's Children

Outreach and Education

A. Increasing Reach and Education through the Website

Vermont Law Help is a statewide website maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section (*https://vtlawhelp.org/health*) with more than 250 pages of consumer-focused health information maintained by the HCA.

HCA advocates work diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

Popular Web Pages

- The total number of **health pageviews increased by 2%** in the reporting quarter ending March 31, 2018 (11,908 pageviews), compared with the same quarter in 2017 (11,676 pageviews).

- The **top-20 health pages** on our website this quarter with change over last year:
  - *Income Limits – Medicaid* – 3,320 pageviews (16% ↓)
  - *Health* – section home page – 1,515 (28% ↑)
  - *Resource Limits – Medicaid* – 496 (138% ↑)
  - *Services Covered by Medicaid* – 495 (41% ↑)
  - *Vermont Choices for Care* – 430 (6% ↑)
  - *Dental Services* – 370 (27% ↓)
  - *HCA Online Help Request Form* – 218 (85% ↑)
  - *Health Insurance, Taxes and You* – 205 (45% ↓)
  - *Buying Prescription Drugs* – 216 (41% ↑)
  - *Long-term Care* – 188 (68% ↑)
  - *Choices for Care Resource Limits* – 186 (39% ↑)
  - *Federally Qualified Health Centers* – 167 (27% ↑)
  - *Medicare Savings / Buy-In Programs* – 165 (14% ↑)
  - *Advance Directive Forms* – 148 (135% ↑)
  - *Choices for Care Income Limits* – 148 (9% ↓)
  - *Medicaid* – 148 (35% ↓)
  - *Prescription Assistance – State Pharmacy Programs* – 143 (86% ↑)
  - *Choices for Care Requirements* – 135 (100% ↑)
  - *Medicaid and Medicare dual eligible* – 131 (24% ↓)
  - *Medicaid Transportation* – 127 (119% ↑)

- Besides the pages listed above, other **spikes in interest** in our pages included:
  - *Health home page* – 1,515 (28% ↑)
  - *Long-term Care Help* (new page) – 91 (100% ↑)
  - *Medical Marijuana Registry Forms* – 33 (450% ↑)
  - *Health Centers and Clinics* – 27 (800% ↑)
  - *Get Help with Part D Costs* – 27 (200% ↑)
  - *Understanding Health Care Costs* – 25 (178% ↑)

Popular PDF Downloads

26 out of 75 or 35% **of the unique PDFs downloaded** from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:

- 16 were created for consumers. The top five consumer-focused PDF downloads were:
  - *Advance Directive, short form* (124 downloads)
  - *Advance Directive, long form* (89 downloads)
  - *Vermont Dental Clinics Chart* (75 downloads)
  - *Simple 5-Step Guide to Getting DME through Medicaid* (40 downloads)
  - *Vermont Medicaid Coverage Exception Request Form* (29 downloads)
  - The advance directive forms were accessed much more often this year as compared to the same period last year (213 downloads versus 64 last year).
- 4 were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused download was:
  - *PTC Rule Allocation Summary* (11 downloads)
- 6 covered topics related to health policy. The top policy-focused download was:
  - *VT ACO Shared Savings Program Quality Measures* (6 downloads)

The *Advance Directive Short Form* is the **fifth most downloaded of all PDFs** downloaded from the entire Vermont Law Help website. The *Long Form* is the **seventh most downloaded**.

The *Vermont Dental Clinics Chart* is the **eighth most downloaded of all PDFs** downloaded from the entire Vermont Law Help website.

New Online Help Tool Adds to Our Reach

In 2017 we added a new Health section to the online help tool on our website. It is found at *https://vtlawhelp.org/triage/vt_triage* and it can be accessed from most pages of our website. Our first Health topic was posted in June and a final section was added in October 2017.

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

Website visitors used this new tool to access health care information **161 times** during this quarter. That's an **18% increase** over the previous quarter.

Of the 44 health care topics that were accessed using this tool, the top topics were:

- Dental Services - I need help finding a low-cost dentist and paying for dental care.
- Dental Services - I need help with dentures.
- Long-Term Care - I have a nursing home complaint.
- Long-Term Care - I want to go over my long-term care options (nursing homes, in-home care, and more).
- Long-Term Care - How do I know if I can get Choices for Care Long-Term Care Medicaid?

B. Other Outreach and Educational Activities

Legislative Day (January 12, 2017)

HCA advocates participated in an outreach event at the Statehouse. HCA advocates talked about constituent services and distributed brochures.

Outreach at the Community Health Center (January 24, 2018)

HCA advocates visited the Community Health Center to discuss Medicaid coverage rules for transgender patients and explain how the HCA advocates for patients.

Kinney Drug Referral Program (February and March 2018)

HCA advocates visited Kinney drugstores throughout the state to discuss the HCA and our referral program and the HCA's policy initiatives for drug coverage.

Tax Time PTC Reminder Fact Sheet (March 8, 2018)

The HCA developed a simple fact sheet to inform consumers and tax preparers of the Premium Tax Credit's benefit cliff at 400% of the federal poverty line. The fact sheet tells consumers they may be able to save significantly on their health insurance and tax credits by contributing money to a retirement

plan. In some cases contributions can be made until the tax filing deadline. The HCA urged consumers to consult their tax advisor to see if they could lower their income for PTC purposes. HCA partnered with the Vermont Department of Taxes to distribute the fact sheet through the Department of Taxes' subscription email lists.

Meeting with Public Defender's Office (March 13, 2018)

HCA advocates met with the Public Defender's office and explained what the HCA does and how we can help. The advocates shared HCA cards and brochures.

Are You Leaving Money on the table? (April 9, 2018)

Mike Fisher, the Chief Health Care Advocate, went on WDEV Radio to educate Vermonters about the opportunities for tax credits and promote the HCA's Tax Time PTC Reminder fact sheet.

C. Promoting Plain Language in Health Communications

During this quarter, the HCA provided feedback and revisions to promote the use of plain language and increase consumers' accessibility to and understanding of important communications from the state and other health organizations regulated by the state. The HCA made plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:

- Macros Language Review
- Macros with Referral to VHC
- EE605-MM, Withdrawn cases-Active MCA
- Dr. D premium reduction notices

Office of the Health Care Advocate

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

http://www.vtlegalaid.org/health

CY 2018 Investment Expenditures

Department	STC #	Investment Description	QE 0318	QE 0618	QE 0918	QE 1218	CY 2018 Total
AHSCO	41	Investments (STC-79) - 2-1-1 Grant (41)	113,250				**113,250**
AHSCO	54	Investments (STC-79) - Designated Agency Underinsured Services (54)	1,664,645				**1,664,645**
AOE	11	Non-state plan Related Education Fund Investments	-				**-**
DCF	55	Investments (STC-79) - Medical Services (55)	17,267				**17,267**
DCF	1	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)	2,208,458				**2,208,458**
DCF	56	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	-				**-**
DCF	57	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	-				**-**
DCF	58	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	-				**-**
DCF	59	Investments (STC-79) - Essential Person Program (59)	226,081				**226,081**
DCF	60	Investments (STC-79) - GA Medical Expenses (60)	54,512				**54,512**
DCF	61	Investments (STC-79) - Therapeutic Child Care (61)	500,417				**500,417**
DCF	2	Investments (STC-79) - Lund Home (2)	555,306				**555,306**
DCF	33	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)	-				**-**
DCF	34	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	25,646				**25,646**
DCF	9	Investments (STC-79) - Challenges for Change: DCF (9)	64,015				**64,015**
DCF	26	Investments (STC-79) - Strengthening Families (26)	215,717				**215,717**
DCF	62	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	54,750				**54,750**
DCF	35	Investments (STC-79) - Building Bright Futures (35)	117,644				**117,644**
DDAIL	63	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	95,581				**95,581**
DDAIL	64	Investments (STC-79) - DS Special Payments for Medical Services (64)	515,509				**515,509**
DDAIL	27	Investments (STC-79) - Flexible Family/Respite Funding (27)	614,914				**614,914**
DDAIL	42	Investments (STC-79) - Quality Review of Home Health Agencies (42)	-				**-**
DDAIL	43	Investments (STC-79) - Support and Services at Home (SASH) (43)	13,291				**13,291**
DDAIL	77	Investments (STC-79) - HomeSharing (77)	82,404				**82,404**
DDAIL	78	Investments (STC-79) - Self-Neglect Initiative (78)	140,884				**140,884**
DDAIL	65	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)	17,807				**17,807**
DMH	28	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	28,098				**28,098**
DMH	66	Investments (STC-79) - MH Outpatient Services for Adults (66)	858,990				**858,990**
DMH	79	Investments (STC-79) - Mental Health Consumer Support Programs (79)	116,533				**116,533**
DMH	16	Investments (STC-79) - Mental Health CRT Community Support Services (16)	509,282				**509,282**
DMH	12	Investments (STC-79) - Mental Health Children's Community Services (12)	1,147,730				**1,147,730**
DMH	29	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,330,483				**2,330,483**
DMH	67	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	302,856				**302,856**
DMH	22	Investments (STC-79) - Emergency Support Fund (22)	256,829				**256,829**
DMH	3	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH	6,338,831				**6,338,831**
DMH	3	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR	954,387				**954,387**
DMH	68	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	2,475				**2,475**
DMH	13	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	122,391				**122,391**
DOC	4	Return House	117,001				**117,001**
DOC	5	Northern Lights	98,438				**98,438**
DOC	6	Pathways to Housing	227,728				**227,728**
DOC	14	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	193,405				**193,405**
DOC	15	Northeast Kingdom Community Action	-				**-**
DOC	69	Intensive Substance Abuse Program (ISAP)	-				**-**
DOC	70	Intensive Domestic Violence Program	-				**-**
DOC	71	Community Rehabilitative Care	638,456				**638,456**
DOC	80	Intensive Sexual Abuse Program	2,615				**2,615**
DVHA	8	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)	467,851				**467,851**
DVHA	51	Investments (STC-79) - Vermont Blueprint for Health (51)	869,072				**869,072**
DVHA	52	Investments (STC-79) - Buy-In (52)	9,916				**9,916**
DVHA	53	Investments (STC-79) - HIV Drug Coverage (53)	668				**668**
DVHA	18	Investments (STC-79) - Patient Safety Net Services (18)	70,560				**70,560**
DVHA	7	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	1,695,275				**1,695,275**
DVHA	72	Investments (STC-79) - Family Supports (72)	-				**-**
GMCB	45	Green Mountain Care Board	384,321				**384,321**
UVM	10	Vermont Physician Training	1,011,554				**1,011,554**
VAAFM	36	Agriculture Public Health Initiatives	-				**-**
VDH	19	Investments (STC-79) - Emergency Medical Services (19)	178,201				**178,201**
VDH	74	Investments (STC-79) - TB Medical Services (74)	37,827				**37,827**
VDH	40	Investments (STC-79) - Epidemiology (40)	291,293				**291,293**
VDH	39	Investments (STC-79) - Health Research and Statistics (39)	427,372				**427,372**
VDH	31	Investments (STC-79) - Health Laboratory (31)	869,855				**869,855**
VDH	50	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	253,040				**253,040**
VDH	76	Investments (STC-79) - Statewide Tobacco Cessation (76)	-				**-**
VDH	75	Investments (STC-79) - Family Planning (75)	352,008				**352,008**
VDH	25	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	466,555				**466,555**
VDH	73	Investments (STC-79) - Renal Disease (73)	-				**-**
VDH	37	Investments (STC-79) - WIC Coverage (37)	1,091,956				**1,091,956**
VDH	21	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	375,000				**375,000**
VDH	47	Investments (STC-79) - Patient Safety - Adverse Events (47)	12,000				**12,000**
VDH	30	Investments (STC-79) - Substance Use Disorder Treatment (30)	2,206,803				**2,206,803**
VDH	17	Investments (STC-79) - Recovery Centers (17)	371,652				**371,652**
VDH	46	Investments (STC-79) - Enhanced Immunization (46)	30,984				**30,984**
VDH	48	Investments (STC-79) - Poison Control (48)	84,756				**84,756**
VDH	23	Investments (STC-79) - Public Inebriate Services, C for C (23)	297,954				**297,954**
VDH	38	Investments (STC-79) - Fluoride Treatment (38)	13,573				**13,573**
VDH	24	Investments (STC-79) - Medicaid Vaccines (24)	-				**-**
VDH	49	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	51,032				**51,032**
VDH	44	Investments (STC-79) - VT Blueprint for Health (44)	535,790				**535,790**
VSC	32	Health Professional Training	204,730				**204,730**
VVH	20	Vermont Veterans Home	-				**-**
			34,206,221	**-**	**-**	**-**	**34,206,221**

P MCO_Investment Institution for Mental Disease (IMD) Services: DMH (3) - Vermont Psychiatric Care Hospital

What We Do

Description/Objective:

This investment pays for direct care costs (i.e. psychiatric care, medication therapy, counseling, activities of daily living, etc.) at Vermont Psychiatric Care Hospital (VPCH). VPCH is a 25-bed, acute care hospital located in Berlin, Vermont that offers patient areas designed for care, comfort, and safety. Patients are encouraged to engage in all aspects of prescribed treatment and participate in activities that will facilitate recovery. The investment funds staff time and patient care at VPCH.

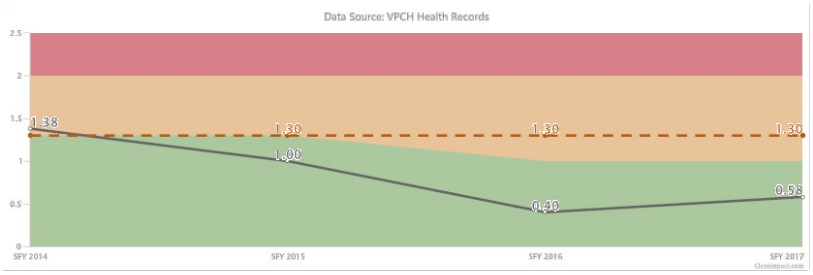
Interpretation of Results

Since its opening in FY 2015, VPCH has been committed to several initiatives related to patient care and patient satisfaction with services.

Seclusions and restraints have been below established targets for 3 of the last 4 years of reporting, due to VPCH's participation in SAMHSA's Six Core Strategies for reducing seclusion and
restraint. As VPCH has been accepting more acute inpatient stays across the system of care, it has still been able to decrease average length of stay for discharged patients and involuntary readmissions have remained stable over the past year. In 2016 VPCH met its target of lowering readmission rates.

Performance Measures

PM How_Well # hours of seclusion and restraint per 1,000 patient hours



Time Period	Actual Value	Target Value	Current Trend
SFY 2017	0.58	1.30	↗ 1
SFY 2016	0.40	1.30	↘ 2
SFY 2015	1.00	1.30	↘ 1
SFY 2014	1.38	1.30	→ 0

Story Behind the Curve

We want the # of hours of seclusion and restraint to go down.

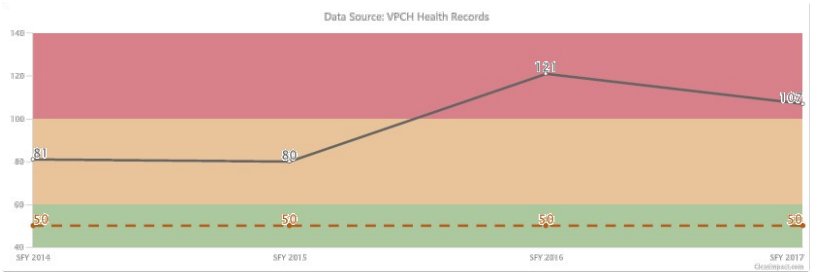
Providing patient care in an environment that is safe and supportive is important for recovery. VPCH, through its work with the SAMHSA Six Core Strategies for Reducing seclusion and restraint has lowered its rate of seclusion and restraint to approximately one half-hour per 1,000 patient hours, which is almost an hour less than the established target.

Updated February 2018

Notes on Methodology

Data is calculated using reports of emergency involuntary procedures (EIPs) and total patient hours captured by VPCH's electronic medical record. The rate is calculated by dividing the total hours of seclusion and restraint divided by the total patient hours and multiplied by 1,000. This rate is the nationally established metric for reporting EIPs.

PM How_Well Average length of stay in days for discharged patients

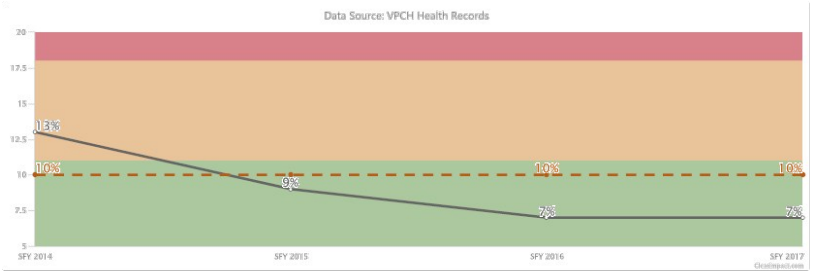


SFY 2017	107	50	↘ 1
SFY 2016	121	50	↗ 1
SFY 2015	80	50	↘ 1
SFY 2014	81	50	→ 0

Story Behind the Curve

While the average length of stay at VPCH is higher than the target rate, the length of stay has decreased over the past year by 2 weeks. VPCH has also been accepting more acute patients resulting in longer stays, thereby creating a slight drop in the inpatient census over the year.

PM How_Well % of discharges readmitted involuntarily within 30 days of discharge



SFY 2017	7%	10%	→ 1
SFY 2016	7%	10%	↘ 2
SFY 2015	9%	10%	↘ 1
SFY 2014	13%	10%	→ 0

Story Behind the Curve

In 2016, VPCH met its target of 10% of patients' that were discharged were readmitted involuntarily within 30 days. VPCH maintained this target rate for 2017.

Our Work Helps Turn These Indicators

	Time Period	Actual Value	Target Value	Current Trend
O MCO_Investment Increase the access of quality healthcare to the uninsured, underinsured, and Medicaid beneficiaries				

Actions

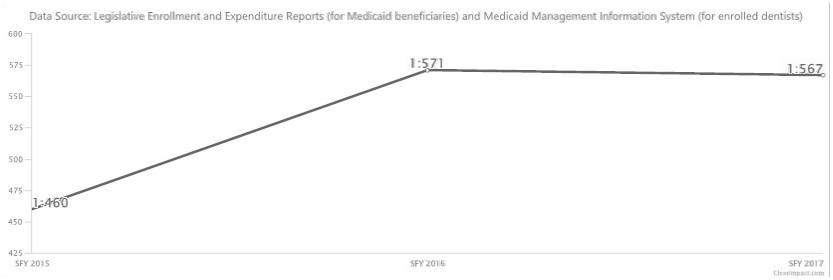
Name	Assigned To	Status	Due Date	Progress

DVHA Dental Incentive Program

The Dental Incentive Program was created to recognize and reward dentists who serve Medicaid beneficiaries and to improve access to dental care. Twice a year, an incentive payment is given to dental practices who, over the last 6-month period, provided more than $50,000 in services.

This scorecard is updated every six months and tracks a) the total number of providers eligible for the incentive payment and b) the number of dental providers in Vermont relative to the total Medicaid population.

O DVHA All Vermonters Are Healthy	Time Period	Actual Value	Current Trend	Baseline % Change
I DVHA # of VT Medicaid-enrolled dental providers relative to the total # of VT Medicaid beneficiaries	SFY 2017	1:567	↘ 1	23% ↑
	SFY 2016	1:571	↗ 1	24% ↑
	SFY 2015	1:460	→ 0	0% →



Notes on Methodology

- The data value used for beneficiary enrollment is the State Fiscal Year (SFY) total, or the timeframe of July 1 – June 30th.
- The data value used for dentists is the number of Vermont Medicaid-enrolled dentists as of Jan. 1 each year.

Partners

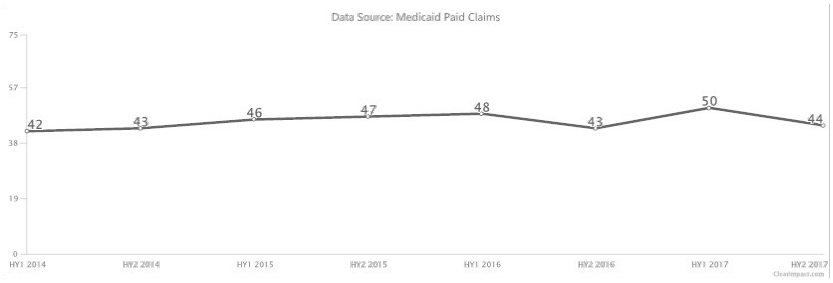
- Department of Vermont Health Access (DVHA) - multiple units: Clinical Operations (Dental staff), Provider & Member Relations, Data and Quality
- Vermont Medicaid Policy Unit
- Vermont Department of Health Dental Program
- Vermont Dentists
- Vermont Dental Society

Story Behind the Curve

DVHA set its baseline for this measure as SFY 2015 due to the implementation of the Affordable Care Act (ACA) and the transition in enrollment numbers prior to that date.

This measure shows the number of Vermont Medicaid enrolled dentists relative to the number of VT Medicaid beneficiaries. For example during SFY 2017 there was one Medicaid enrolled dentist for every 567 Medicaid beneficiaries. For this measure, a lower ratio is better. The number of dentists has decreased since SFY 2015, which is translating into a higher dentist to beneficiary ratio.

P DVHA DVHA Dental Incentive Program	Time Period	Actual Value	Current Trend	Baseline % Change
PM DVHA # of dental practices eligible for supplemental dental payment (total Medicaid paid claims of $50k or more)	HY2 2017	44	↘ 1	33% ↑



HY1 2017	50	↗	1	52% ↑
HY2 2016	43	↘	1	30% ↑
HY1 2016	48	↗	5	45% ↑
HY2 2015	47	↗	4	42% ↑
HY1 2015	46	↗	3	39% ↑
HY2 2014	43	↗	2	30% ↑
HY1 2014	42	↗	1	27% ↑
HY2 2013	31	↘	1	-6% ↓
HY1 2013	36	↗	2	9% ↑

Notes on Methodology

- This measure is calculated on the half calendar year (CY). Payments are made in the fall for services provided January - June of each year (HY1), and then again in the spring for services provided July - December of each year (HY2). The delay in payment is due to claims run out.

Partners

- Department of Vermont Health Access (DVHA) - multiple units: Clinical Operations (Dental staff), Provider & Member Relations, Data and Quality
- Vermont Medicaid Policy Unit
- Vermont Department of Health Dental Program
- Vermont Dentists
- Vermont Dental Society

Story Behind the Curve

For SFY 2008 and beyond, the Vermont Legislature authorized DVHA to begin distributing $292,836 annually to support the program. The DVHA and the VSDS agreed that the funds would be distributed bi-annually; distributions of $146,418 are made in the spring and fall, for an annual total of $292,836. Each dental practice that receives $50,000 or more biannually in Medicaid paid claims is eligible for the payment. The amount paid is calculated as a percentage of the Medicaid claims paid. Historically, 36-48 dentists have qualified for semi-annual payouts and a share of the $146,418 available.

Action Plan

The Dental Incentive program data is reviewed two times per year. In addition, the Agency would like to collect and analyze additional dental measures in order to make system improvements. The Policy Unit is convening a workgroup focused on dental quality generally (not specific to just this incentive program) in order to get a better understanding of what dental data we currently have or want, how we track it, and what we are going to do with it. This will ensure that we have a process to collect, analyze and take action on findings when determined necessary.
